

Support Mission Report and MHPSS Situational Analysis
IDP and Refugee Crisis
Kurdistan, Northern Iraq (KRG) and Mosul-response, Iraq

Background to the support mission and overview of the crisis

The violence between armed groups and government forces in Iraq has resulted in almost 3 million internally displaced people across Iraq. In addition, almost a quarter of a million Syrian refugees fled to the Kurdistan Region of Iraq (KRG-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 2017. According to the Federal Ministry of Health, about 90% of internally displaced persons (IDPs) and Refugees are in Kurdistan, Northern Iraq. Now with the Mosul operations underway, more IDPs are seeking safety in KRG and in Ninewah Governorate of Iraq, which necessitates the scaling up of quality mental health and psychosocial support services, both in camp and out of camp settings.

Objectives of the support mission

1. To enable MHPSS WG member agencies and donors to strategically plan for MHPSS programmes, through an updated situational analysis framework with recommendations.
2. Cluster and Sector leads, and Senior Managers from UN and INGO agencies are familiar with the IASC Guidelines and associated products, such as the Referral Form, Field Checklist, Protection/ Health/ CCCM Handbooks and the 2014 Guidelines Review.
3. MHPSS WG members are familiar with the IASC Common M&E Framework for MHPSS Programmes, and are able to apply it to their work.

Methodology

Data collection was primary through key informant interviews with MHPSS actors (Government officials, MHPSS WG Co-Chairs, INGOs, national NGOs, Iraqi Red Crescent, UNHCR, IOM and WHO Iraq based colleagues), direct observation through refugee and IDP camp visits and attendance at three monthly MHPSS WG meetings related to Mosul response (IDP only), Sulaymaniyah and Erbil (both IDP and refugee response).

Brief Situation Overview

(i) Coordination structures

There are five MHPSS WGs operating in Iraq with different co-chair configurations.

- MHPSS WG Erbil (Co-chaired IMC & UNHCR).
- MHPSS WG Sulaymania (Co-chaired by Preventive Health Department and Wchan organisation).
- MHPSS WG Dohuk (Chaired by Directorate of Health).
- MHPSS WG Mosul operations (Co-chaired IOM & IMC).
- Mental Health WG Baghdad (Chaired by Ministry of Health)

(ii) Government capacity to respond

Funding for the humanitarian response largely stems from external financial aid and support. The Ministry of Health in Baghdad, KRG and the Directorates of Health, Education and Social services in the Governorates of Ninewah, Erbil, Sulaymaniyeh and Dohuk have provided generous direct support for Syrian refugees and internally displaced Iraqis. Public services are struggling to manage with the size and scope of the crisis in Iraq and hosting Syrian refugees. There has been extensive infrastructure damage to some public institutions such as schools in former ISIS areas as a result of the conflict, some health infrastructure has also been damaged in the fighting (e.g., the community mental health centre in Mosul was moved to a Paediatric hospital because the previous residence was bombed). Huge population movements out of Mosul into the countryside and into KRG-Iraq demand the shifting of resources towards these 'mega-IDP camps', to rural areas and into KRG. The utilisation of mental health, social services and education specialists to provide direct services to the displaced and refugee populations is draining resources from the public health, social and education systems with concerns from the MoH in Baghdad that humanitarian actors are 'poaching Government Doctors'.

There are irregular transfers of funds from Baghdad to KRG-Iraq, which has directly impacted Education Services (some Teachers are no longer working in public schools due to salary restrictions), the healthcare system (Doctors are reportedly receiving a portion of their salary on an irregular basis) and Social services. The lack of salaries for public sector staff is having a direct impact upon service provision and delivery, with many public sector services almost completely inoperable. Thus the local (host) Iraqi population are increasingly having to pay for basic services such as healthcare and education for their children, in addition to supporting IDPs and Syrian refugees. Government officials reported that the lack of salaries is also challenging the commitment of public sector staff to attend trainings or professional development courses (such as mhGAP) whilst managing higher workloads in the public clinics due to the large number of IDP & refugees with needs, in addition to the needs of the host population. A similar phenomenon is also noted within the Education and Social Services sectors.

Medication supply (including psychotropics) is inefficient, highly irregular (with multiple stockouts of essential medicines) and policies regarding hospital and medication fees for IDPs are not in place, especially for IDPs who have moved from Ninewah Governorate (Iraq) into KRG-Iraq. International procurement and the importation of psychotropics are challenging, with almost zero domestic production of essential medicines – resulting in imported products from India, China, Pakistan and Turkey. There are differences in prescription guidelines and permissions for mhGAP trained GPs regarding psychotropic medication, with some GPs being granted permission to prescribe such medication and GPs in other Governorates being denied such permissions – which is often linked to levels of training. Disagreements between Baghdad Ministry of Health and the Directorates of Health in KRG have resulted in approximately 25% of KRG's medication needs being met, which poses additional challenges given the large numbers of refugees and IDPs being hosted within KRG, aside from the host populations' on-going needs. All humanitarian actors wishing to run health or mental health programmes need to cover 100% of medications within their respective projects as the KRG-Directorates of Health have openly stated that they cannot support humanitarian actors with medication. The donor community is also requesting humanitarian actors running health/ mental health programmes to have at least 2 months stock of medication to cover any pipeline breakages.

(iii) *Mental Health policies and strategies in Iraq*

The mental health policy exists and was last revised in 2004 with the establishment of a national Mental Health Council that developed a draft national strategy and plan. These were further refined, with the support of WHO colleagues and now form the *theoretical* basis for mental health reform in the country. Priorities include developing community mental health services, downsizing institutional psychiatric hospitals, developing acute care units in general hospitals, and integrating mental health into primary healthcare. *Administratively*, a special section for PHC was established by the MoH in Baghdad and *theoretically* a primary mental care unit was established in every general directorate of health in all Governorates of the country. The practical application and impact of these initiatives on direct service provision remains patchy. There is no specific budget allocation for mental healthcare in Iraq, and none specified within the humanitarian response plan either.

Problem Analysis

Coordination structures: There has been great progress made during the past 18 months with regards to MHPSS coordination in both the refugee and IDP responses. The fragmented nature of MHPSS responses and the paucity of effective MHPSS coordination structures were identified as key problems during the first situational analysis in February 2015 conducted by WHO and UNHCR. The establishment of four MHPSS WGs in KRG and for the Mosul response is a positive step forward and there is a notable increase in the coordination of emergency response activities as well as the more protracted response activities. All groups have established ToRs and meet on a regular basis (with the exception of the Sulaymaniyah group that has recently resumed meeting after a 4 month break). The 4 MHPSS WGS have been a successful platform for the sharing of capacity building activities among actors and with different sectors e.g., local NGOs are invited to send staff to attend trainings (usually offered in English or Arabic) organised by INGOs and UN agencies such as IMC, UNHCR and IOM. There is increasing inter-cluster collaboration and coordination, for example the child protection sub-cluster approach the Erbil MHPSS WG with a specific request for MHPSS training for their members. A training was, thus, organised in April 2017, facilitated by UNHCR and other agencies.

The Baghdad based Mental Health WG, led by the Ministry of Health does not appear to be functioning as well as the four aforementioned groups. There are less international NGOs operating from the Baghdad side, the security restrictions are much more limited (in terms of people being able to attend meetings outside of the Green Zone), there is no technical WHO Mental Health presence in Baghdad, who may be able to support the Government with this coordination function, and there are no known ToRs for this group.

Some local MHPSS actors highlighted the difficulties in sending appropriate staff to the MHPSS WG meetings in KRG-Iraq because they were held in English, with no Arabic or Kurdish translation offered. This was found to particularly affect smaller Iraqi or national NGOs and the Iraqi Red Crescent. Other actors mentioned the multiple emergency response meetings taking place and the need to prioritise which meetings their organisation should attend. These two factors will influence the numbers of MHPSS agencies that are able to attend, but it does not fully explain why larger UN agencies with MHPSS programmes (e.g., WHO, Unicef and UNFPA) and some larger INGOs are not regularly attending MHPSS WG meetings.

Human Resources

Given the size and scale of this Level 3 emergency, there is a notable absence of any full-time international in-country technical Mental Health Advisor for WHO, that is able to freely move between Baghdad and the KRG-Iraq; a person who can speak with high level Government officials, attend MHPSS WG meetings, support the Government with psychotropic supply chain & distribution, legal issues regarding psychotropic prescriptions by General Practitioners, work with the Psychiatry Association, advocate for MHPSS within the overall humanitarian response, and most importantly provide technical MH guidance and leadership.

The Social Work and Psychology sectors are relatively new in Iraq and KRG-Iraq and as such there are few public professionals providing these services. The author is not aware of any accreditation boards for Social Work or Psychology within the country. There are however, promising initiatives to build the local capacity of Psychotherapists and MHPSS practitioners in Dohuk, through a Master's degree funded by the State of Baden-Wurrttemberg in Germany in collaboration with Dohuk University, the Koya University/ SEED Master's programme and an upcoming IOM Master's programme.

Mapping of MHPSS actors

Brief 4Ws mappings in Word documents have been conducted by the respective leads of the MHPSS WGs in KRG-Iraq and Mosul. It is enormously time consuming for the MHPSS Co-Chairs to ensure that the information is up to date and many MHPSS actors have been non-responsive towards requests for 4Ws information on a regular basis. The full IASC 4Ws matrix was completed for Erbil and Mosul in 2017 and for Sulaymaniyah in 2016. There has been no known MHPSS 4Ws mapping by the Baghdad MHPSS WG. To generate more 'buy-in' and engagement, the mapping of MHPSS actors needs to be linked to a service delivery purpose (e.g., case management) and/ or advocacy purposes rather than just being an activity in and of itself.

Referrals

A significant number of MHPSS actors spoke of the 'referral disease' that has plagued many organisations operating in the KRG-Iraq area. There are clear incidences of over-referral of individuals and families for specialised psychiatric services, before 'lower- level' interventions have been tried. Notable examples of this include child protection and PSS actors referring children showing aggressive tendencies within a classroom or a CFS tent, to a psychiatrist for treatment, resulting in an over-medicalisation of PSS problems that should be managed at the level of the classroom, school, family, or within the CFS without requiring a referral to a mental health professional. Similarly, many female survivors of GBV have also been referred to a psychiatrist for 'treatment'. PSS is one of the four key wrap around services (along with physical protection/ shelter, legal advice and medical care) offered to survivors of GBV. The MHPSS needs of GBV survivors should be able to be met by GBV Case Workers trained in additional psychosocial interventions or psychological approaches (such as Interpersonal therapy or Problem Management+). It is the same case for General Practitioner doctors or MHPSS case workers over-referring their clients to a psychiatrist for 'treatment' rather than adapting a triage approach to care where psychiatric intervention is viewed as a last resort. The volume and phenomenon of over-referrals is placing an unnecessary strain on the limited number of Psychiatrists in the country.

Within the Iraqi community and amongst Syrian refugees, there is a wish to be seen by a Doctor (perceived as a 'Professional') for their problem, rather than by a Social Worker, a community worker or a Case Manager for example. Doctors are correctly held in high regard and seeing a Doctor can reinforce the importance of their needs and issues, which they perceive is not the case when supported by a Case Worker. However, attitudes are changing and providing that 'lower level' interventions by other cadres of MHPSS professionals (that are not Psychiatrists) are effective and useful to an individual and family, there is no reason why affected persons cannot be appropriately supported outside of the formal mental health system – indeed this is best practice.

There is a persistent misconception by Government officials, the donor community and MHPSS actors in Iraq and KRG-Iraq regarding specialised services. Unfortunately, specialised services in this context are understood as *only specialised mental health care*, to the detriment of other *equally important* non-medical specialised services. Examples of other specialised services include those carried out by traditional healers or spiritual leaders (important for the Yazidi community for example), legal services/ lawyers supporting survivors of sexual violence, physical protection such as safe zones in camps, shelters for survivors of GBV, special needs teachers working with children with autism spectrum disorders and other disabilities, and Case Workers managing the re-integration of children and other fighters formerly associated with ISIS.

mhGAP Roll-out

There have been 3 mhGAP Training of Trainers projects within Iraq over the past 2 years and yet it is almost impossible to find a trained General Practitioner operating at the primary health care level anywhere in the country who is able to assess and manage a person with a MNS disorder (mental, neurological and substance use disorders). The Ministry of Health in Baghdad has a list of 555 GPs trained in mhGAP across the country, but this list had not been shared with humanitarian MHPSS actors and neither had MHPSS agencies come across these GPs in their work. There is also little possibility to supervise the trained mhGAP Doctors, as Psychiatrist are thinly spread across the country and are unwilling to see their role diminish in favour of increasing the capacity of GPs, in addition to the security restrictions on the movement of Iraqi nationals across the KRG-Iraq and the Iraq Governorate borders (e.g., from Anbar to Erbil for example). The mhGAP ToTs are more theoretical trainings that have taken place in hotels across Iraq, with little practical application and on-the-job training follow up (thus unfortunately de-linked from service provision). Given the challenging operating environment and the state of the public healthcare system it is perhaps too ambitious to invest in a mhGAP roll out at the primary healthcare level at this time.

The notable successful exception to the mhGAP roll-out in Iraq is within the Syrian refugee camps, where UNHCR and its partners (Emergency and UPP), coupled with a high-level of Directorate of Health buy in, have been able to introduce mhGAP trainings and supervision, within a controlled (refugee camp) environment.

A few agencies have begun training and supervising their staff on scalable psychological interventions, such as Problem Management+, which are also recommended mhGAP interventions. World Vision has already trained a cadre of staff and other NGOs such as Un Ponte Per (UPP) are keen to train their Case Workers supporting Syrian refugees in and out of refugee camp environments on PM+. The MHPSS focal point within the Department of Preventative Health in Sulaymaniyah is also keen to introduce PM+ and possibly

Thinking Healthy to Government Health Promotion Workers operating within PHCs across the Governorate supporting women and children. There is merit in investigating the roll out of Interpersonal Therapy (IPT) with GBV sub-cluster colleagues working with survivors of sexual violence too. Whilst these interventions are not able to support persons with severe mental health disorders they can support persons suffering from anxiety, depression, panic, and some acute stress reactions, and moreover it would demonstrate concrete positive steps towards integrating mental healthcare into the health and social systems more broadly in Iraq.

Recommendations

Coordination structures and MHPSS WGs

1. Maintain the running and co-chairing of the four MHPSS WGs for KRG + Mosul response. If agencies wish to step down from their Co-Chair role or if other agencies wish to take on a role, then this should be discussed within the respective WGs well in advance and built into funding proposals with donors to ensure sustainability.
2. There is merit in moving the Mosul group away from Erbil and closer to Ninewah Governorate itself if security permits, or at the very least to rotate the meetings between Dohuk and Erbil to enable more actors to attend the meetings. Any discussions regarding Ninewah Governorate and the Mosul response should take place in consultation with the Ninewah Directorate of Health (DoH) and/ or Social Affairs Ministry, the Dohuk DoH, as well as updating the Ministry of Health in Baghdad.
3. Shift coordination discussions away from purely information sharing between MHPSS actors to more concrete activities such as identifying 1-2 indicators from the IASC Common M&E Framework/ layer of the IASC intervention pyramid that MHPSS agencies feel they are able to report against. A macro level reporting (even if done informally within the WG) would help to advocate for the work of MHPSS actors, would increase the quality of MHPSS programmes and also aid discussions with government officials and donors who are struggling to understand some of the PSS programmes put forward for funding review. Other concrete activities include establishing an SOP for psychiatric inpatient referrals for persons with severe mental health disorders. This needs to be done/ Governorate in collaboration with the respective DoH and the key psychiatric institution, and should ideally be led by WHO as Health/ mental health cluster lead for IDP response. Finally, joint training initiatives should be coordinated through the MHPSS WGs e.g., courses for Social Workers, Problem Management+, Interpersonal Therapy for GBV survivors, MHPSS Case Management and Psychological First Aid. The existing inter-agency training calendars held by the Erbil, Mosul and Dohuk MHPSS groups are a good example of this.

Human Resources

1. Recommend that WHO recruit an international (English-Arabic-speaking) Mental Health Advisor on a minimum 1-year contract to provide the necessary leadership and technical support for the IDP response. This Officer will need to have the freedom to move between Baghdad and the KRG-Iraq, speak with high level Government officials (in Arabic), attend MHPSS WG meetings and advocate for MHPSS within the overall humanitarian response (in English).
2. Recommend that MHPSS actors begin to develop a competency matrix for key MHPSS staffing positions e.g., outreach workers/ community health workers; psychologists; social workers; MHPSS case managers; mhGAP accredited GPs; and activity facilitators in community centres etc. This

would ensure basic inter-agency minimum competencies for each staffing/ volunteer working for MHPSS programmes.

3. Harmonise the training and supervision curriculums for key cadres of MHPSS professionals such as MHPSS Case Workers and Social Workers. Continue to work with relevant Government authorities and Universities to support the creation of Bachelor, Master and shorter accredited training courses in Social Work and Psychology. Pre-existing training curriculums should be made open access and shared with relevant MHPSS, Protection and Health actors, particularly if such training programmes have the accreditation of a University and/ or the Department of Health (i.e., Dohuk Governorate Social Work programme). The focus of any new training programme should be on *practical* trainings for national staff/ local MHPSS actors/ local Government staff, with *on the job training, supervision and observation* by trainers/ facilitators linked to direct service provision (or quality of service provision), and thus a move away from theoretical trainings in hotels.

Mapping

1. The detailed mapping of 'Who is doing What, Where and When' regarding MHPSS actors should be devolved to the IDP/ refugee camp level or that of a specific Governorate. A general macro (simplified) 4Ws mapping for MHPSS actors should be maintained by the respective MHPSS WG Co-Chairs and Government representatives so that agencies have a general idea of who is working where.
2. The MHPSS WGs need to advocate with the IDP and refugee camp level managers to create and/ or update/ maintain the respective 4Ws list (for all service providers) for the respective camp to enable better referral pathways and wrap around care for affected persons. It should be possible for MHPSS Agencies to receive a matrix of all service providers in the camp that they can print out and distribute to their staff – this is particularly required by Protection and MHPSS Case Workers supporting individuals or families with complex needs.

Referrals

1. Advocate for the use of one-set referral form between actors within one camp and preferably within one Governorate. The IASC RG referral form and guide may be useful here, or it could be adapted into a local version in consultation with Health-Protection-Child protection and GBV actors.
2. All referrals should be followed up by the referring agency (as a final step in an effective referral), which is linked to updated service mapping documents at the camp level and the sharing of contact information of service providers on referral forms.
3. Referrals should also be made for all types of services (e.g., to a physiotherapist, to a child friendly space, to a community centre, to an income-generating activity etc.,) and not just 'upwards' towards specialised mental health services.

mhGAP

1. Consider mhGAP roll out at the *secondary healthcare level* across KRG-Iraq and in Ninewah Governorate rather than at the primary health care level. Secondary level hospitals could run

mental health outpatient clinics to ensure that persons with severe mental health disorders are able to access the appropriate care, treatment and support within each Governorate (albeit with the limitations of distance). Effective referral pathways for persons with severe mental health disorders should be created between primary health care facilities (public-Government clinics and NGO/ private run facilities) to the respective secondary level hospital in each specific Governorate and preferably each major city/ Governorate. GPs at the primary healthcare level could receive training on detection and referral of persons with MNS disorders.

2. Scale up the roll out of Problem Management+ and Interpersonal Therapy in Iraq and KRG-Iraq. This should be done in collaboration with the Department of Health, Federal Ministry of Health and the respective Ministry of Social Affairs. It is also worth advocating for such curriculum to be included in the Masters of Social Work and Masters in Psychotherapy courses being offered at Koya University in Sulaymaniyah and Dohuk University.
3. The Government of Iraq with support from the WHO to update, finalise and operationalise the National Mental Health strategy and plan in light of the current operating environment and crisis within the country. Any plan must be discussed and developed in consultation with the Directorates of Health in KRG-Iraq, in addition to the other Governorates of Iraq. Previous attempts to update the national MH plan were perceived to not be inclusive enough by the Directorates of Health from Governorates across Iraq.

General MHPSS programming recommendations

1. Layer 1 Interventions (Social considerations across sectors) - Orientate all frontline workers in IDP and refugee camps on psychological first aid. 1-day or 0.5 day orientation workshops should be coordinated with the respective camp managers and offered on a rolling basis (e.g., quarterly) within the respective camps.
2. Layer 2 interventions (Family and community supports) better inclusion of children/ women/ men/ youth etc., with MHPSS problems within family and community level activities such as child friendly spaces, women's centres and youth groups. There are unfortunate incidences in Iraq and KRG-Iraq for persons with MHPSS problems being excluded from some activities (e.g., child friendly spaces, youth spaces and schools) because of their problems. Reasons given for this include an under-confidence from teachers and activity facilitators on how to manage and support such children and youth within a group environment. Recent capacity- building initiatives by UNHCR, IOM and Unicef to better equip child protection actors with basic skills in supporting persons with MHPSS problems should be encouraged and expanded to Ninewah Governorate/ Mosul response where possible. General community-level psychoeducation and awareness campaigns on mental health conditions should be promoted by all MHPSS actors. General community based activities that promote social cohesion and social connections should be better encouraged. Examples of such activities include spaces for community members to meet in urban areas or in camps, provision for mosques or religious sites (key for Yazidi community) within camps and encourage local markets or small entrepreneurial activities (e.g., small shops or stalls), where possible. Local level peacebuilding and trust-building initiatives (such as those conducted by IOM) are also important to help move communities away from cycles of revenge and violence. Serious long term community level engagement is required to support the reintegration of children formerly associated with armed groups (safely) back into their families and communities again. Organisations such as Heartland

Alliance and Unicef are supporting these children and families on an individual basis in collaboration with the respective Government authorities, but additional actors are required to support with community level re-integration and acceptance.

3. Layer 3 (Focused/ non-specialised services): MHPSS actors should invest more programming in layer 3 interventions (IASC intervention pyramid) to minimise the volume of over-referrals to psychiatrists. Interventions should particularly be developed for children exposed to extreme stressors or distress requiring more individual and tailored MHPSS services (e.g., children displaying signs of anger, aggression and withdrawal, children witnessed the death or torture of family members, separated and unaccompanied children, children formerly associated with armed groups) that cannot be met by child friendly spaces or education services alone. These interventions are likely to be provided by Social Workers, Psychologists and Child Protection Case Workers. Other high risk groups include survivors of torture (both males and females), survivors of GBV, persons with disabilities and persons with mental, neurological or substance use (MNS) disorders. The GBV Case Management tool recently released by the Global GBV AoR may be a useful resource for agencies working with GBV survivors.
4. Layer 4 (Specialised services): Advocate for the broader understanding of specialised services that includes non-medical services for persons with MNS disorders. Advocacy can be conducted through discussions with Government officials, the donor community with MHPSS actors attending the MHPSS WGs, in camp level coordination meetings and in orientations on the IASC Guidelines. This should also help reduce the over referral of persons to a Psychiatrist and also help other cadres of professionals understand that their work is also important in the promotion of well-being and supporting persons with MNS disorders.

Annex 1: IASC Orientation training report

Annex 2: IASC Common Monitoring and Evaluation workshop report

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