SEXUAL HEALTH CHALLENGES AMONG YOUNG WOMEN IN INTERNALLY DISPLACED PERSONS CAMP, NEW KUCHINGORO, AREA ONE, ABUJA, NIGERIA

Shola Dayo ESAN
DSS/12/0605

A PROJECT SUBMITTED TO THE DEPARTMENT OF DEMOGRAPHY AND SOCIAL STATISTICS, FACULTY OF SOCIAL SCIENCES

IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF BACHELOR OF SCIENCE (B.Sc.) HONS IN DEMOGRAPHY AND SOCIAL STATISTICS, FEDERAL UNIVERSITY, OYE-EKITI, NIGERIA

SEPTEMBER 2016

CERTIFICATION

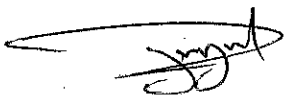
This is to certify that ESAN, Shola Dayo of the Department of Demography and Social Statistics, Faculty of Social Sciences, carried out a Research on the Topic **"Sexual health challenges among young women in internally displaced persons camp, New kuchingoro, Area one, Abuja, Nigeria"** in partial fulfillment of the requirements for the award of Bachelor of Science (B.Sc.) in Federal University Oye-Ekiti, Nigeria under my Supervision

.....

DR. E. O. ADEYEMI
PROJECT SUPERVISOR

.....

DATE



.....

PROF. P.O OGUNJUYIGBE
HEAD OF DEPARTMENT

21/11/16

.....

DATE

.....

EXTERNAL EXAMINER

.....

DATE

DEDICATION

I dedicate this project to God Almighty my creator, my strong pillar, my source of inspiration, wisdom, knowledge and understanding. He has been the source of my strength throughout this program and on His wings only have I soared. I also dedicate this work to my parents, Elder Christopher and Mrs. Funmi Esan who encouraged me all the way and whose encouragements made sure that I gave my all to finish that which I started.

ACKNOWLEDGEMENT

My deepest gratitude goes to God who provided all that was needed to complete this project and the program for which it was undertaken for. There was never lack or want. Throughout this entire study, He took care of everything that would have stopped me in my tracks and strengthened me even through my most difficult times.

I appreciate the Head of this great department, Prof. P. O. Ogunjuyigbe for his relentless effort to ensure that the Department of Demography and Social Statistics becomes a department to be envied.

My appreciation also goes to my supervisor Dr. E. O. Adeyemi whose contributions and constructive criticism pushed me to expend the kind of efforts I have exerted to make this work as original as it can be. Thanks to him, I have experienced true research and my knowledge on the subject matter has been broadened. I will never forget you, Sir.

My appreciation also goes to Dr. L.F.C. Ntiomo, one of the simplest people I have met. My sincere gratitude also goes to the entire academic staff and non-academic staff both past and present of the Department of Demography and Social Statistics.

I also appreciate the efforts of Mr. Bello Saidu Isah who assisted me with the distribution of the questionnaires and my brother from another mother "Mr. Rotimi Oladele" who assisted with the analysis of data.

My utmost regard also goes to my parents, Elder Christopher and Mrs Funmi Esan who painstakingly laid the foundation for my education giving it all it takes. I am and will forever be grateful to my guardian, Dr. E.O. Adeyemi who has given everything possible and even given up important things to make sure I achieve this feat. I can't find the words that express my gratitude.

This page can't tell it all. I appreciate my siblings Bros Babajide (HOD), Folashade (Shade Gold), Oluwatosin (You are wondeful), Bro Dare Akinola (My brother from another mother), truly, you inspired me! Na we all get this degree. I appreciate all my friends, Taiwo Ogunleye, Segun Mustapha and well-wishers especially Mr Olayinka Ogundare and his lovely family who one way or the other have been there and have continually prayed for my success. God bless you.

Finally, I thank my Pastor and Spiritual Head, Pastor E. O. Adeyemi for his prayers, words of motivation and words of comfort that came just in time. God bless you all. You all won't lose your reward in Jesus name. Amen.

TABLE OF CONTENTS

ABSTRACT

This study examined the sexual health challenges among young women in an Internally Displaced Persons camp (IDPs) in Abuja, Nigeria. Both qualitative and quantitative methods were used in this study. For the qualitative method, four Focus Groups Discussion (FGDs) were conducted among young women aged between 15 and 24 at IDP camps while for the quantitative method, a structured questionnaire was used to collect information from 250 respondents. Three levels of analyses were conducted. From the study, 68% of the respondents within the age 15-19 had experienced forced sexual act within the camp. Logistic regression revealed that respondents between ages 20-24 were less likely to have forced sexual intercourse and Sexually Transmitted Infections (STIs) compared with respondents aged 15-19years. The study recommended that young women who have been involved in forced sexual act and who had contacted STIs should get adequate medical attention while government should provide adequate security within the IDPs camps.

Keywords: Internally Displaced Persons, sexual health, forced, displacement, Sexually Transmitted Infections.

CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

Displaced persons under international law are people or sets of people who have been asked or ordered to leave their homes or place of residence, because of or due to the effect of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and they must have either remain within their own national borders (as internally displaced persons) or they must have crossed an internationally recognized state border (as refugees), (Ladan, 2006). Women account for about 50% of the world's 33.2 million internally displaced persons (IDPs) (United Nations, 2013). In addition to the many general human rights violations faced by all IDPs, displaced young women are often at greater risk than other affected populations. They face loss of livelihoods and key documentation needed for daily life. They have less access to assistance, and struggle to access adequate education, healthcare, training and livelihoods. They are more susceptible to sexual and gender-based violence (SGBV), are likely to face difficulties in exercising rights to housing, land and property, and are often excluded from decision-making processes. These human rights violations are compounded by conflict, which exacerbates pre-crisis patterns of discrimination. Age, group affiliation (e.g. membership in minority groups), disability, civil status, socioeconomic status and displacement itself can place particular groups of internally displaced women at heightened risk. For example, indigenous or elderly women who are displaced may find themselves doubly disadvantaged. Recently displaced women usually face different risks than those who have been displaced for lengthier

periods while women resident in camps usually have different needs than those living with host families.

One of the positive developments over the past decade has been the increased attention paid to refugee women in the context of United Nations emphasis on women, peace and security (UNHCR, 2010). There has greater focus on women who are displaced within the borders of their own countries. Indeed, the rights and needs of women and girls in emergency and post-conflict situations have received increased attention since the 1990s from states, international agencies, civil society organizations and other relevant actors. These bodies have also sought to promote gender-sensitive approaches to humanitarian and development assistance (UNSC, 2000). Their attention to these issues is reflected in various resolutions, policies, guidelines and handbooks, as well as gender-mainstreaming efforts and numerous targeted programs. (WCW, 1995) A great deal of effort has been devoted to addressing gender concerns in policies and programs. However, more work is needed. (UNSC, 2013)

In an effort to draw attention to the particular needs and resources of internally displaced women the UN Special Rapporteur on the human rights of internally displaced persons, Chaloka Beyani, presented a report to the UN Human Rights Council (HRC) in March 2013 which provided an overview of some of these issues. This report was in line with Dr. Beyani's HRC mandate, which among other things, asks him to

> integrate a gender perspective throughout the work of the mandate, and to give special consideration to the human rights of internally displaced women and children, as well as of other groups with special needs, such as older persons, persons with disabilities and severely traumatized individuals affected by internal displacement, and their particular assistance, protection and development needs (Sussan Martin, 2011)

Beyani's (2013) report to the HRC is intended for a broader audience including government, humanitarian and development actors as well as IDPs and the general public. The work was based on the analysis of the progress and challenges with regard to the protection of and assistance to internally displaced women.

Internally displaced women face a range of protection issues on a daily basis. Most notable are issue around sexual and gender-based violence. Without the protection of family and communities, internally displaced women are vulnerable to rape, domestic violence, forced prostitution, trafficking and a plethora of other violent situations. Women who have lost their husbands to conflict also face additional challenges and responsibilities as heads of households, and often have to rely on basic survival skills.

Displaced persons are of two categories: Refugees and Internally Displaced Persons (IDPs). Internally displaced persons (IDPs) are caused as a result of situations of armed conflicts (or the threat thereof) and mass violations of human rights, as well as floods, earthquakes and other natural disasters, the number of people fleeing their homes has increased dramatically over recent years. There are also deep-seated factors underlying this phenomenon of mass displacement. For example, under-development, poverty, in equal distribution of wealth, unemployment, ethnic tensions, political and economic subjugation of minorities, intolerance, absence of democratic procedures, and many other factors have been cited as causes. Where such people, in fear of persecution, seek refuge in other countries, their interests are protected by the refugee convention of 1951 and the 1967; protocol relating to the statute of refugees. If those persons are victims of armed conflict situations, they are entitled to protection under the Geneva Convention of 1949 and their additional protocols of 1977. In general, human rights law offers protection to all persons

without any adverse distinction. However, where such people and displaced within their own country, specific problems as the rights and protection arise (Deng, 1994).

In 2009, the United Nations High Commissioner for Refugees estimated there were roughly 27 million internally displaced persons around the world. In 2015, the UNHCR said IDP in the North East had risen to 2.2 million. Internally displaced persons (IDPs) are individuals or groups who are forced to flee their homes, for one reason or another, but remain inside the borders of their own country. The Internal Displacement Monitoring Centre attributes two key characteristics to IDPs: (1) The coercive or otherwise involuntary character of movement and (2) the fact that such movement takes place within national borders. Much of internal displacement comes because of prolonged conflict and violence within a country. Indeed, as Walter Kalin, the Representative of the Secretary General on Human Rights of Internally Displaced Persons, has noted: "IDPs are often the main victims of conflict and they often have specific needs." This is particularly true for vulnerable groups such as women, children, and the elderly and disabled. Females in particular present a challenge for the humanitarian community – it is estimated that about 80 percent of internally displaced populations consist of women and girls. Given the widespread occurrence of IDPs, and the problems they create for national governments and the international community, many different organizations have been created to deal with IDPs.

1.1 Statement of Research Problem

During the past five years, complex humanitarian emergencies have become the order of the day and the resultant consequences have led to the growing percentage of Internally Displaced Persons in Northern Nigeria. By 2014, Boko Haram insurgency had left large numbers of the population of Adamawa, Borno, Kano, Plateau, Kaduna, Abuja and Yobe States in refugee's camps. Most of the refugees were from different ethnic groups in all the states of the Northern Nigeria (National

Emergency Management Agency (NEMA), 2014). These states which were at the center of complex humanitarian emergencies suffered massive internal population displacements.

Statistics regarding Boko Haram internal displacements are less readily available. This is partly because there has been less access to and assistance for internally displaced populations. Most of this internally displaced persons (IDPS) lived in camps or settlements similar to those of refugees but others lived in the homes of their relatives or alongside, normal populations where they are less conspicuous and more difficult to quantify. Many of them were also abducted to Boko Haram camps in Sambisa forest and were rescued by the Nigerian military troops. They were settled in various refugee camps in Northern Nigeria. The internally displaced persons of Boko Haram insurgency are people who have been through heart breaking, sometimes appalling suffering. Yet in camps and settlements, villages and towns all over Northern Nigeria, they very often looked to government intervention as their major or only hope for a decent future. The people who are at major risk among this internally displaced persons are the children and the women. The children often fall victim of malnutrition, while the women are exposed to such risk like sexual health challenges. They are most times victims of rapes which may likely lead to unwanted pregnancy and sexually transmitted infections such as HIV/AIDS, gonorrhea, syphilis, genital herpes, etc. These diseases have posed several reproductive health threats to their lives and wellbeing through the years and they have been unable to get adequate medical attention from the government and NGOs.

This study examines the sexual health challenges among young women in internally displaced persons camp, New Kuchingoro, Area one, Abuja, Nigeria.

1.2 Research Questions

1. What is the prevalence of sexual health challenges among young women in IDPs camp?
2. What are the determinants of sexual health challenges faced by young women in IDPs camp?
3. What are the sexual health seeking behaviour of young women in IDPs Camp?

1.3 Research Objectives

The main objective of this study is to examine the sexual health challenges faced by young women in IDPs camp, New kuchingoro, Area one,Abuja, Nigeria. The specific objectives are:

1. to show the prevalence of the various sexual health challenges among young women in IDPs camp;
2. to investigate the determinants of sexual health challenges among young women in IDPs camp, New kuchingoro, Area one, Abuja, Nigeria; and,
3. to investigate the sexual health seeking behaviour among young women in IDPs camp, New kuchingoro, Area one, Abuja, Nigeria.

1.4 Significance of the Study

This study examined the series of lifestyles of Internally Displaced Persons in their camp at New Kuchingoro, Area One, Abuja, Nigeria. In addition, it provided insight into sexual health challenges among the young women between the ages ranges 15-24 within the camp. Findings from this study are expected to contribute to the rapid assistance by the government to the IDPs. Also, the knowledge shall be of immense benefit to health policymaking at the regional and national levels as it will lead to the planning of intervention programmes and behavioural change campaigns.

1.5 Definition of Terms

Internally Displaced Persons: Persons or group of persons who have been forced or obliged to flee or to leave their homes or places of habitation, 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.

Sexual Health: a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Forced Displacement: it is refers to the movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural hazard or environmental disasters, chemical or nuclear disasters, famine, or development projects.

STIs (Sexually Transmitted Infections): Any infection contracted during heterosexual intercourse. This may include AIDS, Syphilis, Gonorrhea, Public lice, and others.

Violence against women: The magnitude of violence suffered by women before, during and after conflict is overwhelming. The glaring gaps in women's protection must be addressed. Without dedicating resources specifically for women's protection, and without mobilizing the requisite technical and operational capacity, the neglect of women will continue.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

An estimated 37 million people worldwide currently live away from their homes and communities because of natural disasters, persecution, war, or violence. People are considered refugees if they have crossed an international border, and internally displaced persons (IDPs) if they have been forced to leave their homes but remain in their own countries. Worldwide, there are more than 14.5 million refugees. The number of IDPs is even greater, at more than 20 million people (Krause, 2008)

While proportions of female and male refugees are nearly equal on a global basis, regional differences exist. In some areas, women and children make up 90% of the refugee population, because their husbands or fathers have died, been taken prisoner, or become combatants. Many refugees have significant health problems even before being uprooted. Most displaced people come from countries with low life expectancies and high levels of maternal and newborn mortality. They also have limited literacy and skills, as well as low rates of employment and low social status. These problems may be exacerbated by displacement. Refugees and IDPs face myriad changes, including disruption in the social support from family and friends, pressure to change their desired fertility levels, and changing societal roles. Refugees who end up in camps, however crowded, are often the lucky ones, since camps usually provide food, water, and basic health care, along with education, job training, and other activities. Such services are not always available to IDPs or to refugees not living in camps. Women and men may find themselves without any reproductive health care at all, or they may receive care through UNHCR or another

donor (UNHCR, 2007). But basic family planning and maternal and child health services often do not address problems commonly experienced by refugees and IDPs.

Many women who are refugees or IDPs face unwanted, unplanned, and poorly spaced pregnancies, due to a lack of access to contraceptive services and supplies, overburdened providers with little time to educate or counsel clients, pressure from husbands or other family members to "rebuild" the population, and increases in rape and prostitution. Refugees are at higher risk than stable populations for sexually transmitted infections (STIs) and gender based violence (United Nations Economic and Social Council, 2009). Research indicates that the availability of contraceptives has improved in stable refugee populations since the mid-1990s (Hynes, 2006).

In the mid-1990s, several events drew attention to refugees' need for reproductive health care. The Women's Commission for Refugee Women and Children (1994) showed that the needs (with the exception of antenatal and delivery care) were rarely addressed by existing health services. Both the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women called for greater efforts to protect refugee and displaced populations and to guarantee their access to health care services (Wulf, 1994). Following these conferences, several coalitions formed to increase refugees' access to quality reproductive health services, including the Inter-Agency Working Group on Refugee Reproductive Health (IAWG) and the Reproductive Health for Refugees Consortium (RHRC). Conflicts in Rwanda and the former Yugoslavia, where widespread sexual violence and atrocities against women occurred, also drew attention to refugees' reproductive health care needs. The IAWG produced a manual that incorporates World Health Organization technical standards, and concluded that sexual

health for refugees should cover protection from sexual and gender violence, prevention and treatment of STIs and HIV/AIDS, including abortion-related complications (UNHCR, 2009).

During conflict and disasters, whole communities are forced to flee their homes and move to safe havens, like refugee camps in neighboring countries. An often-used figure, from the IASC (2001), points out that 80% of all IDPs and refugees are women. Baden and Byrne (1995:18) object to the use of this figure because it gives a distorted image of reality when they say

> this figure, in itself, is not particularly significant, given that women and children might be expected to make up around that percentage in a 'normal' population

They do however contradict this criticism by stating that, looking at the demographics, there are large amounts of female-headed households. The men that have remained in refugee camps are usually the elderly and disabled.

The IASC (2001:2) observes that:

> Displacement tends to increase the number of households headed by women, particularly by widows, and change gender roles. Moreover, displacement has different gender impacts in each phase of displacement: from the cause of flight, to considerations of protection and assistance while displaced, to specific problems arising in the resettlement and reintegration phase. In all cases, fundamental rights are put at risk

The new reality in refugee and IDP camps can challenge existing social and cultural structures. Turner (2004) gives examples of the changes that arose in Tanzanian camps for refugees from Burundi, adjusting many socio-cultural norms that existed. For instance, "big men" are no longer respected as they used to, because they don't have the property and special status that they had on their arrival in the refugee camps.

Economic pressures and poverty have added a new angle to the problem of child marriage not only in the IDP camps, but all over Africa and the world at large. Early child marriages largely motivated by lack of economic resources have led to the increased vulnerability of the girl child. Poverty and lack of other income generating activities do force internally displaced girls and women into prostitution and hence early marriage and trafficking.

Poverty is one of the major causes of early child marriages in the IDP settlements in Africa. Where poverty is at peak, young children especially the girls are regarded as an economic burden and end up being forced into early marriages by their parents to older men. Evidence suggests that where socio economic situations exist like in the IDP settings, early marriage is on the rise. Families in refugee camps in Burundi, for example, protect their culture by marrying their daughters off as early as possible. In addition to the above, reports from Iraq also indicate that early marriage is rising there in response to poverty inflicted by the post-Gulf War sanctions in Afghanistan, war and militarization have led to an increased number of forced marriages of young girls. Without financial support, IDPs have little or no choice but to arrange marriages for themselves or for their daughters. The bride price that a young girl fetches is needed to support her poor birth family to pay debts and a source of funds to purchase brides for her brothers. This makes the girls family benefit greatly from her marriage at an earlier age.

2.1 Theoretical Orientation

This study is informed by Maslow's theory of a hierarchy of needs which explains human development in stages where an individual rises to the next level upon successful completion of the preceding one, Snowman & Beihler (2010), Maslow points that only when the lower order needs of physical and emotional welfare are met, are humans concerned with the higher order

needs of influence and personal development. Conversely, if the things that satisfy lower order needs are taken away, human beings no longer become concerned about the maintenance of the higher order needs. This model of needs was developed in the 1940s- 50s and it remains valid today for understanding human motivation and personal development.

Rathus (2006) puts it across that at the bottom of the hierarchy are biological and physiological needs which include air, food, drink, shelter, warmth, sex, sleep, child-abuse help-lines, and social security benefits. It is Maslow's opined that internally displaced persons will only be able to sustain themselves when they receive with enough food, love, warmth, shelter.

The theory further explains that with their physical needs relatively satisfied, the individual's safety needs take charge and dominate behaviour in the second stage of the hierarchy (Sprinthal, 2006). In the absence of physical safety, due to war, natural disaster, family violence, childhood abuse, people may experience post-traumatic stress disorder or transgenerational trauma. In the absence of economic safety, due to economic crisis and lack of job opportunities, this safety needs manifest themselves in ways such as a preference for job security, grievance procedures for protecting the individual from unilateral authority, reasonable disability accommodations. Hence, there is need for protection of internally displaced person from these negative elements and afford them some semblance of stability in their lives in order for them to achieve their maximum potential.

After physiological and safety needs are fulfilled, the third level of human needs, according to Maslow in Rathus (2006), is interpersonal and involves feelings of belonging. These feelings can be achieved through work group, family, affection, relationships, schools and dating. This

need is especially strong in internally displaced person and can override the need for safety as shown in a research by Martin (2005). Deficiencies within this level of Maslow's hierarchy, probably due to ostracism, stigma, discrimination, hospitalist, and neglect can impact the individual's ability to form and maintain emotionally significant relationships in general, such as friendship, Intimacy and family. According to Maslow, humans need to feel a sense of belonging and acceptance among their social groups, regardless if these groups are large or small.

In the fourth stage, Maslow points that all humans have a need to feel respected; this includes the need to have self-esteem and self-respect, (Sprinthal & Sprinthal, 2006). Esteem presents the typical human desire to be accepted and valued by others. People often engage in a profession or hobby to gain recognition. These activities give the person a sense of contribution or value. Low self-esteem or an inferiority complex may result from imbalances during this level in the hierarchy. People with low self-esteem often need respect from others; they may feel the need to seek fame or glory. However, fame or glory will not help the person to build their self-esteem until they accept who they are internally. Psychological imbalances such as depression can hinder the person from obtaining a higher level of self-esteem or self-respect.

The highest stage, according to Maslow, is summarized by the quotation, "what a man can be, that he must be" (Kail & Cavanaugh, 2010). This quotation forms the basis of the perceived need for self-actualization. This level of need refers to what a person's full potential is and the realization of that potential. Maslow describes this level as the desire to accomplish everything that one can, to become the most that one can be. Individuals may perceive or focus on this need very specifically. For example, one individual may have the strong desire to become an ideal parent. In another, the desire may be expressed athletically. For others, it may be expressed in

paintings, pictures, or inventions. As previously mentioned, Maslow believed that to understand this level of need, the person must not only achieve the previous needs, but also master them.

Given the above, understanding the completion of these stages is therefore the key in understanding how children develop and what factors lead to their failure. While many situations may hinder internally displaced person successful journey to self-actualization, the researchers are interested in examining how internal displacement affects vulnerable people to influence livelihood and reproductive health achievement by paying attention to their interactions with the host community in which they have been resettled, their livelihood achievement, and psycho-social growth

2.1.1 Sexual and Gender based violence

Many woman and adolescent girls are subjected to sexual violence, during both the emergency phase of a crisis and following stabilization. It is common in refugee settings for sexual and gender-based violence to be used to debase women and their families; it is equally common for the survivors of sexual and gender-based violence to avoid seeking help, for fear of being blamed for the abuse (Krause and Purdin, 2006). In 2000, technical assistance was provided by UNHCR to facilitate the development of a monitoring system for sexual and gender violence (SGV) in the refugee camps in Tanzania. The SGV programme involved four main sectors: the health sector was responsible for examination and treatment; the community sector for counselling and support, socialization/reintegration, and advocacy; the protection sector for protection, police, and the legal/justice system; and the security system for physical safety and prevention. There were international and national NGOs involved in the SGV programme, as well as UNHCR staff, the Tanzanian government, and the refugee communities. Given the size of the programme and

the multiple partners and variety of sectors involved, it was not surprising to find that a certain degree of confusion reigned between the roles and responsibilities of the different actors. In addition, there were inconsistencies in the definition of SGV, data collection and analysis, and a general lack of focus on evaluation of outcomes. NGOs and UNHCR had a different method for classifying and counting types of SGV cases differently, leading to variations in monthly reports of SGV incidents from 0 to 50, depending on the camp and the NGO involved. All police reports required a medical evidence form to be completed by a doctor at a health centre, the forms were often incorrectly filled because doctors misunderstood what they were being asked. It was also unclear who was responsible for returning the form to the police, and completed forms were sometimes lost (UNHCR, 2000)

With regard to SGV, the findings of the assessment of reproductive and sexual health services conducted in 2001 in the refugee camps in Kenya indicated inconsistency between the camps in Kakuma and those in Dadaab. In Kakuma there was no formal mechanism in place for the referral of victims of rape, either from the community to the camp hospital or the reverse. Nonetheless, physical care and counselling were available at the camp hospital and there was a 'safe haven' in the community, run by an NGO, where psychosocial support was provided. In contrast, there was a protocol in place in Dadaab for managing victims of rape, requiring the completion of individual incident forms at the hospital, following examination and treatment of victims. In terms of coordination of services, an inter-agency meeting was held weekly, chaired by the UNHCR Protection Officer, and attended by the SGV focal person from the relevant NGOs and the police force. Community interventions in Dadaab included the provision by GTZ of firewood for women, although the impact of this intervention was not clear as monitoring and evaluation of the SGV programme was inadequate. Nonetheless, there was a widespread

perception that the firewood distribution project was the main reason for a decline in the number of reported rape cases, despite the fact that the project provided only approximately 30 percent of household fuel needs. In both Dadaab and Kakuma, SGV and FGM were topics included in general community education activities for reproductive health (UNHCR, 2001)

The assessment of RHS for IDPs in Angola in 2001 found that there were no specific services available for victims of SGV, even though the problem was said to be widespread. For example, in Huambo, Angola's second largest city, hospital staff told the assessment team that sexual violence was so common that victims rarely bothered to report it. The cases of sexual violence seen at the hospital tended to be children for whom families sought medical care as a means of collecting evidence (presumably to take action against the perpetrator) (Meriwether, 2001)

It has been traditional in disaster research to conceptualize disasters as sudden events, disrupting everyday life and causing death and destruction (Suzette et al 2005). Poverty, environmental degradation, unequal power relations among others, seen as processes that influence the extent of the disaster impact. The concept of vulnerability is often used to explain these social, economic and physical processes. According to Anderson (2003), "Understanding these linkages through gender analysis makes it clear that women are vulnerable not because it is in their physical nature to be weak but because of the arrangements of societies that result in their poverty, political marginalization, and dependence on men." In this sense, the concept of 'gendered vulnerability' becomes important. It places a special focus on gender relations instead of women's needs and positions. It also emphasizes issues of power and powerlessness in its broadest context.

As Blaikie et al. (1994) in Enarson (1998:159) points out 'gendered vulnerability does not occurs from a single factor, such as household hardship or poverty, but reflects historically and culturally specific patterns of relations in social institutions, culture and personal lives'. According to Fordham (2004:176), claiming women's greater vulnerability is based on the fact that, generally, women and girls are disadvantaged compared to men and boys. They are more frequently occupying a position of dependence on other persons and their triple role in society is often invisible. Bradshaw (2004) makes a distinction between technical, political and social vulnerability. Regarding the last, she elaborates on six different gender elements, namely: poverty, health conditions, malnutrition, female-headed households, illiteracy and housing conditions. As far as poverty is concerned, she points to the fact that women and children may live in poverty because the resources available to them are far fewer than the total household resources (Bradshaw 2004:22).

2.1.2 Disaster Impact and Shift in Gender Relations

Real transgressions of cultural norms are rarely done without cost and women risk losing the support of their social network permanently. As is stated by El Bushra and Piza-Lopez (1994) in (Byrne and Baden 1995:34), "crisis often leads to changes in gender situations, notably shifts in or a loosening of the division of labor, changes in household structure and marriage relationships. Women's organizations may have developed, or grown in strength. Rehabilitation thus offers many possibilities for positive change" women may have become increasingly involved in processes of crop production, but at the same time lack land rights or access to credit. The process of rehabilitation may cause potential conflicts "as both men and women adjust to

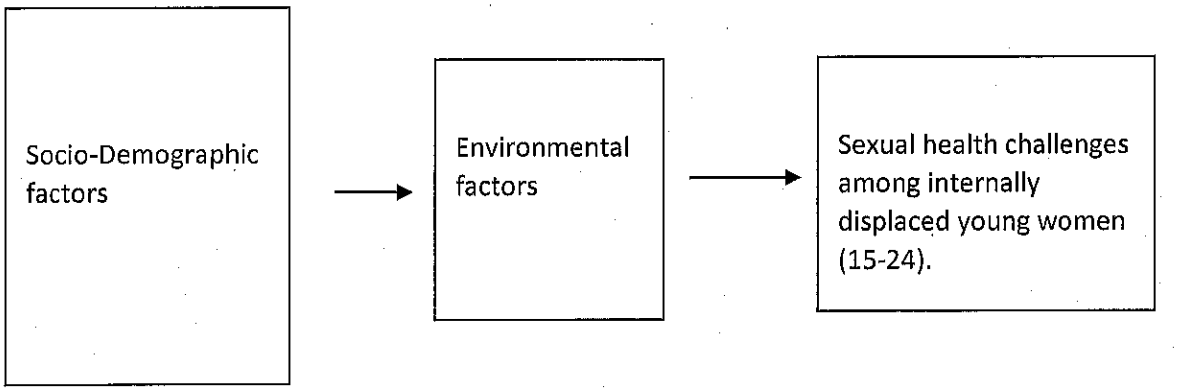
shifts in their respective patterns of control over resources and responsibilities" (Byrne and Baden 1995:36).

Wiest's study (1998) of single mothers in Bangladesh rearing children on the least desirable river plain found that flooding forced women heading households from bad to worse land and eventually into involuntary low-wage agricultural labor on local plantations. Earning income to replace lost crops or livestock is a crucial strategy for women and men alike. However, women's care responsibilities make them less mobile and they are therefore less able to migrate outside the impacted area than men. Women also suffer more than men because of their weak bargaining position in the household. This contradicts with the view that household resources are distributed equally, as relief agencies often assume. 'Women's assets are depleted, their income-earning options become inferior, and they are less mobile, leaving men in crisis a stronger 'fall-back position' (Enarson 2000:11).

According to (UNHCR, 2012), sexual and gender based violence have become defining features of conflict and a direct link has been found between forced displacement and sexual violence. Women and girls are vulnerable to sexual assault, rape or being forced to join armed forces as sex slaves or cooks. According to Dona (2012), experiences of conflict and displacement mostly result to psychological trauma in children as well as adults, but it has been recognized by psychologists since the 1980s, but it was only in the mid-1990s that humanitarian organizations started to fund psycho-social programmed for refugees and IDPs with the aim of helping them recover and adapt to their situations. They may become deskilled if they are not able to practice their normal employment If IDPs do not enjoy access to the resources and assets

needed for their livelihoods in their place of displacement then they quickly become dependent on food aid (Cohen and Deng, 1998).

2.2 Conceptual Framework



This study examines the sexual health challenges among women in internally displaced camp in Kuchingoro, Abuja. The socio-demographic variables will influence the environmental factors which will in turn influence the sexual health of the displaced women.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter describes the method and sources of data used in the research work. It includes the research design, study location, study population, sample size and sample procedure as well as data collection and data analysis method.

3.1 Research Design

A quantitative descriptive study and qualitative study was conducted in New Kuchingoro IDPs camp, Abuja, Nigeria. Primary data was collected via self-administered structured questionnaires to women in the IDPs camp and focus group discussion was also conducted. In the study, all monitors who are in aged between 15-24 in the study area were considered as a source of population.

3.2 Historical Background of Abuja

Abuja is both a Federal Capital Territory within the nation of Nigeria and a city within that territory which serves as the nation's capital. Both were created in 1976, while the city was built throughout the 1980s. It officially became Nigeria's capital on December 12, 1991, replacing Lagos. Abuja was as an entirely purpose-built and planned city. The Abuja Federal Capital Territory, while smaller than other states within Nigeria, is two and half times the size of Lagos city, the former capital. This territory was formed with the express purpose of supporting Abuja city. It is, therefore, virtually impossible to speak of one as separate from the other.

The site for the new capital was chosen because of its central location, easy accessibility, pleasant climate, low population density, and the availability of land for future expansion. Not only was a city designed, but an entire environment. Abuja is surrounded by abundant hills,

highlands, Savannah grassland, and tropical rainforests. However, the unfortunate reality of Abuja is that the idealistic vision of the new city was not backed by solid planning. Less than 20 years after its completion, there are slums and squatters' settlements in the midst of beautiful modern buildings and homes.

The territory is north of the confluence of the Niger and Benue Rivers. Bordering the FCT are the states of Kaduna to the northeast, Plateau to the east and south, Kogi to the southwest, and Niger to the west and northwest. It is slightly west of the center of the country. Its area covers 2,824 square miles (7,315 square km). Abuja's geography is defined by the two renowned rock formations around it—the *Zuma Rock* and the *Aso Rock*. The Zuma Rock is called the "Gateway to Abuja," as the Federal Capital Territory begins at its base. The Aso Rock, a 400-meter monolith left by water erosion, is located at the head of Abuja city, which extends southward from the rock.

Abuja has a cooler climate and less humidity than is found in Lagos. There are three seasons, including a warm, humid rainy season, from April to October, and a blistering dry season, when daytime temperatures can soar as high as 40 degrees Celsius (104 degrees Fahrenheit). Between these seasons is a brief interlude of Harmattan occasioned by the north-east trade wind, with characteristic dust haze, intensified coldness and dryness. The high altitudes and undulating terrain of the territory act as moderating influence on the weather of the territory. Rainfall in the FCT reflects the territory's location on the windward side of the Jos Plateau and the zone of rising air masses. The annual total rainfall is in the range of 43.3 inches (1100 mm) to 63 inches (1600 mm).

The Federal Capital Territory falls within the Savannah Zone vegetation of the West African sub-region. Patches of rainforest, however, occur in the Gwagwa plains, especially in the gullied train to the south and the rugged south-eastern parts of the territory. These areas of the FCT form one of the surviving occurrences of mature forest vegetation in Nigeria.

The Federal Capital Territory is a component of the 36 states and one territory that make up the Federal Republic of Nigeria's administrative system. Abuja is the location of the Presidential Complex, National Assembly, and the Supreme Court, and houses the headquarters of the Economic Community of West African States (ECOWAS), as well as its military arm, ECOMOG. It also has the regional headquarters of OPEC.

The city's Phase One Districts are: Abuja Central, which is the city's principal business zone and includes the National Assembly, the city hall, national cultural institutes, and other government-related offices, Garki, Wuse, Maitama, which is exclusive and is the location of European embassies, and Asokoro.

Phase two districts are: Kado, Durumi, Gudu, Utako and Jabi. Phase three districts are: Mabuchi, Katampe, Wuye and Gwarimpa. There are also five suburban districts, which are Nyanya, Karu, Gwagwalada, Kubwa, and Jukwoyi. Along the airport road are clusters of satellite settlements: Lugbe, Chika, Kuchigworo and Pyakassa. Other satellite settlements are Idu (The Main Industrial Zone), Mpape, Karimu, Gwagwa, Dei-Dei (housing the International Livestock market and also International Building materials market).

Agriculture in FCT produces yams, millet, maize, sorghum, and beans. Mineral resources include clay, tin, feldspar, gold, iron ore, lead, marble, and talc. Abuja's Nnamdi Azikiwe International Airport, named after Nigeria's first president, consists of an international and a domestic terminal, both sharing the same runway. In 2004, the airport served 2,232,905 passengers. Abuja city has major road connections, and has an efficient rapid bus and green cab system. Construction was underway, in 2008, for a light rail system for the city. Abuja did not (2008) have a connection to the national railway network of Nigeria.

The Federal Capital Territory had a population of 778,567 in 2006. Both the city and the Federal Capital Territory have undergone a huge population growth – with some areas growing at a rate of up to 30 percent each year. Abuja was planned as a capital where all Nigeria's ethnic groups, tribes, and religions would come together in harmony. It has avoided the violence prevalent in other parts of Nigeria. The population in the Federal Capital Territory includes the Afo, Fulani, Gwari, Hausa, Koro, Ganagana, Gwandara, and Bassa ethnic groups. English is the official language. Other languages spoken in the territory include Hausa, Yoruba, Ibo, and Fulani. Muslims make up 50 percent of the population, Christians 40 percent, while the remainder adheres to indigenous beliefs.

3.3 Population of the Study

The appropriate populations for this study are the women living in New Kuchingoro Internally Displaced Persons camp in Abuja from whom information on the sexual behavior among women in the IDP camp are elicited.

3.4 Sample Size and Sample Procedure

Since it is impossible to select all the women in the IDP camp, a sample representative of the population was identified. The two hundred (250) samples of women were randomly selected. This sample size covered the whole of Kuchingoro Camp, Abuja. Qualitative data was also collected through Focus Group Discussions.

3.5 Data Collection

Data for this study was collected using a self-administered questionnaire (primary data) and with one or two field assistants to hasten the distributions of the instrument. The study instrument for primary and quantitative data was tested for validity and reliability. Then, to get the appropriate

sample size of two hundred and fifty women, two hundred and seventy questionnaires were administered. Two hundred and fifty were completely filled and analyzed.

3.6 Method of Data Analysis

A structured questionnaire was administered and its results were entered and analyzed using Stata 12 statistical software. Three levels of analysis were employed in this study. These are the Univariate, Bivariate and Multivariate Analyses. The Univariate analysis was conducted with frequency counts and summary statistics of relevant variables, The Bivariate analysis employed the use of Chi-Square and Fishers exact test to the test the relationship between the dependent variables and the independent variables in categorical forms. The multivariate analysis employed binary logistic regression. The general binary logistic regression model used for the multivariate analysis is:

$$\log\left(\frac{p}{1-p}\right) = \beta_o + \beta_1 x_1 + \beta_2 x_2 + \ldots \beta_n x_n$$

Where p = probability of sexual challenges among young women in the IDP camp

x_1-x_n = predictor variables

β_o, β_1 - β_n = regression coefficients

3.7 Field Experience

The field survey could not be carried out by the researcher alone. Three research assistants were educated on the purpose of the survey, and two out of them speak Hausa language which made it easy to communicate with respondents who could not speak English correctly. Two other people who were part of the IDPs also assisted with the study. Problems were however encountered in the course of the data collection. These were no different from the usual problems involved in

data collection in every developing country. The principal investigator and the field workers were mistaken for government officials. Suspicion and outright refusal of the participant in filling the questionnaires were the order of the day. But, because of the interesting nature of the research topic, most respondents usually wanted to engage the field workers in other discussions and the objectives of the study area.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.0 Introduction

This chapter presents the socio-demographic characteristics of the respondents. It also provides information on the sexual health challenges of the study group as well as on the hypotheses testing. This is concluded with the discussion of the findings.

4.1 Univariate Analysis and Discussion of the Findings

Table 1. Socio-demographic characteristics of respondents

Variables	*Frequency* (*N = 250*)	*Percentage (%)*
Age		
15 – 19	164	65.6
20 – 24	86	34.4
Marital Status		
Single	141	56.4
Married	68	27.2
Widowed	19	7.6
Separated	22	8.8
Ethnicity		
Yoruba	40	16.0
Igbo	78	31.2

Hausa	131	52.4
Others	1	0.4
Marriage Type		
Monogamy	82	75.9
Polygamy	26	24.1
Religion		
Christianity	152	60.8
Islam	95	38.0
Traditionalist	3	1.2
Employment Status		
Employed	69	27.6
Self-Employed	68	27.3
Unemployed	113	45.2
Level of Education		
None	119	47.6
Primary	74	29.6
Secondary	52	20.8
Post-secondary	5	2.0

Source: Author's field work, 2016

Table 1 revealed that 65.5% of the respondents fall between 15-19 years age group. 56 percent are single and are mostly Hausas (52.4%). With regards to respondent's marriage type, 76% of

respondents who are currently of formerly married were in a monogamous marriage. 61% were Christians; 45% were unemployed and almost 48% had no education.

Table 2. Displacement to Camp

Variables	*Frequency (N = 250)*	*Percentage (%)*
Cause of displacement		
Boko Haram Insurgency	145	58.0
Natural Disaster	25	10.0
Ethnic crisis	29	11.6
Religious crisis	25	10.0
Lack of financial means	26	10.4
Do you currently work outside your home		
Yes	93	37.2
No	157	62.8
Year of continuous residence at camp		
2010	26	10.4
2011	69	27.6

2012	49	19.6
2013	72	28.8
2014	22	8.8
2015	12	4.8
Time when respondents left for camp		
Immediately after displacement	95	38.0
1-6 months after	100	40.0
>6 months after	55	22.0
Number of displaced household members		
1-4	188	75.2
5+	62	24.8
Household affected by basic food needs?		
No	73	29.2
Yes	177	79.8

Source: Author's field work, 2016

Table 2 explains the reason for displacement among respondents. The table revealed that 58% of the respondents were displaced as a result of Boko Haram insurgence. 29% of the respondents have been continuously on that camp since 2013 while 40% had moved to the camp within 6

months after displacement. Seventy-five percent of the respondent agreed that 1 to 4 members of their household were displaced too and 79% are affected by basic food needs.

Table 3. Sexual Health Challenges

Variables	*Frequency (N = 250)*	*Percentage (%)*
Ever had sexual intercourse		
Yes	224	89.6
No	26	10.4
Age at first intercourse		
11-13	142	63.4
14+	82	36.6
Have sex in exchange for money/gift?		
Yes	157	70.1
No	67	29.1
Had more than one sexual partner?		
Yes	166	74.1
No	58	25.9

Persons you have had sex with in past 12 months		
Spouse	77	34.4
Boy/Girlfriend	81	36.1
Commercial sex workers	34	15.2
Partners you meet daily	32	14.3
Ever had about any STI?		
Yes	121	48.4
No	129	51.6
Contraceptives Knowledge		
Yes	207	82.8
No	43	17.2
Contraceptive Use		
Yes	155	69.2
No	69	30.8
Ever had any STI?		
Yes	154	68.7
No	70	31.3
If Yes, were you slapped?		
Yes	120	77.9
No	34	22.1

Did he twist your arm or hair?		
Yes	74	48.1
No	80	51.9
Punch you with his fist or something to arm you?		
Yes	104	67.5
No	50	32.5
Threaten to attack you with gun, knife or any weapon?		
Yes	101	65.6
No	53	34.4
Did you report the case to anyone?		
Yes	50	32.5
No	104	67.5
Ever had any forced sexual act?		
Yes	154	68.7
No	70	31.3
Did you seek treatment?		

Yes	13	8.4
No	141	91.6

Source: Author's field work, 2016

Table 3 explained respondents' sexual health challenges. About 90% of the respondents had had sexual intercourse and 63% agreed that they had their first sexual intercourse at the age of 11-13. Of the respondents who had ever had sex, 70% had sex in exchange for gift or money. 74% agreed that they have had more than one sexual partner. With regards to respondents' knowledge about sexually transmitted infections (STIs), 48% of the respondents had heard of any form of STIs – HIV, gonorrhoea, syphilis, etc. Majority of the respondents have heard and used any form of contraceptives before, 83% and 69% respectively. Forced sexual act is somewhat rampant on the IDP camp as about 68% of the respondents agreed that they have been forced into sexual act since they have gotten to the camp. This was corroborated by the FGD participants:

> *A 24 years old single: I was raped in 2013, the man beat me and forcefully had sex with me*
>
> *A married woman: I was raped when I was 18 years in our formal camp in Jos. I told my sister but there is nothing she can do. My sister then took me to the chemist to buy drugs. It is not a good experience*

Sixty-nine percent of the respondents have contracted STI and it is interesting to know that only 8.4% of them seek treatment. This was also supported by the FGD participants

> A 24 years old married woman
>
> *The shame of contacting STI will not allow you to seek treatment from the hospital. We only buy drugs from the chemist.*

Hypothesis 1. H_0: there is no significant relationship between socio-demographic characteristics and sexual health challenges

4.2 Bivariate Analysis and Discussion of Findings

Table 4. Relationship between Socio-demographic characteristics of respondents and sexual health challenges

riables	Had STI after Forced Sexual Act			χ2	p - value
	Yes	No	Total		
ge					
– 19	98 (63.6)	45 (64.3)	143 (63.8)	12.459	**0.023**
– 24	56 (36.4)	25 (35.7)	81 (36.2)		
arital Status					
ngle	50 (32.5)	16 (22.9)	66 (29.5)	22.775	**0.042**
arried	76 (49.3)	41 (58.6)	117 (52.2)		
idowed	14 (9.1)	5 (7.1)	19 (8.5)		
parated	14 (9.1)	8 (11.4)	22 (9.8)		
thnicity					
oruba	21 (13.7)	15 (21.4)	36 (16.1)		0.425*
bo	53 (34.4)	20 (28.6)	73 (32.6)		
ausa	79 (51.3)	35 (50.0)	114 (50.9)		
hers	1 (0.6)	0 (0.0)	1 (0.4)		
arriage Type					
onogamy	56 (72.7)	24 (82.8)	80 (75.5)		0.285*
lygamy	21 (27.3)	5 (17.2)	26 (24.5)		

Religion					
Christianity	95 (61.7)	44 (62.9)	139 (62.1)		**0.035***
Islam	57 (37.0)	25 (35.7)	82 (36.6)		
Traditionalist	2 (1.3)	1 (1.4)	3 (1.3)		
Employment status					
Employed	40 (26.0)	21 (30.0)	61 (27.2)	0.407	0.816
Self-Employed	43 (27.9)	18 (25.7)	61 (27.2)		
Unemployed	71 (46.1)	31 (44.3)	102 (45.6)		
Educational Status					
None	72 (46.7)	36 (51.4)	108 (48.2)		**0.002***
Primary	44 (28.6)	19 (27.1)	63 (28.2)		
Secondary	34 (22.1)	14 (20.0)	48 (21.4)		
Higher	4 (2.6)	1 (1.4)	5 (2.2)		

Source: Author's Field work, 2016. **Fisher's exact test applied*

Table 4 shows the relationship between respondents' sexual health challenges and their socio-demographic characteristics. Sixty-three percent of respondents who had forced sexual act belonged to the age group 15-19. Thirty-two percent of those who were forced into sexual activities were single, Hausa (51.3), are Christians (61.7) and are unemployed with no education (46.1 and 46.7.5) respectively.

Hypothesis 2. H_0: there is no significant relationship between health seeking behavior of respondents and sexual health challenges.

Table 5. Relationship between Health seeking behaviour of respondents and sexual health challenges

ariables	Had STI after Forced Sexual Act				
	Yes	No	Total	$\chi 2$	p – value
id you seek treatment fter STI?					
es	13 (8.4)	0 (0.0)	13 (5.8)	6.2732	**0.012**
lo	141 (91.6)	70 (70.0)	211 (94.2)		

Author's field work, 2016.

Table 5 showed the relationship between sexual health challenges and health seeking behavior of respondents. The table revealed that out of those who had had forced sexual intercourse and contracted STIs, only 8.4% seek treatment. This is an indication that the health seeking behavior of the respondents is very low.

4.3 Multivariate Analysis and Discussion of Findings

Table 6: Binary Logistic Regression for predictors of Sexual health challenges among respondents

	S.E	OR	95% CI		p-value
			Lower	Upper	
Age					

15 – 19	.321	1.0 (R.C)	.219	1.711	0.350
20 – 24		.613			
Marital Status					
Single	1.0 (R.C)				
Married	.865	0.963	.334	5.832	**0.002**
Widowed	.974	1.448	.387	5.417	0.582
Separated	.332	.570	.181	1.789	0.336
Ethnicity					
Yoruba	1.0 (R.C)				
Igbo	1.587	2.030	.438	9.402	0.365
Hausa	1.218	1.646	.386	7.022	0.500
Others					
Marriage Type					
Monogamy	.917	1.0 (R.C)	.398	5.040	**0.023**
Polygamy		1.417			
Religion					
Christianity	1.0 (R.C)				

Islam	1.684	0.919	.942	9.044	0.063
Traditionalist	2.102	0.510	.098	23.09	0.767
Employment status					
Employed	1.0 (R.C)				
Self-Employed	.352	.574	.172	1.914	0.366
Unemployed	.841	1.389	.423	4.553	0.587
Educational Status					
None	1.0 (R.C)				
Primary	.567	.979	.314	3.047	**0.032**
Secondary	.598	.961	.283	3.260	0.949
Higher	2.541	.951	.151	25.070	**0.022**

Table 6 shows respondents aged 20-24 are less likely to have forced sexual intercourse and contact STIs compared to respondents aged 15-19. More so, married women in Kuchingoro IDP camp are less likely to have forced sexual act and contact STIs compared to women who are single. Hausa respondents are 1.6 times more likely to be victims of forced sexual act and contact STIs compared to respondents who are Yorubas. Furthermore, respondents who practice Islam are less likely to be victims of forced sexual acts and contact STIs. With regards to respondent's educational status, respondents who have post-secondary education are less likely to be victims of forced sexual acts and contact STIs.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This study has examined the sexual health challenges among young women in Internally Displaced Person camp, Kuchingoro, Abuja. The present chapter concludes the study. It presents the summary of the findings in the study as well as offers recommendations.

5.1 Summary

The overall objective of this study was to explore the relationship between determinants sexual health challenges among young women in Internally Displaced Persons camp, New Kuchingoro, Area one, Abuja, Nigeria. The study had a sample size of 250 women resident in the IDP camp. All the respondents for this study were selected based on a simple random sampling technique. Univariate, Bivariate and Multivariate analysis techniques were employed in the course of this study. The univariate analysis in this study was carried out using tables of frequency distributions to describe the background characteristics of the respondents. The bivariate analysis was done using the chi-square (χ^2) and Fisher's exact test to show the association between sexual health challenges of respondents and the various socio economic and demographic background characteristics that are categorical variables. In addition, the binary logistic regression model was used in the multivariate analysis to determine the strength of association and identify predictors of sexual health challenges among young IDP women population in the study area.

65.5% of the respondents fell between 15-19 years age group. 56% were single and were mostly Hausas (52.4%). With regards to respondent's marriage type, 76% of respondents who are currently of formerly married were in a monogamous marriage. 61% were Christians. 45% were unemployed and almost 48% had no education. Furthermore, the study revealed that 58% of the respondents were displaced as a result of Boko Haram insurgency and 29% of the respondents have been continuously on that camp since 2013 in which majority (40%) of the attest that they moved down to the camp within 6 months after displacement. Seventy-five percent of the respondent agreed that 1 to 4 members of their household were displaced too and 79% are affected by basic food needs.

The study also revealed that about 90% of the respondents had had sexual intercourse and 63% of them agreed that they had their first sexual intercourse at the age of 11-13. Out of the respondents who had ever had sex, 70% of the have had sex in exchange for gift or money and 74% agreed that they have had more than one sexual partner. With regards to respondents' knowledge about sexually transmitted infections, 48% of the respondents have heard of any form of STIs, either HIV, gonorrhoea, syphilis etc. Majority of the respondents have heard and used any form of contraceptives before, 83% and 69% respectively. Forced sexual act is somewhat rampant on the IDP camp as about 69% of the respondents agreed that they have been forced into sexual act since they have gotten to the camp. Sixty-nine percent of the respondents have contracted any form of STI and it is interesting to know that only 8.4% of the seek treatment. This is an indication that the health seeking behavior of the respondents is very low.

With respect to respondents' sexual health challenges and their socio-demographic characteristics, sixty-three percent of respondents who had forced sexual act belonged to the age group 15-19. The logistic regression showed that respondents aged 20-24 are less likely to have

forced sexual intercourse and contact STIs compared to respondents aged 15-19. More so, married women in Kuchingoro IDP camp are less likely to have forced sexual act and contact STIs, compared to women who are single. Respondents who are Hausas are 1.6 times more likely to be victim of forced sexual act and contact STIs compared to respondents who are Yorubas. With regards to respondent's educational status, respondents who have post-secondary education are less likely to be victims of forced sexual acts and contact STIs.

5.2 Conclusion

Bradshaw (2004) observed the psychological influence of natural disasters on women. Interviews with women after Hurricane Mitch in Honduras illustrated their concern about the population's maternal health and sexual health challenges and about the lack of resources dealing with the situation. This study finds credit with Bradshaw because most of IDPs had been identified with some maternal and sexual health challenges such as severe fatigue during pregnancy, abdominal pain fever, vagina bleeding and contract of sexually transmitted infections. Therefore the results indicate that socio-economic characteristics of IDPs such as religion, education, age, marriage type, highest level of education, and knowledge about STIs, employment status, knowledge and use of contraceptives and respondent's health seeking behaviour all have significant predictors of sexual health behaviours among displaced population (IDPs) women at New Kuchingoro, Area One, Abuja at the 5% level of significance.

5.3 Policy Recommendations

With regards to the findings of this study, government should provide health facilities with qualified personnel to reduce sexual health challenges faced by women in IDPs camps in Nigeria. Government should make available, the highest attainable standard of health care

services, which includes, access to health care services with respect to sexual health issues within the camps or the area, health centers where the women can seek and receive information related to sexual health, that is, sexuality education, respect for bodily integrity, consensual sexual relations, consensual marriage and others. When considering sexual health challenges among the women in IDPs, one must recognize the diversity of this population and the different ways health care development are experienced and interpreted. The differences may include: marital status socioeconomic status, place of residence, age, ethnicity, sexual orientation, motivations for sexual activity and health status, Level of education and their religions. There is need for governments, NGOs, private agencies to organize regular workshops, seminars, symposia, lectures and talks for women in the camp aimed at reducing sexual health challenges while health care workers should be provided for these women in the IDPs camp.

Sexual health challenges begin with unsafe sexual activity, usually among young women in the IDPs camp. In the study areas, many of these women suffer lack of access to health care providers, No hospital, they can't afford some private hospitals around them which this had made most of them suffer from one sexual infection or the other, and health care should be provided for this IDPs women. The high level of illiteracy among young women contributed to the failure of then not getting better jobs in the society. There is a saying that 'an idle hand is devils workshop'. These young women engage in unsafe sex in order to make ends meet. Government should therefore organize empowerment programmes that will enable them learn and engage in productive skills as such will reduce sexual health challenges among young IDP women.

Government should provide means of educations for the young women, most specially the young females. If they are in school, it will reduce the rate at which they will contact STIs.

Information and education related to sexual health for young women is critical to build a healthy future generation. Therefore sexual health programmes must move beyond simply providing information to build skills among these young women.

Also, government should provide the young women in IDP camp with adequate security, as many of the women interviewed attest that many people just come from outside the camp to rape them and steal their belongings, there should be provisions of well-structured buildings to accommodate the young women and police stations should be sited within the camp as a way of reducing crime in the camp.

REFERENCES

Akinyemi, O. O., Owoaje, E. T., Ige, O. K., & Popoola, O. A. (2012). Comparative study of mental health and quality of life in long term refugees and host populations in Oru-Ijebu, Southwest Nigeria. *BMC Research Notes, 5*(1), 394. doi:10.1186/1756- 0500-5-394

Alhassan, N. (2011). Response to IDP Protection in Nigeria: - Emerging issues,challenges and Prospects. Being a paper presented at the national conference on IDPs in Nigeria. Organized by CISLAC, Abuja. 21-22 November, 2011 at Bolton White Hotels, Abuja.

AU (Kampala) Convention on IDPs in Africa, 2009.

Bouta, T., G. Frerks and I. Bannon (2005). *Gender, Conflict and Development.* World Bank Group: Washington D.C.

Bradshaw, S. (2004). *Socio-Economic Impacts of Natural Disasters: a Gender Analysis.* Manual of the Sustainable Development and Human Settlements Division of the United Nations: Santiago

Brookings-LSE Project on Internal Displacement (2014). *Brookings-LSE Project on Internal Displacement.* [Online] Available at: http://www.brookings.edu/about/projects/idp/kampala-convention [Accessed 23 June 2014].

Byrne, B. and S. Baden (1995). *Gender, Emergencies and Humanitarian Assistance*, BRIDGE Report No 35, IDS: Sussex.

Cohen, J. (2004). Minimalism about human rights: the most we can hope for? *Journal of Political Philosophy, 12*(2), 190-213.

Abuja Nigeria tourist information. Touristlink.com Retrieved 2013-08-30

Cohen, R. and Deng, F. M. (1998). *Masses in flight: the global crisis of internal displacement.* Washington, DC: The Brookings Institution.

Cohen, R. G., & Deng, F. M. (1998). *Masses in flight: the global crisis of internal displacement*: Brookings Institution Press.

Cohen, S. (2009). The reproductive health needs of refugees and displaced people: An opening for renewed US leadership. *Guttmacher Policy Review, 12*(3), 15–19.

Collinson, S., Darcy, J., Waddell, N. and Schmidt, A. (2009). *Realising protection: the uncertain benefits of civilian, refugee and IDP status, HPG Report 28,* London: ODI. *Colombia,* 14 June 2001, Rome, Italy: WFP.

Constitution of the Federal Republic of Nigeria, 1999 as amended.

Define Abuja's at Dictionary.com". *Dictionary.com.* Random House, Inc. Retrieved 14 April 2015.

APPENDIX 1-Questionaire

QUESTINAIRE CODE NUMBER: .....

TOPIC: SEXUAL HEALTH CHALLENGES AMONG YOUNG WOMEN IN INTERNALLY DISPLACED PERSONS CAMP AT KUHINGURO ,AREA I, ABUJA

Good morning/afternoon/evening. My name is ..... (Researcher's name), I am here with my colleagues in this city/ village..... to administer questionnaires. As this survey is going on, I would be grateful if you could participate by answering some questions for us. All information supplied to us in this study would be treated with utmost confidentiality. Eligible respondents are women of 15 years to 24 years.
(The questionnaire must be filled by qualified candidates only who has shown willingness to participate).

Location Identity

Street Name.....

SECTION A (DEMOGRAPHIC CHARACTERISTICS)

Q1. How old are you as at the last birthday?.....	Q2. Marital Status Married 1 Single 2 Widowed 3 Separated 4 Others specify.....5	Q3. Ethnicity Yoruba 1 Igbo 2 Hausa .... 3 Fulani.....4 Others..... 5	Q4.MarriageType Monogamy 1 Polygyny 2 Others specify..... 3	Q5.Religion Christianity 1 Islam 2 Traditional 3 Others specify.....4
Q6. What is your employment status? 1. Employed 2. Self-employed 3.Unemployed 4. Others specify.....	Q7. If employed, what is your occupation?.....	Q8. What is your average income per month?.....	Q9.What is your highest level of education attainment? a. None b. Primary School c. Secondary School d. OND/NCE e. HND/BSC f. Postgraduate g. Others Specify.....	Q10.What is the average income of your spouse per month?

Q11. What is your spouse's/partner's highest level of educational attainment? a. None b. Primary School c. Secondary School d. OND/NCE e. HND/BSC f. Postgraduate g.Others, specify.....	Q12. What is the age of your spouse/partner as at last birthday?.....			

Displacement

Q13. What is the causes of your displacement

a. Boko Haram Insurgency
b. Natural disaster (flood, fire incidence)
c. Ethic Crisis
d. Religious Crisis
e. Lack of financial means
f. Others.....s

Q14. Aside from your homework, do you currently work outside of the home? 1. Yes 2. No
Q15. Where did you leave before you were displaced for the first time.....
Q16. In what year did you first leave your home.....year.
Q17. How long have you lived here in.....(provide the name of current community)
Q18. In what year did you start to live continuously at this current place of residence.....
Q19. When did you leave the area you were leaving before the displacement 1. Immediately after the displacement 2. 1-6 months after displacement 3. More than 6 months after displacement
Q20. How many members of your household were displaced? .....
Q21. How many of them are currently is this camp? .....
Q22. During the last 30 days, has your household been able to afford basic needs: food, water, shelter and urgent medical care? 1. Yes 2. No

SECTION B

Sexual Health Challenges

Q23. At what age did you had your first sexual intercourse, if ever? _____
Q24. Have you ever had sex in exchange for money/gifts or favor? 1. Yes 2.No
Q25. Surveys reveal that many people have had more than one sexual partner at the same time, would you say this have ever happened to you? 1. Yes 2.No
Q26. Have you had sexual intercourse in the last 12 months? 1. Yes 2. No

Q27. How many sexual intercourse have you had in the last 12 months? _____

Q28. Think about the persons you have had sex with in the last 12 months. How many were they:

A. Your spouse(s) or partner who you were living together with? _____

B. Boy/Girl friends _____

C. Partners with whom you have commercial sex with_____

D. Partners you met on a casual basis_____

Q29. Have you heard about any form of contraceptives before? 1. Yes 2. No

Q30. If Yes, what are the methods of contraception you have heard about?

i.	Condoms	1. Yes	2. No
ii.	Pills	1. Yes	2. No
iii.	Injectable	1. Yes	2. No
iv.	Diaphragm	1. Yes	2. No
v.	Emergency contraception	1. Yes	2.No
vi.	Intrauterine Device(IUD)	1. Yes	2.No
vii.	Female Sterilization	1. Yes	2. No
viii.	Withdrawal method	1. Yes	2. No
ix.	Others? Please specify?		

Q31. Did you use any form of contraceptive during your last sexual intercourse? 1. Yes 2. No

Q32. If No, what is your reason for non-usage? _____

Q33. Have you ever heard of the following sexually transmitted infections?

i.	HIV/AIDS	1. Yes	2. No
ii.	Genital herpes	1. Yes	2. No
iii.	Syphilis	1. Yes	2. No
iv.	Gonorrhea	1. Yes	2. No
v.	Human Papillomavirus	1. Yes	2. No
vi.	Scabies	1. Yes	2. No
vii	Yeast Infections	1. Yes	2. No
viii	Chlamydia	1. Yes	2. No
ix.	Others? Specify.....		

Q34. Have you ever had any forced sexual act after displacement? 1. Yes 2. No

Q35. If yes, how old are you when you were forced into sexual act?.....

Q36. Do you experience any of the following from your partner before being forced into sexual act?

A. Slap you?	1. Yes	2. No
B. Twist your arm or hair?	1. Yes	2. No
C. Punch you with his fist or something to harm you?	1. Yes	2. No
D. Kick you, drag you or beat you?	1. Yes	2. No
E. Threaten or attack you with knife, gun or any other weapon?	1. Yes	2. No

Q37. Did you report the case of forced sexual act? 1. Yes 2. No

Q38. If yes, to who?

i. Parent/Guardian	1. Yes	2. No
ii. Police	1. Yes	2. No
iii. Friends	1. Yes	2. No
iv. Clinic	1. Yes	2. No
v. Religious leader	1. Yes	2. No

vi. Camp leader 1. Yes 2. No

Q39. If No,why.....

Q40. Did you contacted any sexual transmitted infection after the forced sexual act?
1. Yes 2. No

Q41. Which of the following sexual transmitted infection did you contacted?

i.	HIV/AIDS	1. Yes	2. No
ii.	Genital herpes	1. Yes	2. No
iii.	Syphilis	1. Yes	2. No
iv.	Gonorrhea	1. Yes	2. No
v.	Human Papillomavirus	1. Yes	2. No
vi.	Scabies	1. Yes	2. No
vii	Yeast Infections	1. Yes	2. No
viii	Chlamydia	1. Yes	2. No
ix.	Others? Specify.....		

Q42. Did you seek treatment? 1. Yes 2. No

Q43. If yes, where did you seek treatment?

i. Govt. Hospital . . . . .
ii. Govt. Health Centre . . .
iii. Family Planning Clinic . . .
iv. Mobile Clinic . . . . . .
v. Hospital.....
vi. Health Centre.....
vii. Fieldworker.....
viii. Private Hospital/Clinic . . . .
ix. Pharmacy . . . .
x. Chemist/Pms.....

Q44. If no, why.....

Q45. Were you pregnant at the time of assault? 1. Yes 2. No

Q46. How long did the abuse lasted?.....

Q47. Are you currently using any method of contraceptives to avoid sexually transmitted infections? 1. Yes 2. No

Q48.If you are not using methods why?.....
.....

Q49 . If yes , what method are you currently using?

i.	Pill	1. Yes	2. No
ii.	Implants	1. Yes	2. No
iii.	Female Condom	1. Yes	2. No
v.	Others.....		

Q50. Do you know that unprotected sexual intercourse can lead to unwanted pregnancy?
1. Yes 2. No

Q51. Do you know that sexually transmitted infections, such as HIV/AIDS can be transmitted to the unborn child? 1. Yes 2.No

APPENDIX II-FGD-Question Guide

Demographic Characteristics

Q1. How old are you as at the last birthday

Q2. Marital Status

Q3. Religion

Q4. What is your employment status?

Displacement

Q5. What is the causes of your displacement?

Q6. Where did you leave before you were displaced for the first time?

Q7. In what year did you start to live continuously at this current place of residence?

Sexual Health Challenges

Q8. At what age did you had your first sexual intercourse, if ever?

Q9. Did you had sex in exchange for money/gifts or favor? Why and why not

Q10. Surveys reveal that many people have had more than one sexual partner at the same time, would you say this have ever happened to you?

Q14. Have you ever had any forced sexual act after displacement?

Q15. If yes, how old are you when you were forced into sexual act?

Q37. Who did you report the case of forced sexual act to?

Q19. After the forced sexual act, which of the STIs did you contacted?

Q20. Where did you seek treatment?