SITUATIONAL ANALYSIS AND NEEDS ASSESSMENT OF MATERNAL NEWBORN AND CHILD (MNCH) SERVICES IN INTERNALLY DISPLACED PERSONS (IDPS) CAMPS IN YOBE STATE
SITUATIONAL ANALYSIS AND NEEDS ASSESSMENT OF MATERNAL NEWBORN AND CHILD (MNCH) SERVICES IN INTERNALLY DISPLACED PERSONS (IDPS) CAMPS IN YOBE STATE

Conducted By
Network for Health Equity and Development (NHED)

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Contact Us:
3rd Floor, Abia Plaza Plot 979
Off Ahmadu Bello way, Cadastral Zone A0 CBD, Abuja.
Tel: +2348180324263, +2347046090416 E-mail: Info@nhed.org.ng
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**Abbreviations/Acronyms**

ANC  Antenatal Care

FGDs  Focus groups discussions

FP  Family Planning

HeRAMS  Health Resources Availability Mapping System

HMIS  Health Management Information System
IASC  Inter-Agency Standing Committee
IDP   Internally Displaced Population (IDP)
KII   Key informant interviews
MCH   Maternal and Child Health
MNCH  Maternal, Newborn and Child Health
NGO   Non-Governmental Organization
NHED  Network for Health Equity & Development
SEMA  State Emergency Management Agency-SEMA
SMOH  State Ministry of Health
STI   Sexually Transmitted Infections
WCBA  Women of Child Birth Age
WHO   World Health Organization

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1: Introduction

NHED is a young and emerging not-for-profit organization established to provide health systems strengthening interventions and to implement health related programs for a wide variety of clients at national, state and community levels. The organization is registered by the Nigerian Corporate Affairs Commission as a company limited-by-guarantee under the companies and allied matters act of 1990.

Our vision is to become the leading truly indigenous collection of committed health and health-related professionals that are passionate in promoting and carrying out reliable and effective home-grown health/health-related solutions to enhance health equity
and development in Nigeria. Our mission is to contribute significantly to the use of effective and efficient pro-poor health interventions to improve the lives of the marginalised and powerless Nigerians thereby significantly contributing to the transformation of the Nigerian. In doing this we shall draw on local knowledge and expertise that hinges on international norms and best practices.

Our core values include: promoting equity and excellence; people-centered programs; transparency and accountability; patriotism and innovation.

In 2012, NHED established a working business relationship with HPI, an acknowledged global leader in the provision of technical assistance in the area of health systems strengthening particularly as it relates to improving healthcare access to the poor which we now leverage to ensure international best practice.

We focus on following services- advocacy and social mobilisation for accountable and equitable health and other social determinants of health, training and capacity building on a broad spectrum of health and health system issues; social research and organizational/impact assessments; monitoring and evaluation; program management.

NHED was moved by compassion for the plight of people, especially the women and children in IDP camps in the North East region of Nigeria resulting from years of attacks from insurgents. The decision by NHED to carry out an assessment of the health and health related needs of the women and children was two-folds: i) to create awareness about the nature and size of the problem and; ii) to provide evidence-based solutions that will inform cost-effective preventive, promotive and curative policy and practical interventions for the benefit of these marginalised groups in IDP camps.

This document provides a graphic picture of the health situation in IDP camps in Yobe State, one of the States in the NE region. It also provides practical recommendations which policy makers and health managers in government and the development sector,
private and civil society organisations can carry out to get value for money and investment on the people residing in IDP camps and in similar places.

NHED is willing to engage with government institutions, development partners, civil society organisations, private sector and communities to ensure effective implementation of all or any of the proposed recommendations.

2: Background

2.1: The Boko Haram insurgency in Yobe State

Yobe State since 2010 has experienced attacks from the militant group popularly known as Boko Haram (Western education is sin). Initially the group targeted the police and churches, but from 2012 the attacks — bombings, military raids and robberies — expanded to target mosques, schools, hospitals, and banks. The situation created much fear and panic amongst the citizens. People left their homes and migrated to apparently safer locations. This significantly disrupted livelihoods as people were displaced from their land and other places of work. Security concerns and travel restrictions imposed by the state severely curtailed opportunities for commerce. As the insurgency evolved, the Boko Haram terrorists started burning villages and kidnapping community leaders.

Many local and international organizations terminated their operations in the state due to the terrorist’s attacks. The health system has been majorly affected by these events. Health workers, especially those not indigenous to Yobe, have fled to other states.
Indigenous workers are generally reported to have only temporarily abandoned their work places during spikes of insecurity, returning when the situation improved. Some health facilities have been directly attacked, with insurgents taking away drugs, hospital equipment, ambulances and their vehicles.

These attacks led to internally displaced population (IDP) of over 116,595 living in host communities and about 40,177 IDPs camped in five (5) locations within the state (source: State Emergency Management Agency-SEMA, SMOH Data base). The main objectives of setting the IDP camps is to provide shelter, food, water and sanitation to the IDPs in the camp, to prevent outbreak of diseases in the established camp to identify and treat any illness among the IDPs in the camp among others.

2.2: IDP Groups and Camps in Yobe state.
In the last nine months there have been emergence of IDP camps in Yobe state. The population of these camps has fluctuated. For this assessment the two largest camps were selected: Pompamari and KukaReta camps. Camp structure in all sites is more or less the same where by primary schools were converted to camps with the exception of the Kukareta which extended beyond the school. There is a central location with community and health care buildings (in the large camp in Kukareta there are smaller annex buildings in the camp). The camps are divided into zones based on gender (Male-Female) and the zones include blocks with block leaders. Every block includes approximately 20-30 persons. In most case the IDPs are from the same community/village and their respective village head continue to serve it responsibility. Details of the camps established with dates and areas where they came from were summarized below: Table 1: Description of the camps

<table>
<thead>
<tr>
<th>S/N</th>
<th>NAME OF IDP CAMP</th>
<th>LOCATION</th>
<th>DATE ESTABLISHED</th>
<th>CATCHMENT POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pompomari Pri. Sch. IDP Camp</td>
<td>Damaturu</td>
<td>1st April, 2015</td>
<td>Gujba</td>
</tr>
<tr>
<td>S/N</td>
<td>NAME OF CAMP</td>
<td>ADDRESS</td>
<td>TOTAL POPULATION</td>
<td>ESTIMATED WCBA</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------</td>
<td>----------------------------------------------</td>
<td>------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>1</td>
<td>Pompomari IDP Camp</td>
<td>Pompomari primary sch. Damaturu</td>
<td>3,011</td>
<td>662</td>
</tr>
<tr>
<td>2</td>
<td>Kasaisa IDP Camp</td>
<td>Gujba road, Damaturu out sketch</td>
<td>2,700</td>
<td>594</td>
</tr>
</tbody>
</table>

Based on the recent census of all the camps in the state below are the characteristics of the inhabitant as at February 2016.

**Table 2: Demographic Composition of IDP Camps in Yobe State as of February 2016**
<table>
<thead>
<tr>
<th></th>
<th>KukaReta IDP Camp</th>
<th>KukaReta, 35KM along Maiduguri road</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>34,070</td>
<td>7,495</td>
<td>1,704</td>
</tr>
<tr>
<td>4</td>
<td>Geidam IDP (Transit) Camp</td>
<td>Geidam town</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Bukar Ali Ibn Elkanemi IDP Camp</td>
<td>3-Bedroom estate along Gujba road Damaturu</td>
<td>391</td>
<td>86</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td></td>
<td>40,177</td>
<td>8,839</td>
<td>2,009</td>
</tr>
</tbody>
</table>

**WCBA** = *Women of Child Birth Age*

**IDP** = *Internally Displaced Persons*

### 3: Aim and objectives of the study

This assessment is part of NHED’s policy of contributing towards health equity especially for the marginalised groups in resource scarce and insecure settings. The project is part of the activities to develop, implement and evaluate a model of comprehensive services for Maternal, Newborn and Child Health (MNCH) within existing state ministry of Health (SMoH) -supported care structures for IDPs.

**Aim:** The aim of the assessment was to use the continuum of care model as a framework to improve the level of understanding of the MNCH problems the IDPs face and how IDPs and staff from health and community services in the camps currently cope with and respond to these problems. Such information will be used to strengthen MNCH interventions in Yobe state where we did the investigation. The principles can also be applied in other IDP camps.
The project has three specific objectives:

1. To review the MNCH activities and intervention package in the IDP camps setting in order to formulate lessons learned, and to provide recommendations for scaling up MNCH in IDP camps and in other resource scarce and insecure environments.

2. To develop an intervention package for MNCH in IDP settings in Yobe state. Such an intervention package should be comprehensive to address the range of preventive, curative and re-habitation issues. In addition, it should be limited in scope, with a sociocultural fit that also ensures value for money as the health care system is already burdened by many other priorities. This intervention model could serve as a framework for other IDPs camps especially in the north-east geopolitical zone of Nigeria.

3. To strengthen the capacity of health staff and to strengthen partnerships in health and community services in IDP settings in Yobe state through training and technical assistance support in MNCH services.
4: Methodology and approach

4.1: Descriptive and qualitative methodology

The project assessment used explorative and descriptive methods. This assessment used relevant sections of World Health Organization’s (WHO) Health Resources Availability Mapping System (HeRAMS) tool. HeRAMS was developed as a health facility assessment tool to monitor the availability of health services across a large, remote, and largely inaccessible area with frequent disruptions to the availability of health services.

4.2: Guiding principles for the assessment

In developing the methodology we were guided by the principles as described in the WHO guidelines on MNCH Support in Emergency settings. These were:

a) Use a participatory approach, giving due attention to the views of the IDPs themselves.

b) Involve a variety of stakeholders: The respondents included various stakeholders (State Emergency Management Agency (SEMA), implementing partners and IDPs with potentially diverse or conflicting views. This method of selecting different actors ensured that the information generated is context-specific.

c) Strive to be inclusive. The assessment involved all sections of the IDP population including children, youth, women, and men.

d) Use a multi-level perspective. Our assessment addressed stages of socioecologic model and showed the dynamic interactions between those stages.
4.3: The assessment considered:

a) Respondents’ perspectives on MNCH problems related to the IDPs in Yobe state.

b) Existing support structures and services (individual social support systems, community action, NGO and governmental capacities).

c) Clinical skills and competencies of service providers.

4.4: Recruitment and training of assessment team and finalisation of data collection tools

The NHED research team selected a team of two interviewers to collect data from the respondents. The criteria for selecting them were: 1) previous experience in undertaking qualitative data collection, 2) experience with MNCH projects, 3) familiarity with Yobe State environment, especially experience working with IDPs and 4) being able to speak English, Hausa and preferably Kanuri.

The interviewers were trained over two days. The first day of training was used to cover three topics: Losses; Education; Health; and other findings. On the second day, relevant probing questions for each of the three themes to be covered in the interviews were formulated with special emphasis on health. At the end of the training, topic guides for FGDs and individual interviews were developed (see Annex1).

4.5: Data collection techniques

a) Focus groups discussions (FGDs)

FGDs were held with several groups from the IDP population: Mothers; Women of reproductive age group; and Fathers. Males and females had separate FGDs. FGDs
were conducted in the Hausa and Kanuri languages. Therefore, no interpreter was needed. A FGD ranged from 45 to 60 minutes.

Each FGD was led by the two trained two interviewers (one of whom acted as facilitator and the other as note taker. The discussions started with a grand round question, inviting the participants to describe and prioritize the main problems they faced as IDPs. In all FGDs we started with free listing, in which the respondents were asked to mention the problems they face and to prioritize them. The facilitator of the FGDs decided if additional themes (other than those in the topic guidelines) needed to be discussed based on the problem prioritization of the IDP participants. The interviewers took verbatim notes of the responses.

One of the themes in the FGDs was maternal and child health problems. This topic was introduced with an open question, ‘tell us about maternal and child health problems in the camp’, and when necessary conversation was prompted with some examples given by the interviewers. After a quick inventory of the various conditions the participants faced in the camp, the focus shifted to possible sources for support and treatment.

b) Key informant interviews

We held individual interviews with key informants among the IDPs: care providers of the NGOs; members of the SEMA; camp leaders; policemen; healthcare providers from the IDP groups; traditional healers; and religious leaders in the camps. It was not feasible to conduct individual interviews with all members of the SEMA or implementing NGOs. The interviewer took written notes during these group interviews.

In the camps individual interviews were held with service providers in the health clinics (1 nurse and 3 community health workers) to get an overview of their knowledge and opinions regarding the treatment of MCH problems. A questionnaire was distributed that had open questions and case vignettes. All respondents were non-specialist health
workers; although, some had previous experience and training in MCH. c) Personal narratives

Personal narratives were collected from clients and help seekers (for MNCH problem,) in order to gain insight into how the IDPs experienced their illnesses or problems, which coping strategies they used, and how they perceived the health care and support in the camps. Health workers and staff from the community services assisted us to establish contact with these clients.

d) Skills assessment

A questionnaire was administered to health workers to assess their experience with/and knowledge of the common MNCH problems of IDPs and how they are recognized and treated. The case descriptions for MNCH problems in the case management guidelines were used to extract an overview of the health workers’ ability to recognize these problems (see Annex2).

e) Health Management Information System (HMIS) records were reviewed to assess the number, type and treatment of common MNCH problems over the last three months was conducted.

4.6: Summary of collected qualitative data

Data was collected in December 2015. In total, six (6) focus group discussions were undertaken in two camps, 8 interviews with key informants. Seven personal or illness narratives were collected in the camps, 11 other exchanges with service providers among those 6 needs and skills assessments were undertaken.

Table 3: Number and Types of Data Collection

<table>
<thead>
<tr>
<th></th>
<th>KukaReta Camp</th>
<th>Pompomari Camp</th>
<th>Total</th>
</tr>
</thead>
</table>

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### Data entry and data analysis

The information was transcribed and translated into English in MS word software package. The analysis of the qualitative data was carried out using Nvivo software.

### Findings

The findings should be considered as a ‘snap-shot of the situation’, which assessed the circumstances and situations associated with MNCH in IDP camps from the lenses of mothers, fathers, boys and girls. The problems the IDPs and the workers face will be firstly elaborated, and then the coping mechanisms that they adopt to solve the problems will be presented. As the findings in both camps were similar, we will discuss
them in general, but if there are particular differences between camps they will be discussed in details.

Table 4 provides an overview of the most important problems the IDPs mentioned. The data is organised according to the main themes we used in the interviews starting with (1) living conditions, followed by (2) Health (3) Losses, (4) Education, (5) violence and (6) skills of the health workers. The IDPs frequently mentioned two main issues: living conditions in the camp and the opportunity for education in the camp. According to the respondents in both camps, living conditions were the source of many other problems.

Table 4: Overview of the most important social problems to IDPs

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Living Condition</th>
<th>Health</th>
<th>Loss of financial, material and lives</th>
<th>Education</th>
<th>Violence</th>
<th>Other</th>
</tr>
</thead>
</table>

Inside view of one of IDP accommodation hall.
| KukaReta Camp | | | | | |
|----------------|----------------|----------------|----------------|----------------|
| Mothers        | X              | X              | X              | X              |
| Fathers        | X              | X              | X              | X              |
| Girls          | X              | X              | X              | X              |
| Pompomari Camp | | | | |
| Mothers        | X              | X              | X              | X              |
| Fathers        | X              | X              | X              | X              |
| Boys           | X              | | | |

**Living conditions**

The living conditions identified as a problem were often seen by the IDPs and caregivers as the major cause of the burden and healthcare service delivery on MNCH issues. In line with the exposition on the social determinants of health, the IDPs, living conditions can be considered as aspects of the macro level issue that influence the personal health and wellbeing of the people and in return, weak or bad health problems that can deteriorate living conditions. Two main issues were mentioned consistently: (1) lack of privacy; and (2) poverty.

**Lack of Privacy:** It was remarkable that although the camps in Yobe are very different, all the IDPs complained about a lack of privacy, the quality of the sleeping place and the lack of the usual household setting (member of the same family living together). The respondents stated that the lack of family cohesion and togetherness was as a source of many of their problems. The IDPs stated that although their halls of residence were gender specific, whenever you want to see your family, access becomes problem. …*we were caged from coming in contact with our wives, no privacy*- FGD discussant. Other
aspects of privacy which participants may not voice out easily include gender and sexually related issues and the like

**Poverty:** Poverty was mentioned in all FGDs and was linked to the lack of opportunities to generate income. Generally, the husbands do not have many meaningful activities during the day. This has serious consequences for their relations with their wives. According to the cultures in northern Nigeria, the man is head of his household and he receives respect from his wife and children when he is able to take care of them. A man who is in a camp is unable to fulfil his role and this is perceived his losing the position and respect as head of the family.

---no work to do we left our farmland and cows are gone -FGD discussant

**Education**

As shown in Table 4, both parents and the children considered lack of educational opportunities as a major problem in both camps. Hence, an important problem was that children and youth felt restricted in their educational possibilities. The IDPs saw the limited options for education as a major barrier for the future of their children and youth. The problem that was visible in the camps was the lack of educational intervention for children, who in turn just hang around in the camps.

**Loss of lives, finances and material possessions**

Many families lost their relations, material and financial possessions when they arrive in the camp because most of them lost all their property, their jobs, cows, earnings, their social position and respect. The people expounded that they felt very sad because of all the losses. Women talked about their personal losses, which were often severe as in the case of a woman in the FGD in Kuku Reta: ‘I have no future I give birth to eight children and I stay only with 2 daughters, all boys died during the crisis’
Women in a FGD had the following expressions when we talked about the emotions connected to their losses: ‘I am afraid; I feel it would be better for me to die. I feel that nothing interests me’, and I have sleep difficulties’

It appears that men were more focused on their material losses and the loss of their social position. Most men wanted to go back to their communities where they had a good life.

**Maternal Health Problems**

The types of MCH problems that were commonly mentioned by the respondents corresponded roughly with the major causes of maternal and child mortality. The maternal health problems included abortion (post-abortion related problems), bleedings, eclampsia (Gigiga) and prolonged and obstructed delivery (KukaReta). The women mentioned that many women lost their pregnancy on the way to the camp. As one FGD participant stated:

“I was crying four pregnant when we were asked to leave because of the crisis, we walked for 2 days to arrive here and my baby stop kicking, a day after I lost the pregnancy, a boy which I have been wanting for”. (Personal narrative).

**Another FGD participant stated:**

“I had a still birth but the placenta wouldn’t come down and it was in the night, we have to stay all night long before I was transported to Damaturu were I got treated and transfused. Thank God am still alive because we lost two women during process of Delivery”. (Personal narrative)

During the discussion, the participants were asked whether they needed any form of child spacing and the methods available to them. One man mentioned “Condoms were administered to us free but no space and privacy to use it”. This is suggesting willingness to use if the condition or situation prevailed.
In both camps, there were no sexual and gender-based violence (SGBV) units. The SGBV units offer practical support, legal aid, and counselling for individuals, couples and families. For many health care workers it is often difficult to raise the question with IDPs of violence and if it is involved in their complaints, especially sexual violence.

According to a camp staff, there was no SGBV awareness program there was on going. However, the staffs of all camps admitted that due to the culture of keeping such cases secret, there was no clear view of the situation. According to a respondent “There is need to establish such SGBV units to provide programmes in the field of peace education, reproductive health, gender and human rights, and girls’ education” (Health staff).

Child Health

The most common reported causes of illness among children during the early influx phase were diarrheal diseases, measles, acute respiratory infections, malaria, and other infectious diseases.

Intestinal parasites that were linked to diarrheal diseases were strongly associated with crowding, sources of drinking water, and poor sewage networks. These poor conditions were experienced in camps due to overcrowded conditions with sewage and wastewater flowing in open channels posing serious environmental health hazards. It was common for children to play in and around disposal sites, putting children at a high health risk, as contamination of children’s hands is significantly correlated with the incidence of diarrhoea.

Diarrheal diseases have been mentioned in both camps as the most frequent menace affecting children. ..... “Diarrhoea has been an issue here may because of the change in food and how is been cooked” (FGD-Mother).

MNCH problems in the health care system – providers’ perspective

*Maternal and child health knowledge and skills among health care providers*
All respondents had some additional training in MCH and said that MCH had been part of their curriculum during their training as health workers.

*MCH problems were seen in daily work as health workers, though not in emergency situations as presented in the IDP camps.*

**Nurses**

All the nurses had in-depth knowledge and skills in identifying and treating common maternal and child health problem seen the camps. Nurses defined abortion as termination of pregnancy before age of viability. On specific treatment, nurses described manual vacuum aspiration (MVA) as lifesaving procedure.

Knowledge of modern family planning method was equally satisfactory. However none of the nurses had any special training or course on family planning method and their responses on skill section further corroborated with that. *Maternal Health problems diagnosed in the health care system*

Many maternal health problems were diagnosed and treated.

**Table 5: Maternal Health problems diagnosed in the health care system**

<table>
<thead>
<tr>
<th>Respondent</th>
<th>October 2015</th>
<th>November 2015</th>
<th>December 2015</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KukaReta Camp</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC 1</td>
<td>102</td>
<td>77</td>
<td>78</td>
<td>257 (71.8)</td>
</tr>
<tr>
<td>Abortion</td>
<td>13</td>
<td>4</td>
<td>1</td>
<td>18 (5.0)</td>
</tr>
<tr>
<td>Antepartum Bleeding</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>4 (1.1)</td>
</tr>
<tr>
<td>Skill Birth Attendant</td>
<td>18</td>
<td>21</td>
<td>26</td>
<td>65 (18.2)</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>3 (0.8)</td>
</tr>
<tr>
<td>Retained Placenta</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>3 (0.8)</td>
</tr>
<tr>
<td>Postpartum Bleeding</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>4 (1.1)</td>
</tr>
<tr>
<td>Family Planning</td>
<td>-</td>
<td>3</td>
<td>2</td>
<td>4 (1.1)</td>
</tr>
<tr>
<td>STI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Gender Based Violence</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td>358 (100)</td>
</tr>
</tbody>
</table>
Child Health Problems Diagnosed in the health care system

Many child health problems were diagnosed as summarised in Table 6 below

Table 6: Child Health Problems Diagnosed in the health care system

<table>
<thead>
<tr>
<th>Respondent</th>
<th>October 2015</th>
<th>November 2015</th>
<th>December 2015</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KukaReta Camp</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrheal Diseases</td>
<td>186</td>
<td>207</td>
<td>193</td>
<td>586 (30.5)</td>
</tr>
<tr>
<td>Acute Respiratory Infections</td>
<td>141</td>
<td>197</td>
<td>211</td>
<td>549 (28.6)</td>
</tr>
<tr>
<td>Malaria</td>
<td>159</td>
<td>117</td>
<td>183</td>
<td>459 (23.9)</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>93</td>
<td>77</td>
<td>87</td>
<td>257 (13.4)</td>
</tr>
<tr>
<td>Measles</td>
<td>7</td>
<td>14</td>
<td>9</td>
<td>30 (1.6)</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Others</td>
<td>13</td>
<td>20</td>
<td>8</td>
<td>41 (2.1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td>1922 (100.0)</td>
</tr>
<tr>
<td><strong>Pompomari Camp</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrheal Diseases</td>
<td>34</td>
<td>37</td>
<td>29</td>
<td>100 (24.8)</td>
</tr>
<tr>
<td>Acute Respiratory Infections</td>
<td>39</td>
<td>28</td>
<td>31</td>
<td>98 (24.3)</td>
</tr>
<tr>
<td>Malaria</td>
<td>40</td>
<td>38</td>
<td>44</td>
<td>122 (30.3)</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>20</td>
<td>21</td>
<td>58 (14.4)</td>
</tr>
<tr>
<td>----------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>-----------</td>
</tr>
<tr>
<td>Malnutrition</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Measles</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>8 (2.0)</td>
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<tr>
<td>Mental Disorders</td>
<td>-</td>
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</tr>
<tr>
<td>Others</td>
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<td>7</td>
<td>17 (4.2)</td>
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<tr>
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<td></td>
<td></td>
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<td>403 (100.0)</td>
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6: Discussion

In this need assessment we have tried to find answers to the question of how to improve the MNCH of the IDPs in the camps in Yobe state. We used a broad approach by focusing on the social constructions and problems the IDPs’ experience. Using the framework of the continuum of care model it became clear that the dynamics between processes and situations on the macro level, such as the political decisions of the host country and the SEMA, as well as the specific situation in the IDP camps causes mothers and children problems on the meso and micro level. We know that social factors are major determinants of MNCH problems. All the preliminary results were discussed with the SEMA team and NGO staff involved in the two camps.

According to Patel, three key social determinants of health are risk factors for MNCH. The first is poverty, since MCH problem is a family problem which can disrupt productive and hence leading financial hardship. The other two are social exclusion and violence. In addition to the consequences of insurgency or other disasters - loss of property, trauma and displacement are major risk factors for maternal and child health problems. We will discuss these important aspects of our assessment, but it is important to bear in mind that the process has a looping effect: problems in people’s health can result in problems in the society. For the same reason, problems in a society can result in health problems for the individual; the process is interrelated. It is
remarkable that the IDPs and the stakeholders in the camps gave us the same picture and most problem issues were reported across all the camps we visited.

**Lack of social space to express suffering**

We felt a strong motivation among the refugees to share many of their problems in the focus groups. People were eager to reveal their situation to us and to each other. IDPs, living in the artificial setting of a camp, often have limited options to find support and an audience for their problems. The IDPs, especially women, lack any form of cultural support system, which is normally provided by their extended family.

There is limited space for people in camp to express themselves and share their feelings and experiences because of a lack of structure in which they are allowed to speak. Lacking a forum for expressing themselves, focus group participants’ identified the need to be heard. However, this finding also points towards the strength of groupbased interventions. Many the participants in FGD group enjoyed the discussion session and that it’s a source of relief to them……having an opportunity to express our concerns and feelings not only someone to listen to is very important –FGD.

**Disempowerment and loss of agency**

An important aspect of psychosocial wellbeing is the feeling of ‘ownership’ of one’s own situation and future. Many respondents emphasized how the context of a IDPs camp (poor food distribution, inability to work or restricted environment) significantly restrained their ability to find work and continue their education, and thus to improve quality of their lives including MNCH. This situation frequently led to nutritional related problem and all trigger or further fuelling the vicious cycle of poverty- ignorance and diseases. Also IDPs have learned to behave dependently, even when opportunities to improve their circumstances exist. The phenomenon has been described using other terms, such as ‘the refugee dependency syndrome’ (Berckmoes, 2006). Dependency is a central element in the worldview of IDPs, which results in the feeling that their future is blocked and it’s expressed as a kind of loss of their future. This highlights the
importance of a structured citizens voice and other psychosocial support services to IDPs.

**Sexual and gender-based violence**

Gender-based violence is defined by the IASC (2005, p. 7) as ‘an umbrella for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females’. Respondents in all camps did not mention any levels of gender-based violence. In the religious and conservative northern Nigerian milieu, GBV has largely not been addressed. Incidents of GBV are not reported or recorded at health facilities. It is clear, however, that traditions and customs are driving harmful practices. Reports from other similar setting across the globe have captured various forms GBV. In our situation no any structure exists in the camps specifically addressing GBV. While guidelines were developed by UNHCR and UNFPA to manage GBV in 1999, training and monitoring mechanisms were not established to promulgate the guidelines and to provide assistance to survivors. However, in December 2002, UNHCR launched an initiative to establish programs to address the prevention and management of GBV occurring inside the camps.

**Family Planning**

Family Planning services are not functional because none of the camp clinic has a complete contraceptive supplies. The most widely available methods are oral pills and injectables contraception. Staff requires refresher training in modern contraception technology, communication and counselling skills. Overall service point registers indicate the number of current users is very low and discontinuation of use exists. Only a nurse is knowledgeable about emergency contraceptive. Similarly one of all the clinics has some post-abortion care services but little attention is given to postabortion counselling for FP.
Sexually Transmitted Infections and HIV/AIDS

All the staff has not received refresher training and lack proper equipment and supervision to adhere to universal precautions to prevent the spread of HIV/AIDS and other infections through blood and bodily fluids. Water and soap were available for hand-washing between client’s inpatient exam rooms. Condoms were available at all camp clinics visited. However, women refuse to take condoms home as they are unable to negotiate condom use with their partners.

Health providers acknowledged treating cases of STI but no such record was captured in their register and they demonstrated no idea on syndromic management of STIs. Separate registers for STIs are not maintained and protocols and guidelines for syndromic approach and counselling services are not available. Information, education and communication materials on STI/HIV/AIDS prevention are also unavailable.

Children Mental Health

War induced trauma, displacement, immigration, and chronic poverty are a few factors that place IDP children at heightened risk for psychological problems. Children may witness family members or other people being physically assaulted, sexually assaulted, or killed. Furthermore, in war torn communities children may see gruesome injuries or deaths due to bombings. The psychological consequences of these are sleep disturbances, aggressiveness, anxiety and depression and concentration failures. When parents of IPD children are killed or adversely affected, children are especially at risk for mental health issues. Children are not only impacted by what they see and hear; they are also profoundly affected by their own personal experiences. The healthcare providers were asked about symptoms and signs of posttraumatic stress disorder (PTSD) none of them had good knowledge nor the skills to recognise this condition.
Malnutrition

In both camps we found nutrition interventions that were mainly for treatment based on initial screening conducted. The programmes are isolated with little community component. The number of children with severe acute malnutrition that are currently on treatment is relatively small, however the number of those with mild to moderate malnutrition is not known and no intervention to identify and prevent progression to severe forms. Food rations provided to families in camps tend to be too small to meet a healthy caloric intake, leading children to become malnourished and more susceptible to disease.

...“The food we are receiving is small and monotonous but thank God a bigger has no choice FGD

Furthermore, even though a child may enter a camp adequately nourished and in good health, he or she may develop acute malnutrition due to inadequate food rations or severe epidemics of diarrheal disease. This calls for a sound and transparent system for the transport, distribution and rationing of food.
Sanitation & Communicable Diseases

The most common reported causes of illness among children in both camps have been diarrheal diseases, acute respiratory infections, malaria, and other infectious diseases. These diseases are strongly associated with crowding, sources of drinking water, and poor sewage networks. These poor conditions are experienced by IDPs in both camps posing serious environmental health hazards. Children were observed to be playing in and around disposal sites, putting children at a high health risk, as contamination of children’s hands is significantly correlated with the incidence of diarrhoea.

Furthermore, children with diarrhoea are likely to experience other negative health outcomes such as dehydration, which can quickly become fatal when paired with malnourishment. Therefore, it is evident that, efforts to improve water supply and sanitation in camps need to be broadening to prevent potential catastrophe such a cholera outbreak among other.

Problems in service delivery

*Improving the organisation of health services*

In the camps there is a tendency to organise health services targeting specific groups/issues (nutrition, family planning) to work in silos. Integrated health services where all health interventions are under one roof can have multiple benefits like the unifying effect by crossing the boundaries between various service providers, enhance task shifting and sharing, reduce duplication, improve efficiency and effectiveness as well enhance referral system. As we have discussed, most IDP problems are interrelated and are difficult to isolate from the context of the camps. Therefore solutions to problems are often complicated and challenging to offer. Professionals working collaboratively provide more insight and increased opportunities for effective support than those working in silos. *Improving community support*

A reasonable support system for IDPs is a condition that is needed for good health and good health care and a prerequisite for social wellbeing. The results of this assessment
show that many of the problems we documented were directly related to the respondents’ IDP status. In both camps there are no activities to improve the community support, to reduce poverty and to train or educate. These lead to lack personal connectedness in the camps. This is especially important because the original support system, the extended family, is scattered by the insurgency and is not available in the camps. New support systems have to be developed. The IDPs do not find their way to camp health care centres easily, due to their cultural habits for coping, which involve doing nothing and digesting their suffering. Family and child empowerment programmes are initiatives that are important in raising community voices, improving capacity for community management of stress, and the joint identification and implementation of solutions for the needs of the different groups like adolescents, children and the elderly in the IDPs. This is vital and must put in place to promote community support systems.

**Improving the skills of health staff**

In all camps we noticed that health staff providing MCH support services tend to offer advice rather than to assist the individual to make informed choices. We advised training counsellors on the difference between offering advice or counselling the clients and families about their options, particularly in reproductive health issues. Orientation and refresher training of health workers working in IDP camps is therefore important to improve the quality of health services including the ability to identify stress related psychosocial and other mental conditions for appropriate support.
7. Conclusion

We have tried to demonstrate the complex relationship between the context of the IDPs and their wellbeing and MCH health. The root problems cannot be solved by simple interventions and indeed while the problems are being increasingly recognized by expert, often their solutions go beyond the capacity of SEMA to change. We see that MNCH has several determinants. For example, poor living condition may cause increase incidence of childhood communicable diseases such as diarrhoea and acute respiratory infection.

We have demonstrated a variety of expressions of the same concept: health and the distinct relationships between health and factors that may influence health outcomes. Because the focus of this study was on the actual MNCH status and the subjective experiences of IDPs, we now focus our interventions only on MNCH support. We realize that by doing so, we do not offer adequate solutions for all the problems because the sources of their problems are beyond our assignment, scope and government policies. However, we do provide information for a multidisciplinary approach to these complex problems. In the following paragraphs we propose and recommend issues for interventions to improve the MNCH care of IDP camps in Yobe state.
8: Recommendations and policy implications

In this section we provide recommendations for possible MNCH interventions in IDP camps in Yobe state. The package of interventions in the field of MNCH can be centred around three key elements:

1) **Clinical care** with focus on the orientation and retraining of health workers in IDP camps and those working in resource-scarce environments on reproductive health, obstetric care, and care of sick new-born babies and children.

2) **Strengthen health governance** in IDP camps and in resource-scarce environments to ensure integrated family and community care through the lifecycle approach. These packages will be implemented to fit each specific context as “no one size fits all”.

3) **Strengthen community support systems** in order to raise community voices and improve the capacity of the community to handle stress including the joint identification and implementation of solutions for the needs of the different groups like adolescents, children and the elderly in the IDPs.

**Policy Implications**

Providing support to IDP children and their families is a multi-faceted initiative, as IDPs need shelter, protection, food, water, safety, health services, as well as educational resources for children. Government and NGOs are currently providing some of these interventions in parallel manner. Also, in many cases resources are not sufficient for IDPs to maintain a healthy lifestyle within their respective camps. This discrepancy may be a result of having no guidelines declaring the minimum that camps need or how long camps should be provided with aid. There is need to coordinate these assistance efforts by constituting an Inter-Agency Standing Committee (IASC) to bring together all major humanitarian agencies and monitor implementation as well as widely disseminated monitoring reports to stimulate positive action, both within and outside the
government system. The committee should be chaired by the SEMA; the IASC should develop policies and share responsibilities among humanitarian agencies. Adopting the effort to standardize humanitarian initiatives by United Nation called “The Humanitarian Charter and Minimum Standards on Disaster Response” guidebook can be a starting point.
References


