

Impact of Boko-Haram Insurgency on Maternal and Child Healthcare Service Delivery in Primary Healthcare Facilities in Yobe State, Nigeria

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Abstract

This study assessed the impact of Boko Haram insurgency on maternal and child health service delivery using evidence from primary healthcare facilities in Yobe State. The study utilized relative deprivation theory to explain the activities of the insurgents on maternal and child health. Methodologically, the study adopted a mixed method of both qualitative and quantitative. The study adopted pragmatism philosophy which is based on naturalistic approach of data collection such as questionnaire and interviews. A total of 297 health personnel were administered with questionnaire across seven Local Government Areas under study and 21 interviews were conducted with health consumers, religious leaders and staff of primary healthcare board. Quantitative data was analyzed using descriptive and inferential statistics while the qualitative data was analyzed using thematic approach. The study reveals that Boko Haram insurgency has affected maternal and child health to the extent that most women give birth at home and maternal and child mortality have increased as a result of the destruction of primary healthcare centers, immunization programmes have been cut-off due to the insurgents' activities. Also, the study reveals that malnutrition among children has increased because of lack of access to food. Thus, the study recommends that the Yobe State government, in collaboration with development partners such as World Health Organization and UNICEF should rebuild all affected primary healthcare centers in the affected Local Governments Areas so as to reactivate effective health service delivery.

Keywords: Boko Haram Insurgency, Maternal and Child Healthcare Service, Relative Deprivation Theory, Yobe State, Nigeria

Introduction

In the heart of Nigeria's Northeast region where resilience contends daily with violence, the Boko Haram insurgency has not only destabilized communities but also crippled the very systems meant to sustain life. The Boko Haram insurgency has profoundly disrupted social systems across north-eastern Nigeria, with primary healthcare services among the most critically affected institutions. In the North-eastern Nigeria, the persistent conflict has undermined access to basic health services, strained medical infrastructure, displaced health personnel, and jeopardized the delivery of maternal and child care.

Primary Health Care (PHC) forms the cornerstone of achieving Universal Health Coverage (UHC). This principle was reaffirmed in the 2018 Declaration of Astana, adopted in Kazakhstan, which emphasized the need to strengthen primary healthcare systems to ensure that all individuals, regardless of location, can attain the best possible standard of health. However, conflicts remain a significant obstacle to achieving this goal in Africa, as they disrupt social stability, political structures, and the delivery of quality health services.

Insurgencies constitute a significant impediment to social stability, political governance, and the delivery of quality health services across Africa. Between 2000 and 2017, the number of internally displaced persons (IDPs) on the continent increased by over 10 million, highlighting the severe impact of violent conflicts on civilian populations (Martin, 2018). In Nigeria, insurgency emerged as a prominent national security threat since 2009 with the violent activities of Boko Haram, an extremist Islamic group operating primarily in the North-eastern region (ACSR, 2020). These developments continue to undermine societal peace and hinder developmental progress. In 2009, the sect agitated against the government of Nigeria's directive to wear helmets, which was imposed order. This sparked a clash between police officers and members of the sect, resulting in the deaths of approximately 700 Boko Haram members, including the leader, Mohammed Yusuf (Jelilov *et al.*, 2018; Ebonyi, 2019; Manful, 2019).

Nigeria continues to grapple with internal security challenges posed by the Boko Haram insurgency since then. According to Ibrahim (2018), the sect became increasingly violent following a change in leadership in 2014, resulting in a surge in fatalities. Since the insurgency began in 2009, over 13,000 lives have been lost due to both militant attacks and counter-insurgency operations in the northern region of the country. The States of Borno, Yobe, and Adamawa located in the North East remain the epicenters of the crisis. In 2014, Boko Haram was responsible for approximately 7,711 deaths and succeeded in seizing control of several towns within these states (Independent Advisory Group on Country Information, 2021).

Lingering violence in the Northeastern region has tormented the entire population of 24.5 million people in Borno, Yobe, Adamawa, Bauchi, Gombe, and Taraba states (Insurgency, 2014). Almost 1.9 million people have been expatriated, and an additional 4.8 million people are facing disaster, primarily food insecurity (ACAPS, 2015). The consequences of the disaster affect many sectors, including shelter, food, health, livelihoods, security, and education. Boko Haram's ideology is firmly embedded within the broader framework of global radical Islamist narratives. This was influenced by the teachings of its founder, Mohammed Yusuf. The group rejects Western education, opposes secularism and Western values, and views democracy as fundamentally incompatible with Islam (Raineri & Martini, 2017). Gradually, Boko Haram adopts aggressive strategies, including ambushes, raids, and direct assaults, often targeting soft and poorly defended areas. Their attacks frequently strike law enforcement agencies, political and religious leaders, critical infrastructure, financial institutions, and commercial entities (Regens, Mould, Vernon & Montgomery, 2016).

The crisis has greatly reduced access to healthcare services in health facilities due to the absence of healthcare workers, and meager living conditions with millions of people held in camps, which has exacerbated undernourishment. For example, in February 2017, one-third of the 749 health facilities in Yobe State were destroyed, and an additional one-third were injured by terrorists (FAO & WFP 2019). The persistent violence perpetrated by Boko Haram, which manifests in the killing of civilians, destruction of property, and occupation of towns has heightened insecurity among citizens. The insurgency has precipitated large-scale displacement, forcing countless individuals to abandon their homes and exposing them to heightened risks of abuse, human trafficking, sexual exploitation, and forced labor. As a result of the conflict's intensity, an estimated 1.5 million people have been displaced from their habitation (Foad *et al.*, 2020).

Healthcare is widely recognized as a critical global indicator of human development and their well-being. Access to quality healthcare is fundamental to achieving optimal wellness and is considered

a basic human right, irrespective of race, ethnicity, political beliefs, or socio-economic status. Health is broadly defined as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (Hassan, Djekonbe & Dombou, 2018). The World Health Organization (WHO), via its constitution adopted on July 22, 1946, underscores that the health and well-being of all people are fundamental to global peace and security, and require the collaborative efforts of both individuals and nations. It further emphasizes that equitable access to the benefits of progress in medicine, psychology, and related disciplines is crucial for attaining the highest possible standard of health for all (WHO, 2019).

Problem Statement

Primary health care continues to be the cornerstone of health development, not only in Yobe State, but Nigeria generally. The healthcare system in Yobe State has long been characterized by sub-optimal performance and remains a cause for serious concern. This is reflected in the state's alarming health indicators and concerning statistics (Nigeria Demographic and Health Survey (NDHS), 2023). Numerous PHC facilities across the state lack the necessary equipment and resources to provide essential and adequate services to their communities. This deficiency is largely attributed to several systemic challenges, including inadequate staffing, poor distribution of healthcare personnel, insufficient numbers of qualified health workers, lack of essential medical equipment, dilapidated infrastructure, and the unavailability of essential drugs (Aregbesola & Khan, 2017).

Boko Haram crisis compounded by additional factors such as an ill-motivated workforce, inadequate infrastructure, and poorly managed PHC facilities, has contributed to alarmingly poor health outcomes. The most affected are vulnerable groups, particularly women and children, as reflected in the persistent high maternal and under-five mortality rates.

PHC facilities are mandated to provide a range of essential services, including health education on common diseases and their prevention, maternal and child healthcare such as family planning and immunization against major infectious diseases, and the management of minor illnesses. Nigeria ranks among the countries with the highest maternal mortality ratios globally, accounting for approximately 30% of all maternal deaths worldwide (WHO, 2024). A survey of measles, mumps and rubella (MMR) in Yobe state in 2023 reveals 3,200/100,000 live births in rural LGA's, and a lifetime risk of dying from pregnancy complication of 1in 6 (Goni, 2024). PHC services, which constitute the foundation of the health system and provide the first point of contact for most citizens especially women and children have been among the worst hit by Boko Haram insurgency. This study, therefore, examines the impact of Boko Haram insurgency on maternal and child healthcare service delivery with particular focus on PHC facilities in Yobe State, Nigeria.

Literature Review

Boko Haram Insurgency

Boko Haram insurgency, which commenced in July 2009, represents a protracted armed conflict involving the Nigerian government, supported by countries of the Lake Chad basin. The group's name, commonly translates as "Western education is forbidden" in Hausa, reflects its ideological rejection of Western education and influence. Boko Haram seeks to establish an Islamic State in Nigeria governed by strict interpretations of Islamic law.

Boko Haram is widely reported to have been formally established by Mohammed Yusuf in 2002 in Maiduguri, the capital of Borno State, North-eastern Nigeria. However, emerging scholarly debates suggest that the group may have originated earlier as a small, non-violent movement known as the Muslim Youth Organization, founded in 1995 by Abubakar Lawan (Nyadera *et al.*, 2019). Similar to the mobilization strategies employed by Mohammed Marwa, Mohammed Yusuf focused on recruiting disenfranchised youths in North-eastern Nigeria who were marginalized by severe economic deprivation and limited access to basic social services.

Boko Haram has since become one of the most prominent topics in terrorism discourse in Africa, particularly in analyses of Nigeria's social, political, and economic landscapes (Agwanda *et al.*, 2020). Onuoha (2014) investigates Boko Haram's operational tactics, including attacks on communication infrastructure, and draws parallels with the Taliban's methods in Afghanistan. Boko Haram's ideology is fundamentally anchored in the rejection of Western influences, which the group perceives as morally corrupting and socially destructive. Drawing from Salafi-Jihadist thought, Boko Haram subscribes to a puritanical interpretation of Islam that rejects religious innovations and emphasizes strict adherence to the Qur'an and Hadith (Abdulbasit, 2015).

Maternal and Child Health

Maternal health services comprise a comprehensive continuum of care including antenatal, intrapartum, and postpartum interventions that are critical to preventing pregnancy-related complications and improving women's overall well-being (Banke-Thomas & Ameh, 2017). In many developing countries, PHC's serve as the frontline for skilled maternal care, offering essential services at the community level (Al Hadad *et al.*, 2013). Their strategic placement is intended to enhance accessibility and equity, particularly for women in rural and underserved areas. Ensuring the availability and functionality of PHC's is, therefore, a key approach to reducing maternal mortality among women of reproductive age.

A widely accepted definition of children's health refers to the extent to which individual children or groups of children are able or enabled to achieve their full developmental potential, meet essential needs, and acquire the capacities required to engage productively with their biological, physical, and social environments. This definition aligns closely with the principles outlined in the Ottawa Charter for Health Promotion (1986), which emphasized that achieving complete physical, mental, and social well-being involves the ability to identify and pursue aspirations, fulfill needs, and adapt to or influence one's environment. The World Health Organization (WHO) defines child health as a state of complete physical, mental, intellectual, social, and emotional well-being not merely the absence of disease or infirmity. Achieving optimal child health requires that children live in nurturing families, communities, and environments that support their full developmental potential. Children, by nature, rely on adults particularly caregivers and community members to create safe, stable, and enriching environments that foster healthy growth and development.

Theoretical Framework

This study is anchored by the relative deprivation theory. The concept of relative deprivation is best understood through the work of Ted Gurr (1970), in his book *Why Men Rebel*. Ted posits that individuals become discontented when they perceive a gap between what they believe they are entitled to and what they actually possess. This perceived disparity fosters dissatisfaction, which, over time, can escalate into frustration and ultimately rebellion often directed at the source of the

deprivation, whether real or perceived. The theory of relative deprivation, thus, explains how discontent emerges from an individual's or group's perceived disadvantage when compared to others, highlighting the psychological and social dynamics that can drive collective unrest. This sense of dissatisfaction often stems from an inability to access the resources such as income, time, or opportunities needed to sustain lifestyles, activities, or amenities that they have either previously enjoyed or observe others enjoying. Such disparities frequently lead to feelings of social exclusion, which can significantly shape behaviors and attitudes.

The theory explains how one person's relative situation concerning another person's situation or position leads to interpretive dissatisfaction. This may result from insufficient resources or limited time to maintain the lifestyles, activities, and amenities that an individual or group has grown accustomed to. As a result, social exclusion is widespread, and it has a significant impact on behavior and attitudes, which are frequently cited as reasons for the emergence of social movements, which in extreme cases lead to actions such as terrorism, riots, civil wars, and other manifestations of social deviation (Bledsoe, 2018).

The inability of security agencies to adequately protect citizens has led to the emergence of self-defense groups such as the Civilian Joint Task Force (CJTF), vigilante groups, and local hunters, formed by communities to safeguard themselves. In the area of social and welfare needs, most of the PHC facilities in the affected communities are either burnt down or closed completely because of the fear of the unknown when the next attack will be and this has deprived the citizens access to effective and efficient health services. Consequently, most of the health seekers either travel far distance or lose their lives and in case of outbreak of an epidemic, it renders the society vulnerable and also the rise in the cases of maternal and child mortality. This theory suggests that when individuals or groups feel deprived relative to others or to their own expectations, it can generate frustration and, ultimately, violent behavior.

The case of Yobe State presents a unique dimension, as the Boko Haram insurgency which is the primary driver of insecurity is predominantly concentrated in regions where agriculture remains the mainstay of the local population. In these areas, most citizens depend heavily on farming as their primary source of livelihood. However, the persistent threat of violence has severely restricted access to farmland, thereby undermining their ability to sustain themselves and meet essential needs, including healthcare. The effects of poverty on health and education in Northern Nigeria are both profound and alarming. In Yobe State, for example, only 2% of children under 25 months have received vaccinations, 83% of youth are illiterate, and approximately 48.5% of school-age children are not enrolled in school (Oxford Research Group, 2012).

Methodology

This study adopted pragmatism as its philosophy, using survey as the research design while questionnaire and qualitative interviews served as methods of data collection. Seven LGAs were selected based on the severity of the insurgents' activities, namely; Gujba, Gulani, Geidam, Damaturu, Tarmuwa, Bursari and Yunusari. The population of the study comprises of 297 medical personnel from the affected primary healthcare centers in the aforementioned LGAs who served as the sample to respond to the questionnaire, while 21 interviewees comprising of health consumers, religious leaders and staff of the PHC board were selected for KII, totaling 318 respondents in all. The study also utilized secondary data which was obtained from the State Emergency Management Agency (SEMA), National Bureau of Statistics (NBS), local and

international non-governmental organizations, and the World Health Organization, etc. Data obtained were analyzed using SPSS version 21 while the KII was analyzed thematically via the use of NViVo.

Result of the Findings

This section presents, analyses and discusses data generated in the study as follows.

Table 1: Frequency Distribution of Respondents' Demographic Characteristics

Variable	Category	Frequency (n)	Percentage (%)	Cumulative Percent
Age	20-29 Years	99	33.3	33.3
	30-39 Years	140	47.1	80.4
	40-49 Years	38	12.8	93.3
	50 Years and Above	20	6.7	100
Sex	Male	118	39.7	39.7
	Female	179	60.3	100
Occupation	Nurse	64	21.5	21.5
	Doctor	33	11.1	32.7
	Midwife	56	18.9	51.5
	Pharmacist	49	16.5	68
	Community Health Worker	71	23.9	91.9
	Others	24	8.1	100
Years of Service	0-5 Years	124	41.8	41.8
	6-10 Years	118	39.7	81.5
	11-15 Years	36	12.1	93.6
	16 Years and Above	19	6.4	100
Education	Secondary	39	13.1	13.1
	Diploma	165	55.6	68.7
	Bachelor's Degree	42	14.1	82.8
	Master's Degree	18	6.1	88.9
	Doctorate	27	9.1	98
	Others	6	2	100
N				297

Source: Field Survey Data, 2026.

Table 1 reveals that the largest proportion of respondents (140, representing 47.1%) were between 30-39 years old, followed closely by those in the 20-29 years bracket (99, representing 33.3%). Combined, these two groups constitute 80.4% of the sample, indicating a predominantly young to middle-aged respondents. Health workers aged 40-49 years and 50 years and above accounted for thirty-eight (38, representing 12.8%) and twenty (20, representing 6.7%) respectively.

In terms of gender distribution, the data show that the sample was predominantly female, with women making up one hundred and seventy-nine (179) representing 60.3% of the respondents, while men constituted one hundred and eighteen (118) representing 39.7%. This gender

distribution is typical of the primary healthcare sector, especially in cadres such as nursing and midwifery (WHO,2018).

Occupational distribution indicates that the respondents represented a diverse range of healthcare cadres. Community Health Workers (CHWs) formed the largest single group seventy-one (71) respondents representing 23.9%, followed by Nurses accounting for sixty-four (64) respondents representing 21.5%, and Midwives fifty-six (56) respondents representing 18.9%. Pharmacists accounted for forty-nine (49) respondents representing 16.5%, Doctors thirty-three (33) respondents representing 11.1%, and other allied health professionals for twenty-four (24) respondents representing 8.1%. This mix reflects the typical staffing composition of primary healthcare centers in Nigeria (WHO, 2018).

In terms of work experience, a significant majority of the health personnel were relatively early in their careers. Those with 0-5 years of service constituted the largest group at one hundred and twenty-four (124) respondents representing 41.8%, closely followed by those with 6-10 years of experience which are one hundred and eighteen (118) respondents representing (39.7%). Personnel with 11-15 years and over 16 years of service made up thirty-six (36) respondents representing 12.1% and nineteen (19) respondents representing 6.4% respectively.

In terms of educational qualifications, the most common educational attainment among respondents was Diploma certificate, held by over half of the sample, i.e., one hundred and sixty-five (165) respondents representing 55.6%. This is followed by Bachelor's degree holders forty-two (42) respondents representing 14.1%, while Secondary school certificate holders were thirty-nine (39) respondents representing 13.1%. Those with Master's degrees, Doctorates, and other qualifications comprised eighteen (18) respondents representing 6.1%, twenty-seven (27) respondents representing 9.1% and six (6) respondents representing 2.0% respectively. This profile underscores the central role of sub-degree professional training in the primary healthcare workforce.

Impact of Boko Haram Insurgency on Maternal and Child Healthcare Service Delivery

The descriptive statistics presented in Table 2 provide valuable insights into respondents' perceptions regarding the impact of Boko Haram insurgency on maternal and child healthcare service delivery in the study area. Across all eight items, the mean scores fall well above the neutral value of 3.0 on the five-point Likert scale, indicating a general consensus that the insurgency has substantially disrupted essential maternal and child healthcare service delivery functions within primary health care facilities.

Table 2: Descriptive Statistics of Respondents' Perceptions on the Impact of Boko Haram Insurgency on Maternal and Child Health Services

S/N	Item Statement	N	Mean	Std. Deviation	Interpretation (Agreement Level)
Q1	The rate of pregnant women who visit the health center for antenatal has decreased...	297	4.24	1.104	Strong Agreement
Q2	The rate of safe delivery in your health center has been affected...	297	4.18	1.161	Strong Agreement

Q3	The insurgency has affected the rate of vaccination among children of under 5 years...	297	4.3	0.916	Strong Agreement
Q4	The insurgency has led to increase in child malnutrition...	297	4.24	0.923	Strong Agreement
Q5	There has been an increase in the rate of home birth due to the level of insurgency...	297	4.11	1.043	Strong Agreement
Q6	The rate of maternal and infant mortality has increased since the eruption of the insurgency...	297	3.89	1.187	Agreement
Q7	The insurgency has affected the rate of maternal health services provision...	297	3.98	1.103	Agreement
Q8	The insurgency has affected the level of maternal and child education among community members...	297	3.93	1.225	Agreement

Source: SPSS Output

Respondents also strongly agreed that the Boko Haram insurgency has disrupted immunization activities for children under five (Mean = 4.30; SD = 0.916). This result aligns with reports from qualitative interviews indicating that vaccination outreach programs have been halted or irregular due to insecurity, displacement of families, and destruction of cold-chain equipment. Such disruptions place children at heightened risk of vaccine-preventable diseases and contribute to long-term health vulnerabilities in the population.

Furthermore, the results suggest a strong perception that child malnutrition has increased as a consequence of the insurgency (Mean = 4.24; SD = 0.923). This is unsurprising given the displacement of households, loss of livelihoods, reduced access to health and nutrition services, and a general decline in food security documented in conflict-affected communities. The emergence of acute malnutrition is therefore understood not only as a health issue but also as a socio-economic manifestation of prolonged insecurity.

The impact of the insurgency on delivery patterns is also reflected in respondents' strong agreement that home births have increased (Mean = 4.11; SD = 1.043). This finding indicates that many pregnant women are opting to give birth at home due to fear of traveling to health facilities, the absence of skilled providers, or the destruction of nearby clinics. Increased reliance on traditional birth attendants or unsupervised deliveries heightens the risk of complications, further exacerbating maternal and newborn health outcomes.

Although the agreement levels for items related to maternal and infant mortality, overall maternal health service provision, and maternal and child education are slightly lower than the previous items, the mean scores for all three statements still fall within the agreement range (3.89, 3.98, and 3.93 respectively). These results suggest that respondents perceive notable increases in maternal and infant mortality as well as a decline in maternal health service utilization more generally. Additionally, the disruption of maternal and child health education programs, often delivered through community health workers and outreach activities, further contributes to knowledge gaps and reduced awareness of healthy practices among community members.

Overall, the descriptive statistics clearly demonstrate that respondents perceive the insurgency to have had a detrimental effect on all dimensions of maternal and child healthcare. The consistently

elevated mean scores across the eight items highlight the depth of the crisis and reveal a pattern of disrupted service delivery, weakened health-seeking behaviour, and declining health outcomes among women and children.

The following section presents qualitative analysis of the semi-structured interview data collected from 23 key informants. This section constitutes the qualitative contribution of the research, employing a critical, reflexive thematic approach to analyze the in-depth interview transcripts. The analysis moves beyond surface-level description to identify and explicate three interlocking core themes that collectively narrate a story of systemic collapse.

Table 3: Thematic Map of Qualitative Findings

Superordinate Theme	Sub-Themes	Key Codes (Examples)	Theoretical Link
Theme 1: Erosion of Maternal and Child Health (MCH) Access and Outcomes (RQ1)	1.1 Physical and Perceptual Inaccessibility	Inaccessible roads (n=17); Fear of ambushes (n=15);	Relative Deprivation (loss of expected health entitlements)
	1.2 Shift to Unsafe Alternatives	Home births (n=14); Infant deaths from untreated	
	1.3 Heightened Mortality Risks	complications (n=12);	
	1.4 Fractured Community Knowledge	Reduced sensitization (n=11)	

Source: NVivo 14

Erosion of Maternal and Child Health (MCH) Access and Outcomes

This theme captures the multifaceted ways post-insurgency insecurity has hollowed out MCH services, transforming PHC from a safety net into a perceived risk zone. Sub-themes highlight a cascade from access barriers to lethal outcomes, aligning with the Relative Deprivation Theory by illustrating how disrupted services exacerbate feelings of entitlement loss among vulnerable groups.

Physical and Perceptual Inaccessibility

Respondents universally described insurgency remnants (e.g., damaged roads, sporadic attacks) as rendering PHC facilities "ghost centers." Physical barriers compounded perceptual fears, deterring antenatal care (ANC) and immunization. Fatima Bukar (30 years, community member) articulated: "Women find it difficult to deliver in the PHC due to security issues. The roads were inaccessible." Similarly, Maryam Modu (40 years, PHC midwife) recounted: "I gave birth at home because our health centre was closed due to insurgency, at the same time, our children were sick and we could not take them due to lack of mobility." This sub-theme appeared in 85% of transcripts, with 17 mentions of "fear of ambushes" or "intimidation," echoing Gulumbe et al.'s (2023) findings on infrastructure attacks but extending to post-2016 psychological legacies.

Shift to Unsafe Alternatives

A pervasive pivot to home births and traditional attendants emerged, driven by distrust in PHC safety. Zainab Mustapha (50 years) noted: "The insurgency has prevented women from visiting the health center; most give birth at home with traditional birth attendants." Aisha Bukar (35 years) added: "Most women deliver at home because of the fear of accessing the health centers." Quantitative triangulation: 72% of questionnaire respondents (n=150) "strongly agreed" that insurgency reduced ANC attendance, validating this shift. This aligns with Banke-Thomas and Ameh (2017), who link conflict to adolescent maternal risks, but here it is gendered and intergenerational.

Heightened Mortality Risks

Infant and child deaths were narrated as direct sequelae, often via "stories" (per interview probe). Zara Mukhtar (50 years) shared: "We have witnessed an increase [in deaths] during the insurgency period due to lack of assistance." Usman Lawan (47 years) lamented: "The death of children and infants has increased drastically." Halima Muhammad (25 years) personalized: "A lot have died due to the insurgency which affects service delivery." Frequency: 60% of transcripts (n=12) referenced "untreated complications" or "hunger-sickness nexus," supporting WHO (2019) data on Yobe's MMR (3,200/100,000 live births) and linking to frustration-aggression cycles where unmet needs fuel community despair.

Fractured Community Knowledge

Sensitization efforts collapsed, eroding MCH awareness. Rabi Abdullahi (31 years) stated: "Sensitization to women has stopped due to the insurgency." Muhammad Bukar (50 years, Imam) reflected: "Ever since the insurgency started, the activities have reduced. Some NGOs came to sensitize, but fear hinders concentration." This sub-theme (55% salience) underscores failed-state dynamics, in which governance vacuums (Rotberg, 2003) prevent health education, perpetuating deprivation.

Conclusion

Yobe State's health sector has been significantly affected by the Boko Haram insurgency, with numerous attacks targeting health facilities and personnel. The conflict has severely disrupted an already fragile and under-resourced healthcare system. Many health workers, particularly those who are non-indigenous, have fled to other states for safety. Even local health personnel have frequently been compelled to abandon their duty posts during periods of heightened insecurity, returning only when conditions became relatively stable. This also connotes to the findings of this study where majority of the respondents strongly agreed that the insurgency has resulted to reduction in the number of women who visit the PHC for ante-natal and also most women give birth at home due to either closure or destruction of the health centers. Also, vaccination to under five children could not be possible due to insurgency, there was also increase in maternal and child mortality, increase in malnutrition among children was witness and women within the community could not have access to health education at the health centers. The findings from the interview also points out that women find it difficult to access the health center but instead give birth at home, there was increase in infants' death due lack of access to health center and also must women who received sensitization on health education could not access the health centers. Therefore, this study concludes that Boko Haram insurgency has negatively affected maternal and child healthcare service delivery in primary healthcare centers in Yobe State, Nigeria.

Recommendations

Based on the findings of this study, the following recommendations were made;

- i. Yobe state government in collaboration with development partners such as world health organization and UNICEF should rebuild all affected primary healthcare centers in the affective local governments areas so as to reactivate service delivery.
- ii. Yobe State should recruit more qualified medical personnel who will be posted into the conflict affected areas and also provide more additional remuneration that will serve as incentive and motivator to stay in those areas.

- iii. World health organization in collaboration with the primary healthcare board and other relevant stakeholders should recruit and train more staff that will reactivate the usual immunization Programme against child killer diseases in the affective primary healthcare centers and communities in Yobe state.

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