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PROVISION OF HEALTH ASSISTANCE TO INTERNALLY DISPLACED PERSONS OF SOUTH WAZIRISTAN AGENCY IN CAMPS

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Abstract

Since 2009, South Waziristan Agency (SWA) has suffered a number of violent armed conflicts between security forces and Taliban causing massive destruction, several thousand deaths and creating over a half million displaced people. Due to negligence of issues related to internal displacement in UN, international and national law, internally displaced persons (IDPs) were afforded very little health care help during displacement. This research was designed to contribute to a policy or model to be developed to provide health care services for IDPs. The three objectives of this study were: to investigate the prevalence of health related problems in IDPs living in camp according to their sex and age; to explore the causes of mortality in IDPs living in camp from their sex and age perspective: to indicate the current nature and range of health services availability to IDPs living in camp according to their sex and age. The research employed mixed methods in achieving the above objectives. It was conducted through surveys and in-depth interviews (IDIs) with IDPs. Respondents for surveys were selected by applying systematic sampling technique with a random start. For this purpose 155 HHs were selected for survey & 5 respondents for IDIs in IDPs camps. This study found that children and old age people were affected the most by infections and diseases among many age groups while women in reproductive ages suffered more due to reproductive health issues as compared to men. The rate of mortality was also much higher among children and pregnant women as compared to other age groups in this study due to in-appropriateness and irregularity of health care facilities. Although IDPs were affected by mental stress as much as physical one, still health related facilities of psychiatric help were totally absent in camps. Based on the fieldwork it is found that local health department in Tank was not capable to handle huge number of IDPs on its own and the study recommends international community's health related interventions to deal with the situation. It also recommends that there is a need to study IDPs situation in other agencies as well to prepare a comprehensive policy document for IDPs of FATA.

Background of the Study

Hundreds of thousands of people are displaced due to conflict every year globally (UNHCR, 2010). Forced to flee from their homes in search of protection, some are able to find refuge with families and friends, but most are crowded into camps where they become victims of further violence, mental stress, and disease (IDMC, 2012). As near the end of 2013, more than 28.8 million people were internally displaced by conflict and violence across the world with more than 3.5 million people being newly displaced as a result of violence accompanying the "Arab Spring" uprisings in Syria (IDMC, 2012). The largest regional increase in this instance in 2012 was in the Middle East and North Africa where 2.5 million people were forced to flee their homes (UNHCR, 2010).

Recently, Pakistan has experienced large-scale involuntary internal displacement caused by a range of factors. The main cause for this internal displacement in the spring of 2009 was the military operation against militants in Malakand region of the KP province and FATA,

leading to an exodus of about 2.7 million people in a little over a fortnight, creating one of the largest displacement crises in recent times (HRCP, 2010). In FATA including many parts of KP, the hub of this armed conflict is South Waziristan. In October 2009 to December 2011, as the result of Pakistan military's operation RAH-E-NIJAT against militants in South Waziristan, approximately twenty seven thousand households fled from South Waziristan to nearby district Tank (FDMA, 2013).

Local government in district Tank, which is adjacent to South Waziristan Agency (SWA), badly failed in providing satisfactory relief to IDPs. When compared to other recipient areas of IDPs in KP, IDPs in Tank are provided with very limited humanitarian relief by United Nations (UN) and International nongovernmental organizations (INGOs). Except World Food Programme (WFP) and UNHCR most of INGO's were also not present here on the pretext that Tank is not suitable from a security point of view[1]. Currently the IDPs are a persisting element in Tank society, bringing new challenges to the public sectors. This is particularly so in the health sector where the impact of conflict has resulted in the huge number of IDPs settlement in the recipient areas of Tank which has ultimately overburdened the public health delivery. Unfortunately, the public health institutions in Tank had no experience and capacity in developing health programmes and providing health services to a large number of people arriving simultaneously.

Objectives of the study

- To investigate the prevalence of health related problems in IDPs living in camp according to their sex and age.
- To explore the causes of mortality in IDPs living in camp from a sex and age perspective.
- To indicate the difference between current nature and range of health services availability in IDPs camp.

Aims in conducting this research

This research aims to provide recommendations to the public health sector of Pakistan and international humanitarian organizations in order to develop a policy fulfilling the health needs of all internally displaced persons specific to needs of women, children and old.

Several factors point to the value of such research. Firstly, some parts of KP & FATA and Baluchistan are still unstable in terms of security and are prone to armed conflict which can create more IDPs. Secondly, there is almost no research done on armed conflict in tribal context of South Waziristan from a health perspective. Thirdly, there is a need to explore IDPs health needs in camps from a sex and age perspective.

Lastly, it is most important to analyze strengths and weaknesses of government and international humanitarian organizations current health program's adequacy and appropriateness targeting these displaced populations.

[1] Local Mehsud tribes men perception

Literature Review

The International Committee of the Red Cross (ICRC), the UNHCR and some major non-governmental organizations (NGOs) have developed their own definitions of internal displacement, which usually reflects their operational "peoples of concern". A more inclusive (and still evolving) working definition for IDPs used in this study is based on the working description of the UN Guiding Principles on Internal Displacement:

> Internally displaced persons are persons or groups of persons who have been forced or obliged to flee or leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border (R. G. Cohen & Deng, 1998).

Despite the fact that there are more than 28 million internally displaced persons (IDPs) around the world, their plight is still little known (IDMC, 2012). As compared to IDPs who are given less international protection, refugees are treated quite opposite. Both IDPs and refugees have been forced to leave their homes because of armed conflict. While IDPs do not cross boundary, refugees cross it. This crossing of boundary has major consequences in terms of the protection available to them by international law (Rae, 2011). While the number of refugees has been declining in recent years, IDP numbers are drastically increasing to more than double the amount of refugees. When first calculated in 1982, IDPs totaled about 1.2 million in eleven countries. At the end of 2008, that number had grown to 26 million in 49 countries (UNHCR, 2010).

The most significant differences in international laws regarding the rights of IDPs and refugees is that the latter are expertly protected by Convention relating to the Status of Refugees (CSR) (OHCHR 1951), whereas IDPs derive their human rights protection from UN guiding principles (GPs). Refugee's human rights are expertly policed and promoted by the office of the United Nations High Commissioner for Refugees (UNHCR), earning them priority in the law and in institutional protection. On the other hand guiding principles are not protected by any UN institution and hence receive less compliance internationally (Goodwin-Gill & McAdam, 1996).

The underlying assumption of UNHCR operations—that IDPs can be best cared for when they are settled in camps also does not support the real situation of IDPs in camps. These camps portrays a picture of seclusion where a huge number of IDPs are kept in unhygienic and crowded places in urban slums and poor rural localities (Vincet & Sorenson, 2001). In the first few days when IDPs issue is hot on media healthcare facilities are provided to affected peoples but this health care support diminishes very soon. Moreover, whilst 'Band Aid' solutions to existing health problems are useful in the short term, the need for long-term public health interventions to enable displaced communities full access to and participation in their new 'host' communities is not ensured (Vincet & Sorenson, 2001).

Moreover, these health facilities are not in line with the needs and priorities of the internally displaced individuals. It is universally accepted that war victim's health needs are more in line with mental problems like depression, anxiety, sleeplessness (Roberts, Damundu, Lomoro, & Sondorp, 2009). In IDPs camps, however it is the general health related facilities that are provided to all (Hamid & Musa, 2010). Most of the programmes for medical care consider IDPs homogeneous group of people and do not consider the diversity of age and

gender, whereas in crises, the health of women, girls, boys, men and the elderly are affected differently (IASC, 2004). In this regard, the deaths of pregnant women during forced displacement mostly accounts for the highest mortality rate among all age groups (Vincet & Sorenson, 2001).

Children, on account of their young age, are more exposed to the difficulties and risks associated with displacement (Joop & De Jong, 2002). Their health is mostly addressed in perspectives of malnutrition and immunization programmes and their psychological needs remain mostly a neglected area (Betancourt & Khan, 2008). During armed conflict the emotional immaturity results in post-traumatic stress for children on account of their little tolerance of violence (Kim, Torbay, & Lawry, 2007).

During internal displacement, population bearing the brunt of health related inadequacies are peoples in old age (HelpAge, 2010). The highest morbidity levels in elderly is caused by bad environmental conditions which further exacerbated due to non-availability of appropriate health care facilities (Thomas & Thomas, 2004). Where UNHCR categorizes old aged people as the most vulnerable and consider them as people with special needs, very little care is provided to them during displacement.

Methodology

This study was descriptive-exploratory in nature based on mixed study approach by using both qualitative and quantitative research methods for data collection. A structured questionnaire for a quantitative survey among the IDPs of SWA was constructed for data collection. An interview guide was also developed for the In-depth interviews (IDIs) to not only complement quantitative findings of this study but also to dig deeper and find answers to those results which could not be explained without a deeper understanding of issues. For IDIs, the respondents were selected through purposive sampling to find out the issues related to forced displacement, morbidity, mortality and health care availability.

Review and analysis of existing data

The literature for IDPs status in UN and international law was sorted out along with research articles, newspapers etc. WFP and NRC officials provided the number of all registered IDPs living in camp for this study. The data were segregated for all tribes of SWA and was further used to draw the primary sampling frame for this study.

Justification for selecting locale of the study

District Tank situated in the extreme south of KP was chosen as the locale of this study as it hosts majority of the IDPs from SWA. Although easily accessible, negligence of state, UN and INGOs is visible in terms of providing humanitarian relief to IDPs residing in Tank. Most of the INGOs were not delivering any relief on the pretext that security situation is dangerous in the district.

Study Sample

Inclusion of all the IDPs was not possible because of their large numbers; therefore, a sampling procedure was developed to obtain a representative sample size. At the start of this study 200

households were targeted but due to time and monetary constraint 155 households were sampled and data were collected for 1133 individuals.

Sampling Methods

To select a comparative Sample of 155 households from camp following sampling steps were taken:

Step 1: Considering WFP listing of SWA IDPs as a primary sampling unit, 3960 households living in camp were divided into four approximately equal groups; A,B,C & D and group C was randomly selected by lottery method.

Step 2: In group C total number of households of IDPs camps were 990.

Step 3: Calculation of sample interval (**K)** using the formula: **K** = N/n

Where,

K = interval

N = the number of total internally displaced person households in camp (Population size)

n = the number of households to be selected (sample size)

- For camp sampling interval was 990/155 = 6.4 randomly taken as every 6^{th} household.

STEP5. In this step systematic sampling with a random start was used to select 155 households from IDPs camp.

Qualitative Data Analysis

Data recorded from in-depth interviews was thematically organized, transcribed and directly translated into English. Further, in-depth interviews were analyzed by method of "Content Analysis", transcribed and mixed with survey results to provide a more comprehensive understanding of IDPs health issues.

Quantitative Data Analysis

Data from the questionnaire were entered into SPSS and variables were constructed according to the study requirements. Data were then analyzed through calculating frequencies and mutual relationships were identified among health status, chronic diseases, mental stress, sex and age by cross tabulation.

Results and Discussion

Results of this study are consisted of morbidity, mortality and mental stress. Here, quantitative results are corroborated with input from qualitative component of the study. This input from in depth interviews is added to not only complement but to provide a sense of completeness to the quantitative findings for a comprehensive discussion.

Morbidity, Mortality and Mental Stress

Table below shows that in IDPs camps the highest incidence rate for physical illnesses that is 79.2% in males and 72.7% in females was noted for people in age group 65 & above and was followed by 75% in males and 59.3% in females among infants. The incidence was also high in age group 1-5 years where males were affected more (59.6%) compared to females (47.6%). In mature age group 29-64 years females contracted more illnesses (43.4%) as compared to males

(31.1%) while in age group 6-14 years both males and females suffered due to illnesses almost the same (34% to 35%)

Incidence of illness among IDPs by sex and age

Age group	**Male % n=209**	**Female % n=219**
Infants	75	59.3
1-5	59.6	47.6
6-14	34.8	34
15-28	28.4	28.9
29-64	31.1	43.4
15-49 y	27.2	33.8
65 & above	79.2	72.7
Total	35.7	40.03

Source: Primary Data from Tank

Table below for the type of illnesses indicates that in male infants, more prevalent illnesses were consisted of common colds 33.3%, chest infections 16.6% & asphyxia 33.4% while in females common colds accounted for 31.6%, chest infections for 18.7% and asphyxia for 18.8% in camps. In age group1-5 years, common colds and asphyxia affected both sexes almost equally in addition to diarrhea that causes 34.9% cases in male & 41.6% in females.

In age group 6-14 years, in addition to common colds and chest infections more girls (32.5%) were affected by skin infections than boys (25.6%). Among youth in age group 15-28 years IDPs health was followed by the same disease pattern and affected both sexes. Also 10.4% women in reproductive age group of 15-49 years faced not only reproductive health issues in camp but were also affected by cardiac problems, skin infections, common colds and chest infections.

Among people in mature ages in age group 29-64 years and especially in 65 & above year's age, the percentages of cardiac problems, Vision loss, arthritis, conjunctivitis and other mobility related illnesses were higher for both sexes. These people of above 65 years of age who needs special attention and that are identified by UNHCR as people with special needs (HelpAge, 2010) were more affected by specific health issues prevalent in older ages.

The findings in above table confirms with IASC (2006) who asserts that IDPs are almost considered homogeneous group of people and do not consider the diversity of age and sex while designing health care system for them. The findings regarding loads of cases of common colds, diarrhea, skin and chest infections also agrees with Roberts, Odong, et al. (2009) who holds environmental problems of water & sanitation, and overcrowding responsible for those health related problem.

Type of illness suffering IDPs in camp since past three months (n=427)

Illness	**<1 Y**		**1 to 5 Y**		**6 to 14 Y**		**15 to 28 Y**		**29 to 64 Y**		**15 to 49 Y**	**65 Y & above**	
	M %	F %	M %	F %	M %	F %	M %	F %	M %	F %	F %	M %	F %
Common Cold	33.3	31.6	24.1	25	30.8	29.4	24.2	24	18.1	15.7	17.9	-	-
Chest Infection	16.6	18.7	24.2	25	12.8	14.7	14.5	28	32.7	18.5	18.1	31.6	20.8
Asphyxia	33.4	18.8	-	-	-	-	-	-	-	-	-	-	-
Diarrhea	-	-	34.9	41.6	20.5	23.5	19.3	14	5.4	7.1	5.1	-	-
Skin Infections	-	-	-	-	25.6	32.5	30.6	20	10.9	20	18.1	-	-
RH Problems	-	-	-	-	-	-	0	6	-	-	10.4	-	-
Cardiac problems	-	-	-	-	-	-	-	-	14.5	8.5	9.09	0	12.5
Conjunctivitis	-	-	-	-	-	-	-	-	-	-	-	15.8	12.5
Arthritis	-	-	-	-	-	-	-	-	-	-	-	10.1	4.1
Neuro Pain	-	-	-	-	-	-	-	-	-	-	-	5.2	8.2
Vision Loss	-	-	-	-	-	-	-	-	-	-	-	10.1	0
Other diseases	16.7	31.9	17.2	8.4	10.25	0	11.2	8	18.1	30	21.21	26.3	41.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Primary Data from Tank.
Note: Empty cells represent zero prevalence
Table below for mortality pattern highlight that IDPs households living in camp experienced higher number of deaths (30.3%). In in-depth interviews it was aimed to investigate that why a huge number of people have died from very commonly treatable diseases/injuries.

Deaths among IDPs during internal displacement in camps

Response	**IDP Camps % n=155**
Yes	30.3
No	69.7
Total	100

Source: Primary Data from Tank
Participants from IDPs camp commented about high mortality burden:
"…….*my pregnant wife and child died just because they (security forces) did not permit us to visit doctor in Tank at 10 pm in night because they assumed this late travelling is very dangerous for peace* **(Unemployed male, 42 years).**
I asked that why security check posts do not permit to take a dying patient to hospital and he replied"

"……..*We are not allowed to travel to Tank after 5 pm in evening due to so called security reasons even if someone is dying. They (military) assume that every Mehsud is a supporter of Taliban which is false, and on this pretext they have turned this camp into a prison for us. Actually, this big turban (pointing towards the turban he was wearing), my long beard, my Mehsud lineage and my tribal culture are perceived as a security threat by military* **(Unemployed male, 42 years).**

"…… my father died at the age of 72 due to blockage of urinary tract. We had taken him even to district hospital Tank as well but due to unavailability of medical facilities he died soon **(Male laborer, 45 years).**

Table below shows main illnesses responsible for mortality where in under5 years age group, more children died of Asphyxia, diarrhea, still birth, measles and pneumonia. In 6-14 years age group, pneumonia and injuries were the most common reasons of death for boys. In 15-28 years age group mainly more women died due to pregnancy related issues in camps. In reproductive age group of 15-49 years, pregnancy related deaths in addition to hepatitis caused many deaths among them. In 29-64 years age group also, more females than males died due to hepatitis and cardiac failure. In 65 years and above age group cardiac failure was main cause of death. By taking a glance of all this illnesses, it is evident that most of these deaths were caused due to inappropriateness of camps setting and lack of basic health care facilities as already well elaborated in literature by (Rae, 2011) .

Illnesses causing deaths among IDPs during period of displacement from age and sex perspective (n=47)

Disease	**< 5 y**		**6 to 14 Y**		**15 to 28 Y**		**29 to 64 Y**		**15 to 49 Y**	**65 Y & above**	
	M %	**F %**	**M %**	**F %**	**M %**	**F %**	**M %**	**F %**	**F %**	**M %**	**F %**
Asphyxia	16.6	9.1	-	-	-	-	-	-	-	-	-
Diarrhea	33.4	27.3	-	-	-	-	-	-	-	-	-
Still Birth	16.6	0	-	-	-	-	-	-	-	-	-
Measles	0	36.3	-	-	-	-	-	-	-	-	-
Pneumonia	33.4	18.1	50	0	-	-	-	-	-	-	-
Injury	-	-	50	0	-	-	-	-	-	-	-
Pregnancy	-	-	-	-	0	100	-	-	100	-	-
Hepatitis	-	-	-	-	-	-	14.2	50	-	-	-
Cardiac Failure	-	-	-	-	-	-	14.2	37.5	-	33.3	0
Don't Know	0	9.1	-	-	-	-	-	-	-	-	0
Other Diseases	-	-	-	-	100	0	71.6	12.5	-	66.7	100
Total	**100**	**100**	**100**	**0**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Primary Data from Tank

Table below for experiencing mental stress shows that among IDPs living in camp, 32.7% admitted that they experienced it.

Experience of any signs of mental stress by IDPs during last three month

Response	**IDP Camps % n=930**
Yes	32.7
No	67.3
Total	100.0

Source: Primary Data from Tank

Table below for that from a gender perspective, male suffered harder than women in IDPs camp. In age group 9-14, main signs of emotional stress captured in this study are feeling down, depressed, hopelessness and constant crying. In age group 15-28, men and women were more affected by depression almost equally. Other signs of mental stress included sign of feeling down, hopelessness, constant crying and sleeplessness. Sleeplessness was more common in women while men were victim of constant crying.

In age group 29-64 also depression was more common where women as compared to men. Hopelessness was equally higher in both sexes and over thinking was more common in women as compared to men. Population in age group 65 and above, who are recognized by UNHCR as peoples with special needs (HelpAge, 2010), were caught by loss of appetite & depression and this suffering was more prevalent in men as compared to women.

Types of Mental stress signs among IDPs living in camps (n=304)

Signs	**9 to 14 Y**		**15 to 28 Y**		**29 to 64 Y**		**65 Y & above**	
	M %	F %	M %	F %	M %	F %	M %	F %
Feeling Down	35.2	46.7	19.2	4.8	18.2	14.7	-	-
Depressed	17.6	13.3	26.9	22.5	32.9	40	55.7	33.3
Hopelessness	5.8	20	13	20.9	21.9	13.3	-	-
Constant Crying	0	0	16.7	12.9	-	-	-	-
Sleeplessness	-	-	6.4	11.2	-	-	-	-
Overthinking	-	-	-	-	7.3	9.3	-	-
Loss of appetite	-	-	-	-	-	-	33.3	66.7
Other Signs	41.4	20	17.9	27.4	19.5	22.7	1.1	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Primary Data from Tank

Table below for treatment of mental stress shows that in IDPs camp, psychiatric/psychological treatment was completely absent. When they were asked about any coping mechanism against mental stress in absence of a psychiatrist it was found in camp that:

"…….*I had brought a mullet for my son and my mother for relieving mental stress from Molvi sahib. Moreover, when any relatives or friends come here it also relieve our mental stress* **(Unemployed male, 42 years)**

Availability of any Psychiatric/Psychological treatment to IDPs living in camps

Response	IDP Camps % (n=304)
Yes	0.0
No	100.0
Total	100.0

Source: Primary Data from Tank

Table below for accessibility to medical facility shows that majority of IDPs 75.9% living in camp relied upon mobile clinics where 12.4% are still waiting mobile clinic to come. IDPs who prefer to visit DHQ were 4.7% while 6.5% went to RHC for medical treatment.

Accessibility to health care services for IDPs living in camps

Type of health facility	IDP Camps % n=428
BHU	0.2
RHC	6.5
DHQ	4.7
Mobile clinic	75.9
Private hospital	0.0
Still waiting for mobile clinic to come	12.4
Other health facilities (temporary health facilities and Hakeem	0.2
Total	100

Source: Primary Data from Tank

When respondent in camp asked about mobile clinic and the reason to wait for it, they commented:
"*It is an ambulance equipped with a small dispensary, a dispenser and LHV, that visit our camp once weekly or some time visit us after two weeks. Occasionally it is joined by an MBBS doctor as well* **(Unemployed male, 4 years).**
When asked that why mobile clinic come so rarely, they commented:
"…..*Medical staff says we have permission from District health officer only for one day in a week. While DHO says that they are short of medical staff & medicines; and security forces also permit us to send it only once in a week due to security reasons* **(Women household head, 50 years).**
When a respondent was asked that your son is sick and you are still waiting for mobile clinic to come. Why do not you go to Tank and show him to a doctor and he replied in despair:
"……You knew that I have no extra money, city is at a distance of one hour and most importantly security check posts do not permit us to go out of this camp and visit Tank or any other destination **(Unemployed male, 42 years).**
I also asked about medical help provided by NGOs and they replied "…..*they provided very good medical help at first when this camp was newly constructed, but after a couple of months they rarely came here* **(Unemployed male, 42 years).**
Table below shows a description of opinion about their level of satisfaction regarding health care facility. It shows that majority of them (40.5%) rated it as poor, 15.2% mark it as not available at all while 26.9% considered it as fair. Only 15.2% rated it good with merely 2.1% considering it excellent.

Opinion of IDPs regarding quality of health care provided in camps

Response	IDP Camps % n=375
Excellent	2.1
Good	15.2
Fair	26.9
Poor	40.5
Not available at all	15.2
Total	100

When IDPs in camps were asked to tell the reasons for dissatisfaction with health care facilities, they replied:

"*…….because they give us same medicine for all types of sicknesses. Last week when I visited Mobile clinic, they gave me syrup Polybion and tablet paracetamol for fever and given my wife the same medicine who was suffering from backache. Moreover, for diagnosis, there is not available any laboratory, X-ray Machine or specialist doctor* **(Unemployed male, 42 years).**

".. We do not like the medical facilities because they give us same medicine for every types of sickness. Only colored multivitamin and paracetamol is given, they don't bring any doctor and carry antibiotics **(Male laborer, 45 years).**

Conclusion

The main conclusion of this study highlighted the inadequacy and inappropriateness of health services provided to IDPs of SWA due to negligence of UN, international law and the state. The health services for most of health problems were absolutely missing and not tailored according to the age and sex needs of the IDPs. This study found out that the burden of mental health problems was almost equal to the physical health problems among IDPs. The frequency of health services provision was not regular and resulted in huge levels of morbidity and mortality. The security check-posts also proved to be a hurdle for IDPs in camps to seek medical treatment.

Although SWA IDPs were traumatized by war almost equally still the distressing experiences of living in camp affected their health status in negative way by increasing their health needs. The common issues related to physical health in camps mostly targeted female, children and elderly. Most common infections included common colds, skin infections, chest infections, diarrhea for children; reproductive health issues for women in reproductive age and cardiac problems, arthritis, mobility problems among elderly people.

The issues of mental stress emerged to be the most common where it was present among all age groups and in both the sexes however, people in older ages were affected the most. Most common signs of mental stress among children, youth and mature age people were the same namely feeling down, depression, constant crying, anxiety and hopelessness while in elderly it accounted for loss of appetite, overthinking and sleeplessness in addition. Alarmingly mental health care was completely absent and IDPs were mostly dependent on religious healing for sake of mental health relief.

IDPs living in camp reported much higher level of mortality rate. The level of mortality was higher among children under five years of age and women in reproductive age. The most common illnesses for death among children were asphyxia, diarrhea and measles where women died mostly due to pregnancy related problems. The security check posts proved to be the main reason for these deaths as the movement of IDPs from camp to health care facility was stopped by them. Health care availability was also less frequent and inappropriate at IDPs camps. IDPs living in camps were mostly dependent on mobile clinics for their health needs fulfillment and were least satisfied with it. By concluding the argument, it is evident that in absence of international protection, IDPs living in camp bear the load of health problems due to inadequacy and absence of health care facilities.

Recommendations

Based on the findings from this research and the conclusions presented above, the following recommendations are made for effective interventions towards the SWA IDPs health needs fulfillment:

1. There is a need to develop proper policies to integrate IDPs health related provisions in local district health system in the recipient areas.
2. There has to be improved coordination between security forces, DHO and NGOs (international and local) to facilitate IDPs health in conflict ridden areas.
3. There is a need for regular epidemiological surveillance of the IDPs' health problems for better health policy making.
4. Presence of a psychiatrist and psychologist should be made mandatory in camps to resolve their mental health problems.
5. Especially similar research studies should be done on IDPs health problems in all agencies to explore the overall picture of displacement in FATA.

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