A Review on the Effects of Health Management Processes on Health Outcomes among Internally Displaced Persons (IDPs) in Selected States in North Central, Nigeria

Umar Yahaya[1*], Dr. Hassan Suleiman[2], Prof. Y.B Ngwai[3], Prof. Adamu Ishaku Akyala[1], Dr Hassan Muhammed Salisu[4], Kaladi Hassan Ishaya[1], Seriki Onyinoyi Sarah[1], Ismaila Farida[5]

[1]Global Health and Infectious Diseases Control, Nasarawa State University, Keffi, NIGERIA

[2]Department of Zoology, Nasarawa State University, Keffi, NIGERIA

[3]Department of Health Science, Nasarawa State University, Keffi, NIGERIA

[4]Department of Health Economics, Global health infectious development institute, Nasarawa state university Keffi

[5]Department of Chemistry, Nasarawa State University, Keffi, NIGERIA

***Corresponding Author**

DOI: https://doi.org/10.51244/IJRSI.2025.1215000173P

Received: 03 October 2025; Accepted: 09 October 2025; Published: 05 November 2025

ABSTRACT

Internally displaced persons (IDPs) in North-Central Nigeria face persistent and multidimensional health challenges resulting from conflict, communal violence, and climate-induced displacement. This review assesses how health management processes including coordination, resource allocation, service delivery, surveillance, and community engagement shape health outcomes among IDPs in selected states. Findings reveal that weak coordination, fragmented services, inadequate financing, and poor continuity of care exacerbate morbidity and mortality among IDPs. The burden of communicable and non-communicable diseases, poor maternal and child health outcomes, and untreated mental health disorders remains high. Although government agencies and humanitarian organizations provide interventions, these are often fragmented, underfunded, and unsustainable. The review also situates Nigeria's response within the African Union's Kampala Convention 2019, the world's first binding regional treaty on internal displacement. While Nigeria ratified the Convention in 2012, its domestication and implementation remain weak, limiting its transformative potential. Strengthening primary healthcare, integrating mental health services, and aligning domestic frameworks with the Kampala Convention are essential for sustainable health outcomes.

Keywords: Internally Displaced Persons; Health Management; Health Outcomes; North-Central Nigeria; Kampala Convention; Humanitarian Policy

INTRODUCTION

Internal displacement has emerged as one of the defining humanitarian crises of the 21st century, with profound health, social, and political implications. Unlike refugees who benefit from defined international protections, IDPs remain within their countries of origin and fall under the jurisdiction of their national governments (1). This often leaves them exposed to gaps in protection, service delivery, and rights enforcement. Globally, over 43 million people are internally displaced, and Africa accounts for nearly one-third of this number (2).

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV October 2025 | Special Issue on Public Health

Nigeria is among the countries most affected by internal displacement on the continent. As of 2022, more than 4.5 million Nigerians were internally displaced, with the North-Central states of Benue, Plateau, and Nasarawa heavily affected (3). The drivers of displacement in these states are multifaceted, ranging from farmer–herder clashes and communal violence to climate-induced stressors that exacerbate competition for natural resources (4). The consequence is a humanitarian situation where health vulnerabilities are amplified, and displaced populations face limited access to essential services.

To address internal displacement, the African Union adopted the Kampala Convention in 2009, a landmark legal framework that compels states to prevent displacement, protect IDPs, and ensure durable solutions (5). Nigeria ratified the Convention in 2012, but its provisions have not been fully domesticated into national law, and implementation remains patchy (6). This review evaluates the health management processes that shape IDP health outcomes in North-Central Nigeria and considers how the Kampala Convention can provide a framework for more effective policy and practice.

HEALTH CHALLENGES OF IDPS IN NORTH-CENTRAL NIGERIA

Communicable Diseases

Communicable diseases are among the most pressing health problems in IDP settings. Overcrowded camps, inadequate water supply, poor sanitation, and substandard hygiene practices create fertile ground for outbreaks of cholera, malaria, measles, and acute respiratory infections (7). For example, cholera outbreaks have been recurrent in displacement camps, often overwhelming fragile healthcare structures. Similarly, malaria prevalence is significantly higher among IDPs due to poor environmental sanitation and inadequate distribution of insecticide-treated nets. Disruption of vaccination programs has further left children at heightened risk of vaccine-preventable diseases (8).

Non-Communicable Diseases (NCDs) and Chronic Conditions

The health of IDPs is often framed in terms of communicable disease outbreaks, but non-communicable diseases also represent a growing challenge. Conditions such as hypertension, diabetes, and cardiovascular diseases require consistent medication, monitoring, and lifestyle interventions—elements that are severely disrupted during displacement (9). The stress of displacement and poor nutrition can worsen these conditions, leading to a silent but significant health burden. The lack of chronic care services in most IDP settlements means that NCDs remain underdiagnosed and untreated, compounding morbidity and mortality.

Maternal and Child Health

Women and children are disproportionately affected by displacement. Many pregnant women are unable to access antenatal care, skilled birth attendants, or emergency obstetric services, leading to elevated maternal and neonatal mortality (10). Malnutrition among children remains a significant challenge, exacerbated by limited food aid, disrupted livelihoods, and inadequate infant feeding practices. Gender-based violence, which is often prevalent in displacement settings, worsens reproductive health outcomes and leaves survivors with both physical and psychological trauma (11).

Mental Health

The psychological toll of displacement is profound yet often neglected. IDPs are exposed to trauma through loss of loved ones, destruction of homes, and prolonged uncertainty about their future. Rates of post-traumatic stress disorder (PTSD), depression, and anxiety are particularly high (12). Despite this, access to mental health and psychosocial support services (MHPSS) remains minimal, largely due to stigma, lack of trained personnel, and underfunding. The absence of sustained psychosocial support exacerbates vulnerability and undermines resilience in IDP communities.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV October 2025 | Special Issue on Public Health

HEALTH MANAGEMENT PROCESSES AND OUTCOMES

Coordination and Governance

Effective coordination among government agencies, humanitarian organizations, and local authorities is central to improving IDP health outcomes. Strong governance structures enable resource sharing, prevent duplication of services, and strengthen surveillance systems. However, in many North-Central IDP camps, coordination mechanisms are weak, characterized by fragmented service delivery, unclear responsibilities, and inadequate information sharing (13). This contributes to uneven service coverage and gaps in critical health interventions.

Table 1: Coordination Mechanisms, Processes, and Health Outcomes for IDPs in North-Central Nigeria

Coordination Mechanism	Practices	Process Indicators	Expected Health Outcomes
Joint governance & planning	Regular Health Cluster/SEMA meetings; joint response planning	≥2 coordination meetings/month; attendance	Improved ANC coverage; higher skilled birth attendance
Information management	Shared 4Ws; DHIS2/EWARS reporting	Timeliness & completeness of surveillance	Faster outbreak detection; reduced case fatality rates
Referral & continuity of care	Referral SOPs; transport logistics; feedback loops	% referrals completed within 48 hours	Lower maternal/neonatal mortality; higher treatment success
Supply chain & logistics	Joint quantification; buffer stock monitoring	Stockout days; lead time for deliveries	Increased immunization coverage; reduced stockouts of essential medicines

Resource Allocation

Sustainable financing is critical to the success of IDP health programs. In Nigeria, however, funding for IDP health services is inadequate and largely donor-dependent. Federal and state budget allocations are often insufficient and irregular, leaving IDP health services vulnerable to interruptions (14). This underfunding results in frequent drug shortages, understaffing, and limited capacity for preventive and curative interventions. Without sustained investment, IDP health services cannot move beyond crisis management to sustainable, long-term health system strengthening.

Service Delivery Models

Different service delivery models are used in IDP settings, each with strengths and weaknesses.

Table 2: Service Delivery Models and Health Outcome Implications for IDPs

Service Delivery Model	Strengths	Weaknesses	Health Outcomes Implications
Camp-Based Services	Proximity of care; good for surveillance	Resource-intensive; donor-dependent	Effective in emergencies but unsustainable without long-term support
Mobile Clinics	Reaches remote IDPs; flexible deployment	Irregular service; poor follow-up	Improves short-term access but weak for chronic condition management
Integration with Host Facilities	Promotes sustainability; strengthens systems	Overcrowding; drug shortages	Supports long-term care but can compromise quality in overstretched facilities
Public-Private/Faith-Based	Expands access; culturally acceptable	Equity, affordability, and monitoring challenges	Complements public care but risks fragmentation if poorly regulated

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV October 2025 | Special Issue on Public Health

Camp-based services are effective in responding to acute health emergencies but are unsustainable without long-term investment. Mobile clinics improve access for remote populations but lack continuity of care for chronic conditions. Integration with host community facilities offers a more sustainable solution but risks straining existing health systems. Public-private and faith-based partnerships can complement state services but require strong regulation to ensure equity and quality.

Surveillance and Data Systems

Strong surveillance and reliable data systems are essential for timely outbreak detection and effective health planning. In North-Central Nigeria, surveillance systems are weak, with delayed reporting and incomplete data collection. This undermines outbreak response and makes it difficult to allocate resources effectively (15). Strengthening health information systems and integrating them with national databases would enhance accountability and preparedness.

Community Engagement

Community participation is a cornerstone of effective health management. When IDPs are actively involved in planning and decision-making, health services are more culturally appropriate, acceptable, and sustainable. Evidence from Nasarawa State demonstrates that community health committees improve service uptake, accountability, and trust (16). Active community participation and effective local governance are crucial in building resilience and ownership within IDP populations. Establishing community-based health committees, involving IDP leaders in decision-making, and integrating traditional structures can enhance trust and service uptake. Local governance mechanisms such as the State Emergency Management Agencies (SEMAs) and Local Government Health Departments should coordinate with humanitarian actors to ensure services align with community needs.

Resilience-building requires empowering IDPs through health education, vocational training, and inclusion in local health systems. Strengthening these linkages helps transition from short-term relief to long-term recovery and self-reliance.

Monitoring and Evaluation (M&E) Indicators

Effective monitoring and evaluation are critical for assessing progress in IDP health coordination, resource allocation, and outcomes. Table 3 below proposes measurable indicators that can be integrated into health management systems across IDP camps.

Table 3.: Monitoring and Evaluation Framework for Assessing Coordination, Resource Allocation, and Health Outcomes among IDPs

Domain	Indicators	Measurement Approach	Expected Impact
Coordination	Number of inter-agency meetings held per quarter; existence of a functional Health Cluster; presence of IDP health coordination framework	Review of meeting records, reports from SEMA/NEMA	Improved communication, reduced duplication of efforts
Resource Allocation	% of budget allocated to IDP health; timeliness of fund release; availability of essential drugs	Budget tracking, procurement audits	Sustained service delivery and reduced stockouts
Health Outcomes	ANC coverage rate; immunization coverage; malaria incidence; maternal mortality ratio	Health facility and DHIS2 data	Improved population health and reduced preventable deaths
Community Participation	% of IDP representatives in health committees; frequency of community meetings	Observation and feedback	Strengthened accountability and program ownership

Source: Author's synthesis based on World Health Organization (2021), Nigeria Centre for Disease Control (2022), and Owoaje et al. (2016).

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI | Volume XII Issue XV October 2025 | Special Issue on Public Health

THE KAMPALA CONVENTION: POLICY CONTEXT AND IMPLICATIONS

The Kampala Convention is the first legally binding regional treaty in the world focused on internal displacement. Adopted by the African Union in 2009, it obliges states to protect IDPs, provide assistance, and prevent arbitrary displacement (5). By 2024, over 30 African states had ratified the Convention, though levels of implementation vary significantly (6).

Nigeria ratified the Convention in 2012, signalling its commitment to protecting IDPs. However, domestication into national law remains limited, and implementation is weak. Without legal enforceability, IDP health rights remain largely aspirational rather than actionable (17). While Uganda has integrated the Convention into domestic policy and established legal frameworks for IDPs, Nigeria's progress has been slow.

The implications for health are significant. Full domestication of the Kampala Convention would obligate Nigeria to dedicate budgetary resources, establish stronger accountability mechanisms, and ensure access to healthcare, shelter, and protection for IDPs. Without this step, IDP health outcomes will continue to depend on inconsistent donor support and fragmented government responses.

CONCLUSION

The health of internally displaced persons in North-Central Nigeria is deeply shaped by weaknesses in health management processes. Poor coordination, inadequate funding, fragile surveillance systems, and limited community engagement combine to produce poor outcomes across communicable and non-communicable disease control, maternal and child health, and mental health. While humanitarian actors and government agencies have provided critical services, these interventions are often fragmented, short-term, and unsustainable.

The Kampala Convention provides an important framework for addressing these challenges by legally obligating states to protect and assist IDPs. Nigeria's ratification of the Convention in 2012 was a positive step, but the lack of domestication and implementation has limited its impact on health outcomes. A more deliberate effort to domesticate the Convention, strengthen coordination mechanisms, and ensure sustainable financing could transform the way IDP health is managed.

In conclusion, improving health outcomes among IDPs in North-Central Nigeria requires more than humanitarian interventions—it demands strong governance, participatory systems, and sustainable financing. Embedding monitoring and evaluation frameworks, strengthening local governance, and institutionalizing resilience-building mechanisms will transform current fragmented responses into coordinated, rights-based, and sustainable systems. By domesticating the Kampala Convention and prioritizing long-term financing, Nigeria can create a resilient health management structure that ensures dignity, equity, and wellbeing for all displaced persons.

POLICY RECOMMENDATIONS FOR SUSTAINABLE IDP HEALTH MANAGEMENT

To achieve sustainable impact, this review proposes the following actionable policy measures:

1. Strengthen the capacity of SEMA, NEMA, and local health authorities to coordinate IDP health interventions through training, digital data systems, and clear accountability frameworks.
2. Establish a dedicated IDP Health and Resilience Fund within federal and state budgets to reduce dependence on donors.
3. Integrate IDP health services into existing primary healthcare frameworks to ensure continuity of care beyond emergencies.

Funding: This research received no external funding. No specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data Availability Statement: The data that support the findings of this study are available on request from the corresponding author.

Acknowledgments: The authors express their gratitude towards the host Global Health and Infectious Diseases Control, Nasarawa State University, Keffi, NIGERIA

Conflicts of Interest: The authors declare no conflict of interest.

REFERENCES

1. World Health Organization. Health of internally displaced persons. Geneva: WHO; 2021.
2. Cohen R. The Guiding Principles on Internal Displacement: An Innovation in International Standard Setting. Glob Gov. 2019;15(4):455–73.
3. Internal Displacement Monitoring Centre. Global Report on Internal Displacement. Geneva: IDMC; 2023.
4. Williams W. Drivers of Displacement in Africa. Africa Centre for Strategic Studies; 2020.
5. African Union. African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention). Addis Ababa: AU; 2009.
6. Okello J. Implementation of the Kampala Convention in Africa: Challenges and Opportunities. Afr Hum Rights Law J. 2021;21(2):67–83.
7. Nigeria Centre for Disease Control. Cholera Situation Report. Abuja: NCDC; 2022.
8. UNICEF. Immunization coverage in conflict-affected states. New York: UNICEF; 2021.
9. Abubakar A, Abdullahi UA, Dangana A. Health interventions and outcomes among IDPs in North-East Nigeria. Int J Health Sci Res. 2018;8(6):240–7.
10. UNFPA. Reproductive health in humanitarian settings: Nigeria report. Abuja: UNFPA; 2015.
11. Olufemi A, Olaide B. Gender-based violence in IDP camps in Nigeria. Niger J Public Health. 2019;16(2):101–9.
12. WHO. Mental health of displaced populations. Geneva: WHO; 2021.
13. Owoaje E, Uchendu O, Ajayi T, Cadmus E. A review of the health problems of the internally displaced persons in Africa. Niger Postgrad Med J. 2016;23(4):161–71.
14. Budget Office of the Federation. Federal Budget 2020. Abuja: BOF; 2020.
15. Médecins Sans Frontières. Annual Report: Nigeria. Paris: MSF; 2020.
16. Yakubu K, Tanko M, Elijah P. Community-based health management for IDPs in Nasarawa State. Niger J Community Med. 2024;19(1):57–69.
17. African Union Commission. Report on the implementation of the Kampala Convention. Addis Ababa: AU; 2019.
18. Robinson C. Uganda's IDP policy and the Kampala Convention: A model for Africa? J Refug Stud. 2019;32(3):512–27.
19. Olanrewaju FO, Ajibade I, Egbule O. Health service delivery in IDP camps in Nigeria: Policy gaps and challenges. Afr J Health Policy. 2021;13(2):45–56.