REPRODUCTIVE HEALTH CHALLENGES AMONG INTERNALLY DISPLACED PERSONS IN ABUJA, NIGERIA

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CERTIFICATION

This is to certify that BELLO SAIDU ISAH of the Department of Demography and Social Statistics, Faculty of Humanities and Social Sciences, Federal University carried out a research titled 'Reproductive Health Challenges among Internally Displaced Persons in Abuja, Nigeria' in partial fulfillment of the award of Bachelor of Science (B.Sc.) in Federal University Oye-Ekiti under my Supervision.

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DEDICATION

This research is dedicated to almighty Allah, the beneficent, the merciful, most great, generous, worthy, noble and source of all goodness, source of inspiration and sustainer of my life.

I also dedicate this project to my brother SEV. YAKUBU N.A, my mentor, siblings and my entire family and to all demographers in Nigeria who carry out their work dutifully with dedication, to ensure that Nigeria is a better place. May God bless them

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Abstract

Women account for approximately half of the world is 33.2 million Internally Displaced Persons (IDPs). Displaced women and children are often at greater risk of less health care services and key needs for daily life than other affected populations. The study therefore examined reproductive health challenges among internally displaced women in Abuja, Nigeria.

The study utilized primary data collected from a self-administered structured questionnaires among women aged (15-49) in the IDPs in Abuja camp using convenience sampling technique. The data analysis revealed that majority of the respondents who got ever pregnant (53.8%) delivered their recent pregnancies at home. Also 84.9% of those who gave birth were helped by someone else rather than medical officials. 61% of the respondents did not attend antenatal clinic during pregnancy, while 68% of the respondents had experienced at least one still-birth. The study also established a significant relationship between age, number of living children, education, types of marriage and person assisted during delivery. In conclusion, women in IDPs camp face several reproductive health challenges such as heavy bleeding, painful urination, sexually transmissions infections, poor delivery complications and infection with various diseases in camp. The study recommends that government should provide health facilities with qualified personnel to reduce maternal and child mortality with the IDPs camps in Nigeria.

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Background to the Study

Internally displaced persons are groups of persons who have been forced to leave their homes or places of habitation as a result of armed conflict, situations of generalized violence, natural disaster, religious crisis, violations of human rights, natural or human made disasters and have not crossed an internationally recognized State border (UNHCR, 1998-2015). However, it is interesting to note that about 50% of the world's 33.2 million Internally Displaced Persons (IDPs) are women (Lowicki, 2008). Displaced women and children are often at greater risk of general human rights violations. They tend to have less access to assistance and struggle to access adequate education, health care and livelihoods (Lowicki, ibid.). Such women are likely to be affected by Sexual and Gender-Based Violence (SGBV) and are likely to face difficulties in exercising rights to housing, voting, health, land and property, and are often excluded from decision-making processes (Brookings-LSE 2014).

Sub-Saharan African has the largest total number of internally displaced persons. The figure is put at 10.4 million. In Nigeria, most cases of internal displacement occur as a result of violent conflicts with ethnic, religious and political undertones. In addition, thousands are annually displaced as a result of natural disasters including flooding in the Northern and Western part of the country. Presently, the main cause of internal displacement is the deadly Boko Haram insurgency which has overtaken North-Eastern Nigeria. This has led to a sudden displacement of about 1.6 million people, creating one of the largest displacement crises in recent times (NEMA, 2014).

Agencies such as the World Food Programmed (WFP), the United Nations High Commission for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF), as well as many other Non-Governmental Organizations (NGOs) involved in emergency relief, have considered the gender impact of their interventions. Studies on the health effects of conflict have rarely focused on women (with the exception of reproductive health), and most of the data on conflict mortality and morbidity do not provide gender-specific data. Women are seldom mentioned as a special group, but are lumped together with children as 'vulnerable groups' Yet women have peculiar experiences that affect their health. Nigeria is one of the richest countries inhabited by the poor and accounts for about 13% (1.4 million) of Africa's 11.1 million people internally displaced by conflict and generalized violence at the end of 2010. NEMA also estimated in a published report that a total of 7.7 million people were affected by flood disaster across the federation.

According to the United Nations Population Fund (UNFPA), unmet needs for reproductive health deprive women of the right to make 'crucial choices about their own bodies and futures', affecting family welfare. Women bear and usually nurture children, so their reproductive health is inseparable from gender equality. The lifecycle approach incorporates the challenges people face at different times in their lives such as family planning, services to prevent sexually transmitted diseases and early diagnosis and treatment of reproductive health illnesses. As such, services such as health and education systems need to be strengthened and availability of essential health supplies such as contraceptives and medicines must be supported.

1.2 Statement of the Problem

There has been an alarming rise in the number of IDPs in Nigeria for reasons which include ethnic crisis, religious crisis and political conflicts, violations of human rights, and mostly human-made and occasional natural disasters such as floods. The situation dramatically alters habitual activities and social relations, interrupting social support systems and diminishing access to medical care. This consequently leads to decline in already challenging living conditions.

Different statistics are bandied as to the actual number of IDPs in Nigeria. Rapid Assessment as of March, 2014 puts the registered figure at 254,812 in the three states (Borno, Yobe and Adamawa) that were subjected to emergency rule between May, 2013 and March, 2014 (NEMA). An estimated 1.6 million people have fled their homes since Boko Haram began her onslaught on Nigerian, while a total number of about 3.3 million people have been internally displaced by violence and conflict (Kupoluyi, 2015). This figure represents 10% of the global number of displaced persons worldwide. Thousands of people, a large percentage of who are women and children, are scattered all around overcrowded camps and settlements. Young internally displaced persons may begin sexual relations at an earlier age and are more likely to take the risk of engaging in sex without using contraceptives. Unsafe sexual practices, unwanted pregnancies, unsafe abortions and increased exposure to sexually transmitted infections (STIs), are including HIV/AIDS. This study therefore examines the link between internal displacement and reproductive health challenges with particular focus on the female population.

1.3 Research Questions

- What is the prevalence of reproductive health challenges among women in IDPs camp?
- What are the challenges among the internally displaced women?
- What are the health care choices of women in IDP settlements?

1.4 Research Objective

1.4.0 Research General Objective

The study aims to identify and examine reproductive health challenges among internally displace women in Abuja, Nigeria.

1.4.1 Specific Objectives of the Study

The specific objectives of the study are:

- To determine the prevalence of reproductive health related problems among women living in IDPs in camp
- To examine the livelihood challenges among the internally displaced women.
- To examine if the internally displaced women have access to reproductive health services in the camp

1.5 Significance of the Study

In view of the increasing number of IDPs due to conflict induced internal displacement, this study is relevant in the face of reproductive health and kind of livelihood that have been taking place in Nigeria among the internally displaced persons. A comprehensive analysis of reproductive health as well as how and the extent to which IDP are able to sustain their livelihood will add to the body of knowledge on reproductive health issues in Nigeria.

The study will also be an indicator of the extent to which available reproductive health programs and services in the country have assisted IDP to achieve their aims on health issues.

These would assist the government as well as reproductive health programmers in designing appropriate and/or fortifying existing programmed with the aim of improving the level at which internally displaced people achieve their aims towards reproductive health care and sustaining their livelihoods.

1.6 Operational Definition of Terms

Reproductive Health: This implies that people are able to have a responsible, satisfying and safe sex life. They have the capability to reproduce and the freedom to decide if, when and how often to do so.

Health: This is the general condition of the body or mind, especially in terms of the presence or absence of illnesses, injuries, or impairments.

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

HIV/AIDS: The Human Immunodeficiency Virus is either of two strains of a retrovirus, HIV-1 or HIV-2. It destroys the immune system's helper T cells, the loss of which causes AIDS.

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.

Livelihood: Livelihood is defined as a means of living, and the capabilities, assets, and activities required for it. A livelihood encompasses income, as well as social institutions, gender relations, and property rights required to support and sustain a certain standard of living. It also includes access to and benefits derived from social and public services which are made available by the state, such as education, health services, and other infrastructure.

Forced Displacement: This refers to the movements of refugees and internally displaced people 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 hetero-sexual Intercourse includes AIDS, Syphilis, Gonorrhea, Public lice, and others.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The global population of IDPs has risen to 25 million from 1 million in the 1980s (Collinson, et al., 2009). The alarming surge has led to the discussion of the concept of internal displacement and livelihood, effective international legal protection, displacement and vulnerability among displaced people, displacement and girl child health, IDPs and reproductive health, and the situation of internally displaced women. This chapter discusses the theoretical framework, gendered vulnerability, refugee and internally displaced women the birth spacing component of reproductive intentions, socio economic, and reproductive health. It also provides the conceptual frameworks of the study.

2.1 Gendered Vulnerability

Disaster research traditionally conceptualizes disasters as sudden events, disrupting everyday life and causing death and destruction (Suzette et al 2005). The concept of vulnerability is 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.

According to Fordham (2004, p.176), women and girls are disadvantaged compared to men and boys. They are more frequently occupying a position of dependence on other persons.

Bradshaw (2004) makes a distinction between technical, political and social vulnerability. Regarding the last, she elaborates six different gender elements, namely poverty, health conditions, malnutrition, female-headed households, illiteracy and housing conditions. As far as poverty is concerned, women and children may live in poverty because the resources available to them are far fewer than the total household resources (Bradshaw ibid., p.22).

2.2 Disaster Impact and Shift in Gender Relations

El Bushra and Piza-Lopez (1994, in Byrne and Baden 1995, p.34) opine that '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.' 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, p.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 p.11).

According to UNHCR (2012), sexual and gender based violence has become a defining feature 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. Dona (2012) observed that the experiences of conflict and displacement mostly result to psychological trauma in children as well as adults. Humanitarian organizations now fund psycho-social programmes 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).

2.3 Refugee and Internally Displaced Women (IDPs)

During conflict and disasters, whole communities are forced to flee their homes and move to safe havens, like refugee camps in neighboring countries. IASC (2001) points out that 80% of all IDPs and refugees are women. Baden and Byrne (1995) object to the use of this figure because it gives a distorted image of reality since women and children might be expected to make up around that percentage in a 'normal' population (Baden and Byrne 1995, p.8). They do however contradict this criticism, by stating that looking at the demographics, there are large amounts of female-headed households. 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. In all cases, fundamental rights are put at risk (IASC 2001, p.2). The realities in refugee and IDP camps 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, once respected people lose their earlier enviable status because

they do not have the property and special status that they had on their arrival in the refugee camps.

2.4 Livelihoods

Economic pressures and poverty have added a new angle to the problem of child marriage not only in the IDP camps. 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 force internally displaced girls and women into prostitution, early marriage and trafficking. 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, early marriage is becoming the norm in Iraq because of poverty inflicted by the post-Gulf war sanctions, war and militarization. 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.

2.5 Theoretical Orientation

Maslow's theory of Hierarchy of Needs is the theoretical base if this study. The theory explains human development in stages where an individual rises to the next level upon successful completion of the preceding one (Snowman & Beihler, 2010). The theory posits 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 is valid for understanding human motivation and personal development.

Rathus (2006) identified 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. IDPs will only be able to sustain themselves when they receive with enough food, love, warmth, shelter. The theory explains that with their physical needs relatively satisfied, the individual's safety needs take charge and dominates behavior 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 is interpersonal and involves feelings of belonging (Rathus, 2006). 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 (Martin, 2005). Humans need to feel a sense of belonging and acceptance among their social groups, regardless if these groups are large or small.

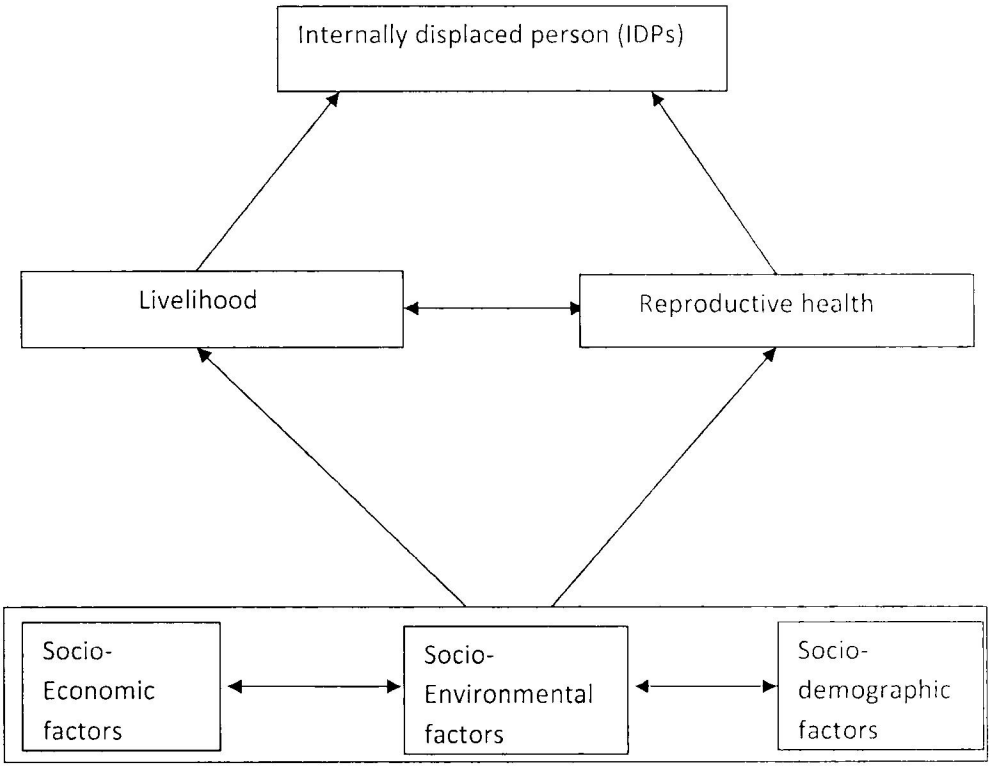
In the fourth stage, all humans have a need to feel respected: this includes the need to have self-esteem and self-respect, (Sprinthal & Sprinthal, 2006). Esteem presents the typical

human desire to be accepted and valued by others. People often engage in a profession or hobby to gain recognition and have a sense of contribution or value. Psychological imbalances such as depression can hinder the person from obtaining a higher level of self-esteem or self-respect.

The last and highest stage is summarized by the quotation - "what a man can be, that he must be" Kail & Cavanaugh (2010). This refers to 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. 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. However, to understand this level of need, the person must not only achieve the previous needs, they also master them.

Given the above, while many situations may hinder internally displaced persons journey to self-actualization, it is necessary to examine how internal displacement affects vulnerable people to influence livelihood and reproductive health achievement. This study pays attention to their interactions within the host community in which they have been resettled, their livelihood achievement, and psycho-social growth.

2.6 Conceptual Framework



This study is entitled "Reproductive health challenges among internally displaced persons in Abuja, Nigeria." This perspective is added to the study of women IDPs' voices and experiences on reproductive health and their livelihood. Dominant discourses can appear in the themes and meanings in the social context and their daily lives, in everyday use of the languages that they use to communicate with other people. Reproductive Health includes access to health care services, sexuality education, access to birth control method, access to HIV/AIDs intervention program. Livelihoods are derived from Problem in human capital, financial capital, poor social capital, inaccessible to natural capital such as land and poor physical capital.

2.7 Hypothesis

- H_o there is no significant relationship between livelihood and reproductive health challenges (ever had pregnancy complication)
- H_1 there is significant relationship between livelihood and reproductive health challenges (ever had pregnancy complication)
- H_o There is no significant relationship between health care choices (using government health facilities for antenatal) and reproductive health challenges (ever had pregnancy complication).
- H_1 There is significant relationship between health care choices (using government health facilities for antenatal) and reproductive health challenges (ever had pregnancy complication).

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter discusses the source of data. It also presents the following headings – Research Design, Study Location, Study Population, Sample Size and Sampling Procedure, Data Collection Methods, Methods of Data Analysis and Field Experience.

3.1 Research Design

A quantitative descriptive cross-sectional study was conducted in New Kuchigoro IDPs camp Abuja Nigeria. Primary data was collected through self-administered structured questionnaire to women in IDPs camps in Abuja, Nigeria. Women within the ages of 15and 49 were the study group.

3.2 Study Location

Abuja, the Federal Capital Territory, is the administrative and geographical centre of Nigeria. With land area of 8,000 square kilometers, it is bounded on the north by Kaduna State, the west by Niger State, the east and southeast by Nasarawa State and the southwest by Kogi State. The FCT is a soil-rich agricultural haven. Abuja has witnessed a huge population boom since its proclamation as federal capital. It officially became Nigeria's capital on 12 December 1991, replacing Lagos, which is still the country's most populous city. According to Demographic, the population of Abuja's Urban Area as of 2012 is 2,245,000, making it the fourth largest urban area in Nigeria only surpassed by Lagos, Kano and Ibadan. New Kuchigoro, which is the immediate study location, is one of the satellite settlements within Abuja. It is now playing host to about 6000 internally displaced persons (NEMA, 2014)

3.3 Study Population

The study population is women between the ages of 15 to 49 years.

3.4 Sample Size and Sampling Procedure

To realize a representative sample size, the convenience sampling technique was used. The primary data were collected among internally displaced women at New Kuchigoro (IDPs) camps along games village Abuja FCT. There are six informal settlements based on the states selected for this study. The states are Kaduna, Bauchi, Borno, Taraba, Plateau and Nasarawa.

3.5 Data Collections Methods

A structured questionnaire was designed to elicit information relating to the objectives of the study. The questionnaire was divided into two sections. Section A sought information on socio-demographic characteristics of the respondents. Section B elicited information on reproductive health behavior, reproductive health risk, health care utilization and livelihood sustainability. The administered questionnaires were processed using Statistical Package for Social Sciences (SPSS) version 20.0.

3.6 Methods of Data Analysis

The administered questionnaires were screened, checked for consistency, and professionally edited. The precoded nature of the questionnaire facilitated easy entry of the data and statistical analysis. The data collected were subjected to basic demographic analytical techniques.

3.7 Field Experience

The field survey required four (4) research assistants who were trained. Three of them speak the Hausa language and this made for easy communication with IDPs who could not speak English. The problems encountered were normal problems that enumerators always face. The researchers were mistaken for government officials. Some women initially refused to participate in the

exercise. They were however convinced on the prospects of the study in alleviating their situation.

CHAPTER FOUR

ANALYSIS OF DATA

4.0 Introduction

This study examines the reproductive health challenges of women IDPs in New Kuchigoro Abuja, Nigeria. This chapter presents the field data collected from the questionnaires, which were drawn based on the postulated research questions. The data were analyzed using the Statistical Package for Social Sciences IBM (SPSS) Statistics version 20.0. The results are also discussed after every analysis.

Table4.1: Background Characteristics of the Respondents

Respondents	Frequency	Percentage
***Age**		
15- 24	111	44.6
25- 34	102	41.0
35- 44	28	11.2
45-49	08	3.2
Total	249	100
***Marital Status**		
Married	171	68.7
Single	67	26.9
Widowed	7	2.8
Separated	04	1.6
Total	249	100
***Ethnicity**		
Yoruba	10	4.0
Igbo	10	4.0
Hausa	177	71.1
Fulani	19	7.6
Others		
Total	33	13.3
	249	100
***Marriage Type**		
Monogamy	151	85.3
Polygamy	26	14.7
Total	177	100
***Religion**		
Christianity	187	76.0
Islam	54	22.0
Traditional	05	2.2

Total	246	100
***Employment status**		
Employed	62	25.5
Self-employed	85	35.0
Unemployed	96	39.5
Total	243	100
***Occupation**		
Farming	6	3.9
Environmental works	11	7.2
House girl/sale girl	8	5.2
Petty traders	55	39.9
Unemployed	25	3.3
Cleaners work	25	16.3
Total	18	16.3
	153	100
***Average income**		
1000- 9000	31	22.8
10000- 19000	86	63.2
20000- 29000	13	9.2
30000- 39000	06	4.4
Total	136	100
***Highest level of education**		
None education	37	15.1
Primary	97	37.6
Secondary	109	44.5
Post- secondary	07	1.0
Total	245	100
***Average income of spouse**		
1000- 9000	6	5.3
10000- 19000	39	34.5
20000- 29000	33	29.2
30000- 39000	13	11.5
40000- 49000	12	10.6
50000- 59000	3	2.7
60000- 69000	6	5.3
70000- 79000+	1	0.9
Total	113	100
***Highest level of education of spouse**		
None education	14	9.0
Primary	27	17.5
Secondary	89	57.5
Post- secondary	20	12.4
Others Specify	05	3.2
Total	155	100
***Age of spouse**		
15- 19	5	3.4

20- 24	27	18.4
25- 29	62	42.2
30- 34	31	21.1
35- 39	8	5.4
40- 44	9	6.1
45- 49	05	3.4
Total	147	100

Source: Field Work Survey, May, 2015 ***Excluding Non-Response Category**

Table 1 shows the background characteristic percentage of respondents. The respondents were grouped into range from 10 years ages from ages 15-49 years. The age groups of the respondents' researches that the majority is from age 15-24 (44.6%) 25-34 (41.0%) years while the least are those in age ranges and the least ranging 45-59 (3.2%). 68.7% were married at the time of the survey while 26.9% were not married. 76% practiced Islam; 22% were Christians and 2.2% were traditionalists.

On educational attainment, 44.5% and 37.6% of the respondents has acquired up to secondary and primary levels. Hausa and Fulani are mostly the occupants in the study areas with 71.1% and 7.6%. 85.3% of the respondents practice monogamy. Polygamists were 13.6%. The majority of the respondents were unemployed and self employed with 38.7% and 34.6% respectively. The occupation of the majority of the respondents is business/ trading with 39.9% and 3.3%. The average income of most of the respondents ranges from 10000 to 19000 with 63.2% while the least was between 30,000 and 39,000 with 3.3%.

Table 4.1.1: The Displacement History of Women IDPs

Respondents	**Frequency**	Percentages
***currently working outside home?**		
Yes	112	46.3
No	130	53.7
Total	242	100

***Where you leave before displaced?**		
KaduDisna	37	14.9
Bauchi	61	24.6
Borno	47	19.0
Nasarawa	8	3.2
Taraba	1	0.4
Plateau	24	9.7
Others	70	28.2
Total	248	100
***Year you first leave your home**		
1995- 1999	2	0.8
2000- 2004	14	5.7
2005- 2009	25	10.7
2010- 2014	175	71.1
2015- 2016	30	12.2
Total	240	100
***How long you lived here**		
1- 5	212	86.2
6- 10	25	10.2
11- 15	7	2.8
16- 20	02	0.8
Total	246	100
***Year you start live continuously at this current place NEW kuchngoro**		
2000- 2004	9	3.7
2005- 2009	11	4.5
2010- 2014	189	77.0
2015- 2016	36	14.8
Total	234	100
***causes of your displacement?**		
Boko haram insurgency	110	45.8
Natural disaster	2	0.8
Ethic Crisis	23	9.6
Religious Crisis	40	16.7
Others	65	27.1
Total	240	100

Source: Field Work Survey, May, 2015 ***Excluding Non-Response Category**

Table 4.2: Knowledge about Pregnancy Issues among Women IDPs

Respondents	Frequency	Percentages
*** Ever pregnant**		
Yes	188	78.7
No	51	21.7
Total	239	100
***Currently pregnant**		
Yes	50	21.3
No	185	78.7
Total	235	100
***months of pregnant**		
0- 3	20	37.3
4- 6	23	42.6
7- 9	11	20.4
Total	54	100
***Danger of pregnancy?**		
Severe fatigue	95	60.5
Several abdominal pain	109	68.6
Bleeding from the vagina	86	57.7
Fever	66	47.5
Unusual swelling of face, figers, legs	50	41.3
Severe and continued headache	40	38.5
Rapid breathing or difficult breathing	42	40.5
Foul smelling vaginal discharge	27	30.7
Convulsions or fits		
Loss of consciousness	30	34.9
Blurred vision	19	25

Source: Field Work Survey, May, 2015 ****Multiple Responses Were Allowed**

The table 3 shows the percentage distribution of knowledge about pregnancy issues among IDPs women. Out of the 239 respondents, 188 of them with (78.7%) have ever been pregnant before, while the remaining 51 of them with (21.7%) have never been pregnant. Out of the 235 respondents that have danger signs for pregnancy, 185 of them with (78.7%) are not currently pregnant, while the remaining 50 of them with (21.3%) are currently pregnant. Also out if the 54 respondents that are currently pregnant, the majority of them with (42.6%) are "4-6"

month pregnant, while the least of them with (20.4%) are "7-9" month pregnant. Furthermore, the danger signs of pregnancy, severe fatigue during pregnancy (60.5%), abdominal pain and vagina bleeding (68.6) and bleeding from the vagina(57.7). The respondents indicates that more than half, approximately(61%) of the respondents tend to have severe fatigue during pregnancy, others are abdominal percent (57.7%) vagina bleeding (47.5%) abortion

Table 4.3.1: Reproductive Health Seeking Behaviour of IDPs

Respondents	Frequency	Percentages
***First pregnant experience**		
Yes	21	33.7
No	42	66.3
Total	61	100
***Ever seen any one for Antenatal care for this pregnancy?**		
Yes	23	39.0
No	36	61.0
Total	59	100
***WHOM you see?**		
Doctors	23	46.9
Nurse	19	59.6
Midwife	12	40.0
Others	09	30.0
****Reasons for not seen someone?**		
Lack of Access	23	88.5
No health care provider available	28	76.2
Could not afford	25	74.2
Distance too far	26	74.2
Lack of transportation	24	72.2
Poor road conditions	25	74.2
Husband/ partner would not permit	6	27.3
Afraid of doctors, nurse	8	34.8
Have never used doctors before	6	33.3
Not treated well previously	5	32.3
Embarrassed or ashamed	4	25.0
***During the 6 weeks after birth, health worker come to check on you?**		
Yes	106	75.2
No	36	24.8
Total	141	100
***Receive immunization for your**		

children?		
Yes	92	69.2
No	41	30.8
Total	133	100
***Receive information on family planning?**		
Yes	32	23.9
No	102	76.1
Total	134	100
***During the 6 weeks after birth did you have any problems or complication?**		
Yes	20	22.5
No	69	77.5
Total	89	100
***problem or complication did you have**		
Yes	19	27.9
No	49	72.1
Total	68	100
***What problem or complication did you have**		
Heavy bleeding	19	27.9
Bad smelling vaginal discharge	10	43.5
High fever		
Painful urination	11	35.3
Hot swollen painful breast	12	57.1
No response	15	44.4
***Did you seek help for the problem or complication**		
Yes	23	41.1
No	33	58.9
Total	56	100
***Where did you seek help for the problem or complication?**		
Had help at home	13	36.1
Health center	11	30.6
Hospital	4	11.1
Others	7	19.4
No response	01	2.8
Total	36	100

Source: Field Work Survey, May, 2015 **** Multiple Responses are Allowed**

The table 3 shows the percentage distribution of reproductive health seeking behavior of IDPs women. It was (33.7%) of those women in IDPs camp just had their first pregnancy. Sixty

one percent of respondents did not go for antenatal care. For those that went for the antenatal care, (46.9%) of them see the doctor, (59.4%) of them saw the nurse, the midwives (40%). Some of the reasons for not seen any one for antenatal were reported lack of access (88.5%), (76.2%) of them reported no health care provider, (74.2%) can't afford it, (72.2%) of the said it is too far, (74.2%) complained about lack of transportation, (27.3%) of then complained about poor road conditions, (34.8%) of them complain about their husband not letting them go, (33.3%) of them are afraid of doctors and nurses. During the sixth week after birth, (75.2%) of them reported that a health worker came to check on them. (69.2%) of them received immunization for their children, while (30.8%) of them did not. Nearly (24%) of the respondents received information on family planning during from the health worker their last visitation, while (76.1%) of them did not. (22.5%) of the respondents had problem or complication during the sixth week after delivery, while (77.5%) did not. This could be as a result of different mode of delivery or different body system. Out of the respondents that had problem (27.9%) had heavy bleeding, (35.3%) with high fever, (57.1%) with painful urination, (44.4%) with hot swollen painful breast, (7%) with others and (26.1%) with no response. For those that had one problem or the other, (41.1%) of them did seek for help while (36.1%) of them seek for help at home.

Table 4.3.2: Reproductive Health Risk among Women IDPs

Respondents	Frequency	Percentages
***Numbers of sons and daughters you have**		
0	23	10.5
1-3	60	39.5
4-6	30	25.2
7+	30	19.9
	151	100
***How many pregnancies resulted in children who were born dead**		
0	12	11.8
1-3	70	68.2

4-6	12	11.8
7+	8	9.8
Total	102	100
***There some women who lose their pregnancies before completing six months**		
Yes	124	69.7
No	54	30.3
Total	178	100
***Thinking back about that pregnancy did you have a problem or complication during pregnancy**		
Yes	67	40.4
No	99	59.6
Total	166	100
***Did you seek for help**		
Yes	58	52.3
No	53	47.7
Total	111	100
***Where did you seek for help**		
Had help at home	32	47.8
Health center	13	18.5
Hospital	19	28.5
Others	04	59
Total	68	100
***Place of deliver most recent pregnant?**		
At home	92	53.8
Health clinic/hospital	73	42.7
On my way to hospital	06	3.6
Total	171	100
***someone help with the delivery**		
Yes	135	84.9
No	24	15.1
Total	159	100
***Who help with the delivery**		
Relative / friend	66	43.2
Traditional birth attendant	22	14.4
Midwife, nurse, or doctor	65	42.5
Total	153	100
***any complication during labor and delivery?**		
Yes	63	40.9
No	91	59.1
Total	154	100

**What complications did you have?		
Heavy bleeding	42	66.7
Labor pains lasting than 12hrs	38	1.7
Vaginal tearing		
Convulsions	13	33.3
Fever	11	28.2
Green or brown water	23	54.8
coming from the vagina	17	47.2
Water breaks and labor is not induced within 6hours	17	47.2
Placenta not expelled within 1hour of the birth	2	22.0

Source: Field Work Survey, May, 2015 ****Multiple Responses are Allowed**

The tables above show the reproductive health risk among IDPs women. Fifty five percent of the respondents had "0-4", children more so (69.7%) of them lost their pregnancy before the completion of the sixth month. Also out of the respondents that were pregnant. (40.4%) of them said they had problem during their pregnancy period. (52.3%) of them seek for help and (47.8%) of them had help at home. The majority of the respondents that were pregnant delivered most of their pregnancy at home (53.8%), while the least with (1.8%) delivered on their way to the hospital, Also (84.9%) of those that gave birth were helped by someone. Among those that were helped, (42.5%) were helped by friends/midwives, nurses and doctors.

Table 4.3.3: Birth Spacing Contraceptive Use and STD

Respondents	Frequency	Percentages
***Do you want to have a baby in the future?**		
Yes	191	79.9
No	48	20.1
Total	239	100
***Where did you want to have your next baby?**		
Within the next 12 months	13	6.6
After 1-2years	31	15.8
After I marry	52	26.8
When God wants	96	38.8
Others specify	24	38.8
Total	196	100
***Currently using any method to delay or avoid pregnancy**		
Yes	102	43.6
No	132	56.4
Total	234	100
***If you not using?**		
Still want more children.	33	25.2
No response.	10	7.6
My husband does not support it.	13	9.9
Am pregnant.	31	23.7
Late for birth.	8	6.1
Am not used to the methods.	30	22.9
Others.	06	4.6
Total	131	100
***Which method are you currently using if yes?**		
Female sterilization	14	14.4
Male sterilization	2	2.1
Pill	14	14.4
IUD	5	5.2
Implants	2	2.1
Male condom	39	40.2
Female condom	8	8.2
Female sterilization	1	1.0
Foam/jerry	2	2.1
Withdrawal	10	10.3
Total	97	100
***Ever heard of diseases that be transmitted through sexual**		

intercourse, HIV/AIDS?		
Yes	197	85.7
No	33	14.3
Total	230	100
***had any unusual denial discharge in the past 12 months**		
Yes	37	18.8
No	160	81.2
Total	197	100
***The last time you had any unusual genital discharge, genital ulcers did you seek for help?**		
Yes	35	23.2
No	116	76.8
Total	151	100
***did you seek for treatment?**		
Govt. hospital	41	56.9
Govt. health center	5	6.9
Family planning clinic	4	5.6
Mobile clinic	4	5.6
Hospital	4	5.6
Private hospital/clinic	12	16.7
Pharmacy	02	2.8
Total	72	100

Source: Field Work Survey, May, 2015 ***Excluding Non-Response Category**

79.9% of the respondents still want to have a baby in the nearest future. 43.6% currently use a method of contraception. Of those are not using any method, 25.2% still want more children while 6.1% were no longer fecund. 40.2% of those avoiding pregnancy use male condom while 1% use female sterilization. Eighty five percent of the respondents have heard of STIs while 14.3% heard not.

Table 4.4: The Livelihood Sustainability among Women IDPs

Respondents	Frequency	Percentages
***Main economic activities in your formal place?**		
Farming	115	49.4
Business/Trading	61	27.1
unemployed	12	5.2
House Wife	6	2.1
Tailoring work	4	2.6
Hair Dressing Work	16	1.7
Others	28	12.0
Total	233	100
***Main economic activities in this place?**		
Petty trading	69	34.0
Environmental work	12	5.9
House help/sales girls	7	3.4
Unemployed	31	15.3
Farming	3	1.5
Cleaner Work	25	12.3
Hair dressers	6	3.0
Trading	37	18.2
Others	13	6.4
Total	203	100
***Have farm land before your displacement**		
Yes	95	39.1
No	148	60.9
Total	243	100
***important to these new activities now for the incomes of your household?**		
Managing and help from outsiders	80	46.2
Supporting the family	42	24.3
No favors	2	1.2
Parents	7	4.0
Others	42	24.3
Total	173	100
***source of your livelihood now**		
Business	57	25.1
Environmental work	12	5.3
House help work	5	2.2
My husband/parent provide	75	33.0
Farming work	5	2.2

Hair Dressing	3	1.3
Cleaners Work	18	7.9
Trading	25	11.0
Others	27	11.9
Total	227	100
***All members of your household get two square meal?**		
Yes	160	66.7
No	80	33.0
Total	240	100
***How do you survive/cope in this camp**		
Business/Trading	57	25.2
House help work	6	2.7
Difficult to survive	46	20.4
Contribution / support	14	6.2
Husband support	14	6.2
Environmental work	6	2.7
Managing	41	18.1
Others	42	18.6
Total	226	100
***What has been the impact of health issues on the people living in IDPs camp**		
Typhoid	35	16.6
Malaria	127	60.2
Water borne Diseases	22	10.4
Fever	13	6.4
Toilet Infection	9	4.3
Others	05	2.4
Total	211	100
***What are the main effects on people ability to gain a reasonable living**		
Lack of capital/No money	65	32.7
Lack of Job/bad leadership	66	33.2
Lack of cooperation/ land ownership	15	7.5
Difficult	22	11.1
Others specify	31	15.6
Total	199	100
***How has the status of women changed**		
Very Difficult	99	72.3
Improving the sustenance	9	6.6
Basically on house issues	6	4.4

Normal	21	15.3
Improved	02	1.5
Total	137	100
***What livelihood activities are women still not permitted to do in this camp**		
Labor work	23	14.3
None	117	72.7
Adultery/prostitution	5	3.1
Others	16	9.9
Total	161	100
***What are your copping strategies in this camp**		
Help from outsiders/Government NGO	130	59.9
Cooperation within	38	17.5
Miner jobs	32	14.7
Others	17	7.8
Total	217	100

Source: Field Work Survey, May, 2015 ***Excluding Non-Response Category**

Table 4.4 shows the livelihood sustainability among the IDPs women. 49.4% of them out of the 223 respondents stated that farming was their main economic activities in their former place, while 1.7% mentioned hair dressing followed by house wife (2.1%). The main economic activity in their present location is business with 34% while farming was least with 1.5%. Thirty nine percent had farm land, while the majority of them (60.9%) did not have.

Among the main effects on people's ability to gain a reasonable living, 33.2% stated a lack of jobs/bad leadership and 72.3% identified lack of co-operation. 72.3% of the respondents had difficulty improving their financial status. Seventy two percent of the women in the camp are allowed to do menial work as a means of livelihood while 3.1% engage in adultery/prostitution, while (59.9%) help from outsiders/government/NGO as part of their coping strategy in the camp.

Table 4.5: Cross-tabulation Analysis of Selected Variables

WHO HELPED WITH RECENT DELIVERY						
VARABLE	MIDWIFE, NURSE OR DOCTORS	PERCENT (%)	RELATIVE/ FRIENDS	PERCENT (%)	TOTAL	TOTAL PERCENT AND P-VALUE. %
Age						
15-24	23	35.4%	24	27.6%	47	100
25-34	36	55.4%	37	42.5%	73	100
35-44	4	6.2%	22	25.3%	26	100
45- 49	2	3.1%	4	4.6%	06	100
Total					**152**	X^2 P=0.02
Marriage Type						
Monogamy	45	42.9%	60	57.1%	105	100
Polygamy	3	17.6%	14	82.4%	17	100
Total					**122**	X^2P=0.01
Religion						
Christianity	53	48.2%	57	51.8%	110	100
Islam	10	25.6%	29	74.4%	39	100
Traditional	1	33.3%	2	66.3%	03	100
Total					**152**	X^2P=0.05
Highest level of education						
None	7	23.3%	23	76.7%	30	100
education						
Primary	25	39.1%	39	60.9%	64	100
Secondary	30	55.6%	24	44.4%	54	100
Post-secondary	3	100%	--	--	03	100
Total					**151**	X^2P=0.01
Attending antenatal care						
Yes	10	58.8%	4	23.5%	14	100
No	7	41.2%	13	76.5%	20	100
Total					34	X^2P=0.01
Number of living children						
1-3	47	88.7%	46	59.7%	93	100
4-6	5	9.4%	22	28.6%	27	100
7+	1	1%	9	11.7%	10	100
Total					130	X^2P=0.01
Place of delivery						

Heath/hospital	5	7.9%	75	90.4%	80	100
Home	58	92.1%	8	9.6%	66	100
Total					146	**X^2P=0.01**
Marital Status						
Married	53	41.7%	74	58.3%	127	100
Single	10	62.5%	6	37.5%	16	100
Widowed	2	18.2%	7	85.5%	09	100
Total					**152**	**X^2 P=0.22**
Copping strategies in camp?						
Petty trading	12	30.0%	23	70.0%	35	100
House help work	1	22.8%	4	78.2%	5	100
Difficult to survive	17	68.5%	9	32.5%	26	100
Contributions and support	8	100%	--	--	8	100
Environmental work	1	50.0%	1	50.0%	2	100
Managing	11	17.5%	1	1.7%	12	100
Total					76	**X^2 P=0.01**

Source: Field Work Survey, May, 2015

Table 4.5 is the cross tabulation of selected variables by who helped with the delivery. The result shows significant relationship with Age (X^2 P=0.02) attending antenatal health care (x^2p=0.01). Religion with (X^2P= 0.05), marriage type (X^2P= 0.01) and highest level of education with (X^2P= 0.01). In addition, Number of living children (x^2p=0.01) and place of delivery with (x^2p=0.01) have significant relationship with who helped with recent delivery.

Table 4.6: Logistics Regression of Selected Variables of any Complication during Delivery and Background of Internal Displaced Persons (IDPS)

Any Complication during P &D)	Odd Ratio	[95% Confidence Interval]	
Age			
15-24	1.00(R.C)		
20-24	6.05*	1.4273835	85.67465
25-29	6.27*	1.4830985	81.36361
30-34	4.16*	1.3064955	56.44044
35-39	1.0584	.0547734	20.45187
40-45	14.92*	1.7073754	314.8849
45-49	3.8495	.1008909	146.8831
Religion			
Christians	1.00(R.C)		
Islam	1.165418	.4617342	2.941518
Others	1		
Education			
None	1.00(R.C)		
Primary	3.14*	.8823116	11.18754
Secondary	2.10*	.5688261	7.761731
Post graduate	1		
Type of Marriage			
Monopoly	1.00(R.C)		
Polygyny	0.44*	0.1390092	0.410436
Length of Stay			
<5years	RC(1.00)		
5-10years	1(Omitted)		
10+	0.1737567	.007638	3.9528

***p-value<0.05, **p-value<0.01 and p-value<0.001 Significant at 95% confidence interval**

The logistic regression revealed that some of the socio-demographic characteristics of the internally displaced person have significant relationship to maternal health challenges. The educational status indicated that women with secondary education are more likely to have complication than their counterpart with no education (OR=2.101, p<0.05). The same was

observed with respondents with primary education (OR =3.1417, p<0.05)) but higher education is not significant (OR=1.00,p>0.05). The types of marriage of internally displaced persons also influences the likelihood of maternal complication during pregnancy/delivery as those practiced polygamy are less likely to have complication during pregnancy/delivery than those that are monogamous (OR=0.4427, p<0.05).

Muslim women with risk ratio of 1.165 are more likely to have complication than their Christians counterpart although significant (OR=1.165, p>0.05). The risk ratio among age groups show those in ages 20-24 years, 25-29years, and 40-44years are more likely risk complication during pregnancy/deliver than those who are in ages 15-19years (OR=6.0511, p<0.05) ,(OR=6.2569,p<0.05) and (OR=14.9245) while others age groups such as 30-34 years, 35-39 years and 44-49years are likely to experience complication but not really significant at 5% level of significant. The length of stay revealed that those who had stayed for 5-10 years are not significant to complication during pregnancy compare to those less than 5years. But it is very interesting to find out that those who had stayed for more than 10 years are less likely to have complication during pregnancy and delivery(OR= 0.1737, p<0.05)

In conclusion, socio-demographic characteristics contribute a risk ratio of having complication during pregnancy and delivery while length of stay does not.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMENDATIONS

5.0 Introduction

This chapter presents the summary and conclusion of the findings of the study. It also provides requisite recommendations.

5.1 Discussion of Findings

This study examined the reproductive health challenges among internally displaced women in Abuja, Nigeria. Its specific objectives were to determine the prevalence of reproductive health related problems among women living in IDPs; to investigate the livelihood challenges among these women; and also to examine if the internally displaced women have access to reproductive health services in the camp.

To realize these objectives, hypotheses were drawn and tested. Different analytical and statistical methods were also adopted. These include the univariate frequency distribution, bivariate analysis distribution and logistics regression. The hypotheses raised were tested by subjecting each of the explanatory variables to dependent variables in a chi-square test.

The univariate analysis revealed that majority of the sample population percentage age groups of the respondents were 15-24 years (35.3%) and 25-35 (27%) respectively. This showed that they were in their reproductive age. Also an overwhelming majority (68.7%) was married. Seventy six percent of the populations were Christians. On educational attainment, 44.5% of the respondents had acquired up to secondary and primary level. The occupation of the majority of the respondents is business/trading with 39.9%. The average income of 63.2% of the respondents was between 10,000 and 19,000.

78.7% have ever been pregnant before coming to IDPs camp. Majority of the respondents with (42.6%) were 4-6 months pregnant. Furthermore, with regard to the danger signs of pregnancy, the prevalent reproductive health challenges among IDPs women ranges from severe fatigue during pregnancy (60.5%) to abdominal pain and vagina bleeding (68.6). The percentage distribution of reproductive health seeking behavior shows that 61% of the respondents did not go for antenatal care due to unavailability of health care centres and hospitals in New Kuchigoro IDP camp. Also, 40.0% of them saw the midwives for delivery. Some of the reasons for no antenatal were lack of access (88.5%), no health care provider (76.2%), and affordability/expensiveness (74.2%). During the sixth week after birth, 75.2% reported that a health worker came to check on them. Twenty five percent had problems or complications during the sixth week after deliver. For those with childbirth problems, 41.1% sought for clinical help while 36.1% sought help at home.

Furthermore 69.7% lost their pregnancy before the completion of the sixth month. The majority of the respondents that was pregnant (53.8%) delivered their pregnancy at home. With regard to the livelihood sustainability among the IDP women, 49.4% stated that farming was their main economic activity before displacement while 46.2% that were working tended to be managing their income and seek help of the outsiders 72.3% had problems in improving their financial status, seventy two percent labour work as a livelihood activity, 59.9% received help from outsiders/government/NGOs as their coping strategies in the camp.

The logistic regression revealed that some of the socio-demographic characteristics of the internally displaced person have significant relationship to maternal health challenges (complication during pregnancy/delivery). The educational status indicated that women with secondary education were more likely to risk having complication [illegible]

counterpart with no education (OR=2.101, p<0.05) also in primary (OR =3.1417, p<0.05) but higher education was not significant (OR=1.00,p>0.05). The length of stay revealed that those who had stayed for 5-10 years are not significant to complication during pregnancy compare to those less than 5years. But it is very interesting to find out that those who had stayed for more than 10 years are less likely to have complication during pregnancy and delivery (OR= 0.1737, p<0.05). Socio-demographic characteristics give a risk ratio of having complication during pregnancy and delivery while length of stay is not associated with such.

5.2 Conclusion

This study is in tandem with Bradshaw (2004:31) because most IDPs have been identified with some maternal health challenges such as severe fatigue during pregnancy, abdominal pain fever and vagina bleeding. The results indicate that socio-economic characteristics of IDPs such as religion, age, marriage type, highest level of education, attending antenatal care, number of living children, place of delivery and also coping strategies in the camp are significant predictors of maternal health of internally displaced population (IDPs) women in Abuja at the 5% level of significance.

While information on reproductive health challenges is still on the lower side, a lot of reproductive health challenges such as bleeding from the vagina, fever, Rapid or difficult breathing, antenatal care, pregnancy issues, delivery issues etc. were identified. This cannot be divorced from their inability to get reliable and accurate information. However, parents, teachers, health workers, government and non-governmental organizations should rise up to the challenge and provide useful and age appropriate information on reproductive health challenges and the risks for women in the camps settlements.

5.3 Recommendations

It is recommended that the government should provide health facilities with qualified personnel to reduce maternal and child mortality in IDP camps in Nigeria. Preference should also be given to the provision of high standard of health care services. The tide of unemployment and underemployed should also be stemmed. The diversity of this population and the different ways health care development are experienced should be put into consideration when considering reproductive health challenges among the women in IDP. The differences 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.

Regular workshops, seminars, symposia, lectures and talks aimed at promoting reproductive health should be regularly organized for women in the camps. Health care workers should be provided in IDP camp.

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

5.4 Suggestions for Further Studies

Future studies should examine the factors militating against reproductive health and the relationship between socioeconomic variables and access to reproductive health information. The attitudes, knowledge and beliefs of women towards the use of contraceptives and sexually transmitted infections STIs should also be considered.

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APPENDIX

QUESTIONNAIRE CODE NUMBER: .....

TOPIC: REPRODUCTIVE HEALTH CHALLENGES AMONG IDPs IN ABUJA, NIGERIA

Good morning/afternoon/evening. My name is ..... (Research Assistant'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 49 years.

(You are to proceed if she is qualified and 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. Retired 4. Unemployed 5 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. Post Secondary e. 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? None Primary Secondary Post Secondary Others specified.....	Q12. What is the age of your spouse/partner as at last birthday?.....			

Displacement

Q13. Aside from your homework, do you currently work outside of the home? 1. Yes 2. No

Q14. Where did you leave before you were displaced for the first time.....

Q15. In what year did you first leave your home.....year.

Q16. How long have you lived here in.....(provide the name of current community)

Q17. In what year did you start to live continuously at this current place of residence.....

Q18. What is the causes of your displacement

a. Boko Haram Insurgency
b. Natural disaster (flood, fire incidence)
c. Ethic Crisis
d. Religious Crisis
e. Others.....

SECTION B: Reproductive Health Outcomes

Q1. What are the danger signs of pregnancy?	Yes	NO
a. Severe Fatigue	1	2
b. Several abdominal pain(pain in the belly)		

c. Bleeding from the vagina 1 2
d. Fever 1 2
e. Unusual swelling of face, fingers, or legs 1 2
f. Severe and continued headache 1 2
g. Rapid breathing or difficult breathing 1 2
h. Foul smelling vaginal discharge 1 2
i. Convulsions or fits 1 2
j. Loss of consciousness 1 2
k. Blurred vision 1 2
l. Other (specify) _____ 1 2
m. Don't Know 1 2

Q2. Have you ever been pregnant 1 Yes 2. No

Q3. Are you currently pregnant? 1 Yes 2. No

Q4. How many months are you in your pregnancy?.....

Q5. Have you seen anyone for antenatal care for this pregnancy? 1. Yes 2. No

Q6. Whom did you see? Anyone else?

Doctor 1 Yes 2. No

Nurse

Midwife

Others

Q7. What are the reasons that you did not see someone? (Circle All Mentioned 1=Mentioned 2=Not Mentioned)

Lack Of Access

No health care provider available 1 2

Could not afford 1 2

Distance too far 1 2

Lack of transportation 1 2

Poor road conditions 1 2

OPPOSITION TO CARE

Husband/ partner would not permit 1 2

PERCEPTIONS OF CARE

Afraid of doctor, nurse, or other provider 1 2

Have never used doctor, nurse before 1 2

Not treated well previously 1 2

Embarrassed or ashamed 1 2

Q8. Is this your first pregnancy 1 Yes 2. No

Q9. How many sons and how many daughters do you have? They can be living with you or elsewhere .....

Q10. How many pregnancies resulted in children who were born dead (stillborn)?.....

Q11. There are women who lose their pregnancies BEFORE completing six months 1. Yes 2. No

Q12. Thinking back about that pregnancy, before you started or went into labor, did you have a problem or complication during pregnancy (not labor or delivery) 1. Yes 2.No

Q13. Did you seek help for the problem(s) or complication(s)? 1. Yes 2. No

Q14. Where did you seek help?

Had help at home 1

Health center 2

Hospital 3

Other (specify)_____ 4

No Response 99

Q15. Where did you deliver your most recent Pregnancy?

At home 1

Health clinic / hospital 2

On the way to the hospital / clinic 3

Other(specify)_____ 4

No Response 99

Q16. Did someone help you with the delivery? 1. Yes 2. No

Q17. Who helped with the delivery?

Relative / friend 1

Traditional birth attendant 2

Midwife, nurse, or doctor 3

Other (specify)_____ 4

No Response

Q18. Were there any complications during labor and delivery? 1 Yes 2. No

Q19. What complications did you have?

Heavy bleeding 1 2

Labor pains lasting longer than 12 hours 1 2

Vaginal tearing 1 2

Convulsions 1 2

Fever 1 2

Green or brown water coming from the vagina 1 2

Water breaks and labor is not induced within 6 hours 1 2

Placenta not expelled within 1 hour of the birth 1 2

Other (specify) _____ 1 2

No Response 1 2

Q20. During the 6 weeks after birth, did a health worker come to your home to check on you or did you go to the health center to check your health 1. Yes 2. No

Q21 Did you receive immunization for your children? 1. Yes 2. No

Q22. During this visit, did you receive information or counseling about family planning 1 Yes 2. No

Q23. During the 6 weeks after birth, did you have any problems or complications? 1. Yes 2. No

Q24. What problem(s) or complication(s) did you have 1. YES 2.NO

Q25 What problem(s) or complication(s) did you have? 1 Yes 2. No

Heavy bleeding 1 2

Bad smelling vaginal discharge 1 2

High fever 1 2

Painful urination 1 2

Hot, swollen painful breasts 1 2

Other (specify)_____ 1 2

No Response 1 2

Q26. Did you seek help for the problem(s) or complication(s) 1. Yes 2. No

Q27. Where did you seek help for these problem(s) or complication(s)?

Had help at home 1 Health center 2 Hospital 3 Other (specify)_____ 4 No Response

Q28. Do you want to have a baby in the future? 1. Yes 2. No

Q29. When do you want to have your next baby?

Within the next 12 months 1

Within 1-2 years 2

After 2 years 3

After I marry 4

When God wants 5

Other (specify) 6

Q30. Are you currently using any method to delay or avoid pregnancy? 1. Yes 2. No

Q31.If you are not using methods why?.....
.....

Q32. Which method(s) are you currently using?

. If yes what method are you currently using?

Female Sterilization . . . . . .

Male Sterilization . . . . . .

Pill . . . . . .

Iud . . . . . .

Implants . . . . . .

Male Condom . . . . . .

Female Condom .

Female Sterilization. Diaphragm . . . . .

Foam/Jelly

Withdrawal

Q33. Have you ever heard of diseases that can be transmitted through sexual intercourse, including HIV/AIDS?
1. Yes 2. No

Q34. Have you had any unusual genital discharge in the past 12 months, such as foul smelling or green/curd like discharge?
1. Yes 2. No

Q35. The last time you had any unusual genital discharge, genital ulcers, or sores, did you seek treatment?
1. Yes 2. No

Q36. Where did you seek treatment?

Govt. Hospital . . . . .

Govt. Health Centre . . .

Family Planning Clinic . . .

Mobile Clinic . . . . . .

Hospital,

Health Centre

Fieldworker

Private Hospital/Clinic . . .

Pharmacy . . . . . .

Chemist/Pms

Livelihood Sustainability.

Q1. What were your main economic activities in your formal place?

a.

b.

c.

d.

Q2. What were your main economic activities in this place?

a.

b.

c.

d