*African Journal of Research in Medical and Health Sciences*
https://doi.org/10.71921/ajrmhs.vol4no1.112

*RESEARCH* *Open Access*

# EXPLORING CAREGIVERS' PERCEPTIONS OF HEALTH CHALLENGES AMONG INTERNALLY DISPLACED CHILDREN IN BANDITRY-AFFECTED COMMUNITIES OF SOKOTO STATE, NIGERIA

Usamatu Abubakar Tarah[1], Umar Yunusa[2], Suberu Ahmad[2], Nasiru Yawale[3], Saadatu Abdullahi[4]

***Correspondence:** Usamatu Abubakar Tarah; **Email:** usamatarah@gmail.com

## Abstract

**Background:** Children displaced by banditry face heightened health risks driven by economic instability, inadequate healthcare access, and unsafe living conditions. Caregivers play a central role in shaping child health outcomes; however, limited research has explored how they perceive and interpret health challenges within displacement settings. This study examined caregivers' perspectives on the health challenges affecting internally displaced children in Sokoto State, Nigeria.

**Methods:** A qualitative descriptive study informed by phenomenological principles was conducted across five internally displaced persons (IDP) camps in Sokoto State, Nigeria. Purposive sampling was used to recruit caregivers of internally displaced children. In-depth, semi-structured interviews were conducted until information redundancy was achieved (n = 11). Interviews were audio-recorded, transcribed verbatim, translated where necessary, and analysed inductively using Braun and Clarke's reflexive thematic analysis approach. Credibility and rigor were enhanced through reflexive journaling, peer debriefing, consensus-based coding, and member checking. Ethical approval was obtained from the Sokoto State Ministry of Health Research Ethics Committee.

**Results:** Four interconnected themes were identified: (1) economic hardship shaping food insecurity and child vulnerability; (2) barriers to healthcare access influenced by financial constraints and perceived inequities; (3) unsafe living conditions contributing to recurrent illness; and (4) reliance on community and external support as adaptive coping mechanisms. Across themes, caregiving emerged as a continuous negotiation with structural instability, reflecting adaptive resilience under constrained conditions.

**Conclusion:** Child health challenges in displacement are multidimensional and embedded within broader socio-economic and environmental stressors. Interventions should be grounded in caregivers' lived experiences and focus on strengthening nutrition support, environmental conditions, accessible community-based healthcare, and caregiver capacity to enhance sustainable child health outcomes in displacement settings.

**Keywords:** *Internally displaced persons; Child health; Caregiver perspectives; Qualitative research; Banditry; Nigeria; Humanitarian settings.*

Cite as*: Tarah UA, Yunusa U, Ahmad S, Yawale N, Abdullahi S. Exploring Caregivers' Perceptions of Health Challenges Among Internally Displaced Children In Banditry-Affected Communities of Sokoto State, Nigeria. AJRMHS. 2026; 4(1): 79 - 87*

## Introduction

Armed banditry has become a sustained driver of internal displacement in north-western Nigeria, particularly in Sokoto State. Beyond episodic violence, attacks on rural communities have disrupted agrarian livelihoods, weakened social support networks, and forced families into informal settlements and host communities where access to basic services is limited. Displacement in this context is not only a security concern but also a structural disruption that reshapes everyday life, including how families secure food, shelter, and healthcare. Children, who constitute a substantial proportion of the displaced population, are especially affected because their survival and development depend heavily on stable caregiving environments and consistent access to health-promoting resources.[1–3]

Research from conflict-affected settings consistently shows that child health risks in displacement contexts arise from intersecting conditions rather than isolated exposures. Food insecurity, overcrowded shelter, unsafe water, interrupted immunisation services, and weak primary healthcare systems interact to increase susceptibility to preventable illnesses such as diarrhoeal diseases, malaria, respiratory tract infections, and undernutrition.[4–6] In north-western Nigeria, these vulnerabilities are compounded by longstanding rural health system limitations, including shortages of trained personnel, essential medicines, and functional facilities.[7–9] Consequently, displacement intensifies pre-existing inequities, creating layered risks that disproportionately affect children.

However, much of the existing evidence in Nigeria and comparable contexts has focused on quantifying disease prevalence, service availability, or humanitarian coverage indicators.[10–12] While such data are essential for public health planning, they offer limited understanding of how health challenges are perceived and negotiated within displaced households. Epidemiological patterns do not automatically translate into insight about how caregivers interpret symptoms, prioritise competing needs, decide when and where to seek care, or cope with barriers such as cost, insecurity, and cultural expectations.

Caregivers occupy a pivotal position in child health trajectories. Their beliefs, experiences, and interpretations influence feeding practices, hygiene behaviours, treatment choices, and engagement with formal and informal support systems.[13–15] In displacement settings, caregiving occurs under constrained circumstances shaped by poverty, trauma exposure, disrupted livelihoods, and altered community structures. These contextual realities influence not only access to services but also perceptions of illness severity, perceived efficacy of available care, and trust in health providers. Without exploring these subjective dimensions, interventions risk overlooking the social and cultural logics that guide health-related decision-making.

Despite increasing banditry-related displacement in Sokoto State, limited research has examined child health challenges from caregivers' perspectives. Existing studies largely privilege institutional or service-level viewpoints, leaving a gap in understanding the lived experiences of families navigating child illness within displacement. Addressing this gap requires an approach that centres meaning, context, and interpretation rather than solely measuring outcomes.

This study is therefore informed by a qualitative paradigm that recognises reality as socially constructed and shaped

by lived experience. Guided by Betty Neuman's Systems Model, which conceptualises individuals as open systems exposed to environmental stressors[13], the study explores how caregivers perceive and make sense of stressors such as food scarcity, inadequate shelter, poor sanitation, and limited healthcare access. By eliciting caregivers' narratives, the study seeks to illuminate how these stressors are experienced at household level, how protective resources are mobilised, and what support mechanisms are perceived as most needed.

Accordingly, this study explores caregivers' perceptions of the health challenges faced by internally displaced children in banditry-affected communities of Sokoto State, Nigeria. By foregrounding lived experience and contextual meaning, the study aims to generate nuanced, context-sensitive evidence to inform culturally responsive health policies, community-based interventions, and humanitarian programming.

## Methods

### Study Design

This study adopted a qualitative research design using a qualitative descriptive approach informed by phenomenological principles, rather than a strictly Husserlian descriptive phenomenology, to explore caregivers' lived experiences and perceptions of the health challenges faced by internally displaced children[13]. While the study was grounded in phenomenological sensitivity to participants' lived experiences, the primary aim was to provide a rich, contextually grounded description of caregivers' perspectives rather than to derive transcendental essences in the Husserlian tradition.

The approach was selected to obtain rich, first-hand accounts of how caregivers interpret and make meaning of their children's health problems within the context of displacement. Bracketing was operationalized through structured reflexive practices rather than as a transcendental reduction. Reflexive journaling was maintained before, during, and after interviews to document researchers' assumptions, professional backgrounds, and emerging interpretations, thereby actively monitoring and managing potential bias throughout data collection and analysis.

### Study Setting

The study was conducted in selected internally displaced persons (IDP) camps within Sokoto East Senatorial District, northwestern Nigeria, an area heavily affected by banditry and communal violence. Selected camps included Guiwa Eka, Guiwa Lowcost, Ramin Kura, Gidan Igwe, and Shiyar Gagi. These camps vary in size, population density, and access to services, reflecting the diversity of displacement experiences.

The camps consist of temporary shelters made from tarpaulin sheets, metal, and locally sourced wood. Access to basic amenities such as clean water, sanitation, and healthcare is limited, with many families relying on humanitarian organizations and community initiatives for food, medical care, and psychosocial support. Overcrowding and poor environmental conditions increase the risk of communicable diseases, malnutrition, and other child health challenges. This setting provides a natural context to explore caregivers' perceptions of child health challenges amid displacement.

**Study Population and Sampling**

The study population comprised adult caregivers responsible for the daily care of internally displaced children in the selected camps. Purposive sampling was used to recruit participants who were information-rich and could provide detailed insights into child health challenges. Inclusion criteria were caregivers aged 18 years and above, who had lived in the camps for at least six months and were directly responsible for one or more children. Although both male and female caregivers were eligible, all participants who consented and met the criteria were female, reflecting the gendered nature of caregiving roles in the study setting.

Sample size was guided by the principle of data saturation and information power, rather than statistical representativeness. A total of eleven (n=11) caregivers participated in the study. Within qualitative descriptive and phenomenologically informed inquiry, smaller samples are appropriate when participants share specific experiential knowledge and the research aim is narrow and focused. Interviews were conducted until no new codes or meaning units emerged from successive interviews. Saturation was observed after the tenth interview, and the eleventh interview confirmed redundancy, with no substantially new insights generated. The sample was therefore considered sufficient to achieve depth of understanding and analytic adequacy.

**Data Collection**

Data were collected using a semi-structured interview guide developed from the study objectives and relevant literature and aligned with the Neuman Systems Model. The guide was translated into Hausa and reviewed by bilingual experts. A pilot interview was conducted to ensure clarity and cultural appropriateness. Interviews explored caregivers' perceptions of common childhood illnesses, nutrition, environmental risks, access to healthcare, and available support systems.

Interviews were conducted face-to-face in quiet locations within the camps, lasted approximately 30–35 minutes, and were audio-recorded with participants' permission. Verbal consent was obtained due to low literacy levels and was approved by the ethics committee. All interviews were transcribed verbatim and translated into English. Back-translation of selected transcripts by an independent bilingual researcher was performed to ensure semantic accuracy.

**Data Analysis**

Data were analysed using Braun and Clarke's six-phase reflexive thematic analysis approach: familiarization with data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

Thematic analysis was selected for its flexibility and suitability for identifying patterns of meaning across participants' accounts while remaining grounded in their expressed experiences. Analysis was inductive and data-driven, with themes developed from participants' narratives rather than imposed a priori.

Coding was conducted independently by two researchers during the initial stages of analysis. Rather than calculating statistical inter-coder agreement, coding consistency was enhanced through iterative discussions and consensus-building meetings. Discrepancies in coding were examined

reflexively, and differences in interpretation were resolved through dialogue and re-examination of the original transcripts. This consensus-based analytic process aligns with qualitative rigor principles that prioritise interpretive depth over quantitative reliability metrics.

Rigor was ensured using Lincoln and Guba's criteria. Credibility was enhanced through prolonged engagement, peer debriefing, and member checking, in which the researcher read the translated transcripts aloud to participants and discussed the content to confirm accuracy, since participants were unable to read the transcripts themselves. Dependability was supported by maintaining an audit trail of methodological decisions. Confirmability was strengthened through reflexive journaling, documentation of analytic decisions, and transparent theme development. Transferability was enhanced by providing detailed descriptions of the study context and participants.

**Reflexivity**

Given the researchers' professional backgrounds in health sciences, reflexivity was treated as an ongoing analytic process rather than a single procedural step. Prior to data collection, each researcher documented personal assumptions about displacement and child health. During analysis, reflexive memos were maintained to record evolving interpretations, emotional responses, and potential biases. These memos were reviewed during analytic meetings to ensure that emerging themes remained grounded in participants' accounts rather than researchers' preconceptions.

**Ethical Approval**

Ethical approval was obtained from the Sokoto State Ministry of Health Research Ethics Committee (Ref: SMH/1580/V.IV). Participants were fully informed of the study purpose, voluntary nature of participation, and their right to withdraw at any time. Verbal informed consent was obtained and audio-recorded, rather than written consent, because most participants were unable to read or write. Confidentiality was ensured by assigning unique identification codes, removing personal identifiers, and securely storing data in password-protected files. Interviews were conducted privately to protect participants' dignity, safety, and privacy.

## Results

**Themes and Sub-Themes:**

**Theme 1: Economic Hardships and Child Health**

Caregivers described extreme financial hardship as a central consequence of displacement. Loss of homes, livestock, and livelihoods resulted in food insecurity and dependence on informal survival strategies.

> *"Anyone forced to leave their home may be left with no option but to beg for food." (P1)*
>
> *"The primary health challenge is hunger." (P9)*

Caregivers frequently described children as weak, frequently ill, or persistently hungry. Rather than representing isolated nutritional deficits, these accounts reflect how economic instability shaped everyday caregiving decisions and constrained caregivers' capacity to maintain children's physical stability.

**Table 1: Socio-demographic profile of caregivers of internally displaced children (n = 11)**

| Variable | Category | Frequency n (%) |
|---|---|---|
| Age (years) | 18–30 | 2 (18.2) |
| | 31–40 | 3 (27.3) |
| | 41–50 | 4 (36.4) |
| | ≥51 | 2 (18.2) |
| Gender | Female | 11 (100) |
| Ethnicity | Hausa | 4 (36.4) |
| | Fulani | 2 (18.2) |
| | Other* | 5 (45.5) |
| Education | No formal | 10 (90.9) |
| | Primary | 1 (9.1) |
| Occupation | Unemployed | 4 (36.4) |
| | Informal/Other† | 7 (63.6) |
| Religion | Islam | 11 (100) |
| Marital Status | Married | 6 (54.5) |
| | Divorced/Separated | 3 (27.3) |
| | Widowed | 2 (18.2) |
| Displacement Duration | 6 months – 1 year | 2 (18.2) |
| | ≥1 year | 9 (81.8) |
| Place of Displacement | Ramin Kura | 3 (27.3) |
| | Guiwa Eka | 2 (18.2) |
| | Guiwa Tanki | 2 (18.2) |
| | Gagi | 2 (18.2) |

*Other ethnicities included minority northern groups.

†Informal/Other occupations include petty trade, casual labour, and other informal work.

**Theme 2: Healthcare Accessibility Barriers**

Financial constraints were consistently identified as barriers to seeking care.

> *"They treat our children based on the money we have to give." (P2)*

Caregivers' narratives suggest that access to healthcare was experienced not only as a financial challenge but as a negotiation shaped by perceived inequities, limited service responsiveness, and reduced trust in formal systems.

**Theme 3: Living Conditions and Environmental Exposures**

Participants linked children's illnesses to overcrowding, poor sanitation, and environmental hazards.

> *"Living in such an environment with offensive smells causes vomiting, diarrhea, and fever." (P1)*

> *"My child died within a day from diarrhea and vomiting." (P4)*

> *"There is a new disease… the abdomen of the children swells." (P6)*

Descriptions such as abdominal swelling are reported as caregivers' observations and may reflect underlying nutritional or health concerns; no clinical diagnosis is inferred.

**Theme 4: Community and External Support**

Caregivers emphasized reliance on camp leaders, neighbors, and humanitarian actors.

> *"The camp leader is understanding… she cooks and shares food when donations come." (P6)*

Support networks functioned as adaptive mechanisms through which caregivers attempted to buffer children from environmental and economic stressors.

**Integrative Experiential Synthesis**

Across themes, caregiving under displacement emerged as a continuous negotiation with instability. Rather than discrete categories of hardship, caregivers described managing overlapping stressors, food scarcity, environmental hazards, financial constraints, and limited healthcare access, while striving to preserve their children's survival and dignity. The shared experiential pattern reflects adaptive resilience under structural constraint, where caregiving involves balancing competing needs within severely limited resources.

## Discussion

This study explored caregivers' perceptions of health challenges faced by internally displaced children in Sokoto State. While the findings reflect recognizable humanitarian realities such as poverty, limited healthcare access, unsafe shelter, and reliance on communal assistance, the analysis reveals a deeper experiential pattern.

Caregiving under displacement emerged as a sustained negotiation with structural instability rather than exposure to isolated hardships. Across narratives, caregivers described managing overlapping stressors that continuously threatened their children's survival and wellbeing. These stressors were not experienced separately but interacted in ways that compounded vulnerability.

**Theoretical Integration**

Interpreted through Neuman's Systems Model, displacement functions as a constellation of intrapersonal, interpersonal, and extrapersonal stressors that weaken children's lines of defence. Poverty, environmental hazards, and constrained healthcare systems operate as extrapersonal stressors that challenge physiological and psychosocial stability.

Within this framework, caregiving practices such as rationing food, prioritizing urgent health concerns, and seeking assistance from community members represent lines of resistance. These actions reflect deliberate efforts to restore balance and preserve child stability despite constrained resources. This interpretation positions caregivers not as passive victims of crisis but as active agents attempting to maintain system equilibrium within structurally limiting conditions.

**Economic Hardship and Child Health**

Caregivers consistently framed hunger as the primary health concern affecting their children. Beyond nutritional deprivation, hunger symbolized the erosion of livelihood security and parental capacity to provide adequately.

These findings align with Salami et al.[18] who reported compounded health risks among internally displaced children linked to poverty and disrupted social systems. Displacement tracking data from the International Organization for Migration[21] further indicate that prolonged displacement in Nigeria weakens household economic resilience. UNHCR reports[19] similarly emphasize that protracted displacement often entrenches dependency and reduces livelihood recovery. The present findings extend this evidence by demonstrating how economic hardship reshapes daily caregiving decisions and generates persistent uncertainty.

**Healthcare Accessibility**

Access to healthcare was described as contingent and uncertain. Caregivers indicated that treatment decisions were influenced by financial capacity and perceptions of fairness and responsiveness within health facilities.

These accounts resonate with Roberts et al.[17] who identified service gaps and cost barriers as determinants of healthcare utilization among displaced populations in Nigeria. However, this study adds interpretive depth by illustrating how trust, perceived dignity, and relational experiences shape care seeking behaviour. Healthcare access therefore operates not only as a structural issue but also as an experiential one.

**Living Conditions and Environmental Exposure**

Overcrowding and inadequate sanitation were described as persistent threats to children's health. Participants linked environmental conditions to recurrent illness and general weakness. Consistent with broader humanitarian evidence[18], poor shelter conditions and inadequate water and sanitation infrastructure remain significant determinants of morbidity in displacement settings. Within Neuman's framework, these environmental factors represent continuous extra personal stressors that erode child stability over time. Descriptions such as abdominal swelling are presented as caregiver observations and may reflect underlying health concerns without implying clinical diagnosis**.**

**Community Support**

Community solidarity functioned as an important protective resource. Caregivers relied on camp leaders and neighbours for assistance when resources were scarce. This finding parallels Meyer et al.[20] who demonstrated that social support networks buffer psychosocial stress among displaced populations. Social capital therefore operates as a line of resistance that mitigates destabilizing stressors. Nevertheless, reliance on informal networks also reflects systemic gaps in institutional protection as highlighted in UNHCR[19] and International Organization for Migration[21] reports.

**Shared Experiential Meaning**

Collectively, the findings articulate a shared experiential meaning of caregiving under displacement as the effort to maintain child stability amid chronic uncertainty. Caregivers described balancing food, health needs, shelter, and safety within severely constrained circumstances. This balancing process reflects adaptive resilience but also reveals the structural limits within which caregiving occurs. The study therefore advances understanding beyond descriptive categories of hardship and foregrounds caregiving as sustained effort to preserve dignity, survival, and developmental potential in conditions of prolonged instability.

**Limitations**

This study has several limitations. First, the small and context-specific sample limits statistical generalizability; findings should be understood as analytically transferable rather than representative of all displacement settings. Second, all participants were female caregivers, limiting insight into male caregiving perspectives. Third, translation may have influenced subtle nuances of meaning despite back-translation procedures. Finally, findings reflect participants' reported experiences within a particular socio-cultural and security context.

## Conclusion

Caregiving in displacement settings is characterized by sustained negotiation with structural instability. Rather than isolated health conditions, children's health challenges are embedded within economic deprivation, environmental hazards, and constrained healthcare systems. Caregivers demonstrate adaptive resilience, yet their capacity to maintain child stability is shaped by systemic limitations.

Interventions should therefore move beyond generic multi-sectoral prescriptions and be grounded in contextual understanding of caregivers' lived experiences. Strengthening nutrition support, improving environmental conditions, enhancing accessible community-based healthcare, and reinforcing caregiver capacity are essential for sustainable child health outcomes in displacement settings.

### Implications

This study highlights that child health challenges in displacement are multidimensional, encompassing economic, environmental, and social determinants. Interventions must integrate caregiver perspectives to improve feasibility and effectiveness.

### Ethical approval

Ethical approval was obtained from the Sokoto State Ministry of Health Research Ethics Committee (Ref: SMH/1580/V.IV). Participants provided verbal consent, confidentiality was ensured, and data were securely stored.

### Conflict of interest

The authors declare no conflict of interest.

### Funding

This study received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

### Acknowledgements

The authors sincerely thank all study participants for sharing their experiences, the camp authorities for facilitating access, and supervisors for guidance.

## References

1. Michael R, Imti O. Armed conflict and child health. BMJ. 2015;350:h280. doi:10.1136/adc.2009.178186
2. Jakob K. Root causes and prevention of internal displacement: the ICRC perspective [Internet]. Geneva: International Committee of the Red Cross; 2023 [cited 2026 Feb 27]. Available from: https://www.icrc.org/en/doc/resources/documents/statement/displacement-statement231009.htm
3. Voskanyan A, Simonyan G, Cahill J. Displaced populations. In: Ciottone GR, editor. Ciottone's disaster medicine. 3rd ed. Philadelphia: Elsevier; 2023. p. 399–403. doi:10.1016/B978-0-323-80932-0.00061-6
4. UNICEF. Humanitarian action for children: Nigeria [Internet]. New York: UNICEF; 2023 [cited 2026 Feb 27]. Available from: https://www.unicef.org/media/131976/file/2023-HAC-Nigeria.pdf
5. Ojeleke O, Groot W, Bonuedi I, Pavlova M. The impact of armed conflicts on the nutritional status of children: evidence from Northern Nigeria. Int J Health Plann Manage. 2024;39(1). doi:10.1002/hpm.3742
6. Bendavid E, Boerma T, Akseer N, et al. The effects of armed conflict on the health of women and children. Lancet. 2021;397(10273):522–532. doi:10.1016/S0140-6736(21)00131-8
7. Human Rights Watch. "Those who returned are suffering": the impact of camp shutdowns on people displaced by Boko Haram [Internet]. New York: Human Rights Watch; 2022 Nov 2 [cited 2026 Feb 27]. Available from: https://www.hrw.org/report/2022/11/02/those-who-returned-are-suffering/impact-camp-shutdowns-people-displaced-boko

8. Makinde OA, Olamijuwon E, Mgbachi I, Sato R. Childhood exposure to armed conflict and nutritional health outcomes in Nigeria. Confl Health. 2023;17:15. doi:10.1186/s13031-023-00505-0
9. Ekezie W, Adaji EE, Murray RL. Essential healthcare services provided to conflict-affected internally displaced populations in low- and middle-income countries: a systematic review. Health Promot Perspect. 2020;10(1):24–37. doi:10.15171/hpp.2020.06
10. Okojie LI, Abdul-Qadir AB. Impact of armed banditry on healthcare delivery in Anka Local Government Area of Zamfara State. Gusau Int J Mgmt Soc Sci [Internet]. 2022;5(3) [cited 2026 Feb 27]. Available from: https://gijmss.com.ng/index.php/gijmss/article/view/137
11. Nidzvetska S, Rodriguez-Llanes JM, Aujoulat I, 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. doi:10.3390/ijerph14010054
12. Ochi IB, Ortindi B, Arinze EO. Crisis of banditry and the internally displaced persons in Nigeria: a political economy approach. Scholars J Econ Bus Manag [Internet]. 2022;9(11):247–256 [cited 2026 Feb 27]. Available from: https://www.saspublishers.com/article/8990/download/
13. Neuman B, Fawcett J. Reliability and validity of the Neuman systems model. Nurs Sci Q. 2015;28(4):302–309. doi:10.1177/0894318415585620
14. Renjith V, Yesodharan R, Noronha JA, Ladd E, George A. Qualitative methods in health care research. Int J Prev Med. 2021;12:20. doi:10.4103/ijpvm.IJPVM_321_19
15. Naeem M, Ozuem W, Howell K, Ranfagni S. A step-by-step process of thematic analysis to develop a conceptual model in qualitative research. Int J Qual Methods. 2023;22:16094069231205789. doi:10.1177/16094069231205789
16. Nmadu A, Nmadu CP, Abba KA, Bello-Muhammad BF. Caregiver perspectives on health challenges of internally displaced children in Sokoto, Nigeria. Int J Healthcare. 2022;8(1):1–12.
17. Roberts LF, Simpson JV, Dean J, et al. Needs assessment of internally displaced persons in Jos, Nigeria: a mixed-methods study. Glob Public Health. 2020;15(2):268–282. doi:10.1080/17441692.2019.1667480
18. Salami B, Stella I, Oluwakemi A, et al. The health of internally displaced children in sub-Saharan Africa: a scoping review. BMJ Glob Health. 2020;5(8):e002584. doi:10.1136/bmjgh-2020-002584
19. UNHCR. Internally displaced people [Internet]. Geneva: UNHCR; [cited 2026 Feb 27]. Available from: https://www.unhcr.org/about-unhcr/who-we-protect/internally-displaced-people
20. Meyer SR, Popham F, Joshi M. The role of social support in promoting refugee resettlement: the experience of settled Yazidi women in Winnipeg. Can J Public Health. 2017;108(1):e12–e17. doi:10.17269/CJPH.108.5825

International Organization for Migration. Displacement tracking matrix: Nigeria [Internet]. Abuja: IOM; 2019 [cited 2026 Feb 27]. Available from: https://reliefweb.int/report/nigeria/dtm-nigeria-displacement-tracking-matrix-august-2019-2019-08-22-en

**Date Submitted:** 13th February 2026

**Date Accepted:** 26th April 2026

**Date Published:** 31st July 2026

**Authors affiliations and ORCIDs**:

[1] Department of Nursing Sciences, Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria. ORCID: Usamatu Abubakar Tarah: 0009-0005-8428-2846

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

[3] School of Post-Basic Paediatric Nursing Programme, Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria.

[4]School of Post-Basic Peri-operative Nursing Programme, Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria.