'I was buried under the ground.
But now my mind is free.'

A Qualitative Study on Vulnerabilities, Traumatisation, and Interventions in Mental Health and Psychosocial Support in Amhara, Oromiya, and Tigray Regions of Ethiopia with a Particular Emphasis on Church-Based Organisations

Brot für die Welt

caritas Germany

misereor
ALLY FOR A JUST WORLD

EECMY - DASSC

This qualitative study is the result of a participatory and collaborative effort by three German-based organisations: Brot für die Welt (Bread for the World), Caritas Germany and Misereor with their partner organisations (in alphabetical order): Daughters of Charity in Mekelle, Diocese of Adigrat, Ethiopian Catholic Secretariate, Ethiopian Evangelical Church Mekane Yesus – Development and Social Service Commission (EECMY-DASSC), Ethiopian Orthodox Tewahedo Church – Development and Inter-Church Aid Commission (EOTC-DICAC), St Mary's College Wukro; with support from Tium Debessay (Don Bosco Salesians).

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CONTENTS

Abbreviations

ACT Alliance	Action by Churches Together Alliance
ANPPCAN	African Network for the Prevention and Protection Against Child Abuse and Neglect
APHI	Amhara Public Health Institute
CAFOD	Catholic Agency for Overseas Development
CBO	Community-based organisation
CBPS	Community-based Based Psychosocial Support
CBT	Cognitive Behavioural Therapy
CST	CAFOD, SCIAF, and Trócaire
CSW	Commercial sex worker
DSM	Diagnostic Statistical Manual
ECS	Ethiopia Catholic Secretariat
EDHS	Ethiopian Demographic and Health Survey
EECMY-DASSC	Ethiopian Evangelical Church Mekane Yesus-Development and Social Service Commission
EOTC-DICAC	Ethiopian Orthodox Tewahedo Church – Development and Inter-Church Aid Commission
EPA	Ethiopian Psychologists Association
EPHI	Ethiopian Public Health Institute
FELM	Finnish Evangelical Lutheran Mission
FGD	Focus Group Discussion
FMoH	Federal Ministry of Health
GBV/SGBV	(Sexual &) Gender-based violence Based Violence
HAL	Helpful Active Listening
HEKS/EPER	Hilfswerk der Evangelisch-reformierten Kirche Schweiz (Swiss Church Aid)
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Persons
IEC	Information, education, and communication
INGO	International non-governmental organisation
IOM	International Organization for Migration (IOM).
JeCCDO	Jerusalem Children and Community Development Organization
KII	Key informant interview
mhGAP	Mental Health Gap Action Programme
mhGAP-HIG	Mental Health Gap Action Plan Humanitarian Intervention Guide
mhGAP-IG	Mental Health Gap Action Plan Intervention Guide
MHPSS MSP	Mental Health and Psychosocial Support Minimum Service Package
MHPSS	Mental Health & Psychosocial Support
NCA	Norwegian Church Aid
NET	Narrative Exposure Therapy
NGO	Non-governmental organisation
N-TWG	National Technical Working Group
PFA	Psychological First Aid
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PTSD	Post-traumatic Stress Disorder
RRAD	Refugee and Returnee Affair Department
R-TWG	Regional Technical Working Group
SCIAF	Scottish Catholic International Aid Fund
SH+	Self-Help Plus
SIL	Summer Institute of Linguistics
SOP	Standardised operating procedure
ToT	Training of trainers
TPLF	Tigray People's Liberation Front
TWG	Technical Working Group
UN	United Nations
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

1 EXECUTIVE SUMMARY

This study explores the **vulnerabilities, traumatization processes, and Mental Health and Psychosocial Support (MHPSS) interventions** in the selected conflict-affected regions of **Amhara, Oromiya, and Tigray**, with a particular focus on the role of **Church-based organisations.** Using qualitative and participatory methods, the research highlights the need for scaling up MHPSS efforts, emphasizing best practices and locally-led initiatives, and culminates in recommendations for enhancing MHPSS in these regions.

Methodology

The study employed key informant interviews, focus group discussions, and extensive feedback loops with Church-based organisations. It defines key terms and concepts related to MHPSS, examines the contribution of faith-based perspectives to MHPSS activities, and discusses the connections between trauma, spirituality, faith, and traditional healing practices. The study's limitations include potential selection bias and a narrow scope due to the focus on church-based organisations and qualitative methods, which may not fully represent the regions studied or the broader context. Additionally, travel constraints due to insecurity in the Amhara and Oromiya regions limited data collection.

Key insights and strategic recommendations for upscaling MHPSS at the national level

At the national level, the study highlights the profound impact of conflicts and natural disasters on mental health in Ethiopia. **Key national actors,** including the Federal Ministry of Health, the National Mental Health and Psychosocial Support Technical Working Group, the Ethiopian Public Health Institute, Amanuel Specialized Mental Hospital, and professional associations, play crucial roles in addressing these issues. Through key informant interviews with these key actors and reflected in the existing psychological research on Ethiopia, the study identifies **vulnerable groups** such as women and girls facing severe gender-based violence, children and youth experiencing trauma, disrupted education, and limited opportunities, and ex-combatants. It also highlights **significant psychosocial challenges**, including the multidimensional nature of psychosocial stress in Ethiopia, the severe impact of displacement, stigma and discrimination surrounding mental health problems, substance abuse as a coping mechanism, and intergenerational and systemic trauma.

The study emphasises several **existing MHPSS approaches used in Ethiopia**, including the Mental Health Gap Action Programme (mhGAP) of the World Health Organisation, which expands mental health services in low-resource settings, Psychological First Aid (PFA) for immediate trauma support, and the "Self-Help Plus" (SH+) approach for stress management. Organisation-specific methods, such as the Norwegian Church Aid's integration of MHPSS with peace-building, and faith-based initiatives such as the so-called "Bible-based approach" and the traditional use of Holy Water, as well as community-based strategies like the Community-Based Psychosocial Support (CBPS) by ACT Alliance, offer valuable responses to the complexity of psychosocial problems related to conflict and emergencies.

However, the study equally found **major challenges** in the provision of MHPSS at national level. These include a general severe shortage of mental health professionals and treatment facilities, particularly in conflict-affected areas, the inconsistent use of standardized and evidence-based approaches among partners, the generally strong focus of MHPSS programmes in the Tigray region only combined with a neglect of regions such as Oromiya and Amhara; and the lack of effective integration of MHPSS services across sectors. Low public awareness, dependency on donor funding, pervasive stigma, and ongoing insecurity equally further hinder service delivery.

Key **recommendations** have been made to improve mental health and psychosocial support at the **national level**, primarily targeting donor organizations working with Church-based groups but applicable to all donors funding MHPSS-related programmes. They may be relevant for various scenarios in Ethiopia, both conflict-related and non-conflict-related, and are therefore also pertinent to the three regions under scrutiny in this research.

- **Develop a national programme for integrating psychosocial competencies into theological and spiritual formation programmes. Have a number of Church personnel who are skilled and interested in culturally appropriate psychotherapeutic training trained in order to provide MHPSS services for severely affected cases transferred to them for treatment:** Create a national initiative to integrate psychosocial skills and knowledge of core mental disorders into religious formation programmes, including specialized training for selected Church personnel to treat highly affected persons.

- **Launch an inter-religious national campaign on de-stigmatisation of mental health problems and traumatic experiences:** Coordinate an inter-religious campaign with Churches and the Muslim community to de-stigmatize mental health issues and trauma, with a particular focus on supporting survivors of sexual and gender-based violence.

- **Include Church-based organisations in the National Technical Working Group:** Ensure Church-based organisations are part of the National Technical Working Group and promote collaboration with non-Church-based organisations to share effective MHPSS practices and address mutual prejudices.

- **Mainstream self-care and staff care in Church-based Organisations:** Implement strategic self-care and team care practices in Church-based organisations to prevent burnout and conflict, emphasizing the importance of maintaining professionalism and professional boundaries.

- **Conduct a national study on the psychosocial needs of ex-combatants:** Undertake a national study on the psychosocial needs of ex-combatants to develop a gender-sensitive MHPSS approach and support peace-building efforts.

- **Form consortia for long-term MHPSS strategies integrating MHPSS with peace-building, humanitarian work, and development:** Establish donor consortia to design long-term MHPSS programmes that integrate with peace-building, humanitarian work, and development, ensuring sustained support and resource mobilisation for traumatised communities.

Key insights and strategic recommendations for upscaling MHPSS in Tigray region

The war in Tigray has caused immense **psychosocial vulnerability**. Survivors of rape particularly suffer from trauma, stigmatisation, and lack of support. Conflict-related sexual violence continues and affects victims in the long-term. As a result of disrupted education and economic pressures, youth struggle with hopelessness, depression, and substance abuse. Ex-combatants suffer from Post-traumatic Stress Disorder (PTSD), substance abuse, and lack of reintegration support. Internally Displaced Persons (IDPs) face overcrowding, insecurity, and economic struggles, which worsens their mental health. People near the Eritrean border experience severe trauma due to the military presence and lack of mental health services. The compounded trauma of war and hunger in Tigray exacerbates mental health issues. Survivors of rape and ex-combatants often have severe injuries and chronic health issues. Because of the stigmatisation of sexual violence many remain silent, which exacerbates their emotional distress. A wide variety of multiple mental health challenges exist with a lack of specialised treatment at the same time.

In Tigray, **MHPSS activities and partner best practices**, as documented in this report, centre on aiding communities and families through sports, agriculture, vocational training, and community-based psychosocial support, including the "Bible-based approach" tailored to various groups in response to trauma. Notably, some successful practices involve volunteers and survivors who, having undergone their own healing, subsequently serve as facilitators to support the recovery of others.

The following **recommendations** regarding Tigray are directed not only at donor organisations working with Church-based actors but also at all donors and international organisations involved in implementing MHPSS-related programmes. While these recommendations are particularly relevant to Tigray, given its (mostly) post-conflict setting, some of them may also be applicable to other regions, such as Oromiya, Amhara, and beyond.

- **Scale up the provision of basic services, food security, medical support, and livelihood support as part of all MHPSS activities in Tigray:** Address high humanitarian needs by providing essential

services to vulnerable groups and IDP camps, which is crucial for mental health and healing. Focus on integrating psychosocial support with basic needs to avoid dependency and promote community self-efficacy.

- **Scale up youth interventions with vocational training and MHPSS, focusing on ex-combatants:** Enhance vocational training with trauma awareness, Psychological First Aid (PFA), and support for ex-combatants, including sports activities and counselling. Create a follow-up system to support reintegration and continued mental health support.

- **Scale up the community approach of MHPSS in violence-affected communities and IDP camps:** Implement community-based approaches like the ACT Alliance Community-based Psychosocial Approach, Helpful Active Listening (HAL) used by the Daughters of Charity, and Self-help +, and promote stress management and income-generating activities. Train community members and staff in psychosocial support and establish referral pathways for specialised care.

- **Scale up and increase standards for the "Bible-based approach":** Rename and enhance the approach to be more inclusive, develop a comprehensive manual, and offer extensive training. Establish monitoring and referral systems to ensure effectiveness and sustainability.

- **Train religious actors in psychosocial methodology:** Equip religious leaders with skills in non-judgmental listening, basic counselling, and understanding psychiatric problems. Integrate faith-based interventions with modern psychological concepts.

- **Scale up intense care facilities for GBV survivors, framed in non-stigmatising ways:** Reframe facilities as inclusive health centres to reduce stigma and serve a broader range of vulnerable groups.

- **Establish trauma-informed leadership and trauma sensitivity as cross-cutting approaches:** Implement trauma-informed practices across organisations to improve service quality and create supportive environments for staff.

- **Encourage Church-based organisations to join the Regional Technical Working Group and strengthen coordination:** Engage Church-based organisations in the Regional Technical Working Group to enhance coordination, share resources, and raise awareness on culturally sensitive approaches and evidence-based practices.

- **Increase capacity for specialised services:** Train more psychologists and psychiatrists for Tigray and continue mhGAP training, especially in remote areas.

Key insights and strategic recommendations for upscaling MHPSS in Amhara and Oromiya regions

In **Amhara and Oromiya**, ongoing insecurity and displacement have resulted in **severe psychosocial stress for various groups**. Internally Displaced Persons (IDPs) endure multiple traumas due to violence, loss, and poor camp conditions. Despite the challenges of camp life, many prefer to remain in the camps rather than return to their places of origin, which lack security and basic services. Women heading households and survivors of sexual violence experience immense stress, while children and youth suffer from malnutrition, lack of education, and violence in camp settings. The compounded distress from past and ongoing violence, coupled with life stressors, creates intense suffering. Hunger and increasing violence, often exacerbated by chronic drought, add to the stress, along with the effects of collective trauma and ongoing mistrust. The rising number of suicides especially among young women highlights the widespread trauma. Access to MHPSS services is severely limited, especially in rural areas.

Key challenges related to MHPSS in Amhara and Oromiya include inadequate MHPSS coverage, the unsustainability of short-term humanitarian aid, insufficient support for children and adolescents, and a lack of community-based interventions. High stress levels among helpers and insecurity hindering the resettlement of IDPs further compound the issues. There is also a severe shortage of MHPSS coverage and income-generating opportunities, exacerbating the impact of trauma.

Effective approaches identified in the study include basic needs and security interventions, community and family support, and specialised support for vulnerable groups. The triple nexus approach, which combines humanitarian, development, and peace work, has shown promise. The Community-Based Psychosocial Approach in Amhara integrates basic needs provision and economic stability into psychosocial support, involving local leaders and volunteers. Best practices also include creating safe spaces for women and girls and employing volunteering survivors to support others.

The following **recommendations** address the specific MHPSS challenges in the **Amhara and Oromiya** regions, considering ongoing insecurity and conflict, and are directed at all donor organisations working with Church-based actors as well as other donors and international organisations implementing MHPSS-related programmes. They particularly take into consideration the need for safety and security in any trauma-sensitive intervention; 'trauma *healing*' approaches are discouraged, as the ongoing threat of armed conflict makes it impossible to initiate a healing process. Some of the recommendations may be equally relevant for other ongoing conflict scenarios in Ethiopia:

- **Strongly emphasise on Oromiya and Amhara:** Donors and international organisations should prioritise MHPSS expansion in these underserved regions.

- **Promote integrated multi-layered MHPSS interventions:** MHPSS programmes should combine income generation, social support, and livelihood activities, focusing on IDP settings and conflict-affected communities.

- **Provide spaces for youth in IDP camps:** Establish youth centres and activities to combat feelings of powerlessness and reduce destructive behaviours, addressing the issue of youth suicides.

- **Adopt the triple nexus approach:** Integrating humanitarian, development, and peace sectors with MHPSS can enhance outcomes and serve as a model for other organisations.

- **Facilitate tailored training for religious leaders and service providers:** Create a training curriculum on psychosocial skills and MHPSS knowledge for religious leaders and service providers across denominations.

- **Implement trauma-sensitive interventions in schools and training centres:** Introduce trauma-sensitive programmes, raise mental health awareness, and equip schools with trained counselling teachers, focusing on suicide prevention.

- **Expand training for health personnel in mhGap and PFA/Counselling:** Increase mhGAP and PFA training for health personnel in affected areas, deploying multidisciplinary teams for treatment and training.

- **Learn from other regions:** Organise learning visits to regions with more extensive MHPSS work, such as Tigray, to gain insights and solutions from successful projects.

- **Support self-care for service providers:** Improve self-care support and resources for emergency workers, community workers, counsellors, and GBV centre staff, including educational materials and stress management tools.

2 INTRODUCTION: BACKGROUND TO THE STUDY AND OBJECTIVES

The literal quotation in our title, 'I was buried under the ground, but now my mind is free,' was gathered during a Focus Group Discussion with survivors of sexual and gender-based violence (SGBV) in Samre Saharti, Tigray. The respondent used these words to describe her own journey of healing from one of the most debilitating forms of psychological trauma: rape.

With this survivor's quote setting the tone for our report, we present the findings of our qualitative and participatory study examining vulnerabilities, traumatisation processes, interventions, and best practices in Mental Health and Psychosocial Support (MHPSS) in the Amhara, Oromiya, and Tigray regions of Ethiopia. Our study places particular emphasis on insights gained from Church-based organisations.

Ethiopia has been characterised in many of our interviews and existing research literature as a nation experiencing ongoing and complex traumatisation, including intergenerational trauma affecting the country as a whole. Since 2020, access to basic social services has deteriorated due to natural disasters and man-made crises, which, combined with economic strains, has led to reduced public budgets for social services, capital investment, social protection, and safety nets. This has exacerbated humanitarian needs and stretched already limited resources. The education sector, for example, saw a significant drop in general enrolment, with 6.81 million children out of school due to conflict, flood, and drought as of the end of 2023.[1]

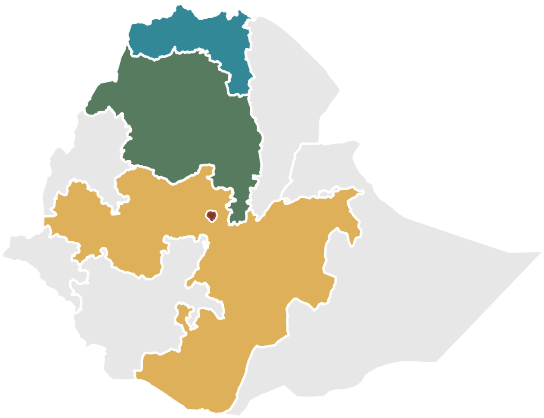
I was buried under the ground, but now my mind is free.

At the beginning of 2022, almost all regions of Ethiopia were affected by active conflict, intercommunal tensions, and violence. According to the UN OCHA report from March 2024, 4.4 million people are currently displaced across Ethiopia due to conflict and drought.[2] The conflict in northern Ethiopia has resulted in significant and urgent humanitarian needs in the regions of Tigray, Amhara, and Afar, which have so far only been partially met. Continuing armed confrontations in regions like Amhara and Oromiya continue to jeopardise lives and exacerbate humanitarian and protection demands.[3]

Global organisations have highlighted the importance of addressing the unmet mental health and psychosocial needs of individuals affected by armed conflicts, natural disasters, and other emergencies, including migrants, refugees, and internally displaced persons.[4] The Ethiopia Humanitarian Response Plan 2023 estimates that 975,081 individuals require mental health and psychosocial support, with 221,609 needing specialised mental health care for severe disorders in the Amhara, Tigray, and Afar regions. However, these regions face challenges in providing these services due to limited capacity and a shortage of essential mental health medications. No psychotropic drugs were supplied for up to two years.[5]

Church-based organisations have played a major role in providing MHPSS, both *indirectly* (i.e. through pastoral work, spiritual guidance, and special religious rituals for mental health recovery) and *directly* (through their implementation of MHPSS projects). However, a gap exists in research regarding their unique contributions and approaches, particularly in the conflict-affected regions of Amhara, Oromiya, and Tigray. To address this gap and to scale up effective interventions and best practices to meet the tremendous needs for psychosocial services, the three German-based organisations Brot für die Welt, Caritas Germany, and Misereor commissioned a participatory study with selected Church-based partner organisations implementing MHPSS-related activities in Ethiopia. These local Church partners, covering a spectrum of Orthodox, Protestant, and Catholic organisations, were actively involved in developing the study objectives, providing insights through key informant interviews, and organising focus group discussions with their beneficiaries during a field phase. Other key players at both national and regional levels were also interviewed to deepen and enrich the findings. The partner organisations offered feedback on the draft version of this report and presented, critically analysed, and further discussed their approaches at a learning and conference event in Addis Ababa in June 2024 and two additional feedback workshops in Mekelle and Wukro (Tigray), see below. This report thus contains the results of all these phases.

MAP OF ETHIOPIA SHOWING REGIONS AND PARTNER ORGANISATIONS SELECTED FOR THE STUDY



TIGRAY
- The Adigrat Diocesan Catholic Secretariat – ADCS
- St. Mary's College, Wukro
- Daughters of Charity in Bora and Mekelle

AMHARA
- EECMY-DASSC
- EOTC-DICAC

ADDIS ABABA
- Ethiopian Catholic Church Social and Development Commission

OROMIYA
- EECMY-DASSC

The insights of these selected partner organisations are therefore central to this study, while we also place the work of these organisations in the broader context of the MHPSS landscape in Ethiopia by including additional voices and perspectives from other non-governmental organisations, key informants, and institutions.

The study process aimed to document and analyse:

- Various types of **traumatisation and psychosocial stressors** in the sampled regions of Amhara, Oromiya, and Tigray that affect the local population in general and specific groups in particular.
- Existing and practised **MHPSS approaches** in Ethiopia to address the psychosocial consequences of armed conflicts, focusing on different categories of survivors and vulnerable groups, with particular attention to local initiatives and practices.
- **Specialised organisations and actors** in the field of mental health and psychosocial support, both among partner organisations and beyond.
- **Best practices, capacities, and needs of partner organisations** in terms of their competences and skills in dealing with traumatised target groups, as well as self-care in the face of their heavy workloads in various areas of the country.

The ultimate objective of the study was to derive concrete recommendations for local organisations and others regarding the potential for scaling up MHPSS activities and practices, but equally to underline the richness of local experiences and projects related to psychosocial activities.

An essential part of the whole study process was the aforementioned learning conference and workshop in Addis Ababa, where the results and recommendations were shared among various organisations and institutions to foster networking, raise awareness, and share insights about locally-led initiatives provided by Church-based organisations. Therefore, this study report doesn't only address the involved local partner organisations but also all relevant stakeholders in the fields of mental health, psychosocial support, and peace-building working in conflict-affected areas of the selected regions in Ethiopia, as well as funding organisations and the public at large.

This research report is organized into key chapters. It starts with a description of the research methodology and the study's limitations, as well as the key concepts relevant to the scope of the study. It then presents the findings of the desk study and national-level data collection, along with recommendations for national strategies, policies, and programmes. The report then shifts its focus to Tigray and looks in detail at vulnerable groups and trauma dynamics in the region, paying particular attention to the approaches and best practices of Church-based partners. The next chapter is structured similarly, covering insights and research findings from Oromiya and Amhara, regions currently experiencing ongoing conflict. It describes vulnerable groups, trauma dynamics, and the needs for Mental Health and Psychosocial Support (MHPSS) programming, as well as recommendations for scaling up. This chapter also outlines the approaches and best practices of Church-based partners in these regions. The report concludes by presenting lessons learned from the overall process of this participatory journey, which culminated in the learning conference and workshop in Addis Ababa in June 2024.

3 METHODOLOGY OF THE STUDY AND ITS LIMITATIONS

The study design adheres to a participatory and qualitative research paradigm, employing key informant interviews, participatory observations, focus group discussions with beneficiaries, and sharing rounds with multiple key informants as the primary methods of data collection. Supported by a thorough literature review of existing MHPSS-related research in Ethiopia, we aimed to obtain first-hand insights that reflect practical experiences and evidence in the field and highlight the uniqueness of various approaches.

Study Design: The participatory approach throughout all phases of the study provided several feedback loops. We discussed the initial draft version with all partner organisations online and further refined the findings and recommendations during a five-day learning conference and workshop with a larger audience in Addis Ababa. Additionally, we held two separate feedback workshops in Mekelle and Wukro. External participants at the learning conference also contributed their reflections, deepening the understanding of the findings from their perspectives and offering valuable validating feedback for the partners. The ideas generated from these discussions were incorporated into the final version of the report, which we consider to be a collaborative product of both researchers and partner organisations.

Study area and period: The study focuses on three conflict-affected regions in Ethiopia – Amhara, Oromiya, and Tigray – selected by the donor organisations commissioning the research, and incorporates insights from key actors regarding MHPSS at the national level. It specifically targets local Church-based actors from Orthodox, Protestant, and Catholic backgrounds working both nationally and within the three regions. Due to the prevailing insecurity, it was difficult to visit projects in Amhara and Oromiya; however, we were able to visit all partner organisations in Tigray in person.

The study was conducted from January to July 2024 and began with a launch event via Zoom with donors and partner organisations. It included a ten-day field phase in February 2024, a five-day learning conference and workshop in Addis Ababa, and two one-day workshops in Mekelle and Wukro in June 2024.

Data Collection, instruments and procedure: The data collection instruments for the study were developed after a comprehensive review of relevant literature (desk study) to ensure alignment with international standards for MHPSS-related studies. Based on the identified research questions, semi-structured key informant interview and focus group discussion guides were created. Informed consent, particularly from the beneficiaries – survivors of various traumatising experiences – was obtained through the partner organisations themselves that organised the focus group discussions. Field-level data was collected from beneficiaries of organisations providing MHPSS-related services, frontline community workers, mental health service providers, programme experts in the sampled regions, professional associations, and MHPSS coordinating bodies at both national and regional levels. The data was transcribed, clustered, and analysed by the researchers according to the research questions.

A total of 29 Key Informant Interviews (KIIs) and 13 Focus Group Discussions (FGDs) were conducted across various stakeholder categories.

Limitations of the Study: Certainly, opting for a qualitative research design coupled with expansive study objectives in terms of content and geographical scope, while constrained by time limitations for the field phase, inevitably introduces certain constraints that we endeavour to underscore here:

- **Selection bias, limitations in research question, scope and generalisability:** Due to our focused investigation on Church-based organisations and their activities, emphasising qualitative, contextual exploration over quantitative exhaustive

data collection, the study's findings cannot provide a fully representative view of the regions under scrutiny. It is apparent that those participants, beneficiaries in the MHPSS projects, who volunteered to take part in focus groups likely reported positively about mental health improvements, potentially omitting insights from those whose experiences differ. To mitigate this response bias, we corroborated findings across multiple focus groups and with key informants.

Moreover, our study design did not incorporate psychodiagnostic tools to assess mental health issues. Instead, drawing from international data and prior research in Ethiopia, we inferred the presence of psychosocial challenges like post-traumatic stress and depression based on discussions within beneficiary groups.

Lastly, insights into Mental Health and Psychosocial Support (MHPSS) practices may not universally apply to other conflict contexts or regions within the country. While our findings are instructive for current and future MHPSS interventions, they are not exhaustive but rather illustrative, acknowledging the potential efficacy of other approaches not covered by our partner organisations' practices.

- **Potential bias in presenting the results from the three regions due to limited reachability of Amhara and Oromiya regions:** Our original intention was to directly engage a representative sample of projects of the partner organisations and beyond across all three target regions by gathering first-hand insights through field visits. However, due to ongoing conflicts and unstable security conditions in the Amhara and Oromiya regions, it was impractical to travel and meet partners during the data collection phase. Consequently, the study team had to employ remote methods, such as telephone interviews and virtual Zoom meetings, where feasible, to connect with key informants from various organisations and government offices in these regions.

  This limitation significantly affected our ability to gather comprehensive insights from Amhara and Oromiya, resulting in the chapters on these regions being less descriptive and practical than those on Tigray, where direct interactions with beneficiaries were feasible and where most partner organisations of this study are located. We believe that valuable insights into best practices should be gathered from these under-reported regions, underscoring the importance of conducting follow-up studies when overall security conditions permit.

Partner workshop: sharing and discussing the results of the study, Addis Ababa, June 2024

4 KEY TERMS AND CONCEPTS

Throughout this study, we use technical terms and underlying concepts related to Mental Health and Psychosocial Support (MHPSS) that we consider essential for providing well-founded recommendations. We aim at outlining these underlying concepts in the following paragraph. Additionally, we want to explore the extent to which faith-based perspectives add value to MHPSS activities, including the connection between trauma and faith-based coping mechanisms.

4.1 What is MHPSS?

The composite term "mental health and psychosocial support" (MHPSS) is used internationally, based on the Inter-Agency Standing Committee (IASC) definitions, to describe any type of local or external support aimed at protecting or promoting psychosocial well-being and preventing or treating mental health conditions.[6]

According to international consensus, mental health needs and psychosocial problems encompass more than just the often-cited "Post-traumatic Stress Disorder" (PTSD). PTSD has been criticised as a Western, pathologizing, and individualised diagnosis that limits the actual range of psychosocial problems after disasters to a specific set of symptoms.[7] In reality, MHPSS covers issues such as relationship problems, emotional distress, depression and anxiety disorders, severe mental disorders (like psychosis), alcohol and substance abuse, and intellectual disabilities.

MHPSS encompasses more than just "trauma". It includes relationship problems, emotional distress, depression, anxiety disorders, severe mental disorders, alcohol/substance abuse, and intellectual disabilities. Some of these challenges may develop due to a crisis, while others are health concerns that exist in any given population, but they worsen during emergencies.

In 2007, the Inter-Agency Standing Committee (IASC) developed widely used guidelines for providing MHPSS during emergencies, based on research, evidence, and expert consensus.[8] These guidelines emphasise the importance of strengthening community-based support, implementing multi-layered interventions, mainstreaming MHPSS across various sectors, integrating it into existing structures and systems, and ensuring coordination.

The system of multi-layered interventions, typically illustrated as a pyramid with four levels of intensity, refers to the complementary levels of MHPSS approaches needed to meet the "continuum of care" requirements in emergencies. This ranges from general support for the majority of people at the most basic level to addressing the needs of those with mental, neurological, or substance use disorders or serious protection needs at the highest level, involving the fewest number of people. While mental health disorders are prevalent in every society, the likelihood of developing severe mental health disorders increases in emergencies and under traumatising conditions.

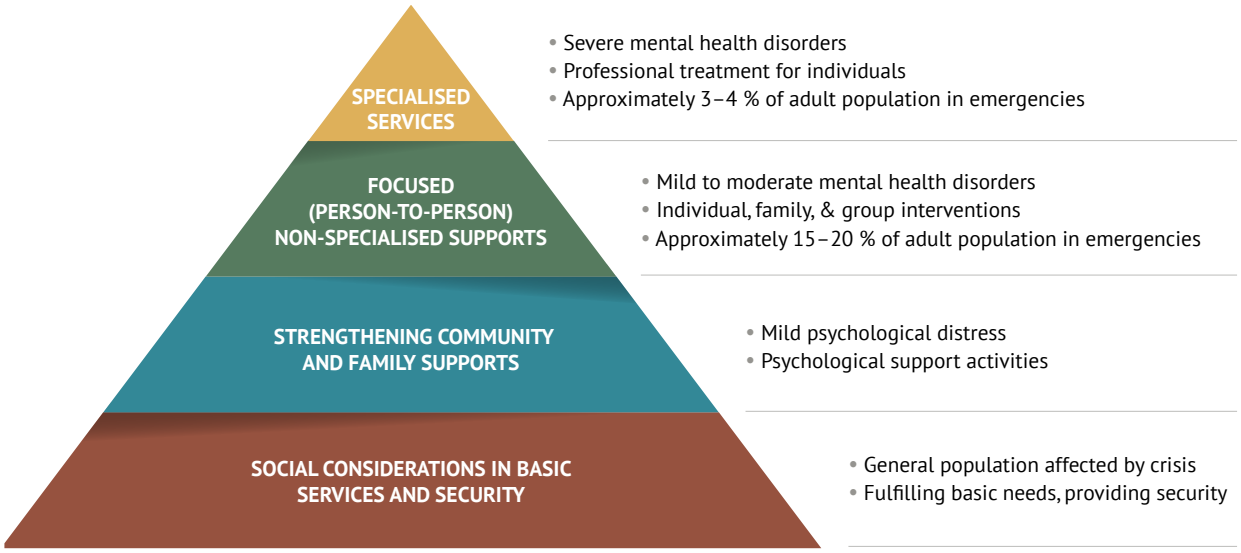
Since we use the four layers in our report to structure the documentation and analysis of interventions, we aim to present the pyramid as outlined in the IASC Guidelines (2007). This includes the WHO's projections regarding the percentages of adult populations affected by emergencies for the most intense levels at the top of the pyramid.[9]

4.2 Psychosocial responses to mass traumatisation: active and post-conflict settings and some comments on the wording "trauma healing"

MHPSS is often associated with the immediate aftermath of a catastrophe, with terms like "Psychological First Aid" or "MHPSS minimum package in emergencies" reflecting this focus. However, there is growing consensus among practitioners and the Inter-Agency Standing Committee that MHPSS needs to be conceptualised beyond immediate emergencies, as many humanitarian situations become protracted and chronic, such as long-term armed conflicts.

A panel of specialists, led by Stevan Hobfoll, who study and treat people exposed to disaster and mass violence, identified five empirically supported intervention principles that should always guide and in-

THE MHPSS INTERVENTION PYRAMID



Adapted from the original pyramid published in Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC

form intervention and prevention efforts in the early to mid-term stages. These principles that need to be addressed in MHPSS interventions are: 1) promoting a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope.[10] These principles provide a framework for understanding and designing trauma-sensitive interventions at all levels of the pyramid and help explain why certain activities, detailed below as "Best Practices", from Church-based programmes may be particularly effective.

Empirically proven intervention principles for MHPSS to guide intervention and prevention (Hobfall et al. 2007)

1. Promote a sense of safety
2. Promote calming
3. Promote a sense of self- and community efficacy
4. Promote connectedness
5. Promote hope

Generally speaking, MHPSS measures can be implemented at any stage of an emergency, though they may require different approaches depending on the phase. During a crisis, interventions often focus on restoring security through providing protection, shelter, and food. Emotional stabilisation measures are also crucial, such as enhancing existing resources for stress management and emotional regulation, establishing positive social connections within groups, and empowering individuals and communities to resolve problems. These efforts help reinforce a sense of mastery and self- and communal efficacy.

Preventative measures are particularly important *during* crises. Constant threats and survival stress can cause individuals to become nervous, hyper-vigilant, and agitated, which affects concentration and focus and can lead to increased psychological suffering. Situations of ongoing insecurity are often associated with domestic violence and substance abuse, creating further traumatising conditions. Therefore, it is not advisable to focus on "trauma healing" during an active crisis when individuals may still be exposed to further violence. All professional approaches to trauma healing require a minimum foundation of safety and security, as well as the presence of trained experts.

After a crisis, stress management and the establishment of safety remain important, while more intensive "trauma healing" methods may be considered. However, it is crucial that trauma therapy is not offered unless continuity can be ensured, and the affected individual is integrated into a relatively stable social environment. In acute displacement situations or insecure living conditions, where therapy is likely to be abruptly discontinued, therapeutic "trauma healing" should not be attempted.

Finally, we recommend using the term "trauma healing" with caution to avoid oversimplifying a complex psychological and social process that requires technical expertise, well-trained specialists, and cannot be achieved in just a few sessions. An oversimplified

concept of "trauma healing" may lead to project designs that promise unrealistic outcomes in a short time and could leave survivors vulnerable to severe distress after so-called "healing sessions" that lack professional boundaries and a safe space. Terms like "psychosocial/trauma-focused support" or "psychological stabilisation" or even more basic "trauma awareness" may be more appropriate for most project contexts.

4.3 Individual versus collective trauma

There are various ways to describe trauma and traumatisation. Generally, trauma (from the Greek word for wound) is understood as an emotional and social response to a life-threatening event, whether human-made or natural, that can manifest in a range of psychological, physical, spiritual, cultural, and social problems. In the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), trauma is defined as "Post-Traumatic Stress Disorder" (PTSD), characterised by symptoms such as intrusion, avoidance, hyper-vigilance, and persistent negative changes in thoughts and feelings following the event.

Traumatisation as a process is more complex, involving both individual vulnerabilities and socio-cultural factors that can either mitigate or exacerbate mental health outcomes. In other words, a particular experience, such as war, can have different impacts on various groups of people depending on their social or cultural contexts and the meanings they ascribe to these events.

However, trauma, as a term for the socio-emotional consequences of life-threatening events, is not solely an individual psychological condition. The term "collective trauma" underscores the social dimension of trauma, indicating that a society, group, or community can collectively experience traumatic circumstances, such as armed conflict or other emergencies. Although "collective trauma" is a contested term – as it cannot be diagnosed through "typical symptoms" and may sometimes be politically misused as a "chosen trauma" (Vamik Volkan)[11] and a narrative by one group against another – it often refers to the damage inflicted on the social fabric of a group or community.

"Inter-generational trauma" can also be considered a form of collective trauma. Families and communities that have not processed their trauma and whose challenging living conditions and psychosocial needs are unmet may be more prone to further cycles of violence. In war-affected areas, it is crucial to consider both the individual and collective dimensions of trauma by paying greater attention to the synergies between mental health and psychosocial work on the one hand, and processes of social change and family and/or communal recovery on the other.

In situations of collective trauma, individual trauma counselling has evident limitations. This is not only because collective traumatisation affects a larger number of people, but also because individuals suffer "social wounds," which are better addressed through collective (i.e., group and community-based) processes.

4.4 The connection between "religion / spirituality" and trauma and its significance for faith-related MHPSS

Since our study addresses the role of faith and Churches in MHPSS interventions, we aim to highlight some important connections between faith, religion, and spirituality on the one hand, and trauma (in its broader sense of psychosocial suffering following experiences of violence) on the other.

In emergencies, faith and spirituality can impact well-being positively or negatively. Spirituality can provide coping resources, consolation, and safety, while forgiveness aids healing. However, trauma can decrease religious beliefs, worsening stress and mental health. Negative religious coping involves feeling abandoned or punished by God.

By definition, traumatic experiences challenge people's spirituality and religious beliefs. Trauma is not just about violence and its emotional impact; it also involves the struggle to recreate meaning in life. In the aftermath of an emergency, especially after a war, faith and spirituality can significantly influence psychosocial well-being. Research suggests that the connection between faith/spirituality and trauma can be both positive and negative.[12] Spirituality can be a powerful coping resource when a positive relationship with one's beliefs and practices buffers the destructive effects of trauma and provides consolation and safety. For some believers,

forgiveness (of self or others) is particularly crucial for processing traumatic wounds through faith, while others may find solace and protection through prayer or support from their faith community.

However, some studies indicate that traumatic events can lead to a decrease in religious beliefs, especially for those struggling to understand how a benevolent and all-powerful God could allow such horrors. This "negative religious coping" or "spiritual strain" can exacerbate post-traumatic stress and lead to negative mental health outcomes. This effect can be particularly strong when believers feel "abandoned" or "punished" by God or when their faith is challenged while they are already questioning the meaning of their lives. When religious meaning is challenged, people may either give up their faith temporarily or permanently ('There is no God') or construct a sense of meaning involving punishment ('I must have deserved this, so I am a bad person'). Changes in faith can be especially profound if traumatic experiences occur during stages of psycho-spiritual development, such as adolescence and early adulthood.

Another important aspect of the relationship between faith, religion, and trauma is the already mentioned concept of forgiveness, which is central to religious coping in many faith communities and holds a positive meaning for many. After experiencing violence inflicted by another person or group, however, survivors belonging to faith communities, may feel pressured to forgive, either by others or internally. If they feel unable to forgive, this can lead to withdrawal, social isolation (particularly from their faith community) and decreased self-esteem, making them feel as though they are failing before God.

International organisations and humanitarian standards increasingly emphasise the importance of integrating faith-sensitivity alongside cultural sensitivity in their work.[13] Benefits of this integration include leveraging faith-based groups' long-term presence at the grassroots level, reinforcing social values in communities, and enhancing programme effectiveness. However, there are also important concerns about the role of faith-based groups and faith-related convictions in humanitarian programmes and MHPSS activities. Not all faith-based groups have an inclusive approach, and differences in religious beliefs or spiritual interpretations can drive conflict. It's also unacceptable for faith actors to try to convert people or impose conditions for assistance that violate human rights principles such as non-exclusivity and equality. In MHPSS, there is a risk of interpreting mental illness spiritually, where mental illness may be seen as a sign of spiritual punishment or curse. This can lead to untreated mental health needs and stigmatisation and abuse within communities (e.g., chaining individuals or withholding medication). Gender inequality and disregard for women's rights are particularly contentious issues. In some contexts, ethnic and minority groups, including sexual minorities, people living with HIV, sex workers, and drug users, may also face conflict with certain religious beliefs. Given the widespread use of gender-based violence and rape as strategic weapons of war, the way faith-based organisations interpret women's roles within their traditions – and their support for women's emotional and social empowerment after trauma or their demand to be silent – can significantly impact the mental health of women and girls, if their experience labels them "impure" or "spiritually less worthy".

5 FINDINGS OF THE STUDY: INSIGHTS GAINED AT THE NATIONAL LEVEL

This section presents the key findings of our study at the national level, drawing from an extensive review of psychological literature on Ethiopia and insights from key national actors gathered through interviews and focus group discussions. It also provides an overview of the current state of MHPSS services in the country, highlighting critical psychosocial issues and emerging needs that guide our recommendations for scaling up MHPSS interventions at the national level.

5.1 A brief introduction to the complexity of traumatisation processes in Ethiopia

In most humanitarian and MHPSS-related documents concerning Ethiopia, both natural disasters like unprecedented droughts and other climatic shocks, as well as human-made disasters from complex conflicts, are cited as major sources of stress and traumatic suffering for the population.

The conflict scenarios in the three regions under study are interconnected, and rooted in a complex historical dynamic that is influenced by political, economic, and social factors. Conflicts in Ethiopia include national-level conflicts, such as those in the three regions sampled for the study, as well as local intercommunal conflicts, for example, between the Oromo and Somali, or the Gedeo and Guji communities. These local conflicts often arise from disputes over land and resources.

The analysis of conflicts in Ethiopia is contested, and narratives significantly differ, making the historical complexity beyond the scope of this study. What is not contested is the fact that they have led to severe human suffering in various forms, including mass killings, human rights abuses, widespread sexual and gender-based violence, internal displacement, and a catastrophic impact on human welfare and socio-economic conditions including the total breakdown of critical infrastructure regarding health and education.

Conflict-related displacement is prevalent in northern Ethiopia and regions such as Amhara, Oromiya, Somali, Afar, Benishangul Gumuz, and Gambela. Insecurity, particularly in western Oromiya, Amhara, and border areas of the Somali and Tigray regions, heightens protection risks, hinders humanitarian operations, and disrupts markets.[14] According to the Humanitarian Needs Snapshot of February 2024, access in areas affected by hostilities remains challenging. In Amhara, ongoing clashes create difficulties for humanitarian organisations, with 93 incidents impacting aid workers in 2023, including kidnapping, robbery, and violence.[15]

Amhara, Tigray, and parts of Oromiya, Somali, and Southern regions are suffering from below-average Kiremt rains (June-August), leading to poor or failed harvests at a time when general food assistance was paused. This has triggered an alarming increase in food insecurity and malnutrition, especially affecting those already impacted by the northern Ethiopia conflict (2020-2022). An estimated 6.9 million people in drought-affected woredas need humanitarian assistance in 2024.[16]

Armed conflicts across different parts of Ethiopia as well as drought have significantly increased mental health problems such as anxiety, depression, and post-traumatic stress disorder (PTSD) among the affected populations, as recent meta-analyses suggest.[17] Against this backdrop, we present those key actors in MHPSS on national levels who are addressing and responding to these needs; we explore identified vulnerabilities and the existing MHPSS approaches that can address this complex suffering effectively.

5.2 National level key actors in MHPSS

Several key institutions and organisations play pivotal roles in MHPSS interventions at the national level in Ethiopia. These entities serve as coordinators, capacity builders, and monitoring bodies, providing technical advice to government ministries and non-governmental organisations. Some of them offer specialised services at the highest level

of the MHPSS pyramid. Due to time constraints, the data collection focused on the following core institutions and organisations: the Federal Ministry of Health, including Ethiopia's National Mental Health and Psychosocial Support Technical Working Group and the Ethiopian Public Health Institute, Amanuel Specialized Mental Health Hospital, as well as two professional associations, the Ethiopian Psychologists Association and the Ethiopian Psychiatrists Association.

The Federal Ministry of Health (FMoH)

The Ethiopian national mental health strategy demonstrates the Federal Ministry of Health's dedication to providing accessible, effective, sustainable, and affordable mental health services.[18] While it doesn't explicitly address MHPSS needs in emergencies, it emphasises that it is developing services for survivors of violence and abuse. The strategy also prioritises integrating specialised health services, including mental health care into Primary Health Care (PHC), thus adhering to the World Health Organization's fundamental recommendations.

To standardise services, the ministry collaborates with humanitarian and emergency response stakeholders to establish a minimum package of services. They provide capacity building on the mental health gap action programme (mhGAP) Humanitarian Intervention Guide (mhGAP-HIG), the mhGAP Intervention Guide (mhGAP-IG), Gender-based Violence and Sexual and Reproductive Health case management, child case management, and community-based MHPSS.

The Federal Ministry of Health of Ethiopia is committed to providing accessible, effective, sustainable, and affordable mental health services, integrating specialised care into Primary Health Care (PHC) as per WHO recommendations, coordinating with humanitarian stakeholders to standardise services, and addressing the mental health needs of violence survivors and those affected by emergencies and crises.

Within the ministry, the Mental Health Program coordinates MHPSS interventions during humanitarian and emergency situations. Key stakeholders include the Ethiopian Public Health Institute, the Ethiopian National MHPSS Technical Working Group, the Ministry of Women and Social Affairs, and other agencies like WHO, UNHCR, and UNICEF. In 2019 the FMoH and its partners established the Ethiopia Mental Health and Psychosocial Support Technical Working Group in recognition of the mental health challenges arising from conflicts and crises. This coordinating body operates within the Ethiopian Public Health Institute (EPHI) and reports to the Federal Minister of Health (see below).

Ethiopia's National Mental Health and Psychosocial Support Technical Working Group

To enhance governance and leadership by the Ministry of Health, one national and several regional MHPSS Technical Working Groups (TWGs) have been established. The national TWG has strengthened the collaboration between the Ethiopian Public Health Institute and the Ministry of Health's Mental Health Program. This group plays a crucial role in bringing partners together to strategise and synchronise the provision of mental health and psychosocial support services in emergency settings, including conducting service mapping exercises.

The national and regional MHPSS Technical Working Groups (TWGs) enhance governance and leadership by coordinating and synchronising mental health and psychosocial support services in emergencies, ensuring a unified and high-quality response.

The TWG meets regularly – quarterly in person and monthly virtually – to discuss MHPSS-related situations, challenges, and opportunities in the country, and to plan and monitor the MHPSS response. Membership is open to government institutions, academic institutions, associations, religious and cultural groups, individuals, donors, NGOs, INGOs, and UN agencies that have technical expertise in MHPSS and are involved in delivering services.

The national TWG works with partners from various sectors to ensure a unified and high-quality MHPSS response during emergencies, adhering to the minimum service package (MSP) guidelines. Their collaboration with EPHI includes providing supportive supervision and mentorship for mental health and psychosocial support providers in emergency settings.

The Ethiopian Public Health Institute (EPHI) trains MHPSS professionals and local actors in essential topics like Psychological First Aid and stress management, while the Technical Working Group helps organise EPHI-led MHPSS mobile teams to provide services across various regions.

Ethiopian Public Health Institute

The Ethiopian Public Health Institute conducts training for MHPSS professionals, including psychologists, psychiatrists, nurses, and social workers involved in service delivery. Additionally, EPHI offers community-based MHPSS training programmes to build the capacity of local actors. These training sessions cover essential topics like basic MHPSS, Psychological First Aid, emotional resilience, and stress management.

The TWG also helps organise MHPSS mobile teams deployed by EPHI and other agencies to regions such as Oromiya (East Wollega, North Showa, and Bale), Amhara (including Debre Birhan IDP centers), Afar, and Somali. These teams, composed of psychologists, psychiatrists, and social workers, provide a range of services from basic support to comprehensive mental health care.

Amanuel Specialized Mental Hospital

Since its foundation in 1938, Amanuel Hospital has been the only public specialised mental health hospital in Ethiopia. The hospital, which is accountable to the Federal Ministry of Health, provides a variety of treatments, including psychological, pharmacological, and social interventions such as psychosocial support, family counselling, community outreach, and vocational training. It also offers extensive training programmes for health professionals, including psychiatrists, psychiatric nurses, clinical psychologists, social workers, and counsellors. The hospital has participated in numerous research projects and collaborations with both national and international partners.

Amanuel Hospital has been Ethiopia's only public specialised mental health hospital. It offers comprehensive treatments, training, and research, while also providing specialised care for trauma survivors and deploying mental health teams to conflict areas.

For trauma survivors transferred from war-torn regions, Amanuel Hospital provides medical services, physical rehabilitation, and psychological services such as cognitive-behavioral therapy and narrative exposure therapy. Specialised approaches for survivors of sexual and gender-based violence are also offered, alongside psychiatric services for conditions like depression, anxiety disorders, post-traumatic stress disorder, and other mental disorders. Social services include family reunification and referrals to other agencies.

In partnership with the Ministry of Health/EPHI, Amanuel Hospital deploys teams of mental health professionals to conflict-affected areas such as Gedeo and Gujji Zones in Oromiya, as well as other regions. In collaboration with the Ethiopian Psychologists Association, they conduct mental health interventions in the Amhara region, including assessments and trainings. The hospital also provides training for NGO staff, including health care workers, social workers, and counsellors, to enhance the quality of mental health and psychosocial support services for those in need.

Amanuel Hospital has introduced a "one-window service model" led by the Women and Children Directorate. This model aims to deliver comprehensive and integrated care for mental health patients, focusing on vulnerable women and children. By consolidating all essential services in one location, the model reduces the need for clients to navigate between departments or facilities, thus decreasing waiting times and improving coordination among service providers. The range of services offered under this model includes medical and psychiatric care (diagnosis, treatment, and follow-up of mental disorders), psychological services (individual and group counselling, and psychotherapy), and social support. Social support encompasses family reunification, legal aid, protection, referrals to other agencies, and assistance with financial and material needs such as food, clothing, hygiene items, and cash transfers.

Professional associations

For this study, we selected two specific national associations, namely the Ethiopian Psychologists Association and the Ethiopian Psychiatrists Association.

The Ethiopian Psychologists Association (EPA)

According to our key informant, the Ethiopian Psychologists Association (EPA) primarily focuses on professionals delivering mental health and psychosocial services on the frontlines. Exposure to severe human suffering, horrific violence, and gender-based violence significantly impacts these professionals

and frontline workers. The EPA views itself as a "trailblazer" in prioritising and actively supporting the well-being of MHPSS service providers. They typically conduct mental health needs assessments for professionals and first responders to thoroughly understand the extent of traumatisation and the support they need. In collaboration with international funding NGOs, they use a rapid deployment model to establish a multidisciplinary team of supervisors, including 2 psychiatrists, 2 psychologists, and 2 social workers. This team delivers capacity-building training to professionals from the Afar, Amhara, Oromiya, and Benishangul Gumuz regions, and strengthens the staff of Primary Health Care Units (PHCUs) in selected woredas to provide effective care to survivors of SGBV. They particularly focus on self- and staff-care, along with supervision, mentorship, and psychosocial support for staff members from One-Stop Centres or PHCUs. Another key aspect of their programme is enhancing emotional resilience and well-being to improve stress management for MHPSS professionals and public health emergency workers.

The Ethiopian Psychologists Association prioritises the well-being of mental health and psychosocial service providers by assessing their needs, delivering training and support, and enhancing their emotional resilience and capacity to manage stress, especially in regions affected by severe human suffering and violence.

The Ethiopian Psychiatrists Association

The Ethiopian Psychiatric Association is dedicated to enhancing the quality and accessibility of mental health services in Ethiopia, provides a platform for knowledge exchange, supports the development of national health strategies, offers continuing education for professionals, and advocates for its members' rights.

The Ethiopian Psychiatric Association consists of Ethiopian psychiatrists committed to improving the quality and availability of mental health services in the country while advocating for their members' rights. It provides a platform for exchanging knowledge among its members and other mental health professionals. The association holds a position on the national mental health task force within the Federal Ministry of Health and offers technical support in developing national mental health policies and strategies. Additionally, it provides continuous medical education to psychiatrists and other health care professionals.

As part of the National Technical Working Group, the association trains professionals in health institutions, with a focus on emergency trauma skills for psychiatric nurses. It played a key role in developing guidelines for addressing mental health issues and training on mhGAP. According to a key informant from the association, there are four institutions in Ethiopia that train psychiatrists. However, this training typically only covers classical psychiatry, with psychotherapy or trauma-focused psychotherapy training only taking place if the psychiatrists organise it themselves.

5.3 Findings regarding psychosocial problems and vulnerabilities at national level

The following is a synthesis of recent research on mental health and psychosocial concerns in Ethiopia, with a particular focus on conflict, and findings from the qualitative data collected. Key informants at the national level, including the aforementioned actors in MHPSS and the Ethiopian Catholic Secretariat, provided insights into specific psychosocial vulnerabilities and selected salient psychosocial problems from a national perspective.

5.3.1 Particular psychosocial vulnerabilities

Women and girls: exposed to a high level of conflict-related, structural gender-based violence and ongoing lack of safety

Women and girls have traditionally been among the most vulnerable groups concerning mental health and psychosocial support (MHPSS), and conflict-related gender-based violence is a pressing concern across regions in Ethiopia affected by conflict, drought, and floods.[19] Being female is a significant risk factor for developing Post-Traumatic Stress Disorder (PTSD) and other psychological problems following armed conflict, as numerous studies from various locations in Ethiopia have shown.[20] In correlation with conflict dynamics, as well as its social and economic consequences, child marriage numbers have also doubled in the country's four hardest-hit regions.[21] More broadly, violence against women, girls, and boys must be recognised as a major social and public health issue in Ethiopia, as well as in many other places around the globe. According to the 2019 Ethiopian Demographic and Health Survey (EDHS), 23% of women aged 15-49 have experienced physical violence, and 10% have encountered sexual

violence, with 7% reporting sexual violence in the past 12 months.[22] Our key informant from the Ethiopian Psychiatric Association at St Paul's trauma clinic noted a high volume of gender-based violence (GBV) cases, including cases of survivors of rape from conflict zones, but also a considerable level of cases of non-conflict-related childhood sexual abuse. Among the ever-married women in Ethiopia, 35% reported to have experienced physical, emotional, or sexual violence from an intimate partner, underlining the prevalence of GBV in intimate relationships.[23]

Children and youth

Children were identified as particularly vulnerable to the effects of trauma. According to various key informants at the national level, they often witness or experience violence, face severe disruptions to their education, and suffer the loss of loved ones in ongoing conflicts. Youth were also highlighted as a highly vulnerable group, with research indicating their susceptibility to developing PTSD and other psychosocial problems.[24] Lacking educational and economic opportunities, especially in conflict-affected areas, many young people attempt to leave Ethiopia, exposing themselves to significant risks of abuse and exploitation on their journey to Europe.

Ex-combatants

Key informants from the mental health profession at the national level have identified ex-combatants as a particularly vulnerable group with significant mental health needs. Some of the most severely affected ex-combatants from Tigray and Amhara are referred to hospitals in the capital, such as Amanuel Hospital or St Paul's Trauma Clinic, for treatment. Combat trauma is expected to become increasingly relevant as other conflict regions undergo demobilisation, and a national MHPSS response will be crucial for contributing to sustainable peace.

5.3.2 A selection of identified salient psychosocial issues

The multi-dimensionality of psychosocial stress in Ethiopia

Key informants, such as those from EPHI, but also from the Ethiopian Catholic Secretariate, highlighted the simultaneous existence of multiple crises. In many regions, drought-induced suffering, leading to crop failure, food shortages, famine, and related psychosocial problems, plays a significant role alongside widespread violent conflicts involving massive violence, killings, sexualised violence, looting, and infrastructure destruction. As statistical analysis shows, women and girls disproportionately suffer from these concurrent crises.[25]

Massive displacement

One major stressor crucial for understanding MHPSS-related needs in Ethiopia is the massive internal displacement. Numerous reviews and studies worldwide have identified displacement and refugee status as major debilitating factors[26], and this holds true for Ethiopia as well. In a study on displacement in Southern Ethiopia, 625 participants were interviewed, revealing an estimated PTSD prevalence of almost 60%, with female gender, depression, and multiple displacements being significant risk factors for developing PTSD.[27] A similar study in Debre Berhan (Amhara) showed PTSD present in almost 68% of respondents.[28] The debilitating effect of displacement on mental health in Ethiopia has been confirmed in all our key informant interviews at the national level. IDPs have been identified as a major risk group with various intersecting vulnerabilities, such as female gender, old age, disabilities, and pre-existing mental health challenges.

Silence about and discrimination against mental health problems and trauma

Various key informants, particularly mental health professionals, highlighted prevalent socio-cultural beliefs in Ethiopia that view mental health problems as a sign of weakness, a perception common in many parts of the world. In Ethiopia, mental health issues are often seen as a curse from God, and seeking help from professionals, especially psychologists, for conditions like depression or anxiety is socially stigmatised. This stigma forces people into silence, caused both by their families and communities, and by their own reluctance to share their suffering. This silence leads to dysfunctional coping mechanisms with highly destructive effects. Not only does this increase the risk of developing post-traumatic problems due to the absence of social support[29] but it also affects the next generation, who suffer from the emotional distance created by their parents' unspoken traumatic experiences.

Substance abuse and addiction

Addictions were identified in key informant interviews as a major mental health concern in Ethiopia, particularly but not exclusively for youth. Many peo-

ple suffer from addictions related to trauma, with international research indicating that substance abuse is highly co-morbid with traumatic stress.[30] Studies suggest that traumatic stress can lead to substance abuse as a way to buffer fear, constant hyperarousal, and sleeplessness. Conversely, substance abuse increases the likelihood of experiencing trauma, as individuals who consume substances are more likely to engage in harmful behaviours and cause harm to others. Domestic abuse is often linked to substance abuse, as indicated in Ethiopian studies.[31] A key informant from the trauma clinic of St Paul therefore emphasised the need for trauma-focused approaches when addressing substance abuse.

Moreover, substance abuse is a widespread problem in Ethiopia beyond conflict-ridden areas and probably largely connected with a sense of lack of economic prospects. Various studies have found that the prevalence of substance use among Ethiopian high school students ranges from 34% to over 50%, with khat, tobacco, and alcohol being the main substances used.[32]

Inter-generational wounds and systemic traumatisation

Key informants such as from the Ethiopian Catholic Secretariate emphasised that Ethiopia has experienced cycles of violence throughout its history, creating a legacy of trauma that is passed from one generation to the next. Historical grievances and inter-communal conflicts have exacerbated vulnerabilities, with current conflicts reopening old wounds. This cycle of trauma extends into the future: informants, particularly from Tigray but potentially relevant to other conflict-affected areas too, highlighted the impact of ongoing wars on the next generation. Traumatised parents may struggle to provide their children with a sense of safety and hope. The current effects of hunger on children's physical and mental development further compound this sense of embodied hopelessness and threat. Although few studies have examined the systemic dynamics of sexual violence and rape on families, and no systematic research has been conducted on Ethiopian rape survivors, anecdotal evidence suggests a high incidence of family breakdowns, leaving children neglected throughout their childhood.[33]

5.4 MHPSS approaches and best practices: findings from the national level

In our national-level key informant interviews, we identified several frequently cited approaches to mental health and psychosocial support (MHPSS) that we want to highlight here. While this list is not exhaustive (and more approaches were mentioned particularly related to approaches manualised by the World Health Organization), it includes the main categories of approaches that are often mentioned or recommended.

Firstly, there are evidence-based psychosocial approaches closely linked to **health capacity** building and supported by organisations such as the World Health Organization (WHO), UNFPA, and UNHCR. Training initiatives in Ethiopia, especially in conflict-affected regions, primarily focus on mhGAP to expand psychiatric services, Psychological First Aid (PFA), Self-help Plus, and the Minimum Service Package for MHPSS. These tools have been extensively researched, validated in various contexts, and endorsed by the WHO. Some of them have already been partially translated into local Ethiopian languages.

Secondly, we highlight organisation-specific approaches relevant to the scope of this study, such as the connection between peace-building and MHPSS, as exemplified by Norwegian Church Aid's approach. Other notable examples include faith-based and community-based initiatives like the "Bible-Based Approach" and the "Community-Based Psychosocial Support" (CBPS) strategy developed by the ACT Alliance, a coalition of Church-based organisations. While these latter approaches have not undergone the same level of rigorous empirical scrutiny as the former, they have shown positive impacts in various regions and are closely monitored.

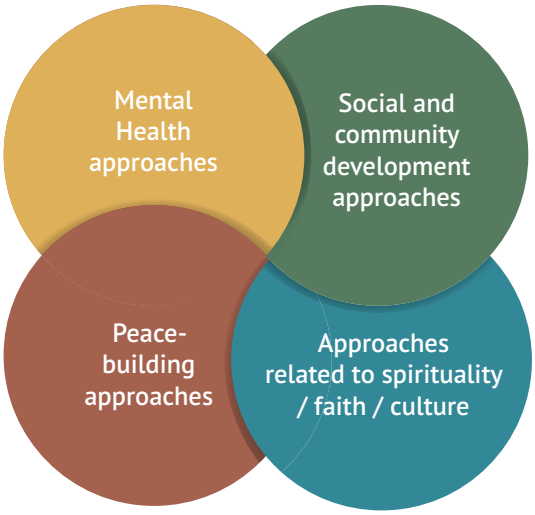
Finally, we emphasise a culture-based approach in Ethiopia, specifically the Holy Water rituals.

5.4.1 MHPSS approaches as recommended by the World Health Organisation (WHO)

mhGAP

Mental, neurological, and substance use disorders exist in all countries all over the world with or without armed conflict. While 14% of the global burden of disease can be attributed to these disorders according to the estimates provided by WHO, most of the people affected – namely 75% in

The WHO Mental Health Gap Action Programme (mhGAP) seeks to expand services for mental, neurological, and substance use disorders in low- and middle-income countries such as for depression, schizophrenia, and epilepsy, to reduce suicide risks, and enable the people to lead fulfilling lives, even in resource-limited settings.



many low-income countries – do not have access to the treatment they need. Therefore, the WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for these disorders for low- and middle-income countries. The core idea is that with proper care, psychosocial assistance, and medication, tens of millions can be successfully treated for depression, schizophrenia, and epilepsy, and prevented from suicide, while being capacitated to lead normal lives – even when mental health resources are scarce.[34] mhGAP training covers the main different psychological disorders by providing input on the general principles of recognising and treating them. Trainees are usually (medical) staff who are not specialised in mental health or neurology, such as general physicians, family physicians, nurses, first points of contact, and outpatient care, staff of first level referral centres, and community health workers.

Psychological First Aid

Psychological First Aid (PFA) is the currently most often used low-threshold training approach around the globe and an evidence-informed approach laid out in modules to help children, adolescents, adults, and families in the immediate aftermath of emergencies. It is designed to reduce the initial distress caused by traumatic events and to foster coping. PFA is based on the idea that not all survivors of traumatising events will develop severe mental health problems or long-term difficulties in recovery, but that people can recover more easily when helped through supportive communication from compassionate and caring helpers providing early assistance through PFA. The core skills of PFA "Look – Listen – Link" are designed to address the survivors' as well as responders' psychosocial needs.

Psychological First Aid (PFA) is a research-based method grounded in the principles of human resilience. Its goal is to alleviate stress symptoms and support a healthy recovery after experiencing a traumatic event, natural disaster, public health emergency, or personal crisis.

Self-help Plus

Self-Help Plus (SH+) is a multi-media guided 5-session stress management course developed by the WHO for large groups of up to 30 people. It is delivered by supervised, non-specialist facilitators who complete a short training course and use pre-recorded audio and an illustrated guide called "Doing What Matters in Times of Stress"[35] to teach different evidence-based stress management skills. The course is for adults who experience stress, wherever they live and whatever their stressful circumstances are, thus including ongoing conflict scenarios. SH+ has proven to reduce psychological distress and prevent the onset of mental disorders. According to the WHO, research already supports the use of guided self-help approaches for reducing psychological distress, while showing that SH+ is not

Self-Help Plus (SH+) is a five-session stress management course developed by the WHO for large groups, delivered by trained non-specialists using pre-recorded audio and a guide, which has been proven to reduce psychological distress and prevent mental disorders, even in ongoing conflict scenarios.

only effective in reducing stress, but that it can also prevent the onset of mental disorders.

The Mental Health and Psychosocial Minimum Service Package

The Mental Health and Psychosocial Support Minimum Service Package (MHPSS MSP), published in 2022, is an inter-sectoral package that outlines a set of activities of high priority in meeting the diverse needs of emergency-affected populations.[36] It was developed by the IASC MHPSS Reference Group and is based on existing guidelines, available evidence, and expert consensus. Each activity of the different humanitarian sectors comes with checklists of core and additional actions. It is meant for humanitarian actors who plan, support, coordinate, implement, and evaluate humanitarian activities within and across sectors.

The IASC Minimum Service Package for Mental Health and Psychosocial Support (MHPSS) outlines a straightforward, cross-sectoral framework detailing the essential activities and measures that humanitarian organisations should implement in all emergencies to ensure a robust MHPSS response.

5.4.2 Examples for other approaches linking MHPSS with peace-building, faith, and community development

Integrating MHPSS into peace-building: Norwegian Church Aid's Initiative

The connection between MHPSS and peace-building has been elaborated and technically outlined in recent international documents.[37] In 2020, the UN Secretary-General emphasised the need to strengthen the integration of MHPSS and peace-building, highlighting the significant role of MHPSS in achieving and sustaining peace. A recent paper published in January 2024 by the IASC MHPSS Reference Group, titled *IASC Guidance: Integrating MHPSS and Peacebuilding: A Mapping and Recommendations for Practitioners* calls for a bi-directional integration of MHPSS and peace-building.[38] The findings indicate that MHPSS and peace-building are inherently complementary and synergistic. Integrating these efforts can enhance positive outcomes and limit negative, unintended consequences for well-being, resilience, social cohesion, and peace. This integration should occur in all phases of a conflict and can guide the implementation of prevention, response, and recovery mechanisms. Reports also underline that if peace-building is implemented without attention to MHPSS-related issues, survivors suffering from emotional wounds and a deep sense of insecurity may not be ready or willing to engage in peace activities. Conversely, if MHPSS activities are planned without consideration for peace and social cohesion, people's well-being will be severely impacted by ongoing insecurity. Therefore, the mutual integration of both MHPSS and peace-building can help reduce "Do No Harm" issues in both fields of intervention.

In line with this, the Norwegian Church Aid (NCA) in Ethiopia is currently implementing peace-building initiatives that incorporate elements of mental health and psychosocial support. NCA is working in the Amhara, Tigray, and Oromiya regions, where they recognised the significant MHPSS and livelihood support needs of groups affected by conflict. To this end, NCA has developed a Training of Trainers (ToT) manual to strategically incorporate MHPSS into peace-building and social cohesion initiatives. NCA has engaged national and regional peace-building actors in the development process and has conducted a local context analysis to understand specific local concepts related to peace and MHPSS needs. NCA is actively collaborating with various national and regional stakeholders in Ethiopia and is involved in the Women, Peace and Security Task Force, coordinated by UN Women. Additionally, they seek to engage with key institutions such as the Ministry of Peace and the National Dialogue Commission to foster broader collaboration. NCA particularly recognises the critical role of women in peace-building, therefore calling for prioritising their MHPSS and livelihood needs.

In line with recent international guidelines that emphasize the critical and mutually reinforcing relationship between mental health and psychosocial support (MHPSS) and peace-building, the Norwegian Church Aid in Ethiopia is integrating MHPSS into its peace-building initiatives.

The"Bible-based approach in trauma healing" developed by SIL Ethiopia and implemented by a number of Catholic partner organisations

Given the prominent role of the "Bible-based approach to trauma healing" among Catholic Church partners in Ethiopia, particularly in Tigray, we aim to analyse this approach in more depth. Introduced in 2021 by the Summer Institute for Linguistics (SIL) Ethiopia, a non-profit organisation dedicated to sustainable language development, the programme began with participants from various Church-based organisations across different denominations, focusing on Tigray and Amhara. Many of these participants now serve as trainers within Catholic organisations such as the Ethiopian Catholic Secretariat, the Daughters of Charity, and the Don Bosco Salesians. The programme is based on the manual "Healing the Wounds of Trauma: How the Church Can Help. Stories from Africa," published by the American Trauma Healing Institute in 2020. Its goal is to help people recover from trauma and loss by guiding local Churches to respond helpfully rather than harmfully. Each lesson combines biblical teachings with mental health best practices to aid trauma recovery.

The "Bible-based approach to trauma healing," developed by SIL Ethiopia and implemented by various Catholic partner organisations, integrates psychological practices with biblical teachings to aid trauma recovery. This approach is particularly relevant in the Ethiopian context, where religious leaders play a crucial role in supporting those affected by trauma through small group sessions that address topics such as grief, trauma, and abuse.

The facilitator guide includes six core lessons covering topics like suffering and faith, psychological trauma signs, effective communication, grief, connecting pain with the cross, and forgiveness. Additionally, there are 10 optional lessons addressing moral injury, children's trauma, rape and sexual assault, HIV/AIDS, domestic abuse, and suicide. The guide also provides detailed instructions on leading healing groups, including necessary preconditions.

The term "Bible-based approach to trauma healing," used by practitioners in Ethiopia, does not fully capture the methodology's theory of change. The healing process outlined in the manual is not "based" on the Bible. Instead, it integrates psychological approaches and trauma-sensitive attitudes that are supported by biblical teachings. These attitudes, such as feeling safe, being listened to, understood, and accepted without judgment, are reinforced by relevant Bible verses, particularly those depicting Jesus as a healer who broke social norms of discrimination.

This approach normalises traumatic experiences, such as rape, as part of the human condition, thereby destigmatising them. The most significant healing value lies in aligning psychological support with biblical narratives, making it particularly valuable for the Ethiopian context where people may feel abandoned or punished by God during traumatic events. This alignment helps counter interpretations of trauma as a curse and encourages viewing suffering through a faith-based lens where God's presence, exemplified by Jesus, is a source of comfort.

Given the influential role of religious leaders in Ethiopian society, this approach can significantly alleviate the suffering of believers who may never seek professional counselling but suffer from unresolved trauma. It positions trauma within a broader societal and communal context, acknowledging its existence and the psychological dynamics it creates. It also counteracts harmful teachings on gender inequality by explicitly condemning child abuse and intimate partner violence.

This approach has several unique characteristics: it integrates mental health practices with biblical wisdom, uses simple language and clear messages, operates in small groups led by trained facilitators who do not need to be professional counsellors, and employs a participatory format with case studies and Bible texts. Moreover, it is adaptable to different cultures and languages, as demonstrated by its use in non-faith and mixed-faith environments and the availability of a Muslim manual.

Community-based approaches with particular focus on the Community-based Psychosocial Approach of the ACT Alliance

Many key informants at the most specialised level 4 (see the pyramid model), and existing research emphasise the importance of community-based approaches to MHPSS in Ethiopia, despite severe gaps in psychotherapeutic and psychiatric services. These approaches stress that communities can drive their own care and change, and should be actively involved in all stages of MHPSS responses. For instance, EPHI utilises existing community structures such as committees, self-help groups, religious leaders, elders, and other community actors to implement MHPSS interventions. They believe community

engagement is crucial for building trust, ownership, and addressing cultural and contextual factors affecting mental health and well-being.

Community resources for mental health care, especially in rural areas, are vital in Ethiopia. Research indicates that traditional healers, Churches, mosques, religious groups, *eddir* groups (traditional funeral associations), social associations, micro-finance institutions, and community volunteers play major roles.[39] Re-initiating social gatherings and culturally appropriate grief practices are essential for post-war MHPSS interventions.[40] Traditional religious associations, like *mähebar* and *sewä sanbat*, provide mechanisms for mutual self-help and encouragement. These associations often represent culturally grounded structures where mutual obligation based on shared religious belief is fundamental, making them more sustainable than externally established psychosocial support groups.[41]

One notable community-based approach used internationally by ACT Alliance members, including the Ethiopian Evangelical Church Mekane Yesus (EECMY-DASSC) and EOTC-DICAC, is the community-based psychosocial support (CBPS) approach. Its guiding principles, designed for ACT Alliance members' psychosocial support initiatives, emphasise respect for human rights, gender equality, understanding, and empowerment. Psychosocial support extends beyond initial emergencies, fostering capacity building for self-governance and collective decision-making in ongoing community development.[42]

According to a key informant from EOTC-DICAC, this CBPS approach is integrated into all interventions and humanitarian relief programmes, making psychosocial support a fundamental component across projects and responses. The CBPS model focuses on the initial two tiers of the IASC intervention pyramid, aiming to prevent trauma and severe psychological distress by addressing material, biological, and psychosocial needs such as food, water, shelter, sanitation, and physical and mental health. Economic stability is also crucial within this framework. CBPS service providers maintain a strong referral system with government health facilities for advanced physical or mental health and psychiatric services when necessary. In urban settings like Addis Ababa, professional psychiatrists and case managers identify and manage mental health cases and facilitate referrals. In rural areas, only referral services are available for those needing advanced mental health care, alongside basic CBPS services focused on fundamental well-being. This approach is consistently implemented across RRAD interventions in the MHPSS Amhara, Tigray, and Afar regions.

EOTC-DICAC collaborates with CBPS providers such as religious leaders, priests, volunteers, community elders, and Sunday school attendants to assist vulnerable populations in achieving well-being and safety through social interaction, mental stimulation, learning, physical security, and nurturing religious and spiritual beliefs. In refugee and returnee settings, EOTC-DICAC utilises trained psychiatrists, medical doctors, refugee outreach volunteers, and case managers to deliver comprehensive services. These professionals have undergone rigorous training, focusing on protection, counselling techniques, client management, and Psychological First Aid. Emphasising the significance of peoples' belief systems, the CBPS approach encourages practices such as visiting Holy Water for healing, recognising the importance of faith in recovery.

Community-based psychosocial support (CBPS) approaches in Ethiopia, especially those used by ACT Alliance members, focus on community involvement and sustainable, culturally grounded structures to address mental health and well-being. These approaches prioritize collective care, with support from religious leaders and local volunteers, and emphasize long-term, system-based interventions over external, donor-dependent solutions.

A key informant from EOTC-DICAC noted that the traditional Western-oriented individualised MHPSS approach may not be as effective in Ethiopian communities, which value collective well-being and strong social bonds. This methodology extends to EOTC-DICAC's peace-building interventions, prioritising community-focused approaches over individual-centred ones. EOTC-DICAC provides technical support, offering expertise in MHPSS, Psychological First Aid, and monitoring in related training for consortium member Church organisations.

Regarding religious approaches to CBPS, EOTC priests and religious leaders actively participate in CBPS efforts, receiving ongoing training, particularly in the Amhara region. These leaders are trained to maintain appropriate boundaries and refer severe cases. EOTC-DICAC does not rely on external Bible-based manuals but encourages consistent provision of psychosocial services by religious leaders within their communities, based on evidence-based methodologies. This preference for system-based

Holy Water ritual performed by a Christian Orthodox priest

interventions highlights EOTC-DICAC's focus on sustainable practices over those solely dependent on donor or other external financial support.

Cultural approaches: the "Holy Water" places

In many non-Western contexts, traditional healers often align their practices with widely accepted cultural explanations of mental illness, which frequently include religious, spiritual, and mythological narratives. In Ethiopia, one prevalent form of traditional healing is the use of Holy Water, based on the common belief that mental illnesses are caused by evil spirits or supernatural interference.

Holy Water holds a central place in the Ethiopian Orthodox Tewahedo Church. Various monasteries are renowned for their Holy Water, attracting many Ethiopian Christians who make pilgrimages to acquire it. Holy Water is particularly important during the Timket (Epiphany) celebration, where priests bless the water to baptise Christians and "purify souls from sins." The Orthodox Christian priests who perform Holy Water treatments are highly respected in Ethiopian society, a status achieved through the Church's central position.

In Ethiopia, Holy Water plays a central role in traditional mental health treatments, with many attributing mental illness to evil spirits and seeking healing through religious practices; despite historical tensions between traditional and biomedical care, some successful collaborations have emerged, combining Holy Water rituals with modern medical treatment.

There are several culturally recognised conditions related to mental illness, though they lack systematic research and consistent diagnostic criteria. Terms like "cherqun yetale" refer to someone severely mentally ill and incapable of responsibility, while "wofeffe" or "nik" describe individuals with erratic behaviour due to episodic outbursts. "Abbsho" denotes a person who, after using psychoactive substances, develops psychosis-like symptoms when consuming alcohol. Three types of spirits are believed to influence mental illness: the familial "Zar", the misfortune-bringing "Ayine Tila", and the "Buda" or "evil eye".[43] Mental health issues are often attributed to being cursed or possessed by these spirits, with causes ranging from divine transgressions to invoking evil spirits. Symptoms can include hearing voices, self-talk, solitary laughter, unexplained fainting, refusal to eat or drink, and suicidal thoughts.

Treatments typically involve Holy Water, exorcism, prayers, anointment with oil, and the use of holy ash. The priests perform all Holy Water treatment-related activities, as well as chanting, blessing, praying, and light ceremonial smacking with a religious cloth, to symbolise exorcising of evil spirits. Using Holy Water includes using it in prayer, consumption, and bathing.

Historically, the relationship between traditional and biomedical mental health care has been challenging. There are differing aetiological perspectives, deep-seated mistrust, and mutual disdain, with biomedical practitioners often viewing traditional healers as unscientific and superstitious. Consequently, there is a lack of collaboration between the two systems. However, some promising reports highlight the potential for cooperation, focusing on building trust with traditional healers and encouraging their referral to biomedical services or the integration of biomedical knowledge into their practices. Active collaborations based on mutual respect and cooperation are needed. In Ethiopia, informal connections between traditional religious healers and biomedical professionals were first noted in a 1968 ethnographic study of the Ghion Holy Water site. Researchers observed a reciprocal referral system between the priest and a nearby health centre, and between the holy site and Amanuel Mental Hospital in Addis Ababa. In 2007, the Ethiopian Orthodox Church has endorsed collaboration, with the late Patriarch Abune Paulos promoting the complementary use of Holy Water and medicine.[44]

The healing power ascribed to Holy Water is extensively documented in existing research on mental health and its connection with local beliefs. For instance, a study from Amhara found that nearly 60%

of Holy Water users were suffering from depression, anxiety, or psychosomatic complaints.[45] Another study shows that most Ethiopians prefer traditional healing methods, such as Holy Water, over biomedical services for mental health disorders, with 98% of initial consultations for mental health issues involving Holy Water.[46]

Additionally, there are noteworthy collaborations between modern biomedical services and Holy Water ceremonies. One study analysing a successful collaborative clinic found that while 54% of the clinic's patients were accessing biomedical services for the first time, a significant majority (92.2%) reported feeling comfortable receiving treatment that combined Holy Water and prayers with medication. Furthermore, 73.6% of the patients believed their illness was caused by evil spirit possession.[47]

5.5 Needs and challenges regarding MHPSS from the perspective of research and key informants at the national level

The following section highlights the needs and challenges related to MHPSS identified in both existing research and our key informant interviews. These insights can serve as a framework for designing strategies to enhance capacity in addressing MHPSS issues.

A tremendous lack of mental health professionals at the highest level 4 of the pyramid and lack of adequate treatment facilities for severe cases

There is a significant shortage of mental health professionals at the highest level of care and a lack of adequate treatment facilities in Ethiopia. Practically all key informants at the national level, as well as current psychological research, highlight the scarcity of qualified mental health professionals. This shortage is even more acute in war-affected areas, where there are, on average, only about three MHPSS service providers for over 5,000 internally displaced persons (IDPs), according to key informants at EPHI. Similarly, a key informant from the Ethiopian Psychiatrists Association noted that there were only 40 psychiatrists serving the entire country. Although this number has recently increased to about 120 psychiatrists, it remains insufficient for a population of 110 million.

Regarding specialised hospital services, a key informant from Amanuel Hospital emphasised the high turnover rate among existing professionals. This is due to factors such as low salaries and poor working conditions, including inadequate infrastructure and facilities for trauma treatment that ensure privacy and respect. Amanuel Hospital has only one ward dedicated to trauma patients, which is insufficient to meet the high demand, especially from war-affected areas. Consequently, they often have to turn away or refer patients to other facilities that may lack the same level of expertise or resources.

Low awareness of mental health and stigmatisation of patients

One significant challenge that mental health practitioners face in many countries is the low level of awareness and understanding of mental health and psychosocial problems among the general public and community service providers, such as health workers, teachers, religious leaders, and local authorities. Key informants reported prevalent misconceptions, myths, and stigmas associated with mental health, often influenced by religious and cultural beliefs, practices, and norms. In a study involving focus group discussions with religious leaders, health workers, and community participants in northern Ethiopia, mental illnesses were often attributed to supernatural causes. Patients were perceived as being controlled by evil spirits due to violating God's rules, attacks by devil spirits, grief from the loss of a loved one, poverty, excessive thinking, or substance use.[48] These stigmas also affect mental health professionals. One key informant, a psychiatrist himself, shared that even training to become a psychiatrist was stigmatised, with family and friends questioning, "Why do you want to work with these people?" This stigmatisation may contribute to the significant shortage of psychiatrists in the country, creating a vicious cycle. Ethiopia's mental health workforce is five times smaller than the global average, placing the country below the average of other low-income countries.[49] A meta-analysis of 37 studies highlighted widespread stigma and discrimination in Ethiopia, which has contributed to the under-utilisation of available mental health services.[50] Feedback from a key informant at Amanuel Hospital underscores this issue, noting that the public often discriminates against patients by labelling them as aggressive and violent, isolating, or even abusing them. This discrimination affects access to and utilisation of mental health and psychosocial support services, as well as the outcomes and satisfaction of the patients.

Lack of effective integration of MHPSS services into other sectors

Key informants from EPHI highlighted the challenge of integrating MHPSS services into other public health emergencies, education, and protection clusters. They emphasised that MHPSS services should be mainstreamed and incorporated into the overall humanitarian response strategy, ensuring MHPSS considerations are included in the design and implementation of other interventions. However, several obstacles hinder this integration: lack of awareness of MHPSS, limited resources, infrastructure and funding, insufficient coordination and collaboration amongst sectors, and a shortage of qualified MHPSS experts who are able to train staff and follow-up on their performance.

Not all partners in MHPSS use standardised and evidence-based approaches and in some instances employ methodologies with a risk of re-traumatisation

The EOTC DICAC / FELM mapping of 2020[51] highlighted the lack of standardised and validated MHPSS approaches among service providers, posing challenges for quality assurance, technical sustainability, and scalability. The inconsistent methods used across different localities suffer from limited replicability. One approach explicitly mentioned is psychological debriefing, done individually and in groups, which the WHO discourages. The EOTC DICAC / FELM mapping noted that 'a large number of humanitarian aid workers believe that prompting people, in the immediate aftermath of a highly distressing event, to revisit the minute details of their factual and emotional experience, may help survivors overcome their feelings of distress.'[52] Similarly, in UNICEF's 4xW 2019 mapping exercise, the authors stated that the majority of the MHPSS activities followed an informal format, with only 12% of the interventions reported to be underpinned by standardised methodologies. Due to this analysis, the 4xW suggested strengthening programmatic convergence by identifying a 'minimum core package' of MHPSS activities that should be systematically rolled out with the widest possible reach.

Ongoing insecurity affecting the presence of MHPSS services and impacting the mental health of service providers

The security situation in many parts of the country has severely hampered the access to and delivery of MHPSS services, as many areas are hard to reach or insecure. This instability makes it nearly impossible to maintain consistent delivery of MHPSS services, including the provision of essential equipment and psychotropic drugs, such as antidepressants and antipsychotics. As highlighted by a key informant from the Ethiopian Psychologists Association, ongoing insecurity affects not only IDPs but also humanitarian and frontline workers, causing tremendous stress and risking professional burnout. Given that aid workers face threats and have even been killed recently in Ethiopia[53], they risk their lives, exacerbating their psychological distress. Furthermore, according to the Ethiopian Psychological Association, public health emergency workers and community-level service providers often lack support and recognition for their efforts, further increasing their stress levels.

Capacity-building interventions rely on donor funding

The specialised key players in MHPSS at the national level rely heavily on donor funding for capacity-building efforts. This dependence poses a significant risk, as these essential services may be discontinued once the funding ends, severely impacting the continuity of care for vulnerable individuals with mental health issues. To effectively scale up MHPSS capacity in the country, it is crucial to establish long-term, sustainable mechanisms to maintain these interventions and ensure ongoing support for MHPSS providers.

A strong focus on Tigray only

UNICEF's joint strategy paper for 2021-2023 highlights a nearly exclusive focus on Tigray in terms of MHPSS, while other regions of the country may also face a high demand for these services.[54] Key informants have pointed out the need to address other areas that are severely under-resourced in terms of MHPSS, with Oromiya being specifically mentioned as a region in need of attention.

The importance of faith in MHPSS in Ethiopia and potential side-effect

In all our interviews with MHPSS experts, the crucial role of faith in mental health support in Ethiopia was emphasised. Many key informants, including psychiatrists and psychologists, openly admitted their own religious beliefs when discussing the importance of faith. Most people, as revealed in our interviews and supported by research on Holy Water practices, first turn to religious figures – such as priests, pastors, and nuns – when dealing with mental health issues

or trauma. Religious leaders play a significant role in this context: their spiritual guidance is essential for holistic healing, offering both meaning and comfort. They are vital for reaching individuals who might otherwise not seek help, and they wield considerable influence in raising awareness about trauma and mental health issues. A psychiatrist working at one Holy Water place in collaboration with a priest noted the potential for collaboration between religious and medical approaches. For instance, while priests conduct prayers, psychiatrists listen to patients, perform diagnostic assessments, and prescribe medication. The mobile clinic at St Paul's Hospital, which operates at the *Entoto* Church Holy Water site in Addis Ababa, serves as a successful example of integrating professional medical practices with cultural and religious methods. Interestingly, the referral process can work both ways: patients treated at St Paul's are encouraged to engage in their faith-based practices, including visiting Holy Water sites. Faith has also been instrumental in preventing suicides, according to one of the key informants. However, and despite the significant contributions of faith-based groups in Ethiopia, medical experts equally emphasised the need for religious leaders to adopt professional standards and evidence-based practices, such as Psychological First Aid (PFA) and to develop basic counselling skills, and to refer patients to specialised mental health care when necessary. There have been instances where patients with severe mental disorders worsened because they were not referred for psychiatric treatment. Some religious leaders, lacking an understanding of trauma or psychiatric conditions, may confine patients to Holy Water sites for extended periods, sometimes even months.

Additionally, there are concerns that priests might require survivors of rape to marry their perpetrators based on religious arguments, or stigmatise individuals with post-traumatic symptoms as being possessed by "evil spirits," thus exacerbating the suffering of those who have already endured violence and abuse. This shows a great need to work with religious leaders on practices and perceptions that are detrimental to the mental health and dignity of survivors.

5.6 Recommendations regarding MHPSS at the national level

Several key recommendations have emerged to enhance mental health and psychosocial support for trauma survivors, directed primarily at donor organizations working with Church-based groups but relevant to all donors funding MHPSS programs. They may be significant for various scenarios in Ethiopia, both conflict-related and non-conflict-related, and are therefore also pertinent to the three regions under scrutiny in this research.

- **Develop a national programme for integrating psychosocial competencies into theological and spiritual formation programmes. Have a number of Church personnel who are skilled and interested in intensive psychotherapeutic training trained in order to provide services for very severe cases transferred to them for treatment:** Create a national initiative to incorporate psychosocial skills into theological and formation programmes for religious leaders of all denominations. This programme should include knowledge of core mental disorders to facilitate effective psychoeducation, collaboration with mental health institutions, and appropriate referrals. Begin with institutions that are eager to integrate psychosocial content and trauma psychology into their curricula. Document the impact of these integrations on the quality of pastoral services to advocate for broader adoption by other institutions and formation programmes. For Church personnel who are gifted and willing, organize specialized training so that more severe cases can be referred to them. Ensure that their superiors give them the time and space to focus on their psychotherapeutic work with clients afterward.

- **Launch an inter-religious national campaign on de-stigmatisation of mental health problems and traumatic experiences**: Coordinate with all Churches, denominations, and the Muslim community in Ethiopia to develop a campaign focused on de-stigmatising mental health issues

and trauma. This campaign should emphasise the commitment of faith-based organisations to addressing the specific stigma surrounding survivors of sexual and gender-based violence. The campaign manual can include a jointly developed inter-religious theology supported by Bible and Quran texts advocating a non-judgmental approach of religious leaders, while discouraging harmful practices and teachings such as forced marriages for survivors of rape and shaming of survivors. Such a campaign could also foster inter-religious collaboration for peace.

- **Include Church-based organisations in the National Technical Working Group:** Ensure that all Church-based organisations working in MHPSS join the National Technical Working Group and raise awareness among non-Church-affiliated organisations about the significance of faith for MHPSS and available resources. Encouraging collaboration between Church-based and non-Church-based organisations can promote mutual learning and help address mutual prejudices, while sharing effective MHPSS practices and avoiding methods with potential psychological side effects. Mutual learning can also be enhanced by project visits and sharing with survivors on their experiences with certain approaches and methodologies.

- **Mainstream self-care and staff care in Church-based organisations:** Implement a strategic approach to self-care and team care within Church-based organisations to prevent burnout and conflict. Emphasise that self-care and staff care are essential for maintaining professionalism and professional boundaries. Address resistance to self-care amongst religious leaders, which may be viewed as selfishness and egocentrism, by highlighting the theological and psychological connection between self-love and the love of others.

- **Conduct a national study on the psychosocial needs of ex-combatants:** Undertake a study to assess the psychosocial needs of ex-combatants and develop a national strategy for a gender-sensitive MHPSS approach to addressing trauma. This is particularly important, as a systematic study on the gender- and age-specific needs of ex-combatants has yet to be conducted in Ethiopia. A comprehensive MHPSS approach for ex-combatants will be vital for peace-building efforts.

- **Form consortia for long-term MHPSS strategies integrating MHPSS with peace-building, humanitarian work, and development:** Recognise that MHPSS needs extend beyond the typical limited project cycles or short-term humanitarian efforts. Traumatised individuals and communities require long-term commitment and an integrated response. For instance, humanitarian actors can address basic needs through a psychosocially empowering approach, while development organisations work on development and peace-building simultaneously. Therefore, it is beneficial for donors to form consortia and design long-term programmes with participatory and collaborative planning, implementation, and phase-out processes to ensure sustained support in a given region. Additionally, consortia have greater potential to advocate for resource mobilisation and create governance structures that support a structural and sustainable approach to MHPSS. This approach is essential for health, peace-building, education, gender, and community empowerment.

6 MHPSS IN POST-CONFLICT AREAS: DEALING WITH THE PAIN OF UNHEALED WOUNDS IN TIGRAY

In the following chapter, we will present the findings from and our analysis of one of the three core regions under scrutiny: Tigray. The chapter begins with an overview of the vulnerabilities identified through literature review, key informant interviews, and focus group discussions in various locations. It provides both evidence-based information and practical, vivid depictions of psychosocial realities, as we had the chance to speak directly with survivors of different forms of trauma. This gives the chapter a richness of detail that will not be as extensive in the sections on Amhara and Oromiya.

Since most of the partner organisations participating in the study are located in Tigray, much of the discussion of best practices occurs in this chapter. A "best practice" is described based on its alignment with the aforementioned intervention principles (the 5 elements of Hobfall et al. 2007), existing trauma-related literature, and the feedback from beneficiaries on how these approaches have helped them. We focus only on analysing the best practices of partners to underline their creativity and impact beyond classical evidence-based categories.

As a reminder to the reader, our analysis is limited: we did not conduct a pre- and post-test assessment to measure the impact of the methods on the beneficiaries, nor did we have a standardised control group scenario where one group received intervention A and another group participated in intervention B. The methodologies presented would benefit from a systematic study on their impact, though this is beyond the scope of the present study.

We will first discuss the findings regarding vulnerable groups, traumatisation processes, and needs concerning MHPSS as identified in the research process. Then, we will describe the interventions, including best practices identified, and conclude with recommendations on how the findings can be used to scale up MHPSS activities in Tigray.

6.1 Findings for Tigray regarding vulnerable groups, prevalent psychosocial problems, existing traumatisation processes, and challenges and needs related to MHPSS programming

6.1.1 Particular psychosocial vulnerabilities

The war in Tigray stands out as one of the deadliest in recent times.[55] In this section, we aim to highlight the core needs and challenges reported during our interactions with partners and organisations working in Tigray. Although we frequently heard that 'everybody in Tigray is traumatized' during our fieldwork, we aim to delve deeper into specific vulnerabilities that we consider to be particularly important for the region.

Survivors of rape and conflict-related sexual violence

The widespread use of sexual violence and mass rape is one of the most destructive and long-lasting aspects of the Tigray war. We aim to explore these dimensions in more detail. A community survey of over 5,000 randomly selected women of reproductive age in Tigray, published in July 2023, found that nearly 8% of respondents reported being raped. Among these survivors, more than two thirds were gang-raped, and a quarter were raped multiple times during the war. Given the social stigmatisation of sexual violence, the rejection by families, and the inaccessibility of some areas due to the presence of Eritrean soldiers, this figure is likely to be an under-

count. Commonly reported problems among these survivors included physical trauma (23.8%), sexually transmitted infections (16.5%) with 2.7% contracting HIV, and almost 10% reported unwanted pregnancies. Nearly 20% of the women suffered from depression. An overwhelming majority (89.7%) did not receive any post-violence medical or psychological support.[56]

Similarly, Physicians for Human Rights, in their research of 305 randomly selected medical records from multiple health facilities in Tigray, also found cases of captivity consistent with sexual slavery, the use of weapons during sexual violence, and the murder of family members before, during, or after rape. Their examination of medical records reflects serious physical and psychological consequences, including PTSD (13%) and depression (17%), unintended pregnancies (8%), and reproductive organ injuries and disorders (11%). They also found that conflict-related sexual violence resulted in pregnancies (27% of patients tested were pregnant) and HIV infections (11% of patients tested were positive). The report highlighted significant delays in seeking medical care due to stigma, fear, ongoing conflict, and transportation issues, suggesting underreporting of war rape cases. Alarmingly, conflict-related sexual violence continued even after the Cessation of Hostility Agreement in November 2022. Out of the reviewed medical records, 169 incidents occurred before and 128 after the agreement. The report noted that 95% of conflict-related sexual violence experienced by children and adolescents under 18 years old occurred after the agreement was signed.[57]

Survivors of rape were the most frequently mentioned vulnerable group in all our key informant interviews and focus group discussions, both in Tigray and nationally. Their psychosocial vulnerability is complex: their traumatic experiences are among the most severe known from global trauma research.[58] Additionally, survivors face high stigma, risking divorce and expulsion if they disclose their experiences. The ensuing enforced silence increases the risk of severe post-traumatic stress. Many survivors also need long-term medical assistance for physical injuries, including surgery and treatment for stress-related conditions like hypertension and cancer, as highlighted by the Daughters of Charity. The physical long-term effects mean many will live with serious disabilities, serving as constant reminders of the violence they endured. Unfortunately, due to the massive destruction of health facilities, many survivors in remote areas lack access to regular care.

When sexual violence is widespread, the likelihood of male rape is also high, as seen in other countries with systematic sexual violence.[59] Anecdotal evidence from our interviews suggests that boys and men have also been victims. CST's key informants noted the lack of services for male survivors, who are typically referred to hospitals. CST plans to make their new project inclusive of gender-based violence, reaching out to the highly stigmatised male survivors who face even greater challenges in disclosing their experiences. Other key informants also pointed out the absence of targeted interventions for male survivors.

Youth

Youth in Tigray has been highlighted as a particularly vulnerable group in our key informant interviews and focus groups, especially at vocational training institutes in the region. They face significant mental health and psychosocial challenges, compounded by educational disruptions over the past four years. Many struggle with hopelessness, lack of concentration, depression, and anger management issues, all exacerbated by their basic survival needs.

At Don Bosco Polytechnical College in Mekelle, we learnt that students often find it difficult to follow vocational training courses because they need to work to afford food. The college had to adjust its schedule to a single shift, allowing students to work during the day. Some students have switched to studying at night to make time for income generation. High dropout rates are common due to economic pressures, including ongoing hardships, drought-related food insecurity, transportation issues, and financial constraints for rent. This makes it challenging for them to see vocational training as a path to positive long-term future prospects when their immediate focus is on surviving poverty and hunger. The traumatic impact of massive losses and instability has led to a pervasive sense of a foreshortened future, a typical sign of ongoing trauma. We had the opportunity to speak with some students at St Mary's College in Wukro. Their testimonies revealed deep emotional suffering from their experiences, but also a strong hope of finding employment through the vocational training provided.

Psychiatrists at Ayder Referral Hospital, Tigray's only referral hospital for mental health patients, have noted a troubling rise in substance use among youth. This problem is made worse by the lack of substance rehabilitation centres or inpatient/outpatient treatment services.

Ex-combatants

Ex-fighters of the Tigray People's Liberation Front (TPLF) have been identified as a group with particularly complex psychological vulnerabilities. A few key informants expressed concerns about the unprocessed trauma of ex-combatants, especially those still residing in camps. Ex-fighters are not receiving adequate mental health and emotional support, and their integration into the community remains uncertain. This lack of support has led to issues such as substance abuse and instances of violence, including sexual violence, in areas surrounding the camps.

Psychiatrists at Ayder Referral Hospital reported receiving many ex-fighters as patients of serious mental health problems. They often suffer from severe physical disabilities, a significant lack of economic prospects, and intense emotional problems, including PTSD with co-morbid substance abuse. They are often in such poor physical condition and without proper nutrition that they cannot consistently take their medication. At the Regional Health Bureau, we heard of a 19-year-old girl, paraplegic due to combat wounds, who has been bedridden for two years and weighs only 22 kg. The emotional wounds of ex-combatants are particularly severe when they perceive their lives as meaningless, having sacrificed their health in the fighting with no substantial plans for reintegration into society.

Young ex-combatants have also been mentioned in relation to vocational training. Both male and female ex-fighters exhibit significant problems with anger management, depression, and substance abuse. Still accustomed to a military lifestyle, they face challenges with educational discipline, frequently arriving late, skipping classes, or showing disrespect for teachers.

Internally displaced persons

Ethiopia hosts over 4 million internally displaced persons (IDPs), with 1 million still in Tigray.[60] These IDPs are living with their families, in schools, and in some cases, in camp-like settlements. Most of these locations are unsafe, and the people there suffer from overcrowding and a lack of prospects. While most IDPs want to return home, damaged infrastructure, a lack of services, and ongoing insecurity in their places of origin – especially in western and southern Tigray – make this unlikely to happen soon.[61]

In one of our focus groups with IDPs in Adigrat, participants highlighted their pervasive economic needs, which further undermine their psychosocial well-being, along with the uncertainty of not knowing when they can return home. Recovering from past traumatic experiences is extremely difficult when current life circumstances are dominated by scarcity and insecurity. Many are likely to react with violence against family members, increasing the suffering of women and children in particular. Additionally, IDPs fully depend on humanitarian aid and many suffer from hunger. According to Refugees International, Tigray's displaced population – especially children, the elderly, and women – are the hardest hit by food shortages.[62]

People from remote areas bordering Eritrea

In our key informant interview at the Regional Health Bureau, we identified another category of vulnerability linked to the remoteness of certain areas and their ongoing occupation by military forces, particularly in places like Erob, which borders Eritrea, but also other places in western Tigray. People from the Erob district are reported to be experiencing significant emotional trauma, with a notable number diagnosed with PTSD upon arriving in other areas. These traumatic experiences among vulnerable groups contribute to various emotional and mental health issues, including PTSD, depression, substance use disorders, and various forms of psychosis.

Alight Ethiopia (formerly American Refugee Committee) is the only organisation providing medical services to support families in Erob, but mental health services are non-existent.

6.1.2 A selection of identified salient psychosocial issues

In the following section, we aim to present the dynamics associated with traumatisation processes both post-conflict and in the ongoing complex situation of insecurity, threat, and woundedness. These insights were identified through key informant interviews in Tigray and focus group discussions with various beneficiaries, including survivors of sexual violence, IDPs, youth, and other vulnerable individuals participating in partner projects. When triangulated, the following key problems emerged, informing our recommendations for scaling up interventions.

Compounded trauma: war and hunger

Key informants in Tigray frequently highlighted the complexity of the situation, emphasising not only the trauma caused by conflict-related events but also the ongoing physical threat posed by hunger in the region. Hunger currently experienced in Tigray is caused by several factors: two years of living under siege during the war, a severe drought due to climate change impacts, and a nearly seven-month pause in food aid intended to fight corruption. This hunger has various debilitating consequences for mental health. Food insecurity in Ethiopia has been significantly associated with mental distress, particularly for mothers unable to provide enough food for their children.[63] Evidently, no mental health and psychosocial support programme can alleviate suffering caused by ongoing physical impairment due to food shortages. Additionally, food insecurity impacts attendance at MHPSS and other health services, as noted by several key informants. For example, mothers who survived gang rape by soldiers should undergo intense treatment but instead leave inpatient treatment programmes because they cannot be absent for long periods when their children need to be fed. In 2023, stunting levels – indicating chronic undernutrition that prevents children from reaching their full physical and mental potential – were at an alarming 43% in Tigray.[64] Furthermore, psychotropic medication and antiretrovirals for HIV-positive survivors cannot be taken properly if patients are not adequately fed, exacerbating both psychological and physical suffering. The combination of war and starvation greatly increases hopelessness and a sense of despair. Therefore, isolated MHPSS activities are insufficient given the level of distress experienced by women when their families cannot be fed.

> *'I am healing and I am eating. But my eight kids I've left at home… They say you are taking care of yourself, but no one is looking after us.'*
>
> *Beneficiary quoted by key informant at CST Mekelle*

Youth, an identified group with high levels of psychological vulnerability, similarly drop out of vocational training because they first need to earn money to feed themselves and their families, which significantly increases hopelessness and a lack of perspective for a better future. Vocational training is vital in Tigray, especially for the youth and their compounded trauma, but it cannot be effectively implemented without addressing the trainees' multiple needs related to food availability, ongoing poverty, and hopeless family backgrounds. To avoid dropout and additional motivational problems, vocational training programmes must support these basic survival needs.

> *You are giving us training, but what are we going to eat tomorrow?*
>
> *FGD with staff at Daughters of Charity, quoting a beneficiary*

These essential limitations of MHPSS in a survival-stress situation also apply to IDPs who are not yet able to return to their places of origin and are left in limbo. When stress and trauma continue – given the deplorable conditions in camps and ongoing violence – mental health interventions are limited in their positive impact. The socioeconomic problems that initially make people vulnerable to psychosocial issues must be removed or at least reduced.

Interestingly, and almost counterintuitively, we found that survival needs and MHPSS interventions are interconnected, as the latter are considered prerequisites for survival. Key informants from Tigray noted that trauma survivors called for psychological support first, as they had lost their sense of meaning in life, before economic measures could be taken. Therefore, the best approach is to address both levels of need *simultaneously*, calling for a thorough, integrated strategy that gradually builds on both psychosocial stability and survival.

Certain groups with severe chronic physical problems and ongoing health issues, particularly survivors of rape and ex-combatants, require long-term medical care

The extensive physical damage resulting from combat-related injuries and mass rape – especially affecting women's and girls' reproductive health – continues to severely impact the physical and mental well-being of survivors, their families, and their communities. Some reported cases are so severe that individuals have spent months in the hospital due to severe injuries, such as torn genital areas or dislocated hips from repeated assaults. Many suffer from chronic sexually transmitted diseases and HIV/AIDS. Fistula treatment is also needed. Survivors often require long-term aftercare and support for income generation, as some may be unable to return to agricultural work. Similarly, combatants who have been severely injured and can no longer engage in farming will need support for economic reintegration. Addressing these long-term physical effects also necessitates medical personnel equipped to

handle both the physical and psychological impacts of trauma. This requires a trauma-sensitive approach in all hospitals treating conflict-related injuries and psychosomatic issues, extending beyond mhGAP training for specific medical staff.

A wide variety of multiple mental health challenges, severe co-morbidities aggravated by the lack of specialised treatment

As in all societies worldwide, mental health disorders exist even without conflict and emergencies. Tigray was no exception, with schizophrenia, bipolar disorder, and anxiety disorders being most prominent, along with neurological problems such as epilepsy, as reported by psychiatrists at Ayder Hospital. However, due to the war, its immense losses, grave atrocities, and the breakdown of health services, including a severe shortage of psychotropic medication, many relapses occurred, and more patients with complex problems are seeking help.

The psychiatrists at Ayder Hospital emphasised the multifaceted nature of mental health issues in Tigray, noting complex and severe cases of PTSD, severe depression with suicidal tendencies, and a growing problem of substance abuse, particularly among young people and ex-fighters.

Addiction is a major concern in Tigray. Drug abuse includes "classical substances" such as alcohol and tobacco, marijuana and cannabis, as well as an increasing number of synthetic drugs and painkillers, leading to severe dependency and numerous side effects. Ayder Hospital lacks treatment facilities for substance abuse, so cases are often referred to St Paul's Hospital in Addis Ababa. Substance abuse and addiction may be signs of complex trauma and ongoing hopelessness, creating vicious cycles of dependency. They are severe forms of dysfunctional coping, leading to more mental health problems, such as sexual risk behaviour, violence, economic hardships, and inevitably an increase in aggressive behaviours in families and communities.

Stigmatisation of traumatic experiences related to sexual violence and resulting mental health problems

Some traumatic experiences are stigmatised because they touch taboos, most often related to sexuality and reproductivity. This is particularly true for rape survivors who in almost all cultures around the globe suffer from stigmatisation and exclusion from marriages and families[65], and Tigray being no exception. In some instances, religious leaders in rural areas said women had been raped because God did not love them, and that some residents reviled the women and their children as rapists' "leftovers."[66]

In addition, as several key informants in Tigray shared with us, they are stigmatised due to the resulting mental health problems. For example, it is believed that nightmares are a sign of being cursed or possessed by demons. This aggravates the problems of those who suffer and forces them into silence, which in turn exacerbates their emotional distress.

6.1.3 Needs and challenges related to MHPSS programming

The following section aims to analyse the concerns, gaps, and challenges raised during key informant interviews, particularly with mental health experts in Tigray and MHPSS programme implementers. This analysis will also contribute to formulating recommendations aligned with the context analysis of MHPSS in Tigray.

Standardised approaches versus non-standardised local methodologies

The debate of whether to prefer standardised approaches or locally adapted methodologies emerged as a critical issue during our interviews in Tigray. Standardised, evidence-based approaches recommended by the WHO, such as Self-Help Plus, PFA, and mhGAP, are advocated for their ability to be monitored and evaluated effectively. They allow for comparing results across different projects and learning from the experiences of others in the region. Additionally, these approaches ensure adherence to "Do No Harm" principles, protecting trauma survivors from methods that could exacerbate their suffering. Given the shortage of experts in Tigray, standardisation also offers the assurance that the methods employed are safe and effective.

On the other hand, some of the organisations we spoke with preferred self-chosen methodologies tailored to their specific context. They argued that these locally adapted approaches are more suitable for the target group and environment, and that they foster a sense of ownership over the process. Furthermore, if staff are already trained in a particular methodology and have prior experience with it, they may prefer to continue using it, possibly in-

tegrating it with other methods. Sometimes, donor requirements dictate certain approaches, which can hinder the sense of ownership. In such cases, focusing on basic intervention principles to be followed rather than prescribing specific manuals may be more beneficial.

Arguments in favour of using standardised (evidence-based) approaches	Arguments in favour of using locally adjusted approaches
Evidence-based: *recommended by WHO, ensuring methodologies are based on proven evidence (e.g. Self-Help Plus, PFA, mhGAP).*	**Context-specific:** *allows for methodologies tailored to the specific needs of the target group and environment.*
Monitoring and evaluation: *facilitates impact assessment and comparison across different projects, allowing for improvements based on lessons learnt.*	**Ownership and engagement:** *encourages a sense of ownership by letting organisations select and adapt approaches themselves.*
"Do No Harm" principles: *ensures methods do not retraumatise survivors and are safe for vulnerable individuals.*	**Practical implications:** *utilises staff expertise and previous experience with certain methods, potentially integrating them with other approaches.*
Consistency and safety: *provides assurance of safe and effective practices in the absence of local expertise*	**Flexibility:** *offers adaptability in situations where donor requirements might restrict the use of standardised methods.*

Helpers affected by trauma too: the need for trauma sensitivity as a cross-cutting approach to staff capacity building and self-care

A consistent piece of feedback from all key informants, partners, and specialised organisations is that the staff implementing MHPSS interventions are themselves profoundly affected by trauma. Most of the personnel involved in projects in Tigray have personally experienced the war to varying degrees or have family members who have suffered losses in the region. Additionally, the overwhelming level of destruction and ongoing sense of powerlessness in Tigray can lead staff to feel easily overwhelmed by the pain they witness in their work, coupled with their own sense of helplessness that their MHPSS efforts may not alleviate peoples' suffering. Consequently, it is essential for organisations working in MHPSS to implement self-care and team care programmes, along with providing regular supervision for their staff.

> *We are also traumatised. People come to us every day, asking us for support, but we don't know what to do.*
>
> *FGD with staff at the Daughters of Charity, quoting priests and teachers*

Lack of specialised MHPSS approaches for particular target groups: children in general, children born of war, and male survivors of sexual violence

Although many organisations employ internationally recognised guidelines and evidence-based interventions for GBV survivors, there is a notable absence of structured approaches for addressing children's trauma, including those born of war, and for male survivors of sexual violence. Children born of rape, in particular, are extremely vulnerable, as they are stigmatised and rejected by families and communities, growing up in conditions of scarcity and poverty. These children often face severe deprivation of food while their families are already suffering from hunger. Additionally, there is a significant gap in professional expertise regarding male survivors of sexual violence. More research and specialised training are needed to address the needs of this group. CST's initiative to include male survivors in their programme is a commendable step toward supporting a group that is particularly vulnerable due to cultural taboos around discussing sexual violence and homosexuality.

Challenges with the "Bible-based approach": loss of faith due to trauma and fears to be converted

While the "Bible-based approach," as discussed in the previous chapter, is regarded effective and applicable, it also presents certain challenges. In Tigray, many young people, burdened by a bleak past and uncertain future, experience a profound loss of faith. Moreover, even practitioners of this approach have reported that participants sometimes fear they might be coerced into converting to Catholicism, given that most organisations implementing this method in Tigray are Catholic. To adhere to the principle of "Do No Harm," it is crucial to approach these methodologies with sensitivity to cultural and religious issues, ensuring that they promote unity rather than division or conflict.

Serious limitations in specialised services and particularly a lack of psychologists at Ayder Hospital and elsewhere

Key informants from Ayder Hospital and the Regional Technical Working Group emphasised a significant shortage of clinical psychologists in the region. The hospital does not offer psychotherapeutic services, and there has been no provision of psychotherapy training to date. Due to this shortage, psychiatrists at Ayder Referral Hospital often lack the time to attend to all patients comprehensively. Some patients rely on porters, such as family members or NGO workers, to collect medications and relay information about their well-being. However, this cannot substitute for essential, ongoing clinical assessment and treatment planning. Additionally, the infrastructure for psychiatric services is insufficient and does not provide a comfortable or patient-friendly environment.

Engaging all actors to collaborate in the Regional Technical Working Group and integrating MHPSS across all sectors is a challenge

In principle, the Regional Mental Health and Psychosocial Support (MHPSS) Technical Working Group, based at the Regional Health Bureau in Mekelle and co-chaired by the WHO and the Regional Health Bureau, has actively operated for a year and a half. It coordinates over 20 partner organisations to integrate MHPSS into interventions across the protection, health, and MHPSS clusters. Partners in Tigray are implementing MHPSS activities in 66 out of 72 accessible woredas. The Technical Working Group (TWG) meets monthly to review MHPSS activities from partners and conducts partner mapping to track "Who is Where, When, Doing What" (4Ws) in Tigray. According to key informants from the TWG, the psychiatric component of MHPSS is decentralised. The Mental Health Gap Action Programme (mhGAP) training has been delivered to nearly all health facilities, accompanied by subsequent mentoring. The TWG is active and functional, which is commendable. It has successfully gathered mapping information from 22 organisations and implementing partners. Community-based MHPSS tools, such as the Self-Help Plus (SH+) approach, are available in the local language, while the Integrated Psychotherapy is being translated by the Regional Health Bureau and World Vision Ethiopia.

However, significant challenges and limitations hampering the efforts of the TWG have also been reported: psychological aspects of MHPSS are seriously limited, with counselling and psychotherapy services being almost non-existent, while a heavy focus is laid on medical treatment instead. Engaging all relevant actors in the TWG is challenging; many Church partners are not involved. Additionally, the TWG has noted a lack of standardised MHPSS practices at the community level, with various partners introducing different methodologies that are difficult to monitor. Often, the TWG is not aware of the specific methodologies and practices used by certain NGOs. Additionally, some key service providers are not part of the Technical Working Group. Currently, MHPSS efforts are primarily focused on the health and protection clusters, while other sectors such as agriculture and WASH have not yet been addressed.

6.2 MHPSS Approaches and best practices of partner organisations: lessons learnt from Tigray

In this section, we aim to particularly outline specific approaches and interventions that exemplify "best practices". We will use the IASC MHPSS intervention pyramid as a framework to categorise the approaches based on different levels of intervention. In addition to CST's approach and the Ayder Referral Hospital, we will focus on the Church partners that participated in the study: the Daughters of Charity, Mekelle; St. Mary's College Wukro; the Diocese of Adigrat; and the Ethiopi-

an Evangelical Church Mekane Yesu (Samre Saharti). Highlighting certain aspects of the MHPSS projects of these Church partners as "best practices" does not imply that there are no other approaches in the region deserving of this label. It also does not mean that an approach is entirely a "best practice," but rather that the highlighted aspects demonstrate a positive impact.

6.2.1 Over-all coordination of MHPSS activities and capacity building in Tigray

As previously noted, the Regional Mental Health and Psychosocial Support Technical Working Group (TWG), based at the Regional Health Bureau in Mekelle and co-chaired by WHO and the Regional Health Bureau, coordinates the integration of MHPSS into partner organisations' interventions across protection, health, and MHPSS clusters, while also organizing capacity-building activities.

6.2.2 MHPSS-related activities at level 1 in Tigray: basic services and security

Given the analysis of compounded trauma in Tigray, it is not surprising that all organisations and their key informants emphasised the necessity of incorporating basic services and security into all higher-level MHPSS interventions. The diverse measures and strategies employed by different projects include multi-purpose cash support, the provision of animals to specific survivor categories, food and school feeding programmes, dignity kits for women and girls, WASH initiatives for the hardest-hit communities, seed funding for vocational training centres, and various income-generating activities and skills training.

The existing vocational training institutions also contribute to level 1 interventions by offering opportunities for secure livelihoods. These programmes cover areas such as agriculture, computer skills, food preparation, tailoring, and mechanics. We will discuss these further under level 2 interventions.

6.2.3 MHPSS-related activities at level 2 in Tigray: community and family support

Some MHPSS projects, in addition to providing basic services, have a strong focus on supporting communities and families. We want to highlight some of the best practices of partner organisations involved in this study, showcasing their unique ways of leveraging inherent potential within their organisations and reflecting attitudes that we consider exemplary.

Forming and strengthening community through sports, agricultural activities, and outreach: the example of the vocational training centre St Mary's College Wukro:

St Mary's College in Wukro is a vocational training centre offering both long-term and short courses for youth. They provide training in agriculture, including livestock raising and farming techniques, as well as short-term courses in information and communication technology. Additionally, they offer arts training, such as music, leather crafting, and other artistic disciplines. The staff at St Mary's employ various low-threshold interventions to enhance the mental health of their students, who continue to suffer from the ongoing traumatising impact of the war. They also support some survivors of sexual violence.

The staff have received training in trauma healing combined with peace-building and social cohesion, as well as the "Bible-based approach" and other smaller trainings that impart psychosocial skills. St Mary's College integrates a low-threshold version of the "Bible-based approach" into their work with students. For example, they conduct half-day training sessions during the five-day induction period for new students and incorporate daily inputs during "morning circles", where concepts from the manual or relevant Bible verses are shared. Additionally, in all community outreach training sessions, such as agricultural training for local farmers, they include trauma awareness components based on the "Bible-based approach".

A similar low-threshold use of this approach in working with students is implemented at Don Bosco Polytechnic College in Mekelle, as we learnt from our focus group discussion there.

The role of sports

St Mary's unique approach includes sports activities not only for students on the campus but also for the youth of Wukro town. These activities are structured with a daily schedule for different training groups, and also include sessions for staff during the school week. We consider the use of sports for students and the broader community a "best practice," even though there may be room for improvement to make these activities more trauma-sensitive.

To promote healing and community engagement, the college rehabilitated its sports fields and invited local youths to participate in various sports tournaments, including football, basketball, badminton, and roller skating. A major event is a two-week sports festival for the entire town of Wukro, during which the vocational training centre is closed. Local youth enrol in courses throughout the week and then attend sessions on nearby sports fields. This collective engagement in sports not only provides a platform

Sports for youth at St. Mary's College Wukro

for relaxation, physical activity, and skill development but also fosters community building, teamwork, and a sense of belonging among participants. It helps alleviate chronic stress, which students in our focus group discussions identified as a source of their suffering.

Sports serve as a significant recreational and community bonding activity, positively impacting recovery from the bodily effects of trauma, such as constant hyper-alertness, nervousness, and sleeplessness. It also helps reduce feelings of social isolation and withdrawal, which are typical for trauma-related problems. The use of sports to address various psychosocial issues is widely promoted in international cooperation and peace work, especially in regions affected by poverty, violence, and conflict.[67]

However, some staff members of St Mary's noted that students participating in sports competitions sometimes react strongly to ambiguous social experiences, such as losing a game or being physically touched during a match. This can provoke intense anger and even physical fights. Such reactions are expected in youth who have experienced tremendous losses, witnessed atrocities like family members dying, or were involved in combat and trained to fight and win. They continue to suffer from ongoing powerlessness due to the economic situation and starvation. Therefore, it is important to integrate trauma-sensitive methodologies in sports activities, introduce non-competitive activities that focus more on community building, and adhere to the "Do No Harm" principle. Additionally, having a person trained in advanced listening skills and therapeutic methods, preferably a psychologist, to whom young people can be referred for more in-depth psychological support, is crucial.

Why using sports at vocational training centres and in communities can be considered a best practice:

Promotes relaxation and stress relief: Sports activities help individuals learn how to calm down and release bodily tension, a common consequence of trauma.

Boosts empowerment and self-efficacy: Achieving success in sports creates a sense of empowerment and self-efficacy.

Fosters community and team spirit: Sports foster a community experience, connecting people and creating a sense of belonging to a team.

Brings joy and positive body experience: Engaging in sports instils joy and fun, providing a positive body experience and offering hope for a joyful future.

Ideas on how to make it more trauma-sensitive:

Emphasise team and cooperative activities: Focus on team and cooperative sports activities to enhance the enjoyment of playing in a group, where feeling a sense of belonging is more important than winning.

Provide secure referral for counselling: For youth showing signs of mental health problems, ensure a secure referral for counselling, such as having a psychologist available at the centre.

Integrate positive body experience methodologies: Use methodologies that connect positive body experiences through sports with increased emotional well-being, such as the TeamUp approach.

Adapt sports for all abilities: Think of sports activities that are safe and empowering for people with physical problems and disabilities. Provide safe sports activities for women and girls who have experienced gender-based violence.

Agriculture and gardening: creating hope and beauty in the environment

Another approach to psychosocial and community building that we consider a best practice is the strong emphasis on agricultural and gardening activities at St Mary's. The staff shared how, immediately after the war, they gathered to plant trees on the compound. Although they could not talk about the destruction that had occurred, they found solace, bonding, and hope in this collective activity. This process helped them rebuild not only physically through planting but also symbolically as a community of service providers who were themselves in need of healing.

Planting and nurturing plants are powerful spiritual experiences of recovery and hope. For students, this activity demonstrates that despite their feelings of powerlessness and hopelessness, they can positively impact something as life-giving as plant growth. This is especially significant in drought-affected regions where food has a profound physical and symbolic role, and crop failure is common. Seeing beauty – flowers and trees – amid visible destruction offers a healing experience, suggesting that a different life is possible.

Creating a beautiful garden with vegetables, flowers, and trees is itself a component of healing and community experience. We observed students walking slowly through the garden and were told that doing so before classes helped them focus and concentrate better. This approach, unique and effective, could inspire other vocational training institutes to encourage students and staff to plant and care for gardens together.

Walking in the garden at St. Mary's College Wukro

Incorporating environmental care and planting drought-resistant plants can also enhance technical skills needed in a region likely to face future climatic changes, further increasing a sense of mastery and empowerment.

This underlying idea of beauty fostering healing extends to the arts and music activities offered at St Mary's, which also provide significant psychosocial benefits.

Why using agriculture and gardening can be considered a best practice:

Fosters spiritual recovery and hope: Planting and caring for plants offers a sense of hope and a spiritual experience that life continues.

Provides symbolic rebuilding: The act of planting trees helps to symbolically rebuild their community after the war.

Encourages Self-efficacy / community efficacy: Gardening allows students and community members to witness their ability to positively impact something despite their feelings of powerlessness.

Provides healing beauty: Seeing beautiful flowers and trees growing amidst destruction provides a healing experience and suggests that a better life is possible and that life offers beauty.

Promotes community bonding / connection: Engaging in collective gardening activities fosters community building and bonding among participants.

Supports calming: Walking in the garden before classes helps students focus and concentrate better.

Enhances environmental efficacy: Planting drought-resistant plants enhances technical skills and prepares students for future climatic changes.

Working with different community actors with the "Bible-based approach": the work of the Diocese of Adigrat

The Diocese of Adigrat, a partner organisation participating in the research, implements various projects related to MHPSS, including support for GBV survivors using the Women and Girls Safe Space methodology and a project on peace-building and social cohesion with an integrated MHPSS component. Additionally, the Diocese employs the "Bible-based approach" to address trauma in communities. We suggest recognising the Diocese's project on implementing the "Bible-based approach" with different target groups and especially with service providers and with IDPs as a best practice, even though we recommend some adjustments.

The Diocese of Adigrat operates services in large IDP camps around the town. IDPs receive an average of two days of training with the "Bible-based approach". The project also trains various service providers, such as teachers, priests, and health service providers with a sense of healing those who give their services to others. After completing a two-day ToT training, these providers are expected to integrate their newfound awareness into their professional settings with students, patients, and vulnerable community members.

> *'Tomorrow is another day.'*
>
> *Internally Displaced Person, focus group discussion Adigrat*

Training group sizes vary, with some groups reported to have 70 to 170 participants. Staff openly shared that the entire community is affected and suffering from the psychological sequelae of trauma. It is therefore hoped that providing even a few inputs to as many people as possible, even in a condensed form, will be beneficial.

A significant challenge of this broadly conceived project is the lack of a sound referral system to technical experts such as psychologists or psychiatric services. Follow-up by trainers during the "Bible-based workshops" is also not possible due to the limited training time and the high numbers of participants. Given the large segments of the population affected by psychological problems, severe distress, and large-scale traumatisation, the two-day training may be considered a "better than nothing" approach. However, we strongly suggest additional measures to ensure good quality and adherence to "Do No Harm".

In a focus group discussion in Adigrat with a mixed group of service providers, such as teachers and health workers, and IDPs from nearby camps, we witnessed the level of gratitude among both subgroups. A significant difference observed was the level of vulnerability of the different target groups. IDPs emphasised their need for more training days with the "Bible-based approach," economic and livelihood support, and a safe possibility to return to their original homes. Participants described in detail the group discussions, role-plays, input on trauma signs and coping, the healing effects of crying, and the usefulness of prayer as particularly helpful. Some participants formed new friendships and continued visiting each other. The IDPs suggested they also be trained as facilitators to help other IDPs using healing groups.

The most commonly used terms to describe the impact of the training were "hope" provided by the training content and the facilitators' attitudes, who were perceived as "soft" and "understanding." A teacher mentioned during that the two-day training helped students persevere in their studies. A nurse who received ToT said she learnt the counselling approach and how to ensure patient safety through the training.

> *'I got hope that I can heal.'*
>
> *Internally Displaced Person, focus group discussion Adigrat*

Group discussion at a "Bible-based trauma healing" session

Why using the "Bible-based approach" for Internally Displaced Persons and for service providers can be considered a best practice:

Uses broad target groups beyond the "classical" group of survivors of GBV: The "Bible-based approach" is implemented in various community settings such as health and education, reaching a wide audience. In addition, IDPs, who are considered to be vulnerable, participate in this group methodology.

Fosters community integration: Training is provided not only for IDPs but also for teachers, priests, and health care providers, who can then pass on the knowledge.

Instils hope: Participants reported increased hope and psychological support through group discussions, role-playing, and emphasis on healing.

Creates social networking: The training fosters new friendships and stronger social connections among participants, especially among IDPs.

Ideas on how to make it more trauma-sensitive:

Establish a professional support system for those who show more psychological or mental health problems: Focus on a referral system to psychologists or psychiatric services for further support.

Extend the training duration and limit participant numbers: The two-day training sessions are too short to provide thorough psychological support. Group sizes should be limited to a maximum of 25 participants to allow for more in-depth work.

Organise sustainable follow-up: Continuous follow-up of participants by trainers is so far hardly possible due to the large number of participants. There is a need to follow-up specifically on those participants who are particularly vulnerable.

Combine MHPSS with support of economic needs: IDPs not only need training but also economic support and safe return options to their places of origin.

6.2.4 MHPSS-related activities at level 3 in Tigray: non-specialised support at Women and Girls Safe Spaces by different actors as well as at the Vocational Training Centre of the Daughters of Charity

CST's model of Women and Girls Safe Spaces with case management, individual counselling, group counselling, and comprehensive referral system

Since CST is a major actor in Tigray for MHPSS and collaborates with several partners in this study, we would like to highlight their comprehensive approach to addressing gender-based violence (GBV).

CST Ethiopia represents the development cooperation and humanitarian agencies of the Catholic Church from England and Wales (CAFOD), Scotland (SCIAF), and Ireland (Trócaire) in Ethiopia. In Mekelle, CST operates a multidisciplinary and comprehensive programme in collaboration with four non-Church social organisations and two Church-based ones, including the Daughters of Charity in Mekelle and the Diocese of Adigrat. CST follows the Women and Girls Safe Space approach (UNFPA)[68], providing a range of comprehensive services and well-structured referral systems.

According to key informants from CST Mekelle, these Safe Spaces are often implemented as low-threshold interventions in health facilities or IDP camps in Tigray and are staffed with case managers. All staff members at the Women and Girls Safe Spaces receive thorough training on UNFPA's GBV guidelines. The Safe Spaces cater not only to survivors of rape – estimated to be about 10-20% of participants according to CST Mekelle – but also to all women and girls seeking help, many of whom have experienced the trauma of losing family members due to war and famine. This inclusive approach has proven effective in avoiding stigmatisation and providing a safe environment for all participants.

Case managers, often with backgrounds in health or social work, follow clear formats and standards. One case manager is responsible for 20 survivors, while one supervisor oversees eight case managers. These managers receive close supervision for handling complicated cases and ongoing training in counselling, problem-solving, and stress management techniques.

Additionally, the Women and Girls Safe Spaces employ two facilitators who focus on group psychosocial counselling, utilising stress management and well-being techniques outlined in CST's INSPIRE toolkit.[69] CST plans to expand its support by implementing the Self-Help Plus (SH+) approach community-wide, enhancing stress management techniques for the entire community. Future facilitators will include teachers and health workers.

CST also plans to provide psychotherapy training for various service providers and has started procuring psychotropic medications for health facilities. Beyond the Women and Girls Safe Spaces, CST integrates basic services such as emergency cash support to help women cover transportation costs to health facilities, medication, and food. For severe health problems, women are referred to appropriate health facilities.

In conclusion, CST's approach, which includes training, support, and comprehensive service provision, offers a robust response to the needs of women and girls affected by GBV and other traumas.

Multi-level approach for a particularly vulnerable community: the Women and Girls Safe Space of the Ethiopian Evangelical Church Mekane Yesu in Samre and their integration into a community approach

In Samre Saharti, Eritrean troops killed many men, looted the village, and occupied it for 3 months. While the boys and men ran away, the women stayed behind. The whole community suffered unprecedented levels of traumatising violence, intense long-term psychological distress and fears during the occupation, with sexual violence and rape rendering especially women and girls extremely vulnerable. The women and girls in our focus group discussion clearly described the level of destruction that they went through during this period of time and in the aftermath when stigma and psychosocial destruction kept them hostage: 'I hid myself for years. When they (i.e. EECMY-DASSC) came and talked to us, then I believed they were really there.'

EECMY-DASSC Tigray is implementing a comprehensive and multi-layered MHPSS programme to address the various social, economic, mental, and psychological needs in the community of Samre with its almost 700 households. The programme ensures a continuum of care, support, and services, while implementing a low-threshold approach in form of a Women and Girls Safe Space that they run at an empty community health centre.

We want to highlight as "best practice" here an application of the Women and Girls Safe Space approach and its multi-layered holistic approach as practiced by EECMY-DASSC, including the strong linkages being provided through volunteers putting in practice a community-based psychosocial approach (CBPS) in a community that was severely hit in the war:

Low-threshold approach protecting women and girl survivors from outside interference

Every Thursday, around 60 women and girls from the Samre community – both survivors of sexual violence and other vulnerable women and girls – gather at a community health centre that is vacant except one day per week. Here, they engage in handicrafts, games, hair care, share coffee, and discuss various issues. This open, non-stigmatising environment allows survivors of sexual violence to feel safe and supported. During a focus group discussion, we noticed that survivors openly shared their experiences, indicating a high level of trust and comfort among the women. They not only support each other during these sessions but also visit and comfort one another at home.

Specialised psychosocial support available beyond the women's and girls' groups focusing on simple psychosocial techniques fostering coping, stress management, and connection

Beyond women's and girls' meetings, trained professionals provide comprehensive case management, trauma support sessions, and skill-building training. These sessions offer counselling and integrated support from case managers who regularly follow up and document new cases. In focus group discussions, participants referred to this as "training," while EECMY staff termed it "trauma healing". This approach includes low-threshold awareness, normalisation of symptoms, and storytelling to foster a sense of solidarity and hope. Advanced therapeutic tools, such as lifelines of stones and flowers, are also used. Regular discussions on stress and trauma management allow women to share coping strategies, often finding solace in the support of the group.

Gebeta, traditional game played at the Women's and Girls' Safe Space, Samre Saharti

Holistic support through strong referral pathways; follow-ups by the case manager

Some women and girls suffered severe injuries from physical violence and multiple rapes, requiring months of hospital and one-stop centre care. The case manager ensures referral and that these intense treatment facilities provide proper care, maintaining close contact with the Women's Association of Tigray and specialised GBV centres for additional support. During key informant interviews, the case manager shared the complexity of cases, such as mothers and daughters undergoing extensive medical treatment and physiotherapy. EECMY has established an effective referral pathway to liaise survivors with advanced psychiatric or medical care and safe house placements for complex GBV cases. These referrals, involving clinical psychologists, are well-documented to ensure continuity of care. Additionally, EECMY-DASSC participates in the Regional MHPSS Technical Working Group, ensuring integrated coordination.

Comprehensive economic support

The women receive holistic economic support, including cash assistance, income-generating activities, recreational activities, dignity kits, and medical care. Some girls benefit from fortified food provided at their schools by EECMY-DASSC. Staff emphasised the need for a comprehensive MHPSS approach, covering all layers of the IASC pyramid: basic support such as cash assistance, food aid (including school feeding programmes), and medical care. During the focus group discussion, the girls reported that dignity kits and fortified food help them attend school and concentrate better. Women receive a total of birr 24,000 and sheep, while survivors of sexual violence receive an additional 10 chickens.

The role of the volunteers as part of CBPS

Women and girls in the Samre focus group emphasised the importance of EECMY volunteers finding them. 'We were hiding in our houses, but they came and found us. We needed to be found, otherwise we would not have come out.' (Focus group discussion, Samre Saharti) "Being found" and receiving services were vital for the survivors. EECMY volunteers play a crucial role in following up on the women, organising meetings at the Safe Space, and providing necessary equipment, while case managers visit bi-monthly for documentation and more intensive psychosocial interventions.

Strong community

The programme extends its reach to the broader community through soil and water conservation efforts, cash and seed support, and other emergency assistance. EECMY-DASSC facilitators hold awareness events for community and religious leaders, as well as teachers, to integrate them into the MHPSS response. These trainings help address the stigma and discrimination survivors face. Women and girls in the focus group emphasised how community awareness, particularly involving religious leaders, reduced stigmatisation and improved their acceptance in the community. One girl shared, 'I want to bring other women out of hiding so they can benefit from the help I received.'

Service providers seen as "part" of the community, not as "agencies" doing a project

A key aspect of EECMY's interventions is their long-standing presence before and during the war, which grants them high credibility and authenticity. They are viewed as part of the community. This highlights the benefits of a Church-based organisation offering support, as they are seen as integral to the community, providing beneficiaries with a sense of safety and continuity.

> *You are our mothers. Even during the war, you supported us.*
>
> *Respondent FGD Samre Saharti*

Why the Women and Girls Safe Space and the community-based psychosocial approach of EECMY can be considered a best practice:

Builds strong connections amongst beneficiaries: The programme fosters a deep sense of unity among women and girls, extending support to the entire community.

Offers comprehensive care: It addresses all survivor needs, including economic support, training, medical care referrals, and safe recovery spaces.

Empowers volunteers and community: Volunteers gain a sense of purpose by supporting survivors, encouraging participation, and organising meetings, boosting both self-efficacy and community efficacy.

Instils hope: As a church organisation with a long history of commitment, EECMY has provided consistent support before, during, and after the war. Their presence and continuity increase hope that the people are not alone.

Healing the community and creating a safe environment for survivors to heal: the Helpful Active Listening project of the Daughters of Charity in Bora

Helpful Active Listening (HAL) is a community- and survivor-based approach, originally developed in Rwanda and adapted for the Tigrayan setting by the Daughters of Charity and currently implemented in Bora. Bora suffered a collective trauma during the war in January 2021, when armed militia massacred boys and men, forcing the women to watch the bodies of their loved ones for three days before they could bury them. The approach is considered a best practice due to its participatory methodological development and its focus on healing the entire community, not just survivors of sexual and gender-based violence. Key informants highlighted the structured approach and the comprehensive healing it promotes for the whole community.

> *If you don't have a kind society that is empathetic to what you are going through, that understands how you can access support, that understands the value of confidentiality, all this exacerbates the experiences of individuals.'*
>
> *Key informant of the HAL project*

Community- and survivor-based group approach being participatorily developed

The HAL approach is community- and survivor-based and was developed with local participation. It utilises cultural practices where women support each other through visits, sharing coffee, and conversations. However, it also addresses harmful cultural beliefs, such as the stigma that trauma or sexual violence is a curse. The project raises community awareness to counter these misconceptions. Beneficiaries attend six HAL sessions, following a manual, where they share the effects of trauma without delving into personal experiences to avoid re-traumatisation. Sessions are led by trained facilitators, who are survivors themselves, accepted by the community. These facilitators guide groups of 10 survivors through structured sessions focusing on identifying trauma, normalising it, and empowering women. Health facilitators may refer individuals needing more in-depth help to case

Community awareness as part of HAL sessions

managers for further support. Mixed groups of survivors from diverse backgrounds ensure that GBV survivors are not singled out or stigmatised. The manual for training HAL facilitators combines various concepts, including GBV, Psychological First Aid, and supportive communication. HAL's project has trained 48 facilitators in Bora, incorporating feedback from the initial training cohorts. PTSD assessments are conducted before and after the intervention to measure significant changes. The groups meet bi-weekly, and new interventions, like integrating art therapy into handicrafts, have been introduced.

Starting with the staff themselves: building a supportive community of helpers

Given the high level of exposure to extremely painful experiences of others and the fact that many staff members have also suffered during the war, it was very important to create awareness about secondary trauma and stress-related problems first.

Engaging community leadership and service providers in the process of creating a safe and conducive environment for survivors

> *When a woman can barely get out of bed, asking her to start a business is not realistic.*
>
> *Key informant HAL*

Community leaders and service providers, including priests, health care providers, teachers, community elders, and security forces, have all experienced trauma themselves and often feel overwhelmed by the needs of their community. They may also lack awareness regarding confidentiality and the specific needs of survivors of sexual violence. The HAL programme engages these influential figures to speak about survivors' needs, fostering empathy and behaviour change. Each group takes responsibility for different aspects: religious leaders focus on families, teachers on students, and local administrators on community outreach. Local administrators also address security issues, such as ensuring emergency funds reach women safely. Ensuring community safety remains crucial, as exemplified by the ongoing challenges posed by the military camp near Bora's only school.

Documentation and learning

The HAL project continuously documents experiences and solicits feedback from similar projects and the Regional Technical Working Group to improve and contextualise its approach. New insights are integrated, and impacts are measured, broadening the approach with techniques like art therapy. This self-directed application, closely monitored with scientific tools, allows for iterative improvements. For example, a refined sequence in healing sessions was implemented based on previous lessons learnt. HAL staff assess trainings, interventions, and PTSD in participants, uncovering key symptoms like nightmares and intrusive thoughts, such as survivors being blamed by their deceased husbands for not burying them.

Livelihood support after healing sessions

HAL advises starting livelihood projects only after the six healing sessions due to the high trauma levels, which prevent women from thinking for the long term. These sessions help women feel psychologically empowered, enabling them to continue with livelihood support. The project has linked women with a microfinance agency for sustainable loans. When developing livelihood projects, HAL seeks local specialists, such as beekeeping experts, to utilise the area's known resources. This approach reconnects women to their agricultural history, as emphasised by the key informant.

Group formation after healing sessions: income-generation and reconnecting to livelihood

Some HAL groups have established small internal lending communities. They revive local food production methods known before the war, with community trainers sharing their expertise and buying some of the group's products for resale.

Health reflecting on their experiences with HAL methodology

Weekly, facilitators, who are also survivors, gather to reflect on their experiences. This practice helps prevent stress-related burnout and secondary trauma, reinforcing the project's core idea that healing is community-driven.

Why the HAL community- based and survivor-centred approach of the Daughters of Charity can be considered a best practice:

Promotes connection in groups as an ingredient for healing: The HAL approach uses cultural practices where women support each other through visits, sharing coffee, and conversations. Survivors attend group sessions, fostering relationships and solidarity among women.

Creates holistic safety for survivors and health facilitators: The HAL approach addresses harmful cultural beliefs and raises community awareness to reduce stigma, promoting a supportive and safe community network. The programme also involves influential community figures to foster empathy and behaviour change. HAL encourages community leaders and service providers to address security issues, ensuring safety for survivors. In addition, safety is central in the lay-out of structured sessions that ensure that survivors share the effects of trauma without re-traumatisation, while health facilitators may refer individuals needing more in-depth help to case managers for further support. Continuous reflection on and documentation of the programme's impact on individuals' well-being helps create evidence on the effectiveness and helpfulness of the methodologies used.

Promotes self-efficacy and community efficacy: The community approach allows for experiences of how survivors and community leaders can be of help in the healing of others. Facilitators, who are survivors themselves, lead groups, fostering a sense of empowerment. Group formation after healing sessions leads to income-generation and a reconnection to livelihoods. Local specialists help women develop sustainable livelihood projects.

Instils hope: HAL sessions help women feel psychologically empowered to continue with livelihood support. Linking women with microfinance agencies provides sustainable financial support, thus fostering survivors' hope for a better future. The programme equally emphasises the benefits of reconnecting to pre-war agricultural practices, providing an experience of continuity in the midst of destruction.

Emphasises self-care of helpers: Awareness about secondary trauma and stress-related problems is prioritised for staff. Weekly reflection sessions for facilitators help prevent stress-related burnout and secondary trauma.

Using the "Bible-based approach" with comprehensive referral and continuity of care system in a vocational training centre: Daughters of Charity Vocational Training Centre

The Daughters of Charity offer a six-month vocational training programme with classes in food preparation, tailoring, and dressmaking. Trainees are referred by local administrators, the Women's Association, and hospitals. Their approach combines various methods, with a central focus on the "Bible-based approach". Two sisters are trained as master trainers. The Daughters of Charity's implementation of this "Bible-based approach" at the vocational training centre is considered a "best practice" due to its comprehensive nature, incorporating trauma-sensitive elements and consistent referrals to specialised services, even within their own premises.

Every staff member has gone through the healing process and is aware of trauma, which contributes to the successful vocational training

All staff members at the Daughters of Charity have attended a five-day "Bible-based approach" workshop to understand both their own and the trainees' trauma. A staff member highlighted, "We are all traumatised." Without personal recovery and self-care, it is difficult to manage the emotional burden of trainees' trauma. During our focus group, we learnt that some trainees experience overwhelming memories and dissociative states during lessons. Some require ongoing psychotropic medication and need special attention to maintain concentration. Instructors closely monitor trainees' reactions to help stabilise them. Trainees noted the attentiveness at the centre, with staff addressing signs of tiredness or grief, offering support, and involving the sisters when necessary. They emphasised that this constant, caring approach – 'with love,' as they call it – enabled them to study for six months. During the focus group discussion, survivors equally shared how they began the process unable to concentrate. By the end of the training, however, one proudly said, 'I started my own food shop.' They expressed pride in being able to support their children with their new livelihoods.

> *'I feel safe here.'*
>
> *Respondent FGD at the Vocational Training Centre, Daughters of Charity*

Five-days workshop at the beginning of the training providing a sense of hope, recovery, and community building

The vocational training at the Daughters of Charity begins with a five-day "Bible-based approach" workshop. Trainees, both male and female, participate together, facilitated by the sisters. These sessions are essential for fostering hope, recovery, and community building. Initially, there were concerns about mixed groups due to the diverse traumas of participants, including sexual violence survivors. However, experience showed that a mixed setting was beneficial, as we also heard from survivors in the focus group discussion. It helped survivors to feel part of a broader community, reducing isolation and fostering mutual understanding. According to a key informant at the Daughters of Charity, they observed during the mixed-group training that male participants empathetically felt the pain of the survivors and understood the cruelty of the perpetrators. This seemed to increase their respect for women and girls. Speaking openly about experiences of violence in front of male participants, on the other hand, seemed to help lifting the stigma and silence that both the men and the survivors associated with accounts of GBV.

Cooking class at Daughters of Charity Vocational Training Centre

During the focus group, female trainees shared that the workshop instilled hope and motivation, which they initially lacked. Exercises from the workshop, like trauma healing and self-forgiveness, were particularly impactful. One trainee valued the mirror exercise for self-appreciation, while others highlighted the sense of belonging and understanding their suffering was shared globally. A "burning of bad memories" exercise was frequently mentioned as especially helpful.

> *'We found strength within ourselves.'*
>
> *Survivor of sexual violence explaining the impact of the "Bible-based approach"; focus group discussion Daughters of Charity*

Consistent referral for more specialised psychological care is needed: psychologist at the vocational training centre for counselling and referral to Ayder Referral Hospital

A psychologist at the vocational training centre provides counselling and referrals to other service providers. Trainees seeking deeper psychological conversations or showing strong trauma and depression symptoms are seen by a male psychologist. Female survivors in our focus group expressed feeling supported by his kind and accepting approach. Surprisingly, having a male psychologist was particularly beneficial for some, as acceptance from a man in a patriarchal society that often blames GBV survivors added significant value. Phrases like 'He is a good person,' 'He helped us,' and 'I am glad he is male' illustrated this sentiment. Many attend weekly counselling sessions with the psychologist, and those preferring a female counsellor approach the sisters. Counselling is available on Tuesdays and Thursdays, both individually and in groups. The psychologist follows a structured process, including rapport building, awareness, intervention planning, and regular follow-ups throughout the six months of vocational training. Survivors shared how they struggled to concentrate initially but, by the end of the training, could achieve milestones like starting their own businesses. They took pride in supporting their children with their newfound livelihoods. The Daughters of Charity collaborate closely with other organisations for additional support, referring cases to Ayder Referral Hospital for psychotropic medication and the One Stop Centre for further health support. This collaboration is crucial, as survivors face numerous health and trauma-related mental health problems, requiring treatment and medication for conditions like hypertension, sleeplessness, anxiety, and panic attacks.

Why the holistic vocational training centre approach using the "Bible-based approach" of the Daughters of Charity can be considered a best practice:

Promotes safety for survivors: All teachers, instructors, and staff are trained to understand trauma dynamics. They can detect strong emotional responses in trainees and know how to stabilise them, referring them to the psychologist or sisters when necessary. In addition, the psychologist at the vocational training centre offers a secure environment for trainees to discuss deep trauma and depression. Female survivors, in particular, find his accepting approach comforting in a patriarchal society. Moreover, aspects of economic security are of utmost importance for survivors: the vocational training aims to create economic security for trainees, especially survivors, protecting them from abuse or exploitation. This economic stability also benefits their children, allowing the women to care for them with their new income.

Fosters strong connections: The five-day "Bible-based approach" workshop features extensive group discussions, fostering bonds among trainees from the start. This helps them to become friends, learn to trust again, and support each other. Regularly accompanied counselling sessions strengthen the sense of connection among trainees. Survivors appreciate the supportive environment, emphasising the importance of being understood and accepted.

Contributes to self-efficacy and community efficacy: Vocational training and the opportunity to start a business provide a therapeutic experience of self-efficacy. Structured counselling and regular follow-ups help trainees to learn to trust themselves and to believe they can influence their lives, even after experiencing extreme terror and helplessness.

Establishes a community of care: The supportive community, including referrals to other organisations, enhances community efficacy, turning the vocational training into a community of care.

Instils hope: The combination of training, "Bible-based interventions", counselling, and collaborative efforts instils hope in survivors. By the end of their training, many feel empowered, proud of their progress, and find motivation and purpose in their lives. For trainees who arrive feeling hopeless after enduring tremendous horror, this transformation is a profound experience of healing.

6.2.5 MHPSS-related activities at level 4 in Tigray: specialist services at Ayder Referral Hospital

Before the war, Ayder Referral Hospital's psychiatry ward and outpatient department mainly dealt with schizophrenia, major depressive disorder, and anxiety disorders. But since the conflict began, the psychiatrists at Ayder Hospital have noticed a significant rise in cases of PTSD, major depressive disorder, psychosis, brief psychotic disorder, functional neurological disorder, and relapses of various mental health conditions due to service shortages. They frequently encounter PTSD co-morbid with depression or anxiety and a high number of patients with substance use disorders. The number of outpatient visits for mental health issues has skyrocketed during and after the war.

> *In the Tigray region, there are only four specialist psychiatrists... This means there are only four psychiatrists available for a population of over 5 million people.*
>
> *Key informant at Ayder Referral Hospital*

The hospital's main approach involves prescribing various psychotropic drugs, with antidepressants and antipsychotic drugs being the most common. However, they faced significant interruptions in their drug supply during the war, which has impacted treatment success. Previously, they also offered psychotherapy facilitated by clinical psychologists, but in the past year, many psychologists left for higher salaries, limiting services to psychiatric care only. Key informants mentioned they see around 78 patients daily at the Outpatient Department, along with many follow-up patients.

Ayder Hospital extends psychiatric support to other hospitals and rehabilitation centres with limited resources, such as Awash Hospital, MIT Centre, Meles Campus, Veterinary Campus Centre, Kelamino Hospital, and the Northern Command Hospital. Psychiatric nurses play a crucial role in these locations, managing cases, prescribing medications, and offering counselling after receiving mhGAP training. Despite their efforts, the support is insufficient given the high caseload at Ayder Hospital. The psychiatrists expressed a need for additional psychotherapy training, including Narrative Exposure Therapy (NET) and trauma-focused Cognitive Behavioural Therapy (CBT), to help bridge the gap in the lack of psychotherapy services.

Ayder Referral Hospital has a strong partnership with Church organisations like the Daughters of Charity. These partners refer clients who need psychiatric support and medication refills and offer additional psychosocial support. However, the infrastructure for psychiatric services at the hospital is inadequate, not providing a comfortable or patient-friendly environment.

6.3 Recommendations for adjusting and scaling up MHPSS activities in Tigray

Based on our analysis and key informant recommendations, here are several key considerations for adjusting and scaling up MHPSS activities in Tigray. These recommendations are directed not only at donor organisations working with Church-based actors but also at all donors and international organisations involved in implementing MHPSS-related programmes. While they are particularly relevant to Tigray, given its (mostly) post-conflict setting, some of them may also be applicable to other regions, such as Oromiya, Amhara, and beyond.

- **Scale up the provision of basic services, food security, medical support, and livelihood support as part of all MHPSS activities in Tigray:** The humanitarian needs in Tigray, especially among IDPs and people in heavily impacted areas, remain high. Providing assistance with basic needs to vulnerable groups and IDP camps, as well as communities severely affected by the war, is crucial for mental health. Healing is about safety and empowerment, which are impossible without addressing hunger and loss due to starvation.
- Establish best practices to prevent dependency on humanitarian aid while fostering community cohesion and self-efficacy. One way to combat dependency is to engage the communities directly in discussions about their role in overcoming it. By using psychosocial methods that enhance experiences of community efficacy and by working with community-formed steering committees, the beneficiaries themselves can be involved in addressing and solving the issue of dependency. This approach not only

empowers the community but also ensures that solutions found are more sustainable and tailored to their specific needs.

- Offer ongoing medical care to survivors of sexual violence, as well as to ex-fighters who are particularly affected by the long-term effects of their injuries and disabilities.
- Encourage livelihood activities familiar to the region to reconnect people with pre-war life and culture. Involve community members in training and advising.
- For vocational training centres: Support trainees' families to prevent discouragement and drop-out due to family dependence on trainees. Adjust schedules and offer flexible training schemes that allow trainees to also secure their basic needs. Establish day care facilities for trainees' children within the training centres.
- For rehabilitation centres for survivors of sexual violence: Create mechanisms to support families and children at home, enabling women to stay in treatment. One helpful idea could be to offer day care for the children of participating women.

- **Scale up youth interventions with vocational training and MHPSS, focusing on ex-combatants:**
  - Train instructors in vocational training institutions in trauma awareness and Psychological First Aid (PFA) to stabilise trainees in distress and undergoing flashbacks.
  - Start with an intense group formation workshop using psychosocial interventions, followed by activities like a buddy system, regular informal discussions, and stress management sessions.
  - Recruit psychologists for vocational training centres for counselling, life skills training, and supervising instructors, or establish a referral system to clinical psychologists and psychiatrists.
  - Include sports activities that promote relaxation, mastery, and team experience, with vocational training students trained as facilitators to engage in trauma-sensitive sports with community youth.
  - Organise regular consultations with Ayder Hospital psychiatrists to discuss complex cases and provide training on addiction and suicide prevention.
  - Create follow-up systems for youth returning to communities, forming support groups, and offering continued counselling.

- **Scale up the community approach of MHPSS in violence-affected communities and IDP camps. Recommended strategies include the ACT Alliance Approach CBPS, HAL, Self-help Plus training for stress management (translated into local languages), and the INSPIRE toolkit.**
  - Use a survivor-centred approach with initial interventions, in-depth training of trainers (ToT), and regular follow-ups, enabling survivors to become group facilitators.
  - Raise awareness among community leaders about the psychosocial needs of survivors, non-stigmatisation, women's rights, and confidentiality.
  - Train project staff in case management and basic counselling skills to support survivors needing more help.
  - Encourage group members to volunteer, identifying and referring community members in need of support.
  - Integrate stress management and sports activities into community or IDP camp projects.
  - Include income-generation and skills training in community groups to sustain engagement and project post-sessions.
  - Establish referral pathways to hospitals for psychiatric care and addiction counselling.
  - Conduct regular mobile clinics with psychiatrists and clinical psychologists for remote consultations.

- **Scale up and increase standards for the "Bible-based approach":** The "Bible-based approach" effectively raises awareness among religious leaders, promoting acceptance, non-judgment, and empathy. We recommend scaling up with the following enhancements:
  - Rename to a more inclusive name ("faith" instead of "Bible") and with a more realistic programme ("awareness" instead of "healing"), such as **"Faith-Inspired Approach to Trauma Awareness."**
  - Develop a manual with texts from the Bible, Quran, and other holy books, promoting healing through compassion and inclusion. Include methods suitable for various settings.

- Offer a minimum of 3-4 days of training with a maximum of 25 participants to allow for follow-up on distressed participants.
- Establish a monitoring system with pre-tests and post-tests to measure psychosocial issues, ensuring interventions are effective and sustainable.
- Create a referral system for participants needing specialised psychosocial care.
- Conduct regular peer supervisions for trainers to handle difficult cases and share experiences with the faith-inspired trauma awareness in the region.

- **Train religious actors in psychosocial methodology:** Given the importance of faith in coping with life's challenges, it's crucial that religious leaders are equipped with adequate knowledge. This includes changing community perceptions on gender, women's rights, and violence against women, often backed by religious ideas. Topics for psychosocially enhanced theological training could include:
  - non-judgmental listening, empathy, and empowerment;
  - understanding and accepting highly stigmatised traumatic experiences;
  - basic counselling skills;
  - core knowledge on psychiatric problems (and how to detect them) and effective treatment referral;
  - integrating faith-based interventions with modern psychological concepts.

- **Scale up intense care facilities for GBV survivors, framed in non-stigmatising ways:** Frame facilities as "women's health centres" or "community health centres" to be inclusive and reduce stigmatisation. Community centres could also serve other vulnerable groups, promoting a collective healing approach.

- **Establish trauma-informed leadership and trauma sensitivity as cross-cutting approaches:** Implement trauma-informed leadership and practices across organisations in Tigray. This will improve service quality and create a supportive working environment for staff affected by personal experiences of the war.

- **Encourage Church-based organisations to join the Regional Technical Working Group and strengthen coordination:** Church-based organisations should participate in the Regional Technical Working Group, holding regular learning events and peer supervisions to share experiences, resources, and challenges. It is particularly important to raise awareness amongst stakeholders on the potentials of local approaches that are sensitive to culture and context, while learning from more evidence-based approaches about their systems of monitoring, evaluation, and research. Strengthening coordination is vital to address the high MHPSS needs effectively.

- **Increase capacity for specialised services:** Train more psychologists and psychiatrists for Tigray. Continue providing mhGAP training to health centres, focusing especially on remote areas.

7 LIVING WITH ONGOING INSECURITY AND DISPLACEMENT: FINDINGS FROM AMHARA AND OROMIYA

The Amhara and Oromiya regions continue to face active conflicts and security challenges, in contrast to the relative stability observed in many areas of Tigray following post-war recovery efforts after the Peace Agreement in Pretoria. Against this backdrop, our objective is to provide a joint analysis of both Amhara and Oromiya. While these two regions will certainly differ in many aspects, a common thread relevant for MHPSS programming is the prevailing insecurity in both regions, which hinders consistent MHPSS programming, and the significant presence of internally displaced persons (IDP) camps that produce ongoing life stress.

7.1 Findings for Amhara and Oromiya regions regarding vulnerable groups, prevalent psychosocial problems, existing traumatisation processes; challenges and needs related to MHPSS programming

It is important to note again the limitations of this section. Our research faced challenges in obtaining a comprehensive understanding of mental health and psychosocial support (MHPSS) needs and services in both Amhara and Oromiya due to travel restrictions and ongoing insecurity. Visits to Bahir Dar and Debre Birhan in the Amhara region provided some insights into the situation on the ground. Additional interviews, conducted in person in Addis Ababa and remotely in both regions, with organisations and staff working in these areas aimed to supplement the data. The following insights reflect the vulnerabilities most frequently identified during data collection, which are thus well-supported through triangulation, and the specific features of psychosocial problems and traumatisation dynamics in Amhara and Oromiya as shared by key informants from partner organisations in this study. These partners include EOTC-DICAC and EECMY-DASSC, which have significant humanitarian interventions in the regions with their special CBPS approach (ACT Alliance). The information is supplemented with insights from other NGOs implementing MHPSS projects and from the two regional health bureaus. Additionally, first hand data was gathered from Focus Group Discussions conducted in Debre Birhan (Amhara) with women in the Women's and Girls' Safe Space (EOTC-DICAC) and in Bahir Dar (Amhara) at the Catholic Eparchy of Dessie with a mixed group of religious leaders and governmental organisations.

7.1.1 Particular psychosocial vulnerabilities in Amhara and Oromiya

Women heading households and survivors of SGBV in IDP settings and beyond

Due to gendered roles and responsibilities, women in IDP settings are particularly vulnerable, as highlighted in all our key informant interviews for both Oromiya and Amhara. This is especially true for women-headed households, due to the emotional pain inflicted on them through loss, injury, or separation from their husbands, but also because of the economic and social vulnerability this creates for them.

> *I can't sleep at night. I am afraid. I have a 9-month-old baby, 7 children; in my mind I am not normal.*
>
> *Focus Group at China Camp, Debre Birhan*

Women in IDP camps assume multiple roles related to caregiving for children, the elderly, or sick relatives while also ensuring that basic needs like food, water, shelter, and health are met. Additionally, many women and girls have survived SGBV during the fighting in their places of origin, and camp life itself comes with insecurity, stress, lack of privacy, and limited space for families. We witnessed this firsthand during our visit to China Camp in Debre Birhan with a team from EOTC-DICAC. Interestingly, during our visit, the government ordered the IDPs to return to their original homes in Oromiya, which they feared more than staying in the camp under extremely difficult circumstances.

SGBV related to armed conflict and within families and communities was consistently mentioned as a major conflict-related mental and physical health concern in Amhara during our interviews and the

Lack of space and privacy, China IDP camp, Debre Birhan

Focus Group Discussion in Bahir Dar. Cultural barriers prevent many survivors from reporting crimes or seeking help. Those who reach out for support find it scarce, as the conflict has strained resources and made access to services challenging. Furthermore, community stigma associated with GBV exacerbates the suffering, leading to self-imposed isolation and untreated psychosocial problems. The cultural context presents significant obstacles for survivors, as societal norms stigmatise and shame them, discouraging them from coming forward. They often fear ridicule or blame more than the violence itself. One interviewee in the focus group discussion in Bahir Dar mentioned a higher suicide rate among GBV survivors, a statement that coincides with other key informants and research literature.

Even if IDPs' compounded psychosocial stress and complex traumatisation processes are particularly prominent in conflict-ridden places in Amhara and Oromiya, we also observed similar issues in non-conflict areas of Oromiya, such as in Sendafa. Here, we held a focus group discussion with mothers of small children who were supported as part of an EECMY project. One mother's experience of violence can be summarised by her quote: 'I am traumatized by my husband.' The mothers' level of emotional stress and depression is so high that many prioritised the need for more specialists to provide counselling, as casual group discussions did not suffice for their severe psychological suffering. Additionally, many women shared that their children are malnourished due to violence at home, especially children with disabilities who are neglected by their husbands. Many reported experiencing economic violence, and some men abandoned their wives and children altogether, leaving them vulnerable to poverty and abuse. Some respondents in the focus group showed us physical wounds from severe and regular beatings and spoke of high levels of depression and chronic insomnia related to their experiences at home. Beyond the scope of this study, we want to highlight the need to consider scaling up MHPSS beyond the conflict settings present in Ethiopia.

Children and youth in IDP settings

Staff members from EOTC-DICAC in Debre Birhan shared vivid accounts of the vulnerabilities faced by children and young people in IDP settings. With no perspective for a safe future, these children lose their sense of safety, stability, and nurturing bonds essential for their development. Many have become half or full orphans, and no longer have caregivers who can protect and support them. They witness or experience violence, abuse, neglect, or exploitation in the camps. This is also the case in the China IDP camp in Debre Birhan, where the absence of educational opportunities hampers cognitive development, affects future prospects, and increases feelings of hopelessness, driving the children to seek escape either physically or psychologically.

Also in Bahir Dar's Focus Group Discussion with inter-religious leaders and institutions related to security and health, children and youth were described as particularly vulnerable to psychosocial stress and traumatisation due to displacement, insecurity, and lack of prospects. For example, key respondents reported that children generally developed an increased fear of loud noises, mistaking them for explosions. Their poverty-ridden family backgrounds make them prone to more stress and to malnourishment, as reported by the Daughters of Charity in Bahir Dar. One nutritious meal per day was reported as an investment not only in their physical health, but also in their mental health, necessary for their capacity to learn.

The youth, disrupted from their education and normal routines, face a heightened risk of engaging in harmful behaviours like alcohol and substance abuse due to the lack of structured activities and support systems, leading to a sense of hopelessness about their future. The closure of educational institutions means that children and youth are deprived of the structure and safety that schools provide for their healthy functioning.

According to a key informant from the African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN) Ethiopia working in Amhara, girls face double vulnerability due to the general hopelessness and gendered lack of protection from sexual abuse and exploitation. The

Daughters of Charity in Bahir Dar mitigate this risk by organising school bus services to ensure safer transportation for girls.

The heightened vulnerability of children and youth is supported by a needs assessment conducted among children and adolescents in Alemwach IDP camp (Amhara) in 2023. [70] The study found that 48% of young respondents experienced mental health problems, with feelings of hopelessness, sadness, and flashbacks being most prominent. Displacement (61%), GBV (51%), insecurity (43%), and long stays at the camp (41%) were cited as main causes. Additionally, excessive anger, learning difficulties, suicidal and self-harming behaviours, relationship problems, and family conflicts were common psychosocial issues among the children and youth. The camp population also reported common issues like fighting, alcohol and substance abuse, and GBV. Among the youth, alcohol and substance use were identified as both a mental health problem and a coping mechanism. Alarmingly, 5.9% of respondents said they had experienced suicidal ideation at the time of the research, while 31% reported they had attempted suicide in their lifetime. Factors that lead to suicidal ideation or attempts include exposure to violence and war, multiple displacements, limited access to basic needs, separation from family or relatives, loss of loved ones during flight, experiencing or witnessing physical and sexual violence, stressful life circumstances, family conflicts, and lack of community support. Interestingly, family members, humanitarian workers, and religious leaders were identified as common sources of support, with praying, talking to someone, fearing God's judgment, and thinking about the family serving as protective factors against suicidal tendencies. However, the study also indicated that children suffering from mental health challenges often face neglect, discrimination, and abuse within their families and communities.

7.1.2 A selection of identified salient psychosocial issues for Amhara and Oromiya

Compounded distress of both past and ongoing violence and life-stress

In our focus group discussion and key Informant interviews in Debre Birhan's IDP camp, the prevailing psychosocial problems of the population were reported as complex and multifaceted. Firstly, IDPs suffer from the traumatic loss of loved ones due to armed conflict and the violence they have been exposed to, including pervasive sexual and gender-based violence. Additionally, they face psychosocial challenges related to camp life, such as the lack of basic needs, including hygiene, which regularly leads to disease outbreaks like cholera. The overcrowded living conditions, the lack of personal and family space, and the loss of hope contribute to domestic violence and substance abuse, creating vicious cycles of suffering. Moreover, the prospect of returning to their places of origin seems worse than staying in the camp. Despite the harsh conditions, IDPs report feeling more secure in the camps, where they have some level of services.

When I enter this place (i.e., in the tent of the Women's and Girls' Friendly (Space), I feel free. When I go out again, I feel sad. We have so many problems.

Women respondent in FGD Debre Birhan

These compounded stressors make MHPSS interventions highly complicated. While activities may temporarily alleviate stress, the ongoing hardships of camp life continue to cause more pain and suffering. Sustainable changes in their actual living conditions are necessary for long-term relief.

Drought-related psychosocial problems in some affected areas

Drought-related psychosocial problems in some affected areas have significantly added to the survival stress experienced by residents, according to a key informant from EECMY-DASSC. In places like the Borana zones in Oromiya, chronic drought has caused residents to lose their livestock, a primary source of livelihood. This loss has led to hunger and the death of family members, particularly those who are physically vulnerable, such as the elderly and children. Witnessing loved ones die slowly from hunger is a major traumatising experience, made worse by the inability to alleviate their suffering. Hunger is severe physical stress and may exacerbate domestic violence; it is also likely to increase the incidence of child marriages, which are seen as a cultural coping strategy to reduce the number of mouths to feed. Furthermore, the scarcity of resources has led to increased intra-communal and inter-communal violence, as people fight for survival.

In the midst of the Borana drought, a family lost all their cattle except for two. A young boy was responsible for herding the two cows, but when both animals perished, he committed suicide. The EECMY-DASSC team intervened, providing Psychological First Aid to the family, cash support to replace some of the lost cattle, and other assistance.

Example quoted during Key informant interview with EECMY-DASSC

Collective traumatisation and grief combined with ongoing mistrust

Participants from the Focus Group in Bahir Dar, which included religious leaders, health and security institutions, and programme managers from the Catholic Church, emphasised the widespread concern for mental health and psychosocial support (MHPSS) across society. They noted that stress and anxiety are prevalent in war-affected areas, with symptoms of PTSD, such as nightmares and flashbacks, being common. Additionally, they highlighted the widespread grief experienced by nearly every family due to the loss of a family member. This pervasive grief leads to depression and prolonged emotional distress throughout communities. The described collective trauma is compounded by social issues stemming from large-scale displacement, unemployment, and the destruction of livelihoods. An integrated response that includes both mental health interventions and economic assistance is necessary in this situation. According to the focus group participants, societal trust has been severely undermined by the impact of war, which has eroded trust within communities and compromised the rule of law. The pervasive fear and insecurity, exacerbated by the presence of armed individuals, have led to insomnia, hypervigilance, and nervousness among the population.

Suicides as a major mental health concern in Amhara

Data from the Amhara Public Health Institute's (APHI) resilience and recovery team indicate a serious mental health crisis in the region. A 2023 assessment (unpublished) revealed that in the first six months of that year, 2,615 people in Amhara attempted to poison themselves with chemicals, resulting in 109 deaths. This alarming trend has continued into 2024, with 99 people committing suicide (until end of March 2024) and around 200 attempting suicide in March alone. Research from this assessment showed that 70% of those who attempted or committed suicide were female adolescents, averaging 25 years old. The primary factors driving these suicides were family or relationship problems and socio-economic challenges. The APHI has prioritised suicide prevention as a public health emergency, noting that deliberate self-poisoning has dramatically increased since 2022 due to the emotional distress young adults face following complex humanitarian crises. The APHI key informant highlighted that experiences of gender-based violence may also have contributed to some of these suicides.

7.1.3 Needs and challenges related to MHPSS programming in Amhara and Oromiya

Several challenges regarding mental health and psychosocial support (MHPSS) in Amhara and Oromiya were shared by service providers and during the quoted Alewach needs assessment. Some challenges are common to both regions, while others are more prominent in one of them. These issues need to be considered when formulating recommendations.

Lack of over-all coverage in MHPSS activities

There are significant gaps in mental health and psychosocial support (MHPSS) services at all levels. In our discussions and interviews, the scarcity of MHPSS services was consistently highlighted, particularly in Oromiya. For instance, women in Sendafa called for more specialised counselling services due to the widespread domestic violence, while women and girls in the IDP camp in Debre Birhan requested additional safe spaces. A major barrier to effective MHPSS services for IDPs in Oromiya is the severe shortage of skilled and experienced mental health professionals. The regional health bureau reported that the vast majority of the region's over 1,450 health facilities lack dedicated MHPSS experts or even personnel with basic training in this field. Only 36% of the region's 107 primary hospitals offer any mental health services, underscoring the critical understaffing crisis.

Humanitarian interventions are needed, but not sustainable

The Amhara Regional Health Bureau emphasised that while humanitarian aid is crucial, it is not a sustainable solution. Although humanitarian assistance, including food and cash distribution, is essential, it fails to provide the population with a lasting sense of purpose or a viable future. Humanitarian projects are often short-term, typically lasting around six months. They are then completed, leaving a gap in essential services. This short-term nature of the interventions contrasts sharply with the need for stability and reliable services that individuals in insecure circumstances have. For example, during a Focus Group Discussion in Debre Birhan's IDP camp, some women receiving psychotropic medication for severe depression and PTSD were informed that the organisation providing the medication was about to cease operations. Consequently, these patients would have to seek medication from health centres that may not offer consistent support. The lack of continuity in humanitarian

interventions undermines the recovery process, particularly for those who have been severely uprooted by displacement.

Gaps in support for children and adolescents and inconsistent medication for the treatment of serious mental health problems

The needs assessment conducted in Alewach camp highlights significant gaps in support for children and adolescents, particularly regarding trauma-informed interventions. There is a shortage of targeted psychosocial support services, limited information and awareness about mental health, coping skills, and available services. In the absence of educational and livelihood opportunities, as well as safe spaces such as child and youth centres and women and girls' safe spaces, children and youth struggle to stabilise and are at risk of developing long-term and chronic issues if their needs are not addressed. The alarming rate of suicides among young women in Amhara further underscores the severity of the problem. Additional gaps include inconsistent access to psychotropic medications and general MHPSS services. This inconsistency often leads to relapses among children and youth with existing severe mental health conditions, exacerbating their struggles and undermining their overall well-being

Lack of community-based interventions

The ongoing trauma and insecurity at the community level are compounded by a severe lack of psychosocial support activities. This situation is exacerbated by the stigma faced by survivors and the struggle of families and communities to meet basic needs. In such settings, community-based support is notably absent. Community-based interventions are crucial as supplementary aftercare for survivors of gender-based violence. Even when individuals receive the best rehabilitation and stabilise, they often return to communities where stigma and discrimination persist, further deteriorating their mental health. In rural areas, the absence of access to and awareness of MHPSS activities is particularly concerning. According to the Focus Group Discussion in Bahir Dar, rural settings face more severe psychosocial stress than urban areas. While urban areas benefit from a better provision of services due to various mental health actors, rural regions suffer from security challenges that impede access to care. Additionally, there is a tendency among rural families to conceal mental health issues, compounded by a lack of awareness about available interventions.

Ongoing insecurity and lack of perspective upon return to original homesteads

Efforts to facilitate the return of internally displaced persons (IDPs) must carefully consider the security situation in their areas of return. Ensuring access to essential services for these returnees is crucial for their successful resettlement. It is equally important to address mental health and psychosocial support needs. Individuals returning to their original homes have faced significant challenges before displacement, and the path to restoring hope and livelihoods is long and complex. Therefore, a coordinated response across mental health, livelihood support, infrastructure, and security domains are essential.

The lack of income-generating possibilities related to displacement

Much of the suffering in IDP camps, both in Amhara and Oromiya, stems not only from past traumatic experiences but also from the harsh living conditions within the camps, including a heavy reliance on humanitarian aid. International research suggests that income generation and self-reliance can significantly mitigate post-traumatic suffering. Even if comprehensive MHPSS services are provided, the absence of income-generating opportunities can exacerbate destructive psychosocial dynamics both for individuals and families.

Self-care and dealing with insecurity of (humanitarian) staff members

In contexts of ongoing insecurity, the high levels of stress and fear experienced by humanitarian staff are as critical as those faced by the displaced population. Key informants have emphasised the need for regular, structured support for helpers to manage their stress effectively and remain effective in their roles. Organisations should implement staff care and team care policies, ensuring that workers have regular breaks from high-stress environments. Additionally, providing training in stress management and creating

In conflict situations like those in Amhara and Oromiya, psychosocial work must prioritise meeting basic needs to reduce survival stress and establish a sense of safety and stability. This includes protecting individuals from further violence – both from ongoing conflict and interpersonal violence within families and communities. Without improving these conditions, psychosocial interventions provide only temporary relief. Effective psychosocial support should focus on building resilience through community empowerment and reconnecting with traditional practices that foster belonging and continuity.

opportunities for team members to share their concerns and challenges are vital for maintaining a supportive and effective work environment.

7.2 MHPSS approaches and best practices: lessons learned from Amhara & Oromiya regions

Our objective here is to highlight the approaches and best practices related to the projects of the partner organisations of this study, as identified through our key informant interviews and focus group discussions. While some approaches may be applicable to both regions, we aim to distinguish them to achieve greater accuracy. It is important to note that the descriptions provided are exemplary and not exhaustive and can therefore not reflect the complex and regionally diverse situations in both Amhara and Oromiya.

7.2.1 Findings from Amhara region

According to the EOC-DICAC/RRAD / FELM mapping exercise from December 2020, 57 out of 164 service-providing agencies in Amhara were active in MHPSS. Most of these activities fall under Level 2 services, which involve facilitating community support mechanisms and have a strong child-focused component. At Level 3, interventions include focused psychosocial support, such as basic counselling and Psychological First Aid, but structured psychosocial interventions by non-specialised professionals are relatively scarce. Specialised services, including psychological and clinical interventions for mental disorders, are even rarer. There is a recognised need for more specialised services across the country, including in Amhara.

Our field visits and remote interviews during the research in February 2024 largely corroborate these findings. The Amhara Public Health Institute highlights that the ongoing conflict and inaccessibility of many areas make it challenging to implement comprehensive, impactful interventions. Apart from the deployment of multi-disciplinary mobile teams funded by UNICEF over the past two years, most interventions in Amhara are confined to IDP centres and remain limited in scope.

We have categorised the MHPSS strategies and approaches found in organisations active in Amhara according to the IASC pyramid, which includes four levels.

7.2.1.1 Over-all coordination of MHPSS activities and capacity building in Amhara

In Amhara, the MHPSS and GBV Technical Working Group, co-chaired by the Amhara Public Health Institute and the Amhara Regional Health Bureau, oversees the coordination of mental health and psychosocial support (MHPSS) activities. This group includes key emergency aid and funding partners such as UNICEF and UNFPA, as well as universities operating in the conflict-affected areas, including Gondar University, Debre Birhan University, Wollo University, and Debre Tabor University.

Capacity building for service providers is crucial for scaling up interventions and enhancing the effectiveness of existing ones. The Amhara Public Health Institute highlighted several initiatives aimed at improving MHPSS services. For instance, mhGap training and self-help group approaches are being utilised to increase service capacity. Among the various initiatives mentioned by the key informant from the Amhara Public Health Institute, WHO is training individuals in healthcare settings to expand mental health services down to the community level. Despite this, the supply of psychotropic medication remains a significant challenge. According to the Regional Health Bureau, this training is crucial in the absence of mental health specialists. Additionally, the regional health bureau, in collaboration with the Amhara Public Health Institute, is actively training health professionals to better identify and assess mental health and psychosocial issues in the region.

In Bahir Dar, the Conflict Transformation and Implementation department, along with the Ministry of Peace, has provided psychosocial support training for local officers to help them identify individuals in need of MHPSS. However, the lack of follow-up support suggests a need for ongoing assistance to ensure the effectiveness of these training programmes.

Furthermore, Amanuel Hospital in Addis Ababa, in collaboration with the Ethiopian Psychologists Association, has been involved in conducting assessments, training, and awareness-raising activities to address the mental health needs of displaced persons. UNICEF has supported these efforts by providing both financial and technical assistance.

7.2.1.2 MHPSS-related activities on level 1 in Amhara: basic needs and security / MHPSS mainstreaming

Given the ongoing insecurity and displacement in the region, the first level of MHPSS interventions is especially critical. Most organisations in the area focus on humanitarian work, and those engaged in higher-level MHPSS activities also provide essential humanitarian assistance. For instance, the Catholic Diocese in Bahir Dar has played a key role in offering services to internally displaced persons (IDPs) in the Amhara region. Their efforts to address the basic needs of displaced individuals are commendable, even if they face challenges due to limited resources. However, there is currently a lack of structural integration of MHPSS into broader humanitarian efforts.

7.2.1.3 MHPSS-related activities on level 2 in Amhara: community and family supports

We identified several project activities related to Level 2 MHPSS interventions that we present here as good practices given the context of ongoing insecurity. While this is not intended to be a comprehensive overview, it provides valuable insights into the potential of MHPSS services in protracted conflict scenarios and may inform future interventions in the region.

Economic empowerment and income generation for women facing psychosocial challenges

The **Jerusalem Children and Community Development Organization (JeCCDO)** in Bahir Dar has implemented a psychosocial support approach focused on the economic and social empowerment of women. This approach includes a robust referral system for addressing more complex mental and psychosocial issues. The programme aims to empower women by facilitating their participation in Income Generating Activities (IGAs), assisting with business plan development, providing financial support, and offering ongoing technical guidance. Additionally, the programme features a peace-building and rehabilitation component. Selected women are organised into groups to discuss important topics such as rehabilitation, forgiveness, healing, and self-sufficiency.

JeCCDO has also developed a comprehensive rehabilitation and reintegration programme specifically for one particularly vulnerable group: commercial sex workers. As sex work has become a means of livelihood for many women and girls due to recent conflicts, this six-month programme offers a number of integrated services that also alleviate the underlying structural causes. These include spiritual encouragement from religious leaders, psychosocial support from psychologists and social workers at the JeCCDO Bahir Dar centre, vocational training, and seed capital support to assist with reintegration following the programme's completion.

Community-based approaches supporting different vulnerabilities

Several NGOs active in Amhara have developed innovative community-level interventions to address different vulnerabilities. Agar's Rehabilitation Centre, for example, has implemented valuable lessons learned in Bahir Dar. They deploy their staff to war-affected areas, such as South Gondar and North Wollo zones, to assist survivors with reintegration into their communities. Women and girls who have been sexually assaulted during conflicts often face significant stigma and discrimination upon returning home after their rehabilitation. To tackle this issue, Agar's Centre conducts targeted community awareness campaigns with the active involvement of local community and religious leaders. These community-based teams are deployed for typically six months, significantly impacting survivors' ability to lead fulfilling lives and bridging the awareness gap within their communities.

In addressing the ongoing psychosocial challenges faced by children and their families, the NGO ANPPCAN offers a range of support services aimed at reducing vulnerability and preventing additional trauma. One notable initiative under their Level 2 activities is the provision of multi-purpose cash assistance as part of a family support intervention tailored to the needs arising from the conflict. Psychologists from ANPPCAN lead community dialogues focused on social cohesion, peace-building, and exploring community support options. They also conduct discussions on parenting skills and caregiving within these groups and provide regular home visits supported by community volunteers. ANPPCAN currently has over 600 volunteers at the community level. Additionally, ANPPCAN has implemented the Team Up approach[71] as part of its child-focused intervention strategy. This approach assists children at risk of or showing signs of psychological distress. Community workers identify these children in various settings, including schools, communities, and IDP centres. The children are then given opportunities to discuss their experiences and explore ways to relieve their stress.

Community-based psychosocial approach of ACT Alliance being used in combination with a survivor-centred approach in an IDP camp setting: the experience of EOTC DICAC in IDP camps in Debre Birhan

Community-based interventions that stand out as best practices are part of the Community-Based Psychosocial Support Approach of the ACT Alliance, implemented by EOTC-DICAC and EECMY. In the key informant interview, EOTC-DICAC staff emphasised the significance of traditional coffee ceremonies and handicraft activities as part of their GBV programme in the IDP camps in Debre Birhan. These activities are conducted in Women and Girls Safe Spaces, where the internally displaced women from the Oromiya region come together during the day. Engaging in these traditional practices helps them maintain psychological stability and focus amidst their sharing of their experiences, challenges, pain and insecurity. Furthermore, these activities reconnect them with their cultural roots and provide a sense of continuity and stability, grounding them in their traditions despite the upheaval and insecurity they face.

In addition, EOTC-DICAC engages the leaders of the camp community and religious leaders in protection issues and raise their awareness on the prevention of GBV.

Why the CBPS approach (ACT Alliance) of EOTC DICAC can be considered a best practice approach:

Creates connection with culture and community in a situation of uprooting: It integrates traditional cultural practices, such as coffee ceremonies and handicrafts into psychosocial support and thus reconnects survivors with their past, creating a sense of connection and continuity. It also involves community leaders in the prevention of gender-based violence (GBV) and assigns them a role and responsibility in combating experiences of powerlessness.

Promotes safety and calming experiences in psychosocial practices: By engaging internally displaced women in these familiar activities, it helps them maintain psychological stability, reconnect with their cultural roots, and find continuity amid upheaval, thereby providing both emotional support and a sense of normal community life. In addition, community leaders help in preventing GBV through awareness raising.

Ensures sustainability through communal efficacy: The group activities and shared experiences can continue beyond the Women's and Girls' Safe Space, allowing camp residents to maintain connections even outside the programme and carry them forward when they return to their homes.

Women ś and Girls Safe Space, coffee ceremony (EOTC-DICAC)

Community awareness raising on GBV prevention with traditional and religious leaders (EOTC-DICAC)

Supporting the community in a holistic way: the triple nexus approach[72]:

EECMY-DASSC operates in Waghemra, North Wollo, South Wollo, and North Shoa zones, regions severely affected by the conflict between the federal government and Tigray forces, as well as ongoing ethnic conflicts in the Oromiya special zone of the Amhara region. EECMY-DASSC implements various programmes using a triple nexus approach, integrating humanitarian, development, and peace efforts to maximise positive outcomes. This approach is crucial for addressing the mental health challenges arising from the conflict and its impact on vulnerable groups. The triple nexus approach integrates mental health and psychosocial support across all sectors, providing a platform for the community to express their trauma and distress.

The triple nexus approach integrates humanitarian aid, development, and peace-building efforts to address the multifaceted impacts of conflict on communities. This holistic strategy enhances mental health support, strengthens community resilience, and promotes social cohesion by coordinating various interventions and involving diverse stakeholders.

EECMY-DASSC collaborates with a range of stakeholders, including community leaders, community-based organisations (CBOs), and government structures. They work together to identify target groups for intervention, deliver "trauma healing training" (i.e. a form of trauma awareness training) over three days, and implement various support measures. Key interventions include case management, gender-based violence (GBV) prevention, need-based material support, recreational activities, intra-community peace conferences, life skills-based psychosocial support training for returnees, provision of start-up capital/material support, and short-term vocational skill training in collaboration with vocational training colleges. Trauma management and awareness training are also provided to both the community and returnees. "Trauma healing sessions" led by EECMY-DASSC staff or experts from partner organisations like EOTC-DICAC and Innovative Humanitarian Solutions (IHS) focus on trauma processing, emotional release techniques, and coping strategies tailored to varying distress levels. Community workers also engage in outreach efforts to support participants, offer on-site assistance, address additional challenges, and identify further needs. Regular coordination meetings help integrate MHPSS services into all sectors and strengthen referral pathways. A standardised operating procedure (SOP) ensures comprehensive assessment, case management, and appropriate referrals to relevant service providers. EECMY-DASSC has supported over 200 survivors of GBV by offering medical assistance, material support, and MHPSS through trauma healing support groups. These groups, comprising religious leaders, local government personnel, and self-help group representatives, convene regularly to address issues, brainstorm solutions, and provide support, including facilitating medical care and psychosocial support. Religious perspectives are also considered in the interventions. Recreational activities are included in the MHPSS interventions for IDP communities to enhance social cohesion and promote the inclusion of IDPs within the host community. Activities such as table tennis provide a platform for IDPs to come together, fostering a sense of community and belonging.

Joining peace building initiatives with psychosocial activities

By integrating peace-building with psychosocial support, ANPPCAN has effectively promoted local peace by addressing conflicts between the Kimant and Amhara communities in North Gondar, Amhara region. They established a peace promoter committee with representatives from both communities and trained them in peace and reconciliation, leading to ongoing dialogue and the successful reintegration of over 320 youth from the Kimant community into their homes and peaceful lives.

Similarly, EOTC-DICAC has incorporated psychosocial support into their peace-building initiatives, reaching over 5,000 individuals with trauma-sensitive training designed to tackle conflict-related psychosocial issues. Their 7-day Trauma Support Training of Trainers (ToT) programme, conducted with Norwegian Church Aid, equipped project staff, religious leaders, and experts from the Women and Social Affairs Bureau to provide counselling and support. These efforts are complemented by emergency aid programmes and a referral pathway with local government offices to address gender-based violence and trauma.

Traditional approaches:

According to the APHI, religious leaders are part of advocacy activities and workshops. Bahir Dar University works with religious leaders at their Holy Water Site where they collaborate with professionals to deliver medical and psychological services alongside the Holy Water intervention.

7.2.1.4 MHPSS-related activities on level 3 in Amhara: focused psychosocial interventions at centres

We found a number of centre approaches of MHPSS that can best be located on the third level of MHPSS activities, even if these approaches also always provide basic services on the first level, too.

The Center Approach for survivors of GBV

The vulnerability of women and girls to gender-based violence (GBV) underpins the programmes of various NGOs working in Amhara, such as the Bahir Dar GBV Rehabilitation Center run by **Agar Ethiopia**. Although based in Bahir Dar, the centre receives survivors from different parts of the region, including the conflict-affected areas of South Gondar and North Wollo zones, through referrals from faith-based organisations and other stakeholders. According to the Project Manager, the emotional trauma primarily involves sexual violence, both in war and non-war contexts. The Agar Ethiopia GBV Rehabilitation Center provides integrated psychological, health, and social support services. Upon admission, survivors benefit from medical treatment, legal assistance, psychological support through group and individual counselling, and vocational and soft skills training for a minimum of three months. The centre also supports income-generating activities, market connections, and provides assistance through local government offices to aid in effective community reintegration. The centre is staffed by 18 professionals, including clinical nurses, social workers, house mothers/caregivers, legal experts, and psychologists. Social workers and psychologists receive training in counselling techniques, burnout management, and other therapeutic approaches. A standard operating procedure ensures that essential service aspects are maintained, including survivor safety, key service offerings, case management, and shelter protocols. The centre collaborates with Bahir Dar Felege Hiwot Hospital for advanced physical and mental health care, and survivors requiring specialised treatment are referred to facilities in Addis Ababa.

Additional to the GBV Rehabiliation Center of Agar Ethiopia, the Women and Children Bureau has established **One-stop centres in Dessie, Debre Markos, and Bahir Dar**, in collaboration with the regional health bureau. These centres provide integrated services, including mental health support and assistance with income-generating activities, and are supported by partnerships with organisations like UNICEF and UNFPA. However, challenges persist due to the high number of survivors and limited resources, including a shortage of psychotropic medications.

7.2.1.5 MHPSS-related activities on Level 4 in Amhara: referrals to advanced mental health care

The Amhara Regional Health Bureau works with various partners to address community mental health needs. These partners have set up a referral system to direct individuals to hospitals that offer mental health and psychiatric services. Although the hospitals are dedicated to enhancing their staff's skills through short-term training, they face significant challenges due to a shortage of mental health professionals, medications, and facilities. This scarcity underscores the urgent need for more resources to provide comprehensive psychiatric care. In Bahir Dar, Felege Hiwot Hospital is the main referral point for survivors needing advanced mental health care, including medication. Some of the patients with severe conditions are also referred to Amanuel Hospital in Addis Ababa.

7.2.2 Findings from Oromiya region

Key informants from the National Technical Working Group indicate that Oromiya has one of the highest needs for MHPSS services. This aligns with findings from the Global Protection Clusters Paper issued in November 2022, which highlighted the critical need for MHPSS interventions in Ethiopia and urged the humanitarian community to prioritise funding for these efforts. Notably, the paper identified Oromiya's West Guji and Gedeo zones, along with East and West Wollega, as areas with the most urgent MHPSS needs in the country.

Oromiya has received the least coverage among the three regions examined in this research concerning mental health and psychosocial support (MHPSS).

Among the 99 organisations involved in the EOC-DICAC mapping of 2020, 29 provide MHPSS-related activities, predominantly offering Level 1 and 2 interventions and Psychological First Aid. Like Amhara, Oromiya lacks structured and manualised psychosocial interventions for individuals facing more severe difficulties, and clinical services are similarly scarce. Patients requiring mental health services are referred to primary hospitals where staff have received training in mhGAP, while more complex trauma cases may be directed to specialised hospitals.

The MHPSS interventions that we reviewed in the field and through phone interviews reflect a situa-

tion similar to that in Amhara, shaped by ongoing conflict, insecurity, and displacement. Of particular note are the approaches by EECMY, which we were able to explore in greater detail through key informant interviews.

7.2.2.1 Over-all coordination of MHPSS activities and capacity building in Oromiya

The Oromiya Health Bureau, responsible for coordinating MHPSS in the region, has been actively training non-specialised healthcare providers in mhGap to improve early detection, management, and referral of various mental disorders. These trainings, conducted by experts from institutions like Addis Ababa University's Black Lion Hospital and Amanuel Hospital, involve participants from different health centres and hospitals across Oromiya. In addition, the bureau has launched community awareness programmes, including campaigns and megaphone announcements about available MHPSS services, and integrated mental health and psychosocial support (MHPSS) conditions into daily briefings at health facilities.

Moreover, the Ethiopian Public Health Institute has deployed MHPSS teams, consisting of psychologists, psychiatrists, and social workers, to emergency areas in Oromiya such as East Wollega, North Showa, and Bale. These teams offer a range of services, from basic psychosocial support to comprehensive mental health care.

Given the complex psychosocial needs in the region – stemming from past traumatic events, losses, and current stressors related to displacement – there is a clear need for comprehensive, integrated care that addresses physical, psychological, and social needs and aims to restore well-being and dignity. In this context, we will highlight various levels of intervention provided by EECMY's operations as detailed through key informant interviews with their regional offices. While this overview is not exhaustive, it provides valuable insights and exemplifies effective practices for structuring MHPSS in ongoing conflict scenarios.

7.2.2.2 MHPSS-related activities on level 1 in Oromyia: Basic needs and security / MHPSS mainstreaming

EECMY-DASSC runs MHPSS programmes in Oromiya through its Western and South Ethiopian Area Offices. The Western Office integrates MHPSS into all its programmes, conducting thorough needs assessments and offering agricultural support, cash assistance, and protection activities. They focus on capacity building for frontline workers and stakeholders in collaboration with UN-OCHA. The South Ethiopia Area Office covers the southern Oromiya region, including conflict-affected zones like Balle, Arsi, Borana, and Gujji. They emphasise a rights-based approach to emergency and humanitarian responses, addressing significant needs for psychosocial support, livelihood assistance, and safety. Their efforts include protection monitoring, multi-purpose cash support, and referrals to counselling services and hospitals, as well as income-generating and business development support.

Notably, EECMY's response to the 2018 West Guji conflict highlights a best practice in phase-based humanitarian aid. Since the conflict between the Guji Oromo and Gedeo people, EECMY has provided food aid, nutrition support, and dignity-sensitive rehabilitation services, including personal hygiene kits for women and girls. Their approach, which includes cash transfers and community mobilisation, respects individual dignity and allows flexibility in meeting immediate needs. As part of the transition to long-term support, they have formed self-help groups and provided vocational training and seed money to IDP returnees, focusing 70% of their efforts on returnees and 30% on host communities. This dual approach aims to foster sustainable livelihoods and economic self-sufficiency through skill development and financial support.

7.2.2.3 MHPSS-related activities on level 2 in Oromiya: community and family supports

Based on insights from key informants at the EECMY-DASSC offices, we want to highlight the significant effectiveness of the community-based psychosocial support (CBPS) developed through the ACT Alliance group and implemented by EECMY-DASSC: Their Western Ethiopia Area Office has established and is continually strengthening its "Mental Health and Community-Based Psychosocial Support" (MH-CBPS) programme through grassroots committees operating in eight *kebelles* (i.e. the smallest administrative units). These committees, consisting of community opinion leaders and "community animators", engage in regular outreach, provide on-site psychosocial support, and identify individuals facing vulnerabilities and adverse events to offer appropriate care and support.

At the *woreda* (district) level, EECMY-DASSC Western Ethiopia has set up a Help and Protection Desk. This desk is crucial for collecting, compiling, and disseminating information related to protection and psychosocial services. In terms of GBV Prevention and Response, the organisation conducts various activities, including preparing and distributing large-scale GBV Information, Education, and Communication (IEC) materials to raise community awareness. There is also a well-established, community-based referral pathway for additional and advanced care. Aira General Hospital in the West Wollega Zone serves as a key referral point for survivors of GBV and women or girls with fistula, featuring a dedicated unit for fistula care.

BEST PRACTICE

7.2.2.4 MHPSS-related activities on Level 3 in Oromiya: safe spaces and working with volunteers

EECMY integrates volunteers into their Community-Based Psychosocial Support programme (ACT Alliance), which we consider best practice for providing psychosocial support in contexts of displacement and ongoing violence.

Survivor-friendly safe spaces using volunteers

The EECMY-DASSC South Ethiopia Area Office has established Survivor-Friendly Safe Spaces with the support of HEKS/EPER (Swiss Church Aid). These spaces are designed to provide a comprehensive range of services for GBV survivors, focusing on their successful reintegration into the community while minimising the risk of re-traumatisation. The safe spaces offer holistic support, including psychosocial assistance, counselling, and material aid, with the goal of empowering survivors to regain control over their lives and rebuild their resilience. Community volunteers play a crucial role by offering routine support to survivors and addressing their psychosocial needs. These volunteers facilitate group discussions led by survivors themselves, providing a platform for sharing experiences and mutual support. They also offer follow-up care to ensure the survivors' ongoing well-being. Additionally, community awareness efforts are in place to enhance engagement in GBV prevention, with large-scale campaigns targeting men to foster broader community involvement.

Survivors as helpers, giving emotional support to other survivors (with fistula problems)

EECMY-DASSC Western Ethiopia has established another valuable community-based structure known as "Safe Mother Ambassadors". These ambassadors are women who have previously suffered from fistula, received treatment, and successfully healed. Now, they act as first responders, offering emotional support to fistula patients both within health facilities and throughout the community. EECMY-DASSC has equipped these ambassadors with technical training in areas such as psychoeducation and emotional support for survivors.

EECMY-DASSC volunteer visiting a family in Oromiya

Why using volunteers as part of the CBPS of ACT Alliance can be considered a best practice in a situation of ongoing violence:

Increases self- and community efficacy: Volunteers enhance both self- and community efficacy by empowering survivors to take active roles in their recovery and support networks. Survivor-Friendly Safe Spaces, facilitated by volunteers, enable individuals to engage in group discussions and mutual support, fostering a sense of agency and collective strength.

Instils hope: Volunteers instil hope by providing consistent emotional and psychosocial support, showing survivors that recovery and reintegration are possible. Through their dedication, the volunteers help the survivors to envision and work towards a brighter future.

Creates safety: Volunteers contribute to creating safe environments where survivors can share their experiences and receive care without fear of re-traumatisation. Initiatives like the Safe Mother Ambassadors ensure that survivors feel secure and supported both within health facilities and in their communities. This support helps reduce stigma, which causes major stress and hinders the healing process for these women.

Ensures sustainability: Volunteers ensure the sustainability of support systems by maintaining ongoing care and community engagement. Activities initiated in safe spaces and facilitated by volunteers, can be continued informally within the community and beyond, fostering long-term resilience and community cohesion.

7.2.2.5 MHPSS-related activities on Level 4 in Oromiya: referrals to advanced mental health care

As previously highlighted, mental health services in Oromiya are currently extremely limited, and we were not able to establish a clear picture on specialised services in the region.

7.3 Recommendations regarding scaling up MHPSS activities in Amhara and Oromiya

Here are several crucial recommendations to address the specific challenges and needs related to MHPSS in the Amhara and Oromiya regions, particularly given the ongoing insecurity and conflict. These recommendations are directed not only at donor organisations working with Church-based actors but also at all donors and international organisations involved in implementing MHPSS-related programmes. As a reminder, MHPSS approaches in ongoing violent conflicts must prioritise safety and security to ensure they are trauma-sensitive. 'Trauma healing' is therefore discouraged, as it may risk retraumatising individuals experiencing ongoing traumatic stress. Some of the following recommendations may also apply to other ongoing conflict scenarios in Ethiopia.

- **Strongly emphasise on Oromiya and Amhara:** As a general recommendation to donors and international organisations, we strongly emphasise the need to focus on both Oromiya and Amhara when planning an expansion of MHPSS in Ethiopia, as both regions have been underserved.
- **Promote integrated multi-layered MHPSS interventions:** It is essential to implement MHPSS programmes that are integrated with income generation, social support, and livelihood activities. A programme that includes Levels 1-3 of support with referrals to specialised services at Level 4 is the most promising approach. This should apply both within IDP settings and in communities affected by conflict and displacement. The integration of MHPSS into humanitarian projects is absolutely crucial, not only to offer interventions like PFA for humanitarian workers, but also to foster community-led processes where camp communities, including representatives from all groups, discuss measures to prevent dependency and increase resilience, while working to protect particularly vulnerable groups from further violence and retraumatisation.
- **Provide spaces for youth in IDP camps:** Offering leisure and educational activities for youth in camps, including the establishment of youth centres, can mitigate feelings of powerlessness and reduce destructive behaviour, thereby addressing the rising issue of youth suicides. Structured spaces and programs for youth are often overlooked compared to those for children and women.

- **Adopt the triple nexus approach:** EECMY-DASSC's interventions in Amhara and Oromiya have successfully embraced a triple nexus approach, integrating humanitarian, development, and peace sectors to enhance outcomes with MHPSS as a common thread. This holistic approach could serve as a valuable model for other organisations involved in humanitarian, development, and peace-building initiatives.

- **Facilitate tailored training for religious leaders and service providers:** Develop and enhance a training curriculum on psychosocial competencies and attitudes for religious leaders and service providers from various denominations as part of their regular formation. This curriculum should include basic helping skills, such as those taught in Psychological First Aid (PFA), as well as fundamental knowledge of MHPSS, mental health disorders, and referral processes.

- **Implement trauma-sensitive interventions in schools and training centres:** Address the gaps in mental health support for youth by introducing trauma-sensitive sports programmes and counselling in schools and vocational training centres. There is a significant need for trauma-informed interventions, increased awareness on mental health, coping skills, and available services. Equip schools and training institutions with trauma-sensitive interventions, and train counselling teachers to detect and manage serious mental health conditions, with a particular focus on suicide prevention.

- **Expand training for health personnel in mhGap and PFA/Counselling:** Intensify training for health personnel in mhGAP and PFA/counselling, as noted by the Oromiya Regional Health Bureau's gaps. There are few specialised services available, so it is crucial to deploy and train multi-disciplinary teams in affected areas to provide both treatment and training.

- **Learn from other regions:** Valuable insights can be gained from regions with more extensive MHPSS work, such as e.g. Tigray. Learning visits to exemplary projects, organised by the Regional Health Bureaus or Regional Technical Working Groups, can help organisations understand others' practices and the solutions they've developed to field challenges. Local organisations interested in implementing similar interventions should consider participating in these learning visits

- **Support self-care for service providers:** Incorporate self-care support and improve access to self-care resources, including educational materials, screening tools, and stress management techniques. This support should be extended to emergency workers, frontline community workers, counsellors, and social workers in GBV rehabilitation centres and survivor-friendly safe spaces.

8 INSTEAD OF A SUMMARY: WHAT HAVE WE LEARNED FROM THE PROCESS?

The entire study was conceptualised as a learning journey and a collaborative project, engaging donor organisations and their partners in a shared quest to understand the effectiveness of MHPSS initiatives and their underlying reasons for success. For the first time, our study emphasised the unique approaches of church-based partners, highlighting some distinctive perspectives and methods for addressing the complex issues of pain and suffering caused by conflicts and natural disasters in Ethiopia.

We integrated our findings with existing literature on MHPSS in Ethiopia and shared our insights both among ourselves, thus the study team with partner organisations and donors, and with a broader audience at a national conference. This included not only presenting the study results to a broader public, but also allowing the conference participants to hear directly from the partner organisations about what they are doing and what they consider beneficial. This strictly interactive reflection process added significant value as we gained a deeper understanding by listening to the experiences of others.

Here are some key learnings we wish to share instead of a summary. They shall rather serve as a road map for the way forward:

1. **Research as a reflective process:** Research can be a powerful tool for self-reflection and mutual learning among like-minded organisations. By sharing experiences, asking questions, and expanding our tools, we have improved our approaches. We recommend more participatory studies that document local experiences, bring people together, and encourage collective evaluation and questioning.

Marketplace of Interventions" at the learning conference in Addis Ababa (18th June 2024): Partner organisations presenting their approaches. Here: Daughters of Charity / the "Bible-based approach

2. **Learning from undocumented experiences:** Many valuable experiences in the field remain undocumented. Visiting and learning from these initiatives can be incredibly enlightening. One key insight was that organisations often work side by side without knowing each other's approaches. Our research fostered awareness of local resources and live training experiences, which are more impactful than formal sessions. We recommend group visits to project sites to share knowledge and solutions, strengthening local problem-solving and fostering a sense of community among practitioners.

3. **Balancing local and evidence-based approaches:** Both local and evidence-based approaches are necessary, and mutual openness is crucial. Extensive research doesn't guarantee universal applicability, nor does local development always serve the best interests of clients.. We should avoid romanticising "culture" or "community", as they can sometimes exacerbate suffering or stigmatisation. We should also avoid "believing" in empirical evidence as the only indicator for validation, as sometimes there is also powerful practical validation.

For our church partners, we suggest that they adhere to minimum quality standards in all their creativity and journeying alongside with "their" target groups, such as:

- Respecting the rights of all individuals without discrimination;
- Avoiding unnecessary emotional pain and the risk of retraumatisation by only using trauma-sensitive "safe" methodologies;
- Recognising professional boundaries and limitations of capacities and ensuring regular proper training and supervision;
- Developing a concise understanding of self-care and organisational care as an organisation;
- Providing clear referral pathways for traumatised individuals to specialised services, considering the IASC pyramid (2007).

4. **Moving Forward:** Our next steps are to integrate these insights and continue the journey toward building a community of practitioners that includes donors. Donors should also learn from their partners about what works and what doesn't, enhancing the overall effectiveness of MHPSS initiatives. This research process has taught us the importance of mutual learning and collaboration. We have discovered that significant expertise already exists in the field and just needs to be identified and documented. This journey is too challenging to tackle alone – we need each other to succeed.

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62 *https://reliefweb.int/report/ethiopia/scars-war-and-deprivation-urgent-call-reverse-tigrays-humanitarian-crisis*. See also *https://fscluster.org/sites/default/files/documents/tigray_smart_surveys_pooled_report_aug_2023.pdf*.

63 Birhanu TT, Tadesse AW. Food Insecurity and Mental Distress among Mothers in Rural Tigray and SNNP Regions, Ethiopia. Psychiatry J. 2019 Jun 19;2019:7458341. doi: 10.1155/2019/7458341. PMID: 31321225; PMCID: PMC6607731. (*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6607731/#B10*)

64 *https://fscluster.org/sites/default/files/documents/tigray_smart_surveys_pooled_report_aug_2023.pdf*.

65 Sofie Rose, Stigmatization and Social Death of Survivors of Wartime Sexual Violence, Global Studies Quarterly, Volume 3, Issue 2, April 2023, ksad021, *https://doi.org/10.1093/isagsq/ksad021(https://academic.oup.com/isagsq/article/3/2/ksad021/7150353*)

66 *https://www.washingtonpost.com/world/2023/11/26/ethiopia-tigray-rape-survivors-stigma/*)

67 See e.g. *https://dialnet.unirioja.es/servlet/articulo?codigo=5589711*

68 *https://www.unfpa.org/sites/default/files/resource* pdf/UNFPA%20UNFPA%20Women%20and%20Girls%20Safe%20Spaces%20Guidance%20%5B1%5D.pdf

69 The INSPIRE Toolkit, developed by Trócaire in a participatory exercise in different countries where Trócaire has worked with partners, is a resource for frontline staff and volunteers supporting women and girls in communities affected by emergencies. It offers a clear outline for a structured cycle of participatory psychosocial support sessions with women and girls. Each of the five sections has headings like "Feeling Safe" (Section A), "Feeling Calm" (Section B), "Feeling connected" (Section C), etc. The toolkit contains a series of session outlines, with a step-by-step guidance on how to prepare for and run the activities. The tools are designed for women and adolescent girls.

70 *https://data.unhcr.org/en/documents/details/103828*

71 TeamUp is a group movement-based intervention aimed at strengthening the emotional resilience of children between 6 and 17 years that has been developed by War Child Holland, Save the Children and UNICEF in the Netherlands, together with their implementation partners, for children who are living in a war context. See: *https://childhub.org/en/child-protection-news/teamup-short-introduction-methodology*

72 The „triple nexus" concept highlights the interconnected roles of humanitarian, development, and peacebuilding actors. Under the UN's „New Way of Working (NWoW)," these entities are encouraged to collaborate toward collective goals over extended periods when suitable.. This strategy leverages the unique strengths of each sector to mitigate needs, risks, and vulnerabilities, in line with the recommendations of the World Humanitarian Summit (WHS) and the 2030 Sustainable Development Goals (SDGs). See: *https://www.icvanetwork.org/uploads/2021/08/Topic-One-Briefing-Paper-The-nexus-explained.pdf*

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