ENGENDERING HUMANITARIAN SUPPORT IN NIGERIA: A CROSS-SECTIONAL SURVEY OF HEALTH-RELATED QUALITY OF LIFE OF INTERNALLY DISPLACED PERSONS IN BENUE STATE.

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ABSTRACT
The humanitarian crisis which was induced by armed conflict in the North Central geo-political zone in Nigeria has assumed a tragic dimension. The crisis has forced hundreds of thousands of people to flee their homes thereby necessitating settlements in internally displaced persons camps. Benue state became the epicenter of the farmers/herdsmen crisis and the year 2018 witnessed an alarming loss of lives and properties including sacking of villages by armed militias thus necessitating IDP camps. Planning, execution and evaluation of humanitarian and health services require understanding health needs and social realities of internally displaced persons (IDPs). It was against this backdrop that the present study was designed to assess and document health related quality of life (HRQoL) of IDPs in Benue State IDP camps. A cross-sectional survey design was adopted and instrument modified from the WHOQOL-BREF. Health related quality of life was assessed using two dimensions of physical and socio-emotional health dimensions. Generated data were analysed using descriptive statistics and inferential statistics of t-test and One-Way ANOVA at 0.05 alpha level. Findings of the study showed poor health related quality of life in both dimensions. There was also significant gender difference in health related quality of life ($t_{cal.}$ = 4.230, df = 746, $t_{crit.}$ = 1.645, p=<0.05) with female IDPs reporting lower HRQoL. The study also suggests that older respondents reported lower HRQoL than younger ones. It is concluded based on the findings of this study that HRQoL of IDPs in Benue State is significantly low and that IDPs have both poor physical, social and emotional health status. It was thus concluded that female and aged IDPs compared to male and younger IDPs face more distress. Provision of humanitarian and health support services for IDPs with specialized care for women, children and aged is strongly recommended.

Keywords: Engendering, Humanitarian Support Health Related Quality of Life, Internally Displaced Persons

INTRODUCTION
The humanitarian crisis which occasioned the intractable violence in some parts of Benue State Nigeria assumed a threatening dimension. The crisis got to the point where sacred institutions like places of worship and priests were not spared. Loss of life and destruction of properties due to armed conflict in 2018 alone in this zone has assumed a tragic dimension. While loss of life and properties remains the most devastating impact of this crisis, internal displacement and the harrowing experiences faced by these internally displaced persons are also of serious concern. Internally displaced persons (IDPs) have been described as the most vulnerable people in the world today (Office of the United Nations High Commissioner for Refugees, 2019).
Quoting the United Nation's Commission on Human Right, Owoaje, et.al (2016, p161) described internally displaced persons as '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 conflicts, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised state border.' A distinction between IDPs and refugees is that while the former are found within their national boundary, the latter cross-national boundary to another nation. Scholars believe that IDPs are often times more vulnerable and disadvantageous compared to refugees since their support are largely more dependent on their national government compared to refugees that are largely dependent on international agencies for support (Keth, 2005; Mooney, 2005; Adio-Moses, 2018). They are distinct from refugees who are displaced outside their national borders. Furthermore, IDPs are often more disadvantaged than refugees because

they do not benefit from assistance provided by international agencies unless the national government requests such assistance.

According to the International Displacement Monitoring Centre, IDMC, (2018), the world experienced some of the highest rates of violence and internal displacement in 2017. This violence was driven by political instability, complex humanitarian emergencies, failed peace agreements, unsustainable refugee returns, urban warfare dynamics, extreme weather and disasters. Armed violence continued to force unacceptably large numbers of people to flee across the Central African Republic, South Sudan, Nigeria, Syria, Iraq and Afghanistan. Available statistics showed that by the end of 2017, 40 million people were recorded displaced due to conflict and violence in 57 countries (IDMC, 2018). In addition, it was estimated that around 8.5 million individuals are in a situation where they remain in conditions of vulnerability related to their displacement. They may have found provisional, but not durable solutions to their displacement and therefore should still be considered and kept on record. Sub-Saharan Africa, which accounted for only about 14% of the world total population and accounts for the largest proportion of IDPs as it constitutes 46.4% of the world total IDPs with 5,472,000 and 2,561,000 persons displaced due to armed conflict and natural disaster respectively.

In fact, there was about 5.5 million new displacements associated with conflict and violence in 2017 in Sub-Saharan Africa which is double the figure for the previous year. This confirms the earlier assertion of Thapa and Hauf (2012) which showed that the largest proportion of IDPs live in developing countries. In Nigeria, 279,000 and 122,000 persons were displaced due to armed conflict and natural disasters respectively. It is however important to note that by the time 2018 data captured, showed higher scores were recorded due to the carnage in the North Central region of Nigeria especially in Benue State which is reported to have about eight IDP camps housing about 175,070 IDPs of which 80,450 are children (Duru, 2018). It is equally important to note that women and the aged population due to the peculiarities of their life situation experience poorer health status. Copious research evidences showed that women IDPs, more than men, experience lower health and well-being (Roberts, et al., 2008; Abdalla et.al.. 2010; Siriwahdarna et al., 2013; Makashvili et al., 2014; Adio-Moses 2018). In the same vein, evidence also show that older IDPs also experience lower physical and psychological functioning compared to younger ones (Araya et al., 2007).

There are copious evidence, based on epidemiological surveys that the prevalence of health disorders is higher in conflict and post-conflict zones than areas that are relatively peaceful (de Jong et.al.. 2003; Roberts et.al.. 2009; Steel, et al., 2009; Shanon, 2014; Getanda et.al. 2015). Quality of life is a significant and important index in profiling health status of individuals and groups. A definite definition of quality of life has proven difficulty (Moons et.al., 2006; Brazier et al., 2014) as the term is polymorphous. The difficulty in defining quality of life has also been attributed to variegated approaches and dimensions to which a definition can be hinged. Bowling (2005) noted that these approaches are based on human needs, subjective well-being, expectations, and phenomenological viewpoints.

Peasgood et.al.. (2014) distinguished between approaches based on objective lists, preference satisfaction, hedonism, flourishing, and life satisfaction. A widely quoted definition was however proposed by the World Health Organization (WHO) (1997, p1) which defined quality of life (QoL) as an "individuals' perception of their position in life in the context of the culture and value systems in which they live in relation to their goals, expectations, standards and concerns". When related to health, quality of life is directed by the collective construction of comfort and well-being, as well as identifies the impact of diseases, dysfunctions and necessary therapeutic health interventions on quality of life

Profiling the quality of life of IDPs can provide a foundation for a new look at the implementation of more effective practices for the promotion of IDPs' health and well-being. Previous researchers have attempted investigating quality or health related quality of life of IDPs. Roberts et al. (2009) investigated factors associated with the health status of internally displaced

persons in Northern Uganda. A cross-sectional survey was conducted in two IDP camps in the study area. The outcome of the study was measured using the SF-8 instrument, which produced physical (PCS) and mental (MCS) component summary measures. Independent demographic, socio-economic, and trauma exposure were measured (using the Harvard Trauma Questionnaire). Multivariate regression linear and regression analysis were used to investigate associations of the independent variables on the PCS and MCS outcomes. The result of the study showed low levels of both physical and mental health as the mean PCS and MCS scores were 42.2 (95% CI 41.32 to 43.10) and 39.3 (95% CI 38.42 to 40.13), well below the instrument norm of 50, indicating poor health. The result also showed that variables with negative associations with physical or mental health included gender, age, marital status, income, distance of camp from home areas, food security, soap availability, and sense of safety in the camp. A number of individual trauma variables and the frequency of trauma exposure also had negative associations with physical and mental health.

In a Kenyan based study, Getanda et al. (2015) designed a study to examine the mental health, quality of life and life satisfaction of IDPs. The study methodology was a cross-sectional triangulated study involving quantitative and qualitative data collection and analysis. Quantitative data were generated using a questionnaire that included the General Health Questionnaire by WHO, Satisfaction with Life Scale, and a modified version of the WHO Quality of Life-BREF tool was used for data collection. An open-ended interview guide was also used to collect qualitative responses about the IDPs' experience as internally displaced persons. The findings of the study showed that all the participants scored low on the all the health indices using different scales. For example, they scored substantially low on general health, quality of life and life satisfaction scores. These findings were validated by the qualitative responses as respondents expressed statements reflecting suicidal thoughts, unhappiness with the government, lack of support, and fear for themselves and their children. When variations in the outcomes were investigated, lower scores were found among older IDPs (rho = .202, sig = .046) and widowers on general health question. For QoL, findings showed that higher scores, reflecting higher QoL were found among IDPs who reported receiving governmental support. The researchers concluded that poor levels of mental health, quality of life and life satisfaction exist among IDPs. The result also led to the conclusion that older IDPs and widowed IDPs as well as those with little or no governmental support are at a greater risk of poor quality of life and overall health.

In a Nigerian based study, Sheikh *et al.*, (2014) conducted a cross-sectional survey to profile post-traumatic stress disorders (PTSD)as well as examine socio-demographic determinants of PTSD and psychosocial adjustment strategies among IDPs in Nigeria. The result of the study showed that destruction of personal property, becoming IDP in a camp, and violent scenes witnessed were the most traumatic experiences in decreasing order of severity. The result also suggest that depression and loss of a family member were the strongest determinants of PTSD as IDPs with these experiences recorded higher PTSDs. In a recent systematic review, Owoaje et.al. (2016) assessed bibliographic databases for studies on health status of IDPs in Africa. The researchers of the nine studies found, only one has been conducted in Nigeria. This is a far cry of the needed social research based on the number of armed conflict that has made Nigeria one of the epicenters and theatres of terror war in the continent. In fact, the only study by Sheik et al., (2014) focused on post-traumatic stress disorders. Following the increasing number of IDPs and the poor handling of humanitarian support (Owoaje et al., 2016), there is an urgent need for more engaging and cutting-edge research to gain understanding that will assist in planning, executing and evaluating health and other humanitarian services to this vulnerable population. It was against this backdrop that the present study investigated health related quality of life and factors associated with it among IDPs in the North Central state of Benue.

Objectives of the Study: The major aim of the study was to examine health related quality of life of IDPs as a research effort aimed at quantifying the humanitarian crisis that are sequalae of

the armed conflict in the study area. This is in the overall goal to provide relevant information for planning and evaluating humanitarian support as well as provide empirical evidence for the need to scale up humanitarian support among the IDPs. Specifically, it is designed to: profile health quality of life of the IDPs and examine variance in health quality of life by socio-demographic variables of age and sex

METHODS

Study Area: Benue state is one of the middle belt states in Nigeria with an estimated population of about 4,253,641 based on the 2006 census figures. It is inhabited predominantly by the Tiv, Idoma and Igede people. The major languages are therefore Tiv, Idoma and Igede. However, there are other ethnic groups, including the Etulo, Abakwa, Jukun, Hausa, Igbo, Igala, Akweya and Nyifon. Makurdi is the state capital and the state is rich agriculture, hence its slogan – 'Food Basket of the Nation.' Benue State is named after the Benue River and was created from the former Benue-Plateau State in 1976. The state has become the epicenter of the farmers/herdsmen crisis and the year 2018 has witnessed alarming loss of lives and properties including sacking of villages by armed militias thus necessitating IDP camps.

Design: The cross-sectional research design was adopted in the study. This approach is a type of descriptive research design that involves collection of data within a short period of time with a view to gaining understanding regarding to the variables of interests and their inter-relationships.

Sample and Sampling Technique: A sample of 800 IDPs was sampled from the eight IDP camps in the state using simple random sampling technique. However, analysis was based on the 748 instruments successfully retrieved and found useful for analysis purpose. The camps are shown in the table below.

Table 1: IDP Camps in Benue State

Camp	LGA
LGEA Primary School Camp	Guma
UNHCR Shelter Camp	Guma
Tse-Ginde camp	Guma
Gbajimba camp	Guma
Abagena or Agan camp	Makurdi
Anyiin Camp	Logo
Abeda Camp	Logo
LGEA Primary School Camp Ugba	Logo

Instruments: The instrument for the study was an adapted questionnaire modified from the WHO Quality of Life Questionnaire. The questionnaire's first section included socio-demographic and background questions including age, gender, occupation, marital status. The second section was modified from the WHOQOL-BREF 12-item scale to assess health related quality of life. The highest possible score which connotes high HRQoL is 53 while the least possible score is 14. The instruments, though in English were administered to respondents in the camps. Respondents who cannot read or write had the questionnaire translated to them by research assistants and their responses filled in accordingly.

Data Analysis: The generated data were analysed using descriptive statistics and inferential statistics of t-test and one-way ANOVA at 0.05 alpha level.

RESULTS

Socio-Demographic Characteristics of Respondents

Table 2: Socio-Demographic Characteristics of Respondents

Variable	Frequency	Percentage
Age		
Below 20 years	82	11.0
20-29 years	103	13.8
30-39 years	147	19.7
40-49 years	168	22.5
50 years and above	248	33.2
Sex		
Male	306	40.9
Female	442	59.1
Occupation		
Student	109	14.6
Artisan	124	16.6
Civil Servant	59	7.9
Farming	456	61.0
Marital Status		
Single	205	27.4
Married	474	63.4
Divorced	06	0.8
Widowed	41	5.5
No Response	22	2.9
Lost a Loved One in the Crisis?		
Yes	102	13.6
No	646	86.4

The result of the study showed that respondents that are 50 years and above accounted for the largest proportion of the respondents at 33.2% while those that are below 20 years accounted for the least at 11.0%. Female respondents constituted the largest proportion as 59.1% with males making up the remaining 40.9%. The result also showed that the largest proportion of the respondents are farmers at 61% while 63.4% of the respondents are married. 13.6% of the respondents reported losing a loved one in the crisis that forced them into the IDP camp.

Health Quality of Life of Respondents

Physical Health Dimension

Table 3: Overall Health Status as Perceived by Respondents

In general, how would you describe your health status	Frequency	Percent
POOR	147	19.7
FAIR	333	44.5
GOOD	159	21.3
VERY GOOD	109	14.6
EXCELLENT	0	0
Total	748	100.0

Based on self-reported assessment of the overall health status of the respondents, findings showed that at the threshold, 19.7% and 0% reported poor and excellent health status

respectively. An implication of this finding is that the largest proportion of the respondents perceived their overall health status as fair. When related to daily living, the extent to which this perceived health status supports the respondents is shown in the table below.

Table 4: Health Status in Relation to Daily Living as Perceived by Respondents

How has your health status limited the understated activities	Limited for more than 3 months	Limited for 3 months or less	Not limited at all
The kinds or amounts of vigorous activities you can do, like lifting heavy objects	225 (30.1%)	464 (62.0%)	59 (7.9%)
Walking uphill	41 (5.5%)	202 (27.0%)	505 (67.5%)
Bending, lifting, or stooping	41 (5.5%)	225 (30.1%)	482 (64.4%)
Long walking	231 (30.9%)	172 (23.05)	345 (46.1%)
Eating, dressing, bathing, or using the toilet	84 (11.2%)	43 (5.7%)	621 (83.0%)

The study result showed that eating, dressing, bathing and using the toilet are the most common activities carried out by respondents without significant hindrance due to their health status. On the other hand, engaging in vigorous activities like lifting, was the most limited activity among the respondents as the least proportion of the respondents (7.9%) disclosed non-limitation in this area.

Feeling of Bodily Pain

Table 5: Experience of Bodily Pain among Respondents

How much bodily pain have you had during the past 4 weeks	Frequency	Percent
VERY SEVERE	189	25.3
SEVERE	208	27.8
MODERATE	124	16.6
MILD	118	15.8
VERY MILD	109	14.6
NONE	0	0
Total	748	100.0

The result of the study further demonstrated low health quality of life as threshold scores on bodily pain revealed that 25.3% and 0% reported very severe and no pain respectively. This further affirms that the majority of the respondents experience low quality of life demonstrated in bodily pain ranging from very severe (25.3%), severe (27.8%), moderate (16.6%), mild (15.8%) to very mild (14.6%).

Socio-Psychological Dimension of Health Quality of Life among Respondents

Table 6: Socio-Emotional Health of Respondents

Items	All of the time	Most of the time	Some of the time	None of the time
How much of the time, during the past month, has your health limited your social activities?	41 (5.5%)	372 (49.7%)	276 (36.9%)	59 (7.9%)
How much of the time, during the past month, have you been a very nervous person?	43 (5.7%)	243 (32.5%)	397 (53.1%)	65 (8.7%)
During the past month, how much of the time have you felt agitated and touchy?	106 (14.2%)	329 (44.0%)	313 (41.8%)	-
How much of the time, during the past month, have you felt downhearted?	59 (7.9%)	207 (27.7%)	308 (41.2%)	174 (23.3%)
During the past month, how much of the time have you been	41 (5.5%)	344 (46.0%)	363 (48.5%)	-

Items	All of the time	Most of the time	Some of the time	None of the time
unhappy?				
How often, during the past month, have you felt so down that nothing could cheer you up?	41 (5.5%)	143 (19.1%)	564 (75.4%)	-

The breakdown of the responses as represented in the table above further confirmed the low health related quality of life among the respondents. This dimension showed that there is poor status of socio-emotional health among the respondents. The result showed that only 7.9% of the respondents reported their health never limited their social activities. Again, 8.7% of the respondents reported they were never nervous in the four weeks preceding the study. Of important note is that none of the respondents reported not feeling agitated and touchy, unhappy and downcast four weeks preceding the study.

Demographics and Health Related Quality of Life

Sex and Health Related Quality of Life

Table 7: t-test Table of Gender Difference in Health Quality of Life

	SEX	N	Mean	Std. Deviation	$t_{cal.}$	df	$t_{crit.}$	p
HEALTH QUALITY OF LIFE	MALE	306	29.6667	5.11827	4.230	746	1.645	0.000
	FEMALE	442	28.0475	5.16661				

The result of the study showed that there is significant gender difference in health related quality of life. The calculated t-test at 4.230 is greater than the table value at 1.645. In the same vein, the p value at 0.05 is also less than the level of significance at 0.000 which affirms significant gender difference in health-related quality of life. Further examination of the result showed that male respondents reported higher quality of life at a mean of 29.6667 compared to female respondents who reported lower mean at 28.0475.

Age and Health Related Quality of Life

Table 8: Mean and ANOVA Table of Age Difference in Health Quality of Life

AGE IN YEARS	Mean	N	Std. Deviation	F	p
BELOW 20	35.1829	82	1.72940		
20-29	32.7670	103	1.92610	723.403	0.000
30-39	32.3469	147	2.44572		
40-49	28.7857	168	2.78177		
50 AND ABOVE	22.6774	248	2.33629		
Total	28.7099	748	5.20478		

The result of the study as shown in the table revealed the mean scores for each age group and the influence of age on HRQoL. The result showed that respondents within the age group of 50 years and above scored the least mean at 22.6774 which is lower than the average mean at 28.7099. Conversely, respondents that are below 20 years recorded the highest mean at 35.1829 which is higher than the average mean. Meanwhile, the result from the ANOVA suggests that age significantly influenced HRQoL at an $F_{(4,743)}$ value of 723.403 and a $p<0.05$.

DISCUSSIONS

The result of the study showed a significantly low level of quality of life based on the responses and the means scores of the respondents. To enhance understanding of the result, analysis was done to assess physical and socio-emotional dimensions of HRQoL. Findings showed marked low HRQoL in both dimensions. As regards physical health and general well-being

relating to physical and physiological functioning, the result of the study showed that respondents are experiencing low quality of life. This is not unconnected to issues relating to poor living standards and poor nutrition. IDPs largely depend on the camp authorities for their support. As regards feeding, their normal diet would have been greatly altered both in quantity and quality.

This has important way of impinging on their health and physical functioning. Having lost their means of livelihood, these IDPs can wield little or no economy power required to maintain minimum standard of living and adequate nutrition, clothing and accessing health care. This finding of the study is in line with the results of previous researchers that have investigated the health and quality of life of IDPs. It supports the findings of Owoaje et al., (2016) who in a systematic review documented poor level of physical health status as one of the agonizing experiences faced by IDPs. The study is also in line with the findings of Getanda et al., (2015) who studied quality of life of IDPs in Kenya and found low quality of life related to physical and physiological functioning.

In the socio-emotional dimension, findings showed that respondents also scored low in social and emotional functioning. This cannot be unconnected from the level of despair and hopelessness that life in the camp predisposes IDPs to. In some special way, poor socio-emotional functioning can as well induce poor physical health in a term known as psycho-somatic illness. The experience of probably losing a loved one and the despair of uncertainties concerning the future and what lies ahead can weigh down IDPs thereby significantly reducing their quality of life. Having lost means of livelihood and probably properties accumulated over time, the distress due to how to start life all over again impinge on the psychosocial functioning of IDPs thereby making them vulnerable to mental health disorders of which depression is prominent. The result of the study from the socio-emotional dimension showed evidences of depression and heightened anxiety or better still, psychological distress among the IDPs. This poor mental health status poses a grave danger to the overall health and well-being of this special population.

The issue is worsened by near governmental negligence or poor handling of the security issues that necessitated displacement. Moreover, since the crisis is intractable and recurring, these IDPs live in utter despair of future attacks even when they leave the camp. All these have some important ways of pushing them towards the negative continuum on the mental and overall health and well-being scale. The result corroborates the findings of previous researchers that have equally documented copious evidences relating to poor emotional health and well-being among IDPs. It supports the findings of Sheik et al., (2014) who investigated posttraumatic stress disorders among IDPs in Kaduna State, Nigeria. The findings of the study showed that the level of mental health status of IDPs investigated was significantly low as mental health disorders were common among the respondents. The study is also in line with the findings of Getanda et al. (2015) who studied quality of life of IDPs in Kenya and reported low level of mental and emotional functioning demonstrated in high levels of anxiety, depression, hopelessness, despair and suicidal ideation.

Significant variance was found in HRQoL between male and female respondents with female respondents reporting lower HRQoL compared to their male counterparts. This result in a way attests to the fact that women, in every circumstance, are far more vulnerable than their male counterparts. This can be attributed to the fact that women's reproductive health and roles make them vulnerable to distress relating to internal displacement than their male counterparts. Women who are pregnant or nursing for instance, are predisposed to higher levels of stress and trauma than their male counterparts. The same is applicable to women observing their monthly cycle that might have limited access to sanitary materials. Again, it is important to also note that women psychological make-up makes them more of emotional than rational beings. So while the man can somehow muster mental resilience to cope with the situation, a woman, who is more emotional and delicate might slid into despair especially when the feministic attributes

earlier highlighted place much demand on the woman. This thus makes giving women IDPs specialized care and support as the most vulnerable gender group in internal displacement important. This result is in line with many evidences that have documented poorer health and quality of life among female IDPs compared to their male counterparts (Roberts, et al., 2008; Abdall et.al.. et.al. 2010; Siriwahdarna et al., 2013; Makashvili et al., 2014; Adio-Moses, 2019).
The study finding also showed that older IDPs reported lower HRQoL compared to younger ones. This is not unconnected to the fact that they have lower coping power and might be more concerned about their children and their children's future especially if they are equally trapped with them at the camp. It is equally important to stress that the health needs of older persons are not the same with younger ones. The aged might have lost vitality and physical stress required to cope in the face of armed conflict and displacement. The result confirms the result of previous researchers that have examined age variegation in mental health and wellbeing of IDPs. The finding confirms the findings of Araya, et.al.. (2007) which also found that older IDPs have lower health and functioning in an Ethiopian based study.

Conclusion
It is concluded based on the findings of this study that HRQoL of IDPs in Benue State is significantly low and that IDPs have both poor physical, social and emotional health status. It is also concluded that female and aged IDPs compared to male and younger IDPs face more distress and as such, reported lower HRQoL.

Recommendations
The following recommendations were proposed:
Provision of humanitarian and health support services for IDPs with specialized care for two men, children and the aged is strongly proposed. Special attention must be paid to women with babies and the aged due to their physiological peculiarities
No amount of care and support could replace resettling IDPs in their ancestral homes, as such; plans for resettlement must go hand in hand with the opening of any IDP camp.
Humanitarian and Health support services must be properly planned and evaluated to ensure that monies released for the care and support of IDPs are judiciously expended with the highest level of accountability.
Government must assume responsibility and decisively deal with perpetrators of armed conflict in the zone. The first and most important duty of government is to secure lives and properties. Over the years, Benue has remained a theatre of war with wanton destruction of lives and properties as aftermath. It is high time the big stick is wielded to bring the situation under permanent control.
There is need for inter-agency and non-governmental organizations partnership in providing care and support for IDPs. Handling the cases of IDPs has overwhelmed the national government with pockets of crisis almost everywhere in the country. A strong partnership could be built with international development partners and NGOs to harness care and support for IDPs.
Ensuring that IDPs are given hope for a post-camp life must be ensured to reduce the level of hopelessness that IDPs are predisposed to.
There is need for research in the area of health risk reduction among IDPS at various camps in Nigeria

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