MEKELLE UNIVERSITY

COLLEGE OF HEALTH SCIENCES

FACULTY OF NURSING AND MIDWIFERY

PREVALENCE AND ASSOCIATED FACTORS OF POST-TRAUMATIC STRESS DISORDER AMONG SECONDARY SCHOOL STUDENTS IN POST-WAR SHIRE TOWN, TIGRAY, ETHIOPIA, 2025.

PRINCIPAL INVESTIGATOR: GETACHEW ABRAHA TEKLE

A THESIS SUBMITTED TO THE FACULTY OF NURSING AND MIDWIFERY, CHS-MU IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN INTEGRATED CLINICAL AND COMMUNITY MENTAL HEALTH.

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We, the undersigned members of the Board of Examiners, have reviewed and assessed the thesis titled " PREVALENCE AND ASSOCIATED FACTORS OF POST-TRAUMATIC STRESS DISORDER AMONG SECONDARY SCHOOL STUDENTS IN POST-WAR IN SHIRE, TIGRAY, ETHIOPIA, 2025." presented by Getachew Abraha Tekle during the final open thesis defense. We certify that the thesis has been accepted as part of the requirements for the Master's Degree in Integrated Clinical and Community Mental Health.

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I hereby certify that all the corrections and recommendations suggested by the Board of Examiners are incorporated into the final thesis entitled "PREVALENCE AND ASSOCIATED FACTORS OF POST-TRAUMATIC STRESS DISORDER AMONG SECONDARY SCHOOL STUDENTS IN POST-WAR IN SHIRE, TIGRAY, ETHIOPIA, 2025" by Getachew Abraha Tekle.

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Abbreviations and Acronyms

ASSIST-Lite	Alcohol, Smoking and Substance Involvement Screening Test
CI	Confidence Interval
DSM-V	Diagnostic and Statistical Manual of Mental Disorders Fifth Edition
ETB	Ethiopian Birr
HCL	Hopkins Check List
HSCL	Harvard Hopkins Symptom Checklist
ICCMH	Integrated Clinical and Community Mental Health
ID	Internally Displaced
IDP	Internally Displaced People
MU-CHS	Mekelle University, College of Health Sciences
PCL	Post-Traumatic Stress Disorder Check List
PTSD	Post-Traumatic Stress Disorder
SPSS	Statistical Package for Social Sciences
VIF	Variance Inflation Factor

Abstract

Background: Post-Traumatic Stress Disorder (PTSD) is a psychological condition that may occur after exposure to a traumatic or stressful event and its onset can persist for many years beyond the initial experience. According to several studies results PTSD is one of the most prevalent mental disorder among secondary school students following traumatic exposure. There are different factors that associated with Post-traumatic stress disorder such as; socio-demographic, trauma event status, psycho-social support, medical and war exposure factors. Despite this, there has been a relative lack of focus on mental health issues among secondary school students in the region. This research aims to fill this gap by determining the estimated prevalence and associated factors of Post-traumatic stress disorder among secondary school students in Shire town, Tigray region, located in northern Ethiopia.

Objective: This study aimed to assess the prevalence and associated factors of post-traumatic stress disorder among secondary school students in Shire, Tigray, Ethiopia, 2025.

Method: This study employed an institutional-based cross-sectional design. A total of 403 students were selected using systematic sampling from a complete list of students in selected schools. Data were collected through structured, self-administered questionnaires on March, 2025. SPSS version 27 was used for data analysis, with logistic regression identifying factors related to PTSD. A multivariable logistic regression model was fitted to identify factors associated with post-traumatic stress disorder. Variables with a p-value of < 0.05 at a 95% confidence interval were considered statistically significant.

Results: A total of 402 samples were included in the study with a response rate of 99.7%. The study revealed that 18.4% of secondary school students experienced post-traumatic stress disorder (PTSD) in the post-war period (95% CI: 14.7%–22.5%). A semester average score below 70% (AOR = 4.48, 95% CI: 1.58–12.67), a history of torture (AOR = 4.56, 95% CI: 1.83–11.38), exposure to sexual violence (AOR = 6.97, 95% CI: 2.49–19.50), poor social support (AOR = 15.44, 95% CI: 4.97–47.90), depression (AOR = 4.93, 95% CI: 1.15–21.14), and substance use (AOR = 2.83, 95% CI: 1.35–5.91). All these factors were significantly associated with PTSD among secondary school students.

Conclusion and recommendations: The prevalence of PTSD among high school students post war period was high and factors included poor social support, low academic performance, exposure to torture and sexual violence, depression, and substance use. The findings emphasize the importance of integrating school-based mental health services and early identification strategies to support students exposed to war-related trauma.

Keyword*: Post-traumatic stress disorder, secondary school students, war trauma, depression, substance use, social support, Tigray, Ethiopia*

1. Introduction

1.1 Background

Post-traumatic stress disorder (PTSD) is a mental health condition that develops in some people who have experienced or witnessed a traumatic or frightening event such as a natural disaster, a serious accident or assault, a terrorist act or military combat, or those who have been threatened with death, sexual violence or injury. The stress caused by witnessing or experiencing the trauma can affect all aspects of a person's life, including their mental, emotional and physical well-being.(1)

Having PTSD can be extremely distressing, as people are re-living their most traumatic experiences frequently, People can deal with these stressful and challenging symptoms in different coping ways, many people misunderstand the complexity of PTSD by addressing some common Post-traumatic Stress Disorder myths; The nature of PTSD can make it very difficult for people to recognize PTSD in themselves. So much time may have passed that they do not associate their symptoms with trauma from their past. (1,2).

War and conflict have well-documented adverse effects on mental health. Adolescents exposed to war are at high risk of developing mental health disorders, including post-traumatic stress disorder. PTSD is characterized by symptoms such as intrusive memories, avoidance behaviors, negative changes in thinking and mood, and hyperarousal. These symptoms can significantly impair the daily functioning and development of adolescents (3).

1.2. Statement of the problem

Post-traumatic Stress Disorder affects millions of people around the world, while estimates vary, it's believed that PTSD affects millions of people worldwide. According to the World Health Organization (WHO), approximately 3.9% of the global population has experienced PTSD in the past year (4).
Evidence of the widespread nature of PTSD among both adults and adolescents comes from cross-sectional studies conducted on different continents.

In Asia, for instance, a cross-sectional study conducted on earthquake survivors in China revealed a PTSD prevalence of 45.5% (5). This indicates the long-term psychological impact of disasters. In the Middle East, a cross-sectional study conducted on adolescents in Palestine revealed a PTSD prevalence of 53.5%. This indicates the severe psychological impact of conflicts and violence (6).

In Europe, cross-sectional studies conducted on refugee minors in Sweden revealed a PTSD prevalence of 42%. Similar results have been observed in adult refugee populations (7). Recent cross-sectional research conducted on civilians in Ukraine who were affected by conflict revealed a PTSD prevalence rate of approximately 25.4%. This indicates a lot of psychological distress due to the current state of war(8).

In Africa, the prevalence of PTSD is also high in different populations. A cross-sectional study conducted on war-affected populations in Uganda found a high prevalence of PTSD in both adult and adolescent populations, with a prevalence rate as high as 54% in some of these populations (9). Another study conducted on adolescent refugees in Uganda found a high prevalence rate of 83%, showing the high level of vulnerability in these young refugees (10). In Kenya, a cross-sectional study conducted on young people affected by post-election violence found a PTSD prevalence rate of 32% in these young people, showing the impact of political instability on these young people (11).

Similarly, a research in Rwanda found that up to 54% of adolescents experienced PTSD after the genocide(12)

In Ethiopia, the rate of PTSD is a major health concern due to the recurring wars and the large number of people exposed to traumatic events. Cross-sectional studies conducted in war-affected areas have shown that PTSD is highly prevalent in adults. For example, a community-based study conducted in Dessie town, Ethiopia, showed that the prevalence of PTSD was 34.5% (13). In addition, a community-based cross-sectional study conducted in Woldia town, Ethiopia, showed that the prevalence of PTSD was even higher, at 56.28%, among war-affected residents, which is a clear manifestation of the psychological effects of war on adults (14).

Research indicates that the prevalence of PTSD among adolescents in post-conflict settings is notably high. For instance, a study in Woldia town, Ethiopia reported the prevalence of post-traumatic stress disorder among high school students who experienced war was 39.2 %.(15)

In Ethiopia, the impact of prolonged conflict on mental health has been a growing concern. A study focusing on children in Northern Ethiopia, including the Tigray region, indicated that the prevalence of PTSD among children affected by the conflict was around 24% (16).

Society has a misconception on PTSD that it is only common in war veterans, and it's true many are at an increased risk of PTSD due to the violent and stressful nature of service, but the fact is that they are not the only people who are only vulnerable for PTSD, and additionally PTSD symptoms can develop at any time after a traumatic event. Your symptoms may start soon after the event, or you may not have them until months or years later. They may come and go over many years (4, 16).

Post-traumatic stress disorder has many psycho-social effects on individuals and society in general. At the individual level, victims of this disorder often experience substance use and abuse, depression, anxiety, dissociation and dissociative disorders, personality disorders, psychosis, and cognitive disorders, at a societal level, the possible consequences can be separation from families, homelessness, poverty and imprisonment, Several systematic reviews indicated that IDP who stay within their own country experience worse mental health outcomes than refugees.

PTSD significantly diminishes students' overall quality of life by leading to grave functional impairments that affect their daily routines, academic work, and ability to participate in school life, and grave emotional impairment**s** such as chronic anxiety, depression, and emotional numbness, impacting their well-being and future prospect**s.** In addition, there is a detrimental cost to society with high financial and social consequences from the significantly elevated rates of hospitalization, suicide attempts and alcohol abuse (17).

Though developing countries are the highly attacked by PTSD, developed countries are also suffering, and when we go deep down, which group of the community is highly attacked, those who are exposed to an actual trauma, witnessed, learned a trauma and, those who are single, divorced and widowed, and basically have low social support, sexually violated or raped, are the most at risk and attacked part of the community (18).

The Tigray region in Ethiopia has experienced significant conflict and turmoil, particularly since late 2020. The conflict has resulted in widespread violence, displacement, and loss of life, profoundly impacting the mental health of the population, especially vulnerable groups such as children and adolescents. This turmoil has disrupted daily life, education, and access to essential services, exacerbating the psychological stress experienced by young people in the region (2).

Even though numerous studies have been done on PTSD among conflict affected population, most of the studies were focused on adults, IDPs or they were conducted during active conflict. Studies regarding PTSD among secondary school students remain limited, particularly in northern Ethiopia. In the context of Shire town, where students have been to prolonged armed conflict followed by post-war healing challenges, there is lack of empirical data on the prevalence of PTSD and its associated factors. In addition, existing studies have inadequately explored the combined influence of academic performance, trauma exposure, psycho-social support, and substance use on PTSD among adolescents.

Therefore, this particular research intended to fill this knowledge and contextual gap by assessing the prevalence of PTSD among secondary school students, in Shire town. The significance of this research lies also on the fact that the population under investigation is in the schools.

1.3 Significance of the study

The findings of this study, particularly regarding the prevalence rate of PTSD and the identification of associated socio-demographic, psycho-social, and war exposure factors, can directly inform policy formulation by evidence-based policy-making**:** Currently, there is be a lack of data on the specific mental health needs of secondary school students in post-conflict Shire town. Our research will provide critical empirical evidence on the prevalence of PTSD and its associated factors. This evidence base is essential for policymakers to understand the scope of the problem and the specific needs of this vulnerable population.

Understanding the prevalence and the associated factors can help in targeted interventions and resource allocation**:** By identifying the factors associated with PTSD, our findings can help policymakers target resources and interventions more effectively**.** For example, if our study finds a strong association between war exposure and PTSD, policies could be developed to prioritize mental health support for students with high levels of war-related trauma. This could lead to the allocation of funding for school-based mental health programs, training for teachers to recognize and respond to PTSD symptoms, and the development of culturally appropriate mental health services.

Research on the mental health of war-affected youth in Ethiopia is limited. This study will contribute valuable data to the global understanding of PTSD in post-war settings. The findings can inform mental health interventions in other conflict zones with similar contexts. Addressing PTSD in adolescence and youth can significantly improve students' academic performance, social functioning, and overall well-being. This can have a lasting positive impact on their future prospects and contribute to a more resilient community.

In conclusion, studying PTSD in this population is crucial for understanding the mental health consequences of war on youth and informing interventions that promote healing and well-being.

2. Literature Review

2.1. Overview of Post-traumatic Stress Disorder

According to the results of a meta-analysis, an estimated 242 million adult war survivors living in post-conflict areas were affected by PTSD, The prevalence of PTSD, which adds to the global burden of disease, is estimated to be around 4% worldwide (9).

A study in post-genocide Rwanda reported PTSD prevalence rates of up to 54% among adolescents (12).

In a study conducted in South Africa, former high school students who served in the South African border war reported a 33% prevalence of PTSD (19).

A large-scale study conducted in Syria's capital town, Damascus, found that 53% of secondary school students reported symptoms of PTSD after 9 years of long conflict. The study highlighted the psychological toll of war exposure, with many students also experiencing problematic anger and other mental health issues (20).

High school students from refugee backgrounds, particularly those from war-torn regions like Syria or Afghanistan, have shown high rates of PTSD (21).

2.2. Factors associated with development of Post-Traumatic Stress Disorder

2.2.1 Socio- demographic characteristics

According to a study conducted in Ukraine, out of the total respondents diagnosed with PTSD 32.2 % of them were between the ages of 31-44, 18-30 (23.8%), 45-59(23.6%) and 60-74(16.2%), respectively (32). According to study done northwest Nigeria, Kaduna, of the total PTSD cases 30.1 % were females (21). Similarly the study conducted in Ukraine reported a result of the total PTSD case, 61.1% of them were females, and 38.9 % were males (22).

Regarding sex, lifetime prevalence of traumatic events was slightly higher in men than in women. The risk for PTSD following traumatic experiences was twofold higher in women than in men, this gender difference was primarily due to women's greater risk of PTSD following events that involved assaultive violence. The probability of PTSD in women versus men exposed to assaultive violence was 36% versus 6%. (23).

Low social support was also found to be a potent risk factor, with [AOR] = 2.5–3.5, CI 95% for the development of PTSD, and this factor accounted for nearly two-thirds of the age-related risk difference in veteran populations (24)

A study conducted on United States veterans (2014) found that unhealthy coping mechanisms, such as substance use, were independently associated with PTSD [AOR] = 2.2 (95% CI, 1.4–3.5) and accounted for age-related risk differences(25).

2.2.3 Social Support related factors

Several studies, including research conducted in northeast Ethiopia, consistently underscore a robust and significant association between poor social support and an increased likelihood of developing post-traumatic stress disorder (PTSD) among internally displaced individuals. These findings align with broader research insights that emphasize the pivotal role of social support structures in mitigating the psychological impact of displacement-related trauma (20, 21).

2.2.4 Trauma event status and displacement related factors

A research from northeast Ethiopia, participants who were exposed to physical assault type of trauma were 2 times more likely to have PTSD More than half (55.68%) of participants had experienced or witnessed murder of their family or friends (26).

Study reported in the USA showed a significant association between sexual abuse and PTSD, close to 30% of cases of PTSD are due to sexual violence alone, It’s estimated that up to 94% of survivors of rape or sexual assault develop PTSD in the first two weeks after the event, leading to around 50% of victims suffering long-term symptoms (27). A study conducted in northern Uganda resulted in a significant association with sexually abused and raped with PTSD, of the total PTSD cases, with 18% of women being raped and sexually abused (30).

According to a study conducted in Somalia Mogadishu Important predictive factors for the development of post-traumatic stress disorder were cumulative traumatic exposure, and frequency of displacement (31).

A study conducted in Ethiopia, revealed, participants who had witnessed or experienced the murder of family or friends were twice as likely to have PTSD as those who had not experienced this event, of those who were severely traumatized (>20 traumatic events), 6 (66.7%) had a diagnosis of PTSD compared to only 3 (33.3%) who did not, All these differences were statistically significant (18). A study done in north east Ethiopia, regarding a significance of association between traumatic factors and PTSD, the odds of developing PTSD were 4.5 times higher among individuals whose family members or friends were seriously injured or killed and witnessed killed (26).

2.2.5 Psycho Social Factors

According to a study done in Mexico, PTSD showed a strong significant association with depression, of the total PTSD cases amongst Guatemalan refugees was recorded at 38% also experienced symptoms of depression. (31). A study done in northern Uganda showed a strong association between depression and PTSD, of the total 727 women who met the criteria for PTSD, 567 (78%) also met the criteria for depression (32). In South Ethiopia, the odds of developing PTSD among those with depression were 2.6 times higher as compared to those without depression (AOR=2.6, 95% CI 1.18 to3.78) (18).Additionally, a study conducted in northeast Ethiopia, Having clinical sign of depression were significantly associated with post-traumatic stress disorder (26). Several studies state the strong association between anxiety and PTSD as well. (33, 34)

2.2.6 Medical, Previous Psychiatry and Behavioral factors

A cross sectional study conducted in Yazidi, Iraq, 3.9% of the total PTSD cases has had a prior psychiatry illness history, the odds of developing PTSD among those with depression were 2.6 times higher as compared to those without depression (35).

Conceptual framework

Post-traumatic stress disorder (PTSD) in secondary school students arises from a complex interplay of socio-demographic, psycho-social, trauma-related, and environmental factors. These elements—such as gender, poor social support, war-related experiences, and co-existing mental health conditions—can independently or collectively increase the risk of developing PTSD. By identifying and addressing these contributing factors, mental health professionals and policymakers can design more effective, targeted interventions to support affected students. Early recognition of PTSD and its associated risks allows for the development of comprehensive mental health strategies that promote recovery and resilience in post-conflict youth populations (5, 6, 9, 10, 13-16, 17-21, 32, and 36).

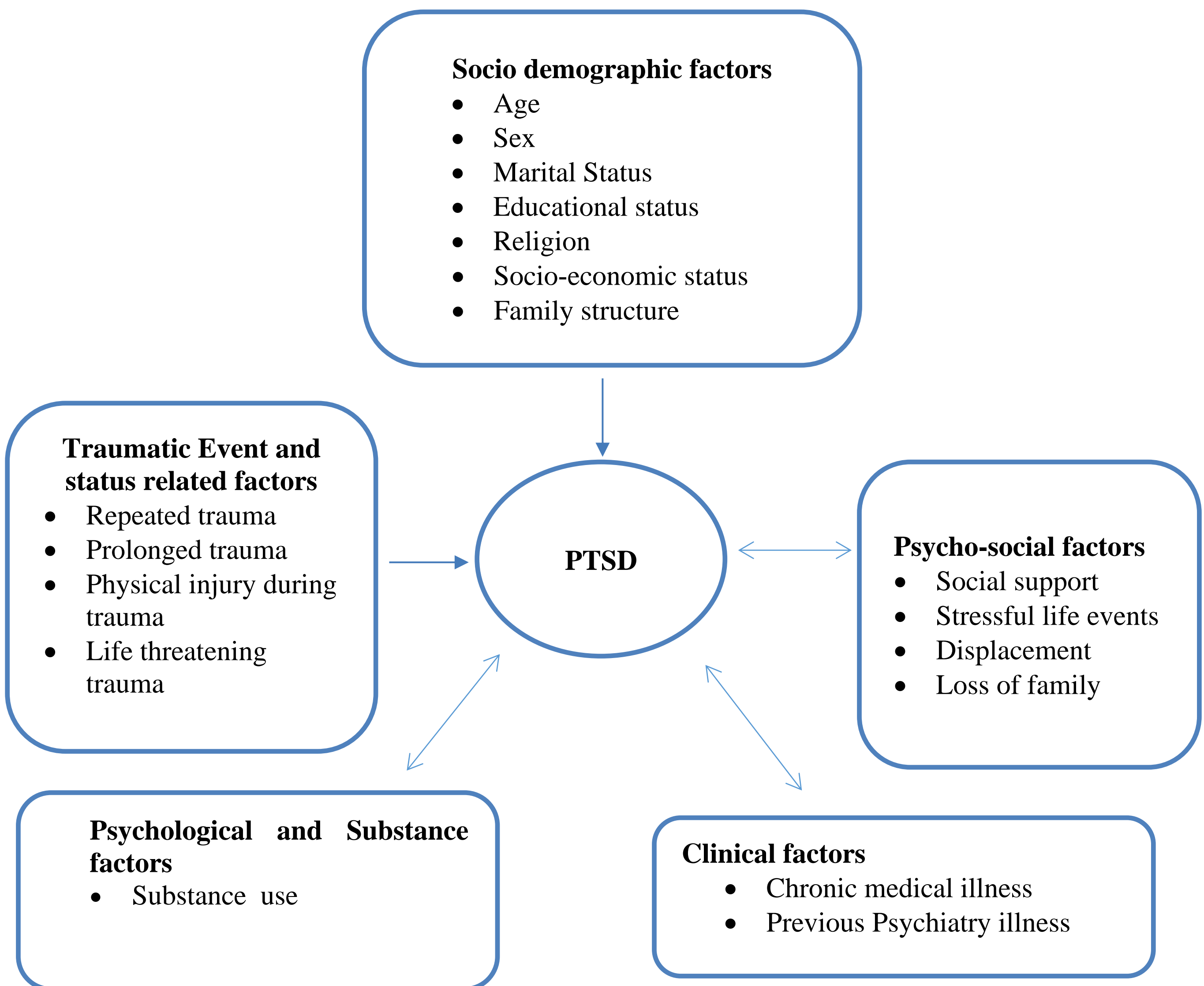


Figure 1: Conceptual Framework of PTSD and associated factors among secondary school students in post war, Shire, Tigray, Ethiopia, 2025.

3. Objectives

3.1. General objective

- To assess the prevalence and associated factors of post-traumatic stress disorder among *s*econdary school students in post-war in Shire, Tigray, Ethiopia, 2025.

3.2. Specific objective

- To determine the prevalence of PTSD among secondary school students in post-war in Shire, Tigray, Ethiopia, 2025.
- To identify factors associated with PTSD among secondary school students in post-war in Shire, Tigray, Ethiopia, 2025.

4. Methodology

4.1. Study area

The research was conducted in Shire Endasellasie town, the administrative center of the Northwest Zone in the Tigray region, northern Ethiopia. Shire is the third most populous town in the region and is situated approximately 1,087 kilometers north of Addis Ababa, the capital city of Ethiopia, and about 304 kilometers northwest of Mekelle, the regional capital. According to the 2007 report by the Central Statistical Agency of Ethiopia, the town had a total population of 47,284, comprising 21,867 men and 25,417 women. Shire is home to four public secondary schools: Midregenet Secondary School, Shire Secondary School, Shire Preparatory School, and Fre-Swuat Secondary School, which served as the study sites for this research.

4.2. Study design and period

An Institution-based cross-sectional study was conducted in Shire town from April – May, 2025.

4.4. Source and study population

4.4.1 Source of population

All secondary school students (grades 9-12) residing in Shire town in the post war time.

4.4.2 Study population

Secondary school students enrolled in selected schools in Shire town who met inclusion criteria and were available for participation.

4.5. Eligibility criteria

4.5. 1. Inclusion Criteria

- All secondary school students enrolled in Shire, Ethiopia, in the post-war period in 2025
- Students aged 18 years and above who were able to provide informed consent, or students under
- 18 years with obtained assent, parental/guardian consent
- Students who resided in Shire during the conflict
- Students with the ability to communicate effectively
- Students currently living within the post-war context of Shire

4.5.2. Exclusion Criteria

- Students who were not attending secondary school in Shire during the study period
- Students experiencing active psychosis or a current mental health crisis

- Students unable to provide informed consent or assent, or whose parents/guardians declined to give consent

4.6. Sample size determination and sampling technique

4.6.1. Sample size determination

The minimum number of sample required for the study was be determined by calculating using single population proportion formula with 39.2% prevalence of PTSD among high school students who experienced war (34) and 95% margin of error of 5%. The formula was:

$n = [(z\alpha/2)^2\ p\ (1-p)]/d^2$

Where, p is the anticipated population proportion,

'd' is the precision required on either side of the proportion, and

'Z' refers to the cut off value of the normal distribution and is based on a 95% confidence limit (=1.96).

$$n = \frac{(1.96)^2\ (0.392)\ (1-0.392)}{(0.0025)} \qquad n = \mathbf{366}$$

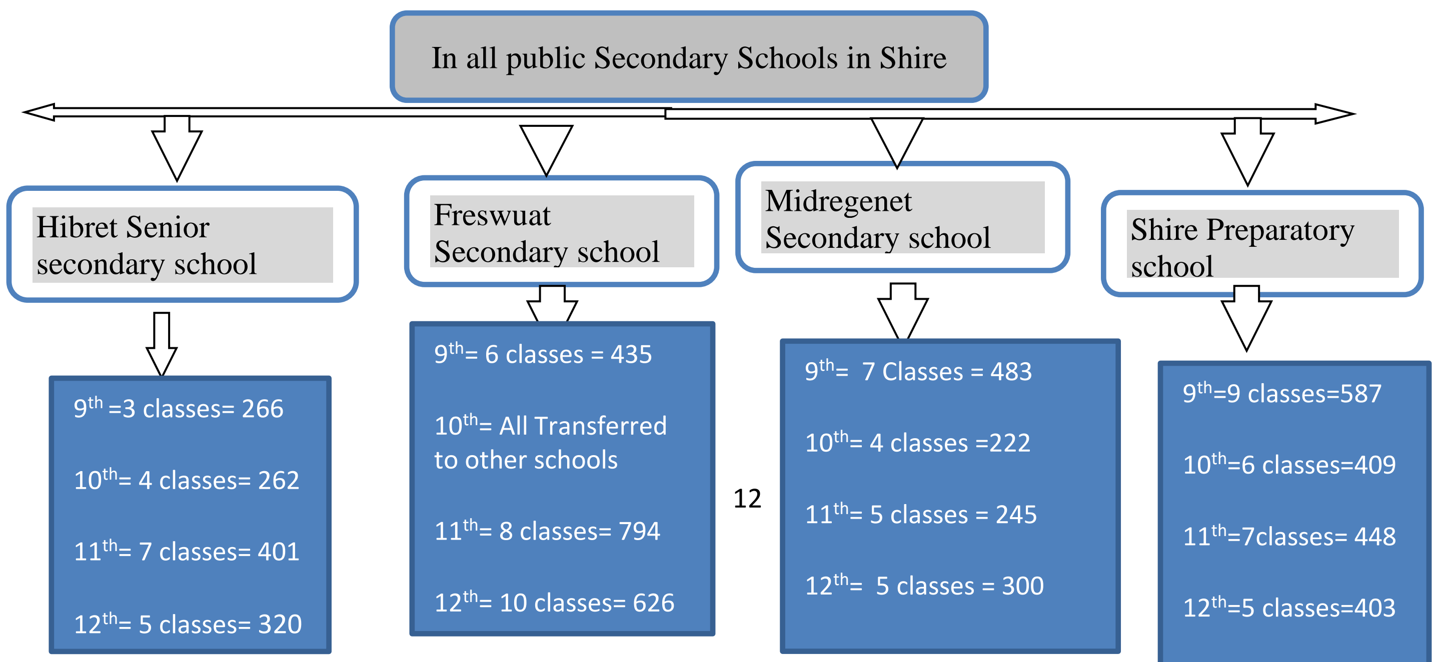
To account for a 10% non-response rate, the final sample size was adjusted as follows:

$$nf = \frac{calculated\ sample\ size}{1-0.10} = \frac{366}{0.90} \approx \mathbf{403}$$

Therefore, **403** was the calculated and final sample size.

4.6.2. Sampling technique

A total sample size of 403 secondary school students was proportionally allocated to the four secondary schools in Shire, based on the size of their source populations. From each school, students were selected using a systematic random sampling technique. The total source population was 6,200 students, and with a sample size of 403, the sampling interval (K) was calculated as 6,200 ÷ 403, which is approximately 15. Accordingly, every 15th student was selected for participation in the study.



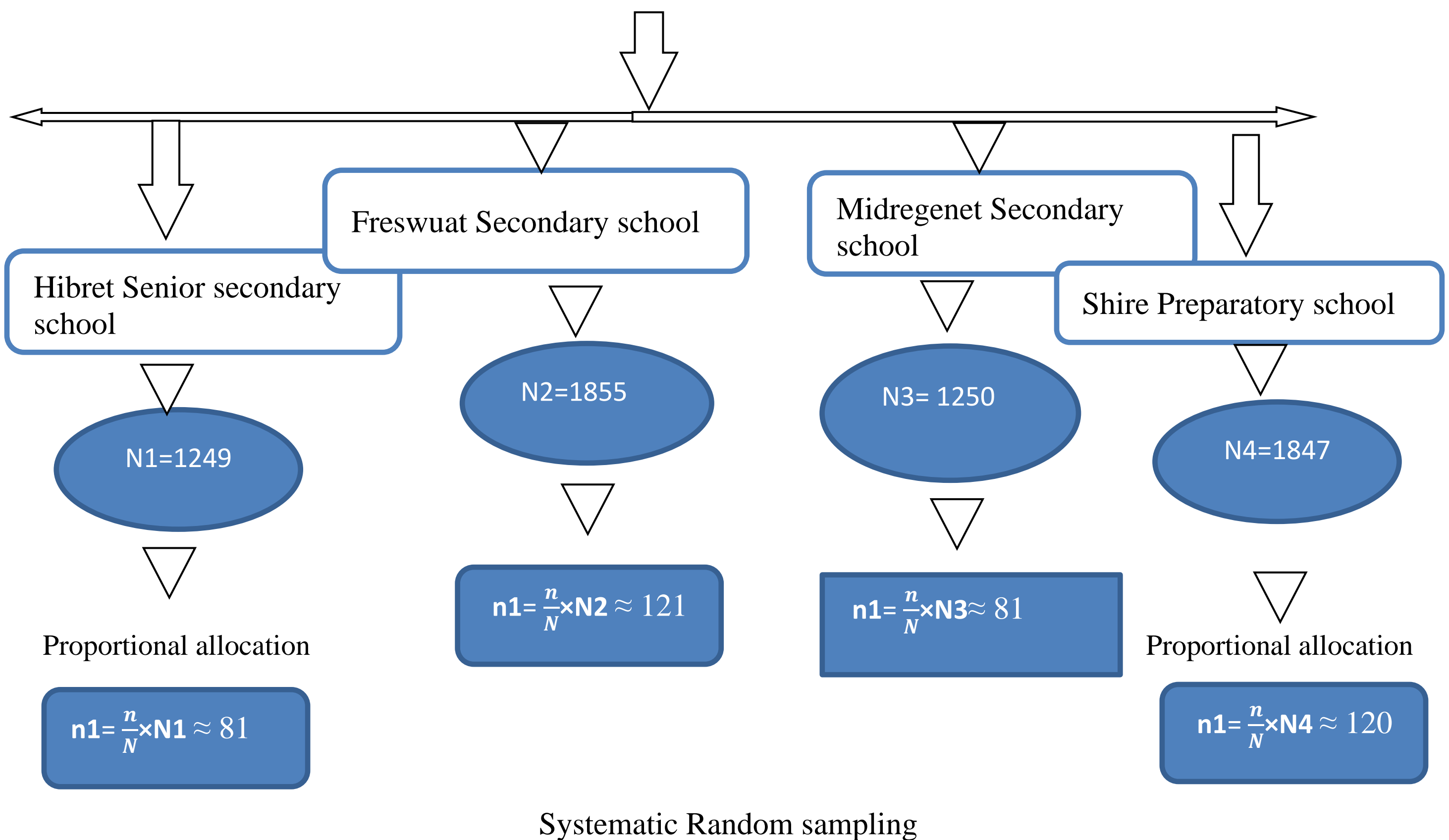


Figure 2: Figure 2: Schematic presentation of sampling procedure for the study on Prevalence of post-traumatic stress disorder among secondary school students in the post-war period in Shire, Tigray, Ethiopia, 2026.

4.7. Data Collection tools and Procedure

A quantitative data was collected from study subjects using a pretested, self-administered, structured, validated and reliable questionnaire. These questionnaires were originally developed in English but they will be translated to Tigrigna and will be administered.

Data collectors explained the purpose of the study and the importance of their participation**.** Data collectors and supervisors were recruited outside the data collection area. A total of 2 Health Professionals were assigned in the selected sites. In addition, one mental health professional served as a supervisor and was assigned to the institutions to facilitate the data collection process.

The questionnaire contained data on the outcome of interest (magnitude of PTSD) which was a PTSD PCL 5 tool.

Socio-demographic was collected by be collected by structured socio-demographic questions. Anxiety and depression were measured by the HSCL-25 (37).

Oslo social support scale (OSS-3) was used to assess the level of social support,

ASSIST lite, was used to classify the use of substance then collected data was translated to local language and back to English to maintain consistency, accuracy and clarity (41).

Trauma event status and related factors (types of abuse, number of displacement social related factors (Social support) Psycho-social factors, chronic medical illness and previous psychiatry illness and the ASSIST LITE screening tool was used to measure the level of Behavioral factors (substance use).

The socioeconomic status of participants was measured using a composite asset-based index, which was adapted from previous studies in low-income settings. The asset-based index was based on household assets, education levels of parents, parents' occupations, livestock ownership, and housing quality. Equal weighting was adopted for simplicity. The SES categories were divided into tertiles.

4.8. Study variables

4.8.1. Dependent variable

- PTSD (Yes/No)

4.8.2. Independent variables

- **Socio-Demographic Factors** Such as Age, Sex, Marital Status, educational level, religion, socio-economic status, family structure.
- **Psycho- Social Factors**: Social support
- **Traumatic event status and displacement related Factors,** physical, sexual, emotional, psychological and financial abuse, cumulative trauma and number of displacement.
- **Chronic Medical illness, Previous Psychiatry illness , anxiety, depression**
- **Psychological -** substance use, previous trauma

4.9. Operational definitions

- Magnitude of post-traumatic stress disorder **PCL-5** was used, it has 20 questions (29)
- Its internal consistency was validated via reliability test: Cronbach's alpha (0.93).
    - 0-10 = minimal or no symptom
    - 11-30 = mild to moderate symptoms
    - ≥33 = probable PTSD.

- **Depression and anxiety: (HSL25)** (17) Depression and anxiety symptoms were measured using the Hopkins Symptom Checklist-25 (HSCL-25). The tool consists of 25 items: 10 items assessing anxiety symptoms and 15 items assessing depressive symptoms. Each item is rated on a 4-point Likert scale. The mean score was calculated by dividing the total sum of item scores by the number of items. A higher mean score indicates greater symptom severity. The final score was determined by dividing the total of all item scores by the number of items. Sum score of items from 1-10 divided by 10 gives mean score of Anxiety and sum score of items from 11-25 gives mean score of depression.

Cut-off point: mean score ≥1.75 means positive symptoms and mean score <1.75 means negative. So mean of items from 1-10 ≥1.75 means Anxiety symptoms are present. While, mean of items from 11-25 ≥ 1.75 shows presence of Depression.

- The following Psychological abuses were assessed as independent variable to examine its specific contribution to PTSD, as different types of trauma may have varying psychological impacts;

  - ✓ Forced isolation / cultural harm (enforced to be isolated, prevented from meeting religious and cultural needs and having privacy invaded or threats of harm or bully)
  - ✓ Robbery or financial exploitation (history of being robbed, prevented from accessing your money, threats and undue put on you in connection with property, inheritance or money transactions, exploited of your money and asset)
  - ✓ Being bullied/prevented from choices (prevented from expressing your choices, addressed in patronizing, belittling way).

  Each are measured using single dichotomous item: Yes (1) - if the participants reports experiencing the event and No (0)- if the participant reports experiencing none.

- **Social support:** According to **Oslo-3** social support scale which ranges from 3-14 (38), those respondents who scored 3–8 considered as having poor social support, those who scored 9–11 were considered as having moderate social support and scores 12-14 were considered as having strong social support(28). the internal consistensy of this tool was 0.57 (Cronbach's alpha)
- **ASSIST-Lite**: The ASSSIT-Lite is a short-form version of the Alcohol, Smoking and Substance Involvement Screening Test - Lite (ASSIST). It was screen the risk for a range of drugs of concern (41).
- Socio Economic Status category interpretation was done using tertiles (39)

0 – 6 Low SES High economic vulnerability; likely lacks basic safety nets.

7 – 12 Medium SES Moderate stability; owns some assets but vulnerable to shocks.

13 – 19 High SES High stability; likely has better access to healthcare/resource

4.10. Data quality assurance

The Structured questionnaires was checked thoroughly for its completeness before it was distributed to the respondents. Structured questionnaires was translated by bilingual mental health professionals into Tigrigna where almost all patients can understand. To check its consistency with its English version, it was also re-translated to the original version. Questionnaires were pre-tested at Endabaguna secondary school. Data collectors and supervisors were trained for two days on the purpose of the study, the content of the questionnaire, the confidentiality of information, and ethical techniques. Data were consistently checked for their validation data type, range and format check.

The principal investigator and data collectors were make close follow up and frequent checks on the data collection process to ensure the completeness and consistency of the gathered information. Also incomplete data were excluded from analysis.

4.11. Data Entry and Analysis

Once all data were collected, they were checked for completeness and consistency, and then analyzed using SPSS version 27. Descriptive statistics (frequency, mean, and standard deviation) were used to estimate the prevalence of PTSD. Bivariate analysis was conducted to examine the association between each independent variable and the dependent variable, and variables with a p-value less than 0.25 were included in a multivariable binary logistic regression model to identify their effect on the dependent variable. The level of statistical significance was set at a p-value of < 0.05 with a 95% confidence interval (CI), and odds ratios (ORs) were used to quantify the strength of association. Assumptions of the logistic regression model were assessed using Hosmer Lemeshow, and the test of parallel lines, while multicollinearity was checked using the Variance Inflation Factor (VIF). The results were presented in narrative form and supported by figures and tables based on frequency distributions and cross-tabulations.

4.12. Ethical Considerations

Ethical clearance was obtained from the Health Research Ethics Review Committee of Mekelle University, College of Health Sciences (**MU-CHS: MU-IRB 2498/2025**). Official supportive letters were submitted to Shire Secondary School. Study participants were informed about the procedures and significance of the study. All data and analysis results were kept confidential, and the findings were communicated only to the appropriate stakeholders. Participation was entirely voluntary, and individuals who chose not to participate were not coerced in any way. No personal identifiers were included in the questionnaire and referral mechanism was provided for those who in need.

4.13. Dissemination and utilization of the result

The study result will be presented to Mekelle University, college of health sciences, School of Nursing Department of Psychiatry and result documents will be disseminated to all responsible bodies in the study area. Finally the findings will be disseminated through different meetings, workshops and publishing in the local or peer to peer reviewed journals.

5. Result

5.1 Sociodemographic characteristics of respondents

A total of 402 participants were included in the study with a response rate of 98.8%. More than half of the respondents were female: 215 (53.5%). The majority were aged 18 years and older: 296 (73.6%), with 106 (26.4%) under 18. Most participants resided in urban areas: 359 (89.3%). In terms of marital status, 22 (5.5%) were married, and 15 (3.7%) divorced or widowed. Religious affiliation was predominantly Orthodox Christianity: 314 (78.1%). Regarding academic performance, 129 (32.1%) scored below 70%,. Education status varied, with 103 (25.6%) in 9th grade, 108 (26.9%) in 10th, 54 (13.4%) in 11th, and 137 (34.1%) in 12th grade. Most, 320 (79.6%), respondents lived with both biological parents and 23 (5.7%) lived alone. A hundred seventy one (42.5%) were from low-income households (Table 1).

Table 1. Socio-demographic characteristics of the respondents in Shire secondary school, Tigray, Ethiopia in 2025. (n=402)

Variables	Categories	N(%)
Sex	Female	215(53.5)
	Male	187(46.5)
Age	Under 18 years old	106(26.4)
	18 years and older	296(73.6)
Residence	Rural	43(10.7)
	Urban	359(89.3)
Marital Status	Single	365(90.8)
	Married	22(5.5)
	Divorced/Widowed	15(3.7)
Religion	Orthodox	314(78.1)
	Muslim	75(18.7)
	Catholic/Protestant	13(3.2)
Semester average Score (%)	<70%	129(32.1)
	70%-84.5%	182(45.3)
	≥85%	91 (22.6)
Education status	9th	103(25.6)
	10th	108(26.9)
	11th	54(13.4)
	12th	137(34.1)
Family structure	Living with both biological parents	320(79.6)
	Living with single parent/guardians	59(14.7)
	Living alone	23(5.7)
Socio-economic status	Low	171(42.5)
	Medium	166(41.3)
	High	65(16.2)

5.2 Clinical related characteristics

In this study, we analyzed clinical factors related to PTSD among a total of 402 secondary school students. Regarding co-morbid mental illness, only 5 (1.2%) participants reported having a mental illness other than PTSD. In terms of depression, 20 (5.0%) students were identified as having depression. With regard to substance use, 152 (37.8%) reported using at least one substance. Anxiety was reported in 14 (3.5%) of the participants. Additionally, 8 (2.0%) participants reported having a chronic medical condition. (Table 2).

Table 2: Clinical characteristics of secondary school students in the post-war period in Shire, Ethiopia, 2025 (n = 402).

Variable	Category	N(%)
Mental condition other than PTSD, Depression and Anxiety	No	397(98.8)
	Yes	5(1.2)
Depression	No	382(95.0)
	Yes	20(5.0)
Substance use(any)	No	250(62.2)
	Yes	152(37.8)
Anxiety	No	388(96.5)
	Yes	14(3.5)
Chronic medical illness	No	394(98.0)
	Yes	8(2.0)

5.3 Trauma related and psycho-social characteristics of respondents

This study showed that experiences of trauma, displacement, and social support among 402 participants. A majority of the participants reported exposure to various forms of violence and harm, with 52 (12.9%) experiencing torture, physical assault, or rough handling, and 39 (9.7%) reporting sexual violence. A small proportion of participants, 43 (10.7%), had experienced forced isolation or cultural harm, and 30 (7.5%) had been subjected to robbery or financial exploitation. Similarly, 3 (0.7%) reported being bullied or prevented from making choices. Regarding displacement, 176 (43.8%) had been displaced once, 98 (24.4%) more than once. In terms of social support, 85 (21.1%) reported poor support, 198 (49.3%) moderate support, and 119 (29.6%) good support. (Table 3).

Table 3: Trauma related, displacement, and Psycho-social characteristics of secondary school in Shire, Tigray, Ethiopia in 2025(n=402).

Characteristics	Categories	N(%)
Tortured, hit, rough handled	No	350(87.1)
	Yes	52(12.9)
Sexual violence experience	No	363(90.3)
	Yes	39(9.7)
Forced isolation / cultural harm	No	359(89.3)
	Yes	43(10.7)
Robbery or financial exploitation	No	372(92.5)
	Yes	30(7.5)
Bullied / prevented from choices	No	399(99.3)
	Yes	3(0.7)
Displacement history	No	128(31.8)
	Once	176(43.8)
	More than once	98(24.4)
Social Support	Poor	85(21.1)
	Moderate	198(49.3)
	Good	119(29.6)

5.4 Prevalence of Post-traumatic stress disorder

The prevalence of PTSD among secondary school students in the post-war period in our study was 18.4% (74) with (95% CI: 14.7%–22.5%).

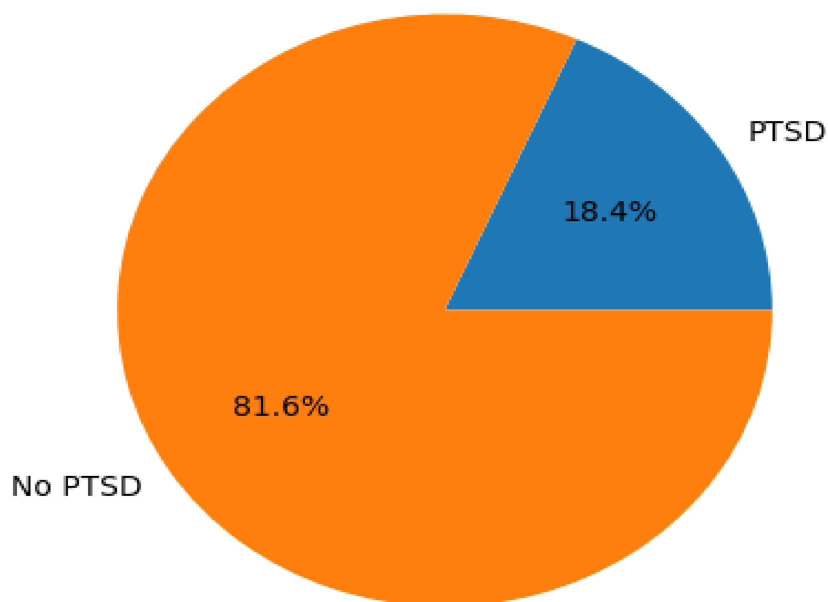


Figure 3: Prevalence of post-traumatic stress disorder among secondary school students in the post-war period in Shire, Tigray, Ethiopia, 2026.

5.5 Bivariate and Multivariable Analysis

Bivariate logistic regression was done to assess the relationship between each independent variables and the occurrence of PTSD. The result reveals that being female, being divorced or widowed, having a semester average score (i.e., score below 70%), and living alone or living with a single carer or guardian, low socioeconomic status, experiences of torture, forced isolation, robbery, exposure to sexual violence, depression, anxiety, chronic mental condition (excluding PTSD), substance use, and poor social support were considered as candidate variables of PTSD for multi-variable analysis at a P-value of < 0.25.

Further, a multivariable logistic regression analysis was used to identify significantly associated factors of Post-traumatic stress disorder (PTSD). The results showed that having a low semester average score (AOR=3.9695% CI: (1.46-10.79), exposure to torture (AOR = 3.86, 95% CI: (1.66-9.02), sexual violence AOR = 7.2, 95% CI: (2.67-19.2), poor social support (AOR = 3.78, 95% CI: (1.52-9.44), depression (AOR = 6.3, 95% CI: (1.52, 26.14), and substance use (AOR = 2.7, 95% CI: (1.33-5.52) were significantly associated with PTSD (p < 0.05) (Table 4).

Table 4: Factors associated with PTSD among Secondary school students of Shire, Tigray, Ethiopia, 2024/25 (n=402).

Variables	Categories	PTSD		COR (95% CI)	AOR (95% CI)	p-value
		Yes	No			
Sex	Male	29	158	1	1	
	Female	45	170	1.44(.67 , 241)	1.24(0.6 - 2.53)	0.56
Marital Status	Single	65	300	2.17(0.49, 9.50)	2.86(0.47-17.34)	0.25
	Divorced/widowed	7	8	8.75 (1.487,51.49)	6.12(0.57-65.17)	0.133
	Married	2	20	1	1	
Semester average score	<70%	45	84	6.43(2.74,15.068)	3.96(1.46-10.79)*	0.007
	70%-84.5%	22	160	1.65(0.677,4.02)	1.04(0.37-2.96)	0.93
	>=85%	7	84	1	1	
Family structure	Living with both biological parents	56	264	1	1	
	Single/Guardian care	4	2	1.97(1.03-3.77)	2.16(0.95-4.89)	0.07
	Living alone	2	21	4.54(1.78-11.53)	1.59(0.39-6.41)	0.51
Socioeconomic status	Low SES	27	144	1.03(0.468 , 2.271)	1.30(0.43-3.90)	0.63

	Medium SES	37	129	1.58(0.733,3.395)	1.6(0.53-4.71)	0.4
	High SES	10	55	1	1	
Tortured	No	52	298	1	1	
	Yes	22	30	4.203(2.252,7.844]	4.02(1.71-9.45)*	0.001
Sexual violence	No	52	311	1	1	
	Yes	22	17	7.74(3.852,15.55)	6.3(2.32-17.10)*	<0.001
Forced to isolate	No	60	299	1	1	
	Yes	14	29	2.41(1.20, 4.823)	1.20(0.36-3.95)	0.76
Been robbed	No	61	311	1	1	
	Yes	13	17	3.89(1.80, 8.442)	2.7(0.76-9.75)	0.122
Social Support	Poor	38	47	11.2(4.86, 25.86)	3.4 (1.39-8.47)*	0.007
	Moderate	28	170	2.28 (1.005,5.196)	1.55(0.69-3.44)	0.29
	Strong	8	111	1	1	
Anxiety	Yes	10	4	7.4(2.55-21.59)	4.2(0.89-20.09)	0.07
	No	64	324	1	1	
Depression	Yes	14	6	11.4(4.18_31.26	4.05(1.07-15.23)*	0.03
	No	60	322	1	1	
Chronic mental illness	Yes	4	1	18.68(2.05,169.73)	8.5(0.68-107.3)	0.09
	No	70	327	1	1	
Substance use	Yes	44	108	2.98 (1.78,5.016)	2.8(1.36-5.63)*	0.005
	No	30	220	1	1	

- **Significant Variables**: Asterisks (*) indicate statistically significant variables ($p < 0.05$), **References** are indicated by 1.
- **Df (degrees of freedom)** = 8, **Hosmer and Lemeshow Test =** 0.313
- **AOR**: Adjusted Odds Ratio, **COR**: Crude odds ratio.
- **C.I.**: Confidence Interval

6. Discussion

The study found that the prevalence of PTSD among secondary school students in the post-war period in Shire, Tigray, Ethiopia was 18.4% (95% CI: 14.7%–22.5%). This finding is within the range reported by global studies in conflict-affected settings but notably lower than some. For instance, a study conducted in post-genocide Rwanda reported PTSD prevalence rates of up to 54% among adolescents, while a study in Damascus, Syria, found that 53% of secondary school students experienced PTSD symptoms after nine years of conflict (12, 20). In South Africa, former high school students who participated in the South African border war reported a 33% PTSD prevalence, indicating the long-term psychological impact of war exposure on adolescents transitioning into adulthood (42). These variations could be attributed to differences in the intensity and duration of conflict exposure, time since trauma, and cultural or systemic support differences.

However, the prevalence found in our study was higher than the global lifetime prevalence rate of PTSD, which is estimated to be around 4% in the general population (43). Similarly, it exceeds the estimated 8% lifetime prevalence and the 9–15% incidence rate of PTSD in the general population reported in broader epidemiological studies (15). These discrepancies may reflect the unique psychological burden of war among youth populations in active or recently post-conflict regions such as northern Ethiopia.

In this study, several factors were found to be significantly associated with PTSD among secondary school students. Students with low academic performance had a higher likelihood of developing PTSD. Low semester average score (AOR = 4.48, 95% CI: 1.583, 12.671) was significantly associated with PTSD and academic difficulties are often both a symptom and a consequence of trauma, with previous studies linking poor academic outcomes to increased psychological distress in war-affected children and adolescents.

Exposure to torture (AOR = 4.56, 95% CI: 1.83–11.38), sexual violence (AOR = 6.97, 95% CI: 2.49–19.50), and traumatic events like the murder or serious injury of family members or friends were also significantly associated with PTSD. This aligns with findings from a study in northeast Ethiopia, which reported that individuals who witnessed the killing or serious injury of loved ones were over four times more likely to develop PTSD (26). Similarly, research conducted in northern Uganda found a strong association between PTSD and experiences of sexual violence, with 18% of women diagnosed with PTSD reporting rape or sexual abuse (9). Studies in the United States have shown that sexual violence is one of the most powerful predictors of PTSD, with up to 94% of rape survivors developing symptoms shortly after the event and around 50% suffering long-term consequences (27).

Poor and moderate social support was also strongly linked to PTSD. This is supported by findings from northeast Ethiopia and other conflict-affected regions, where poor social support was repeatedly associated with a higher risk of PTSD among internally displaced persons (26). The absence of strong social ties during or after traumatic experiences often exacerbates feelings of helplessness and isolation, increasing vulnerability to PTSD.

Depression was another key factor significantly associated with PTSD in this study. This is consistent with research from Mexico, where 38% of Guatemalan refugees with PTSD also exhibited symptoms of depression, and from northern Uganda, where 78% of women with PTSD were also clinically depressed (31, 32). In South Ethiopia, depression increased the odds of developing PTSD by more than two times (45).

Substance use also showed a significant association with PTSD among the study population. While less frequently addressed in PTSD literature focused on adolescents, substance use is often a coping mechanism for trauma, and its presence can both exacerbate and be exacerbated by PTSD. Research from various settings highlights the complex bidirectional relationship between substance use and PTSD symptoms.

7. Limitation of study

This study employed a cross-sectional design, which limits the ability to establish causal relationships between PTSD and its associated factors such as trauma exposure, depression, and social support. The data were collected at a single point in time, making it difficult to determine the directionality of the associations observed. Additionally, due to the sensitive nature of questions related to torture, sexual violence, and mental health symptoms, there may have been under-reporting due to social desirability bias. Participants may have minimized or concealed their experiences to align with social norms or avoid stigma. Recall bias is another potential limitation, as the study relied on self-reported experiences of trauma and psychological symptoms, which may be affected by memory inaccuracies, especially in a post-conflict setting where multiple traumatic events may have occurred.

8. Conclusion and Recommendation

8.1 Conclusion

The study found that the prevalence of PTSD among secondary school students in the post-war setting was 18.4%. Key factors significantly associated with PTSD included low academic performance, exposure to torture, sexual violence, poor or moderate social support, depression, and substance use.

8.2 Recommendations

Based on the finding of this study, which demonstarte a substantial prevalence of PTSD and identify multiple associated academic, psycho-social, and trauma-related factors among secondary school students in post-war Shire, the following recommendations are proposed for policymakers, educational institutions, health sectors, and future researchers.

8.2.1 Recommendations for Education sector:

Integration for school based mental health services that the Ministry of Education, in collaboration with regional health authorities, should integrate school based mental health services within secondary schools in post-conflict areas. Regular mental health screening for PTSD, depression, and substance use should be incoporated into school health programs to enable early identification and timely referral of affected students.

Capacity building should be implemented. Teachers and school staff should receive training on basic mental health literacy, trauma informed care, and early warning signs of PTSD to help them recognize symptoms and facilitate early support.

Given the strong association between low academic performance and PTSD, schools should establish remedial education programs, tutoring services, and flexible academic support mechanism for students affected by trauma.

8.2.2 Recommendations for Health Sectors:

The regional health bureau should prioritize adolescent mental health by expanding access to trauma focused psychological services including counseling and evidence-based interventions such as trauma-focused cognitive behavioral therapy, within primary health care setting.

As identified in this study, the comorbidity between PTSD and depression is high so mental health services should adopted integrated screening and treatment approaches rather than addressing these conditions separately. This may improve treatment outcomes and reduce long-term functional impairment.

Mental health programs targeting adolescents in in post-conflict areas should include substance use education, prevention, and counseling components. Addressing substance use as maladaptive coping strategy is essential for reducing the severity and chronicity of the PTSD symptoms.

8.2.3 Recommendation for social and community based interventions:

Community based psychosocial programs should be strengthened to rebuild disrupted family and peer networks. Community leaders, religious institutions, and youth organizations can play a vital role in fostering supportive environments that improve resilience and emotional recovery among students.

Special attention should be given to adolescents exposed to torture, sexual violence and loss of family members. Confidential, gender sensitive, and culturally appropriate support services should be established to address stigma, promote disclosure and facilitate trauma healing.

Parents, caregivers and/or spouses should be educated on the psychological effects of war-related trauma and the importance of emotional support. Family-based interventions may enhance recovery and strengthen protective factors within the home environment.

8.2.4 Recommendations for Policy-making

Mental health and psycho-social support services should be integrated into post-conflict reconstruction and recovery strategies, both at regional and and national levels. Addressing mental health along side physical rebuilding is crucial for sustainable healing in war-affected communities.

Policymakers should allocate adequate financial and human recourse to adolescent mental health programs, particularly in post-war regions such as northern Ethiopia. Investment in mental health promotion and prevention may reduce long-term social and economic costs.

8.2.5 Recommendation for future researchers

Future studies should employ longitudinal designs for a better understanding of the long-term effects of PTSD and its associated factors among adolescents in post-conflict settings, as cross sectional study designs limit casual inference.

Qualitative studies exploring adolescents experience of trauma and recovery may provide deeper insight into cultural coping mechanisms, barriers to care, and contextual factors influencing mental health outcomes.

In addition, further research is needed to evaluate the effectiveness of the school-based and community-based health interventions in reducing PTSD symptoms and improving academic and psycho-social outcomes among war-affected youth.

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Annex I

Annex -1. Participants` Information Document

Code No: ------------

Dear Sir/Madam.

My name is …………………..….am currently data collectors for a research which is conducted by students who currently are studying at Mekelle university, college of health science. This information sheet and assent form for participants who are currently secondary school student that will participate on the study of "Prevalence And Associated Factors Of Post-Traumatic Stress Disorder Among Secondary School Students in Shire, Tigray, 2025: an Institution-based cross-sectional study".

Significance: importance of the study the results of this study will give a clear picture of the risk of PTSD and its determinants among the secondary school students giving us an idea on the areas we need to work on. It will help Policy makers identify the areas that need modification on care providing system and intervene on them.

Participants to be included: selected participants from all the secondary schools in Shire.

Confidentiality: all information you give will be kept confidential and your name won't be registered on the questionnaire.

Risk and benefits of the study

Risk: the study will be carried out simply by asking you with prepared and structured questions. The procedure doesn't bear any physical or psychological trauma. Those who will have met the criteria for PTSD and were not seen by psychiatrists will be taken and linked to health facility for further investigation and treatment.

Consent: the data collection will take a maximum of 25 minutes. Your participation in the study will be voluntary. You have to refuse or withdraw from participating in the study at any time before and after consent without explaining the reason.

Whom to **contact**

Name of principal investigator: Getachew Abraha

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Name of co-advisor: Mekuria Kassa Nerea (RN, MSc, Asst Prof)

Brhane G/hiwot (BSc, MSc)

Annex- II. Consent form

Dear Sir/Madam;

In signing this document, I am giving my consent to participate in the study entitled "Prevalence and Associated Factors of Post-Traumatic Stress Disorder among Secondary School Students in Shire, Tigray, 2025: a cross-sectional study".

I have been informed that the purpose of this research project and I understand that I am selected to participate in this study randomly. I have been informed that my participation in this study is willing full and voluntary even I have right to refuse or interrupt the filling of questionnaire and my name will not be mentioned on the questionnaire.

I have understood the purpose of the study & fully agree to participate in the study.

Signature of the participant------------------ Date ------------------------

Thank you, have a nice day!

Data collector: name____________________ signature: ___________ date: _________

Supervisor name ________________ signature ____________________

Annex- III. English Version questionnaire

Part 1- Socio Demographic Information

No	Questionnaires	Alternative response/coding
Q-1	Sex	1. Male 2. Female
Q-2	How old are you?	Age in years --------------
Q-3	What is your marital status?	1. Single 2. Married 3. Separated/Divorced 4. Widowed
Q-4	Religion	1,Orthodox 2, Muslim 3,Protestant 4,Catholic Others, specify _______
Q-5	Grade	1, 9th 2,10th 3,11th 4,12th
Q-6	Residence	1. Urban 2. Rural
Q-7	Highest level of education completed by your father or guardian?	1. No formal education 2. Primary school 3. Secondary school 4. Certificate/Diploma 5. Bachelor's degree or above 6. I do not know
Q-8	What is the main occupation of your father or guardian?	1.Farmer 2.Daily laborer 3.Government employee 4.Private sector employee 5.Merchant/ Trader 6.Housewife 7.Unemployed 8.I do not Know Other:_____
Q-9	what is your current family structure?	1. Living with both biological parents 2. Living with mother only 3. Living with father only 4. Living with step-parents

		5. Living with other relatives/guardians 6. Living alone Other:______
Q-10	Does your household own any of the following?	1. Radio 2. Mobile Phone 3. Bicycle 4. Motorcycle 5. Television 6. Generator
Q-11	How many cattle/goats/sheep does your household own?	1. 0 2. 1-5 3. 6-10 4. >10
Q-12	Does your home have electricity?	1. Yes 2. No
Q-13	What material is your house roof made of?	1. Mud 2. wood 3. Concrete

Part 2- Questions Regarding PTSD: The following questionnaire has a total of 20 questions, with Not at all, A little bit, moderately. Quite a bit and extremely alternative responses, for a question answered for each item will be marked as 0,1,2,3 and 4 orderly.

№	**Questions**	Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
2.	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	4
3.	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
4.	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
6.	Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?	0	1	2	3	4
7.	Avoiding activities or situations because they reminded you of a stressful experience from the past?	0		2	3	4
8.	Trouble remembering important parts of a stressful experience from the past?	0	1	2	3	4
9.	Loss of interest in activities that you used to enjoy?	0	1	2	3	4
10	Feeling distant or cut off from other people?	0	1	2	3	4
11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
13.	Trouble falling or staying asleep?	0	1	2	3	4
14.	Feeling irritable or having angry outbursts?	0	1	2	3	4
15.	Having difficulty concentrating?	0	1	2	3	4
16.	Being "super-alert" or watchful or on guard?	0	1	2	3	4
17	Feeling jumpy or easily startled?	0	1	2	3	4
18	Negative beliefs about self, others, or the world, such as 'I am bad', 'no one can be trusted, or 'the world is completely dangerous?	0	1	2	3	4
19	Blaming self or others for the stressful experience or what happened after it?	0	1	2	3	4
20	Negative emotional state because of negative feelings such as fear, horror, guilt, or shame?	0	1	2	3	4

Part 3 Questions to assess presence of Depression and anxiety, it has a total of 25 items in two different parts, first 10 items for anxiety and 15 for depression

3.1. Anxiety

	Question	Not at all	A little	Quite a bit	Extremely
1	Suddenly scared for no reason	1	2	3	4
2	Feeling fearful	1	2	3	4
3	Faintness, dizziness or weakness	1	2	3	4
4	Nervousness , shaking inside	1	2	3	4
5	Heart pounding , racing	1	2	3	4
6	Trembling,	1	2	3	4
7	feeling tense, keyed up	1	2	3	4
8	Headache	1	2	3	4
9	Spells of Terror panic	1	2	3	4
10	Feeling restless , can’t sit still	1	2	3	4

3.2. Depression

Number	Item questions	Not at all	A little bit	Quite a bit	Extremely
1	Feeling low in energy, slowed down	1	2	3	4
2	Blaming yourself for things	1	2	3	4
3	Crying easily	1	2	3	4
4	Loss of sexual interest or pleasure	1	2	3	4
5	Poor appetite	1	2	3	4
6	Difficulty falling asleep, staying asleep	1	2	3	4
7	Feeling hopeless about the future	1	2	3	4
8	Feeling blue	1	2	3	4
9	Feeling lonely	1	2	3	4
10	Thoughts of ending your life	1	2	3	4
11	Feeling of being trapped or caught	1	2	3	4
12	Worrying too much about things	1	2	3	4

13	Feeling no interest in things	1	2	3	4
14	Feeling everything is an effort	1	2	3	4
15	Feeling of worthlessness	1	2	3	4

Part-4, Questionnaires to Assess Social Support (SSQ)

The following 3 questions ask about how you experience your social relationships. The question is about your immediate personal experience.

S .no	Social Support Questionnaire	Response
1	How many people are so close to you that you can Count on them if you have serious personal problems (choose one option)?	1.None 2.1 or 2 3.3-5 4. More than 5
2	How much concern do people show in what you are doing (choose one option)?	1. No concern and interest 2.Little concern and interest 3. Uncertain 4. some 5. a lot
3	How easy is it to get practical help from friends or dorm-mates' if you should need it (choose one option)?	5. Very easy 4. Easy 3. Possible 2. Difficult 1. Very difficult

Part-5. Trauma related, chronic medical and previous psychiatry history questions

No	Items	Yes	No
1	Have you ever been tortured, kicked, hit, rough handled, involuntarily isolated or unauthorisdely restrained?	____	___
2	Have you ever been inappropriately touched, sexually assaulted, harassed, witness a sexual act, attempted rape or raped	____	___
3	Have you ever been enforced to be isolated, prevented from meeting religious and cultural needs invaded your privacy or threats of harm?	____	___
4	Have you ever been robbed, prevented from accessing your money, threats and undue put on you in connection with property, inheritance or money transactions, exploited of your money and asset?	____	___
5	Have you ever been prevented from expressing your choices, addressed in patronizing, belittling way?	____	___
6	Have you ever been diagnosed for any chronic medical illness, like: DM, Heart Attack? HIV, Hypertension?	Yes: ____ If Yes Specify	NO: __
7	Have you ever been diagnosed for any mental health disorders, except PTSD?	Yes: ____ If Yes Specify	NO: __
8	How many times have you been displaced?	1. Once: ___ 2. More than once:____	
	Summed number of traumas		

Part-6. The ASSSIT-Lite is a short-form version of the Alcohol, Smoking and Substance Involvement Screening Test - Lite (ASSIST) that can be used to screen for a range of drugs of concern

	Question	Yes	No
Tobacco	1. Did you smoke a cigarette containing tobacco?	Yes ☐ 1	No ☐ 0
	1a. Did you usually smoke more than 10 cigarettes each day?	Yes ☐ 1	No ☐ 0
	1b. Did you usually smoke within 30 minutes after waking?	Yes ☐ 1	No ☐ 0
		Sub-total:	
Alcohol	2. Did you have a drink containing alcohol?	Yes ☐ 1	No ☐ 0
	2a. On any occasion, did you drink more than 4 standard drinks of alcohol?	Yes ☐ 1	No ☐ 0
	2b. Have you tried and failed to control, cut down or stop drinking?	Yes ☐ 1	No ☐ 0
	2c. Has anyone expressed concern about your drinking?	Yes ☐ 1	No ☐ 0
		Sub-total:	
Cannabis	3. Did you use cannabis?	Yes ☐ 1	No ☐ 0
	3a. Have you had a strong desire or urge to use cannabis at least once a week or more often?	Yes ☐ 1	No ☐ 0
	3b. Has anyone expressed concern about your use of cannabis?	Yes ☐ 1	No ☐ 0
		Sub-total:	
Amphetamine -type stimulants	4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed?	Yes ☐ 1	No ☐ 0
	4a. Did you use a stimulant at least once each week or more often?	Yes ☐ 1	No ☐ 0
	4b. Has anyone expressed concern about your use of a stimulant?	Yes ☐ 1	No ☐ 0
		Sub-total:	
Sedatives	5. Did you use a sedative or sleeping medication not as prescribed?	Yes ☐ 1	No ☐ 0
	5a. Have you had a strong desire or urge to use a sedative or sleeping medication at least once a week or more often?	Yes ☐ 1	No ☐ 0
	5b. Has anyone expressed concern about your use of a sedative or sleeping medication?	Yes ☐ 1	No ☐ 0
		Sub-total:	
Opioids	6. Did you use a street opioid (e.g. heroin), or an opioid-containing medication not as prescribed?	Yes ☐ 1	No ☐ 0
	6a. Have you tried and failed to control, cut down or stop using an opioid?	Yes ☐ 1	No ☐ 0
	6b. Has anyone expressed concern about your use of an opioid?	Yes ☐ 1	No ☐ 0
		Sub-total:	
Ot her Subst	7. Did you use any other psychoactive altering substance?	Yes ☐ 1	No ☐ 0
	What did you take?		

7a. Have you had a strong desire or urge to use the prescribed drug at least once a week or more often?	Yes ☐ 1	No ☐ 0
7b. Has anyone expressed concern about your use of the prescribed drug?	Yes ☐ 1	No ☐ 0
	Sub-total:	*Not scored*
	Total Score:	

<u>Tigrigna version</u>

ልጋብ 1

ልጋብ-1: ናይ ተሳተፍቲ ዝርዝር ሓበሬታ

ናይ ፕሮጀክት ስም

ኣብ ቤት- ትምህርቲታት ሓፈሻዊ ካልኣይ ብርክን መሰናድኦን ከተማ ሽረ ፤ትግራይ፤ ኢትዮጵያ፤ ዝርከቡ ተምሃሮ ዝህሉ ድሕሪ ማህሰይቲ ሕማቕ ተሞኩሮ ዝመፅእ ጸቕጢ መጠንን ኣቃላዕቲ ነገራትን መፅናዕቲ፣ 2017 ዓም ።

ዋና ተመራማሪ፡ ጌታቸው ኣብራሃ

ቀዳማይ ኣማኻሪ፡ ኣቶ ተስፋይ ኣርኣያ (ሓ/ፕሮፌሰር)

ካልኣይ ኣማኻሪ፡ ኣቶ ሓጎስ ፀጋብርሃን (ሓ/ፕሮፈሰር)

ክፍሊ ትምህርቲ: ስነ-ኣእምሮ ነርሲንግ፤ነርሲንግ ትምህርቲ ቤት፤ ኮሌጅ ጥዕና ሳይንስ ፤ዩኒቨርሲቲ መቐለ

መእተዊ፡

ደሓን ዶ ሓዲርኩም/ደሓን ዶ ውዒልኩም ስመይ________ ኣብ ርእሱ ንምግላፅ ከም ዝተሞክረ ኣብዙይ ዝተረኸብኩሉ ናይዚ መፅናዕቲ ዝርዝር መረዳእታ ንምእካብ እዩ። እዚ መፅናዕቲ ዘካይድዎ ኣብ ዩኒቨርሲቲ መቐለ ፤ ኮሌጅ ጥዕና ሳይንስ ፤ ክፍሊ ትምህርቲ ነርሲንግ፣ ስነ-ኣእምሮ ነርሲንግ ፣ **ብዝተጣመረ ሕክምና እና ማሕበረሰባዊ ናይ ስነ ኣእምሮ ጥዕና ኣተሓላልዋ** ናይ 2ይ ዲግሪ (ማስተርስ ዲግሪ) ተመራቒ ተምሃራይ ዝኾኑ ኣቶ ጌታቸው ኣብራሃ ዝተብሃሉ እዮም።

ዓላማ : ኣብ ተምሃሮ ካልኣይ ብርኪ በትምህርትታት ሽረ ዝህሉ መጠን ኣቃላዕቲ ነገራትን ንምንፃር እዩ።

ኣካይዳን ተሳትፎን፡ ኣብዚ ፅንዓት ክሳተፉን ትኽክለኛ መልሲ ንክህቡንን ብትሕተና ይሓትት።

ናቶም/ተን ምትሕብባርን ፍቓድን ድሕሪ ማህሰይቲ ሕማቕ ተሞኩሮ, ዝመፅእ ጸቕጢ ኣቃላዕቲ ነገራትን/ምኽንያታት ንምንፃር/ንምፍላጥ ጠቓሚ እዩ። ነዚ ቃለ-መሕትት ዝወስደሎም/ለን ግዜ ከዓ 25 ደቒቓ እዩ።

ሚሰጥራዊነት፡ ንዝህብዎ መረዳእታ ሚስጥሩ ዝተሓለወ እዩ።

ጥቕሚ፡ ብዝህቡኒ መረዳእታ ተጠቃሚ እየ ንሰም ግን ዝጥቀምዎ ነገር የለን።

ጉድኣት (ሳዕቤን)፡ ኣብዚ ቃለ-መሕትት ብምስታፎም ዝተወሰነ መጠን ምቾት ዘይክስምዖምን ግዚኦም ካብ ክወስደሎምን ይክእል እዩ። ካብዚ ሓሊፉ ግን ዝበፅሖም ምንም ዓይነት ሳዕቤን የለን።

መበረታትዒ/ክፍሊት፡ ንዝህብዎ መረዳእታ ምንም ዓይነት ክፍሊት የብሉን ኮይኑ መጠን ስነ-ልቦናዊ ጭንቀትን ኣቃለዕቲ ነገራትን ንምፍላይ ይጠቕመኒ።

ውፅኢት መፅናዕቲ፡ብሰሚናር መልክዕ ኣብ ዩኒቨርሲቲ መቐለ ኮሌጅጥዕና ሳይንስ ክፍሊ ትምህርቲ ስነ-ኣእምሮ ፤ ቤት ትምህርቲ ነርሲንግ ዝቐርብ እዩ።

ሕቶ ናይ ዘይምምላስ መሰል፡ ደስ ዘይበሎም ሕቶ እንተጋጥሞም ናይዘይምምላስ ወይ እቲ ሕቶ ናይ ምዝላል መሰሎም ሕልው እዩ።

ክረኽብዎ ዝደለዩ ሰብ: ሕቶ ወይ ውፅኢት ናይዚ መፅናዕቲ ውፅኢት ንምፍላጥ እንተደለዮም ኣብ ዝኾነ ሰዓት ብዝቕፅል ኣድራሻ ናይቲ ተመራማሪ ኣድራሻ ብምሓዝ ምርካብ ይኽእሉ እዮም።

ተወሳኺ ሓሳብ ተደልዮም እና ናይዚ ፕሮጀክት ዓላማ ክፈልጡ ተደልዮም ካብዚ ብታሕቲ ዘለው ሰባት ምንግጋር ይኽእሉ እዮም።

ዩኒቨርስቲ መቐለ፣ ኮሌጅ ጥዕና ሳይንስ ቦርድ ትካል ግምገማ ኦፊስ

ስልኪ ቁፅሪ: ________________________

ዋና ተመራማሪ፡ሽምን ኣድራሻን፡ ጌታቸው ኣብራሃ

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ኣማኸርቲ ሽምን ኣድራሻን፡

ቀዳማይ ኣማኻሪ፡ ኣማኻሪ፡ኣቶ ሓጎስ ፀጋብርሃን (ሓ/ፕሮፈሰር)ስልኪቁፅሪ፡ +251 914735498

ካልኣይ ኣማኻሪ: ኣቶ መኩርያ ካሳ (ሓ/ፕሮፈሰር)

ሳልሳይ ኣማኻሪ: ኣቶ ብርሃነ ገ/ሂዎት (ቢኤስሲ፣ኤምኤስሲ)

ዩኒቨርሲቲ መቐለ፤ኮሌጅ ጥዕና ሳይንስ፤ክፍሊ ትምህርቲ ስነ-ኣእምሮ ነርሲንግ፤ቤትትምህርቲ ነርሲንግ

ስልኪ ቁፅሪ: +251 034 559 88 69

እሞ ንምስታፍ ፍቓደኛ ድዮም?

1. እወ____________________________ ናብ ዝቕፅል ገፅ ቀፅል/ሊ
2. ኣይፋልን________________________ ናብ ዝቕፅል ተሳታፋይ ቀፅል/ሊ

ልጋብ-2

ልጋብ-2 ቅጥዒ ናይ ስምምዕነት ፍቓድ

ናይ ፕሮጀክት ስም

ኣብ ቤት- ትምህርቲታት ሓፈሻዊ ካልኣይ ብርክን መሰናድኦን ከተማ ሽረ ፤ትግራይ፤ ኢትዮጵያ፤ ዝርከቡ ተምሃሮ ዝህሉ ድሕረ ማህሰይቲ ሕማቕ ተሞኩሮ ዝመፅእ ጸቕጢ መጠንን ኣቃላዕቲ ነገራትን, 2017 ዓ ም ።

እዚ መፅናዕቲ ዝግበር ን2ይ ዲግሪ (ማስተር) ትምህርቲ መመረቒ ብዩኒቨርሲቲመቐለ፤ኮሌጅ ጥዕና ሳይንስ ክፍሊ፤ ትምህርቲ ስነ-ኣእምሮ ክፍሊ፤ ትምህርቲ ስነ-ኣእምሮ ነርሲንግ ዝምራሕን ዝሕገዝን ኮይኑ በዓል ዋና ናይቲ ትምህርቲ ተመራማሪ ናይቲ መፅናዕቲ ከዓ ጌታቸው ኣብራሃ ከም ዝበሃሉ ፈሊጠ ኣለኹ።ንዓይ ብዝርድኣኒ ቋንቋ ብዛዕባ እቲ መፅናዕትን ናይቲ ፅንዓት ዓላማ ከዓ ኣብ ቤት- ትምህርቲታት ሓፈሻዊ ካልኣይ ብርክን መሰናድኦን ከተማ ሽረ ዝርከቡ ተምሃሮ ዝህሉ ድሕረ ማህሰይቲ ሕማቕ ተሞኩሮ ዝመፅእ ጸቕጢ መጠንን ኣቃላዕቲ ነገራትን, ምንፃር ከም ዝኾነ ታሓቢረን ተረዲአን።

ኩሉ እቲ ሓበሬታ ነቲ ቃለ-መሕትት ዝግበረሉ ሚስጥሩ ዝትሓለወ ከም ዝኾነ ታሓቢረ። እቲ መፅናዕቲ ዘለዉ ገለ ሕቶታት ዝተወሰነ ምቾት ዘይክፍጥሩልካ ይክእሉን ግዘካ እውን ክሻመየካ ይክእል እዩ።ኩን እምበር ምንም ዓይነት ተወሳኪ ጉድኣትን ኮነ ምስ መዋቅራዊ ወይ ሕጊ ዝተተሓሓዘ ነገር ዘይብሉ ምኻኑ ተረዲአ። ከምኡ እውን ነቲ ሓበሬታ ንዘይምምላስ መሰል ዘለኒ ምኻነይ፤ ሕቶ ኣብ ምምላስ ክዘሎ ወይ ካብቲ መፅናዕቲ ኣብ ዝኾነ ሰዓት ክገድፎ ዝኾነ ይኹን ኣካል ፅልዋ ክፈጥረለይ ከም ዘይኽእልን ንምንታይ ከም ዘቋረፅክዎ ምኽንያት ንኽቐርበሉ ከም ዘይሓተንን ፈሊጠ። ብተወሳኺ ኣብ ኩሉ ናይ ጥዕናይ ጥቕሚ ምንም ዓይነት ለውጢ ከም ዘይብሉ ወይ ከዓ ካልኦት ብናይ ኣመራርሓ ለውጢ ዝመፅእ ኣብ መንበርየይ ዘይብሉ ምኻኑ ታሓቢረ።

ዘይተረደኣኒ ሕቶ ምሕታት መሰል ከም ዘለንን ብዛዕባ እቲ ፅንዓት ቅድሚኡ ይኹን ኣብቲ ፅንዓት ግዜ ዝምልከቶ ሰብ ክረክብ ከም ዝኽእልን ኣረጋጊፀ።

ዩኒቨርሲቲመቐለ፤ ኮሌጅ ጥዕና ሳይንስ ቦርድ ትካል ግምገማ ኦፊስ

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ዋና ተመራማሪ : **ሽምን ኣድራሻን**፡ ኣይተ ጌታቸው ኣብራሃ

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ኣማኽርቲ ሽምን **ኣድራሻ**ን፡ **ቀዳማይ ኣማኻሪ፡** ኣቶ ሓጎስ ጋብርሃን (ሓ/ፕሮፈሰር)፣ +251 914 735 498

ሓጋዚ ኣማካሪ ኣቶ መኩርያ ካሳ (ሓ/ፕሮፈሰር) ፣ +251 978 184 439

ካለኣይ ሓጋዚ ኣማካሪ፡ ብርሃነ ገ/ሂዎት (ቤኤሲ፣ኤም ኤስሲ ICCMH) ኣሜል፡

birhanegebrehiwot@gmail.com

ኣንቢበዮ እነሄኩ እዚ ቅጥዒ ወይ ከዓ ንዓይከምብዝርደኣኒ መልክዑ ተነቢብሎይኣሎ አቲ ኣብ ላዕሊ ዝተገለፀ ዘሎ ስለዚ ፍቓደኛ እየ፤ ኣድላዪ ተኾይኑ ከዓ ተሳትፎይ ብፌርማይ ከረጋግፀልካ ይኽእል እየ። ኣብቲ ዝግበር መፅናዕቲንምስታፍ ተስማዕምዒኻ/ኺ/ኹም/ኽን ዶ?

1. እወ 2. አይተስማዕማዕኹን

መልስካ እወ እንተኮይኑ

ናይ ተሳታፊ መለለዪ ቁፅሪ__________ፊርማ ___________

ሽም ናይቲ ሓበሬታ ሰብሳቢ (ኣካቢ) ___________________ፊርማ ___________ዕለት___________

ሽም ናይ ተቖ____________________ፊርማ ___________ዕለት_____________

ልጋብ 3 ቃለ መሕተት

ክፍሊ 1: ማሕበራውንኢኮኖሚያውን ስነህዝባው ንዝምልከቱ ሕቶታት

1	ዕድመካ/ኪ ክንደይእዩ?	-----------------ዓመት
2	ፆታ?	1. ተባዕታይ 2. ኣነስታይ
3	ናይመንሃይማኖትእምነትተከታሊ/ትኢካ/ኪ?	1.ኦርቶዶክስ 2.ሙስሊም 3.ፕሮተስታንት 4. ካቶሊክ 5.ካሊእ
4	ናይ ትምህርት ደረጃ	1, 9ይ 2,10ይ 3,11 4,12
5	ኩነታትሓዳር	1.በዓል/ቲ ሓዳር 2.ዘይተመርዓወ/ት 3. ሓዳር ዝፈተሐ/ት 4. በዓል/ቲ ገዛ ብህይወት ዘየለ/ላ በዓል/ቲ ሓዳርእንተኮይኖም ክንደይ ቆልዑት

		አለውዎም/አለውወን?
6	ዝነብሩሉ ከባቢ ሽረ	1. ከተማ 2.ገጠር
7	ኣቦኻ ወይ መጕዚትኻ ዝዛዘመ ዝለዓለ ደረጃ ትምህርቲ?	1. ወግዓዊ ትምህርቲ የለን 2. መባእታዊ ቤት ትምህርቲ 3. ካልኣይ ደረጃ ቤት ትምህርቲ 4. ሰርተፍኬት/ዲፕሎማ 5. ናይ ባችለር ዲግሪ ወይ ልዕሊኡ 6. ኣይፈልጥን እየ
8	ቀንዲ ስራሕ ኣቦኻ ወይ መጕዚትኻ እንታይ እዩ?	1. ሓረስታይ 2. መዓልታዊ ሰራሕተኛ 3. ሰራሕተኛ መንግስቲ 4. ናይ ብሕቲ ትካላት ሰራሕተኛ 5. ነጋዳይ / ነጋዳይ 6. ሰበይቲ ቤት 7. ስራሕ ኣልቦነት 8. ኣይፈልጥን እየ ካልኦት፡- ______
9	ሕጂ ዘሎ መዋቕር ስድራ ቤትካ እንታይ እዩ?	1. ምስ ክልቲኦም ስነ-ህይወታዊ ወለዲ ምንባር 2. ምስ ኣደ ጥራይ ምንባር 3. ምስ ኣቦ ጥራይ ምንባር 4. ምስ ሰይተቦ ወለዲ ምንባር 5. ምስ ካልኦት ኣዝማድ/መዕበይቲ ምንባር 6. በይንኻ ምንባር

		ካልኦት፡- ______
10	ቤትካ ካብዞም ዚስዕቡ ነገራት ኣሎዶ?	1. ረድዮ 2. ሞባይል 3. ብሽክለታ 4. ሞተር ብሽክለታ 5. ተለቪዥን 6. ጀነሬተር
11	ቤትካ ክንደይ ኣኻፍት / ኣጣል / ኣባጊዕ ኣለዋ?	1. 0 2. 1-5 3. 6-10 4. >10
12	ቤትካ ኤለክትሪክ ኣለዎዶ?	1. እወ 2. ኣይፋል
13	ናሕሲ ቤትካ ብምንታይ ነገር እዩ እተሰርሐ?	1. ጭቃ 2. ዕንጨይቲ 3. ኮንክሪት

2ይ, ክፋል- ሕቶታት ብዛዕባ ድሕሪ ስንባደ ዝመፅእ ጸቕጢ (post traumatic stress disorder): እዚ ዝስዕብ ሕቶታት ብድምር 18 ሕቶታት ኣለዎ፣ ምስ ፈጺሙ ኣይኮነን፣ ቁሩብ፣ ማእከላይ, ኣዝዩ ኣማራጺ መልስታትን፣ ንነፍሲ ወከፍ ኣቕሓ ዝምለስ ሕቶ 0,1,2,3ን 4ን ብስርዓት ክምዝገብ እዩ።

ቁ ፅሪ	ሕቶታት	ፈጺሙ	ቁሩብ	ማእከላይ	ንነፍሲ ወከፍ	ኣዝዩ
1	ተደጋጋሚ፡ ዝርብሽ ዝኽሪ፡ ሓሳባት ወይ ምስልታት ናይ ሓደ ውጥረት ዝመልኦ ተመክሮ ካብ ዝሓለፈ?	0	1	2	3	4
2	ተደጋጋሚን ዝርብሽን ሕልሚ ናይ ሓደ ውጥረት ዝመልኦ ተመክሮ ካብ ዝሓለፈ?	0	1	2	3	4
3	ሃንደበት ውጥረት ዝመልኦ ተሞክሮ ከም ብሓድሽ ከም ዝፍጸም ጌርካ ምውሳእ ወይ ክስምዓካ (ከምቲ ዳግማይ ትነብሮ ዘለኻ)?	0	1	2	3	4
4	ሓደ ነገር ካብ ዝሓለፈ እዋን ዝነበረ ውጥረት ዝመልኦ ተመክሮ ምስ ዘዘኻኽረካ ኣዝዩ ምሕርቃም ይስምዓካ?	0	1	2	3	4
5	ሓደ ነገር ካብ ዝሓለፈ እዋን ዝነበረ ውጥረት ዝመልኦ ተመክሮ ምስ ዘዘኻኽረካ ኣካላዊ ግብረ መልሲ (ንኣብነት ውቂኢት ልቢ ምውሳኽ ፡ ጸገም ምስትንፋስ፡ ረሃፅ) ምህላው?	0	1	2	3	4
6	ብዛዕባ ሓደ ውጥረት ዝፈጥር ነገር ካብ ምሕሳብ ወይ ምዝራብ ምውጋድ ካብ ዝሓለፈ ተመኩሮ ወይ ምስኡ ዝተኣሳሰር ስምዒታት ካብ ምህላው ምውጋድ?	0	1	2	3	4
7	ንጥፈታት ወይ ኩነታት ካብ ዝሓለፈ እዋን ዝነበረ ውጥረት ዝመልኦ ተመክሮ ስለ ዘዘኻኽረካ ምውጋድ?	0		2	3	4
8	ኣገደስቲ ክፋላት ናይ ሓደ ውጥረት ዝመልኦ ተመክሮ ካብ ዝሓለፈ ምዝካር ትሸገር?	0	1	2	3	4
9	ኣብቲ ቀደም እተስተማቕሮ ዝነበርካ ንጥፈታት ተገዳስነት ምጥፋእ	0	1	2	3	4
10	ካብ ካልኦት ሰባት ርሑቕ ወይ ዝተቖርጸ ኮይንካ ዝስምዓካ?	0	1	2	3	4

11	ንነገራት ስምዒት ዘይምህላው ,ወይ ነቶም ቀረባኻ ፍቕራዊ ስምዒት ክህልወካ ዘይክእል	0	1	2	3	4
12	መጻኢኻ ብገለ መንገዲ ከም ዝቑረፅ ኮይኑ ይስምዓካ?	0	1	2	3	4
13	ጸገም ምውዳቕ ወይ ድቃስ ምፅናሕ?	0	1	2	3	4
14	ቁጥዐ ይስምዓካ ድዩ ወይ ቀልጢፍካ ምንዳድ ኣሎካ	0	1	2	3	4
15	ምትኳር ትሽገር?	0	1	2	3	4
16	ካብ ዝተለመደ ግዘ ብላዕ ንቑሕ ምዃን?	0	1	2	3	4
17	ብቀሊሉ ምስንባድ?	0	1	2	3	4
18	ብዛዕባ ገዛእ ርእስኻ፡ ንኻልኦት ወይ ብዛዕባ ዓለም ዚገልፅ ኣሉታዊ እምነታት፡ ከም 'ኣነ ሕማቕ እየ'፡ 'ዝኾነ ሰብ ኪእመን ኣይክእልን፡ ወይ 'ዓለም ምሉእ ብምሉእ ሓደገኛ እያ፡	0	1	2	3	4
19	ነቲ ውጥረት ዝመልኦ ተመክሮ ወይ ድሕሪኡ እንታይ ከም ዘጋጠመ ንነብስኻ ወይ ንኻልኦት ምውቃስ?	0	1	2	3	4
20	ኣሉታዊ ስምዒታዊ ኩነታት ብሰንኪ ኣሉታዊ ስምዒታት ከም ፍርሒ፡ ራዕዲ፡ ናይ በደል ስምዒት ወይ ሕፍረት?	0	1	2	3	4

3ይ ክፋል- ሕቶታት ሕማም ጭንቀት ሕማም ድብርትን ንምፍላይ ኣብ ክልተ ክፋል ፣ ብጠቕላላ 25 ሕቶታት ፣ 10 ን ሕማም ጭሕንቀት 15 ድማ ን ሕማም ድብርት

3.1. ሕማም ጭንቀት

ቁ ፅሪ	ሕቶታት	ፈፅሙ የለን	ብጣእሚ ብዝነኣሰ መልክዑ	ቁሩብ ቁሩብ	ኣዝዩ
1	ሃንደበት ብዘይ ምኽንያት ምፍራሕ	**1**	**2**	**3**	**4**
2	ፍርሒ ዝስምዓካ	**1**	**2**	**3**	**4**
3	ምሕንካስ፡ ምድንዛዝ ወይ ድኻም	**1**	**2**	**3**	**4**
4	ስንባደ ፣ ውሽጡ ምንቅጥቃጥ	**1**	**2**	**3**	**4**

5	ልቢ ብፍጥነት ምውቃዕ ፣ ምሕንፋፅ	1	2	3	4
6	ናይ ኣካል ምንቅጥቃጥ	1	2	3	4
7	ውጥረት ምስማዕ	1	2	3	4
8	ሕማም ርእሲ	1	2	3	4
9	ስሕተት፣ ራዕዲ፣ ስንባደ	1	2	3	4
10	ዕረፍቲ ዘይብልካ ስምዒት ይስመዓካ፣ ኮፍ ምባል ዘይምክኣልን	1	2	3	4

3.2. ሕማም ድብርት

ቁፅሪ	ሕቶታት	ፈፅሙ የለን	ብጣእሚ ብዝነኣሰ መልክዑ	ቁሩብ ቁሩብ	ኣዝዩ
1	ጉልበት ምሰኣን ኣብ አትገብሮ ምንክስቃስ ምፍዛዝን	1	2	3	4
2	ንነገራት ንነብስኻ ምውቃስ	1	2	3	4
3	ብቐሊሉ ምብካይ	1	2	3	4
4	ድሌት ጾታዊ ርክብ ፣ ምስኣን ወይ ደስታ ምጥፋእ	1	2	3	4
5	ድኹም ሽውሃት ምግቢ	1	2	3	4
6	ምድቃስ ምፅጋም	1	2	3	4
7	ብዛዕባ መጻኢ ተስፋ ዘይብሉ ስምዒት	1	2	3	4
8	ስምዕ ት ሓዘን	1	2	3	4
9	ፅምዋ ይስምዓካ	1	2	3	4
10	ህይወትካ ከተብቅዕ ሓሳባት	1	2	3	4
11	ኣርስካ አብዘይ ድስ ዘይብል ን ዘሕፍር ን ኩነታት ምርካብ	1	2	3	4
12	ብዛዕባ ነገራት ኣዚኻ ምጭናቕ	1	2	3	4
13	ኣብ ነገራት ተገዳስነት ዘይምህላው ስምዒት	1	2	3	4
14	ኩሉ ትገብሮ ነገር ከምጻዕሪ ኮይኑ እዩ ይስምዓካ	1	2	3	4
15	ዋጋ ዘይብልካን ትሕቲ ሰብ ከምዝኾንካ ኮይኑ ይስመዓካ ስምዒት	1	2	3	4

4ይ ክፋል. ቃለ መሕተት ብዛኤባ ማሕበራዊ ደገፍ ዝተመልከተ

	ማሕበራዊ ደገፍ መሕተቲ	መልሲ
1	ክንደይ ሰባት እዮም ኣዝዮም ዝቐርቡኻ እሞ ከቢድ ውልቃዊ ጸገም እንተሃልዩካ ክትፅበዮም ትኽእል ኢኻ (ሓደ ኣማራጺ ምረፅ)?	1.ዋላ ሓደ 2.1 ወይ 2 3.3-5 4.ልዕሊ 5
2	ሰባት ኣብቲ እትገብሮ ዘለኻ ክሳብ ክንደይ ስክፍታ የርእዩ (ሓደ ኣማራጺ ምረፅ)?	1. ስክፍታን ተገዳስነትን የለን 2.ውሑድ ስክፍታን ተገዳስነትን 3. ርግጸኛ ዘይኮነ 4. ንእሽተይ 5. ብዙሕ
3	ካብ መሓዙትኻ መደቀሲ’ ግብራዊ ሓገዝ ክትረክብ ክሳብ ክንደይ ቀሊል እዩ’ ከድልየካ እንተኾይኑ (ሓደ ኣማራጺ ምረፅ)?	5. ብጣዕሚ ቀሊል እዩ። 4. ቀሊል 3. ክኸውን ይኽእል እዩ። 2. ከቢድ 1. ኣዝዩ ከቢድ

5ይ ክፋል , ሕቶታት ማህሰይቲ ፣ ሕዱር ህማም ፣ ሕሉፍ ሕማም ስነ ኣእምሮ ፣ ናይ ምፍንቃል በዝሒ፣ ቁ ፅሪ በዝሒ ዘጋጠመ ዓይነታት ማህሰይቲ

ቁ ፅሪ	ሕቶታት	እወ:	ኣይፈል ጥን
1	ተሰቒኻ፡ ተረጊፅካ፡ ተሃሪምካ፡ ተገሪፍካ፡ ብዘይፍቓድካ ተነጺልካ ወይ ብዘይፍቓድካ ተገቲእካ፡ ተቓጺልካን ትፈልጥ ዲኻ?	_____	____
2	ብዘይግቡእ ኣብ ዘይተደልየ ጾታዊ ኣካላትካ ተተንኪፍካ፡ ጾታዊ መጥቃዕቲ ተፈጺምካ፡ ተሃስካ፡ ጾታዊ ተግባር ክትዕዘብ፡ ፈተነ ምዕማፅ ወይ ተዓሚፅካ ትፈልጥ ዲኻ	_____	____
3	ክትነፅል፡ ሃይማኖታውን ባህላውን ድሌታት ከይተማልእ ተኸልኪልካ፡ ንብሕትውናኻ ወሪርካ ወይ ክትጎድእ ምፍርራሕ ወይ ተደፊርካ ትፈልጥ ዲኻ?	_____	_____

4	ብናይ ምቅላል ወይ ዕሽልነት መንገዲ ተገይሩልካ ይፈልጥ ድዩ፣ ምግላፅ ምርጫን ርእይቶን ምክልኻል ወይ ምንቅስቓስ ወይ ናይ ርክብ ሓገዛት ምእላይ ?	_____	_____
5	ምስ ንብረት፡ ውርሻ ወይ ገንዘብ ምትሕልላፍ ብዝተኣሳሰር፡ ገንዘብካ ከይትረኽቦ ተኸልኪልካ፡ ዘይግቡእ ምፍርራሕን ተገይሩልካን፡ ገንዘብካን ሓገዝካን ተመዝሚዝካ ትፈልጥ ዲኻ?	_____	_____
6	ዝኾነ ሕዱር ሕክምናዊ ሕማም ከም ዘለዎ ተረጋጊጹ ይፈልጥ ድዩ፡ ከም: ሽኮርያ, ሕማም ልቢ , መንሽሮ, ኤችኣይቪ፡ ልዑል ጸቕጢ ደም?	_____ እወ እንተኾይኑ ግለፅ: __	_____
7	ቅድሚ ሕዚ ዝኾነ ናይ ኣእምሮ ጥዕና ጸገም ከም ዘለካ ተረጋጊጹ ይፈልጥ ድዩ , ብዘይካ ድሕሪ ማህሰይቲ ሕማቕ ተሞኩሮ, ዝመፅእ ጸቕጢ	እወ: _____ እወ እንተኾይኑ ግለፅ: __	_____
8	ክንደይ ግዜ ተፈናቒልካ?	1. ሓደ ግዜ፡ ____ 2.ካብ ሓደ ግዜ ንላዕሊ፡ _____	
9	ዘገጣመካ ሕማቕ ተሞኩሮ, ፀቕጥን በዝሒ ድምር	1. ሓደ ____ 2. ካብ ሓደ ንላዕሊ ____	

<u>ክፋል- 6. ASSIST Lite: እዚ ናይ ሱስ ተቓላዕነትን ዘዘምብል ሓደጋን ንምምምማይ ዝሕግዘና መለክዒ ዝሓዘ መሕትት እዩ።</u>

ሽጋራ ትንባኾ	1. ሽጋራን ወይድማ ቶባኾ ዘለዎም ዓይነት ዝትኸኹ ትጥቀም ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	1ሀ. ባብዝሓ መዓልቲ ልዕሊ 10 ፍረ ሽጋራ ዶ ተትክኽ?	እወ ☐ 1	ብፍፁም ☐ 0
	1ለ. ብኣብዝሕእ መዓልቲ ልኽዕ ምስ ተላዓልካ ካብ ድቃስ ኣብ ዉሽጢ 30 ደቂቓ ትጥከም ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	ድምር:		
	2. ኣልኮል ዘለወ መስተ ትሰቲ ዶ?	እወ	ብፍፁም

		እወ	ብፍፁም
		☐1	☐0
	2ሀ. ብዝኾነ ኩነታት መሰረት ብምግባር ልዕሊ 4ተ ናይ ኣልኮል ፍሉጥ መጠን ንላዕሊ ትጥቀም ዶ?	እወ ☐1	ብፍፁም ☐0
	2ለ. ንምቁራፅ ወይድማ መጠን እትወዶ ንምቅናስ ሞኪርካ/ኪ ነገር ግን ኣቢዩካ/ኪ ትፈልጥ ዶ?	እወ ☐1	ብፍፁም ☐0
	2c. ዝኮነ ሰብ ስለ ኣውሳሲዳካ ኣልኮል ኣተሓሳሲቢዎ ትፈልጥ ዶ?	እወ ☐1	ብፍፁም ☐0
	ድምር:		
ካናቢስ	3. ካናቢስ ወይ ጋንጃ (ሓሽሽ) ተጠቂምካ ትፈልጥ ዶ?	እወ ☐1	ብፍፁም ☐0
	3a. ኣብ ሰሙን ሃደ ግዘ ወይድማ ልዕሊኡ ናይ ካናቢስ/ጋንጃ ናይ ምጥቃም ድፍኢት ሃሊካ ይፈልጥ ዶ?	እወ ☐1	ብፍፁም ☐0
	3b. ዝኮነሰብስለኣውሳሲዳካካናቢስ ወይ ጋንጃ (ሓሽሽ) ኣተሓሳሲቢዎትፈልጥዶ?	እወ ☐1	ብፍፁም ☐0
	ድምር:		
ኣምፈታሚን ዝዓይነቱ መነቓቕሒታት	4. ናይ ኣምፌታሚን ዓይነታትን ከምኡ'ዉን ናይ መነቃቅሒ ስምዒት ዘልከዎም ኣፃትን ከም'ዉን ብሓኪም ዝተእዠዙ መድሓኒታት ካብ ሓኪም ዝኣዘዘልካኡም ፍቃድ ወፃኢ ተጠቂምካ ትፈልጥ ዶ?	እወ ☐1	ብፍፁም ☐0
	4a. ኣብ ሰሙን ሓደ ግዘ ወይድማ ንብዙሕ መዓልቲ ኦም ናይ መነቃቀሕቲ እፃት ወሲዶም ይፈልጡ ዶ?	እወ ☐1	ብፍፁም ☐0
	4b. ብዛዕባ ኣወሳሲድኦም እዞም መነቃቀሕቲ እፃት ወይ ድማ መድሓኒታት ኣብ ቀረበኦም ዘሎ ሰብ ቕሬታ ነጊርዎም ይፈልጥ ዶ?	እወ ☐1	ብፍፁም ☐0
	ድምር፥		እወ☐1
መደንዘዚ መድሃኒት	5. ብሓኪም ዘይተኣዘዘሎም ናይ መደቀሲ ወይ ድማ ናይ መዘሓሓላይ መድሓኒት ይወስዱ ዶ?	እወ ☐1	ብፍፁም ☐0
	5a. እዚ ዓይነት እፅ ወይድማ መድሓኒት ንምዉሳድ ፍሉይ ዓይነት ድሌት ኮነ ኣምፅእ ኣምፅእ ዝብል ስምዒት ይስመዕም ዶ?	እወ ☐1	ብፍፁም ☐0
	5b. ብዛዕባ ኣወሳሲዳ እዚ መዝሐላይን ናይ ድቃስ ስምዒት ዘምፁ እፅ ወይድማ መድሓኒታት ኣብ ቀረብ ኦም ዘሎ ሰብ ኣብ ኣጠቃቕሞም መሰረት ዝገበረ ቕሬታ	እወ ☐1	ብፍፁም ☐0

	ነገርዎም ይፍልጥ ዶ		
	ድምር:		
ኦፒዮይድስ ዝበሃል መድሃኒት	6. ናይ ኣብ ኣስባልት ዝሸየጡ ከም ኦፖይድ (ሄሮይን) ዝበሉ መድሓኒታት ብዘይካ ናይ ሓኪም ፈቃድ ይወስዱ ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	6a. እዞም ናይ ቃንዛ ወይድማ ናይ ኦፖይድ መድሓኒታት ንሙቁራፅ ሙከራን ፈተነን ገይሮም ዘይተሳኸዐሎም ይፈልጥ ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	6b. ብዛዕባ ኣወሳሲዳ እዚ ዓይነት መድሓኒት ኮነ እፅ ኣብ ቀረባ ዘሎ ሰብ ኣብ ኣጠቃቅሞም መሰረት ዝገበረ ቕሬታ ኣቕሪቡሎም ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	ድምር:		
ካልኦት ንጥረ ነገራት	7. ካሊእ ዓይነት ናይ መነቃቅሒ ሱስ ዓይነት ትጥቀም ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	እንታይ ትጥቀም፥ ________________________________		
	7a. ኣብ ሰሙን ሓደ ግዘ ወይድማ ብኣብዝሓ ናይ ኣምፅእ ኣምፅእ ዝብል ስምዒትን ብርቱዕ ድሌትን ይስመዐካ ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	7b. ብዛዕባ ኣወሳሲዳኻ መሰረት ዝገበረ ቕሬታ ስባት ይህቡካ ዶ?	እወ ☐ 1	ብፍፁም ☐ 0
	ድምርብ:		
ሓፈሻዊ ድምር ዉፅኢት:			

ንትሕብብሮም የመስግን!