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Trauma recovery for Yazidis after the 2014 ISIS genocide:

international approaches and policy recommendations

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Table of Contents

List of Abbreviations

BÄK – German Medical Association (Bundes Ärzte Kammer)
BAfF – German Federal Working Group of the Psychosocial Centres for Refugees and Torture Victims (Bundesweite Arbeitsgemeinschaft der psychosozialen Zentren für Flüchtlinge und Folteropfer**)**
BAMF – German Agency for Migration and Refugees (Bundesamt für Migration und Flüchtlinge)
BA – German Federal Employment Agency
BVOR – Blended Visa-Officer Referred
C-PTSD – Complex post-traumatic stress disorder
CCNP – Community Connections for Newcomers Program
DGPPN – German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology
FYF – Free Yezidi Foundation
GAR – Government-Assisted Refugees
GIZ – German Society for International Collaboration
IASC – Inter-Agency Standing Committee
ICC – International Criminal Court
IRCC – Immigration, Refugees and Citizenship Canada
IDP – Internally Displaced Person
IPP – Institute for Psychotherapy and Psychotraumatology
ISIS – The Islamic State of Iraq and Syria
KRI – Kurdistan Region of Iraq
MFT – Multi-family therapy
NGO – Non-governmental organisation
NI – Nadia's Initiative
OE – Operation Ezra
PKK – Kurdistan Workers' Party
PSR – Private Sponsorship of Refugees
PSZ – Psychosocial Centre
PTSD - Post-traumatic stress disorder
SGBV – Sexual and gender-based violence
UNFPA – United Nations Population Fund
UNHCR – United Nations High Commissioner for Refugees
USAID – United States Agency for International Development
UYCA – United Yezidi Community of America
VoE – Voice of Ezidi
YCC – Yazidi Cultural Center (U.S.)
YPG – Syrian Kurdish forces

Executive Summary

This report complements the RESPOND research (www.respondmigration.com) on migration and immigrant integration by bringing the focus on a specific case, the trauma recovery of Yazidis with an explicit emphasis on their psychosocial needs. To this respect, it draws data and findings from international guidelines in approaching trauma recovery from a holistic perspective and includes also the importance of cultural identity as a contextual factor for understanding trauma recovery dynamics in the context of forced displacement and settlement in a new country. In addition to surveying the existing literature around psychosocial needs of refugees and Yazidis in particular, this report benefits from insights gained during interviews with representatives of Yazidi-run non-profit organisations involved in psychosocial support and advocacy programmes. Many of the lessons learned from the research in this report are also applicable to other refugee populations as they point to general structural shortcomings of national and international support systems, as well as to efforts targeted at addressing these shortcomings.

In 2014, the militant group that calls itself the Islamic State of Iraq and Syria (ISIS) attacked Yazidi settlements in Northern Iraq in their efforts to rid the region of non-Islamic influences. The Yazidi are an ethno-religious minority in Iraq, Syria and Turkey and have experienced religious discrimination and persecution for centuries. During the 2014 genocide, ISIS committed crimes against humanity by murdering over three thousand Yazidis and abducting even more Yazidi women and girls to force them into sexual slavery, while the abducted boys were trained and used as child soldiers for ISIS. More than 400,000 Yazidis fled their homeland. The majority of Yazidis remained in Iraq under the status of internally displaced persons (IDPs). Many Yazidis also sought refuge in other countries around the world.

The atrocities committed by ISIS have traumatised the Yazidi community. With memories of fear, persecution and terror still plaguing the minds of survivors and further effects on the global community, mental health conditions such as depression, anxiety and most notably post-traumatic stress disorder (PTSD) place a tremendous burden on Yazidis. Even though ISIS occupation has ended, the collective trauma of the Yazidi community is ongoing.

In this report, we outline the challenges to trauma recovery for Yazidis, particularly in terms of their psychosocial needs. We follow existing international guidelines in approaching trauma recovery from a holistic point of view that not only requires mental health support but also highlights the importance of cultural identity and rebuilding of future prospects. As a result, we also take into account structural, political and judicial issues that stand in the way of trauma recovery. We discuss the humanitarian and political situation in Iraq and describe the service landscape of healthcare providers and factors affecting mental health in other countries where Yazidis have found refuge after the 2014 genocide, including Canada, Germany, the Netherlands, the UK and the US. We consider their asylum and resettlement programmes and their mental healthcare systems and discuss strengths and weaknesses both with respect to support for Yazidis specifically but also refugees more generally. We draw from prior research and our interviews with Yazidi organisations to describe current approaches to provide psychosocial support, remaining challenges, and policy recommendations to aid trauma recovery.

The report opens with a brief introduction to the Yazidis, their culture, and their status in Iraq, where Yazidis struggle to maintain a separate identity from the Kurds and where they face challenges such as discrimination and voter suppression. We further describe the events of the 2014 genocide, which included the strategic use of sexual and gender-based violence against Yazidi women and girls on the one hand and the forced militarisation of young Yazidi boys on the other, both of which were meant to erase their cultural identity and turn them against their Yazidi community.

Subsequently, the concept of culturally sensitive mental health care is introduced, which is based on an understanding that mental wellbeing is rooted in the culture and religion of Yazidis and that Western treatment methods for PTSD may therefore not be applied to the Yazidi community due to their specific experiences of trauma and their attitudes to mental

health. Existing therapeutic approaches therefore require adjustments, but Western countries mostly fail to integrate even the most basic culturally sensitive practices into their services.

There is a general consensus among experts and Yazidi NGOs that only a holistic approach that considers psychiatric and psychological aspects as well as social, economic, cultural, religious, judicial and political issues can achieve recovery from the severe personal and transgenerational trauma. Professional standard psychiatric healthcare, psychotherapy and psychosocial support are important but by themselves are insufficient in relieving trauma in refugees and IDPs because they cannot address the structural determinants of wellbeing. We therefore collectively refer to specific mental health care and other services that support wellbeing and stability, such as educational, social, cultural and vocational activities, as mental health and psychosocial support (MHPSS) services. Our interviews with Yazidi NGOs and prior research have shown that cornerstones of successful MHPSS services for refugees and in contexts with limited resources specifically are cultural sensitivity, capacity building and training of new staff, coordination of multiple actors through an expert centre, holistic approaches to wellbeing, community engagement, low-threshold access and effective referral pathways. Approaches including aspects of stepped care and peer support as well as one-stop models in which multiple MHPSS services are accessible through one provider are particularly successful because they optimise the distribution of limited specific psychiatric and psychotherapeutic services, foster trust in mental health care services, reduce stigma around mental health problems, and lower the barrier to access to multiple different support services.

Finally, it is not only individual trauma treatment that is crucial to overcome the horrendous experiences following from the genocide, but also the need for political support, justice, new opportunities and protection of a shared heritage that allows survivors to deal with the loss of their homeland and the assault on their culture. Support from the Iraqi governments and the international community will be vital in addressing these challenges.

Internally displaced persons in Iraq

In Iraq, NGOs and the government are using stepped care, peer support systems and capacity building to maximise the reach of their limited resources for the large IDP population. The Kurdish Regional Government (KRG) has collaborated with NGOs and international experts to build a trauma network with a coordinating centre that can connect different service providers. This system is effective in sharing expertise and training new staff to provide culturally sensitive MHPSS. These capacity building activities are crucial in building a sustainable mental health service landscape in Iraq, which is particularly important given a prior complete lack of psychotherapists in the country.

The stepped care approach has been adopted by many NGOs working in IDP camps. This system is based on the observation that mild to moderate mental health problems do not necessarily require specialised psychiatric care. Providers follow a care pyramid where basic stabilisation approaches and psychoeducation about coping strategies and emotion regulation are rolled out broadly by trained laymen. These are supervised by social workers or psychotherapists. For those in need of more psychological support, referrals can be made to group therapy and severe cases may be provided specialised individual psychotherapy or psychiatric care. This approach frees up the few specialised clinicians who can then focus on the most severe cases. In many cases these services are supplemented with social activities, educational and vocational opportunities for women and children which can serve to regain a sense of community and future prospects. Outside the camps, a few survivor centres are specialised in caring for victims of ISIS. These centres provide medical support, including gynaecological and psychological care, typically for women and their children but in some cases also for families.

Despite these efforts, mental health and psychosocial support services cannot even come close to reaching all those in need due to the large IDP population in Iraq. Yazidi NGO representatives note that remaining challenges are manifold. Reintegration of returnees from ISIS captivity with members of their family often poses difficulties and should be supported by more family-based psychotherapy. Stigma around mental health and feelings of shame and guilt as a result of sexual violence or forced militarisation hamper help seeking behaviour. The

psychoeducation approaches supported by trained members within the Yazidi community have been successful in reducing stigma but more needs to be done. In many cases, men are not sufficiently integrated into mental health programmes, which may reduce their effectiveness. Treatment tailored to the specific needs of children, especially for those who survived forced militarisation and sexual violence, are still mostly lacking.

The most pressing issues to the Yazidi community are the return of hundreds of captives remaining with ISIS; safety to guarantee their return to their homelands in Sinjar, which is particularly challenging due to the region's status as a disputed territory which means that neither the Iraqi nor the Kurdish Regional Governments feel responsible to support Yazidis in this endeavour; justice and accountability for ISIS fighters for their crimes against Yazidis specifically, which is still lacking due to little action by national and international governments; and to many women, the acceptance of their children which were born from rape during ISIS captivity. The integration of these children into the Yazidi community requires 1) a decree from Yazidi religious leaders to overcome the endogamy doctrine which dictates that a child can only be Yazidi if it is born to two Yaizdi parents, and 2) overwriting the Iraqi law that states all children born to Muslim fathers are Muslim regardless of their mother's religion. Neither necessity is currently being met. Moreover, accepting children born to the perpetrators of the genocide is particularly challenging to many Yazidis. These issues strongly affect the mental health of many Yazidis and require urgent action from the Kurdish Regional Government (KRG) and the Central Iraqi Government, the Yazidi community itself and international actors.

Finally, the COVID-19 pandemic has posed major problems as NGO staff are forced to leave the country, halt many of their services, or adjust their approaches. For instance, staff of the major Yazidi organisation *Yazda* have taken steps to move their mental health and psychosocial support programmes to a remote system by distributing phone credits, while FYF workers changed from a focus on tent visits to one on capacity building by training new Yazidi peer supporters. Despite these efforts, mental health problems are worsening as a result of the pandemic. Moreover, the crowded conditions in camps provide a high-risk breeding ground for the virus and social distancing and mask wearing are only partially effective. More support is urgently needed to prevent major chronic mental health conditions in the IDP population.

Mental health of Yazidis and refugees in other countries

The degree and type of psychological and political support available to Yazidis varies considerably by country. Nonetheless, upon analysis, a common theme emerges that applies to all countries that host Yazidis: language barriers have yet to be overcome, differences in attitudes towards mental health problems remain, ignorance of many service providers regarding the need for cultural sensitivity is common and issues regarding accessibility of treatments persist. Existing shortages in mental health services further exacerbate these problems.

Stability is a fundamental prerequisite before active steps towards psychological rehabilitation can be considered, yet the uncertainties associated with the asylum process and crowded living conditions can keep refugees from gaining a sense of stability even after having arrived in the host country (Heinrich Böll Stiftung, 2018; Interagency Standing Committee, 2007; Kizilhan & Noll-Hussong, 2017). A prospect of a more stable future with economic autonomy is essential if mental health is to be regained in the long-term. Yet, in many countries hosting refugees, this cannot be guaranteed.

In many of these countries, members of the Yazidi diaspora themselves have significantly contributed to improving conditions for ISIS survivors either in lobbying their governments to provide support through visa programmes and funding of humanitarian efforts in Iraq, or by founding non-governmental organisations that stepped in to provide specialised programmes for Yazidis both in Iraq and abroad.

Germany

Germany is the only country that developed a specialised care programme for Yazidis. Under the Special Quota Programme, 1100 Yazidi women and children who had returned from ISIS captivity were invited to Germany and were provided with specialised mental health care. The Special Quota Programme has drawn from expertise from within the Yazidi community: Prof Kizilhan as a member of the Yazidi community and a specialist in psychotraumatology was the lead of the programme and Yazidi religious leaders supported the initiative. Service providers were trained in culturally sensitive psychotherapy and psychiatry and a stepped care approach was used to optimise resources. The programme has also contributed to many important scientific insights on mental health in Yazidis and in victims of SGBV more generally. However, the resource intensiveness of this programme means that not all in need could be included in such initiatives. Yazidis outside this programme face the same challenges as refugees in Germany more generally.

Officials and professionals in Germany are aware of the need for holistic approaches to mental health but structural barriers pose a challenge for far-reaching coverage of mental health and psychosocial services. The majority of deficits in the German MHPSS system can only be solved through structural changes (BAfF, 2019b). The mental health crisis of refugees in Germany requires fast intervention but increasing the number of psychotherapists is an untenable solution in the short-term given the long duration of the degree. Peer supporters and stepped care approaches are promising options to address the shortage of services (BAfF, 2019b). Given that structural changes are generally slow in the making, community action and support from humanitarian and privately sponsored organisations may be a more realistic aid in the short term.

Canada

Since 2017, Canada has resettled over 1000 Yazidi refugees under its 'Survivors of Daesh' program. The majority are government-sponsored and resettled as permanent citizens, and therefore have access to all provincial health services. The Interim Federal Health Program and Immigration, Refugees, and Citizenship Canada (IRCC) provide additional MHPSS services on top of this, including counselling and therapy sessions. However, these services are not extensively utilised by Yazidis. Those who do try to access them face many obstacles, including language barriers, domestic responsibilities and a lack of cultural sensitivity in treatment. There is a chronic shortage of Kurmanji interpreters to assist with medical appointments for Yazidis.

Local non-governmental organisations that support Yazidi refugees observe that the most effective mental health treatments for Yazidis are holistic, taking into account all of Yazidi's settlement needs. This should include additional childcare support, help booking medical appointments, assistance with grocery shopping and volunteers to transport Yazidi refugees to their destinations. Promising examples in Canada include Aurora Family Therapy's psycho-social settlement needs assessment and Operation Ezra's communal farming project. If social, economic and cultural conditions are stable and accepting, then those with pre-existing health problems can concentrate more time on becoming mentally and emotionally well.

United States

The US have no dedicated resettlement programme for survivors of the 2014 genocide. They do have a long-standing programme to allow Yazidis who worked for the US military in Iraq and Syria to settle in the US. Over 1000 Yazidis have arrived since the genocide, mostly settling in the largest Yazidi community in the US, in the city of Lincoln, Nebraska. There is a broad variety of MHPSS services provided to Yazidis in Lincoln, ranging from support to access healthcare, education and work, to culturally sensitive counselling for refugee school students, to a trauma treatment programme delivering Narrative Exposure Therapy and peer support groups. This support is offered both through local charities supporting refugees generally and through local Yazidi community organisations. However, there is still only limited understanding of whether these programmes are meeting the needs of Yazidi refugees in

Lincoln due to limited publication of any evaluation of these programmes. Yazidis in Lincoln have cited the high cost of healthcare in the US as a key issue they face. Those living outside Lincoln likely face more problems accessing appropriate services given the absence of dedicated MHPSS services for Yazidis.

United Kingdom

The UK has provided aid to assist Yazidis in Iraq but has been criticised for its lacklustre approach to welcoming Yazidi refugees to the UK. The number of Yazidi refugees currently residing in the UK is unclear. Despite widening of the Vulnerable Persons Resettlement Scheme in 2017 to include Yazidis, few appear to have been resettled under this scheme, and concerns have been raised over denial of Yazidi asylum applications. Post-migratory factors often worsen UK refugee mental health. These factors include difficulty securing accommodation and employment, due to administrative shortcomings and the brief 28-day window after allocation of refugee status before withdrawal of government support. Barriers to accessing healthcare include refugees' lack of knowledge of NHS structure and services; inadequate awareness in the NHS of their eligibility for treatment; logistical difficulties such as cost and transport; language barriers; and discrimination when accessing healthcare. The UK should make efforts to ensure basic accommodation and financial needs are met, especially in vulnerable refugees who may struggle to cope with the short 28-day period given to support themselves. Especially Yazidis, with their complex mental health problems, may be more unlikely to establish themselves in the UK and may require more support beyond the "move on" period. The UK should also expedite mental health treatment by improving pre-resettlement screening to identify those in most need. NHS staff should be trained to understand eligibility of asylum seekers and refugees for healthcare. Discriminatory processes within the NHS should be identified and removed. Provision of English language lessons and use of interpretation services in healthcare consultations are essential in allowing refugees to overcome challenges with integration and access to care. Community interventions and basic psychoeducation material may serve to reduce stigma surrounding mental illness.

The Netherlands

An unknown number of Yazidi refugees have settled in the Netherlands since the 2014 genocide, without any dedicated resettlement program. Due to 'spatial dispersal' policies in the Netherlands, Yazidi refugees are most likely scattered across the country, making it difficult to provide specialised MHPSS services for traumatised Yazidis. Such dispersal policies should be rethought critically while bearing in mind that they may be particularly detrimental to members of particularly small and vulnerable communities such as Yazidis. Half of refugees in the Netherlands with PTSD only begin experiencing symptoms a few years after arriving in the Netherlands, and so the need for treatment among Yazidis may still be growing. There is an urgent need for the Dutch government to fund research into the mental health needs of the country's Yazidi refugee population, in order to determine whether general services across the municipalities of the Netherlands are adequately supporting Yazidi refugees, and provide any services which are missing. This will likely include the need for interpreters and mental health professionals trained in providing culturally sensitive MHPSS services.

Conclusions

Across countries examined here, structural barriers are manifold and will take substantial effort to overcome, both on the national and international level but also from within the Yazidi community. Nonetheless, there are low-threshold approaches through which Yazidis and refugees more generally could be supported in their trauma recovery. Providing Yazidis with culturally appropriate information on psychological stabilisation, the local healthcare system, the asylum process, vocational opportunities and employment could have small but positive psychosocial effects. Similarly, distributing such information to local care providers could facilitate a mutual understanding. Through the use of online materials and remote translators more refugees could be reached. Peer support systems could be established even without

governmental involvement, either through local Yazidi communities or by NGOs. Many of the more targeted, culturally appropriate MHPSS services available to Yazidis are run by NGOs rather than government programmes. Collaboration between government and NGOs could be a short-term option to improve capacity and coverage of these programmes if bureaucratic hurdles prevent any immediate action in adjusting existing governmental support structures. A full list of recommendations can be found in the last chapter of this report.

Brief Introduction

This report is prepared within the framework of EC Horizon 2020 RESPOND project (www.respondmigration.com) and conducted in collaboration with Polygeia Global Health Think Tank.

In this report, we outline the challenges to trauma recovery for Yazidis with a specific emphasis on their psychosocial needs. We follow existing international guidelines in approaching trauma recovery from a holistic point of view that not only requires mental health support but also highlights the importance of cultural identity and rebuilding of future prospects. As a result, we also take into account political and judicial issues that stand in the way of trauma recovery. A major focus is on the humanitarian and political situation in Iraq.

We also consider other countries where Yazidis have found refuge after the 2014 genocide, including Canada, Germany, the Netherlands, the UK and the US. We consider their asylum and resettlement programmes and their mental healthcare systems and discuss strengths and weaknesses both with respect to support for Yazidis specifically but also refugees more generally. We draw from prior research and interviews with Yazidi organisations to describe current approaches to provide psychosocial support, remaining challenges, and policy recommendations to aid trauma recovery.

Methodology

The findings presented in this report draw on a combination of methods used for data gathering and analysis: 1) literature searches for scientific peer-reviewed papers and grey literature, and 2) interviews with representatives from relevant organisations that provide psychosocial support to Yazidis.

A systematic literature search for peer-reviewed scientific papers on mental health in Yazidis was carried out using the search terms (Yazidi OR Yezidi OR Ezidi) AND ("mental health" OR trauma OR depression OR wellbeing or "psychosocial support" or therapy) on Pubmed (identified 62 records) and PsycInfo (identified 51 records). Further sources were identified by screening references from relevant articles. Through this search, 35 articles were identified as relevant for this report.

Multiple searches for grey literature such as policy reports, official government documents and other relevant material were carried out on Google. The exact terms of the literature search depended on the respective section, i.e. specific searches were carried out for Iraq, Germany, Canada, the US, the UK and the Netherlands. The searches that focused on psychosocial support and healthcare included terms specific to a given country and terms pertaining to Yazidis (Yazidi, Yezidi, Ezidi), refugees (refugees, internally displaced persons) and mental health (healthcare, trauma treatment, wellbeing, mental health, therapy, psychosocial support). Given limited number of hits for the searches on individual countries, the first 50 sources were screened for relevance. A more general search was also carried out to identify other literature pertaining to policies (policy, whitepaper, working paper) relevant to Yazidis (Yazidi, Yezidi, Ezidi) and refugee mental health. Given a larger number of potentially relevant hits, the first 150 search results were screened for relevance.

For the interview process, relevant organisations were identified via two routes: 1) an internet search of potentially relevant organisations working to provide psychosocial support either directly to Yazidis or to groups that might include Yazidis was conducted using search terms pertaining to Yazidi, trauma treatment, psychosocial support, and internally displaced persons in Iraqi camps or Yazidi refugees in other countries of interest for this report (Germany, Canada, the United States, the United Kingdom, and the Netherlands), and 2) following on from literature sources included in this report or referrals from representatives of non-profit organisations that were contacted with requests for interviews.

Thirteen relevant non-profit organisations were contacted: nine were Yazidi-run organisations or organisations whose primary focus is the support of the Yazidi community (Free Yezidi Foundation, Helpt Yazidis, Nadia's Initiative, Voice of Ezidi, Yazda, Yazidi Association of Manitoba, Yazidi Legal Network, Yezidis International), and four were other organisations with initiatives to either specifically help Yazidis or to support vulnerable groups of refugees that also included Yazidis (Action for Women and Assistance to Minorities in the Middle East - AFAM, AMAR Foundation, the Jewish Federation of Winnipeg, STARTTS). In addition, the London Cross Cultural Learner Centre and Merrymount Family Support and Crisis Centre in Canada were contacted for information on their Yazidi Refugee Peer Support Programme. Four organisations responded to requests for information on their approaches to psychosocial support for Yazidis. These organisations were Yazda (multinational), the Free Yezidi Foundation (Netherlands), Voice of Ezidi (France), and Operation Ezra run by the Jewish Federation of Winnipeg (Canada). In total, eight representatives were interviewed using a semi-structured interview format. This format was chosen because of the differences between organisation in terms of location, activities and approaches to mental health and psychosocial needs.

1. Introduction to the Yazidis

Author: Jai Shende

The Yazidis are an ethno-religious minority indigenous to the area that is now Northern Iraq. Other Yazidi communities in the region also live in Syria and Turkey. They speak Kurmanji, a northern Kurdish dialect. They also practice Yezidism, an ancient faith that predates Islam and shares some religious practices with the Abrahamic faiths (Islam, Judaism and Christianity). It is a monotheistic religion revolving around the worship of seven angels and their leader Tausi Melek (the Peacock Angel). Yazidi leaders advocate strict endogamy, as one cannot convert to Yazidism. To be Yazidi, one must be born to two Yazidi parents. Estimates of the global Yazidi population are around 700,000 (Standing Committee on Citizenship and Immigration, 2018). Before 2014, the majority - around 400,000 - lived in the Sinjar region in Nineveh province. The Yazidis have faced a long history of persecution, having been accused of devil worship and often being decried as pagans or infidels.

According to dominant Yazidi discourse, the 2014 ISIS genocide in Sinjar represented the 74th Firman (persecution) in a long chain of Firmanat, which has aimed at the eradication and annihilation of the Yazidis. These incidents include pogroms in the late 19th and early 20th centuries, as well as the more recent terrorist attacks in 2007 which killed around 800 Yazidis. These incidents of persecution have strengthened the distinct Yazidi identity through a sense of shared trauma that has emerged from fear of religious persecution (Barir, 2014).

On an everyday basis, they face discrimination from local authorities and from their Muslim Kurdish neighbours. Moreover, under the current Iraqi legal system, they are denied the equal power of testimony and equal rights in the courts. There is no acknowledgement of Yazidism as a legitimate religion. Even in government, they are referred to as a sect as if they were a subgroup of Islam, when in fact they have their own distinct religion. While Yazidis are allowed to vote, their votes are often manipulated to weaken their influence (YAZDA, 2017). For example, in the majority-Yazidi Sinjar region, the winning candidates are almost always Muslim Kurds, leading to credible claims that Yazidi votes are being suppressed (Wing, 2014).

The Kurdish Relationship

The Yazidi community is divided in terms of their views on their ethnic identity. Some Iraqi Yazidis identify as Kurdish, whereas others hold that Yazidis constitute their own distinct ethno-religious and ethno-nationalist group (Spät, 2017). As a result, a significant number of Yazidis are increasingly worried that a foreign identity is being imposed upon them. For example, during Ba'ath rule, the Yazidis were 'Arabised' under Saddam Hussein's Arabic nationalism (YAZDA, 2016b). Now, the main concern is that the Yazidis are being 'Kurdified'. Kurdish movements have attempted to incorporate Yazidis in order to achieve their political goals, yet Yazidis complain of being treated as second-class citizens.

This is evident particularly in the mixed response from Arabs and Muslim Kurds to the 2014 ISIS genocide. When the attack first came at 2am, Yazidi men fought against ISIS fighters expecting Kurdish reinforcements to support them. However, Kurdish soldiers had abandoned their bases without attempting to evacuate or even warning the Yazidis of their decision (Wing, 2014). Moreover, while some Arab and Muslim Kurdish civilians helped the Yazidis escape, many welcomed ISIS, showed them Yazidi hideouts, watched them being tortured, and even bought Yazidi women who were being sold as slaves (Nicolaus & Yuce, 2014). This behaviour was not criticised or even discussed within the Kurdish community of the Kurdistan Region of Iraq (KRI). In fact, 15-20% of the Muslim population of the KRI was sympathetic towards ISIS at the time.

However, there have also been governmental efforts to support Yazidis. Yazidi survivors did receive substantial aid from Kurdish organisations and the Kurdistan Regional Government, who provided for around 300,000 Yazidi IDPs in camps and private accommodations with the help of international aid (Nicolaus & Yuce, 2014). The Kurdistan Worker's Party (PKK) helped to rescue 50,000 Yazidis trapped in the Sinjar mountain range

in the days following the genocide. Moreover, Yazidi political leadership is caught in intricate client-patron relationships with Kurdish leaders, which necessitates some of them to identify publicly as Kurds.

In a recent statement, Yazda, a multinational global organisation representing the Yazidi people, called for a recognition of a unique Yazidi global identity (YAZDA, 2016b). It proposes a friendly relationship with the Kurds based on 'mutual respect, not forced assimilation'. As the statement contends, it is important to respect the wishes of the majority of Yazidis and not fuse Yazidi identity with others because of the risk to further disintegrate the community, which is already geographically scattered across the world following their mass displacement after the 2014 genocide. This paper shall therefore treat the Yazidi identity as a discrete ethno-religious identity, separate from the Kurds.

2014 ISIS Genocide

ISIS had never hidden its intention of eradicating the Yazidi people, having published anti-Yazidi propaganda using Sharia law as a pretext. Thus, the attack on Sunday 3 August 2014 upon the Sinjar area of Nineveh province should not have come as a surprise. Local Yazidi men fought from 2am to defend their land, expecting Kurdish forces for support. These never came, as many Kurdish fighters had already abandoned their posts without warning. Yazidi fighters ran out of ammunition by 8am in the morning (Wing, 2014).

Estimates put the number of Yazidis killed by ISIS around 3,000, and the number of those kidnapped and enslaved around 6,800 (Cetorelli, Sasson, et al., 2017; YAZDA, 2017). Those who managed to escape capture or death fled up Mount Sinjar, where they were surrounded and besieged by ISIS forces for days, with no access to food, water or medical care. A mass rescue operation took place between 7 and 13 August involving Yazidi volunteer defenders, Syrian Kurdish forces (YPG), the Kurdistan Worker's Party (PKK), and an international coalition which opened a corridor from Sinjar to Syria (Fobbe et al., 2019). In total, estimates of the forcefully displaced lie around 400,000 - this accounted for 90% of the Yazidi population in Iraq at the time (YAZDA, 2017).

The war crimes committed by ISIS against the Yazidis were numerous and systematic. Distinct atrocities were used against specific groups. Male survivors state that they were forced to convert to Islam. Men who refused were killed from the outset, and even men who converted were often executed. This is because male Yazidis above the age of 12 were considered too old to convert (YAZDA & The Free Yezidi Foundation, 2015). To date, around 70 mass graves have been found, with the number of bodies being yet undetermined (YAZDA, 2016a). Boys who were considered young and impressionable enough were integrated into ISIS through a programme of military and religious indoctrination. They were taught how to operate firearms and were forced to watch beheadings. When they refused, they were severely beaten (YAZDA & The Free Yezidi Foundation, 2015).

There have been a number of studies investigating ISIS's prolific use of Sexual and Gender Based Violence (SGBV) against Yazidi women and girls, confirmed by countless first-hand accounts (Hassen, 2016). Women were sold in open markets in a systematic, coordinated and organised network of sexual slavery, justified by selective interpretation of the Quran and Sharia law. Databases of captured women's names, ages, marital status and photos were created, with prices of their lives ranging from 200 to 1500 USD (Fobbe et al., 2019). Victims were as young as eleven years, with some credible reports of the rape of girls as young as six years (YAZDA & The Free Yezidi Foundation, 2015). According to ISIS ideology, raping Yazidi women was meant to be a purifying process for both rapist and victim, bringing the rapist closer to God. Rape was not just a generic by-product of war - sex trafficking was used in as a tool to increase funds and recruitment among ISIS's ranks. SGBV against Yazidis and others was a specific, organised and targeted military strategy. ISIS used women's and girls' bodies as war spoils in order to attract and recruit more fighters, which they felt served to reinforce the masculinity of ISIS leaders and soldiers. Ultimately, SGBV was used as psychological warfare to disconnect Yazidi women from their communities and to

inflict long-lasting wounds to the Yazidi community as a whole that persist even after the defeat of ISIS (Vale, 2019).

Another significant aspect of the genocide was the deliberate attempts to destroy the cultural bonds holding the Yazidi community together. Mass displacement has impacted Yazidi memory, social experience, culture and worship by denying access to essential heritage sites. In Sinjar, nine shrines were destroyed. Economic bases were also targeted, with irrigation wells sabotaged, approximately half of all properties looted and destroyed, olive groves chopped down and burnt, making rehabilitation almost impossible for Yazidis who want to return (Fobbe et al., 2019). This is particularly crippling for Yazidis, as nearly 70% of household income prior to the invasion consisted of agricultural activities (Nadia's Initiative, 2018).

Although the northern half of Sinjar was liberated from ISIS at the end of 2014, many Yazidis still do not view their homeland to be safe. Authority over the region remains contentious, and the growing presence of militias mean that 37% of IDPs see the lack of security as the main reason preventing their return (Nadia's Initiative, 2018). Landmines planted by ISIS remain; demining campaigns have rendered the north safe for resettlement, but the south of Sinjar is not yet safe for habitation. Government policies restrict the movement of goods and the operations of NGOs delivering humanitarian aid, meaning that returnees have limited access to basic goods and services. Only one understaffed hospital is currently serving in Sinjar, which cannot fulfil the needs of the population, especially as the COVID pandemic unfolds.

The Yazidis' repeated experience of trauma and persecution has inflicted multiple and serious physical and mental health problems among the dispersed population. Rape trauma, PTSD, forced displacement and the anxiety of having missing family members continues to plague Yazidis. The collective identity of the fractured and scattered Yazidi community is under threat (Hassen, 2016). The trauma Yazidis have experienced is not only an individual one but rather, it is collective in nature, spans multiple generations and even has the potential to negatively affect future generations of Yazidis (Jäger et al., 2014).

International response to the 2014 genocide

Author: Imogen Davies

Aid given to support victims

During the initial ISIS attack on Sinjar in August 2014, several countries provided aid to those Yazidis who had become trapped and surrounded by ISIS in the Sinjar mountains, by dropping supplies from helicopters and rescuing small numbers of Yazidis. This included Iraq, the US, the UK, France, and Australia (BBC News, 2014). The US also planned a more significant rescue operation, which was called off after PKK fighters were able to clear a path to allow the majority of the estimated 50,000 Yazidis trapped in the mountains to escape into Syria (Washington Post, 2014).

Since then, these countries and many others have continued to provide funding to support Yazidis who remain in Iraq. The UN Funding Facility for Stabilization (FFS) is a program set up in 2015 aiming to stabilise areas recently liberated from ISIS control in Iraq, in order to allow those who fled the areas to return home safely (United Nations, 2021). By 2019 it had received donations totalling more than $1.3bn from 28 different donors,[1] with the US Agency for International Development (USAID) being the largest donor (USAID, 2021).

In addition, many countries have funded smaller projects aimed specifically at helping Yazidis. For example, the 2018-21 Safe Return project, which supports internally-displaced Yazidis to return to their original homes, is funded by USAID (USAID, 2021). Similarly, the German government funded a project from 2018 to 2020 to help Yazidis living in villages around Sinjar City to promote "sustainable and resilient livelihoods" through agriculture and small businesses (YAZDA, 2018).

Some countries, such as Germany (United Nations International Organization for Migration, 2019), Canada (CTV News, 2019) and Australia (SBS News, 2020) have additionally implemented re-settlement programs for Yazidi refugees. Others, such as the UK, have prioritised projects that support those Yazidis who remain in Iraq.

Recognition as genocide

The actions of ISIS are now recognised by many countries and international bodies as genocide. Following a 2015 United Nations Human Rights Council (UNHRC) report which found that ISIS "may" have committed genocide, crimes against humanity, and war crimes in Iraq (UN Human Rights Council, 2015), the European Parliament unanimously passed a motion in 2016 stating that ISIS actions against religious minorities in Iraq, including Yazidis, amounted to genocide (European Parliament, 2016). This marked the first time that the European Parliament described an ongoing conflict as involving genocide (Global Justice Center, 2016). The US House of Representatives (CNN, 2016), and the UK Parliament (The Guardian, 2016) both then voted unanimously to recognise that ISIS were committing genocide against ethnic and religious minorities in Iraq, including Yazidis.

Later in 2016, another UNHRC report determined that ISIS had indeed committed genocide, war crimes, and crimes against humanity against the Yazidis (UN Human Rights Council, 2016). Other countries where governments or parliaments have subsequently recognised the actions of ISIS against Yazidis as genocide include Canada and France in 2016 (Council of Europe Committee on Legal Affairs and Human Rights, 2017), and Armenia (Armenpress, 2018) and Australia in 2018 (Hutchinson, 2018). Despite these acknowledgements, only Germany has so far tried a former ISIS member specifically for their involvement in the genocide (BBC News, 2020).

[1] Australia, Austria, Belgium, Bulgaria, Canada, Czechia, Denmark, Estonia, European Union, Finland, France, Germany, Italy, Japan, South Korea, Kuwait, Malta, Netherlands, New Zealand, Norway, Poland, Slovakia, Sweden, Turkey, United Arab Emirates, United Kingdom, United States, and Iraq.

2. Mental health in Yazidi refugees

Author: Helena Gellersen

Statistics regarding the prevalence of mental health disorders vary but studies estimate that at least one third of Yazidis suffer from some form of PTSD, depression or anxiety, and other estimates going as high as 75%, with many Yazidis suffering from comorbidities of these conditions (Jäger et al., 2014). Somatoform disorders (67%) and dissociation (28%) are also common (Goodman et al., 2020; Kizilhan, 2020), and even heart problems after the events of the 2014 attack have been reported (Womersley & Arikut-Treece, 2019). There is a direct link between the number of traumatic events experienced (e.g. death of a family member, abduction, and others), and the presence and severity of mental health conditions (Kizilhan et al., 2020). Both, gender-based violence and war-related violence are strongly associated with PTSD and depression (Goessman et al., 2020).

The shock of the trauma following the 2014 genocide is not just felt on the individual, but also on the family, local communal and international level as the whole Yazidi community has been impacted by this repeated assault on their right to exist (Dulz, 2016). The need for psychosocial support in the Yazidi population is therefore extremely dire (UN High Commissioner for Refugees, 2019). Mental health and psychosocial problems are manifold, including a loss of agency and identity as a result of their displacement and reliance on aid; uncertainty and hopelessness about the future; feelings of anger, shame, guilt and worthlessness, especially among survivors of sexual violence and forced militarisation; psychiatric conditions such as depression, anxiety, post-traumatic stress disorder, suicidal thoughts, substance abuse, dissociative episodes and flashbacks; nightmares and lack of sleep; memory or general cognitive impairments; inter-personal conflict and family tensions as survivors return from IS captivity; difficulty trusting others and paranoia. Symptoms of somatoform disorders include chronic headaches, muscle aches, dizziness, intestinal problems, difficulty breathing, cardiovascular problems and long-term injuries from rape or war including chronic pain and gynaecological conditions (Gesellschaft für bedrohte Völker, 2019; Hassen, 2016; Meinel, 2016; Rometsch et al., 2020). Consequently, more than half of female survivors report their general health as poor (Jäger, 2019).

Mental health and psychosocial support (MHPSS) are related concepts, yet constitute different aspects of supporting wellbeing that not only cover traditional clinical psychological and psychiatric services but also take into consideration the social context and broader psychological needs of the beneficiaries (Interagency Standing Committee, 2007). Psychotherapy and other psychiatric treatments were originally developed for the Western context (see Appendix) and are often not appropriate for IDPs and refugees. Besides the cultural difference in dealing with trauma and mental health problems, there is also the stark difference in the kinds of trauma experienced by refugees which include long exposure to war, violence, sexual abuse and generally unstable and dangerous living conditions (Nationale Akademie der Wissenschaften Leopoldina, 2018). The Western focus on trauma of the individual, is insufficient in accounting for collective trauma experienced across the entire Yazidi community which shapes the discourse around and the individual's response to the events of the genocide (Womersley & Arikut-Treece, 2019).

Psychotherapy is the standard treatment for PTSD and other major mental health disorders such as depression and anxiety. Medication can be helpful but on its own is insufficient for long-term healing (BAfF, 2017). Psychotherapy such as narrative exposure therapy is robust across cultures and has the advantage that training for this method can be completed relatively quickly, that it is effective even for patients with multiple traumatic experiences, and that a modified version is among the most promising approaches for children and adults affected by war (BAfF, 2017; Knaevelsrud, 2016). Cognitive therapies are effective but typically require highly skilled therapists.

Not all refugees with traumatic experiences will need psychiatric care or psychotherapy. For many, stabilisation can be achieved through a safe and structured environment, social

connection, cultural and religious activities (BAfF, 2019a; Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016). This knowledge is the basis of the IASC approach to mental health in emergency settings with resource shortages (see below).

3. The IASC framework: culturally sensitive and holistic approaches to mental health

Author: Helena Gellersen

Many of the major humanitarian actors and NGOs active throughout Iraq follow the guidelines of the Inter-Agency Standing Committee (IASC) on Mental Health and Psychosocial Support in Emergency Settings that aim to address urgent need in conditions with extremely limited resources (Interagency Standing Committee, 2007). Cornerstones of the IASC framework are an awareness of and focus on cultural sensitivity and the multifaceted nature of mental health. The core principles of the IASC guidelines are:

1) the involvement of refugees and possibly the diaspora in the design of psychosocial care services,
2) the "do-no-harm" principle focused on avoiding any negative effects interventions may have,
3) a resource-oriented approach focussing on beneficiaries' resources as opposed to their deficits, weaknesses, or victimhood,
4) integration of different activities into one overarching programme, and
5) a stepped care approach (see Figure 2).

All staff should be provided with a minimum of basic training on psychosocial support as well as cultural sensitivity. Culture plays an essential role in shaping a person's mental health. An awareness of the cultural differences between potential patient groups is key in the design of effective programmes and requires a knowledge of values, religious beliefs, behaviours, community structure and the literacy and education levels of a given population (see Box 1A in the Appendix for more information) (Msall, 2018).

When offering MHPSS services, root causes of mental health problems should be considered. A mere focus on psychotherapeutic treatment is insufficient given the many other needs that underpin wellbeing, especially among IDPs. These include economic, cultural, social and political factors (Figure 1). For refugees and IDPs in particular, there are many factors outside their control and approaches that disregard these factors may be experienced as frustrating (Sadowski, 2016).

Strengthening the ability of community self-help is also key to a successful MHPSS programme (Free Yezidi Foundation, 2020b). An obvious example for community resources for resilience is the support through religious leaders and cultural practices that can substantially benefit the mental health of the Yazidi community and help with the reintegration of survivors of ISIS captivity (Kamangar, 2019).

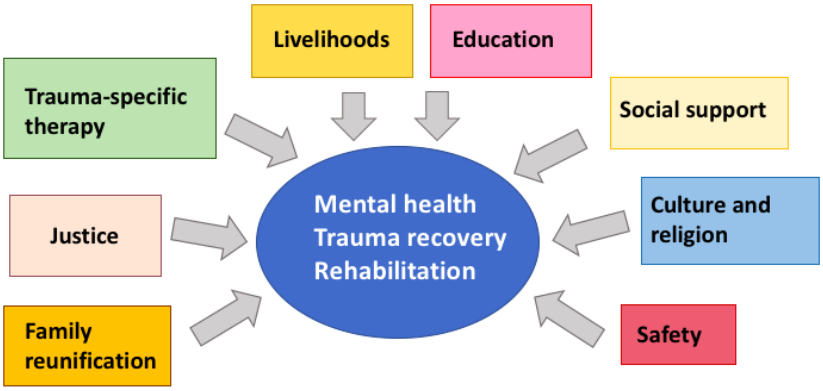

Figure 1. The multi-faceted nature of mental health and trauma recovery.[2]

[2] Adapted from IASC. (2020). *Interim Briefing Note. Addressing mental health and psychosocial aspects of COVID-19 outbreak.* https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing

When rolling out an MHPSS programme, a first important step is effective communication regarding available support to widen coverage. Psychoeducation is crucial to reduce mental health stigma, facilitate help-seeking behaviour and support coping mechanisms. Active MHPSS support is provided through the stepped care approach, which allows for the optimal allocation of services and the maximisation of coverage. The base of the care pyramid consists of non-specialised forms of support such as stabilisation techniques, psychoeducation, psychological first aid and basic mental health care, which can be provided through primary healthcare workers and trained laymen. These may include members of the IDP community who are trained and supervised by professional staff, such as psychologists, psychotherapists and social workers. For those with basic mental health issues, services from the base of the pyramid are sufficient. If this is insufficient, a next step may be person-to-person contact through non-specialised pathways. For more serious cases of mental health problems and disorders, more specialised services are being provided such as support through psychotherapists and psychiatrists or referrals to local specialised services that cannot be provided through the humanitarian actor.

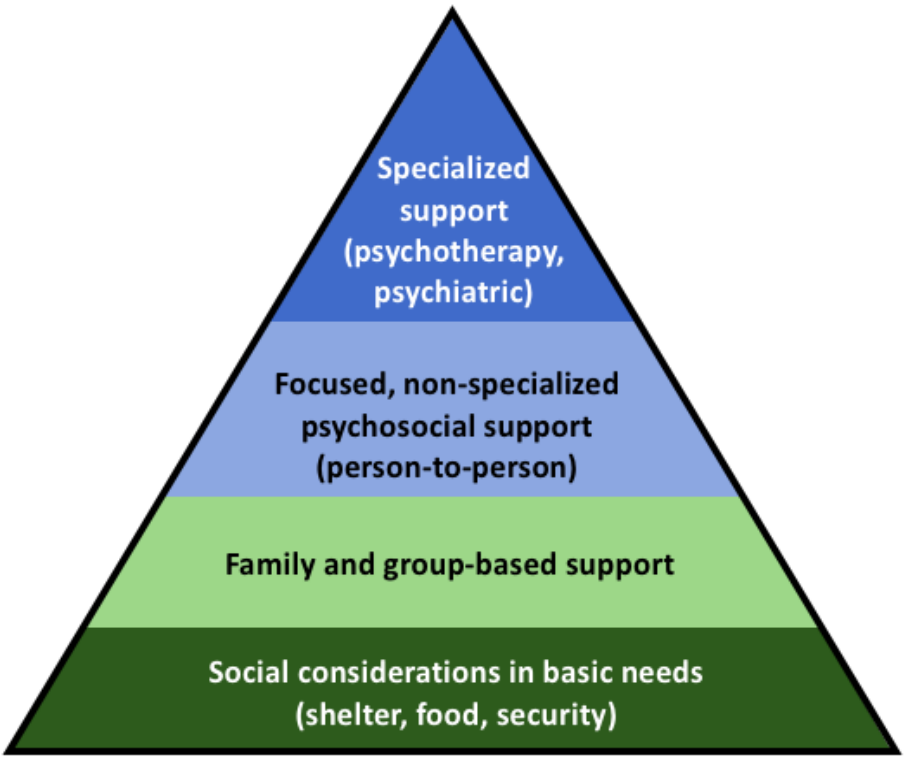

Figure 2. Example of a stepped-care approach.

4. IRAQ

Author: Helena Gellersen

MHPSS service structures in IRAQ

After the IS genocidal attack, more than 400,000 Yazidis were displaced, many residing in camps for internally displaced people (IDP) in Dohuk, Erbil and Sulaymaniyah of the Kurdistan Region of Iraq (KRI) (Al-Obeidi, 2020). The total number of remaining Yazidi IDPs as of summer 2020 is estimated around 200,000 (IOM Displacement Tracking Matrix, 2020). There are serious concerns regarding the capacity of the KRI to provide for the large numbers of IDPs given socioeconomic decline and declining support from humanitarian actors in the past years. The IS conflicts have resulted in almost 5 billion USD in damage in the education and health sectors (World Bank Group, 2018). As services in camps were stretched thin, humanitarian actors and IDPs noted poor living conditions in camps which had worsened over the past five years and have a detrimental effect on mental health (International Republican Institute, 2020; see Appendix, Box 1A).

Healthcare is a public good in the KRI. Primary Health Care Clinics (PHCC) have been established in all IDP camps with joint help from government and NGO partners to provide basic services (Amnesty International, 2020; Cross Sector Task Force 1325, 2018). However, in many camps, no psychosocial support exists.

69 mobile clinics provide basic care to vulnerable groups outside IDP camps, including those in Dohuk and Sinjar (Solomon, 2019; World Health Organisation, 2018).[3] However, the majority of these services are being provided by basic clinicians with specialist doctors lacking, particularly trauma specialists and paediatricians to address long-term physical and mental health conditions and disability in child survivors. Even before the IS conflict, mental health services in Iraq were extremely scarce, with less than 100 psychiatrists, no psychotherapists and an estimated treatment gap of 94% (Gesellschaft für bedrohte Völker, 2019). The majority of specialists are male and speak Arabic rather than Kurmanji, making it unlikely that they could establish a relationship of trust with their female patients.

Since 2014 as a result of the ISIS conflict, WHO and the KRG made MHPSS services a priority, with a focus on aiding survivors (World Health Organisation, 2014). In five MHPSS working groups throughout Iraq in Erbil, Dohuk, Sulaymania, Mosul and Baghdad, the government operated in collaboration with different humanitarian actors (Interagency Standing Committee, 2017). Capacity building among local services with inclusion of government and regional communities was seen as most promising in regions with scarce MHPSS services and was deemed most likely to maintain sustainability of MHPSS programmes after the hand-over of operations from humanitarian actors to local governments (Amnesty International, 2020; Gesellschaft für bedrohte Völker, 2019). The coordination of service delivery was improved and capacity building activities such as training sessions for case management, psychological first aid, trauma care and first care to survivors of sexual violence were organised by humanitarian actors and the government to be made available to local NGOs, government staff, and healthcare workers in Iraq with the aim to close the gap between MHPSS and basic healthcare providers (Cross Sector Task Force 1325, 2018; Interagency Standing Committee, 2017; UNFPA, 2019).[4]

Local government with international funding and multiple NGOs came together to establish a trauma network in Dohuk in 2018. The network connects humanitarian actors and government through the Dohuk trauma centre, and improves cross-agency collaboration for the development of new effective treatment programmes, better coordination and capacity building (Amnesty International, 2020; Gesellschaft für bedrohte Völker, 2019; Mohammadi,

[3] Supported by WHO and UN.

[4] Support provided by IMC, IOM, UNHCR, UNFPA and the KRI Ministry of Health.

2016).[5] As part of this collaboration, an accredited master programme in psychotraumatology was established at Dohuk University (Institute for Psychotherapy and Psychotraumatology (IPP), n.d.).[6] As of 2020, 25 students graduate from the programme (Adick, 2020). Following this example, two other Iraqi universities now also offer Master's programmes in psychotherapy or social work (Interagency Standing Committee, 2017).[7]

The Dohuk Survivor Centre in the KRI provides free care to women and girls returning from IS captivity and those subjected to domestic violence (Cross Sector Task Force 1325, 2018; UNFPA, 2016). The centre follows IASC guidelines by operating under a one-stop model that offers psychosocial services, medical care, vocational courses, social activities, legal assistance and referrals to other specialists. As of 2019, more than 1,100 beneficiaries received some form of care through the centre. Following the success of the Dohuk model, another Women's Centre was established in Amarhiyet Al Falluja in the Al Anbar province of Iraq (UNFPA, 2019).

To date, humanitarian actors shoulder much of the MHPSS service provisions. In 2018, 22 international and eight national NGOs were providing medical care to Iraq.[8] Service mapping of MHPSS actors is extremely challenging due to the frequent changes in activities carried out by multiple actors and due to the lack of responses to mapping requests by some of these actors (Interagency Standing Committee, 2017). We can therefore not provide a full picture of all services provided to IDPs or a total number of beneficiaries reached through those programmes (see list of statistics from key reports in Appendix).

The IASC guidelines in practice

Major actors in the region echo the IASC guidelines by noting that clinical treatment of trauma is insufficient and by emphasising holistic approaches that consider the many different factors that underpin mental health. Community engagement, culture and social connections are seen as key for wellbeing. Moreover, it is crucial to incorporate elements of education, vocational training and livelihoods in MHPSS programmes to establish a positive outlook on the future (Free Yezidi Foundation, 2020b; Gesellschaft für bedrohte Völker, 2019; Interagency Standing Committee, 2007; IOM, 2018; Nadia's Initiative, 2020; YAZDA, 2020b). Interviews with two Yazidi organisations, Yazda and the Free Yezidi Foundation (FYF), who provide MHPSS support in IDP camps gave prime examples of the IASC principles in practice (detailed summaries of the interviews in the Appendix). Both are non-profit organisations operating in the Dohuk province of Iraqi Kurdistan and follow stepped care approaches.

YAZDA

Yazda supports a multitude of projects in Iraq and Iraqi Kurdistan which include global advocacy and legal justice, livelihood, medical services, psychosocial support, psychotherapy and advocacy for the safe return of displaced Yazidis to their homelands in Nineveh. A specific focus of many projects is the support of returnees from ISIS captivity, namely survivors of sex- and gender-based violence (SGBV) and child survivors of forced militarisation. Family and community reintegration and livelihood are also at the centre of many of Yazda's projects. Together, these projects are slated to reach around 1,500 beneficiaries with some form of MHPSS services or livelihood support, potentially more (YAZDA, 2020a).

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[5] The collaboration included the Dohuk Institute for Psychotherapy and Psychotraumatology (IPP), the Dohuk Health Directorate, the German Society for International Collaboration (GIZ), the German Academic Exchange Service (DAAD), the Ministry of Science, Research and Arts of the German state of Baden-Württemberg, UNFPA and multiple NGOs in the region, among them UNICEF.

[6] Collaboration between the Institute for Psychotherapy and Psychotraumatology (IPP) Dohuk and the University of Tübingen in Germany with one million euros provided by the Ministry of Science, Research and Arts of the German state of Baden-Württemberg, which had also funded the German Special Quota that brought 1000 of the most vulnerable Yazidi women and children to Germany.

[7] Supported through SEED and IOM.

[8] Among them UNHCR, YAZDA, Free Yezidi Foundation, UNFPA, IOM, AMAR, SEED, Jiyan Foundation.

Yazda staff for MHPSS programmes includes a small number of clinical psychotraumatologists and a larger group of psychosocial case managers. International mental health expert consultants are also available to support the project. Case managers receive training according to international standards following the IASC with some adaptations to capitalise on Yazda' experience with the Yazidi community. Training focuses on basic psychoeducational and psychosocial aspects including emotional and relational support, listening and conversational techniques. The approach is survivor centred and different methods are taught to support children and victims of rape or violence in the home. The work of case managers is comparable to that of social workers in that they assess psychosocial needs of beneficiaries and arrange referrals to specialised care if needed. The Yazda programme includes group interventions for peer support, exchange of survival strategies and reconnecting to the community. They also run group therapy specialised to children's needs. Programmes offer psychoeducation to help Yazidis to better understand their emotions and their trauma.

Due to a shortage of specialists, Yazda operates with a combination of social and counselling work but cannot follow the Western model of individualised counselling provided by trauma specialists for all beneficiaries. To broaden their reach, Yazda staff are involved in capacity building for their teams, connect with other organisations in the region through the Dohuk trauma network and support the establishment of local MHPSS training programmes. Yazda are now developing an evaluation tool to assess mental health at each therapy session to track the effectiveness of their support services.

Free Yezidi Foundation

FYF provides MHPSS in two IDP camps, Khanke and Sharia. The programme mainly focuses on Yazidi women but also provides support for children and families. The staff directly involved in MHPSS are all female Yazidis except for three international psychologists. One of the team members specializes in children's mental health. Since 2017, FYF has established the Harikara Model which draws on capacity from within the Yazidi community. Yazidi women are trained as peer supporters termed Harikara (helpers) and form the basis of the MHPSS care pyramid.

Harikara are trained in psychological first aid (PFA) for both adults and children, trauma stabilisation techniques and coping skills. The Harikara women approach their beneficiaries in a first visit where they provide psychoeducation about trauma, basic information on coping and self-help techniques and allow for a conversation about mental health to alleviate stigma. This is meant as a community sensitisation visit to normalise the response to trauma. The Harikara take note of individuals who may be in need for further MHPSS services. For mild and moderate mental health difficulties, they revisit the family to provide further PSS. If they identify cases such as those with suicidal ideation, highly somaticized cases and extreme anger, the Harikara can refer them to specialists. Men are not provided designated mental health programmes, but in their field visits the Harikara approach families, thereby offering opportunities to involve men in basic MHPSS community sensitisation. If individuals require specialised trauma treatment, standard psychotherapy options are available, both following validated protocols deemed as effective in trauma alleviation by the WHO. In the Khanke Women's Centre, trauma treatment is offered as part of individual and group trauma therapy. For more severe cases of trauma, FYF also provides Eye Movement Desensitisation and Reprocessing Therapy, which has been effective in refugee populations.

The Harikara Model increases sustainability of MHPSS programmes through community involvement and allows cost-shifting from professionals thereby optimising resources. The approach also has the advantage of directly involving the Yazidi community in the MHPSS services. By integrating community members into the system barriers such as lack of trust or cultural differences may be overcome more readily. The project has also resulted in the development of effective methods of communicating reactions to trauma that take into consideration the literacy levels of beneficiaries (Womersley & Arikut-Treece, 2019).

In 2019, over 4000 beneficiaries could be reached with the psychoeducation visits and in 2020 the programme trained 31 Harikara in two IDP camps. Due to COVID, this number

dropped to 1500 beneficiaries.[9] A FYF representative notes that they cannot reach all individuals in need given that up to 15,000 IDPs live in tents in each of the Khanke and Sharia camps and roughly the same number reside in make-shift tents outside the camps.[10]

Evaluation of the FYF programmes is done using extensive qualitative feedback and focus groups as well as quantitative data. Beneficiaries who are provided MHPSS are assessed in terms of the severity of their case both pre- and post-treatment to track the effectiveness of the programme. Furthermore, the team uses psychometric and standardised screening tools for diagnosis. A first longitudinal evaluation of posttraumatic symptomatology before and after participation in the FYF intervention showed a decrease of PTSD prevalence from 81.25% to 45% and a 74% increase in self-reported wellbeing after six months. 91% of women were satisfied with their experiences of the FYF MHPSS support project (Womersley & Arikut-Treece, 2019). Further evaluation of data collected during the continuation of the FYF project is currently in progress.[11]

In terms of the outlook on this project, the major aim of FYF is not only to provide MHPSS services to as many beneficiaries as possible but also to enable a sustainable care ecosystem in the region. The FYF team has started to do so by hiring local Yazidi psychotherapists. The importance of self-sustainability is echoed by one of the FYF representatives: “We really need to work ourselves out of a job. I’m really looking forward to the time when I say I don't need to come in anymore.” However, it is unclear how the FYF programme continues after the December 2020 funding deadline. As of November 2020, it is unclear whether the Dutch government will be extending their support.

Holistic MHPSS

In interviews, FYF and Yazda representatives highlighted several important points. Holistic approaches to mental health are constantly emphasised as the only sustainable, effective means of trauma recovery. Separating mental health from livelihoods, culture and social considerations is highly detrimental. A sense of empowerment and future prospects is a prerequisite for healing (YAZDA, 2020b). Multiple humanitarian actors, including Yazda, FYF and others therefore include vocational training, livelihoods and education in their MHPSS services (Free Yezidi Foundation, 2020b; Nadia’s Initiative, 2018; UNFPA, 2019; YAZDA, 2020b). For instance, the Khanke Women’s Centre offers vocational and educational courses including literacy classes, English, knitting and sewing, art or sports, as well as a course on women’s rights. They also provide a children’s centre where children can be looked after while their mothers attend courses or therapy. This approach increases attendance and reduces attrition over multiple sessions because it alleviates women from their culturally expected caregiving duties.

These livelihood courses are strongly emphasised by FYF representatives as a crucial aspect of trauma recovery. IDPs still suffer from deprivation, unemployment, lack of resources and money, which all exacerbate mental health problems. Beneficiaries who recover from severe trauma symptoms are capable to take part in livelihood programmes, and similarly those who are enrolled in livelihood programmes also benefit in terms of mental health. Moreover, if the programmes can be seen as an economic opportunity, families are more supportive of women attending MHPSS services and an opportunity for greater female empowerment is given. Indeed, in focus groups beneficiaries highlighted that literacy classes were particularly important for their wellbeing by virtue of a greater ability to carry out more basic tasks (such as signing up for more aid provisions or taking their children to the doctor). Livelihood courses were highly popular as well, indicating the strong interest in economic autonomy. The focus groups also reported increased feelings of safety and an opportunity to take their minds off of the realities of the camp.

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[9] As of November 2020. Free Yazidi Foundation. (26/11/2020). *Personal communication*.

[10] These data were as of end of October 2020 but FYF representatives have informed us that several families have moved back to Shingal in the subsequent months.

[11] As of November 2020. Free Yazidi Foundation. (26/11/2020). *Personal communication*.

MHPSS staff further noted that although programmes should follow established standardised protocols, treatment approaches should also be flexible to allow beneficiaries to make use of their own specific resources such as their faith or cultural beliefs that may be incorporated into treatment.

Interviews have also revealed that a singular focus on relieving traumatic stress through on site MHPSS support is problematic as it neglects wider social and political issues that may play a role in trauma rehabilitation. This is particularly crucial for Yazidis, who suffer from a violation of their Yazidi identity, a loss of their Iraqi identity and a pervasive feeling of discrimination against their people. Examples of other key factors are the acceptance of children born of rape by ISIS perpetrators of the genocide, societal attitudes regarding the role of women, and justice.

Finally, in considering adequate treatment options, it is vital to take into account the different needs of Yazidi women, children and men. Each group has their own struggles and their experiences and expression of trauma differ widely, due to social factors and developmental differences (Heinrich Böll Stiftung, 2018; Tekin et al., 2016).

Specific mental health needs of Yazidi women

Mental health conditions and physical injuries are particularly common in women who return from ISIS captivity (D'Abramo, 2017). In an unprecedented decree in 2014, former Yazidi religious leader Baba Sheick welcomed all abducted Yazidis back into the community, contrasting previously common practices of excommunicating and blaming rape victims. Survivors were newly baptised, which was experienced as cleansing and allowed the women to remarry their husbands. Nonetheless, stigma around rape and mental health problems remains, as do feelings of violated honour, self-blame and shame (Runte, 2018; Vale, 2019). Despite such stigma, many women have spoken openly about their experiences to media or to organisations who aim to document IS crimes against Yazidis (Project on Middle East Political Science, 2019; YAZDA, 2020b).[12]

Although survivors experienced horrible crimes, they were not just passive victims during their time in captivity. Even under extreme risk to their own and their children's safety many took active steps to improve their situation, with many attempting escape and succeeding (Amnesty International, 2020; Vale, 2019; Williams-Annunziata, 2019). Freed from ISIS, many female survivors have taken active steps to improving their own and the community's condition through education, vocational courses, activism or volunteering with humanitarian organisations such as Yazda, FYF, UNICEF and others (Nadia's Initiative, 2018; Salden, 2017).

Key considerations in working with Yazidi women should be cultural attitudes towards rape victims, women's responsibilities regarding child- and home care and higher rates of illiteracy, both of which can reduce attendance in educational and vocational activities (Heinrich Böll Stiftung, 2018). For instance, women often report that they feel more comfortable with female doctors and translators during medical appointments, or they drop out of therapy or vocational courses if there are no childcare options available during sessions. Further, experts note that psychosocial approaches to women's wellbeing should not cast female refugees as victims but rather focus on empowerment, for instance by providing vital information about their rights and their health, through the discovery of personal resources and coping mechanisms and through social networks (Heinrich Böll Stiftung, 2018).

Structural causes of women's disadvantaged status and the pervasiveness of SGBV in Iraq should not be neglected when aiming to empower women. Both women and men should be included in female empowerment initiatives and MHPSS services (Free Yezidi Foundation, 2020b). Besides treatment for specific mental health problems and physical injuries from SGBV, initiatives geared towards empowering women and providing them with livelihoods can be helpful in strengthening their autonomy. Examples are the vocational and literacy courses

[12] Examples are the Head of Commission on Investigating and Gathering Evidence or the Documentation Project run by YAZDA

offered in the MHPSS programmes of multiple actors such as FYF and Yazda, a government programme for the development of rural women (Cross Sector Task Force 1325, 2018), and Nadia's Initiative who rehabilitate 345 female headed farming households and rebuild schools (Nadia's Initiative, 2020).

Specific mental health needs of Yazidi children

Yazidi children suffer from a particularly high burden of mental health disorders (Ceri et al., 2016). According to multiple reports and interviews with NGO representatives, adequate MHPSS services for children returning from IS captivity is one of the most pressing needs (Amnesty International, 2020; Cetorelli & Ashraph, 2019; Coalition for the International Criminal Court, 2020). The Office of Kidnapped Yazidis in Dohuk estimates that around 1000 girls and nearly 1000 boys have returned from IS captivity (Amnesty International, 2020). Girls abducted by IS were victims of SGBV. Boys were given Arabic names, were forced to convert to Islam, and were subjected to indoctrination and forced militarisation, all attempts at erasing their Yazidi identity.[13] Upon returning, Yazidi children have to adjust to a completely different social context compared to their experiences in captivity (YAZDA, 2020b). In many cases, their parents were killed or now live abroad. Many children have forgotten their native language and are unable to communicate with their families. Some adopted IS mannerisms, identify with their IS names, forgot their Yazidi culture, view Yazidis as infidels, are abusive against their Yazidi families or miss their IS families (Kizilhan, 2019; YAZDA, 2020b). Many of these boys and young men now struggle with the confrontation of their former Yazidi and IS Arabic identities (Siebert, 2018). Surviving girls tend to deny their experiences, and suffer from extreme sadness, stress and hopelessness (Amnesty International, 2020).

Both former IS captives and children who were not captured by IS suffer from mental health disorders, but the prevalence and severity are significantly greater in those who were abducted. Yazidi children suffer from PTSD, anxiety and depression but may additionally have sleep, attention deficit hyperactivity and obsessive-compulsive disorders resulting from their trauma. Especially those who experienced forced militarisation are aggressive, have severe nightmares and learning and memory deficits, withdraw themselves from social situations, feel isolated, and exhibit apathy or anhedonia, regressive behaviour (reverting to an earlier developmental stage), hypervigilance, high risk-taking behaviour (Kizilhan, 2019; Kizilhan & Noll-Hussong, 2018). War- and rape-related physical injuries are also common (Amnesty International, 2020). Many have other physical symptoms such as chronic bed wetting or fainting (Gesellschaft für bedrohte Völker, 2019). These children require specialist mental health support. Violence and aggression have been normalised for many child captives of IS and many children have to relearn normal social behaviour.

Children and adolescents need specialised therapy that cannot simply mirror methods used for adults, particularly in the case of boys who experienced forced militarisation and indoctrination (Amnesty International, 2020; Kizilhan, 2019; Langer et al., 2019; Save the Children, 2017; White, 2005; Williams-Annunziata, 2019). The Dohuk Health Cluster and multiple humanitarian aid organisations agree that the psychosocial support services available to Yazidi child survivors do not currently meet their needs and are not sufficiently sustainable (Amnesty International, 2020; Runte, 2018). Although MHPSS services are provided by some humanitarian and government actors there exists no consistent concept for wide ranging coverage with specialised, psychosocial services for child survivors and no long-term rehabilitation efforts specifically tailored towards children and young men subjected to forced militarisation (Kizilhan, 2019; Langer et al., 2019).

The Office of Yazidi Abductees provides aid to returning children through health checks, referrals and accommodation (Kizilhan, 2019; Langer et al., 2019). The Dohuk Survivor's Centre also supports girls returning from IS captivity or subjected to domestic violence with psychosocial services, medical care, vocational courses, social activities, legal assistance and

[13] We will not refer to these boys as "child soldiers" because this term is heavy with stigma and downplays the forcible nature of their experiences.

referrals to other specialists (UNFPA, 2016). As of 2019, the specialised Child and Adolescent Mental Health Center (CAMHC) is the only one in the KRI to provide culturally sensitive services for MHPSS, trauma treatment and psychoeducation to children and young people (Williams-Annunziata, 2019). Of at least 49 organisations in the region, only 11 reported having worked with children, using standard relaxation techniques and known psychotherapeutic methods (Langer et al., 2019). To date, SOS Children's Villages provide one of the few programmes focused on treating child returnees of IS captivity with group-based trauma recovery techniques to develop coping strategies and rebuild their future (D'Abramo, 2017). The programme also involves parents to help them deal with their children's trauma and reported positive effects on the mental health of the children. However, these services only reach a small number of those in need.

There is still relatively little research on effective trauma treatment in child survivors of forced militarisation and SGBV (D'Abramo, 2017). Culturally informed, trauma-focused CBT and transference-focused psychotherapy may be promising specialised treatment options (Draijer & Van Zon, 2013; Langer et al., 2019). There is some evidence that the Crisis Intervention Program for Children and Adolescents (CIPCA), a one-our group session developed to encourage expression of thoughts and feelings in response to crisis, can be effective in reducing post-traumatic psychopathology in internally displaced children in Iraq and Syria even after a 2-year follow-up (Ceri & Ahmad, 2018). This type of brief intervention may be a promising first step in the psychological stabilisation of Yazidi children. It is unclear though to what extent this method is effective in highly traumatised child survivors of ISIS captivity and the long-term effects.

For long-term trauma recovery, experts pointed out several key factors for successful programmes for child survivors of ISIS, including those beyond specialised therapy (Ceri & Ahmad, 2018; Kizilhan, 2019). First, any helpful programme should last three years or longer, especially for formerly indoctrinated boys, and should involve experts in child mental health (Langer et al., 2019). Short-term projects and the use of non-specialised services may be detrimental because they offer support only to withdraw it when the funding period comes to an end and because they are incapable of addressing specific needs (Amnesty International, 2020). A focus should be on avoiding re-traumatisation (Kizilhan, 2019).

Second, a holistic rehabilitation process including education, economic opportunity, family and social support is most likely to be successful and should involve medical and psychosocial care, sensitisation of communities to the challenges that returnees face, family training and reintegration assistance, help to local communities to facilitate the integration process, access to schools, and individualised follow-ups (Betancourt et al., 2008; Interagency Standing Committee, 2007; Kizilhan, 2019; Langer et al., 2019). Family-based support in particular to both caregivers and children is crucial to provide a better social environment and allowing them to "re-learn how to live together as a family" (YAZDA, 2020b). Even though the Yazidi Supreme Spiritual Council had issued a statement welcoming back all captured Yazidis, even those forced to fight for ISIS, many in the community are afraid and suspicious of them, prompting abuse or ostracization (Kizilhan, 2019; YAZDA, 2020b). The distrust of and the stigmatisation against these boys pose major barriers to their reintegration and requires a community-based approach.

Third, language requirements should be considered given that Arabic may be experienced as a trigger by many Yazidis but could also be the only language some of these children remember (Peace Research Institute and Frankfurt Leibniz Institute, 2020; Runte, 2018).

Fourth, schooling is a vital aspect of successful rehabilitation of Yazidi child survivors (Kizilhan, 2019). Boys forced into militarisation are more likely to adjust psychologically if they received schooling (Amnesty International, 2020; Langer et al., 2019). Nonetheless, significant barriers to education remain such as access, learning and concentration difficulties due to trauma, a lack of official documents, years of missed schooling, lack of financial means, language barriers, school overcrowding, lack of basic facilities including electricity, insufficient number of teachers or simply unawareness of existing education services. Although the IFG, KRG and UNICEF have established accelerated learning programmes and a school for displaced Yazidi youth, only 65-75% of children and adolescents outside and 20% in IDP

camps are attending school (Danish Immigration Service, 2016; Wendt et al., 2020).

Yazda's survivor centre aims to provide an open space for survivors of ISIS and refrains from pushing a Yazidi identity onto the returnees. They are also emphasising the need of treating children as individuals, which tends to not be the case in the Middle East with regards to therapy or children's psychological needs. More organised meetings with religious leaders and pilgrimage to the Yazidi holy site in Lalish may be helpful to restore a feeling of connectedness with the Yazidi community but due to COVID, pilgrimages are not currently possible.

In order to meet their substantial needs, services for child survivors of ISIS would have to be scaled up, be offered for a longer period of time and be coordinated under a coherent strategy (Amnesty International, 2020). Without proper reintegration efforts and if subjected to discrimination and ostracization from their community, boys who experienced forced militarisation are at high risk of becoming a security threat and join radical movements (Gesellschaft für bedrohte Völker, 2019; Langer et al., 2019). Risk assessments with new validated tools should be conducted to identify children who may pose a risk to themselves and their community (Kizilhan, 2019).

Specific mental health needs of Yazidi men

Yazidi men often struggle with a substantial adjustment of their societal roles after displacement. Psychosocial support specific to these problems is important to help men adapt to their new role and reduce aggression and potential for violence. This may significantly lessen family tensions and improve cohesion (Die Beauftragte der Bundesregierung für Migration Flüchtlinge und Integration, n.d.). However, there is little psychosocial support explicitly aimed at Yazidi men (Free Yezidi Foundation, 2020b; YAZDA, 2020b). This may in part be due to the major focus of the Western media on the suffering of Yazidi women. Stigma around mental health is more pronounced among men, resulting in reduced help seeking behaviour.

MHPSS service providers at Yazda and FYF voice concern of men being excluded from programmes focused on PSS, vocational training and livelihood support (Free Yezidi Foundation, 2020b; YAZDA, 2020b). Not including men means that the root causes of stigma against sexual or domestic violence and family tensions cannot be addressed. Women in Iraq had to face sexual violence long before the IS genocide. As the patriarchal structure of Iraqi society is a key cause for the pervasiveness of SGBV, not involving men in the provision of MHPSS to Yazidi women is to ignore one important factor in improving women's mental health. UNFPA has developed a programme manual for engaging men in fatherhood but it is unclear to what extent such approaches have been applied to Yazidis (UNFPA, 2010).

A Yazda representative notes men's frustration with the view of the West that sees them as unappreciative of their women. Many men had to make difficult decisions during the fast advance of IS and were forced to consider which of their family members they could save. They carry this psychological burden but are not provided a means to heal. Instead, they may turn to alcoholism and gambling.

Involvement of men in MHPSS may be particularly important in the Yazidi context to support the reintegration of families that have been separated during IS captivity and to reduce blame and feelings of shame (Free Yezidi Foundation, 2020b; YAZDA, 2020b). The return of IS captives to their family can result in substantial relationship stress. Many men have become aggressive, shout more frequently and in some cases beat their children and wives. As a result, women are often concerned about their husband's anger problems. The FYF representative stressed the importance of family dynamics in mental health and the need for more tailored family interventions. However, there is still a lack of family focused approaches to MHPSS in Kurdistan that views the family as a complete system and tailors treatment accordingly (Free Yezidi Foundation, 2020b; YAZDA, 2020b). Yazda representatives have noted that their Women's Centre does include men in their family support services, but this is not the case for all MHPSS providers.

Empowering Yazidi women is seen as important but a lack of involvement of the men's perspective in women's empowerment was deemed as potentially problematic, given the deeply enshrined patriarchal structure of the Yazidi community and the potential for tensions: "You cannot just send the woman home with this new kind of knowledge or attitude … without considering the impact from a community perspective". This feeling is echoed by Yazidi women as well who pointed out that their husbands should also learn about women's rights and empowerment (Free Yezidi Foundation, 2020b; YAZDA, 2020b).

Finally, Yazidi men also carry the burden of responsibility for financial needs of their families that they are often unable to shoulder given an unemployment rate as high as 50% pre-COVID. It is highly likely that the pandemic will have increased this number and put additional psychological pressure on men as they face even more challenges to provide for their families. Livelihood programmes are therefore crucial for the mental health of all Yazidis.

Children born of rape

The issue of the hundreds of children born of rape in ISIS captivity remains the most contentious problem in the Yazidi community. These children have been the most neglected victims of the 2014 genocide (Society for Threatened Peoples, 2020). The exact number of children born of rape is unknown but it is estimated that there are at least 200 (Deutsche Welle, 2019).

According to Yazidi doctrine, only those born to two Yazidi parents can be identified and recognised as Yazidi. Moreover, Iraqi law is patrilineal, meaning that a child's religious identity is classified based on the father's faith, such that children born of IS rape are seen as Muslim by the Iraqi government. Women seeking legal documentation for their children are therefore forced to register them as Muslim (Deutsche Welle, 2019). Iraqi law has no provision to give a non-Muslim mother full custody over their Muslim child without support from a judge as the law prevents parents from being given guardianship over children of a different faith (Greaser, 2018; Society for Threatened Peoples, 2020). As a result, many of these children lack legal documentation and are at risk of becoming stateless.

To date, no solution exists to this political and social problem (Gesellschaft für bedrohte Völker, 2019). After their 2014 decree welcoming back IS survivors into the community the Yazidi Spiritual Council clarified that children born of rape would not be accepted as Yazidi. Although they may be supportive of the women, the majority of Yazidis do not feel that these children belong in their community (Amnesty International, 2020; Greaser, 2018). Without a decree from Yazidi spiritual leaders, the majority of Yazidis will likely never accept children born of ISIS rape. Their mothers often had to choose between giving up their children if they wanted to return to their families or staying with ISIS in order to remain with their children. Some Yazidi families actively participated in the separation of mothers and children born of rape (Amnesty International, 2020; Greaser, 2018; Project on Middle East Political Science, 2019; Society for Threatened Peoples, 2020). These women are in severe mental anguish, often ostracised by their community and fearing for the lives of their children (Amnesty International, 2020).

NGOs report that work on this issue is extremely delicate. The priorities of NGOs are to retain their standing with the Yazidi community and the government. Getting involved in the debate around children born of rape may bear security risks and may bar them from accessing the region. Government officials have not taken decisive steps to address this problem. The KRG has provided a statement that there were efforts to amend laws to facilitate legal documentation for these children but to date there has been no meaningful progress (Amnesty International, 2020). Without acceptance by the Yazidi community, the only option for mothers and their ISIS born children may be to resettle in other countries (Deutsche Welle, 2019).

Barriers to MHPSS and public goods

The healthcare system in the KRI has been overwhelmed by the large number of IDPs in the region. Basic healthcare is technically accessible to IDPs, but long distances, transport costs, wait lists, and lack of official identification after flight or captivity are still barriers (Cetorelli,

Burnham, et al., 2017; Danish Immigration Service, 2016; Runte, 2018; UNFPA, 2019). Without official documentation Yazidis face restrictions on freedom of movement and access to healthcare, schooling, food or financial support (Amnesty International, 2020; Betancourt et al., 2008; Hassen, 2016; Langer et al., 2019). NGOs are aiding Yazidis with legal counsel and to obtain documentation but the programmes are not reaching all those in need (YAZDA, 2020b).

Despite existing support structures provided by a large number of multilateral agencies, governmental departments and NGOs, reports from UNHCR and UNFPA in 2019 state that needs for MHPSS services are still unmet due to the large IDP population (Interagency Standing Committee, 2017; UN High Commissioner for Refugees, 2019; UNFPA, 2019). There are still gaps between medical and psychosocial support systems (Amnesty International, 2019; Bajbouj et al., 2018; H. Ibrahim et al., 2018). There is no widespread coverage of MHPSS services throughout the different IDP camps and other communities in need due to a lack of infrastructure and insufficient numbers of qualified personnel, especially those specialising in trauma and psychotherapy (UNFPA, 2019). Community leaders say more MHPSS services are particularly needed for follow-up and long-term trauma recovery and in rural regions (Abouzeid, 2018).

Other challenges to MHPSS services that remain are a lack of awareness of the importance of mental health and psychosocial services, as well as stigma around sexual violence, suicide and help seeking behaviour with regards to mental health. At the same time, NGO representatives note that there has been an improvement with regards to mental health attitudes and that although stigma remains, many Yazidi women agree that throughout their community everyone would benefit from psychological treatment (YAZDA, 2020b). However, psychoeducation is still not provided enough in the region to reduce stigma sufficiently to open up channels for treatment, particularly those for suicide prevention intervention.

In terms of capacity building, language barriers for KRI locals make training more difficult, as it is typically provided in English or Arabic. There are also not enough slots for all staff of MHPSS service providers to take part in training modules of the Dohuk trauma network and training can be difficult to put in practice in the setting of the IDP camps. The majority of basic care providers are not adequately trained in dealing with mental health problems, substance use disorders or neurological conditions (YAZDA, 2020b).

The IASC stresses that the triage system is still not ideally implemented by local services, leading to unnecessary referrals to specialised services. There is a substantial lack of understanding of the importance of and access to other helpful services, including spiritual leaders, legal services to support SGBV survivors, special needs teachers who can support children with developmental disorders, or case workers (Interagency Standing Committee, 2017). Furthermore, there is still not sufficient evaluation and monitoring of MHPSS projects with clearly defined indicators of effectiveness which is crucial to improve services in the future (Free Yezidi Foundation, 2020b; UNFPA, 2019; YAZDA, 2020b).[14]

Lastly, there has also been criticism of NGOs as some Yazidis expressed their frustration when help is promised but needs are not sufficiently met (Abouzeid, 2018). This may in part be due to funding shortages that restrict programmes to shorter runtimes, uncertainty regarding renewal of funding and logistical hurdles or security concerns that restrict the reach of NGOs (Free Yezidi Foundation, 2020b; USAID, 2020). Chronic underfunding affected all sectors of humanitarian relief with 46% of the funding required to address critical needs missing (UNHCR, 2019). Importantly, funding to support victims of SGBV was less than one third of the funds requested, suggesting needs of SGBV survivors were not sufficiently prioritised by relief agencies. Short durations of funding for some projects proves challenging and can lead to abrupt changes in the services humanitarian actors can provide (YAZDA, 2020b). During periods in between funding retention of staff is challenging. This negatively

[14] Although, the IASC noted a change in attitudes towards mental health support, which is now increasingly being recognised as effective. Nonetheless, all NGO representatives we spoke to still brought up stigma as a barrier to accessing MHPSS services.

impacts the mental health of their beneficiaries and hampers the establishment of a self-sustaining MHPSS ecosystem in the region (Free Yezidi Foundation, 2020b).

Although support is still not reaching all in need, in the last years Iraq has significantly increased its capacities to provide basic psychosocial interventions through non-medical experts (UNHCR, 2019). Naturally, highly specialised services will require longer to expand due to the substantial training and expertise required. The new graduate programmes at Iraqi universities are beginning to establish the occupation of psychotherapist within the Iraqi healthcare system.

COVID-19

The COVID-19 pandemic has exacerbated many of the physical and mental burdens of Yazidis in IDP camps (Kizilhan & Noll-Hussong, 2020). As a result of the pandemic, the prevalence of various mental health conditions such as PTSD, depression, somatoform disorders, dissociation and anxiety has increased by 5-15% depending on the disorder. Suicidal ideation has become more common and suicide rates have increased. The events of the pandemic have reactivated the traumatic experiences of many Yazidis and have led to more widespread feelings of hopelessness and loss of control. Given crowded conditions in camps, social distance is mostly infeasible, increasing risk of infection (Kizilhan & Noll-Hussong, 2020).

As of December 2020, many families have returned to Sinjar to evade the crowded conditions in camps which bore a high risk of COVID infections and because less support could be given by NGOs as some workers were forced to leave. The total number of returnees was estimated to be 97,434 (IOM, 2020). While Yazda are working in the region, many other aid organisations based in Dohuk are unable to reach Yazidis who returned to their homeland in Sinjar. This is due to the presence of the different governing bodies for Iraq and Iraqi Kurdistan which results in visa problems that keep some organisations from accessing Sinjar (Free Yezidi Foundation, 2020b). Yazda representatives noted a severe lack of NGO presence, infrastructure and general established support in the Sinjar area. As a result, returnees may be less exposed to COVID-19 given lower population density compared to the camps but they will have to face other hardships as a result of poorer support structures in Sinjar.

Since COVID-19 has reached Iraq, MHPSS services are severely limited (Free Yezidi Foundation, 2020b; Kizilhan & Noll-Hussong, 2020). FYF note that a strict lockdown was in place from March to May, prohibiting any field visits and group therapy. Tent visits restarted in June with on and off visits according to advice from the local authorities and under appropriate safety measures. During this time tent visits did not only serve to provide MHPSS but also to offer vital information about COVID-19 prevention methods. COVID cases started rising gradually in August and accelerated in September and October and field visits were again prohibited. At the beginning of November, as the pandemic got out of control in the KRI, two of the international FYF staff were asked to leave and one staff member contracted the virus requiring all team members to isolate (Free Yezidi Foundation, 2020b).

Since the start of the pandemic, the IASC has released guidelines for MHPSS during the pandemic. Staff worked remotely and beneficiaries were reached via internet or phone (Interagency Standing Committee, 2020). Organisations such as Yazda have developed online tools to provide psychosocial support. These include group chats and one to one calls which have proven successful in reducing the anxiety and sense of isolation resulting from COVID restrictions. For instance, Yazda has distributed phone credits to ensure their beneficiaries can still reach their caseworkers and have access to important services (YAZDA, 2020b).

The FYF team have been using this time to increase capacity building by offering more training to the Harikara who were no longer conducting tent visits until the end of the funding period in December 2020 (Free Yezidi Foundation, 2020b).

Despite the efforts of MHPSS providers, COVID-19 has resulted in worse mental health, an increase in gender-based violence and a higher number of suicide attempts. Yazda reports

that it is focused on monitoring critical cases closely but interventions have become more challenging (YAZDA, 2020b).

Outlook

Rescue of remaining IS captives

In interviews survivors note that the highest priority is the return of the remaining captives. They feel that the Iraqi and Kurdistan Regional governments have not done enough in terms of rescue operations (Hassen, 2016). Officials from the IFG and KRG, such as the Office of Kidnapped Yazidis in Dohuk, and international organisations such as the UN are still searching for remaining captives but they operate with limited resources. As of August 2020, the number of recorded victims of IS abductions stands at 6,400 Yazidis, 3,532 have been rescued with the remainder still missing. The officials are hoping to receive further funding from the Iraqi government (Al-Obeidi, 2020).

Return and rebuilding of Sinjar

According to estimates, almost 100,000 Yazidis have returned to Sinjar as of December 2020 (Free Yezidi Foundation, 2020b). However, the majority of Yazidis are still displaced. The ISIS conflict has resulted in the destruction of many homes and 80% of the local infrastructure (Hussein, 2017; Izsak, 2017). Many Yazidis note they have not returned due to lack of security, basic services, livelihoods and financial means, as well as remaining mines, fear of discrimination, and tensions with other religious communities in the region, particularly Sunni Arabs (UN High Commissioner for Refugees, 2019). Efforts for rebuilding are still hampered by political tensions, economic shortcomings and security concerns (UNHCR, 2019). Nonetheless, humanitarian organisations are working on multiple rebuilding and livelihood projects in the region but not all in need can be included in these programmes (Nadia's Initiative, 2020; Voice of Ezidi; YAZDA, 2020b). Medical and psychosocial services are still severely lacking, although mobile clinics do exist and humanitarian actors have opened psychosocial centres (Australian Humanitarian Partnership, 2019; Welt, 2019).

Attitudes about the return to Sinjar among the Yazidi community are mixed. Some families have already returned to the region (Nadia's Initiative, 2020). Others do not plan to return and even hope to emigrate. A loss of Iraqi identity as a result of the feeling of abandonment and marginalisation may be contributing to this sentiment. Many of those who had already moved to other countries expressed no plans to return, while others hope to do so but say prerequisites are the guarantee for safety both from the national government and internationally, the provision of basic services and livelihoods, and compensation for their destroyed homes (International Republican Institute, 2020; Norwegian Refugee Council, 2018; Thorson Plesner et al., 2020). Given Sinjar's position in disputed territory, there are no clear security measures that have been taken to ensure the safety of returnees (Minority Rights Groups International, 2017). Many Yazidis believe that their safety in Iraq could never be truly guaranteed due to the Muslim majority in the country. Given the disputed status of Nineveh, it is unclear whether the KRI or the Federal Iraqi government are responsible for the protection of this region. Without governmental support, Yazidis will not be safe upon return (Ohering, 2017).

Many Yazidis both in the Middle East and those in Western countries agree that the loss of Sinjar as the Yazidi homeland will be devastating for their community and their collective identity and so the fate of the region will have substantial effects on Yazidis around the world (Ohering, 2017).

Yazidis and the Iraqi and the Kurdistan Regional Governments

Many Yazidis still feel betrayed by the Kurdish Peshmerga whose troops left the Sinjar region defenceless (Labor, 2018). To date, Yazidis still face institutionalised discrimination from both Iraqi governments and are subject to restrictions on freedom of movement outside the IKR, which Yazidi leaders interpret as politically motivated given the disputed territory in the area

(Service, 2020). Some also report harassment and abuse by KRG Peshmerga and Kurdish intelligence in Nineveh. As a result, many are distrusting of both the Iraqi and Iraqi Kurdistan governments. They feel a lack of political representation and constitutional recognition. Many Yazidis do feel gratitude towards the Kurdish government for providing them with refuge and aid but suspect that a political and territorial agenda to seize the disputed areas in Northern Iraq may be one motivation behind the aid efforts (United States Holocaust Memorial Museum, 2015; YAZDA, 2020b). As a result of this loss of faith in the KRI, there are calls among the Yazidi community for self-governance of the Sinjar region, but there (Spät, 2017).

Justice and international recognition of the genocide

The IASC stresses that MHPSS should also involve legal issues, such as reparations, peacebuilding and reconciliation programmes (Interagency Standing Committee, 2007). Besides the return of the missing women and girls in captivity and the rebuilding of their homeland, many Yazidis do indeed see justice as a requirement for rehabilitation from trauma (Abouzeid, 2018; Free Yezidi Foundation, 2020c; Thorson Plesner et al., 2020). Without justice, a feeling of security may not return. Yazidis demand that their ISIS tormentors and their Sunni Arab neighbours who sympathised with ISIS be held accountable (Gesellschaft für bedrohte Völker, 2019; NGO statement to commemorate International, 2020), but they have little trust in the Iraqi national justice system in doing so (Al-Saiedi et al., 2020). International recognition of the 2014 attacks as genocide was viewed by many general recognition of Yazidis as an independent group, which would justify their autonomy and their calls for international protection (Spät, 2017).

Although international organisations have indeed recognised ISIS attacks on Yazidis as genocide this has not resulted in the kind of tribunals the Yazidi community had called for and support from the international community in legal matters has mostly been lacking (Al-Saiedi et al., 2020; Free Yezidi Foundation, 2020c; Kaya, 2019). Multiple Yazidi NGOs are therefore lobbying the international community to seek justice for Yazidis by prosecuting ISIS members and are actively collecting evidence of ISIS crimes in documentation projects (see Appendix, Yazda; Free Yezidi Foundation, 2020a; YAZDA, 2020b). Even today though, there have only been few cases around the world in which ISIS members have been charged with genocide or been convicted specifically for their crimes committed against Yazidis. Options for prosecuting ISIS members through the International Criminal Court (ICC) face political limitations, since Iraq is not a signatory to the Rome Statute establishing the ICC (Global Legal Monitor), has not ratified articles of the international genocide convention and has also not officially declared that the convention is applicable in the Yazidi case (Tagay & Ortaç, 2016). Furthermore, previous attempts to refer crimes perpetrated by ISIS to the ICC have been vetoed by Russia and China through their positions on the UN Security Council (UN News, 2014).

In 2017, a report of the Council for Europe acknowledged that there was not currently any international mechanism capable of prosecuting ISIS, and that the responsibility would fall to individual countries to try their own citizens who were involved (Council of Europe Committee on Legal Affairs and Human Rights, 2017). To date, Germany is the only country to have begun a trial against one of its own citizens for the crime of genocide in relation to the Yazidis (BBC News, 2020; Der Generalbundesanwalt beim Bundesgerichtshof, 2020). 2020 saw a first case in which a Yazidi woman testified against an ISIS fighter who had raped her during captivity. Her example may prompt other Yazidi women to do the same (Salloum, 2020). In the German court case, the ISIS member was convicted for enslavement, prompting a three-and-a-half-year prison sentence. This sentence has been judged as far too lenient by the Yazidi community (Free Yezidi Foundation, 2020a). Much greater international cooperation will be required in future to ensure that Yazidis receive justice for the crimes committed against them.

The Yazidi community is divided regarding the form justice should take with many emphasising reconciliation and restorative justice, while some prefer punitive justice. It has been argued that a perception of collective Arab guilt would only continue the cycle of violence (Abouzeid, 2018). The National Reconciliation Committee is viewed with criticism because

Yazidis are sceptical of its capabilities to affect change. Yazidi leaders have not taken part in committee meetings, as they felt this to be a pro forma affair without any impact for their community. Reconciliation is among the greatest challenges given the need for governmental programmes and the remaining fear and distrust Yazidis hold against their Arab neighbours (International Republican Institute, 2020).

One substantial step towards reconciliation and restoration of trust in government would be reparations to the Yazidi community. As of 2020, no large-scale reparations have been made to the Yazidi community besides a one-off payment from the KRG to women survivors of ISIS captivity (Minority Rights Groups International, 2017). The KRG drafted the Female Survivors Law in 2019 to provide compensation to Yazidi women captured by IS (Amnesty International, 2020). While an important step into the right direction, the law was drafted without much input from the affected communities (Smith & Dhawan, 2020). This becomes apparent in its narrow focus on kidnapped women while men and boys are not considered. There is also still a general lack of protective laws against sexual and gender-based violence in Iraq (Hassen, 2016). The KRG has criminalised sexual violence but there are no proper means for combatting its root causes (European Asylum Support Office, 2020).

Conclusions and policy recommendations

Recommendations for political action and structural improvements

1) Laws that take on wider systemic issues are needed, including those against domestic and sexual violence as well as war crimes. The Female Survivor Law should include not only women captured by ISIS but should also make provisions for children, especially those subjected to forced militarisation.
    a. Both Iraqi governments should take more action in rehabilitating children of forced militarisation. For instance, governments could sign onto an action plan for reintegration in collaboration with the UN Secretary-General for Children in Armed Conflict (SRCAC) (Runte, 2018).
2) There should be more efforts to provide Yazidis with official documentation. Especially for children born of rape, Yazidi mothers should not be forced to choose between registering their children as Muslim or refraining to obtain documentation for their children altogether.
3) Any laws and regulations aimed at peacebuilding, reconciliation or reparations should be drafted in collaboration with the Yazidi community to ensure that laws adequately address their specific needs.
4) IFG and KRG should further aim to expand their MHPSS service capacities and include wide ranging psychoeducation campaigns to reduce stigma against those in need of mental health support, survivors of sexual violence and survivors of forced militarisation. In addition to more comprehensive and stronger laws, better support for survivors of SGBV can also be achieved by informing multiple service providers including social workers, interpreters, hospital and community centre staff and police (Solomon, 2019).
5) The Yazidi High Council could also be instrumental in furthering the acceptance of mental health care among the community (Hillebrecht et al., 2018).[15]

[15] As has been done in the German Special Quota project.

5. Germany

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Yazidis in Germany

Even prior to the 2014 genocide, Germany was home to the largest Yazidi diaspora outside the Middle East. Germany had already recognised Yazidis as a persecuted group in 1980 and has accepted Yazidi refugees who fled other violent conflicts at multiple times throughout the 20th century (Peace Research Institute and Frankfurt Leibniz Institute, 2020; Runte, 2018; Tagay & Ortaç, 2016). Since 2014, more than 80,000 Yazidis have come to Germany (Gesellschaft für bedrohte Völker, 2019). The total Yazidi community in Germany is estimated at 150,000 to 200,000 (Bathke, 2019). Most reside in one of three German states (Lower Saxony, North Rhine-Westphalia and Berlin; Tagay & Ortaç, 2016). Multiple Yazidi parishes and societies were established by the Yazidi German diaspora. They promote the continuation of the Yazidi culture, facilitate the integration of Yazidis in Germany and the communication with other Yazidi communities in Europe, North America and the Middle East. Education has an important status in the German Yazidi diaspora as it is viewed as key to independence and societal participation. In Germany, Yazidis were not forced to practice their religion in secret and as a result, Yazidis have begun to actively seek dialogue with others outside their religion to foster understanding of their culture among the wider German population (Candan, 2017; Kasem, 2012).

The close ties between members of the German diaspora and the Iraqi community were exemplified in a survey of German Yazidis, 29% of whom reported having friends who were among victims and 17% reported having family members who were ISIS victims. As a result, support in terms of financial help and humanitarian aid was high, with 92% and 85.5%, respectively (Tagay et al., 2017). The Yazidi diaspora played an essential role in lobbying for governmental support for Yazidi ISIS victims (Candan, 2017; Kasem, 2012). Given the large Yazidi diaspora, the voice of this community carries more weight in Germany. The Central Council of Yazidis in Germany (Zentralrat der Êzîden) was essential in communicating the need for assistance to German politicians. In the waves of Yazidi migration to Germany in the past century, the established Yazidi community has often played an important role in helping newcomers integrate. They are still doing so today, for instance by offering German courses, information on German laws or by promoting equality of women (Tagay & Ortaç, 2016).

German reaction to the IS genocide and the refugee crisis

In response to the ISIS genocide, Germany has accepted all asylum requests from Yazidis in 2015 (Bathke, 2019). Since then, the German government has provided substantial funds in support of psychosocial interventions, rebuilding and structural stabilisation projects in Iraq (see Appendix for details on funding). German state governments have created a special quota project in which the most vulnerable Yazidis received special psychosocial care upon their arrival in Germany (Gesellschaft für bedrohte Völker, 2019; Mohammadi, 2016).

To date, Germany is the only country that has prosecuted ISIS members for their crimes against the Yazidi people (Bundesregierung Deutschland, 2020). In the years following 2015, protection rates for Yazidis have now dropped from 100% to 85% despite continuing risks for Yazidis in Iraq (Bathke, 2019).

After German chancellor Angela Merkel announced the open-door policy for Syrian refugees from the ISIS conflicts in 2015, Germany saw the largest influx of refugees to date (H. Horn, 2015). As a result, multiple local actors sprang into action to provide a variety of services for incoming refugees. Measures included administrative issues such as capacity building and streamlining of processing pipelines including simplification of the asylum application process, increasing existing resources for integration courses and putting in place prevention measures against extremism; emergency measures to provide basic support and accommodation; and innovation measures to react to novel challenges (BAMF, 2018a).

According to estimates, there were around 15,000 civil, local and NGO-based measures or projects to support the incoming refugees and develop problem solving concepts. Psychotherapists donated their time and crowdfunding projects were set up to cover the costs of psychotherapy sessions.

Mental health problems of Yazidi refugees in Germany

The traumatic experiences of Yazidis do not end after having left Iraq to seek refuge in safe countries. The journey to Europe is often perilous and many refugees are still victims of abuse on their travels. Having arrived in a potential host country, most Yazidis had to go through the typical asylum process which includes detailed questions about reasons for their flight, which may result in re-traumatisation. The asylum procedure is often experienced as extremely stressful and confusing (Li et al., 2016). Long waiting times until asylum applications have been processed further exacerbate psychological distress. In that regard, Yazidis fared better than other refugees given that their protection rate shortly after the genocide was at 100% as defined by the German government, leading to significantly shortened wait periods (five months on average versus one year or longer; Bathke, 2019).

Even after having arrived in Germany, Yazidis, and refugees in general, still feel isolated and sense a loss of dignity, a loss of their societal status and economic autonomy; many fear for family members who remained in Iraq; they still face stigma, discrimination, uncertainty regarding asylum status, long wait for employment, and rejection by locals (Nationale Akademie der Wissenschaften Leopoldina, 2018). All of these post-migration stressors add to the mental health burden and result in sequential trauma. Contact with officials and the asylum hearing are also experienced as extreme stressors, as are challenges in finding employment, uncertainty regarding family reunification and financial insecurity (BAfF, 2017). The living situation in crowded accommodation further exacerbates the issue. Loss of motivation, demoralisation and a feeling of being overwhelmed even by small challenges may be the result (Sadowski, 2016). There is a risk that these feelings become chronic, resulting in a poor outlook on future prospects, thereby exacerbating mental health problems. In this condition, many refugees do not possess the energy to undergo psychotherapy in which they have to confront their traumatic experiences. Consequently, for some refugees whose asylum status is still uncertain, psychotherapy may not be effective and even harmful (BAfF, 2017).

The Special Quota Programme

In 2015, the government of the German state Baden-Württemberg started a “Special Quota” to bring the most vulnerable young women and their children, who had survived ISIS captivity, to Germany (Gesellschaft für bedrohte Völker, 2019). These women had all experienced sexual violence at the hands of ISIS and 82% of them were also subjected to physical torture. Half suffered from depression, 39% from anxiety and up to 57% had PTSD (Kizilhan, 2018).

1000 women and children were settled in Baden-Württemberg, another 30 in the state of Schleswig-Holstein and 70 in Lower Saxony (Gesellschaft für bedrohte Völker, 2019). Within these three states, Yazidis were hosted by 21 volunteering municipalities. The majority of Yazidi mothers in the special quota programme were between 14 and 30 years of age. The programme did not separate women from their children, meaning that many women arrived with their new-borns. Some of the women gave birth in Germany. Among the total number of 1100 Yazidis of the special quota visa, 409 were women and 690 were children.

The programme was supported through a collaboration with the High Council of Yazidis in Iraq, the Kurdish Iraqi Health Directorate and IOM. Prof Kizilhan, himself a Yazidi, acted as the chief psychologist of the programme. In collaboration with local officials in Dohuk, Prof Kizilhan and the Baden-Württemberg official lead of the Special Quota project, Michael Blume, carefully identified those women in most need of the programme after medical assessment (Hillebrecht et al., 2018). Criteria included the potential for integration, traumatic experiences, age, and ability to travel. Only women residing in the Kurdish Region of Iraq (KRI) could be included in the programme. IOM then helped to arrange for travel. Before they were brought to Germany, the women travelled to the Yazidi high temple in Lalish where they were re-

baptised and received benediction from the former Yazidi religious leader Baba Sheikh. He assured the women that their honour had not been violated by their experiences of sexual violence (Hillebrecht et al., 2018). This was seen as a vital part to healing given the central role religion plays for the mental health of Yazidis. Re-baptism was experienced as cleansing and the involvement of the Yazidi High Council was important in ensuring the acceptance of the special quota project.

German municipalities participating in the programme received information regarding the needs for accommodation, medical and psychological support, need for translators, and food requirements of Yazidis. When allocating women and children to different host communities a key consideration were family relationships, as well as the specific medical and psychological needs and the availability of suitable treatments in the respective region. The allocation also considered future needs and developments in terms of family members returning from captivity. States also covered housing and medical care (Hillebrecht et al., 2018).

A specialised trauma programme was designed for the needs of the women and their children based on a transcultural approach (Kizilhan & Noll-Hussong, 2017). German doctors, therapists, social workers and interpreters received cultural sensitivity training. Women were accompanied during medical appointments, psychotherapy, talks with social workers and when dealing with officials. Both Kurmanji and Arabic interpreters were available, with the former being accepted more readily by most Yazidis. The details of the MHPSS services provided to beneficiaries in the programme were developed by the host municipalities, following recommendations from project experts (Hillebrecht et al., 2018; Mohammadi, 2016).

A prime example is the concept of care developed by the city of Freiburg which hosted 197 women and children (Hillebrecht et al., 2018; Mohammadi, 2016). It was designed in collaboration with the Freiburg Office for Migration and Integration, the university clinic and specialists in psychotraumatology (including those for children and adolescents). The programme followed a stepped-care approach similar to the IASC MHPSS guidelines followed by many NGOs in Iraq (Interagency Standing Committee, 2007). Social workers formed the base of the care pyramid with the higher-tier steps consisting of group-based activities, focused on one-on-one sessions for stabilisation and crisis intervention, assessment by psychotherapists to establish the need for specialised care, and finally specialised therapy provided by experts (Hillebrecht et al., 2018).

Social workers were available in refugee's accommodation and could be approached in case of any medical or psychological needs. Social workers formed the bridge between Yazidi women and psychotherapists, who provided open psychological counselling sessions every two weeks. The goal was to allow psychotherapists to get in touch with all women through short visits or group sessions and initial psychoeducation such as stabilisation and relaxation techniques to establish a trusting relationship and reduce stigma around help seeking. These activities were separate from focused psychotherapy. If it became apparent that other means of psychological support were needed, psychotherapists could get in touch to assess the case further, provide information about psychotherapy, determine the need for and potentially refer severe cases to psychiatric care. In many cases, low level support could already improve the status of these Yazidi women. Acceptance of the programme increased after an initial period of adjustment and continued to do so during the course of the project with 12 women and four children accessing psychotherapy (Hillebrecht et al., 2018).

Besides specialised trauma treatment, women and children also had the opportunity to attend language courses, social, recreational and cultural activities and schools. The programme thereby aimed to offer a structured, everyday life to allow women and children to develop a routine, provide direction, orientation and continuity, all essential aspects for trauma stabilisation and recovery. Children enjoyed attending school and made substantial progress in their language courses. In contrast, women often struggled to learn. Many were illiterate or had low levels of education. Their mental health problems severely affected their ability to concentrate and learn (Gesellschaft für bedrohte Völker, 2019).

Women only slowly began to accept trauma therapy given that dialogue with a psychotherapist is not a standard approach in Iraq. Care had to be taken to incorporate knowledge about the cultural attitudes to issues such as sexual violence in the therapeutic

approach. For children, new approaches to trauma therapy were necessary. As a result of the many traumatic experiences, children tended to use suppression as a coping mechanism, making cognitive access to these experiences challenging. The collective nature of the trauma could be used as a source of resilience when building treatment approaches based on a narrative of the strength of survivors, cultural practises and building on community resources, solidarity and comradery (Kizilhan & Noll-Hussong, 2017). Using this type of positive psychotherapy focused on resilience and post-traumatic growth may be particularly valuable in survivors of extreme violence (Kizilhan & Wenzel, 2020).

It is well known that protective factors to strengthen resilience are familial and other social relations, integration in the host country, approved asylum status and education or occupation (Walther et al., 2019). The Special Quota Programme therefore aimed to develop new approaches and new guidelines to treatment for traumatised women in the context of war, which have been published as a textbook by Prof Kizilhan. The programme has achieved positive results: “the ability to laugh again shows that a new start is possible” (Gesellschaft für bedrohte Völker, 2019). Especially the younger women in their early twenties showed more positive results as they were faster to adapt to their new environment and were actively engaged in efforts to integrate. Those who are older have more difficulties to adapt, possibly because they internalised their culture to a greater degree and find it more difficult to cope with experiences of rape, as feelings of shame remain.

The project also provides important insight into adequate design of other MHPSS programmes for highly traumatised women elsewhere in the world. Following on from this project, Prof Kizilhan was awarded €1 million to train psychologists in Northern Iraq as part of a new graduate programme at the University of Dohuk (Gesellschaft für bedrohte Völker, 2019). The programme is an excellent example for the importance of community action and the success of incorporating members of the Yazidi community into aid programmes.

As in years past, members of the German Yazidi community also sought to aid the newcomers of the Special Quota Project. In fact, 40 of the Yazidi women of the special quota project have now married German Yazidis, with some having born children from their new marriage. The majority of the women from the Special Quota Visa Programme have expressed their desires to stay in Germany. At least 15 of them have returned to Iraq to be reunited with their recently freed family members (Gesellschaft für bedrohte Völker, 2019).

There are also critical voices with regards to the Special Quota Programme. For some Yazidis, such programmes feel exclusionary and create a hierarchy in terms of eligibility for specialised support. Those who are excluded may become even more hopeless (Vale, 2019). Critics have also noted that the programme uproots some of the most vulnerable Yazidis and argued that mental health support should be given to Yazidis in their homeland (Gesellschaft für bedrohte Völker, 2019; Mohammadi, 2016). It has also been argued that a better option to care for those most vulnerable would be to support more services in KRI region in order to expand capacity. However, in Iraq these women resided in IDP camps under poor living conditions and little security and stability which is highly unconducive to trauma healing. Moreover, in camps they could not be provided the same level of specialised care given the current lack of infrastructure (Gesellschaft für bedrohte Völker, 2019; Mohammadi, 2016).

Reception programme in Brandenburg

In 2016, the state of Brandenburg started a new special visa programme to bring 72 Yazidis to Germany (Bathke, 2019; Welt, 2019). German officials collaborated with UNHCR to identify and select eligible Yazidis. All candidates were interviewed and subjected to background checks through German intelligence. Due to the laborious selection procedure, the first Yazidis arrived three years after the state had approved the programme. Yazidis were accompanied to Berlin by IOM staff and were received by a trained team. They do not have to reside in typical housing for asylum seekers but are provided separate accommodation. It is unclear though to what extent specialised psychosocial care is offered to the new arrivals. The state also funds psychosocial centres in Sinjar in Iraq (Land Brandenburg, 2019).

Yazidis outside the Special Quota Project

For Yazidis outside the Special Quota Project, the prevalence of mental health problems is less well established. Studies on mental health of refugees more generally in Germany have shown that adults and minors all experience high rates of symptoms associated with trauma including flashbacks, intrusive thoughts, psychological stress and physical adverse reactions (Bundeszentrale für politische Bildung, 2015). According to estimates, psychological distress affects 41% of the refugee population and severe stress occurred in 11% (Joksimovic, 2016). These data are based on samples in scientific studies. There are no comprehensive statistics in Germany that could provide a complete view of the medical and psychological needs of refugees (Awdal et al., 2020). Data from different reception centres across the country cannot be directly compared due to different screening methods. In one Berlin centre, data suggested that 75% of refugees had psychiatric symptoms including depression, anxiety or PTSD, while data from another centre suggested this number was at 50% (Nesterko et al., 2020; Winkler et al., 2019).

Yazidis seeking asylum in Germany outside the Special Quota Programme have to go through the same channels as other refugees. After having registered as asylum seekers with officials, refugees are allocated to German states based on a specific quota system and accommodated in an initial reception facility where they receive basic care. A formal application for asylum is processed by the Federal Office for Migration and Refugees (BAMF). Refugees are required to be active participants during their asylum procedure and attend their hearings to explain the reasons for seeking asylum. BAMF officials then assess each case after considering statements during the hearing and through other potential evidence available. After a successful application, refugees are granted three years asylum with the possibility of obtaining unlimited right to remain after a second assessment at the end of the three-year period. Those who have been granted asylum have the right to submit an application for family reunification, but major democratic hurdles still pose significant challenges to reunification (UNHCR, 2017).

During the asylum process at no stage are refugees asked standardised questions regarding traumatic experiences, their wish to overcome these experiences or their need for mental healthcare. Experts note that such questions could be important to identify those in need of psychological support (Brücker et al., 2016).

General mental health services for refugees in Germany

Whether psychological support is included in the provisions for asylum seekers depends on the municipality in which they reside (Brücker et al., 2016). Those with approved asylum status and those who have resided in Germany for 15 months or longer receive the same medical insurance as German nationals in the public insurance system (Meinel, 2016). Before having been granted asylum, refugees are only guaranteed medical emergency services. Each state can determine their own policy regarding healthcare coverage for refugees. Whether they extend healthcare coverage for refugees without approved asylum status is therefore voluntary. Some states issue electronic health cards which may provide asylum seekers with public health insurance on par with that for German citizens, even if they are still waiting for their status to be approved (Meinel, 2016).

Children and refugees who have experienced torture, sexual violence or other forms of severe psychological or physical violence are entitled to mental health care regardless of asylum status. Psychiatric care is deemed as a medical emergency and covered by insurance (Frank et al., 2017). Therefore, the experiences of many Yazidis may qualify them to receive care even during the period before their asylum status has been approved. In contrast, psychotherapy is not covered during the wait period unless an official application has been submitted and approved. The application requires substantial paperwork and time, and may still be unsuccessful despite medical evidence proving that psychotherapy is indeed needed (BAfF, 2017). This stands in direct contrast to the research on traumatology that clearly recommends MHPSS services to be provided readily to individuals with traumatic

experiences, and that recovery from PTSD cannot only be achieved through psychotropic medication but requires psychotherapy (Brücker et al., 2016).

In practice, receiving appropriate mental health support is still highly challenging. In most German cities, therapists, psychiatrists and counsellors are already working to capacity (Brücker et al., 2016).This is exacerbated by high numbers of refugees in recent years and by their special needs as a result of their traumatic experiences. There is an insufficient number of qualified personnel to deliver psychotherapy, especially in rural areas and for specialised trauma treatment. Mental health needs of all refugees cannot be met given the current capacity because demand for psychological support is too high (BAfF, 2019b). This is the case for regular psychotherapists and psychiatrists as well as for specialised centres for refugees and torture victims (BAfF, 2019a). Counselling centres, women's centres and family centres do exist but barriers to access are travel distance, shortage of staff and appropriate translators, especially for refugees who speak less common languages, such as Kurmanji.

Although many patients will need specialised trauma services, basic services can offer a first relief, such as psychosocial support through integration into social groups or coping mechanisms. However, there are currently insufficient programmes offered even for these basic services (Nationale Akademie der Wissenschaften Leopoldina, 2018). Social workers are also overworked and cannot adequately consider the psychosocial needs of the refugees they are responsible for given the allocation of up to 140 refugees to a single social worker. Officials in charge of refugee accommodation, social workers, teachers and volunteers report that they do not have the qualifications to provide support to refugees with traumatic experiences (Forum für soziale Psychiatrie, 2017).

Psychosocial Centres in Germany

The Federal Agency for Migration and Refugees recommends that psychoeducation, counselling, and psychotherapy are most important to meet specific mental health needs in refugees. They further stress the importance of multi-disciplinary concepts with integration of different activities into a holistic approach, and low-threshold access. A multi-disciplinary approach may be beneficial in reducing stigma and health seeking behaviour (Walther et al., 2019).

Besides classic clinical mental health support, psychosocial aspects of wellbeing should not be neglected. These include ways to improve future prospects, support during the asylum process, social activities and vocational opportunities (Adorjan et al., 2017). Integration into social networks and aid in developing basic coping methods may be sufficient for those with milder cases of mental health problems (Nationale Akademie der Wissenschaften Leopoldina, 2018). These types of support are typically offered through psychosocial centres (Psychosoziale Zentren – PSZ). As of December 2020, there were 44 PSZs in Germany, with another ten in preparation (Adorjan et al., 2017; BAfF, 2020).

These centres are non-state, charitable organisations funded by private donations and in some cases by the federal or local government. All centres are organised under a federal working group for refugees and torture victims (Bundesweite Arbeitsgemeinschaft der psychozoialen Zentren für Flüchtlinge und Folteropfer; BAfF, 2019b). Each PSZ has at least one psychotherapist and one social worker on staff with the majority of workers being volunteers. PSZs were established to fill the gap in governmental mental health support services. They differ widely in terms of their capacities but follow a holistic approach to wellbeing. Staff members are trained in cultural sensitivity. Their multimodal approach to trauma healing is essential in addition to the stability obtained through a successful asylum application (BAfF, 2017).

In each centre, refugees can request information about employment, education and other aspects of everyday life in Germany. Many centres also offer basic crisis management, psychological stabilisation techniques, psychoeducation, counselling and therapy, including specialised psychosocial counselling for traumatised individuals, children, families and adolescents (Meinel, 2016). Psychiatric services are only available in one fourth of all centres. Social and cultural activities, language courses and vocational classes may also be offered.

Centres aim to include translators for as many different languages as possible but report that there is a chronic lack of interpreters (BAfF, 2017; Institut für Angewandte Forschung (IAF), 2016).

Centres carry out quality management and evaluation to improve their services (BAfF, 2019b). Across PSZs, data are collected on the number of beneficiaries and the accessibility of their services. Most centres can accommodate less than 500 clients, while some have capacity for up to 1,500 per year. In 2017, the 489 staff members (not counting volunteers and translators) across all PSZs could accommodate 21,418 clients with some form of support, while 2451 beneficiaries accessed psychotherapeutic treatment, 6% of whom were Iraqis. The number of Yazidis among them is unclear. Finally, PSZs could refer 2,913 refugees to clinical specialists who are covered by public healthcare. Counselling and psychotherapy offered through PSZs themselves are rarely covered by the government provided health insurance, meaning that the centres typically have to cover these costs themselves.

To put the annual number of PSZ beneficiaries into perspective with the 1.55 million refugees in Germany it becomes very apparent that PSZs could not possibly reach all those in need of support. From 2012-2017 PSZs doubled their capacity while in the same time the number of refugees increased by a factor of three. As a result, many refugees who seek services have to be rejected and those accepted are subject to long wait times. If a suitable translator is unavailable, beneficiaries also have to be rejected by PSZs. Centres tend to provide help to those without asylum in order to aid the most vulnerable asylum seekers who are unable to receive other forms of support. Therefore, it is likely that PSZs can only support a small number of Yazidis given fewer available Kurmanji speakers as translators and because of their protected status in the asylum process (BAfF, 2019b).

In focus group interviews, female refugees in Germany express that they would like more information about topics regarding psychology and education (including psychotherapy and family therapy), women's health and work (BAfF, 2019b). There are multiple women's groups and centres for refugee women to provide psychosocial support and information to empower women to lead a more independent and self-determined life. These centres are also working with peer supporter systems and some offer courses in Kurmanji (Heinrich Böll Stiftung, 2018).

Refugee children and mental health

There is a substantial lack of specialised clinical services for traumatised refugee children even though demand is highest among this group (Bundes Psychotherapeuten Kammer, 2015). There is no data regarding the number of Yazidi children with mental health conditions in Germany. Judging from data gathered in Iraq, they are in dire need for specialised services. Nonetheless, officials note that there is no guarantee that the demand can be met in all refugee centres in Germany (Frank et al., 2017).

PSZs are often the only source for specific psychosocial and psychotherapy support for children because wait times for professionals as part of the public healthcare system are too long.

There are many structural hurdles for child services to arrange access to child and adolescent mental health specialists. The absence of a standardised procedure between different child welfare offices makes this process significantly more challenging (BAfF, 2019b). Moreover, group therapy cannot always be arranged because there may be an insufficient number of clients from similar backgrounds to form a homogeneous group.

Schooling

Providing refugee children with suitable schooling opportunities is crucial for their mental health, integration into German society and future prospects (Sadowski, 2016). However, teachers often have no training in working with traumatised children or in teaching those with limited German skills. Access to schooling is more challenging for adolescents aged 16 and older due to slower rates of language learning, illiteracy, and the lack of a legal requirement to attend schools past this age. Another barrier is access to higher education due to restrictions of asylum laws. The Office for Immigration and other officials may not approve an

application to take up higher education, restrictions of freedom of movement may severely reduce the choices available to refugees and financial support is lacking.

There are dedicated projects to address some of these challenges. The state of Rheinland-Pfalz has established a ten-point plan for language support in schools. The plan offers free vacation language courses, support with homework and more than 150 intensive German courses. It also aims to provide more teachers to refugees in reception facilities where refugees first arrive. In Bavaria, there are 95 locations that provide refugees with two-year preparatory courses for employment. Some businesses have begun to set up special programmes such as paid internships and traineeships for refugees (Langenfeld, 2016).

Teachers should be provided with at least basic cultural sensitivity training and an understanding of the psychological needs of refugee children as to avoid misunderstandings and incorrect interpretations of certain behaviours (Kerres & Bauhofer, n.d.). Between 2016 and 2019, BAMF has offered training in trauma sensitive teaching for 1500 educators.

Other factors affecting mental health

Accommodation

There is no standardisation with respect to refugee accommodation across states in Germany. The condition of refugee accommodation has a substantial impact on mental health. More crowded housing results in a loss of privacy, greater stress, and worse prospects with regards to integration in Germany. For instance, research has found that women living in smaller groups were more focused on their future prospects, while those in crowded accommodation focused on their basic needs. Refugee interviews show high degrees of unhappiness regarding accommodation due to lack of privacy and poor sanitation (in part due to absence of separate bathrooms for men and women; Heinrich Böll Stiftung, 2018). Refugees are often housed under suboptimal conditions that bear a high risk of exacerbating stress and mental health problems (BAfF, 2019b). They live under highly restrictive conditions with few activities in which they could partake.

Integration

Integration is key to mental health in refugees. German policies regarding refugees are focused on a fast integration. In 2014, new policies were passed to facilitate crucial steps for the integration of refugees, such as quicker access to the labour market, language classes and integration courses, which teach the basics of the German language, culture, politics, values and laws. Integration courses are also offered for particular groups of refugees with particular needs, including adolescents, parents, women, and illiterates. Learning material for these courses has also been made publicly available through an online platform (Meinel, 2016).

Refugees in Germany are allowed to take up employment within three months of their arrival if the Federal Employment Agency (BA) has determined that there is no other suitable candidate for a given position (Förderverein PRO ASYL e.V., 2016). After 15 months, this criterion is lifted. For refugees aiming to begin an apprenticeship, there is no requirement for an assessment through the BA (Langenfeld, 2016). Such early integration into the labour market is highly beneficial in reducing the financial burden for the state and providing a future prospect for refugees and allowing for more contact with German society.

However, a major barrier to employment, education and access to medical facilities are restrictions of movement that even apply to those with asylum. Another challenge is the uncertainty regarding accreditation of degrees refugees obtained in their home countries because it cannot be established if training is equivalent to that in the German system. In many cases, there is no documentation to assert the qualification (Förderverein PRO ASYL e.V., 2016).

Refugees provide a major economic opportunity given that many of them are young and eager to take up work but structural hurdles remain that keep them from fulfilling this potential. Reducing these barriers should be in the interest of the government given that 40,000

apprenticeship positions in Germany cannot be filled. Barriers to integration in Germany are the lack of formally trained teachers that can provide German as a second language course. Teachers are also not trained in handling traumatised individuals (Förderverein PRO ASYL e.V., 2016).

For Yazidis outside the Special Quota Project, it is very likely that the high prevalence of mental health problems and the relatively low capacity of support services pose a significant barrier to integration (BAfF, 2019a).

Access to MHPSS

Access to psychosocial support for refugees is challenged by cultural, linguistic and structural barriers (Adorjan et al., 2017; Trilesnik et al., 2019). There is a chronic shortage of available translators. In some cases, family members (especially children who learn the language more rapidly) act as translators, which bears the risk of traumatisation and means that confidentiality cannot be guaranteed (BAfF, 2017).

Cultural differences in attitudes towards mental health pose another hurdle. Differences in values, needs and understanding of psychological problems and the high expectations patients have regarding their healing process are challenging (BAfF, 2016). Childcare during psychotherapy appointments is not provided, forcing mothers to bring children to the appointment, which can have negative effects on the child's mental health (Heinrich Böll Stiftung, 2018).

Structural barriers are the German asylum law and the absence of a streamlined system for MHPSS service provisions to refugees across the country (Heinrich Böll Stiftung, 2018). There is also no requirement for early mental health screening in reception centres that could identify high risk cases (Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016). Even refugees who have been granted the same coverage as German citizens still face the challenge that it is not always clear whether insurance will pay for clinical care or translators (BAfF, 2017).[16] In the case of translators, insurers argue that because German is the country's official language, they are not legally obliged to cover costs (Frank et al., 2017). Only 35% of all social services paid costs for translators (Walther et al., 2019). Restrictions of movement based on asylum law add to reduced accessibility of mental health care services (BAfF, 2017).

Besides existing mental health care structures, other factors also play an important role in supporting the wellbeing of refugees. One of the factors experienced as most damaging to their mental health is the long wait period during the asylum process. There is a well-established link between a longer asylum process and a higher prevalence of mental health conditions (BAfF, 2017; Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016). Experts say that trauma recovery is only possible in a stable environment and with future prospects, which is not given when refugees have to live with the uncertainty of a pending asylum process (Knaevelsrud, 2016). Fortunately, in the case of Yazidis, their priority status meant that wait times during the asylum process were significantly shorter than those for many other refugees.

Approaches to address the shortage of MHPSS services

The Federal Association of Doctors in Germany has noted that capacity limits call for novel, creative approaches to care (Bundesärztekammer, 2017). These should be evaluated scientifically to determine their effectiveness. There are many developments in the MHPSS landscape in Germany. Many efforts are being made to develop and test new support models and adjust therapy methods. The adjustment of psychotherapeutic approaches to a variety of different cultural contexts and languages is still in the early steps and will require significantly more work in the future (Bundesärztekammer, 2017). A variety of different actors in Germany

[16] It should be noted that the former problem is not different from the challenges that Germans with public health insurance face when in need of psychological care, given that care is only covered if a professional deems it necessary.

developed projects to address the shortcomings of the existing MHPSS system. Professional organisations such as the German Society for Psychiatry, Psychotherapy, Psychosomatics and Neurology (DGPPN) have published their model and recommendations. There is also an active community of intercultural clinical professionals who are developing novel treatment plans (Adorjan et al., 2017).

Core features of these models are a stepped-care approach based on the IASC guidelines for better resource allocation, streamlining of services by connecting providers and a focus on peer supporters and community engagement, capitalising on the cultural and linguistic knowledge of refugees and migrants (for more examples and details, see Appendix). By offering low-barrier psychosocial support services, coverage and access can be increased. Moreover, these services do not need to be provided by highly trained experts (BAfF, 2019b). Successful examples of such models are the concept of care from the programme used in Freiburg as part of the Special Quota Programme for Yazidis and the peer support Harikara model in Iraq (Free Yezidi Foundation, 2020b).

German healthcare providers tend to rely on the higher specialised steps on the care pyramid, which may exacerbate service shortages. The potential and feasibility of such a stepped-care approach for the treatment of depression is now being studied at the Charité Berlin as part of the MEHIRA project (Charité, n.d.). The insights gained from this study will also be used to improve existing structures provided to alleviate trauma. Inclusion of refugees into the design of care models should also be expanded in the future (Schellong et al., 2016).

Models that consider the establishment of treatment networks in collaboration with a central coordinating partner with the expertise in traumatology and intercultural competency seem promising and have been developed by multiple German university clinics such as those at the Charité Berlin and Konstanz (Adorjan et al., 2017). The general idea is similar to that of the trauma network established in Dohuk in Iraq. A competent coordinating partner can bring smaller providers into the network and offer specialised training and conferences in which experiences and approaches can be exchanged. The role of university hospitals is particularly promising given their expertise in teaching and their understanding of novel scientific developments and established methods for the evaluation of the effectiveness of such programmes. This approach may also reduce barriers to MHPSS access.

The integration of refugee reception centres and with MHPSS services may also be promising and is being tested in the refuKey programme in Lower Saxony. This approach may lower barriers to MHPSS service access by using a stepped-care process, in which reception centres are directly connected with psychosocial centres and clinics. Staff receive cultural sensitivity training (Trilesnik et al., 2019). A first scientific evaluation has shown that this approach has been helpful in a group of around 450 refugees in terms of depression and anxiety symptoms, but longer-term help may be needed to also achieve a positive effect on traumatisation. This may be challenging to achieve for refugees with uncertain asylum status.

One suggestion to address the need for more personnel is to increase the number of services provided by semi-professionals and trained laymen. For instance, “Language and integration mediator” (referred to as SIM in Germany) is a new occupation that has been developed in a project aimed at improving integration of refugees in Germany. SIMs have a migration background themselves and are trained for a minimum of one year according to a standardised, certified system. SIMs have knowledge of the German healthcare and social system, basic legal matters and psychosocial support approaches. They can function as a bridge between refugees and other services or officials as well as to German culture more generally. As SIMs share the language and migration experiences with their beneficiaries, they can support refugees more readily and are more likely to develop a trusting relationship (Forum für soziale Psychiatrie, 2017).

The use of trained peer supporters is also deemed effective, provided adequate training. Especially for Yazidis, the peer supporter systems may be promising given the otherwise small number of translators and language teachers (Nationale Akademie der Wissenschaften Leopoldina, 2018). Peer supporters could be trained using a trauma module and form the base of the care pyramid providing easy access to first-hand information regarding available MHPSS services. Peer supporters could also offer psychoeducation and stabilisation

techniques and assess the need for MHPSS services through health screenings thereby adding another low-threshold referral pathway. This model allows delegation of basic steps to peer supporters and leaves more time for professionals to focus on severe cases. Peers can provide short-term immediate interventions that can bridge wait times. Peer supporters should be supervised by psychotherapists. A 2018 outline of such a programme has suggested that peer supporters could be trained over six weeks as trauma counsellors and may be supervised by psychotherapists who could oversee four peer counsellors each. The proposal estimates that 500 peers could be trained as trauma counsellors per year.

Example programmes already exist in Germany. In multiple cities, peers who may have been refugees or have a migration background themselves provide psychological first aid, identify individuals in need of more psychological support, offer psychoeducation, information about referrals and may also accompany them to psychotherapy appointments (Ärzte Ohne Grenzen, 2017; Psychosoziales Zentrum für Flüchtlinge Düsseldorf, 2017; Xenion, 2004). One of the programmes with the most thorough training for peer supporters is the Centre for Intercultural Psychiatry and Psychotherapy at the Charité Berlin and involves a two month training and four supervised group sessions (Adorjan et al., 2017). Peer supporters are trained in psychological stabilisation techniques, resilience support, issues of cultural identity, and prevention of radicalisation. The programme is rooted in scientifically validated methods to train peer support (Missmahl et al., 2012). The University of Konstanz also uses this approach (Adorjan et al., 2017).

Some programmes are more generally geared towards aiding in the integration process. Peers provide help with everyday life questions regarding education, parenting and health (Wegweiser Bürgergesellschaft, n.d.). They can refer other refugees to the appropriate services. Examples are programmes in Berlin, Frankfurt, or Düsseldorf.

It should be noted that there is no standardised system for training of laymen. In some cases, peers are provided basic knowledge over two days, whereas others include up to eight training modules and are supervised regularly (BAfF, 2019a). Due to these differences in training it has been suggested that peer supporters should be classified into different categories according to their supporting role. This could be helpful in establishing a clearer understanding of the competencies of peer supporters and could help to develop a standardised system.

Although promising, there remain several caveats of peer support programmes. Refugees placed in rural areas are less likely to benefit from such programmes because of shortages of potential peer supporters with the same language and cultural background. Criticism also concerns the potential of role confusion for peers. On the one hand, they are expected to be a peer supporter and on the other they have to remain neutral during certain appointments (medical or legal). The lines between these different functions can become blurry. Moreover, refugees may confuse peer supporters and social workers, where only the latter are actually qualified to address any concrete requests regarding accommodation or medical needs. Nonetheless, it has been shown that many refugees approach their peer supporters with complex questions regarding issues that should be discussed with their social workers. This can detract from the original role of peer supporters as providing psychological stabilisation techniques. Role specification is therefore highly important. Peers should only provide aid in the activities for which they were trained. However, constantly receiving questions about other topics may lead peer supporters to discuss other issues as well or take on a quasi-therapeutic role for which they are not qualified. The results could be more harmful than helpful, with peers providing incorrect advice potentially leading to increased risk of re-traumatisation and beneficiaries questioning the legitimacy of counselling and psychotherapy (BAfF, 2019a).

In general, it should be refrained from using peers to replace highly trained, more expensive professionals such as social workers, psychologists and psychotherapists. If a reliance on peers for such high-level support is established, this may lead to an even graver systematic lack of support in the long-term as the number of professionals is reduced to reduce costs (BAfF, 2019a).

A major challenge of peer supporter approaches are the costs and the substantial need for training in multiple different languages to meet the needs of different refugee groups.

However, in the long-term, this approach may reduce costs given the reduced burden on specialists and the greater potential to prevent the development of more severe mental health conditions without any short-term intervention, which are likely to lead to a greater need for expensive specialised care in the long-term (BAfF, 2019a).

It is unclear to what extent such peer training programmes currently meet the needs of Yazidis. Most of these peer supporters speak Arabic, meaning that many Yazidis would not be able to communicate with them or could have an adverse reaction to them given the strong association between the Arabic language and their traumatic experiences at the hands of IS.

Other low-threshold services to mental health and general psychosocial support are offered online. For instance, an app was developed to provide refugees with basic information about life in Germany, the asylum process, employment, and education. It also includes a basic German course (BAMF, 2018b; Walther et al., 2019). Unfortunately, as of January 2021, the app is not available in Kurmanji. In another project, the German Survival Centre for victims of persecution and violence has developed two online therapy apps, the Application for Mental Health Aid for Refugees (ALMHAR) and Smartphone Mediated Intervention for Learning Emotional Regulation of Sadness (SMILERS; MacGregor, 2018; Zentrum Überleben, 2018). These apps are meant for fast intervention and self-help but should not replace psychotherapy for those with more severe mental health problems. As in other cases of online support, the apps are available in English, Arabic and Farsi but not Kurmanji meaning that are not accessible for the majority of Yazidis. The centre has also developed e-learning tools for cultural sensitivity for German health professionals.

Finally, demand for mental health services may be underestimated due to lower help seeking behaviour in refugees. This suggests that more information campaigns are needed to increase health literacy and reduce shame around help seeking behaviour. Experience from women and other psychosocial centres show that providing information with flyers is often not enough to reach many potential beneficiaries (Heinrich Böll Stiftung, 2018).

Legal and administrative issues

German officials do not have exact numbers regarding Yazidis residing in Germany because besides country of origin, BAMF does not collect data on the region, language, religion or ethnicity of refugees (Candan, 2017; Heinrich Böll Stiftung, 2018). Data on religious identity are only available if Yazidis clearly disclose their religion during the asylum application process. It is therefore unclear how many Yazidis from Sinjar were granted asylum in Germany and how many were survivors of ISIS captivity.

Since 2017, there have been initiatives focusing on the standardisation data collection during first contact with refugees in reception centres, which would be needed to inform further considerations regarding the provision of care (Frank et al., 2017). The lack of standardisation across states precluded an informative comparison of the medical and psychological needs of refugees across Germany (Schröder et al., 2018). Another challenge is the variety in languages used by different groups of refugees, resulting in a need for health screening tools that are translated to and validated across multiple languages and cultures (Frank et al., 2017). The standardisation of the medical exam in reception centres would be helpful in this endeavour. To mitigate this problem, the government is funding multiple research projects. The Robert Koch Institute has started a project for Health Monitoring in Migrant Populations (IMIRA). They have been publishing recommendations for the standardisation of health data among people with a migration background (including asylum seekers) to improve research and service provision (Schenk & Neuhauser, 2005; Schumann et al., 2019). Another example is the RESPOND Project of the University of Heidelberg funded by the Federal Ministry for Education and Research which carries out research aimed to devise interventions that can make the German healthcare system more effective in providing medical support to asylum seekers and refugees (Universitätsklinikum Heidelberg, 2020). The FlüGe project of the University of Bielefeld similarly aims to identify barriers to healthcare access for refugees across Germany (NRW Forschungskolleg, n.d.).

Outlook

Attitudes of Yazidis towards their experiences in Germany

In interviews with refugees, including Yazidis, they report having chosen Germany because of its security, strong economy, high quality healthcare system and good prospects for education. In questions regarding financial support, many noted they would prefer to find employment rather than receive money from the government. They expected to find employment once being granted asylum. Healthcare was perceived as highly positive. A major criticism was the lack of interpreters (Brücker et al., 2016).

In the German Yazidi diaspora, many Yazidi societies, clubs and parishes are actively working to keep the Yazidi culture alive and have been successful in doing so (Gesellschaft Ezidischer Akademiker, n.d.; Tagay & Ortaç, 2016). Yazidis are campaigning to further integrate Yazidism in Germany through the construction of a Yazidi temple, the establishment of Yazidi curricula in universities or through obtaining official status of Yazidism as a religious community in Germany. There is also an active community of Yazidi academics (Gesellschaft Ezidischer AkademikerInnen - Society of Ezidi Academics) who support research on Yazidi identity and culture, as well as on societal and political issues of interest to Yazidis (Gesellschaft Ezidischer AkdamikerInnen, n.d.).

The openness of the German Yazidi diaspora as a result of religious freedom has many positive aspects such as the ability to practice religious traditions without fear, connecting Yazidis originating from different countries or groups, and lending a stronger voice to Yazidis in Germany and beyond (Tagay & Ortaç, 2016). Nonetheless, in the German diaspora, the question regarding Yazidi identity has become more complex compared to that of Middle Eastern communities. There are differences in opinion regarding political preferences and ethnicity as some Yazidis still identify as Kurds, while others vehemently reject a Kurdish identity, especially following the 2014 genocide.

Disagreements regarding the support for different religious doctrines are not uncommon (Tagay & Ortaç, 2016). For instance, one German Yazidi society notes that they welcome new Yazidis, and that they aim to work with the newcomers on overcoming the “archaic traditions” they may have brought with them from their home countries (Kasem, 2012). Differences between the young and older generations, and differences regarding the extent of integration into German society also contribute to a degree of fragmentation within the German Yazidi diaspora. The younger generation of Yazidis in Germany are more critical of the caste system and the authority of religious and political leaders. The traditional collectivist mindset of younger Yazidis born in Germany is less pronounced than in the older generations. In the face of these differences in opinion, the question whether a collective identity can be maintained is a valid one. The newfound freedoms in the diaspora therefore also go hand in hand with fears of a loss of Yazidi culture, religion and ultimately, their collective identity (Tagay & Ortaç, 2016). The unification of the different points of view within the German Yazidi diaspora is therefore a challenging process and efforts are ongoing.

Conclusions and policy recommendations

Germany is the only country to date that has designed a specialised programme to support the most vulnerable Yazidi refugees who escaped ISIS captivity. The Special Quota Programme has drawn from expertise from within the Yazidi community and involved collaboration between healthcare providers and Yazidi religious leaders. As a result, the programme could integrate cultural needs with standard mental health care approaches. Moreover, having Prof Kizilhan as a member of the Yazidi community as head of the programme was key in bringing the Yazidi perspective and culturally sensitive thinking to the project, which has been essential for its success. Service providers within this programme also successfully applied a stepped care approach to optimise resources. The programme has also contributed to many important scientific insights on mental health in Yazidis and in victims of SGBV more generally. However, the resource intensiveness of this programme means that not all in need could be included in such initiatives.

Officials and professionals in Germany are aware of the need for holistic approaches to mental health but structural barriers pose a challenge for far-reaching coverage of mental health and psychosocial services. In fact, a recent report stresses that the majority of deficits in the German MHPSS system can only be solved through structural changes (BAfF, 2019b). The mental health crisis of refugees in Germany requires fast intervention but increasing the number of psychotherapists is an untenable solution in the short-term given the long duration of the degree. Peer supporters and stepped care approaches are promising options to address the shortage of services. Given that structural changes are generally slow in the making, community action and support from humanitarian and privately sponsored organisations may be a more realistic aid in the short term.
According to UNHCR, priorities for the successful integration of refugees into German society are family reunion, language learning and integration into the labour market (UNHCR, 2017). Mental health support should also be added to this list as wellbeing and the ability to successfully integrate are tightly linked (Nationale Akademie der Wissenschaften Leopoldina, 2018). Those with severe mental health problems are unlikely to live independent lives in a foreign environment. Failure to integrate can lead to frustration and aggression. Programmes aimed at providing MHPSS can therefore contribute substantially to successful integration.

Specific MHPSS recommendations

1) Many peer supporter programmes and online support applications are currently not available in Kurmanji. Collaboration with the providers of these services and members of the Yazidi community to translate available self-help and information materials could significantly increase the reach of basic psychosocial support tools for Yazidis. These online tools can benefit all Yazidis regardless of their country of residence and may be particularly important in regions where access to Kurmanji translators is exceedingly difficult.
2) Health insurance providers should be required to cover the costs for translators needed during medical appointments. They should also compensate psychotherapists in psychosocial centres for their services (BAfF, 2019b).
3) The Federal Agency for Migration and Refugees recommends that access to psychosocial services could be facilitated if centres were close to schools or day-care. There should be more efforts to integrate PSZs with other service providers such as clinics, refugee accommodation, and refugee reception centres to increase access to and effectiveness of MHPSS services (Walther et al., 2019). Similarly, local coordinating networks that connect larger hospitals and clinics with transcultural mental health expertise with smaller practices can improve knowledge transfer and participation of smaller service providers.

Recommendations for political action and structural improvements

1) Refugees should receive a comprehensive first psychological assessment included in the medical exam at reception centres (Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016). The medical examination in reception centres should be standardised across states (Frank et al., 2017). The Refugee Health Screener provides a first sign of a need for care by counting the number of symptoms and their severity. The tool has been developed in collaboration with refugees from a variety of cultures and has been used in studies on mental health among refugees in Germany (Institut für Angewandte Forschung (IAF), 2016). Such screenings are crucial because refugees have a low rate of help seeking behaviour for MHPSS. The PROTECT screen is specifically designed to detect mental health problems related to trauma and can be carried out by non-specialists (Schellong et al., 2016). Personnel in refugee reception centres and housing should be better trained at identifying signs of mental health

conditions in refugees to expedite access to psychiatric care (Danzinger et al., 2018; Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016).
   a. Given that mental health conditions can have a delayed onset after refugees arrive in their host country (BAfF, 2017), the health screening in reception centres is not sufficient to identify those in need of urgent care. Follow-up screenings should also be provided. This could be done by trained peer supporters. It has been scientifically proven that trained peer supporters can reliably detect mental health conditions if using standardised instruments (Adorjan et al., 2017).
2) Bureaucratic hurdles for the collection of comprehensive statistics regarding the mental health needs of refugees and their ethnicity, language, religion and region of origin beyond their nationality should be removed. This would be beneficial for a better understanding of the refugee population in Germany and could improve service provisions. Projects aimed to address this issue are already underway and may also inform data collection systems in other countries (Frank et al., 2017).
3) Refugees with approved asylum status should be given more freedom of movement from state to state to improve access to medical services, employment and higher education, which would benefit integration.
4) Housing provided to refugees should provide at least some room for privacy, which is important for greater psychological stabilisation and has been shown to have positive aspects on integration and language learning (Heinrich Böll Stiftung, 2018).
5) Access to education and the labour market should be facilitated. Although this can only be done through political action, local NGOs and humanitarian actors can have a substantial positive impact in developing basic livelihood programmes as exemplified by the Operation Ezra in Canada. Similar programmes could be established in other countries. As noted by the OE representatives, they have found that their farming project has a more positive impact on mental health and integration than government provided psychotherapy (Operation Ezra).
6) There seems to be no clear overview of peer support programmes in Germany and no one approved or validated a system that is being followed (BAfF, 2019b). A single validated system may be infeasible given regional differences but nonetheless, a clearer picture of the available programmes and their effectiveness would be beneficial. This would be particularly helpful for the optimisation of the training modules for peers. Connecting different peer projects across the country would be highly conducive to the improvement of programmes via the exchange of ideas and experience. There is still a need for more research and formal evaluation of the effectiveness of such programmes, which is essential for the development of best practices. These data should be shared between providers.

6. Canada

Author: Jai Shende

In 2017, the Canadian government resettled 1,215 refugees under the 'Survivors of Daesh' programme, 81% of whom were Yazidi (Wilkinson et al., 2019). The majority of these Yazidi refugees - mostly women and children - now reside in four cities across Canada: Toronto, London, Calgary and Winnipeg (Frangou, 2018). Most of these refugees have been settled under the Government-Assisted Refugees (GAR) program, with a minority under the Private Sponsorship of Refugees (PSR) and the new Blended Visa-Officer Referred (BVOR) programs (Standing Committee on Citizenship and Immigration, 2018).

Mental health of Yazidis in Canada

Like other host countries, Canada is struggling to address the exceptionally high levels of trauma experienced by Yazidi survivors. Trauma is particularly prevalent among refugees in the GAR program (who make up the majority), because they represent the most vulnerable among Yazidis. GAR refugees also tend to have lower levels of education (Wilkinson et al., 2019). In one Canadian study, more than 80% of Yazidi participants had been diagnosed with a mental health problem (Bhattacharyya, Riziki, et al., 2020). Their main issues are anxiety, panic attacks, post-traumatic stress disorder (PTSD), compulsive disorder, conversion disorder, and depression. Some psychologists have noted the presence of Complex PTSD (C-PTSD), which is associated with prolonged or repeated trauma over many months or years, as opposed to PTSD, which typically follows a single traumatic event. While PTSD is triggered by trauma reminders, C-PTSD is considered to be 'a more deeply-rooted disorder that affects the very core of one's self-organisation' (Health Reference Centre Academic Editor, 2018). In one study of resettled Yazidi women, all of whom had been held in captivity by ISIS, 51% had C-PTSD and another 20% had PTSD (Hoffman et al., 2018).

This level of trauma has an impact on all other aspects of integration. For example, research on Yazidi refugees in Calgary has shown that mental health issues, in addition to low literacy rates, affect memory and impede Yazidi refugees' ability to learn English (Bhattacharyya, Riziki, et al., 2020). Worries about family and friends who are missing, still in captivity or left behind in IDP camps in Iraq affects the ability to concentrate in language classes. As one Yazidi mother in Canada says, 'we have seen too much with our bare eyes. We have seen people die in front of us. It's all taking a toll on the mind' (Wilkinson et al., 2019, p. 34). Yazidi refugees in Canada are allowed to take up employment as soon as they are able, but their mental health challenges, gaps in education, weak language skills, lack of foreign credential recognition and lack of Canadian work experience all impede Yazidi refugees' abilities to find employment and become financially independent within their first year of arrival. In one study of 35 Yazidi refugees in Canada, only two participants were employed, in low-paid, part-time jobs (Wilkinson et al., 2019). Addressing their mental health needs is therefore key to successful resettlement and integration.

Mental health support available in Canada

Currently, GARs are resettled by the government as permanent residents and have access to all provincial health services. The Interim Federal Health Program provides additional mental health services on top of this. Refugees are entitled to ten one-hour long sessions with a professional during their first year in Canada. Treatments can include intensive therapy with qualified specialists, Selective Serotonin Reuptake Inhibitors (for PTSD and conversion disorder, depression, anxiety disorders), Eye Movement Desensitization and Reprocessing, narrative therapy, Cognitive Behavioural Therapy, and resettlement. This final option is considered to be the most effective long-term solution (Wilkinson et al., 2019).

Immigration, Refugees and Citizenship Canada (IRCC) also provides funding so that each community can hire a 'wellness coordinator', who provides short-term brief counselling and

therapeutic group support. Provincial settlement organisations such as Merrymount Family Support and Crisis Centre, London Cross Cultural Learner Centre and COSTI Immigrant Services provide services such as art therapy groups for Yazidi children.

However, these services are not always utilised. Statistically, refugee populations are less likely than the general population to seek help for mental health problems. Likewise, not many Yazidis are using available mental health support in Canada. The IRCC is aware of only five Yazidis receiving individual counselling and 50 accessing medication to treat mental health conditions (Standing Committee on Citizenship and Immigration, 2018). This could be explained by a reluctance to disclose traumatic experiences due to fear of shame, or a feeling of having failed to meet cultural expectations. This applies particularly to those Yazidi women and girls who experienced rape and forced marriage (NPR, 2019).

The Yazidis who do try to access mental services face many obstacles. Most cannot book appointments without the assistance of an English or French speaker. Wait lists, complex referral procedures and inconvenient hours add to this difficulty. Yazidis also struggle to use public transport if appointments are far away from their housing. Moreover, women in particular have domestic responsibilities, such as childcare and cooking, which they often prioritise over their own appointments (Saheb Javaher, 2020). Some volunteer organisations, such as Project Abraham in Toronto and Community Connections for Newcomers Program (CCNP) in Calgary, attempt to help with everyday difficulties by driving Yazidis to appointments, helping them shop for groceries and practicing English with them. However, they do not have the resources to be available for Yazidi families all the time. A more capable and universal service is needed.

The IRCC and the Interim Federal Health Program fund translation and interpretation, but there is a shortage of Kurmanji-speaking interpreters for the therapy itself. This scarcity is exacerbated since most Yazidi women prefer same-sex interpreters for cultural reasons and due to the sensitive nature of their trauma, which is often linked to sexual violence (Wilkinson et al., 2019). Arabic-speaking interpreters should not be used as an alternative (Standing Committee on Citizenship and Immigration, 2018). Most Yazidis have limited fluency in Arabic, and it was the language of many Daesh captors, adding to their distrust and fear.

Some felt that treatments they received were unhelpful. A participant in one study complained that physicians in Canada simply dole out antidepressant and anti-anxiety medication instead of doing the psychological work required to recover (Wilkinson et al., 2019). A lack of cultural sensitivity can also mean that available mental support sessions are found to be ‘overwhelming’ rather than helpful, leading to dropouts (Saheb Javaher, 2020). Unfortunately, when doctors are not trained in culturally sensitive psychosocial support and interpreters are not available, medication can often appear to be the only option.

Other programmes

A promising program is provided by Aurora Family Therapy in Winnipeg, who believe that refugees in Canada require long-term, holistic and culturally aware mental health solutions. They have developed a psycho-social settlement needs assessment designed to be taken at the time of arrival (Wilkinson et al., 2019). This consists of a short screening tool with questions about mental health, the family situation and current living conditions. They meet with a counsellor who makes an assessment and directs the refugee towards appropriate psychological and resettlement/integration services. In this way, the Aurora programme is based on the conceptualisation of health as holistic. For example, if a refugee is having difficulty accessing housing, it could negatively affect their mental health. Follow-up assessments are taken at the 6-month, 12-month, and 18-month mark, so that individuals are tracked throughout their resettlement journey.

In fact, successful resettlement and integration of Yazidi refugees is regarded as the most successful ‘treatment’ for many of the milder forms of mental health problems of refugees (Wilkinson et al., 2019). One holistic solution, a communal farming project, has been started by Operation Ezra, an organisation run by the Jewish Foundation of Winnipeg which so far has privately sponsored 11 Yazidi families’ resettlement in Canada (Operation Ezra, n.d.).

Using land and equipment donated by local businessman Bo Wohlers, the project started out intending to provide food assistance to the 30 Yazidi families in Winnipeg (Sarbit, 2020). It has now been nicknamed the 'Healing Farm' for the way that farming helps Yazidi volunteers work through their trauma. In Iraq, 90% of Yazidis are farmers, so Yazidi refugees in Canada are able to use their expertise. According to Yazidi resettlement coordinator Nafiya Naso, working on the farm helps women fight feelings of hopelessness and uselessness in a country where they have no knowledge of the language, no sense of belonging, and no income (Operation Ezra).

Michel Aziza, chairperson of Operation Ezra, points to the gulf in the resettlement experiences under the PSR program and the GAR programme (Operation Ezra). The former, made up of whole families, tend to integrate quickly and often become independent within a year. The latter, however, are selected based on vulnerability, and are much more traumatised, with missing family members and lower levels of education. They therefore tend to remain financially insecure for a longer period of time. Yazidis within the GAR have also been shown to struggle finding housing after their time spent in government sponsored accommodation, meaning they face uncertainty for a longer period of time which has an adverse effect on integration (Bhattacharyya, Ogoe, et al., 2020).

Aziza suggests that the Canadian government should work with the private sector on the selection of refugee families to ensure that those selected are most likely to successfully integrate into Canadian life (Operation Ezra). This is an instrumental approach from the perspective of an organisation that is struggling to use its limited resources to address the substantial needs of a highly traumatised group. The most vulnerable are more challenging to integrate but are in highest need of resettlement. This poses a difficult conundrum. Without appropriate care, the most vulnerable Yazidis, such as those in the GAR programme are unlikely to recover from their trauma and integrate. The OE representative notes that resettlement programmes that do not consider these needs may potentially be harmful for some Yazidis. The two-tier system of privately sponsored families with high potential for integration and a government sponsored resettlement programme for the most vulnerable is in principle promising and uses complementary approaches. However, it may be more effective to restructure the budget such that a smaller number of highly vulnerable refugees is resettlement with a higher degree of dedicated support services.

Aziza also suggests that family reunification should be a priority. He notes that complete families are much more likely to successfully integrate than those with a missing family member or spouse missing. This is supported by research that suggests family reunification will increase the speed of integration, reduce stress and anxiety, and foster a sense of belonging (Wilkinson et al., 2019).

Conclusions and policy recommendations

We suggest that maximum efforts should be made to settle Yazidi refugees near one another and within established communities for improved emotional support and the sharing of childcare responsibilities. This would allow adult refugees the flexibility to attend language classes and medical appointments for themselves. If social, economic and cultural conditions are stable and accepting, then those with pre-existing health problems can concentrate more time on becoming mentally and emotionally well.

Our policy recommendations are as follows:

1) The Canadian government should work more closely with non-governmental organisations in areas of Yazidi resettlement to coordinate resettlement efforts and collectively ensure that the basic needs of Yazidis are being met. According to Operation Ezra, many Yazidis settled under the GAR program are struggling with integration and are mostly unable to achieve economic autonomy. Cooperation between organisations will enable better and more comprehensive service provision.

2) Yazidis should be settled within close proximity of essential services including schools, language teaching, MHPSS services and medical services. If this is not possible, provisions should be made (perhaps through partnerships with local organisations) to ensure that Yazidis have the necessary assistance to access these services.
3) Efforts should be made to track the progress of refugees' resettlement. The psycho-social settlement needs assessment developed by Aurora Family Therapy in Winnipeg is a promising example of how this could work.
4) The success of Operation Ezra's farming project indicates that more holistic treatment efforts should be pursued. Evidence shows that treatment is most effective when mental health is considered in tandem with livelihood.
5) Efforts should be made to connect Yazidis to other members of their community, whether with the existing diaspora in Canada, with other recent refugees or through family reunification. This will enable Yazidis to better deal with gaps in government service provisions through sharing responsibilities such as childcare and cooking.

7. The United States

Author: Imogen Davies

The Yazidi population in the US

There is no official data available on the number of Yazidi refugees living in the US. The largest US Yazidi population has settled in Nebraska where around 3000 Yazidi reside (PBS News Hour, 2018). The Yazidi population is heavily concentrated in the city of Lincoln in Nebraska, where a thousand Yazidis had already settled prior to 2014 under a programme to provide visas to Yazidis who worked as translators for the US military in Syria and Iraq (Flakus, 2015). Lincoln is home to the NGO Yezidis International which supports Yazidis in Iraq (UYCA, n.d.), as well as several community organisations for Yazidis including the United Yezidi Community of America (UYCA, n.d.) and the Yazidi Cultural Center (YCC), which was set up by the charity Yazda and serves as its global headquarters (YAZDA, n.d.-b). The UYCA estimates that about 215 Yazidi families reside in Lincoln. There is evidence of smaller Yazidi populations in Michigan (where the Yazidi American Women Organization has its headquarters; YAM, n.d.), Texas (where Yazda has a second US office; YAZDA, n.d.), and possibly New York, Washington, Arizona, and New Mexico. There is no data available on the prevalence of trauma or mental illness among Yazidis in the US.

Yazidi community organisations in the US

There are no dedicated mental health treatment programs for Yazidi refugees in the US (Clements, 2019). Jolene McCulley, a program manager at YCC, has stated that "Yazidis need any and all help they can get. Counselling, support groups and psychologist assistance. You name it, they need it" (McCoy et al., 2017). And that Yazidis need to be helped to "overcome the trauma and remember their culture,…, before we focus on integration" (Heisey, 2019). The activities of the YCC and UYCA seem to be focused on sociocultural approaches to support mental health, by helping Yazidis preserve and celebrate their culture while integrating successfully into American life (UYCA, n.d.; YAZDA, n.d.-b). Their programmes include English language classes, citizenship classes, classes on navigating the immigration system, and an academic mentorship programme for Yazidi youth.

Besides general psychosocial support, these organisations do not seem to provide more specific help such as trauma counselling or other forms of medical treatment. There are other support services for Yazidis in Lincoln, such as Lutheran Family Services which supports all vulnerable new arrivals (Lutheran Family Services, n.d.). Their services include support for access to medical appointments, access to mental health and medication management as well as other practical support with integration. They do not seem to provide the mental health assistance themselves. In addition, the charity Community Crops has run "The Yazidi Farmer Outreach and Education Project", through which Yazidis will be given access to land and assistance to establish profitable farm businesses (Community Crops, 2019). Such programmes that are focused on the strengths of the Yazidi community may indirectly benefit psychosocial wellbeing by providing economic autonomy and a return to familiarity.

Specific MPHSS initiatives for Yazidi refugees in the US

Although there are no programs unique to Yazidis, in recent years there have been several mental health treatment programmes aimed at the main refugee groups in Lincoln, including Yazidis. The New Americans Task Force program in Lincoln received a $250,000 grant in 2017 for a three-year project to support refugee mental health including several strands (Davenport & Stryker, 2017):

- Lincoln mental health practitioners would receive training in Narrative Exposure Therapy (a PTSD treatment found to be especially effective for refugees), as well as Yazidi cultural awareness training and two other specific ethnic groups;

- Interpreters for the Yazidis and other specific groups would be trained in best practices in translating during mental health treatment appointments;
- One member of the Yazidi community would receive basic training in Narrative Exposure Therapy and in running peer support groups in their own community;
- Incoming refugees would be screened for mental health issues through a partnership with the University of Nebraska Lincoln, in order to better understand their needs.

No reports or updates have been published since 2017 about this programme. There is some small indication it has been successful: a 2020 report found that refugees who arrive in Lincoln more recently are more likely to indicate that they can easily communicate with their doctor. The report attributes this to these specialist programmes (Lincoln New Americans Task Force, 2020).

In addition, there have been programmes aimed at supporting younger refugees in Lincoln. This includes a program of equitherapy provided by the charity Horses for Healing (Williams, 2017). The programme has reported success in increasing self-reported wellbeing among Yazidi adolescent girls as well as supporting general 'protective factors' needed for resilience against mental illness, which include positive and open communication, leisure activities, interconnectedness, and having company at challenging times (Eller, 2019). Starting in 2015, there was also a program of investment in placing culturally-aware therapists and interpreters into Lincoln public secondary schools to provide counselling for refugee school students during the school day (Wtop News, 2017). Within the first year, there were 60 referrals through schools, with only four families declining the support, and the programme was supporting 46 students in 2017, with more on the waiting list (Nangkal, 2017).

Outside of Lincoln, innovative holistic psychosocial support programs are being developed around the U.S (A. Horn, 2017; Nazzal et al., 2014). However, interpreters and culturally-trained medical practitioners are severely lacking in many areas, presenting a significant barrier to mental health treatment for refugees (Vermette et al., 2014). It is likely that Yazidis living in smaller communities have much less provision than those in Lincoln.

Yazidis who participated in a 2018 study of refugee healthcare needs in Lincoln also cited several barriers to accessing individual mental health treatment: high cost, long waiting times, and difficulty finding providers who accept Medicaid (state health insurance provided to people on low incomes; Center for People in Need, 2018). Moreover, due to the intricacies of the U.S. healthcare system, many Yazidis in Lincoln would lose all access to affordable healthcare once they take up employment. A loss of either the prospect of economic autonomy or healthcare coverage are significant risk factors for mental health problems (Warfa et al., 2012).

Conclusions and policy recommendations

A variety of MPHSS programs are available for Yazidi refugees dealing with trauma, particularly in the main Yazidi community in the U.S. in Lincoln, Nebraska. In addition to the services provided within the Yazidi community by the YCC and UYCA, there are other initiatives to improve their mental health. These initiatives include culturally sensitive counselling for refugee school students, the Horses for Healing equitherapy programme for Yazidi teenage girls, and the Yazidi Farmer Outreach and Education project offered by the charity Community Crops. Based on reports and prior findings in other countries such services are likely to have a positive impact on subjective wellbeing. The New Americans Task Force programme that began in 2017 to help Yazidis and other refugee groups in Lincoln is an exemplary initiative, but there is little information on whether it was able to deliver on its plans or whether it has been successful in supporting Yazidis with PTSD. It is unlikely that Yazidis living outside Lincoln have access to the same level of support. Other regions of the U.S. with Yazidi communities should urgently investigate whether the mental health needs of Yazidis in their area are being met and consider implementing initiatives that have been successful elsewhere. However, many problems faced by Yazidis and other refugees in the US can only be addressed at a structural level through healthcare reforms to ensure that refugees have access to affordable healthcare including mental health services.

Our policy recommendations are as follows:

1) There should be continued investment in mental health services and holistic psychosocial support for refugees in Lincoln, including specifically for Yazidis. This should be based on monitoring and evaluation of current provision through the range of mental health service providers, to address remaining unmet needs.
2) For Yazidis living outside of the main Yazidi community in Lincoln, Nebraska, efforts should be made by local services to understand whether Yazidi refugees are adequately served by general mental health services in that locality. If not, cultural awareness training and interpreters should be provided in these areas, following successful models used in Lincoln.
3) There should be wider policy reform in the US and in Nebraska to reduce the cost of healthcare.
4) Reform is also needed to ensure that refugees are never disincentivised from taking up paid work by reductions in the quality of healthcare accessible to them.

8. The Netherlands

Author: Imogen Davies

The Yazidi population in the Netherlands

The number of Yazidis living in the Netherlands is unclear, but estimates of Western Yazidi diaspora suggest that the number does not exceed 5000 (Allison, 2004). There are no data on the number of Yazidi refugees who have arrived in the Netherlands more recently, nor are there data on the distribution of Yazidis across different parts of the Netherlands. Several NGOs based in the Netherlands provide support for Yazidis in Iraq and internationally, including the Free Yezidi Foundation (Free Yezidi Foundation, n.d.), NL Helpt Yezidis (NL Helpt Yezidis, n.d.), and the Yazidi Legal Network (Yazidi Legal Network, n.d.).

At least some Yazidi refugees have settled in the Netherlands since the genocide. Between August 2014 and December 2016, the Netherlands received 5186 asylum claims from Iraqi citizens (Immigration and Naturalisation Service, n.d.), but there is no data on what percentage of these refugees were Yazidis, and it is possible that other Yazidis entered the country without applying for asylum, unofficially or through family reunification programmes. In April 2019, there was widespread condemnation of the Dutch government's decision to stop approving Yazidi refugees' asylum claims, and this decision was reversed later in 2019 (Reis, 2020). The fact that any Yazidi arrivals are classified according to nationality may lead to them becoming an invisible group within the refugee population in the Netherlands, making them more vulnerable as their specific MPHSS needs are less likely to be identified.

Even if the majority of Yazidi refugees in the Netherlands arrived prior to the genocide, they may still require specialist mental health support related to the deaths of many of their family members and friends still in Iraq. This type of multiple loss has been found to contribute to mental health issues in Iraqi asylum seekers in the Netherlands and likely applies to the Yazidi community as well (Hengst et al., 2018).

Refugee mental health in the Netherlands

There is no data on the prevalence of mental health issues among Yazidis living in the Netherlands, but general studies of refugees in the Netherlands have found rates of between 16% and 37% for PTSD and/or depression (Independent Scientific Advisory Body for the Government and Parliament, 2016). PTSD is known to be more prevalent among women and unaccompanied children, and among those who have spent a longer time in the asylum application process (Laban et al., 2004).

Access to free healthcare, including mental health treatment, is legally guaranteed for refugees in the Netherlands (Klaver, 2016). An important aspect of Dutch policy towards refugees is the Increased Asylum Influx Administrative Agreement (Vereniging van Nederlandse Gemeenten [Association of Netherlands municipalities], 2015), developed in 2015 to divide responsibilities between the government and the municipalities (OECD, 2018). Under this agreement, healthcare for asylum seekers (including mental health treatment) is the sole responsibility of municipalities. Since 1987 the Netherlands have also had spatial dispersal policies aimed at avoiding a concentration of refugees in any one area (Andersson, 2003), by spreading out long-term resettlement locations for refugees and temporary accommodation for asylum seekers around the country (Klaver, 2016; van Liempt, 2011). These policies effectively mean that, despite their obligation to provide healthcare, it is difficult or impossible for municipalities to provide services for a particular ethnic group such as the Yazidis, since there is unlikely to be a large number of Yazidis who have settled in any one municipality. As a result, it may be even more challenging to train healthcare staff in culturally sensitive interactions with Yazidi refugees that consider their specific trauma. It may also restrict access to suitable interpreters to Yazidi refugees as these may not be available in every municipality.

It typically takes several years before ethnic groups in the Netherlands begin to 'regroup' in larger towns and cities after being separated during the asylum process (Klaver, 2016; van Liempt, 2011). This could potentially exacerbate mental health issues for Yazidis, since many Yazidi refugees have already experienced forced separation from family members and friends as a result of the genocide, which is known to be a factor in severity of PTSD symptoms (Jongedijk et al., 2020). Continued isolation from any Yazidi community after settling in the Netherlands is therefore likely to have a negative impact on mental health.

There have been calls to centralise and standardise psychosocial assistance programmes for refugees, including those aimed at developing resilience and coping strategies for individuals, and at increasing trust and participation in the wider community (Arq Psychotrauma Expert Groep & Expertisecentrum Gezondheidsverschillen, 2017). So far, however, changes have been limited to greater sharing of knowledge and data between Dutch municipalities, rather than the creation of cross-municipality programmes to support particular groups such as the Yazidis.

Specific MPHSS initiatives for refugees in the Netherlands

There are some refugee mental health programmes in the Netherlands which are aimed at particular refugee demographics. For example, the 2015 Administrative Agreement notes that the government and municipalities will collaborate on researching therapy techniques specifically for refugee children (Vereniging van Nederlandse Gemeenten [Association of Netherlands municipalities], 2015). There is also an ongoing trial of a specific treatment programme for undocumented asylum seekers with PTSD in Amsterdam which aims to provide state-of-the-art evidence-based trauma treatments to this group, instead of the usual provision of "supportive treatment", which has been ineffective in the past (Lahuis et al., 2019). The programme lasts one year, including a 3-month stabilisation phase where participants attend group sessions to learn coping skills (and may start taking medication), a 6-month phase of Narrative Exposure Therapy, and a final 3-month phase of group sessions to discuss plans for the future and develop participants' sense of agency and empowerment. The structure of the programme is based on a review of evidence of the most effective trauma therapies for people in unstable living conditions.

In addition, there is widespread use of multi-family therapy (MFT) in the Netherlands for refugee families, in which some form of MPHSS is offered to multiple generations of several families in one setting. MFT is intended to improve relationships within the family as well as parental mental health. It is seen as effective by clinicians (van Ee, 2018), and research is currently underway to measure its effect for participants (van Es et al., 2019). There have also been recent trials among adult Syrian refugees of a peer-delivered psychological intervention programme that can be delivered after only limited training (de Graaff et al., 2020). Since a requirement of the study was that refugees were Arabic-speaking, it is unlikely that Yazidis participated, but it would be beneficial for future trial programmes to target Yazidi refugees specifically.

There is no data on whether Yazidis in the Netherlands are accessing trauma treatment aimed at refugees more broadly, or on the effectiveness of such therapies. Studies have found that only 20% of refugees with PTSD use mental health services in the Netherlands (Lamkaddem et al., 2014). In addition, there are concerns about the ability of local healthcare providers to provide culturally sensitive mental health services to different refugee populations within the municipality (Gezondheidsraad, 2016), and about the lack of interpreters (Arq Psychotrauma Expert Groep & Expertisecentrum Gezondheidsverschillen, 2017). Some of these concerns are now being addressed: the 'De Evenaar' Centre for Transcultural Psychiatry offers "resilience-oriented", holistic NET-based programs for refugees (Laban, 2018). Researchers there have also developed a shorter version of the 'Cultural Interview' that is used to assess refugees at the beginning of psychiatric care; in a pilot study the new 'Brief Cultural Interview' was successful in achieving the same usefulness in clinical practice while being quicker and more feasible to use (Groen et al., 2017). It would be beneficial for

the new Brief Cultural Interview to be adopted widely across MPHSS program providers, including in non-psychiatric MPHSS settings.

Conclusions and policy recommendations

In light of the 2019 decision that Yazidis are a “vulnerable minority group” in the Netherlands (Reis, 2020), it is essential to understand whether general mental health services in the Netherlands are providing an adequate service to Yazidi refugees. This is particularly urgent given that 50% of refugees with PTSD in the Netherlands begin experiencing symptoms a few years after arrival in the Netherlands (Lamkaddem et al., 2014), meaning that the full effects of the 2014 genocide on Yazidi refugees living in the Netherlands may have been coming to light in the following years, in part due to untreated PTSD symptoms having become chronic. In addition, Yazidis who have come through the asylum process more recently may be especially vulnerable to PTSD due to the substantial publicity in 2019 about Yazidis being deported back to IDP camps in Iraq (Kurdistan 24 News, 2019). Uncertainty about asylum applications is known to increase mental health problems among refugees in the Netherlands and around the world and likely negatively impacted Yazidis’ mental health as well (Alemi et al., 2014). The Dutch government should investigate whether mental health needs of Yazidis are currently being met and invest in specific MPHSS initiatives for Yazidis if this would be beneficial.

Our policy recommendations are as follows:

1) Since Yazidis have been designated as a “vulnerable minority group” in the Netherlands (Reis, 2020), information should be gathered about the Yazidi refugee population in order to understand whether they are accessing existing general mental health services and whether these are meeting their needs.
2) The Dutch government should cooperate with municipalities to ensure that appropriate MHPSS services are provided to members of smaller minority groups like the Yazidis, who may be spread out across municipalities in small numbers. Although the 2015 Administrative Agreement makes refugee healthcare the sole responsibility of municipalities, it also establishes that the government and municipalities may co-operate in healthcare research, and this partnership should be used to understand the needs of Yazidi refugees (Vereniging van Nederlandse Gemeenten [Association of Netherlands municipalities], 2015).
3) Local healthcare providers in municipalities should receive funding to provide training in culturally sensitive MHPSS, and to hire sufficient interpreters for MHPSS to be provided in any languages spoken widely in the local community.
4) The government should consider whether spatial dispersal policies, which spread out resettlement locations for refugees around the country, are appropriate for vulnerable refugee groups such as the Yazidis. If these policies cannot be avoided, the government should ensure that Yazidi refugees living around the Netherlands are able to become part of communities in some way (Klaver, 2016).

9. United Kingdom

Author: Alyssa Ralph

UK approach to aid and resettlement

Since the attack of ISIS on the Sinjar region of Iraq in August 2014, the UK has allocated £169.5 million towards local assistance, including emergency humanitarian aid for Yazidis, restoration of utilities, health and education in liberated areas, and promotion of economic and political stability (UK Government, n.d.). However, despite a unanimous vote in the House of Commons in 2016 to recognise ISIS' violence towards the Yazidis as genocide', the UK government has been less forthcoming in welcoming Yazidis to the UK (UK Parliament, n.d.).

To live in the UK as a refugee, individuals must either seek asylum from the UK government, or enter through a resettlement programme, having already been granted refugee status by the United Nations High Commissioner for Refugees (UNHCR). Until the year 2020, four resettlement schemes existed: (1) the Gateway Protection Scheme, for refugees either living in a protracted situation for at least five years, or with an urgent need for resettlement; (2) the Mandate Scheme, for resettlement of refugees with a close relative in the UK; (3) the Vulnerable Persons Resettlement Scheme (VPRS) for refugees from Egypt, Iraq, Jordan, Lebanon or Turkey who have fled Syria due to the conflict from March 2011 onwards; (4) the Vulnerable Children Resettlement Scheme (VCRS) for children, both accompanied and unaccompanied, deemed "at risk" in Egypt, Iraq, Jordan, Lebanon or Turkey (Sturge & Wilkins, 2020).

The UK does not publish ethno-religious statistics relating to individuals resettled or granted asylum. However, concerns raised in the media are that Yazidi asylum claims in the UK are often denied, and that the UK asylum process does not recognise Yazidis as a particularly vulnerable group despite their targeted persecution (Fallon K., 2017; Polglase K., 2018).

In 2016, a cross-party group of MPs urged the government to expand the VPRS to include Yazidis, 90% of whom are Iraqi, who would satisfy the vulnerability criteria of the VPRS. In July 2017 the scheme was indeed expanded to consider individuals of any nationality (UK Home Office, 2020). Despite this widening of eligibility criteria, from 2017 to 2019, only five Iraqis were resettled through the VPRS scheme, in comparison to 9,217 Syrians. Between 2014 and 2019, a total of 1,178 Iraqis were resettled to the UK over all four schemes. Over this same period, among Iraqi individuals registering asylum claims directly with the UK government, only 14% of claims were successful compared to 79% of the claims by Syrians (UK Home Office, 2020). In 2020, the Mandate Scheme, VPRS and VCRS were combined to form a Global Resettlement Scheme. This scheme aims to resettle 5,000 individuals within the first year and will include a process for emergency resettlement for those at immediate risk (Goessman et al., 2020).

Although the UK have created these programmes, the British government minister for the Middle East stated in 2016 that it was UK policy to prioritise supporting Yazidis who remain in the Middle East, claiming that "for every one person that we are able to support in the UK, we can support more than 20 people in location [with the same financial amount]" (Foreign and Commonwealth Office, 2016).

Mental health of Yazidi and other refugees in the UK

There is no official data regarding the prevalence of mental health conditions in Yazidi refugees in the UK. Given the high prevalence of PTSD and depression identified in Yazidis displaced to other locations (Fazel et al., 2005), it is likely that Yazidi refugees living in the UK suffer high levels of mental illness compared to the general population. This is supported by a meta-analysis of adult refugees settled in Western countries, which identified prevalence of PTSD, depression and generalised anxiety disorder to be 10% (ten times higher than general population), 5% and 4% respectively (Turner et al., 2003). The prevalence of PTSD in children

refugees was thought to be around 11%. Specific to the UK, single studies of other ethnic groups of refugees have identified a high burden of mental illness (Basedow & Doyle, 2016).

Refugees' mental health is affected by pre- and post-migratory factors. Yazidis face multiple pre-migratory risk factors as a result of trauma experienced in their home country. Unfortunately, upon arrival in the UK, refugees and asylum seekers face a host of post-migratory factors which may serve to worsen their mental health (Campbell et al., 2018; Rowley et al., 2020). A UK study of refugee survivors of extreme violence stated, "interviewees reported that past trauma continued to affect them, but challenges in transition also seemed to impact mental health independently of their pasts" ("Asylum Accommodation," 1916).

In a UK-wide study of new refugees, poorer emotional wellbeing was significantly associated with dissatisfaction with accommodation, greater difficulty in managing money, and being a victim of a physical or verbal attack (Ealey P., 2019).

Living conditions of refugees in the UK

Since the Immigration and Asylum Act 1999, asylum seekers have been housed in 'dispersal zones' in the North of England, Scotland and Wales, to prevent their concentration in the Southeast of England. A counter effect has occurred, whereby asylum seekers are clustered in areas of high socioeconomic deprivation, in which accommodation is substandard (Ealey P., 2019).

Once an asylum seeker has been granted refugee status, the housing provision is withdrawn after 28 days, as is government-provided subsistence. New refugees are frequently unable to secure private accommodation straight away due to inability to save a deposit and rent from government subsistence, and administrative holdups, causing delays in ability to access welfare benefits and seek employment. Integration Loans are available to pay for initial housing and settling costs, though delays often cause these not to be available until after the termination of refugees' Home Office housing contract. This "move on" period is therefore one of considerable vulnerability for many refugees, with many becoming homeless and many reporting that this policy had a direct detrimental impact on their mental health resulting in severe stress, anxiety and depression (Basedow & Doyle, 2016; Rowley et al., 2020). In contrast, refugees resettled through the global resettlement scheme, as with the VPRS, will be provided funding to cover accommodation costs within their first year, reduced over years two to five of the scheme (Ealey P., 2019).

The UK has larger detention facilities than most other European countries, and from 2009 to 2019, between 1,600 and 3,500 individuals were detained at any given time. In 2019, over half of detainees (58%) had sought asylum at some stage during their immigration process (Silverman et al., 2020). A 2009 systematic review found high prevalence of mental health problems in detainees, including a positive association between time in detention and severity of distress (Robjant et al., 2009). From 2016 onwards, Iraqis have been amongst the ten most prevalent nationalities entering detention in the UK (Holloway et al., 2019). The number of Yazidis among them is unknown.

Employment

Asylum seekers in the UK are only able to seek employment after being granted refugee status. However, they are often hindered by administrative holdups, such as delays in allocation of a national insurance number and biometric residence permit, and the short "move on" period, which leads to prioritising securing accommodation over employment (Cooper et al., 2020). Of newly recognised refugees interviewed by the Refugee Council available for full-time work, none were able to secure employment within the 28-day "move on" period, and most took six months or longer to find employment (Virdee & McGeever, 2016). A study of new UK refugees identified both unemployment and underemployment, that is, having a job below a person's skill level, to be associated with poorer emotional wellbeing (McColl & Johnson, 2006).

Discrimination

UK public opinion of migrants, including asylum seekers and refugees, is polarised (Holloway et al., 2019). Frequent negative media portrayal likely serves to marginalise these groups further (Cooper et al., 2020; Virdee & McGeever, 2016). These individuals may suffer a double discrimination due to their mental health needs and immigration status (McColl & Johnson, 2006).

Mental health support for refugees in general

Pre-resettlement

All refugees entering the UK through resettlement schemes undergo a pre-departure health assessment, carried out by the International Organization for Migration (IOM), in their country of asylum application (Sturge & Wilkins, 2020). This enables health conditions to be identified and treated pre-departure and upon arrival in the UK, and also allows early recognition by general practitioner's once resettled. The health check is basic, with a limited screening tool for mental illness: clinical judgement is used alongside a proforma that simply requires refugees to state whether they have a history of "mental illness/problems", or "torture/violence", and screens them for substance abuse disorders (UK Home Office et al., 2017). Given the perceived stigma of mental health problems and sexual violence, many refugees may not provide truthful statements regarding their status. Recently, the Global Mental Health Assessment Tool (GMHAT), a computerised programme to assess mental health in greater depth, has been successfully piloted for pre-departure use, and may be implemented in the future to better identify those in need for support (Hough et al., 2019).

Resettlement Schemes

Similar to the VPRS, the Global Resettlement Scheme is a 5-year programme, in which individuals will receive a package of support that includes accommodation, English language teaching, and support to access health services. This includes support to join a general practice, and to access appropriate mental health services, including specialist services for victims of torture, as required (Scheme & House, 2020). Though funding for future years has yet to be announced, £150 million has been allocated to the Global Resettlement Scheme for the year 2020-21, which aims to resettle around 5,000 refugees in its first year (BMA, 2020). Refugees in the UK are granted free access to the National Health Service (NHS), which involves first registering with a GP, who can direct them towards community and secondary care services if required.

Refugees who enter the UK through a resettlement scheme are provided with accommodation and an integration package upon arrival including information signposting to services available to them, such as the NHS. Individuals who reach the UK independently and are granted asylum are provided no such accommodation or support (Basedow & Doyle, 2016).

Healthcare

Currently, there appear to be no mental healthcare services in the UK, provided by the NHS or third sector organisations, specifically for Yazidi refugees. Mental health services for Yazidis appear therefore to be also absent. Additionally, no governmental programmes were identified which might support Yazidis in other ways (for example, social, housing, education etc), which may indirectly improve mental health. One global non-profit organisation with a branch in the UK, Yazda, supports Yazidis specifically (YAZDA UK, n.d.). Yazda works to advocate on behalf of Yazidis globally, including in the UK, although it does not provide mental health services or support for Yazidis "on the ground" in the UK (but see the Iraq section and the Appendix for a summary of their work providing psychosocial support in camps for internally displaced persons in Iraq).

The British Medical Association have published information regarding treatment available to refugees and asylum seekers in the UK (Nylander, 2019). NHS services are available to refugees throughout the UK, but healthcare provisions in each of the four nations are devolved, and therefore services differ according to location. Throughout the UK, asylum seekers with an active asylum application and refugees, are entitled to full NHS care, including primary and secondary services (Freedom from Torture, n.d.). For those for whom asylum has been refused, entitlement to healthcare is less consistent; in all four nations, refused asylum seekers are able to access primary care services, but in England access to secondary care services including psychiatric care is dependent on meeting criteria, including the type and urgency of care required (Helen Bamber Foundation, n.d.).

Third sector organisations

Mental healthcare in the UK is accessed through primary and, by onward referral, through secondary care, as well as via third sector organisations. One such organisation is the Nafsiyat Intercultural Therapy Centre in London (Nafsiyat Intercultural Therapy Centre, n.d.). The centre provides psychotherapy and counselling services to people from cultural minority groups, as well as providing training in cultural competency to healthcare professionals. Therapy is offered in a range of languages, including Kurmanji, and so it is likely that the centre is providing support to Yazidi refugees in London.

Further examples of third sector organisations providing mental health support to asylum seekers and refugees in the UK include: Freedom from Torture, which works specifically with survivors of torture, providing mental health treatment alongside social and practical support; the Helen Bamber Foundation (HM Government, 2019), a charity that provides psychological treatment for victims of human trafficking, sexual violence and religious persecution amongst other human rights violations; Refugee Council (Refugee Council, n.d.-a), which provides psychological treatment, including crisis support, throughout the UK. Third sector organisations are largely positioned in areas with the most need, and such services may be inaccessible to asylum seekers and refugees rehoused in rural parts of the UK (HM Government, 2019).

Third sector services are vital in providing care that the NHS otherwise does not. For instance, in interviews some of the refugees who had accessed support from Refugee Council noted that they would have attempted suicide were it not for the psychological support received through the organisation (Basedow & Doyle, 2016).

Barriers to access

Despite supposed free access to NHS services in the UK, there are multiple barriers faced by asylum seekers and refugees in accessing primary and secondary care services. Refugees themselves note to have poor knowledge of the service landscape and access to specific services. They also reported having received little information about the NHS since arriving in the UK (Kang et al., 2019). Despite entitlement to free primary care, refusal of GP practice registration is also common (Patel & Corbett, 2017). Main reasons for refusal are lack of proof of address (33%), identification (34%), and immigration status (10%). Furthermore, doctors treating refugees and asylum seekers are often unsure of their eligibility for treatment (Khanom et al., 2019), further compounding this problem. Although positive experiences in doctor-patient interactions are reported, discrimination is described by asylum seekers and refugees in multiple domains of healthcare access in the NHS, including consultations with doctors and in communicating with GP practice reception staff (Kang et al., 2019; Khanom et al., 2019).

Although consultations are free of charge, asylum seekers may still struggle with the cost of travel to health centres (Kang et al., 2019), both for themselves and for relatives who accompany them for support or interpretation purposes (Khanom et al., 2019). Language difficulties are an ongoing and significant barrier to access to registering with GPs and having effective consultations, due to inadequate interpretation services (Kang et al., 2019). Stigma associated with mental health problems is also still prevalent among refugees, including

Yazidis, and also constitutes a barrier to healthcare in the UK, as it has in other countries (See Me et al., 2016).

Conclusions and policy recommendations

Many of the barriers to comprehensive mental healthcare are structural in nature and require major changes to the asylum process that are challenging to achieve. These would benefit both Yazidis and refugees more generally. Other support structures could be implemented more readily as they do not require parliamentary action. For instance, the distribution of more comprehensive information for refugees on access to healthcare and for practitioners on basic cultural sensitivity and healthcare eligibility criteria is a relatively low-cost aid to improve access and applicability of healthcare services to refugees. Our recommendations are as follows:

General

- The UK government should prioritise admission of Yazidis to the UK, both through resettlement schemes and in applications registered directly with the Home Office.
- The number of Yazidi refugees living in the UK should be monitored, to gauge the extent to which UK asylum processes are effective for Yazidis, as well as potential service provision requirements. This also applies to refugees more generally given that other particularly vulnerable groups, such as torture victims, require special care.
- The UK should establish an integration support package to aid all newly recognized refugees in accessing healthcare services and integrate them more effectively (Basedow & Doyle, 2016). These packages should include information on the NHS and other third-party providers for special needs, as well as on access to interpreters and employment.

Post-migratory factors

Accommodation

- Integration Loan processing time should be such that these loans are available before the end of the “move on” period.
- Where Integration Loans are not available by this time, refugees should be allowed to remain in asylum accommodation (Basedow & Doyle, 2016).

Employment

- In cases where welfare benefit has been sought, Home Office payments should not cease until commencement of this support.
- The government should establish a support programme either directly or through funding third sector organisations to aid refugees in gaining employment (Basedow & Doyle, 2016).

Health-specific factors

Pre-departure checks

- A comprehensive pre-departure mental health screening tool should be employed to enable early recognition of mental health problems. This information should be provided to GPs upon resettlement in the UK (Hough et al., 2019).

Healthcare services

- GPs receiving Yazidi asylum seekers and refugees should be provided with information regarding the trauma to which the Yazidis have been subjected and their increased risk of mental health problems as a result. Basic information regarding cultural sensitivity should also be available to GPs and mental healthcare providers.
- GPs should consider referral to specialist services, for example The Helen Bamber Foundation and Freedom from Torture, for asylum seekers and refugees with complex mental health needs (Nylander, 2019).

- Training of specialist health services should include a module aimed at promoting a better understanding of experiences, and potential psychological needs of asylum seekers and refugees (Rowley et al., 2020).
- Professionals who frequently interact with new refugees should be aware of the high level of uncertainty and mistrust these individuals often face, and strive to adjust their services accordingly, including increasing transparency of communication (Rowley et al., 2020).

Knowledge of eligibility for care
- Training should be provided to GP practice staff to educate them on:
  - Entitlements to care of asylum seekers and refugees;
  - Local services or organisations to which they may refer or signpost patients.
- GP practices in England may find it useful to provide copies of an existing NHS leaflet, which outlines the process and requirements for registration, to staff and patients (NHS, n.d.).
- Practices should educate their staff that lack of ability to produce identification documents is not reasonable grounds for refusing registration (Nylander, 2019).

Cost
- Asylum seekers and refugees can utilise the NHS Low Income Scheme to help with cost of travel to appointments and prescriptions. GP surgeries and hospitals should provide HC1 application forms to these patients and/or link patients with community organisations who can assist them in completing the form (Nylander, 2019).

Language
- GP practices should consider displaying posters in a variety of languages in reception areas that inform patients that they may request language interpretation (Nylander, 2019).
- GP practices should ensure that staff who are responsible for appointment booking know how to book interpreters (Nylander, 2019). Staff may also find a language ID chart (Refugee Council, n.d.-b) valuable for identifying the language a patient speaks (Nylander, 2019).
- English for Speakers of Other Languages (ESOL) training should be accessible to refugees and asylum seekers in the UK (Khanom et al., 2019).

Discrimination in the NHS
- The ways in which discrimination towards asylum seekers and refugees occurs in the NHS, particularly in primary care settings, requires systematic assessment (Kang et al., 2019).
- It may also be useful to explore the sensitivities of NHS staff who work with refugees and compare their experiences to those of service users (Rowley et al., 2020).
- GP practices should consider ways to identify and reduce discrimination against asylum seekers and refugees:
  - In their administrative processes, by only requesting proof of identity, address or immigration status on a non-discriminatory basis. Doctors of the World advises against enquiring about immigration status altogether, as this is not a requirement for registration and patients may find this intimidating (Patel & Corbett, 2017). As a result, many may end up not seeking medical aid.
  - During communication with asylum seekers and refugees including registration, appointment booking, and in consultations (Kang et al., 2019).

Stigma
- Community interventions, delivered within cultural understandings of mental health, that are developed *by* and not *for* communities, have been shown to be useful in reducing stigma surrounding mental illness in ethnic minority communities (HM Government, 2019). Therefore:
  - Exploration of the stigma experienced by Yazidi asylum seekers and refugees in the UK should be undertaken in the first instance;

- Strategies to combat stigma, designed with Yazidis themselves, should be devised and implemented. Experiences gained by providers in other countries could lend valuable information. These include those made by organisations working with Yazidis in Iraq, such Yazda and FYF, and the German Special Quota Programme, which has been well documented.

Rural locations

- Refugees dispersed to rural areas should be resettled in clustered housing, enabling connections to be fostered amongst refugees and with the local community. Such community connections are known to benefit wellbeing in mild mental health conditions even without further medical intervention (HM Government, 2019).
- Gaps in essential services in rural areas should be identified and training provided for local and community organisations to enable them to deliver these services (HM Government, 2019).
- Refugees should be informed about public transport links, and supported in utilising transport to access services (HM Government, 2019).

10. Summary and conclusions

Six years after the 2014 Yazidi genocide committed by ISIS, Yazidi refugees and IDPs are still in dire need of mental health and psychosocial support. There is a general consensus among experts and Yazidi NGOs that only a holistic approach that considers psychiatric and psychological aspects as well as social, economic, cultural, religious, judicial and political issues can achieve recovery from the severe personal and transgenerational trauma (Free Yezidi Foundation, 2020b; Interagency Standing Committee, 2007; Kizilhan & Noll-Hussong, 2017; Operation Ezra; Womersley & Arikut-Treece, 2019; YAZDA, 2020b). Professional standard psychiatric healthcare, psychotherapy and psychosocial support are important but by themselves are insufficient in relieving trauma in refugees and IDPs because they cannot address the structural determinants of wellbeing.

Mental health in refugees is tied to post-migratory factors including the asylum status, access to education and employment. Security, stability and basic needs coverage are the fundamental prerequisites before active steps towards psychological rehabilitation can be considered (Heinrich Böll Stiftung, 2018; Interagency Standing Committee, 2007; Kizilhan & Noll-Hussong, 2017). These factors as well as the culture shock experienced by refugees can lead to adjustment disorder, in which continued exposure to every-day stressors and a drastic change in environment lead to poor coping behaviour, fatigue, depressed thoughts, anxiety and hopelessness (Gerdau et al., 2017). It is therefore not only the traumatic events experienced in their home country that poses a major burden on the mental health of refugees and asylum seekers. A prospect of a more stable future with economic autonomy is essential if mental health is to be regained in the long-term.

Policy recommendations outlined throughout this report are manifold. Interviews with Yazidi NGOs and prior research have shown that cornerstones of successful MHPSS services for refugees and in contexts with limited resources are cultural sensitivity, capacity building and training of new staff, coordination of multiple actors through an expert centre, holistic approaches to wellbeing, community engagement, low-threshold access and effective referral pathways. Approaches including aspects of stepped care and peer support as well as one-stop models in which multiple MHPSS services are accessible through one provider are particularly successful (Free Yezidi Foundation, 2020b; Hillebrecht et al., 2018; Interagency Standing Committee, 2007; Mohammadi, 2016; YAZDA, 2020b). Policy makers and service providers would benefit from considering these treatment models as they widen coverage and increase capacity. Especially peer support programmes and training of members of specific refugee groups may be capable of providing basic stabilising support and facilitate information exchange to improve accessibility of services.

A key consideration for any successful treatment programmes for mental health disorders is to ensure that beneficiaries develop an understanding of their condition. Moreover, clear communication on how mental health treatments work and what they entail is important to gain acceptance and trust from beneficiaries typically unfamiliar with mental healthcare options (Womersley & Arikut-Treece, 2019). Only if both these prerequisites are met can therapy be effective. Inter-cultural differences in the understanding of PTSD, depression and anxiety can therefore be a major barrier if not taken into account by service providers (Kizilhan, 2017). Healthcare providers should be made aware of cultural differences in the expression of emotion, which can be a hindrance to recognising the presence of a mental health condition (Nehme, 2018). They should also consider the different needs of separate demographic groups, such as women, men and children whose experiences of the genocide and whose emotional expression of and coping with traumatic experiences is shaped by different social and developmental factors (Tekin et al., 2016). Another important consideration concerns the narrative surrounding the experience of survivors. Recovery may benefit from a focus on resilience of survivors and competence building to create a sense of growth and a better outlook for the future (Kizilhan & Wenzel, 2020).

The current literature reviewed here and the opinions of representative of organisations working with Yazidis in Iraq have shown that high-calibre mental health treatment is not required for every refugee with mental health problems. Rather, refugees and IDPs can learn basic psychological stabilisation techniques and coping mechanisms that can significantly aid in alleviating mental health problems with mild to moderate severity. These resources can be used effectively in a stepped care approach as a first means of support before offering psychotherapy or psychiatric care. Similarly, opportunities to maintain social bonds, or practise cultural and religious traditions can be equally helpful (BAfF, 2019a; Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016; Free Yezidi Foundation, 2020b; Kamangar, 2019; Voice of Ezidi; Womersley & Arikut-Treece, 2019; YAZDA, 2020b). Other coping strategies Yazidi women have been using in the resource poor IDP camp environment, such as religious rituals, family support or reaching out in solidarity to other female survivors, may also be incorporated into MHPSS approaches (Erdener, 2017).

Means to secure livelihoods for Yazidis and refugees in general are essential to provide a sense of future prospects and are consistently named by refugees as one of the most important aspects for trauma recovery and healing (Womersley & Arikut-Treece, 2019). Focusing on the strengths of the Yazidi community, for instance their agricultural expertise or resilience as a culture, is important to re-establish a sense of self sufficiency and empowerment.

A large number of structural challenges remain, including asylum and integration processes in host countries, achieving justice for Yazidis, allowing a safe return to Sinjar and dealing with the controversial issue of children born of rape. Below we list general recommendations for MHPSS services that are applicable to all host countries and recommendations for actions needed from the international community to support trauma recovery in Yazidis.

General policy recommendations for MHPSS services applicable across countries

1) Any MHPSS programme for heavily traumatised people such as Yazidis should be designed with the goal of sustainability and long-term healing in mind (Peace Research Institute and Frankfurt Leibniz Institute, 2020; Runte, 2018). Especially for those who returned from ISIS captivity continued support and monitoring would be ideal to assess needs and provide further support if needed.
2) MHPSS providers in both Iraq and other countries would benefit from considering the IASC guidelines in their services where not already done so.
3) Culturally sensitive approaches should be implemented:
    a. Healthcare workers should be provided with basic cultural sensitivity training.
    b. Teachers working with traumatised children should also be provided with training on how to interact with these children. A good example are the certified training modules that have been developed in Germany in response to the refugee crisis.
    c. Culturally appropriate psychoeducation methods, psychological stabilisation and coping techniques and information regarding available MHPSS services should be provided to refugees. Bridging inter-cultural differences in the understanding of mental illnesses is necessary for treatment of PTSD, depression and anxiety. The literacy and education levels of the refugee target group should be taken into account in designing educational information. The costs of cultural sensitivity training may be a deterrent, but it should be noted that the potential increase in efficacy in MHPSS services provided by staff with a cultural understanding of Yazidis' needs may offset the costs in the long run (Msall, 2016, 2018).
    d. In all of the above, online materials can serve as a first point of information.

4) All service providers of MHPSS who have not already done so should consider how stepped care approaches could be incorporated into their healthcare landscape to improve resource allocation and widen coverage.
5) Where possible, MHPSS services should aim to increase community engagement:
   a. As shown in the Special Quota Programme in Germany, collaboration between healthcare providers and Yazidi religious leaders can integrate cultural needs with standard mental health care approaches. Moreover, having Prof Kizilhan as a member of the Yazidi community as head of the programme was key in bringing the Yazidi perspective and culturally sensitive thinking to the project, which was essential for its success.
   b. Including trained Yazidi peer supporters in MHPSS service delivery is highly promising in ensuring a culturally informed programme and reducing barriers to MHPSS pertaining to trust and help seeking behaviour. It is important that the role of peer supporters is made clear to them and their beneficiaries to avoid role confusion. Peer supporters should be trained to maintain neutrality during official visits such as medical appointments or asylum hearings. Under no circumstances should they provide support in areas that they are not trained for and should ensure to refer their beneficiaries to more appropriate channels such as social workers in cases where their training does not allow them to address a certain issue professionally.
6) In all of these considerations regarding stepped care and other peer concepts to support refugees, it should be made sure that the establishment of a second-class healthcare system for refugees is prevented (BAfF, 2019b). The services described by these systems should be seen as a complement but not a replacement to professional psychotherapy for those who do need it. One or the other alone have a significantly lower probability of reducing trauma in refugees (Heinrich Böll Stiftung, 2018).
7) MHPSS services including therapy and vocational courses should be offered in conjunction with options for childcare. Without these options, dropout rates are high and children may be at risk for re-traumatisation if they are brought to therapy appointments (Heinrich Böll Stiftung, 2018).
8) Clinicians of host countries should be made aware that signs of PTSD and other mental health disorders may not be visible during the early phase of relocation. Symptoms may then recur with delayed onset after the arrival of refugees in the host country (Hillebrecht et al., 2018). A single initial clinical assessment may therefore not be sufficient to identify those most in need for psychiatric and psychological services.
9) As Yazidi organisations have shown, connecting members of the diaspora and new Yazidi arrivals in their host countries can foster a feeling of being understood, is vital in providing stability, and allows the newcomers to benefit from the knowledge and experience of the established Yazidi community. Yazidi organisations play a vital part in providing channels through which members of the community can connect, such as the Ezidi Youth Network that has been established by Voice of Ezidi or the Survivors Network run by Yazda (Ezidi Youth Network, n.d.; Free Yezidi Foundation, 2020b; Voice of Ezidi; YAZDA, n.d.-c, 2020b). Where possible and where not already done so, Yazidis in countries with dispersal policies or with a generally smaller diaspora may benefit from better access to these networks.
10) Better approaches are needed to address the needs of Yazidi children. Especially for those subjected to forced militarisation, special treatment approaches are needed. Given the security threat that may arise if these boys and young men are not reintegrated into their community, programmes focused on reducing aggression and family tensions are vital and should be in the interest of the Iraqi governments and the international community. Prof Kizilhan's work on this issue should serve as a guide to rehabilitation programmes for former children captives of ISIS. Brief interventions such as the one-hour group-based, culturally sensitive Crisis Intervention Program for Children and Adolescents (CIPCA) developed specifically in the context of the Iraqi refugee crisis can be a low-cost option for early psychological stabilisation and to bridge wait times for longer-term psychotherapy (Ceri & Ahmad, 2018).

11) MHPSS services should also be expanded to include more family-based psychoeducation and psychotherapy. This is pertinent to relieve family tensions and involve men in the programmes typically reserved for women and children.
12) As seen across all countries examined here, governmental mental health care options offered to Yazidis may not be effective, have insufficient capacity or may be too difficult to access due to long waiting times and problems associated with coverage. Yazidi run organisations and other NGOs or humanitarian actors have provided many privately sponsored support options, such as the psychosocial centres in Germany or the Operation Ezra Healing Farm. Many of these organisations also receive government funding but more collaboration between actors in terms of connecting services may be helpful.
13) To facilitate integration of MHPSS services, keeping up-to-date databases with available providers can improve the effectiveness of therapy and other types of support by allowing for a more holistic treatment of trauma and other mental health problems (Walther et al., 2019).
14) Social activities including the celebration of cultural holidays and traditions, sports, or arts can also be therapeutic and may help with the establishment of a social network (Walther et al., 2019). Increasing the availability of such activities in refugee accommodation or social and community centres can be a low cost option of improving wellbeing and achieve basic psychological stabilisation.
15) The Cultural Formulation Interview should be established as a core means of determining the interpretation refugees may have of their mental health condition (Heinrich Böll Stiftung, 2018; Knaevelsrud, 2016). The interview will provide clinicians with a clearer understanding of the individual's situation, may open ways to better psychoeducation and could avoid misunderstandings.
16) Translators should be trained to ensure their neutrality during the diagnostic or therapeutic process and should be given a basic understanding of the standard procedures of therapy including confidentiality (Heinrich Böll Stiftung, 2018; Knaevelsrud, 2016).
17) Emergency telephone lines may also be helpful in providing a means of stabilisation. Especially for refugee groups who speak languages that are less well represented, this remote approach is promising.
18) It should be noted that those who work with highly traumatised populations are at risk of secondary traumatisation. This has been observed in interpreters, social workers, psychotherapists and physicians (Denkinger et al., 2018). This may also apply to peer supporters. It is therefore important to also consider the health and wellbeing of those providing support to refugees with PTSD to prevent burnout and poor mental health.

International community: Recommendations for political action and structural improvement

1) International mediation of tensions between the IFG and KRG is needed to solve the issue regarding responsibility for the security of Yazidis in Nineveh.
2) There should be more efforts to hold international tribunals against ISIS fighters who should be held accountable for their crimes against Yazidis, including genocide, human trafficking, forced militarisation, sexual violence and torture.
3) As many aid programmes have run out of funding as of 2020, renewal of funding is vital to maintain services to IDPs in Iraq. Continued capacity building is particularly pertinent to ensure a sustainable mental health care system that can function without international support in the long-term. Moreover, more support is needed to address the specific challenges the COVID-19 pandemic is posing to mental health in IDP camps. More aid is also needed for rebuilding of Sinjar. A central consideration in service provisions should be on how to support livelihoods and education.
4) As it is highly unlikely that a decree from the Yazidi religious leaders will call for the acceptance of children born to Yazidi mothers as a result of rape during their ISIS captivity, support from the international community may be the best option to provide these children

and their mothers with a future. Within the diaspora there are many debates regarding religious doctrines such as endogamy of which younger generations are more sceptical. It is possible that some within the Yazidi diaspora may be more supportive of women with children born of rape. Special quota programmes for the resettlement of these women should be granted and should ideally be established in countries with experience of providing specialised care to highly traumatised refugees.

5) Family reunification processes should be facilitated and bureaucratic hurdles removed. This applies to multiple countries. It has been shown that reunification has a profound positive impact on the mental health of refugees and can facilitate integration in the host country (Gesellschaft für bedrohte Völker, 2019).
6) The efforts to find and rescue remaining ISIS captives should continue and be expanded.

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Appendices

1. Supplementary material to the Iraq chapter

Box A1. Living conditions of Yazidi IDPS

Camps provide basic humanitarian and social services, but food rations given out by the governmental public distribution system (PDS) are limited and are insufficient.

The vast majority of those residing in camps were able to afford basic needs but IDPs outside camps are struggling to do so as they receive less humanitarian aid.

Inadequate living conditions: overcrowding, harsh weather conditions, poor safety standards, too few amenities in comparison to the existing need and insufficient access to water and sanitation.

Yazidis both in and outside IDP camps still experience assaults by radical Muslims or discrimination from other IDPs from Afghanistan, Pakistan and other Arab countries.

High rates of unemployment, making it difficult to leave camps and meet their basic needs or cover medical care and education.

Relatively low levels of education among Yazidi, inexperience in other sectors besides agriculture or construction, lack of documentation and discrimination by locals are all barriers to finding employment.

Refs: (Gesellschaft für bedrohte Völker, 2019; Global Justice Centre, 2016; Rizkalla, 2018; UN High Commissioner for Refugees, 2019; UNFPA, 2019)

1.2. Mental health in refugees and cultural sensitivity

Psychotherapy and other psychiatric treatments were originally developed in the Western context and are often not appropriate for IDPs and refugees. Cultural sensitivity and adjustment of treatment options is therefore a prerequisite of successful recovery from trauma. Cultural sensitivity is to be mindful of the different cultural contexts of a given population and to take this into account when assessing their needs and potential interventions (Msall, 2018).

In its core, PTSD is a condition that is stable across cultures. However, the reaction to the condition and the expression of symptoms is dependent on culture, as is its interpretation (Knaevelsrud, 2016). There is also the stark difference in the kinds of trauma experience by refugees. Refugees often experience multiple traumatic events, such that methods focusing on single events are less effective (Nationale Akademie der Wissenschaften Leopoldina, 2018).

As a result, Western approaches of individualised treatment of specific mental health problems are often inappropriate for survivors. Yazidis, as opposed to Westerners, have a collectivist mentality in which personal feelings play a less important role, while experiences and collective feelings of families, tribes and ethnicity take precedence.

For instance, the transgenerational nature of their trauma can generate a universal feeling of fear and insecurity (Mohammadi, 2016). As a result, Yazidis are more likely to refrain from expressing personal suffering as to not cause suffering to their family or community (Gesellschaft für bedrohte Völker, 2019; Kizilhan & Noll-Hussong, 2017). Coping mechanisms and the interpretation of their mental health conditions are shaped by their culture and religion, and feelings of guilt and shame in relation to their traumatic experiences are common (Kizilhan & Noll-Hussong, 2017; Knaevelsrud, 2016; YAZDA, 2020b). Yet, the collective nature of the trauma can also be used as a source of resilience when building treatment approaches based on a narrative of the strength of survivors and building on community resources, solidarity and comradery (Kizilhan & Noll-Hussong, 2017).

It is often difficult for individuals with highly collectivist mentalities to explain their personal thoughts, feelings, and physical status. Rather, they tend to explain themselves based on

metaphors and abstract comparisons and often talk about the pain and hardships of their family and other generations rather than themselves (Gesellschaft für bedrohte Völker, 2019; Kizilhan & Noll-Hussong, 2017). Differences in the expression of trauma can be a challenge for correct diagnosis if clinicians are not adequately trained.

Another difference to Western patients with mental health problems or trauma is the higher rate of somatoform expressions of trauma, where patients suffer from apparent physical conditions without a clear physical cause (Kizilhan & Noll-Hussong, 2017). This may be more challenging to recognise as mental health disorders and may be interpreted by patients as typical physical conditions that require general doctors (YAZDA, 2020b). The result is the expectation of fast solutions through medication. The integration of physical and psychological approaches to treatment may therefore be most promising.

Finally, Yazidis have experienced collective, spiritual, and transgenerational trauma that may require a community-based approach (Kizilhan & Noll-Hussong, 2017; Nationale Akademie der Wissenschaften Leopoldina, 2018). It has been shown that generations who have experienced trauma often pass their trauma on to their children and in severe cases, this can even affect multiple following generations. Accounting for the collective trauma and its effects on the whole community and its future is therefore vital for effective trauma recovery.

Psychotherapy is the standard treatment for PTSD. Medication can be helpful but on their own are insufficient for long-term healing (BAfF, 2017). During trauma therapy, the traumatic events are confronted in a controlled manner such that the fragmented memories, thoughts, emotions and physical sensations are integrated. However, there is no clear consensus between experts on which type of trauma therapy is ideal (BAfF, 2017). Narrative exposure therapy is robust across cultures and has the advantage that training for this method is relatively quick and that it is effective even if the patient has experienced multiple traumatic events (Knaevelsrud, 2016; Walther et al., 2019). There is still little scientific evidence for the effectiveness of different treatment methods for refugee children. A specialised, modified version of NET may be one of the most promising approaches for children and adults affected by war. In contrast, EMDR has not been shown to provide a long-term benefit for refugees although it is still being recommended by some. Cognitive therapies are effective but typically require highly skilled therapists. There does exist an online version of cognitive-behavioural therapy but it is only provided in Arabic (Knaevelsrud, 2016).

Not all refugees with traumatic experiences will need professional support. For many, stabilisation can be achieved through a safe and structured environment, social connection, cultural and religious activities (BAfF, 2019a; Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde, 2016). This knowledge is the basis of the IASC approach to mental health in emergency settings with resource shortages (see below).

2. Supplementary material to the Germany chapter

2. 1 German government support in Iraq

It is challenging to provide a detailed overview of the aid provided by the German government to Iraq. This list is therefore likely to be incomplete. According to one report, the German government provided €166 million in 2015 and 2016 to fund the UN, the International Red Cross and Red Crescent and NGOs operating in Iraq, including Nineveh. In Nineveh, 6.9 million of the funds provided by the German government were used to provide mobile health clinics, cash transfers, food provisions, and MHPSS services. Another report notes that in 2016 alone, UNHCR received 360 million USD from the German government (UNHCR, 2017).

A particular focus of the German funds is on psychosocial support for trauma recovery. For instance, German funds contributed to the establishment of centres for torture victims and SGBV survivors and the Dohuk University graduate programme in traumatology as well as to other stabilising and structural measures in Iraq, including support for Sinjar (Bundesregierung Deutschland, 2020). Between 2016 and 2020, GIZ received €47 million from the German government to collaborate with the Iraqi Ministry of Planning in rehabilitating Sinjar. A housing project provides another €4.3 million. Another project from 2018-19 received €7.5 million in funds to support the local economy, provide livelihoods, education and vocational training. The project focuses on youth, women and disabled people. A conflict monitoring, management and prevention programme in Nineveh was funded with €1.2million in 2019. A similar project with €1.3 million funds aimed to foster peaceful dialogue between Yazidis and Arabs. Other forms of support for the stabilisation of the Sinjar region include the funding of the Commission for International Justice and Accountability (€1.5 million), the International Commission on Missing Persons (€1.19 million) and another two stabilisation projects with €3.19 million in total, which are all provided through the Foreign Office (Bundesregierung Deutschland, 2020).

Between 2018-2019, the state of Brandenburg further supported psychosocial centres in Sinjar with €495,000. Centres are focused on the needs of women, children and adolescents. To date, the centre has provided literacy and math classes to 300 adolescents and vocational courses to 150 adolescents and 140 women (Land Brandenburg, 2019).

2.2 Example projects aiming to expand MHPSS services in Germany

The university clinic in Munich aimed to increase the participation of smaller clinics in the treatment of refugees by establishing a regional cooperation network for Upper Bavaria across larger and small clinics and practices. The Centre for Transcultural Psychiatry and Psychotherapy acts as a coordinator for the district and organises conferences, connects service providers and relays recommendations (Adorjan et al., 2017). Another similar example is the Charite Berlin in which three psychiatric clinics are used as a clearing spot where translators work with social workers of the humanitarian organisation Caritas, local hospitals and special care facilities for refugees. The Centre for Intercultural Psychiatry and Psychotherapy offers ethnopsychological and culturally sensitive approaches and offers weekly open consults for emergencies. These services may not be accessible to Yazidis given a lack of Kurmanji translators.

Another approach to capacity building is that of the University of Konstanz at the Centre for Psychotraumatology who offer training in NET methods which are informed by experiences with children subjected to forced militarisation (Adorjan et al., 2017). This project also provides training for translators to provide information about psychotherapy.

Project OMID supported by the NGO Caritas and the diocese Rottenburg-Stuttgart aims to test a new model for psychosocial support to alleviate trauma in refugees using a resource-

oriented approach recommended by the IASC to achieve psychological stabilisation (Forum für soziale Psychiatrie, 2017). The project includes support groups, provides translators and referral pathways for severe cases. In an evaluation 98% of refugees referred to the project as highly positive or positive and reported that their mental health had improved between.

3. Summary of interviews with non-governmental organisations providing MHPSS to Yazidis

The following sections contain summaries of the interviews with four NGOs who provide support to Yazidi refugees in Iraq, Canada and France. All NGO representatives fact checked the information provided in their given section.

3.1 Operation Ezra

Operation Ezra is a grassroots initiative started by the Jewish Federation of Winnipeg to aid Yazidi refugees who were resettled in Canada after the 2014 IS genocide. OE aimed to raise awareness of the dire situation Yazidis were facing and to provide sponsorship to new Yazidis arriving in Winnipeg for resettlement. According to their website (Operation Ezra, n.d.), they are the only privately organised Yazidi rescue initiative of their size in North America and have sponsored 11 families including 65 individuals to settle in Winnipeg. Sponsorship is decided based on the availability of UNHCR registration and the potential of integration evaluated by a working committee. Given that more that more than 3000 Yazidi families are hoping to resettle in Canada, the selection process is particularly challenging. The initiative is supported by many volunteers and donors, as well as 42 different entities including multi-faith organisations, schools and mostly local businesses with involvement from some larger corporate sponsors, such as IKEA. Up to 80% of the funds have come from private donors and the remaining funds have been provided by the Ministry of Immigration, together making up around one million dollars. Donors provide a vast range of utilities and food, while volunteers aid in finding appropriate housing and assisting with the resettlement process through language classes and help with official tasks including opening bank accounts, accessing healthcare and finding employment. Operation Ezra has also been successful in lobbying the federal government to sponsor 1200 Yazidi refugees to resettle in Canada, 300 of which were resettled in Winnipeg.

We spoke with two representatives of Operation Ezra, Nafia Marceau, a former Iraqi refugee herself who started the initiative by making members of the Winnipeg Jewish community aware of the Yazidis' plight and who has been lobbying the government in Ottawa for further support, and Michel Aziza, a volunteer for the organisation. They provided in depth information on the programmes offered to the Yazidi community by Operation Ezra and the challenges they faced in providing support to the new government sponsored arrivals.

The OE representatives point out that families sponsored by their initiative have successfully settle in Winnipeg. Many learned English quickly, especially the children. They were able to do well in school and some are attending university or have found jobs. Similarly, many parents also gained employment and most families became financially independent within a year of their arrival. These were families that were not held in captivity by IS or lost any of their closest family members to the genocide.

In contrast to the sponsorship Operation Ezra provided privately to carefully selected families with high potential for successful integration, the Canadian government aimed to aid those Yazidis in most need of support. These most vulnerable families were typically headed by a single parent, in most cases women, with multiple children. In many cases, these families were still missing children or a parent who remained in captivity, or had lost family members to the genocide. Oftentimes they had been captives themselves. In the resettlement process, the government has relied on the existing infrastructure to support these Yazidi families. The OE representatives note that this approach has several limitations given the case of these heavily traumatised individuals who require specialised care. The government had aimed to

involve an agency in Winnipeg to provide mental health support for these Yazidi families. Within 24 hours of their arrival, each family underwent psychosocial assessment. Although the assessors had previously reached out to the local Yazidi community to learn about their culture, the OE representatives say that the assessment was still conducted in a manner that was unhelpful for the new arrivals. In many cases, women who had spent time in IS captivity were asked about their experiences and their mental health by male psychologists or with men present in the room, which furthered their reluctance to speak out. Although there were many attempts made at providing mental health services to Yazidis, including art therapy or counselling, local counsellors and psychologists have stated to OE representatives that they were unsuccessful at helping most families. This failure may be due to counselling and therapy approaches that followed standard procedures developed for the North American or European context. Unfortunately, these agencies seem to not have the resources and knowledge to provide more appropriate trauma treatment tailored to the specific needs of the Yazidi community.

Notably, the situation these Yazidi families find themselves in stand in stark contrast to that faced by Western mental health patients given their experiences of excessive violence, death of their family members, captivity and uncertainty about the status of their missing family members. Many of the families spend significant time trying to reach their relatives in camps in Turkey, Syria or Iraq or to find remaining missing family members. Due to their severe depression, many of these Yazidi refugees cannot muster the energy to undertake even mundane tasks. These families typically do not settle well, have trouble learning English, do not have employment and struggle to understand the local culture. Children mostly struggle in school because their learning capacities are significantly poorer than those of their peers. Teachers were not prepared to deal with their new traumatised students and often suffered psychological distress themselves when confronted with these challenges. The OE representatives stress that this is not just the case for the Winnipeg community but has also been reported by the community in Toronto.

The Operation Ezra representatives note that in their experience, any activities that gather the community, such as setting up soccer teams or sewing courses, are perceived as effective in addressing mental health problems or trauma, while standard counselling was not. As a result, OE has continued to provide spaces to celebrate Yazidi holidays with the whole community, which has also allowed for multi-faith interaction between Yazidis, Jews and Christians in the area, fostering greater cultural understanding on all sides.

In the past two years, Operation Ezra has “adopted” the 44 government sponsored families in Winnipeg and their focus since then has been on aiding them in the resettlement process. OE have support multiple programmes that have successfully supported these Yazidi families and that have received positive feedback. In the beginning, the initiative had provided English language courses for their privately sponsored families, which they then also opened up to the government sponsored newcomers with support from governmental funding. The new families were provided transportation to weekly courses that were attended by up to 190 Yazidis. Volunteers helped to provide teaching in small groups or to provide one-on-one support. Furthermore, they provided spaces for the children to play during these sessions. Given the many everyday life challenges these families faced, Operation Ezra also offered courses on banking, finding employment, driving and many other basic issues. Translation was provided by other members of the Yazidi community.

The representatives note that the government sponsored families still struggle financially as a result of not being able to find employment. OE provided food assistance to these families using private donations. Given the shortage of such funds, the representatives aimed to use

the farming skills of the Yazidi community to farm a piece of land. This project started small but has grown substantially since then, in part due to private donations from a local garden centre owner who provided the community with seeds and farming equipment. Termed the "Healing Farm", this project has provided food for the 44 government sponsored families and offered a sense of empowerment to many Yazidis. The families could set up farmers markets and even donate excess food to other charitable organisations in the city. The representatives note that the farming project has made a significant positive impact for the community. Many women have noted that the farm offers them something "worthwhile to do" and to "feel useful". In contrast to the many occasions in which they are reliant on other people's help or have to follow instructions by others, such as their translators during official business, the farm provides a sense of freedom, brings back good memories and a sense of familiarity in a completely strange and at times confusing environment. Operation Ezra had planned to expand their farming projects but COVID has stopped any progress. Moreover, due to COVID, their plan to bring another privately sponsored family to Canada could also not be followed through.

Nafia notes that she has attended two international conferences organised by government officials in Germany and run by Yazidis, where members of the Yazidi community from Australia, Canada, Iraq, the US and Europe come together. She notes that in both cases, it was clear that Yazidis across the world are facing the same struggles to provide support for the traumatised community. The farming project was often pointed out as having great potential. Others, for instance Yazidis in Germany, were hoping to start similar projects but to date there was no success in following through.

Despite these positive developments and the multi-faceted support provided to the government sponsored Yazidi families, Michel and Nafia note that the trauma and the struggles remain. Progress is slow and is projected to take many years. The OE representatives believe that the government sponsorship approach should be revisited in light of the specific community needs, rather than following a generic process applied to vastly different groups of refugees. Operation Ezra have previously reached out to the government, recommending to rethink their reliance on existing infrastructure. They had highlighted that the private sector may be mobilised to work with the government in cooperation with Operation Ezra to improve existing programmes, given the overwhelming support OE have previously received from private donors. The representatives also note that a North American settlement coordinator who is unfamiliar with the culture or the language provides a significant barrier to a successful resettlement programme. Operation Ezra offered to help with the selection of families that may be better equipped to resettle and noted that they could engage more volunteers to support new arrivals. Moreover, they also pointed out that they could support the government in finding for a given candidate family any existing family members or relatives already settled in Winnipeg, who could provide a support structure. However, these suggestions could not be put into practice. Moreover, despite heavy lobbying on part of Operation Ezra, the government is not yet committed to make the family reunification process as effective as possible. Reunification when captive family members have returned, especially in the case of children or spouses, could alleviate psychological distress significantly and aid in the resettlement process.

3.2 Free Yezidi Foundation

The Free Yezidi Foundation is a politically independent non-profit organisation in the Netherlands, the US and Iraqi Kurdistan dedicated to helping the Yazidi community recover from the 2014 genocide. Among their projects are awareness campaigns, the pursuit for legal justice for Yazidis affected by IS crimes and the provision of trauma treatment and psychosocial support to Yazidis in IDP camps in Iraqi Kurdistan. FYF "view trauma recovery as the single most pressing need for individual Yezidi survivors and for the severely damaged community as a whole" (P. Ibrahim, 2020).

For this report, we interviewed two representatives of FYF who are involved in the MHPSS programme for highly traumatised populations in IDP camps in Dohuk province in Iraqi Kurdistan. This project has previously been funded by the United Nations Trust Fund to End Violence against Women and Girls (UNTF) and is now supported by the Dutch Government with funding available until December 2020.

The trauma team is based in the Khanke IDP camp, but MHPSS services are also provided in Sharia camp. The staff directly involved in MHPSS are all female and are all Yazidi except for three international psychologists on the team. The programme focuses on Yazidi women but has also been expanded to include children and whole families since funding has been provided by the Dutch government. The team includes a supervisor specialising in therapy for children, three international psychologists and since 2017 a growing number of Yazidis who are being trained by FYF psychologists as community-based PSS providers called Harikara. The Harikara are building the basis of the MHPSS pyramid as part of a stepped care approach following the model set out by the Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support. This model was developed to ensure the effective allocation of resources in humanitarian emergency settings, whereby individuals with mild and moderate psychological distress are offered non-specialised MHPSS services through trained lay workers and severe cases are referred to specialised service providers such as counselling and psychotherapy experts.

Harikara are trained in psychological first aid (PFA) for both adults and children, trauma stabilisation techniques and coping skills. The Harikara women approach their beneficiaries in a first visit where they provide psychoeducation about trauma, basic information on coping and self-help techniques and allow for a conversation about mental health to alleviate stigma. This is meant as a community sensitisation visit to normalise the response to trauma. The Harikara take note of individuals who may be in need for further MHPSS services. For mild and moderate mental health difficulties, they revisit the family to provide further PSS. If they identify cases such as those with suicidal ideation, highly somaticized cases (including those with symptoms of non-epileptic seizures they call 'collapsing') and extreme anger, the Harikara can refer them to specialists. The Harikara model increases sustainability of MHPSS programmes through community involvement and allows cost-shifting from professionals thereby optimising resources. The approach also has the advantage of directly involving the Yazidi community in the MHPSS services. By integrating community members into the system barriers such as lack of trust or cultural differences may be overcome more readily.

The FYF trauma treatment programme includes both general psychosocial support and specialised trauma treatment. For specialised treatment, EMDR and NET therapy are provided, both following standard protocols deemed as effective in trauma alleviation by the WHO. In the Khanke Women's Centre, treatment is offered as part of individual and group trauma therapy. Individual therapy sessions are only available to children and women in the Khanke Women and Children Centre. Group therapy may be focused on anger management, grief, anxiety, emotion regulation and relational problems. Men are not provided specific

mental health programmes but in field visits in Khanke and Sharia the Harikara conduct community sensitisation visits for whole families, thereby involving men as well. Besides depression and anxiety, somatic symptoms are also prevalent. These include headaches, non-epileptic seizures (collapsing) and chronic pain.

In our interview, FYF representatives highlighted several important points. They noted that although programmes are following established standardised protocols, treatment approaches should also be flexible to allow beneficiaries to make use of their own resources such as their faith or cultural beliefs that may be incorporated into treatment. Another aspect that FYF representatives stressed is a holistic and systemic approach to trauma recovery: "Wellbeing includes the economic, social and psychological aspect. … Everything we do, we have in mind that these people have suffered genocide. They suffered immense loss. We make all our interventions trauma enlightened, including the classes and activities." Accordingly, trauma treatment should not be seen as only addressing specific symptoms but also incorporate means to improve overall wellbeing as well as provide a sense of empowerment and future prospects. The Khanke Women's Centre offers vocational and educational courses including literacy classes, English, knitting and sewing, art or sports, as well as a course on women's rights. They also provide a children's centre where children can be looked after while their mothers attend courses or therapy. This approach increases attendance and reduces attrition over multiple sessions because it alleviates women from their culturally expected caregiving duties.

These livelihood courses are strongly emphasised by FYF representatives as a crucial aspect of trauma recovery. IDPs still suffer from deprivation, unemployment, lack of resources and money, which all exacerbate mental health problems. Beneficiaries who recover from severe trauma symptoms are capable to take part in livelihood programmes, and similarly those who are enrolled in livelihood programmes also benefit in terms of mental health. Moreover, if the programmes can be seen as an economic opportunity, families are more supportive of women attending MHPSS services and an opportunity for greater female empowerment is given. Indeed, in focus groups beneficiaries highlighted that literacy classes were particularly important for their wellbeing by virtue of a greater ability to carry out more basic tasks (such as signing up for more aid provisions or taking their children to the doctor). Livelihood courses were highly popular as well, indicating the strong interest in economic autonomy. The focus groups also reported increased feelings of safety and an opportunity to take their minds off of the realities of the camp.

Despite the reach of the programme and the success of the stepped care approach, major challenges remain. First, the programme cannot reach all individuals in need given that up to 15,000 IDPs live in tents in each of the Khanke and Sharia camps and roughly the same number reside in make shift tents outside the camps[17]. The two funded projects to date were capable of reaching a total of 5,500 beneficiaries. FYF representatives noted that they would like to expand to camps in Shingal but they are currently unable to because of visa problems due to the presence of the different governing bodies for Iraq and Iraqi Kurdistan. As a result, they were unable to support members of the Yazidi community when mass graves in Sinjar were being exhumed. Second, there are periods in between funding provisions where retention of staff is challenging. This negatively impacts the mental health of their beneficiaries and hampers the establishment of a self-sustaining MHPSS ecosystem in the region. Third, COVID has kept FYF from establishing new services and from reaching the number of

[17] These data were as of end of October 2020 but FYF representatives have informed us that several families have moved back to Shingal in the subsequent months.

beneficiaries they set as their goal (5000 beneficiaries annually). The pandemic had a substantial impact on MHPSS services, especially because group therapy could not accommodate more than 4-5 individuals per session while tent visits were still allowed. A strict lockdown was in place from March to May, prohibiting any field visits. Tent visits restarted in June with on and off visits according to advice from the local authorities and under appropriate safety measures. During this time tent visits did not only serve to provide MHPSS but also to offer vital information about COVID-19 prevention methods. COVID cases started rising gradually in August and accelerated in September and October. As a result, the FYF team was forced to stop conducting field visits. At the beginning of November, as the pandemic got out of control in the KRI, two of the international staff were asked to leave and one staff member contracted the virus requiring all team members to isolate. Since then, the team have been working remotely and used this time to continue the work on their respective cases. They have also been offering more training to the Harikara as they were no longer conducting tent visits and will no longer do so until the end of the funding period in December 2020.

Fourth, the programme still suffers from high dropout rates. These are on the one hand due to the traditional duties that women have to take care of such as child, elderly and home care responsibilities meaning that women can only attend courses and therapy sessions if they have someone to take over these responsibilities for a given day. Another reason is the high rate of unemployment. As a result, many IDPs leave the camps during farming season, which results in high dropout rate during this time.

The FYF representatives also note that multiple needs of the Yazidi community are still currently unmet. As mentioned above, there is a substantial lack of jobs and poor prospects of economic autonomy. There is also still no solution regarding the children born of rape during IS captivity, which are not accepted as Yazidi and have forced many women to either give up their children or keep their children but staying away from their community. These women are amongst those with the most challenging mental health needs.

Moreover, men receive relatively less mental health support than women with programmes being not specifically tailored for them but rather to the needs of families as a whole. Stigma around mental health is more pronounced among men, resulting in reduced help seeking behaviour. Many men struggle with alcoholism and gambling addiction. The return of IS captives to their family can result in substantial relationship stress. Many men have become aggressive, shout more frequently and in some cases beat their children and wives. As a result, women are often concerned about their husband's anger problems. The FYF representative stressed the importance of family dynamics in mental health and the need for more tailored family interventions. Empowering Yazidi women is seen as important but a lack of involvement of the men's perspective in women's empowerment was deemed as potentially problematic, given the deeply enshrined patriarchal structure of the Yazidi community and the potential for tensions: "You cannot just send the woman home with this new kind of knowledge or attitude … without considering the impact from a community perspective". This feeling is echoed by Yazidi women as well who pointed out that their husbands should learn about women's empowerment as well.

In terms of the outlook on this project, the major aim is not only to provide MHPSS services to as many beneficiaries as possible but also to enable a sustainable care ecosystem in the region. The FYF team has started to do so by hiring local Yazidi psychotherapists. The importance of self-sustainability is echoed by one of the FYF representatives: "We really need to work ourselves out of a job. I'm really looking forward to the time when I say I don't need to come in anymore." However, it is unclear how the FYF programme continues after the

December 2020 funding deadline. As of November 2020, it is unclear whether the Dutch government will be extending their support.

Effectiveness and evaluation

Evaluation of the FYF programmes is done using extensive qualitative feedback and focus groups as well as quantitative data. Beneficiaries who are provided MHPSS are assessed in terms of the severity of their case both pre- and post-treatment to track the effectiveness of the programme. Furthermore, the team uses psychometric and standardised screening tools for diagnosis. In 2019, over 4000 beneficiaries could be reached with the psychoeducation visits and in 2020 the programme trained 31 Harikara in two IDP camps. Due to COVID, this number dropped to 1500 beneficiaries and has not been increasing since.[18] Evaluation of the project is currently in progress.[19]

[18] As of November 2020. Personal communication with FYF. 26/11/2020
[19] As of November 2020. Personal communication with FYF. 26/11/2020

3.3 Yazda

Yazda is an international NGO aiming to support the Yazidi community and other minorities in Iraq and abroad. Yazda was established in the aftermath of the 2014 genocide. They support a multitude of projects in Iraq and Iraqi Kurdistan which include global advocacy and legal justice, livelihood, medical services, psychosocial support, psychotherapy and advocate for the return of displaced Yazidis to their homelands in Nineveh. A specific focus of many projects is the support of returnees from IS captivity, namely survivors of sex- and gender-based violence (SGBV) and children survivors of forced militarisation. Family and community reintegration and livelihood are also at the centre of many of Yazda's projects. Their work is funded by a variety of donors among them the German Organisation for International Collaboration (GIZ), the Dr. Denis Mukwege Foundation, SANOFI Espoir Foundation, the Dutch Ministry of Foreign Affairs, Stichtung Vluchteling, the German government, and the Arbeiter Samariter Bund in Germany. Moreover, IOM, with financial backing from USAID, is an implementing partner of Yazda as part of a consortium of NGOs lead by IOM. Together, these projects are slated to reach around 1,500 beneficiaries with some form of MHPSS services or livelihood support, potentially more.

Yazda's staff for MHPSS programmes includes a small number of clinical psychotraumatologists and a larger group of psychosocial case managers. International Clinical expert consultants are also available to support the project. Case managers receive training according to international standards following the IASC with some adaptations to better accommodate Yazda's experience with the Yazidi community. This approach has previously been successfully employed by other NGOs in humanitarian settings. Training focuses on basic psychoeducational and psychosocial aspects including emotional and relational support, listening techniques and conversational techniques. The approach is survivor centred and different methods are taught to support children or victims of rape and violence in the home. The work of case managers is comparable to that of social workers in that they assess psychosocial needs of beneficiaries and arrange referrals to specialised care if needed.

The Yazda programme includes group interventions for peer support, exchange of survival strategies and reconnecting to the community. They also run group therapy specialised to children's needs. Programmes offer psychoeducation to their beneficiaries aimed at fostering a better understanding of their emotions and their trauma. Yazda are now developing an evaluation tool to assess mental health at each therapy session to track the effectiveness of their support services. Due to a shortage of specialists, Yazda operates with a combination of social and counselling work but cannot follow the Western model of individualised counselling by trauma specialists for all beneficiaries. To broaden their reach, Yazda's staff are involved in capacity building for their teams, connect with other organisations in the region in a trauma network and support the establishment of local MHPSS training programmes. For instance, in collaboration with Germany and UNITAD the University of Dohuk has trained clinical psychotherapists in psychotraumatology during a two-year programme following standardised, internationally recognised protocols (such as those of the IASC) including for psychological first aid and case management.

In our interview, the representatives point out several challenges faced by Yazda. First, there are not sufficient spaces for staff in training sessions offered by the trauma network made up of multiple organisations providing humanitarian aid in the region. As a result, one case manager from each of Yazda's location has to attend training sessions, which they then conduct in their location for other staff members. There are some language barriers within the team that can make it difficult for the case management director to verify the exact content of

training sessions and whether information is relayed correctly by those who return to teach the Yazda team after having attended the training for the regional trauma network. They note that training is very specific and can sometimes be difficult to apply in practice in the setting of the IDP camps. It can also be challenging to connect and integrate different training modules.

Second, despite the new establishment of the Dohuk MHPSS programme, there is still a severe lack of psychotherapists and clinical therapists.

Third, short durations of funding for some projects proves challenging and can lead to abrupt changes in the services Yazda can provide.

Fourth, COVID has severely hampered the support Yazda can provide their beneficiaries. This, together with the general additional stress from COVID, has resulted in a worsening of their mental health, an increase in gender-based violence and a higher number of suicide attempts. Yazda are focused on monitoring critical cases closely.

Since the start of the pandemic, forced isolation and social distancing, Yazda has developed online tools to provide Psychosocial support. These include group chats and one to one calls, and have proven very successful in reducing the anxiety and sense of isolation resulting from COVID restrictions. The organisation is distributing phone credits to ensure their beneficiaries can still reach their case workers and have access to important services. As of December 2020, many families have returned to Sinjar due to COVID with a total number of returnees estimated to be 97,434 (IOM Displacement Tracking Matrix, 2020). While Yazda are working in the region, many other aid organisations based in Dohuk will be unable to reach Yazidis who returned to their homeland in Sinjar. Yazda representatives noted a severe lack of NGO presence, infrastructure and general established support in the Sinjar area. As a result, returnees may be less exposed to COVID-19 given lower population density compared to the camps but they will have to face other hardships as a result of poorer support structures in Sinjar.

Yazda's representatives further noted that there is still a lack of family focused approaches to MHPSS in Kurdistan that views the family as a complete system and tailors treatment accordingly. The case of returning IS captives is particularly challenging because returnees may have difficulties reintegrating into their families or reconnecting with their religion. Children may have been separated from their parents for a prolonged time such that they may not feel at home when they return. They also have to adjust to a completely different social context compared to their experiences in captivity. Many parents have been killed or now live abroad. Returnees face extreme poverty with most living in IDP camps. Some survivors may feel more loyalty towards the Islamic religion or feel more connected to the name they were given by IS. Yazda's survivor centre aims to provide an open space to these individuals and refrains from pushing a Yazidi identity onto the returnees. They are also emphasising the need of treating children as individuals, which tends to not be the case in the Middle East with regards to therapy or children's psychological needs. More organised meetings with religious leaders and pilgrimage to the Yazidi holy site in Lalish may be helpful to restore a feeling of connectedness with the Yazidi community but due to COVID pilgrimages are not currently possible.

One representative is concerned about men being excluded from programmes focused on PSS, vocational training and livelihood support. They note men's frustration with the view of the West that sees them as unappreciative of their women. Many men had to make difficult decisions during the fast advance of IS and were forced to consider which of their family members they could save. They carry this psychological burden but are not provided a means to heal. Moreover, they also carry the burden of responsibility for financial needs of their

families that they are often unable to shoulder given an unemployment rate as high as 50% pre-COVID. It is highly likely that the pandemic will have increased this number and put additional psychological pressure on men as they face even more challenges to provide for their families.

Another burden on the Yazidi community is a high rate of somatisation of psychological distress. Embodied pain and fainting are common for which specialised medical care is needed. In many cases, patients end up taking medication for their symptoms which may result in side effects that require further medication. The representatives note that specialised trauma treatment in combination with generalised medical care is vital for these cases but there is insufficient support.

There is still the challenge of stigma around mental health, which may paint returnees as “sick” or “crazy”. Oftentimes this is accompanied with the expectation that those suffering from mental distress should simply “stop thinking like that”. The representative notes that although there is stigma, they also heard of Yazidi women who agree that throughout their community all would benefit from psychological treatment. Nonetheless, there is still less hesitation to approach psychiatric services for medication or ask for consultation regarding physical symptoms rather than receiving psychological counselling.

Another challenge is the provision of specific suicide prevention interventions. Suicidality rates are high but stigma keeps individuals from opening up about their pain and acknowledge the need for help. The representative notes that it is important to stop beneficiaries and their families from avoiding responsibility to address mental health problems and to avoid blame. In general, psychoeducation is still not provided broadly enough in the region to reduce stigma and open up channels for treatment.

Besides specific mental health problems, another substantial challenge is the lack of future prospects for many IDPs. Yazda representatives highlight the need for a future focused approach that can foster empowerment, agency and a hopeful outlook for the future. They stress the importance of connecting MHPSS services with livelihood programmes and schooling. Yazda has begun to address this gap in several of their projects, such as sustainable livelihood development in villages around Sinjar City. Projects include vocational training, support in opening new businesses, and a focus on enabling female participation. They also provide legal aid such that Yazidis can receive new passports, identification and other official documents that are needed to access government services. However, numbers of beneficiaries reached with these programmes, especially for livelihood, are still relatively small compared to the many people who still remain in need of economic aid, especially those in IDP camps.

Besides their humanitarian work, Yazda also strongly acknowledge the importance of justice for Yazidis and accountability of IS perpetrators as essential for healing of the community. Besides the return of the missing women and girls in captivity and the rebuilding of their homeland, justice is often pointed out as the third priority for many Yazidis. The organisation supports a documentation project that collects evidence of IS crimes through testimonies from survivors of the genocide and sexual violence and from mass graves sites and religious temples. Initially, documentation was mainly meant for cultural reasons but has shifted its focus to legal purposes over the last 3-4 years. The team has been trained by Justice Rapid Response and the American Anti-Corruption Institute in conducting survivor interviews according to international standards to ensure evidence holds up in court. Interviews with survivors are shared with international war crime units. The project is funded by the US State Department.

Finally, the Australian branch of Yazda is starting a project in which Yazda will refer Yazidis in the resettlement programme to grassroots NGOs that can provide psychosocial support. This programme will follow different standard operating procedures compared to their work in Iraq given the stark differences in available resources and the potential of collaboration with multiple local NGOs and government.

3.4 Voice of Ezidi (VoE)

Voice of Ezidi are an NGO which was created in 2019 by four survivors of the 2014 IS genocide, who have volunteered with international organisations and NGOs (including Yazda) while living in IDPs camps in Iraq. VoE are registered in France and are involved in advocacy work for the Yazidi community to promote the Yazidi culture and cultural exchange, raise awareness of their needs and experiences since the 2014 genocide, combat discrimination, connect international Yazidi communities and cooperate with other European organisations. They also aim to foster integration of Yazidis in France through sponsorship and support of Yazidi students. For this report we spoke with the President of VoE, Farhad Shamo Roto, who arrived in France in 2017 after being granted asylum. He is a survivor of the 2014 genocide and one of the founding members of VoE.

VoE have partnered with national and international organisations including those founded by other members of the Yazidi community. Among the partners are the Shingal Charity Organisation who collaborate with VoE on a project to build housing and an education centre; Yazda, with whom VoE are doing advocacy work; the Eyzidi Organisation for Documentation of the genocide; the Eaglewatch Foundation; the Yezidi Emergency Support who work with VoE on a sponsorship programme for newly arrived Yazidis in France; and with Farida Global Organisation which was also founded by a survivor of the IS genocide and with whom VoE have established the Ezidi Youth Network, which connects Yazidis from around the world to foster cooperation and develop community programmes.

In France, VoE focus on advocacy work, cultural exchange and integration of Yazidis. The organisation aims to raise awareness of and advocate for support of Yazidis' psychological needs. Mr. Roto has noted that the French government has been unaware of the psychological needs of Yazidis. His organisation has gotten in touch with the minister of the interior who is now aware of the dire need for psychological support. VoE are also lobbying to bring more Yazidis to France and to promote family reunification, which they have brought up in their liaison with the French ministry of interior. Due to COVID any progress on resettlement and reunification programmes has come to a halt as a result of movement restrictions.

VoE also promote cultural exchange and aim to facilitate integration of Yazidis in France, such as those who were brought there by a programme run by Nadia's Initiative. For instance, the organisation has started an initiative that provides an opportunity for Yazidis to connect with translators or receive social support from other Yazidi families who have lived in France for a longer time. This initiative has reached more than 60 Yazidi families.

VoE also stress the importance of providing Yazidis with a platform to connect with the community and practice their shared culture. Connecting with the community is seen as a necessary part of the trauma healing process. For instance, VoE have organised community events with local host organisations to bring together Yazidi families who live near each other. These events also invite other members of the local community to join and thereby foster an understanding between French and Yazidi people. Mr Roto highlights the need of Yazidis to feel better understood and seen by French nationals, even if they do not share the same language. Following on from these cultural exchange programmes, some French families have volunteered to become hosts to new Yazidi arrivals.

In Iraq, VoE are also involved in aid programmes, such as those in collaboration with the Shingal Charity Organisation. VoE operate in two IDP camps (Khanke and Sharia) where they provide livelihood programmes and vocational courses. In Sinjar, VoE are working on a farming project to support 200 families with livestock and a housing project to build 70 houses. These projects are funded by the Polish government, Polish churches and private donors. A new camp in the Sinjar mountains was also part of one of their projects to support around

2000 families mainly including widows and their children. The centre provides play rooms for children while women take part in vocational training courses. The aim is to support 240 beneficiaries monthly. Due to COVID, progress on this project has come to a halt.

Similar to the statements made by other Yazidi organisations, VoE also highlight the dire need for a solution regarding children born of rape. They point out the potential of resettlement programmes to provide asylum to mothers and their children. VoE have reached out to activists, human rights organisations and the UN to gain support from political leaders both in and outside of France. Regarding mental health problems, Mr Roto notes that VoE staff would benefit from training of how to best interact with individuals who experienced severe trauma. Many Yazidis cannot seek help for their psychological needs through official channels in France because of illiteracy, language barriers and because of perceived shame of the need for help.

According to Mr. Roto, there is a substantial shortage of Kurdish speaking translators in France and Yazidis are often provided Arabic translators. Many Yazidis do not understand Arabic and for many, the language is associated with their time in captivity. This may result in increased psychological distress. Mr. Roto describes Yazidis as a “trustless people” who are suspicious of non-Yazidis as a result of the genocide and the underwhelming national and international support for their community. This, together with the lack of social workers and psychologists who can communicate with Yazidis, renders the provision of psychosocial support exceedingly difficult. Mr. Roto notes the value and utility of the German approach that follows the principle “from the community for the community”. He states that psychosocial support provided to Yazidis from within their own community has the greatest potential of being successful. Many psychologists in France simply do not know about Yazidis and their experiences. VoE are therefore lobbying for support to train Yazidis to become psychologists. The government has now sponsored private training programmes, with the first nine graduates being now available to support the community.

Besides the challenge of language barriers in France, Mr. Roto points out the dispersal strategy as a severe hindrance to providing specialised support to Yazidis. Only few families live in proximity to one another. The dispersal strategy therefore poses a problem for VoE in providing support and organising community events. While the idea behind this policy is to prevent ghettoization of refugees and promote integration, Mr. Roto deems this strategy as highly detrimental to severely traumatised individuals. These post-migration stressors can further worsen their mental health.

4. Other examples of specialised MHPSS services

4.1 IOM

IOM have provided PSS in Iraq since 2014 across 9 governorates and 22 community centres throughout the country. Since 2014 and up to 2018, IOM has reached 103,278 beneficiaries with 311,682 services (IOM, 2018). Their provisions for psychosocial support are guided by considerations of the importance of re-establishing community connections within a social cohesion framework. They aim to strengthen resilience and engage in capacity building for sustainability. They have established community centres but also provide mobile teams to increase their reach. They follow the IASC guidelines on MHPSS in emergency settings. The approach is holistic and combines both specialised and non-specialised services. They consider the specific needs of children, men and women, respectively, as well as the specific experiences of survivors that shape their particular needs such that individualised plans for groups with similar traumatic experiences can be put into action. Strengthening resilience is a major point of focus (Global Justice Centre, 2016). Their mobile teams that include educators, social workers, psychologists and psychiatrists operate across 15 locations to cover areas without established centres. They also support three universities in conducting research on the effect of displacement on psychosocial needs.

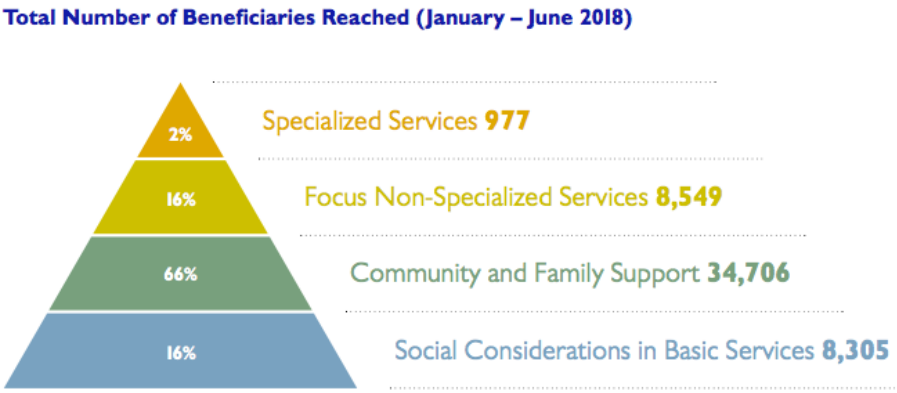

Figure A1. IOM services.

4.2 AMAR

The AMAR Foundation (Assisting Marsh Arabs and Refugees) provides healthcare and education to IDPs throughout Iraq. The foundation has thousands of local employees that are essential in ensuring that AMAR's programmes are culturally appropriate (Solomon, 2019). Their Escaping Darkness programme operated from 2015 to 2017 to deliver psychological support to female survivors of IS. The team involved expert psychiatrists that trained local doctors in Northern Iraq on how to provide psychological treatment to women and children who had experienced trauma. Training involved effective communication, psychiatric interviews, relaxation techniques and anger management but also provided support with respect to basic life skills and emotion regulation. Social workers were also trained in basic PSS and counselling techniques. The programme established 36 PSS centres in and outside of IDP camps. Between 2016 and 2017, ten health clinics were able to treat 2419 patients with counselling (22% of which were male), over 90% of which were Yazidis. Clinics also referred 340 patients to more specialised services. Many patients of the AMAR programme were

directly affected by IS and gender-based violence, or suffered from general consequences of displacement.

Although funding ran out in 2017, AMAR note that the focus on knowledge transfer through community-based training may have been able to have a lasting positive impact to the region.