The CENTER for VICTIMS of TRAUMA

ASSESSING MENTAL HEALTH in Gambella, Ethiopia:

A Representative Survey of South Sudanese Refugees in Nguenyyiel Camp

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The Center for Victims of Trauma

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Sarah Peters
Program Evaluation Advisor
speters@cvt.org

Shannon Golden
Research Associate
sgolden@cvt.org

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The Center for Victims of Trauma (CVT) in Ethiopia carried out a mental health assessment of Nguenyyiel Refugee Camp, Gambella, in January 2019. Survey respondents (N=639) are representative of the adult population of the camp. The goal was to understand the needs and perspectives of South Sudanese refugees in order to inform mental health and psychosocial support (MHPSS) service providers and other stakeholders in designing interventions responsive to the needs of the population. Our findings include: generally positive attitudes about mental health, including reliance on family and friends to talk about mental health issues; mental health concerns ranked highly among daily problems for refugees; moderate levels of symptoms related to post-traumatic stress disorder and depression; high levels of functional difficulties among refugees; moderate prevalence of primary torture survivors; and relatively low awareness of available services. This report includes an overview of the context, data collection methodology, descriptive findings, and recommendations from findings.

Contents

Rationale

Understanding mental health needs of individuals and communities who have experienced war, organized violence, and human rights abuses is fundamental to the success of any mental health intervention with these populations. There can be severe psychological effects from loss of loved ones, torture or other abuse, or witnessing violence or atrocities.[1] Many refugees also experience negative effects of continuous traumas and ongoing stressors or threats associated with forced migration. In this context, it can be extremely difficult to process or cope with grief over those who have died or ambiguous loss over those whose whereabouts are unknown. These factors can impair daily functioning of refugees fleeing conflict or instability, reducing their ability to effectively meet the substantial challenges of daily living in their country of refuge.[2]

Not accounting for these needs can diminish the success of humanitarian interventions (including non-health programs, such as education and livelihood initiatives), as well as potentially contribute to increased levels of ongoing violence in communities and households and high rates of self-harm or destructive activities. Understanding and attending to the mental health needs of survivors is a key part of restoring dignity in the wake of human rights abuses and providing a form of justice for those who suffered harms. It may also be a preventative mechanism to inhibit future cycles of violence and promote more effective peacebuilding.

Globally, there is very little representative data about refugee mental health in humanitarian contexts. First, most existing research on the psychological impacts of conflict or other traumatic experiences for East African refugees are conducted with populations that have been resettled to a third country; this research does not capture symptoms and effects in the contexts in which most refugees are located. Second, in most analyses, claims about refugees' mental health in humanitarian settings are supported by evidence from help-seeking (non-representative) populations. These data do not reveal the full range of needs among the population, but rather only those who have self-selected into services to address their mental or physical health needs. The most vulnerable members of the community are unlikely to seek help, whether due to stigma or restricted ability to access services. Finally, many needs assessments rely on data, typically qualitative, from key informants, community leaders, or other stakeholders who provide perspectives on mental health needs based on their expert positions or their depth of experience within communities. However, despite their knowledge about the community, this data cannot provide prevalence rates or allow inferential or multivariate analyses. Taken

[1] See: Higson-Smith, C. 2014. "Complicated Grief in Help-Seeking Torture Survivors in Sub-Saharan African Contexts." *American Journal of Orthopsychiatry* 84(5):487-495; Nickerson, A., B.J. Liddell, F. Maccallum, Z. Steel, D. Silove, and R.A. Bryant. 2014. "Posttraumatic Stress Disorder and Prolonged Grief in Refugees Exposed to Trauma and Loss." *BMC Psychiatry* 14:106; Priebe, S., M. Bogic, R. Ashcroft, T. Franciskovic, G.M. Galeazzi, A. Kucukalic, … D. Ajdukovic. 2010. "Experience of Human Rights Violations and Subsequent Mental Disorders - A Study Following the War in the Balkans." *Social Science and Medicine* 71(12):2170-2177.

[2] See: Higson-Smith, C. 2013. "Counseling Torture Survivors in Contexts of Ongoing Threat: Narratives from Sub-Saharan Africa." *Peace and Conflict: Journal of Peace Psychology* 19(2):164–179; Li, S.S.Y., B.J. Liddell, and A. Nickerson. 2016. "The Relationship between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers." *Current Psychiatry Reports* 18(9):1-9; Miller, K. E., and A. Rasmussen. 2010. "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-focused and Psychosocial Frameworks." *Social Science & Medicine* 70 (1):7-16; Miller, K. E., and A. Rasmussen. 2017. "The Mental Health of Civilians Displaced by Armed Conflict: An Ecological Model of Refugee Distress." *Epidemiology and Psychiatric Sciences* 26(2):129-138.

together, these factors contribute to a substantial information gap for service providers implementing mental health interventions in humanitarian settings.

CVT has begun fielding a series of representative surveys to collect data to inform its own programming and the sector more broadly.[3] We carried out similar surveys in a refugee camp for South Sudanese and other populations in Kakuma, Kenya in 2016 and in 2018, in two refugee camps for Eritreans in the Tigray region of Ethiopia in 2017, and in Bidi Bidi settlement hosting South Sudanese refugees in western Uganda in 2019. These surveys use rigorous social scientific methods to collect representative data about mental health issues, needs, and resources in humanitarian settings. With methodologies that are replicable and feasible, and with consistent questionnaires, conducting surveys in different locations at different time points contributes to the construction of a global dataset of refugee mental health. This can lead to comparative analyses of levels of trauma, stigma, stressors, and symptoms between refugee camps or between people from the same country of origin in different settings. Such analyses can help the humanitarian sector design and prioritize effective responses, including advocating for resources and informing donors about emerging needs.

Context

In the Gambella region of Ethiopia, there are seven refugee camps hosting South Sudanese refugees: Kule, Tierkidi, Jewi, Pugnido, Pugnido II, Okugo/Dimma, and Nguenyyiel. A majority of refugees in Gambella region are ethnic Nuer and are fleeing violence since the 2013 start of the South Sudanese civil war.[4] Nguenyyiel camp is located near Gambella town, and is the newest and largest refugee camp in the region. The camp was opened in October 2016 with an original capacity to accommodate 60,000 South Sudanese. After an influx of new arrivals in December 2016 (over 55,000 in just one month), the rate of arrival fell to a much lower level, with smaller spikes in 2017 and 2018. Nguenyyiel has received the vast majority of new arrivals, with the population climbing over 80,000 by the end of 2017. Currently completing a registration campaign, UNHCR in Ethiopia is reporting 81,073 registered refugees in Nguenyyiel.[5]

Refugees in Nguenyyiel are fleeing civil war and mass human rights violations in South Sudan. In late 2013, political tensions between President Salva Kiir and his former deputy Riek Machar precipitated a brutal armed conflict. Fighting began in the capital, Juba, but quickly spread to other parts of the country, including the states of the Greater Upper Nile Region, and later to Central and Western Equatoria.[6] Both of the key parties to the conflict, the Sudan

[3] Reports of survey findings are available at https://www.cvt.org/resources/publications.
[4] Pugnido is the only camp that houses the refugees that arrived prior to the 2013 civil war, and its residents include both ethnic Nuer and Anyuak.
[5] See UNHCR's Ethiopia Comprehensive Registration, data available at https://im.unhcr.org/eth/. Last accessed June 24, 2019. This figure is higher than what CVT estimated through fieldwork in January 2019. Obtaining accurate population figures is challenging in humanitarian contexts, particularly with highly mobile refugee populations and shifting security and other situations. Estimates provided by UNHCR to CVT in January 2019 put the population of Ngueyyiel at 79,884. CVT received estimates from ARRA of 53,756, with 8,946 households (average household size of 6.1). This figure was supported by CVT's survey fieldwork, which estimated 8,514-9,168 households. Using the estimated household size of 6.1, this would be a population of approximately 51,935-55,925.
[6] See UNHCR, December 2015. "The State of Human Rights in the Protracted Conflict in South Sudan," p. 2. Available at https://www.ohchr.org/Documents/Countries/SS/UNMISS_HRD4December2015.pdf.

People's Liberation Movement (SPLA) and the Sudan People's Liberation Movement/Army in Opposition (SPLM/A-IO), have allegedly perpetrated gross human rights violations against civilians. These have included forced recruitment, arbitrary detention and ill-treatment, destruction of homes and property, sexual violence, and direct killings.[7]

Thus, it is anticipated that many South Sudanese refugees in Nguenyyiel have experienced interpersonal violence, sometimes quite extreme, and many have lost family members, homes, and livelihoods. These factors increase their risk for a variety of psychological symptoms. Exposure to war trauma has undoubtedly contributed to widespread mental health problems among South Sudanese.[8] Studies within South Sudan have found high rates of mental health symptoms. For example, a 2015 study of 1,525 respondents across six South Sudanese states and one Sudanese state found that 41 percent showed symptoms related to post-traumatic stress disorder. In CVT's programs in Kenya, South Sudanese clients' expressions of traumatic experiences have included traditional trauma cluster responses, as well as symptoms classically associated with depression or anxiety and symptoms somatized as chronic pain, all with a severe impact on functioning. We anticipate similar patterns with the population we serve in Gambella.

Refugees often continue to experience traumatic events and other challenges after fleeing violence and war in their home countries, including physical hardships during migration journeys; separation from loved ones; ambiguous loss; and loss of protective/support mechanisms. These factors can heighten vulnerability to personal, criminal, or communal violence, from tensions between refugees and host communities or within refugee communities themselves. For regions hosting large numbers of refugees in camps, there are strains on limited local resources; the provision of humanitarian assistance and services to refugees, without benefiting host communities can lead to resentment. The influx of South Sudanese Nuer refugees into Gambella has adversely affected the delicate balance and intensified tensions between the local Anyuak population and the once-minority Ethiopian Nuer population.[9] Small altercations can quickly escalate into large-scale violent demonstrations in Gambella town or to cycles of retributive attacks between groups, sometimes resulting in fatalities. Violence has also flared between the Nuer refugees in the camps.

For example, immediately prior to the implementation of this survey, a violent conflict broke out in multiple Gambella area camps. On January 2, 2019, an incident in Kule camp triggered tensions between two Nuer sub-clans. Within a few days, the conflict had spread to Tierkidi and Nguenyyiel camps and the host community, resulting in multiple casualties and the displacement of large groups of refugees. On January 10, UNHCR suspended humanitarian operations in Kule, Tierkidi, and Nguenyyiel camps. Intensive mediation by religious, community, and local government leaders took place immediately following the incidents, leading to the resumption of regular operations by January 14. Despite the return to normal service provision, ongoing exposure to violent conflict is likely to have lasting effects on Gambella-area refugee mental health, as we discuss in greater depth below (see below section, *Difficulties in Daily Life*).

The Center for Victims of Trauma (CVT) began a program in Gambella in 2019. CVT's work in Gambella builds on its significant experience providing specialized mental health

[7] See UNHCR 2015, p. 7.
[8] See Amnesty International, 2016. "Our hearts have gone dark: The mental health impact of South Sudan's conflict." Available at: https://www.amnesty.org/download/Documents/AFR6532032016ENGLISH.PDF.
[9] See Action Against Hunger, April 2019. "South Sudan's struggle with mental health & malnutrition." Available at https://www.actionagainsthunger.org.uk/blog/south-sudan-mental-health-and-malnutrition.

services and assessing refugee mental health in the Tigray region of Ethiopia. CVT's first program in Ethiopia began in 2013, providing services to Eritrean refugees in Mai Ayni and Adi Harush camps. Beginning in 2019, CVT's program in Nguenyyiel provides specialized trauma rehabilitation services, through group or individual counseling, to survivors residing in the camp's Zone D.[10] CVT staff also receive intensive professional capacity building, including training and clinical supervision, to develop their skills to provide these specialized services. To develop services that are accepted by and responsive to affected communities, CVT conducts ongoing consultative meetings with refugee community representatives.

This survey is the first population-level assessment of the mental health effects of war-related traumatic events and ongoing stressors among refugees in Nguenyyiel. This adds to CVT's and other agencies' assessments, based on stakeholder consultations, key informant interviews, and similar methods, that there are likely to be high rates of exposure to traumatic events with significant mental health consequences. International Medical Corps (IMC) conducted two assessments, which included representative surveys, focus groups, and key informant interviews, of four Gambella camps (Jewi, Tierkidi, Kule, and Nguenyyiel) in 2018.[11] These surveys provide valuable information on refugees' attitudes toward mental health and mental illness, their knowledge about mental health generally, and their knowledge of mental health services available to them. The IMC surveys, however, do not assess symptoms related to mental health problems such as depression or post-traumatic stress disorder, trauma history, daily stressors, or coping strategies. CVT's survey will build upon these findings to continue to develop a robust picture of refugee mental health in Gambella.

Sampling Methodology

CVT conducted interviews with a sample of 639 individuals who are representative of the adult[12] resident population of Nguenyyiel Camp as of January 2019. Determining the overall population size of the camp is challenging. In preparing for the survey, CVT received (unpublished) 2018 population figures from UNHCR and ARRA that ranged from 53,756 to 79,884 people, as well as counts of households that ranged from 9,556 to 17,070 households. This divergence in available datasets is indicative of the challenges of tracking mobile refugee populations, and it was a significant complicating factor in designing an appropriate sampling strategy for the survey. In March 2019, following the survey, a new count by UNHCR placed the adult-only population of Nguenyyiel at 24,355 individuals. Using these figures, CVT's survey sample includes 2.6% of the adults in Nguenyyiel camp.[13]

[10] The group counseling approach is outlined in a manual, "Restoring Hope and Dignity," available to download here: https://www.cvt.org/group-counseling-manual.

[11] Note that there are distinct content areas between the surveys, in addition to different design and methodology; notably, IMC's survey sampled household heads, rather than individuals within households. See: International Medical Corps (IMC). July 2018. "Baseline Mental Health Knowledge, Attitude, Practice (KAP) Survey Participatory Assessment: Perceptions by General Community Members." Gambella, Ethiopia.

[12] Although minors represent a large proportion of the camp population, they were excluded from survey participation. There are significant ethical restrictions on research with minors, particularly highly vulnerable minor populations and highly sensitive topic areas.

[13] To estimate a phenomenon with 50 percent prevalence in the population, with 95 percent confidence and a 5 percent margin of error, a sample size of 380 is sufficient; thus, CVT's sample of 639 provides statistical power beyond the required levels.

Nguenyyiel is arranged into Zones, labeled A through D, each further divided into blocks, communities, and households. With a sampling frame of 90 blocks to serve as primary sampling units, CVT designed a cluster sample method. We piloted this sampling approach, but found it was not viable due to inaccuracy of population statistics,[14] based on comparison of the physical count of households by fieldwork teams to the provided statistics. The team collected 44 interviews during the pilot; these responses are not aggregated into the final dataset, but the pilot was used to develop a feasible sampling approach, provide further training and supervision to enumerators, and refine the fieldwork strategy.

CVT implemented the survey using interval-based sampling, with coverage of the entire geographic area of the camp, giving each household an opportunity for inclusion. While more labor-intensive than the cluster sample approach, interval sampling is not dependent upon accurate population statistics for sampling units. Based on our fieldwork, CVT estimates 8,514 to 9,168 households in Nguenyyiel camp. Our contact rate was 35 percent, due primarily to a large number of selected households found empty at the time of fieldwork. Our cooperation rate was 93 percent, and the refusal rate for eligible respondents who were available but chose not to participate was 2 percent.[15]

Oversample

Because CVT services are provided in Zone D of the camp, the survey was designed to include a sufficient number of interviews in that area to conduct zone-specific analyses to inform CVT's design of activities. There had been population movement of refugees in and out of Zone D throughout 2018, and thus population figures for the area were particularly problematic. We received figures from stakeholders citing that Zone D was 6.0 percent, 7.5 percent, 11.6 percent, or 17.7 percent of the overall population; at the time of the survey, our fieldwork suggested 14.6 to 17.9 percent of households were in Zone D. Applying this rate to UNHCR's updated March 2019 statistics, the adult population of Zone D may be 3,556 to 4,360.

To collect a larger sample size to allow Zone D-specific analyses, we gathered an oversample in Zone D. Using a smaller household interval in Zone D, households in that area were three times more likely than households in the other zones to be selected for inclusion. The total sample of 639 respondents included 185 respondents (29 percent) in Zone D and 454 respondents (71 percent) in Zones A through C.

[14] A cluster sample requires an equal number of interviews per selected cluster (block), with all households having a chance of being selected. Without an accurate count of the number of households in each cluster, it is not possible to set an appropriate sampling interval.

[15] Response rates were calculated using the American Association for Public Opinion Research Response Rate Calculator. Version 4 is available here: http://www.aapor.org/Education-Resources/For-Researchers/Poll-Survey-FAQ/Response-Rates-An-Overview.aspx, last accessed 23 June 2019. Included in non-eligible respondents were 81 minor-only households and 504 households with no individual of the required gender. Unknown eligibility included 1,116 selected households that were empty or locked and 47 households in which the supervisor did not record the reason for non-response. Eligible respondents that resulted in non-interviews included: the selected individual not available at the time (525); the selected individual refused to participate (49); and the selected individual did not speak Nuer, English, or Arabic and the survey team did not have enumerators or interpreters available for Shiluk, Anyuak, or other minority languages (9). Accounting for all these factors, and including an estimate for what proportion of cases of unknown eligibility would have actually been eligible (68 percent), the response rate was 32 percent.

Weighting

Two types of weights could be used in analyses to adjust the sample characteristics. First, weights to adjust to known population proportions, most typically by gender, age, or other key factors, can allow the sample to more closely approximate the overall population demographics. However, due to the variation in population statistics, described above, the findings presented do not weight the sample to population characteristics.[16]

Second, a sampling weight is used to adjust analyses to account for the Zone D oversample. In the findings presented in this report, zone-specific figures are presented with the full respective sample sizes. However, overall figures include a down-weight for Zone D respondents to adjust to their overall proportion in the camp population.[17] That is, due to the sampling design, Zone D residents had a three times higher chance of being selected for the survey, but our analyses adjust for this so that each Zone D respondent only contributes one-third of the weight of other respondents.

Household Selection

Households were selected using an interval-based method with geographic coverage of the entire camp. Each zone in the camp is divided into blocks, with blocks further sub-divided into communities. Each community has 16 households, when filled to capacity; households are clearly defined and numbered structures, facilitating an accurate count. We chose sampling intervals to ensure coverage of the entire settlement during the fieldwork period. This was based on estimated levels of productivity of the teams, as well as estimated proportions of households likely to: be empty, be minor-headed, not fit the gender quota, not have the selected individual available, or have the selected individual refuse to participate.[18] The sampling interval was four households in Zone D and 12 households in Zones A through C.

Teams received a starting point assigned each day, with assignments alternating to ensure coverage on each day was spread throughout zones of the camp and the same team was not revisiting the same area on consecutive days. At their assigned starting points, team supervisors drew numbers to identify the first household, selecting from the assigned sampling interval. After conducting a successful interview, a team proceeded according to the four or 12 household interval. After an unsuccessful interview attempt at a selected household, for any reason, a team moved to the adjacent household. Teams used tracking sheets and maps to note areas of coverage and ensure no area of the camp was excluded.

Individual Selection

Within a selected household, adult individuals were selected randomly, without replacement, and with adherence to a balanced gender quota. Interviewers were assigned identification numbers; those with odd identification numbers did their first interview each day with a man, and those

[16] The most significant implication of this are that CVT's sampling strategy alternated men and women respondents, resulting in a sample that is gender balanced. However, this is likely a slight underestimation of women, as population statistics estimate 52 to 55 percent of the population are women or girls.
[17] The sampling weight adjusts Zone D respondents to be 7.5 percent of the sample (rather than the observed 29 percent), using the proportion from the ARRA population figures that were used for sampling.
[18] These estimates are from CVT's previous surveys, adjusted according to local feedback.

with even numbers started with a woman. Thereafter, they alternated respondent gender throughout the day. They drew numbers to select the participant from all eligible potential respondents (all adult residents of the required gender who live in the household). Identified individuals participated in a consent process and decided if they would like to participate.

If a selected dwelling had no adult residents of the required gender, a team moved to the next household. There was no replacement of a selected individual. If the selected individual in the household was not home, reasonable attempts were made to return and complete the interview, based on feedback from other household members about the timing of their return. Additionally, interviewers could not interview their family or close friends, though other interviewers could be assigned.

Survey Team and Fieldwork

Fieldwork was carried out by a team of about 50 people, including enumerators, team supervisors, researchers, psychotherapists, interpreters, drivers, community coordinators, and administrative staff. Six interview teams, with about four enumerators and one supervisor per team, each completed an average of 17 interviews per day. CVT clinical and research staff provided supervision and support across teams. Data collection was completed from January 23 to 31, 2019.[19]

All enumerators spoke Nuer, with most coming from the refugee community. Teams included CVT staff, all of whom had been recently recruited to support the program start-up, and some partner agency staff. CVT's ten Ethiopian counselors, with experience and training in mental health service delivery, functioned as both enumerators and team supervisors (some counselors were not fluent in Nuer, and fulfilled the supervisor role). CVT's psychosocial counselors, newly hired refugee staff, generally had more limited or no previous training in counseling. The team was strengthened significantly through cross-agency collaboration, with staff from partners participating in various roles.[20]

The coordination teams included research and evaluation staff from CVT's headquarters, Tigray-based program, and from the new Gambella program. Each coordination team also had clinical support provided by experienced CVT psychotherapists. Team members received three days of training from CVT research and clinical leadership.[21] Training focused on key mental health concepts and how to sensitively and reliably administer an interview about mental health, including how to administer psychological first aid (PFA) if the respondent became triggered by any questions, when and how to refer to a psychotherapist if a respondent escalated, and how to refer to partner organizations in the case of high-risk respondents. Training also covered survey rationale and design, the content of the questionnaire, how to administer the questionnaire reliably, the informed consent process, sampling strategy and procedures to select households

[19] We planned seven days of data collection. The team used one day as a pilot, completed nearly all the interviews in six days, and finished on a seventh day.

[20] Three ARRA community health workers were enumerators, two ARRA staff did community coordination, three IMC staff were enumerators, two IMC staff were interpreters, IMC had a psychotherapist on standby if support was needed, and two ACF psychologists participated as enumerator and supervisor.

[21] CVT recognizes that sufficient training is necessary for the ethical and effective administration of a survey. One additional day of training was planned; however, due to security concerns, activities were not permitted in the camp, resulting in training modifications.

and individuals, and fieldwork implementation.[22] The supervisors received an additional half day training to discuss sampling methodology in greater depth, team management, and geographic strategy. The team had varied levels of exposure to mental health concepts and to this type of survey interview methodology, thus requiring ongoing monitoring and feedback after the initial training. This included individual reviews after interviews and group debriefs at the beginning of each day.

Security concerns were a significant consideration and challenge throughout fieldwork. Following the outbreak of community violence, as mentioned above, the training and fieldwork did not proceed until normal activities were authorized to resume in the camp. Strategies taken to minimize risk and enhance preparedness included: having multiple vehicles deployed throughout the camp; receiving daily security clearance and updates from relevant authorities; designating security focal persons on the team; monitoring and discussing any perceived discomforts or risks experienced by any team member; and leaving the camp before dusk.

Questionnaire Description

The questionnaire provides a brief assessment of mental health perspectives and needs. Symptoms of mental health-related distress are often expressed physically and socially as well as in classical psychological concepts. Therefore, this survey and report use a holistic and interdisciplinary conceptualization of mental health. Mental health includes emotional, psychological, and social well-being. A diverse range of factors are intertwined with and can affect mental health, including how the body responds to or affects thoughts and feelings.

The content was modeled after CVT's previous surveys in Kenya and Ethiopia, including with South Sudanese populations. The questionnaire integrated feedback from CVT's clinical advisors, research team, and local stakeholder agencies and groups. The questionnaire collects data about attitudes about mental health, difficulties in daily life, mental health related problems or symptom areas, coping strategies, household mental health problems, torture, access to services, and demographics. Almost all items were close-ended questions, with opportunities to specify an "other" response.

Interviews were conducted in person, in or around respondents' homes, using paper and pencil questionnaires. On average, it took 33 minutes to administer the 12-page questionnaire. The questionnaire was translated and back-translated into Nuer. Translation was completed over a multi-week period, with teams of translators completing first round translations, blind back translations, and consultations to resolve points of misunderstanding or disagreement, particularly on key mental health terms and concepts. The bilingual English and Nuer questionnaire is attached to this report.

Enumerators explained to respondents that some questions were sensitive and they may wish to be alone for the conversation. The enumerator made attempts to find a private space for the interview. A small minority of respondents (about 3 percent) actively preferred or allowed

[22] There is some potential risk of enumerator bias, as those working closely with CVT or other service providers may conceivably have motivation to ensure mental health issues are recorded as priorities over food, shelter, or other needs. There is also a potential risk that CVT staff could perceive the survey as a screening or recruitment activity to attract clients. We mitigated such risks by directly discussing these issues during training and by having an intensive supervision structure to monitor how enumerators were interacting with respondents and administering the questionnaire.

their family members or others to be present during the interview. The informed consent process included introducing CVT, explaining the purpose of the questionnaire, clarifying how the respondent was selected, and emphasizing that the purpose was only to collect information, not to provide any service. Before consenting, the participant was told that some of the questions may be upsetting or stressful, that their information would be kept private, that their participation was voluntary, and that they could stop at any time. The participants' names were not recorded.

Knowledge and Attitudes

The first ten items[23] are general statements about mental health and trauma. Respondents reported if they strongly agree, agree, disagree, or strongly disagree with each. The questions address definitions of mental health, stigma, and coping strategies.[24] This scale displays high internal reliability (α=.76).

The interviews began with these general questions to build rapport, rather than to immediately inquire about the respondent's personal experiences. It is also important to understand how the respondent conceptualizes "mental health" in order to aid in interpreting their responses throughout the rest of the questionnaire. In order to not lead respondents to a negative connotation of mental illness or disability, it was essential to accurately translate and train on the meaning of "mental health." CVT's research and clinical team worked closely with enumerators to ensure correct translations and understandings of key concepts were used consistently.

Difficulties in Daily Life

The second section includes questions about problems the respondent may be facing, ranging from meeting basic needs (such as "getting food, shelter, or clothing"), dealing with migration-related issues (such as "worries about people back at home"), to more trauma-related problems (such as "violence, threats, or conflict in the community" or "grief from the loss of loved ones"). This section is modeled after the Post-Migration Living Difficulties (PMLD) measure.[25] Respondents ranked each issue on a four-point scale from "no problem at all" to a "very serious problem," with a visualization of cups to aid in response.[26] This scale displays high internal reliability (α=.85). Respondents were given the opportunity to list any other major stressor that was not included in the list. After completing the list, respondents were asked which one item causes the most stress in their lives currently.

Symptom Areas

The third set of questions asks respondents to report frequency of mental health-related symptoms. This is an essential section to provide baseline data on mental health needs and

[23] For a more detailed assessment of mental health knowledge and attitudes in Gambella, see IMC 2018, *op. cit.*
[24] Several of the questions are closely adapted from knowledge and attitude questions on CVT's client assessment forms, allowing comparability with CVT clients.
[25] See: Aragona, M., D. Pucci, M. Mazzetti, and S. Geraci. 2012. "Post-Migration Living Difficulties as a Significant Risk Factor for PTSD in Immigrants: A Primary Care Study." *Italian Journal of Public Health* 9(3).
[26] See: Miller, K., P. Omidian, A.S. Quraishy, N. Quraishy, M.N. Nasiry, S. Nasiry … A.A. Yaqubi. 2006. "The Afghan Symptom Checklist: A Culturally Grounded Approach to Mental Health Assessment in a Conflict Zone." *American Journal of Orthopsychiatry* 96(4):423-433.

estimate prevalence rates of mental health problems among the population. This section asks respondents to rank how often they have been bothered by ten symptoms in the past two weeks, again using a visual aid for response categories, ranging from "not at all" to "often." The ten questions assess psychological symptoms most commonly associated with post-traumatic stress and depression.[27] These items generate a robust mean symptom score, without overwhelming respondents with this difficult section; this scale displays high internal reliability (α=.86).

These items were selected for a range of reasons. The content of the specific items was selected based on other brief screening tools, particularly the Self-Reporting Questionnaire (SRQ-8)[28] and the Patient Health Questionnaire (PHQ-9).[29] The wording of the items is from CVT's client assessments used across its international programs, with similar refugee populations, allowing comparability of symptom levels among the Gambella population with help-seeking refugee populations (including South Sudanese) in several other contexts. Items are from the Hopkins Symptom Checklist (HSCL-25) and the Posttraumatic Stress Diagnostic Scale (PDS), widely used measures of depression and PTSD symptoms, respectively, and found to be valid and reliable with a wide range of populations. Among CVT's South Sudanese clients in other programs, the individual symptom items included on the survey questionnaire are moderately to highly correlated with overall mean scores on the full HSCL-25 depression sub-scale and the PDS symptom scale.[30]

There are two holistic ratings which provide additional indicators of severity of symptoms. Respondents are asked if mental health problems interfere with their functioning and to rate their mental health overall. These questions are used clinically to evaluate the short-term needs of an individual.

Finally, respondents were asked three questions on somatic symptoms or physical health: if they feel physical health problems cause functional difficulties; if they experience chronic pain (if so, rating their pain on a 0 to 10 scale); and if they have ever had seizures (defined as "uncontrolled convulsions in your body that you can't remember").

The symptom series includes a question on suicidal thoughts. Many psychological measures administered in the context of providing care to a client phrase the question on suicidality as "thoughts of ending your life." To modify this question to be more appropriate for a drop-in survey where services are not being delivered to the individual, we rephrased to "thoughts it would be better to not be alive." This adjustment to a more passive voice can result

[27] A factor analyses suggests a one-factor solution, with nine items having a factor loading of .6 or above, comfortably exceeding a minimum criteria. The item on suicidal thoughts loads at .47. The one factor solution supports clinical and research observations of comorbidity of PTSD with depression in similar populations.

[28] This is a shortened version of a 20-item screening and diagnostic tool that has been validated in post-conflict settings. See: Scholte, W.F., F. Verduin, A. van Lammeren, T. Rutayisire, and A. Kamperman. 2011. "Psychometric Properties and Longitudinal Validation of the Self-Reporting Questionnaire (SRQ-20) in a Rwandan Community Setting: A Validation Study." *BMC Medical Research Methodology* 11(116).

[29] See Sweetland, A.C., B.S. Belkin, and H. Verdeli. 2014. "Measuring Depression and Anxiety in Sub-Saharan Africa." *Depress Anxiety* 31(3):223-232. The authors conclude these screening tools are generally appropriate in African contexts, but minor problems in translation, structure, and connotations should be addressed to improve cross-cultural relevance. Because these items have been used extensively by CVT in diverse programs throughout Africa, we have provided these locally-specific and necessary adaptations.

[30] Among South Sudanese refugee clients in Kakuma, these individual items correlate with overall mean scores on the HSCL-25 and PDS scales at or above .50, with the one exception of "falling asleep" (.43). Among South Sudanese and Sudanese clients in Jordan, all but two items (suicidal thoughts, .41, and crying easily, .44) have high correlations with the full mean scores on the scales. Among South Sudanese refugee clients in Dadaab, four items have low correlations (suicidal thoughts, falling asleep, somatic responses, and low energy; .27-.45).

in greater willingness for survey respondents to report these types of thoughts in a survey setting, particularly in a context in which suicide is highly stigmatized religiously and culturally. Enumerators received training on a follow up protocol to be used if respondents reported suicidal thoughts (see *Psychological Support*, below).

Coping Strategies

The next section of the questionnaire asks respondents whether or not they do particular activities to cope with feeling sad, anxious, or overwhelmed. They are asked about ten activities, some generally healthy (such as "connecting with family or friends"), others generally unhealthy (such as "use alcohol to help you forget" or "sleep or stay in bed"). They are also given the option to specify any other strategy they use. These questions can guide program design toward healthy coping mechanisms that already may be resonant or common among the population.

Household Mental Health

The fifth section asks whether or not any of the respondents' household members experience mental health problems that cause trouble with their daily functioning. If so, they are asked for the age and gender of those people. Three follow up questions, drawn from the WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings-Household Interview (WASSS-H),[31] assess inactivity, low functioning, and fits, convulsions, or seizures due to psychological distress. The goal of this section is to provide additional data to extrapolate about mental health needs within the population, particularly in aiding assessment of minors' mental health needs.

Torture

We included three questions about torture. This section is near the end of the questionnaire, after rapport has been established, and comes after a signaling question about the sensitive topic. We include a basic definition of torture: "Torture is severe physical or psychological suffering caused on purpose by someone in authority." The questionnaire does not ask any details about the torture; therefore, these items are respondents' self-reports of torture. We asked three yes or no questions: if the respondent had been tortured; if anyone in their family or household had been tortured; and if they believe many people in the community had been tortured.

Access to Services

This section asks about services that are available and assesses respondents' ability to or interest in accessing services. Structured as a series of skip patterns and follow up questions, respondents are asked if they know of any mental health or psychosocial support (MHPSS) services available, if they have ever received such services, from which agency they received services, or why they have not received services. This information is valuable in mapping the sector and

[31] See, for example: Llosa, A.E., M. Van Ommeren, K. Kolappa, Z. Ghantous, R. Souza, P. Bastin, …R.F. Grais. 2017. "A Two-Phase Approach for the Identification of Refugees with Priority Need for Mental Health Care in Lebanon: A Validation Study." *BMC Psychiatry* 17:28.

establishing the existing interest in services. We also ask about other types of services received in the past month. Finally, we ask where respondents receive information about services.

Demographics

Finally, the questionnaire includes demographic information: age, languages spoken, household size, number of children, marital status, home country, level of education, family separation, and time in the current community. We also recorded some information not asked of the respondent: duration of interview, respondent gender, location of interview, language of interview, date, enumerator and supervisor, follow-up support required, and whether or not the respondent was alone during the interview.

Data Entry and Cleaning

The first round of data cleaning was done during data collection. Supervisors reviewed completed forms to identify problems with administration, and coordinators noted patterns of errors in administration and discussed with supervisors and enumerators. Supervisors and coordinators observed some interviews and discussed improvements with enumerators. Paper forms were entered electronically into an encrypted platform by monitoring and evaluation staff. The research team cleaned and analyzed data using SPSS.

Psychological Support

Throughout this survey, CVT provided mental health support to both respondents and staff. Often, similar data collection methodologies have an orientation of extracting data from respondents, while adhering to the ethical requirements for protection of human subjects in research. However, as a mental health service provider, CVT advocates a more rigorous ethical standard and commitment to participants' well-being throughout the process.

In the consent process, enumerators explained that some questions may be stressful or remind the respondent of difficult experiences, noting that the enumerator would check in about how the respondent was feeling after the survey. In general, enumerators were trained to administer the survey from beginning to end before asking specifically if respondents were experiencing distress due to the questions they had been asked. The exception to this was if the enumerator observed or heard from a respondent that they were experiencing significant distress throughout the interview.

We had several follow up options for respondents experiencing some degree of distress, explained below. These options were listed on the first page of the questionnaire; after completing the questionnaire, the enumerator indicated any response that had been required.

Follow-up Protocol Response Options

- **Emergency response:** Respondent is in extreme distress and requires immediate intervention
  Trained enumerators will provide PFA and notify their supervisor and/or the CVT or IMC focal person to come to the household immediately.
- **Referral:**
  - Respondent was given information about available services
  - Respondent needs to be connected with referral partner
  - Respondent needs to be referred for CVT services (Zone D)
  - Respondent needs to be referred for IMC services (Zones A, B, and C)
- **PFA:** Respondent experienced some distress and required in-person PFA delivered during survey per CVT training of enumerator
- **Nothing required:** Respondent did not require follow up for psychological distress

Emergency Response

Experienced staff psychotherapists or counselors were available to each interview team to provide immediate support to respondents experiencing severe distress. In those cases, the enumerator was directed to notify their supervisor or a clinical lead, who assigned a clinician to visit the household immediately.

Referrals

In training the interview teams, we reinforced that the survey was not designed as outreach or to screen for CVT beneficiaries. However, for respondents exhibiting particularly severe or immediate needs, we established referral protocols to connect them with appropriate service providers, including referring them to appropriate partner organizations (in Zones A-C) or referring them to CVT's rehabilitation services (in Zone D). When enumerators referred respondents to CVT, staff made plans to follow up with these people and screen them for criteria

to begin CVT services. We also had an option to provide information about available services to respondents, without making a direct referral.

Psychological First Aid (PFA)

Enumerators and supervisors received training in Psychological First Aid (PFA) to equip them to provide brief emotional support to respondents, as needed, while conducting the survey. PFA is accepted by disaster experts as an evidenced-based approach to decreasing emotional and physical responses experienced by those exposed to trauma.[32]

The training covered an abbreviated PFA, which would allow enumerators to observe any signs of respondents' emotional activation, offer some immediate practical support and calming, and make appropriate judgements about when to refer to the clinical teams that were on standby to provide additional more comprehensive PFA support. The abbreviated version of PFA that we provided focused on PFA action principles, taking into consideration the very short training time, to quickly equip enumerators to respond and assist in a humane, supportive, and practical way to any respondent experiencing heightened stress during or at the end of the survey.

Respondents who became emotionally distressed during the survey received PFA; if PFA was not sufficient, the respondent was also referred to a team lead, who conducted brief supportive counseling and taught coping skills. The respondent was also assessed on need for referral to mental health services.

Suicidality Protocol

Enumerators were also trained on a short suicidality screening procedure for respondents who reported suicidal thoughts. The indicator to use the protocol was if the respondents directly stated that they were suicidal or answered "often," "sometimes," or "rarely" to the survey question that asked if they had "thoughts it would be better to not be alive" in the past two weeks. Enumerators would then ask directly if respondent has thoughts of killing themselves and if they have a plan. With that information, the enumerator would consult with the standby clinical team who would assess the level of risk and make appropriate intervention and/or referral. There were 182 respondents who reported having suicidal thoughts in the past two weeks in response to the survey question; 15 of those said they "often" had such thoughts. If the respondent was assessed to be in imminent danger, they received PFA and a referral to existing emergency mental health services.

[32] Ruzek, J.I., M.J. Brymer, A.K. Jacobs, C.M. Layne, E.M. Vernberg, and P.J. Watson. 2007. "Psychological First Aid." *Journal of Mental Health Counseling* 29(1):17-49.

Key Informant Interviews

CVT conducted key informant interviews with service providers and other stakeholders who could provide expert-level information on mental health needs and surrounding issues in Nguenyyiel camp. CVT's monitoring and evaluation officer interviewed six individuals working directly or indirectly in mental health, from government agencies and local and international non-governmental sectors. Key informants provided insights into mental health issues and shared their perceptions of gaps in mental health services in the camps. All key informants considered themselves at least "somewhat knowledgeable" about mental health needs in the camp; four considered themselves "moderately knowledgeable," and one "extremely knowledgeable." Combining data from key informants with representative survey data allows insights on how stakeholder perceptions align or diverge with observed patterns in the population. The perspectives of key informants supplement findings from the survey data and are integrated into the remainder of this report.

Demographic Characteristics

We conducted 639 interviews in Nguenyyiel, with 71 percent of our interviews in Zones A-C and the remaining 29 percent in Zone D (oversample, described above). The sample was roughly balanced in terms of gender, due to the sampling strategy. Respondents in Zone D were slightly older (mean = 38), on average, than respondents from other areas of the camp (mean = 33). The difference was statistically significant ($p = 0.000$). All respondents were from South Sudan. All respondents spoke Nuer, with a minority also comfortable in Arabic or English. Only 2 percent of respondents spoke Amharic and 2 percent spoke Shiluk.[33]

Key Characteristics of Nguenyyiel Survey Respondents

	Zones A-C	Zone D	Total[34]
Sample size	454	185	639
Women (valid %)	53	50	52
Age			
Mean	33	38	35
Range	18-87	18-85	18-87
Languages spoken (valid %, not mutually exclusive categories)			
Nuer	100	100	100
Arabic	19	8	18
English	15	10	15
Amharic	2	2	2
Shiluk	2	0	2
Anyuak	<1	<1	<1

[33] As noted above, there were nine people excluded from the survey due to not speaking Nuer, English, or Arabic.
[34] For all reported combined figures, Zone D respondents are down-weighted to adjust to the appropriate proportion of the overall population.

Key Characteristics of Nguenyyiel Survey Respondents (continued)

	Zones A-C	Zone D	Total
Household size (not including respondent)			
Mean	6.5	5.9	6.5
Range	0-20	1-15	0-20
Completed levels of education (valid %)[35]			
No education	61	73	62
Primary	39	27	38
Secondary	11	6	11
University	1	3	1
Time in current community			
Mean	26 months	23 months	26 months
Range	1-48 months	2-48 months	1-48 months
Number of children			
Mean	3.5	3.9	3.6
Range	0-11	0-13	0-13
Marital status (valid %)			
Married	79	83	79
Single	13	9	13
Widowed	4	3	4
Living as a couple, not married	3	5	3
Divorced or separated	1	1	1
Separated from family (valid %)	48	43	48

Respondents reported large household sizes, with a mean of 6.5 people in addition to the respondent. Respondents in Zones A-C had more education, on average, than those in Zone D. In Zones A-C, 61 percent of respondents had less than a primary education, compared to 73 percent for Zone D (p = 0.004). In Zones A-C, 39 percent had completed primary school, compared to 27 percent in Zone D (p = 0.003). Respondents had been in Nguenyyiel for just over two years, on average, with Zone D respondents reporting being in the camp three fewer months (p = 0.001). Respondents had nearly four children on average, and 79 percent were married. Finally, nearly half of respondents were separated from one or more family members.

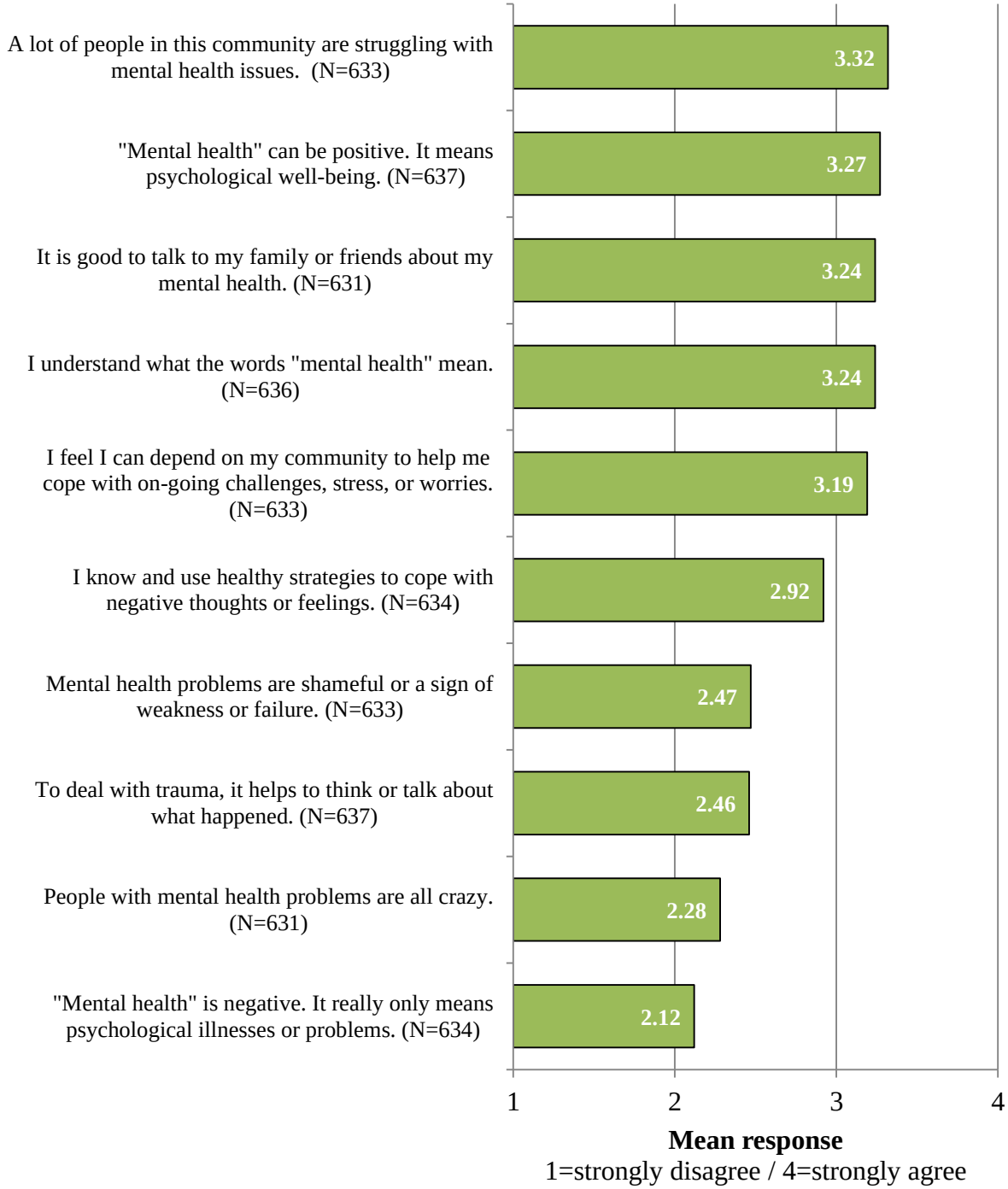
Knowledge and Attitudes about Mental Health

Respondents had generally positive attitudes about mental health. They were most likely to agree with positive statements and more likely to disagree with the most negative, stigmatizing statements. Respondents strongly felt that many people in the community are struggling with mental health issues.

[35] Less than 1% of respondents said they had completed technical school.

Knowledge & Attitudes about Mental Health: Mean Scores

"Do you agree or disagree?"



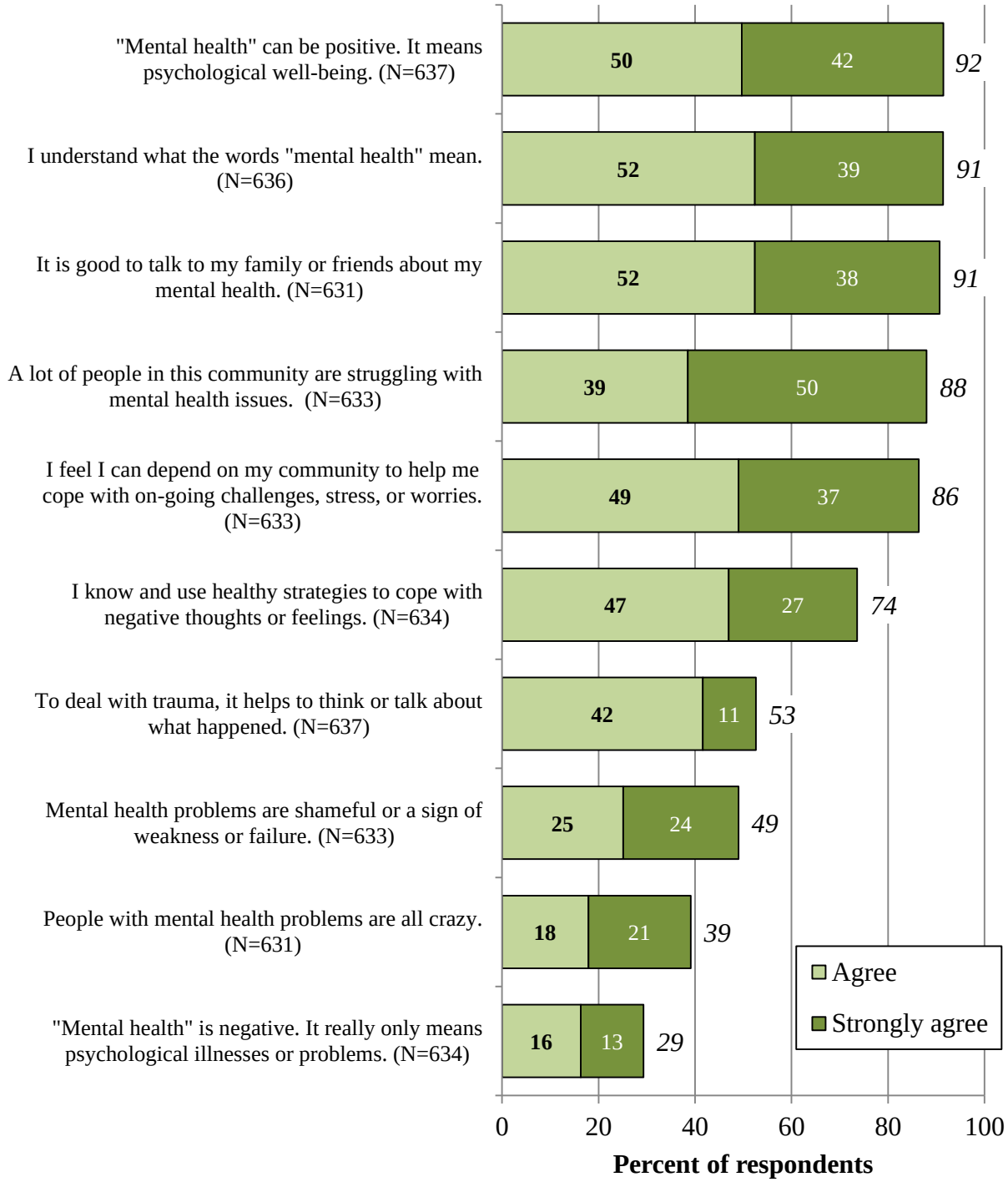
The following figure shows respondents who agreed or strongly agreed with each statement. A strong majority agreed that mental health can be positive, said they understand what "mental health" means, and feel it is helpful to talk with others about their mental health. This evidence suggests that overall attitudes about mental health are relatively positive, and respondents had some awareness of mental health concepts. This contrasts somewhat with responses of a few key informants CVT interviewed, who suggested that awareness of mental health in the community was low. These positive attitudes can be drawn upon as a resource for community mobilization and to encourage individuals to access services. Particularly, there seems to be a willingness to draw upon social support in the form of family, friends, and community in order to cope with mental health problems; service providers may utilize this willingness and craft interventions that integrate individual healing and existing social support networks. A similar finding comes from IMC's survey of knowledge and attitudes, which asked respondents the extent to which they agreed that "I would not want people to know my mental health status." Just over 40 percent of respondents agreed with this statement; a majority were neutral or disagreed, which suggests an openness to talk to others about one's own mental health problems.[36]

While the negative statements fall to the bottom, there are pockets of the population where stigma towards mental health is strong. Nearly half of respondents agreed that "mental health problems are shameful or a sign of weakness or failure." Over a third (39 percent) agreed that "people with mental health problems are all crazy," with this view more common among those who had not completed any formal education, compared to those who had primary or above (43 percent and 34 percent, respectively; $p = 0.039$). Over a quarter (29 percent) of respondents felt mental health is negative, with men more likely to hold this perspective than women (34 percent and 26 percent, respectively; $p = 0.093$). In comparison, IMC's survey generally found more agreement with negative statements; for instance, 73 percent of IMC respondents agreed or agreed somewhat that "mental illness is caused by personal weakness," while 52 percent agreed or agreed somewhat that "I would feel ashamed if people knew that someone in my family had been diagnosed with a mental illness."[37] This difference in attitudes between the two surveys may be explained by the fact that the IMC's questions used the term "illness," which can be more stigmatizing than the term "problems" used by CVT. Despite the overall positive picture supported by CVT's data, there is still substantial variation in attitudes, suggesting the need for targeted outreach and education strategies.

[36] IMC 2018, *op. cit.*
[37] IMC 2018, *op. cit.*

Knowledge & Attitudes about Mental Health: Respondents who "Agree" or "Strongly Agree"

"Do you agree or disagree with the following statements?"



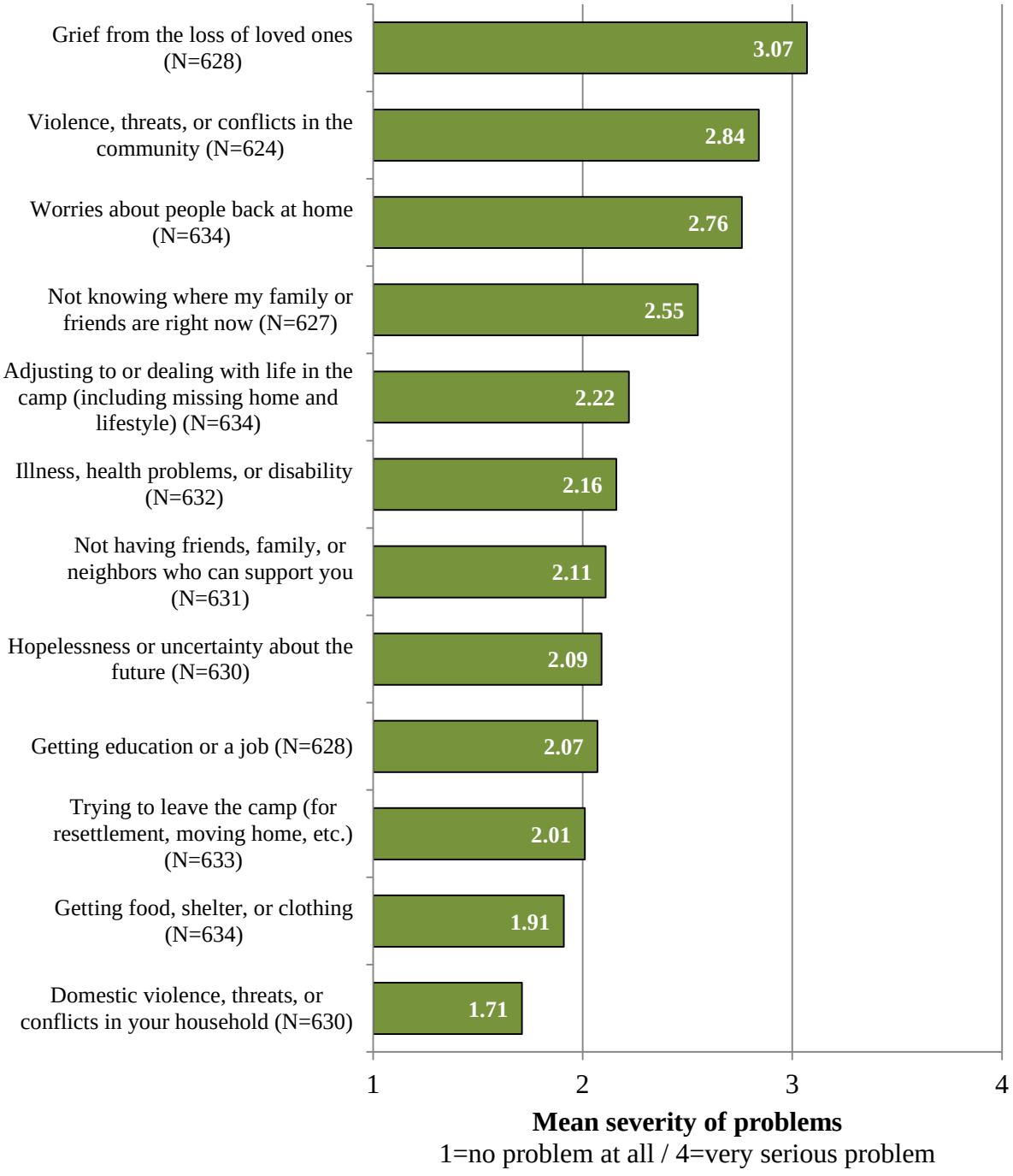
Mental health knowledge and attitudes did not differ substantially between respondents in Zones A-C and Zone D. However, Zone D respondents were somewhat less likely to strongly agree with the stigmatizing statements that mental health problems are shameful ($p = 0.005$) and that mental health is only negative ($p = 0.056$). Zone D residents were also more likely to agree that thinking or talking about traumatic experiences is helpful ($p = 0.046$) and that it is good to talk about mental health with family and friends ($p = 0.002$). This suggests outreach strategies in Zones A through C should be particularly mindful of skepticism towards talking about trauma or other mental health issues.

Difficulties in Daily Life

The problems most frequently reported by respondents in their daily lives were: grief from losing their loved ones; violence, threats, or conflicts in the community; and worries about people back home. Concerns about getting food, shelter, or clothing and getting education or a job were among the least commonly reported problems, suggesting the support available for livelihood and basic necessities is meeting the needs for many camp residents. Difficulty in accessing basic necessities may still affect some, particularly more vulnerable refugees; at least one key informant identified inadequate access to water, food, and health services as an ongoing stressor that negatively impacts beneficiaries' mental health improvement. Overall, though, our findings contradict the perspectives of multiple key informants, who suggested that Nguenyyiel residents more strongly demanded basic necessities, such as food, compared to mental health services.

Daily Difficulties:
Mean Scores

"How difficult is each of these things in your life right now?"

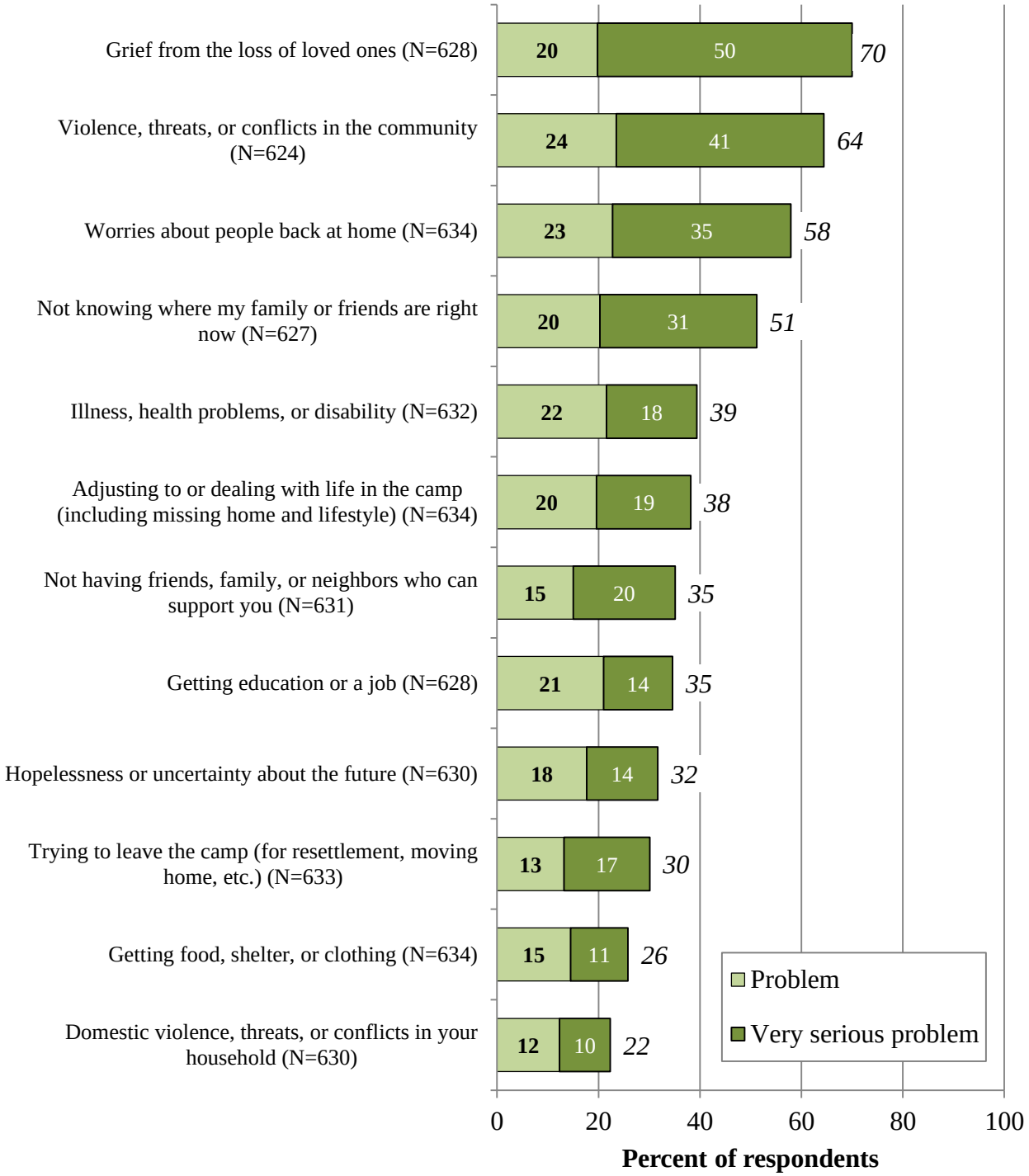


A majority of respondents (70 percent) said that grief from loss of loved ones was a problem or very serious problem for them, suggesting many people may benefit from mental health support to cope with this. While grief is a healthy response to bereavement, research has found a strong link between the violent death of a loved one and symptoms of both PTSD and persistent, severe depression.[38] The second most frequently reported concern overall was violence or conflict in the community, with 64 percent of respondents describing it as a problem or very serious problem in their own life. Living in a situation of ongoing instability is particularly problematic for individuals affected by trauma who have decreased resources to cope with threats of ongoing violence.[39] As described earlier, violence between groups in and around Gambella has been relatively common, with a major incident occurring just before the survey; in this context, it is understandable that there is widespread concern about community violence. Over half of respondents ranked worries about people at home and not knowing where family or friends are as problems; this form of ambiguous loss, with no official verification of death and therefore no opportunity for cultural or personal rituals of closure, has been found to elicit a complex set of symptoms, often with components of depression and anxiety.[40] MPHSS interventions focused on ambiguous loss could help residents cope and find mechanisms for closure. Finally, although it was the least frequently reported problem, over a fifth of respondents (22 percent) indicated that domestic violence was a problem or very serious problem.[41] This indicates the need for integration of protection services with MHPSS support for survivors.

[38] See: Kaltman, S., and G. Bonanno. 2003. "Trauma and Bereavement: Examining the Impact of Sudden and Violent Deaths." *Journal of Anxiety Disorders* 17(2):131-147.
[39] See: Zinner, E., and M. Williams, eds. 1999. *When a Community Weeps: Case Studies in Group Survivorship.* New York: Routledge.
[40] See: Boss, P. 1999. *Ambiguous Loss: Learning to Live with Unresolved Grief.* Cambridge, MA: Harvard University Press; and Boss, P. 2006. *Loss, Trauma and Resilience: Therapeutic Work with Ambiguous Loss.* New York: Norton.
[41] There were no significant gender differences in reported domestic violence.

Daily Difficulties:
Respondents who Select "Problem" or "Very Serious Problem"

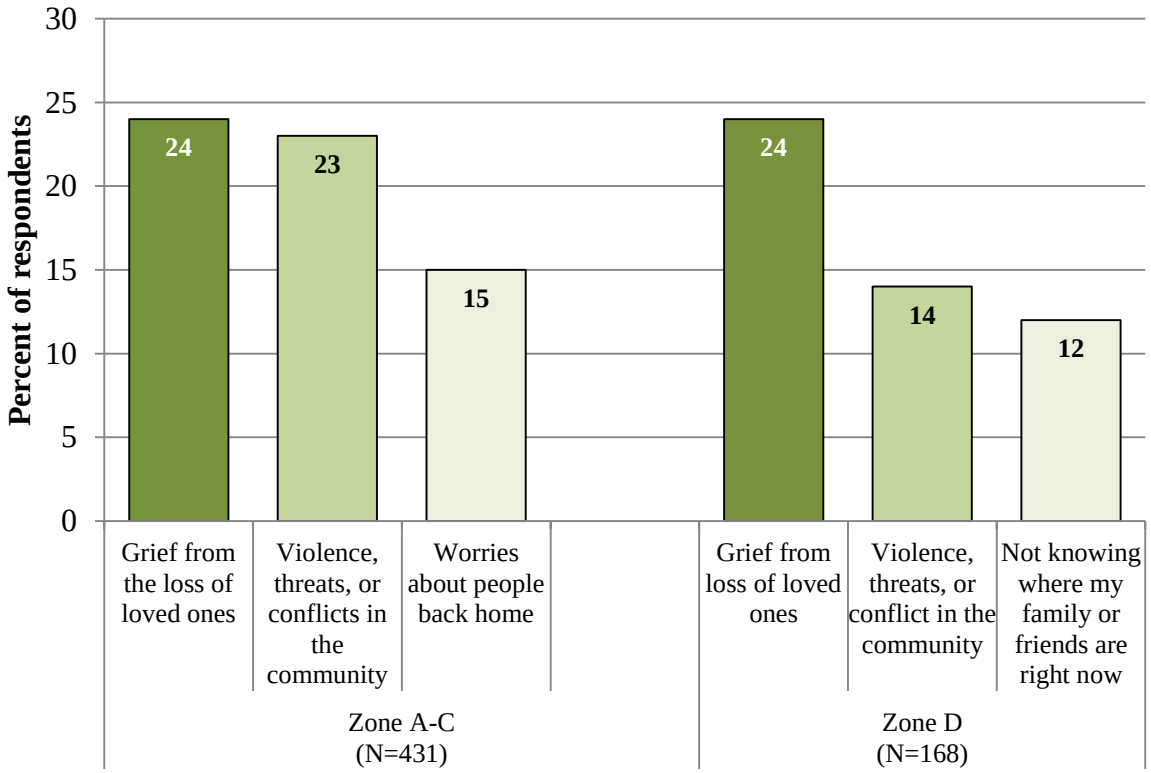
"How difficult is each of these things in your life right now?"



After ranking to what extent each issue is a problem in their life currently, respondents selected just one problem that is causing them the most stress. The most often selected response was grief from loss (24 percent of respondents in both locations). The second most frequent was violence, threats, or conflict in the community, which was more commonly cited in Zones A-C than in Zone D (23 and 14 percent, respectively). For Zones A-C, worries about people at home was the third most identified major stressor; for Zone D, it was not knowing where family or friends are now.

Most Significant Stressors

*"Which of these causes you the **most** stress right now?"*



Those who had not completed any formal education reported more daily stressors. People with no education were more likely to say they experienced problems with getting basic necessities, including getting a job, having social support, and dealing with illness or disability. This could indicate those with low education face higher social isolation and lower access to resources, services, and opportunities. Older people were more likely to be struggling with getting a job (p = 0.001) and dealing with illness or health problems (p = 0.015), whereas younger refugees had more hopelessness or uncertainty about the future (p = 0.068). People who had been in the camp longer also reported more problems with illness or disability (p = 0.084) and with domestic violence (p = 0.084); the latter could suggest family tensions are exacerbated by time spent in refuge (including potentially unaddressed trauma), or could indicate increased awareness, recognition, or willingness to report household violence after more time in the camp.

Being currently separated from one's family was related to more hopelessness about the future (p = 0.003) and struggles with grief (p = 0.030), but also with less illness or health problems (p = 0.005), less of a problem getting a job (p = 0.000), and less worry about basic necessities (p = 0.000).[42] There were very few gender differences in reported daily stressors, though men were more likely than women to report that communal violence was the problem causing them the most stress.

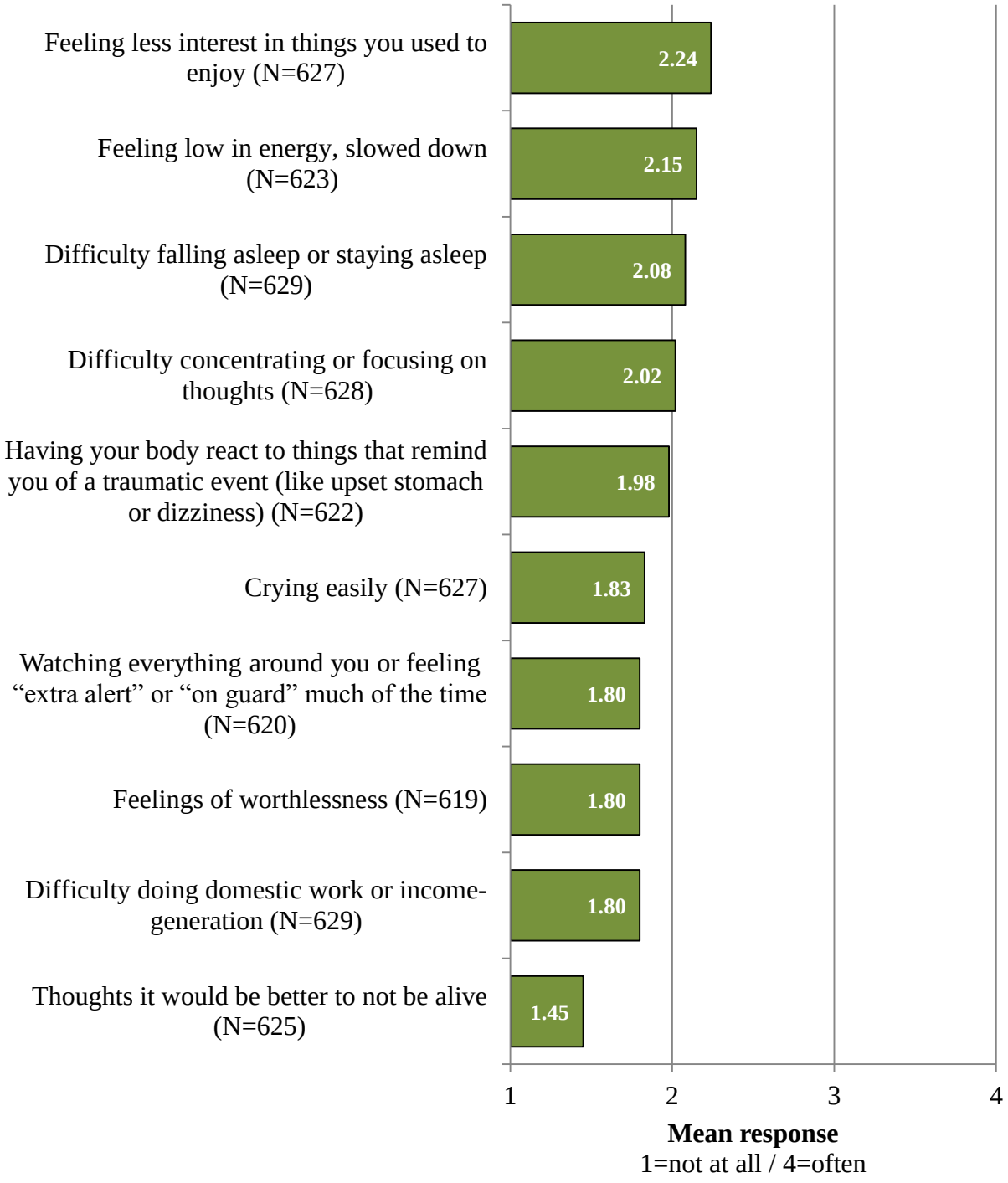
Mental Health Problems and Symptoms

Respondents were asked how frequently they experienced ten depression and post-traumatic stress symptoms in the past two weeks. The most commonly reported symptoms were loss of interest and enjoyment, low levels of energy, and difficulty sleeping. Suicidal thoughts were the least commonly reported symptom. Respondents reported similar patterns and levels of symptoms across zones of the camp. On average across all ten symptoms, we found a mean symptom score of 1.9, where 1 means no symptoms at all and 4 is every symptom reported to be "often."

[42] This could arguably be explained if those who are separated from their families have a different demographic profile, but there are not significant differences in the rate of family separation by gender or age.

Symptom Areas:
Mean Scores

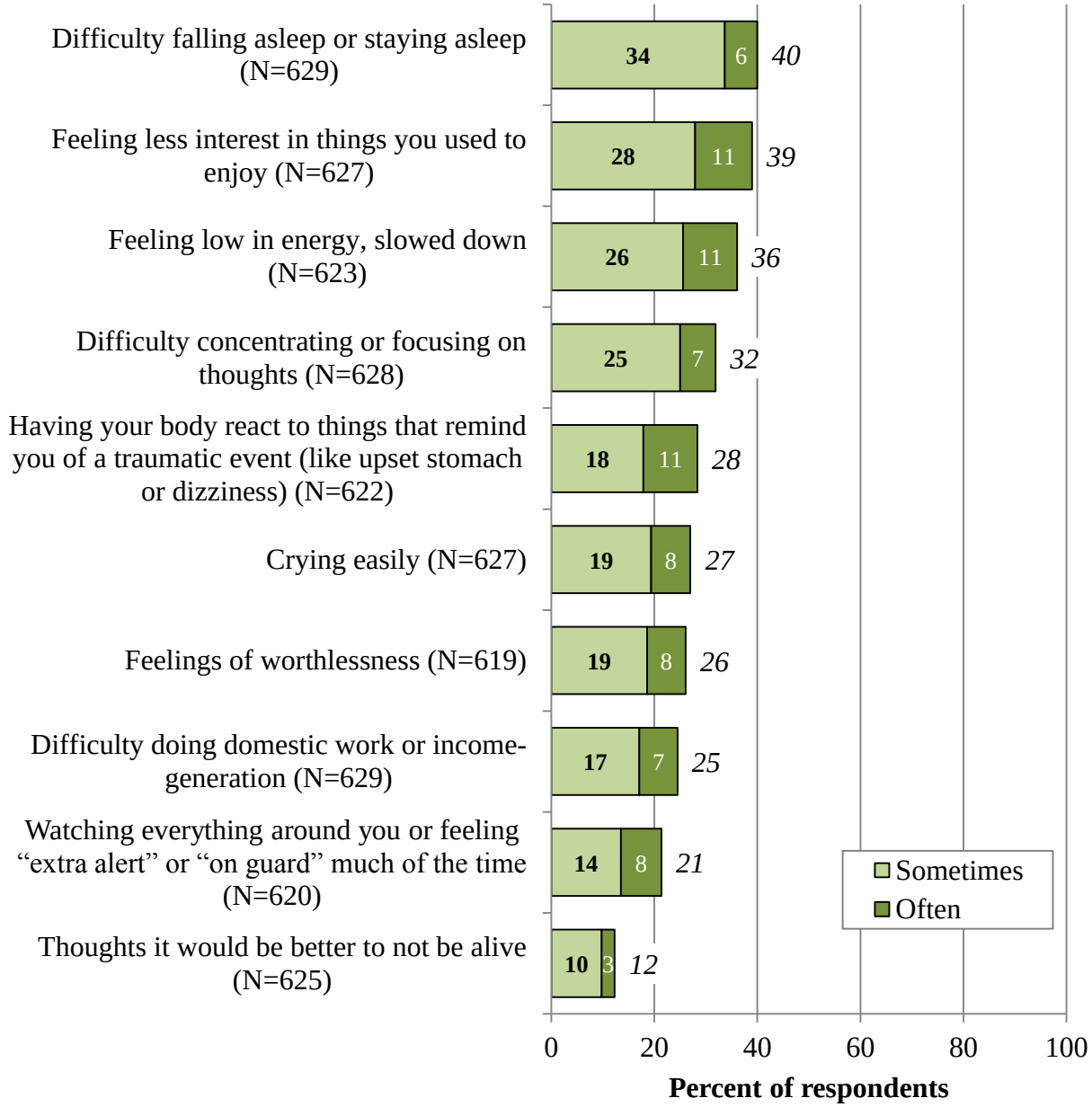
"How often have these problems bothered you in the past two weeks?"



The figure below reports the percentage of respondents who said they sometimes or often experienced these symptoms in the past two weeks. Generally, about a quarter to a third of respondents said they currently experienced these symptoms. Although suicidal thoughts ranked lowest among reported symptoms, 12 percent of respondents said they had had such thoughts within the past two weeks.

Symptom Areas:
Respondents who Select "Sometimes" or "Often"

"How often have these problems bothered you in the past two weeks?"



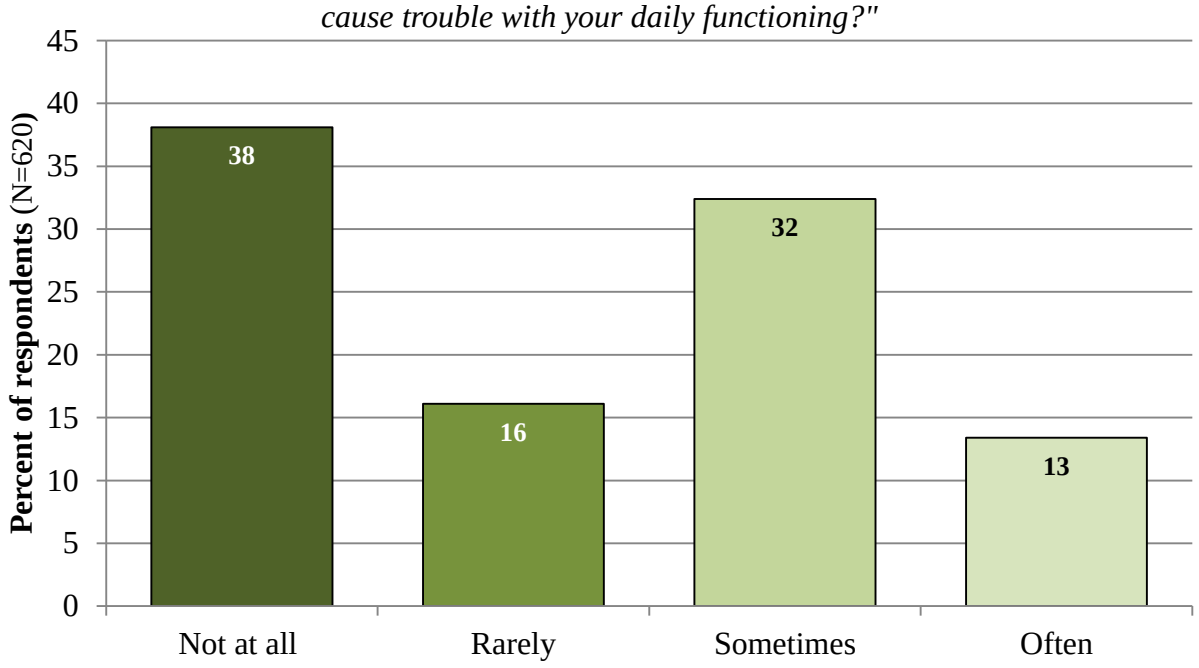
Most key informants interviewed agreed that many refugees in Nguenyyiel are struggling with mental health issues, identifying traumatic experiences during the war in South Sudan as a cause of these issues. One informant indicated that there are frequent suicide attempts in the camp, and three emphasized the need for services to focus on refugees struggling with depression. These perspectives are supported by our survey data establishing the prevalence of mental health symptoms.

Survey respondents' reports of their symptom frequency can be used to establish the symptom prevalence rate for the population overall. There is no clear cut-point on the symptom scale at which point an individual requires services, but a score of 2.0 is often used to indicate a minimum symptom level for service provision. Among all survey respondents in Nguenyyiel, 43 percent have a mean symptom score of 2.0 or higher. From this, we can say with 95 percent confidence that 39 to 47 percent of the adult resident population of Nguenyyiel will have symptoms at or above 2.0 on this scale. Applying this rate to the UNHCR population figure of 24,355 adults, we predict that 9,498 to 11,447 adults in the camp will have symptoms at or above this cut-point. This suggests that over a third of adults in Nguenyyiel may qualify for MHPSS services that address depression and post-traumatic stress.

Although individuals may experience symptoms of mental health problems, usually these are moderate enough that people are able to draw upon their existing coping resources to maintain functionality in daily life. However, nearly half of all respondents (45 percent) said that mental health problems sometimes or often cause trouble with daily functioning. Assessing functional difficulties helps to identify the proportion of refugees who may derive the strongest benefits from mental health support, in order to develop new strategies and techniques for coping with challenges in their lives.

Functional Difficulties

"Do you feel mental health problems (like stress, depression, or anxiety) cause trouble with your daily functioning?"



Most respondents had a moderate self-assessment of their overall mental health, with 73 percent reporting it was overall fair or good. Respondents' perceptions of their functional impairment and overall rating of mental health were significantly correlated with each of the ten individual symptoms (r = 0.288-0.483). Reports of functional impairment were most closely linked to: difficulty doing domestic work or income generation (r = 0.483); hypervigilance (r = 0.433); and feelings of worthlessness (r = 0.461). The overall rating of mental health was most tightly related to difficulty doing domestic work or income generation (r = 0.434) and to somatic reactions to trauma triggers (r = 0.410). Linking functional impairment to fulfillment of social roles (often, domestic work for women and income generation for men) does not establish the causal direction of this relationship, in which mental health challenges may inhibit the ability to engage in work, but the lack of opportunities for meaningful work in a refugee context may also lead to higher levels of mental health problems. Hypervigilance is part of arousal and reactivity,[43] a PTSD symptom cluster that can be particularly disruptive to daily functioning or quality of life.[44]

Overall Mental Health

"How would you rate your mental health overall?"

Older people consistently reported more frequent individual symptoms (significant differences for seven of the ten items), as well as more difficulty functioning, and higher average symptom scores. Women reported more frequent symptoms than men, with differences

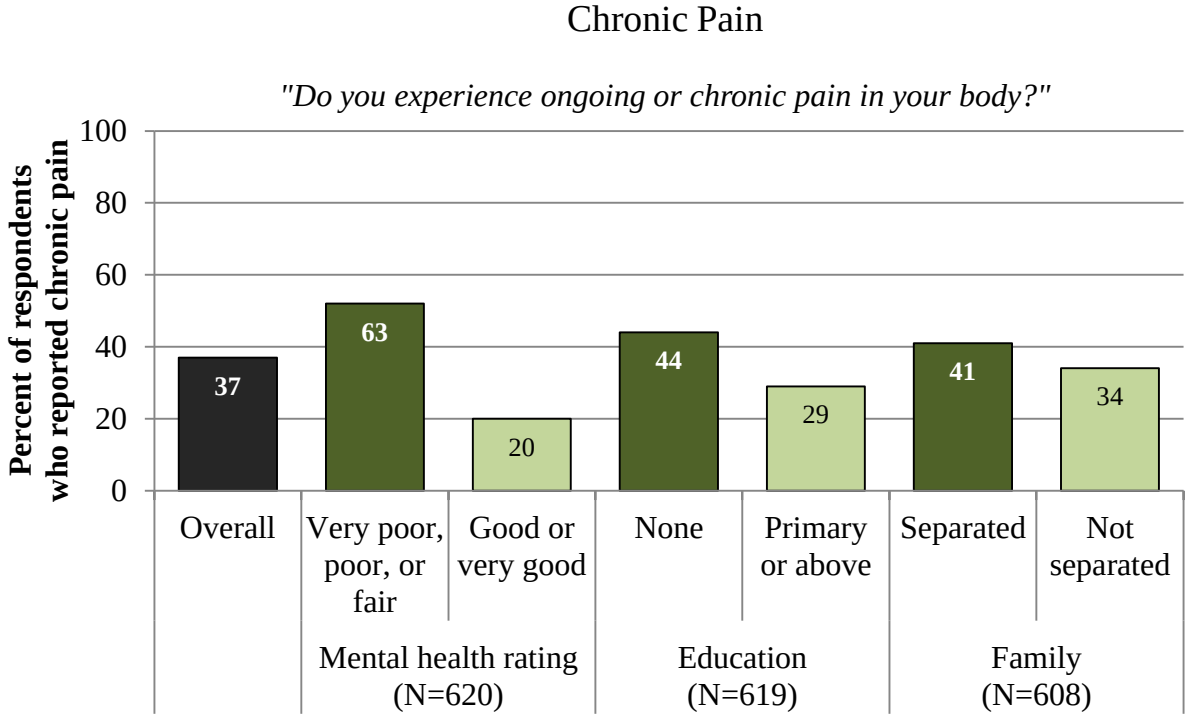
[43] American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition. Arlington, VA.

[44] See: Forbes, D., A. Nickerson, R.A. Bryant, M. Creamer, D. Silove, A.C. McFarlane, …M. O'Donnell. 2019. "The Impact of Post-traumatic Stress Disorder Symptomatology on Quality of Life: The Sentinel Experience of Anger, Hypervigilance, and Restricted Affect." *Australian & New Zealand Journal of Psychiatry* 53(4):336-349.

statistically significant on six items; overall, women's average symptom score was 2.0 and men's average was 1.8. Those with no education and who were separated from their families had more frequent symptoms (for three of the ten items). Those who had been in the camp fewer months also reported two symptoms more frequently than longer term residents.

Respondents' reports of violence in the community as a stressor were also moderately but significantly correlated with nine symptoms[45] (r = 0.146-0.212). Reports of stress from violence in the community were most closely linked to: difficulty doing domestic work or income generation (r = 0.212); having difficulty concentrating or focusing (r = 0.210); physical reactions to reminders of past traumatic events (r = 0.204); hypervigilance (r = 0.203); and feelings of worthlessness (r = 0.200).

We found that 37 percent of respondents reported chronic pain. Those who reported pain were asked to rank the severity of their pain; 46 percent of those said their pain was a 10 (the maximum level on the 0 to 10 scale) with an average response of 7.5. This suggests that for those dealing with chronic pain, it is likely to seriously impair their daily life. Rates of chronic pain were higher among those with no education, those separated from their families, and older people, highlighting an overlap with other categories of vulnerability. Respondents who rated their mental health as fair, poor, or very poor were 215 percent more likely to report chronic pain, compared to those who said their mental health was good or very good (p = 0.000). Chronic pain can be both a cause and consequence of mental health issues, and trauma has powerful effects on both the mind and the body. Notably, key informants interviewed by CVT did not mention chronic pain as a mental health-related concern, despite the strong link identified in our survey results. This suggests a need to raise awareness within the camp of the potential benefits of an integrated mind-body approach to addressing mental health.



[45] With the exception of suicidal thoughts; these were not significantly correlated with problems due to violence in the community.

When asked whether physical health or medical problems had caused trouble with daily functioning in the past two weeks, just under a quarter (24 percent) of all respondents said they sometimes do, and 9 percent said they do often. There was no significant difference between zones, physical health and/or medical problems were reported more frequently by older people and those who had spent at least a year or longer in the camp. Respondents were also asked if they had ever had seizures; about 14 percent reported they had.

Coping Strategies

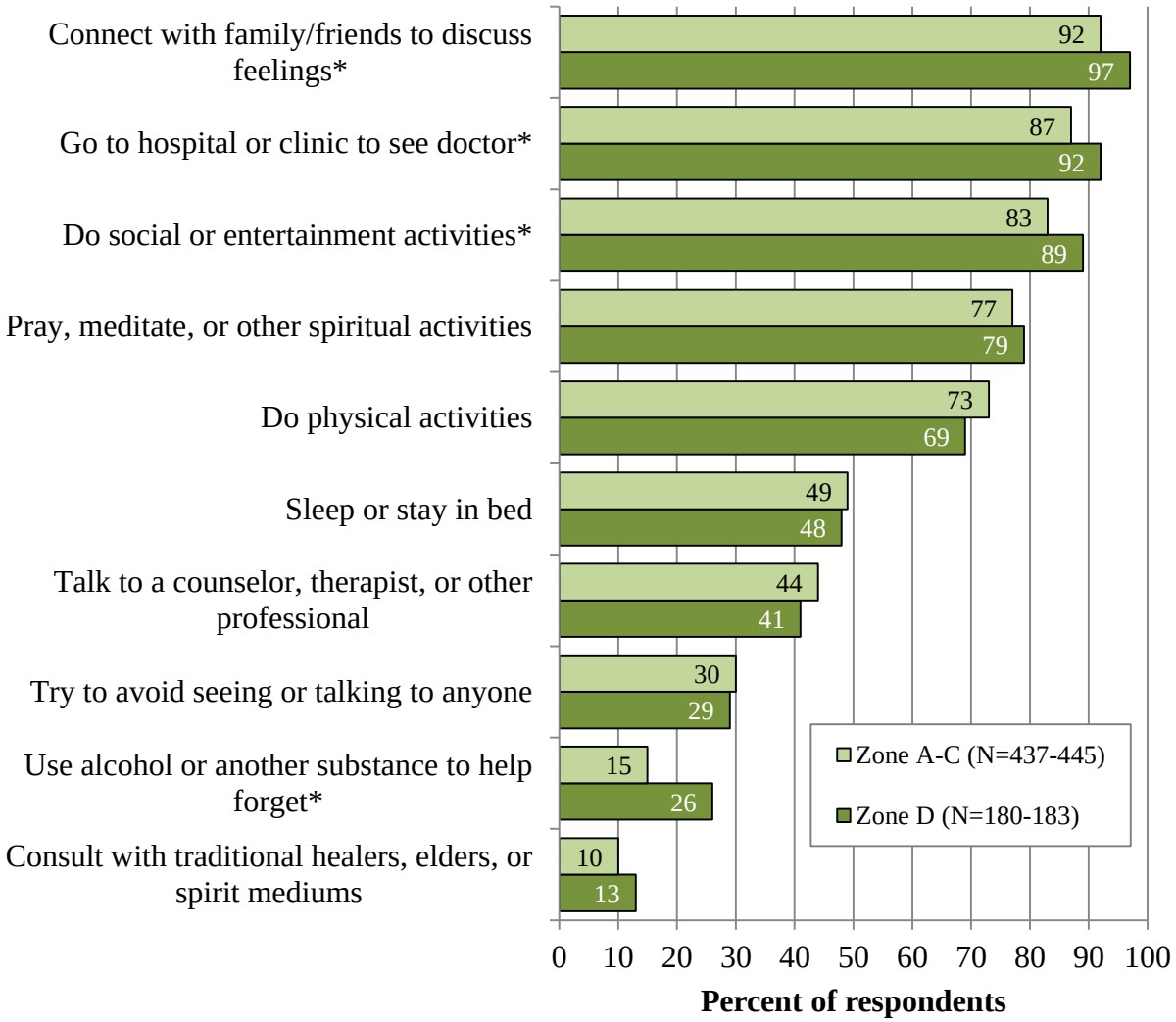
Respondents reported a range of coping strategies that they use to deal with difficult emotions, such as feeling sad, anxious, or overwhelmed. Most respondents reported using positive coping strategies, including: discussions with their family or friends (93 percent); doing social activities (83 percent); doing spiritual activities (77 percent); and doing physical activities (73 percent). A strong majority (87 percent) said they visit a hospital or clinic to see a doctor. While psychological symptoms are often experienced somatically, leading people to seek out medical services, this could also suggest ambiguity or confusion in which services to utilize for mental health concerns and could indicate high levels of trust in medical personnel. In any case, key medical resources in the camp are being spent on responding to mental health problems; medical staff often do not have the training or time to respond to such problems, thus potentially diminishing the efficacy of interventions. Next, nearly half (43 percent) said that they turn to a counselor or therapist for help; many respondents described community members or leaders who had received some training or support to provide counseling within the community. Only 10 percent overall consulted with traditional healers, elders, or spirit mediums. Our list also included a few generally unhealthy coping strategies, which were reported comparatively less often, but still at relatively high rates. Some respondents reported avoidance strategies, such as not seeing anyone or staying in bed (30 percent and 49 percent, respectively). A minority (16 percent overall) reported using alcohol to help cope with difficult emotions.

Key informants CVT interviewed also tended to perceive that refugees in Nguenyyiel have positive coping strategies; one said that the community overall has better coping strategies than they had observed in other refugee camps in Ethiopia. Multiple key informants emphasized drawing on existing community bonds and community structures such as refugee central committees, youth clubs, and other associations as assets for mental health interventions. One key informant stated that there are persistent community beliefs in using traditional healers rather than formal medical service providers; however, our results suggest that this may be less prevalent.

There were some statistically significant differences in the use of coping strategies between zones. Residents of Zone D were more likely to use some healthy coping strategies, such as talking with family or friends ($p = 0.042$), seeing a doctor at a hospital or clinic ($p = 0.054$), or doing social or entertainment activities ($p = 0.042$). However, they were also significantly more likely to report using alcohol or other substances to cope: 26 percent of Zone D residents said they did so, compared to 15 percent in Zones A-C ($p = 0.001$).

Coping Strategies

"On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions?"



* Differences between locations are statistically significant at 0.10-level.

There was variation in who uses these coping strategies. Those who are separated from their families now were particularly vulnerable to social isolation in the face of emotional challenges. Respondents who are separated from family were much more likely to stay in bed (60 percent, compared to 39 percent, $p = 0.000$) and avoid others (41 percent, compared to 21 percent, $p = 0.000$), instead relying on spiritual activities (81 percent, compared to 74 percent, $p = 0.042$) and traditional healers (14 percent, compared to 8 percent, $p = 0.009$) to cope. Respondents with no education were less likely to use positive coping strategies, reporting lower rates of connecting with family or friends, social activities, physical activities, and talking to a counselor. Similarly, respondents struggling with chronic pain reported connecting less with family, friends, counselors, or clinics, and were less likely to do social, physical, or spiritual

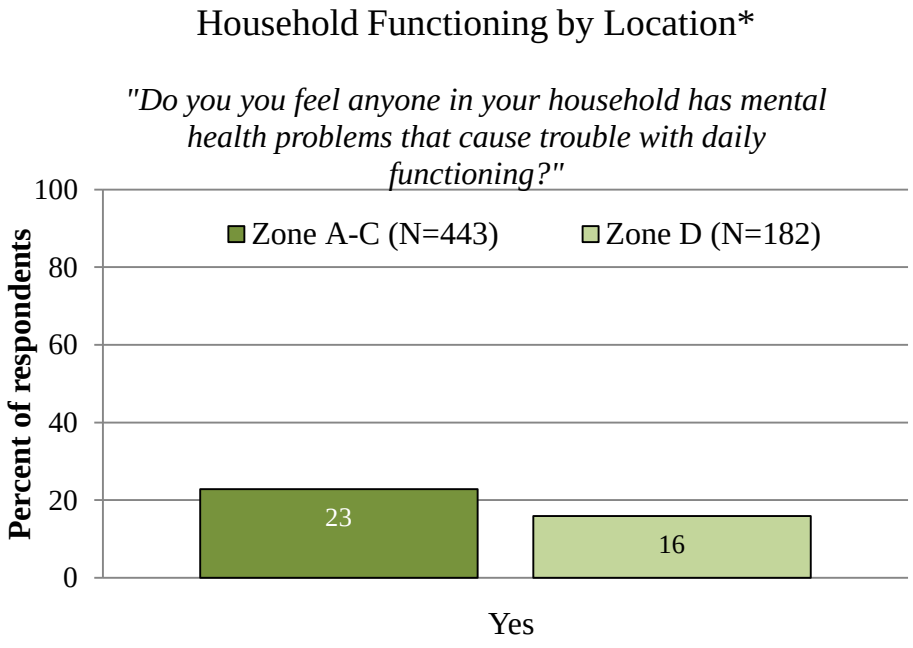
activities; instead people with chronic pain were more likely to stay in bed and avoid social interactions to cope with mental health problems. There were some differences by gender, with men more likely to use social activities and report using alcohol, while women relied more on spiritual activities than men. Older people used less social, physical, and spiritual activities and were less likely to talk to a counselor, but report higher rates of alcohol use and talking to traditional healers or elders. Those who have been in the camp longer also were more likely to report alcohol as a coping strategy.

The use of coping strategies was also related to respondents' mental health. Respondents who reported more difficulty with daily functioning were less likely to use healthy coping strategies (significant differences for seeing family or friends, social activities, doing physical activities, seeing a doctor or counselor, and praying or meditating) and were more likely to sleep or stay in bed. Respondents with higher mean symptom levels followed the same pattern, being less likely to use healthy coping strategies and more likely to stay in bed, avoid seeing anyone, or to use alcohol. Similarly, those with lower ratings of their mental health overall were also less likely to report positive coping strategies. Finally, respondents who reported functional difficulties, higher symptoms, and worse overall mental health were also significantly more likely to consult with a traditional healer, elder, or spirit medium. Relationships between mental health symptoms and coping strategies is likely bi-directional, with more severe symptoms leading to lowered ability to cope positively, but also potentially with less positive coping strategies contributing to higher symptom levels.

Household Mental Health

Overall, 22 percent of respondents said that someone in their household, besides themselves, has mental health problems that interfere with daily functioning. This figure was lower in Zone D (16 percent) compared to Zones A-C (23 percent).

For those who said yes, the average age of the reported household member was 35, with a range of 5 to 86; 13 percent of those who have a household member struggling with functioning said that person was a minor. Overall, only 3 percent of all survey respondents reported having a child in their household who has trouble functioning due to mental health problems. Over half

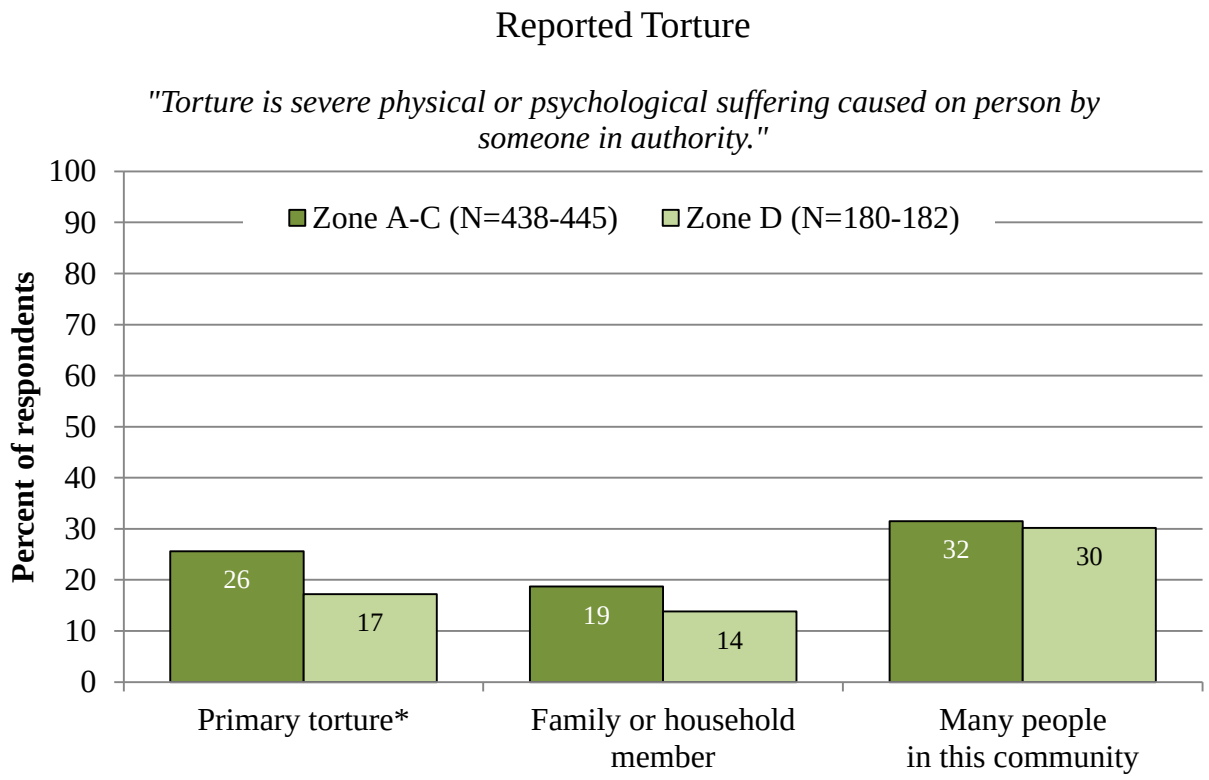


* Differences between locations are statistically significant at 0.10-level.

(57 percent) of the reported household members with mental health problems were women or girls. Furthermore, 83 percent reported that, in the last two weeks, the household member was inactive or completely inactive; 81 percent said the household member was unable to carry out essential activities for daily living; and 70 percent said the household member was acting in a strange way or having fits, convulsions, or seizures.

Torture Survivors

After being offered a simple, brief definition of torture,[46] 25 percent of respondents self-reported that they had been tortured. This rate was significantly lower in Zone D (17 percent), compared to Zones A-C (26 percent). Furthermore, 18 percent of respondents reported that someone in their family or in their household had been tortured, and 32 percent thought many people in their community had been tortured.[47]



* Differences between locations are statistically significant at 0.05-level.

There are no significant differences in reported torture by age, gender, or time in camp. However, those with no education were less likely to self-identify as torture survivors (20

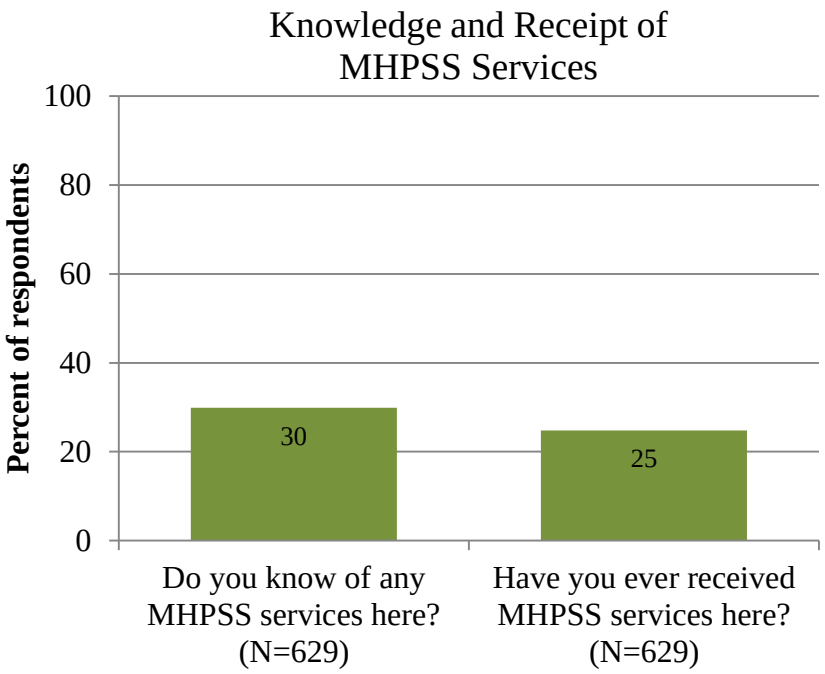
[46] See the *Questionnaire* at the end of the report. The definition provided was: "Torture is severe physical or psychological suffering caused on purpose by someone in authority."
[47] Differences between locations for reported torture for household and community members were not statistically significant.

percent, compared to 28 percent of those with some education). Torture survivors were also more likely to be separated from their family members (55 percent of torture survivors are separated from their families, compared to 45 percent of those who did not report torture).

Those that reported torture suffered significantly more from mental health problems. Those reporting torture more frequently experienced all ten of the symptom areas ($p = 0.000$) related to depression and post-traumatic stress disorder. The average symptom score for those who reported torture was 2.3 out of 4, compared to 1.8 out of 4 for those that did not report torture ($p = 0.000$). Primary torture survivors were more likely to say their overall mental health was very poor, poor, or fair compared to those that did not report torture; they also experienced more frequent trouble with daily functioning, and were more than twice as likely to experience chronic pain (all $p = 0.000$). These findings support the assertion that torture survivors are a particularly vulnerable group among refugees, requiring specific attention from mental health service providers and specialized trauma rehabilitation services. Because torture is related to particularly negative consequences for mental and physical health, a specialized interdisciplinary rehabilitation program is recommended to address the unique needs of torture survivors.

Access to Services

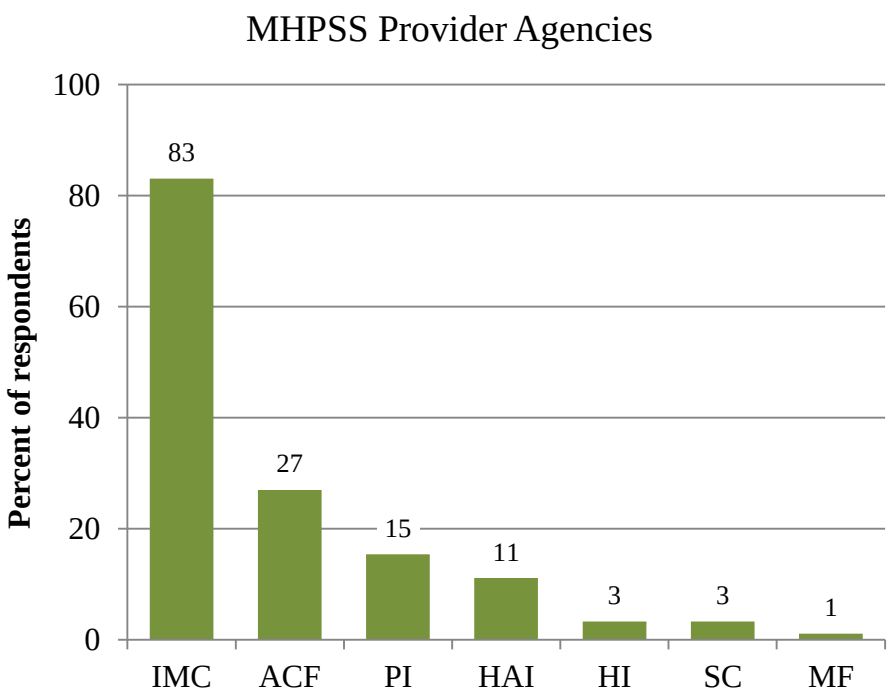
Many respondents (70 percent) were not aware of mental health or psychosocial services available in Nguenyyiel camp or accessible to them in Gambella more broadly; only 30 percent of respondents knew of such services.[48] Among those who knew of services, 88 percent said that they had received MHPSS services; hence, 25 percent of all respondents have received MHPSS services.[49]



[48] These rates are quite similar IMC's finding that 24 percent of respondents knew about MHPSS services, *op. cit.*, p.14. Also, compare to results found by CVT (2017), reported in "Assessing Refugee Mental Health in Ethiopia: A Representative Survey of Adi Harush and Mai Ayni camps." CVT's representative survey (N=548) of two refugee camps in Ethiopia's Tigray region found much higher rates of awareness compared to Gambella: 62 percent of respondents in Adi Harush and 51 percent in Mai Ayni knew about MHPSS services; of those that knew of services, 63 and 58 percent, respectively, had accessed these services.

[49] Knowledge and receipt of services were not significantly different between Zones A-C and Zone D.

Respondents who said they had received MHPSS services were then asked from which agency they had gotten services. International Medical Corps (IMC) was by far the most frequent provider, identified by 83 percent of those who responded the question. This was followed by Action Against Hunger (ACF), with 27 percent of respondents. A minority received services from Plan International (15 percent) and Help Age International (11 percent). A few respondents reported getting services from Humanity and Inclusion (HI), Save the Children (SC), and Maternity Foundation (MF). There were not significant differences between Zones A-C and Zone D in terms of service provider, with the exception of ACF; Zone D residents were significantly more likely to report receiving ACF services (44 percent of those who answered this question) than those in Zones A-C (26 percent).



If yes to received MHPSS services: From where?
(N=158, valid %)

Knowledge of and access to mental health services varied among respondents. In general, more vulnerable groups were less likely to know about services: women, older people, and less educated people were less likely to say they are aware of mental health services available to them. However, among those that knew about services, access did not differ by gender, age, or formal education. This indicates that the major hurdle in reaching more vulnerable groups of refugees with services is ensuring that they are aware of services available. Furthermore, those that knew about services were more likely to use some healthy coping strategies, particularly to connect with friends or family, engage in social and physical activities, and to talk to a counselor or therapist. On the other hand, those that knew about services were also more likely to cope by trying not to see anyone. Mental health was not significantly different among those that knew about or had received services; there was no significant difference in average symptoms, nor in the frequency of problems with daily functioning.

Respondents also received other types of help from NGOs and other service providers, beyond MHPSS services: 97 percent of all respondents received food, 41 percent medical assistance, 40 percent shelter or clothing, 21 percent education, 17 percent legal assistance, 13 percent resettlement or family tracing assistance, 8 percent livelihood assistance, and 2 percent financial assistance. Respondents reported getting information about services available in the camp from a diverse range of sources: 55 percent said they receive information from UNHCR, ARRA, or a refugee coordinating committee; 38 percent from outreach or awareness raising

events; 33 percent from family or friends; and 26 percent from schools or churches.[50] Less than 10 percent of respondents said they get information from radio or mass media, or from NGO referrals, suggesting that referral pathways among service providers could be strengthened.

Conclusions and Recommendations

To assess mental health needs, CVT interviewed 639 individuals representative of the adult resident population of Nguenyyiel camp in January 2019. Similar surveys can be conducted at regular time points and among other refugee populations to monitor shifts over time and place. Any survey in a humanitarian context, particularly about sensitive topics, must be done with a high level of attention to psychological support for respondents, including providing psychological first aid, emergency interventions, and referral pathways.

The resultant representative data identifies attitudes about mental health, daily difficulties facing refugees at Nguenyyiel, psychological and some physical symptom levels, coping strategies, and access to services among the residents of all zones in the camp. This allows service providers, governmental agencies, community leaders, and other stakeholders (including CVT) to design evidence-based MHPSS interventions that are responsive to the needs of this population. Key findings and some implications are highlighted below.

- **There are generally positive ideas about mental health, including broad agreement that social support networks are useful in addressing mental health problems.** Survey respondents tended to agree that it is "good to talk to family or friends about mental health," and that they felt they could depend on their communities for help coping with ongoing challenges, stress, or worries. This can be a resource for MHPSS interventions.

    - **At the same time, some refugees may be unwilling to discuss past traumatic experiences.** Only about half of respondents agreed that "to deal with trauma, it helps to think or talk about what happened." In particular, respondents in Zones A-C were less likely to agree with this statement. This may present a challenge for talk-based trauma-focused rehabilitation services.

    - **There are also strong pockets of stigma towards mental health.** Nearly half of respondents saw mental health problems as shameful or a sign of weakness or personal failing. Targeted, community-based awareness-raising strategies to combat stigma are necessary to address these misperceptions. Additionally, providers ought to create pathways to access services that are minimally exposing or stigmatizing. Individuals in need of services will be less likely to access services if they believe they will face stigma in their community.

[50] Compare to IMC's survey results, which found that 24 percent of respondents received information about MHPSS services from IMC and only 5% had received information from ARRA community health workers, *op. cit.*, p. 14.

- **Most people report using healthy strategies for coping with difficult emotions.** A majority of respondents reported connecting with their family or friends, doing social or entertainment activities, or praying, meditating, or doing spiritual activities were their primary coping mechanisms. MHPSS providers can draw upon these existing coping strategies as opportunities to provide culturally resonant support. Group-based interventions may be particularly salient in this environment. Providers should engage in discussions about how interventions can draw upon religion or spirituality, while also being mindful of the fact that it is common for some survivors to feel disillusionment with their religion given their past and present struggles.

    - **A significant minority of the population relies on unhealthy coping strategies, including staying in bed, avoiding seeing others, and using alcohol.** Those separated from their families, those with chronic pain, and those without education were more likely to stay in bed and avoid social interaction, and less likely to use some healthy strategies. Men, older people, and those who have spent more time in the camp were more likely to cope by using alcohol. MHPSS providers should teach healthy coping methods, particularly to those who are less likely to be currently using them.

    - **Many people report going to a hospital or a clinic when they are facing mental health concerns.** Staff at medical facilities should receive training on protocols to screen and identify people struggling with mental health issues, and they should be equipped with appropriate referral networks to mental health service providers.

- **Refugees rank mental health-related problems as major issues in their current lives, particularly grief over loss of loved ones and worries about people at home.** MHPSS services should be considered essential interventions for refugee populations. To meet these needs and address the interrelated character of many of these problems, service providers should develop a coordinated response, including referral pathways and follow-up processes. Notably, concerns about meeting the basic needs of food, shelter, and clothing were relatively low.

    - **A fragile security situation in the camp causes significant stress and likely impacts refugees' mental health.** Nearly two-thirds of respondents identified violence, threats, or conflict in the community as a problem or very serious problem in their lives. Additionally, community violence was the second-most frequently selected major stressor. Reported symptoms may be related not only to past traumatic experiences but also to ongoing violence and instability. Recognition of refugees' needs for both physical and emotional safety should underlie the development of engagement strategies; MHPSS services should help refugees address past trauma while also providing support to cope with the psychological impacts of continuing threats.

- **Refugees report moderate mental health symptom levels, and half of all respondents indicate impaired ability to function in daily life.** The ten individual symptoms included in the survey are indicative of depression and post-traumatic stress disorder, two of the most common psychological responses to trauma exposure. Respondents reported, on average, experiencing symptoms with a frequency of approximately 2 on a scale of 1 to 4 (or "rarely"). There were no major differences between Zones A-C and Zone D. However, almost half of respondents said that mental health problems sometimes or often cause trouble with their daily functioning; nearly one-fifth said that their mental health was poor or very poor. Respondents' self-assessments of functional impairment and overall rating of mental health were significantly correlated with the individual symptoms. We estimate with 95 percent confidence that between 39 to 47 percent of the adult population in Gambella have symptoms which could indicate a need for specialized mental health care.

    - **The most commonly reported symptoms are difficulty falling or staying asleep; feeling less interest in things one used to enjoy; and feeling low in energy.** These and other symptoms were reported more frequently by women, older people, and those without formal education. MHPSS interventions should focus on integrating these typically more socially marginalized groups. Symptoms were also more frequently reported by those separated from their families and those reporting that violence in the community was a problem in their life, indicating a need for MHPSS services to address ambiguous loss and past and ongoing traumas.

    - **Twelve percent of the population reports currently having suicidal thoughts.** The respondents who said they had had such thoughts in the past two weeks should be considered high risk. Service providers in all sectors should be trained to identify warning signs of suicidality and referral pathways to provide appropriate follow up support should be strengthened, including developing short- and medium-term safety planning in the response. An inter-agency collaboration is recommended to develop a suicide prevention strategy, as well as a protocol for responding appropriately after a suicide attempt.

- **Only 30 percent of respondents know about MHPSS services; those who know of services are likely to have received services.** Given low rates of knowledge and thus overall utilization of services, service providers should actively pursue outreach campaigns in this camp. Findings suggest such efforts may be particularly effective in increasing utilization of services for those in need, so service providers should be prepared to handle a potentially significant influx of beneficiaries. Outreach should particularly focus on more vulnerable groups, including women, older people, and those without education, since these groups are less likely to already be aware of services that exist.

    - **There is no significant difference in awareness or use of services between Zones A-C and Zone D.**

- **Those who have received services have comparable symptom levels to those who have not received services.** Further exploration is needed to understand this finding. Perhaps service providers are not reaching the most symptomatic individuals or the services offered are not effectively reducing symptoms and improving functioning. Alternatively, those who sought services may have had higher symptoms, but with improvements following services, their mental health may have improved to the level of the general camp population.

- **Nearly half of Nguenyyiel residents are separated from family members, and thus are more likely to lack social support structures.** Those who are separated reported higher symptom levels and were more likely to use unhealthy coping strategies, including social isolation. A psychosocial response, informed by knowledge of complicated bereavement and ambiguous loss, could aid in developing social support structures for these people.

- **Levels of education among Nguenyyiel residents are very low, which is associated with increased vulnerability.** Those without formal education reported more difficulties with daily living, higher symptom levels, and higher chronic pain, and they were more likely to use some unhealthy coping strategies. Because of these vulnerabilities, MHPSS service providers should place particular effort on reaching less educated members of this population, and adapt interventions where necessary.

- **Over one-third of respondents report chronic pain.** Rates of chronic pain tripled for those who reported lower-quality mental health (those who said their mental health was very poor, poor, or fair), revealing a powerful connection between physical and psychological well-being. Poor mental health can be expressed through physical pain, and in addition, chronic physical pain can have negative impacts on mental health. A multi-disciplinary approach is necessary to address this: integrating physiotherapy and pain management into mental health interventions, as well as integrating mental health support into primary health care or hospital settings.

- **Approximately one-fourth of the population report surviving primary torture.**

    - **Torture survivors have more severe mental health problems compared to other refugees.** Torture survivors experienced more frequent symptoms related to depression and post-traumatic stress disorder, faced more difficulties with daily functioning, and had worse perceptions of their own mental health relative to those that are not primary torture survivors. They reported chronic pain at a rate double that of non-torture survivors. They were also more likely to be separated from their families, and may have less social support available to them.

    - **Interventions likely to include torture survivors should integrate considerations for this population into program design.** Outreach and education initiatives should focus on population segments likely to have higher rates of torture survivors. Service providers should bring in experts or train their staff on specialized skills needed to provide torture rehabilitation services. Mental

health services for torture survivors should be more intensive and longer-lasting to adequately address needs. Additional research among South Sudanese refugees or in Gambella specifically could aid in understanding how to effectively identify and provide care to torture survivors in this context.

- **Conducting representative surveys to assess mental health needs of refugee communities in camp settings is feasible.** The context presents substantial challenges in designing and implementing a rigorous methodology, but the resultant data can be used in many ways. Non-representative assessment designs, particularly relying on information from service providers, community leaders, or other stakeholders, provide essential insights to help understand needs and design effective services. However, representative survey data can produce prevalence rates, identify vulnerable groups, and contribute to a broader strategic picture of overall need among the full population.

    - **Mental health support is essential to implement a representative survey.** A mental health survey in refugee camps will address sensitive topics with vulnerable populations. The survey design must include team members with mental health expertise, referral networks, high-risk protocols, and emergency support available.

Questionnaire

The bilingual English and Nuer questionnaire is on the remaining pages of this report. Please contact CVT with requests to utilize this questionnaire.

Date: Cäŋ: _____ Interview #: Thiecni: _____

Interviewer ID #:
ID raam min thiec naath:_____

Supervisor ID #:
ID kuar: _____

Location of interview: Guaath in thiec kɛ naath thin:

Zone: Dhuun: _____ Block: Bɔlɔk: _____ Community: Dhɔr/ciëëŋ: _____

Gender of respondent: Biɛl diëëth raam min thieckɛ: ○ Man Wut ○ Woman Ciek

Language of interview: Thok in thiec kɛ raan kɛ jɛ:

○ Arabic Thok jalapni ○ English Thok liŋlithni ○ Nuer Thok Nuäärä

○ Other: Mi dɔŋ: _____

Post-Survey Support Protocol **Kaath lat tin ba guɔɔr kɛ jɔk Thërbɛyä/kä.**

☐ **Emergency response:** Respondent is in extreme distress and requires immediate intervention
Rami mi göör luak kɛ pëth: Ramin thiec kɛ mi te kɛ mi göör luäk, baa dhil luäk kɛ pëth
Trained enumerators will provide PFA and notify their supervisor and/or the CVT or IMC focal person to come to the household immediately.
Nɛy tin caa ŋiaac de kɛn luäk in nhiam thöp kä de kɛn kuaarkiɛn tin te kä *CVT or IMC* lar läär kɛ ɣöö de kɛ naath guil cieŋni kɛ pëth.

☐ **Referral: Jäkni nath guathni ti kɔŋ**

- ☐ Respondent was given information about available services
  Ram min loc thiecni ca lar läärï kɛ kui luäkä kiɛ lätni tin te thin.
- ☐ Respondent needs to be connected with referral partner
  Ram min loc thiecni goorɛ ɣöö dëë jak kä rom kɛ muktäpni tin lät kɛɛl.
- ☐ Respondent needs to be referred for CVT services (Zone D)
  Ram min thiëc kɛ mɔ göörɛ ɣöö ba jek kä CVT kɛ kui luäkä kä (dhuun D)
- ☐ Respondent needs to be referred for IMC services (Zones A, B, and C)
  Ram min thiëc kɛ mɔ göörɛ ɣöö ba jek kä IMC kɛ kui luäkä kä (dhuun A,B and C)

☐ **PFA:** Respondent experienced some distress and required in-person PFA delivered during survey per CVT training of enumerator
Nɛy tin ca ŋiääc ɛ CVT kɛ duɔɔp mi ba gor läärï rɛy wec ɛ kɛn bi ram mi te kɛ jiath lɔaac mi diit mi goor luäk cärï kɛ pëth kɔn luäk ɛ kɛn kɛ nhiam tɔ.

☐ **Nothing required:** Respondent did not require follow up for psychological distress
Thiɛlɛ mi goorɛ: Ram min looc thiecni /cɛ gor i dee naath nyɔk kɛ loc kä jɛ kɛ guuri nath kɛ taa cärï tin la jɛ ɛ jak kä dual.

NOTES: Gɔriɛ piny _____

_____

Was the respondent alone during this interview? Ram mëë thieckɛ tëë kärɔa guaath ëë thiec kɛ jɛ thin?
○ Yes ɣää ○ No ɣëy

Interviewer signature: Thaany raam min thiec raan: _____

Welcome Script & Consent Lat rɔ, taa lat, kɛnɛ matdun kɛ lat

Good morning/afternoon. I am working with an international organization called the Center for Victims of Trauma (CVT). Trauma means mental, emotional, or physical distress caused by a bad experience or event. We provide services to people who have experienced war or have been forced to leave their homes. We are starting a program to provide mental health services in Gambella/Nguenyyiel. We are doing an assessment to learn about mental health needs in this area. We want to understand the needs and opinions of people who live here.
Malɛ kɛ run waŋ/käŋdäär. Ɣän latdä kɛ kui Ɣɔrginaydhëëcinä kiɛ Manadhɛmɛn mi lät wimuɔɔn kɛɛliw mi cɔali Thentɛr puɔr dhɛ Biktim ɣɔp Turɔma /*Center for Victims of Trauma/ CVT/*. Jɛn lätdɛ kɛ kui ciɛŋni tin la tëk nath ɛ tɔɔŋ kiɛ yär. Tɔaaŋ lotdɛ ni ciɛŋ tin la ŋiɛth, cär kɛnɛ puɔny ɛ cuuc, kä kɛn ciɛŋ tɔtɔ la raan kɛ ɛ jek rɛy kä ti jiäk ti ci tuɔɔk kä jɛ. Lät nɛy kɛ kui nɛɛni ti ci rik kori tuɔɔk kä kɛ kiɛ nɛy ti ca joc guath ciɛŋnikiɛn. Kɔn bi nɛy kulɛ tok ni lat kɛ kui rikni tin la doth rɛy cäri nath. Kɛ ɣöö nɔ, goor nɛy ɣöö bi nɛy min gör kɛ ɛ nɛy tin ciɛŋ rɛy wec ɛmɛ ŋac kɛ liɛŋda kɛ cärkiɛn.

We used a statistical procedure to randomly select households in your area, and that is why I am here. I would like to ask someone in your household a few questions about their experiences and their opinions about mental health. The questions will take about 20-30 minutes. These responses will be put together with all other responses and analyzed. We will not collect or record any names at all.
Kɔn kuany nɛy dhor kɛ nombori; mi /känɛ dhɔran jac, /ci nɛy bi wä thin, duŋdɛ ɣöö dhɔr mi ci nombor ɛ mampiny kɛ kuëny bi nɛy wä thin ; ɛ jɛn ku nɛy lɛ ben guaath ɛmɛ kɛ jɛ mɔ. Kɛ ɣöö nɔ, göörä ɣöö dëë raan thiäc dhɔɔrun kɛ thiecni ti tɔt kɛ kui kä tin ŋäcɛ i ci tuɔɔk, kä derɛ min la carɛ lat bä. Kɛn thiecni dɔŋ dee kɛn naŋni digiɛɛkni ti jɛn rɛw ɛ wä kä jɛn diɔk. Tin ci raan kɛ lat ba kɛ mat kɛɛl kɛnɛ tin ca lat ɛ nɛy ti kɔŋ, bi nɛy kɛ kulɛ wä liny. Thiɛlɛ ciöt raam mi bi nɛyɛ gɔar thin.

I would like to randomly pick someone from your household who is available today. Please help me list all adult (18+) [men / women] household members.
Ɛ ɣän bi mɛɛk ɔ kɛ ram mi bä thiec kä nɛy tin ciɛŋ dhɔɔrun. Ram ɛ bi nombor ɛ mampinyɔ ɛ jɛn bä thiec ɔ. Kɛ ɣöö nɔ, luay ciööt nɛɛni diaal wutni kɛnɛ män tin te kɛ run wäl badäk ɛ wä nhiam.

Use numbers to randomly select a household member for inclusion. Switch between men and women – if you interviewed a woman in the last household, you must interview a man in this household. After an interviewee is identified, review any information from above, as necessary.
Ram min ca thiec dhɔr in thieek kɛnɛ ciëŋ ɛ goori ɣöö bi raan thiec thinɔ mi ɛ wut, bi kuany ni ciek kä dhɔr in dɔŋ, kä mi ɛ ciek bi kuany ni wut dhɔr in thieek kɛn. Gɔaa ɣöö bi kɛ guɛl. Kɛ kɔr kä mi ci ram min ci mampiny kɛ kuëny ŋac, gorɛ ɣöö bi tin ci lat ni wen nyɔk kɛ guäc.

Your participation is completely optional and voluntary. You can choose not to answer any question if you don't want to. You can stop the survey at any time. This is not a test and there are not right or wrong answers. I am only interested in learning what you really feel or think. For the questions you do answer, I would be grateful if you could answer as openly as you can.
Ɛn ɣöö bi rɔ mat lät ɛmɛ biɛ nhɔk ɛ jin. Mi lok i ɣöö bi thiec loc**,** ti kɛ cuɔɔŋ kɛ lokdɛ. Deri lat ŋok bä mi ciɛ gor i deri ŋot kɛ wä nhiam kɛ locni thiecni. Nɛmɛ kɛ ɣöö /ciɛ ɣɔɔn, thiɛlɛ jek mi la thuɔk kɛ mi /ci mɔ a thuɔk. Göörä ni ɣöö bä mɔ guici mɔ kɛnɛ mɔ la caru mɔ ŋac. Kɛ kui thiecni tin bi loc, goor lɔcdä jɛ ɛlɔŋ i deri kɛ loc kɛ jɔw mi ɣööŋ.

The goal of these questions is to help provide better services for people here in general, but your participation will not directly benefit you or your family in any way.
Luɔt lat ɛmɛ ɛ ɣöö ba lat mi gɔaa lät kä nɛy diaal tin ciɛŋ ɛn guaath ɛmɛ, ɛn ɣöö ca kuany ni dhɔr ɛmɛ kɛ thiecni /cɛ lotni ɣöö kɛ kɛn jidhɔɔr ɛmɛ bi mi gɔaa jek tɔ.

Some of the questions may remind you of things that cause stress for you. If any question makes you feel upset, just let me know. At the end, we can take a few minutes to see how you're feeling.
Thaaŋ thiecni dee kɛn ji jak kä tiimi duŋ dualä mi ci duɔth jɔk. Mi tëë kɛ thiec mi ci lɔcdu jak kä jiäk, lari jɛ ɣä. Kɛ thuɔk thiecni bi kɔn ruac kɛ kui kä min jakɛ lɔcdu kä jiäk kɛ jɛ.

Are you willing to participate? Ciɛ nhɔk i ba ji thiec? ○ **Yes Ɣää** ○ **No Ɣëy**

Thank you so much for agreeing! Your perspectives will be very helpful to us. I look forward to our conversation!
Ci lɔcdä tɛɛth ɛlɔŋ kɛ ɣöö ciɛ nhɔk . Cär tin ci thöp bi kɛn nɛy luäk ɛlɔŋ. Mi nhɔk kuothɛ bi kɔn nyɔk kɛ jek

Time started: Thaak in tuɔkɛ lat: _____ AM / PM

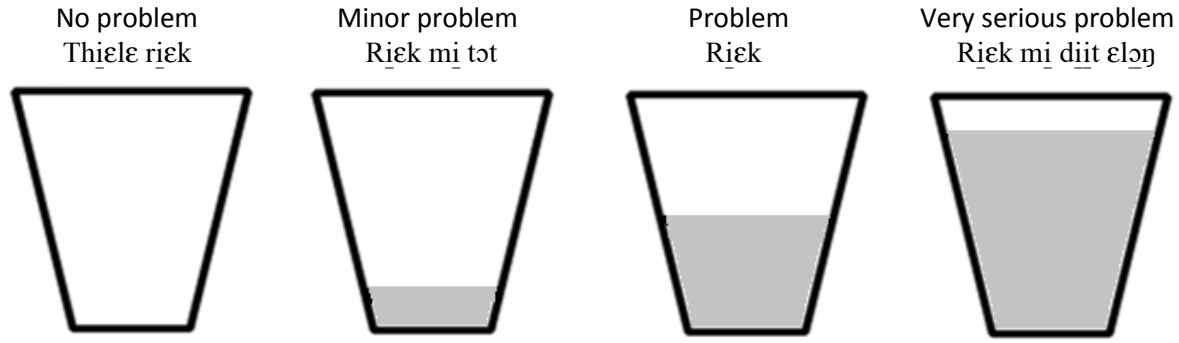
First, I will read some statements about **mental health** that you might agree with or disagree with. Please tell me if you strongly disagree, disagree, agree, or strongly agree.
Kɛ nhiam tëë kɛ rieet ti bä kuɛn ti dɔŋ deri guël kɛkɛ kiɛ deri mat kɛkɛ kɛ kui gɔɔyä ŋithä. Kɛ ɣöö nɔ, läriɛ ɣä mi ci guël ɛlɔŋ, mi ci guël, mi ci mat kɛ jɛ, kiɛ mi ci mat kɛ jɛ ɛlɔŋ.

Use thumbs up and down to illustrate the options. Bi jekdu lar kɛ cuŋdu kɛ yiët in but-but nhial kiɛ piny

	Do you agree or disagree? Ci mat kɛ jɛ kiɛ /käni mat kɛ jɛ?	**Strongly Disagree** ***Cä guël ɛlɔŋ*** *(2 thumbs down)* *(Bi yët 2 tin but-butni luɔŋ piny)*	**Disagree** ***Cä guël*** *(1 thumb down)* *(Bi yët 1 in but-but luɔŋ piny)*	**Agree** **Cä mat kɛ jɛ** *(1 thumb up)* *(Bi yët 1 in but-but cuɔŋ nhial)*	**Strongly Agree** **Cä mat kɛ jɛ ɛlɔŋ** *(2 thumbs up)* *(Bi yët 2 tin but-butni cuɔŋ nhial)*
1.1	I understand what the words "mental health" mean. Ci min lot riät, "gɔɔy ŋithä," wä lɔɔcdä.				
1.2	"Mental health" can be positive. It means psychological well-being; it is important for everyone. "Gɔɔy ŋithä" tëë kɛ luɔt mi gɔaa. Jɛn lotdɛ ni pual puaany rɛy ŋithä. Jɛn gɔaaɛ kɛ nɛy diaal.				
1.3	"Mental health" is negative. It really only means psychological illnesses or problems. Gɔɔy ŋithä tëë kɛ luɔt mi jiääk. Jɛn lotdɛ ni ŋiɛth mi te kɛ juey kiɛ riɛk.				
1.4	To deal with trauma, it helps to think or talk about what happened. Mi lät raan jɔɔ ciɛŋni tin la naath ɛ tɔɔŋ kiɛ la tëk nath ɛ jak kä bɛc, derɛ gɔaa mi cär raan kiɛ ruac raan kɛ kui kä tëë ci tuɔɔk.				
1.5	Mental health problems are shameful or a sign of weakness or failure. Rik tin la tuɔɔk kä ŋiɛth mi gɔaa, kɛ nyin pocä kä la kɛn ɛ nyooth ni nyuään kiɛ thiɛl luäŋä.				
1.6	It is good to talk to my family or friends about my mental health. Gɔaa ɣöö dëë ruac kɛ ciëëmaari kɛ kui gɔɔy ŋithä.				
1.7	I know and use healthy strategies to cope with negative thoughts or feelings about what has happened to me. Ŋacä caap tin la gaŋkɛ cär ti jiäk kä la ɣän kɛ ɛ läth lät mi tëë kɛ car mi ci ben kä ɣä kɛ kui kä tëë ci kɔn tuɔɔk kä ɣä ni wal.				
1.8	People with mental health problems are all crazy. Nɛy tin te kɛ ŋith ti gɔw kä te kɛ rik, kɛn diaal kɛ yɔaŋ.				
1.9	I feel I can depend on my community to help me cope with on-going challenges, stress, or worries. La ɣän a guic i dee te kɛɛl kɛ jiwec kɛ ɣöö dee kɛn ɣä luäk kɛ duɔɔp in dëë rut rik, dual kɛnɛ tin diɛɛrä kɛkɛ.				
1.10	A lot of people in this community are struggling with mental health issues. Nɛy ti ŋuan rɛy wec ɛmɛ te kɛn kɛ rik ti ŋuan rɛy cärikiɛn ti ruut kɛn kɛ kɛ kui gɔɔyä ŋithä.				

Next, I want to ask you about things that might cause **stress in your life** right now.
Min dɔŋ, bä ji thiec kɛ tin guici i **dee dual nöön rɛy tëëkädu** ɛntämɛ.

You can use this picture of cups to help you. The more full cups mean that something is a big problem that causes you a lot of stress. Please tell me how difficult each of these things is in your life right now, ranging from no problem to a very serious problem.
Kothni tɔtɔ bi kɛn ji luäk kɛ duɔɔp mi bi lar riɛkdu. Koth ɛ ci thiaaŋ ɛlɔŋɔ nyoothɛ ni ɣöö riɛk in mooc ji dual ɛ riɛk mi diit. Läri ɣä tin jeki ɛ bɛc rɛy tëëkädu ɛ tookɛ nikä ɣöö thiɛlɛ riɛk ɛ wä kä ɣöö te riɛk mi diit thin.



	How difficult is this in your life right now? Ɛ taa mi tedi jek i jɛ ɛ bum ɔ rɛy tëëkädu ɛntämɛ?	No problem Thiɛlɛ riɛk	Minor problem Riɛk mi tɔt	Problem Riɛk	Very serious problem Riɛk mi diit ɛlɔŋ
2.1	Getting food, shelter, or clothing Jëki kuan, guaath ciɛɛŋä kiɛ bieyni				
2.2	Getting education or a job (generating income) Jek duel gɔrkä jëk kiɛ kɛ lat (lat nyɛgaathä)				
2.3	Illness, health problems, or disability Juey, rik puɔlä puaany kiɛ buɔm				
2.4	Not having friends, family, or neighbors who can support you Mi thiɛlɛ määthdu, jiciëŋ, kiɛ ji-thieekä ti luäk ji				
2.5	Adjusting to or dealing with life in the camp (including missing home and lifestyle) Mi /kän raan tëkdɛ luäŋ kɛ jak kä wä kɛɛl kɛ ciaaŋ kɛmä cetkɛ caran kɛ wec kɛnɛ ciaaŋ tëëkä mëë walɛ				
2.6	Worries about people back at home Diɛɛr kɛ kui nɛɛni tëë ci duɔth wic				
2.7	Trying to leave the camp (for resettlement, moving home, etc.) Ɣɔn ran kɛ ɣöö derɛ ɣöth kä këm kiɛ derɛ loc wic ɛ ku wëë wä.				
2.8	Domestic violence, threats, or conflicts in your household Rɔal kiɛ gak jiciëŋ, nyin dualä kiɛ gak-gaakni ciëŋ				
2.9	Violence, threats, or conflicts in the community Kor, nyin dualä kiɛ gak-gaakni rɛy jiwec/rɛy wec.				
2.10	Not knowing where my family or friends are right now Kuicdä kɛ guaath ɛ te ciëëmaari kiɛ mäthnikä thinɔ ɛntämɛ.				
2.11	Grief from the loss of loved ones Jiath lɔaac kiɛ par nɛɛni tin ci yieykiɛn lɔɔŋ /liw/				
2.12	Hopelessness or uncertainty about the future Thiɛl ŋäthä kiɛ kuic ran kɛ tin bi tuɔɔk kɛ guaath in ŋot nhiam				

You told me that some of the things I just mentioned are problems for you.
Ci ɣä jiök i thaaŋ ŋɔaani kä tin cä lat kɛ rik kä ji.
Review which items they said were the most serious problems. *Guic thiecni tin ci kɛn kɛ lat i kɛ rik ti dit ɛlɔŋ.*

2.13 Which **ONE** of these causes you the **most stress** right now?
Ɛ thiec kɛl in diɛn kä thiecni tɔ ca lat tɔ la ji ɛ jak kä dual ɛlɔŋɔ ɛntämɛ?

Write one item from the list above. *Gɔr kɛl kä tɔ ca luay nhial tɔ.*

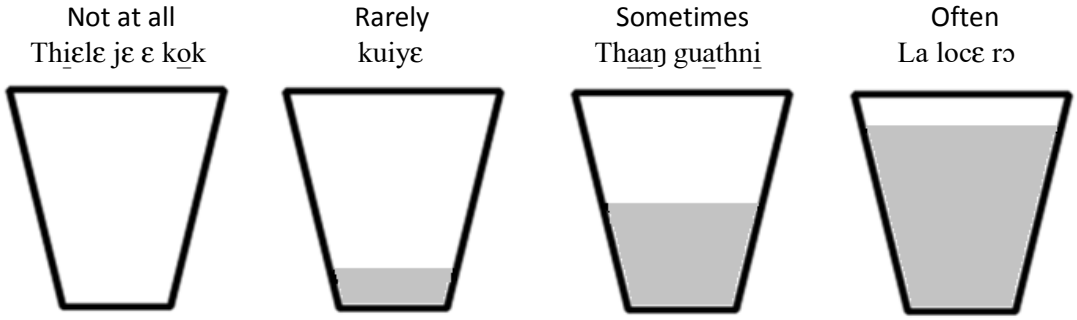
_____

2.14 Is there something else that I **haven't** mentioned that causes you the **most stress** right now?
Tëë kɛ mi dɔŋ mi /kan lar mi la ji ɛ jak kä dual ɛlɔŋ ɛntämɛ?

○ Yes Ɣää (Specify: lar ciötdɛ: _____)
○ No Ɣëy

I would like to ask you how often you experience certain mental health **problems or symptoms**.
Bä ji thiec kɛ taa in ŋäci kɛ guath tin la **tuɔɔk kɛ cär ti jiäk** kiɛ kɛ tin la jɛ ɛ nyooth i tëë kɛ riɛk mi te rɛy ŋithä ran.

You can use the cups to help you again. The more full cups mean that you experience a problem more regularly. Please think about how much these symptoms have bothered you **during the past two weeks**: not at all, rarely, sometimes, or often?
Kothni tɔtɔ bi kɛn ji nyɔk kɛ luäk kɛ duɔɔp mi bi lar riɛkdu. Koth ɛ ci thiaaŋ ɛlɔŋɔ nyoothɛ ni ɣöö riɛk in mooc ji dual ɛ riɛk mi diit. Läri ɣä tin jeki ɛ bɛc rɛy **tëëkädu ɛ tookɛ nikä ɣöö:** Thiɛlɛ jɛ ɛ kok, kuiyɛ, thaaŋ guathni ɛ wä kä ɣöö la locɛ rɔ.



How much have these symptoms bothered you in the past two weeks? Kɛ nyuuthni rikni tɔtɔ ci kɛn ji nyon kɛ taa mi nindi kɛ juɔkni rɛw tëë ci duɔth jɔk?		Not at All Thiɛlɛ jɛ ɛ kok	Rarely kuiyɛ	Sometimes Thaaŋ guathni	Often La locɛ rɔ
3.1	Difficulty falling asleep or staying asleep? La bum ɣöö bi niɛɛn kiɛ bi keer nin?				
3.2	Crying easily? La mala rotdi?				
3.3	Feeling less interest in things that you used to enjoy? Cɛ nhökdu kɛtëë nhɔk i ni wal yuɔth piny?				
3.4	Having difficulty concentrating or focusing on your thoughts? La bum ɣöö bi caru jääny kä kɛl kiɛ bi caru rɔ pal piny kä kɛl?				
3.5	Difficulty doing domestic work or income-generating activities? La bum ɣöö deri lät ciëŋ kiɛ lät ti deri duɔɔr jek thin lat?				
3.6	Feelings of worthlessness? La cari jɛ i thiɛlɛ ji luɔt?				
3.7	Thoughts it would be better to not be alive? La tëë kɛ car mi la bëë kä ji i /cɛ gɔaa i deri lɛ ŋot kɛ tëk? ***IF SOMETIMES OR OFTEN:*** *follow protocol to discuss further.* *Mi la tuɔɔkɛ thaaŋ guathni kiɛ ni ciaŋ, mocɛ kɛ guaath bia ruac jɔɔdɛ.*				
3.8	Feeling low in energy, slowed down? La jek i jɛ i ci buɔm puaanydu rɔ yuɔth piny?				
3.9	Having your body react to things that remind you of a traumatic event (like upset stomach or dizziness)? Puɔnydu la ja jëki idi ɛn tämɛ mi car kɛ kɛ të jiak të ci bany jɔk cäät, bɛc jiɛc, luaŋ puany				
3.10	Watching everything around you or feeling "extra alert" or "on guard" much of the time? Guic ŋɔaani diaal thiëkä du /carku/ kɛnɛ tin diaal tin gaŋ kɛ ji				
3.11 a	Do you feel mental health problems (like stress, depression, or anxiety) cause trouble with your daily functioning? Tëë kɛ rik ti la jek i rɛy ŋithädu cetkɛ dual, thiɛl tɛthä lɔaac kiɛ diɛɛr ?				
3.11 b	***IF SOMETIMES OR OFTEN:*** ***Mi ɛ thaaŋ guathni kiɛ la locɛ rɔ:*** What mental health problem causes the most trouble for you? Ɛ car indiɛn kä cär-rikni tin la tuɔɔk ŋithä ran la ji ɛ nyoon ɛlɔŋɔ?				

3.12 How would you rate your mental health **overall**: very poor, poor, fair, good, or very good?
Deri pual puaany ŋithädu lar idi: Jiäkɛ ɛlɔŋ, Jiäkɛ, päärɛ, gɔaaɛ, kiɛ gɔaaɛ ɛlɔŋ?

- ○ Very poor Jiäkɛ ɛlɔŋ
- ○ Poor Jiäkɛ
- ○ Fair päärɛ
- ○ Good gɔaaɛ
- ○ Very good gɔaaɛ ɛlɔŋ

3.13 Do you feel <u>physical</u> health or medical problems cause trouble with your daily functioning (in the past two weeks)? La jek i rɔ ɛ la ram mi puɔl puɔnydɛ kiɛ tëë kɛ rik ti pen ji ciaaŋ gɔy rɛy lätniku?

- ○ Not at all Thiɛlɛ jɛ ɛ kok
- ○ Rarely kuiyɛ
- ○ Sometimes Thaaŋ guathni
- ○ Often La locɛ rɔ

3.14a Do you experience on-going or chronic pain in your body? Tëë kɛ mi jeki ɛ bɛc kiɛ te puɔɔnydu kɛ liaw?

○ Yes ɣää ○ No ɣëy

IF YES: **3.14b:** On a scale from 0 to 10, where 0 is no pain at all and 10 is the worst possible pain, how much pain have you felt overall in the past week?
Mi ciɛ loc i ɣää: kuany duɔɔr ɛ tookɛ kä baŋ ɛ wä kä wäl . Baŋ lodɛ ni ɣöö thiɛlɛ mi bɛc, wäl lotdɛ ni ɣöö bɛcɛ ɛlɔŋ. Kɛ ɣöö nɔ, ɛ bëc mi nindi ci jekɔ kɛ juɔk ëë ci duɔth jɔk?

_____

3.15 Have you ever had uncontrolled convulsions in your body that you can't remember (seizures)?
Ci kɔn muɔn kɛ muɔn mi diit mi /ci dee luäŋ kɛ tiet (muɔn)?

○ Yes ɣää ○ No ɣëy

On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions? I'm going to read a list of things you might do, and you can tell me if you do them or you don't do them.

Mi tëë kɛ cäŋ mi ci lɔcdu jiääk thin ɛlɔŋ, ci diɛɛr kiɛ ci nyuään, ɛŋu la lätdi mɔkɛ ɣöö bi cär tɔtɔ puɔt?
Bä ji kuën riëët ti nyooth min deri lat, kä biɛ larä mi la lätdi jɛ kiɛ /ci jɛ ɛ lät.

On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions? Mi tëë kɛ cäŋ mi ci lɔcdu jiääk thin ɛlɔŋ, ci diɛɛr kiɛ ci nyuään, ɛŋu la lätdi mɔkɛ ɣöö bi cär tɔtɔ puɔt?		Yes Ɣää	No Ɣëy
4.1	Connecting with your family or friends to discuss your feelings La matdi rɔ kɛ ciëëmuɔɔri kiɛ mäthniku kɛ ɣöö bi caru larkɛ		
4.2	Do social or entertainment activities La matdi lät kiɛ ŋaari kɛɛl kɛ naath		
4.3	Sleep or stay in bed Nien kiɛ jany nin		
4.4	Do physical activities Lät ti lätdi kɛ puɔnydu kiɛ ti goor luaŋ puaany		
4.5	Go to the hospital or clinic to see a doctor Wä duel wal guaath mi te däktöör thin		
4.6	Pray, meditate, or do other spiritual activities Pal kiɛ päl piny kiɛ lät yieekä ti kɔŋ		
4.7	Use alcohol or another substance to help you forget Math kɔaŋ kɛnɛ taap kiɛ kɛc kɛɛc kɛ ɣöö bi kɛ ji luäk kɛ päl duɔɔr kä ruëëc rɛy teek kä du		
4.8	Try to avoid seeing or talking to anyone La wooci rɔ kut nath kiɛ /ci jɛ ɛ goori i bɛ te kɛ ram mi ruac yiɛn		
4.9	Talk to a counselor, therapist, or other professional La ruaci kɛ Kanthɔlɔr, thërapith kiɛ nɛy ti kɔŋ ti ca ŋiääc		
4.10	Consult with traditional healers, elders, or spirit mediums Ci mët we kä gook,kiɛ nɛy ti dit kɛ gör tëëkä		
4.11	Other: *(Prompt: Is there anything else you do?)* *Tëë kɛ mi dɔŋ mi la lätdi?* _____		

5.1 Do you feel that anyone in your household has mental health problems that cause trouble with their daily functioning?
Guic i jɛ ciëë tëë kɛ ram mi te kɛ riɛk mi te rɛy cäri kɛ dhɔɔrun; riɛk mi la penɛ ciaaŋ gɔy rɛy kä tin lätdɛ?

○ Yes ɣää → **5.2** If yes: How many people? Mi ciɛ loc i ɣää: Kɛ nɛy daŋ di? _____

○ No ɣëy

Please tell me the age & gender of person 1: Age: Run _____
Läri ɣä run kɛnɛ biɛl-diëëth ran 1
○ Male Wut
○ Female Ciek

Please tell me the age & gender of person 2: Age: Run _____
Läri ɣä run kɛnɛ biɛl-diëëth ran 2
○ Male Wut
○ Female Ciek

Please tell me the age & gender of person 3: Age: Run _____
Läri ɣä run kɛnɛ biɛl-diëëth ran 3
○ Male Wut
○ Female Ciek

During the last two weeks, was anyone in your household so distressed, disturbed, or upset that he or she: Kɛ kɔr juokni daŋ rɛw tin ci wë,të rami të cieŋ kɛ ji kɛɛl mi të car ti jiak, kiɛ jiak lɔac mi wut /ciëk?		Yes ɣää	No ɣëy	I don't know /Ci ɣän jɛ ŋac
5.3	Was completely inactive or almost completely inactive? /Cɛ lät ɛ luäŋɛ kɛ lat ɛ gɔaa kiɛ /cɛ kɛ ɛ thuukɛ kɛ lat?			
5.4	Was unable to carry out essential activities for daily living? /Cɛ lät tin la lat kɛ kɛ kui tëëkä luäŋ kɛ lätni?			
5.5	Was acting in a strange way or having fits, convulsions, or seizures? Cɛ taa ciɛɛŋädɛ min wen gɛr kiɛ la mon?			

As I told you, I'm from an organization that focuses on helping people who have trauma, which can come from being tortured. **Torture** is severe physical or psychological suffering caused on purpose by someone in authority. I have three questions about torture. Is it okay for me to ask these questions?
Cet kɛ min cä lar ji ni wen, ɣän baa kä ɣɔrginay dhëëcin mi lät kɛ luäk nɛɛni tin te kɛ ciɛŋ ti ci kɛ tɔŋ, kä kɛn ciɛŋ tɔtɔ nooŋkɛ yaak. **Yaak** ɛ muɔc puaany ran kiɛ cär ran kɛ buɔɔt ti bi raan jak kä jek tëk ɛ bɛc, kä nɔmɔ la jɛ ɛ lät ram mi te kɛ buɔm. Taa kɛ thiecni daŋ diɔk kɛ kui yaakä. Gɔaa ɣöö dëë ji thiec kɛkɛ?

6.1 Have you ever been tortured? Ca ji met yak?

○ Yes ɣää
○ No ɣëy

6.2 Has anyone in your family or household been tortured (not including yourself)?
Tëë kɛ ram mi ca met yak kä ji-dhɔaar run (ɛ /ci te thin)?

○ Yes ɣää
○ Not to my knowledge /Ci ɣän jɛ ŋäc

6.3 Do you think that many people in this community have been tortured?
Guic i jɛ ciëë tëë kɛ nɛy ti ŋuan ti ca yak ti te rɛy wec ɛmɛ?

○ Yes ɣää
○ No ɣëy

The next section is about **services** that are available to people in this community right now.
Kath ɛ dɔŋ ɛmɛ ruacɛ kɛ kui lätni tin te thin ɛntämɛ kɛ kui nɛɛni tin ciɛŋ rɛy wec ɛmɛ.

7.1 Do you know of any group, organization, or agency where you can go to receive **mental health or psychosocial support services** in Gambella/Nguenyyiel?
Të kɛ nɛy ti ŋäci,organidhëëcini kiɛ muktapni ti ŋäci ti dëri luak **gɔɔyä ŋithä kiɛ mat comä cari** jëk thin kä Gambɛlɛ/ŋuanyiël?

○ Yes ɣää → **7.2 If yes:** Have you ever received **mental health or psychosocial support services** here?
Mi ciɛ lar i ɣää, ca ji met luäk kɛ kui gɔɔyä ŋithä / mental health / kiɛ luäk duŋ Thay- kö-thöcal/ psychosocial support?

○ No ɣëy

○ Yes ɣää → **7.3 If yes:** From which organization?
Mi ciɛ lar i ɣää, ɛ muktäp kiɛ ɣɔrginaydhëëcin ɛ mith?
Don't read options. Select all that apply.
/Cu jɛ kuën jëkni tɔ ca gɔr piny tɔ. Kuany tɔ cɛ lat tɔ.

- ☐ Action Against Hunger (ACF)
- ☐ Help Age International
- ☐ Humanity and Inclusion International
- ☐ International Medical Corps (IMC)
- ☐ Maternity Foundation
- ☐ Plan International
- ☐ Save the Children
- ☐ Other: Mi dɔŋ: _____

○ No ɣëy

7.4 If no: Why not? Mi /ciɛ lar i ɣëy, ɛŋu penɛ mɔ?
Don't read options. Select all that apply.
/Cu jɛ kuën jëkni tɔ ca gɔr piny tɔ. Kuany tɔ cɛ lat tɔ.

- ☐ I've never needed or wanted these services Ci ɣän luäk ɛmɔ gor kiɛ nhɔk.
- ☐ They are too far away Nan guaathdiɛn
- ☐ I'm afraid of what my neighbors or relatives would think or say Dualä kɛ car mäthnikä kɛnɛ ji thieekädä kiɛ kɛ mɔ dëë larɔ ɛ ji thieekädä kiɛ mäthnikä.
- ☐ I tried to get services, but they didn't select me
  Cä gör i dëë ɣä luäk, duŋdɛ ɣöö /kanä kuany
- ☐ I decided not to get mental health services because they were not giving me anything (material support) Cä car ɛn ɣöö /cän luäk gɔɔyä ŋithä gör kɛ ɣöö thiɛlɛ mi lɛ kɛnɛ a käm ɣä kiɛ kuak
- ☐ Those services are for people who are more ill or worse off than me
  Luäk ɛmɔ dë kam ni jɛ rami cɛ däk ɛloŋ mi lany riɛk dɛ riɛk dä?
- ☐ Other: Mi dɔŋ: _____

7.5 What other kind of help have you received from NGOs or other service providers **in the past month?**
Ɛ luäk ŋu kä ɛn nɔ ci jëkɔ kä organidhëëciini kiɛ luäk mi dɔŋ kɛ **pay ë ci wë?**
Don't read options. Select all that apply. /Cu jɛ kuën jëkni tɔ ca gɔr piny tɔ. Kuany tɔ cɛ lat tɔ.

- ☐ Financial/cash ɛ luäk yiooni
- ☐ Food Ɛ luäk kuan
- ☐ Shelter or clothing Ɛ luäk bieyni/ duël tɔɔc kä
- ☐ Resettlement/family tracing Ti guaath mi nyuri thin ɛntämɛ
- ☐ Education support/scholarships Të baŋ duël gɔrkä ti ci jëk
- ☐ Legal/registration ŋuɔt kiɛ gɔar piny
- ☐ Livelihood/vocational/income-generating Të guaath ŋiicä lätni, lät nyɛgathä
- ☐ Medical Luäk waal

- ☐ Other: Mi dɔŋ: _____

7.6 How do you get information about available services here?
Jek i läär nikä kɛ kui lat ɛmɛ?

Don't read options. Select all that apply. /Cu jɛ kuën jëkni tɔ ca gɔr piny tɔ. Kuany tɔ cɛ lat tɔ.

- ☐ From outreach or awareness raising events by NGOs Liɛŋä kɛ kä laat Ɣɔrginay-dhëëcini tin la naath ɛ ŋiic rɛy kɛm kä
- ☐ From radio or other mass media programs or announcements Liɛŋä jɛ kä radiɛwni kɛnɛ nyin läärі tin kɔŋ
- ☐ From my family or friends Liɛŋä jɛ kä ciëëmaari kiɛ mäthnikä
- ☐ From schools, churches, or other social institutions
  Liɛŋä jɛ duël gɔrkä ,lueek kuɔth kiɛ guäth tin la nɛy ti ŋuan ɛ rom thin
- ☐ From UNHCR, ARRA, or RCC Jekä jɛ kä ji UNHCR,ARRA kiɛ RCC
- ☐ Referral from NGO Jekä jɛ kä ji ɛ Ɣɔrginay-dhëëcini /manadhëmɛni/
- ☐ Other: Mi dɔŋ: _____

Finally, I have a few **basic questions about you**. Kɛ guaath ɛ jɔak ɛmɛ, taa kɛ thiecni ti tɔt kɛ kuidu.

8.1 What is your home country? Ɛ wec ŋu la wecdu mɔ?
- ○ Ethiopia Ithiopia
- ○ South Sudan Thɔth-Thodan
- ○ Other: Mi dɔŋ: _____

8.2 How long have you been at Nguenyyiel? Ɛ pek mi nindi ci jääny kä Ŋuäny-yiel kɛ jɛ mɔ?

_____ months Päth

8.3 What languages do you speak and understand comfortably? Kɛ thuk tin kiɛn ŋäci tɔ tin la ruaci kɛkɛ ɛ thiɛl diw?
Select all that apply. Kuany tin diaal tin lot rɔ kɛ ji.
- ☐ Amharic Thok-buuny
- ☐ Anyuak Thok bär
- ☐ Arabic Thok jalapni
- ☐ English Thok Liŋlithni
- ☐ Nuer Thok Nuäärä
- ☐ Shiluk Tëët
- ☐ Other: Mi dɔŋ: _____
- ☐ Other: Mi dɔŋ: _____

8.4 How old are you? Ti kɛ run di?

_____ years Taa kɛ run

8.5 What levels of education have you completed? Ɛ pek gɔrä mi nindi ci thukɔ?
Select all that apply. Kuany in diaal tin lotrɔ kɛ ji.
- ☐ No education Kan gɔar
- ☐ Primary Piraymëëri
- ☐ Secondary Thɛkɛn dëëri kiɛ Baŋuan ɛ wä kä wäl
- ☐ Technical Ŋjiicni kɛ dup tin dee raan duɔɔr lat kɛ jɛ
- ☐ Post-secondary, university, graduate school Kɔlic, Yu-ni-bö-thi-ti

8.6 How many people live in your household right now, not counting yourself?
Kɛ nɛy daŋdi ciɛŋ dhɔɔru mɔ ɛntämɛ?, /cu rɔ kuɛn thin.

_____ people Naath

8.7 How many children do you have? Ti gaat di?

_____ children Gaat

8.8 Are you married? Ci kuɛɛn?
- ○ Single Kani kuɛɛn/ käni kuɛn
- ○ Living together as a couple (but not married) Ciëŋi yiɛnɛ gooru, duŋ dɛ ɣoo kan yiɛn rɔ kuɛn
- ○ Married (even if currently apart by circumstance) Cä kuɛɛn kiɛ caa ɣä kuɛn cäŋni mɔ ci nɛy te kɛɛlɔ
- ○ Divorced or separated (married but living apart by choice) Cä dak kiɛ ci nɛy dak / ciëŋ ramɔ kä rɔadɛ/
- ○ Widowed Ciëk jɔkä /ci cɔwdu liw/ci ciëkdu liw/

8.9 Are you separated from your family now? ci të kɛɛl yiɛnɛ ji dhɔaru ɛn tämɛ
- ○ Yes Ɣää
- ○ No Ɣëy

Time finished: Ci thaak thuɔk _____ AM / PM