INTERNALLY DISPLACED PERSONS IN NIGERIA – HEALTH NEEDS, CHALLENGES AND SDGS

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Introduction

Forms of discomfort ranging from the physical, psychological, social, financial and even spiritual, may accompany any degree of displacement from a person's usual abode. There may be an emergent need to respond to problems arising from any, or a combination, of these domains. The magnitude of discomfort suffered by individuals depends on a variety of factors that can be individual or environmental. For the internally displaced persons, the circumstances precipitating their displacement are more often violent and dehumanizing like in conflicts of ethnic, religious or political origin, terrorist attacks, banditry and natural disasters like fire outbreaks, oil spillage, flooding and earthquakes. Conflicts and war or war-like circumstances are particularly dangerous because the threat to the lives of displaced persons is ongoing and real, not just limited to the particular experienced natural disaster. For instance, since February 2022 up until the present moment, November 2022, some Ukrainians have been living as displaced persons within their country and are not

only, faced with various health-related challenges, but the threat of being killed at any time is real.

There are several challenges associated with living as an internally displaced person (IDP) and receiving medical attention particularly for emergencies is of great concern. A crude mortality rate of 4.1 deaths/10,000/day and an under-five mortality rate of 6.9 deaths/10,000/day have been reported in an IDP camp in Democratic Republic of Congo. Displacement exposes IDPs to new hazards that are compounded by lack of access to health care, health personnel or equipment. Personal visits to some IDP camps in the Northeast, middle-belt and South-south geopolitical zones in Nigeria as well as reports of many non-governmental organizations (NGOs) revealed the absence of health care system and facility in many of the camps to attend to medical emergencies. The traditional healers and birth attendants play significant roles in the IDP health system while some camp residents travel as much as 40 kilometers (at times, more) to access medical treatment for common ailments. The difficulty in accessing health care could result in added vulnerability to medical emergencies. These dynamics result in greater risk for the development of illness and death.

Vulnerable people at the camp include pregnant women, children, girls and unemployed men who are usually malnourished and may be sick. The major health problems reported among the IDPs were communicable diseases such as measles, malaria, and cerebrospinal meningitis; diarrhea (62% in children and 22% in adults) and acute respiratory infections (45%) while exposure of the current residents to pandemics such as COVID-19 is difficult to be easily quantified. Non-communicable diseases such as malnutrition, mental and reproductive health issues were also frequent.

Late presentation of several medical disorders due to lack of clinics increase the number of medical emergencies beyond the proportion of what is seen in the general population. This could set up a stage for chronic diseases to present as acute on chronic that would necessitate emergency care. Because the IDPs are drawn from the general

population and non-communicable diseases are becoming prevalent, they are susceptible to other medical emergencies such as minor injuries, Overdose/poisoning (alcohol, drugs, poisons, pesticides), emergency complications of acquired disorders such as metabolic disorders, complication from diabetes mellitus, hypertension, inherited disorders for example sickle cell disease crisis and anemia.

Emergency Medical Needs of IDPs

Advancing emergency response in internally displaced persons can be a daunting challenge. It requires collaboration of concerted efforts of government, non-governmental agencies, humanitarian partners and sometimes hosting communities where the IDPs are relocated. The limited response capacity of most affected countries has necessitated the need to engage humanitarian agencies. Various approaches have been adopted, one of such is the Health Cluster approach used in Pakistan IDPs in 2005, as well as in 2008-2009. The " Cluster approach " led by the government health authorities together with WHO were able to mobilize the participation of 46 humanitarian partners to assist the IDPs, of which more than 60% were mothers and children. A package of essential primary health care (PHC) activities and life-saving emergency referral support interventions were provided using a multi-sectoral approach.

A step-by-step analysis of the actions taken in Pakistan included:

- Rapid health needs assessment at the outset of the crisis
- Identify the scope of critical services to be provided.
- Organize key stakeholders meeting to promptly address planning, implementation and monitoring of vital health response interventions needed to promote and safeguard the health of various age groups represented in the displaced population with focus on protection of health rights of IDPs, particularly mothers and children.
- Identify a suitable location.
- Develop a joint health response strategy.
- Develop standard operational guidelines/algorithms.

- Coordinated financial, material and personnel resource mobilization.
- Put in place functioning referral support system.
- Urgently strengthen existing health system in the IDP catchment areas to provide comprehensive emergency obstetric and neonatal care services.

The setting up of an IDP health center which will include the emergency unit may be done in phases depending on the availability of funds, political will and goodwill of NGOs and other humanitarian agencies. It may begin as a rudimentary clinic consisting of a table, chair, an examination couch, a first aid box, a box containing essential drugs and rapid diagnostic test kits and progress to a "Medical tent" with sections for male and female patients. This Pakistani model (which started from the scratch and moved to higher health care/ needs) can serve as a guide for developing countries which are usually resource constrained.

The quality of emergency care response is also determined largely by the number of resources already devoted to health and social welfare schemes in the particular country as IDPs remain confined within internationally recognized boundaries of the country where such untoward events take place. Therefore, for developing countries like Nigeria with characteristic deficient allocation of resources to health and social services, providing emergency care for IDPs portends an additional burden on an already overstretched or poorly functional health system. This should be an important consideration in designing and offering emergency care programs for them while still ensuring that common ailments among IDPs are reasonably taken care of. In addition to quality, care considerations should be multidisciplinary, comprehensive, inclusive (covering all age groups), accessible and continuous.

Meeting the emergency medical needs of IDPs begins with ensuring the availability of such determinants of health as adequate and safe food and water supply, sanitation, and hygiene (WASH), shelter including safe disposal of liquid and solid wastes. These are the basic

health needs that must be met first. A list of common health problems is shown in Table 1.

Table 1: List of common emergency diseases/challenges among IDPs

Broad category	Examples
Violence& Physical injuries	Abrasions, burns, dislocation, and fractures, snake, scorpion and human bites
Infections	Measles, diarrhea, malaria and other parasitic diseases, acute respiratory tract infections, meningococcal meningitis, cholera, yellow fever, polio, Hepatitis A & E,
Mental disorders	Anxiety, depression, acute stress reactions, and post-traumatic stress disorders, substance abuse
Reproductive	Sexual and domestic violence, STIs, unwanted pregnancies, unsafe abortions, complications of pregnancy and labour e.g. preeclamsia/eclampsia, obstructed labour, obstetric fistulas, perinatal asphyxia and sepsis.
Nutritional	Malnutrition, Wasting and Stunting

On-Site Experience at IDP Camps in Nigeria

Between 2017 and 2019, several trips were made to different IDP camps in Maiduguri – Northeast Nigeria, Makurdi in the Middle-belt and Ogoja in the South-south region of Nigeria with the aim of providing some food relief to the inhabitants. It was however observed that none of the camps was provided with functioning medical shed and/or personnel. In fact, personal funds were used to procure emergency/first aid medications for the camp opened for Cameroonian refugees in Ogoja, Cross River state. In addition, reusable sanitary pads were provided for over a thousand young ladies across the camps.

In Maiduguri IDP camps, the priority was more on providing food and security for the refugees ahead of reproductive health issues. As at the time of the visit in December 2017, there were five huge camps within Maiduguri metropolis with overstretched non-medical facilities while individuals were basically left to sort out their reproductive health

challenges on their own. This was the same story in the other two camps visited within Makurdi, Benue state.

Management of Common Symptoms

In view of the various infectious and non-communicable disorders, emergency clinical presentations range from fever, abdominal pain, diarrhea, loss of consciousness, chest pain, difficulty in breathing, headache, and convulsion. The management of these common symptoms are illustrated in table 2.

Table 2: Management of common symptoms

Presenting features	Evaluation	Common disorders	First aid
Fever	Take history of other symptoms. Take Temperature Based on history:check ear, throat, chest, abdomen, other parts of the body	Malaria, depending on age; sore throat, ear infection, viral or respiratory tract infection and urinary tract infection	Tepid sponge, expose patient, antipyretic: paracetamol or ibuprofen (after meal) treat cause or refer
Abdominal pain	Take note of accompanying symptoms and relationship to meals, If female, ask about menstruation and abortion; in young boys torsion of testis	Peptic ulcer, food poisoning, gastrointestinal (GIT) infections, menstrual pain, abortion	Analgesics and buscopan, antihelminth. Lie on the tummy, Treat cause
Diarrhea	Anyone else with diarrhea, Associated fever, abdominal pain, nature of stool, frequency of stooling	Depending on presenting complain, type of GIT infection or food poisoning can be diagnosed,	Oral rehydration therapy, antidiarrheal, with or without antibiotics

		Malaria in children	
Difficulty breathing	Age of patient, Any previous episode, is patient a known asthmatic, history of cough, catarrhal, fever, chest pain is patient a known hypertensive	Upper and lower respiratory tract infections, asthma, in children foreign body, in older adult myocardial ischaemia	Anti-allergy, cough syrup, vitamin C, bronchodilator tablet and inhaler. Train on helping to force foreign substance from respiratory tract, nitroglycerin
Headache	Possible associated complains: Fever, previous catarrhal, blood pressure level, visual acuity,	Malaria, migraine, sinusitis, high blood pressure	Paracetamol Treat cause or refer
Convulsion	Associated constitutional symptoms such as fever, headache, history of epilepsy, last meal. If pregnant, eclampsia	Hypoglycemia, epilepsy, high blood pressure, meningitis, Cerebral malaria	Gag the mouth, place patient on the left side, give anticonvulsant injection; Refer
Loss of consciousness	Any history of diabetes mellitus or hypertension, fruity odour from patient. Consider pregnancy	Hypoglycemia, Diabetic coma, Hypertension; Ectopic pregnancy	Hydration, if patient had not eaten can be given glucose

Medical Emergency of Chronic Diseases: Diabetes and Hypertension

Environmental and social issues among the IDPs in the camp are catalyst to the occurrence of some of the medical emergencies. The health systems usually lack the capacity and human resources to effectively address the specific health needs of the people. A study among IDPs in a Sri Lanka camp showed that the prevalence of having at least one chronic disease was 26.3% for IDPs. Factors such as male gender, increasing age, high dietary diversity, and awareness of alcohol addiction among family members or others were all associated with higher chronic disease status. Alcohol has been seen in the literature as a coping strategy for the stressors related to forced displacement as well as a major risk factor for NCDs. Factors such as malnourishment, low income, being in debt, and limited fruit and vegetable consumption predispose them to complications of their chronic diseases. Another factor contributing to the complication is that camp residents may travel at least 40 km to access medical treatment. Personnel, equipment, and worst still clinics are not available to detect acute complications of diabetes and hypertension. The chronic ailments are neither screened for nor followed up. For those who were aware that they were diabetic or hypertensive, they run out of drugs and may not have money to restock while in the camp.

Acute complications of DM are due to an inability to properly metabolize glucose, resulting in hyperglycemia. They are "Diabetic Ketoacidosis" (DKA) and "Hyperglycemic Hyperosmolar State" (HHS). The Diabetic Ketoacidosis results in hyperglycemia and ketosis for which the patients could present with volume depletion (hypotension and tachycardia), breathe with a characteristic fruity odour and metabolic acidosis which may lead to coma. In patients with Hyperglycemic Hyperosmolar State (HHS), hyperglycemia occurs in the absence of ketosis in which case volume depletion with hypotension and tachycardia will not be associated with symptoms of ketosis.

A hypertensive emergency is high blood pressure with potentially life-threatening symptoms and signs indicative of acute impairment of one

or more organ/systems (brain, eyes, heart, aorta, or kidneys). Hypertensive urgency is defined as having a systolic blood pressure over 180 mmHg or a diastolic blood pressure over 110 mmHg. Hypertensive crises, are defined as a BP of more than 180/120 mmHg

Symptoms of a hypertensive emergency include:

1. Headache or blurred vision
2. Increasing confusion
3. Seizure
4. Increasing chest pain
5. Increasing shortness of breath/ Rapid breathing
6. Swelling or edema (fluid buildup in the tissues)
7. Loss of consciousness or unresponsiveness

Malnutrition, anemia and malaria usually exist together and are important causes of morbidity and mortality in these IDP camps particularly in children. Micronutrient deficiencies is prevalent which could contribute to anemia. Adequate nutrition and control of malaria will reduce the incidence of anemia in IDPs.

Sickle Cell Disease (SCD) vaso-occlusive crisis (VOC): A VOC is characterized by sudden onset of pain in different regions of the body particularly bone (bone pain crisis), chest (acute chest syndrome), abdomen (abdominal crisis). This may be precipitated and associated with malaria, fever and dehydration. Emergency management in the camp should include liberal oral fluid, if possible intravenous fluid using dextro-saline should be administered. Oral analgesics such as paracetamol, DF118, ibuprofen and diclofenac should be administered for mild to moderate pain and parenteral analgesic for severe pain. If crisis does not resolve with emergency management, patient should be transferred to hospital for expert management.

Mental Health Emergencies

This is related to anxiety, depression and post traumatic disorders. Post-traumatic stress disorders (PTSD) as psychological reactions to violence and reported depression as a reaction to loss. Panic attacks and anxiety disorders are other types of mental health problems that

have been reported. The commonest manifestation is sleep disturbances. This is expressed as taking longer time to initiate sleep, staying awake most of the nigh and worrying through the night.

Sexual and Reproductive Health Emergencies

Sexual and reproductive health is a significant public health need in all communities and appears to be worse in those facing displacements. Several reproductive health emergencies are noticed in the IDP camps and these included menstrual abnormalities, family planning needs and post-abortal complications. Cases of gender-based violence, rape and sexual assaults have also been reported.

Most centers lack appropriate channels and processes for accessing sexual and reproductive health services. It is imperative to have an integrated approach to the planning and delivery of sexual and reproductive health services among the IDPs and these services include:

- Family planning (all methods – including long-term and permanent, as well as emergency contraception)
- Safe abortion care to the full extent of the law and post-abortion care
- Pregnancy care
- Childbirth care (including emergency obstetrics care)
- Postnatal care (especially maternal and neonatal care)
- Prevention and management of sexually transmitted infections and HIV, including prevention of mother-to-child transmission of HIV and syphilis.
- Prevention and management of gynecological cancers especially cervical cancer
- Prevention and management of gender-based violence

Finally, it is also necessary to establish structures that will facilitate linkages for other reproductive care activities especially for cases that are beyond the scope of the care available in the camps.

Specific Case Management; Malaria as an Illustration

Malaria is a common and deadly but preventable and curable disease caused by parasites of the genus Plasmodium. Common causative species in Africa are *P vivax, P ovale, P malariae* and the most common and deadliest *P falciparum*. Symptoms are often non-specific at the initial stage and they include headache, muscle and joint pains, fatigue and abdominal discomfort. These may be accompanied by fever, chills, anorexia and vomiting. Children, pregnant women and non-immune adults are particularly at risk of severe disease which may manifest with impaired consciousness (Glasgow Coma Score <11 in adults or Blantyre score < 3 in children), being too weak to walk or sit without support, more than 2 episodes of convulsions in 24 hours, respiratory difficulty, persistent vomiting, features of shock, jaundice, dark-coloured urine, spontaneous bleeding, pulmonary congestion, hypoglycaemia (blood glucose < 40mg/dl), severe anemia PCV < 15% or Hb <5g/dl, hyperparasitaemia, acute renal insufficiency as indicated by a serum creatinine level >265 µmol/l or urea level > 20 mmol/l as well as acidosis with bicarbonate levels > 15mmol/l.

Investigations: rapid diagnostic test (RDT) or blood film microscopy for malaria if RDT is not available or patient was treated for malaria in the previous 2 weeks; PCV and blood glucose check.

Treatment: Coartem® 20/120 tablets based on body weight in 6 doses as statim, after 8 hours and give every 12 hours to complete 6 doses. Advise patient to take drug after food. Give paracetamol 10-15mg/kg/dose (1g in adults) 6-8 hourly in children, for symptomatic relief. Other approved artemisinin-based alternatives are artesunate/amodiaquine and dihydroartemisinin/piperaquine.

In severe malaria, artesunate 2.4mg/kg (3mg/kg if weight <20kg) IV or IM at 0, 12, 24 hours and daily afterwards until oral medications can be tolerated. Alternatively, arthemeter 3.2mg/kg stat then 1.6mg/kg daily until patient can tolerate orally. All patients with severe malaria should receive parenteral medications for at least 24 hours followed by a full course of oral artemisinin-based combination therapy (ACT). Management of certain complications e.g. severe anaemia,

unconsciousness, bleeding diathesis and shock will require referral after initiation of treatment. Quinine and clindamycin is recommended for pregnant women in the first trimester while other ACTs can be used subsequently. Clindamycin is not commonly available in IDP settings; quinine monotherapy for seven days is used instead.

Hypoglycaemia should be corrected with 50% dextrose 1ml/kg (500mg/kg) in triple dilution of water for injection. Convulsions should be managed with IM paraldehyde 0.15mg/kg or 1ml/year (up to 5ml max) or IV/ rectal diazepam. When convulsions are recurrent, IV phenobarbitone 3-5mg/kg/ day in two divided cases can be used. Pulmonary edema will require that the patient is nursed in 45° head-up position, oxygen therapy and IV furosemide 1mg/kg stat.

Management Modalities for Other Common Conditions: The modalities for managing other common conditions are as follows. The summary is presents in table 3.

Upper RTI

Most upper RTIs are mild and self-limiting. Therefore, therapy is mostly symptomatic requiring only the use of antipyretics e.g. paracetamol 10-15mg/kg 6-8 hourly, anti-histamines-diphenhydramine, chlorpheniramine 1-2mg 6 hourly and antitussives and decongestants e.g. phenylephrine and oxymetazoline 2 drops 12 hourly. Antibiotics are however indicated in patients with acute otitis media (ear pain, ear discharge, inflamed tympanic membrane), bacterial sinusitis (persistent, purulent nasal discharge, facial or dental pain, and anosmia) and streptococcal pharyngitis (sore or itchy throat, odynophagia, dysphagia, foul breath and inflamed pharynx).

Lower RTI

Lower respiratory tract infection or pneumonia, like upper RTI is common in all age groups. It may be viral or bacterial in origin. Presentation is usually with fever, cough, fast breathing and crepitation in the lung field. Importantly also, children may feed or drink poorly. Signs of severe illness include age < 6 months or > 65 years, flaring nostrils, chest retractions, grunting, cyanosis and SpO_2<90%,

tachypnea (RR > 50cpm in children < 1 year, > 40cpm in 1-5 years, > 30cpm in > 5 years), persistent symptoms after 2 days of treatment in children. Confusion and blood pressure < 90/60 mmHg in adults. The presence of these symptoms should warrant referral for evaluation and in-patient hospital care. Supportive treatment prior to referral IV fluids, oxygen administration, antipyretics and appropriate empirical antibiotic therapy. Treatment: Amoxicillin 30mg/kg (up to a maximum of 500mg daily) 8 hourly for 5-7 days OR azithromycin 10mg/kg daily for 3 days (500mg max. daily) if patient is allergic to penicillin.

Bronchial Asthma

This is a very common chronic disease of the airways of the lungs characterized by variable and recurring symptoms, inflammation, obstruction to airflow and bronchospasm. Asthma is believed to have both genetic and environmental factors (e.g. air pollution and allergens) as causes. Susceptible persons may be exposed to other environmental triggers like cold, fumes, smoke, exercise and drugs e.g. aspirin, beta blockers during or following circumstances that resulted in internal displacement. It affects all ages and symptoms include coughing, wheezing, shortness of breath and chest tightness.

Diagnosis is often based on a history of atopy, pattern of symptoms and physical findings of features of respiratory distress, dehydration, cyanosis, tachycardia, tachypnea, and rhonchi depending on severity. Response of patient to short-acting inhaled bronchodilator albuterol, spirometry and peak flow metering are confirmatory.

Treatment: Nebulise with salbutamol 2.5mg in children, 5mg in adults double diluted in water or normal saline. Repeat every 20 minutes for the first hour till sufficient relief is achieved.

Note: It is important to avoid nebulization in view of the COVID-19 pandemic. Instead, use pressurized meter-dose inhaler with mouthpiece or a tight-fitting face mask.

Give oral prednisolone 1-2mg/kg OD for 3 days in children or 30-50mg OD for 5 days in adult once a clear diagnosis is established. If

unable to use oral drugs, IV hydrocortisone 200mg 6 hourly (4mg/kg 6 hourly in children). In all patients and upon resolution of acute presentation, an asthma action plan that guides patients on specific therapeutic steps to take when symptoms appear or progress should be initiated.

Findings of a mute patient, inability to recline, short feeble respiratory excursions and rate > 30 cycles/minute, paradoxical chest/abdominal movements, near silent or silent chest, bradycardia, hypotension, altered mental state, oxygen saturation <92% and peak expiratory flow rate (PEFR) <33% are pointers to life-threatening asthma. This requires immediate IV fluid therapy, oxygen supplementation and referral. These measures are also suitable in severe cases or where response to initial measures are unsatisfactory. Where immediate referral is not possible and patient has not responded to the measures above, commence IV magnesium sulphate 1.2-2g in 100ml of 0.9% saline over 20 minutes and/or subcutaneous adrenaline 1:10000 solution, 0.1 – 0.3ml in children and 1ml in adult.

Gastroenteritis

This refers to an acute inflammation of the mucosa of the middle and lower intestinal tract from various causes including viral, bacterial or parasitic. It is variable in severity and often presents with vomiting, abdominal pain and fever diarrhea with mucoid stools, with or without blood, convulsions in children and features of electrolyte imbalance. History should establish duration of illness, frequency of stools and vomiting, nature of stools and vomitus, possibility of potential outbreak.

Physical examination to detect dehydration and its severity. (some dehydration – at least two of restlessness/irritability, sunken eyes, thirsty and drinks eagerly, some loss of skin turgor or severe dehydration – at least two of lethargy or unconsciousness, sunken eyes, drinks poorly, severe loss of skin turgor. Altered consciousness, reduced urine output, clammy extremities, tachycardia, hypotension and peripheral cyanosis in an adult suggest severe dehydration)

Other findings are malnutrition – weight for height/length < -2 SD, (severe acute malnutrition < -3SD or mid-arm circumference <11.5cm) features of chronic illness or sepsis, features of peritonitis – distension, diffuse tenderness, rebound tenderness, rigidity and hyper-or hypoactive bowel sounds. The presence of these features require referral.

Treatment: Some dehydration – correct deficit with oral rehydration solution 50-100ml/kg over 4 hours and maintain on ORS if patient improves

For all children with acute watery diarrhoea with or without vomiting, give zinc tablets 20mg daily (6 months and above), 10mg daily (< 6 months) for 10 to 14 days.

Dysentery with or without vomiting should be treated with cotrimoxazole 8mg/kg TMP 12 hourly for 5 days. Azithromycin, ceftriaxone and ciprofloxacin are other options. Persistence of symptoms after 48 hours may suggest an amoebic dysentery and require the addition of metronidazole 15mg/kg TDS for 7 days

Severe dehydration: IV Ringer's lactate 30ml/kg bolus over 30 minutes followed by 70ml/kg infusion over two and half hours. Start ORS at the same time if patient is not vomiting. Adults should be given 100ml/kg over 4 hours. In all cases, maintenance fluid should be continued until the patient can tolerate orally.

Hypertensive emergencies

Presence of acute target organ damage due to elevated BP above 180/110 mmHg is referred to as hypertensive emergency while similar BP elevation without target organ damage is known as hypertensive urgency. The latter is more common.

Target organ damage from uncontrolled hypertension include encephalopathy, cerebrovascular disease, intracranial haemorrhage, myocardial infarction, acute pulmonary edema, aortic dissection, acute renal failure, retinopathy and eclampsia.

Presenting symptoms may include chest pain, sudden upper back pain (aortic dissection), dyspnea, orthopnoea, palpitations, visual disturbance, seizures, isolated limb weakness or paralysis, slurred or absent speech. Record BP measurements in both arms and in supine and standing positions if possible. Further system-specific examination should seek to establish end organ damage. Patients with hypertensive emergencies should be referred upon initiation of treatment.

Immediate treatment: Ensure patent airway and breathing. Administer intranasal oxygen if needed.

Secure IV access and commence 0.9% saline. Monitor fluid input/output. Drug of choice is IV labetalol 20mg over 2 minutes, then 20-80 mg every 10 minutes up to a maximum dose of 300mg daily. Compelling need for other medications may arise based on the identified end organ damage e.g. nitroglycerine, beta blocker in acute MI, furosemide + enalapril in acute pulmonary oedema/heart failure, magnesium sulphate in preeclampsia/eclampsia.

Suicide/ suicidal tendencies

Globally, refugees and IDPS suffer stress and trauma-related mental health challenges such as anxiety, depression and post -traumatic stress disorder (PTSD). Depression and PTSD are strongly associated with increased rates of suicidal behavior. Many suicides happen in moments of crisis and distress such as conflicts, disaster, violence due to loss of ability to cope with life stresses such as loss of loved ones and homes, lack of means of livelihood, deplorable living conditions and social isolation.

The most common methods of suicide include ingestion of pesticides, firearms, hanging, and overdose of medicines. Prompt treatment of suicide survivors coupled with good follow up care for such individuals and provision of community-based support are key to reducing mortality from suicide. Knowledge of the pattern and common methods of suicide in specific populations can inform strategies and interventions to prevent suicide. Training of non-specialized health workers in the screening and management of

suicidal ideation amongst IDPS as part of mental health promotion can also help prevent suicide.

Snake bites

Poor environmental sanitation with presence of bushes surrounding IDP camps and search for water sometimes predispose IDPs to snake bites. Bites by poisonous snakes are often not dangerous with about 50% - 80% being dry bites (without release of venom). It is important to know and detect symptoms and signs of envenomation. It is worthy of note also that not all symptoms are due to envenomation because the bite itself can provoke anxiety, fear and panic in the individual which may manifest as labored breathing, palpitations, vomiting and fainting. A number of initial treatments such as incising the bite site, suction, application of plant juices and venom extraction devices have been found to have no proven benefit and may cause harm or delay time to access care.

First aid care includes calming the patient, removal of tourniquet, bands or other restrictions, examine the site, rest/ immobilize the affected limb to minimize absorption of the venom, give analgesics and tetanus toxoid. Take blood samples for clotting time. Observe closely for signs of local or systemic envenomation, if present, transfer the individual to a nearby health facility where anti-snake venom is available.

Table 3: Clinical presentations, and management of common emergency conditions at IDP camps

Disease/ Injury/ Condition	Features(Symptoms& Signs)	Treatment/ Management	Other remarks
Upper Respiratory Tract Infections	Eye redness and discharge, nasal congestion and discharge, sneezing, cough, sore throat, cough, fever and other non-specific symptoms like headache, myalgia and malaise.	Most are mild and self-limiting. Therapy is mostly symptomatic requiring only the use of antipyretics, anti-histamine, anti-tussives and decongestants. Antibiotics are however indicated in patients with acute otitis media bacterial sinusitis and streptococcal pharyngitis.	
Lower Respiratory Tract Infections	Fever, cough, fast breathing and crepitation in the lung field. Children may feed or drink poorly. Signs of severe illness: age < 6 months or > 65 years, flaring nostrils, chest retractions, grunting, cyanosis and SpO_2<90%, RR > 50cpm in children < 1 year, > 40cpm in 1-5 years, > 30cpm in > 5 years), persistent symptoms after 2 days of treatment in children. Confusion and BP < 90/60 mmHg in adults.	Amoxicillin, azithromycin if patient is allergic to penicillin.	
Bronchial Asthma	Diagnosis is often based on a history of atopy, pattern of symptoms and physical findings of features of respiratory distress, dehydration,	Nebulize with salbutamol. Oral prednisolone. If unable to use oral drugs, IV hydrocortisone. Asthma	Avoid nebulization in view of the COVID pandemic. Instead, use

	cyanosis, tachycardia, tachypnea, and rhonchi depending on severity. Response of patient to short-acting inhaled bronchodilator albuterol, spirometry and peak flow metering are confirmatory.	action plan in all patients	pressurized meter-dose inhaler with mouthpiece or a tight-fitting face mask.
Gastroenteritis	It often presents with vomiting, abdominal pain and fever diarrhea with mucoid stools, with or without blood, convulsions in children and features of electrolyte imbalance. History should establish duration of illness, frequency of stools and vomiting, nature of stools and vomitus, possibility of potential outbreak. Dehydration and its severity. Other findings are malnutrition, features of chronic illness or sepsis, features of peritonitis. The presence of these features require referral.	Rehydrate. For all children with acute watery diarrhea give zinc tablets. Dysentery should be treated with cotrimoxazole. Azithromycin, ceftriaxone and ciprofloxacin are other options. Metronidazole amoebic dysentery.	Start ORS at the same time if patient is not vomiting. In all cases, maintenance fluid should be continued until the patient can tolerate orally.
Snake Bites	The bite itself can provoke anxiety, fear and panic in the individual which may manifest as laboured breathing, palpitations, vomiting, fainting, swelling and sweating,	First aid care includes calming the patient, removal of tourniquet bands or other restrictions, examine the site, rest / immobilize the affected limb to minimise absorption of the venom, give analgesics and tetanus toxoid. Take	Observe closely for signs of local or systemic envenoming, if present, transfer the individual to a nearby health facility where anti-

		blood samples for 20 minutes-whole blood clotting time. Immobilize, transfer on a stretcher to hospital for specialized care.	snake venom, preferably polyvalent antivenom is available. Incising the bite site, suction, application of plant juices, tourniquet and venom extraction devices have been found to have no proven benefit and may cause harm or delay time to access care.
Scorpion bites	It is usually not life threatening. Symptoms include intense pain, numbness, mild swelling	Cold compress, analgesia with NSAIDS.	
Hypertensive emergencies	Presenting symptoms may include chest pain, sudden upper back pain (aortic dissection), dyspnea, orthopnoea, palpitations, visual disturbance, seizures, isolated limb weakness or paralysis, slurred or absent speech.	Ensure patent airway and breathing. Administer intranasal oxygen if needed. IV fluid 0.9% saline. Drug of choice is IV labetalol. Compelling need for other medications: nitroglycerine,	Target organ damage from uncontrolled hypertension include encephalopathy, cerebrovascular

		beta blocker in acute MI, furosemide + enalapril in acute pulmonary oedema/heart failure, magnesium sulphate in preeclampsia/eclampsia.	disease, intracranial hemorrhage, myocardial infarction, acute pulmonary edema, aortic dissection, acute renal failure, retinopathy and eclampsia.
Diabetic emergencies	Previous history of diabetes. Increase urine volume and frequency, increasing thirsty, body weakness, confusion, fruity breath odour. Symptoms of hypoglycemia. There may be fever, malaise, generalized body pain, painful urination, history of poor antidiabetic medication adherence, or inadvertent overdose.	ABC of resuscitation. Check random blood sugar, urinalysis, rehydrate with 0.9% saline. IV bolus of 50% dextrose, 10% dextrose water in hypoglycaemia. Then transfer to a nearby hospital.	Further specialized care include: Insulin injection, correct the electrolytes imbalance, treat the underlying cause.
Suicidal tendencies	Prior history of depression, deliberate self-harm, feeling of worthlessness, suicide note, evidence of suicide attempt,	Immediate resuscitation. Treat underlying mental illness, psychotherapy	Follow up, social support

Setting up The Camp Health Post

The purpose of the IDP camp health post is to address lifesaving needs and also the provision of essential health services to the people. The importance of early collaboration with local health authorities and ensuring productive collaborations with response agencies such as the National and State Emergency Management Authorities, non-governmental organizations and volunteer groups cannot be over-emphasized. The provision of adequate resources including ambulance and referral services, immunization coverage, and vector control are initial measures with proven benefits.

Setting up a camp clinic should be part of the larger considerations for a camp settlement. Safety from hazards is the first major consideration in siting a camp and this is determined after an integrated hazard mapping has been conducted. An ideal site must offer adequate safety, security and protection. Other factors to be considered include size and prevailing conditions including available resources, access and topography, trees and vegetation as well as social and cultural issues. The potential impact of the camp activities on the environment and the risk on public health are also important points to note, thus an Environmental Impact Assessment (EIA) becomes imperative.

Another important consideration to which sufficient attention must be paid is staffing including selection of volunteers. Staff must be well motivated and remunerated. When hiring staff, priority should be given to the local population where the camp was sited as they know the terrain and are likely to bring in some local expertise. People living in the camps, especially those that are previously inclined to healthcare can also be sourced and identified as potential workers but training and retraining in health promotion is obligatory. They can help to educate people about disease prevention and also help monitor health conditions among the IDPs.

It is also crucial to differentiate the healthcare needs of the various populations at the IDP camps with the aim of identifying vulnerable groups. Sorting at risk groups e.g. under-5 children, pregnant women, people living with disabilities, elderly and people with pre-existing

morbidities and making sufficient provision for their healthcare needs is imperative.

Setting up a medical emergency unit in the IDP camps manned by well-trained personnel is therefore an important part of WHO's regulation for displaced individuals. Important considerations should be given to the personnel, medical materials, surgical needs as well as laboratory facilities.

Healthcare Centre Requirements

Location: One clinic is expected to serve a camp with a maximum population of 20,000 people. Ideally, its location should be as central as possible while ensuring adequate access for ambulances and other support services like administration and food. It should also be near a referral hospital that has the capacity to serve up to a maximum of 10 camps (200,000 people). The required number of latrines/ventilated improved pit toilets are 1 per 10-20 in-patient beds and 1 per 20-50 outpatients. Medical wastes disposal facilities should be made available and safe from the camping population.

Space Allocation: This should aim to allow smooth flow through the center. Actual size of allocated spaces is a function of the camp population. At the minimum, spaces should be allocated for Waiting area, Office and Treatment area, At least one accessible bathroom and toilet, Admission area in the order of one bed per 50 people, An examination room, An isolation room, A kitchen, and Separate nurse's residence with bathroom.

Personnel: The IDP camps are usually remotely located and poorly accessible by road, therefore, members of the IDP camp should receive first aid training. Trained persons must be aware of the risk of potential exposure to blood borne pathogens, therefore, should be taught to practice "universal precautions" on all patients. Personnel who will be in charge of records should also be trained.

Medical materials: There should be a first aid kit. The first aid kit should contain masks and gloves for blood-borne pathogen protection in addition to the following: Disinfectant solution, Adhesive dressing (bandages), Safety pins, Adhesive tape rolls, 1-inch-wide Tweezers

and Scissors, Eye dressing packet, CPR mask, 1 inch gauze roll or compress, Latex gloves, 2 inch gauze roll or compress, Face shield/mouth protector, Sterile gauze pads, Protective gown, Sterile gauze pads and 4-inch square Triangular bandages among other things. The contents of each first aid kit should be checked periodically (at least monthly) to ensure an appropriate supply of each item is kept on hand.

Vital signs monitoring equipment, medical equipment, stethoscope, and torches ophthalmoscope.

Drugs such as deworming agents or anthelmintics; anti-malarials; antibiotics; Cough Syrups; antihistamines; analgesics; antiepileptic treatment drugs and eye ointments among others.

Surgery supplies: These are needed in cases of emergency surgical conditions and will serve the purpose of first aid care: Needles G 18, 21, 22, 24; Syringes 20cc, 10cc, 5cc, 2cc; Disposable dressing packs; Sterile surgical packs; Cotton wool; Wound dressing gauze and surgical gloves – both sterile and nonsterile among other things.

Laboratory needs: Point-of-care diagnostics technology should be made available for appropriate diagnosis especially in cases of malaria and pregnancy tests. Wrong diagnosis can lead to health complications by prescribing the wrong medication, which can lead to significant side-effects without therapeutic benefits.

Essential supplies in an ideal IDP healthcare facility: (Not exhaustive)

Table 4: Categories of essential supplies and their examples

Broad category	Examples
Emergency	Automated External Defribillators (AEDs,), CPR masks and Ambu bags, nebulisers, oxygen tanks, pulse oximeters, intravenous fluids.
Diagnostic	Blood pressure monitors, stethoscopes, thermometers, weighing scales, tape measures, rapid test kits for malaria, HIV, SARS CoV-2, blood glucose etc, test strips for urinalysis, pregnancy.
Infection control	Gloves, aprons, coverall, face masks/shields, hand sanitisers and wipes, handwashing gel, detergents, antiseptics/disinfectants etc.
Orthopaedics	Crutches, splints and braces, casts, orthopaedic bandages etc. Skin care needs – methylated spirits, Savlon, povidone iodine, cotton wool, gauze, bandages.
Medications	oral rehydration salts, vitamin/mineral supplements, paracetamol, ibuprofen, diclofenac, ***

*** And lots more based on initial assessment of health needs of the camp population and national essential drugs list.

Most clinics in IDP camps in developing countries like Nigeria are far from the ideal and may not be more than rudimentary or make-shift clinics.

Actions to Mitigate Medical Emergency

Health Promotion: the need for continuous health education to individuals and their families by trained volunteers most of whom should be members of the camp community and community health nurses periodically on adoption of healthy lifestyle choices such as ensuring adequate nutrition for all ages, exclusive breastfeeding, complementary feeds using healthy, cheap and locally available options. Other relevant areas include hand washing, personal and environmental hygiene.

Disease Prevention: this can be achieved by ensuring immunization of all children between based on national programmes to protect against Vaccine Preventable Diseases, mass dewormimg program, iron supplementation in children, ownership and use of long-lasting insecticide treated nets.

Environmental Sanitation and Vector Control: Getting rid of bushes and stagnant pools of water to reduce breeding sites for vectors like mosquitoes, rodents, arthropods like snakes and scorpions. Also minimizing overcrowding as much as possible to forestall spread of some diseases like tuberculosis, scabies.

Establishing a Disease Surveillance System: this will help identify, and keep record of and report incidence of notifiable diseases and warn of impending disease outbreaks.

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