

Mental Health and Psychosocial Support (MHPSS) Needs Assessment

2026 Report



Acknowledgements

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Acronyms

CPS	Civil Peace Service (GIZ programme)
GIZ/CPS	Deutsche Gesellschaft für Internationale Zusammenarbeit / Civil Peace Service
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person(s)
ISIS	Islamic State of Iraq and Syria
KII	Key Informant Interview(s)
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organisation

Executive summary

Background and Purpose

More than a decade after the 2014 genocide perpetrated by ISIS, the Yazidi community continues to experience deep and persistent mental health and psychosocial challenges. Prolonged displacement, unresolved trauma, economic hardship, uncertainty around return, and limited progress on justice and accountability have created a complex and evolving mental health landscape. While some families have returned to Sinjar, many continue to live in displacement across the Kurdistan Region and Iraq in conditions that remain unstable and under-resourced.

Community exchange forums facilitated by GIZ in 2024 highlighted growing concern among Yazidi community members regarding the scale of mental health needs, the adequacy and quality of existing services, and the cultural relevance of current responses. Participants consistently reported that distress remains high, services are insufficient, and some interventions do not adequately reflect lived realities.

In response, Yazda, in partnership with GIZ/CPS, conducted this Mental Health and Psychosocial Support (MHPSS) assessment to generate evidence on current psychosocial wellbeing, coping and support mechanisms, access to services, and the broader social and economic conditions shaping distress. The findings are intended to inform programming, coordination, and funding decisions.

Methodology

The assessment used a mixed-methods design to examine MHPSS needs among Yazidi communities in Duhok Governorate and Sinjar/Sinuni District. Quantitative data were collected through a household survey administered via KoboToolbox between 19 November 2025 and 11 January 2026, reaching 1,560 households in IDP camps and return locations. Household-level screening covered 5,554 individuals, including children, allowing insight into the distribution of distress within families.

Qualitative data were gathered through key informant interviews with government representatives, service providers, and community actors. Interviews explored mental health challenges, coping strategies, service access and gaps, and the longer-term impact of displacement, return, and justice processes. All tools were informed by the Multi-Sectoral MHPSS Assessment Toolkit.

Key Findings

i. **Widespread and Persistent Distress**

Emotional and psychological distress remains widespread. Over one-third of respondents (34.74%) reported experiencing negative emotional states at least some of the time in the two weeks preceding the survey, with 12.12% reporting frequent or persistent distress. Functional impacts were common, with 42.95% reporting difficulty carrying out daily activities. Household-level screening and caregiver reports indicate that distress affects multiple household members, including children.

Qualitative findings suggest that while acute crisis reactions have diminished over time, chronic distress has persisted and, in some cases, intensified due to prolonged displacement, unresolved loss, economic hardship, and uncertainty about the future.

i. Groups Most Affected

Women, youth, survivors of violence, families of missing persons, long-term IDPs, and children and adolescents were consistently identified as particularly affected. Informants also highlighted underserved groups whose needs receive limited attention, including men, older persons, persons with disabilities, and returnees in remote areas.

ii. Coping, Support, and Community Dynamics

Coping strategies are predominantly informal. Most respondents rely on family support (86.67%), with limited use of formal MHPSS services. While families and communities remain important sources of support, qualitative findings indicate that these networks are under strain and often insufficient for individuals experiencing prolonged or severe distress. Stigma continues to limit help-seeking, particularly among men.

iii. Access to Mental Health and Psychosocial Support Services

Awareness of available MHPSS services is low, with 51.09% of respondents unaware of any services in their area. Awareness and access differ markedly by displacement status: IDPs in camps reported higher awareness, while 76.66% of returnees reported no awareness of services. Use of specialised services remains minimal. Service providers cited barriers including stigma, cost, transportation challenges, weak referral pathways, staffing shortages, and unstable funding.

iv. Living Conditions, Livelihoods, and Economic Stress

Economic hardship and unmet basic needs are major drivers of distress. High unemployment (68.01%), limited healthcare access (44.29%), and insecure housing contribute to ongoing stress. Livelihoods and financial assistance were prioritised above healthcare and mental health services, highlighting the strong link between economic security and psychosocial wellbeing.

v. Return, Future Plans, and Uncertainty

While many displaced respondents expressed a desire to return, intentions were conditional on improvements in housing, services, livelihoods, and security. A significant proportion (23.03%) reported uncertainty or reluctance to return. Camp-based IDPs experience stress linked to dependency and overcrowding, while returnees often face frustration related to unmet expectations, limited services, and feelings of loneliness or social disconnection. Across both groups, uncertainty about the future remains a major source of distress, particularly for youth.

vi. Justice, Accountability, and Long-Term Recovery

Justice and accountability processes continue to shape mental wellbeing. While recognition and legal proceedings provide hope for some, delayed justice and the unresolved fate of missing persons contribute to prolonged grief, frustration, and fear. Informants emphasised that mental health recovery is closely tied to broader recovery and justice processes.

Key Recommendations

Government

- Strengthen leadership and coordination of MHPSS services by clarifying roles, improving referral pathways, and ensuring consistent coverage across camp and return areas, particularly where awareness and access remain lowest.
- Integrate mental health and psychosocial considerations into recovery, return, housing, livelihoods, education, and justice-related policies, recognising the strong link between unmet basic needs, uncertainty, and psychological distress.
- Expand access to basic health and mental health services in return and remote areas, and ensure trauma-sensitive approaches for survivors of violence and families of missing persons engaging with justice and documentation processes

Donors/Funders

- Provide predictable, multi-year funding to support continuity, service quality, and retention of trained staff, addressing the instability and service gaps reported by providers.
- Invest in child, adolescent, and youth-focused MHPSS services, including family-based support and school- or community-linked interventions, to address gaps in largely adult-focused service models.
- Support integrated programming that links MHPSS with livelihoods, education, and basic services, particularly for youth, to address the economic and social drivers of distress.
- Support system strengthening, including supervision, staff wellbeing, and government-led coordination mechanisms, to promote sustainability and national ownership.

Implementers and NGOs

- Expand outreach and awareness activities, particularly for returnees and populations in remote locations, using trusted local actors and culturally appropriate messaging.
- Strengthen child-, adolescent-, and family-focused psychosocial interventions, including parenting support, youth engagement, and community-based approaches.
- Improve identification, referral, and follow-up for individuals experiencing severe distress or suicide risk, ensuring clear pathways to specialised services where available.
- Invest in service quality through regular supervision, staff well-being support, and culturally sensitive, gender-responsive programming.

Conclusion

This assessment confirms that Yazidi communities in Duhok and Sinjar continue to face significant mental health and psychosocial challenges shaped by past trauma, prolonged displacement, socioeconomic stress, and uncertainty about the future. While informal coping mechanisms and family and community support remain central sources of resilience, they are uneven and often insufficient to meet the needs of individuals experiencing severe or prolonged distress.

Access to formal mental health and psychosocial support services remains limited, particularly for returnees and populations in remote areas, with structural, cultural, and awareness barriers restricting utilisation. The findings highlight the need for priority actions that include expanding and decentralising MHPSS services, strengthening community- and family-based support, addressing high-risk psychosocial concerns, and integrating mental health and psychosocial support within broader recovery, justice, and livelihood processes.

01

Introduction



1. Introduction

1.1. Background and Context

Since the 2014 genocide against the Yazidi community, Yazidi families in Iraq have experienced large-scale loss, displacement, and long-term disruption of social and community life. Many households continue to live in displacement in camps or urban settings, while others have returned to Sinjar under conditions shaped by insecurity, damaged infrastructure, limited livelihoods, and reduced access to basic services. Research on Yazidi survivors and other genocide-affected populations consistently shows elevated levels of psychological distress, including symptoms of depression, anxiety, and trauma-related conditions, linked to experiences of mass violence and prolonged displacement.

Over the past decade, a range of mental health and psychosocial support (MHPSS) services has been established in Duhok and Ninewa governorates by government institutions, non-governmental organisations, and community-based actors. These services include community-based psychosocial activities, counselling, and specialised mental health care. At the policy level, national frameworks such as the Yazidi Survivors Law (Law No. 8 of 2021)¹ formally recognise the rights of survivors to health and psychosocial support as part of broader recovery and reparation measures. While such frameworks are an important foundation, their translation into consistent, accessible services varies across locations.

Different living situations continue to shape psychosocial experiences and access to support. IDPs in camps often face overcrowding, limited privacy, and prolonged dependency on assistance. Displaced Yazidi families in urban areas may experience social isolation and reduced visibility to service providers. Returnees to Sinjar frequently report stress linked to insecurity, damaged housing, limited public services, and livelihoods. Across all settings, cultural norms, stigma, and limited awareness of available support influence help-seeking behaviour.

In 2024, an exchange forum supported by CPS partners with Yazidi community members highlighted persistent gaps in mental health service provision. Community members reported that mental health needs remain critically high while available resources are insufficient to meet demand, that the quality of intervention by some actors is low, and that some interventions lack cultural sensitivity or fail to address community-specific needs. These discussions pointed to the need for updated, systematic evidence to better understand current needs and guide future MHPSS programming.

¹ <https://c4jr.org/wp-content/uploads/2022/01/Yazidi-Female-Survivors-Law-March-24-2021.pdf>

1.2. Rationale for the Assessment

Although MHPSS services are present in many parts of Duhok and Sinjar, there has been limited recent evidence that captures current mental health and psychosocial needs across camps, urban settings, and return areas in a comparable and systematic manner. Population movements, evolving recovery processes, and changes in service delivery approaches have altered needs and access patterns over time.

In addition, policy commitments such as the Yazidi Survivors Law and broader efforts to strengthen mental health services in Iraq require up-to-date information to support effective implementation. Without current evidence, it is difficult to assess whether existing services are meeting community needs, reaching the most affected groups, or responding in culturally appropriate ways.

In this context, Yazda, in collaboration with GIZ/CPS, undertook this MHPSS Needs Assessment to generate evidence grounded in community perspectives and service realities. The assessment, conducted between 19 November 2025 and 11 January 2026, was designed to provide a clearer picture of psychosocial wellbeing, access to services, and gaps in provision across different displacement and return contexts, with the aim of supporting more targeted and effective MHPSS responses.

1.3. Objectives of the Assessment

The overall objective of the assessment was to assess the mental health and psychosocial support needs of Yazidi communities living in displacement and return contexts in Duhok Governorate and Sinjar District, in order to inform programming, coordination, and strategic planning.

The specific objectives were to:

- 1) Identify key mental health and psychosocial challenges affecting Yazidi communities across IDP camps and return areas.
- 2) Assess access to, utilisation of, and barriers to MHPSS services across different locations and population groups.
- 3) Examine coping mechanisms, community support structures, and cultural factors influencing psychosocial wellbeing and help-seeking behaviour.
- 4) Identify gaps in service provision and priority areas for strengthening MHPSS responses.
- 5) Examine psychosocial experiences associated with return, including challenges related to living conditions, access to services, and uncertainty about the future.

1.4. Intended Use of Findings

The findings of this assessment are intended to inform the design and adaptation of MHPSS programmes implemented by Yazda and partners. They will also support coordination and dialogue among governmental and non-governmental actors involved in MHPSS service delivery and contribute to evidence-based discussions on priority needs and resource allocation

1.5. Structure of the Report

This report is organised as follows. Section 2 outlines the assessment methodology. Section 3 presents the profile of respondents and study areas. Section 4 details the assessment findings, integrating quantitative and qualitative data. Section 5 discusses the implications of the findings. Section 6 presents recommendations, followed by the conclusion in Section 7.

02

Methodology



2. Methodology

2.1. Assessment Design

This assessment was guided by the IASC Minimum Service Package for Mental Health and Psychosocial Support (MHPSS) assessment toolkit (also referred to as the Multi-Sectoral MHPSS Assessment Toolkit²). The toolkit provides a multi-sectoral framework for assessing mental health and psychosocial needs, coping mechanisms, service availability, and gaps across humanitarian settings, and operationalises the IASC layered model of MHPSS services.

In line with this framework, the assessment focused on understanding how mental health and psychosocial wellbeing are shaped by lived experiences, access to services, and broader social and economic conditions. It examined needs and access across different layers of support, including basic services and living conditions, community and family support, focused psychosocial services, and specialised mental health care. Data collection tools were adapted to the Yazidi context and implemented using a mixed-methods design, combining household surveys with key informant interviews.

Within this design, the assessment was intentionally structured as a needs assessment rather than a clinical or diagnostic evaluation. References throughout the report to psychological distress, emotional stress, impaired functioning, and trauma-related experiences reflect participants' own accounts and caregivers' observations of changes in daily functioning following exposure to adverse events. The term "trauma reactions" is used descriptively to capture general psychosocial impacts, in line with the purpose and scope of the assessment.

2.2. Geographic Scope and Target Population

The assessment was conducted in Duhok Governorate and Sinjar District in Ninewa Governorate. It focused on Yazidi populations living in:

- Internally displaced persons (IDP) camps
- Return areas in Sinjar and Sinuni

The target population for the household survey consisted of members of Yazidi households residing in these locations. The qualitative component targeted key stakeholders involved in mental health and psychosocial support (MHPSS) service delivery, community leadership, and relevant government institutions.

² Multi-Sectoral Mental Health and Psychosocial Support (MHPSS) Assessment Toolkit <https://www.mhpssmsp.org/en/assessment-tools>

2.3. Household Survey

2.3.1. Sampling Approach and Sample Size

The household survey was initially designed using a stratified sampling approach to ensure representation across three population groups: internally displaced persons (IDPs) living in camps, returnees, and Yazidi households in urban settings. Based on population estimates and a 95 percent confidence level with a 5 percent margin of error, the planned total sample size was 1,134 households, distributed as follows:

Location	Sample
IDP camps	377 households
Return areas	376 households
Urban settings	381 households

This design was intended to capture perspectives across different displacement and return contexts.

During implementation, delays in approvals limited access to urban settings. As a result, data collection focused on IDP camps and return areas, with the sample size in these locations increased to maintain the overall sample size. In total, 1,560 households were reached through the survey. A detailed breakdown of the achieved sample is presented in Section 3.

2.3.2. Household Selection

Household selection methods were adapted to the characteristics of each setting:

- In IDP camps, households were selected using systematic selection approaches informed by camp layouts and available household listings.
- In return areas, households were selected using geographically defined approaches, with enumerators selecting households at regular intervals within selected villages or neighbourhoods.

Replacement procedures were applied in cases of non-response or unavailability, following predefined guidelines to minimise selection bias.

2.3.3. Data Collection Tools and Process

The household survey tool was developed to collect information on psychosocial wellbeing, perceived stressors, coping mechanisms, awareness and utilisation of MHPSS services, and barriers to accessing support. The tool drew on the Multi-Sectoral MHPSS Assessment Toolkit, in line with the IASC Minimum Service Package framework, and was adapted to the local context.

Data were collected using KoboToolbox on tablets, allowing for real-time data entry, built-in validation checks, and daily monitoring of data quality. Enumerators received training on the survey tool, ethical standards, informed consent procedures, and trauma-informed engagement prior to data collection.

2.4. Key Informant Interviews

2.4.1. Key Informant Selection

Qualitative data was collected through 16 key informant interviews (KIIs). Informants were selected purposively based on their roles and experience working with Yazidi communities and mental health and psychosocial support (MHPSS) services.

The KIIs included representatives from government institutions, non-governmental organisations, and the Yazidi community, as detailed in the table below.

Title/Role	Number of representatives
Department of Religious Affairs	1
Ministry of Migration and Displacement	2
Member of Parliament	1
Department of Health / Mental Health Unit	1
NGO representatives	8
Yazidi Activist/community representative	2
Yazidi religious leader	1
Total	16

This mix of informants ensured that perspectives from policy, service provision, and community engagement were captured.

2.4.2. KII Tools and Administration

Two semi-structured KII guides were developed: one for community representatives and one for service providers and government actors. The guides were informed by the Multi-Sectoral MHPSS Assessment Toolkit and focused on mental health needs, coping mechanisms, service availability and quality, access barriers, and priority gaps.

KIIs were conducted by trained enumerators using standardised introduction and informed consent scripts. Interviews were documented through structured notetaking.

2.5. Ethical Considerations and Safeguarding

Ethical principles guided all stages of the assessment. Participation was voluntary, and informed consent was obtained from all respondents prior to participation. Respondents were informed of the purpose of the assessment, their right to decline or withdraw, and the measures in place to protect confidentiality.

Enumerators were trained in trauma-informed approaches and instructed not to probe personal experiences of violence or distress. Clear referral pathways were established for cases where respondents disclosed urgent psychosocial or protection concerns, and enumerators were required to inform supervisors in such cases.

No personal identifiers were recorded, and all data were stored securely in accordance with Yazda's data protection protocols.

2.6. Data Analysis

Quantitative data was cleaned and analysed using descriptive statistical methods to identify patterns related to psychosocial wellbeing, service access, and barriers across displacement and return contexts.

Qualitative data from KIIs were analysed thematically using a structured coding framework. Findings from the quantitative and qualitative components were triangulated to strengthen interpretation and to identify converging and diverging trends across data sources.

2.7. Limitations

Several limitations should be considered when interpreting the findings. Although urban settings were included in the original sampling design, approval to conduct household surveys in urban areas could not be obtained within the assessment timeframe. As a result, the sample initially allocated to urban settings was reallocated to IDP camps and return areas to maintain the overall sample size. Consequently, household-level findings reflect the experiences of camp-based IDPs and returnees and should be interpreted accordingly.

In addition, the findings are based on self-reported data and may be subject to recall or social desirability bias. Access and security constraints may also have limited coverage in some locations. These factors should be taken into account when interpreting and applying the results.

03

Profile of Respondents and Assessment Areas



3. Profile of Respondents and Assessment Areas

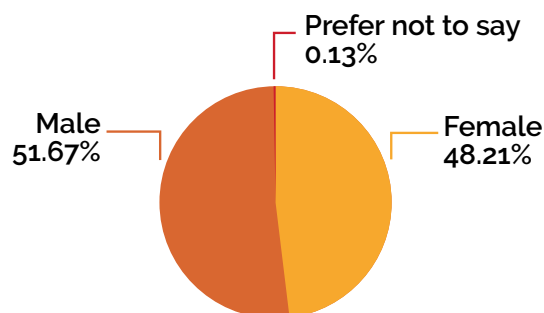
This section provides a descriptive overview of the areas covered by the assessment and the characteristics of respondents who participated in the household survey and key informant interviews.

3.1. Demographic Profile of Respondents

A total of **1,560 respondents** participated in the household survey and provided informed consent to take part in the assessment.

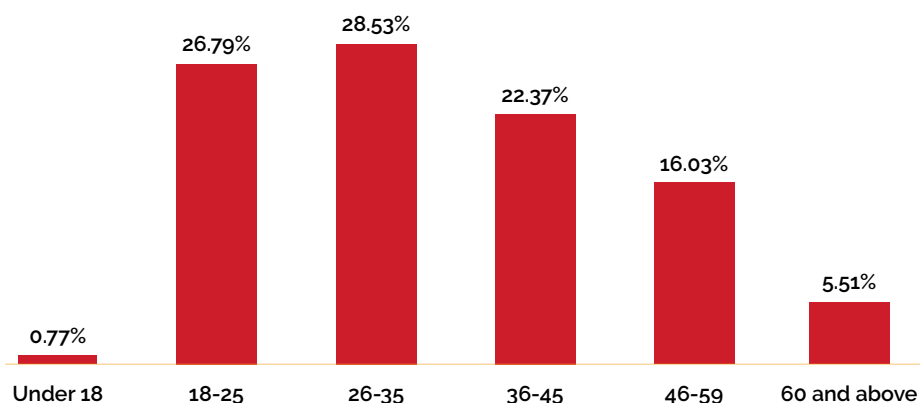
The demographic profile of respondents who participated in the household survey shows a relatively balanced gender distribution, with **51.67% identifying as male** and **48.21% identifying as female**. A very small proportion (0.13%) did not report gender.

Figure 1: Gender distribution of respondents, N=1560



Additionally, the respondents were predominantly adults, with the largest proportions falling within the **18-35 years (55.32%)** and **36-45 years (22.37%)** age groups. Smaller proportions of respondents were aged 46 years and above.

Figure 2: Age distribution of respondents, N=1560



In addition to the household survey, the assessment included **16 key informant interviews (KIIs)** conducted with stakeholders involved in mental health and psychosocial support, community leadership, and governance related to Yazidi communities.

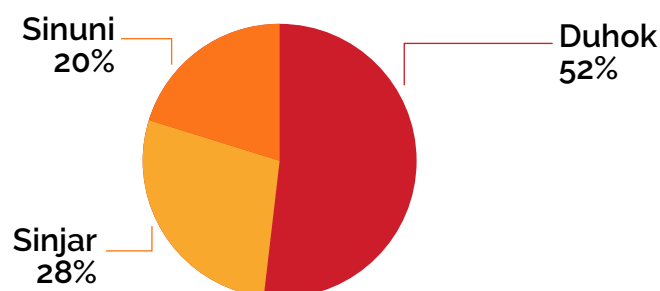
Key informants included representatives from government institutions (5 interviews), non-governmental organisations and service providers (8 interviews), community representatives and activists (2 interviews), and one Yazidi religious leader (1 interview). Informants were based in Duhok Governorate and Sinjar District and were selected purposively based on their roles and experience working with Yazidi populations and MHPSS services.

3.2. Assessment Location

The household survey was conducted in Duhok Governorate and Sinjar District in Ninewa Governorate, including the Sinuni sub-district. Data collection focused on locations where Yazidi populations are currently living either in displacement or after return.

A majority of respondents were interviewed in Duhok Governorate (52%), primarily in IDP camp settings. The remaining respondents were interviewed in Sinjar District (28%) and Sinuni sub-district (20%)

Figure 3: Geographic distribution of respondents, N=1560



3.3. Living Situation of Respondents

At the time of the survey, respondents reported living in different settings reflecting displacement and return patterns. **51.35%** of respondents identified as internally displaced persons residing in camps, while **47.95%** reported having returned to their areas of origin. A small proportion (less than one percent) reported other living arrangements.

Current Status	Frequency	Percentage
IDP in camp	801	51.35%
Returnee	748	47.95%
Host community in Sinjar	4	0.26%
Host community in Sinuni	4	0.26%
Host community in Sharya	3	0.19%
Total	1560	100.00%

3.4. Location of Displacement and Returnees

Respondents residing in IDP camps reported living in several camps located within Duhok Governorate, including Sharya, Kabarto, Cham Mishko, Khanki, Qadia, Bagid Kandala, Shikhan, Mamrashan, Esys, Birsvi 1, Birsvi 2, Dawdia, and Darkari camps.

Camp	Frequency	Percentage
Sharya Camp	126	15.73%
Kabarto Camp	87	10.86%
Cham Mishko Camp	83	10.36%
Khanki Camp	81	10.11%
Qadia Camp	75	9.36%
Bagid Kandala	74	9.24%
Shikhan Camp	60	7.49%
Mamrashan Camp	60	7.49%
Esys Camp	58	7.24%
Birsvi 1 Camp	35	4.37%
Birsvi 2 Camp	25	3.12%
Dawdia Camp	20	2.50%
Darkari Camp	17	2.12%
Total	801	100.00%

Respondents who reported having returned to their areas of origin were living across a wide range of towns and villages in Sinjar and Sinuni, including Sinjar city and numerous surrounding communities.

Village of Returnee	Frequency	Percentage
Sinjar city	82	10.96%
Til Azir	40	5.35%
Sinuni	36	4.81%
Til Banat	35	4.68%
Siba	33	4.41%
Khanasor	29	3.88%
Solagh	26	3.48%
Til Qasab	26	3.48%
Rambusi	25	3.34%
Dugri	22	2.94%
Ghobal	21	2.81%
Borik	20	2.67%
Wardia	20	2.67%
Kahnia Abdi	19	2.54%
Nasiri	19	2.54%

Village of Returnee	Frequency	Percentage
Dohla	15	2.01%
Zorava	15	2.01%
Ashti Qaro	14	1.87%
Topal	14	1.87%
Qubani	13	1.74%
Zaitoni	12	1.60%
Sardasht	11	1.47%
Girzark	10	1.34%
Hardan	10	1.34%
Hatmia	10	1.34%
Sabahia	10	1.34%
Achma	9	1.20%
Hamo	9	1.20%
Hayal	9	1.20%
Kharabsork	9	1.20%
Kharbat Qawala	9	1.20%
Adica	7	0.94%
Kormali	7	0.94%
Hriko	6	0.80%
Karsi	6	0.80%
Khrani	6	0.80%
Kolka	6	0.80%
Aldina	5	0.67%
Baive	5	0.67%
Bakhlifi	5	0.67%
Bakra	5	0.67%
Gormiz	5	0.67%
Kahnia Ido	5	0.67%
Khrba	5	0.67%
Naqsi	5	0.67%
Qandil	5	0.67%
Qasrki	5	0.67%
Shorka	5	0.67%
Tirf	5	0.67%
Zelily	5	0.67%
Zrafki	5	0.67%
Qaseland	4	0.53%
Milk	3	0.40%
Skinie	1	0.13%
Total	748	100.00%

3.5. Displacement History and Return Timing

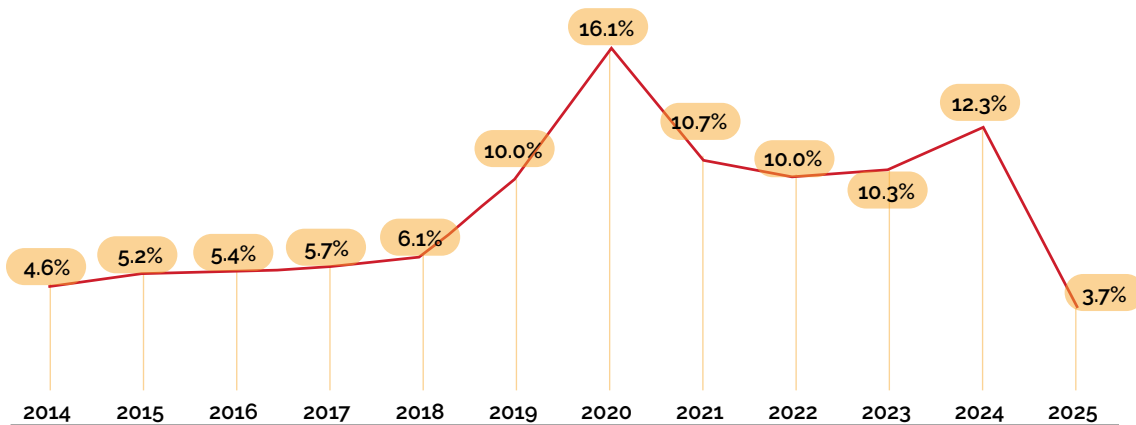
Among respondents who reported a history of displacement, the majority indicated long-term displacement, with most (87.47%) reporting displacement lasting approximately eleven years.

Figure 4: Displacement history of respondents, N=782



Among respondents who had returned to their areas of origin, reported years of return ranged from 2014 to 2025, with a higher concentration of reported returns occurring from 2019 onwards.

Figure 5: Year respondents returned, N=652



Household Characteristics

Most respondents reported being married (70.96%), while approximately 22.95% reported being single. Smaller proportions reported being widowed (5.77%) or separated or divorced (0.32%).

In addition, 68.27% of respondents reported having caregiving responsibilities for children or adolescents within their household.

3.6. Statistics Overview — Profile of Respondents

51.67% Male

48.21% Female

51.35%

IDPs in camp.

87.47%

Displaced respondents reported long-term displacement of 11 years.

63.1%

Returnees returned from 2019 onwards.

70.96%

Married.

68.27%

Caregivers of children or adolescents.

56.09%

Aged 35 years and below (Young people).

04

Findings



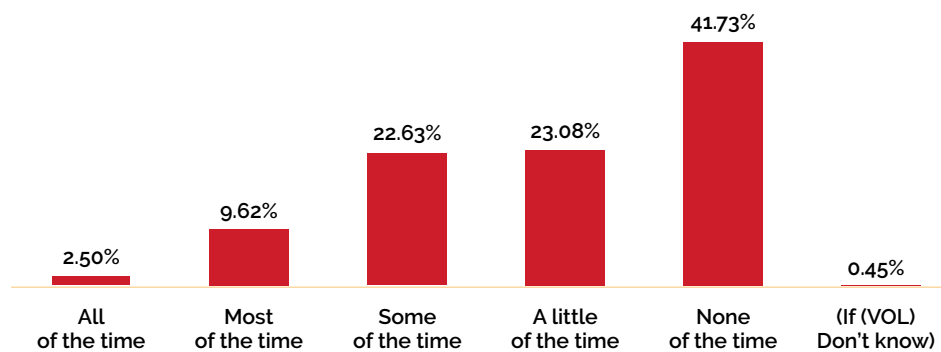
4. Findings

This section presents the assessment findings on the mental health and psychosocial situation of Yazidi communities. It brings together perspectives from community members, caregivers, and service providers, drawing on both quantitative and qualitative data. The findings highlight levels of emotional distress, impacts on daily functioning, experiences of children and families, coping strategies, and groups perceived to face greater challenges in the current context.

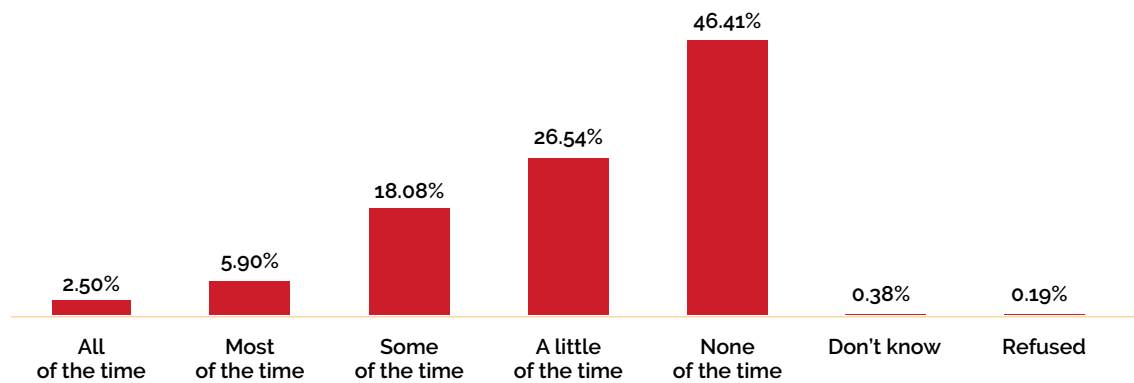
4.1. Mental Health and Psychosocial Wellbeing

The findings indicate that emotional and psychological distress is present among a significant proportion of respondents. Over one-third of respondents (34.74%) reported experiencing feelings such as fear, anger, fatigue, loss of interest, hopelessness, or being upset at least *some of the time* during the two weeks preceding the survey. For 12.12%, these feelings were reported as occurring *most of the time* or *all of the time*.

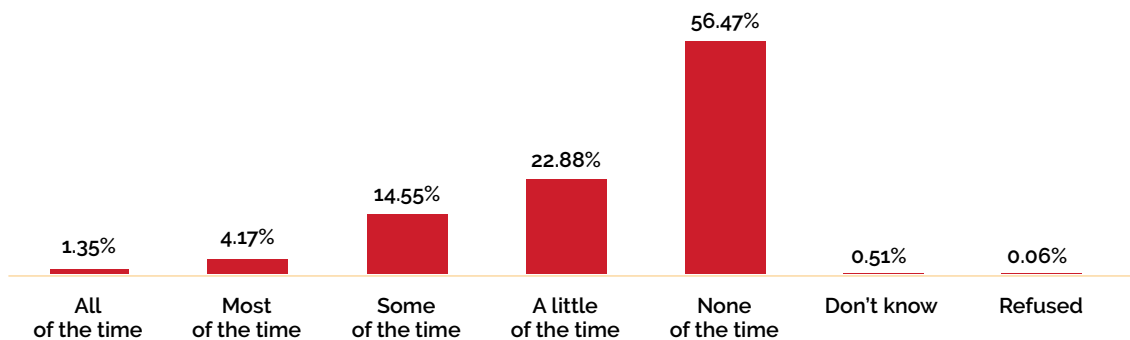
Figure 6: Frequency of emotional distress in the past two weeks, N=1560



Feelings of loneliness and isolation were also commonly reported. Just over a quarter of respondents (26.47%) indicated feeling lonely or isolated at least *some of the time*, while 8.40% reported experiencing these feelings *frequently*.

Figure 7: Frequency of feeling lonely or isolated in the past two weeks, N=1560

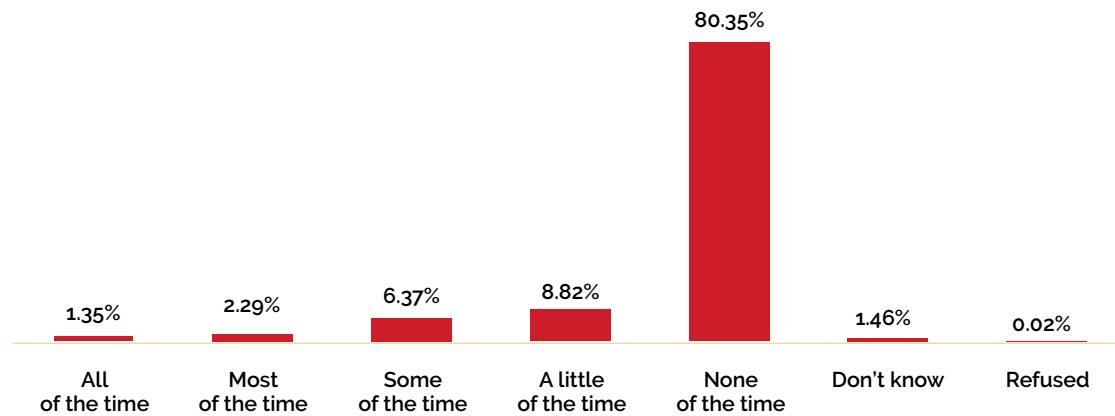
These emotional experiences were reflected in respondents' ability to manage everyday life. **42.95%** reported that emotional difficulties affected their ability to carry out essential daily activities, such as working or managing household tasks, at least a little of the time. For **5.51%** of respondents, these difficulties were reported as occurring *most of the time* or *all of the time*.

Figure 8: Frequency of inability to carry out essential tasks, N=1560

When examined by living situation, both internally displaced persons (IDPs) living in camps and returnees reported similar overall patterns of distress, though differences were observed in how frequently distress was experienced. IDPs were more likely to report experiencing negative feelings *all of the time* (3.2%), while returnees more often reported experiencing these feelings *most of the time* (16.2%).

		IDPs (n=801)	Returnees (n=748)	Host Community (n=9)	IDP outside camp (n=2)	Total (n=1560)
How often in the last two weeks did you have feelings of fear, anger, fatigue, disinterest, hopelessness or upset.	All of the time	26 (3.2%)	13 (1.7%)	0	0	39 (2.5%)
	Most of the time	29 (3.6%)	121 (16.2%)	0	0	150 (9.6%)
	Some of the time	182 (22.7%)	169 (22.6%)	0	2 (100%)	353 (22.6%)
	A little of the time	186 (23.2%)	170 (22.7%)	4 (44.4%)	0	360 (23.1%)
	None of the time	376 (46.9%)	270 (36.1%)	5 (55.6%)	0	651 (41.7%)
	Don't know	2 (0.2%)	5 (0.7%)	0	0	7 (0.4%)
How often in the last two weeks did you have feelings of loneliness or isolation.	All of the time	23 (2.9%)	16 (2.1%)	0	0	39 (2.5%)
	Most of the time	27 (3.4%)	65 (8.7%)	0	0	92 (5.9%)
	Some of the time	117 (14.6%)	164 (21.9%)	0	1 (50%)	282 (18.1%)
	A little of the time	244 (30.5%)	165 (22.1%)	4 (44.4%)	1 (50%)	414 (26.5%)
	None of the time	386 (48.2%)	333 (44.5%)	5 (55.6%)	0	724 (46.4%)
	Don't know	4 (0.5%)	2 (0.3%)	0	0	6 (0.4%)
	Refused	0	3 (0.4%)	0	0	3 (0.2%)

Household-level screening provides further insight into how mental health challenges are distributed within families. A total of **5,554 household members** were included in the screening. Within these households, **18.17%** of household members were reported to have experienced emotional or psychological distress that interfered with their ability to carry out usual daily activities at least some of the time during the two weeks preceding the assessment. Among them, **2.97%** were reported to have experienced such difficulties *most of the time* or *all of the time*.

Figure 9: Emotional/Psychological Distress Among Household Members, N=5553

Caregiver reports also point to emotional and behavioural concerns among children. Among 1,065 caregivers, 6.85% reported noticing changes in how their children felt or behaved in the two weeks prior to the assessment. Reported concerns included increased crying or screaming, reluctance to attend school, reduced communication, decreased playfulness, bed-wetting, aggressive behaviour, and sleep disturbances. Most caregivers who reported concerns indicated that one child in the household was affected, though some reported that more than one child was experiencing difficulties.

Number of children affected per household	Frequency	Percentage
One Child	43	58.90%
Two Children	19	26.03%
Three Children	9	12.33%
Four Children	1	1.37%
Five Children	1	1.37%
Total	73	100.00%

4.1.1. Groups Identified as Most Affected

Qualitative interviews provided further insight into which groups are perceived to be most affected by mental health and psychosocial challenges. Across interviews with community leaders, service providers, and government representatives, several groups were consistently identified as particularly vulnerable.

Women were most frequently described as being affected. Informants linked women's vulnerability to past experiences of violence, loss of family members, caregiving responsibilities, economic dependence, and social stigma around seeking mental health support. Limited mobility, lack of transportation, and distance from health facilities were also cited as barriers that compound distress.

Youth were repeatedly identified as facing significant psychological pressure. Informants highlighted lack of employment opportunities, prolonged uncertainty, and frustration related to limited prospects. Several respondents noted that many young people feel uncertain about whether to remain in their current locations, return to Sinjar, or seek opportunities outside Iraq.

Survivors of violence, particularly Yazidi women who survived ISIS captivity, were described as carrying heavy trauma burdens. Informants noted that unresolved cases, rejection from survivor support mechanisms, and limited access to specialised services contribute to ongoing distress.

Families of missing persons were identified as experiencing continuous psychological suffering due to unresolved grief and uncertainty regarding the fate of loved ones.

Long-term IDPs were described as facing chronic stress linked to prolonged displacement, dependency on aid, and lack of stable living conditions. Living in camps for extended periods was reported to have cumulative psychological, social, and health impacts.

Children and adolescents were also identified as highly vulnerable, with informants pointing to disrupted education, exposure to trauma, and limited access to structured psychosocial support.

Finally, several informants highlighted **underserved groups**, including men, elderly people, persons with disabilities, and returnees living in remote areas, who were perceived as having significant needs but limited visibility within existing support systems.

Qualitative respondents noted that while the initial shock following displacement has diminished over time, long-term psychological distress has persisted and, in some cases, intensified due to prolonged instability and limited progress on recovery.

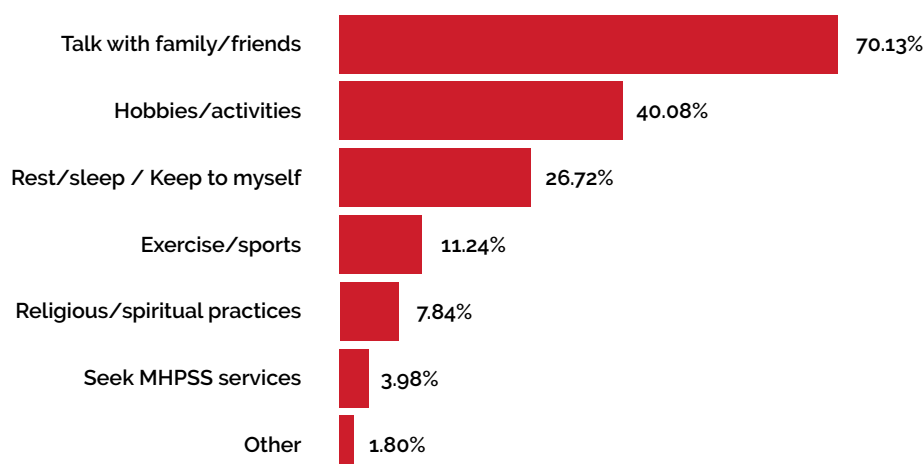
“While the initial shock after displacement has reduced, long-term psychological distress has increased, with hope declining for many people due to slow recovery and lack of justice”.

- Community representative

4.2. Coping, Support, and Community Dynamics

Findings show that most people rely on informal ways of coping when facing emotional or psychological distress. Support is largely sought within families and close social networks, with formal mental health services used by a much smaller proportion of respondents.

Figure 10: Respondents coping strategies, N=1557



Survey data indicate that **talking to family members or friends** is the most common coping strategy, reported by **70.13%** of respondents. Other commonly reported ways of coping included engaging in hobbies or activities (**40.08%**), keeping to oneself or resting (**26.72%**), and physical exercise (**11.24%**). Religious or spiritual practices were reported by **7.84%** of respondents. Only **3.98%** reported seeking mental health or psychosocial support services as a way of coping.

These patterns were reflected in qualitative interviews. Key informants consistently described families as the first and often only source of emotional support for many people. Respondents explained that individuals tend to share concerns with close relatives rather than seeking external help, particularly for emotional or psychological problems. While family support was described as essential, informants also noted that families themselves are often under strain and may not be able to support individuals experiencing more severe or prolonged distress.

Several informants noted that **religious and community leaders** also play a role in providing informal support, particularly through listening, advice, and spiritual guidance. While these forms of support were described as important sources of comfort, informants emphasised that they are often used in the absence of professional mental health care and may not be sufficient on their own.

“A large portion of the community primarily relies on religious and spiritual practices when dealing with psychological distress. While these practices provide comfort and meaning for many, they are often used in the absence of, or instead of, professional mental health support”.

- Government representative

Quantitative data further illustrates the structure of social support within the community. **Family** was identified as the main support network by **86.67%** of respondents, followed by **friends (23.46%)** and **neighbours (10.90%)**. Very few respondents identified **community leaders (4.04%)** or **religious leaders (3.33%)** as their primary source of support. Notably, **3.40%** reported having no support network at all.

Support network	Frequency	% of respondents n=1560
Family	1352	86.67%
Friends	366	23.46%
Neighbours	170	10.90%
Community leaders	63	4.04%
Religious groups/leaders	52	3.33%
NGO/humanitarian workers	88	5.64%
Other Yazidis	86	5.51%
Other	91	5.83%
No Support network	53	3.40%

Qualitative findings confirmed this heavy reliance on family while also highlighting its limitations. Informants noted that while families provide emotional care and daily support, they cannot replace professional mental health services, particularly for individuals with complex or severe needs.

Stigma and social perceptions around mental health were repeatedly raised as factors influencing coping and help-seeking. Informants described reluctance to openly discuss mental health problems, particularly among men, and fear of judgment from family or the wider community.

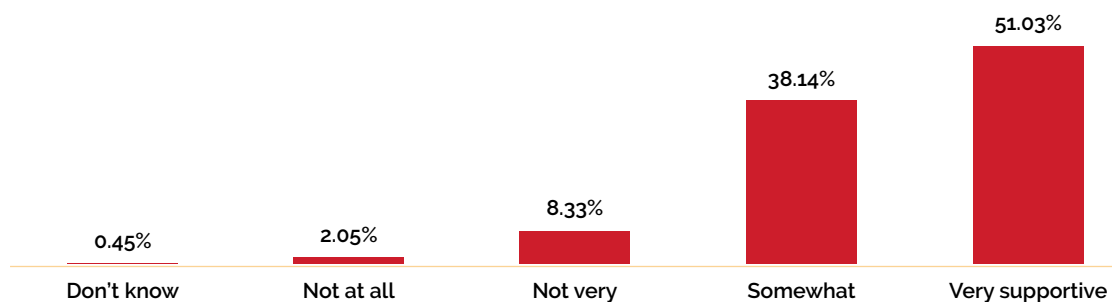
“While some are able to access available MHPSS services, many others require support but cannot seek help due to shame and fear of judgment from family and the community.”

- NGO Representative

Differences in coping and support were also noted across living situations. In camp settings, close living arrangements were described as facilitating reliance on immediate family and neighbours. In contrast, returnees and displaced people living outside camps were described as having smaller or disrupted support networks, with fewer opportunities for social interaction. Across both settings, uncertainty about where to seek support and limited awareness of available services were commonly mentioned.

Despite these challenges, perceptions of community cohesion were relatively positive. **Fifty-one percent (51.03%)** of respondents described their community as *very supportive* in coping with challenges, and **38.14%** as *somewhat supportive*. However, **10.38%** rated their community as *not very or not at all supportive*.

Figure 11: Respondents perception on Community Support in Coping with Challenges, N=1560



Community participation was reported to be relatively high, with **38.53%** participating regularly in religious or cultural activities and **45.45%** participating occasionally. At the same time, **10.64%** reported wanting to participate but being unable to do so.

When asked what would strengthen community support, respondents most frequently identified the need for **community gathering spaces (57.63%)**, followed by **youth groups (37.88%)**, **women's groups (32.18%)**, **religious or cultural events (31.22%)**, and **organised activities (30.51%)**.

What would strengthen community support	Frequency	% of respondents n=1560
Community gathering spaces	899	57.63%
Youth groups	591	37.88%
Women's groups	502	32.18%
Religious/cultural events	487	31.22%
Organized activities	476	30.51%
Skills training	382	24.49%
Sports/recreation	74	4.74%
Other	6	0.38%

Despite generally positive perceptions of community support, isolation and social withdrawal emerged as concerns for some individuals. Informants noted that people experiencing psychological distress may withdraw from social interaction, with isolation reported among adults and behavioural withdrawal observed among children.

Overall, the findings indicate that while family and community support remain central to how people cope with distress, these systems are uneven and under strain. Informal support plays a critical role but cannot fully address the mental health needs identified, particularly for individuals facing prolonged or severe psychological challenges

4.3. Access to Mental Health and Psychosocial Support Services

Findings indicate that access to mental health and psychosocial support (MHPSS) services remains limited for many people in the assessed communities. While services are available through government facilities and non-governmental organisations, awareness, utilisation, and consistent access remain uneven.

Survey data show that awareness of MHPSS services is generally low. Over half of respondents (51.09%) reported that they were **not aware of any MHPSS services** in their area. Among those who reported awareness, the most commonly known services were community activities such as workshops or recreational activities (25.71%) and individual counselling (23.85%). Awareness of more specialised services was much lower, including psychiatric services (7.44%), child-friendly spaces (13.91%), women's spaces (10.71%), and youth programmes (3.85%). Awareness of crisis hotlines was minimal (1.03%).

Level of Awareness of MHPSS Services	Overall Statistics		Disaggregated by status			
	Frequency	Percentage n=1560	IDPs	% IDPs	Returnees	% returnees
Other	2	0.13%	0	0.00%	2	100.00%
Crisis hotlines	16	1.03%	15	93.75%	1	6.25%
Youth programs	60	3.85%	27	45.00%	33	55.00%
Spiritual/religious support	112	7.18%	108	96.43%	4	3.57%
Psychiatric services	116	7.44%	106	91.38%	10	8.62%
Group/Family support	125	8.01%	72	57.60%	53	42.40%
Women's spaces	167	10.71%	116	69.46%	51	30.54%
Child friendly spaces	217	13.91%	181	83.41%	34	15.67%
Individual counseling	372	23.85%	326	87.63%	46	12.37%
Community activities (workshops, recreation)	401	25.71%	364	90.77%	36	8.98%
I'm not aware of any MHPSS services in my area	797	51.09%	177	22.21%	611	76.66%

Differences were observed by displacement status. Awareness of services was generally higher among IDPs in camps compared to returnees, particularly for counselling, community activities, and women's spaces. Returnees were more likely to report limited or no awareness (76.66%) of available services, reflecting both reduced service presence and weaker outreach in return areas.

Consistent with these findings, survey data indicate that only a very small proportion of respondents (3.98%) reported using formal MHPSS services as a way of coping with emotional distress. As described earlier, most people rely on family, friends, or other informal means of support.

Qualitative interviews help explain these patterns. Key informants described a range of barriers that affect whether people seek and access services. These included limited awareness of available services, concerns about stigma, transportation challenges, cost-related barriers, and uncertainty about where to go for support. Several informants noted that even when services exist, people may delay seeking help until problems become more severe.

“There are several obstacles that prevent people from accessing mental health services. One of the most important is the lack of awareness and media information about the availability of these services. The location of service provision also plays a significant role”.

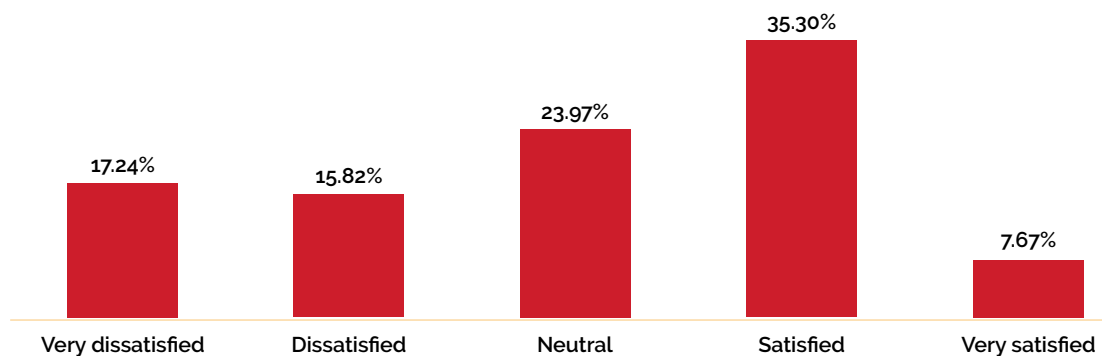
- Government Representative

Qualitative data also identified specific groups with consistently limited access to MHPSS services. Informants noted that **men’s mental health needs are often overlooked**, with services perceived to focus primarily on women and girls. Elderly people and persons with disabilities were described as facing mobility constraints, accessibility barriers, and limited inclusion in programming. IDPs living outside camps were reported to be underserved, partly due to assumptions that they no longer require assistance. Returnees in remote or mountainous areas were described as having minimal access to services because of destroyed infrastructure and distance from service providers.

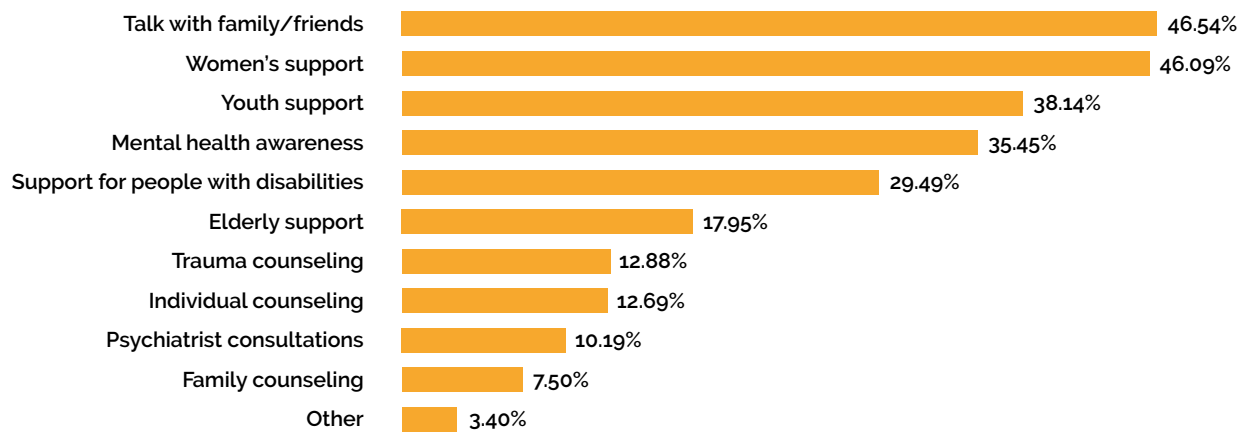
Service providers also highlighted operational challenges that constrain service availability and quality. The most frequently cited challenge was **insufficient and unstable funding**, which has led to programme suspensions, staffing shortages, and limited clinical supervision. Coordination challenges were also reported, with informants noting that while coordination was stronger in earlier phases of the response, it has weakened over time due to funding reductions and the withdrawal of humanitarian actors. Political interference and service design limitations were also raised, particularly in relation to uneven coverage and insufficient service capacity relative to population size.

Among those who had accessed services, satisfaction levels varied. **42.98%** reported being satisfied or very satisfied, while **33.06%** were dissatisfied or very dissatisfied. **23.97%** reported neutral satisfaction. Qualitative interviews echoed these findings, with key informants describing services as insufficient in scale and sometimes poorly matched to community needs.

Figure 12: Satisfaction levels of respondents who accessed MHPSS services, N=847



When asked about priority service gaps, respondents most frequently identified the need for **more mental health professionals (46.54%)**, followed by women’s support services (46.09%), youth support (38.14%), mental health awareness activities (35.45%), and support for persons with disabilities (29.49%). Qualitative respondents further emphasised the need for child-friendly spaces, recreational activities, and expanded community-based support, particularly in Sinjar.

Figure 13: Priority service gaps identified by respondents, N=1560

Overall, the findings indicate that while MHPSS services are present in some areas, access remains limited for many people. Low awareness, uneven coverage, and structural constraints continue to restrict utilisation, particularly among underserved groups and returnee populations.

4.4. High-Risk Concerns: Suicide and Substance Use

Findings from the assessment point to the presence of high-risk mental health concerns within the community, particularly related to suicide and, to a lesser extent, substance use. These issues were raised primarily through qualitative interviews, with quantitative data providing additional context.

Suicide and self-harm were described by key informants as serious concerns, particularly among adolescents and youth. Informants noted that suicide attempts and suicidal ideation are encountered in their work, though such cases are often underreported due to stigma and fear of social consequences.

Several respondents highlighted concerns about young people, including female adolescents, who were described as experiencing significant emotional distress. Informants explained that families and community members may be reluctant to openly discuss suicide, which can limit early identification and timely support.

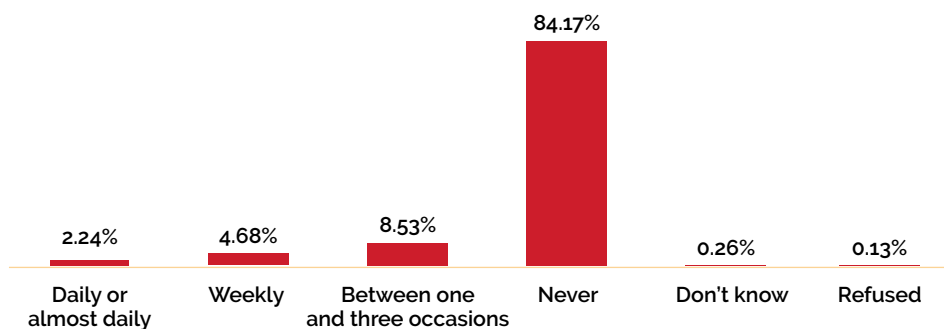
“Overall, the most serious mental health concern in the community is suicide, especially among youth. Female adolescents are particularly at risk due to factors such as trauma, social pressure, and limited access to psychosocial support.”

NGO representative

At the same time, informants noted that structured suicide prevention and response mechanisms are limited. While referrals may occur in some cases, access to specialised care and follow-up support was described as inconsistent across locations.

Substance use was less commonly reported in the household survey. The majority of respondents (84.17%) reported no recent use of alcohol or drugs, and reported prevalence of psychoactive substance use was low (1.28%). However, qualitative interviews suggest that substance use remains a concern for some informants, particularly in relation to young men.

Figure 14: Reported Occurrence of Heavy Drinking (More Than Six Drinks in One Day), N=1560



Key Informants described substance use as an issue that may be hidden or emerging, rather than widespread. Concerns were raised about limited services addressing substance use and the lack of targeted support for individuals who may be struggling with addiction.

Overall, these findings indicate that while suicide and substance use do not affect the majority of the population, they represent high-risk concerns for specific groups and warrant attention due to their severity and potential consequences.

4.5. Living Conditions, Basic Needs, and Economic Stress

Findings indicate that living conditions and access to basic needs continue to place significant strain on households across the assessed communities. Gaps in access to healthcare, livelihoods, and adequate housing remain common and were consistently described as sources of ongoing stress.

Access to healthcare emerged as a major challenge. Overall, 44.29% of respondents reported lacking consistent access to healthcare services. Disaggregated data show that this challenge was more frequently reported by returnees, with 400 out of 748 returnees (53.48%) reporting inconsistent access, compared to 288 out of 801 IDPs living in camps (35.96%). This pattern suggests that while humanitarian services remain more available in camp settings, access to healthcare in return areas remains limited.

Access to water and shelter also differed across displacement and return contexts. While 78.72% of respondents reported consistent access to water overall, lack of water access was more frequently reported among returnees (219 respondents) than among IDPs in camps (113 respondents). Similarly, lack of consistent access to shelter was reported by 243 returnees, compared to 74 camp-based IDPs, reflecting ongoing housing damage, incomplete reconstruction, and insecurity in return areas. Qualitative interviews further highlighted that even among those reporting access to shelter, many returnees live in damaged or temporary housing, contributing to instability and distress.

Food insecurity affected a smaller proportion of households, with 11.79% reporting inconsistent access to food. This challenge was reported predominantly among IDPs living in camps (173 respondents), suggesting continued dependency on assistance among some displaced households

Economic conditions emerged as one of the most significant stressors across all contexts. Overall, 68.01% of respondents reported being unemployed or having no income. Unemployment was more frequently reported among IDPs in camps (626 respondents) than among returnees (430 respondents). However, among those who were employed, income sufficiency remained low across both groups, with only 13.03% reporting income as fully sufficient to meet household needs. Financial strain was consistently described in qualitative interviews as contributing to stress, tension within households, and feelings of frustration and hopelessness.

“Urban displaced families suffer from social isolation, difficulty finding work, and continuous financial stress, which leads to high tension and feelings of hopelessness.”

– Community representative

When asked to identify their top household needs, respondents most frequently prioritised livelihoods or employment (24.09%), followed by financial assistance (17.58%) and healthcare (13.28%). Disaggregated responses indicate that IDPs more frequently prioritised financial assistance and healthcare, while returnees more frequently prioritised livelihoods, shelter, and education, reflecting differing pressures across displacement and return contexts. **Mental health support** was identified as a priority by 11.49% of respondents, indicating recognition of psychological needs alongside material concerns.

Prioritized Household Needs	Frequency	Percentage
Livelihood/employment	1103	24.09%
Financial assistance	805	17.58%
Healthcare	608	13.28%
Mental health support	526	11.49%
Shelter	472	10.31%
Children's education	421	9.19%
Water/sanitation	270	5.90%
Legal assistance	191	4.17%
Safety/security	82	1.79%
Food	76	1.66%
Other	25	0.55%
Total	4579	100.00%

Qualitative findings underscored the interaction between living conditions and wellbeing. Prolonged displacement, inadequate housing, unemployment, and disrupted education were repeatedly described as factors that intensify emotional distress and undermine coping.

“The most important need for displaced and returning populations is livelihood support, particularly the provision of employment opportunities for youth, as unemployment increases the likelihood of mental health issues whereas engagement in work or community activities improves psychological well-being and provides a sense of stability and active participation in life”

– Community representative

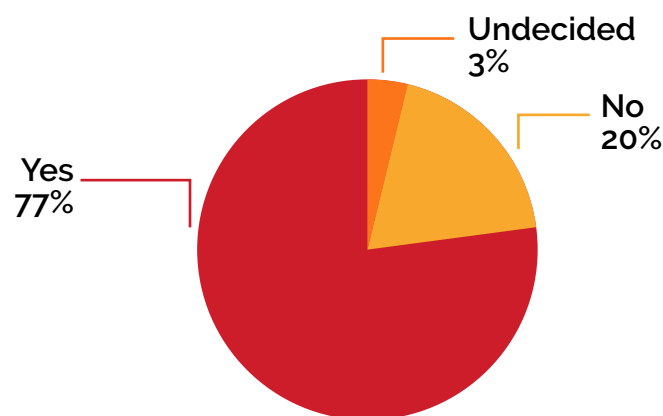
Overall, the findings indicate that unmet basic needs and economic hardship form a persistent backdrop to mental health and psychosocial challenges across the community and help explain why, despite strong interest in return, many households remain hesitant to do so in the absence of adequate services, livelihoods, and living conditions.

4.6. Return, Future Plans, and Uncertainty

Findings related to return and future plans highlight a complex and often uncertain outlook shaped by displacement, living conditions, and access to services.

Among internally displaced respondents, **76.97%** expressed a desire to return to their place of origin if conditions allowed. At the same time, **19.58%** reported that they did not wish to return, and **3.45%** were undecided. Return intentions were largely conditional, linked to improvements in housing, services, livelihoods, and security.

Figure 15: Respondents' Desire to Return to Place of Origin, N=812



Respondents identified multiple barriers to return, most commonly **lack of housing (65.39%)**, **lack of employment opportunities (48.40%)**, and **absence of basic services (47.04%)**. Other reported barriers included limited health services, lack of compensation, security concerns, destroyed infrastructure, and insufficient government support.

Reasons preventing you from returning	Frequency	% of respondents (n=812)
No housing	531	65.39%
No jobs	393	48.40%
No basic services	382	47.04%
Failure by government to provide compensation	314	38.67%
Limited health services	308	37.93%
Safety/security	298	36.70%
Destroyed infrastructure	262	32.27%
Lack of government support	237	29.19%
Limited education	190	23.40%
Armed groups present	163	20.07%
Fear of discrimination	137	16.87%
Government restrictions	101	12.44%
Forced to stay	3	0.37%
Other	3	0.37%
Nothing/No concerns	1	0.12%

Despite these challenges, levels of hope varied. Among those who expressed a desire to return, 43.34% reported feeling very hopeful, while 22.97% were *somewhat hopeful*. At the same time, 33.54% reported being *not very hopeful* or *not hopeful at all*, reflecting a more cautious or uncertain outlook.

Qualitative data highlighted important differences between the experiences of IDPs in camps and returnees. Camp-based IDPs were described as facing chronic stress related to overcrowding, dependency on aid, boredom, and limited control over daily life. Several informants noted that while services may be more physically accessible in camps, prolonged displacement contributes to anxiety, frustration, and loss of motivation.

In contrast, returnees were described as facing insecurity, lack of services, unemployment, and social isolation. Informants noted that return often brings expectations of stability that are not met due to destroyed homes, damaged infrastructure, and limited government support, leading to frustration and emotional fatigue. Some respondents suggested that although returnees may regain a sense of personal control by being back in their place of origin, the scarcity of services and livelihoods creates new stressors.

Across both groups, uncertainty about the future emerged as a key concern. Informants described confusion and anxiety, particularly among youth, about whether to remain, return, or seek opportunities elsewhere, including migration outside Iraq.

Overall, the findings show that while return remains an important aspiration for many, uncertainty about conditions, timelines, and future opportunities continue to shape how people think about their lives ahead. Differences between camp-based IDPs and returnees highlight the need for context-specific approaches that address both displacement-related stress and the challenges of sustainable return.

4.7. Justice, Accountability, and Long-Term Recovery

Qualitative findings indicate that justice and accountability processes related to the 2014 genocide have significant and complex implications for mental health and psychosocial wellbeing within the Yazidi community. Respondents described these processes as having both protective and harmful effects, depending on individual experiences and the stage of proceedings.

Some informants noted that legal processes and recognition of crimes provide a sense of validation and acknowledgment of suffering, which can support emotional wellbeing for certain individuals. At the same time, others described how engagement with justice processes can trigger distress, anxiety, grief, and re-traumatization, particularly for survivors required to recount past experiences or repeatedly revisit traumatic events.

Delayed justice emerged as a major concern across interviews. Respondents described the slow pace of legal proceedings and limited accountability as contributing to frustration, anger, and loss of trust in institutions. The prolonged wait for justice was repeatedly linked to feelings of abandonment and emotional exhaustion.

“Slow justice processes and delayed reconstruction create frustration, anger, and loss of trust. While some legal steps give hope, many people feel abandoned, and the unresolved fate of missing relatives keeps psychological wounds open.”

- Community representative

The unresolved fate of missing persons was consistently described as a source of prolonged psychological suffering. Informants explained that uncertainty regarding relatives who remain missing or whose remains have not been recovered prevents closure and sustains grief over time.

“The lack of justice and unresolved cases profoundly affect mental health. Many people are still waiting for news of relatives, and this uncertainty contributes to persistent feelings of hopelessness and emotional distress.”

- Government representative

Concerns were also raised about the broader community impact of limited accountability. One respondent highlighted that the release of individuals involved in crimes against the Yazidi community has created fear and insecurity, reinforcing concerns about safety and the possibility of future violence.

Several informants reflected on how the psychological impact of the genocide has evolved over time. While the immediate shock following displacement was described as having lessened, long-term psychological suffering was reported to have increased due to stagnation in recovery, delayed justice, and lack of durable solutions.

“While the initial shock after displacement has reduced, long-term psychological distress has increased. Hope has declined for many people due to slow recovery and lack of justice.”

- Religious leader

Overall, the findings suggest that mental health recovery is closely intertwined with broader recovery processes. Respondents emphasized that without progress on justice, accountability, reconstruction, and resolution of missing persons cases, psychological distress is likely to persist. Mental health and psychosocial support were described as essential, but insufficient on their own to address the long-term impacts of unresolved injustice and uncertainty.

4.8. Statistics Overview — Key Findings

57.83%

of respondents experienced fear, anger, fatigue, loss of interest, hopelessness, or being upset in the past two weeks.

42.95%

reported psychological difficulties affecting daily functioning.

51.35%

Rely primarily on family for emotional support.

3.98%

Reported using formal MHPSS services as a coping strategy.

51.09%

of respondents were unaware of any MHPSS services in their area.

76.66%

returnees unaware of MHPSS services in their area.

68.01%

reported being unemployed or having no income.

76.97%

of IDPs expressed a desire to return to their place of origin.

05

Discussion



5. Discussion

This assessment shows that mental health and psychosocial distress remains widespread within the Yazidi community and continues to affect daily functioning for many individuals and households. As a needs assessment, this discussion interprets patterns of self-reported distress and psychosocial challenges in relation to lived experiences, access to services, and broader recovery conditions, rather than clinical diagnoses. Quantitative findings demonstrate that a substantial proportion of respondents experience emotional distress and difficulty carrying out everyday activities, while qualitative data illustrate how these challenges are experienced and understood within the community.

More than ten years after the 2014 genocide, psychological distress has not resolved with time. Instead, qualitative findings suggest a shift from acute crisis reactions to more chronic forms of distress linked to prolonged displacement, unresolved loss, economic hardship, and uncertainty about the future. This is reflected in household-level data showing emotional distress among adults and children, as well as in caregiver reports of behavioural and emotional difficulties among children.

Vulnerability is not evenly distributed. Women, youth, survivors of violence, families of missing persons, long-term IDPs, and children were consistently identified by informants as particularly affected. These vulnerabilities reflect overlapping stressors, including caregiving burdens, disrupted education, unemployment, unresolved grief, and social stigma. At the same time, several groups, such as men, older persons, persons with disabilities, and returnees in remote areas, were described as having significant needs but limited visibility within existing support systems. Taken together, these patterns point to needs across multiple layers of support, from unmet basic services and livelihoods, through strained family and community coping mechanisms, to gaps in focused psychosocial and specialised mental health services.

Coping strategies remain largely informal. Most respondents rely on family members, friends, and personal coping mechanisms, with only a small proportion seeking formal MHPSS services. While family and community networks continue to provide important emotional support, qualitative data indicate that these systems are increasingly strained and often insufficient for individuals experiencing persistent or severe distress. Stigma around mental health further limits help-seeking beyond trusted circles, particularly among men.

Access to formal MHPSS services remains limited. Survey data show low awareness of available services, especially among returnees, and minimal use of specialised support. Qualitative findings highlight multiple barriers, including lack of information, transportation constraints, cost, stigma, and unclear referral pathways. Service providers also face structural challenges, including unstable funding, limited staffing, weakened coordination, and uneven service coverage, all of which constrain service quality and reach.

Living conditions and economic insecurity emerged as central stressors affecting mental wellbeing. Gaps in healthcare access, insecure housing, and widespread unemployment were frequently cited as sources of distress. Livelihoods were prioritised by respondents as a key household need, underscoring the close link between economic stability and psychological wellbeing. Qualitative data suggests that psychosocial interventions are less effective when basic needs and living environments remain unresolved.

Return intentions reflect this complexity. While many IDPs expressed a desire to return, intentions were conditional and shaped by concerns about housing, services, livelihoods, and security. Differences described by camp-based IDPs and returnees point to distinct stress experiences, with camps associated with dependency and lack of control, and return areas associated with unmet expectations, insecurity, and isolation. Across both groups, uncertainty about the future remains a major source of psychological strain, particularly for youth.

Finally, justice and accountability processes continue to shape mental health outcomes. Qualitative data show that while recognition and legal proceedings can provide validation and hope for some, delayed justice, unresolved cases, and the fate of missing persons contribute to prolonged grief, frustration, and loss of trust. The findings indicate that psychological recovery is closely linked to broader recovery processes and that, without parallel progress on livelihoods, basic services, and justice, MHPSS services alone are unlikely to lead to sustained improvements in wellbeing.

06

Recommendations



6. Recommendations

The findings of this assessment indicate that mental health and psychosocial distress among Yazidi communities is shaped by a combination of prolonged trauma, unmet basic needs, economic insecurity, service gaps, and unresolved justice and recovery processes. Addressing these challenges requires coordinated action across government authorities, donors, and implementing partners. The recommendations below are grounded in the assessment findings and aim to support more effective, inclusive, and sustainable MHPSS responses across displacement and return contexts.

6.1. Recommendations for Government Authorities

1. Strengthen leadership and coordination of MHPSS services.

Fragmented coordination and uneven service coverage were consistently highlighted by service providers and community informants. Government authorities should strengthen leadership in MHPSS coordination by clarifying institutional roles, improving information sharing, and supporting consistent collaboration across health, social services, education, and humanitarian actors. Strengthened referral pathways between community-based support, primary healthcare, and specialised services are particularly needed.

2. Improve access to health and mental health services in return and underserved areas.

Returnees and populations in remote locations reported lower awareness of services and greater difficulty accessing care. Government authorities should prioritise the expansion and continuity of basic health and mental health services in return areas, rural communities, and locations with limited mobility, including through integration into primary healthcare and outreach models.

3. Integrate mental health considerations into return, recovery, and reconstruction processes.

Findings show that uncertainty around housing, livelihoods, and services is a major driver of psychosocial distress and shapes return decisions. Mental health and psychosocial considerations should be integrated into planning for return, housing reconstruction, livelihoods, and service provision, recognising that psychological wellbeing is closely linked to broader recovery conditions.

4. Provide sustained support to families of missing persons and survivors of violence.

Families of missing persons and survivors of violence continue to experience prolonged grief, trauma, and uncertainty. Government authorities should strengthen access to specialised, long-term psychosocial support for these groups and ensure that services are accessible, culturally appropriate, and linked to justice and documentation processes.

5. Ensure justice and accountability processes are trauma-sensitive.

Engagement with justice, legal, and documentation processes can be both validating and re-traumatising. Authorities should ensure that these processes are trauma-sensitive and accompanied by appropriate psychosocial support before, during, and after engagement, particularly for survivors and families of missing persons.

6.2. Recommendations for Donors / Funders

1. Support longer-term and predictable funding for MHPSS services.

Short-term and unpredictable funding was identified as a major constraint affecting service continuity, staffing, and quality. Donors/funders should prioritise longer-term funding modalities that allow for sustained service provision, retention of trained staff, and continuity of care.

2. Promote integrated approaches that address psychosocial distress alongside basic needs and livelihoods.

The assessment demonstrates that economic insecurity, unemployment, and poor living conditions are central drivers of distress, particularly among youth. Donors/funders should support integrated programming that links MHPSS with livelihoods, education, basic services, and protection, rather than funding MHPSS in isolation.

3. Prioritise underserved and high-risk groups.

Funding should explicitly prioritise groups identified as facing heightened or unmet needs, including children and adolescents, youth, men, older persons, persons with disabilities, survivors of violence, families of missing persons, and returnees in remote areas.

4. Invest in service quality, staff wellbeing, and supervision.

In addition to service coverage, donors should invest in quality assurance measures, including regular clinical supervision, ongoing training, and staff wellbeing support, to reduce burnout and ensure ethical and effective service delivery in high-stress contexts.

5. Support system strengthening and national ownership.

Donors/funders should support government-led coordination mechanisms, referral systems, and capacity strengthening to promote sustainable, nationally owned MHPSS systems beyond short-term project cycles.

6.3. Recommendations for Implementers and NGOs

1. Strengthen community awareness and outreach, particularly for returnees.

Low awareness of MHPSS services, especially in return areas, limits access to care. Implementers should prioritise community-based awareness and outreach using trusted local actors, culturally appropriate messaging, and clear information on available services and referral pathways.

2. Expand mobile and community-based service delivery.

To reach returnees, IDPs outside camps, and remote communities, implementers should expand mobile and community-based MHPSS approaches and integrate psychosocial support into existing health, education, and community platforms.

3. Scale up child-, adolescent-, and family-focused MHPSS interventions.

Findings highlight emotional and behavioural distress among children and adolescents in the context of prolonged displacement and family stress, yet services remain largely adult-focused. Implementers should expand age-appropriate psychosocial support, including school-linked services, child-friendly spaces, parenting and caregiver support, and family-based interventions that strengthen protective relationships.

4. Address youth distress through combined psychosocial and livelihood approaches.

High levels of distress among youth are closely linked to unemployment, lack of opportunities, and uncertainty about the future. Implementers should design programmes that combine psychosocial support with skills development, livelihoods, and opportunities for meaningful participation.

5. Strengthen referral pathways and responses for severe distress and suicide risk.

Qualitative findings point to gaps in referral mechanisms and limited pathways to specialised care for individuals experiencing severe distress or suicide risk. Implementers should strengthen identification, referral, and follow-up procedures, ensure staff are trained in safe referral practices, and coordinate closely with specialised services where available.

6. Ensure culturally sensitive, gender-responsive, and well-supported service delivery.

All interventions should be adapted to community norms and address stigma around mental health. Regular supervision, peer support, and attention to staff well-being should be standard practice to maintain service quality and ethical standards.

07

Conclusion



7. Conclusion

This assessment provides a detailed picture of the mental health and psychosocial situation of the Yazidi community more than a decade after the 2014 genocide. The findings show that emotional and psychological distress, as reported by community members and caregivers, remains widespread and continues to affect daily functioning, family life, and community wellbeing. While individuals and families rely heavily on informal coping mechanisms and community support, these systems are under increasing strain and are often insufficient to address ongoing and complex mental health needs.

The assessment highlights that mental health challenges are closely linked to broader conditions, including prolonged displacement, economic hardship, uncertainty about the future, and unresolved justice and accountability processes. Differences between camp-based displaced populations and returnees underline the need for context-specific approaches that reflect distinct experiences and stressors.

Access to formal mental health and psychosocial support services remains uneven, with low awareness, limited coverage, and structural constraints affecting both service availability and quality. At the same time, the persistence of distress among vulnerable and underserved groups underscores the need for more inclusive and responsive programming.

Overall, the findings indicate that mental health and psychosocial support cannot be addressed in isolation. Sustainable improvement in wellbeing for the Yazidi community will require coordinated efforts that combine quality MHPSS services with progress in livelihoods, basic services, recovery, and justice. This assessment provides an evidence base to inform policy, programming, and funding decisions and to support more effective, integrated responses moving forward.

