IOM IRAQ

# MENTAL HEALTH AND PSYCHO-SOCIAL NEEDS ASSESSMENT IN SHIRQAT DISTRICT

Republic of Iraq, Salah Al-Din Governorate, Shirqat District

September 2020

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# ABBREVIATIONS

| | |
|---|---|
| **FGD** | Focus Group Discussion |
| **KII** | Key Informant Interview |
| **MHPSS** | Mental Health and Psychosocial Support |
| **NGO** | Non-governmental Organization |
| **WGSSQs** | Washington Group Short Set of Questions on Disability |





# EXECUTIVE SUMMARY


Returning community members in Iraq are subject to numerous stressors caused by various traumatic experiences including the experience of displacement, the struggle to preserve basic living conditions, and having to deal with the uncertainty about the future.

This mental health and psychosocial support (MHPSS) assessment outlines the existing mental health and psycho-social well-being needs, the causes of these needs, coping strategies of returnees, and gaps in MHPSS services in the villages of Al-Eitha and Ganous, Shirqat district, Salah Al-Din Governorate. The assessment also examines the relationships between returnees and families as well as with their neighbours and other community members.

Both qualitative and quantitative methods were used to collect data. The assessment's findings are based on 114 meetings, reaching 166 respondents through Key Informant Interviews (KIIs) that also included surveys and Focus Group Discussions (FGD). Out of these, 29 were youth aged 15–18 years (11 girls and 18 boys) and 147 were older than 18 years (93 women; 54 men).

This assessment reveals the large gap between the need of MHPSS services among community members and provided services.

Overall, this assessment shows that 48,14 per cent of the respondents reported either moderate or very strong feeling of emotional distress. Bad living conditions and displacement are the most frequently reported causes of emotional distress, followed by traumatic experiences during displacement, loss of loved ones, traumatic experiences in the place of origin, family problems, and lack of access to basic services.

While 91,66 per cent of the respondents feel supported by their families, only 47,22 per cent feel such support from their communities. The 52,77 per cent who do not feel supported attribute this lack of support to their families' former links to an armed group or groups.

The need for peaceful coexistence, reconciliation and tolerance stood out as the priority needs to be addressed. Other needs included legal assistance for returning families; social security and stability; employment; psychosocial support, including individual psychological support, awareness sessions, group counselling and creating recreational areas both for adults and children; access to basic services, such as food, electricity, medicine, and education; and access to health services, as there are no medical centres in these two villages.


# RECOMMENDATIONS

Establish holistic and comprehensive MHPSS interventions that complement the protection, health and livelihood needs of adults, children and youth.

MHPSS

Provide both specialized and non-specialized focused MHPSS services.

Ensure the inclusiveness of MHPSS services for different vulnerable groups, including men and women, older people and people with disabilities.

Create spaces for peaceful coexistence and healing.

Promote safety and security in the community.

Establish safe areas for recreational activities.

Invest in long-term interventions as the needs are very complex and require time.





# 1. BACKGROUND

## 1.1 CONTEXT

The protracted situation of displaced families with a perceived affiliation to the Islamic State of Iraq and the Levant (ISIL) in Iraq contributes to compounding needs of these families as they continue to live in poor conditions in camps and urban areas, in fear of retaliation, social isolation and marginalization[1]. While many IDPs remain displaced in camps and unable to return home due to fear of retributive attacks or rejection, those who return despite their fears also face various difficulties, including high levels of daily stress, unemployment, bullying, and exclusion which inevitably affect their mental health and psychosocial well-being.

This assessment focuses on Al-Eitha and Ganous areas of the Shirqat district of Salah Al-Din Governorate in Iraq. Shirqat has a population of 217,296 persons according to the Ministry of Migration and Displacement and returnees make up 25 per cent of the community. While the population of Al-Eitha is 13,500, Ganous has 12,500 inhabitants, the majority of whom have not had to displace from their areas of origin. Two groups of returnee families exist: those with family members who have perceived or former links to ISIL and those who do not. Returns are managed and coordinated by the local leaders and local security forces. Female-headed households make up for the majority of returnee families who have a perceived or former affiliation with ISIL, and they face increased protection risks.[2]

## 1.2 MENTAL HEALTH AND PSYCHOSOCIAL CONTEXT

Emergencies and humanitarian crises create significant psychological and social stress experienced at the individual, family, community and societal levels.[3] MHPSS actors are expected to conduct assessments and mappings to evaluate the needs, challenges and priorities of the target population inclusive of the individual and collective strengths, resources and coping capacities.[4]

The National Mental Health Council of Iraq was established in 2004 with the aim of implementing a plan, policy and legislation addressing main mental health issues. Developing community mental health services, downsizing institutional psychiatric hospitals, developing acute care units in general hospitals, and integrating mental health care into primary health care were included in the priorities of the Council. As a result of the progress made in integrating mental health services within primary health-care services, a special section for this purpose was established in Ministry of Health / Baghdad and a primary mental care unit was established in every general directorate of health in all governorates. The mental health policy that was developed in 2014 is partially implemented, including an ongoing initiative for the integration of mental health into primary health care, and related training and capacity building for medical staff. There is no specific budget allocation for mental health services.[5]

## 1.3 ASSESSMENT OBJECTIVES

**The main objectives of this assessment were to:**

1. Identify mental health and psychosocial conditions and needs of returnees in Shirqatt
2. Explore the community's perceptions and understanding of mental health and psychosocial needs and available resources
3. Explore perceptions about the availability, accessibility and expressed need for MHPSS services

Data collected will assist IOM Iraq in responding to the mental health and psychosocial needs of people of concern.

1 "Addressing the Complex Challenges Related to the Return and Reintegration of Iraqi Families with a Perceived Affiliation to ISIS", IOM, January 2020.

2 Shirqat Protection KIIs Report, IOM, June 2020.

3 Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

4 IOM (2019), Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. IOM, Geneva.

5 WHO-AIMS (2006). Mental Health System in Iraq. Retrieved from: http://www.who.int/mental_health/evidence/iraq_who_aims_report.pdf

# 2. METHODOLOGY

## 2.1 TARGET POPULATION AND SAMPLE SELECTION

The population of interest for this assessment consisted of returnee adults and young people, aged 15–18 years, in the district of Shirqat of Salah Al-Din governorate. The overall population of Shirqat is 217,296[6], while returnees are estimated to be around 122,520.[7]

The assessment was implemented through FGDs and KIIs conducted across in Al Eitha and Ganous villages.

Stratified sampling strategy was employed to address the assessment questions, as it could reasonably be expected that the measurement of interest would vary between the different subgroups. This strategy could also ensure representation from all the subgroups (that is, different ages and gender).

Data collection was undertaken over 11 days in August and September 2020, following the tailoring of tools for FGDs and KIIs targeting stakeholders, returnee adult men, women and young people in the community. In total, 114 data-gathering activities took place including five FGDs and 109 KIIs.

## 2.2 INFORMATION SOURCES

### 2.2.1 Focus Group Discussions

A total of five FGDs were conducted for the assessment, reaching 57 individuals.

Table 1. Focus Group Discussion participation breakdown

| | NUMBER OF FGD CONDUCTED | NUMBER OF PARTICIPANTS |
|---|---|---|
| FGD with adult men (including stakeholders) | 1 | 14 (4 stakeholders included) |
| FGD with adult women | 2 | 33 |
| FGD with boys (aged 15–18 years) | 1 | 13 |
| FGD with girls (aged 15–18 years) | 1 | 7 |

### 2.2.2 Key Informant Interviews

A total of 109 KIIs were conducted for the assessment, reaching 109 individuals.

Table 2. Key Informant Interview participation breakdown

| | NUMBER OF KII CONDUCTED |
|---|---|
| KII with adult men | 36 |
| KII with adult women | 60 |
| KII with stakeholders | 4 |
| KII with boys (aged 15–18 years) | 5 |
| KII with girls (aged 15–18 years) | 4 |

6 This number has been taken from the "Community Description of Shirqat City" document of IOM.

7 http://iraqdtm.iom.int/archive/Hawija-Shirqat.aspx





Map 1. Shirqat district map[8]


8 Retrieved from: https://reliefweb.int/sites/reliefweb.int/files/resources/reach_irq_map_shirqat_reference_23jul2017.pdf

## 2.3 ASSESSMENT TOOLS

"Qualitative Questionnaire for Households" of IOM's "Psychosocial Needs Assessment in Displacement and Emergency Situations" tool was adapted and used as the assessment tool for the KIIs and FGDs conducted.

## 2.4 DATA COLLECTION

- Four IOM MHPSS staff conducted the assessment. These staff members were knowledgeable about conducting interviews and about the mental health and psychosocial support needs and vulnerabilities of the affected population due to their background and experience in the field. The assessment team leader provided them with a briefing session on how to use the tools and enter the data.
- FGDs and KIIs were conducted in an age- and gender-sensitive manner, with separate sessions for women, girls, boys and men.

Informed consent of the participants was ensured through information provided on the purpose of the assessment, how the data would be used, anonymized and kept confidential.

## 2.5 LIMITATIONS

During the data collection, the MHPSS field team faced some challenges and limitations. One of most important challenges was the security situation in Al-Eitha and Ganous subdistricts. This limitation was particularly prominent in Ganous area as some ISIL cells were still present in the vicinity, which impeded coverage of all villages. During the analysis and reporting period, a military operation was declared against ISIL sleeper cells in this area.

Another challenge was that of logistics, due to the unavailability of an appropriate space to conduct KIIs with community members. Therefore, the assessment was conducted in the houses of the respondents, which affected time management, as it was time consuming to visit houses one by one. Although this situation raised concerns over the confidentiality of the interviews, separated rooms with privacy were arranged to ensure confidentiality.

Although the Washington Group Short Set of Questions on Disability (WGSSQs) was used to assess the disability status of the households, segregated data about persons with disabilities in the data is lacking, as the questions did not request elaborating on the gender and ages of those household members with a disability in one or more domains of function including walking, seeing, hearing, cognition, self-care, and communication.

Finally, people from various factions were equally represented, to respond to political sensitivities between community members who are seen to be on different sides of the conflict.





# 3. RESULTS

## 3.1 DEMOGRAPHIC DATA OF SURVEY RESPONDENTS

The quantitative assessment is based on survey data collected from 109 respondents in two villages of Shirqat, namely Ganous and Al-Eitha. The percentage of female respondents (60%) was higher than that of males (40%) (Figure 1), with most of them (91%) being adults (Figure 2). Data collected from surveys with 109 individuals provided information on 614 individuals of which 7,81 per cent were persons aged 60 years and above (n=48), 16,12 per cent were adult men aged 18–59 years (n=99), 25,57 per cent were adult women aged 18–59 years (n=157), and 50,48 per cent were children and adolescents younger than 18 years (n=310).

Figure 1. Distribution of gender of respondents

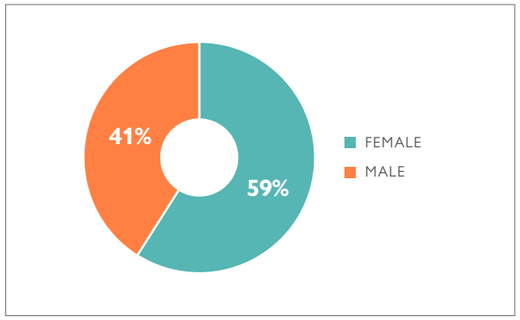
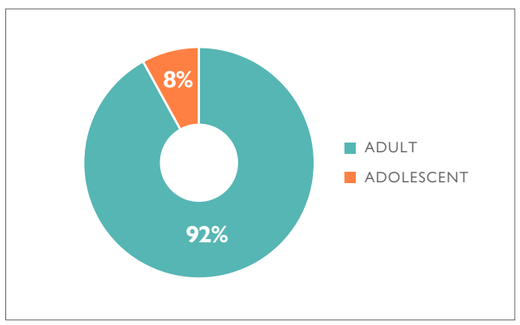



Figure 2. Distribution of ages of respondents




Nearly half of the respondents (40%) had no education (n=44), while 39 per cent had primary school level education (n=42) (Figure 3). As to the marital status of respondents, 35 per cent were widowed (n=38), while 36 per cent were currently married (n=39) (Figure 4).

Figure 3. Distribution of level of education of respondents

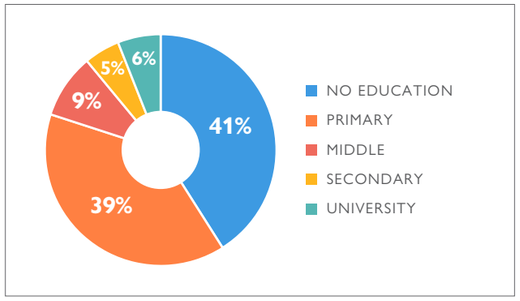
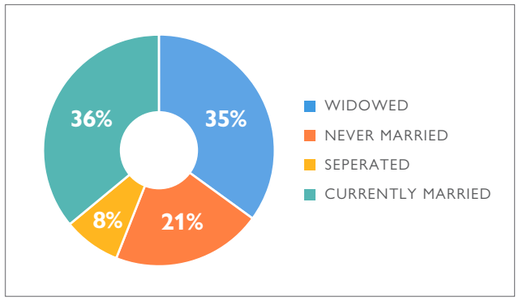
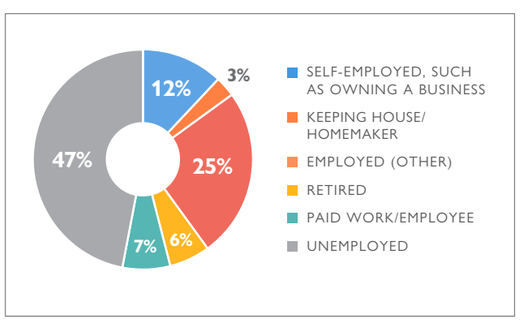



Figure 4. Distribution of marital status of respondents




Results indicated a high rate of unemployment among the adult respondents. While 47 per cent of respondents were unemployed (n=46), almost half of those who reported being employed (25%) were homemakers (n=25), self-employed (12%; n=12), working as a paid employee (6%; n=6), or retired (3%; n=3).

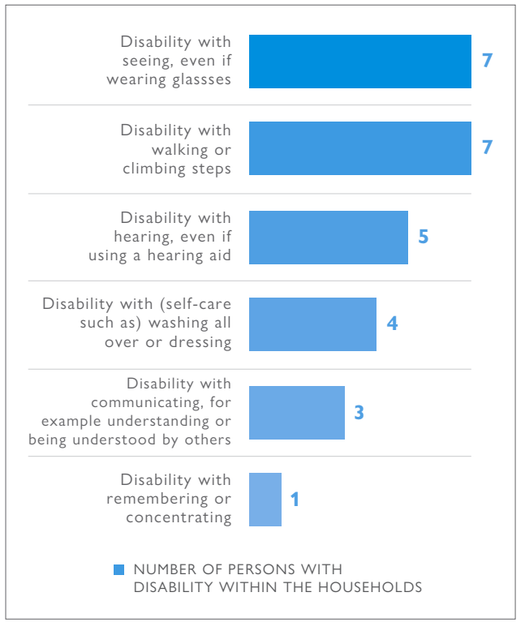
Figure 5. Distribution of employment status of respondents



## Household Data of Survey Respondents

In this section, the WGSSQs was used to ensure accurate identification of people with disabilities. WGSSQs included six domains of function including walking, seeing, hearing, cognition, self-care and communication. Most respondents do not have people with disabilities (in the mentioned domains of function) in their households. According to the Guidelines on WGSSQs, "everyone with at least one domain that is coded as *a lot of difficulty or cannot do it at all"* is included in the *people with disabilities*. Accordingly, Figure 6 only includes those who have chosen either of these two options ("a lot of difficulty" and "cannot do it at all"). Around 6,66 per cent of household members (n=7; among 105 who answered the question) had a visual disability, 4,85 per cent (n=5; among 103 who answered the question) had a hearing disability, 6,66 per cent (n=7; among 105 who answered the question) had a disability that impacted their ability to walk or climb steps, 0,99 per cent (n=1; among 101 who answered the question) had a disability that impacted their memory and concentration, 3,96 per cent (n=4; among 101 who answered the question) had a disability that impacted their capacity to practice self-care, such as washing themselves or getting dressed; and 2,91 per cent (n=3; among 103 who answered the question) had a disability that affected their capacity to communicate, such as understanding or being understood.

Figure 6. Distribution of Disability Status of Households




## 3.2 LIVING CONDITION OF THE RETURNEES

More than half of the respondents (60%; n=65) reported living in a house, with most of them having a temporary residence status (73%, n=72).

Figure 7. Distribution of Housing Type

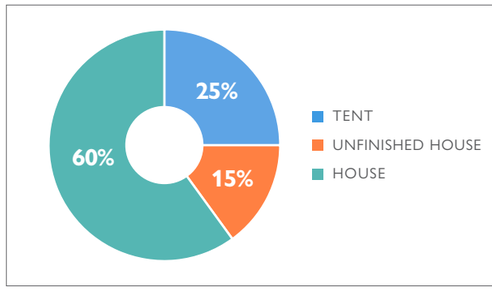
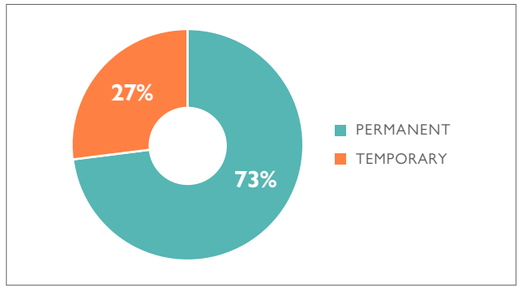



Figure 8. Distribution of Status of Residence




Respondents were asked whether their families face a threat of eviction and how strongly they feel such threat, if any. Although most respondents (72%, n=78) reported no threat of eviction at all, a significant percentage (24%, n=26) reported moderate concern about the threat of eviction and 4 per cent (n=4) reported a strong concern.

Figure 9. Perceived threat of eviction

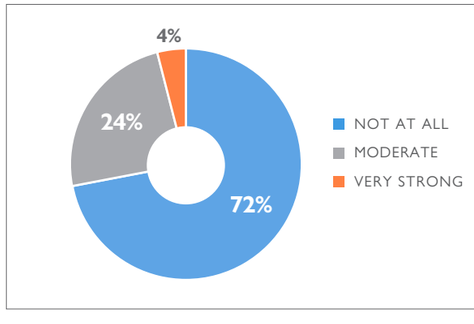
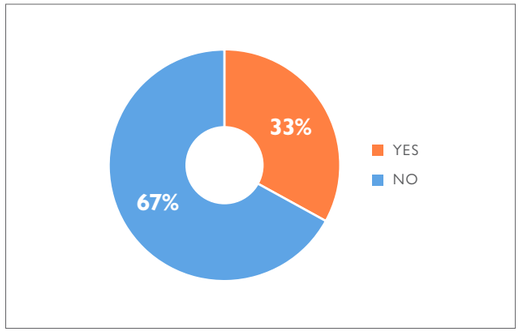







Figure 10. Perceived restriction of movement in the current residence




Thirty-three per cent of respondents (n=36) reported restrictions on their freedom of movement in their current residence. The reasons included lack of legal identification (such as a lack of ID or an expired ID), fear of leaving the village, families of armed groups, not being able to get out without the approval of the government and the army, and being identified as ISIL-affiliated families.

Most of FGD participants confirmed the existence of restrictions on their freedom of movement in their areas of current residence:

> *"The security forces in the region impose a number of barriers to movement, including certain areas where residents cannot go to or mix with them. – FGD with women, Aetha*

To understand the respondents' feelings over their children's safety, they were asked about how safe they feel their children are and about the areas where they play. Sixty per cent of respondents with children (n=61) reported being moderately concerned about their children whereas 37 per cent (n=37) did not have concerns about their children's safety (Figure 11).

When asked about the experience of discrimination, 41 per cent (n=44) reported that they have experienced discrimination including bullying, which made them feel sad, embarrassed, humiliated, anxious, ashamed, angry, hateful, and broken, hate themselves, lose their self-confidence in their relations with others, and fear their future (Figure 12).

A widowed female adult who reported feeling 'not safe at all' said:

> *"I am held accountable for something I have no fault in. – Ab3*

Figure 11. Perceived safety of children

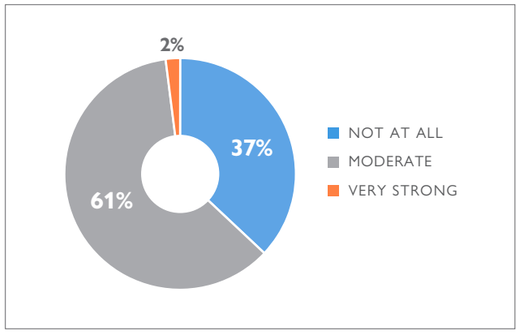
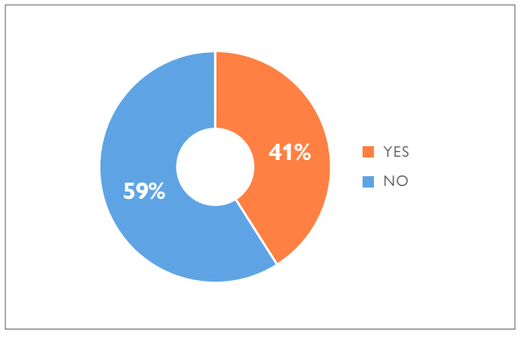



Figure 12. Experience of discrimination

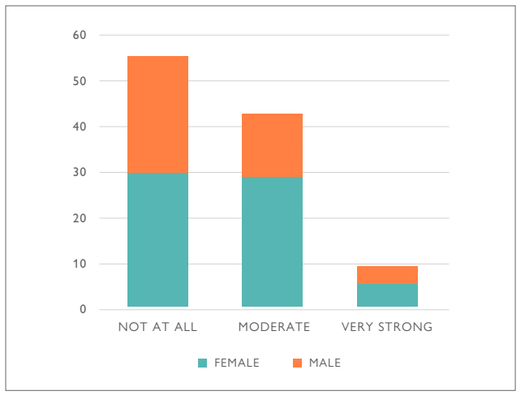



Respondents were also asked whether everyone living around them was treated the same way, and 39,81 per cent (n=43) stated that this was not the case. Widows and children with perceived affiliation with ISIL were identified as the most vulnerable group.

## 3.3 PSYCHOLOGICAL AND PSYCHOSOCIAL NEEDS

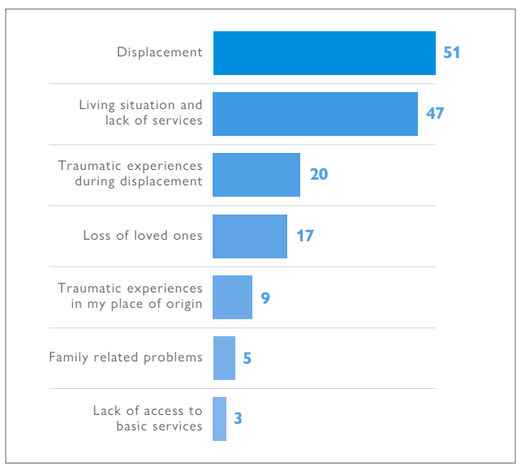
36,11 per cent of survey respondents (n=39) think that the emotional distress is widespread in the community. When asked about how strongly they feel such emotional distress themselves, 48,14 per cent of respondents reported either moderate or very strong feeling of emotional distress (n=52; 34 females and 18 males). Importantly, among the nine young people interviewed, eight (88,88%) reported feeling of emotional distress at some level.

Figure 13. Emotional distress levels of responents




The main causes of emotional distress reported were poor living conditions and the previous displacement experience. These reasons were followed by traumatic experiences during displacement, loss of loved ones, traumatic experiences in the place of origin, family problems, and lack of access to basic services (Figure 14).

Figure 14. Causes of emotional distress




Stress of daily life, the economic situation, family issues, fear of insecurity and bullying, boredom, unknown future, hopelessness and not having something to do to entertain themselves in the community were among the issues related to living conditions and lack of services reported in the daily difficulties faced by the respondents.

Findings from the FGDs are also in line with the KII data exploring the causes of the emotional distress experienced by the respondents.

**The bad living conditions and the displacement situation:**

> *The crisis has caused many problems, the most important of which is the economic one, as the residents lost their livestock and their farms, and the area was subjected to bombardment, which led to the demolition of many homes.*
>
> *– FGD with men, Ganous*

**Loss of trust in society:**

> *Now we are all subjected to raiding at any moment and threatened with arrest and this obsession never leaves our head; we review every word we say every day and it is possible that one of us is arrested because of a post published on a personal page, and this is what actually happened to many young people who are in front of you.*
>
> *– FGD with boys, Al-Eitha*

**Fear of environmental threats:**

> *Now we are all subjected to raiding at any moment and threatened with arrest and this obsession never leaves our head; we review every word we say every day and it is possible that one of us is arrested because of a post published on a personal page, and this is what actually happened to many young people who are in front of you.*
>
> *– FGD with boys, Al-Eitha*



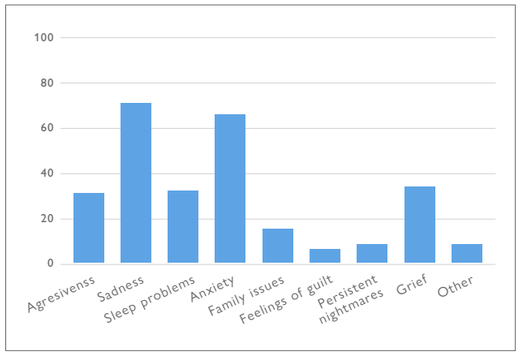


**Loss of hope for the future**

> *There is nothing but despair here in Ganous, and our fate is unknown. No one will accept us for marriage.*
>
> *– GD with girls, Ganous*

Figure 15 below illustrates the mental health symptoms reported as the impact of the main causes of emotional distress faced by the KII Survey respondents, with sadness (65,74%, n=71) and anxiety (61,11%, n=66) being the most reported symptom among all.

Figure 15. Impact of the main causes of emotional distress




**Men** were reported to be affected by unemployment and related outcomes, such as neglecting duties towards the family and being unable to provide for the family, mood and behaviour changes, stress, anger, despair, being unable to communicate with or adapt to the community, lack of interest in daily activities accompanied by inability to work and function properly, lack of self-confidence and isolation.

Loss of interest was the most reported difficulty faced by **women.** Ensuing difficulties included neglect towards their children, inability to do housework, loss of trust and interest, confusion, anger, fear of danger towards their families by the community, lack of self-care and violence against their children.

**Adolescents** reported being unable to continue their education, excessive sleeping, lack of self-care and interests, withdrawal from daily activities, violence exercised by the security forces, bullying, anger, feeling neglected by society, confusion in thoughts and behaviours, and isolation.

**Children** reported isolation, irritability, aggression, lack of interaction with other children, bullying, bedwetting, crying, grumbling, frequent problems with their peers, anger and jealousy. They prefer not going to school and would like to work instead. They reportedly show significant change in their behaviour (acquiring bad habits and showing socially unacceptable behaviours). When KII respondents were specifically asked whether all of their school-aged children go to school, it was noted that not having legal documents and IDs was a prominent barrier to enrolling in formal education. To explore the availability of recreational activities, they were also asked whether their children have any extra additional activities. Around 58 per cent of parents who answered to this question (n=40) said this was not the case, mostly referring to the inexistence of any entertainment area for children.

**Older people** have problems reaching health services and receiving the medical care they require; they reported feelings of despair, anger, sadness and discomfort, and face isolation and neglect both by their families and by the community. They also stay away from the clan gatherings.

**People with disabilities** faced challenges meeting their needs as there are limited or no services suitable for them.

**One of the respondents stated that:**

> *The society's support for them was lost due to the poor living and economic situation, and that affects their health status.*
>
> *– Female KII participant, Shirqat*

When asked about the groups of people that had been most impacted by displacement, widows, minor girls who had been married to ISIL members or fighters, and women and girls from families belonging to armed groups were most commonly identified by FGD and KII respondents. Their responsibilities were reported to have drastically increased after displacement because they had to become the family's breadwinners, on top of their responsibilities at home.

## 3.4 COPING STRATEGIES

KII respondents were asked to identify the coping strategies used by men, women, adolescents, children and older people. Table 3 lists the main coping strategies used by these groups.

Table 3. Coping Strategies of Groups of Concern

| GROUP OF CONCERN | COPING STRATEGY |
|---|---|
| Men | • Accepting the new life and integrating with society again<br>• Living with the status quo and adapting by communicating with others in the community<br>• Coexisting with the community with respect and peace and attending social events<br>• Conducting visits and attending social events<br>• Going to friends or playing sports<br>• Spending time on mobile phone<br>• Attending social events with family, relatives and friends<br>• Searching for a job or a special project to start over |
| Women | • Attending social events with family and relatives<br>• Adapting to the status quo and accept the new life conditions<br>• Supporting each other<br>• Playing on mobile phone<br>• Using free time with housework and handwork, sewing, tailoring and embroidery<br>• Cooking<br>• Drawing<br>• Participating in social events with other women<br>• Strengthening individual skills |
| Adolescents | • Playing with mobile phone<br>• Playing football<br>• Going out with friends<br>• Accepting the new life and integrating with society again |
| Children | • Playing with friends in the village<br>• Going to school |
| Older people | • Accepting the new life and integrating with society again<br>• Exchanging visits and attending social events to reduce stress and boredom, and to improve psychological state and health<br>• Taking an active role in society and in addressing social issues faced by the community<br>• Participating in Majlis (social space where tribe members convene and discuss important community matters)gatherings to improve the situation among returnees through tribal and community conferences and seminars |





## 3.5 COMMUNITY SOURCES OF SUPPORT

Among the 91,66 per cent of respondents (n=99) who stated that they are supported by their families, the most commonly identified type of support received was moral support, followed by material and financial support. Almost two out of three respondents (63,88%, n=69) reported having good relationships with neighbours, while 71,29 per cent (n=77) feel supported by them in various ways, including through exchange of visits and mutual respect.

Figure 16. Relationship with family

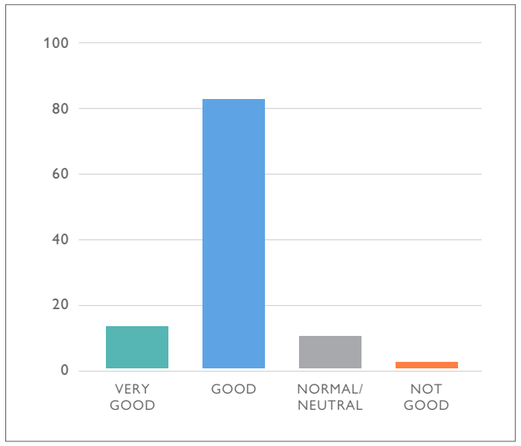
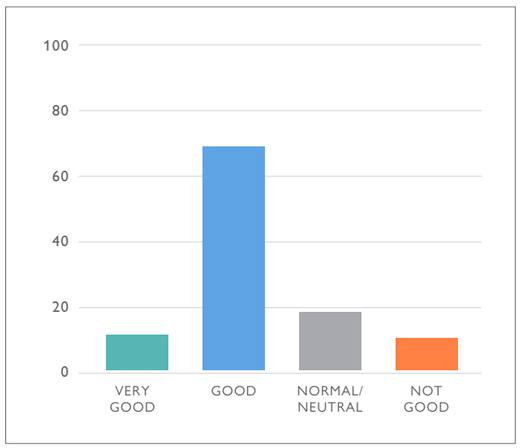



Figure 17. Relationship with neighbours




Almost half of respondents (47,22%, n=51) reported feeling supported by the community through communication with community members, moral support, and living in a cohesive tribal society that helps them with work and study. Those who do not feel supported (52,77%, n=57) said that the main reason for this was their family's links with armed groups.

Nearly all respondents identified [widowed] women and children from families belonging to armed groups as the most vulnerable/suffering group from the crisis. A total of 77,77 per cent of KII respondents (n=84) stated that these vulnerable groups are not supported by the community due to their perceived affiliation with armed groups. For those who indicate that these vulnerable groups are supported, humanitarian aid seems to be the only type of support they receive.

## 3.6 SERVICES REQUESTED TO HELP MANAGE MHPSS CONDITIONS

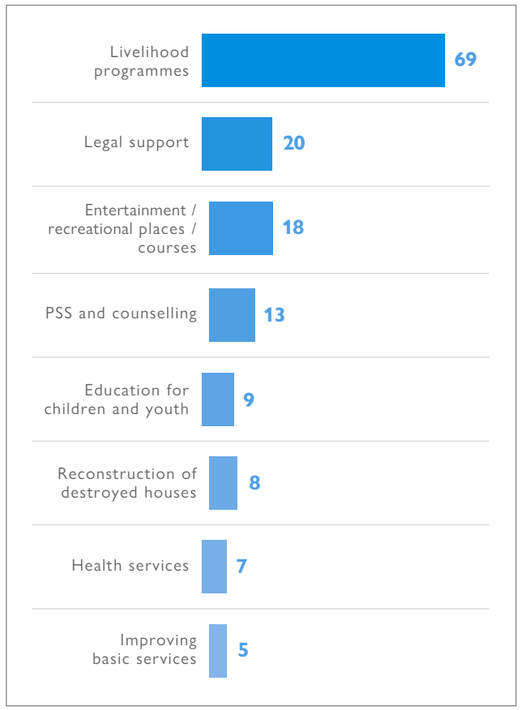
All the KII respondents (100%, n=109) agreed some people in the community need psychological or psychosocial support – a very prominent indicator of needs within the community. All of them think that people in the community will benefit from psychological or psychosocial support if it is provided. As to the specific reasons MHPSS services are required, respondents reported the need to reduce stress and worries, improve psychological conditions and break boring routines. Other reasons included the high number of people requiring support in: mental health and psychosocial well-being, social integration, dealing with everyday stress, forgetting about the past, dealing with gender inequality, and dealing with lack of entertainment / leisure venues.

When asked about the issues that need to be addressed in the community, almost half of the respondents referred to the need for peaceful coexistence, reconciliation and tolerance. Other needs were as follows:

- Address legal obstacles faced by returnee families;
- Enhance social security and stability;
- Address unemployment;
- Provide PSS support, including individual psychological support, awareness sessions, group counselling, and the establishment of recreational areas both for adults and children;
- Improve access to basic services such as food, electricity, medicine, and education;
- Improve access to health services (there were reportedly no medical centres in target areas).

Respondents conveyed a high demand for livelihood programmes to create job opportunities to improve well-being in the community, including support to agriculture-related work, grants to enable livelihood opportunities, and vocational courses. The services requested (Fig. 18) reveal the need for basic service provision and other integrated services, such as livelihood programmes and protection programmes, through which legal support is also provided.

Figure 18. Services requested




During FGDs, participants also noted their wish to coexist peacefully in the community:

> *"We need a real reconciliation between the people of ISIL and the families of the victims.*
>
> *– FGD with girls, Ganous*

The KII Survey data showed that 88,88 per cent of the respondents (n=96) have accepted the situation and would like to move on as opposed to the rest, (n=12) who have no plans or decisions made yet.





# 4. KEY FINDINGS AND RECOMMENDATIONS

The broader purpose of this assessment was to inform the strategic approaches and MHPSS interventions and to promote longer-term and sustainable solutions for Shirqat district of Salah al-Din Governorate.

This section summarizes key findings and puts forward relevant recommendations. The below introductory recommendations should be mainstreamed throughout the programme.

**Ensure the inclusiveness of MHPSS services for different vulnerable groups, including men and women, older people and people with disabilities:**

- Ensure that all interventions are implemented with the necessary arrangements for people with disabilities, and that materials are used with accessible copies such as voice records or brochures in braille for individuals with visual impairments.
- Ensure that all interventions are sensitive to gender, gender norms and discrimination. Be mindful of stress factors impacting girls and boys, such as pressure on girls to marry or pressure on boys to find a job and sustain their families. Include gender analysis in programme design and implementation.
- Take into consideration exclusion factors of these groups that could affect turn out, such as lack of safe spaces or childcare, timing, social norms and values that hamper girls and women's access, working schedule of men/women, accessibility of the venues, and the need for transportation, among others.

### FINDING 1

*The risks and needs resulting in psychological and psychosocial conditions are multifaceted. These risks and needs stem from complex factors linked to current conditions, including lack of documents, poverty, unemployment and lack of access to livelihood support.*

### RECOMMENDATION 1

*Establish holistic and comprehensive MHPSS interventions that complement the protection, health and livelihood needs of adults, children and youth:*

- Advocate for the provision of basic services that are safe, accessible and that protect dignity of the community members through documenting the services' impact on the mental health and psychosocial well-being of the populations; influence humanitarian actors to deliver these services in a safe and socially appropriate way.
- Ensure integrated MHPSS and protection services – neither should take place without consideration for the other. Effective referral pathways should be established so these services are conducted in tandem, for example through providing psychosocial support to gender-based violence survivors. Implement integrated programming that includes support to community members to access livelihood and become economically self-reliant. In addition to the fact that such activities have significant positive impact on individuals' well-being, parenting style and ultimately the children's well-being and resilience, reconciliation and economic development are closely interconnected and require a multisectoral approach due to the complex setting of post-conflict societies.
- Establish a coordination mechanism with relevant stakeholders in the areas of concern inclusive of local authorities and other organizations providing services. This way, service overlapping is avoided, and services are provided in a complementary way. IOM in coordination with the Ministry of Health, Salah Al-Din Department of Health and national MHPSS working groups, will activate MHPSS sub-working group in Salah al-Din to improve coordination between non-governmental organizations working in MHPSS and governmental authorities.

## FINDING 2

*A significant gap has been identified in relation to the mental health and psychosocial support services provided in the two locations of concern, as no government institution provides psychological or social support services.*[9]

## RECOMMENDATION 2

*Provide both specialized and focused non-specialized MHPSS services:*

- Provide psychological first aid and individual counselling services and conduct support group sessions for those who exhibit high levels of emotional distress and trauma symptoms.
- Raise awareness about mental health and psychosocial issues and availability of care to increase the likelihood of community members seeking assistance once the MHPSS programme is established.
- Ensure the availability of specialized services including psychological, psychotherapeutic or psychiatric treatment for people with severe mental disorders. This could be done through the establishment of referral pathways to the already available specialized services, if any; the setting up of an MHPSS programme with the inclusion of specialized MHPSS staff; or through provision of training programmes such as WHO Mental Health Gap Action Programme (mhGAP) to primary health-care workers and physicians to scale up services for mental, neurological and substance use disorders.
- Include people with severe mental disorders and their families and caregivers in planning and implementation of MHPSS programmes.[10]

## FINDING 3

*The need for increasing protective factors for returnees and other community members to mitigate challenges to social cohesion and peaceful coexistence, bullying and discrimination is latent.*

## RECOMMENDATION 3

*Create spaces for peaceful coexistence and healing:*

- Integrate community-based approaches, such as story-telling; such approaches give individuals and communities the opportunity to talk about their experiences and to understand their responses to violence.11 These community-based interventions can also focus on resilience, skill building and self-efficacy, therefore promoting adaptive coping skills and strategies, increasing motivation and hope, providing a sense of productivity and curbing or substituting the negative coping behaviours and aggression mentioned by youth.
- Support/establish programmes that involve all sides to create dialogue, communication and respect, to bridge the gap between victims and perpetrators. Support can be given through partners such as local religious leaders, mukhtars and organizations that are already involved with psychosocial support and peacebuilding/reconciliation work in the areas of concern.
- Build/improve the capacity of community leaders on issues such as negotiation skills, transitional justice, social cohesion and conflict management, among others.

9 Shirqat Protection KIIs Report, IOM, June 2020.

10 IOM (2019), Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. IOM, Geneva.

11 Lykes, M. B., Terre Blanche, M. & Hamber, B. (2003). Narrating survival and change in Guatemala and South Africa: The Politics of representation and a liberatory community psychology. American Journal of Community Psychology, 31(1-2), 79-90.





## FINDING 4

*No available space dedicated to adults or children to conduct recreational activities that would help community members overcome boredom and involve themselves in community based activities has been identified.*

## RECOMMENDATION 4

*Establish safe areas for recreational activities:*

- Establish/increase local facilities and services for extra-curricular activities such as arts, music and sports, and conduct them not only once or twice, but on a regular basis and for longer periods of time. Ensure the financial sustainability of facilities and ensure effective coordination between the local authorities in charge of these facilities and donor organizations such as NGOs.
- Create/increase spaces for monitored positive cultural exchange, such as community or child/youth centres, sports centres, and others, since social isolation is a significant risk factor that discourages adolescents and adults from actively interacting with people.
- Use psychoeducation as a contribution to conflict transformation, since MHPSS education enables conflict-affected communities and individuals to understand how people work under stress, how they deal with grief and loss, how communication can be a positive factor, and what actions can be taken to manage adverse conditions.[12]
- Organize workshops and group activities to raise awareness of functional/adaptive and maladaptive coping skills. These activities may include analysis of case scenarios with significant problems, and determining possible ways to deal with these issues; as well, brainstorming and role playing, or psychodrama techniques may be actively used to facilitate adaptive ways of coping.
- Peer support groups, sensitive to age and gender, may set up a forum for adolescents and adults to share experiences and positive coping strategies.
- At the community level, community centres may be useful to create a peaceful atmosphere for children and adolescents, as well as for their parents and caregivers, to gather and engage in activities together. Different responsibilities may be distributed among community members, such as gardening or organizing events; working together may increase trust and emotional sharing.

## FINDING 5

*Returnees highly reported experiencing discrimination and bullying.*

## RECOMMENDATION 5

*Promote safety and security in the community:*

- Increase awareness in the wider society against racism and discrimination through activities to increase inter-group ties between returnees and other community members.
- Events targeted at adults, adolescents and children (such as theatre and cinema) may be helpful to increase the connection between neighbours or community members from all age levels.
- Teach children and adolescents effective ways of dealing with situations of discrimination, violence or bullying, such as finding an ally or using distraction.
- Train community leaders including teachers, NGO and governmental staff on psychological first aid in the case of reactions related to traumatic stress in children and adolescents.

12 IOM (2019), Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. IOM, Geneva.

## FINDING 6

*The needs are complex and require time to be addressed.*

## RECOMMENDATION 6

*Invest in long-term interventions.*

- In order to create sustainable change in the community, advocate for longer-term funding, as change in post-conflict settings takes time and requires attention and presence because of the lack of resources and breakdown of relationships and trust among community members.
- Invest in longer-term capacity development tailored to the specific contextual needs and learning needs of MHPSS staff; strengthen the mainstreaming of MHPSS approaches with staff across the humanitarian response. Trainings on MHPSS interventions must include regular and systematic supervision, on-site coaching and field practice. It is recommended that organizations conduct assessments on their capacity development gaps and needs and build their capacity development plans accordingly, combining practical and theoretical approaches and exercises that enhance learning. For frontline staff, systematic supervision and coaching must be strengthened.[13]

13 MHPSS Programmes for Children, Adolescents, Youth (24-0 years) and Parents/Caregivers in Syria and from Syria and Iraq Crises Affected Countries, NLG MHPSS Task Force, 8 July 2020.





# ANNEXES

## ANNEX 1: FOCUS GROUP DISCUSSION PROTOCOL

Date:

Location:

### Key Agenda Items

#### POPULATION BACKGROUND

- Can you provide us a general picture about the population in Eitha and Ganous?
- What is the effect of the ISIL crisis on the population?
- Are there people with special needs in the community? Are these people supported by the community?
- What kind of housing is there in the community?
- Do families have any restriction on freedom of movement in their current residence?

#### MHPSS NEEDS

- What do you think are the most urgent psychosocial needs to be addressed for the community in the near future?
- What do you think are the concrete actions that could be taken to improve the overall psychosocial well-being of the community?
- Which groups in this community are suffering the most from the displacement in the past/the current situation?
- Are these people supported by the community? How?
- Do you think people in the community will seek psychological and psychosocial support if it is provided?

#### NEEDS RESPONSE

- What could be IOM's role in supporting these needs?
- What are the most important actions that could be taken to improve well-being in the community?

## ANNEX 2: KEY INFORMANT INTERVIEW SURVEY

### Shirqat Emergency Response – MHPSS Need Assessment
### MHPSS Assessment Questionnaire

#### INTRODUCTION AND CONSENT SCRIPT

*"My name is _____ and I work with IOM. IOM has been working in Iraq for 10 years, providing mental health and psychosocial support, medical services and non-food assistance. Currently, we are talking to people who live in Shirqat. Our aim is to know what kind of problems people in this community have at this moment, and what kind of psychosocial support they might need to improve their wellbeing. We cannot promise to give you support in exchange for this interview/discussion. We are only here to ask questions and learn from your experiences. You do not need to participate, so you are free to take part or not. If you do choose to be interviewed, I can assure you that your information will remain anonymous so no one will know what you have told us. We cannot give you anything for taking part, but we would greatly value your time and responses."*

*Do you have any questions?*

☐ *Yes* ☐ *No*

*Would you like to be interviewed?*

☐ *Yes* ☐ *No*

#### POINTS FOR CONSIDERATION

- If people are unclear about the term "mental health and psychosocial" please clarify this relates to emotional well-being of individuals, families and communities.
- Encourage and reassure when necessary. Take care of the needs. Do not force.
- Remember that severely affected people may have been exposed to trauma or loss.





| 1.SOCIO-DEMOGRAPHIC INFORMATION RETURNEES | | |
|---|---|---|
| Date of Assessment | | |
| **Name of Interviewer:** _____ | | ☐ Displaced ☐ Returnee<br>☐ Host Community |
| **Gender**<br>Female ☐ Male ☐ | **Age:** _____ | **Village of origin:**<br>What village were you displaced from if you were displaced? _____ |
| **Educational level:**<br>Which educational level have you attained? _____<br>How many years in all did you spend studying in school (or college or university)? _____ | | **Work status:**<br>What kind of job did you have in your town/village before crisis? _____<br>What is your main work status currently?<br>☐ Paid work<br>☐ Self-employed, such as owning a business<br>☐ Non-paid work, such as volunteer<br>☐ Student<br>☐ Homemaker<br>☐ Retired<br>☐ Unemployed (health reasons)<br>☐ Unemployed (other reasons)<br>☐ Other (specify) _____ |
| **Marital status:**<br>What is your current marital status?<br>☐ Never married<br>☐ Currently married<br>☐ Separated<br>☐ Divorced<br>☐ Widowed | | **If the interviewee is in paid work or self-employed, ask:**<br>What is your job? _____<br>What do you do for work? _____ |
| How have the economic conditions of your family changed following the crisis? | | |
| Is this a female-headed household? | | ☐ Yes ☐ No |

| 1.SOCIO-DEMOGRAPHIC INFORMATION RETURNEES | |
|---|---|
| Date of Assessment | |
| How many persons per household in the following categories? | Older people (60+) _____<br>Men (18 – 59) _____<br>Women (18 – 59) _____<br>Children and youth younger than 18 years _____ |
| Is there a pregnant woman or an infant (under 2 years) in the HH? | ☐ Yes ☐ No<br>Age of the child : _____ |
| The next questions ask about difficulties you or anyone in your HH may have doing certain activities because of a health problem: | |
| 1. Do you or anyone in your HH have difficulty seeing, even if wearing glasses? | ☐ No – no difficulty<br>☐ Yes – some difficulty<br>☐ Yes – a lot of difficulty<br>☐ Cannot do at all |
| 2. Do you or anyone in your HH have difficulty hearing, even if using a hearing aid? | ☐ No – no difficulty<br>☐ Yes – some difficulty<br>☐ Yes – a lot of difficulty<br>☐ Cannot do at all |
| 3. Do you or anyone in your HH have difficulty walking or climbing steps? | ☐ No – no difficulty<br>☐ Yes – some difficulty<br>☐ Yes – a lot of difficulty<br>☐ Cannot do at all |
| 4. Do you or anyone in your HH have difficulty remembering or concentrating? | ☐ No – no difficulty<br>☐ Yes – some difficulty<br>☐ Yes – a lot of difficulty<br>☐ Cannot do at all |
| 5. Do you or anyone in your HH have difficulty (with self-care such as) washing all over or dressing? | ☐ No – no difficulty<br>☐ Yes – some difficulty<br>☐ Yes – a lot of difficulty<br>☐ Cannot do at all |
| 6. Using your usual (customary) language, do you or anyone in your HH have difficulty communicating, for example understanding or being understood by others? | ☐ No – no difficulty<br>☐ Yes – some difficulty<br>☐ Yes – a lot of difficulty<br>☐ Cannot do at all |





| 1.SOCIO-DEMOGRAPHIC INFORMATION RETURNEES | |
|---|---|
| Date of Assessment | |
| Have you been displaced in the past? | ☐ Yes ☐ No |
| Was that your first experience of displacement? | |
| Where were you displaced to? | ☐ Camp<br>☐ Unfinished building<br>☐ Other _____ |
| How long have you been displaced? | |
| The date of arrival to the current place of habitation | |

| 2.LIVING CONDITION OF THE RETURNEE |
|---|
| 2.1 What kind of housing do you have? |
| |
| 2.2 What is your status of residence? |
| |
| 2.3 Are you sharing your housing with others? |
| |
| 2.4 Does the family face a threat of eviction at any moment? Is this a real threat or a feeling?<br>How strong is this feeling from 0 to 10?<br>*(0 = not at all, 5 = moderate, 10 = very strong)* |
| |
| 2.5 Does the family have any restriction on the freedom of movement in your current residence? |
| |
| 2.6 Do you think your children are safe? Do they have a safe place to play?<br>How strongly do you feel that you children are safe from 0 to 10?<br>*(0 = totally safe , 5 = somewhat safe, 10 = Not safe at all)* |
| |
| 2.7 Have you ever experienced being discriminated?<br>If yes, why? And how did you feel? |
| |
| 2.8 Is everyone who lives here treated in the same way? if not, who are the most vulnerable groups? and why? |
| |

## 3. ASSESSMENT OF PSYCHOLOGICAL AND PSYCHOSOCIAL NEEDS

3.1 Is there a word you traditionally use to define emotional distress? What word/s do you use?

3.2 Is this feeling widespread in the community? Do many people feel like that in this community?
*The interviewer will try to bring the conversation towards family and personal issues.*
*The interviewer can refer to his own experience.*

☐ Yes ☐ No

3.3 Do you feel like this?

☐ Yes ☐ No

3.4 How strongly do you feel like this from 0 to 10 (use suffering scale)?
(*0 = not at all, 5 = somewhat feel like this, 10 = feel like this very much)*

3.5 What are the causes of (use the word the person identified in question 1.1), in this community?
*In case the answer takes too much time, the interviewer might suggest displacement, the security, family matters, or living conditions*

- ☐ Displacement
- ☐ Traumatic experiences in my place of origin
- ☐ Traumatic experiences during displacement
- ☐ Lack of access to basic services in the camp
- ☐ Loss of loved ones (death, kidnapping, separation)
- ☐ Other _____

3.6 What is the impact of these causes (mentioned above)? Choose three maximum.

- ☐ Aggressiveness
- ☐ Sadness
- ☐ Sleep disorders
- ☐ Anxiety
- ☐ Family issues (relationship problems)
- ☐ Feelings of guilt
- ☐ Persistent nightmares
- ☐ Grief
- ☐ Other _____

3.7 Daily functioning: How does …… (name the chosen MHPSS problem above) may make it difficult for a person to perform their usual tasks? For example, things they do for themselves, their family or in their community. What kind of tasks is difficult for men/women/adolescents/children/older people? And what about you?

Men: _____

Women: _____

Adolescents: _____

Children: _____

Older people: _____





## 3. ASSESSMENT OF PSYCHOLOGICAL AND PSYCHOSOCIAL NEEDS

3.8 Coping: what kind of things do men/women/adolescents/children do to deal with such problems? Does doing that help them? What about you?

Men: _____

Women: _____

Adolescents: _____

Children: _____

Older people: _____

3.9 What are other psychological problems in the community? What about you?

3.10 How would you describe your relationship with your family? Are you supported by your family?

☐ If yes, how? ☐ If no, why not?

3.11 How would you describe your relationship with your neighbours? Are you supported by your neighbours?

☐ If yes, how? ☐ If no, why not?

3.12 Do you feel supported by your community?

☐ If yes, how? ☐ If no, why not?

3.13 Which groups of people in this community are suffering the most from the crisis in the past/the current situation?

- ☐ Women
- ☐ Men
- ☐ Children
- ☐ Widows
- ☐ Older people
- ☐ People with disabilities
- ☐ Other _____

3.14 Are these people (identified above) supported by the community?

☐ If yes, how? ☐ If no, why not?

3.15 Do you think there are people in the community who need psychological or psychosocial support?
*If they are not sure what this means, clarify "support for their emotional well-being"*

☐ Yes ☐ No

3.16 Do you think people in the community will go for psychological and psychosocial support if it is provided?

☐ If yes, how? ☐ If no, why not?

3.17 Apart from material needs, what are the main issues that need to be addressed in the community?
*Try to elicit discussion about psychosocial needs.*

## 3. ASSESSMENT OF PSYCHOLOGICAL AND PSYCHOSOCIAL NEEDS

3.18 Can you prioritize these needs in order of importance?

1. _____
2. _____
3. _____

3.19 What are the most important actions that could be taken to improve well-being in the community?
*Please encourage them to discuss activities that IOM could provide that would be helpful – encourage focusing on psychosocial needs and rank in order of importance*

1. _____
2. _____
3. _____

3.20 How have children and adolescents been affected by the crisis?
*Encourage them to think about changes in behavior, emotions etc.*

Children: _____ Adolescents: _____

3.21 Do all your children go to school? If not, why?

3.22 Are you satisfied with their performance?

3.23 Do they have any extra activities after school?

3.24 How have women been affected by the crisis?

3.25 How have men been affected by the crisis?

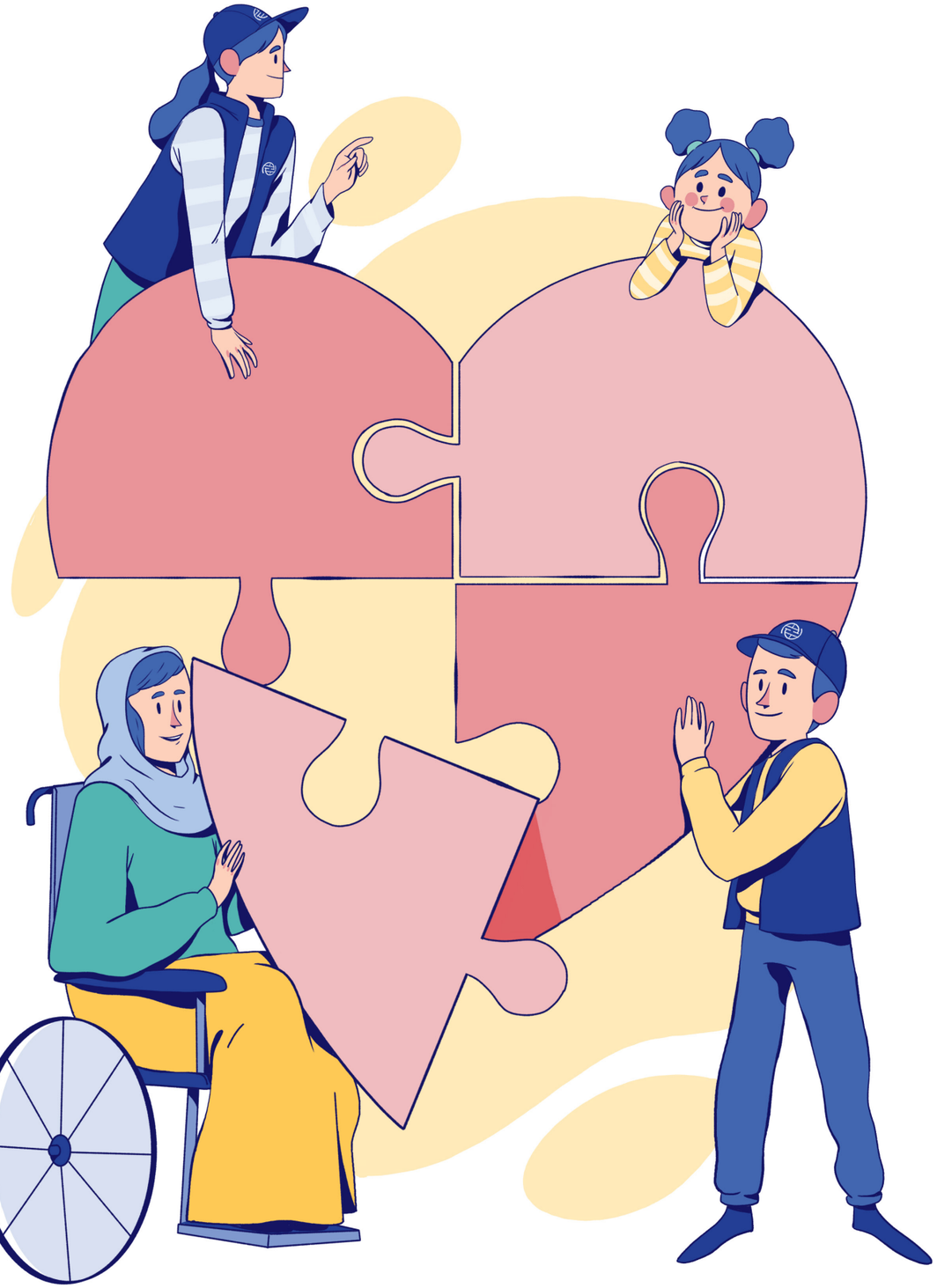
3.26 How have older people been affected by the crisis?

3.27 How have people with disabilities been affected by the crisis?

3.27 What are your family's plans?

☐ Accept the situation and live on ☐ Move abroad ☐ Confused ☐ No plans/decisions

3.29 Interviewer's observations/notes:



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