

**THE PREVALENCE OF MENTAL DISTRESS AND
SEXUAL VIOLENCE AMONG REFUGEES AT
SHERKOLE CAMP**

BY:

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Lists of Acronyms and Aberrations

- WHO- World Health Organizations
- UNHCR- United Nations High commissioner for Refugees
- FGD- focus Group Discussion
- PTSD- Post- Traumatic Stress Disorder
- IDP – Internally displaced persons
- IRC –International Rescue Commute
- IOM- International organization for migration
- ARRA- Administration for Refuge and Returnees Affairs
- SRQ- Self Reporting Questionnaires
- IASC -Inter Agency Standing Committee
- GBV-Gender Based Violence.
- GFHR-Global Forum for Health Research.
- UNIFEM-United Nations Developments Fund for women
- ICD-International classification of disease.
- DSM-Diagnostic and Statistical Manual

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Abstract

The study focused on assessing the prevalence of mental distress and sexual violence among refugees at Sherkole Camp. It also aimed at investigating the causes, consequences, and phases of sexual violence. Furthermore, the study examined the prevalence of mental distress and sexual violence across age, sex and country of origin.

To achieve the objectives of the study in question, 450 randomly selected refugees and 11 purposefully selected national staffs participated in the study. Thus, a total of 465 participants involved in the study. Different data collection instruments (SRQ 20 scale, interview focus group discussion and case history) were employed to gather the necessary data. Chi square was employed to analyze the obtained data.

The prevalence of mental distress among refugees was found to be 44%. About 56.97% of the respondents surveyed in the study had thoughts of ending their life in the past 30 days. Reported mental distresses significantly differ among female and male respondents. More females 175 (83.33%) than male 160(72.72%) were found to suffer from mental distress($X^2=7.02$, $df=1$, $P=0.008$). Furthermore, the prevalence rate of mental distresses were high among Sudanese than non Sudanese ($X^2=58.6$, $df=1$, $P=0.000$) refugees.

On the other hand, the prevalence of sexual violence among refugees was found to be 52.38%.In general according to the findings of the study the majority of the refugees at Sherkole encountered mental distress (44%) and experienced sexual violence (52.38). Far distance between tap water and shelter, intoxication and lack of awareness were among reported causes of sexual violence. Unwanted pregnancy, gynecological complications, sexually transmitted disease (STD), mental illness, suicidal feeling were found to be major consequences of sexual violence. Awareness creation, counseling and psycho social supports are recommended.

Dedication

My dedication goes to those refugees in the Sherkole Refugee Camp who were victims of Sexual Violence and Mental Distress.

Abstract

The study focused on assessing the prevalence of mental distress and sexual violence among refugees at Sherkole Camp. It also aimed at investigating the causes, consequences, and phases of sexual violence. Furthermore, the study examined the prevalence of mental distress and sexual violence across age, sex and country of origin. To achieve the objectives of the study in question, 450 randomly selected refugees and 11 purposefully selected national staffs, 28 purposefully selected refugee social workers and national staffs, 2 purposefully selected rape survivors and 5 key informants participated in the study. Thus, a total of 485 participants involved in the study. Different data collection instruments (SRQ 20 scale, interview, focus group discussion and case history) were employed to gather the necessary data. Chi square was employed to analyze the obtained data.

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CHAPTER ONE

Introduction

1.1. Background of the problem

Displacement is a global problem, which happened due to regional conflicts, persecution and human right abuse (UNHCR 1996). More than 150 million people, almost a fifth of the African continent population, live in countries severely disrupted by conflict and currently the continent is becoming a home to nearly seventeen million refugees and internally displaced people (UNHCR, 2007). Though the number of refugees officially increased in the world, the problem is getting even bigger in African countries. Putting such issue into consideration, the UN general assembly unanimously decided to mark international refugee day coinciding with Africa refugee day (UNHCR, 2007).

Africa is the second largest refugee concentration next to Asia and Europe, which hosted approximately 7.3 million refugees each. Recently Ethiopia has become a host to more than 80,000 refugees from different countries. The largest groups are Sudanese, Somalis and Eritrean refugees. In line with this, more than 27,000 Sudanese refugees are currently sheltered in two different camps in Western Ethiopia, including a few hundred staying in Addis Ababa (UNHCR, 2008). At Sherkole refugee camp (at the study period) well over 8,771 refugees were getting shelter. Most of them represent various African countries mainly Congo, Burundi, Ruanda, Cameroon and Sudan which contains ethnic groups Mabaan, Dinka , Funj, and others.

Refugees may encounter both psychological and social chaos. As a result refugees are exposed to a number of common problems and needs such as physical, psychological, social, medical, food, education and others (Matsuoka, 1993; Mayadas & Elliott, 1992)

The major social problems mainly include violence such as physical,

sexual, economic or socio cultural conflicts. Most often refugee women confront other forms of violence including rape, attempted rape, gangster rape, sexual harassment, forced marriage, early marriage, prostitution, insufficient rations, heavy burden and bad medical care (UNHCR, 2006). Sexual violence also seems rampant across the refugee settings. According to WHO (2000) report, refugees who are fleeing conflicts and other threatening conditions are often at risk of rape in their new setting. For example, among the “boat people” who fled Vietnam in the late 1970s and early 1980s, 39% of women were abducted or raped by pirates.

In addition to the above social problems, refugees also face different psychological problems (Asakura,et.al ,2006). The prevalence rate of mental distress as a psychological problem among refugees seems high. For instance, according to WHO (2005), Angola, Afghanistan, Cambodia, Somalia, Burundi, Rwanda, Sierra-Leone, Kosovo and Chechnya are a few examples of prolonged human destabilization and psychosocial dysfunction caused by traumatic events. Their consequences remain in the personal and collective memory even long after peace agreements and repatriation has been accomplished. Traumatic experiences such as killings, material losses, torture and sexual violence, harsh detention and uprooting, all affect people’s behavior for generations. Life in overcrowded camps, deprivations, uncertainty over the future, disruption of community and social support networks lead to psychosocial dysfunction. Other researches also indicated that millions of refugee groups are exposed to chronic mental disorders (prior to the war), are seriously traumatized, and would need specialized mental health care had it been available. Others also may suffer from psychosocial dysfunction affecting their own lives and their community. It is important to remember that refugees’ reactions are normal reactions to abnormal situations (WHO, 2007).

However, emergency response was limited to food, water and shelter.

Health and other priority needs are often delayed. Recognition of the mental health needs of refugees is emerging but remains poorly addressed, as allocation of resources does not allow (UNHCR 1996).

To the best knowledge of the researcher, assessment of the prevalence of mental distress and sexual violence of refugees is still untouched at least in the Ethiopian context. As a result, the present researcher believes that this study would serve to fill the existing gap and also serve to design intervention strategies to minimize psychosocial problems of refugees.

1.2 Statement of the problem

As mentioned in the introduction section, recently Ethiopia has become a host to more than 80,000 refugees from different countries (UNHCR, 2008). These displaced people are subjected to different psycho-social problems. The psychosocial problems can be exhibited in terms of mental distress and sexual violence such as rape, attempted rape and gangster rape. According to the researcher's knowledge, no adequate systematic study so far has been conducted on the prevalence of mental distress and social problems among rural refugee camps in Ethiopia. Cognizant of the non availability of adequate information on the situation of refugees in Ethiopia, the researcher has undertaken an assessment study on the prevalence of mental distress and sexual violence encountered by Sherkole refugees. To this end, the present study focused on addressing the following questions: -

1. What is the prevalence rate of mental distress among refugees at Sherkole refugee camp?
2. What is the prevalence rate of sexual violence among refugees at Sherkole refugee camp?
- 3 What are the risk factors for sexual violence?

4 What are the major consequences of sexual violence?

5. What are the phases of sexual violence?

1.3 Objective of the study

1.3.1 General Objective

The general objective of this research is to assess the prevalence of mental distress and sexual violence among refugees at Sherkole Camp.

1.3.2 Specific objectives

The study aims to:

1. Analyze the prevalence rate of mental distress among refugees at Sherkole camp.
- 2 Investigate the prevalence rate of sexual violence at Sherkole Refugee Camp.
3. Identify major risk factors for sexual violence.
4. Explore the major consequences of sexual violence
5. Identify the phases of sexual violence.

1.4 Significance of the study

The present study will be helpful in the following ways:-

- The assessment of mental distress and sexual violence of refugees is the first major stage required for the planning and implementation of intervention services focused on minimizing mental distress and social problems of refugees.
- This study will serve as base line data for interventionists to

develop constructive, cost effective and feasible intervention schemes to alleviate psychosocial problems of refugees.

- This study can also be a milestone for further research.

1.5 Delimitation of the study

The scope of this study is geographically delimited to Sherkole Refugee Camp in Benishangul Gumuz Region, because of the following main reasons. The main reason is that at Sherkole Refugee Camp the present researcher was able to get the assistance of service providers in data collection. The camp is representative enough containing many refugees representing different age, culture, sex, country of origin groups. This research mainly emphasized on mental distress and sexual problems as core areas and as investigated in previous research works at international level.

1.6 Limitations of the study

- Sexual violence is a sensitive issue in the refugee settings. This may be due to cultural and religion barriers in the community.
- Most refugees have passed through a number of interviews. So they already may have developed interview fatigue and they often seemed frustrated to take part in the study.

1.7 Operational Definition

- 1. Refugees** – according to UNHCR (2007) refugees are people who have a very real fear of persecution because of their race, religion, nationality, political opinions or social associations. For the purpose of this study the age of refugees is limited to refugees who are above 15 years old as required by SRQ- 20.
- 2. Mental distress** –Refugees who were found to have 11 or more symptoms of the 20 SRQ 20 questions in the last 4 weeks are considered as having mental distress.

3. **Sexual violence-** in this study sexual violence refers to forced rape, attempted rape and gang rape happened in the refugee life cycle.
4. **Rape-**In this study rape refers to the invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force, threat, and coercion, taking advantage of a coercive environment or against a person incapable of giving genuine consent (International criminal court).
5. **Rape survivor-**Person who has experienced sexual violence.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. Major Psychosocial Problems of Refugees: an overview

Refugees living in collective centers/camps may face similar psychosocial problems. Some of these problems are manifested to a greater or lesser degree. However, living in camp has its negative side, which can be the basis for the further development of traumatic stress. Fears of solitude and identity loss are expressed more strongly among refugees and these are the characteristic features of crises among this category of refugees. Fears of solitude and identity loss happen when there is a threat to the process of identification and belonging to one's immediate social environment. For example, refugee finds him/herself in another socio-cultural environment where the language, traditions, values, and life norms are "alien" to him/her. Refugees face a difficult choice: either they should reject their habits, traditions, and social norms and assimilate into an "alien" culture with alien values or preserve their originality and find their own "niches" in order to gain new self-confirmation in the society (De Jong et al, 200).

Many researchers identified the specific problems of refugees. To them, refugees face the challenge of adapting to a new country with cultural norms and values significantly different from those of their homeland without the support of their prior indigenous social networks (e.g. Matsuoka, 1993 & Mayadas & Elliott, 1992). Specific problems of refugees include housing, finances, employment and language problems, lack of access to education, racism, discrimination by the local population, family breakdowns, lack of basic amenities, inability to integrate into host community, various emotional problems as well as personal or family members' illness or death and loss of kinship networks.

Moreover, refugees living in the camp may experience poor housing, disruption of personal networks, lack of medical care, interruption of their children's schooling, uncertainty regarding their rights and legal status and future and dangers of assault or rape.

The above mentioned psychosocial specificity, obviously, does not reflect all the nuances of the factors that are functioning in the displaced and refugee populations, but they give a general impression of these essential phenomena, which need to be considered in order to direct effectively our actions

There are some 50 million refugees and displaced persons in the world (Bruntland, 2000), of which about 271,000 are in Ethiopia. Ethiopia also allowed about 1000 refugees, mostly from different countries in Africa, to live in urban areas. Most refugees have fled from war, repression and poverty in the neighboring countries, usually against their will, often suddenly, and under extremely dangerous conditions.

According to many research findings, refugees or displaced people passed through traumatizing events (e.g. Carlson & Rosser-Hogan, 1994; Kinzie, Fredrickson, Ben, Fleck & Karls, 1984; Kinzie, et al., 1990; Kleinman, 1990; Lee & Lu, 1989). To these researchers, both before and during emigration, all refugees experienced stressful conditions and events that were devastating for many and extremely difficult for most. Many refugees have experienced personal terror or witnessed the physical abuse or death of loved ones.

Large numbers of them have suffered the destruction of their homes and communities, the loss of their traditional livelihoods and of material possessions. They may have been forcibly detained or spent periods in concentration camps and may, prior to arrival in the refugee camp, have been tortured, raped, or otherwise physically abused.

To many researchers, in addition to the flight and pre-flight experiences, life in urban areas is a stressful situation where refugees were forced to adapt to a new country that was quite different from their own, while simultaneously grieving the multiple losses (Bernier, 1992; Bromley, 1987; & Gorst, 1992). Clinical and empirical studies have reported that cultural, language, and value differences added further stress and hindered the process of adaptation (Gong-Guy, Cravens, & Patterson, 1991; Le-Doux & Stephens, 1992; Mayadas & Elliott, 1992).

Although many refugees show resilience to traumatic experiences, others lack the necessary coping strategies and mechanisms. For others, the experience of trauma is so overwhelming that their functioning and recovery may be severely compromised. In addition to suffering the effects of stress and anxiety, refugee's ability to engage with others, to participate in community life and to deal with authorities can be heavily affected (De Jong et al, 200).

Furthermore, the personal status of refugees, their belief in them, trusts in others, and hopes for the future have been shattered. They feel vulnerable and mistrustful. They have become dependent on others for the physical necessities of life.

2.2. Psychosocial Problems of Women Refugees

Many of these traumatic experiences are especially problematic for women. Since they are often the ones responsible for preserving their home and their family, disruption of home and family may be especially distressing. As "little" a thing as not being able to cook for their family may be a source of stress. They may also suffer from changes in family relationships. If their husband is dead, missing, injured, traumatized, or separated from the family, the woman becomes the "head" of the family and must take on unfamiliar and traditionally male roles (UNHCR, 2003).

Another danger for women, while fleeing and in refugee camps, shelters is rape. Rape may be a source of shame, guilt, and denial of the woman's own needs. She may "escape" into illness or become socially isolated. In war settings, rape may take the form of mass or repeated rape.

Women are more vulnerable to the psychosocial effects of displacement and are likely to have more severe psychological problems than their male counterparts. They are more prone to depressive and anxiety symptoms as well as to psychosomatic symptoms. Of course, they are also able to provide higher levels of strength and ability to support others.

In line with this crises have serious and different impacts on the lives of women, girls, boys and men (IASC, 2006). Particularly, Adolescents uprooted by armed conflict may experience difficulties in health, education, livelihood, protection and psychological needs. The uprooting, disruption and insecurity inherent in refugee situations can harm children's physical, intellectual, psychological, cultural and social development. These factors are severely compounded when; in addition, children suffer or witness the torture or murder of family members or other forms of abuse or violence. Unaccompanied children are particularly vulnerable (UNHCR, 1994)

Sexual violence is extremely associated with situations of forced population movement. Women and young girls and, in some cases, men and boys are vulnerable to attack both during their flight and while in exile. They are vulnerable from many quarters and in every case, the physical and psychological trauma that results can only add to the pain of displacement and bitterness of exile (UNHCR, 2000).

In refugee situations, women and children are particularly vulnerable to violence, including sexual abuse, especially if they are unaccompanied. Sexual violence is a serious, life threatening protection issue primarily affecting women and children following social chaos. Various studies

indicate that during severe crises or armed conflict institutions and systems for physical and social protection may be weakened or destroyed. As a result, police, legal, health, education and social services are often disrupted; many people flee and those who remain may not have the capacity or equipment to work (IASC, 2005).

Sexual violence is the most immediate and dangerous type of gender based violence occurring in acute emergencies. It is also a violation of universal human rights strictly safeguarded by international human rights conventions, like the right to security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, in human, or degrading treatment; and the right to life (WHO,2000). UNHCR (1995) also stressed that sexual violence is a gross violation of fundamental human rights and, when committed in the context of armed conflict of a grove breach of humanitarian law.

In the context of armed conflict sexual violence is often used as weapon of war, targeting civilian women and children (IASC, 2005). Rape has been used as a strategy in many conflicts, including in Korea during the Second World War and in Bangladesh during the war of independence, as well as in arrange of armed conflicts such as those in Algeria, India, Indonesia, Liberia, Rwanda and Uganda (WHO, 2000)

2.3. Psychosocial Problems of Child Refugees

Many child refugees have experienced torture and other forms of physical violence and they have witnessed bombing, shooting, and the forceful occupation or/and arrest of people.

They have also seen the torture, rape, killing of their parent(s) or other close relatives and friends and separated from the family – left alone. Separated children are most vulnerable. To survive they have to behave like adult people. They even don't get any support in their mourning

process about the loss of their whole family, social environment etc. and no help to cope with the totally new and stressful situation in the country of exile.

The other especially vulnerable group is children who have served as soldiers. In addition to being traumatized and brutalized by their experiences at a developmentally sensitive time in their lives, they are a stigmatized group, isolated from their former communities.

For men and for women, being a “refugee” may prolong the trauma and prevents self-healing. The usual model of response to disaster assumes that once the disaster is “over,” the victim is in a safe, peaceful, environment. For refugees, this is not true. They remain in a highly stressful, even repeatedly traumatic situation, and may have little prospect of escaping it (Kerimova, 2000).

2.4 Prevalence and Symptoms of Mental Distress among refugees

About 450 million people suffer from mental disorders (WHO, 2000). According to the report one person in four will experience one or more mental disorders including unipolar depressive disorders, bipolar affective disorders, schizophrenia, epilepsy, alcohol and selected drug use disorders, Alzheimer’s and other dementias, post traumatic stress disorder, obsessive and compulsive disorder, panic disorder and primary insomnia during their life.

Mental and behavioral disorders are present at any point in time about 10% of the adult population world wide (WHO, 2004). Murray and Lopez (1996) stressed that five of the ten leading causes of disability world wide are psychiatric conditions, including depression, alcohol use, schizophrenia and compulsive disorders. Mental health has always been the Cinderella of health concerns in developing countries even through health policy and international consensus defined health in broadest

context of physical, mental and social components for about last 30 years (Alemayehu, 2005).

Studies conducted in rural Lesotho, Uganda primary health clinics, Chile and India, revealed prevalence figures approaching 30% and 40% in women and adult primary care population respectively. A study conducted in Borena semi-nomadic community in southern Ethiopia indicates that the life time prevalence of all psychiatric disorders along with substance abuse was 21.6%. A study on the prevalence and socio demographic correlates of mental distress in Butajira, Ethiopia revealed prevalence figures of 17%. Other similar study conducted on correlates of mental distress in Jima town, Ethiopia indicates 22.7% prevalence figures. In a similar development, a study conducted on Assessment of prevalence, determinants and effects of mental distress among Alemaya university students reveal prevalence figure of 19.3%(Kleinman 1990).

Many studies have found high rates of mental disorder among refugees. Post-traumatic stress disorder (PTSD) and depression are the most common (de Jong *et al*, 2000). Similarly, in a study made by Naeem, et.al., (2004) 80% of refugees who attended a psychiatric clinic experienced symptoms of PTSD.

In a very recent study conducted by Hussain, et.al.,(2007) 60% of women & 45% of men scored 9 or more on SRQ- 20 and were considered as suffering from mental distress. This study also reflects the poor living conditions of these people with lack of education & social problems that adds to their trauma. There is a desperate need to improve their living conditions and educate these people, so they could recognise their symptoms & seek help, as the condition like depression is treatable and will improve their quality of life significantly.

Another recent study made by Rahman, et.al.(2003),examined the prevalence of mental distress in a sample of Afghan mothers caring for

children in two refugee camps in Pakistan using the Self-Reporting Questionnaire (SRQ-20). According to the findings of this study, one hundred and six (36%) of women in the sample were found suffering from common mental disorder. Ninety-six (91%) had suicidal thoughts in the previous month, and nine (8%) rated suicidal feeling as their top most concern. The researchers used cut-off score of 13 or more for the SRQ-20.

Muhwezi, et.al. (2004), explored the mental health status and the socio-cultural situation of refugees in Kampala city who came from different African countries. Results indicated that between one out of seven, and one out of five might be suffering from serious mental health problems, in the form of anxiety, depression, psychosomatic symptoms and post-traumatic stress disorders.

Warfa(2005), carried out a study with 189 Somali refugees living in London and Minneapolis. The major objective of the study was to estimate and compare the prevalence of and risk factors for mental disorders in Somali refugees living in London and Minneapolis. According to the results of this study, 21%, 11% and 7% of the participants met diagnostic criteria for major depression, PTSD and suicidal feeling respectively.

Very recent study made by Asakura, et.al. (2006), examined the relationship of demography, immigration background, and concerns and difficulties associated with living in Japan to nonpsychotic psychological disturbance (i.e., "caseness") measured by the GHQ-12. Data were collected from a sample of 265 Japanese Brazilians (JB) residing outside the Tokyo Metropolitan area. It was found that Japanese Brazilians (JB) who experienced lower economic conditions, lived alone, stayed relatively longer in Japan, migrated to Japan due to their dissatisfaction with the socio-economic conditions in Brazil, and who experienced severe family

life concerns had a significantly higher ratio of “caseness,” that is psychologically distressed. In contrast, JB over the age of 25 years, who acquired moderate Japanese language proficiency and decided to return to Brazil as soon as possible, were observed to have a significantly lower ratio of psychological distress.

2.5 Prevalence of Sexual Violence

The incident of rape may vary in different parts of the world. In a study conducted on women at Sherkole/Assosa refugee camp, the prevalence rate of rape was found to be 9.45% (Yi-ling Tan, UNHCR Intern, 2007). In the abovementioned study made by (Yi-ling Tan, UNHCR Intern, 2007), the prevalence of attempted rape among refugees was found to be 4.20%.

For instance from 50,000 to 64,000 internally displaced women in Sera Leone have encountered sexual violence by armed combatants. Half of them who had face to face contact with combatants reported encountering sexual violence (Human Rights, 2002).

In a study conducted on Azerbaijan’s internally displaced populations indicates, 25% experienced forced sex (Kerimova, 2000). A situational analyses conducted on the majority of Tutsi women in Rwanda’s indicates that there were an estimated between 250,000 to 500,000 rape survivors in the country after the 1994 Genocide (Survey on violence against Women in Rwanda 1999). On the other hand, between 20,000 and 50,000 women were encountered rapes during the war in Bosnia Herzo govenia (RHRC consortium, 2002)

A study conducted by IRC(2004) on Liberian refugee women living in Sierra Leon showed, 74% of Liberian women of reproductive age (15-49 years of age) who were living in three selected refugees camps in Sierra Leon, reported being subjected to at least one incident of sexual violence and 71% experienced at least one incident of physical violence before

displacement. In a similar study conducted using a series of FGD and individual interviews with women and men in 7 IDP camps in Montserrat country, the results showed that IDP women and girls experienced various types of gender based violence (Bernier, 1992).

Another study conducted by WHO/ country office in collaboration with MOH/ Sw(2004), using a series of FGD and Face-to-face interviews with 412 women and girls in the selected communities and IDP camps, showed that sexual assault was high (nearly 80%) during the conflicts.

A study conducted by WHO (2005) using FGD and face -to-face interviews with a total of 1,216 women and girls in 6 counties of Liberia, showed that the general mean percentage of rape is 73%.

According to IASC (2005) sexual violence is perpetuated primarily by males against women and girls. Men and boys are also vulnerable to sexual violence, particularly when they are subjected to torture and /or detention. Nevertheless, the majority of survivors / victims of sexual violence are females. Proceedings by UNHCR (2001) focusing on prevention and response to sexual and Gender based violence indicates that during the Armed conflict in Bangladesh in 1971, it is estimated that 200.000 civilian women and girls were victims of rape committed by Pakistan soldier.

A WHO (2000) report on violence and health reports that refugees who are fleeing conflicts and other threatening factors are often at risk of rape in their new settings. For instance, among the “Boat people” who fled Vietnam in the late 1970s and early 1980s, 39% of the women were abducted or raped by pirates at sea (WHO, 2000). In a similar study conducted in the refugee setting of Kenya and united republic of Tanzania, rape has been found to be a major problem (WHO, 2000).

Due to their level of dependence and their limited ability to protect themselves children might be at risk of sexual violence, because, they may have relatively little experience of life, be more easily tricked and coerced than adults (IASE, 2005). Due to the level of development, they may not understand the characteristics of sexual violence and they are unable to give informed consent (UNHCR, 2003.).

Adolescent girls and young women may be the target group for sexual violence in the refugee settings. Women's commission for refugee women and children (2000) revealed that adolescent girls may be more likely than younger girls to be sexually abused or abducted and held as sexual slaves. Adolescent girls maybe targeted for sexual abuse due to their physical maturity and because perpetrators may consider them less of a risk for sexually transmitted diseases (STDs) including HIV/AIDS than older women (WHO,2000).

2.6 Forms of Sexual Violence in the Context of Refugees

It can cost both physical injury and profound emotional trauma. It is also a violation of woman human right, such as the right to life, dignity and privacy security of the person, health, and etc. Most often, those who faced rape are socially abandoned and are considered as promiscuous (Panos Ethioia, 2006).Refugees who encountered sexual violence may experience both social and psychological reactions. As a result, they find it difficult to be accepted by their mates as well as their family members.

The second form of sexual violence is gangster rape. This type of rape refers to if there is more than one assailant.

The third form of sexual violence is attempted rape. International criminal court define attempted rape as attempted forced or coerced intercourse; no penetration.

2.7 Contributing Factors for sexual violence

Research indicates that sexual violence against women is complicated by the multiple forms it takes and contexts in which it occurs. Various factors would have an additive effect. As a result the more factors present, the greater the likelihood of sexual violence. The root causes of sexual and gender based violence lie in a society's attitudes towards and practices of gender discrimination, which place women in a subordinate position in relation to men) (UNHCR, 2003).

According to WHO (2000), age, alcohol and drug consumption, having previously been raped or sexually abused, having many sexual partners, educational level, and poverty are the key factors for sexual violence

2.7.1 Age

Young women found to be more at risk of rape than older women. The report indicates them in wife, Makysie, Mexico, Papua, New Guned and Peru, between one-third and two-thirds of all victims of sexual assaults are aged 15 years or less (UNHCR, 2000).

2.7.2 Alcohol and drug

Increased vulnerability to sexual violence also stems from the use of alcohol and other drugs. Alcohol or drugs makes it more difficult for women to protect themselves by interpreting and effectively acting on warning signs (UNHCR, 1994).

2.7.3 Having previously been raped or sexually abused

According Research results there is a linkage in experiences of sexual abuse in childhood or adolescence with patterns of victimization during adulthood. Women who were raped before the age of 18, years were twice as likely to be raped as children or adolescents (18.3% and 8.7% respectively). The effects of early sexual abuse many also extend to other

forms of victimization and problems in adult hood. The best example is a case- control study in Australia on the long term impact of abuse reported significant associations between child sexual abuse and experiencing rape, sexual and mental health problems, and other problems in intimate relationships even after accounting for various family background characteristics(WHO,2004).

2.7.4 Having many sexual partners

Young women who have many sexual partners are at increased risk of sexual violence (Taylor,et .al ,2001).

2.7.5 Poverty

Poor women and girls may be more at risk of rape in the course of their daily talks than those who are better off, for example when they walk home on their own from work late at night, or work in the fields or collect fire wood alone. Poverty force women and girls in to occupations that carry a relatively high risk of sexual violence particularly sex work (WHO, 2002).

2.8 Consequences

Consequences of sexual violence may rely on psychological reactions or social reactions.

2.8.1 Psychological reactions

According to UNHCR (1995), the victims most commonly experiences fear, helplessness and humiliation. In line with this, rape survivors likely to experience a loss of trust and a loss of sense of safety and security. The victims will probably feel guilt or shame from a sense that perhaps provoked or in some other way was responsible for what happened to them. The victim's trauma my also lead them to aggressiveness or destructiveness, anger, hatred or revenge, taking an outward direction

instead of being internalized or assuming the blame. Further more; the experience of sexual violence often makes the victim feel unclean and unworthy. Virginity, modesty and female chastity define the value of girls and women in many cultures, and consequently sexual abuse is perceived as devaluing a woman and making her “unclean” Since, men are perceived in many cultures in terms of their manhood and virility and therefore the experience of sexual violence against a man can have a devastating psychological impact.

A victim can respond to sexual violence trauma by “psychic numbing”. This is a defensive reaction that significantly mutes the person’s emotions. She may feel numb, show little feeling, speak slowly and invalidly and may appear very calm. After the initial shock and trauma of the incident, the victim might go through a period of thinking frequently about the incident, about the attacker, and re-experiencing the trauma. This may occur in relation with preparations for court proceedings or in preparation for eligibility interviews (UNHCR, 1995)

2.8.2 Health related consequences

2.8.2.1 Pregnancy and gynecological complications

Pregnancy may result from rape, though the rate varies between settings and depends particularly on the extent to which non-barrier contraceptives are being used.

A study of adolescents in Ethiopia found that among those who reported being raped 17% become pregnant after the rape, a figure which is similar to the 15-18% reported by rape crises centers in Mexico (WHO, 2000).

WHO report (2000) indicates a longitudinal study in the United States of America of over 4000 women followed for 3 years found that the national rape related pregnancy rate was 5.0% per rape among victims aged 12-

45 years producing over 32000 pregnancies nationally among women from rape each year. Further more, women who are exposed to rape are forced to bear the child or else put their lives at risk with back street abortions. Exposing to coerced sex at an early period reduces a women's ability to see her sexuality as something over which she has control. The report also shows gynecological complications have been consistently found to be related to forced sex. These includes vaginal problems mainly vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections.

2.8.2.2 Sexually transmitted diseases

Infection and other sexually transmitted disease are recognized consequences of rape (WHO 2003).

2.8.2.3 Mental health

Sexual violence might have a synergistic tie with a number of mental disorders and behavioral problems. For example in one population-based study the prevalence of symptoms or signs suggestive of a psychiatric disorder was 33% in women with a history of sexual abuse as adults (WHO, 2000). Abused women reporting experiences of forced sex are at significantly greater risk of depression and post- traumatic stress disorder than non abused women (WHO, 2002).

2.8.2.4 Suicidal behavior

Women who experience sexual assault in childhood or adult hood are highly exposed to commit suicide than other women. According to WHO (2002) report, the experience of being raped or sexually assaulted can lead to suicidal behavior as early as adolescence.

2.8.2.5 Social ostracization

In most cultural settings it is held that men are unable to control their sexual urges and that women are responsible for providing sexual desire in men (WHO, 2002).

2.9 Phases of sexual violence in the refugee context

UNHCR (1995) studies indicate that refugees confront sexual violence during prior to flight, during flight, in the country asylum, during repatriation operations and during integration phases.

2.9.1 prior to flight

According to the study women and children may be targeted for abuse by the police, the military or other officials in the country of origin. Various studies reveal that, sexual violence may happen at the hands of irregular forces in situations of internal conflict. Sexual violence may even occur with the complicity of male leaders, in the form of bartering women or girls for arms and ammunition or other benefits (WHO, 1999).

2.9.2 During flight

Research shows that refugees may be sexually attacked by pirates, bandits, members of the security forces smugglers or other refugees. Border guards may detain and abuse women and girls, sometimes for extended periods; pirates may capture women as they travel by boat and extort sex in exchange for their safety and onward passage (GFHR, 2000).

2.9.3 in the country of asylum

Research reveals that the country of asylum does not necessarily provide protection from sexual violence. Refugees live in camps or in urban situations; they may be subjected to sexual attacks by persons in

authority or otherwise in a position to take advantage of their particularly vulnerable situations. Further more officials who determine the refugee status of the applicant may extort sex in exchange for a positive determination and refugee women and girls may be approached for sexual favors in exchange for assistance, such as during food distribution (UNIFEM, 2000).

Refugees may be sexually attacked by members of the local population, by officials, including those responsible for their protection such as border guards, police or military personnel, by international refugee workers, or by fellow refugees. Most often, sexual attack may occur at right in the homes of victims and in front of family members or an individual may be abducted and sexually violated away from her home(WHO,2002).

CHAPTER THREE

Methodology

3.1 Study area

The study was carried out at Sherkole refugee camp; which is located in Benshagul Gumuz regional state around 720k.m away from Addis Ababa. The main reason for selecting the Sherkole Refuge Camps is that the present researcher is able to get the assistance of service providers in data collection. The camp is also representative enough containing many refugees representing different age, culture, sex, country of origin groups. This is one of the rural refugee camp known for its stable condition. The total refugee population during the study period was 4000. These are refugees who are above 15 years old.

3.2 Study design

This study employed a survey design to assess the prevalence of mental distress and sexual violence among refugees at Sherkole camp.

3.3 Participants

A total number of 485 refugees and national staffs working with the refugee participated in this study.

3.3.1 Refugees

Refugees who were above 15 years, which were registered in UNHCR-ASOSA data base, were participants of this study. The underlying reason for emphasizing on refugees above 15 years of age rests on the requirements of SRQ-20. The SRQ-20 could only be administered to participants who are above 15 years old.

3.3.2 National staffs

3.3.2 National staffs

National staff workers who were drawn from various organizations such as ARRA, UNHCR, ZOA, IRC, and MOH (ARRA) were participated in this study. Accordingly, ARRA head nurse, nurse, camp coordinator, protection officers, repatriation assistant, UNHCR protection worker, Head of IRC Gender based violence department at Sherkole participated FGD. The total number of participants summarized in table 10 below.

Table: 10 Participants of the study

No	Participa nts	question naire	FG D1	FG D2	FG D3	Intervi ew	Case Study	Total
1	Refugees	450	10	10		2	2	474
2	UNHCR				2	3		5
3	ARRA				4			4
4	ZOA				1			1
5	IRC				1			1
	Total	450	10	10	8	5	2	485

3.4 Sampling procedure

Random sampling technique was employed in order to get the right participants. Primarily, around 4000 refugee population who were above 15 years old were selected from the total refugee population using lists of refugee at UNHCR data base. Secondly, 450 refugees were selected using Systematic random sampling was employed to get the sample.

3.5 Method of data collection procedures

Six data collectors were employed for collecting the required data from the target population. The data collectors were well known and experienced refugee social workers in ARRA. They represented all ethnic languages spoken at Sherkole refugee camp. One and half day training was given to the data collectors on how to conduct data collection. They were well informed that all ethical considerations would be adhered to in order to assure the confidentiality of the data. The next day data collectors received a list which contains house numbers, zonal address of the participants and their house number.

Then, the data were collected using a structured questionnaire having three parts. The first containing socio demographic information, the second focusing on sexual violence and the third part was a self reporting scale to measure mental distress. Self reporting scale (SRQ 20) is a standardized scale having 20 scales that is adopted from World Health Organization (WHO, 1994)

3.6 Data quality assurance

To guarantee the data quality, high consideration was given to designing and adopting the data collection instrument. For the sake of simplicity, the questionnaire and the scale retested, and some modification made. SRQ-20 scale was designed to be answered easily with out any

confusion. Appropriate instruction was given before the survey as to the importance of the study for the refugees as well as data collectors.

3.7 Methods of data analyses

Both quantitative and qualitative analyses were administered for data analyses. The data quantitatively analyzed by percentage and chi-square and qualitatively analyzed by grouping.

Data entry, cleaning and analysis were done using the Statistical Package for the Social Sciences (SPSS) version 13 for Windows. In the present study those respondents who gave 11 or more positive responses out of 20 SRQ items were regarded as having mental distress. Selection of this cut-off score was based on reports from studies in Butajira rural populations in Ethiopia (Alem, et.al., 1999).

3.8 Ethical considerations

Ethical clearance was obtained from Addis Ababa University Department of Psychology, Administration for Refugee and returnees (ARRA) and United Nations High Commissioner for Refugees (UNHCR). Informed consent was assured from refugees who participated in the study. The researcher assured the Refugees who participated in the study would not be responsible for the out come of the research. Confidentiality was highly exercised by omitting their name and personal identification. Thirty five refugees (15 male and 20 female) were found with mental distress during the study period. An appropriate counseling service was given for the clients in collaboration with UNHCR senior field assistant and ARRA head nurses. Some cases which are beyond the capacity of the researcher were referred for medical intervention. The researcher met the aforementioned clients repetitively (See appendix 5).

3.9 Instruments for data collection

3.9.1 Questionnaire

A questionnaire which has 3 parts was administered to 450 refugee participants. The first part of the questionnaire contains socio demographic characteristics of study participants. The second part contained questions focusing on sexual violence and it was prepared for female refugee participants. The last part of the questionnaire mainly contained SRQ-20 scale. SRQ was developed by WHO. It was prepared to screen for psychiatric disturbances in common mental disorders particularly, in developing countries. Questions that touched on different cultural backgrounds were minimized from formerly screening instruments to form SRQ. The SRQ was designed to show mental distress. But, it does not serve us for screening mental illness.

So, it can serve as a bridge for the transfer of the second phase of diagnostic instrument. SRQ can not measure the probable range of all mental disorders mentioned in the international classification of Diseases (ICD) or in the American Diagnostic and Statistical Manual (DSM). It tended to measure depression, anxiety and somatic problems.

Originally, SRQ contains a total of 25 Questions and it was known by SRQ-25. Twenty are directly connected with neurotic symptoms. Four of them deal with psychotic symptoms. The remaining one question is for identifying convulsions. Due to the unreliability of the four psychotic items, the instrument had final 20 items. Then, the instrument was designated as SRQ -20 (Appendix). Originally, the instrument was designed to be self administered. But, due to illiteracy, the instrument invariably was administered in an interview format in low income countries. SRQ has been validated and widely used in developed as well as in the developing countries for the purpose of studies in health and community assessments. The validity (Content, Face, Criterion and

Construct validity) of a test refers to how well a test measures what it intends to measure. The SRQ has been tested for validity in a series of studies carried out between 1978 and 1993. Reliability of the scale was demonstrated by determining the internal consistency of items using cronbach's alpha, average item-total correlation, and split-half reliabilities (WHO, 1994). In this study, I used SRQ20 for measuring the prevalence of mental distress among refugees at Sherkole camp.

3.9.2 Interview

Semi- structured interview guide were prepared (see appendix) and administered to key informants who were purposefully selected from UNHCR, religious institutions, zonal leadership. The content of the interview focused on sexual violence and prepared by the present researcher. Participants were working in top positions with Sherkole refugees. Most of them have an experience of more than 15 years working with refugees in different organizations.

3.9.3 Focus Group discussion

FGD guides were also prepared by the present researcher for assessing the prevalence of sexual violence at Sherkole refugee camp. Accordingly three different FGDs were held in the camp. The first FGD group was held with female refugees who are social workers GBV. The second FGD was held with male refugees. These are social workers at GBV (Gender Based Violence) and zonal leaders in the camp. The third FGD held with national staffs drawn from ARRA, UNHCR, ZOA and IRC. All FGD participants were selected purposefully. The selection was based on relevant experience on sexual violence.

3.9.4 Case History

Two case Histories were conducted on women refugees at Sherkole camp. Cases were gained while the researcher was giving counseling services.

Rape survivors were willing to give information for the purpose of the research. Confidentiality and consent was assured before conducting the research.

3.10. Pilot result

As mentioned in the instrument section, SRQ-20 has been validated and widely used in developed as well as in the developing countries for the purpose of studies in health and community assessments. The contemporary researcher administer pilot test to 40 refugees. According to the pilot result, some minor amendments on the language and expressions were made on the scale. Content validity of Interview and FGD had been conducted. Accordingly, the face validity of the FGD and the Interview was checked by 3 instructors of Addis Ababa University. Following checking the FGD and interview guide lines, some improvements were made based on the recommendations forwarded by the instructors.

CHAPTER FOUR

Results and Discussion

The general objective of this research is to assess the prevalence rate of mental distress and sexual violence among refugees at Sherkole Camp. The collected data was reviewed and checked for completeness before data entry. Respondents who were absent during the data collection phase were removed from the sampling list (N= 20). Data entry format template was produced and programmed.

The following are the specific results of the study.

4.1. Socio Demographic Characteristics of Respondents

Out of 430 refugees, 220(51.16%) were males and 210(48.84%) were females. Majority of the respondents 195(45.38%) and 188(43.71%) were found to be at the age of 15-25, 25-35 years respectively. while the remaining 47(10.91%) were 35 and above years of age. Most of the respondents were found in the reproductive age group or sexually active groups. The table below shows a summary of the socio demographic characteristics of the respondents. As country of origin composition of the respondents 358(83.25%) were Sudanese refugees and 72(16.75%) are non Sudanese refugees (Grate lakes)

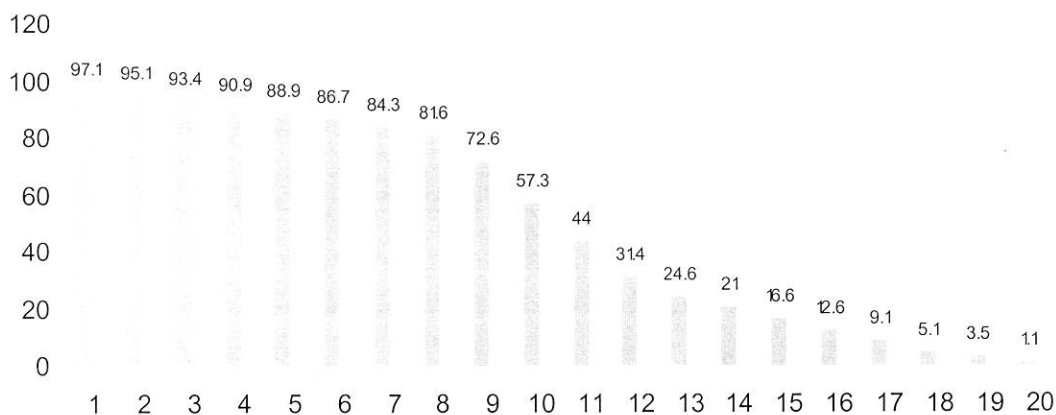
Table 1: Socio-demographic Characteristics of the respondents

No.	Characteristics	N	%
1	Country of origin		
	➤ Sudanese	358	83.25
	➤ Non Sudanese	72	16.75
Total		430	100%
2	Sex		
	➤ Male	220	51.16
	➤ female	210	48.84
Total		430	100%
3	Age		
	➤ 15-25	195	45.38
	➤ 25-35	188	43.71
	➤ 35-45	38	8.83
	➤ Above 45	9	2.08
Total		430	100%

4.2. Prevalence rate of mental distress

The prevalence of mental distress in the past one month among refugees at Sherkole camp is clearly indicated in the figure 1 below. The data clearly show that among the total respondents 199 (44%) of Refugees were mentally distressed in the last 4 weeks while 253 (56%) refugees were not mentally distressed in the past 1 month (Table-2)

Figure1. Distribution of scores for cut off point selection of the SRQ 20 items.



Cut off points

As can be seen from the above figure, the prevalence of mental distress in the present study was found 44% using cut off score (11 or more). 44% of the respondents suffered from clinically significant level of mental distress. In a study made by Ruth, et.al.(2004,) those respondents who gave 11 or more positive response out of 20 SRQ items were regarded as having mental distress.

The prevalence of mental distress found in the present study is high

compared with previous research findings made in India among displaced Kashmiri population living in India using a self responding Questionnaire ,SRQ-20(Kaz,et.al.,2005),where the prevalence of mental distress among displaced people was found to be 33.3% using similar cut-off score (11and more).In the aforementioned study made (kaz,et.al.,2005),those respondents who gave 11 or more positive response out of 20 SRQ items were regarded as having mental distress.

As indicated above, the prevalence of mental distress in the present study was found to be 44%.The mental distress level is found to be high as compared to other local studies. This may be because the refugee setting is quit different from other settings. Refugees are people displaced from their original home. As a result, they exposed to social crises due to a sudden movement from their country of origin. They may pass through bad experience which is beyond the range of normal experience or suffering. Exposing to single, multiple or continuous traumatic events associated with conflict or organized violence such as rape, harassment, persecution, imprisonment and torture, refugees may suffer from severe mental distress. The higher prevalence of mental distress found in the recent study might also reflect the stressful war; violence and displacement experiences rural refugees had encounter and the physical and psychological violence still taking place. Further more, refugees living in the camp may confront difficulties like poor housing, disruption of personal networks, lack of medical care, interruption of their Children schooling, uncertainty regarding their rights and legal status and future and dangers of assault or rape.

4.3. The prevalence rate of mental distress by sex

The following table is clearly indicating the prevalence of mental distress across sex.

Table 2- The prevalence of mental distress among male and female refugees

prevalence of Mental distress	SEX				
	Male	%	Female	%	
Yes	160	72.72	175	83.33	X²=7.02
No	60	27.28	35	16.67	
Total	220	100	210	100	

(P= 0.008)

As indicated in table 2 above, reported mental distresses significantly differ among female and male respondents. More females (83.33%) than male (72.72%) were found to suffer from mental distress (X²=7.02, df=1, P=0.008). Mental distress is found to be high in female refugees and this may be due to the nature of refuge settings. In addition to this, females might be exposed in the camp for different forms of sexual violence and this adds into their mental distress level. Still female refugees may probably have children and these children may also be sources of different psychological problems for mothers in the refugee camps fail to properly meet their needs. Women are more vulnerable to the psychosocial effects of displacement and are likely to have more severe psychological problems than their male counterparts. They seem more prone to depressive and anxiety symptoms as well as to psychosomatic symptoms. Traumatic experiences may be problematic for women. Since they are often the ones responsible for preserving their home and their family, disruption of home

and family may be especially distressing. As "little" a thing as not being able to cook for their family may be a source of stress. They may also suffer from changes in family. If their husband is dead, missing, injured, traumatized, or separated from the family, the woman becomes the "head" of the family and must take on unfamiliar and traditionally male roles. Due to the aforementioned facts females might be mentally distressed more than male refugees.

4.4. Mental distress across age groups

The following table shows the prevalence of mental distress among refugees at Sherkole across different age groups.

Table 3: Prevalence of Mental Distress across age groups

Prevalence of Mental distress	Age category							
	15-25		25-35		35-45		45 +	
	No.	%	No.	%	No.	%	No.	%
YES	132	67.40	29	15.20	5	12	1	5
NO	63	32.60	159	84.80	33	88	8	95
Total	195	100	188	100	38	100	9	100

As indicated in the above table, 67.4 % of mentally distressed refugees were found to be between 15-25 age groups while 15.2% mentally distressed refugees found with in 25-35 age groups. About 12% and 5% of the mentally distressed refugees were found between 35-46 and above 45 years of age categories respectively.

According to the results indicated in table 3, mental distress was high to refugees who were between 15-25 age group. This age group contains

both adolescence and early adulthood period. Adolescence characterized by transitional period, period of change, problem age, time of search for identity a dread age time of unrealism and threshold of adult hood. Early adulthood period is a setting-down age, reproductive age, like adolescence period it is also a problem age, a period of emotional tension, a period of social isolation, a time of commitments, often a period of dependency, a time of value change, time of adjustment, and creative age (Elizabethb&Hurlock,2006). But a refuge location does not fulfill all the above mentioned characteristics due to the nature of refugee living condition and they experience psycho-social problems in their country of origin during their flight. The finding goes inline with the explanations given by the above developmental psychologists. Further more, as the present researcher mentioned in the review literature Many child refugees have experienced torture and other forms of physical violence and they have witnessed bombing, shooting, and the forceful occupation or/and arrest of people.

They have also seen the torture, rape, killing of their parent(s) or other close relatives and friends and separated from the family – left alone

4.5. Mental distress across country of origin

The table below shows the percentage distribution of mental distress among Sudanese and non Sudanese refugees.

Table 4: Mental distress and country of origin

prevalence of Mental distress	Country of Origin				X²=58.6
	Sudanese	%	Non Sudanese	%	
YES	132	36.90	62	86	
sNO	226	63.10	10	14	
Total	358	100	72	100	

(P=0.000)

As indicated in table 4 above, reported mental distresses significantly differ among Sudanese and non Sudanese respondents. More Non Sudanese 62 (86.00%) refugees than Sudanese 132 (36.90%) were found to suffer from mental distress ($X^2=58.6$, $df=1$, $P=0.000$).

According to the finding, the prevalence of mental distress among non Sudanese refugees was found to be high as compared with Sudanese refugees in Sherkole camp. Non Sudanese respondents came from grate lakes countries such as Rwanda, Uganda, Burundi, and Congo. These people might have experienced trauma due to the genocide and war happened in their country of origin. During such conflict, the majority of non Sudanese may encounter sexual violence. In addition to the sexual violence, the majority of the respondent's might lost their parents due to the war happened in their country of origin. Experiencing violent conflict

and war is might be extremely traumatic. In connection with past experience they might be more distressed than other refugees in the camp. Furthermore, these refugees perhaps experienced torture, detain and persecution and harassment during flight.

4.6. The Reported Specific Symptoms of Mental Distress

Reports on specific symptoms of mental distress as measured by the SRQ20 (item 1-20), are presented in the table 6. In the past one month, a large proportion of Sherkole refugees interviewed said they had difficulty to enjoy their daily activities (79.06%), trouble thinking clearly (74.42%). Great numbers of the respondents were easily frightened (72.32%) and found their daily work suffering (69.30%). More than half of the participants were unhappy (64.88%). A trend of feeling miserable and disheartened may result in suicidal ideation. Among Sherkole refugees interviewed the researcher found an alarming prevalence of suicidal ideation: About 56.97% of the respondents surveyed in the study had thoughts of ending their life in the past 30 days. Sherkole refugees reported symptoms of mental distress in general are consistent with the SRQ 20 symptoms described in different clinical and social contexts (Clum, et al. 2001; &Taylor &Janson, 2001).

Table 5: Specific symptoms of mental distress as measured by the SRQ 20(item 1-20).

NO	Specific symptoms of SRQ20	No	%
1	Do you often have Head aches?	267	62.09
2	Is your appetite poor?	210	48.83
3	Do you sleep badly?	233	54.18
4	Are you easily frightened?	311	72.32
5	Do your hands shake?	74	17.20
6	Do you feel nervous, tense or worried?	197	45.81
7	Is your digestion is poor?	210	48.83
8	Do you have trouble thinking clearly?	320	74.42
9	Do you feel un happy?	279	64.88
10	Do you cry more than usual?	119	27.67
11	Do you find it difficult to enjoy your daily activates?	340	79.06
12	Do you find it difficult to make decisions?	260	60.46
13	Is your daily work suffering?	298	69.30
14	Are you unable to play a useful part in life?	275	63.95
15	Have you lost interest in things?	185	43.02
16	Do you feel that you are a worthless person?	219	50.93
17	Has the thought of ending your life been in your mind?	245	56.97
18	Do you feel tired all the time?	172	40.00
19	Do you have un comfortable feelings in your stomach?	245	56.97
20	Are you easily tired?	138	32.09

4.7. Prevalence rate of sexual violence

In an attempt to give answer to the above research question, the next table shows the prevalence rate of sexual violence in the camp.

Table 6: Table shows distribution of sexual violence

No	Sexual violence	No.	%
1	Have you experienced sexual violence?		
	1 .Yes	110	52.38
	2. No	100	47.62
	Total	210	100%

In the present study, the prevalence of sexual violence was found to be 52.38%. The prevalence of sexual violence found in the contemporary study was high as compared to previous research works made at Sherkole refugee camp (Yi-lingTan, UNHCR Intern, 2007), where the prevalence of sexual violence among refugees at Sherkole refugees were found to be 9.45%. In the aforementioned study made by (Yi-ling Tan, UNHCR Intern, 2007), the prevalence of sexual violence among refugees was found to be 4.20%. On the study conducted on Azerbaijan's internally displaced Population's indicates 25% experienced forced sex against their will (J. kerimova, 2000).

According to the FGD result, the majority of female refugees experience sexual violence. The participants also described Sherkole female refugees face different forms of sexual violence. The prevalence of sexual violence among refugees in the present study was found to be high when compared to the results of recent study conducted in the same study area entitled “sexual and gender based violence an assessment under taken in Sherkole refugee camp” (Yi-ling Tan, UNHCR Intern, 2007). The prevalence of sexual violence may be high due to living condition of refugees. Furthermore; far distance between tap water and shelters may aggravate the situation.

4.8. Prevalence rate of sexual violence across age

The table 8 on page 46 shows the prevalence of sexual violence across different age groups.

Table 7: The prevalence of sexual violence across age

Prevalence of Sexual violence	Age category							
	15-25		25-35		35-45		45 +	
	No.	%	No.	%	No.	%	No.	%
YES	58	52.72	42	38.18	10	9.09	0	0

Among 110 female respondents who experienced sexual violence, the majority of respondents (52.72%) were found to be at the age group of 15- 25. The second largest proportion (38.18%) of the refugees was found between 25-35 age groups. According to key informants though rape existed in the camp, attempted rape is still rampant in the community. One of the informants stated that:

“Well I think like other life settings we receive some reports in the past couple of years. So far, I have seen a couple of survivors. Nevertheless, the biggest problem people do not come to report may be because they thought that the office do not have any way to support them. However, for the past two years we have received reports from different corners.”

Rape was found to be high among refugees at the age group between 15-25 and 25-35 years respectively. According to WHO (2000) report, “young women were found to be more at risk of rape than older women”. Therefore, as the above mentioned result rape survivors were found to be young women. Furthermore, refugee setting is highly exposed for rape cases.

4.9. Prevalence rate of sexual violence in terms of country of origin

The following table 9 shows the results of sexual violence attributed to country origin.

Table 8: Sexual Violence and country of origin cross tabulation.

Country of origin	Sexual violence			
	yes		No	
	No.	%	No.	%
Sudan	53	48	52	52
Non Sudan	57	52	38	38
Total	110	100	100	100

Among women’s experienced sexual violence 47.60% were Sudanese and the remaining 62.40% of the refugees were non Sudanese (Table 7). The qualitative result indicated that children’s and girls are vulnerable groups for having rape against their willing. Interview result indicates, *“We are not saying that only women and children are at risk but they are more vulnerable, and we can simply say that every one who lives in refugee camp may experience sexual violence.”*

4. 10. Risk factors for Sexual Abuse

The qualitative result shows that the majority of the respondents reported drinking alcohol is the main reason for initiating peoples to commit sexual violence. A case study result also indicates:

“He was drunker and holding chat in his hand. He said; I’m somalian. He started sexually abusing me,”

Many refugees reported that sex desires, mental ill, lack of awareness, to transmit STD or STI are the main reason for refugees who committed sexual violence. Others also reported that living alone with out a husband or being child will aggravate sexual violence. FGD results also indicated that living alone; alcohol and lack of awareness will expose female refugees to be rape victim. An interview result also indicates that traveling a long distance to collect wood might be the risk factor exposed women refugees for sexual violence.

“Women refugees travel a long distance far from the camp to collect fire wood. As a result they exposed for sexual violence.”

Literatures also indicated increased vulnerability to sexual violence also stems from the use of alcohol and other drugs. Concerning alcohol or drugs makes it more difficult for women to protect themselves by interpreting and effectively acting on warning signs (WHO, 2000).

4.11. Consequences of sexual violence

Result gained from the qualitative data shows the majority of refugees who experienced sexual violence exposed to unwanted pregnancy and gynecological complications. Others also exposed to sexually transmitted disease (STD), to mental illness, developed suicidal feeling and are socially ostracized.

FGD and interview results also showed that rape survivors faced sexually transmitted diseases and gynecological complications. On the FGD result also indicated rape survivors most often exposed to injuries in the vagina, unwanted pregnancy and they can also acquire HIV/AIDS. The results also indicate rape survivors faced social rejection. Interview result clearly indicates the consequences of sexual violence as follows:

“Consequences of sexual violence are different in their nature. Most often refugee women who encountered sexual violence might face stigma. It has also economical aspect that people experience sexual violence they restrain themselves from participating in income generating activities. Then they cannot probably earn living. The other issue that has been totally forgotten was is the psychological part, such people always feel unsafe. So I think the impact could either psychological, social or economy.”

A case study result also indicates almost similar results like FGD and Interview results:

“After rape, I do have headache and fear which is not cured. I tried to go to treatment, but they did nothing. Because I think a lot I’m staying alone, no one to talk about my problems. And some people use to come to my house, I don’t know what they want, I fear. I become emotional person, I’m feeling unhappy always. Because, that guy I met, what he did for me was too bad.”

The other case studies also indicate:

“Since the time I came to the camp I have never felt better, socially, psychologically, physically and health is not sweet for me. I feel that with better ration and better treatment I may be better.”

The results of this study also indicate most of the respondents exposed to sexually transmitted disease quite a large proportion of refugees.

The result of this study showed that drinking alcohol is the main factors for refugees to commit sexual violence. The result also tells us sex desires, mental ill, lack of awareness, to transmit STD or STI are the main reason for refugees who committed sexual violence. This is due to lack of hopes and preparing them selves for revenge. The result also

indicates living alone with out a husband or being child will aggravate sexual violence.

Most often the perpetrators commit violence in obscured place and situations. FGD and Interview results from key informants also indicated that living alone; alcohol and lack of awareness will expose female refugees for sexual violence.

4.12. Perceived phases of sexual violence

FGD result indicates large proportion of refugees face sexual violence prior to flight, during flight and some of them encountered sexual violence at Sherkole refugee camp.

Cognizant of such facts, refugee women's who encountered sexual violence reported that they faced sexual violence while fetching water, collecting wood, on the way to the market, on the way to school, around their fence at night in the forest, while they were working at local homes, and at nights are the major sites where Sherkole

Refugee female encountered sexual violence. The qualitative result also indicates:

"It starts from the country of origin on there way here and in the camp, firewood collecting places, water collecting place and some times on there way to school or from

The contemporary study indicated that most women refugee encountered sexual violence at Sherkole refugee camp. The majority of the refugees experienced sexual violence during flight.

CHAPTER FIVE

Summary, Conclusions and Recommendations

5.1 Summary

The main objectives of this study were to assess the prevalence of mental distress and sexual violence among refugees at Sherkole camp and to set forth recommendations on appropriate interventions.

Participants were 454 randomly selected refugees, and 11 purposefully selected national staffs. Questionnaire, structured interview, focus group discussions and case studies were employed to collect the necessary data. Chi square was employed to analyze the obtained data. Below are summary of the major findings of the study.

Results indicate that the prevalence of mental distress among Sherkole refugees was found to be 44%. About 56.97% of the respondents had thoughts of ending their life in the past 30 days. Sixty seven percent of mentally distressed refugees were found to be between 15-25 age groups while 15.2% mentally distressed refugees were found within 25-35 age groups. Reported mental distresses significantly differ among female and male respondents. More females 175 (83.33%) refugees than male 160(72.72%) were found to suffer from mental distress ($\chi^2=7.02$, $df=1$, $P=0.008$). Further more, the prevalence rate of mental distresses were high among Sudanese than non Sudanese refugees. ($\chi^2=58.6$, $df=1$, $P=0.000$).

The prevalence of sexual violence among refugees was found to be 52.38%. Of 110 female respondents who encountered sexual violence, the majority of respondents (52.72%) were found to be at the age group of 15- 25. The second largest age group (38.18%) of the refugees were found between 25-35 age groups. Among women's who experienced

sexual violence 47.60% were Sudanese and the remaining 62.40% of the refugees were non Sudanese

The qualitative result shows that the majority of the respondents reported that drinking alcohol is the main reason for initiating peoples to commit sexual violence. Furthermore, living alone; alcohol and lack of awareness will expose female refugees to be rape victim. In addition lacks of awareness, to transmit STD are the main reason for refugees who committed sexual violence.

The qualitative study result also indicated that women faced sexual violence while fetching water, collecting fire wood, on the way to the market, on the way to school, around their fence at night in the forest, while they were working at local homes, and at nights are the major sites where the abuse occurred.

Further more result gained from the qualitative data show majority of refugees who experienced sexual violence was exposed to unwanted pregnancy and gynecological complications. Others also exposed to sexually transmitted disease (STD), to mental illness, developed suicidal feeling and are socially ostracize

5.2 conclusions

Taking in to consideration all the limitations and drawbacks of this study the following conclusions can be drawn.

The prevalence rate of mental distress among Sherkole refugees was found to be high (44%). The likelihood of mental distress among Sherkole refugees attributed to country of origin was to the Non Sundanese 62 (86%) than Sudan 132(36.90). The possibilities of mental distress among Sherkole refugees by sex shows more females are mentally distressed than males. The epidemiology of mental distress attributed to age variation showed the highest prevalence rate is between the ages of 15-25 age group.

The prevalence rate of sexual violence among Sherkole refugees was found to be 52.38%. It was also indicated that Refugees who were between 15-25 years of age experienced more sexual violence than the other age group. Sexually transmitted disease was found to be the most common consequence among Sherkole refugees who experienced sexual violence. Rape survivors were also exposed to mental illness and unwanted pregnancy as possible consequences of sexual violence. Qualitative results indicated that most of Sherkole refugees experienced sexual violence during flight and at Sherkole refugee camp. In addition, fetching water, collecting wood, on the way to the market, school, forest and working at local homes were found to be major sites of sexual violence.

5.3 Recommendations

1. The management of the Sherkole camp does not only need to provide food and shelter but also a very important aspect on the psychosocial support should be given a top priority. It is necessary to produce Para counselors under the supervision of trained counselor because Sherkole refugee camp contains people who come from various countries which reflect different culture and language settings. Since rape cases are found to be common in the Sherkole Camp, it is important to adopt peer counseling for rape survivors as a means of reducing the psychological problems (mental distress).
2. In order to create awareness on sexual violence, there is a strong need for Strengthening the knowledge, attitude and skills of the social workers. It is important that female refugees living alone are well protected and familiarization of the 1951 Refugee convention is advisable in Sherkole refugee camp. It is necessary to provide on going education on causes and consequences of sexual violence to shurtas'(police workers), Zonal leaders and to other law implementing bodies. Conducting intensive training to understand all contributing factors in sexual violence needs to be done. Future research priority should be given to assess the prevalence of mental distress, sexual violence and other problems of refugees.

3. In addition to awareness creation as possible strategy to reduce sexual violence, there is also a need for increasing the number of Shurta's (Refugees Police Workers) so as to create a safer environment in the refugee camp more particularly for female and children refugees.
4. Since there are refugees from different cultural background, it appears very important to provide culture and ethnic based awareness on sexual violence.
5. Since sexual violence frequently occurred when female refugees: fetch water, collect fire wood, go to market, school, forest and working at local homes, it is necessary to protect these vulnerable sites from sexual violence. And it is advisable to minimize the distance between the Refugee shelter and the tap water site.
6. To minimize secondary victimization and psycho-social problems, it may sometimes be necessary to assure Transfer rape survivors to other camps.
7. In general reducing sexual violence and psychological problems by doing the following things should be at the top of the management agenda:
 - ✓ Creating adequate opportunities to hold discussions with refugees,
 - ✓ Diversifying youth clubs in the camp,
 - ✓ Creating different and need based Job opportunities for refugees,
 - ✓ Giving special attention for isolated, disabled children,

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APPENDICES

ANNEX ONE

FOCUS GROUP GUIDELINE (FGD)

Introduction

I am too eager in learning about some of the problems and demands of the people in this camp. Of all issues I am interested to in trying to understand basic issues that refugees encountered here. I hope that your answers to my questions will foster the services and protection of this community. I expect our discussion to last about one hour

Please feel free to tell me what you really think or know. I can assure you a guarantee of confidentiality. The information I obtained from you will not be publicized or discussed in a way that would identify you. Amid of the discussion you may ask me to skip a question you cannot or do not want to respond. Your participate is need to be based on voluntary

Do you have any question before we proceed?

If not I am going to ask you some question in relation with what happen to women and men in this camp .

FGD Guide Lines

1. Are there any incidents of sexual violence (rape, attempted rape and gangster rape) imposed up on women /girl refugees in the last six month? What are the major types of sexual violence experienced by women refugees in the camp?
2. When does sexual violence occur?
3. Where does sexual violence occur?
4. With out mentioning the names or indicating anyone specific, who are the perpetrators
5. What are the causes of sexual violence?
6. What are observable consequences of sexual violence?
7. Devoid of mentioning names or indicative any one specific do you know men who are forced to have sex
8. what are the major services given to rape survivors?(Medical, counseling-----)
- 7 What are your suggestions to alleviate the problem?

ANNEX TWO

Interview Guide lines for key informants

1. Is there sexual violence in this camp?
2. Are there raped women in this camp?
3. Who are the victims of sexual violence?
- 5 Who are the perpetrators?

6 what measures have been taken to the perpetrators to fight against sexual violence in the community?

7 What do you think is the prevalence rate of sexual violence? (high, middle, low)

8 What do you suggest to alleviate the problem?

ANNEX THREE

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF EDUCATION
DEPARTMENT OF PSYCHOLOGY**

Questionnaire to be answered by sherkole Refugees

To conduct this study each questions should answered carefully. Your response will be kept confidentially. No need of mentioning your name on the questionnaire. Be sure for your reading instructions correctly before giving answers for each question.

This question is not examination .There is no write or wrong answer. But make sure that you have read each question carefully, and give the answers you think correct for your self.

Part one -Demographic data

After reading the following questions which asks about demographic characteristics, give appropriate answers concerning your demographic information.

1. Country of origin 1. Sudanese 2. Non Sudanese
2. Sex 1.male.....2.female (Circle one)
3. Age

Part two-About sexual violence

4. Have you experienced sexual violence?(only for females) 1 yes 2 No

Part three- SRQ-20

The following questions are related to psychological problems that may have bothered you in the last 30 days. If you think the question applies to you and you had the described problem in the last 30 days, answer YES. On the other hand if the questions does not apply to you and you didn't have the problem in the last 30 days, answer NO.

NO.	SRQ20	YES	NO
1	Do you often have Head aches?		
2	Is your appetite poor?		
3	Do you sleep badly?		
4	Are you easily frightened?		
5	Do your hands shake?		
6	Do you feel nervous, tense or worried?		
7	Is your digestion is poor?		
8	Do you have trouble thinking clearly?		
9	Do you feel un happy?		
10	Do you cry more than usual?		
11	Do you find it difficult to enjoy your daily activates?		
12	Do you find it difficult to make decisions?		
13	Is your daily work suffering?		
14	Are you unable to play a useful part in life?		
15	Have you lost interest in things?		
16	Do you feel that you are a worthless person?		
17	Has the thought of ending your life been in your mind?		
18	Do you feel tired all the time?		
19	Do you have un comfortable feelings in your stomach?		
20	Are you easily tired?		

ANNEX FOURE

CASE HISTORY 1

I was 20 years old. It happened in 2007, when, my house got burned I was transferred to Addis Ababa, and was raped on the way to Addis Ababa. A guy helped by the guard, came to my lodging during night time. As I heard some one calling me "Anchi" I opened the door, and immediately that guy entered. He had a torch and asked me where I come from. He was speaking Amharic and a little English. He started saying he loved me. He was speaking Amharic and a little English. He started saying he was Somalian. Then immediately, he laid me on the floor and started faking, and chewing chat. He warned me not to cry. He would kill me you don't cry again. Don't you know where you are now? He intimidated me that he would kill me and so I under went this shame full experiences. After, he got out, and when I opened the door, looking for the guard, I didn't see any one, it was mid night. I cried a lot. In the morning I continued my way to Addis Ababa. But I didn't know where that guy was.

To be raped like that really, is too bad. When I returned to my home here, I was with my brother. But he is poor also. That's why he said, 'I will not take care of you and my children, better stay alone.' That's why I'm staying alone also.

After having been raped, I had headache and fear which is not yet cured. I tried seek treatment, but nothing they did helped me because, I think I'm staying alone with no one to talk about my problems. And some people used to come to come to my house, did not know what they wanted and was in fear. I become an emotional person, I am feeling unhappy always because, that guy I met, what he did to me was too bad.

ANNEX FIVE

CASE HISTORY 2

I am 34 years old. I came from Rwanda in 1994, when the majority Hutu massacred the minority Tutsi. The interahamwe attacked my home in Galini section in the province. They killed my parents and I managed to jump out of the window and hide in the Banana plantation.

R.P.F came to power, they found me from my hiding place and I took them to my house; RPF helped me to bury my parents. In 2006 the same guy who killed my family came back to Rwanda at my work place; he threatened to kill me; after a few days this guy raped me when I was coming from work at 8:00pm

Residents of that area helped me and, police came for arbitration and the culprit was taken to prison for only two months. When he was released I continuously threatened me and that's why I decided to escape Rwanda and come to Ethiopia.


Arriving in Ethiopia, nothing has kept me to forget all what happened in the past. I always had headache, lack of sufficient food etc. she requested UNCHR and ARRA, for an extra ration since she can not eat wheat.

Since the time I came to the camp I have never felt better, socially, psychologically, physically and health is not sweet for me. I feel that with better ration and better treatment I may be better.

DECLARATION

This thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used for the thesis have been appropriately acknowledge.

Name Solomon Abebe

Signature 

Date June 16 / 2008

This thesis has been submitted for examination with my approval as university advisor.

Name Sentayehu Tadesse, PhD

Signature 

Date June 16/2008