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INFORMATION NEEDS OF HEALTH SERVICE PROVIDER AND QUALITY LIFE OF INTERNALLY DISPLACED PERSON (IDPs) IN ABUJA

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Abstract
The study evaluated the information needs of health service provider on the health status and quality of life of internationally displaced person (IDPs) *camp. The study adopted a descriptive cross sectional design to assess the information needs of Health Service Provider on the quality of life and health status of Internally Displaced Persons (IDPs) camps in Abuja and a structured questionnaire was used to elicit response from respondents. The review indicated findings which reveal lack of adequate health information need on the part of health service provider. A number of health challenges were reported which include fever/malaria (48%), Respiratory problems (45%) and water or bloody diarrhea (22%) while over half of the respondence suffers from post-traumatic stress disorder. Recommendation include strengthen the important role of the international community provision of a legal framework on the "Guiding principles on internal displacement regardless of sovereign of the affected IDPs. Sufficient humanitarian and health rights law must be implementing and tailor to meet the needs of internally displaced person. Health service provider need of information on IDPs should also go beyond service oriented but must cover information on all categories of patients. Which include prevention of communicable diseases and thereby improving their quality of life.*

Keywords: Health related, quality of life, Pregnant women living with HIV/AIDS, Ogun State

Introduction

Quality of life has to do with people's ability to enjoy the normal activities of life. It may also involve the level of people's enjoyment regarding the important possibilities of their lives. Fayers, and Machin (2016) opine that quality of life has been established as a significant thought and target for research and practice in the fields of health services. It is assumed that quality of life is connected with everything from physical health, family, education, employment, wealth, safety, security, to freedom, religious beliefs, and the environment of people. Therefore, assessing and measuring quality of life provide important information about their well-being and especially, their health conditions. It also directs attention to the more complete social, psychological, and spiritual being of the population including people in the Internally displaced person's camps, (IDP). Quality of life is described as the general well-being of individuals and societies, outlining negative and positive features of life. It observes life satisfaction, including everything from physical health, family, education, employment, wealth, safety, security to freedom, religious beliefs and the environment (Braveman, Barcaccia, Egerter, 2013).

WHOqol Group (1995), World Health Organization [WHO] defines quality of life as one's perception of the position in life in the context of the culture, value systems, and in relation to their goals, expectations, standards and concerns in the system in which they live. WHO (2000) maintains that quality of life is a broad concept which could affect in a complex way persons' physical health, psychological state, personal beliefs,

social relationships and their relationship even up to the salient features of people's environment. WHO further states that quality of life has to do with individual's understanding of the function in life in the context of the culture and structures in which they live and in relation to their goals, expectations, standards and concerns. Folasire, Irabor and Folasire (2012) also opine that quality of life is sometimes considered as the degree at which people perceive whether their lives are either desirable or not. Therefore, quality of life could universally serve as a reference against that which an individual or society can use to measure their different domains of their personal lives.

In developing countries, including Nigeria, unresolved tribal conflicts, rifts, political upheavals, border clashes and disasters displace individuals from their homes or places of habitual residence. These populations are moved and/or forced to settle elsewhere (Enwereji, 2009). Internally displaced persons according to the United Nations commission on Human Rights (1998) are 'persons or groups of people who have been forced or obliged to flee or leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects 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.

Global figures indicate that the number of people displaced annually is abysmally high. According to UNHCR 2004, sub-Saharan Africa has over four million displaced persons, the largest number in the world. In an attempt to reduce problems of displaced persons, the United Nations Refugee Agency in 1995 called for concerted interventions and provided guidelines for action. This call culminated in an international conference in 2001, which encouraged countries to respond to the problems of displaced persons. Many internally displaced persons, mainly from rural areas, are forced to resettle elsewhere, especially in urban areas: it is felt that the government and various organizations would provide basic needs, but in most cases this does not occur (Enwereji, 2009).

Amnesty International (2010) estimates that at least 17,000 people have been killed since Boko Haram escalated its insurgency in northern Nigeria in 2009. Sequel to intermittent Boko Haram attacks on Borno towns, villages (Gwoza, Damboa, Askira Uba, Damboa & Chibok), Adamawa (Madagali, Mubi, Gulak, Basa, Shua, & Michika), Yobe and pockets of communal violence in parts of Taraba, Plateau states, millions of Nigerians have fled their homes and manage to eke out a living in IDP Camps. Figures released by the Internal Displacement Monitoring Centre (IDMC), an offshoot of the Norwegian Refugee Council (NRC), an independent, non-governmental humanitarian organization as of April 2015, estimated that about 1,538,982 people that fled their homes in Nigeria were still living in internal displacement camps scattered across Nigeria. In its 'Global Overview 2014 report', the Internal Displaced Monitoring Centre (IDMC) posited that Nigeria has Africa's highest number of persons displaced by conflict, ranking behind Syria and Colombia. The aforesaid figure comprises people displaced as a result of fierce attacks by Boko Haram militants in north-eastern Nigeria, the government-led counter-insurgency operations against the group, sporadic inter-communal clashes and natural hazard-induced disasters'' and also includes the additional 47,276 IDPs in Plateau, Nasarawa, Abuja (FCT), Kano and Kaduna which was collated by Nigeria's National Emergency Management Agency (NEMA) in February 2015 and International Organization for Migration/NEMA, February 2015).

Apart from conflicts and violence, natural disasters resulting from floods, storms, wildfire, earthquakes and droughts have caused the displacement of 203.4 million people globally in the past 8 years. In 2015, 19.2 million people in 113 countries were displaced by natural disasters. Most of these displacements occurred in South and Eastern Asian countries while slightly over a million occurred in Sub-Saharan Africa (Norwegian Refugee Council, 2016).

Internal displacements have significant impacts on public health and the well-being of the affected populations. These impacts may be categorised as direct due to violence and injury or indirect such as increased rates of infectious diseases and malnutrition (Lam *et al.*, 2015; Owoaje *et al.*, 2016). Several risk factors, which promote communicable diseases, work in synergy during displacement. These factors include movement of mass populations and resettlement in temporary locations, overcrowding, economic and environmental degradation, poverty, inadequacy of safe water, poor sanitation and waste management. These

conditions are further compounded by the absence of shelter, food shortages and poor access to healthcare (Ajibade *et al.,* 2017).

The persistent vulnerability of internally displaced person and their relatively poor socio economic recovery rate, indicate a need for attention on their health status. Depending on the location in Sub-Saharan Africa, the combined effects of these factors result in increased risk of diseases such as acute respiratory infections (ARI) (4%), diarrhoeal diseases (18%–22%) and scabies (77%–86%) (Kim *et al.,* 2007; Getanda *et al.,* 2015). Furthermore, malnutrition has been reported among under-five children. In the region, the spectrum includes stunting (38.6%), underweight (28.4%) and wasting (7.2%) (Turnip *et al.,* 2010). Diarrhoeal diseases are major causes of morbidity and mortality among IDPs and mainly result from substandard or inadequate sanitation facilities, poor hygiene and scarcity of soap (Owoaje *et al.,* 2016).
The disruption in public health services also hinders prevention and control programmes consequently resulting in the rise of vector-borne diseases such as malaria and yellow fever. Similarly, routine immunisation services are disrupted, thus increasing the number of individuals susceptible to diseases and the risk of epidemics of vaccine-preventable diseases (VPDs). Outbreaks of VPDs have been reported among IDPs include measles (20%–30%) and meningococcal meningitis (0.3%) (Shultz *et al.,* 2009). Similarly, epidemics of cholera, yellow fever and hepatitis E have been reported in IDP and refugee camps across Africa (WHO, 2008). Furthermore, global polio eradication activities have been hampered in three countries in three conflict-torn countries which have large numbers of refugees and IDPs in Afghanistan, Pakistan and Nigeria (Lam *et al.,* 2015). Epidemics of infectious diseases are quite common in IDP camp settings due to inadequate water and sanitation facilities combined with overcrowding (Siriwardhana & Wickramage, 2014).

Moreover, IDPs, particularly those affected by conflict, are at a high risk of mental health problems. The commonly reported psychological reactions are post-traumatic stress disorders (PTSDs) in reaction to violence and depression as a reaction to loss (Getanda *et al.,* 2015). Other types of mental health problems which have been reported are panic attacks and anxiety disorders (Saxon *et al.,* 2016). The psychological distress occurring in the post-conflict environment also contributes to harmful health behaviours such as hazardous drinking and increased smoking. These behaviours are linked to an increased burden of non-communicable diseases such as hypertension, chronic obstructive pulmonary disease and cancers (Roberts *et al.,* 2012).

Statement of the problem

The persistent vulnerability of Internally Displaced Person (IDP) and their relatively poor socio economic recovery rate, indicate a need for attention on their health status and quality of life. Additionally, Health services providers are faced with a wide variety of health-related challenges including the limited resources and capabilities. In order to maximize the limited resources, public health professionals are increasingly expected to engage in evidence-informed decision making, which is critically dependent on the timely availability of sound and accurate data and information. This information not only is required for health policy makers to make more effective decisions, but also it can be used by health front-line providers to improve the quality of life and efficiency of health initiatives. Health information tools are to be designed to fit the needs of families in IDP camps and the Health Care Providers. Hence, to avoid usability challenges and barriers to healthy living among IDPs, efforts should be made to evaluate the health information needs and assess the quality of life of IDP as a first step in the design and evaluation of new health policies.

The objectives were to address the following questions:

- What is the frequency of health services in internally displace persons (IDPs)?
- What are the levels of quality life IDPs?
- What is the health information needs of health workers in IDP camps?

Methodology

This study adopted a descriptive cross sectional design. There are four Internally Displaced Persons camps in Abuja namely: Lugbe IDP Camp, Area one IDP Camp, new Kuchingoro IDP Camp and Kuje IDP Camp. The population for this study includes a random sample of adults aged 20 years and above from two selected internally displaced persons' camp. According to the International Organization for Migration (IOM, 2016), There are 20,924 internally displaced persons in Abuja camps. Using Taro Yamane's formula for finite population

$$n = \frac{N}{1 + N\ (0.05^2)}$$

Where n = corrected sample size, N = population size (20,924) and e = margin of error (0.05)
Therefore,

$$n = \frac{20,924}{20,925\ (0.05^2)} = \frac{20,924}{52.3125} = 399.98\ \cong 400$$

A total of 400 respondents were recruited for the study. However only 390 respondents returned the completed questionnaire given a response rate of 97.5%
The study employed multistage sampling technique. All the camps in Abuja were first clustered from which four (4) camps were selected through balloting system. The respondents were finally selected through systematic sampling techniques. Inclusion Criteria:- Willingness of the respondents to voluntary participate in the study. The respondents should have been domiciled in campus since the last six months. The respondent should have his/her name registered with an authentic ID card. Exclusion Criteria:- Any responds that was not interested. New arrivals into the camps. Any IDP that was not adequately registered. Self-administered questionnaire was used to gather data from the respondents. The collected data were analyzed using Graphpad statistical package version 5. The responses of the respondents were presented with frequency counts and percentages. The responses of the respondents were presented in descriptive and inferential statistics at P value < 0.05.

Results

Table 1: What is the frequency of health services in internally displace persons (IDPs)?

Adequate	58	14.9
Inadequate	181	46.4
Non-existence	151	38.7
Total	***390***	***100***

From Table 1, majority (46.4%) of the internally displaced persons in the camp agreed that the frequency of health services in the camp is inadequate, 38.7% of the IDPs opined that the Health Service does not exist, while just 14.9% agreed that the frequency of Health Service is adequate. This implies that majority of the responded agreed that the Frequency of health services in the IDP camp is not Adequate or non- existence which will have effect on their quality of life.

Table 2: What are the levels of quality life IDPs?

	Frequency	Percentage
Security	378	96.9
Health	372	95.4
Education	203	52.1
Research	127	32.6
Family and relationship	156	74.1

Shelter	29	40

From Table 2, majority (96.9%) of the internally displaced persons in the camp agreed that the Health information needs of IDPs is on security, closely followed by (95.4 %) of the IDPs who agreed that the Health information needs of IDPs is on Health, while the least (40%) on the rank is the Health information needs on Shelter. This is supported in study by (Braveman, Barcaccia, Egerter, 2013). Which asserted that quality of life is described as the general well-being of individuals and societies, outlining negative and positive features of life. It observes life satisfaction, including everything from physical health, family, education, employment, wealth, safety, security to freedom, religious beliefs and the environment.

Table 3: What is the health information needs of health workers in IDP camps?

	Frequency	***Percentage***
Lack of fund	382	97.9
Irregular medical services	356	91.3
Corruption	298	76.4
Poor living condition	324	83.1
Government policy	152	39.0

Table 3 reveals some of the challenges affecting the health information needs on the health status and quality of life of responded in IDP camp, Lack of fund with 97.9% is the most prominent factor and highest ranked, followed by Irregular Medical Services with 91.3%, also followed by corruption with 76.4 while they don't observe Government policy with 39.0% as a challenge to their Health information needs on their Health Status and quality of life. This result implies that there are a number of factors posing as challenges to the quality of life of people in the IDPs camp.

Discussion of findings

Table I shows that (63.4%) of the respondents were female while (36.6%) were male. This represents the gender distribution of IDPs involved in the survey. There are more female respondents when compared to their male counterpart. This is in consonance with the findings of Sheik et al., (2014) and Sambo, (2017). Also the survey shows that majority of the respondents (45.1%) were between the age of 20 -29yrs, (20.5%) were between the age of 30 – 39yrs, (19.5%) were between the age of 40-49 and (14.9%) of the respondents were between the age of 50 and above. The table also shows (25.6%) of the respondents had formal education, (34.4%) had primary education, (31.57%) had secondary education and 8.3% had tertiary education. We observed that least of our respondents attained tertiary level of education this is consistent with the findings of Sheik *et al,* 2014 and Akhunzada *et al,* (2015).

Table II shows the health profile of the internally displaced person (IDP) and observed that (21.79%) of the respondents had measles, (49.74%) of the respondents had malaria and (28.46%) of the respondents had typhoid. Also the survey shows that 18.46% of the respondents had abortion, 52.56% of the respondents were sexually harassed, and 28.97% of the respondents had unwanted pregnancy. The table further shows that 67.94% had kwashiorkor and 32.05% had marasmus. This is synonymous with Owoaje, *et al.,* (2017) who reported a series of health problems identified on internally displaced persons in Africa to include physical health and mental health problems. This finding is similar to that reported by Ovuga and Larroque (2012). We equally observed that most of the respondents suffer from either physical disease or mental illness. This is also in line with what was reported in similar studies (Akhunzada et al, 2015).

Table III shows the health service providers in which 61.0% are government agencies, 9.0% are non-government agencies, 2.8% are religious agency and donor agencies are 27.2%. This is in consistent with study of Enwereji (2009) that observed that the government had no fiscal policy for providing services to internally displaced persons. Table IV shows that majority 46.4% of respondents found IDPs camps condition inadequate for meeting their needs, 14.9% found the camp inadequate and 38.7% found it non-existence. This is similar with the finding of Olagunju (2006), that government in Nigeria does not have adequate machinery in place to address IDPs issues and the organizations created by the government possess minimal capacity to handle IDPs related problems.

Table V highlighted the information needs of IDP. The majority of the respondents stated security (96.6%), and health (95.4%) information as the paramount information needs. This is in agreement with reports of Sambo (2017) who observed that internally displaced persons, upon safe arrival at their new but temporary location, are more concerned about satisfying their basic needs such as reasonable shelter, food, potable water, healthcare, education, security, clothing, information, etc. From Table VI it is clear that the factors affecting the IDPs information seeking behavior is problem of lack of fund 97.9%, 91.3% irregular medical care, 76.4% corruptions, 83.1% poor living condition, 83.1% poor living condition and 39%% government policy which also affect their quality of life.

Conclusion

The present study shows that the internally displaced persons experienced emotional, psychosocial which is linked to their quality of life as well as other physical health problems. The respondents also expressed serious concern for social support need. The study revealed lack of adequate information need on the part of health service provider. Serious and widespread deficiencies in the existing knowledge and practice of health practitioners are reminder of the crucial importance of improving general health care of Internally Displaced Persons.

Recommendation

This paper recommends the following:

- The government should strengthen its commitment to ensure that the rights of internally displaced persons are protected.
- Health service provider need of information on IDPs should also go beyond service oriented but must cover information on all categories of patients.
- The internally displaced persons should be included in the national programs such as Psychosocial Programmes. Health education with family planning and counseling services should be extended to the internally displaced persons to ensure that many more displaced persons have access to health care programs thereby improving their quality of life.

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