



The  
CENTER for  
VICTIMS of  
TORTURE

# Assessing Refugee Mental Health in Tigray, Ethiopia:

A Representative Survey  
of Adi Harush and Mai  
Ayni Camps

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## Rationale

The Center for Victims of Torture (CVT) conducted a mental health needs assessment with Eritrean refugees in the Tigray region of Ethiopia. Understanding the needs of individuals and communities who have experienced war, organized violence, persecution, and human rights abuses is fundamental to the success of mental health and psychosocial support interventions. Refugees can face severe psychological effects from loss of loved ones, torture or other abuse, or witnessing violence or atrocities.<sup>1</sup> Many refugees also experience negative effects of continuous trauma and ongoing stressors or threats associated with forced migration. In this context, it can be difficult to process or cope with grief over those who have died or ambiguous loss over those whose whereabouts are unknown. These factors can impair refugees' daily functioning, reducing their ability to effectively meet the substantial challenges of living in the country of refuge, particularly in humanitarian contexts.<sup>2</sup>

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

Globally, there is very little representative data about refugee mental health in humanitarian contexts. Most research on the psychological impacts of conflict or other traumatic experiences for African refugees is conducted with populations that have been resettled to a third country, and thus does not reflect mental health needs in the contexts in which most refugees are located. Additionally, in most analyses or needs assessments, claims about refugees' mental health in humanitarian settings are supported by evidence from help-seeking, non-representative populations. These data do not reveal the full range of needs among the population, but rather only those who have self-selected into services to address mental or physical health needs. The most vulnerable individuals are unlikely to seek help, whether due to stigma or restricted ability to access services. Finally, many needs assessments rely on data from key informants, community leaders, or other stakeholders who provide perspectives on mental health needs based on their expert positions or depth of experience. However, despite their knowledge about communities, these data cannot provide prevalence rates or allow inferential or multivariate analyses. Taken together, these factors contribute to a substantial information gap for service providers implementing mental health interventions in humanitarian settings.

CVT has conducted a series of representative surveys to inform its own programming, as well as the MHPSS sector.<sup>3</sup> The 2020 survey in Adi Harush and Mai Ayni is a replication of a survey conducted in the same camps in 2017, and this report will highlight key similarities and divergences

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

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

<sup>3</sup> Reports of survey findings are available at <https://www.cvt.org/resources/publications>.

between the two time-points.<sup>4</sup> Additionally, we have carried out similar surveys in Kalobeyei settlement for South Sudanese and other refugees in Kakuma, Kenya in 2016, 2018, and 2020; in Bidi Bidi settlement hosting South Sudanese refugees in western Uganda in 2019; and with South Sudanese refugees in Nguenyiel camp in Gambella, Ethiopia, in 2019. These surveys use social science methods to collect representative data about mental health issues, needs, and resources in humanitarian settings. With methodologies that are replicable and feasible, and using consistent questionnaires, conducting surveys in different locations at different time points contributes to the construction of a global dataset of refugee mental health. This allows comparative analyses of levels of trauma, stigma, stressors, and symptoms between refugee camps or between people from the same country of origin in different settings. Such analyses can help the humanitarian sector design and prioritize effective responses, including advocating for resources and informing donors about emerging needs.

## Context

In the Shire area of northern Ethiopia provide refuge to asylum-seeking Eritreans. There are four camps in this area (Shimelba, Hitsats, Mai Ayni, and Adi Harush), hosting about 87,000 refugees at the time of this survey.<sup>5</sup> This survey was conducted in Mai Ayni and Adi Harush camps. Most arrivals report fleeing a fear of persecution or military conscription, or are migrating due to general insecurity in their country of origin. A very small proportion of the population intends to return to Eritrea, due to ongoing insecurity.<sup>6</sup> Refugees in Ethiopia face gender-based violence, human trafficking and smuggling, inadequate educational infrastructure, delays and miscommunications in navigating bureaucratic systems of registration and documentation, poor quality shelters, limited livelihood opportunities, inadequate food assistance, and risks of violence and discrimination.<sup>7</sup>

In July 2018, a peace deal was signed by the new Ethiopian Prime Minister Dr. Abiy Ahmed Ali



*Photo of tukul by L. Eloul*

and Eritrean President Isaias Afwerki, ending the two-decade frozen war between the two nations. The subsequent opening of air and ground travel between the two countries, as well as phone connection, allowed many of the Eritrean refugees in the camps to reconnect with loved ones at home. This had previously been impossible, and had been a source of significant distress for the refugees in the camps. Tens of thousands of Eritreans (both refugees and visitors) crossed the border in both directions to reunite with family members. While this was heralded as a positive political move, many refugees emphasized that without major changes in policies and/or leadership within Eritrea, their home

country would remain an unsafe place. At the same time, improved international standing of Eritrea led to lifting of UN sanctions, raising concerns that refugees' resettlement applications may become deprioritized. Refugees began to raise concerns about Eritrean government operatives crossing the border and entering the camps to report on political dissidents and those who escaped the military. Arrival of a large number of new Eritreans led to overcrowding of the camps and shortage of resources,

<sup>4</sup> The 2017 report of survey findings in Adi Harush and Mai Ayni is available at: [https://www.cvt.org/sites/default/files/attachments/u93/downloads/Assessing\\_Refugee\\_Mental\\_Health\\_in\\_Ethiopia\\_letter\\_v1.pdf](https://www.cvt.org/sites/default/files/attachments/u93/downloads/Assessing_Refugee_Mental_Health_in_Ethiopia_letter_v1.pdf).

<sup>5</sup> UNHCR. 2019. "Tigray Regional State Ethiopia: 2019 Pledge Progress Report." Available at: <https://reliefweb.int/sites/reliefweb.int/files/resources/Tigray%20ETH%202019%20Pledge%20Progress%20Report.pdf>.

<sup>6</sup> Ibid.

<sup>7</sup> UNHCR. 2019. "2019 Consolidated Participatory Assessment Report Ethiopia: Summary of Findings." Available at: <https://data2.unhcr.org/en/documents/details/77182>.

as well as created tensions with the host community. Some refugees reported being mocked and criticized by the new arrivals for remaining in the refugee camps for many years without being able to work or having successfully migrated elsewhere. Others learned that their missing loved ones actually had passed away, or that their estranged spouses had found new partners in their prolonged absences. After a few months, the border was closed again, and new arrivals from Eritrea started to be turned away as the Ethiopian authority began individual status determinations, halting the previous policy of granting *prima-facie* refugee status. Moreover, during 2018 and 2019, issues concerning the regional border between Tigray and Amhara led to tensions in the areas not far from the refugee camps, increasing the concerns for potential instability within Ethiopia.



UNHCR, November 2017

Conducted in January 2020, this survey occurred prior to substantial changes in the context due to the COVID-19 pandemic and the armed conflict involving the Tigray People’s Liberation Front (TPLF) and Ethiopian National Defense Force (ENDF). In March 2020, when COVID-19 was declared a pandemic by the World Health Organization, humanitarian operations and many elements of social life in the camps became restricted. Refugees faced new challenges to their psychological well-being, including reduction in services offered, quarantines in overcrowded living spaces, and other additional stressors. In April 2020, plans were announced to close Hitsats camp and relocate residents to Adi Harush and Mai Ayni. This announcement likely affected Adi Harush and Mai Ayni residents’ mental health, given the existing crowded conditions and supply shortages in these camps.<sup>8</sup>

In November 2020, armed conflict broke out between the ENDF and TPLF in Tigray.<sup>9</sup> Fighting

<sup>8</sup> Creta, Sara. 19 April 2020. “Ethiopia plans to close Eritrea refugee camp despite concerns.” Al Jazeera News. Available at: <https://www.aljazeera.com/news/2020/4/19/ethiopia-plans-to-close-eritrean-refugee-camp-despite-concerns>; Ashly, Jaclynn. 17 August 2020. “Eritrean refugees in Ethiopia resist camp closure amid COVID-19 fears.” The New Humanitarian. Available at: <https://www.thenewhumanitarian.org/news-feature/2020/08/17/Ethiopia-Eritrea-refugee-camps-coronavirus>.

<sup>9</sup> Abbink, Jon. 25 January 2021. “The Tigray Conflict in Ethiopia: Post-War Ramifications and International Response.” International Peace Institute Global Observatory. Available at: <https://theglobalobservatory.org/2021/01/tigray-conflict-ethiopia-ramifications-international-response/>.

ensued, including reported massacres and other human rights violations of civilians in multiple locations in the region,<sup>10</sup> including, allegedly, at Hitsats and Shimelba camps. According to interviews with refugees, aid officials, UN representatives, and diplomats, Eritrean troops engaging in the conflict looted aid supplies and burned nearby crop fields and forested areas.<sup>11</sup> Additionally, UNHCR has received reports of Eritrean refugees in Tigray “being killed, abducted, or forcibly returned to Eritrea.”<sup>12</sup> During a UNHCR-led needs assessment in January 2021, teams found buildings and structures in Mai Ayni and Adi Harush largely undamaged. However, refugees there reported that while they were “not impacted directly from the fighting, they were threatened and harassed by various armed groups. . . they continue to have safety concerns, reporting that armed gangs roam the camps at night stealing and looting.”<sup>13</sup> The deteriorating security context and credible fears of being forcibly returned to Eritrea represent significant additional stressors for refugees in Adi Harush and Mai Ayni. The mental health effects of these contextual factors are not reflected in this survey; the results presented here likely understate the prevalence of difficulties in daily life and mental health symptoms among refugees, and may also understate the use of negative coping strategies. Additionally, the population in Adi Harush and Mai Ayni may have shifted, with some residents likely fleeing elsewhere, and others arriving from Hitsats and Shimelba camps. However, though mental health needs are likely greater than what is represented here, this assessment is likely to reflect at least minimum needs for mental health assistance among Eritrean refugees in Tigray.

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

This assessment was conducted to inform CVT’s ongoing programming, as well as that of partner organizations and other stakeholders. The first round of the survey was administered in 2017, and this report highlights some areas of continuity and contrast between 2017 and 2020. This comparison should not, however, be interpreted as an assessment of the impact of MHPSS services in these camps. Because the surveys each drew independent samples, and the transient nature of the population and significant contextual shifts since 2017, each survey represents a snapshot of mental health needs at a particular point in time.

## Survey Sampling Methodology

We conducted interviews with a sample of individuals (N=601 total) who are representative of the adult populations of Adi Harush (N=311) and Mai Ayni (N=290) refugee camps as of January 2020. The 2017 survey included 548 interviews, with 271 in Adi Harush and 277 in Mai Ayni. Comparable sampling methodology was used in both 2017 and 2020.

Determining the overall population sizes of refugee camps can be challenging. At the time

<sup>10</sup> UNHCR. 18 January 2021. “Ethiopians fleeing to Sudan receive Danish support.” Available at: <https://www.unhcr.org/au/50129-ethiopians-fleeing-to-sudan-receive-danish-support>; Latif Dahir, Abdi. 9 December 2020. “Fleeing Ethiopians Tell of Ethnic Massacres in Tigray War.” The New York Times. Available at: <https://www.nytimes.com/2020/12/09/world/africa/ethiopia-tigray-sudan.html>.

<sup>11</sup> Reuters staff. 14 January 2021. “Major violations of international law at Tigray refugee camps: U.N.” Reuters. Available at: <https://www.reuters.com/article/us-ethiopia-conflict-un/major-violations-of-international-law-at-tigray-refugee-camps-u-n-idUSKBN29J2N6>; UNCHR. 25 March 2021. “Deep concern for thousands of Eritrean refugees ‘scattered’ in Ethiopia’s Tigray.” Available at: <https://news.un.org/en/story/2021/03/1088372>.

<sup>12</sup> Al Jazeera staff. 11 December 2020. “‘Overwhelming’ reports of killings of Eritreans in Tigray: U.N.” Al Jazeera News. Available at: <https://www.aljazeera.com/news/2020/12/11/disturbing-un-says-safety-of-eritrean-refugees-greatly-at-risk>.

<sup>13</sup> UNHCR. 19 January 2021. “UNHCR finds dire need in Eritrean refugee camps cut off in Tigray conflict.” Available at: <https://www.unhcr.org/en-us/news/briefing/2021/1/6006a31a4/unhcr-finds-dire-need-eritrean-refugee-camps-cut-tigray-conflict.html>.



the survey was conducted, the most recent official population data from UNHCR for Adi Harush and Mai Ayni was published in January 2018 and October 2018, respectively. In preparation for the survey, CVT received population figures from the Administration for Refugee and Returnee Affairs (ARRA) that indicated 2,677 households and 13,282 people in Adi Harush,<sup>14</sup> and 3,207 households with 13,930 people in Mai Ayni. The ARRA figures are disaggregated by camp zone, but not by gender or age group. Thus, the 2018 UNHCR data was used in conjunction with the ARRA data to estimate the adult population<sup>15</sup> of each camp. UNHCR figures<sup>16</sup> indicate that 60 percent of Adi Harush and 55 percent of Mai Ayni residents are over 18; thus the adult-only population was estimated to be 7,969 and 7,662, respectively. Our sample included about four percent of the adults in these camps and ten percent of the households.

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

The survey's overall response rate was 52 percent. Our contact rate was 57 percent, due primarily to dwellings we found empty. Our cooperation rate was 92 percent, with most eligible respondents completing an interview. Our refusal rate was five percent for eligible respondents who were available but chose not to participate.<sup>17</sup>

### *Dwelling Selection*

The camps are each divided into zones, with varied sizes, demographic profiles, and spatial arrangements. Zones are divided into blocks, then sub-blocks or communities. Finally, each dwelling is numbered. Each team was assigned a starting point for the day.<sup>18</sup> We used Google maps to provide aerial views of the camps and ensure no areas were excluded. At their assigned starting point, the teams drew numbers to identify the first dwelling, selecting from the assigned sampling interval. After

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<sup>14</sup> One of the five zones of Adi Harush was missing a population figure in the data received from ARRA; CVT estimated the population for the zone by multiplying the reported number of households for that zone by the average household size in that camp. Average household size was estimated using the other four zones' population data.

<sup>15</sup> Although a large segment of the population is minors, they were excluded from this data collection, due to ethical restrictions on research with minors, particularly highly vulnerable minors (largely, unaccompanied refugees) and highly sensitive topic areas (here, mental health and trauma).

<sup>16</sup> UNHCR. 31<sup>st</sup> January 2018. "Camp Profile Shire: Adi-Harush Refugee Camp"; UNHCR. 31<sup>st</sup> October 2018. "Camp Profile Shire: Mai-Aini Refugee Camp."

<sup>17</sup> CVT uses response rate calculations recommended by the American Association for Public Opinion Research (AAPOR). The overall response rate is the number of completed surveys (here, 601), which is then divided by the number of completed surveys plus the number of potential survey respondents who we attempted to survey and who were eligible (over the age of 18 and meeting survey sampling protocols for gender balance), but who did not complete a survey. Key reasons eligible potential respondents did not complete a survey (here referred to as eligible non-interviews) include refusal to participate, the selected individual in the household not being available during the data collection period (here referred to as non-contacts), or the selected individual not speaking a language in which the survey was conducted and no interpreter available. In some cases, a selected household was attempted to be reached by enumerators, but no residents appeared to be home and a lock was on the door. These cases are of unknown eligibility; it was unknown if the structure was currently unoccupied (and thus not part of the sampling frame), or if the residents were just temporarily away from home. We used an estimator (equal to the percentage of known eligible potential respondents out of known eligible potential respondents plus known ineligible potential respondents) to estimate the percentage of these cases that would have been eligible (and thus are considered non-contacts). The contact rate is the number of completed surveys plus the number of eligible non-interviews minus the number of non-contacts; divided by the number of complete surveys plus the total number of eligible non-interviews. The cooperation rate is the number of completed surveys divided by the number of completed surveys plus the number of refusals. See <https://www.aapor.org/Education-Resources/For-Researchers/Poll-Survey-FAQ/Response-Rates-An-Overview.aspx> for more information.

<sup>18</sup> Teams' starting points were not randomized as they had been in the 2017 CVT survey. Instead, each team started the day at the geographic point at which they left off the previous day. This choice was made because team leads reported difficulty in locating themselves on the maps they were given, which were Google Earth images. They reported seeing many new households, some of which constructed by refugees themselves, that made the camp layout less orderly and grid-like than it appeared on the satellite image. This is likely due to recent influxes of Eritreans arriving in 2018 and 2019, leading to overcrowding in the camp. Having each team start at the point they left off the previous day reduced the risk of having areas of the camp either skipped or surveyed more than once, but it increased the likelihood of introducing non-random bias based on variation in survey implementation between each team of enumerators.

the first successful interview, they proceeded according to the six or seven dwelling interval. After an unsuccessful interview attempt at a selected dwelling, for any reason, the team moved to the adjacent dwelling.

### *Individual Selection*

All interviewers with odd identification numbers did their first interview on the first day with a man; those with even numbers started with a woman. Through the end of the survey, each enumerator continued to alternate respondent gender.<sup>19</sup> If a selected dwelling had no adult residents of the required gender, they moved to the next dwelling. Teams drew numbers to select the participant from all eligible respondents (all adult residents of the required gender who live in the household). Identified individuals participated in a consent process and decided if they would like to participate. There was no replacement of a selected individual. If they were not home, reasonable attempts were made to return and complete the interview.

There were several exclusion criteria. Minors were not included, as mentioned above. Some dwellings are group care for unaccompanied minors; although there are adult caretakers in group care, we excluded them as well, as most do not live full time in the dwelling. There are also facilities in each camp that admit mentally ill individuals, which were not included in the sampling. We also excluded some halls (communal spaces that can house 25 to 50 people) for newly arrived refugees. Typically, halls are temporary arrangements until housing is available and assigned; however, due to recent influxes of new arrivals in 2018 and 2019, both camps experienced overcrowding. Enumerators reported residents of some halls had lived there for a year or longer. In some cases, halls were set up to provide semi-permanent housing to residents, with walls used to separate households. Halls with distinct households and distinct exterior doors for each household were included in the survey; each exterior door was treated as one household. However, halls that did not have distinct household delineations were excluded.

If a selected individual was a former CVT client, the staff member who did their assessments or facilitated their rehabilitation group was not allowed to conduct the interview; we assigned another interviewer or replaced the interviewer. Similarly, interviewers could not interview their family or close friends; other interviewers were assigned.

### *Weighting*

The combined sample included a total of 601 interviews,<sup>20</sup> with equal proportions of men and women. Respondents' ages ranged from 18 to 70 years old, with an average of 30 years old. The sample



*Adi Harush satellite photo*

<sup>19</sup> This procedure differs slightly from CVT's 2017 survey, in which gender alteration was maintained only through the end of the day; at the start of the next survey day, interviewers with odd survey numbers would again start with a man and those with even numbers would start with a woman. There is a gender imbalance in the camp populations, so we adjust for this imbalance with weighting the data. See section on Weighting.

<sup>20</sup> Enumerators conducted a total of 618 interviews, but there were quality concerns about one interviewer's completed surveys from the first three days of data collection. As a result, the 13 surveys conducted by this enumerator on the first three days (all in Mai Ayni) were dropped entirely from the analysis. On subsequent survey days, the enumerator's surveys were directly observed and supervised by a survey coordinator.

deviates slightly from the population age distribution. Our samples in both camps included fewer young adults, especially young men, than present in the population,<sup>21</sup> which fits the expectation that this segment of the population is least likely to be at home during the daytime when we conducted the interviews. Additionally, our sample includes more people over the age of 60 than present in the population data available.<sup>22</sup> The sample also deviates substantially from the estimated camp gender distribution. This was also expected. Our individual selection in our sampling methodology involved alternating selection of men and women respondents. Although available gender-disaggregated data on camp populations included more men than women,<sup>23</sup> we used this methodology to ensure that women were adequately included in the samples, and to prevent over-inclusion of men speaking as representatives of their households. We created a weight to adjust the survey demographic proportions on age and gender for each camp to match the population proportions. All descriptive analyses are conducted with weighted data, to adjust the samples to match population characteristics.<sup>24</sup>

## Survey Team and Timeline

We conducted fieldwork with three teams of interviewers in each of the two camps. Interviewers conducted an average of three to six interviews in a day, and data collection was completed in about five full days from January 21 to 28, 2020.

Each team had four to five interviewers and one supervisor, and each camp also had a coordination team to provide research, clinical, and logistic support. All interviewers and supervisors were Tigrigna speakers. All team members were CVT staff, with varying levels of exposure to mental health concepts, but with a minimum of two weeks of intensive training from CVT.<sup>25</sup> Research and methodological planning and implementation was provided by headquarters-based research and program management staff and two Ethiopia-based monitoring and evaluation officers. Clinical support was provided by psychotherapists currently based in Ethiopia.



*Photo of CVT staff by E. Kiflom*

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

<sup>21</sup> Of the adult population (using 2018 UNHCR demographic distribution with the population figures provided by ARRA in January 2020), 60.0 and 54.5 percent are aged 18 to 24 in Adi Harush and Mai Ayni, respectively. Our samples included 38.3 and 34.0 percent of respondents in this age range in Adi Harush and Mai Ayni.

<sup>22</sup> The 2018 UNHCR population figures, which were used for demographic distribution estimates, indicate 0 percent women over 60 in Mai Ayni and 0 percent adults over 60, of any gender, in Adi Harush. However, CVT's sample does include men and women over 60 in both camps. It is possible that this discrepancy exists because the demographic data was more than one year old at the time the survey was conducted, or perhaps that figures of less than 1% were rounded down to 0 in UNHCR's publication. Rather than weighting survey responses from women over 60 in Mai Ayni and men and women over 60 in Adi Harush to zero, these responses were simply unweighted, so as not to exclude the perspective of older adults entirely.

<sup>23</sup> The adult population (using 2018 UNHCR demographic distribution with the population figures provided by ARRA in January 2020) includes 38.3 and 45.5 percent women in Adi Harush and Mai Ayni, respectively.

<sup>24</sup> Except for on age and gender, the variables used in the creation of the weight. The age and gender distributions reported in Demographic Characteristics below are the distributions observed in the sample itself, without the weight applied to adjust to population characteristics.

<sup>25</sup> The supervisors were all national Ethiopian staff, with masters degrees completed or in progress. The interviewers were either Ethiopian national staff or Eritrean refugee staff who reside in the camps.

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

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

## Questionnaire Description

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

The content was modeled after CVT's previous surveys, including the 2017 iteration in Tigray. The questionnaire integrated feedback from CVT's clinical advisors, research team, and local stakeholder agencies and groups. The questionnaire collects data on attitudes about mental health, difficulties in daily life, mental health related problems or symptom areas, coping strategies, household mental health problems, torture, access to services, and demographics. Almost all items were closed-ended questions, with opportunities to specify an "other" response.

The questionnaire was completed in person in individual interviews, in or around respondents' homes. About two-thirds (69 percent) of interviews were completed electronically with tablets; the other 31 percent were completed on paper.<sup>26</sup> The questionnaire was bilingual, with both Tigrigna and English, although tablet-based survey questionnaires appeared only in Tigrigna. Translation was completed over a multi-week period, with teams of translators completing first round translations, blind back translations, and consultations to resolve points of misunderstanding or disagreement, particularly on key mental health terms and concepts. Most interviews (99 percent) were conducted in Tigrigna, with a small minority (1 percent) done in Saho or Amharic.

Enumerators explained to respondents that some questions were sensitive and they may wish to be alone for the conversation. The enumerator made attempts to find a private space for the interview. Some respondents (about 22 percent) 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 to provide any service. Before consenting, the participant was told that some of the questions may be upsetting or stressful, that their information would be kept private, that their participation was voluntary, and that they could stop at any time. The participants' names were not recorded.

### *Knowledge and Attitudes*

The first eleven 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

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<sup>26</sup> Tablets were generally used by enumerators who felt most comfortable with electronic data collection; all enumerators who completed interviews with tablets received specific training on using them. Most (64 percent) of enumerators used tablets for almost all of their interviews, 28 percent of enumerators used almost exclusively paper, and 8 percent used a combination of methods.

definitions of mental health, stigma, and coping strategies.<sup>27</sup> This scale displays moderate internal reliability ( $\alpha = .471$ ).

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

### *Difficulties in Daily Life*

The second section includes questions about problems the respondent may be facing, ranging from meeting basic needs (such as "getting food, shelter, or clothing"), dealing with migration-related issues (such as "worries about people back at home"), to more trauma-related problems (such as "violence, threats, or conflict in the community" or "grief from the loss of loved ones"). This section is modeled after the Post-Migration Living Difficulties (PMLD) measure.<sup>28</sup> Respondents ranked twelve potential problems on a four-point scale from "no problem at all" to a "very serious problem," with a visualization of cups to aid in response.<sup>29</sup> This scale displays high internal reliability ( $\alpha = .821$ ). Respondents were given the opportunity to list any other major stressor that was not included in the list. After completing the list, respondents were asked which one item causes the most stress in their lives currently.

### *Symptom Areas*

The third set of questions asks respondents to report frequency of mental health-related symptoms. This is an essential section to provide baseline data on mental health needs and estimate prevalence rates of mental health problems among the population. This section asks respondents to rank how often they have been bothered by ten symptoms in the past two weeks, again using a visual aid for response categories, ranging from "not at all" to "often." The ten questions assess psychological symptoms most commonly associated with post-traumatic stress and depression.<sup>30</sup> These items generate a robust mean symptom score, without overwhelming respondents with this difficult section; this scale displays high internal reliability ( $\alpha = .858$ ).

These items were selected for a range of reasons. The content of the specific items was selected based on other brief screening tools, particularly the Self-Reporting Questionnaire (SRQ-8)<sup>31</sup> and the Patient Health Questionnaire (PHQ-9).<sup>32</sup> The wording of the items is from CVT's client assessments used across its international programs, with similar refugee populations, allowing comparability of symptom levels among the Eritrean refugee population with help-seeking refugee populations in several other contexts. Several items are from the Hopkins Symptom Checklist (HSC-

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<sup>27</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>28</sup> See: Aragona, M., D. Pucci, M. Mazzetti, and S. Geraci. 2012. "Post-Migration Living Difficulties as a Significant Risk Factor for PTSD in Immigrants: A Primary Care Study." *Italian Journal of Public Health* 9(3).

<sup>29</sup> See: Miller, K., P. Omidian, A.S. Quraishy, N. Quraishy, M.N. Nasiry, S. Nasiry ... A.A. Yaqubi. 2006. "The Afghan Symptom Checklist: A Culturally Grounded Approach to Mental Health Assessment in a Conflict Zone." *American Journal of Orthopsychiatry* 96(4):423-433.

<sup>30</sup> A factor analyses suggests a one factor solution, offering further support for combining these variables into a scale.

<sup>31</sup> This is a shortened version of a 20-item screening and diagnostic tool that has been validated in post-conflict settings. See: Scholte, W.F., F. Verduin, A. van Lammeren, T. Rutayisire, and A. Kamperman. 2011. "Psychometric Properties and Longitudinal Validation of the Self-Reporting Questionnaire (SRQ-20) in a Rwandan Community Setting: A Validation Study." *BMC Medical Research Methodology* 11(116).

<sup>32</sup> See Sweetland, A.C., B.S. Belkin, and H. Verdelli. 2014. "Measuring Depression and Anxiety in Sub-Saharan Africa." *Depress Anxiety* 31(3):223-232. The authors conclude these screening tools are generally appropriate in African contexts, but minor problems in translation, structure, and connotations should be addressed to improve cross-cultural relevance. Because these items have been used extensively by CVT in diverse programs throughout Africa, we have provided these locally-specific and necessary adaptations.

25) and the Posttraumatic Stress Diagnostic Scale (PDS), widely used measures of depression and PTSD symptoms, respectively, and found to be valid and reliable with a wide range of populations. Among CVT's help-seeking clients, the individual symptom items included on the survey questionnaire are moderately to highly correlated with overall mean scores on the full HSCL-25 depression sub-scale and the PDS symptom scale.

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

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

The symptom series includes a question on suicidal thoughts. Many psychological measures administered in the context of providing care to a client phrase the question on suicidality as "thoughts of ending your life." To modify this question to be more appropriate for a drop-in survey where services are not being delivered to the individual, we rephrased to "thoughts it would be better to not be alive." This adjustment to a more passive voice can result in greater willingness for survey respondents to report these types of thoughts in a survey setting, particularly in a context in which suicide is highly stigmatized religiously and culturally. Enumerators received training on a follow up protocol to be used if respondents reported suicidal thoughts (see *Psychological Support*, below).

### *Coping Strategies*

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

### *Household Mental Health*

The fifth section asks whether or not any of the respondents' household members experience mental health problems that cause trouble with their daily functioning. If so, they are asked for the age and gender of those people. Three follow up questions, drawn from the WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings-Household Interview (WASSS-H),<sup>33</sup> assess inactivity, low functioning, and fits, convulsions, or seizures due to psychological distress. The goal of this section is to provide additional data to extrapolate about mental health needs within the population, particularly in aiding assessment of minors' mental health needs.

### *Torture*

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

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<sup>33</sup> See, for example: Llosa, A.E., M. Van Ommeren, K. Kolappa, Z. Ghantous, R. Souza, P. Bastin, ...R.F. Grais. 2017. "A Two-Phase Approach for the Identification of Refugees with Priority Need for Mental Health Care in Lebanon: A Validation Study." *BMC Psychiatry* 17:28.

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 access of services. Structured as a series of skip patterns and follow up questions, respondents are asked if they know of any mental health or psychosocial support (MHPSS) services available, if they have ever received such services, from which agency they received services, or why they have not received services. This information is valuable in mapping the sector and establishing the existing interest in services. We also ask about other types of services received in the past month, where respondents receive information about services, and if they can walk to a health center and a protection desk. Finally, we ask if they had heard of CVT prior to the survey.

### *Demographics*

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

### *Data Entry and Cleaning*

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

## **Psychological Support**

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

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

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

### *Referrals*

In training the interview teams, we reinforced that the survey was not designed as outreach or

## Follow-up Protocol Response Options

- Referral:
  - Respondent was given information about available services
  - Respondent needs to be connected with referral partner – Medical
  - Respondent needs to be connected with referral partner - Protection
  - Respondent needs to be connected with referral partner - Psychiatric
  - Respondent should be referred for CVT services – Mental health
  - Respondent should be connected with referral partner - Other
- PFA: Respondent experienced some distress and required in-person PFA delivered during survey per CVT training of enumerator
- Emergency response: Respondent is in extreme distress and requires immediate intervention  

Trained enumerators will provide PFA and notify their supervisor and/or the CVT focal person to come to the household immediately.
- Nothing required: Respondent did not require follow up for psychological distress

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 (for medical, protection, or psychiatric needs) or referring them to CVT's rehabilitation services (for mental health needs). When enumerators referred respondents to CVT, staff made plans to follow up with these people and screen them for criteria to begin CVT services. We also had an option to provide information about available services to respondents, without making a direct referral. Nearly half of respondents (48 percent) were given information about available services. A smaller proportion of respondents were provided with referrals: 10 percent of respondents were referred to CVT for mental health needs, two percent of respondents were referred to a medical partner, one percent were referred to a psychiatric partner, and less than one percent were

referred to a protection partner. Additionally, six percent of respondents were referred for other needs.

### *Psychological First Aid (PFA)*

Enumerators and supervisors received training in Psychological First Aid (PFA) to equip them to provide brief emotional support to respondents, as needed, while conducting the survey. PFA is widely accepted by disaster experts as an evidenced-based approach to decreasing emotional and physical responses experienced by those exposed to trauma.<sup>34</sup>

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

Respondents who became emotionally distressed during the survey and received PFA comprised about 14 percent of those surveyed. If PFA alone was not sufficient, the respondent was

<sup>34</sup>Ruzek, J. I., et al. 2007. "Psychological First Aid." *Journal of Mental Health Counseling* 29 (1): 17–49.



also referred to a team lead, who conducted brief supportive counseling and taught coping skills. The respondent was also assessed on need for referral to mental health services.

### *Emergency Response*

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

### *Suicidality Protocol*

Enumerators were also trained on a short suicidality screening procedure for respondents who reported suicidal thoughts. The indicator to use the protocol was if the respondents directly stated that they were suicidal or answered "often," "sometimes," or "rarely" to the survey question that asked if they had "thoughts it would be better to not be alive" in the past two weeks. Enumerators would then ask directly if respondent has thoughts of killing themselves and if they have a plan. With that information, the enumerator would consult with the standby clinical team who would assess the level of risk and make appropriate intervention and/or referral. There were 79 respondents who reported having suicidal thoughts "rarely," and 59 respondents who reported having them "sometimes" or "often" in the past two weeks. Respondents who answered "sometimes" or "often" to this question were referred to a team lead, who administered a structured series of follow-up questions. If the respondent was assessed to be in imminent danger, they received PFA and an urgent referral to existing emergency mental health services.

## Demographic Characteristics

The survey sample was roughly balanced by camp and by gender: 52 percent of interviews were conducted in Adi Harush and 48 percent in Mai Ayni; within each camp, 50 percent of respondents were women and 50 percent men (this was due to the sampling approach, and the gender proportion was adjusted by weighting the data, as noted above). Respondents in Mai Ayni were slightly older, on average (*mean* = 31), than those in Adi Harush (*mean* = 29). The vast majority of respondents (99 percent) were from Eritrea, although a few respondents (1 percent) said that Ethiopia was their home country. Almost all respondents spoke Tigrigna; a small minority spoke Amharic, Saho, and/or English.

Key Characteristics of Survey Respondents <sup>1</sup>			
	Adi Harush	Mai Ayni	Combined
Sample size (N)	311	290	601
Women (valid %)	50	50	50
Age			
Mean*	29	31	30
Range	18-70	18-70	18-70
Home country (valid %)			
Eritrea	99	99	99
Ethiopia	1	1	1
Languages spoken (valid %, not mutually exclusive categories)			
Tigrigna	99	98	99
Amharic	3	7	5
Saho	3	5	4
English	4	3	4
Other languages <sup>2</sup>	1	1	1
Household size (not including respondent)			
Mean	4.2	3.9	4.1
Range	0-11	0-12	0-12
Completed levels of education (valid %)			
No education	38	32	35
Primary	61	67	64
Secondary	23	28	26
Technical	1	1	1
University	2	3	2
Years in current camp			
Range	0 – 10 years	0 – 12 years	0 – 12 years
Mean*	2.6 years	3.7 years	3.1 years
One year or less (valid %)	39	33	36
* Differences between camps are statistically significant on two-tailed chi-square or independent sample t-tests ( $p < .05$ ).			

Respondents reported moderate household sizes, with a mean of just over four people in addition to the respondent. Respondents in Mai Ayni had more education, on average, than those in Adi Harush. In Mai Ayni, 67 percent of respondents had at least a primary education; the figure was 61 percent for Adi Harush. The amount of time respondents had lived in the camp varied widely: some respondents had arrived less than a month previously, while others had been there ten years or longer. The standard deviation of reported time in camp was just over three years. However, the average time since arrival was shorter for Adi Harush (2.6 years) than in Mai Ayni (3.7 years). The difference was statistically significant ( $p < .01$ ).<sup>37</sup>

<sup>35</sup> All data presented here are weighted, except gender and age, the variables used to create the weights.

<sup>36</sup> Other languages reported included Afar and Blen.

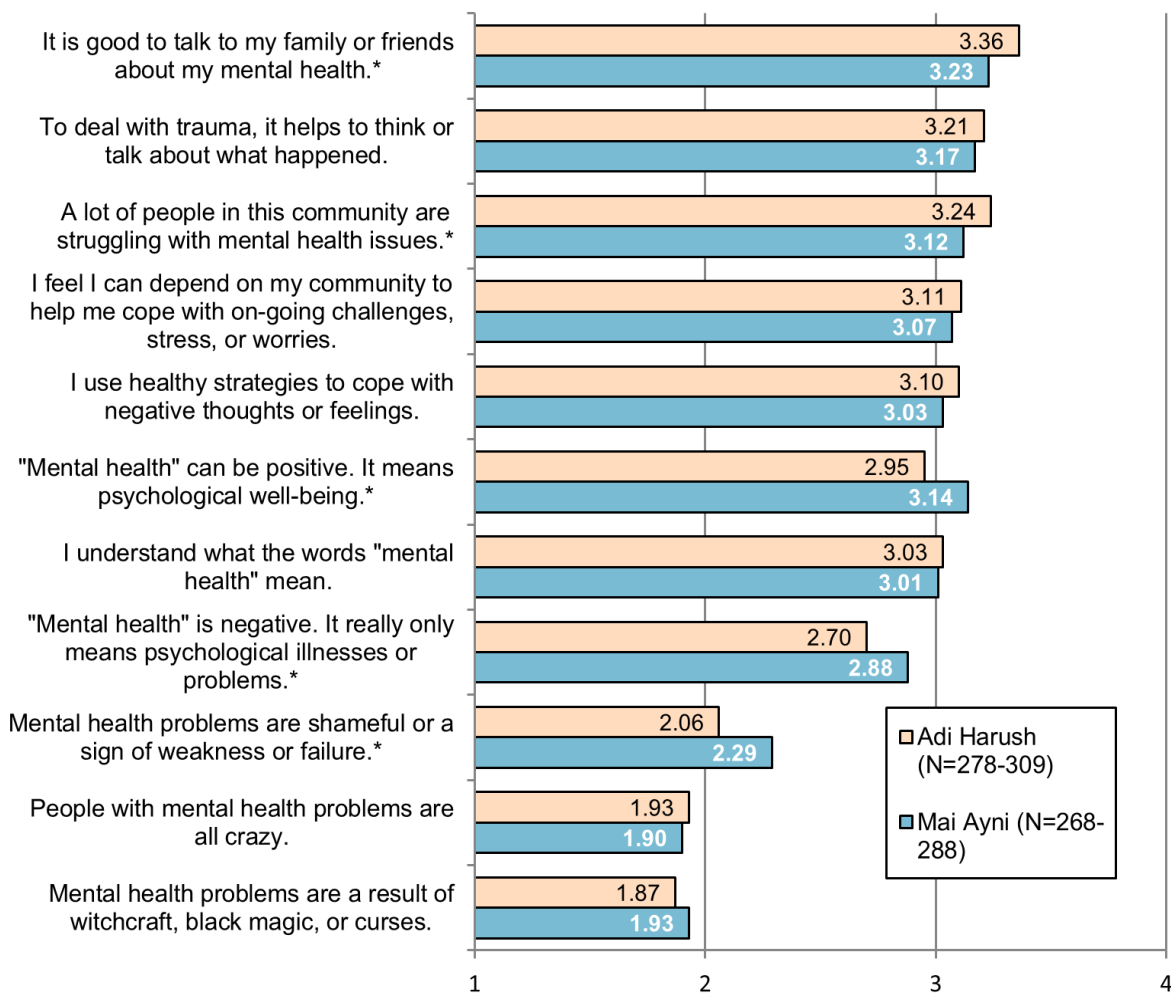
<sup>37</sup> The demographic profile of respondents in 2020 was largely similar to CVT's 2017 survey. The mean age in 2020 was slightly older than 2017 (30 years and 28 years, respectively).

# Knowledge and Attitudes about Mental Health

Respondents had generally positive attitudes about mental health. They were most likely to agree with positive statements, and were more likely to disagree with negative, stigmatizing statements. Respondents also strongly believed that many people in the community were struggling with mental health issues. Respondents strongly felt that they could rely on family, friends, and the community to help cope with mental health challenges, including through talking about traumatic events.

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

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



\* Differences between camps are statistically significant at 0.05-level.

**Mean response**  
1=strongly disagree / 4=strongly agree

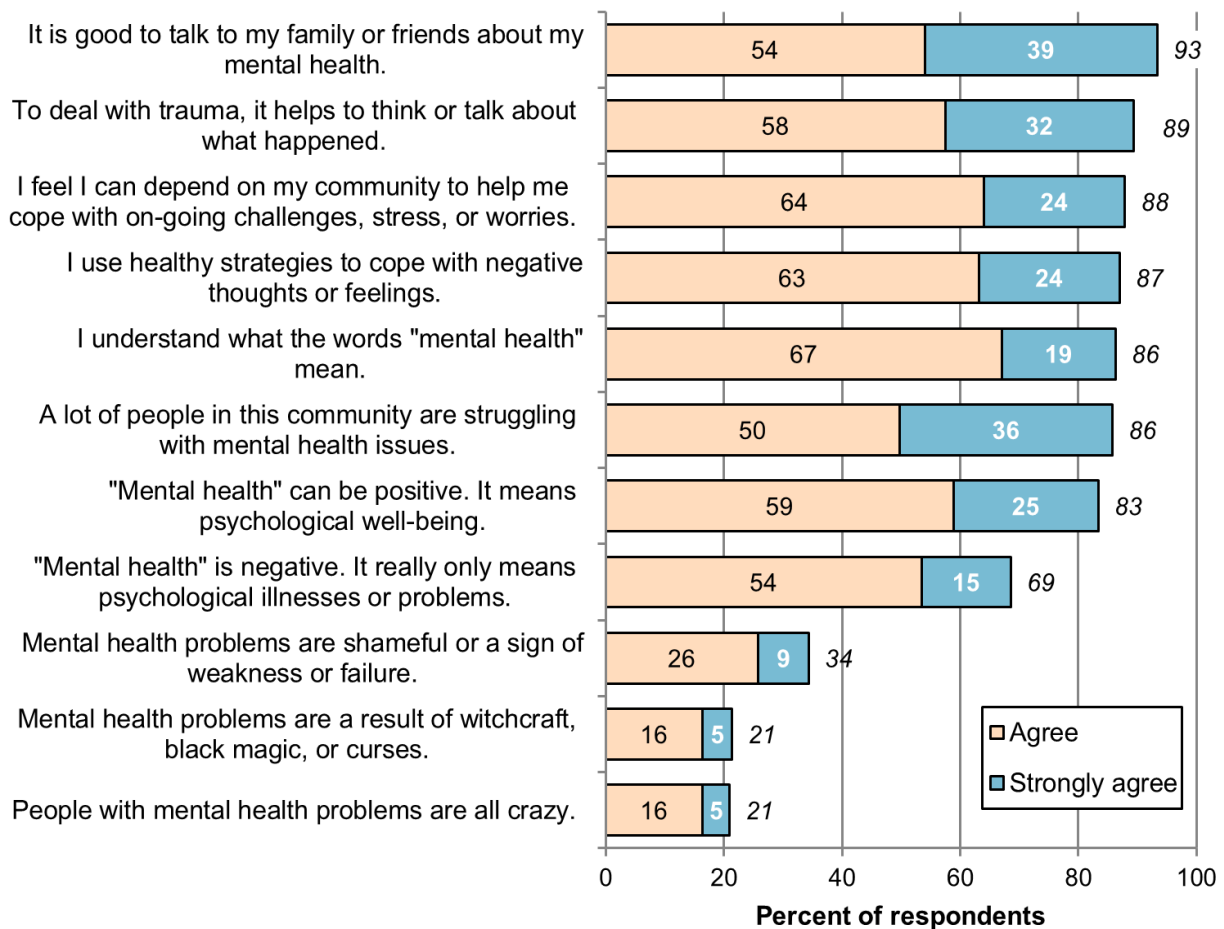
There were some statistically significant differences in knowledge and attitudes between the two camps. Most notably, respondents from Mai Ayni were, on average, more likely than those of Adi Harush to agree both that mental health can be positive *and* that mental health is only negative – suggesting, perhaps, greater polarization of attitudes in Mai Ayni. Mai Ayni residents were also

significantly more likely to agree that mental health problems are shameful or a sign of weakness or failure; 44 percent of Mai Ayni respondents “agreed” or “strongly agreed” with this, compared to 25 percent of Adi Harush respondents. This difference is also related to how long respondents have been in the camp; those who agree that mental health problems are shameful have been in the camp for a mean of 3.7 years, while those who disagree with this highly stigmatizing statement have been in the camp for a mean of 2.8 years.

The figure below disaggregates respondents who agree or strongly agree with each statement, combining respondents from both camps. A strong majority agreed with the positive statements: that it is good to talk to their family or friends about their mental health; that it is helpful to deal with trauma by talking about what has happened; that they can depend on their community to help them cope; that they use healthy coping strategies; that they know what “mental health” means; and that mental health can be positive. While there was less widespread endorsement of negative statements, 34 percent of respondents agreed that mental health problems are shameful and 21 percent agreed that people with mental health problems are “crazy.”

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

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



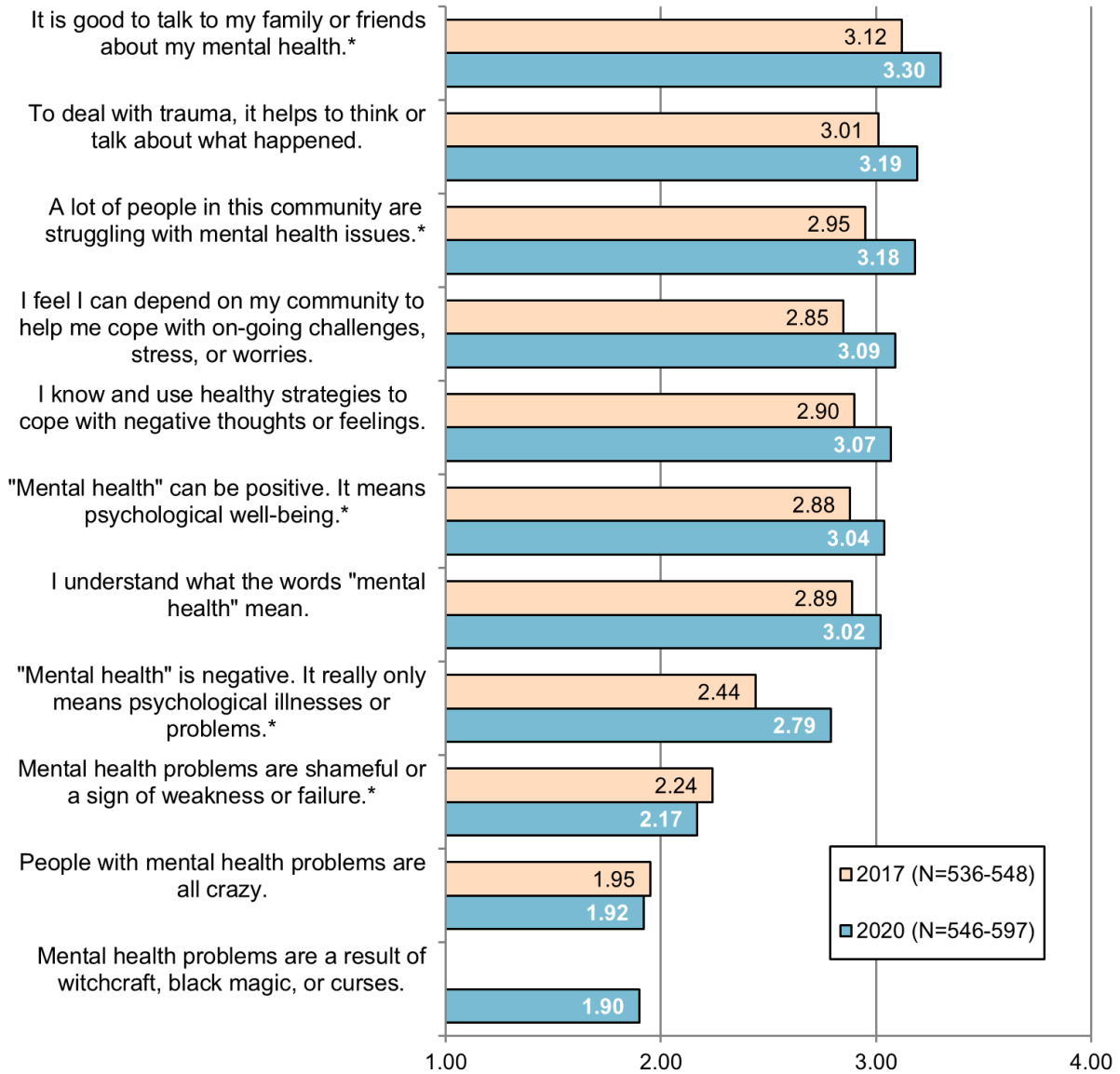
Compared to CVT’s 2017 survey, respondents in 2020 generally had greater knowledge and more positive attitudes about mental health.<sup>38</sup> As the figure below shows, 2020 respondents were significantly more likely to agree with all of the positive statements about mental health knowledge

<sup>38</sup> The item about mental health problems resulting from witchcraft, black magic, or curses was not asked in 2017.

and attitudes ( $p < .05$ ). Differences between 2017 and 2020 respondents on two of the negative statements, that mental health problems are shameful and that people with mental health problems are crazy, were not statistically significant.

## Knowledge & Attitudes about Mental Health: Mean Scores by Survey Year

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



\* Differences between years are statistically significant at 0.05-level.

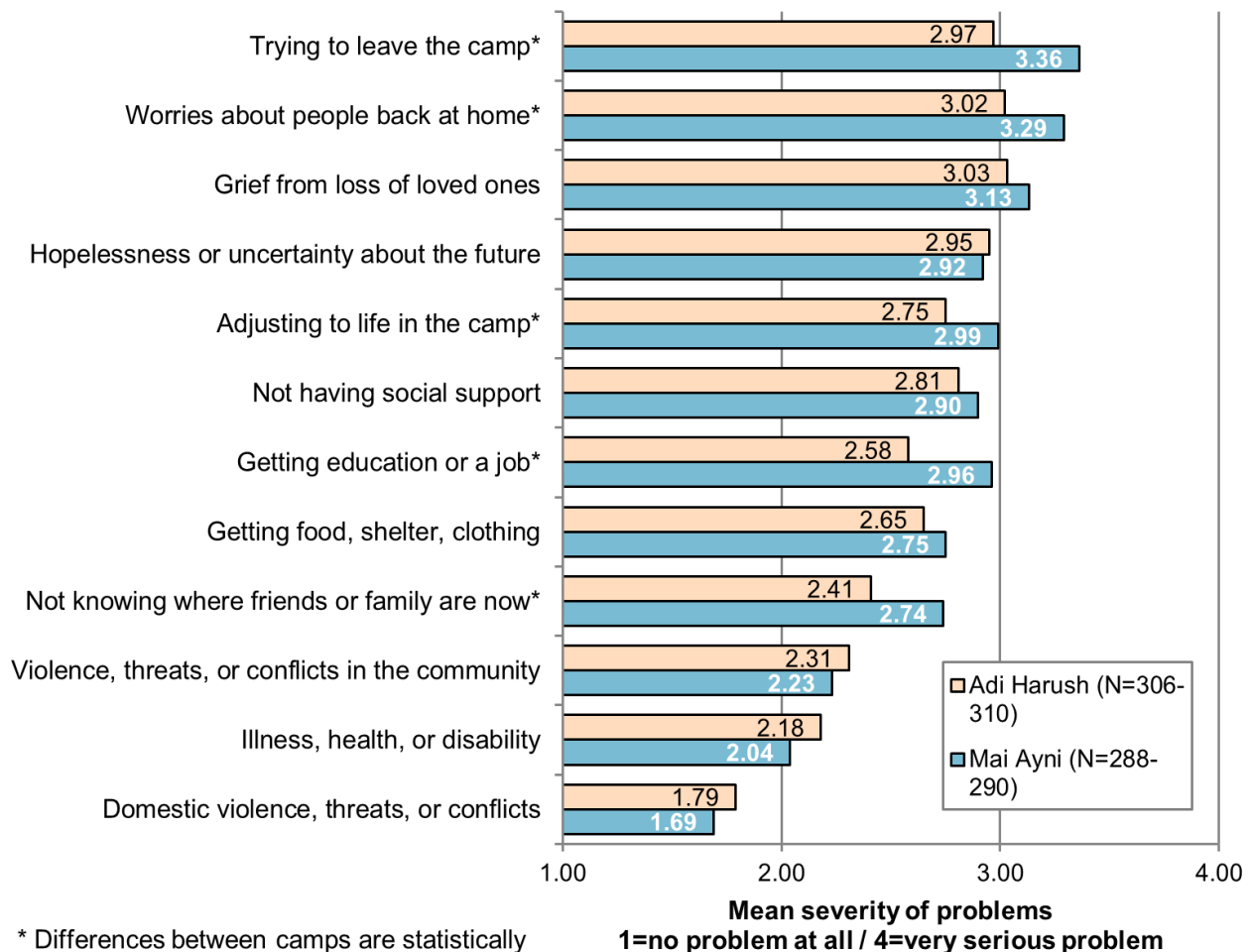
**Mean response**  
1=strongly disagree / 4=strongly agree

# Ongoing Stressors

The problems most frequently reported by respondents in their daily lives were: trying to leave the camp, worries about people back at home, and grief from the loss of loved ones. Residents of Mai Ayni, in general, rated most problems as being more severe than residents of Adi Harush; they reported significantly more difficulty with trying to leave the camp, worries about people back at home, adjusting to life in the camp, getting education or a job, and not knowing where family or friends are. Residents of Mai Ayni have, on average, been in the camp for about one year longer than those in Adi Harush. The average level of ongoing stressors (averaging over the twelve stressors included on the survey) was significantly correlated with the length of time the respondent had lived in the camp; a higher reported level of ongoing stressors was associated with a longer time in the camp ( $r = .17, p < .01$ ). The conditions and characteristics of the camp itself may contribute to residents' stress. For example, CVT teams working in the camps report a perception among refugees that those in Mai Ayni are less likely to be resettled than those in Adi Harush. Also, Mai Ayni is located further from the Ethiopian town of Mai Tsebri than is Adi Harush, potentially making it harder for Mai Ayni residents to go into town and buy necessities or access services that may be unavailable in the camp or to start businesses that may attract clientele from Mai Tsebri.

## Current Problems: Mean Scores by Camp

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

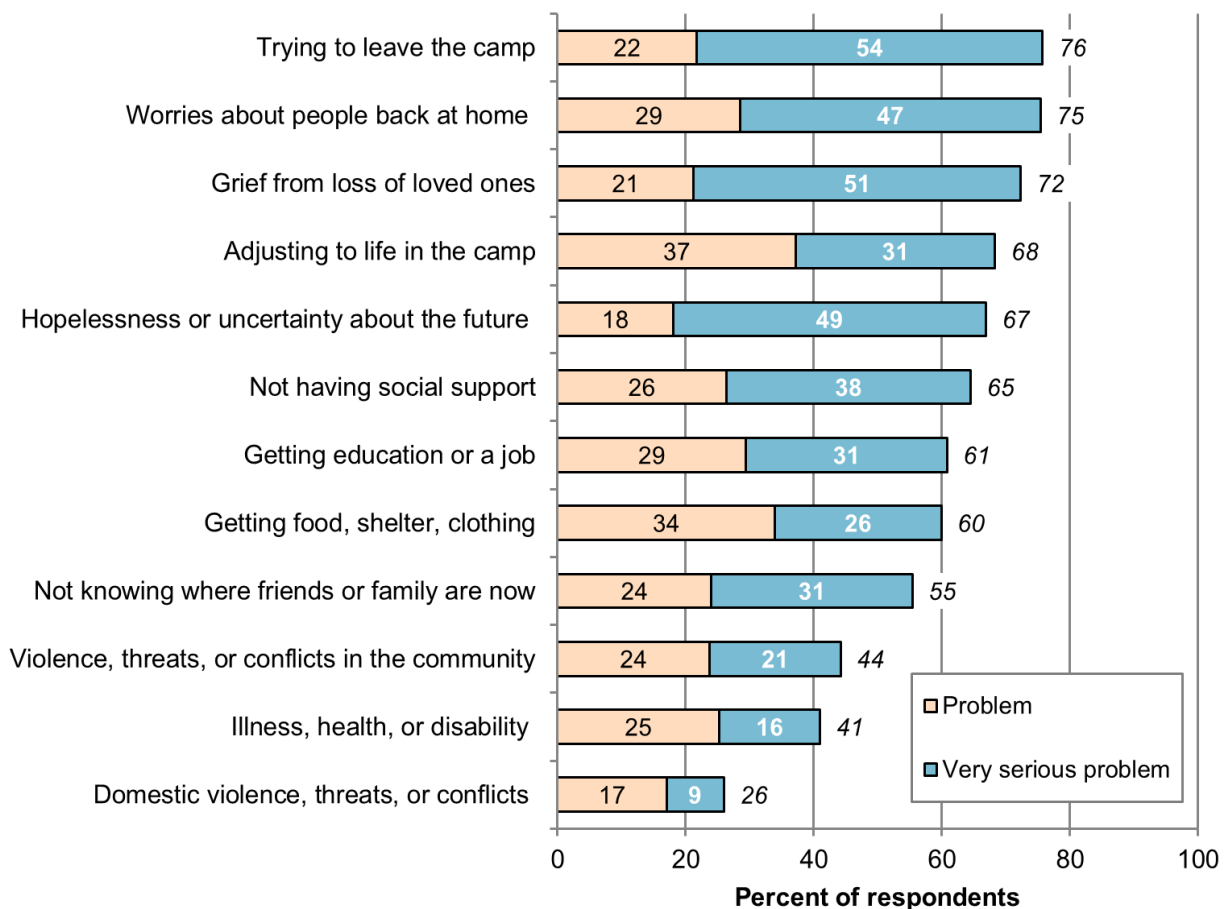


\* Differences between camps are statistically significant at 0.05-level.

Across both camps, around three-quarters of respondents said worries about people back at home and grief from loss of loved ones were a “problem” or “very serious problem” for them, suggesting a strong need for mental health support. Additionally, trying to leave the camp and adjusting to life in the camp were problems or very serious problems for 76 and 68 percent of respondents respectively, indicating that life in the camp is stressful for many and may contribute to mental health issues. It was more common for respondents to say that emotional concerns related to worry, grief, and hopelessness were problems in their life than it was for respondents to report problems with basic necessities like food, shelter, and livelihood – although these were still considered problems by more than half of respondents. Domestic violence was least frequently reported as a problem, but still over one-quarter of respondents said this was a problem or very serious problem for them (under-reporting of this problem is expected due to normalization of intimate partner violence and stigma about reporting).

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

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

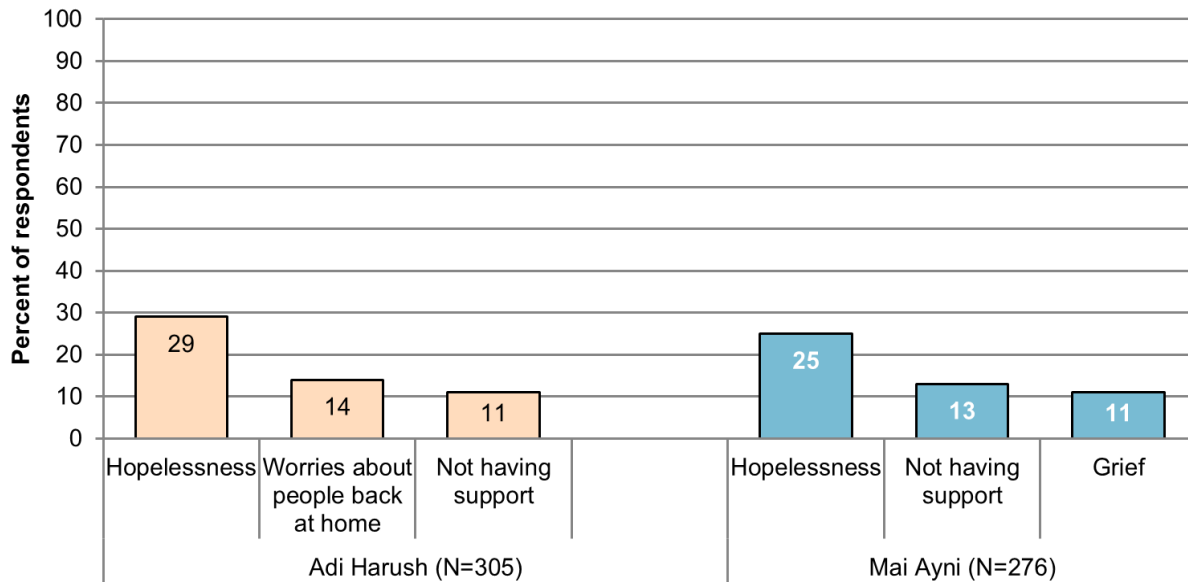


After reporting to what extent each issue is a problem in their life currently, respondents selected just one problem that is causing them the most stress. The most common response in both camps by a large margin was hopelessness or uncertainty about the future. While hopelessness was not reported as a problem for about a third of respondents, for those who did say it was a problem for them, it was what many considered most stressful or challenging. Feelings of hopelessness, powerlessness, or lack

of agency are common responses to chronic stress and traumatic experiences, and thus may reflect the accumulation of other stressors experienced by respondents. Other problems considered most stressful included worries about people back at home, not having social support, and grief.

## Most Significant Stressors

"Which of [the full list of potential problems] causes you the **most** stress right now?"

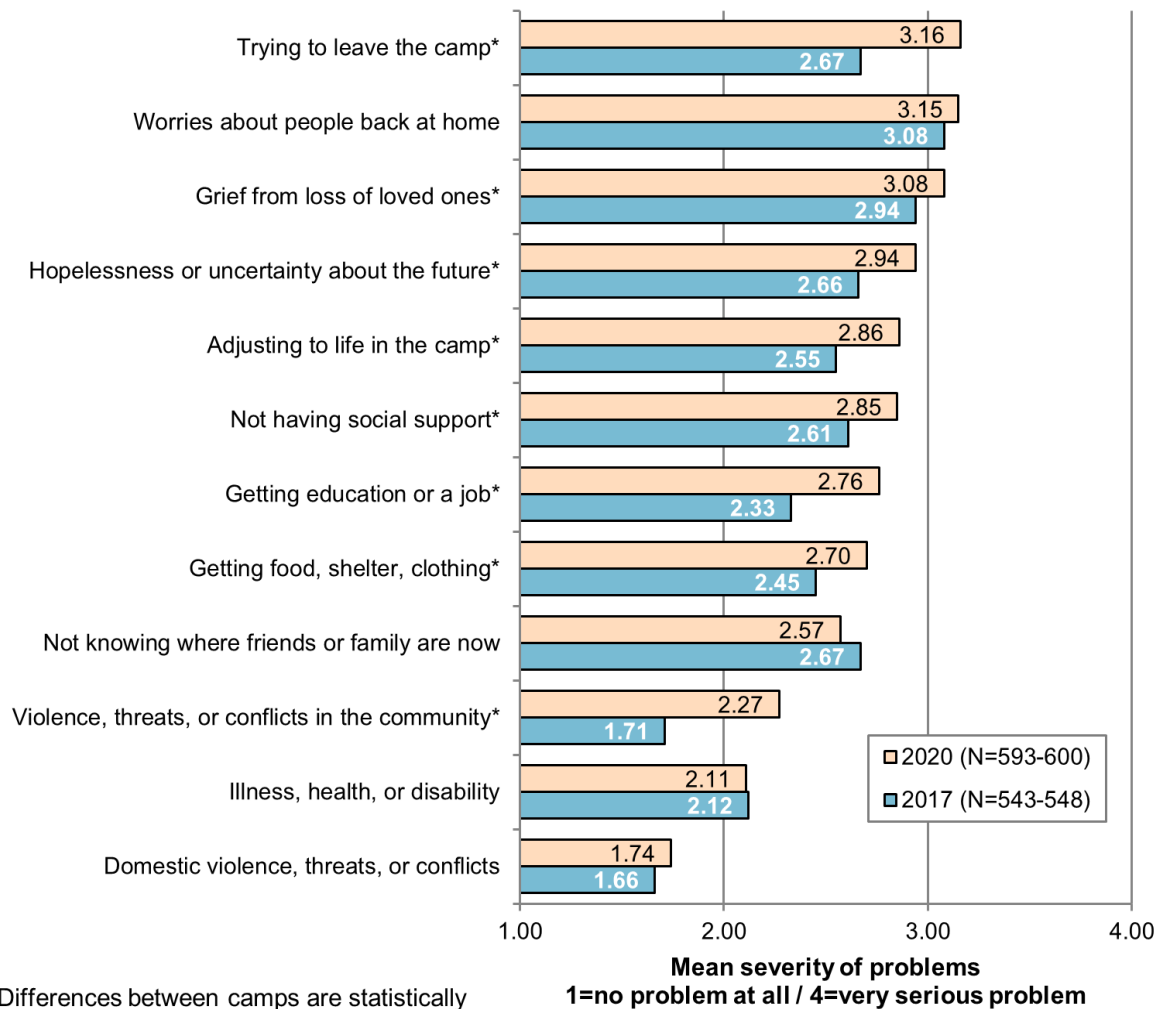


Compared to 2017, it was more common in 2020 for most of these issues to be reported as problems in respondents' lives. Notably, trying to leave the camp was reported as a problem much more frequently in 2020 than it was three years earlier ( $p < .01$ ). Grief from loss of loved ones, hopelessness or uncertainty about the future, adjusting to life in the camp, not and having social support were also more frequently reported as problems, compared to 2017 ( $p < .05$ ). Violence, threats, or conflicts in the community were perceived as problems more frequently ( $p < .01$ ), as were problems with accessing livelihoods and basic necessities. These changes in the frequency of reported problems may be related to significant socio-political developments in Eritrea, Ethiopia, and internationally in 2018 and 2019. Following the 2018 peace agreement between Eritrea and Ethiopia, the border between the two countries was opened, leading to an influx of newly arrived Eritrean refugees in the Tigray camps. This resulted in camp overcrowding and occasional conflicts among residents and between refugees and host communities. The peace agreement raised expectations of political change and openness in Eritrea, but little changed domestically and the border was subsequently closed. Because of reestablishment of regular telecommunications between Eritrea and Ethiopia, many refugees were able to speak to family members and friends at home after long periods of not hearing from them, and some may have learned that loved ones had died. Additionally, political tensions rose between the Tigray region and the Ethiopian federal government fueling concerns that there may be armed conflict near the camp areas. Economically, inflation may have increased financial stress for camp residents. Finally, global political shifts reduced opportunities (or perceived opportunities) for refugees to migrate elsewhere or to be resettled in a third country.



## Current Problems: Mean Scores by Survey Year

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

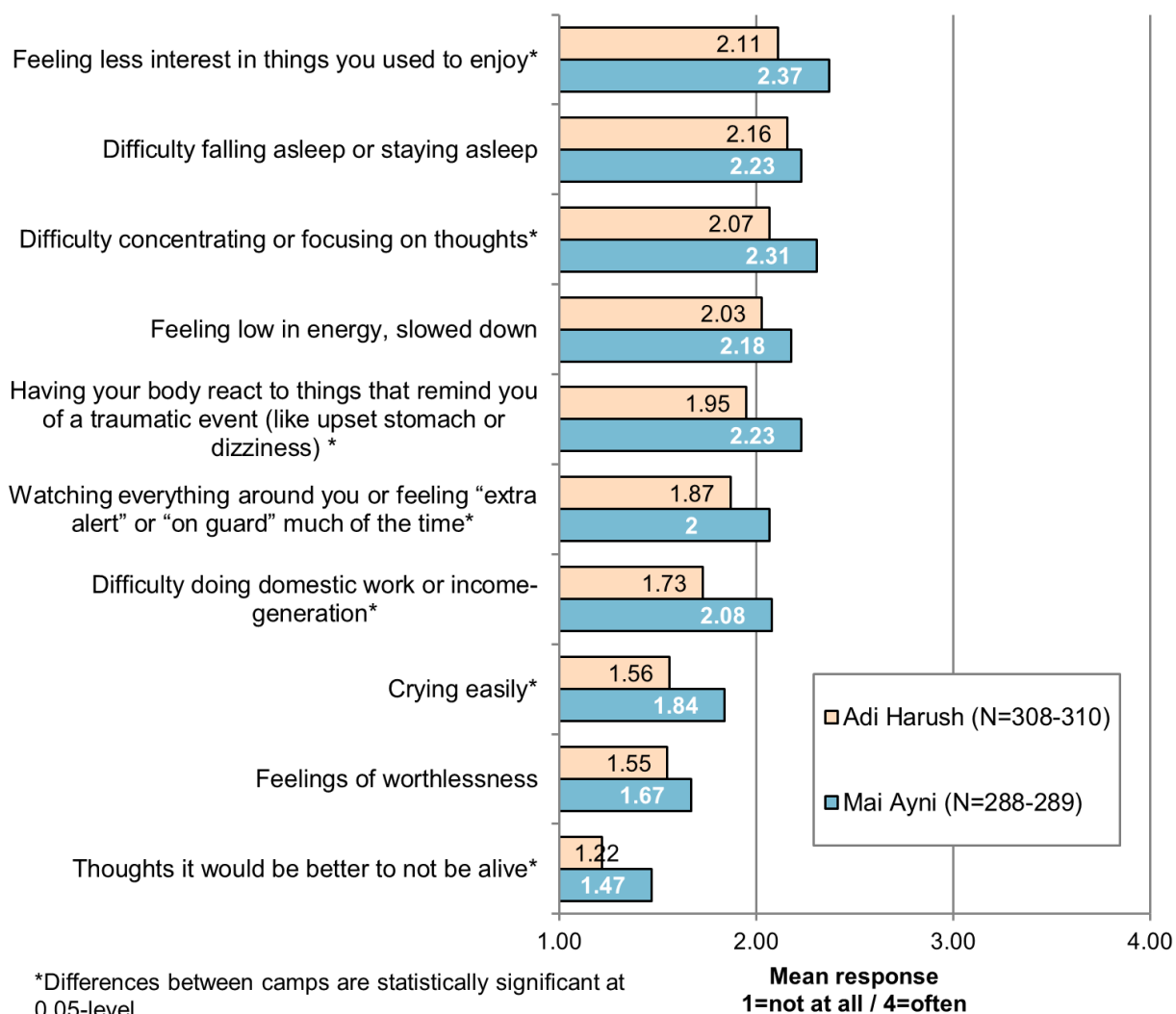


## Mental Health Problems and Symptoms

Respondents were asked how frequently they experienced ten symptoms in the past two weeks. These symptoms are indicators of depression and can also indicate post-traumatic stress. The most commonly reported symptoms were loss of interest and enjoyment, difficulty sleeping, and difficulty concentrating. Every symptom was reported more frequently, on average, by residents of Mai Ayni than those of Adi Harush; in seven of the ten symptoms, the difference was statistically significant. This difference is not unexpected given that average symptom levels (averaging over the ten symptoms included on the survey) are significantly correlated with the average level of ongoing problems or stressors; a higher reported level of ongoing stressors was associated with higher reported symptoms ( $r = .56, p < .01$ ).

## Symptom Areas: Mean Scores by Camp

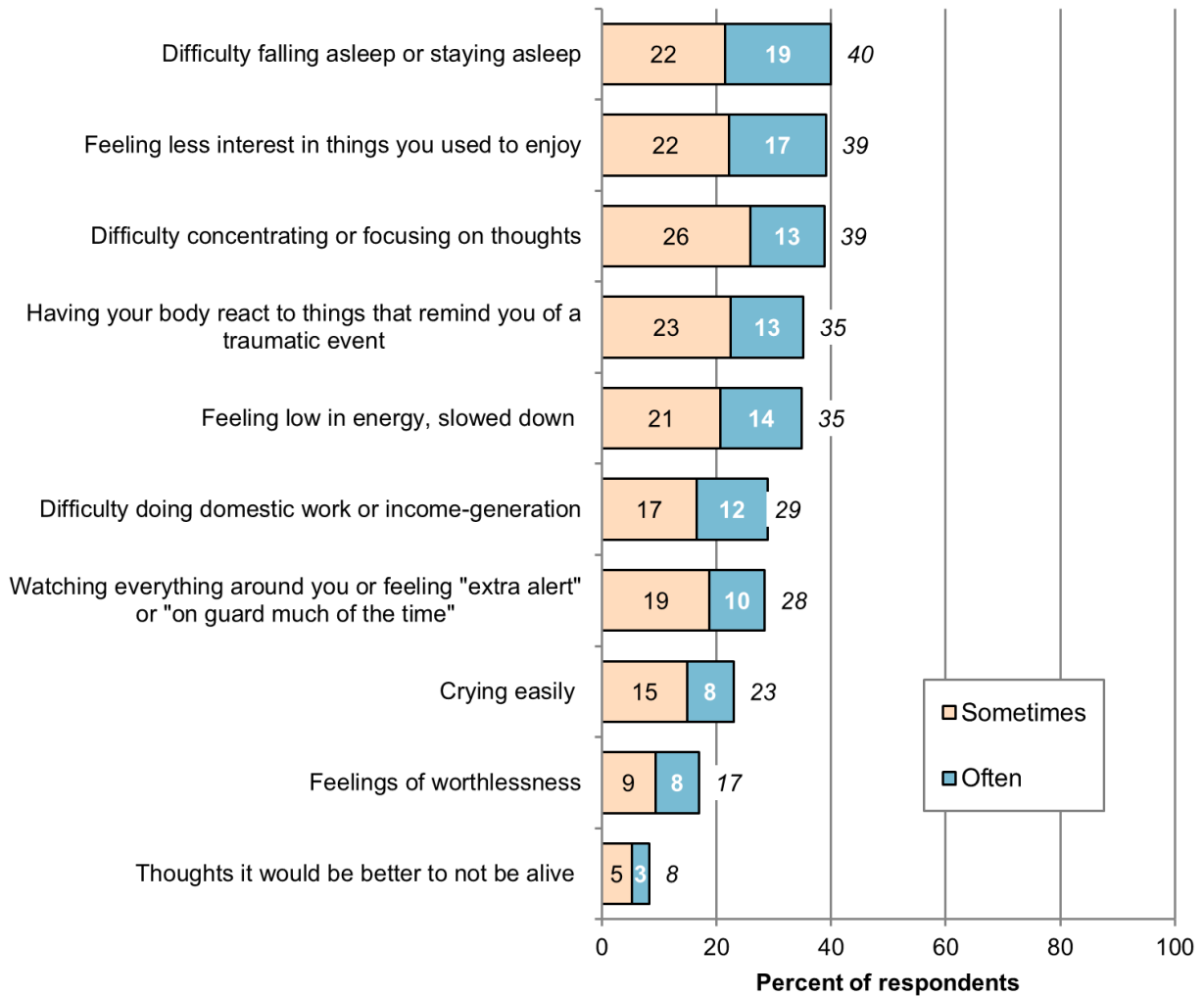
"How often have these problems bothered you in the past two weeks?"



In the past two weeks, 40 percent of respondents sometimes or often had trouble sleeping, and difficulty engagement in things they used to enjoy and in concentrating thoughts were similarly common. Suicidal thoughts were reported by 8 percent of respondents sometimes or often in the past two weeks; 8 percent reported they "rarely" had had such thoughts in that period.

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

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

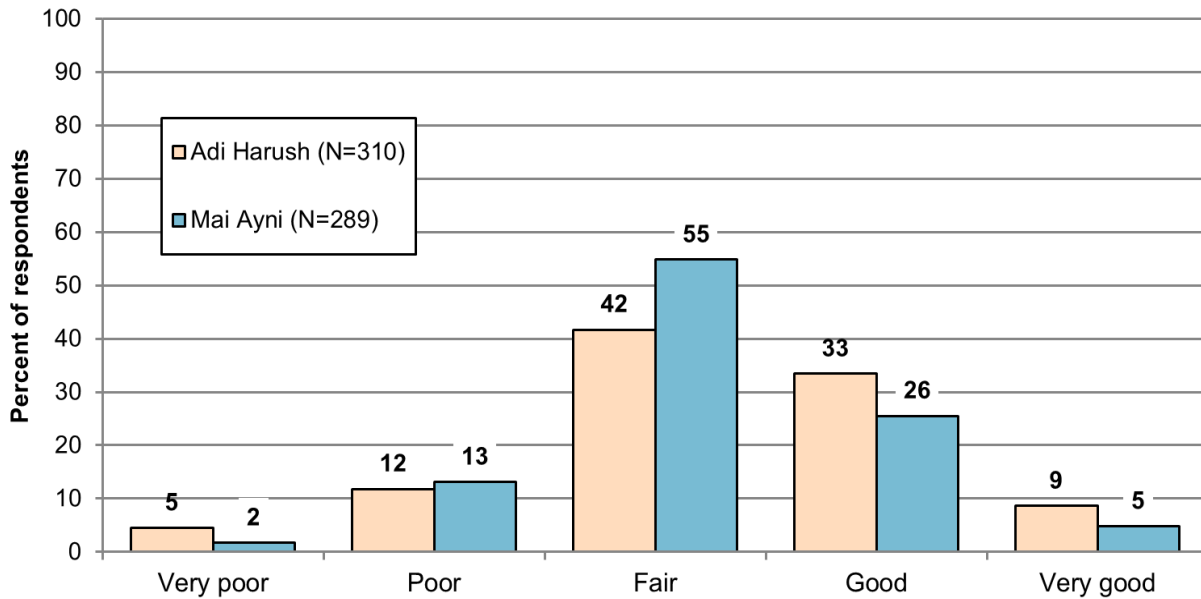


Although individuals may experience mental health symptoms related to past traumatic events or ongoing stress, often these are moderate enough that people are able to draw upon their existing internal and external coping resources to maintain functionality in daily life. However, nearly one-third of respondents said that mental health problems sometimes or often cause trouble with daily functioning in the past two weeks; 12 percent said mental health problems "often" cause trouble with functioning for them, 19 percent said "sometimes," 25 percent "rarely," and 45 percent "not at all." This helps to identify the proportion of refugees who may potentially derive strong benefits from mental health support to help develop new strategies and resources to cope with challenges in their lives.

Among all respondents, 37 percent ranked their mental health as good or very good, 48 percent as fair, and 15 percent as poor or very poor. However, there were statistically significant differences between camps, with Mai Ayni residents less likely to rate their mental health highly, aligning with the greater frequency of their reported symptoms. In Mai Ayni, 15 percent of respondents said their mental health was poor or very poor, while 30 percent said it was good or very good; in Adi Harush, 16 percent said their mental health was poor or very poor, with 42 percent saying their mental health was good or very good.

## Overall Mental Health by Camp\*

"How would you rate your mental health overall?"

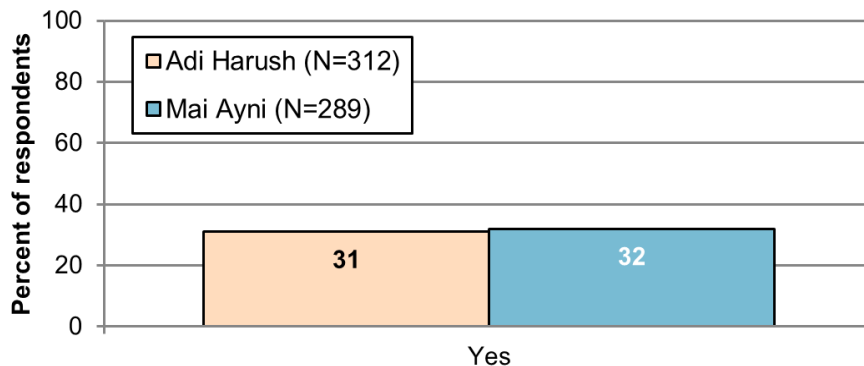


\*Differences between camps are statistically significant at 0.05-level.

Among all respondents, 31 percent 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. Mental health symptoms can be expressed physically, and can exacerbate physical pain; physical problems like chronic pain also can have negative effects on mental health and well-being. Reported physical health or medical problems were significantly related to average mental health symptoms: the more frequently health problems were reported to interfere with daily functioning, the higher the respondent's average mental health symptom levels ( $r_b = .54, p < .01$ ).

## Chronic Pain by Camp

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



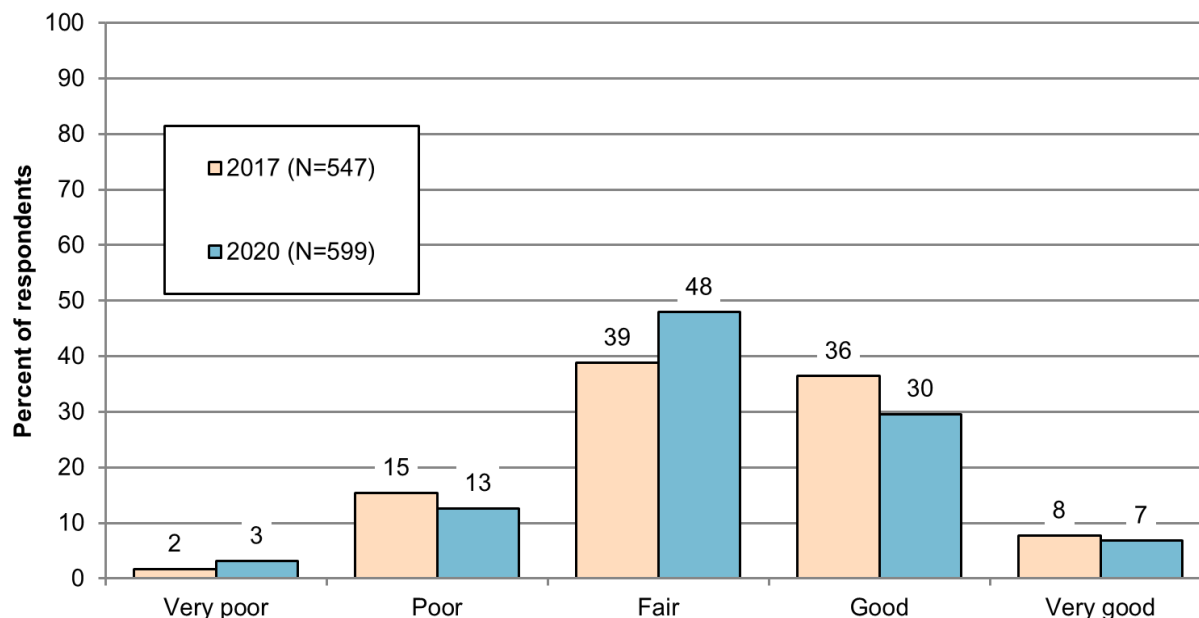
Differences between camps are not statistically significant.

Respondents of the 2017 and 2020 surveys did not report significantly different symptom levels, with a few exceptions. Respondents in 2020 more frequently experienced feeling less interest in things

they used to enjoy, feeling low in energy, and having difficulty doing work compared to those in 2017 ( $p < .05$ ).<sup>39</sup> Additionally, as the figure below shows, there were significant differences in respondents' self-rated overall mental health ( $p < .05$ ). In particular, 2020 respondents were most likely to say their mental health was "fair" – this was true for nearly half of respondents. In 2017, there was greater variation of in self-ratings of overall mental health.

## Overall Mental Health by Survey Year\*

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



\* Differences between years are statistically significant at 0.05-level.

## Coping Strategies

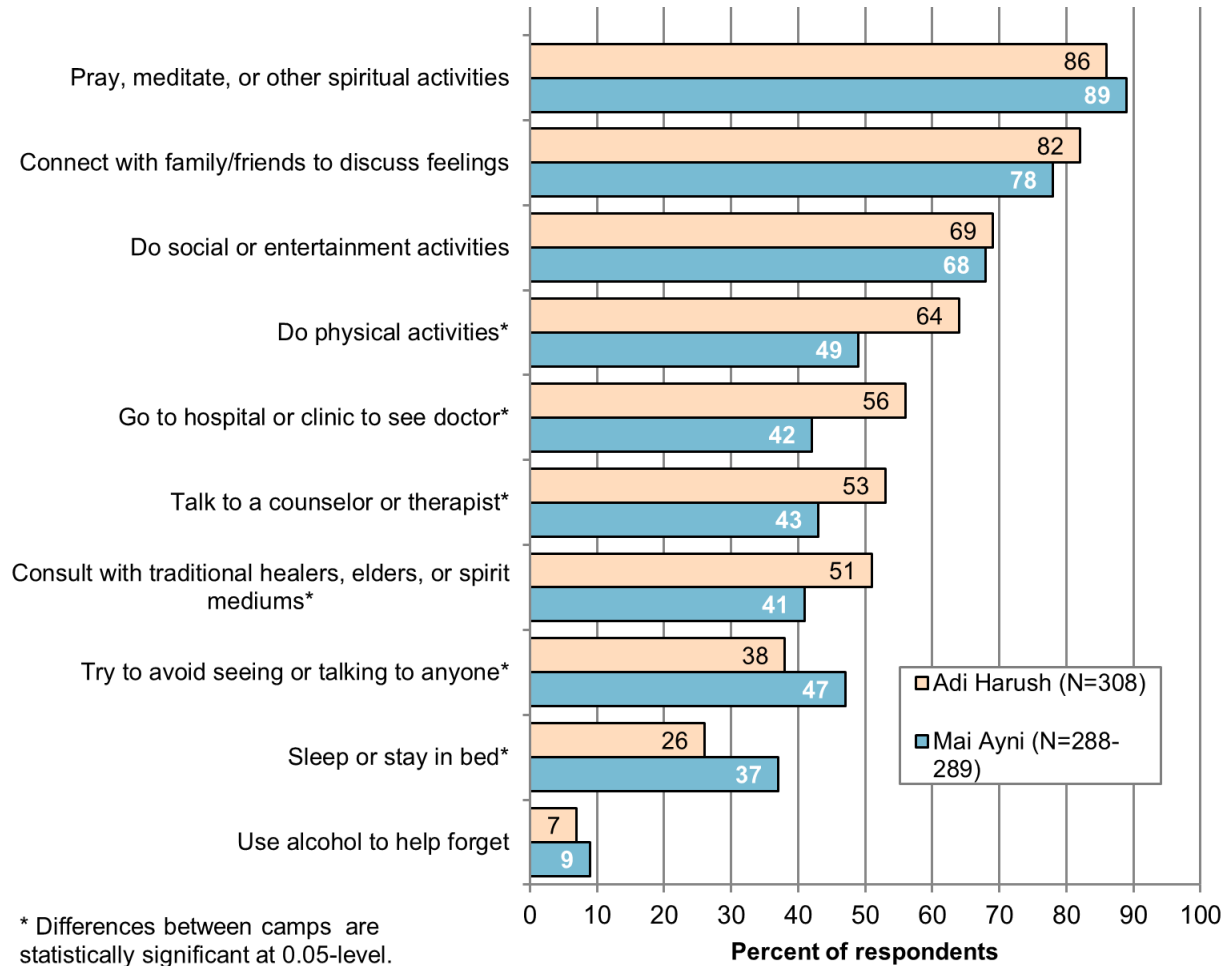
Respondents reported a range of coping strategies that they use to deal with difficult emotions, such as feeling sad, anxious, or overwhelmed. The vast majority (87 percent) reported that they turn to spiritual support to cope. A strong majority also said they rely on social support, connecting with family or friends to talk about their feelings or struggles, and over two-thirds cope with challenges more indirectly by turning to social activities or entertainment. When asked about seeking help from some sort of professional or traditional healer, around half of respondents each said that they seek help from medical doctors or clinics, counselors or therapists, or traditional healers or elders.

Our list included a few generally unhealthy coping strategies, which were reported comparatively less often. Some respondents reported avoidance strategies (not seeing anyone, staying in bed) to help cope with difficult emotions. These unhealthy coping strategies were reported significantly more commonly in Mai Ayni. Furthermore, Mai Ayni residents were significantly less likely to use some healthy coping strategies, such as doing physical activities, or seeing a doctor, therapist or counselor, or consulting traditional healers.

<sup>39</sup> On the scale of one to four, where one is "not at all" and four is "often," these three symptoms were experienced by 2020 respondents, on average, at levels of 2.23, 2.10, and 1.89, compared to 2.12, 2.01, and 1.72 for 2017 respondents, respectively.

## Coping Strategies by Camp

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

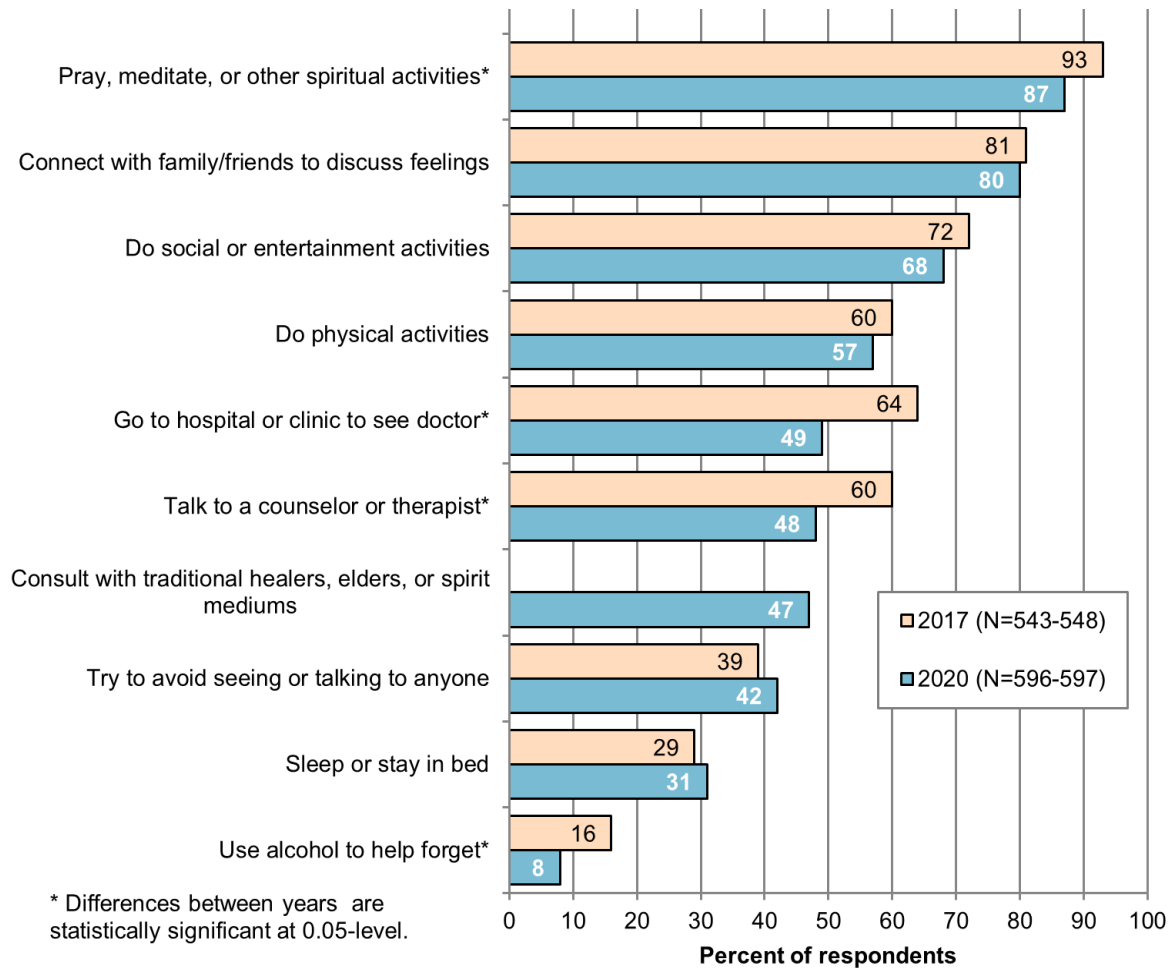


Compared to 2017 respondents, 2020 respondents were less likely to report some healthy coping strategies, and also less likely to use one unhealthy coping strategy. In 2017, 16 percent of survey respondents said they use alcohol to cope, compared to 8 percent in 2020. The difference was statistically significant ( $p < .01$ ). However, 2020 respondents were also less likely to rely on spiritual activities (93 percent in 2020 vs. 87 percent in 2017), see a medical doctor (64 vs. 49 percent), or see a counselor or therapist (60 vs. 48 percent). These differences were statistically significant ( $p < .05$ ).<sup>40</sup>

<sup>40</sup> The item about consulting with traditional healers, elders, or spirit mediums was not asked in 2017.

## Coping Strategies by Survey Year

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



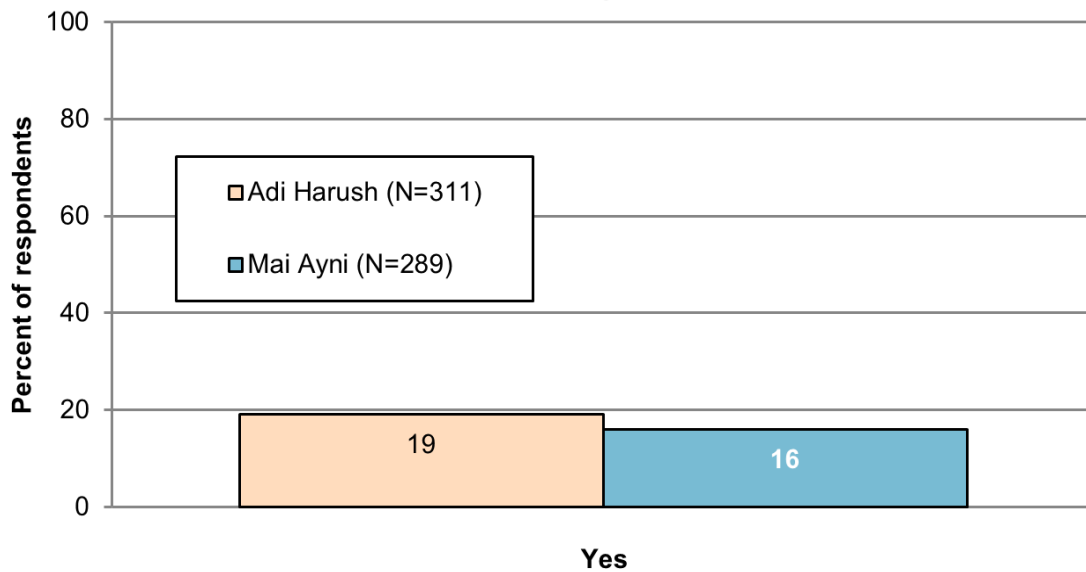
## Household Mental Health

Among all respondents, 17 percent reported that they had household members with mental health problems that interfere with their daily functioning.<sup>41</sup> Given that 30 percent of respondents reported that mental health problems sometimes or often interfere with their own daily functioning, this figure is somewhat lower than expected. There may be an unwillingness to stigmatize family members, or limited ability to recognize mental health problems in others. Reported rates of household mental health problems were not significantly different between 2020 and 2017 survey respondents.

<sup>41</sup> Reported rates of household mental health problems were not significantly different between 2020 and 2017 survey respondents.

## Household Functioning by Camp

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



Differences between camps are not statistically significant.

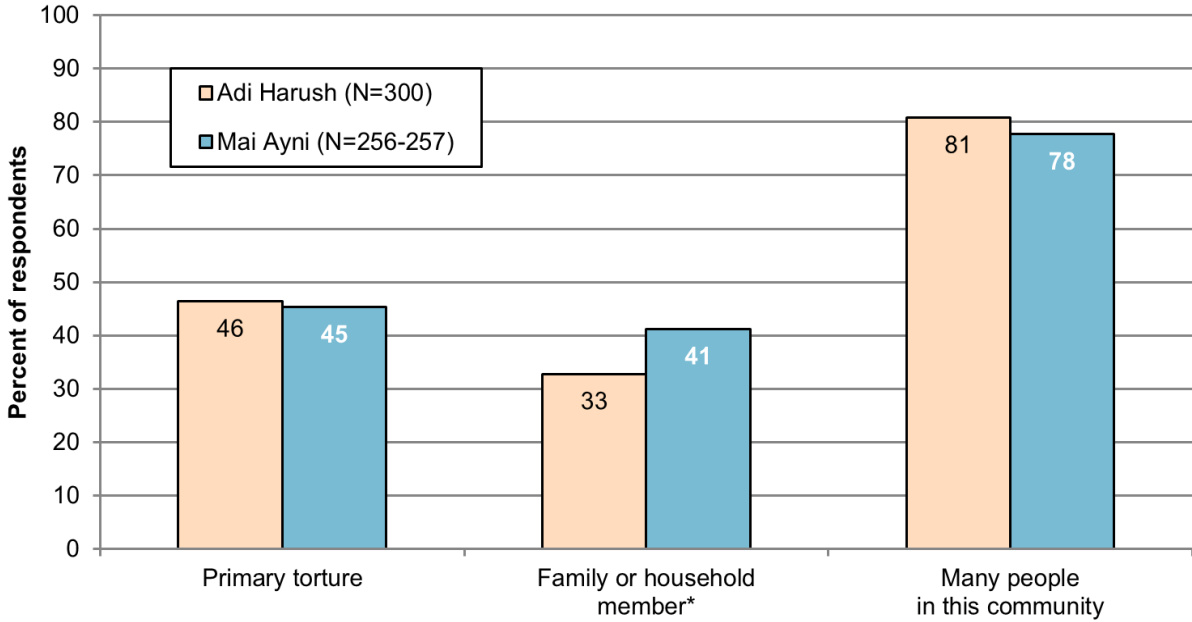
## Torture Survivors

After being offered a simple, brief definition of torture,<sup>42</sup> 46 percent of respondents reported that they had been tortured. Furthermore, 37 percent of respondents reported that someone in their family or in their household had been tortured. When asked whether they thought many people in their community had been tortured, 80 percent of respondents said yes. Differences between reporting by camp were only statistically significant ( $p < .05$ ) for family or household members, with this figure significantly higher in Mai Ayni than Adi Harush. Because torture often results in very particular negative consequences for mental and physical health, a specialized interdisciplinary rehabilitation program is recommended to address these rates of reported torture.

<sup>42</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." Respondents were asked whether they were willing to talk about torture; approximately 9% of respondents did not consent to be asked these questions.



# Torture Reported by Camp



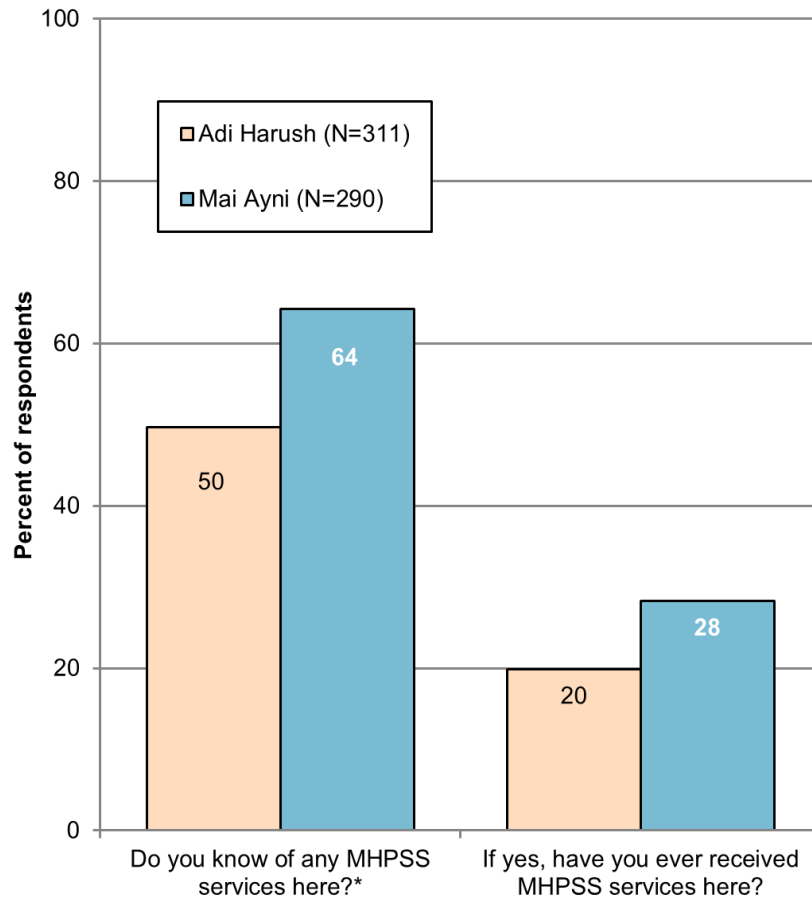
\* Differences between camps are statistically significant at 0.05-level.

Both primary and secondary torture were significantly more likely to be reported by 2020 survey respondents compared to 2017 respondents ( $p < .05$ ). In 2017, 40 percent of respondents reported being tortured, and 27 percent reported that someone in their family or household was a survivor of torture.

## Access to Services

Over half of respondents (57 percent) were aware of MHPSS services available in the camps. However, there were significant differences in awareness by camp; 64 percent of Mai Ayni respondents and half of Adi Harush respondents reported knowing about MHPSS services. This may reflect that Mai Ayni residents had, on average, lived in the camp longer than those of Adi Harush. Among those who reported that they knew of services, 37 percent of respondents had accessed MHPSS services (24 percent of all respondents).

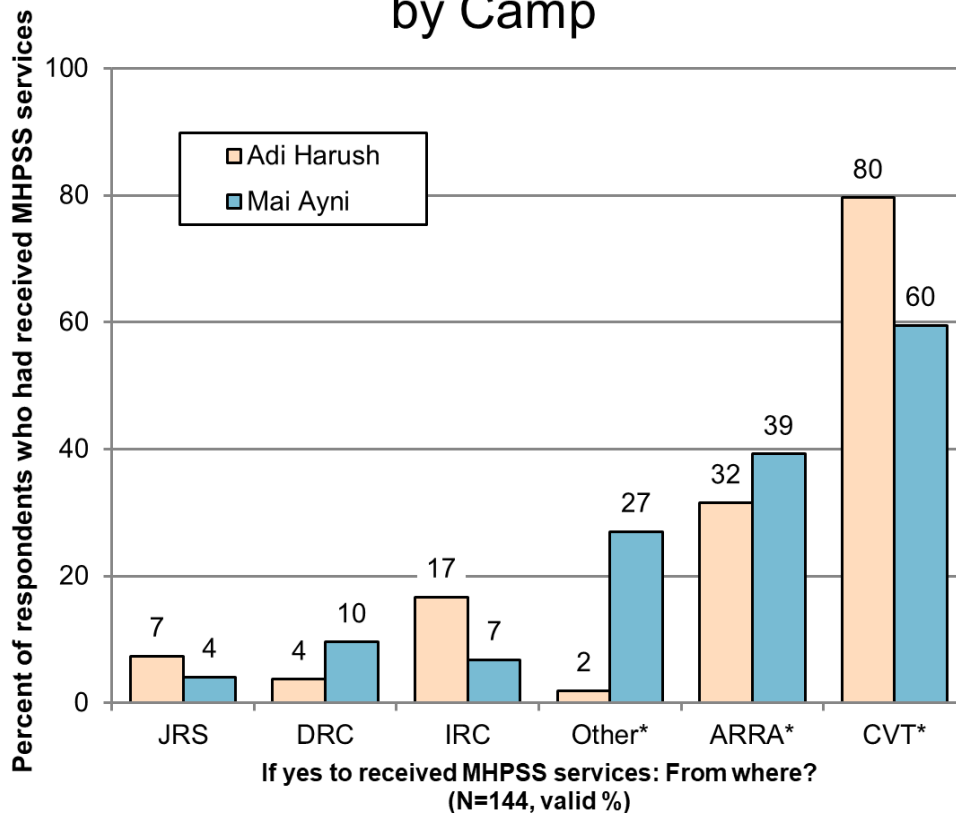
## Knowledge and Receipt of MHPSS Services by Camp



\* Differences between camps are statistically significant at 0.05-level.

Among respondents that said they had received MHPSS services, the majority said they had gotten them from CVT – this was the case for 80 percent of those who reported receiving services in Adi Harush and 60 percent in Mai Ayni. The next most frequently reported provider of MHPSS services was ARRA, with 32 percent of recipients in Adi Harush and 39 percent in Mai Ayni. In Mai Ayni, a sizeable minority of respondents said they had gotten services from other providers not listed on the survey questionnaire; the majority of these “other” respondents said they had gotten services from UNHCR, which to CVT’s knowledge does not directly provide MHPSS services.

## MHPSS Provider Agencies by Camp



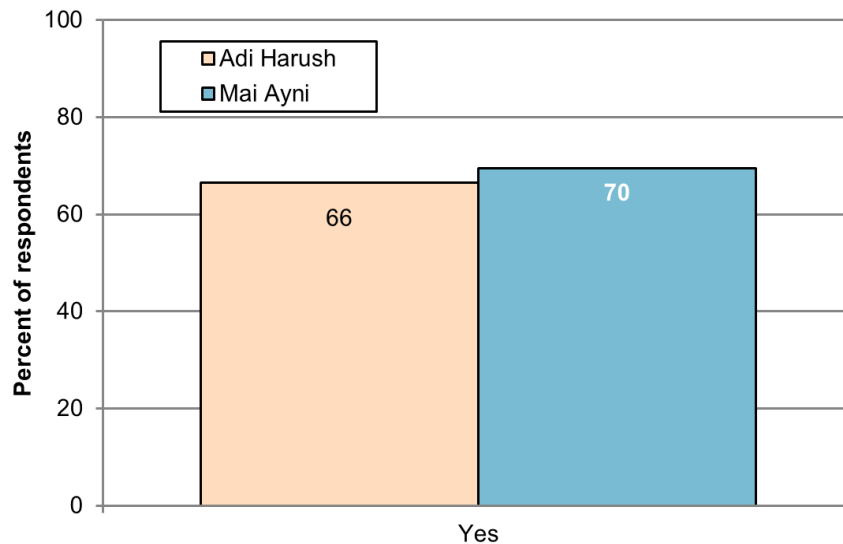
Respondents who knew about MHPSS services available but had not accessed them were asked why they had not done so. Most respondents said that either they did not want or need MHPSS services (42 percent of those who had heard of but not accessed MHPSS services), or that such services were for people worse off than they were (24 percent). About 7 percent said that they had tried but were unable to get MHPSS services. Minor differences between camps were not statistically significant.

Finally, respondents were asked about whether they had heard of CVT.<sup>43</sup> Overall, 68 percent of respondents said yes. Those who had heard of CVT had, on average, lived in the camp for much longer than those who had not heard of CVT, with an average of 51 months for those who had heard compared to 19 months for those who had not ( $p < 0.01$ ). However, residents who had heard of CVT were not necessarily aware that CVT provided MHPSS services, particularly for residents of Adi Harush: while 66 percent of respondents from that camp said they had heard of CVT, only 49 percent had reported knowing about MHPSS services available to them. These results suggest that, while there is a high overall level of awareness of CVT in each camp, greater outreach and psychoeducation about the nature of MHPSS services may still be needed.

<sup>43</sup> Respondents were asked whether they had heard of “The Center for Victims of Trauma, the Center for Victims of Torture, or CVT,” in order to include CVT’s former and current official names, as well as the frequently used acronym.

## Awareness of CVT by Camp

"Have you heard of the Center for Victims of Torture (CVT) before today?" (N=602)



In comparison to 2017 respondents, 2020 respondents were no more likely to be aware of MHPSS services available in the camps: in both years, about 57 percent of respondents knew of MHPSS services. Additionally, in both years, 68 percent of respondents had heard of CVT. However, 2017 respondents who knew of MHPSS services were more likely to have accessed them ( $p < .05$ ); 53 percent of those who knew of services in 2017 had accessed them, compared to just 37 percent in 2020. This may be due to the influx of new arrivals in 2018 and 2019, which may have resulted in reduced access to services. Results for MHPSS service provider agencies for those who had received services were not significantly different by survey year, but 2017 respondents were slightly more likely to have received services from JRS and less likely to have received them from DRC compared to 2020 respondents ( $p < .05$ ).

## Key Findings

CVT conducted a MHPSS needs assessment using probability-based methodology to survey a sample designed to be representative of the adult resident populations of Mai Ayni and Adi Harush camps in January 2020 (N=601).

Since that time, there have been significant global, regional, and local contextual changes, which are likely to have had effects on the demographic profile of displaced persons in these two camps (as well as the surrounding local area) and on the MHPSS-related problems or needs of this population. Results of this survey should be interpreted as representative of the perspectives and needs of the population in January 2020; additional surveys or other needs assessment methodologies are necessary to understand how perspectives and needs may have changed throughout 2020.

This survey is a replication of a similar survey conducted by CVT in 2017. These cross-sectional surveys provide insights into how needs may have shifted in that time period. The data presented in this report are also disaggregated to show results from Mai Ayni and Adi Harush separately. While observed differences between years and between camps are suggestive, additional analyses would be needed to understand the nature, extent, and explanations of the differences.

*Key findings from CVT's 2020 survey include:*

It is **feasible** to conduct an ethical and rigorous representative survey of refugees' mental health needs in a humanitarian context.

- To do so, however, requires resources and expertise in project implementation, psychological support, and research design and implementation.
- It is particularly essential to provide robust mental health support to both survey teams and survey respondents, when collecting data about sensitive topics with vulnerable populations. About 14 percent of respondents required support through Psychological First Aid (PFA) and three percent required an emergency response from an experienced psychotherapist or counselor to cope with distress or safety concerns.

There are not significant **demographic** differences between Adi Harush and Mai Ayni or between the 2017 and 2020 survey.

- Most respondents have a primary education or less, and about one-third reported that they had no formal education.
- Respondents live in moderately sized households, with about four other people.
- There is significant variation in how long respondents have been in these camps, ranging from new arrivals to those who have been in Adi Harush or Mai Ayni for 12 years. On average, respondents reported that they have been in their current camp for about three years, but over a third have arrived in the past year.

Camp residents reported many positive **perceptions about mental health**, but there was some evidence of persistent stigma among segments of the population.

- Positive attitudes about mental health were more prevalent than negative perspectives, but a minority of respondents agreed with statements that may contribute to stigma about mental health, saying that mental health problems are shameful or a sign of failure (34 percent) or that people with mental health problems are all crazy (21 percent).
- Most respondents expressed willingness and ability to rely on sources of family or community support to deal with mental health problems, with 93 percent agreeing that it is good to talk to their family or friends about their mental health and 88 percent feeling that they can depend on their community to help cope with stress and worries.

Refugees in Mai Ayni and Adi Harush report **stress from ongoing problems** associated with forced displacement.

- Respondents frequently reported problems dealing with life in refuge, with 76 percent reporting that trying to leave the camp is a problem in their lives currently and 68 percent saying it is a problem for them to adjust to life in the camp.
- Respondents struggled to cope with loss and worry, with many reporting problems from worrying about people back at home (75 percent), from grief (72 percent), and from hopelessness about the future (67 percent). The latter was most often named as the most significant stressor in respondents' lives.
- Respondents reported problems with daily living significantly more frequently than survey respondents in 2017, with particular increased frequency of problems with trying to leave the

camp, with violence or conflicts in the community, and with getting education or jobs.

- Mai Ayni respondents reported significantly more frequent daily problems or stressors than Adi Harush respondents.

Many respondents reported moderate **mental health symptoms** or functional difficulties, with substantial variation in the reported frequency of symptoms.

- Many respondents did not report struggling with mental health symptoms in the past two weeks. A substantial minority, however, experienced frequent symptoms and difficulty functioning. For example, 40 percent reported sometimes or often having sleep problems, 31 percent said mental health problems sometimes or often interfered with their functioning, and 64 percent said their mental health was fair, poor, or very poor.
- Eight percent of respondents reported sometimes or often having suicidal thoughts in the past two weeks.
- Nearly a third of respondents (31 percent) reported experiencing chronic pain.
- Mai Ayni respondents reported significantly more frequent symptoms than Adi Harush respondents.
- A minority (17 percent) of respondents said that someone in their household had mental health problems that interfere with their daily functioning.

There are a range of **coping strategies** that refugees are using to deal with mental health symptoms or problems.

- Most respondents use spiritual activities (87 percent) and social support (80 percent) to cope with difficult emotions.
- Some respondents reported coping with difficult emotions through avoiding social interaction (42 percent), staying bed (31 percent), or using alcohol (8 percent).

Survivors of **torture** often need intensive trauma rehabilitation services to address negative effects of their experiences.

- Nearly half (46 percent) of survey respondents said that they had been tortured
- Over one-third (37 percent) reported that a member of their family or household was a survivor of torture.

**Awareness and utilization of MHPSS services** in Adi Harush and Mai Ayni is relatively widespread.

- Over half (57 percent) of respondents were aware of MHPSS services, but 43 percent had not heard of any MHPSS services available in the camps.
- About 24 percent of respondents reported receiving MHPSS services; of these, the largest majority had received services from CVT.
- There was self-selection into receiving MHPSS services. About 15 percent of respondents had heard about MHPSS services but did not access them because they felt they were for people who had more serious problems than they did.

## Full Questionnaire

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

Date/ዕለት : \_\_\_\_\_

Interview/ቃለ-መጠይቅ # : \_\_\_\_\_

Interviewer name / ሽምቃለ-መጠይቅ ዝገብር ሰብ: \_\_\_\_\_

Supervisor name /ሽም ሱፐርቫይዘር: \_\_\_\_\_

**Welcome Script & Consent/ ናይ እንኳስ ደሓን መጻእኹም ጽሑፍን ስምምዕነትን**

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

ከመይ ሓዲርካ/ኪ/ከመይ ዊዲልካ/ኪ/ከመይ ኣምሲኻ/ኺ ኣነ ማእኸል ግዳያት ግፍዒ(ሲቪቲ)ምስከበሃል ዓለምለኸዊ ትካል እየ ዝሰርሕ። ስነ-አእምሮዊ ስቃይ/ስንብራት ዝገድፍ ናይ ሂወት ተጓንፎ ዘሕለፉን ከምኡ'ውን ካብ ዓዶም ብሓይሊ ንኸወጹ ዝተገበሩ ሰባት ኣገልግሎት ኣብ ምሃብ ኢና ንሰርሕ። ናይ ስነ አእምሮ ስምብራት ማለት ብሰንኪ ሕማቕ ተጓንፎ ወይ ፍጻመ ዝመጽእ አእምሮዊ፣ ስምዒታዊ ወይ ኣካላዊ ስቓይ እዩ። ኣብ ዓዲ-ሓሩሽን ማይ-ዓይንን ናይ አእምሮ ጥዕና ኣገልጎት ንህብ። እዚ ዳህሳሳ ንገብር ዘለና ኣብዚ ኸባቢ ዘሎ ናይ አእምሮ ጥዕና ኣገልግሎት ንምፍላጥ እዩ። ኣብዚ ኸባቢ ዝነበሩ ሰባት ድልየታቶምን ሓሳባቶምን ክንርዳእ ንደሊ ኢና።

We used a statistical procedure to randomly select households in your area, and that is why I am here. I would like to ask someone in your household a few questions about their experiences and their opinions about mental health. The questions will only take about 20-30 minutes. These responses will be put together with all other responses and analyzed. We will not collect or record any names at all.

እስታስቲካዊ ኣሰራርሓ ተጠቂምና ኢና ሃንደበት ዝዛውቲ ኣብዚ ከባቢኹም መሪጽና፣ በዚ ምኽንያት ድማ እየ ኣብዚ መጻእ ዘለኹ። ኣብዚ ዝዛ ዘሎ ዝኾነ ሰብ ብዛዕባ ናይ አእምሮ ጥዕና ተመክሮአምን ሓሳባቶም ዝምልከት ዝተወሰኑ ሕቶታት ክሓትት ይፈቱ። እቶም ሕቶታት ካብ 20-30 ደቃይቅ ጥራሕ ይወስዱ። እቶም መልስታት ምስ ካልኣት መልስታት ብሓንጻብ ኣጣጣሪና ክንትንትኖ ኢና። ዝኾነ ሽም ብፍጹም ኣይንጥቀምን ወይ ኣይንምዘግብን ኢና።

I would like to randomly pick someone from your household. Please help me list all adult (18+) [men / women] household members.

ካብ ስድራ ቤትኩም ሃንደበት ዝኾነ ሰብ ክመርጽ ይፈቱ። ኣብዚ ስድራ-ቤት ዘለው ኣባላት ኩሎም ልዕሊ ዕድመ (18+) (ደቂ-አንስትዮ/ተባዕትዮ) ዝኾኑ ንኸምዘግቡ ብኸብረትኩም ሓግዙኒ።

*Use numbers to randomly select a household member for inclusion. Switch between men and women – if you interviewed a woman in the last household, you must interview a man in this household. After an interviewee is identified, review any information from above, as necessary.*

*ካብቶም ኣብቲ ስድራ-ቤት/ዝዛ ዘለው ኣባላት ብሃንደበት ዝተመረጹ ተጠቀም። ኣብ ሞንጎ ደቂ-አንስትዮን/ተባዕትዮን ቀያይር- ኣብታ ዝሓለፈት ናይ መወዳእታ ስድራ-ቤት/ዝዛ ጻል ኣንሰተይቲ ቃለ-መጠይቅ ንይርካ እንተይርካ ኣብዛ ዘለ ኻያ ስድራ-ቤት ናይ ግድን ወዲ-ተባዕታይ ቃለ-መጠይቅ ግበር። ድሕሪ ቃለ-መጠይቅ ክትገብር ምስ ፈለ ኻ ፣ ኢድላይ እንተኾይኑ ኣብቲ ላዕሊ ዘሎ ሓበሬታ ክልስ ኢ ኻ።*

Your participation is completely optional and voluntary. You can choose not to answer any question if you don't want to. You can stop the survey at any time. This is not a test and there are no 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.

ተሳትፎኻ/ኺ ሙሉእ ብሙሉእ ብወለንተኛነት /ብድልየትን ምስ ሙሉእ ኣማራጺን እዩ። እንድሕር ዘይደሊ ኻ/ኺ ዝኾነ ሕቶ መልሲ ዘይምሃብ ክትመርጽ ይክኣል እዩ። ኣብ ዝኾነ ሰዓት እቲ መጽናዕቲ ጠጠው ክተብሎ ትክእል ኢ ኻ። እዙይ ፈተና ስለዘይኮነ ሓቂ ወይክዓ ጌጋ ዝበሃል መልሲ የለን ። ኣነ ድልየተይ ንስኻ እንታይ ከምዘሰመዐካ ወይ እትሓስብ ነገር ብርግጽ ንምፍላጥ ጥራሕ እዩ። ነቶም ትህቦም መልሲ ናይቶም ሕቶታት ብዝኸልከሩ ግሉጽ ከምትክእል ከመስግን ይደሊ ።

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

ሽቶ ዓይዞም ሕቶታት ኣብዚ ቦታ ንዘወሃብ ተወሳኺ ግልጋሎት ንምሕጋዝ እዩ ነገር ግን ናትካ ተሳትፎ ብዝኾነ ይኹን መንገዲ ቐጥታ ንዓኻን ወይክዓ ንስድራኻ ዘጥቅም ኣይኮነን ።



Some of the questions may remind you of things that cause stress for you. If any question makes you feel upset, just let me know. At the end, we can take a few minutes to see how you're feeling.

እቶም ሓድ ሓድ ሕቶታት ንዓኻ ጸቕጠ። ንዝገብሩልካ ነገራት ምናልባት ከዛኻኹርኻ ይኸእሉ እዮም። እንድሕር ዝኾነ ሕቶ ዘሕርቀካ እንተኾይኑ ሓብረኒ ኢኻ/ኺ። ኣብ መወዳእታ ከመይ ከምዝሰመዐካ ክንርእ ኢና።

Are you willing to participate? ንክትሳተፍ ፍቃደኛ ዲኻ/ኺ  Yes/እወ  No/ኣይፋል

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

Don't read the questions below. Complete before beginning the interview. ነቶም ኣብ ታሕቲ ዘለው ሕቶታት ኣይተንብብዎም። ቅድሚ ነቶም ቃለ መገትት ምጅምርኩም ኣሕፅር ኣቢልኩም ምልእዎም።

Time started: \_\_\_\_\_ AM / PM/ ቅድሚ ቀትሪ/ ድሕሪ ቀትሪ  
ዝተጀመረሉ ሰዓት

Location of interview:  Adi Harush  Mai Ayni  Other: \_\_\_\_\_  
ቃለ-መገትት ዝተገበረሉ ቦታ  ዓዲ-ሓሩሽ  ማይ-ዓይኒ  ካሊእ:

Zone/ዞን: \_\_\_\_\_ Block/ብሉክ: \_\_\_\_\_ Community/ማሕበረሰብ: \_\_\_\_\_ House number/ገዛ ቁጽራ: \_\_\_\_\_

Gender of respondent:  Man/ተባዕታይ  Woman/ኣንስታይ  
ናይ መልሲ ወሃቢ ጾታ

Language of interview:  Tigrinya/ትግርኛ  Amharic/አምሓርኛ  English/ኢንግሊዝኛ  Saho/ሳሆ  
ቃለ-መገትት ዝተገበረሉ ቋንቋ  
 Other: ካልኣት: \_\_\_\_\_

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.

መጀመርያ ብዛዕባ ኣእምሮ ጥዕና ክትስማዕ መዕሎም ወይ ዘይክትስማዕ መዕሎም ትኽእል ሓሳብኻ ክንብብልካ እየ። ብኸብረትኩም ኣዘየ ኣይስማዕኩን፣ ኣይስማዕኩን፣ ይስማዕኩን ወይ ኣዘየ ይስማዕኩን ኢሎም ይንገሩኒ።

Use thumbs up and down to illustrate the options.  
 እቶም መማረጽታት ንምሕብር ኣጻብዕቲ ንላዕልን ንታሕትን ተጠቀሙ

	<b>Do you agree or disagree?</b> <b>ትስማዕኩ ዲኻ/ኺ ወይስ ኣይትስማዕኩን?</b>	<b>Strongly Disagree</b> ኣዘየ ኣይስማዕኩን (2 thumbs down) 2 ኣጻብዕቲ ንታሕት	<b>Disagree</b> ኣይስማዕኩን (1 thumb down) 1 ኣጻብዕቲ ንታሕት	<b>Agree</b> ይስማዕኩን (1 thumb up) 1 ኣጻብዕቲ ንላዕሊ	<b>Strongly Agree</b> ኣዘየ ይስማዕኩን (2 thumbs up) 2 ኣጻብዕቲ ንላዕሊ
1.1a	I understand what the words “mental health” mean. ናይ “ኣእምሮ ጥዕና” እንታይ ማለት ምዃኑ ይርደእኒ።				
1.1b	<b>IF AGREE OR STRONGLY AGREE:</b> <b>እንድሕር ትስማዕኩ ወይ ኣዚኻ እንተተስማዕኩኻ/ኺ</b> Please give me a short description of mental health. ብኸብረትኩም ናይ ኣእምሮ ጥዕና ሓጺር መግለጺ ሃቡ።	Write response: መልሲ ጽሓፍ Field code, select one option: ናይ ፊልድ ኮድ፣ ኣደ መማረጺ ምረጽ <input type="radio"/> NEGATIVE: unstable, crazy, problems, shame ኣሉታዊ፡- ዘይርጉእ፣ ዕብድ፣ ጸገማት፣ ሕፍረት <input type="radio"/> NEUTRAL: overall psychological state of being ሞንጎኛ፡- ሓፊሻዊ ናይ ስነ-ኣእምሮዊ ኩነታት ጥዕና <input type="radio"/> POSITIVE: well-being, coping skills ኣውንታዊ፡- ጽብቕ ኩነታት ጥዕና፣ ደኅንነት ተጸዋርነት ክእለታት <input type="radio"/> Other / not clearly related to mental health ካልእ/ ብንጹር ምስ ኣእምሮ ጥዕና ዘይራኽብ			
1.2	“Mental health” can be positive. It means psychological well-being; it is important for everyone. “ናይ ኣእምሮ ጥዕና” ኣውንታዊ ክኸውን ይኽእል። እዚ ማለት ስነ-ኣእምሮዊ ጥዕና ምዃን ንኩሉ ኣገዳሲ እዩ።				
1.3	“Mental health” is negative. It really only means psychological illnesses or problems. “ኣእምሮዊ ጥዕና” ኣሉታዊ እዩ። ስነ-ኣእምሮዊ ሕማም ወይ ጸገም ጥራይ ማለት እዩ።				
1.4	To deal with trauma, it helps to think or talk about what happened. ናይ ስነ-ኣእምሮ ስንብራት ንምጽዋር፣ ብዛዕባ እንታይ ከምዘጋጠመካ ምሕሳብን ምዘራብን ይሕግዝ እዩ።				
1.5	Mental health problems are shameful or a sign of weakness or failure. ናይ ኣእምሮ ጥዕና ጸገማት ዘሕፍሩን ምልክታት ድኸመትን ውድቀትን እዮም።				
1.6	It is good to talk to my family or friends about my mental health. ብዛዕባ ናተይ ናይ ኣእምሮ ጥዕና ንቤተሰብይን መሓዞትን ምዘራብ ጽብቕ እዩ።				

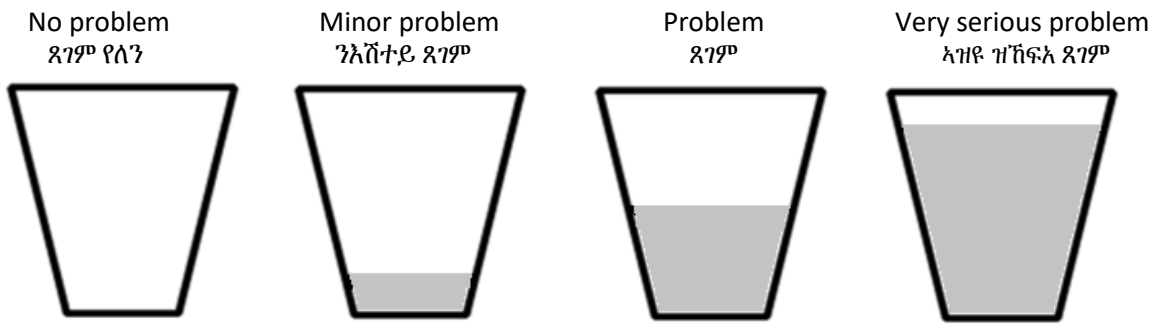
	<p><b>Do you agree or disagree?</b> ትስማማዎ ዲኻ/ኺ ወይስ አይትስማማዎን?</p>	<p><b>Strongly Disagree</b> አዝዮ አይስማማዎትን  (2 thumbs down) 2 አጻብዕቲ ንታሕቲ</p>	<p><b>Disagree</b> አይስማማዎትን  (1 thumb down) 1 አጻብዕቲ ንታሕቲ</p>	<p><b>Agree</b> ይስማማዎ  (1 thumb up) 1 አጻብዕቲ ንላዕሊ</p>	<p><b>Strongly Agree</b> አዝዮ ይስማማዎ  (2 thumbs up) 2 አጻብዕትኻ ንላዕሊ</p>
1.7	<p>I use healthy strategies to cope with negative thoughts or feelings about what has happened to me. ብዛዕባ እቲ ዘጋጠመኒ ተጓንፎ ዘለውኒ አሉታዊ ሓሳባት ወይ ስምዒታት ንምጽዋር ጥዑያት ሜላታት ኢጥቀም እዮ።</p>				
1.8	<p>People with mental health problems are all crazy. ናይ አእምሮ ጥዕና ጸገም ዘለዎም ሰባት ኩሎም ጽሉላት እዮም።</p>				
1.9	<p>I feel I can depend on my community to help me cope with on-going challenges, stress, or worries. ቀጻሊ ጸገማትን፣ ጸቕጠን ሻቕሎትን ክኣሊ ክሕግዘኒ ኣብ ማሕበረሰብይ ዝምረኮስ ኮይኑ ይስመዐኒ።</p>				
1.10	<p>Mental health problems are a result of witchcraft, black magic, or curses ፀገማት አእምሮዊ ጥዕና ናይ ጠንቋላይ፣ኢደ-ሰብ፣ወይ ናይ ርግማን ውፅኢታት እዮም።</p>				
1.11	<p>A lot of people in this community are struggling with mental health issues. ብዙሓት ሰባት ኣብዚ ማሕበረሰብ ብናይ አእምሮ ጥዕና ኩነታት ይሳቀዩ ኣለዉ።</p>				

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

ቀጺሉ፣ ሕጂ አብ **ሂወትካ ፀገማት** ከኾኑ ብዛዕባ ዝኸለሉ ነገራት ክተተካ ይደሊ እዮ።

You can use this picture of cups to help you. The more full cups mean that something causes you a lot of problems. Please tell me how difficult each of these things is in your life right now, ranging from no problem to a very serious problem.

እዚ ናይ ቢኬሪ ስእሊ ንክትግዘካ ክትጥቀመሉ ትኽእል ኢኻ፣ ሙሉእ ቢኬሪ ቡዙሕ ፀገማት ዘሕድረልካ ዓብዩ፣ ጸገም ኣሎ ማለት እዩ፣ አዞም ነገራት ሕጂ አብ ሂወትካ ክንደየናይ ዝእክል ከበድቲ ምኹኖም ንገረኒ፣ ካብቲ ምንም ጸገም ናብ ኣዝዩ ዝኸፍአ ጸገም ብምስራዕ።



	<b>How difficult is this in your life right now?</b> <b>እዚ አብ ሂወትካ/ኪ አብዚ ሕጂ ሰዓት መዓረ ክንደይ ከበድ ምዃኑ ንገረኒ።</b>	No problem at all ምንም ጸገም የለን	Minor problem ንእሽተይ ጸገም	Problem ጸገም	Very serious problem ኣዝዩ ዝኸፍአ ጸገም
2.1	Getting food, shelter, or clothing ምግብ፣ ገዛ ወይ ከዳን ምርካብ				
2.2	Getting education or a job (generating income) ትምህርቲ ወይ ስራሕ ምርካብ(ኣታዊ ምምንጫው)				
2.3	Illness, poor physical health, or disability ሕማም፣ድኹም ኣካላዊ ጥዕና ወይ ኣካል ምጉዳል				
2.4	Not having friends, family, or neighbors who can support you ክትግዙዝ ዝኸለሉ ኣዕሩኹቲ፣ ቤተሰብ ወይ ጎሮቤት ዘይምህላው				
2.5	Adjusting to or dealing with life in the camp (including missing home and lifestyle) ምትዕርራይ ወይ ምእላይ ናብራ ምዕስከር (ገዛኻ ወይ ኣነባብራኻ ምንፋቕ)				
2.6	Worries about people back at home ሻቕሎት ብዛዕባ አብ ዓዲ ዘለዉ ሰባት				
2.7	Trying to leave the camp (for resettlement, moving home, etc.) ማዕስከር ንምግዳፍ ምፍታን (ናብ ካልኣይ ሃገር ንምኻድ፣ ገዛ ምቕያር ወዘተ)				
2.8	Domestic violence, threats, or conflicts in your household ዘቤታዊ ዓመጽ፣ ስግኣት ወይ ኣብ ገዛ ዝግበር ግጭት				
2.9	Violence, threats, or conflicts in the community ዓመጽ፣ ምፍርራሕ ወይ ኣብ ማሕበረ-ሰብ ዘሎ ግጭት				
2.10	Not knowing where my family or friends are right now ስድራይ ወይ ኣዕርኹተይ ኣበይ ከምዘለዉ ዘይምፍላጠይ				
2.11	Grief from the loss of loved ones ካብ እትፈትውዎም ሰባት ምሰላን ዝመጸ ሓዘን				
2.12	Hopelessness or uncertainty about the future ተስፋ ዘይምህላው ወይ ብዛዕባ መጻኢ ርግጻኛ ዘይምዃን				

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

ካብቶም ሓደ ሓደ ዝጠቐስኩዎም ነገራት ሓደ ሓዲኡም ጸገማትካ ምኽኖም ነገርካ ኒ ኢኻ/ኺ።

*Review which items they said were very serious problems.*

*እቶም ኣዝዮም ዝኸፍኡ ጸገማት ዝበልዎም ነገራት ደጊምካ ዳህሰሶም።*

**2.13 Which ONE of the things I mentioned causes you the most stress right now?**

ካብዞም ኣነ ዝጠቐስኩልካ ነገራት ሓደ ኣብዚ ሕጂ ኣዝዩ ጸቕጢ ዝፈጥረልካ ኣየናይ እዩ?

*Don't read options. Select only one.*

*እቶም ኣማረጽኩት ኣይተንብቡሎም ኢኻ። ሓደ ጥራሕ ምረጽ*

- Food, shelter, or clothing  
*መግቢ፣ ገዛ ወይ ከዳን*
- Education or job  
*ትምህርቲ ወይ ስራሕ*
- Illness, health, or disability  
*ሕማም፣ ጥዕና ወይ ኣክል ምጉዳል*
- Not having support  
*ኣገዝ ዘይምህላው*
- Adjusting to life in the camp  
*ምስ ናብራ ማዓስከር ምልማድ*
- Worries about people back at home  
*ብዛዕባ ኣብ ናይ ቀደም ገዛና ዘለዉ ሰባት ሻቕሎት*
- Trying to leave the camp  
*ማዓስከር ንምግዳፍ ምፍታን*
- Domestic violence  
*ዘቤታዊ ዓመጽ*
- Violence in the community  
*ዓመጽ ኣብቲ ማሕበረ-ሰብ*
- Not knowing where my family or friends are  
*ስድራይ ወይ ኣዕርኹተይ ኣበይ ከምዘለዉ ዘይምፍላጥ*
- Grief  
*ሓዘን*
- Hopelessness  
*ተስፋ ምቕራፅ*

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

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

- Yes (Specify) እወ (ግለጽ): \_\_\_\_\_
- No/ ኣይፋል

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

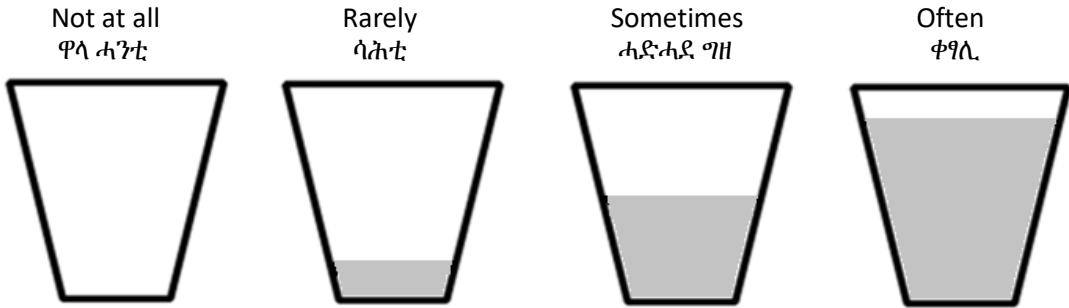
ከንደየናይ ዝኣክል ስነ ኣእምሮዊ ናይ ጥዕና ፀገማት ወይከኣ ምልክታት ከምዘለውኹም ከተተኩም ይፈቱ።

You can use the cups again. The more full cups mean that you have a problem more regularly.

ሕጂ እውን ነዞም ብኬሪታት ከትጥቀሙ ትኸእሉ ኢኹም። እቶም ቢኬሪታት ብጣዕሚ መሊእም ማለት እቲ ፀገም ቀፃሊ ኣለኩም ማለት እዩ።

How much have these symptoms bothered you **during the past two weeks**: not at all, rarely, sometimes, or often?

እቶም ምልክታት ኣብ ዝሓለፉ ክልተ ሰሙናት ከንደየናይ ዝኣክል ኣጸጊሞምልኩም ኣለው? ቀላ ሓንቲ፣ ሳሕቲ፣ ሓድሓደ ግዘ፣ ወይ ሙባሕቲኡ ግዘ ድዩ?



How much have these symptoms bothered you in the past two weeks? እዞም ምልክታት ኣብ ዝሓለፉ ክልተ ሰሙን መዓረ ከንደይ ኣሸጊሮምልኩ/ኪ ነይሮም?		Not at All ቀላ ሓንቲ	Rarely ሳሕቲ	Sometimes ሓድሓደ ግዘ	Often ቀፃሊ
3.1	Difficulty falling asleep or staying asleep? ድቃስ ምእባይ ወይ ነዊሕ ምድቃስ?				
3.2	Crying easily? ብዝጠቓምን ዘይጠቓምን ምብካይ?				
3.3	Feeling less interest in things that you used to enjoy? ቅድሚ ሕጂ ባህ ኣብ ዘብሉኻ ዝነበሩ ነገራት ድሌት ምቕናስ?				
3.4	Having difficulty concentrating or focusing on your thoughts? ኣብ ሓደ ነገር ናይ ምድሃብ ወይድማ ኣብ ሓሳባትካ ምትኳር ዘይምኸኣል?				
3.5	Difficulty doing domestic work or income-generating activities? ናይ ዝ ስራሕ ኣብ ምስራሕ ወይ ኣብ እቶት ናይ ዘምጽኡ ንጥፊታታት ኣብ ምስራሕ ምጽጋም?				
3.6	Feelings of worthlessness? ዋጋ ከምዘይብልካ ወይ ናይ ባዶነት ስምዒት?				
3.7	Thoughts it would be better to not be alive? ዘይምንባር ይሓይሽ ዝብል ኣተሓሳስባታት?  <i>If sometimes or often, follow protocol to discuss further. ሓድሓደ ግዘ ወይ ቀፃሊ እንተደኢሉም ዚያዳ ንክተዛርብዎም ነቲ ኣሰራርሓ ተኸተሉ</i>				
3.8	Feeling low in energy, slowed down? ሓይሊ ናይ ምጽንቓቕ፣ ምዝሕታል ስምዒት?				
3.9	Having your body react to things that remind you of a traumatic event (like upset stomach or dizziness)? ስምብራታዊ ፍፃሞ ንዘዘኻኸሩልካ ነገራት ኣካላትካ (ከም ቁጥፎ ከስዕ ወይ ፀረውረው ምባል) ዝበሉ ግብረ መልሲ ምሃብ				
3.10	Watching everything around you or feeling “extra alert” or “on guard” much of the time? ኣብ ከባቢኻ ንዝርከቡ ሕድሕድ ነገራት ናይ ምክትታል ወይ "ሚሒር ንቕሓታውነት" ወይ ከዓ "ኣብ ሓላዎ" ናይ ምኳን ስምዒት?				

How much have these symptoms bothered you in the past two weeks? እዛም ምልክታት ኣብ ዝሓለፈ ክልተ ሰሙን መዓረ ክንደይ ኣሸጊሩካ/ኪ ነይሩ?		Not at All ቐላ ሓንቲ	Rarely ሳሕቲ	Sometimes ሓድሓደ ግዘ	Often ቀፃሊ
3.11a	Do you feel <u>mental health</u> problems (like stress, depression, or anxiety) cause trouble with your daily functioning? ዕለታዊ ንጥፊታትካ ንክይተከናውን ፅልዋ ዝገበሩልካ ገለ ክም ፀቕጢ፣ ጭንቀት፣ክቢድ ጭንቀት ዝበሉ ኣእምራዊ ናይ ጥዕና ፀገማት ኣለውኒ ዶ ኢልካ ትሓስብ?				

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

- ኣእምራዊ ጥዕናኻ ብሓፈሻ ከመይ ትመዝኖ፡ ብጣዕሚ ትሓት፣ትሓት፣ደሓን፣ፅቡቕ፣ብጣዕሚ ፅቡቕ?
- Very poor ብጣዕሚ ትሓት     
  Poor ትሓት     
  Fair ማእኸላይ     
  Good ፅቡቕ     
  Very good ብጣዕሚ ፅቡቕ

3.13 Do you feel physical health or medical problems cause trouble with your daily functioning (in the past two weeks)?

- ኣብ ዝሓለፉ ክልተ ሰሙናት ኣብ ዕለታዊ ትግባረኻ ዘፀገሙልካ ኣካላዊ ወይ ሕክምናዊ ናይ ጥዕና ፀገማት ነይሮም ዶ ኢልካ ትሓስብ?
- Not at all ብፍፁም     
  Rarely ሳሕቲ     
  Sometimes ሓድ ሓደ ግዘ     
  Often ሙብዛሕቲኡ ግዘ

3.14a Do you experience on-going or chronic pain in your body?

- ቀፃሊ ዝኾነ ወይ ሕዳር ቃንዛ ኣብ ኣካላትካ የጋጥመካ ኣሎ ዶ?
- Yes/ እወ     
  No /ኣይፋል

**IF YES: 3.14b:** On a scale from 0 to 10, where 0 is no pain at all and 10 is the worst possible pain, how much pain have you felt overall in the past week? \_\_\_\_\_

እወ እንድሕር ኮይኑ፡ካብ 0 ክሳብ 10 ኣብ ዘሎ መዐቀኒ፣ 0 ምንም ቃንዛ የብለይን እንተኾይኑን 10 ከዓ ኣዝዩ ዝኾፍኦ ቃንዛ እንድኣኾይኑ ብሓፈሻ ኣብ ዝሓለፉ ክልተ ሰሙናት መዓረ ክንደየናይ ቃንዛ ተሰሚዑካ ትብል?

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

- ከትዝከሮን ከትቆጻጸሮን ዘይትኸእል ናይ ምውዳቅን/ምንፍርፋርን ተጓንፎ ኣጋጣሚካ/ኪ ይፈልጥ ዶ?
- Yes/እወ     
  No/ኣይፋል

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

ጓሂ ፣ጭንቀት፣ ከቢደ ሓዘን አብ ዝስመዓኩም መዓልቲ ፤ነቶም ስምዒታት ንምእላይ/ንምጽዋር እንታይ ትገብሩ?

I will read a list of things you might do, and you can tell me if you do them or you don't them.

ምናልባሽ ክትገበርም ብዛዕባ ትኽእል ሓድ ሓደ ነገራት ክንብብልካ እሞ ትገበርምን እንተኾንካን፣ ዘይትገበርምን እንተኾንካን ክትነግረኒ እ.ኤ.ኣ።

	<b>On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions? ጓሂ ፣ጭንቀት፣ ከቢደ ሓዘን አብ ዝስመዓኩም መዓልቲ ፤ነቶም ስምዒታት ንምእላይ/ንምጽዋር እንታይ ትገብሩ?</b>	Yes/አዎ	No/አይቆፋል
4.1	Discuss your feelings with your family or friends ስምዒታትካ ምስ ስድራኻ ወይ መሓዘትካ ምዝርራብ		
4.2	Do social or entertainment activities ማሕበራዊ ወይ መዘናግዒ ንጥፊታት ምስራሕ		
4.3	Sleep or stay in bed ድቃስ ምብዛሕ ወይ አብ ዓራት ምውዓል		
4.4	Do physical activities አካላዊ ንጥፊታት ምስራሕ		
4.5	Go to the hospital or clinic to see a doctor ናብ ሆስፒታል ወይ ክሊኒክ ኬድካ ብዶክተር ምርኣይ		
4.6	Pray, meditate, or do other spiritual activities ፀሎት ምግባር፣ አእምሮዊ ተመስጦ ወይ ካልኣት መንፈሳዊ ንጥፊታት ምዝውታር		
4.7	Use alcohol or another substance to help you forget አልኮላዊ መስተ ወይ ካሊእ ዕፀ ፋርስ ብምጥቃም ንክትርስዎ ምፍታን		
4.8	Try to avoid seeing or talking to anyone ምስ ሰባት ንክትራኹብ ወይ ክትዘራረብ ዘይምድላይ		
4.9	Talk to a trained counselor, therapist, or other professional ንዝሰልጠነ መማኸሪ ፣ናይ ክንክን ባዓል ሞያ፣ወይ ካልእ ባዓል ሞያ ምዝራብ/ምክፋል		
4.10	Consult with traditional healers, elders, or spirit mediums ምስ ናይ ባህሊ ሓይም፣ዓብይቲ ወይ መንፈሳዊ አቦታት ምምኽር		
4.11	Other: (Prompt: Is there anything else you do to help yourself deal with your emotions?) ካልእ: (ከምዚ በል: ስምዒታትካ ንምእላይ ንክትገዛካ እተትግብር ካሊእ ነገር ኸ እሎ ዶ?)		



**5.1** Do you feel that anyone in your household has mental health problems that cause trouble with their daily functioning? ኣብ ገዛኹም ዕለታዊ ንጥፊታቱ ንክየከናውን ዕልዋ ዝገበረሉ ገለ ናይ ኣእምሮ ጥዕና ፀገም ዘለዎ ሰብ ኣሎ ዶ ኢልካ ትሓስብ?

- Yes/እወ
- No/ኣይቅል



**5.2** If yes: How many people? \_\_\_\_\_  
እወ እንተኢሉ: ክንደይ ሰባት?

Please tell me the age & gender of person 1: Age/ዕድሜ: \_\_\_\_\_  
ብኹብረትካ ናይቲ ሰብ ዕድሜን ስምን ዶ ክትነግረኒ?  
 Male/ተባዕታይ  
 Female /ኣንስታይ

Please tell me the age & gender of person 2: Age/ዕድሜ: \_\_\_\_\_  
ብኹብረትካ ናይቲ ሰብ ዕድሜን ስምን ዶ ክትነግረኒ?  
 Male /ተባዕታይ  
 Female /ኣንስታይ

Please tell me the age & gender of person 3: Age/ዕድሜ: \_\_\_\_\_  
ብኹብረትካ ናይቲ ሰብ ዕድሜን ስምን ዶ ክትነግረኒ?  
 Male /ተባዕታይ  
 Female /ኣንስታይ

	<b>During the last two weeks, was anyone in your household so distressed, disturbed, or upset that he or she:</b> ኣብ ዝሓለፈ ክልተ ሰሙን ኣብ ገዛኹም ብምጭናቁ፤-ብምርባሹ፤ ወይ ብምሕራቁ	Yes እወ	No ኣይቅል	I don't know ኣይፈለጥኩን
<b>5.3</b>	Was completely inactive or almost completely inactive? ሙሉእ ብሙሉእ ፈዚዙ/ዛ ወይ ዳርጋ ፈዚዙ/ዛ ነይሩ/ራ ዶ?			
<b>5.4</b>	Was unable to carry out essential activities for daily living? ንመዓልታዊ ናብራ ዝኸውን ኣገዳሲ ስራሕ/ንጥፊት ክሰርሕ ኣይከኣለን/ኣይከኣለትን			
<b>5.5</b>	Was acting in a strange way or having fits, convulsions, or seizures? ፍሉይ ጠባይ ኣርእዩ ወይ ሃንደበት ምቁጣዕ፤ ሃንደበት ዓመጽ ምግባር፤ ወይ ሃንደበት ናይ ምውዳቅ			
<b>5.6</b>	FOR CHILDREN HOUSEHOLD MEMBERS ONLY: ንቆልዑ ኣባላት ስድራ ዝኾኑ ጥራሕ If you have young children between 7 and 12 years in your household, have they... Had nightmares at least three times in the last week? ኣብ ስድራ-ኹም ኣናእሽቶ ቆልዑ እንተድኣሃሊዎምኹም.... ኣብ ዝሓለፈ ሰሙን እንተንኣሰ ንክልተ ግዘ ዝኣክል ናይ ምብህራር ፀገም ኣጋጢምዎም ዶ ይፈልጥ?			
<b>5.7</b>	FOR ADOLESCENT AND ADULT HOUSEHOLD MEMBERS ONLY: ንዓባይትን ኣባጽሕን ኣባላት ስድራ ዝኾኑ ጥራሕ If you have adolescents or other adults in your household, have they... Avoided contact with others during the last week? ኣብ ስድራ-ቤትካ ኣባጽሕ ወይ ካልኣት ዓባይቲ እንተሃልዮም... ኣብ ዝሓለፈ ሰሙን ምስ ካልኣት ሰባት ምርኻብ ዶ ደው ኣቢሎም ይኾኑ?			
<b>5.8</b>	FOR ADOLESCENT AND ADULT HOUSEHOLD MEMBERS ONLY: ዕድሚኡም ልዕሊ 12 ንዝኾኑ ንዓባይትን ኣባጽሕን ኣባላት ስድራ ዝኾኑ ጥራሕ If you have adolescents or other adults in your household, have they... Used substances (such as alcohol or cigarettes) in the last week? ኣብ ስድራ-ቤትካ ኣባጽሕ ወይ ካልኣት ዓባይቲ እንተሃልዮም... ኣብ ዝሓለፈ ሰሙን ዕፀ ፋርሳት ዶ ተጠቂሙም ይኾኑ?			

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?

ከምትዝነገርግኹም፣ ንግድያት ግፍዒ ሓገዝ ኣብ ምሃብ ኣድሂቡ ካብ ዝሰርሑ ትካል እየ መጊኤ። ግፍዒ ማለት ከዓ ልዑል ዝኾነ ኣካላዊ ወይ ስነ-ኣእምራዊ ማህሰይቲ እንትኸውን ኮነ ተባሂሉ ኣብ ስልጣልን ብዘሎ ዝኾነ ኣካል ዝወርድ ቦደል እዩ። ብዛዕባ ግፍዒ ዝምልከት ሰለስተ ሕቶታት ኣለውኒ። እዞም ሕቶታት እንተሓተትኩኻ/ኺ ይጥዕመካ ዶ ይኸውን?

- Yes/ እወ
- No/ኣይፋል



**6.1** Have you ever been tortured?

ግፍዒ ወሪድካ ይፈልጥ ዶ?

- Yes/እወ
- No/ ኣይፋል

**6.2** Has anyone in your family or household been tortured (not including yourself)?

ኣብ ስድራኹም ወይ ገዛኹም ገለ ግፍዒ ዝወረዶ ሰብ ይህሉ ዶ? (ንባዕልኻ ክይሓወሰኻ)

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

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

ኣብዚ ማሕበረሰብ ውሽጢ ብዙሓት ግፍዒ ዝወረዶም ሰባት ኣለው ዶ ኢልካ ትሓሰብ?

- Yes/እወ
- No/ ኣይፋል



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

እቲ ዝቐጽል ክፋል ኣብዚ ሕጂ እዋን ነዚ ኣብዚ ማሕበረ-ሰብ ዘሎ ህዝቢ ብዛዕባ ዘለው ግልግሎታት ዝምልከት እዩ።

**7.1a** Do you **know** anywhere you can receive **mental health or psychosocial support services** in Adi Harush / Mai Ayni?

ናይ ኣእምሮ ጥዕና ወይከዓ ስነ-ኣእምራዊን ማሕበራዊን ግልግሎት ሓገዝ ክትረኽበሉ እትኽእል ዝኾነ ቦታ ኣብ ዓዲ ሓናሽ/ማይ ዓይኒ ትፈልጥ/ጢ ዶ?

- Yes  
እወ
- No  
ኣይፋል

→ **7.1b** If **yes**: Have you ever received **mental health or psychosocial support services** here?

መልሲ እወ እንተኾይኑ፡- እዞም ናይ ኣእምሮ ጥዕና ወይ ስነ-ኣእምራውን ማሕበራውን ግልግሎታት ረኺብካ ትፈልጥ/ጢ ዶ?

- Yes  
እወ
- No  
ኣይፋል

→ **7.1c** If **yes**: From which organization? *Don't read options. Select all that apply.*

መልሲ እወ እንተኾይኑ፡- ካብ'የናይ ትካል? እቶም ኣማረጽቲ ኣይተንብቡሎም ኢኻ።

መልሲ ክኸውን ዝኽእል ምረጽ።

- CVT/ሲ.ቪ.ቲ
- DRC/ዲ.አር.ሲ
- JRS/ ጄ.አር.ኤስ
- IRC/ኣይ.አር.ሲ
- MSF/ኤም.ኤስ.ኤፍ
- ARRA/ኣ.ራ
- Other: ካልእ፡- \_\_\_\_\_

**7.1d** If **no**: Why not? *Don't read options. Select all that apply.*

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

- I've never needed or wanted these services  
ነዞም ግልግሎታት እዚ እም ድልየት ወይከዓ ምንየት ብፍጹም የብለይን።
- They are too far away  
ኣመና ርሕቕ ዝበሉ እዮም።
- I'm afraid of what my neighbors or relatives would think or say  
ጎረብተይ ወይከዓ ኣዝማደይ እንታይ ክምዝሓሱ ወይ ክምዝሃረቡ ይፈርሕ እዮ።
- I tried to get services, but they didn't select me  
ግልግሎት ንምርካብ ፈቲነ ነይረ ነገር ግን ክመርጹኒ ኣይክእሉን
- I decided not to get mental health services because they were not giving me anything (material support)  
ናይ ኣእምራዊ ጥዕና ግልግሎታት ንዘይምርካብ ወሲኒ እየ ስለምንታይ ሲ ምንም ነገር ክህቡኒ ስለዘይካኣሉ (ንብረታዊ ሓገዝ)
- Those services are for people who are more ill or worse off than me  
እቶም ግልግሎታት ንሓዳም ንኣዝዮም ዝሓመሙ ወይ ካባይ ንዘባኣሉ ሰባት እዮም
- Other: ካልእ: \_\_\_\_\_



**7.6a** Have you ever heard of the Center for Victims of Trauma or the Center for Victims of Torture (CVT) before today?

ቅድሚያ ለመመዘን ብዛዕባ ማእኸል ግዳያት ስነ-አእምሮዊ ስንብራት ወይ ማእኸል ግዳያት ግፍዒ(ሲቪቲ) ሰሚዕኻ/ኼ ትፈልጉ/ጧ ዶ?

Yes

አወ



**7.6b** If yes: How did you know about CVT? እንድሕር እወ ኮይኑ:- ብከመይ ብዛዕባ ሲቪቲ ፈሊጥካ?

No

አይፋል



*Don't read options. Select all that apply. መማረጹ መልሱታት አይተንብብ: ኩሎም መልሲ ክኸውን ዝኸእል ምረጽ*

- I heard others in the community talking about it/ኣብቲ ማሕበረ-ሰብ ካልኣት ሰባት ብዛዕባኡ ክዛረቡ ሰሚዐ
- I went to a community event or outreach by CVT/ሲቪቲ ኣብ ዝገበሮ ናይ ማሕበረ-ሰብ ምብጻሕ/ፍጻሜ ከይደ ነይረ
- One of my family or friends received services from CVT/ኣደ ካብ ናይ ስድራይ ኣባል ወይ መሓዛ ናይ ሲቪቲ ኣገልግሎት ረኺቡ ነይሩ
- I received counseling services from CVT/ኣብ ሲቪቲ ናይ ምኽርን ማዕዳን ኣገልግሎት ረኺብ ነይረ
- Other: ካልኣትን \_\_\_\_\_

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

ኣብ መወዳእታ፤ ብዛዕባኻ ዝተወሰኑ መሰረታዊ ሕዳታት ኣለውኒ።

**8.1** What is your home country? ትውልዒ ሃገርካ ኣበይ ድዩ?

- Eritrea/ኤርትራ
- Other: /ካሊእ: \_\_\_\_\_

**8.2** How long have you been in your current camp? ኣብ ዓዲ-ሓሩሽ/ ማይ-ዓይኒ ክንደይ ዝኣክል ጸኒሕኻ?

\_\_\_\_\_ Years/ዓመታት      \_\_\_\_\_ Months/አዋርሕ

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

እንታይ ቋንቋታት ትዛረብን ከምኡ እውን ብጽቡቕ ትርዳእን? መልሲ ክኸው ዝኸእል ምረጽ።

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

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

ዕድመኻ ክንደይ ድዩ? ኣቲ መልሲ ወሃባይ ርገጻኛ እንድሕር ዘይኮነ ክንድ-ዝኣክል ዝበለጸ ንኸግምት ሓግዞ።

\_\_\_\_\_ years/ዓመት

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

ክንደይ ደረጃ ትምህርቲ ኢኻ ወዲእኻ? መልሲ ክኸው ዝኸእል ምረጽ።

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

**8.6** What is your religion? *Select only one.*

ሃይማኖት/ኪ እንታይ እየ? ሓደ ጥራሕ ምረጽ

*If the respondent is Muslim, do NOT ask specifically about sect. Check the appropriate box ONLY if the respondent specifically mentions their sect; otherwise, select “Not able to determine.”*

*እንደሕር መልሱ ወሃቢ መሰሊም ኮይኑ/ና ብዛዕባ አቦየና ክፋል እስልምና ምዃኖም ብፍሉይ ኣይትሕተት። መልሱ ወሃቢ ብንጹር አቦየናይ ክፋል እስልምና ምዃኖም እንተገሊጸምዎ ጥራሕ ኣብቲ ትኸክለኛ ሳንዩቕ ምልክት ግበር ። እንተዘይኮይኑ ግን “ክፍለጥ ኣይተኻአለን” ዝብል ምልክት ግበር።*

Muslim: መሰሊም

- Sunni ሱኒ
- Shi’a ሸዓ
- Other ካልእ
- Not able to determine ክፍለጥ ኣይተኻአለን
- Orthodox Christian ኦርቶዶክስ ክርስትያን
- Sabian ሳብያን
- Catholic ካቶሊክ
- Protestant or Anglican ፕሮቴስታንት ወይ ኣንግሊካን

- Pentecostal or born again ፔንቴኮስትል ወይ ዳግም ውልደት
- Christian – other or no denomination ክርስትያን - ካልእ ወይ ተወሳኺ ዘይብሉ
- Jewish ኣይሁድ
- Indigenous, traditional, or folk religion ከባብያዊ/ነባር፣ ልምዳዊ ወይ ባህላዊ ሃይማኖት
- No religion ሃይማኖት ኣልቦ
- Other: ካልእ \_\_\_\_\_

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

*ንባዕልኻ እንተይ ቆጸርካ ኣብዙ ሕጂ ኣዎን ክንደይ ዝኣኸሉ ሰባት ኣብ ስድራ-ቤት/ገዛ ይነበሩ ኣለው?*

\_\_\_\_\_ people/ ሰባት

**8.8** How many children do you have?

*ክንደይ ቆልዑ ኣለውኻ*

\_\_\_\_\_ children / ቆልዑ

**8.9** Are you separated from your family now?

*ሕጂ ካብ ስድራኻ ተፈላሊኻ ዲኻ ዘለኻ?*

- Yes /አዎ
- No /ኣይፋል

