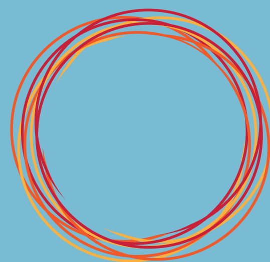

The CENTER for VICTIMS of TORTURE

ASSESSING MENTAL HEALTH IN BIDI BIDI, UGANDA:

A Representative Survey of South Sudanese Refugees in Zone 5

Assessing Mental Health in Bidi Bidi, Uganda:
A Representative Survey of South Sudanese Refugees in Zone Five

The Center for Victims of Torture

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The Center for Victims of Torture (CVT) in Uganda carried out a needs assessment in Bidi Bidi refugee settlement in March 2019, in order to inform mental health and psychosocial support (MHPSS) service providers and other stakeholders in designing interventions responsive to the needs of the population. Identified through probability sampling methods, survey respondents (N=502) are representative of the adult population in Zone 5 of the settlement at the time of data collection. Our findings include: generally positive attitudes about mental health, including reliance on family and friends to cope with mental health issues; both mental health concerns and difficulties providing basic necessities ranking highly among daily problems for refugees; moderate levels of symptoms related to post-traumatic stress and depression; high levels of functional difficulties; high prevalence of primary torture survivors; and moderate awareness and utilization of available MHPSS services. This report includes an overview of the context, methodology, descriptive findings, and recommendations.

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Rationale

Understanding the mental health needs of survivors of war, organized violence, and human rights abuses is fundamental to the design and implementation of mental health interventions, as well as other services delivered to these individuals or communities. There can be severe psychological effects from loss of loved ones, torture or other abuse, or witnessing violence or atrocities (Higson-Smith 2014; Nickerson et al. 2014; Priebe et al. 2010). Many refugees also have negative effects of continuous traumas and ongoing stressors or threats associated with forced migration. In this context, it can be extremely difficult to process trauma, cope with grief over those who have died, or deal with ambiguous loss over those who are missing.

These factors can impair daily functioning of refugees fleeing conflict or instability, reducing their ability to effectively meet the substantial challenges of life in the country of refuge (Miller and Rasmussen 2010, 2017; Li, Liddell, and Nickerson 2016; Higson-Smith 2013). This can diminish the success of humanitarian support (including protection, education, and livelihood initiatives), as well as potentially contribute to increased levels of ongoing violence in communities and households and high rates of self-harm or destructive activities. Understanding and attending to the mental health needs of survivors, including the need for interdisciplinary rehabilitation from trauma, is a key part of restoring dignity in the wake of human rights abuses and providing justice for those who suffered harms. It may also be a preventative mechanism to inhibit future cycles of violence and promote more effective peacebuilding.

Globally, there is insufficient representative data about mental health among refugee populations. Rather, much of the data about refugees' mental health comes from help-seeking populations. These data are not representative of the complete population and do not reveal the full range and prevalence of vulnerabilities and needs. Such datasets exclude the most vulnerable members of communities, those who are unlikely or unable to seek help. Moreover, many needs assessments rely on data, typically qualitative, from key informants, community leaders, or other stakeholders who provide perspectives on mental health needs based on their expert positions or their depth of experience within communities. However, despite their knowledge about the community, such assessments cannot provide prevalence rates or allow inferential or multivariate analyses. Furthermore, much existing research on the psychological impacts of conflict or other traumatic experiences for East African refugees is conducted with populations that have been resettled to third countries, thus not accounting for factors unique to the humanitarian contexts in which most refugees live. All of these factors contribute to a substantial information gap for service providers implementing mental health interventions in humanitarian contexts.

Since 2016, the Center for Victims of Torture (CVT) has been fielding a series of representative surveys to collect data to inform its own programming and the sector more broadly.[1] We carried out similar surveys in Kalobeyei refugee settlement for South Sudanese and other populations in Kenya in 2016, 2018 and 2020, in two refugee camps for Eritreans in the Tigray region of Ethiopia in 2017 and 2020, and in Nguenyyiel Camp hosting South Sudanese refugees in the Gambella region of Ethiopia in 2019. These surveys use rigorous social scientific methods to collect representative data about mental health attitudes, needs, and resources in humanitarian settings. With methodologies that are replicable and feasible, including comparable questionnaires, conducting surveys in different locations at different time points contributes to

[1] Reports of survey findings are available at https://www.cvt.org/resources/publications.

the construction of a global dataset of refugee mental health. This can lead to comparative analyses of levels of trauma, stigma, stressors, and symptoms between refugee contexts and between people from the same country of origin in different settings. Such analyses help the humanitarian sector design and prioritize effective responses, including advocating for resources and informing donors, governments, and other stakeholders about emerging needs.

Context

Refugees in Bidi Bidi are fleeing civil war and widespread human rights violations in South Sudan. In late 2013, political rivalry between President Salva Kiir and his former deputy Riek Machar precipitated armed conflict. Fighting between forces loyal to the leaders began in Juba, but spread to other parts of the country (UNMISS 2015). Both of the key parties to the conflict, the Sudan People's Liberation Movement (SPLA) and the Sudan People's Liberation Movement/Army in Opposition (SPLM/A-IO), have allegedly perpetrated gross human rights violations against civilians. These have included forced recruitment, arbitrary detention, torture, destruction of homes and property, disappearances, sexual violence, and direct killings (Amnesty International 2016; UNMISS 2015). In early 2020, the leaders agreed upon a power sharing agreement, calling for refugees to return to South Sudan (Cumming-Bruce 2020). Affected communities, however, must reckon with a fraught history of peace deals and ceasefires alongside missed benchmarks, flare ups of violence and conflict (International Crisis Group 2019), and ongoing gross human rights violations (Human Rights Council 2020).

As the conflict spread to the southern Equatoria region of South Sudan in 2016, hundreds of thousands of refugees began to cross the border with Uganda, the vast majority into the West Nile sub-region (Action Against Hunger 2017). In northwestern Uganda, five settlements now host South Sudanese refugees: Bidi Bidi, Palorinya, Imvepi, Adjumani, and Rhino Camp. Between its opening in August 2016 and the time of this survey in 2019, Bidi Bidi settlement became the second largest refugee camp or settlement in the world, hosting around 225,000 refugees, about 17 percent of all refugees in Uganda (UNHCR 2019a). Covering 250 square kilometers, Bidi Bidi is divided into five zones, each further divided into clusters and villages, surrounded by rural Ugandan host community villages. A range of non-governmental organizations (NGOs) and other providers coordinate with the Government of Uganda's Office of the Prime Minister (OPM) to deliver services within these zones.

The population in Bidi Bidi is ethnically diverse (UNHCR 2019a). Most residents are Bari speakers from Central Equatoria, which includes a range of ethnic groups: Kakwa, Bari, Pojulu, Kuku, Mundari, and Nyagwara. The settlement also includes residents from other areas in Equatoria, mainly Eastern Equatoria, in particular Ma'di and Acholi ethnic groups. A minority of refugees belong to larger South Sudanese ethnic groups, such as Nuer, Shilluk, and Dinka.

Uganda is known globally for instituting policies that prioritize durable solutions for refugee populations. Refugees and asylum seekers have freedom of movement; are entitled to work, own property, and establish businesses; and can access Ugandan social services, such as education and health care (UNHCR 2019b; Government of Uganda 2018). In Bidi Bidi, this is combined with UNHCR's settlement approach to refugee crises, which emphasizes promoting sustainability and self-sufficiency for refugees; refugees are allocated plots of land for housing and cultivation, and can settle alongside host communities (UNHCR 2019b). There are certainly

challenges to implementation of these policies, including difficulties navigating formal land rights for refugees, balancing self-reliance with the substantial demand for humanitarian aid, and managing host community expectations and relationships. At the same time, residents of Bidi Bidi have drawn from the available resources to develop thriving economic and social communities (Strochlic 2019).

It is likely that many South Sudanese refugees in Bidi Bidi have experienced interpersonal violence, sometimes extreme, and most have lost family members, homes, and/or livelihoods during the war or during their migration to Uganda. A survey in South Sudan in 2015 found high rates of exposure to traumatic events and symptoms related to post-traumatic stress disorder (PTSD), with symptoms more prevalent among respondents who were displaced from their homes (Deng et al. 2015). Interviews with displaced persons within South Sudan document the negative mental health impacts of the conflict, describing South Sudan as "a traumatized nation" (Amnesty International 2016:17). Additionally, refugees often are vulnerable to personal, criminal, or communal violence in the displacement context, including disputes over land or resources, theft or exploitation, domestic violence, rape or other forms of sexual assault, or conflicts based on political, ethnic, or other group identities (Boswell 2018). This ongoing risk of violence can exacerbate the psychological distress symptoms already likely to be prevalent in the population. Because of these reasons, we anticipate high rates of mental health challenges among South Sudanese people living in Bidi Bidi settlement.

The Center for Victims of Torture (CVT) in Bidi Bidi

CVT began a program in Zone 5 of Bidi Bidi refugee settlement in 2019. CVT's work in Bidi Bidi builds on its experience providing mental health capacity-building and direct services in northern Uganda, as well as other countries in the region. Since 2009, CVT's Gulu-based program has worked closely with local organizations and educational and medical institutions in northern Uganda to enhance psychological assistance services for survivors of violence. CVT began providing direct services in 2015 to survivors of the Lord's Resistance Army war.

CVT provides specialized mental health services to trauma survivors through group and individual counseling.[2] CVT also provides stabilization services through Psychological First Aid (PFA) for individuals struggling with daily functioning. CVT staff receive intensive professional capacity building, including ongoing training and clinical supervision, to develop their skills to provide specialized mental health services. To develop services that are accepted by and responsive to the needs of affected communities, CVT conducts ongoing consultative meetings with community representatives.

Photo by D. Sherwood

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

To our knowledge, at the time of its implementation, this survey is the first population-level assessment of the mental health effects of war-related traumatic events and ongoing stressors among refugees in Bidi Bidi. The findings from this survey build upon previous assessments using stakeholder consultations, key informant interviews, and similar methods; these assessments have suggested there are likely high rates of exposure to traumatic events with significant mental health consequences in this settlement. For example, UNHCR conducted a 2018 joint assessment with partner organizations to identify suicide trends in the region, based on incident reports and key informant interviews (Nuri 2020). The Peter C. Alderman Foundation (PCAF) conducted a mental health and psychosocial support needs and resource assessment, using focus groups and key informant interviews, in Rhino Camp in 2014 (Adaku et al. 2016). Such assessments provide essential information on mental health needs in the region, but also face limitations in identifying broad patterns or estimating the prevalence of mental disorders in the settlement. CVT's survey builds upon these relevant findings to continue to develop a robust picture of refugee mental health in Bidi Bidi.

Sampling Methodology

CVT selected a probability-based sample of 502 adults from Zone 5 of Bidi Bidi settlement using a multi-stage design. The survey included the five clusters in the zone (Yangani, Ombechi, Ayivu, Ariwa I, and Ariwa II), further divided into 24 villages. According to UNHCR figures, as of December 2018, the total population of Zone 5 was 48,942, including 13,265 adults.[3] We implemented the survey using interval-based sampling to select households in stage one, with coverage of the entire geographic area of the camp, giving each household an opportunity for inclusion. As stage two of sampling, one adult from the identified household was randomly selected to be invited to participate. Our contact rate was 49 percent, reflecting households found empty or locked at the time of fieldwork. Our cooperation rate was 93 percent, and the refusal rate for eligible respondents who were available but chose not to participate was 2 percent.[4]

[3] A significant proportion (73 percent) of the population is minors; they are not included in this survey, due to ethical protections surrounding data collection from highly vulnerable populations. Our sample of 502 respondents is 3.8 percent of the total adult population at the time of the survey.

[4] Response rates were calculated using the American Association for Public Opinion Research Survey Outcome Rate Calculator. Version 4 (2016) is available here: http://www.aapor.org/Education-Resources/For-Researchers/Poll-Survey-FAQ/Response-Rates-An-Overview.aspx, last accessed 29 January 2020. Included in non-eligible respondents were 268 minor-only households and 492 households with no individual of the required gender. Unknown eligibility included 803 selected households that were empty or locked. Eligible respondents that resulted in non-interviews included: the selected individual not available at the time (209); the selected individual refused to participate or stopped the interview (36); the selected individual did not speak the survey languages (10); and other reasons, such as sickness or inebriation (34). Accounting for all these factors, and including an estimate for what proportion of cases of unknown eligibility would have actually been eligible (51 percent), the response rate was 42 percent.

Household Selection

At the time of the survey, the five clusters in Zone 5 ranged from 3,933 to 19,586 people, with 24 villages ranging from 842 to 3,933 people.[5] To accurately implement an interval-based approach to cover the geographic inclusion area, the primary complication was operationalizing a "household." In order to estimate the interval to be used in household selection, we need an accurate count of the number of households in the population. However, available UNHCR data defines households as the "families" who are officially registered, by family size, to receive aid or support. In terms of physical layout, however, the settlement approach means people live in compounds, arranged as a rural village; houses are not numbered, compounds may not be clearly differentiated, and plots are not arranged in straight rows or blocks. A physical compound has multiple buildings, some used for cooking, seating areas, storage, or sleeping structures. Multiple "families" (by the UNHCR definition) may live in one compound, or, alternatively, a large family may not all live together in one compound. To design our approach, we needed to decide if the physical count of "households" during fieldwork would be based on: 1) compounds, or 2) sleeping structures. After that decision, we needed to estimate how many "households" were in each village, cluster, and the settlement overall.

We consulted with CVT staff members who live and work in the settlement, as well as other members of the survey team and local leaders, initially deciding we would count compounds as the household unit. We then randomly selected two villages for a verification exercise, completing a physical count of the compounds and sleeping structures in each village. The team observed that counting sleeping structures was easier to implement accurately than counting compounds. In both villages, the number of sleeping structures counted was 85 percent of the number of families in the official UNHCR figures. Thus, extrapolating from the UNHCR count of 9,853 families, we estimated 8,374 sleeping structures in the settlement, designating these as the households to be selected in stage one of the sampling.

We estimated a sampling interval of nine households to ensure coverage of the entire settlement during the fieldwork period, based on estimated levels of productivity of the team and expected non-response due to ineligibility, unavailability, and refusal. Teams received a starting point randomly assigned each day, with assignments alternating to ensure coverage on each day was spread throughout clusters of the settlement and the same team was not revisiting the same area on consecutive days. At their assigned starting points, team supervisors drew numbers to identify the first household, selecting from the sampling interval. After conducting a successful interview, a team proceeded according to the nine household interval. After an unsuccessful interview attempt at a selected household, for any reason, a team moved to the adjacent household. Teams used tracking sheets and maps to note areas of coverage and ensure no area of the settlement was excluded. They continued systematically until they completed the entire village. Teams relied on maps, village leaders, and their own local knowledge to identify the boundaries of the villages.[6]

[5] Because villages were the smallest possible disaggregation for an enumeration area, a cluster sample was not a viable method in this context.

[6] Host community households were not included. There were a few selected households where residents included Ugandan citizens, due to the histories of the region and the porous nature of the border. They were included in the survey if they were living within the refugee settlement and their household was receiving aid associated with refugee status.

Individual Selection

Within a selected household, adult individuals were selected randomly without replacement, with adherence to a balanced gender quota. Interviewers were assigned identification numbers; those with odd identification numbers did their first interview each day with a man, and those with even numbers started with a woman, alternating respondent gender thereafter.[7] They drew numbers to select the participant from all eligible potential respondents (all adult residents of the required gender who were living in the household). If a selected dwelling had no adult residents of the required gender, the team moved to the next household. There was no replacement of a selected individual.

If the selected individual in the household was not home, reasonable attempts were made to return and complete the interview, based on feedback from other household members about their schedule. Additionally, interviewers could not interview their own families, close friends, or former clients, though other interviewers could be assigned. Identified individuals participated in a verbal consent process and decided if they would like to participate.

Weighting

Data are weighted to adjust the sample to known characteristics of the population. We adjusted to match UNHCR figures for gender and cluster distribution.[8] All descriptive figures presented in this report display weighted data, except for gender and cluster, which were used to create the weight. Our sample closely approximates cluster adult population figures, indicating reasonable adherence to sampling procedures; the sample deviates from population proportions by 0.4 to 2.5 percent across the five clusters. Because gender stratification was used in sampling design, the sample expectedly deviates from population gender distributions (51 percent women in the sample, and 62 percent women in the adult population).

Survey Team and Fieldwork

Fieldwork was implemented by a team of about 45 people, including enumerators, team supervisors, research and evaluation staff, psychotherapists, interpreters, drivers, and administrative staff. Six interview teams, with three or four enumerators and one supervisor per team, each completed an average of 13 to 14 interviews per day.[9] The team completed six to 37 interviews per village, with a mean of 21 interviews per village. Data collection was completed from March 4 to 13, 2019.

[7] Local consultation suggested that it was not a requirement to match the gender of the respondent and the gender of the interviewer. Although the team was sensitive to respondent preferences on a case by case basis, gender was not a significant factor in assigning interviewers in this context.
[8] Population figures as of December 2018, disaggregated by village (and thus, cluster), gender, and age, were provided by UNHCR. The age distribution, however, included ages 0 to 4, 5 to 17, and 18 and above, thus we cannot adjust to age distribution (all survey respondents were adults).
[9] The first day of data collection had expectedly less completed interviews. Nearly all interviews were completed in six days, with the final 10 interviews completed on a seventh day. Teams were intended to have four enumerators, but due to absences, often had only three enumerators.

Photo by S. Golden

All enumerators spoke a dialect of Bari and also were conversant in English, in addition to some speaking additional languages, including Lugbara, Swahili, Acholi, and others. Of the 35 enumerators and team supervisors, 14 were CVT counseling staff, most of them recently hired as part of the launch of the new program, but one from CVT's existing program in Gulu. About half of these were Ugandan and half South Sudanese. Some of the CVT staff had significant prior experience and training in mental health service delivery, and thus were team supervisors. Additional survey team members were hired on short-term contracts from an advertised position posting. Some of CVT's newly hired staff and most of the survey team staff had limited or no previous training in counseling.

CVT clinical and research staff provided training, supervision, and support across teams. The coordination teams included research and evaluation staff from CVT's headquarters, Gulu-based program, and from the new Bidi Bidi program. Two experienced CVT psychotherapists provided clinical support. Team members received four days of training from CVT research and clinical leadership.[10] Training focused on key mental health concepts and how to sensitively and reliably administer an interview about mental health, including how to administer PFA if the respondent became triggered by any questions, when and how to refer to a psychotherapist if a respondent escalated, and how to make referrals to CVT or partner organizations. This included training on high risk protocols to address respondents who may pose a risk of harm to themselves or others, or to deal with other situations with imminent safety issues. Training also covered survey rationale and design, the content of the questionnaire, how to administer the questionnaire reliably, the informed consent process, sampling strategy and procedures to select households and individuals, and fieldwork implementation.[11] The team supervisors received an additional half day training to discuss sampling methodology in greater depth, team management, and geographic coverage strategy. Because the team had varied levels of exposure to mental health concepts and to this type of survey methodology, ongoing monitoring and feedback was required after the initial training. This included individual reviews after interviews and group debriefs at the beginning of each day.

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[10] Two days were implemented by the clinical leads and two were implemented by the research lead.

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

Interviews were conducted in person, in or around respondents' homes, using paper and pencil questionnaires. On average, it took 42 minutes to administer the 12-page questionnaire. The questionnaire was translated and back-translated into Bari/Kakwa and Juba Arabic, with bilingual versions (with English) used in fieldwork. Most interviews (83 percent) were done with the Bari questionnaire, and 17 percent used the Arabic questionnaire.[12] Translation was completed over a multi-week period, with teams of local 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.[13] The English/Bari questionnaire is attached to this report.

Photo by S. Golden

Enumerators explained to respondents that some questions were sensitive and they may wish to be alone for the conversation. The enumerator made attempts to find a private space for the interview. A small minority of respondents (about 3 percent) actively preferred or allowed their family members or others to be present during the interview. The verbal informed consent process included introducing CVT, explaining the purpose of the questionnaire, clarifying how the respondent was selected, and emphasizing that the purpose was to collect information, not to provide a service. Before consenting, the participant was told that some of the questions may be upsetting or stressful, their information would be kept private, their participation was voluntary, and they could stop at any time. The participants' names were not recorded.

Key Informant Interviews

CVT conducted key informant interviews with service providers and other stakeholders who could provide expert-level information on mental health needs and surrounding issues in Bidi Bidi refugee settlement. CVT's monitoring and evaluation officer interviewed four individuals working directly or indirectly in mental health, from government agencies and local and international non-governmental sectors. Combining insights of key informants with representative survey data provides an indicator of how stakeholder perceptions align or diverge with observed patterns in the population. The perspectives of key informants, as well as from CVT staff, supplement findings from the survey data and are integrated into the remainder of this report.

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[12] The interviewer reported the language(s) used verbally during the interview: 81 percent used Bari, 22 used Juba Arabic, 10 percent used English. Those who used Bari were asked to further specify the dialect in the language family, and 66 percent reported using Kakwa, 18 percent used Pojulu/Pajulu, 13 percent used Kuku, and 3 percent used Bari.

[13] For example, the team had extensive discussions about translating the concept "mental health." The agreed upon Bari translation was *kelan na yeyesi (kwinyit)* and Juba Arabic translation was *saha ta muk.*

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, to include emotional, psychological, physiological, and social well-being.

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

Knowledge and Attitudes

The first eleven items are general statements about mental health and trauma, addressing definitions of mental health, indicating potential stigma, and highlighting general coping strategies.[14] Respondents reported if they strongly agree, agree, disagree, or strongly disagree with each. Beginning with these questions helps build rapport and provides an understanding of how the respondent conceptualizes "mental health" in order to aid in interpreting responses throughout the rest of the interview. CVT's research and clinical team worked closely with enumerators to ensure correct translations and understandings of key concepts were used consistently. In order to not lead respondents to a negative connotation of mental illness or disability, significant attention was devoted to training and ongoing monitoring of use of the term "mental health."

These questions have moderate internal reliability with all items included (α=.46, n=464). However, because this series includes several different concepts,[15] these questions are not designed to be aggregated into a scale.

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-specific 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, with

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[14] Several of the questions are closely adapted from knowledge and attitude questions on CVT's client assessment forms, allowing comparability with help-seeking client populations.

[15] A factor analyses suggests a four component solution, roughly aligned with: 1) utilizing social relationships for mental health support; 2) negative perspectives or stigma about mental health problems; 3) confidence in coping strategies for mental health concerns; and 4) an inverse relationship between defining mental health as "positive" or "negative."

content customized for the context of refugee settlements.[16] Respondents ranked each issue on a four-point scale from "no problem at all" to a "very serious problem," with a visualization of cups to aid in response. This scale displays high internal reliability (α=.74, n=471). After completing the list, respondents were asked which one item causes the most stress in their lives currently. Respondents were also given the opportunity to list any other major stressor that was not included in the list.

Symptom Areas

The third set of questions asks respondents about frequency of mental health-related symptoms in the past two weeks. These data allow estimations of prevalence rates of mental health problems among the population. Respondents are asked 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 frequently associated with post-traumatic stress and depression. The content of the specific items was selected based on other brief screening tools, particularly the Self-Reporting Questionnaire (SRQ-8)[17] and the Patient Health Questionnaire (PHQ-9).[18] 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 Bidi Bidi population with help-seeking refugee populations (including South Sudanese) in several other contexts. Items are from the Hopkins Symptom Checklist (HSCL-25) and the Posttraumatic Stress Diagnostic Scale (PDS), widely used measures of depression and PTSD symptoms, respectively, and found to be valid and reliable with a wide range of populations. Among CVT's South Sudanese clients in other programs, the individual symptom items included on the survey questionnaire are moderately to highly correlated with overall mean scores on the full HSCL-25 depression sub-scale and the PDS symptom scale.[19] These items can be combined into a mean symptom score with high internal reliability (α=.78, n=471).

There are two questions which provide overall ratings of the respondent's perceived severity of symptoms. Respondents were 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, thus are helpful in assessing needs to inform program design.

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[16] We included items frequently reported as serious or very serious problems by refugees in other contexts, including worries about family at home, difficulty finding work, and loneliness or isolation. For example, see Aragona et al. (2012) or Schick et al. (2016).

[17] This is shortened version of the 20-item screening and diagnostic tool that has been validated in post-conflict settings (Scholte et al. 2011).

[18] Sweetland, Belkin, and Verdeli (2014) 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, including with South Sudanese populations, we have provided these locally-specific and necessary adaptations.

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

Finally, respondents were asked two questions about physical health: 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," referring to not remembering what happened while the seizure was occurring).

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 thoughts in a survey setting, particularly in a context in which suicide is stigmatized. 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, or particular segments of the population.

Household Mental Health

The brief fifth section asks whether or not any of the respondents' household members have mental health problems that are causing difficulties in daily functioning. If so, they are asked for the age and gender of those household members. The goal 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 include three questions about torture. This section is near the end of the questionnaire, after rapport has been established, and comes after a signaling question about the sensitive topic. We include a basic definition of torture: "Torture is severe physical or psychological suffering caused on purpose by someone in authority." The questionnaire does not ask any details about the torture; therefore, these items are respondents' self-reports of torture. We asked three yes or no questions: if the respondent had been tortured; if anyone in their family or household had been tortured; and if they believe many people in the community had been tortured.

Access to Services

This section asks about services that are available and assesses respondents' ability to or interest in accessing them, as well as identifying barriers they perceive to accessing services. In follow

up questions, respondents are asked if they know of any mental health or psychosocial support (MHPSS) services available in their area, if they have ever received such services, from which agency or agencies they received services, or why they have not received services. This information aids in mapping the reach of the sector and establishing existing interest in MHPSS services. We also ask about other types of services received in the past month, field-coding responses by sector, and also ask where respondents receive information about services, again field-coding into common categories. Finally, as an indicator of accessibility, mobility, and isolation, we ask if respondents are able to walk to a health center and to a protection desk.

Demographics

Finally, the questionnaire includes demographic information: age, languages spoken, household size, number of children, marital status, level of education, primary religion, family separation, and length of time in the current community. We also recorded some information not asked of the respondent: gender; location, duration, and language of interview; 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. In addition, double entry was conducted to check for errors. The research team cleaned and analyzed data using SPSS.

Psychological Support

Throughout the survey, CVT provided mental health support to both respondents and staff. As a mental health service provider, CVT adheres to a rigorous ethical standard and commitment to participants' well-being throughout the process.

During 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. After completing the questionnaire, the enumerator indicated any response that had been required.

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 qualified clinician to visit the household immediately. There were 14 cases (about three percent of respondents) requiring an emergency clinical response.

Follow-up Protocol Response Options

- **Emergency response:** Respondent is in extreme distress and requires immediate intervention
  Notify supervisor/clinical support to get CVT staff to come to the household immediately.
- **Referral:**
  - Respondent was given information about available services
  - Respondent needs to be connected with referral partner
  - Respondent needs to be referred for CVT services
- **PFA:** Respondent experienced some distress and required in-person PFA delivered during survey per CVT training of enumerator
- **Nothing required:** Respondent did not require follow up for psychological distress

Referrals

In training the interview teams, we reinforced that the survey was not designed as outreach or to screen for CVT beneficiaries. However, for respondents exhibiting particularly severe or immediate needs, we established and utilized referral protocols to connect them with appropriate service providers, including referring them to appropriate partner organizations or referring them to CVT's rehabilitation services. 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. We recorded providing information about services to 96 respondents, making 39 referrals to other organizations, and documenting 51 cases for follow up with CVT services.

Psychological First Aid (PFA)

Enumerators and supervisors received training in PFA to equip them to provide brief emotional support to respondents, as needed, while conducting the survey. PFA is accepted by disaster experts as an evidenced-based approach to decreasing emotional and physical responses experienced by those exposed to trauma (Ruzek et al. 2007).

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

Respondents who became emotionally distressed during the survey received support using a PFA approach; if this was not sufficient, the respondent was also referred to a team lead, who conducted brief supportive counseling and taught coping skills. The respondent was also assessed on need for referral to mental health services. We recorded 73 cases with PFA required.

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 then asked directly if respondent has thoughts of killing themselves and if they have a plan. With that information, the enumerator consulted the standby clinical team to assess the level of risk and make appropriate intervention and/or referral. There were 160 respondents who reported having suicidal thoughts in the past two weeks in response to the survey question; 13 of those said they "often" had such thoughts. If the respondent was assessed to be in imminent danger, they received PFA and a referral to existing emergency mental health services.

Demographic Characteristics

We conducted 502 interviews[20] in Zone 5 of Bidi Bidi refugee settlement. All respondents were from South Sudan, with the exception of one respondent who reported Uganda as their home country. The sample was roughly balanced in terms of gender, due to the sampling strategy, though the weighting adjusts this to the population proportion. There was a large age range, with an average of 34 years old. The largest proportion of respondents spoke Juba Arabic and/or Kakwa, with significant minorities also speaking Bari, Pajulu, Kuku, or English. Two-thirds of respondents had not completed any formal education, and the vast majority identified as Christian.

Key Characteristics of Bidi Bidi Survey Respondents[21]

Sample size	502
Clusters (valid %)	
Yangani	42
Ayivu	27
Ariwa I	12
Ariwa II	12
Ombechi	7
Women (valid %)	51
Age	
Mean	34
Range	18-87
Languages spoken (valid %, not mutually exclusive categories)[22]	
Juba Arabic	74
Kakwa	73
Bari	46
Pajulu	36
Kuku	26
English	25
Kiswahili	12
Lugbara	6
Mundari	6
Nyangwara	5

[20] Of these, 6 were partial interviews, with the respondent needing to end the interview prior to completion. This affects the given response rates throughout this report.
[21] Unweighted data are presented for variables used to create the weight (cluster and gender); all remaining data are weighted.
[22] There was a large degree of language diversity among refugees. Languages reported by one to two percent of respondents are: Acholi, Keliko, and Madi. Minority languages reported by less than one percent of respondents are: Anyuak, Baka, Dinka, French, Jumjum, Kikuyu, Kirish, Lingala, Lopit, Luganda, Mundu, and Zande.

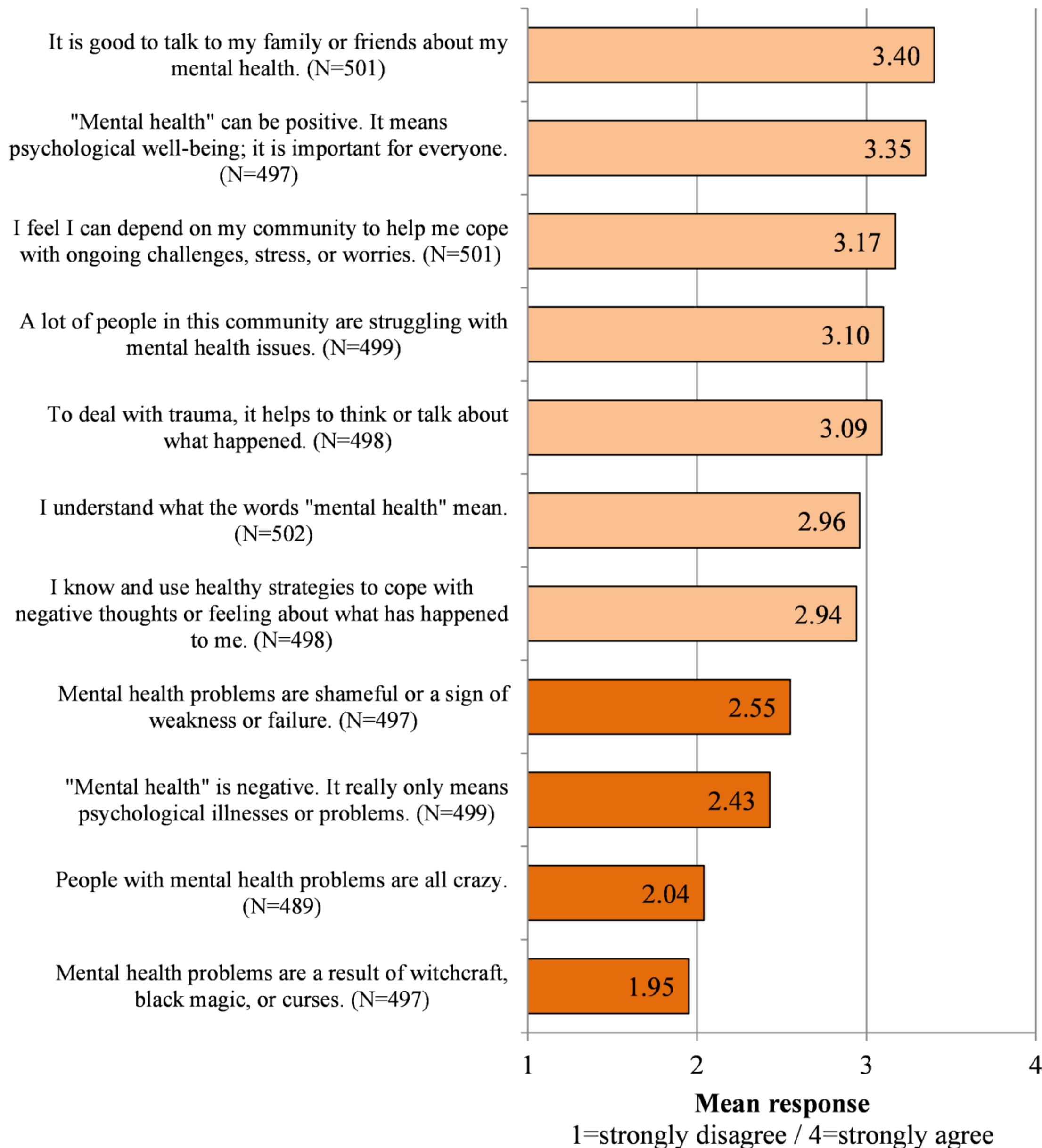
Key Characteristics of Bidi Bidi Survey Respondents (con't.)

Completed levels of education (valid %)	
No education	66
Primary	33
Secondary	10
Technical	1
University	<1
Religion (valid %)	
Christian	96
Muslim	4
Indigenous, traditional, or folk religion	<1
Time in current community	
Range	1-36 months
Mean	26.8 months
1-12 months (valid %)	2
13-24 months (valid %)	11
25-36 months (valid %)	87
Household size (not including respondent)	
Mean	7.1
Range	0-30
Marital status (valid %)	
Married	70
Single	13
Widowed	8
Living as a couple, not married	6
Divorced or separated	4
Number of children	
Mean	3.5
Range	0-16
Family separation (valid %)	51

Most respondents had been in the refugee settlement two to three years. Respondents reported large household sizes, with a mean of over seven people, in addition to the respondent; just one percent reported living alone. Seventy percent of respondents were married, and they had nearly four children on average. Finally, about half of respondents were currently separated from one or more family members.

Knowledge and Attitudes about Mental Health

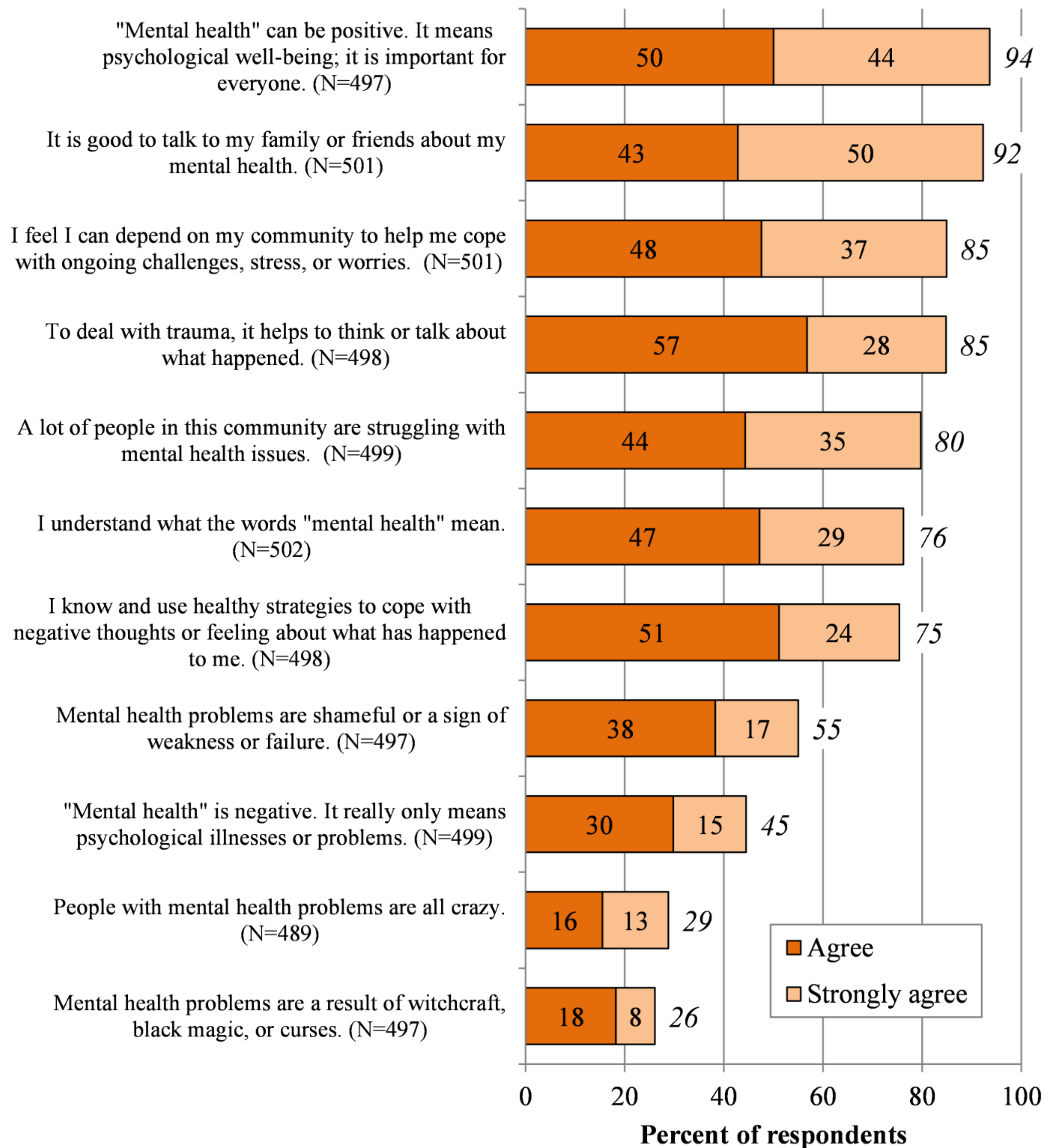
Respondents had generally positive attitudes about mental health. They were more likely to agree with positive statements and to disagree with the most negative, stigmatizing statements (shown by a darker shade below). Respondents most strongly agreed with statements about utilizing social support to deal with mental health challenges.



The next figure shows respondents who agreed with each statement. A strong majority agreed that mental health can be positive and feel it is helpful to talk with others about their mental health. The majority of respondents had some awareness of mental health concepts. Over three-quarters of respondents said they "understand what the words 'mental health' mean," with this view more common among those who had at least primary education, compared to those who had not completed any formal education (87 percent and 71 percent, respectively; p=0.001). Three-quarters of respondents felt that they know and utilize healthy coping strategies to deal with negative thoughts or emotions. Again, this perception was more prevalent among those who had some education, compared to those who had not completed any formal education (82 percent and 72 percent, respectively; p=0.061).

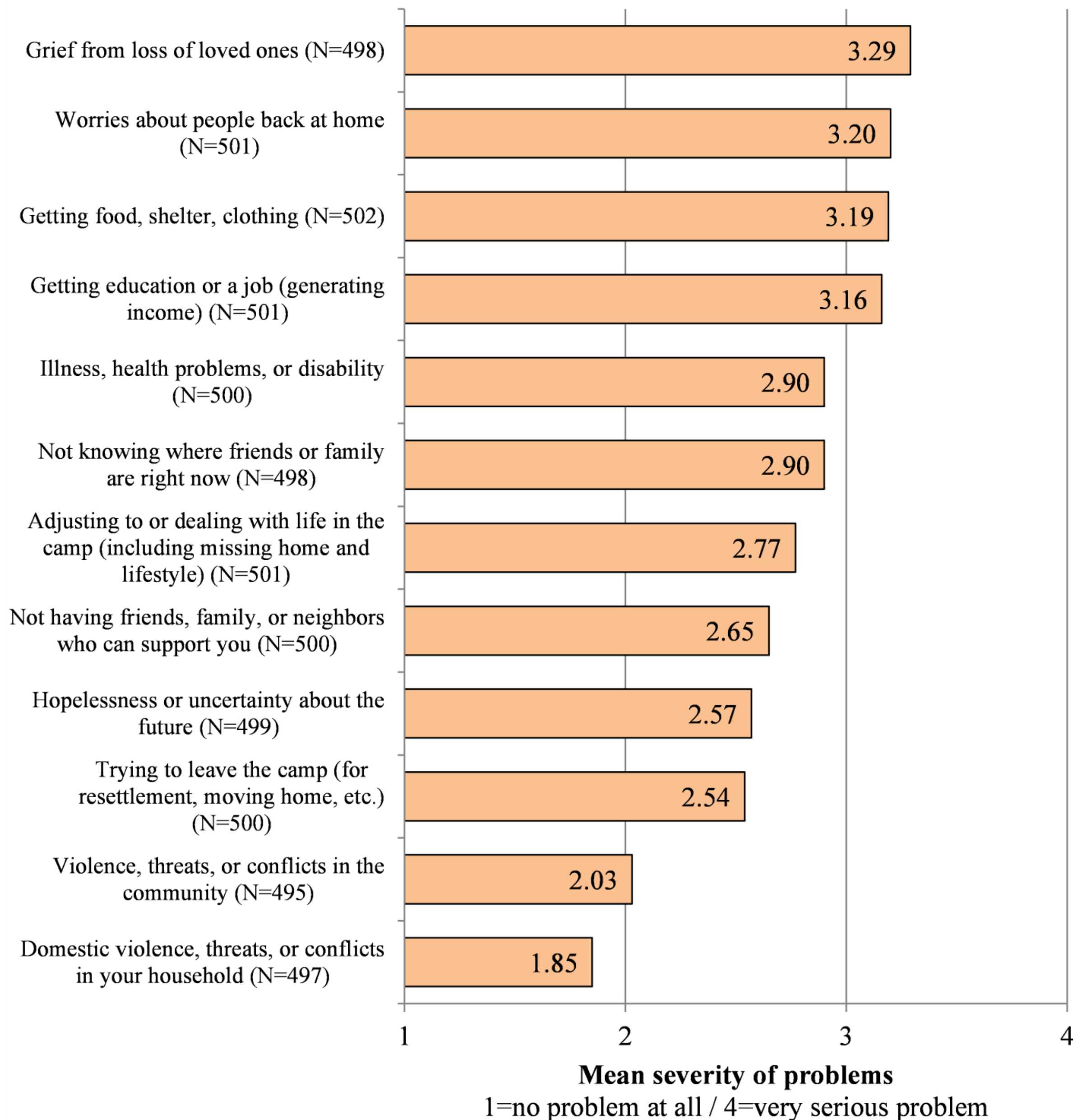
Although the negative statements fall to the bottom, there are significant segments of the population where stigma towards mental health is strong. Over half of respondents agreed that "mental health problems are shameful or a sign of weakness or failure." Over two-fifths of respondents felt that mental health is negative, with women more likely to hold this perspective than men (46 percent and 41 percent, respectively; p = 0.058). Furthermore, 29 percent agreed that "people with mental health problems are all crazy." Just over a quarter of respondents agreed that "mental health problems are a result of witchcraft, black magic, or curses." One key informant suggested that associating mental illness with witchcraft is a common cultural belief among Bidi Bidi residents, and is the the main barrier to seeking mental health support. This suggests the need to raise more awareness about mental health problems to challenge these perceptions.

Overall reported attitudes about mental health were relatively positive, and respondents had some awareness of mental health concepts and openness to coping strategies. This can be drawn upon as a resource for community mobilization and to encourage individuals to access services. Particularly, there seems to be a willingness to draw upon social support in the form of family, friends, and community in order to cope with mental health problems; service providers may utilize this willingness and craft interventions that integrate individual healing and existing social support networks. Despite the general positive picture supported by CVT's data, there is still substantial variation in attitudes, including significant indications of stigma. This may be reflected in the responses of the few key informants CVT interviewed, who suggested that awareness of mental health in the community was low and attitudes are negative. Taken together, these data suggest the need for targeted outreach and education strategies to address stigma, by drawing upon existing willingness in the community to understand and support each other in dealing with mental health challenges.


Knowledge & Attitudes about Mental Health:
Respondents who "Agree" or "Strongly Agree"
"Do you agree or disagree?"
"Mental health" can be positive. It means psychological well-being; it is important for everyone. (N=497)
50
44
94
It is good to talk to my family or friends about my mental health. (N=501)
43
50
92
I feel I can depend on my community to help me cope with ongoing challenges, stress, or worries. (N=501)
48
37
85
To deal with trauma, it helps to think or talk about what happened. (N=498)
57
28
85
A lot of people in this community are struggling with mental health issues. (N=499)
44
35
80
I understand what the words "mental health" mean. (N=502)
47
29
76
I know and use healthy strategies to cope with negative thoughts or feeling about what has happened to me. (N=498)
51
24
75
Mental health problems are shameful or a sign of weakness or failure. (N=497)
38
17
55
"Mental health" is negative. It really only means psychological illnesses or problems. (N=499)
30
15
45
People with mental health problems are all crazy. (N=489)
16
13
29
Mental health problems are a result of witchcraft, black magic, or curses. (N=497)
18
8
26
Agree
Strongly agree
0
20
40
60
80
100
Percent of respondents

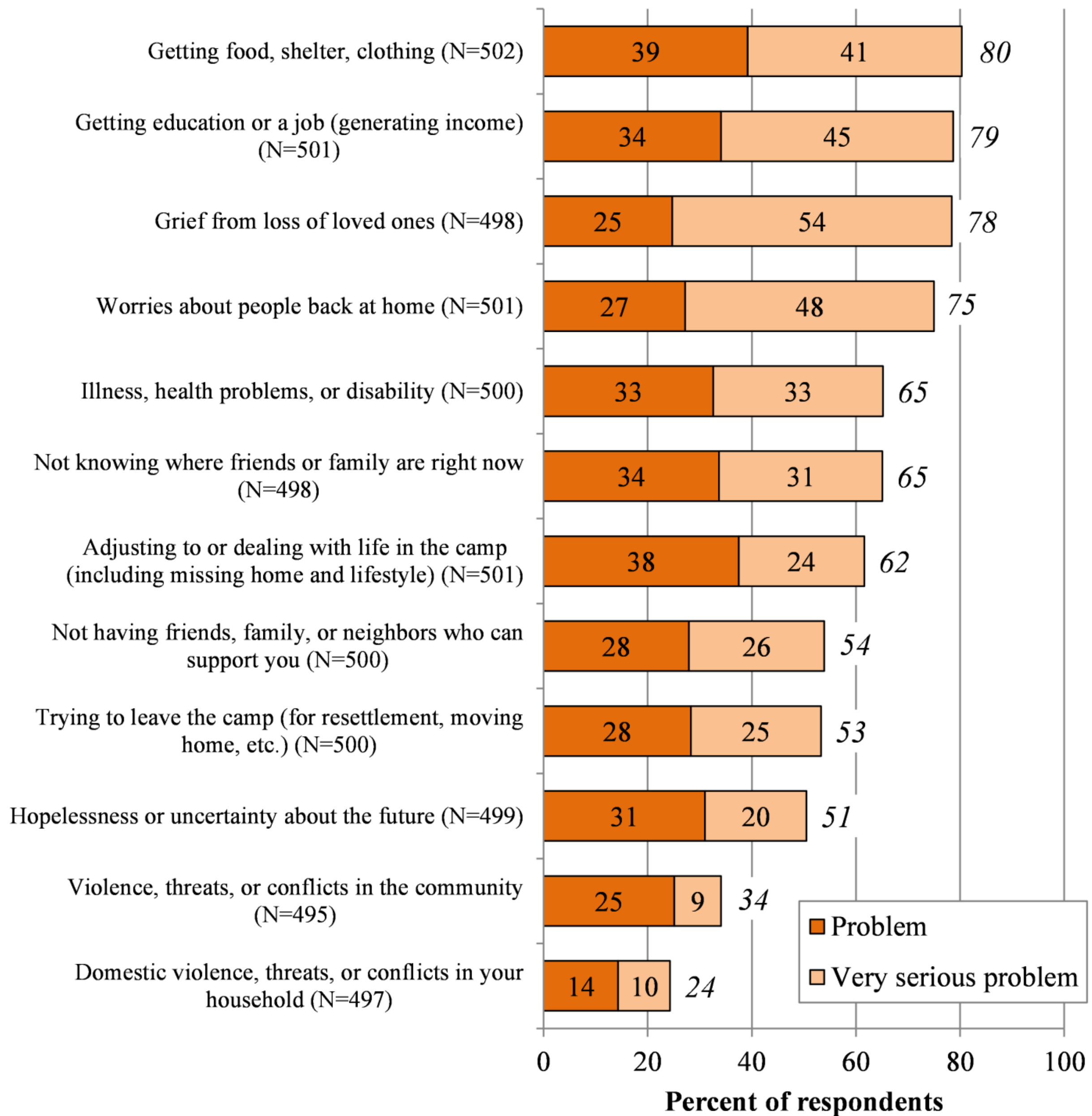
Difficulties in Daily Life

The problems reported by respondents as the most serious in their daily lives were: grief from losing their loved ones; worries about people back home; getting food, shelter, and clothing; and getting education or a job.



Respondents ranked challenges with basic necessities and livelihoods as major problems in their life. With about 80 percent of respondents, shown below, saying these were a problem or very serious problem in their lives, this is a significant consideration in Bidi Bidi. Within a settlement model that emphasizes self-sufficiency, this indicates that residents may require more sustained support in providing for their basic needs. This finding is consistent with research by Amnesty International, concluding that significant funding shortfalls have caused struggles with basic needs, including access to adequate amounts of food, water, and shelter, in West Nile sub-region settlements, and particularly in bigger settlements such as Bidi Bidi (Amnesty International 2017). As of June 2018, UNHCR reported that around 46,000 households in Bidi Bidi needed improved cooking stoves and efficient energy and about 4,300 eligible refugees did not receive all of their food assistance at the last distribution (UNHCR 2018). In addition, one key informant interviewed by CVT said that meeting basic needs in Bidi Bidi continues to be a pressing need facing refugees right now.

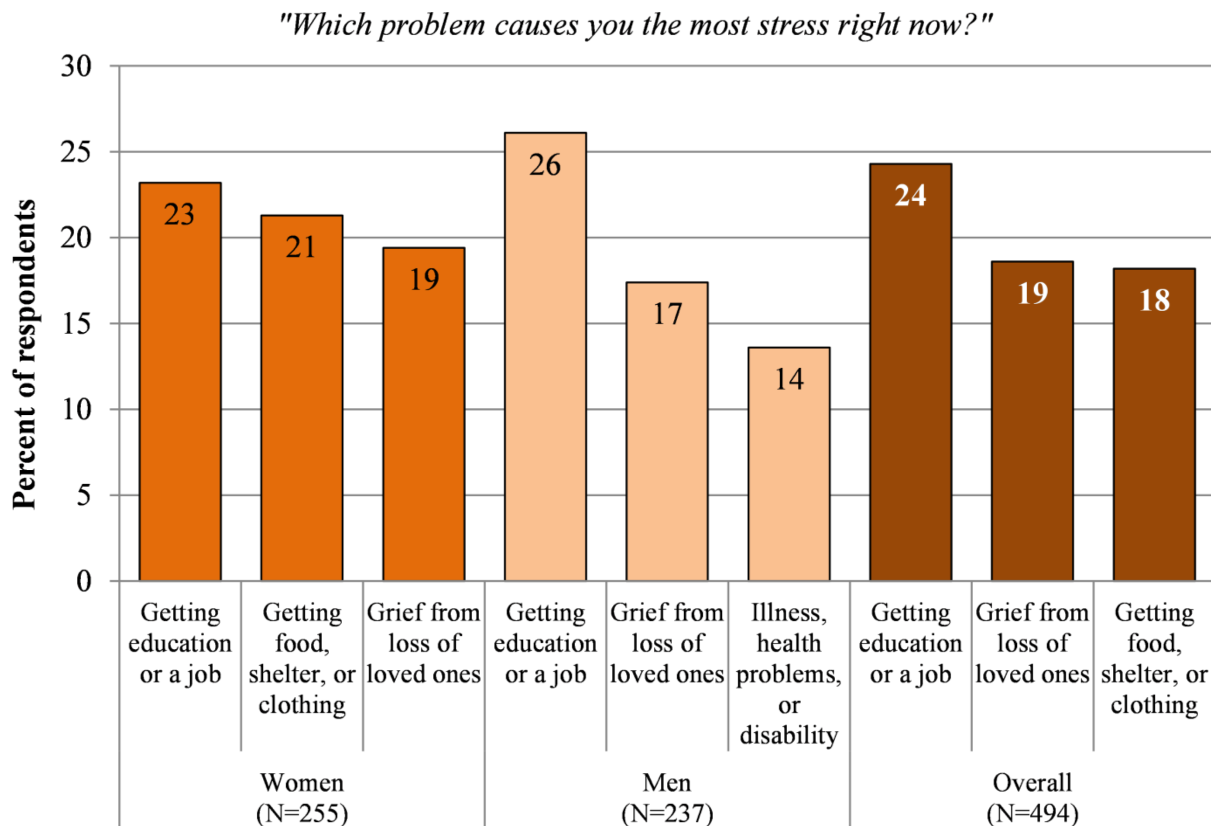
Mental health concerns were also reported as problems for most respondents, suggesting a strong need for mental health support. Over three-quarters of respondents said that grief from loss of loved ones was a daily difficulty, and over half described it as a very serious problem. While grief is a healthy response to loss, research has found a strong relationship between the violent death of a loved one and symptoms of both PTSD and persistent, severe depression (Kaltman and Bonanno 2003). Additionally, trauma can impede the grieving process, preventing progress until the traumatic experience has been processed. Three-quarters of respondents said that worrying about people still at home was a significant problem in their life and nearly two-thirds struggled with ambiguous loss from not knowing the whereabouts of their loved ones.



Many respondents reported adjustment to life in the settlement as a current problem. One way to estimate those in need of stabilization services or interventions, such as PFA, would be to identify those displaying serious trouble adjusting to life in the settlement. About a quarter of respondents reported that adjusting to life in Bidi Bidi was a “very serious problem” for them,

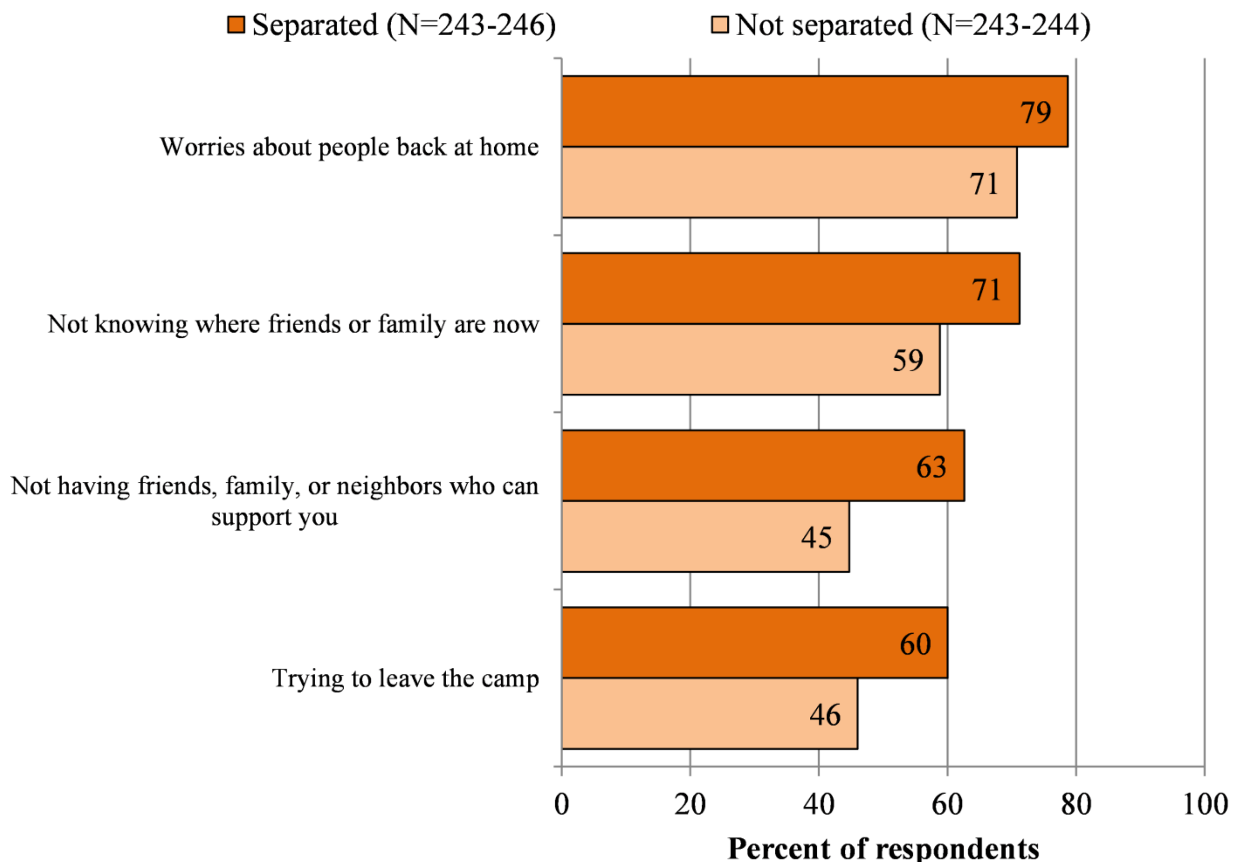
indicating they may potentially derive strong benefits from stabilization services. Additionally, just over half of respondents reported lack of social support and hopelessness as significant problems for them. Finally, although a minority, over a third reported that community violence is a problem, and around a quarter of respondents reported problems with violence in their households. This supports the perspectives of key informants who suggested that community and domestic violence affects many Bidi Bidi residents. This suggests the need for integration of protection services with psychosocial support for survivors.

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. Overall, the most often selected response was getting education or a job (24 percent of respondents), followed by grief from loss of loved ones and getting food, shelter, or clothing. Getting education or a job was most likely to be the most significant stressor, regardless of gender, and grief was also among the top three for both men and women. However, women were more likely to report high stress from providing for basic necessities, whereas physical health challenges ranked more highly for men.[23]



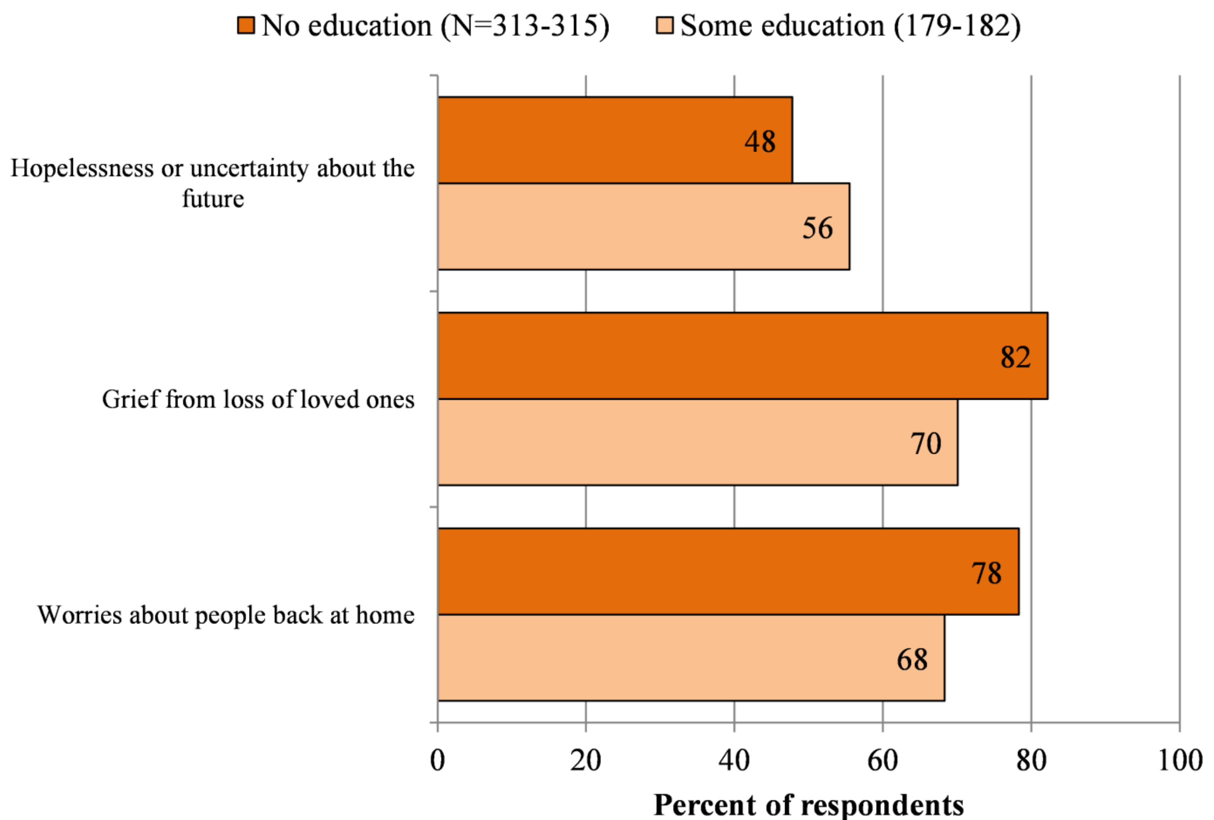
[23] This finding is consistent with AI's claim that female headed South Sudanese households in West Nile settlements face great challenges in constructing shelters due to the physical nature of construction and competing responsibilities, including caring for children (Amnesty International 2017).

Some vulnerable groups were more likely to report mental health concerns as significant problems in their lives. Women were slightly more likely than men to report problems with grief, ambiguous loss, and lack of social support. People separated from their families were significantly more likely to report worries about people back home, ambiguous loss, and lack of social support as daily stressors.



Differences between groups are statistically significant at 0.10-level.

Respondents with no formal education were more likely to report daily problems from grief and worries about people at home. In contrast, those with some education were more likely to struggle with hopelessness about the future, perhaps suggesting particular frustration with the limited opportunities available to them in the refugee settlement.

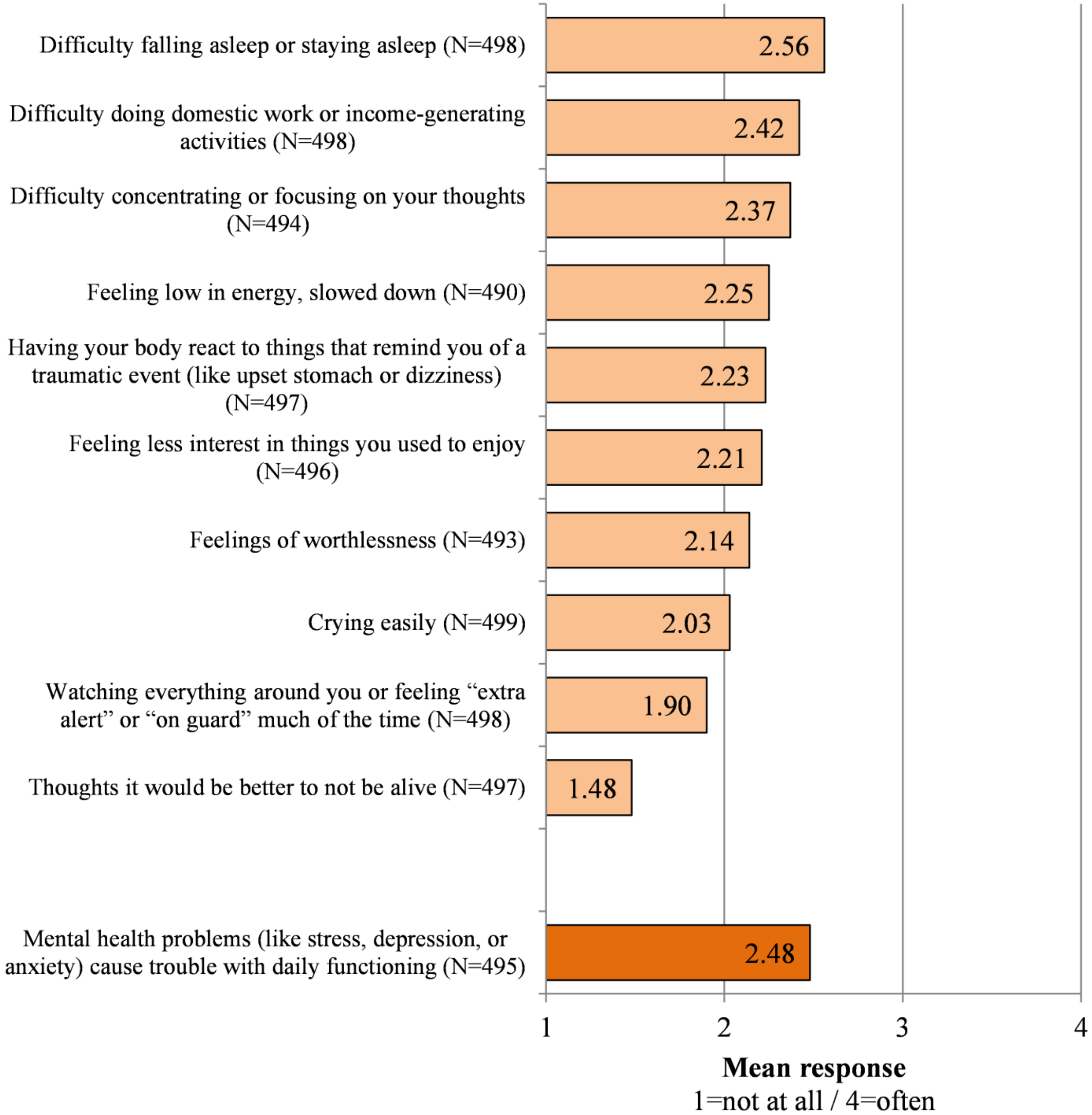


Differences between groups are statistically significant at 0.10-level.

Younger respondents were more likely than those over 30 to report domestic violence as a problem for them (29 percent and 19 percent, respectively; p=0.001). However, most of this is explained by gender: 34 percent of young women report domestic violence as a problem or very serious problem for them, whereas the rates for younger men, older men, and older women are 18 to 20 percent. Similarly, it is worth noting that women are more likely to have no formal education and to be separated from their families than men, highlighting the importance of accounting for intersectional identities when considering vulnerability.

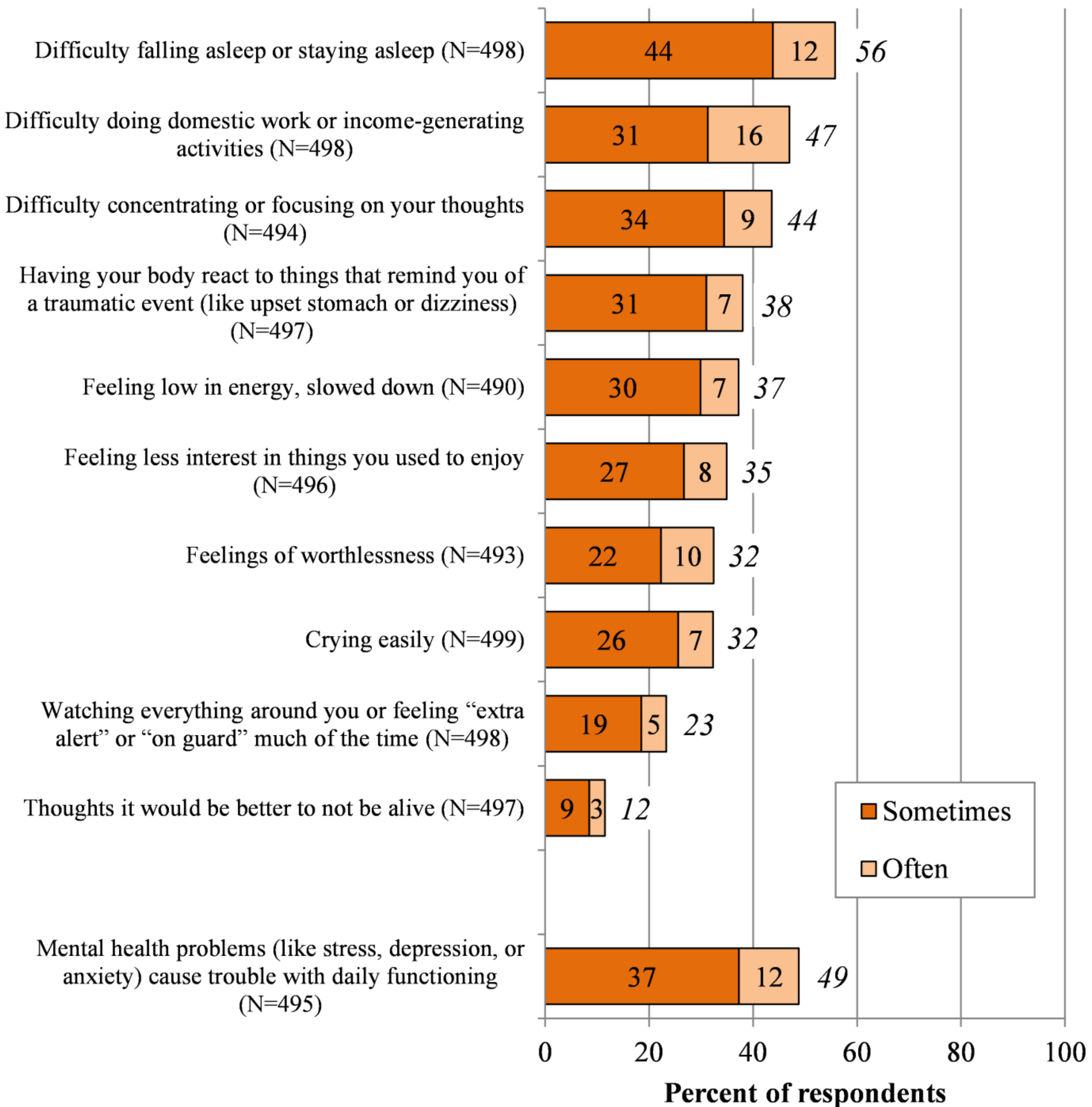
Mental Health Problems and Symptoms

Respondents were asked how frequently they experienced ten symptoms associated with depression and post-traumatic stress in the past two weeks, with options of not at all, rarely, sometimes, and often. The most frequently reported symptoms were difficulties with sleep, with income generating activities, and with concentration. Suicidal thoughts were the least commonly reported symptom. Respondents reported moderate functional impairments from mental health difficulties. The mean score across all ten symptoms 2.2 (on a scale where 1 means "not at all" and 4 means "often"), indicating that, on average, respondents reported experiencing symptoms just a bit more often than "rarely" in the past two weeks. The key informants interviewed emphasized the need for mental health services for refugees struggling with depression and post-traumatic stress, and these data help develop an evidence-based approach to identifying which proportion of the population might require these services.



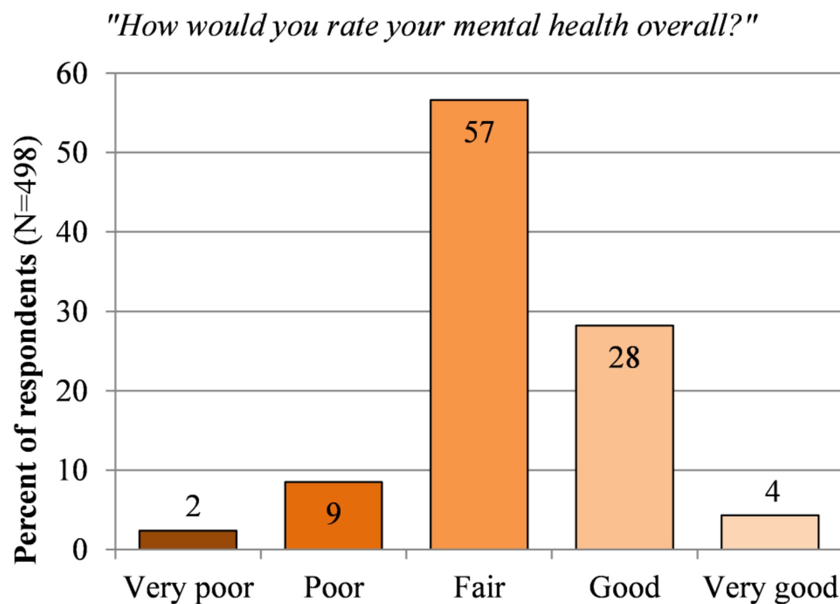
These symptoms are not equally distributed among the population; some people have very mild symptoms, while others are much more severe. Over half of respondents reported sometimes or often struggling with sleep in the past two weeks. For all other symptoms, however, less than half of the population reported experiencing them regularly. Individuals who are experiencing such symptoms have varied levels of resilience and ability to draw upon existing coping resources to maintain functionality in daily life. Around half of respondents,

however, reported that mental health problems were severe enough to have caused trouble with their daily functioning in the past two weeks. Key informants recognized this challenge, emphasizing the importance of providing mental health support to help Bidi Bidi residents become productive and engaged in livelihoods and other programs. These data help identify the proportion of the population who may potentially derive benefit from mental health support in order to develop new strategies and techniques for coping with challenges in their lives.

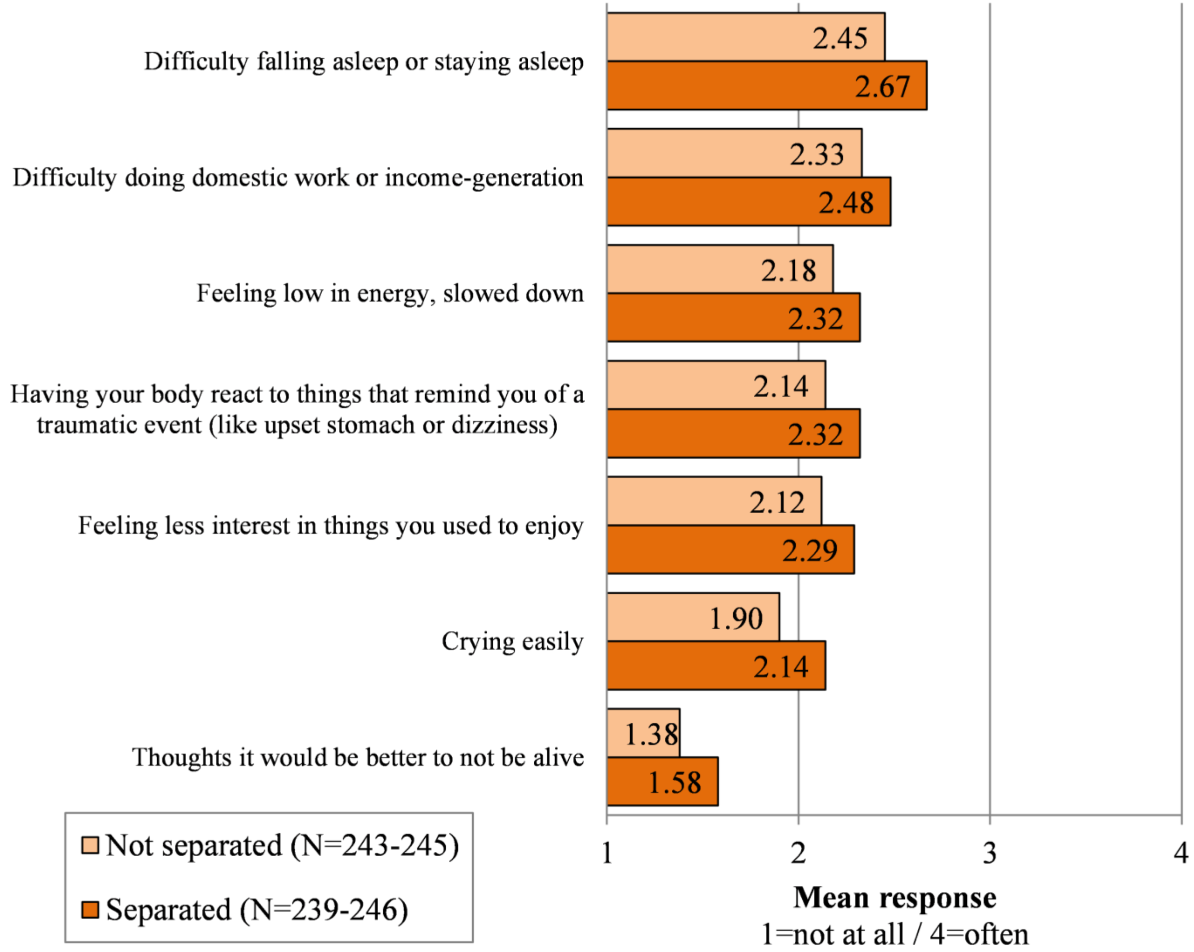


Although less common than other symptoms, about a third of respondents reported thoughts that it would be better if they were not alive: 22 percent said rarely, 9 percent said sometimes, and 3 percent said they have often had these thoughts in the past two weeks. Key informants indicated that there are frequent suicide attempts in the settlement, and one key informant described it as an increasing concern. Suicidal thoughts were reported more commonly among women (37 percent, compared to 28 percent of men, p=0.024), those separated from their family (38 percent, compared to 29 percent, p=0.040), and, most dramatically, those who reported a problem with domestic violence (49 percent, compared to 28 percent, p=0.000). These data indicate that suicidal ideation, and perhaps behavior, may be exacerbated by family separation and violence. These subsets of the population are particularly high risk and likely to be in urgent need of integrated mental health and protection support.

Most respondents had a moderate self-assessment of their overall mental health, with 57 percent reporting it was overall fair. Respondents' functional difficulties and overall rating of mental health were significantly correlated with each of the ten individual symptoms. Functional difficulties were most closely linked to: loss of interest (r_s=0.318); somatic reactions to trauma triggers (r_s=0.324); feeling low in energy (r_s=0.331); and hypervigilance (r_s=0.312). The overall rating of mental health was most strongly related to feelings of worthlessness (r_s=0.261) and to crying easily (r_s=0.245).



Some groups reported more frequent symptoms. Again, refugees who are separated from their family are particularly vulnerable to mental health problems. Those currently separated from their families report significantly more sleep problems, difficulty with work, low energy, somatic reaction to trauma triggers, decreased interest, crying easily, and suicidal thoughts.



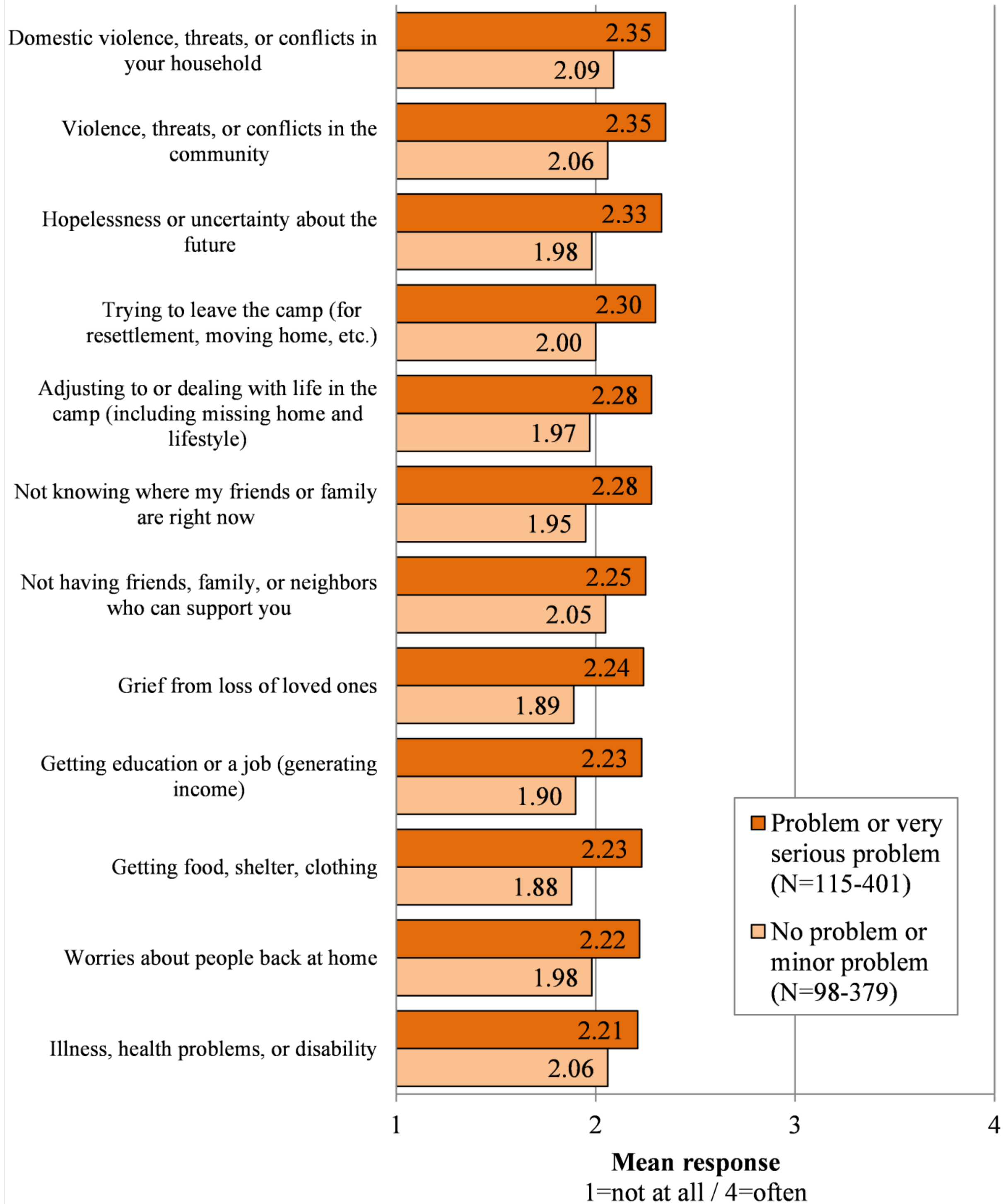
Differences between groups are statistically significant at 0.10-level

Women were also significantly more likely than men to report crying easily, having somatic reactions to trauma triggers, low energy, difficulty doing work, sleep problems, and having difficulty functioning. Overall, women's average symptom score was 2.2 and men's average was 2.0 (p=0.000). Those over age 30 reported more frequent difficulty sleeping, low energy, and somatic reactions to triggers. Those with no formal education were more likely to report crying easily and difficulty functioning.

Stress from daily difficulties of life in the context of displacement can contribute to more frequent and severe mental health symptoms, especially in populations with high rates of exposure to traumatic events.[24] The following figure shows mean symptom scores according to

[24] For example, see: Miller and Rasmussen 2017, 2010; De Schryver et al. 2015; Tay and Silove 2017. This is also consistent with a needs assessment focused on South Sudanese refugees in northwest Uganda (Adaku et al. 2016).

ongoing stressors. Additionally, there are significant relationships between some individual difficulties and particular psychological symptoms. For example, reports of domestic violence were most closely linked to crying easily (r_s=0.240) and hypervigilance (r_s=0.249). Struggles with grief were most closely linked to hypervigilance (r_s=0.234), somatic reactions (r_s=0.218), and functional difficulties (r_s=0.215). Struggles with providing basic necessities were most closely linked to difficulty concentrating (r_s=0.242) and sleep difficulties (r_s=0.239). This suggests the need to develop a layered system of complementary supports that meets the diverse needs of refugees in tandem with mental health and psychosocial support (IASC 2007).



Differences between groups are statistically significant at 0.05-level

Symptom Prevalence in the Population

The symptoms reported by survey respondents can be used to estimate symptom prevalence rates in the population overall. There is not one established cut-point on symptom scales at which point an individual requires services, but a score of 2.0 is often used to indicate symptoms at a level that would suggest some support would likely be helpful or necessary.[25] Among survey respondents in Zone 5 of Bidi Bidi refugee settlement, 59 percent have a mean symptom score of 2.0 or higher. From this, we can say with 95 percent confidence that 55 to 64 percent of the adult population of Zone 5 will have symptoms at or above 2.0 on this scale. Applying this rate to the 13,265 adults in the population,[26] we predict 7,309 to 8,463 adults have symptoms at or above this cut-point, suggesting that more than half of adults in Zone 5 of Bidi Bidi refugee settlement may need support from MHPSS services.

To estimate a more conservative symptom prevalence rate, we can compare survey respondents' reported symptoms to those of CVT clients. To become a client, individuals complete a screening and intake process to assess symptoms and functional challenges and determine if they fit inclusion criteria for intensive mental health support. The aggregate intake symptoms of CVT clients in Bidi Bidi suggest that a cut-point of around 2.4 on this scale may be appropriate for this population and context.[27] The table below shows that, even by this more conservative estimate, at least 4,000 adults in Zone 5 of Bidi Bidi refugee settlement are likely in need of MHPSS services that address depression and post-traumatic stress.

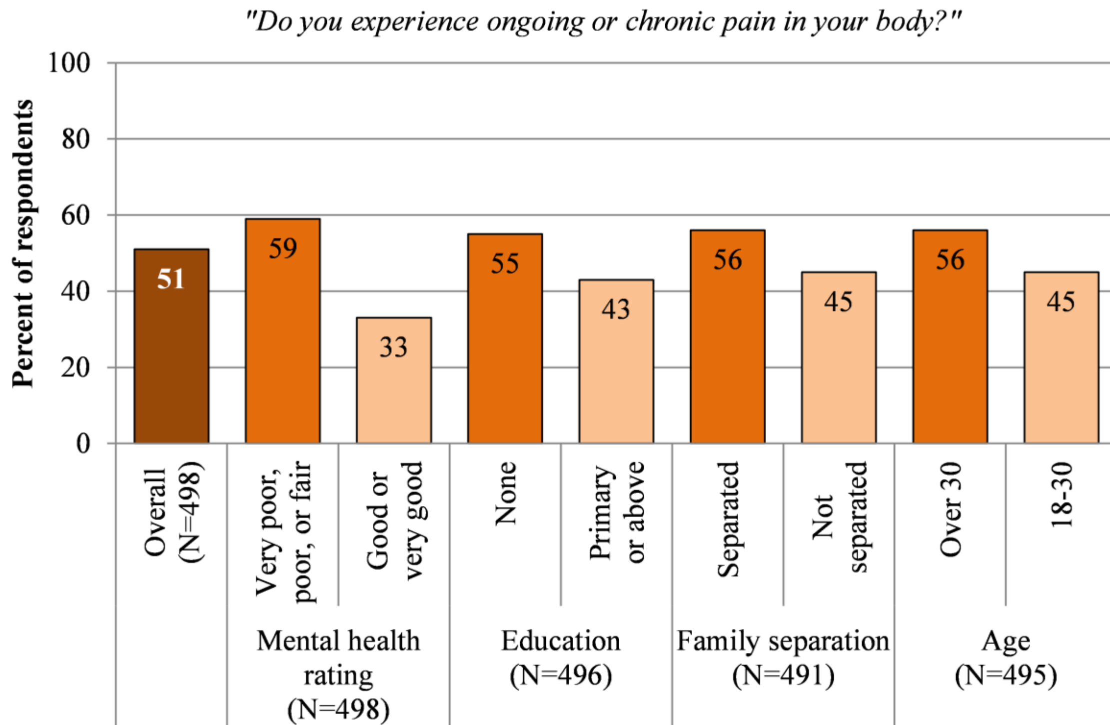
Cut-point on symptom scale	% of respondents that have mean symptom score at or above cut-point	95% Confidence interval for mean symptom score at or above cut-point		Adults in Zone 5 predicted to have symptoms at or above this cut-point
		Lower bound	Upper bound	
2.0	59.4%	55.1%	63.8%	7,309 – 8,463
2.4	34.9%	30.7%	39.1%	4,072 – 5,187

Chronic Pain and Seizures

Over half of respondents (51 percent) reported chronic pain. Those who reported pain were asked to rank the severity of their pain; 28 percent of those said their pain was a 10 (the maximum level) with an average response of 6.5. This suggests that for those dealing with chronic pain, it is likely to seriously impair their daily life. Rates of chronic pain were higher among those with lower overall rating of mental health, those with no education, those separated from their families, and people over the age of 30, highlighting an overlap with indicators of vulnerability. Chronic pain can be both a cause and consequence of mental health issues, and trauma has powerful effects on both the mind and the body. Notably, key informants interviewed

[25] The precise cut-point for a population and context would be established with a validity study and determining the degree of sensitivity and specificity desired. For example, see: Ventevogel et al. 2007; Ertl et al. 2010; Sweetland, Belkin, and Verdeli 2014.
[26] Zone 5 population statistics provided by UNHCR Bidi Bidi.
[27] CVT Bidi Bidi clients have a mean score of 2.79 on these symptoms at intake. We use one standard deviation (0.43) below the mean symptom score to estimate a cut-point of 2.36. This is a preliminary estimation of a cut-point for this population; further research would be needed to verify this.

by CVT did not mention chronic pain as a mental health-related concern, despite the strong link identified in our survey results. This suggests a need to raise awareness within the settlement of the potential benefits of an integrated mind-body approach to addressing mental health.



Differences between groups are statistically significant at 0.05-level.

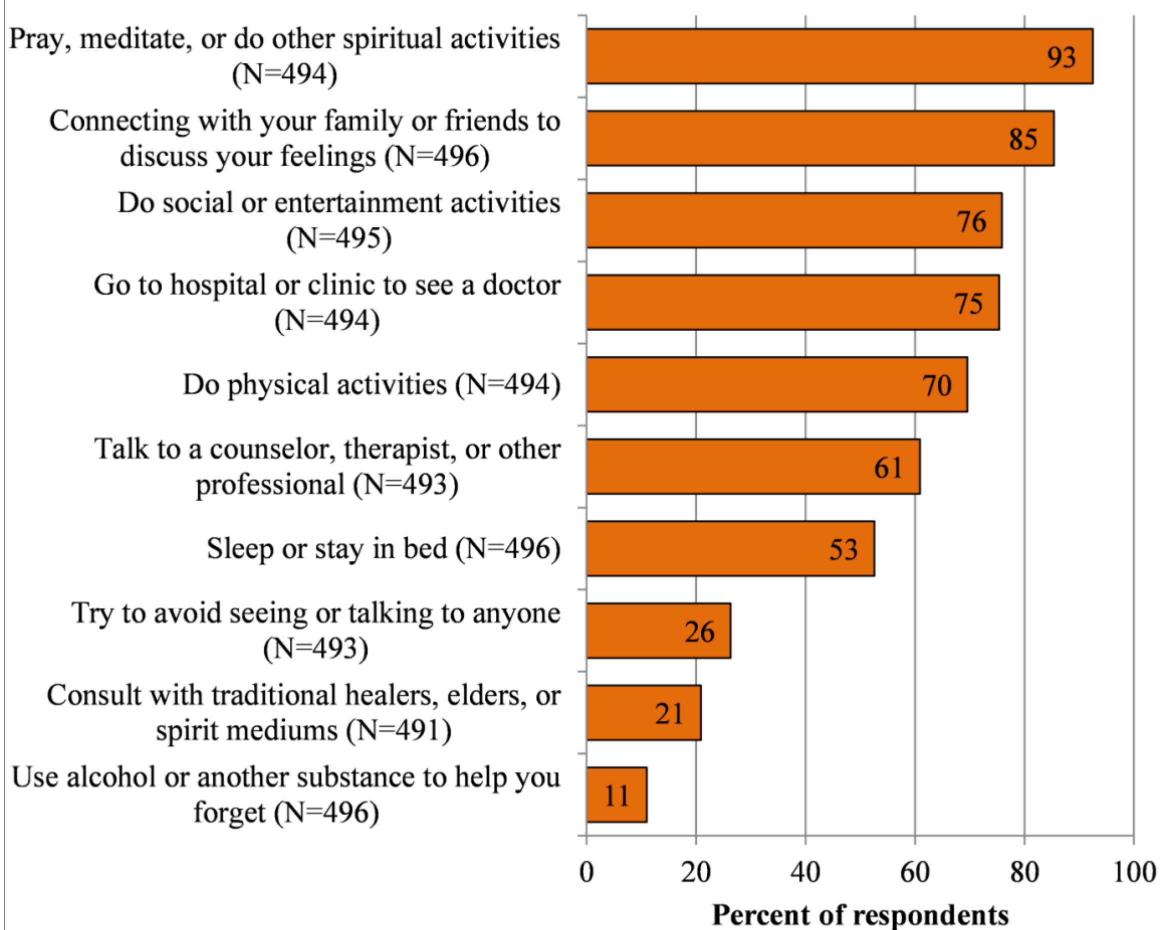
Respondents were also asked if they had ever had seizures; about eight percent reported they had. Those who report seizures are also much more likely to report suicidal thoughts (59 percent, compared to 31 percent of those who do not report seizures, p=0.004). Respondents who have seizures are also more likely to say they sometimes or often are bothered by feelings of hypervigilance (37 percent, compared to 22 percent, p=0.019). Seizures can be linked to epilepsy, but also other causes, including traumatic brain injuries that may have been related to a traumatic event.

Household Mental Health

Overall, 21 percent of respondents said that someone in their household, besides themselves, has mental health problems that interfere with daily functioning. Over half (56 percent) of the reported household members with mental health problems were women or girls. For those who said yes, the average age of the reported household member was 24, with a range of 2 to 76; 38 percent of those who have a household member struggling with functioning said that person was a minor. In the survey sample overall, eight percent of respondents said they have a minor in their household with mental health problems interfering with their daily functioning.

Coping Strategies

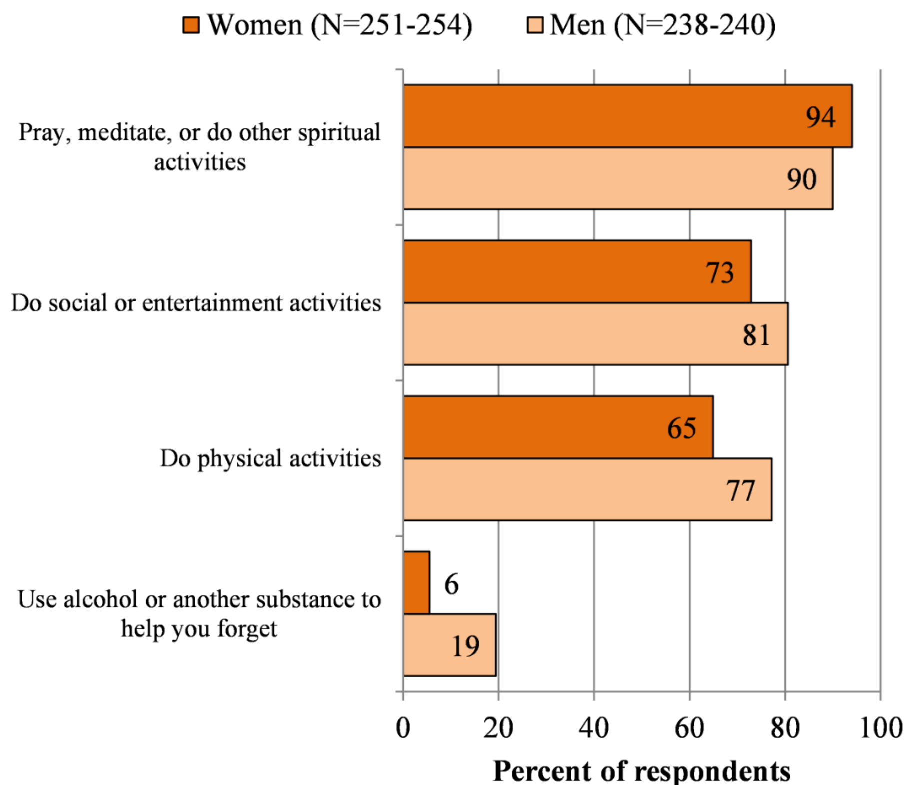
Most survey respondents reported using healthy coping strategies to deal with difficult emotions, such as feeling sad, anxious, or overwhelmed. Over 90 percent reported that they turn to spiritual activities to help them cope. A strong majority rely on social support, by connecting with their family or friends to talk about their feelings or struggles.[28] Seventy-six percent of respondents reported doing social or entertainment activities. Many respondents (75 percent) said they visit a hospital or clinic, suggesting medical resources in the settlement are being utilized to respond to mental health problems. Over sixty percent of respondents say that they turn to a counselor or therapist for help, which could include community members trained in basic counseling skills through a service provider, church, or others. Around a fifth of respondents reported consulting traditional healers, elders, or spirit mediums.



[28] This finding is consistent a needs assessment in Rhino camp (Adaku et al. 2016).

Our list included a few coping strategies which might be considered generally unhealthy. These were reported comparatively less often, but still at relatively high rates. Some respondents said they use avoidance strategies to cope: over half of respondents reported sleeping or staying in bed to escape feeling sad, anxious, or overwhelmed, and over a quarter reported not seeing or talking to anyone. A minority (11 percent) reported using alcohol to help deal with difficult emotions.[29]

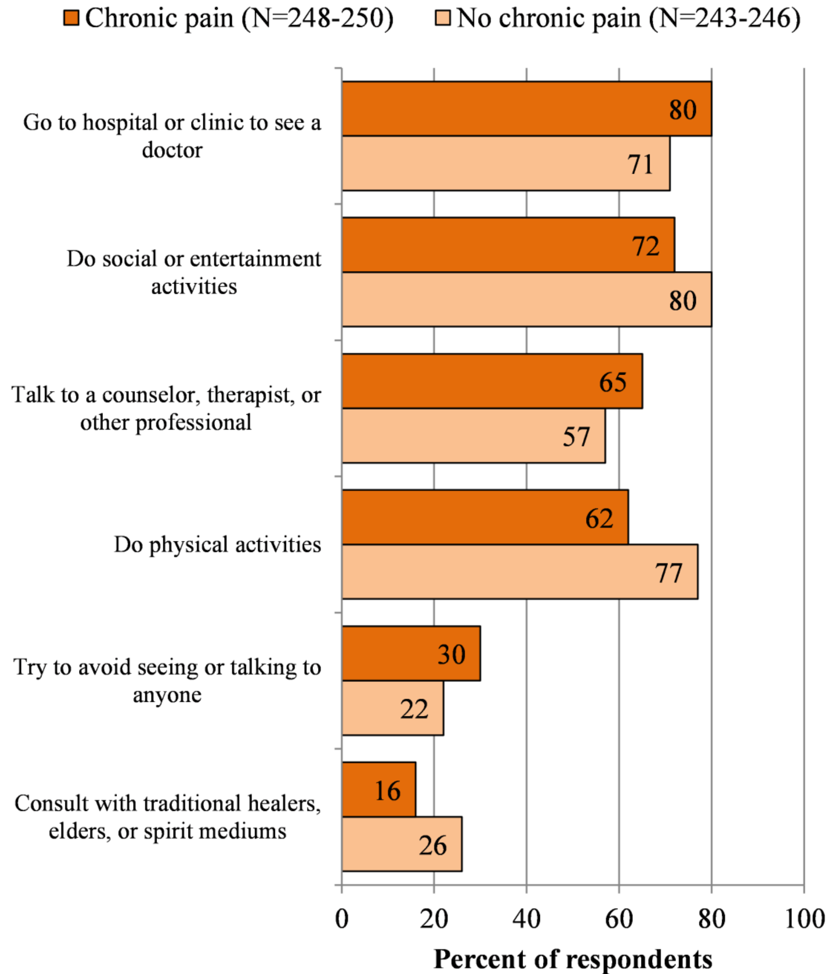
There is variation in who uses these coping strategies. In the survey data, there were some differences by gender. Men were more likely than women to rely on social, entertainment, and physical activities, whereas women were slightly more likely to report spiritual activities. Finally, men were more than three times as likely to report using alcohol to help cope with difficult emotions.



Differences between groups are statistically significant at 0.10-level.

[29] NGO workers in West Nile settlements have raised concerns about trauma contributing to drug and alcohol abuse (Amnesty International 2017).

Respondents struggling with chronic pain were less likely to do social or physical activities or consult with traditional healers. Instead, people with chronic pain were more likely to go to the hospital or clinic, talk to a professional, and avoid seeing others. Respondents with no education were less likely to report connecting with family or friends or talking to a counselor.[30] Younger respondents were more likely to report using social activities, physical activities, and alcohol, and they were less likely to go to a doctor or stay in bed.



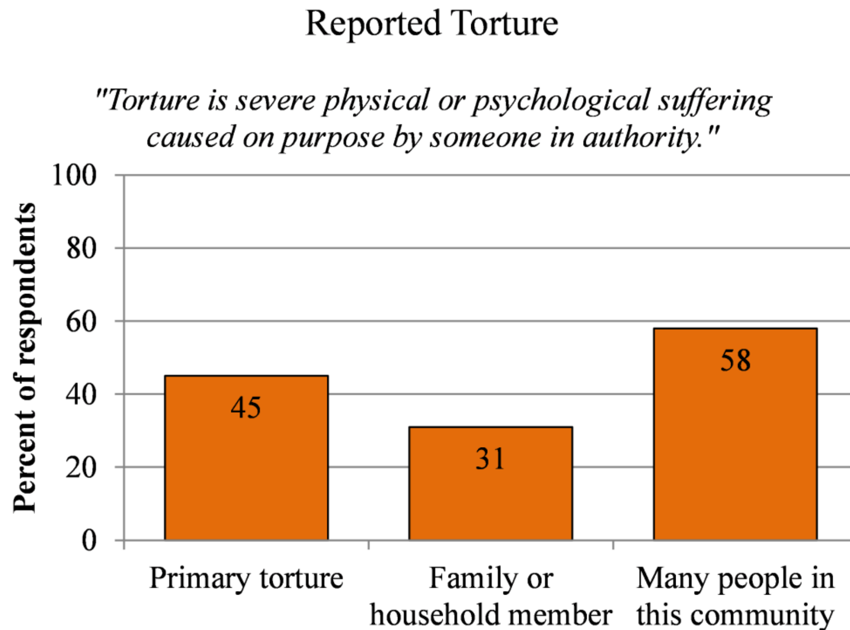
Differences between groups are statistically significant at 0.05-level.

The use of coping strategies was also related to respondents' mental health. Reported difficulty in daily functioning due to mental health problems was related to more unhealthy coping strategies (staying in bed, social avoidance, and using alcohol) and lower rates of coping through physical activities. Higher mean symptom levels were associated with higher rates of social avoidance and consulting traditional healers or elders, and with lower rates of using social and physical activities. Lower overall mental health ratings were associated with higher rates of social avoidance and going to a hospital or clinic for mental health problems. Relationships between mental health symptoms and coping strategies is likely bi-directional, with more severe symptoms leading to lowered ability to cope positively, but also potentially with less positive coping strategies contributing to higher symptom levels.

[30] They were also less likely to report using physical activities and using alcohol, but that variation is likely linked strongly to gender differences.

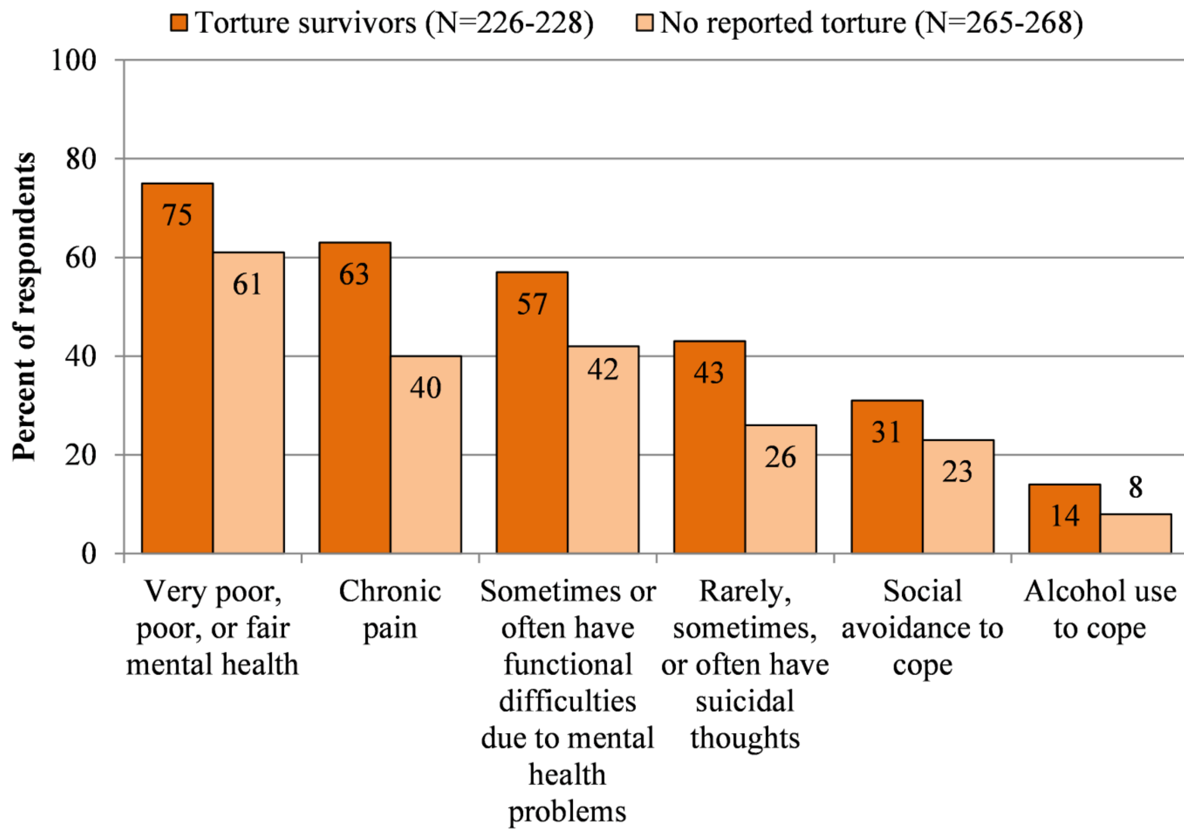
Torture Survivors

After being provided a brief definition of torture,[31] 45 percent of respondents self-reported that they had been tortured. Additionally, 31 percent of respondents said a member of their family or household had been tortured, and 58 percent felt that many people in their community have been tortured. Key informants CVT interviewed similarly perceived a high prevalence of torture survivors, though they estimated rates to be higher than shown in the survey data. Rates of self-reported torture are higher among older men. Half of respondents over age 30 reported torture, compared to 41 percent of those age 30 or younger (p=0.046), and 52 percent of men said they had been tortured, compared to 41 percent of women (p=0.015).



Torture is associated with significant negative mental health effects, as well as other types of vulnerabilities or risk factors. Torture survivors are more likely to feel their mental health is poor and to experience challenges to their daily functioning as a result. They are also significantly more likely to be living with chronic pain, to have suicidal thoughts, to self-isolate, and to use alcohol as a coping mechanism (see figure on the next page). Torture survivors reported higher overall symptom levels,[32] with particularly large differences on some individual symptoms. For example, 31 percent of torture survivors said they sometimes or often experience hypervigilance, compared to 17 percent of those who did not report torture (p=0.000). Over half (51 percent) of torture survivors reported sometimes or often having difficulty concentrating their thoughts, compared to 38 percent of those who did not report torture (p=0.000). These findings indicate that torture survivors are a particularly vulnerable group among refugees, requiring specific attention from mental health service providers and specialized trauma rehabilitation services to decrease symptoms and improve functioning. Because torture is related to particularly negative consequences for mental and physical health, a specialized interdisciplinary rehabilitation program is recommended to address the unique needs of torture survivors.

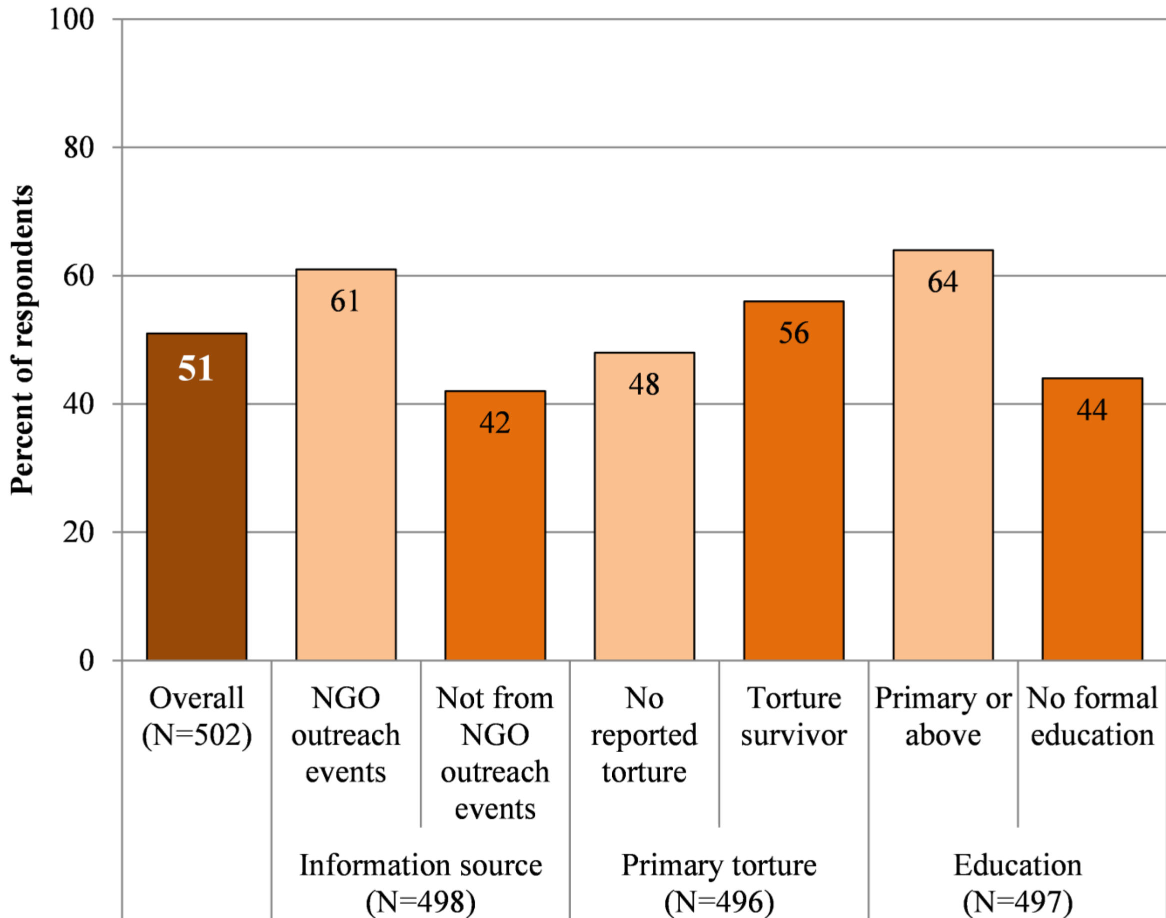
[31] See the *Questionnaire* at the end of the report. The definition provided was: "Torture is severe physical or psychological suffering caused on purpose by someone in authority."
[32] The mean symptom score for torture survivors was 2.3 on the 1 to 4 scale, compared to 2.1 for those who did not report torture (p=0.000).



Differences between groups are statistically significant at 0.05-level.

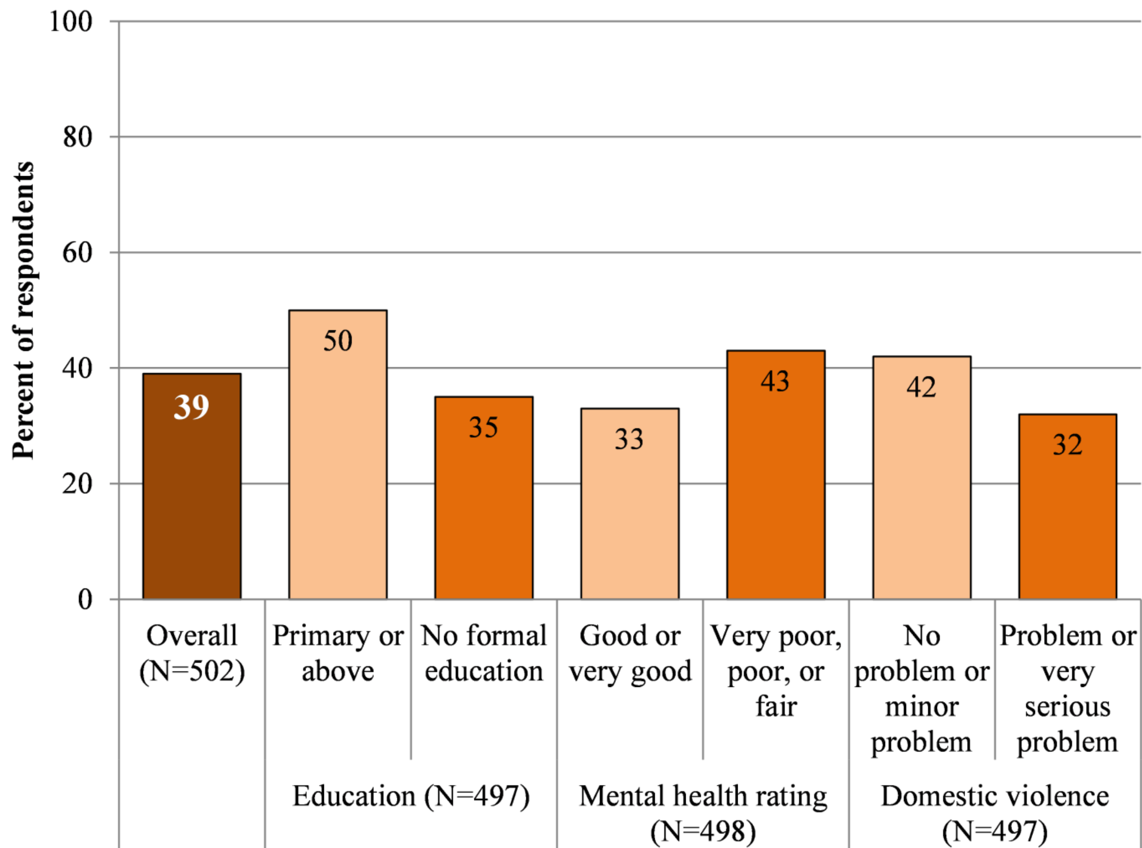
Access to Services

Around half of respondents were aware of mental health or psychosocial services (MHPSS) available in Bidi Bidi settlement. However, there were statistically significant variations in knowledge of MHPSS services. Those who did not go to NGO outreach or awareness raising events were expectedly less likely to know about available services. While this can be regarded as an indicator that outreach events are successfully spreading information about services, it may also suggest that mental health service providers could diversify outreach initiatives. Additionally, those who self-identify as torture survivors and those with more formal education were more likely to know about MHPSS services. There were no significant differences in knowledge of mental health services by age, gender, or time in the settlement.



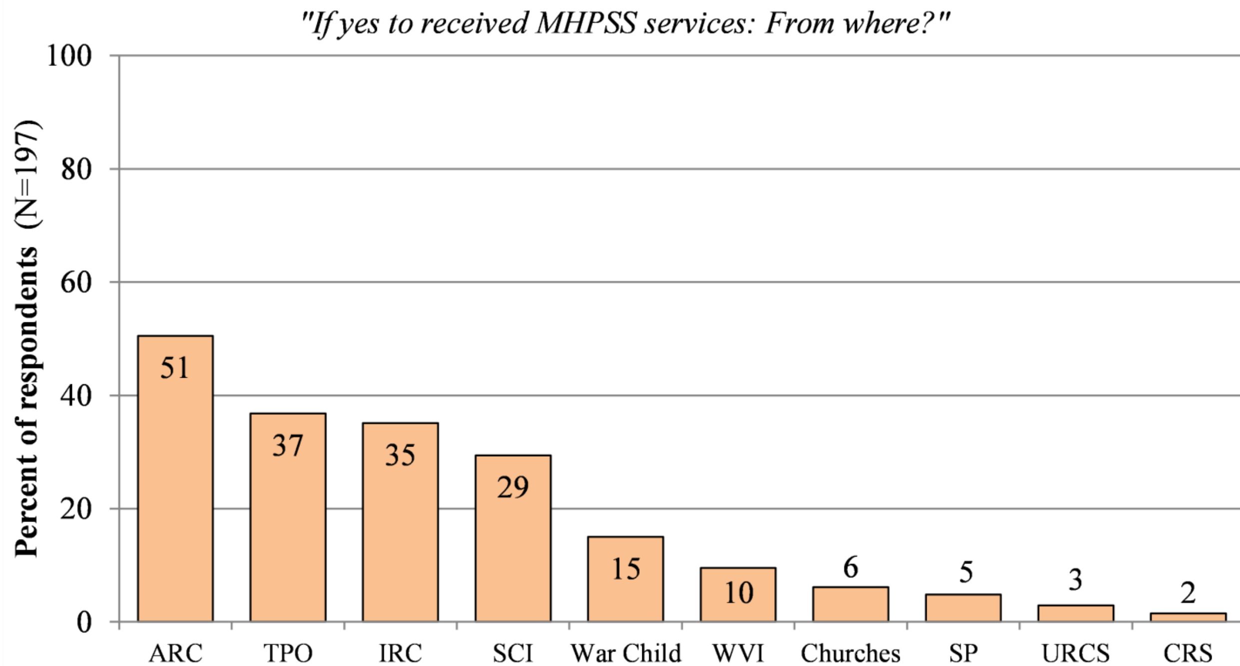
Differences between groups are statistically significant at 0.10-level.

Among those who knew of services, 78 percent said that they had received MHPSS services; hence, 39 percent of all survey respondents reported receiving MHPSS services. Those who rated their mental health as very poor, poor, or fair were more likely to report receiving services. However, respondents with no formal education and those who said domestic violence is a problem in their life were significantly less likely to report receiving MHPSS support. This suggests the need for targeted campaigns to engage these populations.



Differences between groups are statistically significant at 0.10-level.

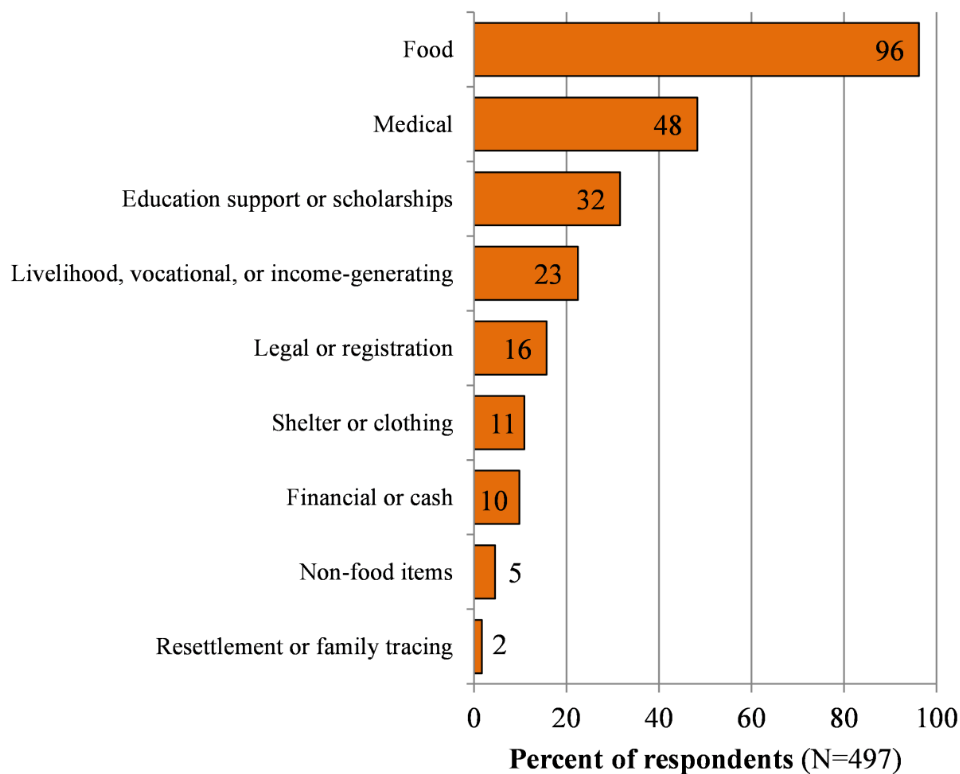
We did not ask which type of service they received, but respondents were asked which organization had provided services. American Refugee Committee (ARC), now Alight, was the most frequently cited, identified by half of those who responded to the question. Transcultural Psychosocial Organization (TPO), International Rescue Committee (IRC), and Save the Children (SCI) were also commonly mentioned.[33] A small number of respondents mentioned receiving MHPSS services from their churches or church leaders.[34]



About 11 percent of respondents were aware of MHPSS but had not personally received any services (55 people). Thirty-nine percent of those respondents reported that they had not needed or wanted such services. Others reported barriers to accessing MHPSS services: thinking the services were for people worse off than them (28 percent); trying but not being selected for services (28 percent); services were too far away (20 percent); deciding not to receive services because of the lack of material support (12 percent); and, finally, being afraid of what people would say if they received services (4 percent). Key informants interviewed by CVT also mentioned barriers related to services not provided in relevant languages and traditional beliefs about mental illness being caused by witchcraft.

[33] ARC has transitioned to the name Alight. At the time of this survey, they were operating in Bidi Bidi as ARC.
[34] Other acronyms in the figure refer to World Vision International (WVI), Samaritan's Purse (SP), Uganda Red Cross Society (URCS), and Catholic Relief Services (CRS).

Beyond MHPSS services, respondents received other types of help from NGOs and other service providers. In the past month, nearly all respondents had received food assistance, almost half received medical assistance, and smaller numbers had received other types of support. Respondents who reported problems in daily life with providing for basic necessities, generating income, and dealing with poor physical health or illness were also less likely to be receiving services in several of these areas.



Most respondents (83 percent) reported getting information about available services in the settlement from UNHCR, Refugee Welfare Councils (RWC), or Local Councils (LC). Half said they received information about services from NGO outreach or awareness raising events; 49 percent from schools, churches, or other institutions; 34 percent from family or friends; and 15 percent from radio or other mass media. Only three percent of respondents said they get information from NGO referrals, suggesting that referral pathways among service providers could be strengthened. Finally, almost all respondents (94 percent) said they could walk to both a health center and to a protection desk.

Conclusions and Recommendations

To assess mental health needs, CVT interviewed 502 individuals selected to be representative of the adult resident population in Zone 5 of Bidi Bidi refugee settlement in March 2019. Similar surveys should be conducted at regular time points and among other refugee populations to monitor shifts over time and place, including other zones of Bidi Bidi or other settlements in the West Nile region.

Data from CVT's survey identify attitudes about mental health, ongoing difficulties from life in the context of displacement, psychological symptom levels, functional challenges, coping strategies, and access to services among the residents of Zone 5. These findings can help service providers, government agencies, community leaders, and other stakeholders (including CVT) design evidence-based MHPSS and other interventions that are responsive to refugee needs in this context. Key findings and potential implications or recommendations are highlighted below.

- **Refugees see their communities struggling with mental health problems and feel that social support can help address these issues (pp. 19-21).** Almost all respondents think that "mental health" is important for everyone and that relying on family, friends, or other community members can help with mental health challenges. A strong majority said that they regularly talk with their family and friends about their challenges when they are dealing with difficult emotions. Even regarding traumatic experiences, most people said that it is good to talk to others. These orientations provide an environment conducive for counseling interventions, particularly those using a group-based approach.

    - **However, there is also misinformation and stigma about mental health (pp. 19-21).** Over half of respondents saw mental health problems as shameful, as a sign of weakness or personal failing, and many others said people with mental health problems are "crazy." Community-based awareness-raising strategies, drawing upon existing knowledge from friends and neighbors, could help address misperceptions. Although very few respondents directly mentioned stigma as a barrier to accessing services (p. 44), providers should offer pathways to access services that are minimally exposing or stigmatizing.

- **Refugees rank mental health-related problems as major issues in their current lives, particularly grief over loss of loved ones and worries about people at home (pp. 22-25).** They also report that not knowing the whereabouts of their loved ones was a problem in their lives. Because of the degree of stress experienced from these problems and their strong association with high psychological symptom levels (pp. 32-34), MHPSS services should be considered essential interventions for refugee populations. Interventions focused on supporting a healthy grieving process and teaching strategies to cope with ambiguous loss would be well-suited to this context.

- **In the settlement, respondents face significant struggles to provide basic needs for themselves and their families (pp. 22-25).** Most refugees were worried about getting essentials like shelter and clothing, as well as not having access to income-generating activities and facing challenges in dealing with physical health problems. Those who report these problems in their lives are less likely to be receiving services in these areas (p. 45), suggesting perhaps a gap in identifying populations most in need of services or indicating resource constraints that do not allow services to reach all people with urgent needs. In general, livelihood stressors are related to lower overall psychological well-being (pp. 32-34), thus addressing these stressors may strengthen the efficacy of psychological interventions, and providing psychological support may be associated with less ongoing stress from livelihood challenges.

- **Exposure to ongoing violence is a current problem for many refugees (pp. 22-25, 27).** These issues put people at immediate risk of physical and psychological harm and necessitate a coordinated protection response. Service providers should be trained in how to identify individuals facing violence in their daily lives and how to provide sensitive and effective support and protection. There should also be a concerted effort to identify the underlying individual, family, and community-level factors contributing to this ongoing violence, including how unaddressed trauma may be leading to ongoing violence. Addressing these issues requires coordinated efforts from multiple sectors.

    - **About one third of respondents said community violence or conflict is problem in their lives (pp. 22-25).** Although the security context of this settlement is relatively calm, this evidence suggests this is still a concern for many residents.

    - **About a quarter of respondents said domestic violence is a problem in their lives (pp. 22-25).** This rate is particularly driven by young women, who reported domestic violence much more frequently than other demographic groups (p. 27). Domestic violence was significantly linked to many other risk factors in our data. Refugees who reported domestic violence were much more likely to have suicidal thoughts (p. 31) and report other elevated psychological symptoms (p. 32-33). At the same time, these individuals were less likely to have received MHPSS services (p. 43), highlighting a gap in the integration of mental health support into protection responses.

- **Refugees report moderate mental health symptom levels, and about half felt mental health problems were impairing their ability to function in daily life (pp. 28-31).** The ten symptoms included in the survey are indicators of depression and post-traumatic stress (pp. 12-13), two of the most common psychological responses to trauma exposure. Respondents reported, on average, experiencing these symptoms with a frequency of approximately 2.2 on a scale of 1 to 4. Respondents' self-assessments of functional difficulties and overall rating of mental health were significantly correlated with individual symptoms (p. 31). We estimate with 95 percent confidence that between 31 to 39 percent of the adult population in Zone 5 of Bidi Bidi settlement have symptoms

which could indicate a need for specialized mental health care, likely at least 4,000 adults in that zone (p. 35).

  - **The most commonly reported symptoms are difficulty falling or staying asleep; difficulty doing domestic work or income-generating activities; and difficulty concentrating or focusing on thoughts (pp. 28-31).** These and other symptoms were reported more frequently by women, older people, and those without formal education (p. 32). MHPSS interventions should focus on integrating these typically more disadvantaged or vulnerable groups.

  - **Twelve percent of respondents report having suicidal thoughts sometimes or often in the past two weeks (p. 31).** These individuals should be considered high risk. Service providers in all sectors should be trained to identify warning signs of suicidality and referral pathways to provide appropriate follow up support should be strengthened, including developing short-and medium-term safety planning in the response. An inter-agency collaboration is recommended to develop a suicide prevention strategy, as well as a protocol for responding appropriately after a suicide attempt.

  - **Eight percent of respondents said a minor in their household had significant mental health problems (p. 36).** Although the survey included only adults, this provides an indication of the rate of children in the camp who may be struggling with serious mental health issues.

- **Most people report using healthy coping strategies to deal with difficult emotions (p. 37).** A majority of respondents said they pray or do other spiritual activities, rely on their family or friends, or do social or entertainment activities. MHPSS providers can draw upon these existing coping strategies as opportunities to provide support in ways that are already comfortable to people in this context.

  - **Seventy-five percent of respondents said they visit a hospital or a clinic when they are facing mental health concerns (p. 37).** Staff at medical facilities should receive training on protocols to screen and identify people struggling with mental health issues, and they should be equipped with appropriate referral networks to mental health service providers. Models for co-locating or integrating mental health services into medical facilities may also be effective.

  - **Some people rely on unhealthy coping strategies, particularly social avoidance or self-isolation (pp. 37-38).** Men were more likely to turn to social and physical activities, but also reported higher rates of using alcohol as a coping mechanism. MHPSS providers should teach healthy coping methods, particularly to those who are less likely to be currently using them.

- **Over half of respondents report living with chronic pain (pp. 35-36).** Rates of chronic pain almost doubled for those who reported lower-quality mental health (those who said their mental health was very poor, poor, or fair), confirming a strong connection between physical and psychological well-being. Poor mental health can be expressed through physical pain, and in addition, chronic physical pain can have negative impacts on mental health. An integrated multi-disciplinary approach to service provision could address this.

    - **People with chronic pain have different strategies to cope with mental health problems (p. 39).** They are more likely to see a doctor or other medical professional at a clinic, and also more likely to turn to a counselor or therapist. At the same time, they less frequently pursue social or physical activities, and are more likely to self-isolate.

- **Eight percent of respondents report seizures (p. 36).** These individuals are more likely to experience some psychological symptoms, including suicidal thoughts.

- **Social support, or lack thereof, is a significant consideration to understand mental health needs and resources.** As described above, respondents see social relationships as key to providing mental health support (pp. 19-21, 37). However, over half of respondents said that a lack of social support is a significant problem in their lives (pp. 24-25) and about half are currently separated from their family members (p. 18). Family separation was a significant risk factor in many areas. Those who were separated from their families were significantly more likely to report suicidal thoughts (p. 31) and chronic pain (p. 35), in addition to reporting higher overall symptom levels (pp. 31-32) and more stress from mental health-related problems (p. 26). About a third of respondents said they rely on family and friends to get information about services (p. 45). A psychosocial response, informed by knowledge of complicated bereavement and ambiguous loss, could aid in developing social support structures for these people.

- **Nearly half of respondents report that they have been tortured, with rates higher among older men (p. 40).** Torture survivors are a particularly vulnerable group and have unique needs (pp. 40-41). Additional research could aid in understanding how to effectively identify and provide care to torture survivors in this specific context. Outreach and education initiatives could focus on sub-populations likely to have higher rates of torture survivors. Service providers could provide training for their staff on specialized skills needed to provide torture rehabilitation services.

    - **Torture survivors have more severe mental health problems and significant risk factors compared to other refugees (pp. 40-41).** Torture survivors reported more frequent symptoms, particularly related to hypervigilance and concentration problems, and lower overall ratings of their psychological well-being. They are much more likely to have chronic pain, daily functional difficulties, suicidal thoughts, tendencies to self-isolate, and reported alcohol use.

- **About half of respondents know about MHPSS services available in the settlement and over a third have received MHPSS services (pp. 42-43).** Most of those who knew about services had also received services, mostly from ARC/Alight, TPO, IRC, or SCI (p. 44). Those who attended outreach or awareness raising events by NGOs were more likely to know about MHPSS services. In addition to actively pursuing awareness raising campaigns, mental health service providers should diversify their outreach initiatives by utilizing other sources of information. Outreach should particularly focus on more vulnerable groups, including those who have been tortured and those with no formal education, since these groups are less likely to already be aware of services that exist (p. 42).

    - **In addition to services provided by NGOs, some respondents mentioned receiving MHPSS services from community churches or church leaders (p. 44).** It is likely that this support may be contributing to the high rates of respondents who said they talk to a counselor to help cope with difficult emotions (p. 37).

    - **Respondents also were receiving other types of services or assistance (p. 45).** Almost all received food aid, and about half reported currently receiving medical assistance and about a third said they were receiving educational support. They primarily get information about services from UNHCR or local councils, and nearly all respondents were able to walk to essential health and protection resources.

- **The settlement represents a mid-point in a humanitarian response (pp. 17-18).** Most respondents had been in their current community for two to three years. Although a large proportion of respondents are separated from some family members, most are living in large households, with an average of eight people. The population continues to be heavily skewed towards women. Most residents identify as Christian. The multilingual population suggests services should be offered in Juba Arabic and Kakwa.

- **There are low levels of formal education, which is associated with increased vulnerability (pp. 17-18).** The two-thirds of respondents without formal education reported more difficulties functioning because of mental health problems (p. 32) and higher rates of chronic pain (p. 35-36). At the same time, those without formal education were much less likely to be aware of or to have received any MHPSS services available to them (pp. 42-43). Because of these vulnerabilities, MHPSS service providers should place particular effort on reaching less educated members of this population, and adapt interventions to their needs where necessary.

- **Conducting representative surveys to assess mental health and other related needs of refugee communities in settlements is feasible (pp. 6-10).** The humanitarian context presents substantial challenges in designing and implementing a rigorous methodology, but the resultant data can be used in many ways. Non-representative assessment designs, particularly those that rely on information from service providers, community leaders, or

other stakeholders, provide essential insights to help understand needs and design effective services. However, representative survey data can produce prevalence rates, identify vulnerable groups, and contribute to a broader strategic picture of overall need among the full population (pp. 3-4).

- **Mental health support is essential to integrate into the implementation of a door-to-door household survey, particularly one addressing sensitive topics (pp. 14-16).** The populations are considered highly vulnerable participants and the subject areas have the potential to be distressing to respondents, thus design and implementation must integrate appropriate psychological support for all participants. The survey design must include team members with mental health expertise, work within referral networks, develop high-risk protocols, and have emergency support available.

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Questionnaire

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

Date:
Perok: ____________________

Interview #:
Kenet na pipiyesi: ____________________

Interviewer ID #:
Kweyet na kenet na pipiyanit: ____________________

Supervisor ID #:
Kweyet na kenet
na kamemetanit: ____________________

Location of interview:
Pirit na pipiyesi:

Village:
Kotunit:_______________

Cluster:
Koji duma na kotumiton: _______________

Gender of respondent: / Gwiyari lo ŋutu nanakwan kode lulalet lo rugo:

○ Man/ Lulalet ○ Woman/ Nunakwan

Languages of interview: / Kutu na pipiyanikin:
- ☐ Bari (specify: / Tokerju: ________________________________)
- ☐ Juba Arabic
- ☐ English
- ☐ Other: / Kulye: _______________________________

Post-Survey Support Protocol / Ŋo na kokana ibot na kune pipiyesi

- ☐ **Emergency response:** Respondent is in extreme distress and requires immediate intervention
  Notify supervisor / clinical support to get CVT staff to come to household immediately
  Ruket na Loket: Karukoni logwon ko yongesi na lwongu deke lokete 'de'de (Wulek)
  Kweke kamemetani, ŋutu lo ŋarakindya, kadi na wini i pujo na kakitanik lo CVT i po i ŋina mede adi wulek/'de'de
- ☐ **Referral:** / **Sondu ŋerot:**
  - ☐ Respondent was given information about available services
    Ŋutu lo atiki longe i kulya ti kitajin nagwon kata
  - ☐ Respondent needs to be connected with referral partner
    Ŋutu lo mindyo/tomora ko ŋutu lo sondu ŋerot
  - ☐ Respondent needs to be referred for CVT services
    Ŋutu lo yengesi lo mindyo sonyoji i ŋariyesi ti CVT
- ☐ **PFA:** Respondent experienced some distress and required in-person PFA delivered during survey per CVT training of enumerator
  PFA: Karukonit gwon ko miyen duma 'deke ŋutu lo PFA i jowe i dendya idiŋit na todinesi ti kawurok ti CVT
- ☐ **Nothing required:** Respondent did not require follow up for psychological distress
  Ako'dekan neneŋo: Karukonit lo ako 'dekan kepo na kulya ti tomiyesi ti yeyesi kanyit

<u>NOTES</u>: / <u>WURÖT</u>:

____

____

Was the respondent alone during this interview? / Karukonit lo gwon geleng i diŋit na pipiyesi?

○ Yes / Yee ○ No / 'Bayin

Interviewer signature: / Nya'dotet lo kapipi'yanit: ____

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Welcome Script & Consent / Wuye ko Tinanpipinedo

Good morning/afternoon. I am working with an international organization called the Center for Victims of Torture (CVT). We provide services to people who have experienced war or have been forced to leave their homes. We are starting a program to provide mental health services in Bidi Bidi. We are doing an assessment to learn about mental health needs in this area. We want to understand the needs and opinions of people who live here.

Do pure/do a parana. Nan kita ko muguu na temorja juron na luŋu a kiden na ŋutu ti yongesi lo toŋonga (CVT). Yi tindu ŋariyesi i ŋutulu logwon arike kugar kade ari'diki i yonga kase i midijin, yi suluja petesi ti tindu na tokelan na yeyesi i camp ni. Yi kulo ga'yu deya na dekesi ti kelan na yeyesi i na pirit. Yi dek kurundyo na 'dekesi ko yenet na ŋutu lo si'da ni kulo.

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

Yi a yakija kikolin ti kendya abur i wuludyo na midijik kasu i pirit ni, nyena gwondi nan ni. Nan kodo 'dek pija ŋutu geleng kanuk mede ni ko piyesi kudik i ŋo nagwon a kondya borik ko lepeŋ. Diŋit gwon a minitan 20-30. Kine rukese ling tiki i liliya i pirit na geleng ko kune. Yi ti 'dumadyu kode wurujo karen ti lele ŋutu akwong.

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

Nan dek dumudya a bur ŋutu konuk mede ni logwon kata i lo lor. Boŋo ŋaraki nan i pidya na ŋutu logo (18+) [lyan/kowate] lo sida ni.

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.

Tokitaji kenet (numba) i wulundyo abur ŋutu lo na mede i moraki. Wulundye i kiden na ŋutu lyan ko wate. ko do a pipija ŋutu nunakwan i mede na dutet, ti do pipije ŋutu lulalet i nene mede na. i mukok nagwon ŋutu anyume nu, nyoki medya kulya na gwon kiyu kune nagwon yoyoyonikin (bura).

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

Kita nonut na gwon konu i mindyo, ko a ŋariyet kanan. Do bubulo wulundyo bain i rugo na pipiyesi ko do a komindyo. Do bubulo tengu na kine pipiyesi i diŋit nagwon kata. Kine 'bayin a temesi ko bayin a rukesi nabut kode narok. Nan gwon ko pusok i dendya na ŋo nagwon tomijo do kode yoyeju nye. Pipiyesi nagwon do de nyonyop kine nan gwon a koliyoŋi ko'de a tokoroju koko liŋ.

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

Yenet na kune pipiyesi anyen logu i tindu na ŋariyesi nabut i ŋutu liŋ logwon ni, ama kune rukesi konuk tine lwogu do kode mede inot i lele kiko.

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.

Kune pipiyesi kune bubulo toyiyikindyo na do kune ŋo nagwon jakindya do deliya, ko piyet kata na tikindya do i deliya tukoki nan. I mukok yi bubulo 'dumadu diŋit nadit i medya ko do gwon ada.

Are you willing to participate? / Do nyanyar/ko pusok i kita?

- O Yes / Yee
- O No / 'Bayin

Thank you so much for agreeing! Your perspectives will be very helpful to us. I look forward to our conversation!
Tinate lolut parik lo rugo! Yenesi konuk ŋaŋarakin yi parik nan medya ŋerot i loki na james i kaŋ.

Time started: / Diŋit suluet: ________________________________ AM / PM

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

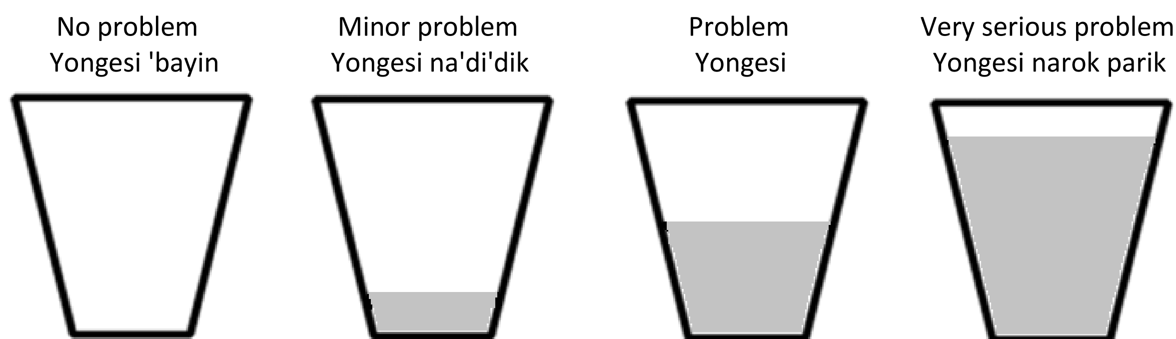
Akokwe, nan kekendya kulya ti **kelen na yeyesi/kwinyit** nagwon do bubulo rugo se kode renya se. Bongo tukokinan ko do gawk/asut a ko rugo, a ko rugo, a rugo, kode gwak a rugo parik.

Use thumbs up and down to illustrate the options.

	Do you agree or disagree? Do a rugo kode ako rugo?	**Strongly Disagree** *(2 thumbs down)* **Gwak/Assut A Ko Rugo** *(2 morine kak)*	**Disagree** *(1 thumb down)* **A Ko Rugo** *(1 merinyet kak)*	**Agree** *(1 thumb up)* **A Rugo** *(1 merenyet ki)*	**Strongly Agree** *(2 thumbs up)* **Gwak A Rugo Parik** *(2 merine ki)*
1.1	I understand what the words “mental health” mean. Nan a kurun ko "kelan na yeyesi" nyonyogu nyo.				
1.2	“Mental health” can be positive. It means psychological well-being; it is important for everyone. "Kelan na yeyesi" gwoloŋ a na’but. Lepeŋ nyoyogu adi gwiliŋet lo ŋutu lo’but lukata; lepeng a nabut i ŋutu liŋ.				
1.3	“Mental health” is negative. It really only means psychological illnesses or problems. "Kelan na yeyesi" gwoloŋ a naron. Lepeŋ 'diri nyonyogu adi gilo lo yeyesi kwinyit kode yoŋesi.				
1.4	To deal with trauma, it helps to think or talk about what happened. Tengu na kulya ti (sida gwon ko yeyesi narok) ŋarakindya i yeyeju kode i jambu i ŋo na kondya borik.				
1.5	Mental health problems are shameful or a sign of weakness or failure. Yoŋesi ti kelan na yeyesi gwon a yuna kwe / a kweyet na tomunyan kode tika.				
1.6	It is good to talk to my family or friends about my mental health. A nabut i jambu ko mede nio kode ko julin kwe i kulya kwe ti kelan na yeyesi ti kwinyit.				
1.7	I know and use healthy strategies to cope with negative thoughts or feelings about what has happened to me. Nan a den ko atokita kikolin ti kelan na yeyesi anyen ŋarikidya nan gwon bak delyesi kode yenet narok i ŋo na kondya borik koyoloki.				
1.8	People with mental health problems are all crazy. Ŋutu logwon ko yongesi ti yeyesi koko liŋ a mamalijin.				
1.9	I feel I can depend on my community to help me cope with on-going challenges, stress, or worries. Nan yendu adi nan bubulo toko ko ŋutu kwe logwon a diŋori i ŋarakindya nan,i te’ya na yoŋesi nagwon kata, kode delyesi.				
1.10	Mental health problems are a result of witchcraft, black magic, or curses. Yongesi ti kelan na yeyesi/kwinyit na po kogwon rubo, kadopak, a ko lomosi.				
1.11	A lot of people in this community are struggling with mental health issues. Ŋutu jore ti na pirit moro kulya ti kelan na yeyesi ti kwinyit.				

Next, I want to ask you about things that might cause **stress in your life** right now.
Nene na nan 'dek pija do ko ŋo logwon jowudya **deliya konuk i gwiliŋet** soŋinana.

You can use this picture of cups to help you. The more full cups mean that something is a big problem that causes you a lot of stress. Please tell me how difficult each of these things is in your life right now, ranging from no problem to a very serious problem.
Do bubulo tokitaju kune ŋojino ti kopolin i ŋarakindya na do. Kopolin logwon jore, kulo nyonyogo adi ŋo na gwon jakindya do deliya duma. Bongo tukoki nan yoŋit tupomoni na kineŋo geleŋ geleŋ konuk i gwiliŋet soŋinana. Suluja i diŋit nagwon yoŋesi ‘bayin tojo, i diŋit na yoŋesi narok parik.



	How difficult is this in your life right now? Togolon na gwoda konu i gwiliget ni soŋinana?	No problem Yongesi 'bayin	Minor problem Yongesi na'di'dik	Problem Yongesi	Very serious problem Yongesi narok parik
2.1	Getting food, shelter, or clothing Pujo na 'diloŋ/kode kadi, kode bongwat				
2.2	Getting education or a job (generating income) Pujo na todino kode kita (kikolin ryosi ti gurut)				
2.3	Illness, health problems, or disability Gilo, kelan yoŋesi ti kode toŋodyan (bata)				
2.4	Not having friends, family, or neighbors who can support you Gwon bak julin, mede, kode 'diŋori lo togu do				
2.5	Adjusting to or dealing with life in the camp (including missing home and lifestyle) Togwidikindya kode diniki i gwiliget lo to'd'upet (morakidya likin na mede e ko sida in pirit na geleŋ) a 'baŋ				
2.6	Worries about people back at home Yeyeju na ŋutu ti bot mede.				
2.7	Trying to leave the camp (for resettlement, moving home, etc.) Morju ko'yu na to'dupion (i tut i nene pirit, mede, ko kune)				
2.8	Domestic violence, threats, or conflicts in your household Sasanyesi ti mede, tokujonyesi, kode moro konuk mede ni				
2.9	Violence, threats, or conflicts in the community Sasanyesi, tokujonyesi kode moro konuk i pirit si'dayet				
2.10	Not knowing where my family or friends are right now Gwon nagwon, nan ako den ko mede nio kode julin kwe gwon ya soŋinana				
2.11	Grief from the loss of loved ones Delya na likin na lo nyanyara koluk				
2.12	Hopelessness or uncertainty about the future Gwon a bur kode bak yenet na ŋerot				

You told me that some of the things I just mentioned are problems for you.
Review which items they said were the most serious problems.

Do a tukokindyo nan adi, kune ŋo nagwon nan atuk kune a yoŋesi konuk.
Nyoke medya ŋo nagwon koko adi a yoŋit narok parik (duma).

2.13 Which **ONE** of these causes you the **most stress** right now?
Nan ŋo **GELENG** i kine tindu do **delya parik** sogingana?
Write one item from the list above. / Wure ŋo geleŋ i ŋo na peta ki yu kunu.

Number:
Namba/kenet: ___________
Description:
Tokoresi: ____

2.14 Is there something else that I **haven't mentioned** that causes you the **most stress** right now?
Ŋo kata nagwon nan **ako tuk kode ako jamun** nagwon tikindya do i **delya parik** songinana?

○ Yes / Yee (Specify: / Tokore: ____)
○ No / 'Bayin

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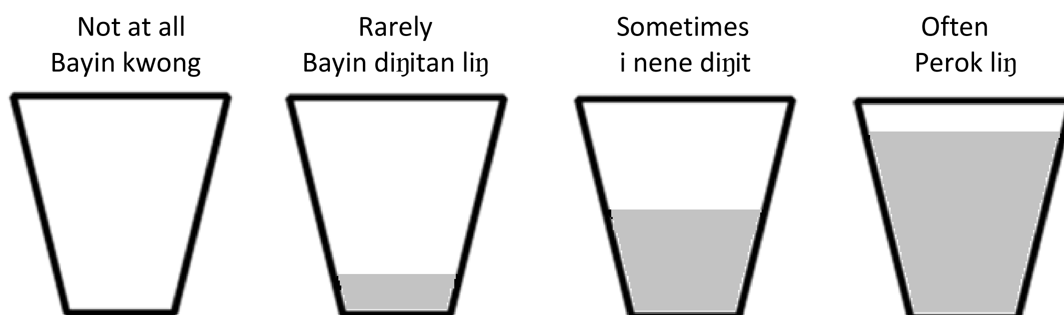
I would like to ask you how often you experience certain mental health **problems or symptoms**.

Nan kodyo dek pija do diŋit gwada nagwon do gwon ko kune **yongesi** ti kelan na yeyesi ti kwinyit.

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

Do bubulo tokitaju na kulo kopolin koti, i lwogu na do. Kopolin logwon jore kolu kweja adi do a gwon ko yonŋesi jore diŋitan ling. Bongo yeyene ko do a gwon ko yeyesi ti yoŋesi muda na toŋonga do **i ŋimalin murek** lo lwongu kulo: bayin kwong, bayin diŋitan liŋ, i nene diŋit, perok liŋ?



How much have these symptoms bothered you in the past two weeks? Do a tongonga/ kodiŋit ŋoro d'a i jimalin murek lo longu kulo?		Not at All Bayin kwong	Rarely Bayin diŋitan liŋ	Sometimes i nene diŋit	Often Perok liŋ
3.1	Difficulty falling asleep or staying asleep? Togolon i doto kode gwon a doto (loto)?				
3.2	Crying easily? Gwiyen wulek?				
3.3	Feeling less interest in things that you used to enjoy? Gwon bak kure i ŋo na do teŋ (tendu) nyanyara kondya?				
3.4	Having difficulty concentrating or focusing on your thoughts? Gwon ko togolon i tindya na tirikuwet i ŋo na do kokon/kode yeye?				
3.5	Difficulty doing domestic work or income-generating activities? Togolon i kondya na kitajin ti mede kode kita na jakindya do gurut?				
3.6	Feelings of worthlessness? Yinga na 'borik a li do'ba temakindya?				
3.7	Thoughts it would be better to not be alive? Yendu adi a nabut i gwon 'bain jorun? ***IF SOMETIMES OR OFTEN:*** *follow protocol to discuss further.* ***Ama i digitan kode perok ling:*** *Kebi temejik i jamadu ngerot.*				
3.8	Feeling low in energy, slowed down? Yinga na rigit nadit, rorokundya kak?				
3.9	Having your body react to things that remind you of a traumatic event (like upset stomach or dizziness)? Mugun nonu na a kwekindya do ŋo na gwon, toyiyikindyo do sida na gwon ko yeyesi narok (gwoso miyen na monyet kode tonunyan na mugun)?				
3.10	Watching everything around you or feeling “extra alert” or “on guard” much of the time? Medya na ŋo liŋ logwon konu i nyona kode gwon ko medya kode sida ko "tiju" i diŋitan ling?				
3.11	Do you feel mental health problems (like stress, depression, or anxiety) cause trouble with your daily functioning? Do yinga ŋongesi ti kelan na yeyesi (gwoso, yeyesi ri'diyesi, lyoŋon) na jowunda togolesi i kitajin konut ti perok ling?				

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3.12 How would you rate your mental health **overall**: very poor, poor, fair, good, or very good?
Do kodo temba kelan na yeyesi konuk **ling ada**: naron parik, naron, madang, a na'but, kode a na'but parik?

○ Very poor / Naron parik ○ Poor / Naron ○ Fair / Madang ○ Good / a na'but ○ Very good / A na'but parik

3.13a Do you experience on-going or chronic pain in your body?
Do yinga tomiyo kode gilo perok ling konuk mugun ni?

○ Yes / Yee ○ No / 'Bayin

3.13b ***IF YES:*** 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?
KODO ARUGO: i temet 0 i 10, 0 = nyonyogu adi miyen 'bain kwong, 10 = nyonyogu adi miyen noron parik miyen gwada nagwon do a pu i jima lo lwongu kulo?

____

3.14 Have you ever had uncontrolled convulsions in your body that you can't remember (seizures)?
Do a gwon ko lilinyija nagwon do ti bulo dendya magun?

○ Yes / Yee ○ No / 'Bayin

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

I lor logwon do a gwon ko delya, lyoŋon kode tumoni do a kondya nyo i ŋarakindya na mugun i kine ŋo? Nan lo tut i kenakindyo na do na ŋo nagwon do bubulo kondya, anyen do bubulo tukokindyo nan ko do a kon se kode ako kon se.

On a day where you felt very sad, anxious, or overwhelmed, what did you do to help yourself deal with those emotions?		Yes Yee	No 'Bain
4.1	Connecting with your family or friends to discuss your feelings Morakindya ko mede inot kode ko julin kulok i ŋaraju na gwiliŋet ilot.		
4.2	Do social or entertainment activities Kondi ŋo i moret na ŋutu kode kitayesi ti lyoŋon		
4.3	Sleep or stay in bed Doto kode sida i gwolong		
4.4	Do physical activities Kondi kitayesi ti mugun		
4.5	Go to the hospital or clinic to see a doctor Iti i kadi na wini i meda na bodo lo winiko		
4.6	Pray, meditate, or do other spiritual activities Kwakwadi, mamandi mamandu kode kondi kune kitayesi ti mulokotiyo		
4.7	Use alcohol or another substance to help you forget Tokitaju na yawa kode kulye ŋo anyen ŋarakindya do i boŋo		
4.8	Try to avoid seeing or talking to anyone Morji tengu na medya kode jambu ko lele ŋutu		
4.9	Talk to a counselor, therapist, or other professional Jambi ko ŋutu kasukani, karudanit, kode kule logwon ko ina koŋon		
4.10	Consult with traditional healers, elders, or spirit mediums Pine ŋutu lo tokeya ko winiko ti ki kak, temejik kode 'bunuk		
4.11	Other: *(Prompt: Is there anything else you do?)* Kune: *(Ŋo kata nagwon do kokon?)* ____		

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

Do yendu adi ŋutu kata konuk mede ni logwon ko yongesi ti kelan na yeyesi nagwon jondya kulya narok i sidayet lose i diŋitan ling kanyit i kitayesi?

○ Yes / Yee → **5.1b** If yes: How many people? Koda arugo: Ŋutu muda? __________

○ No / 'Bayin

Please tell me the age & gender of person 1:
Bongo tukoki nan kiŋajin ko kweyet na gwiyari na ŋutu to geleng:

Age: / Kiŋajin: __________ ○ Male / Lulalet ○ Female / Nunakwan

Please tell me the age & gender of person 2:
Bongo tukoki nan kiŋajin ko kweyet na gwiyari na ŋutu to murek:

Age: / Kiŋajin: __________ ○ Male / Lulalet ○ Female / Nunakwan

Please tell me the age & gender of person 3:
Bongo tukoki nan kiŋajin ko kweyet na gwiyari na ŋutu to musala:

Age: / Kiŋajin: __________ ○ Male / Lulalet ○ Female / Nunakwan

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As I told you, I'm from an organization that focuses on helping people who have been tortured. **Torture** is severe physical or psychological suffering caused on purpose by someone in authority. I have three questions about torture. Is it okay for me to ask these questions?

Gwoso nagwon nan a tukokin do adi nan gwon i mugun na medya i ŋarakindya na ŋutu logwon a **toŋoŋa**. Toŋoŋa na mugun nagwon a duma kode lo delya na yeyesi na jowe aka ko lele ŋutu logwon ko saret. Nan gwon ko piyesi musala i loki na toŋoŋa. A nabut koyo i pija na kine piyesi?

6.1 Have you ever been tortured?
Do a toŋoŋa?

- ○ Yes / Yee
- ○ No / 'Bayin

6.2 Has anyone in your family or household been tortured (not including yourself)?
Ŋutu kata logwon a toŋoŋa kasu mede ni (ku ken mugun)?

- ○ Yes / Yee
- ○ Not to my knowledge

6.3 Do you think that many people in this community have been tortured?
Do yinikindyo adi ŋutu jore kasu kotumit ni a toŋoŋa?

- ○ Yes / Yee
- ○ No / 'Bayin

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The next section is about **<u>services</u>** that are available to people in this community right now.
Nene ŋo na gwe a kulya ti **<u>kitayesi</u>** nagwon kata i ŋutulu logwon kata i na kotumit/kasu pirit ni soŋinana.

7.1a Do you know of any group, organization, or agency where you can go to receive **mental health or psychosocial support services** in the camp?
Do aden nene mugun kude gurube, mugun kode **kaŋara kule logwon do pupujo ŋariyet na kelan na yeyesi ti kwinyit i kulya ti kitayesi** i camp ni?

- ○ Yes / Yee
- ○ No / 'Bayin

→ **7.1b** <u>If yes</u>: Have you ever received **mental health or psychosocial support services** here?
<u>Koda arugo</u>: Do a wuju **kaŋara kule logwon do pupujo ŋariyet na kelan na yeyesi ti kwinyit i kulya ti kitayesi**?

- ○ Yes / Yee
- ○ No / 'Bayin

→ **7.1c** <u>If yes</u>: From which organization?
<u>Koda arugo</u>: I nana mugun?
Don't read options. Select all that apply.
Ando keken nyumudyo. Wulundi liŋ nagwon tetemakindya.

- ☐ American Refugee Committee (ARC)
- ☐ International Rescue Committee (IRC)
- ☐ Medicine du Monde
- ☐ Medecins Sans Frontieres (MSF)
- ☐ Real Medicine Foundation (RMF)
- ☐ Samaritan's Purse
- ☐ Save the Children International (SCI)
- ☐ Transcultural Psychosocial Organization (TPO)
- ☐ Uganda Red Cross
- ☐ War Child
- ☐ World Vision International (WVI)
- ☐ Other: / Kulye: ___________________________

7.1d <u>If no</u>: Why not? *Don't read options. Select all that apply.*
<u>Ko bayin</u>: Konyo bain? *Ando keken nyumudyo. Wulundi liŋ nagwon tetemakindya.*

- ☐ I've never needed or wanted these services
  Nan ako mindi kode ko nyanyar kine kitajin (yariyesi)
- ☐ They are too far away
  Lepeŋat pajo parik
- ☐ I'm afraid of what my neighbors or relatives would think or say
  Nan a kujona ŋo nagwon diŋori kode woti kwe yeyen kode jajam
- ☐ I tried to get services, but they didn't select me
  Nan a moroju i rumbi na ŋariyesi, ama lepeŋat ako wulun nan
- ☐ I decided not to get mental health services because they were not giving me anything (material support)
  Ku in a kwe nan a tiga kine ŋareyise ti kilan na kwinyet kogwon na ako tiki nene ŋo
- ☐ Those services are for people who are more ill or worse off than me
  Kine ŋariyesi a ti ŋutu logwon a gilo parik lwongu nan
- ☐ Other: / Kulye: ____

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7.2 What other kind of help have you received from NGOs or other service providers **in the past month?**
Kunen ŋariyesi nagwon do a pu i kine mugunya kode kulye lo tindya ŋariyesi in **yapa lo lwongu**?
Don't read options. Select all that apply. / Ando keken nyumudyo. Wulundi liŋ nagwon tetemakindya.

- ☐ Financial/cash / Gurut
- ☐ Food / Kinyo
- ☐ Shelter or clothing / Kadi kode bongwat
- ☐ Resettlement/family tracing / Yuworo/ga'yu na mede
- ☐ Education support/scholarships / Ŋariyesi ti kindya/ropaji i kendya
- ☐ Legal/registration / Wuro kode miri
- ☐ Livelihood/vocational/income-generating / Kitayesi na ŋarakidya gwiliŋet ilot, todino na kitayesi ti konin kode kikolin lo jondya gurut
- ☐ Medical / Winiko
- ☐ Other: / Kune: ____________________

7.3 How do you get information about available services here? / Do pujo lonŋe lo kitayesi nagwon kata ni kune ada?
Don't read options. Select all that apply. / Ando keken nyumudyo. Wulundi liŋ nagwon tetemakindya.

- ☐ From outreach or awareness raising events by NGOs
  I tuworoji i midijin kode i diŋitan ti todinesi na petaki ko mugunyan na tomoroja borik i kita
- ☐ From radio or other mass media programs or announcements
  I pirit wuyet nakinyo kode kune momoresi kode loŋiyo lo lalawiya
- ☐ From my family or friends / Koyo mede kode julin
- ☐ From schools, churches, or other social institutions / I pirit todinet, i kanisa kode piriton si'dayesi
- ☐ From UNHCR, RWC, or LC / Ko UNHCR, RWC, kode LC
- ☐ Referral from NGO / Sonyo i nene mugun
- ☐ Other: / Kune: ____________________

7.4 Is it possible for you to walk to a health center? / Do yona bubulo i tut i kadi na wini?
- ○ Yes / Yee
- ○ No / 'Bayin

7.5 Is it possible for you to walk to a protection desk? / Do yona bubulo i tut i kadi gayet kode meja gayet?
- ○ Yes / Yee
- ○ No / 'Bayin

Finally, I have a few **basic questions about you**. / I dutet, nan **gwon ko piyesi**, i loki nonuk.

8.1 What is your home country? / Juru lolut lo a ŋa?
- ○ South Sudan / A Sudan Nabot
- ○ Other: / Kune:____________________

8.2 How long have you been in this camp? / Do a gwon i camp ni ko diŋit gwada?

________ months / tapa

8.3 What languages do you speak and understand comfortably? / Lolon kutuk logwon do jajam ko kukuru bura?
Select all that apply. / Wuludye liŋ nagwon tetemakindya.

- ☐ Juba (simple) Arabic
- ☐ Bari
- ☐ English
- ☐ Kakwa
- ☐ Kuku
- ☐ Lugbara
- ☐ Lulubo
- ☐ Madi
- ☐ Mundari
- ☐ Nyangwara
- ☐ Pajulu
- ☐ Kiswahili
- ☐ Other: / Kune: ____________________
- ☐ Other: / Kune: ____________________

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8.4 How old are you? / Do ko kiŋajin muda?

________ years / kiŋajin

8.5 What levels of education have you **completed**? / Do a **todino gwada**/a yenga i nan keniya?
Select all that apply. / Wuludye liŋ nagwon tetemakindya.

- ☐ No education / Nan ako todino
- ☐ Primary / Laset na kak na kendya
- ☐ Secondary / Siniya
- ☐ Technical / Kitayesi ti keni
- ☐ Post-secondary, university, graduate school / I b'ot na siniya, kenet na ki na kendya, tutungo na kendya

8.6 What is your primary religion? / Keri lolut lo kanisa togeleng lo alolon?
Select only one. / Wulundi geleŋ.

- ○ Islam / Isilam
- ○ Christianity / Kirisitianityo
- ○ Indigenous, traditional, or folk religion / Keri lo 'beron
- ○ No religion / Keri 'bayin
- ○ Other: / Kune:________________________

8.7 How many people live in your household right now, not counting yourself?
Ŋutu muda lo sisida konuk mede ni soŋinana, ko keken mugun?

________ people / ŋutulu

8.8 How many children do you have? / Do gwon ko ŋwajik muda?

________ children / ŋwajik

8.9 Are you married? / Do a yema/yemba?

- ○ Single / Gwon geleng
- ○ Living together as a couple (but not married) / Sida i pirit na geleng gwoso ko lulet ko narakwat (ama ako yema)
- ○ Married (even if currently apart by circumstance) / Ayema (madi soŋinana sida kade kade ko kune yoŋesi)
- ○ Divorced or separated (married but living apart by choice)
  A yanya kode a rekin (ayema ama sida kade kade kese i mindyo)
- ○ Widowed / Karu'be

8.10 Are you separated from your family now? / Do a koroja ko mede nanuk soŋinana?

- ○ Yes / Yee
- ○ No / 'Bayin

Time finished: / Diŋit aje jo: ________________________________ AM / PM

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