



Resilience actions of Internally Displaced Persons (IDPs) living in camp-like settings: a Northern Nigeria case study

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ABSTRACT

Background: There are about 55 million Internally Displaced Persons (IDP), and some live in camp settlements, often for protracted periods. However, there is limited evidence on camp management and self-management strategies adopted by camp-dwelling IDPs. This paper reflects on the camp management and health resilience strategies practised by IDPs settled in camp-like settings, based on the first strategic objective of the International Organisation for Migration (IOM) Progressive Resolution of Displacement Situations (PRDS).

Methods: Eight focus group discussions were conducted with 49 IDP camp leaders across eight camp-like settings in Northern Nigeria. Issues explored included community structure, leadership, public interaction, communication, and health management. Data were analysed using a framework approach under five factors related to the IOM PRDS first objective.

Findings: IDPs exhibited resilience by adapting to their current locations, establishing internal camp and health management structures, and advocating with external organisations. Supportive communal relationships were an integral element in their adaptation. Methods of resilience involved social cohesion, setting up camp leadership committees, and seeking alternative means of income, protection, and healthcare management. Additionally, selecting representatives who could advocate for their well-being allowed them to request support and exercise their rights.

Conclusion: Despite resource shortages, the IDPs adapted by setting up techniques for managing their affairs and available resources, finding innovative ways to cater for themselves, advocating for their needs, and supporting each other. These observations showed how displaced populations can be active actors in their change and development if basic and essential management support is provided. Engaging IDPs in camp management could reduce long-term dependency on humanitarian aid.

1. Introductions

Millions of people have been forcefully displaced from their homes in the past decade. The number who seek refuge within their own country as Internally Displaced Persons (IDPs) is significantly higher than those who cross national borders as refugees or asylum seekers (United Nations Refugee Agency (UNHCR), 2021). There are about 82.4 million forcibly displaced people worldwide (United Nations Refugee Agency (UNHCR), 2021), of which 55 million are IDPs, with 48 million resulting from conflict and violence and 7 million from disasters (Internal Displacement Monitoring Center (IDMC), 2020). Affected populations often settle in camp-like settings or within other communities who act as

hosts (Schmidt, 2003). IDP management differs from refugee management. Unlike refugees who are managed by the international humanitarian community, IDPs are primarily considered the responsibility of the affected countries' national authorities (United Nations 1998).

Generally, disaster resilience is "the ability of countries, communities, and households to manage change, by maintaining or transforming living standards in the face of shocks or stresses - such as earthquakes, drought or violent conflict - without compromising their long-term prospects" (United Kingdom Department of International Development (UKAID), 2011). In an internal displacement context, resilience includes the ability of affected populations to manage the changes and effects of forced displacement on their health, well-being and living conditions within

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their own country. Once displaced for six months, affected people have a high probability of being displaced for protracted periods, at least three years or more (Crawford et al., 2015). These populations live in different settings, including camps initially intended to be temporary but which often become permanent (Turner, 2016). Prolonged dwelling in displacement often results in adverse outcomes, including increased disease incidences, food insecurity, and mental health issues (Mubarak et al., 2016; Food & Agriculture Organisation of the United Nations (FAO), 2022; Siriwardhana et al., 2015; De Bruijn, 2009). Hence, all IDPs are vulnerable to long-term difficulties, which could last many years and beyond the crisis period (Roberts et al., 2009; Salama et al., 2001). Recent agendas have, therefore, shifted from establishing traditional camps towards providing settlements that offer opportunities and resilient systems, which benefit affected populations, nations and humanitarian providers.

Building resilience is central to the International Organization for Migration (IOM) Progressive Resolution of Displacement Situations (PRDS) (International Organization for Migration (IOM), 2016). The PRDS is a framework for action designed to support the development of IOM responses. The framework recognises the broader impacts of migration crises beyond IDPs and refugees and considers affected non-displaced communities. It also offers guidance on navigating the complexity of forced migration dynamics and how to support resolutions in displacement situations. The framework is intended to guide organisations in navigating the complexity of forced migration, encourage multi-level initiatives by recognising and reinforcing actions of individuals, households and communities, encourage partnerships with traditional and non-traditional actors, provide support to governments in affected countries towards taking responsibility in protecting and assisting affected populations, and encourage ways to optimise humanitarian, development, peace and security interventions.

This shift towards encouraging resilience in displacement settings demands alternative management and practices that facilitate effective transition to durable and sustainable solutions. (Idris, 2017; United Nations Refugee Agency (UNHCR), 2005) To improve displacement management, proactive support and structures that consider the affected populations' experiences are needed, and these require an understanding of different IDP resilience actions and IDP-led management approaches. IDP internal management approaches provide vital information which can enable supporting organisations to develop relevant programmes. More effective management, including self-reliance factors, is critical in any strategy aiming to avoid or address displacement situations and find durable, sustainable solutions (United Nations Refugee Agency (UNHCR), 2005). Self-reliant displaced populations are also more likely to achieve better durable solutions. Therefore, understanding the adopted management processes in camp settings would highlight factors that can support effective camp management.

Most displacement studies focus mainly on the needs, social determinants of health, and conflict effects, particularly in refugee settings. In contrast, studies on camp management are generally limited, and those specifically from the perspective of IDPs are lacking (Rass et al., 2020; Blanchet et al., 2017; Ekezie et al., 2020). Considering the complexity of protracted displacement in most IDP situations, the lack of evidence on IDP internal management structures and systems highlights a critical gap in humanitarian crisis management. To address these knowledge gaps and understand IDP resilience strategies in camp settings, it is crucial to explore the management experiences and approaches adopted by IDPs living in camp-like settings (Vincent and Sørensen, 2001). This study, therefore, aims to provide supporting evidence for the PRDS agenda of identifying and strengthening the coping capacities of IDPs. The paper presents findings from the camp management and coping strategies adopted by IDPs displaced by conflict in Northern Nigeria.

1.1. Theoretical action framework

The Progressive Resolution of Displacement Situations (PRDS) framework includes tools to support strategic planning, programme development, implementation and monitoring and evaluation. It also provides a six-step process to guide and support the systematic development of a comprehensive response to contribute toward the progressive resolution of displacement situations. The six-step process includes (1) Analyse the displacement situation within the wider mobility context, (2) Identify and engage with affected populations, (3) Engage with coordination mechanisms and partners, (4) Develop strategic objectives, (5) Integrate key principles and (6) Monitor and evaluate.

In addition, the three strategic objectives of the framework are (i) to identify and strengthen coping capacities, (ii) to foster self-reliance by responding to the longer-term consequences, and (iii) to create conducive environments by addressing the root causes of crisis and displacement (International Organization for Migration (IOM), 2016). Interventions guided by the PRDS Framework are advised to be grounded on four programmatic pillars: Protection, safety and security; Adequate standard of living; Sustainable livelihoods and employment; and Inclusive governance. These respective pillars are based on the eight criteria outlined in the IASC Framework on Durable Solutions for Internally Displaced Persons (Inter-Agency Standing Committee (IASC), 2010). Overall, the PRDS considers multiple factors that need to be considered in displacement management.

Considering that resilience is a critical component of humanitarian response, the first step towards resilience needs to identify and reinforce individual, household and community-level coping strategies to avoid interventions that may undermine existing coping mechanisms. In this light, the PRDS framework was selected for this study because of its specific emphasis on the role and contributions of displaced populations at multiple levels (individual, household and community). This inclusive approach of the capacities of people and positive functioning specific to displacement crisis recognises not only the needs and rights of those affected but also the actions displayed at different levels, which are not often captured in most displacement studies, including those conducted in refugee settings. Hence, the PRDS framework was considered most suitable for assessing and exploring the management strategies used by IDP living in camp-like settings which could offer new opportunities that could enhance development of strategic displacement solutions. However, a shortcoming of the framework was that it was unclear whether resilience was being viewed as a process or an outcome. In reality, resilience is more likely on a continuum, and the PRDS guidance on the shift in differing degrees (e.g. emergency vs protracted settings) was also lacking. In addition, other resilience factors not fully considered in the framework included the interaction of individual and community factors such as gender, age, culture and past experiences, and management shifts at the community levels on resilience expressions and elements that may impede resilience. These points need to be considered as resilience is influenced by internal and external factors that may change over time due to a personal and group exposure, development and interaction with the environment (Southwick et al., 2014; Siriwardhana et al., 2014; Siriwardhana and Stewart, 2013; Aymerich, 2020). Integrating these salient concepts could help strengthen the framework.

More evidence of resilience has been reported in refugees compared to IDP settings; nevertheless, internal resources are considered a major contribution to resilience in both contexts. However, the overall management of both groups also influences the resilience expressions. For instance, with often more organisational support, refugee resilience demonstrates strength and resilience that facilitates their resettlement process in the new country (Hutchinson and Dorsett, 2012). However, in the context of IDPs, with limited external support, resilience response outcomes often lead to re-displacement, increased risk of protracted displacement and return of IDPs with failings to address the long-term safety and sustainability of their return (Aymerich, 2020). This

contrasting evidence highlights the role different displacement communities could have in facilitating durable solutions and the importance of understanding resilience within each displacement context.

For the context of this study, the resilience assessment of IDPs will focus primarily on the first strategic objective of PRDS ([International Organization for Migration \(IOM\), 2016](#)). The goal, outcome, and supporting statement to guide the achievement of the objective are outlined below:

Objective 1: *To identify and strengthen coping capacities weakened as a result of displacement situations.*”

Outcome: *“Existing coping capacities and strategies strengthened, and risks countered”.*

“Primarily in partnership with humanitarian actors, IOM recognises the criticality of identifying and reinforcing individual, household, and community-level coping strategies to avoid interventions which may undermine existing coping mechanisms and mitigate against the adoption of harmful practices, which can have detrimental long-term consequences and undermine recovery. Simultaneously, systems may need to be reinforced to cope with displacement challenges, ensuring duty bearers can provide adequate protection and assistance and that the rights of affected populations are up-held to reinforce coping capacities.”

From the above guidance, five essential factors, based on the key components of the supporting statement (as underlined), will be considered in this paper using a case study from Northern Nigeria. These include the “individual, household and community-level coping strategies”, “pre-existing and adopted practices”, “IDP internal systems”, “protection and assistance provision”, and “exercising personal rights”.

1.2. Case study: internal displacement in Nigeria

Nigeria has experienced various forms of internal displacement, from armed conflict to natural disasters, ethnoreligious disputes, and communal clashes, which have affected millions of people ([Mohammed, 2017](#)). After a decade of conflict crisis caused by the Boko Haram terrorist groups, millions have been affected, and over 2 million remain displaced ([International Organization for Migration \(IOM\), 2022](#)). The majority of IDPs have settled in self-settled locations (non-government authorised sites) and within host communities. These groups have often been considered “invisible” and do not receive needed support ([Olanrewaju et al., 2019](#); [United Nations Office for the Coordination of Humanitarian Affairs \(UNOCHA\), 2016](#)).

The continuous conflict has resulted in a constant population displacement fragmented in time and space, with some people becoming newly displaced and others returning to their area of origin at the same time but later returning to displacement camps ([International Organization for Migration \(IOM\), 2022](#)). The IDPs experience numerous problems, including inadequate assistance, insecurity, health challenges, and lack of rehabilitation options ([NiM et al., 2018](#); [Oluwasanmi et al., 2017](#); [Ibrahim, 2019](#); [Obiefuna and Adams, 2021](#)). Host communities have also been severely affected as increased IDP migration depleted local resources ([Verme and Schuettler, 2021](#)). These challenges illustrate the broader complications of displacement, but despite the significant problems that IDPs face, there is limited information about managing their internal affairs and the resilience actions implemented by IDPs in camp-like settings.

Suggested solutions to internal displacement issues include the need for better data that could improve humanitarian response, human and financial resources investment to develop new approaches, and strengthening political will and commitment to act ([United Nations \(UN\), 2021](#)). However, studies on IDP lived experiences have not elaborated on the adopted IDP management approaches across different camp settings ([Okeke-Ihejirika et al., 2020](#); [Ishaku et al., 2020](#)), which could support the implementation of those suggested solutions. This paper, therefore, aims to present findings from broader research that

investigated the essential services available to camp-dwelling IDPs in Northern Nigeria ([Ekezie, 2019](#)). The current study explores the perceptions, experiences, and internal management strategies of IDPs and provides insights into how they managed their disrupted living conditions and displayed resilience attributes while dwelling in camp-like settings.

2. Methods

2.1. Study setting and participants

This study draws on qualitative data collected between September and October 2016. At the peak of the Boko Haram crisis in December 2015, IDPs migrated from affected areas in Northeast Nigeria. They settled in 13 of 36 states in the country, all within the northern regions (northeast, northwest, and northcentral) ([International Organisation for Migration \(IOM\), 2015](#)). For this research, only camp-like settlements in the seven states were considered, and eight camps were visited. The selected states represented different camp types ([Table 1](#)). Formal and planned camps were government-approved locations, transit camps were temporary locations, while informal and self-settled locations were non-government approved locations selected at the IDPs’ discretions. Locations were sampled randomly based on IDP population size and security clearance. Detailed characteristics of the study camps and IDP demography have previously been reported ([Ekezie et al., 2019](#)).

Since the study was interested in management approaches, participants were those involved in IDP camp management, administration, and leadership. A purposive sampling technique was adopted to recruit participants, and selection was based on individual roles and responsibilities. However, gender representation varied across the groups, and most participants were males.

2.2. Data collection

Data was collected through focus group discussions (FGDs) with the IDP leaders. The topic guide used was developed after an in-depth review of three different tools: “Camp Committee Assessment - A tool for deciding how to work with camp committees” ([Sorensen and Rogers, 2010](#)), “UNHCR Food Distribution Monitoring Checklist” ([United Nations High Commissioner for Refugees \(UNHCR\), 2001](#)), and the “Guidelines for Public Health Promotion in Emergencies” ([Oxfam, 2001](#)). The guide included questions on community structure, interaction, participation, communication, and healthcare, and it was pre-tested for clarity. The FGDs were facilitated by trained bilingual local research assistants in English, Pidgin English, or the most common language in the affected region, Hausa. Potential participants were notified at least one day in advance. All participants were 18 years or older, and had been displaced from their place of residence in Northern Nigeria. Ethical clearance for the study was received from the Nigerian National Health Research and the University of Nottingham Medical School Research Ethics Committees. Permissions to access the camps were obtained from the Nigerian National Emergency Maintenance Agency, and consent were gotten from each participants, who were also given the option to participate voluntarily or opt-out.

2.3. Data analysis

All discussions were audio-recorded, transcribed, translated directly to English, and analysed using the QRS Nvivo 12 software (QSR International). A framework analysis was conducted based on the IOM PRDS objective-1, five critical elements of interest.

3. Results

As shown in [Table 1](#), eight FGDs were conducted with 49 IDPs. A brief description of the common challenges encountered in the camps is

Table 1
Characteristics IDP FGD participations.

Focus Groups (FG)	State	Camp name	Camp status	Camp type	Number of participants	Gender
FG1	Borno	Bakassi	Formal	Planned	11	Female (5) Male (6)
FG2	FCT	Kuchingoro	Informal	Self-settled	5	Female (2) Male (3)
FG3	FCT	Durumi	Informal	Self-settled	6	Female (2) Male (4)
FG4	Kano	Gaida	Informal	Self-settled	5	Female (2) Male (3)
FG5	Nasarawa	Gurku	Informal	Planned	7	Female (3) Male (4)
FG6	Plateau	Stefanos	Formal	Transit	5	Female (3) Male (2)
FG7	Taraba	Mullum	Informal	Self-settled	5	Female (2) Male (3)
FG8	Taraba	Gullum	Informal	Transit	5	Female (2) Male (3)

presented in Section 3.1. The identified challenges experienced by the IDPs while living in the camps highlighted some of the factors that triggered the resilience and management actions implemented by the IDPs. In Section 3.2, these management actions and resilience attributes exhibited by the IDPs are then elaborated according to the five PRDS objective-1 factors, with supporting narrative extracts.

3.1. Key challenges encountered in IDP camp settlements

In addition to being forcefully displaced, challenges faced by most IDPs included being in camps not recognised by the national authorities, having limited access to essential resources, and resulting outcomes from the lack of adequate support. Predominant health challenges reported were headaches, eye infections, diarrhoea, fever, typhoid, and malaria. The IDPs associated some of these health conditions with the high volume of rodents and disease-causing vectors present on the camp premises, including mosquitoes, snakes, and scorpions. Bites from these vectors were reported to have increased disease incidence and mortality. Associated long-term well-being issues included trauma, stress, and loss of income sources. Supplies needed by the IDPs were insufficient, and the IDPs declared that the lack of food affected their overall health status and speculated it might have caused a few deaths. Consequently, it was unsurprising to observe that hunger was the biggest challenge expressed in all camps, as stated by an IDP who reported some deaths were related to hunger.

Six deaths in the past three months, but early in the year when we came, there was no death, only illness. But I do not know if the illnesses cause the death... The food (national agencies) provide is not enough for us... and the big sickness I think is hunger.... (What brings this death?) It is only hunger, nothing else. – FG1

The health of everyone was somewhat affected, but the most vulnerable groups were considered to be “women and children”, who were reported to have the highest mortality rates. Their heightened vulnerability was reported to be because they were more prone to falling ill, especially during childbirth for mothers and young ages of children, and the inability of women and children to cater food for themselves increased their vulnerability. Unaccompanied children, especially children orphaned by the crisis or those with no personal guardian in the camp, were also vulnerable to being exploited. It was generally implied that not having a mature man in a household to help provide food increased the health and well-being risks of women and children, as expressed in the following quote.

Females (are most vulnerable) because it is hard for them to go somewhere to go find something to eat... children too, because when their parents die, they can not help themselves – FG2

3.2. Five PRDS factors and IDP resilience actions

Actions taken by the IDPs to tackle the challenges they experienced and how they took action to support themselves were grouped and discussed under five PRDS objective-1 factors, as described in the following sections.

3.2.1. Individual, household, and community-level coping strategies

Most camps had limited access to sanitation requirements; hence, some IDPs shared the resources of neighbouring communities, which posed some challenges to both groups. For instance, in IDP locations with no access to direct water sources, they sometimes travelled far distances to get water from neighbouring non-IDP communities. Thus, the IDPs were then often faced with long waiting times because they had to wait for the local community residents to collect water before they could. Similarly, most camps had either poorly organised toilets or none at all, so IDPs sometimes shared toilets with neighbouring communities or defecated in nearby outdoor bushes, in the process contaminating the shared surrounding environments and affecting neighbouring communities. Such negative adaptive actions cause environmental pollution and consequently increase the risk of infectious diseases, such as contamination of water, which could heighten the risk of diarrhoeal diseases.

In camps with on-site toilets, managing the toilets was usually the responsibility of women, who were also responsible for ensuring children washed their hands after using the toilets. As such, women were primarily responsible for the sanitation and hygiene of the camps. The IDP leaders also encouraged the general IDP community to dig personal pit toilets for human wastes (faeces) and minimise outdoor defecation, but this was not always implemented safely. For example, pit toilets were often constructed within the camp premises and were left uncovered, thus contributing to air pollution. In addition, non-human solid wastes were also poorly disposed of, and in these cases, they were either accumulated in heaps outdoors, burnt in the open air, or left on the ground outside for rainfalls to wash them off from the premises. The observed waste management practices likely contributed to the presence of disease vectors like mosquitoes and the high incidence of reported vector-borne diseases. The water and waste management adaptation actions were described by an IDP who stated that:

...for water, we have always complained to the government because we only have one borehole for the owners of the community... we will wait for the community owners to fetch (water) first before we go to fetch... There is a place where we gather our refuse to burn, but some we'll just put it in the gutter, and when it rains it will pack them, while some we will just dispose it anywhere... (to improve sanitation) I will let everyone in the camp to try and construct their own toilet themselves so that the surrounding will be hygienic for everyone. – FG7

In some camps, the IDPs had set up a health support team to manage medical-related issues. Sick people were generally taken to see a medical doctor, often at distant facilities, who would prescribe some medications. These health services were in most locations that often required direct financial payments since no insurance or subsidy schemes were available to the IDPs. In such situations, the IDPs often contributed to supporting each other. But when out-of-pocket expenditure exceeded their budgets, they resorted to alternative treatments like traditional remedies, including herbs, and obtaining medicines from street vendors. The use of herbs and medicines from street vendors was reported to be sometimes ineffective, and as a result, the conditions the IDPs experienced were often not well adequately treated. Overall, the lack of finances influenced healthcare access and prioritisation as described in

the following comment:

We go to the health centre... But no money. So instead of going for at least full treatment, they rather go to a chemist to get drugs of 50 naira because they do not have money. – FG8

To mitigate the lack of food and healthcare financial shortage, some IDP leaders advised their camp residents to find means of generating some income, for instance, by farming and selling firewood. When food was provided to the IDP community from external support groups, three approaches were commonly used to distribute the resources: quantity of the food supplied, number of households (shelters), and family size (number of people in one household). In some camps, specific food rations were used to ensure fair distribution. Pre-collated information about each household, including household sizes and members, was often used to guide the process. However, the use of food portion sizes and household information were more common in formal camps where food supplies were provided by the government or supporting humanitarian organisations that often used a standard supply and management protocol. Still, the supplies were often insufficient for the IDP needs, contributing to undernutrition, malnutrition and weaken immunity, which is needed to fight diseases. In addition, the shortage and duration between food supplies encouraged begging among the IDPs, as described in the quote below.

When they bring food, we will go and collect it ourselves... We get food supply every month, so if your family members are between 7 and 10, they will give you one bag of rice, one packet of Maggi and four litres of oil... You just have to manage it ... if they bring food in the camp, it is to last for 20 days, but the camp authority will allow it to last for 30 days instead. Then we will have to go from house to house to ask for some food, or we buy... – FG1

3.2.2. Pre-existing and adopted practices

Within the context of this study, pre-existing practices included what IDPs did previously before displacement and what they carried on doing while in displacement in addition to the new practices adopted while in displacement. An example of a pre-existing practice was using local regions of origin before displacement, Local Government Areas (LGA), as a criterion for leadership selection. LGA represents the administrative division of states in the country and is a national administrative management protocol. Hence, the IDPs adopted the LGA selection criteria in nominating their camp leaders and representatives.

Communal living and sharing were also common among the IDPs before displacement and camp settlements. The most common personal and collective assistance required was often related to food and healthcare, especially medication payment. To avoid feelings of isolation, new proactive communal relationships were developed to support each other. For instance, individuals close to someone with undisclosed personal challenges informed the leadership committee about those challenges on their behalf, and the IDP leaders, in turn, intervened and provided support within their capacity, as described in the next quote. Such actions exhibited positive social support, which helped improve IDP's mental health by reducing the factors that increase anxiety and depression.

...there are some close relatives... say they know that somebody has a problem and they do not want to reveal it... that close relative will come and let us know... through that person, we will address it. – FG6

3.2.3. IDP internal systems

There was a level of systematic leadership coordination within the camps. Most camps had well-established IDP leadership teams, known as IDP camp committees. These committees were responsible for coordinating and representing all IDP residents. The sizes of the committee ranged from five to 15 members and included males and females. However, gender representations were often uneven, with fewer female

members. This disproportionate representation reflected the patriarchal culture of the region. As a result, management of female-related issues, including pregnancy, child delivery, and needs of female-headed households in the camps, was not always addressed effectively. One reason for the partial negligence of female-related issues was observed in an exchange between a male and female IDP leader, as presented below. The male IDP leader commented that women's affairs were "stressful". In response, the female IDP directly highlighted the importance of female leaders and advocated for more women to be involved in camp leadership.

When we have a meeting, we mainly deal with the men. You know there is always stress handling women, so when we share things, we only do so to the men, and they, in turn, will take it home. But if you have a meeting with women, it takes a long time to finish. – Male, FG7

It's always good to have a woman involved in the meeting because she understands what the women are going through, and the woman must be respected too... I want them (camp leaders) to involve the women in the dealings of the camp – Female, FG7

In addition to leadership selection by LGA stratification, in some camps, leaders were also nominated based on their education level, particularly their English Language skills. The education selection criterion was considered to ensure that selected leaders could communicate and advocate effectively. Furthermore, to ensure strategic handling of leadership tasks, most committee members had specific roles and responsibilities, including a chairman, secretary, and sanitation officer. Female leaders were often assigned responsibilities related to women, children, and sanitation, and they were sometimes supervised by male leaders, as described by one male IDP leader.

Anything that has to do about women and children, they (women among the leadership) are the ones that handle it... we give the women (items) to share, and we just supervise them. – Male, FG4

There were no formal communication processes. Information received on issues such as the status of conflicts was often through informal communication channels, such as phone conversations with people still in the areas of conflict, conversations with visitors or camp officials, and listening to discussions in surrounding host communities. IDP leaders acted as main communication links between external organisations and all IDP residents, including acting as health liaison persons between IDPs and external supporting organisations or groups. Some camps had a designated person for the communication role, often called the "public relations officer (PRO)". These PROs were responsible for disseminating information to all IDP residents, both on behalf of the IDP committee leaders and other matters, including conflict status updates and visits from health organisations, for instance, during mass vaccination campaigns. Using radios was considered the only means of getting broader and more accurate information from outside the camps, and the IDPs requested for more radios to be provided.

If we did not get (information), we go to the camp chairman, to get whatever information we need in the camp... Radio is better to access information. – FG1

No standardised internal management process was identified across all the camps; hence each camp committee adopted its unique method. But overall, camp management processes varied by the type of settlement: formal vs informal. Formal camps appeared to have more structure and standardised management processes compared to informal camps. Those camps also had more formal reporting chains for decision-making, managing IDP complaints, and engaging with supporting organisations. As a result of the defined structure in the formal camps, high-priority needs and problems were addressed much quicker than in the informal locations that relied solely on the capacities of the IDP leaders. For instance, suspected disease outbreaks were quickly reported and assessed by healthcare staff who visited formal camps more frequently than informal camps. To manage internal disputes and

complaints within the camps, this was first reported to any IDP leadership representative – for example, the LGA, female, or youth representatives depending on the issue of concern – and if unresolved, it was forwarded to the IDP Camp Chairman and explained here:

So when we have a complaint, we carry the complaint between members of the committee of the camp; and the committee of the camp, also if it is above them, they carry it to the...Chief – FG3

The most common complaints were often related to poor health, lack of food, and theft. Depending on the seriousness of the problem, complaints were also escalated to the police if the matter was related to security and theft. Issues associated with general camp conditions were directed to organisations managing the camp; for example, suspected disease outbreaks were reported to the primary healthcare representatives, who responded swiftly by conducting a disease monitoring assessment.

3.2.4. Protection and assistance provision

When external healthcare interventions and supplies were provided to the camps, IDPs were sometimes involved in the intervention programme design, particularly in coordinating IDP residents for resource distribution, for instance, mass vaccination. Generally, resources provided came through multiple sources, including private individuals, local institutions, and international aid organisations, including the World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF). Despite the involvement of multiple providers, supplies were still inconsistent, insufficient, and unreliable, with long waiting periods in between deliveries, including visits by healthcare staff who were scarce in the IDP locations. The delays affected supply rationing, which sometimes resulted in door-to-door begging among the IDPs and delayed presentation and diagnosis of health conditions.

To most camps, the nearest healthcare facilities were health posts or primary healthcare centres (PHC), which offered basic healthcare. However, most facilities were either not in operation, lacked essential medical resources and staff, or were permanently closed. In rare circumstances, complex health cases were often sent to hospitals (secondary care) and federal hospitals (tertiary care). These hospitals were often located far away from the camps, thus requiring faster means of transportation or long walks, and these sometimes included health service financial charges. The accumulative finances needed to access the services at those locations occasionally discouraged the IDPs from seeking further medical care. Medications used by the IDPs were sometimes donated by philanthropic groups or directly purchased from local pharmacies, as described below. The IDPs also reported that the donated drugs were usually deposited at the closest PHC accessed by IDPs, but this was often exhausted, and the clinics get closed. In camps with no health facilities, medicine donations were given to IDP leaders, and they were responsible for determining how to administer it when needed. Considering IDP leaders were not trained in healthcare, such a medical management approach could have some negative consequences, such as wrong medicine dispensing that could trigger other health conditions.

...sometimes, the NGO used to process some drugs and some organisations they used to help us with some drugs, but as for now, we do not have a drug now. The clinic is even closed, it's empty. The drugs that have been brought by the NGO has already finished. – FG5

Considering the most common health conditions in camps were infectious diseases, vaccination was essential for population protection. In most camps, it was reported that vaccinations had been done on the camp premises, but mainly for women and children. During these vaccination campaign activities, IDP involvements varied, but it often specifically included sharing household information, which they collected for distributing resources, with the healthcare staff administering the vaccines. In addition, some IDP leaders also liaised directly

with local health centres to plan vaccines, but they were usually less involved during days when the vaccines were administered to the IDPs in the camps.

3.2.5. Exercising personal rights

The national authorities did not officially recognise most camps, so these unofficial sites lacked external support. IDPs in such locations expressed how weak government involvement influenced the physical and environmental conditions of the camp, including the lack of adequate shelter, food and healthcare. As a result, the IDPs managed the camps solely at their discretion. Nevertheless, IDPs across all the camps believed that the government and international organisations were meant to be responsible for designing, providing and executing life-supporting and health interventions. As illustrated in the quote below, some IDPs specifically expressed how they had sent multiple pleas and actively solicited governmental support for various issues in the camps, including water supply and security, but the national authorities had been unresponsive. Instead, most assistance received came from private and non-governmental groups, particularly in informal camps.

Like here, the government has not recognised it as a standard camp, so we need government intervention to provide security, water supply etc. ... we just work here according to our knowledge... – FG8

In areas where and when supportive interventions were provided, IDP representatives also advocated for the rights of all IDP camp residents and for appropriate interventional approaches that were reflective of cultural preferences to be considered when engaging with the IDP population. For instance, low vaccination rates were reported. To improve the overall vaccination process, IDP leaders suggested that giving advance notice to the IDPs before scheduling vaccination campaigns would give them time to develop appropriate internal vaccine advocacy, as described in the quote below. This finding demonstrated the need for improved culturally relevant vaccine communication in displacement camp settlements.

Yes, there are different ways to improve their services first of all they will need to employ more health workers, those going from house to house should ensure every member of the household was given the vaccines... we have some people that still do not believe in vaccine we have to beg them to accept, they should let us know about it so we can tell the elders to be able to talk to them... We need every type of vaccine here because they are all important, especially hepatitis. Because many of them they have a liver problem – FG8

4. Discussion

The study explored the experiences, challenges and adopted resilient management strategies of IDPs living in camp-like settings. The main difficulties encountered in the camps were the lack of essential resources, including food, water, hygiene and healthcare resources, and weak government involvement, especially in the informal camps. Most coping strategies were identified at a community level, but general resource distributions were primarily done at household levels, while healthcare was often provided based on individual needs. Observed pre-existing and adopted practices were leadership selection approach being determined by IDP individual's community of origin (i.e. LGA) before displacements and communal sharing of the personal burden, especially food, social support and finances. Internal leadership structures, including healthcare management leadership, existed in most camps through functioning committees selected using the national LGA stratification approach and individual leaders' education levels. The IDP leaders were also actively involved in advocacy and managing interactions with external organisations, for example, during health intervention planning and vaccine delivery. Some slight management disparities were observed in resource availability and management between the different camp types (i.e. formal vs informal camps), with

IDPs in formal camps having more external organisational support and needed resources than those in informal camps. Extensive details about the resource availability and accessibility disparity in the study locations have previously been reported in the camp resource audit assessment conducted (Ekezie et al., 2019).

High levels of resilience were evident among IDPs in this study, as shown in their ability to adapt depending on the conditions and locations. Similar resilience was reported in another study conducted in Nigeria, which showed a sense of self among IDPs before displacement empowered them to create their leadership and governance structures (Okeke-Ihejirika et al., 2020). This study also showed that community resilience alone was insufficient for overcoming social and environmental barriers, such as access to individual healthcare; and similar findings were also identified in other studies (Roberts et al., 2009; Mendelsohn et al., 2014). IDPs in this current research considered women and children as the most vulnerable groups due to their inability to adequately provide and protect themselves. This observation corroborates with a study from Sri Lanka that reported that women had particular protection and assistance needs that exceed the requirements of men and significant economic differences between females and males (Amirthalingam and Lakshman, 2013). In addition, two recent reviews on women and children in conflict settings also identified similar insufficient nutrition and healthcare resources, security concerns and the limited evidence available on the coverage and effectiveness of interventions (Shah et al., 2021; Munyuzangabo et al., 2021). These disparities in gender need and protection has significant healthcare consequences, especially since women and children are more exposed and affected by reproductive health issues (including pregnancy and childbirth) and malnutrition.

Lack of direct organisational oversight, especially in the informal camps, placed the IDPs at a further disadvantage due to poor access to health-supporting factors such as food and healthcare. A similar observation was reported in another study, where some IDPs in informal camps had expressed the desire to relocate to government recognised IDP camps which had more access to services, especially healthcare (Chi et al., 2015). The observed association between camp types and provision of resources in Nigeria has also been reported in other studies, which showed that destinations of IDPs determined the level of vulnerability, deprivation and neglect (Olanrewaju et al., 2019; Ibrahim, 2019; Shehu and Abba, 2020). Nevertheless, the establishment of IDP camp committees empowered the IDPs and made them more proactive in managing their affairs, resources, health and well-being. Such active involvement of community members in camp, resource and healthcare management fostered a sense of ownership and promoted effective IDP management (Solheim, 2005). Although external management varied slightly due to camp status, IDP internal management strategies, with designated roles and sub-groups within the committees and identification of innovative ways to generate needed resources and manage available resources, were similar in most camps. The observed use of a common leadership selection approach in the different locations could be attributed to the adoption of the national approach of using LGA selection criteria and assigning a leader for key areas such as health and communication. If similar standardised management approaches are harnessed in humanitarian aid management planning, the identified positive management structures could be used to improve the health and well-being of IDPs, as well as boost future rehabilitation and integration of IDPs into normal society.

Overall, the IDPs exhibited high levels of health and social self-reliance, as shown in their ability to provide mental and psychological support amongst themselves. These resilience outcomes were portrayed through how the IDPs functioned with cohesion, social accountability, mutual dependence in taking decisions, mobilising resources, and building and maximising interpersonal capacity. All these factors helped them address several issues and initiatives for mutual benefit, which aligns with the United Nations High Commissioner for Refugees (UNHCR) self-reliance recommendations (United Nations Refugee

Agency (UNHCR), 2005). Despite the observed positive resilience observed in this research, there is still much to be done to foster resilience among IDPs, especially with the high rates of protracted conditions in affected countries, and related long term health consequences. Hence, more global effort is needed to promote self-reliance, health management and positive resilience among all displaced populations. Some key factors that would need to be considered to support the effective engagement of IDP community participation, as summarised in a review on participation of displaced communities in humanitarian healthcare responses, includes political will at the national and local level, financial and economic factors, and socio-cultural dynamics of communities (Rass et al., 2020). Furthermore, support from humanitarian organisations through targeted interventions, supply of sanitation, healthcare staff, and training of IDPs could help minimise the negative harmful management practices, such as poor waste management, which contribute to increased disease incidence and de-prioritisation of healthcare due to lack of access to affordable services.

4.1. Implications for research, policy, and practice

Interventions for IDPs need to consider existing coping mechanisms and harmful practices that undermine their personal experiences. Recognition of IDPs at individual, household, community and camp levels as recovery agents is also fundamental. Effective implementation of this will enhance the two other PRDS objectives of fostering self-reliance, economic productivity and upholding the rights of the affected populations by creating more conducive environments (International Organization for Migration (IOM), 2016). The findings in this study will also support effective planning for the PRDS four intervention levels: individual, household, community and systems. On the other hand, lack of prioritisation and exclusion of IDPs in camp and health management will lead to further neglect, need for more post-crisis responses, potential weakening of existing positive resilience actions, and limit broader efforts being made to resolve displacement challenges and up-hold IDP rights.

Overall, comprehensive global and national humanitarian policies that include guidance for self-reliance and resilience would be required to empower IDPs to strive to increase their abilities in dealing with hardships (Krause and Schmidt, 2020). The approach to empowering IDPs would also require more local political engagement and solutions for tackling the structural issues at a country-level (Rass et al., 2020). Also, to foster a sense of ownership and enhance effective camp and healthcare management planning, the identified internal IDP structures in this current study could be factored into IDP humanitarian interventions, rehabilitation and integration plans.

Further studies on the structures developed by IDPs to govern their lives during displacement, beyond focusing on poverty and material deprivation, and more on health management, community adaptation and individual resilience, are needed. Such deeper and multi-level understanding of the broader internal management of IDP camps can inform the strategies required to establish more sustainable living conditions, health and well-being, and empirical evidence required to support the development of relevant interventions needed for improving humanitarian crisis management.

4.2. Limitations

The study only explored the experiences of IDPs dwelling in camp settings, thus exempting IDPs living in host communities who may have different resilience adaptations. Recognising that affected populations are not homogenous, how different communities have different needs and levels of vulnerability, and how displacement situations are not static events, observations in this study may not be generalisable to every IDP displacement settlement. Nevertheless, the high degree of saturation in the findings from different locations and camp types

ensured the critical points related to the research aims were well covered.

5. Conclusion

This paper contributes to the growing literature on the management of IDPs by drawing on samples of IDPs from eight displacement camps in Northern Nigeria. Gaps in needed resources and support among camp-dwelling IDPs in Nigeria were mainly influenced by the camp type and weak national authority involvement. Despite their experience of resource shortages, the IDPs adapted by setting up techniques for managing their affairs, health and available resources by finding innovative ways to cater for themselves, advocating for their needs, and supporting each other. These traits exhibited positive resilience and effective coping mechanisms. Hence, the findings from this research indicate that IDPs can be personal actors for their change and development, and they constitute a valuable human resource that can be deployed to improve their lives and overall health and well-being.

Understanding how IDPs manage themselves in camp settings will enable supporting organisations to leverage their strengths and develop culturally relevant programmes, especially healthcare interventions, required for establishing sustainability among the affected populations and nations. Therefore, engaging IDPs in camp and health management from the inception of camp set up in formal and informal locations could reduce long-term dependency on humanitarian aid. With the provision of structured management support, IDPs can adapt and integrate into normal society, thereby minimising the reliance on humanitarian assistance. This study, therefore, proposes that an IDP-centred approach to camp management would enhance the well-being of IDPs. Implementation of this approach will ensure that IDPs are productively engaged as they gain positive and greater self-reliance at the early stages of the displacement process. Also, this approach has the potential to ensure that IDPs do not become accustomed to a life of dependency, especially in relation to protracted displacement or suffer further from associated health consequences.

Declaration of Competing Interest

None.

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