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ARMED BANDITRY IN NIGERIA'S NORTHWEST REGION: IMPLICATIONS FOR HEALTHCARE SERVICE DELIVERY.

Niagwan Timothy Terver[1]* & Kums Simon Nankap[1]

[1] Department of Political Science, University of Jos, Nigeria; niagwant@unijos.edu.ng.
[1] Department of Political Science, University of Jos, Nigeria.

* Correspondence: niagwant@unijos.edu.ng.

Abstract

Armed banditry has emerged as a critical security challenge in Nigeria's Northwest region, with profound implications for human security and public service delivery. This study examined the impact of armed banditry on healthcare service delivery in Nigeria's Northwest region, within the framework of Human Security Theory. The study was guided by three research objectives: to examine the ways in which armed banditry has disrupted healthcare infrastructure and service delivery in Northwest Nigeria; to analyse its implications for healthcare infrastructure, personnel and patient access and to evaluate its broader implications for achieving Nigeria's UHC targets. The study adopted a qualitative descriptive research design, relying on secondary data drawn from academic literature, policy documents and institutional reports. Data were analysed using thematic and content analysis. The findings revealed that armed banditry has precipitated a multidimensional healthcare crisis in the Northwest, characterised by the closure of primary healthcare centres, mass displacement of health workers, reduced access to medical services, disruption of medical supply chains, heightened vulnerability of women and children and a significant increase in conflict-related morbidity and mortality. The study concluded that persistent insecurity and its cumulative effects pose a grave threat to UHC attainment in the region. The study recommended integrated security and health policy interventions, including strengthening healthcare infrastructure, protecting health personnel and enhancing state capacity in conflict-affected areas.

Keywords: Armed Banditry, Human Security, Healthcare Service Delivery, Universal Health Coverage, Northwest Nigeria

Introduction

The health of a nation's citizens is a fundamental determinant of its national development. Consequently, any society that aspires to sustained growth must prioritise the wellbeing of its population, as health is both a fundamental human right and a critical enabler of productive participation in national life. Recognising this imperative, the World Health Organisation (WHO) and the United Nations have enshrined Universal Health Coverage (UHC) as a central target within the Sustainable Development Goals (SDGs). UHC ensures that all individuals have access to essential health services without suffering financial hardship. This vision which is rooted in the WHO Constitution of 1948 and reaffirmed by the 1978 Alma Ata Declaration, cuts across all health-related SDGs and remains one of the most ambitious global commitments to equity and human dignity (Okpani & Abimbola, 2015). Nigeria aspires to attain UHC by 2030. However, this aspiration is gravely threatened by the pervasive insecurity that afflicts the country's six geopolitical zones. The Nigerian state faces a complex security landscape that includes the Boko Haram insurgency in the Northeast, kidnapping for ransom, sea piracy, armed separatist agitation, and, most prominently for the purposes of this study, the escalating

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menace of armed banditry in the Northwest. Armed banditry in this region spanning the states of Kano, Kebbi, Sokoto, Jigawa, Kaduna, Katsina, and Zamfara has become one of the most destabilising security crises in contemporary Nigeria. It has resulted in mass killings, displacement of millions of persons, cattle rustling, sexual violence, kidnapping for ransom and the systematic destruction of social infrastructure, including healthcare facilities. Against this backdrop, the paper notes that Nigeria's aspiration to attain UHC by 2030 is fundamentally imperilled so long as its most populous geopolitical zone remains under siege by armed bandits.

Statement of the Problem

Despite growing literature on armed banditry in Nigeria, limited scholarly attention has been paid to its specific implications for healthcare service delivery in the Northwest region. In essence, although armed banditry is systematically dismantling the healthcare architecture of Northwest Nigeria, there is limited comprehensive and empirically grounded evidence on the precise mechanisms and scope of this disruption. Thus, while prior studies have examined the effects of banditry on food security (Ajiboye, 2023; Ladan & Matawalli, 2020), education (Ejiofor, 2022; Ofoma & Onwe, 2023), national security (Mahmoud, 2020; Okoli & Ugwu, 2019) and sexual violence (Mohammed & Alimba, 2015; Murtala, 2018), the implications for healthcare service delivery remain underexplored. This gap undermines evidence-based policymaking for health and security interventions.

Aim and Objectives

The study was guided by the following research objectives:

i. To examine the ways in which armed banditry has disrupted healthcare infrastructure and service delivery in Northwest Nigeria.

ii. To assess the effects of armed banditry on the safety, availability of health workers and medical supplies in Northwest Nigeria.

iii. To analyse the broader implications of banditry-induced healthcare disruption for the attainment of UHC in Nigeria.

The study contributes to the intersection of security studies and public health by providing empirical insights into how violent conflicts undermine healthcare systems. Beyond its academic contribution to the security-health nexus literature, the findings of this study are intended to inform policymakers, humanitarian actors and development partners in designing evidence-based interventions for conflict-affected communities in Nigeria and similar contexts across sub-Saharan Africa.

Research Questions

The study was guided by the following research Questions:

Correspondingly, the study is directed by the following research questions:

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i. In what ways has armed banditry disrupted healthcare infrastructure and service delivery in Northwest Nigeria?

ii. How has the phenomenon affected the safety and availability of health workers and medical supplies in the region?

iii. What are the broader implications of banditry-induced healthcare disruption for achieving UHC in Nigeria?

THEORETICAL FRAMEWORK

This study is anchored on Human Security Theory. The theory provides the most analytically appropriate lens for examining the relationship between armed banditry and healthcare disruption in Northwest Nigeria. Human Security Theory, prominently articulated in the United Nations Development Programme's (UNDP) 1994 Human Development Report, represents a paradigmatic shift in security studies away from a state-centric conception of security toward one centred on the protection and empowerment of individuals. The theory identifies seven dimensions of human security: economic, food, health, environmental, personal, community and political security, each of which can be threatened by violence, deprivation and institutional failure. Fundamentally, the theory rests on two foundational pillars: freedom from fear and freedom from want. Freedom from fear refers to protection from physical violence, armed conflict, and coercion, while freedom from want encompasses access to basic necessities including food, shelter and healthcare. Armed banditry in Northwest Nigeria directly violates both pillars. This is because it subjects communities to persistent fear of physical violence, while simultaneously destroying the social and institutional structures that provide for basic needs most critically, access to healthcare. Therefore, within this theoretical framework, the disruption of healthcare delivery in Northwest Nigeria is not merely a sectoral problem, it is an expression of a profound human security failure. Thus, when health centres are closed due to bandits' attacks, when medical personnel flee insecurity-infested communities, when patients cannot reach facilities without risking kidnapping or assault and when medical supply chains are severed by armed actors, the human security of the affected populations is fundamentally compromised. Human Security Theory, therefore, allows this study to connect micro-level disruptions in health service delivery to macro-level patterns of insecurity, state fragility and institutional collapse. This framework is particularly well-suited to the present analysis because it highlights the experiences of the most vulnerable populations women, children, internally displaced persons (IDPs) and individuals with chronic illness who bear the disproportionate burden of banditry-induced healthcare disruptions.

METHODOLOGY

This study adopted a descriptive-analytical research approach. This was considered appropriate for systematically examining, interpreting and analysing complex social phenomena such as the impact of armed banditry on healthcare service delivery in

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Northwest Nigeria. Given the inaccessibility of the study area due to prevailing insecurity and the absence of comprehensive primary data, a qualitative secondary data approach was employed. This design enabled the study to draw on a wide range of existing evidence to construct a coherent and evidence-informed account of the phenomenon under investigation. Data were sourced from secondary sources, including peer-reviewed academic journal articles, textbooks, government policy documents, reports by international humanitarian and health organisations (such as the WHO, UNICEF, ACAPS, and the International Displacement Monitoring Centre), National Health Surveys (including the Nigeria Demographic Health Survey and the Nigeria Malaria Indicator Survey), reputable newspaper reports and verified online databases. These sources were selected based on their relevance, credibility and recency. The data were analysed using qualitative content analysis and thematic analysis. Content analysis was employed to systematically identify, categorise and interpret information on the nature and consequences of armed banditry in the Northwest. Thematic analysis was used to organise the findings into coherent themes that reflect the multidimensional impacts of banditry on healthcare delivery including effects on health facilities, health workers, patients, medical supplies and transportation. The study acknowledges certain methodological limitations. Reliance on secondary data means that the findings are subject to the quality, completeness and potential biases of the original sources. Furthermore, the dearth of granular, facility-level data from conflict-affected areas of the Northwest limits the precision with which healthcare disruption can be quantified. Notwithstanding these limitations, the study represents one of the most comprehensive syntheses of available evidence on this subject and makes a significant contribution to an underexplored area of research.

CONCEPTUAL CLARIFICATION

Banditry

Banditry means different things to different people (Warto, 1994) and attempts to understand the concept in both its historic and contemporary dimensions have yielded contested and ambiguous definitions. Although banditry is not a new phenomenon, time, geography and circumstance have significantly altered its conceptual and operational character. Mohammed and Alimba (2021) observe that modern-day bandits, unlike their historical counterparts, are markedly more vicious and destructive, typically associated with maiming, killing and the wanton destruction of property. Bunker and Sullivan (cited in Mohammed & Alimba, 2021) characterise bandits as gangs, criminal enterprises, insurgents or warlords who dominate social life and erode the boundaries of effective governance and the rule of law. For Okoli and Okpaleke (2014), banditry refers to the prevalence of criminal acts involving armed robbery and violent crimes, characterised by the use of threat or force to intimidate, rob or kill victims. Osasona (2023) describes bandits as a loosely organised collection of criminal groups engaged in cattle rustling, sexual violence, kidnapping, armed robbery, pillage and attacks on traders, particularly in Northwest Nigeria. From this body of scholarship, banditry may be understood as a composite crime and a catch-all term for organised armed criminal activity that targets individuals and communities for purposes of economic predation, coercion and violence.

Armed Banditry

Department of Political Science,
University of Jos

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Armed banditry refers to banditry characterised by the use of sophisticated weapons, escalating the lethality and scope of criminal violence. This characterisation derives from the heightened level of violence and the increasing sophistication of weapons employed by bandit groups. As Slatta (cited in Mohammed & Alimba, 2021) notes, bandits typically operate in the shadows, on the fringes of society, in geographically isolated areas. In the Nigerian context, armed banditry encompasses cattle rustling, armed robbery, kidnapping for ransom, arson, rape, and illegal toll collection and has evolved into a sophisticated enterprise with the capacity to challenge the authority of weak or under-resourced states (Mohammed & Alimba, 2021). The use of AK-47 rifles and other sophisticated weapons has dramatically increased the lethality of bandit attacks across the Northwest region. Hence, banditry refers to organised criminal activities involving violence, including kidnapping, robbery and cattle rustling. Armed banditry represents a more violent and sophisticated form characterised by the use of advanced weaponry and large-scale attacks.

Healthcare Service Delivery

Healthcare service delivery refers to the organisation and provision of health services to individuals and populations, encompassing preventive, promotive, curative, rehabilitative and palliative care. The World Health Organisation conceptualises service delivery as one of the six core building blocks of a health system, emphasising access, quality, safety, and continuity of care. Therefore, within health system frameworks, service delivery functions as the mechanism through which system inputs including financing, human resources, and infrastructure are transformed into effective health coverage and population health outcomes (WHO, 2010). Access to healthcare is understood as the ability of individuals to obtain and appropriately use quality health services when needed (Ojeleye et al., 2022). Hence, healthcare service delivery encompasses the organisation and provision of preventive, curative and rehabilitative services to include populations. It is a core component of health systems and central to achieving UHC.

STUDY AREA

The Northwest geopolitical zone of Nigeria comprises seven states: Kano, Kebbi, Sokoto, Jigawa, Kaduna, Katsina and Zamfara. Occupying a landmass of approximately 214,395 km², the region is the most populous in Nigeria, with an estimated population of 35.7 million people. Unlike the Boko Haram insurgency which is largely concentrated in Borno State in the Northeast, armed banditry affects all seven states of the Northwest, making it a region-wide crisis. The menace of armed banditry has assumed alarming proportions in the Northwest, which has been described as the epicentre of bandit activity in Nigeria, characterised by a geometric rise in violent incidents perpetrated primarily by armed groups based in remote rural areas and forests, with active networks extending into urban centres. The region's vulnerability to banditry is partly structural. It shares borders with the Northeast the hub of Boko Haram activity as well as with Niger, Chad and Cameroon, facilitating the movement of arms and combatants across porous boundaries. The precise scale of bandit activity is difficult to verify, but Murtala (2021) estimated the presence of approximately 120 bandit camps in the region, with more than 60,000 AK-47 rifles in circulation. Further, Osasona (2023) reported that over 100,000 armed bandits may be active in the Northwest, with more than 30,000 operating in a single state.

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Health Profile of Northwest Nigeria

The Northwest region of Nigeria presents some of the most challenging health indices in the country, a reality that predates and is now severely compounded by armed banditry. According to the Nigeria Demographic and Health Survey (NDHS, 2018), the maternal mortality ratio in the Northwest stands at approximately 1,526 deaths per 100,000 live births among the highest in the country. Malnutrition among children under five is pervasive, with stunting rates as high as 50% in some states. Vaccination coverage is markedly below national averages; only 20% to 50% of children aged 12 to 23 months received all basic vaccinations (NDHS, 2018). Malaria prevalence is also disproportionately high: the Nigeria Malaria Indicator Survey (NMIS, 2020) reported that 30% of children aged 6 to 59 months tested positive for malaria in the Northwest the highest rate among all geopolitical zones. Furthermore, only 30% of women in the region receive antenatal care from a skilled provider, compared to the national average (NDHS, 2018). Access to clean water and adequate sanitation remains severely limited in many parts of the region. This has contributed to the spread of waterborne diseases such as cholera and dysentery. These pre-existing vulnerabilities render the region's health system particularly fragile in the face of the destabilising impact of armed banditry.

ORIGINS OF ARMED BANDITRY IN NORTHWEST NIGERIA

Examining the origins of armed banditry in Northwest Nigeria requires an understanding of its historical trajectory, evolving social contexts and the competing explanatory frameworks that scholars have advanced. The most prominent narrative in the literature traces banditry to the degeneration of farmer-pastoralist conflicts in Northern Nigeria. Okoli (2015) situates armed banditry within the broader crisis of transhumance, characterising it as a violent expression of intensifying competition over increasingly scarce arable land and water resources between farming communities and Fulani pastoralist groups. As these groups compete for access to land and its resources, the resultant tensions have, over time, transformed from localised disputes into organised armed violence, accompanied by the proliferation of small arms. An alternative perspective positions banditry as a new form of terrorism or as a continuation of historical patterns of organised aggression targeting agrarian communities in Northern Nigeria. A further, and arguably more controversial, interpretation views certain manifestations of banditry as state-sanctioned or politically instrumentalised violence. However, the most widely supported analytical position is that banditry is primarily a political economy problem. Scholars such as Egwu (2015) and Kusa and Salihu (2015) argue that banditry is rooted in structural inequalities, including the exclusion of marginalised groups from equitable access to social and economic resources. Consistent with this view, Osasona (2023) and Ojo et al. (2023) contend that individuals turn to armed banditry as a desperate mode of economic accumulation and socioeconomic empowerment, driven by mass unemployment, lack of educational opportunities and extreme poverty. Many analysts also attribute the persistence of banditry to state incapacity the failure of government to effectively exercise sovereignty and maintain security in rural areas (Okoli & Ugwu, 2019). Ungoverned or poorly governed spaces create permissive environments in which bandit groups operate with relative impunity. Compounding these structural factors are broader social pathologies including political

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instability, pervasive corruption and economic depression. These dynamics have collectively created a self-reinforcing cycle of insecurity in which banditry thrives, thus perpetuating the marginalisation and vulnerability of the affected communities.

IMPACTS OF ARMED BANDITRY ON HEALTHCARE SERVICE DELIVERY IN NORTHWEST NIGERIA

Armed banditry has generated profound and multidimensional consequences for public health and healthcare service delivery in Northwest Nigeria. These consequences operate through both direct and indirect pathways. Direct consequences include conflict-related casualties gunshot wounds, physical injuries, disability, and death resulting from bandit attacks. Indirect consequences encompass the systematic breakdown of health systems, the displacement of health workers, the disruption of medical supply chains and the collapse of food and water security, all of which amplify disease burden and mortality (Akuto, 2017; Owoaje et al., 2016; Adedokun, 2019). The following sub-sections analyse these impacts systematically.

Destruction of Health Infrastructure

The activities of armed bandits have caused significant disruption to health infrastructure throughout the Northwest region. Both public and private health facilities have been targeted, vandalised, or forced to close. Fear of attacks, the displacement of health professionals and the disruption of supply chains have together resulted in the closure of the majority of health facilities in affected areas. The burden on those facilities that remain operational is consequently immense. The scale of facility closure is striking. According to Suleiman (2024), the Executive Secretary of the Zamfara State Primary Healthcare Board disclosed that due to banditry-related insecurity, only approximately 200 of the state's 700 Primary Health Care (PHC) centres remained functional. In Katsina State, 69 health centres were shut across five local government areas Batsari, Jibia, Safana, Faskari, and Sabuwa as a direct consequence of bandit activity. A study by Okojie and Ahmad (2022) found that in Anka Local Government Area of Zamfara State, at least 23 of 41 healthcare centres had been deserted due to fear of attack. The same study documented a dramatic decline in healthcare utilisation between 2019 and 2021: antenatal care attendance across the 41 facilities fell from 13.1% to 6.5%; skilled birth deliveries dropped from 7.7% to 3.4%; and immunisation rates declined from 8.8% to 4.2%. Patient visits fell from an average of 20 per week to approximately 5 in most PHCs. These data underscore the catastrophic impact of armed banditry on the operational capacity of primary healthcare in the region. Beyond closures, health facilities that remain open face additional challenges. Armed bandits have been reported to loot medications and medical equipment from facilities, use hospitals as shelters during conflict and obstruct vaccination and immunisation campaigns. Private healthcare facilities including clinics, pharmacies, and laboratories have also been forced to close, eliminating an important complementary source of care for communities.

Displacement of Health Workers

The insecurity generated by armed banditry has driven a widespread exodus of health personnel from affected communities, thereby creating critical shortages of skilled

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healthcare providers. Health workers have been subjected to harassment, assault, kidnapping and in some cases murder, making service delivery in banditry-affected areas extraordinarily dangerous. Suleiman (2024) reports that many health workers in the affected communities feel deeply threatened, with some kidnapped or killed in the course of their professional duties. Maishanu (2022) documented the kidnapping of three health workers including a medical doctor along the Gusau-Dinse highway in Maru Local Government Area of Zamfara State. Suleiman (2024) further noted that many health workers have abandoned health centres in Anka, Shinkafi, Zurmi, and Maru Local Government Areas, creating what have been described as 'health deserts.' Those health workers who remain face severe operational challenges. Night travel to facilities is acutely dangerous, with bandits operating roadblocks and conducting stop-and-search operations during which valuables including patients' money for treatment are seized. The absence of protective mechanisms, transportation support, and professional incentives compounds the difficulty of retaining health personnel in these areas. The resultant collapse of the healthcare workforce is a direct driver of the deterioration of health outcomes across the region.

Reduced Access to Healthcare Services

The healthcare crisis precipitated by armed banditry is particularly devastating for individuals living with chronic conditions such as hypertension, diabetes, cardiac disease and HIV. In the Northwest, the conflict-induced collapse of health services has severely disrupted access to essential medications and follow-up care for chronic disease patients. Many such individuals have lost their lives as a direct consequence of treatment interruptions, a humanitarian crisis that receives relatively little attention in the broader discourse on conflict and health (Ojeleye et al., 2022). The breakdown of formal health service provision and associated shortages of pharmaceuticals have driven many patients to use unprescribed, counterfeit or expired medications. In the absence of functional pharmacies or medical supply chains, patients procure whatever medications they can access, often without regard to prescriptions or expiration dates (McCartey et al., 2013). This practice poses serious risks of adverse health outcomes, antimicrobial resistance, and treatment failure, further exacerbating the community health crisis.

Increased Morbidity and Mortality

Bandit attacks generate significant direct morbidity and mortality through gunshot wounds, bomb blasts and other forms of physical violence (Adetayo, 2022). Haar et al. (2021) note that morbidity and mortality rates in conflict settings are substantially affected by both direct conflict-related injuries and disease-related factors, reflecting the compound health burden imposed by protracted insecurity. Beyond physical injury, the disruption of healthcare systems and the breakdown of supply chains further amplify conflict-related mortality, as injured and ill individuals are unable to access timely and appropriate treatment. Armed banditry has indirectly damaged community health in the Northwest by destroying supply chains and social support structures, precipitating food insecurity and famine (Ajiboye, 2023; Saminu et al., 2023). When compounded by shortages of clean water and disruptions to electricity supply, food insecurity creates conditions conducive to the spread of infectious diseases such as malaria, typhoid,

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dysentery and acute respiratory infections, all of which amplify the conflict-related disease burden.

Population Displacement and Humanitarian Crisis

The most immediate and pervasive consequence of armed banditry is the mass displacement of civilian populations. Displacement profoundly disrupts access to food, healthcare, clean water, nutrition and personal security (Abdullahi, 2021; Internal Displacement Monitoring Centre, 2017). Adults and breadwinners flee conflict-affected areas leaving elderly and vulnerable persons without support. A study by ACAPS (2020) found that banditry in the Northwest region had displaced residents in their thousands to neighbouring Niger Republic and to internally displaced persons (IDP) camps, most of which lack access to potable water, healthcare services, toilets and adequate shelter. For example, by March 2020, an estimated 210,000 persons had been internally displaced, while over 35,000 refugees had crossed into Maradi, Niger Republic (ACAPS, 2020). The conditions in IDP camps characterised by overcrowding, open defecation and inadequate sanitation create acute risks of diarrhea and cholera outbreaks.

Disruption of Medical Supply Chains

Armed banditry has severely disrupted the supply chains that sustain health facility operations. Bandits have been repeatedly reported to have looted medications, medical equipment and consumables from both health facilities and supply vehicles (Jalili & Olanrenwaju, 2016). These shortages limit patients' access to essential medicines, particularly for severe and chronic conditions, thereby resulting in delayed or inadequate treatment and increased morbidity and mortality. Relatedly, transportation disruptions further compound the access problem. Bandit-controlled roads and checkpoints, combined with the ever-present threat of attack during travel, deter patients from seeking care even when they are acutely unwell. In this regard, Ajiboye (2023) notes that the pervasive sense of insecurity discourages people from travelling to health facilities, particularly during periods of heightened bandit activity. Restrictions on night-time movement, imposed either by security forces or by the fear of bandit attacks, prevent access to emergency healthcare, with potentially fatal consequences. The absence of reliable electricity and the general deterioration of road infrastructure in affected areas further constrain health-seeking behaviour and health system functionality.

Vulnerability of Women and Children

Women and children constitute among the most severely affected groups in conflict settings, and the Northwest is no exception. Pregnant women face acute challenges in accessing quality intrapartum and postpartum care, as well as adequate nutrition and support during and after childbirth (Saminu et al., 2023). In many instances, women are compelled to deliver at home without skilled birth attendants, substantially increasing the risk of maternal and neonatal mortality. Access to markets is severely disrupted, and where food is available, prices are often double or triple their pre-conflict levels, thereby rendering basic nutrition unaffordable for displaced and conflict-affected households. Children in the Northwest face elevated rates of vaccine-preventable diseases, diarrhea,

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trachoma and pneumonia, as a direct result of the disruption of preventive and health-promotive services.

The consequences for women extend further: those subjected to rape and abduction face compounded psychological trauma, unwanted pregnancy and the risk of HIV and sexually transmitted infections. Women who return from captivity bearing children of their abductors frequently face social stigma and rejection, further diminishing their access to support and healthcare (Abdullahi, 2022). The prevalence of sexual violence is a well-documented feature of conflict settings, and armed banditry in Northwest Nigeria is no different. Bandits systematically target women and girls for rape as a strategy of intimidation and community coercion (Ejiofor, 2022; Murtala, 2018). Victims of sexual violence suffer immediate and long-term health consequences, including psychological trauma, pregnancy and sexually transmitted infections, including HIV. Women in IDP camps are also at elevated risk of sexual exploitation, contributing further to poor health outcomes and increased female mortality (Abdullahi, 2022). The lack of effective protection mechanisms by both government and civil institutions in these settings compounds the vulnerability of women and girls.

CONCLUSION AND RECOMMENDATIONS

This study has examined the impact of armed banditry on healthcare service delivery in Northwest Nigeria, drawing on Human Security Theory as its analytical framework. The findings confirm that armed banditry has generated a multidimensional healthcare crisis in the region, operating through both direct pathways conflict-related casualties, sexual violence and displacement and indirect pathways, including the systematic destruction of health facilities, the flight of health workers, the disruption of medical supply chains and the exacerbation of pre-existing disease burdens. The cumulative effect of these disruptions is a profound deterioration of health outcomes in the region's most vulnerable communities, including among women, children, internally displaced persons and individuals living with chronic diseases. Critically, these findings demonstrate that Nigeria's aspiration to achieve Universal Health Coverage by 2030 cannot be realised if the country's most populous geopolitical zone remains paralysed by armed banditry. The evidence presented in this study strongly suggests that achieving UHC in the Northwest requires not merely health system investment, but a fundamental resolution of the security crisis that is destroying the institutional foundations of healthcare delivery. Attacks on healthcare workers, facilities, patients and supply chains constitute violations of international humanitarian law and fundamental human rights and must be addressed with the urgency they demand. Better documentation of the scope and impact of attacks on healthcare systems is also urgently needed. Comprehensive data are essential for understanding the true burden of banditry-induced healthcare disruption, developing effective protection mechanisms, holding perpetrators accountable under international human rights law, and enabling humanitarian actors to target resources and programmes toward the communities most severely affected. On the basis of these findings, the following policy recommendations are advanced:

First, governments at the federal and state levels must initiate structural interventions that address the root causes of armed banditry including poverty, unemployment, inequality, and institutional failure through good governance, inclusive development programming

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and sustained investment in rural communities. Second, adequate security must be provided at health facilities to protect personnel, patients and infrastructure from bandit attacks. Third, health workers serving in conflict-affected areas should be provided with life insurance coverage, hazard allowances and comprehensive compensation schemes for those who are victims of bandit violence to incentivise their continued service and retention. Fourth, the coverage of the National Health Insurance Scheme (NHIS) should be extended to all populations, with priority given to violence-affected communities in the Northwest. Fifth, secondary health institutions such as general hospitals should be strengthened to absorb referrals from primary healthcare centres in conflict-affected areas to reduce the burden on the most frontline facilities. Sixth, the federal government should actively collaborate with the global health community encompassing multilateral organisations, international donors, civil society, academia and the private sector to develop coordinated responses to the health consequences of the conflict. Seventh, immediate rehabilitation of damaged health infrastructure and psychosocial support for affected communities and health workers should be prioritised as part of humanitarian response programming. Eighth, resource allocation to health should be significantly increased to rebuild infrastructure, restore medical supply chains and retain skilled health personnel through competitive remuneration packages. Finally, more rigorous, empirically based research is urgently needed to generate comprehensive data on the precise scope and ramifications of armed banditry on health services in Nigeria, to inform evidence-based policy and programming.

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