An Assessment of Psychosocial Needs and Resources in Yola IDP Camps: North East Nigeria

International Organization for Migration

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List of Acronyms

- DTM: Displacement Tracking Matrix
- IASC: Inter-Agency Standing Committee
- IDP: Internally Displaced People
- (I)NGO: (International) Non-Government Organization
- LGA: Local Government Area
- MHPSS: Mental Health and Psychosocial Support
- MoH: Ministry of Health
- MOWSA: Ministry of Women Affairs and Social Services
- NEMA/SEMA: National Emergency Management Agency/State Emergency Management Agency
- NFI: Non Food Items
- PFA: Psychological First Aid
- SPSS: Statistical Package for the Social Sciences
- WASH: Water, Sanitation and Hygiene

Background

The psychosocial needs assessment that is described in his document was conducted in the period of twenty one days in April, 2015. The assessment took place in Adamawa State, and aimed at identifying self-perceived stress factors and coping mechanisms among the populations displaced to Yola, the Adamawa capital, due to the activities of the Boko Haram Insurgency, and to map existing services and provisions, to identify gaps to be covered.

Yola, the capital of Adamawa State in North Eastern Nigeria, continues to struggle due to a prolonged humanitarian crisis, arising from the insurgency and counter-insurgency activities in the region, in relation to the Boko Haram movement. Boko Haram, as the group is popularly known, can be roughly translated to 'western education is prohibited'. Founded in 2002, the group started systematic attacks in 2009 against the Nigerian security operatives, traditional leaders and the civilian population. Since then, Boko Haram has targeted markets, motor parks, places of worship, government offices, detention centers, religious figures and, increasingly, schools and children. The group's tactics began with hit-and-run attacks and have evolved into take-and-hold attacks, controlling large swaths of territory. Their activities have progressively expanded beyond Nigeria's borders into Cameroon, Chad and Niger. An alarming trend observed since July, 2014 is the recruitment and use of boys and girls by Boko Haram in support roles and in combat. Children were also used as human shields to protect Boko Haram elements. In addition, it was reported there is a growing number of girls used as suicide bombers in populated urban centers (for more information: UN Annual Report on Children and Armed Conflict, June 2015).

The ongoing crisis has generated an estimated 13, 000 – 17, 500 deaths, and resulted in massive population displacement arising from fear of insurgents, assaults, destruction of property, and loss of livelihood (Human Right Watch, 2014; Amnesty International, 2014; Walker, 2012). The deteriorating security situation in and around surrounding villages of Adamawa State, coupled with a comparatively more stable situation in Yola, has culminated into a high number of individuals fleeing into the town to seek refuge. In Yola, Internally Displaced Persons (IDPs) from Borno and border communities of Adamawa, such as Gwoza, Askira, Uba, Baga, Lassa, Biu, Michika, Madagali, Mubi North and Mubi South, Hong, Gombi among others, have been displaced since late 2013 and over 45% of IDPs have been displaced more than twice (Oxfam, 2014, and International Rescue Committee (IRC), 2014). According to IOM (Displacement Tracking Matrix program), in June 2015 Borno State had the highest number of the IDPs (1,002,688) followed by Yobe State (125,484) and Adamawa State (113,437).

The psychosocial needs of the displaced population continue to remain unmet, due to the instability of the situation, direct exposure to violence, and family separation. This situation is further aggravated by the limited access to social, educational and health services for the displaced population. The capacity to provide psychosocial support to the affected population by the various governmental actors involved in humanitarian assistance, coordinated by National Emergency Management Agency (NEMA) and State Emergency Management Agency (SEMA)in Adamawa, have been overstretched due to the magnitude of the problems and the limited resources available. In June 2015, the INGO Forum performed an assessment in order to evaluate the needs of the displaced population, identify gaps in support and recommend action points. The conclusion of this exercise highlighted that the most urgent needs of the affected and displaced population were Food, Protection and Livelihoods, while needs at the critical stage included Health, Nutrition, Shelter/NFIs, Education, WASH and Psychosocial Support (ING Forum in Nigeria, 2015). The IOM found similar results from their assessments, stating Food and Shelter as the primary needs for the displaced population (IOM-DTM program, 2015).

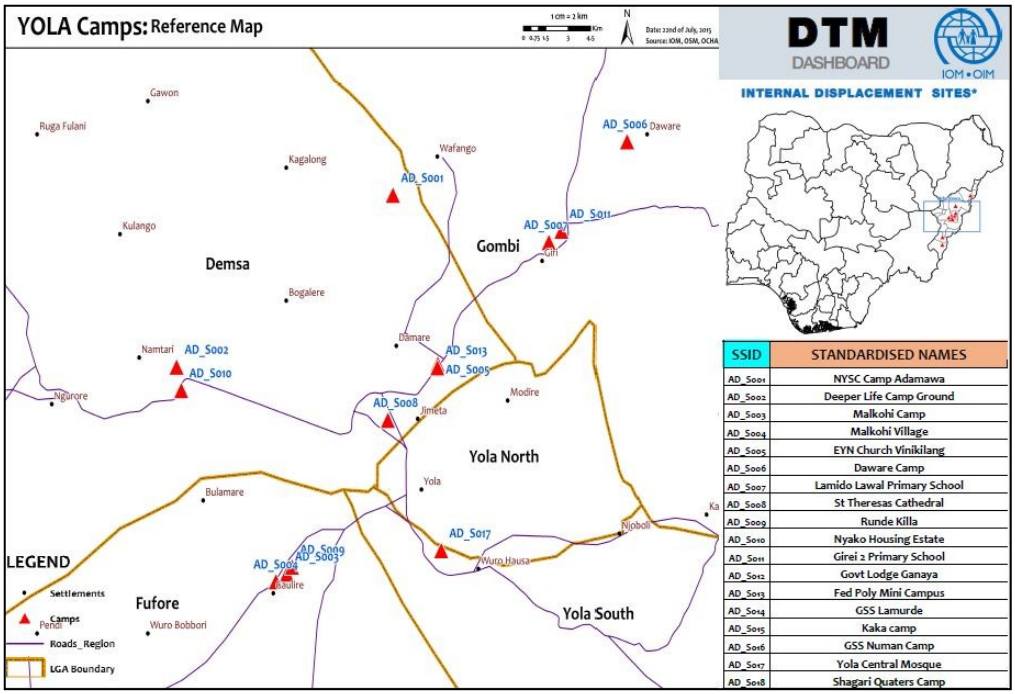
Since 2014, International Organization for Migration (IOM) has been implementing psychosocial support interventions in Nigeria for the released abducted girls of Chibok, their families, and the community in Borno State; in IDP camps in Maiduguri metropolis; and, more recently for conflict-induced displaced populations in Yola camps (official and unofficial) and host communities. This psychosocial need assessment of the IDP population in Yola was conducted to inform these activities with data identified in a participatory manner with the beneficiaries.

Profile of Yola

Yola is the capital city and administrative center of Adamawa state, with a population of 336,648 people according to the 2010 census. The town is split into two parts. The old town, where the traditional leaders of Adamawa State (known as Lamido) reside, is considered the traditional city. It was established by the first ruler of Adamawa in 1841 and since then has been the residential area of authority. The new city of Jimeta (about 5 km NW) is the administrative and commercial center, where government offices, banks, factories and business are located . Generally, the term Yola is now used to refer to both towns. The major occupations of the people are agriculture , fishing, animal farming and commercial business. There are few industries/factories in Yola that are functioning at the present time.

Adamawa State has been impacted by the activities of the insurgents following various attacks, mainly targeting Police Stations in a number of towns and villages in the State since December 2012. In October 2014, the violent attacks escalated causing hundreds of deaths and thousands of displaced persons. IDPs fleeing Boko Haram are increasingly becoming vulnerable and their coping strategies have been exposed to numerous stressful events. In the beginning of 2015, there was a relative state of calm in Yola; however, the fragile situation has been destabilized by several attacks in July 2015.

The latest IOM report indicates that there are 113,437 individuals (15,317households) living in displacement sites in Adamawa state. 81,3% of the IDP population comes from Adamawa and particularly from Michika and Madagali LGA. The majority of sites are located in Yola South and Girei. The results of the displacement site assessments indicate that 52% of the IDP population in sites is female while 48% is male. Half of the total number of individuals residing in sites is comprised of children under 17 years old. , Particularly vulnerable populations identified



within the IDPs are single headed households, breastfeeding mothers and pregnant women were identified among the most vulnerable categories together with unaccompanied and separated children. According to the report, the main cause of displacement in Adamawa is the insurgency (IOM-DTM project, 2015).

Four of the IDP camps are designated as "official" and are organized and run by Federal and State authorities. They get more support from NEMA/SEMA, in terms of food, health, informal education, NFIs, WASH and security than the informal camps and host communities. However, most of the displaced population resides in "unofficial" camps, defined as such because they have been established as a result of the spontaneous settlement of one or more communities. Finally, IDPs living with their extended families are defined as residing in "host communities". The population of IDPs in host communities is greater than those residing in camps. The percentage as per the June DTM report was indicating that 92% of IDPs live in host communities while 8% live in the camps (data collected from six states in the North East of Nigeria, Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe states). Most of the official camps are situated in schools and the management opted to divide the population within each camp according to gender. Men stay in one section while women and children stay in a separate one. According to SEMA/NEMA, this segregation was enacted to ensure that women and children are better protected. However, this creates a gap in the psychosocial intervention since one of the objectives is to strengthen family and community systems by promoting family units.

Assessment

The psychosocial needs assessment, conducted between the 9th and 30th of April, 2015 was aimed at identifying:

a) Psychosocial needs and resources in the designated camps (official and unofficial) and host communities, in order to determine gaps to be addressed by the IOM psychosocial program,

b) The existing technical resources on a State level that could be mobilized to respond to identified needs,

c) The coordination mechanisms available at a state level and

d) Specific psychosocial interventions to be implemented for the affected population.

The general objective was to inform on IOM's activities in the psychosocial domain in response to the humanitarian crisis the State is currently facing.

The assessment consisted of:

- Ø 32 interviews with national key actors, camp leaders and other agencies/stakeholders working in the 'official' and 'unofficial' camps and host communities.
- Ø Participation at relevant state-level clusters, sub clusters and working groups (Health, protection, Camp Coordination and Camp Management (CCCM)/humanitarian coordination forum and collection of secondary information presented in these fora.

- Ø 261 individual and family interviews with 746 camp residents, conducted by the IOM psychosocial mobile teams.

During the period of the assessment, all camps within Yola and its environs, with the exceptions of camps located in Michika, Madagali and Mubi LGA were cleared of any insecurity and made accessible for the assessment team.

A simplified version of Renos Papadopoulos' grid of outcomes (Papadopoulos, 2004), which analyzes the interrelation of negative outcomes, resilience factors and adversity-induced developments on the individual, family and societal levels after a disruptive event or a series of disruptive events, was used to analyze the needs of the IDP population vis-à-vis their coping strategies and adversity activated developments.

Grid of Outline of Consequences

	Wound	Resilience	Adversity-Activated Development
Individual			
Family			
Community			
Society			

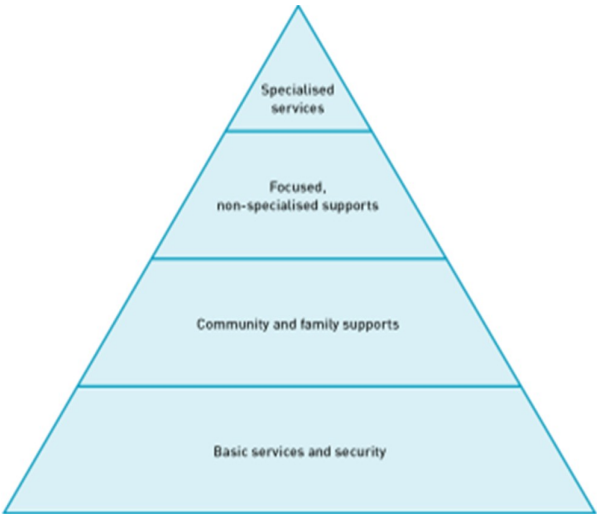
(From Papadopoulos, 2004)

A questionnaire with open-ended questions was developed. The responses were analyzed qualitatively. Semantic groupings were analyzed descriptively using SPSS, and mapped through both the simplified version of Papadopoulos' grid and the pyramid of MHPSS services, as identified in the relevant IASC Guidelines.

Simplified Grid Used for the Assessment

	Suffering	Resilience-Responses
Individual	Feelings/Factors	Activated
Family	Feelings/Factors	Activated
Community	Feelings/Factors	Activated/Potential

Figure 1: The pyramid of psychosocial interventions



(IASC, 2007)

Respondents:

261 interviews with 746 individuals were conducted in the camps within Yola and its environs. The assessment team leaders met camp managers from SEMA/NEMA, community leaders and religious leaders in all the camps where the assessment took place, with the aim of explaining the reason and purpose of the exercise and requesting community collaboration. In addition, when they first approached the communities, team members organized a discussion over the importance of this assessment (concerning the number of interviews conducted per camp and the number of persons interviewed see annex 1).

Interviewers:

The interviewers team was composed by the members of the IOM Psychosocial Mobile Teams. A two days workshop was organized to introduce and revise the assessment tool, in order to ensure that questions were well understood. Moreover, simulation and role play were held, in order to make the team familiar with the process.

Nevertheless, the team didn't have any background or previous experience in conducing a qualitative interview, which inevitably had an impact on the quality of the data collected. The major challenge faced was in the ability of the assessors to make respondents express their actual feelings and emotions. Instead, respondents would refer to the stressor rather than the resulting feeling, or to the feeling directly connected to the stressor. It was therefore difficult to differentiate between feelings and stressors when analyzing the results.

To minimize the effect, coaching sessions were repeatedly organized.

Results

Figure 2: Psychosocial Needs and Resilience Factors on the Individual Level

	Suffering	Resilience
Individual	**Feelings:** 1. Feeling sad (44.8%) 2. Feeling happy (19.9%) 3. Feeling of loss (19.2%) 4. Feeling uncertain about the future (16.1%) **Factors:** 1. The desire to go home (23.0%) 2. Loss of status/loss of identity/loss of lives & property (21.1%) 3. Lack of basic/social amenities of life (19.5%) 4. Displacement/separation from the family (14.2%) 5. 9. Lack of jobs/lack of capital to start up business (8.8%) 6. Mistreatment by security personnel (5.4%) 7. No "good" food (3%) 8. Lack of freedom (3%) 9. Lack of privacy (2.0 %)	1. Prayers (37.2%) 2. Recreational activities (22.6%) 3. Income generating activities (18.8%) 4. We sit in group to discuss our challenges (9.6%) 5. Patience to endure (8.4%) 6. Nothing (3.4%)

When respondents were asked to identify their main feelings at the time of the interview, the majority expressed negative feelings and a few reported positive feelings, such as feeling happy (19.9%). Therefore the most accessible emotions and feelings among the IDP population on the individual level are negative, and include feelings of uncertainty about the future, sadness due to separation from family, and feelings of loss (due to loss of identity, status, but also loss of family members and property). Factors provoking negative emotions and feelings were identified as the willingness of the respondents to go back home (and the uncertainty associated with the return due to the security reasons, or lack of means to return home), displacement and separation from the family, lack of freedom, loss of lives and property, lack of basic/social amenities, lack of jobs or income generating activities, maltreatment by security personnel in the 'official' camps and issues with food (in terms of availability, quantity, quality and distribution). The willingness to go home and the uncertainty associated with the return, or lack of means to go back home, play a substantial role in determining the negative feelings of people, irrespective of gender. It is a determining factor, but also an aggravation. In the words of a respondent "... we are approaching raining season, we need to go home and farm". When the interviewees were asked to elaborate more this statement, they explained that farming is their main source of livelihood and the only way to ensure enough provision of food for next year, but due to the attacks they experienced in the past and due to the current insecurity, they cannot return to their villages and farm their

lands. These two aspects combined together resulted in anxiety and feeling uncertain about the future. Another factor causing distress on the individual level is the loss that people incurred due to displacement. These two factors were also highlighted as the main sources of concern by leaders and stakeholders, who explained that the willingness of the respondents to go back home and the lack of means to return have been the main distressing factors at the moment. The desire to go home is commonly associated with the fast approaching rainy season, the living conditions in the camps and shortages of food items among the displaced population.

A significant number of the respondents confirmed the presence of people with severe mental disorders both in the 'official' and the 'unofficial' camps. Based on the responses offered, most of the mental health issues reported were most likely pre-existing. Based on descriptions collected in the assessment, some cases might be due to epilepsy, while others are a form of psychosis. It is possible that most of the cases might be relapses due to shortage of medications as a consequence of displacement. However, this is not an exclusive explanation.

When the respondents were asked to describe how they cope with their negative feelings, the majority of the respondents resorted to prayers and other religious activities like singing; 37.2% of the respondents fall under this category. This indicates the heavy reliance on faith (God) and religious activities to achieve a sense of relief from their current situation in displacement.

Other activities the respondents are engaged in to overcome these negative feelings are group discussions (9.6%), income generating activities like petty trading, commercial motor cycling, and manual jobs (18.8%), recreational activities such as drought or cards games (22.6%), while 3.4% of the respondents did not think of anything to do to overcome their negative feelings. 8.4% of the respondents answered of having the "patience to endure" as their attitude to cope with negative feelings. In host communities, most respondents learned to engage in a number of commercial activities, including petty trading, commercial motorcycling and other menial jobs, to earn an income. Many respondents reported having positive experiences due to displacement as well. A significant number have learned to engage in different kinds of skills such as weaving, knitting, or tailoring. Others have identified making new friends, learning to adapt to their new environment and take on new small business opportunities as positive experiences.

Figure 3: Psychosocial Needs and Resilience Factors at the Family Level

	Suffering	Resilience
Family	**Feelings:** 1. Feeling bad (35.6%) 2. Feeling uncomfortable (21.0%) 3. Feeling of loss (18.8%) 4. Worried (10.0%) 5. No response (7.7%) 6. Feeling happy (6.9%) **Factors:** 1. The desire or willingness to return back home and the lack of means (36.0%) 2. Loss of lives & property (21.5%) 3. Lack of basic and social amenities of life (21.5%) 4. Separation of family members due to displacement and separation in camps (12.6%) 5. 5. Lack of school for their children (8.4%)	1. Prayers (37.8%) 2. Recreational activities (19.2%) 3. Income generating activities (19.2%) 4. Supporting each other (18.4%) 5. Nothing is done (5.4%)

Many of the negative feelings reported at individual level were reflected at the familial level as well, but in different proportions. The accessible negative feelings and emotions the respondents identified include loss, feeling bad (which is a way to define feeling unhappy or sad), feeling uncomfortable and feeling worried about the future of their children. However, there are some respondents that expressed positive feelings such as feeling happy (6.9%), while 7.7% of the respondents did not respond to the question.

Factors commonly associated with these negative feelings are also similar to those expressed by the respondents at individual level. The factors still include the desire or willingness to go home and the uncertainty associated with the return or lack of means to go home, loss, lack of basic and social amenities, separation of family members due to displacement and lack of schooling for their children.

Though the majority of respondents expressed their desire or willingness to go home, during interviews with stakeholders, camp officials and camp leaders expressed doubts concerning the feasibility of allowing populations to return home. These doubts take the form of three macro-narratives. The first series of narratives are related to the fact that IDPs from the 'safe' part of Adamawa state are keen to return, and some have even voluntarily returned to their communities. The second concerns those from the 'uncertain' part of the state, who wish to return but want a clear statement from the government that their communities are safe before returning home IDPs from Borno State, those in the third narrative category, have no intention to return at this current time. However, some are considering resettlement as an option. This category of IDPs disclosed that their communities are not secured and have been completely ravaged by the insurgents. Returning there is "tantamount of committing suicide".

When asked to identify what the family does to overcome distress, 5.4% of respondents say that they do nothing or they cannot think about a suitable coping mechanism. Others use the same coping mechanisms identified at the individual level such as prayer and other forms of religious rituals (37.9%). Recreational activities, such as playing or watching football (19.2%), income generating activities such as petty trading (19.2%), and supporting each other through actions such as giving advice (18.4%) are also relevant coping strategies. The significant role of religious, livelihood and recreation activities, is even clearer. Additionally, these responses also reiterate the importance of mutual support at the familial level, reinforcing the suitability of establishing community mobilization groups, and the creation of a peer-to-peer support system .

Figure 4: Psychosocial Needs and Proposed Actions for Promoting Resilience at a Community Level

	Suffering	Resilience/possible actions
Individual	**Feelings:** 1. Feeling bad (40.2%) 2. Fear (33.3%) 3. Feeling distressed (14.2%) 4. Feeling happy (12.3%) **Factors:** 1. Loss of lives and property (36.8%) 2. Separation from family members (22.6%) 3. The desire or willingness to go home and the lack of means (18.0%) 4. Shortage of food and shelter (11.9%) 5. Lack of trust (6.9%) 6. 5. Breakage of familial system (3.8%)	1. We need promotion of cultural, religious, recreational, communal activities (35.39%) 2. We need skills acquisition/vocational centers (21%) 3. We need schools for our children (20%) 4. We Need promotion of peaceful coexistence (18.0%) 5. We need financial assistance (5.7%)

The negative feelings and emotions identified by the people at a community level are also similar to those expressed by the displaced population at the individual and familial levels. As listed in the above table, some of the accessible feelings include feeling bad (40.2%), fear (33%) due to insecurity, and feeling distressed (14.2%) because of suffering caused by the displacement, but also feeling happy (12.3%) that they are now safe.

When asked to identify factors provoking psychosocial distress in the community as well as existing and potential resilience factors, the respondents gave relatively similar responses to those identified on the individual and family levels. Some of the concerns however, were lack of trust related to ethnic divisions and religious sensitivities (6.9%) among the IDPs. As one person explained, "I don't know any more my neighbors…I don't know who I can rely on"., Similarly a minor number of the respondents, mentioned a lack of trust towards the Government for "…not taking care of us". Loss of lives and property was also mentioned as a factor (36.8%). Another concern expressed was the lack of food and the perceived inadequacy of proper shelters in the camps to withstand forthcoming raining season. An additional concern was raised about parents and care givers having difficulties upholding the moral education of their children; this could be due to the breakdown of familial and community systems. Traditionally, community and extended family play a central role in the education of children, but since the families and community groupings were not considered in camp organization, the communities are now separated and thus are no longer able to act as authorities and educators. .

When asked to identify what services they would desire to see implemented, respondents gave a variety of answers:

1. Educational, skills acquisition and vocational services, such as provision of sewing machines, financial assistance or support of income generating activities, and training in other traditional trades and skills.
2. Recreational activities to engage children in play, games and other forms of sporting activities.
3. Allocation of farm lands and support of farm inputs, and provision of capital (these are for the communities who are considering resettling in Yola; the majority of them are from Borno State but live in host communities)
4. Organize community mobilization and promote the necessity for peaceful coexistence among people and communities.

Figure 5: Mapping and Assessment of Psychosocial Service Provisions in Yola, Adamawa State

Level of Intervention	Direct Intervention	Capacity Building
Focused Specialized Services 	Creation, coordination and management of effective referral systems for patients with pre-existing and emerging mental disorders. The existing agreement with specialists on the referral system needs to be strengthened and alternative outlets needs to be identified. Transportation of identified patients from the camps to the hospitals and back to their point of residence.	Training in designing and managing an efficient referral system be continued Training in mental health and mental disorder: principles of care for people with mental, neurological and substance use condition, psychopathology, psychopharmacology (see mhGAP-Humanitarian Intervention Guide) The mobile team members and the referral teams need to be continuously trained in identification of people with special MHPSS needs.
Focused Non-Specialized Services 	Focused group discussion for women and men who lost their husbands/wives, children and other family members Lay counseling/ couple lay counseling/ group lay counseling Focus Group Discussion based on specific identified problematics	Establishment of buddy-buddy systems Training on community mobilization Training on counseling skills
Family and Community Support 	Provision of outlets for skills acquisition and vocational learning Organize recreational and sport activities for adolescents and youth Support religious and related activities Organize storytelling for children and discussion groups for adolescents/youths Facilitate communication or link with separated relatives Provide non formal education sessions and other educational activities	Training in community messaging and Psychosocial Support Approach in emergencies for camp leaders, community actors and religious leaders Creating awareness on Sexual Gender Based Violence (SGBV)
Basic Services and Security 	Advocacy for strengthen the provision of sufficient food items and Non Food Items (NFI) Advocacy for strengthen the provision of efficient health facilities and personnel	Training of camp leaders in Psychological First Aid (PFA) and psychosocial approach on camp coordination and camp management

Agency/(I)NGO	Description of activities	partners	Status of activity
UNICEF	Capacity building and psychosocial support for the affected population. Largely relies on public servants from the Ministry of Women Affairs for their psychosocial support provision, child protection, nutrition, WASH, child friendly spaces and informal schools for children in the camps	Adamawa State Government	Ongoing
UNFPA	Capacity building and psychosocial support for the affected population. Like UNICEF, it relies largely on public servants from the Women Affairs & Health Ministries for their support	Adamawa State Government	Ongoing
ICRC	Family linkages, unaccompanied minors, shelter/NFI, medical referrals, etc.	Adamawa State Government	Ongoing
IRC	Protection, unaccompanied and separated children identification and case management, women health, SGBV.	Adamawa State Government, IRC, UNFPA, UNICEF, UNCHR	Ongoing
IOM	Capacity building and psychosocial support provisions – lay counselling, recreational activities, Focus Group Discussion, specialised counselling, mental health referrals,	Adamawa State Government, IRC, UNFPA, UNICEF, UNCHR .	Ongoing
API (Adamawa Peace Initiative)	Inter-faith mediation, shelter & NFI, food distribution & protection	AUN, Adamawa State Government	Rolling
Mercy Corps	Protection concerns	Adamawa State Government	Planned
CRUDAN	Protection concerns, lay counselling, SGBV, child protection, etc.	Adamawa State Government	Planned
UNHCR	Capacity building and coordination in protection	Adamawa State Government	Planned

Figure 6: Mapping and Assessment of available facilities, technical expertise, resources and Understanding in Yola, Adamawa State

Agency	Facilities	Technical Expertise and Resources	Remark
Adamawa State Government: 1. Primary Health Care Development Agency 2. State Specialist Hospital 3. Children's Home 4. Specialist training schools – nursing, midwifery, community health workers, etc.	Primary health care centres across the state Specialist & Cottage Hospitals across the state Home for unaccompanied minors and the orphans	Primarily community health practitioners, nutritionists, laboratory technicians, community pharmacists, etc. Medical doctors, psychiatrists, nutritionists, social workers, laboratories, and other specialists. Nurses, social workers and case workers Nurses, community health practitioners, laboratory technicians, midwives, etc.	Rolling

Federal Government of Nigeria: 1. Federal Ministry of Health 2. NEMA	The Federal Medical Centre, Yola Mobile and stationery clinics in the 'official' camps	Medical doctors, nurses, nutritionists and other specialists (no psychiatric unit) Nurses, community health practitio-ners	Rolling
AUN (American University of Nigeria)	Guidance & Counselling Unit	Clinical Psychologist	Rolling
Private psychiatric hospital	Private psychiatric hospital	Run by the Consultant Psychiatrist (Dr. Umar of the Specialist Hospital, Yola)	Rolling
Federal College of Education	Department of Fine & Applied Art	Designers, painters, & creative re-sources	Rolling

Figure 7: The Humanitarian Coordination Mechanisms

Sector	Lead Agency	Current Provision	Frequency of Meeting	Secretariat
CCCM/Humanitarian Coordi-nation	SEMA/NEMA	Coordination of overall Humanitarian activities in Adamawa State	Fortnightly	SEMA
Protection Sector Working Group	MWASD/UNHCR	Coordination of activities of agencies interested in protection concerns	Fortnightly	MWASD
Health Sector Working Group	Ministry of Health	Coordination of activities of agencies in the health care provision	Fortnightly	Ministry of Health
Food Security Working Group	Ministry of Agricul-ture and FAO	Coordination of activities of agencies in the provi-sion of agricultural services and care for the envi-ronment	Fortnightly	Ministry of Agriculture
Education Sector Working Group	Ministry of Educa-tion	Coordination of activities of agencies in the educa-tional provision	Fortnightly	Ministry of Education
WASH Sector Working Group	UNICEF	Coordination of activities in the WASH domain	Fortnightly	Ministry of Water Re-sources
Shelter/NFI Sector Working Group	SEMA/IOM	Coordination of activities of agencies in the provi-sion of shelter & non-food items	Fortnightly	SEMA
Security Sector Working Group	Military	Coordination of security affairs of the humanitarian group		Military Command

Recommended Actions

Outline of Recommended Actions:

Levels of intervention	Direct intervention	Capacity building
Focus-Specialized Services	Creation, coordination and management of effective referral systems for patients with pre-existing and emerging mental disorders. The existing agreement with specialists on the referral system needs to be strengthened and alternative outlets needs to be identified. Transportation of identified patients from the camps to the hospitals and back to their point of residence.	Training in designing and managing an efficient referral system be continued Training in mental health and mental disorder: principles of care for people with mental, neurological and substance use condition, psychopathology, psychopharmacology (see mhGAP- Humanitarian Intervention Guide) The mobile team members and the referral teams need to be continuously trained in identification of people with special MHPSS needs.
Focus Non-Specialized Services	Focused group discussion for women and men who lost their husbands/wives, children and other family members Lay counseling/ couple lay counseling/ group lay counseling Focus Group Discussion based on specific	Establishment of buddy-buddy systems Training on community mobilization Training on counseling skills
Family & Community Support	Provision of outlets for skills acquisition and vocational learning Organize recreational and sport activities for adolescents and youth Support religious and related activities Organize storytelling for children and discussion groups for adolescents/youths Facilitate communication or link with separated relatives Provide non formal education sessions	Training in community messaging and Psychosocial Support Approach in emergencies for camp leaders, community actors and religious leaders Creating awareness on Sexual Gender Based Violence (SGBV)
Basic services and security	Advocacy for strengthen the provision of sufficient food items and Non Food Items (NFI) Advocacy for strengthen the provision of efficient health facilities and personnel	Training of camp leaders in Psychological First Aid (PFA) and psychosocial approach on camp coordination and camp management

The results of this assessment revealed several weak points in the provision of psychosocial support to the displaced population and, consequently, different plans of action to be taken were identified.

In general, there is a considerable neglect of mental health issues (as highlighted in the WHO report on Mental Health systems in Nigeria, 2006). The existing Mental Health Policy document in Nigeria was formulated in 1991. Since then, no revision has been made and no formal assessment of how much it has been implemented has been conducted. As revealed by the WHO report, there is no coordinating body to oversee public education and awareness campaign in mental health and mental disorders. Also, no systemic reporting of information exists for mental health concerns.

At the fourth level of the IASC Pyramid (Focused-Specialized Service), the gap in the mental health care system is evident upon examination of the number of mental health professionals working in Adamawa State. Presently, there is only one psychiatrist, working in State Specialist Hospital located in Yola. No clinical psychologists in the area have been identified. Due to the lack of mental health resources in the area, people with serious conditions in need of specialized mental health care may be neglected, or conversely, people in need of psychological (but not necessarily psychiatric) care may be unnecessarily hospitalized. Filling this gap would be impossible for the humanitarian agencies without the initiative and the commitment of the Government.

To address this gap in services, IOM designed a referral system for beneficiaries in need of mental health care for treatment of pre-existing and emerging mental disorders. In the referral system the criteria for referral is also outlined, which includes: risk of harming him/herself or others, suicide attempt, violent/aggressive behavior, state of confusion and/or disorientation. The referral system has been shared with other agencies and government authorities involved in mental health care and the psychosocial support field. In addition, the IOM psychosocial teams received training on the referral system. However, this system needs to be strengthened within the IOM psychosocial program, the other agencies, INGOs and the Ministry of Health. Training on mental health disorders and case management is needed at each level of the health system. In addition, shortage of psychotropic drugs is also common; therefore advocacy is needed for psychotropic drug availability.

It is recommended that IOM continues and strengthens collaboration with the Ministry of Health regarding the provision of care for psychiatric patients, including the elaboration of an exit- strategy for chronic psychiatric patients in order to transfer them to the health system. In addition, it's important to liaise with WHO regarding specific issues beyond IOM capacity (specifically, training on mental health disorder and case management for health staff). Since gaps in the referral pathway for patients in need of specialized mental care have been identified by various agencies and actors, it is strongly suggested that all stakeholders involved in mental health and psychosocial activities jointly elaborate on Standard Operating Procedures, including a referral pathway, to address the abovementioned gaps. . The SOP would fill the gap while responding to the emergency and prepare the ground for more durable solution in a subsequent phase.

During the assessment implementation phase, one clinical psychologist was identified. She is employed at the American University of Nigeria and has been trained in United States. It's advisable that IOM liaise with her in order to create a working partnership to provide specific advanced counseling skills to the PSS mobile teams and to engage her in any other activities related to mental health care in the region (such as referral of patients in need of psychological care, supervision session for staff care, etc.).

At the third level of the Pyramid (Focused- Non Specialized Service), it has been observed in Yola that IOM is one of the few agencies providing lay counseling related to specific, problematic issues and basic emotional support for the displaced population. UNFPA is also present, providing psychosocial support related to women and child health, while UNICEF and IRC are dealing with protection issues (child protection and

It is recommended to liaise with the agencies and (I)NGOs operating at this level for improved harmonization. At the Yola coordination level, the creation of an MHPSS discussion group was created (the form of the group will be decided by the participants), in order to discuss MHPSS issues and specific case management within the different agencies and (I)NGOs. The first meeting was held in July 2015. At the time of the assessment some INGOs (Mercy Corp, Crudan, and UNHCR) were commencing their interventions., It is important to liaise and follow up with them as well.

At the second level (Community and Family Support), the assessment results emphasized the need for income-generating activities for the IDP population, such as netting, tailoring, or hat-making,. It also showed that several people in the camps have been previously trained in such skills, but they lack in materials and equipment to set up a small business. Predominately women are requesting this kind of support, as the men are farming during the raining season. In addition, recreational activities for children and youth were repeatedly requested, which can serve as prevention mechanisms against risky behavior (drug and alcohol abuse among teenagers).

It is recommended that IOM examines the possibility of creating a stable group of women trained on one of the aforementioned activities and provides the needed materials in order to equip IDP's to engage in income-generating activities. The same group participating in the livelihood programs would be the basis for the establishment of a peer support system, which can be duplicated to other groups. Integrating livelihood support into psychosocial programs, represent a way to make a psychosocial support program more comprehensive and able to address more effectively the holistic impacts of displacement. When livelihood supports are organized, it contributes to strengthening the psychosocial well-being of the beneficiaries because it can mitigate stress they are experiencing and enable the physical improvement needed to give people a sense of recovery and hope. Recreational activities for children and youth with a therapeutic aim are also needed to enable self expression in a manner appropriate for their age(s). It is highly recommended to liaise with other agencies working with children, mainly UNICEF, for coordination and to avoid repetition and overlapping of activities.

At the first level of the Pyramid (basic service and security), the mainstreaming of the psychosocial approach at this level is critical.

In May 2015, IOM carried out 3 days training for 30 camp managers and camp coordinators on Psychological First Aid, Do Not Harm Rules and the psychosocial approach regarding basic services, camp setting/ camp management.

> It is recommended to follow up on the effectiveness of the training and how the camp managers and camp coordinators are putting in place what they learned during the training. Also, it is recommended to examine the possibility of repeating training for additional staff working in IDP camps. Finally, the participation of the PSS expert at CCCM working group and Shelter/NFI sector working group is advised.

ANNEX 1

List of camps assessed, and number of people interviewed per camp

S/N	Location	Number of Interviews	Number of People Interviewed	Male	Female
1	Bajabure Host Community	18	18	12	6
2	NYSC IDP Camp	19	80	41	39
3	Malkohi 1 IDP Camp	15	33	18	15
4	Malkohi 2 Host Community	9	39	20	19
5	PPSMB	12	40	17	23
6	Shagari Host Community	12	54	24	30
7	Nyokore Host Community	9	58	26	32

8	Song 10 Housing Est	8	21	7	14
9	Deeper Life Camp	9	10	4	6
10	Malamre Host Community	6	20	11	9
11	Ganye Host Community	9	15	7	8
12	EYN Church	9	9	4	5
13	Toungo Host Community	2	2	0	2
14	Jambutu Host Community	6	18	9	9
15	Damare Host Community	6	9	6	3
16	Runde Killa Host Community	12	46	24	22
17	Fed Poly, Yola Camp	6	6	4	2
18	Bole/Lakare Host	12	48	22	26
19	St. Theresa's	12	46	26	20
20	GSS Numan Camp	6	7	3	4
21	Girei 2 IDP Camp	28	99	45	54
22	Girei 1 IDP Camp	17	39	16	23
23	Daware Host commmunity	9	15	12	3
24	Badrisa Host Commmunity	10	14	7	7
	Total	261	746	365	381

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