Mental Health and Psychosocial Support needs among refugees in the Somali region of Ethiopia

Assessment report 2025

UNHCR The UN Refugee Agency | Ethiopia

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COVER PHOTOGRAPH
Somali refugees preparing to board a bus to the new Mirqaan settlement in Somali Region in 2023.
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Executive summary

The Somali Region of Ethiopia currently hosts over 350,000 refugees, primarily from Somalia. Forced to flee their homes, many have faced severe and interconnected challenges, including prolonged exposure to conflict and violence, the loss of livelihoods and community networks, and limited access to essential services. These factors contribute to elevated levels of psychological distress and increase vulnerability to mental disorders. In the absence of targeted mental health and psychosocial support (MHPSS), affected individuals may experience severe and prolonged distress, develop chronic mental health conditions, and have a reduced capacity to rebuild their lives, engage within their communities, and contribute productively to society.

This comprehensive assessment aims to deepen the understanding of the mental health and psychosocial support needs and resources of refugee communities in the Somali Region. The findings are intended to inform the development and delivery of responsive, inclusive, and culturally relevant MHPSS services that foster resilience, promote social inclusion, and strengthen local support systems in the Somali Region.

Following guidance by the Multi-sectoral Mental Health and Psychosocial Support Assessment Toolkit (IASC MHPSS Reference Group, 2024), a systematic needs assessment was conducted from October to December 2024 across nine refugee camps in the Somali Region. The mixed-methods assessment involved 1,289 respondents in a household survey and 770 participants in 72 focus group discussions.

Key findings

- **Nearly half of respondents reported mental health issues**, including sadness, hopelessness, flashbacks, and anxiety.
- The assessment documented symptoms of **severe mental health conditions**, including psychosis, and reported **cases of suicide**.
- **Loss of livelihoods and ongoing adversity** are significant sources of psychological distress.
- **Women and youth are disproportionately affected**. Gender-based violence (GBV) is a major contributor to psychological distress among women, while youth face stressors related to limited education, unemployment, and lack of livelihoods.
- **Mental illness is highly stigmatized in the Somali communities.** Over one-third of respondents stated that individuals with mental health conditions are not accepted in their communities, and one-fifth cited shame as a barrier to seeking care. **Harmful practices including chaining and confinement** for people with severe mental health conditions are prevalent.
- **Families are the main caregivers** but often lack the resources and knowledge to provide adequate support. Emotional and physical exhaustion among caregivers is common.
- **Formal MHPSS services are extremely limited**. Barriers include lack of specialized services, shortages of psychotropic medication, long travel distances, and health workers who are insufficiently trained in mental health.

Recommendations

(See page 39 for details)

1. Strengthen integration of refugees into national mental health and protection systems.
2. Invest in government capacity and ownership for refugee MHPSS.
3. Advance UNHCR's protection mandate through MHPSS integration into multisectoral planning.
4. Support integration of mental health into primary health care in refugee sites
5. Strengthen community-based psychosocial support in refugee and host communities.
6. Expand MHPSS to in education, GBV and child protection.
7. Partner with academia and Ethiopian universities for capacity building and research.
8. Support data collection, monitoring, and learning.

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Acronyms

FGD	Focus group discussion
FGM	Female genital mutilation
GBV	Gender-based violence
IASC	Inter-Agency Standing Committee
IMC	International Medical Corps
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MNS	Mental, neurological, and substance use
MSP	Minimum Service Package
MTI	Medical Teams International
NGO	Non-governmental organisation
OWDA	Organization for Welfare and Development in Action
PRM	Bureau of Population, Refugees, and Migration
PTSD	Post-traumatic stress disorder
RCC	Refugee Central Committee
RRS	Refugees and Returnees Services
TWG	Technical Working Group
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Introduction

Displacement contexts are marked by heightened mental health and psychosocial support needs.

Populations affected by conflict and displacement are at increased risk of experiencing mental health conditions. The World Health Organization (WHO) estimates that one in five of people living in conflict-affected areas have a mental health condition, with one in 11 living with a moderate to severe mental health condition (Charlson et al., 2019). According to a recent systematic review and meta-analysis, at least one third of adult refugees and asylum-seekers live with a mental illness (Blackmore, Boyle, et al., 2020). While these rates offer a general indication of the devasting impact of conflict and displacement, actual prevalence rates can vary significantly across settings depending on factors such as the severity of the crisis, the availability of community and social support, and the capacity of local mental health and social care systems. Moreover, certain population groups are disproportionately at risk. Displaced women, for example, often have more mental health challenges, due to differences in exposure to potentially traumatic events, including higher rates of sexual violence (Hanáková et al., 2024), as well as gender-specific social and structural risk factors related to living in refugee camps (Im & Swan, 2022; Lambert et al., 2024). Similarly, refugee children and adolescents are also significantly affected by mental health conditions, with a recent meta-analysis estimating high rates of PTSD (23%), anxiety (16%), and depression (14%) (Blackmore, Gray, et al., 2020). Refugees with mental health conditions are at risk for educational disadvantage, unemployment, and poor social integration in host communities, which can significantly impact their life trajectories (Silove et al., 2017).

The impact of displacement on mental health is often worsened by disrupted social networks and support but also limited availability of adequate mental health and psychosocial (MHPSS) services. Especially in low- and middle-income countries access to such services often remains scarce (Dickson et al., 2024). Yet, addressing the mental health and psychosocial needs of displaced populations is crucial to improving their quality of life, well-being and long-term prospects (Sheath et al., 2020). Given these factors, understanding mental health and psychosocial needs and improving the availability and quality of MHPSS is critical for mitigating psychological distress and fostering resilience among displaced populations (IASC, 2007, 2022; UNHCR, 2024).

The Refugee Context in Ethiopia

Ethiopia hosts over one million refugees, with nearly one-third residing in the Somali Region in the country's east.

Ethiopia has a long-standing tradition of hosting refugees and maintains a progressive asylum policy that facilitates humanitarian access and guarantees protection for those seeking refuge. It is the third largest refugee-hosting country in Africa, with 1.1 million registered refugees and asylum seekers in 2025 (UNHCR, 2025). The majority originate from South Sudan, Somalia, Eritrea, and Sudan. They are accommodated in 27 refugee camps, sites, and settlements spread across six regional states: Afar, Amhara, Tigray, Benishangul-Gumuz, Gambela, and Somali. The Somali Region, situated in eastern Ethiopia and bordering Somalia, Djibouti, and Kenya, hosts 360,131 refugees as of August 2025 (UNHCR, 2025). Refugees in Somali Region are primarily settling in three locations: Jijiga, Bokh, and Melkadida (see Figure 1).

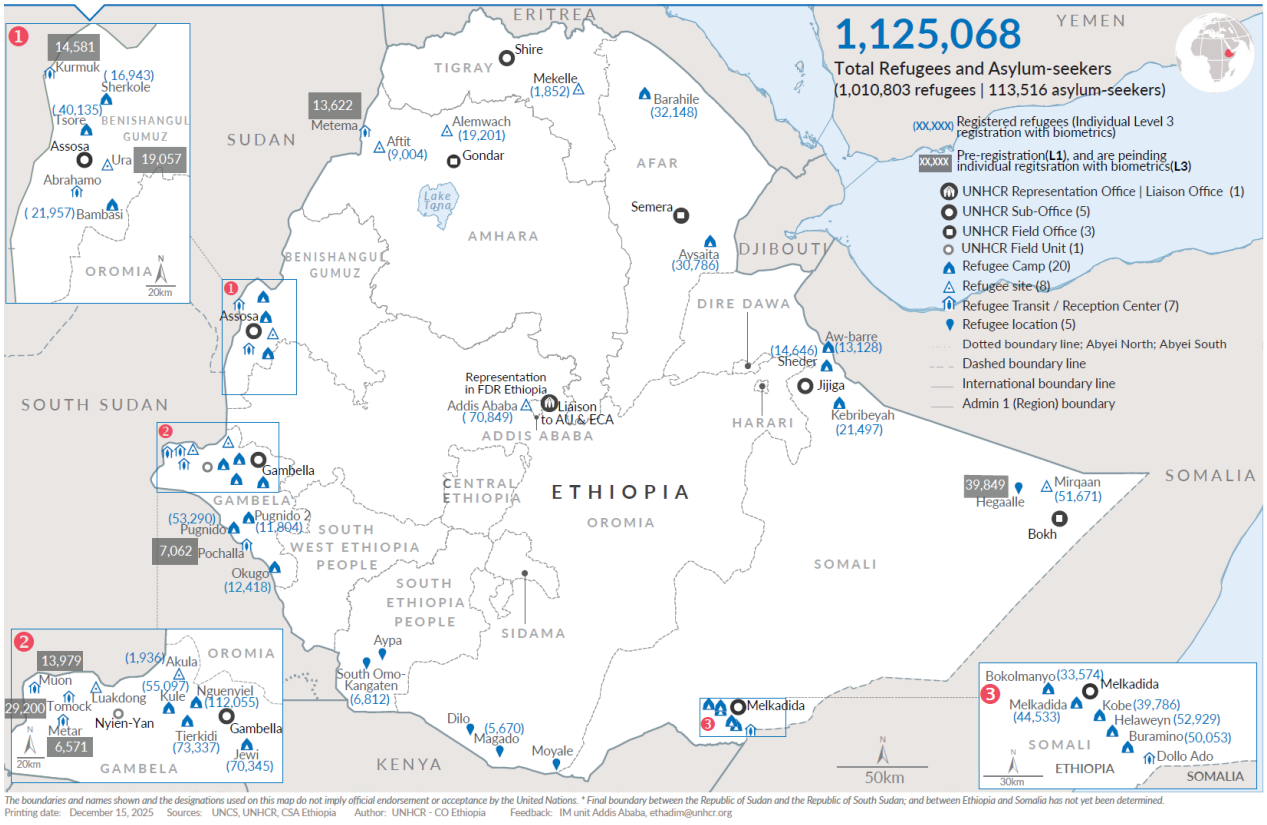

Figure 1. Map of Ethiopia showing the registered refugee population as of November 2025. (UNHCR, 2025).

Refugees in the Somali Region

Jijiga, the capital of the Somali Region in Ethiopia, serves as a critical hub for refugees, particularly those fleeing instability and environmental challenges in Somalia. In August 2025, Jijiga hosted 48,049 refugees across three camps: Aw-Barre, Kebribeya, and Shedder (UNHCR, 2025). Bokh, located in the far eastern part of Ethiopia, has emerged as a crucial refugee-hosting area following the outbreak of conflict in northern Somalia in early 2023 (UNHCR, 2023). Bokh hosted 91,372 refugees in one refugee site (Mirqaan) and spontaneously settled across the host community (Hegaalle) as of August 2025 (UNHCR, 2025), with refugees and the host community often sharing essential services (IOM, 2023). Melkadida, the third key refugee-hosting area in Ethiopia's Somali Region, is similarly home to a substantial refugee population primarily from Somalia. Here, 220,350 refugees lived across five camps (Bokolmanyo, Kobe, Melkadida, Helaweyn, and Buramino) as of August 2025 (UNHCR, 2025).

The Somali refugee population in Jijiga, Melkadida, and Bokh has been driven from their homes primarily by two interrelated factors:

1. **Conflict and violence**: Prolonged insecurity has left many Somalis with no choice but to flee. Armed groups, including Al-Shabaab, continue to pose a significant threat, particularly in southern and central Somalia, where civilians are frequently caught in the crossfire of violent confrontations (UNHCR, 2022). Recurring hostilities have made it difficult for many to return home, forcing them to seek long-term refuge in neighbouring Ethiopia.
2. **Environmental disasters:** Recurrent droughts and other environmental shocks severely impact communities reliant on pastoralism and subsistence agriculture. With water sources drying up and pastureland becoming increasingly scarce, many Somali families have been forced to migrate in search of food, water, and livelihood opportunities (UNHCR, 2022).

Given the complex and often traumatic experiences that have led to displacement, refugees in the Somali Region are at high risk of significant mental health and psychosocial challenges. Displacement stressors, compounded by limited access to services and prolonged uncertainty, underscore the critical need for a comprehensive assessment of the mental health and psychosocial needs. Such an assessment is essential to better understand the specific needs, coping mechanisms, and service gaps within these communities, and to inform targeted, culturally appropriate, and sustainable MHPSS interventions.

Assessment Methodology

This assessment applied a comprehensive multi-methods approach to identify mental health and psychosocial support needs and resources among refugees in Ethiopia's Somali Region.

Objective

The objective of this assessment was to strengthen the understanding of mental health and psychosocial needs, coping mechanisms, and service gaps among refugee communities in the Somali Region in order to inform evidence-based MHPSS programming and improve service delivery.

Setting

The assessment was carried out in Ethiopia's Somali Region, covering nine refugee camps in Jijiga (Kebribeyah, Awbare, and Sheder camps), Melkadida (Melkadida, Kobe, Hilaweyn, Bokolmanyo, and Buramino camps), and Bokh (Mirqaan site) as well as nearby health facilities.

Conducted between 21st October and 13th December 2024, the study was led by UNHCR MHPSS specialists, with support from the Ethiopian Government's Refugees and Returnees Service (RRS) and stakeholders from local authorities, health facilities, (I)NGOs, and community structures.

Sources of Information

The assessment utilised tools adapted from the Multi-Sectoral MHPSS Needs and Resources Assessment Toolkit (IASC MHPSS Reference Group, 2024). This toolkit is designed to support and guide the integration of MHPSS into both sector-specific and multi-sectoral assessments to strengthen humanitarian response efforts. We used the following data collection tools from the Multi-Sectoral MHPSS Needs and Resources Assessment Toolkit for this assessment:

Brief Desk Review

We carried out a brief desk review using the MHPSS Needs and Resources Assessment Toolkit desk review template to provide an overview of existing information on MHPSS within the refugee population in Somali Region.

Household survey

We used a structured survey to assess the level of psychological distress in the community, patterns of help-seeking, and barriers to accessing MHPSS services (Tool 5: Survey of mental distress and help-seeking in humanitarian settings). The tool was adapted to the context of the Somali Region, adding questions primary

related to suicide ideation and behaviour as well as substance use. The questionnaire is available upon request.

Focus Group Discussion

We used the tools described below to explore community and stakeholder perceptions of MHPSS needs and resources in the community:

- Tool 6A: Topic guide for community members: adults, including caregivers
- Tool 6B: Topic guide for children and adolescents
- Tool 7: Topic guide for formal and informal service providers
- Tool 8: Topic guide for people with lived experience of mental health conditions

Facility Visits

We used a structured guide (Tool 10: Checklists for integrating mental health into general health care) to carry out visits to health facilities in the refugee settings.

Procedures & Participants

Brief Desk Review

A brief desk review was conducted to provide a basic overview of existing information and inform the subsequent collection of primary data. Relevant literature was searched using academic databases, including Google Scholar and PubMed. The unsystematic searches included combinations of keywords related to the population (e.g., refugees), context (e.g., Somali Region), and variables of interest (e.g., mental health, psychosocial well-being, mental health care). Sources were selected based on their relevance to the study objectives and thematic focus. Given that a comprehensive desk review on the mental health and psychosocial well-being of Somali refugees was conducted by UNHCR in 2016 (Cavallera et al., 2016), the brief desk review prioritized more recent studies to capture newly generated evidence.

Household survey

The target population for the household survey were adult refugees. The sample size calculation was achieved for each refugee location through an online tool by UNHCR's Information Management team. The objective was to ensure representativeness at each refugee location level. Sample sizes were determined to ensure statistical representativeness for each assessed refugee location, applying a 95% confidence interval (CI) and a 5% margin of error. The sampling frame was based on the latest population figures from the refugee database *proGres v4*, and the design incorporated gender and age stratification to minimise potential bias. The sample size was divided into the different zones in the camps. For the selection of respondents, no predefined list was designed, and a systematic sampling method was applied to select households physically present in the camp during data collection. The respondents were selected ever five houses in the selected zones in Jijiga and Melkadida and every two houses in Bokh the various camps. In each selected household, one adult per household was invited to participate in the household survey. The reason of not using a predefined list and a reserve list generated from proGres during the data collection are many: refugees are not always presents in the camps, even if they are in the camps they change their addresses and the household addresses in the camps are not updated in proGres.

A total of 1,336 individuals were approached, of whom 22 declined to participate. Among the 1,314 who consented, eight were excluded from this assessment report because they were not of Somali origin, and 17 were excluded for being under the age of 18. This resulted in a final sample of *N* = 1,289 respondents, all Somali refugees. Detailed socio-demographic information is presented in Table 1. The majority of respondents were female (62%) and between the ages of 18 and 59 (95%). All participants spoke Somali. Most respondents in the household survey were long-term residents of displacement camps, with approximately two-thirds having lived in the camps for more than six years. When asked about the reasons for their displacement, 81% cited war, followed by conflicts (49%), insecurity (30%), poverty (29%), inequality (7%), and discrimination (6%). Table 2 shows the distribution of the sample to the nine camps where assessments took place.

All data was collected digitally using the Kobo Toolbox platform by trained data collectors. The interviews were conducted in Somali language. All 60 (41 male, 19 female) data collectors had experience in conducting MHPSS needs assessments and familiarity with using Kobo. Prior to the assessment, all data collectors received an eight-hours orientation session on basic concepts in MHPSS and suicide, enabling them to accurately interpret MHPSS-related terms and suicide-related expressions into the local language. The training also emphasised the importance of confidentiality and the necessity of making immediate referrals for individuals identified as being at risk.

Somali refugees warm up before playing football. © UNHCR/Diana Diaz

Table 1. Socio-demographic characteristics of respondents (N = 1289) in the household survey.

Characteristic	n	%
Gender		
Female	803	62.3%
Male	486	37.7%
Age group		
18 – 59 years	1236	95.9%
> 59 years	53	4.1%
Education		
No formal education	633	49.1%
Primary education completed	388	30.1%
Secondary education completed	192	14.9%
University degree	58	4.5%
Vocational or technical training	18	1.4%
Occupation		
Unemployed	774	60.0%
Self-employed	209	16.2%
Casual worker	176	13.7%
Student	90	7.0%
Steady employment	35	2.7%
Displacement		
Once	1119	86.8%
Twice	129	10.0%
> 2 times	41	3.2%
Time in camp		
< 1 years	6	0.5%
1 – 2 years	332	25.8%
3 – 5 years	39	3.0%
6 – 10 years	243	18.9%
> 10 years	669	51.9%

Table 2. Household survey respondents in each assessment location.

Location	n	%
Jijiga	**295**	**22.9%**
Kebribeyah camp	120	9.3%
Aw-barre camp	90	7.0%
Sheder camp	85	6.6%
Melkadida	**659**	**51.1%**
Melkadida camp	148	11.5%
Buramino camp	144	11.2%
Hilaweyn camp	143	11.1%
Bokolmanyo camp	125	9.7%
Kobe camp	99	7.7%
Bokh	**335**	**26.0%**
Mirqaan site	335	26.0%

Focus Group Discussions

Focus group discussions were conducted in each camp. Participants were selected purposefully based on key participant categories, these included:

- **Children** (ages 7–11 years, 12–14 years, and 15–17 years)
- **Community representatives**, including Refugee Central Committee (RCC) members, block leaders, religious leaders, persons with disabilities, women and youth representatives, and older persons
- **Women**, including those at heightened risk of gender-based violence
- **Individuals with lived experience of mental health conditions**
- **Caregivers** of people with mental health conditions
- **Key institutional actors**, such as staff from education, health, and protection sectors, implementing partners, and government officials from the Refugee and Returnee Service, the Ministry of Health, and the Bureau of Women and Children Affairs

Each focus group discussion consisted of 7 to 20 participants and lasted between one and two hours. They were facilitated by one assessor and supported by a community-based interpreter. The assessors were UNHCR MHPSS experts. Discussions were held in safe and confidential spaces, such as schools, child-friendly spaces, women's centres, or other community venues. In total, 72 focus group discussions were conducted, involving 770 participants. Table 3 provides a breakdown of the number of focus group discussions conducted per category in each location.

The focus group discussion took place with the help of interpreters translating from English to Somali. During the focus discussions, assessors took detailed field notes, which were subsequently transcribed and analysed. Initially, data from each assessed group were analysed individually to identify recurring patterns and themes. These findings were then shared among the three assessors to cross-check information, discuss emergent themes, and reach consensus on the most salient and recurrent themes.

Table 3. Number of focus group discussion by participants categories in each location.

Focus group discussions	Bokh	Jijiga	Melkadida	Total
Children	3	9	15	27
Community representatives	1	3	5	9
Women	1	3	5	9
Key institutional actors	1	3	5	9
Caregivers of people with lived experience	1	3	5	9
People with lived experience	1	3	5	9
Total	**8**	**24**	**40**	**72**

Site Visits

As part of the site visits, the MHPSS team visited the refugee camps and health facilities to assess the provision of MHPSS services. A total of 13 health facilities were visited, including nine health centres located within the refugee camps and managed by UNHCR health partners (OWDA, MTI and DICAC), two government-run institutions (Bokh health centre and Dolo Ado Primary Hospital), and two community-based health facilities (one *Ilaaj*, a private, faith-based institution, and Janaale Community Clinic). Interviews were conducted with the heads or assistant heads of the institutions, and in their absence, with the doctors or medical personnel in charge. The assessment included the number and type of staff and their training, the types of MHPSS services provided and the availability of psychotropic medication.

Ethics

Initial consultative meetings were conducted with the Ethiopian Refugees and Returnees Service (RRS) and partner organizations to obtain approval and foster collaboration for the planned assessment. Following this, consent of the respondents and caregivers of children engaged was obtained before engaging them in the assessment and thus, only participants that agreed to take part in the assessment were interviewed. In doing so, the nature of the study and its purpose was explained, and the identity of informants or participants was concealed in order not to harm their safety, dignity and privacy as guided by the UNHCR Data Protection Policy.

To ensure appropriate oversight and support, mental health professionals from the MHPSS partners in the field were assigned as supervisors. In each camp, a multifunctional team was established comprising representatives from the MHPSS TWG (when existing), partner organizations, RRS, and community leaders. While the technical staff provided supervisory roles, they were also tasked with offering immediate psychosocial support to individuals identified as at risk of suicide, ensuring timely referral and follow-up care.

Balumu, 19 years old, escaped clashes in Somalia, that killed her husband and other 25 people from her neighborhood. © UNHCR/Reath Riek

Assessment Findings

Data shows high psychological distress, stigma, and major barriers to mental health and psychosocial support among refugees in Ethiopia's Somali Region.

Brief Desk Review

In 2016, UNHCR published a comprehensive report on the culture, context, and mental health of Somali refugees (Cavallera et al., 2016). Based on an extensive literature review and key informant interviews, the report explores how cultural and contextual factors mould the mental health experiences of Somali refugees and offers insights for practitioners working in MHPSS. The Somali population has been profoundly affected by prolonged exposure to violence, hardship, and displacement. These experiences can have had deep and lasting impacts on individual and collective mental health and psychosocial wellbeing. To understand these impacts, it is important to realise how deeply embedded cultural and religious values shape Somali understandings of mental and psychosocial problems. These beliefs influence not only how distress is perceived and explained, but also the methods of treatment that are considered appropriate.

Cultural concepts of mental health and idioms of distress

(Based on Cavallera et al., 2016)

Among Somali, mental health issues are rarely framed in psychological terms are often considered a medical disorder but are often interpreted through spiritual and social lenses (see Table 4). Somali culture expresses mental distress through a rich vocabulary rather than through Western psychiatric categories. The most severe condition, *waali* (madness), denotes psychosis-like symptoms and carries strong stigma; those labeled *waalan* are often socially excluded and considered irrecoverable—illustrated by the proverb *Lafjabtay sideedii mano qoto* ('a broken bone cannot be fixed'). Milder emotional distress is described in somatic and experiential terms—pain, fatigue, sleeplessness—rather than psychological. Emotional suffering is conveyed through idioms such as *murug* (sadness), *qalbi-jab* (broken heart), *niyad-jab* (broken spirit), and *buufis* (restless longing for migration). These terms often link emotional and physical pain, reflecting the inseparability of mind, body, and spirit in Somali worldview. Emotional distress is not typically medicalized unless it disrupts daily functioning.

Table 4. Somali terms for mental illness and psychological distress.

Somali Term	Translation	Interpretation
Waali / Waalan	Madness / insane	Severe mental disorder with stigma
Murug	Sadness	Ranges from mild sorrow to depression
Qalbi-jab	Broken heart	Linked to disappointment or loss
Niyad-jab	Broken spirit	Hopelessness, demoralisation
Buufis	"Balloon-like" longing	Migration-related anxiety or obsession

Source: Cavallera et al., 2016 (pp. 29 – 32)

Explanatory models of mental illness and psychosocial problems

(Based on Cavallera et al., 2016)

Somali explanatory models combine religious, supernatural, and emotional understandings (see Table 5). Illness is often viewed as *Qadar Allah* (God's will), either as divine punishment, a test, or fate, yet people still actively seek healing. Mental distress may also be attributed to possession by *jinn* (spirits), believed to cause symptoms from fear and violence to paralysis. Treatment includes Qur'anic recitations, amulets, or holy water rather than biomedical care. Other explanations involve *maseeyr* (jealousy, often linked to polygamy), love disappointment, or excessive emotions, particularly affecting women. Biological or psychological explanations are rarely recognized. These overlapping models influence how Somalis interpret suffering, choose healers, and view recovery, blending faith, morality, and social harmony into concepts of wellness.

Table 5. Explanatory models of mental illness in Somali refugee communities.

Explanatory Cause	Local Term	Typical Interpretation
Divine will	*Qadar Allah*	Fate, punishment, or test from God
Spirit possession	*Jinn*	Supernatural disturbance causing illness
Excessive jealousy	*Maseeyr*	Emotional cause of female distress
Love disappointment	—	Leads to crying, sadness, or 'madness'
Social/moral weakness	—	Opens one to spirit attack or misfortune

Source: Cavallera et al., 2016 (pp. 38 – 42)

Help seeking behaviour

In Somali discourse, the mind, body, and spirit are viewed as inseparable, and distress is frequently expressed in somatic language. Consequently, when Somalis seek support for negative emotional states, they often turn first to religious and traditional healers. Moreover, for many Somali refugees, the extended family and paternal clan serve as primary sources of emotional and social support. This reflects cultural norms but is also the consequence of the limited accessibility of formal mental health services in Somali refugee settings. Somali refugees often do not use medicalized labels for mental health problems and are often not inclined to seek help in the formal health system. The report also draws attention to the heightened vulnerability of individuals with severe mental disorders, such as psychosis. These individuals are at significant risk of maltreatment and human rights abuses. Somali terms used to describe severe mental illness often carry strong negative connotations, contributing to stigma and shame. As a result, many people with severe mental health conditions are unable to access appropriate care, either due to the lack of available services or because of social exclusion. For MHPSS systems to be effective, they must take into account traditional support systems, cultural interpretations of mental health, and the barriers that prevent access to care, particularly for those experiencing severe mental health challenges.

Research shows that Somali refugees rely on informal support, but face major gaps in formal mental health care due to cultural and structural barriers.

Since the UNHCR review on the culture, context, and mental health of Somali refugees has been published (Cavallera et al., 2016) additional research publications on Somali refugees similarly consistently emphasizes the prevalence of contextual understandings of mental health challenges and the central role of informal support systems (Im et al., 2024; Kindie et al., 2023). Few recent studies have specifically investigated aspects of mental health and psychosocial support among refugees living in the Somali Region. No empirical study with refugees in Ethiopia published after 2018 was found during the literature search for this assessment. Findings from focus group discussions with Somali refugee youth in Kobe camp in the Somali Region found that lack of access to education, safety and security concerns, early marriage and harmful traditional practices profoundly affect mental health and psychosocial well-being (Ortiz-Echevarria et al., 2017). Murray et al. (2018) evaluated a common elements psychotherapeutic approach for conflict-affected Somali children and their caregivers in three refugee camps in the Somali Region (Kebri Beyah, Sheder, and Aw Barre). The intervention, delivered by trained lay providers, led to reductions in internalizing, externalizing, and post-traumatic stress symptoms, and improved overall well-being. Qualitative findings indicated that the psychological intervention was generally well accepted. However, it was described that participants expressed urgent needs for access to basic support (e.g., blankets, sleeping mats, help with resettlement) and that participants' religious and cultural views influenced engagement with the intervention. In particular, it was pointed out that many in the camps believed that mental health issues stem from a higher religious power and are best addressed through reading religious texts, making counselling a relatively unfamiliar and less accepted form of treatment (Murray et al., 2018). Warfa et al. (2023) outline the current state of mental health services in the Somali Region, revealing significant gaps in care. Although their focus is not specifically on MHPSS for refugees, their observations are highly relevant as Ethiopia aims for inclusion of refugees in national health system (ILO, 2024). According to their observations, Somali Region lacks specialized psychiatric hospitals, private psychiatric services, and clinical psychology facilities (Warfa et al., 2023). Moreover, mental health services availability in general hospitals was also identified as being severely limited. Lastly, the authors describe that there are no dedicated child mental health services or specialist addiction clinics in the region. These observations align with the limited mental health care resources in Ethiopia documented in the WHO Mental Health Atlas (WHO, 2021), and highlight Somali Region as a particularly under-resourced region.

Semier, 23, and her five children (Hafta 9, Mako 7, Madina 5, Nimo 3 & Hiyman 1) fled to Ethiopia's Somali region. © UNHCR/Reath Riek

Site Visits

Bokh

The community-based hospital in Bokh, the Janaale community clinic, established by the Somali diaspora, is located approximately nine kilometres from both the host community centre and refugee settlements, limiting its accessibility. The hospital does not have a psychiatric department, nor does it employ staff trained in WHO's mhGAP, highlighting a critical gap in mental health service provision. The Bokh Health Centre, a governmental primary health facility located approximately one kilometre from the refugee centre, offers only basic healthcare services. It lacks trained mental health professionals, with general clinicians prescribing psychotropic medication (i.e. mostly antiepileptics) to patients.

The health facility in Mirqaan Settlement, operated by UNHCR's partner Organization for Welfare and Development in Action (OWDA), is staffed by one medical doctor, one health officer, four nurses, two midwives, two laboratory technicians, one nutrition supervisor, two outpatient nurse, and one senior nurse. While the facility receives medications through UNHCR with support from WHO, the supply is limited and considered insufficient, particularly for mental, neurological, and substance use conditions. There is no psychiatric nurse on staff, and none of the clinicians are trained in mhGAP. Staff reported a high prevalence of epilepsy among the population and noted frequent disruptions in the supply of essential medications. In summary, Bokh district lacks any health personnel trained in mhGAP, and there are no psychiatric nurses or specialized mental health staff across the entire district.

Jijiga

In Jijiga, each of the three refugee camps has a health centre that provides medical services, managed by UNHCR's health partner Medical Teams International (MTI) at the time of assessment. On average, these centres receive 100-120 patients daily. Each health centre is staffed with a medical doctor, a health officer, a nurse, a pharmacist, and a psychiatric nurse. However, the health staff have limited training in mental health and psychosocial support. Services are primarily focused on medication, with minimal or no provision of psychosocial interventions or community-based outreach. Additionally, the availability of essential psychotropic medication remains inadequate.

In Jijiga, there are private faith-based inpatient mental health centres known as *Ilaajs* that use a combination of religious healing by Sheiks and medication provided by part-time nurses. Refugees from Jijiga reported attending these centres, as also confirmed by WHO colleagues. These centres have been supported with mhGAP training, but access to psychological care is not available, and coercive practices (such as chaining) have also been reported.

Melkadida

Each of the five camps in Melkadida has at least one health center, managed by partners with support from UNHCR. Psychiatric nurses trained in mhGAP are present across the camps and provide general mental health care. With funding from the United States (Bureau of Population, Refugees and Migration – PRM), the implementing partner International Medical Corps has expanded community-based MHPSS services. These include livelihood initiatives and other community-driven activities that have significantly strengthened the coping mechanisms of refugees in the camps. Additionally, a visit was conducted to Dolo Ado Primary Hospital which is the main referral hospital in Melkadida. The hospital has a consultant senior specialist who supports with psychiatric outpatient care. The hospital does not have a unit for psychiatric cases.

Melkadida Refugee camp in Melkadida, Somali region of Ethiopia. © UNHCR/Tiksa Negeri

Among men, increased aggression was noted, including behaviours such as throwing stones and acting erratically. In Bokh, stakeholders identified overthinking and stress as common issues, often linked to unemployment and discrimination. In Jijiga, respondents linked psychological distress to potentially traumatic experiences such as the loss of family, discrimination and harmful practices such as forced marriage. Focus group discussion participants also highlighted that signs of depression, social isolation, addiction, and hopelessness are particularly observed in relation to financial stress. Participants also reported incidents of rape affecting both girls and boys, and mentioned the long-term psychological and social consequences, including social isolation.

More severe psychiatric conditions, such as psychosis, were also reported in the focus group discussions. In some cases, individuals displaying aggressive or erratic behaviours were reportedly chained at home, a practice described as a protective measure for both the individual and the community.

Psychogenic seizures

During focus group discussions in Jijiga, participants reported that adolescent girls may suddenly faint. They mentioned that this occurred particularly among girls who had been married at a very early age and felt unhappy in their marriage but had no means of discussing their issues with anyone. According to the participants, fainting could also occur in girls and women who had experienced 'bad things' (such as being beaten, denied food by their husbands, or subjected to sexual violence), which they were unable to talk about. When girls or women would recall the events that had happened to them, they could feel so distressed and overwhelmed that they collapsed to the ground.

In focus groups with teachers and NGO workers in Sheder and Keribeyah, reports emerged of multiple girls fainting simultaneously in school settings. Participants described episodes in which schoolgirls began shouting and became agitated, followed by one girl fainting, after which the others also fainted, resulting in an entire classroom of girls collapsing. Some stakeholders, including health workers, noted that the girls and their families were reluctant to seek care at health centres. Many refugees reportedly believe the phenomena are linked to evil forces and therefore seek help from religious or traditional healers, including herbal remedies. While the assessment did not explore the cases in sufficient depth to determine specific mental health conditions, the symptoms described are consistent with a phenomenon known as mass psychogenic illness.

"Girls don't control their emotion. For example, first one girl faints and then all the girls faint. The whole class faints […] We don't know how to act, we don't know if it is epilepsy or another problem […] We need training to help these girls."

Gender-based violence officer working with an NGO in Sheder camp

Substance Use

Across focus group discussions, substance use emerged as a major concern in the community. Participants identified several contributing factors, including educational challenges, easy access to substances, and socio-economic hardships.

In Melkadida, one of the most commonly abused substances is tramadol, an opioid painkiller consumed both in pill form and via injection. In addition to tramadol, *khat* - a legal stimulant in Ethiopia and Somalia - is widely consumed due to its affordability and cultural acceptance. Tramadol and *khat* are available in local shops. Alarmingly, participants noted increasing tramadol abuse among children. Health workers were also mentioned as frequent users, relying on the drug to sustain energy levels during long working hours. Partners and stakeholders highlighted that tramadol and khat use is particularly prevalent because it is easily accessible, not heavily regulated, and no policies exist to govern the substance use. Community leaders raised further concerns about the misuse of prescription medications, noting that some caregivers mix tramadol into children's drinks to boost their energy, inadvertently fuelling addiction from an early age. This practice has resulted in school dropouts and severe health complications in children. Women participating in the focus group discussions reported that men struggling with substance dependency often neglect their familial responsibilities and engage in domestic violence.

Suicidality

Across multiple focus group discussions, participants reported instances of individuals expressing suicidal thoughts. Common methods mentioned included hanging (using ropes) and self-poisoning. In Melkadida, participants highlighted a particularly high number of suicide attempts within the camps. Suicidality was frequently linked to loneliness, forced marriages and gender-based violence. Women in the discussions noted that while suicide attempts are relatively frequent, religious and cultural beliefs often prevent open reporting. It was emphasized that even in cases where individuals die by suicide, families and communities tend to conceal the cause to avoid stigma and social repercussions.

Amiin (name changed for protection concerns) lost his mother years ago, lost his father to the conflict and found himself completely alone. © UNHCR/Diana Diaz

Local Conceptualization of Mental Health Problems

Focus group participants used various terms to describe individuals living with mental health problems. These terms primarily referred to people with severe mental health conditions and carried stigmatising connotations. Participants living with severe mental health conditions reported being labelled with expressions implying insanity and madness such as *waali / waalan, usidayi, wuuku dhuftay,* and *wuu isla hadlay*. While terms are frequently used in the communities, they are considered disrespectful and humiliating. Focus group participants also used words derived from Arabic such as *mushakil* (meaning 'problem') and *fikr* (meaning 'to think').

Respondents in the household survey expressed commonly held beliefs and perceptions about individuals with mental health problems, many of which reflect that mental health problems are primarily understood as severe mental health conditions. Regarding the causes of mental health problems, 46% (n = 592) described affected individuals as having a brain disorder, 24% (n = 312) attributed mental health conditions to possession by evil spirits, 10% (n = 127) believed conditions were inherited, and 9% (n = 110) linked mental health issues to substance abuse. In terms of symptoms, people with mental health problems were perceived to talk to themselves (35%, n = 451), experience sleeplessness (23%, n = 296), nightmares (11%, n = 141), uncoordinated speech (8%, n = 103) and epilepsy (5%, n = 64). In terms of perceived behaviour and risks, 33% referred to individuals with mental health problems as "a crazy person" (n = 428), 22% (n = 286) believed they frequently run away from home, 20% (n = 262) considered them dangerous, and 13% (n = 163) described them as not taking care of themselves or their children.

One in three refugees say people with mental health conditions are not accepted in their community. One in five considers them as dangerous.

When asked about the social acceptance of individuals with mental health problems, 34% (n = 443) of respondents stated that they were not accepted, a sentiment echoed by caregivers and individuals with lived experiences during focus group discussions. Many reported being regarded as misfortunes or outcasts within their communities.

Sources of Distress

Respondents in the household survey highlighted a range of stressors contributing to mental health challenges, many of which are linked to ongoing social, economic, and security-related hardships. Displacement was identified as the most significant stressor by 52% (n = 584) of respondents, followed by loss of property (42%, n = 543), loss of livelihood (38%, n = 496), and experiences of gender-based violence (34%, n = 438). Further stressors to mental health included difficult living conditions, lack of basic services, and long stay in the camps (see Figure 2).

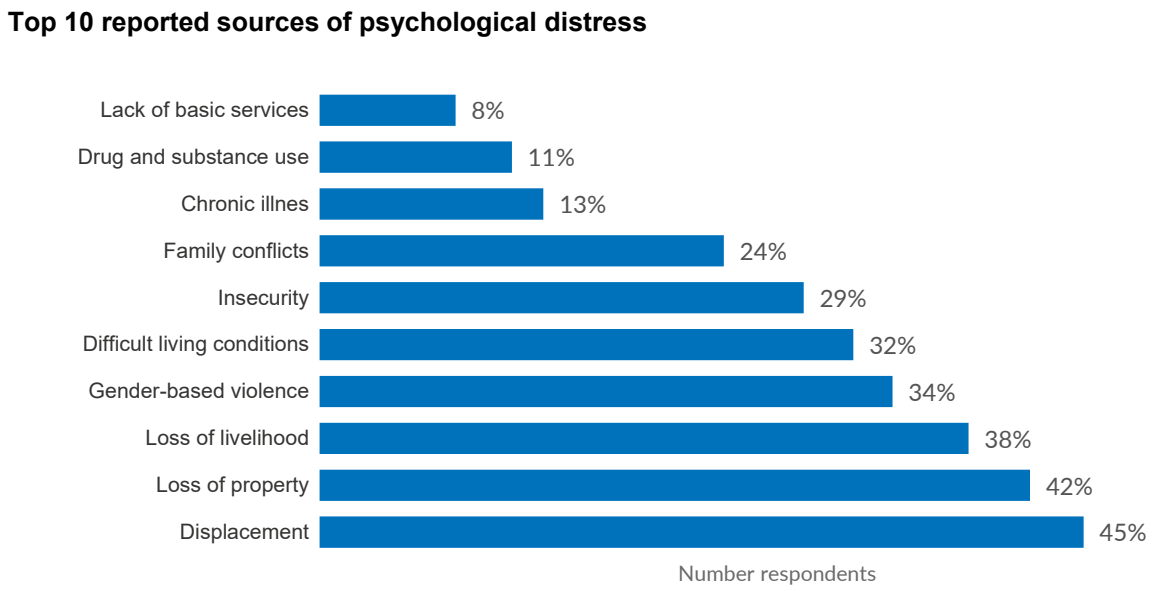

Figure 2. Reported sources of psychological distress in the communities.

These findings aligned with insights shared during focus group discussions. Although mental health issues were often attributed to God's will by participants, there was also recognition that war causes suffering and mental illness. When discussing experiences in their home country, participants identified witnessing the killing of family members, kidnappings, and the seizure of their properties as sources of distress and suffering. Additionally, grief and the loss of loved ones were frequently mentioned as contributing factors to mental distress.

"Some children, born as their mothers fled war and hardship, are now living with mental health challenges linked to that trauma."

48-year-old male community leader in Bokh

Participants emphasized the significant changes they observed in their family and community members following displacement. In the camps, women particularly highlighted the stress of being unable to provide adequate food and care for their children, alongside education-related concerns affecting their children's mental health. A lack of educational opportunities and limited future prospects were also consistently raised as major concerns by children and youth during the focus group discussions. Key stressors included lack of school enrollment, restricted access to educational materials, difficulties with exams, and the frustration of young people who graduate from higher education but face limited job opportunities. These challenges were reported to contribute significantly to emotional distress and feelings of hopelessness among young people.

Mental Health Implications of Gender-based Violence

During focus group discussions, community leaders reported that gender-based violence is very high in the community. Participants described various instances of rape, including cases where men assaulted girls who refused marriage proposals, as well as incidents where perpetrators recorded the assaults and shared videos on social media. Women noted that rape frequently occurs in insecure areas, for instance, when collecting firewood. Participants mentioned that survivors are often forced to marry their perpetrators and

face severe stigma and social exclusion within their communities. This stigma was identified as a significant driver of suicidal behaviour among young girls during focus group discussions. Additionally, participants emphasized that not only survivors but also their children frequently face discrimination, leading to mental health challenges, suicidal ideation, and substance use.

Sexual abuse and harmful practices like FGM and child marriage are driving mental health crises and suicidal behaviour among girls in the Somali Region.

Additionally, community members reported cases of sexual exploitation, particularly involving individuals who use drugs. During focus group discussions, women also raised concerns about the ongoing practice of female genital mutilation (FGM). Despite awareness that FGM is harmful, participants noted that some elders continue to exert pressure, leading to girls being secretly subjected to the practice. Women in the discussions also mentioned that husbands taking additional wives can be a cause of mental distress. Moreover, participants reported that girls as young as 13 years old were being forced into marriage with older men, facing physical and sexual abuse. Participants linked these experiences to cases of self-harm and suicidal behaviour among affected girls.

"I was asked for my hand in marriage but declined. That same night, the boys attacked and raped me while recording the assault. The video was later circulated on social media, leaving me with shame and fear, and feeling that I no longer have any hope of being accepted or married within my community. The memory of that night still haunts me and often fills me with the urge to end my life just to escape the pain and humiliation. I have tried to end my life multiple times."

23-year-old woman from Aw-barre camp

Coping Mechanisms and Sources of Support

Respondents in the household survey indicated that individuals with mental health conditions seek support from a variety of sources (see Figure 3). The most frequent reported source of support was family members, cited by 61% of respondents (n = 792). Health facilities were the second most reported source at 37% (n = 480), followed by religious leaders (23%, n = 298) and humanitarian service providers (23%, n = 294).

Top 5 reported sources of support for individuals with mental health problems

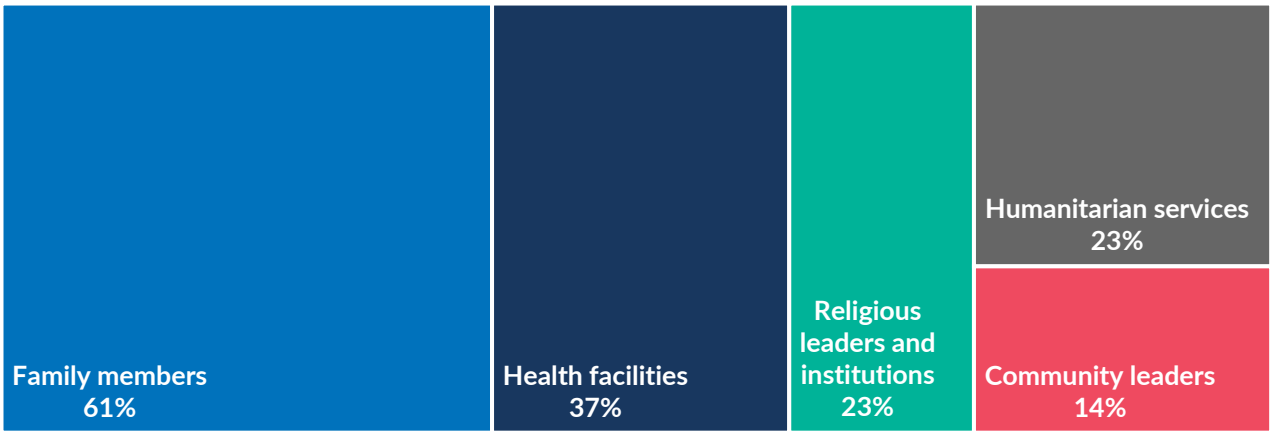

Figure 3. Reported sources of support for individuals with mental health problems

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Participants in the focus group discussions identified several strategies to cope with distress and mental health issues. These included seeking informal support from religious leaders and engaging in religious practice such as prayer. Some participants also mentioned seeking formal support through health services and visiting community centres. Additionally, securing basic livelihoods was highlighted as a crucial form of support, for example providing food and essential resources to families with members experiencing mental health issues.

Maladaptive coping mechanisms mentioned in the focus group discussions included chewing *khat* or smoking cigarettes to manage distress. Furthermore, participants reported that people exhibiting aggressive or erratic behaviours were sometimes chained at home, which was seen as a common practice to prevent them from harming themselves or the community.

Women in the focus group discussions frequently reported that there are no psychological support services or safe houses for survivors of GBV. Participants further reported that mental health services are not available in hospitals, and access to reproductive healthcare is extremely limited, with reportedly no female doctors available to provide care in the Bokh settlement.

"A lot of students undergo stress […] It would be good for us students to be trained in mental health so as to be aware of how to cope with the difficult feelings and support each other."

15-year-old girl from Aw-barre camp

Children and adolescents identified coping strategies for dealing with distress and mental health problems such as playing with other children or toys, spending time with family and friends, praying and reading the Quran, attending school, and participating in sports and recreational activities at community centres and playgrounds. According to participants, social support plays a crucial role in promoting the emotional and psychological well-being of children and young people facing mental health challenges. Family, friends, relatives, teachers, and the wider community were identified as key sources of support for children and adolescents. Additionally, child-friendly spaces, community playgrounds, and wellness centres were recognized as important places where young people seek psychosocial support. Conversely, maladaptive coping mechanisms that were mentioned in the focus group discussions included physical or verbal aggression, withdrawal from family and friends, and substance abuse, particularly among adolescents and youth. Cigarettes and *khat* were reported to be the most abused substances.

Secondary movement to other areas of Ethiopia, the Middle East, Kenya or Libya, was identified as a strategy to escape the harsh living conditions and the lack of prospects in the camps. Focus group discussion participants mentioned that, on some occasions children were left behind in camps by their caregivers, leading to an increase in the number of unaccompanied and separated children.

Barriers to Accessing MHPSS Services

Access to MHPSS services in the Somali Region is severely limited, as highlighted by respondents in the household survey (see Figure 4). A range of supply-side barriers were identified, including the unavailability of services, long distances to health facilities, shortages of medication, language barriers, inadequate

numbers of specialized professionals, insufficient services, lack of information, and negative staff attitudes. On the demand side, respondents reported barriers such as shame, lack of awareness, religious beliefs, cultural beliefs, stigma, unsupportive family members, and limited knowledge about available services.

Top 10 Barriers to accessing mental health and psychosocial support services

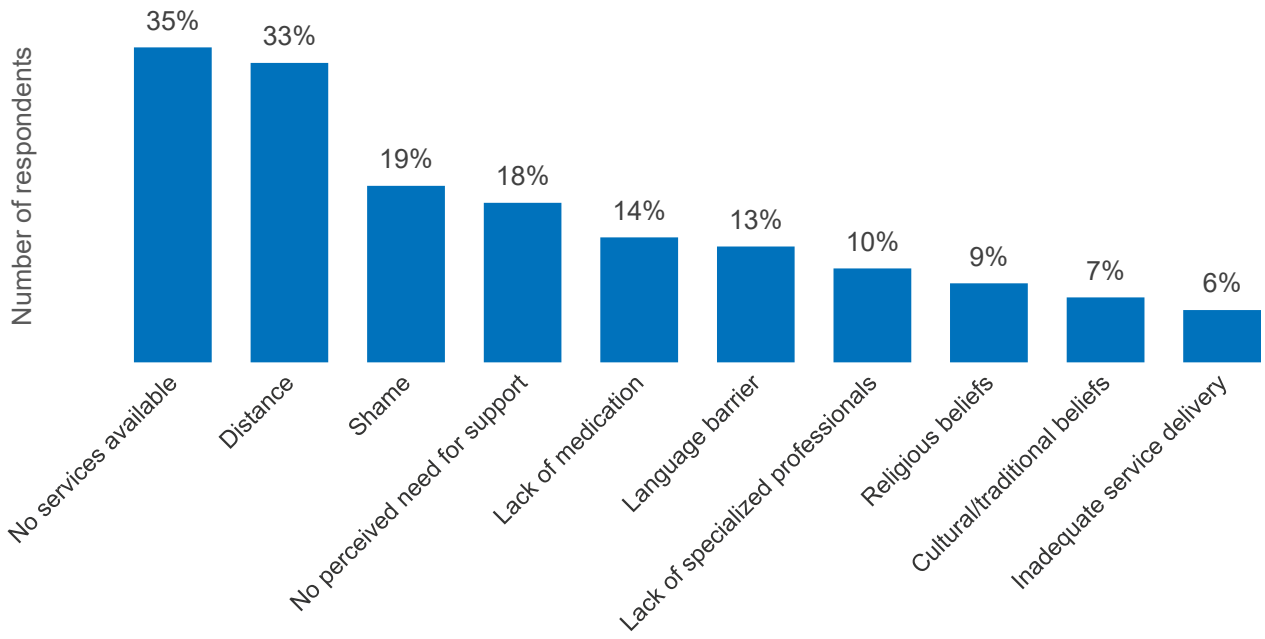

Figure 4. Reported barriers to accessing mental health and psychosocial support services.

Regarding access to medication, 36% (n = 467) of survey respondents reported that people with mental health problems do not get medication when they visit a health care facility. When asked why individuals with mental health problems do not get medication, respondents highlighted the unavailability of medications and a shortage of mental health specialists to prescribe medications.

Over a third of refugees say people with mental health conditions don't receive required medication when they seek care.

These challenges were strongly emphasized during focus group discussions, particularly by individuals living with mental health conditions. In particularly, they expressed that limited availability of services hindered their access to necessary medication and treatment.

"It gets unbearably hot here, and yet we have to walk for miles to access medication and counselling services. Many of us experience headaches due to the heat, and some even collapse on the way to the hospital. However, we have no choice but to keep going – our sanity and lives depend on it. No services are provided through home visits, making access even more difficult."

32-year-old man from Melkadida camp

Participants from Bokh similarly highlighted that medication and specialized services are virtually non-existent. This lack of access placed affected individuals at significant risk, with participants reporting that

families were forced to seek medications from unregulated vendors or travel across regions that are unsafe due to ongoing conflict.

During the focus group discussions, participants from UNHCR's partner organisations and community leaders reported significant challenges in supporting individuals with severe mental health conditions. While they noted having the capacity and basic knowledge to identify cases and provide initial psychosocial support, they emphasized a strong need for regular supervision. This need was particularly linked to the complexity and comorbidity of certain mental health disorders, which often exceed the scope of basic interventions. Participants underscored the critical importance of having specialized mental health staff (e.g., psychologist, psychiatrist) present to strengthen the capacity in health services and ensure the provision of adequate care to those in need. In addition to significant barriers in providing care for individuals with severe mental health conditions, participants expressed particular concern about the availability of mental health services for children with disabilities, including those with autism spectrum disorder and other developmental conditions. They highlighted a growing need for such services, yet emphasized that adequate support systems remain largely unavailable.

Challenges for People Living with Mental Health Problems in the Community

Individuals with mental health conditions in the Somali Region face numerous challenges, including widespread abuse, stigma, and neglect. According to the data, 64% of respondents (n = 823) reported that people with mental health conditions are subjected to abuse, while 59% (n = 765) noted experiences of discrimination, and 34% (n = 440) reported neglect. In addition, 26% (n = 333) indicated that individuals are physically restrained through chaining, 16% (n = 218) reported instances of starvation, and 15% (n = 194) stated that individuals are locked indoors without appropriate care. Furthermore, 8% (n = 110) mentioned restrictions on movement, further limiting access to essential services and support (see Figure 5).

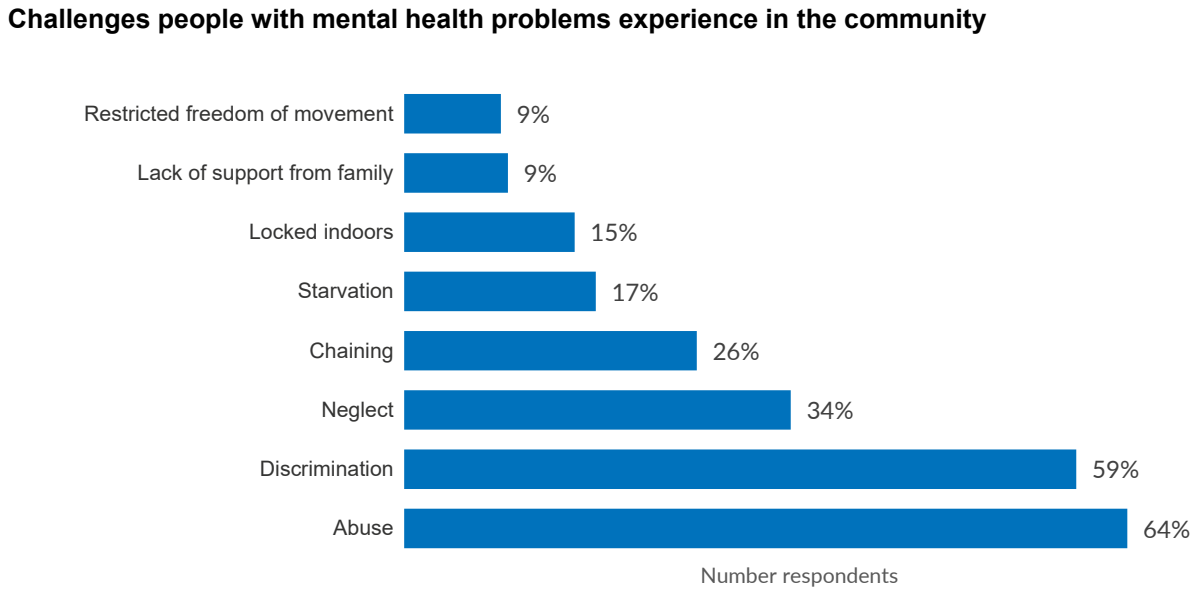

Figure 5. Reported challenges people with mental health problems experience in the community.

These findings were reinforced during focus group discussions, where participants emphasized that not only individuals with mental health conditions but also their caregivers face stigma and exclusion.

Refugees with mental health conditions face widespread abuse, discrimination, and neglect – including chaining and confinement.

The practice of chaining or confining individuals at home - particularly those displaying aggressive or erratic behaviour and perceived as potentially harmful to themselves or others - was commonly reported and regarded as a protective measure for both the individual and the community.

Burden of Caregivers

During focus group discussions, caregivers expressed experiencing significant stigma, stress, and uncertainty. They often mentioned sacrificing their priorities to care for the patients. A 14-year-old boy shared that he had to discontinue his education to take care of his mother, who has bipolar disorder, and his brother, who has epilepsy. He reported struggling with the overwhelming responsibility, sometimes having to physically restrain them to ensure they take their medication. Due to the high burden of caregiving, he has been unable to secure a stable livelihood.

"I sometimes feel like running away to a place where no one can find me. But when I look at my helpless mother, I break down and cry. I gather the strength to keep going, hoping that one day, we will get through this. There are times when I think about ending my life or all our lives."

14-year-old boy from Buramino camp

Caregivers further expressed being emotionally exhausted, struggling to access services while having to compete with others who do not face similar challenges. Due to the nature of the conditions their loved ones have, they often cannot leave home to secure food or other necessities. Individuals with mental health problems and their caregivers further frequently expressed challenges related to livelihood. To overcome these challenges, individuals with lived experiences in Melkadida can attend a community centre run by the NGO International Medical Corps. At the centre, individuals can participate in arts and crafts activities, producing items for sale that help generate income to support their families. Participants reported that these activities have not only strengthened their livelihood opportunities by equipping them with business skills and resources, but also contributed to their mental well-being and boosted their confidence.

“My mother has bipolar disorder, my brother has psychosis, and my father has epilepsy. It’s hard for me to leave home or participate in any livelihood activities because I have to care for my family, yet I also need to find a way to provide food for them.”

34-year-old man from Hiloween Camp

Discussion

Findings reflect common challenges in displacement settings, and highlight how refugees in Ethiopia's Somali Region face particularly high mental health needs amid adversity and inadequate formal support systems.

This report provides a comprehensive picture of the extent and complexity of mental health and psychosocial issues among Somali refugees in the Somali Region of Ethiopia. It draws from a household survey with 1289 respondents and 78 focus group discussions conducted in nine camps across Melkadida, Bokh, and Jijiga. The convergence of quantitative and qualitative data shows substantial levels of reported psychological distress, stigma, and structural barriers to care for refugees in the Somali Region.

Almost half of survey respondents stated experiencing mental health challenges. The high proportion of respondents reporting sadness, hopelessness, flashbacks, and worry reflect the mental health impact of protracted displacement, loss of livelihoods, and ongoing adversity for Somali refugees. Qualitative data further corroborate these findings, revealing widespread emotional distress and noticeable behavioural changes within the community - particularly among youth and women. These elevated rates of mental health problems are consistent with global evidence among forcedly displaced and conflict-affected populations (Blackmore, Boyle, et al., 2020; Charlson et al., 2019). As highlighted in previous research, youth and women are often especially at risk in displacement contexts (Blackmore, Gray, et al., 2020; Hanáková et al., 2024), a trend mirrored in this assessment.

Women and youth face elevated mental health risks due to gender-based violence, limited livelihoods, and lack of future prospects.

Gender-based violence emerged as a critical determinant of mental health among women. Over one-third of survey respondents identified GBV as a major stressor contributing to psychological distress in the community. Earlier research has documented high levels of GBV experiences among Somali refugee women and host community women in the Somali Region in Ethiopia (Parcesepe et al., 2016) and among people in Somalia (Wirtz et al., 2018). These findings align with existing literature (Adebayo et al., 2024; Meinhart et al., 2021; Pérez-Vázquez & Bonilla-Campos, 2023), which emphasizes that GBV induces and exacerbates mental health conditions but also increases the risk of self-harm and suicide, and can result in long-term social exclusion if left unaddressed. For youth, structural challenges - such as limited access to education, high unemployment, and a lack of prospects - were identified in this assessment as key factors influencing mental health outcomes among youth. Reports of multiple girls fainting simultaneously in school settings in the Somali region align with patterns of mass psychogenic illness, a phenomenon documented globally (Halimi et al., 2025) and also in school contexts in Ethiopia (Ajemu et al., 2020; Ayehu et al., 2018). A systematic review of mass psychogenic illness in school contexts identified several contributing factors, including education-related psychological stressors (e.g., examination periods), psychological vulnerability (e.g., separation from the family, exposure to physical abuse or neglect, and post-traumatic stress), as well as community pressure and misinformation about the presentation of mental health symptoms (Halimi et al., 2025). All of these risk factors are highly prevalent in the displacement setting in Ethiopia's Somali region.

Psychogenic seizures and fainting may also be related to perceived possession by spirits ('jinn'). Somali refugees in Kenya describe that *jinn* can cause a wide range of symptoms of which the most prominent initial symptomatic feature is fainting (Im et al., 2017). During the assessment it was not possible to explore the issue of 'fainting' more in depth, but it is likely that fainting is a cultural way of expressing distress and its increased occurrence may be related to the mounting uncertainly and collective anxiety among refugees in the Somali region of Ethiopia. This warrants further exploration.

While limited educational and employment opportunities have been linked to the prevalence of mental health problem among refugee children and adolescents across displacement settings in a systematic review (Scharpf et al., 2021), these issues may be particularly pronounced in the Somali Region, where the education system faces significant limitations: school enrolment are low, transition rates for primary and secondary education are limited, and only a small number of students successfully transition to university (Ali, 2023). For refugee youth, these barriers can be even more difficult to overcome due to additional resource constraints, making access to education and employment disproportionately challenging.

Conceptualizations of mental health can influence help-seeking behaviours

This assessment documented a range of local conceptualisations of mental health challenges among Somali refugees. Somali terms collected during the study reflect specific cultural understandings of mental health conditions. While most refugees experiencing mental health problems reported symptoms commonly associated with disorders such as depression and anxiety, local expressions often described behaviours typically linked to more severe mental health conditions - for example, *wu islahadlay* ("talking to himself") or *waali* ("madness"). These terms were frequently used in stigmatizing ways, which has been described in other research with Somali communities (Islam et al., 2024; Linney et al., 2020). In line with this, more than one-third of respondents indicated that individuals with mental health issues are not accepted within their communities. Such perceptions echo previous research which highlighted how Somali communities link mental illness to shame and dishonour (Cavallera et al., 2016; Im et al., 2017). These beliefs can directly affect help-seeking behaviour and social inclusion (Ventevogel et al., 2013). Systematic reviews report that stigma and discrimination are major barriers to accessing mental health support among refugees (Byrow et al., 2020; Dumke et al., 2024). In line with this, one fifth of respondents of this report stated that shame prevents individuals with mental health problems from accessing formal support services, while religious and cultural beliefs also played significant barriers to access in the present assessment.

Families are the main source of support for people with mental health conditions, but without training or resources, many struggle to cope, sometimes resorting to harmful practices like chaining.

The assessment identified the family as the most commonly reported source of support for individuals with mental health conditions. Over half of respondents indicated that people experiencing mental health challenges are cared for by family members. This finding aligns with previous research among Somali refugee communities, which found that family members and friends often are the primary source of support (Im et al., 2025). Systematic reviews further highlight the role of family caregivers in supporting and coping with stressors and adversity, while also strengthening participation in society (Nickerson et al., 2024; Scharpf et al., 2021). However, families often lack the necessary skills and resources to provide adequate care, and

may become overwhelmed by the emotional, physical, and financial burden (Bunn et al., 2021). This was also observed in the current assessment: Caregivers shared testimonies highlighting the burden of supporting individuals with mental health conditions. Moreover, due to limited understanding and awareness of mental health, the practice of chaining or confining individuals, particularly those exhibiting aggressive or erratic behaviour, was frequently reported. These findings are consistent with previous documentation of chaining practices in Somali populations (Cavallera et al., 2016; World Health Organization, 2010). While often intended as a protective measure for both the individual and the community, this practice highlights the urgent need to strengthen the capacity of family members to provide care, as well as access to adequate specialized MHPSS services. In addition to family support, many individuals experiencing mental health challenges rely on religious and cultural practices and private mental health institutions as an important source of support. Such support also plays a significant role for the host community in the Somali Region (Warfa et al., 2023). In Somalia, including the Somaliland region, such unregulated, private mental health in-patient facilities, known as '*ilaaj* centres' (*ilaaj* is Arabic for 'cure or treatment') are ubiquitous (Abdi Abdillahi et al., 2020; Ibrahim et al., 2022). They may be run by traditional or faith healers and sometimes employ medical staff, often with limited formal mental health training. Such facilities often provide substandard clinical care to their patients and are known for challenges related to safety, accountability, and long-term sustainability and risk for human rights abuses (Human Rights Watch, 2015). Faith leaders in the Somali Region in Ethiopia have previously highlighted their struggles in addressing severe mental health conditions, pointing to a lack of specialized knowledge and insufficient capacity to provide appropriate care (Warfa et al., 2023).

The Somali Region faces a severe shortage of mental health services for refugees and host communities.

Access to formal MHPSS services is severely limited for refugees in the Somali Region of Ethiopia. Site visits revealed a lack of specialized services, which respondents identified as the most significant barrier to seeking care. Additional commonly reported challenges included the unavailability of services, shortages of essential medications, and lack of trained treatment providers. These barriers are consistent with findings from other regions in Ethiopia (e.g., Fekadu & Thornicroft, 2014) and reflect global patterns in displacement settings (e.g., Byrow et al., 2020; Dumke et al., 2024). However, our assessment underscores that the Somali Region faces an especially acute shortage of dedicated mental health resources, both within refugee camps and across the broader region. This is consistent with previous research indicating an almost complete absence of mental health infrastructure and systems in the area (Warfa et al., 2023). While training frontline health workers to deliver MHPSS safely and effectively within primary health care settings is feasible (Keynejad et al., 2021) including in refugee camps (Echeverri et al., 2018) (Echeverri et al., 2018), the current capacity of primary care providers to identify and manage mental, neurological, and substance use disorders remains insufficient. Our assessment showed that staff some health centres have yet to receive mhGAP training, while in others, staff have received such training but mental health care is still not being provided. These findings underscore the urgent need to strengthen mental health resources and build provider capacity across the Somali Region to improve access to adequate mental health care for refugees and host community. This requires collaboration with the national health system and universities which have some encouraging experiences with mhGAP implementation, capacity building, and mental health system strengthening (Demissie et al., 2024; Tadesse Gebremedhin et al., 2021; Warfa et al., 2023). This aligns

with the national mental health strategy of the Federal Ministry of Health which as one of its objectives to integrate mental health services into primary health care (Federal Ministry of Health, 2020).

Given the limited availability of formal MHPSS services, community-based and non-specialized MHPSS interventions were recognized by assessment participants as essential for reducing distress and promoting psychosocial well-being. At-risk groups, particularly youth and women, emphasized the importance of safe spaces and accessible support mechanisms within their daily environments, such as schools and community settings. Previous research underscores this reported value of community support mechanisms. For instance, child- and youth-friendly spaces have been shown to not only improve psychosocial outcomes but also enhance protection and educational outcomes among Somali refugee children and youth in Dollo Ado (Metzler et al., 2021). Community-Based Sociotherapy (CBS) is another promising approach for strengthening community support mechanisms and well-being in displacement settings (Richters et al., 2008; Ubels et al., 2025). CBS is a group-based intervention led by trained community members, aimed at strengthening social networks and helping individuals cope with the stressors of displacement through structured peer support. Integrating such community-based approaches into broader MHPSS strategies and national mental health planning can help ensure sustainable, culturally relevant, and scalable support systems for refugees and host communities (UNHCR, 2024).

Strengths and limitations

This assessment is the first assessment of refugees in all major refugee sites in the Somali region of Ethiopia. It is based on findings from large household survey with more than 1000 participants, 72 focus group discussions with more than 700 participants, and site visits. It was done in close collaboration with many stakeholders making it a joint effort. The study has several limitations. First, despite a random sampling approach for the household survey and efforts to make the focus group discussions inclusive of all segments of the refugee community, this is a rapid assessment in the context of humanitarian programme. We lacked time and resources to conduct a representative epidemiology study with a full battery of validated instruments. Second, the use of community-based data collectors, is a strong point in terms of language and contextual understanding, but it may also have led to social desirability bias or fear of community judgment and may have led participants to withhold information or provide responses they believed to be more acceptable. Third, while data collectors were trained extensively in data assessment, the assessment tools were not translated to Somali, hence translations were conducted ad-hoc by data collectors. Lastly, the assessment was focused on refugees only as we did not have the resources to also assess the host community.

Conclusions

This comprehensive assessment highlights the profound mental health and psychosocial challenges faced by refugee populations in the major refugee hosting sites of the Somali Region of Ethiopia. In a large household survey with more than 1000 participants as well as focus group discussions, participants reported high levels of distress linked to past events and current living conditions. Women and youth emerged as particularly at risk, with mental health challenges related to gender-based violence and lack of prospects. Caregivers, too, face immense burdens, often foregoing their well-being and opportunities to care for family members with mental illness. Stigmatizing attitudes and harmful practices are widespread, with individuals with mental health conditions facing significant social exclusion. Community perceptions frequently associate severe mental illness with shame, spiritual possession, or personal failure, reinforcing barriers to help-seeking and inclusion. Notably, chaining individuals with mental health conditions was a reported practice. Access to MHPSS services is severely limited through a range of demand-side (such as shame, lack of mental health awareness, preferred support options) and supply-side (such as lack of availability of services, capacity of staff, shortage of medications) barriers. Informal support systems such as family and religious leaders as most important, but face challenges related to safety and accountability.

Addressing the identified mental health needs among refugees in the Somali Region requires a multi-sectoral, culturally relevant approach. Key priorities include expanding access to MHPSS by integrating services into existing health, education, and protection systems; strengthening the capacity of primary health care providers to identify and manage mental health conditions; and training and deploying specialized MHPSS personnel. Community engagement, particularly through refugee-led organizations, can be an essential means to raise mental health awareness and reduce stigma. Special attention must be given to the protection and mental well-being of women, girls, and youth, with targeted interventions to prevent and respond to gender-based violence and improve access to education and livelihoods.

Ultimately, sustainable progress in mental health care for refugees in the Somali Region can be achieved through the meaningful inclusion of refugees in national systems, the strengthening of those systems, and close collaboration with government partners. Given the Somali Region’s severe resource constraints, enhancing MHPSS services for refugees is not only critical for individual recovery but also essential for building community resilience, social cohesion, and long-term development.

Recommendations

Addressing the high mental health and psychosocial support needs, requires a multi-layered strategy focused on expanding access to formal services, increasing mental health awareness, and strengthening community-based systems.

1. Strengthen integration of refugees into national mental health and protection systems

UNHCR in collaboration with the Refugees and Returnees Service (RRS) should support the national and regional authorities to include refugees in national mental health and social protection systems. Including MHPSS as a transformative, cross-cutting element in transition plans towards full inclusion of refugees will contribute to strengthened national protection and health systems.

2. Invest in government capacity and ownership for refugee MHPSS

To ensure sustainability, UNHCR and partners should support government structures at national and regional levels to take ownership of refugee MHPSS service delivery by support regional technical working groups (TWGs) to coordinate and monitor MHPSS activities and enhance cross-sectoral collaboration between health, education, social welfare, and justice systems.

3. Advance UNHCR's protection mandate through MHPSS integration into multisectoral planning

Given the clear protection risks linked to unaddressed mental health needs, particularly for women, children, and persons with specific needs, UNHCR should integrate MHPSS within its sectoral plans for protection, health, education, and livelihoods in and promote that partners do the same, in line with the Minimum Service Package (MSP) and global guidance.

4. Support integration of mental health into primary health care in refugee sites

UNHCR and partners should make services for mental, neurological and substance use conditions a routine element of primary health services through training government and NGO staff (using methods such as mhGAP) and by ensuring regular supply of essential psychotropic medications, in line with the Ethiopian Essential Medicines List.

5. Strengthen community-based psychosocial support in refugee and host communities

UNHCR and partner should invest in training refugee led- organizations, community leaders, teachers, and volunteers in basic psychosocial support and in supporting community initiatives that promote mental health and psychosocial well-being and promote social cohesion and address stigma and harmful practices, such as chaining or forced isolation.

6. Expand MHPSS to education, GBV and child protection

Integrate MHPSS into schools, child protection structures, and GBV response services using the Minimum Service Package for MHPSS as an intersectoral planning tool. This can include training teachers in basic psychosocial support and psychological first aid and establishing MHPSS activities in women and girls-safe spaces, schools, and child-friendly spaces.

7. Partner with academia and Ethiopian universities for capacity building and research

Intensification of the collaboration with local academic institutions is critical to localizing and scaling up MHPSS interventions. It is recommended to work with universities (e.g. Jijiga University, Addis Ababa University School of Public Health) to co-develop training curricula, offer student internships, and conduct operational research.

8. Support data collection, monitoring, and learning

Strengthen information management and accountability by integrating MHPSS indicators into protection and health monitoring tools; encouraging participatory feedback systems from affected populations and disseminating learning from field interventions and academic partnerships.

References

Abdi Abdillahi, F., Ismail, E. A., & Singh, S. P. (2020). Mental Health in Somaliland: A critical situation. *BJPsych International*, *17*(1), 11–14. https://doi.org/10.1192/bji.2019.14

Adebayo, C. T., Olukotun, O. V., Olukotun, M., Kirungi, J., Gondwe, K. W., Crooks, N. K., Singer, R. B., Adams, S., Alfaifi, F. Y., Dressel, A., Fahmy, L., Kako, P., Snethen, J., & Mkandawire-Valhmu, L. (2024). Experiences of gender-based violence among Somali refugee women: A socio-ecological model approach. *Culture, Health & Sexuality*, *26*(5), 654–670. https://doi.org/10.1080/13691058.2023.2236163

Ajemu, K. F., Weldearegay, T. W., Bezabih, N. M., Meles, Y., Mehari, G., Desta, A. A., Berhe, A. A., Jorjo, M., Weldegebriel, A. G., Gebru, T. S., & Tesfadingle, A. (2020). Mass Psychogenic Illness in Haraza Elementary School, Erop District, Tigray, Northern Ethiopia: Investigation to the Nature of an Episode. *Psychiatry Journal*, *2020*, 1–7. https://doi.org/10.1155/2020/2693830

Ali, A. H. (2023, April 11). The status of education in the Somali Region of Ethiopia and overcoming some of the challenges. *The Education and Development Forum (UKFIET)*. https://www.ukfiet.org/2023/the-status-of-education-in-the-somali-region-of-ethiopia-and-overcoming-some-of-the-challenges/

Ayehu, M., Endriyas, M., Mekonnen, E., Shiferaw, M., & Misganaw, T. (2018). Chronic mass psychogenic illness among women in Derashe Woreda, Segen Area People Zone, southern Ethiopia: A community based cross-sectional study. *International Journal of Mental Health Systems*, *12*(1), 31. https://doi.org/10.1186/s13033-018-0207-1

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLOS Medicine*, *17*(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Blackmore, R., Gray, K. M., Boyle, J. A., Fazel, M., Ranasinha, S., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). Systematic Review and Meta-analysis: The Prevalence of Mental Illness in Child and Adolescent Refugees and Asylum Seekers. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(6), 705–714. https://doi.org/10.1016/j.jaac.2019.11.011

Bunn, M., Gonzalez, N., Falek, I., Weine, S., & Acri, M. (2021). Supporting and Sustaining Nonspecialists to Deliver Mental Health Interventions in Low- and Middle-Income Countries: An Umbrella Review. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, *19*(2), 155. https://doi.org/10.4103/INTV.INTV_47_20

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

Cavallera, V., Reggi, M., Abdi, S., Jinnah, Z., Kivelenge, J., Warsame, A., Yusuf, A., & Ventevogel, P. (2016). Culture, context and mental health of Somali refugees: A primer for staff working in mental health and psychosocial support programmes. *Geneva: United Nations High Commissioner for Refugees*.

Charlson, F., Van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. *The Lancet*, *394*(10194), 240–248. https://doi.org/10.1016/s0140-6736(19)30934-1

Demissie, M., Birhane, R., Hanlon, C., Eshetu, T., Medhin, G., Minaye, A., Habtamu, K., Cleare, A. J., Milkias, B., Prince, M., & Fekadu, A. (2024). Developing interventions to improve detection of depression in primary healthcare settings in rural Ethiopia. *BJPsych Open*, *10*(2), e52. https://doi.org/10.1192/bjo.2024.1

Dickson, K., Ko, S. Y. (Jessica), Nguyen, C., Minchenko, D., & Bangpan, M. (2024). Mental health and psychosocial support programmes for displaced populations in low- and middle-income countries (LMICs): A systematic review of process, perspectives and experiences. *Cambridge Prisms: Global Mental Health*, *11*, e62. https://doi.org/10.1017/gmh.2024.56

Dumke, L., Wilker, S., Hecker, T., & Neuner, F. (2024). Barriers to accessing mental health care for refugees and asylum seekers in high-income countries: A scoping review of reviews mapping demand and supply-side factors onto a conceptual framework. *Clinical Psychology Review*, *113*. https://doi.org/10.1016/j.cpr.2024.102491

Echeverri, C., Le Roy, J., Worku, B., & Ventevogel, P. (2018). Mental health capacity building in refugee primary health care settings in Sub-Saharan Africa: Impact, challenges and gaps. *Global Mental Health*, *5*, e28. https://doi.org/10.1017/gmh.2018.19

Federal Ministry of Health. (2020). *National mental health strategy, 2020-2025 (2013-2017 EFY)*. Ministry of Health, Federal Democratic Republic of Ethiopia. http://repository.iphce.org/xmlui/handle/123456789/1423

Fekadu, A., & Thornicroft, G. (2014). Global mental health: Perspectives from Ethiopia. *Global Health Action*, *7*(1), 25447. https://doi.org/10.3402/gha.v7.25447

Halimi, A., Jarrahi, A. M., Kian, N., Nejadghaderi, S. A., Jorjani, G., Keramatinia, A., Al-Marzouqi, A., Shams, J., & Adel, N. (2025). Factors related to the occurrence of mass psychogenic illness in schools: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*. https://doi.org/10.1007/s00127-025-02949-6

Hanáková, K., Lindberg, L. G., & Carlsson, J. (2024). Sex differences in trauma exposure and PTSD symptomatology among refugees, internally displaced people, and asylum seekers: A systematic literature review. *Psychiatry Research*, *339*, 116014. https://doi.org/10.1016/j.psychres.2024.116014

Human Rights Watch. (2015). "Chained Like Prisoners". Abuses Against People with Psychosocial Disabilities in Somaliland. *Human Rights Watch*. https://www.hrw.org/report/2015/10/25/chained-prisoners/abuses-against-people-psychosocial-disabilities-somaliland

IASC. (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. https://interagencystandingcommittee.org/sites/default/files/migrated/2020-11/IASC%20Guidelines%20on%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings%20%28English%29.pdf

IASC. (2022). *The Mental Health and Psychosocial Support Minimum Service Package*. https://interagencystandingcommittee.org/sites/default/files/migrated/2023-01/IASC%20MHPSS%20Minimum%20Service%20Package.pdf

IASC MHPSS Reference Group. (2024). *Multi-sectoral mental health and psychosocial support assessment toolkit—Draft Version for Field Testing*. https://www.mhpssmsp.org/sites/default/files/2024-07/Multi-sectoral%20MHPSS%20assessment%20toolkit%20for%20field%20testing%202024.pdf

Ibrahim, M., Rizwan, H., Afzal, M., & Malik, M. R. (2022). Mental health crisis in Somalia: A review and a way forward. *International Journal of Mental Health Systems*, *16*(1), 12. https://doi.org/10.1186/s13033-022-00525-y

ILO. (2024). *ILO and partners advance refugee inclusion in Ethiopia's National Health Systems*. https://www.ilo.org/resource/news/ilo-and-partners-advance-refugee-inclusion-ethiopia's-national-health#:~:text=Key%20stakeholders%20in%20Ethiopia%20convened%20a%20high-level%20dialogue,Insurance%20to%20ensure%20equitable%20healthcare%20access%20for%20all.

Im, H., Ferguson, A., & Hunter, M. (2017). Cultural translation of refugee trauma: Cultural idioms of distress among Somali refugees in displacement. *Transcultural Psychiatry*, *54*(5–6), 626–652. https://doi.org/10.1177/1363461517744989

Im, H., Lee, S., Warsame, A., & Isse, M. (2025). Beyond Individual Coping: The Role of Social Capital in Community-Based Mental Health Support for Displaced Somali Youth. *International Journal of Environmental Research and Public Health*, *22*(5), 784. https://doi.org/10.3390/ijerph22050784

Im, H., Saleh, M., & Khetarpal, R. M. (2024). Embodiment of structural vulnerability: Illness experiences among Somali refugee women in urban displacement. *Ethnicity & Health*, *29*(8), 963–986. https://doi.org/10.1080/13557858.2024.2385112

Im, H., & Swan, L. E. (2022). Trauma exposure, social functioning, and common mental health disorders in Somali refugee male and female youth: An SEM analysis. *International Journal of Social Psychiatry*, *68*(8), 1539–1551. https://doi.org/10.1177/00207640211037726

IOM. (2023). *Crisis Response Overview—Ethiopia—April 2023*. https://ethiopia.iom.int/sites/g/files/tmzbdl996/files/documents/2023-06/iom-ethiopia-crisis-response-overview-april-2023_0.pdf

Islam, M. M., Siyad, A. A., & Malik, S. M. M. R. (2024). Mental health problems in Somalia after decades of humanitarian crises: A qualitative exploration of perceptions and experiences. *Tropical Medicine and Health*, *52*(1), 58. https://doi.org/10.1186/s41182-024-00618-z

Keynejad, R., Spagnolo, J., & Thornicroft, G. (2021). WHO mental health gap action programme (mhGAP) intervention guide: Updated systematic review on evidence and impact. *Evidence Based Mental Health*, *24*(3), 124–130. https://doi.org/10.1136/ebmental-2021-300254

Kindie, F. M., Abeje Kassie, W., & Dube, E. E. (2023). Examining livelihood strategies of urban refugees through sustainable livelihoods perspective: A focus on Eritrean and Somali refugees in Addis Ababa. *Cogent Social Sciences*, *9*(2), 2262771. https://doi.org/10.1080/23311886.2023.2262771

Lambert, J. E., Karugahe, W., & Baguma, P. K. (2024). Unpacking gender-specific risk and protective factors for mental health status among Congolese refugees in Uganda. *European Journal of Psychotraumatology*, *15*(1), 2334190. https://doi.org/10.1080/20008066.2024.2334190

Linney, C., Ye, S., Redwood, S., Mohamed, A., Farah, A., Biddle, L., & Crawley, E. (2020). “Crazy person is crazy person. It doesn’t differentiate”: An exploration into Somali views of mental health and access to healthcare in an established UK Somali community. *International Journal for Equity in Health*, *19*(1), 190. https://doi.org/10.1186/s12939-020-01295-0

Meinhart, M., Seff, I., Troy, K., McNelly, S., Vahedi, L., Poulton, C., & Stark, L. (2021). Identifying the Impact of Intimate Partner Violence in Humanitarian Settings: Using an Ecological Framework to Review 15 Years of Evidence. *International Journal of Environmental Research and Public Health*, *18*(13), 6963. https://doi.org/10.3390/ijerph18136963

Metzler, J., Jonfa, M., Savage, K., & Ager, A. (2021). Educational, psychosocial, and protection outcomes of child- and youth-focused programming with Somali refugees in Dollo Ado, Ethiopia. *Disasters*, *45*(1), 67–85. https://doi.org/10.1111/disa.12392

Murray, L. K., Hall, B. J., Dorsey, S., Ugueto, A. M., Puffer, E. S., Sim, A., Ismael, A., Bass, J., Akiba, C., Lucid, L., Harrison, J., Erikson, A., & Bolton, P. A. (2018). An evaluation of a common elements treatment approach for youth in Somali refugee camps. *Global Mental Health*, *5*, e16. https://doi.org/10.1017/gmh.2018.7

Nickerson, A., Mai, V., Keegan, D., Willoughby, C., Humphreys, K., Im, J. J. Y., Sundram, S., Procter, N., Seidler, Z. E., Scharpf, F., & Liddell, B. J. (2024). A systematic review of protective and promotive factors in refugee mental health. *Nature Mental Health*, *2*(11), 1415–1428. https://doi.org/10.1038/s44220-024-00336-9

Ortiz-Echevarria, L., Greeley, M., Bawoke, T., Zimmerman, L., Robinson, C., & Schlecht, J. (2017). Understanding the unique experiences, perspectives and sexual and reproductive health needs of very young adolescents: Somali refugees in Ethiopia. *Conflict and Health*, *11*(S1), 26. https://doi.org/10.1186/s13031-017-0129-6

Parcesepe, A., Stark, L., Roberts, L., & Boothby, N. (2016). Measuring Physical Violence and Rape Against Somali Women Using the Neighborhood Method. *Violence Against Women*, *22*(7), 798–816. https://doi.org/10.1177/1077801215613852

Pérez-Vázquez, S., & Bonilla-Campos, A. (2023). Women Refugee’s Perceptions, Experiences and Coping Mechanisms in Situations of Sexual and Gender-Based Violence (SGBV): A Metasynthesis. *Trauma, Violence, & Abuse*, *24*(5), 3313–3327. https://doi.org/10.1177/15248380221126470

Richters, A., Dekker, C., & Scholte, W. F. (2008). Community based sociotherapy in Byumba, Rwanda. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, *6*(2), 100–116.

Scharpf, F., Kaltenbach, E., Nickerson, A., & Hecker, T. (2021). A systematic review of socio-ecological factors contributing to risk and protection of the mental health of refugee children and adolescents. *Clinical Psychology Review*, *83*, 101930. https://doi.org/10.1016/j.cpr.2020.101930

Sheath, D., Flahault, A., Seybold, J., & Saso, L. (2020). Diverse and Complex Challenges to Migrant and Refugee Mental Health: Reflections of the M8 Alliance Expert Group on Migrant Health. *International Journal of Environmental Research and Public Health*, *17*(10), 3530. https://doi.org/10.3390/ijerph17103530

Silove, D., Ventevogel, P., & Rees, S. (2017). The contemporary refugee crisis: An overview of mental health challenges. *World Psychiatry*, *16*(2), 130–139. https://doi.org/10.1002/wps.20438

Tadesse Gebremedhin, L., Giorgis, T. W., & Gerba, H. (2021). Policies, delivery models, and lessons learned from integrating mental health and substance abuse services into primary health care in Ethiopia. *FASEB BioAdvances*, *3*(9), 694–701. https://doi.org/10.1096/fba.2020-00145

Ubels, T., Kinsbergen, S., Koch, D.-J., Kanshabe, J., & Tolsma, J. (2025). Analysis of the possible pathways between social and well-being outcomes: A mixed-method study about community-based sociotherapy for refugees in Nakivale Settlement, Uganda. *Conflict and Health*, *19*(1), 44. https://doi.org/10.1186/s13031-025-00682-0

UNHCR. (2022). *UNHCR Somalia—Operational Update November 2022*. UNHCR Operational Data Portal (ODP). https://data.unhcr.org/en/documents/details/97658

UNHCR. (2023). *Las Caanood Situation—Emergency Response in Somalia and Ethiopia; External Update #1*. UNHCR Operational Data Portal (ODP). https://data.unhcr.org/es/documents/details/99634

UNHCR. (2024). Mental Health and Psychosocial Support (MHPSS). In *Emergency Handbook*. https://emergency.unhcr.org/emergency-assistance/health-and-nutrition/mental-health-and-psychosocial-support-mhpss

UNHCR. (2025). *Registered Refugee Population by Location | August 2025*. UNHCR Operational Data Portal (ODP). https://data.unhcr.org/en/documents/details/118643

Ventevogel, P., Jordans, M., Reis, R., & De Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health*, *7*(1), 3. https://doi.org/10.1186/1752-1505-7-3

Warfa, N., Hanlon, C., Handuleh, J. I. M., Willott, C., Hassen, M. A., & Abdulahi, E. (2023). Mental health services in the Somali region of Ethiopia. *The Lancet Psychiatry*, *10*(11), 824–826. https://doi.org/10.1016/S2215-0366(23)00259-6

WHO. (2021). *Mental Health ATLAS 2020*. https://www.who.int/publications/i/item/9789240036703

Wirtz, A. L., Perrin, N. A., Desgroppes, A., Phipps, V., Abdi, A. A., Ross, B., Kaburu, F., Kajue, I., Kutto, E., Taniguchi, E., & Glass, N. (2018). Lifetime prevalence, correlates and health consequences of gender-based violence victimisation and perpetration among men and women in Somalia. *BMJ Global Health*, *3*(4), e000773. https://doi.org/10.1136/bmjgh-2018-000773

World Health Organization. (2010). A situation analysis of mental health in Somalia. *World Health Organization. Available at Http://Applications. Emro. Who. Int/Dsaf/EMROPUB_2010_EN_736. Pdf (Accessed 4 February 2017)*.

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MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT NEEDS AMONG REFUGEES IN THE SOMALI REGION OF ETHIOPA

Assessment report

December 2025

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