COMMUNITY DEVELOPMENT IN EMERGENCY SITUATION: A CASE STUDY OF INTERNALLY DISPLACED PERSONS IN BORNO STATE

BY

Augusta O. Okwute (PhD)*[1] Amina Sanda (PhD)[2] Musa Usman (PhD)***[3]**
Department of Continuing Education and Extension Services University of Maiduguri

ABSTACT

The rate at which people and community are been displaced by either natural disasters or act of terrorism is quite alarming, presently, there are over 2.1 million internally displaced persons (IDPs), representing more than 300,000 households in parts of northern Nigeria. This is according to fifth round of the Displacement Tracking Matrix (DTM) report produced by the International Organization for Migration (IOM). The recent spike in attacks by insurgents in north eastern Nigeria has given rise to steady increase of displacement in the country. The main issue here is how are these people (IDPs) been taken care of; what are the measures taken by government, community and NGOs to resuscitate and develop them. These pending questions prompted this research work. This study was carried out among the internally displaced persons in Borno State. The objective of the study was to determine the needs of the internally displaced persons in emergency situation. Three camps located in Maiduguri Metropolis namely; Dalori I, Arabic Teacher's College and Bakassi Camps were used in the study. The population of this study comprised of 7,243 displaced adults. Through random sampling technique, 764 adults were used as the samples for this study. Data was collected through questionnaire and analyzed using frequency distribution, percentage count and chi-square. The result revealed that provision of health care services and facilities, education and vocational training needs are required for community development in emergency situation. Thus, the study recommends that agencies responsible for the welfare of IDP's (Government and Non-governmental agencies) at both national and international level should make these provisions for IDPs when they have overstayed in the camps.

Keyword: **Community development, Emergency situation, *needs* internally displaced persons**

INTRODUCTION

The issue of people abandoning their homes and livelihood (internally displaced person) due to civil conflict, natural or economic disaster and other threats is no longer news. Internally displaced people (IDPs) are people or group of persons who have been forced or obliged to flee or to leave their homes or place of habitual residence in particular as a result of or in order to avoid the effect of armed conflict, situations of generalized violence, violations of human rights or natural or human made disasters and who have not crossed an internationally recognized state border (1998 guiding principle on internal displacement).

According to global review (2015) estimated 15 million people are internally displaced in West African countries at the end of the year 2015. Among these countries, Mali, Niger, Senegal, Togo, while Cameroun and Nigeria held the highest number of displaced persons with at least one million. One of the severities of displacement in addition to casualties is the extent to which persons have been displaced from their communities. People are forced to leave when they do not feel safe when coping strategies such as when the hiding and negotiating with warring groups failed (Ferris

and Winthrop 2010). Displacement can occur in three basic ways, such as: when the people are caught in crossfire, confrontation between insurgent groups and government forces and if the armed group attack communities and any anticipated attack by armed group. In such situations many communities will be forced to flee their homes and livelihood and move to a safer place. While forced displacement is a humanitarian crisis, it also has significant developmental impact affecting human and social capital, economic growth, poverty reduction efforts and environmental sustainability (World Development report 2011).

The displaced are faced with family's breakup and communities tiers. They are unemployed, limited access to land, education, food and shelter. Displacement disrupts the live not only the individual and families concerned but the society as a whole. Both the areas left by the displaced and new settlement also suffer.

Camps are set up to meet emergency needs of displacement apart from those that may decide to live with relations and friends outside the camps. However camps settings are associated with challenges especially when the displaced overstayed more than expected period in the camp. When aid/assistance from the government and other donors agencies were no longer adequate and other needs of the displace starts to emerge.

The situation of inadequate aid/assistance and overstayed displaced in the camp calls for upgrading temporary settlement and improving access to basic services and livelihood opportunities (community development).

Community development in emergency situation thus is the provision and accessibility of necessities of life while in the camp such as health services, education, provision of skill acquisition programmes, improvement on the acquired skill to meet the societal demands all geared towards improving the condition of living within the camp. The camp which now serves as the community of the displaced need to be developed to serve the developmental needs of the displaced.

Education provides physical, psychosocial and cognitive protection that can be both life saving and life sustaining. It offers safe space for learning as well as ability to identify and provide support for affected individual particularity children and adolescents. Education mitigates the psychosocial impact of conflict and disaster by giving a sense of normality, stability (Ferris and Winthrop 2010). According to Zerrougui (1) education in emergency situation saves lives and it serves as a major component of strategies for child protection. It provides children with live saving information; sustain progress already made by patents and communities. In fact, education in emergency situation gives hope and reduces the trauma already suffered.

Another area of community development in emergency situation is health. Displacement of persons has major consequences on the health of the displaced. Apart from the fear and trauma, the new settlement (camps) is often compounded with environmental health issues that affect the health of the displaced. In most cases, children and women are particularly vulnerable to malnutrition diseases and violence. The displaced are faced with overcrowding, poor water and sanitation facilities resulting to diarrheal, acute respiratory infections, malaria, meningitis.

According to article 3(1) (K) of the Kampala convention, it is the responsibility of the state to ensure internally displaced persons protection and assistance. The state must also promote their self-reliance and sustainable livelihood. To any internally displaced person, the key condition is restoring livelihood. Developing economic opportunities relies upon offering training, apprenticeship, job replacement programmes and seed grants for starting up income generating project. Vocational training programmes/or short skills training programmes are also needed by the displaced. Restoration or improvement of livelihood opportunities and provision of health and education services are needed by the internally displaced persons in Borno State; who have

overstayed in the camps. Thus, this study aimed at finding out how these services are being provided to internally displaced persons in Maiduguri metropolitan council of Borno State Nigeria.

2.0 REVIEW OF RELATED LITERATURE

HEALTH

Health is wealth so goes a popular saying. Unfortunately, many do not have this wealth as they strive to attain this state of well being. Injuries and diseases are inevitable and if not properly taken care of can cause gradual deterioration of health and even the death of an individual. Some IDP's have been managing various ailment/sicknesses of varying severity prior to and during displacement. In a situation where they could access primary, secondary and even tertiary health care services to tackle their discomfort before displacement and can no longer access such services raises an alarming concern. This concern is of significant importance as it is the responsibility of the government to help in this situation; as stated in the United Nations 'Guiding Principles on Internal Displacement'. Principle 19 specifically addresses the provision of appropriate heath care, stating:

1. *All wounded and sick internally displaced persons as well as those with disabilities shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention they require, without distinction on any grounds other than medical ones. When necessary, internally displaced persons shall have access to psychological and social services.*
2. *Special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproductive health care, as well as appropriate counselling for victims of sexual and other abuses.*
3. *Special attention should also be given to the prevention of contagious and infectious diseases, including AIDS, among internally displaced persons* (Samantha and Stuart 2004).

In most cases, IDP's do not enjoy the benefits of these principles due to lack of awareness and helplessness during these striving period. For instance, in the study conducted by Deborah and Raoul (2002) on Assessment of Needs of Internally Displaced Persons in Colombia, malnutrition, respiratory illnesses, diarrhoea, parasitic diseases and sexually transmitted diseases were some of the health risks faced by IDP's. These diseases were prone to occur as only about 50% of the total displaced populations are covered by the national social security scheme in Colombia. It was reported that a primary obstacle to receiving health care services is the lack of an identity card. Thus, health institutions were unwilling to provide free assistance to the displaced.

Colombia ranks fourth highest in number of IDPs worldwide after Afghanistan, Sudan and Angola (Refugee Studies Centre, 2002). Children represent 50% of IDPs in Colombia of which 45% are 14 years or younger, while 20% are between 3 and 10 years old. According to the Women's Commission for Refugee Women and Children (1999) majority of these children suffer from some level of malnutrition. A typical example is Turbo (Antioquia Department) where 68% of displaced children in displaced camps are malnourished. On the same note, Deborah and Raoul (2002) clearly stated that children suffer the most serious effects of minimal and irregular medical care: 80% of IDP children do not receive social security or vaccination coverage; for displaced children under 5 this is 20% below the national average (Human Rights Watch, 1998).

Similarly, Robert (2007) conducted a desk study on Health and Mortality of Internally Displaced Persons. The study aimed at reviewing data on related articles and defining directions for research. He stated that in the year 1990, Dr. Michael Toole stated that during 1988, several million people were displaced by the war in Southern Sudan located in various camps in the South Darfur

and South Kordofan. As a result, over 150,000 children died due to the displacement by war. Dr. Michael further cited malnutrition as the cause of death in most cases amongst primary causes like measles, diarrhoea, pneumonia, meningitis, and hepatitis. These have overshadowed severe crowding, inadequate food, water, shelter and sanitation in camps for displaced people which he also noted. However in Sudan, *Medecins sans Frontières* (MSF) in August and September 2004 conducted assessments of mortality and malnutrition for three sites in South Darfur, representing a population of 137,000 IDPs. For two of the survey sites, non-displaced local populations were included in data as aid agencies considered equal vulnerability to IDPs. Crude Mortality rates (CMRs) reported were 3.2 in Kass, 2.3 in Muhajiria and 2.0 in Kalma. For Kass and Kalma, Mortality rates for children under age 5 (U5MRs) exceeded emergency thresholds, and diarrhoea being as the single largest cause of deaths from medical causes (80 percent and 90 percent of deaths respectively).

Medecins sans Frontières (MSF) also conducted health assessments for IDP populations in the Ituri (2005) and Katanga (2006) regions. The Ituri study involved a two-stage household-based cluster survey of 450 families of IDPs (2476 persons) residing in the Tche camp. The recall period of 100 days was divided into two periods, framed by significant events for the population in order to facilitate recall, as well as to reflect the implementation of the MSF emergency response at the midpoint. The study revealed in period 2, diarrhoea accounted for 91 percent of the death of children under 5 years of age. The study concluded that extremely poor sanitary conditions and high population density were factors seriously harming the health of the population.

Furthermore, WHO in collaboration with the Ugandan Ministry of Health and other partners in IDP camps conducted a health and mortality survey among IDPs residing in Gulu, Kitgum and Pader districts, for both recognized and unrecognized camps. The study aimed primarily to estimate CMR and U5MR from January to July 2005, and also to investigate other demographic indicators (population structure, reported causes of death, excess mortality, violent deaths and abductions). The survey revealed an excess mortality rate between 24,000 and 33,000 estimated in the first half of 2005 and malaria ranked the highest amongst the causes of death reported by respondents with 28.5 percent overall and 67.8 percent among children under five. The second highest reported cause of death was AIDS, at 13.5 percent overall, 71.8 percent of which were among adults aged 25-50. In the same vein, in Angola, CRED produced a data review of 88 field surveys in Angola from 1999-2005 that examined differences in health and mortality indicators by 'legal status', comparing residents, IDPs, refugees, and a mixed resident-IDP category (for surveys that did not disaggregate the two). The review revealed an overall pattern of significantly higher mortality and malnutrition rates for IDPs. This was attributed to poor living conditions in transit centres and IDP camps, unsafe water, inadequate sanitation, overcrowding, and increased risk of communicable disease transmission. Lack of access to primary health care, low vaccination coverage and food insecurity were some of the causes of higher IDP mortality through diseases such as measles, fever and diarrhoea which greatly affected the IDPs disproportionately.

Meanwhile Health Cluster (2014) conducted a Rapid Health Need Assessment in Bannu District, North Waziristan, Pakistan. The assessment aimed at determining the Health Situation Report (10) of displaced persons in Pakistan: North Waziristan. According to the North Waziristan Agency there were about 993,166 internally displaced persons during that period. The result revealed that the highest percentage of disease prevalence reported was Diarrhoea (52%) whereas the lowest been recorded was measles (5%). Similarly cough/cold/fever and malaria comprised of 47% and 43% of the reported diseases while skin diseases and other diseases such as hepatitis, hypertension, TB, Diabetes were documented at 19% and 7% respectively. Only 33% of the respondents reported that their children were immunized leaving a high percentage of 67% of the

children unimmunized thus, prone to diseases in the nearest future. The main reason for no vaccination was being observed that centres were not functional, 34% of the respondents believed that this was the prime reason whereas 5% believe that cultural, religious beliefs and distance to the vaccination centre are the jeopardizing the vaccination. 26% respondents believed that the teams did not visit whereas 18 % believe that centres are not available. On the question of nutrition supplies for mothers and children, only 3% of mothers responded in affirmation while 97% denied to have received nutritional supplements. While only 1% of the respondent reported their children received such supplies with 99% denying.

A report on the situation of internally displaced people (IDPs) in the village of Tassakane Commune of Alafia Region of Timbuktu, Mali (2015) was conducted. The report was aimed at ascertaining the basic needs of the IDP's in the region. It was reported that there was only one nursing station, managed by only one nurse. This station lacked medication and equipment. At the time of filing the report, there were risks of contracting hydric diseases such as cholera, because of the current living conditions of IDP. The exposition of children to bad weather was also a potential health and malnutrition risk that might worsen if the situation persists. Similarly, Samuel Hall Consulting (2014) conducted a study on Displacement Dynamics: IDP Movement Tracking, Needs and Vulnerability Analysis on Herat and Helmand provinces. Conducting a quantitative survey among IDP households, assessing the IDP households' socio-economic and demographic characteristics, displacement history and movement patterns, basic needs and vulnerabilities in Helmand and Herat provinces were the main aim of the study. In each of the two provinces, the team selected three Primary Sampling Units (PSUs); Urban IDP location (PSU 1), Semi-urban IDP location (PSU 2) and Rural IDP location (PSU 3). The selection of respondents was based on a random sampling techniques where interviewers started from a landmark (mosque, community centre, community leader's house or school), then moving to cover all four directions of the camp. Every third household was selected in order to keep the sampling random. The respondents were either head of households or their spouses. The result revealed that the PSUs surveyed did not have any health clinics near them – especially in semi urban and rural areas. This meant that the residents had to travel to the city for medical attention, a financial obstacle for them and imposing health hazard in cases of emergency needs. The access was termed difficult due to the distance or the lack of paved roads in both Helmand and Herat. 72% of respondents reported that one of their household members had been sick or injured in the last 3months, with 56% in Helmand and 44% in Herat. Among health issues reported by respondents were 74.2% - fever, cough and cold 25.3% - vomiting and diarrhoea 6.1% - and 5.1% - wound, infections 0.3% - trauma or injury. 81% people in Helmand and 68% people in Herat were household's afflicted with fever cough and colds. Another 31% in Helmand and 20% in Herat said that vomiting and diarrhoea were the main medical issues they suffered from.

Heavy prevalence of tuberculosis and hepatitis was also observed in the IDP settlements, most notably in Helmand. This is not surprising as the provinces lacked potable water, consumed a food diet dependent on oil and general lack of hygiene. These are said to be the main reasons of the chronic diseases. Medical intervention would have brought remedy to this situation because IDP households were willing to attend clinics (41.4%) or hospitals (30.3%) when one of their relatives was injured or sick. However, given their limited access to such facilities, one in four relied instead on local traditional healers or private doctors (24.1%). This might have led to the 9% of the respondent who declared not relying on medical help. Apart from that, lack of nutrition, vulnerable living conditions and ill-equipped shelter to deal with winter, naturally result in health issues among the IDP families. It was revealed that the health concerns were more serious for women and infants for not only did the IDPs suffer from severe health issues; they lacked access to the clinics and

doctors. Finally, a lack of solid waste disposal and waste water management, poor sanitation, led to desperately unhygienic conditions of living. All these led to respiratory diseases and diarrhea.

EDUCATION

Despite the fact that internally displaced persons undoubted suffer a great deal of hardship and trauma, they also show tremendous determination to make the best of a bad situation and to prepare for the day when they can resume a normal way of life. This determination is clearly exhibited in the very high value which IDP's place on all forms of education. Based on experience, once IDP's have met their basic need for food, water and shelter, their primary concern is to ensure that their children can go to school (Jeff, Christopher and Daiana 2001). Thus, Marc (1998) describes it as "one of the most overlooked aspects of refugee and internally displaced populations in their demographic composition". Generally, emergency situations affect education whether or not they are displaced. Schools are often destroyed, teachers and educational personnel are often unavailable, shortages of teaching materials are experienced and insecurity inhibits the possibility of students to attend classes.

According to Jeff, Christopher and Daiana (2001), in many displaced populations, about one in three persons are in the age group for schooling and majority of this displaced persons are women and children. According to the *Guiding Principles on Internal Displacement 1998*, the responsibility of the IDP's lies with national authorities. Principle 23 of these principles recognize the right to education and emphasizes that special efforts must be made to ensure that women and girls enjoy equal and full participation in educational programme in relation to children (Oduwole and Fadeyi 2013). Do these principles guide internal displacement?

Elizabeth and Rebecca (2010) conducted a review on Education and Displacement: Assessing conditions for Refugees and Internally Displaced Persons affected by conflict The study aimed at assessing the level of education in displacement: refugees and IDP's. The study revealed that there are more than 40 million refugees and IDPs forcibly displaced by armed conflict of which at least 27 million are children and youth who lack access to formal education, 90% of whom are IDPs. The study also revealed that in the IDP camps "the single most common cause of school absenteeism is the need to be present at food distributions to secure and transport the family's ration." (Barbara 2000). Assessing the Women's Refugee Commission's 2004 report *Global Survey on Education in Emergencies* which used 2002 data for ten countries, it was estimated that of the 3.5 million school-age refugees and IDPs in those countries, 1.8 million were in school and 1.7 million were out of school. However, a case study of the Democratic Republic of Congo 2008 conflicts revealed that in North Kivu nearly one million people were displaced. The national enrolment level was 52 percent and only 34 percent of children had access to a basic education. More so, in Chad a total of 185,000 IDPs where recorded from various departmental values. Between 61 to 67 percent of the school-aged IDP children were not enrolled in school as of August 2008 and 90 percent of these populations suffer from extreme education poverty.

Similarly, in Pakistan in the year 2009, Elizabeth and Rebecca (2010) also reported that an estimate of three (3) million people were displaced due to fighting between government and Taliban in the North West Frontier Province (NWFP) and around 130,000 people also displaced later that year in South Waziristan Agency in the Federally Administered Tribal Areas (FATA). According to the report, around 600,000 children in the NWFP district have missed one or more year of school. In South Wazirinstan were the government terminated NGO-work, nearly 5,000 schools were used as camps for the IDPs in host communities. This meant that not only were IDP children deprived of access to education, but so were the children in the communities to which IDPs arrived. UN Education Cluster Pakistan report on the FATA and NWFP (2009) revealed that of the

31,925 children between the ages of (5-11 yrs) in camps, only 17,389 (54%) had access to educational had access to educational services and only 1,841 (8%) of the 22,804 children between the ages of (12-17 yrs) in camps had access to educational services. All these studies reveal that IDP'S and refugees do not have access to educational services as required that is to say that less attention has been paid to their education.

VOCATIONAL SKILL ACQUISITION

Over the years, the role of vocational skill acquisition as a tool for human empowerment and community development cannot be estimated. It has proven to increase dependency and self reliance most especially in situations where the individuals sway due to inevitable conditions; of natural or man-made origin. A typical example is the IDP's living in camps; with family or relatives who have been forced out of their comfort zone where they use to carter for their own needs. At a point, the families and relatives of such individuals can no longer harbour the responsibility and burden of sustaining them thus, negligence sets in. On the other hand, for undeveloped, developing and mismanaged countries, the IDP's do not access their basic primary necessities of food, shelter, health and clothing. One thing is providing the needs and another thing is accessing these needs. When these needs among other secondary needs are not met, only vocational skill acquisition programmes can salvage this situation.

An assessment of women's needs in IDP camps, Kachin State (2013) was conducted and aimed to deepen the understanding of women's needs in IDP Camps in Kachin State among humanitarian actors involved in the response, including the donor community. The assessment was undertaken in 17 camps in 4 townships in Kachin State, with a population totalling over 30,000 IDPs. The analysis was based on the responses of 83 Focus Groups, and 6 Key Informants totalling 849 respondents (men, women and youth). It was reported that among the sectoral needs, women needed sewing training, girls (women under 18) needed materials for sewing, knitting, weaving while the men needed vocational training to generate income. "Only women who had no children and those whose children had grown up could go and work for daily wages work. However, only the people from Lai Za, Mai Ja Yang and Lana Zup Ja camps could work like this. In other camps, there were less chances to get income because there were no areas to cultivate their own farms because the camps were based at rocky hillsides, the camps were too far away from the Kachin Towns/ villages and Chinese border, and the difficulties of the transportation. Most of the people from each camp said that they needed money whenever they were asked what else they needed. They said they could buy anything they truly needed if money was given and not the materials." Restriction from in and out of the camps and depletion of most of the resources and assets of the IDP's were some of the difficulties encountered.

Similarly, an assessment report on multi-sector needs assessment of Syrian refugee residing in camps; Kurdistan region of Iraq (2015) was carried out. The study was aimed at assessing the needs of nine camps across the three governorates of the Kurdistan Region of Iraq (KRI). By November (2014), 223,923 Syrian refugees (79,296 households) had sought refuge in the KRI of which 42% resided in the nine camps. A fifth of households across the KRI reported having received livelihoods-based assistance in the three months preceding assessment. Livelihoods assistance had been received by the least proportion of households in Gawilan (7%) and the most in Domiz One (15%). More specifically with regard to types of assistance, in all of the camps apart from Arbat and Basirma the majority of households received information on where to find employment (on average 50%). Meanwhile cash assistance was mostly reported in Basirma (69%). Households in Arbat had also on average received more cash assistance (29%) than information (10%). Vocational training saw the highest variation between camps, with 35% of households in

Gawilan having received this assistance compared to none in Akre. Instead 38% of households in Akre had received professional IT training – a much higher proportion compared to other camps, Basirma, Kawergosk and Qushtapa did not receive this at all. The limited livelihoods raises concerns as 14% of households have not been able to afford their basic needs since arrival at their camp.

Furthermore, Samuel Hall Consulting (2014) conducted a study on Displacement Dynamics: IDP Movement Tracking, Needs and Vulnerability Analysis on Herat and Helmand provinces. Obtaining livelihoods due to lack of skills, discrimination favouring local people over IDP, and discriminations towards youth seen as unskilled or illiterate (especially raised in Helmand) was one of the three-fold livelihood challenges IDPs faced.

METHODOLOGY

It is a survey study to assess the community development need in emergency situation of internally displaced persons (IDP's) in Borno state. The population for this study comprised seven thousand, two hundred and forty-three internally displaced adults in three different camps in Maiduguri metropolitan council Borno state. The respondents were, selected through conducive sampling techniques. Arabic teachers collage has a total of three thousand, forth-four displaced adults (3044). One thousand three hundred and thirty seven (1337) were male while one thousand six hundred and seven (1607) were female. Bakassi camp has a total of two thousand two hundred and one displaced adults. Eight hundred and ninety five (895) were male while female adults where one thousand three hundred and six (1306). National youth service corps (NYSC) camp has a total of one thousand, nine hundred and ninety eight (1998) displaced adults. Eight hundred and sixty four were male while one thousand, one hundred and thirty four where female.

Population and Sampling

CAMPS	NO OF MALE	NO OF FEMALE
ATC	1337	1607
BAKASSI	895	1306
NYSC	864	1134

Source MICAID 04/06/20/16

In distribution of the questionnaire, three hundred and fifty questionnaires were distributed in ATC due to large population of the adult in the camp compared to the other two camps. Three hundred and seventeen questionnaire where properly filled and collected male adults 161 respondents and female 156 respondent. In NYSC camp two hundred and fifty questionnaires were distributed to the displaced adults. Out of this number two hundred and twenty questionnaires were properly filled and collected. Eighty three respondents were male while one hundred and thirty seven (137) were female. Similarly two hundred and fifty questionnaires were distributed in Bakassi camp. Out of this number two hundred and twenty seven questionnaires were properly filled and collected. Eighty six (86) were male respondents while the remaining one hundred and forty one (41) were female.

A thirty five item questionnaire was used to collect the data in the three areas that were assessed (Health, Education and vocational skills) the data collected were analyzed using frequency and percentages scores while the chi square was used to analyze the summary the three variables (Health, Education, and vocational skills.

RESULTS

Frequency Table

Table 1. Distribution of respondents

	Frequency	Percentage (%)
Male	330	43.19
Female	434	56.81
Total	764	100.0

Source: field survey, 2016

DISCUSSION OF RESULT

The study assessed the community developmental needs in emergency situation. The assessment of community developmental needs in emergency situation became necessary when the IDPs have overstayed in the camps and the time to go back to their original abode became unknown. Thus the camps have to be upgraded to serve the developmental needs of the displaced.

The questionnaire was administered on the respondents to illicit relevant information for the study on three key areas Health, Education and Vocational skills.

Table 1 Shows that 38.5% of the respondents are male while 61.5% are female indicating that large percentage of the respondent are female.

Table 2. Distribution of respondent's opinion on health care services and facilities in the IDPs camp

S/N	VARIABLES	YES	NO
1	Is there hospital/clinic in your camp?	501 (65.6%)	263(34.4%)
2	Do you assess doctors at least once a week?	573(75.0%)	191(25.0%)
3	Do you have a pharmacy/dispensary or any other means to asses' drugs in your camp?	462(60.5%)	302(39.5%)
4	Are there first aid services in your camp?	494(64.7%)	270(35.3%)
05	Do you have a nursing home in your camp?	216(28.3%)	548(71.7%)
6	Do pregnant women asses' ultrasound in your camp?	164(21.5%)	600(78.5%)
7	Can you check your blood pressure in your camp?	341(44.6%)	423(55.4%)
8	Do you have an ambulance in your camp?	461(60.3%)	303(39.7%)
9	Do you assess radiological services in your camp?	518(67.8%)	246(32.2%)
10	Do you have test laboratories in your camp?	346(45.3%)	418(54.7%)
11	Do the people in your household who need prescribed medicine have enough?	492(64.4%)	272(35.6%)

Source: field survey, 2016

Table 2 shows the distribution respondent opinion on health care services and facilities in the IDPs camps. The first item on the table sought find out if there are hospitals/clinics in the camps. Majority of the respondent 501 respondents representing 65.5% of the respondent said yes while 263 respondents representing 34.4% said no to the statement. For the IDPs accessibility to

doctors at least once a week, about 573 respondent representing 75.0% said yes to the statement while 191 respondent representing 25% said no to the statement. The table indicated that women have no access to nursing homes as 548 representing 71.1% said no to the statement. In provision of facilities such as Ultra sound machine, majority of the respondents' 600 respondents representing 78.5% said such facilities is not existing in their camps and 423 respondent representing 55.4% cannot check their blood pressure in their camps. Similarly, majority of the respondents 518 respondent representing 67.8% cannot access radiological services in their camps and 418 respondents representing 54.7% have no access to laboratory tests. The issue of having enough prescribed medicine was also raised 492 respondent representing 64.4% have not been getting enough prescribed medicine in the camps. The result on provision of healthcare services and facilities indicated that through there were clinics in the camps and access to doctors, the facilities have not been available and thus the services are not being rendered to the satisfaction of the IDPs. This result is contrary to the article 3(I) (K) of the Kampala convention which Nigeria is a signatory that the state should ensure that IDPs are protected and assisted it is also contrary to the United Nation (UN) guiding principles on internal Displacement. Principles 19 specifically addressed the provision of appropriate health care to the internally displaced.

Table 3. Distribution of responses on education

S/N	Items	Variables	
		Yes	No
1	Is there school in your current place of residence (IDP camp)?	205(26.8%)	559(73.2%)
2	Are there teachers in the school?	200(26.2%)	564(73.8%)
3	Do your children attend school?	273(35.7%)	491(64.3%)
4	Do you pay for the wards school fees?	123(16.1%)	641(83.9%)
5	Are there instructional/teaching materials in the schools?	282(36.9%)	482(63.1%)

Source: field survey, 2016

Table 3 shows the distribution of respondents responses on education in the camps. Majority of the respondent (559) respondents representing 73.2% said that there is no school, thus their children are not attending school. Provision of education in emergency situation supposes to be the first priority for IDPs as one in three persons in many displaced population are in age group for schooling. The parents and youths require education on how to conduct their health in terms of personal hygiene and environmental sanitation. Sex education is also needed for the youths to avoid unwanted pregnancy, rape and others form of social problems. However, this is no surprise as Mac (1988) described education as one of the most overlooked aspect of community needs in emergency situation. This study concurred with the reports carried out by Elizabeth and Rebecca (2010) and Barbara (2000) that in emergency situation the IDPs lack access to formal education. Their report also revealed that host communities were also denied education as most of their schools and colleges were turned to camps for IDPs which is a typical situation in Maiduguri Metropolitan council.

Table 4: Frequency distribution and percentage of vocational skill

S/N	Items	Variables	
		Yes	No
1	Do you or any member of your family have other source(s) of income?	183(24.0%)	581(76.0%)
2	Do you want to engage in any skill acquisition?	612(80.1%)	152(19.9%)
3	Since the emergency situation have you had any vocational skill training?	178(23.3%)	586(76.7%)
4	Do you think vocational skill acquisition can be of beneficiary in this situation?	511(66.9%)	253(33.1%)

Source: field survey, 2016

Table 4 shows the distribution of vocational skill acquisition response. The respondents were first asked if they have any member of their family with a source(s) of income. Majority of the respondents 581 representing 76% of the respondents said no to the statement. 612 of the respondent's equivalent to 80.1% of the total respondents showed interest in engaging in any vocational skill acquisition training. Similarly, 586 representing 76.7% of the respondents have not had any vocation skill acquisition training with majority of them 511(66.9%) agreeing to the fact that vocational skill acquisition can be beneficiary to them.

Table 5: Distribution of respondents opinion on vocational skills

	Variables	Frequency	Percentage (%)
Which vocational skill will you like to acquire?	Tailoring	186	24.34
	Painting	67	8.77
	Tiles and Marbles Laying	132	7.28
	Electrical wiring	30	3.93
	Computer/GSM repair	18	2.36
	Poultry	36	17.91
	Soap/Pomade making	109	14.27
	Barbing	33	4.32
	Weaving	52	6.81
	Total	764	100

Source: field survey, 2016

Table 5 above shows the opinion of the respondent on opinion on vocational skill. The responds were sought on different vocational skill training they will like to acquire. Tailoring had the highest percentage of variation (24.34%) followed by poultry (17.91%) and soap and detergent making (14.27%). This result concurred with assessment report on multi-sector needs of internally displaced persons in camps in Kurdistan region of Iraq (2015) that indicated tailoring as the highest variation in vocational training.

In conclusion vocational skills acquisition is a community development needs in emergency situation that can enable IDPs to increase dependency and self- reliance.

Table 6: Summary of chi-square analysis on health

Variables					
	Yes	**No**	**χ2**	**Df**	**p. value**
Male	143(18.7%)	187(24.5%)	13.453	1	0.023
Female	207(27.1%)	227(29.7%)			
Total	350(45.8%)	414(54.2%)			

Source: field survey, 2016

Table 5 shows that there is significant difference on the demand for health services between the male and female as described by the calculated chi –square value $\chi 2 = 13.453$ at 1 degree of freedom consider the p value of 0.02. This could be due to maternal mortality and morbidity. Female are more vulnerable to may disease due to their roles as mothers.

Table 7: Summary of chi-square analysis on education

Variable					
	Yes	**No**	**χ2**	**Df**	**p. value**
Male	114(14.9%)	216(28.3%)	21.145	1	0.018
Female	162(21.2%)	272(35.6%)			
Total	276(36.1%)	488(63.9%)			

Source: field survey, 2016

Table 7 shows there is significant difference between the male and female demand for education as the number of the female is higher than male described by the calculated chi –square value $\chi 2 = 21.145$ at 1 degree of freedom consider the p- value of 0.018. Civil-child education falls under goals two and three of the millennium development goals enshrined under UNs resolution in 1996. In support of strategy for accelerating girl's education in Nigeria (SAGEN), other major partners are also reinforcing their effort for girl's education. For example the World Bank has recently recruited a focal point for girls education, UNESCO has commissioned research in this area, United Nations populations fund (UNPF) has been putting effort to ensure that girls remain in school longer and USAID is scaling up their work with Islamiya schools in Northern Nigeria etc (Makama, 2014).

Table 8: Summary of chi-square analysis on vocational skills

VARIABLES					
	Male	**Female**	**Total**	**Chi – χ^2**	**p. value**
Tailoring	69 (9.03%)	117(15.31%)	186(24.349%)		
Painting	67(8.77%)	0(0%)	67(8.77%)		
Tiles and Marbles laying	132(17.28%)	0(0%)	132(7.288%)		
Electric wiring	30(3.93%)	0(0%)	30(3.93%)	13.063	0.042
Computer/GSM repair	18(2.36%)	0(0%)	18(2.36%)		
Poultry	36(4.17%)	101(13.22%)	137(17.93%)		
Soap Making	0(0%)	109(14.27%)	109(14.27%)		
Barbing	33(4.32%)	0(0%)	33(4.32%)		
Weaving	34(4.45%)	18(2.36%)	52(6.81%)		

Source: field survey, 2016 ***Note***: df = 8

Table 8 shows that there is also significant difference in the choice of vocational skills to be acquired as described by the calculated chi –square value $\chi 2 = 13.063$ at 8 degree of freedom consider the p value of 0.042. Majority of the male choose painting as it refers as masculine work while majority of the female prefer weaving. Tailoring has the highest preference since both male and female are seen in the skill.

Findings of the study

The result of this study found out that;

1. there are available health facilities in the various camps but its utilization is poor.
2. there is no enough educational facilities such as classrooms teachers or even instructional materials that could cater for the IDPs in the camps
3. the IDPs have not had any vocation skill acquisition training since they were displaced from the homes.

Conclusion

Though efforts have been made by both governmental and non-governmental agencies both at national and international level, considerations have not been given in case of the IDPs who have overstayed in the camps. This case scenario worsens daily as the problem that forced them out of their original abode is yet to be resolved. Some major issues that needed to be addressed are most likely forgotten; it is quiet important to stressed that act of terrorism was one of the most challenging issues that lead to people displaced from their home, in the case of Northeastern Nigeria "BOKO HARAM" which means education is prohibited was the cause of high rate of displacement of communities, and as such education should not be taken lightly. The IDPs should have equal educational right, health, employment opportunity and any privileges just like any other Nigerian citizen.

Recommendation

The study therefore recommends that government and stakeholders should erect schools equipped with basic educational facilities that will enhance the educational need of the IDPs and that when considering the issues of IDPs, agencies involved with their welfare should strongly consider providing community development programmes and projects.

REFERENCES

Barbara H. B (2000). Are Refugee Camps Good for Children? *New Issues in Refugee Research*. UNHCR. http://www.unhcr.org/3ae6a0c64.html.

CRED (2002). Armed Conflict and Public Health: A Report on Knowledge and Knowledge Gaps.' Brussels,: 13, http://www.cred.be/docs/cred/publications/rocpressweb.pdf.

CRED (2004). Conflict Mortality: Comparing the Data.' CE-DAT Working Paper CD/2004/001.

Deborah H. and Raoul B. (2002). Assessment of Needs of Internally Displaced Persons in Colombia: *Working Paper; 189.*

Estimates. Reproduced from UN Education Cluster Pakistan. *Education strategy document for Conflict affected populations in NWFP/FATA*, (2009); 2. http://pakistan.oneresponse.info.

Human Rights Watch (1998). *War without Quarter, Colombia and International Humanitarian Law*, Human Rights Watch, New York, USA.

Kachin Women's Association Thailand (2013). *Women's Needs Assessments in IDP Camps Kachin State*, (internal document).

Medecins sans Frontieres (MSF) *Food, Nutrition and Mortality Situation of IDPs in Dubie, Katanga* (2006); 23-25 http://www.doctorswithoutborders.org/publications/reports/2006/nutritional_survey_dubie_03-2006.pdf

Multi-Sector Needs Assessment of Syrian Refugees Residing in Camps (2015). Kurdistan region of Iraq; assessment report.

Refugee Studies Centre (2002) '*Forced Migration Review*'. Forced Migration Review Issue 12, In-house Journal of the Refugee Studies Centre. Queen Elizabeth House, University of Oxford. *http://www.fmreview.org/1frames.htm*

Report on the situation of internally displaced people (IDPs) in the village of Tassakane Commune of Alafia Region of Timbuktu, Mali (2015). International Emergency & Development Aid (IEDA Relief). *http:// www.iedarelief.org*

Robert L. (2007). Health and Mortality of Internally Displaced Persons: Reviewing the Data and Defining Directions for Research. *Brookings-Bern Project on Internal Displacement*. The Brookings Institution – University of Bern.

Samantha L.T. and Stuart D.M (2004). Displacement and health. *British Medical Bulletin;* 69: 115–127. DOI: 10.1093/bmb/ldh009

Samuel Hall Consulting (2014). "Displacement Dynamics: IDP Movement Tracking, Needs and Vulnerability Analysis, Herat and Helmand". *International Organization for Migration (IOM), Kabul.*

Tesfaye .B, Sara .V, Amy .S, Michelle .P, Rebecca and Amy .W, (2012). Centre for Disease Control and Prevention (CDC). Community Assessment for Public Health Emergency Response (CASPER) Toolkit: (2). Atlanta (GA): CDC.

WHO and Ministry of Health of Sudan, *Mortality Survey among Internally Displaced Persons and other Affected Populations in Greater Darfur, Sudan*, September 2005, *http://www.emro.who.int/sudan/pdf/CMS%20Darfur%202005%20final%20report_11%2010%2005.pdf*

WHO, *Retrospective Mortality Survey Among the Internally Displaced Population, Greater Darfur, Sudan, August 2004*. Khartoum, 13 September 2004, *http://www.who.int/disasters/repo/14652.pdf*

Women's Commission for Refugee Women and Children (1999). *A Charade of Concern: The Abandonment of Colombia's Forcibly Displaced,* New York, USA.

World Health Organization (WHO), *Health and Mortality Survey among Internally Displaced Persons in Gulu, Kitgum and Pader Districts, Northern Uganda*, July 2005, *http://www.who.int/hac/crises/uga/sitreps/Ugandamortsurvey.pdf*.