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- We are a group of researchers conducting a study titled **Prevalence of physical and mental health problems among internally displaced persons in White Nile State, Sudan 2023**".

- This study is designed to explore aspects related to physical and mental health problems and displacement status.

- All Individual living in internally displaced camps in White Nile state are invited to participate in filling out questionnaires which will ask questions regarding the topic.

-Estimated time for filling the form is 20 minutes.

-Your Participation in this research is voluntary, and all information are anonymous and will only be used for research purposes.

- The participant can quit the research at any time. By agreeing to complete this form, you permit us to use the data in our research project.

1. What is your age?
a) 0-5 b) 5-18 c) 18-24 d) 25-34 e) 35-44 f) 45-54 g) 55 and above

2. What is your gender?
a) Male b) Female

3. What is your marital status?
a) Single b) Married c) Divorced d) Widowed

4. What is your educational level?
a) No formal education b) Primary education c) Secondary education d) Vocational training e) University degree or higher

5. What is your current occupation?
a) Employed (full-time) b) Employed (part-time) c) Unemployed d) Self-employed e) Student

6. How long have you been displaced due to the war?
a) Less than 1 month b) 1-3 months c) 4-6 months d) More than 6 months

Major Depressive Episods

A1	a	Were you ever depressed or down, or did you feel sad, empty or hopeless,most of the day, nearly every day, for two weeks?	No		Yes		
		IF NO, CODE NO TO **A1b**: IF **YES** ASK:					
	b	For the past two weeks, were you depressed or down, or did you feel sad, empty or hopeless, most of the day, nearly every day?	No		Yes		
A2	a	Were you ever much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for two weeks?	No		Yes		
		IF NO, CODE NO TO **A2b**: IF **YES** ASK:					
	b	In the past two weeks, were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the time?	No		Yes		
		IS **A1a** OR **A2a** CODED **YES**?					
A3		IF **A1b** OR **A2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE IF **A1b** AND **A2b** = **NO**: EXPLORE **ONLY** THE MOST SYMPTOMATIC **PAST** EPISODE.					
		Over that two-week period, when you felt depressed or uninterested:	Past 2 Weeks		Past Episods		
	a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lb or ± 3.5 kg, for a 160 lb/70 kg person in a month)? IF **YES** TO EITHER, CODE **YES**.	No	Yes	No	Yes	
	b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	No	Yes	No	Yes	
	c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day? Did anyone notice this?	No	Yes	No	Yes	
	d	Did you feel tired or without energy almost every day?	No	Yes	No	Yes	
	e	Did you feel worthless or guilty almost every day?	No	Yes	No	Yes	
		IF **YES**, ASK FOR EXAMPLES**.**					

		No	Yes	No	Yes
f	Did you have difficulty concentrating, thinking or making decisions almost every day?				
		No	Yes	No	Yes
g	Did you repeatedly think about death **(FEAR OF DYING DOES NOT COUNT HERE)** or have any thoughts of killing yourself, or have any intent or plan to kill yourself? Did you attempt suicide? If yes T**O EITHER, CODE YES**				
		No	Yes	No	Yes
A4	Did these symptoms cause significant distress or problems at home, at work, at school, socially, in your relationships, or in some other important way, and are they a change from your previous functioning?				
		N/A		No	Yes
A5	In between 2 episodes of depression, did you ever have an interval of at least 2 months, without any significant depression or any significant loss of interest?				

How many episodes of depression did you have in your lifetime? _____

A6 Between each episode there must be at least 2 months without any significant depression.

NO	YES
MAJOR DEPRESSIVE EPISODE	
CURRENT	☐
PAST	☐
RECURRENT	☐

POSTTRAUMATIC STRESS DISORDER

B1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else?	No	Yes
B2	Starting after the traumatic event, did you repeatedly re-experience the event in an unwanted mentally distressing way, or did you have intense physical or psychological reactions when you were reminded about the event or exposed to a similar event?	No	Yes
B3			
a	***In the past month:***		
b	Did you persistently try to avoid thinking about or remembering distressing details or feelings related to the event?	No	Yes
B4	Did you persistently try to avoid people, conversations, places, situations, activities or things that bring back distressing recollections of the event?	No	Yes
	ARE **1** OR MORE **H3** ANSWERS CODED **YES**?	No	Yes
a	***In the past month:***		
	a Did you have trouble recalling some important part of the trauma? (but not because of or related to head trauma, alcohol or drugs).	No	Yes

b	Were you constantly and unreasonably negative about yourself or others or the world?	No	Yes
c	Did you constantly blame yourself or others in unreasonable ways for the trauma?	No	Yes
d	Were your feelings always negative (such as fear, horror, anger, guilt or shame)?	No	Yes
	Have you become much less interested in participating in activities that were meaningful to you before?	No	Yes
e	Did you feel detached or estranged from others?	No	Yes
f	Were you unable to experience any good feelings (such as happiness, satisfaction or loving feelings)	No	Yes
g	ARE **2** OR MORE ***H4*** ANSWERS CODED ***YES***?	No	Yes

In the past month:

B5 a	Were you especially irritable or did you have outbursts of anger with little or no provocation?	No	Yes
b	Were you more reckless or more self-destructive?	No	Yes
c	Were you more nervous or constantly on your guard?	No	Yes
d	Were you more easily startled?	No	Yes
e	Did you have more difficulty concentrating?	No	Yes
f	Did you have more difficulty sleeping?	No	Yes
	ARE **2** OR MORE ***H5*** ANSWERS CODED ***YES***?	No	Yes
B6	Did all these problems start after the traumatic event and last for more than one month?	No	Yes
B7	During the past month, did these problems cause significant distress, or interfere with your ability to function at home, at work, at school or socially or in your relationships or in some other important way?	No	Yes
	AND IS "RULE OUT ORGANIC CAUSE (***O2 SUMMARY***)" CODED ***YES***?		

SPECIFY IF THE CONDITION IS ASSOCIATED WITH DEPERSONALIZATION, DEREALIZATION OR WITH DELAYED EXPRESSION.

NO	YES
POSTTRAUMATIC STRESS DISORDER CURRENT	
DEPERSONALIZATION	☐
DEREALIZATION	☐
DELAYED EXPRESSION	☐

GENERALIZED ANXIETY DISORDER

C1 a	Were you excessively anxious or worried about several routine things, over the past 6 months? IN ENGLISH, IF THE PATIENT IS UNCLEAR ABOUT WHAT YOU MEAN, PROBE BY ASKING (Do others think that you are a worrier or a "worry wart"?) AND GET EXAMPLES	No	Yes
b	Are these anxieties and worries present most days?	No	Yes

	ARE THE PATIENT'S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	No	Yes
C2	Do you find it difficult to control the worries?	No	Yes
C3	FOR THE FOLLOWING, CODE ***NO*** IF THE SYMPTOMS ARE CONFINED TO FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT. ***When you were anxious over the past 6 months, did you, most of the time:***		
a	Feel restless, keyed up or on edge?	No	Yes
b	Have muscle tension?	No	Yes
c	Feel tired, weak or exhausted easily?	No	Yes
d	Have difficulty concentrating or find your mind going blank?	No	Yes
e	Feel irritable?	No	Yes
f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	No	Yes
	ARE **3** OR MORE ***N3*** ANSWERS CODED ***YES***?		
C4	Do these anxieties and worries significantly disrupt your ability to work, to function socially or in your relationships or in other important areas of your life or cause you significant distress?	No	Yes
	AND IS "RULE OUT ORGANIC CAUSE (***O2 SUMMARY***)" CODED ***YES***?		

NO	YES
GENERALIZED ANXIETY DISORDER	
CURRENT	

Physical Health Questionnaire

1. How often have you had difficulty getting to sleep at night ?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

2. How often have you woken up during the night?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

3. How often have you had nightmares or disturbing dreams?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

4. How often has your sleep been peaceful and undisturbed?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

5. How often have you experienced headaches?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

6. How often did you get a headache when there was a lot of pressure on you to get things done?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

7. How often did you get a headache when you were frustrated because things were not going the way they should have or when you were annoyed at someone?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

8. How often have you suffered from an upset stomach (indigestion)?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

9. How often did you have to watch that you ate carefully to avoid stomach upsets?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

10. How often did you feel nauseated ("sick to your stomach")?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

11. How often were you constipated or did you suffer from diarrhea?
1_Not at all 2_ Rarely 3_ Once in a while 4_ Some of the time 5_Fairly often 6_Often 7_All of the time

12. How many times have you had minor colds (that made you feel uncomfortable but didn't keep you sick in bed or make you miss work)?
1_ 0 times 2_ 1-2 times 3_ 3 times 4_ 4 times 5_ 5 times 6_ 6 times 7_ 7+ times

13. How many times have you had respiratory infections more severe than minor colds that "laid you low" (such as bronchitis, sinusitis, etc.)?
1_ 0 times 2_ 1-2 times 3_ 3 times 4_ 4 times 5_ 5 times 6_ 6 times 7_ 7+ times

14. When you had a bad cold or flu, how long did it typically last?
1_ 1 day 2_ 2 days 3_ 3 days 4_ 4 days 5_ 5 days 6_ 6 days 7_ 7 days

Malnutrition

1. Weight for Age:
- Is the child's weight appropriate for their age?
- If not, please rate the severity of the weight deficit.

2. Height for Age:
- Is the child's height appropriate for their age?
- If not, please rate the severity of the height deficit.

3. Weight for Height:
- Is the child's weight appropriate for their height?
- If not, please rate the severity of the weight deficit.

4. Edema:
- Does the child have visible swelling or edema in any body parts?
- If yes, please rate the severity of the edema.

5. Muscle Wasting:
- Does the child have visible muscle wasting or thinning?
- If yes, please rate the severity of muscle wasting.

6. Dietary Intake:
- How would you rate the child's overall dietary intake?
- 0 - Poor, 1 - Fair, 2 - Good, 3 - Excellent

7. Clinical Signs:
- Are there any other clinical signs of malnutrition observed in the child? (e.g., dry skin, brittle hair, delayed healing)
- If yes, please describe and rate the severity of the signs.

8. General Health Status:
- How would you rate the child's overall health status?
- 0 - Very Poor, 1 - Poor, 2 - Fair, 3 - Good, 4 - Excellent

9. Access to Healthcare:
- Does the child have access to regular healthcare services?
- If no, please describe the barriers to accessing healthcare.

Additional Questions:
10. Breastfeeding:
- Is the child currently breastfed?
- If yes, please specify the frequency and duration of breastfeeding.

11. Complementary Feeding:
- Is the child receiving appropriate complementary feeding along with breastfeeding?
- If yes, please describe the types and frequency of complementary foods.

12. Food Security:
- How would you rate the household's food security status?
- 0 - Very Insecure, 1 - Insecure, 2 - Moderately Secure, 3 - Secure

13. Water and Sanitation:
- How would you rate the household's access to clean water and sanitation facilities?
- 0 - Very Poor, 1 - Poor, 2 - Fair, 3 - Good, 4 - Excellent

14. Socioeconomic Status:
- How would you rate the household's socioeconomic status?
- 0 - Very Poor, 1 - Poor, 2 - Average, 3 - Good, 4 - Excellent