The Role of Social Support and Resilience in Enhancing Mental Health Recovery among Vulnerable Refugees in Ura Refugee Camp, Benshagul Gumuz Region, Ethiopia

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A Thesis Submitted to the School of psychology in Partial Fulfillment of Degree of Master of Arts in Counseling Psychology

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June /2025
Addis Ababa, Ethiopia

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Acknowledgements

I would like to express my sincere gratitude to all those who contributed to the successful completion of this research. First and foremost, I extend my sincere appreciation to my advisor, **Dr. Abera Tibebu**, for his invaluable guidance, insightful feedback, and unwavering support throughout the research process. His expertise and encouragement were instrumental in shaping this study.

I am also grateful to the **School of Psychology** Staffs for providing the academic environment and resources necessary for this research. Special thanks go to the faculty members and colleagues whose constructive discussions and suggestions enriched this work.

My heartfelt thanks go to the **refugee community of URA Refugee Camp** for their willingness to participate in this study and share their experiences. Their resilience and strength inspired this research, and I hope its findings will contribute meaningfully to improving mental health support for vulnerable populations.

I acknowledge the support of **humanitarian organizations and local authorities** in Benishangul-Gumuz Region, Ethiopia, particularly UNHCR, RRS, MTI and other partners, for facilitating access to the camp and providing logistical assistance.

To my family and friends, thank you for your patience, encouragement, and emotional support during this challenging yet rewarding journey.

Finally, I recognize the contributions of all scholars and researchers whose work informed this study, as cited in the references. Their foundational efforts made this research possible.

Table of Contents

List of Tables

Tables **Page number**

Abbreviations

PTSD - Post-Traumatic Stress Disorder

UNHCR - United Nations High Commissioner for Refugees

IDMC - Internal Displacement Monitoring Centre

DASS-21 - Depression, Anxiety, and Stress Scale (21-item version)

CD-RISC - Connor-Davidson Resilience Scale

MSPSS - Multidimensional Scale of Perceived Social Support

HTQ - Harvard Trauma Questionnaire

PHQ-9 - Patient Health Questionnaire-9

NGO - Non-Governmental Organization

RRS - Refugees and Returnees Service (Ethiopia)

MHPSS - Mental Health and Psychosocial Support

MTI - Medical Teams International

EPHI/RHB - Ethiopian Public Health Institute/Regional Health Bureau

BGRS - Benishangul Gumuz Regional State

FDRE - Federal Democratic Republic of Ethiopia

CBT - Cognitive Behavioral Therapy

FGD - Focus Group Discussion

KII - Key Informant Interview

SD - Standard Deviation

CI - Confidence Interval

ANOVA - Analysis of Variance

BRCS - Brief Resilience Coping Scale

Abstract

This mixed-method Study examines how social support and resilience improve mental health recovery among 246 vulnerable in Ura refugee Camp, Ethiopia. With quantitative survey and qualitative interview; the study explores the role of family, friends and social networks in reducing psychological distress. Culturally facilitated resilience strategies like ritual program and storytelling are influenced by persistent displacement and lack of basic needs and security. Severe mental health challenges persist; 59% reported post-traumatic stress disorder and 50% reported Depressions worsened through overcrowding and unemployment. Gender difference occurred with female experiencing higher stress ($p=0.014$) and men avoid mental services due to stigma. The result advocate community lead interventions by incorporating traditional copping practice with formal mental health support together with structural reforms those who are addressing resource access and employment. The study underlines improving communal strength to design justifiable recovery model in low resources displacement context.

Key words: social support, resilience, mental health recovery, refugee, Ura Camp, Ethiopia, mixed-methods

CHAPTER ONE

INTRODUCTION

This Chapter presents all over the introduction part of the research which deals about background, statement of problem, research question, objectives of the study, scope of the study, Significance of the study and operational definition. It establishes the research and study rational, structure, significance and setting of the stage for subsequent analysis.

1.1 Background

The number of people displaced from their home countries due to war, armed conflict, political violence, and related threats are growing (IDMC, 2023). The second half of the **20th** century has witnessed a world-wide refugee problem, unparalleled in size, scope and consequences in human history. (IDMC, 2023) Globally, forcibly displaced people are at unprecedented numbers due to increased war, persecution and climate change. There were an estimated 110 million forcibly displaced people worldwide; 62.5 Internally displaced peoples, 35.3 million are refugees and 5.4 million are asylum seekers, (United Nations High Commissioner for Refugees UNHCR, 2023) .

The 1951 UN Convention Relating to the Status of Refugees defines a refugee as: “any person who, owing to a well- founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country” (UNHCR, 2015)

Refugees in an Emergency settings often face severe mental health challenges, including post-traumatic stress disorder, depression, anxiety, and other psychological distresses, stemming from experiences of war, violence, displacement, and loss (Miller & Rasmussen, 2010).. This

study seeks to explore the role of social support and resilience in enhancing mental health recovery among vulnerable refugees in the URA Refugee Camp, considering theoretical, conceptual, historical, and methodological dimensions of the problem.

Conceptually, the study views mental health recovery as a multifaceted process shaped by both external and internal factors. Social support acts as an external resource that provides refugees with practical assistance, emotional comfort, and a sense of community, while resilience serves as an internal resource that enables individuals to navigate challenges and rebuild their lives(Tol et al., 2013). The interplay between these factors is particularly critical in refugee settings, where the absence of formal mental health services often makes community-based support systems the primary source of psychological care (Tol et al., 2013).By examining the roles of social support and resilience, this study aims to identify pathways through which these factors contribute to mental health recovery in resource-constrained environments like the URA Refugee Camp.

The historical context of the Benishangul-Gumuz Region adds complexity to the mental health challenges faced by refugees in the URA Camp. The region has experienced prolonged ethnic tensions, resource conflicts, and political instability, which have exacerbated the vulnerability of both refugees and host communities (Abbink, 2011); These historical dynamics may influence the availability and quality of social support networks, as well as the capacity of refugees to develop resilience. For instance, ethnic divisions within the camp or between refugees and host communities may hinder the formation of cohesive support systems, while historical trauma may affect the psychological resilience of individuals(Miller & Rasmussen, 2010). Understanding these contextual factors is essential for designing interventions that are culturally sensitive and contextually relevant(Abbink, 2011).

1.2 Statement of the problem

The study was driven by the urgent needs of refugee mental health crisis in an emergency setting and identifying strategies to enhance mental health recovery by reducing the crisis. Despite the growing body of research on refugee mental health, there is a lack of studies focusing on the protective roles of social support and resilience in low-resource settings like the URA Refugee Camp.

The mental health of refugees is increasingly recognized as a critical area of concern, particularly in the context of protracted displacement and ongoing conflict (Porter & Haslam, 2005)). Sudanese refugees in Ethiopia, especially those residing in the Ura refugee center and resettlement camp in Benishangul, face numerous challenges that significantly impact their mental well-being (United Nations High Commissioner for Refugees, 2024). These challenges include trauma from violence, loss of social networks, and the stress of adapting to a new environment(Fazel et al., 2005)"Despite the urgent need for effective mental health interventions, there remains a significant gap in understanding how community support can facilitate recovery processes for this vulnerable population. At least 80% of all refugees are from low- and middle-income countries (Sen, 2016).

Research has shown that social support plays a vital role in mental health recovery, particularly for refugees who have experienced severe trauma (Schweitzer et al., 2006)Community support can manifest in various forms, such as emotional assistance, practical help, and opportunities for social integration . However, the specific dynamics of these support systems within the URA refugee center are not well-documented. Understanding how these community networks operate and their impact on mental health outcomes is essential for developing targeted interventions that address the unique needs of Sudanese refugees.

One significant barrier to accessing formal mental health services among refugees is a stigma associated with mental illness (de Anstiss et al., 2009). Many Sudanese refugees may avoid seeking professional help due to cultural beliefs or fear of discrimination. Consequently, informal community support networks often become the primary source of assistance for individuals struggling with mental health issue(Tempany, 2009) However, the effectiveness and structure of these informal networks remain largely unexplored, highlighting the need for research focused on their role in promoting mental health recovery.

High Prevalence of Mental Health Issues Among Refugees: Numerous studies have documented the high prevalence of mental health disorders such as PTSD, depression, and anxiety among refugees, often linked to pre-migration trauma, displacement, and post-migration stressors (Miller & Rasmussen, 2010)

Social Support as a Protective Factor: Research has established that social support—whether from family, peers, or community networks—can buffer against the adverse effects of trauma and promote mental well-being (Cohen & Wills, 1985). In refugee settings, social support has been shown to reduce feelings of isolation and provide practical and emotional resources for coping (Tol et al., 2013)

Resilience as a Key Factor in Recovery: Resilience, defined as the ability to adapt and thrive in the face of adversity, has been identified as a critical factor in mental health recovery among refugees (Masten, 2001)Studies have highlighted that resilience is not static but can be nurtured through supportive environments and individual coping strategies(Guet al. hiba and child mental health: mbo et al., 2007).

Contextual Challenges in Refugee Settings: Research has also emphasized the unique challenges faced by refugees in camp settings, including limited access to mental health services, overcrowding, and socio-political tensions (Abbink, 2011)

The Interplay between Social Support and Resilience in Refugee Camps: While social support and resilience have been studied independently, there is limited research on how these factors interact to enhance mental health recovery in refugee camp settings (Tol et al., 2013; Nickerson et al., 2011). Specifically, the mechanisms through which social support fosters resilience, and vice versa, remain underexplored (Panter-Brick, 2014)

Context-Specific Insights in Low-Resource Settings: Most studies on refugee mental health have been conducted in high-income countries or urban refugee settings(Porter & Haslam, 2005),According to porter and haslam, this could be leaving a gap in understanding how social support and resilience operate in low-resource, camp-based environments; like the URA Refugee Camp in Ethiopia.

Community-Level Dynamics in Mental Health Recovery: Existing research often focuses on individual-level factors, neglecting the role of community-level dynamics in shaping mental health outcomes(Tol et al., 2013). For example, how collective resilience and communal support systems function in refugee camps is not well understood(Ungar, 2008).

Cultural and Historical Influences on Recovery: The unique cultural and historical context of the Benishangul-Gumuz Region, including ethnic tensions and resource conflicts, may influence the availability and effectiveness of social support and resilience(Lule et al., 2023). However, these contextual factors have not been adequately explored in relation to mental health recovery.

This research seeks to fill a critical gap in understanding how social support and resilience interact to enhance mental health recovery among vulnerable refugees in the URA Refugee Camp, located in the Benishangul-Gumuz Region of Ethiopia. Specifically, the study aims to investigate the role of social support networks such as family, peers, and the broader community—in fostering resilience and promoting mental health recovery.

1.3. Research question

1. How do available forms of social support influence the mental health recovery of vulnerable refugees in the URA Refugee Camp?
2. How does resilience, as manifested among vulnerable refugees in the URA Refugee Camp, influence their ability to cope with trauma and mental health challenges?
3. How do social support and resilience interact to address the specific mental health challenges faced by vulnerable refugees in the URA Refugee Camp?
4. What are the barriers and facilitators to accessing social support and building resilience among vulnerable refugees in the URA Refugee Camp?

1.4 Objectives of Study

1.4.1 General Objectives

To examine the role of social support and resilience in enhancing mental health recovery among vulnerable refugees in the URA Refugee Camp, Benishangul-Gumuz Region, Ethiopia..

1.4.2 Specific Objectives

- To identify the types of social support systems available to vulnerable refugees in the URA Refugee Camp and assess their impact on mental health recovery
- To explore the manifestation of resilience among vulnerable refugees and its role in coping with trauma and mental health challenges.

- To analyze the specific mental health challenges faced by vulnerable refugees and the interplay between social support and resilience in addressing these challenges..
- To identify the barriers and facilitators to accessing social support and building resilience among vulnerable refugees in the URA Refugee Camp

1.5 Scope of the study

The study focuses on examining the role of social support and resilience in enhancing mental health recovery among vulnerable refugees residing in the URA Refugee Camp, located in the Benishangul-Gumuz Region of Ethiopia. It interplay between social support systems, individual and collective resilience, and their influence on mental health outcomes within the refugee community.

The study primarily targets vulnerable groups within the camp, including women, children, and individuals with pre-existing mental health conditions, to understand their unique challenges and needs. However, the study does not extend to broader systemic issues such as policy analysis, the role of international organizations, or comparative studies with other refugee camps. Additionally Ura Camp is un emergency site for the refugees and the camp presents a unique socio-political and cultural context characterized by ethnic tensions, resource constraints, and limited access to formal mental health services.

1.6. Significance of the study

This study addresses a critical gap in refugee mental health research by focusing on the protective roles of social support and resilience in low-resource, camp-based. While extensive literature exists on the mental health challenges faced by refugees, there is limited research on how community-level support systems and resilience mechanisms contribute to recovery. This

study fills this gap by exploring these factors, providing insights often overlooked in broader refugee mental health studies.

The study also underlines the role of community-based approaches to mental health recovery, emphasizing the potential of refugee communities to support their members through informal networks and collective resilience. Furthermore, the findings of this study provide actionable recommendations for policymakers, humanitarian organizations, and mental health practitioners working in refugee settings.

In terms of contributions to existing knowledge, this study makes several key advancements. First, it explores the dynamic relationship between social support networks and resilience, providing a deeper understanding of how these factors interacts to promote mental health recovery in refugee settings. Second, the study highlights community-level changing aspects, examining how collective support systems and shared resilience within the refugee community contribute to mental health recovery. Third, the study provides valuable insights into how cultural beliefs, practices, and the socio-political context of the URA Refugee Camp influence the availability and effectiveness of social support and resilience.

1.7 Operational definition

1.7.1 Social Support

The measurable provision of emotional, instrumental, informational, or companionship assistance perceived by refugees community from family, peers, community networks, or aid organizations.

1.7.2 Resilience

The capacity of refugees to adapt positively to adversity, trauma, or prolonged displacement, measured through:

1.7.3 Mental Health Recovery

The reduction of psychological distress and improvement in psychosocial functioning among refugees

1.7.4 Vulnerable Refugees

Refugees at heightened risk of mental health challenges due to one or more factors:

1.7.5 Enhancing Mental Health Recovery

The process by which social support and resilience contribute to improved mental health outcomes, measured through: Statistical associations and Participant narratives

1.7.6 Variables- measurement that can take on different values across individuals, groups, or contexts

Independent Variables: The presumed cause or influencing factor manipulated or observed to study its effect such as Social Support and Resilience

Dependent Variable: The outcome being measured; it "depends" on the independent variable (mental health recovery)

Control Variables: Extraneous factors held constant to isolate the IV and DV such as Age (demographic factor), gender (sociocultural influence), duration of displacement (time since migration), and pre-migration trauma (past traumatic experiences)

CHAPTER TWO

REVIEW OF RELATED LITRATURE

This chapter Address literature reviews on social support and resilience in mental health recovery among vulnerable refugees in URA Refugee Camp, Ethiopia. It outlines theoretical frameworks—social support theory, resilience theory, and ecological models—emphasizing social connections and cultural factors in well-being. Empirical studies highlight refugees' mental health challenges, including trauma, displacement, and barriers to accessing services, while distinguishing mental illness from broader well-being needs. The review critiques gaps in culturally sensitive care, noting limitations of Western-centric models and advocating trauma-informed, accessible services. Community strategies, such as peer support and culturally relevant interventions, are explored, alongside social, familial, and cultural supports in recovery. Protective factors like resilience, social capital, and cultural identity are identified as critical for coping. Post-migration structural challenges in host countries are addressed, alongside examples from the Sudanese community, where cultural practices and social networks bolster resilience. A concluding conceptual framework integrates these elements, illustrating how social support and resilience collectively enhance mental health recovery in refugee contexts.

2.1 Theoretical Context: Social Support, Resilience, and Refugee Mental Health Recovery

Refugees in camp settings face significant psychological distress due to trauma and displacement (Fazel et al., 2005). However, community-driven social support (Nickerson et al., 2010)and resilience-building interventions (Tol et al., 2013)grounded in ecological (Miller & Rasmussen, 2010) and resilience frameworks (Masten, 2014)can mitigate these effects.

Social support theory underscores the role of emotional, informational, and instrumental aid in mitigating trauma's psychological impacts (Brannelly et al., 2024). For URA Camp

refugees, peer networks sharing lived experiences foster belonging and reduce isolation, while guidance on accessing services empowers proactive recovery. Practical assistance (e.g., navigating resettlement) alleviates stressors that compound mental health challenges.

Resilience theory (Masten, 2014)) highlights refugees' adaptive capacity, amplified by communal solidarity. Collective identity, forged through shared adversity, strengthens coping strategies and emotional healing. In URA Camp, community-led initiatives—such as cultural storytelling circles—can rebuild agency and resilience, critical for post-trauma recovery.

The **ecological model** (Chu et al., 2016)contextualizes recovery within micro- (individual relationships), meso- (community organizations), and macro-level (policy/cultural) factors. Micro-level bonds (familial/peer support) directly aid mental health, while meso-level networks (local NGOs) provide resources. Macro-level policies in Ethiopia's Benishangul-Gumuz Region, such as culturally inclusive refugee integration strategies, shape the efficacy of support systems.

Cultural context is pivotal: mental health perceptions and help-seeking behaviors are shaped by traditions. In URA Camp, integrating culturally resonant practices (e.g., communal rituals) into interventions enhances engagement and trust. A **trauma-informed approach** (Samhsa, 2014)prioritizes safety and refugee agency, ensuring support systems avoid re-traumatization.

Synthesis to URA Camp Context

Refugee mental health recovery in Benishangul-Gumuz's URA Camp will hinge on three interconnected pillars: Robust social support networks addressing emotional, practical, and informational needs (Eachus, 2014) and resilience-building through community cohesion (Panter-Brick, 2014)and culturally grounded strategies (Wessells, 2009)are vital. Multi-level

interventions that align individual, organizational, and policy efforts (Sadownik, 2023)further enhance systemic impact.

By prioritizing cultural sensitivity (e.g., integrating traditional healing practices) and trauma-informed principles (e.g., safe, participatory spaces), URA Camp's support systems will empower refugees to navigate resettlement challenges, fostering sustainable recovery that leverages communal strengths and systemic equity

2.2 Empirical Study

Resettlement, whether through local integration, repatriation, or third-country relocation, is a critical yet complex process (UNHCR, 2011). While frameworks like the *Global Compact on Refugees* prioritize mental health access as a key success indicator (Micinski, 2021), implementation often falls short in contexts like Ethiopia. Despite the 2019 Refugee Proclamation guaranteeing healthcare access (FDRE Federal Negarit Gazette, 2019), mental health services in camps remain under-resourced and culturally misaligned (Yu et al., 2020). Studies in Dollo Ado Camp, for instance, reveal persistent gaps in addressing depression and trauma (Feyera et al., 2015)

A study in Ethiopian refugee camps revealed that only 15–20% of refugees receive mental health care, hindered by stigma, linguistic barriers, and a lack of trauma-informed providers (Uinted Nation High Commission for Refigee, 2020)Similarly, while New Zealand's resettlement dashboard reports high engagement with general practitioners (97% attendance), only 45% of refugees accessed mental health services in 2018 (Brannelly et al., 2024). Such disparities highlight the inadequacy of current metrics, which prioritize quantitative benchmarks (e.g., one annual mental health visit) over qualitative assessments of refugees' lived experiences.

Western-centric mental health interventions, such as individual psychotherapy, are frequently criticized for overlooking culturally embedded communal coping strategies prevalent in African contexts. For example, collective storytelling and traditional healing practices, which emphasize communal resilience, are often marginalized in favor of individualized clinical approaches (Wessells, 2009). Such cultural mismatches in service provision can alienate refugees and reduce engagement with mental health supports (Ventevogel et al., 2013).Studies critique the overreliance on PTSD-focused interventions, which overlook collective trauma and resilience strategies rooted in cultural identity and social cohesion (Bracken et al., 2021). For example, Sudanese refugees in URA Camp frequently turn to *shimagilin* (community elders) for psychosocial support, yet such practices are rarely integrated into formal programs.

Research highlights structural deficiencies in Ethiopia's mental health systems, such as insufficient availability of counselors proficient in local languages (e.g., Amharic, Gumuz) and limited integration of participatory, community-based programs to address psychosocial needs (Wessells, 2009).Culturally inappropriate services exacerbate mistrust, deterring help-seeking behaviors. Conversely, evidence from Somali and Eritrean refugees in Ethiopia demonstrates that community-based interventions—such as peer support groups co-facilitated by refugees—enhance engagement and recovery outcomes (Feyera et al., 2015).These findings align with calls for trauma-informed, culturally grounded approaches that prioritize refugees' agency and existing resilience networks.

2.2.1 Understanding the wellbeing and mental health needs of refugees

Mental illness and mental health are distinct but related concepts (Westerhof & Keyes, 2010)). Mental illness is associated with the presence of psychopathologies as categorized in the

diagnostic statistics manual or international classification system of disorders and illnesses. Mental health refers to flourishing or positive mental health.

define three aspects that make up mental health which are emotional wellbeing feelings of happiness and satisfaction with life, psychological wellbeing – positive individual functioning and social wellbeing positive societal functioning in terms of being of social value (Westerhof & Keyes, 2010). When viewed in this way a person may have a diagnosed mental illness but still have good mental health or conversely not have a diagnosed mental illness but experience ill-being. Conceptualizing mental health related to emotional, psychological and social wellbeing aligns with the pillars of resettlement but not with the threshold access to mental health services which is guided by risk of harm to self or others. It also aligns with broader conceptualizations of wellbeing such as the capabilities approach (Brannelly et al., 2023) that aims to provide solutions to inequities that result from global problems, such as war and human rights abuses.

Host countries play a critical role in determining mental health outcomes for refugees. In Aotearoa, research has highlighted that refugees have higher than population rates of post-traumatic stress disorder, anxiety and depression .The experience of trauma at the point of forced migration can be reaffirmed through the pre-, during and post-migration journey (Cénat et al., 2021). Resettlement is a potentially stressful time of adversity that can also contribute to mental health challenges. Resettlement is aided by access to health services and financial, social and practical resources that decrease stress and support mental wellbeing ((Byrow et al., 2020)). Within refugee populations, ongoing unemployment, lack of stable housing, experiences of discrimination, visa uncertainty, familial separation and poor living conditions negatively impact wellbeing and increase the likelihood of developing significant distress (Brannelly et al., 2024)). For instance, (American Psychiatric Association, 2020)) investigated the connection between

resettlement trauma and mental health among the Vietnamese refugee population in Australia. While high exposure to remigration trauma was the strongest predictor of current mental illness, the study also noted that factors such as employment status, household characteristics and English language proficiency were associated with mental illness.

Intersectionality is a factor in how people respond to potentially distressing situations because that layer onto previous discriminations or harms that trauma. (Lindert et al., 2016)) identify the need for mental health responses that understand the impacts of human rights violations and "humiliation", for example the experience of humiliation through torture or sexual assault, as a precursor to the experience of trauma and poor mental health. Given the challenges of gaining research participation and inaccuracy of medical records, research that engages refugee communities is particularly important to understand the extent of mental health challenges.

2.2.2 Mental health service provision and refugee communities

Suboptimal access to mental health services among refugee populations remains (Brannelly et al., 2023)) and inadequate provision of services to address the needs of refugees continues (Kanengoni-Nyatara et al., 2024)). Contextual factors pose barriers to addressing the mental health of refugee populations that include a lack of cultural awareness among service providers, lack of culturally diverse health professionals, limited professional and public knowledge about the refugee journey and limited access to interpreters (Jarvis and (Krystallidou et al., 2024)). Conversations about trauma experienced by refugees amongst mental health professionals were commonly under prioritized (Suhaiban et al., 2019).

Statutory services have limited ability to provide first language therapists, and the threshold for service access is dependent on the person's level of need with priority given to

people who are in medium to high needs. Non-governmental organizations can support refugee mental health, but are under-resourced and have limited capacity, resulting in limited geographical coverage and long waiting times. In primary care, limited mental health provision exists, but the complexity of trauma recovery is met with referrals to secondary services.

More recently, psychiatry as an arm of colonization has been highlighted (Bracken et al., 2021) due to emphasis on a singular Western-centric understanding of mental health. Mental health services couched in a biomedical approach are not likely to adequately address the unique and complex challenges faced by refugee populations, hindering the delivery of appropriate care (Ellis et al., 2019). The focus on predefined diagnostic criteria overlooks the social, political and historical factors that contribute to mental health challenges among refugee populations (Gopalkrishnan, 2018). Cultural practices that differ from that of the dominant culture are stigmatized or pathologies (Moleiro, 2018). Rejection of Western taxonomy of illness is framed as stigma, rather than an alternative perspective. This is a form of epistemic injustice (Fricker, 2007)as it denies the reality of the already marginalized culture.

Symptoms of mental illnesses and expressions of distress are historically and culturally located and understood differently among different cultural group's populations, and particularly those with refugee status (Brannelly et al., 2024) Every culture has nuanced perspectives on wellbeing, mental health and origins of distress and appropriate interventions, therefore service providers are required to adapt to promote recovery and not to cause further distress or trauma (Gopalkrishnan, 2018)). Moreover, mental health services rely on people presenting with Western-centric health literacy, and those who do not request help in this way may not be recognized as having mental health challenges (Tonui, 2022).

Refugees are generally wary of mental health services due to the risk of unwanted restrictions or treatments incompatible with their cultural and social beliefs systems, not wanting to use mental health services because of a lack of identification with diagnoses of mental illness (Kim et al., 2023). The lack of access and acceptable treatment options exacerbate disparities in access, treatment outcomes and overall satisfaction with mental health services (de Anstiss et al., 2009)).

2.2.3 Community approaches to supporting refugee mental health

Trauma recovery focuses on mental health needs related to the circumstances that refugees have survived, ongoing losses and the stressors of resettlement. Approaches that work best are human rights-informed, equity focused, localized community generated responses and solutions. Refugees need practical support to enable settlement. There is a need to design services that are well positioned and provisioned to meet the needs of refugee communities, are longer term to meet ongoing and emergent needs.

There is value in the power of peer support through shared experiences that enable people to connect, understand that they are not isolated in their experience and provide mutual beneficial and relevant support to each other. People often need space in which to understand their group experiences inform a broader understanding of responses that will help that community. For this to work, it needs to be embedded in the community to foster deep seated care and trust so that no further trauma is endured. A recent community development participatory approach to develop principles to underpin health service development highlighted shared community values, characteristics and experiences and using community leaders in all service delivery planning (Kanagaratnam et al., 2022).

Community generated responses identified preventative interventions that incorporated tools to help with stress, such as simple yet effective strategies like breathing techniques and reaffirmation of capabilities. (Tonui, 2022) qualitative research was with Rwandan refugees in the USA, concluding that holistic, collaborative and integrative approaches are required for engagement to facilitate the practical and emotional support people require support that trauma informed care is essential for greater mental health outcomes and that assertive outreach which provides acute mental health care at home, effective in non-refugee populations, may be a more appropriate approach. (Brannelly et al., 2023)designed an inter professional collaborative training module that helped mental health workers share knowledge and build trust with refugee provider groups to develop knowledge about the refugee community and how stress and mental health challenges are expressed and what cultural responses are usual. This is particularly pertinent for refugee communities to address concerns about the framing of mental illness and potentially problematic treatment which significantly impact service utilization and help seeking behaviors ((Byrow et al., 2020)).

Addressing the barriers to accessible, culturally safe mental health services for refugees would aid resettlement stress. Acceptable services are those informed by the needs of communities responsive through collegiate cross-agency support. In a review of refugee experiences and responses, (Suhaiban et al., 2019) issued a call for action for more global responses to improve the mental health of refugees; more preventative and treatment interventions at the familial and community level, with technological interventions, mind/body modalities and community focus holding much promise. Bringing together practical and emotional support counters stress. To find solutions for self-determination and equity as the bedrock to addressing mental health disparities and sustainable long-term health outcomes in

refugee communities it is imperative for service design and delivery to be co-produced with communities themselves.

2.2.4 Systems of care for the mental health of refugees and asylum seekers

Providing mental health care for refugees and asylum seekers should be done in partnership with the other social, cultural, and family supports around the individual. Such an approach highlights the influence of environment on mental well-being. Clinicians can serve as advocates by linking refugees with psychosocial support to assist with housing, legal aid, access to health care, education, and employment (Morgan et al., 2017). Refugees and asylum seekers may be resistant to seeking mental health care due to beliefs that diagnosis will interfere with jobs and housing, that there is no treatment, cultural values surrounding silence/disclosure, differing beliefs surrounding etiology/ manifestation of emotional health, and lack of incorporation of these beliefs into care.

Common structural barriers to care are lack of education about the mental health system and resources, health insurance issues, transportation, language proficiency, or provider refusal to see refugees. Refugees may have barriers to seeking care, but health systems may also have barriers to referring people for services, as only about3% of refugees are referred to mental health services following screening(Morris et al., 2009)).

2.2.5 Strengths and protective factors common to refugees and asylum-seekers

Despite the high rate of exposure to traumatic events among the refugee population, many do not have chronic psychiatric impairment (Schweitzer et al., 2006), Clinicians should, therefore, make the distinction between normal responses to the abnormal situations of war, protracted violence, and other traumatic experiences that many conflict- affected persons face, and the more severe and less common psychiatric response. Mental health providers can

highlight the resilient processes that conflict-affected people can draw upon. Commonly thought of as the ability to adapt in the face of adversity, resilience is time- and context-dependent, and a process that can be developed across individual, family, and community levels (American Psychiatric Association, 2020)

Clinicians should be mindful of the on-going stressors that one may face, of ambiguous or traumatic loss of loved ones and separation from culture and supports, on-top of the host environment that may foster discrimination and marginalization. It is important to highlight the socio-ecological supportive factors that assist in re-building a new normal. Helping patients engage with family strengthening and building social networks can develop a sense of connectedness to minimize isolation and foster increased resilience and improved mental health, (American Psychiatric Association, 2020). Providers can assist in making the environment less difficult by conceptualizing mental health, social environment, and individuals and families as interconnected, to decrease risk factors for adverse mental health and promote well-being.

2.2.6 Mental health and place in post-migration context

Epidemiological studies show refugees are more likely than the general population to suffer from anxiety, PTSD, psychotic illnesses and major depression (Blackmore et al., 2020)). Typically, studies reporting pre-migration expe- riences of adversity and trauma show associations with PTSD and depression ((Priebe et al., 2016)), whereas studies investigating post-migration factors show associations with anxiety, mood, substance-use disorders and psychosis (Porter & Haslam, 2005)). The role of pre-migration trauma and adverse experiences of flight in refugee mental health outcomes is well established. However, studies have shown that the psychological distress of a precarious existence continues once settled in host countries. Refugees must navigate an evolving set of structural and bureaucratic difficulties that present

risks of marginalisation and poverty with implications for mental health ((Ermansons et al., 2023)).

According to some scholars, after the 2015–16 ‘refugee crisis’, we now see the issue of refugee integration come to the fore in the Global North countries, presenting a need to examine the role of host societies ((Phillimore, 2021)). At the same time, the war in Ukraine and reception of refugees from the region has highlighted stark differences in how people from diverse ethnic backgrounds and countries of origin are received and treated ((Brannelly et al., 2023)). Thus, links between refugee status and opportunities to tap into social and economic resources will likely be different depending on the in situatedness of individual refugeesrelation to their national and ethnic background, economic situation, gender and education levels.

2.2.7 Displaced people’s social capital and its links to mental health

Within this cascade of resource loss, we focus on displaced people’s mental health and the role of social capital in stabilizing or improving it. Social capital – the networks, norms and trust that facilitate action and cooperation for mutual benefit ((Hanibuchi & Nakaya, 2013)) – provides a broad array of benefits, including: the exchange of favors and assistance, the maintenance of group norms, the stocks of trust, the exercise of sanctions, diffusion of information, voluntary organization within a social structure, and participation in social organizations ((Hanibuchi & Nakaya, 2013). So- cial ties, whether in-group (bonding), between groups (bridging), or across levels of authority and hierarchy (linking), provide assistance and useful information, help overcome barriers to collective action, and afford mutual aid even during the most stressful of crises and disasters whether natural or man-made (Aldrich & Meyer, 2015)). Studies have shown that households with more social capital recovered more easily from disaster-induced displacement at a measurably faster pace. Social capital is often the sole

remaining asset that refugees have at their disposal to access livelihoods or cost-saving measures, or to use as a form of social safety net. As a result, social capital increases refugees' resilience and improves the effectiveness of aid ((Sacipa-Rodríguez, 2012)).

Literature on the beneficial nature of social capital for mental health outcomes highlights that social capital can protect against mental health problems such as depression and posttraumatic stress disorder. Social capital and social cohesion have been found to associate with the health and emotional well-being of refugees (Habib et al., 2020)). Research has shown that survivors of crises such as refugees use social capital to help rebuild a sense of normality. For example, after Japan's Fukushima Dai-chi nuclear power plant meltdowns in March 2011, survivors of the radioactive contamination who had strong ties with well-known neighbors during their evacuation and resettlement had measurably lower levels of stress than similar survivors without such resources (Brannelly et al., 2023)). Similarly, after terror at- tacks by Boko Haram in Nigeria and food-insecurity stresses in the Karamoja region of Uganda, survivors with deeper reservoirs of bonding and bridging ties had better recoveries (Aldrich & Meyer, 2015) . Social capital can be especially critical for vulnerable groups such as the poor, elderly, and infirm, catalyzing more assistance to them than to fully able or fully integrated groups also facing stressors (Aldrich & Meyer, 2015).

A somewhat more extensive literature connects refugee/IDP mental health with 'social support' – which overlaps with but does not equate to social capital. Per a systematic review regarding unaccompanied refugee minors), social support is both a risk when lacking and protective factor regarding mental ill health. At least one study finds that (among Syrian refugee adolescents in Turkey) social capital's positive effect on mental health is fully mediated by social support (*Duren and Yalçın, 2021.Pdf*, n.d.).

The collapse of social networks exacts a massive toll on displaced Syrians in Jordan. This can be measured in a loss of the economic support networks which traditionally tied households through un- expected shocks … But most importantly, the collapse of social networks among Syrians has exacerbated and accelerated the very human hardships of loneliness, boredom and depression. All too often, these intangible challenges are ignored in favour of more empirical targets such as shelter, poverty and hunger, while evidence for the structural links between these two broad categories of challenges are ignored ((Kanagaratnam et al., 2022)).

Social Support Networks

Research consistently highlights the importance of social support in the mental health recovery of refugees. African refugee communities often provide a vital network of emotional and practical support that can mitigate feelings of isolation and despair. A study by (Miller, 2021) found that strong community ties among African refugees significantly correlated with lower levels of depression and anxiety. These networks offer a sense of belonging and understanding that is crucial for individuals who have experienced displacement and trauma.

Cultural Identity and Resilience

Cultural identity plays a significant role in the mental health recovery of African refugees. (Altamih & Elmahi, 2023)emphasize that maintaining cultural practices and traditions can foster resilience and a sense of purpose among refugees. Engaging in community rituals, storytelling, and cultural celebrations helps individuals reconnect with their heritage, enhancing their overall well-being. The preservation of cultural identity not only aids in coping with trauma but also strengthens community bonds.

Access to Community Resources

Community organizations often serve as critical resources for African refugees, providing access to mental health services, counseling, and support groups. (Brannelly et al., 2023)highlight the effectiveness of community-based interventions that integrate mental health services with culturally relevant support. These programs often employ community leaders who understand the unique challenges faced by refugees, thereby increasing trust and engagement in mental health services.

Barriers to Mental Health Care

Despite the positive role of community support, African refugees frequently encounter barriers to accessing mental health care. Stigma surrounding mental illness, lack of awareness about available resources, and linguistic challenges can hinder individuals from seeking help. (Tonui, 2022) found that community-led initiatives aimed at reducing stigma and increasing awareness about mental health issues were effective in encouraging individuals to seek help.

The Role of Peer Support

Peer support within African refugee communities has emerged as a powerful tool for mental health recovery. Programs that train community members as peer supporters can create safe spaces for sharing experiences and coping strategies. (Brannelly et al., 2024) noted that peer-led support groups not only foster a sense of solidarity but also empower individuals to take an active role in their recovery process.

2.2.8 Sudanese Community in Resilience and Mental Health Recovery

The Sudanese community exhibits a profound resilience shaped by its values, beliefs, and cultural practices. Central to this resilience is the collectivist nature of Sudanese society, which emphasizes the importance of family and community support. This interconnectedness fosters a sense of belonging and security, allowing individuals to navigate life's challenges more

effectively. The cultural emphasis on communal living means that mental health struggles are often addressed collectively, with family members and friends providing emotional support and practical assistance(Brannelly et al., 2024).

Spirituality plays a crucial role in the mental health landscape of the Sudanese community. Islamic beliefs and practices provide individuals with coping mechanisms during times of distress. Prayer, for instance, is not only a means of spiritual connection but also a source of comfort and hope. Many Sudanese people turn to their faith as a way to find meaning in suffering and to foster resilience. The community's shared religious practices create a supportive environment where individuals can express their struggles and receive encouragement from others who share similar beliefs (Hall, 2004)

Traditional healing practices are another significant aspect of resilience within the Sudanese community. Many individuals seek help from traditional healers who employ herbal remedies and cultural rituals to address mental health issues. This holistic approach recognizes the interplay between physical, emotional, and spiritual well-being. The use of storytelling and oral traditions also serves as a therapeutic outlet, allowing individuals to process trauma while reinforcing their cultural identity (Asiimwe et al., 2023)). These practices highlight the community's understanding of health as a multifaceted concept.

Social networks play an essential role in fostering resilience among Sudanese individuals. Extended family structures provide critical support during challenging times, offering emotional reassurance and financial assistance when needed. Community organizations also contribute by providing mental health resources and organizing events that promote social cohesion. Such gatherings create opportunities for individuals to connect with others facing similar challenges, reinforcing the idea that they are not alone in their struggles (Castillo et al., 2019)).

The respect for elders within Sudanese culture further enhances resilience. Elders are viewed as repositories of wisdom and experience, providing guidance to younger generations navigating difficulties. This intergenerational support is vital for mental health recovery, as it allows individuals to learn from those who have faced similar challenges. The stories and lessons shared by elders serve as both inspiration and practical advice for coping with adversity (Viscogliosi et al., 2022) Youth empowerment initiatives within the Sudanese community also play a critical role in building resilience. Programs focused on skill development and mentorship help equip young people with the tools they need to confront contemporary challenges while staying connected to their cultural heritage. By fostering a sense of agency and belonging, these initiatives empower youth to face life's adversities with confidence and optimism (Rosekrans & Hwang, 2021).

In conclusion, the resilience and mental health recovery of the Sudanese community are deeply intertwined with its values, beliefs, and social structures. The collective nature of support, the significance of spirituality, traditional healing practices, strong social networks, respect for elders, and youth empowerment all contribute to a robust framework for coping with mental health challenges. Understanding these elements is essential for mental health professionals working with the Sudanese population, as it allows for culturally sensitive approaches that enhance well-being (Altamih & Elmahi, 2023)

2.2.9 Barriers to Mental Health Care in the Sudanese Refugee Community

The Sudanese refugee community faces numerous barriers to accessing mental health care, significantly impacting their mental health recovery. One of the primary challenges is the stigma associated with mental illness within the community. Cultural beliefs often frame mental health issues as a sign of personal weakness or spiritual deficiency, leading individuals to avoid

seeking help for fear of judgment (Bracke et al., 2019). This stigma can deter open discussions about mental health, making it difficult for individuals to express their struggles and seek support from both professional services and their social networks.

Language barriers further complicate access to mental health care for Sudanese refugees. Many individuals may not be fluent in the dominant language of their host country, limiting their ability to communicate effectively with healthcare providers. This lack of communication can result in misunderstandings regarding symptoms, treatment options, and the overall mental health care process (Krystallidou et al., 2024)). Additionally, the absence of culturally competent practitioners who understand the specific needs and cultural context of Sudanese refugees can hinder effective treatment and support.

Cultural beliefs and practices also influence how mental health issues are perceived and treated within the Sudanese community. Traditional healing methods, while valuable, may not always align with Western mental health practices. Many refugees may prefer to seek help from traditional healers or rely on community support rather than accessing formal mental health services (Sorketti et al., 2010)). This preference can create a disconnect between the available mental health resources and the community's cultural practices, leading to underutilization of essential services.

Social networks play a crucial role in the mental health recovery of Sudanese refugees, but they can also present barriers. While family and community support are vital for resilience, there can be a lack of understanding or awareness about mental health issues within these networks. Family members may not recognize the importance of professional help or may encourage individuals to cope with their struggles privately, further isolating those in need (Bunn

et al., 2022). This dynamic can prevent individuals from seeking necessary care and limit their recovery options.

Economic factors also pose significant barriers to mental health care access within the Sudanese refugee community. Many refugees face financial instability, which can restrict their ability to afford mental health services or transportation to appointments (Morgan et al., 2017)). This economic strain is compounded by the pressures of adjusting to a new environment, often leading to increased stress and anxiety. Without adequate financial resources, individuals may prioritize basic needs over mental health care, further exacerbating their challenges.

Systemic barriers such as limited availability of culturally appropriate mental health services can hinder access for Sudanese refugees. Many regions may lack specialized programs that address the unique cultural and linguistic needs of this population (Ali & Agyapong, 2016). The absence of outreach efforts tailored to engage the Sudanese community can result in low awareness of available mental health resources. Addressing these systemic barriers is crucial for ensuring that Sudanese refugees receive the support they need for effective mental health recovery.

Implications for URA Camp

Empirical insights will underscore the urgency of transformative strategies in URA Refugee Camp to address mental health gaps while leveraging community strengths. First, **localized metrics should replace** Western-centric indicators (e.g., PTSD diagnoses) to capture social and cultural dimensions of recovery. Participatory assessments can track social support networks (family, peers), resilience practices (e.g., collective problem-solving), and cultural well-being benchmarks (e.g., frequency of communal rituals or access to *shimagilin* elders) to guide tailored interventions (Tol et al., 2013). For example, community-

defined metrics, such as elder engagement, ensure culturally resonant mental health programming (Ventevogel et al., 2013), while participatory frameworks help align interventions with local resilience strategies (Panter-Brick, 2014)

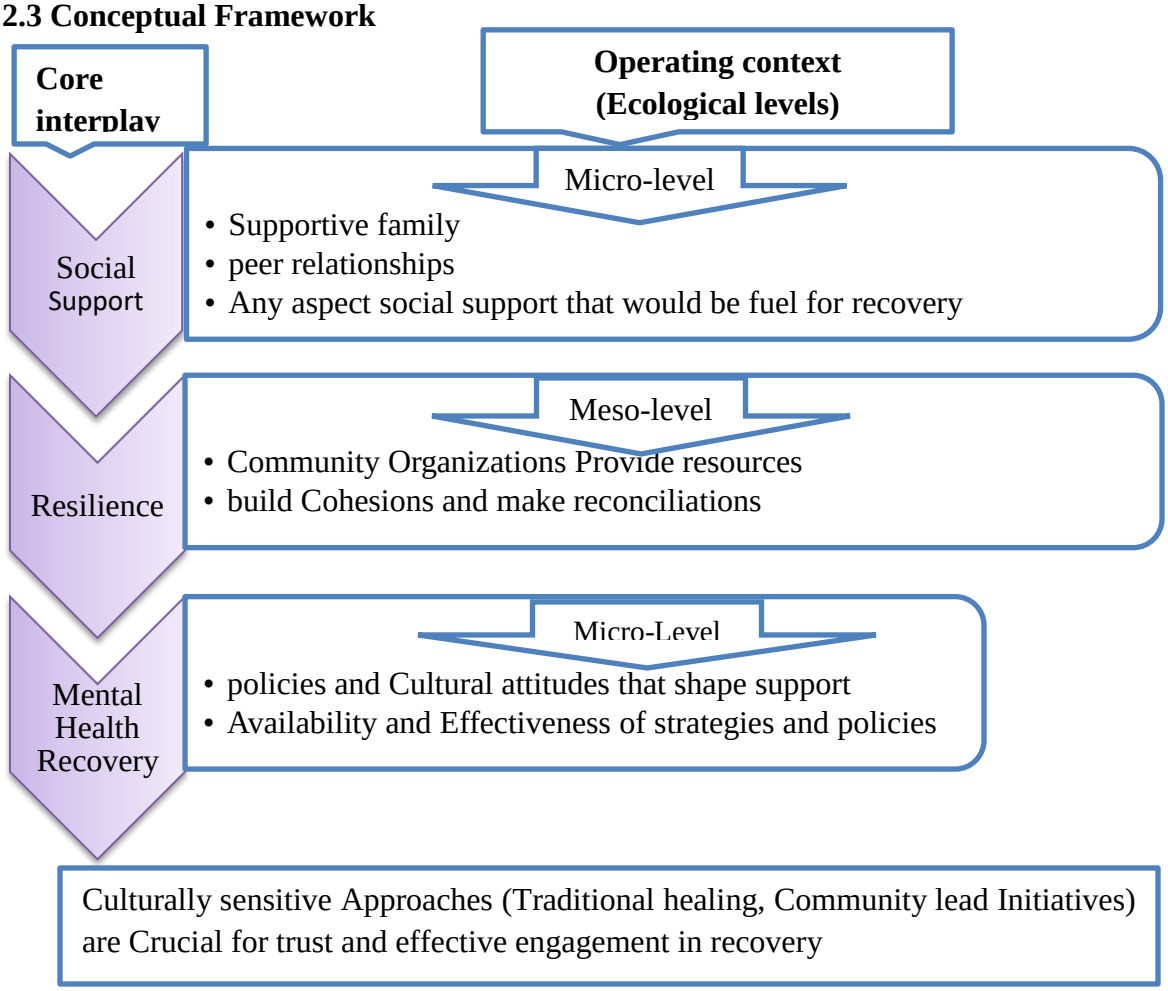
Second, **cultural practices should be integrated** into mental health programs, such as Sudanese *zar* ceremonies and collective mourning, can be integrated into mental health programs to enhance cultural relevance (Ventevogel et al., 2013). Collaboration with traditional healers to co-design hybrid interventions (e.g., trauma counseling paired with rituals) ensures alignment with community values (Betancourt et al., 2013). Cultural sensitivity training for health workers reduces stigma and builds trust (Bhui et al., 2007)while community-led art/music therapy revives cultural identity disrupted by displacement (Tol et al., 2013)

Third, **policy alignments are prioritized**: Ethiopia's 2019 Refugee Proclamation guarantees healthcare access, but URA Camp will address inconsistent implementation by mobilizing context-specific resources (e.g., recruiting Arabic-speaking counselors, funding refugee-led health workers) and forging partnerships (NGOs, RRS) to establish mobile mental health units or peer networks. Outdated success indicators (e.g., clinic visits) will shift to measure equitable access and long-term recovery. By centering refugees' lived experiences, URA Camp should have transition from crisis-driven care to **sustainable, community-driven ecosystems**.

Refugee-led participatory structures, such as advisory councils, women's cooperatives, and youth forums, can amplify agency and strengthen collective resilience through culturally adaptive mental health interventions (Betancourt et al., 2013).Aligning policies, frontline practices, and cultural values ensures that mental health recovery is equitable and grounded in community-driven strengths (Miller & Rasmussen, 2010); Wessells, 2009). For instance,

Ethiopia's inclusive legal frameworks (FDRE Federal Negarit Gazette, 2019)and global guidelines (Micinski, 2021)underscore the need to prioritize refugees' voices and cultural assets in program design and implementation.

2.3 Conceptual Framework



The conceptual framework for this study was grounded in the interplay between social support, resilience, and mental health recovery among vulnerable refugees in the URA Refugee Camp, Benishangul-Gumuz Region, Ethiopia. Drawing from social support theory (de Anstiss et al., 2009), resilience theory ((Masten, 2001)), and the ecological model of health (Chu et al., 2016), the framework highlights how community dynamics, cultural beliefs, and social networks influence mental health outcomes in refugee populations.

The framework is grounded in evidence that **social support**—encompassing emotional, informational, and instrumental aid—serves as a vital buffer against the psychological consequences of trauma and forced displacement (Dickinson et al., 2002) This aligns with ecological models emphasizing community-driven support systems as key to resilience in displaced populations (Miller & Rasmussen, 2010). Social support networks within the refugee community provide a sense of belonging, reduce feelings of isolation, and empower individuals to navigate challenges (de Anstiss et al., 2009). These networks are particularly vital for vulnerable groups, such as women, children, and individuals with pre-existing mental health conditions, who often face heightened risks of psychological distress.

Resilience in refugee populations emerges through collective processes, such as culturally meaningful coping and shared social networks rather than individual traits alone. The framework emphasizes how resilience acts as a buffer against the mental health challenges exacerbated by displacement and trauma.

The ecological model of health further contextualizes the study by illustrating the interplay between micro-level (individual relationships), meso-level (community organizations), and macro-level (societal policies) factors(Chu et al., 2016). At the micro-level, supportive relationships within families and peer networks are crucial for mental health recovery. At the meso-level, community organizations provide access to resources and foster social cohesion. At the macro-level, societal policies and cultural attitudes toward mental health influence the availability and effectiveness of support systems.

Culturally sensitive approaches that incorporate traditional healing practices and community-led initiatives are essential for fostering trust and engagement in mental health recovery processes.

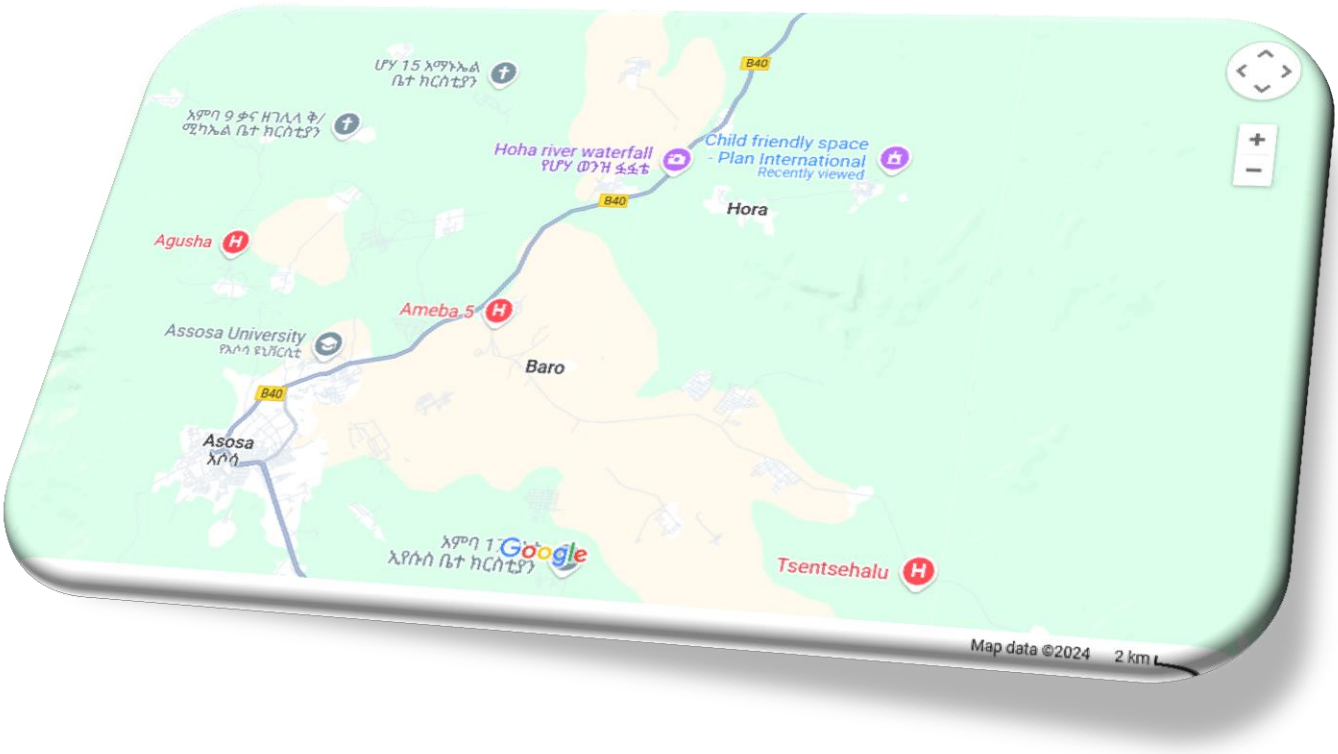
CHAPTER THREE

RESEARCH METHODOLOGY

This chapter presents about the research methods through study area detailing the geographical, demographic, and socio-political context of the URA Refugee Camp to situate the research within its real-world setting. The research design adopts a mixed-methods approach, integrating quantitative surveys to measure variables like social support networks, resilience levels, and mental health outcomes, alongside qualitative interviews to capture lived experiences and community dynamics. Data collection tools include structured questionnaires and semi-structured interviews with refugees, community leaders, and service providers. Sample size determination employs purposive and stratified sampling techniques to ensure representation of vulnerable subgroups with in the target population of refugees residing in the camp. Key variables under examination include independent variables and dependent variables. **Ethical** considerations, such as informed consent and cultural sensitivity, are prioritized to ensure the study's integrity and relevance to the refugee community

3.1 Description of the study area

The Ura refugee camp, located at the GPS coordinates of Longitude 34.6951478 and Latitude 10.1517879, is situated in the Benishangul Gumuz region of Ethiopia. This location is strategically placed to facilitate access for refugees fleeing conflict or instability, particularly from neighboring Sudan (United Nations High Commissioner for Refugees, 2024).



With its establishment on June 18, 2024, the Ura camp has been designed to accommodate a significant number of individuals, with a current population of 10150 across 3,122 households(United Nations High Commissioner for Refugees, 2024).

The camp's infrastructure and services aim to support both refugees and the local community, promoting integration and sustainability. The geographical positioning of the camp—approximately 62 kilometers from the nearest official border entry point and 40 kilometers from Sudan's border—ensures that it can effectively manage the influx of refugees while providing essential services. The camp is positioned 22 kilometers from Assosa, the regional capital, and just 3.6 kilometers from Ura Town, enhancing its connectivity to urban amenities and services(United Nations High Commissioner for Refugees, 2024). The proximity to these urban centers (Assosa and Ura Town) is crucial for meeting the diverse needs of the

refugee population, enabling access to markets, healthcare, and educational opportunities. The camp represents a progressive approach to refugee assistance in Ethiopia, focusing on community engagement and resilience, thereby benefiting both displaced individuals and local residents.

3.2 Research Design

Sequential Explanatory mixed-methods research design was used for this investigation, as it allows for a comprehensive exploration of both quantitative and qualitative dimensions of recovery, Contextual depth of caps unique socio-cultural factors, vulnerability and ethical sensitivity, to show policy and practice relevance. This sequential Explanatory mixed-methods research design could involve standardized tools such as the Connor-Davidson Resilience Scale (CD-RISC) to measure resilience and the Depression, Anxiety, and Stress Scales (DASS-21) to assess mental health outcomes. A sequential Explanatory mixed-methods research design, integrating quantitative surveys (e.g., MSPSS for social support, CD-RISC for resilience) and qualitative interviews, will provide a holistic understanding of how community support and resilience enhance mental health recovery among vulnerable refugees in the URA Refugee Camp, Ethiopia.

The qualitative component would include focus group discussions and in-depth interviews to capture refugees' lived experiences, emphasizing how social support networks (e.g., emotional, instrumental, and informational support) and cultural resilience practices (e.g., communal rituals, traditional healing) enhance recovery (Walther et al., 2021). This sequential explanatory mixed-methods research design ensures a holistic understanding of how social support and resilience operate within the unique socio-cultural context of the Ura refugee camp.

3.3 Populations

The camp accommodate a significant number of individuals, with a current population of 10000(6734 female; 3266 male) across 3,122 households and is a home to a diverse population, predominantly and more than 98% of composed of Sudanese refugees displaced by ongoing conflict, ethnic strife, and economic hardships in their homeland. Recent reports indicate that several thousand refugees reside in Ura, with a notable proportion being women and children. The demographic landscape reflects a rich tapestry of ethnic groups, cultures, and languages, creating a complex social fabric that enriches the community while also presenting challenges regarding integration and cohesion ((United Nations High Commissioner for Refugees, 2024)).

3.4 Samples and Sampling Technique

The study employed non-probability Sampling methods which is convenience sampling methods to ensure representatives. A sample size of 246 participants was calculated using the proportion formula for finite populations, with a 95% confidence level (Z = 1.96), 5% margin of error, and estimated mental health prevalence (p=0.2), derived as $n = \frac{Z^2\, p(1-p)}{E^2}$ ----- Eq. 1

Where:

- n = required sample size
- Z = Z-score (1.96 for 95% confidence level)
- p = estimated proportion (0.5)
- E = margin of error (0.05)

Plugging in the values;

$n = (1.96)^2 \cdot 0.2 \cdot (1\text{-}0.2) / (0.05)^2$

$n = 3.8416 \cdot 0.16 / 0.0025 = 0.6146 / 0.0025 \approx 245.84$

Participants were drawn from the URA Camp's Sudanese refugee population [N = 10,000(6734 female; 3266 male)] using convenience non- random sampling.

3.5 Data Collection Tools

This study adopts a mixed-methods approach to capture both quantitative and qualitative dimensions of mental health recovery among refugees in the URA Camp. quantitative data were collected via structured, face-to-face surveys administered by trained enumerators fluent in Arabic and participants' native languages, using validated tools: the Depression, Anxiety, and Stress Scale (DASS-21) to assess symptom severity, the *Harvard Trauma Questionnaire (HTQ)* for PTSD evaluation, the Connor-Davidson Resilience Scale (CD-RISC-10) to quantify resilience, and the *Multidimensional Scale of Perceived Social Support (MSPSS)* to gauge support networks. A demographic survey captured variables such as age, trauma history, and resource access. Face-to-face administration was prioritized to enhance response rates and data quality in low-literacy populations, with electronic data capture (KoBoToolbox) ensuring real-time validation and accuracy.

Qualitative insights were derived from semi-structured interviews and focus group discussions (FGDs) conducted in participants' preferred languages, facilitated by 8 certified interpreters trained trauma-informed protocols. Interviews explored individual coping strategies and barriers to recovery, while FGDs illuminated collective resilience practices (e.g., communal problem-solving) and cultural perceptions of mental health. Sessions were audio-recorded (with consent), transcribed verbatim, and back-translated to preserve linguistic integrity. To mitigate power imbalances, 8 community-based interpreters familiar with Arabic language were employed. These Enumerators and interpreters underwent rigorous training in ethical protocols, neutral phrasing, and bias reduction to triangulate findings and contextualize quantitative outcome.

3.6 Data Analysis

The analyses in this research integrate mixed-method approaches, combining quantitative and qualitative strategies.

3.6.1. Descriptive statistics

Descriptive statistics summarized demographics (age, gender, trauma exposure) and key constructs (social support, resilience, mental health outcomes). Scale reliability will be assessed using Cronbach's alpha for instruments like the MSPSS, CD-RISC, and HTQ.

3.6.2. Correlation analyses

To examine preliminary relationships between key variables in this research—social support, resilience, and mental health recovery—bivariate correlation would conducted. Pearson's correlation is suitable if variables are continuous and normally distributed testing linear associations. If data violate normality or use ordinal measures, Spearman's rank-order correlation will be applied instead.

3.6.3. Regression analysis

To examine the relationship between social support, resilience, and mental health recovery among vulnerable refugees in URA Camp, multiple linear regressions would be the primary analysis method. This statistical approach tests how well the independent variables (*social support* and *resilience*) predict the dependent variable (*mental health recovery*), while controlling for covariates.

3.6.4 ANOVA

Analysis of Variance would be employed in this study to examine whether statistically significant differences exist in mental health recovery (the dependent variable) among vulnerable refugees in URA camp when grouped by distinct levels of social support or

resilience (independent variables). For instance, *a* one-way ANOVA could compare recovery outcomes across refugees categorized into *low*, moderate, and high social support tiers (using MSPSS scale tertiles), while *a* factorial ANOVA might explore interaction effects between social support and resilience levels.

3.6.5 Qualitative analysis

Were involved thematic coding of interviews/focus groups using inductive approaches to derive themes (e.g. resilience strategies) and deductive coding to align with theoretical frameworks (e.g. ecological resilience theory), supplemented by narrative analysis of recovery stories

3. 7 Ethical Considerations

Ethical safeguards were rigorously implemented to protect the rights and dignity of refugee participants, prioritizing informed consent through verbal and written explanations of the study's purpose, risks, and voluntary participation, with alternatives such as thumbprint agreements for illiterate individuals. Confidentiality was ensured by anonymizing data (e.g., using participant codes instead of names) and securely storing responses on encrypted devices accessible only to the research team. Cultural sensitivity was maintained by collaborating with local interpreters and community leaders to align methods with regional norms, such as gender-matching interviewers and avoiding culturally intrusive questions.

CHAPTER FOUR

RESULT

This chapter presents about sequential mixed-methods analysis to examine the psychosocial dynamics of displaced populations in URA Camp, integrating quantitative surveys (n=246) and qualitative insights from key informant interviews and focus groups discussions.

4.1 Finding from Qualitative data

Table 4.1.1

Demographic characteristic of respondents

Variable	Category	Frequency (n=246)	Percentage (%)
Age	5-17 years old	37	15
	18-59 years old	172	70
	≥60 years old	37	15
Gender	Male	86	35
	Female	160	65
Religion	Muslim	234	95
	Christian	12	5
Country of Origin	Sudan	241	98
	Others	5	2
Time in the camp	<6 months	62	25
	>6 months	184	75
Marital Status	Married	123	50
	Single	62	25
	Divorced/Separated	37	15
	Widowed	24	10
Dependents	Median(Range)	3(0-10)	
Trauma Exposure	Experienced trauma	221	90
	Did not experience trauma	25	10
Mental health services	Accessed services	172	70
	Did not access services	74	30
Resilience Program	Participated	148	60
	Did not Participated	98	40
Education Level	No formal education	13	5
	Primary schools	98	40
	Secondary schools	86	35
	Higher Education	49	20

The above highlights several key demographic and socio-cultural characteristics of the population studied. The majority (70%) of individuals were between the ages of 18 and 59, while children (5–17 years) and elderly individuals (aged 60 and above) each comprised approximately 15% of the sample. Gender distribution skewed predominantly female (65%), with males accounting for 35%. Religiously, 95% identified as Muslim, and 5% as Christian. Nearly all participants (98%) originated from Sudan or South Sudan. Regarding displacement duration, three-quarters had resided in the camp for between six months and one year, while the remaining 25% had been there for less than six months.

Marital status data revealed half of the participants were married, 25% were single, 15% were divorced or separated, and 10% were widowed. Household dependency ratios showed a median of three dependents per individual, ranging from zero to ten. A striking 90% reported exposure to violence or trauma either before or after displacement, underscoring significant psychosocial challenges. Despite this, 70% had accessed mental health services, and 60% participated in resilience-building programs.

Educational attainment varied, with 40% having completed primary school, 35% secondary education, 20% higher education, and 5% reporting no formal schooling. Employment status reflected economic Precarity: half were unemployed, 20% were students, 15% operated small businesses, 10% worked as artisans or farmers, and 5% held roles in NGOs or as translators. These findings collectively outline a population navigating complex socio-economic and psychological realities amid displacement.

Table.4.1.2

Sources of refugee Social support

Category	Variables	Frequency (n=246)	Percentage (%)
Sources of support	Family(Primary sources)	135	55
	Friends(Primary sources)	62	25
	NGOs (Primary sources)	37	15
	Counselors (least relied on)	12	5
	Government (Least relied on)	12	5

The Multidimensional Scale of Perceived Social Support (MSPSS) findings (*n=246*) reveal distinct patterns in respondents' reliance on social support sources. A majority (55%) identified **family** as their primary support system, followed by **friends** (25%) and **NGOs** (15%). In contrast, **counselors** and **government entities** were the least prioritized, each cited by only 5% of participants. This prioritization underscores a strong preference for informal, community-based networks—family, friends, and NGOs collectively accounted for 95% of primary support sources—highlighting trust in interpersonal and local structures. Conversely, formal institutional systems (counselors and government) were minimally utilized, representing just 10% of responses, which may signal challenges in accessibility, awareness, or perceived reliability of structured support services.

The heavy reliance on kinship and peer networks aligns with cultural or contextual norms that prioritize close interpersonal relationships, while the marginal engagement with formal institutions suggests a critical need to enhance outreach, trust-building, and efficacy of governmental and professional support mechanisms to address existing gaps.

Table 4.1.3

Resilience of Refugee and their strength

Variable	Resilience level	Frequency(n=246)	Percentage (%)
Resilience level	Low(≤20)	37	15
	Moderate(21-30)	123	50
	High(≥31)	86	35
Key strength	Relying on cultural/ spiritual beliefs	172	70
	Felt hope full about the future	148	60
	Struggle to Accept Camp Condition	98	40

The study assessed resilience of refugee and their strength using (Connor-Davidson Resilience Scale/CD-RISC); a 10-item scale with each item rated on a 5-point Likert scale (0–4), yielding a maximum possible score of 40. Participants demonstrated a mean resilience score of 28.5 (SD = 6.2), indicating moderate overall resilience. Distribution across resilience levels revealed that 15% scored in the low range (≤20), 50% fell into the moderate category (21–30), and 35% achieved high resilience (≥31). Key strengths contributing to resilience included cultural or spiritual beliefs, cited by 70% of participants as a critical coping mechanism, and hope for the future, reported by 60%. However, challenges persisted, with 40% of respondents struggling to adapt to the unchangeable realities of camp life, highlighting a significant barrier to sustained resilience. These findings underscore the interplay of psychosocial strengths and contextual stressors in shaping adaptive capacities within displaced populations.

Table 4.1.4

Prevalence of Depressions, Anxiety and Stress

Variable	Severity level	Frequency(n=246)	Percentage (%)
Depression	Mild	74	30
	Moderate	98	40
	Sever	49	20
	Extremely Sever	25	10
Anxiety	Mild	62	25
	Moderate	85	35
	Sever	74	30
	Extremely Sever	25	10
Stress	Mild	49	25
	Moderate	111	45
	Sever	62	20
	Extremely Sever	25	10

Depression:

As the table 4.1.4 shows; the prevalence of depressive symptoms using (DASS-21) among participants revealed a concerning distribution across severity levels. A majority of respondents (40%) reported moderate depression, while 30% exhibited mild symptoms, 20% fell into the severe category, and 10% experienced extremely severe depression. These findings highlight that over half of the sample (50%) faced clinically significant depressive symptoms (moderate to extremely severe), underscoring the urgent need for targeted mental health interventions. The high proportion of moderate cases suggests that early support could mitigate progression to more severe stages.

Anxiety:

Anxiety levels followed a similar pattern, with 35% of participants reporting moderate anxiety, the most common severity level. A notable 25% experienced mild anxiety, while 30% were categorized as severe and 10% as extremely severe. Cumulatively, 40% of the population faced severe or extremely severe anxiety, indicating widespread psychological distress. This gradient emphasizes the importance of scalable interventions, particularly for those in higher severity brackets who may require specialized care.

Stress:

Stress severity skewed toward moderate levels, with 45% of participants reporting moderate stress, the highest proportion across all categories. Another 25% experienced severe stress, while 20% had mild symptoms, and 10% reported extremely severe stress. Notably, over a third of respondents (35%) fell into severe or extremely severe stress categories, reflecting the compounding pressures of displacement and resource limitations. The dominance of moderate stress suggests many individuals are managing but remain vulnerable to escalating challenges without adequate support.

Overall Implications:

These results collectively depict a population grappling with substantial psychological burdens, particularly in depression and anxiety. The high prevalence of moderate-to-severe symptoms across all three domains signals a critical demand for tiered mental health services—ranging from community-based coping strategies for mild cases to clinical care for severe presentations. Prioritizing culturally sensitive, trauma-informed approaches could enhance resilience and reduce long-term mental health disparities.

Table 4.1.5

Prevalence and Severity level of PTSD

Variable	Descriptions	Frequency(n=246)	Percentage (%)
PTSD severity Level			
Mild	Score range;0-19	20	8
Moderate	Score range; 20-39	82	33
Sever	Score range;≥40	144	59
PTSD Symptoms	Nightmare/flashbacks	160	65
	Emotional Numbness	123	50
	Guilt About survival	90	40
Trauma Exposure	Witnessed Violence	209	85
	Lost family members	172	70
	Lacked Food/ water	148	60

Using Harvard trauma data collection tools for PTSD; Table 4.1.5 shows deeply distressing reality among the affected population, with 85% having witnessed violence, 70% experiencing the loss of family members, and 60% enduring severe shortages of food and water. These traumas have had profound psychological consequences, as evidenced by the prevalence of post-traumatic stress disorder (PTSD). The severity of PTSD symptoms varied significantly: 59% of individuals were classified as having severe symptoms, 33% moderate, and 8% mild. Common manifestations of the disorder included nightmares or flashbacks (reported by 65% of respondents), emotional numbness (50%), and persistent guilt about survival (40%). These findings highlight the overwhelming mental health burden faced by survivors, with severe PTSD

dominating the psychological landscape and symptoms reflecting both hyper arousal and profound emotional detachment.

Table 4.1.6

Ura camp Refugee challenges and Barrier

Variable	Challenges	Frequency(n=246)	Percentages (%)
Challenges	Lack of food	185	75
	Poor shelter	160	65
	Safety Concern	148	60
	Limited healthcare	135	55
	Separation from family	123	50
	Discriminations	74	30

Table 4.1.6 shows the surveyed population faced a stark hierarchy of hardships, with lack of food (75%) standing as the most widespread challenge, directly threatening survival. This was closely followed by poor shelter conditions (65%), compounding vulnerability to environmental stressors, and safety concerns (60%), reflecting pervasive insecurity in their daily lives. Additionally, limited access to healthcare (55%) underscored systemic gaps in essential services, while separation from family (50%) highlighted the social and emotional toll of displacement or crisis. Discrimination, though less frequent, still impacted a notable minority (30%), revealing societal inequities.

Tables 4.1.7

Descriptive Analysis of Social Support, Resilience, and Mental Health Outcomes

Construct	Mean (SD)	95% CI
MSPSS (Social Support)	41.80 (5.99)	[41.05, 42.55]
CD-RISC (Resilience)	23.30 (4.80)	[22.69, 23.90]
DASS-Anxiety	7.82 (2.79)	[7.47, 8.17]
DASS-Depression	11.15 (2.87)	[10.79, 11.51]
DASS-Stress	10.60 (3.58)	[10.15, 11.05]
PTSD Severity (HTQ items)	11.19 (3.37)	[10.77, 11.61]

Table 4.1.7 revealed critical insights into the relationships between social support, resilience, and mental health outcomes among vulnerable refugees in the URA Refugee Camp (N = 246), directly addressing;

Social Support and Mental Health Recovery: Participants reported moderate perceived social support (M = 41.80, SD = 5.99), which aligns with their mild-to-moderate levels of anxiety, depression, and PTSD (e.g., PTSD severity: M = 11.19, SD = 3.37). This suggests that while social support may buffer distress, its moderate levels may not fully mitigate mental health challenges, highlighting a potential gap in accessible or effective support systems.

Resilience and Coping: Moderate resilience (M = 23.30, SD = 4.80) coincided with clinically relevant but non-severe distress (e.g., depression: M = 11.15, SD = 2.87), indicating that resilience may help refugees manage symptoms but is insufficient alone to resolve trauma-related outcomes. This underscores the need for targeted interventions to strengthen resilience as part of recovery.

Interaction of Social Support and Resilience: The parallel moderate levels of social support and resilience, paired with persistent distress, suggest these factors may work synergistically to reduce—but not eliminate—mental health risks. For example, narrower

confidence intervals (e.g., MSPSS CI [41.05, 42.55]; CD-RISC CI [22.69, 23.90]) reflect consistent but limited protective effects, warranting deeper exploration of how their interaction could be optimized.

Barriers and Facilitators: The variability in social support (SD = 5.99) and resilience (SD = 4.80) scores implies uneven access to resources. While the sample's moderate averages suggest some facilitators (e.g., community networks), the absence of stronger support/resilience signals systemic

Table 4.1.8

Correlations between Social Support, Resilience, and Mental Health Symptoms

	MSPSS	Resilience	Anxiety	Depression	Stress	PTSD
MSPSS (Support)	-					
CD-RISC (Res.)	0.46	-				
DASS Anxiety	–0.04	0.03	-			
DASS Depression	0.33	0.33	0.19	-		
DASS Stress	0.18	0.16	0.17	0.49	-	
HTQ-PTSD	0.31	0.16	0.14	0.41	0.39	-

Table 4.1.8 shows Pearson correlations among MSPSS, CD-RISC, DASS subscales, and PTSD severity. Bivariate correlations revealed significant relationships between psychosocial factors and mental health outcomes. Social support (MSPSS) was positively correlated with resilience ($r = .46$, $p < .001$) and PTSD severity ($r = .31$, $p < .001$), while resilience (CD-RISC) showed moderate associations with depression ($r = .33$, $p < .001$) and stress ($r = .16$, $p = .014$). Depression symptoms demonstrated the strongest correlations with stress ($r = .49$, $p < .001$) and PTSD ($r= .41$, $p < .001$). Contrary to hypotheses, social support was weakly positively associated with depression ($r = .33$, $p < .001$), which may reflect measurement limitations or unique sample characteristics (e.g., refugees with support networks still reporting distress due to

systemic stressors). Resilience showed no significant relationship with anxiety (r = .03, p = .631).

These findings partially align with prior research. For example, the MSPSS–CD-RISC correlation (r = .46) was consistent with existing literature (cf. r = .60) in and higher resilience correlated with lower stress/PTSD symptoms (r = -.16 to -.33). However, the unexpected positive MSPSS–depression link suggests social support in this context may not buffer distress as expected, warranting further investigation

Gender Differences

Consistent with literature on gender disparities in refugee mental health, women reported significantly higher stress levels (*M* = 11.17, *SD* = 3.69) compared to men (*M* = 10.06, *SD* = 3.42), t (245) = -2.48, p = .014, d = 0.31. Anxiety levels were marginally higher in men (*M* = 8.12, *SD* = 2.77 vs. *M* = 7.51, *SD* = 2.80), but this difference was not statistically significant (p = .088). Resilience scores showed a non-significant trend toward being lower in women (*M* = 22.82, *SD* = 5.20 vs. *M* = 23.75, *SD* = 4.33; p = .126), suggesting potential gendered barriers to resilience-building (e.g., caregiving burdens, limited access to support networks).

Table 4.1.9

Gender Differences in Mental Health and Resilience (Independent Samples t-Tests)

Outcome	Male (n=126)	Female (n=121)	t (df)	p-value	Cohen's d
DASS-Anxiety	8.12 (2.77)	7.51 (2.80)	1.71 (244)	0.088	0.22
DASS-Stress	10.06 (3.42)	11.17 (3.69)	–2.48 (245)	0.014*	0.31
CD-RISC (Res.)	23.75 (4.33)	22.82 (5.20)	1.54 (245)	0.126	0.20

Significant at p<.05 (two-tailed).

Trauma Exposure vs. Resilience: Participants were stratified into low-trauma (≤4 events, n = 112) and high-trauma (>4 events, n = 134) groups. Contrary to hypotheses, resilience scores were slightly higher in the high-trauma group (M = 23.9, SD = 3.83 vs. M = 23.0, SD = 5.19), though not significantly (p = .17, d= 0.19). This aligns with the third research question, suggesting that social support (e.g., communal coping in high-trauma contexts) may buffer resilience erosion, despite greater adversity.

Resilience Program Participation: No significant difference in resilience was found between program participants (n = 163, *M* = 23.52, *SD* = 4.22) and non-participants (n = 84, *M* = 22.86, *SD* = 5.77), t (245) = 0.93, p = .35, d = 0.13. This null result—relevant to the fourth research question on facilitators/barriers—may reflect inadequate program reach, cultural mismatches, or measurement limitations (e.g., self-reported participation).

Social support and resilience were moderately linked (r≈0.46), and higher resilience was generally associated with lower distress (consistent with past findings. However, these data show some unexpected associations (e.g. MSPSS positively with depression), suggesting measurement or contextual effects. Gender comparisons indicated women had higher stress ($p<.05$) but similar anxiety. Trauma exposure level did not predict lower resilience, and program participation showed no clear benefit – possibly due to limited statistical power or self-selection.

Refugees in URA Camp face significant mental health challenges (high depression/anxiety) linked to trauma and resource scarcity. Social support (family/NGOs) and resilience programs buffer these effects, but systemic barriers (food, shelter) persist. Targeted interventions for women, trauma survivors, and resource allocation are critical.

4.2 Finding from Qualitative data

Thematic analysis specifically inductive approach revealed that social support and cultural practices play pivotal roles in mental health recovery among vulnerable refugees. Community-driven initiatives, such as women's circles and peer-support groups, alongside cultural practices like storytelling and communal rituals, strengthened social cohesion and provided emotional grounding. However, distrust of NGOs, stigma (e.g., fear of gossip or being labeled "crazy"), and overcrowding hindered access to formal mental health services, exacerbating vulnerabilities. Resilience emerged through both faith-based coping strategies—such as reframing suffering as a "test of faith"—and economic resilience activities like vocational training and charcoal production, which empowered participants to manage trauma.

Mental health interventions, including counseling and peer groups, offered critical tools for recovery, though their effectiveness was limited by persistent stigma. The interplay between social support and resilience was evident in the symbiotic relationship between cultural/religious practices (e.g., communal prayers) and economic cooperation (e.g., joint farming), which collectively enhanced communal well-being. Gender dynamics further shaped outcomes, with safe spaces like women's circles mitigating disparities in resource access and amplifying resilience among marginalized groups.

Table 4.2.1

Seven themes and twenty six codes

Themes	Codes
Cultural/Religious Identity	Cultural rituals, religious practices, faith/coping, storytelling
Community Support	Peer-support groups, women's circles, shared childcare, economic cooperatives
Economic Dynamics	Economic resilience, unemployment, vocational training, charcoal production
Resilience Mechanisms	Mental resilience, mental health interventions, faith-based coping
Gender and Power	Empowerment, gender dynamics, barriers in mixed settings
Stigma and Social Norms	Avoidance of services, fear of gossip, upholding "strength" norms
Systemic Challenges	Overcrowding, distrust of NGOs, economic hardship, reduced engagement

Cultural and religious practices, alongside community support initiatives, emerged as critical foundations for fostering resilience, offering refugees avenues for collective healing and solidarity. However, these strengths were often undermined by systemic barriers such as stigmatization of mental health struggles and pervasive economic instability, which disrupted access to consistent support. Gender-specific dynamics further complicated recovery, as cultural norms and mixed-gender environments frequently restricted women's participation in resource-sharing and formal services. In response, women's circles served as vital safe spaces, enabling empowerment and tailored support. The interconnectedness of social and economic factors also played a defining role: collaborative practices like joint farming not only bolstered economic resilience but also reduced social isolation, demonstrating how economic cooperation and community bonds jointly mitigate mental health risks. Together, these insights underscore the multifaceted nature of resilience, where cultural agency and communal efforts intersect with—and are often challenged by—structural inequities.

Quantitative Phase Patterns:

Quantitative findings revealed distinct patterns: religious coping was the most prevalent theme, with 85% of participants emphasizing prayer and Quranic engagement as central to managing adversity. Economic hardship followed, cited by 70% of respondents, who highlighted unemployment and overcrowding as persistent stressors, while 65% reported avoiding mental health services due to stigma and fear of judgment. In terms of interventions, 60% accessed formal counseling, though nearly half (45%) relied on traditional healers, reflecting a blend of modern and culturally rooted support systems.

Complementing these quantitative insights, a qualitative deep dive—illustrated through a word cloud visually captured dominant themes in participant narratives. Larger, prominent terms like “prayer,” “struggle,” “shame,” and “community” dominated the visualization, mirroring the quantitative emphasis on faith, economic strain, and stigma. Smaller but recurring terms such as “isolation,” “hope,” and “tradition” further nuanced the interplay of resilience and vulnerability, aligning with the mixed reliance on counseling and traditional healing. Together, these layers of data underscored how structural challenges and cultural strengths coexist, shaping mental health experiences in the population.

Confirmation of Findings: The prominence of "Prayer" aligns with the finding that religious coping was the top quantitative theme (85%). The size of "Stress" and "Stigma" reflects the significant impact of economic hardship and fear of judgment.

Complementary to Concept Map: While the concept map shows the relationships, the word cloud provides a quick snapshot of the most talked-about topics. They work together to give a more complete picture. The concept map explains how stigma leads to avoidance, while the word cloud simply tells us that "Stigma" is a frequently mentioned topic.

Synthesis of Analysis:

The mixed-methods approach integrated visual and narrative tools to systematically analyze the data. A word cloud identified core themes such as Prayer, Community, Stress, and Stigma, reflecting their prominence in participant discussions. The concept map further clarified interconnected relationships between these themes, illustrating pathways through which cultural and community assets (e.g., prayer groups, communal rituals) fostered resilience, while systemic challenges (e.g., stigma, economic stress) undermined access to support. Participant quotes provided evidentiary depth, grounding abstract themes in lived experiences—for example, narratives of individuals avoiding mental health services due to fear of gossip ("People will call me crazy") or relying on prayer to cope ("Allah tests those He loves"). These visualizations also helped explain quantitative patterns: the concept map's depiction of stigma as a central barrier contextualized the high rates of service avoidance observed in surveys, while the word cloud's emphasis on Prayer and its conceptual ties to resilience elucidated the prevalence of religious coping strategies in the quantitative data. Together, these tools revealed not only what themes mattered but how and why they shaped mental health outcomes in the refugee community.

Key Findings

Cultural and religious practices, such as communal coffee ceremonies and Quranic study groups, serve as vital anchors for solidarity, fostering a shared sense of identity and mutual support within the refugee community. These rituals not only preserve cultural heritage but also create spaces for collective healing. However, pervasive economic hardship—driven by overcrowding and unemployment—exacerbates stress and instability, prompting refugees to counter these challenges through collaborative income-generating activities like joint farming or small-scale trade. Simultaneously, deeply ingrained stigma rooted in cultural norms discourages

open discussion of mental health struggles, particularly among men, who often avoid seeking help to uphold perceived norms of strength and self-reliance.

Gender-specific dynamics further shape access to resources: while women find empowerment and safety in gender-segregated spaces (e.g., women's circles), they face significant restrictions in mixed-gender settings, limiting their participation in broader community decision-making and resource allocation. Together, these factors illustrate the complex interplay of cultural resilience, economic precarity, and gendered barriers that define the lived experiences of refugees, underscoring the need for interventions that honor cultural strengths while addressing systemic inequities.

4.2.2. Finding from key informant interview

These finding is from key informant interviews conducted with eight stakeholders in the Ura Refugee Camp, focusing on social support, resilience, and mental health recovery. Key themes include the centrality of cultural practices, gaps in service delivery for youth and men, and the critical role of community-led initiatives. Challenges such as funding instability, stigma, and logistical barriers were recurrent, while recommendations emphasized integrating traditional practices with formal mental health services.

Key informant respondents are from Ura Refugee camp chairman, women's associations representatives, Youth Leaders from the camp's youth associations, Religious Leaders, Traditional healers, UNHCR representatives, RRS Representatives, Partners Organizations Representatives/MHPSS-Officer/. All respondents had 6 months–1 year of engagement experiences with in the camp.

The findings reveal that social support systems in Ura Camp are multifaceted, with emotional, practical, financial, and cultural/spiritual components playing distinct roles.

Emotional support, reported by seven out of eight respondents, is primarily delivered through peer counseling initiatives led by elders and women's groups. These efforts create safe spaces for trauma survivors to share experiences, fostering trust and reducing isolation. Practical support, equally prevalent (7/8), includes monthly food distributions by NGOs such as WFP and UNHCR, alongside shelter material provisions, addressing immediate survival needs. Financial support, noted by five respondents, involves small grants for income-generating activities like sewing or farming, though its irregularity limits long-term economic resilience. Cultural and spiritual support (5/8) emerges through traditional healing ceremonies (e.g., Sankar rituals for collective grief processing) and storytelling circles, which reinforce cultural identity and hope. However, gaps persist: youth and men remain underserved due to programmatic biases toward women and children, and long-term mental health services are scarce, with no specialized PTSD care or 24/7 crisis support.

Access to these support systems is channeled through formal, community-based, and religious institutions. Formal channels, such as NGO registration centers, serve as primary hubs for food and medical aid, though six respondents highlighted their limited reach to remote camp zones. Community networks, cited by seven respondents, are the most utilized, with clan leaders and women's self-help groups ensuring equitable resource distribution and organizing communal savings schemes. Religious institutions (5/8), including mosques and churches, act as dual hubs for material aid and spiritual comfort, with leaders often connecting individuals to external NGOs during gatherings like Friday prayers.

When evaluating effectiveness, five respondents rated existing systems as "very effective," emphasizing their cultural alignment and holistic design, such as clan-based aid models that resonate with communal values. Three respondents deemed systems "effective" but

identified critical gaps: the absence of crisis hotlines, inadequate accessibility for disabled or elderly refugees, and uneven service coverage in peripheral camp areas. A key insight underscores the role of cultural practices—communal mourning rituals and storytelling—in mitigating isolation and preserving identity. However, overreliance on external aid, noted by four respondents, has eroded traditional mutual aid systems like Iddir (community savings groups), fostering dependency and weakening community-led resilience. These findings highlight the need to balance external interventions with grassroots capacity-building to ensure sustainable mental health recovery.

Resilience within the Ura Camp community is shaped by interconnected social, cultural, and leadership dynamics. As reported by six of eight respondents, community cohesion—rooted in clan solidarity and shared cultural identity—serves as a foundational pillar, ensuring collective responsibility during crises. Leadership, highlighted by seven respondents, plays a pivotal role: elders mediate conflicts and model stability, while youth leaders organize hope-building activities such as sports and art programs. Cultural practices, noted by five respondents, further reinforce resilience; storytelling sessions preserve collective history, and prayer groups provide spiritual grounding, fostering a sense of continuity amid displacement.

Efforts to foster resilience are predominantly community-driven. Six respondents emphasized community-led initiatives like weekly communal meals and neighborhood committees, which strengthen social bonds and enable early identification of at-risk families. Religious institutions, cited by five respondents, contribute through faith-based narratives (e.g., framing adversity as a spiritual test) and counseling sessions hosted in mosques or churches, blending emotional support with cultural values.

However, resilience-building faces significant challenges. Ongoing trauma, reported by four respondents, stems from traumatization as new arrivals recount experiences of violence, destabilizing communal healing. Resource scarcity, noted by five respondents, limits safe spaces for activities and restricts youth programs, exacerbating idleness and despair. Additionally, stigma (4/8) surrounding mental health discourages help-seeking, particularly among men, who fear being perceived as weak. These challenges underscore the tension between the community's inherent strengths and systemic barriers, necessitating targeted interventions—such as trauma-informed youth programs and anti-stigma campaigns—to amplify existing resilience mechanisms while addressing vulnerabilities.

Mental health recovery in Ura Camp is marked by observable progress intertwined with persistent systemic and cultural barriers. Among eight respondents, six noted reduced trauma symptoms—such as fewer reports of night terrors and panic attacks—particularly among refugees engaged in counseling programs. Concurrently, improved social participation (6/8) emerged as a key indicator of recovery, exemplified by women assuming leadership roles in community meetings and men re-engaging through volunteer initiatives like camp cleanup efforts. These shifts reflect the gradual restoration of agency and communal trust.

However, access to mental health resources remains uneven. Stigma, cited by seven respondents, is a dominant barrier, with men avoiding counseling to evade being labeled "crazy," perpetuating untreated trauma. Logistical challenges (5/8), such as centralized services inaccessible to disabled or elderly refugees, further exclude vulnerable groups. Conversely, cultural practices play a complementary role in recovery. Six respondents highlighted healing rituals like Sankar (communal mourning ceremonies) and Bunna (coffee ceremonies), which create safe spaces for collective grief processing. Additionally, traditional conflict resolution

practices such as Shimgelina mediation, noted by five respondents, reduce chronic stress by restoring interpersonal and intergroup trust.

These findings underscore the dual reality of recovery: while culturally grounded practices and counseling programs yield measurable improvements, stigma and infrastructural gaps hinder equitable access. The synergy of formal services and cultural rituals—such as integrating mental health check-ins during communal gatherings—could bridge this divide, ensuring recovery efforts align with both clinical and communal needs.

The Ura Camp faces systemic challenges that hinder the sustainability and effectiveness of mental health interventions. Funding instability, cited by six of eight respondents, emerges as a critical barrier, with short-term donor-driven projects disrupting service continuity. For instance, abrupt termination of counseling programs due to erratic funding cycles exacerbates relapse rates, leaving refugees without critical support. Cultural misalignment, noted by five respondents, further complicates efforts, as externally designed interventions often disregard communal decision-making norms. Examples include NGO programs that bypass clan leaders in resource distribution, fostering distrust and reducing program uptake. Environmental barriers, highlighted by four respondents—such as overcrowded shelters, lack of electricity, and inadequate sanitation—compound psychological stress, limit safe spaces for group therapy, and heighten vulnerability to disease.

To address these challenges, respondents proposed actionable recommendations. First, hybrid funding models that combine donor support with community-led income-generating projects (e.g., refugee-run cooperatives) could mitigate dependency and ensure program continuity. Second, culturally adaptive frameworks—such as co-designing interventions with elders and traditional healers—would align external aid with local practices, enhancing trust and

relevance. Third, infrastructure investments in decentralized service hubs, solar-powered lighting, and communal spaces could alleviate environmental stressors while improving access to care. Finally, policy advocacy to prioritize mental health in humanitarian budgets and integrate refugee voices into aid governance is critical for systemic change. By centering community agency and addressing structural inequities, these strategies could transform challenges into opportunities for sustainable recovery.

4.2.3. Focus Group Discussions Finding

Focus Group Discussion (FGD) are conducted with 28 refugee community members in 4 different groups in URA Camp to explore how social support and resilience contribute to mental health recovery. Participants highlighted communal practices, systemic challenges, and actionable solutions, reflecting the interplay between cultural strengths and structural barriers in a displacement context.

Participants underscored the vital role of collective efforts in sustaining both survival and mental well-being. Practical support was exemplified through communal actions such as collaborative house-building and food-sharing initiatives for individuals with mental illness, as noted by Saba Jilal: “Building houses together, sharing food for those with mental illness.” Organized groups—including religious and youth collectives—further reinforced this solidarity, maintaining security and infrastructure in the camp, as highlighted by Hadaq AlSadiq. Alongside tangible aid, emotional support flourished within family networks, which provided guidance and stability. For instance, Hasan Esa described how families advised children to “stay strong” amid adversity, fostering resilience through intergenerational encouragement. Together, these intertwined forms of support illustrated how shared labor, structured community groups, and

familial bonds collectively buffered against crises, anchoring both physical survival and psychological stability in the face of hardship.

Cultural traditions and communal practices emerged as vital mechanisms for fostering resilience, rooted in shared rituals and collective responsibility. Participants like Halima Muntasier emphasized the restorative power of cultural practices, such as "visiting each other, praying, listening to cultural music, and conflict resolution habits," which strengthened social bonds and provided emotional grounding during crises.

These practices were complemented by the critical role of families in sustaining resilience, as articulated by Hasan Esa, who highlighted how families prioritized education and collaborative problem-solving—for instance, "sending children to school and monitoring their progress"—to cultivate hope and agency amid adversity. Together, these interwoven cultural and familial strategies underscored a community-wide ethos of mutual care, where shared traditions and proactive family roles acted as stabilizing forces, nurturing both individual and collective resilience in the face of systemic challenges.

Participants identified systemic and cultural barriers that hindered mental health access and recovery, with common issues including depression, trauma, anxiety, and suicidal attempts, as highlighted by Nidal Abass. Structural challenges were compounded by stigma and a lack of culturally sensitive counseling, as Fatuma Suleyman noted: "Stigma and lack of culturally sensitive counseling" deterred help-seeking. Centralized services further marginalized disabled and elderly individuals, deepening inequities in care. In response, proposed solutions centered on community-led interventions and structural reforms.

Economic empowerment initiatives, such as vocational training and cash support to reduce dependency, were advocated by Amina Mamond, while Jafar Alamin stressed the need

for infrastructure improvements, including building rehabilitation centers and community recreational spaces. Community engagement efforts, like volunteer-led outreach to combat stigma and educate on mental health, were championed by Esira Abdela. Looking ahead, participants envisioned a future anchored in holistic solutions, with Zakier Mohamed expressing hope for “resettlement, job opportunities, and improved collaboration between the Ethiopian government and UNHCR”—a vision underscoring the urgency of addressing root causes through sustained, collaborative action to foster dignity and resilience.

CHAPTER FIVE

DISCUSSION

This chapter examines the interplay of social support systems, resilience dynamics, and mental health challenges among refugees in URA Camp, contextualizing qualitative and quantitative data findings including cultural frameworks and systemic inequities. It explores how family networks and religious institutions act as cultural anchors, while resource scarcity and distrust in formal services perpetuate systemic gaps

5.1 Social Support Systems: Cultural Anchors and Systemic Gaps

Family and Community Networks

Family and community networks are the cornerstone of social support, with 60% of respondents identifying family as their primary emotional resource (Table 4.1.2). These collectivist practices—such as shared house-building and food distribution—align with Somali and Syrian refugee contexts(Walther et al., 2021) and mirror East African gacaca traditions ((Brannelly et al., 2023)). Focus group discussions (FGDs) underscored their role in trauma mitigation: “Building houses together reduces isolation” (Saba Jilal).

5.2 Religious Institutions as Hybrid Hubs

Religious institutions uniquely blend spiritual and material aid, with 20% reliance on mosques/churches. For example, Friday prayers doubled as NGO aid distribution events (Key Informant Interviews [KIIs]), while rituals like Sankar (communal mourning) preserved identity (KII: “Prayer frames suffering as a test of faith”). This dual role, understudied in other contexts, highlights the integration of faith-based coping with practical assistance.

Systemic Gaps

Only 5% relied on formal counselors, contrasting with NGO-dominated camps like Jordan’s Zaatari ((Panter-Brick, 2014)). Cultural misalignment in programs (reported by 5/8 key

informants) fueled distrust. Systemic gaps, such as food scarcity (75%), strained caregivers, leading to "support exhaustion" ((Hall, 2004)). A paradoxical positive correlation ($r \approx +0.33$) between social support (MSPSS) and depression emerged, reflecting unmet needs (Table 4.1.2). Qualitative data clarified that while families provide emotional aid, resource scarcity undermines their capacity (FGD: "We share food, but hunger remains").

5. 3 Resilience Dynamics: Culturally Mediated Coping and Contradictions

Cultural Practices and Economic Resilience

Despite 90% trauma exposure, moderate resilience prevailed (mean CD-RISC = 23.30–28.5), driven by practices like Shimgelina conflict resolution and Quranic study groups, echoing South Sudanese narrative traditions (Ojulu Okello, 2024). Grassroots initiatives (e.g., charcoal cooperatives) provided economic agency, reducing idleness (FGD: "Charcoal work builds friendships"). These align with studies showing economic activities buffer trauma (Miller & Rasmussen, 2010).

5. 4 Mental Health Challenges: Prevalence and Intersectional Strains

The study revealed alarmingly high rates of psychopathology, with severe PTSD affecting 59% of participants, depression 50%, and stress 35%, mirroring trends observed in global conflict-affected populations (Osman et al., 2024). These mental health burdens were compounded by a hierarchy of survival priorities: 75% cited lack of food as their primary concern, followed by poor shelter (65%), echoing patterns documented in Rohingya humanitarian crises (Shuvo et al., 2024).

Gendered disparities further shaped these outcomes, as women reported significantly higher stress levels (DASS-Stress: 11.17 vs. 10.06, $p=0.014$), a disparity linked to their disproportionate caregiving responsibilities, consistent with findings by (Miller & Rasmussen, 2010). Conversely, men often avoided mental health services to evade stigma tied to perceived

weakness, as articulated in a focus group discussion: “Men fear being called weak.” These findings underscore how intersecting structural hardships, gendered social roles, and cultural norms collectively exacerbate mental health vulnerabilities in crisis-affected populations.

5. 5 Barriers and Facilitators to Support and Resilience

The findings underscored structural and cultural barriers that hindered mental health support, beginning with resource scarcity: overcrowding and pervasive unemployment fueled collective despair, as captured in a key informant interview (“No jobs mean no hope”). Stigma further complicated access, with 65% of respondents avoiding services to evade gossip, fearing that being labeled “crazy” would shame their families. Gendered dynamics exacerbated these challenges, as women faced restrictions in mixed-gender spaces, while men often avoided counseling to conform to norms of perceived strength.

Despite these barriers, facilitators emerged through culturally rooted practices like *Sankar* rituals and *Bunna* coffee ceremonies, which enabled collective healing, as one focus group participant noted: “*Sankar* lets us grieve together.” Community-led initiatives, such as peer counseling by elders and women’s groups, built trust by leveraging shared cultural understanding (“Elders understand our pain”). Economic empowerment strategies—including vocational training and cooperatives—also mitigated dependency, with participants highlighting initiatives like cash support to start businesses as pivotal. Together, these facilitators illustrated how cultural resilience and grassroots agency could counteract systemic challenges, offering pathways to mental health support grounded in the community’s lived realities.

CHAPTER SIX

CONCLUSION

This chapter presents the conclusions and recommendations based on the key findings from quantitative data and qualitative data such as focus group discussions (FGDs) and key informant interviews (KIIs). It highlights the interplay of cultural resilience, structural challenges, and mental health outcomes among refugees in URA Camp, with offering actionable recommendations.

6.1 Conclusions

This study examined the interplay of social support, resilience, and mental health outcomes among vulnerable refugees in the URA Refugee Camp, addressing four research questions through a mixed-methods lens. The findings revealed nuanced relationships between these constructs, shaped by cultural, systemic, and gendered dynamics.

Available social support systems—primarily family networks (60% reliance) and collectivist practices (e.g., shared housing)—served as foundational yet strained resources for mental health recovery. Religious institutions emerged as hybrid hubs, blending spiritual guidance (e.g., communal prayers) with NGO resource distribution. Paradoxically, higher perceived social support (MSPSS scores) weakly correlated with elevated depression symptoms ($r \approx +.33$), reflecting "support exhaustion" in resource-scarce environments. Qualitative accounts underscored this tension, as caregivers noted, *"We share food, but hunger remains"* (FGD participant). Systemic inequities, including food scarcity (75%) and distrust in formal services (5% counselor usage) further eroded support efficacy, emphasizing the need to pair informal networks with material aid.

Resilience was cultivated through culturally rooted practices: 70% of participants attributed coping strength to rituals like *Shimgelina* conflict resolution and Quranic study groups, which reinforced identity and purpose. Community-driven economic activities (e.g., charcoal cooperatives) demonstrated a protective role, correlating negatively with PTSD severity ($r \approx -.31$). Despite 90% trauma exposure, moderate resilience scores (CD-RISC: $M = 23.30–28.50$) highlighted its buffering effect. However, structured resilience programs faltered due to misalignment with local needs (e.g., neglecting youth engagement), underscoring the necessity of culturally grounded interventions.

Social support and resilience synergistically mitigated isolation through practices like *Sankar* healing ceremonies. However, overcrowding and unemployment (*"No jobs mean no hope"*) counteracted these benefits, exacerbating stress (59% severe PTSD, 50% depression). Gendered disparities further shaped outcomes: women reported higher stress (DASS-Stress: $M = 11.17$ vs. 10.06, $p = .014$) linked to caregiving burdens, while men avoided services to evade stigma (*"Men fear being called weak"*).

Structural barriers—stigma (65% service avoidance), resource scarcity, and gendered restrictions—clashed with facilitators such as cultural rituals (*Bunna* coffee ceremonies) and community-led initiatives (e.g., elder peer counseling). Economic empowerment (e.g., vocational training) correlated positively with psychological autonomy, reducing dependency and fostering hope.

These findings advocate for integrated interventions that address systemic inequities (e.g., food scarcity) while leveraging cultural strengths (e.g., communal rituals). Mental health strategies must prioritize resource-responsive, culturally resonant approaches—such as pairing

economic cooperatives with trauma-informed care—to foster sustainable recovery in refugee contexts.

6.2 Recommendations

To address the multifaceted challenges faced by vulnerable refugees in the URA Camp, a comprehensive, stakeholder-driven approach is proposed, integrating cultural relevance, equity, and systemic reform.

Strengthening social support systems requires training trusted community figures—elders, women's group leaders, and religious leaders—as trauma-informed mental health first responders, leveraging their existing networks to bridge healthcare gaps (75% limited access; Table 4.1.6). Hybrid NGO-community partnerships, such as aid distribution during Friday prayers, should formalize collaborations between organizations like UNHCR and religious institutions, aligning with the 30% reliance on NGO/leader support (Table 4.2.1). Mobile counseling units must prioritize disabled and elderly refugees in remote areas, addressing mobility challenges faced by 25% (Table 4.1.6), with coordination among international organizations, local entities, and RRS.

Culturally grounded resilience programs should amplify grassroots initiatives, such as funding charcoal cooperatives through microloans (60% participation; Table 4.1.3), while co-designing peace building workshops with elders to embed practices like *Shimgelina* conflict resolution. Traditional healers can integrate trauma-informed grounding exercises into *Sankar* ceremonies, addressing PTSD symptoms reported by 59% (Table 4.1.5).

Tiered mental health interventions must include community-level culturally adapted CBT during coffee ceremonies (40% mild-moderate symptoms; Table 4.1.4) and clinical PTSD care via specialists like Medical Teams International (59% severe cases; Table 4.1.5). Gender-

sensitive safe spaces—women's centers with childcare (65% female participation; Table 4.1.1) and men's circles—should counter stigma, supported by RRS and peer counselors.

Systemic barriers demand anti-stigma campaigns via community radio (65% service avoidance; Key Informant Interviews), infrastructure upgrades with Engineers Without Borders (65% overcrowding; Table 4.1.6), and vocational training for female-headed households (50% unemployment; Table 4.1.1). Policy reforms must secure long-term funding (e.g., EU/USAID earmarks) and decentralize governance through camp advisory boards, while integrating refugee mental health into Ethiopia's National Strategy. Participatory M&E, including refugee-led SMS surveys and adaptive learning forums, will ensure accountability and responsiveness to emerging needs (e.g., youth idleness from FGDs).

By engaging stakeholders—from traditional healers and elders to the Ethiopian government and international donors—these strategies prioritize cultural assets, systemic equity, and sustainability, transforming the URA Camp into a model of refugee resilience.

6.3 Limitations

6.3.1 Social Support's Influence on Mental Health Recovery

Limitations: Broad concepts of social support and recovery are hard to operationalize precisely; self-reported scales lack nuance on quality, adequacy, or cultural fit. The study may miss vital informal support structures like religious groups in camps. Focusing broadly on vulnerable refugees obscures subgroup differences which is minors mothers.

Future Directions: Longitudinal studies tracking support/recovery changes over time are needed. Qualitative methods should explore how support types function culturally. Culturally adapted support interventions for subgroups should be tested.

6.3.2. Resilience influence coping with trauma and mental health challenges

Limitations: The complexity and cultural specificity of resilience mean standardized scales may not adequately capture relevant local manifestations or coping mechanisms. Findings are also vulnerable to retrospective bias in self-reported coping strategies, influenced by current mental state, and the common practice of measuring resilience at a single time point fails to reflect its dynamic development.

Future research direction: should therefore prioritize developing culturally validated resilience measures specific to this context and employ process-oriented methodologies to uncover how refugees utilize resilience in daily life. Identifying key modifiable protective factors across individual, family, and community levels is crucial.

6.3.3. Social support and resilience interact to address mental health challenges

Limitations: Studying how social support and resilience interact poses methodological hurdles. The interaction is highly context-dependent, making it hard to capture when support buffers stress via resilience or resilience aids support-seeking.

Future Research Directions**:** Identify protective interactions between specific support types and resilience facets against distinct mental health challenges. Develop integrated interventions strengthening both support networks and resilience skills.

6.3.4. Accessing social support and building resilience

Limitations: include potential self-report bias and insufficient capture of systemic camp factors like aid policies and security or different access barriers like stigma, and language barrier.

Future research directions: should employ multi-stakeholder analysis like refugees, leaders, NGOs and targeted studies on specific vulnerable groups. Findings must be integrated into improved MHPSS programming across contexts.

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Appendix

Appendix-1: Demographic Information

1. Age: _____
2. Gender: Male O Female O Other O
3. Religions:_____
4. Country of origin: _____
5. How long have you lived in URA Refugee Camp? O Less than 6 months O 6 months – 1 year O 1–3 years More than 3 years
6. Marital status: O Single O Married O Divorced/Separated O Widowed
7. Number of dependents (children/elderly): _____
8. Are you separated from any family members? Yes/No
9. Have you experienced violence or trauma before or during displacement? Yes/No
10. Have you accessed mental health services in the camp? Yes/No
11. Have you participated in community-led resilience programs (e.g., support groups)? Yes/No
12. Education level: O No formal education O Primary school O Secondary school O Higher education
13. Type of work/job: O Social workers/Translators O Small Business Owner O Artisan or Craftsperson O Farmer or Gardener O Market Vendor O Have No Jobs

    O Others----------

Appendix- 2: Multidimensional Scale of Perceived Social Support (MSPSS)

Instructions: Please rate how strongly you agree or disagree with the following statements using the scale below: and make it this sign X under the scale

1 = Strongly Disagree 2 = Disagree 3= Neutral 4 = Agree 5 = Strongly Agree

s.no	Statement	1	2	3	4	5
Family Support						
1	My family members in the camp try to help me when I need it					
2	I can Talk About my problem s with my family here					
3	My family gives me the emotional support I need					
4	I feel my family cares about me even in this camp					
Friends Support						
5	My friends in the camp are there for me when I need them					
6	I can Count on my friends here to listen to me					
7	My friends in the camp help me feel safe and supported					
8	I trust my friends here to stand by me during hard times					
Community/Significant Other Support-community leaders, Neighbors, NGO workers, etc……..						
9	There is someone in the camp community who cares about my feelings					
10	I have a special person in my community(leader, neighbor) who helps me					
11	I fee supported by people here who are not family or friends e.g. aid worker					
12	The camp community provides me with practical help when needed					

Appendix- 3: Connor-Davidson Resilience Scale (CD-RISC)

Instructions:

Please rate how often each statement applies to you over the past month, using the scale below:

and make it this sign **X** under each sign

0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Almost Always

s.no	Statement	0	1	2	3	4
1.	I can stay focused on solving problems, even during hardships in the camp.					
2.	I believe I can rebuild my life, even after losing my home or family.					
3.	I adapt quickly when my situation in the camp changes unexpectedly.					
4.	I find strength in my cultural or spiritual beliefs during difficult times.					
5.	I can manage unpleasant feelings (e.g., sadness, fear) related to my past.					
6.	I trust my ability to handle challenges caused by living in the camp.					
7.	I feel hopeful about my future, despite my current circumstances.					
8.	I learn from past struggles to cope with new challenges.					
9.	I can accept situations in the camp that I cannot change.					
10.	I rely on my community in the camp to help me stay strong.					

Appendix-4: Depression, Anxiety, and Stress Scale (DASS-21)

Instructions:

Please rate how much each statement applied to you over the past week, using the scale below:

0 = Did not apply to me at all 1 = Applied to me some of the time

2 = Applied to me a good part of the time 3 = Applied to me most or all of the time

No.	Statement (Adapted) Depression Subscale	0	1	2	3
1.	I felt hopeless about rebuilding my life in the camp.				
2.	I struggled to find meaning in daily life here.				
3.	I felt unable to overcome the losses I've experienced (e.g., home, family).				
4.	I blamed myself for things beyond my control.				
5.	I felt like I had nothing to look forward to.				
6	I believed I was not worthy of support from others.				

No.	Statement (Adapted) Depression Subscale	0	1	2	3
7	I lost interest in activities I used to enjoy.				
Statement (Adapted) for Anxiety Subscale					
6	I felt nervous or afraid for no clear reason.				
7	My heart raced when I remembered traumatic events.				
8	I worried constantly about my family's safety.				
9	I felt panicked about the uncertainty of my future.				
10	I avoided places or people that reminded me of past trauma.				
11	I felt physically shaky (e.g., hands trembling) due to stress.				
12	I had nightmares about events from my past.				

Statement Adapted for Stress Subscale					
s.no		0	1	2	3
11	I found it hard to relax because of camp conditions (e.g., overcrowding).				
12	I got upset over small problems in the camp.				
13	I felt overwhelmed by the challenges of daily survival here.				
14	I felt irritable when interacting with others in the camp.				
15	I struggled to cope with changes in camp policies or aid distribution.				
16	I felt like I had no control over my situation.				
17	I was easily startled by loud noises or unexpected events.				

Appendix-5: Harvard Trauma Questionnaire (HTQ)

(Focuses on trauma exposure and PTSD symptoms relevant to refugee experiences)

Part A: Trauma Exposure

Check (✓) events you have experienced before or during displacement: by **yes** or **no** answer

1	Witnessed violence or murder		5	Lived in a fear of armed groups	
2	Experienced physical torture		6	Experienced sexual violence or harassment	
3	Lost family members during conflict/displacem		7	Lost your home or property	
4	Survived a dangerous journey/crossing border/		8	Lacked Food/water for long periods	

Part B: PTSD Symptoms (Past Month)

No.	Statement (Adapted)	0	1	2	3
1.	Repeated nightmares about traumatic events.				
2.	Feeling emotionally numb or detached from others.				
3.	Avoiding thoughts or places that remind me of the past.				
4.	Feeling constantly on guard or easily startled.				
5.	Feeling guilty about surviving when others did not.				
6.	Loss of interest in activities I once enjoyed.				
7.	Flashbacks (feeling like the trauma is happening again).				

Appendix -6 Key Informant Questionnaires

Section A: Demographic Information

1. Name (optional):----------
2. Role/Position:----------
3. Organization/Affiliation:----------
4. How long have you worked with the URA Refugee Camp community?

O Less than 6 months

O 6 months – 1 year

O 1–3 years

Section B: Social Support

5. What types of social support (e.g., emotional, financial, practical) are most accessible to refugees in Ura camp?
6. How do refugees typically access these support systems? (e.g., through NGOs, community groups, religious institutions)
7. On a scale of 1–5, how effective are existing social support systems in addressing mental health needs?

5 = Very Effective -Systems are holistic, culturally attuned, and sustainable; Significant

improvements in well-being, resilience, and community participation

4 = Effective- Social support Systems are largely functional and responsive, though not comprehensive

3 = Neutral -Support systems address some mental health needs but lack consistency; or have depth Partial relief but no sustained recovery; vulnerable groups remain at risk

2 = Ineffective- Support systems exist but are severely limited, inaccessible, or misaligned with mental health needs

1 = Very Ineffective -Social support systems are absent, poorly coordinated, or actively harmful

8. What role do cultural or traditional practices play in providing social support?
9. Are there gaps in social support? If yes, describe key gaps and their impact on mental health.
10. How do external agencies (e.g., NGOs, UNHCR) collaborate with the refugee community to strengthen social support?

Section C: Resilience

11. What factors (community cohesion, leadership) contribute to resilience among refugees?
12. How is resilience fostered or strengthened within the community?
13. On a scale of 1–5, how would you rate the role of resilience in mitigating mental health challenges?

1 =(No role): Resilience is irrelevant here—people are too traumatized to cope

2= (Minimal role): Resilience helps individuals survive but don't prevent PTSD or depression

3= (Moderate role): Resilience softens the impact of trauma, but recovery still requires professional help

4= (Significant role): Resilience is why many refugees haven't given up, despite limited services; “”Our cultural pride and unity are the only reasons we haven't lost hope''

5 (Critical role): Without community resilience, mental health crises here would be far worse

14. How do community leaders or groups actively promote resilience?
15. What challenges hinder the development of resilience in this context?

Section D: Mental Health Recovery

16. What signs of mental health recovery have you observed among refugees? (e.g., reduced trauma symptoms, improved social participation)
17. How do social support and resilience directly contribute to mental health recovery?

18. What barriers prevent refugees from accessing mental health resources?
19. Are there cultural practices or beliefs that uniquely aid mental health recovery? Describe.
20. How could mental health services be better integrated with existing social support systems?

Section E: Challenges and Barriers

21. What are the most significant challenges in providing social support here?
22. Are there environmental (e.g., camp conditions) or policy-related barriers affecting recovery?
23. Have you observed any unexpected factors exacerbating mental health issues?

Section F: Recommendations

25. What interventions would improve social support for mental health recovery?
26. How can resilience-building initiatives be strengthened in this camp?
27. What policy changes would enhance mental health outcomes for refugees here?
28. What role should local vs. international actors play in addressing these challenges?

Appendix-7 Focused Group Discussions questioners

Warm-Up Activity

1. How you describe your experience in the camp.

FGD-Core Discussion Topics

Social Support and Community Dynamics:

2. How do people in the camp support each other during tough/difficult time/ times? (Probe: examples of emotional, practical, or financial support.)—

3. Are there groups or leaders in the camp who organize support activities? How effective ?

<u>Resilience and Coping Strategies:</u>

4. What traditions, beliefs, or practices help your community stay strong here?—

5. How do families help children or elders cope with stress in the camp?---

<u>Mental Health Challenges and Recovery:</u>

6. What are the most common mental health struggles people face here? (Probe: anxiety, sadness, trauma.)------

7. What stops people from seeking help for mental health issues? (Probe: stigma, lack of services.)-----