

# Assessment of Health Care Provisioning and Utilization at an Internally Displaced Persons' Camp in Nigeria: Time for Integrating Essential Primary Health Care in Delivery Strategies

Usar IJ<sup>1\*</sup>, Akosu JI<sup>1</sup>

<sup>1</sup> Department of Community Health, College of Health Sciences, University of Jos, Nigeria

\*Correspondence Author. GSM: +2348033935661,

## Abstract

**Background:** Years of Boko Haram insurgency in the north east, herder-farmer clashes in the middle belt and serial communal clashes across Nigeria have forced millions of people away from their homes into ad-hoc camps with limited access to the most basic necessities of life, including health care. Consequently, in 2012, the Nigerian government adopted a national policy on internally displaced persons (IDPs) with the aim of strengthening institutional mechanisms for the realization of the rights, dignity and wellbeing of individuals in humanitarian situations. Despite these policy objectives, internally displaced persons in Nigeria still get less than dignified conditions in humanitarian conditions and access to health care has remained challenging. This study sought to understanding health care provisioning and utilization at an IDPs' camp in Jos, north central Nigeria.

**Method:** The study adopted a mixed method design, using survey questionnaires and in-depth interviews to collect data from study subjects. Survey data was analyzed using Epi Info (version 3.5.4) statistical software and results presented as descriptive summary statistics. Qualitative data were transcribed, the content analyzed and interpreted guided by the purpose of the study.

**Results:** The camp housed 256 persons comprising of 129 children and 127 adults, with adult age range of 19-60 years and a mean of 34.3 years. 57% of the sample was males and 43% females, with 96% of surveyed adults never being in formal employment. Communicable diseases constituted greater health problems, with malarial fever, typhoid fever and diarrheal disease making the four most common illnesses suffered in the camp.

**Conclusion:** Access to adequate and timely health care services were constrained in the studied camp, as a result of resources and funding gaps. We recommend the integration of primary health care approaches in health care planning and delivery in IDPs camps, as cost-effective strategy to achieving optimal health care in humanitarian situations.

**Key words:** internally displaced persons, health care, resource limitation, primary health care, Nigeria.

Date of Submission: 09-07-2020

Date of Acceptance: 26-07-2020

## I. Introduction

The combination of armed conflicts with natural disasters has created a staggering 41.3 million internally displaced persons (IDPs) globally, with the vast majority occurring in low and middle-income countries.<sup>1</sup> IDPs are individuals, or their groups who have been forced to flee their usual places of residence, but remaining in their countries of origin, as a result of natural or man-made disasters, generalized violence or human rights violations.<sup>2,3</sup> This definition also covers peoples abandoning their homes to avoid the effects of conflict as well. IDPs differ from refugees in that the latter are displaced outside their national borders.<sup>2</sup> Conflicts and disasters often cause large-scale destruction of homes, infrastructure and the environment, resulting in general problems such as housing, security, sanitation and schooling deficits, but health related problems are the most pressing.

Displaced persons move with their health problems and vulnerabilities, and frequently become exposed to new health challenges.<sup>4</sup> Whilst refugees receive appropriate attention for their health problems, because of the many international conventions and treaties targeting their needs, the same cannot be said of IDPs.<sup>5</sup> Thus, IDPs encounter a number of unique health problems, but have limited access to health care services. Furthermore, organizing health services for IDPs is particularly challenging. With these factors interacting, IDPs tend to experience more negative health outcomes relative to refugees.<sup>6</sup>

Circumstances of internal displacement exerts significant impact on the health and well-being of affected populations by causing direct injuries or indirectly, through raising their vulnerability to infections and malnutrition.<sup>7,8</sup> The group of indirectly acting factors includes large populations settling in overcrowded camp

spaces with inadequate portable water supply, poor sanitation, poor waste management and environmental degradation. Others are economic deprivation, material poverty, food shortages and constrained access to healthcare, following disruption in public health care services.<sup>9</sup> The disruption also hinders disease prevention and control programs, such as routine immunization against vaccine preventable diseases such as polio, measles, meningitis, cholera, yellow fever and hepatitis.<sup>10,11</sup> Also frequently reported among IDPs are infectious diseases epidemics as a result of poor water and sanitation facilities in the context of overcrowding.<sup>12</sup>

Women and children who form about 80% of the population in most camps do not only face significant risk of having health problems, their health care needs are also unique.<sup>13,14,15,16</sup> For example women and girls are frequently not only victims of physical and sexual violence, they also have higher risks of unwanted pregnancies, unsafe abortions and maternal morbidity and mortality.<sup>17,18</sup> They also suffer significant burdens from rape, sexually transmitted infections including HIV/AIDS and unwanted pregnancies.<sup>19,20</sup>

Mental health issues are also commonly observed in displaced persons' camps in the forms as post-traumatic distress syndrome (PTSD), depressive disorders, anxiety and panic attacks.<sup>21,22</sup> These psychological disorders occurring in post-conflict environments may further trigger harmful health behaviors such as cigarette smoking and hazardous drinking, which tend to enhance the burden of non-communicable diseases like hypertension, chronic airway diseases, diabetes and cancers.<sup>23</sup> These disease etiologies (communicable, non-communicable and vaccine preventable diseases) together account for a staggering 95% of mortalities in internally displaced persons camps.<sup>24,25,26</sup> Therefore, the United Nations has adopted the 'Guiding Principles on Internal Displacement' convention.<sup>2</sup> The treaty outlines the rights of IDPs, one of which is protection and healthcare provision. Consequently, the African Union adopted the Kampala Convention on IDPs in Africa and required States to develop national legal and policy frameworks on the protection of the right IDPs.<sup>27</sup>

Nigeria adopted her national policy on IDPs in 2012, with strengthening of institutional mechanisms and frameworks for the realization of the rights, dignity and wellbeing of internally displaced populations as an overarching goal.<sup>28</sup> Boko Haram insurgency in the north eastern part of the country in the last decade have forced over 2 million people to flee their homes and the middle belt region is dotted with camps holding over 700,000 displaced persons as a result of the intractable clashes between Fulani herdsmen (fleeing desertification in the north) and local farmers.<sup>1,29</sup> These multiple conflicts have resulted in an unprecedented humanitarian crisis in the country and a corresponding bolstering of the demand for of health care.<sup>30</sup> Despite the clear goals of the IDPs policy, displaced persons in Nigeria are often housed in overcrowded temporary camps, consisting of structures such as schools, police stations, military barracks, unoccupied public buildings or worship places, with minimal or no basic amenities.<sup>5</sup> This study therefore, sought to understand health care access (availability and utilization) and its organization in an IDPs' camp in Jos, Plateau State, north central Nigeria. We aim to deepen our insights of health care delivery and uptake in a humanitarian context that may improve health care intervention planning and delivery in humanitarian settings, a crucially important requirement for meeting the health system goal of universal healthcare coverage.

## **II. Methodology**

The research adopted a mixed method study design. Firstly, a cross sectional descriptive survey of the Geo-science's IDPs camp, Anguldi in Jos south LGA of Plateau state, Nigeria was undertaken. The camp was home to 256 IDPs, fleeing herder-farmer clashes in the state. The survey recruited all 127 adults who gave oral consent to participate in the study. Data from the subjects were collected using a self-administered questionnaire, which elicited participants' biodata and information in relation to their knowledge of diseases and health services seeking and utilization behaviors. Then, the two most senior health workers (out of four) attached to the camp clinic were interviewed in-depth in respect to scale and scope of services provided, their utilization and the limitations to the delivery of health care services in the camp. All interviews were conducted in English and digitally recorded.

Survey data was entered into the research laptop and analyzed using the statistical software Epi Info (version 3.5.4) and results presented using descriptive summary techniques. The interview data were transcribed and the transcription notes reviewed for accuracy. The contents were then carefully re-read and manually coded line by line into structured categories, guided by apriori codes generated based on the purpose of the study.

Ethical clearance for the study was granted by the Research Ethics Committee of the Jos University Teaching Hospital (JUTH). Information obtained from respondents was anonymized and kept confidential.

## **III. Results**

In total, the camp was home to 256 persons comprising of 129 children and 127 adults. The age spread of the study participants was 19-60 years, with an average of 34.3 years. 57% of the sample was males and 43% females, with 52% unmarried and 48% in a marriage relationship. A hugely 96% of the adult IDPs were not in any formal employment, leaving just 4% evenly distributed between the public and private sectors. These features and qualities are shown in Table 1, below:

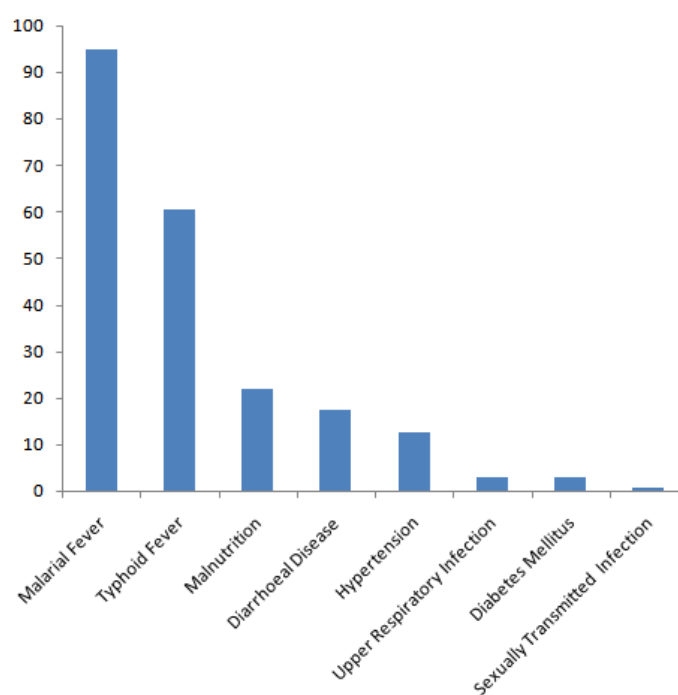
**Table 1: Socio-demographic characteristics of respondents**

Variable	Frequency (n=127)	Percentage (%)
<b>Age</b>		
18-39	77	60.6
40-59	46	36.2
≥60	1	0.8
<b>Gender</b>		
Males	72	56.7
Females	55	43.3
<b>Marital Status</b>		
Married	61	48.0
Single	48	37.8
Widowed	18	14.2
<b>Occupation</b>		
Private employee	2	1.6
Public employee	3	2.4
Self-employed	24	18.9
Unemployed	98	77.2

The IDPs surveyed acknowledged the burden of several ailments in the camp, but most commonly malaria (98%), typhoid (60.6%) and malnutrition (22%). Other disease entities experienced in the camp are diarrheal disease, hypertension, diabetes mellitus, upper respiratory infections and sexually transmitted diseases and are displayed in Table 2 and Figure 1 below:

**Table 2: Patterns of Disease Occurrence among Camp Occupants**

Disease	Frequency (n=127)	Percentage (%)
Malarial Fever	118	94.9
Typhoid Fever	77	60.6
Malnutrition	28	22
Diarrheal Disease	22	17.3
Hypertension	16	12.6
Upper Respiratory Infection	2.4	3
Diabetes Mellitus	2.4	3
Sex. Transmitted Infection	1	0.8



**Figure 1: Pattern of diseases among camp inhabitants**

The figure shows that communicable diseases (malaria, typhoid, diarrhea, respiratory infections and sexual infections) dominate as the class of health problems in this camp compared to non-communicable ailments (malnutrition, hypertension and diabetes).

Interviews of health workers attached to the camp revealed that only outpatient consultations were offered, without a full complement of essential drugs that were scarcely available. No emergency services or laboratory investigative and diagnostic services were rendered. IDPs' rating of satisfaction with the level and quality of services provided showed that over 70% were dissatisfied. The implication is that the inhabitants of this camp do not have access to the minimum health care package guarantee in the primary health care (PHC) charter adopted by all tiers of governance in the country.

Qualitative interviews revealed several obstacles to the provision and utilization of health care services in the researched camp. Health care providers decried poor supply of drugs and medical consumables in the camp as captured by this respondent:

“We don't have enough drugs and equipments here for working. Most a times, we just prescribe for them to go and buy outside.” (R1)

This was corroborated by another interviewee who said:

“Sometimes we see cases but can't help them because there are no medicines.” (R2)

The utilization of the clinic facility by IDPs was judged to be low by interviewees, citing non-availability of essential medicines and non-provision of emergency services as key obstacles to utilization of the camp clinic.

“People in the camp don't like coming to us because we don't always have drugs and things to work with and when we close work, they have to go to chemists outside the camp.” (R2)

Questioned about the barriers to providing adequate services in the camp, one interviewee responded:

“..., things are difficult, but the state government should allocate more money to buy essential drugs for the clinic all the time, so that we can provide the basic primary care for them.” (R1)

These responses underscore the resource constraint to the provision of basic health services in the IDPs' camp. They also reflect poor utilization of current services and highlight the need to meet the minimum primary health care standard of care for persons living in camps.

#### **IV. Discussion**

Women and children constituted about 72% of the camp's population, which is similar to the 80% reported by the Brookings Institution,<sup>13</sup> and may be due to the fact that men are more likely to be killed during conflicts, or sometimes remain behind to watch over farm lands and other possessions. The most common health problems experienced in the studied camp related to communicable (malaria fever, typhoid fever, diarrhea, respiratory infections and sexually transmitted infections) and non-communicable (malnutrition, hypertension and diabetes mellitus) diseases, which corroborate the findings in Darfur, south Sudan.<sup>31</sup> Communicable diseases were more common, and can easily be attributed to the intrinsic vulnerability of displaced persons to ill health and the poor overall conditions they live under, such as overcrowded tents, inadequate water, food and sanitation.<sup>5,8</sup> Our study found malarial fever, typhoid fever and malnutrition to be the three most prevalent diseases reported in that order. Roberts and colleagues discovered malarial fever, respiratory problems and diarrhea to be the three main health problems in an IDPs camp in Uganda.<sup>32</sup> The difference in ordering may be as a result of variations in socio-cultural and environmental factors. The finding is however, similar to the UN report which identified malaria, acute respiratory infections, and watery diarrhea as three top causes of illness among internally displaced persons.<sup>15</sup> We found diarrhea to be the 4<sup>th</sup> commonest disease, while respiratory infections came in the 6<sup>th</sup> place in the ordering of illnesses occurring in this camp. Of note was the finding of no cases of vaccine preventable diseases in the camp, despite their high vulnerability. This may be attributed to the fact the study was undertaken in May, a period of the year between the dry windy harmattan and the onset of the rainy season.

Health care providers surveyed reported inadequate resources as constraining the volume and level of health services provided in the camp. It is known that public healthcare in Nigeria has remained chronically underfunded and the country is among the league of African countries with the lowest health care budgeting.<sup>26,33</sup> It is therefore not surprising that the country is not able to mobilize adequate funding to deal with the health care needs of the IDPs effectively. For these reasons, the health personnel could not provide the minimum pack of

care guaranteed under primary health care (PHC). This is against the backdrop that the principles of primary health care form the bedrock of health services planning and delivery in Nigeria. PHC stresses health promotion and disease prevention strategies as key pillars for health and wellbeing. Underpinning the model is universal access, needs based service coverage and health inequity mitigation encapsulated in eight core components of disease prevention, health education, water and sanitation and food and nutrition. Others include maternal and child health (MCH), immunization, treatment and provision of essential drugs.<sup>34</sup> The best public health approach to managing health and well-being in resource constrained settings like Nigeria is health promotion and disease prevention, which are more efficient compared to treatment of existing conditions.<sup>35</sup> Prevention approaches such as screening, surveillance, education, immunization and pre-disease management are said to be the most effective strategies in humanitarian conditions.<sup>36,37,38</sup> Although each component of the PHC model is essential in all humanitarian situations, they were lacking in the studied camp. To address the basic health problems of IDPs satisfactorily, there is the need to constantly sensitize health care providers to deploy comprehensive community driven strategies as embedded in the PHC charter, rather than disease focused approaches as discovered in this study. These essential methods may include screening and surveillance, education, immunization and pre-disease management and have been shown to be the most cost-effective approaches in humanitarian conditions.<sup>36,38</sup> Although stand alone health promotion and prevention interventions can be effective in health outcome improvements in IDPs camps, approaches that integrate multiple PHC components offer better scope for improved uptake and coverage of IDPs with essential health enhancing services in low resource settings.<sup>39,40</sup> For example, water treatment interventions aimed at minimizing contamination, by disinfecting water either at point-of-use or storage point, have been associated with reduce incidence of diarrheal diseases by about 90% in humanitarian settings.<sup>41,42</sup> It is equally known that when early surveillance systems are adopted in IDPs' camps, diseases incidences can be recognized and reported in a timelier manner.<sup>43</sup> Food and nutrition uptake interventions studies have also reported reduced incidences in all forms of acute malnutrition.<sup>44</sup> The major implications for these key health intervention gaps in the studied IDPs' camp and similar humanitarian situations are increased morbidity and mortality as reported here and related literature and the derailment of the health system goal of universal health care coverage, as well as the broader global sustainable development goals.

## V. Conclusion

The occupants of the studied camp have a high incidence of both communicable and non-communicable diseases, but access to adequate and timely health care services is constrained due to inadequate resources and provisioning of health care services. The dominant approach to provision of health services is vertical disease based, inefficient approach. Achieving optimal health care intervention in IDPs' camps and other humanitarian situations would require not only an understanding of the pattern of diseases in the settings, but grounding delivery interventions on primary health care (PHC) paradigm, especially in low resource settings. We therefore recommend that health care planning and delivery in IDPs must be holistic, encompassing both medical and non-medical dimensions, the latter embedding preventive, promotive and curative services. These innovations offer the best scope for improved health outcomes for internally displaced persons, while strengthening the health system at the same time.

**Funding support:** This publication was made possible through the training support received from STAMINA, University of Jos, Nigeria.

**Acknowledgement:** The technical support of Jae, P.H., Sunday, N.M and Daspan, S. is acknowledged

## References

- [1]. IDMC, NRC. Global Report on Internal Displacement 2019. [Online]. Available at: <http://www.internal-displacement.org/global-report/grid2019/>. Accessed May 13, 2019.
- [2]. United Nations. 1998. Guiding Principles on Internal Displacement. 2nd ed. New York: Office for the Coordination of Humanitarian Affairs (OCHA).
- [3]. United Nations Commission on Human Rights. 1998. Report of the Representative of the Secretary-General on Internally Displaced Persons: Guiding Principles on Internal Displacement, UN doc.E/CN.4/1998/53/Add. 2.
- [4]. Odusanya, O.O. 2016. The Health of Internally displaced persons. *Niger Postgrad Med J* 2016;23:159-60
- [5]. Owoaje ET, Uchendu O, Ajayi TO, Cadmus E. 2016. A review of the health problems of internally displaced persons in Africa. *NigerPostgrad Med J.*, 23:161-71.
- [6]. Salama P, Spiegel P, Brennan R. 2001. No less vulnerable: the internally displaced in humanitarian emergencies. *Lancet*. 2001;357(9266):1430-1.
- [7]. Olwedo MA, Mworozi E, Bachou H, Orach CG. 2008. Factors associated with malnutrition among children in internally displaced person's camps, Northern Uganda. *Afr Health Sci*. 8:244-52.
- [8]. Lam E, McCarthy A, Brennan M. 2015. Vaccine-preventable diseases in humanitarian emergencies among refugee and internally-displaced populations. *Hum Vaccin Immunother*. 11:2627-36.
- [9]. Connolly MA, Gayer M, Ryan MJ, Salama P, Spiegel P, Heymann DL. 2004. Communicable diseases in complex emergencies: Impact and challenges. *Lancet*. 364:1974-83.

- [10]. Huhn GD, Brown J, Perea W, Berthe A, Otero H, LiBeau G, *et al.* 2006. Vaccination coverage survey versus administrative data in the assessment of mass yellow fever immunization in internally displaced persons – Liberia, 2004. *Vaccine*. 24:730-7.
- [11]. Nicole W. 2015. The WASH approach: Fighting waterborne diseases in emergency situations. *Environ Health Perspect*. 123:A6-15.
- [12]. Siriwardhana C, Wickramage K. 2014. Conflict, forced displacement and health in Sri Lanka: A review of the research landscape. *Confl Health*. 8:22.
- [13]. Brookings Institution. 2014. Improving the Protection of Internally Displaced Women: Assessing Progress and Challenges. [Online] Available at: <https://www.brookings.edu/>. Accessed on 11<sup>th</sup> March 2015).
- [14]. Getanda EM, Papadopoulos C, Evans H. 2015. The mental health, quality of life and life satisfaction of internally displaced persons living in Nakuru County, Kenya. *BMC Public Health*. 15:755.
- [15]. UN OCHA, Nigeria: 2018 Humanitarian Needs Overview; Nigeria Centre for Disease Control, Disease Situation Reports. [Online] Available at <https://ncdc.gov.ng/diseases/sitreps>. Accessed May 20th 2019.
- [16]. Mooney E. 2005. The concept of internal displacement and the case for internally displaced persons as a category of concern. *Refug Surv Q*. 24:9-26.
- [17]. Amowitz LL, Reis C, Lyons KH, Vann B, Mansaray B, Akinsulure-Smith AM, *et al.* 2002. Prevalence of war-related sexual violence and other human rights abuses among internally displaced persons in Sierra Leone. *JAMA*. 287:513-21.
- [18]. Vu A, Adam A, Wirtz A, Pham K, Rubenstein L, Glass N, *et al.* 2014. The prevalence of sexual violence among female refugees in complex humanitarian emergencies: A systematic review and meta-analysis. *PLoS Curr*. 6.
- [19]. Austin J, Guy S, Lee-Jones L, McGinn T, Schlecht J. 2008. Reproductive health: A right for refugees and internally displaced persons. *Reprod Health Matters*, 16:10-21.
- [20]. McLean I, Roberts SA, White C, Paul S. 2011. Female genital injuries resulting from consensual and non-consensual vaginal intercourse. *Forensic Sci Int*. 204:27-33.
- [21]. Saxon L, Makhshvili N, Chikovani I, Seguin M, McKee M, Patel V, *et al.* 2016. Coping strategies and mental health outcomes of conflict-affected persons in the Republic of Georgia. *Epidemiology and Psychiatric Sciences*. doi:10.1017/S2045796016000019.
- [22]. Roberts B, Patel P, McKee M. 2012. Non-communicable diseases and post-conflict countries. *Bull World Health Organ* 90:2, 2A.
- [23]. Noji EK. 2005. Public health in the aftermath of disasters. *BMJ*. 330(7504):1379-81.
- [24]. Connolly MA, Gayer M, Ryan MJ, Salama P, Spiegel P, Heymann DL. 2004. Communicable diseases in complex emergencies: impact and challenges. *Lancet*. 364 (9449):1974-83.
- [25]. Omole O, Welye H, Abimbola S. 2015. Boko Haram insurgency: implications for public health. *Lancet*. 385 (9972):941.
- [26]. Mulugeta, A.A. 2010. The African Union Convention on internally displaced persons: Its codification background, scope, and enforcement challenges. *Refug. Surv. Q*. 29, 28–57.
- [27]. Federal Government of Nigeria. 2013. National Policy On Internally Displaced Persons (IDPs) In Nigeria. Abuja: National Commission for Refugees.
- [28]. International Crisis Group. 2018. Stopping Nigeria’s Spiralling Farmer-Herder Violence. Report No. 262, Africa.
- [29]. WHO and Government of Nigeria. 2018. Nigeria: Northeast Response—Health Sector WHO Bulletin No. 10 [Online] Available at: [www.humanitarianresponse.info/en/operations/nigeria/document/nigeria-northeast-response-healthsector-bulletin-no-10-october-2018](http://www.humanitarianresponse.info/en/operations/nigeria/document/nigeria-northeast-response-healthsector-bulletin-no-10-october-2018).
- [30]. Kim AA, Malele F, Kaiser R, Mama N, Kinkela T, Mantshumba JC, *et al.* 2009. HIV infection among internally displaced women and women residing in river populations along the Congo River, Democratic Republic of Congo. *AIDS Behav*. 13(5):914-20.
- [31]. Roberts B, Odong VN, Browne J, Ocaka KF, Geissler W, Sondorp E. 2009. An exploration of social determinants of health amongst internally displaced persons in Northern Uganda. *Confl Health*. 3:10.
- [32]. Usar, I.J. 2015. An Economic Analysis of Retail Pharmaceutical Market in Nigeria: Towards Access Expansion and Policy. PhD Thesis. Institute for International Health and Development, Queen Margaret University, Edinburgh. Available at: [www.thesis.qmu.ac.uk/id/eprint/2089](http://www.thesis.qmu.ac.uk/id/eprint/2089)
- [33]. World Health Organization (WHO). Declaration of Alma-Ata. WHO; 1978. [Online] Available at: [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf). Accessed September 25, 2017.
- [34]. WHO. 2018. Disease prevention, including early detection of illness. [Online] Available at: <http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/policy/>. Accessed August 20, 2019.
- [35]. Ramesh A, Blanchet K, Ensink JH, Roberts B. 2015. Evidence on the effectiveness of water, sanitation, and hygiene (WASH) interventions on health outcomes in humanitarian crises: a systematic review. *PLoS One*. 10(9):e0124688.
- [36]. Graham K, Rehman H, Ahmad M, Kamal M, Khan I, Rowland M. 2004. Tents pre-treated with insecticide for malaria control in refugee camps: an entomological evaluation. *Malar J*. 3:25.
- [37]. Young H, Borrel A, Holland D, Salama P. 2004. Public nutrition in complex emergencies. *Lancet*. 364(9448):1899-909.
- [38]. Cronin AA, Shrestha D, Cornier N, Abdalla F, Ezard N, Aramburu C. 2008. A review of water and sanitation provision in refugee camps in association with selected health and nutrition indicators--the need for integrated service provision. *J Water Health*. 6(1):1-13.
- [39]. Sphere Association. 2018. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 4th ed. Geneva, Switzerland: Sphere Association;
- [40]. Doocy S, Burnham G. 2006. Point-of-use water treatment and diarrhoea reduction in the emergency context: an effectiveness trial in Liberia. *Trop Med Int Health*. 11(10):1542-52.
- [41]. Steele A, Clarke B, Watkins O. 2008. Impact of jerry can disinfection in a camp environment - experiences in an IDP camp in Northern Uganda. *J Water Health*. 6(4):559- 64.
- [42]. Pinto A, Saeed M, El Sakka H, Rashford A, Colombo A, Valenciano M, *et al.* 2005. Setting up an early warning system for epidemic-prone diseases in Darfur: a participative approach. *Disasters*. 29(4):310-22.
- [43]. Jayatissa R, Bekele A, Kethiswaran A, De Silva AH. 2012. Community-based management of severe and moderate acute malnutrition during emergencies in Sri Lanka: challenges of implementation. *Food Nutr Bull*. 33(4):251-60.

Usar IJ, *et al.* “Assessment of Health Care Provisioning and Utilization at an Internally Displaced Persons’ Camp in Nigeria: Time for Integrating Essential Primary Health Care in Delivery Strategies.” *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 19(7), 2020, pp. 26-31.