MHPSS Needs Assessment Report for Children in Alemwach Refugee Site, Amhara, Ethiopia 2023

Feedback:
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EXECUTIVE SUMMARY

Globally, it is estimated by WHO that 22% of forcibly displaced people suffer from a mental disorder (Charlson, et al., 2019). Children make up to almost half of the displaced populations and are most vulnerable and at increased risk in times of emergencies (Dangmann, Dybdahl, & Solberg, 2022). According to UNICEF, "prolonged conflict, mass displacement, violence, exploitation, terrorism, poverty, outbreaks, intensifying natural disasters and climate change can have a catastrophic impact on children's behaviour and emotions as well as learning and development in the short and long term" (UNICEF, 2018) (UNICEF, 2023). Studies show that children and families have shown great resilience, once they are safe, have their basic needs met, and have access to social and community support (UNICEF, 2023).

Due to limited psychosocial support services targeting children, it was a challenge establishing their key psychosocial support needs. It is for this reason the multiagency MHPSS Technical Working Group (MHPSS TWG) spearheaded by UNHCR decided to conduct a needs assessment in Alemwach with the main objective of determining the mental health and psychosocial needs among children and adolescents. This is therefore a report on the needs assessment conducted in June 2023 from a sample size of 441 KII respondents aged 12-17 years, 70 activity-based interviewees aged 6-11 years and 7 FGDs with community resource persons.

Key findings of the assessment indicated that 48% of the respondents have experienced mental health problems with feelings of hopelessness, sadness, flashbacks being most prominent. It also highlighted Displacement (61%), GBV (51%), insecurity (43%) and long stays at the camp (41%) as the main causes for mental health problems. 56% respondents shared that people with mental health problems are accepted in the community with family members, humanitarian workers and religious leaders being the most common sources of support. Despite this, children with mental problems experience several challenges namely: neglect (59%), discrimination (50%) and abuse (41%).

The study also indicated excessive anger, learning difficulties and suicidal and self-harm behaviors as common psychological impact, relationship problems, family conflicts and isolation/withdrawal as common social impacts and fighting, alcohol and substance abuse and GBV (both as survivor and perpetrator) as common behavioral impacts across the population. Child neglect (68%) was highlighted as a major behavioral impact among caregivers. 5.9% of the respondents shared to having experienced suicidal ideation with 31% reported having attempted suicide in their lifetime. Exposure to violence and war, multiple displacements, limited access to basic needs, separation from family or relatives, loss of loved ones during flight and experiencing of witnessing physical and sexual violence were highlighted in the FGDs as common predisposing factors. The assessment also identified stressful life circumstances, family related conflicts and lack of support from the community as common risk factors for suicidal behavior. The most common method for

attempting suicide used included drinking poison and use of rope. Praying, talking to someone, fear of God's judgement and thinking about one's family were identified as protective factors. Alcohol and substance use was found to be both a mental health problem and a means of coping. The respondents shared that 2% use alcohol, 2% smoke cigarettes and 5% chew khat. Of those using alcohol, 7 reported to taking it daily and 4 respondents consume weekly.

60% reported that the children with mental health problems receive medications at the health centres and 50% can talk to a psychologist/ counsellor/psychiatric nurse. Distance, language barrier, lack of medications and lack of services were listed as the main existing barriers to accessing MHPSS services. Talking to family members and friends, community members, counselling and prayers were among the common coping mechanisms. The FGDs highlighted physical or verbal abuse, self-injurious behaviours (burning, scraping, slashing, etc.), withdrawal from family and friends, experimentation, subsequent abuse of drugs or alcohol Refusing support from loved ones, stealing, disobedience as common negative coping mechanisms that are in use among the children and adolescents.

Gaps identified during this study include limited psychosocial support services targeting children and adolescents especially trauma informed interventions, limited information and awareness on mental health, coping skills and services available and limited access to basic services namely energy, education and livelihood opportunities, health care and safe spaces (child and youth safe spaces, women and girls' safe spaces). Other gaps include inconsistent provision of psychotropic medications and MHPSS services which leads to increased relapse and decreased quality of life, limited funding for MHPSS interventions and suicide and self-harm response and prevention and lack of behaviour change/modification interventions to address alcohol and sub-stance use in the community.

This report suggests the following recommendations: first, integration of MHPSS to other sectors with a key focus on Child protection, Education, GBV and Health guided by the MHPSS Minimum Service Package. Another recommendation is to mainstream the implementation of community Based MHPSS Interventions targeting strengthening of children and youth spaces, community support systems and creation of awareness of child and family wellbeing and protection needs. Additionally, there is need to develop child and adolescent suicide prevention programmes for promotion of mental, emotional and social wellbeing, prevention of suicide and development of mental health conditions as guided by the Helping Adolescents Thrive Toolkit. Moreover, there is need for implementation of interventions targeting alcohol and substance use. This report further recommends strengthening of care systems through capacity building of professional and lay staff and volunteers in coordinated MHPSS care for children and families. Also, there is need for strengthening the referral systems for children with protection risks or MNS disorders. Finally, there is need for advocacy for additional resources (financial and human) for effective implementation of MHPSS activities and interventions.

Table of Contents

EXECUTIVE SUMMARY 2
Table of Contents 4
Table of Figures 5
List of Abbreviations 6
INTRODUCTION 7
I. Background information 8
II. Objectives 9
Broad Objective 9
Specific Objectives 9
III. METHODOLOGY 10
a. Study Area Target population and sample size 10
Ethical Considerations 11
Data Collection and Data analysis 11
FINDINGS 11
Key interviews 11
Demographic Information 11
Local Expressions of Distress and Concepts of Mental Health Conditions 12
Ecological Influences on Mental Wellbeing 13
Impact of mental health problems across various populations 14
Suicidality 16
Alcohol and substance use 16
Accessibility and Barriers to mental health care 17
Copying mechanisms 17
Activity based assessments. 17
Focused Group Discussion (FGD) 18
DISCUSSION 21
GAPS 25
RECOMMENDATIONS 25
A. Integration of MHPSS to other sectors 25
Child protection 25

GBV 26
Education 26
Health 26
B. Community Based MHPSS Interventions 27
C. Suicide prevention and response 27
D. Interventions targeting alcohol and substance use 28
E. Capacity building, Coordination and Advocacy 28
REFERENCES 29

Table of Figures

Figure 1: Gender of respondents Figure 2 Age group of respondents 12
Figure 3 Level of education Figure 4 Occupation of respondents 12
Figure 5 Expression of mental health problems 12
Figure 6 Understanding of mental health problem 12
Figure 7 Challenges faced Figure 8 Sources of support 13
Figure 9 Causes of Mental Health Problems ..... **Error! Bookmark not defined.**
Figure 10 Frequency of displacement ..... **Error! Bookmark not defined.**
Figure 11 Causes of displacement ..... **Error! Bookmark not defined.**
Figure 12 Access to Services 14
Figure 13 Emotional and Psychological impact in Children Figure 14 Social Impact of Children **Error! Bookmark not defined.**
Figure 15 Behavioural impact among Children ..... **Error! Bookmark not defined.**
Figure 16 Emotional and psychological impact among adolescents Figure 17 Social Impacts among adolescents 15
Figure 18 Behavioural impacts among adolescents ..... **Error! Bookmark not defined.**
Figure 19 Psychological impact among caregivers Figure 20 Social Impacts among caregivers. **Error! Bookmark not defined.**
Figure 21 Behavioural Impacts among caregivers ..... **Error! Bookmark not defined.**
Figure 22 Risk factors for suicidality among adolescents ..... **Error! Bookmark not defined.**
Figure 24 Age vs Chewing of khat 16
Figure 23 Age group vs alcohol use ..... **Error! Bookmark not defined.**
Figure 25 Barriers to accessing MHPSS services 17
Figure 26 Coping mechanisms ..... **Error! Bookmark not defined.**
Figure 27 Socioecological Model (Bronfenbrenner,1997) ..... **Error! Bookmark not defined.**

List of Abbreviations

CFS	Child Friendly Space
CVT	Center for Victims of Torture
DICAC	Ethiopian Orthodox Church - Development and Inter-Church Aid Commission
FGD	Focus Group Discussion
GBV	Gender Based Violence
IASC	Inter-Agency Standing Committee
IHS	Innovative Humanitarian Solutions
KII	Key Informant Interviews
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MHPSS MSP	Mental Health and Psychosocial Support Services Minimum Service Package
MHPSS TWG	Mental Health and Psychosocial Support Services Technical Working Group
MNS	Mental, Neurological and Substance Use Disorders
MTI	Medical Teams International
NFI	Non-Food Items
PAHO	Pan African Health Organization
PFA	Psychological First Aid
PTSD	Post Traumatic Stress Disorder
RADO	Rehabilitation and Development Organization
RCC	Refugee Central Committee
RRS	Refugees and Returnees Service
UN-HABITAT	United Nations Human Settlements Programme
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
YFS	Youth Friendly Space

INTRODUCTION

According to IASC, Mental Health and Psychosocial Support (MHPSS) is defined as "any type of local or outside support that aims to protect and promote psychosocial well-being and/ or prevent or treat mental disorders"(Inter-Agency Standing Committee (IASC), 2007). This has become a key area of focus due to the adversities that are happening globally resulting in significant mental, emotional and social distress to the affected populations.

Children are among the most vulnerable and at increased risk in times of emergencies. According to UNICEF, 2019, the following adversities have exacerbated the environments affecting the children's wellbeing and development, "prolonged conflict, mass displacement, violence, exploitation, terrorism, poverty, outbreaks, intensifying natural disasters and climate change." This is due to their impact on the community and family structures that support and offer safety for the children, affect their day-to-day activities by limiting their access to education and socialization with their peers and affect their caregiver's capacity to provide safe and nurturing environments and care.

One of the key priorities is to protect and improve people's mental health and psychosocial wellbeing (Inter-Agency Standing Committee (IASC), 2007). International bodies, governments and non-governmental humanitarian actors have provided guidelines like the IASC Guidelines on mental health and psychosocial support in emergency settings (2007), UNICEF operational guidelines on community based MHPSS in humanitarian settings

(2018), UNHCR Operational guidance mental health and psychosocial support programming for refugee populations (2013), UNHCR Strengthening mental health and psychosocial support in 2021 among others that provide guidance in the implementation of MHPSS activities in a coordinated and integrated manner.

MHPSS programmes among children and adolescents aim to "(1) reduce and prevent harm, (2) strengthen resilience to recover from adversity, and (3) improve the care conditions that enable children and families to survive and thrive" (UNICEF, 2018). This is achieved by the restoration, strengthening and mobilization of family and community supports and systems which is essential in creating a safe and nurturing environment for the holistic growth and development of the children.

In Ethiopia, mental health and psychosocial support for children has been highlighted as one of the key activities under strategy 2: Provision of targeted support for children with specific needs in their best interests.

"Respond to the MHPSS needs of refugee children through the implementation of holistic MHPSS intervention at all levels such as respectful basic services and security; community and family strengthening support; focused non-specialized support and specialized service."

According to UNHCR Ethiopia, 2022, strengthening of MHPSS was identified as a key intervention in the UNHCR and UNICEF model and transformative Blueprint partnership in 2020. The Blueprint partnership is aimed at providing a fair deal for refugee children as guided by the Global Compact on Refugees. (UNHCR, 2022) In order to achieve this, a participatory assessment for MHPSS among children, adolescents and caregivers was deemed necessary in Alemwach Refugee Site to bridge the information gap and provide clear guidance in the MHPSS programming.

I. Background information

As of August 2022, Ethiopia hosted approximately 80,000 refugee children which accounts for 9.2% of the total refugee population (874,239) from various countries. In Alemwach, there are a total of 8,813 refugee children according to Gondar site profile (December 2022). Alemwach refugee site was established in June 2021 in the Amhara region aimed at accommodating up to 25,000 refugees.

Children are identified as a vulnerable population at heightened risk. According to the 2021 Participatory Assessment, refugee children across Ethiopia face various protection risks. These include, "rape, child labour, child marriage, an increase in negative coping mechanisms such as transactional sex among adolescent girls; chewing khat and alcohol abuse by the youth; an increase in criminal activities such as theft and robbery by children

and youth; school drop outs mainly among adolescent girls, conflict between refugee and host community youth due to lack of opportunities for the youth; onward movement/migration and exposure to the associated protection risks and limited access to different services for children with disabilities." (UNHCR, 2022)

The factors above have been associated with trauma and other mental health issues and there is a big gap in the implementation of mental health and psychosocial activities as highlighted by the Ethiopia Child Protection Strategy (UNHCR, 2022) This can lead to the exacerbation of mental health issues as they may go undiagnosed or untreated. Limited access to MHPSS services may cause profound consequences on a person's resilience and could affect the reuptake and the benefit from other forms of support for example education or livelihood initiatives.[6] This can also be reflected as increased levels of ongoing violence in the community or household level or high rates of self-harm or destructive behaviours. Due to this, there was need for understanding the mental health and psychosocial challenges experienced by the children and adolescents in Alemwach. This will guide the design and effective implementation of MHPSS interventions for children and adolescents.

II. Objectives

a. Broad Objective

To determine the mental health and psychosocial needs among children and adolescents in Alemwach Refugee Site

b. Specific Objectives

1. To determine common of mental health and psychosocial issues among children, adolescents, and caregivers
2. To describe the presentation of mental health and psychosocial support issues of children and adolescents.
3. To determine the risk and protective factors for the mental health and psychosocial issues People
4. To identify the positive and negative coping mechanisms applied by children and adolescents at Alemwach
5. To determine the supportive systems, present for children and adolescents in Alemwach
6. To determine present gaps in and recommendations for mental health and psychosocial support interventions in Alemwach Refugee Site.

III. METHODOLOGY

The UNHCR Tool for Participatory Assessment in Operations and Listen and Learn: Participatory Assessment with Children and Adolescents were used as a guiding documents for the planning and conducting of the participatory assessment. Other guiding documents that were used though not limited to include: UNHCR Policy on Age, Gender and Diversity (March 2018) and UNHCR Operational Guidance on Accountability to Affected People (Sept 2020).

a. Study Area Target population and sample size

The assessment was conducted in Alemwach Refugee Site.

The target population was refugee children and adolescents at Alemwach Refugee Site aged between 6-17 years. The total number of children in Alemwach as per site profile for December 2022 is 8,813.

Below is the breakdown by age groups:

Alemwach Refugee Site	
Age Group	**# of children**
Under 5	1,816
5-11 years	4,272
12-17 years	2,725
Total	**8,813**

The sample population for the study was 383 children and adolescents served at Alemwach. This was arrived at using the Slovin's Formula as shown below:

$$n = \frac{N}{1 + Ne^2}$$

where n= Number of samples

N= Total population

e= Error of tolerance (±5%)

$$n = \frac{8{,}813}{1 + 8{,}813 \times 0.05 \times 0.05}$$

$$n = 382.63$$

$$n = 383$$

Community key informants and key informants from humanitarian agencies in Alemwach were also involved in the assessment.

b. Ethical Considerations

Prior to conducting this assessment, approval was sought from Refugees and Returnees Service (RRS). Additionally, consent of the respondents/informants and caregivers of children engaged was obtained before engaging them in the analysis and thus, only participants that agreed to take part in the assessment were interviewed. In so doing, the nature of the study and its purpose was explained and also, the identity of informants or participants was concealed in order not to harm their safety, dignity and privacy.

c. Data Collection and Data analysis

The participatory assessment consisted of a process of information gathering and interactive analysis through key informant interviews (KII), activity-based interviews, focus group discussions (FGD) and desk reviews.

Focus group discussions were conducted for the following groups: children and adolescents, caregivers, child welfare committee, community leaders, religious leaders, community staff and educators.

Data was collected using the Kobo platform and manual collection and recording of data. Observation and spot checks techniques were also be applied.

Breakdown of data collection as per age group

6-11 years– activity-based group interviews 88 (88 refugees)

12-17 years– Key interviews and FGDs 300 (200 refugees – 100 host)

IV. FINDINGS

a. Key interviews

i. Demographic Information

441 children were interviewed out of which 45% the respondents were male and 55% female of Eritrean nationality.

The participants' age groups and sexual orientation are as highlighted in the graph below.

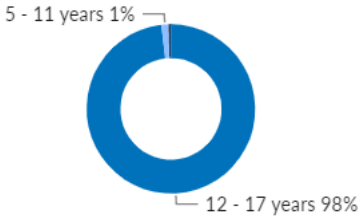
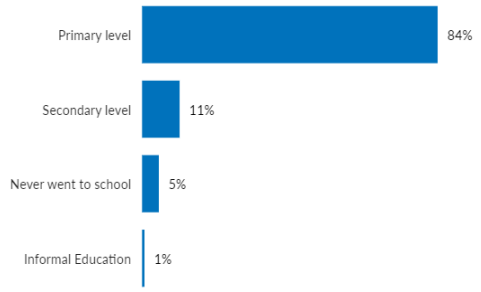


Figure 1: Gender of respondents

Figure 2 Age group of respondents

84% respondents reported to have had primary school education as the highest level as indicated in figure 3. 70% of the respondents indicated they were students by profession while 6% reported to be engaging in daily/casual jobs.



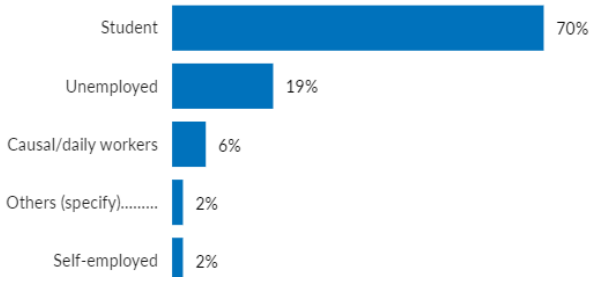


Figure 3 Level of education

Figure 4 Occupation of respondents

ii. Local Expressions of Distress and Concepts of Mental Health Conditions

The assessment findings showed that 48% of the respondents had experienced mental health problems with feelings of hopelessness, sadness, flashbacks being most prominent as shown in figure 5.

Figure 5 Expression of mental health problems

According to the respondents, a child with mental health problems is defined as a person with a brain disorder/ one who talks to self/ running from home/a dangerous person. 56% respondents shared that people with mental health problems are accepted in the community. Despite this, they also shared that children with mental problems experience several challenges namely: neglect (59%), discrimination (50%) and abuse (41%) as shown in figure 7 below. According to figure 8, family members humanitarian workers, religious leaders are the most common sources of support for children with mental health problems.

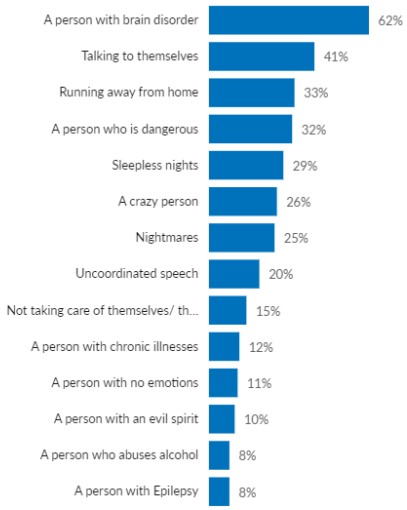


Figure 6 Understanding of mental health problem.

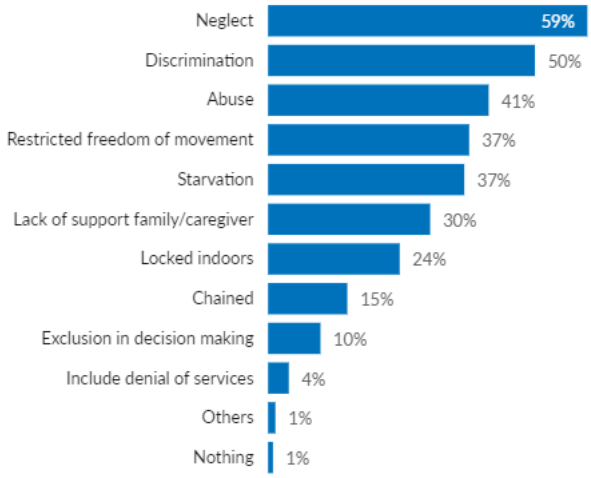


Figure 8: Challenges faced.

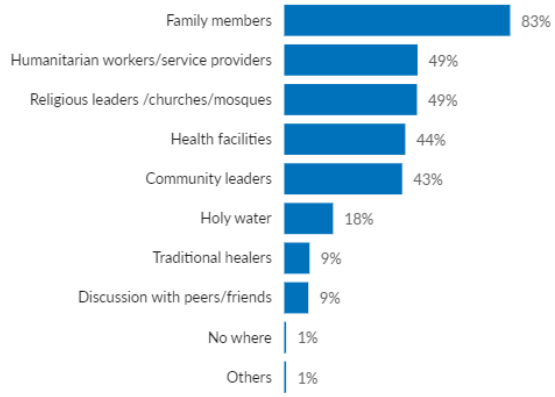
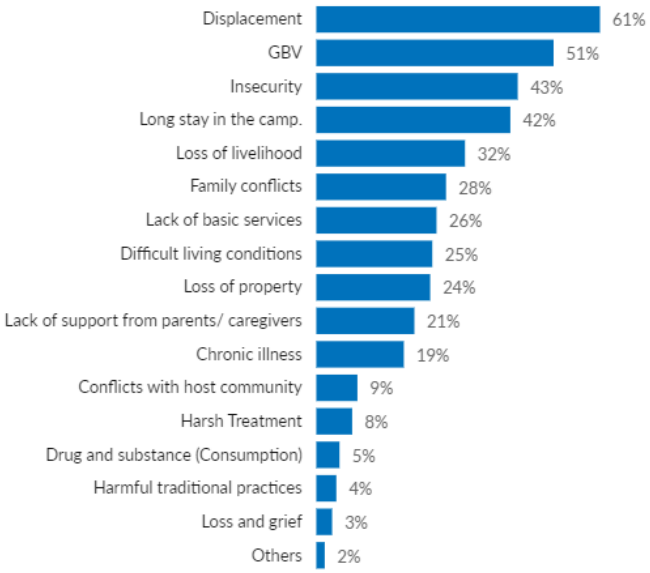


Figure 7: Sources of support



ii. Ecological Influences on Mental Wellbeing

Displacement, GBV, insecurity and long stays at the camp were identified as the main causes for mental health problems. 61.22% of the children reported to experiencing displacement twice while 33.11% experienced it thrice with wars being the main cause standing at 76% as shown in figure 10 and 11.

Answers	12 - 17 years	18 - 59 years	5 - 11 years	Total
More than three times	0.91%			0.91%
Once	3.17%			3.17%
Thrice	32.88%		0.23%	33.11%
Twice	61.22%	0.45%	1.13%	62.81%
Total	98.19%	0.45%	1.36%	100.00%

Figure 10: Frequency of displacement

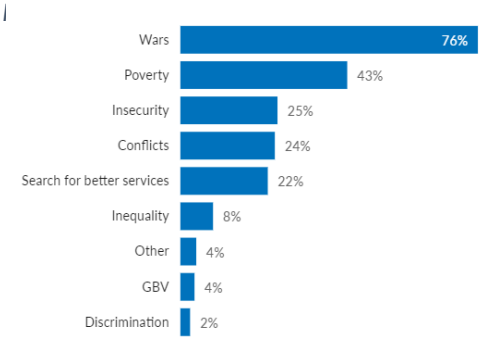


Figure 11:mayeso

According to the respondents, shelter (46%) is the most available service while women and girls safe spaces, rehabilitation centres and livelihoods were the least available services as shown in figure 12.

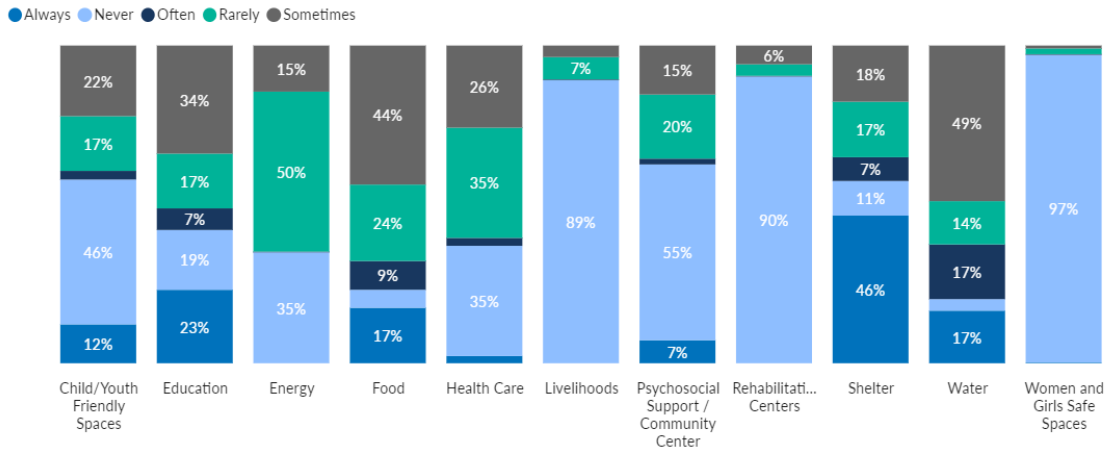


Figure 13: Access to Services

.v. Impact of mental health problems across various populations

During the study, excessive anger, nightmares and self-harm were described as the most common emotional and psychological impact in children while relationship problems with peers, poverty in the family and social withdrawal were the common social impacts. Fighting and school dropout were listed among the behavioral impacts of mental health problems among children.

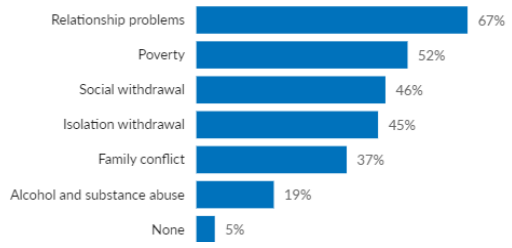


Figure 14: Emotional and Psychological impact in Children

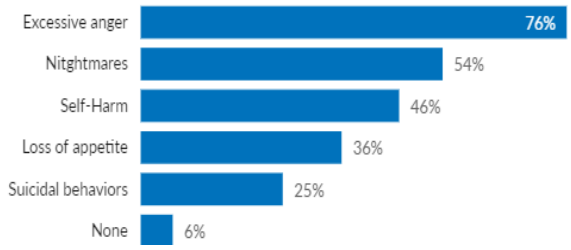


Figure 15: Emotional and Psychological impact in Children

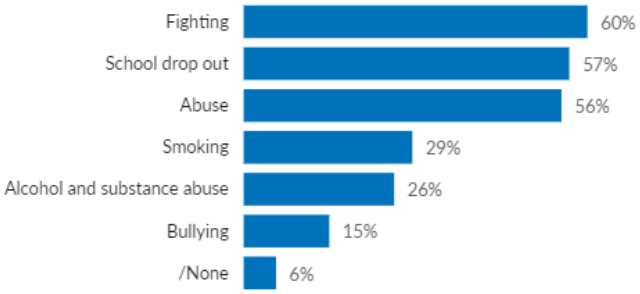


Figure 16: Behavioural impact among Children

Among adolescents, excessive anger, learning difficulty and loss of appetite were listed as common emotional impact among adolescents. Running away from home and self-harm were also reported as social impacts while fighting, pregnancy and school drop-outs were identified as behavioral impacts.

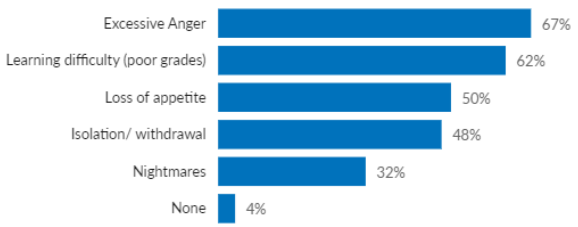


Figure 17: Emotional and psychological impact among adolescents

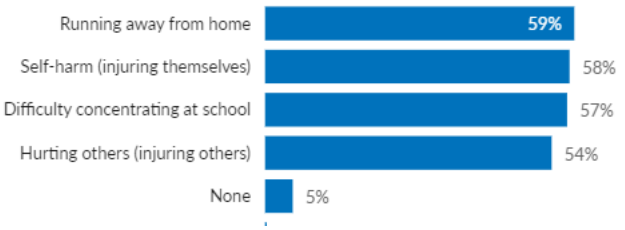


Figure 18: Social Impacts among adolescents

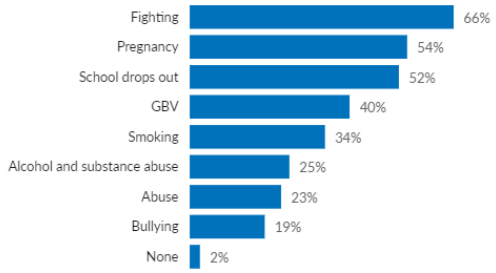


Figure 19: Behavioural impacts among adolescents

Among caregivers, the respondents shared that excessive anger, self-harm and loss of appetite are the common psychological impact. They added that relationships problems, family conflicts and poverty were common social impacts while child neglect, running away from home and GBV were common behavioral impacts.

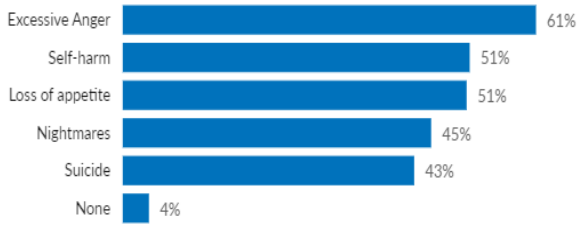


Figure 21: Psychological impact among caregivers

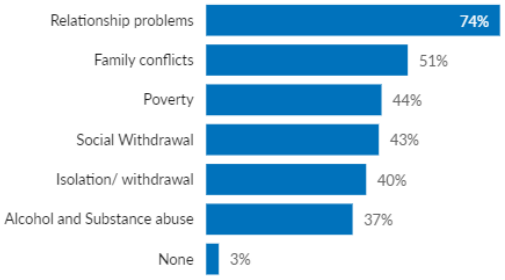


Figure 20: Psychological impact among caregivers

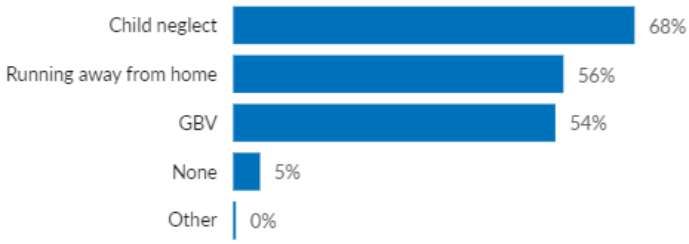


Figure 22: Behavioural Impacts among caregivers

v. Suicidality

Findings show that 5.9% of the respondents shared to having experienced suicidal ideation. Out of the 5.9%, 31% reported having attempted suicide in their lifetime. The common risk factors for suicidal behavior were listed as stressful life circumstances, family related conflicts and lack of support from the community as highlighted in figure 22. The most common method used included drinking poison and use of rope. Praying, talking to someone, fear of God's judgement and thinking about one's family were identified as protective factors for suicidal behavior. 5 children who had attempted suicide, expressed thoughts of suicide during the assessment and were referred to IHS and UNHCR for immediate care and support.

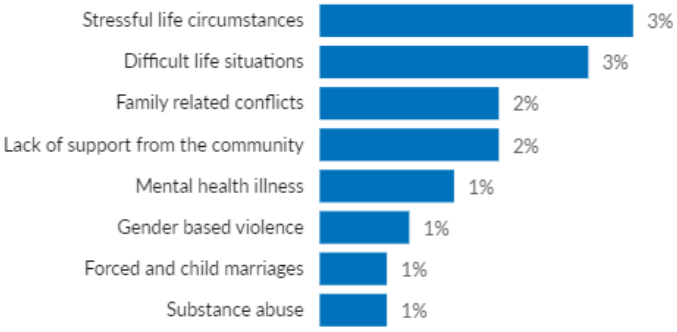


Figure 23: Risk factors for suicidality among adolescents

vi. Alcohol and substance use

From the study, alcohol and substance use was found to be both a mental health problem and a means of coping. According to figure 23 and 24 alcohol use and chewing of khat is most common among those aged 18-59%.

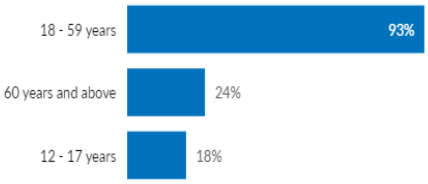


Figure 24: Age group vs alcohol use

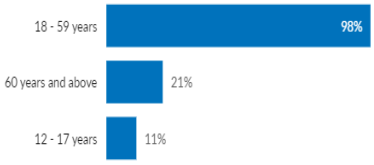


Figure 25 Age vs Chewing of khat

The respondents shared that 2% use alcohol, 2% smoke cigarettes and 5% chew khat. Of those using alcohol, 7 reported to taking it daily and 4 respondents consume weekly.

vii. Accessibility and Barriers to mental health care

60% of the respondents reported the children with mental health problems receive medications at the health centres and 50% can talk to a psychologist/ counsellor/psychiatric nurse when they go to hospital. Distance, language barrier, lack of medications and lack of services were listed as the main existing barriers to accessing MHPSS services as shown in figure 25. Limited supply of drugs at the health facilities was raised and echoed by the community as the main challenge in accessing mental health care.

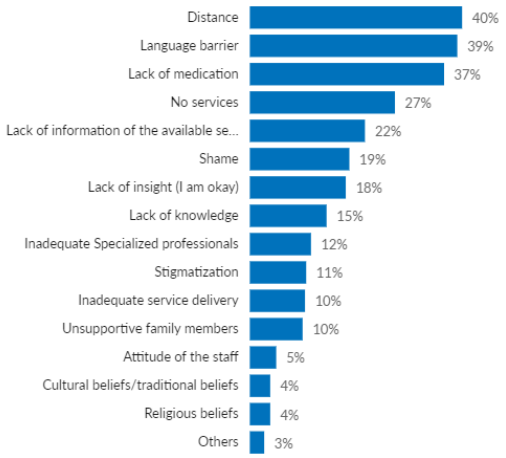


Figure 26 Barriers to accessing MHPSS services

viii. Copying mechanisms

Talking to family members and friends, community members, counselling and prayers were among the common coping mechanisms as shown in figure 26. Resettlement was mentioned as a key future desire for 73% of the respondents while 4% aimed at advancing their education.

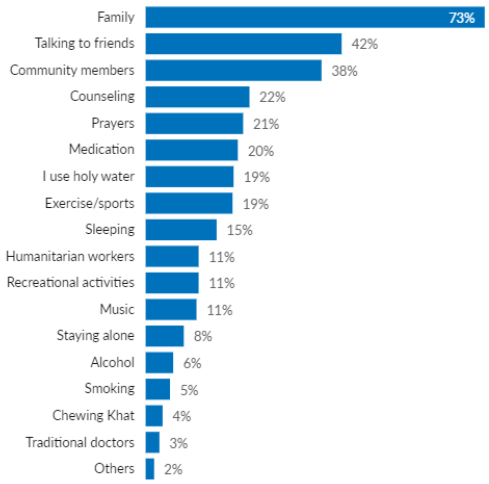


Figure 27: Coping mechanisms

b. Activity based assessments.

70 children aged between 6-11 years old were engaged in activity-based assessments which highlighted an understanding of emotions, causes of negative emotions and available support systems.

All children were able to identify key emotions such as anger, happiness, sadness and fear. The children locally identify happiness as “hagos” in Tigrinya and “gogoda” in Kunama language and sadness as “Mahezan” in Tigrinya and “Amada” in Kunama.

Children felt happy when able to play with other children and family members. School going children shared feeling happy when in school as they can engage with other children and learn letters and numbers from teachers. Feelings of sadness were associated with being robbed in the houses at night, having limited food and firewood, limited hygiene materials like soap, shelter, and hospitals. In addition, falling sick during the cold weather

or when it floods. Feeling afraid when there was shooting particularly from the previous camp and also in Alemwach Refugee site. When beaten by other children and adults.

Children who have lost their parents and other family members were identified as the ones mostly affected. In addition, they shared that when parents were stressed or not happy, they were also affected.

The children reported that sometimes they share their toys and play with those who are sad to make them feel better. They added that getting support from parents and older siblings can also help someone to feel better. Going to school was also identified as a way of supporting children. Some children shared that fighting back helps them to feel better.

The children shared that there are several places and people that they approach when they feel sad. Parents or caregivers, older siblings, friends, teachers, and the school director. UNHCR office, the child friendly spaces, Refugee Central Committee (RCC) offices and the schools were identified as safe spaces that children can access.

The older children reported that lack of cash support had affected unaccompanied and separated children as they were not able to access materials such as clothes, scholastic materials and hygiene materials like soaps. The need of provision of scholastic materials in schools was highlighted which would help more children go to school. The recommended that Innovative Humanitarian Services (IHS) and other partners provide more trainings and engagement with children was also underscored.

c. Focused Group Discussion (FGD)

A total of 72(26F,46F) community members were engaged in Focus Group Discussions aimed at highlighting key needs and challenges faced by children and adolescents. The FGDs engaged the adolescents, caregivers, educators, refugee leaders, religious leaders and community staff.

All participants mentioned that mental health problems (commonly referred to as ayemero tsegem or ayemero senkelena) are common among children and adolescents with anger problems, trauma, epilepsy, depression, substance use being the most common. According to the participants, these reflect in the form of nightmares, wetting the bed, self-isolation, sleeping problems, irritability and aggressive behaviour, delays and lack of interest in participating in physical activities, frequent tantrums, frequent crying and screaming, repeated traumatic events narration and dramatic play, fear and anxiety, difficulty paying attention and poor memory, engaging in altercations with other children and adults, frequent complaints of headaches and stomach-aches with no apparent causes and disobedience and disregard for their caregivers ad elders.

The participants mentioned that prior to their relocation to Alemwach Refugee Site, violence and war, limited access to basic needs, separation from family or relatives, loss of loved ones during flight, experiencing of witnessing physical and sexual violence were the main causes of stressors to children and caregivers. In Alemwach, inadequate services for example food, shelter and education, feelings of insecurities due to kidnappings reported, delay of ration provision, limited number of recreational facilities and the delay of the resettlement process posed as key risk factors for mental health problems.

To cope or manage the challenges and stressors faced, the children and adolescents engage in both positive and negative coping mechanisms. The participants mentioned playing with other children or toys, spending time in person with family members and friends, praying, going to school and engagement in recreational activities like listening and giving stories, sports, dance, and music. These were identified as good ways of coping while engaging in physical or verbal abuse, self-injurious behaviours (burning, scraping, slashing, etc.), withdrawal from family and friends, appetite loss, refusing to eat, overeating, experimentation and subsequent abuse of drugs or alcohol, refusing support from loved ones, stealing, and keeping bad company, disobedience were identified as negative ways.

As an addition to the negative coping mechanisms shared, the participants all agreed that use of substances is a common practice especially among adolescents. The participants described substances like alcohol (beer, areke, and tella), tobacco, chewing kat, hasheeh (marijuana) as the most common substances used. They also shared that it is common for children and young people expressing self-harming thoughts and actions especially unaccompanied and separated children. This was mainly seen in Mai Aini where many young people would hang themselves with a rope, drink alcohol, take more drugs, throw themselves in the water holes that they found or try to hurt themselves with sharp objects. The participants were aware of these actions and observed these in the community Cases of children who had attempted suicide and also others that had expressed the desire to die due to feelings of hopelessness as they deemed their lives as meaningless were also highlighted.

According to the participants, the community plays an important role in promoting the emotional and psychological wellbeing of children and young people facing different mental health problems. First, the community members provide advice and support to children and adolescents expressing mental health problems and their family members. They also refer the children to religious leaders who provide spiritual counselling and support in effort to support them cope with the challenges faced. Thirdly, the community refers to the children to humanitarian agencies namely IHS, Center for Victims of Torture (CVT), Rehabilitation and development organization (RADO) or Ethiopian Orthodox Church - Development and Inter-Church Aid Commission (EOC-DICAC) for counselling services. Women associations was also reported to be providing support to caregivers through identification

and making referrals to mental health and other services as well as providing motherly advice.

The community leaders were instrumental in spreading awareness and sensitization, promoting positive healthy behaviours learned from different actors and making referrals to available services within the community. There are also peer support groups for both children and caregivers which provide emotional and psychological support to each other. These groups have gained trainings and teachings from different humanitarian partners who impact them with positive coping skills and knowledge.

The participants reported that there are support services from agencies namely IHS, CVT, DICAC, RADO, Plan International and Medical Teams International (MTI). However, they shared that the services are inadequate. Participants shared a challenge on the provision of MHPSS services for children and adolescents. One caregiver reported:

"I have a daughter who has had mental issues since she was 15 years old. She has not received any service as compared to when we were at Mai Aini Camp where mental health services were provided to people of all ages."

The following recommendations were provided by the participants in effort to strengthen MHPSS Services for children and adolescents.

1. Strengthening of counselling services to children and adolescents as well as caregivers.
2. Strengthening and increase of playing environments -child and youth friendly spaces (CFS and YFS. The current CFSs have limited playing materials.
3. Establishment of a rehabilitation center to support physical and mental disabilities affecting children, adolescents and the general population.
4. Increase awareness sessions on mental health, trauma, GBV, resettlement, safety, medical and psychiatric services, protection services, education services and WASH.
5. Enhance the provision of timely and adequate medications to children with severe mental health problems.
6. Enhanced case management and provision of counselling services to GBV survivors and girls at risk
7. Educators to focus on the children emotional state and social interaction besides teaching. They should actively provide Psychological First Aid (PFA) and link children with mental health issues to partner agencies for complementary services.
8. Hasten the resettlement process as it provides better opportunities for growth and wellbeing for children and adolescents.
9. Enhanced support to UASC through provision of cash assistance and other material support

10. UNHCR to enhance protection counselling and provision of Non-Food Items (NFIs) for example clothes, blankets due to the harsh weather conditions.
11. Enhanced accessibility of services for example food, water, firewood, and health services. In particular, more health professionals need to be brought on board and additional ambulances to support the refugees.
12. Enhanced provision of nutritional support to children with physical and psychosocial disabilities.
13. Implementation of livelihood and tertiary education opportunities for the young people.
14. Provision of worship places that will allow for the children to access spiritual counselling and be engaged in spiritual activities geared towards their spiritual and emotional growth.
15. UNHCR, RRS and partner agencies to collaboratively work on addressing the root causes for mental health issues.

V. DISCUSSION

According to WHO, mental health is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2022). A striking finding from the study was on the number of children who reported to have experienced a mental health problem which stood at 48% (55% females and 45% males) with feelings of hopelessness, sadness, flashbacks being most prominent. According to Marković, Gašić, Ilić, Bjekić, & Živanović, 2017, emotional distress in refugee children predominantly manifests itself through anxious and depressive symptoms often followed by somatizations such as frequent headaches. Mental health problems are highly prevalent globally and are major contributors to morbidity, disability, and premature mortality (PAHO, n.d.). During humanitarian emergencies, there is widespread suffering which affects people's mental health and psychosocial wellbeing (Inter-Agency Standing Committee (IASC), 2022). It is estimated that, one in five (22.1%) people living in areas affected by conflict is estimated to have a mental health condition globally (Charlson, et al., 2019). Evidence shows that the estimated higher prevalence rates for refugee children for PTSD, Anxiety and depression as compared to other child populations (Dangmann, Dybdahl, & Solberg, 2022).

In the study, displacement, GBV, insecurity and long stays at the camp were identified as the main causes for mental health problems with 62% experiencing displacement twice. Globally forced migration is seen as a global threat to mental health and particularly refugee children are more vulnerable, as displacements impacts their holistic growth and development (WHO, 2022). Risk factors for mental health problems are better understood through the socioecological model (figure 27) which highlights complex interactions between different levels of the social ecology (Bronfenbrenner, 1977). In the study, factors such as family conflicts and loss of loved ones which fall under the relationships layer are very key as precipitating, predisposing and perpetuating factors (Dangmann, Dybdahl, & Solberg, 2022). Children who are unaccompanied are at higher risk of exploitation and trafficking, report more traumatic events, daily stress and mental health problems (Höhne, van der Meer, Kamp-Becker, & Christiansen, 2020). Lack of access to services has also been highlighted in the study and serves as a major perpetuating factor as the children and adolescents are not able to seek the support needed (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014).

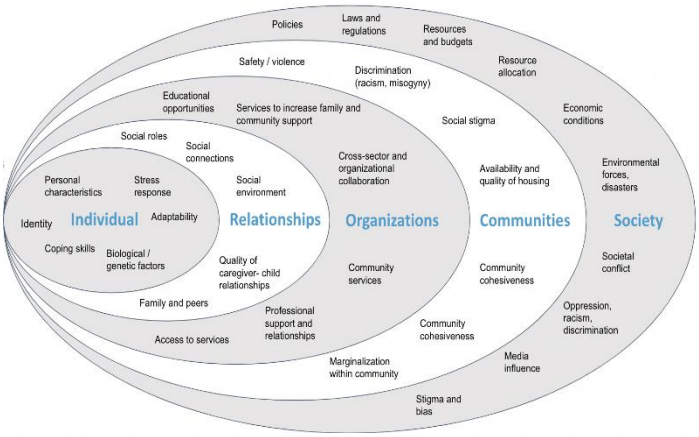


Figure 28: Socioecological Model (Bronfenbrenner,1997)

Mental issues are known to have profound effects on the holistic wellbeing of a person. According to the study, excessive anger, nightmares and self-harm, learning difficulties, relationship problems with peers and poverty in the family are described as the most common psychosocial impact in children and adolescents. Evidence has shown that mental health problems have an adverse impact on the life satisfaction, academic achievement, social relationships, risky health behavior and sexual and reproductive health (Sharpe, et al., 2016) (Schlack, Peerenboom, Neuperdt, Junker, & Beyer, 2021).

The wellbeing of children has a strong relationship with the wellbeing and parental relationships. According to the study, mental problems among caregivers led to excessive anger, self-harm, poverty in the family, relationships problems, GBV and child neglect. As Dangmann, Dybdahl, & Solberg, 2022 explain, parental distress can lead to harsher parenting strategies that will greatly affect the wellbeing of children. Caregivers affected by forced displacement face psychosocial issues which may threaten their ability to offer safety, stability and nurturance (UNICEF, 2018).

Globally, suicidal behavior has become a great concern and has been described as a public health problem with an upward trend (WHO, 2012). In the study, suicidal behavior was

described as a common occurrence among the population in Alemwach Refugee Site. A concerning finding was on the expression of suicidal behavior among children and adolescents standing at 5.9% with suicidal ideation. Out of the 5.9%, 31% reported to have attempted suicide in their lifetime. Evidence shows that the prevalence of suicidal behavior among refugees and asylum seekers lie within the range of 3.4%-34% (Vijayakumar & Jotheeswaran, 2010). A study was conducted with the Eritrean Refugees in the refugee camps in Tigray, that highlighted the high prevalence of suicidal behavior among UASC, and this triggered contagion among other UASC (Alem, Githaiga, Kiflom, & Eloul, 2021). During CVT's intervention implementation within 2017 and 2019, 12% reported to have had suicidal ideation with 40% who had made plans and 33% who had previously attempted to end their life (Alem, Githaiga, Kiflom, & Eloul, 2021).

Suicidal behaviors are considered a complex mental health issue as it not only multifaceted but also inter-sectoral (American Psychological Association, n.d.). Young refugees experience a dual burden that enhances their vulnerability and risk of suicidal behavior as they are affected by the risks due to migration as well as the risks due to young age (Basu, Boland, Witt, & Robinson, 2022). Stressful life circumstances were reported and are highly linked to access to basic needs and livelihood and education opportunities. Access to basic needs is a global concern affecting refugees and displaced persons as most camps have been setup in remote areas stricken by poverty in developing and least developed countries (UN-HABITAT, 2016). Family related conflicts and interpersonal conflicts are known to heighten the feeling of isolation by making one feel disconnected from one's social circle (World Health Organization, 2014). Interparental conflicts are known to have negative effects in the mental wellbeing of the child (Hess, 2022). Feelings of isolation and hopelessness especially among UASC have been mentioned in this study and echoed in the FGDs. These compounded with daily life stressors increase the risk of suicidal behavior.

According to the respondents, various means of suicide have been applied or attempted, with the most common means being drinking poison and use of rope. This can be attributed to their ease in availability as this was also echoed among Syrian refugees and Congolese refugees in Nepal and Rwanda respectively (Schininà, Sharm, Gorbacheva, & Mishra, 2011) (Ingabire & Richters, 2020). Despite the suicidal behavior expressed, the respondents have developed protective factors namely praying, talking to someone, fear of God's judgement and thinking about one's family. According to (Posselt, Eaton, Ferguson, Keegan, & Procter, 2019 and Olatunji, Idemudia, & Olawa, 2020), support received from family and friends were very key in the identification and management of individual distress and attended to the root causes of distress which in turn significantly predicts a decrease in suicidal ideation.

From the study, alcohol and substance use was found to be both a mental health problem and a means of coping. Evidence has shown that alcohol and substance is related to mental

health problems and the bidirectional nature in terms of being used as self-medication and a risk factor for mental health issues (Vasic, Grujicic, Toskovic, & Milovancevic, 2021). The respondents shared that 2% use alcohol, 2% smoke cigarettes and 5% chew khat. From the FGD discussions, stressful life circumstances and limited livelihood and educational opportunities were associated with alcohol and substance use among the young people. This related with findings of relevant literature that suggested that untreated mental health problems, stressful living conditions, and a lack of support and control might put unaccompanied refugee children at risk of substance use (Vasic, Grujicic, Toskovic, & Milovancevic, 2021).

Despite the reported rates of mental health problems among the refugee children, they show remarkable resilience (the ability of refugees to maintain positive mental health despite adversity becomes an important goal) (Purgato, Tol, & Bass, 2017). From the study, the children utilize several coping mechanisms to manage the day-to-day challenges. The most common mechanisms are talking to family members and friends, community members, counselling, and prayers. These were congruent with relevant literature which lists going to school, praying and reading the Holy Quran, listening to music, and talking to friends and engaging with them were reported as the main coping mechanisms among refugees in Jordan (Al-Shatanawi, et al., 2023).

According to the study, the respondents reported that 60% of the children with mental health problems receive medications at the health centers and 50% can talk to psychologist/counsellor. Limited access to services was highlighted and echoed in the FGDs. Women and girls' safe spaces, rehabilitation centers and livelihoods, child and youth safe spaces, energy and healthcare were also identified as the least available services. Evidence suggests that displaced children are more vulnerable due to disruption and trauma from the displacement, reduced access to services and loss of community networks and livelihood opportunities (UNHCR & UNICEF, 2023). This in turn leads to poverty, lack of food security and limited access to education and learning and experience violence, exploitation and abuse (UNHCR & UNICEF, 2023).

Distance, language barrier, lack of medications and services were listed as the main existing barriers to accessing MHPSS services. Limited supply of drugs at the health facilities was raised and echoed by the community as the main challenge in accessing mental health care. Evidence has shown that aside from lack of services, lack of knowledge about host country services, stigma around mental illness, linguistic obstacles and lack of cultural sensitivity (availability of interpreters and training of clinicians) led to the underutilization of MHPSS services by young refugees (Frounfelker, et al., 2020). According to members of the community, this has contributed to the exacerbation of mental health issues among the population of Alemwach Refugee Site.

VI. GAPS

1. Inadequate psychosocial support services targeting children and adolescents.
2. Limited information and awareness on mental health, coping skills and services available.
3. Constrained access to basic services namely energy, education and livelihood opportunities, health care and safe spaces (child and youth safe spaces, women and girls' safe spaces)
4. Absence of trauma informed interventions targeting children and adolescents due to the adversities that they have experienced.
5. Inconsistent provision of psychotropic medications and MHPSS services which leads to increased relapse and decreased quality of life.
6. Reduced funding for MHPSS interventions and suicide and self-harm response and prevention.
7. Lack of behavior change/modification interventions to address alcohol and substance use in the community.

VII. RECOMMENDATIONS

a. Integration of MHPSS to other sectors.

This can be guided by the MHPSS Minimum Service Package which outlines a set of activities that are of the highest priority in meeting the immediate critical needs of emergency-affected populations, based on existing guidelines, available evidence and expert consensus. The goal of the MSP is contributing to reduced suffering and improved mental health and psychosocial well-being among populations affected by humanitarian crises. Below are some of the key sectors:

i. Child protection

a. Strengthen the child protection programming for effective identification of children at risk and provision of needed support. This will support in addressing some of the risk factors for mental health issues.
b. Enhance the provision of trauma informed MHPSS interventions targeted towards children and adolescents. For example, trauma informed cognitive behavioral therapy and tree of life that utilize art in the processing and recovery from traumatic experiences.
c. Provision of life skills for in and out of school children to enhance their self-awareness and build on their skills to deal with day-to-day challenges.
d. Initiation of peer-to-peer groups for adolescents aimed at enhancing positive relationships with caregivers, friends, teachers, and others in the community. This is essential to children's self-esteem and sense of inclusion, supporting their optimal development.

Family/Caregivers

a. Enhance positive parenting sessions that will make them aware of distress reactions among children of different ages and promotion of parenting knowledge and skills. This will also offer support for caregivers in caring for children with mental health issues.
b. Provision of support for caregiver wellbeing through focused care for distressed caregivers and specialized/clinical care for caregivers with MNS disorders. Interventions to reduce caregiver stress and support caregiver mental wellbeing have the potential to positively influence adolescent mental health outcomes. Scalable interventions for example mhGAP for identification of MNS conditions and Group Problem Management Plus, Interpersonal Therapy can be implemented to support the caregivers.

ii. GBV

a. Enhance GBV case management for child survivors and girls and boys at risk
b. Provide individual and/or group MHPSS activities that promote the mental health and psychosocial well-being of boys and girls.
c. Advocate for the establishment of women and girls' friendly spaces
d. Male and Boys engagement in the prevention and risk mitigation of GBV

iii. Education

a. Advocacy for implementation of Socioemotional learning. Social and emotional learning is a process of acquiring social and emotional values, attitudes, competencies, knowledge, and skills that are essential for learning, being effective, well-being, and success in life.
b. Life skills and self-awareness training
c. Mental health literacy to enhance mental health awareness and wellbeing.
d. Teacher training on basic psychosocial support and promoting teacher wellbeing.

iv. Health

a. Screening, identification assessment and management of Mental, Neurological and Substance Use (MNS)conditions among children and adolescents
b. Nutritional support to children and caregivers with MNS conditions
c. Creation of awareness and stigma reduction campaigns towards MNS conditions
d. Advocacy for regular and consistent accessibility of psychotropic drugs
e. Addition of a psychologist to the clinical team

There is a strong need for integration of MHPSS programming and activities to other sectors as shown below.

Key considerations: Examples of how MHPSS can be integrated into programming across different sectors and areas of work

b. Community Based MHPSS Interventions

i. Strengthen and equip the Child Friendly Space (CFS) and Youth Friendly Space (YFS) with age appropriate educational and recreational materials to cater to the various age groups i.e. (0-4 years, 5-11 years, 12-17 years and 18-24 years)

ii. Creation of awareness of child and family wellbeing and protection needs. This will help to mobilize communities to take positive action by providing clear information about the needs of children and how to fulfil them. Interventions may include:
   1. Stigma reduction campaigns for mental health issues through awareness sessions on mental health
   2. Child protection messaging on key child protection risks and sources of support.
   3. Awareness creation sessions on key issues affecting children and adolescents for example alcohol and substance abuse, secondary movement.

iii. Strengthening of community support systems for child and family wellbeing acknowledges and strengthens community resources to support children and families. Interventions may include:
   4. Strengthen and empower community-based child protection networks and other community structures with basic psychosocial support skills to build capacity for outreach to vulnerable families.
   5. Involve caregivers as part of the community-based child protection networks and have regular sessions for feedback and also for provision of basic psychosocial support.
   6. Collaboratively work with community leaders, such as Refugee Central Committee (RCC), Women Association, religious leaders and youth association in promoting child protection and wellbeing.

c. Suicide prevention and response

Developing child and adolescent suicide prevention programmes for promoting mental, emotional and social wellbeing, preventing suicide and development of mental health conditions in addition reduces engagement in self-harm and risky behaviors. This can be

achieved through the four strategies as highlighted in the Helping Adolescent Thrive toolkit. They include:

i. Implementation and enforcement of policies and laws provides guidance on, laws and policy provisions to improve children mental health outcomes, embracing a whole-of-government, a whole-of-society approach.
ii. Environments to promote and protect children mental health focuses on actions to improve the quality of environments in schools, communities and digital spaces. This strategy seeks to enhance children' physical and social environments, through a range of evidence-based activities such as school climate interventions (life skills training), children's safe spaces in communities and teacher training.
iii. Caregiver support refers to interventions to build caregivers' knowledge and skills for promoting children' mental health; strengthen children' and adolescents' relationships; and support caregivers' own mental health and well-being.
iv. Child psychosocial interventions focus on evidence-based psychosocial interventions for universal, targeted and indicated promotion and mental health prevention.

d. Interventions targeting alcohol and substance use

Prevention programs aim to reduce modifiable risk factors known to increase the likelihood of initiation of substance use or development of a substance use disorder. Gordon's framework for disease prevention, which is also used by the United Nations Office on Drugs and Crime, classifies prevention programs as those that are applied universally to members of a population regardless of individual risk (universal prevention), to people at high risk for disease (selective prevention), or to those at high-risk and presenting with early, sub—threshold symptoms of disease (indicated prevention)

i. Early identification and management of mental health problems and hazardous and harmful substance use
ii. Universal substance use psychoeducation to the community
iii. Restriction of harmful use of alcohol and substance abuse
iv. Adolescent and youth groups engagement and peer to peer groups
v. Provision of Individual/group behavior modification interventions

e. Capacity building, Coordination and Advocacy

i. Strengthening of care systems for children and families through capacity building of professional and lay staff and volunteers in coordinated MHPSS care for children and families.
ii. Strengthen the referral systems for children with protection risks or MNS disorders.
iii. Strengthening MHPSS coordination through the MHPSS Technical Working Group (MHPSS TWG) as guided by IASC MHPSS Coordination Handbook, 2022.

iv. Mainstreaming the implementation of MHPSS Minimum Service Package (MHPSS MSP) for effective integration of MHPSS with other sectors
v. Advocacy for additional resources (financial and human) for effective implementation of MHPSS activities and interventions

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