NEEDS ASSESSMENT REPORT

EXPLORING THERAPEUTIC VIRTUAL REALITY FOR SURVIVORS OF GBV IN IRAQ

NORWEGIAN CHURCH AID
actalliance

Innovation Norway

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Acronyms

DoH	Department of Health
FGD	Focus group discussion
FSC	Family support center
GBV	Gender-based violence
IDP	Internally displaced person
IPV	Intimate partner violence
ISIS	Islamic State of Iraq and Syria
KII	Key informant interview
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual and other sexual orientations, gender identities and gender expressions
MHPSS	Mental health and psychosocial support
NCA	Norwegian Church Aid
NGO	Nongovernmental organization
PHC	Primary health center
VR	Virtual reality

Section 1: Background and Context

Humanitarian Context

In humanitarian contexts, many challenges hinder gender-based violence (GBV) survivors' access to the specialized mental health and psychosocial support (MHPSS) services they need to recover, including damaged and underdeveloped social service and health infrastructure, overburdened or underqualified providers, distrust of providers, and stigma against survivors of GBV. Specialized MHPSS services and trained providers are not widely available, yet 1 in every 10 people is estimated to need mental health care at any one time.[1]

In Iraq, several recent events have challenged—and continue to challenge—the resilience of Iraqi people and the state's institutions. These events include current political and economic instability, the conflict with the so-called Islamic State of Iraq and Syria (ISIS), ongoing security concerns, internal displacement and challenges returning home, the COVID-19 pandemic, and Syrian refugee crisis. The psychosocial impact of these situations has been profound.

NCA also recognizes that oppression, marginalization and abuse of power are in part responsible for causing, exacerbating and maintaining emotional distress and other psychosocial issues. This is especially true of gender inequality, which has "led to the domination over and discrimination against women by men and to the prevention of the full advancement of women."[2] One such manifestation of gender inequality at individual and societal levels is GBV.[3] During these humanitarian emergencies, the risk of GBV increased, including intimate partner violence, child and forced marriage, exploitation, and sexual violence. Members of minority groups—such as Yazidis—were particularly targeted by ISIS, including through acts of sexual violence and slavery. GBV and other manifestations of gender inequality have a deep impact on women's and girls' mental health and psychosocial well-being. Amidst the struggle, women, girls and GBV survivors have demonstrated immense strength and fortitude.

Innovation Norway Project

Norwegian Church Aid continually seeks to improve the quality of care for survivors of GBV so that they can heal from trauma, reconnect with their communities, and be agents of social change. With support from Innovation Norway, NCA's latest GBV innovation project seeks to explore the use of virtual reality (VR) as a medium through which therapeutic interventions can be delivered. The outcome of the project is an VR-based intervention that will be:

- Targeted for specific psychosocial problems
- Safely delivered by paraprofessionals
- Guided by feminist, survivor-centred and empowerment-based principles
- Culturally relevant and accessible for survivors with diverse experiences
- Sustainable and scalable over time in humanitarian contexts

[1] World Health Organization (2018). *Mental health atlas 2017*. Geneva. https://www.who.int/publications/i/item/mental-health-atlas-2017
[2] UN General Assembly (1993). *Declaration on the Elimination of Violence against Women*, A/RES/48/104. https://www.refworld.org/docid/3b00f25d2c.html
[3] "Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private." From: Inter-Agency Standing Committee (2015). *Guidelines for integrating gender-based violence interventions in humanitarian action.* www.gbvguidelines.org

This Needs Assessment is the first of three main activities of the Innovation-Friendly Procurement Process that NCA will use for this project.[4] Following this Needs Assessment, NCA will begin the Market Dialogue activity followed by a Request for Proposals. Through this process, NCA will seek to leverage private sector expertise in adapting and/or designing and building VR-based interventions for therapeutic or behaviour change purposes, resulting in a partnership to procure or develop the VR-based intervention. The needs assessment is the foundation of this process, as any therapeutic intervention needs to reflect the needs and perspectives of the end users and other key stakeholders that are outlined in this report.

Therapeutic uses of VR have the potential to revolutionize MHPSS service delivery worldwide. For survivors of GBV in humanitarian settings, a therapeutic VR solution would transform availability, access, delivery and quality of care. Targeted MHPSS for particularly challenging psychosocial impacts of GBV can promote healing and resilience to future adversity. VR is touted as a safe virtual space to learn, fail, and practice new ways of being, free from judgment and stigma. It also allows paraprofessionals to offer higher quality care more efficiently to survivors, reducing the burden on the local health system.

A few humanitarian agencies have piloted VR interventions for service providers and clients alike. As an example, Mercy Corps, a US-based humanitarian NGO, piloted a VR therapeutic, meditative experience in Iraq.[5] Mercy Corps incorporated the VR pilot into two different in-person interventions for adolescents, training facilitators to guide clients through VR meditations. The International Committee of the Red Cross (ICRC) has a dedicated VR Innovation unit, which has explored the use of VR for engendering empathy. The ICRC has also collaborated with the Norwegian Red Cross to develop a multiplayer safety and security training for humanitarian workers who find themselves working in areas where they may experience hostility.[6] The Humanitarian Leadership Academy has created a VR program to teach aid workers about safeguarding and practice responding compassionately to disclosures of sexual exploitation and abuse.[7] UN Women tested a VR-based training for police officers in Moldova on responding to violence against women.[8] The International Organization for Migration and Yazda used a VR-based documentary in Iraq and around the world to raise awareness about the genocide of Yazidi people by ISIS.[9] Despite a few VR pilots, there has not yet been wider adoption or experimentation with the use of VR as a part of humanitarian interventions.

[4] The innovation-friendly procurement process is outlined in Innovation Norway's *Innovation-friendly procurement tools for the humanitarian sector:* https://www.innovasjonnorge.no/globalassets/0-innovasjonnorge.no/subsites/hipnorway/innovation-friendly-procurement-tools_02062020.pdf/

[5] https://www.mercycorps.org/blog/field-testing-vr-therapy

[6] https://blogs.icrc.org/inspired/2021/06/11/icrc-and-norwegian-red-cross-create-remote-multiplayer-vr-security-trainer/

[7] https://www.humanitarianleadershipacademy.org/safeguarding-vr-case-study/

[8] https://moldova.unwomen.org/en/noutati-si-evenimente/noutati/2018/04/realitatea-virtuala-pentru-eliminarea-violentei

[9] https://www.nobodys-listening.com/virtualreality

Section 2: Methodology

Objectives

Virtual reality-based therapeutic interventions—as well as the innovation process—are relatively new to the humanitarian sector and to Iraq. To ensure a successful and acceptable innovation, the Innovation-Friendly Procurement Process is driven by end user needs, rather than detailed product specifications; therefore, end users are involved early to clearly define and prioritize their own needs, which will allow for the market to develop ideas of how they can contribute to solving the defined needs.

The main objectives of this assessment were to:

- To identify, prioritize and better understand psychosocial problems that GBV survivors face in the cultural context (e.g., shame, self-blame, social isolation, stigma, etc.)
- To better understand how VR can be leveraged to support or improve therapeutic interventions
- To better understand risk factors and success criteria related to project implementation
- To better understand the potential target users of a VR-based therapeutic intervention
- To identify the kinds of technology considerations, workarounds and/or design that will be necessary to implement a VR intervention in these locations

Methodology

Target Population, Location and Sample Selection

The target population for this assessment was women and girls, ages 14 and above, who were from the IDP, returnee and host communities. The sample was selected from women and girls who visit NCA's Family Support Centers (FSC) in Mosul and in Al Qosh. NCA currently provides services within two FSC in Mosul: one within a government-run primary health center (PHC) and one in a community-based location. NCA also runs one FSC in Al Qosh within a government-run PHC. Women and girls were selected by the NCA's caseworkers and outreach workers, who are based inside the FSCs and have direct contact with women and girls through various activities.

Data collection took place in June and July 2022.

Information Sources and Data Collection

The assessment was implemented via key informant interviews (KII) and focus group discussions (FGD).

Table 1: Focus Group Discussion participant breakdown

	# of FGD Conducted in Mosul	# of FGD Conducted in Al Qosh	Total Number of Participants
FGD with Women	7	2	95
FGD with Girls	3	2	47

Table 2: Key Informant Interview participant breakdown

	# of KIIs Conducted in Mosul	# of KIIs Conducted in Al Qosh
KIIs with Women	5	3
KIIs with Girls	2	2

Additionally, KIIs were held with six subject matter experts in Iraq–i.e., people with expertise on MHPSS and GBV who currently work for nongovernmental organizations in Iraq. Also, two FGDs were held—one in Mosul and one in Al Qosh—with four NCA caseworkers who provide case management and other psychosocial support services to survivors of GBV.

Informed consent of the participants was sought by providing information on the purpose of the assessment, how the data would be used, voluntary nature of participation and confidentiality

Assessment Tools

The FGD tool for women and girls utilized the Participatory Ranking Methodology to 1) generate responses to the question "What are the psychosocial issues that affect women and girls emotionally and psychologically and make them feel uncomfortable?" and 2) rank the identified psychosocial problems according to the question: "Based on the earlier list, which are the most important psychosocial issues?" Participants were also asked about psychosocial problems unique to survivors of the following types of GBV: child marriage, denial of resources, physical abuse, and psychological/emotional abuse. The GBV types were selected by NCA's team in advance because these GBV types are most commonly reported by survivors who receive services at NCA's centers in Mosul and Al Qosh. Participants were also asked about psychosocial problems unique to widows, divorced women, and people with diverse sexual orientations and gender identities. NCA's staff selected these groups based on discussions during the assessment planning workshop, whereby staff identified these groups of women, girls and GBV survivors who are particularly at risk of experiencing psychosocial issues within their context (i.e., communities in Mosul and Al Qosh).

The KII tool for women and girls was designed to elicit participants' descriptions of the highest ranked psychosocial problems, their causes, coping strategies and barriers to coping. During KIIs with women and girls, they were offered the chance to experience VR, and were asked about perceptions of risk and benefits, and general first impressions before and after trying a brief VR meditation experience.

The KII tool for subject matter experts inquired about the highest ranked psychosocial problems to further understand the problems, as well as the approaches other service providers use to address them and any challenges they face. The FGD tool with caseworkers was used for the same purpose, as well as to gauge the caseworkers' general familiarity with technology, ask about perceived benefits and risks of VR, and to obtain ideas for integrating VR into their current work with clients.

A Center Observation Tool was used to collect and/or consolidate demographic information about service users at each center, as well as available space, internet connectivity and other factors related to technology use.

Limitations

The assessment and its results have certain limitations. The psychosocial problems and their ranking are not representative of all women and girls across Mosul and Al Qosh as the sample was selected only from those already visiting NCA's centers and receiving one or more NCA services. Also, focus group discussion participants were 40 years old and younger, meaning that older women are not represented in the data. Questions about people with diverse sexual orientation and gender identity were only asked to participants in Al Qosh because NCA's staff felt that it would not be culturally/socially appropriate to ask this widely to community members in Mosul and that it

risked alienating them and may result in the women/girls asking to end the FGD. Overall, the respondents in Al Qosh were generally not knowledgeable about this group. Lastly, only one focus group was conducted with women with disabilities between 20-30 years old in Mosul; while this group reflected diversity in type of disability--including disability acquired during lifetime and those from birth--other age groups are not represented in this data and the sample size is small.

Section 3: Assessment Results

Psychosocial Problems Among Affected Population

This section includes descriptions of the psychosocial problems that women and girls identified. These descriptions are based on qualitative data from women, girls, NCA caseworkers and other subject matter experts. The focus group participants–not the assessment team–labeled and made the distinctions between the psychosocial problems that are included in this section; however, many of the psychosocial problems are interrelated and/or have overlapping features.

Based on the results of the ranking exercise during FGDs with women and girls, the highest rank psychosocial problems—in order—are:

1. Depression
2. Overthinking/Anxiety
3. Sadness
4. Isolation/Loneliness; and
5. Fear of Shame

These problems were then investigated further via KIIs and, thus, have robust descriptions presented below. The complete list of psychosocial problems that women and girls mentioned–in Arabic, English and Kurdish–is available in Annex 1. Brief descriptions of other psychosocial problems are available in Annex 2.

Depression خةموکی کأبة

The most commonly mentioned psychosocial problem across both locations and age groups was depression; nearly two-thirds of the FGDs raised the issue–with five FGD (two FGDs with adolescent girls and three FGDs with adult women) ranking it as their highest priority issue. When asked to describe depression, women and girls mentioned a range of characteristics and consequences, including: unhappiness, low energy or exhaustion, avolition, "loss of passion" (i.e., akin to hopelessness), loneliness, self-isolation, feeling like a burden to others, "being uncomfortable," negativity (i.e., negative outlook on the present and future), sadness, suicidal thoughts and/or attempts, easily distracted and/or difficulty focusing during conversations, fear of causing harm to children or spouses. Women and girls paid particular attention to the ways depression affects interpersonal relationships and communication, including inattentiveness to one's children and difficulty with child rearing. They also noted depression's negative influence on physical health and its somatic presentation, including difficulty sleeping and/or oversleeping, weight loss, appetite issues, heart pain, and illness.

NCA caseworkers and other subject matter experts affirmed the widespread problem of depression. They highlighted their clients with depression struggle with self-care (including grooming) and caring for others, as well as overthinking, guilt and self-blame, crying, marital discord, anger, aggression toward themselves and/or their children, issues with school performance, mood fluctuations, loss of daily routine, sense of powerlessness, and menstrual delay. They mentioned women and girls with depression have difficulty making future plans. Women's high level of responsibility compounds the effects of depression, and girls may overuse social media and avoid seeing friends. Religion was mentioned as able to both positively and negatively influence someone with depression. Subject matter experts highlighted that families and spouses cope with a person's depression by "ignoring her" in hopes that the problem resolves itself or because they view the person as attention-seeking. Families and spouses are worried about stigma and/or view depression as normal, so they discourage or restrict the person who is depressed from speaking with others about their problem.

Perception of the causes of depression varied. Many respondents focused on the poor economic situation as a cause of depression; for example, despair from a women's inability to provide for her family's needs and wants. GBV was also commonly noted as a cause; for example, physical and emotional abuse from husbands and/or in-laws, husbands and their families preventing their wives from visiting their loved ones, family members telling survivors that GBV within their marriage is normal and must be endured, husband abusing their children. Other relational causes included: inattentiveness from husband, families or friends unsupportive of one's dreams or needs, general issues within the family, death of a loved one. Several respondents mentioned depression as a result of an accumulation of many problems, and prompted by sadness, anxiety and fear. Others were unsure of the causes. Girls highlighted gender inequality as a cause of depression, for example noticing when boys are preferred over them within their families, as well as movement restrictions, scrutiny and judgment placed on their behavior as compared to their male peers. Subject matter experts highlighted the significant effects of IPV and abuse, peripartum depression and genetic predispositions to depression. They added that girls especially struggle when they have relationship problems with peers.

Overthinking/Anxiety زور هزركرن / دلةراوكي التفكير المفرط / القلق

Overthinking and anxiety appeared to be of greater concern for adult women as compared to adolescent girls. These closely related problems were mentioned by five of eight FGD with women, compared to one of five FGD with girls; one-third of FGD with women ranked this as their highest-priority problem. That said, subject matter experts highlighted the problem as common for teenage girls. Many women highlighted their perception that overthinking and anxiety affect most women they know. Women and girls described overthinking and anxiety as a manifestation of fear and discomfort, characterized by many thoughts about a wide range of concerns. These thoughts are difficult to stop, constant, cause suffering, and go beyond what would be considered a reasonable amount of worry or concern about that topic. Thoughts can be focused on the past, present or future, and often are a mix of all three.

The content of thoughts range widely: concerns related to the poor economic situation, unemployment, personal finances and daily stressors; child-related concerns such as worry that something bad will happen to their children (including GBV against their daughters), worry about children's school performance, fear of harming their children, worry that child will have a worse future than them, and concern about being able to afford food and school expenses for children; general uncertainty of the future; general anticipation and fear that something bad will happen, as well as specific worry that they will experience the same traumatic event again or have to suddenly evacuate; regret of past decisions; self-blame about their current circumstances and past events, including GBV. Adolescent girls worried about losing their family, their school performance, and whether or not their families would make them drop out of school and/or get married. Subject matter experts highlighted that overthinking includes imagining outcomes and possibilities that are not realistic or likely.

Sleep difficulties and appetite issues were often mentioned as consequences of overthinking and anxiety. Other consequences included: physical health issues, headaches, muscle tension, exhaustion or lack of energy, general sense of discomfort, difficulty focusing, indecision, anger and confusion. Overthinking and anxiety have significant behavioral consequences, including an anecdotal report of women not allowing their children to leave the home or go to school due to a fear something bad will happen to them despite low likelihood. Overthinking can also negatively impact family and spousal relationships. Some women and subject matter experts reported overthinking as a cause of depression, hopelessness and obsessions. One subject matter expert highlighted that because overthinking is so common, it has been normalized and many do not consider it a problem that can be alleviated. A common belief that impedes help-seeking is that talking about the fear or worry will cause it to happen.

Women, girls and subject matter experts attributed previous negative or traumatic experiences as causes for overthinking and anxiety–including living under ISIS and various types of GBV. In cases of IPV, one expert shared that survivors internalize the abusive messages that the perpetrator tells them–such as "You deserve this life. That is why God gave you this life"–resulting in overthinking about self-blame (e.g., questioning "Why did I allow myself to bring children into this life?").

Present-day situations–such as the poor economic condition, unemployment, high rents and safety concerns–also prompt overthinking. Many experts suggested the high burden of responsibilities for women in society contribute to their anxiety, especially for widows, divorced women and those assuming more household responsibility after the death of a loved one. Social media use, especially by adolescent girls, was mentioned as another cause or contributing factor.

Sadness خةمكين الحزن

Sadness was raised as a significant psychosocial problem in all but five FGDs, by both women and adolescent girls. It was framed as closely related to, though distinct from, depression. Sadness was variably described as feeling unhappy, displeased, uncomfortable, "a tingling in the heart," misery, and part of grief. It was characterized by crying, helplessness, powerlessness, fatigue, low desire to do anything, negative outlook or attitude, and self-isolation, as well as at times accompanied by anger, appetite issues, sleep problems, aggression, and easily distracted. Some viewed it as a precursor to depression and suicide, and it affects relationships and school performance.

Sadness was also viewed as ubiquitous: "There is no woman here in this community who does not suffer from sadness," said one respondent. That is in part due to the wide range of causes and contributing factors, including death of a loved one, loss of something valuable, illness (self or others), having a different life than what they dreamed, inability to provide for themselves or their family (in part due to economic stress), seeing their children suffering or struggling and feeling unable to help, difficulty maintaining their regular responsibilities, abuse or mistreatment from their partners, miscommunication between partners, being prohibited from attending school, being denied resources and opportunities unlike their male siblings, discord with in-laws, and after giving birth (postpartum sadness). Subject matter experts noted that adolescent girls often experience sadness from relationship conflict with peers, neglect from boyfriends, and shaming from their fathers.

Subject matter experts highlighted sadness as a normal state with a wide range of causes, and differentiated the typically temporary nature of sadness from the longer-term nature of depression. It also often co-occurs with other conditions, such as depression, panic, and anxiety disorders. They mentioned that given the atrocities that occurred under ISIS, people in Mosul and Al Qosh have suffered many losses, including loss of loved ones to homicide, kidnapping and illness, as well as loss of their home, community, jobs, roles and other important aspects of their life.

Isolation/Loneliness كوشةكيري / تنئ بوون الانعزال / الوحدة

Isolation and loneliness are interrelated problems that were raised in all but one FGDs with adolescent girls, as well as about two-fifths of FGDs with women. Put simply, isolation was described as not having the desire to see or talk to anyone. This is different from forced isolation, which also occurs amongst women and girls, especially in cases of GBV and disability. Isolation was identified as both a problem and a coping mechanism, with loneliness being a common consequence. Isolation can be short-term or last for days or weeks. Several causes and contributing factors are discussed in the section below "Difficulty Discussing Distress;" however, isolation and loneliness may also result from bullying and being disrespected, having low self-esteem, experiencing harassment and other forms of GBV. Women with disabilities noted that bullying, feeling different from others, feeling unwelcomed by others, and worrying that others will not understand them all contribute to their isolation and difficulty connecting with their peers. Adolescent girls also highlighted fear of shame contributing to their isolation, including worrying how their family or community would react when they leave (or ask to leave) the house. Subject matter experts highlighted isolation's negative effect on self-confidence, caregiving ability, relationship and marital health, women's and girls' ability to complete regular activities, and their ability to receive love and care from others who are capable of providing it.

Fear of Shame ترسا شةرمئ الخوف من العار

Women and girls highlighted the extent of fear present in their lives. The sources of fear largely resemble the aforementioned topics of overthinking and anxiety (e.g., fear of children's safety, of past traumatic events happening

again in the future, such as death of loves ones or GBV); however, fear was described as feeling "life threatening"–even if the feared situation is unlikely to occur–and prompting anxiety, discomfort, emotional instability and/or debilitation.

One particular kind of fear was repeatedly raised as a significant problem for women and girls: fear of shame and judgment from others. Women and girls voiced concern about "what people are going to say about me." They noted feeling under constant scrutiny and fearing a wide range of their behaviors—as simple as leaving the house or going shopping—would be viewed as shameful by the community at large, their spouses, particular family members, or peers. The consequences of shameful behavior are significant; a woman's or girl's behavior is seen as a reflection of her family and could harm her family's reputation and honor, as well as her own. At its extreme, some women and girls may be killed by the family or community (so-called "honor killings"), particularly for survivors of sexual violence and LGBTQIA+ individuals.

This psychosocial problem is connected with the cultural concept of '*ayb'* عيب , a term that is disproportionately used to discipline women and girls. It creates and enforces a gendered social code that deems certain behaviors as "shameful;" as a result, women and girls fear being seen as stepping outside rigid gender roles and prescribed social norms. As such, these social codes of '*ayb'* are viewed as a means of social control of women and girls and a manifestation of gender inequality. Women and girls highlighted that "we are always the one being blamed at the end," and some mentioned the lack of supportive family to "defend us." In fact, these social codes are often enforced by the family, ostensibly in an effort to preserve the family's honor. Girls reported relatives chastising or threatening them for associating with peers who are viewed as acting outside of acceptable gender norms (e.g., not wearing the hijab). One adolescent girl shared that peers fear asking their families to leave the house in case their family accuses them of having a romantic relationship, an accusation viewed shameful to them and their family and could lead to family members physically abusing or killing their daughters.

Women mentioned that women are often blamed and judged for things outside of their control, such as if someone else posted her picture on social media without her knowledge. They also fear being blamed and judged for the GBV they experience if others found out. They highlighted that widows and divorced women face particular fear of judgment, threats and accusations of doing something shameful if they, for example, leave their homes to shop for groceries or visit relatives, dress in particular ways, or have a happy demeanor in public. This also reportedly deters women from getting divorced, forcing them to stay in unhealthy or abusive marriages. Girls too noted that the community will "shame us if we leave [home]." This fear of shame and public judgment causes women and girls to isolate and question leaving the house, keep their problems silent, and fear abuse from their family or husband. And movement restrictions placed on women and girls–as well as risk of harassment–make being in public difficult. One woman commented, "fear prevents us from claiming our rights" and gets in the way of women and girls being able to go about their daily lives. Mental health stigma is also partly a cause in cases when women and girls fear the judgment of others if they discuss their problems and emotions.

Difficulty Discussing Distress

"Women cope by bearing what she is suffering from; whatever it is, she thinks that she must hold and bear it because she feels that no one could support her." - Respondent in Al Qosh

While investigating the psychosocial problems affecting women and girls, a separate but cross-cutting problem strongly emerged. Talking to a close, trusted person is a widely preferred way of coping with psychosocial problems; however, women and girls were clear that this option is largely unavailable to them in their personal lives, so they instead chose to keep their problems private and suffer alone. One respondent put it this way: "We come to [NCA's Family Support Center] since it is our last resort where we feel safe and we trust; we feel free to speak whatever we want with no fear, because sometimes all that we want is for someone to listen to us."

Overarching beliefs exist that "we have no one to support us," "no one understands us," and "we do not trust anyone." Common reasons why women and girls have difficulty discussing their distress with family and friends include: unsupportive families or friends who neglect their emotions, blame the person or tell them they "must bear it," as well as worry that their family or friends will make the situation more complicated or cause problems. One adolescent girl shared that "sometimes all [girls] want is a nice word like 'I love you' from their family" to make them feel better, but instead are met with criticism. Past experiences also impede discussing distress, such as when women and girls confided in others who then broke confidentiality and told others. Adolescent girls were particularly concerned about confidentiality breaches if they talked to friends about their struggles. Others may have felt misunderstood after confiding in a friend who told them "You have to love life" or "You should [do something]" instead of listening and validating.

Social norms contribute to the problem: women mentioned that once married, a woman's contact with her family is limited by the husband and his family and/or by her own family. Women mentioned being unable to discuss their suffering from IPV with their mothers because of culturally entrenched harmful beliefs that violence within a marriage is normal; one participant shared "her mother used to tell her that she has to handle it because it's normal for women once she gets married." Adolescent girls mentioned their families restricting their movement–and not their brother's–which limits their ability to see friends or attend school. Mental health stigma poses another barrier to disclosing distress; women and girls highlighted fear of being labeled as "crazy" or viewed negatively by the community, fear of their children being taken away from them, and fear of being threatened (especially by their partner in the case of disclosing GBV). Due to stigma, families and friends may discourage them from sharing their struggles with others, including GBV and MHPSS providers.

Others mentioned difficulty in identifying and explaining how they feel, as well as the discomfort of sharing something so emotionally difficult. Respondents were also aware of the negative consequences of keeping their problems to themselves and their relationships, including physical and psychological effects. Subject matter experts noted that it is easier to discuss a problem early on as opposed to when it has progressed significantly.

Hardest & Easiest to Talk About

When asked which psychosocial problems are the most difficult or uncomfortable to discuss with others, fear and depression were mentioned most often, then overthinking. Stigma attached to depression was a driving factor. For overthinking and fear, there is concern that if one talks about their fear, it might happen. In terms of GBV, NCA caseworkers highlighted that women and girls have the most difficulty disclosing sexual and physical violence.

When asked which issues are the easiest or most comfortable to discuss with others, women and girls mentioned financial issues because they are commonly experienced and well understood.

NCA caseworkers also highlighted several ideas that could help survivors feel more comfortable discussing distress with people in their lives:

- Raise awareness about effective communication skills and how to be good listeners
- Increase the awareness level for the parents about the importance of supportive communication with their family members;
- Increase the awareness for the community leaders on psychosocial problems, stigma and supportive communication
- Use therapeutic interventions that help strengthen family dynamics and relationships
- Support survivors to discern who in their lives is honest and trustworthy, a good listener, open-minded, and nonjudgmental; and encourage them to talk to those people.

Caseworkers' Priorities

NCA caseworkers in Al Qosh and Mosul were consulted as to which psychosocial problems they believe need more support to address with their clients. Depression was the top priority for caseworkers in both locations. Other common priorities included Overthinking/Anxiety, Trauma, Fear, and Stigma.

Specific Groups & GBV Types

During FGDs and KIIs, women and girls were asked to identify psychosocial problems that may be uniquely or differently experienced by particular sub-groups. These subgroups include:

- Widows and Divorced Women
- People of Diverse Sexual Orientations and Gender Identities
- Women and Girls with Disabilities
- Survivors of the following types of GBV:
    - Denial of Resources, Opportunities or Services
    - Child Marriage
    - Psychological and Emotional Abuse
    - Physical Abuse

Widows and Divorced Women

Women and adolescent girls both easily identified psychosocial problems unique to widows and divorced women, and several women in this subgroup participated in the assessment. Women and girls highlighted that widows and divorced women commonly suffer with isolation, fear of judgment, depression, loneliness, sadness and hopelessness due to stigma, marginalization and poor treatment by the community. They reported that poor treatment by the community prevents widows and divorced women from "living normally and claiming their rights." Threats and fear of threats or judgment cause women in this group to restrict their movements, behaviors, attire (e.g., wearing something colorful, using makeup) and facial expression (e.g., looking happy, laughing) in public out of fear of being labeled a "bad woman" and publicly discredited. Divorced women are often blamed and shamed for the divorce; one woman noted a commonly held belief in the community that "If she were a good wife, she would not get divorced." Widows are judged for how they should behave and are warned against behavior that suggests they have "moved on" from their deceased spouse. Women and girls noted that widows and divorced women struggle more when their family and/or in-laws are unsupportive or controlling. Women also highlighted the higher risk of GBV among this group. Widows and divorced women often have difficulty supporting themselves and their children financially and difficulty obtaining a job/income. NCA caseworkers highlighted that some women want to get divorced but fear the aforementioned consequences if they do, causing them to stay in unhealthy or abusive relationships and feel shame and powerlessness. They also noted a reluctance of widows and divorced women to seek assistance from nongovernmental organizations due to shame if the community were to find out they asked for help. In cases when a husband marries a second wife, NCA caseworkers noted that the first wife often blames herself for not being "enough" for him and questions what about her and their life would cause him to do this.

People of Diverse Sexual Orientations and Gender Identities

There were no openly LGBTQIA+ members of FGDs or KIIs for this assessment. Moreover, KII respondents were largely unaware of the challenges people in this subgroup face. Therefore, data is limited. One respondent noted that that people of diverse sexual orientations and gender identities struggle with isolation, depression and hopelessness because of stigma and marginalization from the community. Another respondent highlighted that having a supportive family is a protective factor. Subject matter experts noted several issues faced by this group, including: higher rates of GBV, suicide, homicide, lack of specially trained providers, discrimination by service

providers (often due to religious reasons), and providers referring them elsewhere instead of providing care directly. Other sources include more information about this group's psychosocial struggles and resilience.[10,11,12,13]

Women and Girls with Disabilities

One focus group with women with disabilities was conducted during the assessment period, as well as consultation with subject matter experts about this group. Stigma and discrimination against people with disabilities was a major contributing factor to psychosocial problems for this group, including bullying, exclusion, and accessibility issues. Women with disabilities highlighted anger, "sensitivity," negativity, isolation/shyness, and boredom as their major psychosocial concerns. For those who acquired a disability during their lifetime (e.g., due to an accident), sensitivity related to emotional experiences and dysregulation from reminders of the cause of their disability or of their life and abilities prior to acquiring a disability. Both those with acquired disabilities and those with a disability from birth reported struggling emotionally when comparing themselves to others without disabilities, feeling a sense of inferiority, and sometimes prompting aggression. One subject matter expert highlighted the higher risk of GBV for women and girls with disabilities, as well as common experiences of depression, sadness, and limited social support among this group.

Survivors of Certain Types of GBV

Denial of Resources, Opportunities or Services[14]

Women highlighted several common experiences of this form of GBV, including being restricted from going to school, working, leaving the home, and going shopping. They mentioned the psychosocial consequences are depression, sense of inferiority (i.e., low self-esteem), sadness, fear, overthinking, isolation and loss of trust with others. They also noted tangible consequences of having not been allowed to go to school and being illiterate, such as struggling to visit a doctor and read relevant signs and information.

Adolescent girls focused on being denied the opportunity to attend school and complete their education when under ISIS, as well as in some circumstances today. They also noted restrictions placed on them for being girls, which their brothers do not have. These restrictions include being prevented from leaving the house and seeing friends. Girls reported movement restrictions prevent them from learning about the world, learning social skills, and speaking confidently. Girls highlighted a range of psychosocial problems resulting from this type of GBV, including shame, isolation, sadness, anger, suicidal thoughts, low self-esteem/self-confidence, sense of inferiority, depression, hopelessness, and negativity.

Child Marriage[15]

Women and girls acknowledged that gender inequality and its related social norms are a primary driver of child marriage in their contexts. Women and girls also mentioned that bad economic conditions also drive families to marry their daughters at early ages to relieve their financial burden, as well as marriage being seen as a way to protect girls from other forms of violence. "Love marriages" also occur, with and without initial family support.

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[10] IraQueer (2018). *Living on the margins: LGBT+ stories from Iraq*. https://www.iraqueer.org/uploads/1/2/4/0/124034920/living_on_the_margins.pdf

[11] Bishop, A. (2022). *"I need to be free": What it means to be a queer woman in today's Iraq.* OutRight Action International and IraQueer. https://outrightinternational.org/sites/default/files/Iraq_EnglishLowRes.pdf

[12] Human Rights Watch (2022). *"Everyone wants me dead": Killings, abductions, torture, and sexual violence against LGBT people by armed groups in Iraq.* https://www.hrw.org/report/2022/03/23/everyone-wants-me-dead/killings-abductions-torture-and-sexual-violence-against

[13] MADRE, IraQueer et al. (2019). *Violence and discrimination based on sexual orientation and gender identity in Iraq: A report for the United Nations Committee on the Elimination of Discrimination against Women.* https://www.iraqueer.org/uploads/1/2/4/0/124034920/cedaw_shadow_report_sogie_74th_session_iraq_updated.pdf

[14] Defined as "denial of rightful access to economic resources/assets or livelihood, opportunities, education, health or other social services" (GBVIMS)

[15] Child marriage is a formal or informal union in which one or both spouses is under the age of 18. It is sometimes used interchangeably with the term early marriage because they largely refer to the same thing. "However, early marriage is also sometimes used to describe marriages in which one or both spouses are 18 or older, but with a compromised ability to grant consent." UNFPA (2022). *Child marriage – Frequently asked questions*. https://www.unfpa.org/child-marriage-frequently-asked-questions

Women noted the powerlessness girls face when being forced to marry, as well as subsequent feelings of regret, self-blame, sadness, shame, depression, anger, isolation, "reckless" behavior, hopelessness, overthinking and suicidal thoughts. Similar struggles were noted for girls who entered into "love marriages."[16] Women highlighted that girls are often "shocked" by the new marriage, including by relationship difficulties, the higher level of responsibilities they have, and problems with in-laws. Some noted how they thought being married would be easier than the disrespect and lack of freedom in their families, but they were disappointed and shocked to find restrictions continued and other challenges exist. Women also noted child marriage as increasing the likelihood of divorce–especially in the context of IPV–and as one cause of girls dropping out of school.

Adolescent girls also highlighted answer, suicidal thoughts and attempts, sadness, depression, anger, hopelessness, loss of trust, low self-esteem, isolation and regret as common psychosocial problems among girls who married early. They highlighted issues related to communication and connection with their often-older husbands, as well as the high burden of responsibilities as a wife. Some girls lamented that they do not have the right or ability to refuse marriage in their community, and there is a sense that others in their life won't support or listen to their opinion.

Psychological and Emotional Abuse[17]

Adolescent girls and women focused on psychological and emotional abuse perpetrated predominantly by their families, boyfriends and husbands. Girls also noted emotional neglect from their families, and women noted psychological and emotional abuse at times co-occurring with physical violence. Depression was a predominant psychosocial consequence of this form of GBV; other reported consequences include fear of judgment, fear of further abuse/violence, suicidal thoughts, isolation, overthinking, anger, family issues, sadness, sleep difficulties, shame, loss of trust in others, and regret. One respondent noted that psychological and emotional abuse from families prompts some girls to enter into dating relationships to satisfy their desire for attention, respect and emotional attunement.

Physical Assault[18]

Women highlighted gender inequality–and its social norms–as a cause of physical abuse, both inside and outside an intimate partner relationship; one respondent stated, "Physical abuse happens because people believe that men are allowed to do everything but not women." They also noted economic stress as a contributing factor to physical assault. Both women and adolescent girls highlighted the various ways physical violence occurs within families, including violence used by brothers and fathers to punish certain behavior (e.g., wearing makeup or certain clothes). Girls noted how their families condone their brothers' use of violence against them "because he is a boy and everything is allowed" and girls are viewed as "weak."

Some of the psychosocial impacts of physical assault that women noted were: "mental breakdown," depression, anger, overthinking, powerlessness, thoughts of revenge, feeling inferior, low self-esteem, trauma, sadness, suicidal thoughts and attempts, escaping the house, difficulty regulating emotions, sleeping problems and fear. Women also mentioned health impacts, such as body pain, deformities and disabilities.

Adolescent girls highlighted the following psychosocial impacts of physical assault: isolation, fear, suicidal thoughts and attempts, fear of disclosing violence and their feelings, fear of further abuse, loneliness, low self-esteem, sadness, difficulty sleeping, anxiety, negativity, anger, aggression, lack of trust and love for others, and difficulty regulating emotions.

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[16] However, any child marriage is considered a form of forced marriage because one or both persons have not given their full, free and informed consent due to lack of physical and psychological maturity to make informed adult decisions.

[17] Defined as "infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc." (GBVIMS)

[18] Defined as "an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury" (GBVIMS)

Coping Strategies

Women and girls noted various ways of coping that are common across most of the psychosocial problems. Most respondents mentioned a proclivity for women and girls to "bear it" alone (i.e., not talking to anyone) and/or isolate themselves from others, as discussed early. Other coping strategies included:

- Talking to trusted family or friends
- Going outside
- Visiting friends and family
- Distracting or "busying" oneself (e.g., with housework, social media)
- Try to ignore the problem
- Drawing
- Reading a book
- Listening to music
- Crying
- Journaling
- Sleeping and staying in bed
- Reading Qur'an or praying
- Visit religious leaders and/or doing rituals
- Going to live with parents
- Talking to stuffed animal
- Seek psychopharmacological intervention (particularly for depression)

In some cases, women and girls (or their families) may seek support from religious or community leaders, such as sheikhs and mokhtars. This was noted to have both negative and positive consequences, depending on the case. Their involvement may help prevent further GBV from occurring or it may exacerbate the violence and any psychosocial problems.

Wellbeing

During FGDs, women and girls were asked what psychosocial wellbeing means to them. A few common themes amongst participants were having healthy relationships (especially with partners and families), good interpersonal communication, and a sense of inner peace.

Women also mentioned the following:

- Being aware of their rights and using them
- Economic stability and/or income
- Having an education
- Being brave
- Having passion to live
- Sense of positivity about life
- Seeing children in good health
- Feeling comfort, calm, happiness, joy, and/or self-love
- Sleeping well
- Dressing well and grooming
- Laughing and smiling
- Spending time outside
- Doing something they love
- When others encourage them to work toward their dreams

Girls also mentioned the following:

- Feeling safe and without fear
- Speaking nicely
- Laughing
- Feeling calm
- Seeing their families satisfied and in good health
- Not seeing parents having conflicts
- Economic stability
- Being passionate about life
- Sense of positivity about life
- Feeling happiness, joy, self-love
- Speaking more than usual

Simply put, one woman said that wellbeing is "wanting to go to the next day and just spend the day peacefully."

Virtual Reality

Assessment participants-key informants and FGD participants- were provided the opportunity to try a brief meditative experience from Healium, using a VR headset. Respondents were placed in VR in order to ask them for

their initial perceptions and imagined risks and benefits. Given that virtual reality may not be widely experienced by beneficiaries and mental health professionals alike in Iraq, the assessment wanted perceptions from those who had tried it, albeit briefly.

Center Observations

The needs assessment team completed observation forms for each of the three centers. The observation activity included an assessment of the centers' facilities to determine if there was space and the amenities to support a VR intervention. All of the centers had WiFi, electricity, and a safe place to store and lock the VR headsets. Two of the centers have a room that can be dedicated to a VR intervention, and one center (Al Qosh) did not have additional space for a VR intervention, but the observation exercise indicated that space could be adapted. Ultimately, all of the three centers could maintain a VR intervention with no or little adaptation required, and would (theoretically) be able to download and maintain content on the headset. Additionally, at the time of the assessment, all centers carried out both group activities with women and girls, as well as individual sessions with caseworkers and psychologists.

Focus Group Discussions with Caseworkers: Perceptions of VR

In Mosul, two caseworkers explored VR with a guided meditation experience in the headset. Before trying on the headset their initial first impressions were that VR is "surprising," "amusing," and "interesting because it is something new to the community." The two caseworkers did not identify any major risks at the time of the assessment. Instead, they noted that there could be "positive" applications of VR including providing "positive energy" and a sense of "safety and peace" to users. While the caseworkers raised the potential that some end-users may experience phobias of what they see in VR (i.e., water or heights), that VR interventions could be used to help people address their phobias.

Key Informant Interviews: Women and Girls

Five key informants in the centers were provided the opportunity to try a VR meditation experience after completing their interview. They first provided their initial impressions without having tried the headset, and then were prompted to share their first impressions after trying the experience. Due to time constraints, some key informants were not able to try the VR meditation experience, but provided feedback on their initial impressions of the headset.

None of the key informants had previously tried VR before. The informants did not identify any major risks in using VR, except for one who stated that her neck felt sore after trying the headset. Two of the five stated they had either seen information about VR online before or heard about VR from their children. All of the respondents were interested in trying VR, with one stating that she was a bit nervous initially. Three respondents stated that they believe that others will enjoy VR, one stated that VR is "nice; it takes you to beautiful places, and another said VR would allow people "to go to beautiful places," and to "isolate themselves from reality."

Key Informant Interviews: Subject Matter Experts

One expert KII described VR as "fantastic," and noted that she felt more relaxed after the VR meditation experience. If used for trauma cases, a VR intervention, according to this key informant, would require education about the intervention and training. They did express concern about the risk of retraumatizing and increasing survivors' fear.

The key informant hypothesized that VR may assist women and girls who have difficulty with imagination (e.g., finding a safe space in their mind), and said there is a benefit even if for a short time if beneficiaries feel "happy and relaxed." A VR experience could potentially prompt the idea that "we have something beautiful in our life."

Services and Centers

NCA plans to pilot this project out of two of its Family Support Centers: one in Mosul and one in Al Qosh. The FSCs operate 5 days a week (weekdays) during normal working hours.

Demographics

Below is a table that reflects the demographic information of women and girls who visit and participate in any activity or service at NCA's centers in Mosul and Al Qosh.

Table 3: Demographics of FSC service users

	Mosul	**Al Qosh**
Ages range	6-50	9-65
Language spoken	Arabic	Mostly Kurdish, some Arabic
Estimated literacy rate	70%	70%
Percent of beneficiaries who have completed secondary school	30%	50%
Percentage of beneficiaries who are married	80%	50%
Religious affiliations	Islam	Yazidi and Christianity
Ethic groups served by this center	Arab	Yazidi and Assyrian

Staffing

Caseworkers–and potentially psychologists–will be responsible for delivering the VR-based intervention to their clients. There will be at least one NCA caseworker staffing and providing GBV response services at each location alongside Department of Health (DoH) staff who NCA supports. Caseworkers are paraprofessionals with bachelor's degrees who are trained on GBV Case Management, basic counseling skills and therapeutic techniques, and non-structured Group Psychosocial Support facilitation; some caseworkers may have additional training in Art Therapy, Adolescent Girls-Specific Programming (e.g., life skills training) and other topics.

The Mosul FSC–located within the PHC–will have the following staff:

- 1 NCA caseworker, full-time
- 1 DoH caseworkers, part-time
- 1 Psychologist, part-time
- 1 Psychiatrist, part-time

The Al Qosh FSC–located within the PHC–will have the following staff:

- 1 NCA caseworker, full-time
- 1 DoH caseworkers, part-time
- 1 Psychologist, part-time
- 1 Psychiatrist, part-time

Case Management Services[19]

The VR-based intervention will be used during one-on-one case management between the caseworker and client. Caseworkers typically meet with clients for approximately 30-60 minutes, though session length varies case-by-case, for an average of 6-10 sessions per month for 1-3 months. Caseloads per caseworker range from 6-15 clients at a time.

There are many ways in which a client is referred for case management services, including:

- Self-referral by calling hotline or visiting the center in person
- Referral from partner organizations within the interagency referral network
- Referral from DoH medical providers
- From other NCA services and activities such as GBV community outreach workers, GBV volunteer committees, adolescent girls groups, and women's groups.

Often, women and girls will participate in other NCA activities, interact with caseworkers and other NCA staff, and build enough trust before reaching out for case management services and talking to a caseworker about her problems. Other subject matter experts affirmed this is common in their organizations' services as well.

NCA caseworkers reported that the basic psychosocial support alongside case management is effective in improving the wellbeing of many GBV survivors. For some cases–particularly depression and trauma and depending on their assessment of severity–the caseworker will refer the survivor to higher-level care, such as a psychologist and/or psychiatrist. Caseworkers will also offer survivors the opportunity to participate in other NCA services and activities, if available and appropriate, such as vocational training, adolescent girls groups, and psychosocial support groups.

The VR-based intervention may also be used by psychologists during their one-on-one sessions with clients. Staff may also refer clients from other NCA-run activities to the caseworker if they believe the clients would benefit from the VR-based intervention, regardless of whether they receive case management services.

Challenges Providing Case Management

NCA caseworkers and psychosocial staff noted several challenges when providing case management–including psychosocial support–for survivors. One challenge is that some clients stop attending case management appointments in the middle of their case; reported reasons for this vary and include:

- Inability to continue visiting the center due to movement restrictions from family/spouse, lack of transportation or money for transportation, lack of childcare at home while she is out, difficulty scheduling, or having moved out of the area; n.b. NCA typically discourages home visits for case management services to ensure safety of both NCA staff and clients.
- Some clients assume their problems will be resolved and they will feed better after one session, so they feel discouraged when this does not happen.

Other challenges that NCA staff have when providing case management and psychosocial support are:

- High turnover of caseworkers and the resulting need to continuously hire and train new staff. Caseworkers are paraprofessionals, and typically not specialized in psychosocial support, counseling, etc.
- Fear, anxiety and internalized shame and stigma about GBV and emotional distress prevent some survivors from openly sharing with the caseworker.

[19] "GBV case management is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process." This often entails safety planning, basic psychosocial support, and referral to medical care, legal services, spiritual support, and other service providers according to each survivor's material and non-material needs. (IASC GBV Case Management Guidelines, 2017)

- The need for many follow-up sessions
- Some survivors learn new skills to help with their emotions and struggle to use these skills outside of the session and in their daily life. This was especially noted for survivors of IPV who may leave the session feeling positive but then return to unsafe homes and have difficulty remembering to use new skills and tools. Other survivors report having "no time."
- Caseworkers at times feel unequipped to support survivors with certain psychosocial problems and severities, especially depression for which they refer to the psychologist or psychiatrist.
- Caseworkers feeling anxious about their ability to effectively provide emotional support due to the severity of a case, so they instead refer the survivor to higher-level care, even when such referral may not be necessary
- Many survivors struggle with mindfulness and imagination-based exercises. For example, finding an imaginary safe place in their mind. ("I have a lot of things in my mind; I can't stop them"). Survivors also struggle at times with relaxation skills

Group Psychosocial Support

NCA and other organizations in these locations offer group psychosocial support–both non-structured and focused groups. In 2023, NCA will offer the following groups:

- Psychoeducation groups on various GBV-MHPSS topics
- Art therapy groups
- Women Rise group[20]
- ENGAGE groups[21]
- Smart Skills activities

NCA caseworkers and subject matter experts raised several benefits and challenges related to running groups. One benefit was that they allow for women and girls to see others modeling how to talk about their problems, which in turns encourages some to share their own struggles, receive support from their peers, and have hope for themselves. Conversely, several subject matter experts noted that trust issues–mainly fear that other groups members will break confidentiality–prevent many women and girls from openly sharing their problems in groups; some women and girls know other group members because their neighborhood is small and tight-knit; some may have relatives in the group. Another mentioned that groups are not always appropriate for people who already have difficulty with public speaking. Experts mentioned other group challenges: the need for "specialized"/trained group facilitators, which is difficult given high turnover rates common in the industry; participants requesting support covering the cost of transportation; difficulty with group member selection and coordinating schedules.

Other Programming

Alongside its services mentioned above, NCA works with the community to try to prevent GBV, increase support for survivors, raise awareness of key issues related to GBV and gender equality, increase women's and girls' participation within the community, change social norms and end harmful traditional practices (e.g., child marriage), and other GBV prevention efforts. These activities complement the GBV response services, including the VR-based intervention.

[20] This is a structured group psychosocial support intervention for women (including GBV survivors) with a specific focus on intersectional, feminist and trauma-informed approaches to care, developed by the International Rescue Committee. https://womenrise.gbvresponders.org/

[21] ENGAGE is a holistic program that aims to prevent, mitigate and respond to child, early and forced marriage. It includes separate group sessions and curricula for adolescent girls, adolescent boys, male and female caregivers, teachers, religious leaders and general community members. Read the project brief for more information: https://www.kirkensnodhjelp.no/contentassets/1502ace59e2b4d65ae80b9ba3b0bcf72/engage-2_overview.pdf

Annexes

Annex 1: List of Psychosocial Problems

Below is the complete list of psychosocial problems—in Arabic, English and Kurdish—that women and girls mentioned during the focus group discussions.

English	Arabic	Kurdish
Depression	كآبة	خةموكي
Loss of Trust	عدم الثقة في الاخرين	دةستدانا باوةري
Isolation	الانعزال	كوشةكيري
Shame	الخجل	شةرم
Regret	الندم	بةشيمانبوون
Anger	العصبية	تورةبون
Overthinking	التفكير المفرط	زور هزركرن
Sadness	الحزن	خةمكين
Hopelessness/Loss of Passion	فقدان الشغف	نائوميدي
Lack of self-esteem	فقدان الثقة بالنفس	باوةري بخو نةبون
Suicidal thoughts	الانتحار	هزرين خوكوشتنى
Loneliness	الوحدة	تنئ بوون
Fear	الخوف	ترس
Insomnia/Sleep issues	الارق/اضطرابات في النوم	نةخةوتن/كيشةي خةوتن
Obsessive	الوسواس	الوسواس
Illness	المرض	نةخوشي

Anxiety	القلق	دلةراوكي
Trauma	الصدمات	تروما
Confusion	تشتت الذهن	سةرلئشئواوي
Appetite problems	مشاكل في الشهيه	كيشةي هةتيو
Inferior	النظرة الدونية	ژێرەوە
Self-blame	للوم النفس	سەرزەنشتكردنى خۆى
Negativity	السلبية	السلبية
Reckless behavior	تهور /اضطرابات في التصرفات	ڕەفتارى بێباكانه
Family Issues	مشاكل عائلية	كيشةي خيزاني
Breakdown	انهيار نفسي او عصبي	تيكشكاني دةروونى
Lack of privacy	عدم امتلاك الخصوصية	نةبونى تايبةتمةندي
Lack of Power/Energy	عدم امتلاك الطاقة او اللياقة	نةبونى هێز
Shyness	الخجل	شةرم
Boredom	الملل	بيزاري
Sensitivity	الحساسية	هةستياري

Annex 2: Additional Psychosocial Problem Descriptions

During key informant interviews with women, adolescent girls and subject matter experts, the assessment team collected detailed information about the five highest-ranked psychosocial issues. However, at times respondents mentioned details about other psychosocial problems. When this occurred, the assessment team recorded their responses. Below are some of the other psychosocial issues that respondents mentioned for which the team recorded brief information. These descriptions are not intended to be exhausted and were not investigated to the same extent as the five highest-ranked problems (Depression, Overthinking/Anxiety, Sadness, Isolation/Loneliness and Fear of Shame).

Anger

Several FGDs with women and girls raised the issue of anger, and it was the highest ranked psychosocial problem in the focus group with women with disabilities. Anger was described occurring "when something happens contrary to our desires and wishes." Many of the examples that women and girls gave as the cause of anger related to family issues; for example, when in-laws scrutinize a woman's life and ways of doing things, accuse her of talking badly about them, or criticize her; when a husband does not believe her; when a girl's family prevents her from visiting her friend or refuse her requests; tensions caused by living in overcrowded house with multiple other families; when a woman's children misbehave, overuse social media and games, or do not cooperate with requests. Women living with disabilities described anger as a result of others seeing them as inferior or when comparing their life and abilities with others who do not have a disability.

Negativity

Negativity was described by women and girls as a generally negative outlook on life and assumption that bad things will happen. One respondent noted that experiencing negative or traumatic events in the past prompted negativity toward the future. Negativity may occur for those who suffer from overthinking and anxiety. Women with disabilities highlighted their similar experience with negativity, including pessimism and sense of life being meaningless.

Suicide

Suicide and suicidal thoughts were raised as significant psychosocial problems in two FGDs with adolescent girls and three FGDs with women; it was ranked as the highest priority issue by one of the adolescent girls FGDs. Respondents highlighted suicidal thoughts emerging when someone feels hopeless and powerless about their problems, including forced marriage, IPV, abuse by father or brother, other forms of GBV, and families preventing girls from marrying the person they love.

Subject matter experts affirmed that the problem is common amongst adolescent girls, with particular risk factor being cyberbullying on social media. They also noted several potential protective factors that prevent suicide, including strong religious beliefs, having children, fear of bringing shame to their family, and fear of family response.

Regret

Regret was raised especially in the context of child marriage, entering into unhealthy relationships, and dropping out of school for girls. Regret is at times accompanied by self-blaming thoughts and depression. NCA caseworkers also highlighted regret from disclosing GBV to untrustworthy people or to the police, due to a subsequent escalation in violence when the husband found out.

Stigma

If stigma was not mentioned unprompted, FGD participants were specifically asked about stigma. Participants predominantly viewed stigma as related to those women and girls who experienced violence perpetrated by ISIS members, including sexual violence and sexual slavery. Women and girls also noted the stigma and blame that all GBV survivors experience, causing isolation, depression, regret and lack of support. However, some adolescent girls also highlighted the stigma attached to being female in a patriarchal society that favors males and ascribes strict social norms to females; one respondent said, "the community gives us the feeling that being female is stigma, and

we do not have the right to do anything because it is shameful. This makes us feel unsafe, sad, and lose hope." Overall, the issue of stigma is embedded in many of the other psychosocial problems mentioned.

Lack of Self-Esteem/Inferiority

One FGD with adolescent girls in Mosul ranked the problems of inferiority and low self-esteem as their highest priority issue. Girls across locations acknowledged the role of gender inequality in their feelings of inferiority and low self-esteem, particularly when discussing two types of GBV: denial of resources and child marriage (see relevant sections above). They are keenly aware of the different ways their families and communities treat them and the opportunities they are afforded as compared to their male peers and siblings. Girls also noted feeling inferiority and low self-esteem–as well as shame–if they did not complete their education and spend time with friends who are still in school or complete school. Subject matter experts highlighted feeling inferior often occurs when adolescent girls compare themselves to their friends (e.g., getting lower marks in school; on social media), when girls struggle to make friends, when they are bullied, when they experience abuse or neglect, when their families and peers do not take their opinions seriously, as well as lack of freedom and decision making in matters concerning their lives and futures. One expert also highlighted the role of psychological abuse in intimate partner relationships as causing a feeling of inferiority among women and girls. Sadness, isolation, overthinking and fear of judgment often accompany feeling inferior and low self-esteem.