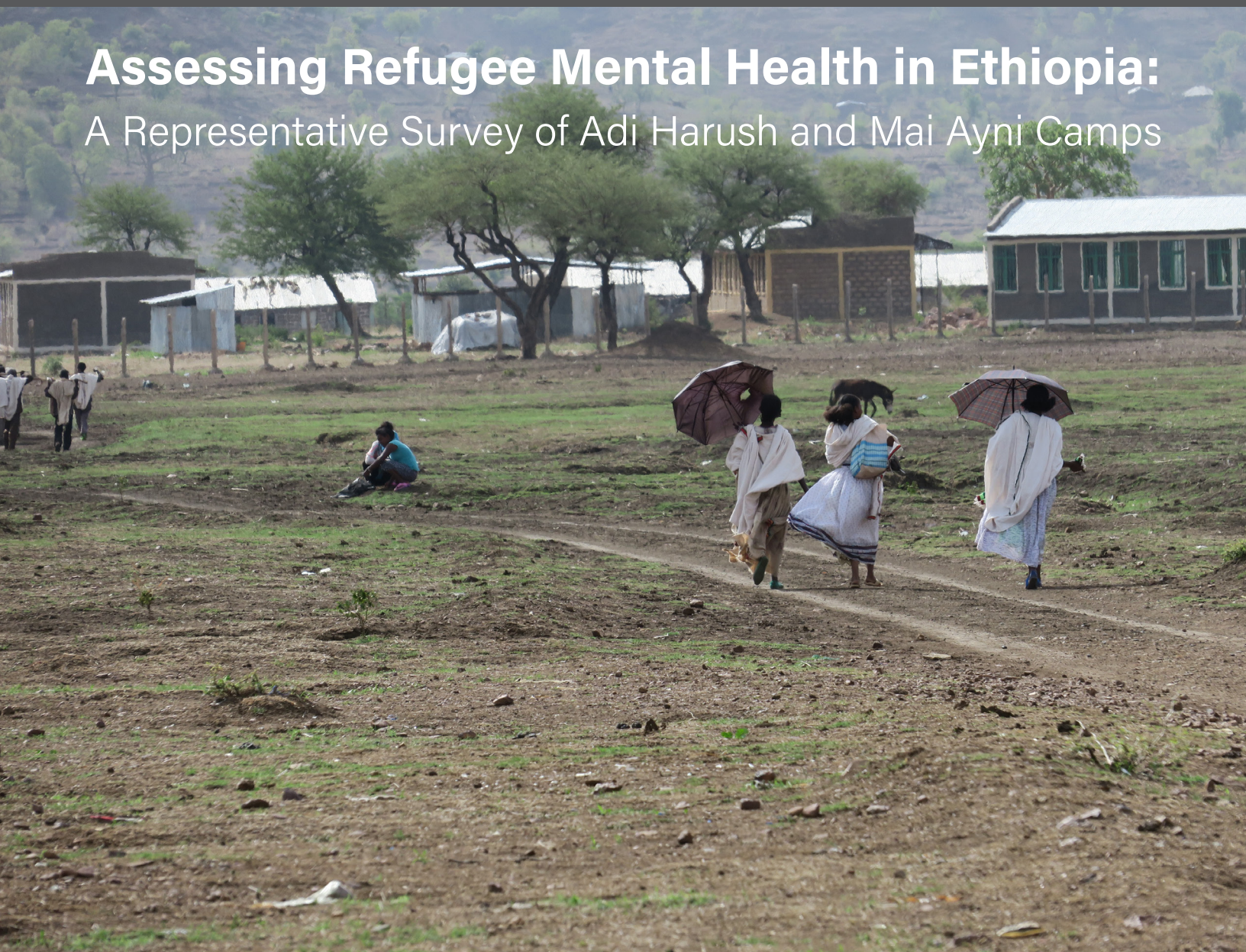




The
CENTER for
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TRAUMA

Assessing Refugee Mental Health in Ethiopia:

A Representative Survey of Adi Harush and Mai Ayni Camps



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A Representative Survey of Adi Harush and Mai Ayni Camps**

The Center for Victims of Trauma

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The Center for Victims of Trauma (CVT) in Ethiopia carried out a mental health assessment of Adi Harush and Mai Ayni refugee camps in September and October 2017. CVT conducted a survey (N=548) that is representative of the adult populations of these camps. The goal is to understand the needs and perspectives of refugees in these camps 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 towards mental health; significant daily stress coming from mental health-related problems; moderate levels of psychological symptoms; low prevalence of symptoms associated with psychiatric illnesses; reliance on spirituality to cope; high prevalence of torture survivors; and moderate awareness and utilization of MHPSS services. This report includes an overview of data collection methodology and a summary of descriptive findings.

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Rationale

Understanding and meeting mental health needs of individuals and communities who have experienced war or other types of violence or human rights abuses is fundamental to the success of any mental health or other type of intervention with these populations. There can be severe psychological effects of past traumas from loss of loved ones, experiences of torture or other abuse, or witnessing violence or atrocities. 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.

All of these factors can impair daily functioning of refugees fleeing conflict or instability, leading to an inability to effectively meet the substantial challenges of daily living in their country of refuge. This can mean diminished success of humanitarian interventions (such as education or livelihood initiatives), increased levels of ongoing violence in communities and households, or high rates of self-harm or destructive activities. Understanding and attending to the mental health needs of survivors, including interdisciplinary rehabilitation from trauma, 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 an important preventative mechanism to inhibit future cycles of violence and promote more effective peacebuilding.

There is very little representative data about mental health among refugee populations.¹ Rather, much of the data we typically collect and analyze comes from help-seeking populations, those who come to service providers to receive care for mental health or physical health needs. This is problematic because it does not reveal the full range of needs among the population. The most vulnerable members of the community are unlikely to seek help for their needs. We also get 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. Few NGOs have the capacity to collect data beyond this, and few scholars have contributed to filling this gap. This survey is one step in demonstrating the feasibility of representative sampling methods, conducted by a practitioner organization in a humanitarian setting.

CVT carried out a similar survey in Kenya in 2016, with plans to replicate and conduct a second survey in that site. 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, conducting surveys in different locations at different time points will allow nuanced analyses of how mental health needs shift over time and place. By using comparable questionnaires, we are building 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. This will contribute to helping the humanitarian sector design and prioritize effective responses, including advocating for resources.

¹ In reviewing the available literature to inform CVT's programming in places where we work, for some sites we found essentially no available data to assess the mental health of refugees. In others, there was very limited data, either out of date in rapidly shifting humanitarian contexts, or from refugees who had migrated to high-income settings, or from more limited segments of the population. In almost all cases, we found claims about refugees' mental health in humanitarian settings were supported by evidence from help-seeking (non-representative) populations or from key informants.

Context

Camps in the Shire area of northern Ethiopia provide refuge primarily to Eritreans. There are four camps in this area, currently hosting about 43,000 refugees. Most arrivals report fleeing a fear of persecution or military conscription, or are migrating due to general insecurity in their country of origin.



UNHCR, November 2017

CVT has been providing specialized trauma rehabilitation services since 2013 in Adi Harush and Mai Ayni, two Shire camps. CVT provides group and individual counseling to refugees experiencing a decrease in functionality due to trauma-related symptoms. CVT also provides a range of less intensive MHPSS services, including psychoeducation and community outreach. CVT also provides training for other agencies working with trauma survivors, as well as builds the professional skills of its own team of Ethiopian and Eritrean staff.

Key Informant Interviews

CVT conducted key informant interviews with service providers and other stakeholders in Adi Harush and Mai Ayni in order to understand their perspectives on: 1) the mental health needs of refugees; and 2) the impact of CVT services on refugee individuals and communities.

Participants were selected by CVT Ethiopia staff to include representatives of agencies with existing partnerships with CVT, those who work with refugee populations in the area, and those who could provide expert-level information on mental health issues. We interviewed eight

individuals working directly or indirectly in mental health, representing governmental and local and international non-governmental sectors.² Key informants provided in-depth 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 “moderately knowledgeable” and a few considered themselves “extremely knowledgeable” about mental health needs in the two camps.

Insights from key informants provide a valuable source of information about the mental health needs of refugees in Adi Harush and Mai Ayni. Combining data from key informants with representative survey data can allow insights on how perceptions of key stakeholders align or diverge with observed patterns in the populations more broadly. The perspectives of key informants supplement the patterns observed in the survey data and are integrated into the sections describing findings in the remainder of this report.

Survey Sampling Methodology

We conducted interviews with a sample of individuals (N=548) who are representative of the adult populations of Adi Harush (N=271) and Mai Ayni (N=277) refugee camps in September and October 2017. The November 2017 population of Adi Harush was 10,909 and Mai Ayni was 13,074 with 40% and 43%, respectively under age 18.³ Although a large segment of the population is minors, they were excluded from this data collection, due to ethical restrictions on research with minors, particularly highly vulnerable minors (largely, unaccompanied refugees) and highly sensitive topic areas (here, mental health and trauma). Our sample included about 4 percent of the adults⁴ in these camps and 13 percent of the households.⁵

Due to the relatively contained geographic areas and known number of total dwellings, we used a geographic interval method to sample dwellings for inclusion. We selected the intervals based on estimations of minor-headed households, exclusion rates, and non-response rates, as well as estimates of the productivity of our interview teams. We used an interval of four dwellings in Adi Harush and six in Mai Ayni; these intervals resulted in full geographic coverage of both camps.

Our response rates for the two camps were nearly identical, suggesting strong adherence to sampling protocols. Our contact rate was 59 percent, due primarily to dwellings we found empty. Our cooperation rate was 90 percent, with most eligible respondents completing an interview. Our refusal rate was 4 percent for eligible respondents who were available but chose not to participate.⁶

² Interview participation was voluntary, and participants completed an informed consent process. Interviewees were assured of confidentiality of the information they shared in the interviews. The interviews included a structured mix of close- and open-ended questions. Interviews were recorded and detailed notes were taken to provide a basis for thematic analysis. Interviews lasted an average of 40 minutes.

³ UNHCR. 30 November 2017. “UNHCR Sub Office Shire, Ethiopia: Eritrean Refugee Population in Tigray Region.”

⁴ *Ibid.* In November 2017, there were 13,980 adults in the two camps.

⁵ According to the Administration for Refugee and Returnee Affairs (ARRA) August 2017 reports, there were 1,704 dwellings in Adi Harush and 2,484 dwellings in Mai Ayni.

⁶ 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>. Included in non-eligible respondents were minor-only households (135 households) and households with no individual of the required gender (307 households). Unknown eligibility

Dwelling Selection

The camps are each divided into zones, with varied sizes, demographic profiles, and spatial arrangements. Zones are divided into blocks, then sub-blocks or communities. Finally, each dwelling is numbered. Each team was assigned a starting point for the day, based on random selection of zone numbers or intentional variation from the team's previous assignments. We used Google maps to provide aerial views of the camps and ensure no areas were excluded.



At their assigned starting point, the teams drew numbers to identify the first dwelling, selecting from the assigned sampling interval. After the first successful interview, they proceeded according to the four or six dwelling interval. After an unsuccessful interview attempt at a selected dwelling, for any reason, the team moved to the adjacent dwelling.

Individual Selection

All interviewers with odd identification numbers did their first interview each day with a man; those with even numbers started with a woman. Thereafter, they alternated respondent gender throughout the day.⁷ If a selected dwelling had no adult residents of the required gender, they moved to the next dwelling. We drew numbers to select the participant from all eligible

included selected households that were empty or locked (342 households) and a small number (31 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 (60 households); the selected individual refused to participate (45 households); the selected individual did not speak an interview language (4 households); and other reasons, generally that the interviewer had a relationship with the selected individual or household (16 households).

⁷ There is a gender imbalance in the camp populations, so we adjust for this imbalance with weighting the data. See section on *Weighting*.

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. There was no replacement of a selected individual. If they were not home, reasonable attempts were made to return and complete the interview.

There were several exclusion criteria. Minors were not included, as mentioned above. Some dwellings are group care for unaccompanied minors. Although there are adult caretakers in group care, we excluded them as well, as most do not live full time in the dwelling. If an individual was a former CVT client, the staff member who did their assessments or facilitated their rehabilitation group was not allowed to conduct the interview; we assigned another interviewer or replaced the interview. Similarly, interviewers could not interview their family or close friends, though other interviewers could be assigned. We also excluded halls (communal spaces that can house 25 to 50 people) for newly arrived refugees. The halls are temporary arrangements until housing is available and assigned; according to Administration for Refugee and Returnee Affairs (ARRA) representatives, at the time of our survey, most of the halls were empty. There are also facilities in each camp that may admit mentally ill individuals, which were not included in the sampling.⁸

*Weighting*⁹

The combined sample included a total of 548 interviews, with equal proportions of men and women. Respondents' ages ranged from 18 to 70 years old, with an average of 28 years old. The sample deviates slightly from the population age distribution. Our samples in both camps included fewer young adults than present in the population,¹⁰ which fits the expectation that this segment of the population is least likely to be at home during the daytime, when we conducted the interviews. The sample deviates substantially from the camp gender distribution. This was also expected. Our individual selection in our sampling methodology involved alternating selection of men and women respondents. Although we knew the camp populations included more men than women,¹¹ we used this methodology to ensure that women were adequately included in the samples, and to prevent over-inclusion of men speaking as representatives of their households. We created a weight to adjust the survey demographic proportions on age and gender for each camp to match the population proportions. All descriptive analyses¹² are conducted with weighted data, to adjust the samples to match population characteristics.

⁸ At the time of the survey, the ARRA clinic in Adi Harush had no mental health in-patients in its ten available beds. The number of mental health related in-patients of the ARRA clinic in Mai Ayni at the time of the survey is unknown, but unlikely to be large enough to have any influence on the patterns reported in our findings.

⁹ *Ibid.*, 3. Population statistics for age and gender are from figures provided to CVT Ethiopia by the UNHCR Shire office.

¹⁰ Of the adult population in November 2017, 59.8 and 54.4 percent are aged 18 to 24 in Adi Harush and Mai Ayni, respectively. Our samples included 50.2 and 43.7 percent of respondents in this age range in Adi Harush and Mai Ayni.

¹¹ The adult population in November 2017 includes 37.3 and 39.2 percent women in Adi Harush and Mai Ayni, respectively.

¹² Except for on age and gender, the variables used in the creation of the weight. The age and gender distributions reported in *Demographic Characteristics* below are the distributions observed in the sample itself, without the weight applied to adjust to population characteristics.

Survey Team and Timeline

We conducted fieldwork with six teams of interviewers divided between camps. Interviewers conducted an average of five to nine interviews in a day, and data collection was completed in about four full days from September 25 to October 3, 2017.

Each team had three or four interviewers and one supervisor, and each camp also had a coordination team to provide research, clinical, and logistic support. All interviewers and supervisors were Tigrinya speakers. All team members were CVT staff, with varying levels of exposure to mental health concepts.¹³ Research and methodological planning and implementation was provided by headquarters-based research staff and the Ethiopia-based monitoring and evaluation officer. Clinical support was provided by psychotherapists currently based in Ethiopia.

There were advantages to working with staff to conduct the survey. Their exposure to mental health concepts aided in accuracy of the explanations of these ideas. Their training as counselors led to a demeanor conducive to building rapport and providing support if respondents experienced negative reactions to any of the questions. On the other hand, we needed to carefully clarify the distinction between doing service provision and doing data collection or an assessment. When staff participate in community outreach, it is to spread a message about mental



Photo by R. Shrestha

health or to identify and screen new potential clients for CVT services. In the case of conducting the survey, however, interviewers needed to be neutral, not engaging in psychoeducation, but providing an open space for respondents to express what they personally think about mental health issues. Similarly, conducting an interview is distinct from providing services. Interviewers received training and ongoing supervision on these issues.

We provided two days of training for the full team, including presenting and discussing: the survey goals; all items on the questionnaire; suicide and referral protocol; psychological first aid; sampling strategy and procedures; mapping the camps; and team coordination. The supervisors also received an additional half day training to discuss sampling methodology in greater depth, team management, and geographic strategy.

¹³ The supervisors were generally national Ethiopian staff, most with masters degrees completed or in progress. The interviewers were generally Eritrean refugee staff, themselves residents of the camps. Three national counselors also worked as interviewers, as did several new refugee staff who had received a two-week intensive training about trauma rehabilitation counseling, but had not yet begun full-time work with CVT.

Questionnaire Description

The questionnaires were designed to be brief assessments of mental health perspectives and needs. The content was modeled after CVT's survey conducted in Kenya, with adaptations to be responsive to the Ethiopian context and to add suggestions from stakeholders. The questionnaire collects data about attitudes about mental health, current stressors, psychological and psychiatric symptom areas, household symptom areas, coping mechanisms, access to services, torture, and demographics.



Photo by S. Golden

Interviews were conducted in person, in or around respondents' homes, using paper and pencil questionnaires. On average, it took about 30 minutes to administer the 11-page questionnaire. The Tigrinya translation was completed by CVT translators and included a full back translation. The English and Tigrinya questionnaire is attached to this report. Our interview teams had the capacity to conduct interviews in Tigrinya, English, Amharic, and Saho, though the vast majority were conducted in Tigrinya.

Interviewers explained to respondents that some questions are sensitive and they may wish to be alone for the conversation. The interviewer made attempts to find a

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

Knowledge and Attitudes

The first questions 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.¹⁴ If the respondent reported that they understand what "mental health" means, they were asked for a short description, which the interviewer field-coded as negative, positive, or neutral.

The interviews began with these general questions, not focused on the respondent's personal experiences, to build rapport. 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. Translation of the term "mental health" and training the interviewers on the

¹⁴ Several of the questions are closely adapted from knowledge and attitude questions on CVT's client assessment forms, allowing comparability with CVT clients.

meaning is particularly important, in order to not automatically lead respondents to a negative connotation of mental illness or disability.

Current Stressors

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 acute or trauma-related problems (such as “violence, threats, or conflict in the community” or “grief from the loss of loved ones”). This section is loosely modeled after the Post-Migration Living Difficulties (PMLD) measure.¹⁵ 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. After completing the list, respondents were asked which item causes the most stress in their lives currently. Respondents were given the opportunity to list any other major stressor that was not included in the list.

Symptom Areas

The third set of questions asks respondents to report frequency of symptoms; this is an essential section to provide baseline data on mental health needs among the population assessed. This section asks respondents to rank how often they have been bothered by each symptom in the past two weeks, again using a visual aid for response categories.

Eight questions focus on psychological symptoms, modeled on the eight items of the Self-Reporting Questionnaire (SRQ-8).¹⁶ Eight questions in this section are sufficient to generate a mean symptom score, without overwhelming respondents with this difficult section. Drawing a subset of items from commonly used measures provides a meaningful prediction of what the respondents’ scores may be on the full measures. There are three questions to serve as indicators of more severe psychiatric illness, drawn from schizophrenia screening tools.¹⁷

There are three holistic ratings which provide an additional indicator of severity of symptoms, asking respondents if they feel mental health problems interfere with functioning, physical health problems interfere with functioning, and rating their mental health overall. These questions are used clinically to evaluate the short-term needs of an individual. Finally, there are questions about chronic pain and seizures.

This series does include a question on suicidal thoughts, in the series on psychological symptoms. Most measures administered in the context of providing care to a client phrase the

¹⁵ See: Aragona, Massimiliano, Daniela Pucci, Marco Mazzetti, and Salvatore 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).

¹⁶ This is a shortened version of a 20-item screening and diagnostic tool that has been validated in post-conflict settings. See: Scholte, Willem F, Femke Verduin, Anouk van Lammeren, Theoneste Rutayisire, and Astrid 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). We kept the content areas for each of the eight items, but adjusted question wording to CVT client assessments across international programs, which are based on the Hopkins Symptom Checklist (HSCL-25) and the Posttraumatic Stress Diagnostic Scale (PDS). This allows comparability of symptom levels among these populations with help-seeking refugee populations in several other contexts.

¹⁷ See, for example: Schizophrenia Screening Test, available: <https://psychcentral.com/quizzes/schizophrenia.htm>.

question on suicidality as “thoughts of ending your life.” To adjust this question to 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 is designed to allow greater comfort for survey respondents to report these types of thoughts. Interviewers 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 nine 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 are designed to guide program design towards healthy coping mechanisms that already may be resonant or common among the population.

Household Mental Health

The brief fifth section asks whether or not any of the respondents’ household members experience mental health problems that cause trouble with their daily functioning. The goal of this section is to provide additional data to extrapolate about mental health needs within the population. There is also a series of five questions drawn from the WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings-Household Interview (WASSS-H).¹⁸

Torture

We included three questions about torture experiences. 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 also 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 experience; 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 MHPSS services that are available in the camps and 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 services available, if they have ever received such services, from which agency they received services, or why they have not received

¹⁸ We adapted this, due to time constraints of a brief survey, to not ask about each household member individually. See, for example: Llosa, Augusto E., Mark Van Ommeren, Kavitha Kolappa, Zeina Ghantous, Renato Souza, Pierre Bastin, Andrej Slavuckij, and Rebecca 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.

services. This information is valuable in mapping the sector and establishing the interest in services. Respondents are also asked if they had heard of CVT before today, and from where.

Demographics

Finally, the questionnaire includes demographic information: age, languages spoken, household size, home country, level of education, and years 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, interviewer 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 interviewers. Supervisors and coordinators observed some interviews and discussed improvements with interviewers.

Paper forms were transported to CVT's Minnesota office, where volunteers entered data electronically. The research team cleaned and analyzed data using SPSS.

Psychological Support

In conducting this assessment, CVT prioritized providing 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. CVT attempted to hold ourselves to a more rigorous ethical standard and commitment to participants in the research, as a mental health service provider.

In general, interviewers 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 they were observing or hearing from the respondents that they were experiencing significant distress throughout the interview. In the consent process, interviewers explained that some questions may be stressful or remind the respondent of difficult experiences, noting that the interviewer would check in about how the respondent was feeling after the survey.

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 interviewer would select the appropriate option.

Emergency Response

Experienced staff psychotherapists and counseling supervisors were available to each interview team to provide immediate support to respondents experiencing severe distress. In those cases, the interviewer was directed to notify their supervisor or a clinical lead, who assigned a clinician to visit the household immediately. There were five cases requiring an emergency response.

Referrals

As stated above, 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 CVT services, psychiatric services, or more general services. Interviewers referred about nine percent of respondents for CVT services, and just four individuals for psychiatric referrals. We also had an option to provide information about available services to respondents, without making a direct referral.

Follow-up Protocol Response Options

- Emergency response: Respondent is in extreme distress and requires immediate intervention
- Referral:
 - Respondent was given information about available services
 - Respondent needs to be connected with referral partner – GENERAL
 - Respondent needs to be connected with referral partner – PSYCHIATRIC
 - Respondent should be referred for CVT services
- 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

Psychological First Aid (PFA)

Interviewers 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 widely accepted by disaster experts as an evidenced-based approach to decreasing emotional and physical responses experienced by those exposed to trauma.¹⁹

The training covered an abbreviated PFA, which would allow interviewers to observe any signs of respondents' emotional activation, offer some immediate practical support and calming, and appropriately make judgement about when to refer to the clinical teams that were on standby to provide additional more comprehensive PFA support, if needed. 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. Interviewers administered PFA in about seven percent of interviews.

¹⁹ Ruzek, Josef I., Melissa J. Brymer, Anne K. Jacobs, Christopher M. Layne, Eric M. Vernberg, and Patricia J. Watson. 2007. "Psychological First Aid." *Journal of Mental Health Counseling* 29 (1): 17–49.

Suicidality Protocol

Interviewers were also trained on a short suicidality screening procedure for respondents who reported suicidal thoughts. The trigger to use the procedure was if the respondents directly stated that they were suicidal or answered with “often” or “sometimes” the survey question that asked if they had “Thoughts it would be better to not be alive?” Interviewers would then ask directly if respondent has thoughts of killing themselves. If the respondent answered in the affirmative, the interviewer would ask if they have a plan. If respondents reported that they were thinking of killing themselves, the interviewer would make a referral to the standby clinical team who would further assess and make appropriate intervention and/or referral. There were 44 individuals who reported sometimes or often having suicidal thoughts.

Demographic Characteristics

Nearly all respondents were Eritrean refugees, although we did not exclude a small number of Ethiopians, if they were permanently residing in the camps; these individuals were typically married to an Eritrean. The dominant language was Tigrinya, but minority languages included Amharic, English, Saho, and Arabic.

Key Characteristics of Survey Respondents

	Adi Harush	Mai Ayni	Total
Total N	271	277	548
Women (valid %)	49	51	50
Age			
Mean	28	29	28
Range	18-70	18-66	18-70
Home country (valid %)			
Eritrea	99.1	99.1	99.1
Ethiopia	0.9	0.9	0.9
Languages spoken (valid %, not mutually exclusive categories)			
Tigrinya	99	99	99
Amharic	9	4	6
English	9	3	6
Saho	4	7	6
Arabic	5	2	4
Tigre	3	2	2
Other ²⁰	2	2	2

²⁰ Other languages specified include Afar, Azar, Bilen, Italian, and Oromigna.

Key Characteristics of Survey Respondents (continued)

	Adi Harush	Mai Ayni	Total
Household size (not including respondent) ²¹			
Mean	4	4	4
Range	0-9	0-11	0-11
Completed levels of education (valid %)			
No education	40	32	36
Primary	37	45	41
Secondary	21	20	20
Post-secondary	3	2	2
Years in current camp			
Range	0-8	1-11	0-11
Mean	3.6	4.6	4.2

Households on average included four individuals, in addition to the respondent. Over one third of respondents had completed less than a primary education, and 41 percent had finished primary; very few had education beyond secondary. Finally, respondents had been in these camps for an average of about four years, though the range was large (less than a year to 11 years), and Mai Ayni respondents had on average been in the camps about one year longer.

Knowledge and Attitudes about Mental Health

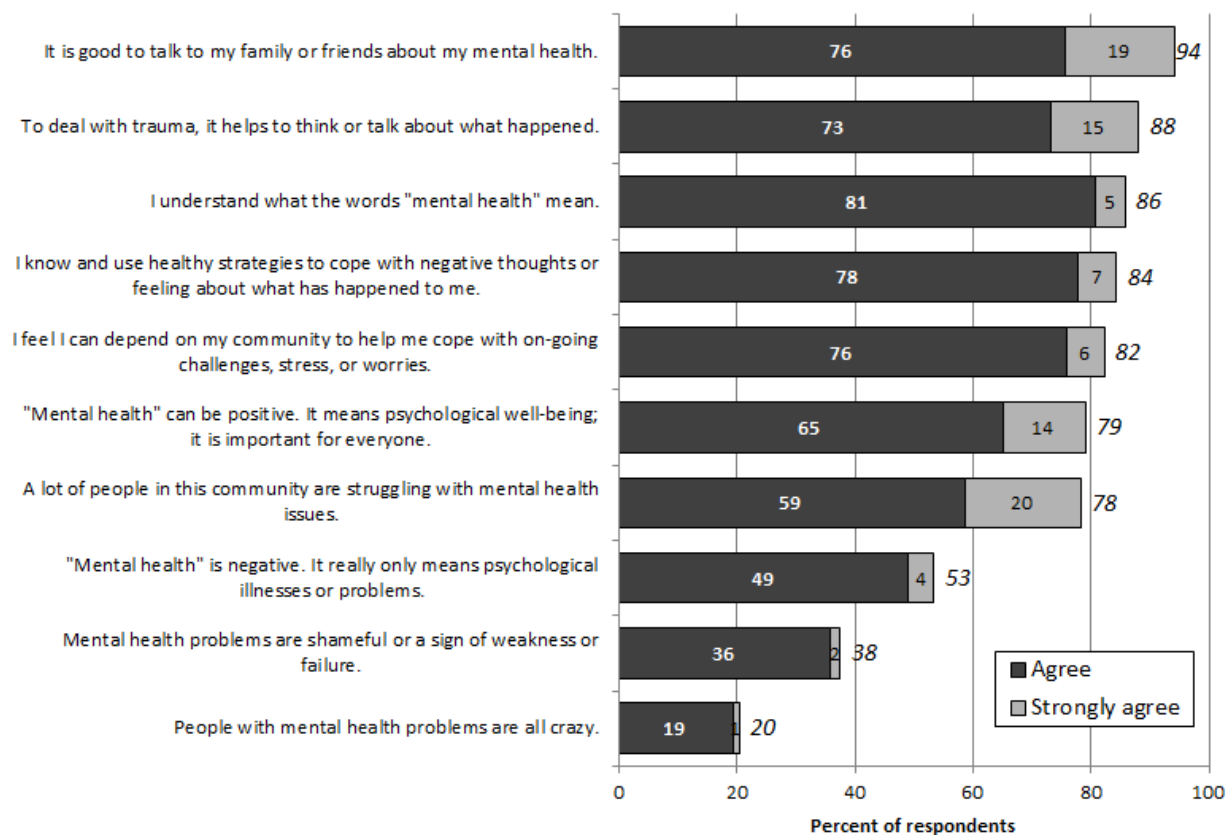
Respondents had generally positive attitudes about mental health, and they were particularly open to utilizing social support to deal with trauma or other mental health challenges. Fully 94 percent of respondents agreed that it is good to talk about their mental health with their family members or their friends. A similarly substantial majority, 88 percent, agreed that thinking or talking about what has happened to them helps in dealing with trauma. This suggests openness to utilization of relationships in addressing mental health needs. With a mean score of near 3 (where 3 equals “agree”), respondents generally believed that mental health challenges are widespread in their communities.

Responses to these statements present a contrast to key informants’ perceptions that an unwillingness to talk about mental health as a major barrier to refugees accessing MHPSS services. Key informants noted “culture” as one of the biggest barriers to refugees’ accessing services for mental health problems. They describe mental health as taboo among refugees, and explained how this leads to those struggling with psychological problems finding it difficult to share or reach out for services. One key informant noted that some individuals will instead present with somatic complaints (such as headaches or stomachaches), to provide an alternative vocabulary to express their problems. Altogether there is likely some element of social desirability bias in how survey respondents answered these questions, the overwhelmingly positive responses, compared to other questions, suggest there may be more space to talk with refugees about their mental health problems than stakeholders may believe.

²¹ One outlier removed who reported 24 household members.

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

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



Ongoing Stressors

Most respondents struggled on a daily basis with mental health-related problems of worry, grief, and loss. The majority of respondents reported worries about people at home, grief from loss of their loved ones, hopelessness or uncertainty about the future, and not knowing the whereabouts of their loved ones as problems in their daily lives. On average, worrying about people they left behind in Eritrea was reported most often as a very serious problem. These items are all focused on areas directly linked to mental health. Comparatively fewer respondents were actively facing problems of livelihood and support. Notably, respondents were much more likely to list issues directly linked to their mental health as problems in their daily lives than they were about the more tangible issues related to their food, shelter, livelihood, or physical health. This suggests that assistance programs designed to be responsive to refugee needs and priorities must begin with a focus on mental health related problems.

This is consistent with insights from key informants, who emphasized that mental health is a serious public health issue in these camps, arguing that it should be prioritized as much as other basic needs. For example, one respondent explained:

Mental health intervention should always come first because it is impossible to think of change or development without mental health. It doesn't mean that basic necessities such as food and shelter should be compromised but mental health issue should be treated [the] same way as food and shelter.

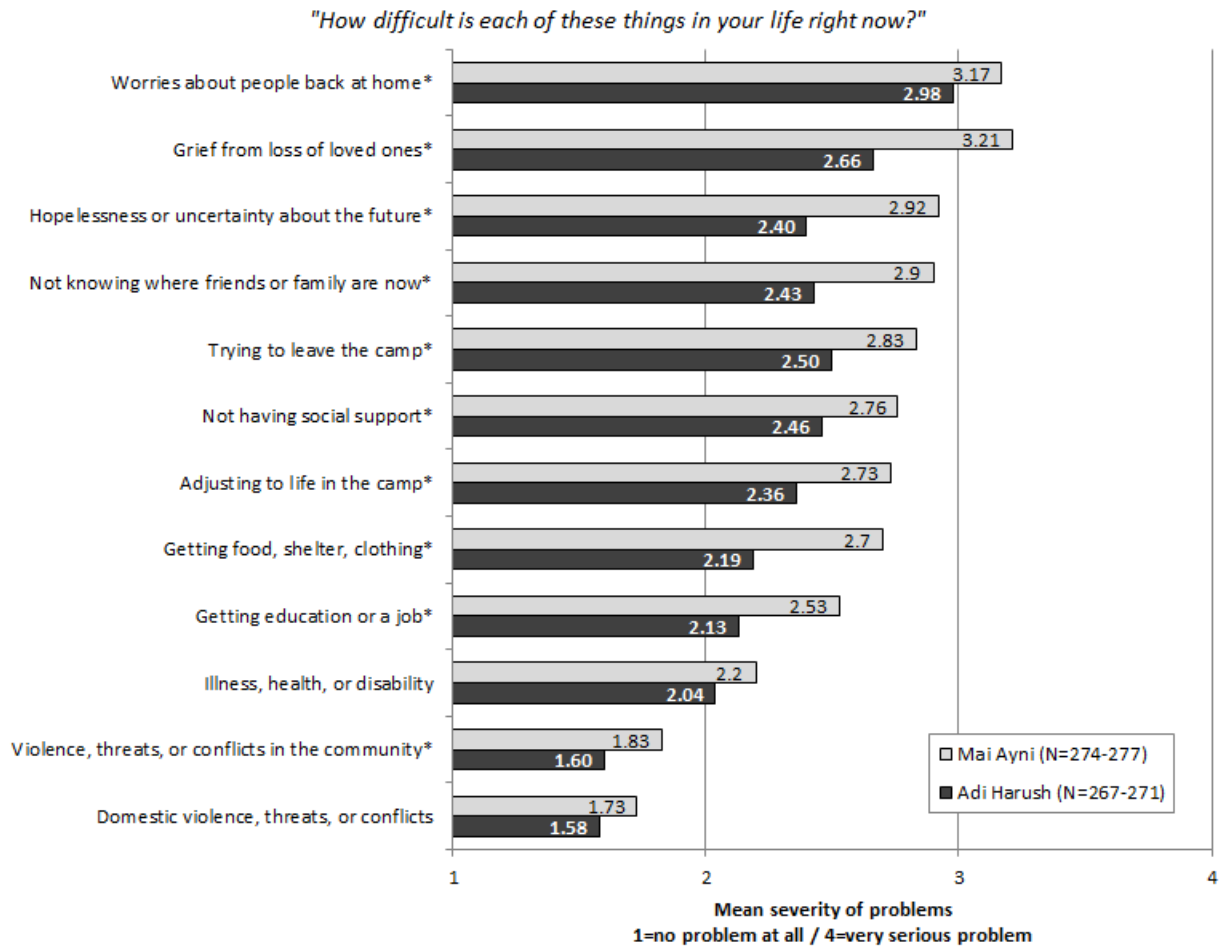
Based on their direct experience in these contexts, many key informants explained that mental health is reported as one of the key problems faced by refugees who arrive in the camps. They noted that most refugees arrive with a range of past traumatic experiences, which can include abuses related to religious persecution, gender-based violence, or other kinds of discrimination. After arrival, their mental health problems are compounded or worsened as their expectations for a better life contrast the reality of their situation as a refugee. Additionally, key informants explained that refugees' uncertainty surrounding the resettlement process can contribute to development of depression, post-traumatic stress disorder (PTSD), and anxiety disorders. In the camps, refugees are unable to lead lives they had previously experienced or expected, and they face ongoing stressors (such as poverty and lack of economic self-sufficiency, separation anxiety, or chronic physical pain) accentuated by their issues adjusting to life in the camps. These observations are directly supported by our survey data.

There are substantial divergences between the two camps on how difficult they perceive these problems to be in their current lives.²² In all areas, Mai Ayni residents were more likely to report these issues as problems they currently face. This may be linked to a range of other differences between the camp populations, including the comparatively longer time spent in the camp and other differences, described below.²³

²² There is some potential that differences in the interview teams' administration of these questions contributed to differences. However, we believe this is likely a small contribution, as both teams received the same training and comparable and proactive supervision and debriefing. All other measures of methodological consistency between camps are favorable.

²³ See figures: Symptom Areas, Mean Scores by Camp; Overall Mental Health by Camp; Seizures by Camp; Coping Strategies by Camp; Household Mental Health Problems by Camp; Torture Experiences by Camp; Knowledge and Receipt of MHPSS Services by Camp; MHPSS Provider Agencies by Camp; Barriers to MHPSS Services by Camp; and Contact with CVT by Camp.

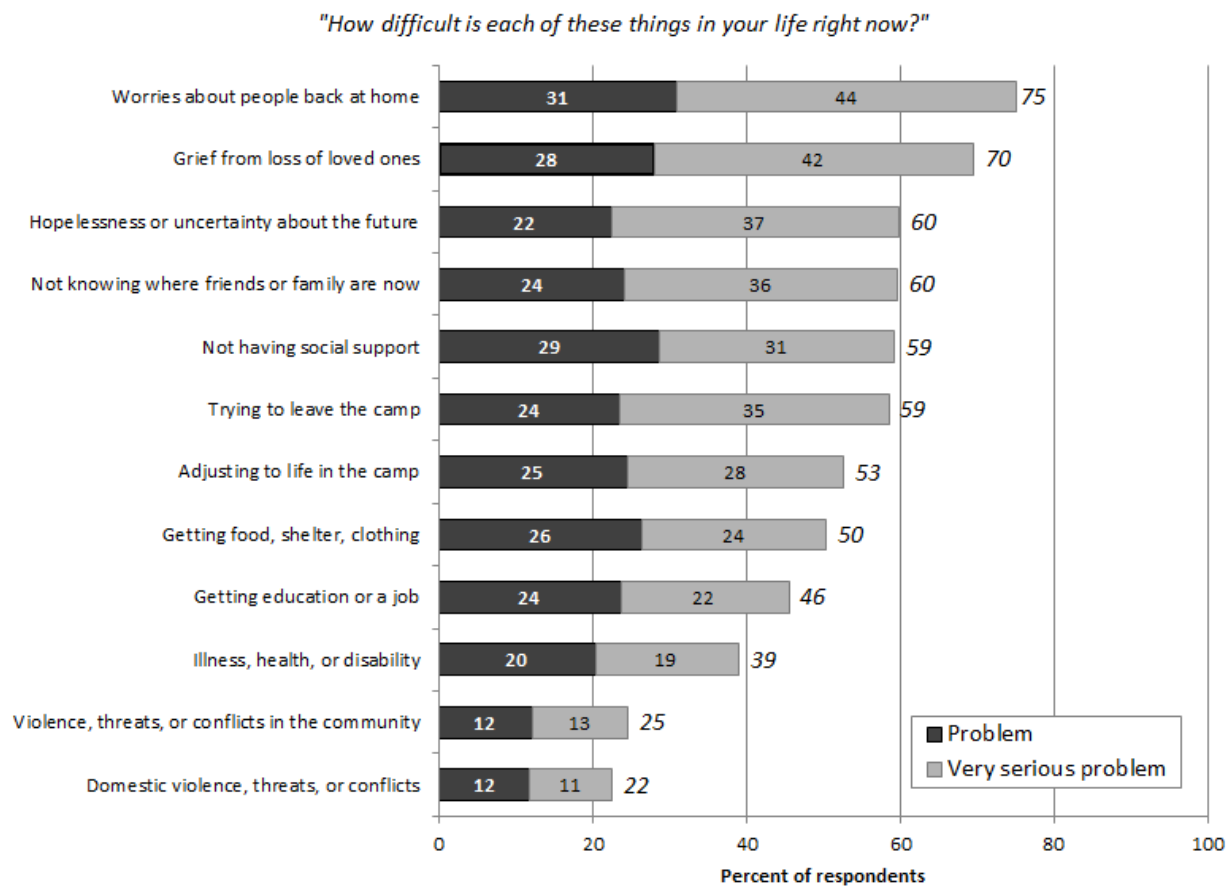
Current Problems: Mean Scores by Camp



* Differences between the camps are statistically significant at 0.10-level.

About a quarter reported facing daily challenges of ongoing violence or threats of violence. It is a positive outcome that community violence and domestic violence were not reported as problems by most respondents. However, a substantial minority reported community violence (25 percent) and domestic violence (22 percent) as difficult problems they face in their current lives. Key informants varied widely on their estimates of the prevalence of community and domestic violence, with some estimating it as a rare occurrence affecting just one percent of the population, while others predicted up to 70 percent of refugees face ongoing violence. To be sure, domestic violence, in particular, is likely to be an issue that is underreported, even in a confidential survey. We did not find significant differences in rates of reported domestic violence between men and women or those who were alone or not during the interview.²⁴

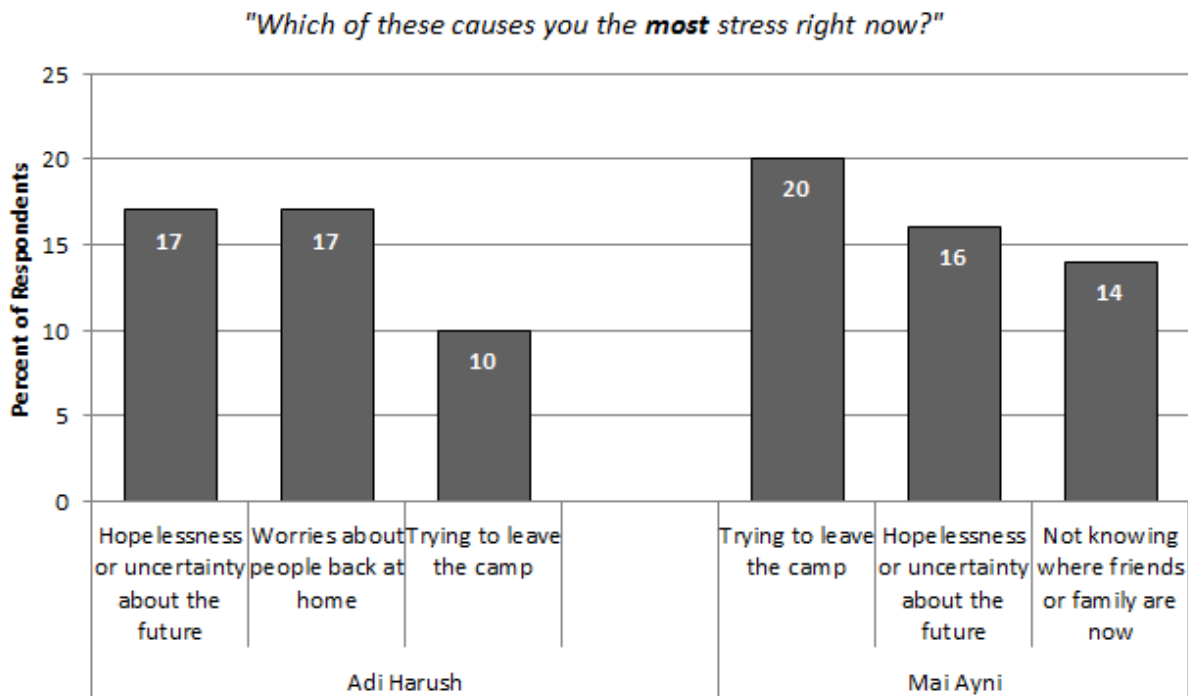
Current Problems: Respondents who Select "Problem" or "Very Serious Problem"



²⁴ About 24 percent of women reported domestic violence as a problem or very serious problem, compared to about 21 percent of men. Among women only, about 26 percent of those who were alone during the interview reported domestic violence as a problem or very serious problem, compared to about 33 percent of those who were not alone. These differences are not statistically significant.

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.²⁵ Again, mental health-related problems are causing the most stress in respondents' lives, compared to more tangible or physical problems. Residents are experiencing significant stress around the problems of: trying to leave the camps; feeling hopeless or uncertain about the future; and worrying about or not knowing where loved ones are now.

Most Significant Stressors



Mental Health Problems and Symptoms

Key informants reported that psychological and psychotic disorders are common among both adult and minor populations, and they perceive negative effects on refugee health and well-being. They see stress, depression, anxiety, and PTSD, as well as psychotic or dissociative disorders, as relatively common mental health problems. We asked key informants to estimate proportions of the camp populations dealing with these problems, and there were inconsistent

²⁵ Respondents were also given the option to select something else as their biggest stressor, to account for the possibility that our list of daily problems may not be comprehensive. A minority of respondents listed another stressor, and mentioned a range of issues, including: raising their children alone; losing weight; financial problems; not knowing their identity; or not having resettlement opportunities. Many of these were further specification of categories already provided in the question series.

responses between key informants. This highlights the need for representative data directly from the population, rather than reliance on key informants to estimate prevalence of mental health problems.

When asked about how often they have experienced mental health symptoms in the past two weeks, survey respondents' answers on average hovered around "rarely" for most symptoms related to depression, anxiety, and post-traumatic stress disorder (PTSD). The most often reported symptoms were difficulty sleeping and concentrating, and challenges with maintaining levels of interest and energy, with 34 to 44 percent of respondents report that they have sometimes or often experienced these problems in the past two weeks. These symptoms are behavioral indicators of depression, and can also indicate PTSD.

These survey data provide a reference point for estimates provided by key informants. Some of the key informants CVT interviewed estimated that depression and anxiety affect 65 to 70 percent of the refugee population, while others estimated the rate was less than 10 percent. In actuality, rates of depression and anxiety fall in between these extremes. Although the questions included in the survey are not diagnostic, they are commonly used indicators of mental health problems. Due to our sampling methodology, we can infer similar rates of these symptoms in the entire adult population.

Although our survey did not include minor respondents, we asked key informants about mental health issues that affect minors, and they described depression and complex somatic disorders deriving from torture, detention, accidents, or other traumatic experiences faced in country of origin or in cross-border travel. Key informants consider minors without adult family members in the camps to be particularly vulnerable to problems arising from separation anxiety, loss of loved ones, and loneliness, as well as from poverty and an inability to sufficiently provide for themselves or their siblings. These problems manifest in a variety of ways, interviewees note, and many minors struggle with substance abuse or addiction, suicidal thoughts, bed-wetting, sleep walking, or aggression.

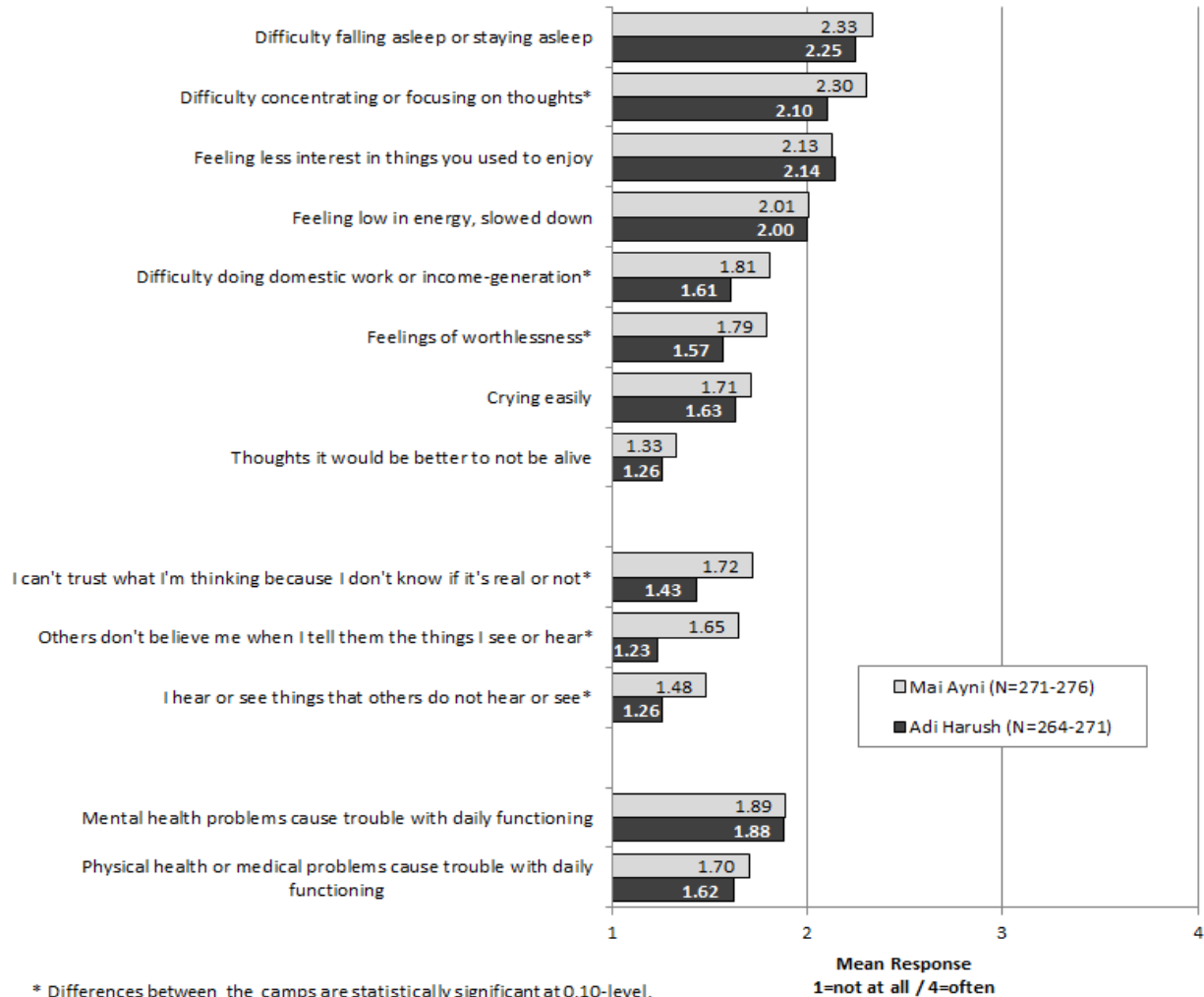
Suicidal thoughts are a significant risk factor that can lead directly to attempts to end one's own life. As such, any reported suicidal thoughts must be taken seriously and responded to with appropriate support in any humanitarian intervention. However, we found relatively²⁶ few respondents (eight percent) reported having thoughts that it would be better if they were not alive, a more passive indicator of suicidal ideation.²⁷ Despite attempts to provide a safe space for respondents to report suicidal thoughts, stigma surrounding suicide likely did contribute to underreporting.

²⁶ As a point of reference, our survey in Kenya, in Kalobeyei settlement of Kakuma camp in 2016, found 32 percent of respondents reported sometimes or often thinking it would be better if they were not alive. Although there are many contextual and methodological variations between the two surveys, this divergence in prevalence of suicidal ideation is large.

²⁷ As described in an earlier section, if survey respondents reported suicidal thoughts, the interview teams followed suicidality protocols to provide support.

Symptom Areas: Mean Scores by Camp

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

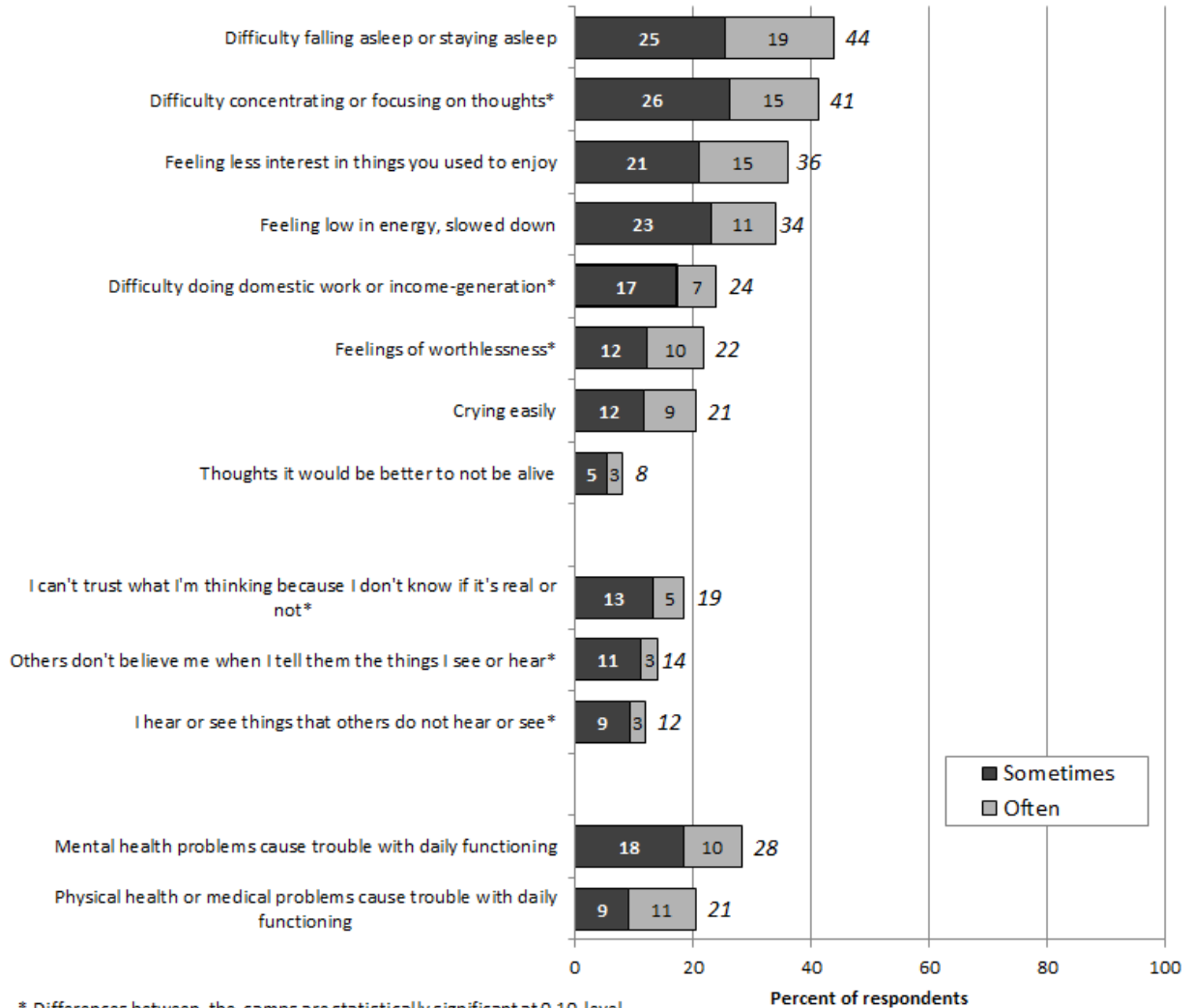


A minority of respondents reported experiencing symptoms that could be related to psychiatric problems. Overall, 19 percent said they sometimes or often have felt they cannot trust the reality of their thoughts, 14 percent said others do not believe that they see or hear, and 12 percent reported hearing or seeing things that others do not. The prevalence of these reported symptoms is significantly higher in Mai Ayni, compared to Adi Harush; this is supportive of the reasoning that longer periods in camps may be associated with increased strain on mental wellbeing. WHO and UNHCR estimate three to four percent of adults after an emergency will have severe disorders, such as psychosis.²⁸ Key informants offered a broad range in estimating the prevalence of psychiatric or psychosis symptoms among adults, ranging from less than one percent to 60 percent. The survey data (again, not diagnostic) provides some empirical evidence that the likely prevalence rate falls somewhere at the lower end of these stakeholder estimates.

²⁸ World Health Organization and United National High Commissioner for Refugees. 2012. "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings." Geneva: WHO. P.18.

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

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



Although individuals may experience symptoms of mental health problems, commonly these are moderate enough that people are able to draw upon their existing coping resources to maintain functionality in daily life. In the total sample of this survey, 28 percent reported that mental health problems were severe enough to have caused trouble with their daily functioning in the past two weeks. This helps to identify the proportion of refugees who may potentially derive strong benefits from mental health support to help develop new strategies and techniques to cope with mental health challenges in their lives.²⁹ Future analyses on these data can be

²⁹ On its own, aiding in the development of new coping skills is a psychosocial intervention. Specialized mental health work may also include a focus on coping skills, but integrates more in-depth treatment (such as trauma

conducted to predict what makes individuals in this context more or less likely to feel they are able to function in their daily lives and cope with mental health challenges. In the combined sample, about 44 percent of respondents ranked their mental health as good or very good, and 56 percent said their overall mental health was fair, poor, or very poor.

Overall Mental Health by Camp*

"How would you rate your mental health overall?"



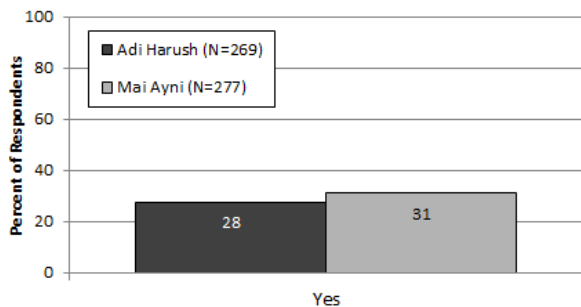
* Differences between the camps are statistically significant at 0.10-level.

In comparison, slightly fewer respondents (21 percent) reported that physical health or medical problems cause trouble in their current daily functioning. Some of this may be attributable to chronic pain; 28 percent of respondents in Adi Harush and 31 percent in Mai Ayni reported chronic pain. Chronic pain can be directly linked to mental health issues as well, as trauma has powerful effects on both the mind and the body.

We also asked respondents if they have experienced seizures, using a simple explanation for those unfamiliar with the term. Few respondents (6 percent and 12 percent in Adi Harush and Mai Ayni, respectively) said that they had ever experienced seizures at any time in their lives.

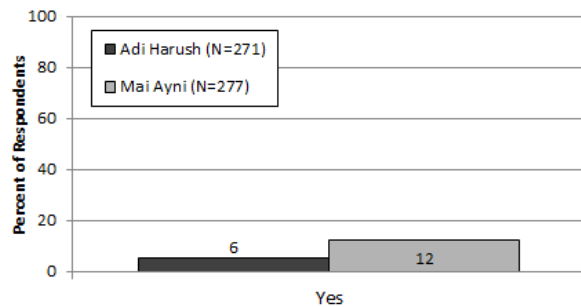
Chronic Pain by Camp

"Do you experience ongoing or chronic pain in your body?"



Seizures by Camp*

"Have you ever had uncontrolled convulsions in your body that you can't remember (seizures)?"



* Differences between the camps are statistically significant at 0.10-level.

processing or cognitive behavioral therapy) to address acute symptoms and core thought or behavioral patterns that have been impacted by traumatic experiences.

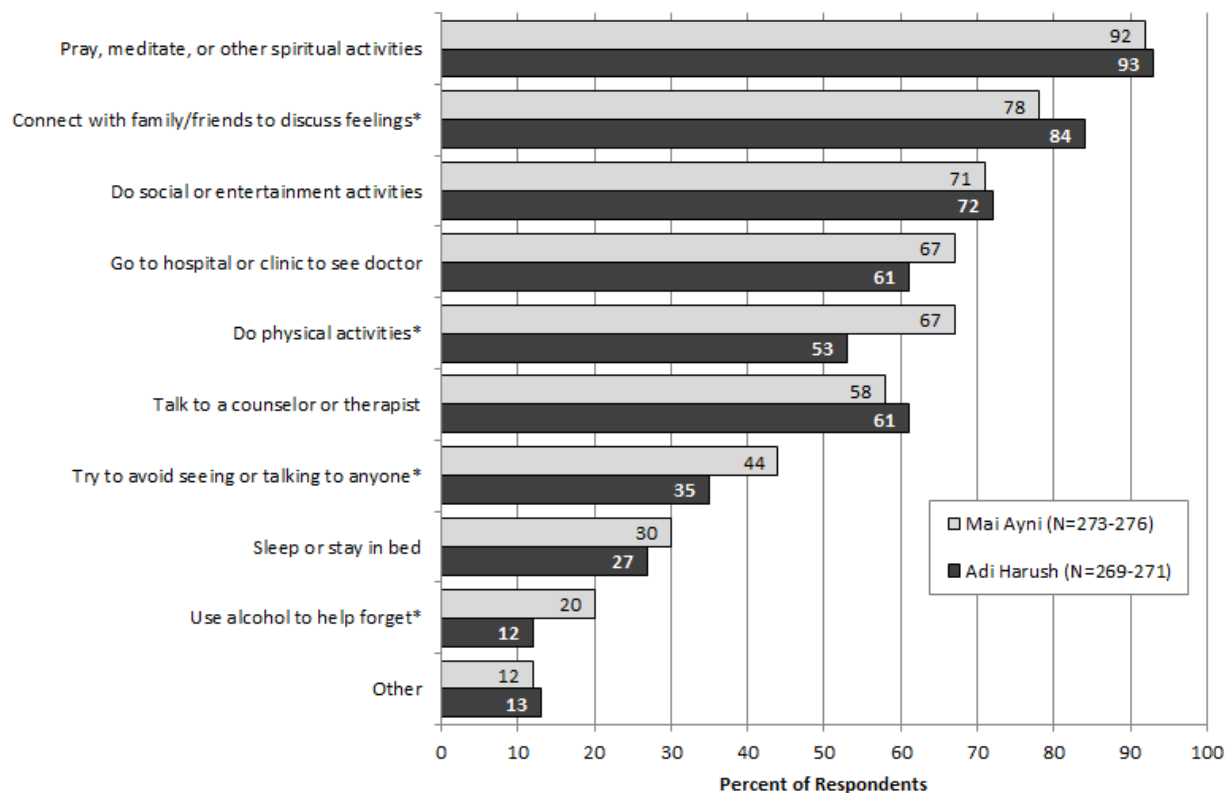
Coping Strategies

Respondents reported a range of coping strategies that they use to deal with difficult emotions, such as feeling sad, anxious, or overwhelmed. A vast majority, over 90 percent, reported that they turn to spiritual support to help them cope. A strong majority also relies on social support, by connecting with their family or friends to talk about their feelings or struggles. Nearly three-quarters cope with challenges more indirectly by turning to social activities or entertainment. Over half (58 percent in Mai Ayni and 61 percent in Adi Harush) say that they turn to some type of professional for help, dealing with their emotions by talking to a counselor or a therapist.

Our list included a few generally unhealthy coping strategies, which were reported comparatively less often. Some respondents reported avoidance strategies (not seeing anyone, staying in bed) and a sizable minority also reported using alcohol to help cope with difficult emotions. These unhealthy coping strategies were reported more commonly in Mai Ayni.

Coping Strategies by Camp

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



Respondents who reported other types of coping strategies provided both healthy and unhealthy responses, such as: trying to pursue positive thoughts; going on a walk; reading books; smoking; trying to take care of themselves; beating themselves; or focusing on problem solving. Understanding the full range of coping strategies utilized already can help service providers design interventions that may be more resonant to affected individuals.

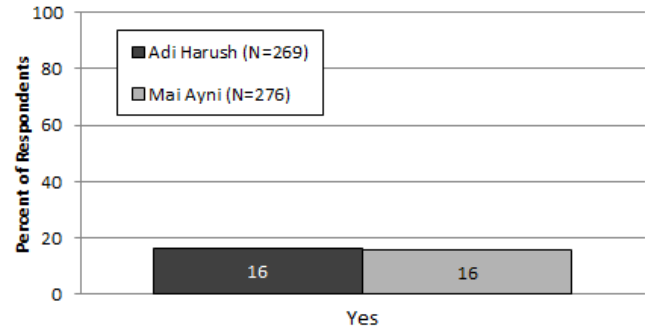
Household Mental Health

In both camps, 16 percent of respondents said they have a household member whose mental health problems interfere with their daily functioning. Most of these respondents (90 percent) said it was just one person, and about a third described someone under age 18.

Respondents also reported some indicators of more severe mental health challenges in their households. Although these issues were reported by fewer than a third of respondents, they are areas for particular attention. Notably, these problems are again reported more frequently in Mai Ayni than in Adi Harush.

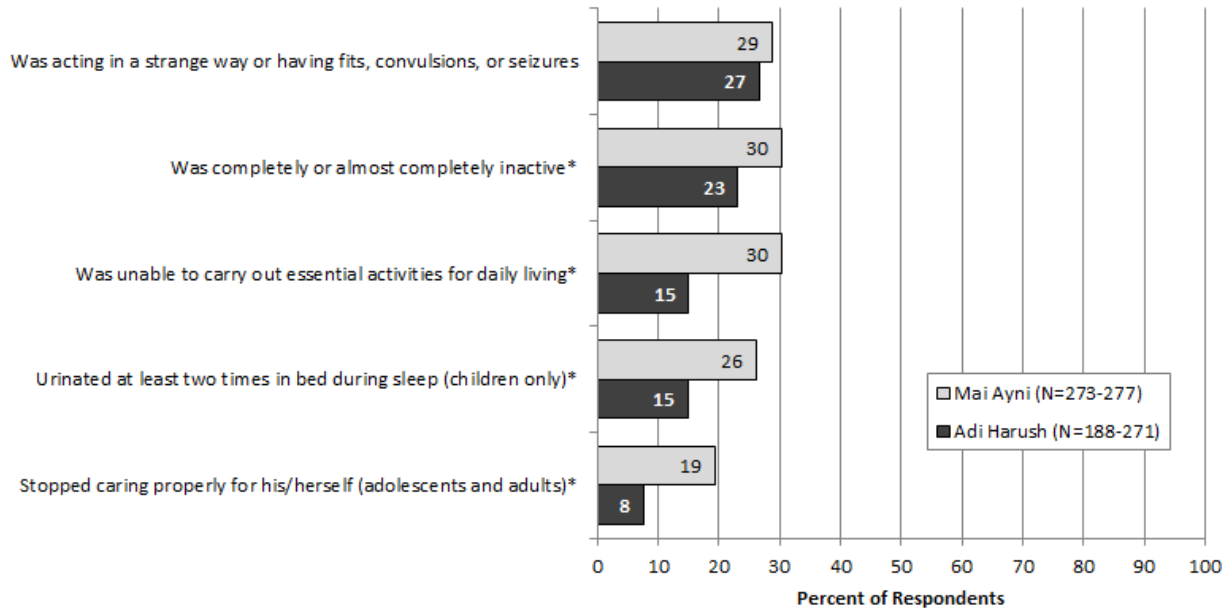
Household Functioning by Camp

"Do you feel anyone in your household has mental health problems that cause trouble with daily functioning?"



Household Mental Health Problems by Camp

"During the last two weeks was anyone in your household so distressed, disturbed, or upset that he or she...?"



* Differences between the camps are statistically significant at 0.10-level.

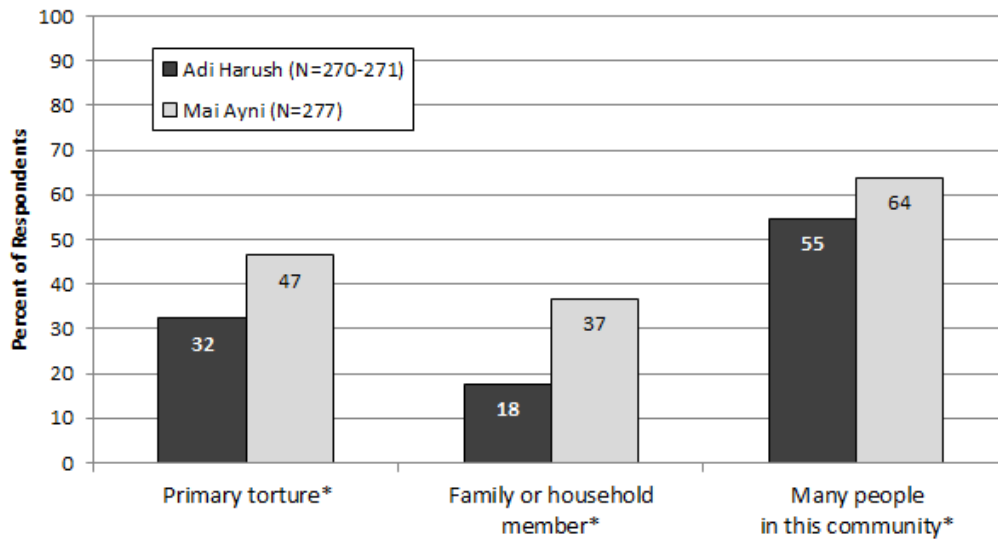
Key informants discussed how mental health problems can have negative repercussions on families and communities. For example, as individuals experience feelings of worthlessness, they tend to isolate themselves from family members and society. Mental health problems thus hurt people's social relationships and their ability to engage with others. As another example, when faced with psychological problems, individuals tend to become economically unproductive, which further hurts their household finances. One key informant explained:

[If those who have been tortured] don't get the appropriate services to heal from this torture then it will lead to health problems...feelings of depression, hopelessness and even fear, and they don't think [about] good things in their future. They don't feel confident and don't believe they can work and change their lives. It can also lead to suicide. Those who have been tortured [have difficulty expressing] love to their families and they don't want to have intimacy with their close family members because they [tend to] concentrate on the effects of the torture.

Torture Survivors

After being offered a simple, brief definition of torture,³⁰ a combined total of 40 percent of respondents reported that they had personally been tortured. This suggests that over 5,500 adults in these camps are likely to have experienced torture. Overall, 28 percent reported that someone in their family or in their household had been tortured. Finally, 60 percent speculated that they thought many people in their community had been tortured. The rates were significantly higher for Mai Ayni in all three areas. Because torture often results in very particular negative consequences for mental and physical health, a specialized interdisciplinary rehabilitation program is recommended to address these high rates of reported torture.

Torture Experiences by Camp



* Differences between the camps are statistically significant at 0.10-level.

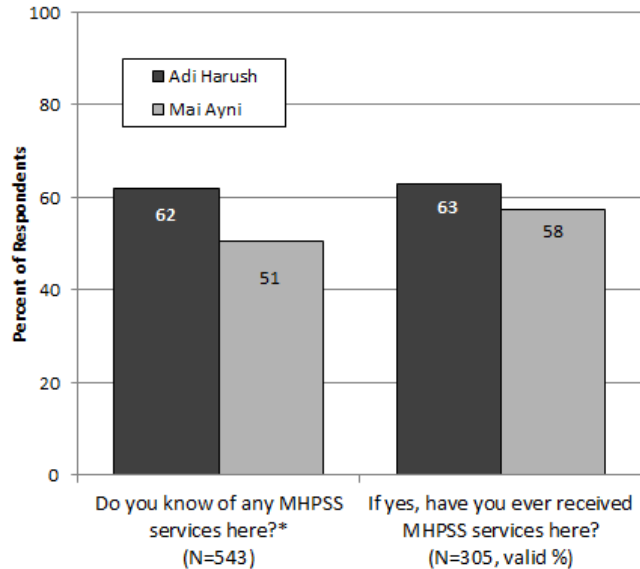
³⁰ See the *Questionnaire* at the end of the report. As noted in an earlier section, the definition provided was: "Torture is severe physical or psychological suffering caused on purpose by someone in authority."

Access to Services

In Adi Harush, 62 percent of respondents were aware of mental health or psychosocial support services (MHPSS) available in the camp; significantly fewer (51 percent) in Mai Ayni were aware of services. Among those who knew of services, 63 and 58 percent respectively, had personally received MHPSS services in the camp.

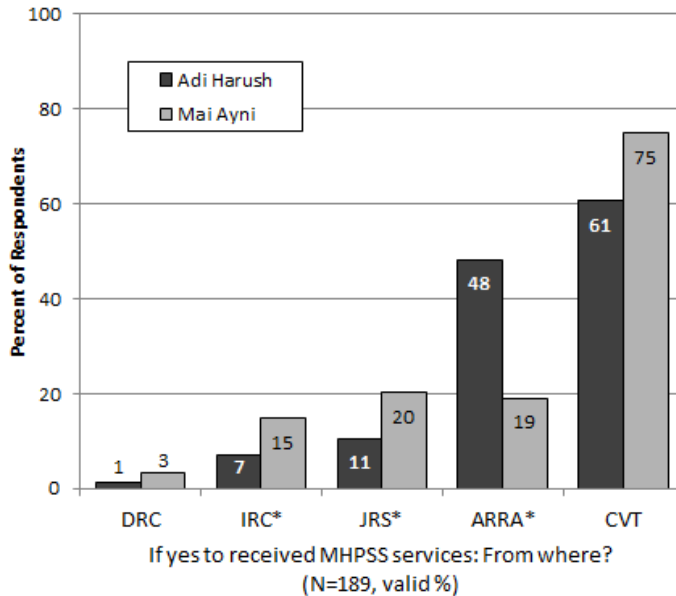
Among those who had received MHPSS services, a combined total of 67 percent said they had received some type of service from CVT;³¹ this percentage was higher in Mai Ayni. The next largest segment of these respondents reported receiving MHPSS services from ARRA, though these were disproportionately reported in Adi Harush.

Knowledge and Receipt of MHPSS Services by Camp



* Differences between the camps are statistically significant at 0.10-level.

MHPSS Provider Agencies by Camp



* Differences between the camps are statistically significant at 0.10-level.

For those who had heard of MHPSS but had not personally received any services, there were few reported barriers to receiving services. Many respondents in Adi Harush simply reported that they had not needed or wanted such services. In general, our survey identified few barriers to accessing MHPSS services.

Key informant interviews supplement survey data in helping to identify barriers to accessing services. As described in the *Knowledge and Attitudes* section above, key informants perceived social stigma to be a significant barrier to utilization of MHPSS services.

According to key informants, a second barrier to meeting mental health needs is

³¹ With weighted data, it is difficult to directly link percentages to number of respondents. However, this suggests about 126 people reported receiving some type of MHPSS services from CVT; in the unweighted data, 128 people reported services from CVT. This is higher than the figure below that reports eight percent of respondents said they had received CVT counseling services, which would be about 29 people; in the unweighted data, 33 people reported CVT counseling services. This discrepancy in figures is most likely due to the first figure being more inclusive of all CVT services, including outreach events, with the latter specifying counseling.

a lack of community awareness about mental health and available services. This includes a lack of understanding about effective service utilization, such as inconsistency in taking prescribed medications or attrition in counseling services. Third, key informants noted that poverty and unmet basic needs can heighten stress and anxiety and present a barrier to accessing appropriate mental health services. Finally, a perceived barrier to meeting mental health needs is the insufficient services available, particularly in psychiatric services.

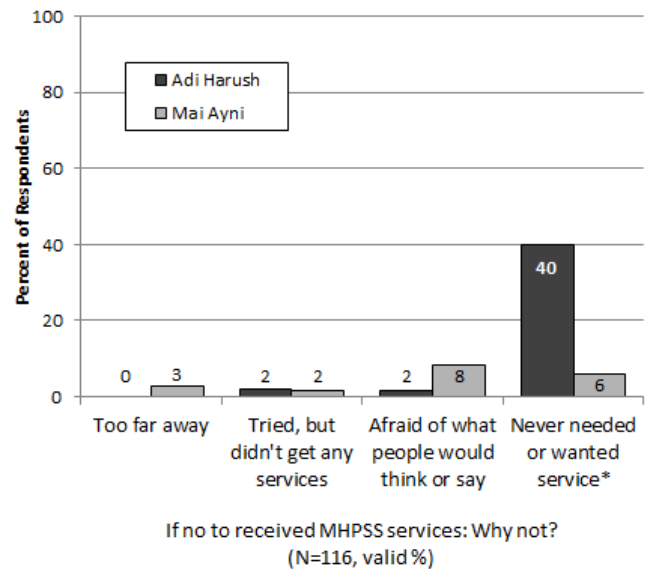
Many respondents told our interviewers that they had heard of the Center for Victims of Trauma (CVT) prior to the survey, and rates were comparable in both camps. This suggests name recognition is relatively high.

For those who had heard about CVT prior to the interview, respondents were most likely (45 percent, combined) to have heard about CVT through word of mouth, saying they had heard people in the community talk about CVT. Around a third of respondents had attended a CVT community outreach event or activity. A minority of respondents had more direct exposure to CVT’s services, with a combined total of eight percent reporting they had personally received counseling services.

Most key informants reported that they were moderately familiar with CVT and its activities, and most had interacted fairly frequently with CVT staff. A few described CVT as particularly “responsive” to refugee needs and concerns, particularly for refugees who experienced torture or other traumatic events. Key informants were appreciative of CVT’s counseling approach, reporting that they believe CVT’s intervention has been highly effective with individuals they have referred to CVT. One interviewee shared that they would typically offer their patients sleeping pills to help address their problems, but that CVT can provide life skills and coping mechanisms to more effectively deal with their problems. This interviewee believed this to be a more sustainable and “life-changing” solution for refugees’ mental health problems.

Key informants believed that CVT has either a “moderate” or “very strong” positive multi-level impact on individuals, families, and communities. One interviewee working in close

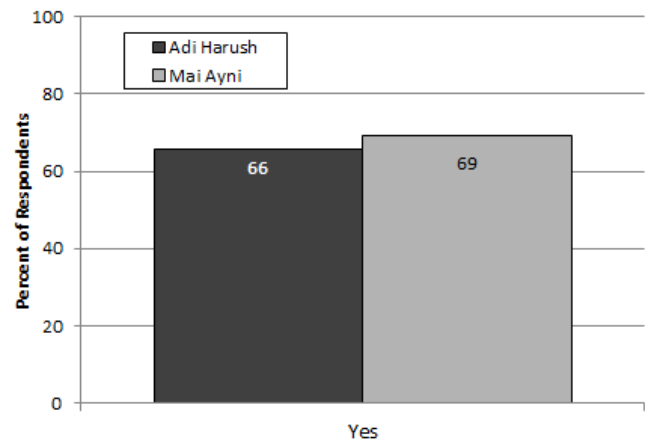
Barriers to MHPSS Services by Camp



* Differences between the camps are statistically significant at 0.10-level.

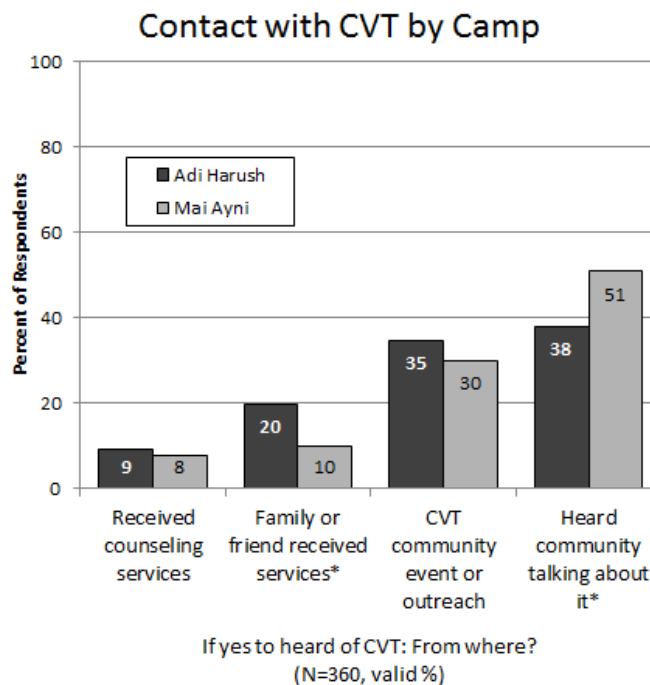
Awareness of CVT by Camp

"Have you heard of the Center for Victims of Trauma (CVT) before today?" (N=532)



partnership with CVT stated that, “We are witnessing improvements in clients [after CVT counseling].” They explained that minors who previously were not communicating well or socializing with their peers are now able to do so comfortably, showing significant improvements in social functioning after CVT counseling. They added:

Torture and trauma experiences have negative impacts on the household, [and] healing the individual is healing the household. Individuals make households and households make community. Positive change in individuals has a greater impact in creating healthy and hopeful community.



* Differences between the camps are statistically significant at 0.10-level.

Conclusion

CVT interviewed 548 individuals in Adi Harush and Mai Ayni, demonstrating the feasibility of representative sampling methods in humanitarian settings. The resultant representative data identifies attitudes about mental health, daily stressors, psychological symptoms, coping strategies, and abilities to access services among the populations of these camps. This allows service providers and other stakeholders to design evidence-based MHPSS interventions, well-suited to the needs of refugees. Similar surveys should be conducted in other camps or at later time points, 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.

We found that psychological difficulties are the major challenges refugees face in their daily lives, including depression, anxiety, PTSD, and somatic symptoms. The refugees rated worry, grief, and loss as major ongoing issues, more serious than their physical or material challenges. Although interventions cannot address these problems themselves (that is, cannot change the loss of a loved one, for example), refugees can be aided in developing resources to cope with these problems (that is, learn to process and deal with the grief they feel). The data suggest that any interventions with refugees must prioritize mental health related problems.

MHPSS services can draw upon resources already available in the refugee population. For example, we found refugees in Adi Harush and Mai Ayni report generally positive attitudes towards mental health. Stakeholders could draw upon refugees’ willingness to talk about what happened to them in order to deal with mental health related stressors. There also need to be

continued efforts to address stigma, as over a third of refugees associate mental health problems with shame, failure, or weakness. Refugees also are already using some healthy strategies to cope with psychological stresses, notably turning to religion or spirituality and to their social support networks to help them. Although just about a third of refugees report accessing any MHPSS services, more than half are aware of services and few report significant barriers to accessing services.

Prevalence of trauma and torture experiences among refugees in these two camps is high, with fully 40 percent reporting they had been tortured, and many others reporting symptoms consistent with traumatic experiences. Not everyone is symptomatic, suggesting the need for effective tools to screen for those having trouble functioning. However, 34 to 44 percent of respondents do report that they have sometimes or often experienced in the past two weeks difficulties sleeping and concentrating, as well as challenges with maintaining levels of interest and energy. These symptoms are indicative of depression, anxiety, and PTSD, which are anticipated in post-emergency or refugee populations and should respond to treatment through counseling services. Some refugees report symptoms which may be consistent with psychiatric illness and require further in-depth assessment.

The results of this survey highlight the need for representative data about mental health for entire populations of refugee camps, to provide an evidentiary basis for designing and prioritizing interventions. Further analyses of data from this survey can continue to refine our understanding of mental health attitudes and needs, such as developing predictive models to identify vulnerability factors that are associated with high levels of psychological symptoms or functional challenges. It is our hope that this survey is one contribution to the ongoing effort to develop responsive and effective services for survivors of violence, persecution, and human rights abuses.

Full Questionnaire

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

Date/ዕለት : _____

Interview/ቃለ-መጠየቅ # : _____

Interviewer ID # / ቃለ-መጠየቅ ዝገብር ሰብ ኣይዲ: _____

Supervisor ID # / ናይ ሱፐርቫይዘር ታሴሪ: _____

Location of interview: ቃለ-መጠየቅ ዝተገበረሉ ቦታ
 Adi Harush ዓዲ-ሓሩሽ Mai Ayni ማይ-ዓይኒ

Zone/ዞን: _____ Block/ብሎክ: _____ House number/ገዛ ቁጽራ: _____

Gender of respondent: ናይ መልሲ ወሃቢ ጾታ
 Male/ተባዕታይ Female/ኣንስታይ

Language of interview: ቃለ-መጠየቅ ዝተገበረሉ ቋንቋ
 Tigrinya/ትግርኛ Amharic/አምሓርኛ English/ኢንግሊዝኛ Saho/ሳሆ
 Other: ካልኣት _____

Post-Survey Support Protocol/ ድሕሪ መጽናዕቲ መሓዘቢ ፕሮቲኮል/አሰራርሓ

- Emergency response:** Respondent is in extreme distress and requires immediate intervention
Notify supervisor / clinical support to get CVT staff to come to household immediately
ናይ ህጹጽ ሓገዝ: መልሲ ወሃቢ ኣብ ኩቱር ጭንቀት ይርከብ ከምኡ'ውን ቀጥታ ሓገዝ ይደሊ
ንሱፐርቫይዘር ምሕባር/ናይ ስነ-አእምሮ-ዊ ሓገዝ ንምርካብ ናይ ሲቪቲ ሰራሕተኛ ብቀጥታ ናብ ገዛ ንምኻድ/ንምልኣኽ
- Referral: ሪፈራል**
 - Respondent was given information about available services
መልሲ ወሃቢ ብዛዕባ ዘለው ኣገልግሎታት ሓበሬታ ተዋሂብዎ
 - Respondent needs to be connected with referral partner-GENERAL
መልሲ ወሃቢ ምስ ናይ ሪፈራል መዳርግቲ ኣካላት ክተሓሓዝ ኣለዎ- ሓፈሻዊ::
 - Respondent needs to be connected with referral partner – PSYCHIATRIC
መልሲ ወሃቢ ምስ ናይ ሪፈራል መዳርግቲ ኣካላት ክተሓሓዝ ኣለዎ- ናብ ናይ ኣእምሮ ሕክምና
 - Respondent should be referred for CVT services
መልሲ ወሃባይ ንናይ ሲቪቲ ኣገልግሎት ሪፈር ክበሃል ኣለዎ::
- PFA:** Respondent experienced some distress and required in-person PFA delivered during survey per CVT training of enumerator
ናይ መጀመርታ ስነ-አእምሮ-ዊ ረድኤት: መልሲ ወሃቢ ዝተወሰነ ጭንቀት ዘለዎ ኣብቲ መጽናዕቲ ናይ መጀመርታ ስነ-አእምሮ-ዊ ረድኤት ኣብቲ ናይ ሲቪቲ ስልጠና እቲ ሓበሬታ ዝእክብ ዘሎ ሰብ ብኣካል ይወሃብ::
- Nothing required:** Respondent did not require follow up for psychological distress
ምንም ኣየድልን: መልሲ ወሃቢ ምንም ናይ ስነ-አእምሮ-ዊ ጭንቀት ዝኸውን ክትትል ኣየድልዮን ::

NOTES: መዘከር

Interviewer signature: ቃለ-መጠየቅ ዝገብር ሰብ ፊርማ _____

Was the respondent alone during this interview? Yes No

Welcome Script & Consent/ ናይ እንኳሶ ደሓን መጻእኹም ጽሑፍን ስምምዕነትን

Good morning/afternoon/evening. I am working with an international organization called the Center for Victims of Trauma (CVT). We provide services to people who have experienced trauma or have been forced to leave their homes. Trauma means mental, emotional, or physical distress caused by a bad experience or event. We provide mental health services in Adi Harush and Mai Ayni. We are doing an assessment to learn about mental health in this area. We want to understand the needs and opinions of people who live here.

ከመይ ሓዲርካ/ከ/ከመይ ዊዲልካ/ከ/ከመይ አሚስኻ/ኸ:: ምስ ዓለም-ለኻዊ ዝኾነ ማእኸል ግዳያት ስነ-አእምሮዊ ስቃይ/ስንብራት ሲቪቲ ዝበሃል ትካል እየ ዝሰርሕ:: ስነ-አእምሮዊ ስቃይ/ስንብራት ዝገድፍ ናይ ሂወት ተጓንፎ ዘሕለፉን ከምኡውን ካብ ዓዶም ብሓይሊ ንኸወጹ ዝተገበሩ ሰባት ኣገልግሎት ኣብ ምሃብ ኢና ንሰርሕ:: ናይ ስነ አእምሮ ስምብራት ማለት ብሰንኪ ሕማቕ ተጓንፎ ወይ ፍጻመ ዝመጽእ አእምሮዊ፣ ስምዒታዊ ወይ ኣካላዊ ስቓይ እዩ:: ኣብ ዓዲ-ሓሩሽን ማይ-ዓይንን ናይ አእምሮ ጥዕና ኣገልግሎት ንህቡ:: እዚ ዳህሳሳ ንጉብር ዘለና ኣብዚ ኸባቢ ዘሎ ናይ አእምሮ ጥዕና ኣገልግሎት ንምፍላጥ እዩ:: ኣብዚ ኸባቢ ዝነበሩ ሰባት ድልየታቶምን ሓሳባቶምን ክንርዳእ ንደሊ ኢና::

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 only 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.

እስታስቲካዊ አሰራርሓ ተጠቀምና ኢና ሃንደበት ገዛውቲ ኣብዚ ከባቢኹም መሪጽና፣ በዚ ምኽንያት ድማ እየ ኣብዚ መጻእ ዘለኹ:: ኣብዚ ገዛ ዘሎ ዝኾነ ሰብ ብዛዕባ ናይ አእምሮ ጥዕና ተመክሮአምን ሓሳባቶም ዝምልከት ዝተወሰኑ ሕቶታት ክሓትት ይፈቱ:: እቶም ሕቶታት ካብ 20-30 ደቃይቕ ጥራሕ ይወስድ:: እቶም መልስታት ምስ ካልእት መልስታት ብሓንሳብ ኣጣሚርና ክንትንትኖ ኢና:: ዝኾነ ሽም ብፍጹም ኣይንጥቀምን ወይ ኣይንምዘግብን ኢና::

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.

ሎመዓንቲ ካብ ኣብ ገዛ ዘለው ሰባት ሃንደበት ሓዲ ሰብ ክመርጽ ይፈቱ:: ኣብዚ ስድራ-ቤት ዘለው ኣባላት ኩሎም ልዕሊ ዕድመ (18+) ደቂ- ኣንስትዮ/ተባዕትዮ ዝኾኑ ንኸምዘግብ ብኸብረትኩም ሓግዙኒ::

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.
ካብቶም ኣብቲ ስድራ-ቤት/ገዛ ዘለው ኣባላት ብሃንደበት ዝተመረጹ ተጠቀም:: ኣብ ሞንጎ ደቂ-ኣንስትዮን/ተባዕትዮን ቀያይር- ኣብታ ዝሓለፈት ናይ መወዳእታ ስድራ-ቤት/ገዛ ጻል ኣንስተይቲ ቃለ-መሕትት ገይርካ እንተይርካ ኣብዛ ዘለኻያ ስድራ-ቤት ናይ ግድን ወዲ-ተባዕታይ ቃለ-መሕትት ግበር:: ድሕሪ ቃለ-መሕትት ክትገብረ ምስ ፈለኻ ፣ ኣድላይ እንተኾይኑ ኣብቲ ላዕሊ ዘሎ ሓበሬታ ክልሰ ኢኻ::

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 no rights 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.

ተሳትፎኻ/ኸ መላእ ብመላእ ብወለንተኛነት /ብድልየትን ምስ መላእ አማራጺን እዩ:: እንድሕር ዘይደሊኻ/ኸ ዝኾነ ሕቶ መልሲ ዘይምሃብ ክትመርጽ ይክአል እዩ:: ኣብ ዝኾነ ሰዓት እቲ መጽናዕቲ ጠጠው ክተብሎ ትኸእል ኢኻ:: እዙይ ፈተና ስለዘይኮነ ሓቂ ወይክዓ ጌጋ ዝበሃል መልሲ የለን :: ኣነ ድልየተይ ንስኻ እንታይ ከምዘስመዐካ ወይ እትሓስቦ ነገር ብርግጽ ንምፍላጥ ጥራሕ እዩ:: ነቶም ትህቦም መልሲ ናይቶም ሕቶታት ብዝኸልኩሉ ግሉጽ ከምትኸእል ከመስግን ይደሊ ::

The goal of these questions is to improve services provided here, but your participation will not directly benefit you or your family in any way.

ሽቶ ናይዞም ሕቶታት ኣብዚ ቦታ ንዝወሃብ ተወሳኺ ግልጋሎት ንምሕጋዝ እዩ ነገር ግን ናትካ ተሳትፎ ብዝኾነ ይኹን መንገዲ ቐጥታ ንዓኻን ወይክዓ ንስድራኻ ዘጥቅም ኣይኮነን ::

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.

እቶም ሓዲ ሓዲ ሕቶታት ንዓኻ ጻቕጢ ንዝገብሩልካ ነገራት ምናልባት ከዛኻኹርኻ ይኸእሉ እዮም:: እንድሕር ዝኾነ ሕቶ ዘሕርቀካ እንተኾይኑ ሓብረኒ ኢኻ/ኸ:: ኣብ መወዳእታ ከመይ ከምዘስመዐካ ክንርእ ኢና::

Are you willing to participate? ንክትሳተፍ ፍቃደኛ ዲኻ/ኺ.

Yes/አወ

No/አይቶላ

Thank you so much for agreeing! Your perspectives will be very helpful to us. I look forward to our conversation!
 ስለዝተስማማዎኻ/ኺ የመስግን! ናትካ/ኪ ኣመለኻኻታ ንዓና ብጣዕሚ ሓጋዚ እዩ ክኸውን። ንክንዘራረብ/ንኸነዕልል ይጽብ።

Time started: _____ AM / PM/ ቅደሚ ቀትሪ/ ድሕሪ ቀትሪ
 ዝተጀመረሉ ሰዓት

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.

መጀመርታ ብዛዕባ **አእምሮ ጥዕና** ክትስማምመዎሎም ወይ ዘይክትስማምመዎሎም ትኸእል ሓሳብት ክንብብልካ እዩ። ብኸብረትኩም ኣዝዩ ኣይስማምማዎን፣ ኣይስማምማዎን፣ ይስማምማዎ ወይ ኣዝዩ ይስማምማዎ ኢሎም ይንገሩና።

Use thumbs up and down to illustrate the options.
 እቶም መሃረጽታት ንምሕባር ኣጸብዕቲ ንላዕልን ንታሕትን ተጠቀሙ

		Strongly Disagree ኣዝዩ ኣይስማምማዎን (2 thumbs down) 2 ኣጸብዕቲ ንታሕት	Disagree ኣይስማምማዎን (1 thumb down) 1 ኣጸብዕቲ ንታሕት	Agree ይስማምማዎ (1 thumb up) 1 ኣጸብዕቲ ንላዕሊ	Strongly Agree ኣዝዩ ይስማምማዎ (2 thumbs up) 2 ኣጸብዕቲ ንላዕሊ
1.1A	I understand what the words “mental health” mean. ናይ “አእምሮ ጥዕና” እንታይ ማለት ምዃኑ ይርደእኒ።				
1.1B	IF AGREE OR STRONGLY AGREE: እንድሕር ትስማምማዎ ወይ ኣዚኻ እንተተስማማዎኻ/ኺ Please give me a short description of mental health. ብኸብረትኩም ናይ አእምሮ ጥዕና ሓጺር መግለጺ ሃቡ።	Write response: መልሲ ጽሓፍ Field code, select one option: ናይ ፊልድ ኮድ ፣ ሓደ መሃረጺ ምረጽ <input type="radio"/> NEGATIVE: unstable, crazy, problems, shame ኣሉታዊ፡- ዘይርጉእ፣ ዕብድ፣ ጸገማት፣ ሕፍረት <input type="radio"/> NEUTRAL: overall psychological state of being ሞንጎኛ፡- ሓፊሻዊ ናይ ስነ-አእምሮዊ ኩነታት ጥዕና <input type="radio"/> POSITIVE: well-being, coping skills ኣውንታዊ፡- ጽብቕ ኩነታት ጥዕና፣ ናይ ተጻዋርነት ክእለታት <input type="radio"/> Other / not clearly related to mental health ካልእ/ ብንጹር ምስ አእምሮ ጥዕና ዘይራኽብ			
1.2	“Mental health” can be positive. It means psychological well-being; it is important for everyone. “ናይ አእምሮ ጥዕና” ኣውንታዊ ክኸውን ይኸእል። እዚ ማለት ስነ-አእምሮዊ ጥዕና ምዃን ንኩሉ ኣገዳሲ እዩ።				
1.3	“Mental health” is negative. It really only means psychological illnesses or problems. “አእምሮዊ ጥዕና” ኣሉታዊ እዩ። ስነ-አእምሮዊ ሕማም ወይ ጸገም ጥራይ ማለት እዩ።				

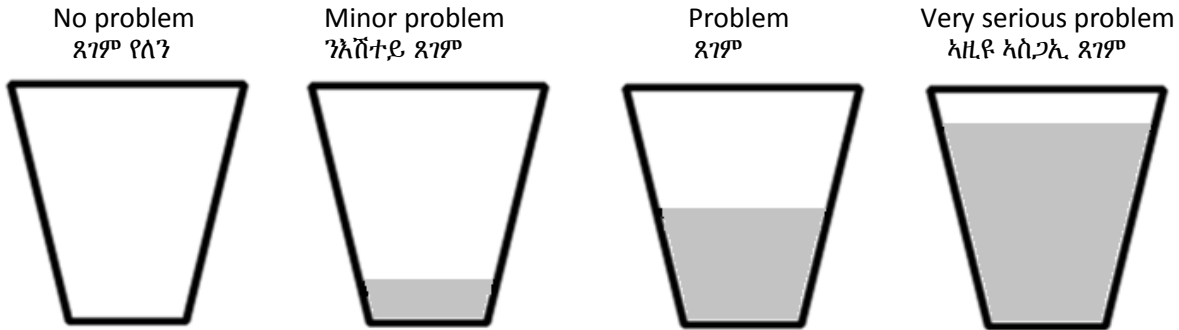
	Do you agree or disagree? ትስማማዎ ዲኻ/ኺ ወይስ አይትስማማዎን?	Strongly Disagree አደስማማዎን (2 thumbs down) 2 አጻብዕቲ ንታሕቲ)	Disagree አይስማማዎን (1 thumb down) 1 አጻብዕቲ ንታሕቲ	Agree ይስማማዎ (1 thumb up) 1 አጻብዕቲ ንላዕሊ	Strongly Agree አደስማማዎ (2 thumbs up) 2 አጻብዕትኻ ንላዕሊ
1.4	To deal with trauma, it helps to think or talk about what happened. ናይ ስነ አእምሮ ስንብራት ንምጽዋር፣ ብዛዕባ እንታይ ከምዘጋጠመካ ምሕሳብን ምዘራብን ይሕግዝ እዩ።				
1.5	Mental health problems are shameful or a sign of weakness or failure. ናይ አእምሮ ጥዕና ጸገማት ዘሕፍሩን ምልክታት ድኽመትን ውድቀትን እዮም።				
1.6	It is good to talk to my family or friends about my mental health. ብዛዕባ ናተይ ናይ አእምሮ ጥዕና ንቤተሰባይን መሓዙትን ምዘራብ ጽቡቕ እዩ።				
1.7	I know and use healthy strategies to cope with negative thoughts or feelings about what has happened to me. ብዛዕባ እቲ ዘጋጠመኒ ተጓንፎ ዘለውኒ አሉታዊ ሓሳባት ወይ ስምዒታት ንምጽዋር ጥዑያት ሜላታት እፈልጥን እጥቀምን እዩ።				
1.8	People with mental health problems are all crazy. ናይ አእምሮ ጥዕና ጸገም ዘለዎም ሰባት ኩሎም ዕቡዳት እዮም።				
1.9	I feel I can depend on my community to help me cope with on-going challenges, stress, or worries. ቀጻሊ ጸገማትን፣ ጸቕጠን ሻቕሎትን ክአሊ ክሕግዘኒ ኣብ ማሕበረሰባይ ዝምረኮስ ኮይኑ ይስመዐኒ።				
1.10	A lot of people in this community are struggling with mental health issues. ብዙሓት ሰባት ኣብዚ ማሕበረሰብ ብናይ አእምሮ ጥዕና ኩነታት ይሳቀዩ ኣለዉ።				

Next, I want to ask you about things that might cause **stress in your life** right now.

ቀጺሉ፣ ሕጂ ኣብ **ሂወትካ ጸቕጢ** ከፈጥሩልካ ዝኸለሉ ነገራት ከተተካ ይደሊ እዮ።

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.

እዚ ናይ ቢኬሪ ስእሊ ንክትግዘካ ክትጥቀመሉ ትኽእል ኢኻ፣ ሙሉእ ቢኬሪ ቡዙሕ ጸቕጢ ዘሕድረልካ ዓብዩ ጸገም ኣሎ ማለት እዩ፣ ኣዞም ነገራት ሕጂ ኣብ ሂወትካ ክንደየናይ ዝኣክል ከበድቲ ምኹኖም ንገረኒ፣ ካብቲ ምንም ጸገም ናብ ኣስጋኢ ጸገም ብምስራዕ።



	How difficult is this in your life right now? እዚ ኣብ ሂወትካ/ኪ ኣብዚ ሕጂ ሰዓት መዓረ ክንደይ ከቢድ ምዃኑ ንገረኒ።	No problem at all ምንም ጸገም የለን	Minor problem ንእሽተይ ጸገም	Problem ጸገም	Very serious problem እዚዩ ኣስጋኢ ጸገም	Most stressful (select only one) ኣዞም ጸቕጢ ዝፈጥረልካ (ሓይ ጥራይ ምረጽ)
2.1	Getting food, shelter, or clothing ምግብ፣ ገዛ ወይ ከዳን ምርካብ					
2.2	Getting education or a job ትምህርቲ ወይ ስራሕ ምርካብ					
2.3	Illness, health, or disability ሕማም፣ ጥዕና ወይ ኣክል ምጉዳል					
2.4	Not having friends, family, or neighbors who can support you ክትግዘካ ዝኽእሉ እእሩኹቲ፣ ቤተሰብ ወይ ጎረቤት ዘይምህላው					
2.5	Adjusting to or dealing with life in the camp (including missing home and lifestyle) ምትዕርራይ ወይ ምእላይ ናብራ ምዓስከር (ገዛኻ ወይ ኣነባብራኻ ምንፋቕ)					
2.6	Worries about people back at home ብዛዕባ ኣብ ናይ ቀደም ገዛና ዘለዉ ሰባት ሻቕሎት					
2.7	Trying to leave the camp (for resettlement, moving home, etc.) ማዓስከር ንምግዳፍ ምፍታን (ናብ ካልኣይ ሃገር ንምኻድ፣ ገዛ ምቕያር ወዘተ)					
2.8	Domestic violence, threats, or conflicts in your household ዘቤታዊ ዓመጽ፣ ስግኣት ወይ ኣብ ገዛ ዝግበር ግጭት					
2.9	Violence, threats, or conflicts in the community ዓመጽ፣ ምፍርራሕ ወይ ኣብ ማሕበረ-ሰብ ዘሎ ግጭት					
2.10	Not knowing where my family or friends are right now ስድራይ ወይ ኣዕርኹተይ ኣበይ ክምዘለዉ ዘይምፍላጣይ					
2.11	Grief from the loss of loved ones ካብ ትፈተዎም ሰባት ምስኣን ዝመጸ ሓዘን					
2.12	Hopelessness or uncertainty about the future ተስፋ ዘይምህላው ወይ ብዛዕባ መጻኢ ርግጽኛ ዘይምኾን					

You told me that some of the things I just mentioned are problems for you.
ካብቶም ሓደ ሓደ ዝጠቀስኩዎም ነገራት ሓደ ሓዲኦም ጸገማትካ ምኽኛም ነገርካ ኢኻ/ኺ።

Review which items they said were the most serious problems.
እቶም ኣዝዮም ኣስገእቲ ጸገማት ዝበልዎም ነገራት ደጊምካ ዳህሲሶም

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

ካብዚኣቶም ኣብዚ ሕጂ ኣዝዩ ጸቕጢ ዝፈጥረልካ ኣየናይ እዩ?

Mark the corresponding tick box in table above.

ምስኡ ዝስማማዕ ኣብቲ ላዕሊ ዘሎ ናይ ምልክት መግቢሪ ሳንዱቅ ምልክት ግበር

2.14 Is there something else that I **haven't** mentioned that causes you the **most stress** right now?

ካልእ ዘይዘርዘርኩልካ ሕጂ እዘዩ ጸቕጢ ክገብረልካ ምኽንያት ዝኸውን ነገር ኣሎ ዶ?

- Yes (Specify)እወ (ግለጽ): _____
- No/ ኣይፋል

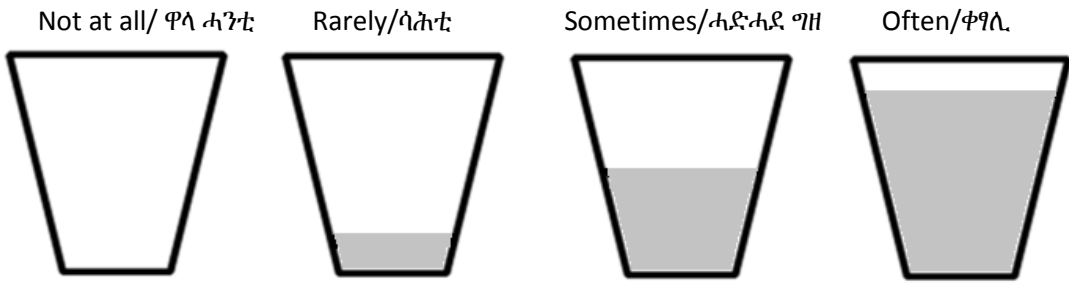
I would like to ask you how often you experience certain mental health **problems or symptoms**.

ክንደየናይ ዝኣክል ስነ ኣእምራዊ ናይ ጥዕና ፀገማት ወይከዓ ምልክታት ከምዘጋጥሙኹም ክሓተኩም ይፈቱ።

You can use the cups to help you again. The more full cups mean that you experience a problem more regularly.
ንክሕግዝኹም ምእንቲ ነዞም ብኬሪታት እውን ክትጥቀሙ ትኽእሉ ኢኹም። እቶም ቢኬሪታት ብጣዕሚ መሊኦም ማለት እቲ ፀገም ቀፃሊ ብተደጋጋሚ የጋጥመኩም እሎ ማለት እዩ።

Please think about how much these symptoms have bothered you during the past two weeks: not at all, rarely, sometimes, or often?

ብኸብረትኩም እቶም ምልክታት ኣብ ዝሓለፉ ክልተ ሰሙናት ክንደየናይ ዝኣክል ከምዘተሓሰብኹም ሕሰብሉ። ዋላ ሓንቲ፣ ሳሕቲ፣ ሓድሓደ ግዘ፣ ወይ መብዛሕቲኡ ግዘ ድዩ?



How much have these symptoms bothered you in the past two weeks? እዞም ምልክታት ኣብ ዝሓለፉ ክልተ ሰሙናት መዓረ ክንደይ ኣሸጊሩካ/ኪ ነይሩ?		Not at All ዋላ ሓንቲ	Rarely ሳሕቲ	Sometimes ሓድሓደ ግዘ	Often ቀፃሊ
3.1	Difficulty falling asleep or staying asleep? ድቃስ ምእባይ ወይ ነዊሕ ምድቃስ?				
3.2	Crying easily? ብዝጠቕምን ዘይጠቕምን ምብካይ?				
3.3	Feeling less interest in things that you used to enjoy? ቅድሚ ሕጂ ባህ ዘብሉኻ ዝነበሩ ነገራት ድሊት ምቕናስ?				
3.4	Having difficulty concentrating or focusing on your thoughts? ኣብ ሓደ ነገር ናይ ምድሃብ ወይድማ ኣብ ሓሳባትካ ምትኳር ዘይምኽኣል?				
3.5	Difficulty doing domestic work or income-generating activities? ናይ ገዛ ስራሕ ኣብ ምስራሕ ወይ ኣብ እቶት ናይ ዘምጽኡ ንጥፈታታት ኣብ ምስራሕ ምጽጋሚ ?				
3.6	Feelings of worthlessness? ዋጋ ከምዘይብልካ ወይ ናይ ባዶነት ስሞዒት?				

How much have these symptoms bothered you in the past two weeks? እዞም ምልክታት ኣብ ዝሓለፈ ክልተ ሰሙን መዓረ ክንደይ ኣሸጊሩካ/ኪ ነይሩ?		Not at All ቀላ ሓንቲ	Rarely ሳሕቲ	Sometimes ሓድሓደ ግዜ	Often ቀፃሊ
3.7	Thoughts it would be better to not be alive? ዘይምንባር(ሞት) ይሓይሽ ዝብል ኣተሓሳስባ? <i>If sometimes or often, follow protocol to discuss further.</i> <i>ሓድሓደ ግዜ ወይ ቀፃሊ እንተደኢሎም ዚያዳ ንክተዛርብዎም ነቲ ኣሰራርሓ ተኸተሉ</i>				
3.8	Feeling low in energy, slowed down? ሓይሊ ናይ ምጽንቃቕ፣ ምዝሕታል ስምዒት?				
3.9	I can't trust what I'm thinking because I don't know if it's real or not./ ይሓሰቦም ዘለኹ ሓሳባት ኣይኣምኖምን ምኽንያቱ ናይ ብሓቂ ድዩ ወይስ ኣይኮነን ዝብል ኣይፍለጥን ::				
3.10	I hear or see things that others do not hear or see. ካልኣት ሰባት ዘይርእይዎ ወይ ዘይሰምዖዎ ይርእን ይሰምዖን				
3.11	Others don't believe me when I tell them the things I see or hear. እቶም ዝርእይዎም ወይ ዝሰምዎም ነገራት ንካልኣት ክንግሮም ከለኹ ኣይኣምኑን				
3.12a	Do you feel <u>mental health</u> problems (like stress, depression, or anxiety) cause trouble with your daily functioning? ዕለታዊ ንጥፈታትካ ንክይተከናውን ፅልዋ ዝገበሩልካ ገለ ከም ፀቕጢ፣ ጭንቀት፣ ከቢድ ጭንቀት ዝበሉ ኣእምራዊ ናይ ጥዕና ፀገማት ኣለውኒ ዶ ኢልካ ትሓሰብ?				
3.12b	IF SOMETIMES OR OFTEN: እንድሕር ሓድሓደ ወይ መብዛሕትኡ ግዜ ኮይኑ What mental health problem causes the most trouble for you? እንታይ ዓይነት ናይ ኣእምሮ ጥዕና ጸገም እዩ ኣዚዩ ሽግር ዝፈጥረልካ ዘሎ?				
3.13	Do you feel <u>physical health</u> or medical problems cause trouble with your daily functioning? ዕለታዊ ንጥፈታትካ ንክይተከናውን ፅልዋ ዝገበረልካ ገለ ኣካላዊ ጥዕና ወይ ናይ ጥዕና ፀገም ኣለኒ ኢልካ ትሓሰብ ዶ ?				

3.14 How would you rate your mental health **overall**: very poor, poor, fair, good, or very good?
ኣእምራዊ ጥዕናኻ ብሓፈሻ ከመይ ትመዘኖ፣ ብጣዕሚ ትሑት፣ ትሑት፣ ደሓን፣ ፅቡቕ፣ ብጣዕሚ ፅቡቕ?

- Very poor ብጣዕሚ ትሑት
 Poor ትሑት
 Fair ማእኸላይ
 Good ፅቡቕ
 Very good ብጣዕሚ ፅቡቕ

3.15 Do you experience on-going or chronic pain in your body?
ቀፃሊ ዝኾነ ቃንዝ ወይ ሕዳር ሕማም ኣብ ኣካላትካ የጋጥመካ ኣሎ ዶ?

- Yes/አወ
 No /ኣይኣል

3.16 Have you ever had uncontrolled convulsions in your body that you can't remember (seizures)?
ክትዝከሮን ክትቆጸጸሮን ዘይትኸእል ናይ ምውዳቅን/ምንፍርፋርን ተጓንፎ ኣጋጣሚካ/ኪ ይፈልጥ ዶ?

- Yes/አወ
 No/ኣይኣል

On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions?
 ባህሪ ጭንቀት፣ ከቢደ ሓዘን አብ ዝሰመዓኩም መዓልቲ፣ ነቶም ስምዒታት ንምለላይ/ንምጽዋር እንታይ ትገብር?

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 them.
 ምናልባሽ ክትገብርዎም ብዛዕባ ትኽእል ሓድ ሓደ ነገራት ክንብበልካ እሞ ትገብርዎን እንተኾንካን፣ ዘይትገብርዎን እንተኾንካን ክትነግረኒ ኢኻ።

	On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions? ባህሪ ጭንቀት፣ ከቢደ ሓዘን አብ ዝሰመዓኩም መዓልቲ፣ ነቶም ስምዒታት ንምለላይ/ንምጽዋር እንታይ ትገብር?	Yes/አወ	No/አይፋል
4.1	Connecting with your family or friends to discuss your feelings ስምዒታትካ ንምዝራብ ምስ ስድራኻ ወይ መሓዘትካ ምርኻብ		
4.2	Do social or entertainment activities ማሕበራዊ ወይ መዘናግዒ ንጥፊታት ምስራሕ		
4.3	Sleep or stay in bed ድቃስ ምብዛሕ ወይ አብ ዓራት ምውዓል		
4.4	Do physical activities አካላዊ ንጥፊታት ምስራሕ		
4.5	Go to the hospital or clinic to see a doctor ናብ ሆስፒታል ወይ ክሊኒክ ኬድካ ብደክተር ምርእይ		
4.6	Pray, meditate, or do other spiritual activities ፀሎት ምግባር፣ እለምራዊ ተመስጦ ወይ ካልእት መንፈሳዊ ንጥፊታት ምዝውታር		
4.7	Use alcohol to help you forget አልኮላዊ መስተ ብምስታይ ንክትርስዎ ምፍታን		
4.8	Try to avoid seeing or talking to anyone ምስ ሰባት ንክትራኹብ ወይ ክትዘራረብ ዘይምድላይ		
4.9	Talk to a counselor, therapist, or other professional ንመማኸሪ ፣ንናይ ክንክን ባዓል ሞያ፣ወይ ካልእ ባዓል ሞያ ምዝራብ/ምክፋል		
4.10	Other: (Prompt: Is there anything else you do?) ካልእ፡(ካልእ ትገብር ነገር ኸ አሎ ዶ?)		

5.1 Do you feel that anyone in your household has mental health problems that cause trouble with their daily functioning? አብ ዝህኹም ዕለታዊ ንጥፊታቱ ንክክናውን ፅልዋ ዝገበረሉ ገለ ናይ አእምሮ ጥዕና ፀገም ዘለዎ ሰብ አሎ ዶ ኢልካ ትሓሰብ?

- Yes/አወ
- No/አይፋል

5.2 If yes: How many people? _____
 እወ እንተኢሉ፡ ክንደይ ሰባት?

Please tell me the age & gender of person 1: Age/ዕድሜ: _____
 ብኹብረትካ ናይቲ ሰብ ዕድሜን ስታን ዶ ክትነግረኒ?
 Male/ተባዕታይ
 Female /አነስታይ

Please tell me the age & gender of person 2: Age/ዕድሜ: _____
 ብኹብረትካ ናይቲ ሰብ ዕድሜን ስታን ዶ ክትነግረኒ?
 Male /ተባዕታይ
 Female /አነስታይ

Please tell me the age & gender of person 3: Age/ዕድሜ: _____
 ብኹብረትካ ናይቲ ሰብ ዕድሜን ስታን ዶ ክትነግረኒ?
 Male /ተባዕታይ
 Female /አነስታይ

During the last two weeks, was anyone in your household so distressed, disturbed, or upset that he or she: አብ ዝሓለፈ ክልተ ሰሙን ኣብ ዝሃዘ/ኹም ብምጭናቁ፣ብምርባሹ፣ ወይ ብምሕራቁ

		Yes እወ	No ኣይፋል	I don't know ኣይፈለጥኩን
5.3	Was completely inactive or almost completely inactive? ሙሉእ ብሙሉእ ፈዚዙ/ዛ ወይ ዳርጋ ፈዚዙ/ዛ ነይሩ/ራ ዶ?			
5.4	Was unable to carry out essential activities for daily living? ንመዓልታዊ ናብራ ዝኸውን ኣገዳሲ ስራሕ/ንጥፊት ክሰርሕ ኣይከኣለን/ኣይከኣለትን			
5.5	Was acting in a strange way or having fits, convulsions, or seizures? ፍሉይ ጠባይ ኣርእዩ ወይ ሃንደበት ምቁጣዕ፣ሃንደበት ዓመጽ ምግባር፣ ወይ ሃንደበት ናይ ምውዳቕ			
5.6	FOR CHILDREN HOUSEHOLD MEMBERS ONLY: ንቆልዑ ኣባላት ስድራ ዝኾኑ ጥራሕ If you have young children in your household, have they... Urinated at least two times in bed during sleep? ኣብ ስግራ-ቤትካ ኣናእሸቱ ቆልዑ እንተሃልዮም ኣብ ድቃስ እዋን እንተ ወሓደ ክልተ ግዜ ኣብ ዓራት ይሸይን ዶ?			
5.7	FOR ADOLESCENT AND ADULT HOUSEHOLD MEMBERS ONLY: ንዓባይትን ኣባጽሕን ኣባላት ስድራ ዝኾኑ ጥራሕ If you have adolescents r other adults in your household, have they... Stopped caring properly for his/her self?/ ኣብ ስግራ-ቤትካ ኣባጽሕ ወይ ካልኦት ዓባይቲ እንተሃልዮም ነብሱ ብኣግባቡ ክኣሊ ደው ኣቢሉ/ላ			

As I told you, I'm from an organization that focuses on helping torture survivors. **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?

ከምትዝነርግኹም፣ ንግድያት ግፍዒ ሓገዝ ኣብ ምሃብ ኣድሂቡ ካብ ዝሰርሕ ትካል እየ መጻኤ። ግፍዒ ማለት ከዓ ልዑል ዝኾነ ኣካላዊ ወይ ስነ-ኣእምራዊ ማህሰይቲ እንትኸውን ኮነ ተባሂሉ ኣብ ስልጣልን ብዘሎ ዝኾነ ኣካል ዝወርድ ቦደል እዩ። ብዛዕባ ግፍዒ ዝምልከት ሰለስተ ሕቶታት ኣለውኒ፡ ፡ እዞም ሕቶታት እንተሓተትኩኻ/ኺ ጸገም ኣለዎ ድዩ?

6.1 Have you ever been tortured?

ግፍዒ ወሪድካ ይፈልጥ ዶ?

- Yes/እወ
- No/ ኣይፋል

6.2 Has anyone in your family or household been tortured?

ኣብ ስድራኹም ወይ ዝኹም ገለ ግፍዒ ዝወረደ ሰብ ይህሉ ዶ?

- Yes/ እወ
- Not to my knowledge/ብዘኹ ኣይፈለጥን

6.3 Do you think that many people in this community have been tortured?

ኣብዚ ማሕበረሰብ ውሽጢ ብዙሓት ዝተበደሉ/ግፍዒ ዝወረደም ሰባት ኣለው ዶ ኢልካ ትሓሰብ?

- Yes/እወ
- No/ ኣይፋል
- I don't know/ኣይፈለጥኩን

The next section is about **services** that are available to people in this community right now.
እቲ ዝቐጽል ክፋል ኣብዚ ሕጂ እዋን ነዚ ናይዚ ማሕበረ-ሰብ ህዝቢ ዘለው ኣግልግሎታት ዝምልከት እዩ።

7.1 Do you know of any group, organization, or agency where you can go to receive mental health or psychosocial support services in Adi Harush / Mai Ayni?

ዝኾነ ጉጁለ፣ትካል ወይ ሓገዝ ወሃቢ ትካል ኣእምሮ ጥዕና ወይከና ስነ-ኣእምሮ-ዊን ማሕበራዊን ግልጋሎት ሓገዝ ክትረኽቡሉ እትኽእል ኣብ ዓዲ ሓሩሽ/ማይ ዓይኒ ትፈልጥ/ጢ ዶ?

- Yes እወ
- No ኣይፋል

7.2 If yes: Have you ever received mental health or psychosocial support services here?

መልሲ እወ እንተኾይኑ፡- እዞም ናይ ኣእምሮ ጥዕና ወይ ስነ-ኣእምሮ-ዊን ማሕበራዊን ግልጋሎታት ረኺብካ ትፈልጥ/ጢ ዶ?

- Yes እወ
- No ኣይፋል

7.3 If yes: From which organization? Don't read options. Select all that apply.

መልሲ እወ እንተኾይኑ፡- ካበ'የናይ ትካል? እቶም ኣማረጽቲ ኣይተንብቡሎም ኢኻ። መልሲ ክኸውን ዝኽእል ምረጽ።

- CVT/ሲ.ቪ.ቲ
- DRC/ዲ.አር.ሲ
- JRS/ጆ.አር.ኤስ
- IRC/ኢይ.አር.ሲ
- MSF/ኤም.ኤስ.ኤፍ
- ARRA/ኣ.ሪ
- Other: ካልእ፡- _____

7.4 If no: Why not? Don't read options. Select all that apply.

መልሲ ኣይፋል እንተኾይኑ፡-ሰለምንታይ ዘይኮነ? እቶም ኣማረጽቲ ኣይተንብቡሎም ኢኻ። ኩሎም ዝጥቀሙሎም ምረጽ።

- I've never needed or wanted these services
ነዞም ግልጋሎታት እዚእም ብፍጹም ድልየት ወይከና ምንየት ብፍጹም የብለይን።
- They are too far away
ኣመና ርሕቕ ዝበሉ እዮም።
- I'm afraid of what my neighbors or relatives would think or say
ጎረባብተይ ወይከና ኣዝማደይ እንታይ ከምዝሓስቡ ወይ ከምዝዛረቡ ይፈርሕ እዮ።
- I tried to get services, but they didn't select me, give me anything, etc.
ግልጋሎት ንምርካብ ፈቲነ ገይረ ነይረ ነገር ግን ክመርጹኒ ኣይክእሉን፤ ዝኾነ ነገር ኣይሃቡንን ወዘተ...
- Other: ካልእ፡- _____

7.5 Have you ever heard of the Center for Victims of Trauma (CVT) before today?

ቅድሚ ሎመዓንቲ ብዛዕባ ማእኸል ግዳያት ስነ-ኣእምሮ-ዊ ስቃይ/ሰንብራት(ሲ.ቪ.ቲ) ሰሚዕኻ/ኺ ትፈልጥ ዶ ?

- Yes እወ
- No ኣይፋል

7.6 If yes: How did you know about CVT? እንድሕር እወ ኮይኑ፡- ከመይ ገይረካ ብዛዕባ ሲ.ቪ.ቲ ፈሊጥካ?

Don't read options. Select all that apply. መማረጺ መልስታት ኣይተንብብ፡ ኩሎም መልሲ ክኸውን ዝኽእል ምረጽ

- I heard others in the community talking about it/ኣብቲ ማሕበረ-ሰብ ካልኣት ሰባት ብዛዕባ ክዛረቡ ሰሚዐ
- I went to a community event or outreach by CVT/ሲ.ቪ.ቲ ዝገበሮ ኣብ ናይ ማሕበረ-ሰብ ምብጻሕ/ፍጻመ ከይደ ነይረ
- One of my family or friends received services from CVT/
ሓደ ካብ ናይ ስድራይ ኣባል ወይ ሙሓዛ ናይ ሲ.ቪ.ቲ ኣገልግሎት ረኺቡ ነይሩ
- I received counseling services from CVT/ኣብ ሲ.ቪ.ቲ ናይ ምኽርን ማዕዳን ኣገልግሎት ረኺብ ነይረ
- Other: ካልኣትን _____

Finally, I have a few **basic questions about you**.

ኣብ መወዳእታ፤ ብዛዕባኻ ዝተወሰኑ መሰረታዊ ሕቶታት ኣለውኒ።

8.1 How old are you? *If respondent is unsure, assist them in making the best estimate possible.*
ክንደይ ዕድመኻ ? እቲ መልሲ ወሃባይ ርገጻኛ እንድሕር ዘይኮነ ክንድዝክአል ዝበለጸ ንኸግምት ሓግዞ።

_____ years/ዓመት

8.2 What languages do you speak and understand comfortably? *Select all that apply.*
እንታይ ቋንቋታት ትዛረብን ከምኡ እውን ብጽቡቕ ትርዳእ? መልሲ ክኸው ዝኸ እል ምረጽ።

- Tigrinya/ትግርኛ
- Saho/ሳሆ
- Amharic/አምሓርኛ
- English/እንግሊዝኛ
- Arabic/ዓረብኛ
- Tigre/ትግረ
- Other: ካልእ _____
- Other: ካልእ _____

8.3 How many people live in your household right now, not counting yourself?
ንባዕልኻ እንተይ ቆጸርካ ኣብዙ ሕጂ ኣዋን ክንደይ ዝኣኸሉ ሰባት ኣብ ስድራ-ቤት/ገዛ ይነብሩ ኣለው?

_____ people/ ሰባት

8.4 What is your home country?
መብቆል ሃገርካ ኣበይ እዩ?

- Eritrea/ኤርትራ
- Other: /ካልእ _____

8.5 What levels of education have you completed? *Select all that apply.*
ክንደይ ደረጃ ትምህርቲ ኢኻ ወዲእኻ? መልሲ ክኸው ዝኸእል ምረጽ።

- No education / less than primary/ትምህርቲ የብሉን/ላን /ትሕቲ መባእታዊ ደረጃ
- Primary/መባእታዊ ደረጃ
- Secondary/ካልኣይ ደረጃ
- Technical/ቴክኒካዊ
- Post-secondary, university, graduate school/ድሕሪ ካልኣይ ደረጃ፣ ዩኒቨርሲቲ፣ ድሕሪ-ምረቃ

8.6 How long have you been in your current camp?
ኣብ ዓዲ-ሓሩሽ/ ማይ-ዓይኒ ክንደይ ዝኣኸል ጸኒሕኻ?

_____ Years/ዓመታት _____ Months/ኣዋርሕ

Time finished: _____ AM / PM
ዝተወደእሉ ሰዓት ቅድሚ ቀትሪ/ ድሕሪ ቀትሪ