

# **Addis Ababa University**



## **College of Social Sciences**

**School of Social Work**

**MSW-Extension Program**

**Assessment on the Mental Health Status and Provision of Psychosocial  
Support to Internally Displaced Women in Benishangul Gumuz, Metekel zone  
Mandura woreda, Ethiopia**

**Prepared by: Tenawork Mulugeta (GSE/6054/12)**

**Advisor: Dr. Mengistu Legesse (PhD)**

**June, 2022**

**Addis Ababa, Ethiopia**

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**A Thesis submitted to the School of Social Work, Addis Ababa University in  
partial fulfillment of the requirements for the Degree of Master of Arts in  
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**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**  
**MSW EXAMINING COMMITTEE**

This is to certify that the thesis prepared by Tenawork Mulugeta, with a title of: *Assessment on the mental health status and provision of psychosocial support to internally displaced women in Benishangul Gumuz, Metekel zone Mandura woreda, Ethiopia*; submitted in partial fulfillment of the requirements for the Degree of Master of Arts (School of Social Work) complies with regulation of the University and meets the accepted standards with respect to the originality and quality. Thus, the paper is acknowledged by the examining committee.

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## **Acronyms & Abbreviations**

<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>IASC</b>	Inter-Agency Standing Committee
<b>WHO</b>	World Health Organization
<b>OCHA</b>	Office for Coordination of Humanitarian Assistance
<b>IDMC</b>	Internal Displacement Monitoring Center
<b>IDP</b>	Internally Displaced Persons
<b>MHPSS</b>	Mental Health and Psychosocial Support
<b>IHL</b>	International Humanitarian Law
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>LMIC</b>	Low- and Middle-Income Country
<b>NRDMC</b>	National Risk and Disaster Management Commission
<b>GPLM</b>	Gumuz People Liberation Movement
<b>DRMO</b>	Disaster and Risk Management
<b>FGD</b>	Focus Group Discussion
<b>CFS</b>	Child Friendly Space
<b>FMOH</b>	Federal Ministry of Health

## **Abstract**

The objective of the study is to assess the current mental health status of internally displaced women and their needs for psychosocial support as well as the provision and access to support services. A total sample size of 327 internally displaced women, who were selected using simple random sampling method, participated in this study. To conduct this study, mixed research method and descriptive design was employed. The results of the gathered data were triangulated with field observation, key informant interview and focus group discussions (FGD) were employed to accomplish the above stated objectives of the study. Pre-established and modified structured and semi structured questionnaire, interview and FGD guides and field observation checklists were used as instruments to collect data. SPSS were used for a thematic analysis to utilize both the qualitative and quantitative data. As per the findings of the study, the prevalence of mental health on IDP women both in the camps and host communities identified through the mental health problems' symptoms outlined by IASC guidelines on mental health and psychosocial support in emergency settings. Among the symptoms they show feeling so afraid, so angry, so uninterested, so hopeless and so severely upset about the emergency/conflict/war or another event in your life, trying to avoid places, people, conversations, or activities that reminded you of such event. Additionally, this feelings makes them being unable to carry out essential activities of daily living were the major ones. The result of the study also puts the rank of mental health problems seen among the IDP women. Accordingly stress as to what to do next comes first, followed by depression, sadness and grief, worry over situation and their future, despair (hopelessness), Tension (anxiety and short temper) and stigmatization and mistreatment. To cope up these problems IDP women use their own coping mechanisms. Among the coping mechanisms begging (to cover their own expenses) comes first followed by smoking (especially among Gumuz ethnic groups), sleeping and crying, engaging oneself in prostitution and forcing their children to early marriage. Although psychosocial supports are equally important as that of emergency supports and even though there are some improvements in mental health services have begun to spread in cities and urban centers, counseling and psychotherapy for the individual has not yet deep-rooted in the area.

# Chapter One

## Introduction

### 1.1 Background of the study

Internal displacement has emerged as one of the greatest human tragedies in the world today (Yigzaw and Abitew, 2019). It can happen due to many reasons among which, as per the guiding principles on internal displacement (1998), armed conflicts, situations of generalized violence, violations of human rights and natural disasters are prominent ones. It can be caused by natural disasters (famine, flood, and drought), conflict (war and ethnic violence) and violation of human rights and development induced displacement (Lwabukuna, 2011).

Internal Displacement Monitoring Centre (IDMC) has reported that, there exists over 25 million IDPs as a result of violent conflicts and human right violations in the world. The number has doubled itself as compared to the number recorded in 2017 as per recent international organization's reports it becomes approximately 48 million internally displaced persons who have fled conflict and violence. (UNHCR, Geneva, 2021). Most of the new displacements triggered by conflict and violence in 2019 were recorded in Sub-Saharan Africa and the Middle East and North Africa. The majority took place in Syria, DRC and Ethiopia, as in previous years. (IOM, December 2019).

Ethiopia is listed under those low-income countries experiencing internal displacement of large number of peoples in the horn of Africa. Internal displacement is indeed rapidly increasing in Ethiopia, meaning it is now one of the worst affected states by total IDP numbers. (Wakgari, January 2019) The ethnic conflicts here and there are the major factors for the huge number of displacement.

According to UNHCR'S initiative on internal displacement (2020-2021), conflict-induced internal displacement began in significant numbers in 2017 along the Oromia and Somali regional borders. In 2018, Ethiopia witnessed large numbers of persons fleeing their homes, reaching an estimated

3.19 million IDPs by the start of 2019, with approximately 80% displaced due to conflict and 20% displaced for climate-change related causes. Reports of large-scale return began in 2019 and by the end of May, upwards of 1.3 million IDPs were noted to have returned to their areas of origin, including to areas where conditions were not fully conducive due to security risks, and not all returns were sustainable, resulting in some secondary and tertiary displacement. (UNHCR, 2020 – 2021).

Additionally, in the first half of 2018, a new conflict broke out in West Guji and Gedeo, along the border between Oromia and Southern Nations, Peoples and Nationalities (SNNPR) regions, triggering more than a million new displacements. Inter-communal violence also continued along border areas of the Oromia and Somali regions. Similar to global trends, the causes of internal displacement in Ethiopia are multifarious. According to Mehari, three principal factors contribute to the causes and consequences of internal displacement in Ethiopia: the ethnic federal structure, the persistent threat of famine, and ethnic conflicts. Both famine and ethnic federalism (as the outcome and aggravating factors of ethnic conflicts) often result in population displacement. (Wakgari, January 2019).

The researcher select Benishangul-Gumuz region Mandura woreda as the study site because, the region is one of places where a huge number of IDP's from neighboring woredas. There are also IDP-Returnees and Refugees living in these areas coming from different parts of the zone due to the inter-communal conflicts between the Gumuz ethnic community and other ethnic community mostly Amhara and shinasha ethnic community due to mainly an armed communal conflict.

The main cause of internal displacement in Metekel zone was the communal violence between the Gumuz ethnic groups and other ethnic groups mostly the Amhara and Shinasha ethnic groups. It started with weeks of attacks on civilians which took place on early September, 2020, especially in Bullen. According to the information gathered from different social Medias estimated number of 150 deaths of which the targets were ethnic Amhara's though officials stated that the attacks had no ethnic motivations. There were many killings here and there in different woredas of the zone including the bus attack on the road from Chagni to Gilgel Beles on November, 2020 which leads to the killings of 34 civilians.

Despite the fact that both the Federal and Regional security forces were coordinating in "annihilating 'anti-peace forces', arresting them, and confiscating firearms by detaining members of criminal groups and suspected perpetrators of the violence via door-to-door hunt, the GPLM (Gumuz People Liberation Movement) continued to perpetrate violent attacks against civilian populations. On the night of 22–23 December 2020, a massacre and burning down of houses took place in Bikuji kebele of the Zone. According to the Ethiopian Human Rights Commission 100 deaths were counted as of 23 December 2020. Other sources stated 220 were killed of mostly Amharas, Oromos, and Shinashas by a suspected Gumuz militias.

This leads to a huge number of displacement in the zone. The number of displaced peoples, as per the updated report of the zone's Disaster and Risk Management office (DRMO), is total of 254,500 among which about 40,083 are children less than the age of 5 and about 13,825 are pregnant and lactating women.

According to the report shared by the regional authorities, 142 schools and 107 health facilities have been damaged and/or vandalized by parties to the conflict since 2021. As a result, over 42,000 children are affected, mostly out of school, while access to health services is extremely limited and non-existent in rural areas. In 2022, an undetermined number of IDPs has been moving to woreda centers, establishing themselves in sites easier to reach by aid partners. However, the conditions in these sites remain substandard with very limited aid and protection services delivered. Overall, partners are facing major challenges in scaling up the response not only because of insecurity but also due to shortage of resources and limited funding. (OCHA, 2022) The above issues are what makes the researcher to be interested and to study further on the topic.

## **1.2 Statement of the problem**

UNHCR handbook for the protection of internally displaced persons clearly indicates that forced from their homes, IDPs experience specific forms of deprivation, such as loss of shelter, and often face heightened or particular protection risks. These risks may include: armed attack and abuse while fleeing in search of safety; family separation, including an increase in the number of separated and unaccompanied children; heightened risk of sexual and gender-based violence,

particularly affecting women and children; arbitrary deprivation of land, homes and other property; and displacement into inhospitable environments, where they suffer stigmas, marginalization, discrimination or harassment. Among the total number of internally displaced persons, which is 2.7 million in Ethiopia, 24% constitutes Women and 53% are children (OCHA, February 2021).

Being exposed to traumatic events that might be inflicted by the displacement, IDP's face many economic, social and psychological problems. Specially, women tend to be the most vulnerable in having psychological problems including Post-Traumatic Stress Disorder (PTSD). From this perspective, it was imperative to undertake this research to show that, mental health and psychosocial support are equally important as that of basic needs (food, shelter & clothing). The researcher believed that assessing the mental health and the adequacy and effectiveness of psychosocial support plays a vital role in ensuring the societal wellbeing of a society.

This sharply contrasts with the wide coverage of other displaced groups, such as the refugees or the asylum seekers, who are covered under a well-structured system of international care and protection. The IDP phenomenon remains less understood, given the internal nature of the crisis, linked to a nation's sovereignty, which assigns the responsibility for care and protection to national actors instead of an international body, such as the United Nations High Commission for Refugees (UNHCR) that oversees the refugee population. In the interest of keeping the displaced populations protected from further harm and the larger populations uninterrupted, often, the national actors feel compelled to downplay the IDP crisis by either reframing it or disguising it in ways that keep the displaced populations hidden and the larger populations uninformed, and thus unconcerned about those who become internally displaced. (Sudha G. Rajput)

Even though mental health and psychosocial support are equally important, as that of basic needs for IDP's, services rendered by national settings especially in low-income countries is grossly insufficient and less attention is given to the emotional and mental well-being of those victims. Exposure to traumatic events, food insecurity, and the length of displacement lead to a higher likelihood of mental health issues among IDPs. Research conducted by IDMC in Somalia, Ethiopia and Nigeria in 2021, asked participants about their mental health before and after displacement. In

Ethiopia and Nigeria, just over a third of respondents reported feeling worried, nervous, angry or sad more often than before they became displaced.

Although women and men are affected by severe consequences of armed conflicts and war leading to displacement, women and men are likely to be vulnerable in somewhat different ways. Women are more likely to be exposed to abuse and rape and also carry a heavier family burden, whereas men are more exposed to direct combat activities and war conflicts (Carballo et al, 1996; 2004). In general, women are more than twice as likely to develop post-traumatic disorder as men as a result of trauma (Breslau et al, 1997; Eytan et al, 2004; Solomon et al, 2005). Undoubtedly, various types of severe trauma these persons have gone through are expected to lead to higher mental distress and lower quality of life, but further research is needed to understand the pathways underlying this process. According to different researches efficient intervention strategies to rehabilitate and assimilate these persons into the society will be facilitated by a deeper understanding of the role of social support and coping strategies employed by the subjects living in such environment. An understanding of which of the coping strategies are of benefit and which are dysfunctional can be incorporated in the sort of intervention strategies employed. It is also important to have an assessment of how beneficial social support is, or its role in general, in order to choose between different interventions strategies adequately.

Ethiopia lacks a comprehensive, dedicated policy on internal displacement. The government, however, is working on a draft policy and roadmap. The 2013 Disaster Risk Management Policy is designed to reduce risks associated with disasters but does not make specific provisions for IDPs. The Somali region in 2017 was the first to endorse a regional, durable solutions strategy specifically targeting IDPs, with the support of the Durable Solutions Working Group. This regional strategy has been the starting point for a new federal strategy, the Durable Solutions Initiative, which was launched in December 2019. (C. Cazabat, B. Desai and P. Wesolek, IDMC, 2020). Even though, there are guidelines in relation to the protection of internally displaced persons, the international organizations and even the governmental settings failed to outline a detailed procedures for the purpose of intervention with the aim of rendering the better psychosocial support.

According to many researches, there is an urgent need to address the mental health of people in humanitarian settings and in displacement (Morina et al. 2018). Disasters and other emergency situations lead to an array of mental health problems, ranging from short-term stress reactions, through to anxiety and depressive disorders and psychosis (Tol et al. 2013). Exposure to stressful events, impoverishment, and other daily stressors can trigger or worsen mental health problems, whilst often the mental health infrastructure is weakened (IASC 2007). Different studies failed to show how one can determine the status of mental health along with the provision of psychosocial support.

There are many studies which dealt with the mental health and psychosocial support. However, research on the relationship between mental health and displacement, and the effectiveness of different interventions, is still scarce. Further research is a pressing need. Understanding the scale of the problem and reducing barriers to mental health support are important steps towards improving the wellbeing of displaced populations. Overall, different scholars, apart from putting the defining terms of mental health and psychosocial support to IDP's, they failed to see the seriousness of failed psychosocial support which can inflict a double effect on mental health of IDP's in particular and on the society in general. Thus, this study will focus on filling the gaps of other studies on the given topic.

Therefore, this study will focus on assessing the current mental health status of internally displaced women which helps to know the seriousness of mental health issue. It also aimed at identifying and discussing the provision of psychosocial support services which can have an adverse effect on the overall wellbeing of the society.

### **1.3 Research questions**

To respond effectively to the study's general and specific objectives the following essential research questions are formulated.

1. What is the current mental health status of internally displaced women?
2. What are the psychosocial needs of internally displaced women?

3. How is the availability, accessibility & appropriateness of psychosocial support services being delivered to internally displaced women in the zone?
4. What are the psychosocial supports and how are they provided to internally displaced women in the zone?

## **1.4 Objectives**

The traumatic events inflicted on mental health of internally displaced women due to the internal displacement, have a double effect on them and on the environment that they are residing in. meaning it affects their daily life as well as the peaceful co-existence of the environment they are living in. The objective of this study is to assess up to what extent the effect goes and the currently available psychosocial supports. And in the end, to identify possible ways of serving better psychosocial support and in order to provide meaningful insights for service providers and future researchers. Taking into consideration the double effect of this internal displacement the study lists the following general and specific objectives.

### **1.4.1 General objective**

The general objective of the study is to assess the current mental health status of internally displaced women and their need for psychosocial support.

### **1.4.2 Specific objectives:**

- To identify the current mental health status of internally displaced women in the zone;
- To discuss the psychosocial needs of internally displaced women in the zone;
- To discuss the availability, accessibility and appropriateness of psychosocial services delivered to internally displaced women in the zone;
- To identify the important mental health services and possible ways of rendering psychosocial support to internally displaced women the zone.

## **1.5 Significance of the Study**

There is a need to understand the relationship that exists between protracted/prolonged internal displacement and mental health of IDP's. Taking into consideration the importance of mental health and psychosocial support to IDP's, the significance of this study is showing the relational effect of internal displacement on mental health of IDP's in general and internally displaced women in particular. This is because the researcher strongly believed that, the inadequate psychosocial support service and the non-availability of detailed intervention procedures are the major contributing factors for mental health problems occurred due to internal displacement.

Additionally, the purpose of this study will be to discuss the adequacy and appropriateness of provision of psychosocial support being provided to IDP's. It also has a significance for the social workers in international humanitarian settings and governmental institutions to outline detailed procedures on how to engage in interventions in a better way. It also helps in providing meaningful insights for service providers and future researchers and to forward some recommendations on the betterment of the services rendered by the international humanitarian settings as well as governmental institutions which are engaged in the field of protection of IDP's.

## **1.6 Scope of the study**

The study will be delimited to assessing mental health status of internally displaced women, in Benishangul Gumuz, Metekel zone, Mandura Woreda. This area was selected because it is one of the two woredas which are relatively safer than other woredas which are characterized as hard to reach areas where most of the roads that takes to the IDP sites are accessible only with a public convoy by the FDRE Military Forces and the zonal Special Forces.

## **1.7 Operational definitions**

**Armed Conflict:** An armed confrontation between the armed forces of states (international armed conflict) or between governmental authorities and organized armed groups or between such groups within a state (non-international armed conflict).

**Communal Violence:** Violence perpetrated across ethnic, religious or communal lines that has not met the threshold of a non-international armed conflict. Communal, in particular inter-communal violence can overlap to a significant extent with political violence with one type of violence triggering the other.

**Coping Mechanism:** Coping mechanisms are the strategies people often use in the face of stress and/or trauma to help manage difficult and/or painful emotions. Coping mechanisms can help people adjust to stressful events while maintaining their emotional well-being.

**Durable Solutions:** In the context of internal displacement, a situation where internally displaced persons no longer have any specific assistance and protection needs that are linked to their displacement and can enjoy their human rights without discrimination on account of their displacement.

**Forced evictions:** The permanent or temporary removal against their will of individuals, families and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection.

**Internal Displacement:** refers to the forced movement of peoples within the country they live in.

**Internally Displaced Persons (IDPs):** persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflicts, situation of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.

**Mental health:** Mental health refers to the capacity of individuals and groups to interact with one another in ways that promote subjective wellbeing, optimal development and the use of mental abilities (cognitive, affective and relational), and the achievement of individual and collective goals consistent with the law.

**Mental health problems:** A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.

**Psychosocial support:** refers to any type of support that aims to protect or promote psychosocial well-being and/or prevent or treat mental conditions.

**PTSD (post-traumatic stress disorder):** is a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident or sexual assault. Often, the patient develops a set of symptoms that also include flashbacks (reliving the experience) and avoidance behavior.

**Region:** refers to lands or territories, are areas that are broadly divided by physical characteristics (physical geography), human impact characteristics (human geography), and the interaction of humanity and the environment (environmental geography). It is consciousness of and loyalty to a distinct region with a homogeneous population.

**Relocation:** The act of moving evacuated people to a place where they stay until return or settlement elsewhere in the country becomes possible (temporary), or the act of moving people to another location in the country and settling them there when they no longer can return to their homes or place of habitual residence (permanent).

**Resettlement:** A situation where former IDPs who, based on a voluntary and informed decision, have settled in a location other than their place of former habitual residence or place of displacement, and have achieved safe, dignified and sustainable integration in this location.

**Return:** For internal displacement, return implies movement from the place of displacement back to the place of former habitual residence, ideally the former home. In the case of cross-border displacement, return signifies movement from the host country back to the country of origin.

**Vulnerability:** The characteristics determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards.

**Zone:** a subdivision of a biogeographic region that supports a similar fauna and flora throughout its extent. It is a region or area set off as distinct from surrounding or adjoining parts.

## **Chapter Two**

### **Literature Review**

In this section of the thesis the researcher discusses the issue in light of other related literatures. The concept of internal displacement, its impacts, psychosocial challenges of internally displaced women and their opportunities, mental health and psychosocial support along with durable solutions and coping mechanisms are discussed.

#### **2.1 Conceptual framework**

According to a research conducted Catherin, 2013 on research guide on internal displacement, recognition of internal displacement emerged gradually through the late 1980s and became prominent on the international agenda in the 1990s. The chief reasons for this attention were the growing number of conflicts causing internal displacement after the end of the Cold War and an increasingly strict international migration regime. The phenomenon of internal displacement, however, is not new. According to United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2003) the Greek government argued to the United Nations (UN) General Assembly in 1949 that people displaced internally by war should have the same access to international aid as refugees, even if they did not need international protection. India and Pakistan repeated this argument after partition.

Involuntary departure and the fact that the individual remains within his/her country are the two defining elements of an IDP. The first element distinguishes IDPs from individuals who left their homes out of choice and could have otherwise safely remained where they lived. The second element explains why IDPs are not refugees. Refugees, by definition, are outside their country of nationality or habitual residence. In other respects, however, both categories of displaced persons often face similar risks and deprivations. (Catherine, 2013)

Many studies are conducted on the issue of internal displacement all over the world. The concept of internal displacement simply defined as refers to the forced movement of peoples within the country they live in. But, the reasons for this forced movement are different as per the definition

of the guiding principles on internal displacement peoples may be forced or obliged to flee or to leave their homes or places of habitual residence in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters. (UNHCR, 2020).

Displacement often leads to dramatic changes in family structure and gender roles, relations and identities (Mertus 2003). In conflict situations, many women are suddenly thrust into the role of head of household because the men are recruited to combat, stay behind to maintain land, or migrate in search of work (Cohen 1998) (see Forced Migration Review no 9 for a special issue on Gender and Displacement). Cohen examines the relationship between land, property and gender. Internally displaced people are likely to lose some or all of their land as a result of displacement. In Colombia, for example, it is estimated that as much as 87 percent of the displaced people who owned land have had to abandon it (OCHA 2003). The high number of female headed households in conflict and displacement situations makes preexisting restrictions on women's ability to own, acquire, manage or dispose of property an impediment to their reintegration. Cohen (1998) gives examples from Burundi and Rwanda, where women are unable to inherit land or other immovable property from either their husbands or parents (unless they have sons) and therefore often lose the property to their deceased husband's relatives. (Cathrine, 2013)

## **IDPs and refugees**

The main difference between IDPs and refugees is that the internally displaced remain within the borders of their own country. Refugee status entitles individuals to certain rights and international protection, while being an IDP is not a legal status because IDPs are still under the jurisdiction of their own government and may not claim any rights additional to those shared by their compatriots (Hathaway 1991, Vincent 2000). However, IDPs are often in need of special protection, not least because the government responsible for protecting them is sometimes unwilling or unable to do so, or may itself be the cause of displacement. Despite the differences in legal status and of entitlement to aid from the international humanitarian community, the causes of displacement and the experience of being displaced are often similar for both IDPs and refugees. Much like refugees, IDPs often feel like strangers in their place of refuge, where the local population may be from a

different ethnic and/or religious group and/or may speak another language. Consequently, IDPs may not feel welcomed, despite sharing the same citizenship as the host population.

Mental health and psychosocial support (MHPSS) assessments in emergencies is important to provide; (a) understanding of the emergency situation; (b) an analysis of threats to and capacities for mental health and psychosocial well-being; (c) an analysis of relevant resources, in consultation with stakeholders, whether a response is required and if so, the nature of the response (IASC, 2007). An assessment should include documenting people's experiences of the emergency, how they react to it and how this affects their mental health/psychosocial well-being. It should include how individuals, communities and organizations respond to the emergency. It must assess resources, as well as needs and problems. Resources include individual coping/life skills, social support mechanisms, community action and government and NGO capacities. Understanding how to support affected populations to more constructively address MHPSS needs is essential. An assessment must also be part of an ongoing process of collecting and analyzing data in collaboration with key stakeholders, especially the affected community, for the purposes of improved programming. (IASC, 2007)

## **2.2 Impacts of internal displacement**

Internally displaced persons (IDPs) are exposed to many economic, social and psychological problems as a result of eviction from their homes and habitual residences due to natural and human made disasters (e.g., flood and armed conflict respectively) which led them to be among the most vulnerable in the world. The impact of internal displacement on Mental Health and Psychological wellbeing of the victims seems unattended compared to that of other problems such as economic and social problems.

World Health Organization (WHO) already explicitly included mental health as part of the health definition: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO 1946). The notion that "without mental health, there can be no true physical health" was also highlighted by the first Director-General of the WHO back in 1951 (Chisholm 1951). The relationship between mental health, psychosocial wellbeing and displacement is complex. Accumulated evidence indicates that the mental health burden is

significantly higher amongst displaced populations, reflecting the increased prevalence of mental health problems during humanitarian crises (UNHCR, 2012). Numerous models and conceptual frameworks attempt to explain why displaced persons suffer a higher mental health burden than the general population (IASC, 2007; JHSP & IFRC, 2009; Miller & Rasco, 2004; Miller & Rasmussen, 2010; Tay & Silove, 2017). A pertinent example is the Adaption and Development after Persecution and Trauma (ADAPT) model, which posits that mass conflict and displacement disrupt five core psychosocial pillars: safety and security, bonds and networks, justice, roles and identities, and existential meaning (Silove, 2013; Tay & Silove, 2017). Restoration of communal psycho-social well-being subsequently requires the repair of these disruptions (Silove, 2013).

Many experts have also described how issues such as poverty, social inequity, social exclusion, social deterioration and lack of sense of coherence, all of which are potentially exacerbated by mass conflict and displacement, impact on communal mental health and wellbeing (Antonovsky, 1979; Eriksson & Lindstrom, 2006; Patel, Flisher, € Hetrick, & McGorry, 2007; Patel & Kleinman, 2003; Somasundaram, 2007). For instance, Patel and Kleinman (2003) indirectly link displacement and poverty by discussing common factors such as insecurity, hopelessness, rapid social change, and limited opportunities as a result of less education. These factors have been shown to negatively affect mental health and psychosocial outcomes, including the wellbeing of children and young people (Patel et al., 2007; Patel & Kleinman, 2003) (Benjamin Wood and Per Kallestrup, 2021).

### **2.3 Economic and Psycho-social challenges of internally displaced women**

According to the IASC guidelines on mental health and psychosocial support in emergency settings among the groups of people who frequently have been shown to be at increased risk of various problems in diverse emergencies: Women (e.g. pregnant women, mothers, single mothers, widows and, in some cultures, unmarried adult women and teenage girls) are the major ones. Internally displaced women confront completely new social and livelihood scenarios with notably high risk of vulnerability to different kinds of attacks in times of emergencies. For instance they may be raped and face gender based violence to obtain different kinds of basic needs such as shelter, food and security. Additionally, they might be exposed to sexual violence and other multiple economic, social and psychological problems. (IASC, 2007)

Loss and deprivation of rights presents another huge challenge for refugee women and girls. Often, the loss of rights is linked to women losing or being unable to access vital documents like birth certificates, marriage certificates, and proof of citizenship. Without these, access to medical care, food, housing, and the labor market can be difficult or even impossible. (Deng, 2013)

### **Economic Challenges:**

Female heads of households are involved in numerous types of petty work in the informal sector. Categorizing them into the formal groups of occupation is rather very difficult. The vast majority of female heads are working in the informal sector. Women households' heads are very likely to lose control of any land or assets they may have inherited. Access to employment is another severe problem, as there are few jobs available to them and they are relatively unskilled. Problems of Women Headed Households (Hossain, 1995). Like in other developing countries, women in Ethiopia have also faced gender-based inequalities and discrimination for a long time. They were left out of access to economic resources with men. They did not have equal entitlement to resources and other social and economic issues. (Beza, 2020)

Displaced women are often worse off with an average disadvantage of about 24 percent when compared to women of the host country (Georgetown, 2021). Overall, they are less likely to be financially included, economically empowered, and feel less free to move about. Their vulnerability is heightened by their loss of civil documentation, social networks, and sources of income often subsistence agriculture which impedes access to public services and job opportunities, information, nutrition, education, and social participation.

### **Social Challenges:**

As per the African Union Convention for the protection and assistance of internally displaced persons in Africa, like all human beings, internally displaced persons among whom especially women are entitled to enjoy human rights that are articulated by international human rights instruments. (Kampala Convention), Uganda, 2009) since, women are more vulnerable than others, to many social and psychological problems. They suffer from high rate of mortality, physical attack, sexual assault and abduction, and frequently are deprived of adequate shelter, food

and health services, which lead to a severe psychological distress causing both the physical and mental health problem on them.

Women fleeing their homes, run a frighteningly high risk of rape and other forms of violence and abuse. According to a report 2018 from the Mixed Migration Centre under DRC Danish Refugee Council, almost half of all women on the run are subjected to some form of abuse. This includes rape, robbery, kidnapping, bribery and other forms of abuse. Even when women and girls reach a source of help, they remain vulnerable. In a refugee camp, everyday tasks like fetching water or going to the toilet can pose an intolerable risk of rape or harassment. When becoming a refugee or internally displaced, women and girl's dreams of education and careers often fall by the wayside, replaced by an impoverished life of domestic duties and childcare - and for some even forced marriage and early pregnancy. (DRC, 2021)

### **Psychological Challenges:**

One of the many challenges that displaced women may face is discrimination, marginalization and negative labeling (Dereje, 2019). Labelling has the effect of separating individuals from their context, their former lives and the causes of their displacement. Hence, labels tend to depoliticise, de-historicise and universalise identities (Rajaram 2002). Roger Zetter (1991) terms these identities as 'misconceived and spoilt', because they do not represent the ways the group would choose to perceive themselves. When the displaced represent themselves to outsiders, they commonly deploy the language and labels of the refugee regime because they need the entitlements associated therewith, thus reinforcing these stereotyped identities. However, this does not mean that people conform passively to the stereotyped identities. <sup>20</sup> The IDP label also conceals the fact that individuals within it are treated differently. For instance, ethnicity and other group identities can effect one's experience of being an IDP, as can one's location in a camp vs self-settlement. In such cases, the IDP label de-politicizes the issue of forced movements and conceals the importance of identity politics. When differences among forced migrants are accounted for, they are often based on gender. This gender focus is often limited to women, which though useful in many respects can also be seen as problematic, as it reinforces the primacy of female differences over

other identity attributes, and can further entrench unequal gender relations between women and men (Hyndman, 2000). (Catherine, 2013)

Women affected by displacement generally suffer from major health challenges. On their escape routes and in refugee camps, there is often minimal access to basic hygiene products such as bandages, tampons, and underwear, meaning women are forced to use whatever they can find: leaves, dirty rags, or even pieces of old mattresses. This can cause serious problems, including infections and associated complications. For some girls and women menstruation itself is a source of stigmatization, which may discourage them from going to school and receiving an education. (DRC, 2021)

This situation in addition with other contributing factors may pose a serious psychological threat to the displaced women including Post Traumatic Stress Disorder (PTSD). According to different studies, PTSD is one of the most prevalent mental health conditions in humanitarian settings. It can develop in response to exposure to extremely stressful or traumatic events, or an exceptionally threatening situation. Examples include rape, violent attack, severe accidents, sudden destruction of home or community, or harm to close relatives or friends. It is characterized by re-experiencing the event in nightmares, flashbacks, or physical sensations, avoidance and emotional numbing, panic attacks, sleep disturbance and poor concentration. People experiencing PTSD may also be at higher risk of depression, difficulties managing anger, and misuse drugs or alcohol.

## **2.4 Opportunities of internally displaced women**

Many situations of displacement turn out to be long-term, lasting for more than a decade. During this lengthy waiting period, capacities and skills should be enhanced so that the women become self-reliant and better prepared to meet the many difficulties they will face upon returning home.

UNHCR (2018) indicated that internal displacement has many impacts on the lives of IDPs, their hosts and the communities they leave behind. Consequences are felt in the dimensions of health, livelihoods, education, housing and infrastructure, security, the environment and social life. Aside from their number and range, the close and complex links between them and their mutually

reinforcing effects are striking. Thus, creating various opportunities to overcome such constraints are indispensable to maintain in life as well to decide their future fate.

Three quarters of internally displaced households do not receive aid assistance, and half have trouble meeting their food needs. Many resort to harmful coping strategies (skipping meals, child labor) (Samuel et al., 2018). Given the economic challenges faced by IDPs in lower and middle-income countries and the wide-ranging consequences of these challenges, there is an emerging consensus that IDPs should be allowed to pursue self-reliance through local economic integration. Some of the greatest opportunities for expanding IDPs' economic integration are in urban areas, where the presence of economic activity clusters are in box (Huang & Graham, 2019). (Mohammed, 2020)

## **2.5 Mental health and psychosocial support to internally displaced women**

Psychosocial support is about helping children, families and communities to improve their psychosocial wellbeing and is about encouraging better connections between people, and building a better sense of self and community. It is expressed through caring and respectful relationships that communicate understanding, tolerance and acceptance and is about promoting everyday consistent care and support in the family and community. (Arc, 2009)

Mental health and psychosocial support refers to any type of support that aims to protect or promote psychosocial well-being and/or prevent or treat mental conditions (IASC 2007). The term 'Psychosocial' refers to the close connection between psychological and social processes. MHPSS aims to equip people with skills to address risks, mediators or consequences of mental health conditions and enable circumstances for recovery. The term MHPSS was coined by the Inter-Agency Standing Committee in 2007 to point out the complementarity between mental health and psychosocial interventions and to facilitate a more integrated approach and multi-sectoral collaboration in humanitarian responses (IASC 2007). Social and psychological processes are two types of interrelated effects of conflict and displacement (UNHCR 2013). The term is now widely and increasingly used by all type of actors, especially fragile settings and in conflict and disaster-affected environments (UNHCR 2013). (B. Tolboom, L. Juanola, M. Dieleman & M. van Duijl, 2020).

The word 'psychosocial' is a combination of the concepts of the individual 'psyche' and the 'social' community in which the person lives and interacts. Psychosocial support recognizes the importance of the social context in addressing the psychological impact of stressful events experienced in emergencies and other problems (Binega & Molla, 2011). In practice, this means facilitating the reconstruction of local social structures (family, community groups, schools and social settings) which may have been destroyed or weakened by an emergency, so that they can give appropriate and effective support to those suffering from severe stress, heart break frustration and hopelessness related to their experience. (Binega, 2013)

According to some international media reports, psychosocial support is used to emphasize the close connection between psychological aspects of the human experience and the wider social experience. Psychological effects are those that affect different levels of functioning including cognitive (perception and memory as a basis for learning) which affects emotion and behavior where as social effects concerns relationships, family and community networks. These two aspects are closely intertwined in the context of complex emergencies whereby the provision of psychosocial support is part of the humanitarian relief and early recovery efforts. One of the foundations of psychosocial wellbeing is access to basic needs (food, shelter, livelihood, healthcare and education services) together with a sense of security that comes from living in a safe and supportive environment.

Primary health care is about providing 'essential health care' which is universally accessible to individuals and families in the community and provided as close as possible to where people live and work. It refers to care which is based on the needs of the population. It is also decentralized and requires the active participation of the community and family. (National Mental Health Strategy 2012/13-2015/16). The Federal Ministry of Health's (FMOH) initiative to develop a National Mental Health Strategy marks an important milestone towards the delivery of a comprehensive and integrated program to address the mental health needs of Ethiopians. The strategy is consistent with the overall health policy and plan of FMOH and the World Health Organization's (WHO) recommended guidelines for the development of a mental health policy, plan and program. (National Mental Health strategy, 2012/13-2015/16)

Most individuals experiencing acute mental distress following exposure to extremely stressful events are best supported without medication. All aid workers, and especially health workers, should be able to provide very basic psychological first aid (PFA). PFA is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support. PFA is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress.

The strategy is based on the five-tiered pyramidal structure known as Optimal Mix of Services which is recommended by WHO. Focusing on priority disorders and vulnerable groups, this pyramidal structure seeks to utilize all existing human potential such as mental health specialists, general practitioners, health officers, nurses, urban and rural health extension workers. The strategy relies heavily on the primary health care system to provide seamless, sustainable and quality integrated mental health treatment, with care provided at all levels of the health system from tertiary referral and general hospitals, down to health centers and health posts.

## **2.6 Durable solutions to internally displaced women**

Displacement is a life-changing event. While the often traumatic experience of displacement cannot be undone, internally displaced persons (IDPs) need to be able to resume a normal life by achieving a durable solution. As articulated in principle 28 of the Guiding Principles on Internal Displacement, IDPs have a right to a durable solution and often need assistance in their efforts. Guiding Principles 28-30 set out the rights of IDPs to durable solutions, the responsibilities of national authorities, and the role of humanitarian and development actors to assist durable solutions. Principle 28 recognizes that the competent authorities have the primary duty and responsibility to establish conditions, as well as provide the means, which allow IDPs to return voluntarily, in safety and with dignity, to their homes or places of habitual residence, or to resettle voluntarily in another part of the country. Securing durable solutions for the internally displaced is also in the State's best interests. Leaving IDPs in continued marginalization without the prospect of a durable solution may become an obstacle to long-term peace stability, recovery and reconstruction in post-crisis countries. Facilitating durable solutions requires that all stakeholders,

including national and local authorities as well as humanitarian and development actors, work together, identify the right strategies and activities to assist IDPs in this process, and set criteria that will help to determine to what extent a durable solution has been achieved. (The Brookings, 2010).

The core principle of UN for displaced persons has suggested three interventions to people to bring durable solutions. The first principle is voluntary and sustainable reintegration at the place of origin (return). The second principle is sustainable local integration in areas where IDPs take refuge (local integration). The third principle is voluntary and sustainable integration in another part of the country (settlement elsewhere in the country). The intervention done should be strategic and must bring durable solutions. (Dereje, 2019).

The specific needs and human rights concerns of internally displaced persons (IDPs) do not automatically disappear when a conflict or natural disaster ends. Nor do they fade away when people initially find safety from ongoing conflict or disaster. Rather, the displaced—whether they return to their homes, settle elsewhere in the country or try to integrate locally—usually face continuing problems, requiring support until they achieve a durable solution to their displacement. A durable solution is achieved when internally displaced persons no longer have any specific assistance and protection needs that are linked to their displacement and can enjoy their human rights without discrimination on account of their displacement. It can be achieved through Sustainable reintegration at the place of origin (hereinafter referred to as “return”); sustainable local integration in areas where internally displaced persons take refuge (local integration); sustainable integration in another part of the country (settlement elsewhere in the country). (The Brookings, 2010)

The search for any of these durable solutions for IDPs should be understood as it is a gradual, often long-term process of reducing displacement-specific needs and ensuring the enjoyment of human rights without discrimination; a complex process that addresses human rights, humanitarian, development, reconstruction and peace-building challenges and a process requiring the coordinated and timely engagement of different actors.

The primary responsibility to provide durable solutions for IDPs needs to be assumed by the national authorities. International humanitarian and development actors have complementary roles. The authorities concerned should grant and facilitate rapid and unimpeded access to humanitarian and development actors that assist IDPs in achieving a durable solution. The needs, rights and legitimate interests of IDPs should be the primary considerations guiding all policies and decisions on durable solutions. Thus, all relevant actors need to respect the right of IDPs to make an informed and voluntary choice on what durable solution to pursue and to participate in the planning and management of durable solutions.

Even though the primary responsibility for the protection and assistance of IDPs rests with national governments, their response to conflict-induced internal displacement is, in most cases, inadequate to meet the needs of these populations. Ethiopia lacks a comprehensive, dedicated policy on internal displacement. The government, however, is working on a draft policy and roadmap. The 2013 Disaster Risk Management Policy is designed to reduce risks associated with disasters but does not make specific provisions for IDPs. The Somali region in 2017 was the first to endorse a regional, durable solutions strategy specifically targeting IDPs, with the support of the Durable Solutions Working Group. This regional strategy has been the starting point for a new federal strategy, the Durable Solutions Initiative, which was launched in December 2019.

A number of criteria determine to what extent a durable solution has been achieved. IDPs who have achieved a durable solution will enjoy without discrimination, long-term safety, security and freedom of movement; an adequate standard of living, including at a minimum access to adequate food, water, housing, health care and basic education; access to employment and livelihoods; access to effective mechanisms that restore their housing, land and property or provide them with compensation. In a number of contexts, it will also be necessary for IDPs to benefit, without discrimination, from the following to achieve a durable solution: access to and replacement of personal and other documentation; voluntary reunification with family members separated during displacement; participation in public affairs at all levels on an equal basis with the resident population; effective remedies for displacement-related violations, including access to justice, reparations and information about the causes of violations.

## **2.7 Coping mechanisms of internally displaced women**

The concept of coping mechanisms and/or strategies is closely related to the idea of survival, and threat. It is a key concept of emergency management. The use of effective coping skills can often help improve mental and emotional well-being. People who are able to adjust to stressful or traumatic situations (and the lasting impact these incidents may have) through productive coping mechanisms may be less likely to experience anxiety, depression, and other mental health concerns as a result of painful or challenging events.

To overcome their socio-economic problems, displaced people use both positive and negative coping mechanism. Report from Norwegian Refugees Council (2018) reports that, displaced people borrow money, work as a daily laborer and participate in sexual activities, not sending or dropping their children from school and begging as a coping mechanism. (Dereje, 2019)

People who find themselves defaulting to maladaptive coping mechanisms and/or experience difficulty utilizing effective coping strategies may eventually see a negative impact on mental and emotional well-being. Consuming alcohol can often help people feel less stressed in the immediate moment, for example, but if a person comes to rely on alcohol, or any other substance, in the face of challenging situations, they may eventually become dependent on the substance over time. A therapist or other mental health professional can often help people develop and improve their coping skills. Therapists can provide support and information about coping skills, and therapy sessions can be a safe, nonjudgmental environment for people to explore the coping methods they rely on and determine how they help or hinder stress management. (Fasil, 2018)

Coping strategies employed by women are largely related to diversification of sources of income, reducing number and quantity of meals. And the most prevalent mechanisms for coping with food insecurity were reducing the number of meals per day which accounted for 87.3 percent and 34 percent of female-headed and MHHs respectively (Mossa, 2013). (Beza, 2020)

## **Chapter Three**

### **Methods and Research design**

#### **3.1 Study Design**

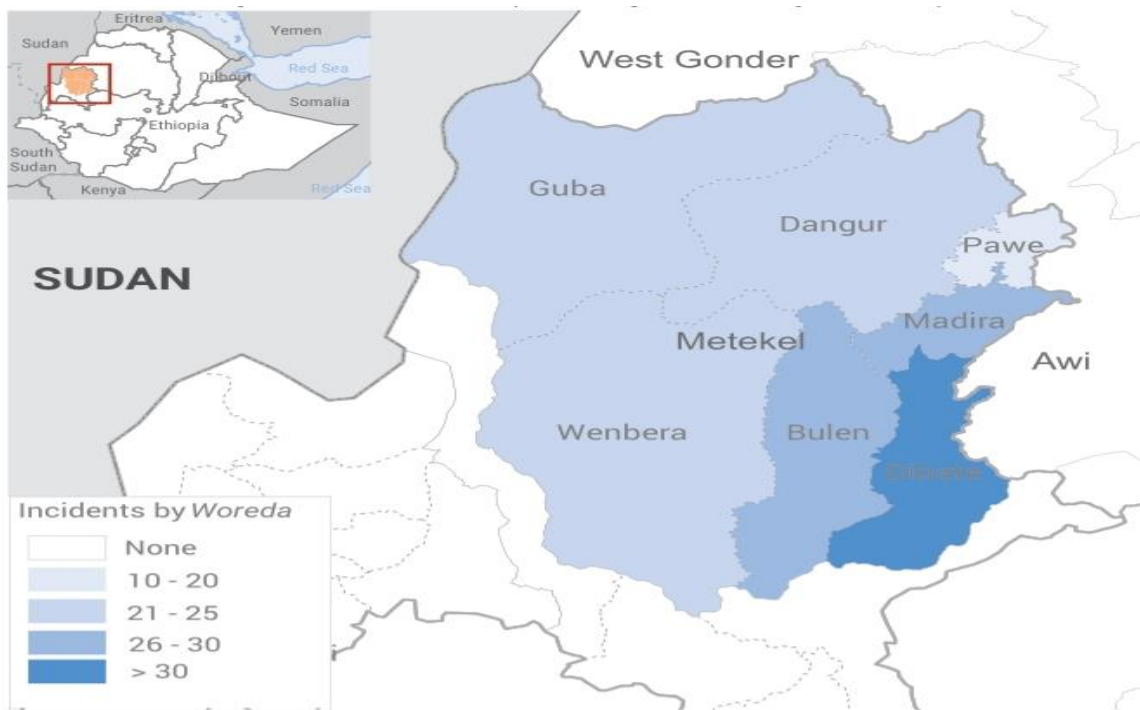
The study is a descriptive type of study. A cross-sectional quantitative study in which the results were triangulated with key informant interview and focus group discussions results were applied to accomplish the above stated objectives of the study. Qualitative and Quantitative methodologies were used to complement data collection and enrich the findings. Using mixed method provides an opportunity for presenting greater diversity of divergent views. It also reduces the limitation of each approach or helps to get more reliable data (De Silva, 2010 P.23-24). The triangulation is used to compare results from qualitative and quantitative components, increasing data confidence, highlighting specific findings and providing a clearer understanding of the status of the problems. Conclusions are made by analyzing results from both quantitative and qualitative components.

#### **3.2 Study Site**

Benishangul-Gumuz is a regional state in north-western Ethiopia to the border of Sudan. It was previously known as Region 6. The region's capital is Assosa. Following the adoption of the 1995 constitution, the region was created from the westernmost portion of the Gojjam province (the part north of the Abay River), and the northwestern portion of the Welega Province (the part south of the Abay). The name of the region comes from two peoples – Berta (also called Benishangul) and Gumuz.

Like other regions in Ethiopia, Benishangul-Gumuz is subdivided into three administrative zones namely, Assosa (also capital of BG), Kamashi and Metekel. This study focuses on Metekel zone. It is bordered on the south and southwest by Kamashi, on the west by Sudan, and on the north and east by the Amhara region. The Abay River defines the Zone's boundaries with Kamashi, while the Dinder River defines part of its boundary with the Amhara region. The administrative center

of Metekel Zone is Gilgel Beles. It has seven woredas namely Mandura, Dangur, Bullen, Wembera, Guba, Dibate and Pawe woreda.



*Figure 1: Map of Benishangul-Gumuz region, Zones and Woredas (source: OCHA access snapshot, Metekel Zone)*

This study was conducted on internally displaced women in the IDP camps and host communities of Mandura woreda of Metekel zone, Benishangul-Gumuz. Metekel zone was selected because there are a huge number of displaced persons due to the protracted/prolonged displacement occurred a few years ago in the area.

### **3.3 Study Population**

The total population of three hundred twenty seven in this study were internally displaced women residing in the camps and host communities including key informants from different INGOs. The reason for targeting this population is because the main objective of this study is to assess

psychological and social impact of displacement on women compared to other members of the community.

### **3.4 Sampling Method**

The quantitative part of the study used a multi-stage random sample, proportionate to the size of population in the area of interest (i.e. Mandura woreda in this case) were selected. This is one of the most accurate and representative sampling method in these kinds of studies in which our study area is too large and/or the study population is dispersed. The basic sampling units are selected within groups (i.e. woreda in our case). The objective of this method is to choose a limited number of smaller geographic areas in which simple or systematic random sampling can be conducted.

As per the information from different sources, the IDP's households are found in the woredas of the zone. Therefore, Mandura woreda was randomly selected from the seven woredas. After selecting the woreda, the IDP households, were listed and similar to the first stage two Kebeles were selected in the woredas. After the two kebeles selected the total sample size (i.e 327) were divided to the two kebeles proportionally based on the number of IDP households found in both woredas.

### **3.5 Sample size determination**

According to Krejcie and Morgan (1970), if the target population is around 1000-2000 approximately 20% of the population would make the sample. Therefore, in the current study the total population is 1484 and 20% of them was 297 participants. But considering the fluctuation (the increase and decrease) in the number of IDPs additional 30 participants were added to the sample for the purpose of contingency. Thus, the sample size for this study was 327, which represents the total population.

After selecting the study area the total sample size for the study is (i.e. 327 based on the below calculation) divided for these two Kebeles proportionally based on the number of IDP households found in them. In addition the IDPs are found both in camps and in the host communities of the

woreda. Consequently this number has also to distribute for them in the same way. The below table shows the proportion of data to be collected from the woreda within the towns and from the camps.

The sample size for the quantitative study is determined using scientific formula. The numbers of the samples is determined using the following formula: (WHO, 2005)

$$n = t^2 * p * q / d^2$$

Where: n = first estimate of sample size

t = 95% confidence interval will be taken and correspond to 1.96.

d = precision tolerated is taken as 0.05 (5%) and

p = considering the absence of recent study in the study area, 0.5 (50%) is taken as proportion of expected level in the target population and

$$q = 1 - p$$

Based on this the total sample size is 327. Therefore, 327 households will be chosen from the listed households.

No	Study Area	Study population		Sample		Percent (%)
1	Mandura Woreda	Population in the IDP camps	598	Sample from the IDP Camps	125	38.2
		Population in the Host Community (Kebeles)	889	Sample from the Host Community	202	61.7
		<b>Total</b>	<b>1484</b>	<b>Total</b>	<b>128</b>	<b>100</b>

*Table: Proportionate sample size across the study areas*

Concerning the key informant interview, interviews were conducted with representatives from Metekel zone, Gilgel Beles city Disaster and Risk Management (DRMO) office and Women and Children offices. In addition, heads (focal persons) and program coordinators of different

international organizations (FH Ethiopia, Plan International, Mother and Children Multi-Sectoral Development Organization (MCMDO) and Norwegian Refugee Council (NRC)) operating in the area in which the IDP's are residing were interviewed. On the other side, the focus group discussion (FGD) was conducted with women (mothers). Three FGD were conducted (one in the camp and two in the host community Genete Mariam Kebele and Foto Manjarie Kebele) found in Mandura woreda, with women (mothers), religious fathers and with elders. As per Escalada & Heong (2009 p. 11), a good size for a discussion group is between Eight to Ten participants. Therefore, the number of participants in each of the focus group discussions was eight. Finally, community representatives (i.e elders, religious leaders and other members who can give deep information about the issue) were interviewed.

### **3.6 Sampling procedure**

The study population consisted of IDP households living in the selected two Kebeles. Using the systematic random sampling method households were randomly selected from the listed households, which was received from Disaster and Risk Management offices in the zone. However, the sampling procedure for both the camp and Kebeles settings are different.

For the camp, using the systematic random sampling method the above stated number of households are randomly selected from the whole listed households who were getting different support from the camp. The first household in the north eastern part of the camp is chosen at random. Subsequent households are visited systematically using a "sampling interval". From the first household selected, the team always moved in right direction to the next household. This procedure is followed until the last house hold in that direction was obtained in the camp.

On the other side in the two Kebeles found in the woreda selected the first household at random. Then the nearest subsequent IDP households were visited continuously using a snowball method. From the first household selected, the data collectors always moved in right direction to the next household. This procedure will followed until the last household in that direction was obtained in the Kebele.

In both settings, all sampled households were visited, if the household has the required women and girl in which case whole part of the questionnaire was administered and both the mother and girl were interviewed. If there are more than one girl in the selected households, only one girl was randomly selected and interviewed only with the assent of parent or caregivers. If the mothers were not present, an appointment is to be made for a later visit in the next day.

Key informant interviews were conducted with the heads and other concerned officers in the selected concerned offices. One person from one concerned office was interviewed. The community representatives were also selected by being together with community members and the committees found in the camps.

### **3.7 Data sources and study instruments**

Both structured and semi-structured questionnaires and field observation checklists were used as instruments to gather the required data. Both the questionnaire and observation checklists were formulated based on assessing mental health and psychosocial needs and resources toolkit for humanitarian settings and IASC guidelines on mental health and psychosocial support in emergency settings.

The instruments were translated to Amharic prior to collecting data and pilot test was done using 54 IDPs in order to check the reliability and validity of the survey questionnaire. Moreover, self-developed questions and guides were used to gather data from FGD and key informant interview participants. Two experts (psychologists) from Assosa University were invited to comment on the prepared questionnaire before it was used for the actual data collection. As per their comments, some technical errors which makes some of the questions vague and ambiguous, were corrected. No changes were made as per the numbering and sequencing of the questions. As per their feedbacks the face validity of Amharic and English versions questionnaires was given a good face validity. In general the comments of the experts shows the questionnaire has a good reliability and validity and can be used for actual data collection.

#### **Primary data sources**

For the study, both quantitative and qualitative instruments were used to answer the key research questions. As the study is cross-sectional household-based study aimed at generating a baseline data on the status of mental health and psychosocial support to the IDP community, a household questionnaire was prepared. This structured questionnaire was designed with the purpose of generating household level data including information about the household and women and children interviewed and organized across three main parts.

In addition to this, qualitative tools is used to serve two purposes. First, to cover expertise issues found from those who work in the area of the IDP's key informant guide was prepared. This gave the possibility of examining topics in-depth by asking the respondents to clarify information and explanations and create relatively easy access to a wealth of knowledge from those working in the area. Second, to explore deeper insights about the status of the IDP's from community member representatives in the study area. It enabled to identify community opinions on different issues and the different views held by the different sub-groups. The discussions were also enabled to reach a larger number of the people at the same time and understand what the community think about the problem and services being provided. Both the qualitative tools also help to answer the 'what' and 'how' questions.

### **Secondary data sources**

A range of published and unpublished secondary data sources were used in order to generate literature review and get additional information about the number of internally displaced women, internal displacement and psychosocial support as a whole and other important information of IDP households and to place the findings in the more general context. For the purpose of this different geographical, population characteristic, livelihood strategies and support service-related information were collected during the whole study period.

### **3.8 Data collection method**

In the study, the different kinds of measurements and their definitions and indicators are mainly based on assessing mental health and psychosocial needs and resources toolkit for humanitarian

settings and IASC guidelines on mental health and psychosocial support in emergency settings guidelines.

### **Survey**

Due to the nature of the study, it is recommended not to make the field team large because the more the number of data collectors, the more chances to have poor interviewing. Therefore, the researcher formed field team consists of the researcher herself and four enumerators. After the pilot test the data enumerators collected door to door both in the IDP sites and in the host communities it took almost three week days to gather the data.

### **FGD & Key informant interview**

The researcher has done all the qualitative data collection meaning the interview and the FGD. However, one of the enumerators served as note taker during the focus group discussions. Three FGDs were conducted (one in Mandura IDP site, two in Genete Mariam Kebele and Foto Manjarie Kebele host communities) consisted of Eight participants in each FGDs. The IDP camps are comprised of IDPs displaced from different kebeles of the seven woredas. The participants of the FGD were selected by the help of representatives from each Kebeles. The focus group discussions is done on other days when there is no quantitative data collection mostly in weekends.

Key informant interviews also conducted with two government officers one from DRMO and one from Women and children offices. Additionally four representatives of non-governmental organizations (FH Ethiopia, Plan International, MCMDO and NRC) were also interviewed. When collecting qualitative data, preliminary data analysis is done while the collection is ongoing mainly at the end of each data collection sessions. This can help to establish preliminary ideas and tighten the data collection plan accordingly (i.e for filling gaps in knowledge on specific groups of participants, or changing the type of questions).

## **3.9 Data Analysis**

Once the data necessary for the study is properly collected, response verification and editing work is conducted and the questions were organized in such a way as to facilitate the analysis of the

study. After the data was organized in this way, it is entered in to a database prepared using a social science statistical application software called SPSS. The data entered is then re-edited and made ready for the analysis work.

The study was to primarily focus on answering questions such as who, what and how. It also focused on indicators that can show some of the major differences based on the basic characteristics of the study participants. Based on this data was analyzed using different types of statistical analysis methods, such as Percentile, frequency, mean average and standard deviation.

The qualitative data, generated from key informants' interview and focus group discussion were described and presented during discussion and triangulated with the quantitative results. The qualitative research analysis focused on the thematic analysis by listing the relevant topics, summarizing key ideas, and comparing them with the quantitative data. To this end, the baseline information necessary for the study was properly collected and organized. The questions were organized in such a way as to enable the analysis of the study. The properly collected and organized data were coded and organized into an analysis framework designed in a way to able to describe the essence of experiences.

### **3.10 Data quality assurance**

The quality of the study is depending highly on the work done in the field. So, it was tried to carefully plan the field work activities in terms of the recruitment and the capacity of the interviewers.

The enumerators were IDP's with the experience of community services focused in health and social areas. Adequate orientation was given to the team in order to ensure all assessment team members to enable them administer their work properly. In order to have similar understanding in the study process at all levels and in all the wordas of the study. Orientations is given on the selection of the participants, the content of the questionnaire and other data collection issues to be standardized as well as the overview of the study, the objectives, nature of the data to be collected, description of the sampling method, field procedures and interviewing techniques.

Before the actual fieldwork, the prepared questionnaire is checked by the pretest. The reliability of questionnaire was checked by Cronbach Alpha  $\alpha$  and it is found to be  $\alpha=.769$ . In addition, after the pretest, discussion was held with the data collection team. The issues were about question of clarity, cultural and local context appropriateness and other problems. On this, it is tried to arrive at consensus on many of the issues raised.

### **3.11 Ethical considerations**

Ethical consideration has been strictly followed in this study. The study respected the right and privacy of all participants who agreed to take part in it. First letter of support is written to Metekel zonal offices from Addis Ababa University School of Social Work Department. The offices write a letter to the respective bodies such as Disaster and Risk Management office and women and children office in the woreda.

Verbal consent to participate in the assessment was obtained from all adult respondents for the household questionnaire and Assent from legal guardians has been obtained for interviewing girls whose age is less than 18 years. At the beginning of the questionnaire is a paragraph requesting consent from the interviewees. The consent or refusal is recorded on the form by the interviewer. During this process households are informed that the study is confidential and that their answers would not affect their access to different services and their overall livelihood. Respondents were also assured that their responses would not be discussed at household level and the information would not be assessed by other people outside of the study team.

Participants also told that participation is voluntary and that they have the right to refuse to answer any or all questions. The respondents' consent is recorded on each questionnaire. Similarly, consent was requested from participants of the qualitative study especially from FGD participants.

## Chapter Four

### Findings of the Study

This section of the research presents the findings of the study from the collected data. The findings are presented under the major topics of Socio-demographic information of participants, prevalence of mental health problems on women, psychosocial needs of women in the camps and host communities (Kebeles), provision of psychosocial support to internally displaced women and the impact of internal displacement on mental health.

#### 4.1 Socio-demographic characteristics of participants

The table below presents the demographic information of respondents in the study.

No	Demographic Variables	Categories	Frequency	Percentile
1	Age	Underage (12-18)	64	19.5
		Early adulthood (19-35)	169	51.6
		Adulthood (35 & above)	94	28.7
		<b>Total</b>	<b>327</b>	<b>100</b>
2	Educational Status	Illiterate	97	29.6
		Elementary school	127	38.8
		High school	54	16.5
		University & above	49	14.9
		<b>Total</b>	<b>327</b>	<b>100</b>
3	Marital status	Married	113	34.5
		Single	61	18.6
		Divorced	48	14.6
		Widowed	105	32.1
		<b>Total</b>	<b>327</b>	<b>100</b>
4	Average family monthly income	Low income $\leq$ 3000 birr	124	37.9
		Moderate income (3001-6000)	113	34.5
		High income $\geq$ 6001	90	27.5
		<b>Total</b>	<b>327</b>	<b>100</b>

*Table 2: Socio-demographic information of respondents*

As can be inferred from the above table, out of the 327 respondents the highest number of respondent's age 169 (51.6%) ranges from 19-35 (early adulthood) years old followed by 94 (28.7%) respondent's age ranges from 35 and above years old and 64 (19.5) respondent's age ranges from (12-18).

Regarding the educational status out of the total respondents 127 (38.8%) were found to be in elementary school followed by 97 (29.6%), 54 (16.5%) and 49 (14.9%), Illiterate, high school and University respectively. With regard to marital status, out of 327 respondents 113 (34.5%) are married followed by 105 (32.1) widowed, 61 (18.6%) single and 48 (14.6%) divorced.

Furthermore, regarding average family income, out of the total respondent's income 124 (37.9%) were found to be under the category of low income followed by, 113 (34.5%) under the category of moderate income and 90 (27.5%) under the category of high income.

## **4.2 Mental health and psychosocial needs of internally displaced women**

According to the gathered data, internally displaced women have seen many traumatic events in the course of their displacement starting from the cause of their displacement to the temporary camp that they are currently residing in. the following case stories shows the horrific events that they have experienced.

### **Case stories showing the horrific events of those deadly nights where mass killings started**

#### **During the one of the FGD**

- 1. There was a situation where a woman and her husband shot to death, and while her husband died, she survived but wounded and stayed a night with his corps till she gets support. Then in the morning when woreda officials and members of the community who survived rounds they found her and give her a transport to flee to her family somewhere else...*
- 2. There was a boy who witnessed his mother raped and shot to death while they were trying to escape the violence. Now the boy stays with his aunt and she told the crowd*

*that he is having a nightmares always and she said he might feel nothing for now but will start getting ready for revenge when he gets sexually active and he becomes adolescent.*

3. *There was a situation where Gumuz-Ethnic rebel groups held captive farmers who were on their daily routine farming job, and forced them to leave their own lands claiming that the land belongs to the ethnic forefathers no them.*

One of the farmers who was held captive was a participant in the FGD, and he said that

*‘.....I have seen/ experienced richness and Poorness in my whole life. The only thing I have left to see is death, I would rather die than to live like this...’*

The information gathered from the FGD shows that, the prevalence of mental health and psychosocial problems differ from the IDP women found in the host communities (Kebeles) to that of IDP women found in the camps. The reason behind is that, IDP women in the host community (Kebeles) are in better situation compared to IDP women found in the camps with regard to stigmatization and marginalization. Additionally, IDP women in host communities shared community gatherings and other social events which helps them to cope up with the difficult situation that they have been going through. Also the community accepts them and give them all the necessary supports starting from financial support and food. Whereas, IDP women found in the IDP camp sites suffer from food insecurity. They get wheat flour from the government via DRMO office once in a month or two, and from which they sell a portion of it to buy other necessary inputs for making food such as oil and salt. Since they sell the portion of what they get they will finish it in short of the time to get another wheat flour for the next round. Furthermore, IDP women in the host communities has a greater chance to send their children to school than those who found in the IDP camps. Because, those who resides in the IDP sites tend to push their children to stay in a tent for many reasons among which one is fear of attack. They fear that their children might be attacked so that they prefer to let them stay in a tent. The other reason is to let their children help their mothers at home with chores such as caregiving to their siblings.

Ato Abebe, one of the Key informant said that,

*‘.....I have never seen a horrific event in my whole life except the events I have seen in the communal violence. Being the head of the DRMO office also exposed me to hear other horrific event other than what I have seen which could not be imagined in human beings mind.’*

He even suggested that not only the IDPs but also the whole community needs a psychosocial support step by step since, the whole experienced the traumatic events.

The outcome of the study shows that, the IDPs in general especially women are vulnerable to different kinds of attacks such as gender based violence. These attacks apart from the displacement inflicts mental health and psychosocial problems on these vulnerable groups. The mental health and psychosocial needs is related with the basic supports such as (economic support, food, shelter and hygiene protection materials), that these groups get from both governmental and non-governmental institutions.

### 4.3 Prevalence of mental health on internally displaced women

One way of categorizing IDPs is to look at differences between the displaced living in camps and those being self-settled. The following table tries to present the responses of respondents to with the aim of identifying the prevalence of mental health on IDP women residing in the camps and in the host communities (Kebeles) based on the gathered data.

Mental Health problems' symptoms	Internally Displaced Persons	Responses of respondents for the past two weeks before they responded to the questionnaire				
		All of the time	Most of the time	Some of the time	A little of the time	None of the time
Feeling so afraid that nothing could calm you down	In Camp	15%	16%	49%	15%	5%
	Out Side Camp	14%	14%	46%	19%	7%
Feeling so angry that you felt out of control	In Camp	30%	26%	24%	16%	4%
	Out Side Camp	26%	21%	25%	20%	8%
	In Camp	27%	25%	34%	12%	2%

Feeling so uninterested in things that you used to like, that you did not want to do anything at all	Out Side Camp	23%	21%	35%	16%	5%
Feeling so hopeless that you did not want to carry on living	In Camp	30%	26%	22%	18%	4%
	Out Side Camp	27%	23%	19%	23%	8%
Feeling so severely upset about the emergency/conflict/war or another event in your life, trying to avoid places, people, conversations, or activities that reminded you of such event	In Camp	39%	23%	20%	16%	2%
	Out Side Camp	37%	21%	24%	10%	8%
Being unable to carry out essential activities for daily living because of these feelings	In Camp	20%	22%	33%	21%	4%
	Out Side Camp	18%	20%	31%	24%	7%

***Table 3: Prevalence of Mental health problems on IDPs***

As can be seen from the above table, the prevalence of mental health problems on internally displaced persons is high in the IDP camp sites than outside the camps. Out of the total respondents in the camps 49% of IDP women some of the time, feel so afraid that nothing could calm them down, followed by 16% of IDP women most of the time, 15% of IDP women all of the time and 15% of IDP women a little of the time feel so afraid that nothing could calm them down. Additionally out of the total respondents only 5% of IDP women none of the time feel so afraid that nothing could calm them down.

On the other hand, Out of the total respondents out of the camps or in the host communities 46% of IDP women some of the time, feel so afraid that nothing could calm them down, followed by 19% of IDP women a little of the time, 14% of IDP women all of the time and 14% of IDP women most of the time feel so afraid that nothing could calm them down. Additionally out of the total respondents only 7% of IDP women none of the time feel so afraid that nothing could calm them down.

As can be depicted from the second row of the table, out of the total respondents in the camps 30% of the IDP women feel so angry that they felt out of control, followed by 26% of the IDPs most of the time, 24% of the IDPs some of the time and 16% of the IDPs a little of the time feel so angry

that they felt out of control. Additionally, out of the total respondents only 4% of IDPs none of the time feel so angry that they felt out of control.

On the other hand, out of the total respondents of out the camps or in the host communities 26% of the IDP women feel so angry that they felt out of control, followed by 25% of the IDP women some of the time, 21% of the IDP women most of the time and 20% of the IDP women a little of the time feel so angry that they felt out of control. Additionally, out of the total respondents only 8% of IDP women none of the time feel so angry that they felt out of control.

Feeling so uninterested in things that one used to like is the other bench mark to measure the prevalence of mental health problems. Out of the total respondents in the camps, 34% of the IDP women some of the time feel so uninterested in things that they used to like that they didn't want to do anything at all, followed by 27% of the IDP women all of the time, 25% of the IDP women most of the time and 12% of the IDP women a little of the time feel so uninterested in things that they used to like that they didn't want to do anything at all. Additionally, out of the total respondents only 2% of IDP women none of the time feel so uninterested in things that they used to like that they didn't want to do anything at all.

On the other hand, Out of the total respondents out of the camps or in the host communities, 35% of the IDP women some of the time feel so uninterested in things that they used to like that they didn't want to do anything at all, followed by 23% of the IDP women all of the time, 21% of the IDP women most of the time and 16% of the IDP women a little of the time feel so uninterested in things that they used to like that they didn't want to do anything at all. Additionally, out of the total respondents only 5% of IDP women none of the time feel so uninterested in things that they used to like that they didn't want to do anything at all.

With regard to feeling so hopeless, out of the total respondents in the camps, 30% of the IDP women all of the time feel so hopeless that they didn't want to carry on living, followed by 26% of the IDP women most of the time, 22% of the IDPs some of the time and 18% of the IDP women a little of the time feel so hopeless that they didn't want to carry on living. Additionally, out of the total respondents only 5% of IDP women none of the time feel so hopeless that they didn't want to carry on living.

On the other hand, out of the total respondents out of the camps or in the host communities, 27% of the IDP women all of the time feel so hopeless that they didn't want to carry on living, followed by 23% of the IDP women most of the time, 23% of the IDP women a little of the time and 19% of the IDP women some of the time feel so hopeless that they didn't want to carry on living. Additionally, out of the total respondents only 8% of IDP women none of the time feel so hopeless that they didn't want to carry on living.

As can be seen from the fifth row of the table, out of the total respondents in the camps, 39% of the IDP women all of the time feel so severely upset about the emergency/conflict/war or another event in their life, they try to avoid places, people, conversations, or activities that reminded them of such event, followed by 23% of the IDP women most of the time, 20% of the IDP women some of the time and 16% of the IDP women a little of the time feel so severely upset about the emergency/conflict/war or another event in their life, they try to avoid places, people, conversations, or activities that reminded them of such event. Additionally, out of the total respondents only 2% of IDP women none of the time feel so severely upset about the emergency/conflict/war or another event in their life, they try to avoid places, people, conversations, or activities that reminded them of such event.

On the other hand, out of the total respondents out of the camps or in the host communities, 37% of the IDP women all of the time feel so severely upset about the emergency/conflict/war or another event in their life, they try to avoid places, people, conversations, or activities that reminded them of such event, followed by 24% of the IDP women some of the time, 21% of the IDP women most of the time and 10% of the IDP women a little of the time feel so severely upset about the emergency/conflict/war or another event in their life, they try to avoid places, people, conversations, or activities that reminded them of such event. Additionally, out of the total respondents only 8% of IDP women none of the time feel so severely upset about the emergency/conflict/war or another event in their life, they try to avoid places, people, conversations, or activities that reminded them of such event.

Finally, out of the total respondents in the camps, 33% of the IDP women some of the time, are being unable to carry out essential activities for daily living because of these feelings, followed by

22% of the IDP women most of the time, 21% of the IDP women a little of the time and 20% of the IDP women all of the time, are being unable to carry out essential activities for daily living because of these feelings. Additionally, out of the total respondents only 4% of IDP women none of the time, are being unable to carry out essential activities for daily living because of these feelings.

On the other hand, out of the total respondents out of the camps or in the host communities, 31% of the IDP women some of the time, are being unable to carry out essential activities for daily living because of these feelings, followed by 24% of the IDP women a little of the time, 20% of the IDP women most of the time and 18% of the IDP women all of the time, are being unable to carry out essential activities for daily living because of these feelings. Additionally, out of the total respondents only 7% of IDP women none of the time, are being unable to carry out essential activities for daily living because of these feelings. In general, the prevalence of mental health problem on IDP women in the camps, is much higher than the IDP women outside of the camps or in the host communities. These can be seen from the general symptoms of mental health problems.

#### 4.4 Mental health and psychosocial support services

Mental health problems are prevalent on IDPs residing both in IDP camps and in host communities. Most INGOs operating in the area, mainly provide emergency supports for conflict affected areas such as WASH (Water, Sanitation and Hygiene), LFS (Livelihood and Food Security), Education support and other Protection supports. Some of the INGOs also included mental health and psychosocial supports in their emergency service programs.

Internally Displaced Persons	Kind of PSS (Psycho-social support) that the IDPs get			
	Basic services and security	Community and family supports	Focused, non-specialized supports	Specialized services
In Camp	52%	24%	18%	6%
Out Side Camp	51%	49%	0%	0%

*Table 4: Mental health and psychosocial services to IDPs*

As can be seen from the table, out of the total respondents in the camps 52% of the IDP women in the camps have received basic services and security since arriving in to the camp, followed by 24% of the IDP women who have received community and family supports, 18% of the IDP women who have received focused, non-specialized supports and 6% of the IDP women who have received specialized services. And out of the total respondents 51% of IDP women in the host communities have received basic services and security followed by 49% of IDP women who have received community and family supports.

According to the data from key informant interview and FGD conducted the following mental health services were listed as mainly provided in the camps and in the host communities. Only two INGOs are providing psychosocial supports incorporating it as one of the major emergency supports. The listed mental health services were:

**Basic services and security:** which incorporates basic emergency supports such as WASH kits (Soap, dignity kits and other hygiene materials), livelihood and food security and Non-food items (house hold utensils, canvas, blankets and so on).

**Community and family support:** which incorporates different social and religious events such as community gatherings and preaching.

**Focused non-specialized support:** which incorporates mobile health care services

**Specialized services:** mainly found in the health centers or other psychological institutions which incorporates mental health and psychological service such as counseling.

Ato Wondimagegn from MCMDO, of the key informants said that,

*‘..... We believe that our organization has achieved 78% of target beneficiaries by providing them psycho social support via our mobile service. But it doesn’t mean that we have provided a specialized services we need to work on that in collaboration with health centers in the future...’*

This indicates that there is a lot to do in facilitating the provision of specialized services in every available health centers in a way accessible to all IDPs.

Mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature. Significant problems of a predominantly social nature include: Pre-existing (pre-emergency) social problems (e.g. belonging to a group that is

discriminated against or marginalized; political oppression); Emergency-induced social problems (e.g. family separation; safety; stigma; disruption of social networks; destruction of livelihoods, community structures, resources and trust; involvement in sex work); and Humanitarian aid-induced social problems (e.g. overcrowding and lack of privacy in camps; undermining of community structures or traditional support mechanisms; aid dependency). Similarly, problems of a predominantly psychological nature include: Pre-existing problems (e.g. severe mental disorder; depression; alcohol abuse); Emergency-induced problems (e.g. grief; non-pathological distress; alcohol and other substance abuse; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution). (IASC, 2007)

Interview and focus group discussion conducted shows that, the prevalence of mental health problems on women in the IDP camp and host communities hosting internally displaced persons, is characterized as unattended problem. They explained how the attitude of the host community changed towards IDP women due to many reasons among which one is marginalization and discrimination. The members of the community were supportive in many ways to the IDP women but due to the protracted displacement, they became reluctant from time to time and unwilling to be supportive to these IDP women.

According to the discussion of the participants, these problems leads them to be engaged with negative coping mechanisms. For instance in order to make money some are engaged with begging, some gives their children to early marriage so that they can bring money and other support for their family and some are engaged with prostitution as a way of making money and to support their families. One of the FGD participants said that:

*‘.....I have given my baby girl she was just 13 years old to the richest farmer as a wife. This is because I have nothing left to give her as inheritance in case I died in this camp, I would rather give her to the man who is old enough to be like her father...’*

They have also discussed that, they don't know what to think about their future and their children's future. They said that, the communal violence costs them their peaceful daily life. Most of them lost their lands which they engage themselves with farming and agricultural activities to make a

living and provide for their families. They are waiting responses from the government to support them if possible in getting back their former lands so that they could continue farming but if not possible support them in getting new land in a form of compensation.

In general, all these problems inflicts stress, depression and anxiety apart from the post-traumatic stress disorder that they are currently struggling with due to the communal violence. And because of the non- existence of a responsible organ which can follow up and give solution to the issues and situations of IDP’s the prevalence of mental health problems on IDP’s specially on women and children left unattended.

#### 4.5 Significance of Psychosocial support

The IDPs both in the camps and outside of the camps understands the significance of the mental health services and psychosocial supports they are receiving. The following table presents the responses of respondents while asked how psychosocial support provided to them is significant.

Respondants	How significant is the psychosocial support provided to the IDPs?				
	Very Significant	Significant	Insignificant	Very insignificant	Total
<b>IDP's from the camps</b>	53%	44%	3%	0%	100%
<b>IDP's from the Host communities</b>	46%	51%	2%	1%	100%
<b>Total</b>					<b>100%</b>

*Table 5: Significance of psychosocial supports*

As can be inferred from the table, out of the total respondents in the camp 53% of the IDP women believed that the mental health service and psychosocial support is very significant, followed by 44% of the IDP women believed it is significant and only 3% of the IDP women believed it is insignificant. On the other hand, out of the total respondents outside the camps, 46% of the IDP women believed that the mental health service and psychosocial support is very significant, followed by 51% of the IDP women believed it is significant and only 2% of the IDP women and 1% of the IDP women believed it is insignificant and very insignificant respectively. In general, it

can be said that the IDP women have a positive reaction towards the importance of the psychosocial support currently provided to them even though it is not quite enough. Thus, it can be concluded that even though psychosocial support is very significant for the wellbeing of internally displaced women, it is provided in an appropriate way and adequately.

Ato Zerihun from FH Ethiopia, one of the key informants said that,

*‘.....He doesn’t believe that psychosocial support is provided in an appropriate way and adequately to the target beneficiaries. This is because there is no intervention almost in all INGOs except few operating in the area in terms of psychosocial support as compared to other emergency supports.’*

#### **4.6 Mental health problems’ outcomes and behaviors**

While social and psychological problems will occur in most groups, it is important to note that every individual will experience the same event in a different manner and will have different resources and capacities to cope with the event. Thus, the mental health problems and behaviors manifested differs from one individual to another. Out of the scale of Ten, Three might be given for the psychosocial support which can be characterized as almost non available. This is because there are only two INGO’s operating in the area which have a mental health and psychosocial support system in their emergency support programs. Having large number of IDP’s and addressing only a few beneficiaries’ entails the non-adequacy of the psychosocial support being provided now. Additionally, these INGO’s provide these PSS supports for IDP’s in the camp settings meaning the PSS support is only accessible to IDP’s who resides in the camps.

Even if there is a psychosocial support, there is no uniform system that can have an impact for the effective implementation of such supports. Since the INGO’s addresses only a few number of beneficiaries due to many reasons, the psychosocial supports are accessible for only these beneficiaries. According to the words of key informants the appropriateness of the psychosocial support which is currently being provided, when it is seen from the perspective of specialized supports it can be said that the supports are less appropriate. This is because for one thing the non-

availability of adequate support providers, social workers and psychiatrists and another reason is the ways that these supports are being provided.

#### **4.7 Coping mechanisms**

According to the data gathered the IDPs especially women used a negative coping mechanisms to handle the situation that they are in currently. Women engaged themselves in commercial sex works to make money and bring for their families. They are also engaged in begging (to cover their own expenses) quitting their school for almost a year and try to help their families. Additionally, Smoking (especially the Gumuz ethnic groups), Sleeping and crying (mostly women and children) and forcing their children to early marriage (mostly as a source of economic support) are the major coping mechanisms they are using currently.

##### **Begging**

It is said that one of the bad culture in the zone is begging. Peoples residing in Metekel zone strongly hate begging it is even considered as a sin among them. But, after the displacement has occurred some years back displaced peoples especially women started to engage themselves in begging to get relief from the financial and economic crisis that they face due to the displacement and to cover their expenses. They even face stigma and marginalization from the peoples residing in the host communities due to the reason that they are begging in the road ways and religious places.

##### **Smoking**

There are a number of IDPs who smokes the whole day in the IDP camp. Even though most of them are men, an increasing number of women also smokes. As per the information gathered from FGD conducted, they said it gives them some relaxation so that they got addicted (especially the Gumuz ethnic groups) smoking the whole day since most of them spent their time doing nothing in the camp. They also often drink alcohol (Areke) in order to relax.

##### **Sleeping and crying**

As per the data gathered, IDP women spent most of their day time in sleeping and some of them crying while sleeping. They said that they feel relieved when they cry out the grief, the anger and the hopelessness they face due to the displacement.

### **Engaging oneself in commercial sex work**

As per the FGD conducted, IDP women participants especially those residing in the host communities (Kebeles) and who live in a house for a rent engage themselves in commercial sex work. Mandura Woreda is the only road way to the Grand Renaissance Dam which is found in Guba Woreda. They said that the road way gives an opportunity to attract customers especially huge truck city drivers who pass by and who might take a lunch break or who stayed a night or two in Gilgel Beles city. They said they cover their monthly expenses by the money they got from such work.

### **Forcing their children to early marriage**

Most of the IDP women force their children to early marriage. One of the reasons why they would force to early marriage is to use them as a source of income. The other is out of a need to broaden their children's opportunities such as get better life. The participants in the FGD said that they prefer to force their children to early marriage than to let them stay with them in the camp. They said they worried about their children's future if their children stays in the camp.

### **Outcomes of Field Observation**

According to the field observation checklist it is hard to say the Mandura IDP site fulfills the basic standard of living. Because it lacks safe latrine and waste management, electricity and safe shelter (more than 20 families are found in some of the tents). Additionally, the IDP sites are partially accessible areas for emergency relief partners.

## **Chapter Five**

### **Discussion on the major findings**

In this section of the study, the major findings of the study are presented in relation to the relevant articles and researches conducted on internal displaced persons in general and internally displaced women and children in particular.

#### **5.1 Mental health and psychosocial needs of internally displaced women**

When war or conflict strike, women's lives and their familial roles are often turned upside down. Before having to flee, they may have been responsible for the home and the family, with their husband taking care of finances and practical matters outside the home. That reality changes radically if the man is killed, imprisoned, or severely wounded, leaving many women to flee their homes alone, assuming all responsibility for finances, security, health, and the future and well-being of their children. Their responsibilities also include some unbearable decisions – such as whether to leave their children alone at home so they can go out and work, or to let the children work instead of going to school. These awful decisions are part of a grinding daily struggle – the struggle to raise money for rent, food, clothing, health services, schooling, and more. (DRC, 2021)

As it is indicated previously mental health and psychosocial support refers to any type of support that aims to protect or promote psychosocial well-being and/or prevent or treat mental conditions (IASC 2007). But, before jumping into the support one should understand the mental health and psychosocial needs of a beneficiary. According to the findings of the study, internally displaced persons especially women and children have their own psychosocial needs. Mostly the psychosocial needs differs by type and range meaning that a children who are labelled as IDPs needs a play ground and other child friendly spaces to have fun and enjoy their childhood to the fullest just like their peer friends. Whereas, women who are labelled as IDP needs economic support (mostly cash money) for household expenditures (mostly food items) for their families.

The humanitarian situation in Metekel zone remains complex requiring an urgent scale-up to respond to the dire situation. Hostilities and high levels of violence have been occurring for years and continue affecting the lives of civilians. (OCHA, 2022)

As it is said earlier, post-traumatic stress disorder comes after a traumatic event happened. Due to the communal violence (ethnic conflict), there are mothers who watch the horrific deaths of their own children, there are women who have seen their husbands being shot, and there are children who witnessed their parents slaughtered.

Most of the IDPs used to live stable life before the displacement, this makes them so unhappy and hopeless even they got angry easily by things which seems to be easy to handle. Their children stopped school for almost a year until they get admitted to other schools temporarily. They are attending the class in a plastic tents where there is no basic educational materials such as desk and others. Most of them resides in a tent with a lot of family members and twenty up to fifty peoples share the same tent composed of women, children, elderly and persons with disabilities all in one tent without any protection.

In general, as it is defined in the operational definitions wellbeing is the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Therefore if the above stated physical, psychological and social needs of the IDPs especially women and children is secured it can be said that the psychosocial wellbeing is secured.

## **5.2 Prevalence of mental health problems**

It is often the case that those internally displaced who remain in camps belong to the lower classes/castes (Schrijvers 1999), while people with wider networks and/or access to more resources tend to move out of the camps and stay in rented houses, acquire good jobs, or even move abroad. It has also been documented that when social structures and support systems break down in camps, both men and women become vulnerable to discrimination, physical violence, and other forms of abuse (Mertus 2003). There are major gaps in our knowledge about IDPs who move out of or never move into camps, due to their invisibility. (Catherine, 2013)

According to the focus group discussion (FGD) and interview with the IDPs in the camps and in the host communities, the prevalence of mental health problems is much higher in the camps than in the host communities. This is because the IDPs especially women and children are vulnerable to different kinds of attacks compared to those who resides in the host communities. But this doesn't imply that there is no vulnerability in the host communities.

Most of the IDPs from the survey data shows symptoms of mental health problems according to the indicators which are listed under the IASC guidelines on mental health and psychosocial support in emergency settings. These are feeling so afraid that nothing could calm one down, feeling so angry that you felt out of control, feeling so uninterested in things that you used to like, that you did not want to do anything at all, feeling so hopeless that you did not want to carry on living, feeling so severely upset about the emergency/conflict/war or another event in your life, trying to avoid places, people, conversations, or activities that reminded you of such event and being unable to carry out essential activities for daily living because of these feelings. The data gathered from the FGD indicates the rank of the mental health problems both in the IDP camps and in the host communities ranked stress as to what to do next in the first place followed by depression, sadness and grief in the second place. Worry over situation and the future comes in the third place; despair (hopelessness) in the fourth; tension, anxiety and short temper in the fifth and Stigmatization and mistreatment in the sixth place.

The INGOs operating in the area provides basic supports which can be counted as a base for the PSS. There are a number of IDPs who still needs serious monitoring and follow-up. Among the basic supports these INGOs providing are divided into four major streams namely Education, Water, Sanitation and Hygiene (WASH), Shelter, Livelihood and Food security (LFS) and Child protection. Additionally only two INGOs provide MHPSS and information, Counseling and Legal Assistance (ICLA) services. The gap here is the imbalance between the need and the support. In other words, the INGOs addresses only a few number of IDPs according to the funding of their donors, while the number of IDPs who needs the support is much higher.

### **5.3 Mental health and psychosocial support services**

According to (Gobopamang, 2011) the models of psychosocial support broadly defined as personal and social support of the individual that enhances positive coping mechanisms and behaviors. The cognitive models of psychosocial support, based on the theory that knowledge motivates productive support, have been fortified with concepts from the more complex models that describe psychosocial support as a process involving not only giving support to people, but also matrix of attitudes and beliefs about making the individual part of the productive society. (Binega H, 2013)

It is not only individuals who face traumatic events but entire communities. Many studies highlighted the importance of the sociocultural environment for the way in which individuals, and indeed entire communities, experience trauma and recovery. The trauma associated with forced displacement has a psychosocial impact not only on the individual, but also their family, community and the larger society. At the family level, this includes the dynamics of single parent families, lack of trust among members, and changes in significant relationships and child-rearing practice. Communities tend to be more dependent, passive, silent, without leadership, mistrustful and suspicious. Additional adverse effects noted in the literature include the breakdown of traditional structures, institutions and familiar ways of life, and deterioration in social norms, ethics and loss of social capital (Somasundaram, 2014).

The Inter-Agency Standing committee clearly puts MHPSS interventions on a pyramid. And from up to bottom it is explained as follows. First specialized services (psychological or psychiatric services) are provided to those who are in a situation of suffering which is intolerable and peoples having difficulties in basic daily functioning beyond the scope of existing primary/ general services. Secondly focused non-specialized supports (psychological first aid and basic primary mental health care) for those who require more focused intervention by trained and supervised workers. Thirdly community and family supports for people who are able to maintain their mental and psychosocial wellbeing if they get help in accessing key community and family supports. And lastly social considerations in basic services and security for peoples who are in need and who are vulnerable. The wellbeing of all people should be protected through the provision of basic needs in a way that is participatory, safe and socially appropriate. (IASC, 2007)

According to recent reports of UNHCR on internally displaced women, women should have access to credit to enable them to start up their own businesses. Small loans to buy sewing machines, looms, seeds and transport vehicles can enable women to become self-supporting or at least able to meet the daily subsistence needs of their families. Because gender discrimination often affects women's credit opportunities, international financial institutions and development banks should be encouraged to orient more of their funds to supporting small-scale programs of direct benefit to uprooted women.

Support services provided by both governmental and non-governmental organizations are inter-dependent. Thus, these support services should be integrated. Most Non-governmental organizations focuses on emergency food supports and materials (non-food items) such as temporary tents, barrel, pot, utensils, etc... but providing only material supports couldn't effective unless it is backed by other essential supports like psychosocial support. For instance, it can't be expected that the psycho social support to be effective to woman or child who are being starved due to the shortage of food support that is why it is recommended that the supports should be integrated.

As per the information gathered, it can be said that the provision of psychosocial supports to internally displaced women and children is poor. In principle one of the WHO's fundamental health care recommendations is integrating specialized health care services such as mental health services into primary health care system which requires mental health service into integration into all routine health service delivery systems. Because of the lack of attention to the support, legal and institutional gaps, the mental health and psychosocial support services are still almost non-applicable. According to the interview conducted with the key informants, the provision of psychosocial support in the INGO's differ based on their types of programs. The MCMDO for example, provides psychosocial supports as one part of the support program. The social workers and mental health professionals (Psychiatrists) with the help of the committees in the camps will verify who needs special attention regarding mental health. They round the camps every 15 days to conduct mobile support. After they verify the persons who needs further support they will admit them to the counseling offices to give them the psychosocial support. If they found active cases

meaning if they found there are persons who are seriously ill will be sent to the available health center via referral pathway.

The institution also has a group information sessions regarding the possible problems and possible solutions especially regarding gender based violence by working with both the Justice Office and Women and children offices.

#### **5.4 Mental health problems' outcomes and behaviors**

Being displaced can have severe adverse effects on the physical, social, emotional and spiritual well-being of a person. Exposure to violence or disaster, loss of or separation from family members and friends, deterioration in living conditions, the inability to provide for one's self and family, and lack of access to services, can all have immediate and long-term consequences for individuals, families and communities, including post-traumatic stress disorders, psychosomatic illness, depression, anxiety and even violence (OCHA, 2021).

As per the findings of the study, it can be concluded that psychosocial support is not available in the area, even if there is a little effort by some of the non-governmental organizations to render these support it is not accessible by all of those who need the support. Additionally, the appropriateness of these supports are under the question mark. This is because due to the nature of the problem which have different outcomes and different manifestations there is no a uniform kind of support.

Psychological and Social distress tends to inflict four major problems which are emotional problems, cognitive problems, physical problems and behavioral (social) problems. Emotional problems can be manifested through sadness, grief, fear, frustration, anxiety, anger and despair while cognitive problems can be manifested through (loss of control, helplessness, worry, ruminations, boredom and hopelessness). Fatigue, sleeping problems (nightmares), loss of appetite and medically unexplained physical complaints can be manifestations for physical problems whereas behavioral and social problems can be manifested through (trauma related disorders, withdrawal, aggression, interpersonal difficulties, avoidance behavior and hyper arousal).

The existence of mental health problem due to lack of psychosocial support is inevitable. These happens mostly in emergency situations triggered by war or any other violence which costs peoples their habitual residences and them to be displaced. The IDPs used their own coping strategies in order to cope with the situation they are in. Most of the coping mechanisms they are using are negative. Even though, the strategy has been developed to provide a general blueprint for responding to the mental health services, training and research needs within Ethiopia, to outline the broad objectives to be achieved, and to lay a foundation for future actions, there exists a gap in monitoring and following up of its implementation. Thus, the FMOH should focus on its implementation.

Protection strategies should therefore include interventions to protect and promote mental health and psychosocial well-being. Because these types of interventions focus on highly sensitive issues, they must be conducted in a socially and culturally appropriate way and take into account the age, gender and diverse backgrounds of all members of the communities. Interventions should promote resilience among populations and be based on human rights principles, as well as on the principles of participation and “Do-No-Harm”. (Guiding principle)

## **Chapter Six**

### **Conclusion, Recommendations and Social Work Implications**

#### **6.1 Conclusion**

There are a number of difficult situations that a person can be trapped in while living in this world one of which is internal displacement. When people especially women are being forced migrants within their own country especially as a result of communal violence (ethnic conflict), they become vulnerable for different kinds of attacks since physical displacement is a prima facie evidence of vulnerability because people who are deprived of their homes and communities and means of livelihood are unable to resort to traditional coping capacities.

Whereas international law entitles refugees to physical security and human rights protection in addition to assistance to offset their other vulnerabilities, no such legal guarantees exist for those who participate in an “exodus within borders.” Thus, agencies seeking to help persons who have not crossed a border require permission from the very political authorities who may be responsible for the displacement.

The IDP phenomenon remains less understood, given the internal nature of the crisis, linked to a nation’s sovereignty, which assigns the responsibility for care and protection to national actors instead of an international body, such as the United Nations High Commission for Refugees (UNHCR), oversees the refugee population. In the interest of keeping the displaced populations protected from further harm and the larger populations uninterrupted, often, the displaced populations are kept hidden and the larger populations uninformed and unconcerned about those who become internally displaced.

Ethiopia is one of those low-income countries in the Horn of Africa experiencing internal displacement of a large number of people. This internal displacement might be characterized as natural and human-made disasters, which forces large number of peoples to flee their homes in order to spare their lives. Among the natural disasters, conflicts and other situations of political or economic tension often cause population movements.

Ethiopia lacks a comprehensive, dedicated policy on internal displacement. The government, however, is working on a draft policy and roadmap. The 2013 Disaster Risk Management Policy is designed to reduce risks associated with disasters but does not make specific provisions for IDPs. The Somali region in 2017 was the first to endorse a regional, durable solutions strategy specifically targeting IDPs, with the support of the Durable Solutions Working Group. This regional strategy has been the starting point for a new federal strategy, the Durable Solutions Initiative, which was launched in December 2019.

The psychosocial needs of women and children can be characterized as unattended from the point of view of PSS services currently being provided to the IDPs both in the IDP camp settings and in the host communities. Additionally, the provision of psychosocial support in the camp setting and in the host communities (about its availability, accessibility, adequacy and appropriateness of ways of provision of PSS services), in general can be summarized as not assessed. There are only two NGO's currently providing PSS services in the Woredas thus, it can be concluded that there are only few PSS services available. Also these NGO's provide these PSS services only in a camp settings thus it is also can be concluded that it is available to only those IDP's who are currently residing in the camp.

## **6.2 Recommendations**

Based on the above conclusion, the researcher forwarded the following recommendations showing possible ways of serving better psychosocial support and providing meaningful insights for service providers and future researchers.

- ❖ Metekel zone is one of the most affected areas due to ethnic conflict. Thus, it is recommended that IDP women residing both in camps and host communities (Kebeles) in Metekel zone Mandura woreda should get psychosocial supports since the conflict inflicts both psychological and social harm on these target beneficiaries.
- ❖ The Benishangul Zonal administration especially the Health sector should work on institutionalizing or incorporating psychosocial supports in the existing health centers. Apart from institutionalizing the psychosocial support system, it should also focus on

following up the proper implementation of the policies and procedures of durable solutions. So that, the IDP's especially women will get a continuous and consistent support.

- ❖ The Social Workers working in different Non-governmental organizations operating in the region should focus on rendering both specialized support (by psychologists and psychiatrists) and non-specialized support (by family, religious fathers, community gatherings and any other similar supports) to the IDPs especially to women.
- ❖ The INGO's should work hand and glove with government institutions and co-operate among themselves for the proper documentation of profiles of beneficiaries and other important information to support the right target beneficiaries.
- ❖ The number of Humanitarian organizations operating in the area should increase because the organizations are currently operating with a limited capacity. Not only that but co-operation and working together for integrated service provision is important in order to avoid duplication of service and resources.
- ❖ The zonal administration should work on peace keeping and durable solutions because the IDPs are eager to resettle to where they used to live before they got displaced and wanted to engage themselves in agricultural activities so that they can provide for their families. The zonal administration should also focus on rehabilitation of the damaged health centers, schools and other facilities one by one so that the internally displaced persons especially women get these services.
- ❖ Advocacy should be given to different zonal institutions (government offices) to fill the gaps in terms of providing organized and reliable data of beneficiaries so that the Humanitarian organizations meet their goals in addressing those affected by the conflict. Additionally, these governmental institutions should avoid excess bureaucracy in order to simplify the provision of the services provided by these humanitarian organizations. One of the reasons why there exists bureaucracy is the instability in the zonal administration structure due to the reshuffle of staffs repeatedly.
- ❖ Both governmental and non-governmental health institutions should be part of the intervention in a way that they give psychosocial supports as an independent health

intervention same as any other health streams because this issue hasn't been given enough attention. There should be capacity building trainings to health professionals.

- ❖ Although the Federal Ministry of Health (FMOH) drafted a strategy on goals in training mental health professionals and a desired outcome to increase effective mental healthcare delivered via primary healthcare settings, Regional and zonal administrations failed to follow up its implementation. Thus, it should take a consideration on how it should strive for better ways of providing PSS services in every primary healthcare settings.

### **6.3 Social work Implications**

In line with the findings of the study the following implications to future Social Work researches, Social Work education, Social Work policy and Social Work practices are forwarded.

#### **Implication to Social Work Education**

Students while attending their education in school of Social work should learn the importance of policies, procedures and guidelines while working with families, children, women and other vulnerable members of the society in a way to enhance better intervention mechanisms in the field works. Additionally they should know the importance psychosocial supports in every emergency situations happened be it due to natural or manmade causes.

#### **Implication to Social Work Researches**

There are a number of researches conducted on mental health and psychosocial supports to internally displaced persons. But, so far there very few researches directly linked to the role of mental health and psychosocial support in emergency settings. This implication shows that Social Workers should undertake researches on mental health and psychosocial supports in emergency settings for the betterment of societal wellbeing.

#### **Implication to Social Work Practice**

Social Work professionals should have a very unique quality while engaging themselves in field works. Among these qualities one is building trust with the members of the society especially with

the target groups so that they could find out the root cause of a certain social problem which needs an immediate action from the concerned bodies. Thus, while working with internally displaced persons they should focus on rapport building so that they could find out the contributing factors for the problems they face due to the displacement and the long lasting effect on their day to day life, before they engage in finding a solution and intervention.

### **Implication to Social Work Policy**

The issue of Mental Health and psychosocial support is becoming the major concern of Federal Ministry of Health. And as a step forward it drafted the National strategy on Mental Health back in 2019. As per this research psychosocial support is equally important as that of emergency basic supports being provided in emergency settings. Thus, Social Workers should conduct needs assessment and projects proposals be prepared solely to the needs of internally displaced women to operate effectively and to provide psychosocial supports both in the camp settings and in the host communities. They should also engage themselves in advocating the inclusion of mental health and psychosocial supports as basic emergency responses which should be accessible to the target beneficiaries same as other supports such as Shelter, Food and other basic emergency supports, to the concerned policy makers and support developers.

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# Appendices

## Appendix-A: Questionnaire

Exploring the mental health status and provision of psychosocial support for internally displaced women and children												
Household Questionnaire												
<i>Respondents: Mother/Caretaker and eligible children</i>												
Questionnaire ID	Zone				Block			HH				
DESCRIPTION	INTERVIEWER'S VISITS											
	1	2				3						
DATE												
INTERVIWER'S NAME												
RESULTS*												
NEXT VIST: DATE												
TIME												
*RESULT CODES												
01=Completed	05=Respondent refused				9= Not eligible							
02=Not at home/workplace	06=Parent /guardian refuse				10 = Other, Specify _____							
03=Away for extended period	07=Partly completed											
04=Postponed	08=Incapacitated											
QUALITY ASSURANCE - FIELD WORK												
	NAME				DATE			SIGNATURE				
Completed (enumerator)												
Field edited (supervisor)												
For Data entry use only												
	NAME				DATE			SIGNATURE				
Edited by												
Keyed by (data encoder)												

## INFORMED CONSENT

Good morning/afternoon! My name is \_\_\_\_\_. Currently, we are undertaking a study, which is doing on exploring the mental health status and provision of psychosocial support for internally displaced women and children in this camp. We would like to ask you about your experience concerning different mental health related issues. We would also interview your children if they become eligible for the study.

Your household has been selected for the interview by means of a random or chance selection process, much like picking an orange out of a basket without looking.

If you agree to participate in the study, I ask you few questions. If I may, but you can refuse to answer any question I ask. You may also end the interview at any time. You can also refuse to participate in the study entirely. The interview will take about half an hour.

The interview is strictly confidential so your responses are not shared with anyone. Your name will not appear on any of my notes or any of the reports.

Are you willing to participate in the study?

Yes

No

If you have any doubts or questions in future, you may contact the study investigator with 251938-28-08-20. Thank you.

*I, the undersigned interviewer, have explained to the volunteer in a language he/she understands, and he/she understands the procedures to be followed in the study and agree to participate in it.*

\_\_\_\_\_  
Signature of interviewer

\_\_\_\_\_  
Date

<b>Household Questionnaire</b>	
<b>Profile of the house hold members</b>	
<i>Respondents: Father, Mother/Caretaker and eligible children</i>	
Questionnaire ID	
Zone	
Woreda	
HH	
Date	
Interviewee's Name	
Age	
Gender	
Educational Status	A. Illiterate B. Elementary school C. High school D. University Degree
Marital Status	A. Married B. Single C. Divorced D. Widowed
Number of HH Members (12-18) years old	
Number of HH Members (19-60) years old	
Average HH income in birr	
Length of stay in the IDP camp	

Respondent Code				
No	Questions and Filters	Coding Categories		Go to Q
01	During the last two weeks how often, did you feel so afraid that nothing could calm you down?	01	All of the time	
		02	Most of the time	
		03	Some of the time	
		04	A little of the time	
		05	None of the time	
		98	I don't know	
		99	Refused to answer	
02	During the last two weeks how often, did you feel so angry that you felt out of control?	01	All of the time	
		02	Most of the time	
		03	Some of the time	
		04	A little of the time	
		05	None of the time	
		98	I don't know	
		99	Refused to answer	
03	During the last two weeks how often, did you feel so uninterested in things that you used to like, that you did not want to do anything at all?	01	All of the time	
		02	Most of the time	
		03	Some of the time	
		04	A little of the time	
		05	None of the time	
		98	I don't know	
		99	Refused to answer	
04	During the last two weeks how often, did you feel so hopeless that you did not want to carry on living?	01	All of the time	
		02	Most of the time	
		03	Some of the time	
		04	A little of the time	
		05	None of the time	
		98	I don't know	
		99	Refused to answer	
05	During the last two weeks how often, did you feel so severely upset about the emergency/conflict/war or another event in your life, which you tried to avoid places, people, conversations, or activities that reminded you of such event?	01	All of the time	
		02	Most of the time	
		03	Some of the time	
		04	A little of the time	
		05	None of the time	
		98	I don't know	

		99	Refused to answer	
06	During the last two weeks how often, were you unable to carry out essential activities for daily living because of these feelings?	01	All of the time	
		02	Most of the time	
		03	Some of the time	
		04	A little of the time	
		05	None of the time	
		98	I don't know	
		99	Refused to answer	
07	Have you experienced this problem previously before the conflict in your area?	01	Yes	
		02	No	Go to Q 09
08		01	Yes	

	If yes, have you received services for this problem previously in your area?	02	No	
09	Have you received any services to address this problem since arriving in to this area?	01	Yes	
		02	No	Go to Q 11
10	If Yes, what were the supports you have received? <i>(Interviewer: more than one answer is applicable)</i>			
11	Do you feel you need additional services or support with this problem?	01	Yes	
		02	No	Go to Q 13
12	If yes, What kind of services or support would you need for this problem? <i>(Interviewer: more than one answer is applicable)</i>			

**Psychological and social Distress**

13	Could you list the problems you are currently experiencing because of the humanitarian situation? <i>(Interviewer: list all the problems stated. Probe by saying if any other else)</i>			
14	Have you experienced problems in your relations with other people?	01	Yes	
		02	No	Go to Q 16
15	If 'yes', what are the problems you have experienced? <i>(Interviewer: list all the problems stated.)</i>			
16		01	Yes	

	Do other people stigmatize you or not give you support?	02	No	
17	Are you not as involved in community activities as you would like to be?	01	Yes	
		02	No	
18	Have you been experiencing problems with your feelings?	01	Yes	
		02	No	Go to Q 20
19	If 'yes', what are the problems you have experienced? <i>(Interviewer: list all the problems stated.)</i>			
20	Do you feel sad or angry, or are you afraid?	01	Yes	
		02	No	
21	Have you been experiencing problems with the way you think?	01	Yes	
		02	No	Go to Q 23
22	If 'yes', what are the problems you have experienced? <i>(Interviewer: list all the problems stated.)</i>			
23	Do you have problems concentrating?	01	Yes	
		02	No	
24	Are you thinking too much?	01	Yes	
		02	No	
25	Are you forgetting things?]	01	Yes	
		02	No	
26	Have you been experiencing any problems with your behavior?	01	Yes	
		02	No	Go to Q 28
27	If 'yes', what are the problems you have experienced? <i>(Interviewer: list all the problems stated.)</i>			
28	Are you doing things because you are angry?	01	Yes	
		02	No	
29	Are you doing things other people have found strange?]	01	Yes	
		02	No	
<b>Social Support and Coping Strategies</b>				
30	Could you tell me how the above stated problems affect your daily life?			
31	Have you tried to find support for these problems?	01	Yes	
		02	No	Go to Q 33

32	Could you describe how you have tried to deal with this problem? <i>(Interviewer: list all the deals stated. Probe by saying if any other else)</i>			
33	Have you received support from others in dealing with this problem?	01	Yes	
		02	No	Go to Q 37
34	Who gave you this support?	01	Family member	
		02	Community member	
		03	Community leader	
		04	Community facilitator	
		05	Health professional	
35	What kind of support did you get? <i>(Interviewer: circle all the answers stated.)</i>	01	Basic services and security	
		02	Community and family supports	
		03	Focused, non-specialized supports	
		04	Specialized services	
36	To what extent did this help you to deal with the problem?	01	Very significant	
		02	Significant	
		03	Insignificant	
		04	Very insignificant	
37	Do you feel you need additional support with this problem?	01	Yes	
		02	No	
38	What kind of support you think you need? <i>(Interviewer: list all the deals stated.)</i>			

## Appendix-B: Key Informant Interview Guide

<b>Exploring the mental Health status and provision of psychosocial support to Internally Displaced Women and Children</b>
<b>Key Informant Interview Guide</b>
<b>Representatives of different organizations</b>

Interviewees: Representatives of different governmental and Non-governmental organizations working in the Area.

### Interview General Instructions

To make the interview a success, you need to follow these guidelines.

- Identify and select the appropriate person who can provide sufficient information according to the purpose of the interview.
- Start the interview by introducing yourself, explaining the purpose of the interview and thanking the respondent for taking the time.
- Explain that any information provided by the interviewee is for the study use only and is confidential.
- Not ask questions in an impartial, biased and indicative manner, and in a manner that influences and motivates decisions.
- Use as many probing questions as possible.
- Prepare to finish the interview by the time allotted for it (i.e. from 1:00 – 1:30 hours) and

Finally, the respondents are to be commended for devoting their precious time to the interview.

### Profile of the Interviewee

1. Age: \_\_\_\_\_

2. Gender: \_\_\_\_\_

3. Educational status: \_\_\_\_\_

4. Field of study: \_\_\_\_\_

5. Year of professional service in the Field: \_\_\_\_\_

6. Position or role in the assigned office: \_\_\_\_\_

7. Year of professional service in the assigned office: \_\_\_\_\_

Time of start of the interview: \_\_\_\_\_ Time of completion of the interview:  
\_\_\_\_\_

### **A guide for the Interviewer**

*The interview will take place in the following order. Questions will be asked according to the list. Be sure to ask all the questions and following probing questions.*

### **Interview Questions**

1. How many internally displaced women and children are there in the camp?
2. What was the cause for the displacement?
3. How do you explain for the prevalence of mental health problems in the community (on women and children)?
4. How do you manage to provide all the necessary services to these groups of people?
5. What are the different supports that are provided to the internally displaced women?
6. What are the psychosocial support that are provided to the internally displaced children?
7. How these psychosocial supports are provided? Or what are the ways or means used to provide these supports? (to know the accessibility of the psychosocial supports & whether they are friendly to the beneficiaries or not)
8. How is the work to facilitate for the development of community-owned, managed, and run programs? How is the work to build local capacities, supporting self-help and strengthening the resources already present in affected groups?
9. Are there established effective systems for referring and supporting severely affected people? How these systems are working?
10. What educational programs are provided in order to provide accurate information that reduces stress and enables people to access different services? What are the channels used for this?
11. Do you think the psychosocial supports that are currently provided to internally displaced women and children are adequate? If your answer is YES/ NO, how?
12. How do you think the support service can be improved?

## Appendix-C: Focus Group Discussion Guide

### Exploring the mental health status and provision of psychosocial support for internally displaced women and children

#### Focus Group Discussion

#### Community Members

**Group Discussion Participants:** Community elders, religious leaders, selected residents of the camp.

#### Group Discussion General Instructions

1. Identify and select participants carefully.
2. Arrive early to the place and prepare the appropriate discussion area. This allows time to deal with unexpected discussion area scheduling, and to set up materials and other important things.
3. Test your recording equipment or other electronic equipment to be sure it works.
4. During opening the session, introduce yourself, your assistant, and the purpose of the focus group. Explain to participants that they have been invited to share their opinions and that you guide the discussion by asking the group to reflect on specific questions. Tell them what time the session will conclude.
5. Explain the ground rules for the focus group discussion. These will set the tone and expectations for behavior so that everyone will feel safe and willing to participate. This has to include:
  - Participation in the focus group is voluntary.
  - It is all right to abstain from discussing specific topics if you are not comfortable.
  - All responses are valid—there is no right or wrong answer.
  - Respect the opinions of others even if you do not agree.
  - Try to stay on topic; we may need to interrupt so that we can cover all the material.
  - Speak as openly as you feel comfortable.
  - Avoid revealing very detailed information about your personal issues.
  - Help protect others' privacy by not discussing details outside the group.

6. Facilitating the focus group and during closing the session, end the discussion by summarizing the main points. If there is time, invite participants to reflect on the main ideas, and ask if they have any additional thoughts to share. Thank the group for participating; let them know how the discussion results will be used.

**Consent to participate in the Focus Group Discussion**

You have been asked to participate in a focus group discussion for exploring the mental health status and provision of psychosocial support for internally displaced women and children study in your camp. The purpose of the discussion is to try and understand how mental health status is and explore the provision of different supports for internally displaced women and children. The information learned in the focus groups will be used to provide meaningful insights for service providers and future researchers.

You can choose whether to participate in the focus group or to stop at any time. Although the focus group will be tape recorded, your responses will remain anonymous and no names are mentioned in the report.

There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints. We also would like to hear from everyone. We hope you can be honest even when your responses may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

I understand this information and agree to participate fully under the conditions stated above:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Profile of the Participants**

No	Gender	Age	Educational status	Marital status	Responsibility in the community


**Instruction to the facilitator:**

The following is the focus group discussion guide. Try to ask the questions below in the order given but it is important to keep the flow of discussion. Probing questions are also included. Make sure you go through all of them.

**Questions related with living status before displacement**

1. Where were your habitual residence before you got displaced?
2. What was your job for a living?
3. How do you describe life before displacement?

**Questions related with living status after displacement**

1. What do people in your community believe has caused the current displacement?
2. According to community members, what are the consequences of the displacement?
3. According to community members, what will be further consequences of this displacement?
4. How has the displacement affected daily community life?
5. How the displacement has affected people’s livelihood, activities/ work?
6. How are people trying to rebuild and recover from this crisis?
7. Which people in your community are suffering the most from the current crisis?

**Questions related with the mental health status and provision of psychosocial support**

1. What kind of problems do you have because of the humanitarian situation? Please list as many problems that you can think of. *(Interviewer: Probe if mental health /psychosocial/ problems are not stated. List all of the problems stated.)*
2. Which mental health /psychosocial/ problems are perceived to be important? Why? *(Interviewer: list the rank of the stated problems based on the below table.)*

Rank of the Problem	The mental health /psychosocial/ problem	Reason for the rank
1		
2		
3		
4		
5		
6		

3. What are the impact of mental health /psychosocial/ problems on daily functioning of the affected people? *(Interviewer: Identify the impact of mental health /psychosocial/ problems on daily functioning (i.e. things they do for themselves, their family or in their community) by asking about the above stated and ranked mental health /psychosocial/ problems.)*

Rank of the Problem	The mental health /psychosocial/ problem	Problems on daily functioning
1		
2		
3		
4		
5		
6		

4. How people cope with each of these mental health / psychosocial problems? *(Interviewer: try to identify how people cope (i.e. things they do by themselves, things they can do with their families or things they do with their communities.) with the above stated mental health / psychosocial problems and whether this helps them.)*

Rank of the Problem	The mental health /psychosocial/ problem	Coping mechanism used	Is it helpful? 1=yes 2=no
1			

2			
3			
4			
5			
6			

**Questions related with nature of distress and support to women and children**

5. How would an outsider recognize a woman and child who is emotionally upset/ distressed by the displacement? *(Interviewer: try to probe in detail by asking questions like what the child look like does? How do they behave? Are there different types of being upset? What are they?)*
6. In normal circumstances (before the recent displacement), what did community members usually do to reduce the upset/ distress of women and children?
7. What are community members doing right now to reduce the upset/ distress of women and children?
8. What else is being done right now to help women and children who are upset/ distressed?
9. How psychosocial supports to women and children are provided? What are the ways or means used to provide these supports? *(Interviewer: Try to know deeply about the accessibility of the psychosocial supports & whether they are friendly to the beneficiaries or not)*
10. What more could be done to help women and children who are upset / distressed? Do you think the psychosocial support that are currently provided to women and children are adequate? If your answer is YES/ NO, how?

**If you have anything to add, you can add. Thanks for sharing your time with me!**

## **Appendix-D: Field observation checklist**

1. Location of settlement camp in relation to accessibility to social services.
2. Housing structures of the IDP camp (room's size, classes, sanitation, how it furnished...)
3. Infrastructures available in the camp (water, electricity, sanitation, latrine, waste management...)
4. Physical capital available in and around IDP camps
5. Emotional condition of the IDPs when visited by outsider and speaking to third party about their condition.