

ASSESSMENT OF HEALTH RISKS AMONGST VULNERABLE GROUPS OF INTERNALLY DISPLACED PERSONS IN POMPOMARI CAMP, DAMATURU, YOBE STATE, NIGERIA

UMAR, S.S.

Radiotherapy and Oncology Unit

Ahmadu Bello University Teaching Hospital, Zaria, Kaduna State, Nigeria

(+2347035595262)

SULEIMAN, M.S.

PhD Candidate

Department of Sociology and Anthropology,

Faculties of Humanities and Social Sciences,

Khon Kaen University, Khon Kaen, Thailand

mohammedsaeedsuleiman@gmail.com

mohammedsaeedsuleiman@fugashua.edu.ng

(+2348036469928/ +66994761331)

MAGAJI, R.A. PhD

Department of Human Physiology,

Ahmadu Bello University, Zaria, Kaduna State, Nigeria

Abstract

The insurgency affecting majorly the North-East region of Nigeria has led to the loss of lives, destruction of livelihoods. It also caused displacement of a significant proportion of the affected communities; majority of them seeking shelter with relatives and acquaintances away from harm, while others were sheltered in camps for the internally displaced persons. Pompomari primary school in Damaturu, Yobe State is one of those camps designated by the Yobe State Emergency Management Agency to provide temporary shelter to internally displaced persons. The displaced persons in Pompomari camp are victims of the dreaded Boko Haram insurgency who fled their places of domicile in Gujba Local Government Area of the state. Assessment of health risks amongst the vulnerable displaced people in Pompomari camp was carried out using direct observation, focus group discussion and questionnaire administration as the primary sources of data. The official demographic records of the camp, the routine record of the camp clinic and the comprehensive report of the clinic from its inception were also utilized as secondary sources of data in this research. Attempts were made to interpret and discuss the data collated. The research found out that the vulnerable groups constitute 83% of the

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

displaced persons in the camp. They were predisposed to health risks like inadequate sanitation, vector control, and nutrition and housing standards. However, health facility in the camp was very functional and adequate in capacity and water supply was adequate in quantity and quality. The research has helped create a scientific framework for managing the health aspect of IDP camps.

Key words: Health risk assessment, Vulnerable groups, Internally Displaced Persons, Pompomari camp

Introduction

The growing number of internally displaced persons in Nigeria in the last decade is worrisome. The estimation was put to about 1.2 million by the end of 2014 and over 1.5 million by April 2015 (International organization for Migration, 2015). The on-going insurgency affecting the North-East of Nigeria was accountable for most of the internal displacement. However, a minority of the IDPs was fleeing inter-communal clashes and natural disaster like a flood. More worrisome is the poor condition in which these esteemed population of displaced persons lives in. Most are housed in overcrowded camps across the disturbed Northern regions. These camps are mainly school facilities and empty government buildings with few basic amenities provided and are supervised by the National Emergency Management Agency (International Organization for Migration, 2015). Pompomari camp is located within the facility of Pompomari primary School in Damaturu Yobe State. It is one of the several IDP camps in Damaturu coordinated by the Yobe State Emergency Management Agency. It was opened on Friday, March 27th, 2015 to serve as temporary shelter for IDPs from Gujba Local Government Area of Yobe State.

According to Internal Displacement Monitoring Centre (IDMC) report by Global View (2014), that as at the end of 2014, it was estimated that there were 38.2 million IDPs worldwide. The countries with the largest IDP population were Syria (7.6 million), Colombia (6 million), Iraq (3.6 million), Democratic Republic of Congo (2.8 million), Sudan (2.2 million), South Sudan (1.6 million), Pakistan (1.4 million), Nigeria (1.2 million) and Somalia (1.1 million). In addition, most of the IDP population it has been estimated that between 70 to 80 percent of all IDPs do women and children- thereby constitutes double vulnerability (Global View, 2015).

As earlier stated, the majority of the internally displaced persons (70-80%) are women and children who are classified as vulnerable groups. Vulnerable groups

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

refer to specific populations within a country that have been excluded from financial and social services for a variety of reasons which could be cultural or peculiar to that country. From the cultural perspective, women and children constitute vulnerable groups. However, internally displaced persons and refugees from post-conflict regions, people living in remote or difficult to assess regions, people with disabilities, ethnic and religious minorities etc. also constitute vulnerable groups. It, therefore, goes that women, children and disabled people amongst the IDPs are doubly vulnerable; first by virtue of the pre-existing cultural circumstances and secondly by virtue of being internally displaced. Internally displaced persons do not enjoy international privileges and recognition like refugees. This is because, though displaced, they are still confined within the borders of their country of origin and therefore subjected to the laws of their country. To this effect, the United Nations Office for the Co-ordination of Humanitarian Affairs in 1998 developed a document titled: *The Guiding Principles on Internal Displacement*. The document intended to provide a valuable practical guide to Governments, competent authorities and intergovernmental organization in their work with internally displaced persons. The document outlined 30 principles with Principles 18 and 19 having a direct relation to health. This document also inspired other policies like the Popular Kampala Convention on IDPs in Africa in 2009 and the Nigerian National Policy on Internally Displaced Persons in Nigeria in 2012 (Kampala Convention, 2009 and Nigerian National Policy on Internally Displaced Persons in Nigeria, 2012). The health assessment in this study will be limited to physical and environmental components. Therefore, this study focuses on health risks amongst a vulnerable group of IDPs who reside in Pompomari camp.

Research Problem

Displacement impacts on health in fundamental ways, often exposing populations to higher risks of disease and malnutrition. Although forcibly displaced people move to escape direct violence and the high mortality that it produces, they face new threats from overcrowding, poor sanitation, inadequate provision for basic needs, ongoing insecurity and an unfamiliar environment. Also, there is very limited information on IDPs needs in Nigeria. The continuing shortage of accurate and reliable data on internal displacement across Nigeria has resulted in a distorted picture of displacement and assistance needs in Nigeria and an alarming lack of understanding of the country's displacement dynamics by national actors and the international community.

Aim and Objectives

The aim of this research is Assessment of health risks amongst vulnerable groups of Internally Displaced Persons in Pompomari camp, Damaturu, Yobe State with specific objectives: to obtain basic demographic information about internally displaced persons in the camp, assess the vulnerabilities of IDPs in the camp to health risks as well as appraise the capacity of the health facility in the camp to cope with health challenges of IDPs.

Literature Review

According to Internal Displacement Monitoring Committee (IDMC) by Global View (2014), there has been a global rise in the number of displaced persons over the last 15 years. The total number of IDPs worldwide in 1998 was 19.3 million; in 2001 around 25 million; by the end of 2012 it was about 28.8 million; by the end of 2013 it was 33.3 million and by the end of 2014 it was estimated to have risen to 38.2 million. For the years of 2013 and 2014, there was a 16% and 15% rise in the IDP population when compared to their preceding years respectively. As at the end of 2013, Sub-Saharan Africa had the highest number of IDP with about 12.5 million. This was followed by Middle East region with 9.1 million. Overall, by the end of 2013, 8.2 million people have newly displaced with Syria alone accounting for 3.5 million. Other countries include Democratic Republic of Congo (1 million), Central Africa Republic (930,000), Nigeria (470,500), Sudan (470,000), South Sudan (383,000) etc. The causes of these displacements were conflicts and violence.

Global View (2015), also reported that by the end of 2015, there were 11 million newly displaced persons, surpassing the 8.2 million recorded at the end of 2013. This increase is unprecedented in the past 15 years. The five countries of Iraq, South Sudan, Syria, Democratic Republic of Congo and Nigeria accounted for 60 percent of the increase. Currently, the numbers of IDPs have doubled those of refugees globally. 77 percent of the world's IDPs live in the 10 countries of Syria, Colombia, Iraq, Sudan, DR Congo, Pakistan, South Sudan, Nigeria, Somalia, and Turkey. Also, it was reported through a survey done across 22 of the countries monitored in 2013. More than 60 percent of IDPs were living outside camps, and in some countries, the proportion was much higher. In 13 countries, IDPs living outside of camps made up 95 to 100 percent of the displaced population. IDPs living outside camps may have the opportunity to integrate and overcome their displacement, and it is perhaps this perception that drives people in that direction. The downside, however, those non-camp settings, whether urban or

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

rural, can be hostile environments where IDPs encounter threats to their safety and wellbeing (Global View, 2014 and National Policy on Internally Displaced Persons in Nigeria, 2014).

As at the close of 2013, it was noted that there were 12.5 million IDPs spread across 21 countries of Sub-Saharan Africa. This figure represented more than a third of the global figure (Global View, 2014). However, by the end of 2014, Central Africa became home to the some of the continent's most protracted and dynamic displaced population. The figure of IDPs in Central Africa alone at the end of 2014 was 7.9 million representing 70 percent of total displacement in Africa. It spread across countries like Burundi, Central Africa Republic, Democratic Republic of Congo, South Sudan, and Sudan. In the Central Africa Republic and Sudan, IDPs constitute about 10 percent of their respective population while in South Sudan, the IDPs constitute up to 13 percent of the total population (Global View, 2015). According to IDMC report, as of December 2014, there were a total of 1.9 million IDPs in East Africa spread across Eritrea, Ethiopia, Kenya, Somalia, Uganda, and Zimbabwe. The overall figure represents little change from 2013. Somalia continues to host by far the largest displaced population in the region with 1.1 million IDPs, followed by Ethiopia with 397,200 and Kenya with 309,200. At least 446,250 people were newly displaced across the region during the year. As in 2013, new displacements only took place in Ethiopia, Kenya, and Somalia, which continue to be affected by violence and conflict. No new displacement was reported in Eritrea, Uganda or Zimbabwe. The overall figure is an increase of more than 132,400 on 2013, a significant spike in Kenya outstripping a decrease in Ethiopia. More than 220,000 people fled their homes in Kenya in 2014, compared with 55,000 in 2013, mainly as a result of inter-communal violence. Many forms of violence forced people to flee their homes in East Africa in 2014, including armed conflict and struggles for political power. Two other drivers, inter-communal violence and the activities of extremist groups, were also prevalent across various countries and often affected the same areas (Global View, 2015).

United Nations Guiding Principles on Internal Displacement

The Guiding Principle on Internal Displacement is a document developed in 1998 by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) which was meant to give an overview of the rights of IDPs and the responsibilities of national authorize and non- State actors towards them (OCHA, 2008). Even though not a binding document, the Guiding Principles

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

authority is reinforced by the wide international acceptance that they have received. They are recognized by States as "an important international framework for the protection of internally displaced persons" as well as serving as a "tool" and "standard" to guide governments international organizations and all other relevant actors in situations of internal displacement. It has been translated into over 40 languages. The overview of the Guiding Principles contained in The Handbook for the Protection of Internally Displaced Persons which was compiled by Global Protection Cluster Working Group gave a comprehensive review of this document (OCHA, 2008). Despite its comprehensive nature and wide acceptance amongst member countries of the United Nations, many analysts opine that the Guiding Principles is not a legal document and as such cannot be enforced upon member countries. In a publication titled: Support to Internally Displaced Persons- Learning from Evaluation, Borton, Smith, and Otto (2015) summarized the insufficiency of the Guiding Principles to address problems of IDPs thus: 'Since the publication of the Guiding Principles in 1998 progress has been made on incorporating them into national legislation. In 2001 Angola became the first country to incorporate the Guiding Principles into domestic law and several countries have followed suit or incorporated the Guiding Principles into their cooperation agreements with UN agencies. However, there are many countries that have yet to incorporate the Guiding Principles. Experience in Angola and Colombia shows that incorporating the Guiding Principles into domestic law does not necessarily lead to better government policies or to automatic improvements in the rights of IDPs, but at least there is legislation in place against which governments can be held to account' (Borton, Smith and Otto, 2015).

African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa

The Heads of States and Government of Member States of African Union met on a special summit in Kampala, Uganda in October 2009, and adopted the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa popularly referred to as the Kampala Convention (Ferris, 2012). Furthermore, Ferris (2012) in her article titled: Internal Displacement in Africa; an Overview of Trends and Opportunities, elucidated the overall purpose of the Convention thus: 'The Kampala Convention comprehensively affirms the importance of addressing the protection and assistance of IDPs in all stages of displacement - from prevention of displacement to protection and assistance during displacement to durable solutions. Significantly, the Convention

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

incorporates the 1998 UN Guiding Principles on Internal Displacement; it also recognizes that the Guiding Principles are an important international framework for the protection of internally displaced persons" which, together with international human rights and humanitarian law, protects "the inherent rights of internally displaced persons (Ferris, 2012). The Kampala Convention consists of 23 articles, which covers a wide range of issues on displacement. It is worthy of note that Article 5 specifically addresses obligation of state parties relating to protection and assistance as stated below:

State parties shall bear the primary duty and responsibility for providing protection of and humanitarian assistance to internally displaced persons within their territory or jurisdiction without discrimination of any kind. States parties shall cooperate with each other upon the request of the concerned State Party or the Conference of State Parties in protecting and assisting internally displaced persons. States parties shall respect the mandates of the African Union and the United Nations, as well as the roles of international humanitarian organizations in providing protection and assistance to internally displaced persons, in accordance with international law. State parties shall take measures to protect and assist persons who have been internally displaced due to natural or human-made disasters, including climate change. State parties shall assess or facilitate the assessment of the needs and vulnerabilities of internally displaced persons and of host communities, in cooperation with international organizations or agencies. States parties shall provide sufficient protection and assistance to internally displaced persons, and where available resources are inadequate to enable them to do so; they shall cooperate in seeking the assistance of international organizations and humanitarian agencies, civil society organizations and other relevant actors. Such organizations may offer their services to all those in need. States Parties shall take necessary steps to effectively organize, relief action that is humanitarian, and impartial in character, and guarantee security. State parties shall allow rapid and unimpeded passage of all relief consignments, equipment, and personnel to internally displaced persons. States Parties shall also enable and facilitate the role of local and international organizations and humanitarian agencies, civil society organizations and other relevant actors, to provide protection and assistance to internally displaced persons. State parties shall have the right to prescribe the technical arrangements under which such passage is permitted. State parties shall uphold and ensure respect for the humanitarian principles of humanity, neutrality, impartiality, and independence of humanitarian actors. State parties shall respect the right of

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

internally displaced persons to peacefully request or seek protection and assistance, in accordance with relevant national and international laws, a right for which they shall not be persecuted, prosecuted or punished. States Parties shall respect, protect and not attack or otherwise harm humanitarian personnel and resources or other materials deployed for the assistance or benefit of internally displaced persons. State parties shall take measures aimed at ensuring that armed groups active in conformity with their obligations under Article. Nothing in this Article shall prejudice the principles of sovereignty and territorial integrity of states (Kampala Convention, 2009).

Unlike the Guiding Principles on Internal Displacement, the Kampala Convention was developed to provide a legal framework that will be adopted by member states and binding upon them once it is effected into law. The condition for its entry into force is stated in Article 17: 'This Convention shall enter into force thirty (30) days after the deposit of the instruments of ratification or accession by fifteen (15) Member States' (Kampala Convention, 2009). However, Elizabeth Ferris further noted as of April 2012 that the Convention has been signed by 36 member states, and ratified by 17 although instrument for ratification had only been submitted by 11 member states. This meant that it wasn't put into force as it will require 15 deposited ratification of the convention to do so (Ferris, 2012).

National Policy on Internally Displaced Persons in Nigeria

As part of her obligation to reflect the international human rights and humanitarian laws on IDPs, the Federal Government of Nigeria passed The National Policy on Internally Displaced Person (NPIDP) in Nigeria into law in July 2012. The mission statement of the policy is to provide a framework for national accountability and responsibility to protect and promote the rights of internally displaced persons, families, and host communities as well as adopt strategic measures for coordinated gender-sensitive response to all types and phases of internal displacement in Nigeria (NPIDP, 2012). The overall goal of this policy is to strengthen institutional mechanisms and framework for the realization of the rights, dignity, and well-being of vulnerable populations through the prevention of the root causes, mitigation of the impact and achievement of durable solutions to internal displacement in Nigeria (NPIDP, 2012).

It, therefore, goes without saying that the policy was not just inspired by the United Nations Guiding Principles on Internal Displacement and the Kampala Convention; but they also served as a template for the development of the policy. It emphasized on the rights and obligations of IDPs with specific emphasis to vulnerable groups like children, women, elderly, disabled persons and people living with Human Immunodeficiency Virus (HIV) disease; and also outlined the obligations of the IDPs (NPIDP, 2012). The policy placed the primary responsibility for IDPs on the Government and also outlined the responsibility of humanitarian agencies as well as host communities. In the policy document, the responsibility of the Government for IDPs was drawn in line with international human right laws which impose on Government the obligation to respect the human rights of internally displaced persons, i.e. to refrain from actively violating them; to protect such rights, i.e. to intervene and take protective action on behalf of the victims of internal displacement against threats by others or stemming from their displaced situation; and the obligation to fulfill these rights, i.e. to provide goods and services necessary to allow internally displaced persons to fully enjoy their rights; and to discharge these obligations without discrimination.

The responsibilities of the Government as outlined in the policy include: preventing all causes of displacement in Nigeria and minimize its adverse effects; raising national awareness of the problems of displacement; collecting data on the number and conditions of internally displaced persons in Nigeria, supporting training on the rights of internally displaced persons among all relevant government authorities, host communities and the IDPs themselves; creating a legal framework for upholding the rights of internally displaced persons including domestication and implementation of the Kampala Convention; implementing and continuously reviewing a national policy on internal displacement; creating the institutional framework for effectively coordinating all interventions targeting all phases of internal displacement in Nigeria; empowering and ensuring that the National Human Rights Commission, Legal Aid Council, security agencies and other relevant agencies adequately integrate internal displacement into their work; ensuring the active participation of internally displaced persons in decision making; supporting durable solutions from prevention of displacement to long term development goals; allocating adequate resources to tackling the problem of internal displacement through the various intervening ministries, departments and agencies of government; seeking and strengthening cooperation with the

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

international community when national capacity is insufficient to address the challenges of internal displacement; and putting in place measures to protect properties left behind by IDPs (NPIDP, 2012). It is interesting to note that the National Policy went further to outline the framework and strategies for the implementation of the policy statement by designating specific tasks to specific government departments or agencies.

Health Challenges of Internally Displaced Persons

In the last decade, a lot of international attention was placed on internally displaced persons with many agencies catering for their specific needs. However, it was observed that support to Internally Displaced Persons, it was noted that very little is done on a needs assessment of IDPs before putting up interventions. Even in areas where it is carried out, the quality of such assessments are often poor (Borton Smith and Otto, 2015). In a study carried out by United States Agency for International Development (USAID) in 2015, on Health and Social Needs amongst Internally Displaced Persons in Iraq, in 2013, 55.6% of them lived in dwellings of concrete block construction, 39.1% lived in dwellings made of mud while 4.5% lived in tents or caravans. 78% of the households claimed they were living in poverty while 19.6% said their economic status was average for Iraq and 2.4% said theirs was good. 24.4% of households indicated that a clinic inside the settlement area. 39.9% of household said the nearest clinic was within 1 kilometer while 75.3% said it was within 2 kilometers. Only 6.2% of households were 5 kilometers or more from the clinic. 85.7% of the household said they had visited the clinic when needed, however, only 45.6% said the services provided by the clinic was good enough or acceptable. The study further found out that the most pressing health needs of these IDPs were access to health facilities, sewage disposal, access to water supply and rodent control. When households were asked about illness in the last four weeks, 23.6% indicated diarrhea have been present in a family member, 5.3% indicated a respiratory tract infection had occurred, and 20.8% said a respiratory infection in combination with another condition had occurred. Households were also asked if one of their members had been diagnosed with a non-communicable disease. There were 19.1% with a household member with diabetes, 30.1% with hypertension, and 4.4% with asthma. Of persons with diabetes, 8.8% also had hypertension (USAID, 2015). In the 2015 Humanitarian Needs Overview (HNO) for Nigeria, it stated that 'Boko Haram insurgents have attacked numerous health facilities and health workers leaving large areas of Borno, Yobe, and Adamawa States grossly underserved. Almost 75% of the affected people do not have access to health care and

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

remaining PHCs have been overwhelmed by the recent influxes of IDPs. 80% of the displaced people do not have sustainable access to water, sanitation, and hygiene. Poor hygiene behaviors are contributing to outbreaks of water-borne diseases, increase in mortality and morbidity. Lack of adequate emergency sanitation facilities also places individuals, particularly women and children at increased risk of protection issues. With deliberate attacks on schools, abduction of girls and use of schools as IDP camps, education has been seriously disrupted (United Nations' Office for the Co-ordination of Humanitarian Affairs, 2015). In another survey concluded in February 2015 by Displacement Tracking Matrix (DTM) on IDP households in the North Eastern states of Nigeria affected by the Boko Haram insurgency, the following findings were made: The most common types of shelter identified during site assessment were schools and government buildings. 37.8% of individuals live in tents, while 29.3% live in government buildings, and 24.3% reside in schools. The predominant majorities of sites (75%) do not have adequate lighting in the majority of communal points and do not have access to safe cooking facilities. In 13 sites the main water source is located on-site within a 20-minute walk and in 9 sites the main water source is located on site but requires more than a 20-minute walk. In 10 sites the main water source is located off-site. In 17 sites there were about 10-15 litres of water available per person and per day whereas 9 sites have less than 10 litres of water per person and per day. Households in the majority of sites (29 out of 33) reported that the drinking water is potable and households in 27 sites reported no complaints about the quality of the drinking water. In the sites assessed there is on average one toilet per 368 individuals when the sphere standards recommend 20 persons per toilets. The availability of toilets is particularly critical in Borno where there is one toilet per 472 individuals. The majority of sites (25 out of 33) have separate male and female toilets and separate bathing areas (24 sites). The households in the majority of sites (26 out of 33) reported "not so good condition" of the latrines. Households in 20 sites have access to food distribution. In terms of frequency, 13 sites receive food distribution every day; another 13 sites receive irregular food distribution. In 3 sites (all located in Adamawa) individuals have never received food distribution. Households in all sites with the exception of one reported having no supplementary feeding for children or breastfeeding mothers. Screening for malnutrition has not been conducted in 27 sites. Eighteen (18) sites do not have regular access to medicine. In 19 sites, health facilities are located on-site within 3 km walk. In addition, 18 sites do not have a referral system for IDPs to be transferred to medical facilities in case of necessity.

Malaria, cough, and fever are the most prevalent health problem identified on sites (International Organization for Migration, 2015).

Methodology

The consent of the Yobe State Emergency Management Agency that serves as coordinators of the camp was also sought. The consent of the responders was also sought before administering questionnaires. While the study design was a cross-sectional descriptive study. The sources of information for this research were primary and secondary respectively. The Primary sources of information were direct observation, focus group discussion and questionnaire were used in this research so that the data obtained could complement one another thereby making it more reliable. Direct observation method involved visual inspection of the camp facilities like housing, toilets, water sources, drainages, clinic and open spaces using the designed check-list. Also, pictures were taken to boost the clarity of visual observation. Focus group discussion was organized involving two health personnel, security personnel, two leaders from IDPs and the researcher where issues bordering on the composition and organization of the camp as well as health care in the camp were discussed. Two sets of questionnaires were administered at the camp: one to the IDPs and the other to the health officials. The IDPs were organized into a social structure with the smallest unit being a household. It was assumed that vulnerable members of the same household receive the very similar treatment and are subjected to similar health risks, thus household was used as the basis of administering the questionnaires rather than individuals avoid unnecessary duplication. A member of the randomly selected household was chosen to administer the questionnaire upon (usually a housewife of the household who falls within the scope of this study). The questionnaire was administered by the researcher using an interpreter and health officials of the camp (who didn't need an interpreter). The second type of questionnaire was solitary and was directed to the health officials of the camp. It was responded to by the head of the camp health clinic, Abubakar Danladi. While the secondary sources of information used in this research were the official demographic records of the camp, the routine record of the camp clinic and the comprehensive report of the clinic from its inception in March 2015 to October ending 2015. The study population is finite. There were 3011 registered IDPs in Pompomari camp divided into 502 household units. It is assumed that members of the same household units experience similar conditions and risks. Thus the household units were sampled and one member of

the household unit (usually the housewife) was selected for administering of a questionnaire. The total number of households in the camp N = 502.

Using the finite correlation, the adequate sample size (n) was determined thus:

$$n = n_0 / (1 + n_0/N)^1$$

$$\text{Where } n_0 = \frac{Z^2 p_0 q_0}{d^2}$$

Z = Standard normal deviate at 95% confidence interval which corresponds to 1.96.

p_0 = Proportion of IDPs that are vulnerable from previous studies = 0.8

q_0 = Complimentary probability of p_0 ($1 - p_0$) = 0.2

d = Degree of precision assuming a 5% margin of error

$$n_0 = \frac{1.96^2 \times 0.8 \times 0.2}{0.05^2}$$

$$n_0 = 246$$

$$n = 246 / (1 + 246/502) = 165$$

The attrition rate is 10% of sample size of this study 16.5.

Therefore the adequate sample size of this study is $165 + 16.5 = 181.5$.

Sampling technique was simple random sampling was used to select one representative of a household in the camp. Care was taken not to select two members of the same household. Housewives of selected households were the preferred choice for administering questionnaires for the study. While the data collected using the various tools were harmonized and analyzed statistically with reference to international minimum standards.

Findings of the study

The vulnerable group which consists of children and women were the majority in the camp. Children made up 61% while women of childbearing age made up 22% of the IDP population in the camp. This finding is consistent with International Organization for Migration Report (February 2015) conducted across households of IDPs in five affected states in Nigeria where they found out that children made up 56% of the total IDP population. The children and women in this study made up 83% of the total IDPs which slightly above the United Nations Human for Refugees Commission (UNCHR) estimate of 70- 80% (UNCHR,2014). There were no available records of sex distribution of the IDPs in the camp and that of the respondents in this study was not used. This is because one respondent was selected per household and most of the respondents were

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

women, thus not a true reflection of the sex distribution of the IDP population. The average number of persons per household in this study (6.0 persons per household). This is similar to the value obtained by USAID on IDPs in Iraq (5.4 persons per household). This could explain why it was difficult for the relevant authorities to provide tents to every household unit in the camp. Smaller household units tend to occupy the tents while large households lived along with others in large classrooms (Olagunji, 2006; Fagen, 2011; and USAID, 2015). The study found out that IDPs in the camp have regular access to portable water which was situated within the camp within a 5-minute walk. The IDPs were also satisfied with the water quality and quantity. The reason for the availability of water in the camp was the easy access to municipal services as the camp is situated within the state capital. This finding is similar to that of round II report where the majority of the camps (29 out of 33) had access to potable water with about two-thirds of these sites located within the camp (International Organization for Migration, 2015). While the finding of this study is in congruence with that of round II report earlier stated, it apparently contradicts HNO report which stated that about 80% of IDPs in Nigeria do not have sustainable access to water, sanitation and hygiene (Lidstone, 2007; Norwegian Refugees Council, 2014; and United Nations' Office for the Co-ordination of Humanitarian Affairs, 2015). The findings in the two studies above can, however, be reconciled with findings of this research. The HNO report was done on the entire IDP population in Nigeria. The same report also states that 87% of all IDPs in Nigeria live with host communities thereby stretching out available municipal services to the host communities like water and sanitation. According to the report, only 13% of the total IDPs lived in organized camps that are coordinated by government agencies and Non- Governmental organizations. The round II report was conducted on the 13% of IDPs living in the camps. This implies that IDPs in the camp have more sustainable access to portable water than those living with host communities.

As there were no incinerators or waste bins fixed at strategic positions within the camp, wastes generated from the camp are dumped in open spaces at some corners, and later burnt when accumulated. There are no drainages constructed to allow passage of wastewater. Rather, wastewater is poured on the floor randomly. These findings are consistent with the findings of Depoortee and Brown (2006), Durosaro and Ajiboye (2011), Tajudeen and Adebayo (2013), and Hall (2014) that the average of one toilet for every 81 IDPs was far below the sphere standard of one toilet per 20 persons for a camp, yet better than the round

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

It report where camps in Borno state had as worse as one toilet per 472 IDPs. The relevant authorities might not be aware of the standard ratio for constructing toilets in camps. A similar argument also follows for housing. Open drainage and open dumping of refuse in the camp were obvious impediments to whatever vector control measure instituted by the health officials in. This is because they serve as good sites for vectors of diseases like flies, mosquitoes, rodents, and cockroaches to breed. There was a good measure to prevent malaria by giving every household in the camp adequate numbers of insecticide-treated nets to use. However, the compliance of the IDPs could not be ascertained. Also, there was no provision of insecticides or rodenticides to the IDPs but there was regular cleaning of open drainages and burning of accumulated refuse. Overall, some measures of vector control were put in place in the camp but a lot needs to be done for improvement.

The food distribution in the camp was impressive. The SEMA was responsible for supplying food items which are given to the representatives of the six clans on a daily basis. The different clans are responsible for processing, cooking and distributing their food to their members. Every IDP in the camp is entitled to three meals in a day. However, there is no supplementary feeding for children or breastfeeding mothers. These findings seem better than the International Organization for Migration report (2015) in which 13 sites had access to food items daily while 13 sites had access to food but not regularly. While another 3 sites had never received food items from camp officials. The food distribution in the camp does not include protein from animal sources like beef, mutton or fish, which are essential for growth and repair of damaged body tissues, especially in children. Individual households are with the initiative to complement their diets with protein sources which majority of them cannot afford. The good health service delivery in the camp could be attributed to the adequate political will of the Yobe State Government, situation of the camp in Damaturu, the capital of Yobe state, constant supervision by relevant health authorities and the fact that the health officials in the camp were also displaced persons affected by the insurgency. It is, however, worthy of note that the commonest diseases in the camp were Malaria, diarrheal diseases and respiratory tract infections which have a direct relationship with the sanitation, hygiene and housing pattern found in the camp.

Conclusion

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

This research was able to find out that 83% of the IDPs in the camp were of the vulnerable group and were predisposed to health risks like inadequate sanitation and hygiene, inadequate vector control and sub-optimum nutrition. However, they had an adequate water supply, immunization, housing, health officials, drugs and good referral system for severe cases.

Overall, the research was able to establish that the camp officials grossly satisfied Principle 18 but did not satisfy Principle 19 of the United Nations Guiding Principles on Internal Displacement. The research was unable to compare the camp condition to those of neighbouring ones and was unable to assess the nutritional status of children Under 5 years amongst the IDPs. More researches need to be done in these areas.

Recommendations

- i) The Yobe State Government and State Emergency Management Agency should keep up the hard task of providing optimum conditions for IDPs in the camp so as to reduce their vulnerabilities to health risk.
- ii) Health education should be made a priority in the camp so that IDPs will be taught more about environmental health, sanitation, hygiene and reproductive health and services available at the camp clinic.
- iii) The officials of the Yobe State Emergency Management Agency should make it an obligation to familiarize themselves on the United Nations Guiding Principles on Internal Displacement, resolutions of the Kampala Convention and National Policy on Internally Displaced Persons in Nigeria with the aim of applying these in the management of IDP camps. They should also ensure those managing the camps are taught about these principles.
- iv) More research on the needs assessment of internally displaced persons by indigenous researchers should be encouraged and even sponsored by agencies responsible for IDPs.

Contributions to Knowledge

- i) A modest attempt that provided a systematic procedure for health needs assessment in IDP camps.
- ii) Location of IDP camps within proximity to the seat of power and use of camp officials who are related to and familiar with the IDPs go a long way in providing essential services to the IDPs in the camp.

(A Publication of Tansian University, Department of Philosophy and Religious Studies)

References

- Borton, J., Smith, M., Otto, R. (2015). Support for Internally Displaced Persons; Learning from Evaluation. *Synthesis Report of a Joint Evaluation Programme*: 46-55.
- Depoortere, E. and Brown, V. (2006). Rapid Health Assessment of Refugees or Displaced Population. *Medecins Sans Frontierers*: 1-16.
- Durosaro, I. A. and Ajiboye, S.K (2011). Problems and Coping Strategies of Internally Displaced Adolescents in Jos Metropolis, Nigeria. *International Journal of Humanities and Social Science*, 1(20):2-5
- Fagen, P. W. (2011). Refugees and IDPs After Conflict: Why They Do Not Go Home. *United States Institute of Peace Special Report*: 3-9.
- Ferris, E. (2012). Internal Displacement in Africa: An Overview of Trends and Opportunities. *A paper presented at the Ethiopian Community Development Council Annual Conference*: 6-12.
- National Policy on Internally Displaced Persons (2012). Federal Government of Nigeria: 16-42.
- Global Overview (2014). People Internally Displaced by Conflict and Violence. *International Displacement Monitoring Committee (IDMC)*: 8-64
- Global Overview (2015). People Internally Displaced by Conflict and Violence. *International Displacement Monitoring Committee (IDMC)*: 18-40
- Hall, S. (2014). Displacement Dynamics: IDP Movement Tracking, Needs and Vulnerability Analysis, Herat And Helm. *International Organisation on Migration, Kabul*: 16-18.
- International Organization on Migration (2015). Displacement Tracking Matrix Round II Report on Nigeria: 2-11.

- Kampala Convention (2009). African Union Convention for the Protection and assistance of Internally Displaced Persons in Africa. *African Union IDP Convention Assembly*, 7-9.
- Lidstone, R. (2007). Health and Mortality of Internally Displaced Persons: Reviewing the Data and Defining Directions for Research Study. *University of Bern Project on Internal Displacement*, 1-10.
- National Policy on Internally Displaced Persons (2014). Poll Report. *Special Edition Poll Report on IDPs in Nigeria*: 1-11.
- Norwegian Refugee Council (2014). Nigeria: Multiple Displacement Crises Overshadowed by Boko Haram. www.internal-displacement.org
- United Nations' Office for the Co-ordination of Humanitarian Affairs (2008). Guiding Principles on Internal Displacement, 1-8. www.ocha.unog.ch/Humanitarian-reform
- United Nations' Office for the Co-ordination of Humanitarian Affairs (2015). Nigeria: Humanitarian Need Overview: 3-15 www.ocha.unog.ch/Humanitarian-reform
- Olagunji, O. (2006). Management of Internal Displacement in Nigeria. *A project thesis of Brandeis University*: 1-4, 43-45.
- Tajudeen, A.O., Adebayo, F. O. (2013). Issues of Refugees and Displaced Persons in Nigeria. *Journal of Sociological Research*. Vol. 4 No. 1.
- United Nations Humanitarian Commission Refugees (2007). Handbook for the Protection of Internally Displaced Persons. *Global Protection Cluster Working Group*: 2-17.
- USAID (2015). Health and Social Needs among Internally Displaced Persons (IDPs) in Iraq. Assessment Report. 1-6