building peaceful futures

Sexual Reproductive and Maternal Health (SRMH) Baseline Assessment Report

Australian Humanitarian Partnership

Primary health care project in Sinjar

SINJAR CITY CENTER AND SURROUNDED VILLAGES

Australian Aid

care

1. Executive summary:

1.1 Introduction and context:

Over three million people remain internally displaced in Iraq since the defeat of IS. Returns to Sinjar (Ninawa) and Hawiga (Kirkuk)[1] remain particularly slow, partly due to the high levels of destruction and slow rehabilitation of infrastructure and essential services. Populations have suffered the physical and psychological impacts of ISIS rule. Returnees are extremely vulnerable to protection threats, and report; violations of principles relating to return movements; security incidents resulting in injury or death; risk of sexual violence and abuse; explosive hazards and rights violations by state or non-state security actors[2]. Community tensions are predicted to increase with retaliatory attacks against Sunni Muslims in Hawiga – viewed as ISIS collaborators – and blocked returns of this group have recently been reported.[3]

In August 2014, fighters from the terrorist group, the Islamic State of Iraq and Al-Sham (ISIS), flooded out of their bases in Syria and Iraq, and swept across Sinjar. The Sinjar region of northern Iraq is, at its nearest point, less than 15 kilometres from the Syrian border. It is home to the majority of the world's Yazidis a distinct religious community whose beliefs and practice span thousands of years, and whose adherents ISIS publicly reviles as infidels. Within days of the attack, reports emerged of ISIS committing almost unimaginable atrocities against the Yazidi community: of men being killed or forced to convert to Islam; of women and girls, some as young as nine, sold at market and held in sexual slavery by ISIS fighters; and of boys ripped from their families and forced into ISIS training camps. Iraq's estimated 500,000 Yazidis fear the end of their people and their religion. In less than two weeks, nearly all the Yazidis of Sinjar fled northern Iraq, seeking refuge in Kurdish territory, while thousands remained trapped in the rugged Sinjar Mountains, awaiting rescue. It was quickly apparent that the horrors being visited upon captured Yazidis were occurring systematically across ISIS-controlled territory in Syria and Iraq[4].

1.2 Project Introduction:

CARE is implementing a Sexual, Reproductive and Maternal Health (SRMH) Project in three locations in Ninawa Governorate (Zummar, Sinjar and Rabia), which involves providing a full package of SRMH services through existing hospitals and/or PHCs in close coordination with Ninawa Directorate of Health and in partnership with a local partner, Harikar. 230 Primary Health Care (**PHC)** facilities have been destroyed across the country and there is a heavy burden on PHCs with consultations increasing eight-fold[5]. **The consortium will provide a physiological response to returnees' needs through the rehabilitation of two accessible PHC centres by CARE** to support pregnant and lactating mothers, sexual and reproductive health, management of childhood illnesses and other infections. This will include the training of 40 community health volunteers that will identify and refer cases to the PHCs, including gender-based-violence (GBV) survivors and at-risk children to the closest GBV services and provide essential information at the household level about nutrition, WASH, and disability awareness and referral information. The two PHCs that have been selected in Sinjar are AL Shahada PHC and AL Nasser PHC.

CARE will not be refurbishing any PHCs in Hawiga but will be conducting awareness and community outreach initiatives related to SRMH, gender and preventing and mitigating GBV.

[1] IOM's Displacement Tracking Matrix (DTM) indicates that only 48,816 individuals have returned to Sinjar and 72,750 to Hawija. October 2017

[2] [2] Global Public Policy Institute, 30 Aug 2017

[3] Global Public Policy Institute, 30 Aug 2017

[4] Human Rights Council, Thirty-second session, 2017l

[5] Iraq Humanitarian Response Plan, February 2017.

1.3 Summary purpose of the baseline study:

The purpose of this baseline is to provide an information base on which to monitor and assess an activity's progress and effectiveness during implementation and after the implementation. The objective of the baseline will be to consolidate existing information in relation to SRMH indicators, gender inequality indicators and information on protection risks associated to accessing primary health care services. The baseline study also makes recommendations that project partners and the stakeholders might use to improve the design and implementation of other related SRMH projects and programs.

1.4 Summary of baseline methodology assessment:

The questionnaires to be used can be found in annex 1, 2. A separate quantitative and interview questionnaire has been developed for the technical assessment of the PHC and a qualitative questionnaire has been developed within the context of the broader consultation with the affected population (KIIs, household visits and FGDs) and key stakeholders (INGOs, NGOs, religious leaders, men and women community leaders). FGDs conducted with women, men, girls and boys of diverse ages, backgrounds, life stage groups including people with disabilities.

1.5 Summary of key findings:

Based on the findings of the carried out baseline SRMH Assessment CARE International in Iraq proposes to work in two PHCCs in the center of the Sinjar city, namely Al-Shuhada PHC in Al-Shuhada neighbourhood and Al-Nasser PHC in Al-Nasser neighbourhood to provide the full package of medical equipment and laboratory kits as well as stuff of delivery room with a catchment area of Al-Shuhada 32,000 and Al-Nasser 21,000 population and to rehabilitate both PHCCs building in coordination with directorate of health (DoH) which have been partially damaged during the military operators. CARE International in Iraq has established relationship with community and local authorities, including Ninawa DoH. Moreover, CARE could facilitate a quick start for the project based on data collected through baseline evaluation.

The SRMH needs of Sinjar city have changed considerably in recent years. In addition to basic primary health care services, there is a growing need for a range of mental health services, services for key chronic and non-communicable diseases, as well as critical obstetric, maternal, and neonatal health services. The assessment demonstrated weaknesses in PHCCs capacity to provide these services. The deficiencies are related to lack of policy or guidelines related to new or emerging threats, lack of targeted capacity-building programs to build skills in emerging health areas, and lack of infrastructure and equipment to diagnose and provide primary treatment (i.e., X-ray, ultrasound, medication …etc.).

A key challenge is the uneven distribution of staff at the PHC level. There is a critical need for lab assistants, eye examiners, and dental assistants, while there is a significant nursing surplus. There is a need for in-service training, especially for paramedical staff and nurses in PHC. A second challenge is the lack of supplies and equipments, with frequent stock outs for essential drugs and laboratory supplies. Both facilities lacked storage room for drugs and supplies or sufficient rooms for treatment and care. PHCs have a significant need for clinical standards and improved reporting. Some treatment guidelines exist for limited areas of clinical care, but they need to be revised to better orient them to the needs of PHC. Referrals are made in the past years but without much capability for follow-up. Without improvements in information and feedback systems between.

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2. Purpose of the baseline

The purpose of this baseline is to provide an information base on which to monitor and assess an activity's progress and effectiveness during implementation and after the implementation. The objective of the baseline will be to:

- To consolidate existing information in relation to SRMH indicators, gender inequality indicators and information on protection risks associated to accessing primary health care services.
- Compliment incomplete or data of poor quality relevant to the activities being implemented within the context of the BPF project.

The baseline will look at the situation before the project implementation and after the activities have been implemented to measure the change over time in the activity location alone. The data collection included qualitative and quantitative approaches (Key Informant Interviews-KIIs, Household visits, Focus Group Discussion-FGD and interviews). Due to the sensitivity of data collect on gender-based violence the CARE team conducting the data collection enumerators are trained on how to handle this information to ensure the safety and confidentiality of the individual. They didn't speak directly to survivors and instead will be focusing on implementing a safety audit survey.

3. Limitations

The scope of this baseline assessment was limited in its' capacity to complement all the information gaps that are identified because of ongoing insecurity which limits the ability of CARE team to travel to Hawiga and to all the nearby villages in Sinjar due to ongoing insecurity and the sensitivity of the information. Although the safety audit is adapted and tailored to the context it remains a very sensitive topic that is not openly discussed and stigmatized. In addition, the distances between the villages, time and financial resource constraints have limited the sample size.

All information collected through this process was time-bound, Sinjar remains a complex and volatile environment that is constantly changing and evolving.

4. Baseline Study Methodology

The questionnaires to be used can be found in annex 1, 2. A separate quantitative and interview questionnaire has been developed for the technical assessment of the PHC and a qualitative questionnaire has been developed within the context of the broader consultation with the affected population (KIIs, household visits and FGDs) and key stakeholders (INGOs, NGOs, religious leaders, men and women community leaders). FGDs were conducted with women, men, girls and boys of diverse ages, backgrounds, including people with disabilities. CARE also ensured that the team leaders were trained to be able to directly consult boys, girls and people with disabilities to accurately reflect their needs and feedback. The selection of the households to be consulted and the participants in the FGD were done in

consultation with maximum 17 and minimum 12 participants. Women headed households, child headed households and households with people with disabilities, elderly people and households representing minority and/or marginalized groups are prioritized for the FGDs. Focus group discussions included individuals of diverse background and ages.

The technical quantitative survey of the primary health care centre and the safety audit were carried out using a digital data capture that CARE has already been using-KoBo collect. The qualitative component of the data collection used a paper-based format.

4.1 Coverage

The focus of both the technical and qualitative assessment was Sinjar center (Al-Shuhada and Al-Nasser neighbourhoods) and surrounded villages. More details can be seen in the below table.

Sinjar Neighborhoods/villages	Households citizen	FGD	KI	Technical assessment
Al-Shuhada neighbourhood	188	women and girls Men and boys	FGD with representatives of Neighborhood and community leaders	PHC manager, a doctor (one woman and one man), a medical assistant
East Al-Shuhada neighbourhood	217			
West Al-Shuhada neighbourhood	146			
Al-Nasser neighbourhood	279	women and girls Men and boys	FGD with representatives of Neighborhood and community leaders	PHC manager, a doctor (one woman and one man), a medical assistant
Kaniya Avde village	55	Men and boys women and girls	FGD with representatives of Neighborhood and community leaders	N/A
Nssreia village	38	women and girls Men and boys	FGD with representatives of Neighborhood and community leaders	

4.2. Technical assessment

Each PHC (AL Shuhada PHC and AL Nasser) benefited from a technical assessment and interviews with a selection of PHC personnel which included: the PHC manager, a doctor (one woman and one man), and a medical assistant. This information complimented with responses received by ten (five women and 5 men) individual access in the PHC the day of the assessment. The technical assessment led by the CARE MEAL and Health team and took a day.

4.3 Qualitative Assessment (Household and FGD)

The qualitative assessment covered 2 villages and 2 neighborhoods in Sinjar (Al-Shuhada neighbourhood, East and west Al-Shuhada neighbourhood and Al-Nasser neighbourhood). A simple random sampling method used to identify the households who qualify for a household visit and FGD.

4.4 Sample size Sinjar

- ***Key informant interviews:*** Head of sectors (Mukhtars), religious leaders, local authorities, community leaders (one-man, one-woman representative), CSOs, NGOs and INGOs working in the area of operation (DORCAS, Medicine du Monde)
- ***FGDs:*** *Separate FGDs with women and men from the affected community. An FGD with men and a FGD with women conducted in each village and neighborhood (2 neighborhoods + 2 villages) assessed. FGD included no more than 17 participants and lasted about 60-90 minutes.*

CARE team	Day 1	Day 2
CARE team with support of HI	Al Shuhada Neighbourhood	Village 1
CARE team with support of HI	Al Nasser Neighbourhood	Village 2

The qualitative data collection in Sinjar took place between 2 days.

Staff: CARE staff conducted both quantitative and qualitative assessments and MEAL coordinator provided technical support, training, and oversight/supervision. The staff worked in pairs (one man and one woman). The CARE Gender team provided an inception session for the staff on Protection from Sexual Exploitation and Abuse, Child Safeguarding, Collecting Information in a Safe and Confidential manner and providing them with information about Gender-based violence (GBV) and protection specific referral pathways.

5. Complaints Response Mechanism (CRM):

A complaints/feedback response mechanism (CRFM) is designed for the whole CARE Iraq response and is adapted to the different geographical areas, including Sinjar and for the types of interventions in those areas. Given the differences from one operation to the next, a broad standard CFRM is established among CARE operation areas and adjusted depends on the local context.

A complaint response mechanism to receive and respond to feedback and complaints will be established in both identified PHCCs: a complaint box as well as a comments/feedback box, a free hotline number (80010170), a help desk (reception desk) during the registration of patients while coming to PHCCs and an accountability mobile team will be established. The comments box was designed to capture general feedback on CARE intervention in Sinjar and was designed to capture information easily from the affected population taking into consideration their preferred channel of communication, language and the level of literacy. Community members are also able to submit complaints in ways that suit them and that takes power dynamics, cultural, geographical, and protection and safety issues into account. Women, men, boys, girls, the elderly, the non-literate, people living with chronic illness, people with disabilities, communities, all are taken into account to be able to submit complaints with relative ease and confidence.

Once completed, the individual simply puts the form into the box and the results are collated by MEAL staff and after the investigation on the feedback/complaints. The Hotline team receive calls and are responsible for providing the feedback to the calls and the complaints and feedback collected in the complaints box. FGDs are also used as a tool to consult with the affected population more broadly. In

addition, the field staff will establish help desk (reception desk) to receive and help patients and visitors. This process is anonymous, the type of complaints received, the response time to the complaint, and the type of actions taken to address the complaints are all recorded to monitor CARE staff's capacity to close the feedback loop.

If the complaint is serious, then it needs to be dealt with separately through the established channel and brought to the attention of the nominated person (Country Director, head of programs and Human Resources department). Complaints however will be processed by someone who has suitable qualities and is trained and supported to deal with them. They should be confident in directing complaints through the right channels and judging the sensitivity of complaints. Even less serious complaints demand greater or lesser degrees of sensitivity or a more objective view. The Accountability assistant is responsible for directing complaints received in their field location and is supported by a MEAL Coordinator in this role.

If the complaint is not sensitive, then, as a general rule, it is solved as locally as possible, by bringing the issue to the attention of the relevant sector leader at the field level, such as the Field Office Team Leader, or the relevant Project manager. If it cannot be resolved at this level, it is elevated to head of Programs and then to Country Director. The complainant receives a response that comprises a clear answer and explanation (even if no action is needed to be taken) as well as an indication that the complaint has gone through an established process. People need to know they have been heard and provided with a response. Experience has shown that in most cases in Iraq, even when no action is taken, receiving a clear explanation satisfies the complainants. In other instances, people are left unhappy with the result, and the mechanism has an appeal system that users are able to access and follow up.

The data collected through the complaints and feedback mechanism will be consolidated and analysed on a monthly basis to identify trends and will be used to inform the decision making of senior management and the complaints/feedback form used to capture complaints from beneficiaries, and flyers and banners will be used in both PHCCs.

6. Data management and analysis:

All quantitative and qualitative data was analysed using Kobo toolbox itself and Microsoft Excel. Based on the raw data, available for download from KoBo Toolbox, a master database was developed, and data cleaning was carried out. A quantitative data framework was set up in Excel for all validated data. A series of frequencies count, and other statistical methods were employed in the analysis of the data. Qualitative data are collected and cleaned by MEAL team and been transferred to a standardized excel sheet to compare data of each IDP camp with others. All collected and analysed data refer to annex 1 and 2

7. MAIN BASELINE FINDINGS:

This section of the document seeks to provide more detailed information on community needs, challenges, access to services, such as, basic services available within Sinjar context and more focused on health services and challenges. This is with the intent of both measuring the logframe indicators, as well as providing the broader analyses and data requested by Health and Gender and Protection team to provide contextualized recommendations for the project period. These have been broken down by project outputs and activities, to ensure relevance and promote understanding.

When examining this data, it is crucial to bear in mind that local authorities responding to FGD questions may not be reliably informed. Equally, some respondents may not have been aware of the differences

between various sources of services available in the area, as such, the different answers could reflect different levels of awareness rather than different primary sources.

The report findings are divided into two parts:

- Qualitative findings
- Identified primary health care centres (Al-Shuhada and Al-Nasser PHCCs) technical findings

7.1 Qualitative findings

Findings of FGDs with men, women, boys, girls and vulnerable people, such as, FHHs, elderly persons, people with disabilities and key informants, such as, Mukhtars, religious leaders, of both neighbourhoods in the Sinjar city center as well as villages and Sinjar Mayor are stated below in the relevant sections:

7.1.1 Demographic information:

Partial Population Sex and Age Pyramid: the below information is based on key informant's expectations and percentages are used to breakdown the current statues of returnees:

Age breakdown	Al-Shuhada neighbourhood	Al-Nasser neighbourhood	Kaniya Avde Village	Nsseria Village
All	**1560**	**1410**	**210**	**300**
Men (+18)	328	296	44	63
Women (+18)	546	494	74	105
Boys (0 – 18)	296	268	40	57
Girls (0 – 18)	359	324	48	69
PWD	30	28	4	6
Average household size:	6 family members			

There is no exact percentage on the returnees, however, based on community and key informant's expectations, returnees' percentage is very low in comparison to year ago. Moreover, some returnees reported they regretted that they returned back to Sinjar because there are no job opportunities, lack of security and political stability, no public services such as schools, hospitals and so on.

7.1.2 Community needs and challenges accessing services:

Majority of participants in different places are in agreement that there are men and women living without their family at the time being, meaning they live with, either their relatives or friends or rent accommodation in Sinone or Sinjar center, if they are from surrounded villages which security isn't stable there (because they have not moved their family back yet).Whenever job opportunities are available, such as, working in private sector or employed by government, men and women come back to Sinjar during working days and back to IDP camps in Duhok during the weekend.

During the FGDs it was highlighted that there are people having problem in seeing, hearing, communicating in the community, but exact numbers are not available since no assessment has been done by either government or humanitarian aids at the time being. It was highlighted that there are people having difficulties in walking\climbing especially elderly people who suffer a lot from their knees

and some of them are unable to walk. Besides that, there are paralysed and children who suffer from polio or other kind of disease as well such as autism, down syndrome…etc.

It's also been discussed and stated by participants that there are people who have difficulties remembering or with self-care. However, once it come to numbers, since movement is ongoing and identifying their locations, remain unanswered due to the unavailability of data to depend on. This indicates that women in this community have restriction mobility and they are only aware about what is happening to people who live near them (their closest neighbourhoods) and neighbors.

According to the discussion with women that returnees' percentage is very low, estimating in between 2 -5 percent in comparison to year ago. Also, some FHHs claimed that they regret that they returned back to Sinjar due to the unavailability of job opportunities and public services such as schools, hospitals and so on. They also stated that their husbands are away from Sinjar during two weeks in a month because they couldn't get a job opportunity in the neighbourhoods and or interviewed villages. However, a widow woman with 10 children mentioned that her husband with one of her sons passed away two months ago, because of an explosion in SINJAR and has no monthly source of income to meet her 10 children basic needs. She said with a deep sorrow in her voice that she wished she didn't return back to SINJAR because their return was the reason behind passing away her husband and son. And this gives an indication that there are still uncleared places from land mines that makes people to worry to return, especially people living from south of Sinjar city.

The returnees to Sinjar city centre are living for the time being in other people's houses, such as Yazidi, Muslim and Christian's houses and majority of them are originally from villages around Sinjar and due to the either uncleaned properties in some villages from mines or unstable security situation in the villages and fear from ISIS as well as because their properties are either partially or fully destroyed during the conflict. However, the relationship is good and there is no tension between host community and IDPs. Also, almost all the people are secondary IDPs for the time being. Moreover, it's expected that in the future once the remaining people return back, there will be tensions between people who are living in Sinjar now and future returnees, due to competition for the available resources.

7.1.3 Impact of the Conflict and Basic Access to Services

Changes that the community has experienced since the crisis are as follow:

Baseline SRMH findings show that 95% of women and 85% of men during the FGDs as well as the house to house visits suggest the changes that women and girls have experienced are as following:

1. Less access to job opportunity than before;
2. Less financial income;
3. Restriction and limitation of movement and mobility due to instable political and security situations;
4. Loss of family member and up to now some family's member are held captive by IISL or have disappeared and this make all members of family very depressed and uncomfortable.
5. Lack of maternity unit;
6. Lack of doctors and medicine;
7. Lack of public transportation;
8. Less entrainment activities such as playground, football stadium…etc.

The changes that men and boys have experienced are:

1. Community and social pressure of being unable to provide for their households as before due lack of job opportunities and this irritates them;
2. Feel unsafe that anytime another crisis happens again, and they will lose their family members like before;
3. Feel that in Sinjar there is not sense of life because they are just killing time;
4. Less mobility movement due to not all areas are cleaned from land mine.

The main needs of community as identified by the community are the following:

Women	1. Maternity unit including gynaecologist and pre\post-natal care; 2. Access to education; 3. Job opportunity to be independent financially some women will be able to a certain type of works but some others cannot because of households' chores; 4. International security; 5. And return back the captive women and girls who were kidnapped by IISL 6. Provide health services including lab-tests, ultrasound, medication…etc.
Men	1. Job opportunities; 2. International protection; 3. Compensation to repair their houses and buy properties; 4. Clean their lands and properties from
Boys	1. Provide good quality of education including rehabilitating schools, providing transportation, provide teachers, stationaries, etc. 2. Playground and public places;
Girls	1. Provide international security; 2. Provide access to education through financial supports.
People with disabilities	1. PWDs need such as wheel chairs, cane, financial support to buy their require needs…etc. 2. Ensure PWDs have access to resources such as education, health services as currently PWDs have no access to job services due to environmental, social and cultural barriers.
Elderly people	1. Financial support; 2. Health support as in Sinjar there are only PHCC and specialist doctors are not available and PWDs cannot meet their health needs in Sinjar and force to go other places such as KRI but unfortunately, they have no financial ability to pay for medication, tickets, transportation fees from Sinjar to Duhok and back to Sinjar
Infant	1. Winterization kits such as clothes; 2. Formula; 3. Playground.

These changes are very significant because of the following reasons:

1. Many pregnant women and girls die because they have no timely access to maternity care. They passed away during baby delivery during the crisis after August 2014;

2. Many children are deprived from education which is basic human rights which means there are more uneducated children, more children begging on the street, more poverty and more problems rising to juvenile crime.
3. Not having access to job opportunities, places people in a vulnerable position and they cannot meet their basic needs. For example, one FHH said that her son has neck problem since he was born, and he cannot eat all kind of food, nor sleep on that side and always he cries because of his neck but they cannot do operation in Iraq. The doctor informed them if they do surgery in Iraq, the nine years old boy will be paralyzed and unable to live a normal life; this is why he should undergo operation in foreign countries.
4. The widow woman cried and said that she has ten children and all of them are unemployed because some of them are young and can't work; some other can't find job opportunity otherwise they would work even they are young. Her brother in law, has 5 children and he is doing a daily wages labour. He supports her and her ten children sometimes when he can get a daily job. Before the conflict her husband was working, and the family has their own income and they were not dependent;
5. They lost all their livelihood resources and job opportunities including properties such as cars, lands, houses, live stocks and farms.
6. However, the most significant change and issue that make them very worried is losing a member of family.

Services are safely available to men, women, boys and girls in this community:

- Food aid / food distributions: they receive food aid from government\food agent and they have PDS card. They receive only four items: sugar, flour, oil and rice. All other food items, people need to buy and those who have income and can afford them do, but those who can't they don't buy them.

- Shelter: one NGOs repair the targeted communities' doors and windows, but their original houses are still not cleaned from land mines and majority of houses in the villages are completely destroyed. Some families use nylon and blanket as a door and window.

- Non-food items (specify which NFIs): they haven't received any assistance from any NGOs.

- Health care (including reproductive health): MSF in collaboration with DoH provide health care services which is 10-15 minutes far away from them by car and 30-40 minutes by walking. There is lack of maternity unit in Sinjar; the targeted people have to go either Mosul, Sinone, KRI or Telfer. The majority of pregnant women go to KRI for maternity care because the operation room is not available and to be in the safe side they go to KRI one month before delivery in case to have an operation if they need it.

- Hygiene/dignity kits: they haven't received any hygiene\dignity kits and if they can afford them, hence they do buy them.

- Education: government and children pay 5000 IQD per month for teachers' incentive and 15000 IQD for transportation those who are far from schools.

- Women-friendly spaces: KIIs mentioned that they are one NGOs that provide vocational training, but they weren't aware about the name and location of NGO

- Clean water: no NGOs provide WASH assistance and they buy water from water trucker on regular basis.
- Latrines: each family has its own latrine and showers.

Regarding mobility analysis, both women who were interviewed highlight that women & girls of different life stages including PWDs have very limited mobility movement and before they go anywhere outside the house they should take permission from males' partners' and must be accompanied by someone and this depends on distance and kind of services. If women and girls need to go outside Sinjar they must be accompanied by one male family member and if they move inside the Sinjar they can go with a accompany of female member, friends or relative in group or pair after getting permission from men but it is worth noting that this is related to household decisions and depends on individuals. The situation of FHH, widows and divorce are the same and they need to get permission from men partners' if they live with their parent's in-law families if not, they inform their adolescent children. Also, if FHHs, widows, divorce women have a son above 18 then he is replacing his father's position and have authority to make decision and protect the family but still husbands' families do interfere into the household issues.

However, men and adolescent boys' mobility is not restricted, and they can travel anywhere they want at any time without any limitation. In summary, it is worth to mention that People mobilization is restricted based on the genders, ages, social stages, life stages, physical ability and so on this is because society has different expectations and attitude on women, men, boys and girls of different life stages. Besides that, women and girls including girls and women with disabilities freedom of movement is more restricted because of unstable security, political and social situations. As for PWDs mobility movement depends on their genders whether they are women, men, boys or girls including their physical ability for example there is a huge different between women and men with disabilities as men with disability can move around without limitation if they have physical abilities and availability\accessibility, but the situation is different for women and girls of disabilities this is because of their sex and gender identities. However, For Person of disability and elderly person, their movement is restricted to their gender and physical ability for example if it is a disabled woman\girl\old women, she needs to get permission and be accompanied by someone but if it is a disabled old man\boy, he can travel and move alone. One FHH mentioned that "I send my children if I need to buy something and if it is needed to go by myself then I take my adult children with me". The other FHH reported that when her husband is on duty she seeks support from her brothers if she needs to go hospitals, market places…etc.

Service	Women	Girls	Men	Boys	PWD
WASH	Different groups procure water in front of home by water trucking. Cost depends on the distance. However, the average can be estimated between 10,000 – 15,000 IQD per 1,500 liter of drinking water.				
Shelter	They are secondary IDPs and living in people's house as their properties are destroyed.				
Health Care	They can't access it alone and they should be accompanied by someone. They have to use car because they can't walk by feet as it is more than 30 minutes far from their homes by		They can access it and it is fine to access it without accompanying anyone.		Those who are able bodied, and men can access it alone but those who don't

	walking. There is no public transportation. Women seek support from their relatives. The widow family seek support from their brother in law and the FHH seek support from their brothers when their husband is on duty.				have abled body and are females cannot access it alone.
Livelihood	Generally vulnerable groups, such as, FHHs, widows can't access to job opportunities because they have young children and they have no one to take look after their children. Or young girls don't have skill.		Men are keen and can access to any kind of job if opportunities are available. The main issues are not having job opportunities.		PWDs do have access to job opportunity but this depends on their genders and physical ability. If they have skills, abled body and culturally acceptable is not acceptable they cannot access the job.
Education	Women don't have access to education because they are overage and in education system only up to certain age can access education. Literacy training are not available in the area. Accessing girl's education depends on various factors as following: 1. Family believes and statues in traditional cultural and gender norms, 2. Economic/social statues; 3. Security and political instabilities; 4. Child marriage...etc. It is worth to mention that some girls only have access to primary school because some families don't allow their daughters to live in a far place for education.		Men don't have access to education because they are overage and in education system only up to certain age can access education. Literacy training are not available in there. Boys can access to education if they have financial ability. Vulnerable groups do send their children to schools, but they don't send all family members to school due to financial issues. Generally speaking, boys have more access to education than girls because community think that girls will housewives after all and their salaries will go to a strange man this is why they think girls' education is useless.		PWDs have very limited access to education because of physical inability, environment, physical and social barriers. PWDs who have less health or physical issue can access to education which mean who are independent and can take care of themselves but those who are depend and have difficulty in walking, seeing, hearing and so on have no access to education.
Food	They have access to it but food items depend on the family income.	Girls have access to food items, but it is men responsibility to bring food and women and girls cook foods.	Men do have access to food and they are responsible	Boys have access to food and they are responsible to buy in food when the father	They do have access as well, but it depends on their abled bodies and physical abilities.

			to buy in bazar.	is way and he is on duty.	
Protection	If there are any kinds of issues with a person outside family member, people consult with PMU, traditional, religious and tribes' leaders. If the woman is widow\FHH her husband's in-law family interfere in the issues. If issues related to GBV, women do have right to raise a case against that even legally. Generally speaking, in the community It is shame if women\girls share her problems with others because society have a negative perception and attitude on woman\girl who seek support from someone outside family member.	It is not acceptable socially girls take her issues outside family framework. She should keep her problems inside herself.	Men solve family issues that are related to household internally. If there are any issues including protection, they inform tribe and religious leaders to intervene.	Boys inform their parent if they have protection issues and it is father's decision how to deal with the issues.	PWDs access to protection services depends on physical ability and gender whether it is a female\male.

7.1.4 Women and Girls Access to Basic Human Rights:

With the female key informant discussions, including widows and FHH with 85% of women reported that women control the resources and assets because this is the case of widows and FHH if they don't have any adult men but generally speaking in the community men control the household resources inside and outside the house. During FGDs with both men and women as well as KIIs, it's realized that 75% of Men and 20% jointly and only 5% of women make decision on the using money inside and outside the house, otherwise women and girls should take permission from men on spending money unless something urgent happens when male partners' are not at home (for example if he is on duty or living in abroad), then women can decide to use money but still they can spend only up to certain amount of money which is little. A women representative of KII said "I can decide how to spend money only if the amount is little

which means no more than 25,000 IQD but I should do consultation with my husband". A girl representative of KII said "I always ask money from my mother and tell her how I am going to use, then the parent decides whether to give me money or not"

Women and girl headed households are more vulnerable to protection risks and sexual gender-based violence (SGBV) because of the following reasons:

- More vulnerable to GBV/SGBV harassments;
- They face cultural movement and mobility restrictions because the community displays a negative perception of widows, FHHs, divorces and girls if they move alone without accompanying anyone;
- Limited access and control to resources and job opportunities which means they don't have independent source of income if they are not educated or employed by government;
- Women and girls cannot do much outside doors jobs and use their skills because of traditional gender norms and relations.

There are not many girls headed households which means child headed households (15 girls have been reported by Mukhtars in both neighbourhoods for the time being). However; this number changes on regular basis and once girls come back to Sinjar they live with their relatives\grandparents. However, some widow women participants claimed that orphan girls are more vulnerable to GBV because not having parents especially father means no bread winner in the household that's why many girls become victims of child marriage and other kind of GBV. Sometimes, relatives\family members such as cousins, brothers force girls to marry at young age because they think they will be less financial burden in the family and another reason why they marry girls at early age is they are afraid the girls do something wrong outside marriage and bring shame to the family according to their believes.

As a result of their perceived gender roles and responsibilities, women in the targeted community face a number of obstacles accessing basic services and information on their human rights. For example, they face barriers in accessing resources due to limited educational opportunities and controlling resources due to discriminatory inheritance practices. They are particularly isolated from the public sphere which further limits their ability to acquire information on basic services, rights and other forms of livelihood and economic opportunities. So, not having skills and education background means less access\control to dignified works, more financially dependent and can therefore be considered more vulnerable to GBV (including exploitation and harassment risk). "What is worse than this is those women and girls who encounters risks are not able even to speak up against their rights" an FHH said. They are not able to seek out information on their basic rights due to the traditional perception that a woman who discusses family issues outside of the household is not a good woman. In both selected villages, an elderly representative of FHHs who 65 years was old as well as with 80% of women respondents claimed that all men in their communities have controlled everything. 80% of women stated that decision making both in community and household levels are made by men. However, 20% of them reported that men do consult with women on decision making.

During the FGDs with men and women as well as with key informants, 97% with almost all of the participants agreed that community level decision is made through Mukhtars, tribe leaders and religious leaders who are mostly men. Based on the existing structures, women and girls have no roles and opportunity at all to participate in the discussions and decision makings while all decisions are made in community level are from masculine perspective. It is worth noting tribe and religious leaders have a huge influence on the community and what they are saying is practiced among community. If there is a conflict

and hostility between two families, tribe and religious leaders solve it within themselves, most of the time even without raising the issue in the court. The structure is the same for different ethnicity and religious group.

Common barriers to women and girls' claiming their rights that were reported during the FGD and KIIs included:

1. Not aware about their entitlement;
2. The community and households are ruled by men (male dominated society);
3. Not having laws to defend them legally (no punishment against the perpetrators) and even if the law exists, it is not activated for the time being;
4. Less of access to education because of traditional beliefs that women and girls don't need education as they will be ended up being house wives and currently because of lack of education system in many places in Sinjar district.

Person with disabilities are not able to work because there isn't any kind of opportunities available. They can only do that kind of work which is suitable for them according to their physical and mental ability. One KII said that person with disability are deprived from the following rights:

1. They are deprived from education because of physical and environmental barriers i.e. access to schools, lack of special schools, lack of human resources because person with disability needs different kind of care and treatment, lack of financial ability to send them to another place.

2. One KII said community that "our community makes person with disability more disable otherwise some of them they have more potentiality and ability to work than others but the environment and community they are living in put barriers for them". Another KII said that "our community doesn't take into account person with disability needs and they are neglected in here this is why they have no access to their entitlements"

7.1.5 Observed Protection Risks Disaggregated by Gender and Age:

In the FGDs with women and men, it was highlighted with 85% of women and 60% of men reporting that men don't face any kind of risk such as forced eviction, forced recruitment in military or harassment, but because they can't find jobs related to their specialties, they join military to have a stable source of income. The main issues highlighted by FHHs were that men face is lack of job opportunities. Moreover, all participants were in agreement that the main risk that the community faces, including men and boys is that not all areas are cleaned from land mines, especially villages close to Sinjar city.

During the FGDs with key informants, such as, Mukhtars and religious leaders present in the area (including women representatives), it has been reported that the community has a negative perception of FHH, widows and girls if they move alone inside the community alone because it is not accepted culturally and socially for women and girls to be seen traveling alone in town. Therefore, women and girls don't leave their houses unless it is absolutely necessary\urgent, such as, going to PHCCs/hospital and to support a family member outside. For example, during discussions with a representative of widows an individual stated, "I can go out a lot but due to the unpredictable security situation and because it is

culturally perceived as shameful for women and girls to go out that's why I do not go out to protect myself from people's speeches and gossips". In the FGDs discussions with women the majority of girls with 70% interviewed reported that they cannot access to education or other service unless they are accompanied by a male partner because of the current situation as they are afraid they will be sexually harassed by either different militia groups present in the area or strangers (men) in the community. Families want their daughters' to be with them all the time in case of an emergency situation happen abruptly in order to be in front of their eyes to rescue them. There is a genuine fear that if households that they feel very afraid send their daughter outside the home they are not able to protect them since almost all of the interviewed with 97% of both men and women think that they are expecting another attack.

Currently the majority of targeted community is Yezidi and all of them are followed by the above structure. The other minority, religious and ethnicity groups have the same structure. 68% of women and 55% of women participants believe that Men with disability have opportunity to discussions and decision making while women with disability have no opportunity at all and they are more vulnerable to risks and have limited access to resources than disabled men.

Girls and boys with disabilities face many challenges as following:

- Social barriers such as poor economic conditions, not able to buy wheel chairs, cane, not having transportation, not having income to pay visit doctor (for medications, tickets, etc.) and so on.
- Environmental barriers such as not having accessible roads, no ramps, no symbols on streets for people who have difficulties in seeing…. etc.
- Lack of special doctor for treatment as it was mentioned by the FHH that an operation needs to be done for her son but in abroad not in Iraq if he does surgery in here then he will be paralysed.

7.1.6 General Health Needs & Practices:

Inside Sinjar city, there is a big gap in SRMH services and it's been reported that one of the biggest needs in the community is SRMH\maternity unit with a specialist gynaecologist. Pregnant women travel to Duhok, Sinone and Talefer for seeking SRMH support. In the discussions with women, one of them stated "my daughter in law moved to KRI a month before her delivery because she needed an operation which is not available neither in Talefer nor Sinone". Also, it was mentioned that MSF has opened a maternity unit, but it is not in a good quality and not all medicines and services are available such as operation room, blood bank, gynaecologist, ultrasound…. etc.

Women are more affected by health problems because there is lack of maternity unit in Sinjar and many pregnant women passed away during baby delivery during crisis in 2014. There is a lack of adequate health equipment and medication such as not having blood bank, lab, x-ray, medicine, etc.

It is worth to note that different ages, genders and life stages suffers from health issues because in the current PCHHs in Sinjar there are many gaps and challenges for women, men, boys, girls, PWDs and elderly persons. Some of the gaps are as following:

- Lack of blood bank;
- No X-ray;
- No ultrasound;
- Not all medicine can be found in there;

- Lack of lab-tests'
- Lack of specialist doctor.
- Lack of referral

In the community it is not acceptable for male health workers to provide health care for female because of traditional beliefs and cultures. Men health workers can only provide a certain type of support such as measurement of diabetes, blood pressure…etc.

7.1.7 Community Beliefs on Health Care and Access to SRMH

CARE also sought to understand and identify community related beliefs that limited women, men, girls' and boys' access to SRMH. These findings will be used to tailor awareness-raising messages for the different target audience.

1. Not bathing babies after delivery, until 40 days is a harmful practice for women and baby from personal hygiene perspectives. It is worth to mention that this is related to tradition and culture. Otherwise, all other practices related to hand washing, disposal of dead bodies, water use, cooking and animal care are normal. However, in the community there is a traditional believe that it is not healthy for women and girls of menstrual age to take bath during menstrual days.

2. Some menstrual age girls believe that taking bath during menstrual days is not good for their health. Also, some girls follow traditional norms, they don't take bath after baby delivery. Women KII addressed that in their community some women don't take bath for certain number of days after baby delivery because they believe if they wash themselves the mother's milk will be dirty, moreover, some tribes don't wash baby till 7 days after birth, which is related to religion and cultural believes.

7.1.8 Access to Family Planning

Women's perception of using contraception is culturally acceptable and common and women talk about contraception amongst themselves openly. during the FGDs with both men, women and KIIs it's been agreed by on average 82% of participants in separate discussions that men & boys decide and give permission to women to use contraception, except cases if a woman is sick and gynaecologist advice that she should not be pregnant because of mother and baby health. An FHH claimed that she used to take pills secretly without her husband knowledge otherwise he would fight with her, because her past deliveries are complicated, and doctor informed her not to be pregnant, so she took injection in order not to be pregnant for three years. Sometimes women consult (about what kind of contraception they use, if it is good from health side, ask about price…. etc.) with other women in the family, relatives and neighbours.

Girls' perception of using contraception depends on their partners' if they agree and allow girls to use contraception then girls' can do so if not then they can't. It is worth to mention that many women and girls face GBV because they can't bear children and they are infertile; hence, community has perception that every family should have many children and preferably boys. The husbands and mother in laws are complaining and point finger at women\girls that it is their fault that they can't bring children, though sometimes men too are infertile. But still community blames women\girls on this. Also, the FHH said that she knows that many men married a second wife to have children.

Women and men have equal access to family planning but in general women seek use more contraception devices for family planning than men. Also, not all kinds of contraception are available in the clinics and

sometimes some women\girls cannot use those types of contraception that are available in the PHCCs because of health conditions. So, the doctors refer them to the private clinics and other hospitals, but they cannot go because of economic conditions such as not being able to pay for transportation fees' and afford for tickets and medication.

There are some beliefs and practices that may affect the nutritional status of women, men, girls and boys differently. Most of the community don't eat certain kinds of vegetables such as cabbages and lettuce and this is related to religious believes.

7.1.9 Delivery Practices

In the past years back to 2003, almost all women delivered at home, not because of cultural beliefs\tradition but because of lack of accessible hospitals\ maternity units. Currently almost all women and girls deliver in the hospitals and if a woman\girl deliver at home this is because she cannot afford for transportation fees' and medication expenditure…. etc. Also, women and girls a month before their delivery go and stay in KRI for easy and timely access to RH Care, because maternity unit is not operation well in Sinjar.

7.1.10 Access to the health facilities:

Those families that have cars they use their own cars to access PHC and those who don't they seek support from neighbours or relatives, unless someone is too close to the PHCC, they walk. Currently all patients travel to Sinjar\Sinone PHC if they need a simple treatment but if they have a serious issue, they travel to KRI and especially Duhok city.

Patients seek health services based on their diseases, if they suffer from a disease and the treatment is available in the PHCC, they aim to access PHCCs but if the required treatment and medication are not available then they travel to a place which are available, taking into account the security situation. As it was highlighted before, almost all pregnant women and girls travel to KRI a month before delivery in order to be on the save side because all the required treatments are available, such as, blood bank, operation for complicated pregnancy …etc.

Fare from Sinjar to Sinone is 10,000-15,000 IQD per person only one way which means 20,000-30,000 IQD for two ways, moreover, from Sinjar to Duhok is 30,000 IQD per person which means for two ways is 60,000 IQD

Women, men, boys, girls, PWDs and elderly people do face the following challenges accessing to the PHC:

1. Lack of income which makes a lot of barriers for different genders, ages and people of different life stages to access the PHCCs. Having a poor economic condition makes a lot of challenges for the community to access the health facilities because that makes them not being able to afford for transportation fees', medication cost, ticket for visiting doctor…etc.
2. Not having financial ability to pay for health care make many communities to ignore their health issues and not to access the health facilities.
3. Lack of specialists in the PHCCs such as cardiologist, gynecologist (only available two days per week), and dentist and other experts. All these gaps present in the PHCC make them to seek health services in KRI.
4. Adolescent girls, women including disabled women can access PHCC with no male family member as escort only inside Sinjar and if it near to their settlements. However, they still don't feel comfortable

to go out without accompanying any partners that is why they prefer to accompany in pairs or groups such as, with friends, neighbors, adult children, …etc.
5. Lack of medications;
6. Maternity unity is not fully functional,
7. Lack of surgery dep.
8. Lack of blood bank;

It is acceptable inside the community for women and girls, women and girls with disabilities including older people to travel accompanied by someone either males or females inside Sinjar after getting permission from men and this depends on the family perception's and attitudes toward women and girl's freedom of movement. Women and girls travel outside Sinjar is limited and they must be accompanied by men. However, men and adolescent boys' mobility is not restricted, and they can travel anywhere they want at any time without any limitation. Besides that, women and girls including girls and women with disabilities freedom of movement is further restricted. The FHH that was interviewed said that "sick and people with disabilities are neglected here because the services are not adopted basic on their needs."

Number of hours by transport/Foot/Car:

- To PHCC inside Sinjar is 10-15 minutes by cars and about 30-40 minutes by walking.
- To Sinone PHCC is 50 to 60 minutes by car and transportation fee is about 20,000 IQD.
- To KRI is about more than four hours and transportation fees is about 60,000 IQD.

Health services in health facilities is either free charge or small payment in Sinjar, depends on the type of services but it is worth to note that the community need to afford for transportations, medications, and other health, education and public services expenditure.

7.1.11 Access to Information about Service Provision:

Women, men, boys and girls including person with disability groups receive information about the services provided by the health care centre through:

1. Relatives and friends who visited the doctors;
2. Male partners';

In the discussion during FGDs with men, women, boys and girls it's been reported that they didn't hear any kind of support provided to GBV survivors and also, they highlighted that they don't share their GBV issues to someone who is outside the family. However, they keep their GBV issues to themselves and they suffer in silence. A representative of woman KIIs said "if I take my GBV problems outside the family, then the issues will be more complicated and less chance to be solved and from community perspective a woman who takes out her complain to a stranger\outside the family framework is seen as not a good woman because she takes out family's secrets.

7.1.12 GBV Service Provision:

There are currently no actors (at the time of writing this report) providing GBV services (psychosocial support and GBV case management) in Sinjar town. However, Harikar has a woman friendly space and a case manager that covers Sinjar and Sinuni. In addition, Mission East is rolling out a mobile team based in Sinuni. Currently GBV cases have to be referred to Sinuni. Dorcas provides basic PSS and case management.

Survivors of violence usually seek help from family members and friends of the same sex and sometimes they consult with tribe and or religious leaders which depends on the kind of violence and from whom. If the violence is from a member of family, the survivors keep the issues secretly and does not share with someone outside the family. If the violence is from someone who is outside the family member, majority of participants with 75% of the respondents agreed that they seek police in some cases, religious and tribe leaders.

7.2 Identified primary health care centres (Al-Shuhada and Al-Nasser PHCCs) technical findings:

7.2.1 General Information on facilities:

Many hospitals and PHCCs buildings were destroyed by the heavy military operations, equipment vandalized and supplies stolen. The fragile security situation and prevailing social tensions in parts of the country most affected by the heightened conflict has eroded the confidence of health professionals from returning to work in areas considered insecure.

During the first day of assessment, meeting with directorate of health (DoH) and both identified PHCC managers had been arranged, generally discussion was about the health situation and needs in Sinjar district and focused on city center and mountainous area, DoH director has suggested the identified primary health care centers (PHCCs) to be technically assessed by assessment team:

Al-Shuhada and Al-Nasser primary health care centers (PHCCs) located in the center of Sinjar city in Al-Shuhada neighbourhood with latitude N 36.1858 and longitude E041.5137 and Al-Nasser neighbourhood with latitude N 36.1903 and longitude E041.5039 which was densely populated before the crisis and generally limited income families inhabiting the neighborhoods belonging to these PHCCs with catchment area of Al-Shuhada PHC around 32,000 and Al-Nasser PHC around 21,000 population. The PHCCs haven't received any support from neither humanitarian actors nor DoH, all equipment and medications are non-functional as well as building is partially damaged. The generator is been taken by ISIS during the crisis to run their basic daily activities. City power is only available every 3 hours. There is no maternity unit available in the whole area expect in general hospital which is not covering the whole city. Sometimes it is very difficult for patient to travel, especially during night due to many security checkpoints or even curfew with a lot of delay until arriving the only maternity unit. RNA team has used an initial assessment tool to capture the gaps of PHCC. See annex 1: the detailed result of assessment and annex 3: the photos of the building and PHCC stuff. Currently the Al-Shuhada PHC is closed and government staff are not working because of the unavailability of budget from government as well as from humanitarian actors.

General information on both PHCCs can be found in the below table:

Consolidated technical information	Options	Al-Shuhada PHC	Al-Nasser PHC
Point of delivery type:	• Hospital • Health Centre • Health post • Clinic	Health centre	Health centre
Management:	• Ministry of Health • NGOs	Ministry of health	Ministry of health

Is facility / outreach site temporary or permanent?	• Temporary • Permanent	Permanent	Permanent
Has facility / material been damaged?	• Yes • No	Yes	Yes
If Yes what type of damage? (Select the appropriate answer)	Building:	Partial damage	Partial damage
	Equipment:	Full damage	Full damage
	Medical supplies:	Full damage	Full damage

7.2.2 Access to the Facility:

Taxi fare from Sinjar to Sinone is 10,000-15,000 IQD per person only one way which means 20,000-30,000 IQD for two ways, moreover, from Sinjar to Duhok is 30,000 IQD per person which means for two ways is 60,000 IQD

Number of hours by transport/Foot/Car:

- To PHCC inside Sinjar is 10-15 minutes by cars and about 30-40 minutes by walking.
- To Sinone PHCC is 50 to 60 minutes by car and transportation fee is about 20,000 IQD.
- To KRI is about more than four hours and transportation fees is about 60,000 IQD.

Access health services in facilities is either free charge or small payment (3,000 IQD) in Sinjar, depends on the type of services but it is worth to note that the community need to afford for transportations, medications, and other health, education and public services expenditure

People mobilization is restricted based on the genders, ages, social stages, life stages, ability and so on this is because society has different expectations and attitude on women, men, boys and girls of different life stages. Besides that, women and girls including girls and women with disabilities freedom of movement is more restricted because of unstable security, political and social situations. As for PWDs mobility movement depends on their genders whether they are women, men, boys or girls including their physical ability for example there is a huge different between women and men with disabilities as men with disability can move around without limitation if they have physical abilities but accessibility, but the situation is different for women and girls of disabilities this is because of their sex and gender identities. Majority of PWDs don't use mobility aids\assistive devices like walking sticks, wheelchairs, hearing aids because of financial issues and even if some PWDs have them, they are not functioning in Sinjar due to environmental barriers (roads and pavement is not in the same levels, no ramps, no walking stick figures and symbols). All the highlighted gaps make PWDs disabled, more dependent and not having access to their entitlements. The FHH that was interviewed said that sick and disabled people are neglected here because the services are not adopted basic on their needs.

Not washing babies after delivery until a certain number of days and women until 40 days are a harmful practice for women and baby from personal hygiene perspectives. It is worth to mention that this is related to tradition and culture. Otherwise, all other practices related to hand washing, disposal of dead bodies, water use, cooking and animal care are normal. However, in the community there is a traditional believe that it is not healthy for women and girls of menstrual age to take bath during menstrual days.

Some menstrual age girls believe that taking bath during menstrual days is not good from health side. Also, some girls follow traditional norms they don't take bake bath after baby delivery

Generally speaking, Men & boys decide and give permission to women to use contraception, except cases if a woman is sick and gynaecologist advice that she should not bring baby because of mother and baby health.

7.2.3 Service Provision:

Generally, women and adolescent girls receive primary health care services such as, neonatal care, postnatal care, Information on family planning and/or access to contraception, complications during pregnancy, regular check-up with pediatrician for baby following delivery, Breastfeeding and/or child nutrition sessions and Skin diseases, UTIs, diarrhea.

As for men and adolescent boys receive primary health care services such as, Neonatal Care, Postnatal Care, Information on family planning and/or access to contraception, complications during pregnancy, Regular check-up with pediatrician for baby following delivery, Breastfeeding and/or child nutrition sessions and Skin diseases, UTIs, diarrhea.

As per the Iraqi government working hours, both PHCCs will be open from 8:30 AM to 2:00 PM

Both facilities don't have an available ambulance for emergency cases even before the damage, community has to take their patients to the place of PHCCs. However, facilities are responsible to refer the emergency cases to Sinjar general hospital and ambulance is available in the hospital, moreover, drivers are not available 24/7 due to the capacity of the hospital and limitation of referral mechanism costs. However, ambulance is not fully equipped with supplies and paramedic.

Government is responsible to provides health care in the facilities and make sure human resources is provided to both PHCCs. However, the below essential drugs, vaccines, and supplies were reported to be available and government to provide once PHCCs became functional.

Consolidated technical information	Options	Al-Shuhada PHC	Al-Nasser PHC
Who provides health care in this facility (please include number of staff and disaggregate by gender for each):	• Nurses: • Medical doctors: • Medical assistance: • Vaccinators: • Midwives: • Lab technicians: • Public health officers: • Gynaecologist:	*One female nurse and *4 male nurses, * one medical doctor *and one female. * 3 vaccinators, *1 lab technician, and *other administration staff	*One female nurse and *4 male nurses, *one medical doctor *and one female. * 3 vaccinators, *1 lab technician, and *other administration staff
Essential drugs, vaccines, and supplies:	Antibiotics:	Available	Available
	ORS:	Available	Available
	Anti-malarial:	Unavailable	Unavailable
	Antipyretics:	Available	Available
	Contraception:	Unavailable	Unavailable
	Dressing materials:	Available	Available
	Tetanus toxoid:	Available	Available
	Measles:	Available	Available
	DPT:	Available	Available
	Polio:	Available	Available

	BCG:	Available	Available
	Functioning cold chain:	Available	Available

8. CONCLUSION AND RECOMMENDATIONS:

The recommendations were developed by the evaluation team, according to the findings of the evaluation. The evaluation team focused on the challenges of the SRMH project and its possibilities for improvement, to help achieve its objective of improving HEALTH conditions for the most vulnerable population in Sinjar districts.

There are multiple armed actors operating within Sinjar district (ISF, local police and Iraqi Intelligence). However, all appear to be cooperative and the only request has been to provide a copy of the cover page from the JCMC letter and newly requested to ask special permission from Ninawa ISF once cross cutting Talefer and Sinone border and entering only Sinjar city center (with the list of staff names) to the entrance (ISF) checkpoint.

Based on the findings of the carried out baseline Health Assessment CARE International in Iraq proposes to work in two PHCCs in the center of the Sinjar city, namely Al-Shuhada PHC in Al-Shuhada neighbourhood and Al-Nasser PHC in Al-Nasser neighbourhood to provide the full package of medical equipment and laboratory kits as well as stuff of delivery room with a catchment area of Al-Shuhada 32,000 and Al-Nasser 21,000 population and to rehabilitate both PHCCs building in coordination with DoH as it's been partially damaged during the military operators. CARE International in Iraq has established relationship with community and local authorities, including Ninawa DoH. Moreover, CARE could facilitate a quick start for the project based on data collected through baseline evaluation.

The average transportation costs from Sinjar to Sinone is 10,000-15,000 IQD per person only one way which means 20,000-30,000 IQD for two ways, moreover, from Sinjar to Duhok is 30,000 IQD per person which means for two ways is 60,000 IQD. Low economic situation of families affected the health situation of many families and increased GBV cases. Functioning both PHCCs will prevent and or reduce to some extend these issues in the area.

Women's perception of using contraception is something normal and women talk about contraception among themselves openly. An FHH claimed that she used to take pills secretly without her husband aware otherwise he would fight her but because her deliveries are complicated, and doctor informed her not to be pregnant, she was using contraception. Sometimes women consult (about what kind of contraception to use to be good from health side, ask about price…. etc.) with other women in the family, relatives and neighbours. However, it is been highly recommended that CARE HEALTH team to focus on this subject during the family planning and health awareness sessions and consult men as well.

People mobilization is restricted based on the genders, ages, social stages, life stages, ability and so on that's because society has different expectations and attitude on women, men, boys and girls of different life stages. Besides that, women and girls including girls and women with disabilities freedom of movement is more restricted because of unstable security, political and social situations. As for PWDs mobility movement depends on their genders whether they are women, men, boys or girls including their physical ability for example there is a huge different between women and men with disabilities. Thought once designing the activities on the ground, this restriction needs to be taken into consideration.

In the community it is not acceptable men health workers to provide health care for women because of traditional beliefs and cultures. Men health workers can only provide a certain type of support such as measurement of diabetes, blood pressure…etc. although some menstrual age girls believe that taking bath during menstrual days is not good from health side. Also, some girls follow traditional norms they don't take bake bath after baby delivery. This sensitivity needs to be focused during awareness sessions

PHC Facility Level

The SRMH needs of Sinjar city have changed considerably in recent years. In addition to basic primary health care services, there is a growing need for a range of mental health services, services for key chronic and non-communicable diseases, as well as critical obstetric, maternal, and neonatal health services. The assessment demonstrated weaknesses in PHC capacity to provide these services. The deficiencies are related to lack of policy or guidelines related to new or emerging threats, lack of targeted capacity-building programs to build skills in emerging health areas, and lack of infrastructure and equipment to diagnose and provide primary treatment (i.e., X-ray).

A key challenge is the uneven distribution of staff at the PHC level. There is a critical need for lab assistants, eye examiners, and dental assistants, while there is a significant nursing surplus. There is a need for in-service training, especially for paramedical staff and nurses in PHC. A second challenge is the lack of supplies and equipment, with frequent stock outs for essential drugs and laboratory supplies. Both facilities lacked storage room for drugs and supplies or sufficient rooms for treatment and care. PHCs have a significant need for clinical standards and improved reporting. Some treatment guidelines exist for limited areas of clinical care, but they need to be revised to better orient them to the needs of PHC. Referrals are made in the past years but without much capability for follow-up. Without improvements in information and feedback systems between.

Interviews with community members and both PHC clients indicated that each patient pay minimum 3,000 IQD and this amount can be increased while patients use all services in the PHC, such as, tests, medication… etc. The clients also reported inequitable treatment and limited programs for women and youth. Health promotion programs was existing but since the crisis it's stopped or happening in ad-hoc basis, and they are focused only on a few specific issues.

The private sector is a key provider of services and has strong potential to provide services to IDPs and returnees. However, there is a lack of training/awareness programs for private sector groups and poor coordination between these private sector organizations and the ministry of health.

Support the finalization and dissemination of patient rights throughout communities via various communications efforts such as providing free text messages to PHC clients that inform them of their rights and health promotion messages.

Improve the management and leadership skills of both PHCCs personnel staff.

Develop trainings (including via electronic media) in equipment monitoring and management for all relevant departments.

Increase patient's awareness of available services in order to improve access to quality coordinated care.

Create a strong network of CHPs that support patients' ability to receive quality health care.

9. ANNEXES:

Annex 1: Qualitative data analysis:

Qualitative analysis– FGD and K

Qualitative analysis– FGD and K

Annex 2: Technical data analysis:

Technical analysis.xlsx

Annex 3: Photos of both PHCCs:

Al-Shuhada PHCC building

Al-Shuhada PHCC building

Building maternaty unit in Al-Shuhada PHC

FGDs with women in Al-Shuhada neighbourhood

Al-Nasser PHCC building

Al-Nasser PHCC building