Baseline Assessment Report

WASH, PROTECTION AND SRHR SUPPORT TO IDPS AND RETURNEES IN IRAQ 2020-2021, CARE

Global Affairs Canada

Location: Chamishko and Essyan IDP camps, Duhok governorate and Sinjar, Ninawa governorate, Iraq

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CHVs	Community Hygiene Volunteers
COVID-19	Corona Virus Disease – 2019, referring to the 2019 novel coronavirus or 2019-nCoV
DoW	Directorate of Water
FGD	Focus group discussions
HH	Household
HIV	Human Immunodeficiency Viruses
IDP	Internally Displaced Person
KIIs	Key Informants' Interviews
PHCC	Primary Health Care Center
PWD	Person(s) with Disabilities
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health and Rights
SRMH	Sexual Reproductive and Maternal Health
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive Summary

Chamishko and Essyan IDP Camps

Community satisfaction rate with the water supply in the IDP camps was 61% in Chamishko and 64% in Essyan camps. The rest reported 'not satisfied' because of the low water supply especially during summertime, which the camp management attributes to the shortage of electricity during the season and due to illegal connections to the network by household that use it for irrigation and livestock. The water supplied during the summer (July, 2020) is measured at about 60 l/p/day in Chamishko and 135 l/p/day in Essyan compared to the minimum summer-time water supply recommended by the WASH Cluster at 80 l/p/day.

A pressing issue in both camps is that a large number of the household water tanks (73% in Chamishko and 50% in Essyan) are rusted beyond repair and need replacement, since they pose various health risks, as they are unable to clean the tanks. Water quality is not a major concern. Only 8% in Chamishko and 16% in Essyan complained about bad taste, color or contamination with visible impurities.

Toilets exist in all the households, 85% of them in Chamishko are fully functional, but in Essyan the number was lower, only 45% have fully functional toilets. Only 2% in Chamishko and 1% in Essyan stated that the toilets are non-usable, the remaining are partially functional they are in need in various repairs. At the time of the survey, the household itself was in charge of any necessary repairs to the toilets and sanitation facilities. Bathrooms are available in the majority of the households but only 68% in Chamishko and 35% in Essyan considered their facilities to provide safe access to all genders, due to unavailability of water inside the toilet, non-functional lights and door locks .

Solid waste management has its own issues like piling up of the garbage outside of the tents, air pollution due to burning the garbage and dumping near the camp and in public areas. Part of the pile up is due to misuse of the communal containers. The collection is done Essyan with a frequency of twice to thrice a week according to 73% of the households and daily collection according to another 22%. The number of HH garbage containers is not more than 15% in Essyan.

While the pipes that collect the blackwater from the toilets are ok with mostly repairable blockages due to misuse or pipe design faults, the septic tanks that receive the wastewater are in need for rehabilitation in 29% of the HH in Chamishko and other 20% need expansion or extra construction. In Essyan about 56% need rehabilitation and 3% extra construction.

In both camps, about 80% of the respondents reported receiving active hygiene promotion. The most convenient methods of delivery were tent visits according to 80% in Chamishko and 92% in Essyan IDP camps. There were complaints from the key informants that the topics are somewhat repetitive and some of the promoters are not well-trained for handling some of the topics. The effectiveness of hygiene promotion can be increased by the improvement of the sanitation facilities and implementing participatory approaches and interactive methods. There is a knowledge gap in sanitation and handwashing practices especially where related to child care and handling their food, for instance, 41% the participated women in Essyan did not find it necessary to wash hands after changing the baby.

The majority of the interviewed women in both camps had received dignity kits at some point. The camps have been receiving the kits in the latest period from the Ministry of the Migration and Displaced. According to the participants, the quality of the feminine hygiene kits was ok at the beginning but the latest distribution at the time of the survey had very bad quality items and they were unfit for use. About 75% of the women in Chamishko and 78% in Essyan are willing to use re-usable sanitary pads.

According to the 86% in Chamishko's respondents and 91% of Essyan's, the earliest marriage age for girls and boys has increased since they moved to the camps. The earliest age for marriage of girls is 15-17 years for about half of the respondents, while for boys it is 15-20 years old for ¾ of the respondents in both camps.

The main legal issues facing women in the camps are getting a work permit (62% in Chamishko and 77% in Essyan), other services included legal issues during to child labor and domestic abuse. People face challenges in accessing the public services such as legal and health services. The challenges include family responsibilities, lack of money and discrimination.

The denial of liberty, denial of resources and opportunities, forced marriages and physical abuse were the top of the list of the things that fell under the definition of violence against girls, women, boys and men according to the survey respondents.

Sinjar District

Concerning the water supply in Sinjar district, Gohbel neighborhood had the highest dissatisfaction level with about 63%, followed by Qadesiya (43%), Sinouni (39%) and Azadi (20%), with complaints ranging from poor water quality, insufficient supply and damaged water networks. Rust-damaged water tanks is an issue for 87% of the households.

About 97% of the houses have their own toilets, of those, only 55% are in good conditions, the rest need rehabilitation and suffer blockages and low flow rates. About 62% had dedicated handwashing basins. Bathing facilities are available in 90% of the houses, of those 33% are partially functional and require rehabilitation.

Solid waste management is performed by the municipality, but the coverage lacks in most neighborhoods. Nearly 23% have to burn their garbage, which can potentially cause various health problems. About 34% of the surveyed households had garbage piled up in their vicinity.

The greywater is collected via open channels which suffer damages in some areas and leads to stagnation of water in nearby 25% of the surveyed households. Blackwater is stored in septic tanks which 52% of it need either rehabilitation or reconstruction.

Nearly two thirds of the survey group claimed that they received no hygiene promotion in their areas, 32% of them said that they did receive hygiene promotion visits from NGOs, which were primarily in Sinouni. Both group discussions and door to door visits are equally favorable as modes of delivery for the hygiene topics. The respondents believe that the impact of hygiene promotion can be increased by improving sanitation facilities, providing garbage cans and bags and adopting interactive and participatory approach in the delivery of the topics.

Community hygiene volunteers are important to improve the hygiene practices according to 93% of the respondents, as nearly 50% think that the current practices are bad and in need of interventions.

Prior to this survey, dignity kits were not distributed in the areas covered in this study according to the majority of the respondents. Access to sanitary pads is important to 83% of the women and yet only 85% of those can afford to buy it regularly.

The earliest marriage age for girls falls in the age group (14-16) for 58% of the respondents, and (17-19) for another 25%, and about 69% think that this age has increased during the last 12 months. As for boys, the earliest age was (14-19) for 81% and (20-22) for 15%.

The top three challenges that face the people from accessing the basic services such as health services and legal services, are the long distance, lack of money and being overburden by family responsibilities.

The respondents believed that violence against girls, boys, women and men mostly primarily indicates to denial of liberty, economic deprivation, psychological and emotional abuse, and denial of resources and opportunities. The common instances that exist in their areas is denial of liberty of girls, however for boys, most respondents deny that violence against boys exits and some of them thought economic deprivation exists.

Sexual Reproductive and Maternal Health (SRMH) in Essyan IDP camp:

A group of 123 women whom participated in the interview had a live birth during the last two years prior to the date of the survey, 81% of them had planned pregnancy and only 19% of the pregnancies were not planned. About 95% of these women had antenatal care visits to a health care professional (usually a doctor), with 7-14 visits during the pregnancy for 71% of them and 4-6 visits for 19%, and 9% only had 1-3 visits.

It is most common for the women to deliver their babies in hospitals (private or public), only 4% reported having home delivery. For their postnatal care, 80% of the women had checkups for them and their babies directly after birth. During the recovery while still at the health facility, 67% had visits from health care professionals to do checkups on them and 61% had their babies checked up as well. After leaving the health facility, 42% had checkups for themselves and 47% had checkups for their babies.

Of the women that already had a live birth during the last two years, 42% preferred to have more children, however 37% did not wish to have any more and the rest have not decided yet. Of the women who wanted more children in the future, 68% hoped to wait for years before the next pregnancy and the rest were planning for shorter periods. According to the health center key informants, contraceptives are commonly used by people aged 25 years old and over.

There were no common harmful beliefs and practices to public health reported by the key informants, however some or the population might not allow females to visit the health centers on their own which can cause harm especially in emergency cases.

While the sexually transmitted diseases are not common (according to the health center data), the common knowledge about these diseases (AIDS as an example) is generally weak, as only 8% of the interviewed women had heard of AIDS.

Introduction

With funding support from the Global Affairs Canada (GAC), CARE implements a 24 months multi-sectoral live-saving project: WASH, Protection and SRMH support to IDPs and Returnees in Iraq 2020-2021 in Duhok governorate (Chamishko and Essyan IDP camps) and Ninewa governorate (Sinjar district) with 64,434 individuals (18,169 women, 14,701 girls, 16,924 men, 14,640 boys) direct beneficiaries aiming at the following:

- *Water, sanitation and hygiene (WASH)*: In line with the WASH HRP and WASH Cluster objectives, CARE implements a comprehensive WASH program that includes in Sinjar: water facilities rehabilitation, environmental sanitation, solid waste management, and hygiene promotion & education through PHAST methodology to improve access to safe and clean water. In IDP camps: the intervention supports maintenance of water and sewer infrastructure, water quality testing, and removal and disposal of solid waste augmented through a hygiene promotion component. In Sinjar district: the project aims to rehabilitate water systems damaged during the conflict, thus eliminating the acute drinking water shortages facing returnee. These include water distribution networks, boreholes and chlorination systems. The DoW is involved in the rehabilitation process from the beginning of the project until its completion; rehabilitated structures is planned to be handed over to them at the end of the project.). The project engages poor households without steady sources of income through cash-for-work in clean-up campaigns to improve their environmental sanitation by removing solid waste from public areas. Hygiene items are planned to be distributed using a market-based voucher approach. The package includes the distribution of safe pads, a safe, washable and infection-free option for women to use during menstruation which has been done by CARE in Chamishko & Essyan, following a successful pilot by the Oxfam Innovation Lab.
- *Protection intervention* in Chamishko and Essyan IDP camps as well as Sinjar to tackle knowledge gaps, attitudes and practices while providing critical information on available services to enhance access to services for GBV survivors, particularly women and adolescent girls. Gender sensitive community centres is planned to be established in pre-existing community centers to provide a safe space to receive services including case management. These will provide Psychosocial Support (PSS) activities and awareness raising sessions on protection issues and referrals as needed. The cases are managed by a gender-balanced team of Gender Workers in each location. A separate space for women and girls as well as childcare services will be provided to remove barriers for attendance. One psychologist will be based in each community centre to assist case management, provide beneficiaries with counselling and lead group sessions. Tent-to-tent awareness raising sessions will be used to raise awareness of protection risks and GBV issues in all three project locations. CARE aims to engage male gatekeepers and community leaders, as champions to address GBV and gender equity and equality. WASH activities will be used as entry points to conduct outreach sessions. In addition. In Sinjar, a one-time cash transfer will be provided to vulnerable individuals including widows, divorced women, female-headed households, women with disabilities and the elderly to meet urgent protection needs. The total amount of the support is determined by the socio-economic criteria based on the Survival Minimum Expenditure Basket (SMEB) and the eligibility criteria is aligned with the criteria of the cash working group in Iraq and the World Bank and follows UNHCR's cash for protection approach. Dignity kits will be provided to vulnerable women and girls based on GBV Sub-Working Groups Criteria, designed in consultations with the communities.
- *Sexual Reproductive and Maternal Health (SRMH)*: CARE provides SRMH services in Essyan camp in collaboration with the Department of Health (DoH), including Antenatal Care (ANC), Postnatal Care (PNC) Family Planning (FP) and Referral services. CARE supports the deployment of a 2 female doctors to provide gynecological, obstetric consultations and monitor the SRMH services 6 days a week in addition to one trained female nurse to support the female doctors and work 6 days a week (Saturday-Thursday) . Other health staff working at Essyan camp PHCC are being supported by another local partner who is providing Primary health care services for Essyan camp residents, the staff include a dentist who provides in the existing Dental Unit as studies increasingly link dental health of pregnant women with the health outcomes of newborn babies (DJM, 2013). Other PHCC staff (nurses, lab technician, and an ambulance driver) are supported through a modest incentive pay[1]. The referral pathway between Essyan camp and the main

[1] This is standard practice among other implementing partners in KRI as the DoH does not have the resources to deploy sufficient staff required to run the PHCC.

hospitals is strengthened to improve access to services for patients in need of extensive emergency care. Transportation will be available through ambulances for emergency SRMH patients to a main hospital outside of government funded working hours.

Methodology

The methodology for baseline survey is based on using mixed-method participatory approach as baseline team believes that participation improves quality and enhances ownership.

The CARE baseline survey data collection for the camps took place from May 21, 2020 to May 31, 2020, and in Sinjar district from September 1, 2020 to September 10, 2020. The purpose of the baseline study is to better understand the situation and current needs of the population in order to ensure more effective and responsive project implementation as well as improved living conditions for IDPs, returnees and host communities in the project areas. The survey includes a range of questions, covering the demographics, household details, makeup of the community, and access to WASH, SRH and protection needs. The baseline was conducted through household survey and qualitative interviews targeting a range of groups (IDPs, host communities, and returnees) and KIIs with government authorities, community leaders and Mokhtars.

The qualitative methods was used to collect data generated from both individual interviews and KIIs are triangulated with HHs. Additionally, REACH initiative monitoring reports, HRP 2020, HNO 2020 municipality and camp management plans were identified as secondary data as well as official handover documents, photographs or public records. Data triangulation combine more than one method or data source to research a topic; this is to strengthen the validity of data through the cross-verification of information whilst also capturing different dimensions to provide more insight.

The KIIs interviews were semi-structured questionnaires open-ended discussions with specific prompting as required to better understand the context and underlying causes of a problem. They were developed based on the relevant indicators as per the project log frame as well as any other identified best practice standards pertaining to WASH and SRMH.

The questionnaires were translated into Arabic and administered by data collection team who explained the questions to the householder and then recorded their answers. HHs survey were conducted using Kobo Collect platform. However, KIIs and individual interviews were conducted through semi-structured questionnaires open-ended discussions using paper-based approach. CARE's MEAL team supervised the survey quality, including coordination, planning, and implementation etc.

Household Survey

The household survey was conducted through a questionnaire-based interview using the digital data collection tool, 'Kobo Collect" in Chamishko and Essyan IDP camps and in Sinjar district. The questionnaire included closed-ended questions in order to generate information about the current conditions regarding water supply, sanitation, hygiene and waste management, SRH and protection.

However, not all the questions were asked to the respondents due to the question linkages and dependencies. Kobo Collect allows for follow up questions to appear based on the respondents answer to the initial main question. This tool minimizes the risk of error in data as questions are only asked if they are relevant and linked to the first question.

The household (HH) survey was conducted in the four targeted neighborhoods in Sinjar district with a total population of 25,400 individuals and Chamishko & Essyan IDP camps in Duhok governorate. The sample size based on a 95% confidence interval and a 5% margin of error, calculated to be 1,401 HH's.

Table 1: Sampling and Sample Size Breakdown (HH Survey)

Location	Geographical unit	Population size	Sample
Sinjar district	Sinouni, center	20,000	240
	Gohbel Village	3,000	180
	Azadi Neighbourhood	1,080	180
	Qadesiya Neighbourhood	1,320	180
Chamishko camp	All sectors	26,427	354
Essyan camp	All sectors	14,823	330
Total			**1464**

Individual In-depth interviews

Individual qualitative interviews with randomly selected men and women were conducted instead of FGDs due to COVID-19 pandemic restrictions to ensure safety of respondents. All efforts were made to ensure the privacy and confidentiality to those involved, including taking notes so that participants are not identifiable in the dissemination of findings. The qualitative interviews questionnaire was developed to avoid sensitive topics to eliminate any risks of potential harm to participants.

Qualitative interviews were held and Chamishko & Essyan IDPs camps, using semi-structured questionnaires with open-ended questions. The interviews were separated based on gender; 25 interviews were conducted with men, by male enumerators, and 25 interviews were conducted with women, by female enumerators (Table 2). The qualitative interviews were not held in Sinjar district.

CARE staff ensured that informed verbal consent was obtained from all participants. The interviews took place in safe and neutral environments such as public buildings for men, or in a private house for females, taking into consideration also the cultural and religious context.

Table 2: qualitative interviews with community members.

Location	Number of men participants	Number of women participants
Chamishko camp	5	5
Essyan camp	5	5
Total	**10**	**10**

Key Informants Interviews

The Key Informant Interviews (KIIs) aimed to collect information from individuals familiar with the details of the context and people living in the area who are well known and respected in the community. The purpose of the KIIs is to aid in verifying the qualitative interviews and household survey outcomes.

In total, 19 KIIs will be conducted, using semi-structured questionnaires. They were conducted with the Directorate of Water in Duhok & Sinjar, municipalities, and mukhtars of targeted neighborhoods, camp managements and the Mayor of Sinjar.

Table 3: Key informants' interviews (KIIs)

Location	Respondent	Number of KIIs
Sinjar district	Directorate of Water in Sinjar	1
	Mukhtars of targeted neighborhoods	4
	Sinjar Municipality Director	1
	Mayor of Sinjar	1
Chamishko camp	Camp management and head of sectors	2
Essyan camp	Camp management and head of sectors	2
	Primary health care center (PHCC) staff	4
Duhok	Directorate of Water	1
	BRHA	1

Municipality	2
Total	**19 interviews**

Desk Review

The unstructured desk review analyzed internal and external documents to allow the team to better understand the needs, to draw on the knowledge gained from previous studies or research, identify potentially key issues in the camps as well as in Sinjar district. The selected instruments comprised; review of secondary sources (e.g. previous Assessments, baseline & endline Evaluation, camp profile from REACH initiatives, HRP and HNO 2020) and key informant and stakeholder survey questionnaires.

Data Collection Phase

Data collection was based on data collection plan (field plan) which is defined in the baseline assessment methodology and can be found in annex 4. This phase is divided into three sub-phases;

Training and orientation to enumerators

A team of 27 enumerators were trained by MEAL team(MEAL assistant based in Sinjar and consultant) and supervised by the MEAL coordinator on all aspects of data collection, compilation and transmission. The training included, but was not limited to the following;

- Objectives of data collection and expected output
- Understanding of data collection tools, indicators and timeline of data collection visits
- Use of tablets or smart phones for data collection and KoBoCollect application.
- Method of data compilation and transmission to CARE office.
- Deadlines for data collection and providing verbatim will be shared.
- Security guidelines and code of conduct of collecting the data.
- Ethical considerations and code of conduct while collecting the data.
- Standard operating procedure (SOP) for data collection.
- Mock-up for data collection to assess the quality of questions, format of questionnaire, time to collect data, how to record responses etc.
- Induction session in CI PSEA-CP and gender equality policies
- CI photography policy

The data collection team are local and professional data collectors. The data collection instruments were translated into Arabic for better understanding of respondents.

Data Quality Assurance

In order to collect quality data, the MEAL team used the following approaches:

- All enumerators were trained by baseline lead on how to conduct the questionnaires prior to data collection.
- Orientation was provided to all enumerators on the baseline assessment methodology.
- Quantitative data were collected through mobile data collection mechanism using KoBoCollect mobile application to maintain data integrity and avoid unnecessary data entry which can result in errors.
- Data cleaning was performed to ensure correct and complete data prior to the analysis.
- Spot check and supervision of the data collection and entry process was conducted by the MEAL team.

Data Compilation

The data were compiled electronically using smart tablets, the data were codified automatically. Each code is unique and shows all the properties of collected data like name of instrument, type/gender/age/location of respondent, questions and answers, type of services received etc.

Findings

Chamishko and Essyan Camps

Survey Group Characteristics

The characteristics of the survey group in Chamishko and Essyan camps are shown in (Table 4). In Chamishko, the female respondents shaped up 52% (n=184) of the group and males were 48% (n=169), while in Essyan females were 61% (n=194) and males were 39% (n=123).

Table 4: Characteristics of the survey group of the camp for the WASH component in Chamishko and Essyan camps.

		Chamishko Camp		Essyan Camp	
		#	%	#	%
No. of respondents	**Total**	**353**		**317**	
	Female	184	52%	194	61%
	Male	169	48%	123	39%
Age Group	**under 18**	**11**	**3%**	**12**	**4%**
	Female	5	1%	6	2%
	Male	6	2%	6	2%
	18-40 years	**222**	**63%**	**203**	**64%**
	Female	121	34%	122	38%
	Male	101	29%	81	26%
	41-60 years	**118**	**33%**	**88**	**28%**
	Female	58	16%	57	18%
	Male	60	17%	31	10%
	60 and over	**2**	**1%**	**14**	**4%**
	Female		0%	9	3%
	Male	2	1%	5	2%
Formal Education level	**Illiterate**	**132**	**37%**	**127**	**40%**
	Female	100	28%	92	29%
	Male	32	9%	35	11%
	Primary school	**112**	**32%**	**119**	**38%**
	Female	43	12%	74	23%
	Male	69	20%	45	14%
	High school	**64**	**18%**	**37**	**12%**
	Female	25	7%	18	6%
	Male	39	11%	19	6%
	Institute	**25**	**7%**	**24**	**8%**
	Female	11	3%	8	3%
	Male	14	4%	16	5%
	University undergraduate	**20**	**6%**	**10**	**3%**
	Female	5	1%	2	1%
	Male	15	4%	8	3%
	Total	**353**		**317**	

Water, Sanitation and Hygiene (WASH)

Water Supply and Distribution

The source of water in Chamishko is from six boreholes, all of them are functional, according to the camp management. The water from these boreholes are pumped to 12 elevated communal tanks each with a capacity around 30,000 liters. Then distributed by gravity network to the tents. An identical similar setup is available in Essyan camp, 6 boreholes feeding to 12 elevated water storage tanks each 30,000 liters.

In Chamishko camp, about 61% (n=216, f:22%, m:39%) of the survey respondents are fully satisfied with the access to water supply in sufficient quantity and quality, while 33% (n=118, f:20%, m:13%) are somewhat satisfied and 5% are dissatisfied. Similarly, 64% (n=202, f:21%, m:42%) in Essyan camp are fully satisfied, 32%

(n=102, f:23%, m:9%) are somewhat satisfied, and 4% are dissatisfied with the water supply (Table 5). The reasons for their dissatisfaction being low supply frequency during summer season in Chamishko, especially with the high demand for evaporative air coolers, and some areas get no supply for days. In Essyan, the complaint was low flow in some of the areas, especially those away farther away from the source and the follow of water was not enough to reach to the far houses. Based on the water supply flow measurements from the borehole operators for July 2020, each person got 60 liters/day in Chamishko and 135 liters/day in Essyan. These flow rates are calculated by dividing the pumped water quantity by the population numbers. The minimum supply determined by the WASH Cluster in Iraq in 2019[2] is 80 liters/person/day during the summer season.

In Chamishko, the camp management had the issue of shortage of electricity during summer, and provided gas for the generators that was limited, therefore the supply is decreased during the summer and there are some sectors that do not get the adequate amount of water. In addition, the boreholes are overloaded. There are also some illegal connections that are occasionally discovered by the authorities, these lead to reduced water supply to some sectors.

Table 5: Are you satisfied with the access to safe water supply in sufficient quantity and quality to meet the household needs Chamishko and Essyan camps?

Satisfaction with access to water supply	Chamishko Camp		Essyan Camp		Total	
	#	%	#	%	#	%
Satisfied	**216**	**61%**	**202**	**64%**	**418**	**62%**
Female	77	22%	68	21%	145	22%
Male	139	39%	134	42%	273	41%
Somewhat satisfied	**118**	**33%**	**102**	**32%**	**220**	**33%**
Female	72	20%	74	23%	146	22%
Male	46	13%	28	9%	74	11%
Dissatisfied	**19**	**5%**	**13**	**4%**	**32**	**5%**
Female	16	5%	7	2%	23	3%
Male	3	1%	6	2%	9	1%

According to survey finding, 71% (n=251) of the respondents, Chamishko camp has trained maintenance workers for mending the water supply system when it breaks down. In Essyan only 19% (n=60) believe that there are active maintenance workers. About 25% in both camps were not sure about the availability of such workers.

As described by the key informants in Essyan, the maintenance on the household level is almost non-existent during the time of this survey, the stoppages of care and maintenance work occurred due to the COVID-19 pandemic for almost 6 to 8 weeks. People have to rely on themselves to do the necessary maintenance if needed during this period. It is important to point out that the maintenance on household level is only limited to the 30% vulnerable households only.

Those that have knowledge about the maintenance workers were asked, whether they had the necessary skills and tools to carry out the repairs; nearly 73% (n=138) and 92% (n=55) in Chamishko and Essyan respectively believed that they do have the necessary skills. About 26% in Chamishko and 7% in Essyan were not sure and the remaining 1%-2% said that the workers lack training and the necessary tools.

[2] "*WASH CLUSTER MINIMUM TECHNICAL STANDARDS IRAQ – 2019, Post Emergency Phase*", available at https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/wash_cluster_minimum_technical_standards_final.pdf, accessed 21/10/2020.

Water Network

The condition of the water supply network in Chamishko and Essyan is good according to 78% (n=272) and 53% (n=167) and does not require expansion or rehabilitation. However, 22% (n=76) and 45% (n=143) in Chamishko and Essyan believe that it is partially functional and may need expansion and repairs.

Household Water Tanks

As many as 99% of the respondents in both camps reported having household tanks. The capacity of the household tanks is typically 500 liters for 85% (n=295) of the respondents in Chamishko and 86% (n=270) Essyan. Another 13% in Chamishko (n=46), and 14% in Essyan (n=44) have tanks with a capacity of 600-700 liters. The remainder have tanks with bigger capacities up to 1000 liters.

The condition of these tanks is not optimal. In Chamishko it is an issue as 73% (n=253) reported that the tanks need replacement, this was also the case for 50% (n=157) of the respondents in Essyan, while another 10% (n=34) and 34% (n=108) in Chamishko and Essyan respectively reported that the tanks need some sort of repairs (see Figure 1). Most of the complaints indicate that rust is the dominant issue as the vast majority of the tanks are metal and many of the tanks become unusable once they are cleaned due to the appearance of pinholes in the rusted areas, this is according to the camp managements. While maintaining household tanks is not within the scope of this project, the data and KIIs indicate that this is a growing issue in both camps and require attention.

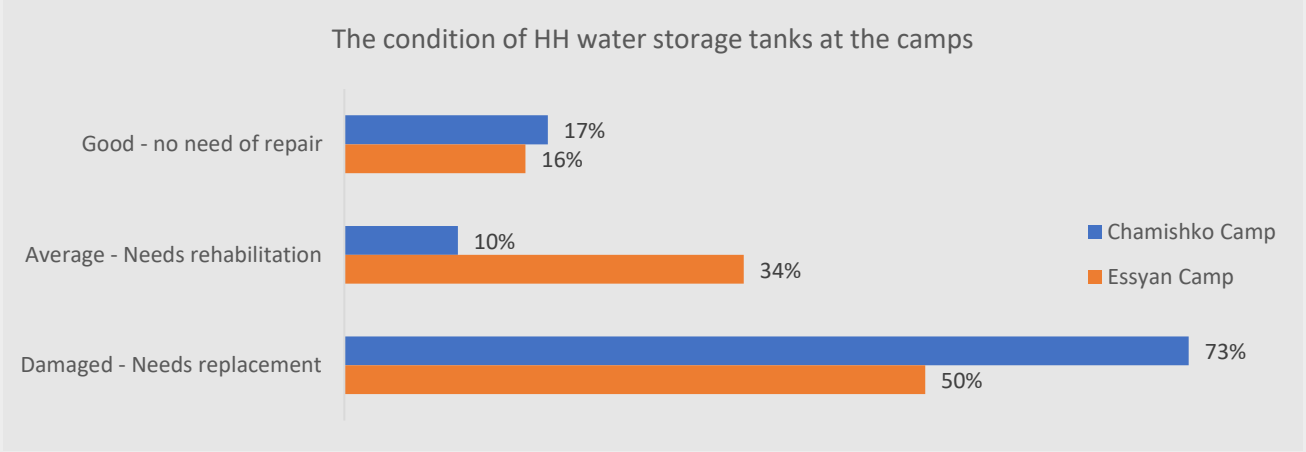

Figure 1: What is the condition of your household water tank? Chamishko and Essyan camps.

For 61% (n=217) and 72% (n=229) of the respondents in Chamishko and Essyan, the quantity of the supplied water /day is sufficient to fill the storage tank. About 31% (n=108) and 24% (n=76) say that they usually can only fill about half of their tanks (see Table 6).

Table 6: The amount of water collected during each delivery day in Chamishko and Essyan.

How much water is typically collected per household per each water delivery day?	Chamishko Camp		Essyan Camp	
	#	%	#	%
All the tank(s) can be filled usually	217	61%	229	72%
Half of the tank(s) can be filled usually	108	31%	76	24%
A quarter of the tank(s) can be filled usually	14	4%	12	4%
I don't know/not sure	14	4%	-	0%

The water delivery occurs daily according to 68% (n=239) and 95% (n=294) of the respondents in Chamishko and Essyan respectively. In Chamishko, it can extend to three times or even two times a week according to 23% (n=79) and 8% (n=28), see Figure 2.

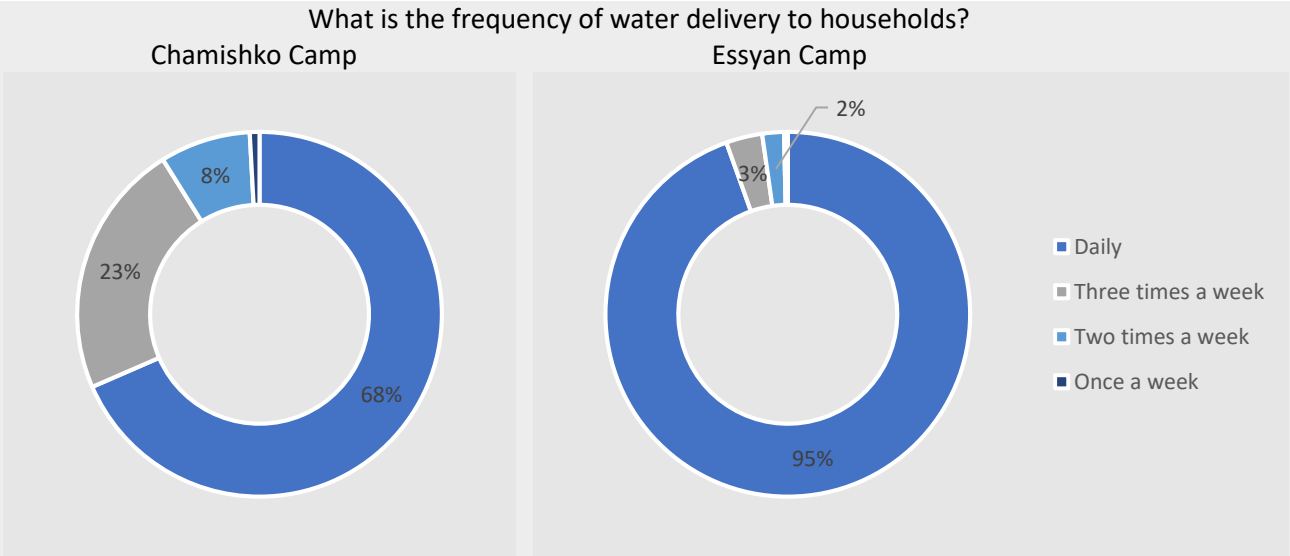

Figure 2: Frequency of the water delivery to the households of Chamishko and Essyan camps.

Water Quality

Water chlorination is being carried out and monitored CARE, however, there are few water qualities concerns according to 8% (n=29) and 16% (n=51) of the respondents in Chamishko and Essyan respectively. The concerns included bad taste, color, visible impurities, and high chlorine concentration.

Sanitation

All of the households in both camps have toilets, about 85% (n=301) of the respondents in Chamishko had fully functional toilets, which needed no major repairs and another 13% (n=46) thought that the toilets needed some sort of major repairs, the remaining 2% (n=6) had completely damaged toilets. In Essyan, a smaller percentage (45%, n=143) of the surveyed household had functional toilets and the remaining 54% (n=171) needed repairs and only 1% (n=3) had completely damaged units (See Figure 3).

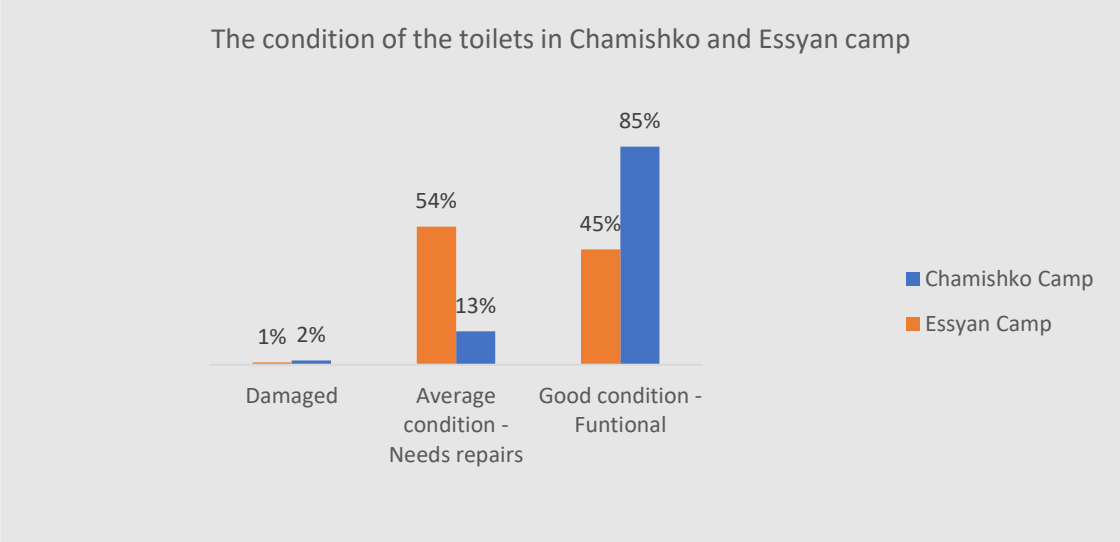

Figure 3: The condition of the toilets of the households in Chamishko and Essyan camps.

As of the date of the survey, 77% (n=272) of the respondents in Chamishko and 51% (n=163) in Essyan answered that the community itself is responsible for maintaining the water and sanitation system at the household level, but 16% (n=55) and 47% (n=150) in Chamishko and Essyan respectively thought that the systems are maintained by NGOs. Only 4% in both camps believed it is maintained by the camp management.

Of the surveyed households 9% (n=33) in Chamishko and 15% (n=48) in Essyan had persons with disabilities in their families, of those, 61% (n=20, Chamishko) and 44% (n=21, Essyan) had toilets suitable for their disabilities.

Almost all of the surveyed households (99%, n=313) in Essyan had dedicated bathrooms attached to their tents with the exception of 1% (n=3). The percentage of households missing these facilities in Chamishko was 13% (n=47), the key informants indicated that some of the household have repurposed the bathrooms into storage facilities.

Regarding the safe access to the bathroom and the level of privacy the users have, three criteria were selected for the survey. The first one being the availability of running water inside or close to the facility, thus making it more accessible to the users during the day and night especially to females, about 68% (n=207) in Chamishko and 35% (n=110) in Essyan considered the bathroom suitable to fulfil this criteria. The second criterion was the availability of lighting inside and outside of the facility, which 85% (n=245) of the bathrooms in Chamishko and 80% (n=267) in Essyan do fulfil. The last criterion was whether the door lock is functional, and about 70% (n=213) in Chamishko and 82% (n=257) in Essyan indicated that the door locks are functional.

The functional level of these bathrooms varies, as 76% (n=233) of Chamishko respondents and 44% (n=138) of Essyan stated that their bathrooms are fully functional, the remainder need some sort of repairs or improvements. Only 1% (n=4) of the respondents in Chamishko and 2% (n=5) in Essyan reported that they currently do not have a separate bathroom in their household.

Solid Waste Management

The solid waste collection is currently the responsibility of the Directorate of Municipality through a private company, in Chamishko, there are 3 trucks in operation, one of them 12 m^3 and the other two are 8 m^3 of capacity. In Essyan, two collection trucks are in operation by CARE/Harikar. The respondents were asked about the various aspects of this service as described below

Frequency of Collection

In both camps people's perception about the frequency of solid waste collection varied considerably. In Chamishko, the collection is done once a week according to 53% (n=186) of the respondents, while another 21% (n=75) indicated that it is being collected twice a week. The collection frequency in Essyan looks a little better, as 51% (n=195) say that it is collected three times a week and 22% (n=146) say it is collected twice a week, see Figure 4.

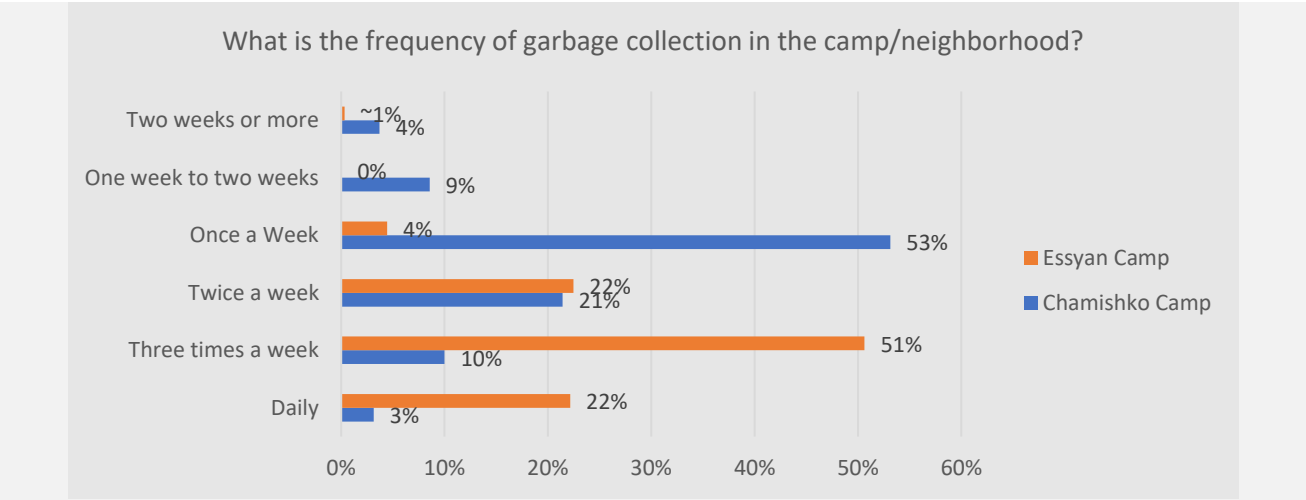

Figure 4: Frequency of garbage collection. No. of responses (Chamishko n=350, Essyan n=316).

Availability of Garbage Containers

Only a limited number of households have their own garbage containers, 88% (n=310) of the population in Chamishko and 85% (n=270) rely on the communal garbage containers for the waste disposal. As an alternative to the proper containers, households use plastic bags, cardboard boxes and other temporary containers. The common size for the household garbage bins is 120 liters, and the communal ones are 500 liters in size.

In the vicinity of about 54% (n=191) of the surveyed household in Chamishko and 28% (n=89) in Essyan, there was evidence of garbage accumulating outside of the garbage containers, measured as a sign of the effectiveness of the current frequency of garbage collection.

The in Essyan dump site is nearby the camp and often the garbage is burned which causes serious health risks for the residents in nearby locations. The recommendation is to select another dump site or transfer the waste to a recycling facility. There is also a lot of garbage that is burnt alongside the roads leading to both camps.

Picture 1: Burning garbage on the sides of the road leading to Chamishko camp.

Picture 2: Burning garbage just outside of the camp in Essyan.

Wastewater Management

Greywater

The greywater in both camps is collected in both camps via open channels that run along the streets between the households. In most of the areas the network is functional, but stagnant water was found in the vicinity of 13% (n=47) of the households in Chamishko and 16% (n=52). In Essyan. There are several reasons for the presence of stagnant water, including clogging of the drains due to accumulation of debris in some areas and due to faults in the design and construction of the network. In Essyan blackwater from some of the toilet join the greywater network.

Blackwater

In both camps, the blackwater is collected in septic tanks that are built underneath the tents' blocks. The septic tanks require frequent desludging, and this is currently being carried out by the Municipality.

About 85% (n=300) of the household surveyed in Chamishko and 58% (n=185) think that the number of desludging trucks is insufficient to serve the camps. Each camp has two desludging trucks in operation.

According to the respondents, the blackwater network is "good and functional" in about 51% (n=177) and 41% (n=129) in Chamishko and Essyan respectively. Some other 29% (n=103) and 56% (n=177) in both camps think that it needs some rehabilitation. The remainder think that rebuilding the septic tanks or adding more storage is necessary. See Table 7.

Table 7: Status of the black water system in Chamishko and Essyan camps.

	Chamishko Camp		Essyan Camp		Total	
What is the status of black water system?	**#**	**%**	**#**	**%**	**#**	**%**
Good and functional	177	51%	129	41%	306	46%
Need rehabilitation	103	29%	177	56%	280	42%
Need extra cesspools and/or septic tank	70	20%	9	3%	79	12%
Total	**350**		**315**		**665**	

There seems to be a lot of cases of clogging drains that occur a few times a month on regular basis and sometime on weekly basis. This has been reported by 30% (n=106) in Chamishko and 41% (n=130) in Essyan. The reasons for clogging may include misuse (trash or other objects thrown in the toilets), insufficient pipe slopes and overflow of the septic tanks.

Hygiene Promotion

According to the respondents in both camps, NGOs are the main actors in raising awareness in the camp on hygiene promotion matters, this was according to about 80% of the respondents in both camps. However, in Chamishko about 11% say that they receive no hygiene promotion service and similar complaints was raised by about 18% of Essyan's survey respondents.

The preferred method for receiving hygiene promotion awareness for most of the respondents is via tent visits. For example, in Chamishko 76% (n=140) of the females interviewed preferred tent visits, that was also the case for 84% (n=142) males in the camp. In Essyan, even a higher percentage of the women respondents (96% (n=186)) voted for the tent visits in addition to 86% (n=106) of the males. The other methods were groups sessions, celebration of hygiene days and hygiene promotion in schools, in the order of their preference (see the details in Table 8).

Table 8: The preferred method of raising hygiene awareness in Chamishko and Essyan Camp.

Preferred methodology of raising hygiene promotion in the camp**	Tent to tent visit		Sessions		Hygiene promotion in schools		Celebration of hygiene world days	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Chamishko Camp	**282**	**80%**	**111**	**31%**	**42**	**12%**	**53**	**15%**
Female	140	76%*	65	35%*	22	12%*	26	14%*
Male	142	84%*	46	27%*	20	12%*	27	16%*
Essyan Camp	**292**	**92%**	**132**	**42%**	**36**	**11%**	**33**	**10%**
Female	186	96%*	68	35%*	30	15%*	21	11%*
Male	106	86%*	64	52%*	6	5%*	12	10%*

* Percentage of the specified gender in the camp. For example, 35% of the women respondents in Chamishko prefer sessions

** Respondents were given the choice to choose more than one method.

The survey shows that the impact of the hygiene promotion can be enhanced by further improving on the water and sanitation in the camp, this is according to 91% (n=321) and 82% (n=259) of the respondents in Chamishko and Essyan respectively. The other suggestion by 62% (n=218) in Chamishko and 58% (n=183), was to adopt a participatory approach in the promotion ranging from participating in the selection of promotion topics to the introduction of practical demonstrations into the programs.

The key informants believe that hiring hygiene promoters with higher qualification will improve the trust in the information delivered and will therefore render the hygiene promotion more effective.

To understand the current hygiene practices, the respondents were asked about the occasions at which they usually wash their hands, the categories included occasions related to eating, using the toilet and

baby/childcare and feeding. The answers outlined in Table 9 show that handwashing related to child care might be an area that needs improvement in both camp as well as the overall practise in Chamishko.

Table 9: When do you wash your hands? Chamishko and Essyan Camps.

When do you wash your hand?		Chamishko Camp			Essyan Camp		
		Female	Male	Camp Total	Female	Male	Camp Total
Before preparing food	#	158	100	258	192	121	313
	%	**45%**	**28%**	**73%**	**61%**	**38%**	**99%**
Before eating food	#	164	144	308	188	121	309
	%	**46%**	**41%**	**87%**	**59%**	**38%**	**97%**
After using the toilet	#	161	153	314	180	114	294
	%	**46%**	**43%**	**89%**	**57%**	**36%**	**93%**
After changing baby's diaper/cleaning	#	91	53	144	169	83	252
	%	**26%**	**15%**	**41%**	**53%**	**26%**	**79%**
Before feeding the child	#	91	58	149	175	90	265
	%	**26%**	**16%**	**42%**	**55%**	**28%**	**84%**

The diseases and medical conditions related to hygiene practices and the quality of WASH services seem to exist in both camps. In Chamishko 31% (n=110) reported that skin diseases are common, but that percentage was high as much as 78% (n=248) in Essyan. Diarrhea was also reported by 11% (n=40) and 43% (n=135) in Chamishko and Essyan respectively, which is reported to have affected people from all ages.

Nearly 18% (65) and 16% (52) of the respondents in Chamishko and Essyan camps think that the hygiene practices in their camps are poor and need improvement. About 2-3% more in both camps think that the practices are bad and need in critical intervention. The remainder think that they are fair to good (see Figure 5).

Key informants from within the camps reported spread of a type of bugs all around the camp threatening an infestation.

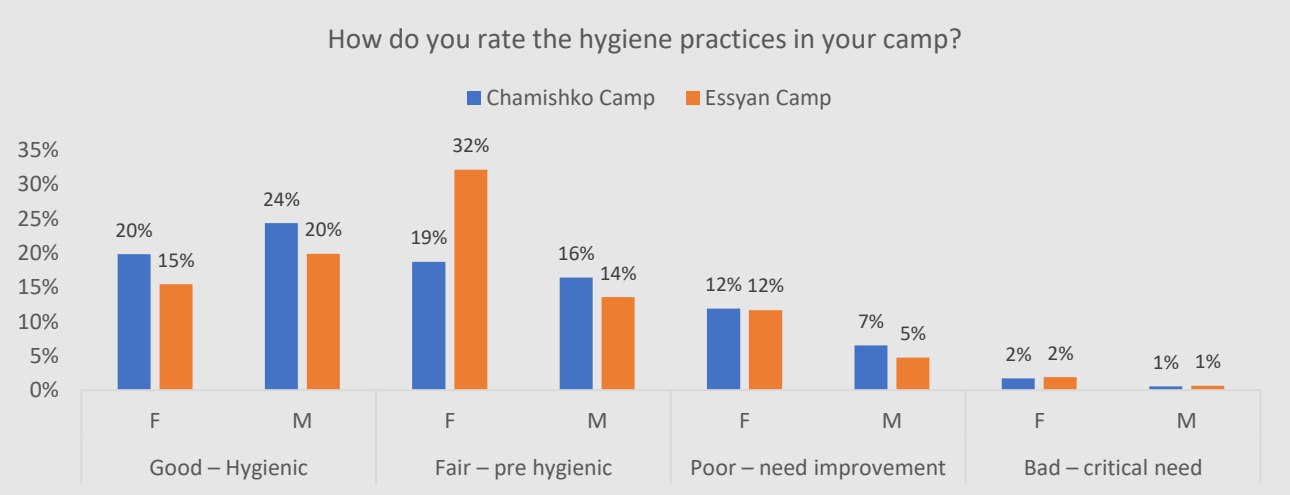

Figure 5: How do you rate the hygiene practices in your camp?

Feminine Hygiene

Women respondents were asked about their ease of access to sanitary pads. In Chamishko, 91% (n=94) of the women whom had at least one menstruating woman in their household, indicated there has been distributions

that included sanitary pads in the form of dignity kits. All the respondents (n=122) in Essyan said that they have received dignity kits. The distribution was carried out by the Ministry of Migration and Displaced.

About 72% (n=68) and 84% (n=103) of the respondents in Chamishko and Essyan respectively thought that the quantity of the materials in the kits are enough for their use. While another 24% (n=23) and 15% (n=18) of the women respondents in those camps said that it was not sufficient, the rest of the respondents were not sure.

For most of the interviewed women, access to suitable sanitary pads is important. Figure 6 shows the degree of important of the pads for different age groups. When asked about any alternatives they would use in place of the sanitary pads, about 50% (n=51) and 56% (n=70) in Chamishko and Essyan mentioned that they would use a piece of cloth, but the rest of the women were against the idea of using any alternatives.

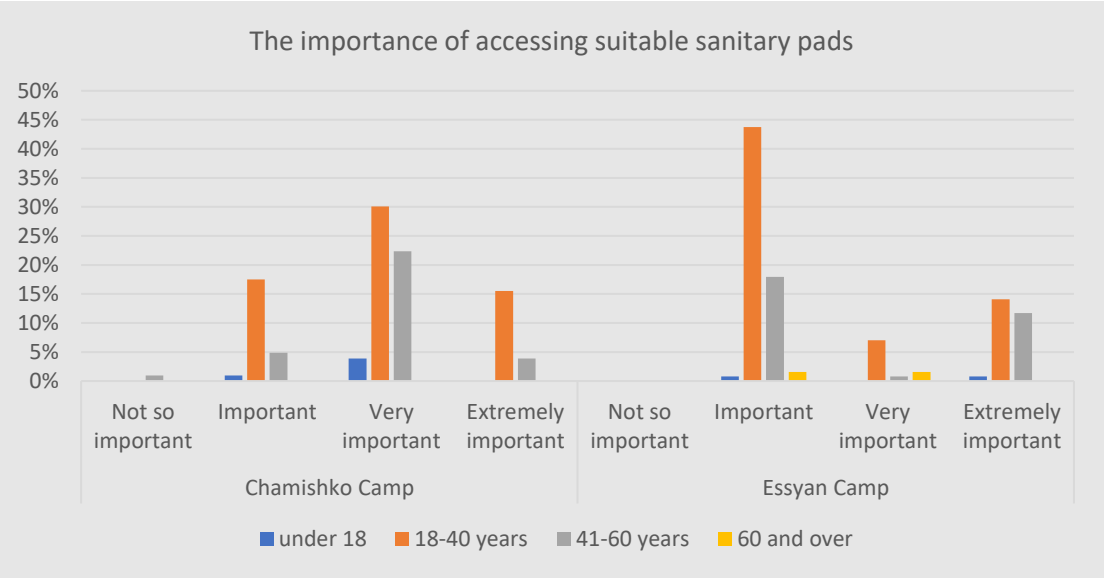

Figure 6: The importance of sanitary pads according to women of different groups ages in Chamishko (n=103) and Essyan Camps (n=128).

As many as 75% (n=77) and 61% (n=78) of the respondents in Chamishko and Essyan camps were willing to use re-usable sanitary pad in place for the disposable ones. About 4% in Essyan were not sure how they feel about using these pads.

In Chamishko and Essyan respectively, about 95% (n=98) and 86% (n=110) of the respondents were in favor of having sanitary pads workshop in the camp led and managed by women as sources of hygiene and livelihood opportunity for the women. The majority of those women thought that it would be culturally acceptable for women to work in those workshops.

Protection

Marriage and Freedom of Choice

The respondents in both camps were asked about the youngest age girls get married in their communities, and according to their observation about 67% (n=233) in Chamishko and 71% (n=214) in Essyan girls may get married below the age of 18 (Figure 7). Almost 86% (n=304) and 91% (n=289) of the respondents in Chamishko and Essyan respectively believe that the minimum marriage age has risen since they have moved to the camps, but another 12% (n=41) and 1% (n=4) in those camps think that it has remained the same. The remainder believe that the marriage age has actually decreased.

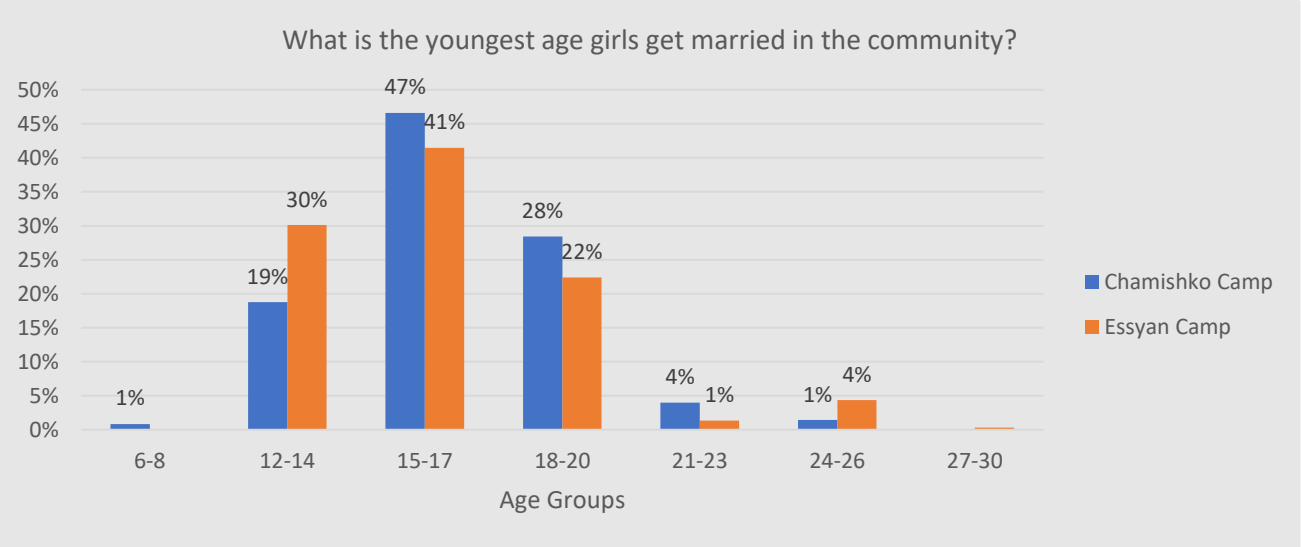

Figure 7: The youngest age girls get married in the community of Chamishko (n=352) and Essyan (n=299) Camps according to the respondents.

The decision of how and when a girl gets married is left to the girl herself according to 51% (n=108) and 93% (n=296) of households in Chamishko and Essyan camps respectively, but the parents have the final decision in 44% (n=156) and 6% (n=19) in those camps. In the other households, the other family members have the decision in the matter.

Table 10 shows the opinions of the respondents in both camps on the effects early marriage has on the different aspects of the life of a girl. It is evident that a higher percentage is against marriage under the age of 18, however there is still a portion of the community that believes that early marriage can actually benefit the girl or her family.

Table 10: Effects early marriage under 18 years old on the different aspects of a girl's life according to the respondents in Chamishko and Essyan Camps.

What effects will marriage under 18 have on *:	Chamishko Camp		Essyan Camp		Total		Positive and Negative Points
	#	%	#	%	#	%	
The happiness of the girl?							
Mostly negative	85	83%	115	90%	200	87%	**Negative** ▪ Loss of happiness ▪ Loss of freedom ▪ Future problems because of little knowledge the basis of marriage ▪ Loss of childhood ▪ Unable to bare the responsibilities **Positive** ▪ Stability
Mostly positive	6	6%	7	5%	13	6%	
Mixed	5	5%	6	5%	11	5%	
No answer	7	7%		0%	7	3%	
The physical health of the girl?							
Mostly negative	89	86%	117	91%	206	89%	**Negative** ▪ Physical problems due to pregnancy and childbirth ▪ Weight increase ▪ Change of way of thinking ▪ Low immunity
Mostly positive	3	3%	8	6%	11	5%	
Mixed	10	10%	3	2%	13	6%	
No answer	1	1%		0%	1	0%	
the education prospects of the girl?							
Mostly negative	79	77%	116	91%	195	84%	**Negative** ▪ Mostly will leave school ▪ Less time for education
Mostly positive	4	4%	8	6%	12	5%	
Mixed	18	17%	4	3%	22	10%	
No answer	2	2%		0%	2	1%	
the parents of the girl?							
Mostly negative	71	69%	118	92%	189	82%	**Negative** ▪ Phycological effects due to worrying about the girl ▪ Issues due to high divorce probability ▪ Increased responsibility
Mostly positive	2	2%	7	5%	9	4%	
Mixed	23	22%	3	2%	26	11%	
No answer	7	7%		0%	7	3%	
* The questions in this section were asked by female enumerators to female respondents only.							

The survey responses show that there are two major age groups considered as the youngest age for marriage for boys. The first age group is the 15-17 years old according to 37% (n=131) and 41% (n=112) in Chamishko and Essyan respondents respectively, and the second group is the 18-20 years old, this is according to 41% (n=143) and 47% (n=126) in both camps (see Figure 8).

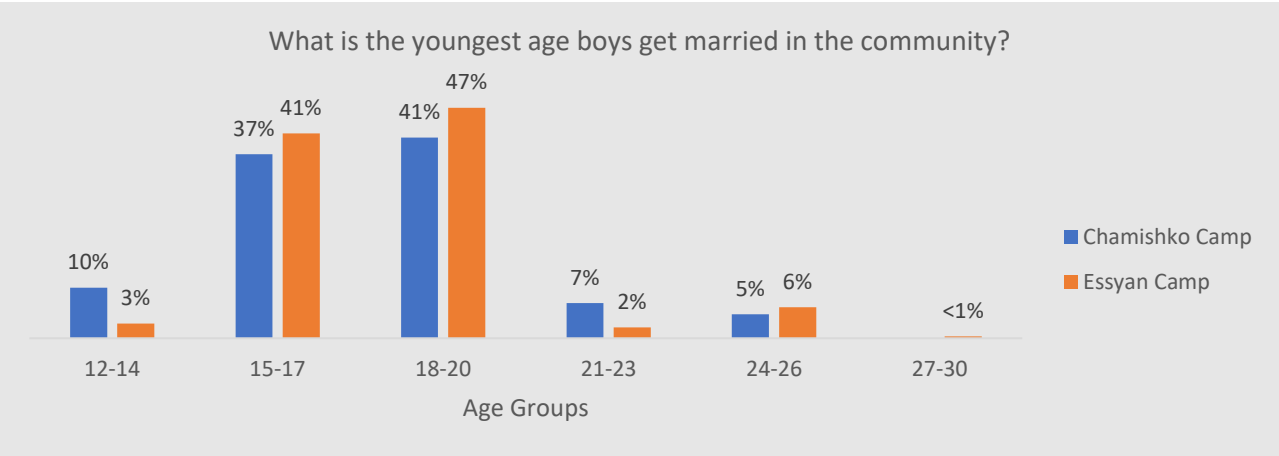

Figure 8: The youngest age boys get married at according to the respondents of Chamishko (n=352) and Essyan (n=270) Camps.

The minimum age of marriage for boys is believed by the majority of the respondents to be increased since the two communities have moved to the camps as indicated by 86% (n=302) of them in Chamishko and 91% (n=288). About 12% (n=43) in Chamishko think that it has remained the same compared to the time they were in their original areas. About 52% (n=185) of the respondents in Chamishko believe that the boy himself is the decision maker related to his marriage choices, while 36% (n=126) think it is up to the father (or head of the family). The same does not apply to Essyan, as 91% (n=289) think it is up to the boy, and the rest say it is up to the parents or head of the family. Small percentages (3%-5%) believe it is a joint decision.

Access to Basic Services

The basic services, such as health services and legal services, and the way to access them are known to about 76% (n=270) of Chamishko respondents and 85% (n=269) of Essyan's. The remainder are not aware of all those services or the way to access them.

The main legal issues that face women in the camp communities is getting a work permit, according to 62% (f:29%, m: 33%) and 77% (f:50%, m:27%) in Chamishko and Essyan survey respondents. The other issues include legal issues related to child labor and domestic abuse (see Figure 9).

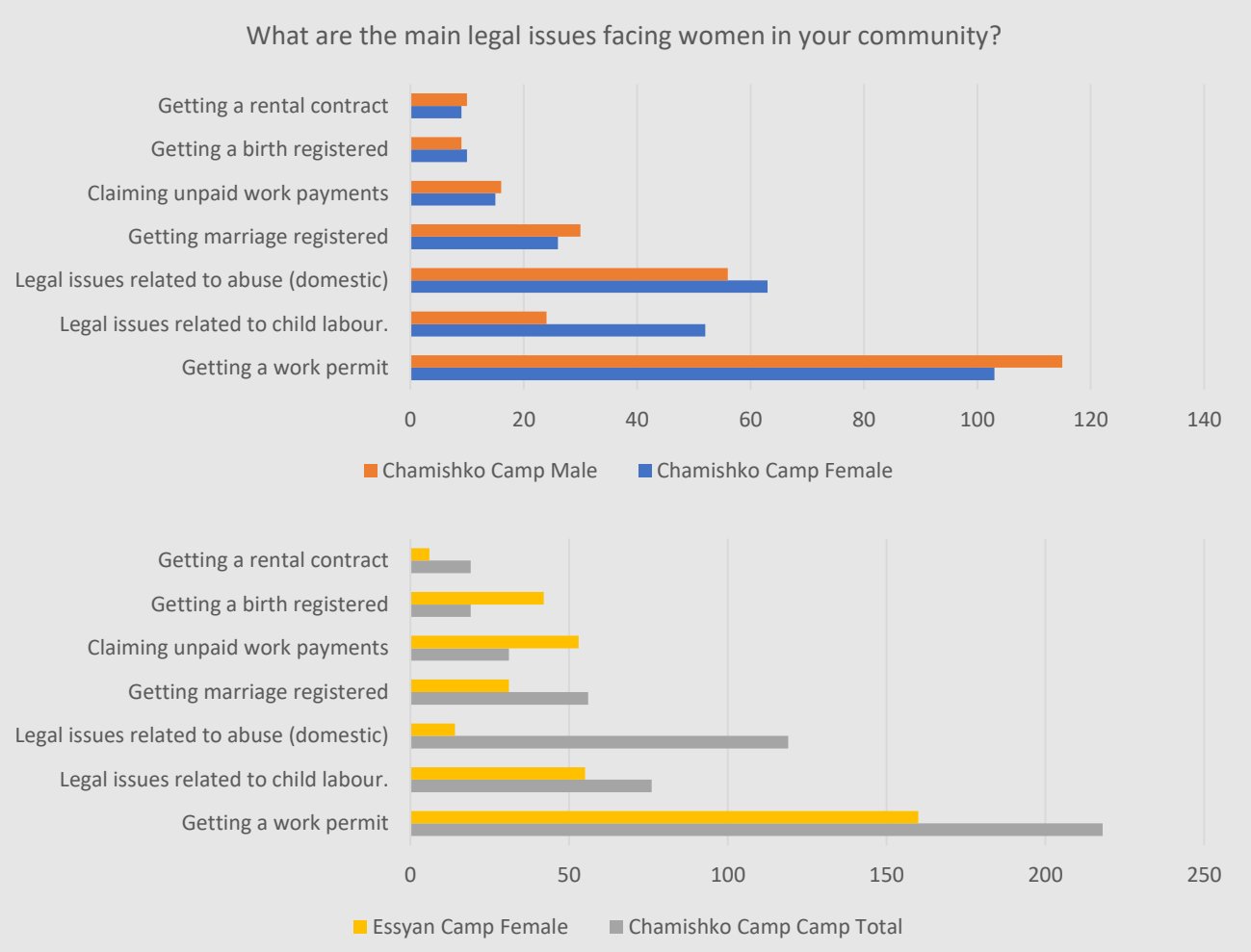

Figure 9: The main legal issues facing women in the Chamishko and Essyan Communities.

There are a number of challenges that face the families in the camps when trying to access the basic services such as health care, education, work and legal support. In Chamishko, family responsibilities pose challenges for 15% (f: 10%, m:5%) of the families and discrimination due to the IDP status for another 13% (f: 7%, m: 6%). While in Essyan, lack of money is what keeps 36% (f:25%, m:10%) of the families from accessing the services, another 20% (f:16%, m: 4%) also feel discriminated, see the other challenges.

GBV

When the participants were asked what the term "violence against women and girls" means and what some of the types of it are varied considerably amongst the survey participants. Denial of liberty and denial of resources and opportunities were the top choices by the participants, and surprisingly, rape and sexual assault was the last one, but the participants were not given a list to choose from, rather they listed instances on their own and were perhaps simulating the current situation in the community, see Table 11 for the percentages on each choice.

Table 11: What do you think the term "violence against women and girls" means?

What do you think the term "violence against women and girls" means?	Chamishko Camp						Essyan Camp					
	Female		Male		Camp Total		Female		Male		Camp Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Denial of liberty	55	16%	43	12%	**98**	**28%**	108	34%	58	18%	**166**	**52%**
Denial of resources or opportunities	39	11%	61	17%	**100**	**28%**	97	31%	50	16%	**147**	**46%**
Forced marriage	69	20%	58	16%	**127**	**36%**	58	18%	46	15%	**104**	**33%**
Physical Violence	42	12%	44	12%	**86**	**24%**	59	19%	39	12%	**98**	**31%**
Economic deprivation	30	8%	32	9%	**62**	**18%**	90	28%	27	9%	**117**	**37%**
Violence by family members	55	16%	41	12%	**96**	**27%**	39	12%	39	12%	**78**	**25%**
Violence former intimate partner	54	15%	50	14%	**104**	**29%**	9	3%	7	2%	**16**	**5%**
Violence by others	25	7%	35	10%	**60**	**17%**	27	9%	15	5%	**42**	**13%**
Rape/sexual assault	24	7%	32	9%	**56**	**16%**	12	4%	2	1%	**14**	**4%**
Don't know / no answer	24	7%	29	8%	**53**	**15%**	12	4%	14	4%	**26**	**8%**

The most common instances of GBV in Chamishko according to the survey respondents are family abuse (2%) and forced marriage (3%), although, only 37 responses were collected for this question in this Camp mentioned any instances. The situation in Essyan camp were different, as 270 responses were collected, The top three instances where forced marriage (19%, f:9%, m:10%), denial of liberty (19%, f: 14%, m: 5%) and family abuse (11%, f: 6%, m:5%). See Figure 10.

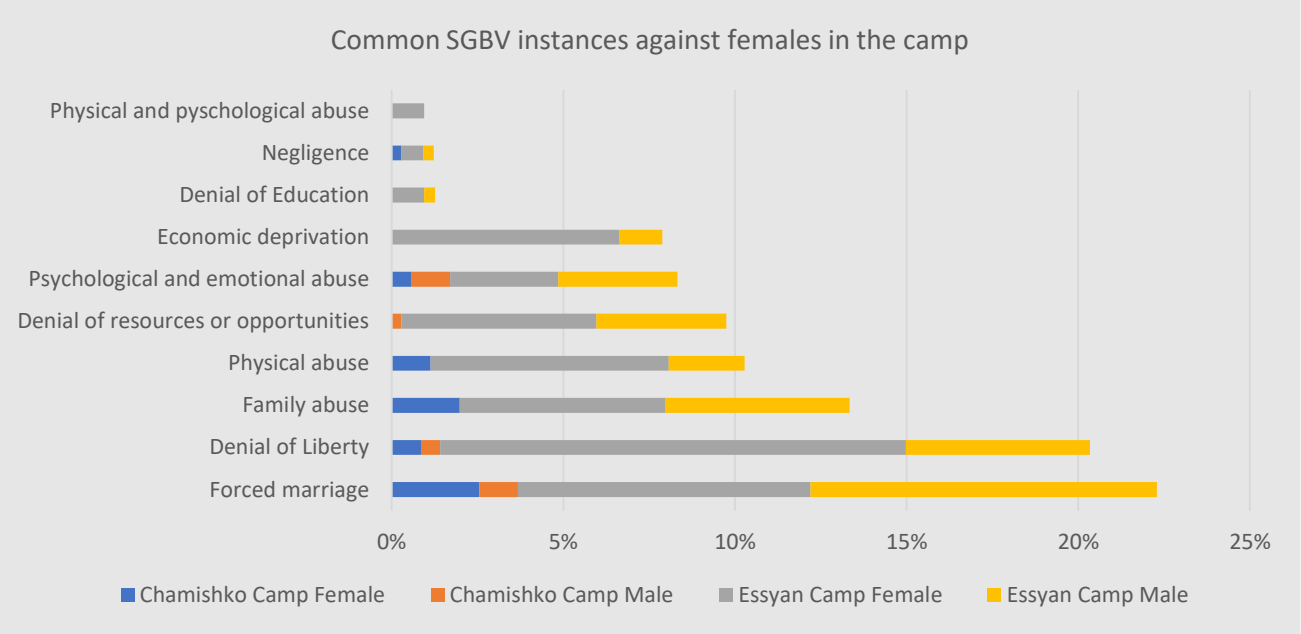

Figure 10: Common instances of SGBV against females in Chamishko and Essyan camps.

In both camps, women would most likely turn to her other family in case she experienced any kind of violence according to 75% (f: 38%, m: 37%) of the respondents in Chamishko, and 79% (f: 49%, m:31%) in Essyan. Other likely places are neighbors and friend.

The survey participants expressed their opinions on what they think is an example of violence against men and boys. Table 12 shows the answers of the respondents in both camps.

Table 12: What do you think the term "violence against men and boys" means?

What do you think the term "violence against men and boys" means?	Chamishko Camp						Essyan Camp					
	Female		Male		Camp Total		Female		Male		Camp Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Denial of resources or opportunities	31	9%	48	14%	79	22%	84	26%	40	13%	124	39%
Economic deprivation	37	10%	40	11%	77	22%	75	24%	36	11%	111	35%
Denial of liberty	26	7%	33	9%	59	17%	52	16%	41	13%	93	29%
Physical Violence	51	14%	52	15%	103	29%	30	9%	11	3%	41	13%
Psychological and emotional abuse	18	5%	19	5%	37	10%	68	21%	26	8%	94	30%
Violence by family members	41	12%	36	10%	77	22%	19	6%	18	6%	37	12%
Forced marriage	31	9%	41	12%	72	20%	14	4%	17	5%	31	10%
Violence by former intimate partner	36	10%	23	7%	59	17%	6	2%	6	2%	12	4%
Violence by others	16	5%	20	6%	36	10%	11	3%	5	2%	16	5%
Rape/sexual assault	1	0%	1	0%	2	1%	9	3%	2	1%	11	3%
Don't know / no answer	47	13%	45	13%	92	26%	32	10%	31	10%	63	20%

Respondents were also asked about the common instances of GBV in their camp, only 2% of the respondents in Chamishko believed that there are such instances, however 9% of the respondents stated that males are not likely to be subjected to GBV. In Essyan, 36% of the respondents believed denial of resources or opportunities is the most common instance of SGBV, leading denial of liberty and economic deprivation. 5% of the respondents in Essyan also thought that males are not likely to be subject to GBV (see Figure 11).

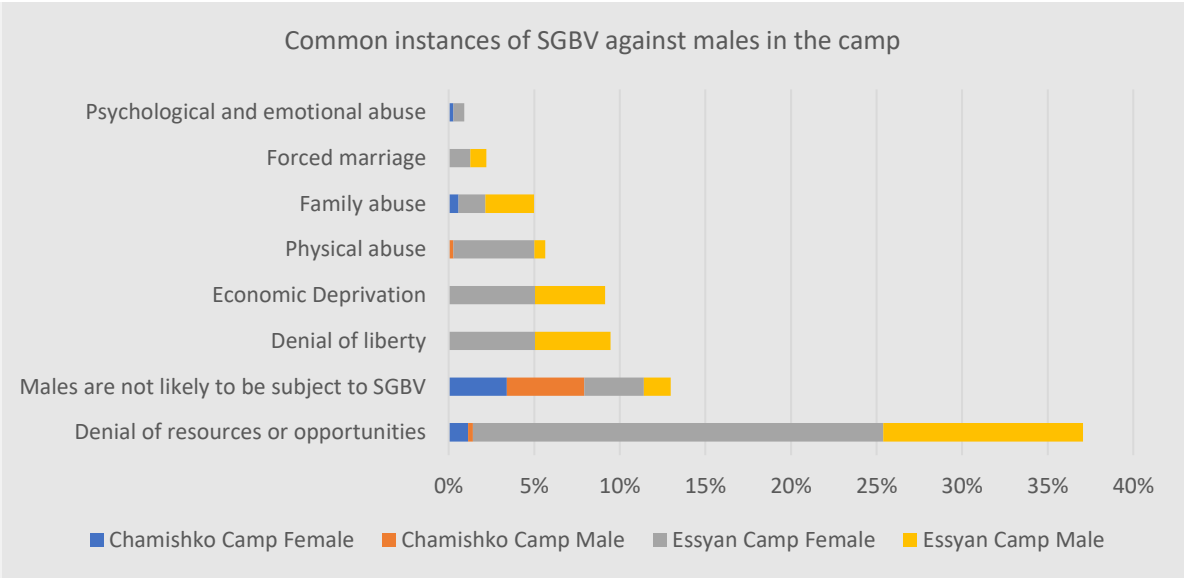

Figure 11: Common instances of SGBV against males according to the respondents in Chamishko and Essyan camps.

Sinjar District

Survey Group Characteristics

A total of 783 (f:46%, m: 54%) respondents were interviewed in Sinjar district from the four areas included in the intended interventions, Azadi and Qadesiya neighbourhoods, Sinouni town (center) and Gobhel village (Table 13).

Table 13: Gender distribution of the respondents in Sinjar district.

Row Labels	Female	Male	Total
Azadi	98	81	179
Gohbel	52	92	144
Qadesiya	69	122	191
Sinouni	140	129	269
Total	**359**	**424**	**783**

More than the half, 59% (n=460, f: 30%, m: 28%) of the respondents were in the age bracket 18-40 years, and about 32% (n=251, f: 13%, m: 19%) where between 41-60 years old, the remaining 9% were primarily 60 years of age or older (Table 14). About 10% of the respondents had a high school diploma, 32% had a primary school education, 4% had a university or institute degree while the remaining 54% had no formal education.

Table 14: Demographics of the survey group in Sinjar district.

		Female		Male		Total	
Age Group		**#**	**%**	**#**	**%**	**#**	**%**
	under 18	1	0%	2	0%	**3**	**0%**
	18-40 years	237	30%	223	28%	**460**	**59%**
	41-60 years	101	13%	150	19%	**251**	**32%**
	60 and over	20	3%	49	6%	**69**	**9%**
Formal education level	High school	30	4%	45	6%	**75**	**10%**
	No formal education	235	30%	189	24%	**424**	**54%**
	Institute	1	0%	16	2%	**17**	**2%**
	Primary school	90	11%	157	20%	**247**	**32%**
	University postgraduate		0%	1	0%	**1**	**0%**
	University undergraduate	3	0%	16	2%	**19**	**2%**
	Total	**359**	**46%**	**424**	**54%**	**783**	**100%**

About 50% (n=393) of the respondents in the district are returnees during the last year (Sep. 2019-Sep. 2020) and 12% (n=90) have returned to their homes during the last six months (after Mar. 2020). The remaining 38% (n=298) are displaced from other areas.

Water, Sanitation and Hygiene (WASH)

Water Supply and Distribution

The satisfaction level with water supply about safe access, quality and quantity is variable throughout the surveyed neighborhoods. Gohbel neighborhood had the highest dissatisfaction level about 63% (n=90), followed by Qadesiya (43%, n=82), Sinouni (39%, n=105) and Azadi (20%, n=35), see Figure 12.

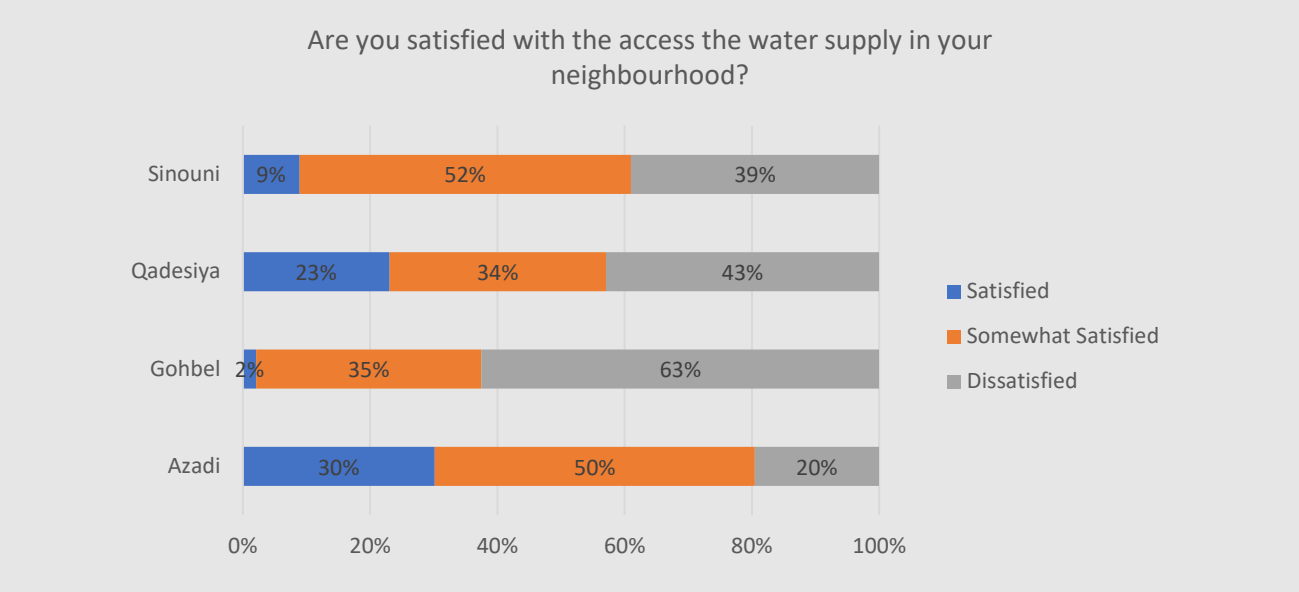

Figure 12: Satisfaction with the access to safe water supply in sufficient quantity and quality that meet the household needs in the neighbourhoods in Sinjar district.

The most common problems with the water supply range from bad water quality in Azadi (71%, n=25) and Qadesiya (56%, n=46), insufficient water quantity (83%, n=87) in Sinouni and damaged or absence of water supply network in Gohbel (66%, n=59). These percentages are from the people who are dissatisfied with the system (See Figure 13).

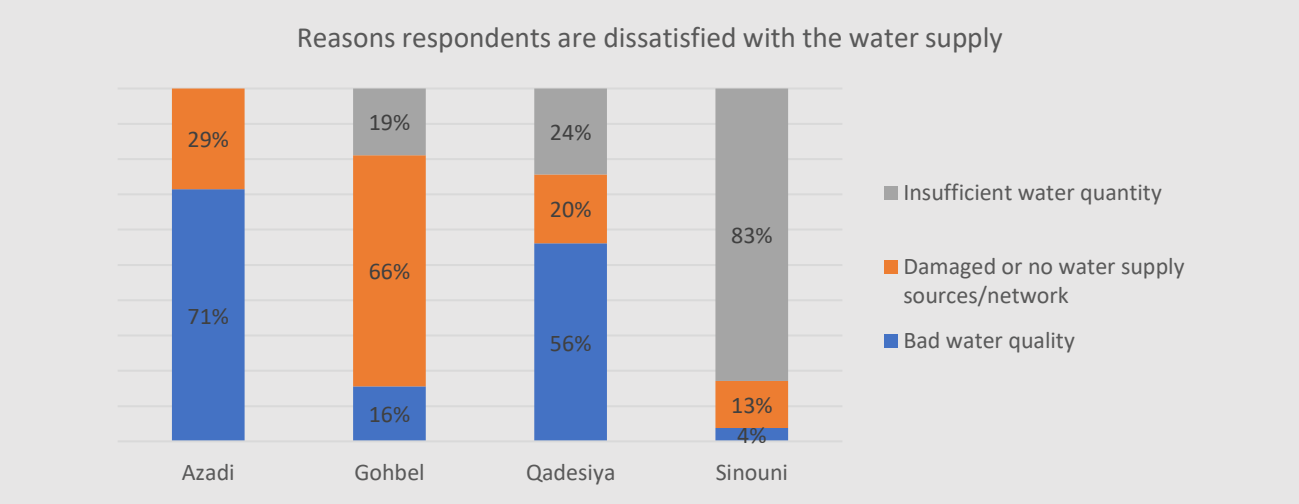

Figure 13: Issues related to the water supply in the in Sinjar district. Azadi n=35, Gohbel n=90, Qadesiya n=82, Sinouni n=102.

The primary water source in Azadi, Gohbel and Qadesiya are boreholes which belong to the residents and managed by them. In Sinouni the water network managed by the Directorate of Water supplies the area from boreholes.

The water distribution network is not nearly non-functional in Azadi and Gohbel, according to the 93% (n=166) and 77% (n=111) in both areas respectively (see Figure 14).

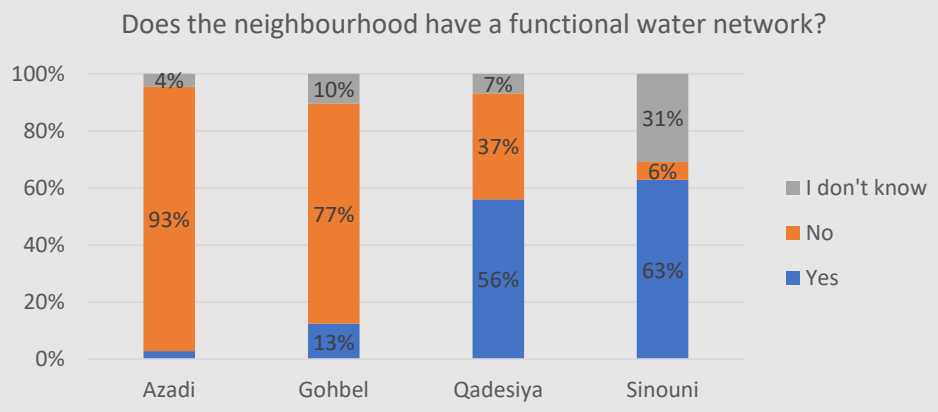

Figure 14: The status of the water distribution network in Sinjar district.

About 93% (n=729) of the surveyed households own storage tanks in their residences, of which about 50% are 1000 to 2000 liters in capacity, the remainders are less than that. The majority (87%) are made from metal sheets and 34% need replacement.

Table 15 shows the information given by the key informants in the surveyed areas regarding to the water supply situation.

Table 15: Key informants' assessment of the water supply in Sinjar district.

Location	Key informants' Assessment of the Water Supply situation
Azadi	There is no water distribution network in Azadi to serve the 474 households needs of water. The only way the residents get clean water is by purchasing water from water tankers , usually once a week. According to the community, the water is saline , and the water quality produced from the boreholes is not suitable for drinking they are already contaminated, even the distributed water is not disinfected and causes diseases related to water.
Gohbel	The water distribution network and the main line connecting to the boreholes is about 80% damaged in Gohbel. There are currently 13 boreholes constructed, of which 7 are not operational and need rehabilitation. There is no chlorination system, water is consumed without any sort of treatment, which poses various health risks to the residents.
Qadesiya	There are three boreholes in Qadesiya of which only one is currently operational, which prohibits about 1000 individuals in the neighbourhood from accessing clean water with the required quantity. The water distribution network suffers damages and about 3 km of the pipelines need rehabilitation. The quality of the water is substandard, and residents complain about the taste of the water and do not use it for drinking.
Sinouni	The main sources of water are boreholes, 2 out of the BH are not functional. The quantity of the water produced is not enough to cover the needs of the entire households. The water networks is partially damaged, disallowing a fair distribution of the water to the residents. An estimated length of 10-15 km of the pipelines needs to be rehabilitated/expanded and the maintenance workers need training and tools. There is also many illegal pipes connected to the mainline that are not authorized by the DoW. Each household currently has access to an estimated 100 liters per day (according to DoW) and the quality of the water is not up to standards because the water at the source is not being purified thus a large percentage of the residents suffer from urinary tract infections and kidney diseases are common.

Sanitation

Around 97% (n=756) of the households have toilets in their residences usually made of concrete blocks with concrete or clay roofs in some cases. Only about 3% (n=27) of the respondents reported not having one, those were damaged during the conflicts. About 55% (n=432) are in good condition and 42% (n=325) need

rehabilitation. About 34% (n=262) of the toilets are shared units with the bathrooms, 66% (n=517) have separate bathing facilities. The toilets have handwashing basins for 62% (n=486) of the households, 14% (n=108) have issues such as low flow rates of water supplied to the toilet, blockages and lack of handwashing soap. The surveyors and key informants had not found indications of open defecation in any of the surveyed areas.

Households whom do not have a dedicated handwashing basin, they wash hands anywhere they find the water in 59% (n=173) of the cases, other 37% (n=108) wash hands openly (for example a tap in the garden or using a flask).

16% Of the surveyed households, (n=126) had at least one disabled person in their families, only 40% (n=75) had toilets and bathing facilities that are suitable for persons with disabilities. (see Figure 15).

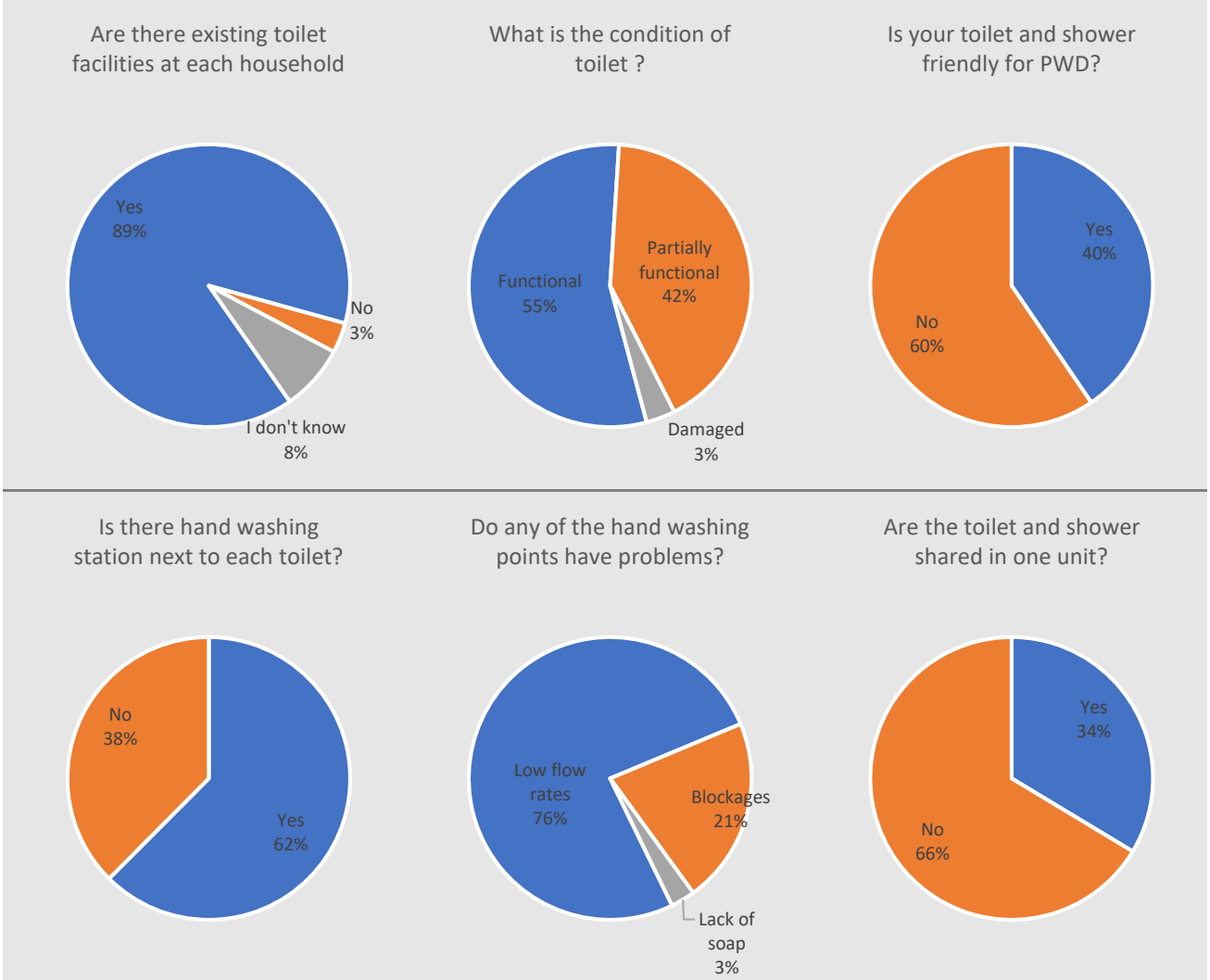

Figure 15: The status of the toilets in Sinjar district.

Bathing facilities exist in 90% (n=701) of the households, of those 67% (n=467) are fully functional and 27% (n=188) are partially functional. The remaining 6% (n=46) need rehabilitation including full plumbing, doors, lighting, windows, shower heads and sinks.

Concerning the privacy and safe access to the bathrooms, 84% (n=587) of the facilities have doors with functional locks, 50% (n=348) have lights inside and outside, and 32% (n=227) have running water inside the facility.

Solid Waste Management

The solid waste in the surveyed areas in Sinjar district was somewhat similarly managed, as an average, 84% (n=660) of the respondents say that the municipality collects the garbage, 23% (n=183) report that it is being buried in some cases and 16% (n=123) responded it is being burnt in some other cases. There are other cases where garbage is being dumped elsewhere or in some cases is collected by NGOs (2%).

In general, at the surveyed locations, the garbage collection most commonly occurs once a week for 68% (n=534) of the households, see Figure 16, this period can extend in some cases (8%, n=66) to 10-14 days or even once a month (3%, n=23), where some residents resort to dumping the garbage elsewhere for burial or burning, which can potentially cause various health risks for the entire population.

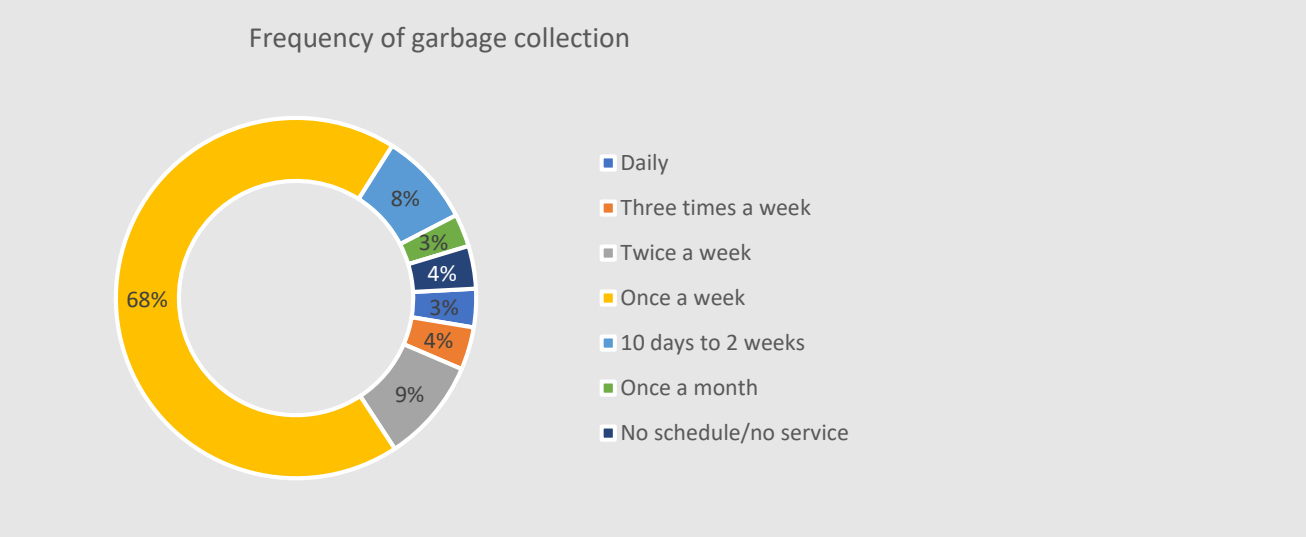

Figure 16: Frequency of garbage collection in Sinjar District.

In Azadi, Qadesiya and Sinouni the majority (about 90%) of the households have their own garbage containers, however, in Gohbhel, more than half of the population do not own containers of their own, they tend to use communal containers. Households whom do not own garbage containers mostly use garbage bags instead.

About 34% (n=267) of the respondents reported having encountered spots in their neighbourhoods with garbage piled up outside of the containers. These are found near schools, roadsides, dwellings and even vital locations such as food outlets and bakeries.

Generally, there is a shortage in garbage trucks in the surveyed areas, in Gohbel for instance, there is a tractor in operation instead, this is according to the key informants. There is an acute need for increasing the frequency of collection, proper designation of dumping sites, distribution of garbage bins for households and distribution of garbage bags.

Wastewater Management

Greywater

In about 88% (n=689) of the surveyed households, the greywater management is done through open channels that run along the sides of the roads. The rest flows through the pipelines of the sewage network.

In 25% (n=200) of the cases, there was evident stagnant water around the neighbourhoods, that was especially a problem in Azadi neighbourhood, as indicated by 47% (n=84) of their respondents. This is mostly due to partial damage to the drainage network.

Blackwater

All the surveyed neighbourhoods use septic tanks for blackwater from the toilets. The residents hire desludging trucks to empty the tanks when it gets filled. There are no desludging trucks in service that belongs to the municipality and operate free of charge or at cheaper rates. Each neighbourhood need 1-2 trucks to

serve the needs of the residents, according to the key informants. About 35% (n=263) of the septic tanks need rehabilitation, and 17% (n=133) need to be reconstructed or added to the existing ones, according to the survey respondents.

Hygiene Promotion

In the surveyed neighbourhoods, about 65% (n=510) of the respondents indicated that there is currently no active hygiene promotion by any entity, while around 23% (n=182) indicated that it is being implemented by NGOs. The responses varied from an area to another. According to the key informants, in Sinouni, there is one NGO that is conducting hygiene promotion.

The most preferred mode of hygiene promotion delivery are group sessions 46% (n=133, f:18%, m:27%,) and the door to door visits 45% (n=130, f: 17%, m=28%), to a lesser degree hygiene promotion is preferred (8%, n=25). Only respondents that have had previously received hygiene promotion were asked this question.

To increase the effectiveness of the hygiene promotion programs, 90% of the respondents (n=705, f: 39%, m: 51%) suggested improving water and sanitation facilities and 37% of them (n=287, f:20% , m:17%) suggested implementing a more participatory approach including interactive activities, other suggestions included improved garbage collection and the provision of garbage containers (households and communal), see Figure 17.

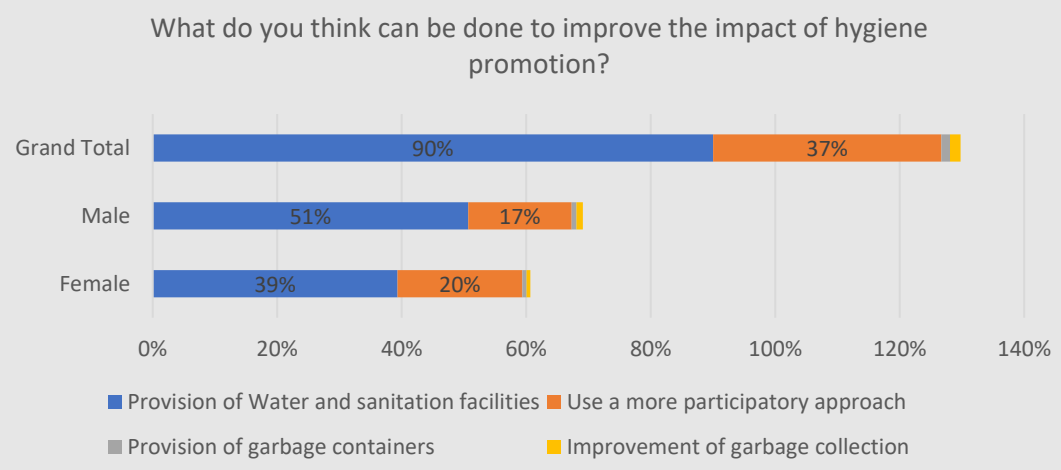

Figure 17: What can be done to increase the effectiveness of hygiene promotion programs in Sinjar districts? N=783 (multiple choices were allowed).

Table 16 shows the current handwashing practices compared to what the respondents think are the correct practices. In most cases the current practice is in line with the knowledge, however, in some instances such, both the knowledge and practices are at alarming rates, for example, as low as 46% (n=218, f: 28%, m: 19%) think it is necessary to wash hands after changing the baby's diaper.

Table 16: Handwashing practices in Sinjar district, comparing current knowledge and correct practices.

		When do you wash your hands?			What do you think are the important timings for handwashing?		
		Female	Male	**Total**	Female	Male	**Total**
Before preparing food	#	344	246	590	331	266	597
	%	**44%**	**31%**	**75%**	**42%**	**34%**	**76%**
Eating food	#	353	415	768	330	401	731
	%	**45%**	**53%**	**98%**	**42%**	**51%**	**93%**
After using the toilets	#	346	403	749	335	402	737
	%	**44%**	**51%**	**96%**	**43%**	**51%**	**94%**
After changing the baby's diaper/cleaning	#	230	131	361	218	150	368
	%	**29%**	**17%**	**46%**	**28%**	**19%**	**47%**

Before feeding the child	#	257	172	429	240	181	421
	%	**33%**	**22%**	**55%**	**31%**	**23%**	**54%**

The most common diseases or symptoms that currently exist in the communities of the District according to the respondents, are diarrhea (42%, n=330), skin diseases (28%, n=216), malaria (6%, n=44) and typhoid (3%, n=27). The key informant also indicated that Maltese fever is common in Sinouni.

About 89% (n=294) of the respondents that indicated that diarrhea exist in the community, also indicated that it mostly affects children of the age 5 year and younger while 9% (n=31) say it affects males and females of all ages alike. While as low as 13% (n=42) of these respondents believed that they know how to make an oral rehydration solution, only a small percentage of them could actually describe how to make it correctly, as none of them mentioned adding the sugar to the solution compared to the common methods.

Only 15% (n=118, f: 5%, m: 10%) of the respondents believe that the hygiene practices in their community are good, another 35% (n=280, f: 16%, m: 19%) think that the practices are fair (pre hygienic), the remaining half believe they are bad or even in need of critical interventions.

To enhance the hygiene behavior in the neighborhood, 93% (n=732) think that the presence of community hygiene volunteers is necessary, 6% (n=46) where not sure about the answer and 1% (n=5) thought that it is not necessary as their presence is not effective for this purpose.

Knowledge of COVID-19

Due to the recent COVID-19 pandemic, several questions related to the common knowledge of the symptom, and subsequent necessary actions were included in this survey. Concerning the symptoms of the disease, 88% (n=692) of the respondents had some knowledge of the symptoms, spread ways and what to do when infected, however, there seems to be a knowledge gap at the time of conducting this survey as demonstrated by the answers in Table 17.

Table 17: What are the common symptoms of COVID-19?

Question	Answers	Female		Male		Total	
What are the symptoms of COVID-19? n=692	Cough	287	**37%**	373	**48%**	660	**84%**
	Fever	219	**28%**	334	**43%**	553	**71%**
	Body pain	178	**23%**	300	**38%**	478	**61%**
	Flue	174	**22%**	271	**35%**	445	**57%**
	Shortness of breath	5	**1%**	8	**1%**	13	**2%**
How can you avoid the risk of the spread COVID-19? n=783	Frequent Handwashing	305	**39%**	391	**50%**	696	**89%**
	Maintain physical distance	246	**31%**	344	**44%**	590	**75%**
	Avoid touching	218	**28%**	335	**43%**	553	**71%**
	Using masks	230	**29%**	354	**45%**	584	**75%**
	Avoid gatherings	196	**25%**	260	**33%**	456	**58%**
What you will do if you have close contact with someone effected with COVID-19? n=783	Quarantine	154	**20%**	236	**30%**	390	**50%**
	Visits Doctor (inform COVID-19 response team)	204	**26%**	186	**24%**	390	**50%**
	I don't know	1	**0%**	2	**0%**	3	**<1%**

The residents get information related to COVID-19 through several channels, such as NGOs (69%, n=538), Community leaders (19%, n=150) and friends and neighbors (17%, n=136). About 15% (n=120) had no channels to get messages related to the disease.

Feminine hygiene

In 322 interviews carried out by female enumerators with female respondents it was seen that in 33% (n=102) of the surveyed household, there was only one menstruated women, other 29% (n=89) household had 2 women, and 22% (n=68) had 3 women.

As low as 4% (n=14) of these 322 households reported having received sanitary pads during distributions.

As demonstrated by Figure 18, accessing suitable sanitary pads is important for the women of all ages, but especially important for the women of age 18-40 years, see Figure 18.

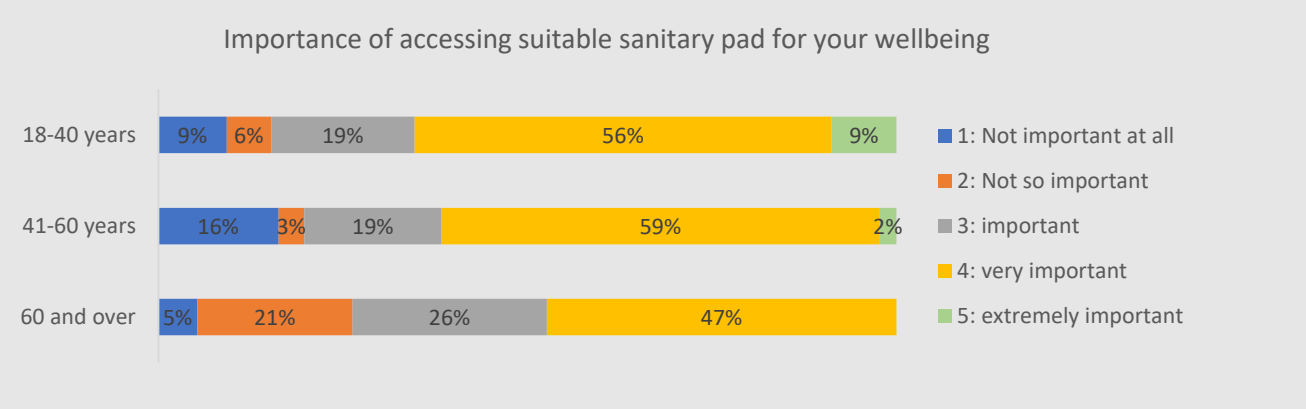

Figure 18: Importance of accessing suitable sanitary products for the wellbeing of women in Sinjar district.

About 85% (n=274) of the households can afford to buy the required feminine products each month, 13% (n=41) are not able to do so and 2% (n=7) are not sure that they have a steady income to be able to afford them. The alternative for sanitary pads in most of the cases is a piece of cloth or paper tissues, according to the respondents.

Re-usable sanitary pads are not favorable for about half of the women, 48% (n=153) feel uncomfortable using these types of pads. Another 36% (n=116) think it is ok to use them, and the remainder 16% (n=53) where not sure about them.

Having sanitary pads workshop in the camp led and managed by women as sources of hygiene and livelihood opportunity for the women is welcomed by 82% (n=263) of the respondents, while 5% (n=16) find it unsuitable. Moreover, 79% (n=253) believe such workshops will be culturally acceptable, and 7% (n=22) disagree with that.

Protection

In the surveyed neighbourhoods, the respondents believe that the youngest age girls most commonly marry at is between 14-16 years (58%, n=457), there are girls that marry at younger age between 11 and 13 (11%, n=83), see **Error! Reference source not found.**. Some 69% (n=539) think that the marriage age has increased during the last 12 months, but the other 24% (n=186) think that the age has decreased, while the remainder 7% think it has stayed the same. The girl herself is responsible of the marriage decision according to 73% (n=571) and the father is responsible in other 20% (n=160) cases, other 5% (n=38) think it is up to the mother of the girl.

Boys marry at the age 14-16 in 40% (n=314) of the cases and 17-19 in 41% (n=318) in other cases (**Error! Reference source not found.**). The youngest marriage age for boys has increased according to 66% (n=514) and has decreased according to 23% (n=180). The boy himself is responsible for the marriage decision in 81% (n=632) of the households, and it is up to the father in 14% (n=112) other households.

Access to Basic Services

As high as 82% (n=643, f: 39%, m: 43%) of the respondents are not aware of the basic services, such as health care, education, legal services, offered in their communities and how to access them. About 58% (n=456) of

the households are facing challenges in accessing these services. The most common challenges are long distance (74%, n=337, f: 28, m: 46%), lack of money (69%, n=210, f: 27%, m: 43%) and family responsibilities (34%, n=154, f: 11%, m: 23%).

GBV

The (783) respondents in Sinjar district were asked about what the term "violence against women and girls" means. More than half of them (55%, n=428) believe it primarily means denial of liberty, the second choice at 40% (n=311) was economic deprivation followed by emotional abuse and physical violence at 38% (n=295) and 34% (n=267) respectively (check Table 18 for the other options).

Table 18: What do you think the term "violence against women and girls" means?

What do you think the term "violence against women and girls" means?	Respondents (N=783, multiple choices)					
	Female		Male		Total	
	#	%	#	%	#	%
Denial of liberty	208	**27%**	220	**28%**	428	**55%**
Economic deprivation	138	**18%**	173	**22%**	311	**40%**
Psychological and emotional abuse	122	**16%**	173	**22%**	295	**38%**
Physical Violence	168	**21%**	99	**13%**	267	**34%**
Denial of resources or opportunities	118	**15%**	122	**16%**	240	**31%**
Forced marriage	133	**17%**	73	**9%**	206	**26%**
Violence by husbands/ former intimate partner against wives	94	**12%**	55	**7%**	149	**19%**
Violence by family members; father, brother etc. against women and girls	98	**13%**	45	**6%**	143	**18%**
Rape/sexual assault	54	**7%**	86	**11%**	140	**18%**
Don't know / no answer	49	**6%**	87	**11%**	136	**17%**
Violence by others against women and girls	72	**9%**	47	**6%**	119	**15%**

The most common instances of GBV as indicated by the respondents were cases of denial of liberty (31%, n=246, f: 16%, m: 15%). The second answer was there are no cases found according to 25% (n=195, f: 7%, m: 18%), see Figure 19. In cases of GBV, the women and girls are likely to turn to their families for support according to 80% (n=620, f: 36%, m: 44%) of the respondents. The other common places they would go to are friends (43%, n=340, f: 15%, m: 29%) and neighbors (23%, n=183, f: 10%, m: 13%).

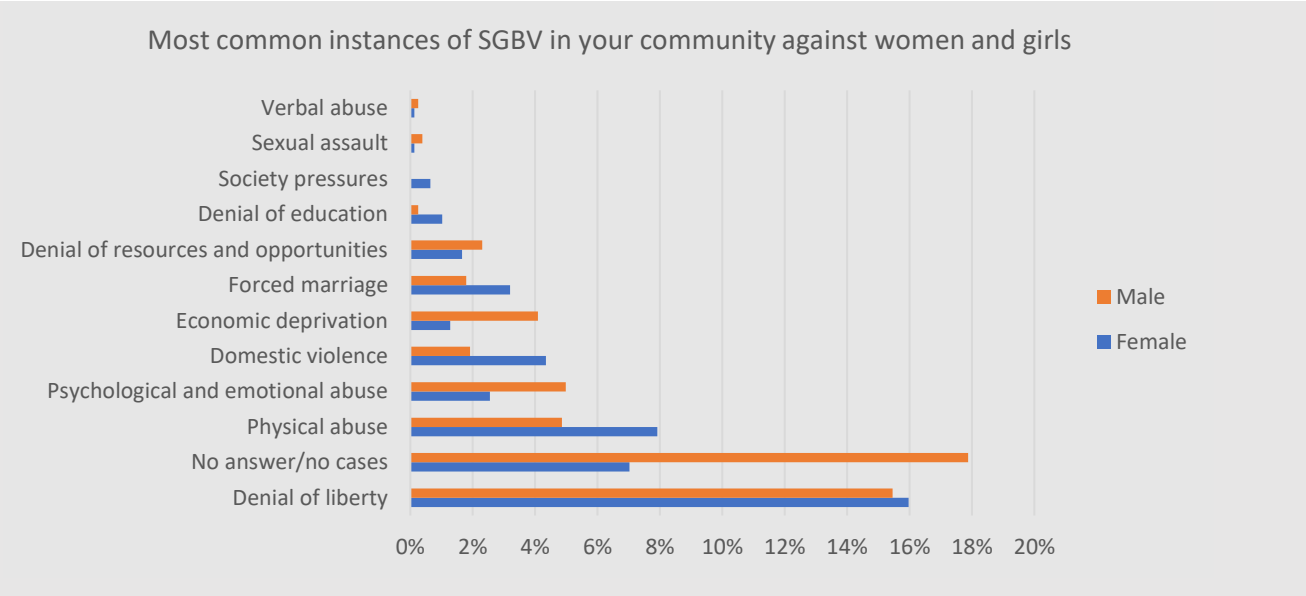

Figure 19: Most common instances of GBV against women and girls in Sinjar district. N=783.

Violence against men and boys means economic deprivation to around 50% (n=392, f: 23%, m: 27%) of the respondents. The other top instances where denial of liberty and denial of resources or opportunities at 32% (n=250, f: 13%, m: 19%) and 28% (n=220, f: 11%, m: 17%) respectively. See Table 19.

Table 19: What do you think the term "violence against men and boys" means?

What do you think the term "violence against men and boys" means?	Respondents (N=783, multiple choices)					
	Female		Male		Total	
	#	%	#	%	#	%
Economic deprivation	182	**23%**	210	**27%**	392	**50%**
Denial of liberty	103	**13%**	147	**19%**	250	**32%**
Denial of resources or opportunities	85	**11%**	135	**17%**	220	**28%**
Don't know / no answer	95	**12%**	93	**12%**	188	**24%**
Psychological and emotional abuse	62	**8%**	121	**15%**	183	**23%**
Forced marriage	85	**11%**	57	**7%**	142	**18%**
Physical Violence	60	**8%**	78	**10%**	138	**18%**
Violence by husbands/ former intimate partner against wives	30	**4%**	42	**5%**	72	**9%**
Violence by others against women and girls	23	**3%**	35	**4%**	58	**7%**
Rape/sexual assault	8	**1%**	49	**6%**	57	**7%**
Violence by family members; father, brother etc. against women and girls	25	**3%**	16	**2%**	41	**5%**
There is no violence against boys	21	**3%**	14	**2%**	35	**4%**

The most common answer provided by the respondents that there are no cases of GBV or none that they know of against men and boys, according to 39% (n=306, f: 17%, m: 22%). Economic deprivation was the second top instance of GBV (32%, n=247, f: 16%, m:15%), see Figure 20. In such cases 63% (n=490) of the men or boys would turn to friends for support, in other 50% (n=393) would turn to the family or 15% (n=120) to the neighbors.

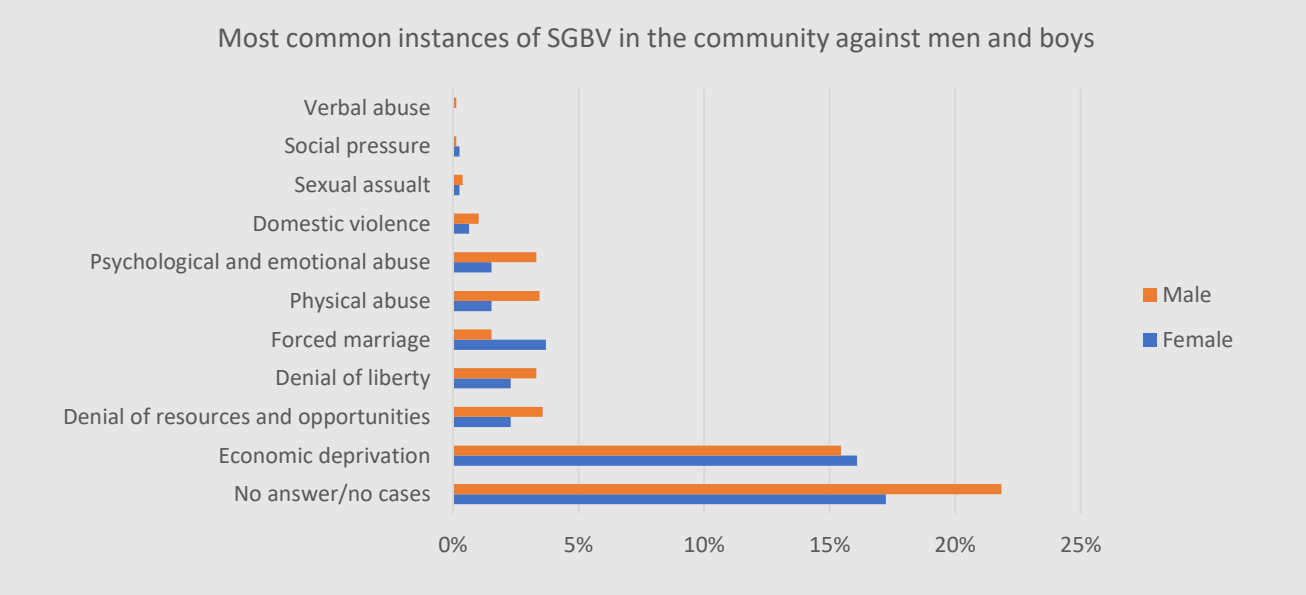

Figure 20: The most common instances of GBV in Sinjar district against men and boys. N=783.

SRMH in Essyan

In Essyan camp 192 women were interviewed to understand the current issues related to sexual, reproductive and maternal health, also to assess the current needs in the health center providing the necessary services.

About 40% (n=77) of the women where in the 15-24 age group and the other 60% (n=115) where in the age 25 and 49. More than the half (57%, n=110) had no formal education and about 23% (n=44) had primary education, See Table 20.

Table 20: Age group and formal education level of the women for the SRMH survey respondents.

	Age Group	#	%
Age group	15-24	77	**40%**
	25-49	115	**60%**
Formal education level	Preschool	7	**4%**
	Primary	44	**23%**
	Secondary	27	**14%**
	Higher Education	4	**2%**
	No formal Education	110	**57%**
	Total	**192**	

The interviews were conducted in the waiting rooms of the health center in Essyan camp and some of the interviews were conducted in the tents.

The Findings

Access to Information and Media

The women were asked about their preferred means of getting news and information in their daily lives. Magazines and newspapers are not favorable for the survey group, about 86% (n=165) do not read magazines at all, and 91% (n=175) do not listen to the radio. The more preferred media was the television with 76% (n=146) daily watchers (see Figure 21). Also, 71% (n=136) had used the internet during the last 12 months. Previously, women received health information through sessions organized by NGOs in the camp, according to key informants.

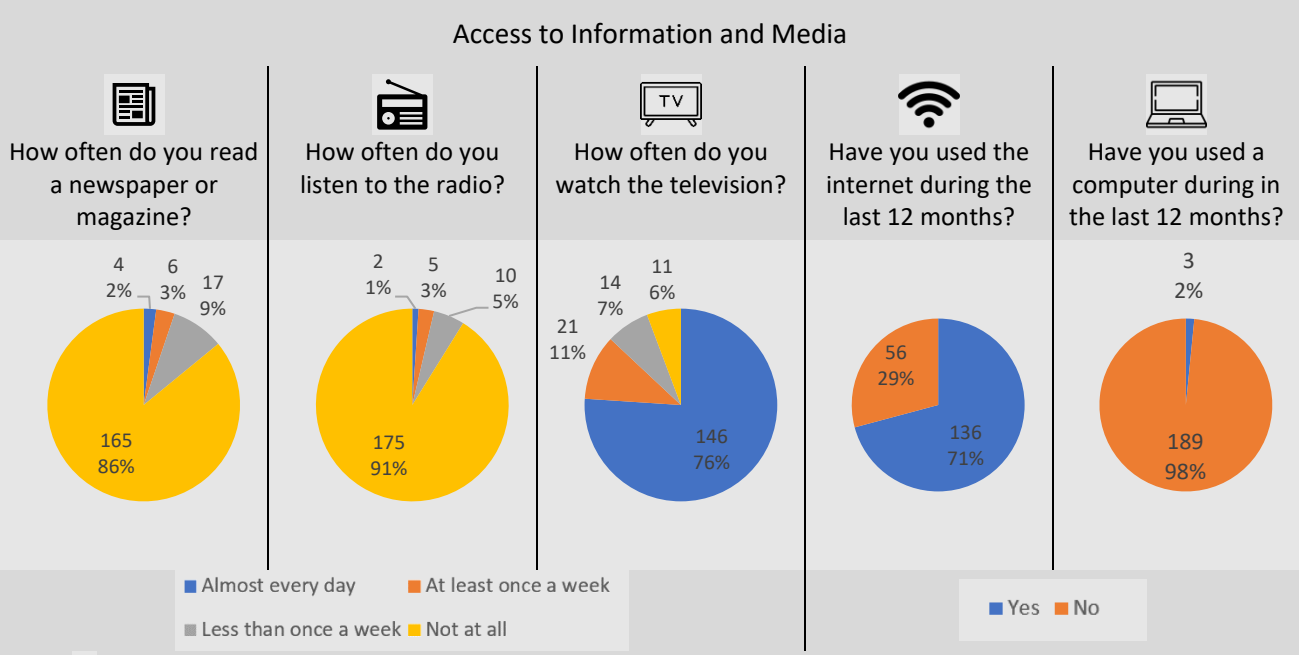

Figure 21: Respondents' access to the different media. Numbers on top are the number of respondents, below are the percentages of all respondents (192 respondents).

Antenatal Care

About 90% (n=173) of the women who took the survey, have had at least one live birth in their lives, and about 64% (n=123) have had a live birth during the last two years before the date of the interview, of which 81% (n=100) were planned or desired pregnancies and 19% (n=23) where not planned.

The 123 women whom had recent pregnancies (two years or sooner), were asked about their antenatal care experience during the last pregnancy, and 95% (n=116) of them reported having consultation visits during the pregnancy, of those 62% (n=72) had 7 to 9 visits, 19% (n=22) had 4 to 6 visits, 9%(n=11) had 10-14 visits and another 9% (n=11) had only 1-3 visits. WHO's most recent recommendation state that eight visits to health providers can reduce perinatal deaths up to 8 per 1000 births when compared to the older four visits recommendations[3].

All of the respondents whom had sought antenatal consultation, reported seeing a doctor at least once, and about 25% (n=29) had seen a nurse or midwife, the rest had either seen an auxiliary midwife, a traditional birth attendant or a community health worker (see Table 21).

Table 21: Healthcare providers seen by the women during their pregnancy for antenatal care. Multiple choices were allowed.

Which healthcare provider(s) did you see during your pregnancy?	No. of respondents	Percentage (n=116)
Doctor	116	**100%**
Nurse/midwife	29	**25%**
Auxiliary midwife	12	**10%**
Traditional birth attendant	7	**6%**
Community health worker	3	**3%**

The majority of the women reported that they were provided with the basic checkups or tests during their antenatal visits, including blood pressure checkup, blood analysis and urine analysis. Also, 61% (n=71) has reported getting at least one tetanus shot during their latest pregnancy, and about 34% (n=39) did not receive the shot, while the remaining 5% where not sure about the injection.

According to the responses of the survey group, the majority (about 88%, n=108) of the women whom had a live birth during the last two years, had given birth in governmental hospitals and about 8% (n=10), gave birth in a private hospital, only a small percentage (1.5%h, n=3) gave birth at home (see Figure 22).

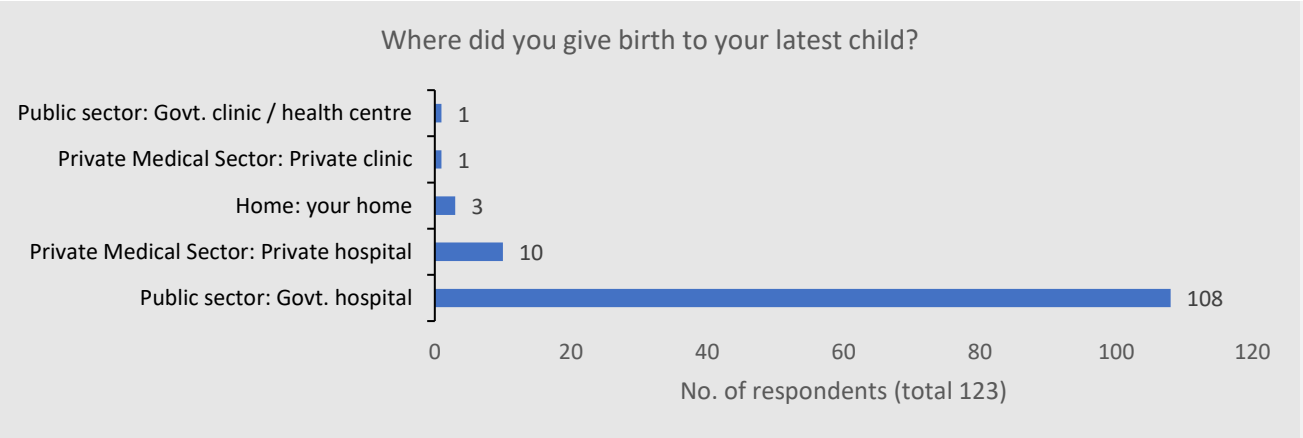

Figure 22: The place where the respondents gave birth to their latest child during the last two years.

[3] New guidelines on antenatal care for a positive pregnancy experience. (2017, December 5). Retrieved June 3, 2020, from https://www.who.int/reproductivehealth/news/antenatal-care/en/

Postnatal Care

The baby delivery for 68% (n=84) of the women was a normal vaginal delivery, and the other 32% (n=39) had a caesarean section delivery. Upon delivery the weight of the baby was average for 83% (n=102) of the cases and 7% (n=9) it was below average. The average birth weight is around 3.5 kilograms[4] and the low birth weight is determined by WHO as 2.5 kilograms[5]

Nearly 77% (n=95) have breastfed their babies. Of those, 32% (n=30) breastfed immediately after birth and 47% (n=45) after an hour to several hours. Some women breastfed the baby several days after the delivery (21%, n=20). See Table 22.

Table 22: Have you ever breastfed your child during the last two years, if yes, how long after the birth?

Have you ever breastfed?		
Response	#	% (n=123)
Yes	95	**77%**
No	28	**23%**

How long after birth did you first put to the breast?		
Response	#	% (n=95)
Immediately	30	**32%**
1 Hour to several hours	45	**47%**
Days after the delivery	20	**21%**

In addition to or in place of breast milk, 53% (n=42) of the women had given artificial milk to their babies during the first three days of its life. Some 48% (n=48) women had given the babies sugar water and 37% (n=29) had fed the baby infant formula, see Table 23 for the list of other substances given to the babies in their first three days of life.

Table 23: Substances that were given to the child to drink other than breast milk during the first three days post-delivery according to 79 respondents out of the 123 whom had a live birth during the last two years?

What substances were given to the newborn during the first three days of its life other than breast milk?		
Responses	#	% (n=79)
Milk (other than breast milk)	42	**53%**
Sugar or glucose water	38	**48%**
Infant formula	29	**37%**
Plain water	3	**4%**
Tea	2	**3%**
Sugar-salt-water solution	1	**1%**
Fruit juice	1	**1%**

Care at the Facility

The women whom had a live birth during the last two years (n=123) were asked about their experience with their latest pregnancy in relation to access to Post-Natal health checkups for them and their babies during the three primary stages, namely, directly after the delivery; during the recovery inside the facility; and after leaving the health facility.

About 80% (n=98) of the women have had health checkups for them and their babies. The checkups were mostly carried out at governmental hospitals -where they most commonly gave birth- and they were performed 1 to 2 times (for 62% of them) and 3 to 4 times (for 27% of them), see Figure 23 (a). Similarly, the women themselves received checkups for 1 to 2 times (60% respondents) and 3-4 times (27% respondents), see Figure 23 (b).

[4] Physical Growth in Newborns. (2018, August, 21). Retrieved September 20, 2020, from https://www.uofmhealth.org/health-library/te6295

[5] Global Nutrition Targets 2025: Low birth weight policy brief. (2014). Retrieved September 20, 2020, from https://www.who.int/nutrition/publications/globaltargets2025_policybrief_lbw/en/

During the recovery period, only about 61% (n=75) of the babies and about 67% (n=83) of the mothers had their health status been checked before discharge, see Figure 23 (c) and (d).

About 38% (n=47) and 42% (n=52) of the respondents reported having access to a health checkup for their babies and themselves respectively, after leaving the health facility. The checkup was done either by a health professional or a friend/relative with experience. About 60% of these checkups happened hours after returning homes (see Figure 23 (e) and (f)).

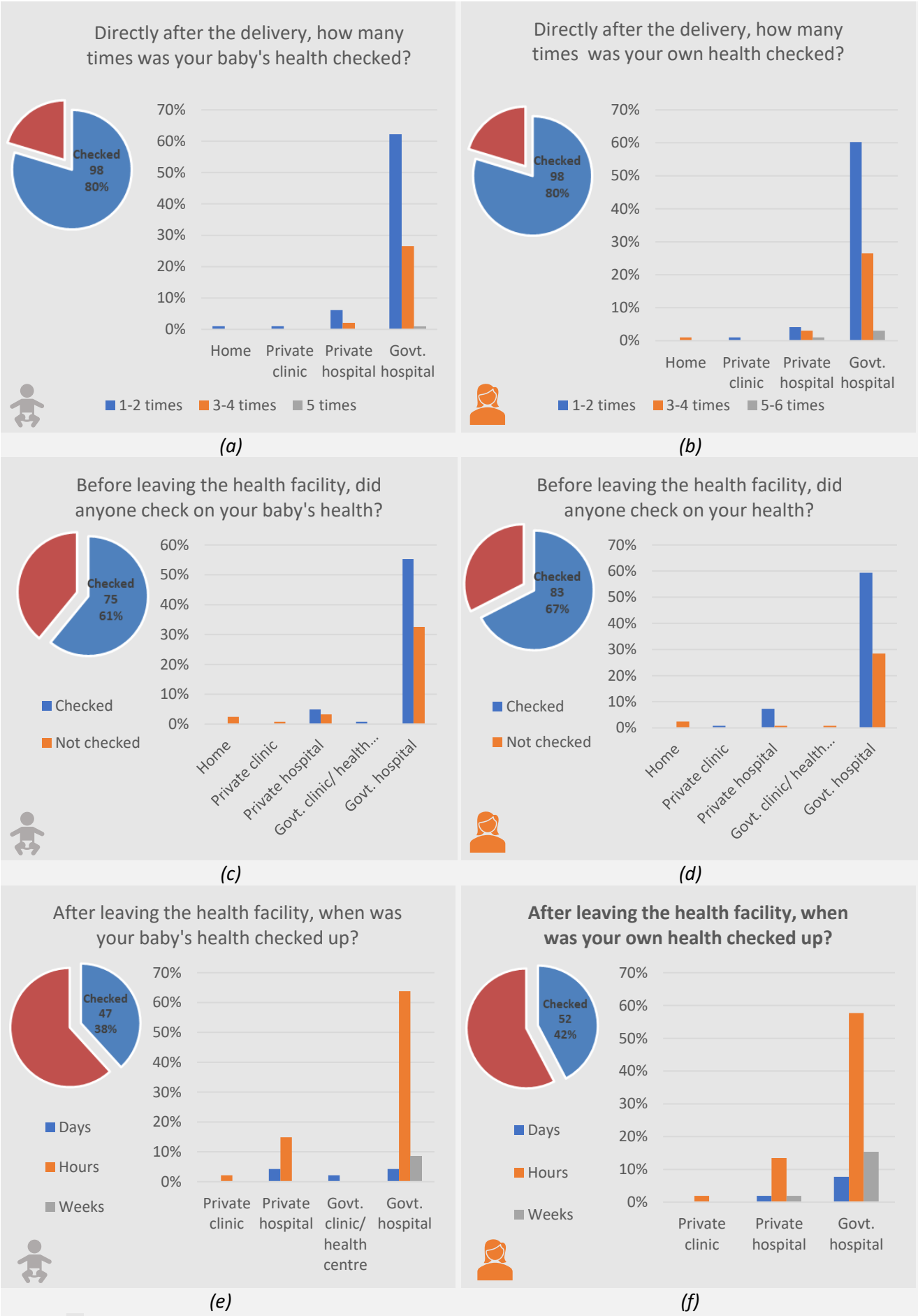

Figure 23: Health checkup access for the child and mother for the women whom had a live birth during the last two years (n=123).

Future plans for pregnancy

Women whom have had previously given birth were asked whether they are planning to have more children in the future, on average 42% of the women preferred to have more children, while about 37% did not want to have more children. Nearly 16% (n=17) of the women in age group (25-49) and 22% (n=15) of the women in age group (15-24) were undecided on this matter. Almost 69% (n=119) of the women whom previously had birth, think they are physically able to be pregnant again, 16% (n=27) did not know whether they were capable of being pregnant, and the remainder 16% (n=27) did not think they are able to, due to cases such as hysterectomy, infections, menopause and other issues.

Nearly 68% (n=49) of the women who would like to have another child preferred to wait for anywhere from one year to several years before having another child. A smaller percentage (14%, n=10) preferred to wait for several months (see Figure 24).

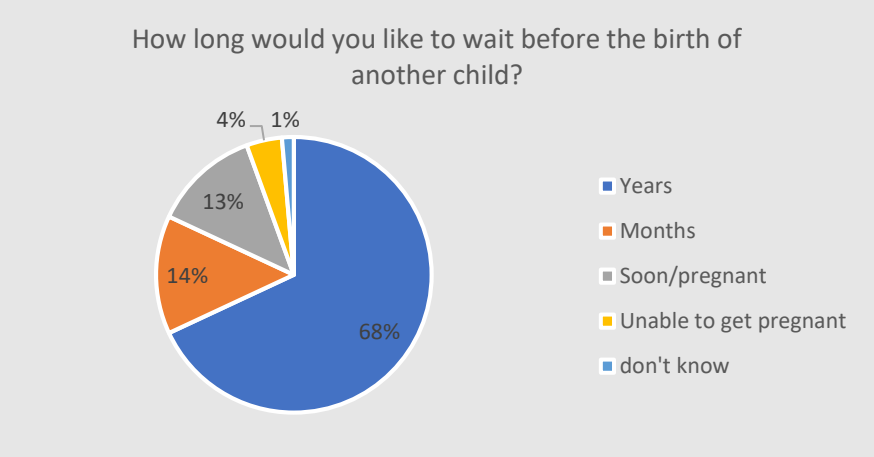

Figure 24: How long would you like to wait before the birth of another child? (n=72).

According to the key informants at the health center, commonly, people over 25 years mostly use contraceptives. Most commonly male condoms and pills are used. Some use intrauterine devices (IUD). The percentage of people using contraceptives are increasing.

Sexually Transmitted Diseases

As an example, on sexually transmitted diseases, the survey group were asked about AIDS and their knowledge of the ways it is transmitted and the society's perception on infected people.

Only 8% (n=15) of the women had some knowledge about the diseases, the remainder 92% had not heard of it. Table 24 shows the responses of the survey group about their knowledge of the disease. This maybe due to the fact that no HIV/AIDS are registered at the health center.

Table 24: The survey group's knowledge of the different aspects of AIDS disease. (15 respondents).

	Yes		No		I don't know	
15 respondents	#	%	#	%	#	%
Can people reduce their chance of getting the AIDS virus by having just one uninfected sex partner who has no other sex partners?	11	73%	1	7%	3	20%
Can people reduce their chance of getting the AIDS virus by using a condom every time they have sex?	8	53%	4	27%	3	20%
Can people get the AIDS virus because of witchcraft or other supernatural means?	0	0%	13	87%	2	13%
Can people get the AIDS virus from mosquito bites?	4	27%	9	60%	2	13%
Can people get the AIDS virus by sharing food with a person who has the aids virus?	3	20%	10	67%	2	13%

Is it possible for a healthy-looking person to have the AIDS virus?	9	60%	3	20%	3	20%
Can the virus that causes AIDS be transmitted from a mother to her baby:						
[a] during pregnancy?	7	47%	4	27%	4	27%
[b] during delivery?	9	60%	3	20%	3	20%
[c] by breastfeeding?	8	53%	3	20%	4	27%
In your opinion, if a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?	6	40%	9	60%	0	0%
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?	5	33%	8	53%	2	13%
If a member of your family got infected with the AIDS virus, would you want it to remain a secret?	7	47%	7	47%	1	7%
If a member of your family became sick with AIDS, would you be willing to care for her or him in your own household?	9	60%	5	33%	1	7%
I don't want to know the results, but were you tested for the AIDS virus as part of your antenatal care?	0	0%	10	67%	5	33%

Key Informants' Findings from the PHCC

Changes to the health of the population since the beginning of the displacement

Mostly psychosocial issues are more prominent with the female patients (30-50 years). The issues are related to fertility, miscarriages, and other maternity problems. They are also related to the camp life conditions. It is also noted that the number of pregnant women is on the increase in the camp.

Regarding the gender of the health provider professionals and the patient they are treating, the majority of the males do not mind being examined by a female physician. Some women find it unfavorable to be examined by male health professionals except in some cases, such as ultrasonic examinations, which can be received better.

Harmful beliefs and practices to the public health

Some (small percentage) families do not prefer their women to give birth in the hospital and rather use traditional birth attendants, however, there are no beliefs or practices that are considered to be harmful to the population.

There is a percentage of the population that beliefs that women cannot visit the health facilities alone even if it is somewhat an emergency case.

Common needs and problems

- Pregnant women whom live far from the PHC and their families do not have cars have difficulty accessing the facility. The center is about 15-17 mins walking (1.5 km) distance from the first sector of the camp (farthest).
- Iron and vitamin D supplements are not available in the center.

Recommendations

Overall Recommendations

- Ensure regular consultations with different groups of women, men, girls and boys with and without disabilities and inclusive and accessible water, sanitation and hygiene services and materials for all communities across project sites about the overall needs and issues appearing with the implementation of garbage collection, dislodging and hygiene awareness, and preferences concerning the services and the locations of service points. Inform the program implementation team with the consultation results.
- Ensure the dissemination of information, education and communication (IEC) is accessible and appropriate for all members of the communities, including women, girls, boys, elderly, people with disabilities, those with low literacy rates or those who belong to the linguistic minorities.
- Ensure collection of sex and age disaggregated data (SADD) as all WASH, protection and SRMH activities must collect at minimum. If possible, make sure using Washington Group Questionnaire[6] to collect disability disaggregated data. Once collected, utilize data to analyse trends to respond and inform programming.
- Ensure coordination with other actors, including government, to provide aid which will respond to the needs and prevent duplication. Active participation in cluster meetings to track services being provided, besides the changing protection risks and vulnerabilities would help to ensure delivery of quality services.

Gender and protection mainstreaming recommendations

- Develop gender and protection mainstreaming tools for the project activities. Some of the resources that can be used are IASC gender handbooks and the GBV guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action.
- Set up a gender-sensitive complaints response and feedback mechanism system to manage protection concerns from women, girls, boys and men equally and take corrective measures by informing project activities.
- Provide safe referrals trainings for the GBV and non-GBV staff to ensure GBV integration to the project.
- Provide awareness raising sessions on sexual exploitation and abuse to the communities; and socialize the Complaints Feedback and Response Mechanism.
- Promote women and girls' leadership in programming and encourage meaningful participation in the activity design.
- Support the targeted community for the creation of a women's safe space to enable women to have safe and appropriate space to gather and discuss issues.
- There is a gap of knowledge in areas related to SGBV based on the responses on what is considered an instance of SGBV. Raising awareness and providing hotline services might prove valuable in this situation.
- A high percentage of people in Sinjar might not be aware on how to access the basic services offered to them, raising awareness is necessary to reduce the protection risk.
- Since the long distance was the most challenging aspect in accessing the basic services in Sinjar, actions might be taken to reduce this risk.

[6] collecting data in humanitarian action using the Washington Group Questions: https://humanity-inclusion.org.uk/sn_uploads/document/2019-01-Factsheet-1-Collecting-data-in-humanitarian-action-using-the-WGQs.pdf

WASH related recommendations

- Coordination with Duhok Directorate of Municipality (DOM) to explore sustainable solution for garbage collection and care & maintenance water network related activities in the camps by taking gender and equity into consideration when adapting the best mechanisms to achieve that.
- Water System Management: The survey and qualitative results suggest that there is substantial diversity in terms of water infrastructure, resources, and facilities in the camps. While it appears, there are regular distributions of drinking water, the consistent availability and quality of water in some sectors such as; sector "B" in Chamishko is uncertain. For example, 95% of the respondents indicated that they rely on water network. Ensuring that camps citizens have consistent access to clean water could be a strong area of focus moving forward in sector "B", particularly where the water source appears to be most uncertain or unregulated/untested.
- Toilet Availability & Maintenance: Although the results from quantitative survey in both camps indicates that all of respondents have access to a toilet. However; the data proofs that there are some issues with toilet cleaning and maintenance. Involving the hygiene promotion team to create awareness about toilet cleaning and link the cleaning with diseases, involving the WASH committee on monitoring of cleaning and training local community members on toilet maintenance could be positive routes for improvement moving forward.
- Toilet Safety & Hygiene: The data suggests that most respondents use toilet and/or bathing facilities shared by both men and women. Most respondents indicated that they felt safe using these areas, although respondents seem to feel much safer in toilets than in bathing areas. Based on the reasons provided by respondents about why they feel unsafe using these facilities, improving the cleaning and maintenance of toilets used by populations would likely help with perceptions of safety. The recommendation is to involve the community hygiene volunteer and WASH committee to create the maximum awareness about the HH level maintenance and cleaning of facilities, since the HH level maintenance is not propose in the GAC project, this comes under the community responsibility.
- Providing Relevant WASH-Focussed Education: The majority of adult and child respondents in Sinjar district indicated that they had not received any training or education in water cleanliness, sanitation, or hygiene. Providing such trainings, particularly ones designed to address particular issues relevant to the community or seasonal concerns – rather than more generic, less-targeted education (Diarrhoeal transmission rotes and prevention matehoods, three pile sorting and water / sanitation ladder) could help expand community knowledge about water, sanitation, and hygiene issues affecting them, their families, and their communities as well as to improve the rates of good WASH practices. Furthermore, it's recommended to use the participator approach for Hygiene awareness, since this approach involves the community is decision make based on evidence and help community to understand the issue in a better way.
- Based on the world health organization (WHO), Iraqi ministry of health (MOH) and cluster approved IEC materials for prevention of COVID-19. The IEC materials must be adapted to the local context in the IDP camps to ensure appropriateness and effectiveness of the messaging (e.g. local dialect, social media campaigns etc.) and used in order to provide the necessary promotion around social distancing, travellers who are sick to delay or avoid travel to affected areas, in particular for elderly travellers and people with chronic diseases or underlying health conditions. As well as general recommendations for personal hygiene, cough etiquette and keeping a distance of at least one metre from persons showing symptoms remain particularly important for all travellers.
- As the camps responses varied considerably regarding their water supply, it is recommended to survey the whole camp to identify the low flow areas and factor contributing to the problems and develop a concrete plan to overcome the issue.

- Create awareness about the pest and insect control, highlight the poor practices of environmental sanitation that cause the insects breeding in the camp and Sinjar and make plan to get ride of issue.
- As the returnees and displaced people suffer from the economical hardships, it certainly affects the hygiene and health of their households. Income sources such as cash for work opportunities in Sinjar Districts can contribute to the alleviation of the sufferings.
- Work on preventing burning the garbage both in the camps and in Sinjar district because of the potential health risks. This can be done through increasing the solid waste collection trips and through raising awareness among community.
- Use participatory approach and interactive methods in hygiene promotion to close the gap in knowledge of the handwashing and other hygiene practices.
- It has been recorded that community presumption about the water quality is not good, they believed that water is not safe for drinking, therefore it is recommended that do the comprehensive water quality analysis and distribute the water filter, if water quality food not potable.

Sexual Reproductive and Maternal Health (SRMH) related recommendations

- Based on the above findings and in consultation with SRMH team. Project team may wish to consider increasing quality essential sexual reproductive and maternal health services in Essyan PHCC through providing required materials, capacity building of Ninawa and Duhok DoH staff (as the facility has staff from both governorates), promote sexual reproductive and Maternal health (SRMH) messaging among the communities, this will be done through door too door visits with strict commitment to wearing Personal Protective Equipment (PPE) and implementation of Physical distancing. More specifically, the following recommendations can be considered to increase access of target beneficiaries to essential primary SRMH in the targeted primary health care centre (PHCC).
- (Supply Side- Access & Quality) System Strengthening to expand services and improve quality: Improvements during the neonatal and postnatal period can have a significant impact in reducing early child mortality and improving overall health outcomes for children. Hence, the main focus should be an overhauling of the whole system with particular focus on Improving access to Services, quality of services in the PHCC, capacity building of the PHCC staff through provision of essential training, replace non-functioning equipment, provision of essential new laboratory devices and kits and accurate information from Health Management Information System (HMIS), Monitoring and Supportive Supervision.
- (Demand Side) Raising awareness of Care Givers and improved practices at Community: Capacity should be bolstered to deliver parenting education and community awareness programmes, with a particular focus on promoting new-born care, infant and young child feeding and vaccinating the children as per the schedule of Iraqi DOH and targeted PHCC. Campaigns will need to be holistic, targeting all caregivers including community leaders and caregivers at tents. They will also need to address social and gender norms, including consanguinity and early marriage (to avoid congenital anomalies), raising awareness of the risks and providing links to relevant support services like professional bodies and care providers in health facility as well.
- Provision of required medical instruments, equipment and utilities.
- Organize integrated awareness-raising sessions in the catchment area of Essyan PHCC in Essyan camp, targeting adolescent and young first-time mothers to improve their knowledge on relevant subjects such as baby-adequate nutrition, nutrition during pregnancy, breast feeding, hygiene, and sexually transmitted diseases during outreach. The awareness sessions should be according to international standards (by UNFPA, UNICEF, Health Cluster), i.e. on breast feeding versus industrial milk for babies, on family planning, pre-and postnatal clinical care, childhood vaccinations as well as nutrition for new-born and pregnant

women. Community health workers can be engaged ensuring appropriate gender balance due to cultural constrains in a male dominated community and sensitivity of the suggested SRHM topics with women.

- Provision of essential nutritional supplements for pregnant women and new-borns as well as contraceptives, laboratory support (essential lab equipment, consumables, kits and reagents) and provision of medical equipment and consumables to PHCC.
- Support Ninewa and Duhok DoH to prepare a sustainability plan to ensure that activities continue after the end of the project. This can be done by the capacity building of PHCC staff (female doctors) on SRMH, referrals and maternal/children's health including IUCD insertion and sonography for pregnant women.
- Based on the above findings, one activity should address the nutritional requirements of pregnant women and small children. Pregnant women should receive micronutrient supplements (Standard package of iron, folic acid and Vitamin A) during their regular Antenatal (At least 3 ANC visits during the whole pregnancy) consultations in primary health care facility in order to improve the nutritional status, development and health of infants and young children by supporting optimal feeding practices. Awareness creation, the commitment of public health facilities and the creation of an environment that helps families to take informed decisions is needed.7 The promotion of exclusive breastfeeding in the first 6 months as well as the additional supplementation with Vitamin D for infants is related measures, with positive long-term effect.
- Based on the world health organization (WHO), ministry of health (MOH) and cluster approved IEC materials for prevention of COVID-19. The IEC materials must be adapted to the local context to ensure appropriateness and effectiveness of the messaging (e.g. local dialect, social media campaigns etc.) and used in order to provide the necessary promotion around social distancing, travellers who are sick to delay or avoid travel to affected areas, in particular for elderly travellers and people with chronic diseases or underlying health conditions, also instructions for home isolations for COVID-19 mild cases As well as general recommendations for personal hygiene, cough etiquette and keeping a distance of at least one meter from persons showing symptoms remain particularly important for all travellers
- Based on the survey findings, provision of COVID-19 pandemic related trainings to health care professionals in the PHCC is highly recommended. CARE might want to organize essential trainings for the doctors and midwives and nurses working in the PHCC. The training must include essential concepts on how to deal with suspected COVID-19 cases and proper referral pathway.
- The survey showed that about 4% of the deliveries are still being done at homes. Interventions might be necessary in the form of awareness messages to further limit this practice.
- The fact that the usage of the internet among the women in Essyan is spread to a good extent can be an opportunity to messages about SRMH, family planning and sexually transmitted diseases.

[7] WHO/UNICEF, Global Strategy on Infant and Young Child Feeding (2003).