



The  
CENTER for  
VICTIMS of  
TORTURE

# Assessing Mental Health in Kalobeyei:

A Representative Survey of Refugees and Host Communities



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A Representative Survey of Refugees and Host Communities**

**The Center for Victims of Torture**

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The Center for Victims of Torture (CVT) carried out a mental health assessment of refugee and host community residents in Kalobeyei, Kenya, in January and February 2018. CVT conducted a representative survey (N=633) of adult populations in Kalobeyei refugee settlement and Kalobeyei and Lonyuduk host community sub-locations. The goal was to understand the needs and perspectives of refugees and host community members in order to inform mental health and psychosocial support (MHPSS) service providers and other stakeholders in designing interventions responsive and proportional to the needs of the populations. Our findings include: positive attitudes about mental health; reliance on social support to deal with mental health challenges; mental health concerns ranked highly among daily problems for refugees; comparable symptom levels between refugees and host communities; high levels of functional difficulties among refugees; utilization of religious and spiritual coping strategies; high prevalence of primary torture survivors; and moderate awareness of available services. This report includes an overview of the context, data collection methodology, descriptive findings, and key conclusions.

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## Rationale

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Understanding mental health needs of individuals and communities who have experienced torture, war, and other types of violence or human rights abuses is fundamental to the success of any mental health or other intervention with these populations. There can be severe psychological effects of past traumas from loss of loved ones, being subjected to 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 the 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.<sup>1</sup> 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 researchers 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.

Another contribution of this data is to contrast mental health issues among two communities with different histories of and vulnerabilities to future conflict or violence: first, refugees recently settled in a host country after fleeing civil wars and persecution; and second, rural communities struggling with high poverty and recent histories of conflict over livestock and land. Considering different populations, such as these, shed light on the complex types of relationships that may emerge between war, violence, forced migration, poverty, and mental health.

This assessment is part of CVT's response to this information gap. CVT carried out a similar survey in Kenya in 2016 and Ethiopia in 2017, with plans to replicate similar surveys in the coming year in several additional locations. These surveys use rigorous social scientific

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<sup>1</sup> 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.

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 needs shift over time and place. By using comparable questionnaires, we are building a global dataset of refugee (and host community) 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 may help the humanitarian sector design and prioritize effective responses, including advocating for resources.

This survey and report use a holistic and interdisciplinary conceptualization of mental health. Mental health includes emotional, psychological, and social well-being. A diverse range of factors are intertwined with and can affect mental health, including how the body responds to or affects thoughts and feelings. This mind-body connection is central to CVT's understanding of mental health. This survey includes physiotherapy (physical therapy) components as a key part of a mental health assessment.

## Context

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Kakuma refugee camp, located near Kakuma town in the Turkana West District of Kenya, has been in existence since 1992 and has hosted refugees from many neighboring countries. One of the world's largest and most diverse camps, at the time of this survey, Kakuma camp was hosting 185,449 refugees from 19 countries. The largest populations are South Sudanese (about 106,000) and Somali (about 35,000), followed by Congolese, Ethiopian, Burundian, Sudanese, and Ugandan refugees and asylum seekers.<sup>2</sup>

These populations are fleeing civil wars, situations of intensifying mass human rights violations, protracted conflicts, and persistent political or social persecution. Kakuma is also receiving many residents who have been relocated from Dadaab as part of the Kenyan government's effort to move towards the closing of that camp; since announcing that target, minority communities from Dadaab have been increasingly relocated to Kakuma. While these inflows continued, Kakuma's four sprawling camps were at or above full capacity, prompting consideration of where and how to expand to meet the continuing need. Thus, UNHCR begun promoting "alternatives to camps" in Kakuma, as in other similar situations.



Photo by S. Golden

Kakuma camps are located in one of the poorest regions in Kenya, where the local Turkana population depends on livestock and limited subsistence agriculture. It is a region that

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<sup>2</sup> UNHCR Kakuma. 31 January 2018. "Kakuma and Kalobeyei Population Statistics by Country of Origin, Sex and Age Group." Available at: <https://data2.unhcr.org/en/documents/details/61821>, accessed 20 July 2018.

has seen cycles of widespread violence, as the proliferation of small arms, breakdown of state control, and militarized social norms have increased the stakes of cattle raiding at the intersection of Kenya, Uganda, and South Sudan.<sup>3</sup> There has been a complex relationship between refugees and Turkana at Kakuma, including a framing that sees one another each as the violent “other,” occasional eruptions of violence, and increases in psychosocial stress of the host community due to the presence of refugees.<sup>4</sup> Because of this, UNHCR and humanitarian partners have allocated resources to support the host communities and promote peaceful coexistence between refugees and the local population.

Kalobeyei settlement is one attempted response to these issues. Located about 20 kilometers northwest of Kakuma along the Lodwar-Kakuma-Lokichoggio paved road, Kalobeyei is a 14-year project, begun in June 2016, to promote more sustainable solutions to the refugee crises in the region. The vision of Kalobeyei is a “major paradigm shift,” to integrate refugees and members of the host community into a hybrid settlement, a planned urban center.<sup>5</sup> The hope is that this will allow greater autonomy and self-sufficiency for refugees and promote parallel developments for the local Kenyan population, in the meantime promoting social cohesion and interdependence among the two populations. Since 2016, the population of Kalobeyei has increased exponentially to nearly 40,000 people at the time of this survey in early 2018. The goal is for the settlement to integrate 60,000 refugees and 20,000 members of the Turkana host community.

Any successful service provision effort in or around Kalobeyei settlement must account for the needs of both refugee populations and the host community residents. This assessment included surveys with both populations, providing data that can aid in tailoring interventions to be responsive to the unique needs found in both contexts.

### *The Center for Victims of Torture (CVT) in Kalobeyei*

The Center for Victims of Torture (CVT) began a program in Kalobeyei in 2017. Over multiple assessments from 2014 to 2016, CVT found MHPSS services in Kakuma were minimal and insufficient to meet perceived needs. Reactionary psychosocial services were often developed with few resources after organizations observed beneficiaries unable to utilize the primary services offered by their organization, due to unaddressed mental or psychosocial problems. Cases of severe mental health dysfunction overwhelmed such organizations and their capacity to provide assistance to highly traumatized beneficiaries was extremely limited. As the camp populations reached capacity and new refugees continued to arrive, the impact of the lack of MHPSS support on the service sector and also on camp cohesion and stability was felt among refugees and service providers. Since CVT’s first visit to Kakuma in early 2014, interest in

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<sup>3</sup> See, for example: Leff, Jonah. 2009. “Pastoralists at War: Violence and Security in the Kenya-Sudan-Uganda Border Region.” *International Journal of Conflict and Violence* 3 (2): 188–203. See also: Osamba, Joshua O. 2000. “The Sociology of Insecurity: Cattle Rustling and Banditry in North Western Kenya.” *African Journal on Conflict Resolution* 1 (2): 11–38.

<sup>4</sup> Vemuru, Varalakshmi, Rahul Oka, Rieti Gengo, and Gettler. 2016. “Refugee Impacts on Turkana Hosts: A Social Impact Analysis for Kakuma Town and Refugee Camp, Turkana County, Kenya.” Washington, DC: The International Bank for Reconstruction and Development / The World Bank Group. <https://openknowledge.worldbank.org/bitstream/handle/10986/25863/111309.pdf?sequence=5&isAllowed=y>, last accessed 20 July 2018.

<sup>5</sup> UNHCR. “Kalobeyei Settlement.” Available at: <http://www.unhcr.org/ke/kalobeyei-settlement>, last accessed 20 July 2018.

strengthening mental health services in Kakuma has grown among service providers, UNHCR, and other agencies.

CVT carried out the first representative survey of mental health and related needs among Kalobeyei refugee and host community populations in November 2016 (N=323). A report summarizing key findings is available upon request. Survey findings suggested key opportunities



Photo by M. Kamau

or strengths could be found in low levels of stigma surrounding mental health, strong social support among refugees, and positive strategies to cope with emotional struggles. The data also suggested a high need for trauma-sensitive services, as over half of the populations were likely to be in need of rehabilitation support. There were also very high rates of reported torture and suicidal thoughts among refugees and the host community, providing evidence of high needs that can be used to advocate for effective interventions. These findings strengthened the call for increased MHPSS service provision.

Beginning in 2017, CVT's program in Kalobeyei provides specialized mental health services to trauma survivors, with an objective to serve both refugee and host community populations. CVT is providing stabilization services through offering Psychological First Aid (PFA) to individuals unable to function in their daily lives. CVT clients are offered trauma rehabilitation services through group or

individual counseling<sup>6</sup> and physiotherapy.<sup>7</sup> CVT staff also receive intensive professional capacity building, including training and clinical supervision, to develop their skills to provide specialized trauma counseling and physiotherapy services. To develop services that are accepted by and responsive to affected communities, CVT has formed a community advisory group to offer feedback and guidance.

CVT is also committed to the regular collection of representative population data. The first survey provided valuable feedback to strengthen the design of methodology and tools for the second round. Now, after having carried out two similar surveys, CVT has developed a methodology that is replicable and feasible in this context, and plans to re-administer the survey on a regular basis. These representative data allow stakeholders to understand mental health issues, needs, and resources among refugees and host communities, including identifying prevalence rates and factors associated with increased vulnerabilities. Replicating surveys can also allow nuanced analysis of how the mental health needs shift over time, especially as the two populations move increasingly towards an integrated settlement. This can help CVT and the broader humanitarian sector in Kalobeyei design and prioritize effective responses and advocate for resources.

<sup>6</sup> The group counseling approach is outlined in a manual, "Restoring Hope and Dignity," available to download here: <https://www.cvt.org/group-counseling-manual>.

<sup>7</sup> Physiotherapy components, such as pain, sleep, and functional mobility, are assessed to determine the need for a physiotherapy intervention. Not all clients receive physiotherapy.

We conducted the 2018 survey prior to the start of intensive client services. This fieldwork served the additional purpose of raising widespread awareness of CVT and available trauma-related services. Teams of interviewers walked down every street in Kalobeyei settlement and many paths within local villages. In the settlement, in particular, many people heard about CVT for the first time during the course of the survey. Interview teams had continual opportunities to introduce themselves and the organization in the community, to the survey respondents as well as their neighbors and families.

## Sampling Methodology

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CVT conducted interviews with a sample of individuals (N=633) who are representative of the adult populations of Kalobeyei refugee settlement (N=487) and Kalobeyei and Lonyuduk host community sub-locations (N=146). Although large segments of these populations are minors, they were excluded from data collection due to ethical restrictions on research with minors, particularly highly vulnerable minors and highly sensitive topic areas. Data collection was completed from January 27 to February 8, 2018.

The January 2018 population of Kalobeyei refugee settlement was 38,363, with 34 percent age 18 or above.<sup>8</sup> According to the UNHCR field office, there were about 8,900 households. Our sample included about 3.7 percent of the adults and 5.5 percent of the households in Kalobeyei refugee settlement. We used a geographic interval-based sampling method in the refugee settlement.

The population of Kalobeyei and Lonyuduk sub-locations<sup>9</sup> was 8,379 at the time of the survey, with an estimated 46 percent age 18 or above.<sup>10</sup> By this estimation, our sample included approximately 3.8 percent of the adult population of these sub-locations.<sup>11</sup> We

consulted with area leaders and chiefs to generate a list of villages and approximate populations; they identified three villages in Lonyuduk and 24 villages in Kalobeyei sub-location.



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<sup>8</sup> UNHCR. 21 January 2018. "Kalobeyei Settlement Population Statistics by Country of Origin, Sex and Age Group." UNHCR Kakuma.

<sup>9</sup> We considered including additional nearby sub-locations, such as Morungole, Nadapal, and Lopur. However, some of these areas were challenging to access in terms of geographic dispersion and permissions, so we limited the scope of coverage for the host community survey to the sub-locations most immediately surrounding Kalobeyei refugee settlement. These were the same sub-locations included in CVT's 2016 survey.

<sup>10</sup> We were not able to locate demographic population distributions by sub-location. The total population of Turkana county, according to the 2009 census, was 855,399 and 389,343 people were age 18 or above (45.5%). See: Kenya National Bureau of Statistics. "Single and Grouped Ages in Years by County and District." Available at <https://www.knbs.or.ke/census-2009/>, last accessed 20 July 2018.

<sup>11</sup> Although these were the most accurate population figures available, the current population was likely to have been lower. During fieldwork, our teams found many host community residents had migrated in search of food or water or to care for livestock. This population is semi-pastoralist.



Villages were the primary sampling unit for a cluster sampling methodology. The first stage of sampling was proportional random selection of villages within the sub-locations; 15 of 27 villages were selected for inclusion.<sup>12</sup>

Our contact rate was 61 percent in the refugee settlement, due primarily to households we found empty, and 85 percent in the host communities, where neighbors often aided in locating residents who were not at home. Our cooperation rate was 77 percent in the refugee settlement and 98 percent in the host communities. Within the settlement, this rate was heavily affected by selected respondents who were eligible and willing to participate, but were unable to do so due to not having language capacities to complete the interview. Despite our efforts to prevent this by hiring a diverse team of interviewers, adopting creative fieldwork strategies to respond the respondents' languages spoken, and adjusting the analyses with weights to match the population distribution on country of origin, this remains a limitation of our survey, and a challenge for any future data collection in Kalobeyei. Our refusal rate for eligible respondents who were available but chose not to participate was 0.5 percent for refugees and 1.1 percent for host communities.<sup>13</sup>

### *Household Selection for Refugee Sample*

Kalobeyei refugee settlement is divided into three villages, with populations ranging from about



10,000 to 15,000 residents. Villages are further divided into neighborhoods, and neighborhoods are divided into compounds. Each compound has numbered households, some with multiple dwelling structures. For the 2016 survey, CVT was able to obtain current occupancy levels for these units and use a proportional cluster methodology to select

Photo by S. Golden

<sup>12</sup> The steps used to apply selection proportional to size are outlined here: [http://www.who.int/tb/advisory\\_bodies/impact\\_measurement\\_taskforce/meetings/prevalence\\_survey/psws\\_probabilty\\_prop\\_size\\_bierrenbach.pdf](http://www.who.int/tb/advisory_bodies/impact_measurement_taskforce/meetings/prevalence_survey/psws_probabilty_prop_size_bierrenbach.pdf), last accessed 20 July 2018.

<sup>13</sup> Response rates were calculated using the American Association for Public Opinion Research Response Rate Calculator. Version 4 is available here: <http://www.aapor.org/Education-Resources/For-Researchers/Poll-Survey-FAQ/Response-Rates-An-Overview.aspx>, last accessed 20 July 2018. Included in non-eligible respondents were minor-only households (102 in refugee sample and 3 in host sample) and households with no individual of the required gender (206 in refugee sample and 12 in host sample). Unknown eligibility included selected households that were empty or locked (356 in refugee sample and 16 in host sample) and a small number (25 in refugee sample) 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 (17 in refugee sample and 11 in host sample); the selected individual refused to participate (5 in refugee sample and 2 in host sample); the selected individual did not speak an interview language (138 in refugee sample); and other reasons (2 in refugee sample and one in host sample). Accounting for all these factors, and including an estimate for what proportion of cases of unknown eligibility would have actually been eligible, the response rate was 54 percent in the refugee sample and 84 percent in the host community sample.

neighborhoods for inclusion. For this iteration, comparable statistics were not available. We adopted an interval selection approach to cover the entire geographic area of Kalobeyei settlement.

Teams received assigned starting points each day, based on distribution of teams throughout the settlement and moving teams to areas where they had not worked previously. In some areas where it was known that a particular language group was common, we assigned a team with interviewers who could conduct interviews in that language. At their assigned starting points, team supervisors drew numbers to identify the first household, selecting from the assigned sampling interval.

We estimated a sampling interval of ten households to ensure coverage of the entire settlement during the fieldwork period, based on estimated levels of productivity of the teams, rates of minor-headed households, proportion of households likely to be empty, not fit the gender quota, would not be available, would not speak a survey language, and would refuse to participate. These estimates were adjusted to fit observed rates halfway through the fieldwork, and teams began using an interval of 15 households. Interview teams identified households, some of which included more than one dwelling structure, through utilization of local knowledge and conversations with residents of the area.

After conducting a successful interview, a team proceeded according to the 10 or 15 household interval. After an unsuccessful interview attempt at a selected household, for any reason, a team moved to the adjacent household. Teams used tracking sheets and maps to note areas of coverage and ensure no area of the settlement was excluded.

#### *Household Selection for Host Community Sample*

Teams were assigned to the selected villages, described above. Upon arrival, a team selected a central starting point and interviewers moved in opposite directions using an interval method to select dwellings. In more populated areas, the four interviewers could move from the central location in four distinct directions. In more dispersed villages, teams relied more on local knowledge and creativity to distribute interviewers in relevant directions and ensure full coverage of the village.

Due to the low population size, the sampling interval was set at three households. The geographic boundaries and exact populations were not known, particularly with seasonal variation in semi-nomadic pastoralist communities. Teams were to complete a maximum of ten interviews in an assigned village. To select their first household, an interviewer would draw a random number from three and count from their starting point. After a successful interview, they would proceed with the three household interval. If they failed to complete an interview for any reason, they would move to the next household.



Photo by S. Golden

### *Individual Selection*

For both samples, within a selected household, adult individuals were selected randomly, without replacement, and with adherence to a balanced gender quota. Interviewers were assigned identification numbers; those with odd identification numbers did their first interview each day with a man, and those with even numbers started with a woman. Thereafter, they alternated respondent gender throughout the day. They drew numbers to select the participant from all eligible potential respondents (all adult residents of the required gender who live in the household). Identified individuals participated in a consent process and decided if they would like to participate.

Language considerations were central to this process. In some areas or households, it was clear which language would be necessary and the team assigned an interviewer able to speak the language prior to individual selection (to adhere to gender criteria). Often, there was language variation among household members. Thus, after an individual was identified and their language abilities were known, the team occasionally reassigned interviewers as needed. Supervisors and coordinators were also aware of other nearby teams and the languages spoken by their interviewers, allowing some coordination and transfer of interviewers to meet the language needs of as many identified respondents as possible.<sup>14</sup>

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

### *Weighting*

The data for the refugee sample presented in this report is weighted to adjust to population proportions for each of the three villages in Kalobeyei refugee settlement. Within each village, we weight for characteristics available from UNHCR: gender, country of origin, and age category (18-59 and 60+ only).<sup>15</sup> The sample did not deviate dramatically from population proportions, but weighting adjusts for the presence of minority groups and helps address the challenge of some non-response due to not having required language abilities on interview teams. All descriptive analyses are conducted with weighted data,<sup>16</sup> to adjust the samples to match population characteristics.

Because demographic population data were not available for the host community sub-locations, we present unweighted data for this sample. Due to the smaller sample size and the inability to compare the sample to the population demographics, findings from the host community sample should be interpreted more tentatively.

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<sup>14</sup> Occasionally, we utilized “interpreters” to aid in particularly difficult situations. This was often in the form of a younger family member or community member serving as a de facto interpreter for a respondent who only spoke a more rare language and none of the survey languages. The teams never pressured respondents to accept this scenario, but in some cases it was preferable to skipping the respondent altogether.

<sup>15</sup> UNHCR Kakuma. 21 January 2018. “Kalobeyei Settlement Population Statistics by Country of Origin, Sex and Age Group.”

<sup>16</sup> Except for on village residence, gender, country of origin, and age, the variables used in the creation of the weight. For these variables, the 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 Fieldwork

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Fieldwork was carried out by six teams, each with four enumerators<sup>17</sup> and one supervisor; host community teams also had a community guide. Four teams were assigned to the refugee settlement and two teams to the host community villages. CVT clinical and research staff provided supervision and support across teams. Data collection was completed in about seven days from January 27 to February 8, 2018.<sup>18</sup> Interview teams in the refugee settlement conducted an average of about 18 interviews per day; teams in the host communities conducted an average of about 19 interviews per day.

Host community interviewers and guides were all members of the local community, speaking English and Turkana, and most speaking Kiswahili. Refugee sample interviewers all spoke English, as well as a range of other languages: Kiswahili (9), Arabic (6), French (5), Lotuko (4), Oromo (3), Didinga (2), Kirundi (2), Anyuak (2), Somali (1), Lopit (1), Kiswa (1), Pari (1), Lingala (1), Boya (1), and Acho-Dinka (1). Team supervisors generally spoke English and Kiswahili. Ensuring language coverage was one of the most difficult parts of planning this



Photo by P. Traspas

survey, and an area that would benefit from continued refinement.<sup>19</sup>

About 45 percent of the interviewers and team supervisors were CVT staff, and 18 percent had worked with CVT on the 2016 survey. Remaining team members were identified through advertising the position and also seeking referrals from partners.

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<sup>17</sup> Four enumerators planned per team, though teams varied on a daily basis from three to six interviewers.

<sup>18</sup> We planned five full days of data collection. Host community teams completed planned sample ahead of schedule, whereas the refugee settlement teams faced challenges that decreased expected productivity. The host community teams finished after three and a half days of fieldwork, and team members able to speak at least one other survey language were assigned to assist with the survey in the refugee settlement. At the end of five days in the refugee settlement, a few geographic areas were not yet covered. Smaller teams of CVT staff only completed data collection during the following week.

<sup>19</sup> It was difficult to plan the necessary languages among the team for a range of reasons. First, statistics are not available about languages spoken by refugees. UNHCR does track country of origin for residents, but there is substantial linguistic variation within countries of origin. The perceptions of key informants and/or residents about the proportion of the population who speaks a particular language are often significantly skewed or inaccurate. Second, the sheer number of languages spoken is challenging, particularly with the lack of a reliable lingua franca. Even if it were possible to convene a team of interviewers able to speak all languages in the settlement, it would be impossible to distribute the teams in such a way to ensure the one interviewer who speaks a particular language is available at the needed time and place. Third, CVT was relying on its own staff to be core members of the survey team. The staff are in part hired with language diversity in mind, but they are also hired for their qualifications to provide services. Thus, we were immediately somewhat limited in our ability to compile a survey team with sufficient language diversity.

The coordination teams included research and evaluation staff from CVT's headquarters and Nairobi office. Each coordination team also had clinical support provided by experienced CVT psychotherapists. 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 received an additional half day training to discuss sampling methodology in greater depth, team management, and geographic strategy. The non-CVT staff received an additional half day training prior to the full training, which included a more thorough introduction to mental health concepts. The team had varied levels of exposure to mental health and to this type of survey interview methodology, thus requiring ongoing monitoring and feedback after the initial training.

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

## Questionnaire Description

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The questionnaire was designed to be a brief assessment of mental health perspectives and needs. The content was modeled after CVT's previous surveys in Kalobeyei and Ethiopia. The questionnaire collects data about attitudes about mental health, current stressors, psychological and physical symptom areas, coping mechanisms, household mental health problems, torture, access to services, and demographics. Almost all items are close-ended questions, with opportunities to specify an "other" response.

Interviews were conducted in person, in or around respondents' homes, using paper and pencil questionnaires. On average, it took about 30 minutes to administer the 9-page questionnaire. The English questionnaire is attached to this report. The questionnaire was available in English, Arabic, Swahili, Turkana, Oromo, Lotuko, and Anyuak; enumerators also spoke additional languages. Translation was completed over a three day period, with teams of translators completing first round translations, blind back translations, and consultations to resolve points of misunderstanding or disagreement.

Interviewers explained to respondents that some questions were 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 31 percent of refugee respondents and 14 percent of Kenyan respondents actively preferred or allowed their family members or others to be present during the interview. The informed consent process included introducing CVT, explaining the purpose of the questionnaire, clarifying how the respondent was selected, and emphasizing that the purpose was only to collect information, not provide any service. Before consenting, the participant was told that some of the questions may be upsetting or stressful, that their information would be kept private, their participation was voluntary, and they could stop at any time. The participants' names were not recorded.

### *Knowledge and Attitudes*

The first ten items 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.<sup>20</sup>

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

### *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 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.<sup>21</sup> There are a few items asked only of Kenyan or refugee samples. 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 one 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.

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<sup>20</sup> Several of the questions are closely adapted from knowledge and attitude questions on CVT's client assessment forms, allowing comparability with CVT clients.

<sup>21</sup> 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).

## 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 and physical health needs among the populations. This



Photo by M. Kamau

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, ranging from “not at all” to “often.”

Eight questions focus on psychological symptoms, modeled on the eight items of the Self-Reporting Questionnaire (SRQ-8).<sup>22</sup> 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. These symptoms can indicate post-traumatic stress, depression, and anxiety.

There are three holistic ratings which provide additional indicators of severity of symptoms. Respondents are asked: if mental health problems interfere with their functioning; if physical health problems interfere with functioning; and to rate their mental health overall. These questions are used clinically to evaluate the short-term needs of an individual. Finally, respondents are asked if they experience chronic pain, and those who do are asked to rate their pain on a 0 to 10 scale.

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

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<sup>22</sup> 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.

### *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 can 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.

### *Torture*

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

### *Access to Services*

This section asks about services that are available and assesses respondents’ ability to or interest in accessing services. Structured as a series of skip patterns and follow up questions, respondents are asked if they know of any services available, if they have ever received such services, from which agency they received services, or why they have not received services. This information is



valuable in mapping the sector and establishing the interest in services. We ask about MHPSS services and then a parallel series about services for mobility or pain issues. Respondents are also



asked if they had heard of CVT before today. This question helps inform CVT’s specific response and programming, in addition to the survey’s broader objective to inform the wider sector’s humanitarian response.

### *Demographics*

Finally, the questionnaire includes demographic information: age, languages spoken, household size, home country, level of education, and time in the current community. We also recorded some information not asked of the respondent: duration of interview, respondent gender, location of interview, language of interview, date, 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 Nairobi office, where data entry staff entered data electronically. The research team cleaned and analyzed data using SPSS.

## **Psychological Support**

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

In the consent process, 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. 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.

### **Follow-up Protocol Response Options**

- Emergency response:** Respondent is in extreme distress and requires immediate intervention  
*Notify supervisor / clinical support to get CVT staff to come to household immediately*
- Referral:**
  - Respondent was given information about available services
  - Respondent needs to be connected with referral partner
  - Respondent needs to be referred for CVT services
- 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

The exception to this was if the interviewer observed or heard from a respondent that they were experiencing significant distress throughout the interview.

We had several follow up options for respondents experiencing some degree of distress, explained below. These options were listed on the first page of the questionnaire; after completing the questionnaire, the interviewer indicated any response that had been required. Overall, immediate support was required significantly more often among refugee respondents.

### *Emergency Response*

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

### *Referrals*

In training the interview teams, we reinforced that the survey was not designed as outreach or to screen for CVT beneficiaries. However, for respondents exhibiting particularly severe or immediate needs, we established referral protocols to connect them with appropriate service providers, including referring them to appropriate partner organizations or referring them to CVT's rehabilitation services. Interviewers referred 34 refugee respondents and 2 host community respondents to partner organizations. In the refugee settlement, 59 respondents were referred for CVT services, and one host community respondent. CVT staff made plans to follow up with these people and screen them for criteria to begin CVT services. We also had an option to provide information about available services to respondents, without making a direct referral; overall, interviewers gave information about services to about 13 percent of respondents.

### *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.<sup>23</sup>

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 judgements about when to refer to the clinical teams that were on standby to provide additional more comprehensive PFA support. The abbreviated version of PFA that we provided focused on PFA action principles, taking into consideration the very short training time, to quickly equip enumerators to respond and assist in a humane, supportive, and practical way to any respondent experiencing heightened stress during or at the end of the survey. Interviewers administered PFA in about nine percent of refugee interviews and three percent of host community interviews.

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<sup>23</sup> 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 indicator to use the protocol 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 102 refugee respondents and 14 host community respondents who reported sometimes or often having suicidal thoughts.

## **Demographic Characteristics**

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We conducted about three-quarters of our interviews in the refugee settlement, reflecting the larger population size, the emphasis of CVT programming, and the high heterogeneity of the population. Our samples were both roughly gender balanced. Refugee respondents were younger, on average, than host community respondents. Most refugees were from South Sudan, with substantial minorities from Ethiopia, Burundi, and the Democratic Republic of Congo. Nearly all host community respondents spoke Turkana, with a few comfortable in Kiswahili or English. Among refugees, the largest proportion of respondents spoke English or Arabic; just under a quarter spoke Kiswahili and Lotuko.

### **Key Characteristics of Survey Respondents**

	<b>Refugee<sup>24</sup></b>	<b>Kenyan</b>	<b>Combined</b>
<b>Sample size</b>	487	146	633
Kalobeyei Village 1	163		
Kalobeyei Village 2	185		
Kalobeyei Village 3	139		
Kalobeyei Sub-location <sup>25</sup>		125	
Lonyuduk Sub-location		20	
<b>Women (valid %)</b>	51	53	52
<b>Age</b>			
Mean	30	43	33
Range	18-70	18-92	18-92

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<sup>24</sup> For the refugee sample, unweighted data are presented for variables used to create the weight (village, gender, age, home country); all remaining data are weighted.

<sup>25</sup> Sub-location and village is missing for one host community respondent.

### Key Characteristics of Survey Respondents (continued)

	Refugee	Kenyan	Combined
<b>Home country (valid %)</b>			
Kenya		100	
South Sudan	65		
Ethiopia	16		
Burundi	10		
DRC	8		
Uganda	<1		
Rwanda	<1		
Sudan	<1		
<b>Languages spoken (valid %, not mutually exclusive categories)<sup>26</sup></b>			
English	44	3	34
Arabic (typically Juba Arabic)	42	0	32
Turkana	1	97	24
Kiswahili	24	8	20
Lotuko	21	0	16
Kirundi	11	0	9
Anyuak	10	0	8
Didinga	9	1	7
Somali	9	0	7
Bari	8	0	6
Amharic	5	0	4
French	4	0	3
Kinyarwanda	3	0	2
Dinka	3	0	2
Acholi	3	0	2
Lopit	2	0	1
Oromo	1	0	1
Lokoya	1	0	<1
Congolese	1	0	<1
Toposa	1	0	<1
<b>Household size (not including respondent)</b>			
Mean	5.3	6.5	5.6
Range	0-15	2-17	0-17

<sup>26</sup> There was a large degree of language diversity among refugees. Minority languages reported by less than 1% of refugee respondents include: Bembe, Buya, Imurok, Kakwa, Karamojong, Kifulero, Kinande, Kinyamulenge, Lango, Luganda, Luo, Mabaan, Murle, Nuer, Rufumbira, Shilluk, Talinge, and Tennen.

### Key Characteristics of Survey Respondents (continued)

	Refugee	Kenyan	Combined
<b>Completed levels of education (valid %)</b>			
No education	37	89	49
Primary	57	8	45
Secondary	20	3	16
<b>Time in current community<sup>27</sup></b>			
Range	1-20 months	0-92 years	
Mean	11.8 months	21.7 years	

Respondents in both samples reported large household sizes, with a mean of over five people, in addition to the respondent. Refugee respondents had more education than those in the host community. Nearly 90 percent of Kenyan respondents had less than a primary education, compared to 37 percent of refugees; one-fifth of refugees reported completing secondary education. Finally, refugee respondents had been in Kalobeyei for about a year, on average, compared to host community respondents, who had been in their villages for an average of over 20 years.

There were a few shifts from CVT's 2016 survey. Among refugees, respondents in 2018 are more likely to speak English (20 percent in 2016 to 44 percent in 2018), have larger households (4.0 to 5.3 members), and have been in their current community longer (3 months to nearly 12 months).

### Knowledge and Attitudes about Mental Health

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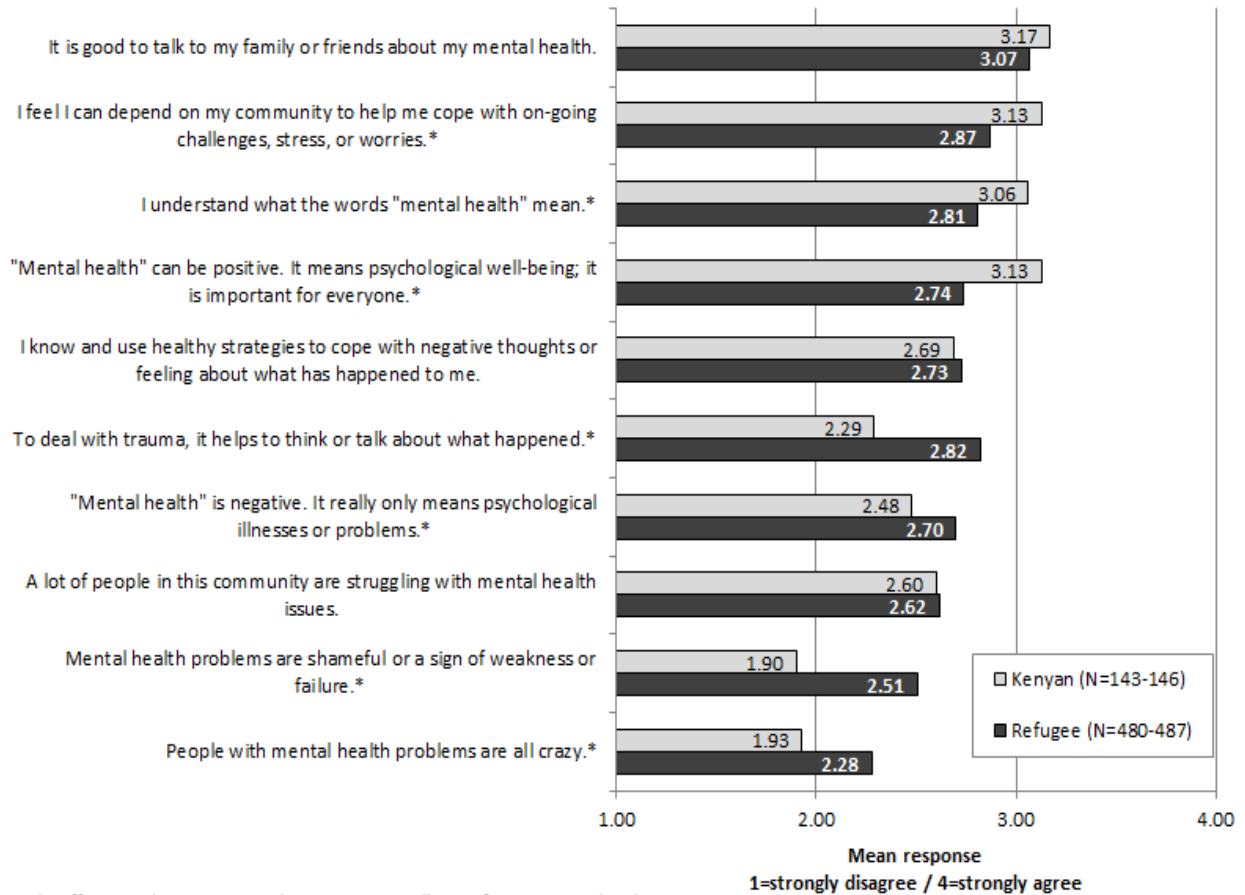
Respondents had generally positive attitudes about mental health. They were most likely to agree with the survey's positive statements and more likely to disagree with the most negative, stigmatizing statements. Overall, respondents most strongly agreed with statements about utilizing or relying upon social support to deal with mental health challenges.

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<sup>27</sup> Kalobeyei settlement began about 20 months before this survey. Some refugee respondents had been in other Kakuma camps for longer than 20 months.

## Knowledge & Attitudes about Mental Health: Mean Scores by Sample

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

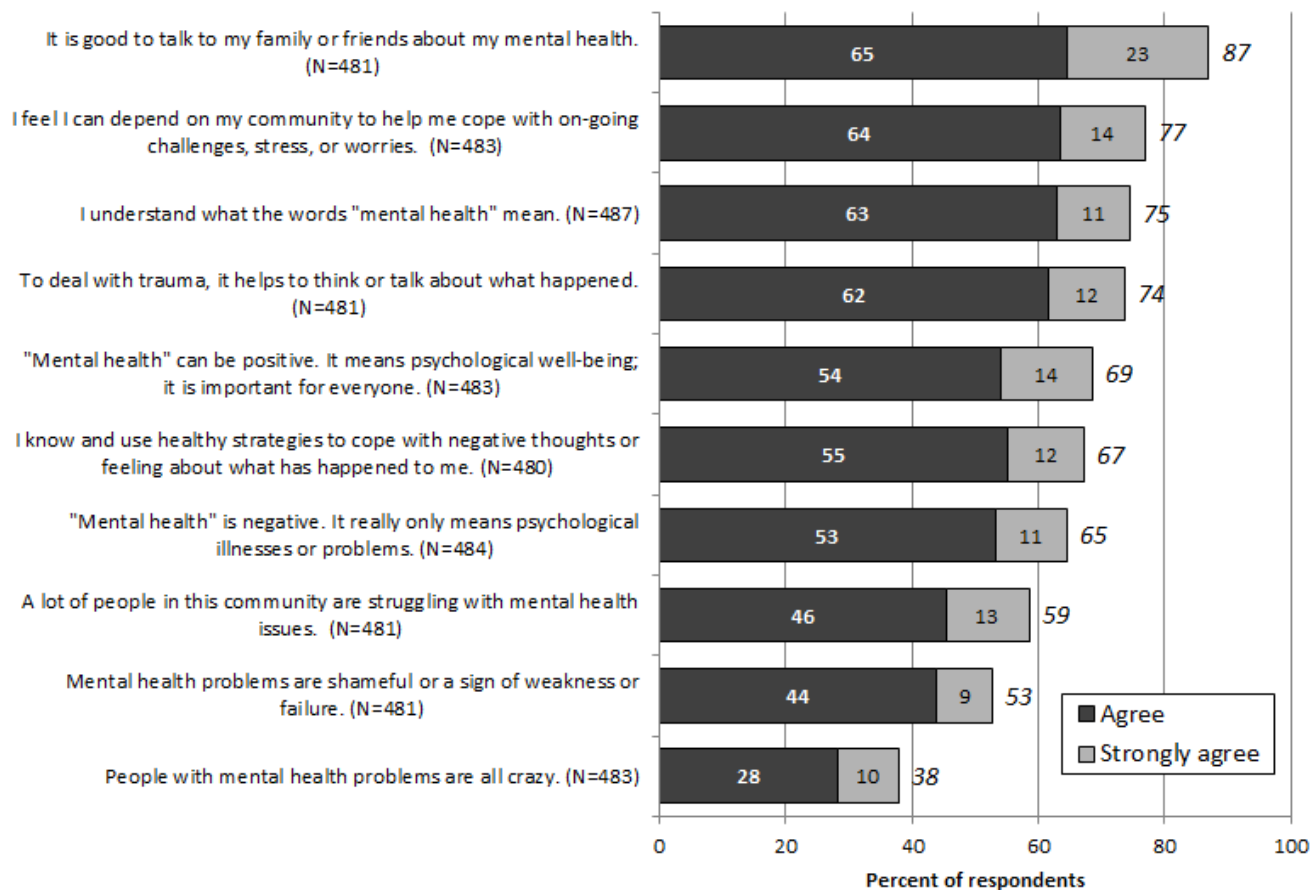


There were statistically significant differences between refugee and host community respondents. Refugee respondents more strongly agreed that thinking or talking about traumatic experiences is helpful. On the other hand, there is evidence that host community members may have more positive attitudes about mental health, reflected in stronger agreement with framing mental health as “psychological well-being” and stronger disagreement with associating mental health problems with shame, weakness, failure, or being “crazy.”

The figure below disaggregates respondents who agree or strongly agree with each statement among the refugee sample. A strong majority agree that it is helpful to talk with others about their mental health. While the negative statements fall to the bottom, on average, there are still 38 percent of respondents who agree that “people with mental health problems are all crazy” and over half agree that “mental health problems are shameful or a sign of weakness or failure.”

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

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



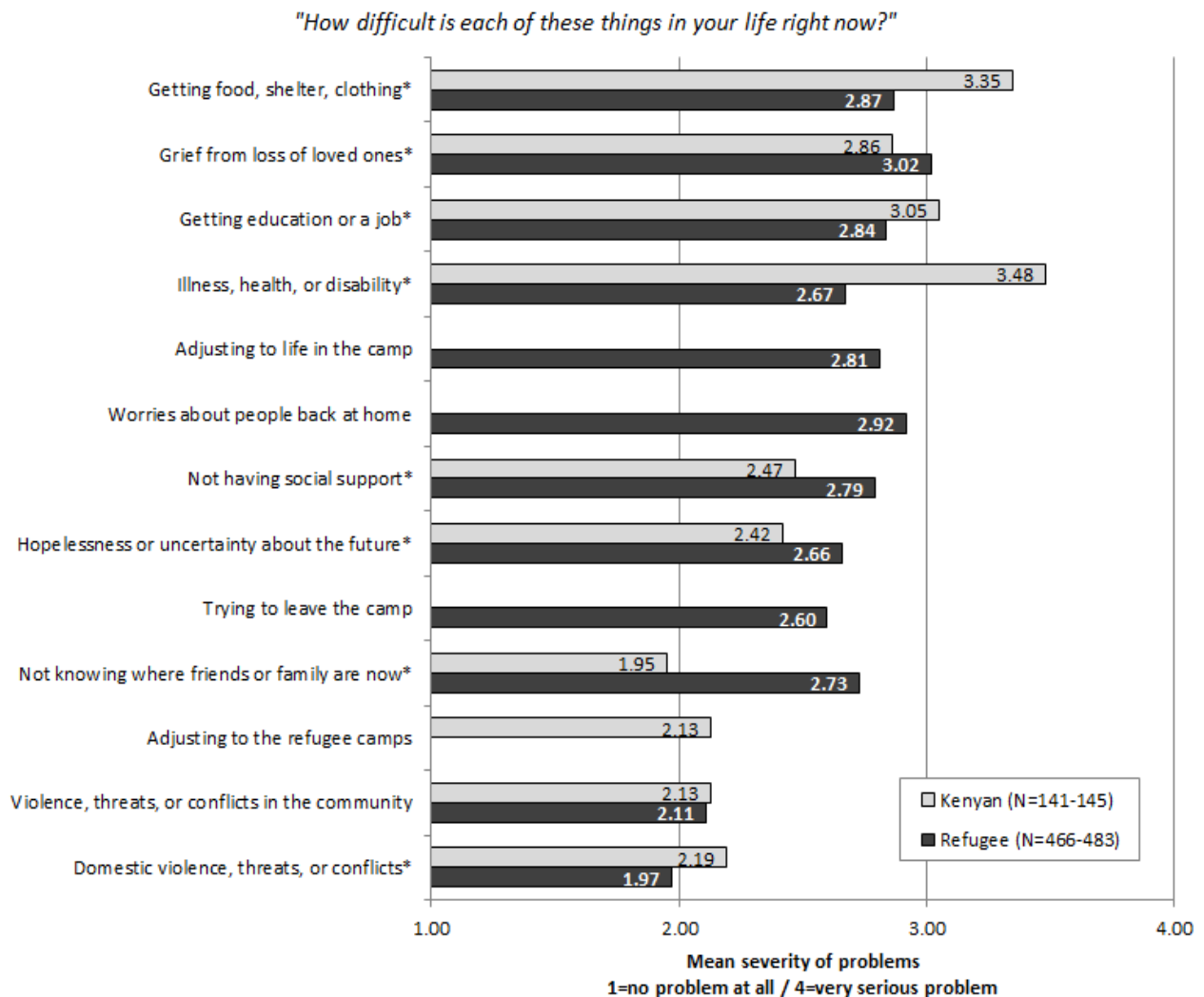
There are some significant differences between men and women. Refugee men are more likely to say they understand what “mental health” means (82 percent, compared to 69 percent of refugee women) and that it helps to think or talk about traumatic experiences (80 percent, compared to 69 percent of women). On the other hand, refugee women were more likely to believe that mental health problems are shameful (57 percent, compared to 48 percent of refugee men).

Overall attitudes about mental health seem to be positive. This can be drawn upon as a resource for community mobilization and to encourage individuals to access services. Particularly, there seems to be a willingness to draw upon social support in the form of family, friends, and community in order to cope with mental health problems; service providers may utilize this willingness and craft interventions that integrate individual healing and existing social support networks. Despite this positive picture, there is still substantial variation in attitudes. There are pockets of the population where stigma towards mental health is strong, suggesting the need for targeted outreach and education strategies.

## Ongoing Stressors

Across refugee and host community populations, the problems most commonly reported by respondents in their daily lives were: getting food, shelter, and clothing; grief from losing their loved ones; and getting a job or education. However, there were noticeable divergences between the two samples. The Kenyan sample more often reported basic necessities and physical health challenges as problems they face; they also more often reported domestic violence as a problem in their life. The refugees were more likely to report problems related to loss of their loved ones, lack of social support, hopelessness about the future, and ambiguity about the whereabouts of their families. Several items were asked only of refugees pertaining to life in the camp, worrying about people at home, and struggles with resettlement or repatriation.

### Current Problems: Mean Scores by Sample



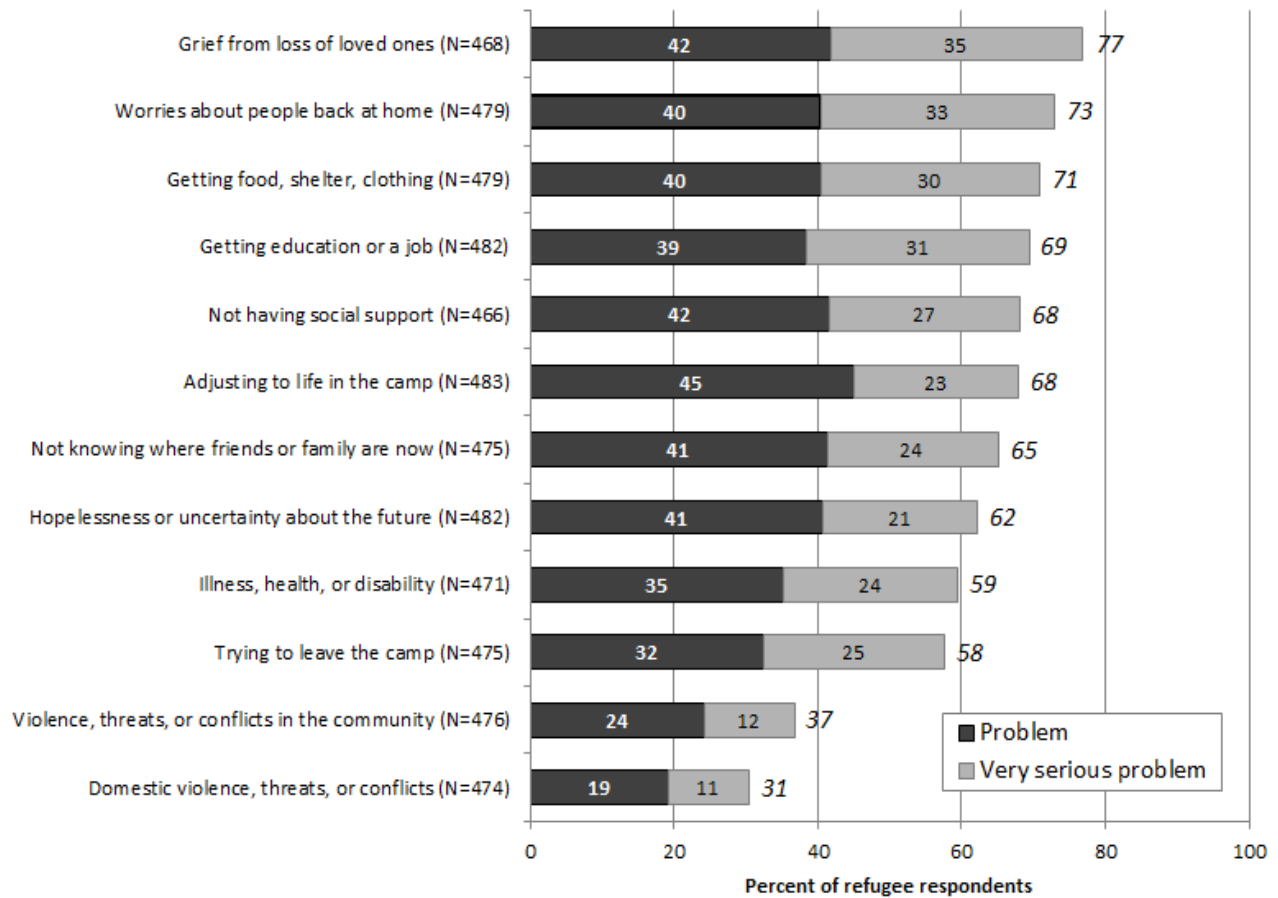
\* Differences between samples are statistically significant at 0.10-level.



Among refugees, the most frequently reported problem is grief, suggesting a strong need for mental health support. More respondents ranked grief and worries about people at home as problems in their life than did those who reported problems of basic necessities, like food, shelter, and livelihoods. Well over half reported lack of social support, adjustment to camp life, ambiguous loss, and hopelessness as current problems in their life. Over a third reported that community violence is a problem, and just under a third reported violence in their own households.

### Current Problems for Refugees: Respondents who Select "Problem" or "Very Serious Problem"

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

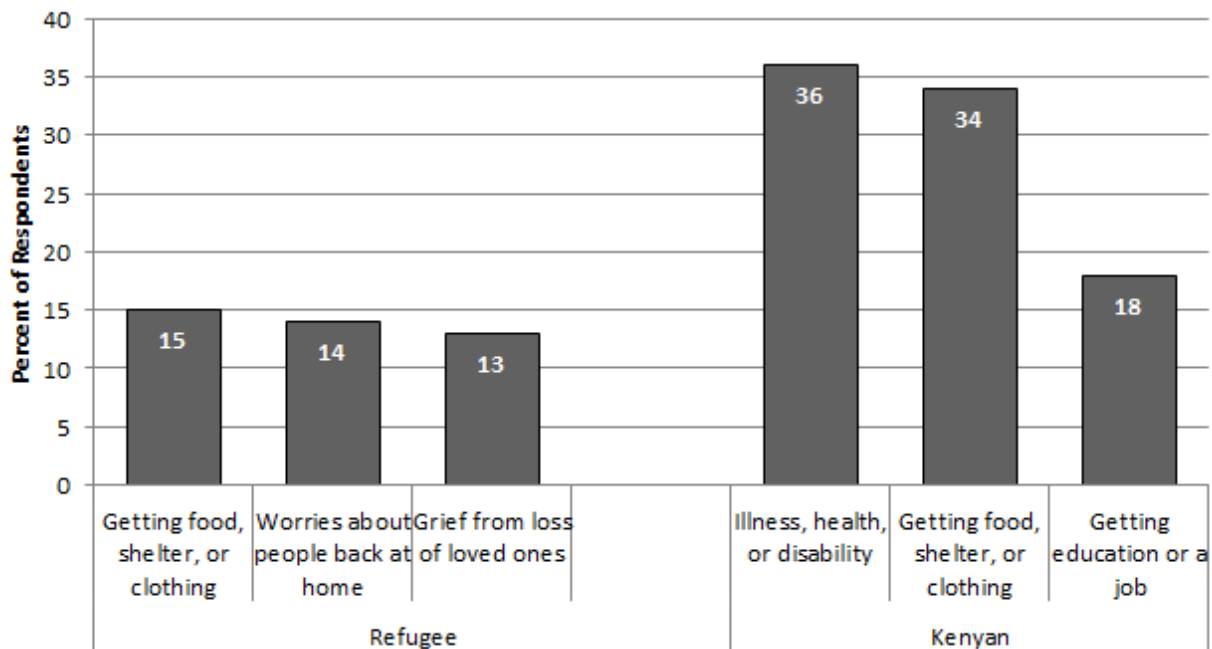


After ranking to what extent each issue is a problem in their life currently, respondents selected just one problem that is causing them the most stress. Host community respondents experience the most stress from physical health challenges, providing for basic necessities, and meeting livelihood concerns. Refugees reported a more diverse range of major stressors, with the most often selected responses being around food and shelter, worries about home, and grief from loss.

In the 2016 iteration of the survey, refugees reported similar stressors, but also included hopelessness about the future and not knowing the whereabouts of their friends at family near the top of their lists of problems. Among the host community, the most significant stressors reported in 2016 were consistent with what was reported in 2018, although grief from loss of loved ones was also included in their top stressors.

## Most Significant Stressors

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



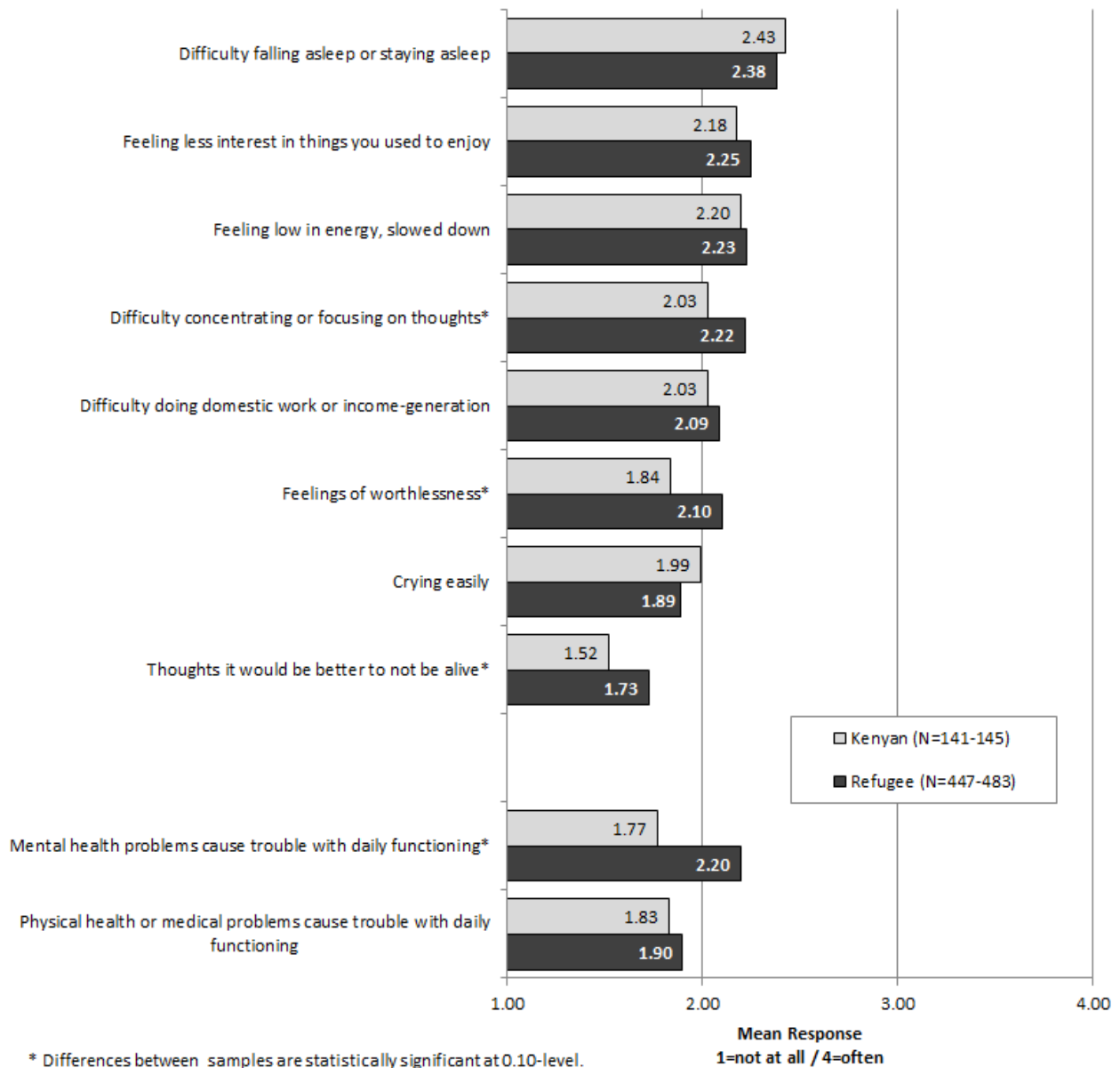
There were very few differences by gender on daily stressors. However, men were significantly more likely than women to share feeling hopelessness about the future is a “very serious problem” in their life; 27 percent of refugee men, compared to 17 percent of refugee women, and 25 percent of Kenyan men, compared to 13 percent of Kenyan women. Perhaps surprisingly, men and women reported domestic violence as a problem or very serious problem in their lives at approximately similar rates: 31 percent of refugee men, 31 percent of refugee women. In fact, refugee men were slightly more likely than women to rank domestic violence as “very serious.” Among the Kenyan respondents, 29 percent of men and 36 percent of women reported it as a problem or serious problem, a statistically significant, though not particularly large, gender gap.

## Mental Health Problems and Symptoms

Respondents were asked how frequently they experienced eight symptoms in the past two weeks. These symptoms are behavioral indicators of depression, and can also indicate PTSD. The most commonly reported symptoms were sleep difficulties, loss of interest and enjoyment, and low levels of energy.

### Symptom Areas: Mean Scores by Sample

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



Across many symptom areas, refugees and host community samples showed similar patterns, though refugees were more likely to report frequent difficulty focusing their thoughts and feelings of worthlessness. Suicidal thoughts were the least commonly reported symptom, but were significantly more common among refugees. Overall, the mean score on all eight items is 2.1 for refugee respondents and 2.0 for Kenyan respondents.<sup>28</sup> This indicates that, on average, respondents reported experiencing these symptoms “rarely” in the past two weeks.

One approach to evaluate the severity of the symptoms reported across this refugee population is to compare symptom levels to those of existing CVT clients. To become a client, individuals complete a screening process that assesses symptoms and functioning. At intake assessment, CVT clients in Dadaab have a mean score of 2.9 on these eight symptoms. The mean score for refugee survey respondents in Kalobeyi is 2.1. Survey respondents in Kalobeyi are representative of the entire population, so we would expect their mean to be lower (indicating less frequent symptoms) than those of CVT clients. Among refugee survey respondents, 27 percent have a mean that is at or above one standard deviation below the mean in Dadaab.<sup>29</sup> In the host community sample, 15 percent fall in this range of symptoms.<sup>30</sup> This is one indicator of what proportion of the Kalobeyi population may have symptoms consistent with a need for intensive mental health support.

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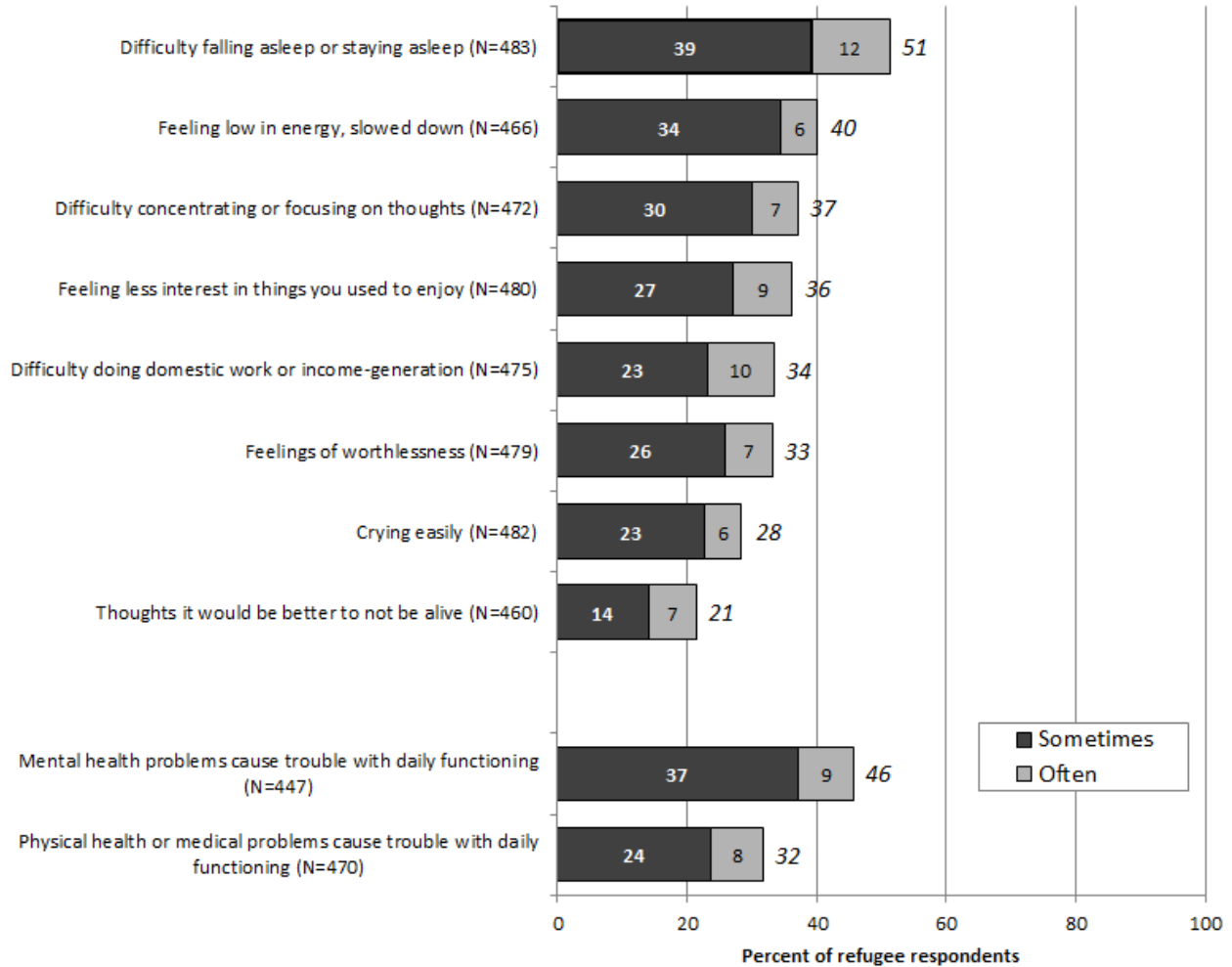
<sup>28</sup> These mean scores are a bit lower than in the 2016 survey. At that time, the mean for both samples was 2.3.

<sup>29</sup> Mean scores at intake in Dadaab range from 1.25-4.00, mean 2.94, SD 0.45. A cut-point one SD below the mean is 2.49; just 14% of Dadaab clients fall below that point at intake. The Kalobeyi refugee sample has mean scores from 1.00-3.88, mean 2.11, SD 0.59. If we apply the cut-point of 2.49 to the Kalobeyi refugee sample, 73% of respondents fall below, suggesting population symptom levels substantially lower than the typical CVT client at intake. Twenty-seven percent had a mean of 2.49 or above, indicating those with symptoms consistent with CVT clients in Dadaab. We compare to Dadaab clients because it is also a camp-based population of refugees, from similar countries of origin, although of course there are some notable differences that may affect mental health symptoms.

<sup>30</sup> For the host community sample, mean scores on the eight symptom items range from 1.25-3.38, mean 2.03, SD 0.43. There are 85% of respondents with means below the Dadaab cut-point of 2.49, suggesting about 15% of Kenyan respondents would have symptoms comparable to those reported by CVT clients at intake in Dadaab.

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

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



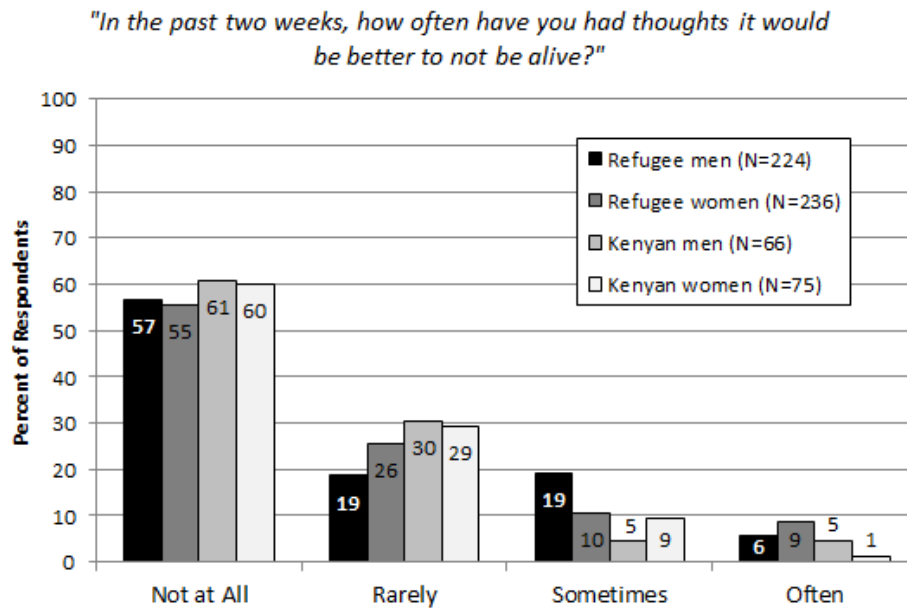
Just over half of the refugee sample and 44 percent of host community respondents reported sometimes or often struggling to sleep in the past two weeks. Sleep difficulties were the most commonly reported symptom for both samples. Interventions that focus on improving sleep are likely to have an immediate impact on beneficiaries' lives.

Although comparatively less common than other symptoms, 21 percent of refugee respondents and 10 percent of Kenyan respondents reported having thoughts at least sometimes in the past two weeks that it would be better if they were not alive.<sup>31</sup> Refugee men were more likely than women to report suicidal thoughts.<sup>32</sup> This subset of both populations are particularly high risk and likely to be in need of mental health support.

<sup>31</sup> In CVT's 2016 survey, 32 percent of the refugee sample and 23 percent of the host community sample reported sometimes or often having suicidal thoughts. It is unclear why this proportion was lower in 2018.

<sup>32</sup> There were no major, consistent gender differences in symptom levels. Among both samples, women were significantly more likely to report crying easily, perhaps suggesting a cultural acceptability for women to express themselves in this way. Refugee men were also more likely than refugee women to report decreased interest in activities.

## Suicidal Thoughts by Sample



Although many individuals may experience symptoms of mental health problems, often these are moderate enough that people are able to draw upon their existing coping resources to maintain functionality in daily life. In the refugee sample, however, many respondents were struggling with daily functioning. Nearly half (46 percent) reported that mental health problems were severe enough to have caused trouble with their daily functioning in the past two weeks, and 32 percent reported the same about physical health or medical problems. This is cause for significant concern, particularly as resources are invested in peacebuilding initiatives, livelihood programs, or many other areas that depend on the active participation of affected communities. These data help 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 challenges in their lives and maintain functional abilities.

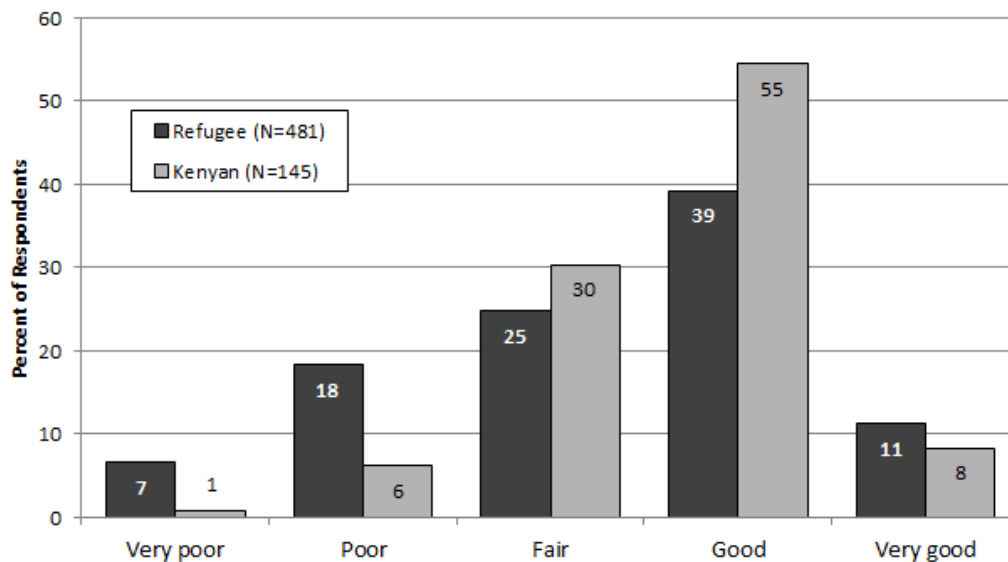
Kenyan respondents were less likely to feel that their functioning was impaired; 17 percent said they sometimes or often struggled with functioning due to mental health problems and 18 percent reported the same due to physical health problems. This may indicate that coping resources are less well developed among populations who are displaced from their homes, compared to populations facing similar symptoms but with the resources of their home community available to them.

Some refugees may be in immediate need of stabilization services or interventions, such as Psychological First Aid (PFA). One way to estimate those in need of stabilization would be to identify those reporting serious trouble adjusting to life in the camp and those who report impaired functioning. Twenty-two percent reported that adjusting to life in Kalobeyei was a “very serious problem” for them, and 46 percent (as noted above) have difficulty functioning. Among refugee respondents, 14 percent fell into both of these categories, and 54 percent fit at least one of these criteria.

In the combined sample, about 53 percent of respondents ranked their mental health as good or very good, and 47 percent said their overall mental health was fair, poor, or very poor. Refugees were more likely to report poor mental health, while Kenyan respondents were more likely to report good mental health.

### Overall Mental Health by Sample\*

*"How would you rate your mental health overall?"*

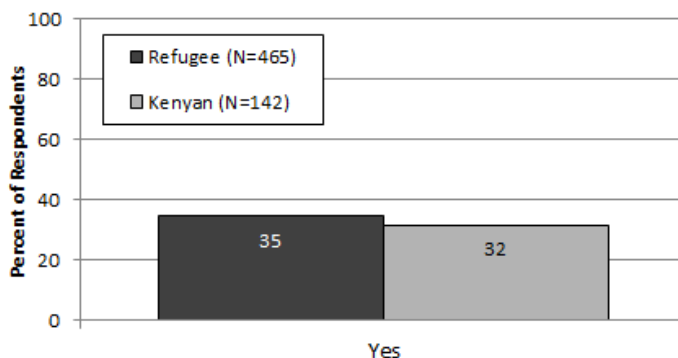


\* Differences between samples are statistically significant at 0.10-level.

Compared to mental health problems, fewer respondents reported that physical health or medical problems cause trouble in their current daily functioning. Some physical functional difficulties may be attributable to chronic pain; 35 percent of refugee respondents and 32 percent of Kenyan respondents 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. Those who reported chronic pain were asked to rate how much pain they felt in the past week overall, on a 10 point scale where 0 is no pain at all and 10 is the worst possible pain. Among refugees, the mean response was 4.7 and among Kenyans the mean was 5.0.<sup>33</sup>

### Chronic Pain by Sample

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



<sup>33</sup> This difference is not statistically significant.

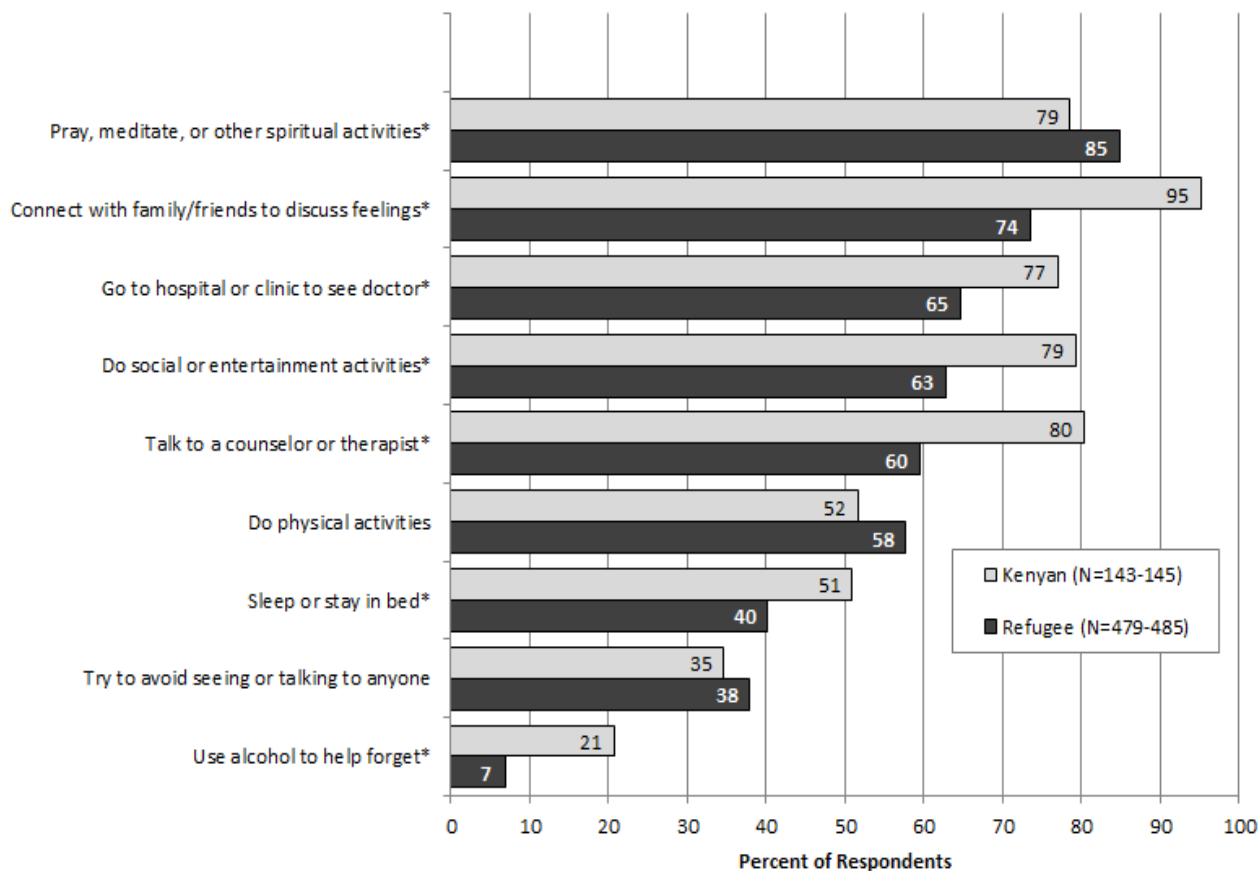
## Coping Strategies

Respondents reported a range of coping strategies that they use to deal with difficult emotions, such as feeling sad, anxious, or overwhelmed. Most respondents (a combined sample total of 83 percent) reported that they turn to spiritual activities to help them cope. A strong majority rely on social support, by connecting with their family or friends to talk about their feelings or struggles; nearly all host community respondents reported doing this. Many respondents also said they visit a hospital or clinic. Nearly two-thirds (60 percent among refugees and fully 80 percent among Kenyan respondents) say that they turn to a counselor or therapist for help, suggesting a need for further explanation or consultation.

Our list included a few generally unhealthy coping strategies, which were reported comparatively far less often. Some respondents reported avoidance strategies, such as not seeing anyone or staying in bed. A minority (10 percent overall, more common in the host community) reported using alcohol to help cope with difficult emotions.

### Coping Strategies by Sample

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





Among refugees, men are more likely than women to turn to social or entertainment activities and physical activities. Refugee men and women were equally (7 percent) likely to report using alcohol, whereas Kenyan men were more likely (27 percent) than women (16 percent) to report that they use alcohol to cope with difficult emotions.

Older respondents are more likely to rely on family and friends to talk about their feelings and to report talking to a counselor. Younger respondents are more likely to rely on physical activities and spiritual activities.

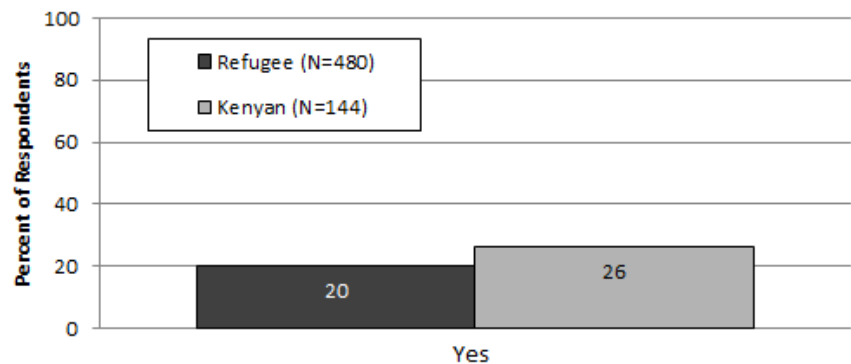
## Household Mental Health

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Overall, 22 percent of respondents said they have a household member whose mental health problems interfere with their daily functioning. Most of these respondents (68 percent) said it was just one person or two people (22 percent), and about 35 percent described someone under age 18.

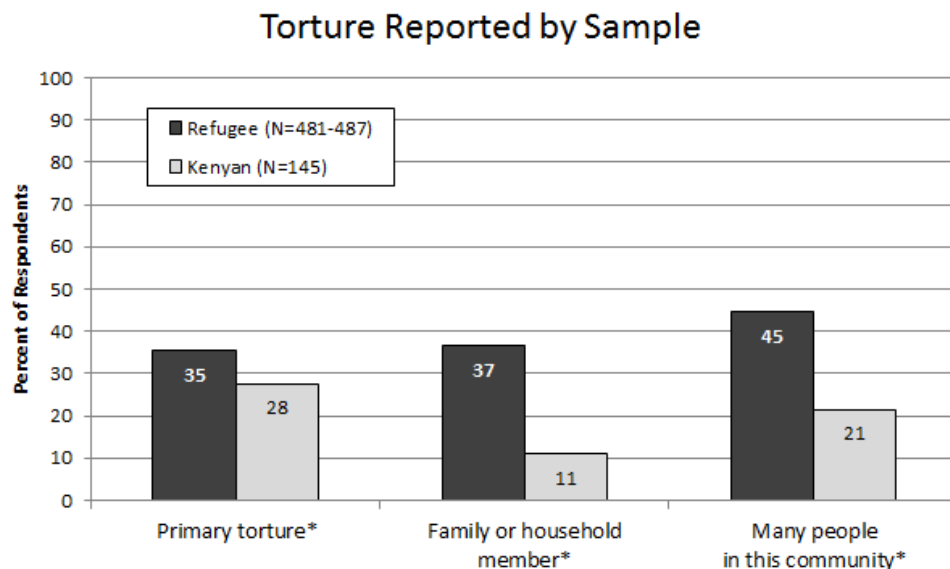
### Household Functioning by Sample

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



## Torture Survivors

After being offered a simple, brief definition of torture,<sup>34</sup> a combined total of 34 percent of respondents reported that they had personally been tortured. Overall, 31 percent reported that someone in their family or in their household had been tortured and 39 percent said they thought many people in their community had been tortured. The rates were significantly higher for

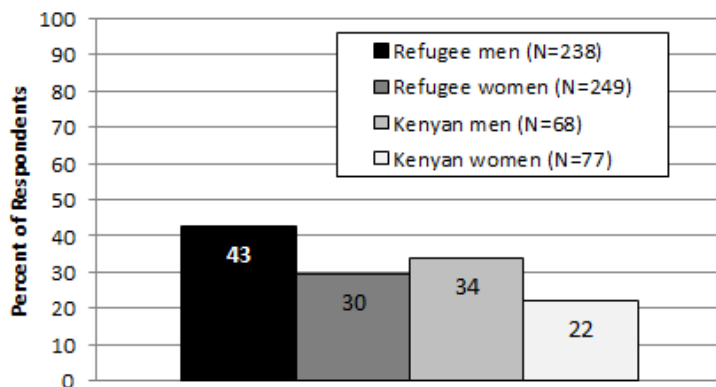


\* Differences between samples are statistically significant at 0.10-level.

refugee respondents 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.

Men are more likely to report having been tortured, among all respondents. Among refugees (not Kenyans), older people are more likely to report torture and rates are significantly higher among refugees from the DRC and Burundi.<sup>35</sup>

### Primary Torture Survivors by Sample and Gender

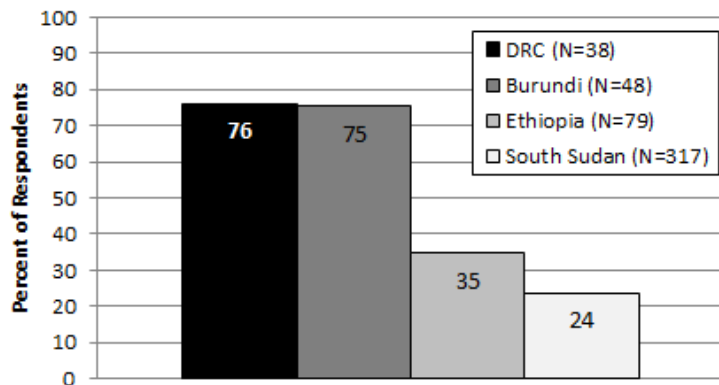


<sup>34</sup> See the *Questionnaire* at the end of the report. The definition provided was: “Torture is severe physical or psychological suffering caused on purpose by someone in authority.”

<sup>35</sup> The number of respondents from Uganda, Rwanda, and Sudan are not large enough to make it meaningful to analyze rates.

Torture survivors have significantly higher levels of overall mental health symptoms, as well as more frequently reporting nearly all individual symptoms.<sup>36</sup> For example, across both samples, 25 percent of torture survivors report sometimes or often having suicidal thoughts in the

**Refugee Primary Torture Survivors  
by Country of Origin**



past two weeks, compared to 15 percent of non-torture survivors. Torture survivors are also more likely to report difficulty with sleep (60 percent, compared to 44 percent), difficulty concentrating (44 percent, compared to 31 percent), and feeling worthless (40 percent, compared to 26 percent). Nearly half (48 percent) of torture survivors feel mental health problems cause functional difficulties, compared to 34 percent of those who said they had not been tortured.

Torture is also associated with particular negative physical effects. Among torture survivors, 42 percent said they struggle with chronic pain, compared to 30 percent of non-torture survivors. Over a third (35 percent) of torture survivors reported physical health problems are interfering with their daily functioning, compared to 25 percent of non-torture survivors.

Torture survivors are more likely to report going to a hospital or clinic and relying on prayer or spiritual activities to cope with difficult emotions. Torture survivors are a distinct group among both refugee and host community populations, and require specialized interventions to address their unique types and scope of needs.

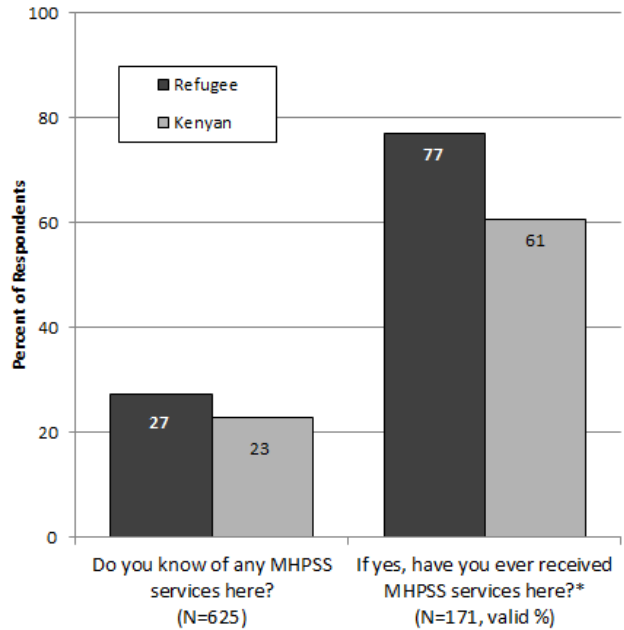
Torture survivors are more likely to report going to a hospital or clinic and relying on prayer or spiritual activities to cope with difficult emotions. Torture survivors are a distinct group among both refugee and host community populations, and require specialized interventions to address their unique types and scope of needs.

<sup>36</sup> For the combined sample, the mean symptom level for torture survivors is 2.3, compared to 2.0 for those who did not report torture (sig.=.000).

## Access to Services

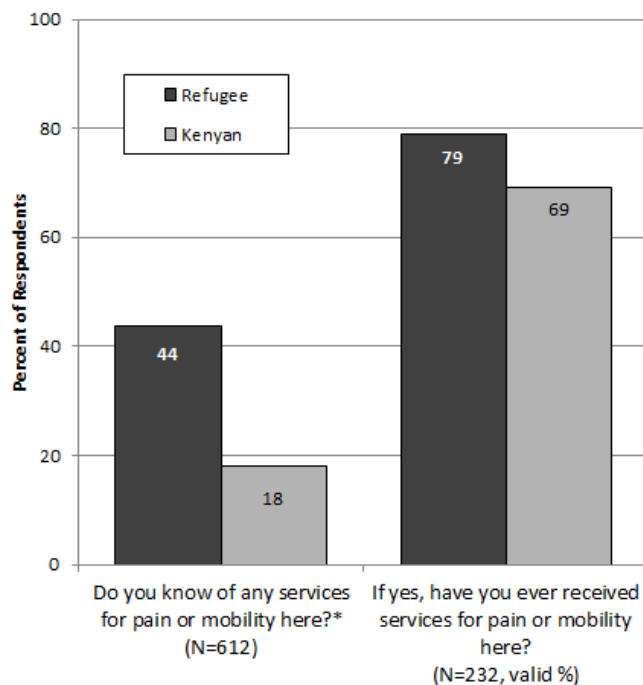
Respondents were not commonly aware of mental health or psychosocial services available in their communities. Just around a quarter of both samples knew of such services. Among those who reported that they knew of services available to them, 77 percent of refugee and 61 percent of Kenyan respondents said that they had received MHPSS services. Among the overall samples, this means that about 22 percent of refugee and 14 percent of Kenyan respondents reported receiving MHPSS services.

### Knowledge and Receipt of MHPSS Services by Sample



\* Differences between samples are statistically significant at 0.10-level.

### Knowledge and Receipt of Physiotherapy Services by Sample

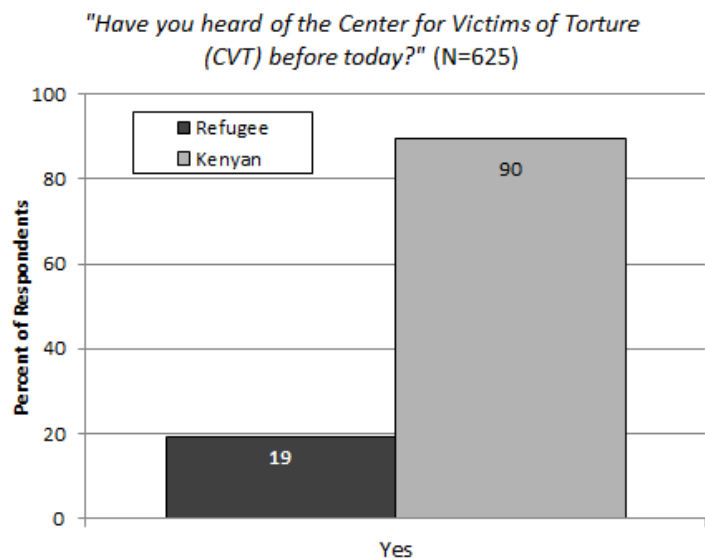


\* Differences between samples are statistically significant at 0.10-level.

Refugee respondents were more likely than host community respondents to have heard of services available for mobility or pain issues, 44 and 18 percent respectively (38 percent overall). Again, of those who had heard of services, the majority of respondents reported having received such services. Out of the overall samples, therefore, about 35 percent of refugee and 12 percent of Kenyan respondents reported receiving some type of service for pain or mobility issues.

Finally, there was a significant divergence between samples on whether or not respondents said they had heard of CVT prior to their interview. Fully 90 percent of the host community respondents said that they had; this is likely linked to the small, close-knit nature of these villages, where CVT had done a similar survey one year prior. In the refugee settlement, on the other hand, most respondents had arrived less than a year prior, and only 19 percent said they had previously heard of CVT.

## Awareness of CVT by Sample



## Conclusions and Recommendations

CVT interviewed 633 individuals in Kalobeyei refugee settlement and host community villages, demonstrating the feasibility of representative sampling methods in humanitarian settings. Similar surveys should be conducted at regular time points and among other populations to monitor shifts over time and place. Any survey in a humanitarian context, particularly about sensitive topics, must be done with a high level of attention to psychological support for respondents, including providing psychological first aid, emergency interventions, and referral pathways.

The resultant representative data identifies attitudes about mental health, daily stressors, psychological symptoms, coping strategies, and access to services among the populations of Kalobeyei refugee settlement and host community villages. This allows service providers and other stakeholders to design evidence-based MHPSS interventions, well-suited to the needs of these populations. Key findings and some implications are highlighted below.

- **There is substantial language diversity among refugees in Kaleobeyei.** The most frequently reported common languages were English, Arabic (typically Juba Arabic), and Kiswahili, but there are substantial segments of the population that do not speak any of these languages. To be inclusive of this diversity, language considerations must be integrated into early planning stages of any intervention and significant resources must be allotted to ensuring adequate coverage of minority languages.
- **There are low levels of formal education, and very few host community members have any formal education at all.** Fully 89 percent of the host community had less than a primary education. Service providers should account for this and ensure their approach to service provision is accessible to those with no formal education.

- **There are generally positive ideas about mental health, including broad agreement that social support networks are useful in addressing mental health problems.** Survey respondents most strongly agreed that it is “good to talk to family or friends about mental health,” suggesting this can be a key resource for MHPSS interventions.
  - **Despite this, there are strong pockets of stigma towards mental health, particularly among refugees.** More than half of refugee respondents see mental health problems as shameful or a sign of weakness. Targeted strategies to combat stigma are necessary to address these misperceptions. Individuals in need of services will be less likely to access services if they believe they will face stigma in their community.
- **Refugees rank mental health-related problems (particularly grief over loss of loved ones and worries about people at home) as major issues in their current lives.** While they do note struggles with food, shelter, and education, these are often secondary to feelings of grief, worry, and loss. MHPSS services should be considered essential interventions for refugee populations. To meet these needs, including addressing the interrelated character of many of these problems, service providers should develop a coordinated response, including referral pathways and follow-up processes.
  - **Host community residents struggle most often with illness or physical health challenges and obtaining food, shelter, education, and livelihoods.** Their symptoms may be more directly attributed to struggles in these areas. Successful interventions should prioritize tangible services or support, as well as providing support to cope with the psychological impacts of these ongoing struggles. In general, such livelihood stressors affect overall psychological well-being, thus addressing these stressors may strengthen the effectiveness of psychological interventions.
  - **Community violence and domestic violence are a current problem for about a third of these populations.** These issues put people at immediate risk of physical and psychological harm. Service providers should be trained in how to identify individuals facing violence in their daily lives and how to provide sensitive and effective support and protection. There should also be a concerted effort to identify the underlying individual, family, and community-level factors contributing to this ongoing violence. Addressing these issues requires coordinated efforts from multiple sectors.
- **Refugees and host community residents show very similar levels of psychological symptoms, despite very different past experiences and current life situations.** There are significant needs among both populations and so efforts to provide services to both are well founded. We estimate that 27 percent of refugees and 15 percent of the host community have symptoms consistent with needing specialized mental health support. Current resources are inadequate to meet this level of need.

- **The most commonly reported symptom is difficulty sleeping, and this is even more common among torture survivors.** Physiotherapy (physical therapy) interventions can teach beneficiaries how to improve issues related to their sleep. Physiotherapists instruct in how to improve sleep hygiene, modify sleep positions to decrease pain, and practice grounding and breathing techniques to promote relaxation and decrease insomnia. These techniques can also be helpful for falling back asleep after nightmares, a symptom commonly associated with posttraumatic stress.
- **A significant minority of the population reports currently having suicidal thoughts.** These 21 percent of refugees and 10 percent of host community residents should be considered high risk. Service providers in all sectors should be trained to identify warning signs of suicidality and strengthen referral pathways to provide appropriate follow up support. An inter-agency response is recommended to develop a suicide prevention strategy.
- **Many people are struggling with daily functioning due to mental health or physical health problems.** Restoring functional ability depends on teaching effective coping strategies to deal with challenges faced from past traumatic events and ongoing daily stressors.
  - **Refugees struggle more often with functioning than host community residents.** This may indicate that displacement is particularly disruptive to coping strategies that people typically develop to deal with difficult life situations. Dual-focused interventions should address both trauma-related problems and developing resilience in the face of ongoing disruptive life circumstances.
  - **Physical health concerns impair functioning and impede the ability to participate in daily tasks and income generating activities.** Physiotherapy can help beneficiaries improve their physical functioning, including teaching ways to improve body mechanics and posture, enhance balance and flexibility, and promote strength and overall fitness. Improving their ability to lift, bend, carry, and do repetitive activities can help affected people participate in household tasks and income generating activities.
- **About a third of these populations report living with chronic pain, and torture survivors are particularly likely to report chronic pain.** Physiotherapy can help alleviate pain and teach coping strategies. An effective intervention should include an intensive focus on pain education and helping beneficiaries understand pain and how to manage it. Physiotherapists can address avoidance of movement and activity due to fear of injury or the assumption that chronic pain means injuries have not healed. After a physiotherapy intervention, beneficiaries often report improved mobility and ability to perform daily activities.

- **Most people rely on religious or spiritual activities and beliefs to help cope with difficult emotions.** MHPSS providers should seek to thoroughly understand these practices and beliefs, and engage in discussions about how interventions can draw upon religion or spirituality, while also minding the fact that it is common for some to feel disappointment in their own religion given their past and present struggles.
  - **Similarly, people commonly rely on social support to help cope with difficult emotions.** Networks of family, friends, and neighbors are already providing mental health support, and so MHPSS interventions can draw upon these resources. Group-based interventions may be particularly resonant in this context.
  - **Many people report going to a hospital or a clinic when they are facing mental health concerns.** This suggests that staff at medical facilities should receive training on protocols to screen and identify people struggling with mental health issues, and they should be equipped with appropriate referral networks to connect individuals with MHPSS providers. Models for co-locating or integrating mental health services into medical facilities may also be effective.
  
- **Over one third of these populations report being primary torture survivors, with rates higher among refugees, men, older people, and those from DRC and Burundi.** Torture survivors are a particularly vulnerable group and have unique needs. Additional research could be conducted to more thoroughly understand how to effectively identify and provide care to torture survivors in this context. Outreach and education initiatives could be focused specifically on sub-populations known to have higher rates of torture survivors. Service providers should bring in experts or train their staff on specialized skills needed to provide torture rehabilitation services.
  - **Torture survivors have higher symptom levels overall, including more suicidal thoughts, chronic pain, and functional difficulties.** Torture survivors should be considered a particularly vulnerable group, requiring increased attention and resources to meet their higher levels of need.
  
- **About a quarter of refugees and host community residents know about MHPSS services, and those who know of services are likely to have received services.** Awareness raising campaigns should be actively pursued. Findings suggest such efforts are likely to be effective in increasing utilization of services for those in need, so service providers should be prepared to handle a potentially significant influx of beneficiaries.
  - **Refugees are much less likely to know about services for pain or mobility issues, compared to the host community.** A central part of any new service available must be outreach to increase awareness of the service and who is likely to benefit from it.



## Questionnaire

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

Date: \_\_\_\_\_ Interview #: \_\_\_\_\_

Interviewer ID #: \_\_\_\_\_ Supervisor ID #: \_\_\_\_\_

Location of interview:  Kalobeyei  Host community

Level 1: \_\_\_\_\_

Level 2: \_\_\_\_\_

Gender of respondent:  Man  Woman

Language of interview:  Arabic  Congolese  Didinga  Dinka  English  
 Kinyarwanda  Lotuko  Nuer  Swahili  Turkana  
 Anyuak  Other: \_\_\_\_\_

**Post-Survey Support Protocol**

**Emergency response:** Respondent is in extreme distress and requires immediate intervention  
*Notify supervisor / clinical support to get CVT staff to come to household immediately*

**Referral:**

- Respondent was given information about available services
- Respondent needs to be connected with referral partner
- Respondent needs to be referred for CVT services

**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

**NOTES:**

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Was the respondent alone during this interview?  Yes  No

Interviewer signature: \_\_\_\_\_

## **Welcome Script & Consent**

Good morning/afternoon/evening. I am working with an international organization called the Center for Victims of Torture. We provide services to people who have experienced war or have been forced to leave their homes. We provide mental health services in Kalobeyei, as well as in Nairobi and in Dadaab. We are doing an assessment to learn about mental and physical health needs and opinions of people who live here.

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.

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.

*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.*

Your participation is completely optional and voluntary. You can choose not to answer any question if you don't want to. You can stop the survey at any time. This is not a test and there are not right or wrong answers. I am only interested in learning what you really feel or think. For the questions you do answer, I would be grateful if you could answer as openly as you can.

The goal of these questions is to help provide better services for people here in general, but your participation will not directly benefit you or your family in any way.

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.

Are you willing to participate?

- Yes
- No

Thank you so much for agreeing! Your perspectives will be very helpful to us. I look forward to our conversation!

Time started: \_\_\_\_\_ AM / PM

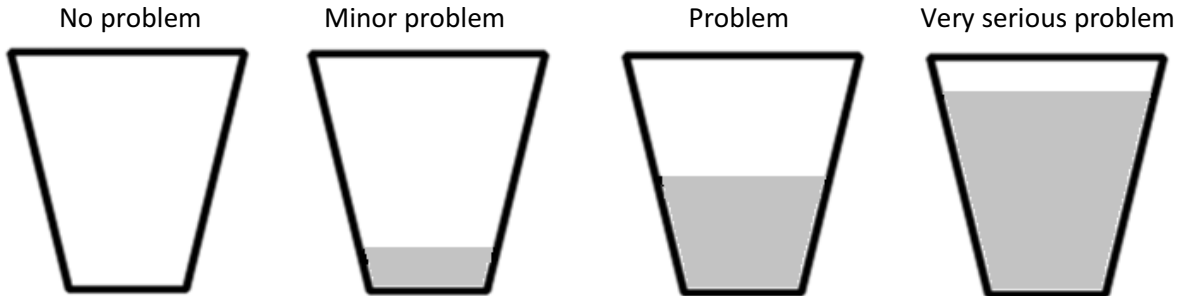
First, I will read some statements about **mental health** that you might agree with or disagree with. Please tell me if you strongly disagree, disagree, agree, or strongly agree.

*Use thumbs up and down to illustrate the options.*

	Do you agree or disagree?	Strongly Disagree (2 thumbs down)	Disagree (1 thumb down)	Agree (1 thumb up)	Strongly Agree (2 thumbs up)
1.1	I understand what the words “mental health” mean.				
1.2	“Mental health” can be positive. It means psychological well-being; it is important for everyone.				
1.3	“Mental health” is negative. It really only means psychological illnesses or problems.				
1.4	To deal with trauma, it helps to think or talk about what happened.				
1.5	Mental health problems are shameful or a sign of weakness or failure.				
1.6	It is good to talk to my family or friends about my mental health.				
1.7	I know and use healthy strategies to cope with negative thoughts or feelings about what has happened to me.				
1.8	People with mental health problems are all crazy.				
1.9	I feel I can depend on my community to help me cope with on-going challenges, stress, or worries.				
1.10	A lot of people in this community are struggling with mental health issues.				

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

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.



	How difficult is this in your life right now?	No problem at all	Minor problem	Problem	Very serious problem	<i>Most stressful (select only one)</i>
2.1	Getting food, shelter, or clothing					
2.2	Getting education or a job					
2.3	Illness, health, or disability					
2.4	Not having friends, family, or neighbors who can support you					
2.5a	<i>Only host community:</i> Adjusting to or dealing with the refugee camps at Kakuma					
2.5b	<i>Only Kalobeyei:</i> Adjusting to or dealing with life in the camp (including missing home and lifestyle)					
2.6	<i>Only Kalobeyei:</i> Worries about people back at home					
2.7	<i>Only Kalobeyei:</i> Trying to leave the camp (for resettlement, moving home, etc.)					
2.8	Domestic violence, threats, or conflicts in your household					
2.9	Violence, threats, or conflicts in the community					
2.10	Not knowing where my family or friends are right now					
2.11	Grief from the loss of loved ones					
2.12	Hopelessness or uncertainty about the future					

You told me that some of the things I just mentioned are problems for you.

*Review which items they said were the most serious problems.*

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

*Mark the corresponding tick box in table above.*

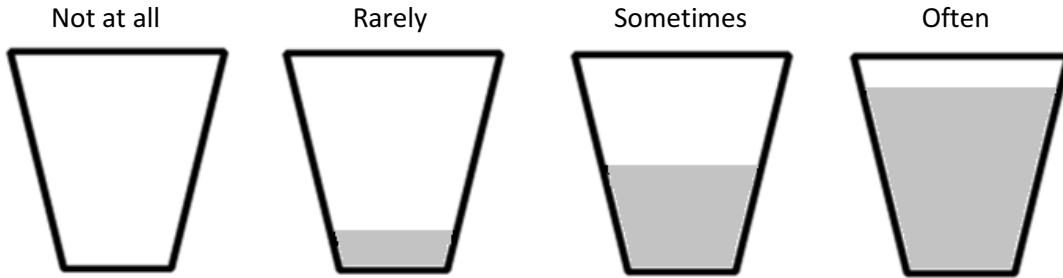
**2.14** Is there something else that I **haven't** mentioned that causes you the **most stress** right now?

Yes (Specify: \_\_\_\_\_)

No

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

You can use the cups to help you again. The more full cups mean that you experience a problem more regularly. Please think about how much these symptoms have bothered you during the past two weeks: not at all, rarely, sometimes, or often?



How much have these symptoms bothered you in the past two weeks?		Not at All	Rarely	Sometimes	Often
3.1	Difficulty falling asleep or staying asleep?				
3.2	Crying easily?				
3.3	Feeling less interest in things that you used to enjoy?				
3.4	Having difficulty concentrating or focusing on your thoughts?				
3.5	Difficulty doing domestic work or income-generating activities?				
3.6	Feelings of worthlessness?				
3.7	Thoughts it would be better to not be alive? <i>If sometimes or often, follow protocol to discuss further.</i>				
3.8	Feeling low in energy, slowed down?				
3.9a	Do you feel <u>mental health</u> problems (like stress, depression, or anxiety) cause trouble with your daily functioning?				
3.9b	<b>IF SOMETIMES OR OFTEN:</b> What mental health problem causes the most trouble for you?				
3.10a	Do you feel <u>physical</u> health or medical problems cause trouble with your daily functioning?				
3.10b	<b>IF SOMETIMES OR OFTEN:</b> What physical health or medical problem causes the most trouble for you?				

3.11a: Do you experience on-going or chronic pain in your body?

- Yes       No

**IF YES: 3.11b:** On a scale from 0 to 10, where 0 is no pain at all and 10 is the worst possible pain,

how much pain have you felt overall in the past week? \_\_\_\_\_

3.12 How would you rate your mental health **overall**: very poor, poor, fair, good, or very good?

- Very poor       Poor       Fair       Good       Very good

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

		Yes	No
4.1	Connecting with your family or friends to discuss your feelings		
4.2	Do social or entertainment activities		
4.3	Sleep or stay in bed		
4.4	Do physical activities		
4.5	Go to the hospital or clinic to see a doctor		
4.6	Pray, meditate, or do other spiritual activities		
4.7	Use alcohol to help you forget		
4.8	Try to avoid seeing or talking to anyone		
4.9	Talk to a counselor, therapist, or other professional		
4.10	Other: <i>(Prompt: Is there anything else you do?)</i> _____		

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

- Yes
  - No
- 5.2 If yes: How many people? \_\_\_\_\_

Please tell me the age & gender of person 1: Age: \_\_\_\_\_

- Male
- Female

Please tell me the age & gender of person 2: Age: \_\_\_\_\_

- Male
- Female

Please tell me the age & gender of person 3: Age: \_\_\_\_\_

- Male
- Female

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?

6.1 Have you ever been tortured?

- Yes
- No

6.2 Has anyone in your family or household been tortured?

- Yes
- Not to my knowledge

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

- Yes
- No



The next section is about **services** that are available to people in this community right now.

**7.1** Do you know of any group, organization, or agency where you can go to receive **mental health or psychosocial support services** in Kakuma/Kalobeyei?

- Yes
- No

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

- Yes
- No

→ **7.3** If yes: From which organization?

*Don't read options. Select all that apply.*

- CVT
- Danish Refugee Council (DRC)
- International Rescue Committee (IRC)
- Kenya Red Cross
- Jesuit Refugee Service (JRS)
- Other: \_\_\_\_\_

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

- I've never needed or wanted these services
- They are too far away
- I'm afraid of what my neighbors or relatives would think or say
- I tried to get services, but they didn't select me, give me anything, etc.
- Other: \_\_\_\_\_

**7.5** Do you know of any group, organization, or agency where you can go to receive help for mobility or pain issues in Kakuma/Kalobeyei?

- Yes
- No

→ **7.6** If yes: Have you ever received these services?

- Yes
- No

→ **7.7** If yes: From which organization?

*Don't read options. Select all that apply.*

- Handicap International
- International Rescue Committee (IRC)
- Lutheran World Federation (LWF)
- Jesuit Refugee Services (JRS)
- National Council of Churches in Kenya (NCKK)
- Other: \_\_\_\_\_

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

- I've never needed or wanted these services
- They are too far away
- I'm afraid of what my neighbors or relatives would think or say
- I tried to get services, but they didn't select me, give me anything, etc.
- Other: \_\_\_\_\_

**7.9** Have you ever heard of the Center for Victims of Torture (CVT) before today?

- Yes
- No

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

**8.1** How old are you? *If respondent is unsure, assist them in making the best estimate possible.*

\_\_\_\_\_ years

**8.2** What languages do you speak and understand comfortably? *Select all that apply.*

Amharic

Congolese

Dinka

Didinga

English

French

Kinyarwanda

Lotuko

Nuer

Oromo

Swahili

Turkana

Anyuak

Other: \_\_\_\_\_

Other: \_\_\_\_\_

**8.3** How many people live in your household right now, not counting yourself?

\_\_\_\_\_ people

**8.4** What is your home country?

DR Congo

Ethiopia

Kenya

Rwanda

South Sudan

Other: \_\_\_\_\_

**8.5** What levels of education have you completed? *Select all that apply.*

No education

Primary

Secondary

Technical

Post-secondary, university, graduate school

**8.6** How long have you been at Kakuma/Kalobeyei?

*If respondent is unsure, assist them in making the best estimate possible.*

\_\_\_\_\_ years

\_\_\_\_\_ months

Time finished: \_\_\_\_\_ AM / PM