Gender, communication and health inequality in a Nigerian IDP camp

Abigail Izang Ambi

Linguistics & English Language

Lancaster University

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Abigail Izang Ambi

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Abstract

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Abigail Izang Ambi

This dissertation explores the communication dynamics between internally displaced persons (IDPs) and medical practitioners (MPs) in a Nigerian IDP camp, focusing on health inequality and communication barriers. Using a critical sociolinguistic ethnographic approach, it examines multilingualism, the use of interpreters, and factors contributing to health communication challenges. The study emphasizes the importance of understanding the socio-political context, lived experiences, and perceptions of IDPs to interpret health communication issues effectively.

Conducted from January 2021 to February 2023, the research involved observations, field notes, interviews, and focus groups with 11 female IDP patients and 3 medical practitioners. Five key findings emerged: First, medical interactions in the camp primarily occur in Hausa or English, creating comprehension difficulties due to the lack of indigenous language equivalents for medical terms. Second, language diversity often requires interpreters, but the absence of professional medical interpreters leads to reliance on inadequately skilled individuals. Third, gender differences, lack of privacy, and fear of reprimand prevent IDP patients from disclosing vital health information. Fourth, patient needs, such as relational aspects of care, remain unmet due to limited medical staff, time constraints, and patient resistance. Fifth, cultural beliefs, illiteracy, and a lack of voice hinder effective communication, especially for women.

The study suggests several implications: creating indigenous health terminologies, establishing professional interpreting services, educating MPs on effective communication with IDPs, incorporating communication training in medical education, ensuring gender-sensitive care, improving privacy in consultations, and addressing health literacy and equality for IDPs. These recommendations aim to improve healthcare access and reduce health disparities in the camp.

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Abigail Izang Ambi

Declaration

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the text.

It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the Lancaster University or any other University or similar institution except as specified in the text. I further state that no substantial part of my dissertation has already been submitted, or is being concurrently submitted for any such degree, diploma or other qualification at the Lancaster University or any other University or similar institution.

It does not exceed the prescribed word limit for the relevant Degree Committee.

Preface

My decision to focus on MPs-IDP-patient interactions in a Nigerian IDP camp for my dissertation research was partly influenced by some personal experiences. It all began in early 2011 few months into matrimony; I visited my husband in Jos Plateau State from Keffi- local government area of Nasarawa State where I work. After spending the weekend, I decided to return to Keffi the following Monday; on my way back, tragedy stroke. On arriving Mararaban Jama'a -Jos South local government area of Plateau State, protesters -mostly women and youths all in black clothing- had blocked the Jos-Abuja express road. Before the main round about where four connecting road meets leading to Barkin Ladi, Jos South, Jos city center and yet another road that takes you out of the State (to Kaduna, Nasarawa and Abuja) from where protesters emanate from. There was a security check point which is still there (at the time of compiling this report) but considering it began like a peaceful protest by women, children and youths over the massacre of an entire family in their community days before the incident and for previous massive killings by 'unknown gunmen' in the community, there was nothing the security personnel could do at that moment. Considering also there was no forewarning for the security personnel or any one, most people realized too late after they had driven into the protest like we did. Before I could realize what was going on, I and other passers-by were in the midst of these provoked youths and women; one thing led to another and a reprisal attack began on innocent travellers arriving or departing the state. This eye witness account left a terrible experience of what insecurity, crises and killings does to the minds of people on the Plateau, Nigeria and indeed Sub-Saharan Africa and the world at large.

I witnessed human beings butchered, machete and beaten without remorse, just because they were of different religious background and cultural beliefs, it immediately send fear and confusion to my very being. I began to vomit and instantly became sick on the sight of human blood. The attack went on for about two hours and within those times we kept running for our lives before the intervention of security personnel (military) which paved way for us to return to the city center. I recall this security officer (I later found out is a military Doctor) in mufti whom I helped; he was among the passers-by we ran into during the attack; he is from the south and speaks and understand only English and Yoruba and had just been posted to Jos. Some hoodlums among the protesters wanted to take advantage of the situation by offering to

show him another route to Abuja. I sensed the danger and offered to help. I had to interpret all that was going on because the protesters spoke in Hausa and their dialects mainly and because they were largely from the rural centers. What would have been the fate of this officer if there was no honest interpreter at that point in time I often wonder? To show appreciation, I and some passengers were escorted back to Jos by that military officer I offered help. I could not travel till the following day after recovering from the shock of the attack. It was a near death experience and this could have happened to anyone -the innocent people murdered; the lynching- etc. I kept thinking of this very experience for years and each time there is an attack which is ongoing, like the most recent in December of 2023 “the Christmas eve massacre” at Bokkos L.G.A. (Local Government Area) of Plateau State and the ongoing killings (2024) at Mangu L.G.A., I question myself about the fate of the survivors, what they go through and what condition they are often left in: mentally, psychologically, health wise and otherwise. This personal experience and the ongoing attacks and killings in Plateau State and most states in Nigeria leading to internal displacement in Nigeria and indeed most African countries partly informed my decision to focus on investigating health communication barrier in MPs-IDPs interaction and challenges women face in access to healthcare in a Nigerian IDP camp for my research.

CHAPTER ONE

1 INTRODUCTION

1.1. Introduction

This study investigates multilingual health communication practices of Internally Displaced Persons' (IDPs) residing at an IDP camp in north-central Nigeria. It investigates health communication barriers and challenges women face in access to healthcare at the camp. This research was partly motivated by the sudden spread of communicable diseases in IDP camps across Sub-Saharan African countries (Lam et al., 2015; Owoaje et al., 2016; Roberts et al., 2012), and a rise in the number of internally displaced persons globally. On a global scale, in 2020, an estimated 9.8 million new incidents of conflict-driven internal displacements were recorded (IDMC 2021). By the end of that year, UNHCR recorded a global population of 48 million people who had fled conflict and violence which is almost twice the population of refugees (26.4 million) (2021). This is only partially explained by the influence of COVID-19 during 2020 which had a significant reduction in refugee flow (UNHCR 2021). At the end of 2023, in Nigeria around 3.3million people were living in displacement camps as a result of conflict and violence, half of the population lives in Borno state. Nigeria is still among the ten countries with the largest number of IDPs globally (IDMC 2024). This result is also supported by the Global Internal Displacement Database (GIDD).

Nigeria has 309 camps and camps-like settings and 60 % of IDPs live in 2, 072 host communities (Dyvik, 2025). The total number of IDPs due to conflict worldwide in 2023 by countries (in 1,000s) from highest to the least are: Sudan (9,053), Syria (7,248), and the Democratic of Congo (DRC) (6,734), Colombia (5, 077), Yemen (4, 516) followed by Afghanistan (4187), Somalia (3,862), Ukraine (3,689) then Nigeria at number 9 with a displacement population of 3, 340 and Ethiopia (2,852).

In Nigeria and in most low- and middle- income countries (LMICs) at present, IDPs from different geographical, social, ethnic, and cultural backgrounds experience fundamental challenges in accessing healthcare services (Lam et al., 2015; Obiefuna & Adams, 2021;

Owoaje et al., 2016). In particular, this affects the most vulnerable groups of displaced persons: women with low literacy levels, speakers who lack knowledge of a local Lingua Franca, and children.

The research setting is an IDP camp in Barkin Ladi Local Government Area of Plateau State - Nigeria which serves as a 'temporary shelter' for IDPs[1]. The term internal displacement refers to an old phenomenon which existed from world -wars to date. "Around the globe, millions of people are forced from their homes by a spreading of a rash of state breakdowns and wars, and other violent disorders, with no assured access to international humanitarian relief and even less prospect of international protection from the worst sorts of abuses" (Weiss and Korn 2006, p. 11). These 'temporary' shelters frequently become comm2munities where IDPs live for a number of years. IDP camps are typically created by governmental bodies or non-governmental organizations (NGOs) as part of proactive steps to provide basic necessities (such as food, shelter, health care and security) to internally displaced persons. IDPs are by law protected and cared for by the government of the state where they reside and, the national commission for refugees, migrants, and internally displaced persons (NCFRM)/ UNHCR assist IDPs through their national government to find their rights and find a safe place to call home by partnering with other UN agencies to ensure that IDPs are protected and supported. In reality, this results in underfunded camps, very limited healthcare provisions, as well as inadequate housing.

Sub-Saharan African countries and in particular Nigeria have witnessed a recent increase in the population of internally displaced persons (Hampton 2014; Owoaje et al., 2016; UNHCR 2021) that is ongoing (e.g., see Saminu et al., 2023). Research on this phenomenon has centered mostly on the political and historical aspects (Adesote and Peter 2015; Omotola 2010), but little is known about the effectiveness and accessibility of specific provisions for this vulnerable population, especially in relation to communication barriers that limit access to healthcare or make access virtually impossible. In particular, there exists a gap in research that explores the relation between health disparities and gender inequality in relation to the larger social inequalities this relationship is indicative of. Further, to date there is only limited research on the factors that inform language choice in medical encounters experienced by

[1] An IDP is a person who is uprooted or forced out of his/her home by man-made causes or natural disasters but remains within their country's border and is provided temporary shelter in an IDP camp.

extremely vulnerable populations within multilingual settings. In an attempt to bridge this gap, this research proposes to first, document language practices and identify high-stakes conversations like in medical consultations (between IDPs & Medical Practitioners[2]') in moments when communication matters. Second through transcripts from audio recordings of interviews, interactions and observations, I will identify when and how barriers emerge for women and what groups (linguistic, cultural, ethnic & social class) are disproportionately affected. Third, I will suggest measures to address these barriers.

This study shall be limited in scope to the study of a single-sited ethnography (Bowie, 2009; Gielis, 2011). This research is based on ethnographic work on health communication using; the concept of -Talk, Work and Institutional Order- by Sarangi and Roberts (1999), as well as Heller et al.'s (2017) -Critical Ethnographic Sociolinguistic approach to investigate how health inequality, gender, and structural inequalities create communication barriers when accessing healthcare. This study will be contributing to the (linguistic) communicative aspect of fundamental social causes of health inequalities of an IDP group. It will also contribute to the literature in the following ways: First, I will provide a descriptive account from semi-structured interviews and observational data of the health challenges of women IDPs surrounding gynecological issues during medical consultations. Second, I will delineate the different health inequalities in the IDP camp and their impact on health communication. In other words, further investigation can reveal or identify risk factors for major disease (such as gynaecological diseases). There are two reasons for this claim. First, I argue that individually-based risks factors must be contextualized, by examining what puts each patient at risk of (re-)infection –or not- in order to craft effective interventions and improve or address the health challenges of IDPs. Second, I argue that inequality and social factors such as socio-economic status (see Table 1 for participants' demographic profile) particularly, lack of access to formal education and language barrier are likely "fundamental causes" of disease, because they embody access to important resources and consequently affect health and health outcomes. Third, based on ethnographic studies on social action (Gordon 1993; Rampton, 2010; Sanday, 1992; Wolf, 2012), I will then use the ethnographic data collected, to identify and suggest measures to address findings.

[2]Medical practitioners (MPs) are a group of trained medical professionals consisting of medical Doctors, Nurses, Pharmacists, nutritionists and psychotherapists who work as a team to provide healthcare for IDPs.

Based on these propositions therefore, the underlying questions this research intends to answer include: what are the effects of multilingualism on the health communication of Internally Displaced Persons (IDPs) –particularly, what role does gender and disparity play in the health interaction of women-IDPs surrounding gynaecological issues? This research argues that to know the causes of health communication barriesr in such settings, the socio-political context of those displaced, their lived experiences and narratives must be understood. So, the first argument is that, the perception of the IDPs in relation to that of the researcher's findings (through observation) are relevant in understanding and interpreting prevailing issues. Second, this research argues in tandem with a number of studies on multilingual health communication practices which emphasise the lack of competence of patients in the language of consultation (often selected by countries) due to illiteracy, migration status or other factors such as prestige given to some languages over others and the exclusion of minority languages in multilingual settings (De Wild et al., 2018; Khadidja 2017; Sobane 2012). The assumption by traditional linguistic anthropologists and sociolinguists of some degree of shared understanding of social linguistic norms in multilingual communities (Mortesen 2017) and the influence of Western –based communicative practices on the health communication of non-western countries, e.g., in East Asia (Pun et al., 2018) have been identified as some of the barriers to effective multilingual health communication.

Reports exist in support of language choice in multilingual health information sharing, for example Sobane (2012) recommends a more inclusive approach –which involves the use of minority languages- as a way to improve behavioural change in communication about HIV/AIDS by bringing more awareness to the people of Lesotho. Similarly, Pun et al., (2018) identify the need for a specific culturally –appropriate model of health communication in East Asia to meet the communicative need of both professionals and their patients. Subsequently, questioning the assumption that shared understanding of social linguistic norms in transient communities may not be in place a priori (Mortesen 2018) but investigating those contextual differences and similarities therein. There is a need therefore to examine the social and linguistic processes that characterise transient communities as well as identify them through analyses and theorise a meaning making at the interface of sociolinguistics and linguistic anthropology (ibid 2018).

As a result of these overriding causes of a (health) communication gap in multilingual settings, this research argues in line with Mortesen (ibid) that transient communities are a

field of investigation with challenges and opportunities that could enrich the field of sociolinguistics and linguistic anthropology. Unlike Mortesen however, this research is limited to interpreting and discussing the notion of similarities and shared linguistic communicative challenges or difficulties women living in a displaced persons' camp (a transient multilingual community) who are affected by gender, power and privileges face. Here, I argue that gender, cultural diversity and beliefs in this context could lead to miscommunication or create communication gap. Finally, I argue that social inequality, socio-economic status of the displaced, corruption, political affiliations, and language choice and/ or gender consideration in providing health care are major factors and challenges of communication barriers at the IDP camp.

This research employs a critical ethnographic approach to interpret and explain these three factors in relation to the barriers in health communication of IDPs for effective health care. Drawing from the first argument, the perceptions of participants were sought and identified on how to improve the health needs of women IDPs. Furthermore, to understand the perception of both participants- IDPs and MPs- on the role gender plays in health communication, an insight into the Nigerian Medical Association (NMA)-gender ratio and conditions for participation as humanitarian aid workers are investigated alongside other factors that may discourage female professionals to volunteer in the provision of health care of IDPs.

1.2. Historical account of displacement, causes and effects

Insecurity and insurgency among other man made causes such as using terror as a political tool are the major causes of displacement in Nigeria (Gabrielle, 2012; Hickey 1984; Human Rights Watch 2012; Iyekekpolo, 2014, 2016; Mohammed, 2017). Adesoji, (2011), Brinkel et al., (2012), Danjibo (2010), Okoraofor et al., (2015) and Salaam (2012) argue that 'economic greed, hardship,' 'grievance', 'extreme religious ideology and political opportunity' fuel insecurity and challenges experienced in Northern Nigeria. The interplay of aforementioned factors by Boko Haram insurgency and the Fulani herdsmen–farmers crises are among the major causes of displacement of people, loss of lives and property in Nigeria. Although political opportunity ignited their onsets (Iyekekpolo, 2014**)**, unemployment and poverty also act as sources and consequences of insecurity in the country[3] (Capta, 1990; Collier et al., 1998; Islahi, 2008; Ordu, 2017; Solomon, 2015); as a result, the state's response to insurgencies in Nigeria has been a major challenge.

The exact date Boko Haram emerged has remained a subject of speculation but the sect was largely a low profile movement until the emergence of Mohammed Yusuf in 2002 whose death led to a new leadership under Abubakar Shekau (Blanquart et al 2012; Femi, 2013; Theo et al., 2012). Approximately, Boko Haram insurgency dates 2-3 decades ago with major attacks in the northern states of Nigeria.

Boko Haram evolved from a non-violent group professing hatred for Western cultures and values to a violent sect thus becoming a major threat to the security of the country (Abimbola et al, 2012; Gabrielle, 2012; de Montclos, 2014; Walker, 2012). It has been involved in series of terrorist acts which include the bombing of places of worship particularly the Church; motor parks, police stations, markets, military barracks, and abduction of school children (Adebiyi, 2015; Aloieuwa, 2017; Reinert et al., 2014; Iyekekpolo, 2016). Some of these bombings include the 2011 Christmas day attack on St. Theresa Catholic Church in Madalla, Suleija (a satellite town of Abuja located 40 km from the city centre); the abduction of 276 girls from a secondary boarding school in Chibok, Borno State on April 14, 2014 among other acts (Aloieuwa et al., 2017). Among the documented and publicised attacks are those on the United Nation building in Abuja, the Federal Capital Territory (killing 23 people); the Nyanya motor park in Abuja-FCT-killing over 102 people-; the Nigerian police headquarters

[3] Among these insecurities is that perpetuated by the sect, Boko Haram, an alias given to j'ama'at Ahl us-Sunnah li''d' wah wal Jihad;' the name Boko Haram is a compound name comprising both Hausa and Arabic languages. Boko in Hausa means 'Western education' while 'Haram' means 'sinful or forbidden' in Arabic (Ayigba 2015). So 'Haram' is appended to 'Boko' to mean 'Western education is sinful'.

in Abuja and in recent years, the bombings on NDA barracks in Kaduna, Nigeria (Anyebe, 2014; Okoroafor et al., 2015; Onuoha, 2014; Iyekekpolo, 2016) and the Kuje (maximum) prison jail-break at Abuja, the Federal Capital Territory, on the 6th of July, 2022 where inmates including captured members of the Boko Haram sect were freed. The Islamic State in West Africa Province ISWAP claimed responsibility for the attack on Kuje Prison (The Punch, pungng.com accessed 6th July, 2022). With the most recent Christmas Eve attack of 2023 in Bokkos, Barkin Ladi and Mangu local government areas of Plateau state (https://www.premiumtimesng.com) by Fulani herdsmen where over a hundred and forty-eight people were killed in Bokkos and many were displaced (www.france24.com).

Their strategies and/ or weapon of choice include the use of female suicide bombers in a number of suicide attacks; machete, guns and improvised explosives devices (IED) to attack diverse public locations (Kyari, 2014; Ordu, 2017; Iyekekpolo, 2016; Mohammed, 2014). They pledged allegiance to terror –groups like al-Qaeda and the Islamic State and have evolved from using guerrilla tactics which saw its operation from the Sambisa forest, to capturing of territories in similar fashion to Islamic State **(**Adebiyi, 2015; Anyebe, 2014). Although the Nigerian military recaptured some of these territories in 2015, (Adebiyi, 2015), recent Fulani herdsmen-farmers crises mostly perpetuated in northern Nigeria are argued to be one of Boko Haram's tactics to attack and kidnap innocent people as their victims **(**Aremu, 2011; Ordu, 2017; Reinert et al., 2014**)**.

A report from the UN refugee agency put the total number of people killed by Boko Haram attacks as at 2015 to fifteen thousand (15, 000) with a countless number of others including women and children targeted for diverse forms of abuse, including sexual enslavement (Adesoji, 2011; Agbiboa, 2013; Chouin, et al 2017). The internal displacement monitoring centre puts Boko Haram displaced persons at 1,538, 982 as of April 2015 (Agbiboa, 2013); while UNICEF puts the number of children among them at 800,000 (UN children's fund 2015; Aghedo, 2014). Thus, pointing the group's target on the most vulnerable population-women and children. The humanitarian system remains somewhat tolerant of irregular and inaccurate estimates of population size and -composition (Diggle et al., 2017; Checchi et al. 2020). Despite using standard approaches, humanitarian efforts to estimate IDP populations – for istance in in Burkina Faso, Cameroon, Syria or Yemen – are likely affected by inaccuracies in population estimation (Diggle et al., 2017; Bowden et al., 2012). Persistent insecurity may trigger repeated movements whereby movements of IDPs become difficult to

trace and measure (Andrè 2020). In that sense, assessments that are based on surveying IDP populations and their demographic characteristics may be inaccurate.

By the end of 2020, the United Nations High commissioner for refugees (UNHCR) estimated that 82.4 million persons were forcibly displaced globally that year, 48 million of whom were IDPs (UNHCR, 2021). The question therefore is how (do) government and humanitarian organizations approach the estimatation of IDPs? For instance, estimating IDP populations during armed conflicts is particularly challenging given that estimations need to be equally dynamic and systematic to capture population influx (Abdelmagid & Checchi 2018; Checchi et al., 2017). Insecurity can render data collection efforts risky and humanitarian access can be severely restricted in chaotic contexts as described in research on IDPs in Northern Nigeria and Anglophone areas of Cameroon (Andrè 2020). IDPs may be displaced multiple times and there is usually great uncertainty as to when and if ever they can go back to their home communities. Most frequently, IDPs take up residence in either the new host community and remain in or near the camp or move on to larger urban centres where there are more economic opportunities, in particular for men (Spiegel et al., 2010). In addition, many IDPs remain hidden and without access to humanitarian assistance and healthcare, fearing retributions, for instance within their host communities. In this sense, trajectories of IDPs are neither linear nor straightforward and as such it remains exceptionally hard to follow their movements.

Estimation of IDP population flows from one locality to another and forecasting of IDP population sizes and destinations have also been made (Checchi & Koum Besson, 2022; Huynhand & Basu, 2020). These efforts are reliant on the availability of repeated satellite images, expertise in statistics and modeling, and time for rigorous analysis (Global Health Cluster 2018; Checchi et al., 2013).

For instance, in 2020, the International Organization for Migration (IOM) initiated a displacement tracking matrix (DTM) program to track such events through key informants (International Organization for Migration, IOM, 2021). Exemplarily, in their research of IDPs in Yemen, Checchi et al., (2022) highlight discrepancies between data from the Displacement Tracking Matrix (DTM) and the United Nations – in this case data from the DTM was five times higher than UN estimates at the time.

Historians like Agbiboa and Azumah (2013 & 2015) have traced this turn of insurgency in northern Nigeria to the 1804 Uthman dan Fodio led jihad of Sokoto State (for further

argument on this theory see Gérard et al 2014; Hickey, 1984 Hiskeitt, 1987) and maitatsine sect led by Muhammed Marwa (a Cameroonian residing at Kano) at Kano State in the 70's which ended after the sect was overwhelmed by the Nigerian security forces in the early 1980s (Paul et al., 2004). Insurgent leaders in northern Nigeria from the days of Uthman Dan Fodio to the present day Boko Haram have sought to espouse conditions in society (i.e., economic hardship) in their justification of and recruitment for insurgency. The maitatsine sects like that of dan Fodio's era were poor and could easily fall prey to any semblance of economic justice (James et al., 2003). It is worthy to note that these five decades old attacks on the northern region have led to depopulation, displacement, as a result creating more poverty, unstable government, orphans who are out of school and more widows. Ironically empowering the sects now turned insurgents or terrorists fighting innocent citizens as against the initial goals to improve the conditions in Nigerian societies.

Research projects on insurgency tend to focus more on the extreme acts of violence perpetrated by the Boko Haram sect and the Fulani herdsmen-farmers crises than on the aftermath or effect of displacement on the survivors (e.g., Iyekekpolo, 2016; Weeratne 2017). While in no way overlooking the relevance of these works, it is important to know the effect of displacement as a result of these attacks, the level of recovery and or rehabilitation of those displaced.

In addition, most displacement studies focus mainly on the needs, social determinants of health, and conflict effects, particularly in refugee settings. In contrast, studies on camp management *and health communication* are generally limited. And those specifically from the perspective of IDPs are lacking (Rass et al., 2020; Blanchet et al., 2017; Ekezie et al., 2020). Considering the complexity of protracted displacement in most IDP situations, the lack of evidence on IDP internal health communication management structures and systems highlights a critical gap in humanitarian crisis management particularly, in multilingual contexts.

1.3. Displacement, poverty and inequality in Sub-Saharan Africa

In the vast majority of Sub-Saharan countries, "poverty -measured in economic terms as well as in terms of access to health and education – is concentrated in rural areas" (Delfin et al., 2007 p.19). Six decades after attaining independence in most African nations Sub-Saharan

African countries face regional poverty with million people living below the poverty line (Ali, 2001; Johnson & Robinson 2004; Caridad et al., 2004; Artadi & Sala-i-Martin 2003; Chen & Ravallion 2004; Cantor, et al.). Poverty in Sub-Saharan Africa has not only become more widespread but also much deeper when compared to the rest of the world Chen and Ravallion (2004) point out, redistribution towards the poor will not only require higher levels of growth to lift people out of poverty, but also developing policies that address the problem of acute and pervasive income and consumption inequality.

The magnitude, persistence, and depth of poverty and inequality in Sub-Saharan Africa calls for a closer look at the evolution of poverty and inequality (Delfin et al., 2007). Studies also observe the wide gap in rural-urban inequality and poverty level; with girls-to-boys primary enrolment ratios lower in the rural areas (Sahn & Stifel 2003).

Economic growth is important to poverty reduction (Delfin et al, 2007). However, amidst insecurity and displacement, economic growth has become a greater challenge in most Sub-Saharan African countries. Thus, the danger of displacement has increased the poverty indices in the continent. The socio-economic status of citizenry plays a significant role in their survival in case of displacement, disparity and in surviving economic meltdown in the African continent.

1.3.1. Voice, inequality and resistance in medical settings

Here, voice is defined (Following Hymes, 1996) in general as the ways in which people manage to make them-selves understood or fail to do so. The capacity to make oneself understood, I argue, is a capacity to accomplish desired functions through language. In other words, the capacity to create favorable conditions for a desired uptake: mobilizing ones information (denotation-ally) adequate, and in a contextually appropriate way. But such capacity is not self-evident, for this capacity although creativity is subject to several conditions and constraints. Hence we need to find an analytic way to see voice at work and relate it to a larger pattern of inequality.

The issue of voice is an important social issue, and a linguistic description of what goes on in interaction will not suffice to produce an analysis of voice. It is about function, and function is affected by the social values- in a political and economic sense has attributed to particular linguistic resources. Linguistic form, “as conventionally understood, is often amenable to

description and categorization, and hence relevant in the first stage of analysis. However, there are subtler elements in talk that are often much more important to a social analysis, such as the fact that people speak in different voices" (Heller et al, 2017 p. 143). People are complex social agents who adapt different voices; although the nature of an activity plays a major role in distributing roles or turns at talk. We will see below that 'voices can be both mapped and also be treated as traces of wider processes' (cf. ibid 2017 p. 143). There is also access to meta-commentary. As people talk, whether to each other, they often signal in a variety of ways what they think about what people are saying or doing (including themselves). Whether this may be explicit or implicit, people might sigh, hesitate, reformulate, laugh or comment indirectly.

Looking at the field of intercultural communication which has navigated in great detail the challenges that come about when individuals from one particular cultural background interact with individuals from another, a focus on temporary shelters/displaced people camp emphasizes processes of mutual socialization in which members negotiate sociolinguistic norms not just to get along and accomplish goals but also as a way of enacting membership in social configurations that are emergent and temporarily bounded. How to enact membership and collaborate successfully across sociocultural and linguistic boundaries in such settings characterized by transience arguably constitutes a central challenge for many displaced individuals, as evidenced by the massive increase in the population of displaced persons in recent years. Of course, the problems related to displacement cannot and should not be reduced to matters of lingua-cultural difference alone, but the use of language undeniably plays a central role in all processes involved in the large scale provision of shelter for displaced persons; from the day-to-day interaction in the camp to medical interactions taking place at the camp's clinic with medical professionals. In all these contexts, people from diverse backgrounds regularly find themselves in situations where they have to negotiate solutions to shared problems without being able to rely on extensive shared linguistic experience or sociocultural habit. Although navigating and interacting in such settings is obviously not an impossible task, however, it is certainly not straightforward either. For that reason, social configurations characterized by transient IDP camps call for the attention of sociolinguists, ethnographers, linguistic anthropologists and scholars from complementary fields in order to build a better understanding of how such communities are formed (or structured), managed, and (de)stabilized, what their main challenges and potentials are, and

how we can help these marginalized populations facilitate processes of reinstatement that are seen as beneficial by those displaced.

Aside the practical problems that members in multilingual IDP camps may face, the empirical phenomenon of transient camps also presents a theoretical challenge for sociolinguists and ethnographers- or perhaps rather a welcome opportunity to (re)consider how to account for sociolinguistic processes in contexts where norms of language use and social interactions are under negotiation in some fundamental ways. This challenge is related to one of the focuses of recent sociolinguistic research devoted to conditions of *super-diversity*, linked both to speaker mobility and to the multiplication of channels and media of communication (see, e.g., Budach & de Saint Georges 2017; Muth & Suryanarayan 2020). Thus, this research presents a discussion of how the notion of transient community of IDPs may be utilized in a research agenda that aims to describe and theorize social change or inequality and linguistic barriers caused by diversity in an integrative manner.

The multilingual transient community of IDPs consists of individuals or displaced persons who speak different first languages, but they share some forms of beliefs, activities and characteristics of activity which will often be the reason why the social configuration was formed in the first place. Most transient IDP camps are formed for the sole purpose of providing shelter for the displaced whether it is caused as a result of natural disaster or man-made cause these temporary shelters are a means to providing an immediate solution.

1.4. Multilingualism in Africa and language choice in Nigeria

The African continent has a large number of languages, over 2,158, equivalent to 30% of the world's linguistic heritage (7,151 living languages) (Ethnologue 2022). Several of the African languages are widely used for inter-ethnic communication. Most of the African languages are alive and linguistically speaking stable. A number of African languages now have stronger socio-political standing than they did three decades ago and these languages (Hausa, Yoruba and Igbo in Nigeria, Setswana in Botswana, Kiswahili in Tanzania and Kenya, Wolof in Senegal, Bambara in Mali, and Bamilèkè in Ivory Coast among others) have gained ground against the former colonial languages (the British/European official languages e.g., English and French).

In most African states, the mother tongue (MT) serves as a medium of informal education in the home and socialization processes among families. There are also the languages of the immediate or wider community which serves as local or regional lingua francas' and are therefore mastered by the majority of the members of the group. In the majority of African states, the colonial language (English, French, Spanish or Portuguese) is the official language but this has little impact on day-to-day communicative situations.

A look at the standard classification of African languages into four major linguistic families or phyla: Afro-Asiatic, Nilo-Sahara, Niger-Congo and Khoisan (Greenberg, 1963; Grimes, 2000; Williamson and Blench; Blender 2000; Hayward, 2000; Hodge, 2001; Vossen and Tom 2000) shows African languages are (unevenly) geographically spread across the continent (cf. Table 1 below).

Table 1: African language family

Language Group	No. of languages	Geographical spread	No. of speakers
Afro-asiatic	200	North Africa to the Horn of Africa	250+
Nilo-Saharan	140	Sudan and Chad	11 million
Niger-Congo	1000	West, Central & Southeast Africa	200 million
Khoisan	30	Deserts of Namibia and Botswana	Data not available

Source: **www.ethnologue.com**

Most African countries were colonised from the mid-nineteenth century to the 1960s (Baten, 2016; Hall, 2011; White, 1996). Each colonial power imposed its language on the African states according to their colonial ambitions. The colonialists differ in the level of entrenchment of the colonial languages and the extent to which indigenous languages were tolerated and promoted in the educational system. For instance, states colonised by French and/ or Spanish and the Portuguese were taught in foreign languages at all levels i.e., a total immersion into the French/Spanish/Portuguese system; while in countries colonised by the British, the use of indigenous languages was tolerated in the first years of formal education

whilst English language was encouraged within higher education. For example, in Nigeria, after the amalgamation of the nation in 1914, three languages were assigned the prestige of major languages out of over four hundred indigenous languages –Hausa, Yoruba and Igbo-based on the number of speakers. Based on this role therefore, the three native languages are taught in the first few years of formal education alongside the official language-English to date.

The colonial experiences had an indelible impact on the colonies, and most of them adopted the colonial master's language after their independence. The post-colonial era is indicative of these changes and outcome of linguistic choices. Although after independence, educational reform was a particular agenda in most African states. The concern for increased access to formal education, greater need to transform education to national realities and the desire to promote indigenous languages gave rise to th'African renaissance'. The period witnessed bold initiatives with innovative decisions involving the choice of national languages and their full development for use in basic education and literacy. An initiative of this period is the Ife Six Year Primary Project in Nigeria (Adegbija, 2004).

Most African countries are known to be multilingual (Bamgbose, 1976; Han 2013; Whiteley 1974). It is a common situation that the less multilingual a country is, the easier it is to develop a national language policy and the quicker it is to implement it. A few monolingual or bilingual countries in Africa such as Somali, Burundi, Rwanda, found it relatively easy to promote either a single or a few interrelated languages to national status although it is a sensitive process (Bamgbose, 2002; Boyd, 2009; Makalela, 2015; Rosendal, 2009; Kaschula & Kretzer 2019). As earlier stated, after Nigeria was formed as a united territory (by British colonial forces in 1914) with artificially created borders arbitrarily including certain ethnic groups while dividing others with neighbouring states, this complex ethno-linguistic situation in many ways is an issue faced by many developing states in Africa especially with regard to making national language policy and planning decisions (Simpson & Oyètadè 2008; Luiz, 2015; Orekan, 2010).

The three major indigenous endoglossic languages dominating the Nigerian linguistic landscape are Hausa-Afro-asiatic; Yoruba –Nilo-Saharan and Igbo-Niger-Congo. The foreign or exoglossic languages in evidence in Nigeria are English, Arabic and French, spoken by 30%, 15% and 5-10% of the population respectively. Other exoglossic languages (e.g., German, Italian and Russian) have a minimal presence as they are mainly used in embassies

and in families of embassy employees, among a few individuals, in university classrooms and among modern foreign languages departments' staff. The third linguistic classification consists of the Nigerian Pidgin varieties of languages, the most dominant being the largely English-based Nigerian Pidgin English (NPE) (Kaplan and Baldauf, 2007).

Nigeria's linguistic complexity manifests itself first by the existence of such a large number of languages within the country, and second, by the present state of multilingualism and its implications for development and communication. Out of the four phyla (Afro-asiatic, Nilo Saharan, Niger-congo and Khoison) in to which African languages are classified, three (Afro-asiatic, Nilo Saharan and Niger-congo) are represented in Nigeria. Linguistic diversity in Nigeria has resulted in widespread bilingualism and multilingualism. Many people in Nigeria speak at least one language and in addition to their first language, some speak as many as five languages (Orekan, 2010).

Nigerian languages are further classified into three functional groups: Group A consists of the three major languages -Hausa, Igbo and Yoruba- classified by the government and used widely outside their states within Nigerians with different mother tongues; Group B are the (20) officially recognised languages in Nigeria and used at the national and federal levels but which do not enjoy much usage outside the state of their origin. Under this category are Kanuri, Fulani, Edo, Efik, Tiv, and Ijao, etc. and lastly, Group C, are the minor languages with no official recognition at the state level. Examples of languages in the third category are Eggon, Affizere, Berom; etc (Adebija, 2004). Superimposed on the indigenous languages is English, the language of commerce and industry and, in its written form, the language of administration. One of the major problems of multilingualism in Nigeria is the lack of an effective communication between the different ethnic groups and also between different classes. Closely connected with problems of inter-ethnic communication is the question of national unity, the presumed threat which linguistic diversity poses for peace and stability and the potential uproar which would result if one language is favoured to the detriment of others. Perhaps this is why Nigeria has been unable to decide on a single national language.

Nigeria is the largest nation in Sub-Saharan Africa and host to 25% of the subcontinent's population. It is a country with one of the highest incidences of linguistic diversity although languages have unequal status and over 35% of the population is illiterate despite the language and education policies in place (Orkar et al. 2020). The two documents currently existing in Nigeria that include policy statements on languages are (1) the National

Constitution (Federal Republic of Nigeria, 1999) and (2) the National Policy on Education (NPE) (ibid, 2004). The prescribed national policy on language within the NPE recognises the multifaceted dimensions of the country and tries to capture the multi-ethnic and multilingual goals therein as:

1. The mother-tongue and/ or other language of the immediate community are to be used as the language of initial literacy at the pre-primary and primary levels as well as in adult/non-formal education

2. The three major indigenous languages (Hausa, Igbo & Yoruba) are to be used as the languages of national culture and integration at L2

3. English, as the official language, is the language of formal literacy, the bureaucracy, secondary and higher education, the law courts and of international communication.

4. Selected extra exoglossic languages, especially French and Arabic as regional- and international languages of wider communication.

Although not explicitly stated within the NPE, Emananjo (1990) suggests in terms of unstated policy that the NPE policy on language advocates for multilingualism as a national goal, recognises the English language as the official language in administrative matters and all tiers of formal education and accords the three major languages as potential national languages to be developed as L2 throughout the educational system and finally, it recognises the Nigerian languages as meaningful media of instruction, including in lifelong and other non-formal education. His suggestion was later supported by the adoption of three major languages as the country's languages of education alongside English (Oyetade, 2003).

In Nigeria, like most African countries, the multilingual nature of the society does not permit the use of a single indigenous language in the government or in education, and any attempt to do so will certainly be met with resistance. Related literature shows that despite the existing language policy (NPE & the constitution) in Nigeria, and indeed most of African states, there is lack of implementation and controversies. It is argued that implementing language policies in multilingual African countries such as in Nigeria will need to be economically feasible: by creating orthographies and dictionaries for the development of indigenous languages, and writing of primers and other textbooks. It will also require teaching and learning resources, funding and training of qualified teachers to teach these selected indigenous languages to its in habitants. Thus, arguing on the failure of these policies as a result of lack of funding for

linguistic projects as outlined; as a result of insufficient resources and little importance accorded to indigenous languages to promote language policy has accorded English language the 'aura' of superiority over the indigenous languages in most domains of Nigerian society.

The impact of selecting fewer of Nigeria's languages as majority groups and having the official language to function as means of communication in healthcare has an adverse effect on health communication. Building on the argument that over 30% (percent) of Nigeria's population are illiterate and about 80% of other languages are classified as minority; this means the minority language groups may not necessarily understand either the official and /or the majority languages if they are not literate or exposed (Adegbija, 1997; Orekan, 2010).

Bamgbose argued that language-planning and language education policies in Africa are (still) largely characterized by numerous problems including vagueness, fluctuation, avoidance, arbitrariness and declaration without implementation (1991). Arguably, many of the Nigerian problems with regard to policy implementation are replicated elsewhere on the continent. Most observers who have looked at the issue of language policy in Africa agree that there is a big gap between intended policy and outcome (e.g., Bamgbos,e 2000; Posel & Casale 2011). It is reasonable to argue that to rectify a problem of such magnitude requires a strong political will.

1.5. Rationale for research

This research as earlier identified was motivated by the sudden spread of communicable diseases in IDP camps across Sub-Saharan African countries (Lam et al., 2015; Roberts et al., 2012), and the rise in the number of internally displaced persons in Nigeria (Hampton, 2014; Owoaje et al., 2016; Saminu et al., 2023).

Studying MPs-IDPs health interactions in Nigerian IDP camps is relevant because neither ethnicity nor language proficiency is routinely added to medical history taking in general practice; there is a lack in secondary data of records that pertain to the language differences of IDP patients. As discovered during the course of this research, no organization interpreting service exists, and the health care does not take responsibility for ensuring communication between the IDP patients and MPs. Hence the patients must find an interpreter, if necessary. Moreover, there is the need to know how inequality and other socio-cultural factors affect health interactions and/or how various aspects of MPs'-IDP patient communication in IDP

camps in Nigeria mirror (or not) other parts of the world. Notably, our knowledge of practitioners'- patient interaction is gleaned from studies in more advanced Western countries and often in hospital settings. As applied linguists (sociolinguist/ethnographers/ communication scholars), we need to interrogate the potential challenges that a developing system in context, a multilingual country such as Nigeria struggles with. Thus, this research will not only expand our understanding of medical communication in other geographical locations other than what the current literature offers, but the case of Nigerian IDPs can provide insights into health care interactions in other multilingual countries in Africa.

1.6. Formulation of research questions / problem statement

The approach in this research draws insight from the perception of both IDPs and MPs' experiences of inequalities- aimed at a change in the processes that address gender inequality in the IDP camp. Through a gender lens or gender linguistics (e.g., Cameron, 1992; Eckert & McConnell-Ginet 2004; Lakoff, 1973; Maynard-Tucker 2014) and a critical sociolinguistic approach (Heller et al., 2017), this ethnographic research seeks to interpret and make sense of the experiences of IDP women in the camp; their access to health care, resources and issues relating to privilege, language choice, power and control. Within this framework, the research will be guided by the following questions:

1. A) What are the effects of inequality on health communication between IDPs and MPs?

   B) What role does gender play in the medical encounter of women- IDPs in a Nigerian IDP camp?

   C) What are the possible health communication barriers of women IDPs?
2. How is communication managed in a multilingual temporary shelter for the displaced in Nigeria?
3. What practical measures can be identified towards improving (health) communication barriers of women- IDPs for effective healthcare delivery?

Based on the above research questions, the first step is to investigate the effects of inequality to the health communication between IDPs' and MPs' in relation to IDPs living condition and availability of resources and or basic amenities. Secondly, we can learn about the effects of gender and group consultation on health communication surrounding gynaecological problem presentation in a Nigerian IDP camp. In relation to IDPs' living conditions and availability of resource or basic amenities (such as physical structures providing shelter; provision of food, clean water, electricity, security and health care), this then leads to the investigation of their (IDPs) access to basic amenities and resources in comparison to their social position in relation to others-in the larger society- as possible "fundamental causes" of health disparities. Third, based on the study's findings, I shall interpret practical measures MP employ to address or manage communication barriers during medical interactions. Lastly, I try to identify health communication barrier(s) and gender inequality that may prevent women-IDPs from accessing healthcare and together with IDPs and relevant stakeholders (MPs)

propose practical ways to address these inequalities and barriers for effective healthcare provision.

The importance of focusing on how gender relations are enacted and maintained in moment-to-moment linguistic interaction has been a recurrent theme in previous reviews of empirical work on gender and language (e.g., Eckert & McConnell-Ginet 1992; West, 1995). Also recent studies address the need for research on language diversity and gender inequality in interactive context (e.g., Liu et al., 2018; Tolstokorova, 2006). However, little is known of the role of gender on the health communication of a linguistically diverse and highly transient setting such as an IDP camp.

The issues identified in this investigation are worthwhile for the following reasons: first, the investigation seeks to contribute to existing literature on the need to address communication barriers for effective health care delivery through understanding feminine health communication; particularly, this research addresses the plight of women-IDPs living in displaced persons' camp- where they do not only face challenges of displacement / poverty but have to bear the burden of diseases due in part to the communication gap. Secondly, this investigation contributes to sociolinguistic and linguistic ethnography by investigating the context of displacement; the social inequality of the study group and their health communication challenges using both sociological factors and their lived experiences (Heller et al., 2017; Galasinski & Ziólkowska, 2007). Thirdly, the investigation seeks to promote participatory solution to existing problems in the camp through the lens and perception of participants that is, the IDPs, MPs and the researcher to provide practical solution.

This research therefore seeks to access the lived experiences of women-IDPs suffering with diseases in order to build an understanding of the communicative needs of women in a displaced camp and to account for the ways healthcare information is disseminated in a linguistically diverse and highly transient setting. Within this context therefore, it is the aim of this research to identify language and communication barrier(s) that have potentially negative effects on health outcomes and to provide practical, low-cost solutions for government and non-governmental stakeholders to address the health needs and empowerment of a linguistically and culturally diverse group of (IDP) patients.

1.7. How the dissertation is organized

This study consists of eight chapters. The first chapter is the introduction. In this chapter, I introduced the aim and objectives of the study, i.e., it is concerned with the investigation of health communication barriers and challenges women face in access to health care at a displaced person's camp in northern Nigeria. The chapter also identifies the researcher's motivation based on the conditions existing in IDP camps in Sub-Saharan African countries with regards to their health and condition of living and in particular, the rise in population of IDP in Nigeria. In this chapter, I also identified the gap in research and related research this investigation aligns with. The scope being a single-sited ethnography and methodological framework is discussed therein. A historical account of displacement, its causes and effects is also discussed in this chapter. The discussion led to the two sub-topics: voice, inequality and resistance in medical settings and a brief discussion on the concepts displacement, poverty and inequality in Sub-Saharan Africa. This is followed by the multilingual health communication policies adopted in Nigeria with reference to related policies inherent in some African countries. These policies are identified in the chapter with a brief historical account of colonialism, the socio-political standing of such languages in the countries and other relevant factors. I identified four research questions and presented the problem statement; these research questions relate to the effects of inequality on health communication between IDPs and MPs; the role of gender in medical encounters of women IDPs and health communication barriers they face, communication management in a multilingual IDP camp and lastly, identifying practical measures towards improving the health communication barriers for effective healthcare delivery at the camp. The significance of the study is discussed in this chapter as well as how various methods can be employed to investigate and/ or address the concerns identified in the study. This chapter concludes with a description of how the dissertation is structured.

Chapter two is subdivided into six subchapters which discuss related literatures ranging from health communication as an interdisciplinary field concerned with the investigation of patient-doctor interactions to highlighting other fields of study which adopt different approaches to theorizing patients-health care and providers' issues. The chapter begins with a brief insight into health communication research and previous scholars' methodological stance. The sub-section also reviewed the role of health communication within an understanding of a multilingual setting; what factors hinder or support linguistic choices in a multilingual setting, the effects of language choice in a multilingual health care setting and

what the literature proposes as a solution or complications to remedy the language barrier as a hindrance to effective health care. A number of suggestions and complications to certain health communication barriers were identified from previous literature; for example, the use of interpreters and or translators, adopting minority ethnic language of patients, etc. Gender and language is also identified as yet another lens to understanding health communication. This sub-section discusses gender inequality and the varying approaches scholars use in their analyses. The chapter further discusses gender and the burden of disease as a challenge in non-Western settings. Subsequently, it presents health inequality and the domestic neglect of internally displaced persons. Here, I present the various health inequalities and the distinction in international law between the displaced and other marginalized groups, i.e., Refugees as contained in the literature. This is followed by the discourse surrounding voice, inequality and resistance in medical settings. The discourse opens up a broader insight into the phenomenon of displacement, poverty and inequality in Sub-Saharan Africa. Chapter two concludes with a summary.

Chapter three presents and discusses the research participants -the IDPs and MPs and the research context- Nigeria. It begins by introducing the chapter and what it encapsulates. The chapter describes the geographical location of the study area, its population and linguistic make-up. With the aid of a map, the study area is further highlighted and described for in-depth knowledge of the setting and context. Reasons for the choice of the setting are discussed in the chapter and a successive in-depth description to the nature of shelter provided for the displaced, their basic health provisions are accounted for with the aid of pictures from the research site and observation carried out during field work. The chapter further presents the key stake holders in the study and other relevant officials/organizations who assist in the maintenance of the camp. This follows the introduction of each participant in the study and a brief insight into their life trajectories. The chapter concludes with a summary.

Chapter four discusses the methodological approach of the research. It begins with a chapter introduction and discussion of how the analysis is organized in twelve various sub-sections. The second sub-section discusses the methodological underpinning adopted in the research as well as the methodological framework; how the researcher gained entry into the site, the sampling method and how the participants were recruited. This is followed by an account of data collection procedures employed with methodological techniques adopted in the study. The various data collection methods used are then discussed which include: field-notes, semi-

structured interview and focus group interactions, with transcriptions. Following Heller et al, (2017), mapping and tracing as a methodological framework are employed in explaining the diversity in the context – the IDP camp –; this begins the analysis of what is observed. What follows is a mapping of person category at the camp with a tabular representation of participants' socio-demographic profile to provide insight to the reader about the participants and stakeholders in this research. Subsequently, field-site mapping and categorizing of linguistic resources at the research setting is presented and is followed by the mapping of things, resources and activities at the IDP camp with the aid of pictures from the setting. Discussion follows the various ethnographic methods adopted with literature backing to support each choice made. This then leads to a discourse on ethnography and health communication: methodological assumptions and then the data analytical procedure is presented. The chapter summarizes some challenges in conducting data collection in the research context and presents ethnography and reflexivity from the stand point of this research. This reflexivity is followed by a critical ethnographic description of health inequalities at the camp. The next subtopic is a discussion of how critical sociolinguistic analysis complements ethnography; this then leads to the final subtopic which is a description of the chapter with a summary that concludes chapter four.

Chapter five is an analytical chapter which begins with an introduction to the forms of health inequality and discussions relating to communication barriers existing at the camp. The sub-section opens a discourse on how women IDPs access healthcare with an insight into the participants' own narratives on this. What follows is an analytical presentation of focus group interview with interpretive discussion of themes generated from the interactions. After which we identify the role gender plays at the camp, particularly in the interaction between IDP patients and MPs with the help of participants' input. A number of themes were identified as possible hindrances caused by gender inequality and/ or differences and their role in the provision of healthcare for the displaced. In conclusion, a chapter summary which revisits what was discussed is presented.

Chapter six is a continuation of data analysis; it discusses communication management in the multilingual IDP camp. The chapter begins with an introduction and identifies other sub-topics discussed therein. These sub-topics include participants' perceptions on how communication in medical consultation is conducted at the camp; the various methods adopted where there is a communication barrier specifically, the methods adopted by the MPs in resolving communication barriers in this diverse linguistic setting. In this chapter, I relied

mostly on the use of the interview data which relies heavily on informants' subjective statements. However, in the analysis, I draw on both field notes from observation taken during the course of the study (data collection) as well as participants' perceptions. The concept of inequality is reviewed with a focus on social inequality as a leading factor in the communication barrier. In a bid to understand the level of social inequality at the IDPs camp, the participants' socio-economic statuses were reviewed and data from interviews relating to this notion were analyzed. Chapter six concludes with a summary of what was discussed in the chapter.

Chapter seven attempt to make sense of unequal access to healthcare through discourses of resistance and acceptance surrounding healthcare of the IDPs. The chapter begins with an introduction. It then presents some effects of social inequality, deprivation and the role socio-economic status plays in accessing health care at the IDP camp. It therefore opens up discussion of participants' perception about healthcare provision at the camp. Their perception and that of the researcher is employed to suggest a number of strategies that may be relevant in reshaping the perception of women-IDP patients as well as proffering solutions to existing communication barriers or gaps existing at the camp. After which, discussion of the different strategies displaced persons develop in making sense of their positioning follows. This finding leads to suggestive practical measures identified in the chapter both for short term and long term by specifying ways to improve health communication of the study population. The chapter concludes with a summary of what was discussed.

Lastly, the summary and conclusion of the study findings is presented in chapter eight. This chapter also discusses the IDP camp as a socio-political tool; the camp and the multilingual language policies in Nigeria as well as the role of MPs and/ or stake holders in bridging the gap in health communication barriers in Nigeria. It then re-visits the effects of gender and health inequality on health care of IDPs in Nigeria. This leads to the limitations of the study and implications of the study for further research. Finally, the chapter summary is presented.

CHAPTER TWO

HEALTH COMMUNICATION: LINGUISTIC DIVERSITY, GENDER AND STRUCTURAL INEQUALITY

2.1. Health communication

Research in health communication is interdisciplinary and is addressed in various fields from a number of different perspectives. Two branches of health communication scholars exist. First, the health care delivery scholars examine how communication influences the delivery of health care (Belin et al., 2020; Kwame & Petrucka, 2021). The second is the health promotion branch; health promotion scholars study the persuasive use of communication messages and media to promote public health**.**

These two branches of health communication parallel a division found within the larger discipline of communication between academic interest in human and in mediated communication. The health care delivery branch of the field has attracted communication scholars who have primary interests in the ways interpersonal and group communication influence health care delivery, focusing on issues such as the provider or consumer relationship, therapeutic communication, health care teams, health care decision making, and the provision of social support. The health promotion branch has attracted many mass communication scholars who are concerned with the development, implementation and evaluation of persuasive health communication campaigns to prevent major health risks and promote public health (for example, Friedman et al., 2022; Shen et al., 2015; Wakefield et al., 2010).

Consequently, various disciplines (e.g., Medical sociology and anthropology, nursing, cross cultural studies, interpersonal communication and applied communication) have investigated MPs-patient interactions. Each of these fields adopted different approaches to theorizing patient-MPs issues. In the subsections that follow, I review and synthesize various literatures relevant to this research.

Earlier research on health communication backdates to the work of paediatrician Barbara Korsch and colleagues in the late 1960's (cf. Korsch et al., 1969). Succeeding sociological

and psychological work on the diffusion of ideas related to health and medicine also appeared throughout the 20th century (e.g., Coleman et al., 1966 cited in Thompson et al., 2014).

A number of topics identified from earlier health communication studies range from interpersonal communication and social behaviour of provider/patient (e.g., Arborelius, et al., 1991; Barsky, 1981; Beckman et al., 1984; & Carter, et al., 1982); realities and routine (e.g., Heath, 1981; Heritage & Sefi, 1992) and health/lifestyle (e.g., Larsson et al., 1987).

Subsequent work in health communication examines the role of social media (such as television, print and YouTube, Face book, or Twitter), information technology within health care (e.g., Khorakhun & Bhatti, 2013), as well as health literacy (e.g., Nutbeam, 2008; Schwartzbeerg et al., 2005). In addition, a focus on critical and cultural issues also emerged, (Dutta-Bergman, 2005). It was concerned with for example, power relations in a particular culture that may impact health care processes. Research foci were centred on sender; audience, message and interaction in health communication with major research topics as medical communication, Aids/HIV/safe sex, cancer/smoking, alcohol, and health in general (Kim et al. 2010). These topics and others dominate the field (health communication) from the early 1980s to 2010 with a shift and addition to topics such as the structure of medical consultation (e.g., Heritage et al 2006; Sarangi & Roberts, 1999); gender and health inequality (e.g., Galasinski, 2007; Maynard-Tucker, 2014); health communication barriers /language policy (Bernard et al 2006; Hussey, 2012) and linguistic diversity (e.g., Mortensen, 2017).

With the emergence of health-related publications in fields such as social and behavioural sciences and clinical medicine (e.g., Norris & Hastings, 2021); Sociology (e.g., Timmermans, 2013; Richardson & McMullan, 2007) and Linguistics (e.g., Baker & Brookes, 2019; Kreuter & McClure, 2004); research in health communication from a sociolinguistic perspective became concerned with the 'interaction order' as a decisive model to study health communication (Sarangi & Roberts 1999, p.10). Prior to that, research was mainly concerned with the interrelation of language and context addressing more institutional themes such as asymmetrical power relations; patterns of lay expert information exchange; discursive representation of health, illness, normalcy, deviance etc., (e.g., West, 1984; Fisher & Todd, 1893; Cicourel, 1992; cf. Sarangi & Roberts, 1999, p.10).

Up to the early 2000s, work in health communication was mostly quantitative in nature (Watson, 2000. Qualitative research is now also common and is providing important

contributions (Ngenye & Kreps, 2020; Small & Calarco, 2022). The emergence of a more interpretive (meaning making) perspective makes evident the recognition of the roles of other frameworks and methodologies in the study of health communication processes. An important lesson which emerged from recent decades of health communication research is that 'the classic survey sometimes does capture all that is relevant to our understanding of the ways in which visual and verbal content affects health beliefs, perceptions, and behaviours' (cf. Thompson et al, 2014, p.15). Though healing is said to be greatly aided by 'drawing out and listening to patients' concerns' (Erin, et al in 2014, p. 21).

Like other types of social interaction, the medical consultation is a dynamic, creative, and socially constructed event. Although certain technical activities may take place (e.g., a physical examination, diagnosis), the primary activity is talk as the medical practitioner and patient exchange information about health-related concerns; make decisions about medical care; and in the best cases, establish or maintain a relationship characterized by rapport, trust, and respect. How the interaction unfolds depends on how the participants select, adapt, and coordinate their responses to accomplish their individual and mutual goals (Street, 2003). Thus, establishing good *rapport* between medical practitioners and patient has been of concern for communication scholars (e.g., Beck, 2001; Ellingson, 2005; Roter and Hall, 1993; Smith-Dupre & Beck, 1996; Street, 2001; Thompson et al., 2003). Generally, health communication scholars have paid attention to specific settings like hospital units, (e.g., oncology; paediatrics, end of life; emergency unit/OPD etc.) (Toh et al., 2021; Laronne et al., 2022; Semino, 2023; Gonella et al., 2023; Kaur et al., 2022); attributes related to the communication encounter including patient satisfaction (Wanzer, Booth-Butterfield, & Gruber, 2004; Wright & Frey, 2008).

Researchers have argued that paying attention to full descriptions of patients' concerns can affect health outcomes through improved diagnosis and treatment (Arborelius et al., 1991; Fisher, 1991; Larsson et al., 1987; Mc Whinney, 1989; Mishler, 1984; Peppiate, 1992; Saukar, 1986; Swiatoniowska-Loc et al., 2020**;** Todd, 1989). This is because, patients' description of their symptoms, circumstances, and feelings associated with their problems are significantly associated with reductions in patients' systolic blood pressure (Orth et al., 1987) and increase patients' affective satisfaction (Stiles et al., 1979; cf. Carter et al., 1982; Putnam et al., 1985); since patients' frequently have multiple concerns, which can be biomedical, psycho-social or both in nature (Barsky, 1981; Lipkin et al., 1995; Stoeckle & Barsky, 1981; White et al., 1994; White et al., 1997). Though there is an assertion that patients' problem

presentation tends to be brief due to physicians' interventions (Beckman, & Frankel, 1984; Beckman et al., 1985; Marvel et al., 1999) to keep to timing (Schwartzbeerg et al., 2005); nonetheless, Weiss suggests (physicians') adopting the techniques such as "asking patients to explain or demonstrate what they have been told" and slowing the speed of the communication can enhance patients' understanding of critical health information (2007, p.33).

Likewise, research has shown miscommunication caused by a language barrier results in increased patient avoidance behaviour (which may result in later presentation of diseases) and add to the uncertainty and emotional stress experienced by patients (Deumert, 2010; Saha & Fernandez, 2007). While medical sciences do have an objective and examinable component, the importance of communication is irrefutable. Stressing the need for effective health communication, Deumert states that "if the patient, for instance, was talking, let's say TB treatment, and she didn't finish the treatment, I won't hear it from the stethoscope" (2010, p.56) thus, emphasizing the need for effective communication in health care. Alongside the negative impact of a language barrier on Health providers, studies revealed that the consequences on patients can be devastating (e.g., Jacob et al., 2004). Thus, according to Jacob et al., people with limited English (language) proficiency are:

> [...] less likely to have a regular source of primary care and are less likely to receive preventive care. They are less satisfied with the care that they do receive (...), more likely to report overall problems with care... may be at increased risk of experiencing medical errors (pp.866-9)

One of the ways language barriers in multilingual health care settings can be addressed is the use of trained (or un-trained) interpreters who are often professional staff, junior or student nurses and family members of the patients and/or auxiliary staff (e.g., Yakushko 2010; Hussey, 2012; Antia & Bertin, 2004).

Another proposed method is the use of code switching to bridge the language barrier; which includes the medical practitioners' ability to pick some essential words (e.g., knowledge of words such as pain, point where it hurts, bowel movement, vomiting, common phrases- date of return, today, etc.,) that allow them to practice some independence in the absence of the ad-hoc interpreters (Pasquandrea, 2011; Davitti, 2012; Bührig, 2004). This will further create a direct contact with the patient thus, allow for bonding and trust to develop between them.

Code switching will also allow for rapid communication and a practical tool for transferring instructions quickly. Belaskin's (2007) and Alhamami's (2020) studies of multilingual context support the use of code-switching (a linguistic phenomenon where speakers change between two languages in a single sentence or conversation); common phrases, change of accent and the use of simple English as a means to transferring meaning. They argue that speaking and understanding the language of the patient allow for mutual understanding and can be developed through effective translation and/ or increasing the bi/multilingual workforce.

Foucault (1973) argued that language plays a crucial role in all stages of the medical process (e.g., taking the patient's history, finding out the symptoms, writing a prescription, etc.). Even so, language barriers constitute one of the most common impediments to efficient communication. In health care settings, language barriers have been recognized to have adverse effect on patient-medical practitioners' satisfaction and quality of care (e.g., Garrett, et al., 2008; Goldsmith et al., 2005). Even in situations where interpreters have been used, triad (Doctor, interpreter, patient) communication is still fraught with problems, such as omission of phrases and words, false fluency, editing information (Flores et al., 2003; Valero Garcès, 2005) co-diagnosing (Hsieh, 2006a, 2007), and compromising informed consent (Goldsmith et al., 2005).

Additionally, cultural competence is necessary for providing appropriate care in the language of the patient and developing rapport, understanding and respect. For an effective health care, Yakushko, (2010, pp.449-55) proposed five main models of interpreting. These are approximate interpreting model, ad hoc interpretation from anyone that can speak the language, tele-active model using telephones or computerized interpretation devices, bilingual worker model-hiring of clinicians that have language skill; volunteer interpreter pool model-hiring interpreters and translators on an as –needed basis and staff interpreter model-formally trained interpreters that are part of the clinical staff (see Candlin & Candlin, 2003 on interpreters).

While a change in tone of health providers is also suggested when speaking to patients and the use of simple language (English) with the hope of transferring meaning; most importantly, the exchange of information between doctors and patients is considered relevant to healing. Furthermore, Kaplan, Greenfield and Ware (1989) describe three aspects of communication that has a critical link with patients' health outcomes: first, the amount of

information exchanged between the patient and the physician; second, the rapport between them; and third, the patient's control of the dialogue (p. 110-27). From their submission, understanding the patient allows for effective communication and can be developed through efficient translation and/ or by increasing the bi/multilingual workforce. Also, cultural competence is necessary for providing appropriate care in the language of the patient and this in turn will develop rapport, understanding and respect. In light of this, Schlemmer and Marsh (2006) are of the opinion that medical practitioners should learn basic skills and understanding of the patient's language and culture; while language acquisition (according to them) may be a difficult and complex process, greetings and pronunciation of patient's names should be seen as absolute necessity. They highlight the need for taught vocabulary which allows for independence from interpreters and increases direct interaction with the patient. Though, there is no substitution for proper communication.

Zooming in on Kaplan et al. (1989) three aspects of communication will greatly depend on some factors; such as availability of medical personnel, the context and other relevant conditions attached to a healthcare setting. While the first aspect is central to medical consultation; the second point has been somewhat challenging to healthcare. Another aspect is structural barriers, a major theme across developing nations-such as shortage of manpower; illiteracy, religious and/ or cultural barriers among other communication barriers (ibid). Topmost on the lists is diversity and language policies. Most of the developing nations faced with communication barriers may (not) likely adopt the submissions of learning basic skills (Schlemmer and Marsh, 2006) due to diverse languages/dialects existing in the context aside from the choice of language for education which only favors the literate populace.

2.1.1 Health communication and the management of multilingualism

Within an understanding of multilingualism "as the presence of two or more languages with different statuses in a given speech community" (Moyer 2010, p.2), research in health communication addresses the following issues: the demand that communication practices should accommodate the diverse linguistic repertoires, especially in the health sector considering health institutions are responsible for the distribution and or scaling of languages (cf. Collins & Slembrouck, 2007). This submission like in this thesis is related to an advocacy for the use of minority languages by health organisations and institutions (e.g., Deumert, 2010). Even though the focus of multilingual health communication is on doctor-patient

interactions, the finding on language policy can be generalised to all forms of related healthcare context and health education communication.

The proposal for the use of minority language is prominent in some specific contexts and in tandem with a consensus among researchers that when healthcare is carried out in a patient's foreign language, positive healthcare outcomes are indeed compromised. A number of the problems highlighted from those studies revealed 'the silencing of patients' voices thereby limiting patients from presenting problems' (Deumert, 2010, p. 58); misunderstanding of their health condition (Harmsen et al., 2003, p.108) and generally, non-compliance withtreatment as a result of a lack of understanding (Bischoff et al., 2003, p. 508). Researchers suggest that if healthcare and education is to become accessible and effective, the problems that language barriers pose will have to be addressed.

In a bit to address diversity as a language barrier in health communication, research to date has shown a wide range of language support that could be available to patients, ranging from multilingual medical-and non-medical staff (Drenan & Swart, 2002; Dressler & Pils, 2009), professional and lay interpreters (e.g., Angelli, 2004). Apart from the use of bilingual translation manuals, other literary materials; bilingual word phrase lists and or health dictionaries are often employed to address multilingual health communication barriers (e.g., Collins & Slembrouck, 2006; Moyer, 2010).

Sequels to the above challenge, a number of other complications have been identified with the use of translators/interpreters in linguistically diverse health communication discourses (e.g., Valero-Garces, 2007). For instance, the use of family members (often small children), cleaners, administrative staff, other patients or any adhoc bilingual person is considered not ideal, as it might affect patients' confidentiality (Schemmer & Marsh, 2006). These interpreters are unlikely to understand medical terminology, may struggle to break bad news to patient and translate /interpret sensitive issues and may have conflicting agendas or priorities (Flores, 2006). This is because they are neither counsellor nor are not accountable legally for any mistakes or breaches of confidentiality; depending on the context. Since an interpreter inevitably becomes an intermediary in the doctor-patient relationships; this can have a negative impact on the communication between them that is, patient relying on the interpreter more than the Doctor (Saha & Fernadez, 2007). In addition, Pfaff & Couper (2009) identify that interpreting staff may be frequently unavailable or may insert their own values and views into the conversation. In some cases for example, Aranguri et al (2006) and

Rosenberg, et al. (2008) have shown interpreters to make errors in translating and this affects patient care. Also, nurses have been shown to be inaccurate interpreters (Levin, 2006).

From a European perspective, Angelelli (2004) proposes the need to standardize health care translation and interpreting. The use of multimodal approaches, non-verbal means of communication (e.g., eyes, paralanguage, visual gestures and body languages, etc.) and training of medical staff interpreters have been proposed to improve health communication in a multilingual context. Following this proposal, language translation training is necessary; although language translation is complex, training of translators does not always equal or result in effective translations which convey the true meaning and the nuances of a language. That is, the interpreter may not always translate the language directly. In addition, certain words may not be easy to translate into another language (Swartz, 2008).

Even though interpretation or translation has been criticized to have a number of negative effects on health communication, there are however, a number of significant impacts to their use. First, Yakushko (2010) suggests that the use of professional interpreters improves health communication (e.g., errors in comprehension); utilise (of health resources) clinical outcomes and provide satisfaction with care for both low-English Proficiency (LEP) patients and healthcare practitioners. Second, Jacobs et al. suggest that interpreters may increase the reception of preventive services, physician visits and adherence, which increase patient access to primary care (2004, pp. 866-9). Third, Jacobs et al. (2004) consider the cost of hiring interpreters as an important consideration but the cost of not using interpreters may be even greater. As Brach et al., suggest interpreting services have been shown to lower costs by decreasing the use of diagnostic testing or reducing post-emergency department visits, (2005, pp.424-34). Though the short-term cost may increase as primary and preventive medication increases in use, over the long term this could see a possible reduction in cost, morbidity and mortality. This cost may also be overestimated ultimately, according to Deumert (2008), no single model exists that would provide the best method of translation for low-resource settings such as those found in developing countries. Finally, interpreters serve as cultural mediators and can pick on the semantic subtitles and underlying tones of patient discourse. At the moment, they are regarded as the best available communication method and for this reason, are valuable (facilitate a greater reflection on culture-specific topics).

From the foregoing discourse, structural problems, language policies, social inequalities and economic conditions (labour shortage) appear to be the greater barriers to effective care. In

summary, a language barrier decreases work efficiency and the provision of holistic treatment; it increases frustration levels; is time consuming and decreases empathy and approachability. Revisiting the approaches to multilingual health communication practices earlier discussed presents an extended argument on the use of minority language in multilingual healthcare settings as a way to address communication barriers in health organisations and institutions (e.g., Bischeff et al., 2003; Bernard et al., 2006; Deumert, 2010).

2.1.2. Ethnography and health communication

In health communication research, ethnography has been utilized for the purpose of studying interactions within groups, including interdisciplinary teams (Gardezi et al., 2009; Opie, 2000), nursing care teams (Propp, et al., 2010), and social support groups for patients and caregivers (e.g., Arrington et al. 2006; Golden, 2010).

According to Lincoln & Guba (1985), ethnography assumes a naturalistic paradigm meaning that it involves studying groups of people in their naturalistic contexts (cited in Atkinson, et al. 2001). Lindlof and Taylor, (2011) suggest ethnographers to be present in the space(s) being studied, for the ability to make knowledge claims is grounded in researchers' direct observation of that space and the interpretations within. Likewise, earlier ethnographers according to Denzin and Lincoln (2011) made positivist claims of discovering "the truth" about their subjects' culture, but contemporary ethnographers acknowledge (to a varying degree) the role of the ethnographer in co-constructing meaning in research.

Ethnography also offers access to informal or "backstage" communication (outside of formal meetings) among healthcare provider interactions (O'Shay 2023), including uses of humor (Scholl & Ragan 2003; Schöpf et al., 2017) and the impact of electronic medical records on interaction (Ventres et al., 2006). An example of an intimate health communication topic explored through ethnography is death and dying (Foster, 2007). Auto-ethnography, a subgenre of ethnography that uses ethnographic techniques to study one's own health experiences, yields insightful, often painful stories of death and dying (Knopke 2018; Golden, 2010, Golden et al., 2010; vande Berg & Trjillo, 2009), as well as intimate portraits of suffering due to trauma, such as rape and sexual abuse (Minge, 2007; Rambo Ronai, 1995). Subsequently, Hesse-Biber (2010) and Walford (2009) demonstrated the usefulness of

ethnography in multi-method health communication studies as a way to gather data and findings to guide development of questionnaires and measures and to enhance understanding of survey or epidemiological data.

Ethnography involves a non-linear, inductive process. Importantly, analysis does not begin after data collection, but is concurrent with it in the form of notes, reflections, and analytical memos. In line with Richardson (2000) who stated that writing is not merely a "mapping up" phase, but begins with the writing of notes and reflec in this study field-notes through observation are employed to get an understanding of what is going on in the camp and how inequality manifests itself.

2.1.3. Linguistic diversity: multilingualism and healthcare

Much of healthcare and health related studies have been carried out in linguistically diverse contexts (see 2.1.1). A number of studiesidentify an increase in multilingual /multicultural health care challenges which has been attributed to extensive international (or national) migration. With an increasing migration population globally, the need to provide and address interpreting services arises in both emergency and non-emergency health care for equitable and high-quality care (e.g., Alhamami, 2020; Muth, 2018; Muth & Suryanarayan, 2020). Structural barriers to healthcare such as doctor-patient ratio, spatial accessibility, technological interventions, etc. affects members of multilingual settings and might pose challenges for foreign born population and minority language speakers to access healthcare. One of the proposals by researchers in addressing this challenge is by providing interpreting services /translation technologies (e.g., Lundin et al., 2018; Hussey 2012; Flores, 2006).

Studies in terms of language and communication in the Western countries reveal the difficulties practitioners have in sharing information with immigrant patients due to language barrier, and cultural issues (e.g. Bischoff et al., 1999; Wearn et al., 2007).

Language barriers between health practitioners and patients have been studied as possible sources of frustrations, misunderstanding and miscommunication (Biscoff et al., 1999; Garrett et al., 2008). For example, when dealing with non-English speakers, issues of language accuracy, fluency, structuring of explanations and presentation of symptoms emerge (Ali, 2003). Moreover, when language barriers pervade medical interactions, misdiagnosis or poor medical care can occur (Abbe et al., 2006; Garrett et al., 2008). Further concerns with

language barriers include patients' inability to understand health care Provider's instructions (Dohan & Levintova 2007; Gerrish, 2001), dissatisfaction with the quality of care (Flores et al., 2003; Garcia et al., 2004), and reluctance to disclose information (Julliard et al., 2008; Penn 2007; Sankar & Jones 2005).

Other challenges associated with language barriers include lengthy interview times due to the use of interpreters (e.g., Hampers & McNulty, 2002), lack of patients' satisfaction (Flores et al., 2003; Hornbergeret al., 1997), and concerns related to patient non-compliance (Sarver & Baker, 2000; Stotland 2003). Apart from these issues providing informed consent has proven challenging for patients (Berstein 2005). Available literature also suggests that language barriers have been linked with the utilization of, or access to, facilities and quality of care (e.g., Lasater et al., 2001).

In addition to previous concerns, language barriers have also created communication difficulties in Paediatric care (Abbe et al., 2006; Sarver & Baker, 2000). For example research undertaken in a paediatric hospital in Cape Town, South Africa, revealed that parents who spoke Xhosa as their first language had difficulty communicating with health providers who spoke English and Afrikaans. As a result, parents expressed difficulty with understanding doctors and making themselves understood (Levin, 2006b).

Looking at related studies from developing countries, for example, in the area of information sharing, Sobane (2012) provides an account of how multilingualism is handled in behavioural change around communication about HIV /AIDS by 'Phela health and development communications,' an NGO in Lesotho. The study discuss the distribution of languages in the print media –a publication of the NGO- by highlighting the bilingual nature of these publications which emphasise English and Sesotho as enshrined in the constitution but exclude other minority languages of the country. Although the primary purpose of the study was to aid illiterate people, however, in the report, accommodating linguistic diversity seems to be secondary. Apart from minority language exclusion, the findings reveal the problem of illiteracy and cultural influence as hindrance. Some of the cultural influences include themes and nature of the information contained in the media publication of the NGO's booklets, for example, 'sexual conduct or behaviour on 'how to use a condom' would be very difficult or uncomfortable for a child to translate to his/her parents in that particular context (Sobane, 2012).

Besides adopting the minority/ethnic language of a patient, factors such as age, demographic change, socio-economic background and gender also influence patients' beliefs and values (cf. Robinson and Gilmartin, 2002). Again, culture, language, lifestyles and religions differ greatly between ethnic groups (Vydelingum, 2000, p.100 cited in Robinson and Gilmartin, 2002). As a result, individual needs of minority ethnic patients are not met adequately in some healthcare contexts (e.g., Gerrish, 2001 cited ibid).

Contrary to studies from developing countries, Gunnarsson (2013) conducted a study in a multilingual workplace from different regions which is aimed at giving a cross-cultural picture of workplace studies on different languages by discussing both positive and problem-based accounts of multilingualism at work. The study methods involve an overview of studies on multilingualism at work with a focus on workplaces in the inner, outer and expanding English circles, in transactional companies and multilingual regions/ English lingua franca workplaces in Europe. Investigation from the study reveals globalisation and technological advances have created new types of cross-cultural networks; thus highlighting both positive and problem-based accounts of multilingual workplace in Europe.

Similarly, De Wilde et al. (2018) investigate the shift in multilingual strategies in a Flemish public healthcare service by addressing the challenges service providers are facing amidst growing ethno-linguistic diversity in a neoliberal climate. They focused on the public service provider 'Kind and Gezin' the agency that monitors the wellbeing of children on behalf of the Flemish authorities in Belgium. Drawing on ethnographic methods, they explore the organisation's decision to restrict its multilingual policy and the way the decision is influenced by neoliberal principles. Similarly, Muth (2018) examines the management of multilingualism in the Swiss healthcare industry and the negotiation of the oftentimes fluctuating and unstable value of linguistic resources in the care for medical tourists. The study highlights how international healthcare and medical tourism emerge as sites emblematic of the global new economy, and the exploitation of those linguistic resources such as the value of languages and that of Russia in particular, at what instance language gains or loses a market value and how institutional policy reacts to that (ibid, 2018).

Finally, Lindout et al., (2012) discuss safety in multilingual work setting. The study identifies the dangers of multilingual work settings and assesses the risks. They propose five ways to control risks: provision of guidance, the use of lingua franca, the reduction of illiteracy, implementing controlled readability and introduction of a range of practical measures. In

their review of the neglected subject in European Union policy, they highlighted seven unresolved dilemmas required for language policy in the EU to be further developed.

The on-going Western discourse of multilingual settings tends to focus more on power structure and how hierarchy/position influence choices. These studies however differ from the non-Western contextual approach which predominantly focuses on language competence, cultural influence as well as linguiastic dominance. For instance, Alhamami (2020) investigates code switching phenomena in Saudi hospitals from the point of view of the healthcare workforce and patients. The study's methods include semi-structured interviews for data collection and qualitative analysis to obtain findings. Nilsen (2015) studied interpreted communication with children in the public-sector. It argues that shifting from a monolingual to a multilingual perspective may assist public service professionals when planning and conducting meetings with children from ethnic minority backgrounds. Lastly, Belaskri's research on linguistic gaps in doctor-patient communication in Algeria (2017) investigates the effects of code switching in an Arabic speaking context where health practitioners are trained in French and perform medical consultations more in French than Arabic. The study submits that communication problems arise as a result of linguistic barriers which are related to proficiency levels in some language varieties, mainly French as it predominates over Modern Standard Arabic (MSA), Algerian Arabic (AA) and other Algerian local varieties in the Algerian healthcare settings.

Likewise, the developing countries' point of convergence is the argument for an improved policy implementation and healthcare provision for the disadvantaged-minority and marginalised groups. Although, there is a consensus in both contexts about language choice and use (minority/ethnic); an all-inclusive medical interactions to the consideration of other factors that hinder effective communication in multilingual settings (see Lindout et al. above).

To further make the argument about the need for research on language barriers, especially in Nigeria, we must note the high levels of illiteracy in English (which is the official language) and native languages / the three major languages –Hausa, Igbo and Yoruba. Considering most research on health communication barrier has been centered mostly on health facilities, it is necessary to investigate beyond clinical settings such as the displaced camps.

2.2. Gender and language as terrains for understanding health communication

Gender inequality is defined as unequal treatment or perceptions of individuals based on their gender (Njoku & Orchardson-Mazruri, 2006). Njoku et al., (2006) argue that gender inequality primarily derives from the glaring gaps in policy, legal frameworks, education, and investment opportunities that lead to the creation of difficulties for women towards performing to their full potential in social, economic and political spheres as active members of the society.

The concept of gender appeared in research in the 20th century (60's) dealing with a broad spectrum of gender issues across the social realm, but it began to generate interest in linguistics in the 80's , later than in other social sciences such as history, psychology and sociology. From the West, research was conducted by Western linguists (Baylon, 2002; Cameron, 1992; Christie, 2000; Coates, 1986; Eckert and McConnell-Ginet, 2004; Houdebine-Gravaud, 2003; Jespersen, 1964; Kotthoff, 2002; Lakoff, 1973).

Gender is interpreted as a factor that reveals (gender) stereotypes and is fixed in native speakers' consciousness. West and Zimmermann (2000) assert: "Gender characteristic is not just an aspect of personality but man's interaction with others" (p. 84). They further assert the distinctiveness ~~difficulty~~ of gender linguistics consisting mainly from a huge amount of theory coming from the feministic perspective of gender (ibid). This area is closely connected with psycholinguistics, sociolinguistics, and pragmatics / communication theory. At the end of the 1960's and the beginning of 1970's, gender linguistics became widespread due to a new women's movement in the USA and Germany, as a consequence, a new approach called feminist linguistics appeared in linguistics. The main research revealed the subordinate state and defectiveness of the image of women created in language. Particular features of feminist linguistics are its strong argument against a belief or opinion, its use of interdisciplinary studies (psychology, sociology, ethnography, anthropology, history) and its attempts to influence linguistic policy.

The precursor of gender terminology was the book –*The second Sex* by Simone de Beauvoir (1975). De Beauvoir argued that men had made women the "other" in a patriarchal society (West and Zimmermann, 2000 p. 29). The *Second Sex* published in French in 1975 sets out the question of androcentricity of language as a manifestation of the world's androcenricity." "Two notable (and notably problematic) names in literatures on gender and discourse often

come up: Robin Lakoff and Deborah Tannen, and, when they do, this is often in the context of a critique of the taken for granted …" (ibid, p. 29).

Robin Lakoff's study *Language and Women's place* (1975) became the fundamental work on feminist linguistics which introduced to the field of sociolinguistics many ideas about women's language that are now common place. She proposed that women's speech can be distinguished from that of men in a number of ways lexically, syntactic, and in intonation. For example, the uses of phrase like "sort of," "kind of" "it seems like", etc. This publication (by Lakoff 1975) and later ones provoked many reactions in gender study (e.g., Aina, 1998; Kramarae, 1992; Lerner 1986; Stacey, 1993).

Earlier discourse on gender and language research was dominated by a major theme, that of difference (Weatheran, 1998, p.1). Three different currents are identified in Weatheran's (1989) study: first, "differences as deficits"- which can be found in popular beliefs about language. Citing a widely held Western world stereotypes about "how loquacious women are but how trivial their talk is" (p.2), she draws from Lakoff's (1973; 1975) cluster of linguistic features which suggests typified women's speech-style negatively as being 'hesitant ingratiating and weak' (1998, p.2). Weatheran argued that women are socialized to hedge meaning in order to avoid offending men' (ibid).

By contrast, Weatheran argued that the differences in language between women and men can also be understood in terms of androcentric rule (1998, p.2). It is argued that men dominate and control language to define their gender by occupying positive semantic space; whereas women are unable to express experiences adequately. This argument is supported by earlier literatures (e.g., Stanley 1977; Henley, 1989; Spender, 1980 and Kramarae, 1981). Afterwards, two approaches (dominance approach & cultural) have been applied by theorists to construct gender differences and linguistic behaviour of women as being powerless to express their experiences of the world (e.g., Kramarae 1981; Rich 1972). Reiterating alienation in women's language use and feelings of helplessness, Cameron (1985) describes women's silence and 'having no social language', which itself makes them 'passive and silent' at women's conference (p.188).

With regards to Weatheran's criticism that identifies or clusters features of women's language as not a function of gender but a function of power' (1998 p.2); a similar argument is the research by O'Barr & Atkins (1980) entitled "women's language" or "powerless language"? The point of argument being that relevance is focused on powerless language-

function to divert attention away from language as one of the factors which reflects and perpetuates women's subordination -thereby replacing gender with the issues of power (Weatheran, 1989 p.2). Moreover, in practice, the assumptions underlying the dominance view were translated into an assertiveness training movement in the belief that women are 'inept communicators' (Crowford, 1995 p.2.). Thus, linking women's understanding and poor performance in business to be understood as a consequence of their inability to talk correctly (i.e., like men). Thus, the dominance theory lends credence to the 'androcentric rule'.

Subsequently, cultural approach theorists of sex differences attribute every aspect of women's linguistic behaviour simply to their subordination. This approach led researchers to focus more on identifying positive aspects of women's speech style (e.g., Holmes, 1984; West, 1995; and Tannen, 1990). According to Maltz & Borker (1982), sex differences in speech styles is developed as a result of early communication patterns; for example, it is argued that girls and boys are thought to play predominantly in single sex groups -thereby developing gender specific cultures- hence, generating unique communication patterns (cited in Weatheran, 1998 P.2).

Whilst previous research on gender had focused more on sex bias in language and sex difference in language use; it is important however to investigate the influence of male dominance on women's (health) communication. Whereas recent studies on gender are approached in relation to contextual relation; thus, the place of gender is argued in relation to components such as *naturalization*, *minimization*, *culture*, *marginalization*, and others in the interpretations of gender roles in Africa for instance (Kramarae 1992; Salaam, 2003; Bonilla-Sillver, 2006).

Bonilla-Sillver's theory on gender (2006) consists of four components (naturalization, minimization, culture etc.) Based on Bonilla-Sillver's theory, this study relates to two of these being naturalization and culture. Naturalization according to the framework entails situations where women or wives give a high level of respect to their husbands or men, but in many incidents, men or husbands do not give back the same respect to wives or women (Bonilla-Silver, 2006). The second assumption is culture which has to do with the inherent assumption that gender inequalities continue in Africa because of cultural ideologies. The two components of Bonilla-Silver's framework (2006) will guide the discussion of gender inequality in this research for both sets of participants': the role of gender in MPs' volunteering and the role gender plays in accessing health care for the female IDPs at the

camp. Particularly, the analysis will elaborate and show how naturalization and culture as critical components are the factors that enhance gender inequalities in both groups of participants.

In concordance with recommendations for further research in female social behaviour in communication (e.g., see Weatheran, 1998), there is the need to investigate the influence of male dominance around gynaecological problem presentation by female patients. Based on that suggestion, the research aim attempts to investigate the influence of gender, health (inequality) and structural inequality in a linguistically diverse IDP camp in northern Nigeria. The aim here is not to review this burgeoning field rather, to contribute to the already vast scope of the literature.

Gender and language have been approached individually and together to address social issues, in particular, gender in health inequality is one of such issues. Subsequently, health communication barriers have also been approached from different lens and fields. One of such lens is gender and gender inequality. Taking a leaf from the Historian, Joan Scott's comprehensive description of the term gender as "a constitutive element of social relationships based on perceived differences between the sexes {and} a primary way of signifying relationships of power" (1986, p.1067 cited in McElhinny, 2007, p.2), four elements were classified in the study's description of gender which encompasses: culturally available symbols; normative concepts; forms of subjective and super-subjective identity and forms of socialization. "Studies of subjective and especially, inter-subjective identities have long been the strength of feminist work in sociolinguistics and linguistic anthropology" (McElhinny, 2007, p.2).

Contrary to the above view, Galasinki and Zio' Ikurska (2007) argued that the gender of the gynaecologist is not an important factor in the appraisal of pelvic examination (see also Areskog-Wijma, 1987; Hilden, et al., 2003), as against the notion by Childs et al., (2005); Delgoo et al., (1993) Ekeroma & Harillal (2003); Elstad (1994); Moettus et al., (1999) and Philips & Brooks (1998) where gender is perceived as the most important characteristics of the gynaecologist. Their approach differs from Galasinki and Zio'Ikurska, which include drawing on male gynaecologists' narratives and "problematizing the notions of patients' desexualisation and individualization during the gynaecological examination" (2008). Similarly, this research is interested in the strategy employed by MPs surrounding the discourse of gender differences and gynaecological problem presentation by patients during

consultation as a possible health care challenge in an IDP camp. The reason for approaching both aspects of informants' narratives is because of the point of view from which it is told and the identity work it accomplishes.

In a nutshell, context is considered relevant in the investigation of health inequality; hence the discussion in the subsequent literature focuses on the relative importance of compositional and contextual effects in determining health variables from related studies. In light of this investigation and focusing on research findings from developing countries and their counterpart, the role of context in addition to policies, organisational structures and power dominance as a contributing factor to health inequalities is discussed by comparison and identifying what is trivial in the later discourse which is considered vital in the former.

2.2.1. Gender and the burden of disease: challenges from non-western perspectives

Despite many positive changes in terms of gender inequality as a possible communication barrier in healthcare, in recent decades, "women remain underrepresented in positions of power and prestige; ..." (Morgenroth and Ryan, 2018 p. 671). Although the last decades have encountered many positive changes in terms of gender inequality in most Western countries; for example, creating a positive fertility-development link among Western countries (Buyukkececi & Engelhardt, 2021); full time employment and gender equality (Cislaghi, et al., 2022) and integration into the labour market (e.g., European Commission, 2003; Kena et al., 2015; United States Department of Labor, 2015). However, that may (not) be similar to other developing countries such as in Sub-Saharan Africa.

In Sub-Saharan Africa for instance, the number of women in Science, technology, engineering and mathematics (STEM Fields); politics and other sensitive government positions are underrepresented (Elu et al., 2017 p.367). With the dominance of male gender in some fields and Africa being a patriarchal society, the consequence is the resultant gender inequality in most positions of power and prestige such as executive leadership (e.g., Makama, 2013; Bassey & Bubu, 2019; Jaiyeola, 2020).

The importance of focusing on how gender relations are enacted and maintained in moment to moment linguistic interaction has been a recurrent theme in previous reviews of empirical work on gender and language (e.g., Eckert & McConnell-Ginet 1992; West, 1995). Also

recent studies address the need for research on language diversity and gender inequality in interactive context (e.g., Liu et al., 2018; Tolstokorova, 2006).

Research on gender, particularly in understanding feminine health communication reveals some disadvantages women/girls in most developing countries face in seeking healthcare and the burden of diseases they have to bear. For instance, Maynard-Tucker (2014) found that more women than men are HIV positive. There were around 12 million women living with HIV and AIDS in 2008 compared to 8.3 million men and by the end of 2010, it was estimated that out of 34 million adults living with HIV/AIDS, half were women, and an estimated three-quarters of these women live in sub-Saharan Africa (UNAIDS, 2008 cited in Maynard-Tucker, 2014, p.10). The study findings reveal also how pregnant women tested for HIV and were found positive are blamed for getting the virus through unfaithful sexual relationships, although most were infected by their husbands and partners (Twimukye, et al., 2024; Makusha, et al., 2020; Maynard-Tucker, 2014). The likely causes of women being infected more has been attributed to their physiology, unsafe sex and/ or the inability to negotiate condom use with their partners; because women are said to be subjected to non-consensual sex (ibid, p.2). Yet preventive programmes have not been developed with specific information for women, especially rural, non-literate women and government in most of these contexts do not take a legal stand against non-consensual sex thereby denying women and the girl-child the rights to speak out (cf. Maynard-Tucker, 2014 pp.2-3).

Consequently, cultural customs have created burden of diseases on the girl-child in many parts of Africa (depending on ethnicity and religious tenets) who undergo genital mutilation (Maynard-Tucker, 2014, p.3). The World Health Organization (WHO) also estimates that 130 million girls have undergone one of these procedures globally (ibid p.2). Again, girls have no say about the violent ceremony and failure to participate will result in family or community rejection of the victim. The ritual endangers women's reproductive health during childbirth and also reminds women that sex is for the pleasure of men (ibid)-thus, supporting a patriarchal society (where the girl-child/women has no say).

2.3. Health inequality: the domestic neglect of internally displaced persons

Writing on health disparity and inequalities between refugees and IDPs, Rae (2011) proposes ways to address this injustice in the political environment by outlining her own perspective

on how the international community might realistically resolve differences in international law to accommodate and promote the health rights' of IDPs like refugees.

Displacement whether through 'population facing conflict –induced' or individuals suffering the direct effects of violence and forced migration are often confronted with social exclusion, impoverishment and loss of government provision of welfare, education and particularly susceptible to violations of the right to health, which makes protecting this group a priority in the field of health, conflict and peace (Krug et al., 2002; Lavoyer, 1998 Castles et al., 2005; Mooney, 2005, Betts, 2009). However, a major challenge is how to eliminate health disparities created within this group as a result of discrimination between IDPs and individuals more generally in international human rights law. Here, refugees are distinguished from their counterparts 'internally displaced persons' (IDPs), primarily where the former have crossed an international border and the latter have not (office of High Commissioner for Human Rights (OHCHR) 1951, 1966). Refugees have a legal human rights instrument safeguarding their rights (OHCHR, 1966a) which increases their health protection whilst causing a corresponding neglect of IDPs.

The most significant difference between the IDPs and refugees is in the international law regarding the rights of the latter who are protected by 'the Convention relating to the Status of Refugees' (CSR) (OHCHR, 1951), whereas IDPs derive their rights protection from two universal human rights treaties, namely, the international Covenant on Economic, Social and Cultural rights (ICESCR) (OHCHR, 1966a) and the International Covenant on Civil and Political Rights (ICCPR) (OHCHR, 1966b). This has led to neglect in the protection of IDPs, not because their rights are not covered by legislation, but because specific conventions relating to particular populations are often better respected by the international community. It has been proposed that further human rights instruments should be drafted to provide protection to other populations who are vulnerable to abuse (Cohen, 2004). It could be argued, however, that this is a reflection of a general lack of respect of fundamental human rights, a situation which further is encouraged by sanctifying the prioritization of the rights of certain groups over others. Where states are held more accountable for fulfilling the rights of certain groups, those protected by law that go beyond the general are afforded more protection- as is the case with refugees (Lee, 1996).

Although IDPs have their rights specifically addressed in the guiding principles (GPs) on internal displacement however, these are not comparable to the protection provided by the

government because they are non-binding (OHCHR, 1996a). Certainly, the GPs have raised awareness of IDPs and articulated their specific needs (Droege, 2008). They have even been incorporated into national law with measureable benefit. However, for the most part, the GPs have remained rhetorical statements that are not been used practically to improve the human rights situations of IDPs (Weiss 2003; Mukwana and Ridderbos, 2008). The reality is that although hard law is often blatantly disregarded by states (Hafner-Burton and Tsutsui, 2005), soft law utilized for IDPs is barely even beginning to challenge states' perceptions of their obligations to fulfill human rights. Thus, the rights of refugees have remained better protected because of their articulation in a specific human rights instrument.

2.4. **Chapter summary**

In chapter two we discussed previous related literature on health communication, linguistic diversity, gender and structural inequality. The sub-section includes discourse on health communication from earlier scholars to recent arguments. This discussion further introduces health communication and the management of multilingualism. Here, the varying view from literatures in different context is presented alongside their submissions or findings. Linguistic diversity in multilingual healthcare settings from both Western and non-Western setting is discussed next. The discussion from both settings avails us with situations of multilingual healthcare setting in these contexts. What follows is a discussion on gender and language as terrain for understanding health communication. Gender as a concept is discussed with a view to understanding the different approach it has taken from previous scholars to date. Gender and the burden of diseases, here we discuss the challenges from a non-Western perspective. The focus here is on how gender this relations are enacted and maintained in moment to moment linguistic interaction. After which we looked at health inequality and the domestic neglect of IDPs. In general, this sub-topic draws a stern difference between IDPs and refugees particularly in the Western world.

CHAPTER THREE

RESEARCH CONTEXT: IDPS AND THE CAMP

3.1. Introducing the research context

Nigeria is a multilingual country and - by population – the largest nation on the African continent. Hundreds of languages are spoken in the country which includes Hausa, Yoruba and Igbo (three major languages), other ethnic groups and English as its official language. Although there are estimated 200-400 languages spoken in Nigeria (Adegbite, 2006), however, the lack of tentative records could be attributed to a number of factors mitigating against adequate effective language planning, these are lack of communication system, insufficient funds for interested individuals or bodies interested in the surveys, lack of government impetus and large expanses of groups needed to do the survey. It is likely that ethnic affiliation in the country over land ownership and sentiments of superiority over major and minor language groups have further brought about disunity in the states and country at large (e.g., Ishola, 2019; Nwakanma & Boroh, 2019; Omisore, 2018).

The country (Nigeria) has experienced various forms of internal displacement, from armed conflict to natural disasters, ethno-religious disputes, and communal clashes, affecting millions of people (Mohammed, 2017). After two decades of conflict crisis caused by Boko Haram terrorist group, millions have been affected and over 2million remain displaced (International Organization for Migration (IOM), 2022). Majority of IDPs have settled in self-settled locations (non-government authorized sites) and within host communities. These groups have often been considered “invinsible” and do not receive needed support (Olanrewaju et al., 2019; United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA, 2016).

The continuous conflict has resulted in a constant population displacement where effort to return the displaced persons living in camps are often met with newly displaced ones and others who have returned to their communities being displaced a second time (IOM, 2022). The IDPs experience numerous problems: such as inadequate assistance, insecurity, health challenges, and lack of rehabilitation options (Oluwasanmi et al., 2017; Obiefuna & Adams, 2021). Host communities have also been severaly affected as increased IDP migration

depleted local resources (Verme & Schuettler, 2021). These challenges illustrate the broader complications of displacement at the macro level, there is however limited information about managing their health communication barrier and managing their internal affairs at the camp.

This study has identified women and children as the most vulnerable groups due to their inability to adequately provide and protect themselves. Although this study centers on women-IDPs due to ethical consideration, the observation of their vulnerability collaborates with Amirthalingam and Lakshhman (2013) study in Sri Lanka that reported the need for protection and assistance for women exceeds the requirements of men; also there exists significant economic differences between females and males. In addition, Shah et al., (2021) and Munyuzangabo (2021) reviews on women and children in conflict settings identified insufficient nutrition and healthcare resources, insecurity concerns and limited evidence available concerning interventions. These disparities in gender need and proection has significant healthcare consequencies, especially since women and children are more exposed and affected by reproductive health issues, they need a medium to Chanel their concerns. Their view is similar to the stance taken in this research.

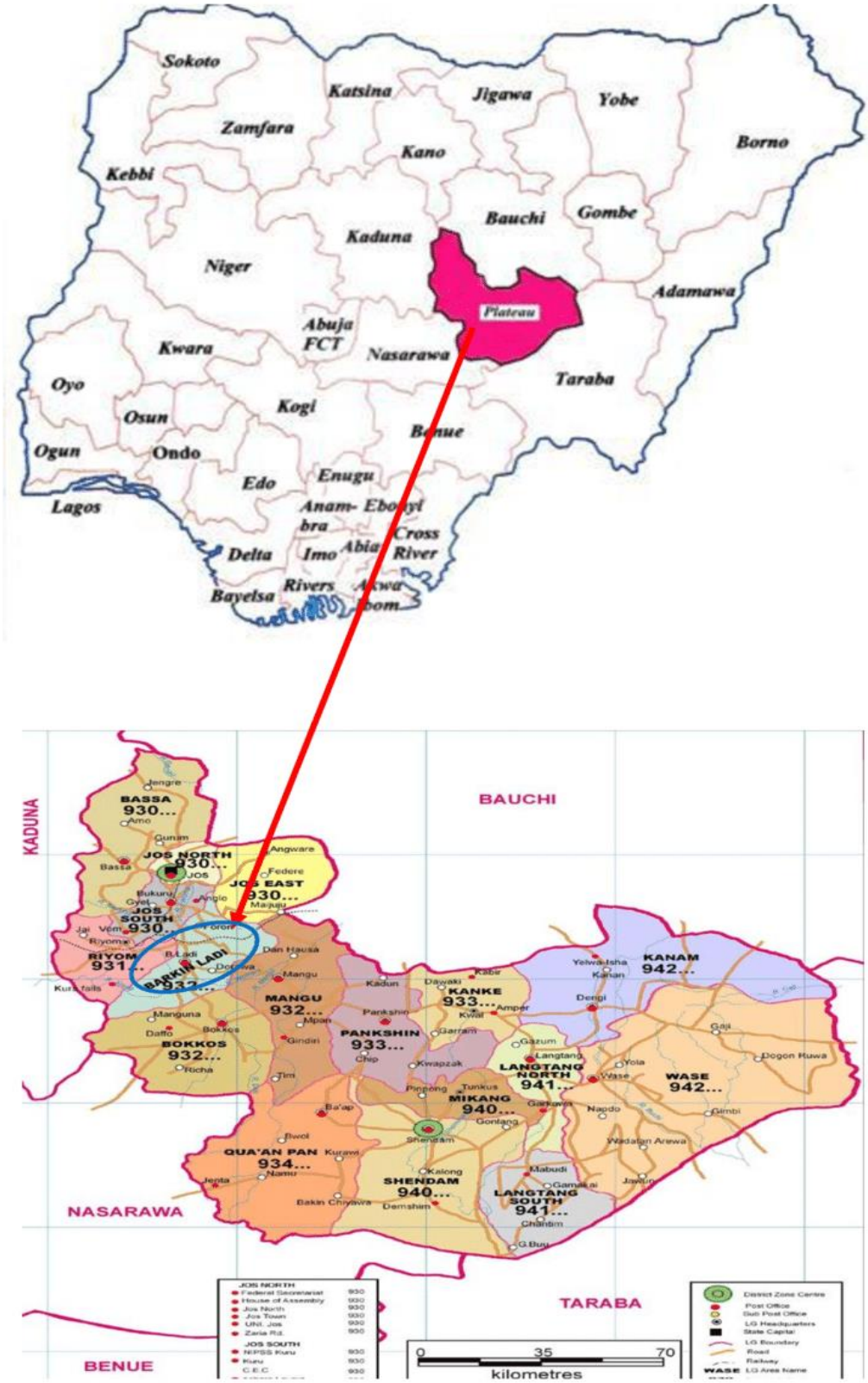

Figure 1: Map of Nigeria showing the 36 states and FCT[4] with study area highlighted/LGA[5]'s in the State

Map data © 2022 Google

[4] Federal Capital Territory (Nigeria's Capital)
[5] Local Government Area

The study site is Plateau State. It is the twelfth-largest State in Nigeria. Situated approximately in the center of the country, a north-central[6] State which was created in 1976 (February 3rd) out of the northern half of former Benue-Plateau. It shares boundaries with Kaduna and Bauchi on the north, Taraba on the east and Nasarawa on the southwest. Plateau State has a population of over three million residents (2018/2019 population ranking) with forty (40) ethnic groups including the *Ankwei, Angas, Izere, Berom, Miango, Anaguta, Mwagavul,* among others. These ethnic groups occupy the seventeen (17) local government areas of the State. Each local government area has a unique ethnic lingua Franca that is peculiar to the languages of that community and not the Hausa language as classified under the groupings of the country's three major languages in the amalgamation of the language states. Thus, there is need to put in place necessary policies that can address issues of unshared codes in the system in order to address disputes of land ownership and sentiments as earlier stated.

The research setting is heterogeneous with a culturally diverse population which consists of about five minority ethnic groups /six dialects from twelve different communities in the north-central state of Plateau. The common Lingua Franca of the host community is one of the minority languages, and the ethnicity/dialects of the IDPs differ from what is obtainable in the host community. The IDP camp consists of twelve communities from different ethnic groups of speakers. Approximately, seven languages and six dialects of one language make up these groups. Each of the community has representative at the camp to serve as their mouth piece when aids are supplied or basic need needs to be communicated to the appropriate committee and/or persons. The languages spoken at the camp include:

1. Berom: Berom is a major language spoken in the state and has six dialects spoken in the eleven districts of Bachi, Du, Fan, Foron, Gashish, Gyel, Heipan, Kuru, Ropp, Riyom and Vwang (Gwom, 1992). The six dialects are:
    a) Gyel-kuru-Vwang cluster
    b) Du-foron cluster
    c) Fan-Ropp-Riyom cluster
    d) Bachit cluster
    e) Gashish cluster

[6](Other geo-political zones in the country are North West, North East, South East, South-South and South West).

f) Rahoss-Tahoss cluster

2. Mwagavul
3. Angas
4. Kulere
5. Ron
6. Foron
7. Gashish

The languages spoken are from 7-8 local government areas of the 17 L.G.A.'s in the state. Berom is spoken in four (4) local government areas including Jos North, Jos South, Barkin Ladi (where the IDP camp is located), and Riyom. Mwagavul is spoken in Mangu L.G.A., while Angas /Ngas is from Pankshin / Kanke; Kulere and Ron are languages spoken by people from Bokkos. Gashish and Foron are both dialects of Berom from Barkin Ladi. Although Gashish and Foron are dialects of the Berom language, cultural differences exist between the two different groups of speakers.

The choice of the research setting is intentional. Reasons being that, first, Nigeria is the sixth among the ten most populated countries with IDPs in the world after Columbia, Syria, DR. Congo, and Somalia with Yemen, Afghanistan, South Sudan and Sudan after Nigeria (Mandic, 2022; Okeke-Ihejirika et al., 2020). In a recent study, Nigeria was ranked 9th (3, 340 IDPs) out of 10 countries globally with the highest number of displaced persons and Sudan being the 1st with a total of 9,053 IDPs (UNHCR, 2024). Apart from being one of the most populated countries with IDPs, Nigeria is Africa's most populous country with socio-cultural and multi-ethnic groups, which provides the basis for a multilingual study. Second, as a researcher, I live in the area close to the camp thus making this kind of research feasible. In addition, Plateau State is among states in Nigeria with the highest report of crises and displacement (on Jos crises see e.g., Ojukwu & Onifade, 2010; Higazi, 2011) others are Maiduguri in Borno State and Kaduna State. However, unlike Borno and Kaduna states that have a common Lingua Franca (Kanuri & Hausa), Plateau state has a different lingua franca in each community, which relates to the concern in my research. This, therefore, informs the choice of Plateau over other States.

At first, I approached the field site with the question of linguistic diversity and its effect on the health communication between the MPs and IDPs in the IDP camp. After the first few visits and getting immersed, what Agar (1980) refers to as "gaining entre" into the research

site, I observed a number of relevant categories that are at play at the camp. Following Heller et al.'s (2017) 'mapping, tracing and connecting' technique, I was able to gain entry into the camp through my first informant –an NGO- who is familiar with stakeholders at the camp. Although gaining the trust of the IDPs and some of the MPs to work with took some time, however, a number of Pre-visitations which began from March, 2019 to February 2021 (when the actual data collection began formally and continued to mid-2022), provided a useful 'bonding time' with the informants I later identified at the camp.

The IDP camp clinic

A single room outside the government-owned structure housing over 500 displaced persons serves as the IDP 'clinic'. The room has some basic equipment and medical supplies such as stethoscope, thermometer, and an examination table/partition screen on casters with curtain, four to five plastic chairs around a consultation table, and another table displaying medicines/drugs in different containers (see pictures below). Initially, different medical teams of specialists from Medecins Sans Frontieres (MSF), *Urgence Internationale, Medecis du Monde,* and others visited the camp fortnightly- within the first few months of their arrival at the camp in 2018. Subsequently, these medical visits have changed to irregular visits by the medical teams. Consequently, two healthcare practitioners were stationed at the camp by Nigerian Medical Association (NMA) to cater for the IDPs' health needs. They are trained health technicians and non-natives of the host community.

Figure 2: A cross section of IDPs inside the camp: 4/14/21

Figure 3: The IDP clinic set up 1: 4/14/21

Figure 4: The IDP clinic set up 2

The IDPs are grouped in small numbers for easy allocation of chores, food distribution and orderliness. Upon arrival at the camp, IDPs queue to receive food and it's often inadequate; however, this became more organized and tentatively easy with the reduction in the population of IDPs living at the camp. At the onset also, the IDPs had difficulties finding conducive space at the shelter to lay their heads at night; it was run on – as one informant remarked - "a first come - first serve basis" no one having monopoly of space.

The IDP camp is a repurposed food depot originally used to store bounty harvest such as, *irish* potatoes or cocoyam from local farmers. The building has 20-30 rooms each contains a single window and door.

At the time of the research, the majority of displaced persons were accommodated in 30 rooms. Hence, there is limited ventilation, inadequate space and lack of basic provisions such as bedding.

3.2. Key stake holders and informants at Barkin Ladi camp

This research takes into account a number of key stake holders for an in-depth view into the phenomenon of displacement. In order of relevance to this investigative study, the stakeholders here include study participants, officials, and relevant organisations assisting in the camp with other key individuals and groups which I found relevant to the study. Below are the key stake holders in the study:

- The IDPs
- The MPs
- The Government
- The NGOs
- Others e.g., IGPs[7]/the Church

Before we describe each stakeholder, it is relevant to note that although these stakeholders enumerated above are relevant to the description and interpretive work in this study, however, emphasis is placed on the first two, i.e., the IDPs and MPs who are directly affected by the concerns discussed in this research. Based on this reason therefore, the different method(s) of data collection focus on the two stakeholders.

Considering the different groups of people involved in the entire process, from those displaced to the healthcare providers and security personnel in charge of their security, etc., it is relevant to describe the nature of communication in such a diverse population. Owing to the linguistic hierarchy in Nigeria, languages spoken at the study area are categorized under the minority languages; while the language of health communication is the English language distinct from the lingua franca in the urban center- Hausa, a major language spoken in the country. The Hausa language only serves as lingua franca within the urban center of the study area, but most IDPs are from rural areas and predominantly speak minority indigenous languages and/ or MT only. Hence, IDPs at the study area have little or no knowledge of the lingua franca, the national or major languages (Hausa, Igbo & Yoruba) and/ or the official language English; especially, those without formal education.

[7] Intergovernmental Organizations/International non-governmental Organizations

Below is a short description of the above listed stakeholders. For a better understanding of the participants at the temporary shelter, the role of each stakeholder at the camp and as part of this research and how each relates to this investigation is presented.

1. The IDPs

The IDPs in this research are the key participants and study group in the research. They consist of people from diverse linguistic groups, with different political affiliations, socio-economic class, religious and cultural beliefs that have experienced one form of abuse or another and are living in the camp at the time of research. The IDPs are from thirteen different ethnic communities within the state. The language groups spoken by the displaced are among Nigerian minority language group. The majority of the displaced persons are non-literate who practiced subsistence farming as a major source of lifelihood before coming to the camp.

2. **The MPs:** The MPs in this context are the medical practitioners who volunteer to provide healthcare for those living at the camp. They consist of professionals, trained medical personnel and health care or social workers providing health information, care and treatment to IDP-patients at the camp. Here, the MPs are also key informants and serve as participants in the research. Considering also the medical training of MPs in Nigeria is in English, all the MPs can speak the official foreign language and their MT in addition to one of the lingua franca and /or a majority language not necessarily the minority languages of the community they are providing health care. There is inadequacy on the part of the MPs sometimes in understanding the lingua franca or indigenous languages of their patients.

3. **The Government:** The government both at the State and Federal level is the institution in place that is by law responsible for the well-being of the internally displaced persons in the state and country at large. Although the state is by law guided by the federal government, it however has autonomy over certain privileges on how they address issues of basic care of the displaced based on their revenue generation and federal allocation. This consists of the state government, National Emergency Management Agency (NEMA)/ State Emergency Management Agency (SEMA), the military (e.g., Nigerian Army,) and Paramilitary (e.g., NDLEA, FRSC and Police force). During the cause of the investigation, their response to the plight of the displaced persons is studied. During the data collection, I sought permission from the security in charge of the IDP camp to gain access to the camp**.** The IDP-camp is guarded by security personnel to provide a form of protection to the displaced. I noticed a

form of hierarchy when I sought permission to meet with the group representatives at the camp; the Police men I met at the entrance further introduced me to their superior who then asked a number of questions like my identification, affiliations, etc. I provided identification like my work identity card, school identity card and ethics approval to conduct the study. Considering the number of NGOs and humanitarian aid workers visiting the camp on a regular basis, it was easy to gain access to the site and my acquaintance -a humanitarian aid worker also provided ease to the process. There have been a number of researchers who had earlier visited the camp for data collection that also provided pre-informed knowledge for my non-literate participants. As such, there was no need for a written permission from government representatives, although I had to conduct preparatory meetings with research participants –the group representatives of the IDPs and the MPs- in order to seek formal permission from participants to discuss my project with them. I engaged both written and oral consent forms before those meetings were conducted.

4. The NGOs: The Non-Governmental Organizations are humanitarian aid agencies, charitable and volunteer groups and/ or individuals who contribute to the care and well-being of IDPs. These NGOs include International non-governmental organizations (IGOs), the religious bodies (e.g., the Church), Red Cross, MSF, etc.

During the course of my data collection, I met with a number of NGOs like Caritas and Peace International; I was privileged to attend a number of their meetings with the IDPs. I also met with a number of religious bodies- the Church- at the host community and observed how the Nigerian Medical Association doctors consult at the camp during medical visits. The two medical doctors (MPs) in the study are members of the NMA.

Some of the contributions from NGOs I observed include that of the Red Cross, they built the toilets in the camp and the NMA provides care, medical essentials, medication etc., to run the clinic. The clinic is also managed and maintained by the NMA. The NMA put in place two trained health workers from within the IDPs on shift at the clinic to provide temporary care in absence of the MPs. These two personnel are given a stipend to carry out the job of providing care for the IDPs in their absence. They kept a medical record for all clinical visits of IDPs and for record keeping on medical supplies provided by the NGO at the camp clinic. This record includes the patient's name, age, gender, problem presented/diagnosis and prescription.

5. Others: Other groups include the individual humanitarian aid workers and those who assist in the maintenance of the temporary shelter by providing and caring for the IDPs. I met with two groups of IGOs; one of the group leaders is an acquaintance and they are interested in the provision of sanitary products especially for the women-IDPs and also provide basic amenities for the IDPs. It is worthy to note that their visits although not consistently regular, however, they provide a form of temporary relief to the immediate needs of the displaced persons.

The church also play a role in the sustainance of the displaced: The IDPs are predominantly Christian and the churches in the host community offer assistance to displaced persons, including shelter and the provision of food in the church building for IDPs; in addition, Christian groups provide pastoral care.

3.3. The research participants and their life trajectories: MPs and IDPs

This section of the chapter presents a brief insight of participant - their life trajectories, socio-economic status, experiences and encounters with one another whether as IDPs or as MPs; and the insecurity challenges they face at the camp. Below is a personal description garnered over a period of two years of fieldwork at the camp -starting with key informants –the MPs to other IDP participants -.

3.3.1. MP participants

1. **Mrs. Felicia Daniel**: Felicia (also known as Aunty Nurse) is Birom and she speaks Gyel-Kuru- Vwang dialect. She is from Riyom L.G.A. Although an IDP; she was employed by NMA to act as a nurse in their absence. Felicia is a trained health care worker at the school of health technology, Pankshin and her area of specialty is community health. She is yet to attain the requirements needed to serve as an expert. Her basic knowledge is guided by record keeping and collaboration with other trained doctors whom she contacts in case of emergencies via phone-call. She began as an interpreter after a year of stay at the camp because she is also an IDP who was pregnant (the girl delivered at the camp is now 4 years old) during the first year of their displacement. Having lost a child, her mother in-law and other family member's aside property and businesses as a result of the

attack on their community by Fulani herdsmen; she was “depressed and suicidal” during the first year of their arrival at the shelter. Her effort as an interpreter has brought in relief to some of the women-IDPs although she could only speak four dialects of a language, Hausa and the English language, there are other languages of the IDPs she cannot understand or speak in such situation, she often relied on body and sign language and other means to understand their problems. She is in her mid-forties and married with 5 children. At the time of this analysis, she delivered another baby (son). During her delivery, there were complications and she was delivered of the baby at the city center in a conventional hospital (Ecwa Hospital ‘Jan’kwano’). She was on admission for days before she got discharged. Being my key informant, Felicia opened her home to me and we journeyed together through informal and formal interactions of her experiences and trauma of life’s tragedy on displacement, lost and pains. She calls me ‘sister’ and indeed she is considerate and kind.

2. **Dr. Andre Maxwell** is a trained family Physician with over twelve years of experience as a Medical doctor. He is a consultant and is in his mid-forties. He is married with two children (a girl- 8years and a boy- 5years). He has worked with various public health institutions in the State and country at large and is also a member of the NMA who volunteer as humanitarian aid workers in various IDP camps within the country. Dr. Maxwell an indigene of Plateau State speaks and understands three Nigerian native languages-Ngas, Hausa and Mwagavuul and the English language. He is outspoken, patient, friendly and a very jovial person. He speaks rather very fast but is elaborate and eloquent in his conversations. As a consultant who is in private –practice, –he visits other clinics or private hospitals within the FCT-Abuja for extra financial gains, thus, that makes Dr. Maxwell very busy. Some of the interviews I had with him were virtually although we later discussed in person at the camp and other times in the city-center in his free time. A notable point is the fact that most times appointments are rarely met and the researcher’s expectations in achieving the scope of the study is delayed because of the participants’ commitment due to busy schedules and emergencies –considering their role as medical practitioners-. In this study also, failed appointments were partly because of insecurity and frequent curfew installed at various times in the state during data collection.

3. **Dr. Alexander Burt** is a trained medical doctor in the field of health management; a member of the NMA and also a volunteer at the IDP camp. His area of specialty entails the overall management and/ or leadership of both public and private healthcare facilities/organisations. His tasks include improving patient care and patient experience; managing the storage and privacy of patients' information and ensuring that everything within the healthcare organisation runs smoothly, among other duties. His area of specialty matters to the management and smooth running of the IDP camp.

   He is forty-six years of age and is married with three children (two boys and a girl) between the ages of 6-12. Dr. Burt has over five years of experience as a medical practitioner and he is in private practice. He owns a clinic at the research site or the host community. In fact, his clinic also offers the IDPs' health care services at a subsidised rate. He has more contact with the IDPs considering he speaks and understands the majority of the dialects of the displaced population. Although he is not an indigene of the host community, but of a neighbouring community- Du-foron, he believes "a person is not appreciated in his home town" (like the Biblical saying of Jesus). Dr. Burt like Dr. Maxwell speaks and understands four languages (Birom and 3 other dialects of Birom and Hausa) including the English language. Although he is an introvert- the quiet type, but he is welcoming and sympathetic to the struggles of the displaced people. Apart from his private practice which offers pre- and post-natal care services, laboratory- tests, admission (IPD/OPD) and medications, referral among other care, he is a civil servant with the State-owned public hospital in the city center. He has more contact with the IDPs especially pregnant women at the camp who frequent his clinic for ante-natal during their arrival at the camp. Hence, his perceptions and contribution made a huge impact in the data collection and analysis. Part of this data collection is the observation during part of his medical consultations with the patients at the camp. Being a public servant and in private practice made him busy, as such sometimes I have to book an appointment to suit his schedule and at other times, during such meetings, it tends to be really brief but relevant issues are often discussed.

3.3.2. IDP participants

4. **Felicia Daniel** (also known as Aunty Nurse) is married and in her early 40s (Refer to MP participant 1 above). She received formal education to 'A' level as a trained public health assistant. Apart being a trained public health assistant, Felicia is also an entrepreneur. She has knowledge of marketing clothing and has received training as a hair dresser. She had shops where those businesses were thriving before she was displaced. After years at the IDP camp and with the assistance of the NGOs, and her spouse who is into mining and other businesses too, she plans on opening a saloon to start up another business at the host community. Felicia is Birom by tribe and speaks and understands three languages (Hausa, Birom, and English). She is from Riyom L.G.A. and speaks the Gyel—Kuru- Vwang birom dialect.
5. **Salomé Vincent** is in her early 50's; she is educated and a widow but displaced and deprived of her daily livelihood, home, carreer and freedom. She had hoped on the government to rescue them from such situation to achieve better living -which was not so. She was frustrated and disappointed at the government. She has an 'O'-level education and some level of awareness. Before their displacement, she workd as a civil servant. Salomé's husband died during the attacks on their community. She is outspoken, sympathetic and knowledgeable. Salomé is Kulere from Bokkos L.G.A. and speaks three languages (Kulere, Hausa, Ron) as well as some English.
6. **Mary Abel** is one of the oldest among the women IDPs. She is an 85 year old widow and grandmother who also witnessed the Fulani attacks on her home community. She has been living at the IDP camp since 2018. 'Grandma' Mary was a farmer before her displacement. Some of her challenges include body pain -considering her age and poor living condition, she requires basic needs such as food, warm clothing, decent accommodation and medication; however, these needs are hardly met. '*Mama*' Mary understands only her native language and Hausa - though she has no formal education, she is wise and from our interaction, she strikes me as a contented individual with a positive mind-set. 'Ngo' Mary is Berom and speaks the Fan-Ropp dialect of the language. She is neither proficient in Haussa nor English.

7. **Sarah Ishaya** (aka ‘Ma’ Faith): she is a widow in her mid-40s and lacks formal education. One aspect of her life trajectory is the plight of widows especially in their condition. She is a dependant and had no-skilled acquisition, nor education, and no entrepreneurial skill except that she assisted her (late) husband on small scale farming to cultivate their inherited land. She is left with six children to cater for after the demise of her husband, with nothing to depend on except humanitarian aid which is not consistent. She resolves to fate. Her countenance is that, she has ‘nowhere to go to’, no one to help her except the government come to their aid. Her late husband’s brothers have confiscated his remaining inherited land to farm and considering their home was destroyed during the attack, she now has nowhere to live with her children if she decides to return to her husband’s home town. She has boys and girls in their teens and between the ages of 3 -12 who are dependants and out of school. She also suffered from infections of the genitalia but was ashamed to discuss this with MPs on medical visit. Sarah hails from Pankshin L.G.A. and speaks the Ngas language. She also understands and speaks Hausa and Pidgin English.
8. **Nancy Paul** is in her 30’s and single although once married with children. Nancy has low level knowledge of the Lingua Franca though she is comfortable with the use of interpreters during medical consultation. She is an advocate of peace and the need to intensify security in the state at large. Reason is that, she believes when people learn to live in peace with one another, such re-occurrence is avoidable. Nancy is Berom and speaks the Rahoos-Tahoss dialect of Berom and a low level of Hausa.
9. **Tabitha Duniya** is divorced and in her early 40’s. She has major health challenges and needs regular medical check-ups although that is not feasible considering the skeletal services they receive at the camp. The effect of this has been a major challenge on her general health. She is helpless due to financial constraints. From our encounter, it is obvious that Tabitha has been managing her health condition for years and only receives inconsistent medical attention from MPs. It is glaring the MPs are overwhelmed following the lack of x-ray testing machines and medical supplies at the camp. Tabitha is from Mangu LG.A., and speaks Mwagavul language. She is also competent in Hausa.
10. **Esther Solomon** like other IDPs, Esther came to the camp in 2018 due to prevailing insecurity and previous attacks at her home town. She is one of the study participants who narrowly escaped death as a result of the serious wounds she sustained during that attack. She still suffers the effects of these wounds caused by machete on her head and some parts of her body. Esther is a widow with children and she is in her early 30s. She has low

level education (O' level) and speaks low level English language, Hausa and her native language. She was a farmer before her displacement but now engages in 'tin mining' for survival. Her current need is to be provided with proper health care services. She is in need of proper medical attention but this has not been possible due to financial constraints. Esther is from Bokkos and speaks Ron language, too.

11. **Naomi Ibrahim** is in her mid-40s and married. She has no formal education and her major source of income before they were displaced is farming. She has one surviving child because she lost other children during the crises. She had PID infection and was treated by the MPs during one of their visits but got re-infected. After the first treatment, the infection became unbearable and she had to consult the nurse on duty (AN) for help. Naomi is Berom from Du; she speaks the Du-Foron dialect of the Berom language and understands the Hausa language.
12. **Jummai Dauda** has some level of education (A' level) and basic health awareness. This is seen in the way and manner she handled the case of Pelvic inflammatory diseases (PID)/infections of the genitalia both in her situation and that of her adolescent son. Her awareness provided a means to solving what would have been a major setback in her son's life. She spoke up, advised him and supported his treatment, and later surgery and post-surgery recovery. Jummai disclosed her health challenges with the visiting MPs without shame or fear; as a result, they (she and her son) both received help through free treatment and free surgery also for her son. This is an exceptional case considering she is one out of the 11 women in the survey group that break such silence. However, considering her level of education, awareness and exposure, her educational level could be the logical explanation to the reason for her decisions to disclose her health condition. Jummai is Berom by tribe and speaks the Gyel-Kuru-Vwang dialect. She is competent in Hausa and English, too.
13. **Deborah Charles:** Deborah is married and she is in her early 40's. Deborah and others from her community voluntarily relocated to the IDP camp for safety following security alert of an intending attack on her village by Fulani herds-men (whom at that point in time were attacking neighbouring villages). The men in her community stayed behind to look after their homes while children and women were asked to move to a safe location such as the IDP camps. Their village was later attacked and she lost her home and some of her family members that is the reason she and others remained all these years at the IDP camp for safety and survival. Some of her health challenges include low-blood pressure and ulcer. Deborah is a positive spirited individual; she is at ease with the

diverse groups at the camp. Deborah has no formal education; she has limited proficiency in Hausa but is fluent in her native language Berom (Rahoss-Tahoss dialect). Her source of livelihood before their displacement was farming.

14. **Veronica David** is in her late 50's and married with children. Veronica has been in the camp since 2018 too and like others, she and other people from her community were displaced as a result of Fulani attacks. Before their displacement, she was engaged in a small scale business enterprise and farming. She had suffered from pelvic inflammatory disease (PID) and an impending ailment (not stated) which she needed surgery but due to financial challenges, she had been managing her health condition. Veronica is Berom by tribe and speaks the Bachit dialect of the language.

The above fourteen participants grouped into MPs and IDPs are featured in the focus group discussion (see chapter 5 for details) and were later interviewed individually as a follow-up. The two MPs and Aunty Nurse served as key informants of the study.

3.4. Causes of displacement

As outlined in the first chapter, research has identified two major causes of displacement: natural- and man-made. The most common causes of displacement in Nigeria are man-made and stem from religious-, and interethnic conflicts, informed and fuelled by wider social- and economic inequalities. Natural causes such as floods (for instance the devastating Maiduguri flood in 2023) are further causes of displacement. In this research, participants identified "fulani-herdsmen'" as the main perpetratous and causes of their displacement. Accounts of attacks on members from thirteen communities who were displaced and sheltered in the camp were documented during fieldwork, for instance the massacres at Riyom and Bokkos L.G.A.'s. According to the IDP participants, armed men indiscriminately targeted mean, women and children. It is unclear however why and what informed the choice of villages they attack; but from various analysis and comparison, a number of similarities have come up as to 'why' the attacks and 'what' their choice of certain villages than others were. First, the villages attacked are predominantly peasant farmers within arable land and naturally endowed locality with good location. The search for land for their livestock is one driving factor of those attacks; another is the search for arable land in order to settle down and cultivate crops and other agricultural products to be sold at local markets. Their interest in acquiring agricultural land and the underlying struggle for economic resources has been a key

reason for displacement in Nigeria in the past two decades – in fact, most of the research participants attributed the loss of arable land and their crops to the attackers and to those struggles. Accounts of attacks from farmers from a number of Nigerian states such as Nasarawa, North East–Maiduguri, Zamfara, Plateau and other places shows also how food crops and grazing are a leading factor in the "Fulani herds-men"/farmers attacks. The farmers are often attacked and killed on their farms prior- or during harvest, making farm-work insecure for other family members. Barkin Ladi, the area where the IDP camp is located is a case in point in that respect – its fertile lands have been under continuous threat by Fulani herdsmen and at the time of research, most IDPs in the camp from the Gashish community of Barkin Ladi.

However, people are not only driven from their land during acts of violence but also in fear of future attacks, in particular since their communities cannot rely on support by security forces. Rumours around kidnappings and killings in neighboring areas also contribute to growing numbers of IDPs, with women and children leaving their villages and men staying behind to protect their land.

3.5. Chapter summary

In this chapter, I presented an account of the research context - a Nigerian IDP camp; its physical structure, day-to-day activities and available health care system in relation to multilingualism and medical communication. I also introduced key stakeholders in the study and provide insights into the research participants and their life trajectories. I noted that even though five to six stakeholders were identified in the study, only two, that is, IDPs and MPs are investigated because they are directly affected by the problems of health communication and inequality under investigation.

The next chapter comprises a description and discussion of the methodological approach to the research. The approach used in the research is guided by Heller et al.'s (2017) method of mapping of things, activities, and people. Here, I employ this strategy to identify the relevant and sensitive impact these activities, persons or things have on the general process at the camp. Mapping of persons, things and activities helps to identify the best method for data collection.

CHAPTER FOUR

METHODOLOGICAL FOUNDATIONS

4.1. Chapter introduction

There is no prescribed recipe as to how to conduct linguistic ethnography research (Copland & Creese, 2015); rather, the linguistic ethnographer pulls from both linguistic and ethnographic data collection and analysis methods to work towards unpacking the relationship between language and social context(s), demonstrating this through interpretive–based evidence (Sarangi and Roberts, 1999) and critical sociolinguistic ethnographic analysis (Heller et al, 2017). Basically, these methods that the linguistic researcher employs to do so may vary depending upon the *theory* (claims that can be measured and tested), *ontology* (general beliefs about the topic at hand), *epistemology* (what is defined as knowledge), and *axiology* (values) to which they subscribe (Rampton, 2006).

Following the above therefore, in subsequent sections, I discussed the methodological underpinning / techniques to the study, methodological framework, data collection procedures and methods. This is followed by mapping of person, field-site, things, resources and activities (time/space/material objects at the camp); and mapping and categorization of linguistic resources. I also discuss data analysis procedures from methodological foundations each of which have been selected carefully, the goals of the study, and my own aforementioned ontological and epistemological views. Later in the chapter, I discuss challenges that I had encountered during data collection as well as reflect on my own positioning within the field. My position in this thesis is an objective outsider who also has the perspective of an insider.

4.2. Methodological foundations

Hymes' (1996) collection of essays addresses theoretical, methodological and political issues about the study of language in social context. At the heart is an analysis of the complex relationships between language, speech communities and social inequality (Hymes, 1996 p.

iv). Its diverse contents range from the critical discussion of American language planning and policy, to the study of the traditional narratives of Native Americans and stories written by African-American school children. The essays span the period from 1972-1996. Hymes asks how we can use theory and research in ethnography, linguistics and education to understand how particular discourses, languages and literacies count and act in particular cultures' and communities' interests (ibid p.vi). He provides a critical commentary to the contributions of Habermas, Bourdieu (1996) and especially, Basil Bernstein to discussions of language and inequality (ibid, p vii).

Writing on Rousseau's 1756 essay on inequality, Hymes proposes ethnography of language that is a science of activism and intervention; that the proper role of scientists should not be "extractive," but 'mediative.' It should be to help communities be ethnographers of their own broader proposal for a science of 'mediative' practice, involving interventions with, on behalf of and alongside of marginalized communities of speakers (p. Vii). This challenge was pursued by Gumperz and Hymes (1972/1986) and colleagues in the formation of ethnography of communication, described across the chapters.

In western civilization, the dominant intellectual response to the existence of diversity has been to seek an original unity, either of historical or psychological origin (sometimes of both). The dominant practical response has been to impose unity in the form of hegemony of one language or standard (Hymes 1996, p.viii). According to Hymes, "the issue of linguistic and social inequalities have remained central to our work as teachers and researchers" particularly, consequences of new economies and communities, hybrid voices and cultural identities (ibid.).

Linguistic ethnography captures "a growing body of research by scholars who combine linguistic and ethnographic approaches in order to understand how social and communicative processes operate in a range of settings and contexts" (Snell et al, 2015, p.1). Building on the foundational work of scholars such as Frederick Erickson; John Gumperz and Dell Hymes, contemporary scholars adopt an interdisciplinary approach to research in the area of medicine (e.g., Swinglehurst, et al., 2011) social policy and sociology (e.g., Shaw et al., 2015); social semiotics (e.g., Bezemer & Kress, 2015; Bezemer & Abdullahi, 2019); language and discourse (e.g., Blommaert, 2013; Blommaert & Rampton, 2011; Rampton et al., 2004; Jacobs & Slembrouck, 2010; Tusting & Maybin, 2007, Maybin & Tusting, 2011; Martin-Jones et al., 2016; Roberts, 2009), among others.

Linguistic ethnography involves understanding the everyday lives and practices of a particular social group involving time spent 'lurking and soaking' as participant observers in the field (Werner & Schopfle, 1989 in Snell et al, 2015, p.7). In contrast to Werner and Schoeplfle (1989) or Madsen and Karrebaek (2015) who propose long periods of time for participant observation, Collins (in Snell et al, 2015) describes an ethnographic study over a five-month period.

Different understandings exist as to what constitutes primary and secondary data and how useful these are for analysis. Some viewed video and audio recording as primary and other data collection methods such as field-notes, interview transcripts, etc., as secondary (e.g., Lefstein and Israeli, in Snell, 2015). Others maintain that field-notes in particular are not simply useful for contextualising events but are as vital to linguistic ethnography as any other data (Snell et al, 2015). In addition to the relevance of field-notes in ethnographic research, they argue that field-notes should be subjected to the same rigorous linguistic analysis as interactional data. It is important to bring together different sources of data and demonstrate how and why they focused on these within their analysis. For instance, Craig et al., 2021 employ triangulating transcript via multimodal coding (audio and video recordings), interviews and written texts in their study in order to explore media engagement with sexual and gender minority youth (SGMY). Some also argue for the need of a diverse range of data to ensure that linguistic ethnographers are able to access areas of social life that may not be open to direct observation (Hamersley, 2018). Whatever data choices an ethnographer chooses, it is important to note that "reliance on only one method or a small number of methods for all research in this arena would greatly limit our understanding of health communication and the knowledge claims that would be possible" (Thompson et al., in Whaley, 2014, p.6).

What makes linguistic ethnography appealing is the use of linguistic and ethnography in ways to help understand the complexities of modern life (e.g., processes of globalisation and multiplicity) (see Blommaert, 2013; Blommaert & Ramptom, 2011). Also, it is the combination of linguistics in ethnography that "links the micro to the macro, the small to the large, the varied to the routine, the individual to the social, the creative to the constraining, and the historical to the present and to the future" (Bezemer, cited in Snell et al, 2015, p.8).

Hymes (1996) identifies some of the problem areas as "diversity of language", "medium of language (spoken /written)", "structure of language" and "functioning of language" (ibid,

p.27). Following from Hymes list of plausible linguistics problem areas, this study aligns with the effects of diversity of languages in use and language management. In overcoming diversity of language, the difference of language is not itself divisive; it can become a symbol of conflict in certain economic and political circumstances. A good way to make a language a symbol of conflicts is to repress it (Hymes, 1996 p.210).

4.2.1. Methodological framework

The overall design of this research follows the general methodological principles of interpretive-critical ethnography. Zoller and Kline (2008) note that interpretive approaches focus on the basic assumption that perception or reality is constituted as individuals engage in interactions and attach meaning to phenomena. With regards to health, "interpretive scholarship demonstrates the ways that individuals define and make sense of health and illness through factors such as personal experiences, interpersonal negotiations, cultural backgrounds, and class frameworks" (Zoller and Kline, 2008, p.98). In relation to this study, interpretive approach proves useful in understanding the "local context within which health meanings are constituted, health care relationships are negotiated, and health practices enacted" (Zoller & Dutta, 2008, p.12).

In addition to interpretive framework, I follow a sociolinguistic approach (Heller et al., 2017) and gender linguistics (lens) (Motscnbacher, 2016**)** as my model in gathering and analyzing data. In the analysis that follows, four sets of analytical activities, "mapping, tracing, connecting and claiming" allow me to figure out what kinds of people do what kinds of things, why and with what consequences in terms of their ability "to gain access to valued resources, or to influencing the conditions that give those resources value" (Heller et al., 2017 p.142). In order to understand how health care is negotiated and experienced at the camp, I adopted an interpretive approach to gathering and analyzing data.

The analytical strategies based on Heller et al. (2017) are described into four sets of activities these are mapping, tracing, connecting and claiming. These four analytical activities allow one to figure out 'what kind of people do what kinds of things, why, and with what consequences in terms of their ability to gain access to valued resources, or to influencing the conditions that give those resources value' (cf. Heller et al 2017 p.142). Furthermore, the four

analytical strategies lead you to the argument you want to make: 'that something is happening for specific reasons, you identify and it has observable consequences' (ibid).

Language is especially useful as a lens for identifying material that is socially relevant: form, sequence and meta-commentary (Heller et al., 2017 p. 143). So first, is the matter of distributing linguistic form in speaker's practice; here we mark the contrasts on which categorization rests, i.e., this can be used to mark off groups (those who speak Hausa, or any of the three major languages, those who speak English the foreign language; those who cannot understand any lingua franca, or language of consultation, etc.). Thus, speakers can be built or grouped on these distinctions to use those associations to construct other meanings, symbolically positioning these groups in the speaking position of one or other group, calling into play what these groups and their relationships might represent (for instance power and prestige, feminity and masculinity; urban or rural lives).

The process of the research therefore includes immersive fieldwork that seeks to provide a 'thick description' (Geertz, 1973 cited in Sarangi & Roberts 1999, p.1) of data from understanding of the participants in their everyday conduct of life as it occurs in a natural temporary setting (Hammersley & Atkinson, 2019; Walford, 2009; Heller, et al., 2017). 'Participant –observation' is broadly defined by taking field notes and audio recording of interactions from specific activities (in this case, medical consultation; meetings; and interviews). Given the insecurities in the State and Country at large, the fieldwork is largely deliberative and pre-arranged by telephone calls and telephone chats with my contact (AN). In addition, some information is generated from telephone conversation. Subsequently, semi-structured interviews were pre-arranged with purposely selected participants of both IDPs and MPs for further data collection.

The nature of my research questions warranted specific respondents. Therefore two groups of participants engaged in this project. These include Medical practitioners who speak English and a Nigerian language, and IDP –patients who identify as women or adult female above 18 years of age (either literate or semi-literate), who can speak or understand a Nigerian language preferably, the lingua franca of the study area and/ or English. In other words, my selection of participants was based on a purposeful sampling process. Therefore, I included

individuals who could provide specific information regarding my research questions (Creswell 2007; Lindlof & Taylor, 2011; Patton, 2002). With this approach, I could explore the similarities and differences in perception and opinion among the MPs and IDP- patients which added scope and breath to the study.

I also employed the snowball sampling process (Lindlof & Taylor, 2011) by contacting my major informant and known MP to refer me to other colleagues. MPs who participated in this study were a family physician specialist, a Community Health Officer (CHO**)** and consultant and a trained public health assistant (who was an IDP too). I interviewed three MPs both specialists are male while the employed assistant is a female IDP (For their demographic characteristics and trajectories see Table in 4.3.1). At the beginning of an interview, I assigned each participant a pseudonym.

In terms of recruiting IDP- patients, I sought permission from the management and security personnel (gatekeepers) of the IDP camp facility; I then addressed the IDPs in general and asked their participation. I was assisted by the trained public health assistant who organised meetings with twelve gatekeepers/representatives of each community at the camp, meetings were held at the camp clinic and only invited voluntary participants took part. Basically, I ensured that the IDP volunteers were comfortable to disclose their health condition and could discuss for at least 30 minutes or more and are willing to reflect on, and share their experiences.

I collected initial data from January to June 2021. After reviewing my initial data from focus group interview and observation, the second batch of data collection (observation/interviews) began in January of 2022 through Febuary, 2023 for additional information. My research questions focused on participants' experiences as they pertain to language barriers in communication, practical approaches to addressing language barriers and reliance on interpreters, presenting health challenges or problems to MPs during consultations and their perception on how best to address any challenges they have (or not). Although I focused on guided interview questions during data collection process, I kept an open mind about related topics on MPs-IDP patients' interactions.

As most of my IDP informants were illiterate and not able to read the participant information or understand a consent form, I read the participant information document in English and translated the content of the read information sheet in Hausa for better understanding. After reading and explaining the information to my participants, those who accepted to participate

appended their signature in the English version. Patients who participated in this study spoke their native dialects, Hausa language and a bit of Pidgin English and a few also speak English. I did not encounter any difficulty explaining and translating the consent form to IDP patients because I could read, write and speak the common indigenous language (Hausa), pidgin and English; although I do not speak or understand any of the thirteen indigenous languages/dialects spoken at the camp. In order to verify that each participant understood the process, I verbally reviewed each item on the consent form as I did with the MPs. I clearly stated (assured) that all identifying information would be edited during the transcription process. Furthermore, I assured IDP-patients that their decision to participate in this study would not in any way interfere with their health information, re-instatement, or their relationship with the visiting MPs. I made it explicit also that our conversation would be audio recorded. After explaining the process, I asked clarifying questions from IDP- patients to confirm that they indeed understood.

In order to ensure the IDP participants felt comfortable during our interactions, we (my informant and I) decided to make use of the camp clinic as our particular location (since there were no medical supplies at the moment, patients hardly come in to seek for medical attention). To make patients feel at ease with the recording and interview process, I started with questions such as introduction of self after I had introduced myself again, my objectives and affiliations. I then followed up with specific questions about their experiences at the camp and reasons they were sheltered at the camp. This opens up the interactions further to other questions and clarifications or follow-up on particular response. With permission from both IDP and MP participants, all interviews were recorded, transcribed in full and annotated with field notes.

After each interview, I turned off the recorder and spent 5-10 minutes talking informally with each participant. I took brief notes during these interactions to use as additional data if needed. Interestingly, the post-interview process served as a forum where IDPs shared their frustrations about various challenges. MPs also expressed their concerns about the conditions of the IDPs and their working condition during such moments. During our interactions, I also informed participants that, if I needed clarification on any subject that we discussed, I might return to ask further questions. All the participants understood and said they would be happy to speak with me again. After every interview or group meeting, we had an informal group talk and this is usually followed with a light refreshment of snacks (coca cola/malt drink and biscuits) which I provided. The snacks were bought from a nearby shop by two participants.

4.2.2. Data collection procedures

Throughout the data collection, I audio recorded (many hours of some incoherent recordings were not included in the study) the interactions, interviews and focus group discussions I had with the IDPs and MPs, where permitted. I utilized a bilingual knowledge to create transcriptions of these meetings in order to later code and analyse the data. Although video recording would have provided for a more detailed analysis (e.g., use of body language and facial expressions), this information was not the focus of the current study and was, in fact, substituted with information from observation and anonymity of the participants. In addition, asking to video record marginalized displaced groups of individuals who are expected to speak on their experiences and challenges may have been an act of surveillance (Martinez, 2016; O'Connor, 2017) and /or may have discouraged their participation.

4.2.3. Methodological techniques

"Within an ethnographic tradition, it is not only the professional or worker contexts which may be studied but also that of the client, patient or inmate" (Sarangi & Roberts, 1999, p.28); so the institution is not observed only from the work perspective but from the perspective of those who are regulated by it. Hence, this study technique includes investigating two person categories that is, IDPs and MPs using ethnographic methods of observation, field notes, recordings from semi-structured interviews, and the use of artefacts/relevant documents. It will involve the use of extra-linguistic data such as policies, any relevant documents in the discussion of the phenomenon of internal displacement, health communication barriers and gender impact on the health (communication) of female IDPs. Ethnographic methods and techniques allow for in-depth investigation as embedded in wider social and historical orders.

Emerson et al., (2001) argued that participant observation involves not only gaining access to and immersing oneself in new social worlds, but also providing written accounts and descriptions that bring versions of these worlds to others. Again one of the central beliefs of ethnography is the use of multiple methods in investigation; in particular, that interviews are unlikely to be productive by themselves thus the 'only reasonable method' is to observe, interview and collect artefacts alongside the 'subject' ethnographer as the researcher goes about the tasks (cf. Walford, 2009 p.118).

Another method adopted is writing of field notes through participant observation and field-notes (Papen, 2019) Walford (2009, p.117) describes field notes as 'the basis on which ethnographies are constructed'. In a study, Walford (ibid) interviewed four 'well-known ethnographers of education' (Paul Connolly, Sara Dalamont, Bob Jeffrey & Lois Weis) about their practices in order to document how field notes are constructed. The study found no particular method to writing field notes. On the nature of what may be recorded (e.g., Bogdan & Biklen 2007, pp.118-29; Emerson, Frets & Shaw, 1995; 2001; Jackson, 1990; Sanjek, 1990) in field-notes (Papen, 2019) also varies according to research interest and one's observation. Lofland describes observation as the first characteristic of qualitative field work (cited in Walford, 2009). Findings from the group interview in the study show the basic tasks as the same –to record as much as possible what is perceived to be relevant to the research project so that there is a record that can be used later in the analysis and writing process-. The ethnographers all recognised the limitations of memory in developing their field notes and seek to record what they see and hear immediately. The findings show no common language to describe what they do when they are writing field notes; what they actually do, depends on context and personal preferences as well as being comfortable (or not).

4.3. Data collection methods

In practice, while examining the IDP camp structure in a Nigerian context, I collected data by interviewing, observing and making field-notes, and collecting key documents e.g., from media, statistics and information records of patients at the camp clinic. My interviews varied from very informal discussions to carefully planned narrative research interviews where my aim was to try to collect people's narratives of the account that led to their displacement and challenges at the temporary shelter. My observations include making field-notes, taking lots of pictures and sometimes also audio recordings. The textual data was collected by saving the key documents to a hard drive.

Field notes

This observational data served as an opportunity to examine the participants in the sociolinguistic/ethnographic practices and relationship –building in the context of actual interactions between IDPs and MPs. As described by Papen (2019), even with the advent of

increasing complex technologies that offer various affordances, field notes are still the hallmark tool for the ethnographer to provide additional context to such observational data. Field notes may take shape as descriptions of pertinent components of the research context (space, people, interactions, roles), "verbatim accounts of what was said "(Hammersley, 2015, p.2), a place for the researcher to make personal commentaries, and /or a blend of these and other forms.

Although there is no one or correct way of writing up field notes, it is vital that the researcher reflect on *"what to write down, how to write it down and when to write it down"* (Hammersley & Atkinson, 2007, p.142, emphasis maintained) to make this a valuable collection method. Additionally, if possible and conducive to the goals of the study, the researcher may incorporate audio and/or video recording into their study design as a complement to these field notes or collection of language data through recording and observing (Hammersley, 2015; Papen and Nance, 2022).

During the observational period at the IDP camp, I took detailed handwritten field notes in which I highlighted important features of the interactions and the spaces in which they took place, biographical details of pertinent social actors, relationships between these actors and personal reflections. In case of the IDPs, I audio-recorded their interactions after gaining these individuals' permission to use this interactional data. In case of the MPs, I only use permitted observation during medical consultations and patient appointments and field notes in order to respect the patient privacy which does not include recordings or video recording during medical consultations.

Semi –structured interviews and conversations

Interviews are a valuable instrument in the social sciences (Briggs, 1986) that can assist the linguistic ethnographer to better understand and incorporate participants' perspectives (Copland & Creese, 2015; Richards, 2003). There are two overarching categories of interviews, each with their own purpose: *formal* and *informal* (Richards, 2003).

Formal interviews (semi-structured interviews) take on different shapes in qualitative research: structured (explicitly following a set of questions) or semi-structured they are guided by but not limited to a set of questions (Richards, 2003). The latter is widely preferred in linguistic ethnography as it offers the researcher and the participant the freedom to explore other topics and engage in these topics more deeply (Copland & Creese, 2015).

Although less common in traditional ethnographic research (Agar, 2008; Gobo, 2008), formal interviews are ubiquitous within Linguistic Ethnography, Copland and Creese (2015) anticipate that their higher prevalence stems from the fact that linguistic ethnographers who "adopt an ethnographic perspective" may not spend a substantial amount of time in the field in comparison to traditional ethnographers (p.3). Therefore, these types of interviews offer researchers who "have established respectful, on-going relationships with their interviewees" an efficient, alternative approach to addressing research questions that would have otherwise been addressed through more extensive participant observation (Heyl, 2001, p.369). Nevertheless, there are disadvantages associated with formal interviews, including difficulty for participants to reflect on certain experiences in the moment, as well as the issue of comfort-ability and /or sensitivity to both recording devices and a formal atmosphere, among others.

In this research I carried out pre- and post- semi-structured interviews (n=11 +3) at various points in the data collection period. The pre- interview took place a few weeks into the data collection period (2001 ending –January 2022) while the post- took place at the first quarter of 2002 and towards the end of data collection period–Febuary 2023-. I created a set of questions (in both English and Hausa) focusing on the participants' backgrounds, socio-economic status and or/ professional expertise, language and community of affiliation to guide the discussion (See Appendix). Additionally, I included questions based upon topics that arose during the interview and information from previous data collection from the onset of the study.

Overall, the interviews helped me to not only build a better understanding of the IDPs' (and MPs') experiences, but also to promote reflection on various features of their communicative competence, challenges and relationships throughout their stay at the temporary shelter. The interview methods allow the participants, particularly the IDPs, space to express their concerns and air their views with the hope of being heard. Following this method, I assume a stance of learner-listener -with a question now and then so that data emerge genuinely as "stories (IDPs) tell themselves about themselves" (Geertz 2005, p.85) both by observing and listening to their comments. Most importantly, as the participants answer the interview questions, they tend to narrate their experiences thereby providing additional insights into what is obtainable at the camp: the structural inequalities, political and social inadequacies prevailing at the camp. Through their narration also, they provide clues to their past socio-economic status (SES); beliefs and identity.

While the choice here is formal semi-structured interview, informal interviews in comparison to formal interviews on the other hand are more common for traditional ethnographers who spend extended periods of time in the field. They take the shape of spur of the moment interactions that occur in a variety of different contexts and spaces and typically focus on a specific topic without the use of pre-formulated questions. Unlike formal interviews in which the researcher takes an authoritative position in the informal interviews "he/she positions him/herself as ignorant and the interviewee as the one taking the lead" (Copland & Creese, 2015, p. 6).

An adjustment that can be made for linguistic ethnographers who are unable to dedicate a prolonged amount of time in the field is to use the "go-along" technique (Kusenbach, 2003), in which they conduct an informal interview with a participant before or after an activity (Copland & Creese, 2015). Even if this adjustment is made, these types of interviews can pose certain complications, such as the risk that the participant will not perceive the encounter as part of the research process, as well as the feasibility of recording these encounters.

Complementing the semi-structured interviews, I incorporated the "on-going" technique through seeking out communication with IDPs through a variety of more informal channels of communication. Specifically, conversations with participants in the course of their daily actions were carried out in order to build rapport with the displaced, prompt reflections asked for additional information, and clarify my doubts regarding topics or events that arose during observations or from the participant-reported tasks. If the interview would not interfere with their tasks, I would ask IDPs impromptu questions before, during and after the observations. I also engaged in conversations virtually (e.g., text message, phone calls, and messenger) during lock-down periods especially due to insecurity challenges in the state (at that time) or to respect their busy schedule in the case of the MPs. Reaching out to them in this way provided time for me to review the data that I had collected up until that point and identify any important areas that I would later check with the participant.

Focus group

As a participant observer, my aim was not just to collect objective data about the IDPs and the camp daily practices prevalent on the field-site but to understand those practices as the

women in the study understood them, through their use of the communicative resources available to them.

Focus group discussions or interviews, fieldnotes and semi-structured interviews formed a major part of my data collection techniques in my field work. I used focus group interviews with the IDPs only. It served different purposes, besides eliminating formality and exaggeration, a group situation gave some less confident IDPs the courage to participate and share their ideas. Focus groups are generally viewed as giving voice to members of vulnerable and marginal groups (Carey and Asbury 2012; Robson 2011). I believe it provided a good platform for some of my participants. The greatest advantage was that, it gave me the opportunity to observe more carefully the interactional behavior of the participants, what they said and more importantly how they say say it and how the other members reacted and interacted. I concluded at least two sets of focus group discussions with the women-IDPs is enough to clarify or strengthen the themes that had emerged discursively during the field work.

In addition to observations and interviews, I initiated focus group meetings to better understand and contextualise my ethnographic observations. Focus group meetings allow for insightful discussions that elicit a range of feelings, opinions, and ideas, often those that can go unnoticed in individual semi-structured interviews (Kreuger & Casey, 2009; Tusting, 2022). Due to MPs' busy schedule and the inability to find suitable time for each person, only IDP-patients participated in the focus group discussions. Fortunately, I did not encounter any difficulty in bringing IDP-participants together for focus group discussions, a clear advantage being that they were all living at the camp. I conducted focus group discussions twice with 11 to 12 participants respectively but in the analyses, I only present, interpret and analyse the first discussion. I made a decision to use only one of the two focus group discussions to avoid repetition. As participants were the same in both focus groups, topics participants addressed during the second focus group meeting mirrored those from the first; since I had a huge volume of audio recordings and handwritten fieldnotes to deal with, I decided to use only one of the focus group discussions. All the participants in the first focus group were interviewed individually (see Table 2: IDP participants' demographics).

During the focus group discussions, I posed an open-ended question about some aspects relating to my research which needed more clarification. For example, I asked IDP-patients to

share their perceptions about clinical interactions especially in cases of language barrier; if they were from the same community; and if they have any challenge with the provision of health care. I listened while participants engaged in dialogue about their perceptions and /or experiences. The focus group lasted approximately two hours. Overall, the focus group discussions provided useful information because it changed the objectives and aim of the research focus. The focus group did not only supplement the observation and interview data, but also allowed for additional concepts to emerge and existing ones to be more defined.

Transcription decisions

This study adopts a broad orthographic transcription method that uses the standard spelling convention of the languages (English / Hausa) to represent the spoken words, focusing on content rather than pronunciation. The choice of transcription method includes choosing not to repeat repetitions, false starts, hesitations, overlaps and interruptions, stress or loudness because what I am primarily interested in is what people are saying rather than the way they are saying it.

Of the many variations (Kano Hausa, western Hausa, Northern Hausa, Southern Hausa, Ghanaian Hausa, Non-native Hausa) and dialects (Sakkwatanci, Arewachi, Zazzaganci, Duaranchi, and Kananci) of the Hausa language, the Kano Hausa variant was adopted because it is usually referred to as "standard" Hausa and this variety of Hausa is the one used in nearly all printed materials in Hausa including the Hausa language newspapers of Nigeria. It is also the variety of Hausa most heard in broadcast media, including both Nigerian radio and television and international Hausa broadcasting, such as the BBC, Deuttsche Welle, The Voice of America, and others (http://aflang.humanities.ucla.edu). With regard to English, I've adopted British English and its spelling convention as this allowed for almost verbatim representation of the audio data.

Gatekeepers / security personnel debriefing

In order to bring the gatekeepers and /or security personnel in charge of the IDP camp perspectives into play, I asked for their verbal consent to engage in informal debriefing sessions after their interactions with the IDPs. During this time, I asked them a brief set of questions relating to their background / occupation and language use, ethnic extractions and perceptions of the IDP camp safety. This debriefing took place in Hausa Language, English and/ or a combination of the two according to the gatekeepers/security personnels

preferences. The interaction with gatekeepers was not recorded but notes were taken because it was beyond the scope of this investigation.

Written Medical records of IDPs consultation:

A medical record (n = 20) containing patients' personal information served as secondary document for analysis. Out of the 20 medical records collected as documents, only the female adult consultations records were used in the analysis. The motivation for this decision was to compare and identify the nature of medical concerns reported to the IDP clinic. The document also provides biographic data of (IDP) patients particularly, their age, sex and medical conditions. These medical records in form of a diary will give insight into the existing challenges, concerns and or reference made with regards to health care and health challenges. For ethical reasons, I shall present a modified version of the documents in place of original copies to protect participants' identity. Below is a tabular representation of IDPs' previous medical records:

Table 2: Patients' personal information/medical records (2019)

S/NO.	IDP patient Initials	Diagnosis	Age	Treatment
1	TA	PUD/fever	ADULT (AD)	Accounted for
2	RL	PTSD	AD	Accounted for
3	SB	PUD/worms	AD	Accounted for
4	LA	URTI	AD	Accounted for
5	PD	PID	AD	Accounted for
6	MI	HBP	AD	Accounted for
7	FD	Fever	AD	Accounted for
8	AI	Ulcer/worms	AD	Accounted for
9	SC	URTI/PUD	AD	Accounted for
10	HD	Fever/PUD	AD	Accounted for
11	MD	URTI	AD	Accounted for
12	EN	Malaria	AD	Accounted for
13	MA	B/P, leg pain	AD	Accounted for
14	UL	Diabetes	AD	Accounted for
15	SM	Leg & toothache	AD	Accounted for
16	HU	HBP	AD	Accounted for
17	RD	PID	AD	Accounted for
18	DS	Catarrh	AD	Accounted for
19	DG	Malaria	AD	Accounted for
20	RT	PUD/Plasmodiasis	AD	Accounted for

Key: PID: Pelvic Inflammatory Disease / **PUD:** Peptic Ulcer disease / **URTI:** Urinary Tract Infection / **BP/AD:** Blood Pressure/Adult / **PTSD:** Post Traumatic Stress Disorder

4.4. **Mapping and tracing diversity in an IDP camp at Plateau State, Nigeria**

The first step taken in mapping the research site is conducting a focus group chat with some gatekeepers (11 in number) who were selected with the help of my key informant Felicia Daniel aka–Aunty Nurse (henceforth AN). The selection was based on group representation classified according to the ethnicity present at the camp. Although there are about 13 ethnic groups, we were able to narrow it down to 11 persons. I had met with some fewer IDP males during the initial visits and most of these IDPs work as day labourers and others left the camp during formal data collection. On the other hand, a focus group chat with the women representatives led to one major concern, health inequality-particularly, gender inequality and its effects on health communication and health care.

To understand how language is involved in the making of social difference and social inequality first, there is need to identify and observe who deploys what linguistic forms and practice, how and where; and how language relates to how people orient to each other, in space and time (Heller et al., 2007). The second is how all of these are rendered meaningful through discourse. In doing that, ethnographic methods are relevant in obtaining data particularly by observing and recording medical encounters between the MPs and the IDP-patients; shadowing key informants to understand the 'how and where' and writing field notes on observable threads about linguistic diversity among the IDPs. Also, in mapping out where participants are to be found in the organizational structure that is, what jobs they had, whether they were male or female, their age groups, how they socialize in the camp especially during activities, and who uses what language more or less in what activity. During observation, I attempt to also evaluate 'to what extent my research participants actually fit my assumptions by making hypotheses about unexpected or unlooked –for profiles of people (for example, the assumption that most of the IDPs are from poor background and uneducated).

The mapping manifests the following categories: people, things/resources, space, time and activities. See figure 5 below of the IDP camp mapping and some relevant person categories:

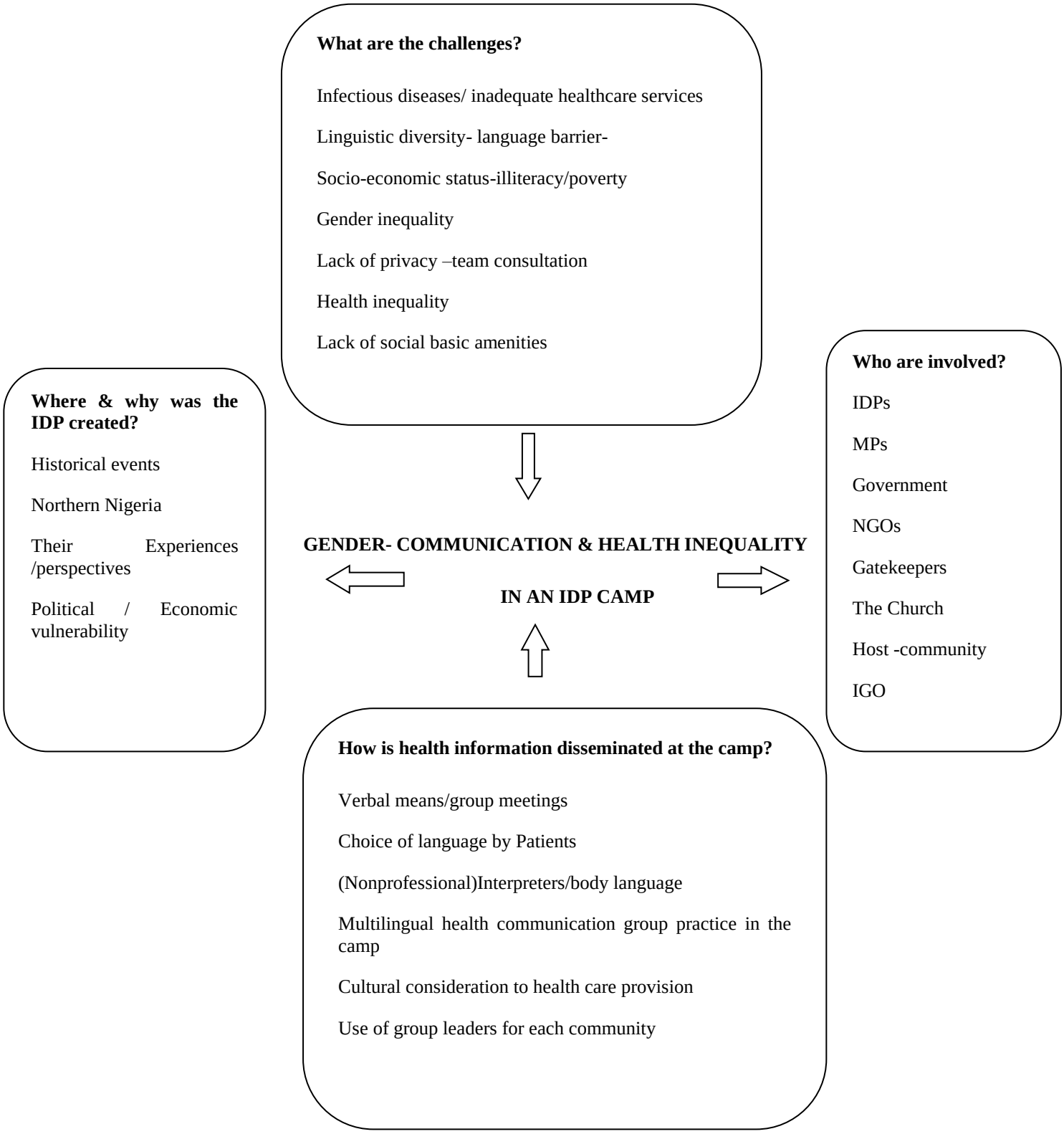

Figure 5: Field site mapping

The tables (3&4) below summarizes the demographic profile of the participants in the study. However, a more defined description of person mapping at the camp consists of:

1. A male dominant healthcare team
2. A female (and children) dominant IDP camp
3. A substantial number of children without formal education
4. A team of medical practitioners from the Nigerian Medical Association (NMA) visiting fortnightly.
5. The church in the host community and other religious NGOs like the Justice, Development & Peace Caritas – a Catholic Church relief funds Initiative – "Impacting Live" by empowering women – through microloans.
6. The state Government /gatekeepers
7. Other International NGOs e.g., MSF, UNICEF, etc.

4.4.1. Mapping person categories at the IDP camp

Table 3: IDPs Participant/researcher's socio-demographic profile

Participant	Names	Age	Language Group	Highest level of Education	Marital status	(Previous) source of income
1.	Salomi Vincent	45	4	NCE	Widow	Civil servant
2.	Mary Abel	85	1	None	Widow	Small scale farming
3.	Sarah Ishaya	43	3	None	Widow	Subsistence farming
4.	Nancy Paul	30	1	Secondary	Widow	Small scale trading
5.	Tabitha Duniya	40	2	Primary	Separated	Small scale trading
6.	Esther Solomon	33	5	Primary	Widow	Small scale trading
7.	Na'om Ibrahimi	45	6	None	Widow	Subsistence farming
8.	Jummai Dauda	46	1	A'level	Widow	Subsistence farming
9.	Deborah Charlse	42	1	None	Married	Subsistence farming
10.	Veronica David	58	1	None	Married	Small Scale trading
11.	Felicia Daniel	45	1	A'level	Married	Large scale trading
*12.	Abigail Izang Ambi	42	X	A'Level	Married	Civil servant / Researcher

KEY

NCE: National Certificate for Education-Teacher training programme

A' level: Above O' level-higher degree obtained

Table 4: MPs participant demographic profile

S/NO.	Names	Age	Languages spoken	Area of specialty	Years of experience	Affiliations
1	Dr. Andre Maxwell	45	4	Family Physician	12 years'+	NMA / public hospital
2	Dr. Alexander Burt	46	4	Health Management	10+	NMA / Private Practice
3	Mrs. Felicia D.	42	4	Public health	5+	IDP Employed by NMA / Trained health care

From the above mapping therefore, person categories vary from numerous ethnic groups of IDPs, MPs to the religious bodies (church), the Nigerian Medical Association, government or non-governmental (NGOS) organizations acting as either gatekeepers and/ or humanitarian aids for the displaced persons. There is a major role played by the Nigerian Medical Association (NMA) in the sustenance of healthcare at the camp. The NMA act as humanitarian aids by providing two stationary health practitioners at the camp for daily healthcare services while the team visits fortnightly for medical consultation. Subsequently, the role of the Church and or religious bodies particularly, the ones in the host community and 'Catholic (International) Relief Funding body-who cater for disadvantaged women' in the context is investigated. Sequel to this formation is the grouping of the IDPs into ethnic affiliations and gender. Most of the IDPs are categorized in (6) dialects of one of the majority language group in the state while others are from (5) minority language groups. The eleven (11) languages/dialects are from different government areas and communities[8] (see figure 2 for study area). They are either classified as Aged (65 and above); Adult Female/Male (between the ages of 25-65); Young People (adolescent) male/female (18-25) and or Children-0-17 years (who are not a part of the study). Apart from age differences, gender is one other person category that intersects. It is important to investigate the reasons for the obvious dominance in population by female IDPs. In a bid to investigate this category, the narrative of IDPs' lived experience is necessary during the semi-structured interview. In the person categories, their demographic information and Socio-economic status is classified and critically analysed in order to find out how inequalities manifest.

4.4.2. Field-site mapping and language grouping

Linguistic resources on the other hand are categorized following Heller et al.'s (2017, p. 143) proposal; based on different linguistic affiliations, different languages, linguistic varieties and or the different discourses or genres inherent at the camp (see the description below in A-F).

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[8] The language communities at the IDP camp are labelled group A-M.

a) One Majority language group Berom consist six (6) dialects/communities of speakers. The communities are labeled ‘language group 1-7’.
b) Five minority language groups with five different language groups from different Local Government Areas in the State. These language groups are labeled ‘language group 9- respectively’.
c) Language groups 1, 6 and 7 speak different dialects of the same language while language groups 9-11 speak different languages.
d) The Hausa language is the Lingua Franca and language of medical consultation; however, where the MPs/IDPs are not competent in the Lingua Franca, an interpreter (MPs/IDP) is used.
e) English being the official language/language of medical training is only used by MPs who do not understand the Lingua Franca and or native languages/dialects of the MPs; this is often required to either diagnose/prescribe medication after the patient’s problems have been identified by the interpreter.
f) During medical consultations, patients queue and select MP(s) that can speak /understand the Lingua Franca or their native language(s) after which they receive a written note of their problem presentation and present to the MP that does not speak or understand their languages for diagnosis/treatment.

4.4.3. Mapping of things, resources and activities (time/space) /material objects at the camp

Mapping of things, resources and activities at the camp reveal some of the living conditions identified and enumerated below:

1. Poor sanitary conditions for the IDPs
2. Lack of basic amenities such as medicine and medical supplies, toilets, safe water supply, food and electricity at the camp
3. (Initially) queuing up at 2pm for meals. Presently cook meals for self and family.

4. (Recently) engage in menial jobs (tin mining, farming, small scale businesses like buying and selling of food items, seedlings etc., for survival.
5. Meetings with NGOs (e.g., Caritas International) and subsequently, group meetings of micro finance loan beneficiaries once a month to remit and/ or take loans.
6. Medical visits by MPs –fortnightly- to provide healthcare for IDPs-patient; daily medical check-up available at the camp clinic.
7. Visits by individuals and group organisations to provide humanitarian aid.
8. The host community church (Pastor's wife and group of elders) serving as gatekeepers to the IDPs, also attend to any unforeseen difficulties/advice or needs.
9. A diverse linguistic IDP setting with about 11 ethnicities who do not necessary speak English or the lingua franca in the host community
10. The use of interpreters during activities in the camp
11. A transient clinic with referrals of emergencies to major government facilities at the 'city centre' or private clinics in the rural host community
12. Daily routine assigned in groups for various chores at the camp / labour brokers (casual labour) at the host-community

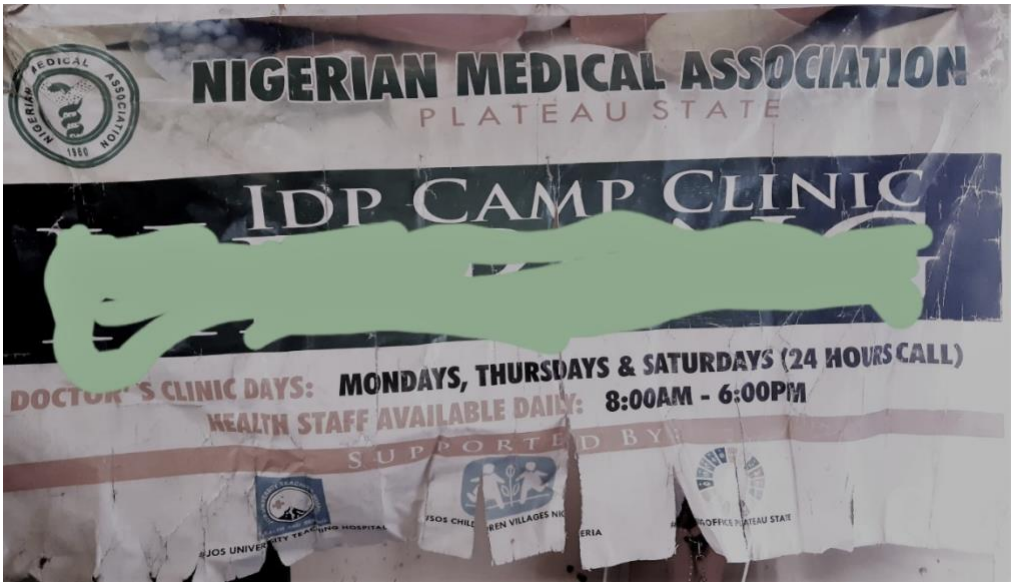

Figure 6: A banner at the IDP camp

Figure 7: The IDP clinic set-up

A relatively systematic presentation of health challenges and/ or health communication barrier topics that circulate across particular communication events, for example, the role of gender and or gender inequality that suffice in the interaction I had with the IDPs women is a case in study. We could approach this finding as a communicative barrier and further trace this pointer to what the MPs think of the reasons behind gender inequality; how it affects health provision, and how to resolve or address this problem. Using semi-structured interviews (and observations) to garner the perception of both the IDPs and MPs on the effects of gender inequality, their experiences surrounding the notion of certain gynaecology issues, would provide possible findings as to how gender is a barrier to health communication in the camp. Finally, a critical analysis on the provision of basic amenities like medical care, food, shelter and potable water and basic sanitation facilities –the lack of functional improved sanitation facilities which is a major concern at the IDP camp is discussed.

The responsibility to provide shelter, food, and healthcare lies with Plateau State government. However, the activities at the camp involve not only the government- but also NGOs and international bodies, as well as humanitarian aids and the religious organizations. These organizations have provided avenues such as micro loans for women (Caritas International); basic amenities (Protestant churches in the host community/international organisation) and medical supplies to the camp. During such supplies, communicative activities between donor and recipients ensue for example, during provision of micro loan by the NGO- Justice, Development and Peace Caritas, one major activity is the use of language by the NGO's representatives to address the IDPs, to interview or create awareness/disseminate information to the recipients at the IDP camp. Find below (Figure 8) a cross section of IDPs' address by Representatives of Caritas International during a meeting

Figure 8: A cross section of IDPs addressed by Representatives of Caritas International

Another major activity in the camp is medical consultations. A number of MPs (e.g., NMA; MSF) and humanitarian aid workers provide health care and health information/supplies to the IDP camp, in such encounter's, communication often ensues between the medical practitioners and the IDPs. Subsequently, the grouping of the IDPs for daily chores at the camp is yet another such activity; such an encounter results in communicative events which may provide insights into the social structure and power dominance in play. The discussions include for example, how they interact within a multilingual space and how they negotiate their identities and perform these acts keeping in view their language differences as relevant for the social event.

All the highlighted activities unfold in space and time, and people often use them to signal when thing begins and when it ends, as well as who participates and what can circulate there (cf. Heller, et al., 2017 p.144). In addition to what people do and the way they speak, there may be untapped 'materiality's' that get 'inscribed in social practices' (ibid) like dress, objects, tools, food, etc. Some noticeable activity-during the raining season- at the camp is the absence of adults during the day who seek menial jobs in the host community to augment their source of livelihood. An insight into these activities from the point of view of the IDPs within the host community, the space and timing and how complementary (or not) it is to their survival is relevant to the idea of inequality, gender and justice/survival in a displaced camp.

Bringing together specific categories (person, things/resources, activities, and time and space or material objects) while focusing on person categories and resources, I will develop plausible descriptions of gender and health inequality particularly, discourses on gynaecologic issues and how those issues are related to health communication barriers. The tracing of people (women) and resources involves tracing their histories: where they come from, how they end up at the camp. This step sets up a relationship between the descriptive and the explanatory data, since it will allow the researcher to discover and link findings related to people, place, time and reasons; considering social practice has a history where it draws from past events and experiences of participants. (cf. Heller et al., 2017 p.145). That is why biographical information collected through interviews is relevant in my choice of ethnographic methods. This information provides a clearer pattern of health inequality and the effects of gender on discourse on gynaecologic issues by tracing what category of women are affected by this factor and why. Based on this argument, a semi-structured interview was conducted with eleven (11) women-IDPs from

previous focus group and field notes were written from shadowing AN –the major informant for collection of data. Other artefacts collected are pictures from the field, photocopies of medical records (in a book form) of patients' treatment and medical visits for additional references.

The audio transcripts were translated from Hausa language to English language; using these data and other transcripts from field notes/ artefacts collected, codes were assigned based on themes generated in relation to 5 major themes enumerated (in 4.6.).

The sampling strategy for the participants' interview was purposive to ensure coverage across ethnic groups within the IDP camp and this included 2 Medical practitioners; and a nurse. The MPs' interview guidelines focused on experiences and interactions with minority –language speaking patients, barriers to caring for these patients, the role of language in history taking, diagnosis and treatment, also their experiences with the use of interpreters during medical consultation, privacy, challenges/ perceptions on gender and health inequality at the camp.

The key informant is a trained health practitioner stationed at the camp clinic; she doubled as an IDP and MP. She was (later) employed as an MP by the Nigerian Medical Association (NMA) visiting team after rehabilitation. Her experiences, insight and knowledge of the camp, the people, activities and other social practices engaged in the camp were necessary resources to be tapped. A way of engaging her knowledge of the camp, to understand 'what resources have value, for whom, and under what conditions' (Heller, et al 2017, p.141) requires using ethnographic methods to obtain relevant data. This is because ethnography as a method allows me to get a better understanding of what is going on in the camp by shadowing my key informant, observing/asking and identifying 'silent' concerns of the marginalised.

4.5. Ethnography: Methodological assumption

The choice of ethnography as a methodological frame is because it is 'thought of as a toolbox' that allows for significant choice on how data is gathered, analyzed, and represented, while also responding to cultural, organizational, interpersonal, and intrapersonal forces on the ethnographer and on the process of ethnography (Ellingson & Rawlins, 2005, p.81). Ethnography tends to be employed where researchers face questions about complex communicative processes

in real world settings that do not lend themselves to precise definition of valuables or measurements. Through participant observation in the chosen setting (IDP camp) or with people of a particular type (e.g., the vulnerable groups), ethnographers can observe and develop rich descriptions of behavior and language as they occur (at the IDP camp). The benefit of this approach over researcher –controlled data generation (e.g., surveys, experiments) is the opportunity to participate in joint sense making with participants in the actual settings and circumstances in which they normally emerge in the types of communication that constitute the focus of the research (Denzin et al., 2011). Another practical aspect this approach has is the advantage in conducting investigation with informants who are illiterate. Ethnography can shed light on taken-for- granted patterns of verbal and non-verbal communication by participants and often vital insights into health behaviors and healthcare delivery at the IDP camp.

4.6. Data Analysis

In this section, I will explore data analysis common to LE, as well as describe the specific procedures that I utilize in order to answer the research questions outlined in chapter one.

Specifically, the goals of data analysis in LE are to understand the overall (social) complexity of a lived experience from the participants' point of view (Dyson & Genishi, 2005), while diving deeply into the discursive evidence to support and present these social claims. However, as ethnographer Wolf (1992) explains, "Experience is messy" (p. 129) and the task of purposefully making sense of the messiness of human experience falls most heavily upon the researcher. The process of doing so is both *inductive* and *reflexive* on the part of the researcher (Dyson & Genishi, 2005), as well as is grounded in the data itself, experiences of the research, and guiding theoretical descriptions (Corbin & Strauss, 1990).

To purposefully wade through this messiness, linguistic ethnographers can work to develop what Copland (2015) describes as an *analytical framework grounded in ethnography* "which employs detailed linguistic data" (p.126). In the following subsections, I will explore three different data analysis methods that may aid the linguistic ethnographer to do just that.

Coding

Diving head first into the messiness, a fundamental data analysis method in ethnographic research is known as coding. Although this process takes a variety of names and procedures (see Bazeley, 2013 for examples), I explore one such version that I see most fruitful for the current study; analytic coding. Working directly with the collected data, analytic coding assists the researcher in figuring out "the conceptual importance of the human actions and reactions that have been inscribed in the data set" (Dyson & Genishi, 2005, p. 84), as well as cultivating the necessary vocabulary to communicate the narrative of the data.

Using pen and paper, the researcher begins to engage in analytic data analysis by combining through the pieces of data, or basic units, with the intent of organizing and sorting it. The investigator may begin by using open coding in which they first get a feel for the data as a whole by making notes and indicating descriptions of imported excerpts. After that, they may then move to more focused coding, in which they drill down on specific ideas that will most likely involve the expansion, collapse and elimination of certain coding categories (Dyson & Genishi, 2005). Through the repetitive process, the researcher identifies themes and patterns with the hope of uncovering a narrative within the data set.

Due to the inductive and reflexive nature of this type of analysis, there are infinite ways in which the researcher can categorize and organize the data (Wolcott, 2005). Therefore, it is essential that the researcher be aware of their own positionality and that findings can later be collaborated further using previous literature, appropriate theoretical frameworks, and participants' discursive data.

Table 3: Data Collection Instruments Used for Data Analyses
Based on the research questions, table 5 summarizes the data collection instruments used.
(Table 5 detail the origin of the data used for each data analysis)

Data Collection Instrument	**Research Question 1 Inequality & barriers**	**Research Question 2 Communication management**	**Research Question 3 Practical measures**	**Research Implications**
Field notes	X	X	X	X
IDPs Observations	X	X	X	X
MPs Observations	X	X	X	X
Conversations (e.g., follow-up)	X	X	X	X
MPs semi-structured interviews	X	X	X	X
IDPs semi-structured interviews	X	X	X	X
Focus Group Discussion	X	X	X	X
Documents and pictures	X	X		X

Note: **X** signified relevance of data to research questions and research implications

Data analysis

The analysis of interview data relied on the informants' subjective statements. They were a window through which I explore the medical encounters between Nigerian MPs (trained in the English language) and IDPs. In the analysis, I sought to explore how communication takes place in a linguistically diverse setting. Also how this situation and other factors such as inequality (health, gender and social) may hinder effective communication, show or mask certain values which are situated in the participants' interrelation, peaceful co-existence, survival and many other aspects.

Analysis in this research will proceed from the basic organization of topics or line of questioning in this investigation which is generally in terms of five major themes and related themes.

1. Health inequality (the various forms of health inequality; diseases, shame, lack of social amenities and poverty);
2. Gender (male dominated healthcare, patriarchal society, illiteracy);
3. Power dominance (politics, deceit);
4. Identity (cultural influence, beliefs) and
5. Survival (hopelessness/hope, appreciation, justice and resignation).

While 1, 2 and 5 are common thematic concerns from the on-going discourse with IDPs (see preliminary data analysis), 3 and 4 in no particular order require in-depth investigation into the political, social and historical account of their existence. Some of the practices (see figure **1** below) in the camp highlight the issues enumerated as likely thematic concerns to be investigated.

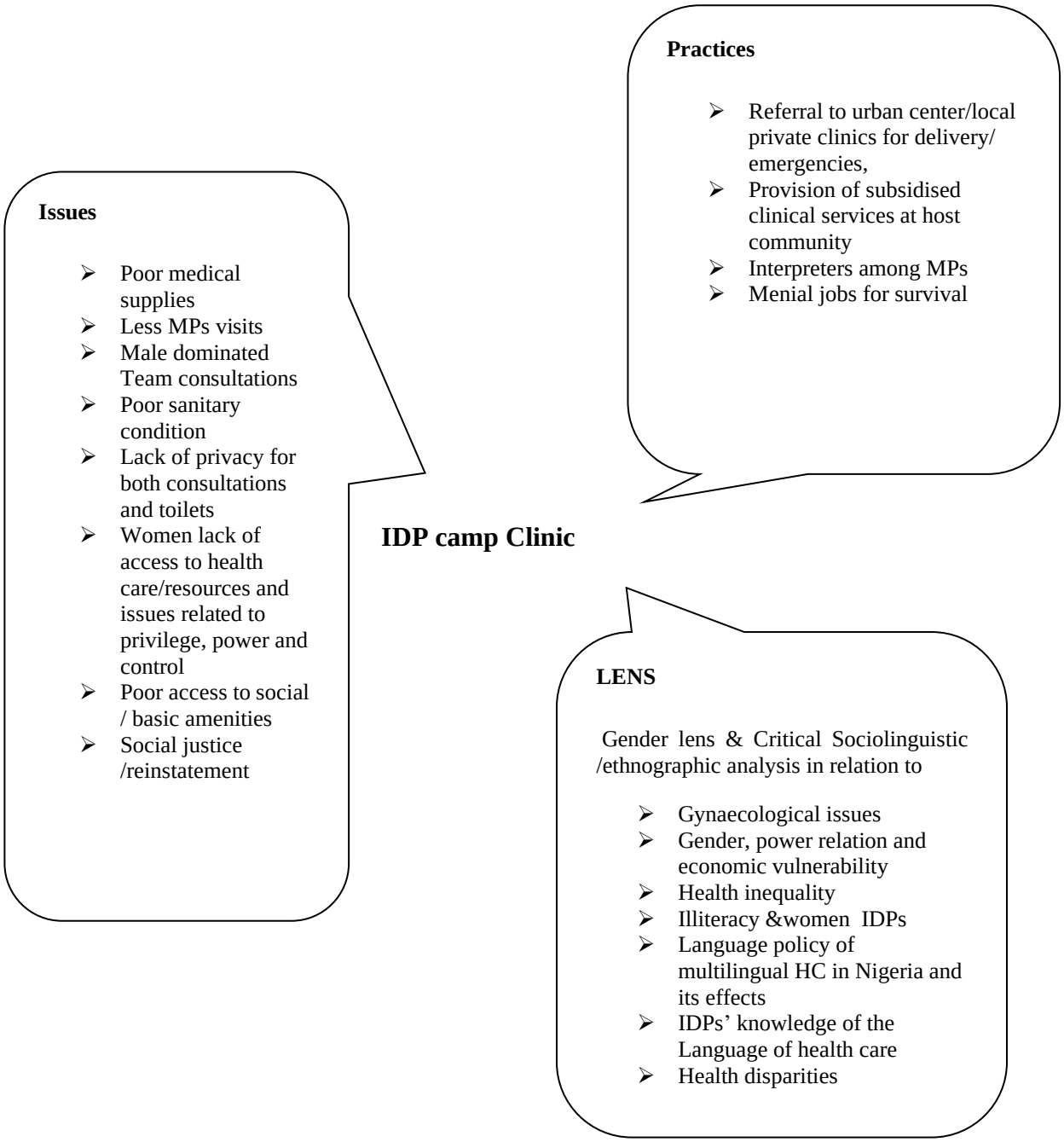

Figure 8: The IDP camp clinic and proposed analytical framework

In the column for 'issues' the collection of data focused on the participants' personal experiences at the camp during various activities such as medical interactions; chores; health information dissemination and socializing. In the second column (practices), MPs/IDPs' perception through interaction, interview and observation will account for the data. Here, I pay attention to their

communicative coherence and use/choice of language-whether minority, majority, or official language in their daily conversation. The last column (lens) provides the theoretical framework and methodology in analyzing the data collected.

In analyzing data, the approach here is interpretive - I present, correlate, connect, compare and/ or juxtapose the information collected; my reading of the data will be interpretive in making sense of unequal access to healthcare and gender equity and power shift that defines feminine communication around gynecological issues in the camp. What follows is a description of the approaches adopted in the analytical processes.

4.6.1. Analytical Approaches to the study

This dissertation employed two analytical approaches to interpret data, a Critical Ethnographic Sociolinguistic approach by Heller et al. (2017) as well as the concept of *Talk, Work and Institutional Order* by Sarangi and Roberts (1999). Heller et al. (2017) present an innovative critical ethnographic approach to sociolinguistic research in their book *Critical Sociolinguistic Research Methods*. According to the authors, it means gaining an understanding of the part that language plays in social processes of power and inequality, whilst also mapping how these processes work (p. 2). The examples used to illustrate this critical approach to language and power involve the authors' own research projects on three linguistic minorities, Canadian francaphones (Heller), the Sάmi of Northern Finland (Pietikäinen), and Catalan speakers in Barcelona (Pujolar).

The main focal points here are not around language itself but rather concern the "conditions and consequences of language", that is, the sociology of language (p. 4). Within this contructivist persective, the authors see "knowledge as not derived directly from evidence or experience but mediated by how we choose to formulate it and present it in specific contexts of communication" (p. 74). Such emphasis on communication highlights the importance of conversation, which may be defined as the dialogue beween a project and the field of research, the exchange of information between a researcher and the audience, or the discourse between a researcher and the people affected by or involved in the project. Contrary to positivist' approaches that claim that

scientific knowledge is unbiased and neutral; the data is always the product of the researcher's engagement with the topic (Heller et al. 2017, p. 58).

In the following I will outline the key steps of analysis an important step in analytic procedure identified in Heller et al's work is *mapping and categorizing. Mapping* here refers to activity of organizing one's data (or elements in your data) in a systematic way, informed by the rationale of the work. In other words, *mapping* involves addressing the question of *what there is.* In the subsequent section, I will present each element as described by the authors as it relates to analysis.

4.6.2 Key steps of analysis

Mapping and categorizing

Mapping here refers to the activity of organizing research data (or elements of this data) "in a systematic way, informed by the rational of your work" (Heller et al. 2017, p. 145). In other words, mapping involves addressing the question of "what there is" (ibid). Mapping as an analytical activity therefore involves mapping out what there is in your whole data set. In critical language reseach, mapping according to Heller et al (2017) is about:

> "Figuring out first what relevant categories are at play, that is, what the meaning boundaries around linguistic or other communicative forms, people, things, spaces, time and activities actually are: what kinds of resources are at stake, for what kinds of people (in what social positions), in which kinds of activities? What social practices do they engage in? How do they mobilize language to engage in activities? [...] What resources have value, for whom, and under what conditions? "Mapping is about situating them in relationship with each other in time and space" (p. 145).

Mapping therefore provides a good way to get familiar with the details of my data and, at the same time helps to gain a general overview of the scope of my research, i.e., to see what terrain it covers or not; furthermore, this process allow me to explore how the elements in the data connect

to each other. The basic "zones" or "features" of the map are the categories that you see as most relevant, understandable and transparent. By categories Heller et al. (2017) refer to the various logics or principles at your disposal to organize, group or sort out your data into an order or into smaller groups (p. 145).

In mapping, it is important to pay attention to the relevant types of social actors, to the resources they exchange, the activities in which boundaries are made and resources produced, circulated, consumed and valued, and of course, to the communicative forms involved, e.g., languages, forms considered "dialects" or "jargons" or other linguistic or semiotic features, both in terms of how communication is involved in regulating boundaries and participation of people in activities, but also as a potentially valued resource in and of itself (ibid, p. 146). How language is involved in the making of social difference and social ineqality are the building blocks of a critical ethnographic sociolinguistic and discourse analysis.

An important aspect to mapping that informed my research approach is set in the principle that there should be a place in my work for everybody or every phenomenon that is relevant. The 'map' should therefore include both the phenomena that are easy to categorize and those that are difficult, both the expected and the unexpected ones, both the "straight" specimen and the "deviant" one, both the rules and the exceptions (ibid, p.151). In that respect, mapping is not to try to attend to everything I encounter during fieldwork, but to use my hypothesis to guide me towards what is relevant and what is not. In addition, mapping is also the moment where you might discover that there is a much more important 'thread' for you to follow, or a different formulation of your research question that makes more sense given what is actually going on (2017, p.152).

More broadly, mapping is how you get started by figuring out what it is to look at closely. It shows you the need to ask question in certain activities done differently and to start answering those questions, you need to start *tracing* where the people, resources, activities come from and go to, across space and time, and how the deployment of language facilitates or hinders those circulations.

There are two ways to discover these categories that I've followed in relation to this work. The first is in "what is observable to you: who deploys what linguistic forms and practices, how,

when and where; how language relates to how people orient to each other, in space and time" (Heller et al. 2017, p. 146). The second is in "how they talk about the making, unmaking or continuation of categories, that is, how they are rendered meaningful through discourse" (ibid, p. 146).

People

This category is defined by concepts or properties relevant to my research questions. Following Heller et al. (2017), people categories can be mapped out in an organizational structure based on their literacy, gender or age or interacted with whom more during what kind of activities. Mapping out also who uses specific communicative practices, for instance who talks and who stays silent (p. 148).

This category helps to also evaluate to what extent my research participants actually fitted my assumptions about them and to what extent I made hypotheses about unexpected or *unlooked-for* profiles of people. A person may fit into more than one people category and you will likely see some people moving across boundaries. Notably, people categories are fundamentally social categories that people enact or are seen as enacting rather than the actual material bodies that do the performance.

Resources

Resources are "the things, whether material or not, that have value and are exchanged; they are implicated in the making of the boundaries that divides one category from another by virtue of where their circulation is facilitated or blocked" (Heller et al. 2017, p. 149). They further describe mapping of linguistic resources to include documenting the occurrence of: (1) different linguistic or paralinguistic features (e.g., an accent); (2) different languages, linguistic varieties or registers, and (3) different discourses or genres.

The IDP participants are not only displaced they also tend to form their bonds and boundaries by sharing material things connected to their bodies (food, accommodation, etc) or humanitarian aid supplies (e.g., money).

Activities

Activities are where you find those resources and those categories of people. What activities they engage in, the stories they tell about the things they do, or the material objects they hold and that have meaning in their everyday life (reports cards, catalogues, patient cards).

Space, Time and Material Objects

Activities are said to unfold in space and time, and people use them to signal when things start and whn they end, as well as who can participate and what can circulate there (Heller et al. 2017, p.151). In addition to what people do and the ways they speak, there may be a wealth of *materialities* that are relevant to your questions, particularly how these *materialities* get inscribed in social practices: dress, objects, tools, food, etc. (ibid, p.151).

Tracing

"Tracing is an analytical activity used to find out more about the specific categories and resources that you are focusing on" (Heller et al. 2017, 153). At the 'mapping' sage, we put together types of activities, people, or resources and we worked out plausible descriptions of them: "smokers," "displaced," "marginalized," in and out of class, illiterate. Tracing focuses on the processes involved in how people and resources circulate over space and time, and how activities persists or change (ibid). We then pick specific categories of people, practices or phenomena and we follow them: we examine where they appear, when, how often and in what conditions or with what implications. More specifically, in critical language research, Heller et al. describe *tracing as* following the circulation of categories such as: how do resources get produced, circulated, and consumed? How do people come to the activities where that happens and where do they go next (2017, p.153)? Simply put: "tracing is about the elaboration of trajectories or patterns of circulation of activities, people and resources" (ibid). Biographies of participants are obvious examples, particularly in research that investigates the reproduction of social difference and their consequences. Here, "language, social class, race, gender or sexuality are not elements that participants can create anew on the spot, and their position in relation to these axes of differenciation is something that gets negotiated along the lifespan –even at times in the interactional moment" (ibid, p.154). Tracing, then helps to:

> Discover where and how things happen, in what sequences or cycles, and under which conditions, so you can take a closer look at why that might be the case […] see how social categories form, and whether they are stable and unified, or shifting and blurry […] See what linguistic resources are valuable for whom, and where and how people deploy them in navigating the varied circumstances of their lives. […] (Also) to see what is meaningful to people. In that sense, tracing is about laying the groundworl for identifying discourses, which bring together different but interrelated sets of social practices, social relations and views (Heller et al. 2017, p. 154).

From the above excerpt, therefore, it is through tracing you are setting up a relationship between descriptive and explanatory data. By figuring out the connection between the two, you are prepared to make an argument based on your data, instead of just describing it (cf. Heller et al. 2017, p. 156).

Connecting

Connecting is the means we use to provide an informed explanation for what we have mapped and traced in the two previous interrelaed steps of the analytical processes. It requires making hypotheses as the relationship among the categories and processes identified earlier (1-6 above), leading you to build a bigger picture. Connection can be across your data or to previous research. 'It is not the statistical probability that something will happen that matters here; rather, we look for substantive meaningful connections and consequences (ibid, p. 157). Heller et al. (2017) further argue that connecting is where ethnography earns its stripes as a powerful mode of explanation (p. 157).

At the same time, connecting also shows you how identity categories are historical and social, discursively constructed and enacted in situated interaction, and therefore, too, subject to change. Connections point to explanations to answer the question: why? Explanations are the bedrock of our claims. More broadly, "they allow us to return to our research questions and answer not just what, under what conditions, with what consequences for whom, and why, but more broadly, it allows us to anwer the question: so what?" Heller et al. (2017, p. 160).

Claiming

The final step of the analysis is to claim, basically what those previous steps allow me to say in relation to my research questions and -objectives, that is, how and why language matters and what is at stake, and for whom within this constellation? At this stage, "it is particularly important "[...] to think about the ontological status of your data, and about the scope it covers" (Heller et al. 2017 p. 161).

4.7. Challenges in conducting data collection in the research context-Nigeria

A number of challenges identified during data collection at the research context-Nigeria include the following: first, insecurity which was a constant barrier to visit the site as planned. Some of the months when fighting broke out in certain parts of the state required curfew in either the city center where as a researcher- reside or nearby villages to the study area. On a number of occasions, we had to reschedule through phone-calls due to such insecurity challenges. Also, this means putting an effort into listen to the various media of communication /information (radio, television or newspapers) to be informed of any dangers lurking in areas of the research interest. Secondly, dealing with vulnerable people who double mostly as uninformed or illiterate with high expectations of provision of basic needs is difficult. One has to remind them at each meeting of the 'disappointing' fact that it is for the sole purpose of research with no- immediate incentives whatsoever. The IDPs low level of understanding needs a lot of patient, time and effort in achieving tasks. Also discussion of some sensitive topics such as their life trajectories is yet another difficulty we (I and IDP participants) faced. Fourth, the distance I travel to the research site was yet another difficulty; sometimes I had to travel at short notice when I receive calls from the IDPs with regard to visits from NGOs or humanitarian aid agencies in order to observe activities. These amongst other things such as financial implication in transportation, etc., although all of these is made possible knowing I am one of them-a Nigerian who shares a number of similarities with them, such as State of origin, language competence (which would include knowledge of a lingua franca, religious belief, etc.).

The main challenge of the study is insecurity. Insecurity happens to be the major cause for the displacement of people in the study area. At the time of data collection, specifically during

observation on three occasions or more, we had to cancel and re-schedule visitation due to insecurity on a community in the state either close to the research site or the researcher's location. Thus, the constant fear of the unknown whenever I travel to research site and timing that suits me as the researcher since I have had to travel back to the State capital (city-center) where I reside limiting the time I would have had more insight. Later into the field work, in particular during the rainy seasons, the participants prefer early visitation so as to find alternate sources of survival outside their shelter by seeking menial jobs like mining, farming etc. As such, long meetings and frequent visits were limited considering there is no incentives provided for participants, and I had to consider their sacrifice in the study through participation.

The informants I interviewed do not represent the entire socio-cultural demographic distribution at the camp. I have observed a number of the IDP women who have no comprehension of the lingua franca or English except their native languages. At some point into the research, I had to speak with some of the participants through their interpreter Felicia. Compared to the informants of this study; people like these women appeared to be facing more mental health problems and emotionally challenging situations. I have learnt something about these IDP women through my informants. They appeared to have little understanding of their entitlements and how to stand up for themselves in the IDP camp. Insights into the experiences of other women at the camp were gathered through our major informant. There would have been richer insights into the experiences of these women whom we shall refer to here as "invisible".

There is a significant gender imbalance between the IDPs and MPs informants and as mentioned in the section on study design, this imbalance in fact represents the gender distribution of each group. The large population of IDPs living at the camp are predominantly women (mostly widowed as stated earlier) while the MPs are predominantly male. This also explains the difference in profile between the IDPs and MPs. Although informants in both groups represent each population, it is possible that this affected the analysis of data. In order to avoid biases in data analysis, particularly for data from women-IDPs informants, I included comparative cases from the experiences of the MPs with IDP camps (situated at urban centers) and cases which are in contrast to the study area.

4.7.1. Reflexivity and positionality

My position in this thesis is an objective outsider who also has the perspective of an insider. I keep in mind the risk of disorientation resulting from the overconfidence about my (lack of) experience and from the misapplication of the concept of "thick description" (Geertz 1973 p. 3).

A thin line exists between merely showcasing a series of peculiarities and providing new insights which dispel dominant views and norms in the field. The aim of this thesis is opening up new possibilities of thought and context concerning the human condition that were closed to other disciplines. Merely showcasing the peculiarities of the field as "a merchant of the strange" (Kapferer 2013, p. 827) … risks the kind of experience that some critics argue, underpins the increasingly popular, but ambiguous, concept of social inequality/disparity in health care of a marginalised population.

I intentionally chose IDP-patients' and MPs to be the informants of this study because their views have been underrepresented in existing literatures. The analyses of interview data involved the transcription of all recorded interviews and the translation of Hausa transcripts into English. Since I conducted all these processes myself, I thoroughly engaged in the entire accounts of the informants. Also bearing in mind Bourdieu's idea of "objectivi-(zation) of the subjective relation to the object" (2003, p. 282), an objective reflection by the researcher on the subjective relation of themselves to the object of the research. I objectivise my own experience as a Nigerian Hausa-English interpreter while sharing informants' subjective views. By Bourdieu's 'objectivization', instead of being ignorantly subject to the world the study is exploring to be "equipped with your (one's) theoretical and methodological tools, with the full store of problematic inherited from your discipline, with your capacity for reflexivity and analysis, and guided by a constant effort…to objectivize this experience and construct the object" (Wacquant, 2011 p. 87).

4.7.2. A critical ethnographic description of health inequalities at the IDP camp

Agar (1996) writes that a product of ethnography is the knowledge an outsider has gained on the world in which others lives. It involves the researcher's immersion into the community or institution she explores. Atkinson and Hammersley (2007) emphasize the everyday (or "natural")

context of ethnographic study, with the participant observation as the dominant source of data collection.

The analysis here is self-reflective. It is impossible to avoid bringing into research and analysis the analyst's values and evaluations. I was looking at the camp and the participants with the eyes of an outsider, a visitor, but firmly placed on the side of the displaced. I gained 'entre' pass which let me visit the camp as I pleased, I could contact the MPs which also gave me access to patients' records and also the IDPs. I participated in various NGOs meetings with the IDPs although I was not a benefactor; I attended doctors' consultation or visits with the IDP patients- it was clear I was watching them. I also talked to the patients; most were very happy to talk to me, especially after the meetings when we were discussing in a group made up of women-IDPs who also serve as gatekeepers. I could tell that the IDP participants are very much in control of what issues to disclose and what to keep until they felt safe and convinced they were not monitored by a government observer. This made sense at the last interview when they were convinced; they talked, revealed their concerns and expressed their selves without limitation thereby providing the researcher the priviledge into their life experiences. Some IDP-patients were sad and lost hope of reinstatement; others are hopeful however they seemed to have lost hope in the government whose responsibility is to protect and provide for them. Although I have no first-hand experience of being displaced, my participation and interactions with participants provided the needed experience to interpret and present how the IDPs and MPs relate to the problem at hand. Through their perceptions also, I was able to identify the challenges and needs of the displaced as well as the health communication barriers/inequalities that hinder access to efficient healthcare.

Exemplarily, consider the experience of Sarah (Mamman' Faith), one of the informants of this research. Sarah, a widow without any form of education or source of livelihood aside knowledge of small scale farming, is saddled with the responsibility of caring for six children after the demise of her husband who was killed during the attack on their community by armed Fulani herdsmen. She lost hope in the government and the possibility of reinstatement after over three years of living at the temporary shelter with her children where she also gave birth to her last child Faith. Similarly, Salomé Vincent –an IDP participant-has lost hope in the stakeholders. She suspects diversion of free will donations made to the camp by caretakers of the IDP camp.

The (two) instances above from the IDPs' narration are exemplification of experiences I knew nothing about, yet, I had practical access to listen and observe. Moreover, as I have never been displaced or had to live in a shelter, I could not even relate to what these people experienced aside from the pain of losing dear ones-family which in my case was not brutal or caused by another person but sickness over a long period of time (both of my parents). I could not even relate to what those people experienced. I have never experienced direct attacks although I witnessed a reprisal attack on my way out of the state in 2011 at 'Mararaban Jama'a-Jos South, Plateau State. Innocent passers-by were intercepted at the round-about to the State capital and killed near a security check point by youths. It all began like a peaceful protest by women, children and youths leading the cause in protest of the murder of an entire family in their community that week and for previous massive killings by 'unknown gunmen' in the community. One reason the security personnel on duty could not intervene was that, one of the killers intercepted at the crime scene was said to be wearing a military uniform stained with blood. That singular act (whether probed or not) fuelled the crises and protesters dislodged the military check-point thereby carrying out the grievous acts in broad day light for hours before other security personnel arrived at the scene to arrest the situation. The memory of that incident was my first experience of man's inhumanity to his fellow man; I became sick (vomiting) instantly at the sight of the killings. We kept running and hiding for our lives to avoid stray bullets from security personnel. I was lucky being a Christian as attackers were targeting the opposite religion (Muslims).

I had never lost a shelter or had to depend on people or strangers for survival or needed treatment and could not afford it. I realized how little I actually knew about displacement and the effects thereof (living /surviving in a camp). But then, I had access to some of the patients' private conversations, to their views on certain 'intimate illness, treatment, re-infection, views and reasons why those problems persisted. Yet, there was a deep concern on why sometimes the MPs cannot help them. Those concerns were those of the IDPs patients and their perspectives, their level of awareness and relate-ability; not only on their experiences but also, crucially on their role in problem presentation and that of the MPs in helping them address their health communication barriers: shame and inequality, misconceptions about diseases and faulty beliefs.

4.7.3. A critical sociolinguistic analysis: a complement to ethnography

The knowledge of IDPs' experiences can be obtained from a critical sociolinguistic analytical approach to participants' narratives. The semi-structured interviews and observations provided the research with an opportunity to see the practical unconventional clinical services from the view of both participants-service providers and service users (transient consultation); accounting not only for language choices but also for practical measures in the face of communication barriers and social use of language signs, signage, body language as a tool to understand how patients and MPs interact (or how patients construct their problem presentation and MPs diagnoses) to the social reality they live.

Incidentally, it is the context of gender inequality and communication barriers caused by gender differences (shame & belief) in confronting issues relating to diseases of the female genitals I find of particular importance for this ethnographic study. My point of departure for this section is that 'critique' is fundamentally about identifying and explaining the construction of relations of social differences and inequality. For this, I will focus on Heller et al.'s (2017) *Critical Sociolinguistic-Ethnographic methods;* namely, the linkage between linguistic practices and social practices (Heller et al. 2017). I consider this problem to be important to the research of interpretive linguistic ethnography insofar as the analysis of local linguistic practices in the face of social inequality can show us some immediate consequences for the non-representativeness, gender differences in the provision and /or distribution, or access to healthcare resources for the displaced, and hence for the construction of social differences; but without an ability to situate those local practices in time and space, it is difficult to know what to make of them. Sociolinguistics and linguistic ethnographic analytical literatures on issues of gender and language in relation to African contexts remain scarce or infrequently achieve international circulation (Atanga, et al., 2012 cf. Ndimande-Hlongwa, et al., 2014). As such, this investigation aims to contribute to existing ethnographic approach in the field of linguistic ethnography, health communication and sociolinguistic practices of a peculiar population (the displaced/ disadvantaged/marginalised).

4.8. Chapter summary

Chapter four encapsulates the methodology. This chapter begins with a brief introduction to the methods adopted in the study and what is obtainable in the entire sub-section. This is followed by a discussion of the methodological framework of this research. After which the data collection procedure adopted in the research is highlighted and is preceded by methodological techniques to the study. The various data collection methods: field-notes, interview, focus group meetings, documents/pictures of the site and other data collected were discussed. Mapping and tracing diversity in the research site is presented; here, I identify the important features of participants, activities and selection methods. This led to field site mapping, mapping of person categories at the research site, tabular representation of the participants' demographic profile and field site mapping and categorization of linguistic resources at the site. The subsequent discussion is on ethnography and health communication: methodological assumptions followed by data analytical procedure. The challenges of conducting data collection in the research context were highlighted and are followed by ethnography and reflexivity/ a critical ethnographic description of health inequality in form of reflexivity. Lastly, a critical sociolinguistic analysis as a complement to ethnography is discussed.

CHAPTER FIVE

FORMS OF HEALTH INEQUALITY AND FEMALE IDPS

5.1. Chapter introduction

This chapter discusses and analyses one of the foci of the study-inequality and its different expressions. The chapter identifies health disparity and gender as key expressions of inequality in an IDP camp; in particular, identifying disparity from the perspective of language barriers, gender difference and injustice. First, I introduce the concept of inequality and outline its forms. Then I explain how these forms of inequality have effect on the daily lives of IDPs; specifically, the effects of health inequality on the female IDPs. For this, I draw from observational data; semi structured interviews as well as focus group discussions. Through interpretive analysis I then identify challenges female IDPs are facing at the camp. I then conclude with a critical discussion into gender inequality prevailing at the camp and a descriptive account of participants' perception with regards to health inequality for the displaced.

In this chapter, I examine how health inequality and other forms of inequalities such as social and gender inequalities have stemmed from the distinction of health services offered at the temporary shelter and lack of policies guiding and /or protecting this injustice in the current political environment in the country where so much power is vested in state sovereignty. Subsequently, I identify the activities in which such inequalities are visible. Finally, I discuss my perception of the observed activities, the study participants and things I observed during discussions and interviews. I also present participants' perception on how the State and/ or communities in dispute might realistically resolve current crises.

At its broadest level, this chapter is aimed at understanding nothing less than the health communication barrier in the IDP camp as a result of social inequality perpetuated on the displaced persons in a Nigeria IDP camp, in particular, the role of language choice: the politics of majority or minority language choice and the place of the official language (English) and the role English plays in specific situations. This study brings together two major ways in which

language use and choice are relevant to the study of a diverse marginalized population and the factors which determine language choice in a multilingual medical setting.

5.2. Different forms of health inequalities at the IDP camp

This subchapter also promises an overall discussion of the concept of health inequality. It tries to extend the 'social science' concept of "structural vulnerability" to make it a useful concept in defining health care and health inequality. Defined as a state that imposes physical and /or emotional suffering on specific population groups and individuals in patterned ways, structural vulnerability is a product of class-based economic exploitation and cultural, gender/ sexual and racial discrimination (Bourgois et al., 2017; Jegede, et al., 2021; Quesada et al., 2011 p. 340).

The term structural violence is generally attributed to the sociologist Johan Galtung (1969). Arguing for a social-democratic commitment to universal human rights, Galtung defines structural violence as "the indirect built violence built into repressive social orders creating enormous differences between potential and actual human self- realization (Galtung cited in Quesada, et al., 2011 p. 340). In this research, we employed structural violence as a theoretical tool to understand how unequal treatment of the displaced is enacted in subtle ways which requires thorough knowledge of historical understanding of the larger scale social economic structures in which affliction is embedded. For example, the strong association of poverty with social inequalities to an understanding of how such inequalities are embodied as different risks for those already displaced is a relevant tool for the investigation.

Vulnerable populations have been described as subgroups with shared social characteristics; who are at higher forms of inequality risks and by virtue of being vulnerable, are much more likely to be at high risk of being exposed to risk of illness (c.f. Schillinger, 2011 p. 13).

In a bid to eradicate risk of exposure to illness, the embattled passage of health care legislation in Nigeria in the early 90's founded the rhetoric of "health care for all" by the year 2000 (The Punch newspaper 6th November 2017). Ironically however, the early 2000s were characterized by rising numbers of displaced persons (Brinkel et al., 2012; Ojukwu & Onifade, 2010; Higazi, 2011; Okoraofor et al., 2015) resulting in insecurity. At the same time, increased insurgency in

the country has exacerbated personal insecurity, homelessness, residential segregation and closure of schools (ibid 2015). Most importantly, from a health perspective, this kind of systemic social marginalization inflicts pain leading to unemployment and poverty (Collier et al., 1998; Islahi, 2008; Ordu, 2017; Solomon, 2015). Explicit marginalization of the displaced is one of the most visible manifestations of structural violence created by insecurity. Often those at the lower social class level in rural areas or settlements are victims of this marginalization caused by displacement. IDPs are disproportionally affected by a lack of access to healthcare provisions, making health a key concern in safeguarding this vulnerable population. It therefore makes protecting this group a priority in the field of health, conflict and peace (Krug et al**.,** 2002 cited in Rae, 2011). IDPs are individuals already suffering the direct effects of violence and are confronted with the social exclusion, impoverishment and loss of government provision of welfare, health care, education associated with forced migration which tragically exacerbates their existing vulnerability (Castles et al., 2005; Betts, 2009). Thus, the major challenge is how to identify and eliminate these disparities created within this group as a result of discrimination between forcibly displaced individuals and those who are not.

5.2.1. Access to health care

Concerns with regard to access to health services in displaced shelters are a critical issue. There are disparities in the provision of basic needs and care of the displaced in developing countries, thus, it is difficult to generalize from one geographical area to another. This variability and diversity may account for the paucity of data on women-IDPs' health status and access to care in low income countries in the literature review. There is therefore, the need to examine women's physical health and well-being and access to health care services in the developing world, specifically Africa (a case of Sub-Saharan West African country-Nigeria), as evidenced by the significant gender inequality of MPs, structural barriers to health care such as the lack of privacy in consultation and MPs/IDPs-patient ratio/spatial accessibility, some important health indices.

To date, research suggests that health behaviours, social and economic factors often referred to as social determinants of health are the primary drivers of health outcomes and that social and economic factors shape individuals' health behaviours (Braveman et al., 2014; Marmot, 2007;

WHO, 2008). However, health and health care disparities are often viewed through the lens of race and ethnicity, but they occur across a broad range of dimensions.

In this study, I focus on the problem of the linkage between local practices and processes of social (language) structuration that is, language choices and policies in the major context Nigeria. I consider this problem to be important to the research of critique of Critical ethnographic sociolinguistic health communication study of the displaced insofar as the analysis of linguistic practices can show us some immediate consequences for the regulation of the production and distribution of resources, and hence for the construction of social difference and social inequality; but without an ability to situate those local practices in time and space, it is difficult to know what to make of them. In particular, what criteria of inclusion and exclusion are used to regulate access to resources or to get access to what? A connected problem is the consistent lack of security. It is important to understand how it comes to pass that some kinds of people end up with more opportunities in certain kinds of situation-i.e., displacement while others end up with fewer. For instance, disparities occur across socioeconomic status, age, geography, language, gender, disability status, and sexual identity and orientation. Research suggests that disparities occur across the life course from birth, through mid-life, and among older adults (Nugga et al. 2021). Disparities also occur within subgroups of populations. For example, there are differences among IDPs based on the geographical location of the camps, on their health and health care, gender and level of education and /or exposure. What follows is a personal description of the different causes of health inequality as observed in the study area:

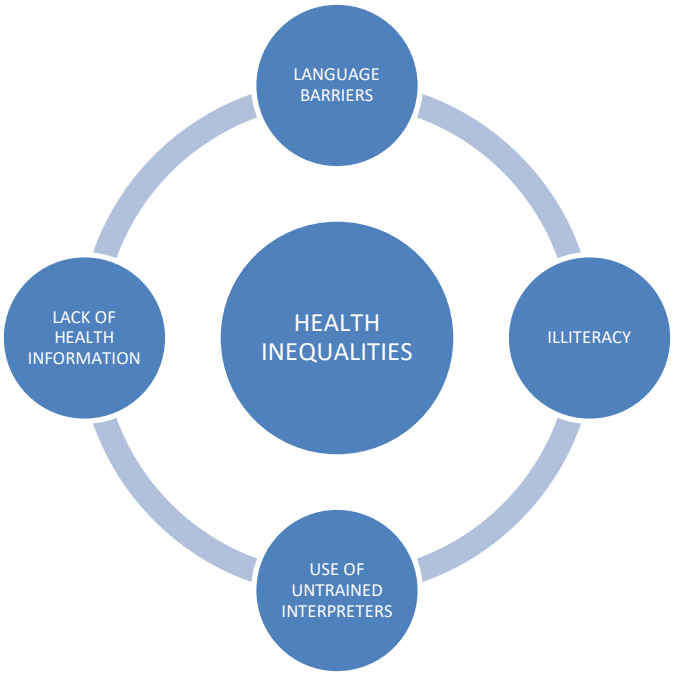

Figure 9: Different forms of health inequality

In figure 9 above, some of the highlighted forms of health inequality at the camp are indicative of a number of factors that (may) hinder effective health care provision. First, is language barrier: the IDP camp is a multilingual setting -as earlier stated- with about thirteen indigenous languages /dialects spoken at the camp apart from the lingua franca-Hausa and the official language: English. The MPs who volunteer at the camp do not speak or understand the indigenous languages spoken by IDP-patients; they therefore employ the services of untrained interpreters during medical visits in cases where the patients cannot speak or understand the official language or lingua franca of the host community. Thus, the issue of accuracy in interpretive services, privacy and confidentiality often ensue.

During semi-structured interviews, both sets of participants (MPs and IDPs) in this research recount how the use of interpreters has limitations; although it remains the only available option to bridge the communication gap between the MPs and IDP patients at the moment.

When I sought the views of Dr. Maxwell on the major challenges they face at the camp during the interview, he elaborated thus:

"For me I think the major problems we have in the IDP camps is the problem of communication; because with effective communication we are able to get to know their main problems and that way we will be able to solve some of those challenges but without getting to have an effective communication with the members of the IDP camps, we will not be able to solve their challenges. So communication is a key thing for me at the IDP camps. And I think an easy way to summon these kinds of things is to have interpreters"

Data from semi-structured interviews reveal how the use of untrained interpreters creates a lack of privacy for the IDP patients especially the female IDPs who want to discuss problems relating to their reproductive organs with the MPs. Here, there is little or no confidentiality between MPs and their patients considering other IDPs serve as interpreters. Apart from the use of interpreters, there is no provision or proper physical structure to serve as a covering during group consultations, and as a result of the population at the camp, the MPs consult in an open space which further complicates the issue of privacy. Lack of privacy during consultation is likely to contribute to the health challenges that limit effective health communication at the camp.

There is also the problem of infrequent visits of MPs to the camp. Although the NMA-MPs were consistent in their routine visits, however, after two years the association reduced the frequency of visits because of its cost implication, limit volunteers and lack of adequate resources needed for consultaions. Consequently, the IDPs sometimes receive incomplete treatment or are left unattended to for a while before another batch of medical practitioners visits the camp. A new group of MPs visiting may not be aware of the health information and /or medical history of the patient they are treating as a result of irregular visits by MPs or inconsistencies of health services provided at the camp. The health condition of the IDPs can be affected in a number of ways: first, the IDPs may find re-visiting their health challenges frustrating especially where the MP does not understand the language they speak and would have to interact through different interpreters. Second, the IDP-patients have no proper treatment records or -patient files- for a follow-up by different MPs to treat their diseases or infections probably due to the transient nature of the IDP camp. Also, the lack of patients-record could be attributed to over population of the displaced persons, poor management and documentation often result in omission of

patients' information and it wastes time. Lastly, lack of health awareness and illiteracy may discourage the MPs from documenting history taken and/ or collecting patients' information for record keeping.

The two participating MPs - Dr. Maxwell and Dr. Burt - attest to the limitations created by illiteracy and the lack of health awareness amog IDPs that create barriers in access to proper healthcare. Below is the excerpt during the semi-structured interview followed by a discussion:

Researcher: **"***Is there any patient or group of patients that are a challenge particularly in the area of communication at the IDP camp?"*

MP 1: ***"****Many of the patients at the IDP camps err constitute a problem to us in terms of communication. Because communication is the key thing for us-to be able to understand their problems and proffer solutions or give them help. ... There is a barrier in our interaction with many of those patients at the IDP camps. And the problem is simply because of their level of education, their level of exposure and as I had mentioned earlier you find out many of the persons in those IDP camps are native, people from the local areas that have not been exposed to a lot of things; have not had the privilege to be educated."*

Similarly, MP 2 relates his views when I asked him:

Researcher: *"What are your experiences with volunteering because most of the Nigerian Medical doctors who are visiting at the camp I understand volunteer? What are some of your experiences with the IDPs?"*

MP 2: ***"****Okay consultations at the IDP camp, you know people come from diverse villages with less understanding educationally-wise […]"*

From the narratives of the MPs above, linguistic diversity and illiteracy has created a communication gap in the medical interactions' between them and the IDP-patients'. In relation

to the above interview question, Dr. Maxwell - further explains his experiences (as MP) in consultations thus:

> *"You find the way they explain their medical conditions to us, is completely different from how one would understand from a clinical setting. So those are some of the problems, they are not able to communicate with us in clear terms."*

While Dr. Burt –MP 2- further explains IDP-patients' resistance during medical encounter as:

> *"[…] The experiences with the IDPs, there is difficulties in understanding and whenever you are communicating with them, they like to do or to respond with what they know but to bring up new ideas to them you have to take time and to make it in a lay man language for them to understand."*

Based on the above findings, it is reasonable to identify illiteracy and lack of awareness on the part of the patients as a likely barrier to health communication at the camp. Although MP 2's experience shows the likelihood of 'patient practices of resistance, identity-making and solidarity in contexts of inequality' (Bonnin, 2019 p.2), he however attributes this behavior to illiteracy and /or lack of awareness.

Poor sanitary condition is yet another cause of health inequality faced by the displaced. The lack of proper physical structures such as toilets, and the absence of other social amenities – such as clean water and sanitary products- have exposed the IDPs to a number of diseases like "diarrhea, malaria," (c.f. Dr. Burt, semi-structured interview).

During semi-structured interview, the participants also complain of poor medical supply at the camp. The medications provided at the IDP camp were largely anti-malaria, antibiotics, pain killers and anthelmintic. Although a referral service was instituted, the question of 'who pays for the care' often emerged. In comparison with the recent conditions, a 2016 report (Ireogbu, 2016) also ascertained that medical personnel are not enough in the camps notwithstanding a Memorandum of Understanding that exists between the National Emergency Management Agency (NEMA) and government's tertiary and secondary hospitals for referral cases. An

examination of the National Disaster Response Plan (2011) locates NEMA's responsibilities to provide ambulance, services mobile clinics, immediate needs (search rescue and relocating resources); and support the Federal Ministry of Health (FMoH) in the emergency transport of personnel, medical supplies and other lifesaving resources (Ireogbu, 2016). The FMoH is primarily the provider of health and medical services during emergency.' The health services claim the camp is not sufficient but tentative; first aid services are provided thus for the women-IDPs who experience diseases or illness which the IDPs suffered from whether contracted from their various communities or were contracted at the camp. Care was to be sought at secondary or tertiary health facilities where the burden of care is higher and cost of treatment has to be sorted by these women -IDPs. Bearing in mind the population of internally displaced women and children without any form of social network in the camp is higher; it is often difficult for the women to cater for their selves and their children. Hence, the expenditure on health has to be covered or the women will be subjected to unconventional patterns of treatment, since they have been disconnected from livelihood sources and/or social support services ('bread winner') that can care for them and pay their health bills. Consequently, the challenges that displacement poses on the women-IDPs is enormous. Thus, there is a disconnection from family living/shared responsibilities; they are therefore left to grapple with the challenges of health.

Hence, an account of personal experience of the internally displaced is collated through a recorded focus group interaction. This is because, variation is important for the way that we understand risk to health and what to consider in creating developmental policies to address health inequalities. Based on their personal experience therefore, the subsequent sub-chapter presents and discusses the account of field work undertaken in this regard.

5.3. **Analysis of focus group interview**

The data presented here is a focus group interview with some (n=11) women-IDPs that took place on May, 9th 2021 during a field site visit.

The group interactions include questions relating to health challenges, communication barriers as well as the overall quality of healthcare available in the camp. Specifically, respondents were asked questions relating to how they communicate with the team of medical practitioners visiting

the camp; if they ever needed an interpreter during such medical visits; what language is used for medical consultation and who or what factor is used to decide which language to be used and what challenge(s) they face at the camp generally. Lastly, they were asked about the availability of health care (maternal and childcare), frequency of medical visits and availability of amenities, medical supplies and infrastructure. Respondents were also asked to suggest possible solutions to any issue highlighted. During focus group discussions, a range of various participatory techniques were used. The techniques used included exploring individual experiences through narration, supportive comments and collaborations from the participating IDPs; contrary views, brain storming of problems, facilitated discussions on solutions to problems, clarifying misunderstood concepts and problems, among other techniques.

Audio recordings of the group discussions were transcribed verbatim in MS-word and translated into English. All transcripts were verified for correctness and coded. Following in-depth study and extensive immersion in the data, an initial coding framework was developed based on themes such as: basic health / social needs; infrastructural needs; gender and shame, (political) power dominance, survival / effects of displacement and illiteracy/poverty. Following Heller et al.'s (2017) Critical Sociolinguistic Ethnographic approach which uses a series of steps (mapping, tracing & connecting) to organize and interpret data, this research adopts its methods and how it's particularly relevant in understanding what is obtainable in the field site by making sense of the taken for granted clue that explains impacts of health inequalities and factors that may influence health outcomes.

In the transcript below, I, the researcher is participant **AAI** and women- IDPs (n=11) are represented by their first names (see participants' demography in Table 1 and participants' trajectories in previous chapters).

AAI: Addresses the meeting and exchanged pleasantries with the participants.

After(re)-introduction, I briefly inform them of the research aim and asked the participants to introduce their selves and identify which community they come from; languages they speak and if they understand Hausa language.

IDPs: They took turns to introduce themselves, as asked above.

AAI: I noticed the sitting positions were mostly by group identification and affiliation; either of the same tribe or social status.

AAI: I asked if they were comfortable in the language chosen during the consultation and if they had ever required the services of an interpreter during medical visits or not. And what is their perception on how medical consultations are carried out at the camp.

Based on the above question guide, five IDPs out of the eleven participants contributed in great detail while others concur with what they said.

Salomé: Speaker 1- Salomé appreciates the services provided by the government through

State Emergency Management Agency (SEMA) to include the provision of shelter, evacuating / transporting them from their communities to safety. She also appreciates the NGOs and the Church in the host community who are assisting in the provision of basic necessity and security since their arrival at the camp in 2018. Her concern centers on gender- difference in medical care provision. She narrates her ordeal with health challenges which she referred to as "toilet infection" (PID/STI/STD) and re-infection even after treatment. Her greatest concern is the 'shame' in explaining medical concerns during consultations because all the MPs were male and attend to patients in a group. She said an NGO provided a complaint box (for medical challenges), she was able to write and drop her complaint.

Jummai: Speaker 2- Expressed her appreciation especially to NGOs that assisted them at the camp. She raised similar complaints as Salomé (speaker 1) although she was 'bold in presenting medical concerns and straightforward' with the MPs-and that enabled her receive treatment. However she said she got re-infected with "same toilet infection" due to poor sanitary condition at the camp. She narrated how her (19) year old son had to undergo free surgery due to such infections. She encouraged her son to be "free and to comply with the MPs" (counseling) so as to get better. Other participants agreed to what the two speakers said and wished something can be done about it.

Sarah: Speaker 3- Spoke about ante-natal (clinic visits by pregnant women before delivery) and how they were given assistance and free treatment to post-natal services. She said the team members (MPS) served sometimes as interpreters in case of language barrier. She narrates her lived experiences at the camp, and told of how other IDPs lost their lives when they first arrived due to mental –illness. She repeated the already voiced concerns by previous speakers that infections are still lingering. She however said, it has been two years now, they are more at ease at the community and can access menial jobs (like farming) for survival unlike before. She said the population of IDPs at the camp have reduced because most people had returned to their home town but some of them whose homes were

destroyed or burnt could not return and are therefore still at the camp. While other IDPs who could afford to pay rent had gotten immersed into the host community.

Nancy: Speaker 4- Re-echoing the complaint by Jummai (speaker 2) of poor sanitary condition and the lack of basic amenities such as clean water and disinfectants to keep the toilets at the camp clean. She wondered if the only (two) available toilets/convenience they share with no gender disparity is the reason for their persistent health challenges. The others tend to share in her thoughts and question.

Veronica: Speaker 5- Is particularly concerned about government deceit and failure in keeping to their promises to reinstate them to their lost communities. She complains about the failure of the government to reinstate them and their failed responsibility in providing basic needs such as food, water and decent shelter. It has been years and they feel neglected and abandoned since they no more feel the impact of the government like the first year of their arrival at the camp.

From observing the person category, it is safe to conclude that IDPs move in groups related to their social class, level of literacy, communual affiliations/relationships and tribe; that is, those who speak the same language or dialect (or share a lingua franca) often cluster together. The literate ones frequently represent them during meetings, interviews or focus groups. Sometimes competence in the language of communication is an added advantage for those who get to speak at meetings in contrast to those who do not understand or speak the language of interaction and who are likely not able to contribute but reaffirm or agree with others. Those who are silent are therefore mostly those with limited or no proficiency in a local lingua franca.

Although the majority of the IDPs at the camp were lacking formal education, they were, however, literate in social, traditional and cultural norms, aware of their humanity and spirituality.

5.3.1. **Expressions of health inequalities**

From the above data, all group members reported lack of resources such as inadequate toilets/convenience and lack of proper sanitation; poor medical supplies as a challenge to accessing proper health care and shame in presenting gynecological issues to a male dominated team of medical practitioners. The last speaker however decried neglect and abandonment by the government and the need for the government to reinstate them to their original communities.

The identification of the themes is based on the focus group discussion and my continuous engagement with the members of this focus group throughout the field research; so the discussion here illustrates the different themes, but the themes itself are informed. Some of the prevailing themes in the focus group interview which reveals health communication barriers of women-IDPs are:

1. Gender difference and shame / prejudice surrounding illness
2. Lack of resources /funding
3. Communication barrier
4. Hope (less-ness) in government policies and corruption
5. Poverty
6. Resignation to fate

Gender differences and shame / prejudice surrounding illness

The IDP participants in the above focus group discussion identify gender difference and shame as a communication barrier in access to healthcare. For example, Salomé, Jummai, Sarah and Nancy (speakers 1-4) identify the difficulties they encounter as women discussing issues of the genitalia during medical visits by the MPs at the camp. For instance, Salomé's major concern is the lack of privacy and shame in problem presentation to a group of medical practitioners attending to IDP patients. She narrates how during MPs visits, the consultation takes place in an open space within the camp. Considering the nature of the consultations, it means there is no confidentiality since other patients will be listening-in on the interactions.

Another related issue to gender and shame is prejudice surrounding certain illnesses; that is patients with PIDs are often time perceived as being promiscuous. Considering the attitude and mind-set of people regarding such illnesses of the genitalia, and being aware there is no confidentiality or the lack of privacy during medical consultation, female IDP patients will be sceptical in the amount of information they present during medical interactions. Another angle to prejudice is the cultural and some religious beliefs that hinder the patient to communicate certain aspects of their lives. For example some Nigerian cultural beliefs forbit counting the number of children one has; as it is believed to attract evil. Such cultural beliefs can limit the MP for example in asking how many children the woman-IDP birthed. Similar to these limitations either from cultural and or religious beliefs is the limitations for a woman to discuss or expose certain private information about her body to another adult male that is not her spouse. Such beliefs go further to limiting the male MPs from examining female-patients. As a result, the MPs can only treat the women-IDP patients by the (inaccurate or incomplete) information provided during medical interactions. Like the MP participants said, therein lies the problem with health care provision for the displaced persons. In the excerpt below, Salome Vincent expressed shame in problem presenting with regards to diseases of the genitals:

> *"Domin dayawa akwai dayawa wandada ta dalilin wanan toilet infection din sunyi miscarriage. Ya je ya fitar musu da juna biyu wandada dama suna da shidin. In'da za a taimaka mana sai aturo mana da ko mata zalla Kaman mu; ka gan zamu ji dadi muyi masu bayanni damuwan da muke ciki. A'ma indan miji ya zo haka kana ganin zai yi wuya ka bude baki ka fada mishi -ka ga yar' uwan ka namace ne ma if possible za ka iya ma ka tubai sai ka nuna mata ba ka ji kun ya ba. Na wa roko kena in'dan za a'taimaka sai a taimaka mana da magungunna da treatment yada za'a koya mana yarda zamuyi da zamu rabu da wanan damuwan."*
>
> *"There are many women who because of this 'toilet infection' have had miscarriages. If they will help us (women), they should send female MPs –like us- we will then feel free to express our challenges and medical problems we are facing. But if a male MP comes, it is difficult to open up and tell what you would ordinarily tell a female practitioner like you 'if possible' you can even freely*

undress and show her what is wrong with you (examination) without shame. My plea is for the provision of medication and treatment and to be provided with health awareness on how to avoid re-infection from this problem."

Lack of resources and funding

Lack of resources and funding for basic amenities such as medical supplies, food, (warm) clothing, sanitary provisions, etc., is identified by Jummai and Nancy (speaker 2 & 4). Considering the nature and living situation of the displaced, this is evident in the physical structures where they are sheltered; the lack of basic accommodation and exposure to other forms of abuse was identified during observations.

> The camp structure is built as a store for storage of grains and other food items for farmers by the past state governor of Plateau state. The building is a single room, each in a row of four blocks with about 10-15 rooms on each block. This building had been converted to temporary shelter for the IDPs when their populations became overwhelming for the emergency management Agency (SEMA) accommodation provided in the urban centers. Each room consists of a single window and a door facing the –store-compound or open surrounding. The entire structure has two rooms which serve as toilets / convenience at the extreme of the compound. (Field-notes January 25th 2021)

From the field notes above, the displaced have no decent accommodation and toileting conditions. Sequel to the over-population managed at the temporary shelter, these structures have poor ventilations and like the IDP participants identified during semi-structured interview, the porous nature of their accommodation exposes them to mosquito bites and subsequently, they suffer from malaria (especially, the children). Dr. Burt confirms this claim during a semi-structured interview where he stated that, the common ailments the IDPs are battling with is malaria, diarrhoea among others due to their living condition. The female IDPs decry their lack of resources to cater for their health because there is limitation on the part of the government in

attending to issues like caring for their health; the inadequate medical supplies and/ or fewer visits by MPs.

During the semi-structured interview, Mama Mary Abel and Esther Solomon described the nature of how they survive the harsh environment below:

> *"Muna sami ruwan sha daga rigiya, babu wuta, muna zama da su "Obansanjo nan"- aci bal-bal (locally made lentern). In dare ya yi, muna rokan Allah mu wayai gari. Akwai sanyi ama da' macize suna nan sai Allah ya ji tausayin mu bamu sake gani ba. Da shike ana naumai wujin, da' ciyawa ne."*
>
> *"We have drinking water from the well; there is no electricity we manage a locally made lantern popularly called 'Obasanjo' (nicknamed after the then serving President of Nigeria- Olusegun Obasanju) and another-'a'ci balbal'- of its type made from bottle and a thread with kerosene in the bottle to keep the thread burning. When it is evening, we often pray God to see the next morning. It is very cold here and also there were snakes but God has had pity, we no longer see snakes because people began farming the place and this has reduced the bushy parts around here."*

The two IDP participants' further advice on ways to alleviate their sufferings in the excerpt below:

"Toh kin gan a'gyefen shawara, domin ko ba niba, wanda suke fama baza su sami 'opportunity; su gaya wa jama'a ba. In akwai hanya, da hali sai a' taimaka a' panyi rashin lafiya, da yawa sukan nima likitoci ama ba hanya da zasu fada kuma basu da hali. Shi ya sa za ki iya gan abi zai iya faruwa ki gan akwai 'pre-matured dead' ki gan mutun yana ta nishi da shi ba' mai taimako" (Esther Solomon)

"So you see, on the part of advice, if not for us or for me, others who are suffering will not have the 'opportunity' to tell the public. If there is a way and or will, to assist us, on the part of health care, so many are in need of MPs/doctors but there is no way to say so. That is why you will see pre-matured death; you will see a person managing his/her health without assistance"

Communication barrier

Power and socio-economic status of the female IDP-patients' disallow female IDPs certain privileges and rights. As stated earlier in relation to gender differences and shame, a communication barrier exists in many forms at the camp. Beginning from IDPs' inability to speak the language of health communication (English) and on the other hand, the lack of understanding of the language of the IDPs by MPs has created gap in communication. Also, lack of awareness of their health condition due to illiteracy, lack of exposure and certain cultural beliefs surrounding illness make communication difficult during medical encounters. Speakers 2 and 3-Jummai and Sarah in the focus group-chat further (follow-up chat) highlighted socio-economic factors such as lack of education, poor sanitary provision, poverty, illiteracy and prejudice surrounding certain illness among others as hindrance to accessing effective healthcare.

"Toh a'gaskiya dai wandasu likitocin basu jin hausa. Wandasu kam zai fada mana da turanchi sai ita nurse na mu (Felicia), sai ta fada mana da hausa. Ta ce ga'abinda yake fada. Sai mu sami ganewa daga gareta. Inta fada mana da Hausa." (Sarah Ishaya)

"Sincerely speaking some MPs do not understand Hausa. Some will speak to us in English then Aunty Nurse (Felicia) will interpret in Hausa. She explains to us in Hausa what the MP says and we understand."

"Ai wuni lokaci in wanda basu ji Hausa, ana sami wanda yeke 'interpret' masu, sai su yi da turanchi sai ah 'interpret' masu." (Veronica David)

"Sometimes there are those who do not understand Hausa but they always find someone who understands to interpret for them then the MP will speak in English and it is interpreted."

In the above excerpt, Sarah Ishaya and Veronica David narrate their experiences in access to medical care and their encounter with MPs who have little or no knowledge of the lingua franca, their native language or the language of the immediate community but they could speak the official language-English and probably the MPs' native language which differ from that of the IDP patients. They explained how communication takes place during such instances, that is, through an interpreter; most commonly is the IDP –Aunty Nurse who later serves as MP in the account given by Sarah. In her account of the medical interaction procedure, it is evident that the IDPs rely so much on the interpreter and are confident of her competence. While in Veronica's account, anyone speaking the right language could potentially interpret.

In a similar scenario, the IDPs who are not competent in the lingua franca or commonly shared linguistic code communicate with the MPs in their native language and they sought the services of an interpreter to relate such information to the MPs who in this case understand both Hausa and English. This situation is captured in the excerpt below by Naomi Ibrahim:

"Akwai wandada suke jin Hausa toh za'a' iya kai ke wanda za ki iya fada ama da turanchi idan zamu iya fada ko da yaran mu. Wanda bai gane ba, sai a' maimaita mashi/mata."

"There are some who understand Hausa but they may take you where the MP can only speak English if you can speak in your dialect someone will interpret and if the MP does not understand, and then they interpret for him or the female –IDP."

Communicating with an interpreter as we have seen in the description given by MPs earlier on has its challenges. Revisiting what Aunty Nurse says, it is not all the languages she understands, therefore in most instances, she employs different means such as paying attention to patients' body language, sign and her intuition to assist in the interpretation and lastly, her faith in God. Unlike the confidence instilled in her by some of the IDPs to represent their medical concerns, she on the other hand, is not confident as an interpreter. Like knowledge of her incompetence, the MPs are aware of the gap in communication caused by the use of interpreters in such situation but choose to accommodate it because of the need to communicate.

Language and illiteracy as communication barrier

Language and literacy play a vital role in the communication of the IDPs and NGOs who provide humanitarian services to the displaced. The role of language in the interaction during meetings which I observed indicates disparity in the way the displaced receive assistance or not. For example, in the excerpt below, the IDPs who were able to access funding for small scale businesses or farming are the literate ones who could express their plans on how to utilise the funding to the NGO representatives. The two most represented languages in the interactions between the IDPs and NGO representative is English and Hausa. Below is an excerpt of the field notes:

> The meeting with the NGO (Catholic relief team) was a follow –up visit to provide relief funds in form of micro-finance to displaced "women" who are ready to begin a trade. The IDPs present at the camp were mostly women, children and a fewer old and sick men. This is because of the farming season which provides menial jobs for the IDP men. The leader of the NGO team

> addresses the IDPs in Hausa language and asked if they remembered his team and their promise to return after most of them filled forms sometimes last year (2020). They acknowledged and he further asked if those selected and got a call from their NGO are present, and they affirmed. I noticed they understood to some reasonable extent the lingua franca –Hausa-he employed however, they often code switched when they speak in group with their indigenous native dialects and only answer with fewer words possible. There seemed to be different communities (13) at the camp who speak different languages /dialects of some of the languages. The NGO team leader calls out names after the address and advice beneficiaries to be productive with the funds because there would be a supervisory team to monitor those selected after the disbursement. While the other two team members attended to each beneficiary in form of an interview to ascertain their readiness by choice of trade, etc. Most of the IDPs went to the lady in the group because of their literacy level and/ or gender preference I think. Although the second group member a male, does not speak Hausa and only communicates in English and his native language Yoruba (south western Nigeria). His presentations were translated by the second representative from the NGO at the IDP camp.

From the field notes the representative of the NGO who cannot speak Hausa depends on his colleague to explain to the IDPs in the language they understand. The NGO representatives carried out a brief interactive session and interviewed those selected for the poverty alleviation initiative, judging from the preference to be interviewed by the two representatives who speak and understand Hausa, only a few IDPs went to the representative who could neither speak nor understand Hausa, the lingua-franca or native language of the IDPs. This scenario is a typical example of the level of literacy at the camp and as such, communication barriers exist due to language diversity among those displaced and other humanitarian aid workers.

Hope-(less-ness) in government policies and corruption

The next theme generated is hope-(less-ness) in government policies and promises. The theme of insecurity and deceit in politics raised by Veronica relates to promises by the government to resettle and/ or reinstate the IDPs from the status-quo which had left the IDPs to either resign to fate or lose hope in the face of difficulties in the camp. This has great impact on their well-being. Political deceit, corruption and diversion of relief materials have been identified by Veronica during the discussion. She explains how she/they had become resigned to fate. Participants in the focus group interaction agreed that they had not been treated fairly by the government. This particular theme is later elaborated when it resurfaces during the semi-structured interviews with participants on how they are neglected and mismanaged.

> *"[…] ina rokon gomnati ta tanada mana mu koma gidagen mu shi ne mafin komai. Ta kuma lura da rashin lafiya da ke kewayen kawyuka sa bo da a' magan ce na gobe." (Nancy Paul)*
>
> *"[…] I am pleading with the government to assist by re-instating us back to our communities that is to me the ultimate. They should also take care of insecurity that has engulfed the surrounding villages /communities so as to prevent this from happening again."*
>
> *"[…] mutanin (named host community) garin suka karbai mu da hannu bi-biyu sun yi mana abinchi, sun yi mana komai. Sun kawo masara, da ...sun dafa mana abinchi da kunu muna sha sabo da muna da yara. Yaran ma lokacin suna makaranta, daidai lokacin da yara zasu dauka hutu kenan, basu ma rubuta exam ma ba sai mun gudu zuwa nan babu jarabawan ma ba. Sai wayansu suna zuwa su taimaka wa yaran da koyarsuwa kadan wanda su ba yar da kan su suna taimaka wa yaran kar su manta. Toh, ta dalilin haka ne suna ta zuwa suna taimaka da abinchi, gomnati kam bamu gan wanni ba, bamu gan taimakon da gomnati ta yi mana ba. A'ma mutanin churchi da ban wadda sun bamu chi da sha, mun ce mun gode" (Tabitha Duniya)*

"[…] people of the host community welcomed us well and provided us with food and every need. They provided corn and made food, pap because most of us came with children. That time, the school was in session towards vacation period although they were yet to take their examination, we had to escape here for safety. Some humanitarian aids were coming in to assist in tutoring the children so as to refresh their memory in learning and through that, they came with food items, as for the government, we didn't see them and there was no help from the government but the Churches gave us food and drink, we are grateful"

The women-IDPs in the excerpt above (Veronica and Tabitha) recount their experiences when they arrived at the camp and how the people of the host community and the Church assisted them with basic necessities like food, shelter etc., but denounce feeling the impact of the government except for their role in relocating them from danger to the camp for safety. Tabitha listed the many areas individuals, humanitarian aid workers and Non-Governmental Organisations (NGOs) assisted them and are still assisting, yet, the government failed in their responsibility. In the excerpt below, Veronica criticises the views of government in the media, that they have reinstated the IDPs and betrayal of denying their existence.

"Haka muna nan muna nan dai, government mu dai ba mu gan woni taimanko da government (da) sukayi mana ba har ga Allah. Domin in'da sun taimaike mu zamu fada a'ma basu taimaike mu ba. Ga yaran mu ba makarantu, haka muna lalaba a kore su yau, a'kore su gobai-ba kudin da zamu biya makaranta. Muna rokan Allah government ta taimaka mana yada zamun samu yaran mu su cigaba a makarantu… Hakan dai muna bin kali haka muna ce. Rashin lafiya haka ya zo mu ne mai lokaci mu sami magani wuni lokaci mu bar wa Allah, Allah shi ke biya mana komai. Government ba'sa taimokon mu sakani da Allah. Don suma sun san har ma sunna ce ai babu IDP, sun riga sun salaimai IDPs toh gamu muna nan har'yau a' IDP gida je sun kokone zaka ji ka kama ina, gidan wa (za) kaje ka zauna? Gidan har sun rurushe ma." (Veronica David)

> *"We have been here and no help came from the Government between me and God (swear) because if they had helped, we would have said so but they did not assist us. See our children, no education that is how we have been managing to send them to school, they keep sending them back to us for lack of fees and we do not have money to pay their fee. We pray to God for government to assist us in order to send our wards to school […] similarly, we manage our health sometimes for lack of finances, we surrender everything to God. Government are not helpful (swore) because of that they had device a means to claim that there are no IDPs because they had claimed to have reinstated the displaced to their communities. But here we are still at the IDP camp because our homes have been burnt and the houses have even fallen; we have no house to return to."*

Relating to her account of government failure to maintain the camps, Veronica describes how their children have no stability in learning due to lack of finance; the lack of finance according to her also has impacted negatively in their health. There is an undertone of corruption and political deceit used against the displaced for personal and political gains. Here, the IDPs are portrayed as being reinstated by the same government whom the IDPs swore to have not felt their presence. While the Government are applauded for their effort, the displaced are left to fend for their selves and families without any form of assistance. Probably, there may be a bridge in communication between the government and those saddled with the responsibility to seeing the marginalised attended to and reinstated but who failed to do so by channelling such funds to their pockets. Either way, the Government has failed by not instituting the right channel, people and policies to ascertain the displaced are properly taken care of.

Poverty

Poverty according to the participants is the reason they depend on government, NGOs and individuals for their daily need. For example, Jummai in the focus group discussion narrates how their conditions which should be managed led to avoidable deaths of some IDPs. The IDPs

narrated during informal chats the number of victims who had either committed suicide or died from stress related issues like high blood pressure/hypertension. Poverty is yet another fundamental reason those displaced linger longer than necessary at the camp; reasons –they do not have any home to return to or means to recover their losses. Citing an example from Sarah, a widow with six children who lost her husband, their home was destroyed and considering her source of livelihood is farming, with no formal education or entrepreneurial skills, she resigns herself to fate. Such are cases of most women-IDPs who are often found at the camps located in rural areas of the country.

> *"[…] Ya bar ni da yara anan din (He died from paralyses and hyperthension). mu na da yara sai na ce bari akama masu makaranta, so-ro ma ya kama mu, sai mun ce mu koma ma, mutane suna gudu za a' sa yara amakaranta ma yaya? Sai mun sa su amakaranta a'nan. Toh da mu kama masu makaranta muna lalaba, wani lokacin ma-wancan term ma, babu kudin biya, toh abincin ci ma muna lalaba. Toh mun gode ma mutane sa bo da yanda suka taimaka da haka din." (Tabitha Duniya)*

> *"[…] he died of paralysis and hypertension left me with the children. I wanted them to return to our community for schooling but fear engulfed us since people are running from the community because of insecurity, how can they go back to school? We then enrol the children here-at the host community- but we have been struggling to pay for their fees like last term, I couldn't pay for their tuition fees considering even feeding is a huge challenge but we are grateful people have been helpful in all of these."*

Struggles and the cycle of poverty are created with the condition and situation the women-IDPs are relegated to. Tabitha a widow, displaced and left to cater for her children narrates her ordeal in struggling to educate her children when feeding is a bigger issue for them. In the face of all these challenges, she is grateful to the individuals and humanitarian aid workers that have been supportive.

> *"Mazagen mu babu aikin yi, mu matan, ba aikin yi. Suka zo suka kore mu daga can' gidaje sun kokone gidaje ba'inda zamuyi. Toh shine mu ke nan."*

"Our men had no work except farming and the intruders chased us out of our lands and burnt our homes we had nothing else to do. And that is why we have been here."

In the above excerpt, the IDP-participant laments the reason they are suffering, being that they are peasant farmers and since their men only knows how to farm and because they were forcefully removed from their farmlands (with others killed), they (both men and women) are left without any source of livelihood and that can only bring more poverty to the people.

Resignation to fate

In the face of these challenging experiences of the IDPs, they (all the participants) have faith and appreciate the contribution, aids and prompt rescue they received when they were rendered homeless. However, Humanitarian NGOs both local and international can only assist in providing for the immediate needs of the displaced population because in the absence of a supportive government -who places individuals as its first principal responsibility- the resettlement, challenges that keep pulling Nigerians into chaos and render people homeless are unlikely to abate.

"[…] inna so in nuna godiya ga churchi da ken an da kuma mutane da yawa da kan kawo mana taimako. Fatan mu shine ah taimaka mu sami hanya da za mu koma kawyukan mu da kuma gomnati su tanada mana da halin haka." (Jummai Duada)

"[…] I want to express my appreciation to the Church that is in the host community and the many people who have helped us in one way or another. Our wish is to find help in returning to our communities and also for the government to help us in this regard."

An examination of the above data collected for this research leads to the understanding that to prevent and better manage IDPs' related problems, certain practical steps need to be put in place. For further argument, I have identified some practical steps in subsequent chapters that can help to address issues raised in the investigation.

5.4. Gender role at the IDP camp

The observations, field notes and interview transcripts, support my earlier assumption that gender plays a significant and specific role in access to healthcare at the IDP camp; specifically, for the female-IDP patients. Taking a leaf from my observation of gender difference of MPs participants, only male MPs visit the camp for medical consultations and this had created a communication gap in particular cases for women-IDP patients during medical interactions; particularly, in discourse relating to the reproductive organs. The women-IDP patients identify this imbalance of gender inequality as a barrier to their health communication. The MPs also identify the effect of gender on effective health communication by citing an example of disease involving the genitals as a case in point in which the patients withhold information and give stereotypical names to infections.

In a bid to identify reasons for gender inequality at the camp, Dr. Maxwell identified patriarchy as *a possible reason for* the lack of or minimal volunteering of female MPs at IDP camps which he also sees as a "s*ocial problem*":

> *At the IDP camps, volunteers, medical volunteers are mostly males-… This is so because… the problem may also be because "they have a head" which is their husband and if their husbands' decline to giving them consent to volunteer then of course they would not be able to volunteer as against the man who is usually the head-considered as the head of the home –he single handily takes the decision-if he wants to volunteer, he goes ahead to volunteer and many a times the woman may not be able to say no to his choices-I think those are some of the problems. So they are mainly social problems that stop females or reduce the number of females that can volunteer to IDPs camps. I don't think is something too special (he laughs).*

The patriarchal dominance in most African cultures arguably plays a bigger role in the decision of female MPs to volunteer at IDP camps. Tradition, culture and religion have dictated men and

women's relationship for centuries and entrenched male domination into the structure of social organization and institution at all levels of leadership. Patriarchy in most African countries justifies marginalization of women in education, economy, labour market, politics, business, family domestic matters and inheritance (Salaam, 2003). Dr. Maxwell also identifies other 'social' reasons as likely challenges female MPs -at child bearing age- faced in volunteering at the IDP camps. He states that:

> *... The female MPs have a lot to deal with and mainly it is problems or challenges of the home-front. So you find some of these female MPs who are actively breastfeeding and are not able to err... volunteer to IDP camps or female MPs who are heavily pregnant and because of some of the challenges of pregnancies, they would not be able to volunteer or female MPs who (are) because of their religious inclinations would not be able to commit themselves whole heartedly or completely to being or staying in the IDP camps …*

In the excerpt above, Dr. Maxwell's view is similar to Dr. Burt who thinks the nature and risks of the work at the IDP may be the reasons female medical practitioners are generally fewer as volunteers:

> *At times why females are not contributing much in not all areas because of the hectic (nature) of the work or because of the environment where they are sends to work. It's not all females that can … endure to (work)...in those environments and (due to) the hectic (nature) of the work…*

Examining Dr. Burt's reasons as to why female MPs are fewer as volunteers in the IDP camps is peculiar to the setting and situations of such shelters. It is reasonable to say some of the camps where the displaced are sheltered (for example, in the far North-East Maiduguri, Borno State) are mostly in remote areas or rural communities; hence, there is insecurity considering the bad-unsafe roads volunteers travel to such distance and being the vulnerable gender, female MPs avoid such risks (kidnapping/bombing) and exposure. Another reason could be the poor structural provision of such shelters like Dr. Burt said, "The environment", and "hectic" nature

of the job discourages the female MPs from volunteering. This is true because most IDP camps in the country lack basic social amenities and there is always the risk of contracting communicable diseases.

As a result of the above enumerated risk, there are fewer female MP volunteers and the low rate of female MPs has its direct or indirect effects on the health and /or communicative needs of women-IDP patients particularly, for female patients where there are no female *chaperons* in place during medical consultations. As stated by Dr. Maxwell:

> *The low rate of female medical volunteers to the IDP camp also has its attendant problems. Some of the problems constitute the problem of medical consultation or examination of the patient. For instance, if the patient at the IDP camp who needs to see the medical practitioner is a female, and the MP is a male, you know that would constitute a problem; especially when it comes to patient examination because the female may not feel very comfortable exposing herself, her body to the medical practitioner at the IDP camp. And again/ and especially if there are no female chaperons and again you know this is not the … conventional clinical set up.*

The IDP camp although heterogeneous, is however dominated by women and children. Information gathered from observation, group discussions and interview conducted reveal that most of the men -"head of the family-" died as a result of injuries sustained from the attacks (by Fulani) or were killed during those attacks; leaving the widows and young children homeless. These women are predominantly peasant farmers with little or no-source of livelihood to rely on. The displaced women recount during an interview (see appendix I) that aside from these challenges, access to healthcare has been a major challenge. The challenges in accessing healthcare range from inadequate provision of medicine, lack of a conventional clinical set-up to lack of laboratories for further investigation; other challenges include earlier on discussed -lack of privacy and confidentiality in terms of the use of non-professional interpreters; to in-frequent visits by MPs to (a male dominated MPs volunteers) the camp.

The effect of male dominance as MPs in IDP camp to accessing healthcare according to these women-IDPs disallows proper presentation of problems during consultation, particularly where

they are faced with issues relating to their genitalia. The women-IDP patients express shame in presenting their "genital tract infections" which they referred to as "toilet infections" to the male dominated MPs during medical visits. A further investigation into this challenge was supported by MP1 (Dr. Andre Maxwell) in a semi- structured interview where he complains about the absence of privacy and gender difference as a hindrance for MPs in carrying out examination, particularly, on female patients. Since the female patients sometimes do not present signs and symptoms due to 'religious beliefs,' cultural beliefs and/ or shame, it is difficult to diagnose ailment-he said. In support of Dr. Maxwell (MP1), Dr. Alexander Burt (MP2) attributes the barrier to proper problem presentation (by IDP patients) and to lack of awareness and difficulty in adapting to change due to their belief system/or way of life. Thus, it becomes difficult introducing new ideas or information to the IDPs unless the MPs relate with them 'as friends' he said. Consequently, it is reasonable to argue that power and role of the gender plays a key role in providing a space and platform where the IDPs (especially women IDPs) can relate whether on issues of healthcare or other challenges. During the focus group interview and semi structured interview, women-IDPs revel their gender preference for female MPs in addressing issues of genital tract (re)infections ('toilet infection'). This is because 'they will not be ashamed to express their selves' and for ease of examination since 'she (MP) is a woman like us' (citing from the view). Here, the issue of shame, gender inequality and gender preference for the female-IDPs' in accessing healthcare is emphasised in the discourse.

Although gender preference by women-IDPs for female MPs volunteers has been raised, this is a challenge because of a number of factors enumerated by the MPs participants. Foremost is the unavailability of MPs -irrespective of gender- who in this context are volunteers as such, shortage of medical personnel makes gender preference in providing healthcare difficult. Next, the 'nature of the job and settings'-may also be a hindrance to the female MPs to volunteer. Then the view by MP1 that unequal gender representation of MPs at the camp could be because of nature of the home front, the responsibilities shouldered by the women (pregnancy related, etc.) has a role in discouraging female MPs in volunteering. Lastly, due to the patriarchal system practiced in Nigeria, female MPs unlike their male counterparts have no rights to volunteer without their spousal permission but the male MPs can volunteer with or without the wife's knowledge (rephrasing MP1). Thus, the issue of power, dominance and gender inequality at the societal level re-surfaces and is identified in relation to provision or access to healthcare.

Also, the absence of a conventional clinic set-up to investigate the health needs of IDPs contributes to other challenges in accessing healthcare particularly for the women-IDPs. In view of the narration about 'shame' in presenting some diseases, the difficulties MPs encounter in examining female patients, further investigation into problems presented in a laboratory is sometimes needed; however, that is not readily available at the camp. Referrals are made but that requires financial responsibility on the IDP patients –who are mostly dependant on humanitarian aid for survival. As such, further investigation or treatment is mostly neglected until their health deteriorates. An example is Jummai (see interview excerpt) who said she needed surgery but due to her financial status and the unavailability of such services at the camp, she has been managing her health condition for the past two years.

Lack of privacy is not only attributed to the absence of a physical structure but also the presence of a third party; it could be an interpreter, other MPs or patients. In some cases, the IDPs do not have a say as to who serves as an interpreter during medical consultations (citing from MP 1 interview data). Largely, this is so because of the need to access medical care and the urgent need to communicate with the patient- in this case, where there is no mutual intelligibility of shared language of communication by both participants- (IDPs/MPs). The first MP laments the use of untrained interpreters as another hindrance to effective healthcare provision. He emphasised the misinformation and/ or misinterpretation often provided by these interpreters during consultations. In addition to this, medical terminologies often lose their meanings when an IDP and MP depend on or engage the services of an (untrained) interpreter, he said.

Besides, there is the unconventional method of medical examination whereby patients are treated simultaneously in an open space with other patients (IDPs) and other MPs present. This hinders confidentiality and the observance of privacy in access to healthcare thereby promoting barriers to communication. In similar fashion, the lack of medical examination screens to provide some level of privacy during medical examination further contribute to the challenges faced by MPs where there is need to examine women- IDP patients' for proper diagnosis.

In addition to gender preference in the treatment of IDP-patients, there is the problem of gender inequality in the representativeness of MPs at the camp. The MPs are predominantly males (as earlier stated) and like the two MPs –in this research-agreed, "the low rate of female medical

volunteers to the IDP camp has its attendant problems" (Dr. Maxwell). Dr. Maxwell listed some of the challenges of a male dominated MPs volunteers to the IDP camp as:

Researcher: *Why do you think there are more male volunteers that are medical practitioners' at the camp?*

MP 1 *Some of the problems constitute the problem of medical consultation or examination of the patient. For instance, if the patient at the IDP camp who needs to see the medical practitioner is a female, and the MP is a male, you know that would constitute a problem; especially when it comes to patient examination because the female may not feel very comfortable exposing herself, her body to the medical practitioner at the IDP camp. And again/ and especially if there are no female chaperons and again you know this is not the/ err... a conventional clinical set up. Unless if the medical practitioner is smart enough to remember that he needs he/she needs chaperons who (are) female to standby as one is trying to examine the female patient at the IDP camp. Then again another problem sometimes would be maybe the issue of may be, religion. There are religions that females are not very forward when it comes to communication or interaction with a male. And so, you find those females with that kind of religion not being so open or free to communicate with a male MP who is attending to their care. So that also is another problem of not having many female volunteers at the IDP camps.*

In tandem with the MPs' concerns about gender role in the effective health care of women-IDPs, some of the participating IDPs identified the issue of 'shame' in discussing pelvic inflammatory disease- also known as "toilet infection" as earlier discussed. In similar fashion, the women-IDP participants identify gender as a factor that creates 'shame' during medical interactions as contained in the interview excerpt below by Salomé:

Mata suna fama da wana toilet infection ba na kadan ba. ***Kaman wada sun zo mana a'na, jin kunya a' fada ga damuwan da muke fuskanta.*** *Ama muna rokan Allah Ubangijiyasa'da mu sa'mi wandadan zasu zo su talafa mana domin a zo atalafawa' mu mata da wanan damuwana toilet infection-gaskiya da' mun ce mun gode mun gode sosai.*

Women are suffering with this "toilet infection" seriously. If MPs visits the camp, some of us (women) are ashamed to state their health challenge (making reference to the infections of the genitalia). But we are asking God Almighty to send people to help especially to assist us women who have this toilet infection-truly speaking, we would have been very grateful indeed.

In the excerpt above, Salomé identified 'shame' in identifying or expressing such condition as infections of the genitalia to a male MP for some women. Hence, this study argues that gender difference plays a major role in the medical interactions between IDPs and MPs and this has been a major cause of miscommunication and/or a communication barrier for both ses of participants in this study. In an informal chat with Sarah Ishaya- 3rd IDP participant, she expresses her ease in discussing the issue of diseases of the genitalia with me because I am a woman like her; she wished there are female MPs so they can feel free to identify with, especially when discussing their health conditions. Sarah further explained why the topic of PID may be difficult for some women:

Researcher: *"What are your suggestions and or advice to these health challenges?"*

IDP: *"Hakadin'ne da anyimana Kaman danasibiti ne haka wanan zai shiga ya je sai yayi bayani irin jikin da shi yake ji. Amaza' zonna toh wani lokaci wayansu matan suna ganni ace wa ga wayana fari fari abu yana fita a gaba kuma maza ne sukangan (ni) mu-zakaji kunya ka fada musu ga damuwa da ke damin ka, shi yasa ba ma iya mu fada din ba."*

"Like that, if they can build or provide us with clinic or hospital to ease problems of privacy when presenting medical concerns to the MPs; but sometimes some women are ashamed to present signs /symptoms like telling a male MP of white discharge from the private area. We feel ashamed to tell them the problem we are facing and that is why we cannot say or present it."

In the interview excerpt above, the IDP patient cited an instance where discussing signs and symptoms of PID is difficult and in general how difficult it is discussing such sensitive issues to a group of male MPs and that is why it is hard to get proper treatment. She also wishes there was privacy like a conventional clinical set-up where the women-IDPs may feel free to discuss in private with the MP.

There are scarce literature on whether or not socio-economic status such as educational level of the women-IDPs, and their belief –religion or cultural views determine the choices they make in accessing health care; hence, this investigation attempts to have a cursory look at these components in relation to other challenges the displaced faced.

The third part of my research question pertains to investigating possible health communication barriers of women IDP-patients. One key finding is patient disclosure pattern. Specifically, I inquired what information patients would or not share, and under what circumstances. The finding shows that an IDP-patient's decision to disclose problems during medical interactions is often influenced by:

1. Sensitive topics
2. Presence of an interpreter
3. Gender of the MPs
4. Privacy of consultation space or room and
5. Power relation and friendliness of MPs.

As earlier discussed, a language barrier calls for the use of interpreters. Consequently, women-IDP patients would prefer female MPs or the female nurse (AN) to do the interpretation if

possible. Otherwise, MPs generally use any-other MPs, or patients who can speak the patients' language. Obviously, IDPs sharing pertinent health information with another patient or acquaintance can be unnerving**.** For instance, the argument and excerpt by Salomé about presentation of disease of the genitalia to a male dominated MPs. The presence of interpreters, the data suggest that, even in medical interactions with MPs without the use of interpreters, IDP-patients seemed reluctant to discuss issues bordering on disease of the genitals, or sexually transmitted diseases. The findings echo previous studies which have argued that patients are reluctant to disclose stigmatizing diseases and are even embarrassed to discuss it with their physician (e.g., Cauglin et al., 2009; Mitchell & Knowlton, 2009).

A major pointer to the finding in this study regarding patients' disclosure behaviour is related to gender preference and lack of privacy in the camp during medical consultation. As earlier established, there is no conventional structure for consultations; MPs attend to IDPs in an open space with sometimes medical examination screen or artificial arrangements for IDPs to cover a female patient during examination. As a result, no privacy exists for IDP patients to share their medical concerns thus, various issues regarding privacy and confidentiality issues arise. For example, participants in this study clearly express their dissatisfaction about the condition and lack of access to health care. While MPs admitted that the lack of conventional clinical set-up compromises patient privacy and confidentiality, they did not state how else the situation could be resolved except that these could be resolved when the government or other NGOs provide assistance. Let us not forget that insecurity led to these problems; infrastructural problems might account for a part of the challenges with inadequate volunteers especially gender inequality. What appears to be overlooked is the presence of social inequality creating more of the challenges with absence of initiative by the government who are by obligation, responsible for the safety and basic human needs of this population. I make this claim because, as discussed earlier, the life experiences and trajectories of the displaced population first and foremost is the failure of the government to protect its citizen through provision of safety for its jurisdiction as contained in the constitution and rights of each citizenry. Also, people who are displaced should by law enjoy the constitutional rights to be cared for through provision of basic amenities and security which is denied to the displaced population.

Findings in terms of patient disclosure pattern are linked to power relations between the MPs and IDPs-patients and the level of friendliness of the MPs. As stated by Dr. Burt, "the MPs need to be patient, make the IDPs their friend and ask a lot of question" (Dr. Maxwell) to be able to arrive at the problem of the IDPs. The point raised by the MPs is an indication of how much MP's relationship, cordiality and relate-ability means to the medical interaction of the IDP patients.

From the point of view of the IDPs, a related finding in terms of having a say in their medical treatment and inquiry about their health status and / or condition with regards to power relation, is absent. Findings from this study indicate that patients avoid sharing pertinent information, such as how long they have had a disease; lack of understanding of treatment prescription and sometimes, fail to request preferred treatment.

In this research, MPs also justify their limited healthcare services on the basis of an overall growing population of IDPs across the nation, inadequate supplies of medicines, and other necessary supplies to work with the IDP-patients' as such they could only offer what the NMA provides. Also due to gender difference, the women-IDPs present mild symptoms avoiding discussing intimate issues like STDs or PIDs which may be the major concerns for visiting the MPs as a result of lack of privacy and gender difference as earlier discussed. This study observed the feeling of dissatisfaction with the medical treatment on the IDPs and failed treatment as a result; they referred to it as "re-infection". Limited healthcare services at the camp are as a result of health disparities. Health disparities are driven by underlying social and economic inequalities that are rooted in corruption, greed, and power tussle. Addressing disparities in health and health care is important not only from a social justice and equity standpoint, but also for improving the nation's overall health and economic prosperity.

On a larger context, the IDPs identify a challenge with receiving care at the camp due to the influx of people (patients) from the host community- it means therefore the camp is porous- and since the medical supplies are not enough, they tend to receive pain killers as treatment in absence of proper medication. Below is an elaborate description of this point by an IDP (Tabitha Duniya)

"[…] woni-lokacin muna da yawa, sai wandasu daga gari sukan zo suyi gaba saisu sami magunguna masukyau. Sai mu na bayanna, sai ka fada ciwo sai abaka magunguna wanda bazai taimaka ma ka. Sai abaka [...] an riga an ba wana farko magunguna masu kyau mu na bayanna sai baza mu sami ...daidai karfi kawai."

"[…] sometimes we are many, and people from the host community comes early to receive treatment at the camp and they end up receiving the best medical supplies the MPs have. Later, we who are treated subsequently are given medication that will not help your health condition. Because they had given the previous patients the best medication available, we who come later do not receive same… but manageable medications."

In such situation, the IDP patients have no confidence (power relation) to complain, they appreciate the humanitarian aids provided by the NMA as such, appreciate whatever little assistance they can get from these health providers. On the issue of incomprehensiveness on the part of the patient, we see the case of Naomi an IDP who said the MPs advised her to take dissolved sugar and add salt to her meals whenever her blood level is low:

Researcher: *"What are your challenges?"*

Na'omi: *"Gaskiya, masala kam nasamushi, nasamu masala jinni na yanasa uka baya hauraba. Kuma inya sauka haka din, yana bani damuwa sosai. Har sai suga bobina su dinga mutuwa. Sai kai bazan ji daidaiba' da kuma ulcer. Ina ci wani abumaizafi, sai ya bi ya fadimun a zuchiya. Sai in ji zafi. Na gaya wa likitoci da ke zuwa ai sun bani magani. Yanzu dama dama, ama saukan jinin, nakan ji shi awani lokaci. Sun ce in'najihakasai in sharuwan sugar. Ai, sai in karagishiri a' abincisaiin'rika chi. Toh ne inayihaka.*

"Truly speaking, I had some challenges; I had issue with low blood pressure. Again, if it is low, I have a lot of problems, to the extent my joints and legs get very weak. I often feel very sick whenever my blood pressure is low and I have ulcer. Whenever I eat hot food, I often feel pains in my chest and pains. I have told the MPs that visits the camp and had received medication. However, I have occasional attacks of low blood pressure. They (MPs) said I whenever I feel like that (low blood pressure), I should drink diluted sugar. Again, I should increase my salt intake in my food and I have been doing so."

The finding reveals a lack of proper information on the part of the patient as a result of power dominance, lack of awareness and misinterpretation from interpreter. The various aspects of disclosure patterns which emerged from this study can be identified within the framework of communication privacy management (CPM) (Petronio, 2002). Petronio noted that sometimes confidentiality and privacy are in tension with each other, which influences an individual decision to reveal or conceal their private information. The theory further posited that individuals' develop privacy rules based on their cultural values, gender, assessment of risk-benefit and the situational context. Moreover, individuals would prefer to share information with others based on the relationship they share and the conviction that the other person will keep the information confidential. In this case, Petronio describes such a receiver of private information as a co-owner or confidant (others are shareholders, reluctant confidants and deliberate confidants) (for more discussion see Petronio, 2002; Petronio & Reierson, 2009).

Within the CPM theory, it is reasonable to argue that the IDP-patients in this study do not regard their MPs or their interpreters as confidants. Rather, they choose whether or not to share certain information with the MPs on visits. For instance, women-IDPs in the focus group discussion were less likely to inform their MPs about sexually transmitted diseases or PIDs. They argued that the gender of the MPs made it difficult to disclose such sensitive topics and therefore, the shame involved in discussing such problems. Such behaviours constitute 'pre-emptive privacy control' (Petronia & Reierson, 2009). According to Petronia and Reierson, "people use a strategy of 'pre-emptive privacy control' to thwart anticipated privacy violations … people retain control

over their information by setting up thick boundary walls preventing disclosure or permission for access" (2009, p. 378).

Thus, it can be reasonably argued that IDP-patients interpret male dominance and open consultation as a possible compromise of trust with other patients listening in-on their interactions. Consequently, patients guard information that they share by utilizing 'pre-emptive privacy to control' strategies and invariably exercise their autonomy over what information to give to their MPs. Hence, we can also interpret patients' behaviour as a reaction to MPs' powerful status. For instance, Sparks and Villagran (2010) found that "patients who perceive their provider to be significantly more powerful than themselves may not be completely honest about certain habits, risky behaviours, or lack of adherence to a medical treatment plan" (p. 44). We can infer from this study, that, the dominant position of the MPs plays a role in patient disclosure decisions.

5.5. Chapter Summary

In this chapter, I provided responses from participants and used that as data to answer a part of my research questions. Notably, I discuss the effects of inequality on health communication of IDPs during medical interactions with their MPs'. Also I sought information about language barriers, interpreters, patient disclosure behaviours, and the effect of inequality on the rational aspect of MPs-IDP-patient interaction. In the process, I developed various categories such as gender differences, shame, and prejudices surrounding illness; lack of resources and funding, communication barrier, hope (less-ness) in government policies and corruption; poverty, resignation to fate and appreciation. Other categories are gender and health disparities, power and socio-economic differences, illiteracy or patients' level of education, limited vocabulary, lack of privacy and the use of untrained interpreters. In interpreting the focus group interview, I identify the role of gender in the medical encounter of women-IDPs in the IDP camp. In addition to these, I sought the perception of MPs towards women –IDPs. I also work to discover the similarities or differences among these categories and to represent the taken-for-granted challenges and constraints which engulf MPs-IDPs patient interaction in the IDP camp in Nigeria.

The next chapter investigates how linguistic diversity is managed in the camp and at the camp's clinic.

CHAPTER SIX

COMMUNICATION MANAGEMENT IN A MULTILINGUAL IDP CAMP

6.1. Chapter Introduction

In this chapter, I present an overview of the findings on communication management in the multilingual temporary shelter for the displaced persons' in Nigeria. The discussion include participants' (IDPs/MPs) perception, unique findings on how medical consultation is conducted, related findings on the use of interpreters for medical interactions, and in later chapters I present practical implications, limitations to the study and suggestions for future research.

The analysis of interview data in this chapter relies on the informants' subjective statements. They were a window through which I explored native IDP-participants from diverse language groups interacting with English language trained MPs' within medical encounters. In the analysis, I sought to explore how communication takes place in a linguistically diverse setting. Also how this situation and other factors such as social inequality may hinder effective communication, slow or mask certain values which are situated in the participants' inter-relational peaceful co-existence, survival and many other aspects.

6.2. Language diversity and the management of communication in the IDP camp

One of the research questions focuses on the management of communication in the multilingual IDP camp. Management of communication here include choice of language used during healthcare provision (activities and day to day management of the IDPs); and whether or not it shapes medical interactions in any way. Responses from participants reveal the existence of a communication barrier, especially where the patient could not speak English or the lingua franca (or Hausa language) and the MPs do not understand the patient's dialect. While participants noted the need for shared linguistic comprehension, however, there are difficulties encountered during communication; particularly, during medical consultation due to language diversity, illiteracy and poor health information on the part of the IDPs. They also referenced various

challenges as explored further by Dr. Maxwell with regards to difficulties encountered at the camp in the excerpt below:

> *For me I think the major problems we have in the IDP camp is the problem of communication; because with effective communication we are able to get to know their main problems and that way we will be able to solve some of those challenges but without getting to have an effective communication with the members of the IDP camps, we will not be able to solve their challenges. So communication is a key thing for me at the IDP camps. And I think an easy way to summon these kinds of things is to have interpreters…*
>
> *Because for me I regard that setting in the IDP camp as an informal way of communication because many of the times we are not able to communicate person to person because many of the times we are not able to communicate specifically or directly. So communication takes an indirect manner in the sense that, we have to use either interpreters, we have to use sign symbols, we have to use, we have to use ... crude or native languages of which some medical terminologies of medical expressions ... do not really exist in those languages; so, it becomes a problem…*

The two MPs' data shows that, because they are trained to use medical terminology in English, it is only when they are confronted with patients who do not speak English that they realize certain words or phrases prove difficult to transfer from English to the indigenous dialects. Findings from previous studies on vocabulary and medical terms reveal "patients' limited vocabulary, compounded by physicians' overuse of medical terms, is perhaps the major source of inadequate communication between patients and their health providers" (Davis, Williams, Branch, & Green, 2000, p. 128). In support of the problem about medical vocabulary, Kanter and Horowitz (2009) noted that "medical knowledge is a specialized area of understanding that requires intensive study to comprehend, it uses specialized language or jargon that is unfamiliar to most patients … (and) it falls to physician to translate for the patient" (p. 216).

Unfortunately, the translation process is not without its benefits and drawbacks. MPs in this study noted the difficulties that come with the use of interpreters; i.e., certain medical

vocabularies in English do not exist in the indigenous dialect, and, even if vocabularies existed, interpreters '*occasionally do not even interpret what the patient is trying to infer instead, they make inference base on their own understanding of what the patient means*…' (Citing Dr. Maxwell) hence, MPs did not know them and therefore could not use them.

Vocabulary limitations and unclear interpretations of patients' description of problems by the interpreters are often engaged in lengthy descriptions and explanations about symptoms and in certain cases encounter problems understanding each other. Such assertion might be warranted because translation issues such as unclear "inferences based on their (interpreters) own understanding" of medical vocabulary and indigenous African languages (in this case, Nigerian languages) exist within health care (Deumert, 2010; Levin, 2006b, 2007). For example, studies by Levin (2006a, 2006b, 2007) at various hospitals in South Africa reveal that while medical staff spoke English or Afrikaans, many patients spoke Xhosa. Study by Pfaff & Couper (2009) also identify the challenge of interpreting staff either being unavailable or may insert their own values and views in to the conversation. Similarly, Belaskri's research (2017) in Algeria shows how health practitioners are trained in French and perform medical consultations more in French than in Arabic and most times, code switch with the variety of Arabic dialects; the latter being the predominant language of the patients'. Thus creating linguistic barriers related to proficiency level in some language varieties such as Modern Standard Arabic, Algerian Arabic and other Algerian local varieties in Algerian health care settings. This study argue in support of the proposal that communication barrier exist when a medical practitioner does not understand the patient's language and this can be managed with trained interpreters and/ or knowledge of the patients' native languages by the MPs. The view in the study is supported by the perspective of Dr. Maxwell (from interview transcript):

> *Occasionally we are able to communicate in a very clear term or in a specific way when we get patients who understand err... official languages like English Language, where we the native practitioners understand some of the native languages that the patients in the IDP camps speak. So we speak to them directly in that native language so in that way, we are able to have a more specific communication without that, most of the communication is non-specific.*

However, in 'non-specific' communication, the MPs are left with the only option of using an interpreter. In this context, it is the untrained interpreters that are accessible at the camp. It could be a family member, an MP or even an IDP patient who can help to interpret the language of the IDP-patient to the MP and vice-versa. This scenario is described by both the MPs and IDPs in the interview excerpts below:

> *But for most of the time, communication is usually not specific. We mostly engage the use of interpreters which are not even formal interpreters they are just err... make up arrangements … Bearing in mind the multilingual nature of the IDP camps, Occasionally if we are not able to share ourselves into the languages/the common languages, what we do simply is to get interpreters and those interpreters mostly range from the relatives of that patient we are seeing at the time or we have designated people in the IDP camps who help us as interpreters. …Occasionally we use symbols; occasionally we use...pictures to do ... medical education to some of these ... patients in these IDP camps. And of course, they understand … (laughs).*

Communication barrier (at the camp) between the MPs and IDP patients is not limited to language diversity alone, Dr. Maxwell (an MP) further lament barrier in communication as a result of the IDPs' mental health challenges. He explains:

> *… We could also have problems with people who have mental health conditions, people who are into substance abuse. And these are people who usually would not communicate in a very coherent manner, people who are restless, who would not even cooperate in terms of clinical consultation; so it becomes a problem for us in medical consultations at the IDP camps.*

With the above claim by the MP, what the professionals need is to investigate their patients' mental health condition further and since this will require an in-depth interaction with the patients; as such, the need for effective communication between the MPs and IDP-patients' ensue. Apart from the difficulty in achieving effective communication during medical

consultations at the IDP camp despite the use of interpreters and difficulty in interpreting the medical terminology, there is likewise the problem of misinterpretation as Dr. Maxwell says:

> "*Sometimes some interpreters would want to give their own meanings to what a patient might say. For instance, a patient might say she has a headache that is one sided but instead of the interpreter to just say it just as the patient has said, the interpreter might just interpret it as migraine. But we well know that it's not all cases of unilateral headache that is migraine, so, occasionally that may become a problem for us. So until the medical practitioner is able to ask question very properly, the medical practitioner may not be well guided as to err the diagnosis of that patient.*

This further align with the argument in this study that effective communication in a multilingual setting such as the IDP camp under study play a vital role in the health care of the IDP- patient. Communication barrier can thus be achieved with well-trained interpreters and this could range from within the MPs, the IDPs and /or the humanitarian workers serving at the camp.

Although IDP-Patients did not express their inability in understanding what the MPs says during medical consultations because they relied most of the time on interpreters, however, their inability to relate to their health condition, treatment plan and preventive measures (cause, symptoms etc.) observed during medical consultations and interview with the IDPs shows the low level awareness of the IDP-patients and lack of health awareness. An example of lack of basic health information amongst the IDP-patients begins with the lack of knowledge of the causes and name of disease like in the excerpt below:

> *(Da) mun zo, su Red Cross sun zo su gyara mana toilets muna shi-shiga, maza a'shiga, mata-a shiga, ga yara. Mun zo mun kamu da toilet infection din na. Wanda Kaman ni ma ina da shi har ma ya zo ya 'stopping' al'ada na. Ba'na ganin alada. Mata suna fama da wana toilet infection ba na kadan ba.*

When we arrived at the IDP camp, Red Cross came and built toilets which were used by men and women (both gender and even children. We began to get that "toilet Infection."

Like me, I still suffer from the infection and it caused my menstrual flow to stop. I have stopped seeing my menstrual periods. Women are suffering with this "toilet infection" seriously.

In the excerpt above, the IDP patient Salomé Vincent lament on the effects of sharing toilets between both male and female gender at the camp which had led to women contacting what she referred to as "toilet infection". She further attributes amenorrhoea or the cause of her period stopping to this infection. She expresses her concern to the spread of this disease among the women in the IDP camp and how these women are ashamed to present the problem to the MPs. Another IDP participant Sarah Ishaya also referred to this disease as "toilet infection" and claimed the last child she gave birth to at the camp contacted the infection during child birth. Felicia Daniel who is an IDP and serves as a nurse in care of the clinic in the absence of the MPs also referred to the said infection as "toilet infection" and believes the causes of that infection are un-hygiene, the use of toilets by both gender in an over populated shelter like the first and second IDPs stated-. In the same vein, Veronica David (An IDP) also says:

`Kaman na "toilet infection" mun dan sami magani toh har yanzu ma akwai chutan da ina fama da shi…

Like this „toilet infection "we got some medication but up til now there are infections I am battling with...

Veronica expressed their fear in re-infection and persistent health challenges she referred to as "toilet infection". The view of the women-IDPs is summed up by Dr. Maxwell when he interpreted the symptom and made diagnosis below:

Many of the patients at the IDP camps err constitute a problem to us in terms of communication. Because communication is the key thing for us-to be able to understand their problems and proffer solutions or give them help. So, because of the communication, there is a barrier in our interaction with many of those patients at the IDP camps. And the problem is simply because of their level of education, their level of exposure and as I had mentioned earlier you find out many of the persons in those IDPs are native, people from the local areas that have not been exposed to a lot of things have not had the privilege to be educated. And so, you find the way they explain their medical conditions to us, is completely different from how one would understand from a clinical setting. For instance, a woman who suffers genital tract infection will just come to say she has "a toilet infection" and that becomes a problem. A toilet infection, one would wonder is it a genital tract infection or somewhere in the gastro-intestinal tract, so, it becomes a problem for us. If one does not probe further, you will not be able to understand clearly, what they mean by "toilet infection." So those are some of the problems, they are not able to communicate with us in clear terms. Tell us some of their symptom-mythologies- the way a medical person would understand. So many of the times we would have to probe them further, we have to ask a lot of question around what you think might be their problem to be able to uncover what exactly their medical conditions they are presenting with.

The MP (Dr. Maxwell) in the excerpt above explains the medical term for what women-IDPs referred to sometimes as "toilet infection". This he says can lead to misdiagnosis because the problem could be either *genital tract infection* or *gastro-intestinal tract infection* and this, is a barrier in communication to the medical practitioner.

In a bit to understand patients' problem presentation during medical consultation, Dr. Burt also highlights the need to probe further and for the MPs to be patient with the IDP-patients in other to make them comfortable and free to disclose health challenges, (quoting him below):

> *Okay consultations at the IDP camp, you know people come from diverse villages with less understanding educationally-wise. So to communicate with them, you have to consider the language that they understand first and to be friendly with them-to make them* as a friend and they will be able to compose and tell you their problems.

Dr. Burt further narrates his experience with the IDPs as "... there is difficulty in understanding and whenever you (MPs) are communicating with them, they like to do or to respond with what they know but to bring up new ideas to them you have to take time and to make it in a lay man language for them to understand. Some of the communication barriers stem from illiteracy, low level of awareness (health-wise), cultural beliefs and religious beliefs as well. For example, Dr. Burt stated that:

> *... the challenges we face in the field, most at times clients are not educated err... in terms of prevention measures and the need at least health education, awareness before the condition persist and they are able to go to the hospital.*

On the contrary, IDPs claim they have no communication barrier or difficulties with regards to language diversity because; they relied on either -Felicia- or other interpreters whenever they have need for interpretations.

> *Toh a'gaskiya dai wandasu likitocin basu jin hausa. Wandasu kam zai fada mana da turanchi sai ita nurse na mu (Felicia), sai ta fada mana da hausa. Ta ce ga'abinda yake fada. Sai mu sa'mi ganewa daga gareta. Inta fada mana da Hausa.*

According to Sarah Ishaya, sometimes the MPs do not understand the most commonly shared indigenous language- Hausa, then aunty nurse (Felicia Daniel) helps to interpret in Hausa for us and then we understand. Looking at the IDPs' reliance and trust in the interpretive services, it therefore means that any error in the interpretation by the nurse will be accepted by the patients. When I asked my key informant -Felicia what she thinks of her role as interpreter being an IDP herself she explained:

Ai haka ne, (ina jin hausa da turanchi da yarai). Ai wani locakin akwai wanda ba su'jin hausa, basu jin turanchi. Toh akwai yarai daban daban kuma ba kowani yarai ka iya ba. Toh dole akwai masala anan wurin domin yare barkatai ne. Ba in'da zaka iya yaren kowa. Toh wani lokacin da zasu yi kwantache daide inda ka iya daide gurgodo shi zaka bayar. Toh wani lokachi kuma indan suna nunawa, suna fada suna nuna in'da abu yake damin su, so sai a'kayi kokari sai Allah ya taimaka.

It's like that, (I understand Hausa and English and my native language). Sometimes there are IDPs who do not spseak or understand either Hausa or English. There are many languages spoken here at the camp and I do not understand all these languages. Definately there bound to be problem because of the diversity. It is not possible for someone to understnd all the languages spoken at the camp. Sometimes also, if the patient is presenting such problems during consultation and pointing or touching where the probem is, I then manage to understand using these body sign and with the help of God diagnosis and treatment is made.

Felicia understands and speaks three languages (Hausa, English and her native dialect); according to her, there are times patients do not understand both English and the Hausa languages and since there are many languages/dialects at the camp, definitely there is bound to be problems in interpretation because it is not possible to speak all the languages of IDP-patients, as such, when the patients' are presenting their problems and pointing to the place – body language, she tends to use these signs and then 'God helps'. The summary in her role as an interpreter provides insights to what challenges both IDPs and MPs face in a bid to communicate without shared code. Although communication in the same language proves more engaging, observation from the data in this study suggest that concerns exist over mutual understanding. For example, MPs assumed that IDPs-patients had understood and were satisfied with explanations only to realize that a huge miscommunication had occurred. For example, Naomi Ibrahim-7th IDP participant said:

Gaskiya, masala kam na samu shi, na samu masala jinni na yana sauka baya haura ba. kuma inya sauka haka din, yana bani damuwa sosai. Har sai su gabobi na su dinga mutuwa. Sai kai bazan ji daidai ba' da kuma ulcer. Ina ci wani abu mai zafi, sai yabi ya fadi mun a zuchiya. Sai in ji zafi. Na gaya wa likitoci da ke zuwa ai bani magani. Yanzu dama dama, ama saukan jinin, nakan ji shi awani lokaci. Sun ce in'na ji haka sai in sha ruwan sugar. Ai, sai in kara gishiri a' abinci sai in'rika chi. Toh ne ina yi haka.

The IDP-patient in the above excerpt, recounts the MPs' prescription that she takes dissolved sugar whenever her blood level gets low and she should add salt intake in food and she has been doing that. I find that contradictory and this is just one case out of many. Sudore et al., (2009) identified potential misunderstanding of patients during medical consultations which are only discovered during patients' follow-up visits. In the case of a transient medical setting such as the IDP camp, it is difficult to identify such misunderstanding as there may be inconsistency for patient' follow-up visits.

Previous studies (e.g., Dougherty, et al., 2009, 2010; Sparks & Villagran, 2010) as well as findings from this research give credence to potential miscommunication and limitation which engulf medical consultation and in this case, medical consultation at the IDP camp. In this study however, I argue that, in the midst of limitation in personnel and especially with reference to particular gender of personal, lack of privacy and lack of confidentiality of IDPs, female-patients are the most affected, as (health) care might be compromised. Moreover, the findings in this study suggest that illiterate -IDP women- are discouraged by the nature of the symptoms of their diseases to seek for help from a male dominated MP and /or do not possess enough knowledge to avoid re-infection.

Other communication difficulties at the IDP camp range from confidentiality, lack of privacy and illiteracy among others. Confidentiality is bridged when an interpreter (untrained) that is either a family member, a fellow displaced person is used by MPs during consultations. The IDP might in this case decide what sign/symptoms to present and what information to keep due to probably sensitive topics like the case of disease of the genitalia in the case of women-IDP patients'.

Yes, again the issue of confidentiality is not only with respect to medical examination; even the process of consultation is another challenge where we have problems with confidentiality. If the patient does not understand official or contemporary conventional language and we have to look for an interpreter for instance, the interpreter must /will not necessarily be from the family of the patient, or will not necessarily be who the patient would want to approve as an interpreter. So of course, the patient would just have to give consent to whoever would understand his or her native language just in a bit to try to communicate ...with the medical personnel so that err... the patient can have err... some help to his or her conditions. So that is a problem too. So it is not always only in terms of err... medical examination but occasionally, even in terms of the whole process of medical consultation we have the problem of privacy or confidentiality in that way, it has to be bridged, because we need an interpreter. And if we have an interpreter that the patient mostly would not approve, but would have to approve just simply because of the need to communicate effectively then of course we don't have any choice and the patient too does not have a choice, so too that is a problem too.

In the above excerpt, Dr. Maxwell explicitly narrates the challenges of addressing communication barrier which in some case further opens up other problems rather than solving it. This argument is in line with the studies by Flores (2006) and Schemmar & Marsh (2006); who attribute the challenges faced by using untrained interpreters who are unlikely to understand medical terminology and may struggle to break bad news to patients or translate and /or interpret sensitive issues may have conflicting agendas or priorities. And since they are not counsellors and are not accountable legally for any mistakes or breaches of confidentiality in this context, it thus, tend to have negative impact on the communication of IDPs and MPs whereby we see how IDPs rely on the interpreter than the MPs (Sha & Fernadez, 2007).

On the issue of confidentiality and /or privacy, Dr. Maxwell said:

Confidentiality indeed or privacy is a problem for us in the IDP camp, especially if we have to do open consultation but in other IDPs where there are structures, we have rooms so we are able to have more like a close to a conventional clinical setting, so that way we don't much of the problem of confidentiality or privacy. But where we do have problems with privacy are commonly instances where err... where you have to examine a female because the female body is usually very sensitive and is one body that should be treated with caution and with utmost care. So because of that, we have the problem of privacy. So we try to get either other females to shield or cover that female patient that we are trying to examine or we simply use medical screens but that is not always available so, it is a problem indeed at the IDP camps.

This study area has an open consultation whenever MP volunteers come in large number to provide health services to the displaced due to lack of infrastructure as such, privacy to medical interactions or examination is a major challenge for both the patients and the MPs. Reviewing the steps improvised by these MPs to resolve some of the challenges for an effective communication, Dr. Maxwell in the above excerpt narrates how they try to resolve gender preferences for improved health care of women-IDPs.

6.3. Social inequality as communication barrier

The lack of and/ or existence of unequal opportunities and rewards for different social positions or statuses within the displaced population has created health challenges for both the MPs and IDPs. Out of the various kinds of social inequalities (economic, racial/ethnic, gender inequality and others), economic and gender inequality are the two most visible disparities observed in the temporary shelter. Hence, social inequality, particularly, economic and gender inequality accounts for disparities in perceived access to IDPs basic services at the camp. This research found that economic and social inequality causes a wide range of health and social problems (as discussed in previous chapter) from exposure to infectious diseases to poor educational attainment, thereby creating gap in communication and barrier to accessing effective healthcare.

To understand the IDPs' socio-economic status, first, I investigate their educational level, social class status, and source of livelihood before their displacement and the general awareness of their condition (see table 1 for participants' socio-demographic profile). For instance, the MPs classify the IDP patients as "people (who come) from diverse villages with less understanding educationally-wise" (Dr. Burt). In the same vein, Dr. Maxwell describes the IDP-patients as "people from the local areas that have not been exposed to a lot of things; have not had the privilege to be educated". So, illiteracy-as earlier established is one of the issues the MPs are battling with in a bid to provide health care. With regards to health education awareness, MPs referenced behaviours such as IDP patients' lack of basic health awareness and information; lack of interest in learning about their health conditions and poor knowledge of preventive measures before their condition persists then they feel the need to see an MP. According to Dr. Burt in the interview transcripts:

> *... there is difficulties in understanding and whenever you are... communicating with them (IDP-patients), they like to do or to respond with what they know but to bring up new ideas to them you have to take time and to make it in a lay man language for them to understand… the challenges we face in the field, most at times clients are not educated ... in terms of prevention measures and they need at least health education awareness before the condition persist…*

In addition to the above excerpts, Dr. Burt further highlights the issue of language as well as communication gap created by lack of literacy and awareness as major health challenges of IDPs. As a result of their lack of awareness, illiteracy, and poor hygienic environment, health issues such as diarrhoea and cholera are a common health challenge at the camp.

While the impact of socio-economic status and gender on health inequalities may be mediated by differences in levels of urbanisation –rurality of the displaced, it is quite difficult to separate out effects of urbanisation or rurality from the more general contextual effects of the socio-economic environment of the IDP camp. One of the obvious (neglected) policy issues arising from this discussion concerns whether it is the literacy level, gender inequality or the poor management of the IDPs that affects the health needs of the marginalized population the most, or all three? This argument about inequality is best put into perspective when individual and contextual dimensions of the displaced population in northern Nigeria are considered.

6.4. Effects of social inequality (deprivation) and socio-economic status in access to health care at the IDP camp

Following the outcome of semi-structured interviews with the participants in this research and observation from field work, a number of reasons were identified as possible reasons that have enabled social inequality to thrive in the context under investigation.

Lack of awareness like the MPs described in the interview can lead to (re)infection or exposure to diseases. Since the IDPs are in touch with the micro –host community- as well as the macro society in the country such as medical referral, reinstatement and shopping, infectious diseases can easily be spread/transmitted to such wider communities through various means if not addressed in the shelters.

Poor education and its effect on the economy of the nation: there is human capital reduction when IDPs are not educated or engaged in entrepreneurial skills. This can also lead to generations of unskilled or untrained persons in poor families growing in communities with little or no provision for unskilled jobs.

Idleness is often created as a result of displacement and lack of skilled training can expose IDPs –youths as easy prey to be initiated into terrorism /extremists' groups or kidnappers- a common ill bedevilling the country.

Children and Orphans raised in such marginalised camps are often exposed to negative societal ills. Also, girls and women are easy targets to various forms of abuses in other to survive (they offer sex for money or food). Sometimes they are forced into early marriage which affects both micro and macro society.

A popular saying that 'when you educate a woman, you educate a nation,' as a backbone of any society/nation, there is need to encourage women's awareness; cater for their health and basic necessities for example, through provision of a platform to effectively communicate their challenges by the various stakeholders.

Also, since the population of women out numbered the male in the IDP camp, implication is that, most widows become the 'head of the family'-they are saddled with the responsibility to cater for their family (children), and any other vital decision concerning the home-front. Thus, their well-being is important to be studied in order to provide information on the nature of prospective future generation they will bring forth and/or nurture. Likewise, IDP-women's health, particularly, infections of the genitals can affect the population's reproduction if not addressed and preventable death can be avoided.

Where women-IDPs most especially widows and wives who witness the crises that led to their displacement, the narrative of their live trajectories can serve as a major link to resolving future crises.

In a bid to survive, the most vulnerable being children (in particular, girl-child) and women, tend to be exposed to sexual abuse and various forms of abuse in such temporary shelters. All of these affect their mental and psychological health thereby impacting negatively on their role in the society.

The implication for investigating the challenges of displacement can serve as therapeutic strategy for policy makers to address problems faced by the IDPs.

Absence of information and knowledge of the marginalized population has been detrimental in resolving crises due to insecurities where constant reappraisal attacks on communities in the region had been recorded.

Study of displacement is thus relevant because lives matter, especially for the marginalized group whose rights and privileges have been denied. In order to uplift the constitutional rights of the displaced; have fair hearing and resolve insecurities as well as address existing mayhem to prevent future occurrences.

In a situation where there is a major disease breakout like epidemic (like Ebola) or pandemic (e.g., Corona virus), it will be difficult to control infections and spread of diseases where there is likely lack of awareness, poor basic structural facilities to monitor its spread particularly in overcrowded shelters and poor ventilated accommodations like in the study area.

6.5. Chapter summary

In this chapter, I discussed and presented findings with regards to communication management in a multilingual IDP-camp. Based on my interpretation, I concluded that various studies have been able to identify the existence of language barriers in the clinical encounter like is obtainable in this context and the benefits of interpreters in communication process. However, these studies have been conducted in places and settings other than Nigeria and the IDP-camp. Also to the best of my knowledge, these studies did not establish whether or not indigenous populations who speak multiple native languages encounter similar language issues during medical interactions. Further, the chapter identified some of the challenges of patients' disclosure focusing on pelvic inflammatory diseases and other stigmatizing diseases and only offer fragments of other health conditions for which IDP-patients might chose to disclose or not. Having presented the challenges of communication and language barrier and the advantages and/or disadvantages of the use of interpreters, I then identified ways on how to address these challenges from the point of view of the participants, particularly, the MPs. In the next chapter, I discuss unequal access to healthcare for the displaced population and how to make sense of it.

CHAPTER SEVEN

MAKING SENSE OF UNEQUAL ACCESS TO HEALTHCARE: DISCOURSES OF RESISTANCE AND ACCEPTANCE

7.1. Chapter Introduction

IDPs in northern Nigeria constitute a group of marginalized persons subjected to structural violence. Their subordinated location in the national economy and their culturally depreciated status in the states and country at large are exacerbated by the political ruling class. This chapter accounts for an understanding of ethnographic analyses of the health condition and/ or privileges denied (or not) to IDPs in access to healthcare. It further opens up discourses of resistance and acceptance of the displaced persons living at the camp.

The chapter also identifies the effects of social inequality, deprivation and the role socio-economic status play in access to healthcare for the displaced. It therefore opens up with the discussion of participants' (MPs and IDPs) perceptions about healthcare provision at the camp. Their perception is gathered majorly through (semi-structured) interview and verified during observations recorded as field-notes. Furthermore, the participants' perception is compared for uniformity; thus, the MPs' perception of the IDP-patients' views are documented and interpreted as observed.

Subsequently, the chapter identifies the perception of both participants towards unequal access to healthcare for the displaced persons particularly female IDPs living at the camp. After which, I proffer a number of strategies that may help to shape the perception of female IDP patients which is informed by the participants' contributions as well as researcher's observation.

In this chapter also, I identify and discuss the different strategies displaced people develop to make sense of their positioning. This discussion further opens up a number of strategies in addressing various forms of health inequalities at the camp and concludes with suggestive practical measures (long term and short term) that may improve health communication of the study population.

7.2. Inequality as communication barrier: discourses of resistence and acceptance

In this sub-section, I examine the effects of unequal social privileges as communication barriers in access to healthcare and provision of healthcare for the IDPs. In particular, I examined how social inequality contributes (or not) to health disparity for the IDPs through discourses of rsistence and acceptance.

Based on Heller et al.'s (2017) four sets of analytical activities- mapping, tracing, connecting, and claiming, the logic employed to sort out the data in this study and in particular, this chapter includes gender, literacy level, language dynamic and age. The selected logic is helpful in finding answers to the research questions or further provides yet another possibility to the investigation. For example, during mapping and categorizing, people category identifies participants' language abilities, that is, which IDP participants speaks English/Hausa/Pidgin English/indigenous dialects or understands more than a language.

In addition, person category distinguishes where participants are situated within local hierarchies. This categorization helps to distinguish participants who speak more and those who are silent, reasons for their actions as it relates to their socio-economic status. For instance, during group discussions with the 11-IDPs representatives, I identified 5 speakers who expressed their concerns on behalf of others too, while the other 6 participants agreed with their submissions. The focus group discussion is an indication that both groups have *voices* but are limitated to contribute due to language barriers. I also noticed that during semi structured interviews that participants who remained silent during focus groups were also less outgoing and more reluctant to talk during semi-structured interviews.

The literacy level of the marginalised population can be likened to the macro level of the educated population in Nigeria. "Nigeria is the most populous country in Africa and has a very high population momentum with an annual growth rate of 3.2 percent per annum". Also variation exists across rural-urban, educated and uneducated dichotomies (cf. Akinyemi & Abanihe, 2014). Census figures have put the Nigerian population at 40 million illiterates out of whom 60% are women (Oyitso & Olomukoro, 2012; Kainuwa, 2013). Approximately, there are 1.5 million out of school children due to insurgencies/insecurity/poverty and other reasons; this has put the overall non-literate population to a disadvantaged situation of attaining good health, or accessing

proper awareness of their well-being (Akinyetun, 2020; Owolabi, 2021). The avoidable condition of the Nigerian populace in accessing proper education is arguably the failure of the system of governance which is largely due to corruption.

Gender inequality from time immemorial has been supported by culture and the patriarchal system in the country. Educating the girl-child was not a popular option until 1859 (Alabi & Alabi, 2014) when missionaries introduced western education to cater for the needs of both genders. However, being the most vulnerable gender, the female population faced a lot of discrimination and many forms of abuse ranging from rape, forceful marriage, kidnapping and are often used by their captors as weapons for destruction, etc. The kidnappers often threaten their victims in this case abducted females with the loss of family members if they do not cooperate; hence, they are made to carry out many bombings within the country. Some of the returnees who were victims of insurgents narrate horrendous accounts of their experiences on national television and national dailies (see also Aloieuwa et al., 2017; Reinert, et al., 2014; Iyekekpolo, 2016). Their experiences range from religion conversion, multiple rapes, still birth, starvation, etc. Gender inequality is visible in the manner insurgents for instance maltreat and treat differently their victims. For instance, discourses of Boko-haram insurgency reveals that if a male/man is kidnapped, he is likely to be forced to join the group or killed however, this is not always the case with female victims.

While the IDP camp can be said to be mismanaged, this can be likened to the socio-political state of affairs in the country where state property is hardly maintained. Policies are often enacted without proper guidelines to maintain or account for good outcomes. The state of government hospitals, schools, roads and police stations or their residents is a good case in place for this argument. Recently (2023) in Lagos State, a dilapidated police quarters where police officers' families lived collapsed; fortunately, no life was lost. If such institutions are not maintained, managed and invested in, new policies such as the creation of temporary shelters like -camps- will likely face the same fate as those before it. It can be argued that corrupt individuals may have been the reasons behind such failed policies; however, the government needs to put in place laws to prosecute individuals or groups who failed to carry out their assigned duties unless there are other reasons for this loophole.

IDP patients cope with these social inequalities, in part, through their use of discourses of acceptance and resistance. For instance IDP patients accept their fate as an act of God (see semi structured interviews and focus group discussion) and are therefore resilient in their positionality as survivors despite the many challenges they encounter at the temporary camp. Although there are IDPs who accept and are appreciative of humanitarian aid they receive, some remain traumatized and in need of professional help:

> *At the IDP camp apart from having problems with communication, err... from people who don't understand conventional languages or official languages, we could also have problems with people who have mental health conditions, people who are into substance abuse. And these are people who usually would not communicate in a very coherent manner, people who are restless, who would not even cooperate in terms of clinical consultation; so it becomes a problem for us in medical consultations at the IDP camps (MP 1: semi structured interview).*

Discourses of resistance can also be observed, which may provide IDPs with a sense of agency but could also reduce their access to healthcare. For instance, IDPs who are experiencing substance abuse issues may find it hard to communicate with, or even resist the support of, MPs. Substance abuse as identified by MP1 is – apart from the medical dimension – a social challenge. First, it can be dangerous as it could expose other IDPs who are in the abuser's peer group to drugs (e.g., youths). Second, the abusers can detoriate and pose as a risk to other displaced persons. Third, their health challenges will not be giving adequate attention as complaint by the MP in the excerpt above, leading to further problems and resistance to proper healthcare services provided for the IDP patients by the MPs.

7. 3**. Perception of participants (IDPs & MPs) for unequal access to healthcare**

During semi-structured interviews, I collade the MPs' perception towards IDPs as well as both participants' perception towards unequal access to healthcare for the displaced; below are the perceptions of MPs towards the IDPs -followed by participants' perceptions about IDPs' unequal access to health-care:

a) Perception of MPs towards IDP patients

- **Lack of awareness:** The MPs describe IDPs' lack of awareness of their medical needs as a health challenge in the provision of health care. In particular, Dr. Burt says, their lack of basic health information hinders the IDPs from seeking medical attention early until their health situation persists or becomes critical.
- **Lack of exposure and illiteracy:** The MPs classify the IDP patients as mostly illiterates who lack basic health information. For example, Dr. Burt says the IDPs are often resistant to new ideas and information and are likely to insist on their belief, or way of approaching illness. He further explains that an MP has to be "patient and friendly" with the IDP-patients and with time, they will eventually relate better.
- **Peculiar illness related to IDPs:** From their experience with the IDP patients, the MPs describe a number of common illness/diseases peculiar to IDP camps such as malaria, cholera, etc. This also is related to the living condition of the displaced and lack of basic amenities.
- **Care of IDP as training ground:** The MPs approach IDPs' health challenges as a training ground to improve on their clinical skills. The volunteer MPs see these challenges in the unconventional clinical structure as a way of practical learning and resilience in emergency situations.
- **Commonly found diseases at peculiar IDP camps:** The MPs' perception of IDP camps is uniquely based on location and this differs. According to MPs, there are more of infectious diseases than non-communicable diseases at IDP camps located in rural areas. These findings by MPs are said to be likely due to their level of education, exposure, lack of basic health awareness and poor sanitary conditions of the camps.
- **IDPs disparity:** The MPs volunteer at different IDP camps which are also located in different geographical regions of the states and country at large. According to these MPs, there is prevalence of non-communicable diseases as against infectious diseases in urban IDP-camps.
- **Education plays a key role in health communication at the camp:** The (poor) level of education and (lack of) exposure of IDPs according to the MP

participants makes communication difficult during medical consultations and or health care delivery at the camp.

- **IDPs at the study area are natives of Plateau State:** according to the MPs, IDPs at the study area are indigenes of Plateau displaced from local communities within the state and therefore have various cultural / religious beliefs, and lack common knowledge of the lingua franca spoken around the region or the official language.

- **Stereotypes for illness / diseases by patients:** IDPs believe certain diseases have common stereotypical history/symptoms and they tend to use different names for illness during problem presentation for example 'genital tract infection'- according to Dr. Maxwell would be referred to as "a toilet infection" by an IDP patient.
- **Need for patience and probing:** The MPs believe there is need to always probe further during medical interactions with IDP patients so as to be guided; and to be properly guided also, MPs need to ask the IDPs appropriate questions. There is need therefore for MPs to be cordial and friendly with IDPs for ease of communication
- **Majority of the IDPs do not understand the official language:** From their experiences, the MPs believe majority of the patients do not understand or speak the official language-English. This finding has been established during interactions, meetings and interviews (see excerpt from field notes below) I had with the IDP participants because, they insist on using the Hausa language and in some cases, when I ask if they want to use the official language, their response is either that they do not speak/understand or are more fluent in their native language/Hausa than the official language. The preference of the lingua franca is related to their level of education and exposure.

The meeting was conducted in Hausa language. After an opening prayer, the team leader introduced two of his colleagues -a lady who happened to be from around the north and speaks Hausa- and a gentleman who is from Southern Nigeria and could only speak English and his native language-Yoruba. He emphasised that only IDPs who understand English can be interviewed by him. I noticed most of the selected beneficiaries were interviewed by the only

lady in the team. This could be due to their literacy level or it could be that they were at ease with the lady. (Field Notes II: May 29th 2021)

- **Gender role in consultation:** The realization that poor problem presentation by IDPs to MPs is as a result of gender inequality/difference; shame, religious and cultural beliefs is established after working in the field with female IDPs in other camps.
- **Consideration of the native language an IDP patient understands and speaks:** The MPs realizes the need to inculcate the IDP patients' native language for effective health communication; this they manage to bring into the interactions with the help of untrained interpreters. However, in their opinion, there need to be room for a common language of mutual understanding between the patients and medical practitioners to function properly i.e., devoid of interference, lack of privacy and to maintain a certain level of confidentiality for the patients.
- **Gender preference:** The MPs identify the need for gender preference because the 'female body is sensitive' (Dr. Maxwell). They are aware of the lack of privacy as a major set-back for medical examination as well as gender differences, considering they are a male-dominated team of MPs examining females in an open consulting space with strangers as interpreters. The MPs consider lack of privacy a major challenge in healthcare provision.
- **Use of untrained interpreter**: The use of untrained interpreters to resolve communication barrier sometimes affects interactions between IDPs and MPs rather than resolve problems. The MPs highlight some of these problems as poor or inaccurate translation of what the patient present to the interpreter. As a result of inaccurate interpretation, there tends to be a communication gap.

b) Perception of participants towards unequal access to healthcare for IDPs

- Poor medical supplies at the IDP camp
- Infrequent MPs visit at the camp
- Lack of physical structures/laboratory for further examination and the need for referral without financial provision for the displaced to access proper

health care; patients' privacy and confidentiality is often breached in a bid to provide health care

- Neglect and poor sanitary conditions of the IDP camp which has led to infectious diseases
- Poor condition of the camp in providing shelter for pregnant women, nursing mothers and / or children.

7.4. Strategies towards shaping the perception of female IDP patients.

A number of ideas generated during fieldwork and with participants' views on how to shape the female IDP patients' perception for an improved health care include:

1. For MPs and or social workers to serve as advisers to IDP patients or prompt to IDPs.
2. Provide health information frequently and educate the female displaced persons through provision of basic health knowledge, cleanliness, etc., to reduce infection or re-infection.

7. 5. Discussion of different perceptions people developed to make sense of their positioning

The second analytical approach I adopted from Sarangi and Roberts (1999) description of workplace or institutional order inolves what they described as "recording and analyzing of talk by an "overarching […] ethnographic endeavor" (ibid p. 392). In their volume, Silverman (1999) also views ethnography as a question of timing; that is, approaching the 'how' before the 'why'. Although Silverman casts CA as the method for 'how' and ethnography as significant in addressing the 'why;' Familiarizing myself with the *communicative ecology* of the IDP camp made it possible to understand how people especially the participants in the research employ a number of strategies to make sense of their positioning; below are some of these strategies:

1. **Religious extremism**: for example in the semi-structured interview with the second IDP, she referred to the killers of her husband making reference to him as "karton ar'ne" meaning 'unbeliever' a derogatory term often associated to one who does not know God or does not observe same religious beliefs as the religious extremists.
2. **Sacrifice**: sacrifice has been show-cased in most of the role played by men in the interviews; particularly in the case of Sarah Ishaya (Ma Faith) husband who saved his family by hiding them in the toilet thereby protecting his family till his death. Another scenario is the community that asked the women and children to flee to other neighbouring villages and camps for safety when rumours of attacks were known through the villages.
3. **Faith in supernatural being**: faith in their God (Christian believers) plays key role in their survival and during the period of lost. An example is Sarah's, (Ma Faith) narration

of how her husband died; even at the point of death, he was still positive about living and singing religious songs. Another example is in each interviewer's positive mind-set on how God has saved them despite all they had witnessed during the attacks and living at the camp, they each attribute their survival to their faith in God and therefore rely on Him for providence.

4. **Privileges (as against Rights) / Lack of awareness**: there is a sense of lack of awareness of their basic human rights as citizens; also the lack of proper information on healthcare and health information. For instance, the women IDPs referred to diseases of the genitalia (pelvic inflammatory diseases (PID)) as "toilet infection" and they all held the notion that it is contacted through the use of infected toilets. Others believe this infection causes their menstrual cycle to stop while others still believe it could result in infertility. The lack of basic health information on how to avoid re-infection and how to address this health problem is revealed. Their rights to live, rights to basic amenities have been denied, yet, they had no understanding of these basic human rights but see it as privilege.
5. **Education as Solution** to liberate the marginalised the displaced persons believe educating their wards is a solution to relieving them from poverty. As such, lack of access to education for the out-of –school children of the displaced though relevant has been placed secondary to lack of basic needs**:** such as clean water, decent meals, available healthcare and electricity to their survival. Many of the displaced persons strives hard to educate and train their children even though most of them are not literate, they have positive mind sets towards education. Education is among many needs lacking in the camp. Other needs are empowerment, the provision of decent accommodation, etc.
6. **Over dependence on intermediaries:** the low level of education and /or illiteracy of majority of the displaced have made them dependent on intermediaries between them and the government, they have no alternate medium of addressing pressing needs; complaints or request to appropriate bodies without these intermediaries. As such, corrupt middle men serving in such capacity-sometimes divert funds, or aids provided for the displaced group.

7.6. Developing practical measures towards improving health communication of (female) IDPs

An examination of the data collected during group interview in chapter 5 has led to the understanding that to prevent and better manage IDPs' related problems, certain practical steps need to be put in place. First, government and relevant NGOs need to: reinstate and provide economic empowerment for the displaced and find lasting solution to the constant insecurities (such as Boko-Haram[9]; kidnappers; herds-men[10]/farmers crises) which are some of the leading causes of displacement in the state and country at large. Secondly, the failed policy of 'education for all by the year 2020' – should be considered as top priority as that will partially address IDPs' health awareness and rights.

From observation and the group discussion carried out, there is possible poor management and distribution of relief materials either through diversion or some corrupt practices which is not covered in the scope of this study. In addition to the above, the socio-economic status and life experiences of participants under investigation, it can be connected and traced to these health challenges discussed as either a fundamental causes of their health disparities or otherwise.

Below are further highlighted practical measures towards improving health communication barriers of (female) IDPs.

(A) **Short term measures**

1. **Social action:** This should include the use of volunteer healthcare practitioners or train personnel to enlighten IDPs on basic health practices and healthy living**.**
2. **Equality:** There should be provision of basic amenities and physical structures or facilities in rural temporary shelters as is obtainable in urban centres. Such as provision of basic human needs like decent shelter, available (balanced diet) food; electricity, clean water and basic health needs.

[9]Boko-haram is an Islamist extremist group terrorising Nigeria (Particularly the northern parts) for the past two decades.
[10]A group of nomads (Fulanis') kidnapping and attacking farmers in villages and city centers particularly in northern Nigeria.

3. **Improve standard of living for IDPs:** Standard of living like basic accommodation; convenient toilet facilities and decent meals at the camp should be improved.
4. **Empowerment:** There is the need to train IDPs in entrepreneurial skills to alleviate poverty and create sustenance of livelihood and to be self-sufficient during and/ or after the duration of their stay at the camp for survival. This will discourage reliance or over dependence on small scale farming for survival in case of insecurity and displacement.
5. **Provide security:** The government should provide security by resolving crises and punishing offenders. Also, there should be law prohibiting such offenders to deter future occurrences.
6. **Provide privacy:** The government should provide a temporary structure that will reduce the problem of privacy through provision of medical examination screen for privacy during consultation. Evidence form this study suggests that what is lacking in terms of clinical communication in the IDP camp is the interpersonal dimension, which is apparent in the lack of responses by IDP-patients as opposed to MPs. Previous scholars (E.g., Beck, 2001; Sparks & Villagran, 2010; Thompson et al, 2003; Whaley, 2000) have argued that broadening and deepening our understanding of interpersonal communication in health provides insights to how individual beliefs, decisions about health, and experiences of illness are negotiated by patents and their medical practitioners.

In terms of the dialogic and relational aspect of care, it is necessary we apply caution in interpreting patients' "silences". In the field of health communication, some studies (e.g., Carabas & Harter, 2005; Zhang & Siminoff, 2003) have characterized silence as marginalization, oppression, and lack of power. While I acknowledge that patients' responses (and lack of it in some instances) to questions were minimal, the silence would not be an accurate representation of this research process.

(B) Long term measures

1. **Long lasting solution-** Policy makers in the state and country at large should document language practices at the IDP camp and employ these minor languages in educating marginalised group. Also train MPs in Lingua Franca of the geo-political zones of the country they are to practice in (E.g., Hausa, Yoruba and Igbo).
2. **Encourage gender equality:** Gender equality can be encouraged by engaging female MPs in the provision of health care at the IDP camps to accommodate challenges of 'shame', cultural and religious beliefs in interfering with health communication. Female MPs can be encouraged to participate if the camp and location of the temporary shelter is safe. Hence, security of roads and the camp is relevant in the involvement/ services of female MPs.
3. **Create awareness:** Policy makers should create awareness on health and health care; cleanliness and sanitation and cause and effect of certain life style such as drug abuse, promiscuity to prevent (re/infection) diseases. They should engage female volunteers and/ or social workers for talks to create such awareness.
4. **Provide free Education for the displaced:** There should be provision of free education or sponsorship for the displaced; this will resolve the issue of illiteracy which is a major challenge in the provision of health care.
5. **Develop curriculum:** Trained MPs' curriculum should be developed to include training in Lingua Franca and one of the major languages in the country as an alternative for practice. Posting should be based on MPS' area of specialty.
6. **Provide professional interpreters or train interpreters for easy consultations at the IDP camp:** There is need for the provision of professional or trained interpreters at the IDP clinics for ease of communication and to bridge the gap created by language diversity/ illiteracy. In my opinion, working to initiate a policy framework for medical interpretations is feasible. However, I must caution though that while I am advocating that the Nigerian Health services and policy makers and the Ministry of Health should consider incorporating interpreting services in the health care system particularly, to oversee the needs of medical interactions in IDP camps, I do acknowledge the potential costs, infrastructural, logistics and human resources and other possible constraints this might pose for a developing country such as Nigeria. However, the platform already

exists because the three major languages are already studied in the primary to A' level and are used in the media. Some minority languages are used in state media houses to translate news and for advertisements, etc., moreover, initial interpretation services can focus on a few languages and limit services to diverse rural IDP camps which received huge numbers of patients with diverse needs.

7.7. Chapter Summary

This chapter accounts for an understanding of the analyses regarding health care and privileges of displaced persons. It opens up discourses of resistance and acceptance of IDPs living conditions and how to make sense of unequal access to health care. This chapter also identifies effects of inequality, deprivation and the role socio-economic status plays in access to healthcare at the IDP camp. Furthermore, the chapter identifies participants' perceptions in view of health services and how to best address issues of inequality at the IDP camp. After which I identified and discussed the different strategies displaced persons develop to make sense of their positioning. A number of strategies that can be used to address the various forms of health inequality at the IDP camp were identified and suggestions on both long term and short term measures were proffered. This chapter led to the final chapter (chapter eight) which summarizes and concludes the study's findings.

CHAPTER EIGHT

SUMMARY AND CONCLUSION

8.1. Conclusion and summary of findings

In this dissertation, I developed a data-driven interpretation of IDP-MPs' communication in a Nigerian IDP camp. The research focused on investigating language and communication barriers; health and gender inequality, the use of interpreters and other ways MPs manage communication difficulties in a multilingual setting. I also investigate how patients present problems during medical interactions as well as generate practical measures to addressing communication difficulties from the perspective of the participants and observation from field work. In this chapter, I present an overview of my findings by addressing each research question and its related categories.

The first research question focused on the various forms of inequality (health, gender and social) existing in an IDP camp and how it influences medical interactions between IDP-patients and MPs. A rather peculiar finding in terms of gender inequality is linked to female IDP-patients' disclosure pattern. Findings from this study indicate that patients avoid sharing pertinent information. IDP patients avoid disclosing medical problems such as what symptoms they have; wrong reference of the disease, and how long they have had a disease or an infection. Notably female-patients express shame about particular health conditions which are often related to their reproductive organs and often suffer in silence. The MPs in this study identified this loop-hole by identifying the misinformation, and /or lack of pertinent information from female-patients at the camp; there is the wrong reference to name of diseases or infections by the same gender also and according to the MPs, this proves difficult in diagnosis.

Aside from shame, another problem regarding female-IDP-patients' disclosure behaviour is the lack of privacy during consultation. As clearly elaborated in previous chapters, there are no conventional physical structures to serve as a consulting room and MPs consult most times in an open field or in a single room with other MPs, interpreters or patients listening-in-on their conversation. As a result, no privacy exists for patients to share concerns which they consider confidential. Although lack of privacy contributes to the patients' disclosure pattern, the female-

IDP patients' identified the gender of the practitioners –MPs- as the major setback. While the MPs admitted that the set-up of the clinical room compromises patients' privacy and confidentiality, they however stated that a temporary provision of medical screens could resolve the issue of privacy to enable them examine the patients better. But for the gender differences, their opinion is that volunteers irrespective of gender are scarce at the IDP camps due to the hectic nature of the job and particularly, female MP volunteers are rare because of the location of the camps and other existing gender bias.

Women-IDPs' reoccurring PID reinfections has been attributed to the sharing of toilet with male gender and the poor sanitary condition of the convenience. Let us not forget that infrastructural problems account for a number of challenges at the IDP camp and might have contributed to their medical concerns also. What appears to be overlooked is the absence of initiatives by the stake holders to protect the privacy, health and well-being of the IDPs in Nigeria. I make this claim because, as earlier discussed, the existing two-toilets were built by an NGO and patients' rights have been violated by not providing privacy during medical encounter (Charter on patients' rights). However, the findings suggest a lack of equality both health-wise and gender-wise or social considerations for the displaced. Responses from participants revealed the existence of inequality (health, gender and social inequalities) at the IDP camp and are thus, the major communication barrier female IDPs faced.

The second research question focused on communication management, the choice of language used during medical interactions at the IDP camp and whether or not it shaped medical interactions in any way. Responses from participants revealed the existence of a language barrier, especially where the IDP-patients could not speak English or Hausa and the MPs do not understand the patient's dialect. While MPs noted that fluency in the lingua franca-Hausa language proves useful for one-on-one interactions, they also referenced various challenges such as inability of some MPs to speak the language. In addition, MPs reported that because they are trained to use medical terminology, it is only when they are confronted with patients who do not speak English that they realize certain words or phrases prove difficult to translate from English to the indigenous dialect. Most times when this happens, it becomes the MPs' responsibility to translate to the patient or find an interpreter. Unfortunately, the translation process is not as seamless as it might appear.

MPs in this study noted that certain medical vocabularies in English do not exist in the indigenous dialect, and even if vocabularies existed, MPs did not know them and therefore could not use them. IDP-patients also expressed their inability to speak the official language-English and/ or the lingua franca- hence, it is often difficult to use appropriate terminologies to express their health condition; hence, they often rely on an interpreter.

One of the interpreters (Felicia) I interviewed expressed her inability in understanding certain languages, thus, vocabulary limitations on her part meant that patients and MPs often engage in lengthy descriptions during problem presentation and in certain cases encounter problems understanding each other. Such assertion might be warranted because translation issues surrounding medical vocabulary and indigenous African languages exist within care facilities as we have seen in the literature. As a result, patients visit the IDP-clinic with cultural/assumed specific label of diseases which differed significantly from MPs' label for the same disease (e.g., generic 'toilet infection' for PID or STDs). Such incidents often result in misunderstanding and sometimes misdiagnosis.

Vocabulary constraints are not peculiar to Nigeria nor are they limited to spoken language. Difficulty in vocabulary translation occurs because arguably, African languages are not used in mainstream education. Moreover, scientific concepts are not developed nor explained in African languages; even if they were, the different dialects of each language would have been another issue to consider. Although multilingualism provides rich cultural diversity for Sub-Saharan Africa, there is often the issue of dialects of each language; a variation which can hinder understanding thus, such a language barrier can make managing health information /education of the non-literate patients difficult by providing information in every language. Although one-on-one communication in the same language proves more engaging, data from this study also suggest that concerns exist over mutual understanding; for example, MPs assumed that IDP-patients had understood and were satisfied with explanations during consultations only to realize a huge miscommunication had occurred either due to misinformation or other barriers.

Other barriers such as gender difference of the MP and the IDP-patient often limit the information process during medical interactions. The majority of the IDP-patients report their inability to express freely certain health conditions and symptoms due to shame and/ or stereotype surrounding certain medical conditions when they are attended to by an opposite

gender. One such difficult topic for women-IDPs is discussing problems relating to their sexual reproductive organs to male MPs. As the MP said, this is a problem because addressing health challenges of this nature is difficult to treat without proper information from the patient.

Previous studies as well as findings from this research give credence to potential miscommunication and dissatisfaction which engulfs the clinical interaction in a multilingual setting. In this study, we argued that in the midst of limited vocabulary and assumed meaning, patients are the most affected, as care might be compromised. Moreover, findings from this study suggest that illiterate patients either chose to disengage in treatment decision or do not possess enough knowledge to interrogate their MPs.

Apart from the vocabulary limitations, which occurred when the same language is used, major challenges arise when a patient and MP cannot communicate in the same language which happens often at the camp thereby forcing both parties to require the services of an interpreter. One of the foci in this research is to investigate how MPs managed health communication difficulties in the multilingual IDP-camp. Findings from this study revealed the use of (untrained) interpreters who are mostly IDPs to help facilitate communication between MPs' and the IDP patients. Typically, individuals who offer interpretation at the camp-clinic include patient relatives or friends who are also IDPs, other MPs who understand the patient dialect or other patients.

The utilization of interpreters to bridge language barriers have been well documented in physician-patient literatures; while the majority of research on health care interpreting has been conducted in North America and certain parts of Europe, such studies have focused on professional or trained medical interpreters (e.g., Diamond et al,. 2009; Mirza et al., 2022; Rosenberg et al,. 2009; Torresdey et al., 2024).

In the case of Nigeria, findings from this study revealed that no policy exists on health care interpreting and the health care system lacks standardization or control over who should be invited to offer interpretation. Thus, the lack of institutionalized interpreting services suggest that persons who offer interpreting services at health facilities such as the camp clinic do not receive any training about ethics or guidelines in health care interpreting. Answering questions about interpreters, the MPs in this study reported various frustrations and challenges they encountered.

Although MPs report a number of challenges they encounter with the use of untrained interpreters, however, based on report from participants as well as evidence from existing literature, this investigation argues that health care interpreting is not just about language fluency. It is a matter of bridging a language barrier which should yield an expected satisfaction for both the patient and MPs. Consequently, interpreters perform a vital role in facilitating clinical interactions.

The data from this study suggest that, while the MPs cannot function well without interpreters, the quality of interpreting might sabotage clinical interaction. MPs noted that working with individuals who have no training in medical interpreting can be problematic. MPs identify problems with interpreting such as summarizing, asserting and even suggesting patients' symptoms. Despite all these issues, this study identifies that untrained medical interpreters prove useful in bridging language barriers during medical interactions at the camp. However, we must consider issues regarding ethics, privacy and confidentiality. As earlier identified, unavailability of trained interpreters sometimes forces patients and MPs to utilize the services of other patients. Hence, a patient's privacy might be violated because patients feel compelled to divulge personal information to total strangers. What happens to the tenets of the patients' charter-their right to confidentiality during consultation? Is their consent sought before their information is disclosed to a third party, in this case the interpreter? With the present state of affairs, a key question remains to be answered: can the privacy of a patient be guaranteed when interpreters have not received any training in medical ethics? However, with the current state of using untrained interpreters, MPs have a responsibility to ensure that their patient's privacy is protected. As such, another important question remains to be answered is: to what extent do MPs' make attempt to protect the privacy of patient?

In a similar manner, the existence of language barriers marginalizes illiterate patients and data from this study suggests that patients are less likely to express their objection to an interpreter. From observation, in this study, patients may obscure information about sensitive issues even if the interpreter is known to the patient. Judging from participants' response about interpreters, it could be argued that providing trained interpreters would mean more accurate information to determine a proper diagnosis and prognosis. Thus to reduce health inequalities, the use of trained interpreter this study argues far out-weighs the cost.

Addressing the question of gender inequality in this study reveals how this is important to patient's disclosure patterns during problem presentation. Specifically, IDP-patients identified what information they would not share under certain circumstances. Findings showed that an IDP-patient's decision to disclose medical condition was influenced by the following:

a) Gender difference of MP,
b) Presence of interpreter,
c) Sensitive topic,
d) Set up of consulting space or privacy, and
e) Power struggle.

MPs identified one of the challenges they have with IDP-patients as health illiteracy. The vulnerable population constitutes majority illiterate patients and confronts a huge maze whenever they encounter a health Problem. As a result, MPs' must be cognizant of their IDP-patients' educational background and how that shapes patient's health care experiences. In this regard, it would be useful for MPs to pay more attention to the needs of illiterate patients. For example, it is advisable for MPs to have patience and inquire more information from the patient like one of the MPs suggested. Another possible way is the art of repetition and the use of visual cues method to teach back and ensure patients understood information through repetition of what the MP says about a diagnosis or treatment plan. These steps can verify whether or not the patient fully understands medical information or instructions (Sparks & Villagram, 2010).

Additional findings from the research highlights IDPs' lack of privacy during medical consultation, thus, it creates communication barrier and difficulty for the MPs to carry out further examination of the patient in the absence of adequate information from patients' disclosure. MPs in this study recounted the various struggles they experienced when interacting with patients and how they improvised means to provide privacy either by using other women to cover with cloth material or sometimes they make use of medical screens. They also referenced the absence of medical laboratory for further investigation which is a challenge to further diagnosis and treatment.

Evidence from this study suggests that what is lacking in terms of medical interactions in the IDP camp is the interpersonal dimension, which is apparent in overwhelming responses provided by

MPs as opposed to patients. Scholars have argued that broadening our understanding of interpersonal communication in health provides insights to how individual's health beliefs, decisions about health, and experiences of illness are negotiated by patients and their MPs' (Cegala & Street 2010; Sparks & Villagran 2010; Thompson et al., 2003).

In terms of dialogic and relational aspect of care, we caution how we might interpret IDP-patients' "silences." Some health communication scholars have characterized silence as marginalization, oppression, and lack of power (e.g., Carabas & Harter 2003; Zhang & Siminoff 2003). While the MPs have acknowledged that patients' responses to questions were rather minimal, the silence pattern in this study would not be an accurate representation of this research process. Moreover, not all researchers agree that silence signifies a lack of power (e.g., Kim, 2002). Silences could be intended or imposed; these could be specific to cultural contexts and unlike Western cultures that view silence as problematic, non-Western cultures may value silence (cf. Charmaz 2002b). In relation to patients in this study, their lack of knowledge about health literacy, shame due to gender differences and /or inequality could be the reasons why women-IDPs patients shared very little health information with the MPs.

The fourth research question addresses practical implications for the communication gap/barriers existing at the IDP camp between IDPs and MPs. First, we suggest that an approach to optimize patients' level of trust and comfort at sharing information will have to begin with providing periodic communication training skills for MPs who are already practicing; particularly for those who are volunteers at the displaced persons' camp. At the remote level however, it could begin with collaboration between the Ministry of Health and the public Universities which have medical schools to incorporate communication skills courses in the medical school curricula with special training addressing diverse marginalized clinical communication. In this regard, content areas or syllabi must be specific as to which areas of competency medical students need training.

This study founds illiteracy to be a major obstacle to health care delivery. With the high illiteracy rate in Nigeria, MPs through the policy makers should collaborate with health educators to design simple and comprehensible health promotion campaigns in indigenous dialects to ease specific health awareness. Other means is to intensify the adult education programs which occur in indigenous dialects and air on national television to serve as a ready platform for patient education.

In terms of how best to support IDP-patients, the concept of *patient-centeredness* (e.g., Cegala & Streer 2010) has proved useful in clinical interactions, and has universal appeal in terms of benefits. Basically, the idea is for MPs to move from merely focusing on a patient's illness and more towards the concerns, preferences, and feelings of the patient, and also allow the patients to participate in decision-making to the degree that they wish. Since MPs in this study already acknowledged that they need to relate better and be friendlier with patients, they can begin to incorporate patient-centered care into their clinical interactions and focus on a more relational approach with their patients.

Another concern which emerged in the study relates to gender preference for female IDP-patients. The women-IDPs relate their frustration over a male-dominated MP team of professionals visiting the camp. This has affected their disclosure pattern and thus, led to communication barrier. This issue could be addressed by incorporating a schedule of clinical appointments for female-IDPs with more volunteers who are female MPs.

Finally, it is worthy to note that compared to mainstream communication programs such as journalism, advertising, and public relations, health communication as an academic field is still evolving in Nigeria. Furthermore, a host of health issues (e.g., poor medical provisions and information, health literacy of the displaced, follow up treatment, IDPs' reproductive & mental health, etc.) in the Nigerian IDP camp seek attention of health communication scholars. With momentum growing towards global health, such research would not only benefit African academics, but would enrich the field of linguistic ethnography, communication and Applied Linguistics both in research and theory. In Nigeria and Sub-Saharan Africa by large, research by communication scholars especially in the health care settings has potential for making huge difference by identifying pertinent health care issues and enhancing interactions between health care seekers and health care professionals.

8.2. The IDP camp as a socio-political tool

The IDP camp from a social and political point of view can be termed a socio-political tool in the hands of the government, politicians, and sometimes corrupt individuals. The purpose of its

creation is defeated when the marginalized displaced person do not have access to basic amenities, and or/ are further exploited and displaced in the temporary shelter provided to shield them from harm whether it is natural or man-made disasters.

The IDP camp and the displaced are sometimes used as a means to an end to politicize the role of the government by either expression of its effort in reinstating those displaced or denying the existence of such a population at the camp. An example of such political gains is the case in study; whereby government stopped providing basic and social amenities to the research site with a claim that the IDPs at the camp had been reinstated. Whereas, most of the displaced are still living at the dilapidated structures and others had secured a manageable accommodation within the host community for a safer and better lifestyle. This argument was raised by some of the IDP- participants during the semi-structured interview, when they complained about government negligence and betrayal on account of re-instating them or denying their existence at the camp.

Sometimes the population of these IDPs is minimized and/or exaggerated to suit political purposes. Corrupt individuals and some government officials sometime divert food items, medicine supplies and warm clothing provided by NGOs (e.g., The Red Cross) for the IDPs. This corrupt practice the participants decry during interview is yet another means of relegating IDPs as a socio-political tool. From observation, this practice does not stop at the level of government or stakeholders; within the displaced, there is unequal treatment of those who are semi-literate and those who are illiterate. There are advantageous favors some groups of individuals enjoy that the general IDP population does not enjoy. For instance, the micro finance loan provided by Caritas peace international was mostly accessible by the semi-literate or literate IDPs and not the non-literate IDPs. Language serves as a means to accessing loans and privileges for the IDPs; because the first step in accessing the said loan is to be able to convince the NGO representatives on how to use the loans. Thus, communication in the language of the immediate environment (whether English or Hausa) is relevant for this purpose and many more.

8.3. **The IDP camp and the multilingual language policies in Nigeria**

In the literature review, we discussed Nigeria's language policy where the three major languages-Hausa, Yoruba and Igbo- and the foreign language-English- are adopted as languages of communication, education and medical interaction in the multilingual nation. Thus, the multiplicity of languages amongst the displaced where neither of the national languages are spoken nor understood by the majority of the population becomes a hindrance for the English language trained MPs. In such instances, there are no policies guiding the professionals on how best to approach or resolve such language issues.

Using their initiatives, the MPs improvise through the use of untrained interpreters and in resolving immediate language needs. From previous discussions, we have realized the impact of such decisions on the well-being and health concerns of the displaced populations, particularly, female-IDPs. The lack of policy guiding the use of interpreters in this case can lead to quite a number of issues: inability for MPs to safe guard patients' privacy thus, limiting patients' willingness in problem disclosure as earlier identified apart from other difficulties medical professionals encounter with the use of untrained interpreters.

Language diversity and the need to revisit the language policy in multilingual Nigeria, is of the essence. It is important to also provide basic training of MPs to suit the needs of their immediate environment and country at large. This will encourage one-on-one medical interaction between the MPs and their IDP- patients for effective healthcare provision than creating communication barrier due to language diversity.

8.4. The role of MPs/ stakeholders in bridging the gap in health communication barrier in Nigeria

The MPs and /or stakeholders have a role to play in bridging the communication gap in the health communication of IDP-patients in Nigeria. First, we have identified the need for policy makers /stakeholders to revisit the language policy in multilingual Nigeria by identifying what to do in instances where the three major languages and English language is not serving its purpose. Secondly, the MPs need to learn the language of its immediate environment, basic words,

phrases and especially, key phrases that can be used to ask basic health questions at the clinic; this can serve a purpose in limiting the communication barrier. In emergency situations, the MPs can in addition to the above apply the use of body language and other non-verbal cues to assist in understanding patient's problems. A long term goal such as revisiting and adopting other language learning strategies for medical professionals in the medical training institute can reduce the problem of language barrier. A more adequate method is encouraging education /learning for the citizenry at least to secondary level (High school); with the majority of the Nigerian populace educated, language will not be a barrier to medical communication in Nigeria.

Providing training for MPs, IDPs and social workers to serve as interpreters in such situations and in some hospital settings will limit privacy issues and other problems identified with the use of untrained interpreters used in camps. Although we have identified the financial implications and long term means of such training, however, this is less expensive when compared to the loss of lives, exposure and spread of diseases to endemic as a result of the communication barrier.

8.5. Re-visiting the effects of gender and health inequality to health care of IDPs in Nigeria

Studies suggests that health behaviours, social and economic factors often referred to as social determinants of health, are the primary drivers of health outcomes and that social and economic factors shape individuals' health behaviours.

Health and healthcare disparities are often viewed through the lens of race, and ethnicity, but they occur across a broad range of dimensions. For instance, disparities occur across socioeconomic status, age, geography, language, gender, disability status, and sexual identity and orientation. Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults. Disparities also occur within subgroups of populations. For example, there are differences among IDPs based on the geographical location of the camps on their health and health care, gender and level of education and /or exposure. Health inequalities exist in the camp based on their underlying health conditions, and increased barriers to testing and treatment due to existing disparities in access to health care. The broader implication in addressing disparities in health and health care is important not only for a social

justice and equity standpoint, but also for improving the nation's overall health and economic prosperity. IDPs and other underserved groups experience high rates of illness and death across a wide range of health conditions, limiting the overall health of the nation. Research further finds that health disparities are costly. The prioritization of health equity, effective institutionalization epidemic/insecurity response and recovery makes it difficult to address health disparities. However, supporting states, territories, and tribes in identifying and sustaining health equity-promoting policies, programmes, and practices; expanding the utilization of community health workers to address health and social service needs within communities of IDPs, and strengthening cultural competence among healthcare providers throughout the nation might help.

Health disparities are driven by underlying social and economic inequalities that are rooted in corruption, greed, and power tussle. There is need for the government to identify as a priority and launch a range of initiatives to address disparities both in response to insecurity, displacement and more broadly among its citizenry. States, local community's private organizations, and providers should also be engaged in efforts to reduce health disparities. A broad range of efforts both within and beyond the health care system will be instrumental in advancing equity, These include: prioritizing equity across sectors; providing resources to support efforts to advance equity; increasing availability of IDP data; supporting and re-building existing communities destroyed by insecurities /wars to strengthen and provide resources for the people; establishing incentives, accountability, and oversight for equity; and recognizing and addressing political insecurity, greed, corruption and quest for power tussle as root causes of disparities in the country.

In Nigeria, SEMA focused on understanding and improving the settlement of displaced persons in temporary shelters and did not deal with policies against health inequality. As a way of addressing this gap, this study particularly illustrates that there is a strong association between socioeconomic status and gender to their health disparity. The global phenomenon (internal displacement) made it clear that economic development was an important prerequisite for positive health development, but also that a problematic access to health could be a barrier to economic development.

8.6. Limitations of study

This study is a single sited research and required locating both the IDPs and MPs who are willing to participate in interviews and focus group discussions. Hence, an important limitation of this study is the small number of MPs compared to IDP patients. A large group of MPs could have provided more in-depth richness to the study. Thus, the research questions capture more of patients' experiences as opposed to both sets of participants. Consequently, additional research is needed to understand the different experiences and perception of MPs on medical interactions with illiterate/literate IDPs.

Since this research focused on a diverse linguistic IDP camp in a single sited setting, the results may not be characteristic of all IDPs or camps in Nigeria. I also suggest that caution is applied when applying these results to other multiple sited researches on MPs'-IDP patients' relations that border on language barrier, use of interpreters, and the nature of IDP patients' problem presentation.

Finally, I tried to limit my personal bias, and I ensured that links between the data, categories, and emerging analysis encompass a representative interpretation of participants' experiences. However, I do not dispute that my analysis might incorporate some form of subjectivity. Therefore, I respect an alternative interpretation which adds scope to my study but does not diminish its credibility.

8.7. **Implications for further research**

In my opinion, this dissertation generates more questions than answers. Hence, great potential exists for future research into various aspects of IDP patients' – MPs' interaction in Nigerian IDP camps. First, future studies can focus on identifying particular medical terminologies for which IDP patients and their MPs encounter difficulties. Such studies' findings can then be used to guide the development of a medical terminology glossary list in the indigenous dialects.

Second, language diversity and the associated language barriers at the IDP camp present a ready avenue for investigating medical processes for health care facilities. Specifically, an explanatory study will be useful to determine which indigenous dialects require interpretive services, as well as the cost and benefits of incorporating medical interpreting services into health care delivery at the IDP camp. Although this study discussed diversity, language barrier and the use of interpreters and their role in medical interactions at the IDP camp, it however captured findings through the lens of patients and MPs. Thus, future studies can focus on various consulting processes which utilize interpreters; their experiences and the roles they are required to play.

A third avenue for research could focus on patients' terminologies for different illness and the different stereotypes surrounding diseases. Such an investigation should seek to understand the extent to which MPs know about the tenets of the patients' disclosure. This finding can be used as a guide to develop a medical training guide by creating terminology glossary list in indigenous dialects and their presumed meaning.

Fourth, future studies can examine female MPs' biases to volunteering at IDP camps. It can also investigate the perception of gender inequality specifically, about healthcare of women IDP patients in a multilingual setting.

Finally, MPs in this study expressed frustration over patients visiting the IDP clinic only when their illness had worsened, and they linked this pattern to patients' lack of health awareness. Future studies can focus on understanding patients' treatment preference and reasons why they choose the clinic as their last option when their condition begins to degenerate. Although this study is a single sited research; these suggestions for future research can be approached in multiple sited research or a comparative analysis between rural and urban cited camps could yield more insights to the inequalities existing in IDP camps.

8.8. Chapter Summary

In this chapter, I presented an overview of major findings from the research; summarised and concluded on key findings and identified practical suggestions on the role of MPs/ stakeholders in bridging the gap in health communication barrier in Nigeria. I also provided my understanding and interpretation of the data and noted the implication for this study. Finally, I acknowledged the limitations in this study, and offered suggestions for future research.

By extension, this dissertation explored the communicative relationship between IDP –patients and MPs at an IDP camp in north-central Nigeria. Drawing on Heller et al.'s (2017) critical ethnographic sociolinguistic approach and Sarangi and Robert's (1999) health communication and the concept of Talk, Work and institutional order to provide a critical descriptive report of issues pertaining to multilingualism, the use of interpreters, and communication barrier of female IDP-patients. A total of eleven (11) female IDP patients' and three (3) MPs participated in this study. I gathered data through observations and field notes, semi-structured interviews and focus group meetings.

A number of major findings emerged from this study. First, data revealed that, although English is the language used in the training of MPs, medical interactions at the camp especially with illiterate patients are carried out in indigenous dialects or lingua franca. Unfortunately not all MPs understand the indigenous dialects/languages of the IDP-patients.

Second, due to huge linguistic diversity, language barriers are a common occurrence between IDPs and MPs at the camp. Consequently, untrained interpreters frequently help with translation during medical consultations. However, the non-existence of professional medical interpreting services demand that the patient and their medical practitioners have to depend on relatives, friends, health workers, or individuals whose inadequate translation skills are likely to compromise health outcomes.

Third, adult female IDP patients are less likely to disclose pertinent health information due to shame in the nature of their sickness, gender difference, and /or lack of privacy in the consulting space and room used for clinical practice.

Fourth, the need for IDP patients such as relational aspects of care were unmet because of communication barriers due to patients' illiteracy, time constraints; gender difference and patients' lack of health information.

Implications from this study include the need to first review and adopt certain indigenous dialects as languages for health communication in certain needs; work to provide terminologies for health related topics and make those available to MPs-working in such settings. Secondly, identify indigenous dialects for which interpreters will be required, and establish a policy framework for the provision of professional medical interpreting services at the IDP camps' health care facilities. Thirdly, educate MPs on how to better dialogue and relate with IDP patients to ensure that patients feel comfortable disclosing various health information especially providing MPs that are the same gender to treat and care for IDPs who are already marginalized, abused and traumatized.

Fifth, another way of addressing communication barriers is by incorporating communication skills courses for MPs in training to cater for emergency situations like the IDP camps with diverse linguistic settings (George & O'Reilly 2023).

Sixth, to encourage IDP patients to ask and disclose questions, or seek clarification during medical interactions, and to incorporate scheduled health information awareness meetings with the displaced persons in the dialect they understand that is, the medium of communication they can relate with. This will help ease the workload of MPs and enhance patient care.

Lastly, to provide equality be it gender, health wise, social to include provision of basic amenities for the displaced persons.

APPENDIX

APPENDIX A: ETHICS APPROVAL

This study has been reviewed and approved by the Faculty of Arts and Social Sciences and Lancaster Management School's Research Ethics Committee.

Appendix B: Recruitment Information for Interviews

My name is Abigail Izang Ambi; I am a doctoral student in the faculty of Arts and Social Sciences, Lancaster University, Lancashire, United Kingdom. I would like to invite you to participate in a study which seeks to investigate how language barriers, diversity and gender influence the medical practitioners'-IDP patients' interactions. If you agree to take part in this study, I will give you a form and explain further details about the research. You will be asked to sign this form, which means that you have agreed to take part in the project.

As part of the process, you will be invited to take part in an audio recorded interview which will last for approximately 30 minutes. The questions that I would ask during the interview are not sensitive in nature and pertain to your experiences.

Participation in this study is voluntary and you can stop any time. I would like to assure you that your identity will remain confidential since your actual name will not be included in my field-notes or report.

This study has been reviewed and approved by the Faculty of Arts and Social Sciences and Lancaster Management School's Research Ethics Committee.

Thank you for considering your participation in this project.

Abigail Izang Ambi

Appendix C: Recruitment Information for Focus Group Discussions

My name is Abigail Izang Ambi; I am a doctoral student in the faculty of Arts and Social Sciences, Lancaster University, Lancashire, United Kingdom. I would like to invite you to participate in a study which seeks to investigate how language barriers, diversity and gender influence the medical practitioners'-IDP patients' interactions. If you agree to take part in this study, I will give you a form and explain further details about the research. You will be asked to sign this form, which means that you have agreed to take part in the study.

As part of the process, you will be invited to take part in a group discussion which will last approximately 2 hours. This discussion will be audio recorded. The questions that I would ask during the discussion are not sensitive in nature, and pertain to your experiences. Participation in this study is voluntary and you can stop at any time.

I would like to assure you that your identity will remain confidential since your actual name will not be included in my field-notes or reports.

This study has been reviewed and approved by the Faculty of Arts and Social Sciences and Lancaster Management School's Research Ethics Committee.

Thank you for considering your participation in this project.

Abigail Izang Ambi

Appendix D: Participant information sheet

Observation for Medical Practitioners (MPs)

My name is Abigail Izang Ambi, I am a PhD student at Lancaster University and I would like to invite you to take part in a research study about multilingual communication during medical consultations at the internally displaced persons (IDPs) camp in north-central Nigeria.

Please take time to read the following information carefully before you decide whether or not you wish to take part.

What is the study about?

The aim of this study is to investigate how the use of more than one language influences communication between IDPs and Medical practitioners during consultation.

Why have I been invited?

I have approached you because am interested in understanding the way different languages are used during medical consultations in the camp to communicate. I also want to find out how you talk to the IDPs when they are sick and if they understand the language you speak. I am also interested in finding ways to inform policy makers (government) about any difficulties you have in the camp as a Medical Practitioner. I would be very grateful if you would agree to take part in this study.

What will I be asked to do if I take part?

If you agree to take part in the study, it would involve the following: visits to the camp clinic and observation during medical consultations by the researcher. I will also take notes during those visits. The research field work will take three to six months in total.

What are the possible benefits from taking part?

If you agree to take part in the study, you can, through your experience(s) at the camp, help me to understand how easy or difficult it is providing treatment at the camp. Your insights and knowledge will contribute to our understanding of how the IDPs and medical practitioners communicate when they speak different languages and what is needed for better communication to take place so that people can get better treatment and attention**.**

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. Your participation is voluntary.

If you change your mind, you are free to withdraw within the first three weeks. If you want to withdraw, please let me know, and I will destroy field notes or recording you are part of. If I am not around, please talk to your team leader at the camp: I will leave my telephone number, so s/he can call me and tell me about your decision.

What are the possible disadvantages and risks of taking part?

There are no risks or disadvantages in taking part. You will only be observed during such clinical visits if you agree to take part.

Will my data be identifiable?

After the observation, only I, the researcher conducting this study, will have access to the ideas you share with me.

I will keep all personal information about you (e.g. your name and other information about you that can identify you) confidential, that is, I will not share it with others. I will remove any personal information from the written record of your contribution.

How will we use the information you have shared with us and what will happen to the results of the research study?

I will use the information you have shared with your patients during observations only for research purposes. This will include my Ph.D. thesis and publications like journal articles. I may also present the results of my study at academic conferences and I will attend practitioner conferences or inform policy-makers about my findings. It will not be possible to identify you in any case.

When writing up the findings from this study, I would like to reproduce some of the views and ideas you shared with your patients. I will only use anonymous quotes so that although I will use your exact words, you cannot be identified in the thesis or any publications.

If anything you tell your patient in the field notes suggests that you or somebody else might be at risk of harm, I will be obliged to share this information with your team leader. If possible, I will inform you of this breach of confidentiality.

How my data will be stored

The observed data/field notes will be stored in files that no-one other than me, the researcher, will be able to access. The files will be stored on password-protected computers and once I have transcribed them, it will be stores in a secure server at Lancaster University. In accordance with University guidelines, I will keep the transcripts of data collected for a minimum of ten years.

What if I have a question or concern?

If you have any queries or if you are unhappy with anything that happens concerning your participation in the study, please contact your team leader. You can also contact my supervisor in my school using the address below:

Dr. Sebastian Muth, Linguistics and English Language, County South LA1 4YL, Lancaster University, United Kingdom Tel: **+44 1524 592921; E-mail: s.muth@lancaster.ac.uk**

If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact:

Professor Uta Papen, Professor of Literary Studies, Linguistics and English Language, County South, LA1 4YL, Lancaster **u.papen@lancaster.ac.uk**;

http://www.lancaster.ac.uk/linguistics; Tel: +44 (0)1524 593245

This study has been reviewed and approved by the Faculty of Arts and Social Sciences and Lancaster Management School's Research Ethics Committee.

Thank you for considering your participation in this project.

Appendix E: Participant information sheet for Internally Displaced Persons' (IDPs)

My name is Abigail Izang Ambi, I am a PhD student at Lancaster University and I would like request for your permission to take part in a research study which involves participants' observation about multilingual communication at the internally displaced persons (IDPs) camp in north-central Nigeria.

Please take time to read the following information carefully before you decide whether or not you wish to take part.

What is the study about?

The aim of this study is to investigate how the use of more than one language influences communication between IDPs and Medical practitioners during consultation.

Why have I been invited?

I have approached you because am interested in understanding the way different languages are used during medical consultations in the camp to communicate. I also want to find out how you talk to the medical practitioners when you are sick and if they understand the language you speak. I am also interested in finding ways to inform policy makers (government) and health care practitioners about any difficulties you have in the camp as an IDP. I would be very grateful if you would agree to take part in this study.

What will I be asked to do if I take part?

If you agree to take part in the study, it would involve the following: visits to the camp and observation by the researcher at the camp clinic and recording of your talk with the medical practitioners during consultation. I will also take notes during the visit at the camp. The research will take three to six months in total.

What are the possible benefits from taking part?

If you agree to take part in the study, you can, through your experience(s) at the camp, help me to understand how easy or difficult it is receiving treatment at the camp. Your insights and knowledge will contribute to our understanding of how the IDPs and medical practitioners communicate when they speak different languages and what is needed for better communication to take place so that people can get better treatment and attention.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. Your participation is voluntary.

If you change your mind, you are free to withdraw within the first three weeks. If you want to withdraw, please let me know, and I will destroy any audio recording or interview you are part of. If I am not around, please talk to your leaders at the camp: they have my telephone number, so they can call me and tell me about your decision.

What are the possible disadvantages and risks of taking part?

There are no risks or disadvantages in taking part. You will be observed and notes will be taken during your visits at the clinic if you agree to take part.

Will my data be identifiable?

After the audio recording / interview / observation, only I, the researcher conducting this study, will have access to the ideas you share with me.

I will keep all personal information about you (e.g. your name and other information about you that can identify you) confidential, that is I will not share it with others. I will remove any personal information from the written record of your contribution.

How will we use the information you have shared with us and what will happen to the results of the research study?

I will use the information you have shared with me only for research purposes. This will include my Ph.D. thesis and publications like journal articles. I may also present the results of my study at academic conferences and I will attend practitioner conferences or inform policy-makers about my findings. It will not be possible to identify you in any case.

When writing up the findings from this study, I would like to reproduce some of the observed strategies you used in communication. I will only use anonymous quotes from my observations so that although I will use your exact words, you cannot be identified in the thesis or any publications.

If anything you tell the MPs during consultation and observation suggests that you or somebody else might be at risk of harm, I will be obliged to share this information with the leaders at the camp. If possible, I will inform you of this breach of confidentiality.

How my data will be stored

Your observed data or field notes will be stored in files that no-one other than me, the researcher, will be able to access. The files will be stored on password-protected computers and once I have transcribed them, it will be stored in a secure server at Lancaster University. In accordance with University guidelines, I will keep the transcripts of data collected for a minimum of ten years.

What if I have a question or concern?

If you have any queries or if you are unhappy with anything that happens concerning your participation in the study; please contact your leaders at the IDP camp (male or female leader). You can also contact my supervisor in my school using the address below:

Dr. Sebastian Muth, Linguistics and English Language, County South LA1 4YL, Lancaster University, United Kingdom Tel: **+44 1524 592921; E-mail: s.muth@lancaster.ac.uk**

If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact:

Professor Uta Papen, Head of Department, Professor of Literary Studies, Linguistics and English Language, County South, LA1 4YL, Lancaster u.papen@lancaster.ac.uk

http://www.lancaster.ac.uk/linguistics; Tel: +44 (0)1524 593245

This study has been reviewed and approved by the Faculty of Arts and Social Sciences and Lancaster Management School's Research Ethics Committee.

Thank you for considering your participation in this project.

Abigail Izang Ambi

Appendix F: Lancaster University Oral Consent Form

Lancaster University Consent Form

(Oral consent process for focus group discussion with IDP patients)

Title of Research: Gender, communication and health inequality in a Nigerian IDP camp

Researcher: Abigail Izang Ambi- Lancaster University, UK

I am undertaking a research for my academic work and I need volunteers. For you to be able to decide whether you want to participate, you should understand what the research is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. The form that I am holding describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. I will verbally translate and explain the information on this form to you. You will need to verbally confirm (by saying yes you voluntarily want to participate). This will allow you to take part in the discussion. I will also give you a copy of this document to take with you.

Explanation of Study

The purpose of this study is to explore how different languages affect the communication between a medical practitioner and an IDP patient. For example, if you do not speak the same language as the medical practitioner. DO you rely on an interpreter? How comfortable or uncomfortable do you feel sharing your health information with a third person? In order for me to undertake this research, I will be asking for your voluntary participation. If you agree to take part, you will be asked to come to a particular location at the camp where you and a group of other IDP persons who are also participating in my research will be discussing the topic. In order to gather the information which I need, a digital audio recorder will be used to record the discussions.

Risks and Discomfort

Please do not discuss any medical conditions you want to keep private during our discussion. This is because I (the researcher) cannot assure the confidentiality. In other words, if you reveal

information about your medical conditions in the focus groups, I cannot guarantee that other group members will keep the information confidential.

In terms of risks and discomfort, I would like to state that the purpose of the discussion is for you to share communication difficulties you have experienced with your medical practitioners due to the fact that you do not speak the same language. None of the questions involve sensitive information. Also the information you provide in this discussion will not in any way affect your safety and care at the IDP camp/ provision of shelter /security in general. As a voluntary patient, you can choose to disengage in this process at any time you wish and there will be no consequences.

Benefits

You will receive no direct benefit from this study. However, it is my hope that data generated will be used to provide training aimed at enhancing communication between IDP patients and their medical practitioners.

Confidentiality and Records

All materials collected in this study will be kept in a locked office not seen by anyone who is not working directly on the study. No summaries or other reports of this research finding will contain information about particular individuals. During the transcription process, Pseudonyms will be assigned to all participants to protect identities.

All audio recordings (tapes) will be destroyed after the report in this study has been completed.

Please do not discuss any medical conditions in the focus groups, I cannot guarantee that other group members will keep the information confidential.

Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:

- Federal agencies, for example, the Office of Human Research Protections, whose responsibility is to protect human subjects in research
- Representatives of Lancaster University, including the Institutional Review Board, a committee that oversee the research at Lancaster University.

Contact Information

If you have any questions regarding this study, please contact: Abigail Izang Ambi at (+234) 8063207550 or Dr. Sebastian Muth, Linguistics and English Language, County South LA1 4YL, Lancaster University, United Kingdom Tel: +44 1524 592921; E-mail: **s.muth@lancaster.ac.uk**

If you have any concerns or complaints that you wish to discuss with a person who is not directly involved in the research, you can also contact:

Professor Uta Papen, **Professor of Literary Studies, Linguistics and** English Language, County South, LA1 4YL, Lancaster **u.papen@lancaster.ac.uk**; **http://www.lancaster.ac.uk/linguistics**; Tel: +44 (0)1524 593245

By providing oral consent, you are agreeing that:

- This consent form has been read/ translated to you and you have been given the opportunity to ask questions.
- Known risks to you have been explained to your satisfaction
- You understand Lancaster University has no policy or plan to pay for any injuries you might receive as a result of participating in this research protocol
- You are 18 years of age or older
- Your participation in this research is given voluntarily
- You may change your mind and stop participation at any time without penalty

Witness: Abigail Izang Ambi (Researcher) Date: _____

Witness signature: _____

Appendix G: Recruitment Information for Focus Group Discussion (Guide for Patients)

My name is Abigail Izang Ambi, a doctoral student in the Faculty of Arts and Social Sciences, Department of English and Linguistics, Lancaster University, UK. I would like to invite you to participate in a study which seeks to investigate how language barriers and health inequality influence MPs-patient interactions. If you agree to take part in this research, I will give you a form and explain further details about the research. You will be asked to sign this form, which means that you have agreed to take part in the project.

As part of the process, you will be invited to take part in a group discussion which will last for approximately 2hours. This discussion will be audio recorded. The questions that I would ask during the discussion may be sensitive in nature, and pertain to your experiences. Participation in this research is voluntary and you can stop at any time.

I would like to assure you that your identity will remain confidential since your actual name will not be included in my field-notes.

Thank you.

Abigail Izang Ambi

APPENDIX H: INTERVIEW PROTOCOL FOR MEDICAL PRACTITIONERS (MPS)

Demographics

1. Gender: (a) male (b) female
2. Age: (a) 25--35 (b) 35-45 (c) 45-55 (d) 65 (e) 65 and above
3. Which Nigerian (major) language (s) do you speak?
   (a) Hausa (b)Yoruba (c) Igbo (d) None
4. What are the most common Nigerian languages you speak with your IDP-patients?
   (a) Hausa (b) Igbo (c) Yoruba (d) other_____

Questions

1. Can you briefly tell me something about yourself and your position at the camp?

Probe: What are your experiences with volunteering?

Probe: Are you selected based on language competence to work in the camp, considering the diversity of the language groups in the camp?

2. What is the lingua franca of this community?
   Probe: Do you understand or speak the language of the IDP community?

Probe: how do you communicate with patients if a language barrier exists?

3. I am aware your training was in the official language of the country –English-, how do you handle situations where the patient does not understand or speak English?

Probe: How do you manage consultation considering the diversity of language speakers at the camp?

4. Tell me about your knowledge of the internally displaced persons' background; is it comparable to other camps you know of; or is there something special about this camp?
   Probe: Also, is there room for improvement?
5. Is communication with patients at the IDP camp specific or not?
   Probe: How do you explain (difficult) medical terminology to your patient?

Probe: What are some possible reasons why patients might not disclose health challenges with you (MPs')?

6. How do you manage privacy during consultation at the IDP camp considering the structure that is available on ground; have you encountered any difficulties in discussing any health challenges with any of the gender at the IDP camp?

Probe: Would you say consultation at the IDP camp is confidential or not considering the need to engage interpreters some times?

7. What are the ways you disseminate health information, for example, on infectious disease at the camp?
8. What major challenges do you face in the provision of health care services at the IDP camp?

   Probe: What can be done to help?

   Probe: Are there any challenges you face working with a diverse group at the camp?

9. In medical interactions where you encounter language difficulty, who have you depend on for interpretation?

   Probe: In situations where you have had to depend on an interpreter, how has it influenced you communication with patients?
10. What do you think can be done to create effective health communication to promote healthcare of the IDPs?
11. What are your motivations for participating as a volunteer at the IDP camp?

Probe: Why do you think there are more male volunteers that are medical practitioners at the camp?

Probe: Based on our discussion, what ideas or recommendations do you have for communication barriers between MPs' and IDP-patients?

12. What are some of the benefits of volunteering at an IDP camp in spite of the language barrier?

APPENDIX I: INTERVIEW QUESTION GUIDE FOR IDPS

Demographics

1. Gender: (a) male (b) female
2. Age: (a) 18--25 (b) 25-40 (c) 40-55 (d) 65 and above
3. Which is the common Nigerian language (s) do you speak with the MPs'?

(b) Hausa (b)Yoruba (c) Igbo (d) others

4. What are the most common Nigerian languages you speak with your IDP-patients?

(b) Hausa (b) Igbo (c) Yoruba (d) other_____

Interview questions

1. Can you tell me something about you; like your name, where you come from and what you do before you were displaced?
2. When you meet with your MP, what are some of your expectations?

   Probe: How often have you visited the clinic?

   Probe: Are you able to express your health challenges clearly? If so how, if not, why?
3. In what language(s) do you communicate with the medical practitioners and why?

   Probe: tell me about a situation you have encountered in communication with MPs who do not speak the same language as you.

   Probe: how did you and your MP manage the interaction process when both could not speak the same language?

   Probe: Have you ever had to depend on an interpreter because of language barrier? If yes, how much of your personal health information were you willing to share?
4. Do you have any difficulties using a particular language to explain your health issues?
5. What would you prefer the MPs should do more or less during consultations?
6. When the MPs visit the camp, what type of information would you rather not disclose to them and why?
7. Do you face any other health challenge(s) at the camp?
8. How do the MPs pass on/disseminate health information at the camp?
9. What input do you want to add to promote effective healthcare provision at the camp?

APPENDIX J: FIELD NOTES

Field Notes I: April 30th 2021

Files Name	Health communication barrier of a multilingual IDP Camp clinic in northern Nigeria 2021/Data collection for Ph.D. Thesis
Place	IDP Camp north -central Nigeria
Date	30.04.2021
Occasion	First Official familiarisation visit of MPs-AN &Dr. Burt/shadowing
Participants	Felicia, Dr. Burt, AAI
Researcher	AAI
Duration	1:00hr (familiarization visit with Felicia & IDPs) 2:hrs (shadowing in total)
Language	English, Hausa
Remarks	Meeting takes place at the consulting room inside the camp clinic, at the waiting room of a private clinic behind the IDP camp building. Felicia & Dr. Burt agree for AAI to take handwritten notes. Felicia and AAI then walked 3-minutes (but took 10minutes because we stop at interval to greet familiar faces to Felicia) from the camp to the host community to commiserate with a bereaved family, where an older man was being buried that same day. During the walk, we had an in-depth interaction about family, her experiences and recent tragedies –deaths- in the host community.

9:25

I arrived at the IDP camp in north central Nigeria. It is a re-familiarization visit from the city centre to a nearby village where some of the IDPs were camped. The camp building is surrounded by individual buildings of the indigenes of the host community. Behind the camp is a private clinic owned by an indigene and tribesman whom I later learnt hail from a neighbouring community that speaks a different dialect of the same tribe/native language. According to Felicia, he is a part of the consulting medical team from NMA offering health services (humanitarian aids) at the IDP clinic. There are churches –a Catholic and Protestant church- beside and behind the building that camped the displaced persons. I was told later that the protestant church offered shelter, food and general assistance to the IDPs when they first arrived in large number over 3,400 people 2years ago because the camp was too small to accommodate their population. When I arrived, Felicia was still at home getting ready so I took the few minutes before her arrival to observe activities around and within the IDP camp. After few minutes she arrived and pointed to her house when we left the camp. It is a three to five minute walk behind the camp. We first entered the clinic which is outside the camp gate/entrance. The camp seems less populated and quiet compared to my last pre-visit. I asked and Felicia said most of the able bodies at the camp are now engaged in menial jobs like faming during the day since it is the 'rainy season' and most farmers engage workers to cultivate their farms most especially, the men and young mothers/youths. The camp clinic seemed rather deserted probably due to the absence of medical team and scarcity of medical supplies as this was later confirmed.

10:30

After the condolence visit, Felicia and I walked to a private clinic behind the camp to visit Dr. Burt who is a medical doctor and also a part of the visiting medical team at the IDP camp. His clinic is more organised in terms of the setting-extra room for consultation, a pharmacy with displayed medication on the shelf, labour room, a waiting room and laboratory attached at the rare end of the clinic structure. We met him relaxing in the consulting room seemed there were no patients present. We exchanged pleasantries and Felicia introduced me as a friend and researcher. After that, we discussed the purpose of my visit and the research goals. Dr. Burt was surprised I have been visiting for a while; he agreed to take part in the study and we exchanged contact. Felicia provided two other contacts of MPs on the team (doctors) who visit the clinic fortnightly.

11:05

We left the private clinic and after a 3-minute walk we arrived at the camp clinic. Felicia & AAI had some talk about happenings around like the insecurities, frequent killings and kidnapping around the locality and State in general. Felicia also discussed some recent mysterious death at the host community, the challenges they face at the camp and how she was a part of the IDP (still is) before she got co-opted into serving as a clinical health assistant at the camp. She narrated her ordeal during the 2018 crises, how she lost her son and home -he was burnt in their personal house; her business and money over half a million Naira. She suffered post-traumatic stress and during this time she was pregnant. She told me how she was fearless and looked for reasons to annoy security personal –she hated at the time – so as to 'end it all'. I noticed she is more open than during my pre-visit, probably this could be because of familiarity over some time and the testament from my acquaintance at the host community.

12: 25

Felicia and I (AIA) left the camp clinic for the city centre in a public 8-passenger 'sharon' bus. Felicia needed to purchase a generator for her niece who just completed her apprentice and wants to start her own saloon business. We picked the niece and her friend along the way to town after some 10-minutes' drive from the village. Felicia & AAI sat together at the back of the bus during the 30-40 minutes' drive to town chatting. Felicia did most of the talking while AAI complimented where need be or ask for clarity. The talk centred on her experiences, the rivalry at the camp, the leadership at the camp who needs to report directly to the wife of the protestant church Pastor and how depressing it was to fight for food during sharing- she said they cook and does chores in group at the camp. Also how before now, one has to find a space to lay his/her head at night because of the population, it was a 'first come first served' at the church and IDP camp; that means there was no right to a sleeping place. One other challenge she had was that, she was among the 20 pregnant women at the camp then. AAI arrived at her destination and offered to pay their fare. They appreciated the gesture and AAI asked Felicia to keep in touch when there is any visit from either the MPs team or any NGO visiting the camp and she agreed.

FIELD NOTES II: May 29th 2021

Files Name	Health communication barrier of a multilingual IDP Camp clinic in northern Nigeria 2021/ Data collection for Ph.D. Thesis
Place	IDP Camp north -central Nigeria
Date	29.05.2021
Occasion	Second Field work: NGO visit, Observation; Group discussion with IDPs Representatives/ field notes
Participants	NGO-Catholic relief group(2 men and a lady), Dr. Burt, Felicia, 11 IDP Group representatives, AAI
Researcher	AAI
Duration	1:00hr (Observation of NGO visit/ address; shadowing of r. Burt consultation) 3:00hrs (Group discussion, shadowing in total)
Language	English, Hausa
Remarks	Meeting of the NGO and IDPs takes place inside the over a 10.000 square meters compound accommodating the IDPs. I observed and took notes, pictures and some audio recording of the meeting. It was a microfinance offered to some selected women (15) to start up a business. The meeting was conducted in Hausa language. After an opening prayer, the team leader introduced two of his colleagues -a lady who happened to be from around the north and speaks Hausa- and a gentleman who is from Southern Nigeria and could only speak English and his native language- Yoruba. He emphasised that only IDPs who understand English can be

	interviewed by him. I noticed most of the selected beneficiaries were interviewed by the only lady in the team. This could be due to their literacy level or it could be that they were at ease with the lady. Felicia was among the beneficiaries and I excused myself while she was attending the interview and walked to the private clinic to shadow Dr. Burt. While I was still there, a young boy came for treatment and he attended to him in Hausa language. I asked him for permission and took some shots of the clinic before I left to attend to our pre-planned group discussion. The group discussion was held inside the IDP clinic. In attendance was the IDP 11 group representatives; Felicia & AAI. Felicia and the 11 IDP representatives agree for AAI to take handwritten notes/audio recording during the group discussion. The question guide was on their health challenges, communication barrier and or perception on how medical consultation is conducted at the camp. (For further background check see pictures below for insights)

9:25

I arrived at the camp in advance for a 10am meeting of the IDPs with an NGO after Felicia informed me of the meeting. Before their arrival, I took time to take pictures of the clinic, the surrounding and that of the private clinic behind the IDP camp.

10:30

The NGO (Catholic relief team) was a follow –up visit to provide relief funds in form of micro-finance to displaced "women" who are ready to begin a trade. The IDPs present at the camp were mostly women, children and a fewer old and sick men. This is because of the farming season which provides menial jobs for the IDP men. The leader of the NGO team address the IDPs in Hausa language and asked if they remembered his team and their promise to return after most of them filled a forms sometimes last year (2020). They acknowledged and he further asked

if those selected and got a call from their NGO are present, and they affirmed. I noticed they understood to some reasonable extent the lingua franca he employed however, they often code switched when they speak in group to their indigenous native dialects and only answer with fewer words possible. There seemed to be different communities (13) at the camp who speak different languages /dialects of some of the languages. The NGO team leader calls out name after the address and advice beneficiaries to be productive with the funds because there would be a supervisory team to monitor those selected after the disbursement. While the other two team members attended to each beneficiary in form of an interview to ascertain their readiness by choice of trade, etc. Most of the IDPs went to the lady in the group because of their literacy level and or gender preference I think. Although the second group member a male, does not speak Hausa and only communicates in English and his native language Yoruba (south western Nigeria).

12:00

After the NGO group meeting ended, I took few minutes to unwind and walked to a near-by 'provision store' to get some water and snacks to eat while Felicia arranged for light refreshment-cola- for the group discussion ahead. 11 IDP representatives (gate keepers) / Felicia, AAI were in the group discussion. Some of the questions raised after taking time to re-introduce myself and inform them of my research goals/aim include: If they understand Hausa and we could discuss freely using it; if they had ever employed the services of an interpreter during medical visits by MPS; if they have had any communication challenges during medical consultations with MPs? If there is any medical challenge they are free to share with me and what is their perception on how consultation is conducted at the camp and what advice can they give to better improve consultations here. I asked their permission and they agree for me to take audio recording alongside field notes during the chat which I did. Afterwards, they insist they introduced their selves and I allowed them though outside of the audio recording which made them talk freely. 6-speakers contributed to the questions I raised during the discussion and others concur to their submissions.

Based on the aforementioned question guide, **speaker 1** appreciated the services provided by the government, NGOs; the Protestant Church in the host community, NEMA, and NMA for their assistance, necessity and security they were provided with since they came to the camp 2years

ago. Her concerns centred on gender differences in the provision of medical care. She particularly emphasised on what she termed “toilet infection” that is, infections and re-infections around the genitals. She complains of shame in discussing or presentation during medical team visits by MPS who are mostly or all male. Although she said an NGO provided a complaint box and she was able to drop her concerns. The concern here is what about those who cannot read or write and have no one to confide in? What was the outcome of that procedure- were the NGOs able to follow up on the complaints? **Speaker two** also appreciated the helpers at the camp and raised similar complain as speaker 1. Although she was bold enough to share medical concerns with the male –medical team visiting at that time, she was particularly concerned about re-infection due to poor sanitary condition of the few (two) toilets they shared with male IDPs at the camp. She narrated how her 19 year old son had to undergo surgery as a result of severe infections at the camp. She was thankful she open up and asked her son to do same and that led to his receiving help from the team of doctors. Other participants concur and lament on the difficulty to discuss such concerns particularly that the team have no female doctor. From her expression, speaker 2 sound lettered. **Speaker 3** talked on anti-natal and post-natal care they received at the camp. She was grateful for all the free treatment, care and medical services they offered her and other pregnant women at the camp. While **speaker 4** informed me of some medical team members who double up as interpreters during medical consultation where there was communication barrier. She narrated how so many IDPs died due to PTSD, mental ill-health and how ‘toilet’ infections are still lingering. **Speaker 5-**a widow said at least they are more at ease in the host community and can freely mingle and even search for menial jobs (like farming) which substituted their livelihood because that was not the case before now. She said some who still have their homes were reinstated or they returned while others who could afford got accommodation at the host community and now pay rent but those whose houses were burnt and have no families to return to, like herself, remain at the camp hoping and depending on government to come to their aid. **The last speaker** is particularly dismayed at ‘government deceit’ and failure in keeping its promises of reinstating them. The concern here is that with frequent attacks and displacements ravaging most communities in Nigeria, can the government fill this gap of reinstating; raising the standard of the marginalised especially those already at the IDP camp?

1:30

After the discussion, Felicia shared the cola and I took time to appreciate them and commend their resilience despite everything they had experienced. I further advise them not to lose hope. They offer to participate in the research as participants and are willing to be a part of the interview group when am ready. I left the camp for the city centre.

22 July, 2021 FIELD NOTES III

Name of Project/ID Information	Health communication barrier of a multilingual IDP Camp clinic in northern Nigeria 2021/ Data collection for Ph.D. Thesis	
Date	22:07:2021	
Time	10:00 am -2:00 pm	
File code	PhD. Thesis	
Researcher	A.A. Izang (aka AAI)	
Description	Observation	
A	Event	Observation
	Place	Home of key Informant behind IDP Camp, northern Nigeria
	Length	4 hrs.
	Keywords	IDPs, key informant, follow-up visit, empowerment, life trajectories
B	Summary of the event	I visited my key informant who was sick at her home situated behind the IDP camp. During the visit, we talked about her life trajectories, life during and after the displacement period most especially her experiences living at the IDP camp with pregnancy and her perception of the displaced in general. During the visit, I

		met with another informant/participant who is a widow and still living at the camp as a displaced person whose ordeal with her in-laws were discussed. The visit proffers opportunity to intimate discussions on needs, family, losses and life struggles in the lives of these IDP-women.
	Field notes	Field notes NO. 2/4
D	Reflections	From my observation, during the visit, I realise the mind-set of the displaced play a major role in their survival. Some of the displaced are eager and ready to work hard to recover what they have lost while others have lost hope in struggling for survival. Another idea is the role placed by men as a figure head in sustaining the family. Where the strength of the family depends on the presence of both spouse to restore the family in the case of my key informant is highlighted and in opposite to a widow (Ma'Faith) who had 'no one to stand for her'. The widow is further exploited of her husband's properties by his siblings. Yet another idea is the level of education and exposure. While my key informant has had a number of successes in business, her mind-set and that of her husband who had been a successful business man is not only dependant on their mind-set but also their level of

		education and empowerment/exposure in the business world. Whereas the widow in this case was a dependant and peasant farmer who only cultivate for her immediate family consumption seasonally. Thus, the micro-finance provided by NGO's will be judiciously put to use in business for profit returns than in the case of other displaced persons who had no-prior business sense but farming.

SEMI-STRUCTURED INTERVIEW TRANSCRIPTS

CONTENT ANALYSIS OF TRANSCRIPTS FROM SEMI-STRUCTURED INTERVIEW

AIA: Researcher/interviewer; **MPs: Medical Practitioners /participant**

1. **MP1**

Introduction of self

AIA: Hello, my name is Abigail Izang Ambi, a Ph.D. scholar with Lancaster University, UK. My research is in gender, communication and health inequality in a Nigerian IDP camp. Considering the diverse medical groups at the camp, I am here to investigate the effects of these challenges and others to health care provision. I will like to thank you for accepting to be a part of this research also, I have a number of questions I will be asking to enable me collect data for further analysis. Can you please tell me who I am speaking with and your field or area of specialty?

MP1: Thank you very much. I am Dr. Andre Maxwell ; I am a family physician, thank you.

Medical consultation within the IDP camp

AIA: How do medical practitioners consult within the IDP camp?

MP1: Well, medical consultation in the IDP camp varies and it depends on the setting of the IDP camp. In more formal setting where you have physical structures, the consultation is almost like a hospital setting because there are rooms for consultation where patients come in to see the attending physician or the hospital healthcare worker.

Then again, in places where there are no physical structures, consultation can be open; so tables can be arranged, medical practitioners get seated and the patients queue up and they come in line that way to see the attending physician.

And then, also, there are times when these patients don't even know that they have need for medical attention but their attention may be drawn to that need by the social worker who probably tells them or directs them to go see a doctor.

And then again, in some cases where there are emergencies-urgent need for care and those patients are rushed to the medical unit.

And then another issue about the medical consultation in the IDP camp is the problem of communication. There are people who don't understand certain languages, either the physician having problem understanding the language that is understood by the IDPs or an IDP member having problem with understanding the language that the healthcare giver speaks. So, sometimes language too is a problem.

Then occasionally there are problems also of having some facilities apart from just the personnel, drugs, some required bedside investigation or point of care tests and then the problem of having to direct those patients to specialist if here is need. But basically, this is how medical consultation goes on in the IDP.

Experience(s) with Volunteering at IDP camps

AIA: What are your experiences with volunteering?

MP1: Well, experience in (with) the IDP, well, *errhm*...is so nice working at the IDP (*camp*) as a medical practitioner because I get to encounter different people with diverse medical conditions-ranging from skin and other systems of the body conditions involving from either infectious diseases or even non-communicable diseases are prevalent especially, having to do with injuries- trauma particularly; so you know, those are the experiences.

And then the other experience is in terms of social *eerh*... conditions, cases of rape, cases of violence, you know and then again problems with communication. Problems with having to manage resources both human resources, material resources and so forth; so, for me, it's really a good experience. It helps to *errhm*... it helps me to improve on my clinical skills. It helps me to also improve on my managerial skills. It also helps me to understand much more about how, what experiences people have *as, as,* as social entities. So, it's a good experience for me.

Language role in Volunteering

AIA: Are you in any way selected or volunteer based on language role in your job description?

MP1: Well, volunteering is hardly based on language. *Ahh* ahh, Based on my experience but of course, selection is based on language. Like for instance, sometimes we group ourselves based on the languages that we understand and of course that are prevalent in the IDP camp so that way we make medical consultation a little bit easier for ourselves and even for the *err errh* the patients we attend to.

Comparison of IDP camps

AIA: Tell me about your knowledge of the internally displaced persons' background; is it comparable to other camps you know of? Or is there something special about this camp? Also, is there room for improvement?

MP1: Most of the IDP camps that I visited are located in villages and you will find that most of the people in those IDP camps are natives; local people who (are) have not been exposed to life in the city. And so, here, you will find out that they are mostly people who have little or no formal education and so, communication becomes a problem for us *err* with them in the IDP camps.

Again, they have other social problems and even medical conditions that you would/ usually would not find with people who are in IDP camps in cities and towns. And that is just the basic difference. The differences in education, differences in socio-economic status, differences in even their medical conditions because these IDP camps has more of infectious diseases than people who are coming from/ who are within the IDP camps in cities and towns who have less of infectious diseases but more of non-communicable diseases and that is majorly the difference.

Communication is generally a problem in IDP camps in local areas or in villages which is far from town but then in IDP camps in cities and towns, communication is usually not much of a problem because many of them understand official languages and that is just the basic difference.

Challenges with particular IDP or Group of IDPs

AIA: Is there any patient or group of patients that are a challenge particularly in the area of communication at the IDP camp?

MP1: Many of the patients at the IDP camps err constitute a problem to us in terms of communication. Because communication is the key thing for us-to be able to understand their problems and proffer solutions or give them help. So, because of the communication, there is a barrier in our interaction with many of those patients at the IDPs camps. And the problem is simply because of their level of education, their level of exposure and as I had mentioned earlier you find out many of the persons in those IDPs are native, people from the local areas that have not been exposed to a lot of things have not had the privilege to be educated. And so, you find the way they explain their medical conditions to us, is completely different from how one would understand from a clinical setting. For instance, a woman who suffers genital tract infection will just come to say she has "a toilet infection" and that becomes a problem. A toilet infection, one would wonder is it a genital tract infection or somewhere in the gastro-intestinal tract, so, it becomes a problem for us. If one does not probe further, you will not be able to understand clearly, what they mean by "toilet infection." So those are some of the problems, they are not able to communicate with us in clear terms. Tell us some of their symptom-mythologies- the way a medical person would understand. So many of the times we would have to probe them further, we have to ask a lot of question around what you think might be their problem to be able to uncover what exactly their medical conditions they are presenting with.

Diversity & Practical Solutions at the IDPs camp

AIA: How do you manage consultation considering the diversity of language speakers at the camp?

MP1: Bearing in mind the multilingual nature of the IDP camps, we share (group) ourselves into the diverse languages that are prevalent at the IDP. And that depends also on the number of staffs or the medical practitioners we have, who understand some of the languages that are prevalent in that specific IDP; so that is basically what we do. Occasionally if we are not able to share ourselves into the languages/the common languages, what we do simply is to get interpreters and those interpreters mostly range from the relatives of that patient we are seeing at the time or we have designated people in the IDP camps who help us as interpreters. This is just an informal arrangement is not

like they are trained interpreters *(professionals).* So, it is still a problem occasionally because sometimes some interpreters would want to give their own meanings to what a patient might say. For instance, a patient might say she has a headache that is one sided but instead of the interpreter to just say it just as the patient has said, the interpreter might just interpret it as migraine. But we well know that it's not all cases of unilateral headache that is migraine, so, occasionally that may become a problem for us. So until the medical practitioner is able to ask question very properly, the medical practitioner may not be well guided as to err the diagnosis of that patient.

Difficulties in Communicating with the IDPs

AIA: Is communication with patients at the IDP camp specific or not?

Well...communication with patients at the IDP camps is not always specific to my thinking. I say so because many of the patients are not able to understand official language and so, because we as the medical practitioners are not able to communicate with them in their native language. And occasionally if one as a MP understands the native language, they could just easily speak the native language; so in that setting, communication could be specific. But for most of the time, communication is usually not specific. We mostly engage the use of interpreters which are not even formal interpreters they are just *err...* make up arrangements to/just try to see that we communicate with these patients.

Occasionally we use symbols, occasionally we use *err...*pictures to do *err...* medical education to some of these err... err... patients in these IDP camps. And of course, they understand Hehehe.

Most of the time communications in IDPs camps are non specific and this is so because most of the patients in the IDP camps don't understand formal language, and we the MPs are not able to speak their native language at all times. So some of the times we tend to engage the use of err... interpreters who occasionally don't even interpret what the patient is trying to infer instead they make inference based on their own understanding of what the patient means. Mind you this is medical terminologies so, sometimes, err this interpreters are not able to err understand medical terminologies or they are not able to

communicate in clear terms with medical terminologies; so, it becomes a problem for us. So communication is usually not specific. Occasionally we are able to communicate in a very clear terms or in a specific way when we get patients who understand *err*... official languages like English Language, or where we the native practitioners understand some of the native languages that he patients in the IDP camps speak. So we speak to them directly in that native language so in that way, we are able to have a more specific communication without that, most of the communication is non-specific.

Gender Inequality /Representations as MPs Volunteers

AIA: Why do you think there are more male volunteers that are medical practitioners at the camp?

MP1: Despite the fact that many articles tends to suggest that female MPs are more in number than male MPs, at the IDP camps, volunteers, medical volunteer are mostly males-I agree with you. This is so because, I think err ... the female MPs have a lot to deal with and mainly it is problems or challenges of the home-front. So you find some of these female MPs who are actively breastfeeding and are not able to err... volunteer to IDP camps or female MPs who are heavily pregnant and because of some of the challenges of pregnancies they would not be able to volunteer or female MPs who (are) because of their religious inclinations would not be able to commit themselves whole heartedly or completely to being or staying in the IDP camps so that's / I think. Again, I think the problem may also be because "they have a head" which is their husbands and if their husbands' decline to giving them consent to volunteer then of course they would not be able to volunteer as against the man who is usually the head-considered as the head of the home –he single handedly takes the decision-if he wants to volunteer, he goes ahead to volunteer and many a times the woman may not be able to say no to his choices-I thinks those are some of the problems. So they are mainly social problems that are ... stop females or reduce the number of females (*MPs*) that can volunteer to IDPs camps. I don't think is something too special.

The low rate of female medical volunteers to the IDP camp also has its attendant problems. Some of the problems constitute the problem of medical consultation or examination of the patient. For instance, if the patient at the IDP camp who needs to see the medical practitioner is a female, and the MP is a male, you know that would constitute a problem; especially when it comes to patient examination because the female may not feel very comfortable exposing herself, her body to the medical practitioner at the IDP camp. And again/ and especially if there are no female chaperons and again you know this is not the/ err... a conventional clinical set up. Unless if the medical practitioner is smart enough to remember that he needs he/she needs a chaperons who is a female to standby as one is trying to examine the female patient at the IDP camp. Then again another problem sometimes would be maybe the issue of may be religion. There are religions that females are not very forward when it comes to communication or interaction with a male. And so, you find those females with that kind of religion not being so open or free to communicate with a male MP who is attending to their care. So that also is another problem of not having many female volunteers at the IDP camps.

Major Problems in the IDP Camps

AIA: What are your major challenges or problems as a medical practitioner?

MP 1: For me I think the major problems we have in the IDP camps is the problem of communication; because with effective communication we are able to get to know their main problems and that way we will be able to solve some of those challenges but without getting to have an effective communication with the members of the IDP camps, we will not be able to solve their challenges. So communication is a key thing for me at the IDP camps. And I think an easy way to summon these kinds of things is to have interpreters. When we have interpreters to some of the native languages, we would be able to overcome some of those problems but of course those interpreters would need to be trained it's not just enough to have interpreters, because anyone/body in the IDP could understand the official language we speak which is English and understand the native language should be able to interpret but even at that many of the times we are not able to have a very effective communication because err...you would find out that communication stops the...the...the...fruitfulness of that communication and /hence with

the interpreter who most of the time is not able to give to us the correct feedback from the patients. Many of the times they give their own personal perception of what the patient is trying to explain in their native languages; so, that is a problem for us at the IDP camps.

At the IDP camp apart from having problems with communication, err... from people who don't understand conventional languages or official languages, we could also have problems with people who have mental health conditions, people who are into substance abuse. And these are people who usually would not communicate in a very coherent manner, people who are restless, who would not even cooperate in terms of clinical consultation; so it becomes a problem for us in medical consultations at the IDP camps.

Personal motivation

AIA: What are your motivations for participating as a volunteer at the IDP camp?

MP1: My personal motivation, volunteering as err...a medical practitioner to the IDP camp mostly is the fact that am able to help somebody in need especially with my medical knowledge; that is enough motivation for me. It is not whatever stipend I get from there, it is not err...any medical knowledge, experience or expertise I intend to derive from there, no. The fact that 'am able to help somebody in need of a medical attention and to me that is a key motivation. And again, sometimes the challenge of having to interact is another motivation to me because err... that way am able to improve on my communication skills both in the formal and informal settings. Because for me I regard that setting in the IDP camp as an informal way of communication because many of the times we are not able to communicate person to person because many of (of) the times we are not able to communicate specifically or directly. So communication takes an indirect manner in the sense that, we have to use either interpreters, we have to use sign symbols, we have to use, we have to use errr... crude or native languages of which some medical terminologies of medical expressions err... do not really exist in those languages; so, it becomes a problem. So err that helps me to try to, you know get more exposed in terms of ways/ possible ways to communication, possible ways of improving my skills in

communication, so it is another motivation for me apart from personal things that I derive.

Language Role in Volunteering for MPs

AIA: Are you selected based on language competence to work in the camp, considering the diversity of the language groups in the camp?

MP1: Our selection for the volunteering to the IDP camps is usually not based on language competence but mainly medical competence. Occasionally errr... they bear into cognisance err... the languages that one understands if you understand a particular language that is prevalent in the natives that exist in the IDP camp, of course occasionally the preference will be given to that individual medical practitioner but it is not in all cases. Most of the time, err... we have short falls of participation from medical practitioners, so err... competence in language is not paid/ attention to competence in language is not given but most of the time the focus is competence in medical practice but of course, I acknowledge that competence in language should be given attention to but unfortunately we can't do that because of numbers of volunteers we have, and of course because of the diverse languages that are prevalent in the IDP camps. If you have more than four to five languages and you have medical practitioners who are spread just within two to three languages, would you say that those /other medical practitioners should not volunteer to the IDP? I think the answer is simply no. So because of that, many of the times we just have to find other means of trying to communicate with the people in the IDP camp despite the language barrier-the communication difficulties, we try to find our ways around it, that's just the simple thing.

Confidentiality/Privacy in IDP camp consultations

AIA: How do you manage privacy during consultation at the IDP camp considering the structure that is available on ground; have you encounter any difficulties in discussing any health challenges with any of the gender at the IDP cam?

MP1: Confidentiality is one thing that we've paid keen attention to in clinical setting. This is so because confidentiality is a right- the basic right of the patient. But unfortunately in the

IDP camps, we are not able to have err... full confidential set up –if I may say so- at all times. Many of the times our consultations is in an open setting so because of that confidentiality, we are not able to adhere strictly to it. But many of the times what we try to is to improvise. So we improvise by using err examination screens-to screen the patient around so that others will not easily see the person. But even then err... if you have to ask question somebody who is just standing close by might hear the question and the answer that the patient is giving; so that becomes a problem. Confidentiality indeed or privacy is a problem for us in the IDP camp, especially if we have to do open consultation but in other IDPs where there are structures, we have rooms so we are able to have more like a close to a conventional clinical setting, so that way we don't much of the problem of confidentiality or privacy. But where we do have problems with privacy are commonly instances where err... where you have to examine a female because the female body is usually very sensitive and is one body that should be treated with caution and with utmost care. So because of that, we have the problem of privacy. So we try to get either other females to shield or cover that female patient that we are trying to examine or we simply use medical screens but that is not always available so, it is a problem indeed at the IDP camps.

Confidentiality in consultation with interpretation

AIA: Would you say consultation at the IDP camp is confidential or not considering the need

to engage interpreters some times?

MP1: Yes, again the issue of confidentiality is not only with respect to medical examination; even the process of consultation is another challenge where we have problems with confidentiality. If the patient does not understand official or contemporary conventional language and we have to look for an interpreter for instance, the interpreter must /will not necessarily be from the family of the patient, or will not necessarily be who the patient would want to approve as an interpreter. So of course, the patient would just have to give consent to whoever would understand his or her native language just in a bit to try to communicate ...with the medial personnel so that err... the patient can have err... some

help to his or her conditions. So that is a problem too. So it is not always only in terms of err... medical examination but occasionally, even in terms of the whole process of medical consultation we have the problem of privacy or confidentiality in that way, it has to be bridged, because we need an interpreter. And if we have an interpreter that the patient mostly would not approve, but would have to approve just simply because of the need to communicate effectively then of course we don't have any choice and the patient too does not have a choice, so too that is a problem too. But we are trying at most times to try to see how we can errm... ermm... improve on the privacy of the patient and that way, the patient would have some form of confidentiality. We do that by just simply excusing the interpreter if we are using an interpreter or use a screen to screen the patient just to cover the patient from other onlookers so that we are able to examine the patient- especially if the patient is a female; because they have sensitive body parts. So that is basically it.

Perception on addressing or solving challenges /Appreciation (conclusion)

AIA: I will like to thank you for participating in this research and for your honest contributions. Before we round off, I will like to ask if there is any (further) contributions based on your perception on how to assist the internally displaced persons or how to improve the medical structures/medical conditions that are in the camp based on your observation? Thank you

MP1: Thank you very much for finding me worthy to be interviewed by you on this subject matter. I am really grateful. Yes, just to err... respond to your question, I think since most of the problems we have at the IDP camp is, that's in terms of medical consultation is the problem of communication, I would think that to solve this problem since we have been trying to use interpreters all the times if we could have interpreters who are trained that will go a long way in solving some of our problems. And these interpreters could come from the social workers and even the err... some of the members of the IDP camps themselves. If we could train some of them on interpretation, that way we would solve the problem of effective communication. And then again, some of the problem of privacy, if we can have more screens, medical examination screens to use, and specifically if we have structures where we would have we would be able to set up near

conventional clinical set ups, then we will have less problems of privacy and confidentiality. Thank you very much.

2. **MP 2**

Introduction of self

AIA: Hello Doctor, my name is Abigail Izang Ambi, a Ph.D. scholar with Lancaster University, UK. My study is on Gender, communication and health care inequality in an IDP camp in Nigeria. Based on that information, I am here to investigate how you manage language diversity in the camp, and some of the challenges that you have been facing. I will like to thank you for your time and because of this interview, I have some questions that I will want to ask for you to address this afternoon. First, can you tell me who I am talking to?

MP 2: Okay, thank you very much. My names are Alexander Burt ; a CHO **(**Community Health Officer**)** and consultant

Area of Specialty

AIA: Ok. Dr. Alexander, what is it your carreer all about or your field-area of specialty, I will like to know?

MP 2: I specialised in health management

Consultation at the IDP camp

AIA: OK. And how do medical practitioners (those that take care of their medical health) consult within the IDP camp here?

MP 2: Okay consultations at the IDP camp, you know people come from diverse villages with less understanding educationally-wise. So to communicate with them, you have to consider the language that they understand first and to be friendly with them-to make them as a friend and they will be able to compose and tell you their problems.

Experiences with volunteering

AIA: **Okay, that is nice to know. What are the experiences with volunteering because most of the Nigerian Medical doctors who are visiting at the camp I understand they volunteer. What are some of your experiences with the IDPs?**

MP 2: Toh, the experiences with the IDPs is ...there is difficulties in understanding and whenever you are... you are communicating with them, they like to do or to respond with what they know but to bring up new ideas to them you have to take time and to make it in a lay man language for them to understand.

AIA: okay, when you talk about lay man language do you mean using the Lingua Franca? Is it that some/most of them understands the lingua franca which is Hausa –I guess here (in this context) or is it the native language? Also, when we talk about bringing it down to their level, do you sometimes find it difficult to relate with them in the language they understand and you need somebody to interpret or you?

MP 2: Yes, the languages they understand much is native and err... if you cannot (not) at least comply with them in the native language, you need somebody to at least interfere (interpret).

Privacy with interpretation/Open consultation

AIA: SO, it means therefore that there is no complete privacy because of the nature of the camp? I realised it is an open clinic and since we have people that can also interpret for those that cannot understand, how do you manage privacy in such an open consultation?

MPs 2: Okay to manage privacy in such condition, you have to use your initiative in consultation and to make appropriate diagnosis based on lab (laboratory) tests' to confirm and add(ask) certain things they could not able to speak out.

Structural arrangement/lack of resources

AIA: I understand that the structural arrangement there is no provision for such investigation (laboratory testing) do you refer them to other clinics, laboratory or other hospitals for tests?

MPs 2: Yes, in such cases where those facilities are not intact, or available in such places (camps), we refer them to a nearest and a competent clinic that can able to handle those conditions.

Language role in volunteering

AIA: Okay. Are you selected based on your language preferences or language competence, I mean what language you understand when you are visiting camps in your role as a doctor? DO they select you based on your language or they just send you to where may not be able to speak the language like the case of the IDP camp?

MP2: Okay, in such areas at times they select based on a language you are able to speak with the IDPs.

Patients /group of patients as challenge

AIA: Okay that will make it understandable. So do you have any patients or group of patients that are a challenge to you, particularly in the area of communication?

MP2: Ermm, For now, no

Challenges/problems as an MP

AIA: AH I need to also understand how consultation is carried out or conducted with regards to language use. Initially you talked about selection based on the language they understand and also, I understand you also talked about interpretation where there is difficulty with the IDPs. So the next question would be what major challenges or problems as a medical practitioner do you face generally?

MP2: Ah the general challenges we face? Errh the challenges we face in the field, most at times clients are not educated err... in terms of prevention measures and they need at least

health education, awareness before the condition persist and they are able to go to the hospital. But by the time they have those *(that)* awareness in their houses on how to keep their surrounding clean and *errh...* keep their premises neat, not for them to at least harbour some diseases conditions right from the sources. But if they can have proper awareness, that can curtail all these situations.

Prevalent cases

AIA: Okay.So we have major challenge of lack of awareness (MP2-Yes); due to probably some reasons like coming from the rural areas, or lack of education, right? I hope I understand you well? MP2- Yes. **SO have you ever noticed any peculiar problem coming from those that are displaced?**

MP2: Err...most at times the conditions we are having from displaced people *err...* issues of diarrhoea cases and cholera because of the poor hygiene environment. (AIA- Okay) Yeah.

Perception for Alleviation of Prevalent cases at the IDP camp

AIA: SO what in your own perception or in your own contribution do you think can be done to alleviate such a condition?

MPs 2: Okay, for those conditions *(diarrhoea/cholera)* in IDPs they need to have proper sanitary environment such as toiletries, good water supply and provision of *errr...* mosquito nets that is to curtail all these pre-matured problems.

Developing Practical Measures

AIA: Okay. I will like to know in your own perception where those contributions can come in or what can be done to provide such things?

MP 2: Hmm toh... well due to the environment we find ourselves, the NGOs, any well meaning individual and the government can help assist to alleviate these conditions.

IDP Background

AIA: Well thank you for your contributions. I will like to know finally if errhh, you have any idea about the IDPs background? Probably as a medical practitioner, you could be close to some of them or you had privilege of discussing one-on-one with some of them? Do you have any background of who the IDPs are?

MP 2: Ok, IDPs are people displaced from their original environment due to forces that led them to migrate to another environment that they are not conversant with and that they are not convenient under the environment due to the inconveniences from their home town or houses.

Gender inequality Male dominated MPs volunteers

MPs 2: At times why females are not contributing much in not all areas because of the hectic *(nature)* of the work or because of the environment where they are send to work. It's

not all females that can (be) endured to ...in those environment and the hectic (nature) of the work. (AIA- probably because they have family and so, MP2 –Yes)

Motivation

AIA: What is your motivation for your contributions to the IDP as a humanitarian aid, what is your motivation? What makes you to be one of the volunteers?

MPs 2: So, it's all about service to humanity. At least you just feel and be in 'their own shoes'. At least try to render service to humanity.

Appreciation

AIA: Thank you very much Dr. Maxwell. It is nice talking with you.vI will like to appreciate you for taking part in this research; if we have more questions, I will contact you through the phone or visit. For now, this will be all for our interview, thank you very much.

MP2: You are welcome.

In some cases, private supports organization provided a one-off health services in areas of eye care, surgeries and...

In such call, the NMA provided, a one bed clinic was set up with two trained health personnel who take shift. The drugs provided were largely anti-malaria, antibiotics and pain killers

TRANSLATION /TRANSCRIPTION OF IDPS' SEMI STRUCTURE INTERVIEW (FROM HAUSA TO ENGLISH LANGUAGE)

1ST IDP Participant

AIA: A takaice gabatar da kanki / Introduction of self

SV: (Salomi Vincent) Toh nagode da wana tanbaya da keka yi. Na gode domin ubangiji ya bishe ki ya kawo ki, abin farin ciki ne mu gan yanuwan mu sun zo wanan camp -su zo suji bukatan mu-. Da kuma su tayamu makokin damuwa da (ya) shafe mu. A twenty eighteen, mun sami kan mu dadama bamu san hawaba bamusan sauka ba, Fulani kawai sun zo sun kashe mana yanwani, sun kokone gidaje, abincin da ke gonakin mu gabaki daya Kaman dankali sun tawna. Mun siya dankali da ni da maigida na domin mai gida na yanna aikin lambu ne. Mun yi dankali. Mun cire kudi mun saya iri da sada toh mun sa dankalin nan a'gona ga masara, ga atargu ama ba abinda mu ka samu gabaki daya. Su lalartar mana. Gaskiya mun gode domin wandasu mu da Ubangijin Allah ya fitar da mu da rai ama gaskiya ba mu samai shi da sauki ba. In mun ce mun samai shi da sauki mun yi wa Allah karya. Kaman ni masanma ma abin ya ta gyefen iyaye na da can kauye (named) na rasa wayansu yanwane na. Acikin gidan **iyaye** mun rasa mutane sun kai guda goma.Toh ga damuwa kuma a gidan maigidan na inda na yi aure-abin bai zo mana da sauke ba. Mun sami damuwowi sosai lokacin da muka zo nan wurin. Mutanin (host community) nan mun gode musu da sun karbe mu da hanu biyu. Sun yi tare taren abinci a churches churches sun zo muna dafawa. Haka zamuyi layi da kwannuka muna karba. Da mu da yayan mu, muna kwanciya a cikin church. Mun gode wa ubangiji da ya sa yayi anfani da mutani da yawa sun zo sun kawo mana taimako masanman yan organizations. Domin na gaskiya Allah ya yi masu albarka domin sun talafa mana a wurare daban daban-sutura, abinci,rashin lafiya,duk sun taimaka mana. Kai har sun' dan bude mana Kaman chemist sun dauke wanda sunna kula da mu. Mun sami damuwoyi sosai a camp lokacin da muka zo; yan zu gomnati bata iya mana wani abu ba. Gaskiya, gaskiyan kenan basu damu da mu ba. Ama organisation wanda sun taimaka mana mun ce wa Allah-Allah ya yi masu albarka.

Mun zo mun hadu da mutane dayawa. Inna ganni mun kai kawuka (kaiwuka kamar) mu anan camp mun kai kaiyuka sun kai goma-sha uku. (Da) mun zo, su Red Cross sun zo su gyara mana toilets muna shi-shiga, maza a'shiga, mata-a shiga, ga yara. Mun zo mun kamu da toilet infection din na. Wanda Kaman ni ma ina da shi har ma ya zo ya 'stopping' al'ada na. Ba'na ganin alada. Mata suna fama da wana toilet infection ba na kadan ba. Kaman wada sun zo mana a'na, jin kunya a fada ga damuwan da muke fuskanta. Ama muna rokan Allah Ubangiji ya sa'da mu sa'mi wandadan zasu zo su talafa mana domin a zo atalafa wa' mu mata da wanan damuwa na toilet infection-gaskiya da' mun ce mun gode mun gode sosai.

Sirri a cikin shawara / Privacy & consultation

AIA: wani shawara za ki iya ba da? / what is your advice to the issue of privacy during consultation?

SV: Haka din'ne da anyi mana Kaman dan asibiti ne haka wanan zai shiga ya je sai yayi bayani irin jikin da shi yake ji. Ama za' zonna toh wani lokaci wayansu matan suna ganni acewa ga wayana fari fari abu yana fita a gaba kuma maza ne sukan gan (ni) mu-za ka ji kunya ka fada musu ga damuwa da ke damin ka, shi ya sa bama iya mu fada din ba.

Bayani da fahimta / Solution & Perception

AIA:

SV: Gaskiya akwai shawara wanda zan bayar domin ina gani wana toilet infection din, in'ba an taimaka mana don a' cure-ing wanan damuwan ba zai kan kawo mana rashin haifuwa. Domin dayawa akwai dayawa wandada ta dalilin wanan toilet infection din sunyi miscarriage. Ya je ya fitar musu da juna biyu wandada dama suna da shidin. In'da za a taimaka mana sai aturo mana da ko mata zalla Kaman mu; ka gan zamu ji dadi muyi masu bayanni damuwan da muke ciki. A'ma indan miji ya zo haka kana ganin zai yi wuya ka bude baki ka fada mishi -ka ga yar' uwan ka namace ne ma if possible za ka iya ma ka tubai sai ka nuna mata ba ka ji kun ya ba. Na wa roko kena in'dan za a'taimaka sai a taimaka mana da magungunna da treatment yada za'a koya mana yarda zamuyi da zamu rabu da wanan damuwan na gode.

Karshe / Conclusion

AIA:

SV: Toh ina da dan tanbaya. Tanbaya na shi'ne, Kaman yanzu da akwai wayansu yanwani mu a'yanda ba'su da rai kuma sun bar yaran su masanma yanmata. Kuma yanmatan wanan lokacin suna bukata za su gan al'ahda suna bukatan awdiga, inda za a dan taimaka mana ko da dan su 'inner wears' na su. gaskiya da an taimaka mu basu. Kaman ni inna da guda uku-ina da orphans da sunna karkashi na inda za adan taimaka ah talafa. Toh ban san ko ya ba. (...)Toh na gode.

2nd IDP Participant ('Mama')

AIA: A takaice gabatar da kanki / Introduction

MA: **('Mama' Mary Abel)** Muna da shaikara hudu da rabi, ton lokacin da an yi yake muna da shaikara hudu da rabi, mun zo nan saboda Fulani ne sun kore mu daga can'. Shi ya sa mun gudu da kyar mun sira muka zo nan. Toh mun ce mun gode wa mutanin da suke taimako. Suna taimaka mana da su magani na rashin lafiaya nan da abinchi, suna taimaka mana a'lokacin. Toh yake bana abin ya zama da yanda yake, kowa na ta kan shi; ana tah... ba abinda zamu ce ba. Fulani sun sa mun rikece gaba daya babu abin da zamu ce. Mu ma muna ta fama a'cikin camp din, sanyi gashi, ba wanni abu ba; ba komai ba. Toh zamu ce mun gode maku da magani kukan zuwa ku taimake mu. Rashin lafiya kenan kulum toh zan ce na gode.

Ni kaka ce shekaru na tamanin da biyar. (jokes). Ni kade ne anan yaran su yi girma guda uku suna nan an kakashe sauran, jikoki na guda biyar. An kashe maigidana, sun kone gidan mu ba a'bin da na fita da shi daga zani daya. Da kudi da akuyoyi da mai hai!! Duk (an kona) ba a'binda muka fito da shi. Babu sauki in mutun ya tuna fa Kaman zan haukace. Gaskiya, kana zama kana jin dadi ka da iyalin ka- sai a zo kawai barkatai da rana daya kawai ayi takarkashe mutani kama kiyashi.

Duk jiki na yana zafi, dasu kafa. Likitoce sukan bani magani. Nakan fada rashin lafiya da hausa, su kan gan ne.

AIA: Fahimta da shawarwari / Perception & Advice

MA: Ina fata dai nine baba achikin su ina fata dai ko za a ji tausayin mu a'taimake mu afara da su abinci da su magani, fata na kenan. A ji tausayin mu, muna nan anan sai mun sami wurin ama in bahaka, ba' wurin da zamu je.

(Basic amenities?) Muna sami ruwan sha daga rigiya, babu wuta, muna zama da su "Obansanjo nan"- aci bal-bal (locally made lentern). In dare ya yi, muna rokan Allah mu wayai gari. Akwai sanyi ama da' macize suna nan sai Allah ya ji tausayin mu bamu sake gani ba. Da shike ana naumai wujin, da' ciyawa ne.

AIA: Karshe / Conclusion

MA: Na gode

3rd IDP Participant

AIA: A takaice gabatar da kanki / Brief Introduction

IDP 2: SI- Sarah Ishaya Toh na gode da tambayan da kika yi. Toh two –eighteen (2018) wanan abu ya samai mu a' watan shida on the twenty-three, ranan sati. Muna nan sai Fulani suka shigo, da suka shiga sai suka fara papasa mana su windodi suka sa wuta. Muna nan' da maigida na muna zaune sai kawai muka gan wuta a daki. Maijida na sai ya tashi sai ya fara kashe wuta. Da ye fara kashe wuta sai suka gan wutan ya mutu. Sai suka repitin sai suka sa wuta, sai suka pasa window sai suka gan shi sai su ka ce –ga katon arne mu zaga mu samai shi. Sai ya ce mun 'toh gashinan sun ce zasu zaga su samai mu-indan zai fita kada in fita ba'. Sai na ce mishi don mai ne ni bazan fita ba? Sai ya ce mun 'kara in fita ba sabuda in'dan an kashe shi sai wanin mu zai duba yara'. Sai na ce haka-'ai'. Toh sai munana sai suka shiga, da suka shiga sai suka tsarai shi da wuka, bai fadi ba sai yana waka, yana waka 'bazai mutu ba' shi ma zai rayu acikin duniyan na' sai daya daga cikin su ya ce 'bazaka mutu ba zaka rayu' zamu nuna maka hikiman mutuwa' sai daya ya ce a'tsarai shi a wuya- sai ya fadi. Da ya fadi, muka fita. Da muka fita yananan a kasa-ya daga ido ya kale ne sai ya ce 'mumi ina yara'? Sai na ce suna daki. Sai ya sake

dubawa sai -first born na shi ya zo-. zai shiga rijiya sai yana ce mishi da hannu yana gaya mashi-toh mu bamu san abunda yana mishi da hannu ba sai yaron ya shiga rijiya. Sai ya' ce mashi ya'wah na gode Stanley. Da ya ce mashi na'gode sai na fita sai na bar wata karaman yarinna mai shekara biyar a' hayaki-sai ya bude baki -Allah ya bude mashi baki sai ya ce 'ina momsie'? sai na ce mashi tana daki- sai ya ce in'je in doke ta. Da na' je in doke ta sai ya sa'ke ce mun 'kai thank you mommy' sai na ce mishi, thank you daddy-zaka rayyu? Sai ya ce 'ban ji wakan da ya yi ba' zai ra'yu bazai mutuba.' Sai na' ce toh. Munanan sai ya ce mun in shiga toilet domin basu shiga cikin toilet. Sai yace mun in'shiga cikin toilet. Dana shiga cikin toilet-bafroom sai muka zauna, da muka zauna sai, muka zauna har gari ya wa'ye irin su four sai muka tashi muka gudu muka je filin ball akwai wadadan suka waye mu awajen. Da muka je filin ball time din i'na da cikin yarinya na wata uku a' ka kashe shi ciki na ya na wata uku. Sai aka dibai mu muka zo camp muna nan. Su church sukan bamu sukan taimaka mana da abinchi. Suna taimaka mana da abinchi muna ci muna layi Kaman marayu. Suna bamu, muna ci muna sha. Muna layin nan ana bamu wani sometime din ma sai karfe biyu ko karfe uku kamin mu sami mu ci. Duk da haka muna hakuri muna ta hakuri -mukan zo muka zauna church suna/wanna churchi su kawo, wanan churchi su kawo ana dafa mana. Sai muna nan, muna nan da su chiki, muna nan harna zo na haife yarinya na a nan cikin camp -ba wurin barci. Muna lalabawa muna kwana a kasa. Harna zo na haife ta muna kwana a kasa. Har ta kai shekara daya muna kwana ah kasha tukuna aka zo yan gari suka dan san mana mattress shine muke anfani da shi har yan'zu acikin camp din muna amfani da shi. Yawancin mu basu da mattress, yawancin mu ma abinci da ma za mu ci yanzu ma ba'bu. Munana muna lalaba rayuwa. Muna rokon gomnati ma basu taba taimakon mu da wanni abu acikin camp din na ba sai dai su church. Muna rokon gomnati inda dai taimako sai su taimaka mana. Ya yan mu ma suna nan -ba makarantu suke ba-, wayansu sunna yawo don kudi da an sa yaran mu a makarantu ma bamu da shi ba. Masanman mu gomrah'ye ma. Da kyar muke samuwa mu ciyar da yara. Ba makarantu ha ka suke ama akwai wadan da su ka gama sekondari, ba kudin da za su shiga baban makaranta ba. Muna rokon gomnati da akwai dan taimako da zasuyi mana, sai su taimaka mana.

Mata masu ciki a' lokacin /Pregnant Women at IDP camp from inception

AIA:

SI: Toh lokacin masa juna biyu da na wayi su guda uku ne. Ai duk sun haifu a'nan camp.

Kalabulen likita ku/ Your Medical Challenges at the camp

AIA:

SI: Gaskiya na samu, (na samu) chutan ciwon gaba wanda ruwa yana fita, har da ya zo yarinya na ta na nan aciki ma ita ma na haife ta da shi. Gaskiya ni da ita har yanzu muna fama da ni da ita. Wani lokacin sometimes haka sai ta ta kuka gindin ta yana mata zafi-sai dai in diba rowan zafi da gishiri sai in wanke mata da shi kamin ta sami salama. Woni lokaci kuma zatayi fisari sai ruwa fari nan yana zuba mata. Toh muna rokon gomnati su taimaka mana ta wurin –don woni lokacin yana hana haifuwa ma. Muna rokon gomnati su taimaka mana da magunguna.

Shin kin sanar da likitan kalualen ke? /Did you inform the MPs about your challenges?

AIA:

SI: Na gaya masu, wani lokaci na gaya masu toh sai suka bani flagyl suka ce mun in dinga sha. Toh ina ta shan flagyl don yarinyan dai lokaacin ba'ta shan nono bale ace zata sha a nono.

Fahinta da mfita ga kalubale/Perception & Solution

AIA:

SI: Gaskiya ina son in roko gomnati su taimaka mana da magunguna da kuma magunguna da zamu dinga wanke muna sapta toilets na **musabo** da toilets dinna don muna shiga domin inmun gama abinda zamuyi sai mu wanke shi sai mu zuba mishi abinda ana zubawa soboda chuta kada ya kama wani daga cikin mu kuma. Muna amfani dashi gabaki daya mu kusan mutani wanda sun auna a camp din gari gari ya kai guda goma sha-uku, goma-sha uku. Mutani kusan dubu dari shida munanan a nan (da fari) wurin. Kuma muna amfani da toilet guda daya.

Tuntubar Shingen Harshe / Language Barrier during Consultation

AIA:

SI: Toh a'gaskiya dai wandasu likitocin basu jin hausa. Wandasu kam zai fada mana da turanchi sai ita nurse na mu (A.N.), sai ta fada mana da hausa. Ta ce ga'abinda yake fada. Sai mu sami ganewa daga gareta. Inta fada mana da hausa.

AIA: Karshe / Conclusion

SI: Toh bani da abinfada sai dai gomnati ta duba abin da zata iya ta yi mana. Na

gode.

4th IDP Participant

AIA: A takaice gabatar da kanki / Introduction of self

NP: Sunana Nancy Paul. Ina da shekaru talatin, kuma na siya da makaranta

a' aji shida na sekandari.

AIA: Kalabulen ku / Challenges/Perception

NP: Toh sabila da rashin zaman lafiya a kawye ne ya sa muka dawo da zama a nan camp. Watotun shekara hudu day a wuce, da Fulani suka kawo mana harbi a can kawye sai muka rasa gidagen mu har da iyayen mu gaba daya. Da ma mu uku ne ah cikin iyaye na kuma ni ce babba; yanzu mun zama marayu a nan camp. Ina da masaloli dayawa, ma saman zaman mu awanan wurin. Na daya, na yi fama da rashin lafia ama babu ishenshen magani a clinic na mu. Wayan su lokaci sai mun cirai zuchiya kamin mu sami taimako ma sanman panyi rashin laifiya. Na biyu kuma, babu hanyan da kanne na za su je makaranta ko nema sana'a anan.

AIA: Shawara da ma su kiwon lafiya / Consultation

NP: Fata na shine in dan gonmati zata iya lura da kiwon lafiya na mu ah nan ta worin hanya Ma'gunguna ko isheshen likitoci masanman ta mace domin mu samu sukunin iya maimaita alurai da ke damin mu da ked a siri.

AIA: Karshe / Conclusion

NP: Ah karshe ina rokon gomnati ta tanada mana mu koma gidagen mu shi ne mafin komai.

Ta kuma lura da rashin lafiya da ke kewayen kawyuka sa bo da a' magan ce na gobe. Na gode

5th IDP Participant

AIA: A takaice gabatar da kanki / Introduction of self

TD: Sanana Tabitha Duniya daga Gashish kaw'yen kuma...(inaudible) (originally she is Mwagavul an indigene of Mangu local government area). Abinda ya sa muka zo nan sabo da fa'da da Fulani. Mu ba musan ko ya ya ba, sun taso mana kawai. Shi ya sa muka gudu zuwa nan, an taimaka mana sojoji sun kwaso mu a mota zuwa nan agaban churchi, mutanin (named host community) garin suka karbai mu da hannu bi-biyu sun yi mana abinchi, sun yi mana komai. Sun kawo masara, da ...sun dafa mana abinchi da kunu muna sha sabo da muna da yara. Yaran ma lokacin suna makaranta, daidai lokacin da yara zasu dauka hutu kenan, basu ma rubuta exam ma ba sai mun gudu zuwa nan babu jarabawan ma ba. Sai wayansu suna zuwa su taimaka wa yaran da koyarsuwa kadan wanda su ba yar da kan su suna taimaka wa yaran kar su manta. Toh, ta dalilin haka ne suna ta zuwa suna taimaka da abinchi, gomnati kam bamu gan wanni ba, bamu gan taimakon da gomnati ta yi mana ba. A'ma mutanin churchi da ban wadda sun bamu chi da sha, mun ce mun gode har da magunguna, magunguna ma dama daga can ma, da yara da maigida na ...abubuwa sun zo sun yi yawa. Aikin da da' muna aikin noma abincin da da' muna samu, yaya za mu samu, ga yara nah bukatan makaranta, sai yace yaya zamu yi? Har yanzu da ma muna noman ne mu sa yara a makaranta. Ya za mun yi? Ya zo ya dauka wani tunani sai hawan jinni ya tar mishi. Dama anan ne dama ana taimaka mana da magani, toh har ya zo ya paralyse. Da ya paralyse sai hawan jinin ya hawo mishi mu yi ta jinya har ya gagara har ya o ya ra'su. Ya bar ni da yara anan din. mu na da yara sai na ce bari akama masu makaranta, so-ro ma ya kama mu, sai mun ce mu koma ma, mutane suna gudu za a' sa yara amakaranta ma yaya? Sai mun sa su amakaranta a'nan. Toh da mu kama masu

makaranta muna lalaba, wani lokacin ma-wancan term ma, babu kudin biya, toh abincin ci ma muna lalaba. Toh mun gode ma mutane sa bo da yanda suka taimaka da haka din. (Questioned number of children) Ina da Yara hudu.

AIA: Kalabulen ku / Challenges/Perception

TD: Walahi ciwo. Kuma baban abu da farko shi'ne ciwo... in yaro ya samu ciwo ma ko kai ka samu ciwo ma baka sami magani ba ko ka je asibiti ba kagan zai dan kai ka damuwa. In sami magunguna da a' dan taimaka shine zai taimaka ko kana da rashin lafiya ko zai taimaka.

Na biyun sa' kuma panyi abinci... babu **kayi** haka, babu ga Magana kudin makaranta muna fuskanta abubuwa da son samu ne sai ataimaka mana da abinchi da ko magunguna. In bamu da lafiya ma zamu fita mu nema taimako.

(source of livelihood) Kamin mu zo nan, da ma ina noma.

AIA: hawara da ma su kiwon lafiya / Consultation

TD: Ai kan su likitoci suna kan zuwa sunna taimaka, woni lokacin muna da yawa, sai wanda su daga gari sukan zo su yi gaba sai su sami magunguna masu kyau. Sai mu na bayan na, sai ka fada ciwo sai abaka magunguna wanda bazai taimaka ma ka. Sai abaka ...an riga an bawa na farko magunguna masu kyau mu na bayan na sai bazamu sami ...daidai karfi kawai.

AIA: Karshe / Conclusion

TD: Na gode.

6th IDP Participant

AIA: A takaice gabatar da kanki / Introduction

ES: Na farko sunana Esther Solomon. Damuwa ne ya kawomu domin abubuwan da mun facing a kaw-yukan mu; domin na rasa mamana ma a yakin, mun rasa gida, gidan iyaye

na. Na rasa gidan miji ko nima na zo da ciwo don lokacin sun sa'mai ne sun sasare ne. Kuma na yi aure ina da yara biyu. Mun zonan mun gode wa mutane da taimakon da su ke yi. Da ...bamu san ma zamu fita da rai zamu sami wannan taimakon ba. Mutanin garin dai kowa yayi taimakon daidai gorgodon shi. Muna ce wa mutane mun gode domin su ne sukan sa muna da hope a rayuwa domin 'its not easy' (ka bar)- ka rasa duka abinda kana dashi a rana daya ka zo ka fara komai 'a'fresh'. 'so', sune sukan dan taimake mu su kan sa muna da hope na rayuwa. Muna na anan mu kan je guza (tin minning) don mugan mudan kara taimakon junna. Kin ga 'to the extend' ma, inna da 'problem' da za ce ya'kamata a'ce in 'facing' wajin doctor ama babu abin da za yi. Domin lokacin da suka samai ne sun tsare ne a kai. So. kin gan wanda yakamata a' ce lokacin ya kamata in ga likita a gan ni yanzu ina fuskanta shi kullum zazabi, kuma yanayin doka abi mai nauyi kuma yanayin aiki na dolai in yi haka don in 'survive...'

AIA: Kalabulen ku / Challenges & Consultation

ES: Duk wande suka zo dai, zan 'complain' sai abani 'pain relief', ama ni na gani kam yawani na ba na pain relief ba, bazai warka da ni ba, sai ya dan'na ko yanzu ma in ya fara nakan je in' saya. Ton 2018 har yau inna fa'ma da shi.

AIA: Fahimta da shawarwari /Advice & Perception

ES: Toh kin gan a'gyefen shawara, domin ko ba niba, wanda suke fama baza su sami 'opportunity; su gaya wa jama'a ba. In akwai hanya, da hali sai a' taimaka a' panyi rashin lafiya, da yawa sukan nima likitoci ama ba hanya da zasu fada kuma basu da hali. Shi ya sa za ki iya gan abi zai iya faruwa ki gan akwai 'pre-matured dead' ki gan mutun yana ta nishi da shi ba' mai taimako.

AIA: Karshe / Conclusion

ES: Na gode

7th IDP Participant

AIA: A takaice gabatar da kanki / Introduction

NI: Sunana Na'omi Ibrahim. Inna da aure, inna da yara. Ton da rikicin na ya fara daga 2018, inna **neman** wurin zama na ma yaran ma duk sunna na. Sun je Christmas a gida ne -ama sunna zama anan. Maigida na yanna nan. Hmm abinda ya faru, mun ji anfara rikici, toh rikicin ya zo ya shafe mu. Da an karkashe mutani sai maza sun ce mana toh tun da haka, ku fita da yara sai ku bar mu a gida mu zauna, sai mun tashi daga gidan mun dawo nan, mun zo mun zauna da yara a'nan sai su sunna gidan. Toh tun lokacin rikicin ma bai siya ba, muna duba masaman kama ya **damun tashi sun** fara mana, munyi gonna sun cinye abinchin a'gonna tas. Nayi acha, na yi masara, sun cinye tas, basu bar mana kalila ba, rikicin kenan. Su na ta sa shanekai su ci abinchi a' gonakin mu. Toh lokacin bamu tafi ba, muna gidan tukuna sai lokaci da an shiga xxx –named neighbouring village an kakashe mutane sosai. Toh indan sun fara daga waniwuri, sai su bi su zo su sa'mai mu-toh shi ya sa mazaje suka ce mata su bar su agida- ai dalilin kenan.

AIA: Kalabulen ku / Challenges

NI: Gaskiya, masala kam na samu shi, na samu masala jinni na yana sauka baya haura ba. kuma inya sauka haka din, yana bani damuwa sosai. Har sai su gabobi na su dinga mutuwa. Sai kai bazan ji daidai ba' da kuma ulcer. Ina ci wani abu mai zafi, sai yabi ya fadi mun a zuchiya. Sai in ji zafi. Na gaya wa likitoci da ke zuwa ai sun bani magani. Yanzu dama dama, ama saukan jinin, nakan ji shi awani lokaci. Sun ce in'na ji haka sai in sha ruwan sugar. Ai, sai in kara gishiri a' abinci sai in'rika chi. Toh ne ina yi haka.

AIA: Hangen nesa da shawara / Advice & Perception

NI: Toh zaman...akwai abubuwa kai. Muna ne'man taimako ataimake mu don yanzundinma ba'mwa yi wuni abu ba. A' iya taimaike mu.

(Cordiality & communal living) Munahadan kai da wasu yarai da suke a camp babu damuwa.

AIA: Maimaitawa / Translation

NI: Akwai wandada suke jin Hausa toh za'a' iya kai ke wanda za ki iya fada ama da turanchi nnn zamu iya fada da yaran mu. Wanda bai gane ba, sai a' maimaita mashi/mata.

AIA: Karshe / Conclusion

NI: Na gode.

8th IDP Participant

AIA: A takaice gabatar da kanki / Introduction of self

JD: ne ce mai suna Jummai Dauda daga...(). Na rasa mijin aure na a' fada da faru a 2018. Ina da yara kma ina aikin gomnati kamin fadan da faru. Na yi makaranta zuwa college kamin na tafi aure.

AIA: Dalilin da yasa kike nan /What was the reason for being in the camp

JD: Kaman da na fada ah farko, wato Fulanin ne suka kawo harbi ah kawyukan mu bayan sun sa shanakan su sun babata mana gonakinmu sais sun shigo kawyukan da muke zama da dare sun kakashe mutane da dama. Sanan aka sa sojoji da dama su taimaka mana zuwa nan camp washe gari. Gaskiya ba mu samai shi da dama ba ko kadan.

AIA: Kalabulen ku / Challenges

JD: toh ah taikace dai, inna ta fama da ciwon gaba wanda aake kira 'toilet infection'. Lokacin da na fara gannin wana 'discharge' sai na gaya wa likitocin da ke zuwa su gan mu, aka bani magani ama bayan sawon lokaci sai na sake ganni ya dawo. Haka baban yaro na namiji da ked a shekara goma sha bakwai shi ma ya sami masala agaba har ya nema operation. Na bashi shawara day a sake da ma su lura da kiwon lafiyan mu ya gaya masu abin da ke damin sa, bayan haka Allah ya tanada har muka sami treatment na kyaota har ya sami aka yi mashi aiki ah baban asibiti da ke cikin gari. Akwai lokacin da wayansu likitoci sun kawo mana suggestion box domin wanda basu iya maimaita damuwowi su saisu rubuta su sa aciki, na tuna har na rubuta wanan damuna na day a sa ban samai kai na ko kadn ba.

AIA: Gudumawa ma'aikatan lafiya ga kalubale / MPS contributions to the challenges

JD: A taikace dai, likitoci da masu lura da rashin lafiya a nan camp sukan tanada mana sosai. Masanman lokacin da mun zo da farko. Masalan yanzu shine basu zuwa Kaman da, kuma clinic da suka bude babu magani ko alurai indan muna da anfanin su.

AIA: Matsalolin sadarwa / Communication difficulties

JD: Ina da sannin yare biyu wato yarai na da hausa, kuma nakan fada turanci ko pidgin English kadan. Indan wandada basu iya turanci ko hausa sun kan gaya wa nurse da ke lura da clinic sai ta maimaita wa likitocin wani lokaci kuma su kan zabe a cikin likitocin da ke iya hausa sais u lalaba haka.

AIA: Fahimta da shawarwari / Perception and suggestions

JD: Toh shawara na a kan masalan rashin lafiya da mata kan fuskanta a nan ne. Inna so da za a' taimaka da mata masu kiwon lafiya ko kuma likitocin da ke zuwa a kowani lokaci sabo da yawa mu kan rasa taimako lokacin da mu ke bukata.

AIA: Karshe / Conclusion

JD: da karshe, inna so in nuna godiya ga churchi da ken an da kuma mutane da yawa da kan kawo mana taimako. Fatan mu shine ah taimaka mu sami hanya da za mu koma kawyukan mu da kuma gomnati su tanada mana da halin haka.

9th IDP Participant

AIA: A takaice gabatar da kanki / Introduction of self

DC: Sunana Deborah Charlse daga...(inaudible)da ina da aure kamin ya rasu da yara shida. Mun zo sabila da abinda ya faru. Mun gode wa Allah da su ka taimake mu da abunda ya samai mu ba a' barmu a baya ba. Muna da godiya kwarai da gaskiye. Toh ama cikin abinda muka sami kanmu matsolali da muka samu kan mu wani lokaci ana kawo mana taimako wani lokaci da kyer mu samu duk da haka Allah yana biya bukata. Muna ce Mishi -mun gode da... fatan mu shine inda' a'ka cirai am bamu, Allah ya mai ma kowa.

Kuma bukatan mu a'yi mana adu'a soboda Allah ya sa duka komai ya zama da sauki sabila mu sami mu koma gidajen mu.

AIA: Dalilin da yasa kike nan /What was the reason for being in the camp

DC: Yaki ne ya sa muna nan camp. Sakanin garinmu da Fulani-sun hanamu da gonakin mu; gidajen mu ma yazama...(inaudible).

AIA: Kalabulen ku / Challenges

DC: Gaskiya kam wani lokaci mukan fuskanta masala kamar toilet infection din'na. Mukan fama da'shi mu rasa mai za muyi. mu kan je asibiti ma ama bukatan kudi ne toh wani lokacin da ba'ka da kudin ma ka rasa ya zaka fara zuwa asibitin yaya ka za ka je ka fara wa, yaya za baka magani ba kai za a' ita fama haka.

AIA: Gudumawa ma'aikatan lafiya ga kalubale / MPS contributions to the challenges

DC: Su kan bamu magunguna. Kaman ka dan sami sauki, anjuma ya sake dawo. Sukan zuwa su bar mana magunguna a'nan wani lokaci sai ya karai inka zo ba za ka samu ba. Domin mutane kan sun yi yawa. Sun yi iya kan kokarin su. ... () Gaskiya mutani sun yi yawa.

AIA: Matsalolin sadarwa / Communication difficulties

Ah ah. Inna Magana (da MPs) da Hausa. Na kan yi yare na sai Hausa. Ina yi pidgin English kadan kadan.

AIA: Fahimta da shawarwari / Perception and suggestions

DC: Ina gani shawaran da zan iya bayar inna tunanin za a' iya sa mana wasu magungunan in tunanin ko mutane su gaji da mu don wahalan yayi yawa domin gaskiya mutani sun yi kokari sun bamu iya goyan bayan taimako ba shaka. Ama indan da hali, a' aiya taimaka mana da adan sanmana wuni chemist anan in mun dan ji zazabi mu zo mu roka magani. Domin abubuwan suna da zafi yanzu. To bamu mu je munyi gonna ba kuma ba sana'an komai muna yi ba. Ga gonan, ga chi da kyar, kace kuma zaka je ka nima kudin asibiliti, babbu. Ko dan magunguna ne adan sanmana a clinic.

AIA: Karshe / Conclusion

DC: Ina gan yakacin kenan zan ce na gode, mun gode maki Allah ya saka kowa da alheri.

10th IDP Participant

AIA: A takaice gabatar da kanki / Introduction

VD: Ne ne mai suna Veronica David. Ne matan aure ne. Inna da yaro daya sauran sun mutu. Rikichi ne ya fitar damu daga (named) kawye ya kawo mu, bamu taba zama awuni IDP camp ba zaman kenan na farko da muka fita a' 2018.

Abinda ya kawo mu, hakan Fulani kawai suka shigo mana a' 23, June 2018, around 5 0'clock ne suka fara harbe harbe. Toh yin Allah ne kawai da adduwowi ruhun Allah ne ya fito da mu ama sauran mutane sun mutu 'about fifty' aka kashe su. Mu ma yada muka zo nan muna nan muna lalaba rayuwan haka, ba aikin yi, ba abinchi, sai wasu organization suka fara zuwa suka kawo mana taimako, ta hanyoyi daban daban, su kiwon lafiyan mu duk suna taimakon mu. Haka muna nan muna nan dai, government mu dai ba mu gan woni taimanko da government (da) sukayi mana ba har ga Allah. Domin in'da sun taimaike mu zamu fada a'ma basu taimaike mu ba. Ga yaran mu ba makarantu, haka muna lalaba a kore su yau, a'kore su gobai-ba kudin da zamu biya makaranta. Muna rokan Allah government ta taimaka mana yada zamun samu yaran mu su cigaba a makarantu.

Mazagen mu babu aikin yi, mu matan, ba aikin yi. Suka zo suka kore mu daga can' gidaje sun kokone gidaje ba'inda zamuyi. Toh shine mu ke nan. Dama muna chikin nan toh mun zo mu nemai haya domin abin sauki toh mun nema haya muna zama achiki gari muna haya. Hakan dai muna bin kali haka muna ce. Rashin lafiya haka ya zo mu ne mai lokaci mu sami magani wuni lokaci mu bar wa Allah, Allah shi ke biya mana komai. Government ba'sa taimokon mu sakani da Allah. Don suma sun san har ma sunna ce ai babu IDP, sun riga sun salaimai IDPs toh gamu muna nan har'yau a' IDP gida je sun kokone zaka ji ka kama ina, gidan wa (za) kaje ka zauna? Gidan har sun rurushe ma.

Kamin fadan, ina sana'a da gonna da sar da abinchi.

AIA: Kalabulen ku / Challenges in Consultations

VD: Akwai kam, Kaman na "toilet infection" mun dan sami magani toh har yanzu ma akwai chutan da ina fama da shi. Ba kudin da a' ji asibiti. Dah da kudi da na riga na je asibiti ama zai kai ga operation ama haryan zu ina fama ina lalaba da shi haka.

AIA: Gaggawa / Emergencies

VD: Toh akai wuni dan kwanakin baya da ya zo dai, inda dan damuwan operation din haka yana kan tafiyada mutane aje ayi, toh 'Air force' ma sun zo, in kana da dan damuwa na operation da bai yawa ba, sun tafi da mutane sun fi...wa su ma sun zo da damuwan ido an yi su operation na ido. Ina fama da wanan chutan two years kennan.

AIA: Hangen nesa da shawara / Perspective & Advice

VD: Gaskiya shawaran da ne ke da shi dazan bayar ina rokon taimako ne da za 'a taimake mu akan masololin na ("toilet infection") da muka samu, domin bamwa samai shi da sauki ba. Na wa shawaran kenan. Wada Allah ya buda ma shi, ya taimaka mana. Ta hanyoyi da ban da ban.

Akwai gyarai gyare gashi wajen a na zaune haka, ga wurin 'open' shi ya sa muma muka samu muka fita domin nan wurin da muke zaune 'is not safe'. Shine muka fita muka shiga wurin gidaje muka kama haya (could not sustain it).

AIA: Yayin shawarwari / Consultation & Translation

VD: Ai wuni lokaci in wanda basu ji hausa, ana sami wanda yeke 'interpret' masu, sai su yi da turanchi sai ah 'interpret' masu.

AIA: Karshe / Conclusion

VD: Toh mun gode.

11th IDP Participant

AIA: Gabartar da kanku / Introduce yourself

IDP 11 -AN: Sunana Felicia Daniel da'ga Ex-land, Gindin Akwati ward, Gashish district-Barkin Ladi local goverment (Area). Mun zo nan' sanadiyan rikici da a' kayi awajen mu -ishirin- da uku ga watan shida, dubu biyu da'sha takwas- (23-6-2018); an' shigo an' kashe mutani da yara da safe. Toh bayan haka ne (da) mu ka zo /muka dawo anan da zama.

A' zaman mu anan kuwa, mun samu domuwoyi da'yawa, mun sammi matsaloli da'yawa. Domin a can' damma inna da sana'o'i da yawa. An kone shago na', an kone gida na, na fito ba bu komai. Lokacin ma i'na da ciki. Allah ya yi na zo na sauka lafiya a kan (lokaci). Mun zo camp mun samu taimako daban daban ta hannun kungiyoyi da dama. Mun sauka a church, church ne ta fara karban mu, ana mana girki ana ba-ba mu. Da muka zo, kungiyoyi suka fara zuwa suna talafa mana da koyarsuwa inda zamu zauna da ra'yuwan mu, da inda kuma za mu yi hakuri da juna; da mu yafe da abubuwa da'ya faru. Harwayau gamunan muna chikin shekara na hudu kena anan. Mu-ma wuchi shekari na uku muna shekara uku ishirin da uku ga watan shida. Yanzu mun shiga na shekara hudu kenan.Har yanzu munanan anan.

AIA: Tushen rayuwa / Source of livelihood

AN: Ai, da' din inan da gona ina da sana'ah. Ina gona i'na ser da zanuwa kuma, a' shagon, ana dinki, kuma i'na da wurin gyaran kai. Duka a'na yi achiki (shagon) da zanuwa da kayan sa'wa da dogayen riga da inner wear na mata.

AIA: Matsayin abu/Marital status and family size

AN: Ina da maigida na da yara, dama yara biyar ne ah'ka kashe daya a' fadan (a' ka kashe daya) an'kashe maman shi (maigida). Toh an kashe maman maigidana, da yaro na daya. Mai shikara tara alokacin. (Researcher: Allah ya sa' sun huta)- Amin.

AIA: Kalubale/Challenges

AN: Ai, sosai, mun dinga fuskanta da shike mun zo daga garorika daban daban muka hadu a nan. Akwai su kaikayin gaba ah bayan gida in a ka je, in ka je kayi wanka, ko ka sunkuya kayi fisari. Toh baka san waye waye ba, an dinga fama da su kaikayin gaba ne, su maleria

ne, su typhoid da shike ba dakin ka- kake ba- ana kwana awoje. Kowa da kowa, ga dabobi ga komai. Allah ma ya'na tsaraiwa waiansu abubuwa.

AIA: Fahimata da mafita /Perception & Solution to Challenges

AN: Ai toh da wanan kam. Gaskiya, wurin bai yi ace' jinsin daya, jinsin biyu suna haduwa ah woji daya suna anfani. Yakamata a ce an banbanta in'da mata za suyi anfani da shi- da na maza. Sannan kuma a' banbanta mana- muna roko in'dan zai yu a'nima mana randa a' ijiye da ruwa da sinsiya ko' da za a'ce ka zo zaka dan zuba mashi sai ka dan kada inda zaka sunkuya domin mu mata gaban mu yana bude. Kowa zai iya sunkuya ya dauka ba' kaman na miji ba. Sa'nan kuma, in'ba a' raba ba, sai kana kai sai na miji ya sauka ah kanka -bai yiba-.

AIA: Tawili yayin shawarwari / Interpretation during consultation

AN: Ai haka ne, (ina jin hausa da turanchi da yarai). Ai wani locakin akwai wanda ba su'jin hausa, basu jin turanchi. Toh akwai yarai daban daban kuma ba kowani yarai ka iya ba. Toh dole akwai masala anan wurin domin yare barkatai ne. Ba in'da zaka iya yaren kowa. Toh wani lokacin da zasu yi kwantache daide inda ka iya daide gurgodo shi zaka bayar. Toh wani lokachi kuma indan suna nunawa, suna fada suna nuna in'da abu yake damin su, so sai a'kayi kokari sai Allah ya taimaka.

AIA: Karshe/ Conclusions

AN: Na gode.

CONTENT TRANSLATION

1. **1st IDP Participant**

AIA: Introduction

SV: Salomi Vincent is from Bokkos L.G.A and speaks Ron, Kulere and Hausa including English language. She came to the camp since 2018. 'We had no idea what was going on, Fulani's invaded our farm lands, our homes and village killing and destroying our farmlands, store houses and barns.' 'I and my husband are into irrigation farming and we bought seedlings of potatoes with most of our savings; this was destroyed and even the peppers we planted were destroyed.' We are thankful that God spared our lives but we did not find it easy at all if we say we did, we lie.' From xxx where I am from, I lost like 10 people and also from my husband's place. We are grateful to the host community they were hospitable and the churches provided food where we often queue with our children with plates on hand to receive. We are grateful to many NGOs who provided some basic necessities for us. They (Nigerian Medical Association-N.M.A.) even opened a clinic with medicines available for our health care.

Challenges

We had so many challenges at the camp because the truth is that the government did not care for us, they were not forth coming with any help but those organisations that assisted and still assist, we are grateful and we pray God bless them. We had about 13 localities here at the camp and an NGO -**Red cross-** provided toilets for us and we all use it, -men, children and women- as a result, we began to suffer from infections in the feminine region. I believe that infection caused me to even stop menstruating because I suffered this toilet infection too much. When MPs visit, we sometimes find it difficult to explain our health condition. We wish and hope they will provide us medium to properly explain how we feel. Especially shame in explaining how whitish discharge comes out of our private parts to a male medical team

Perception

My advice is that this toilet infection should be looked into because this has led to miscarriage and can also lead to infertility if not properly handled. My views and plea is that government should provide means to treat handle and manage this toilet infections here at the camp by providing a proper hospital and medication for us the IDPs. Also if they can deploy female doctors or Mps whereby one can freely -unashamedly get diagnosis during examination we can freely open up even undressing before the female MPs without shame.

Question

My question is that some of our relatives that lost their lives left some female children -orphans- who are adolescent and are staying with her, these girls are already seeing their menstrual cycle and she had three in her custody. Her concern is if stakeholders can provide sanitary paths to ease their difficulties.

Socio-Economic Status

She is a trained teacher and farmer; married with children. She is in her late forties to early fifties. Speaks English/Hausa/native (MT)-other dialects/ pidgin

Appreciation

2. 2nd IDP Participant

AIA: Introduction

Mama- Mary Abel (85years) is from Fan-Ropp-Riyom**,** she has been at the camp since 2018 due to Fulani attacks. 'We narrowly escaped death and we are grateful to all the people who provide for us food, shelter and necessity' she said. We have little help now may be due to the hardship in the country.

Status

She is a widow with three children, five grand children and she is aged with no source of livelihood now; before the displacement she was a farmer.

Challenges

Bodily pain and especially leg pain, during Mps visits she speaks Hausa language

Perception

The need for food and medication which has always been a challenge according to her should be address. There is no provision of electricity they have been living in the camp without it. They have challenges with the weather which is cold and no blankets to protect them from it. They only have well (source of water which may not be hygienic for drinking-my views because in the villages most times they use water from streams-which flows which is better).

Socio-Economic Status

Mama is an aged grandmother she has no formal education and is a widow and a farmer.

3. **3rd IDP Participant**

Introduction-On 23/6/2018, Sarah Ishaya also known as Faith's mother ('Maman Faith') came to the camp as a pregnant widow who witness criseswhereby Fulanis' attacked them and burnt their house, killing her husband and so many people at the village. She narrated how he died from the hands of the killers and had chance to talk to her and the children before dying. He protected them from the killers by hiding them in the toilet because it is believed that the killers do not check the toilets (normally a rural setting the toilets are constructed outside of the home) and sacrificed himself by remaining in the house to avoid suspicion. After their escape from the crises, they returned to the camp and the church at the host community (Heipang) received them, provided shelter and food for the displaced in their care. She narrated how they queue like orphans (poor) to receive cooked food and this sometimes take a while in coming like they sometimes wait till 2pm to get a day's meal (Being pregnant and lack of food was a big challenge for her). They had to be patient and many churches-(different denominations) at the host community

provided food for them. She and few other pregnant women were at the camp but no provision for mattress or proper feeding was made - she had to sleep on bare floor for a year in her condition and even after she had her baby, before she was lucky to have a better place to sleep in.

The church played a key role in their survival at the camp, the government were not visible and little or no help came from them. She is soliciting for the government to assist them find their feet. She lamented the lack of means to educate their children and especially for her a widow with many children (about 6). She knew three other pregnant women when they arrived at the camp where 13 different communities were accommodated. Sarah hails from Pankshin L.G.A. she understands and speaks the Hausa language and her native Ngas language.

Challenges

She has vagina discharge and even her infant birthed at the camp got infected as a result, she believes it's a transmission from her. She was treated by visiting MPs.

Perception

She lamented the lack of hygienic condition in the IDP camp toilets, and wished the government would provide disinfectants and necessary toiletries &necessary things to reduce the rate of infections. In her opinion, Government intervention can reduce the challenges and sufferings of IDPs through basic amenities, financial provision or subsidies to train children living at the IDP camp.

Interpretation

Interpretationis often used for treatment where there is difficulty in communication however, Felicia Daniel–A.N. - sometimes assist the MPs to interpret to us (the IDPs) in Hausa what the MPs' says.

4. **4th IDP Participant**

Introduction

NP: My name is Nancy Paul and I am in my thirties. I stopped my education at Secondary school class 6 (O'level). She is from Rahoos-Tahoos communit. The reason we are here is due to insecurity and lack of peace in our community. It was insecurity and attacks between their community and Fulanis' that brought them to the camp. 'They burnt our villages and destroyed our farms and we are majorly farmers' she said. Four years ago, Fulani attacked our villagewhere we lost our home, our parents and my partner. I had two other siblings and being the oldest, we became orphans in the camp.

Challenges

Here in the camp, I have so many challenges especially our stay here. First, I was sick but there were no medical supplies at the camp clinic. Some times we have to loose hope befire we even receive help especially in the case of medial care.

Secondly, there is no means for my sibling to further their education even if it is an avenue to learn a trade. I hope the government will provide health care and care for our well being by providing adequate medical supplies, and send in MPs regularly especially female MPs for easy access to our gender concerns.

Other challenges at the camp are that sometimes help is brought through humanitarian aids but it hardly gets to us. 'Toilet infections' and the lack of funds to properly treat one-self is our major challenge. The MPs sometimes give medication and provide healthcare services but the population of IDPs does not help and also their visit is not frequent; this makes it difficult to access medication and most times there is re-infection of this infection (toilet).

Perception

Provision of medication in the absence of MPs and if there is possibility a chemist/pharmacy can be provided. Difficulty to survive and do not have means to treat or take care of their health. She is appreciative of the assistance people, -NGOs and individuals (humanitarian aids) provided in their stay at the camp and wonder if they are

tired because life has suddenly become so difficult with little coming in recently. (There is no mention of government contribution)

Socio-economic Status

She is married with children and a farmer who lost both farmland and home and have no source of livelihood; her educational level is -primary 6.

Conclusion

In conclusion, government should help by re-instating us to our communities that is a better option for us.

5. 5th IDP Participant

AIA: Introduction

TD: My name is Tabitha Duniya from Mangu (Mwagavul) LG.A. What led to our relocation to this IDP camp was due to the attacks by Fulani on our village. We did not know what went wrong and were taken unaware by the Fulani's. That attack led to our excape to this place (camp). We were transported and assisted by the military to this host community. At first, we were kept at the church; the people at the host community welcomed us warmlywith food and drinks-because we came in with children. During the crises, the children were in session and were preparing for the term examination when it happened. Though they had not written exams, we had to excape for our lives. Some humanitarian aid workers at the IDP camp assisted in training the children so they do not forget what they were taught. These humanitarian aids sacrificed their time to teach our children so they keep them informed while they are away from school. They also provided us with food as for the government; we did not feel their impact at all. But the churches were of trmendeous help with provision of food and drink and for that, we are eternally grateful. Apart from food, the church also provided some form of medical supplies for us too.

Before then things had become tedious with the children, my spouse and I were engaged in farming as a source of livelihood but our needs increased with school fees and since we cannot farm to meet the school requirements, the children had to drop out of school. This worried my husband that he had high blood pressure which led to heart attack that left him paralysed.

Before we receive medical help but when things deteriorated, he later died. He left me with our children here at the camp. I wanted to send the children back to our community to study after his demise however, the inseciurity and risks involved and lack of financial aid made me reconsider otherwise. Since there are schools here in the host community, I decided to enrol the children here and ever since, we have been struggling to meet up at times in a whole term, I do not have means to pay for their school fees and other needs; even feeding has been challenging. We are grateful to people for their assistance.

Challenges

I asked how many children she has and she said four. Her challenges at the camp include sickness, especially when the children are sick, they hardly could access proper health care. And they do not have the means to pay for medical care (treatment) at available hospitals /clinics at the host community. She wished they could be provided with medical care and free access to that too; this she said will help the IDPs.

Secondly, the issue of food scarcity, she said there is no provision of essential food. Also, the issue of education for their children considering they do not have means to pay for their wards education. 'If only they can provide food and basic medical care, it will reduce our going out to look for help when we are sick,' she said.

Experiences with Medical Consultation

Her experience with medical consultation is that, they are attended in large number, sometimes people from the host community attend the medical services provided for the displaced and since consultation is on first come, first serve basis, some of those people receive the best medication and those who comes later do not.

6. 6th IDP Participant

AIA: Introduction

Esther Solomon is from Bokkos (speaks Kulere language) village she came to the camp since 2018 due to the prevailing insecurities and previous attacks at her home town... she narrowly survived the attack because she was caught and machete was used on her head and body; she came to the camp with wounds on her body. She is married with two children but lost her house and that of her parents who werekilled during the crises.She appreciated the host community and all NGOs who provided for them since they got here. She said it is because of these humanitarian aids that gave them hope because it is not easy to lose everything you have and become a dependant. Presently she is into tin mining as a way of sustenance (I observed an open mining taking place along the road to the host community).

AIA: Challenges

'I some health challenges due to the injuries inflected on me, they hit me on the head with a cutlass and needed to see a specialist' but I am not buoyant enough to see one 'she said. And the MPS can only provide pain killers for my situation, whenever she get sick which is often.Despite her condition she still goes out to source for daily livelihood.

AIA: Did you present your situation to the MPs

If she discusses with the MPs, she said yes but they could only provide pain killers. What she thinks she needs is an –x-ray and proper investigation into her health condition.

Perception

'I speak for not just me but for others (IDPs) who need MPs or specialist but cannot get access to proper health care as a result some experience premature death due to this challenge. She is of the opinion that a proper health care should be provided and proper medical investigation to reduce mortality rate.

Socio-Economic Status:

AGED Bet 30-35yrs; married, low level of education jss; she speaks a little bit of English, Hausa and her native language. She is a farmer and now into tin mining as well.

7. 7th IDP Participant

AIA: Introduction

NI: My name is Na'omi Ibrahim (from Du) I am married and have children. The crises began in 2018 and that led to our displacement (I my children) and we sought shelter here at the IDP camp. (At the time of this interview, her children traveled) the children traveled for Christmas holiday but they are a par tof the people staying at the camp. What happened was that we heard there was a crisis and it later affected our community. We lost so many people. The men decided we (women & children) leave for safetywhikle they remain behind.

Long before the crises began, the Fulani's have been terrorizing our communit, we will farm and they will come in at odd hours to destroy and vandalise our farmlands. Since farming is our major source of survival, for example, I farm mostly grains like Acha, corn, etc, they bring bring in their cows to eat and destroy what is remaining of the crops. That act triggers the clash.

Challenges

Sincerely speaking, I have several challenges like health: high blood pressue, constant headache and ulcer. I told the MPs on visit here and they gave me some medication. I felt relieved hen and the high blood pressure occassionaly disturbs. I was advised to take diluted sugar in water and increase my salt intake.

Perseption/Advice

My advice is to solicit for help and means of livelihood for us here. We are idle and need some form of trade for sustenance.

Conclusion

In conclusion, I would like to say there is peaceful coexistence at the camp despite the diversity-many languages and dialects existing here. We live in peace with one another.

8. 8th IDP Participant

AIA: Introduction:

JD: Jummai Dauda is from Riyom (Gyl Kuru-Vwang cluster) she came to the camp in 2018, she is married and a Farmer who left her community due to the attacks by Fulanis'. She has 4 children (adolescent and young ones). She is between 45-50years of age. Her level of education is JSS 2 (high school) and she is a farmer.

Challenges

Her children often come to see MPs for fever and other related illnesses.

Interpretations

Her challenge is poor knowledge of the Lingua Franca however; there are room for interpretation during consultations.

Perception

'If the world sleeps well, all sleeps well' she said. Her advice is in the effort of government to ensure there is security so that all can live peacefully and these problems can be avoided.

9. 9th IDP Participant

Introduction

I am Deborah Charlse from Rahoss-Tahoss community, and I am married with a child I have lost other children. It was insecurity that forced us out of our community, we have not stayed at any IDP before now but we have been here since 2018.

Why we left is because the Fulanis' invaded our homes on the 2rd of June 2018 in the evening around 5pm we were overtaken and defeated. It was only the grace of God and His spirits that protected us and brought us out alive but so many people lost their lives in the crises-over fifty people were killed.

When we arrived here (the camp), we began to settle in and manage our lives then later some organisations began visiting and provided some basic needs like food, clothing, etc for us.W did not enjoy any help from the government, God is her witness she said (she swore).If the government assisted us in any way, we will say they did. Here we are faced with so many challenges ranging from feeding, no livelihood or means to educate our children, etc. Our childrenget kicked out of school always due to failure to pay fees. We are pleading to the government to assist us so we can train our children and live a better life.

Our men have no jobs or sources of livelihood and we the women have none as well, these people (Fulanis) came and destroyed our homes, burnt our place and destroyed our lives by rendering us homeless and jobless. Sometimes we get ill/sick we and are provided with medical care other times, we cannot even have access to medication for our health conditions, it's only God that will repay. The government have not helped in any way and they know but are saying there are no IDPs because they claimed they have settle and reinstated IDPs but here we are at the camp. Where will you go? Whose home will you go and stay since yours has been burnt and or destroyed? Before the crises/displacement, I was into small scale business and I farm too.

Challenges

Yes, like 'toilet infection.' We are provided with medication however, sometimes, we do get re-infected and it has been a lingering disease here in the camp. There is a disease I am still suffering from. This sickness needs surgery and I do not have money to visit a conventional hospital that is why I am still managing with it.

Emergencies

Wella humanitarian aids worker came sometimes ago and attended to some emergencies by providing free surgeries for those in need at the city canter. Another time, the Air force also provided free medical surgeries for those with eye problem.I have been managing this condition for two year now.

Perspective/Advice

The advice I can give is a plea if only we can have solution to this 'toilet infection' that will help us because we do not find it easy at all. Any meaning individual who can afford should help in any little way they can.

There is no security the camp is so porous that is the reason we worked so hard toget a safer accommodation outside the camp by renting a place, (however I learnt later the difficulty to sustain their selves brought them back to the camp).

Consultation and Translation

Some of the times during consultation (which is open), those who do not speak English or the Hausa language request for someone to interpret during medical consultation.

Conclusion

We are grateful.

10. 10th IDP Participant

Introduction

Veronica David is from Bachit**, she** came to the camp due to the crises that erupted in 2018 in their community the men decided to stay behind while the women and children were asked to leave for safety due to invasion by the Fulani herdsmen who destroy their farmlands and invaded their homes after attacking other villages. This has been ongoing in the State.

Challenges

She has low blood pressure, as a result she often feels weakness in her knell; she also suffers from ulcer and these two has been a constant problem for her. The knowledge of her situation (that the Mps asked her to drink sugar water and add salt to her meals) and she has been keeping to the MPs advice but the low blood pressure is still a problem for her. She said there is/had been no problem within the ethnic groups (13), they co-habit peacefully.

Socio-Economic Status

She is married with children and does not have any formal education; and she is a farmer. She is an adult in her early fifties.

Interpretation

The patients often speak to an interpreter either in local dialect or Hausa language; this is interpreted for the Mps who speaks Hausa and the medical condition is identified and further interpreted to other MPs who only speak English for diagnoses and treatment.

11th IDP

Introduction

Felicia Daniel (aka Aunty Nurse.) is from Ex-land, Gindin Akwati ward, Gashish district-Barkin Ladi local goverment area of the state, she (pregnant then) and her family came to the IDP camp on 23/06/2018 following the crises that occurred in their community. During the crises, she (they) witnessed the killing of people especially men and children. On arrival at the camp, they were faced with a lot of problems and challenges. Before the crises, she was a business woman (an entrepreneur) who was independent. However, the aftermath of the crises led to losing her businesses (burnt shop), her home (burnt) and she was left with nothing. Theywere provided shelter on arrival at the camp; after settling in at the camp, they received some donations and aids from groups and spirited individuals. For instance, it was the church that first received them in the host community; later some

groups such as -NGO's visited and encouraged them on how to settle and manage life while at the camp; how to learn to live with others at the camp and how to live through forgiveness despite what had happened. She said 'This is the 4th year 'we are here.'

Life before the camp /status

She is an entrepreneur and lost everything. She is married with five (5) children, though she lost one of her sons (9yr) old as at the time of the crises and her mother in-law was also killed during the crises. She was pregnant when they were displaced and she birthed her last child at the IDP camp.

Struggles/challenges

Yes, like 'toilet infection' and malaria/typhoid because they sometimes had to sleep outside and because of the prevalence of mosquitoes, they often fall ill.

Perception

Yes, the toilets are not conducive; there need to be distinction between the sexes for use because the female organ is open and can easily contact diseases and likewise lack of privacy-sometimes the male barge in on the females. She also raise the need to provide basic provisions for proper hygiene of the toilets like drums-water reservoir-, disinfectants, toilet- brush, etc.

Interpretation during consultation:

Yes, I speak English, Hausa and my local dialect. I also assist the MPs to interpret for those who cannot speak or understand the lingua franca or English during consultation. I have limitations because there are so many languages here at the camp and I can only interpret the ones I understand although some of the IDPs point where they have problems with and I tend to get idea and through such body language, I manage to interpret what I am able to understand at the time for the MPs who are not able to understand or speak such languages-lingua franca/native language.

Socio-economic status/Educational attainment-

A’level, a trained health care practitioner (average class)-she is a small scale business owner before being displaced and **an** adult between 40-43years of age.

Appreciate/further plans to meet.

Medical Records & Documents

Due to ethical reasons, medical records and documents containing participants' details are not attached here.

List of abbreviations

AIA	Abigail Izang Ambi (Researcher)
AN	Aunty Nurse (key informant/ participant)
CAN	Christian Association of Nigeria
FAAN	Federal Airport Authority of Nigeria
FRSC	Federal Road Safety Commission
GOs	Governmental Organization
ICVA	International Council of Voluntary Agencies
IDPs	Internally Displaced Persons
IGOs	Intergovernmental Organizations/International non-governmental Organizations
IOM	International Organization for Migration
LE	Linguistic Ethnography
LGA	Local Government Areas
MSF	Medicines sans Frontiers
MPs	Medical Practitioners
MT	Mother Tongue
NGOs	Non- Governmental Organizations
NEMA	National Emergency Management Agency
NMA	Nigerian Medical Association
NPE	The National Policy on Education
SEMA	State Emergency Management Agency
SSS	State Security Service
UNICEF	United Nations International Children's Emergency Fund

UN	United Nations
USCR	United States Committee for Refugees
UNHCR	United Nation Human and Children's Right
UNHCR	United Nations High Commisioner for Refugees
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
NCR	National Commission for Refugees
UNDP	United Nations Development Service
UNHRA	United Nations Human Rights Agenda
WCC	World Council of Churches

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