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Conflict, Displacement and Health Challenges: A Study of Internally Displaced Persons (IDPs) Camps in Niger State, Nigeria

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Abstract

This study examines the multifaceted health challenges faced by internally displaced persons (IDPs) in Nigeria, emphasizing their implications for peacebuilding and social reintegration. Driven by conflicts, insurgencies like Boko Haram, environmental crises, and communal clashes, Nigeria's internal displacement has escalated significantly since 2014, particularly in Niger State, where thousands are displaced into overcrowded camps with inadequate health infrastructure. The research employs a qualitative phenomenological approach, gathering insights from IDPs, healthcare providers, and policymakers through Key Informant Interviews, focus groups Discussion, and observations within selected camps. Findings reveal pervasive deficiencies in healthcare access, compounded by infrastructural decay, cultural insensitivity, gender disparities, and policy gaps, resulting in low trust and reliance on informal treatments. Displaced individuals report ongoing physical ailments, mental health trauma, and social stigmatization. Environmental conditions, systemic neglect, and sociocultural barriers exacerbate health disparities, fueling resentment and social fragmentation. The study underscores that health is integral to human security and societal stability, advocating for comprehensive policies that integrate culturally sensitive healthcare, mental health support, and community participation into peacebuilding frameworks. Addressing these systemic and cultural barriers is essential for sustainable recovery, social cohesion, and long-term peace in conflict-affected Nigeria.

Keywords: Internal Displacement, Healthcare Access, Re-integration, Systemic Barriers, Niger State

1. Introduction

Conflicts, natural disasters, and socio-political instability continue to be primary drivers of internal displacement worldwide (Chesler, 2024, Mateko & Vutula, 2024, Kelly-Hope, 2023). In Nigeria, many individuals, particularly women and children, have been compelled to abandon their homes due to violent insurgencies, most notably from Boko Haram, as well as environmental challenges and communal clashes (Raji et al., 2021). This form of displacement occurs within national borders and is classified under international frameworks as internally displaced persons (IDPs), who do not cross international boundaries and thus remain under their home country's jurisdiction. This thus limits their access to direct international humanitarian protection unless specifically invited by the government (Dirikgil, 2023, Schimmel, 2022).

The establishment of IDP camps in Nigeria has been a crucial, albeit temporary, response to the displacement crisis. These camps serve as vital sites for delivering humanitarian assistance, aiming to restore essential services, provide physical security, and lay the groundwork for eventual reintegration efforts (International Organization for Migration [IOM], 2019, Stephen, 2016). Health plays a central role in both immediate crisis response and long-term recovery (Ravaghi *et al.*, 2023, WHO, 2019). Displacement often leads to complex health deterioration, beginning with psychological trauma and advancing to chronic physical illnesses and increased vulnerability to infectious diseases, exacerbated by poor sanitation, overcrowding, and food insecurity (World Health Organization [WHO], 2018).

Nigeria's internal displacement problem notably escalated from 2014 onward due to the Boko Haram insurgency in the Northern and Central Nigeria. Data from humanitarian agencies such as IOM and NEMA indicated a rapid increase in IDP numbers, from around 650,000 in May 2014 to over one million by the end of the year, placing significant pressure on existing health and infrastructure systems within the camps (IOM, 2019; Madugu & Ushama, 2015).

Health outcomes among displaced populations are influenced not only by direct exposure to violence and trauma but also by secondary factors including malnutrition, inadequate reproductive healthcare, limited disease surveillance, and shortages of medical supplies (Ajibade et al., 2017, Bello, 2015). Research in Nigerian IDP camps has revealed deficiencies particularly in maternal and child health, mental health services, and the treatment of communicable diseases such as HIV/AIDS, tuberculosis, and malaria (Yerima & Ranjit-Singh, 2017, Caritas Nigeria, 2015). These issues are compounded by limited access to accurate health information and preventive care (Adebayo et al., 2020).

Previous research has identified various health challenges faced by IDP populations; however, much of this information is derived from institutional reports or focused on specific medical conditions, highlighting the need for more comprehensive, ground-level assessments of their health realities, particularly in relation to social reconstruction efforts (Brian et al., 2016; Das et al., 2016; Lam et al., 2015). Mori et al. (2004) noted that health is a core element of human security and crucial for societal rebuilding, emphasizing that neglecting health services for displaced populations can weaken societal stability and hinder processes like disarmament, rehabilitation, and reintegration. Addressing these health needs is thus both a humanitarian obligation and a strategic necessity for Nigeria's peace and security. While healthcare services are widely regarded

as a key component of aid, their true effectiveness depends on how displaced persons perceive and experience them. Therefore, this study explore the subjective views of IDPs regarding the healthcare available within camps, including perceptions of accessibility, adequacy, dignity, and trust, can provide vital insights into the real-world impact of health interventions and the extent to which they meet the needs of those they aspired to serve.

2. Conflict-Induced Internal Displacement in Niger State, Nigeria

Niger State, located in north-central Nigeria, has witnessed a surge in conflict-induced internal displacement over the past decade, primarily driven by escalating banditry, armed herder-farmer clashes, and insurgent spillover from the North-East. These conflicts have significantly disrupted local livelihoods, security, and community cohesion, forcing thousands of individuals to flee their homes. Armed banditry and communal violence have particularly intensified in Shiroro, Rafi, Munya, and Mariga local government areas (LGAs). According to reports by the International Organization for Migration (IOM, 2023), over **17,000 persons** were displaced in Shiroro and Munya LGAs between 2021 and 2023 due to sustained attacks by armed groups. These groups typically raid rural communities, burn homes, destroy farmlands, and abduct residents for ransom, creating a climate of fear and insecurity.

Government Intervention Plan for IDPs in Niger State is to:

- Provide immediate lifesaving assistance (shelter, food, water, health) to IDPs within 72 hours of displacement.
- Protect vulnerable groups and ensure access to basic services (health, WASH, education, protection).
- Restore livelihoods and support durable solutions (return, local integration, or relocation) within a phased timeframe.
- Strengthen coordination, monitoring, and accountability across state agencies, partners and affected communities (Niger SEMA, 2024)

The question is to what extent the government is able to provide the above-mentioned programme?

The National Emergency Management Agency (NEMA) noted that in 2023 alone, over **30,000 persons** were displaced across several LGAs in Niger State due to conflict-related incidents, including large-scale armed invasions and inter-communal clashes (NEMA, 2023). The displacement has placed immense strain on host communities and led to the establishment of informal IDP settlements in towns such as Gwada and Kuta, where basic services like shelter, food, and healthcare are inadequate.

A 2024 report by the Niger State Emergency Management Agency (NSEMA) further indicated that over **50 communities** in the state were abandoned due to fear of attacks, contributing to the growing number of internally displaced persons. Many of the displaced are women and children, living in overcrowded and insecure temporary shelters with limited access to psychosocial or humanitarian support (NSEMA, 2024). The conflict-induced displacement crisis in Niger State underscores the urgent need for both security interventions and sustainable resettlement strategies. Without decisive government action and donor support, the displacement trend is likely to worsen, further deepening poverty, food insecurity, health inequalities and social instability across the state.

3. Methodology

This research employed a qualitative approach rooted in an interpretivist perspective to examine the intricate experiences and institutional factors influencing healthcare delivery and integration efforts within Internally Displaced Persons (IDP) camps in Nigeria. Using a phenomenological and case study framework, the study deeply explores residents' experiences, perceptions, and the structural elements affecting health outcomes and their broader implications for reintegration and social cohesion.

The study was carried out in Minna IDP camps in Niger State, areas most severely impacted by conflict-driven displacement. Participants comprised adult IDPs, healthcare providers, humanitarian workers, and relevant government officials. A combination of purposive and snowball sampling methods was used to ensure a diverse range of voices, representing different genders, ages, and Local Governments in the State. Informed consent was secured from all participants prior to data collection.

Data collection involved semi-structured in-depth interviews, focus group discussions (FGDs), and non-participant observations. These methods provided detailed, context-rich insights into issues related to healthcare access, service experiences, and perceptions of peacebuilding initiatives. Additionally, relevant documents and policy reports from humanitarian agencies and government entities were reviewed to supplement the field data. All interviews and FGDs were audio-recorded, transcribed verbatim, and analyzed thematically using NVivo software. An inductive coding approach was employed to allow themes to naturally emerge from the data. Triangulating information from various sources helped strengthen the credibility and depth of the findings, facilitating a comprehensive understanding of health and peacebuilding challenges within displacement settings.

3.1 Health Conditions and Well-being of the Internally Displaced Persons (IDPs)

Internally Displaced Persons (IDPs) are among the world's most vulnerable groups, with their health outcomes often reflecting the hardships of displacement, social exclusion, and systemic neglect (Khai, 2023, Fatokun & Olise, 2024). In Nigeria, ongoing insurgencies and natural calamities have led to a significant IDP population whose experiences are not thoroughly documented (Olanrewaju et al., 2019). Very central in this situation are the issues concerning how health issues intersect with their daily survival, identities, and aspirations. This study aims to qualitatively explore the lived experiences of IDPs, focusing on how displacement has influenced their physical, mental, and social well-being.

Employing a phenomenological research design, the study involved direct engagement with displaced individuals living in IDP camps in Niger State. Through collecting personal narratives via in-depth interviews and focus group discussions, the research seeks to understand how IDPs express their health concerns, their perceptions of the support provided by humanitarian agencies, and how they interpret the ongoing impacts of displacement on their health trajectories. Central themes include trauma, healthcare access, nutritional challenges, stigmatization, and resilience strategies.

Existing literature indicates that displacement often results in inconsistent healthcare, declining mental health, increased exposure to infectious diseases, and limited access to reproductive and preventive health services (Owoaje et al., 2016). Nonetheless, there is limited understanding of how displaced individuals personally perceive and respond to these health challenges in real time. Their stories can provide deeper insights into the physical and emotional toll of displacement beyond official statistics and aid narratives. For instance, accounts of mothers losing children to preventable illnesses, young people enduring long-term injuries, or elderly individuals managing chronic conditions without adequate medication highlight systemic gaps in healthcare delivery.

By centering the voices of IDPs, this research seeks to bring their experiences into policy discussions and academic debates. Their perspectives are vital for developing health interventions that are culturally appropriate, emotionally considerate, and socially inclusive. Additionally, these insights can shed light on the psychosocial aspects of displacement that often go unnoticed but have a significant impact on health outcomes and engagement with healthcare services. Giving voice to these lived realities aims to challenge top-down approaches and encourage more participatory health policy formulation for IDP communities. Ultimately, understanding their health experiences not only enhances humanitarian efforts but also supports peacebuilding efforts by restoring dignity, fostering agency, and elevating the visibility of displaced populations.

3.2 Accessibility and Adequacy of available Healthcare Services within IDP camps

Preliminary narratives from interviews with IDPs in camps in Niger State revealed a common thread: health services are present, but uneven, inadequate, and often perceived as symbolic rather than impactful. A 38-year-old woman in Gwada Camp, Shiroro Local Government Area (LGA) narrated, *“When we arrived here, they said there was a clinic. But when my child had fever, there was no nurse for two days. I had to give him herbs from home.”* Such statements capture the disconnection between the formal presence of healthcare infrastructure and the reliability or responsiveness expected by users.

Access issues are compounded by logistical, financial, and cultural barriers. Many IDPs complained about long waiting times and discriminatory behavior from health workers, particularly against women or the elderly. A displaced man in his fifties stated in Tumtum IDP Camp, Kuta town, *“You must know someone before they attend to you quickly. If not, you wait all day. Sometimes they say there is no medicine, only paracetamol.”* This perception erodes trust in the system and encourages reliance on informal treatments or self-medication, often with negative health consequences.

For women, especially those of reproductive age, perceptions are marked by deep frustration and anxiety. Pregnant women interviewed spoke of having to walk long distances, often without transport, to access basic maternal health services. Others feared being mistreated during delivery. One respondent in Kagara IDP Camp said, *“When I was in labor, the nurse shouted at me. I was too scared to go again. Now, I prefer the traditional midwife in the camp.”* These narratives reflect not only physical barriers but emotional and psychological dimensions of exclusion that often go unnoticed in formal assessments.

In addition to direct healthcare experiences, many IDPs spoke about the lack of health education and preventive care within camps. Diseases like malaria, diarrhoea, and skin infections are common, yet IDPs feel uninformed and unprepared to manage them. They noted the absence of regular outreach, hygiene campaigns, or community health workers. In their words, health workers only come when there is a major outbreak. remarked one camp resident, highlighting a reactive rather than preventive model of healthcare provision.

In summary, IDPs perceive healthcare services as available but highly inadequate, inaccessible, and sometimes demeaning. Their voices suggest a profound need for system-wide reforms that center the displaced population not merely as beneficiaries but as rights-holders whose dignity and agency must be preserved. Addressing these perceptions is vital for restoring trust, improving health outcomes, and advancing peacebuilding efforts in conflict-affected Nigeria.

3.3 Health-related Interventions among Internally Displaced Persons (IDPs)

The humanitarian landscape surrounding Internally Displaced Persons (IDPs) in Nigeria is shaped by a complex interplay of logistics, resource constraints, political mandates, and frontline realities. This objective investigates how health-related interventions are conceptualized, delivered, and evaluated by key stakeholders, including humanitarian workers, donor representatives, and government officials, tasked with overseeing healthcare for displaced populations. Through in-depth interviews, this study explores their experiences, motivations, challenges, and reflections on the provision of healthcare services in displacement settings.

Several humanitarian health workers interviewed in Munya and Shiroro LGAs, Niger State expressed deep concern over persistent gaps in coordination and resource allocation. A field health officer working with an international NGO explained, *“the needs on the ground are overwhelming. We have mobile clinics, but they cannot cover all the camps regularly. Often, we’re forced to prioritize outbreaks or pregnant women, and even then, we’re stretched thin.”* This sentiment reflects the practical challenges of scaling limited interventions to meet expansive and diverse health needs within volatile environments.

From the perspective of government health officials, bureaucratic bottlenecks and funding inconsistencies emerged as dominant themes. One official from a state ministry of health remarked, *“even when there’s a directive from the federal level, the funds or medicines may not arrive on time. Coordination with NGOs is helpful, but without sustainable infrastructure, we’re treating symptoms, not the system.”* This view illustrates how structural inefficiencies and reliance on emergency responses hinder long-term planning and system integration.

Narratives from humanitarian coordinators also revealed tensions between donor expectations and realities on the ground. One senior project manager shared, *“donors want to see rapid results, vaccination numbers, clinic visits, HIV testing figures, but the human side of this crisis, the emotional trauma and chronic conditions, is hard to quantify and thus often under-prioritized.”* This underscores the pressure faced by humanitarian organizations to meet performance metrics that may not align with community-defined priorities or holistic well-being.

Gender dynamics also surfaced as a critical concern. A reproductive health specialist working with a UN agency observed, *“there is an assumption that if we provide condoms or offer antenatal care, reproductive needs are met. But many women are dealing with sexual trauma, STIs, and deep mistrust. These issues require time, cultural sensitivity, and community engagement, not just service delivery.* Her account underscores the disconnect that often exists between the design of programs and the realities faced by communities, particularly in settings where trauma and cultural norms influence health-seeking behaviors.

Despite facing numerous challenges, many participants demonstrated a strong sense of responsibility and showed ingenuity in adapting to their circumstances. Some pointed to effective community health worker initiatives, while others described informal partnerships between organizations aimed at sharing resources and information. These stories illustrate a resilient system and a willingness to innovate, even within limited operational conditions. The perspectives of both humanitarian and government personnel depict a health system under significant strain, well-intentioned and sometimes successful during emergencies yet facing structural limitations that affect its sustainability and cultural responsiveness. These observations are essential for developing health strategies that better reflect both the capacities of health providers and the lived experiences of displaced populations.

3.4 Health Challenges within IDP camps and Reintegration Processes

In post-conflict environments, health transcends mere biological concerns, serving as a vital component of human security and a key foundation for sustainable peace efforts. Within this context, it is crucial to examine how unresolved health issues among Internally Displaced Persons (IDPs) in Nigerian displacement camps impact their reintegration processes and the stability of the nation. Utilizing qualitative insights from IDPs, peacebuilding practitioners, and camp officials, this research explores the complex relationships between health, trust, social reintegration, and conflict mitigation.

Many of the displaced individuals interviewed reported ongoing health problems that hinder their ability to rebuild their lives or engage in income-generating activities. For instance, a young man from an IDP camp in Mararaba, Niger State, who lost his leg in a Boko Haram attack, expressed his frustrations, *“I want to work again, I want to go back to my village, but I can’t walk, and there is no proper treatment here. No one has come to help me since I arrived in this camp.”* His testimony highlights how the lack of rehabilitative care can delay or derail reintegration into society and livelihood restoration, especially for those with physical disabilities.

Beyond physical injuries, mental health issues were repeatedly cited by camp dwellers and health workers alike. A female resident, displaced from *Sarkin Pawa* for over five years, shared, *“many of us are tired. We have lost our homes, our families, and our minds. Some women cry all night. Some stop eating. How can we return home like this?”* These narratives highlight the ongoing struggles of psychological trauma, grief, and persistent uncertainty that afflict IDPs, eroding the emotional stability essential for reconciliation and successful social reintegration.

Peacebuilding officers working with civil society organizations underscored the direct link between health services and the restoration of trust in state institutions. One remarked, *“when*

people feel abandoned by the government in matters of health, it breeds resentment. Some begin to see the state as complicit in their suffering, which can fuel renewed conflict". This indicates that equitable health service delivery is a form of social contract reinforcement, which, when absent, can deepen grievances in already fragile communities.

The perception of inequity in health distribution also emerged as a recurrent theme. An official in a camp in Gwada, Niger State explained, *"there is tension when one camp receives more attention than another. It creates rivalry and weakens unity among IDPs."* Such disparities, whether real or perceived, complicate the collective identity and cohesion necessary for peaceful coexistence post-return. Furthermore, youth in the camps expressed disillusionment with their prospects. Many associated poor health and lack of access to mental and sexual health services with growing anger and susceptibility to negative influences. As one youth put it, *"if you are sick, hungry, and forgotten, you begin to think that violence is the only language they understand."* This chilling remark underscores how health neglect can morph into a security threat if not addressed comprehensively.

In summary, the ongoing health issues faced by IDPs extend beyond mere humanitarian concerns; they are intricately linked to the prospects for peace, social reintegration, and national reconciliation. Tackling these health challenges is crucial for moving beyond emergency aid towards lasting recovery and sustainable peace efforts.

3.5 Structural, Cultural, and Policy-related Barriers shaping Healthcare experiences among IDPs

The healthcare experiences of Internally Displaced Persons (IDPs) in Nigeria are influenced not only by humanitarian efforts but also by the wider social, institutional, and policy environments in which healthcare services are provided. This study aims to examine the complex array of barriers, structural, cultural, and policy-related, that affect how IDPs access, perceive, and utilize health services in displacement contexts. Gaining insight into these challenges is vital for developing inclusive and sustainable health systems that effectively address the needs of displaced populations.

From a structural standpoint, a significant obstacle is the poor state of physical infrastructure within and around IDP camps. Many camps are without functional health clinics, reliable electricity, safe drinking water, or dependable transportation for medical referrals. One healthcare worker interviewed at a camp in Mararaba, Niger State highlighted this issue by stating, *"we sometimes work without essential equipment. There are days when the clinic runs without paracetamol, much less antibiotics or HIV test kits."* This statement reflects the operational weaknesses that limit the quality and continuity of care, especially for chronic or emergency conditions.

Policy-related challenges also play a significant role in shaping healthcare access and delivery. Several local health officials pointed out the lack of a comprehensive, coordinated national health strategy specifically designed for IDPs. Although emergency health interventions are in place, they tend to be piecemeal, temporary, and heavily reliant on donor support. One official at the state level explained that, *"we respond to outbreaks and acute needs, but we don't have a long-term*

policy framework for displaced populations. Once media attention fades, so does funding and commitment.” This reactive model leaves IDPs vulnerable to health crises and undermines efforts to integrate them into the national health system.

Cultural and language differences also pose additional challenges to accessing healthcare. Many IDPs originate from various ethnic and religious communities, and their health beliefs frequently differ from the biomedical practices prevalent in formal medical settings. A female IDP displaced from *Dangun* shared that, *“sometimes, the doctors don’t understand our customs. We use herbs for delivery, and they say it is wrong. That makes some women afraid to go to the clinic.”* This highlights the importance of cultural competency among health workers and the need for community-based approaches that honor traditional healing practices while promoting medical safety.

Sociocultural expectations around gender and associated stigma further hinder the use of healthcare services, especially in sectors such as reproductive health, HIV care, and mental health support. Young girls and women frequently express feelings of shame or fear of moral judgment when accessing these services. A humanitarian nurse noted that, *“many young girls hide their pregnancies or STIs. They fear judgment or violence from their communities.”* Such stigma fosters underutilization and poor health outcomes, especially among vulnerable subgroups.

3.6 Observational Insights on Health Conditions and Re-integration in IDP Camps

To supplement the data collected through interviews and focus groups, observational techniques were utilized to assess the physical environments, behaviors, and interaction patterns within selected Internally Displaced Persons (IDP) camps in Niger State, Nigeria. This method offered a more comprehensive understanding of the daily realities of displacement and healthcare access that spoken accounts alone could not fully convey.

A key issue observed across the camps was overcrowding coupled with unsanitary living conditions. Temporary shelters were densely packed, lacked proper drainage systems, and had inadequate waste disposal facilities. These environmental challenges were associated with visible health problems among residents, especially children and the elderly, including skin infections, malnutrition symptoms, and untreated injuries. Such findings underscore how environmental factors influence health outcomes in displacement settings.

Further observations indicated that healthcare facilities were severely insufficient. Many clinics were either closed, understaffed, or lacked essential medicines and diagnostic equipment. Patients often faced long wait times and expressed frustration. Women and adolescent girls appeared hesitant to access reproductive health services, likely due to concerns about privacy or discomfort with male healthcare providers. This gender-based disparity in service access reflected underlying social norms and stigmas related to sexual and maternal health.

Behavioral observations also pointed to signs of psychological distress, such as withdrawal, inactivity, and agitation, particularly among youth and older adults. The absence of psychosocial support programs and recreational activities was evident. Additionally, some residents seemed to receive preferential treatment at service points, potentially fueling tensions within the camps.

Hygiene practices were generally poor, with little effort observed to promote handwashing or safe water storage. These conditions suggest a lack of health education initiatives and limited public health outreach. Lastly, the presence of armed security personnel, while aimed at maintaining order, appeared to cause discomfort among residents, who often exhibited cautious body language and avoided close contact with them.

From the foregoing, the health experiences of internally displaced persons in Nigeria are influenced by a complex interplay of systemic shortcomings, cultural mismatches, and gaps in policy. Overcoming these challenges necessitates a holistic strategy that includes improving infrastructure, delivering culturally sensitive healthcare, and implementing thorough policy changes. Only by addressing these foundational issues can the health and dignity of displaced populations be truly safeguarded, ultimately supporting inclusive recovery and long-term peace.

4. Conclusion

The accounts collected indicate that access to healthcare within IDP camps is often inconsistent, insufficient, and can feel dehumanizing. Although some camps have health facilities, many displaced individuals report significant shortcomings in the quality of care, including shortages of vital medicines and a lack of adequately trained healthcare workers. The psychological impact of displacement, characterized by trauma, uncertainty, and grief, further worsens health challenges, especially in the absence of adequate mental health services. These conditions not only intensify human suffering but also foster feelings of disconnection, alienation, and erode trust in public institutions.

Similarly, insights from humanitarian workers and government officials highlight the numerous logistical, political, and financial hurdles they face. Despite their dedication, their efforts are often hindered by fragmented policies, donor-driven agendas, and the absence of comprehensive national frameworks specifically designed for displaced populations. These systemic issues limit health responses to immediate crisis management, rather than integrating them into sustainable development and peacebuilding initiatives.

The study also underscores various structural, cultural, and policy-related obstacles that influence healthcare experiences for displaced persons. These include neglecting traditional health beliefs, overlooking gender-specific needs, and persistent social inequalities that exist even within humanitarian settings. Cultural insensitivity, stigma, and bureaucratic complexities further isolate IDPs and diminish their ability to influence their health outcomes.

The wider implication of these findings is that health should be viewed as a crucial component of peacebuilding efforts. Disregarding the health of a population prevents meaningful recovery and leaves communities vulnerable to recurrent instability. Therefore, health interventions must go beyond emergency relief, becoming part of broader strategies rooted in justice, equity, and social cohesion.

In conclusion, meeting the health needs of IDPs in Nigeria requires shifting from disjointed emergency responses toward comprehensive, inclusive, and culturally appropriate health systems.

This transformation involves not only government agencies and humanitarian organizations but also the displaced persons themselves, whose voices and participation are vital for sustainable solutions. Through such an approach, Nigeria can better transition from crisis to recovery and move toward lasting peace and stability.

5. Recommendations

Develop and Implement a National Health Policy for Internally Displaced Persons (IDPs): The federal government, working alongside state authorities and humanitarian organizations, should formulate a comprehensive national policy that explicitly addresses the health needs of IDPs. This policy should outline sustainable healthcare approaches, including preventive care, treatment services, mental health support, and maternal and child health programs, ensuring continuity of care well beyond emergency situations.

Invest in Sustainable and Culturally Sensitive Healthcare Infrastructure in IDP Camps: Both government and development partners should prioritize building and equipping durable healthcare facilities within or near IDP settlements. These facilities must be gender-responsive, culturally respectful, and accessible in multiple languages, staffed by trained personnel from both the host and displaced communities to build trust and improve healthcare access.

Strengthen Mental Health and Psychosocial Support (MHPSS): Mental health services should be integrated into camp healthcare offerings, with qualified professionals providing trauma-informed treatment, counseling, and community-based emotional support. Special focus should be given to conflict survivors, children, and other vulnerable groups to address their specific psychological needs.

Improve Multi-Stakeholder Coordination and Community Involvement: Enhancing collaboration among federal agencies, NGOs, donors, and local health authorities is essential to avoid service duplication and make efficient use of resources. Additionally, establishing health committees or peer-led education groups can institutionalize community participation, enabling IDPs to play an active role in developing and monitoring health services.

Align Health Programs with Peacebuilding and Reintegration Efforts: Healthcare initiatives should be integrated into broader peacebuilding and reconciliation strategies. By linking health services with activities such as livelihood support and social reintegration, policymakers can promote healing, foster social cohesion, and contribute to lasting national stability.

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