Improving Healthcare Access Among Internally Displaced Persons in Benue State, Nigeria: An Assessment of Displacement Effects and Mitigation Strategies

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Abstract
Internal displacement has become a major humanitarian challenge in Benue State, Nigeria, largely due to persistent farmer–herder conflicts, communal violence and insecurity. Displacement disrupts established healthcare arrangements, increases vulnerability to diseases and creates barriers to accessing essential health services. This study examined the effects of internal displacement on healthcare access among internally displaced persons (IDPs) in Benue State, identified the factors influencing access and assessed the effectiveness of existing healthcare mitigation strategies. The study was adopted Kunz's Kinetic Model of Refugee Movement (1973) and adopted a cross-sectional descriptive and analytical survey design using a mixed-methods approach. The study covered six Local Government Areas and seven recognised IDP camps. A sample of 400 IDPs was determined using the Taro Yamane formula and selected through multistage sampling. Data were collected using a structured questionnaire, Key Informant Interviews and Focus Group Discussions. Quantitative data were analysed using frequencies, percentages, means and standard deviations, while qualitative data were analysed thematically. The findings indicated that 69.5% of respondents reported deterioration in overall healthcare access following displacement, while 53.9% of those who needed healthcare within the preceding six months experienced unmet healthcare needs. Economic, geographical, institutional and socio-cultural factors were identified as important barriers, with institutional and socio-cultural factors recording the highest dimension mean scores of 3.07 each. Although 68.0% of respondents were aware of existing healthcare interventions, concerns remained regarding service adequacy, coordination and sustainability, with sustainability recording the lowest mean score of 2.19. The study concludes that internal displacement is associated with substantial healthcare access challenges among IDPs. It recommends strengthening primary healthcare facilities, improving the affordability and physical accessibility of healthcare services, and enhancing government–humanitarian coordination, sustainable funding and IDP participation in healthcare planning and implementation.

Keywords: *Healthcare access, internal displacement, internally displaced persons, mitigation strategies.*

Introduction

Internal displacement has become one of the most pressing humanitarian and development challenges in contemporary Nigeria. Persistent farmer–herder conflicts, communal violence, and insecurity have led to large-scale population displacement across several states, with Benue State emerging as one of the most severely affected (Okoli & Atelhe, 2023; Akinwotu, 2024). Thousands of households have been forcibly displaced from their communities into formal internally displaced persons (IDP) camps, informal settlements, and host communities, resulting in prolonged humanitarian crises and increasing pressure on already fragile public service systems (Onyishi & Eme, 2023). Healthcare access represents a critical dimension of vulnerability among internally displaced persons. Displacement exposes individuals and households to heightened health risks, including communicable diseases, maternal and child health complications, malnutrition, and mental health disorders associated with trauma and loss (Olanrewaju, Ajayi & Sadiq, 2024). These risks are further intensified by overcrowded living conditions, inadequate water and sanitation facilities, food insecurity, and limited access to preventive and curative health services (Ezeh & Nwankwo, 2023). In Benue State, many IDPs are located in rural and peri-urban areas where health infrastructure is weak, understaffed, and under-resourced, thereby compounding existing inequities in healthcare access (Terlumun & Iorhen, 2025). Although Nigeria's National Health Policy and the Basic Healthcare Provision Fund emphasize universal health coverage and the inclusion of vulnerable populations, health system responses to internal displacement at the subnational level remain largely inadequate (Abubakar & Yusuf, 2023). Public health facilities in displacement-affected areas often lack essential medicines, skilled health personnel, functional referral systems, and reliable financing (Adeola & Oladipo, 2024). Humanitarian health interventions, while vital, are typically short-term, donor-driven, and poorly integrated into state and local health systems (Ibrahim, Musa & Salihu, 2025). As displacement becomes increasingly protracted in Benue State, these gaps have resulted in fragmented, inequitable, and unsustainable healthcare access for internally displaced persons. Furthermore, the broader fiscal and governance environment constrains effective health service delivery. High recurrent expenditure burdens, limited capital investment in health infrastructure, and weak intergovernmental coordination have reduced the capacity of the Benue State health system to absorb displacement-induced pressures (Udeh & Gever, 2023). Without evidence-based strategies to integrate IDPs into routine healthcare planning and financing, health outcomes among displaced populations are likely to deteriorate further, with implications for social stability and long-term development (Tyokyaa & Orngu, 2024). This study seeks to address these challenges by systematically examining how internal displacement affects healthcare access among IDPs in Benue State and by evaluating existing mitigation strategies implemented by government, humanitarian actors, and communities. By generating strategic policy evidence, the study aims at promoting sustainable and inclusive health system responses aligned with national development goals and to contribute to impactful research on displacement and development in Nigeria.

Statement of the problem

Based on general global experiences where proactive intervention measures are put in place as bulwarks for emergencies in developed climes like the US and UK, much is left desired for internal displacement victims in Sub-Saharan Africa (Nigeria inclusive). Despite the scale and persistence of internal displacement in Benue State, healthcare access for internally displaced persons remains severely uncertain. Displacement disrupts established healthcare-seeking patterns, increases the physical and financial distance to health facilities, and exposes IDPs to institutional exclusion and social marginalization. Many displaced households are unable to afford healthcare costs, lack awareness of available services, or face discrimination within host

community health facilities or may have none at all. Existing health interventions targeting IDPs are fragmented and insufficiently institutionalized. Government health facilities may be overstretched, while humanitarian health services often operate in parallel to state systems without long-term sustainability plans. As a result, IDPs may experience limited access to essential services such as antenatal care, immunization, treatment of communicable diseases, and mental health support. These challenges undermine the official commitment to universal health coverage and exacerbate health inequities at the subnational level. Although several studies have examined internal displacement and humanitarian response in Nigeria, there is a notable gap in empirical, state-specific research that systematically links displacement dynamics to healthcare access and health system performance. In Benue State, limited evidence exists on the specific barriers faced by IDPs, the comparative experiences of host communities, and the effectiveness of existing mitigation strategies. Without such evidence, policy responses remain reactive, inefficient, and poorly targeted. This study therefore seeks to address this gap by providing a comprehensive assessment of displacement-induced healthcare access challenges and mitigation strategies in Benue State, thereby supporting evidence-based policy articulations and sustainable health system outcomes for improved wellbeing among IDPs. The study is justified by the urgent need to generate localized, policy-relevant evidence capable of informing inclusive health planning, strengthening system resilience, and enhancing equitable healthcare access for vulnerable displaced populations.

Objectives of the Study

The main objective of this study is to examine the effects of internal displacement on healthcare access among internally displaced persons in Benue State and evaluate mitigation strategies aimed at improving health service delivery to displaced populations. The specific objective are to:

The specific objectives are to:

1. examine the effect of internal displacement on healthcare access among internally displaced persons in Benue State, Nigeria;
2. identify the factors influencing healthcare access among internally displaced persons in Benue State, Nigeria and
3. assess the effectiveness of existing healthcare mitigation strategies for improving healthcare access among internally displaced persons in Benue State, Nigeria.

Research Questions

The following research questions should guide the study:

1. What is the effect of internal displacement on healthcare access among internally displaced persons in Benue State, Nigeria?
2. What factors influence healthcare access among internally displaced persons in Benue State, Nigeria?
3. How effective are existing healthcare mitigation strategies in improving healthcare access among internally displaced persons in Benue State, Nigeria?

Literature Review

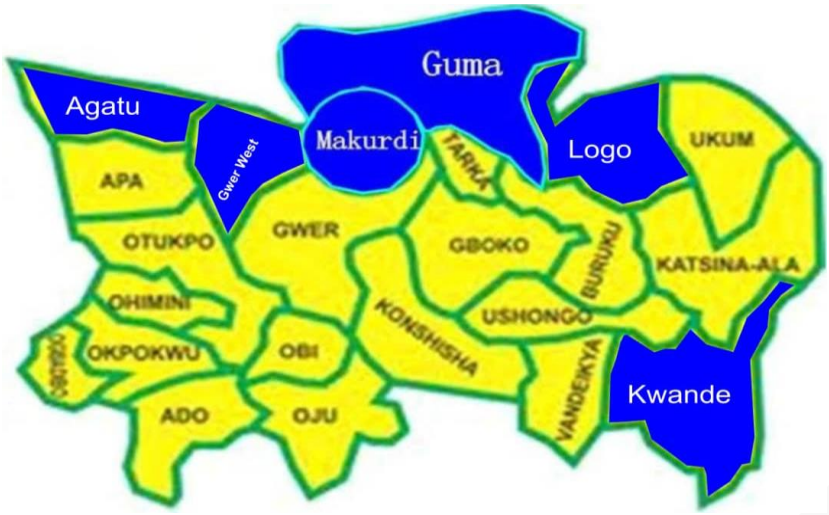
This study adopts Kunz's Kinetic Model of Refugee Movement (1973) as its theoretical framework. The model conceptualises forced displacement as movement compelled by threats, violence and insecurity, resulting in the disruption of established livelihoods, social networks and access to essential services. It provides a basis for understanding how displacement exposes affected populations to increased vulnerabilities, including difficulties in accessing healthcare. The conceptual framework on the other hand argue that access to healthcare for

internally displaced persons (IDPs) in low- and middle-income countries is hindered by structural, socio-economic, and institutional barriers, worsening health outcomes (Ekezie et al., 2022; Saeed & Auwal, 2025); Displacement disrupts health-seeking, with many relying on traditional healers or informal providers (Gidado et al., 2023); Camp healthcare systems face personnel, supply, and coordination deficiencies, especially in informal camps (Ekezie et al., 2022). While financial, cultural, and logistical barriers limit women's access, including maternal services (Saeed, 2025; Ugoje & Giwa, 2025; Author, 2025). On the other hand, Poor infrastructure and governance further exacerbate disease risk and hinder service delivery (Okafor & Brisibe, 2025; Ekezie et al., 2022; Gidado et al., 2023), highlighting the need for context-specific studies in Benue. Empirical studies in Nigeria show that internal displacement creates significant barriers to healthcare access, with interventions often limited in effectiveness. Gidado et al. (2023) found IDPs relied more on informal providers, influenced by camp recognition, health information, and perceived illness severity. Ekezie et al. (2022) highlighted structural barriers, including fragmentation, staffing shortages, and weak coordination, especially in informal camps. Saeed (2025) noted financial, cultural, and transport constraints limiting women's access, particularly maternal care, while Ugoje and Giwa (2025) identified economic deprivation as a key mediator of lower utilisation. Okafor and Brisibe (2025) emphasized poor camp infrastructure increasing disease burden, and Agbu and Yusuf (2024) showed mobile clinics improved access temporarily but lacked sustainability. Collectively, these studies underscore displacement-related disparities and the need for context-specific, sustainable interventions in Benue State.

Methodology

The study adopted a cross-sectional descriptive and analytical survey design, integrating quantitative and qualitative approaches. The design was appropriate for examining the effects of internal displacement on healthcare access, identifying factors influencing access and assessing existing healthcare mitigation strategies. Quantitative data were obtained through questionnaires, while qualitative information was collected through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). The integration of both approaches facilitated triangulation and provided a comprehensive understanding of the issues investigated.

The study was conducted in Benue State, located in Nigeria's North-Central geopolitical zone. The state was predominantly agrarian and was widely known as the "Food Basket of the Nation." However, recurrent farmer–herder conflicts, communal violence and insecurity had resulted in widespread internal displacement and increased pressure on public services, particularly healthcare. The study focused on six Local Government Areas (LGAs): Makurdi, Guma, Gwer West, Agatu, Logo and Kwande, which hosted substantial populations of internally displaced persons (IDPs). Seven recognised IDP camps within these LGAs were selected for the study.



The population comprised internally displaced persons residing in recognised camps and displacement-affected communities in Benue State. According to the State Emergency Management Agency (SEMA, 2025), the estimated IDP population was 491,147. However, the accessible population for the quantitative survey consisted of 233,657 IDPs residing in the seven selected camps. Relevant stakeholders, including camp coordinators, health officials, SEMA officials, community leaders and representatives of humanitarian organisations, constituted the population for the qualitative component.

The quantitative sample size is determined using the Taro Yamane formula, suitable for large, known populations. The formula is used to calculate the sample size as follow:

Formula: $n = \frac{n}{1+N(e)2}$

Where:

N= given population
e= margin of error
1= constant
n= sample size

To determine the sample size using this formula: thus,

Total population = 491,147

Sample size (n) = $\frac{491,147}{1+491,147 \quad (5\%)2}$

$n = \frac{491,147}{1+ 491,147\ (0.05)2}$

$n = \frac{491,147}{1+ 491,147\ (0.5)\times(0.5)}$

$n = \frac{491,147}{1+ 491,147 \times (0.0025)}$

$n = \frac{491,147}{1228.87}$

$n \approx 400$

Applying a 95% confidence level and a 5% margin of error, a population of 491,147 yields a sample size of approximately 400 IDPs, ensuring statistical representativeness and reliability of findings. This approach is straightforward, transparent, and widely used in large-population studies where table-based methods (e.g., Krejele & Morgan) may be impractical.

The study adopted a multistage sampling technique. First, six LGAs were purposively selected based on their concentration of IDPs. Second, seven recognised IDP camps were selected within the LGAs. Third, the sample of 400 respondents was proportionately allocated across the selected camps based on their respective populations. A stratified proportionate sampling procedure is employed where seven official IDP camps are stratified and selected from the

seventeen recognized camps in six local governments of Benue State from where the 400 respondents shall be drawn to ensure equitable representation and minimize bias. Selected camps include:

Proportionate Sampling of Respondents across Selected IDPs Camps

Camp Name	Number of IDPs	Proportionate Sampling	Sample size
Abagana Camp	8,210	8210/233,657*400	14
Dauda Camp I	5,851	5,851/233,657*400	10
Gbajimba Camp	29,500	29,500/233,657*400	50
Agagbe Camp	65,347	65,347/233,657*400	112
Ugbah Camp	65,496	65,496/233,657*400	112
UPE Naka Camp	43,344	43,344/233,657*400	75
Jato Aka	15,909	15,909/233,657*400	27
Total	**233,657**		**400**

Computed from SEMA Records 2025

Individual respondents were selected using simple random sampling from available camp registers. For the qualitative component, purposive sampling was used to select relevant stakeholders and IDPs with adequate knowledge and experience of healthcare challenges and interventions. Primary data were collected through structured questionnaires, Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). Questionnaires were administered to the 400 selected IDPs to obtain information on healthcare accessibility, affordability, utilisation, service quality and mitigation interventions. KIIs and FGDs were conducted with selected stakeholders and IDPs to explore healthcare challenges, institutional responses, intervention effectiveness and sustainability. Qualitative participants were selected separately from the quantitative sample. Quantitative data were analysed using descriptive and inferential statistics, while qualitative data were subjected to thematic analysis. For Objective One, frequencies, percentages, means and standard deviations were used to examine respondents' experiences of displacement-related healthcare access. Where appropriate, regression analysis was used to examine the relationship between displacement-related experiences and healthcare access. For Objective Two, means and standard deviations were used to assess the identified factors influencing healthcare access, while multiple regression analysis was employed to determine their relative contributions to variations in healthcare access. For Objective Three, frequencies and percentages were used to examine the availability and utilisation of healthcare mitigation interventions, while means and standard deviations assessed their perceived effectiveness and sustainability. Where appropriate, regression analysis examined the relationship between intervention exposure and healthcare access. Qualitative data from interviews and focus group discussions were transcribed, coded and organised into themes corresponding to the research objectives. Finally, quantitative and qualitative findings were triangulated to provide a comprehensive understanding of healthcare access and mitigation strategies among IDPs in Benue State. Inferential statistical tests were conducted at the 0.05 level of significance, subject to the assumptions of the selected statistical procedures.

Results

The result is presented in line with the objectives of the study that guides the study:

Examine the effect of internal displacement on healthcare access among internally displaced persons in Benue State, Nigeria. The analysis used the dataset of 400 respondents. It examines two aspects of the objective: Changes in healthcare access following displacement and healthcare needs, utilisation and unmet healthcare needs among displaced persons.

Table 1: Changes in healthcare access since displacement (N = 400)

Healthcare access indicator	Much worse + Worse (%)	Same (%)	Improved (%)
Ability to reach health facilities	72.4	21.0	6.6
Distance to health facilities	72.8	22.6	4.7
Time taken to obtain medical attention	72.7	23.7	3.5
Affordability of healthcare	73.7	20.5	5.8
Availability of prescribed medicines	72.4	21.5	6.1
Availability of qualified health personnel	74.0	19.1	6.9
Access to maternal/reproductive healthcare	67.5	24.4	8.1
Access to child healthcare/immunisation	76.5	18.2	5.4
Access to emergency medical attention	73.1	18.2	8.7
Access to mental health support	73.0	22.0	5.1
Access to referral services	71.8	24.1	4.1
Overall access to healthcare	69.5	22.8	7.6

Note: Percentages are calculated from valid responses for each indicator. Minor differences in totals are due to rounding and item-level missing responses.

The results indicate that a substantial proportion of respondents reported deterioration in healthcare access following displacement. The highest proportion of reported deterioration was in access to child healthcare and immunisation (76.5%), followed by the availability of qualified health personnel (74.0%) and affordability of healthcare (73.7%). Similarly, 72.8% reported deterioration in access in relation to distance to health facilities, while 72.7% indicated deterioration in the time required to obtain medical attention. The findings also show that 72.4% reported worsening conditions regarding the ability to reach health facilities and the availability of prescribed medicines. Regarding maternal and reproductive healthcare, 67.5% reported deterioration, while 73.0% indicated worsening access to mental health and psychosocial support. Furthermore, 71.8% reported deterioration in access to referral services. Concerning overall healthcare access, 69.5% reported that access had become worse or much worse following displacement, while 22.8% indicated that the situation remained unchanged and only 7.6% reported improvement. These suggest that displacement may be associated with difficulties in accessing essential healthcare services, particularly child healthcare, qualified personnel, affordable services and medicines.

Healthcare needs and utilisation among Internally Displaced Persons

Table 2: Healthcare needs and utilisation among IDPs

Variable	Response category	Frequency	Percentage
Needed healthcare in last six months (N=400)	Yes	317	79.2
	No	83	20.8
Obtained healthcare when needed (N=317)	Every time	122	38.5
	Some of the time	143	45.1
	Not at all	52	16.4
Unmet healthcare need (N=317)	Yes	171	53.9
	No	146	46.1

The results show that 317 respondents, representing 79.2%, needed healthcare within the preceding six months, while 83 respondents, representing 20.8%, did not report such a need. Among the 317 respondents who needed healthcare, 122 (38.5%) indicated that they obtained healthcare every time they needed it. Another 143 (45.1%) obtained healthcare only some of the time, while 52 (16.4%) indicated that they did not obtain healthcare at all. Furthermore, 171 respondents (53.9%) reported experiencing unmet healthcare needs, compared with 146 (46.1%) who did not. These findings illustrate the distinction between needing healthcare and successfully obtaining healthcare. They suggest that the existence of healthcare needs does not necessarily translate into consistent utilisation of available services.

Usual sources of healthcare among IDPs

Table 3: Distribution of respondents by usual source of healthcare

Source of healthcare	Frequency	Percentage
Government health facilities	90	28.4
Private health facilities	27	8.5
NGO/mobile clinics	82	25.9
Pharmacy/patent medicine vendors	77	24.3
Traditional sources	24	7.6
Other sources	17	5.4
Total	**317**	**100.0**

Denominator: 317 respondents who reported needing healthcare.

The results indicate that government health facilities constituted the most frequently reported source of healthcare, accounting for 90 respondents (28.4%). This was followed by NGO/mobile clinics, reported by 82 respondents (25.9%), and pharmacies or patent medicine vendors, reported by 77 respondents (24.3%). Private health facilities accounted for 27 respondents (8.5%), while 24 respondents (7.6%) relied on traditional sources. The remaining 17 respondents (5.4%) obtained healthcare from other sources. The distribution suggests that displaced persons may depend on different healthcare providers, including government facilities, humanitarian organisations and informal healthcare providers. This highlights the importance of coordination between public health institutions and humanitarian health interventions.

Travel time and transportation to healthcare facilities

Table 4: Distribution of respondents by travel time to healthcare facilities

Travel time	Frequency	Percentage
Less than 30 minutes	53	16.7
30–59 minutes	86	27.1
1–2 hours	117	36.9
More than 2 hours	61	19.2
Total	**317**	**100.0**

The results indicate that 117 respondents (36.9%) spent between one and two hours travelling to obtain healthcare, while 61 respondents (19.2%) spent more than two hours. Another 86 respondents (27.1%) spent between 30 and 59 minutes, whereas only 53 respondents (16.7%) spent less than 30 minutes. Thus, 56.1% of respondents reportedly spent at least one hour travelling to access healthcare. This illustrates how geographical distance and transportation difficulties could constrain healthcare accessibility among displaced populations.

Table 5: Distribution of respondents by means of transportation to healthcare facilities

Means of transportation	Frequency	Percentage
Walking	65	20.5
Motorcycle	145	45.7
Vehicle/bus	83	26.2
Boat	3	0.9
Other	21	6.6
Total	**317**	**100.0**

The results reveal that motorcycles were the most frequently reported means of transportation to healthcare facilities, accounting for 145 respondents (45.7%). Vehicles or buses accounted for 83 respondents (26.2%), while 65 respondents (20.5%) walked to healthcare facilities. Only three respondents (0.9%) reported using boats, while 21 respondents (6.6%) indicated other means of transportation. The distribution suggests that transportation arrangements constitute an important consideration in healthcare accessibility among displaced persons, particularly where access to formal transport services is limited.

Factors responsible for unmet healthcare needs

Table 6: Reasons for unmet healthcare needs among IDPs

Reasons for unmet healthcare needs	Frequency	Percentage
Lack of money	75	43.9
Distance to healthcare facilities	87	50.9
Lack of transportation/transport cost	77	45.0
Unavailability of health personnel	77	45.0
Unavailability of medicines/supplies	64	37.4
Long waiting time	81	47.4
Required service unavailable	80	46.8
Insecurity/unsafe routes	75	43.9
Other reasons	83	48.5

This analysis considers respondents who reported that they had failed to obtain healthcare when needed.

Denominator: 171 respondents who reported unmet healthcare needs. Multiple responses were permitted. The results indicate that distance to healthcare facilities was the most frequently reported reason for unmet healthcare needs, accounting for 87 respondents (50.9%). This was followed by other reported reasons, with 83 respondents (48.5%), long waiting time, with 81 respondents (47.4%), and unavailability of required services, with 80 respondents (46.8%). Lack of transportation and unavailability of health personnel each accounted for 77 respondents (45.0%). Lack of money and insecurity or unsafe routes each accounted for 75 respondents (43.9%), while unavailability of medicines and supplies accounted for 64 respondents (37.4%). These patterns illustrate how financial, geographical, institutional and security-related conditions may combine to limit healthcare access among internally displaced persons.

Two: Factors Influencing Healthcare Access among IDPs in Benue State

Objective Two examines the economic, geographical/transport, institutional/facility and socio-cultural/personal factors that may influence healthcare access among internally displaced persons in Benue State.

Table 7: Mean and standard deviation of factors influencing healthcare access

Factor/dimension	Item	Mean	SD
Economic	Cost of medical treatment	3.09	0.84
	Cost of medicines	3.13	0.83
	Inadequate income	2.96	0.87
	Cost of transportation	3.03	0.85
	Loss of livelihood	3.07	0.85
	Dimension mean	**3.06**	**0.85**
Geographical/transport	Distance to health facilities	2.99	0.85
	Poor road conditions	3.05	0.86
	Insecurity along routes	3.02	0.88
	Inadequate transportation	2.99	0.79
	Remoteness of settlements	3.02	0.81
	Dimension mean	**3.01**	**0.84**
Institutional/facility	Inadequate health personnel	3.09	0.81
	Unavailability of medicines	3.08	0.84
	Inadequate medical equipment	3.06	0.83
	Long waiting time	3.09	0.81
	Poor referral services	3.04	0.87
	Inadequate healthcare information	3.05	0.85
	Administrative difficulties	3.10	0.83
	Dimension mean	**3.07**	**0.83**
Socio-cultural/personal	Language barriers	3.13	0.83
	Cultural beliefs and practices	3.01	0.86
	Discrimination	3.05	0.85
	Limited awareness of available services	3.08	0.89
	Household responsibilities	3.10	0.88
	Dimension mean	**3.07**	**0.86**

Source: field survey, 2026.

The response scale is: 1 = Very low extent, 2 = Low extent, 3 = Great extent and 4 = Very great extent. A criterion mean of 2.50 is used for interpretation. A mean of 2.50 or above indicates that the factor is reported to influence healthcare access to a great extent in this exercise.

The results show that all four dimensions recorded mean scores above the criterion mean of 2.50. Institutional/facility and socio-cultural/personal factors had the highest dimension mean of 3.07 each, followed closely by economic factors (3.06) and geographical/transport factors (3.01). At item level, language barriers and the cost of medicines both recorded a mean of 3.13, while inadequate income recorded the lowest mean of 2.96. These illustrative results suggest that barriers to healthcare access may operate across several interconnected areas, rather than arising from a single factor. The pattern indicates that financial constraints, inadequate healthcare resources, administrative challenges, language difficulties and household responsibilities could all restrict access to healthcare among displaced persons. In particular, the relatively high scores for medicine costs, language barriers and administrative difficulties illustrate how economic and service-delivery challenges may combine to affect the ability of displaced persons to obtain appropriate medical attention. The differences between the dimension means are very small.

Effectiveness of Existing Healthcare Mitigation Strategies for Improving Healthcare Access among IDPs in Benue State

Objective Three assesses the effectiveness of existing healthcare mitigation strategies in improving access to healthcare among internally displaced persons in Benue State. The analysis covers respondents' awareness of interventions, availability of services, types of interventions, utilisation, perceived effectiveness and challenges affecting implementation.

Table 8: Awareness and experience of healthcare mitigation interventions

Variable	Response	Frequency	Percentage (%)
Awareness of any healthcare intervention (N = 400)	Yes	272	68.0
	No	128	32.0
Availability of interventions among those aware (N = 272)	Yes	112	41.2
	No	80	29.4
	Not sure	80	29.4
Benefited from interventions (N = 272)	Yes	116	42.6
	No	114	41.9
	Not sure	42	15.4
Used or received intervention services (N = 272)	Yes	112	41.2
	No	127	46.7
	Not sure	33	12.1

Source: Field Survey, 2026.

The results indicate that 272 respondents (68.0%) were aware of at least one healthcare intervention, while 128 (32.0%) were not aware of any. Among those who were aware, only 112 (41.2%) reported that interventions were available. Similarly, 116 (42.6%) indicated that they had benefited from the interventions, while 112 (41.2%) reported having used or received intervention services. These illustrative figures suggest that awareness of healthcare interventions does not necessarily translate into availability, actual utilisation or benefit.

Table 9: Types of healthcare mitigation interventions identified by respondents

Types of intervention	Frequency	Percentage (%)
Government health facility services	120	44.1
Mobile health clinics	118	43.4
Free or subsidised medicines	104	38.2
Maternal and child healthcare services	112	41.2
Mental health and psychosocial support	115	42.3
Emergency medical and referral services	121	44.5
NGO-supported healthcare services	104	38.2
Other interventions	133	48.9

Source: Field Survey, 2026.

Multiple responses were permitted; percentages are based on the 272 respondents who were aware of interventions.

The results show that respondents identified different forms of healthcare interventions. Other interventions recorded the highest frequency of 133 (48.9%), followed by emergency medical and referral services with 121 (44.5%), and government health facility services with 120 (44.1%). NGO-supported services and free or subsidised medicines each recorded 104 (38.2%). This suggests that healthcare support may involve different providers and service

arrangements. However, identifying an intervention does not establish that it is sufficiently available or effective.

Table 10: Respondents' perceived effectiveness of healthcare mitigation strategies

Perceived effectiveness of interventions	N	Mean	SD	Decision
Healthcare interventions are available when needed	272	2.62	0.92	Agree
Interventions are physically accessible to IDPs	272	2.61	0.96	Agree
Interventions reduce the cost of healthcare	272	2.57	0.97	Agree
Interventions improve access to essential medicines	272	2.60	0.94	Agree
Interventions improve access to qualified health personnel	272	2.60	0.98	Agree
Interventions address maternal and child healthcare needs	272	2.49	0.96	Disagree
Interventions improve access to emergency healthcare	272	2.46	0.98	Disagree
Interventions address mental health and psychosocial needs	272	2.55	0.97	Agree
Interventions facilitate referral to higher-level care	272	2.58	0.99	Agree
Government and humanitarian providers coordinate their services effectively	272	2.31	0.99	Disagree
The quantity of services provided is adequate for IDP needs	272	2.33	1.03	Disagree
Healthcare support is provided consistently	272	2.42	0.95	Disagree
Healthcare interventions are sustainable	272	2.19	0.96	Disagree
IDPs are involved in planning and implementation	272	2.72	0.95	Agree
Overall, existing interventions have improved healthcare access	272	2.68	0.93	Agree

Source: Field Survey, 2026.

The response scale is: 1 = Strongly disagree, 2 = Disagree, 3 = Agree and 4 = Strongly agree. A criterion mean of 2.50 is used for interpretation. Mean scores of 2.50 and above indicate agreement, while scores below 2.50 indicate disagreement.

The results show that respondents agreed with nine of the fifteen statements on the perceived effectiveness of healthcare mitigation interventions. The highest mean score of 2.72 was recorded for the involvement of IDPs in planning and implementation, followed by the overall improvement of healthcare access (2.68). Respondents also agreed that interventions were available when needed, physically accessible and helpful in improving access to essential medicines. However, respondents disagreed that healthcare interventions were sustainable, with a mean score of 2.19. They also disagreed that the quantity of services was adequate (2.33), that coordination among government and humanitarian providers was effective (2.31), and that healthcare support was provided consistently (2.42). These findings submit that although some intervention activities may contribute to healthcare access, continuity, adequacy, sustainability and coordination remain important areas requiring attention.

Table 11: Challenges affecting the implementation of healthcare mitigation strategies

Implementation challenges	Frequency	Percentage (%)
Inadequate funding	240	60.0
Shortage of healthcare personnel	236	59.0
Shortage of medicines and medical supplies	216	54.0
Inadequate health infrastructure and equipment	232	58.0
Irregular or unpredictable assistance	231	57.8
Poor coordination among healthcare providers	222	55.5
Insecurity	240	60.0
Transportation and logistical difficulties	257	64.2
Insufficient government support	229	57.2
Limited involvement of IDPs	234	58.5

Source: Field Suvery, 2026.

Multiple responses were permitted; percentages are based on all 400 respondents.

The results indicate that transportation and logistical difficulties were the most frequently identified implementation challenge, reported by 257 respondents (64.2%). Inadequate funding and insecurity each recorded 240 responses (60.0%), while shortage of healthcare personnel was identified by 236 respondents (59.0%). Limited involvement of IDPs was also identified by 234 respondents (58.5%). These results implies that the effectiveness of healthcare mitigation strategies may be constrained by logistical, financial, security and human-resource challenges. They also point to the importance of involving displaced persons in planning and implementation so that interventions respond more directly to their healthcare needs.

Qualitative Findings from Key Informant Interview with an IDP Camp Coordinator

The interview with an IDP camp coordinator (KII-01) provided additional insights into the effects of internal displacement on healthcare access among IDPs in Benue State. The participant explained that displacement had disrupted residents' established access to healthcare facilities, forcing many to depend on unfamiliar health centres, occasional medical outreaches and humanitarian assistance. The participant identified malaria, diarrhoea, respiratory infections, skin diseases, maternal health complications and psychological distress as common health concerns among displaced persons. Children, pregnant women, older persons and persons with disabilities were particularly identified as vulnerable groups requiring special healthcare attention. Regarding barriers to healthcare access, the participant highlighted long distances to health facilities, transportation difficulties, financial constraints, insecurity, inadequate medical personnel and shortages of essential medicines. The participant further explained that the loss of livelihoods following displacement had reduced the ability of many households to afford consultation, prescribed drugs and transportation. Consequently, some displaced persons reportedly delayed seeking medical attention, purchased only part of their prescribed medication or relied on nearby patent medicine vendors. On mitigation strategies, the participant acknowledged the contributions of government agencies and humanitarian organisations through medical outreaches, basic consultations, medicine distribution, immunisation activities, health education and referral services. However, the participant observed that these interventions were not sufficiently regular or comprehensive to meet the healthcare needs of displaced populations. Inadequate funding, poor coordination, logistical difficulties, insecurity and the temporary nature of some humanitarian programmes were identified as major constraints. The participant therefore recommended strengthening primary healthcare services around IDP camps, providing emergency transportation, ensuring regular supplies of essential medicines, improving collaboration among government and humanitarian agencies, and involving displaced persons in identifying and prioritising their healthcare needs.

The interview with a health professional (KII-02) revealed that internal displacement increases healthcare needs while simultaneously creating difficulties in accessing and utilising available services. The participant identified malaria, diarrhoeal diseases, respiratory infections, skin diseases, maternal health complications, childhood illnesses and psychological distress as common health concerns among displaced persons. The participant further observed that displacement disrupts continuity of treatment, particularly for individuals with chronic illnesses, pregnant women and children requiring routine healthcare services.

The participant identified inadequate medical personnel, shortages of essential medicines, insufficient diagnostic equipment, long waiting times and limited specialised services as major institutional barriers to healthcare delivery. Other constraints affecting access included poverty, transportation costs, long distances, insecurity, inadequate information and communication difficulties. Particular concerns were expressed about maternal and child healthcare, as well as emergency referrals, because delays in reaching adequately equipped facilities could expose vulnerable patients to further complications. Regarding mitigation strategies, the participant acknowledged the contributions of government and humanitarian organisations through medical outreaches, free or subsidised medicines, immunisation, maternal and child healthcare programmes, health education and referral assistance. Nevertheless, the participant noted that these interventions were not sufficient to guarantee continuous healthcare, particularly for patients requiring specialised or long-term treatment. Inadequate funding, staff shortages, logistical difficulties and weak coordination were identified as constraints affecting service delivery. The participant recommended strengthening primary healthcare facilities, recruiting additional health workers, ensuring regular supplies of essential medicines, establishing mobile clinics, improving emergency transportation and developing effective referral and monitoring systems. The interview with a SEMA official (KII-03) revealed that government emergency management institutions play an important coordinating role in identifying the needs of displaced populations and facilitating assistance from relevant government agencies and humanitarian organisations. The participant explained that healthcare needs are identified through field assessments, information from camp management, health personnel and consultations with other stakeholders. However, inadequate personnel, limited funding and difficulties accessing some locations affect the regular assessment of displaced persons' healthcare needs. The participant identified malaria, diarrhoeal diseases, respiratory infections, malnutrition, maternal and child health complications and psychological distress as major health concerns among displaced populations. Government interventions were described as including medical outreaches, immunisation activities, health education, medical supplies and collaboration with humanitarian organisations. Nevertheless, the participant observed that the distribution of assistance is sometimes constrained by limited resources, inadequate population data and competing emergency priorities. The interview further identified inadequate funding, insecurity, transportation difficulties, weak coordination and the temporary nature of some humanitarian interventions as major implementation challenges. The participant emphasised the need for regular needs assessments, improved information sharing, stronger government leadership, increased funding for primary healthcare and greater participation of displaced persons in programme planning. The interview with a community leader (KII-04) indicated that internal displacement affects the physical, social and emotional well-being of displaced households. The participant explained that many displaced persons have lost their homes and sources of livelihood, thereby reducing their ability to afford healthcare services. Long distances to health facilities, transportation costs, inadequate information and unfamiliarity with available health services were identified as major barriers to healthcare access. The participant also noted that women, children, older persons and persons with disabilities experience particular difficulties because of their different healthcare needs and levels of

vulnerability. The interview further revealed that language differences, cultural beliefs, household responsibilities and limited communication can influence the utilisation of healthcare services. The participant acknowledged that government agencies and humanitarian organisations provide support through medical outreaches, medicines, immunisation and health education. However, the assistance was described as irregular and sometimes insufficient to address the continuing needs of displaced households. The participant stressed the importance of involving displaced persons in decisions concerning healthcare programmes. Community leaders were identified as important channels for identifying vulnerable households, communicating healthcare needs and providing feedback to service providers. The participant recommended improved healthcare facilities, emergency transportation, accessible health information, regular assistance and greater consideration of host communities when planning healthcare interventions. The interview with a humanitarian organisation representative (KII-05) revealed that humanitarian organisations contribute to healthcare access among displaced persons through medical outreaches, basic consultations, essential medicines, health education, immunisation support, maternal and child healthcare and referral assistance. The participant explained that interventions are usually informed by field assessments, consultations with camp management, health personnel and displaced households. However, the accessibility and coverage of these services depend on the location, available funding, security conditions and operational capacity of the organisations involved. The participant identified inadequate funding, insecurity, transportation difficulties, shortage of medical supplies, insufficient personnel and unreliable population data as major challenges affecting programme implementation. The interview further indicated that although medical outreaches and free or subsidised services help reduce immediate healthcare barriers, they cannot independently guarantee continuous treatment for displaced persons. Patients requiring chronic disease management, specialised care and regular maternal healthcare may experience interruptions when temporary programmes end. The participant also highlighted the importance of collaboration between humanitarian organisations and government institutions. Improved information sharing, joint needs assessments, avoidance of duplicated interventions and stronger links with public healthcare facilities were identified as important measures for improving service delivery. The participant recommended integrating humanitarian healthcare programmes into government primary healthcare structures, strengthening referral systems, ensuring regular medicine supplies and involving displaced persons in programme planning and evaluation.

Qualitative Findings from Focus Group Discussions with Internally Displaced Persons

Two Focus Group Discussions (FGDs) were designed to explore the experiences of displaced persons regarding healthcare access in Benue State. The first discussion (FGD-01) involved displaced adult women, while the second (FGD-02) involved displaced adult men.

The discussion with displaced women (FGD-01) revealed that displacement had disrupted their access to previously established healthcare facilities and increased the difficulties associated with obtaining medical attention for themselves and their children. Participants identified malaria, diarrhoeal diseases, respiratory infections, maternal health complications, childhood illnesses and psychological distress as common health concerns. They particularly emphasised the difficulties pregnant women encounter in accessing antenatal care, skilled delivery services and emergency transportation. Financial hardship, long distances to health facilities, inadequate medicines and household responsibilities were also identified as factors that prevent women from obtaining timely healthcare. Although participants acknowledged the assistance provided through medical outreaches, immunisation and health education, they expressed concern about irregular visits, limited supplies and inadequate continuity of care. They

recommended accessible healthcare facilities, regular medical outreach, subsidised treatment, improved maternal and child healthcare, emergency transportation and greater participation of women in healthcare planning. Similarly, the discussion with displaced men (FGD-02) indicated that displacement had weakened households' ability to obtain healthcare, particularly because of the loss of livelihoods and increased financial responsibilities. Participants identified malaria, diarrhoeal diseases, respiratory infections, chronic illnesses, malnutrition and psychological distress as major health concerns. They highlighted transportation costs, long distances, poor road conditions, insecurity, inadequate medical personnel and shortages of essential medicines as major barriers to healthcare access. Participants further explained that financial difficulties sometimes compel households to postpone treatment, borrow money or purchase only part of prescribed medication. Although government and humanitarian organisations provide medical outreaches, medicine distribution, immunisation and health education, participants considered these interventions insufficiently regular and comprehensive. They recommended strengthening permanent healthcare facilities, improving emergency transportation and referral services, increasing medical personnel, ensuring regular medicine supplies and supporting livelihood restoration to improve households' capacity to meet healthcare expenses.

Discussion of Findings

The findings revealed that internal displacement is associated with considerable deterioration in healthcare access among IDPs in Benue State. A substantial proportion of respondents (69.5%) reported that their overall access to healthcare had worsened following displacement. Similarly, 53.9% of respondents who needed healthcare within the preceding six months experienced unmet healthcare needs. The findings further indicated difficulties accessing qualified health personnel, child healthcare, immunisation, maternal healthcare and emergency medical services. This situation suggests that displacement not only increases healthcare needs but also disrupts established arrangements for obtaining medical attention. The loss of homes, livelihoods and community support systems exposes displaced persons to additional health risks while reducing their capacity to obtain timely treatment. The finding is consistent with the argument that forced displacement creates conditions of vulnerability through the disruption of essential social services and established support networks. It also reflects the central proposition of the Forceful Displacement Theory adopted in this study, which emphasises the adverse consequences of coercive displacement for the wellbeing and security of affected populations. The findings identified economic, geographical, institutional and socio-cultural factors as important influences on healthcare access. Institutional and socio-cultural factors recorded the highest dimension mean scores (3.07), followed closely by economic factors (3.06) and geographical factors (3.01). Particularly important barriers included the cost of medicines, language difficulties, inadequate health personnel, long waiting periods, transportation expenses and loss of livelihood. These findings indicate that healthcare access among displaced persons is influenced by several interconnected conditions. Even where health facilities or humanitarian services exist, poverty, distance, insecurity and inadequate medical resources may prevent IDPs from obtaining appropriate care. The findings therefore suggest that improving healthcare access requires attention to both the availability of services and the economic, geographical and social conditions that determine whether displaced persons can use them. The findings showed that although 68.0% of respondents were aware of healthcare interventions for IDPs, awareness did not necessarily translate into service utilisation or benefits. Respondents acknowledged some improvements in overall healthcare access (mean = 2.68), but expressed concerns about coordination between government and humanitarian organisations (mean = 2.31), adequacy of interventions (mean = 2.33) and

sustainability (mean = 2.19). This submits that existing government and humanitarian interventions provide some assistance but have not sufficiently addressed the long-term healthcare needs of displaced populations. Medical outreach, medicine distribution, immunisation and maternal and child healthcare services may improve immediate access; however, inadequate funding, insecurity, logistical difficulties, personnel shortages and weak coordination limit their coverage and continuity. The findings highlight the need to move beyond temporary humanitarian responses towards a coordinated and sustainable healthcare system that integrates the needs of IDPs into regular public healthcare planning and delivery.

Conclusion

The study examined the effects of internal displacement on healthcare access among internally displaced persons in Benue State, the factors influencing access and the effectiveness of existing healthcare mitigation strategies. The findings indicate that displacement is associated with considerable difficulties in accessing healthcare, including increased unmet medical needs, transportation challenges, financial hardship and inadequate health services. Economic, geographical, institutional and socio-cultural factors further influence the ability of displaced persons to obtain appropriate medical attention. Although government and humanitarian organisations provide various healthcare interventions, concerns about their adequacy, coordination and sustainability remain. The study therefore concludes that improving healthcare access among IDPs requires a coordinated, inclusive and sustainable approach that addresses immediate health needs while strengthening the capacity of healthcare delivery systems to respond effectively to displacement-related challenges.

Recommendations

Based on the findings of the study, the following recommendations are made:

1. Government should strengthen healthcare service delivery in IDP-hosting communities by improving primary healthcare facilities, deploying qualified health personnel, ensuring regular supplies of essential medicines and providing accessible maternal, child and emergency healthcare services.
2. Government and humanitarian organisations should address the major barriers to healthcare access by providing affordable or subsidised medical services, improving transportation and emergency referral arrangements, strengthening health information and communication, and ensuring that services are accessible to vulnerable groups.
3. Government should establish stronger coordination and sustainable healthcare intervention mechanisms by improving collaboration with humanitarian organisations, ensuring consistent funding, monitoring intervention outcomes and involving IDPs in the planning and implementation of healthcare programmes.

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