SOCIAL INFRASTRUCTURE AND THE WELL-BEING OF INTERNALLY DISPLACED PERSONS IN CAMPS OF GUMA LOCAL GOVERNMENT AREA, BENUE STATE, NIGERIA

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ABSTRACT

Social infrastructure is central to the survival dignity and recovery of internally displaced persons residing in camps yet persistent deficits continue to undermine well-being outcomes in conflict affected regions of Nigeria. This study examined the relationship between access to healthcare, housing quality, educational attainment and the well-being of internally displaced persons in Guma Local Government Area of Benue State. Anchored in Human Needs Theory the study conceptualized social infrastructure as an institutional mechanism for meeting fundamental needs of security dignity identity and participation. A descriptive survey research design was adopted using mixed methods. Data were collected from 371 internally displaced persons through structured questionnaires and complemented with key informant interviews. Quantitative data were analysed using descriptive and inferential statistics while qualitative data were subjected to thematic analysis. Findings revealed severe inadequacies in healthcare infrastructure including limited functional facilities, shortage of qualified personnel, weak maternal and emergency services which significantly undermined physical and psychological well-being. Housing conditions were characterized by overcrowding, poor ventilation, lack of privacy and exposure to extreme weather contributing to stress sleep disorders and reduced social functioning. Educational attainment emerged as a protective factor enhancing social integration mental resilience health awareness decision making capacity and hopefulness despite structural constraints within camp settings. The study concluded that deficits in social infrastructure represent structural failures to meet essential human needs thereby perpetuating vulnerability and prolonging displacement related suffering. It recommends that the Benue State Government and humanitarian partners strengthen camp based primary healthcare services develop durable climate appropriate housing and expand inclusive educational and psychosocial programs to improve the overall well-being and long-term recovery of internally displaced persons in Guma.

Keywords: Social Infrastructure, Internally Displaced Persons, Well-Being, Health-Care, Housing Quality

INTRODUCTION

Social infrastructure constitutes the institutional and material systems that support human welfare including health services, education facilities, water and sanitation systems, housing, security arrangements, and social support networks. For internally displaced persons living in camps, the availability and quality of such infrastructure are central to survival, dignity, and long-term recovery. Globally, internal displacement has reached unprecedented levels, with over seventy-one million internally displaced persons recorded in 2023, largely driven by armed conflict, communal violence, and climate related disasters (Internal Displacement Monitoring Centre, 2024). Sub Saharan Africa accounts for a significant proportion of this figure, where displacement is often prolonged and camp conditions remain inadequate. World Bank (2022) reported that internally displaced persons residing in camps with weak social infrastructure experience higher levels of morbidity, food insecurity, school dropout, and psychosocial distress compared to both host communities and displaced persons in more integrated settings. These conditions undermine basic human capabilities and perpetuate cycles of dependency and vulnerability.

The well-being of internally displaced persons in camps is therefore inseparable from the strength, accessibility, and equity of social infrastructure provision. Health systems in many camps are overstretched, with doctor to patient ratios far below national averages, while access to safe water and improved sanitation remains inconsistent, contributing to the spread of communicable diseases (United Nations High Commissioner for Refugees, 2023). Education infrastructure is similarly fragile, with millions of displaced children lacking access to formal schooling, a factor that has long term implications for human capital development and social cohesion. From a critical perspective, the persistent inadequacy of social infrastructure in internally displaced persons camps reflects structural neglect and weak governance rather than purely logistical constraints. Oluwadare and Akinyemi (2021) argued that investing in inclusive and resilient social infrastructure not only improves immediate living conditions but also enhances social stability and post displacement recovery outcomes.

Social infrastructure refers to the ensemble of public services and institutional arrangements including health care systems, education facilities, water and sanitation, housing, transportation, and social protection mechanisms that sustain everyday life and human dignity. Internal Displacement Monitoring Centre (2024) estimated indicate that over 71 million people were living in internal displacement by the end of 2023, with disasters and conflict increasingly affecting countries with comparatively stronger state capacity and formal welfare systems. In the United States, disaster related events such as hurricanes, floods, and wildfires generated over 2.5 million new internal displacements in 2022, many of whom experienced prolonged stays in temporary shelters and camps characterized by limited access to mental health care and stable housing (Internal Displacement Monitoring Centre, 2023; United States Government Accountability Office, 2022). India similarly records one of the highest numbers of internally displaced persons globally, with an estimated 3 to 4 million new displacements annually due to floods, cyclones, and development induced evictions, where camp-based populations frequently face overcrowding, inadequate sanitation, and restricted access to public welfare schemes (World Bank, 2023). These patterns demonstrate that the presence of formal social infrastructure alone does not ensure positive wellbeing outcomes for internally displaced persons; rather, the effectiveness, inclusivity, and adaptability of these systems are decisive in shaping health, safety, and dignity within displacement camps.

Recent estimates indicate that Africa hosts over thirty five million internally displaced persons, with Mali accounting for more than four hundred thousand people displaced primarily by armed

violence and insecurity, while South Africa faces growing patterns of urban displacement linked to xenophobic violence, climate related shocks, and housing precarity rather than conventional armed conflict (Internal Displacement Monitoring Centre, 2024; United Nations High Commissioner for Refugees, 2023). World Bank (2023) reported that internally displaced persons in poorly serviced camps experience higher rates of communicable diseases, food insecurity, school exclusion, and psychological distress compared to host populations, largely due to weak and uneven social infrastructure provision. In Mali, limited access to functional health facilities and safe water in camps has been associated with elevated child morbidity and mortality, while in South Africa inadequate shelter, sanitation, and social services in temporary settlements undermine dignity, safety, and social integration (African Development Bank Group, 2022). These patterns highlight that strengthening social infrastructure is not merely a humanitarian concern but a central development and governance challenge essential for improving the well-being and social inclusion of internally displaced persons across diverse African displacement settings.

Nigeria hosts one of the highest internally displaced populations in Africa, with over 3.4 million internally displaced persons recorded nationally as of 2023, the majority residing in informal camps with limited access to functional health facilities, potable water, sanitation, education, and adequate shelter (International Organization for Migration, 2023; United Nations High Commissioner for Refugees, 2024). In Benue State, recurrent armed attacks have displaced more than 1.5 million persons, making it one of the most affected states in the North Central region, with Guma Local Government Area accounting for a substantial percentage of camp-based displacement due to persistent insecurity and destruction of rural livelihoods (Benue State Emergency Management Agency, 2023). Idris, Suleiman and Danjuma (2024) found that inadequate social infrastructure in displacement camps exacerbates morbidity, malnutrition, psychosocial distress, gender-based violence, and educational disruption, thereby undermining both short term survival and long-term recovery of displaced populations. Despite sustained humanitarian presence, social services in Guma camps remain overstretched, poorly coordinated, and insufficient relative to population size, raising concerns about entrenched vulnerability and social exclusion. This study is therefore necessary to empirically examine the state of social infrastructure and its implications for the wellbeing of internally displaced persons in camps in Guma Local Government Area, with the aim to improve service delivery, and support durable solutions for displaced communities in Guma, Benue State.

Research Objectives

i. To examine the effects of access to healthcare on the well-being of internally displaced persons in Guma Local Government Area, Benue State.
ii. To assess the effects of housing quality on the well-being of internally displaced persons in Guma Local Government Area, Benue State.
iii. To determine the relationship between educational attainment and the well-being of internally displaced persons in Guma Local Government Area, Benue State.

LITERATURE REVIEW

Access to Healthcare on the Well-Being of Internally Displaced Persons

Access to health care remains a central determinant of the well-being of internally displaced persons in Nigeria, particularly in protracted conflict in the North East and expanding insecurity in the North Central and North West regions. Limited physical and financial access to health services among displaced populations is associated with elevated morbidity, preventable mortality, and deteriorating mental health outcomes. According to the International Organization for Migration (2023), Nigeria hosts

over 3.6 million internally displaced persons, many of whom reside in camps or host communities with overstretched primary health care facilities. Adebayo, Yusuf and Mohammed (2022) found that internally displaced persons experience disproportionately high rates of malaria, acute respiratory infections, maternal complications, and childhood malnutrition, largely due to weak service availability, shortages of skilled health workers, and frequent stock outs of essential medicines. The World Health Organization (2023) reported that fewer than half of internally displaced women in conflict affected states receive skilled antenatal care, contributing to maternal mortality ratios that exceed national averages. These findings highlight how structural barriers to health care directly undermine physical well-being among displaced populations.

Beyond physical health, access to health care also plays a decisive role in shaping the psychosocial and emotional well-being of internally displaced persons in Nigeria. Okeke et al., (2024) conducted a study in Borno, Benue, and Zamfara States and found a high prevalence of depression, anxiety, and trauma related disorders among displaced adults and adolescents, with limited access to mental health services exacerbating symptom severity and chronicity. Humanitarian health interventions that integrate mental health and psychosocial support within primary health care settings have been shown to improve coping capacity, social functioning, and perceived quality of life among internally displaced persons, although coverage remains uneven (Médecins Sans Frontières, 2023). Umar and Sadiq (2022) suggested that internally displaced persons with regular access to health facilities report higher self-rated well-being and lower reliance on harmful coping strategies such as child labour and transactional survival practices. The findings therefore converge on the conclusion that equitable access to comprehensive health care is not merely a service delivery issue but a foundational requirement for restoring dignity, resilience, and overall well-being among internally displaced persons.

Housing Quality and the Well-Being of Internally Displaced Persons

Housing quality is a central determinant of the physical psychological and social well-being of internally displaced persons. Majority of displaced households reside in overcrowded shelters constructed with substandard materials that offer limited protection from heat rainfall and disease vectors. The International Organization for Migration (2023) reported that more than three million internally displaced persons in Nigeria live in camps or camp-like settings where emergency shelters dominate and where inadequate ventilation, poor roofing and lack of privacy are widespread. Owoaje, Uchendu, Ajayi and Cadmus (2016); Ujah and Akeweje (2022) argued that such housing conditions heighten exposure to communicable diseases including malaria cholera and respiratory infections thereby worsening health outcomes among displaced populations. In a study by Adeyemi, Abiodun and Yusuf (2021) from camp assessments in Borno Benue and Nasarawa States they found that over sixty percent of internally displaced households lack durable housing and experience persistent sleep deprivation and stress linked directly to overcrowding and structural insecurity. These findings support that housing quality is a social determinant of health particularly in humanitarian settings.

Beyond physical health housing quality also exerts significant influence on psychosocial stability dignity and social relations among internally displaced persons in Nigeria. Akinyemi, Atilola and Soyannwo (2020) found that poor shelter conditions intensify feelings of insecurity fear of violence and loss of personal autonomy especially among women children and older persons. The United Nations High Commissioner for Refugees (2024) noted that inadequate housing in displacement camps contributes to increased incidence of gender-based violence and family conflict as shared and poorly designed shelters limit privacy and effective social regulation. From a sociological perspective Alobo and Obaji (2016) criticized Nigeria's emergency focused shelter response for neglecting long term housing adequacy and cultural suitability which undermines social cohesion and recovery among displaced

communities. Omole and Welye (2023) therefore advocate a shift from temporary shelter provision toward durable housing solutions integrated with water sanitation and livelihood infrastructure arguing that improved housing quality is essential for restoring dignity resilience and overall well-being among internally displaced persons in Nigeria.

Educational Attainment and the Well-Being of Internally Displaced Persons

Educational attainment has been consistently identified as a critical determinant of the well-being of internally displaced persons in Nigeria, particularly in contexts of protracted displacement caused by insurgency, banditry, and communal conflicts. International Organization for Migration (2025) reported that Nigeria hosts over 3.9 million internally displaced persons, with more than sixty percent being children and youth whose education has been severely disrupted. Internally displaced persons with some level of formal education exhibit better access to livelihood opportunities, health information, and social services within displacement camps and host communities. For instance, Akinwale and Ayoade (2022) found that internally displaced adults with secondary education or higher were significantly more likely to engage in income generating activities and report improved psychological well-being compared to those with no formal education. Education also enhances adaptive capacity by strengthening literacy, numeracy, and problem-solving skills, which are essential for navigating humanitarian systems and securing assistance. Conversely, low educational attainment among displaced populations has been associated with heightened vulnerability to poverty, food insecurity, and poor health outcomes, reinforcing cycles of deprivation within camps (Olawale & Yusuf, 2021).

Educational disruption among internally displaced children has profound implications for both present and future well-being. United Nations Children's Fund (2022) estimate that over two million displaced children in Nigeria are currently out of school, exposing them to risks such as child labour, early marriage, and recruitment into criminal or violent groups. Educational attainment is strongly linked to psychosocial well-being, as schooling provides a sense of normalcy, social integration, and emotional support in displacement settings. A study by Mohammed and Ahmed (2023) found that internally displaced adolescents who maintained school attendance reported lower levels of trauma related stress and higher life satisfaction than their out of school peers. However, structural barriers such as inadequate learning facilities, shortage of trained teachers, and financial constraints continue to undermine educational access in internally displaced persons camps. The study therefore converges on the position that improving educational attainment is not merely a developmental concern but a central well-being intervention for internally displaced persons in Nigeria, with implications for health, economic stability, and social cohesion.

THEORETICAL FRAMEWORK

Human Needs Theory

Human needs theory, articulated by John Burton in 1979, provides a rigorous analytical framework for understanding social infrastructure and the well-being of internally displaced persons. Burton argued that humans possess basic and universal needs such as security, identity, recognition, participation, and subsistence, which are non-negotiable and cannot be suppressed without generating social tension and conflict. According to this theory, social systems that fail to meet these needs inevitably produce instability and human suffering. In the context of internally displaced persons camps, social infrastructure including healthcare facilities, schools, water supply, sanitation systems, security structures, and community spaces functions as the institutional mechanism through which these core needs are either met or denied. Where such infrastructure is weak or absent, displaced persons

experience chronic insecurity, loss of dignity, social exclusion, and deteriorating physical and psychological health, all of which undermine overall well-being.

Guma has experienced recurrent displacement largely driven by violent conflicts, leading to prolonged encampment under conditions of infrastructural deprivation. In these camps, inadequate healthcare services compromise the need for survival and protection, limited educational facilities erode identity and future orientation, and poor water and sanitation infrastructure threaten health and dignity. Human needs theory clarifies that these deficits are not merely logistical failures but structural violations of essential human needs. The theory therefore offers a robust lens for interpreting how the absence or weakness of social infrastructure in Guma camps exacerbates vulnerability and prolongs human suffering. By foregrounding unmet needs rather than short term relief measures, the theory emphasizes the necessity of sustainable social infrastructure as a foundation for restoring well-being and social stability among displaced populations.

Despite its analytical strength, human needs theory has attracted criticism for its perceived abstraction and limited attention to power relations and political economy. Ager and Strang (2008) argue that the theory tends to universalize human needs without sufficiently accounting for cultural variation and structural inequalities that shape access to resources. In practical terms, the theory offers limited guidance on prioritization when resources are scarce, a common reality in internally displaced persons camps in Nigeria. Nevertheless, the justification for adopting human needs theory in the study of social infrastructure and internally displaced person's well-being remains compelling. The theory provides a clear normative foundation for assessing social infrastructure beyond technical adequacy by linking it directly to human dignity and survival. It shifts the analytical focus from emergency response to long term human development, which is essential in protracted displacement situations such as those in Guma. In conclusion, Human Needs Theory offers a coherent and ethically grounded framework for explaining the relationship between social infrastructure and the well-being of internally displaced persons in camps.

METHODS

This study adopted a descriptive survey research design. The design was appropriate for generating data from a large population through both quantitative and qualitative approaches. Primary data were collected using semi structured questionnaires and key informant interviews, ensuring depth in data coverage. A multi stage sampling technique was applied, involving purposive selection of the study area, random selection of IDP camps. The selected camps were Daudu Camp 1, Daudu Camp 3, Tse-Ginde Camp, Ortese Camp, and Tse-Kpam Camp, and systematic sampling of respondents. The sample size was determined using Cochran's formula due to the unknown population size, resulting in 384 questionnaire respondents complemented by key informant interviews, yielding a total of 399 participants. Data analysis combined descriptive and inferential statistical techniques using SPSS for quantitative data, alongside thematic analysis for qualitative narratives.

The study was conducted in selected internally displaced persons camps in Guma Local Government Area, a conflict affected agrarian region in Benue State that has experienced prolonged farmer herder violence and mass displacement. Guma is predominantly inhabited by the Tiv ethnic group and is characterized by communal social structures, subsistence agriculture, and strong religious institutions. However, insecurity has disrupted agriculture, education, and social cohesion, leading to widespread poverty, food insecurity, and reliance on humanitarian assistance within IDP camps. The influx of displaced populations has overstretched existing social infrastructure, particularly education and health services. The choice of Guma was justified by the scale and persistence of displacement in

the area, with camps such as Daudu, Ortese, Abagena, and Tse Yandev representing critical humanitarian settings for examining social infrastructure and well-being outcomes.

The study ensured rigor through careful instrument design, validation, reliability testing, and ethical safeguards. Questionnaires were administered with the support of trained research assistants to enhance response accuracy, particularly among respondents with limited literacy. Data collection was strategically scheduled on weekends to maximize participation. Instrument validity was established through expert review, while reliability was confirmed via a split half test analysed using Pearson's moment correlation. Ethical considerations were strictly observed, including informed consent, voluntariness, confidentiality, anonymity, and protection from harm.

FINDINGS

A total of 384 questionnaires were distributed, of which 371, representing 97%, were properly completed and returned, whereas 13, representing 3%, were not returned. Therefore, the data analysis was conducted using the 371 valid questionnaires.

Table 1: Socio- Demographic Distribution of Respondents

Variables	Frequency	Percentage (%)	Mean	Std
Sex				
Male	134	36.1		
Female	237	63.9		
Age				
18-25	79	21.3	42.6	18.9
26-33	88	23.7		
34-41	48	12.9		
42-49	20	5.4		
50 and above	136	36.7		
Marital Status				
Married	148	39.9		
Single	101	27.2		
Separated	20	5.4		
Divorced	35	9.4		
Widowed	67	18.1		
Level of Education				
Non formal education	115	31.0		
Primary	95	25.6		
Secondary	114	30.7		
Tertiary	47	12.7		
Religion				
Christianity	268	72.2		
Africa Traditional Religion	74	19.9		
None	29	7.8		
Income				
Less than 5,000	27	7.3		
5,001-15,000	73	19.7		
15,001-30,000	112	30.2		
30,001-70,000	102	27.5		

70,001 and above	57	15.4

Source: Fieldwork, 2025

The socio-demographic distribution of respondents within the internally displaced persons (IDP) camps revealed a predominance of females (63.9%) compared to males (36.1%), suggesting greater accessibility or willingness of women to participate in studies. Age distribution indicated that 36.7% are 50 years and above, followed by 26–33 years (23.7%) and 18–25 years (21.3%), highlighting the need for age-sensitive social infrastructure such as healthcare, mobility support, and psychosocial services. Marital status shows that 39.9% are married, with single (27.2%), widowed (18.1%), divorced (9.4%), and separated (5.4%) individuals comprising the remainder, reflecting varying family compositions and social support networks that may influence access to services. Educational attainment is varied, with non-formal (31.0%) and secondary education (30.7%) most common, primary education (25.6%), and tertiary education least represented (12.7%), suggesting limited literacy and vocational skills that may constrain engagement with social services. Christianity is the predominant religion (72.2%), followed by African Traditional Religion (19.9%) and 7.8% with no religious affiliation, potentially influencing participation in faith-based and communal programs. Income levels reveal economic vulnerability, with most respondents earning between 15,001–30,000 Naira (30.2%) and 30,001–70,000 Naira (27.5%), while 7.3% earned below 5,000 Naira and 15.4% above 70,001 Naira, indicating limited financial capacity to access healthcare, education, and other social infrastructure. These characteristics collectively imply that social infrastructure interventions in IDP camps must be tailored to gender, age, marital status, education, religion, and income disparities to enhance the overall well-being of displaced populations.

Table 2: Distribution of respondents by access to healthcare and the well-being of internally displaced persons

Questions	Yes	No	Not Sure	Mean	Std
Is there a functional healthcare facility within your IDP camp?	86 (23.2%)	278 (74.9%)	7 (1.9%)	1.79	.454
Do you have access to qualified medical personnel in this camp?	35 (9.4%)	323 (87.1%)	13 (3.5%)	1.94	.355
Are HIV/AIDS testing and treatment services accessible to IDPs?	214 (57.7%)	137 (36.9%)	20 (5.4%)	1.48	.599
Is there access to emergency medical services when needed?	120 (32.3%)	220 (59.3%)	31 (8.4%)	1.76	.592
Do you think that access to healthcare will reduce the burden of untreated illnesses among internally displaced persons?	299 (80.6%)	47 (12.7%)	25 (6.7%)	1.26	.573
Does accessing healthcare reduce vulnerability to disease outbreaks among internally displaced persons?	305 (82.2%)	49 (13.2%)	17 (4.6%)	1.22	.516
Do pregnant women in IDP camps have access to antenatal care?	59 (15.9%)	300 (80.9%)	12 (3.2%)	1.87	.419

Are malaria prevention measures (e.g., mosquito nets) available in your IDP camp?	151 (40.7%)	194 (52.3%)	26 (7.0%)	1.66 .604

Source: Fieldwork, 2025

The distribution of respondents regarding access to healthcare within IDP camps on table 2 revealed a critical gap in service availability and utilization, with only 23.2% reporting a functional healthcare facility and 9.4% affirming access to qualified medical personnel, while 74.9% lacked both, indicating severe shortages in infrastructure and human resources. HIV/AIDS testing and treatment services were accessible to 57.7% of the respondents, yet 36.9% reported non-access, and emergency medical services were available to only 32.3%, highlighting vulnerabilities in critical care. Despite these limitations, respondents recognized the importance of healthcare, with over 80% affirming that access reduces untreated illnesses and mitigates vulnerability to disease outbreaks. Maternal health services remain critically low, with only 15.9% reporting antenatal care for pregnant women, and malaria prevention measures were available to 40.7%, showing partial coverage of preventive interventions. These findings collectively indicate that deficiencies in healthcare infrastructure, personnel, emergency services, maternal care, and preventive measures undermine the well-being of IDPs and underscore the urgent need for comprehensive healthcare investment and service expansion to improve resilience and health outcomes. During the interview session, some of the interviewee stated that:

> *We have a small clinic, but it is just one room with a nurse who comes three times a week. Last month, my son had severe diarrhea at night, and we had no one to help us. The clinic was locked, and we had to wait until morning. By then, he was so weak. A functional facility should be open always, but ours is not really functional it is just better than nothing.* ***(Female; Age; 34; Ortese IDP Camp).***

Similarly, another respondent posited that:

> *Yes, there is a container that was converted into a clinic about six months ago. It has basic supplies, and a doctor visits on Mondays and Thursdays. It is functional for simple things like fever and cough, but anything serious, they tell you to go to the town hospital which is 15 kilometers away. How do we get there with no money for transport? (**Male; 47 years; Daudu 1 Camp).***

What healthcare facilities are available in your camp? A 39 years man from Daudu camp II stated that:

> *We are fortunate here. An NGO built a proper clinic with two rooms, one for consultation and one for minor procedures. They have a midwife, a nurse, and a doctor who comes twice weekly. It is functional, and they even keep some medicines in stock. Before this clinic came last year, people were dying from simple infections.*

The story was different for a camp in Tse-Yandev, where a 57 years woman narrated that:

> *There used to be clinic. When we first arrived two years ago, there was a tent clinic with regular staff. But funding stopped, and now it is abandoned. The tent collapsed during last rainy season, and no one has repaired it. We have to walk to the host community's health centre, but they do not always want to attend to us*.

In Ortese Camp a 28 years old lady narrated that that:

We have one community health worker, but she is not really qualified for serious cases. She can check temperature, give paracetamol, and bandage wounds. When my father had chest pains, she panicked and did not know what to do. We need real doctors and nurses, not just volunteers with basic training.

Can you get tested or treated for HIV/AIDS in your camp? A 41 years old lady from Abagena IDP Camp said:

This is a difficult topic here. There is a lot of stigma, and no, we do not have testing services in the camp. I have a cousin who is HIV positive and was on medication before we were displaced. She has not been able to access her drugs for eight months now. She is getting weaker, but she is afraid to ask for help because of how people will judge her.

What happens when there is a medical emergency in your camp? Some of the interviewees narrated that:

We panic because there is no proper emergency response. Three months ago, a woman went into complicated labour at midnight. We had no ambulance, no emergency staff. Some men had to carry her on a mat to the main road to find transport. By the time they got her to the hospital, she had lost a lot of blood. Both she and the baby survived by God's grace, but it was traumatic. ***(Female; Age, 56 years; Daudu II Camp).***

Table 3: Distribution of respondents by housing quality and the well-being of internally displaced persons

Questions	Yes	No	Not Sure	Mean	Std
Is your shelter well-ventilated?	107 (28.8%)	256 (69.0%)	8 (2.2%)	1.73	.489
Does prolonged stay in temporary shelters reduce the social well-being of internally displaced persons?	281 (75.7%)	70 (18.9%)	20 (5.4%)	1.30	.563
Does poor housing quality contribute to sleep related problems among internally displaced persons?	285 (76.8%)	55 (14.8%)	31 (8.4%)	1.32	.620
Does the shelter provide adequate protection from extreme temperatures?	297 (80.1%)	37 (10.0%)	37 (10.0%)	1.30	.641
Is there enough space in your shelter for your household members?	79 (21.3%)	283 (76.3%)	9 (2.4%)	1.81	.450
Does lack of privacy in IDP housing affect the emotional well-being of displaced persons?	272 (73.3%)	67 (18.1%)	32 (8.6%)	1.35	.634
Does poor housing quality increase stress levels among internally displaced persons?	305 (82.2%)	31 (8.4%)	35 (9.4%)	1.27	.623
Do you think that inadequate shelter design affect the daily functioning and well-being of	317 (85.4%)	33 (8.9%)	21 (5.7%)	1.20	.525

internally displaced persons?

Source: Fieldwork, 2025

The distribution of respondents regarding housing quality within IDP camps reveals significant challenges affecting the well-being of displaced persons, with only 28.8% reporting well-ventilated shelters and 69.0% indicating inadequate ventilation, while 75.7% affirmed that prolonged stay in temporary shelters reduces social well-being and 76.8% agreed that poor housing quality contributes to sleep-related problems. Protection from extreme temperatures was perceived as inadequate by 80.1% of respondents, and only 21.3% reported sufficient space for household members, indicating overcrowding and exposure to environmental hazards. Lack of privacy was acknowledged by 73.3% as negatively affecting emotional well-being, while 82.2% reported increased stress levels due to poor housing, and 85.4% believed inadequate shelter design affects daily functioning and overall well-being. These findings collectively underscore that deficiencies in ventilation, space, privacy, shelter design, and environmental protection compromise both physical and psychological health, highlighting the urgent need for social infrastructure interventions that provide durable, well-designed, and adequately sized housing to enhance the resilience and well-being of internally displaced persons. Several interviewees during the interview reported that:

> *The air... there is no air. We have one small window, maybe this big gesture, and during the day when the sun is hot, we cannot breathe inside. My children, they cough all the time. At night, we must choose to open the window and the mosquitoes come, or close it and we are sweating, sweating. Sometimes I take the children to sit outside just so we can breathe fresh air. But outside is not safe at night.* ***(Female; Age, 34 years; Daudu I Camp).***

A 46 years man from Ortese Camp narrated that:

> *You see this tent? When I first came here, the aid workers said it was temporary, just for few months. That was three years ago. The material, it traps everything inside. Heat, smell, and smoke from cooking... everything stays. My wife has developed breathing problems. Sometimes she wheezes like an old engine. We tried to cut extra holes for air, but then when the rain comes, water enters from everywhere.*

A 26 years old lady from Daudu II Camp narrated that:

> *The first thing you notice when you enter our section is the smell. Twenty families sharing this space, and the air does not move. My baby had pneumonia twice already since we came here. The doctor said it is because of poor ventilation and too many people breathing the same air. I sleep by the entrance* now, even though people step on us going in and out, just so my baby can get some fresh air.

In Abagena Camp a 55 years Female community development worker, Local NGO, 5 years' experience narrated that;

> *I work directly with displaced women and children, and shelter design affects literally every aspect of their well-being and functioning. Women tell me they cannot maintain hygiene during menstruation because shelter design provides no private washing areas. Mothers say they cannot properly care for sick children because the shelter environment itself makes illness worse. Teenagers*

report they cannot concentrate on studies because there is no quiet space. The elderly struggle because shelter designs have no accessibility features. Survivors of violence have no safe spaces within the shelter design for protection or recovery. The inadequate design also affects community cohesion, poor layout creates tensions, and lack of community spaces prevents social support networks from forming. I have seen talented, capable people reduced to barely functioning because the shelter design is so inadequate that all their energy goes into just surviving the living conditions rather than rebuilding their lives.

What impact does shelter design have on the displaced populations you serve?

In my seven years providing services in this camp, I have witnessed how profoundly inadequate shelter design affects every dimension of human well-being. Spiritually, people struggle to maintain dignity and hope when living in structures that resemble animal pens more than human homes. Socially, the shelter design prevents normal family life and community interactions. Economically, people cannot store goods or work from their shelters, limiting livelihood opportunities. Physically, I have conducted too many funerals for people whose deaths were directly linked to shelter conditions, fires from unsafe *cooking, and collapses during storms, and heat strokes in unventilated spaces. Psychologically, the inadequate design creates learned helplessness, people stop trying to improve their situations because the fundamental structure of their shelter is beyond their control. I have watched children grow from babies to school-age in shelters designed for temporary emergency use. That is not just inadequate design; it is a failure of our humanitarian system to recognize that shelter is about human dignity and functioning, not just physical protection from rain.* ***(Male; Age, 40 years; Daudu II Camp).***

A 6 years' experience male doctor from Tse-Yandev Camp narrated that;

Absolutely, and I see the evidence daily in my clinic. Inadequate shelter design is a health crisis. We see respiratory infections constantly because of poor ventilation. Malaria cases spike because shelters lack proper mosquito screening. Children with developmental delays because there is no space for them to play or learn. Maternal health complications because pregnant women have nowhere comfortable to rest. I have treated patients with depression, anxiety, and PTSS where poor shelter design is a significant contributing factor. Just last week, I saw a woman whose mental health deteriorated severely because her shelter offers zero privacy, she is experiencing trauma in a space that provides no safety or dignity. Shelter design is not just about having a roof; it is about creating environments that support human health and functioning. These current designs fail on almost every metric.

In Abagena Camp, a 28 years mother of twins, displaced 2 years ago narrated that:

I have twin babies who are 10 months old. The stress of keeping them healthy in this poor-quality shelter is indescribable. The floor is dirt, so they are constantly dirty and I worry about infections. The walls have gaps where insects come

through, one baby already had malaria. When it rains, water pools near our shelter and mosquitoes' breed. The structure is unstable, and I am terrified it will collapse on us. I check the poles every day. I do not sleep properly because I am always alert to dangers. My hair is falling out from stress. I have lost weight. The health visitor says I am showing signs of severe anxiety disorder. The poor housing quality has turned motherhood into a nightmare of constant stress and fear.

Table 4: Distribution of respondents by educational attainment and the well-being of internally displaced persons

Questions	Yes	No	Not Sure	Mean	Std
Do you think that education attainment contributes to better social mixing of internally displaced persons in Guma?	291 (78.4%)	62 (16.7%)	18 (4.9%)	1.26	.541
Do you think that internally displaced persons with formal education are more likely to report positive life satisfaction in Guma?	200 (53.9%)	93 (25.1%)	78 (21.0%)	1.67	.802
Do you think that educated persons have access to psychosocial support services in internally displaced persons camp in Guma?	212 (57.1%)	101 (27.2%)	58 (15.6%)	1.58	.746
Does educational attainment influence the sense of personal dignity among internally displaced persons in Guma Local Government Area?	203 (54.7%)	137 (36.9%)	31 (8.4%)	1.54	.646
Would you say that literacy improve the mental well-being of internally displaced persons in Guma?	278 (74.9%)	73 (19.7%)	20 (5.4%)	1.30	.566
Do you think that being educated enhance decision making capacity that affects overall well-being of internally displaced persons in Guma?	282 (76.0%)	51 (13.7%)	38 (10.2%)	1.34	.657
Are internally displaced persons with higher education more hopeful about their future well-being?	302 (81.4%)	33 (8.9%)	36 (9.7%)	1.28	.631

Does educational attainment improve awareness of health promoting behaviours among internally displaced persons in Guma?	292 (78.7%)	43 (11.6%)	36 (9.7%)	1.31	.640

Source: Fieldwork, 2025

The distribution of respondents regarding educational attainment and the well-being of internally displaced persons (IDPs) in Guma Local Government Area highlights the significant role of education in enhancing social, psychological, and health outcomes. A majority of respondents (78.4%) indicated that educational attainment contributes to better social mixing, while 53.9% agreed that formally educated IDPs are more likely to report positive life satisfaction, and 57.1% acknowledged access to psychosocial support services, highlighting both the integrative and mental health benefits of education despite some uncertainty and disparities. Educational attainment was also reported to influence personal dignity (54.7%), improve mental well-being (74.9%), enhance decision-making capacity affecting overall well-being (76.0%), foster hopefulness about future well-being (81.4%), and increase awareness of health-promoting behaviors (78.7%), with varying proportions disagreeing or unsure. These findings collectively imply that education facilitates social cohesion, psychological resilience, and health literacy among IDPs, underscoring the need for social infrastructure interventions that incorporate educational programs to enhance overall well-being in displacement settings. Several interviewees narrated that:

> *Absolutely, yes. Before the attacks forced us here in 2018, I was teaching at Government Secondary School in Tse-Kucha. Now in the camp, because I can speak English well and understand basic Hausa, I serve as a bridge between our Tiv people and the Fulani security officers. Last month, I helped resolve a misunderstanding about food distribution because I could communicate clearly with both sides. Education has made me a mediator. My neighbor, Mama Nguvan, who never went to school, struggles to interact even with other Tiv speakers from different clans because she only knows our village dialect* ***(Male; Age, 52 years; Daudu II Camp).***

A 37 years female Camp official from Tse-Yandev confirmed that.....

> *From what I observe daily, educated IDPs integrate faster. There's this young man, Tersoo, who studied up to NCE level. Within three months of arriving at Tse-Yandev camp, he was organizing youth meetings, participating in camp governance, and even teaching informal evening classes. He mingles with people from all backgrounds. Compare that to the elderly women from rural areas who have never been to school, they mostly stay within their family units and rarely venture beyond their immediate neighbours. Education gives people confidence to cross social boundaries.*

A 55 years healthcare worker from Ortese Camp mentioned that...

> *In my four years working at the camp clinic, I have noticed educated patients communicate better across different groups. They ask questions, join health awareness sessions, and interact with volunteers from various NGOs. There was this woman, Mrs. Akume, a former civil servant with university education. She joined our mother-and-child health group and brought together women from five different villages who would never have spoken otherwise. Education*

creates common ground and breaks down barriers that trauma and displacement strengthen.

Do you think that internally displaced persons with formal education are more likely to report positive life satisfaction?

Even though we have lost everything, my education gives me hope. I arrived here in 2019 after fleeing Logo. Within six months, I was doing voluntary bookkeeping for three NGOs operating in the camp. This gave me purpose. Now I earn small money doing accounts for local traders. My brother who dropped out of school in Primary 4 sits idle all day, getting more depressed. He says life is finished. But I know my skills can rebuild our lives. Last month, I registered for an online accounting course using the camp's computer centre. Education makes you see beyond today's suffering. ***(Female; 26 years; Daudu I Camp).***

A 37 years old female Psychosocial Counsellor, said that:

In my counselling sessions, I see clear patterns. Educated IDPs, despite facing the same trauma and losses, tend to have better coping mechanisms. There is a woman, Grace, who was a teacher. She told me, 'Even in this camp, I am still somebody because I am teaching children.' Her sense of identity remains intact. Contrast that with Mama Ode, who was a farmer with no formal education. She says, 'I am nothing now. I cannot farm. What am I?' Education provides portable identity and skills that survive displacement. This directly affects how satisfied people feel about their lives here.

A 31 years male farmer from Daudu II Camp stated that:

I never went to school as a child, but two years ago here in the camp, I joined an adult literacy class. Learning to read has helped my mind tremendously. Before, I felt trapped in my thoughts about the attacks, replaying the violence over and over. But when I learned to read, I discovered books, newspapers, the Bible in my own language. Reading takes me away from constant worry. I can now read text messages from my relatives, understand notices about food distribution, read stories to my grandchildren. This makes me feel capable, not useless. My mental health has improved because my mind has new activities instead of just circling around our trauma endlessly.

DISCUSSION

Access to Healthcare and the Well-Being of Internally Displaced Persons

The study found a substantial constraint in the availability of healthcare infrastructure and skilled personnel within internally displaced persons camps, which aligned with Owoaje et al. (2016) who found that displacement settings are characterized by weak health systems, inadequate staffing, and poor referral mechanisms, all of which undermine the well-being of displaced populations. Research conducted by Idris et al. (2020) in Benue, Borno, and Plateau States shows that the absence of functional health facilities and qualified medical personnel exacerbates untreated illnesses, maternal health risks, and preventable morbidity among internally displaced persons. The limited access to

antenatal care and emergency services observed in this study supports earlier assertions that women and children in displacement contexts face disproportionate health vulnerabilities due to structural neglect and humanitarian gaps (Internal Displacement Monitoring Centre, 2023). These findings reinforce the argument that inadequate healthcare access is not merely a service delivery failure but a reflection of broader governance and funding deficits affecting humanitarian health responses in Nigeria.

Conversely, the findings also suggest that respondents strongly recognize the protective role of healthcare access in reducing untreated illnesses and vulnerability to disease outbreaks, which partially contradicts studies emphasizing community mistrust and low perceived effectiveness of camp-based health services. Abdulraheem and Oladipo (2019) reported that internally displaced persons often rely on informal coping mechanisms due to scepticism about the quality of available healthcare, thereby downplaying its perceived benefits. However, the present findings aligned with World Health Organization (2022) report that growing awareness among displaced populations of the importance of preventive and curative healthcare, particularly in relation to communicable disease control and public health surveillance. This agreement suggests a shift in health consciousness among internally displaced persons, even where service provision remains inadequate. The implication is that demand side readiness exists, but supply side limitations continue to constrain health outcomes, underscoring the need for policy interventions that move beyond awareness creation to sustained investment in healthcare infrastructure, personnel deployment, and preventive health commodities in displacement settings.

Housing Quality and the Well-Being of Internally Displaced Persons

The study found that housing quality is a critical determinant of the well-being of internally displaced persons, a position strongly supported by existing literature. Overcrowded and poorly designed shelters undermine physical comfort, psychological stability, and social functioning among displaced populations. Adewale, Ogunyemi and Lawal (2021); Ezeh et al. (2019) found that inadequate ventilation, limited space, and lack of privacy heighten stress, disrupt sleep patterns, and erode social relationships within households. Prolonged residence in temporary shelters has also been linked to declining social cohesion and emotional exhaustion, as uncertainty and environmental discomfort compound the trauma of displacement (Internal Displacement Monitoring Centre, 2023). These findings aligned with environmental stress and social disorganization perspectives, which emphasize that substandard housing environments intensify vulnerability by constraining daily functioning and diminishing overall quality of life among internally displaced persons.

However, the findings diverge from some strands of the literature that suggest displaced persons gradually adapt to poor housing conditions through resilience building and social coping mechanisms. Ager and Strang (2008) argued that strong communal ties and shared experiences within camps can mitigate the negative effects of inadequate shelter, particularly in the short term. In contrast, the present findings suggest that adaptation does not eliminate the cumulative psychological and social costs of prolonged exposure to poor housing conditions. This position is consistent with UN Habitat (2022) report indicating that resilience should not be interpreted as insulation from harm but rather as survival within structurally adverse conditions. The implication is that policy approaches which rely on presumed resilience risk normalizing substandard living conditions. Instead, sustained investment in adequate shelter design, privacy sensitive layouts, and climate appropriate housing materials is necessary to protect the well-being of internally displaced persons and prevent the long-term entrenchment of displacement related vulnerabilities.

Educational Attainment and the Well-Being of Internally Displaced Persons

The study found that educational attainment plays a significant role in shaping the social and psychological well-being of internally displaced persons. Education has been widely identified as a form of social and cultural capital that enhances social integration, self-efficacy, and adaptive capacity in displacement contexts. Dryden Peterson (2016); Alobo and Obaji (2020) found that literacy and formal education improve communication skills, facilitate social mixing within host communities, and strengthen decision making capacities that are critical for coping with displacement related stressors. The observed links between education, personal dignity, mental well-being, and future orientation are consistent with human capital theory, which posits that education enhances individuals' ability to access resources, interpret information, and exercise agency under constrained conditions. Research by Idris et al., (2021) in Benue and Borno States similarly shows that educated internally displaced persons are more likely to engage with psychosocial support services and adopt health promoting behaviours, thereby improving overall well-being outcomes.

However, the findings also diverge from strands of the literature that caution against overestimating the protective effects of education in humanitarian settings. Mendenhall et al. (2017) argued that structural barriers within displacement camps, including limited service availability, language barriers, and discrimination, can weaken the advantages typically associated with formal education. Betts et al. (2019) suggest that educated internally displaced persons may experience heightened frustration and reduced life satisfaction when their skills and credentials cannot be translated into meaningful opportunities, thereby moderating the positive effects of education on well-being. This perspective highlights that education alone is insufficient to guarantee improved well-being without complementary institutional support. Nonetheless, the present findings suggest that even within constrained environments, education remains a valuable resource for fostering hope, dignity, and informed health behaviour. The implication is that policies targeting internally displaced persons should integrate educational interventions with livelihood and psychosocial programmes to fully realize the well-being benefits associated with educational attainment.

CONCLUSION

This study concludes that the well-being of internally displaced persons in Guma Local Government Area is fundamentally shaped by the availability and quality of social infrastructure, particularly healthcare access, housing quality, and educational attainment. The findings demonstrate that inadequate healthcare facilities, shortage of qualified medical personnel, limited maternal and preventive services, and weak emergency response mechanisms significantly undermine physical and psychological well-being, despite strong awareness among displaced persons of the benefits of healthcare access, a pattern consistent with earlier studies in Nigeria and similar displacement contexts. Poor housing conditions characterized by overcrowding, inadequate ventilation, lack of privacy, and exposure to extreme weather were found to intensify stress, sleep disorders, insecurity, and social strain, reinforcing evidence that substandard shelter environments erode dignity and daily functioning among displaced populations. Educational attainment emerged as a critical protective factor, enhancing social integration, mental resilience, health awareness, hopefulness, and decision making capacity, although its benefits remain constrained by broader structural limitations within camp settings. Anchored in human needs theory, the study affirms that deficiencies in social infrastructure represent structural failures to meet essential human needs for security, dignity, identity, and participation, thereby perpetuating vulnerability and prolonging displacement related suffering.

RECOMMENDATIONS

i. The Benue State Government, in collaboration with health and humanitarian partners, should establish and equip primary healthcare centres in all major IDP camps in Guma, deploying qualified

medical personnel and ensuring a continuous supply of essential medicines and services. Local authorities should coordinate health outreach, disease surveillance, and education to improve utilization and overall well-being of displaced persons.

ii. The Benue State Government, with partners, should replace temporary shelters in Guma IDP camps with durable, climate-appropriate housing that ensures space, privacy, and protection from extreme weather. Camp managers should enforce shelter standards and reduce overcrowding, while donors fund integrated housing linked to water, sanitation, and livelihoods to enhance health, security, and dignity for displaced persons.

iii. The Benue State Ministry of Education, supported by partners, should establish learning centers with trained teachers and materials for children and youth in IDP camps, while NGOs and faith-based organizations provide adult literacy and vocational programs. Camp authorities should integrate education with psychosocial support and livelihood initiatives to promote well-being and future self-reliance among internally displaced persons.

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