



MENTAL HEALTH AND PSYCHOSOCIAL NEEDS RAPID ASSESSMENT REPORT

JEDDAH 1 CENTER
AUGUST- SEPTEMBER 2022

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ABBREVIATIONS

NES	North East Syria
ISIL	Islamic State of Iraq and the Levant
J1	Jeddah 1
MHPSS	Mental Health and Psychosocial Support
IOM	International Organization for Migration
WGSSQs	Washington Group Short Set of Questions on Disability
IDPs	Internally Displaced Persons
NGOs	Non-Governmental Organizations

1. BACKGROUND

1.1 CONTEXT

Currently, around 28,000 Iraqi nationals reside in Al Hol Camp which is a complex of tents located in North-East Syria (NES). The camp is home to Iraqis who travelled to Syria prior to 2014, those who fled when the Islamic State of Iraq and the Levant (ISIL) took over their area of origin, those who crossed the border during the military campaign to dislodge ISIL from Iraqi territory, and others who arrived after remaining strongholds in Syria were recaptured.

Early around 2021, the Government of Iraq has resumed the facilitation of the voluntary returns of Iraqis after the process has been temporarily put on hold in 2018/2019. Accordingly, there have been 6 batches of new arrivals to the Jeddah 1 (J1) Center from NES since May 2021; the most recent one taking place on 12 August 2022 where a total of 155 families and 622 individuals were registered at the center.¹



Map 1. Locations of Al-Hol camp (NES) and Jeddah 1 center (Ninewa- Iraq)

1.2 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT CONTEXT

Reflecting on previous returns and experiences shared by J1 center residents, the journey from Al-Hol Camp to Iraq has been perilous. Individuals were not only exposed to extreme violence and traumatic experiences during the ISIL conflict since 2014 but also during their dislodgment late in 2017. Residing at Al-Hol thereafter further complicated the situation with the extremely precarious humanitarian and security conditions that prevail to date at the camp.

Since the first returns to from Al-Hol to J1 center in May 2021, IOM’s MHPSS Program has been providing a wide range of community-based MHPSS services at the center. IOM conducted this assessment to further tailor its support and inform partners and other actors on current mental health and psychosocial needs among the affected population.

1.3 ASSESSMENT OBJECTIVES

The main objectives of this assessment were to:

- i. Assess MHPSS needs, capacities and resources of the respondents residing at the J1 Center at the time of the assessment.
- ii. Inform MHPSS actors of key mental health and psychosocial needs and resources in J1 Center.
- iii. Inform relevant actors and partners about other identified needs such as basic needs, protection, health and legal services.
- iv. Support the development of relevant MHPSS programming to address the needs of returnees both at the center and upon their return to areas of origin or settlement in a third location.

Mental Health and Psychosocial Support (MHPSS)

Mental Health and Psychosocial Support (MHPSS) teams provide specialized and non-specialized MHPSS services to Jeddah 1 residents. Partners also host community-based PSS activities including arts, crafts, sewing, baking, and haircutting courses/classes to help them strengthen their family and support networks.

#	of individual counselling services provided	113	Achieved (August)	4,699	Achieved (Overall)
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#	of individuals provided with Psychiatric assistance	56	Achieved (August)	2,276	Achieved (Overall)
<hr style="border-top: 1px dotted #ccc;"/>					
#	of individuals provided with Psychological First Aid	1,284	Achieved (August)	12,582	Achieved (Overall)
<hr style="border-top: 1px dotted #ccc;"/>					
#	of individuals receiving group psychosocial support	294	Achieved (August)	4,783	Achieved (Overall)

Table 1. MHPSS services at J1 center (extracted from J-I August 2022 dashboard)

Age	5-0	17-6	-18 35	59-36	+60	Total	Current Total Individuals	Current Total Households
Male	163	316	108	51	14	652		
Female	127	315	209	136	29	816		

Table 2. Current population number of residents at J1 center (extracted from J1 August 2022 dashboard)

1. Jeddah 1 center is located close to the town of Qayyarah, which is lies around 70 km south of Mosul in Ninewa governorate.

2. METHODOLOGY

2.1 TARGET POPULATION AND SAMPLE SELECTION

For the purposes of this assessment, data collection was carried out over a period of 15 days in August 2022. Given the dynamic state at the J1 Center regarding the continuous arrivals from AL-Hol Camp and the departures of families from the center whether to their areas of origin or relocations otherwise, the assessment team ensured the inclusion of individuals representing households who have already been residing at J1 as well as from households arriving on 12 August 2022.

2.2 ASSESSMENT TOOL

The “Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return” tool was adapted to be used with the target population at J1 Center. An abbreviated version of the assessment tool was modified and revised by IOM’s technical MHPSS team overseeing MHPSS service provision in J1 Center.

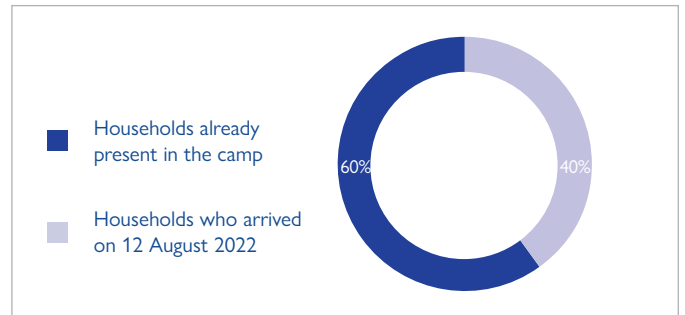


Figure 2. Arrival status

2.3 DATA COLLECTION

Five IOM MHPSS staff conducted the assessment on site. All staff are experienced in the field of MHPSS and had been involved in similar needs assessments. Informed consent of the participants was obtained after staff provided information on the purpose of the assessment, how the data would be used, data anonymization, and confidentiality.

3. RESULTS

3.1 DEMOGRAPHIC DATA OF SURVEY RESPONDENTS

Age and sex

Data was collected from 100 adult respondents in J1 Center. The number of female and male respondents were equal in number i.e., 50 per each group (50% each).

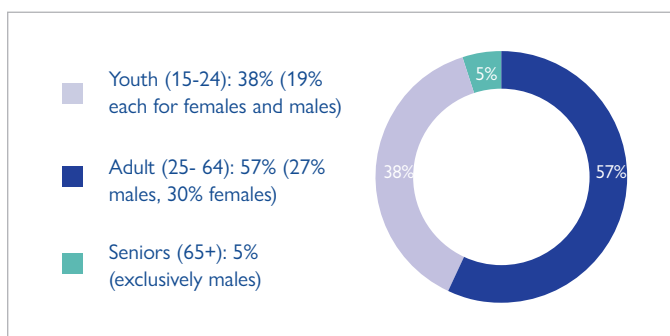


Figure 1. Age and Gender

Important note: Since the assessment sample includes an equal number of females and males, percentages that reflect the true numbers of the individuals will be used as default to describe data throughout the report unless otherwise specified.



Photo 1: Sarah Ali/IOM Iraq

Areas of origin of the interviewed sample:

The majority of the sample were originally from Ninewa governorate (50%), followed by Al-Anbar (38%) and Salahdin (12%) governorates.

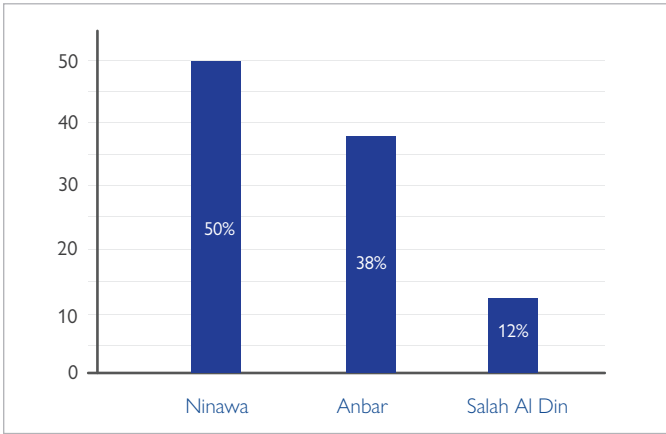


Figure 3. Area of origin

Total duration of displacement of the respondents

Years spent in displacement amongst the respondents ranged between 5 and 9 years with more than half of the sample (55%) of the sample spending 7 to 9 years of their lives being displaced.

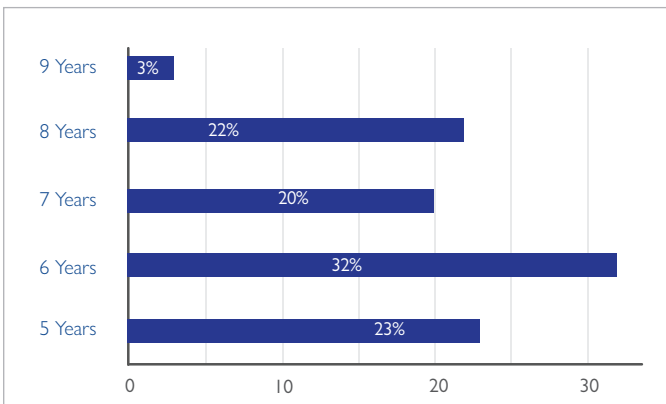


Figure 5. Years in displacement

Education

Among those interviewed, 44% did not possess formal reading or writing skills (14% of which were from the youth age group (15-24) where 11% of them were females), 40% attained primary education, 16% had secondary school education.

Social status

Regarding the social status of the sample, 51% of the respondents were married at the time of the assessment while 49% were either never married, divorced, separated or widowed. The latter 3 groups comprising exclusively of females.

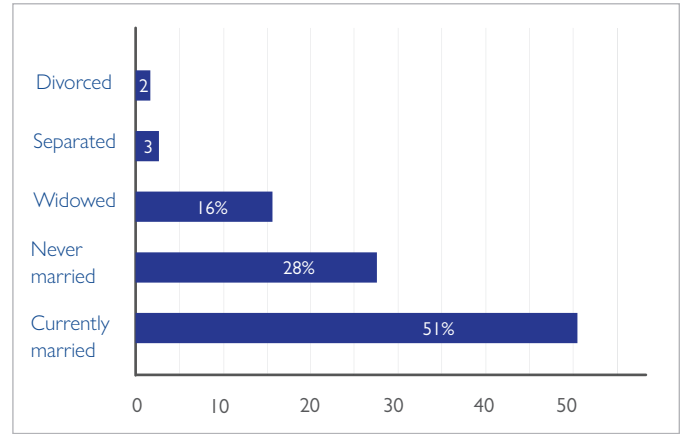


Figure 4. Social status

Female headed household

43% of all respondents indicated that their households were led by and taken care of by adult and young women.

Work status before displacement

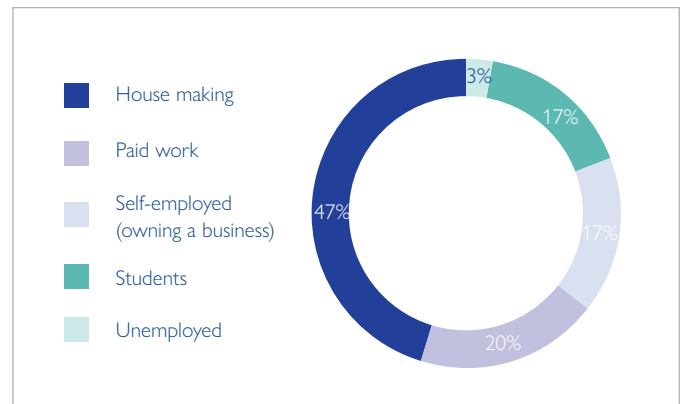


Figure 6. Work status

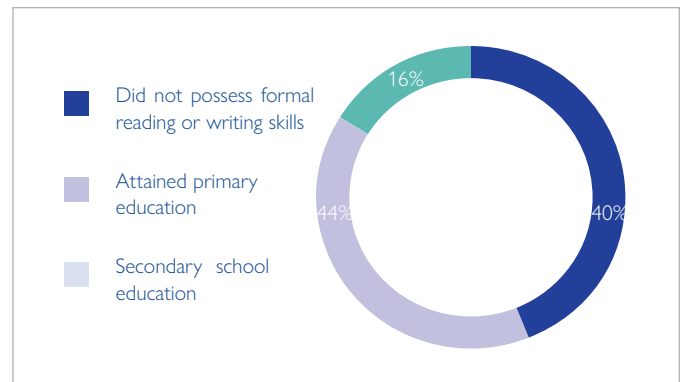


Figure 7. Education

DISTRIBUTION OF DISABILITY STATUS OF HOUSEHOLDS

In this section, the Washington Group Short Set of Questions on Disability (WGSSQs) was used to ensure accurate identification of people with disabilities. WGSSQs cover six domains of function, including walking, seeing, hearing, cognition, self-care, and communication. According to the Guidelines on WGSSQs, “everyone with at least one domain that is coded as ‘a lot of difficulty’ or ‘cannot do it at all’” is included in the disabled population.

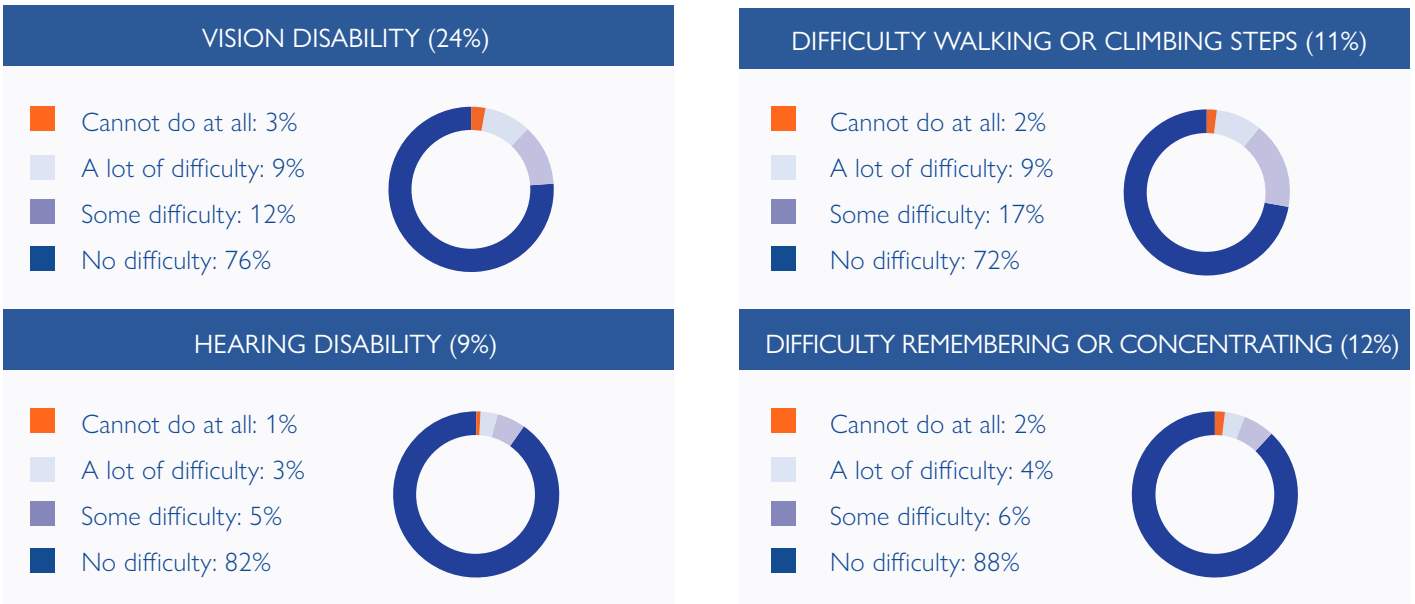


Figure 8. Distribution of disability status

Note: IOM has noticed an increase in persons with disabilities arriving at the J1 center since the most recent wave of returns from Al-Hol Camp.

3.2 LIVING CONDITIONS DURING DISPLACEMENT

The level of threat families faced at Al-Hol:

To measure the level of threat respondents faced at Al-Hol, they were asked to rate the extent to which they have experienced feelings of threat on a scale from 0-5 where 0 indicated not feeling threatened at all and 5 indicated having a very strong feeling of threat.

Individuals who gave either of the responses 4 or 5 (n=67) were further asked for the reasons behind this feeling to understand better the toll of this threat on their mental health wellbeing. The below highlights these reasons, some of which are reiterated with quotations by the respondents:

- Receiving of death threats, fear of harm being done to them and witnessing of violent incidents

“They were threatening to kill my husband, so he left and then they threatened me with the same.” Female adult

“I have seen bodies and babies thrown away in the streets.” Female adult

- Perception of Al-Hol as a detention camp with harsh living conditions, lack of basic needs, medical services, and livelihood opportunities

“Al-Hol camp is a detention camp, not a camp for the displaced.” Male adult

- Receiving threats of and witnessing incidents of individuals being kidnapped within Al-Hol Camp
- Lack of safety and fear of being attacked upon especially at night by unknown security forces
- Fear of unwarranted arrests where they have witnessed arrests taking place randomly and unjustifiably within the camp
- Restriction of movements within the camp due to safety related concerns and in one of the instances, an individual shared that family members had to urinate and/or defecate inside their tent due to the fear of leaving the camp in the evening
- Clashes between different forces within the camp such as Kurdish forces or ISIL affiliated members
- Experiencing incidents where personal belongings were stolen from their tents
- Fear over the safety of the children

“If your child went out you would never know if they will ever come back.” Female youth

- References to sexual exploitation and prostitution²

“I hope no one lives what I have lived or sees what I saw” Female adult

2. IOM did not have enough information regarding whether what the respondents referred to was related to either sexual exploitation or prostitution.

In summary, most of the shared reasons by the respondents revolve around witnessing and/or experiencing immense amounts of violent and traumatic events within Al-Hol Camp.

Priority needs as perceived by the IDPs at J1 center:

To better understand the needs of the IDPs currently residing at J1 and to draw key recommendations within the report, individuals were asked about their perception of the priority needs within the Center.

The following are a summary of these needs in order of the highest in frequency of the responses to the lowest:

- Legal needs such as receiving assistance with documentation and identification cards
- Basic needs such as food, water, sanitation, blankets, baby formula and pacifiers

- Safety and security related needs
- Provision of livelihood opportunities especially focusing on female headed households
- Setting up recreational activities and cultural events
- Provision of health related and medical services
- Financial support
- Provision of psychosocial support
- Reuniting with other family members still present at Al Hol Camp
- Providing educational programs to children and youth
- Setting up a safe place/center for separated and unaccompanied children

3.3 MENTAL HEALTH AND PSYCHOSOCIAL IMPACT OF STRESSORS

Local terms describing stress

To prevent possible misunderstandings that could be brought about using MHPSS related technical jargon in the sections of the assessment concerned with MHPSS needs and resources, respondents were asked about the traditional words they used to describe experiencing psychosocial distress or stressors. Based on the answers received, discussions about psychosocial needs and capacities adopted the same terminology to ensure the cultural adaptation and sensitivity of the MHPSS assessment.

Some of the terms used to describe stress by the respondents are added verbatim to the list:

English	Arabic
Injustice or humiliation.	الظُّيْم (Al-thay-m)
Hopeless	مأيس (Ma-ya-Es)
Distressed	ضايح (Tha-Yej)
Hell	جحيم (Ja-Heem)
Tragedy	مأساة (Ma'a-Sah)
Suffocated	مخنوق (Makh-Noog)
Disaster	المصيبة (Al-Moseeba)
Dark	مظلمة (Mo-thy-ly-ma)

Table 3. Local terms used to describe stress in Arabic and in English

Other terms used were pressure, depressed, stressed, black days, time of hardship, misery, sadness, horror, worry, time of pain.

Causes of stress as perceived by the respondents:

Causes of emotional and psychological distress experienced by the respondents were further explored and the mentioned reasons are ranked in order of the frequency of the responses in a descending manner.

- Traumatic experiences during displacement
- Life in displacement
- Loss of loved ones whether due to death, separation, kidnappings, incarceration or gone missing
- *“My son was killed by armed groups” Female adult*
- Traumatic experiences that took place in the areas of origin due to the ISIL conflict
- Lack of basic services such as food, water, sanitation, shelter and medical services
- Other causes: loss of educational opportunities, loss of sense of safety, feelings of loneliness and helplessness, the stigma experienced having been displaced from Al-Hol Camp.

Impact of expressed causes of stress on mental health:

Experiencing immense stress for prolonged periods of time especially within the context of vulnerable situations such as displacements could lead to the emergence of serious psychological manifestations, let alone if the population of concern is one that has experienced or witnessed a great deal of traumatic and violent events.

For these reasons, individuals participating in the assessment were asked if they have experienced any of the listed feelings, behaviours or thoughts in the two weeks that preceded the time of the interview. This supported the identification of the true MHPSS needs of the respondents and can further inform MHPSS interventions, services, and activities within the J1 center and in areas of origin or of return.

The following findings are of the 71 individuals who responded to having experienced at least one or more of the following manifestations, the remaining 29 reported not experiencing any of the below.

“ We are now very happy to be back, so we don't feel sad or afraid.” Female adult

“People generally feel better after coming back to Iraq from Syria, but they are still angry and nervous after what they have been through.” Female adult

Feelings, thoughts, behaviors experienced in the 2 weeks prior to the assessment:

- Sad, down, depressed: 73%
- Feeling so angry to the extent of feeling out of control 53%
- Have little interest or pleasure in doing things: 49%
- Trouble falling or staying asleep, or sleeping too much: 48%

“It has been almost 2 weeks since I arrived at Jeddah, and I still have not been able to sleep well because of the fear I experienced at Al-Hol at night.” Female adult

- Trouble concentrating on things: 45%
- Poor appetite or overeating: 39%
- Feeling afraid beyond being calmed down: 36%
- Having multiple body pains without a clear medical cause: 28%
- Feeling hopeless to the extent of having thoughts of ending one's life: 7%

With suicide being a complex human phenomenon, it is quite challenging to infer causal or absolute risk factors from the findings of a rapid needs assessment, let alone from a relatively small sample. However, some descriptive characteristics of the 5 individuals who were identified to experience thoughts of ending their lives at the time of the assessment are summarized in the following table:

Gender	Age	Area of Origin	Years in Al-Hol	Marital Status	Psychological symptoms at the time of assessment							
					Anger	Anxiety	Sadness, depression	Loss of interest	Appetite changes	Sleeping problems	Concentration problems	Somatic symptoms
Male	Adult	Ninewa	6	Married	x	x	x	x	x	x	x	x
Male	Youth	Anbar	8	Single	x		x	x	x			
Male	Adult	Anbar	5	Married	x		x	x	x	x	x	x
Female	Adult	Anbar	6	Married	x		x				x	
Female	Adult	Ninewa	6	Married	x	x	x	x	x	x		

Table 4: Descriptive characteristics of respondents with suicidal thoughts

Most of the reported psychological manifestations amongst respondents with suicidal thoughts are feelings of anger and sadness or depression, followed by reported loss of interest or pleasure in doing things and experiencing appetite, sleeping and concentration problems. Additionally, while being married is well known to be a protective social factor against suicide, our findings demonstrate that 4 out of the 5 respondents were

currently married at the time of assessment. This highlights the importance of being mindful of the context at hand while exploring and inferring causal, risk and protective factors of suicide.

The identification of the above characteristics could help flag individuals requiring specialized mental health and psychosocial services early on and improve their mental health wellbeing in the long term.

Impact of expressed causes of stress on daily functioning:

To further explore the psychosocial impact of experiencing stress, respondents were asked on how often they have been unable to carry out their daily activities in the two weeks prior to the assessment. Examples of activities of daily living include carrying out daily tasks, taking care of things at home or of other family members, taking care of oneself and getting along with others. More than half of the respondents (54%) shared that they could not carry out with their daily activities at all. An interesting finding is one that is contrasted with the previous section where, although 29% of respondents reported not experiencing any of the listed psychological manifestations, 100% of the sample had trouble in performing daily tasks in one way or the other which uncovers the hidden impact of experiencing prolonged stressful events.

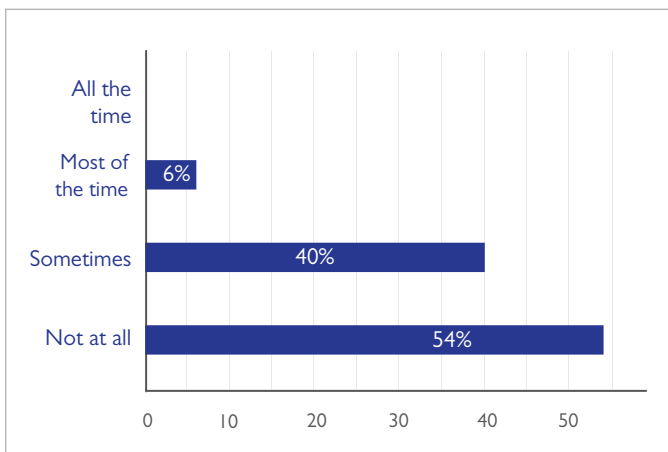


Figure 9: Psychosocial impact on daily functioning

3.4 MENTAL HEALTH AND PSYCHOSOCIAL CAPACITIES AND RESOURCES

One of the main aims that are prioritized when designing or informing community based MHPSS interventions is to build on already available resources within individuals and the communities.

This section is concerned with highlighting the main psychosocial strengths, capacities and resources of the respondents.



Photo 2: Sarah Wilson/IOM Iraq

Coping mechanisms with stressors

Respondents were first asked about how they usually deal with stressors. To avoid possible reporting bias, both positive and unproductive/harmful coping mechanisms were included in the findings. Responses are listed in the table according to their frequency in a descending manner.

Positive coping mechanisms	Unproductive/harmful coping mechanisms
Having patience while trying to adapt to the current situation, trying to find solutions to problems faced and being hopeful about the future	Waiting for things to happen relying solely on faith to improve the situation
Falling back on spiritual beliefs such as praying, reading the Quran, practicing الاستغفار (Al-Es- Tegh-Far) which is a form of a religious practice in Islam	Isolating oneself and preferring to spend time alone with minimal social interactions
Distracting oneself by working around the house	Indulging in distractions such as spending time on the phone aimlessly
Seeking psychosocial support from organizations	Smoking
Emotional release in the form of crying	Taking out feelings of anger and stress on children
Spending time with friends	
Spending time with the family talking, playing with children, taking walks	
Practicing interests such as drawing, writing, playing sports	

Table 2: List of coping mechanisms

“We are generally happy that we are back in our country and seeing NGOs here supporting us is a huge help when we feel down.” Female adult

“I pray and I remind myself that right now we are safe and secure.” Female adult

“When I remember that I have left Al-Hol camp, I can take a break and rest.” Male adult

“I look to those who possess high levels of energy and have a positive attitude to life, so I encourage myself.” Female adult

“I can’t control my anger and I usually take it out at my children.” Female youth

Perceptions of being supported by the family and the community

Community based MHPSS draws heavily on the importance of establishing and strengthening local family and community ties and support. As such the assessment incorporated questions on the perceptions of the respondents on being supported by their families and communities.

i. Family support

The majority of individuals (91%) felt supported by their family members. Females (wives, mothers, sisters, daughters) were predominately mentioned as the principal sources of this support, followed by males (fathers, husbands, sons) and finally other extended family members.

Configurations of support shared by the respondents included mainly forms of psychosocial support such as receiving words of encouragement, talking and spending time together, not being pressured to get things done, sharing personal stories about difficult times and how to deal with them, and not being left alone when feeling distressed.

Other forms of support included being provided with financial assistance, opportunities to work and helping each other with family-related matters.

“Due to what we have experienced from fear and other things, we learned to stick together and support each other.”
Female youth

“ I was staying with my relative, so we were supporting each other.” Female adult

The remaining 9% of the respondents reported that although they would need family support, they are not seeking it, being mindful of the fact that their family members themselves need assistance and support.

ii. Community support

On the other hand, 66% of the respondents felt supported by members of their community, mainly neighbors and friends. The forms of support expressed reflect the importance of promoting community-based psychosocial support. Examples of this include talking with others, sharing experiences and spending time with each other in times of stress.

“We sometimes share some updates of our lives with each other.”
Female adult

“We share with each other our hopes and emotions.” Female adult

Some of the remaining 34% of the respondents mentioned that other community members do not have the capacity or resources to support other people since they need to be supported first and the rest expressed that they have recently arrived at the center and did not yet know anyone.

“I’m new in the camp and I don’t have any relationships at the moment.” Male youth



Photo 3: Anjam Rasool/IOM Iraq

3.5 MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

In order to explore further the MHPSS needs of the residents at J1 center, they were asked about their perceptions on the main psychosocial issues that need to be addressed in the community.

The following are the responses arranged in a descending order according to the frequency of the responses in the assessment:

- Awareness sessions on different mental health and psychosocial topics such as dealing with stress with a special focus on returnees, caregivers' skills support, substance abuse, family violence.
- Providing life skills and vocational skills training courses. Mentioned examples include practicing sewing, knitting and embroidery, computer skills, carpentry, sweets making and baking, barbering.
- Providing safe spaces to share experiences with each other through arts and sports activities (with a focus on providing sports activities to females).
- Group sessions on dealing with emotions of fear, stress and anger.
- Supporting children's mental health and wellbeing.
- Integrating awareness on mental health within arts, cultural and sports activities.

"People have psychological difficulties but they are unable to identify and understand it" Female Youth

"We need to feel relaxed after going through all those traumatic events for the past 10 years until now." Female adult

"Provide psychological support to the new arrivals as they are extremely overwhelmed because of their experiences." Female Youth

"Linking people with what they were doing before so they feel alive again and they feel safe again." Female adult

Other issues shared by them:

- Awareness sessions on sexual harassment
- Providing livelihood opportunities.
- Dealing with radical and violent thoughts.
- Family reunification with family members still in Al Hol Camp.
- Supporting children who have dropped out of or were not enrolled in school.
- Working on strengthening social ties and promoting nonviolence within communities in return areas.

- Facilitating family visits.
- Awareness sessions to men on women's rights.
- Tribal and clan awareness sessions for the elders of the community.
- Setting up orphanages or centers for separated and unaccompanied children.

"Bringing together people with different backgrounds so there will be better understanding between them." Female adult

"Prepare people to go back to their home after being away for a long time." Female Youth

"People who got separated need to get back to their families." Female Youth

"I don't want anything; I just want to reunite with my family still residing at Al-Hol camp." Male adult

3.6 RESPONDENTS' CONCERNS AND ASPIRATIONS FOR THEIR LIVES AFTER RETURN

Concerns upon returning

After exploring the respondents' MHPSS needs, resources and capacities, they were asked about the main concerns they have regarding their departures to their areas of return.

Not being well received, respected or accepted by the receiving community was the main concern, followed by the lack of legal documentation and not having a place to live in when they arrive. Other concerns mentioned were facing financial constraints and a lack of job opportunities.

"We have to ask if it is safe to go back and we are also not sure if we want to go back after all that has happened there." Female adult

Aspirations upon returning

To conclude the assessment on a positive note and to rekindle the respondents' hope for the future, they were asked about the aspirations that they have for themselves and for their families upon their arrival at areas of return.

Most of the respondents expressed their wish to return and recommence their lives in their areas of origin, settling and reuniting with their families, and living peacefully within their communities. Responses also included setting up and reopening private businesses and to pursue educational opportunities whether within Iraq or out of the country.

"I wish my children will not see what we have been through in future." Female adult

4. KEY FINDINGS AND RECOMMENDATIONS

The main purpose of this assessment is to inform the strategic approaches and the design of concrete community based MHPSS services at J1 and subsequently in areas of return. This section summarizes the key findings produced from this report with corresponding recommendations.

KEY FINDINGS	RECOMMENDATIONS
Psychological and psychosocial needs	
<ul style="list-style-type: none"> • Emotional distress is the outcome of an interplay of a multitude of factors including experiencing traumatic events prior to and during the displacement at Al Hol, the loss of loved ones, a lack of basic services and the sense of safety. • The most common psychological manifestations encountered are having feelings of sadness, anger, loss of interest, sleeping and appetite problems. • Suicidal thoughts have been identified in 5 of the respondents who were also experiencing a range of other psychosocial symptoms. • Isolating oneself and refraining from social interactions is identified as one of the unproductive coping mechanisms applied. • Learning practical skills on how to effectively deal with children is identified as one of the needs by respondents who are caretakers. • Lack of a safe space for separated and unaccompanied children stands out as a key need. • Other needs identified are requiring assistance with legal documentation, provision of basic needs, medical services, reuniting with other family members still present at Al Hol, provision of educational programs to children and youth. 	<ul style="list-style-type: none"> • Provide both specialized and focused non-specialized MHPSS services as well as psychological first aid for already present center residents and new arrivals. • Address reported mental health challenges, such as intense sadness and grief, emotions of fear, anger and grief through individual and group counselling. • Develop and disseminate MHPSS-related information, education, and communication materials on stress responses and maintaining self-care following distressing events. • Conduct awareness raising sessions on suicide prevention to for the early identification of suicidal thoughts, and to provide information on how and where to seek immediate MHPSS. • Develop and disseminate suicide prevention sessions and referral SOPs to other divisions within IOM and other MHPSS implementing partners in J1. • Provide MHPSS service orientation awareness sessions to J1 center residents during their stay and upon their departure to their areas of return. • Strengthen social ties within the J1 center through conducting MHPSS integrated cultural, art and sports activities. • Roll out PSS sessions to caretakers within the center on supporting caregivers' skills to help them with effectively dealing with children and youth. • Work with relevant actors that implement MHPSS and protection services for children in J1 center while emphasizing to protection actors the needs to closely followup cases of separated and unaccompanied children and to advocate for their reunification with their family members to mitigate relevant protection risks. • Reinforce links between MHPSS and Livelihoods programming to provide community members the access to livelihood and become economically self-reliant with a focus on supporting female headed households. • Reinforce referral mechanisms to relevant IOM divisions and other NGOs to provide assistance with other non MHPSS needs.

MHPSS capacities and resources	
<ul style="list-style-type: none"> • Having patience and practicing problem solving skills are identified as the most adopted positive coping mechanisms. • Falling back on spiritual beliefs and religious practices are identified as the second most used positive coping mechanism. • Social and interpersonal support received through personal relationships, especially from supportive family members, friends and neighbors are identified as the main resources of social support. • Emotional support provided by family members in the form of words of encouragement and sharing personal experiences in times of stress is identified as the main source of perceived support by family members. 	<ul style="list-style-type: none"> • Reinforce the importance of and disseminate practical skills on having patience, adapting to stressful situations, and problem solving through outreach and group MHPSS awareness sessions. • Set up community based MHPSS activities to help connect and integrate new arrivals at the center with individuals already residing there. • Establish/increase spaces to create peaceful and inclusive atmospheres for community members to gather and engage in activities together. • Facilitate peer support groups that are sensitive to age and gender may set up a forum for adults and adolescents to share experiences and positive coping strategies. This will also contribute to the sense of cohesion and belonging in the community.
MHPSS considerations for reintegration in areas of return	
<ul style="list-style-type: none"> • Assessment respondents cited fears of being stigmatized, discriminated against, and/or refused by the receiving community upon their return • Uncertainty on where the returnees will live upon arrival in areas of return has been identified as a main stressor 	<ul style="list-style-type: none"> • Collaborate with and mobilize local leaders (tribal, community and religious) to promote community acceptance of the returnees. • Train local leaders (tribal, community and religious) on psychosocial stressors that the returnees might face during and after their return and throughout reintegration. Training should include psychological first aid, suicide prevention and safe referral mechanisms. • Disseminate MHPSS services information brochures to J1 camp residents before their departure to their areas of return so that they are informed on how to reach to IOM (and other) MHPSS services when required in return areas. • Reach out to relevant governmental actors to advocate for the provision of more information on the housing plans for returnees before their departure from the J1 center to alleviate stressors as much as possible.

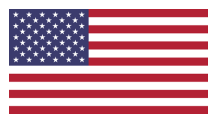
Table 5: Key findings and Recommendations

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