Armed Conflict, Disruption of Essential Social Services and Restoration Challenges in Conflict-Affected Communities of Borno State, Nigeria

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Abstract
Armed conflict disrupts the social and institutional systems through which communities obtain healthcare and other essential services. In Borno State, Nigeria, the Boko Haram insurgency has contributed to displacement, loss of livelihoods, damage to public infrastructure and reduced access to basic services. This study examined the effects of conflict on social provisioning and healthcare delivery and assessed the restoration programmes and challenges reported in selected conflict-affected communities. A pragmatist philosophy and convergent mixed-methods design were adopted. The study covered Gwoza, Konduga and Magumeri Local Government Areas and involved 400 questionnaire respondents selected through a multistage sampling procedure. Key informant interviews and documentary sources complemented the survey. The questionnaire recorded a Cronbach's alpha coefficient of 0.904. Quantitative data were analysed using frequencies and percentages, while qualitative evidence was analysed thematically. Findings indicate substantial disruption across essential services: 68.00% of respondents reported that healthcare access was highly or severely affected, 70.50% reported comparable disruption to education, and 98.25% reported that they or a family member had experienced displacement. Restoration interventions covered security, education, infrastructure, livelihoods and healthcare. However, perceived effectiveness was mixed: 51.25% rated programmes as at least moderately effective, while 48.75% rated them as slightly effective or ineffective. Corruption, insecurity, limited community involvement, inadequate funding and weak institutional coordination were identified as major barriers. The study concludes that rebuilding facilities alone is insufficient. Sustainable recovery requires secure access, functioning services, livelihood support, accountable institutions and meaningful participation by affected communities. The findings support an integrated approach to restoring essential services in conflict-affected settings.

Keywords: *armed conflict, healthcare delivery, social provisioning, service restoration, displacement, Borno State, Nigeria*

1. Introduction

Armed conflict affects public health not only through deaths and physical injuries but also by weakening the systems that sustain everyday life. Health facilities may be damaged, health workers displaced, supply chains interrupted and access routes rendered unsafe. At the same time, households may lose access to food, safe water, sanitation, housing, education and income. These

disruptions reinforce one another: poor living conditions increase health risks, while illness and the loss of care reduce household capacity to recover. The consequences of conflict therefore extend beyond the health sector and require attention to the wider systems of social provisioning (Levy & Sidel, 2016; Rubenstein & Bittle, 2010; World Health Organization [WHO], 2016). Healthcare delivery depends on more than the physical existence of clinics and hospitals. Effective services require trained personnel, medicines, equipment, financing, referral arrangements, institutional management and safe access for patients. In fragile settings, these components are often weakened simultaneously. Evidence from conflict-affected health systems shows that health workers may sustain services through professional commitment and community relationships, but individual resilience cannot replace adequate institutional support (Witter *et al.*, 2017). Similarly, research in Iraq demonstrates that the reopening of facilities does not necessarily mean that routine services, preventive care and public confidence have been restored (Ibrahim *et al.*, 2021).

The Boko Haram insurgency, which began in northeastern Nigeria in 2009, has had particularly severe consequences in Borno State. The conflict has involved attacks, abductions, destruction of property and infrastructure, population displacement and disruption of livelihoods. The resulting humanitarian crisis has placed pressure on healthcare and other public services. Evidence from neighbouring Yobe State indicates that displacement, transport restrictions and the movement of health personnel weakened service delivery, while staff-retention measures, medicine availability and community resources supported resilience (Ager *et al.*, 2015). Research on maternal, newborn and child health in northeastern Nigeria similarly identifies the relationship between armed conflict and reduced access to health services (Tyndall *et al.*, 2020). Government institutions, security agencies, humanitarian organisations and development partners have undertaken interventions intended to restore services and support affected populations. Such measures include security and policing, reconstruction of houses and public infrastructure, healthcare support, education initiatives, livelihood assistance, humanitarian relief and resettlement. Yet the presence of programmes does not automatically establish that services are reliable, accessible or sustainable. The effectiveness of restoration also depends on how programmes are coordinated, financed, monitored and shaped by the priorities of affected communities. Studies of post-conflict health-sector reform emphasise the importance of political commitment, institutional capacity, financing and coordinated workforce policies (Bertone *et al.*, 2014; Kruk *et al.*, 2010). The concept of social provisioning provides a useful way to examine these interdependencies. It directs attention to the institutions and relationships through which societies organise the production and distribution of goods and services required to meet human needs (Jo, 2011). In conflict-affected communities, this includes public agencies, households, local markets, community organisations, humanitarian actors and development partners. A service may be physically available but remain inaccessible because of cost, distance, insecurity, exclusion or inadequate information. Consequently, restoration should be assessed in terms of the functioning of the wider service system and the experiences of people who depend on it.

Although previous studies have examined health-system resilience, humanitarian assistance and post-conflict reconstruction, evidence remains fragmented across locations, services and population groups. Research in Yobe State provides useful insight into health-service resilience (Ager *et al.*, 2015), while studies in other post-conflict settings show the value of integrating healthcare with livelihood and social programmes (Christensen & Edward, 2015). However, there is a need for integrated evidence from communities in Borno State that considers the effects of conflict on several essential services, the restoration interventions undertaken and the barriers that

residents associate with their effectiveness. This article addresses that need using evidence from Gwoza, Konduga and Magumeri Local Government Areas.

Social provisioning refers to the social and institutional processes through which essential goods and services are organised and made available to meet human needs. It is broader than the distribution of emergency relief because it includes the arrangements that sustain access to healthcare, education, food, water, sanitation, housing and livelihoods. Jo (2011) explains that provisioning is shaped by institutions and social relationships, not simply by market exchange or individual purchasing power. In conflict settings, the weakening of public institutions and local economies may shift responsibility among government, humanitarian organisations, communities and households. For this study, restoration is understood as the re-establishment and strengthening of the services, infrastructure and institutional arrangements disrupted by conflict. Health-system reconstruction requires facilities, health workers, essential medicines, financing, governance and equitable access to operate together (Kruk *et al.*, 2010). Emergency assistance remains important, but sustainable recovery also requires the restoration of routine services and local institutional capacity. The relationship between healthcare and other social services is reciprocal: inadequate housing, food and sanitation increase health risks, while poor health can undermine household income and recovery. Human Needs Theory provides a complementary perspective by emphasising the importance of security, identity, recognition and participation in individual and collective well-being (Burton, 1990). Conflict can undermine these needs through violence, displacement, loss of livelihoods and exclusion from public services. The perspective is relevant because restoration is not only a technical exercise in rebuilding facilities; it is also a process of enabling people to regain security, dignity and meaningful access to the services required for everyday life. The study also draws on the Social Provisioning Approach to examine the institutions responsible for delivering essential goods and services. Together, these perspectives frame the analysis around both the needs of affected populations and the institutional arrangements required to meet those needs. The purpose of the study was to examine how armed conflict affected social provisioning and healthcare delivery in selected communities of Borno State and to assess the interventions and challenges associated with restoration.

2. Methodology

2.1 Research design and study area

The study adopted a pragmatist research philosophy and a convergent mixed-methods design. A cross-sectional questionnaire survey was combined with key informant interviews and documentary review. The quantitative and qualitative strands addressed related aspects of the research problem and were brought together during interpretation. This design was appropriate because numerical patterns alone could not fully explain the institutional and operational circumstances surrounding restoration. The study was conducted in Gwoza, Konduga and Magumeri Local Government Areas of Borno State, northeastern Nigeria. The three LGAs were purposively selected because they had experienced insurgency-related disruption and subsequent restoration interventions and were accessible for fieldwork during the study period. The study's geographical coverage was therefore limited to these three LGAs and should not be treated as a census of all communities in Borno State.

2.2 Population, sample and sampling

The target population comprised adults in conflict-affected communities and stakeholders involved in the restoration of healthcare and social services. The quantitative sample consisted of

400 respondents. A multistage procedure was used: the three LGAs were purposively selected, and the questionnaire sample was allocated almost equally across them. Konduga contributed 134 respondents, while Gwoza and Magumeri each contributed 133. Simple random sampling was used to select eligible adult respondents within the selected communities. Key informants were selected purposively based on their roles and knowledge of conflict management and restoration programmes.

2.3 Data collection and analysis

Data were collected using a structured questionnaire, a key informant interview guide and a document-review guide. The questionnaire covered demographic characteristics, conflict experiences, access to essential services, restoration programmes, programme effectiveness, implementation challenges and recommendations. The instrument was subjected to face and content validation. The reported Cronbach's alpha coefficient for the relevant service-disruption items was 0.904, indicating high internal consistency. Quantitative responses were analysed using frequencies and percentages. Multiple-response questions were treated as selections rather than mutually exclusive categories; therefore, percentages for these items may exceed 100%. Interview material was analysed thematically, while documentary evidence was reviewed for relevant contextual information. Findings from the different sources were integrated during interpretation. Participation was voluntary, informed consent was obtained, and confidentiality and anonymity were maintained.

3. Results

3.1 Respondent profile and conflict exposure

All 400 questionnaires were reported as completed and valid, giving a response rate of 100%. Respondents were drawn almost equally from the three study LGAs: 134 (33.50%) from Konduga and 133 (33.25%) each from Gwoza and Magumeri. A majority had lived in their communities for more than 10 years (62.75%), providing substantial direct experience of the conflict and its consequences. The conflict was described as involving different combinations of violent attacks, kidnapping, property destruction and displacement. When asked to identify its most significant consequence, 40.50% selected loss of lives, 25.50% economic hardship and 23.00% displacement. Disruption of social services and psychological trauma were each selected by 5.50%. Insurgent groups were identified either alone or alongside other actors by 85.75% of respondents. Conflict incidents were reported at varying frequencies: 31.25% experienced them daily, 17.75% weekly, 9.75% monthly and 41.25% rarely.

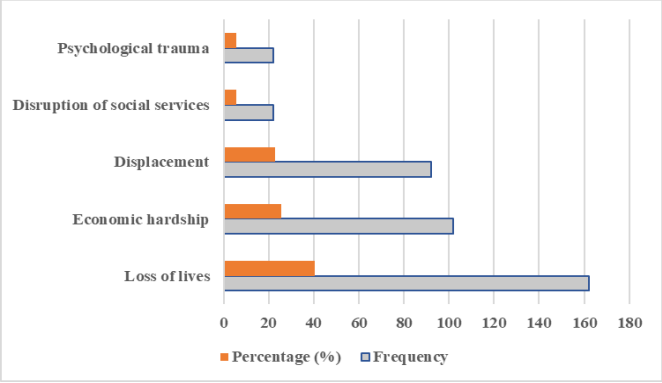


Figure 1. *Most significant reported consequences of conflict*
Source: author's data analysis, 2026

The results in fig. 1 above indicate that respondents experienced the conflict as a broad social crisis rather than only a security problem. The prominence of loss of life was accompanied by economic hardship and displacement, both of which can weaken household capacity to obtain food, shelter and healthcare. This pattern is consistent with evidence that armed conflict produces interconnected effects on population health, livelihoods and public services (Levy & Sidel, 2016; Tyndall *et al.,* 2020).

3.2 Effects on healthcare and other essential services

Respondents reported substantial disruption across the services examined. Healthcare access was highly affected for 149 respondents (37.25%) and severely affected for 123 (30.75%). Thus, 68.00% reported high or severe disruption. Only eight respondents (2.00%) indicated that healthcare access had not been affected. The findings suggest that the effects of conflict were not limited to damage to health facilities; they also concerned the ability of residents to reach and use available services.

Table 1. Respondents' assessment of the effect of conflict on access to healthcare

Level of effect	Frequency	Percentage (%)
Not affected	8	2.00
Slightly affected	44	11.00
Moderately affected	76	19.00
Highly affected	149	37.25
Severely affected	123	30.75
Total	400	100.00

Source: author's data analysis, 2026

Table 1 above shows that disruption extended to education, water and sanitation, food supply and housing. Education was highly or severely affected for 70.50% of respondents. For water and sanitation, 82.00% reported moderate, high or severe effects. Food supply was highly or severely affected for 70.00%, while 68.00% reported high or severe effects on housing. These findings show why healthcare restoration cannot be treated in isolation from wider social provisioning. Inadequate water and sanitation can increase disease risks, while food insecurity and damaged housing can undermine health and the ability of households to recover.

Table 2. Reported disruption to selected essential services

Service	High effect (%)	Severe effect (%)	Combined high/severe or stated threshold (%)
Education	38.25	32.25	70.50
Healthcare	37.25	30.75	68.00
Water and sanitation	27.25	26.75	54.00*
Food supply	37.25	32.75	70.00
Housing	36.50	31.50	68.00

Source: author's data analysis, 2026

The findings in table 2 above shows that for water and sanitation, 82.00% reported moderate, high or severe effects; the combined high/severe figure shown is 54.00%. The results align with

research from northeastern Nigeria showing that displacement, transport restrictions and the movement of health workers can weaken healthcare access and continuity (Ager *et al.*, 2015). They also reflect the wider health-system vulnerabilities documented in conflict-affected settings, where facilities may remain operational at reduced capacity because of shortages of personnel, medicines and supplies (Ibrahim *et al.*, 2021; Witter *et al.*, 2017).

3.3 Household vulnerability, psychological well-being and displacement

The household consequences reported by respondents included loss of income, increased poverty, loss of property and higher living costs. The most frequently reported combination of economic consequences was the presence of all four conditions, identified by 124 respondents (31.00%). Psychological well-being was also affected: 181 respondents (45.25%) reported a high level of impact, while 38 (9.50%) reported a severe impact. These are self-reported assessments and should not be interpreted as clinical diagnoses of a mental-health condition. Displacement was widespread. A total of 393 respondents (98.25%) indicated that they or members of their families had been displaced. Among those reporting displacements, 220 (55.98%) indicated that they had been resettled, while 173 (44.02%) had not. The remaining proportion points to the continuing challenge of achieving safe and sustainable return. Resettlement requires more than housing: it also depends on security, access to healthcare, schools, water, livelihoods and other services.

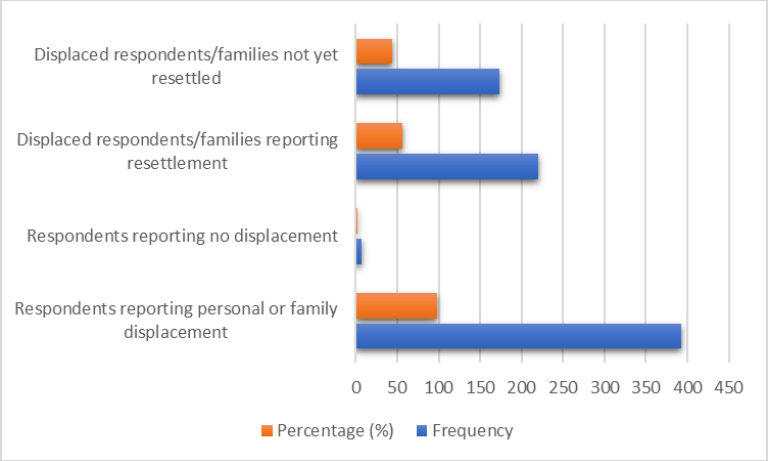


figure 2. *Displacement and reported resettlement*
Source: author's data analysis, 2026

In Figure 2, Resettlement percentages use the 393 respondents who reported displacement as the denominator. The scale of reported displacement reinforces the need to connect resettlement policy with the restoration of services and livelihoods. The finding is also consistent with research documenting the relationship between conflict-related trauma, material deprivation and psychological distress among displaced populations in northeastern Nigeria (Abiama *et al.*, 2022).

3.4 Restoration programmes and perceived effectiveness

Respondents identified a range of interventions intended to restore social provisioning and healthcare delivery. These included security and policing, educational initiatives, infrastructure reconstruction, economic and livelihood support, and healthcare services. Across 891 programme selections, security and policing accounted for 27.27%, education 20.43%, infrastructure reconstruction 18.18%, livelihood and economic support 17.96%, and healthcare services 16.16%.

Table 3. Restoration programme areas identified by respondents

Programme area	Share of programme selections (%)
Security and policing	27.27
Educational initiatives	20.43
Infrastructure reconstruction	18.18
Economic and livelihood support	17.96
Healthcare services	16.16
Total	100.00

Source: author's data analysis, 2026

According to Table 3 above, Percentages are based on 891 programme selections, not 400 mutually exclusive respondents. Key informant evidence in the thesis also described reconstruction of houses and public facilities, including health institutions, alongside interventions by government and humanitarian partners. One health-sector account reported the reconstruction and re-equipping of 58 health institutions, including 23 health centres supported through partnerships with organisations such as WHO, UNFPA, ICRC, UNICEF and Action Against Hunger. These interview accounts provide institutional context, but they should be interpreted as reported programme information rather than independently audited outputs.

Respondents' assessment of programme effectiveness was mixed. A combined 51.25% rated programmes as moderately effective, effective or very effective. However, 48.75% rated them as slightly effective or ineffective. In particular, 25.75% considered the programmes ineffective. This distribution suggests that the existence of interventions did not translate into a uniformly positive experience across the selected communities.

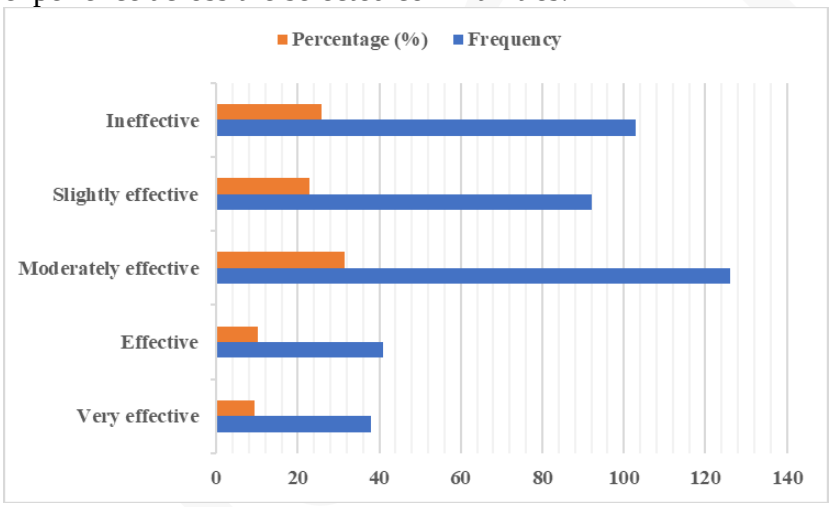


Figure 3. *Respondents' assessment of restoration programme effectiveness*

As shown in Fig. 3 above, government was identified by 49.25% of respondents as the most effective restoration actor, followed by NGOs (29.75%), community leaders (12.50%) and international organisations (8.50%). These perceptions indicate the visibility of government and non-governmental interventions, while also suggesting that local leadership and international partners were recognised as part of the restoration landscape.

3.5 Challenges affecting restoration

The most frequently identified general challenge was corruption, which accounted for 188 of the 696 challenge selections (27.01%). Insecurity accounted for 158 selections (22.70%), insufficient

community involvement for 125 (17.96%), inadequate funding for 117 (16.81%) and poor coordination for 106 (15.23%). Because respondents could identify more than one challenge, the percentages are calculated from total selections rather than from the number of respondents.

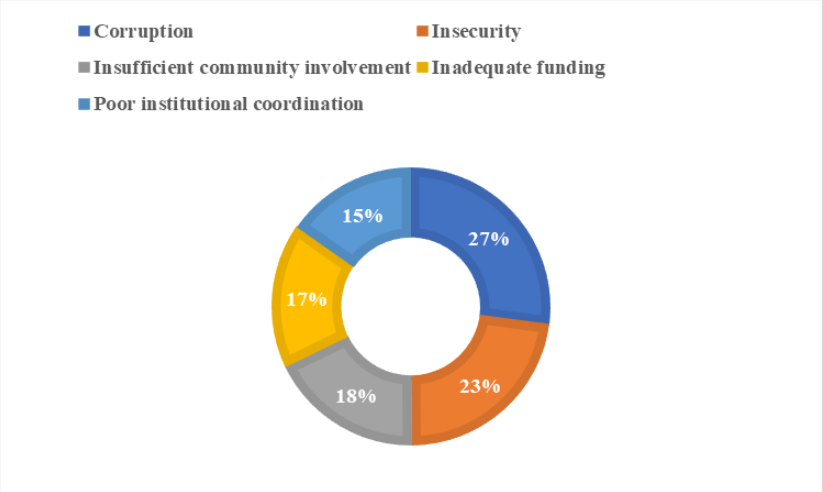


Figure 4: *Major challenges affecting restoration*
Source: *Author's data analysis, 2026*

Figure 4 pointed that Security-related challenges included poor coordination among security agencies (29.82% of 627 selections), the continuing presence of insurgents (27.27%), inadequate policing (25.52%) and community mistrust (17.38%). Social barriers were also prominent. Lack of social cohesion represented 48.25% of 601 social-barrier selections, followed by discrimination (22.63%), gender-based violence (19.30%) and child exploitation (9.82%).

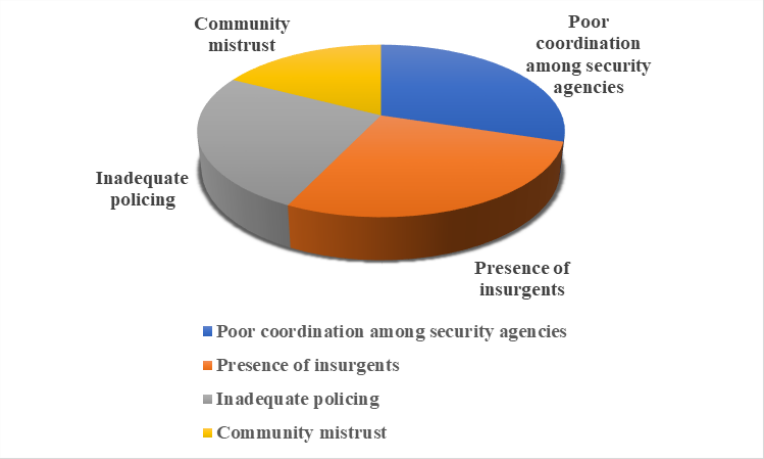


Figure 5. *Security and social barriers reported by respondents*
Source: *Author's data analysis, 2026*

Table 4. Social barriers to effective restoration

Barrier	Frequency of selections	Percentage (%)
Lack of social cohesion	290	48.25
Discrimination	136	22.63
Gender-based violence	116	19.30
Child exploitation	59	9.82
Total social-barrier selections	601	100.00

Source: *Author's data analysis, 2026*

The results in Table 4 above indicate that restoration is constrained by linked governance, security and social conditions. Corruption and weak coordination can reduce the reach and reliability of programmes, while insecurity can prevent staff, supplies and patients from moving safely. Social fragmentation, discrimination and mistrust can further undermine participation and equitable access. These patterns are consistent with evidence that post-conflict health-sector reform depends on political commitment, institutional capacity, financing and coordination (Bertone *et al.*, 2014), and that community relationships can support service resilience but cannot substitute for functioning institutions (Ager *et al.*, 2015; Witter *et al.*, 2017).

3.6 Strategies proposed by respondents

Of the 400 respondents, 330 provided substantive recommendations. Improved security and enforcement of the rule of law were the most frequently coded theme, appearing in 191 responses (57.90%). Community participation and local ownership appeared in 107 responses (32.40%), while employment and livelihood support appeared in 92 responses (27.90%). Other themes included equitable assistance, accountability, institutional coordination, improved healthcare and education, and reconstruction of infrastructure. Multiple themes could be coded from a single response; therefore, the percentages are not expected to total 100%.

Table 5. Strategies recommended by respondents

Recommended strategy	Frequency	Percentage of valid responses (%)
Improved security and enforcement of the rule of law	191	57.90
Community participation and local ownership	107	32.40
Employment and livelihood support	92	27.90
Equitable assistance and social inclusion	36	10.90
Accountability and reduction of corruption	29	8.80
Better institutional coordination and collaboration	23	7.00
Improved healthcare and education	20	6.10
Reconstruction of infrastructure and social amenities	16	4.80

Source: *Author's data analysis, 2026*

The recommendations place security and community ownership at the centre of restoration, while also recognising employment and livelihood recovery as important conditions for sustainable progress. The emphasis on community participation is consistent with the view that locally

informed recovery can improve the relevance of interventions and strengthen confidence in institutions. Integrated service delivery may also support social cohesion when healthcare is connected with wider economic and social programmes (Christensen & Edward, 2015).

4. Discussion

The findings demonstrate that conflict affected the selected communities through a combination of direct violence, displacement, economic hardship and disruption of essential services. Loss of lives was the most frequently identified major consequence, but the high proportions reporting displacement and economic hardship show that the effects extended into household stability and everyday access to services. The finding that 98.25% of respondents reported personal or family displacement is particularly important because displacement changes where people live, how they earn income and whether they can maintain continuity of healthcare, education and social support. The reported disruption to healthcare and other services illustrates the interdependence of social provisioning. More than two-thirds of respondents reported high or severe effects on healthcare access, while education, food supply and housing were also substantially affected. Water and sanitation disruption was widespread when moderate, high and severe responses were considered together. This pattern suggests that health outcomes in the study communities cannot be understood only through the number of functioning health facilities. Safe movement, household resources, water, sanitation, food and housing also shape whether people can maintain health and use available services. This interpretation is consistent with the wider evidence on conflict-related effects on population health (Levy & Sidel, 2016; Tyndall *et al.*, 2020).

The restoration interventions identified in the study were multisectoral. Security and policing represented the largest share of programme selections, followed by education, infrastructure, livelihood support and healthcare. This spread is appropriate to the multidimensional effects of conflict, but the mixed programme-effectiveness ratings indicate that coverage or programme presence should not be equated with successful restoration. Almost half of respondents rated programmes as slightly effective or ineffective. A facility may be reconstructed, for example, without having sufficient staff, medicines, equipment or reliable access for patients. Health-system reconstruction literature similarly emphasises the need to restore governance, workforce, financing and essential services together (Kruk *et al.*, 2010).

The institutional and operational barriers identified by respondents help explain the mixed assessment of programme effectiveness. Corruption was the most frequently selected general challenge, followed by insecurity, insufficient community involvement, inadequate funding and poor coordination. These barriers are mutually reinforcing. Weak coordination may produce duplication or gaps in service coverage; inadequate funding may interrupt supplies and staffing; and corruption may reduce the resources reaching intended beneficiaries. Insecurity can restrict access for service providers and communities even when infrastructure is available. The findings therefore support the argument that sustainable restoration requires both physical reconstruction and stronger institutional arrangements.

The security-specific results add a further dimension. Poor coordination among security agencies and the continuing presence of insurgents were prominent concerns, while inadequate policing and community mistrust were also reported. These findings suggest that security restoration should not be assessed solely by the presence of security personnel or the conduct of operations. Community confidence, information-sharing and predictable protection are also relevant to whether residents can use services and resume economic activities. The recommendation for stronger rule of law and community participation reflects this connection between security and civilian recovery.

Social barriers also deserve attention. Nearly half of the social-barrier selections concerned lack of social cohesion, while discrimination, gender-based violence and child exploitation were also identified. These issues can affect who receives assistance, who feels safe accessing services and whether returnees and host communities can rebuild relationships. The findings are consistent with integrated approaches to post-conflict recovery that connect healthcare with economic and social programmes rather than treating health services as isolated interventions (Christensen & Edward, 2015). The high proportion of respondents reporting psychological impact further indicates that restoration needs to include psychosocial support. The survey item measured respondents' perceived effect on psychological well-being and did not constitute a clinical assessment. Nevertheless, the finding supports the need for accessible mental-health and psychosocial services within primary healthcare and community recovery programmes. Studies among conflict-affected and displaced populations in northeastern Nigeria have documented substantial trauma-related needs, while also highlighting the importance of interpreting screening outcomes carefully (Abiama *et al.*, 2022). Taken together, the results support a model of restoration built around five connected requirements: safe access; functional healthcare and other essential services; household livelihood recovery; accountable and coordinated institutions; and meaningful participation by affected communities. This integrated position is consistent with the Social Provisioning Approach and the Human Needs perspective. Restoration is more likely to be sustainable when it addresses the practical conditions through which people meet their needs and when institutions are responsive to the communities they serve.

5. Conclusion

This study examined the effects of armed conflict on social provisioning and healthcare delivery in Gwoza, Konduga and Magumeri Local Government Areas of Borno State. The findings show that conflict was associated with loss of lives, economic hardship, displacement, psychological distress and substantial disruption to healthcare, education, water and sanitation, food supply and housing. Although government institutions and humanitarian actors implemented interventions across security, infrastructure, education, livelihoods and healthcare, respondents' assessments of programme effectiveness were mixed. Corruption, insecurity, limited community involvement, inadequate funding and weak institutional coordination were identified as major obstacles. Security-sector coordination, social cohesion, discrimination and community mistrust also emerged as important concerns. The study concludes that sustainable restoration cannot be achieved through infrastructure reconstruction or short-term relief alone. It requires coordinated institutions, reliable funding, secure access, functional services, livelihood recovery, psychosocial support, accountability and active community participation.

The end of the study, recommendations were made as follows:

1. Establish a coordinated restoration framework involving federal, state and local authorities, security agencies, humanitarian organisations, traditional institutions and community representatives.
2. Strengthen security coordination, information-sharing and community engagement to improve safe access to healthcare facilities, schools, farms, markets and resettlement locations.
3. Ensure that reconstructed health facilities are staffed, equipped and supplied with essential medicines. Workforce-retention measures should be considered for hard-to-reach and conflict-affected communities.
4. Integrate mental-health and psychosocial support into primary healthcare and community

recovery services, with referral arrangements for people requiring specialised care.
5. Create community restoration committees that include women, young people, returnees, internally displaced persons and other vulnerable groups. These committees should participate in needs assessment, implementation oversight and monitoring.
6. Expand livelihood recovery through agricultural support, vocational training, access to credit, cash assistance and employment initiatives, particularly for households affected by displacement and loss of income.
7. Improve transparency in the allocation and use of restoration funds through public reporting, independent monitoring and accessible complaint mechanisms.
8. Prioritise the continuous operation—not only the reconstruction—of healthcare facilities, schools, water systems, housing, roads and other essential infrastructure in communities identified as safe for return.
9. Support social cohesion and reconciliation initiatives that address discrimination, gender-based violence, child exploitation and tensions between returnees and host communities.
10. Conduct regular evaluations of restoration programmes to assess access, quality, equity, effectiveness and sustainability, and use the findings to adjust programme design.

9. Limitations of the Study

The study covered three LGAs and therefore cannot be assumed to represent all conflict-affected communities across Borno State. The findings are based partly on respondents' recollections and perceptions, which may be influenced by memory and individual experience. The cross-sectional design also captures conditions at a particular period and does not establish how restoration outcomes changed over time. In addition, the reported programme outputs from key informants are presented as interview accounts and were not independently audited within this study. These limitations should be considered when interpreting the findings.

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