

Mental health literacy of internally displaced Iraqi young people and their parents in Iraq: paving the way for mental health education and promotion in vulnerable communities.

Survey Based Study Protocol

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**Proposal Information**

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Leylan 3 IDP camp, Daquaq District, Kirkuk Governorate, Iraq

Jalawla town, Khanaquin District, Diyala Governorate, Iraq.

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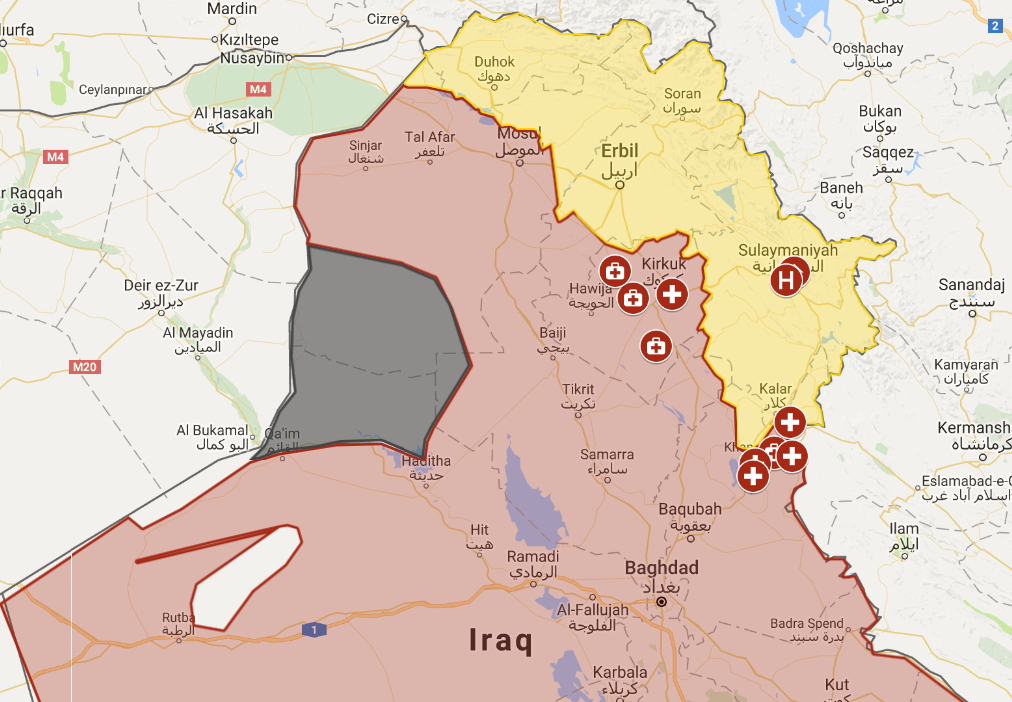
1. **List of abbreviations**

|  |  |
| --- | --- |
| CI | Confidence Interval |
| DoH | Directorate of Health |
| EUR | Euro |
| GIS | Geographic Information System |
| GPS | Global positioning system |
| IBM SPSS | Statistical Package for the Social Sciences |
| IDP | Internally displaced population |
| IED | Improvised explosive device |
| IOM | International organization for migration |
| IQD | Iraqi Dinar |
| ISF | Iraqi security forces |
| ISIL | Islamic state of Iraq and the Levant |
| IT | Information Technology |
| MdM | Médecins du Monde |
| MedCo | Medical coordinator |
| MFQ | Mood & Feelings Questionnaire |
| MHAM | Mental Health Activity Manager |
| MHL | Mental Health Literacy |
| MSF | Médecins Sans Frontières |
| MTL | Medical team leader |
| OCA | Operational centre Amsterdam |
| PHC | Primary Healthcare Clinics |
| PI | Principle Investigator |
| PMF | Popular mobilization forces |
| PTSD | Posttraumatic Stress Disorder |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |

1. **Background**
   1. Context

Iraqi society today has been shaped by a recent history of political repression, punctuated by wars, episodic violence, and internecine conflict during which basic service provision and institutional capacity diminished. Iraq continues to experience pervasive levels of violence and displacement with no end in sight. The country is undergoing a massive humanitarian crisis compounded by an uneven emergency response and critical access constraints hampering the delivery of assistance to millions of civilians in a violent environment (1, 2). As of 02 March 2017, there were 3,062,808 internally displaced persons (510,468 families) displaced after January 2014, dispersed across 106 districts and 3,660 locations in Iraq (3).

Map 1: MSF OCA Project Locations



Kirkuk Governorate

Kirkuk governorate hosts an estimated 380,412 IDPS with a 4% increase (9,216 individuals) from February to March 2017 as a result of the ongoing military operations in Al Hawija district. The displacement caused by the military operations affected not only Kirkuk, but also neighbouring governorates. According to the International Organisation for Migration Displacement Tracking Matrix, as of 6 March 2017 the total number of IDPs from Al Hawija (monitored from the beginning of August 2016) stands at 88,950 individuals. The majority of IDPs from Al Hawija are currently displaced in Kirkuk, Salah al-Din and Erbil governorates. As of April 13, 2017, there are 6 IDP camps within Kirkuk (42,541 Iraqi IDPs) of which 5 (Yahyawa – 3,758; Nasarawa – 9,300; Leylan 1 – 10,998; Leylan 2 – 4,607; Leylan 3 – 3,822) are 20km south east & 1 (Daquaq – 9,631) is 44km south of Kirkuk city (15 km east of the IS-Peshmerga/ISF/PMF front line ).

Daquaq camp opened in early October 2016 and is commonly referred to as the ‘Hawija camp’. The camp population are confined without identification or means to leave the camp. Some of them are accused of having links with ISIL but the main reason seems to be to avoid more IDPs in the host community which can change the demography of the city. Daquaq camp has reached maximum capacity and is now using the so-called emergency tents; the camp was forced to open prematurely before any permanent health services were in place. MSF took over the MdM mental health service in January 2017. For urgent psychiatric referrals people can be referred to Daquaq Hospital (if they are able to negotiate their exit). Non-emergency referrals for secondary and tertiary care are uncertain and very restricted.

Leylan 3 started to receive IDP’s in Feb 2017, at that time the camp already contained 2500 tents and a population of 640 families (3553 individuals), meaning that 25.6% of its capacity was full. In March 2017 the population was 3822 people. The families living here arrived from Maktab Khalid, Salah Al-Din (few) & Debes reception centres.

Prior to the conflict Hawija town had a population of about 100,000 inhabitants. During ISIL occupation, Hawija’s residents suffered severe shortages of critical supplies, including food, water, and medicine, resulting in many of the town's residents have fled into the camps. ISIL-occupied Hawija became isolated from the rest of ISIL's territory in July 2016 during the Battle of Mosul. Hawija was ISIL’s last enclave in central Iraq; however on September 21, 2017, Iraqi Prime Minister announced an offensive to reclaim the city and it was liberated from ISIS by October 4, 2017. Since the fall of Hawija in October 2017 the population is already moving out of the camps and back to their homes hence it is not possible to know even if the camps will still be populated in a few months’ time. Previously it was thought that Hawija had a population of approx. 100,000 people. There are currently no accurate figures on the population demographic because of the regular movement of people back from the camps, with some being forced to move back to camps after arrival due to tensions, arbitrary rest and ongoing insecurity in the area.

Diyala Governorate

The IOM DTM estimates the displaced population in Diyala at 9,834 families (59,004 individuals based on an average household size of six), with 88% of IDPs in Diyala were from elsewhere in the

Governorate. People displaced with the arrival of ISIL in 2014, which lead to the establishment of numerous camps, where people have been living for a number of years. In Alwand 1 the current population is 3166 individuals and in Alwand 2: 1252 individuals (December 2017).

In recent years the security dynamic has been stable in the contested areas of Khanaquin (KRG), Jalawla (KRG) and Sadiya (Iraq) facilitating access for the return of IDP’s. However, as remaining IS areas (Ninawa/Mosul) are liberated sectarian conflict between Sunni/Shia, political sectarianism (Shia dominated government marginalizing Sunni’s) and conflict between Kurdistan/Iraq (between Shia militias and Peshmerga) have been exacerbated due to power struggles for territory, ethnic repatriation and resources. The sectarian conflict (between Shia and Sunni) continues, manifesting in IED attacks by IS affiliated groups (former Al-Qaeda) on Shia populations/militias; leading to indiscriminate retaliation attacks (abductions, IED’s, Mortars, arbitrary arrests) by Shia militias on Sunni populations accused of supporting IS affiliated groups. Additionally, internal conflict within Shia militias has started to escalate due to a power struggle for the control of Diyala. The populations of Sadiya and Jalawla have started returning home in 2017 with the current population being Jalawla: 76 800 and Sadiya: 15 000 people (December 2017).

2.2 Mental health in Iraq

According to a 2007 World Health Organization (WHO) study, the last reliable healthcare survey conducted in the country, mental health disorders [were the fourth leading cause](https://www.msf.org/sites/msf.org/files/english_iraq_mental_health_final_report.pdf) of ill health in Iraqis over the age of five years (4). Populations affected by situations of unrest, violence, loss, separation, and drastic changes in social and living conditions, are likely to experience a number of distressing psychological reactions such as hopelessness, helplessness, anxiety, as well as behavioral and social problems (5).

A 2010 survey of public opinion regarding mental health, conducted jointly by the Iraqi Ministry of Health and International Medical Corporation, outlined this challenge (6). Approximately 60% of respondents agreed with the statement that “mental illness is caused by brain disease,” 65% declared that psychological problems were borne of “personal weakness,” and 80% affirmed that people with mental health problems are largely to blame for their condition. On the other hand, approximately 65% agreed that “mental illness was caused by something bad happening to you”. Highlighting the stigma many Iraqis suffering from mental illness experience, only one-fifth of respondents said they would marry a person with unmet mental health needs, and over half declared that they would feel ashamed if a family member suffered from mental illness. These data also indicated a general lack of awareness regarding mental health treatment options and illness among the general population. Just 15% of respondents felt that Primary Healthcare Clinics (PHCs) provide adequate information to patients regarding psychological and psychiatric care, and 14% thought they could receive adequate care for mental illness at their local PHC. Only half of those surveyed believed mental illness was curable. This survey showed that whilst respondents views on the aetiology of mental illness was broadly compatible with scientific evidence, understanding of the nature of mental illness, its implications for social participation and management remains negative in general (6).

The upheaval to which many Iraqis have been subjected since ISIS’s advance in summer 2014 has reshaped the dynamics and etiology of mental illness and care. Results from the 2010 public opinion survey presaged this development, indicating that two-thirds of respondents “felt comfortable discussing intimate psychological problems with a physician (6)” After 2014, the dissolution of familial and local support networks through mass displacement has forced many individuals to seek alternative sources of comfort, regardless of associated stigma. Psychologists working in displacement camps across northern Iraq reported a sharp increase in the number of individuals seeking mental healthcare a trend that is especially pronounced for women (7).

Numerous studies confirm the traumatic experiences and consequent trauma related disorders amongst people fleeing Iraq [18, 19, 20]. One such study, focused on Iraqi refugees residing in Sydney, found that almost half of participants reported the unnatural death (47%) or murder (46.7%) of a member of their family or a friend, 41% had experienced being close to death, and almost 40% had suffered a lack of food or water [18].

2.3 Mental Health Literacy

Although poorly understood, factors such as cultural beliefs regarding the nature and treatment of mental illness, lack of insight, limited understanding of treatment options, and a lack of knowledge regarding risk factors for and causes of mental disorders have all been postulated to impede early and appropriate mental health service use (8). Mental health is a socially constructed and socially defined concept in that each society, group (class, gender, ethnicity, and age), culture, religion, institution and profession has different ways of conceptualizing its nature and causes. This can include determining what is considered mentally healthy, how people experience and express suffering, how they explain illness and misfortune, and deciding what interventions, if any, are appropriate (9). If people perceive the origins of psychological distress as somatic they will usually expect their treatment to follow medical lines and may not present at mental health services. Therefore, in order to devise an effective mental health promotion campaign, assessing the public’s knowledge and prevailing attitude towards mental health as well as sources of support and coping, and how these are changing as a result of conflict and displacement would be the prerequisites. As many of the previously-published studies were conducted in the West, it is important to understand and explore clients’ cultural idioms of distress (common modes of expressing distress within a culture or community) and explanatory models (the ways that people explain and make sense of their symptoms or illness), which influence their expectations and coping strategies.

2.4 Consequences of war and conflict on children

Research on the consequences of war and conflict on the mental health and development

of children has greatly increased in the last decade (29, 30).The majority of children exposed to armed conflict show signs of mental health difficulties (31,32). A systematic review of child mental health in ongoing or post war situations revealed elevated levels of posttraumatic stress disorder (PTSD) (47%; 17 studies), depression (43%; four studies)(22), Other studies have shown that children exposed to war are also at high risk of developing various types of psychopathology (33, 34).

Extreme adversity in early childhood can hamper children’s healthy development and their ability

to function fully, even once the violence has ceased. However, these impacts are not inevitable and, if children have supportive relationships with caring adults early in their lives, the damaging

effects can be reversed (21).

A youth consultation in Iraq in 2015 showed that children in protracted displacement face a variety of hardships such as isolation, insecurity, psychological distress, extended disruption of education, heightened protection risks, exploitative working conditions, desperation and hopelessness. Over one year into their displacement feelings of hopelessness were already pervasive amongst youth with the majority saying that they saw no future as internally displaced people in Iraq. They reported that violence had spread to all aspects of their lives and severely constrained their access to school and general freedom. They talked about key issues such as sexual abuse and harassment, rumors of kidnapping and killing of children, physical punishment at home and at school and harmful child labor. Girls were identified as a particularly vulnerable group due to the crisis’ exacerbation of existing harmful cultural norms, putting adolescent girls at risk from gender-based violence such as harassment, sexual violence and child marriage. Moreover, girls talked about isolation as contributing to depression because of their physical confinement to their tents or houses due to concerns for their safety (27).

In 2017 Save the Children undertook research on children’s mental health in Iraq since the beginning of the most recent crisis in 2014 that aimed to highlight and explore the impact of the conflict and displacement on the mental health of displaced children and youth (25). The findings show that children are experiencing very different mental health issues depending on whether they fled ISIS early on or stayed and lived under ISIS control for several years. For parents and children who lived under ISIS for a short period of time and are currently in prolonged displacement mental health has been relatively protected from the negative impact of war and displacement (25). Children in protracted displacement benefit from the protective factor of being with parents who were able to support them in times of insecurity. Although parents were showing signs of distress, particularly due to financial issues, they gave the impression of coping with their own stress and serving as positive role models to their children. After successive crises, Iraq has become a nation of survivors and parents may be experiencing post-traumatic growth, although it may be that the results highlight the normalization of violence and insecurity. Children surveyed potentially suppressed or denied the impact of their traumatic experiences and stress as a coping mechanism (25). Whilst in the study children scored relatively low for post-traumatic stress disorder symptoms, and children and adolescents rated themselves as not facing issues associated with distress or social impairment their parents were worried about their mental health. 94% of parents believing that the conflict had affected the daily life of children and adolescents with 84% responding it affected them “a lot”. They saw the children as beginning to have moderate problems, particularly around the emotions displayed, as well as some increases in bedwetting (19%). More than half saw an increase in children’s fearfulness or nervousness, symptoms often associated with post-traumatic stress disorder (25).

Key findings from the focus group discussions with children recently displaced by the Mosul offensive whom were living in ISIS-controlled areas for almost three years found that children were witnesses to daily acts of severe violence. Those who fled from the recent Mosul offensive continue to live in constant fear of punishment and fear for their own lives and their families. Almost 80% of adolescents said they feel shocked and afraid by attacks from ISIS. Many children, despite knowing that they are now out of reach of ISIS inside a camp, still fear violent attacks from the armed group and have nightmares that are so vivid that they haunt them during the day. Around 90% of children surveyed expressed feeling upset due to the loss of a relative and 45% shared lengthy stories of violent deaths of loved ones. Their parents are dealing with their own mental health issues and are struggling to provide comfort to their children. Children mentioned domestic violence as much as the loss of loved ones as a source of distress and children themselves became more aggressive in response to a violent environment (25).

An assessment conducted in the Kurdistan region of Iraq (KRI) in 2016 reported behavior changes

in 76% of children, with unusual crying and screaming cited as the most common behavior, followed by sadness, nightmares and violence (28). Staff interviewed reported that children were in an initial state of shock when they arrived at their new settlements due in particular to the poor shelter conditions. They noted that children were particularly hyperactive, isolated, introverted, aggressive and not inclined to play. With time, this state of shock transformed into frustration, boredom, tensions and an increase in negative coping mechanisms such as drinking alcohol, smoking, and in extreme cases attempts to commit suicide. They also noticed that parents were showing signs of stress due to their inability to provide their children with decent shelter and meet financial needs, which translated into neglect and domestic violence (28).

Children need mental health and psychosocial support to improve their wellbeing in both the immediate term and for years to come. With support, and in a safe environment, children who have gone through trauma can recover (26). Research into PTSD among communities in post-conflict countries such as Afghanistan (30) has shown that even after several years in conflict zones, behavioural therapy and support can significantly reduce symptoms. For this reason, this research will focus on children (defined as 8-12 years in this study), their parents and young people (13 to 17 years).

Whilst the needs have been identified there is however no existing research examining the Mental Health Literacy of Iraqis within Iraq or displaced to neighbouring countries who represent a wide diversity of social, socioeconomic, ethnic, and religious backgrounds among the population. The aim is to use the survey to assess the attitudes of key study populations in the project locations and use the knowledge and understanding of these local conceptualisations to allow better development of appropriate services and enable the design of interventions that mobilise individual and collective strengths, and resilience.

2.5 Current mental health services offered by MSF-OCA in northern Iraq

MSF currently runs mental health activities in both Daquaq Camp, Kirkuk and in 3 camps and 2 health facilities around Khanaquin. In Daquaq camp in January 2017 MSF started running mental health activities providing psychoeducation and as well as individual counseling, for adults and children. The focus of the mental health activities is to support mental health related to traumatic events and displacement, The plan for 2018 is to increase the counseling activities, both individual and groups, for children and adults, following the movement of the population.

In Diyala Governorate MSF is working in 2 camps (Alwand 1 & Alwand 2) providing psychoeducation and psychosocial activities as well as individual and group counseling for adults and children. The team is providing similar activities in the health centres supported by MSF in both Sadiya and Jalawla. The focus of the mental health activities is to support mental health related to traumatic events and displacement, as well as patients with non-communicable diseases and sexual and reproductive health patients. The plan for 2018 is to increase the counseling activities, both individual and groups, for children and adults, within the health centre and in a community location in towns, if security allows.

Due to the defeat of ISIS in Hawija in October 2017, and the change of context, at this time it is not possible to know even if the camps will still be populated in a few months’ time given that the government is encouraging the population to return home. MSF is currently reviewing its operations in line with the movements of the population and so if the population moves back then it is likely that MSF will shift the focus its activities to these location. If this is the case then it is proposed that the research will take place in these locations.

1. **Justification**

Displaced people, and in particular the young, are a particularly vulnerable group. They have very high levels of mental health problems, such as, trauma-related disorders, but traditionally a very low uptake of mental health care. Whilst this is changing, evidence suggests that poor “mental health literacy”, namely, poor knowledge and understanding of the nature and treatment of mental health problems is a major factor in low or inappropriate treatment-seeking among individuals with mental health problems. Hence, worldwide there have been efforts to identify specific aspects of mental health literacy likely to be problematic in different demographic subgroups and to use this information to develop mental health promotion programs.

The term “mental health literacy” (MHL) was introduced by Jorm and colleagues (10) as an extension of the concept of “health literacy”. It is defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (10). By measuring and quantifying levels of MHL, mental health promotion programs can be developed with intention empower individuals in need of mental health care with the means by which to make an informed decision about accessing this care (11).

The most relevant previous work was undertaken by Dr Slewa-Younan who investigated the MHL of two of the largest populations of refugees being resettled in Australia, namely, those from Iraq and Afghanistan [12, 23, 24]. In this research, adult participants were presented with culturally adapted vignettes of fictional characters, resettled refugees experiencing symptoms of PTSD and asked to give their opinions about a range of issues concerning the nature and treatment of the problem described, such as problem recognition, beliefs about the helpfulness of different possible treatment providers and perceived barriers to treatment. Findings from this study found that approximately 52% of the Iraqi participants selected ‘experiencing a traumatic event’ as the ‘most likely’ cause and 34.4% identified being ‘born in war torn country’ as the most likely risk for developing PTSD However, in regard to the key aspects of mental health literacy, such as awareness of the symptoms of PTSD and beliefs about treatments likely to be helpful, were found to be problematic for those populations [12, 23, 24]. Participant’s beliefs were found to vary as a function of participants’ demographic characteristics, such as their level of education and the time since resettlement.

Whilst the 2010 survey of public opinion (6) regarding mental health it is a good start the findings are a more broad measure of attitudes, is not specific to disorders and is not able to assess recognition, which is an essential skill for MHL. The proposed survey is able to assess knowledge specifically related to PTSD / Depression, which is needed to develop a MH promotion program for Iraqi displaced people. This study also focused on adults and was conducted prior to the recent upheaval due to ISIS, hence the proposed survey that instead focus on children and adolescents to gain an understanding of their current needs. Therefore, the aim of this project is to utilise an appropriately modified version of Dr Slewa-Younan et al MHL survey, to investigate levels of MHL of displaced adolescents and parents of young children in the project locations and use the knowledge and understanding of these local conceptualisations to allow better development of appropriate services and enable the design of interventions that mobilise individual and collective strengths, and resilience. Importantly, this lack of information is hindering the development of mental health promotion programs and the goal of this study is to redress this situation.

1. **Objectives** 
   1. Primary objectives

To determine levels of MHL relating to trauma related mental health disorders, namely posttraumatic stress disorder (PTSD) and depression among the displaced Iraqi young people in northern Iraq (see study population).

* 1. Specific objectives

1. To estimate MHL relating to PTSD (and Depression) in a group of displaced Iraqi young people (13-17 years old) and the parents of children (8-12 years old) pertaining to:
2. Problem recognition (including “self-recognition”)
3. Beliefs about the severity of the problem described and its prevalence in the target population
4. Beliefs about causes and risk factors
5. Beliefs about how best to support someone with PTSD/depression
6. Beliefs about the helpfulness of specific treatments and treatment providers
7. Beliefs about likely outcome with and without treatment
8. Beliefs about possible barriers to treatment
9. Stigma and perceived discrimination towards someone with PTSD/depression
10. To determine associations between specific aspects of MHL as outlined above, and individuals’ demographic characteristics (age, gender, religion, ethnicity, lengthen of displacement etc.) and symptom levels.
11. To estimate the prevalence of mental health distress (major depression, anxiety disorders or suicidality ) using the Self Reporting Questionnaire (SRQ-20) in care takers of children 8-12 years old;
12. To estimate the prevalence of constructs of intrusion, avoidance and arousal in children 8-17 years of age in the study population;
13. To estimate the prevalence of self-reported depression in children 8-17 years old.

The categories specified in objective 1 above were chosen because they were considered to be the aspects of MHL most likely to be of interest in informing the determinants of mental health in the proposed population. Objective 2 which seeks to examine the associations between specific aspects of MHL and individuals’ demographic characteristics and symptoms levels is important because associations of this kind can indicate specific targets for health promotion programs.

**5. Methodology**

5.1. Study design and area

Due to the changing security and context situation in Syria, it is not possible in advance to confirm exactly where the survey will take place, hence all possible locations are listed. We will aim to conduct the survey in the locations as described below; however, it is possible that certain locations will be considered off-limits at the last moment due to security concerns.

MHL relating to trauma related mental health disorders, namely posttraumatic stress disorder (PTSD) will be conducted with the population in Daquaq camp and Hawija town, in Kirkuk Governorate. The PTSD vignette will be completed with this population as they were living under ISIL control for several years, fleeing with the escalation of violence in 2017 so are likely to have experienced significant violence and hence be more susceptible to PTSD.

MHL relating to depression will be conducted with the population in Jalawla town and if this is not possible then in Alwand 1 & 2 camps, Diyala Governorate, Iraq. The Depression vignette will be completed with this population as the majority has been living without direct violence for some time but are more susceptible to depression due to living with uncertainty and in difficult living conditions for a number of years.

In all locations where we are able to implement the survey, it will be population based and cross sectional using simple random sampling.

5.2. Study Population

The study population includes young people between the ages of 8-17 divided into 2 groups. For the first group (Group 1) we will aim to interview the parents/caretakers of those persons 8-12 years old with regards to their (the caretaker’s/parent’s) knowledge and attitudes (i.e. levels of MHL) relating to trauma related mental health disorders among their children.

For the second group (Group 2) which will include persons aged 13-17 years old, we will question them directly in order to determine their own levels of MHL relating to trauma related mental health disorders.

5.3. Eligibility criteria

General inclusion criteria:

A person will be included in the survey if he / she satisfy the following criteria:

* Currently living in the randomly selected household

AND

* Informed consent for inclusion in the survey is provided by the head of the household and the person participating (the parent, if not the head of the household and the adolescent).

Inclusion criteria Group 1: (parents/caretakers of children aged 8-12 years old):

1. A child must be residing in the household that meets the age criteria

2. In cases of households with multiple children aged 8 to 12 years, responses will be recorded from the parent/caregiver pertaining to a randomly selected child in the target age group.

Inclusion criteria For Group 2 (adolescents aged 13-17years)

1. An adolescent must be residing in the household that meets the age criteria

2. In cases of households with multiple adolescents aged 13-17 years, responses will be recorded from a randomly selected adolescent in that household.

In the case where there are both adolescents and children in one household, only one from each group will be surveyed and will be selected as outlined above. That means only a maximum of two surveys will be collected from each household.

Exclusion criteria:

A person will be excluded from the survey if he / she satisfy any one of the following criteria:

* Inability to locate the potential participant after two attempts of tracing

OR

* Refusal to participate in the survey.

5.4. Definitions

A household is defined as a group of people who live together under the same roof and are under the responsibility of one person (head of household). A head of household is defined as:

• The person accepted as the head by the other members of the household, and

• can give consent for the person identified for the survey to participate and

A household will be excluded from the survey if none of the household members fulfill all these criteria

5.5. Sample size

Sample size requirements were based on the need to ensure sufficient completed surveys to permit analysis of associations between specific aspects of MHL, demographic variables and symptom status. In the absence of data on the proportion of participants giving responses to the MHL survey that could be considered to be indicative of “good mental health literacy”, sample size calculations assumed a 50% proportion, for this indicator in order to provide the largest sample size that will potentially be required. The below calculated sample size estimates would be for each location in which we are able to conduct the study.

Thus, in order to estimate a 50% prevalence of “good mental health literacy” with a precision of 8% and an alpha of 0.05, a minimum of 150 completed interviews will be required in each of the two target groups (Group 1 and Group 2). With this sample size, the study will also have 80% power to detect a medium effect size of between 0.23 to 0.27 using 1 to 3 degrees of freedom Chi-square test of associations between key demographic variables, symptom levels and specific aspects of MHL.

Based on recent data from a health access survey that was conducted in Ein Issa and Menbij camps in northern Syria (MSF, unpublished data, August 2017), the average household size in these locations was between 6.38 and 6.66 persons. Of these, 20.5-22.4% (equating to approximately 1.6 children per household) of total household members include children 8-12 years and 11.1-12.3% are adolescents aged 13-17 years (equating to approximately 0.8 persons per household). It is assumed that the population make up in Iraq is similar.

Taking into account this known data, we would need to approach the following number of households per group to achieve required number of (n=150 per group):

• Group 1, we would need approach 240 households (1.6 children 8-12 years per household) with non-response rate of 40% to achieve desired sample size of 150.

• Group 2 we would need approach 282 households (0.8 adolescents 13-17 years per household) with non-response rate of 40% to achieve desired sample size of 150.

As members of group 1 and 2 may reside in the same household, it is possible that the true number of households need to be approach may be lower.

5.6. Sampling and recruitment strategy

We will aim to sample all study participants from Group 1 and Group 2 from households that are randomly selected in the study site. Thus there will be two stages of sampling where the first stage includes simple random sampling of potential participating households and a second stage of sampling within the household to identify study participants for Group 1 and Group 2.

For the first sampling stage, as the precise locations of the study sites is yet to be determined we foresee two possibilities for the simple random sampling of households. These are shown below as option 1 and option 2.

**Option 1: Random selection from household list method**

This option may be used if a current and comprehensive household list for the study is available. Random numbers (between 1 and the total number of households in the study site) are generated to obtain the target sample size of (maximum) 282 households is achieved. Only these households will be visited.

**Option 2: GPS-based sampling method**

This option may be used if a current household list is not available. Using satellite imagery or conducting a perimeter walk around the study site, an electronic outline of the camp will be created. GIS software will be used to generate random points within the study site corresponding to the number of households to be visited. Teams using either GPS machines or Android phones with GPS localization functionality will visit the households that coincide exactly with the randomly-generated points (this is to reduce any potential bias due to households in less built-up areas being more likely to be selected than households in densely populated areas). So in fact surplus random points will be generated to allow for events in which households do not coincide with GPS points.

For the second stage of sampling we will make a list of all the persons in the household that meet the eligibility criteria for group 1 and group 2 separately. A participant will be randomly selected from these two lists and asked to participate in the study. Random selection will be done by choosing a random number between 1 and the maximum number of household’s members in that household within that group using a random number table. With this second stage sampling approach it is possible that two participants (one from each group) are selected in a single household.

**6. Survey Instruments:**

Below are tables that articulate what survey instruments are completed by whom:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PTSD MHL Literacy Study | Mental Health literacy Survey on PTSD in child / adolescent | Self-Reporting questionnaire (SRQ) | CRIES-13 | Annex |
| Group 1 (child 8-12 years and parent pair) |  |  |  |  |
| Child |  |  | √ | Annex 2 |
| Parent | √ | √ | √ (parent version) | Annex 3 |
| Group 2 (13-17 years) |  |  |  |  |
| Adolescent | √ |  | √ | Annex 4 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Depression MHL Literacy Study | Mental Health literacy Survey on Depression in child/adolescent | Self-Reporting questionnaire (SRQ) | MFQ (mood and feelings questionnaire) | Annex |
| Group 1 (child 8-12 years and parent pair) |  |  |  |  |
| Child |  |  | √ | Annex 5 |
| Parent | √ | √ | √ (parent version) | Annex 6 |
| Group 2 |  |  |  |  |
| Adolescent | √ |  | √ | Annex 7 |

Following obtaining informed verbal consent, individual interviews will be conducted where survey instruments are administered according to above protocol detailed in tables. Data will be collected in de-identified format (research code) and will collect socio-demographic information such as age, gender, ethnicity and religion.

Following is a description of the survey instruments. Validity and internal reliability assessment results of the tools is provided in Annex 8.

6.1.1 Mental Health Literacy Survey (administration time 40mins)

Attitudes and beliefs concerning the nature and treatment of PTSD and depression will be examined using a modified version of the MHL survey developed for adult refugee populations (12). In order to investigate MHL related to PTSD, a case vignette of a fictional person suffering from PTSD will be presented, followed by a series of questions addressing the nature and treatment of the problem described, including: problem recognition; beliefs about the severity of the problem and its prevalence in the target population; beliefs about the likely helpfulness of various possible treatments and treatment providers; beliefs about causes of and risk factors for the problem described; beliefs about how best to support someone with PTSD, stigmatising attitudes towards someone with PTSD; and beliefs about likely barriers to treatment among individuals with a problem such as the one described. Appropriate modifications will be undertaken to ensure suitability of the survey instrument for the groups 1 and 1. Further, a similar survey will be undertaken to examine MHL related to depression however the case vignette will be of a fictional person suffering from depression with questions related to this.

6.1.2: SRQ-20 (administration time 5 minutes)

The SRQ-20 is a 20-item Self-Reporting Questionnaire, which has now been widely used and validated in many cultural contexts. SRQ-20 was developed by the World Health Organization (WHO) as a screening instrument to study mental health disturbances in developing countries (13). The SRQ-20 is effective in identifying participants with major depression, anxiety disorders or suicidality.

6.1.3a: CRIES-13 (administration time 10 minutes) (with PTSD MHL vignette)

The Impact of Events Scale (IES) was originally developed by Horowitz et al (1979) (14) to monitor the main phenomena of re-experiencing the traumatic event and of avoidance of that event and the feelings to which it gave rise. It was not originally designed to be used with children, but it has been successfully used in a number of studies with children aged 8 years and older. These separate studies identified identical factor structures of the IES and these were used to select eight items that best reflected the underlying factor structure and so produced a shortened version – the IES-8 for children. It consists of 4 items measuring Intrusion and 4 items measuring Avoidance. An additional 5 items were developed that were designed to reflect the 5 DSM-IV Cluster D symptoms of arousal – hence it is called the CRIES-13. It is designed for use with children aged 8 years and above who are able to read independently.

Or

6.1.3b: Mood and Feelings Questionnaire (administration time 10 mins) (with Depression MHL vignette)

The short version of the Mood and Feelings Questionnaire (MFQ) was developed by Angold et al (1995) (15). The MFQ consists of a series of descriptive phrases regarding how the subject has been feeling or acting recently and is a screening tool for depression in children and young people aged between 6 and 17 years. There is a corresponding parent version, in which the parent is also asked to rate their child. Peer-reviewed studies have found the Mood and Feelings Questionnaire to be a reliable and valid measure of depression in children (16, 17). The MFQ has been translated into Arabic.

6.2 Administration

The interviewers will read the psychological scales, survey items and response choices aloud to overcome limitations in literacy, and to provide further clarification as necessary. The interview will last approx. 60 minutes. Participants who show signs of distress, with scores on the SRQ 20 that reach the cut off and/or express an interest in advice or treatment will be referred to appropriate care in the existing MSF services.

6.3 Interview Language

The interviews will take place in Arabic. All psychological screening tools are available in Arabic and have been validated in such populations. The MHL survey was developed by Slewa-Younan et al (2014) [12] and was modeled on Jorm [11] protocol, with appropriate cultural considerations. Care was taken to ensure the vignette was culturally valid and the final survey was translated into Arabic and independently back-translated into English, using the services of nationally accredited translation and interpreting service. The questionnaires are available in English in the Annexes.

6.4 Implementation

In order to improve the engagement with the research project assistance will be sought in form of discussion with potential community and/or camp leaders and permission to conduct the study in the camps will be requested.

The survey will be piloted with 10 children (and their parents and caretakers) and 10 adolescents for consistency of language and for cultural acceptability by the survey team before the implementation of the study. Any suggested modifications to the questionnaires will then be implemented before the roll out of the study.

In the households randomly selected according to the above methodology, the head of the household and the participant will be provided with an information sheet explaining the survey purpose, data to be collected, risks and benefits, how confidentiality will be maintained and how the data will be used. The trained survey staff will read and/or explain the information sheet if required and answer any questions in the language the head of household and participant are ~~is~~ familiar with.

Verbal consent will be sought from the head of the household and the person participating in the survey and documented by the person obtaining the consent. If they give consent the young person will receive the same information and verbal assent will be sought. If they decline to participate this will be accepted, written down and the next household approached; the number of household refusals should be noted on the survey control form.

If an eligible participant is absent at the time of the visit, it will be noted on the data collection and survey control forms and the team will revisit the household later in the day.

If a household is empty, the neighbours will be asked about the family that lives there. If the residents are likely to return that day the team should also return later in the day. If the residents do not return before the team leaves, a note will be made on the data collection and survey control forms. The household should not be replaced as a non-response rate was factored into the sample size calculations.

**7. Data management**

7.1 Data Collection

All questionnaires will be printed and data collection will be done by hand.

No identifiable (name-related) data will be collected during the survey. The interviews will take place in the participant’s home, if possible, with only the interviewer and the participant being present for protection of privacy and confidentiality. Participants will have the option not to participate if it is not possible for them to be alone.

We are conscious that in the event we use GPS based sampling for the household sampling stage, that the GPS coordinate corresponds to an address of the household. The study coordinator will ensure that GPS coordinates are provided to teams on a daily basis and that these are deleted from their GPS machines or phones at the end of each data collection day. This way only the Study Coordinator will have access to the GPS coordinates for the duration of the survey at all times. At the end of the survey and once all data has been checked and validated, the file containing the household GPS coordinates will be deleted. .

The electronic database used for data entry will be password protected. The paper versions of the questionnaires and the electronic database will be stored at the MSF-OCA headquarters or country management level for 5 years after the survey, after which they will be destroyed. The electronic database will be stored in the headquarters in Amsterdam and will be available on appropriate request based on MSF’s Data Sharing guidelines.

For the duration of the survey, the analysis of the data and the writing of the report access to the electronic and paper version of the survey will be restricted to the Study coordinator, the co-investigators of the study and the Medical Coordinator.

7.2 Data entry

A data entry mask will be prepared in EpiData Manager for the electronic entry and storage of all collected data. This file will be password protected and only accessible to the Study Coordinator, the study co investigators, the medical coordinator and the data entry clerk. . All data from paper questionnaires will be entered into this password protected file by a trained Data Entry clerk. Data cleaning will be done to check for inconsistencies in data entry and responses. The Study Coordinator will review 20% of all questionnaires at random and compare them to the original paper format to ensure that the data quality is of sufficient quality.

7.3 Data analysis

All data cleaning and statistical analysis will be carried out using IBM SPSS Statistics version 22.0 (35). . For all continuous variables the survey participants will be described in terms of means, medians and ranges. Data from categorical variables will be reported in proportions and respective 95% confidence intervals. Associations between responses to specific questions (e.g. problem recognition, perceived helpfulness of specific treatment providers), demographic characteristics and symptom levels will be examined by means of correlational analysis (Pearson or Spearman’s rho coefficients), independent samples t-tests or ANOVA, chi-square tests and/or non-parametric methods, depending on the response options for the outcome of interest concerned. Where appropriate, multiple linear and/or logistic regression analysis will be employed to examine associations between variables (e.g. symptoms levels, MHL and use of health services) while controlling for potential covariates (e.g. demographic variables)

7.4 Data protection and management

Data will be coded by participant numbers and the questionnaires will only have the basic demographic information. Confidentiality is paramount, and no information about individual participants or their household members will be accessible to any individuals not directly involved in data entry. Participant identifiers will not be included in results and disseminated reports. The research team will be required to sign a non-disclosure and privacy form stating that they will not discuss information about individuals participating in the study outside of the research team. The research team will ensure the ethical principles of beneficence, non-maleficence, justice, autonomy and respect of persons are adhered to throughout the study.

Documents will be coded by participant numbers; hence the questionnaires will only have the basic demographic information. No identifying data will be kept on individuals, such as name, address, identification number, either on the questionnaire or held separately. Although the results of this study may be published, no information that could identify any of the participants will be included. All reports and publications will refer only to anonymous or aggregated data. Nominal data will not be distributed outside the study location or appear in any report or publication.

7.5 Quality assurance

During the field work, supervision of field teams will be ensured by the Study Coordinator. All data collection forms will be checked by one supervisor at the end of each study day to ensure that there is no missing or unclear data.

**8. Ethical Considerations**

The study will be conducted in accordance with the Council for International Organisations of Medical Sciences (CIOMS) International Ethical Guidelines, 2016 and the World Medical Assembly (WMA) Helsinki Declaration on Ethical Principles for Medical Research Involving Human Subjects.

The protocol will be approved by the Ethical Review Board of Médecins san Frontières before implementation. In addition official permission will be requested from Directorates of Health for both Kirkuk & Diyala Governorate and the Ministry for Displacement and migration, Kirkuk & Diyala Governorate, Iraq.

The camp administrator and the relevant authorities (including identified community leaders) will receive a letter one week prior to the start of the survey explaining the purpose of the survey and its procedures, specifically also explaining how the survey ensures anonymity of respondents and their right to refuse participation in the interview. If feasible, a meeting with camp administration and relevant authorities (including identified community leaders) will be held to answer questions and address any concerns regarding the survey two weeks before the implementation. This will also enable input from community leaders about mental health issues that matter most to them.

Due to the uncertainly of the location that the survey will be conducted it is not possible to define which relevant authorities, including community leaders will be approached prior to conducting this survey. This will be defined when the precise study location is identified.

The MSF mental health responsible in the field will advise the study team on the referral practices when finding survey participant who show signs or symptoms of psychological distress requiring immediate clinical attention or in the event that a study participant or member of a participating household expresses the desire to access mental health care services.

8.1 Informed consent

Heads of the selected households will receive oral and written information about the survey objectives, study procedures and a clear explanation of the risks and benefits derived from participation in the research through a trained study staff. In order to ensure each head of household provides informed consent, and in recognition of low literacy levels, an information sheet and consent form will be read out loud by the interviewer in and the main aims, nature and implications of the study will be explained (Annex 1). The trained survey staff will answer to any queries that they may have. Those heads of households willing to permit the identified person to participate will have their verbal consent noted by the person obtaining consent. If permission is granted the same information and procedure will be applied to the identified participant for the survey. For all persons participating aged <18 years we will ask for informed consent from the parents/caretakers and informed ‘assent’ from the participating young person.

Participants will be informed that they have the right to withdraw from the study at any time during the research. Participants will be made aware that participating in the study is in no way linked to the care they will receive from MSF, and that no incentives will be given for participation in the study.

8.2 Risks and benefits related to survey participation

Risks

The study participation is not expected to convey any risks to the participants. The interview will be conducted in privacy by trained survey staff. The questionnaire has been designed to deal the sensitive topics delicately. However, participating in this study may include possible anxiety induced by the interview (MHL survey and psychological scales), psychological discomfort related to the disclosure of personal information, and the inconvenience to the participants as a result of taking the time to participate in the research. To minimise any such possible discomfort or anxiety related to the data collection for this study, the data collection procedures will be clearly explained so that participants are well informed about what to expect from the study.

This risk will be mitigated by ensuring well trained staff conducts the interviews and care is taken during instrument design to minimize risk. Interviews will be terminated if the interviewer observes that the respondent is under undue stress. Regular briefings and debriefings will be held with interviewers throughout the research process to identify issues and provide further training as required. We will try to mitigate this by ensuring that our interview teams are appropriately trained in psychological first aid. In the event of a visibly traumatized individual, the team will conclude the interview and will offer appropriate referral to the MSF Mental health service. Each respondent will be assured of the confidentiality and privacy of the interview, and individuals will be informed that they are able to cease their participation in the study at any time should they feel uncomfortable and refuse to answer any questions. Furthermore, information on MSF counseling services will be made available to all participants.

For MSF, the risk would be that the security situation may deteriorate to a level that we would not safely be able to deploy the survey team. The project locations are based in areas of fluctuating insecurity. In order to mitigate security risks, all interview teams and researchers will be asked to comply with MSF security guidelines. These guidelines might limit the ability to move to camps to collect appropriate information. The security implications for the implementation of the study cannot be planned beforehand and will require adjustments at various stages to ensure all risks are mitigated. Changes in security context might impact on ability to collect the data, and if teams cannot be work safely then it may require the survey to be abandoned at one or more locations.

Benefits

This study represents the first of its kind worldwide to adapt the MHL paradigm to explore displaced community’s understanding of PTSD and depression. This information will then be used to inform culturally relevant health promotion and early intervention programs, while also indicating future research initiatives likely to be of interest in for the populations. First, the findings from this study will have the immediate benefit of improving our knowledge and understanding of how Iraqi populations view, understand and respond to trauma-related mental health problems for themselves, their social and family networks, health professionals, other service providers and the community as a whole. Second, findings from this study will lay the foundation for the development and implementation of health promotion programs - both prevention and early intervention - designed to improve MHL at the individual and community levels.

A direct benefit to the at-risk population will come from the strengthening of MSF's current programming by providing essential information from which more effective intervention strategies can be developed. There will be no immediate or direct benefit to the participant as a result of participating in the study, with the exception that participants who score highly (over the clinical cut-offs) on the psychological scales can be referred to MSF clinical services. Additionally, they will be informed that their participation will generate knowledge that may improve the health and wellbeing of its members and of other Iraqis. Similarly, dissemination of results will help inform other actors and other organizations involved in mental health care in Iraq by contributing to the body of knowledge around mental health. Direct benefit to the individual participant is limited to the overarching benefit to the population as a whole.

8.3 Outcome

The expected outcomes include;

* Improved understanding of local beliefs, traditions and language used in relation to mental health amongst the surveys target population groups;
* To lay the foundation for the development of targeted, culturally appropriate mental health programmes in the MSF project locations, including mental health promotion and the development of culturally appropriate services that meet the needs of the specific beneficiaries.
* Estimates of mental health distress in child and adolescent displaced Iraqis and the caregivers of children.

**9. Collaboration**

This survey will be conducted by MSF OCA, with cooperation of the Directorate of Health, Kirkuk & Diyala Governorate, the Ministry for Displacement and migration, Kirkuk & Diyala Governorate, Iraq and the School of Medicine, Western Sydney University, Australia.

MSF OCA is the study sponsor and is responsible for funding. It is in charge of the field part fo the study, the analysis and report writing, with latter to be undertaken in collobration with Western Sydney University. Permission for publication must be obtained from the MSF OCA, the Directorate of Health Iraq, Ministry for Displacement and migration, Iraq and The School of Medicine, Western Sydney University, Australia. Study results will belong to MSF OCA, the Directorate of Health, Kirkuk & Diyala Governorate, Iraq and the Ministry for Displacement and migration, Kirkuk & Diyala Governorate.

9.1 Dissemination of findings

The findings will be written up under the supervision of the Principle Investigator (Eleanor Hitchman) into an internal report which will be shared with all collaborators for their input. The report will be translated from English into Arabic. At project level, the findings will be disseminated with the project / mission and shared with the staff at the project locations (MHAM, MTL and MedCo) and with the Health Adviser and Operational Manager at headquarters. MSF-OCA commits to sharing study results with everybody who has participated in the survey. Study results will be shared with key stakeholders including camp leaders and other health actors. The local community will be involved and informed though posters at the MSF clinics. The MSF medical team will decide about the best venues to display the results.

The data collected from the overall project will give rise to publications in peer-reviewed journals relating to: 1) the level of PTSD and depression related MHL among internally displaced Iraqi young people and their parents in each of the project locations (Kirkuk & Diyala Governorates); 2) the prevalence of clinically significant PTSD / depression symptoms in the study population. Likely outlets for publication include the BMC Psychiatry and World Psychiatry. There will also be ample basis for presentations at peak academic forums such Refugee conferences the International Mental Health Conference and the World Congress of Social Psychiatry. In addition to these traditional means of dissemination, a report comprehensively covering the findings of the study and the key research, policy and practice implications reports will be prepared for dissemination to a broad range of non-academic audiences.

**10. Recruitment, training and implementation**

10.1 Selection and tasks of study teams

The task of the interviewers will be to collect the necessary data for the study.

Each survey team is composed of two interviewers. To finalise the field part in a reasonable time we need ten survey teams of two people each

General selection criteria for all interviewers:

* Able to read and write in English *and*
* Fluent in the local language Arabic *and*
* Available for the ENTIRE time of the study (training and interview days), *and*
* Motivated to participate in the study, *and*
* Not biased in expectations of the outcome of the study
* Experience in social work, mental health interventions or previous humanitarian surveys will be an advantage.
* Experience with interviews in difficult settings and study populations would be an advantage

In addition, two local supervisors will be employed to supervise the survey teams in the field.

Recruitment will be done through the routine MSF recruitment strategies in northern Iraq.

10.2 Supervision

The principal investigator is the overall responsible for the final version of the protocol, overall quality of the survey and data analysis, and the final report.

The principal investigator will ensure that the following tasks are performed:

* Preparation of all necessary documents (protocol, questionnaires, informed consent forms) for the study
* Briefing of the Study Coordinator in the field
* Data analysis
* Report writing

The survey will be facilitated in the field by the expatriate Study Coordinator based in the country. This person will be responsible for:

* Preparation of the field component of the study (training of the study teams, logistics, materials) together with the MSF team in the field
* Follow-up of the field component of the study
* Data collection and data entry
* Quality of data and consistency checks
* Cleaning of data

10.3 Suggested MSF support in the field

* Administrative support for study preparation at the field level and during field part, such as obtaining permission from the Directorate of Health, Kirkuk & Diyala Governorate, Ministry for Displacement and migration, Kirkuk & Diyala Governorate and payment of study teams, according to the final study locations.
* Human resources support, such as hiring study team/interviewers, a translator for the principal investigator, expatriate epidemiologist or mental health activity manager if needed.
* Logistic support for study preparation at the field level and during field part, such as organizing sufficient cars including drivers for the field part of the study, providing communication tools and MSF ID (e. g. aprons, vests or arm bands) to the study teams, stationary, printing the consent forms

10.4 Training of study teams and pre-testing of the questionnaires

Four days training will be given to all interviewers to familiarise them with the background of the study, the questionnaires, the information sheet and the informed consent form. The training will be given in English with translation if needed by the Study Coordinator with support from the Principal Investigator. It consists of an intensive review of the questionnaires and the information sheet including role-plays. As the interviews will be held in Arabic, the Study Coordinator should ensure that all interviewers are using the same and correct wording for providing information to the households and for the interviews.

The 4-days training will finish with a pilot study. The pilot study allows for the testing and possible final adaptation of the questionnaires and informed consent to field conditions.

10.5 Timeframe in the field

Ten field teams of two staff will be deployed for data collection. It has been estimated that 10 field teams will be able to complete 30 households per day, assuming a working day from 9.30 am to 4 pm. (Table 1). To reach the desired number of participants (300 in total) will take ten days, although extra time will be allocated to allow for those who might refuse. However, due to the uncertainly of the location that the survey will be conducted, whether the population are in camps or not, and the security situation, the precise time needed to reach the desired number of participants will be defined when the precise study location is identified.

**Table 1**: Assumptions for calculating number of households/team/day

|  |  |
| --- | --- |
| Activity | Estimated time (minutes) |
| Daily briefings/feedback | 60 |
| Lunch and tea breaks | 60 |
| Community engagement/feedback | 15 |
| Time to complete survey & walk to next household | 75 |
| Total time available/day (9.30am – 4pm) | 390 |
| Time required for non-survey activities | 135 |
| Time available for surveys | 255 |
| Number of households/team/day | 3 - 4 |

**Table 2**: Field activities and days required for Principal Investigator

|  |  |
| --- | --- |
| **Activity** | **Number of days** |
| Travel days for arrival in Iraq | 1 |
| Final preparation of the study (including briefing of relevant people) | 2 |
| Training including the pilot study (Kirkuk) | 4 |
| Availability to support implementation (Kirkuk) | 12 |
| Travel to Khanaquin | 1 |
| Training including the pilot study (Khanaquin) | 4 |
| Availability to support implementation (Khanaquin) | 12 |
| Buffer days for data entry and cleaning | 5 |
| Debriefing | 2 |
| Travel days to return | 1 |
| **TOTAL** | **44** |

**11. Logistics**

11.1 Supplies required

Supplies for the conduct of the study will be purchased locally. See table 3 for a list of required supplies. Some IT supplies may already be available within the Iraq mission (from the health access survey).

**Table 3:** Supplies needed for the survey teams/supervisors

|  |  |  |  |
| --- | --- | --- | --- |
| **Item (number needed)** | **Per team** | **Per supervisor** | **Total** |
| Back pack/shoulder bag | 1 | 1 | 12 |
| Clipboard | 1 | 1 | 12 |
| Pencil | 3 | 2 | 34 |
| Rubber | 2 | 2 | 24 |
| Sharpener | 2 | 2 | 24 |
| Eraser | 2 | 2 | 24 |
| Aprons, vests, arm bands or similar with MSF identification / logo | 2 | 1 | 22 |
| Plastic sleeves (for protection of documents) | 3 | 3 | 36 |

**Table 4:** IT requirements

|  |  |  |
| --- | --- | --- |
| **Item** | **Number required** | **For whom** |
| Telephone & chargers for GPS | 10 (minimum) | Survey teams |
| Laptop | 1 | Field coordinator |

11.2 Transport

Transport requirements will depend on where the field teams are recruited from; if they are from outside of the camp, 2 taxi minibuses will be required. However, due to the uncertainly of the location that the survey will be conducted the transport requirements can only be defined when the study location is identified.

11.3 Budget

An estimated budget for the study is included in Annex 6.

The cost for 1 location is 4,100 EUR. If the survey is conducted at the second location, once the first location has been completed then the price would be 2,450 EUR as the same mobile phones can be used. There will be an additional cost of 4000 EUR if there is no Epidemiologist in the field when the research is due to take place and one has to be sent specifically for the survey. However, due to the uncertainly of the location that the survey will be conducted the precise budget can only be defined when the study location is identified.

11.4 Study schedule

We have pre-defined the following time points in the implementation of this study:

|  |  |
| --- | --- |
| **Output** | **Estimate Deadline** |
| Submission to MSF ERB | December 2017 |
| Submission to ERB of Iraq Ministry of Health | January 2018 |
| ERB approval MSF and Ministry of Health | February 2018 |
| Preparation field study (hiring of staff, training of staff, piloting of questionnaires and logistics for field implementation) | March 2018 |
| Study implementation | April - May 2018 |
| Analysis of data and report write up by PI | –June - July 2018 |
| Dissemination of report to stakeholders | August 2018 |
| Submission of manuscript to peer reviewed journal (if relevant) | October 2018 |

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**13. Annexes**

Annex 1: Information sheet / Consent & Assent Forms

Annex 2: PTSD Group 1: Child (8-12 years)

Annex 3: PTSD Group 1: Parent (of Child 8-12 years)

Annex 4: PTSD Group 2: Adolescent

Annex 5: Depression Group 1: Child (8-12 years)

Annex 6: Depression Group 1: Parent (of Child 8-12 years)

Annex 7: Depression Group 2: Adolescents

Annex 8: Validity and internal reliability assessment results of the tools.

Annex 9: Estimated study budget

Annex 10: CVs Eleanor Hitchman and Dr Shameran Slewa-Younan

**Annex 1:** Information sheet / Consent & Assent Forms



**Annex 2:** PTSD Group 1: Child (8-12 years)



**Annex 3**: PTSD Group 1: Parent (of Child 8-12 years)



**Annex 4:** PTSD Group 2: Adolescent



**Annex 5:** Depression Group 1: Child (8-12 years)



**Annex 6:** Depression Group 1: Parent (of Child 8-12 years)



**Annex 7:** Depression Group 2: Adolescents



**Annex 8:** Validity and Internal Reliability of the Questionnaires



**Annex 9:** Estimated study budget



**Annex 10:** CVs Eleanor Hitchman and Dr Shameran Slewa-Younan

