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Health assistance to internally displaced persons of South Waziristan Agency in camps and host community

A comparative analysis

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HEALTH ASSISTANCE TO INTERNALLY DISPLACED PERSONS OF SOUTH WAZIRISTAN AGENCY IN CAMPS AND HOST COMMUNITY: A COMPARATIVE ANALYSIS

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By Shahid Khan

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Executive Summary

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. Right at the start of this armed conflict, the displaced people from SWA took flight to district Tank. The recipient area was selected for this study because it is among the most backward areas in Khyber Pakhtunkhwa (KP)[1], hosting IDPs from the most neglected agency of federally administrated tribal areas (FATA)[2].

Government failed in providing adequate health care support to IDPs due to the absence of legislation regarding their rights in national law. Further, due to negligence of issues related to internal displacement in UN and international law, 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 evaluate the role of economic and social capital level of SWA IDPs in selection of temporary shelter in IDPs camp and host community during armed conflict; to compare the prevalence of health related problems in IDPs living in camp and host community according to their sex and age; to indicate the difference between current nature and range of health services availability in IDPs camp and host community 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

[1] Pak, J. "Budgetary Imbalances in the Health Care System of Khyber Pakhtunkhwa: 1990-2007."
[2] Abbas, H. and S. H. Qazi (2009). Pakistan's Troubled Frontier, Washington.

selected for survey & 5 respondents for IDIs in IDPs camps while in host community 105 respondents were selected for survey and 3 respondents for IDIs.

This study found that in the situation where government and international community was not interested to help them out during displacement, IDPs relied more on their level of social capital and economic status. Those IDPs who could afford a house or had found help from their relatives, fellow tribesmen or friends joined host community but those IDPs who were poor and unable to find any help regarding shelter, loan or food, were left with only one choice that is to join IDPs camp.

The health needs of IDPs were already heightened due to war trauma and were further worsened due to the situation of accommodation, water & sanitation, weather and overcrowding in camp; widening the gap between their health needs and health care availability. On the other hand, IDPs living in host community were free to avail the private and public health services lessening the gap between their health needs and health care availability.

It also found out that IDPs living in camps were more affected by health problems as compared to IDPs living in host community. Where, IDPs in camp were offered inadequate health facilities and were not allowed to visit Tank city for medical treatment even during emergencies causing many deaths, especially among pregnant women.

Moreover, children and old age people were most affected among many age groups while women in reproductive ages suffered more as compared to men. Even the basic mother and child health facilities related to pregnancy and neonatal health care were not incorporated in IDPs camp. Although IDPs were affected by mental stress as much as physical one but psychiatric help was totally absent in camps as well as in host communities.

Based on the results of this study, the thesis provides recommendations for the health sector reform in the areas that receive the IDPs. Like the fieldwork 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 further recommends that livelihood and shelter related issues of IDPs should be addressed legislatively and 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.

Dedication

Dedicated to my Friend, Shatir Afandi for his friendship …

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Praise is to God for bestowing on me the ability, poise and velour to walk successfully through the laborious path of completing this project.

My deepest and heartiest gratitude is to my parents who gave me strength in my career and for their everlasting support and encouragement.

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List of Abbreviations

ANC	:	Antenatal Care
BHU	:	Basic Health Unit
CDC	:	Centers for Disease Control
DHQ	:	District Head Quarter
FATA	:	Federally administrated Tribal Area
FCR	:	Frontier Crimes Regulations
FDMA	:	FATA Disaster Management Authority
FR	:	Frontier Region
HRCP	:	Human Rights Commission of Pakistan
ICRC	:	International Committee of the Red Cross
IDI	:	In-Depth Interviews
iDMC	:	internal Displacement Monitoring Center
IDP	:	Internally Displaced Person
INGO	:	International Nongovernmental Organization
KP	:	Khyber-Pakhtunkhwa
NGO	:	Nongovernmental Organization

NRC	:	Norwegian Refugee Council
PA	:	Political Agent
PNC	:	Postnatal Care
RHC	:	Rural Health Centre
SPSS	:	Statistical Package for the Social Science
SWA	:	South Waziristan Agency
TBA	:	Trained Birth Attendant
UNHCR	:	United Nations High Commission for Refugees
UNICEF	:	United Nations International Children Emergency Fund
UN OCHA	:	United Nations Office for the Coordination of Humanitarian Affairs
WFP	:	World Food Program
WHO	:	World Health Organization

Chapter 1. Introduction

1.1 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 in 2013 as a result of violence accompanying the "Arab Spring" uprisings in Syria and democratic republic of Congo with 2.4 million and one million respectively, while an estimated 0.5 million people fled their homes in both Sudan and India (IDMC, 2012).

The largest regional increase in the number of internally displaced people in 2012 was in the Middle East and North Africa where 2.5 million people were forced to flee their homes. There were almost 6 million IDPs in the region at the end of 2012, a rise of 40 per cent on the 2011 (UNHCR, 2010).

The region with the largest total number of IDPs was sub-Saharan Africa, which was hosting 10.4 million, an increase of 7.5 per cent compared to last year, thus reversing the downward trend recorded since 2004. The South American region hosted the second largest number of IDPs in 2012 with a total of 5.8 million, an increase of 3 per cent. Colombia remains the country with the highest number of IDPs in the world, with a total of between 4.9 and 5.5 million, according to the IDMC (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). Besides human rights abuses by militant groups, conflicts between tribal leaders and sectarian clashes even further swelled the volume of internal displacement in Pakistan (HelpAge, 2010).

In FATA including many parts of KP, the hub of this armed conflict is South Waziristan. In October 2009, 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[3].

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 resulted in the huge number of IDPs settlement in the recipient areas of Tank which ultimately overburdened the public health delivery. Unfortunately, the public health institutions in Tank that

[3] Local Mehsud tribes men perception

provided services to the IDPs had no experience of developing health programmes and providing health services for a large number of people arriving simultaneously.

In this instance, very few studies are undertaken in the context of conflict to analyze the situation of IDPs health. Especially no one has taken account of the health problems faced by IDPs in complex setting of camp and host community. Most of the researchers are concerned with IDPs health problems in camp and ignore IDPs problems living in host community. Even more, studies are required to look at the health from age and gender perspective to formulate a health policy to better address health problems.

1.2 **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 according to their sex and age.

Several factors point to the value of such research. Firstly, some parts of KP & FATA and Balochistan 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, it is important to know the effects of economic status and social capital on IDPs health in a tribal cultural setting.

Fourthly, there is a need to compare IDPs health needs in camps and host communities from a gender and age perspective. In this regard an emphasis on psychological health is deemed very important. Fifthly, it is most important to analyse strengths and weaknesses of government and

international humanitarian organizations current health programme's adequacy and appropriateness targeting these displaced populations.

1.3 **Locale of the study**

Tank is currently holding huge number of SWA's IDPs both in camps at kot Azam a rural area that is 25 km away and in host community in city as well. Tank has a spread of more than 1679 Sq.Km and estimated population is about 0.55 million for the current year. Tank is bounded by the districts of Lakki Marwat to the northeast, Dera Ismail Khan to the east and southeast, and South Waziristan to the southwest, west, and northwest. The climate in Tank reaches 110-120 °F in summer. However in the cold, harsh winters in the mountains to the west, people from SWA come to Tank for milder weather and then move back during the summer.

1.4 **Historical overview of FATA**

Over the years difficult terrain, lack of education, and poor infrastructure has created a wedge between the tribal belt and the rest of the country. It has approximately 27,220 square kilometers of land, which shares nearly three hundred miles of the total 1,640 miles of border with Afghanistan (Cheema, 2008). "It is the poorest, least developed part of Pakistan. Literacy is only 17 percent, compared to the national average of 40 percent; among women it is 3 percent, compared to the national average of 32 percent. Per capita income is roughly $250, half the national average of $500 (Fishman, 2010).

The FATA is not subject to rulings by national or provincial courts, instead it is governed through Frontier Crimes Regulation (FCR), a legal system adopted by Pakistan at independence and rooted in British colonial practice and traditional tribal Jirga (Latif & Musarrat, 2012). Under

the FCR disputes between tribes and the Pakistani state are managed through the interaction of political agents and tribal representatives, or Maliks (Cheema, 2008).

The political agent is empowered to coerce tribesmen through threats and bribes. His coercive power includes collective punishment of a tribe for the actions of individual members and his rulings are not subject to judicial review or appeal. The political agent's executive authority is backed by a local constabulary force (levies and khassadars) and under more extreme circumstances by the Frontier Corps (FC) and Pakistan Army (Abbas & Qazi, 2009).

FATA comprises of seven tribal agencies namely Bajur, Mohmand, Orakzai, Khyber, Kurram, North and South Waziristan and six Frontier Regions (FRs) namely Peshawar, Tank, Bannu, Kohat, Lakki and Dera Ismail Khan. The president of Pakistan directly administers FATA through the governor of NWFP and his appointed political agents (PAs). The FATA has newly been given the right of representation in National Assembly and political parties are allowed to contest seats from here.

1.5 **South Waziristan Agency**

It is a mountainous region of northwest Pakistan, bordering Afghanistan and covering some 11,585 km² (4,473 mi²). It comprises the area west and southwest of Peshawar between the Tochi River to the north and the Gomal River to the south, forming part of Pakistan's Federally Administered Tribal Areas (FATA). Troops of the British Raj coined a name for this region "Hell's Door Knocker" in recognition of the fearsome reputation of the local fighters and inhospitable terrain. The region became part of Pakistan in 1947 (Cheema, 2008).

The Agency is divided into three administrative subdivisions of Sarwakai, Ladha and Wana. These three sub-divisions are further divided into eight Tehsils: Ladha, Makin (Charlai),

Sararogha, Sarwekai, Tiarza, Wana and Toi Khullah. Birmal Sarwakai is administered by Assistant Political Officer whereas Ladha and Wana Sub Divisions are administered by Assistant Political Agents. Each tehsil is headed by a Political Naib Tehsildar. The Malik system introduced by the British government is functioning in the Agency. Maliks used to work like media between administrations and the (Qaum) or Tribe.

The Maliki is hereditary and devolves on the son and his son so on and so forth for which regular benefits and subsidies are sanctioned from time to time (Abbas & Qazi, 2009). During this armed conflicts in SWA, Maliks were very much targeted by Taliban because Taliban considered them corrupt and declared them brokers working for establishment. Moreover, common youth opinion in SWA regarding Malik in also not positive and most of them consider them responsible for under development of their agency.

1.6 **Tribes & Clan**

The Mahsuds and Waziris are the two main tribes of this Agency. There are also the Burki (whose enclave is in the heart of Mahsud territory), some Dotanis, Sulaiman Khail and other Powindah settlers in the southwest corner of the Agency between Thati to Zarmelan. The Bhittanis inhabit a strip of country along the southeast border of the Agency. Its total population is 0.8 million.

1.7 **Problem Statement**

FATA is a conflict endemic area with periodic outbreaks of violence since 2002 (Fishman, 2010). The mass displacements of people from FATA in 2009 have not repatriated yet and majority of them are living in IDPs camp and host communities in many cities of Pakistan. The SWA IDPs situation is going to be even worse due to recent killing of Hakimullah Mehsud and in response Taliban are once again organizing against government in South Waziristan, FATA and many parts of KP namely Swat that will eventually result in more internal displacement of people.

It is evident that UN & international community's lack of interest in solving problems related to internal displacement at global level and weak response by government to facilitate IDPs in South Waziristan has resulted in high levels of mistrust and dissatisfaction. On one side SWA IDPs are blamed for supporting Taliban and provided with very less humanitarian help by government while on the other side UN, INGOs, government and media has been obsessed with war on terror in Swat and most of the development funds are spent there.

During armed conflict, when SWA IDPs were struck equally hard by deaths, diseases and unemployment many among them on their basis of higher economic status & social capital managed to join host community to share public and private available facilities as compared to those who were poor and left with no choice but to join IDPs camp.

IDPs that were already in miserable condition got even worse due to absence of many public facilities especially health related facilities in camp. These facilities were inadequate to their needs and some avenues of health like mental health care was absolutely absent. The health facilities were not tailored according to the sex and age of IDPs. Especially the health needs of people with special

needs in age group 65 and above were not addressed at all.

A comparative study was therefore needed, to explore the many important issues related to IDPs in both localities, that is camp and host community, Firstly, those local tribal dynamics of support system needs to be explored that had played a key role in facilitation of IDPs in the times when government and other international players have almost neglected them. Secondly, it is important to know the perception of IDPs living in both settings regarding the effects of type of accommodation on their health.

Thirdly, to explore psychological and as well physical health needs of IDPs in both localities in a comparative manner to evaluate the effect of available health facilities was also very important. Lastly, health needs of IDPs of both sexes & of all ages and inadequacy in provision of health facilities at both localities, was much needed to be found out for designing of an effective health policy for them.

1.8 **General objective of the study**

To assess the health needs of SWA IDPs who temporarily settled in IDPs camp and in host community in District Tank.

1.9 **Specific objectives**

- To evaluate the role of economic status and social capital of SWA IDPs in selection between temporary shelter in IDPs camp and host community during armed conflict.
- To compare the prevalence of health related problems in IDPs living in camp and host community according to their sex and age.
- To indicate the difference between current nature and range of health services availability in IDPs camp and host community according to their sex and age.

1.10 Thesis Overview

The thesis begins with background information on IDPs legal status, their health needs and is then followed by literature reviews of armed conflict and their consequences, health needs and health services availability. Furthermore, the thesis explains the details of the research methodology, analysis of results and discusses the important findings of the study.

This study id organized in six chapters, the outline of which is as follows:

Chapter 1: Background of study

In this chapter information on status of internally displaced persons is discussed from a global perspective. Further background of area of study and origin of IDPs, their health needs and availability of health care facilities is discussed. Lastly, problem is stated and objectives are framed to address this problem.

Chapter 2: Literature review

In this chapter, IDPs legal status and their health needs are analyzed with the purpose of gaining a more detailed understanding of their causes and consequences, particularly with regard to the affected population and health services availability. It also highlights the deficiency in academic literature regarding health related data and material.

Chapter 3: Research Methodology

Details of the research methodology employed in the study are presented in this chapter. It discusses the conceptual framework of the research; methods used and the reasons for choosing

the methods and their application; and the research process such as the sampling procedure and the analysis of the data.

Chapter 4 & 5: Results of the study

These two chapters present qualitative and quantitative data through parallel approaches and demonstrate the characteristics of the IDPs' health status during their exile from their homelands. Themes, sub-themes and categories were developed from both qualitative and quantitative data regarding IDPs' health status and access to essential health services offered by the public sector. It also examines barrier to health services for IDPs and discusses their level of satisfaction with the available health services in the areas where they lived.

Chapter 6: Conclusions & recommendations

This chapter brings together the findings of the research with the evidence of the health needs of the IDPs and the local authorities' response to them. This is followed by discussion and arguments regarding the findings of the research and their support in the literature. Further limitations of the study and insights for relevant research are explored. Lastly, it concludes the argument by formulating recommendations for the Pakistani public health sector in order to improve health systems, particularly as applied to the displaced populations.

Chapter 2. 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 thesis 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)*."*

Given the broad scope of the description, this thesis chooses to focus only on those internally displaced who have been forced to flee from "armed conflict, situations of generalized violence, and violations of human rights". Those who have been internally displaced as a result of natural or man-made disasters are not included in this thesis.

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).

Although refugees and IDPs often flee for similar reasons, IDPs do not cross international borders largely because they expect their governments to protect them, or they are denied asylum by other nations. 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 law regarding the rights of IDPs and refugees is that the latter are 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).

These GPs are basically drawn from international human rights and humanitarian law. Whereas human rights provisions are too general in nature and are meant to be universally applied, those linked to humanitarian law are meant to cover more specific needs arising in armed conflicts and are more directly applicable to internal displacement. In cases where humanitarian law is ineffective human rights law becomes the only source of legal protection for IDPs since core human rights, such as the right to life and the prohibition of cruel treatment are not tolerable under any circumstances (Phuong, 2004).

Despite the fact that main provisions of humanitarian law addresses the needs and human rights of war victims irrespective of their boundary crossing; still it is used in a way to favours those

who (refugee's) crosses national boundary. It provides a more comprehensive protection for refugees during international armed conflicts, whereas the law regulating internal armed conflicts is less elaborate and provides fewer benefits to IDPs (Goldman, 1998). Since, it is during internal conflicts where displaced persons number is often increased and requires more specific protection against the warring parties.

Although the number of IDPs in 1980´s arose to10 million as a result of armed conflict in Sub-Saharan Africa, it was in 1991 when the need of a separate law concerning IDPs was realized. This delay was caused by many UN institutions and international organizations. In this regard, international committee of the Red Cross, who is the regulatory body of Humanitarian law, was of the concern that existing humanitarian law is capable enough to look after IDPs during armed conflict and there is no need to devise a separate law for IDPs as it may undermine the existing refugee protection system (Phuong, 2004).

Same was the opinion of UN human rights commission that only wanted to devise an ´appropriate framework´ out of existing human right law for IDPs protection and avoided word legal (R. G. Cohen & Deng, 1998). Some UN officials argued for a comprehensive approach to protect refugees and IDPs inside the refugee law and emphasized the negative impact of formulating new standards for the protection of IDPs on the status of refugees and asylum seekers (Phuong, 2004).

Hence, influenced by many UN and international humanitarian actors, Guiding Principles on IDPs were formulated instead of formulating a binding law. These GPs take a very broad approach to internal displacement based on a general understanding of the meaning of protection for the internally displaced. It covers a broad range of human rights and all phases of

displacement. The emphasis is put on the protection of special groups, notably women and children, who represent the great majority of internally displaced persons (Kalin, 2008).

The GPs have certainly raised awareness of IDPs, sensitized international community and articulated their specific needs. That's why, keeping in view the importance of these guide lines on IDPs protection; African Union has introduced 1st binding law for IDPs protection termed as Kampala protection formulated in 2009 that was enforced on 6th December, 2012, and is ratified by fifteen African countries.

Although the Guiding Principles address most aspects of the problem of internal displacement, some issues are mentioned too briefly or not at all. Minorities are often the first targets of persecution and, as a result, the first populations to be internally displaced. Cases of forcible relocation of minority groups are too numerous to be cited here. However, minorities are only mentioned once in the whole document, in Principle 9, where they are referred to together with peasants and pastoralists. Another provision contained in Principle 6(2)(a) prohibiting 'ethnic cleansing' indirectly addresses the issue, but more specific and stronger provisions could have been included (Kalin, 2008).

The issue of safe areas is not mentioned at all in the Guiding Principles and consequently, it hinders freedom of movement within country and right to asylum in case of IDPs. The most significant weakness of the GPs however, is that it is a non-binding instrument. Hence, usefulness of GPs is greatly limited where states and international humanitarian actors are not legally bound to respect them (Phuong, 2004).

In the absence of an overarching binding law, states that had ratified adherence to the human rights protection are responsible to look after IDPs (Clapham, 2006). However, even when states

have ratified key human rights treaties, the rights of the individual cannot be assured. For example, IDPs in Colombia have endured decades of human rights violations despite the fact that state has ratified key human rights treaties and laws (Mooney, 2005).

In the case of Pakistan situation is even worse where due to the military operation against extremists an exodus of IDPs took place from the affected areas in 2009. It is surprising that despite hosting one of the world's largest displaced populations in modern times-4 million refugees from Afghanistan- the country remains surprisingly ill-equipped to deal with large scale internal displacement both at policy and implementation level (HRCP, 2010). Pakistan has not even implemented through domestic legislation the UN guiding principles on internal displacement.

Due to lack of international support, both in law and capacity and ill-preparedness of state to protect the overload of IDPs resulted in huge suffering for internally displaced Persons. In these sorts of situations IDPs mostly rely on their economic status and social capital to decide whether to go to IDPs camps or take refuge somewhere else (Goodhand, Hulme, & Lewer, 2000).

As many people from FATA are already settled in big cities of Pakistan for business purpose (Shinwari, 2012) the wealthiest IDPs easily found refuge in major cities, including cities outside the conflict area; the vulnerable were displaced within their districts of origin or to neighbouring rural areas; and the most vulnerable went to camps during displacement.

In a house-hold level study in Columbia the majority of the study population recovered from unemployment on the basis of their relatives and kinship support after violence (Engel & Ibáñez, 2007). In the same manner, Many IDPs settled in these cities on the basis of their own wealth while many got help from their relatives and friends for the sake of their settlement.

The provision of help and support during displacement by relatives, friends and tribesmen termed as social capital is a function of trust, social norms, participation and it play an important role in recovery (Murphy, 2007). People in traditional societies in times of disasters highly depend on their social capital that consists of resources embedded in their social networks and social structure (Woolcock, 1998). It can be a sort of safety net for IDPs to rely on their ethnic background for support during displacement both in finding some suitable shelter and fulfil their food intake.

It is estimated that among 14.7 million IDPs who were protected and assisted by UNHCR in 2010 globally; an estimated 52% of the total live outside formal camps in both rural and urban areas (IDMC, 2012). The phenomenon of internally displaced persons (IDPs) residing within host communities is still relatively unexplored in comparison to what is known about IDPs living in camps (UNHCR, 2010).

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).

IDPs camps embody a number of other striking contradictions. While they are supposedly governed by international law and human rights, the operation of such law and rights in camp sites is often non-existent. On the other hand, in host community settings, IDPs through their strength of social capital cope better with the problems arising during displacement (Rae, 2011).

There are many issues associated with the way these camps are conceived and built. These shelter camps are not designed keeping in mind the cultural values and gender divide of the

IDPs. Peoples feel humiliated to live in tents most of the cases. As evident in case of KP IDPs camps, internally displaced Women observe 'Purdah', and they do not come out and are kept in tent all the day to avoid interaction with unrelated men (IDMC, 2012). Girls and women are also rarely permitted to deal with men alone, that's why they are usually missing in the distribution queues and hence are deprived of support in camps especially in case of female headed households (UNICEF, 2011).

In these camps in KP, women suffer due to non-consideration of cultural norms in designing of many facilities. For example toilet facilities for male and female are constructed adjacent to each other, making it extremely difficult for women to visit toilets in day time. They have to wait for male family members to return and accompany the girls to toilets. Water and sanitation conditions are also bad. (HRCP, 2010).

Due to insufficient recreational space in the camps, children and young adults are victimized by drug addiction. Many young girls end up in prostitution due to absence of parental guidance and poverty in these camps. When these camps are dissolved by state; many children become homeless and as a result join criminal gangs (Ronstrom, 1989).

Humanitarian actors often overlook environmental factors while designing IDPs camps facilities (Salama, Spiegel, & Brennan, 2001). The location of camp is often not suited to IDPs in most of the case where people from cold areas are located in camps in hot plains in extreme heat, as in the case of KP. IDPs camps are overly crowded as well where tents are too close and under one tent some 10-12 peoples are living together.

As compared to IDPs living in host communities who share basic facilities with host communities, IDPs living in camps are more vulnerable to environmental factors, mostly in

terms of overcrowding and unsuitable weather resulting in higher morbidity levels (Roberts, Odong, et al., 2009). Where as in host communities it is easier to forget the trauma of armed conflict due to busy life, relatives and availability of health practitioners, in camps, the scenario is totally opposite.

In camps, IDPs are kept in social exclusion and are not provided with psychological counselling and psychiatric treatment (Porter & Haslam, 2005). In IDPs camps many social rituals like marriages and birthdays that are great source of entertainment & happiness are not celebrated. This unhealthy mental and social status of IDPs is compounded by lack or complete absence of physical and mental health facilities which leads to over thinking about the loved ones that are killed or lost hence, resulting in mental disorders (Roberts, Odong, et al., 2009).

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). In recently displaced persons from South Waziristan, 15 percent of the total households included at least one pregnant woman of which only 44 percent had received any antenatal care (UNICEF, 2011).

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). Where majority of the children displaced in the wake of the military operations in KP were aged between 3 months to 11 years and complained of problems including depression, phobias, acute stress disorder, post-traumatic stress syndrome and sleep disorders (HRCP, 2010).

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.

The loss of status and prestige, exclusion and poor quality of life in camps result in severe depression for the elderly. In older ages they are more prone to cardiovascular disease,

disabilities and dementia compounded by general physical weakness (Haywood, Garratt, & Fitzpatrick, 2005). They are also challenged by mobility problems to get medical help. Their reliance on assisting devices like walking sticks, hearing aids, glasses that are lost due to displacement make them more vulnerable during displacement (IASC, 2004).

Chapter 3. Methodology

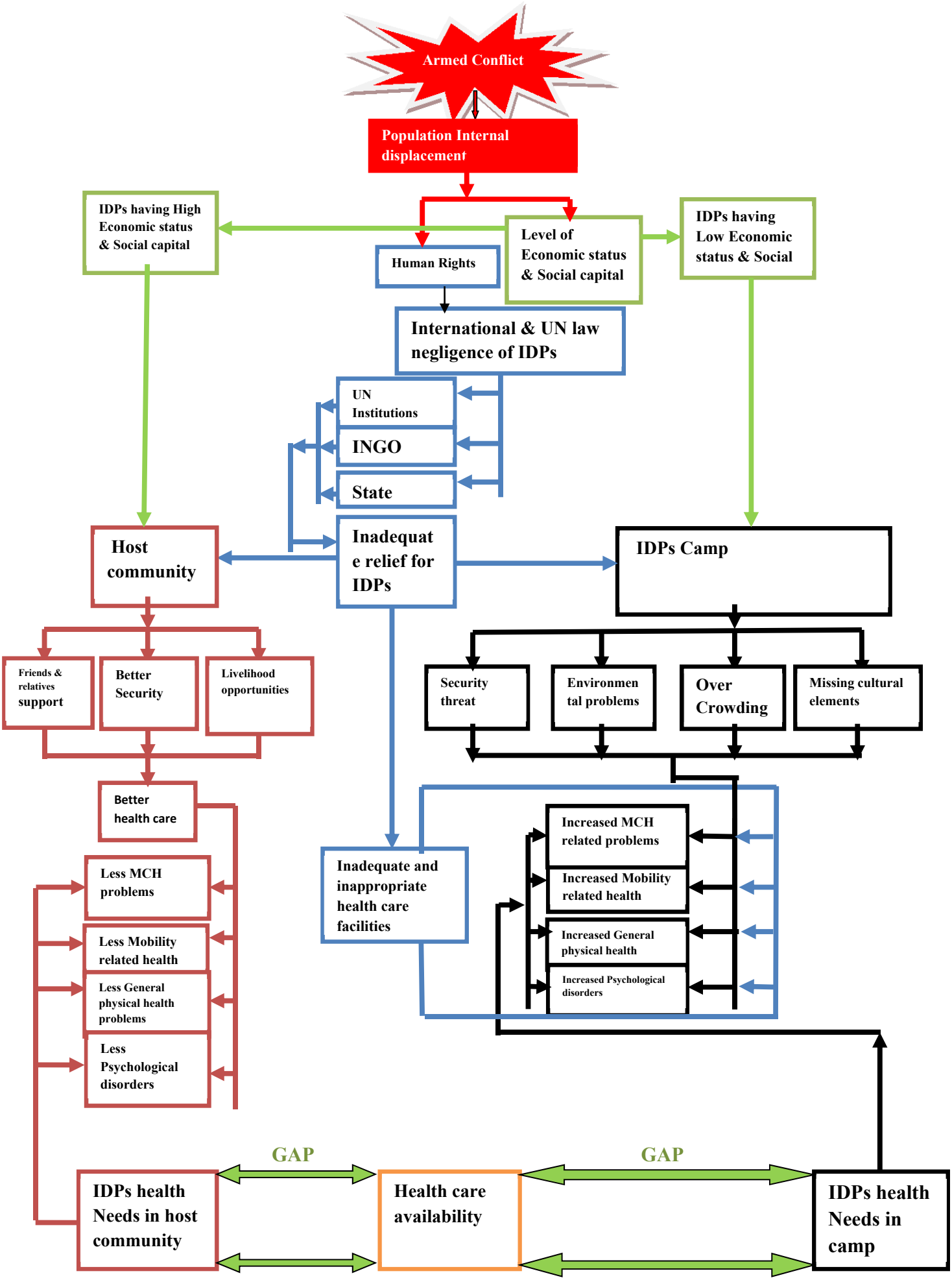
3.1 Introduction

This chapter focuses on the methods applied in this research. It begins with the overall objective of the study and proposes a conceptual framework for the study design. It further explains the methodology used, following the process of research design, the development of the questionnaires, the sampling procedure, the collection and the process of analyzing the data.

3.2 Research Design

Research design is the plan, structure, and strategy of investigation conceived so as to obtain answers to research questions and to control variance (Sarantakos, 1993). The concept of this research is based on the failure of the UN and other international bodies to address health related issues of IDPs in specific and their human rights issues in general of IDPs. It is shown in the conceptual framework that how in the absence of relevant legislation the low level of economic status and social capital compounds the miseries of IDPs during displacement.

For this purpose a comparison is drawn between IDPs living in camps and host community from a sex and age perspective to measure the gap between their health care requirements and health needs fulfilment. The purpose of this conceptual framework is to describe in an organized way the researcher's conceptual thinking in order to achieve the objectives of the research.


Armed Conflict
Population Internal displacement
IDPs having High Economic status & Social capital
Human Rights
Level of Economic status & Social capital
IDPs having Low Economic status & Social
International & UN law negligence of IDPs
UN Institutions
INGO
State
Host community
Inadequate relief for IDPs
IDPs Camp
Friends & relatives support
Better Security
Livelihood opportunities
Security threat
Environmental problems
Over Crowding
Missing cultural elements
Better health care
Less MCH problems
Less Mobility related health
Less General physical health problems
Less Psychological disorders
Inadequate and inappropriate health care facilities
Increased MCH related problems
Increased Mobility related health
Increased General physical health
Increased Psychological disorders
GAP
GAP
IDPs health Needs in host community
Health care availability
IDPs health Needs in camp

3.3 Methodology

This study was a descriptive-exploratory study based on mixed study approach by using both qualitative and quantitative research methods for data collection.

3.4 Mixed study approach

According to Miles and Huberman (1994), using both qualitative & quantitative methods by applying mixed study approach for collection of data enables a researcher to corroborate data from different sources, enhance the richness of the investigation, and meet the challenge of considering views that might not have been considered or encountered. Mixed methods for data collection were used in this study to explore the weaknesses and gaps in the provision of better health programmes and services for the IDPs by the government and other concerned organizations.

3.5 Data Collection Tools

3.5.1 Survey questionnaire

A structured questionnaire for a quantitative survey among the IDPs of SWA was constructed for data collection. There were seven sections in the questionnaire:

1) Socio-demographic profile

2) Level of social capital

(3) Situation of IDPs camp verses host community setting

4) Prevalence of physical health problems (morbidity & mortality)

5) Health services availability, its diversity and satisfaction of respondents

6) Emotional stress

7) Mother and child care

The questionnaire was first field tested among 20 Mehsud IDPs who came from SWA to live in Barakahu, Islamabad. After consultation with the research supervisor and the comments received in the proposal defense it was revised as necessary before the final survey.

3.5.2 In-depth interview

In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation (Miles & Huberman, 1994). An interview guide (annex.3) was 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 this purpose, researcher has done eight in depth interviews to find empirical saturation regarding quantitative findings. Five IDIs were held with IDPs living in camps and three with those living in host community to delve more deeply into the quantitative findings of the study. The respondents were selected through purposive sampling to find out the issues related to forced displacement, morbidity and mortality.

3.6 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 households, and total population for this study. The data were segregated for all tribes of SWA registered with them. Data were further subdivided into IDPs living in camp and in host

community with complete addresses. The same data was used to draw the primary sampling frame for this study.

3.7 The Research Activities

This research activity was conducted from September 2012 – August 2013 when the armed conflict in SWA was over. This research was conducted in key stages. First, conducting a literature and document review to give background and context to the study. Second, preparation of data collection tools such as constructing a survey instrument (a structured questionnaire), a guiding document consisted of questions for the in-depth interviews. The formulation of the research questions was based not only on knowledge gained from the available literature but also from being employed in the public health sector there for over four years.

Third, to determine the locale for conducting this study this ended up with District Tank as the chosen area. Fourth, data was collected by using survey questionnaire and in depth interviews to obtain a grounded understanding of issues. Work experience at Agha Khan university Hospital outreach department provided a background of research which was of use in this study.

3.8 Justification for selecting locale of the study

District Tank situated in the extreme south of KP was chosen as the locale of 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.

In addition, the choice of the field area was based on the presence of IDPs both in camps and host community which enabled comparing the health assistance offered to IDPs both at rural and

urban settings. Also these two places were accessible to the researcher in terms of security and access to conduct interviews.

3.9 Study Samples

Inclusion of all the IDPs in the two field areas 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 300 households were targeted but due to time and monetary constraint 260 households were sampled and data were collected for 2158 individuals.

3.10 Sampling Methods

To select a comparative Sample of 260 households consisted of 155 households from camp and 105 households from host community, 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. Same procedure was adopted for 1760 households living in 32 *Mohalla's* containing IDPs from SWA by selecting 8 *Mohalla's* randomly by lottery method.

Step 2: In group C total number of households of IDPs camps were 990 while total households of IDPs living host community in randomly selected 8 *Mohalla*'s was 948.

Step 3: In case of IDPs living in host community study sample of 105 respondents was calculated from 8 *Mohalla*'s on the basis of their population proportion by applying following formula:

$$NI = \frac{n}{N} \times Ni$$

Where

NI= number of *mohalla's*

n = total sample size i.e 105

N=total number of the respondents in 8 *mohalla's* (targeted population)

Ni= total number of the respondents in each *mohalla*

N1= Number of respondents in *mohalla* Dr. Rabnawaz 105/948*88 =	10
N2= Number of respondents in *mohalla* Mehsudaan 105/948*252 =	28
N3= Number of respondents in *mohalla* Mission hospital 105/948*342 =	38
N4= Number of respondents in *mohalla* Qazianwala 105/948*57 =	6
N5= Number of respondents in *mohalla* Ilahi Abad 105/948*76 =	8
N6= Number of respondents in *mohalla* Qasaban 105/948*39 =	4
N7= Number of respondents in *mohalla* Mianlal 105/948*86 =	10
N8= Number of respondents in *mohalla* Khudrianwala 105/948*8 =	1
Total	**105**

Step 4:

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

Where,

K = interval

N = the number of total internally displaced person households in district (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.
- For host community sampling interval was 948/105 = 9.1 randomly taken as every 9^{th} household.

STEP5. In this step systematic sampling with a random start was used to select 155 households from IDPs camp and 105 households from host community.

3.11 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 (appendix 3).

3.12 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.

3.13 Ethical Consideration

Prior to the start of every activity, the researcher explained the purpose of the activity to the participants and also asked for their consents for recording and documentation. Confidentiality was ensured throughout the study process. All participants' names were separately documented on the reference sheets and kept in a secure place that only the researcher could access. The structured questionnaire excluded respondents' names and informed consent was taken prior to administering them. The survey results were presented back to the IDPs at both the locations.

3.14 Limitations of the Research

Several limitations in the research process can be identified. Firstly, in the planning phase of this research, breadth versus depth was consciously preferred. This meant that a large number of variables were covered by the questionnaire to grasp the breadth of issues while for measuring the depth of issues, limited numbers of IDIs were conducted. It was important to include all health related issues prevailing at camps and host community because diseases are interlinked with each other and one cannot choose between them when it comes to study them. Also in-depth analysis of major health issues was important to figure out the important reasons for increase in their prevalence.

Secondly, due to time and resource constraints, the study was limited to only one settlement of IDPs in one district that were displaced due to armed conflict between Taliban and security forces. But in agencies like Kurram and Aurakzai armed conflict was started on sectarian basis. Hence the findings of this study cannot be generalized for all FATA regions.

Thirdly, due to time constraints the comparison of health status between IDPs living at both localities and local population in district Tank was not undertaken that could have made this study more useful.

Fourthly, many people were reluctant to speak openly during in depth interviews because of fear of Taliban & security forces and tried to hide the truth which may have kept some information undescribed in this study.

Chapter 4. Socio-economic and Demographic Profile

This chapter contains quantitative results of the study for socio-economic and demographic profile that are corroborated with the findings from the in-depth interviews. This input from in depth interviews is added to not only complement but to provide a sense of completeness to the quantitative findings.

I. Age and Sex structure

Table 4.1 shows that the proportion of population in each age group is almost same when IDPs living in camp and living in host community are compared. The percentage of most vulnerable age groups in context of armed conflict and internal displacement at both localities lies at below 3.5% for <1 year age group, below 8.5% for 1-5 years old and 5% to 6.6% for 65 years & above age people. The proportion of school going age group of 6-14 years was between 18 to 19% at both localities. The youth in age group 15 to 28 years accounted for the largest age group around 34% at both localities. The people in working ages in age group 29 to 64 years accounted for the second largest age group around 29% to 30% at both localities. From a sex perspective male were slightly higher in number as compared to female at both localities. In host community males are more than female in each age group. In IDPs camp in age groups <1 year, 1-5 years and 65 years and above, females are higher in number than males who dominate school, youth and mature age groups.

Table 4.1 Distribution of respondents by Age and Sex

age groups	IDPs Camp				IDPs in Host Community			
	Age group %	Male %	Female %	Total % n=1133	Age group %	Male %	Female %	Total % n=1025
< 1	3.1	22.9	77.1	100	3.5	58.3	41.7	100
1-5 Y	8.8	47.0	53.0	100	8.3	55.3	44.7	100
6-14 Y	18.7	52.8	47.2	100	18.3	51.6	48.4	100
15-28 Y	34.5	55.8	44.2	100	34.1	53.0	47.0	100
29-64 Y	29.8	52.4	47.6	100	29.2	50.2	49.8	100
65 years & above	5.2	42.1	57.9	100	6.6	52.9	47.1	100
Total	100	51.7	48.3	100	52.2	52.2	47.8	100

Source: Primary Data from Tank

Table 4.2 shows that the level of education of IDPs living in host community is much higher as compared to those who lived in IDPs camp. It indicates that majority (71.1%) of the IDPs living in camp had either not gone to school or left school before completing primary education as compared to those 52.4% IDPs who lived in host community. It further highlights that only 9.7% IDPs living in camps completed their primary schooling as compared to 16.2% living in host community. Although the gap shrinks in case of high school completion for IDPs living at both localities but still in higher education those living in host community are much better educated when compared to IDPs living in camps.

Table 4.2 Highest Level of education background of Head of household

Level of education	IDPs in Camps % n=155	IDPs in Host Community % n=105
Illiterate	71.1	52.4
Primary	9.7	16.2
Middle	5.8	6.7
High school	9.1	11.4
Intermediate college	1.9	4.8
B.A	0.6	3.8
M.A	0.0	2.8
Madrassa	1.3	0.9
Total	100.	100.

Source: Primary Data from Tank

Table 4.3 shows that IDPs came from a variety of areas of South Waziristan in District Tank, with the majority from Makeen followed by Ladha. This quantitative detail shows a snapshot of the origin of IDPs who settled in district Tank.

Table 4.3 Origin of respondents resettled in District Tank

Area	IDP Camps % n=155	IDP Host Community % n=105
Makeen	23.9	31.4
Wana	5.1	4.8
Tairzah	7.8	7.6
Kaniguram	3.2	1.5
Ladha	20.6	12.2
Sararogha	4.5	5.7
Sarwakai	11.6	4.8
Barwand	9.7	9.6
Preghal	9.8	4.8
Zarmilan	5.8	0.9
Total	100	100

Source: Primary Data from Tank

To know the details of their settlement in Tank, they were asked to elaborate their journey during in-depth interviews. IDPs living in camp and living in host community provided useful information. Participants living in IDPs camp commented that:

"*.....Right at the start of Rah-E-Nijat operation against Taliban by security forces, we along with our villagers came to Tank. The travel from Sararogha to Tank proved to be extremely difficult. The first few days, we stayed with our relatives but soon we felt the need of our own shelter so we built our own hut from wood and thatch in an abandoned place and later on we shifted to IDPs camp* **(Unemployed man, 42 years)**.

"……When security forces occupied our village; they forced us to vacate our houses. We did not want to shift anywhere from our village but they put us in one vehicle and send us to this camp **(Widow household head, 50 years)**.

"*…….military forcefully dislocated us from our home from Makeen during operation Rah-e-Nijat. We were sent here against our will and during displacement we were not allowed to even take important household articles with us. At first, we lived in a hotel room with our grown up daughters (very disgraceful in our community to live in absence of a male with grown up daughter in a hotel) and when money was finished we literary came on the street asking people for help. Some kind families took care of us and when camp was established, we rushed into it. It's being two years now living here (***Widow household head, 52 years).**

Participants in host community commented:

"*……..During conflict, we flee from Sararogha and joined our relatives for few days in Tank. Soon we found a house and rented it. Now we are living since 2 years in this Mohallah Mehsudan* **(Unemployed, 42 years).**

"……..*when security forces occupied our village, we flee from Makeen to IDP camp in Kot Azam, Tank. But just after two days, we left camp because Camp was full of problems. It was crowded, no purdah, water and sanitation problem was there as well and most of all we were*

bound to live in a tent and settled in Tank city and from that time we are residing here in our relative's house **(Hotel entrepreneur, 45 years).**

It was also important to know that why IDPs chose Tank as their temporary residence and when asked IDPs living in camp they commented:

"…….*Tank is just on a 3 hour drive from my village. Other people from our village are also present here in huge numbers, we visited the town few times ago for the purpose of medical treatment and most importantly we assume that as soon as this conflict will end, it will be easy to go back home from here easily* **(Unemployed, 42 years).**

"……*we are not accompanied by male family members and only have relatives in Tank* **(Women head of the household, 72 years).**

While IDPs living in host community commented:

"……..*We settled here because we have got free residence from our relatives. In fact we were trying since few years to settle here in Tank for better education of our children but were unable because of our cultural values which do not permit us to live as a nuclear family in life of our elder* **(Shop owner, 35 years).**

Table 4.4 shows that among IDPs living in camp, 47.8% were living in nuclear composition followed by extended 39.3% as compared to 35.2% nuclear and 50.5% extended composition living in host community. Only 7.8% IDPs lived in joint family system followed by 5.1% who lived in a non-specified family setting in camp as compared to 6.7% and 7.6% in host community.

Table 4.4 Type of IDPs household structure who settled in District Tank

Type of household	IDP Camps % n=155	IDP Host Community % n=105
Nuclear	47.8	35.2
Joint	7.8	6.7
Extended	39.3	50.5
Non specified	5.1	7.6
Total	100	100

Source: Primary Data from Tank

By looking at the quantitative findings about household composition there is a big difference between IDPs living in camp and host community especially with regard to extended composition where more people prefer to live in this composition in SWA.

IDPs living a in camp commented:

"……..*I migrated along with my two brothers households towards Tank and now we live separately but eat together in camp and we have registered our self with WFP separately so that we can get food for three households* **(Unemployed male, 42 years).**

"……..*we already wanted to live separately but due to local tribal culture (before death of elders it is impossible for his/her children to separate their households) it was impossible for us but as we left Makeen, now we are separate and we are happy* **(Laborer, 42 years)**

While IDPs in host community commented:

"…….we moved as an extended family but we have split the family and my brothers are living separately because houses here are small in Tank and we cannot manage extended family anymore **(Shop owner, 35 years)**

Table 4.5 shows that IDPs of this study are predominantly Mehsud and are followed by Barki. Although Wazir tribe is the second largest in SWA but their presence at both localities as IDPs is

minimal because they were not displaced due to signing of a peace treaty by Wazir Taliban with security forces. Same was the case for Sulaiman khel tribe who occupies a strip in the area of Wazir dominant region and hence not displaced in huge numbers.

Table 4.5 Ethnic background of respondents

Tribe	IDP Camps % n=155	IDP Host Community % n=105
Mehsud	83.8	81.2
Barki	4.6	10.5
Sulaiman khel	8.4	2.9
Wazir	3.2	4.8
Total	100	100

Source: Primary Data from Tank

Table 4.6 below shows that majority of IDPs (44.5%) living in camp and in host community (48.8%) are displaced for 13-24 months followed by 36.1% in camp and 26.7% in host community that are displaced for 7-12 months. There are 7.8% IDPs living in camp and 18.1% in host community who are displaced since almost three years from their home town. The newly displaced IDPs for 1-6 months also accounts for 11.6% in case of IDPs living in camp and 6.7% of those who are residing in host community.

Table 4.6 Time since displacement from Area of Origin

Time since Displaced	IDP Camps% n=155	IDP Host Community% n=105
1-6 moths	11.6	6.7
7-12 months	36.1	26.7
13-24 months	44.5	48.8
25-36 months	7.8	18.1
Total	100	100

Source: Primary Data from Tank

Table 4.7 shows that IDPs living in camps are mainly dependent on agriculture 20.0%, construction 17.4% and remittances 8.4% for their livelihood as compared to IDPs living in host community who are mainly dependent on remittances 27.6%, transportation 19.1% and

government jobs 15.2%. Alarmingly, 37.4% IDPs living in camps are having no income source as compared to only 10.5% IDPs living in host community. Interestingly, sizeable proportions of IDPs living in host community are engaged in government jobs, transport business and are receiving remittances as well whereas small numbers of people among those living in camps are engaged in these valuable sources of income generation.

Table 4.7 Income sources of head of IDPs households in District Tank

Income Source	**IDP Camps % n=155**	**IDP Host Community % n=105**
Agriculture/livestock	20.0	0.9
Construction	17.4	11.4
Manufacturing	1.9	3.8
Transportation	3.9	19.1
Wholesale trade	0.0	1.9
Retail trade	1.2	6.7
Government job	3.6	15.2
No income source	37.4	10.5
Remittances	8.4	27.6
Hoteling	5.2	2.9
Private job	0.6	0.0
Total	100	100.0

Source: Primary Data from Tank

Table 4.8 below indicates that IDPs in camp are earning less where 30.7% belong to 5001-1000 income group, 18.7% belong to below 3000 income group and 22.6% are having no income at all, while IDPs living in host community are earning more where 32.4% belong to 15001-25000 income group, 28.6% belong to 25001-50000 income groups, 9.5% earning more than 50000 and only a small proportion of 2.8% is having no income.

Table 4.8 Total household monthly income of respondents

Income groups	**IDP Camps % n=155**	**IDP Host Community % n=105**
No income	22.6	2.8
1- 3000	18.7	5.7
3001-5000	12.9	0.9
5001-10000	30.7	6.7
10001-15000	10.9	13.3
15001-25000	3.2	32.4
25001-50000	0.6	28.6
50001 & above	0.0	9.5
Total	100	100

Source: Primary Data from Tank

A large number of IDPs living in camp were unemployed with no income or living with very less amount of money as compared to IDPs living in host community. When asked about managing their lives with that much little amount IDPs living in camps commented:

"…..*we sell out extra ration to get money and get at least 3000 rupees by selling extra ration per month. As food is given free by WFP and some help is provided by local community as well which help us manage our lives here* **(Unemployed male, 42 years).**

"……*I sell out jewelry whenever I need money to fulfill my household responsibilities* **(Widow household head, 50 years).**

Chapter 5. Protection to IDPs in Camps and Host Community

This chapter contains quantitative results of the study concerning IDPs protection in camps and host community. This chapter is consisted of the results for social capital, morbidity & mortality including mental stress and child & mother health care. In this chapter 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.

I. Level of Social Capital

Table 5.1 below provides the snapshot of help provided by relatives to IDPs during displacement. It is shown that relatives help was comparatively much higher in case of IDPs living in host community where 80% IDPs were helped for shelter, 81.90% for food, 60.90% were offered loans and 63.80% were gifted money. On part of IDPs living in camp, only 22.90% were helped for shelter 25.20% for food, 34.20% were offered loans and 43.90% were gifted money.This finding not only configures Woolcock (1998) notion of displaced persons dependency on social capital in emergencies but also brings into notice that the intensity of help greatly depends on their socio economic status. In this study IDPs living in camp are mostly from lower economic strata that got much lower help from their relatives as compared to those living in host community.

Table 5.1 Help provided to IDPs of SWA by their relatives during displacement

Statement	IDPs in Camp				IDPs in Host Community			
	Yes %	No %	Not needed %	Total % n=155	Yes %	No %	Not needed %	Total n=105 %
Relatives help in providing shelter	22.90	72.90	4.5	100	80	14.30	5.70	100
Relatives help providing in food	25.20	70.30	4.5	100	81.90	13.30	4.80	100
Relatives help in offering loan	34.20	61.90	3.90	100	60.90	25.70	13.30	100
Relatives gifting money as help	43.90	45.80	1.20	100	63.80	22.90	13.30	100

Source: Primary Data from Tank

Table 5.2 shows that friends help during displacement was again comparatively higher in case of IDPs living in host community where 34.3% IDPs were helped for shelter, 34.3% for food, 31.4% were offered loans and 33.3% were gifted money. While among IDPs livings in camp only 7.7% were helped for shelter, 3.9% for food, 14.8% were offered loans and 22.6% were gifted money. Friends provided less help as compared to relatives because in tribal societies people live close to their kinship and they prefer to rely on their brothers, cousins and uncles as compared to friends.

Table 5.2 Help provided to IDPs of SWA by their friends during displacement

Statement	IDPs in Camp				IDPs in Host Community			
	Yes %	No %	Not needed %	Total % n=155	Yes %	No %	Not needed %	Total n=105 %
Friends help in providing shelter	7.7	87.1	5.1	100	34.3	50.5	15.2	100
Friends help providing in food	3.9	91.0	5.1	100	34.3	59.5	16.2	100
Friends help in offering loan	14.8	81.3	3.9	100	31.4	59.5	19.1	100
Friends gifting money as help	22.6	75.5	1.9	100	33.3	48.6	18.1	100

Source: Primary Data from Tank

Table 5.3 shows that fellow tribesmen help during displacement was also much higher in case of IDPs living in host community where 51.4% IDPs were helped for shelter, 50.4% for food, 28.6% were offered loans and 32.4% were gifted money. While among IDPs living in camp, only 8.4% were helped for shelter, 6.4% for food, 8.4% were offered loans and 16.1% were gifted money. This finding once again confirms the importance of kinship (Woolcock, 1998) in facilitation of internally displaced persons by their fellow tribesmen. The successful integration of those IDPs who joined host community as compared to IDPs who joined camps in Tank was a result of their strong tribal lineage where they were offered huge support from their fellow tribesmen.

Table 5.3 Help provided to IDPs of SWA by their fellow tribesmen during displacement

Statement	**IDPs in camp**				**IDPs in Host Community**			
	Yes %	**No %**	**Not needed %**	**Total % n=155**	**Yes %**	**No %**	**Not needed %**	**Total n=105 %**
Tribes men help in providing shelter	8.4	85.8	5.8	100	51.4	35.2	13.3	100
Tribes men help providing in food	6.4	88.4	5.2	100	50.0	36.2	13.3	100
Tribes men help in offering loan	8.4	87.7	3.9	100	28.6	54.3	17.1	100
Tribes men gifting money as help	16.1	81.9	1.9	100	32.4	50.5	17.1	100

Source: Primary Data from Tank

This table 5.4 shows that level of help provided on the basis of political/religious basis during displacement was low but still higher in case of IDPs living in host community where 31.4% IDPs were helped for shelter, 32.4% for food, 11.4% were offered loans and 22.9% were gifted

money by political/religious parties. While among IDPs living in camp, only 5.2% were helped for shelter, 2.6% for food, 1.9% were offered loans and 7.1% were gifted money.

Table 5.4 Help provided to IDPs of SWA by political/religious Parties during displacement

Statement	IDPs in Camp				IDPs in Host Community			
	Yes %	No %	Not needed %	Total % n=155	Yes %	No %	Not needed %	Total n=105 %
Political/religious help in providing shelter	5.2	89.0	5.8	100	31.4	48.6	20.0	100
Political/religious help providing in food	2.6	92.3	5.2	100	32.4	49.5	18.1	100
Political/religious help in offering loan	1.9	94.2	3.9	100	11.4	64.8	23.8	100
Political/religious gifting money as help	7.1	91	1.9	100	22.9	55.2	21.9	100

Source: Primary Data from Tank

When it was inquired that why so little help is provided to IDPs living in camps during the in-depth interviews, one respondent commented that:

"……..*Our relatives and friends are mostly poor and unable to help us but tribal men helped us a bit. Few faith based parties tried to help but were denied access to IDPs camp by security forces.* **(Unemployed male, 42 years).**

"….*Our relatives and friends are mostly in Afghanistan. Only host community is trying to help us* **(Women household head, 52 years)**

Table 5.5 below shows that host community help during displacement was much higher in case of IDPs living in host community where 73.3% IDPs were helped for shelter, 71.3% for food and 35.2% were offered loans. While among IDPs living in camp only 23.9% were helped for shelter, 25.2% for food and 24.5% were offered loans. Only in case of host community help,

IDPs living in camp got preference over IDPs living in host community by getting more gifted money 54.8% as compared to 43.8%. As IDPs living in camps were living in seclusion at a distance from surrounding host community and security forces also did not allowed people from surrounding communities to see them; it resulted in less help for them.

Table 5.5 Help provided to IDPs of SWA by their host community during displacement

Statement	**IDPs in Camp**				**IDPs in Host Community**			
	Yes %	**No %**	**Not needed %**	**Total % n=155**	**Yes %**	**No %**	**Not needed %**	**Total n=105 %**
Host community help in providing shelter	23.9	71.6	4.5	100	73	15.2	11.5	100
Host community help providing in food	25.2	70.3	4.5	100	71.3	12.2	11.5	100
Host community help in offering loan	24.5	70.9	7.8	100	35.2	42.9	12.5	100
Host community gifting money as help	54.8	43.2	1.9	100	43.8	35.2	11.5	100

Source: Primary Data from Tank

II. Accommodation and Food

Table 5.6 below shows that apart from IDPs who took refuge in camps, many IDPs joined host community where 61.9% households rented accommodation followed by 35.2% who were living with host family without paying any rent. Only 2.9% IDPs in host community were residing with their host family with paying rent.

Table 5.6 Type of Accommodation where IDPs are residing/ have taken refuge

Residence Type	IDP Camps % n=155	IDP Host Community % n=105
Camp	100	0.0
Host family without paying rent	0.0	35.2
Host family paying rent	0.0	2.9
Rented accommodation	0.0	61.9
Total	100	100

Source: Primary Data from Tank

Table 5.7 shows that in comparison to those IDPs who are living in camp and provided accommodation by government, 60% of IDPs in host community were paying for their accommodation on their own. Accommodation to 23.8% was provided free or paid for them by their relatives whereas 11.4% were supported for the same by their friends.

Table 5.7 Source of providing/paying for accommodation of IDPs living in District Tank

Response	IDP Camps % n=155	IDP Host Community % n=105
Government	100	0.0
By own sources	0.0	60.0
By friends	0.0	4.8
By relatives	0.0	23.8
By host community	0.0	11.4
Total	100	100.0

Source: Primary Data from Tank

It is shown in table 5.8 that only 34.8% IDPs living in camp agreed that camp is good security wise in comparison with 77.1% IDPs who felt secured in host community. In case of weather suitability, only 6.8% IDPs living in camp agreed that weather conditions are good in camp and this finding confirmed agrees with Salama et al. (2001) who argue that environmental factors are often overlooked while designing IDPs camp. In comparison 61.1% IDPs agreed that weather in host community is good because they have a choice to live at any place in Tank city.

In case of water and sanitation, only 20.6% IDPs living in camp agreed that camp conditions of water and sanitation are satisfactory in comparison with 78.1% IDPs who were satisfied with it in host community. Findings of this research also confirm with that of (UNICEF, 2011) regarding absence of purdah arrangements in IDPs camps where only 41.9% agreed upon the existence of purdah arrangements. Also only 9% IDPs living in camp not considered this place over crowded in comparison with 57.2% of those IDPs who were living in host community.

Table 5.8 Opinion of IDPs about living general condition of their accommodation/Place of Refuge

Statement	**IDPs Camp % n=155**	**Host community% n=105**
There is no security threat	34.8	77.1
Conditions of weather are pleasant	16.8	61.1
Water and sanitation facilities are satisfactory	20.6	78.1
Cultural arrangement for purdah are provided	41.9	97.6
Place is overcrowded	91	42.8

Source: Primary Data from Tank

An IDP when first settled in a camp and then left it commented:

"……*we were bound to live in a tent while it is below our standard because in our area homeless nomads and people without any tribal recognition like Musicians, Dancers and people from lower segments of society live in tents* **(Hotel entrepreneur, 45 years).**

One woman living in a camp also lamented:

"…… build small houses for us having basic water & sanitation and cooking facilities. We feel restless and disgusted to live in tents. It is against our values and culture **(Women head of the household, 50 years).**

Table 5.9 shows that when respondents living in camps were asked about the standard of accommodation 55.6% rated it poor, 25.2% average and only 19.3% rated it good. While, only 3.8% rated it poor, 27.6% average and 68.5% rated their standard of accommodation good by IDPs living in host community.

Table 5.9 Opinion of IDPs about standard of their Residence/Refuge

Response	**IDP Camps % n=155**	**IDP Host Community % n=105**
Poor	55.6	3.8
Average	25.2	27.6
Good	19.3	68.5
Total	100	100

Source: Primary Data from Tank

Table 5.10 shows that almost all IDPs living in camps and host community considered their food intake sufficient for their living. Almost all 98.7% IDPs living in camps were provided food by UN agencies while among IDPs living in host community, 60% were supported by UN agencies and 33.3% were self-supporting.

Table 5.10 Sufficiency of food intake and sources of food provision by IDPs living in Tank District

Response	IDP Camps % n=155	IDP Host Community % n=105
Sufficiency of food intake	98.0	97.2
Source of food provision UN/INGO/NGO Host family Friends and relatives Self-supported	 98.7 0.0 0.0 1.3	 0.6 33.3 5.4 60.0

Source: Primary Data from Tank

It was quite satisfactory that food was provided to almost all IDPs by WFP but when IDPs in camps were asked about the process of getting their ration they commented:

"……*getting food is very tough due to long queues that are lining up at dawn to get ration because we are not those lucky people with 'links' who get it easily and without standing in queues* **(Unemployed male, 42 years).**

"……..*getting food is very tough due to long queues and due to absence of adult male in my household. So I hire a man for 500 rupees to stand in queues and get us ration* **(Widow household head, 50 years).**

When asked about getting ration from WFP, an IDP living in host community commented:

"…..*it (WFP ration) is for poor people we can manage our ration on our own* **(Shop owner, 35 years).**

III. Morbidity, Mortality and Mental Stress

The above table shows that incidence of illnesses was almost double among IDPs living in camps as compared to those living in host community. It also elaborates that female IDPs suffered slightly higher as compared to male at both localities.

Table 5.11 below shows that IDPs living in camps were more affected by illness (37.7%) in comparison to IDPs (21.9%) living in host community. People in age group 65 years and above was the most affected group (75.4%) followed by infants (62.9%) and children in age group 1-5 years (53%) among IDPs living in camps. In case of IDPs living in host communities elderly (41.1%) were affected the most followed by mature age people in age group 29-64 years (27.8%), and infants (25%). The reproductive age group which is consisted of females highlights the severity of illnesses at both localities where in camps 33.8% and in host community34.9% women were affected.

Table 5.11 Frequency of illness during last three months among IDPs by Age

age group	**IDPs in Camp %** **n=428**	**IDPs in Host community %** **n=224**
Infants	62.9	25
1- 5 y	53	17.6
6 -14 y	34.4	16.5
15-28y	28.6	19.5
29-64y	37	27.8
15-49 y	33.8	34.9
65 & above	75.4	41.1
total	37.7	21.9

Source: Primary Data from Tank

Table 5.12 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 age group 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%).

Among IDPs living in host community also, the highest incidence rate 44.4% in males and 37.5% in females was noted for people in age group 65 & above and was followed by 19.1% in males and 33.3% in females in infants. The incidence was also high in age group 1-5 years age group where males were affected more (12.3%) compared to females (23.3%). In mature age group 29-64 years females contracted more illnesses (28.8%) as compared to males (20%) while in age group 6-14 years both males and females suffered due to illnesses almost the same (16.5%). In reproductive age group 15 to 49 years females at both localities suffered at the almost equal rate of 33% to 35%.

Table 5.12 Incidence of illness among IDPs by sex

Age group	**IDPs in Camp**		**IDPs in Host Community**	
	Male % n=209	**Female % n=219**	**Male % n=102**	**Female % n=122**
Infants	75	59.3	19.1	33.3
1-5	59.6	47.6	12.8	23.7
6-14	34.8	34	16.5	16.5
15-28	28.4	28.9	16.2	23.2
29-64	31.1	43.4	20	28.6
15-49 y	27.2	33.8	25.9	35
65 & above	79.2	72.7	44.4	37.5
Total	35.7	40.03	19.02	24.9

Table 5.13 shows 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 case of host community, male infants were affected more by common colds 25% & chest infection 75% in comparison to girl infants who were affected by asphyxia by 40% and chest infections by 20%. In age group1-5 years, common colds and asphyxia affected both sexes almost equally at both localities in addition to diarrhea that causes 34.9% cases in male & 41.6% in females among IDPs living in camp. In case of host community more girls 22.2% suffered due to diseases as compared to boyes16.7%.

Almost same was the pattern of illnesses among children in age group 6-14 years where in addition to common colds and chest infections more girls (32.5%) were affected by skin infections than boys (25.6%) in camps while for IDPs living in host community children suffered almost in equal percentages from a sex perspective.

Among youth in age group 15-28 years IDPs health was followed by the same disease pattern at both localities and affecting both sexes where in addition 6% female in camp and 13.1% in host community among IDPs were affected by reproductive health issues as well.

Also 10.4% women in reproductive age group of 15-49 years faced not only reproductive health issues in camp but also 16.3% faced it in host community as well. Women in this age group were also affected by cardiac problems, skin infections, common colds and chest infections at both localities.

Among people in mature ages in age group 29-64 years, the disease pattern was almost the same for both males and females where the percentages of cardiac problems and other mobility related

illnesses to people in mature ages also affected them at both localities. Importantly the disease pattern present among elderly people of 65 years and above age was very much similar to that of people in 29-64 years age group at both localities. These people which demand special attention and that are identified by UNHCR as people with special needs (HelpAge, 2010) were more affected by specific health issues prevalent in elderly. These health issues are consisted of cardiac problems, conjunctivitis, Neuro pain, arthritis and vision loss which has affected both sexes at both localities.

The findings in above table confirms with Committee (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 agrees with Roberts, Odong, et al. (2009) who holds environmental problems of water & sanitation, and overcrowding responsible for those health related problems.

Table 5.13 Type of illness suffered by the respondents in the past three months

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 %
	IDPs Camp (n=1133)												
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**
IDPs in Host Community (n=1025)													
Common Cold	25	0	66.6	55.5	18.7	66.6	36.6	28.9	20	16.2	22.9	-	-
Chest Infection	75	20	16.7	22.3	43.7	13.3	26.7	23.8	13.3	18.6	21.5	12.5	8.3
Asphyxia	0	40	-	-	-	-	-	-	-	-	-	-	-
Diarrhea	-	-	16.7	22.2	6.2	0	0	0	26.7	11.6	7.5	-	-
Skin Infections	-	-	-	-	25	26.1	36.7	28.9	13.3	16.2	20.4	-	-
RH Problems	-	-	-	-	-	-	-	13.2	-	-	16.3	-	-
Cardiac problems	-	-	-	-	-	-	-	-	10	4.6	-	25	16.6
Conjunctivitis	-	-	-	-	-	-	-	-	-	-	-	6.3	16.3
Arthritis	-	-	-	-	-	-	-	-	-	-	-	12.5	32.5
Neuro Pain	-	-	-	-	-	-	-	-	-	-	-	12.5	0
Vision Loss	-	-	-	-	-	-	-	-	-	-	-	6.4	8.3
Other diseases	0	40	0	0	6.2	0	0	5.2	16.5	32.6	12.3	25	2
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 5.14 shows that IDPs households living in camp reported more deaths (30.3%) than IDPs living in host community (17.2%). In in-depth interviews it was aimed to investigate that why a huge number of people have died from very commonly treatable diseases/injuries.

Table 5.14 Death of IDP during internal displacement in Tank

Response	IDP Camps % n=155	IDP Host Community % n=105
Yes	30.3	17.2
No	69.7	82.8
Total	100	100

Source: Primary Data from Tank

Participants from IDPs camp commented:

"…….*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 5.15 shows that in under5 years age group, more children died in camp as compared to host community where most frequent causes of death were, Asphyxia, diarrhea, still birth,

measles and pneumonia for both male and female children. In 6-14 years age group, pneumonia and injuries were the most common reasons of death for boys living in IDPs camp while children in host community died only of Pneumonia and no girl was died at any locality in this age group. In 15-28 years age group mainly more women died due to pregnancy related causes in camps and host community. In reproductive age group of 15-49 years, pregnancy related deaths in addition to hepatitis caused many deaths in both IDPs localities. 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) .

Table 5.15 Illnesses causing deaths among IDPs during period of displacement from age and sex perspective

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 %
IDPs Camp (n=47)											
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**
IDPs in Host Community (n=18)											
Asphyxia	0	100	-	-	-	-	-	-	-	-	-
Diarrhea	0	0	-	-	-	-	-	-	-	-	-
Still Birth	50	0	-	-	-	-	-	-	-	-	-
Measles	50	0	-	-	-	-	-	-	-	-	-
Pneumonia	0	0	100	0	-	-	-	-	-	-	-
Injury	-	-	0	0	-	-	-	-	-	-	-
Pregnancy	-	-	-	-	0	50	-	-	100	-	-
Hepatitis	-	-	-	-	-	-	0	50	-	-	-
Cardiac Failure	-	-	-	-	-	-	0	0	-	0	100
Don't Know	-	-	-	-	-	-	-	-	-	-	-
Other Diseases	-	-	-	-	100	50	100	50	-	0	0
Total	**100**	**100**	**100**	**0**	**100**	**100**	**100**	**100**	**100**	**0**	**100**

Source: Primary Data from Tank

Table 5.16 shows that among IDPs living in camp, 32.7% and in host community 25.3% admitted that they experienced sign of mental distress.

Table 5.16 Experience of any signs of mental stress by IDPs during last three month

Response	IDP Camps % n=930	IDP Host Community % n=842
Yes	32.7	25.3
No	67.3	74.7
Total	100.0	100.0

Source: Primary Data from Tank

Table 5.17 shows that when IDPs were asked about experiencing emotional stress during last three months, more people suffered in each age group in IDPs camp as compared to IDPs living in host community. Males suffer harder than females in camps whereas in host community female IDPs were worse off than males. Overall the mental health burden is found out to be almost equal in size that is 32.7% in camps & 25.3% in host community to physical health burden that is 37.7% in camps and 21.6% in host community.

The findings of this study indicate that the psychological needs of the children is the most neglected area in designing and providing health care, the findings are in the line of previous evidence like Betancourt and Khan (2008) who assert that their health is mostly addressed in perspectives of malnutrition and immunization programmes and their psychological needs are mostly neglected. In age group 9-14, main signs of emotional stress captured in this study explored are feeling down, depressed, hopelessness and constant crying. By drawing a comparison between IDPs living in camp and host community it is evident that almost both localities are equally mentally stressed with girl children more depressed as compared to boys.

Population in age group 65 and above, who are recognized by UNHCR as peoples with special needs (HelpAge, 2010), was caught by loss of appetite and depression at both localities and this suffering was more prevalent in men as compared to women.

In age group 15-28, men and women were more affected by depression at both localities. Other signs of mental stress included sign of feeling down, hopelessness, constant crying and sleeplessness at both localities. At both localities sleeplessness was more common in women while men were victim of constant crying more than women.

In age group 29-64 also depression was more common where women as compared to men in both localities were more affected by it. Hopelessness was equally higher in women and men in both localities. Over thinking was more common in women as compared to men in both localities.

Table 5.17 Types of Mental stress signs among IDPs living in Tank

Signs	**9 to 14 Y**		**15 to 28 Y**		**29 to 64 Y**		**65 Y & above**	
	M %	F %	M %	F %	M %	F %	M %	F %
IDPs in Camp (n=304)								
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**
IDPs in Host Community (n=213)								
Feeling Down	10	26.3	15	17.6	9.8	2.3	-	-
Depressed	20	15.8	45	35.2	61.2	48.6	27.8	16.7
Hopelessness	0	5.3	2.5	5.8	6.7	13.9	-	-
Constant Crying	50	26.3	10	8.8	-	-	-	-
Sleeplessness	-	-	2.5	2.9	-	-	-	-
Overthinking	-	-	-	-	9.6	14	-	-
Loss of appetite	-	-	-	-	-	-	27.8	16.7
Other Signs	20	15.8	25	29.4	12.7	9.2	44.4	66.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Primary Data from Tank

Table 5.18 shows that among children in age group 9-14 years, 26.7% girl children were more stressed about their future and memories of past violence whereas boys were more concerned about loss of loved ones and loss of property in conflict at both localities. In 65 and above year age group, 88.9% men were worried about future in camp and 27.8% in host community whereas due to loss of home town 55.6% women were mentally stressed living in host community.

In camps both women and men almost equally stressed due to loss of property, loss of home town, financial problems and due to memories of past violence. In host community 32.3male IDPs felt more stressed due to future worries and 35% due to loss of loved ones as compared to 14.7% women who were more stressed due to worries of property and 32.4% who were worried about loss of home town.

In age group 29-64 years, male 19.1% in camp were more stressed to financial problems as compared to women who were more stressed due to future worries 30.3%, loss of loved ones 25.7% and loss of hometown 20%. In case of IDPs living in host community men were more stressed due to future worries 48.4%, loss of home town 22.6% and loss of property 9.6% whereas women were also affected by future worries 42. 2% and loss of loved ones 33.2%.

Table 5.18 Reasons for mental depression in IDPs by sex and age

Reason	9 to 14 Y		15 to 28 Y		29 to 64 Y		65 Y & above	
	M %	F %	M %	F %	M %	F %	M %	F %
	IDPs in Camp (n=304)							
Worried about future	5.9	26.7	16.7	14.5	26.8	30.7	88.9	33.3
Loss of loved ones	41.1	33.3	17.9	14.5	19.5	25.3	0	33.3
Loss of hometown	11.8	13.3	-	-	18.3	20	0	0
Memories of past violence	18.1	26.7	15.3	17.7	-	-	-	-
Loss of property	-	-	10.3	12.9	9.8	10.7	-	-
Financial problems	-	-	24.4	27.4	17.1	12	-	-
Other signs	23.6	0	15.4	12.9	8.5	1.3	11.1	33.3
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
IDPs in Host Community (n=213)								
Worried about future	0	11.8	32.5	26.5	48.4	41.9	27.8	22.2
Loss of loved ones	66.7	47.1	35	17.6	19.4	32.6	16.6	5.5
Loss of hometown	8.3	0	12.5	32.4	22.6	16.3	50	55.6
Memories of past violence	25	23.5	2.5	2.9	-	-	-	-
Loss of property	-	-	10	14.7	9.6	4.6	-	-
Financial problems	-	-	5	2.9	0	4.6	-	-
Other signs	0	29.4	2.5	2.9	0	o	5.6	16.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Primary Data from Tank

Table 5.19 shows that in both localities of IDPs residence psychiatric/psychological treatment was completely absent.

Table 5.19 Availability of any Psychiatric/Psychological treatment to IDPs living in Tank

Response	IDP Camps % n=304	IDP Host Community % n=213
Yes	0.0	0.0
No	100.0	100.0
Total	100.0	100.0

Source: Primary Data from Tank

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)**

In host community a mother in law told:

"……*I will show her to Psychiatrist once my son will get back from Dubai as we have no male present at home. I have brought a mullet for my daughter in law from Molvi sahib but it is not working* **(Women head of the household, 52 years)**.

IV. Health-seeking Practices

Table 5.20 shows that for sake of medical treatment, majority of IDPs living in camp relied upon mobile clinics 75.9% and 12.4% are still waiting to come for mobile clinic. In host community 46.9% went to private hospitals followed by 40.2% who went to DHQ hospital while only 11.2% went to mobile clinic.

Table 5.20 Accessibility to health care services for IDPs living in District Tank

Type of health facility	**IDP Camps % n=428**	**IDP Host Community % n=224**
BHU	0.2	0.8
RHC	6.5	0.0
DHQ	4.7	40.2
Mobile clinic	75.9	11.2
Private hospital	0.0	46.9
Still waiting for mobile clinic to come	12.4	0.0
Other health facilities (temporary health facilities and hakeem	0.2	0.8
Total	100	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).**

When an IDP living in host community was asked about medical treatment of his mother in private hospital in D.I Khan instead of DHQ hospital in Tank, he replied:

"…….Because no treatment is available for heart related problems here in Tank. It is too crowded with patients and medicines & laboratory facilities are not good as well.

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 5.21 shows that Majority of the IDPs in both localities were able to reach health facility within 1 hour. Many IDPs settled/taken refuge in rural areas in host community had travelled up to two hours to reach health facilities. In case of IDPs living in camps they rarely travel more than two hours in absence of health care availability at camp instead they have to wait for mobile clinic to come even for couple of weeks.

Table 5.21 Time to reach the nearest health facility in District Tank

Response	IDP Camps % n=375	IDP Host Community % n=224
Within 1 hour	89.1	83.1
1-2 hours	9.1	12.9
More than 2 hours	1.8	4.0
Total	100.0	100.0

Source: Primary Data from Tank

Table 5.22 shows that in IDPs camp health care facility was available free of cost while in host community 46.4% IDPs were availing health facilities free of cost, 39.7% were required to pay above Rs. 100 for the services and 13.8% were required to pay up to Rs. 100 to access health care facilities. In host community majority of IDPs relied more on private hospitals and clinics for their efficient health care as compared to that of public sector.

Table 5.22 Payment of cost to avail health care facility

Response	IDP Camps n=375	IDP Host Community n=224
Free of charge	99.5	46.4
Payment up to Rs.100	0.5	13.8
Payment above Rs.100	0.0	39.7
Total	100.0	100.0

Source: Primary Data from Tank

Table 5.23 shows that in camps 87.5% people were provided medical treatment by government while 12.5% were provided by UN/INGO. In host community, 46.9% were paying on their own, for 42.4% it was paid by government and for 10.3% it was paid for their treatment by UN/INGO.

Table 5.23 Source to provide/ pay for health care services for IDPs living in Tank

Response	IDP Camps % n=375	IDP Host Community % n=224
Government	87.5	42.4
UN/NGO	12.3	10.3
Friends/relatives	0.2	0.01
By own sources	0.0	46.9
Total	100	100

Source: Primary Data from Tank

Table 5.24 shows that when asked about level of satisfaction about health care, almost all IDPs living in host community were satisfied but in camp majority of them were dissatisfied with the quality of health care facilities and many among them said that it is not available at all.

Table 5.24 Opinion of IDPs regarding quality of health care provided

Response	**IDP Camps % n=375**	**IDP Host Community % n=224**
Excellent	2.1	8.9
Good	15.2	50.9
Fair	26.9	34.4
Poor	40.5	4.9
Not available at all	15.2	0.9
Total	100	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).**

V. Mother and Child Health Care

Table 5.25 shows that during IDPs refuge in camp and host community women got pregnant at almost equal percentage of 37%. In case of IDPs living in camp only 29.2% pregnant women were provided with antenatal care whereas in host community 86.4% women were able to get it. It was complained by 92.7% women in camp that there were no facilities for antenatal care while only 7.3% said they do not require it.

Babies were born in almost equal percentage of 37.4% households at both localities. In camp most of the deliveries 44.8% were assisted by their own family members followed by 34.5% by doctors as compared to host community where 74.3% were assisted by doctors followed by 20.5% TBAs. Majority of women were not provided with post natal care 69.0% in camp whereas 82.0% in host communities were provided with it. When asked about the reason for not providing postnatal care in camp, it was stated that it was not available almost in case of 92.3% households while 7.5% said that they do not required it.

Table 5.25 Mother and Neonatal care at household level among IDPs living in District Tank

Question	IDPs Camps %	IDPs in Host Community %
Frequency of pregnancy (Camp n=155 & Host community n=105)	37.4	37.2
Availability of antenatal Care (Camp n=58 & Host Community n=39)	29.2	84.6
Reason for unavailability of antenatal care (Camp n=41 & Host Community n=6)		
Not available in Camp/Host Community	92.7	50
Not required by family	7.3	50
Birth of Baby (Camp n=155 & Host Community n=105)	35.5	37.2
Delivery assistance (Camp n=55 & Host Community n= 39)		
by own family help	44.8	24.3
midwife	19.0	32.6
TBA	1.7	40.5
doctor	34.5	2.6
Postnatal care (Camp n=55 & Host Community n= 39)	31.0	82.0
Reason for no availability of Postnatal care (Camp n=55 & Host Community n= 39)		
Not available in camp/host community	92.5	14.3
Not required by family	7.5	85.7

Source: Primary Data from Tank

VI. Health priorities and their possible solution

Table 5.26 shows that when IDPs were asked about health priority of their family 35.5% households in camp and 40.0% in host community replied that they have no health issue. The second majority 23.8% households in camps and 30.5% in host community considered psychiatric health as a great issue of concern. IDPs at both localities also showed issue of concern regarding chest & skin infections and common colds as well while almost 14% peoples were affected by more than one health issues in camp and 5.8% in host community.

Table 5.26 Health issue of great concern at household level among IDPs living in Tank

Response	IDP Camps % n=155	IDP Host Community % n=105
No health issue	35.5	40.0
More than one health concerns	14.2	5.8
Mental health issues	23.8	30.5
Chest infections	3.2	4.8
Skin infections	2.6	6.7
Common colds	1.9	5.7
Total	100	100

Source: Primary Data from Tank

Table 5.27 shows that majority of the IDPs households 34.0% in camp proposed that medical facilities should be available on permanent basis in camp. The second solution prioritized was about availability of mental health care facilities by 29.2% IDPs living in camp and by 45.3% IDPs living in host community.

Table 5.27 Proposed solutions for health issues by IDPs living in Tank

Response	IDP Camps % n=100	IDP Host Community % n=62
Don't know	0.1	23.4
Availability of medical care in camp/host community on permanent basis	34.3	0.0
Availability of mental health care	29.2	45.3
Availability of mother and child care facilities	9.0	1.5
Other suggestions	25.7	29.6
Total	100	100

Chapter 6.Conclusion & Recommendations

6.1 Discussion

This chapter discusses the results of the study, supported by literature, to address the study objectives. The main aim in this regard, is to investigate the gap between health needs of IDPs and the health services available to them; through a focus on demand and supply of such services through study results in chapter four and five.

But before discussing health needs and health services availability for IDPs, it is important to discuss the first objective that is importance of level of social capital and economic status in tribal society of SWA supported by research findings. Here a contrast is presented between the health problems those were faced by IDPs living in camp with those of IDPs living in host community to understand the basis of difference in health services availability.

As already emphasized in chapter two, due to lack of international support both in law and capacity and, ill-preparedness of developing states to protect the overload of IDPs, usually it results in huge suffering of the internally displaced persons (Phuong, 2004). In situation of disasters, peoples mostly rely on their economic status and social capital to decide whether to go to IDPs camp or take refuge somewhere else (Woolcock, 1998).

The results of this study show that SWA IDPs with lower economic and social capital status joined camp while those with higher economic and social status joined host community. Right at the start of forced displacement of IDPs from SWA, level of economic and social capital drew a

line between IDPs where most of the IDPs meet help for shelter in Tank from their relatives or managed it on their own while poor IDPs were left with no option but to join IDPs camps.

Review of existing literature suggests that people in traditional societies in times of disasters highly depend on their social capital that consists of resources embedded in their social networks and social structure (Woolcock, 1998). In this regard, apart from relatives help during displacement, IDPs with higher level of economic and social capital were blessed more by their fellow tribal men, friends and political/religious parties by not only offering loans and cash gifts but also offered food and shelter also as compared to IDPs who joined camp got very limited support.

In addition, majority of the IDPs in camp have no income or have an income below 5000 rupees but majority of IDPs in host community have income level between 25000-40000 rupees. Importantly among IDPs living in camp, most of them are earning their money by selling extra ration up to 3000 rupees whereas IPDs in host community are better off and are more dependent on remittances, transport business and public sector jobs.

The situation for SWA IDPs in camp, who were already vulnerable in their area of origin; their situation got even worse due to unhygienic conditions and lake of amenities in the camp. The inadequacy in shelter for IDPs in camps is already well elaborated in the reviewed literature. On the other hand, in host community settings, IDPs through their strength of social capital, better cope with the problems arising due to displacement (Rae, 2011).

The results showed mismanagement in camps as despite the fact that rations were provided to all IDPs still most of them considered it extremely difficult to get it due to long queues and

favoritism. The situation of security around IDPs camps was also considered dangerous by majority of the IDPs living there.

Many things were considered wrong in the design of these camps. These shelter camps were not designed keeping in mind the cultural values, especially regarding gender of the IDPs (IDMC, 2012). Majority of the IDPs in camps considered it overcrowded where tents were too close to each other to affect privacy and the size of tent was also small to support an average household having 8-10 members. The problem of overcrowding was made even worse by environmental factors like intense hot weather of district Tank where it was impossible to live in a tent without fans.

It was especially intolerable for children and women who observe Purdah and use to remain in tent for all 24 hours of a day. Most importantly, the situation of water and sanitation was considered unsatisfactory by almost 80% of IDPs living in camp as compared to only 20% who raised the same concern in host community.

IDPs majority who lived in such poor conditions of camp for a period of more than 2 years were already affected by war trauma and all this has resulted in increased psychological and physical health problems for them. The results of this study showed that the health of children, elderly and women of reproductive ages were affected both in camp and host community, particularly IDPs living in camp were more severely affected.

It is evident from the reviewed literature that the health problems are faced differently by children, men and women of different ages (IDMC, 2012). Children, on account of their young age, are more exposed to the difficulties and risks associated with displacement, whereas people in old age are more prone to mobility disorders and cardiovascular problems. Women in

reproductive age especially pregnant ones are the most vulnerable during armed conflict and need special care for themselves and their babies.

Keeping in view the diversity of IDPs population the results are arranged for all age groups sex wise in order to achieve the 2nd objective of the study. The result of this study has clearly shown that the disease prevalence in IDPs living in camp was higher as compared to IDPs living in host community. This heavy disease burden in IDPs camp is due to unfriendly and unhygienic shelter arrangements in camp.

Importantly, less than five years old girl children were more affected by physical health related issues as compared to under five boy children in both localities. Most prevalent health problems included diarrhea, chest infections, common colds and asphyxia. While, in age group 6-14 years at both localities, more boys were affected by chest infections, diarrhea and common colds and skin infections as compared to girls.

As mentioned earlier, the psychological health is the most neglected part of medical care provided to IDPs and especially children are most vulnerable to it due to low tolerance of violence, bloodshed and terror. In camps, IDPs are kept in social exclusion where psychological counselling and psychiatric treatment is totally absent (Roberts, Odong, et al., 2009).

The results of this study for age group 9-14 years children show that feeling down, constant crying, depression and hopelessness are most common signs of mental stress at both localities. Children in camp are affected more as compared to host community where in camp girls and in host community boys are more affected.

In the age group 15-28 years, physical health problems were same and coupled with reproductive health problems in women. The disease prevalence in camp was a bit higher for men as compared to women whereas; it was almost equal in both sexes in host community. In this age group psychologically, male in camp and host community were more stressed due to future worries as compared to females. In camp men were more stressed due to loss of property and due to memories of past violence compared to host community.

In age group 29-64 years IDPs living in camp were again more affected by physical health problems as compared to IDPs living in camp. Men were more affected by cardiac problems, chest infections, skin infections and common colds as compared to women while in host community both sexes were equally affected by these health issues. In this group, males in the camps were slightly less mentally stressed in host community as compared to females. In camps females were equally stressed due to loss of property, loss of hometown while in host community female IDPs felt more stressed as compared to men due to worries of future and loss of loved ones.

IDPs aged 65 and above who are already categorized by UNHCR as people with special needs (HelpAge, 2010) are struck extremely hard. In this age group, chest infection and arthritis was more prevalent in men as compared to women in camp while in host community females were more affected by arthritis as compared to men. Women were more affected by cardiac problems as compared to men at both localities.

Most of all, the loss of status and prestige, exclusion and poor quality of life in camps results in severe mental stress for majority of the old age peoples in 65 and above years age group. In both localities men were more worried about future as compared to women. More men in older ages

in camp were caught by loss of appetite while IDPs in host community it was equal for both men and women. Depression was more common in men as compared to women in both localities.

Overall in reproductive age group it was found that the most frequent issue of health they faced was gynecological problems that were present in displaced women in both localities exceptionally greater in camp as compared to IDPs living in host community.

A number of factors were identified at IDPs camp and host community regarding third study objective about health services availability in response to their health needs. Discussion of the health services experiences of the IDPs is focused on access, utilisation, satisfaction and consequences, inadequacy and absence of health care services provided by local and international health authorities.

Most of the programmes for medical care consider IDPs a 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 old age peoples is affected differently (IASC, 2004). In this study, the results showed that the gender divide and age aspects are extremely important for designing successful health care system.

Further investigation through in depth interviews explored that the main source of health facility in camp was only a mobile clinic, which consisted of an LHV, a dispenser and small quantity of medicines that used to visit them once weekly or after two weeks. Majority of the IDPs in camps considered this health facility unsatisfactory because they said medicine were inadequate, doctors were absent and for diagnosis no investigations were done. Whereas in host community the situation was better for physical health care and majority of IDPs were using private health

facilities on small payment. Many IDPs in host community also used to visit district headquarter hospital for medical checkup but were not satisfied with the available health care.

In case of maternal and child health care, only one third of the pregnant women in camp were provided antenatal care as compared to 84.6% who had access to such facilities in host community. Among those who were not provided with antenatal care in camp majority stated that these were not available while a few said they do not require it.

Moreover, in camp most of the babies were deliveries through assistance by their own family women and fewer were done by doctors as compared to host community where majority were assisted by doctors and rest of them were done by TBAs. Majority of women were also not provided with post natal care in camps where in host communities majority got it.

Due to such reasons IDPs in camp were not satisfied with health services and they tried to seek medical treatment from the nearby Tank city but they were not allowed by security check posts most of the time. Especially after 5 p.m., even in case of emergency they were not allowed to go for treatment. This restriction has resulted in most of the deaths that occurred in camps and was condemned by most of the IDPs during the in-depth interviews. It is strange that such practices by security forces have not been indicated once by media or explored in any research report by INGOs or government, due to which, almost every third household in camp has suffered a death in IDPs camp.

By looking at the mortality from age and sex perspective, in under five groups, more female died in camps due to difficulty in breathing, diarrhea, still birth, measles and pneumonia as compared to host community where deaths were caused only by still birth and difficulty in breathing.

In the 6-14 years age group, pneumonia and injuries were the most common reasons of death for boys and no girl had died at any locality. In the 15-28 years age group, more women died due to pregnancy related causes where more died in camps as compared to host community. In the 29-64 years age group, more females than males died, the main causes of death were hepatitis and cardiac failure at both localities.

Although it is already well established in literature that during internal displacement people bearing the brunt of health related inadequacies are people in old age (HelpAge, 2010) despite this fact no special arrangements were made and they suffered due to it.

It is universally accepted that war victim's health needs are more in line with mental health problems like depression, anxiety and sleeplessness. In IDPs camps, however, it is mostly general health related facilities that are provided by UN and governments (Hamid & Musa, 2010). In this study results, there was nothing available for psychiatric care at both localities which has resulted in huge morbidity.

When asked about proposing solutions to health related problems, 34.0% IDPs in camp proposed that medical facilities should be available on permanent basis in camp. The second majority 29.2% IDPs in camp and 45.3% in host community proposed availability of mental health care facilities in this regard.

6.2 Conclusions

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. Even the security check-posts proved to be a hurdle for IDPs in camps to seek medical treatment whereas IDPs in host community were freely using it.

Several other conclusions emerged from this research. Firstly, the social capital and economic status decided the fate of SWA IDPs whether to join host community or camp. The IDPs with low level of economic status and social capital joined camp and became the victims of inadequate and inappropriate arrangements of accommodation, water & sanitation, purdah arrangement, security situation and unorganized relief activities like food distribution in IDPs camp.

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 while health needs of IDPs living in host community contracted due to better shelter availability and support provided by relatives, friends & tribesmen at host community.

The common issues related to physical health in camps and in host community were almost same which mostly affected 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 IDPs in camp were more affected as compared to IDPs living in host community. It was present among all age groups and in both the sexes however, people in older ages were affected the most at both localities. 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. Alarmingly mental health care was completely absent from both localities and IDPs were mostly dependent on religious healing for sake of mental health relief.

IDPs living in camp reported more deaths than IDPs living in host community. 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 less frequent and inappropriate at IDPs camps as compared to host community. In host community most of the IDPs went to private hospital and were paying on their own for their health care and their level of satisfaction was much higher. In comparison, IDPs living in camps were mostly dependent on mobile clinics for their health needs fulfillment and were least satisfied with it. Mother and childcare facilities like antenatal, post natal care and

birth assistance were also more frequently available to pregnant women at host community as compared IDPs living at camps.

By concluding the argument, it is evident that in absence of international protection, higher level of social capital and economic status facilitated many of IDPs to join host community and utilize health facilities present in district Tank. Whereas in comparison, IDPs living in camp bear the load of health problems due to inadequacy and absence of health care facilities.

6.3 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 of an overarching binding international law for IDPs complete protection encircling shelter and health by binding UN, INGOs and national governments.
2. The support and protection provided to IDPs at both localities during displacement by relatives, friends, fellow tribesmen and host community should be acknowledged and they should be paid back by government or any other concerned institution. Although it is improper from the cultural point of view, it would be of great help for them as they are already overburdened by expenditures form last five years since the start of the armed conflict. Moreover, it would lessen the burden on the minds of those IDPs who were helped by host communities and who consider it as a social loan and want to pay it back in future.
3. The cultural norms of purdah and prestige in tribal society should be incorporated in building small shelter homes to protect their self-esteem instead of keeping them in tents.

4. To eliminate unemployment among IDPs government and NGOs should initiate livelihood programs.
5. The WFP should also give cash along with food as many of the IDPs sell ration to fulfill their other than food needs. This could be done by rationalizing the size of the ration distributed.
6. There is a need to develop proper policies to integrate IDPs health related provisions in local district health system in the recipient areas.
7. It is important that displaced persons have access to involvement in the policy-making process in order to open up channels of dialogue with health decision planners, to clarify misunderstandings and build a relationship between health providers and IDPs.
8. There has to be improved coordination between security forces, DHO and NGOs (international and local) to facilitate IDPs health in conflict ridden areas. Especially security forces should be kept away from camp and roads so that a free movement is possible for IDPs for health seeking and employment.
9. There is a need for regular epidemiological surveillance of the IDPs' health problems at both localities for better health policy making.
10. There is a need to create a health service package for IDPs based on their complete exemption from all health service fees in host communities.
11. Presence of a psychiatrist and psychologist should be made mandatory in camps and host community and this staff should go to IDPs houses and resolve their mental health problems at household level and at hospital level both because many IDPs do not consider its treatment necessary though it has serious consequences.

12. The health assistance under broader umbrella of central, provincial and international health bodies should be made available at district level to solve health related issues of IDPs in foreseeable future.

6.4 Need for Further Research

The process and results of this research indicate the need for further research on exploring the reason for IDPs negligence in international law, culture of tribal support, disease specific to displacement and health services provided to IDPs. Especially similar research studies should be done on IDPs health problems in all agencies to explore the overall picture of displacement in FATA. Also, the reasons for less and inadequate health support offered to IDPs by national health institutions in specific and international health authorities in general should be found out as well.

Livelihood strategies adopted by IDPs living in camp and host community should be explored in a greater detail to design a livelihood framework. It will not only help in systemization of ration schemes but will also explore the missing elements necessary for IDPs welfare in WFP and other organizations area of concern.

Studies should be done to explore the law, attitude and practices of security forces deployed in FATA regarding IDPs facilitation and control. It will help to explore the hidden reasons for the non-cooperation of security forces in case of IDPs.

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APPENDICES

Appendix A. Guideline for in-depth Interview

1. Explain objectives of the study
2. Describe how you and your family arrived in this camp/host community?
3. Describe if any among your Relatives, Friends, tribal men, and political parties helped you during displacement?
4. Tell about the conditions of the accommodation in which you are now living.
5. How do these conditions affect your health?
6. How do you cope if you have an illness?
7. Did anyone died in your household during your stay here?
8. Describe is any one suffering from Mental stress in your household?
9. Describe Mother and Child Health care practices during pregnancy?
10. What are the health services available in this camp/host community?
11. What are your experiences in obtaining health services in this camp/host community?
12. How satisfactory are the health services offered by the public health sector in this camp/host community?
13. What are your suggestions particularly for health services in this area?

Appendix B. Questionnaire

	HP1	HP2	HP3	HP4	HP5
1. HOUSEHOLD POPULATION					
	A complete list of all the members of this household, who usually live and eat here.	How old is (name), in completed years?	Gender Male .....1 Female.....2	Can (name) read and write in any one language? Yes.....1 No.....2	What is the highest education level completed by (name)?... 1. None...2. Primary... 3. Middle...4. High school...5. Intermediate College...6. B.A. /B.Sc....7. M.A. /M.Sc...8. M.Phil./PhD...9 Other
	Name	Years	Code	Code	Code
				Ask only for household	Ask only for household head

HP6. Encircle Appropriate option			
Area of origin	Household composition	Ethnicity	Time displaced
_____	1. Nucleus 2. Joint 3. Extended 4. Non specified	1. Mehsud 2. Wazir 3. Barki 4. Bhittani 5.Other:_____	_____

2. ECONOMIC STATUS AND SOCIAL CAPITAL

ES1. Source of income/ main occupation (encircle appropriate)

Activity sector	**Position**	**Activity sector**	**Position**
1. Agriculture / livestock 2. Construction 3. Manufacturing 4. Transportation 5. Wholesale trade 6. Retail trade 7. Government job 8. None / Unemployed	1. Day Labourer 2. Salaried worker (private sector) 3. Salaried worker (public sector) 4. Self-employed	1. Agriculture / livestock 2. Construction 3. Manufacturing 4. Transportation 5. Wholesale trade 6. Retail trade	1. Day Labourer 2. Salaried worker (private sector) 3. Salaried worker (public sector) 4. Self-employed

ES2. What is your current household total monthly income? (include monthly income of all earning members)	_____PKR

ES3. Have you received any assistance/support from; Yes 1 No 2 Not needed 3	During displacement			After displacement		
	Shelter	Food	Loan	Shelter	Food	loan
Relatives						
Friends						
Ethnic/Tribal						
Same faith/ religious network/Political						
Host Family /Pukhtunwali						

3. SHELTER

S1. What is your accommodation now? (please tick appropriate)	
1.IDPs Camp	○
2. Host family without paying any rent	○
3. Host family paying rent	○
4. Rented accommodation	○
5. Collective centres (schools/public buildings)	○
6. If others, specify	

S2. Who is responsible/ running this facility? (encircle appropriate)
1. Government 2. UN institution 3 INGO 4. Local NGO 5. Political/Religious Party 6. Options 1, 2 &3 7. By own sources 8. By friends 9. By

relatives 10. By host community

S3. How much do you agree with below statements regarding threats, facilities and utilities present/provided in/around this camp/house? (Please tick appropriate)

Statements	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
There is a security threat	O	O	O	O
Conditions of weather are harsh (too hot in summer and too cold in winter)	O	O	O	O
Lack of water and sanitation facilities (lack of toilets)	O	O	O	O
Missing cultural arrangements for Purdah	O	O	O	O
Camp is Overcrowded	O	O	O	O
Non availability of place to play for children	O	O	O	O

S4. How would you rate the standard of the housing you live in today? 1- Very poor 2- Poor 3- Average 4- Good 5- Very good

4. FOOD/MEALS

F1. How many times do you eat food/meals? 1. Once a day 2. Two times a day 3. Three times a day 4. more than 3 times a day
F2. In your opinion, do you think the food/meals are enough for each day? 1. Yes 2. No
F3. Where did you get your food/meals from each day? 1. Government 2. UN & INGOs 3.Private/NGOs 4. Self-supported 5. Friends/relatives 6 Others

5. PHYSICAL HEALTH (MCH related illnesses are not asked here)

PH1	PH2	PH3	PH4	PH5	PH6

Identification code	In the last month, since you have been staying here, have any members of your household suffered from diseases/injuries?	During the time he/she was ill, where did he/she gone for the treatment? 1. BHU 2. RHC 3. THQ 4. DHQ 5. Private clinic 6.Temporary Health Facility 7. Mobile Clinic 8. Hakeem	What kind of sickness was it /were these? 1. Common cold 2.Stomach problem 3.Diarrhoea 4. ENT problem 5. Skin infections 6. Cardio vascular 7. Other specify	Describe your access to the nearest health facility point for medical treatment? 1. Within 1 hour O 2. 1-2 hours O 3. More than 2 hours O 4. Don't know	Is facility of ambulance to carry patient to hospital from home is available? 1. Yes 2. No	Is access to health care at delivery point (check one): 1. Free of charge O 2. Small payment (explain) O 3. Large payment (explain) O 4. Don't know
	Code	Code	Code	Code	Code	Code

PH7		PH8	PH9	PH10	PH11
Identification	Is this medical facility provides free eye/hearing/mobility/aids? 1. Yes 2. No	In general how do you feel about health care provided to you? 1.Excellent 2.Good	What organization is providing these facilities? 1. Government 2. UN & INGOs 3. Local NGOs 4. Political/religious organizations 6. Any other	Have any of your household members become disabled during your stay here? 1. Yes Who was that…… 2. No	Do you know what the cause of disability was? .....
	Name	Years	code	code	

PH12. Have any of your household members died during your stay here? 1. Yes 2. No skip to Q. 24
PH13. Do you know what the cause of death was? ……..

6. EMOTIONAL STRESSES

ES1		ES2	ES3	ES4	ES5
Identification code	Do you have any emotional stress in last 3 months? 1. No 2. Feeling down 3. Depressed 4. Hopeless 5. Constant crying 6. Over thinking 7. Suicidal ideation 9. Anxiety 10. Sleeplessness 11. Loss of appetite 12. Extreme anger 13. Frustration	Why emotional stress? 1. Worried about future 2. Loss of loved ones 3. Loss of property in conflict 4. Unemployment 5. Financial problems 6. Any other	What facilities are available to relieve your stress? 1. No 2.Psychological/psychiatric counselling 3. Religious counselling 4. Friends/relatives 5. Any other	What organization is providing these facilities? 1. Government 2. UN & INGOs 3. Local NGOs 4. Political/religious organizations 5. Any other	In general how do you feel about psychological care provided to you? 1.Excellent 2.Good 3.Fair 4.Poor
	Code	Code	Code	code	code

7. ESSENTIAL MOTHER AND CHILD HEALTH CARE

M1. During your stay here, have any women in your household become pregnant? 1. Yes 2. No skip toM3
M2. Where did she gone for ante natal care? And how many times? No of times------- 1. Community Health Centre 2. Hospital 3. Health Post 4. Others (please explain) 5. Not at all
M3. Has any baby been born during your stay here? 1. Yes 2. No skip toM7
M4. Who was the assistant during the delivery? 1. Doctor 2. Midwife 3. Nurse 4. TBA 5. Others
M5. Who paid for the delivery? 1. Government 2. Private/NGOs 3. Family 4. Others

M6. Where did she go for post natal care? 1. Community Health Centre 2. Hospital 3. Health Post 4. Others
M7. Do women of reproductive age in your HOUSEHOLD use contraceptives for birth control? 1. Yes 2. No
M8. What is immunization status of your children? 1. Completed 2. Not completed
M9. Do women in your household practice Breastfeeding? 1. Yes 2. No
M10. Are pregnant women in your household have been vaccinated against tetanus? 1. Yes 2. No
M11. Has any women died due to pregnancy since emergency? 1. Yes 2. No
M12. What organization is providing these facilities? 1. Government 2. UN & INGOs 3. Local NGOs 4. 5. Political/religious organizations 6. Any other
M13. In general how do you feel about MCH care provided to you? 1.Excellent 2.Good 3.Fair 4.Poor

M14. What are your health concerns within the household right now? 1. ---------- 2. ---------- 3. ----------
M15. What could be the possible solutions for these health problems? 1. ---------- 2. ---------- 3. ----------

Appendix C. Map of FATA and KP

Source: Map derived from Map of NWFP, 1/1 M Scale, 10th Edition 1995, Published by Survey of Pakistan.

Appendix D. Pakistan and Key International Human Rights Treaties

Treaty	Signature	Ratification/accession(a)
International Convention on the Elimination of All Forms of Racial Discrimination	19-Sep-66	September 21, 1966
International Covenant on Economic, Social and Cultural Rights	3-Nov-04	April 17, 2008
International Covenant on Civil and Political Rights	17-Apr-08	June 23, 2010
Convention on the Elimination of All Forms of Discrimination against Women		March 12, 1996 (a)
Convention on the Rights of Persons with Disabilities	25-Sep-08	-
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	17-Apr-08	June 23, 2010
Convention on the Rights of the Child	20-Sep-90	November 12, 1990
Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography	26-Sep-01	-
Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in armed conflict	26-Sep-01	-

Appendix E. In-depth Interviews transcripts

IDPs camp IDI Transcripts 1. (Unemployed male, 42 years)

Q. Tell me how you and your family arrived in this temporary accommodation?

-Right at the start of *Rah-E-Nijat* operation against *Talibans* by security forces, we along with our villagers came to Tank. The travel from Sararogha to Tank proved to be extremely difficult. The first few days, we stayed with our relatives but soon we felt the need of our own shelter so we build our own hut from wood and thatch in an abandoned place and later on soon we shifted to IDP camp as government announced.

Q. Why did you stay in Tank and did not go further to other big cities?

-Tank is just on 3 hours of drive from my village. Other people from our village are also present here in huge numbers, we visited the town few times ago for the purpose of medical treatment and most importantly we assume that as soon as this conflict will end, it will be easy to go back from here easily.

Q. Did your all family dislocated together?

-yes I migrated along with my two brother's households towards Tank.

Q. Do you all live together in this camp?

-No, we live separately but eat together.

Q. why do you live separately when you were living as a one family in Sararogha?

-we have registered our self with WFP separately so that we can get food for three households.

Q. what do you do with that much food?

-we sell out extra ration to get money.

Q. How much money you get from selling Ration?

-I get at least 3000 rupees by selling extra ration per month.

Q. Do you get food easily?

-No, getting food is very tough due to long queues that are lining up at dawn to get ration because we are not those lucky people with links who get it easily and without standing in queues.

Q. What is your total monthly income?

-I am unemployed and trying to manage with 3000 rupees that I get from selling extra ration.

Q. How it becomes possible to manage a household of 7 peoples with 3000 Rs only?

- Food is already free and some help is also provided by local community.

Q. In what form this help is provided?

-it is mostly in cash but on festivals clothes, shoes and other household articles are provided too.

Q. Did any among your Relatives, Friends, tribesmen and political parties helped you during displacement?

-Our relatives and friends are mostly poor and unable to help us but tribesmen helped us a bit. Few faith based organizations tried to help us but were denied access to IDPs camp by security forces.

Q. Did anybody fell ill in your household during your stay in IDPs camp?

-from the very first day we have moved in here, one or other always felt sick in our household. Presently, my 7 month old son is suffering from asphyxia, while my mother is a permanent patient of arthritis and I feel fever since last two weeks too.

Q. Did you people get any medical treatment at camp?

- Yes, we visited mobile health clinic and got medicine as well but it was totally in effective.

Q. What is this mobile health clinic?

- 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 MBBS doctor as well.

Q. You told that medication was not much effective, why is that?

-Yes, 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 blood laboratory, X-ray Machine or specialist doctor.

Q. Who is providing this medication in mobile health clinic?

- Government of Pakistan is providing this facility.

Q. Did any NGO have provided any health facilities?

-Yes, they provided very good medical help at first when this camp was newly constructed, but after a couple of months they rarely came here.

Q. You told that your son is suffering from asphyxia since last week, why don't you take him to Mobile health clinic?

- I am waiting since last week but it is still to come as I have told you already that it visits us only once a week or some times after two weeks.

Q. Then why don't you take him to any other health facility in district Tank?

-(while smiling in despair) You know 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 further destination.

Q. Why security check posts do not permit you to visit Tank or any further destination?

-Ask security forces if they can give you any good reason.

Q. You are right but I would prefer to listen from you.

-This big turban (pointing towards the turban he was wearing), my long beard, my Mehsud lineage and my tribal culture are so called security threat for military. They (military) assume that every Mehsud household is a supporter of *Taliban* which is false and due to this pretext they have turned this camp in a Jail for us. We are not allowed to travel to Tank after 5 pm in evening even if someone is dying of injury/disease/pangs.

Q. Did anyone died in your household due to this reason?

-Yes, my pregnant wife and child died just because they (military) did not permit us to visit doctor in Tank at 10 pm in night because they assumed this late travelling is very dangerous for so called peace (cursing military).

After condolence for her wife and unborn child, I continued interview

Q. Did you provide antenatal care to your wife?

-Yes, I took her to LHV in Mobile clinic for checkup before her death.

Q. I just knew that you and your family has suffered a lot during living in this camp, would you like to let me know if anybody is suffering from mental stress in your household too?

-Yes, my 12 years old child is weeping all the time remembering his mother. My mother is suffering from anorexia and sleeplessness and I am just hopeless about the future of my household.

Q. Did you or anybody consulted with any psychiatrist to get rid of this mental stress?

- Psychiatrist never visits us here in camp. I have brought a mullet for my son and mother from *Molvi sahib*. Moreover, when any relatives or friends come here it also relieves our mental stress.

Q. Why did not you bring a mullet for yourself?

-I believe that time is the best healer and when, we will get back home this mental stress will be relieved.

Q. What is biggest health issue in your household now?

-mental stress is biggest health issue in my household.

Q. What could be the most suitable way to get rid of this mental stress?

-If we get back to our hometown, this issue will be solved.

Q. Please elaborate your answer a bit.

-Look, all these tensions are here because we are away from our hometown, house and land. If we get out of this tent (camp), our health will be good because fresh air and water and fruits will be available to us. We will be working in our small farms which will not only generate income but also keep us busy. The fresh breeze revolving around tall trees of walnuts in great mountains and zigzag water streams will blow away all our worries.

(THANK YOU VERY MUCH)

IDPs camp IDI.2 (Widow women household head, 50 years)

Q. Tell me how you and your family arrived in this temporary accommodation?

-When security forces occupied our village, they forced us to vacate our houses. We did not want to shift anywhere from our village but they put us in one vehicle and send us to this camp.

Q. Why did you not want to escape war when it was too intense in South Waziristan?

-Look, we have already lost most of our men in war with security forces. I am left with responsibility of three young women and few children. We have been bankrupted financially and emotionally. Only thing that is important for me is my village having graves of my sons and husband.

Q. Did your all family dislocated together?

-yes I migrated along with whoever is left alive.

Q. Do you all live together in this camp?

-Yes, we live here together.

Q. I guess you are not happy in this camp because you miss your village so much but are there anything that could be made better to provide you ease and comfort here?

- build small houses for us having basic water & sanitation and cooking facilities. We feel restlessness and disgust to live in tents it is against our values and culture. Just try to make us free of these security check posts at least. We are free people and cannot live in so many restrictions of movements.

Q. Do you get food easily?

-no, getting food is very tough due to long queues and due to absence of adult male in my household. So I hire a man for 500 rupees to stand in queues and get us ration.

Q. What is your total monthly income?

-I am a housewife with my both sons and husband dead and hence no monthly income.

Q. How it becomes possible to live a life without any income?

- I sell out jewelry whenever I need money to fulfill my household responsibilities.

Q. Did any among your Relatives, Friends, tribal men, political parties or host community helped you during displacement?

-Our relatives and friends are in Karachi and unable to help us but fellow tribal men helped us a bit by sending us food and other things from Tank city. Political parties have not helped us as well.

Q. Is anybody fell ill in your household during living in camp?

-Yes, flu, cough and scabies are few big problems for us from last couple of days.

Q. Did you people are provided any medical treatment here?

- Not yet, Mobile clinic has still to come, it comes once a week and my grandson is suffering from fever since last five days.

Q. Why it comes only once a week or after two weeks?

Ans. 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 and medicines and security forces also want us to send it only once in a week due to security reasons.

Q. Did any NGO come for medical help?

-Yes they came but rarely and we cannot get any benefit from them.

Q. Why they came so rarely?

- Everyone is worried about security situation which is only a pretext. Situation around this IDPs camp is quite peaceful and they should come and provide us help. But security forces do not want anyone to lend us any help.

Q. Are you satisfied with medication provided?

-Yes, it is satisfactory.

Q. Did anyone died in your household during your stay in IDPs camp?

-No,

Q. Did any women have given birth to a child during living in this camp?

-No.

Q. I just knew that you and your family has suffered a lot during armed conflict and during living in this camp, would you like to let me know if anybody is suffering from mental stress in your household?

-Yes, my 10 years old son has become a victim of horrible dreams and is weeping all the time remembering his father and uncles. Me and my two daughters in law are unable to eat well and are victims of overthinking. My youngest daughter in law, whose husband was killed by security

forces just after three days of her marriage do not talk to anyone and is very weak physically due to eating disorder.

Q. Did you or anybody consulted with any psychiatrist to get rid of this mental stress?

- Psychiatrist is not needed. It is only an examination from God and we will be good once again. I have brought a mullet for my grandson and Daughter in law from *Molvi sahib*.

Q. What is biggest health issue in your household now?

-mental stress is biggest health issue in my household.

Q. What could be the most suitable way to get rid of this mental stress?

-If we get back to our hometown and security forces withdraw from our village.

Q. How getting back to home and withdrawal of security forces can get you out of this mental stress?

-Look, all these tensions are here because we are away from our hometown and security forces have forcefully captured South Waziristan. Unless they (Security Forces) move aside from our eyes, our wounds cannot be healed.

(THANK YOU VERY MUCH)

IDPs camp IDI3. (Women household head, 72 years)

Q. Tell me how you and your family arrived in this temporary accommodation?

-I along with my two grandchildren arrived first in Tank in our relative's house from Ladha but as soon as IDPs camp was established we shifted into it.

Q. Why did you stay in Tank and not gone further to other big cities?

-we are not accompanied by male family members and only have relatives in Tank.

Q. Did your all family dislocated together?

-yes I migrated along with my three grandchildren and that is what I was left with.

Q. You are 72 years old and taking care of two children as well, it would be very difficult for you. How do you manage it?

-Yes it was very hard but God has given me the strength to take care these two orphans. Besides, IDPs living near us cooks our food on daily basis and men also help us in illness and other difficult times.

Q. Do have any monthly income?

-No

Q. How do you manage your living?

-I sell out extra ration that I get from WFP almost up to 3000 rupees per month to manage my household living.

Q. Do you get food easily?

-No, getting food is very tough but every one gives me a favor because I am too old to wait for ration.

Q. did any among your Relatives, Friends, tribal men, political parties; host community helped you during displacement?

-Yes I got help from all peoples except political parties.

Q. Is anybody fell ill in your household?

-Yes, my both grandchildren are major thalassemia and they need blood infusions on regular basis.

Q. Did you get this facility available here?

- No, we take them to Tank hospital for blood transfusion.

Q. is it easy for you to take them to Hospital in Tank?

- It is extremely difficult for me due to security check posts who do not allow us to visit Tank. But mobile clinic staff is very cooperative and they took me with them to transfuse blood to my grandchildren.

Q. Did anyone died in your household due to this or any other reason during living in camp?

-Yes, my elder grandchildren died two months ago. He was a Major thalassemia as well and he died at age of 17. It is quite natural for them to die between ages of 15 to 20 years.

Q. I just knew that you and your family has suffered a lot during living in this camp, would you like to let me know if anybody is suffering from mental stress in your household?

-Yes, my both Grandchildren are very sad and talk very less because they have seen their elder sister died of the same disease. They are both near to 15 and are scared of death as they know they cannot live more than 18 years of age.

Q. Did you or anybody consulted with anyone to get rid of this mental stress?

- Yes, I have brought a Mullet for both of them from *Molvi sahib*.

Q. What is biggest health issue in your household now?

-What could be other than Thalassemia?

Q. What could be the most suitable option to solve this issue?

-I do not know much but if a small hospital is established near this camp, not only my grandchildren but many other people lives can be saved from death.

(THANK YOU VERY MUCH)

IDPs camp IDI 4. (Day laborer, 42 years)

Q. Tell me how you and your family arrived in this temporary accommodation.

-when armed conflict rose to highest peak, we flew down from mountains of Makeen to IDPs camp in Tank.

Q. Did your all family dislocated together?

-yes I migrated along with my three brothers families towards Tank.

Q. Do you all live together in this camp?

-No, we live separately.

Q. why do you live separately when you are one family?

-we were already agree to separate our families but due to local tribal culture (before death of elders it is impossible for his/her children to separate their households it was impossible for us but as we left Makeen, now we are separate and we are happy.

Q. what do you do and what is your monthly income?

-I am a laborer and earn 5000 per month.

Q. How it becomes possible to manage a household of 7 peoples with 5000 Rs?

- Food is already free and some help is also provided by local community.

Q. in what form this help is provided?

-it is mostly in cash but on festivals clothes, shoes and other used household articles like utensils and beds are offered also.

Q. did any among your Relatives, Friends, and fellow tribal men, political parties helped you during displacement?

-we do not need it as we can earn ourselves.

Q. Is anybody fell ill in your household during living in camp?

-Yes, cough, flu, fever and diarrhea is most common in our household. It is because camp environment is so dirty, water is not clean and sanitation is bad.

Q. Did you people get any medical help in camp?

- Yes, mobile health clinic visits us but its medication is useless.

Q. You told that medication is not effective, why is that?

-Yes, because they give us same medicine for all types of sicknesses. Only colored multivitamin and paracetamol is given, they don't bring any doctor and antibiotics.

Q. Who is providing this medication in mobile health clinic?

- Government of Pakistan is providing this facility.

Q. Did any NGO provide any health facilities?

-they provided at first when this camp was newly constructed, but after a few months they rarely came here. Their health facilities were very good.

Q. Did anyone died in your household due to any reason during living in this camp?

-Yes, my father died at age of 72 due to blockage of urinary tract. We have taken him to district hospital Tank as well but due to unavailability of medical facilities, he died soon.

(After condolence for his father, I continued interview)

Q. Did any women have given birth to a baby during living in this camp?

-Yes, my wife has given birth to a baby girl.

Q. Did you provide her antenatal care?

-It is not practiced in our family and elder women helps during delivery of child.

Q. Would you like to let me know if anybody is suffering from mental stress in your household?

-No one in our household is suffering from mental stress.

Q. What is biggest health issue in your household now?

-Nothing

(THANK YOU VERY MUCH)

IDPs camp IDI Transcripts 5. (Separated women household head, 52 years)

Q. Tell me how you and your family arrived in this temporary accommodation.

-military forcefully dislocated us from our home from Makeen during operation *Rah-e-Nijat*. We were sent here against our will and during displacement, we were not allowed to even take important household articles with us. At first, we lived in a hotel room with our adult daughters (very disgraceful in our community to live in absence of a male with adult daughter in a hotel) and when money was finished we literary came on the street asking people for help. Some good families took care of us and when camp was established, we rushed into it. It's being two years now living here.

Q. Why did you not stay with your relatives or friends?

-Our relatives and tribe is living in Afghanistan.

Q. Did your all family dislocated together?

-No, my husband is in Afghanistan with his 2nd wife and my sons are died. Rest of the family that is consisted of my grandchildren and my daughter in law came along with me.

Q. Do you all live together in this camp?

-yes, we live together.

Q. Do you have any monthly income?

-we do not have any income and we live on *Zakat and Khairat* given to us by nearby host community.

Q. How it becomes possible to manage a household of 7 peoples with only *Zakat and Khairat* because it would be a very less amount to live with?

-we try and God fulfill our desires within this small amount.

Q. Did any among your Relatives, Friends, and fellow tribesmen, political parties helped you during displacement?

-Our relatives, friends and people of our tribe are mostly in Afghanistan. Only host community is trying to help us other than WFP ration.

Q. Is anybody fell ill in your household during your stay in camp?

-Yes, my daughter in law is suffering from bleeding per vagina (this sign was extracted by me from her conversation as she was hesitating)

Q. Did you get her any medical help?

- Yes, we visited mobile health clinic but LHV is not able to diagnose the problem. She has promised that she will discuss this case with lady doctor and will bring medicine for my daughter in law soon.

Q. Why do not you go to Tank and show her to lady doctor yourself?

- We don't have any male member with us who can take her to Tank. Without permission of her father in law, we cannot take her to Tank. It is against our culture.

Q. Did anyone died in your household due to any reason during living in this camp?

-no

Q. Did any baby is born in your household during stay here in camp?

-Yes, my grandchild is born.

Q. Was any doctor or TBA present during delivery?

-No, I helped her deliver the baby.

Q. Did you provide her any antenatal or post natal care?

-No, she does not need it. It is not practiced in our tribe.

Q. Did anybody is suffering from mental stress in your household?

-Yes, I am very worried about our sheep and goats that we have left to our neighbors in Afghanistan and cannot sleep well due to this worry. My daughter in law is eating very less due to murder of her husband.

Q. Did you or anybody consulted with any psychiatrist to get rid of this mental stress?

- We are not familiar with psychiatrist nor need his help. I have brought a Mullet for my daughter in law from *Molvi sahib* and it is better for us.

Q. What is biggest health issue in your household now?

-mental stress is biggest health issue in my household.

Q. What could be the most suitable way to get rid of this mental stress?

-If we get back to our hometown, this issue will be solved.

Q. how?

- I will remarry my Daughter in law with my nephew and will take care of my sheep myself. It will result in more money and happiness. Moreover, environment will be pleasant and calm which will improve our health.

(THANK YOU VERY MUCH)

Host Community IDI 6. (Unemployed, 42 years)

Q. How did you settle in this locality/*Mohallah* in Tank?

-During conflict, we flee from Sararogha and joined our relatives for few days in Tank. Soon we found a house and rented it. Now we are living since 2 years in this *Mohallah* Mehsudan.

Q. Why did you settled in Tank? I mean D.I.Khan and many other big cities like Peshawar are equipped with so many facilities?

- We settled here because we have got support from our relatives and moreover, at the end of conflict it would be easy to go back from here as compared to other cities because it is nearest to South Waziristan. Besides, we are also familiar with Tank and many times visited it for the sake of medical treatment.

Q. Did your all family move here together?

- Yes

Q. What is your total monthly income? Means to say in cities life is expensive and you need more money to survive as compared to village?

-my monthly income is 30000 and we are easily managing it. Food is provided by WFP and our relatives and neighbors help us a lot. Life is quite easy here for us.

Q. Did any among your Relatives, Friends, and tribal men, political parties helped you during displacement?

-Our relatives and friends and fellow tribe all helped us. Especially host community helped us a lot.

Q. Did anybody fell sick or got injured in your household during your stay in this house?

-Yes, my Daughter in law broke her leg last month by falling from the stairs.

Q. Did she have any treatment for it?

-Yes she was taken to a private hospital where an iron rod was fixed to her neck of femur. She is quite well now.

Q. Who paid for the treatment?

-Myself.

Q. Why she was not taken to the public hospital in Tank?

-Because treatment is not good there and I cannot suffer my daughter in law in pain.

Did anybody died in your household during your stay here in this house?

-No,

Q. Did any baby is born here?

-Yes,

Q. Did any Doctor or TBA was present during delivery?

-Yes, the baby was delivered in Hospital in presence of a lady doctor. Moreover, I ensured regular checkup of my Daughter in law before and after delivery as well.

Q. Did anybody is suffering from mental stress in your household?

-Yes, my daughter in law is suffering from anxiety and bad dreams because her husband was killed by security forces.

Q. Did you or anybody consulted with any psychiatrist to get rid of this anxiety and bad dreams?

- No, I will show her once my son get back from Dubai as we have no male present at home. I have brought a mullet for my daughter in law from *Molvi sahib* but it is not working.

Q. What is biggest health issue in your household now?

-mental stress is biggest health issue in my household.

Q. What could be the most suitable way to get rid of this mental stress?

-If we take her to Psychiatrist for proper diagnosis.

(THANK YOU VERY MUCH)

IDI7 HOST COMMUNITY (Shop owner, 35 years)

Q. How did you settle in this locality/*Mohallah* in Tank?

-During conflict, we flee from Preghal and joined our relatives in Tank and they have given us three rooms to live. Now we are living since 2 years in this *Mohallah* Qasaban.

Q. Why did you settled in Tank?

- We settled here because we have got free residence from our relatives. Even in fact, we were trying since few years to settle here in Tank for better education of our children but were unable because according to our customs and values, we cannot separate from my brothers before death of household head (my father).

Q. Did your all family move here together?

- Yes we moved as an extended family

Q. you are living in the same extended family system in this house?

-No, we have split the family and my brothers are living separately because houses here are small I Tank and we cannot manage extended family anymore.

Q. What is your total monthly income? Means to say in cities life is expensive and you need more money to survive as compared to village?

-my monthly income is 20000 and we are leading a happy life. Food is provided by WFP and our relatives and neighbors help us a lot. Life is quite easy here for us.

Q. Did any among your Relatives, Friends, and fellow tribal men, political parties helped you during displacement?

-Our relatives and especially host community helped us a lot. Others are ready to help as well but we cannot accept it because we do not need it.

Q. Did you take any ration from WFP?

-No, it is only for poor people we can manage our ration on our own.

Q. Did anybody fell sick in your household during your stay in this house?

-Yes, cough and fever is common here because Tank is muddy and dusty, but our real health issue is of my mother cardiac problem.

Q. Is she provided with any cardiac treatment?

-Yes we frequently take her to D.I.Khan and she is quite well.

Q. Who paid for the treatment?

-Myself.

Q. Why she was not taken to the public hospital in Tank?

-Because treatment is available for heart related problems here. Tank hospital is too crowded with patients and medicines and laboratory facilities are not good as well.

Did anybody died in your household during your stay here in this house?

-No,

Q. Did any baby is born here?

-Yes,

Q. Did any Doctor or TBA was present during delivery?

-Yes, the baby was delivered in home in presence of a TBA. Moreover, I ensured regular checkup of my Daughter in law before and after delivery as well.

Q. Did anybody is suffering from mental stress in your household?

-Yes, my mother is so sad and thinks a lot about our village and home in Preghal Mountain.

Q. Did you or anybody consulted anyone about this over thinking?

- No, we help her to forget about it by giving her more time and concentration and she is getting better.

Q. What is biggest health issue in your household now?

-My mother's heart problem.

Q. What could be the most suitable way to solve this health issue?

-You know heart problems needs to be treated with patience and we are trying our best but it could be better to have a small center of cardiology so that heart patients could be treated at Tank.

(THANK YOU VERY MUCH)

IDI8 HOST COMMUNITY (Hotel entrepreneur, 45 years)

Q. How did you settle in this locality/*Mohallah* in Tank?

-when security forces occupied our village, we flee from Makeen to IDP camp in Kot Azam, Tank. But very soon just after two days, we left camp because we settled in Tank city and from that time we are residing here in our relative's house.

Q. Why did you left IPDs camp and settled in relative's house?

- Camp was full of problems. It was crowded, no purdah system, water and sanitation problem was there as well and most of all we were bound to live in a tent.

Q. Is there any problem to live in a tent?

- Yes, it is below our standard because in our area homeless nomads and people without any tribal recognition like '*Damoon or Workee*' (Drum beaters and Dancers) live in tents. We stayed in our relative's home because they have a big house and they have emptied 4 rooms for us to live.

Q. What is your total monthly income? Means to say in cities life is expensive and you need more money to survive as compared to village?

-my monthly income is 25000 and we are easily managing it. Our relatives help us a lot because they are very rich. Life is quite easy here for us.

Q. Did any among your, Friends, tribal men, political parties helped you during displacement?

- They have offered us but we don't need it..

Q. Did you receive any ration from WFP?

-No, it is only for poor people we can manage our ration on our own.

Q. Did anybody fell sick in your household during your stay in this house?

-Yes, Cough, fever and scabies is common in our home.

Q. Did you have any treatment for it?

-Yes we frequently pay visits to nearby private clinic.

Q. Who paid for the treatment?

-Myself.

Q. Why don't you paid a visit to public hospital in Tank?

-Because it is too crowded and facilities are very few.

Did anybody died in your household during your stay here in this house?

-No,

Q. Did any baby is born here?

-No,

Q. Did anybody is suffering from mental stress in your household?

-No,

Q. What is biggest health issue in your household now?

-There is no health issue in my household.

(THANK YOU VERY MUCH)