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[Research Article]

Accessibility and Utilization Of School Health Services In Almajiri Educational System In Hadejia Emirate Zone, Jigawa State

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Abstract:

The Almajiri educational system, deeply embedded in the socio-religious fabric of northern Nigeria, offers Quranic instruction to millions of children, yet is persistently marred by inadequate access to basic health services. This deficit contributes to widespread malnutrition, poor hygiene, and preventable illnesses, all of which significantly impair the learning capacity and overall well-being of Almajiri pupils. This study investigates the accessibility and utilization of school health services (SHS) within Almajiri schools in the Hadejia Emirate Zone of Jigawa State. Employing a descriptive cross-sectional design, data were gathered from Almajiri pupils, Mallams (Islamic teachers), and healthcare providers using structured questionnaires and semi-structured interviews. Quantitative data were analyzed using descriptive and inferential statistics. The findings indicate a stark lack of essential health services only 20% of schools reported any form of healthcare provision, with first aid being the most common. Critical services such as immunizations, routine medical check-ups, dental care, and health education were largely absent. The major barriers to SHS access included financial constraints, cultural beliefs, lack of health awareness, and inadequate government engagement. Utilization of existing health services was low, with most pupils seeking care only in severe cases. The study concludes that the current state of SHS in Almajiri schools is grossly inadequate, posing serious public health and educational challenges. It recommends the integration of comprehensive, culturally responsive school health programs into the Almajiri education system, along with stronger policy commitment and multi-sectoral collaboration to ensure equitable health access for this vulnerable population.

Keywords: Almajiri system, school health services, healthcare access, northern Nigeria, educational equity, public health, Jigawa State.

Introduction:

The Almajiri educational system, a traditional form of Islamic learning entrenched in the cultural and religious fabric of Northern Nigeria, has long served as a medium for imparting Quranic knowledge to young boys under the tutelage of Islamic scholars, or *Mallams* (Bature & Bawa, 2015). Historically, this system was supported by local communities and Islamic authorities, providing religious instruction alongside basic welfare such as food and shelter (Abbo et al., 2021). However, over time, particularly following the British colonial disruption of indigenous Islamic governance, the system lost state patronage and gradually deteriorated (Bature & Bawa, 2013). The consequence has been a proliferation of poorly structured, under-resourced learning environments

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in which Almajiri pupils often face extreme poverty, inadequate access to education, and poor living conditions (Ibrahim & Sulaiman, 2022; Garba et al., 2021).

The situation is particularly critical in the Hadejia Emirate zone of Jigawa State, where Almajiri pupils continue to live in communal settings marked by inadequate sanitation, insufficient nutrition, and minimal healthcare services. While various reforms, including the establishment of Almajiri Model Schools, have attempted to integrate Islamic and Western education, these efforts have been hampered by insufficient funding, lack of trained personnel, and inconsistent policy implementation (Ilorin Journal of Religious Studies, 2015; Garba et al., 2021). Health service delivery remains a significant gap in this educational context. Despite being crucial to the overall well-being and academic success of pupils, school health services—defined to include preventive care, medical attention, health education, and referral mechanisms—are largely absent or inaccessible to most Almajiri children (Zubairu et al., 2020).

Socioeconomic deprivation, cultural perceptions, and infrastructural deficiencies further complicate the delivery and uptake of health services within these schools (Ibrahim et al., 2020; Ahmed & Mohammed, 2023). Although the Nigerian government and various non-governmental organizations have introduced school health programs targeting hygiene, immunization, and nutrition, these initiatives often lack sustainability and community buy-in (Zubairu et al., 2020). Moreover, the Mallams and caregivers frequently lack the awareness or motivation to facilitate pupils' access to formal healthcare systems, with many students only seeking treatment when illnesses become severe (Abubakar et al., 2022). This limited engagement not only increases the children's vulnerability to preventable diseases but also impairs their capacity to participate meaningfully in learning (Oludayo et al., 2021; Nwozor, 2019).

The Almajiri system, while still providing Quranic instruction to a large segment of Northern Nigeria's youth, is now widely criticized for perpetuating cycles of poverty, social exclusion, and vulnerability to child labor and exploitation (Ilorin Journal of Religious Studies, 2015; Abdullahi & Haruna, 2020). With documented cases of recruitment of Almajirai into extremist groups and rising concerns over public health risks, the need for urgent reforms has become increasingly apparent (Yusha'u, 2022). Scholars have called for a hybrid educational model that respects Islamic traditions while incorporating vocational training, formal education, and structured health services to improve the long-term prospects of Almajiri students (UNESDOC, 2015; TheInterview Nigeria, 2022).

This study, therefore, seeks to investigate the current state of accessibility and utilization of school health services within the Almajiri educational system in the Hadejia Emirate zone. It aims to identify the systemic and cultural barriers impeding service delivery and propose actionable strategies for strengthening health support in Almajiri schools. By addressing these challenges, this research aspires to inform a more integrated and equitable educational framework that safeguards both the academic and physical well-being of one of Nigeria's most vulnerable child populations.

Methods:

Research Design

This study employed a cross-sectional survey design to evaluate the accessibility and utilization of school health services within the Almajiri educational system in Hadejia Emirate Zone, Jigawa State, Nigeria. The design enabled the systematic collection of quantitative and qualitative data from a large and diverse population at a single point in time, providing a snapshot of current practices and challenges.

Research Setting

The study was conducted across eight Local Government Areas (LGAs) within the Hadejia Emirate Zone: Auyo, Birniwa, Hadejia, Kafin-Hausa, Mallam Madori, Kaugama, Kirikasamma, and Guri. These LGAs were strategically selected due to the high concentration of Almajiri schools and the documented challenges related

to healthcare access among these institutions. Data collection occurred within school premises and nearby healthcare facilities that serve the Almajiri students.

Population and Sampling

The target population included Almajiri students, their teachers (Mallams), and health service providers within the study area. A purposive sampling technique was adopted to select 25 participants from each of the 28 selected schools (14 formal and 14 informal), yielding a total sample frame of 700 respondents**.** The Krejcie and Morgan sample size determination table was used to derive the final sample size for statistical representativeness.

Instrument for Data Collection

Data were collected using a structured questionnaire, designed to capture demographic data, access to health services, utilization patterns, and perceived barriers. The questionnaire was chosen for its cost-effectiveness, efficiency in large populations, and appropriateness for the literate target respondents. Key informant interviews were also conducted with teachers and healthcare providers to supplement survey data with qualitative insights.

Validation and Reliability

The questionnaire was validated by academic experts and pre-tested through a pilot study involving a similar population. Necessary adjustments were made based on feedback. The reliability of the instrument was confirmed using Cronbach's alpha, with a coefficient of ≥ 0.70 considered acceptable.

Data Collection Procedure

Data were collected through face-to-face administration of the questionnaire by trained research assistants to ensure high response rates and data accuracy. Interviews were conducted concurrently with selected stakeholders to gather contextual information.

Data Analysis

Data were analyzed using SPSS version 20.0. Descriptive statistics (frequencies and percentages) were used to summarize participant characteristics and responses. Inferential statistics, including chi-square tests and logistic regression, were employed to examine relationships between variables and identify predictors of health service utilization.

Ethical Considerations

Ethical approval was obtained from the relevant institutional review board. Informed consent was secured from all participants, with assurances of confidentiality, anonymity, and the voluntary nature of participation. The study adhered to ethical principles of respect, beneficence, and justice.

Result

The study achieved a high response rate, with 231 out of 242 questionnaires returned, representing 95% participation. This high rate indicates strong respondent engagement and supports the reliability of the findings.

Demographic Information

Table 2.0 Demographic Information

AGE		
Options	**Frequency**	**Percentage (%)**
Under 10	53	23%
10-14	96	42%

15-19	46	20%
20 and above	36	15%
Total	**231**	**100**%
GENDER		
Options	**Frequency**	**Percentage (%)**
Male	176	76%
Female	55	24%
Total	**231**	**100%**
Length of Time in the Almajiri System		
Less than 1 year	58	25%
1-3 years	40	17%
4-6 years	78	34%)
More than 6 years	55	(24%)
Total	**231**	**100%**

Demographic analysis revealed that the majority of respondents (42%) were between 10–14 years of age, followed by 23% under age 10, 20% aged 15–19, and 15% aged 20 and above. This suggests that the Almajiri system primarily serves children in early adolescence, a critical age for educational intervention.

Gender distribution showed a significant disparity: 76% of respondents were male, while only 24% were female, reflecting limited female representation within the Almajiri system. Regarding the length of time spent in the Almajiri system, 34% of pupils had been enrolled for 4–6 years, while 24% had spent more than six years in the system. A smaller proportion had been enrolled for less than one year (25%) and 1–3 years (17%). These findings indicate a trend of long-term enrollment, raising concerns about limited progression into formal or vocational education.

Research objective one: Healthcare Services Available at the Almajiri School

Healthcare Services Available	**Frequency**	**Percentage (%)**
Yes	46	20%
No	185	80%
Total	**231**	**100%**

The data indicates that only 20% of Almajiri students reported having access to healthcare services at their schools, while a staggering 80% lack such access. This reveals a critical gap in the provision of basic health facilities within the Almajiri education system.

The absence of healthcare services exposes students to untreated illnesses, poor hygiene, and potential disease outbreaks, which can severely affect their health and academic performance. This situation underscores the urgent need for government and NGO intervention, including the integration of mobile clinics, regular health check-ups, and health education initiatives to safeguard student well-being and support effective learning.

Research objective two: Types of Healthcare Services Available

Types of healthcare services available	Frequency	Percentage (%)
First Aid	167	72%
Routine Health Check-ups	20	9%
Vaccination Programs	0	0%
Health Education	20	9%
Dental Care	0	0%
Others	24	10%
Total	**231**	**100%**

The data reveals that 72% of Almajiri students have access to first aid, making it the most common healthcare service provided. However, access to routine health check-ups and health education is significantly lower at only 9%, while 10% reported access to other unspecified services. Critically, no respondents (0%) reported access to vaccination programs or dental care.

These findings suggest that while basic and immediate care is somewhat available, there is a severe deficiency in preventive and long-term healthcare services. The complete lack of vaccinations and dental care presents major health risks, leaving students vulnerable to preventable diseases and oral health problems.

To address these gaps, there is a clear need for policy reforms and targeted interventions by government and NGOs. Priorities should include implementing routine health check-ups, vaccination drives, oral health programs, and health education campaigns to promote student well-being and improve educational outcomes in the Almajiri system.

Research objective three: Nearest Healthcare Facility from Your School

Nearest Healthcare Facility	Frequency	Percentage (%)
Less than 1 km	45	19%
1-3 km	90	39%
4-6 km	76	33%
More than 6 km	20	9%
Total	**231**	**100%**

The data reveals that only 19% of Almajiri students have a healthcare facility within 1 km of their school, while the majority 81% must travel longer distances: 39% between 1–3 km, 33% between 4–6 km, and 9% more than 6 km. This distribution highlights a significant accessibility challenge, especially for students who may face delays in receiving timely medical attention during emergencies.

The findings underscore the healthcare access gap in Almajiri schools. Long travel distances pose serious risks, particularly for young children who may lack the means or support to reach healthcare services quickly. This situation demands urgent intervention to ensure that students can access care without compromising their health or safety.

To address these issues, stakeholders including government bodies, NGOs, and health organizations should consider implementing on-site healthcare units, mobile clinics, or school-based health services. Improving the referral system and emergency transportation options would also enhance responsiveness to medical needs.

These measures would significantly improve healthcare accessibility, leading to better health outcomes and a more supportive learning environment for Almajiri students.

Research objective four: Frequency of Healthcare Providers Visit to Your School

nearest healthcare facility	Frequency	Percentage (%)
Weekly	0	0%
Monthly	20	9%
Quarterly	85	37%
Annually	90	39%
Never	36	16%
Total	**231**	**100%**

The data in Table 4.6 reveals a critical gap in the frequency of healthcare provider visits to Almajiri schools. None of the respondents (0%) reported weekly visits, while only 9% indicated monthly visits. A larger share, 37%, reported quarterly visits, but the majority either receive visits once a year (39%) or not at all (16%). This pattern indicates that healthcare services are highly irregular and insufficient within the Almajiri education system.

The lack of consistent medical attention poses significant health risks for students, including untreated illnesses, preventable disease outbreaks, and deteriorating health conditions. Even quarterly visits fall short of meeting the ongoing healthcare needs of schoolchildren. The absence of structured and frequent healthcare services highlights a systemic neglect of the students' health and well-being. To address this issue, stakeholders must prioritize the implementation of regular, structured healthcare interventions in Almajiri schools. This could include monthly or biweekly visits from healthcare providers, mobile clinics, or the establishment of permanent school-based health services. Ensuring regular medical support would greatly improve early disease detection, access to treatment, and overall student health, thereby fostering a safer and more conducive learning environment.

Research objective five: Access to Healthcare Services

Nearest healthcare facility	Frequency	Percentage (%)
Yes	184	80%
No	47	20%
Total	**231**	**100%**

Table 4.7 indicates that 184 (80%) of the respondents reported having access to healthcare services, while 47 (20%) of the respondents stated that they do not have access. This suggests that a significant majority of Almajiri students can receive some form of healthcare, whereas a notable proportion still lacks medical care. The 80% access rate implies that healthcare services are available to most Almajiri students, possibly through nearby health facilities, mobile clinics, or school-based programs. However, the 20% who lack access to healthcare services face significant risks, including untreated illnesses, increased susceptibility to diseases, and poor overall health. The lack of access among these students could be due to factors such as distance to healthcare facilities, financial constraints, absence of healthcare providers in schools, or inadequate medical infrastructure. The findings highlight the need for more inclusive and equitable healthcare interventions for Almajiri students. While a majority have access to medical services, the 20% without access remain highly vulnerable to

preventable health risks. By addressing these gaps, policymakers can ensure universal healthcare access for all Almajiri students, ultimately improving their health, educational outcomes, and overall well-being.

Research objective six: Utilization of School Health Services

Table 4.8: Utilization of available Healthcare Services

Utilization of healthcare services	Frequency	Percentage (%)
Frequently (more than once a month)	20	9%
Occasionally (once a month)	86	37%
Rarely (a few times a year)	105	45%
Never	20	9%
Total	**231**	**100%**

The data in Table 4.8 highlights the low frequency of healthcare utilization among Almajiri students. Only 9% of respondents reported frequent use of healthcare services (more than once a month), and 37% indicated occasional use (once a month). In contrast, a majority 45% reported rare usage (a few times a year), while 9% stated they never access healthcare services. This means 54% of students either rarely or never seek medical care, reflecting serious gaps in healthcare accessibility and utilization. Several barriers may contribute to this low usage rate, including distance to facilities, financial limitations, lack of awareness, cultural beliefs, and inadequate medical personnel. The trend also suggests a reactive rather than preventive approach to healthcare, where students seek care only when illnesses become severe, missing out on essential services like check-ups, immunizations, and health education. These findings underscore the need for targeted interventions to increase both access to and utilization of healthcare services. Strategies could include deploying school-based clinics, mobile health units, health education programs, and community outreach efforts. Enhancing healthcare utilization will not only improve the health and well-being of Almajiri students but also contribute to better educational outcomes and reduced absenteeism.

Discussion:

The study revealed that only 20% of Almajiri pupils in Hadejia Emirate Zone had access to any form of healthcare services within their schools, highlighting a substantial gap in school-based health service provision. The dominant service available was basic first aid (72%), while critical preventive services such as routine medical check-ups and health education were available to merely 9% of pupils. Notably, no school reported offering vaccination programs or dental care. These findings align with national data that underscore the inadequacy of school health services in Nigeria, particularly among non-formal education settings (Ughasoro et al., 2024; UNICEF, 2022). Approximately 81% of the respondents reported needing to travel more than 1 kilometer to reach the nearest healthcare facility, with 33% traveling as far as 4–6 kilometers. These distances are considerable, especially for young children without access to transportation, increasing the likelihood of delayed or forgone treatment (Adamu & Yahaya, 2021). Similar studies in northern Nigeria have noted that distance remains a major deterrent to healthcare utilization among out-of-school children (Garba, Umar, & Bello, 2021).

Even among students with nominal access to healthcare, utilization rates were low. Only 9% reported frequent use of health services (more than once per month), while 45% accessed care only a few times per year, and 9% never used available services. These findings suggest a reactive rather than preventive approach to healthcare, often driven by acute illness rather than routine check-ups or health education. Low utilization rates have previously been linked to financial constraints, lack of health awareness, and cultural perceptions about illness

(Okafor, Uchenna, & Nwankwo, 2020; Bako, 2021). The absence of comprehensive school health programs and immunization coverage significantly increases the vulnerability of Almajiri pupils to infectious diseases, malnutrition, and oral health issues. Without early detection and health promotion, these children face elevated risks of chronic illness, absenteeism, and academic failure (Ibrahim & Sulaiman, 2022; Ene-Obong & Ekpo, 2019). The lack of school-based sanitation and hygiene programs further compounds these risks (Audu, Ibrahim, & Danjuma, 2021). The findings reflect broader systemic issues in the Nigerian education and health systems. Many Almajiri schools operate informally and fall outside the regulatory purview of government school health programs. The lack of policy integration between education and public health authorities has perpetuated health inequities among Almajiri pupils (Mohammed, Ibrahim, & Yusuf, 2023; Ughasoro et al., 2024). This calls for a multi-sectoral strategy to institutionalize school health services within traditional educational settings.

The study found that despite limited availability of healthcare facilities, utilization of existing services by Almajiri pupils in the Hadejia Emirate Zone remains critically low. Only 9% of the students reported visiting healthcare centers when they needed medical attention, a finding that underscores a broader pattern of underutilization of healthcare services within the Almajiri education system. Even where facilities exist, they are either geographically distant, lack adequate staffing, or are financially inaccessible to pupils, many of whom rely on street begging for subsistence (Bako, 2021; Abubakar, Bello, & Usman, 2021). Moreover, none of the students reported receiving vaccinations or dental care two of the most fundamental components of school health programs globally (WHO, 2021). This complete absence of preventive health interventions highlights a major systemic deficiency. Routine immunizations are vital for reducing child morbidity and mortality from vaccine-preventable diseases, especially in densely populated or vulnerable communities like Almajiri schools (Adeoye, Salami, & Musa, 2020). Similarly, the neglect of oral health is of public concern, given the links between poor dental hygiene and systemic illnesses, as well as its impact on nutrition and school attendance (Onyema & Chijioke, 2022).

The findings are consistent with those of Garba et al. (2021), who reported that a lack of health literacy, financial hardship, and cultural attitudes contribute significantly to health service underutilization among Almajiri children. Additionally, stigmatization by healthcare workers and societal perceptions that equate the Almajiri with poverty and deviance further discourage these children from seeking care (Bako, 2020). The low demand for healthcare services, therefore, is not merely a reflection of availability but of structural and social barriers that must be addressed through targeted, inclusive public health interventions. The observed underutilization also suggests that the few available services are reactive rather than preventive, accessed mainly in the event of visible or severe illness. This reactive model is inadequate for promoting long-term health or supporting cognitive development and educational attainment. Without consistent access to comprehensive health services, Almajiri students remain vulnerable to preventable conditions that may hinder their academic progress and overall well-being (Ibrahim & Sulaiman, 2022; Ughasoro et al., 2024).

The study identified several structural and socio-cultural barriers that hinder Almajiri students' access to and utilization of school health services. Most notably, 80% of Almajiri schools lacked any form of basic healthcare infrastructure, thereby making timely medical attention difficult or impossible for the majority of students. This aligns with prior findings that school health systems in informal and non-integrated learning environments are often neglected in national health planning (Ughasoro et al., 2024; UNICEF, 2022). One of the most pervasive barriers reported was the distance to the nearest health facility, with more than half of respondents indicating that they must travel at least 3 kilometers to reach medical care. This is consistent with previous research highlighting distance and poor transportation access as major impediments to health service uptake among children in marginalized communities (Adamu & Yahaya, 2021; Garba et al., 2021). Another significant obstacle is the lack of awareness and health literacy among students and teachers (Mallams), which limits both demand for and understanding of health services (Ahmed & Garba, 2022). Compounding this challenge are traditional and cultural norms, which particularly affect female students, who constituted only 24% of the respondents in

this study. The cultural perception that Islamic education is primarily male-oriented may contribute to the exclusion of girls from Almajiri schools, and by extension, from school-based health initiatives (Ibrahim & Sulaiman, 2022; Mohammed et al., 2023).

These barriers indicate that healthcare in the Almajiri system is not only under-resourced but also structurally and socially inaccessible, reinforcing health inequities among this vulnerable population. The contribution of healthcare facilities to the health and development of Almajiri students was found to be minimal and sporadic. The study revealed that only 9% of students had access to routine medical check-ups, while 10% reported receiving unspecified or intermittent healthcare support. Critically, none of the respondents reported access to vaccination programs or dental care, which are considered fundamental components of child health services (WHO, 2021; Adeoye et al., 2020). This lack of structured preventive care undermines the role of healthcare in supporting learning outcomes. According to Onyema and Chijioke (2022), the absence of services such as immunizations, oral health care, and hygiene education in school settings significantly increases the risk of absenteeism, underperformance, and long-term health complications. Furthermore, existing healthcare facilities where available are not tailored to the specific needs of Almajiri pupils, many of whom lack adult supervision, permanent addresses, or financial means to access formal health systems. Without targeted programs that address these unique vulnerabilities, the current healthcare framework remains ill-equipped to support the holistic well-being of Almajiri students (Garba, Umar, & Bello, 2021; Bature & Bawa, 2015).

The study revealed that both Almajiri students and their teachers (Mallams) exhibit a general awareness of the need for healthcare services within the school environment. Despite this awareness, there is a prevailing acceptance of limited or nonexistent medical care as the norm. This passive attitude may be attributed to the normalization of systemic neglect, where health deprivation is internalized as a routine part of the Almajiri educational experience. Similar findings have been reported by Mohammed et al. (2023), who noted that sustained exposure to substandard conditions fosters a culture of resignation among marginalized groups.

The study further showed that only 9% of Almajiri pupils actively sought medical care, reflecting low health-seeking behavior despite existing needs. This behavior may stem from several interrelated factors, including lack of trust in the healthcare system, poor awareness of available services, and perceptions of healthcare as inaccessible or unaffordable (Abubakar, Bello, & Usman, 2021). Furthermore, teachers' attitudes are shaped by their own limited training in health promotion and their prioritization of religious education over physical well-being (Garba, Umar, & Bello, 2021). These findings suggest that both students and educators require targeted sensitization and empowerment to break the cycle of passive disengagement with healthcare. Attitudinal barriers—such as the belief that illness is an inevitable part of life or a divine test—have also been documented in similar settings and are known to influence the perceived relevance of preventive care (Okafor, Uchenna, & Nwankwo, 2020). Addressing these mindsets through culturally sensitive health education is critical for fostering proactive health behaviors.

Conclusion:

This study provides critical insight into the accessibility, utilization, and systemic challenges associated with school health services (SHS) in the Almajiri educational system in the Hadejia Emirate Zone, Jigawa State. The findings reveal a stark health service deficit, with only a minority of Almajiri pupils having access to even the most basic medical interventions such as first aid, while comprehensive services like immunization, dental care, and routine health screenings remain virtually absent. Geographic distance, infrastructural inadequacies, financial constraints, and socio-cultural barriers—including the underrepresentation of female students further exacerbate this gap. Despite some level of awareness among pupils and teachers regarding the importance of healthcare, widespread normalization of inadequate services has led to low health-seeking behavior and passive acceptance of preventable suffering. The near-total lack of institutionalized SHS within Almajiri schools not

only undermines child health and development but also perpetuates cycles of educational disadvantage, poverty, and social exclusion.

Addressing these challenges requires urgent and coordinated policy action. Strategies should include the integration of culturally sensitive, school-based health programs; deployment of mobile clinics; health education for students and Mallams; and improved coordination between government agencies, NGOs, and community stakeholders. Gender-inclusive policies and equitable access must also be prioritized to ensure no subgroup is left behind. In conclusion, improving the accessibility and utilization of school health services within the Almajiri system is not only a matter of public health it is a fundamental step toward promoting educational equity and safeguarding the rights and dignity of some of Nigeria's most vulnerable children.

Recommendations

To improve the Almajiri education system, it is essential to integrate health services alongside educational initiatives. Key recommendations include formally incorporating School Health Services (SHS) into the Almajiri framework, offering health screenings, immunizations, hygiene education, and nutrition support to address students' holistic needs. Mobile and community-based health clinics should be established to bridge geographic barriers to healthcare access. Islamic teachers (Mallams) should receive training in health promotion, disease prevention, and first aid, allowing them to play an active role in identifying health issues and promoting positive behaviors. Government ministries must collaborate to allocate dedicated funding for health services in non-formal education, with monitoring and evaluation frameworks to ensure sustainability. Health education campaigns should align with Islamic values to improve acceptance, covering essential topics such as hygiene, nutrition, and disease prevention. Gender-sensitive policies should address barriers limiting female participation and access to healthcare in Almajiri schools.

Partnerships with NGOs, religious institutions, and community leaders are crucial for mobilizing resources and fostering community ownership of health interventions. Minimum SHS standards should be established for Almajiri schools, ensuring access to first aid, clean water, and sanitation. Regular data collection and surveillance systems will inform evidence-based interventions and improve service delivery. Finally, ongoing research and evaluation should assess the impact of these interventions on health outcomes, school attendance, and academic performance, guiding further improvements in the system.

Conflict of interest:

The authors declare that there is no conflict of interest.

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