# MHPSS SITUATION ANALYSIS

IDP and Refugee Crisis

**Kurdistan, Northern Iraq (KRG)**

**February 19-March 10, 2015** **Mission Report, Findings & Recommendations**

**2 million**
Internally Displaced across Iraq

**250,000** Erbil

**860,000** Duhok

**317,000** Sulaymaniyah

**235,000**
Refugees located in 9 camps and 4 non-camp settlements

**101,480** Erbil

**97,005** Duhok

**27,261** Sulaymaniyah

*Source: UNOCHA Report January 2015*

## SITUATION OVERVIEW

### OVERVIEW OF THE CRISIS

The violence between armed groups and government forces in Iraq has resulted almost 2.5 million internally displaced people across Iraq. Almost a quarter of a million Syrian refugees fled to the Kurdistan Region of Iraq. The UN Office for the Coordination of Humanitarian Affairs (UNOCHA) estimates that the number of people impacted by the crisis may reach seven million by the end of 2015. According to the Federal Ministry of Health, about 90% of internally displaced persons (IDPs) and Refugees are in Kurdistan, Northern Iraq.

### PRIORITY MHPSS NEEDS OF IDPS AND REFUGEES IN KRG

**1)** Lack of functional coordination on MHPSS, **2)** MHPSS assessments not in accordance with IASC guidelines, **3)** Fragmented MHPSS service provision with few 'lower level' MHPSS interventions, lack of trained non-specialized mental health (MH) care providers, a strong reliance on specialized MH services, weak reporting on MH categories within routine data reporting, irregular supply of essential psychotropic medications, ineffective referral system & pathways, and limited opportunities for staff care, **4)** Research practices not conforming to best practice guidelines, and **5)** Insufficient community engagement in service planning and provision.

### GOVERNMENT CAPACITY TO RESPONSE

Funding for the humanitarian response largely stems from external financial aid and support. The Ministry of Health (MOH) KRG and Directorates of Health (DOH) in the Governorates of Erbil, Duhok and Sulaymaniyah have provided generous direct support for the displaced, including the federal government continuing salaries for civil staff even though they are no longer attending work due to displacement. However, there have been problems in cash transfers to pay IDPs and salaries given the irregular transfer of funds from Baghdad to KRG. Public services are also struggling to deal with the size and scope of the crisis, Utilization of mental health (MH) specialists to provide direct services to the displaced populations is draining resources from the regular health system, medication supply is insufficient and irregular, and policies regarding hospital and medication fees are not in place for those with IDP or refugee status. Lower level MHPSS services are limited, and while the government supports MHPSS integration with health and other sectors such as education and protection, it lacks the capacity to roll out integration strategies due to shortage in budget and human resources.

### MENTAL HEALTH POLICIES AND STRATEGIES IN IRAQ

Iraq MH policy exists and was last revised in 2004 with the establishment of a national MH council that developed a draft national strategy and plan. These were further refined and now serve as the basis for MH reform in the country. Priorities include: developing community MH services, downsizing institutional psychiatric hospitals, developing acute care units in general hospitals, and integrating mental health care into primary health care (PHC). Progress was made in integrating MH services within the PHC services during 2009- 2011. Administratively, a special section for PHC was established in the MOH/ Baghdad and a primary mental care unit was established in every general directorate of health in all governorates. In addition, a list of essential psychotropic drugs is present and can be presrcribed by trained physicians. There is no specific budget allocation for MH in Iraq.

Photo Top: Sharia Camp, Duhok. Credit: Peter Hughes, WHO Consultant

## Acronyms

| | |
|---|---|
| ACF | Action Contre La Faim |
| CETA | Common Elements Treatment Approach |
| DOH | Directorates of Health |
| GBV | Gender-Based Violence |
| HAARG | Humanitarian Assistance Applied Research Group |
| HI | Handicap International |
| HIG | Humanitarian Intervention Guide |
| HIS | Health Information System |
| IASC | Inter-Agency Standing Committee |
| IDP | Internally displaced persons |
| IMC | International Medical Corps |
| INGO | International NGO |
| IOM | International Organization for Migration |
| KRG | Kurdistan Regional Government |
| KSC | Kurdish Save the Children |
| MDM | Médecins du Monde |
| MH | Mental health |
| mhGAP | Mental Health GAP Action Plan |
| MHPSS | Mental health and psychosocial support |
| MOH | Ministry of Health |
| MSF | Médecins Sans Frontières |
| NGO | Non-governmental organization |
| PFA | Psychological First Aid |
| PHC | Primary health care |
| PSS | Psychosocial Support |
| SGBV | Sexual and Gender-based Violence |
| UN | United Nations |
| UNAMI | United Nations Assistance Mission for Iraq |
| UNFPA | The United Nations Population Fund |
| UNHCR | United Nations Humanitarian Commission for Refugees |
| UNOCHA | United Nations Office for the Coordination of Humanitarian Affairs |
| UPP | Un Ponte Per |
| WG | Working Group |
| WHO | World Health Organization |

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## 1. Goals

The World Health Organization (WHO) and the United Nations High Commission for Refugees (UNHCR) organized a joint mission to better understand the current MHPSS situation, as part of the overall humanitarian response to the IDP and refugee crisis, in the three governorates of Erbil, Duhok and Sulaymaniyah in KRG. The mission aimed to identify gaps in the coordination and provision of MHPSS services for Syrian refugees, internally displaced Iraqi and host Iraqi communities, across camp, rural settlement and urban settings.

Experts leading the mission also sought to promote consensus around identified needs and problem areas, in addition to recommended MHPSS intervention standards and best practices among all stakeholders, resulting in the development of an outline of a roadmap for action on MHPSS with proposed recommendations in line with global and inter-agency standing committee (IASC) standards and guidelines.

## 2. Methodology

A situational analysis was conducted from February 21st to February 27th 2015 and included:

- **2.1. Desk Top Review:** was conducted with support from the Humanitarian Assistance Applied Research Group (HAARG) at the University of Denver, and included a brief review of literature and most recent policy documents, assessments and mapping exerices.
- **2.2. Interviews and Discussions:** were held with government and various stakeholders involved in providing MHPSS to IDPs and Refugees in Kurdistan region of Iraq. Interviews were conducted during field visits to sites to meet refugees and hold meetings with representatives from the districts of health, and services providers. Discussions aimed to foster shared view and then reach consensus about prioritry actions.

## 3. Existing MHPSS Services and Capacities

A brief mapping activity was carried out during the course of this mission through stakeholder interviews and workshops in the three governorates of Erbil, Duhok and Sulaymaniyah. While not all MHPSS actors have been captured, the activities of the primary providers of MHPSS services are summarized according to the four intervention levels of the IASC Guidelines for MHPSS in Emergency Settings[1]:

- **Level 1: Social considerations in basic services and security** such as advocacy for basic services that are safe, socially appropriate and protect dignity
- **Level 2: Community and family supports** including activation of social networks, communal traditional supports, and supportive child friendly spaces

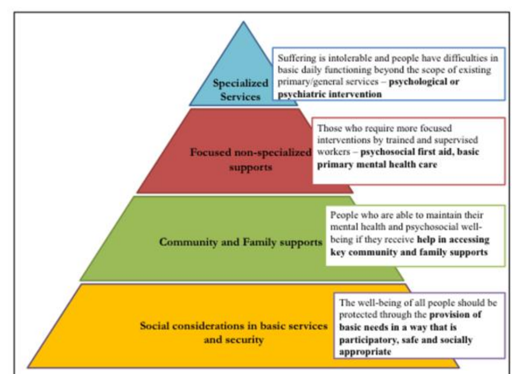


Figure 1 :IASC MHPSS Intervention Pyramid

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[1] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. http://www.who.int/mental_health_psychosocial_june_2007.pdf

- **Level 3: Focused non-specialized support** including basic mental health care by PHC doctors, and basic emotional and practical support by community workers, and
- **Level 4: Specialized services** by mental health specialists including psychiatrists, psychologists, counselors, etc.

**3.1. Services and Capacities in Erbil**

This governorate has limited capacity for integrated MH in PHC services by trained PHC providers in management of mild to moderate MH problems. The, focus is on provision of specialized services for acute and chronic needs through local mental health specialists, most of whom are staff from the DOH. There are concerns about a risk of draining resources from the central healthcare system, including manpower and medications. There is less activity in the areas of advocacy and family and community support activites. Coordination has not been initiated.

**Primary providers of MHPSS programming in Erbil by levels of intervention:**

**Level 1:** Erbil currently has one agency (UNAMI) planning to advocate at the policy level, particularly regarding protection and prevention.

**Level 2:** No activity at level 2 was documented during this mission in Erbil.

**Level 3:** MOH and MSF France conduct MH trainings that include psychoeducation, MSF has integrated MH services within PHCs set up in camps, and also through mobile clinic within urban communities, and IMC is using an integrated model of MHPSS and GBV in the PHC services. UPP has para social workers in some refugee camps, and Handicap International has trained community workers.

**Level 4:** Specialized psychiatric and psychological services are being provided by several organizations, including MOH, Jiyan Foundation, UPP, MSF, Handicap International, and IMC.

**3.2. Services and Capacities in Duhok**

With 860,000 IDPs and Syrian refugees, Duhok has organizations performing activities across all 4 levels, with greater representation in referrals and PHC integration, but also risks draining DOH resources given over reliance on MH psecialists in the provision of specialized services. Family and Community support activities are also made available by a number of NGOs. This governate has recently initiated coordination through WHO and DOH, and meetings of an MHPSS Working Group that includes health and non-health actors.

**Primary providers of MHPSS programming in Duhok by levels of intervention:**

**Level 1:** Duhok currently has 2 agencies focused on advocacy (UPP, IOM).

**Level 2:** Three organizations (UPP, ACF, and IOM) are currently reporting communication and family and community support activites across a spectrum of groups including teenagers, men, women, etc.

**Level 3:** Referrals to specialized services being made by 4 organizations (IOM, ACF, MEDAIR, HI), 2 others (MDM, and IMC) are incorporating MHPSS into PHC services, and ACF, IMC, MEDAIR, and UPP report providing additional focused non-specialized support through training, psychoeducation and provision of psychological first aid through community work.

**Level 4:** Specialized psychiatric and psychological services are being provided by 4 organizations, including MOH, Jiyan Foundation, MDM, ACF, IMC, and UPP.

**3.3. Services and Capacities in Sulaymaniyah**

Specialized and focused non-specialized services appear to be most represented in this governate, with fewer activites in advocacy and informal community support. A Health Cluster for coordination exists, but few MHPSS actors attend, and PSS actors are largely divided among their specialty working groups such as Child Protection and SGBV. According to partners there are some local NGOs and other actors doing PSS whose activities would fall in layers 1 and 2, but there is lack of participation in coordination and information sharing activiites, and an absence of an MHPSS service directory or comprehensive MHPSS mapping that captures all, International NGO, UN agency and local NGO MHPSS providers. An MHPSS Working Group is absent in this area.

**Primary providers of MHPSS programming in Sulaymaniyah by levels of intervention:**

**Level 1:** Two organizations (UNFPA, Christian Aid) implementing livelihood and advocacy activities respectively.

**Level 2:** Two organizations (UNFPA, Christian Aid) report vocational, training, safe space and other support activities.

**Level 3:** Referrals to specialized services are being made by at least 2 organizations (Emergency, Christian Aid), and Jiyan, Kurdish Save the Children (KSC), Christian Aid and World Vision report providing additional support through case management, education and focused non specialized community based work through staff trained in psychological first aid.

**Level 4:** Specialized psychiatric and psychological services are being provided by 5 organizations, including Jian Foundation, KSC, ACF, World Vision and Wchan.

## 4. Problem Analysis

**Services**. While there is currently a range of services within each of the governorates that represent the four distinct layers of MHPSS, most service provision is in layer 4 (specialized services). Services are currently provided to some degree to the entire affected population through advocacy for psychosocial consideration in basic services which will benefit all, from those experiencing mild psychological distress, mild to moderate mental health disorders and the small percentage of the affected population with severe or complex psychological disorders. While the MoH and DOH in the assessed governorates have been active in the response to the current crisis and using existing national resources, the massive influx of displaced people into the KRG region requires additional support to help strengthen capacity and services, and support an already frail and overburdened national public service system. Few organizations reported lower level family and community-focused support and basic needs support, and few reported integrated or cross-sectoral efforts with other services such as protection, SGBV, or child protection. According to the recent mapping exercises, the majority of activities fall into Level 3 and Level 4 of the intervention pyramid. The majority of the services reported include some basic mental health support provided through PHCs and more prominantly specialized mental health services provided through mental health specialists, mainly psychiatrists, set up within camps, attached to mobile health and non health teams, and linked to urban health and non health service delivery points. The primary services discussed included training, basic mental health services provided in PHCs, referral to specialized services, psychiatric and medication services, psychological and therapeutic support, and services focused on assessing and supporting trauma-affected people. MSF, Jiyan Foundation, UPP, IMC, ACF, and IOM were represented in each governate and communicated either existing or planned MHPSS activities. The limited availability of specialists such as clinical psychologists and psychiatrists and their recruitment by MHPSS service providers were described as pulling resources away from and weakening the central health system. Additionally, while the Health response has included MH from the start and the agencies in the refugee setting use the 7 MH categories of the Humanitarian health information system (HIS), the MH categories have yet to be included in regular reporting through the national health information system.

**Coordination, Assessment and Mapping.** Obstacles to services include the need for coordination and the establishment of MHPSS working groups. Communication across INGOs and NGOs is limited, and there is little information disseminated on duplication of or gaps in services. There was acknowledgment among stakeholders that there are local NGOs providing services at levels 1 and 2, but they were not identified at this time. This imbalance of services or lack of awareness or referral pathways between services challenges the effectiveness and consistancy of care provision. A lack of community engagement, focus on academic rather than operational research, and ineffective assessments and mappings are also seen as priority problem areas that need to be addressed.

**Resources and Opportunities.** There are, however, a number of resources and existing work that can provide opportunites for overcoming the obstacles mentioned in this analysis. There is an existing pool of frontline workers, PHC staff, NGO staff, and volunteers from the displaced community, who have already been trainid in MHPSS interventions such as Psychological First Aid who could be used to suppliment existing services, and in fact be available to carry out non specialized focused support. There are also organizations well practiced in providing training, following Johns Hopkins University Common Elements Treatment Approach (CETA) for use with lay counselors[2], which could help to expand the pool of trained non-specialists, and further engage people from the affected communities in a productive way. Additionally, mhGAP has been used to train PHC providers by some organizations, which provides a foundation for MH PHC integration. Additional training and guidance from WHO and UNHCR will also promote clarity on the breadth of activities that fall into MHPSS support.

[2] Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., … Bolton, P. (2014). A Common Elements Treatment Approach for Adult Mental Health Problems in Low- and Middle-Income Countries. Cognitive and Behavioral Practice, 21(2), 111–123. doi:10.1016/j.cbpra.2013.06.005

## 5. Recommendations

The five main problem areas in the provision of MHPSS to displaced population in KRG include: 1) Coordination, 2) Assessment and Mapping, 3) Services, 4) Research, and 5) Community Mobilization and Particpation. Based on analysis of information gathered through this joint WHO and UNHCR mission, the following recommendations have been developed, and consensus around them achieved through final stakeholder workshop in Erbil, and aim to improve the quality and availability of MHPSS services provided for displaced populations in the KRG.

### 5.1. Problem Areas & Recommendations

#### Problem Area 1: Coordination

***Problem Statement 1.1. Insufficient mechanisms for effective coordination and harmonization of approaches (promoting useful practices, flagging potentially harmful practices, and advocating for psychological and social considerations in other sectors).***

→ Recommendations:

- Establish inter-sectoral coordination groups for MHPSS with MOH and DOH leadership and technical support of UN agencies
- The MHPSS coordination group should be functionally linked with Health, Protection, and Education Clusters and, where appropriate, with any additional national coordinating mechanisms.
- Provide Brief orientation seminars on IASC guidelines and PFA (specifically for first line responders) in coordination with all cluster leads.

#### Problem Area 2: Assessment & Mapping

***Problem Statement 2.1. Lack of coordinated MHPSS assessments and availability/sharing of MHPSS information that helps to improve programming and support to affected populations.***

→ Recommendations:

- Include general MHPSS questions, adapted for local use, in other sector or multi-sectoral assessments, such as health system capacity assessments or nutrition surveys.
- Organizations should inform the MHPSS coordination group and MOH/DOH on which issues they are conducting assessments/research, as well as where and how, and should be prepared to adapt their assessments if necessary and to share information.

***Problem Statement 2.2. Ineffective referral system and pathways to and from MHPSS service providers***

→ Recommendations:

- Carry out quarterly mapping exercise through MHPSS working groups, using simplified 4Ws mapping tool, to assess who is doing what, where and until when.
- Interagency Referral Orientation sessions to establish clear interagency referral pathways and guidelines.

#### Problem Area 3: Services

***Problem Statement 3.1. Fragmented lower level MHPSS interventions, including family and community supports***

→ Recommendations:

- Advocate through MHPSS WGs, and scale up, lower level MHPSS community-based services and supports, such as outreach volunteers (by IDPs and refugees themselves), community councils, peer-to-peer support, and service user lead initiatives.
- Ensure trainings of outreach workers and community mobilizers linked to MHPSS and non MHPSS services are trained in PFA, and providing basic PSS, and psycho-education.

***Problem Statement 3.2. Lack of trained non-specialized mental health care providers to provide community based integrated care as part of the current humanitarian response***

→ Recommendations:

- Strengthen management of MHPSS problems by non-specialists, and reduce pressure on specialized MH services by:
    - Training of general health care providers in mental health using the mhGAP (humanitarian version).
    - Training of paraprofessionals (social workers, counselors, etc.) on MHPSS case management that includes basic counseling, problem solving and other evidence based interventions.
- Expanding on existing efforts for training of trainers (specialists) to ensure follow up and supervision.

***Problem Statement 3.3. Considerable Focus on specialized mental health services, overlooking the public***

***health approach that advocates for an integrated model.***

→ Recommendations:

- Task shifting and re-configuration of role of specialists to become referral points for severe cases, and technical focal points for trained non-specialists.

***Problem Statement 3.4. Routine reporting at health and PHC facilities does not include MH categories***

→ Recommendations:

- Include key mental health categories within existing national health information system.

***Problem Statement 3.5. Irregular supply of essential psychotropic medications***

→ Recommendations:

- Ensure the regular supply of essential psychotropic medications to PHC centers according to the national essential list of psychotropic medication.
- Training and supervision of health care providers in appropriate and rational prescription of essential psychotropic medications (via mhGAP training).

***Problem Statement 3.6. Non-adherence to IASC Human Resource Principles***

→ Recommendations:

- Apply recruitment and selection principles in line with Guidelines to ensure staff retention, without compromising standard national MHPSS services.
- Ensure proper induction and orientation of all staff and volunteers on MHPSS approach.

***Problem Statement 3.7. Limited opportunities for staff care***

→ Recommendations:

- A systemic and integrated approach to staff care is required including ongoing support to staff and orientation sessions on stress management and self-care.
- Advocate for welfare of staff as one of the principles of good practice.

### Problem Area 4: Research

***Problem Statement 4.1. Ongoing and planned research on MHPSS tends to be of limited operational value and may pose burden/risk on displaced populations***

→ Recommendations:

- Advocate for best practice and guidance presented through IASC publications, including the IASC guidelines for MHPSS in Emergency Settings, and Recommendations for Conducting Ethical MHPS Research in Emergency Settings[3].

### Problem Area 5: Community Mobilization & Participation

***Problem Statement 5.1. Insufficient community engagement in overall service provision***

→ Recommendations:

- Advocate for the participation of displaced and host families and communities in the design and implementation of community-based activities across all sectors.
- Support community initiatives, actively encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk.

## 6. Way Forward

The growing and unaddressed MHPSS needs of IDPs and refugees in KRG, coupled with drained and limited governmental capacities, deems the call for UN agencies, MHPSS and non MHPSS actors, such as health and protection, and government entities responding to displacement, to work in line with guidance toward coordinated and integrated services that produce an effective and more sustainable MHPSS response that can more readily scale up to also serve the existing and additional anticipated influxes of displaced people in this protracted crisis.

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[3] Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2014. Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings.

In accordance with recommendations that resulted from the WHO and UNHCR joint mission to KRG, sustained efforts will be made in advocating for securing political commitment for MOH/DOH to exert leadership and coordination, working in line with national MH strategy, utilizing available human resources from the IDPs on federal government payroll and ensuring MHPSS is part of the basic package of services for all IDPs and refugees.

A first step towards implementation included trainings in Dohuk and Sulaymanieh for health care providers from host, IDP and refugee community, including from UN agencies and NGOs, on the MH GAP Action Plan (mhGAP) Humanitarian Intervention Guide (HIG), for managing MH conditions at the PHC level. Trainings took place in March 2015, and included MH specialists as trainees, with the aim of identifying potential future local trainers for the expansion and sustained roll out of MH PHC integration, including support and supervision, across the governorates.

Advoacy efforts and support for the implementation of recommendations set forth in this document will be lead by a WHO/UNHCR expert that will hold formal discussions and work with the MOH and DOH of Baghdad and KRG, to set up governorate stakeholder workshops that aim to develop area specific 6 month implementation plans that dileanates responsibilities of agencies and government.