th Study of the Knowledge, Attitude, Behavior and 
Behavior (KABP) of Internally Displaced Persons (IDPs) in 
Towards HIV/AIDS and their Health Status and 
Medical Care Assessment

Under the 
Auspices of the UN Country Team and 
with the Support of the Netherlands Government
In-depth Study of the Knowledge, Attitude, Behavior and Practice (KABP) of Internally Displaced Persons (IDPS) in Ethiopia Toward HIV AIDS and their Health Status and Medical Care Assessment

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<td>AIDS</td>
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<td>HC</td>
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<td>Knowledge Attitude and Behavioral Practice</td>
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<td>MOH</td>
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<td>MOLSA</td>
<td>Ministry of Labor and Social affairs</td>
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<tr>
<td>MCDO</td>
<td>Mother and Child Development Organization</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>OSSA</td>
<td>Organization of Social Services for AIDS</td>
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<tr>
<td>PLWHA</td>
<td>Person Living with HIV/AIDS</td>
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<tr>
<td>REST</td>
<td>Relief Society of Tigray</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>STD</td>
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<tr>
<td>TB</td>
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Acknowledgements

The UN Country Team in Ethiopia launched a consolidated appeal in August 2000 for Internally Displaced Persons (IDPs) in Ethiopia. The HIV/AIDS component received a contribution from the Netherlands government to carry out a Knowledge, Attitude, Behavior and Practice (KABP) survey among the IDPs which was carried out in two phases.

While the first phase identified and mapped the major IDP groups and sites in Ethiopia, this study focused on documenting and analyzing the behavior and attitude of IDPs towards HIV/AIDS. The study, which covered eight IDP sites throughout the country and combined qualitative and quantitative methods to collect data, was carried out with the support and contributions of a lot of individuals.

We gratefully acknowledge the professional contributions of Dr. Meera Sethi of IOM Addis Ababa and the support of the UN Theme Group on HIV/AIDS.

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Finally, we would like to express our sincere gratitude to the IDPs and their leaders and/or representatives without whose critical support and participation this study would have been impossible.

Thank you all.
Executive Summary

The in-depth study of the knowledge, attitude, behavior and practice (KABP) of internally displaced persons (IDPs) in Ethiopia toward HIV/AIDS and their health status and medical assessment included eight selected sites throughout Ethiopia. These are, Kaliti and Mesalemia (in Addis Ababa), Shashemene and Shakiso (in Oromiya), Hararisheik (in Somali), Loggia (in Afar), Zalambesa (in Tigray), and Metema (in Amhara regions). The study showed the following major characteristics of IDPs in these sites:

- Over 90 percent of IDPs in all sites have been displaced for more than three years and the causes of displacement include war, conflict, drought and unemployment.

- More than 89 percent of IDPs are women and children, over 60 percent have families, many of which are headed by women.

- Site life is characterized by high mobility within and outside the sites, mostly motivated by the desire to find employment opportunities. Unfortunately, it is this widespread mobility that exposes IDPs to risky behaviors such as pre and extramarital sex, commercial sex, rape, sexually transmitted infections (STIs), HIV/AIDS, alcohol and drug abuse.

- Although to varying extent, IDP sites severely lack basic necessities including adequate food, clean water, shelter and access to health care. Available health facilities experience chronic shortages of manpower, medicine and equipment.

- Many IDPs have heard of HIV/AIDS, can articulate transmission and prevention methods, and many have an idea of symptoms related to, and signs of, HIV/AIDS. However, HIV/AIDS remains widespread in the sites studied.

- Tuberculosis, pneumonia, diarrhea, as well as an array of other opportunistic diseases are mentioned as the main causes of mortality. IDPs routinely practice risky sexual behaviors including commercial sex that expose them to HIV/AIDS.

- A majority of IDPs support testing for HIV, is eager to learn their sero-status, and would be careful not to infect others if they know their sero-status. Some, however, also say it is good to have the blood test in order to isolate those HIV positive people and put them in a separate place.
Many IDPs say they will not disclose their status if they were found to be HIV positive; they fear discrimination and isolation by the community. But, few say they would disclose and even start teaching the community on preventing HIV infection.

IDPs who are HIV positive tend to hide their status and continue to infect others knowingly or unknowingly. There are misconceptions about transmission and prevention of HIV/AIDS, religious beliefs about sexual behavior, gossip and rumor in the community, and blame for being immoral and promiscuous as well as self stigma caused by feeling of worthlessness.

In order to address the adverse conditions of IDPs and effect behavioral and attitudinal changes toward HIV/AIDS, the following ideas are forwarded for programmatic interventions:

- Immediate steps should be taken to address the food, water and shelter needs of IDPs as well as livelihood opportunities. At present, most IDPs have no employment or land to farm, or bury their dead; Harsiheik IDPs being a case in point.

- Health services to IDPs need to be given special attention since they are exposed to all sorts of illness. Government health facilities, although largely accessible, are ill equipped and poorly staffed to meet the health service needs of IDPs. It may be necessary to encourage more non-governmental organization (NGO) based health facilities to provide health services. The presence of a local NGO called Mother and Child Development Organization (MCDO) has become of great help to the IDPs in Harsiheik, for example.

- Voluntary testing and counseling (VCT) services need to be expanded to determine the HIV status of IDPs. It would also be important to prepare the IDP community to give care and support to IDPs living with HIV/AIDS. At present this not available and there is nothing that motivates a HIV positive IDP disclose and, hence, openly work with the community to stop the spread of HIV/AIDS. International Office of Migration's (IOM) support to VCT in Shakiso has made a difference, for example.

- Adequate support should be given to those Anti-HIV/AIDS groups and associations that are engaged in providing education, care and support to HIV/AIDS patients. Some such organizations, although newly formed, have been accepted by communities for their good work to develop clear understanding of the disease and what care and support PLWHA need from
the community and health institutions. They have succeeded to some extent in bringing PLWHA and the community together in the fight against the infection. The activities of the anti-AIDS youth associations in Shashemene can be cited as good example of effecting behavioral change in the community.

- Educational programs have to be designed to address misconceptions about HIV/AIDS so as to help the communities develop self-efficacy in protecting themselves from the infection. Misconceptions on transmission and prevention of HIV/AIDS, about providing care and support to HIV/AIDS patients, as well as the negative attitude towards the use of condom and towards HIV patients associated with fear of contagion, need to be addressed through educational framework.

- Education on HIV/AIDS transmission, prevention and care would be meaningful to IDPs only when they are able to see a future for themselves. This is a pre condition to bringing about changes in behavioral practices that help control the spread of HIV infection.

- Attitudinal change towards sex and sexuality is necessary in the fight against HIV/AIDS. Many IDPs do not openly discuss sex and the critical issues in reproductive health have remained taboos. Attempts need to be made to change this attitude of hiding and not disclosing important matters related to reproductive health.

- Expanding sex education by involving the youth and parents as well as community and religious leaders can help bring about attitudinal change. Programs and projects that enhance openness in sex and sexuality issues have to be developed and supported. The big problem in HIV/AIDS prevention is the fact that it is a sexually transmitted disease and people are not ready to discuss sexually related issues openly.

- Programs that address youth reproductive health, welfare and employment have to be in place. Most of the sex workers as well as the young men involved in risk behaviors emigrate because the problems of the youth are not addressed. The IDP youth in particular do not see any future in themselves. They are exposed to all sorts of problems: hunger, disease, unemployment, and mistreatment. Designing programs that focus on youth health and employment opportunities, based on skill acquisition training, may create conducive environment for bringing change in behavioral practices.
- Special attention needs to be given to women and children since they are the primary victims of displacement. MCDO in Hartisheik is doing a good work, although very limited. Programs that focus on women and children’s well being need to be designed and those in place need to be supported and expanded.

- Rehabilitating all IDPs in places where they can lead independent life must be a priority. This would address both the psychological and material problems of IDPs. Many IDP would like to be rehabilitated in their places of origin or else where. They would like houses and means for generating income. The IDPs in Shashemene are asking for resettlement in an area where they can farm and live as farmers. Most of the IDP in Hartisheik would like to be rehabilitated in their home of origin. All attempts to rehabilitate IDP by taking them out of their present conditions and giving them sustainable support until they are able to stand on their feet need be supported.

- The long-term programs need to focus on poverty reduction. This includes making education, health, social, cultural, political participation accessible to all; ensuring employment and creating a stable and peaceful society; building good governance and democracy; and respecting the human rights of all.

- It needs to be underlined that poor governance leads to conflict, war, and poverty. Military mobilization enhances the spread of HIV/AIDS. The availability of sex service at cheaper price enhances the spread of HIV/AIDS. The displacement of people due to internal or external war/conflict and unemployment enhances the spread of HIV/AIDS.
Chapter 1

Displacement and HIV/AIDS: An Overview
The Major Causes of Displacement

Ethiopia has had several civil wars and conflicts that disrupted the peaceful life of its people. In addition to lack of political stability and peace, it has been subjected to repeated drought and famine that have forced millions of people to migrate to other parts of the country in search of food, employment and shelter. The Ministry of Labor and Social Affairs (MOLSA, 1994/5) estimates that the number of displaced people to be 1,670,326.

Displacement in Ethiopia is not a new phenomenon. In the early 1970s, famine and drought were the major causes of massive displacement and misery. Since then, wars, ethnic conflicts and chronic unemployment have become additional factors for displacement under successive regimes.

The drought and the subsequent famine of Wollo and Tigray in 1974 were the major causes for displacement and death of millions of people. Today, Somali and Oromo nomads affected by drought, and poor farmers from other ethnic groups are temporarily settled in the different valleys in Shakiso Wereda. They have become gold miners and live in sites with little (if any) educational and health services available to them. They lead a very harsh and risky life, and are exposed to all types of diseases. Similarly, drought, coupled with lack of security in the Ogaden, is forcing thousands of people to flee their habitats. The IDPs in Hartisheik are displaced because of drought and war in the Ogaden. Drought is also a problem in Afar and has been displacing people from their homes and livelihoods. Most of the present residents in Loggia were also originally cattle breeders who are now forced to live as petty traders in sites.

When the EPRDF led government was formed in 1991, it introduced an ethnic based administration as a political solution to the question of nations and nationalities. However, this type of regional administration has not been smooth as hoped. It triggered ethnic conflict causing hundreds of thousands of people to be displaced from their settlement areas. The IDPs in Shashemene and its environs as well as the IDPs in Gode are examples of people who were evicted because of the ethnic conflict that ensued in the early 1990s.

The 1998 border war between Ethiopia and Eritrea caused massive displacement of people in the border areas including deportation of Ethiopians living in Eritrea and vice versa. The IDPs of Zalambesa in Tigray and Loggia in Afar administrative regions as well as the IDPs at Kaliti and Mesalemja in Addis Ababa are displaced due to the tragic border war. The deportees from towns in Eritrea numbering tens of thousands who are now leading very difficult life, are examples of IDPs as a result of inter state conflict.
Unemployment is another factor for displacement. Tens of thousands of demobilized former soldiers of the Derg and Ethiopian Peoples Revolutionary Democratic Front (EPRDF) and unemployed youth from urban as well as drought-affected rural areas have ended up as IDPs in various sites in the country, particularly as gold miners in Shakiso site. They live exposed to diseases including HIV/AIDS.

Consequences of Displacement

Displacement makes people obscure, since their social environment is unique in that all sorts of people coming from different regions with different cultural and religious background are forced to live in a site or shelter together. Consequently, they lack identity and a shared reference for regulating their way of life. Unlike refugees, IDPs do not have international recognition. They are classified as internal matters of sovereign countries. At times, they are also political victims. They are not given the support they need to lead a normal life even from national governments.

Displacement affects the well-being of people irrespective of age and gender. Many children die and many women get raped on their way to temporary shelters. Many families are disrupted. The men heads of family in most cases abandon their families in search of job opportunities. Some also get killed in wars/conflicts. Young women are forced to engage in sex work to support themselves and their families.

Displaced people have no right to choose or decide where to live. They settle in marginalized, risky and hazardous areas. Kaliti and Mesalemia IDP sites are densely populated and exposed to sanitation problems and communicable diseases. Shashemene is a business center where many merchants and truck and bus drivers use as a transit and engage in all sorts of risky behaviors including commercial sex. The Shakiso site is crowded with bars, bar girls and alcohol, which are the only means of entertainment. Hartisheik, Loggia, Zalambesa and Metema share the same features, as trade centers, routes and campsites for soldiers. Hence, most IDPs, one-way or another, are at risk of being infected by communicable diseases.

The Threat of HIV/AIDS

HIV/AIDS is a big threat in Ethiopia. Many millions are infected with the virus and several thousand are being infected daily. The HIV/AIDS prevalence rate in Ethiopia is estimated at 6.6 percent (UNH, 2002). It is believed that in urban Ethiopia at least one in six is HIV positive. The death rate particularly among the youth is on the rise. Displaced people, having little access to social services such as education and health, are particularly vulnerable to HIV infection. Although HIV/AIDS has been killing indiscriminately, it is becoming apparent that the poor and marginalized sector of the society is the most vulnerable group. Poverty and displacement expose people,
particularly women, to risk behaviors such as sex work for income and sex with multiple partners as well as forced sex. Lack of access to education and health services blocks people from being aware and informed about problems that threaten their very survival, and from acquiring the skills and behavior necessary to help them deal with the problems.

Heterosexual relationship is the major cause of infection; over 90% of the cases in Ethiopia, for example. The other ways are mother to child transmission during pregnancy, delivery and breast feeding; use of unsterilized medical tools; use of infected blood during blood transfusion; some harmful traditional practices that involve body mutilation using unsterilized tools such as razor, knife, blade etc.

Today HIV/AIDS is recognized as a major health risk among IDPs as well as the general population in Ethiopia. Attempts are being made by government and non-government organizations to make the people aware of the ways of transmission and prevention of the infection. The international community through its various organizations is showing concern about the disease. Seminars and conferences on HIV/AIDS are being held at all levels of local and international structures involving political and religious leaders, scientists, activists and interested groups. Although the awareness raising activities have helped people realize the threats of HIV/AIDS, sexual related practices and behaviors have not changed as desired, for unsafe sex is still practiced widely. The question is why is that awareness is not influencing behavioral practices as desired.

The fight against HIV/AIDS has proved to be a much more complex problem than expected since it is not a simple health matter where you talk about preventive measures. One cannot address HIV/AIDS devoid of the socio-cultural, economic, and religious context in which the infection occurs. Unsafe sex for money, displacement, stigma and poverty all expose one to HIV/AIDS. On top of this, health care systems are not well organized to deal with the problem. Communities are not well informed to deal with HIV/AIDS related stigma and the resulting discriminatory practices, and give care and support to PLWHA. Government institutions lack the capacity to implement policy and programmatic ways to control the spread of the infection. Moreover, droughts, wars and economic problems displace people, exposing them to bitter social, economic and health problems.

This study assesses the knowledge attitude and behavioral practices of IDPs toward HIV/AIDS and their access to health delivery services. It attempts to identify the needs of the IDPs toward protecting themselves against HIV infection. The following chapters discuss the methodology of the survey, the findings and the ideas put forward for designing HIV/AIDS intervention programs in the IDP sites throughout the country.
Chapter 2

Research Objectives, Expected Outcomes and Methodology
Research Objectives and Expected Outcomes

This study is conducted in eight selected IDP sites throughout the country: Kaliti and Mesalemia (Addis Ababa administration), Shashemene and Shakiso (Oromiya Administrative region); Hartisheik (Somali administrative region), Loggia (Afar administrative region), Zalambesa (Tigray administrative region) and Metema (Amhara administrative region) (Annex 1a-f).

This study is a continuation of the first study on IDPs in Ethiopia which mapped IDP site locations, population size and reasons for displacement. It also identified a total of 30 sites with IDPs localized to a particular site. The total number of IDP localized adds up to 115,111. Somali region has the largest number of IDP localized to a particular site (26,000), followed by Tigray (19,553), Afar (18,350), Addis Ababa (17,820), Amhara (17,209) and Oromiya (16,170). Most IDPs have stayed in their site from 3 to 10 years.

The main objective of this is to identify the knowledge, attitude and behavioral practices of IDPs toward HIV/AIDS, as well as to assess their health status and access to health services.

The specific objectives of the study are to document and analyze:

- The knowledge, attitudes, and behavioral practices of IDPs toward HIV/AIDS by different groups of IDPs,
- The specific determinants that increase the risk of HIV transmission among the IDP population, and their analysis by different groups of IDPs, and
- The IDPs' needs (actual and projected needs) toward social and medical services dealing with HIV/AIDS prevention and support as well as access to existing social and medical services.

The expected outcomes include:

- A detailed report on knowledge, attitude and cultural practices of IDPs toward HIV/AIDS,
- An assessment of the HIV/AIDS situation in IDP sites, and
- A set of recommendations that lead to appropriate interventions dealing with HIV/AIDS prevention care and support to IDPs.
Methodology

The research methodology follows multiple data collection processes involving qualitative and quantitative data. The qualitative data are collected using in-depth interviews of key informants and selected members of the target group as well as focus group discussions (FGDs). The quantitative data are collected using a structured survey questionnaire of randomly selected respondents in each IDP site. The data collected are triangulated to identify the major and cross cutting themes that describe the conditions, needs, and behavioral practices of IDP in relation to HIV/AIDS.

The qualitative data gathered through in-depth interviews and focus discussion groups are recorded, transcribed, translated and organized by themes. The quantitative data are used to conduct both univariate and bivariate data analyses that are used to identify the critical issues of IDPs as a whole and by selected characteristics. Themes that come out strongly in the qualitative and quantitative data are triangulated, and those themes that are supported by evidence collected from the respondents are used to describe the knowledge, attitude and behavioral practices of IDPs towards HIV/AIDS as well as their access to health services. Ways forward and program implications are suggested based on this evidence.

Information is gathered from a cross section of the IDP population, which helps to representatively gather information from the target group. In-depth interviews from key informants and randomly picked IDPs and FGDs of different groups (male, female, youth, etc.) give deeper understanding of the IDP population in the sites visited. Univariate analyses help highlight the common issues of the target groups while bivariate analyses help show the specific issues by selected background characteristics. Nodding qualitative information helps identify themes whereas triangulating data validates the themes identified and arrives at valid and reliable conclusions and recommendations.

Research Instruments

Three survey instruments are used in this study: (i) the structured survey questionnaire, (ii) the medical and non-medical in-depth interview guide, and (iii) the focus group discussion guide. Moreover, available documents in the health facilities giving service to IDPs, and observations of medical facilities and the conditions in the sites are used to supplement the data collected using the research instruments. The instruments, developed in consultation with the staff of IOM and the World Health
Organization (WHO), were pre-tested in Addis Ababa IDP sites for clarity and practicability before being used for the study.

A group of interviewers who have been working at the Miz-Hasab Research Center (MHRC) for several years were trained for two weeks on the use of the survey instruments. Consequently, two teams of six people each were formed that included two medical specialists and two senior consultants. One team surveyed Mesalemia, Shashemene, Zalambesa and Metema IDP sites while the other surveyed Kaliti, Shakiso, Hartisheik and Loggia sites.

The Survey Design and Analyses

For the quantitative data, a total of 1,243 respondents were randomly selected and interviewed using the survey questionnaire. For the qualitative data, a total of 53 in-depth interviews (5-8 in each site) involving medical and non-medical informants (Annex 2), 22 focus group discussions (24 in each site) involving 6-13 participants were conducted (Annex 3).

The quantitative data are analyzed using SPSS/PC+, a statistical package for the social sciences. Bivariate analysis of behaviors of IDPs were made by selected background characteristics such as age, gender, marital status, ethnicity, location, education and religion. Both univariate and bivariate analyses were used to identify the determinants of knowledge, attitude, behavior and practice of IDPs towards HIV/AIDS and their access to health delivery services.

The qualitative data collected from key informant interviews and FGDs were transcribed verbatim, analyzed thematically and summarized. Notes taken by researchers during the field trip were included to enrich the discussions of the findings. Medical reports and records were examined to determine conditions of health facilities in terms of staff, equipment, drugs and major diseases of morbidity and mortality.

Triangulation of major findings from the structured interviews, in-depth interviews, FGDs and notes was made to identify the main factors that determine the behavioral practices of IDPs towards HIV/AIDS and access to health delivery services. On the basis of the findings suggestions that have programmatic implications are forwarded.
Chapter 3

Demographic and Socio-economic Characteristics of Internally Displaced Persons (IDPs)
General Characteristics of IDPs

The estimated IDP population in the eight sites visited is 56,619: Kaliti (1,600), Mesalemia- (2,000), Shashemene (6,964), Shakiso (12,000) Hartisheik (19,305), Loggia (4,500), Zalambesa/Adigrat (3,200) and Metema (4,050).

Based on the 1,243 IDP respondents in all sites, the top four places of birth are Amhara (30 percent), Oromiya (21 percent), Tigray (21 percent) and Somali (12 percent). 49 percent are women and 52 percent men, all ranging between age 15-59. The mean age is 29.6 years; 31.7 years for men and 27.4 years for women. Fertility is high among IDPs. Over 65 percent of families have four or more children. Sexual activity is very high, too, in all sites visited.

Christians comprise 70% of the IDPs and the remaining 30 percent are Moslems. 64 percent have some education while the remaining 36 percent have no education at all. Half of the IDPs are married and monogamous, 35 percent single, 3 percent polygamous; 4 percent widowed and 8 percent divorced. 54 percent have children living with them, of which 11 percent have children under one year old. 79 percent have been displaced for more than three years. 44 percent usually speak Amharic, 17 percent Somali and 17 percent Tigrigna. Before displacement 19 percent were unemployed, 18 percent were students, 8 percent were housewives and the rest 45 percent were laborers, service givers and farmers.

On the basis of information obtained from key informants, over 80 percent of the IDP population is composed of children and women. Women head over 65 percent of the IDP households. Most women that head families are separated from their husbands or widowed. Most men leave their families to look for jobs elsewhere and lose connection to their families after separation. In Shakiso about 40 percent of the miners are single and most of them have no connection with their families. Those families that are currently headed by men also experience separation for a period ranging from a week to several months. Men move from place to place in search of jobs and better opportunities, while their wives stay in the camps to look after their children.

Ethnic and religious composition of IDPs is determined by geographical location and by reasons of displacement. Almost all of the IDPs in Zalambesa are all Tigrawi; over 90 percent of the IDPs in Hartisheik are Somalis; over 49 percent of the miners in Shakiso are Oromos; over 70 percent of the IDPs in Metema are Amhara; over 80 percent of the IDPs in Shashemene are Kambata and Hadiya; over 60 percent of the IDPs in Loggia are Afars; and over 50 percent of the IDPs in Addis Ababa are Amharas followed by over 20 percent Tigrawi. The major reason for displacement is...
war/conflict. However, drought and unemployment also play a significant role. Almost all the IDPs in Addis Ababa, Zalambesa, Shashemene and Metema are Christians; over 65 percent of the IDPs in Shakiso are Christians and the rest Moslems; Most of those in Harsheik, Afar, and Loggia are Moslems (Annex 4.1).

The IDP population is dynamic. In Harsheik and Shakiso, it is on the rise. The drought and conflict in Ogaden is forcing families to flee and join the IDP sites in Hartisheik. One camp has grown from a size of 700 households in March to 1,028 households in April of the same year. Many unemployed youth, drought victims and farmers are flooding to the gold mines in Shakiso raising dramatically the size of IDPs there. However, the IDP population in Addis Ababa, Zalambesa, Metema and Loggia is declining.

There have been several IDP rehabilitation activities undertaken by the government and humanitarian organizations: The Ethiopian Orthodox Church (EOC) has rehabilitated 684 families; the IDP Affairs Bureau, 157 families; LVIA (Live Volunteers International Association) 95 families; Norwegian AID, 31 families; and Propride, 78 families from among the Addis Ababa IDP. Most of the 37,794 deportees from Eritrea that temporarily settled at Adigrat are rehabilitated. About 70 percent of those displaced from the nearby areas in Zalambesa have also been rehabilitated.

Some IDPs in Addis Ababa, Loggia, and Adigrat are reported to have started living in rented houses on their own and have integrated into the nearby communities. Some IDPs, namely Sudan returnees and Assab deportees, are reported to have returned to their places of origin while a significant number have migrated to other countries namely the Sudan and other Arab countries.

All IDP sites have strong organizational structures that are responsible for IDP administration and welfare. A committee of 6-7 elected people manages each site. Each committee has a chairman and a secretary. Each IDP community closely works with the nearby Kebele administration and presents IDP cases to government and NGO offices. There are also women and youth organizations and health committees. Other social organizations such as gender issues exist. Cooperation among IDP is exemplary. They care for the sick and collectively contribute money for medication and transportation of the sick.
Site-Specific Characteristics of IDPs

Although mining, agriculture and daily labor are the piedmont livelihoods of IDPs, each site has its own unique characteristics.

Mesalemia and Kaliti Sites, Addis Ababa

A total of 310 randomly selected IDPs participated in the study in both Mesalemia (151) and Kaliti (159) IDP sites in Addis Ababa.

The Addis Ababa IDPs included in this study are those in Mesalemia and Kaliti. Among those aged 15 and above, there are more females than males in Mesalemia (57 percent), while it is more or less balanced in Kaliti. All use Amharic for communication. Kaliti has more married IDPs (40 percent) compared to Mesalemia (30 percent). The proportion of IDPs who are widowed/divorced and separated is 13 percent in Kaliti and 16 percent in Mesalemia. In Kaliti 66 percent are Amharas, 19 percent Tigrawi and 11 percent Oromos. 94 percent are Christians and 6 percent are Moslems. In Mesalemia 52 percent are Amharas, 25 percent Tigrawi and 21 percent Oromos. All are Christians (Annex 4.1). About 8 percent of IDPs in Kaliti and 9 percent in Mesalemia have children under the age of one year. 99 percent in both sites have been displaced for more than three years. The major occupation they had before displacement was service (28 and 22 percent for Kaliti and Mesalemia, respectively). Unemployment is high. About 22 percent (Kaliti) and 30 percent (Mesalemia) are still unemployed. Major source of income now is wage labor, which comprises of 23 and 17 percent for Kaliti and Mesalemia IDPs, respectively (Annex 4.2).

The Addis Ababa IDPs were displaced from Eritrea in 1991. The Assab deportees mostly came via Djibouti by train and those who came from Asmara came via Adigrat and Adowa, staying at Mekele for a while. And then they stayed in Dessie for ten days before moving on to Nazareth, with the support of the Red Cross. Finally they made their way to Addis Ababa. There were about 40,000 displaced heads of families, and those who came to Addis Ababa numbered about 10,886 families. Tigrawi and Amhara from the Wollo area were the predominant groups initially. There were also Oromos and ethnic groups from the South. They were supplied with basic food and temporary shelter.

Some of the IDPs were rehabilitated by government, religious organizations and various NGOs: Ethiopian government (89 households); Ethiopian Orthodox Church, (184 households); Organization for Displaced and Returnees (157 households); LVIA 95 households; Norwegian Church (31 households); and Prop Pride (78 households). About 3,867 households were distributed among 14 Weredas.
in Addis Ababa. The major source of income of the IDPs in Addis Ababa is day labor, followed by petty trade, housemaid, cleaning, washing and sex work. There are some who live on begging.

Shashemene and Shakiso Sites, Oromiya Region

The Shashemene IDP site is located in Oromiya Administrative Region, East Shewa, Shashemene Woreda, about 250 km south of Addis Ababa along the Addis -Mowak Road. The population of the Wereda is estimated at 255,430. Shashemene is an active city and trading center.

Among the randomly selected IDPs of Shashemene age 15 and above, 51 percent are males and 49 percent females; 76 percent use Amharic for communication; 57 percent are married and in monogamous relationship while 39 percent are single; 76 percent were born in Oromiya and 16 percent in Welaita; 97 percent are Christians and 3 percent Moslems (Annex 4.1). 20 percent have children less than one year of age; and all of them were displaced more than three years ago. 46 percent lived on agriculture before displacement and 31 percent were unemployed. Currently, their source of income is agricultural and non-agricultural wage labor (41 percent), service (9 percent), business (14 percent); and about 19 percent are unemployed (Annex 4.2).

The Shashemene IDPs used to live around Shashemene in the Kuyera and Wondo Genet areas. They were displaced in 1991 from the nearby villages due to ethnic conflict. DPPC, the Catholic and Protestant missions gave them food supply at the initial stage of displacement. The Shakiso IDPs are miners and petty traders, mostly composed of ex-soldiers from the Derg regime, farmers, drought victims, and unemployed people. They came by car at different times from different parts of the country and are of mixed ethnic groups. The following is based on 159 randomly selected IDPs surveyed at the site.

The Oromos form the majority (49 percent) of IDPs in the Shakiso site, followed by Amhara (26 percent). About 54 percent frequently use Amharic for communication and 34 percent use Oromifa. About 68 percent do 32 percent Moslems follow Christians; the male population is 55 percent. All came to the valley camps, locally called shit to mine gold. They were followed by service providers such as sex workers, cooks, bar and hotel and shop owners. There are single miners (40 percent) and those with their families (60 percent) (Annex 4.1). The service providers are mostly settled and have families (about 60 percent. 30 percent have a child of age less than a year, 35 percent have no education 64 percent were displaced for more than 3 years. Currently 36 percent are engaged in business and 38 percent in mining. Before displacement, some were engaged in services (13 percent), business (10 percent), agriculture (30 percent), and 21 percent were unemployed (Annex 4.2).
The major source of income at Shakiso site is mining and selling gold. There are also those who sell food, drinks, and sex. Chewing chat, drinking alcohol, watching pornographic films, and having sex are among the means of entertainment for the miners. The population size of a shet constantly changes. When gold is discovered, it increases and when gold production dwindles, the size also dwindles and miners start moving to a new shet. It is quite possible to see 100 miners come to a shet on a given day and also to see 100 miners leaving a shet in a day. Miners and the service providers that follow them are extremely transient.

The Shakiso IDP miners come from all over the country looking for easy access to wealth, but suffer a lot. The mining work is tough and risky, and the miners face serious health problems and have little access to health services. Most of them simply die and get buried in the valleys. Water and sanitation are serious problems. Most of them suffer from waterborne diseases. Malaria, TB and pneumonia are common. Sexually transmitted infections (STIs) are widespread and HIV/AIDS is highly prevalent. The miners are not well informed about health matters. They use money obtained from selling gold mostly for relaxing with bar girls. Their attitude is to live today and not bother about tomorrow. The mine sites are the breeding centers of communicable diseases especially HIV/AIDS. Sex workers are in every site. They are employed by the bar owners and are required to meet all demands put on them by the miners. People who get ill are normally sent back to their relatives or home of origin. Some die and get buried in the nearby valley. All those who leave the site due to illness never return.

Zalambesa Site, Tigray Region

Zalambesa is the northern border town located in Tigray administrative region. Two groups of IDPs live in the Zalambesa site. The first group consists of deportees from Eritrea, who settled in Zalambesa and Adigrat towns following the overthrow of the Military Government in 1991 by the EPRDF. The second group consists of the IDPs of the Zalambesa town and the surrounding areas (indigenous inhabitants and deportees of 1991 who settled in Zalambesa) during the 1998 Ethio-Eritrea border conflict. The total number of IDP households in Zalambesa was 2,210 and the total population was estimated between 11,050-13,260. Both IDP groups are of one ethnic group -Tigrawi.

Among the randomly selected 150 Zalambesa IDPs, 53 percent are females and 47