IRAQ

AL-QAIRAWAN AREA-BASED ASSESSMENT

August 2022

INTRODUCTION

Context

Al-Qairawan town and the surrounding villages covered in this assessment (Akhnesi, al-Mualih, al-Qahra, Biskqi, Hazeel al-Kabeer, Hazeel Alwasti, Sibaya Ammash, and Um Amar villages) are located in the al-Qairawan sub-district of Sinjar district and Ninewa governorate. During the conflict that developed with the so-called Islamic State of Iraq and the Levant (ISIL), who captured the area in 2014, almost the entire population was forced into displacement.[1]

The conflict, as well as prior and subsequent neglect, has damaged critical service infrastructure in Al-Qairwan. This has led to a reduced access to livelihood opportunities and essential services such as water supply, healthcare, and schools.[2] In addition, the conflict has strained inter-communal relationships, which reportedly resulted in additional barriers to equitable access to basic services.

Since the end of the ISIL's occupation and the subsequent stabilisation of security in the affected areas, **internally displaced people (IDPs) have been returning to their homes and areas of origin.** According to the latest IOM DTM data from June 2022, a total of 2,623 households (15,738 individuals) had returned to al-Qairawan and surrounding villages.[3] Al-Qairawan sub-district had been noted as having high severity conditions in the villages and medium severity conditions in al-Qairawan town in terms of livelihoods, basic services, safety perceptions, and social cohesion.[4] **Returnees still face challenges recovering their lives in the area due to the conditions there;** the IOM DTM's Return Index and previous REACH outputs indicated challenges around access to livelihood, shelter conditions, access to drinking water, healthcare, education, and safety and security. However, there was previously a lack of in-depth localised information on this area to enable actors to make localised, evidence-based decisions.

Objectives

As the context in Iraq transitions into post-conflict recovery and stabilization, the priority of the government and the humanitarian community has shifted to **facilitating safe and durable solutions to displacement through sustainable returns, local integration, or relocation.** In April 2020, the Durable Solutions Task Force (DSTF) was established through the humanitarian coordination architecture of Iraq. **The DSTF is a body designed to bring together humanitarian, development, stabilization, and peacebuilding actors** in a dedicated platform working towards solutions to displacement in Iraq. The Task Force is supported by two national-level groups, the Returns Working Group (RWG) and the Durable Solutions Technical Working Group (DSTWG). The DSTWG was designed to focus on the design and implementation of programs and approaches aimed at supporting durable solutions in Iraq. As part of this mandate, the DSTWG has established area-based coordination (ABC) groups in several locations across Iraq to promote area-based approaches to durable solutions and coordinate programming, response, and strategy on a local scale. Sinjar district is one of the areas where an ABC has been established.

Detailed information on service provision and household needs and vulnerabilities in areas of return is crucial to inform planning and activities. To support the ABC's planning and the operations of fellow members and other actors, REACH conducted an area-based assessment (ABA) in al-Qairawan town and eight of the surrounding villages. Data collection was carried out between the 17 July and 2 August 2022. The ABA was funded by the United Nations High Commissioner for Refugees (UNHCR), and REACH developed its research design in collaboration with UNHCR, IOM, and the Sinjar ABC. Consistent with previous ABAs, this assessment collected information on the current needs and vulnerabilities of households living in al-Qairawan town and surrounding

[1] REACH, Rapid Assessment on Returns and Durable Solutions - Al-Qairawan Sub-district, Iraq, August 2020. Available here.

[2] Ibid

[3] IOM DTM, DTM Returnee Master List 126, June 2022. Available here.

[4] "Subdistricts are classified as 'hotspots' if they score highly in terms of severity on at least one of the two scales (either livelihoods and basic services, or safety and social cohesion) or if they score medium in terms of severity but also host relatively large numbers of returnees, at least 60,000 returnees in a subdistrict." IOM DTM, Return Index: Findings Round 15 – Iraq, March 2022. Available here.

villages, as well as existing services and households' perceptions of these. Data was collected to provide a multi-sectoral overview of circumstances in the communities, bridge existing information gaps, and inform ongoing or planned humanitarian, stabilisation and development interventions. More specifically, in addition to demographic data, needs were assessed across various sectors, including livelihoods, protection, shelter and non-food items, food security, health, education, water, sanitation and hygiene (WASH) and electricity. A dashboard presenting the data from the household survey component of the ABA can be found via this link. The participatory mapping can be found via this link.

METHODOLOGY

This ABA on al-Qairawan town and the surrounding villages implemented a predominantly **quantitative methodology (household, IDP households survey from al-Qairawan, and key informant interviews), with qualitative elements in the key informant interviews (KIIs), and participatory mapping.** The geographical coverage of this ABA was al-Qairawan town and eight surrounding villages (Hazeel Alwasti, Akhnesi, Um Amar, Sibaya Ammash, al-Mualih, al-Qahra, Biskqi, and Hazeel al-Kabeer villages). Before the start of primary data collection, REACH conducted a secondary data review (SDR) of existing data relevant to the situation in this geographical area and information gathered through this process was used to build contextual knowledge to inform the data collection plan, identify information gaps, and triangulate findings from the ABA primary data.

B**etween the 19 July and the 2 August 2022, a total of 279 household surveys were collected face-to-face through the use of kobo tools** (137 in al-Qairawan town and 142 in the villages), and a representative randomised sample for the town and villages was drawn with a 95% confidence level and 8% margin of error. For the IDP survey, of hosueholds originaring from al-Qairawan sub-district, a purposive sample was used based on contact information provided by partners, and although REACH aimed to collect enough surveys to ensure the reliability of the data, findings should be considered indicative. IDP surveys were collected via phone calls from REACH's call centres.

The KIIs had two components: KIIs with community leaders and KIIs with subject-matter experts (SMEs). For the community leaders, REACH conducted 12 phone-based KIIs, five in al-Qairawan and seven in the villages to obtain general information on the living conditions, functionality of services, social cohesion and rule of law within their areas of responsibility. For the SMEs, REACH conducted 47 phone-based KIIs with experts from different sectors: education (seven), healthcare (seven), waste management (six), water (six), livelihoods (seven), electricity (eight), and legal services (six).

REACH also conducted 13 participatory mapping exercises with community leaders to map the infrastructure and services, including their presence, quality, and other attributes, in each neighbourhood. The mappings were conducted in a face-to-face setting using physical maps obtained from satellite imagery.

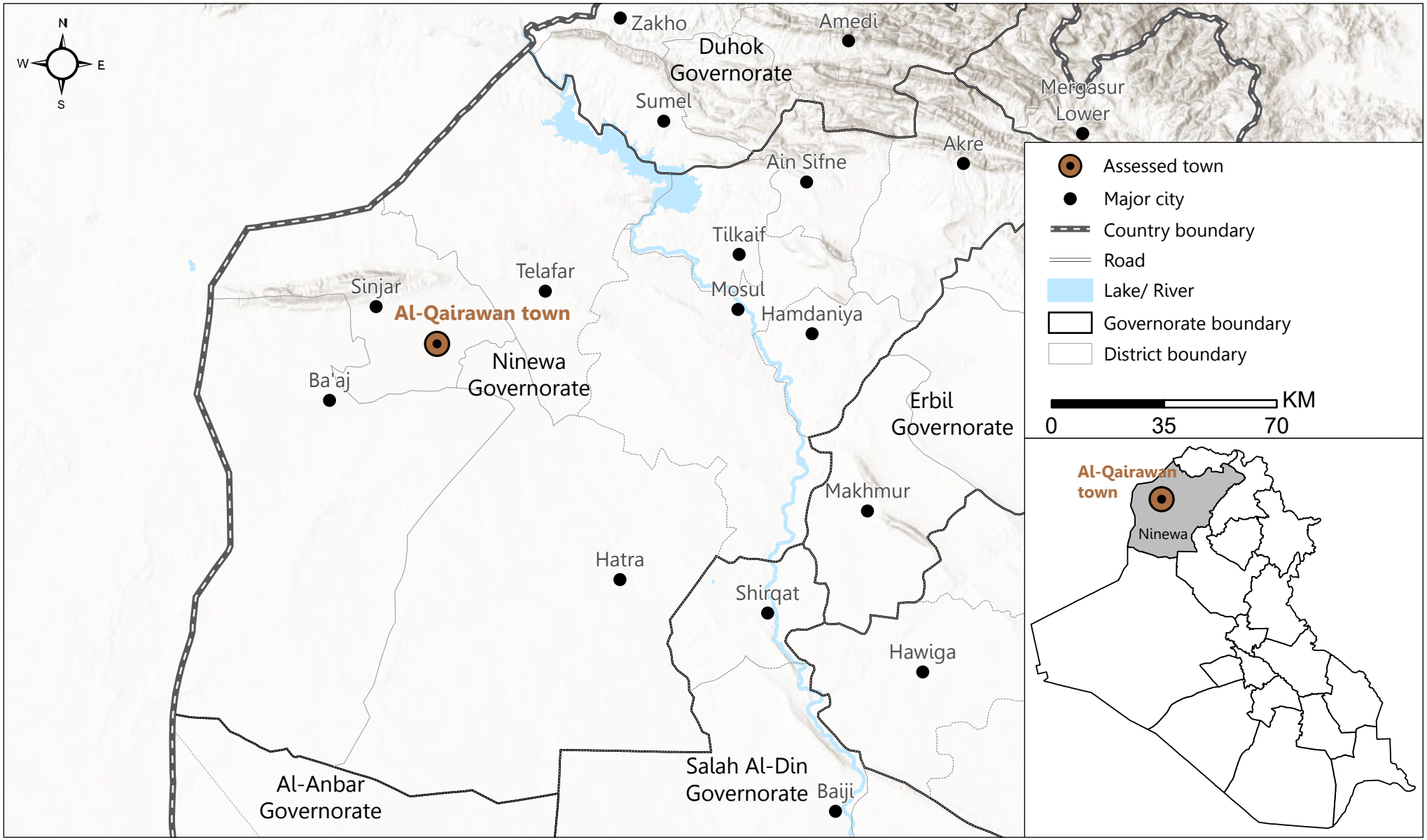
A limitation of this methodology is that the data does not provide generalisable results at a neighbourhood or village level. For this reason, an accurate comparison of the conditions in individual neighbourhoods and villages could not be done and the analysis had to be kept at the broader area level (al-Qairawan town and villages).

Table 1: Number of surveys conducted

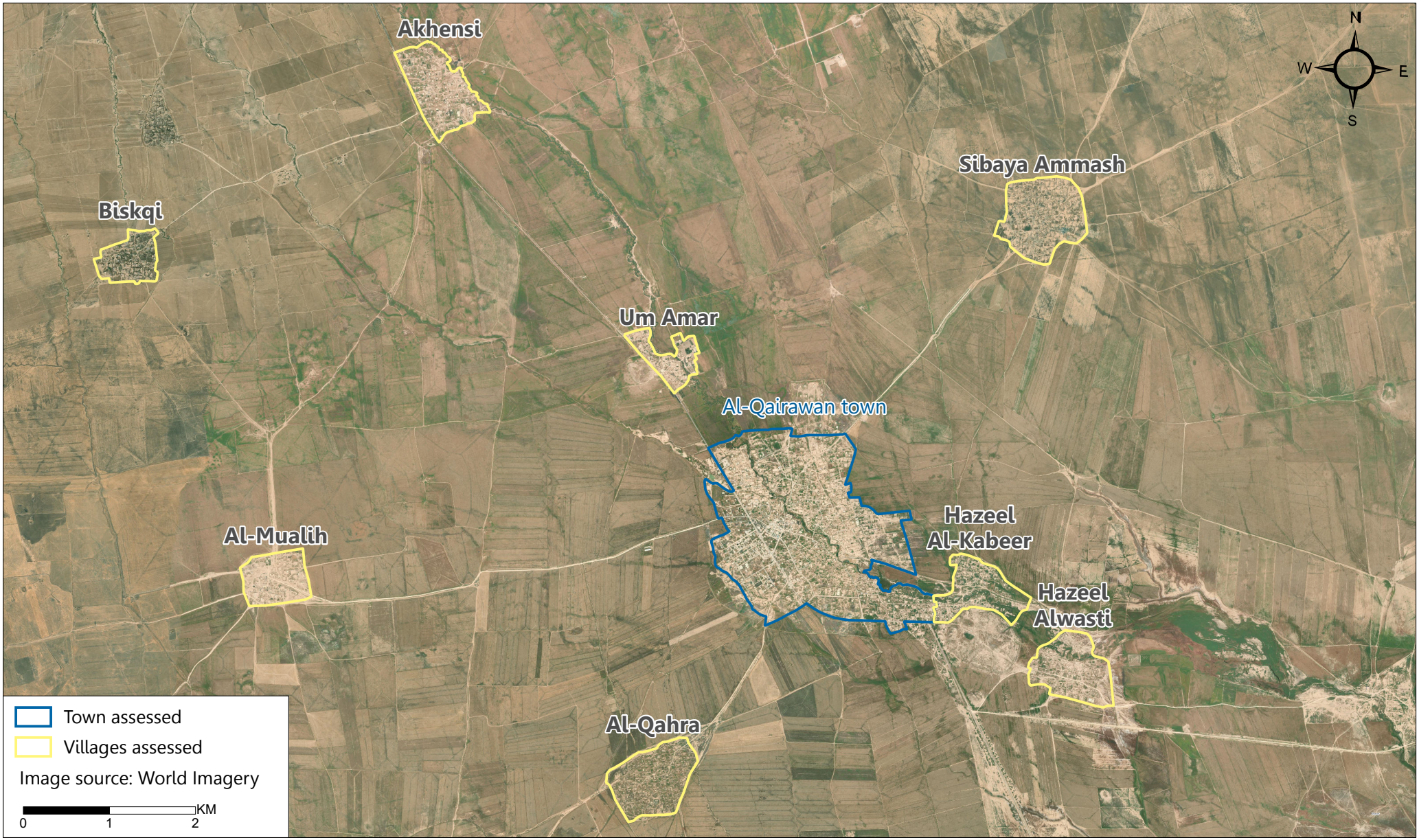
Data Collection Method	#	Disaggregation
Mapping KIIs	13	NA
HH Surveys	279	Town: 137; Villages: 142;
IDP Surveys	69	NA
Community leader KIIs	12	Town: 5; Villages: 7;
SME KIIs	47	Education: 7; Water: 6; Waste: 6; Livelihoods: 7; Electricity: 8; Healthcare: 7; Legal: 6;

MAPS

Map 1: Coverage map of the area assessed



Map 2: Assessed area



ASSESSMENT FINDINGS

DEMOGRAPHICS

The household-level survey was conducted across two geographical strata: households living in al-Qairawan town (49% of the households interviewed), and households living in the surrounding villages (51%).**The vast majority of households living in the assessed areas were returnees** (93% in al-Qairawan town and 94% in the villages) as they reported having lived in the same location prior to 2014 but having spent a period in displacement since then. A small minority (3% in the town and villages) were households of IDPs, having been displaced by conflict from elsewhere since 2014. The remaining proportion of households were reportedly host community (4% in town and 3% in villages).

The ABA found that a large proportion of the population of the town and villages was young, around half of the household members being under 18 (48% in town and 53% in villages), and a small minority being above 60 (3% in town and 2% in villages) (Figure 1).

Figure 1: Population pyramid

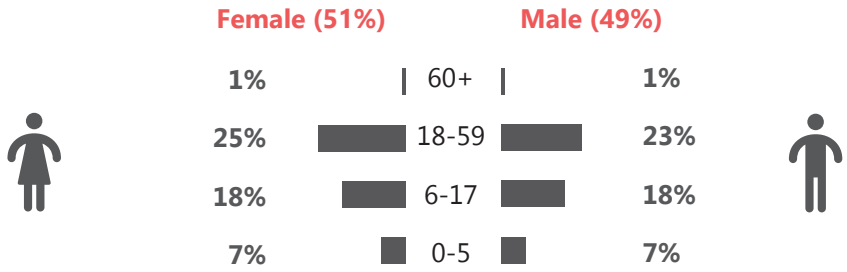
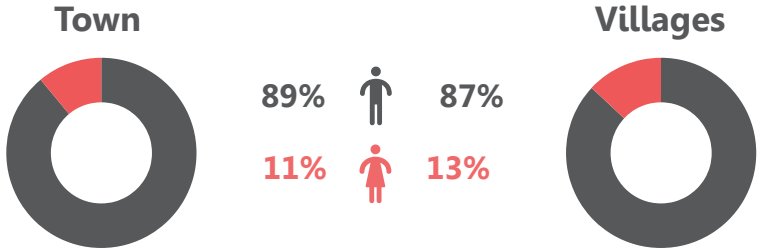


Figure 2: Gender of the head of household



The majority of the households were headed by men (89% in town and 87% in the villages) with a slightly higher proportion of female-headed households in the villages (Figure 2). **The majority of the female heads of household were widows** (28 responses out of 34 female heads of household), and only one was reportedly working. Overall, less than half of the heads of household were working for in al-Qairawan town (43%) and in the villages (37%).

In terms of vulnerable population groups (Table 2), 11% of household members in the town and the villages were reported to have at least one chronic disease. The most common types of chronic diseases were hypertension (5% in both), diabetes (3% in the town and 2% in the villages), and heart disease or stroke (2% in both). It was calculated that 3% of individuals in the town and 2% in surrounding villages reportedly had a physical or mental disability.

Figure 3: Head of household's marital status

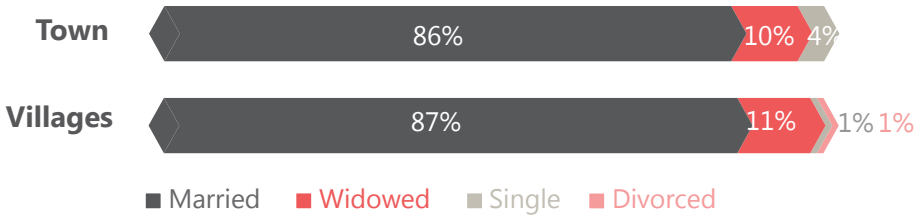


Table 2: Vulnerable groups

	% of female headed HHs:	% of older persons:	% of pregnant or lactating persons:	% of persons with chronic diseases:	% of persons with disabilities:
Town	11%	3%	10%	11%	3%
Villages	13%	2%	8%	11%	2%

PRIORITY NEEDS AND HUMANITARIAN ASSISTANCE

Priority needs

Food, shelter support, healthcare, employment/livelihoods support, and drinking water were the top priority needs reported by households in both al-Qairawan and surrounding villages. However, the level of prioritisation differed between al-Qairawan and its surrounding villages. For example, for households in al-Qairawan town the most reported priority needs were shelter (57%), followed by food (54%) and healthcare (51%). However, for households in the villages, they were food (57%), healthcare (57%) and employment/livelihoods' support (55%). Additionally, nearly half of the households in the villages (47%) reported their priority need was drinking water, while this was reported by a third of the households in town (35%) (Table 3). Compared to national-level MCNA data, the priority needs for food and healthcare were reportedly higher in both town and villages, as well as shelter in al-Qairawan town.[5] In the villages, the biggest difference compared to the national results was the high proportion on households reporting needing support to obtaining drinking water.

Change in needs since displacement

Over half of households in al-Qairawan town (60%) and the villages (65%) reportedly rated their assistance and protection needs at the time of data collection as much higher than before their displacement, but for other households they rated their current needs as being the same (18% in the town and 9% in villages) or lower (22% in town and 26% in the villages) (Figure 4). For those reporting their needs were higher, the top three reported needs in both locations were healthcare, drinking water and employment/livelihoods support.

According to all (5/5) community leaders from al-Qairawan town and over half (4/7) in the villages, **some returnee households had settled or redisplaced** in different areas of Sinjar district in the 12 months prior to data collection. The reported reasons were that the households' homes were damaged or destroyed, a lack of job or livelihoods opportunities, insufficient services (e.g., education, electricity, water), and one community leader in the town reported that it was because of the households' fear of being perceived as being affiliated with ISIL.

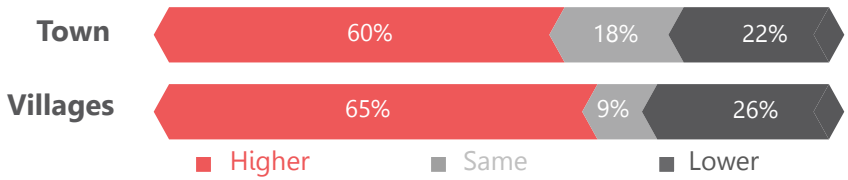
Humanitarian assistance

All households in the town (100%) and almost all in the villages (98%) reported not receiving any type of humanitarian assistance in the 30 days preceding data collection. Only two households in the villages reported receiving humanitarian assistance and the reported types of assistance among those two households were cash (2 out of 2 that reported receiving aid), and health services (1 out of 2 that reported receiving aid). Among the two households that reported receiving aid, one reported dissatisfaction with the reason being the poor quality of the assistance.

Table 3: Households' most reported priority needs by location[6]

Town			Villages	
Shelter/housing	57%	1	57%	Food
Food	54%	2	57%	Healthcare
Healthcare	51%	3	55%	Livelihood opportunities
Livelihood opportunities	50%	4	47%	Drinking water
Drinking water	35%	5	45%	Shelter / housing

Figure 4: Households reporting how their needs have changed compared to before displacement by location



[5] REACH 2022 Multi-Cluster Needs Assessment (MCNA) X, Dataset and analysis. Available here.

[6] Multiple answer options could be selected for this question so the total result may exceed 100%

LIVELIHOODS

Finding livelihood opportunities was one of the most commonly reported priority needs for households in al-Qairawan town (50%) and the villages (55%). **The proportion of economically active adults that were reportedly working for pay or profit at the time of data collection was less than half** (41% in al-Qairawan town and 33% in the villages) (Figure 5). The main reported challenges to access work opportunities in both the town and the villages were high competition for jobs or lack of job opportunities (67% of households in the town and villages), jobs available were too far from their location (36% in town and 37% in the villages), and lack of job opportunities for women (27% in both the town and villages) (Table 4).

Figure 5. Proportion of economically active adult household members who reportedly worked for pay or profit by location

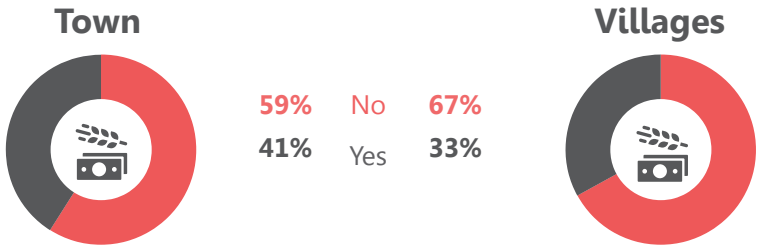


Table 4: Most reported obstacles to finding work, among individuals actively seeking work[7]

1	67%	High competition for jobs / not enough jobs available
2	36%	Available jobs are too far away
3	27%	Lack of livelihood/employment opportunities for women
4	18%	Only low-skilled, socially degrading or low-paying jobs

[7] Multiple answer options could be selected for this question so the total result may exceed 100%

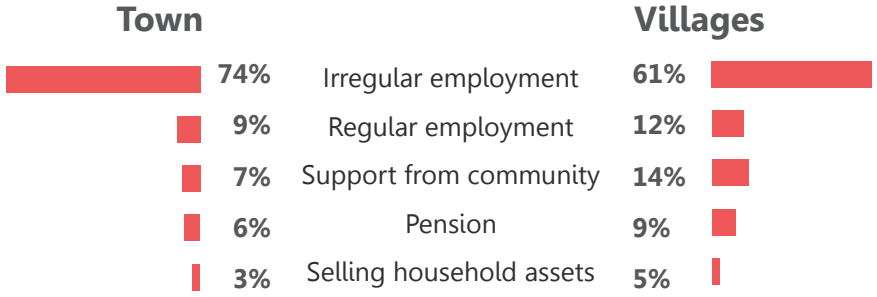
The findings suggested that livelihoods had not yet fully recovered to pre-ISIL levels, with all livelihoods experts reporting that wages were still lower than before 2014 and that **agriculture and construction had declined since 2014 (Figure 6), largely due to water scarcity, a decrease in demand, and a reduction in businesses' capital (Figure 7).**

Irregular employment (temporary or daily wage earning) was the most reported source of income for households in the 30 days preceding data collection in both the town (74%) and the villages (61%) (Figure 8). The next

Figure 6: Economic sectors that had reportedly declined most significantly since June 2014, according to livelihoods SMEs

Figure 7: Reported reasons why some of these economic sectors had declined, according to livelihoods SMEs

Figure 8: Most reported household income sources for the 30 days preceding data collectionby location[8]



[8] Multiple answer options could be selected for this question so the total result may exceed 100%

most mentioned source of income differed by area: in the town, it was regular employment (12%), while, in the villages, a higher percentage relied on support from community, friends and family (14%).

The most common sectors for work at the time of data collection were agriculture (24%), public services (19%), and skilled manual work (16%) in al-Qairawan town, and skilled manual work (32%) public services (24%) and construction (18%) in the villages. However, **the majority of households reported a higher total expenditure than their reported income (69% of households in town and 59% of households in the villages).**

The majority of households were reportedly in debt (96% in the town and 90% in the villages), with an average of 1,286,000 IQD of debt per household in the town and 1,000,000 IQD in the villages. The reported reasons for the debt were t**o cover healthcare expenses** (33% of in debt households in the town and 36% in the villages) **or food** (25% of households in the town and 26% of households in the villages).

To improve livelihood opportunities, SMEs suggested opening investment projects in the area (6/7), drilling water wells in the area to combat drought (4/7), providing more job opportunities for youth in the area (4/7), providing professional courses such as sewing or barbering (3/7), and providing government support for farmers and herders, new businesses and business enterprises (3/7) (Table 5).

These findings suggest that water scarcity, low availability of jobs and high competition, distance to job opportunities and lack of job opportunities for women were the main barriers to access livelihood opportunities, and, although most of the households reported receiving income from paid labour, a relatively high proportion of households in the villages relied on their communities and family for support.

Figure 9: Most reported sectors of employment, among individuals who reported currently working[9, 10]

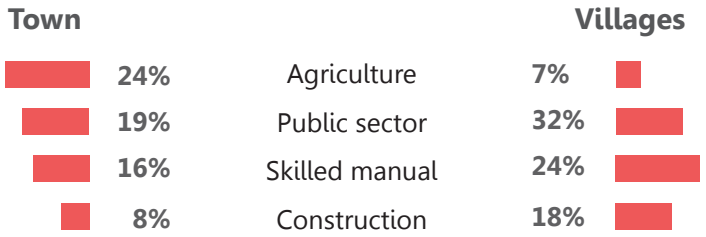


Figure 10: Comparison of reported monthly income and expenditure, and average debt[10]

Town			Villages	
IQD	USD		IQD	USD
320,750	221	Average monthly income	302,000	208
524,000	360	Average monthly expenditure	415,500	286
147,250	101	Average food expenditure	153,000	105
1,285,750	886	Average debt	1,024,250	705

Table 5: Livelihoods SMEs suggestions to improve livelihood opportunities in the area

Livelihood projects or business investment	✓
Drilling water wells	✓
Job opportunities for youth	✓
Vocational training	✓
Assistance for farmers, herders, business enterprises	✓
Fuel for water pumps	✓
Reconstruction and rehabilitation of infrastructure	✓

[9] Public services: e.g., civil servant, police, public healthcare worker. Skilled manual work: e.g., carpenter, butchers, plumber

[10] Multiple answer options could be selected for this question so the total result may exceed 100%

FOOD SECURITY

The ABA findings indicated that most households in the town and villages were food secure, with 90% having acceptable food consumption scores (FCS),[11] however it was lowerthan the national average (95%).[12] Around 10% of households in town were calculated to have borderline FCS while 9% had borderline and 1% poor FCS in the villages (Figure 11). **The majority of households reported using at least one coping strategy** in the 30 days prior data collection due to being unable to afford food, 68% in town and 73% in the villages, with the most commonly reported types of coping strategies being buying food on credit or through borrowed money (72% in town ad 61% in the villages) and reducing spending on non-food items (33% in town and 41% in the villages). This could be partially explain due to a number of households reporting that their food expenditure comprised half or more of their total expenditure (15% of households in town and 32% in villages) (Figure 12).

Although the majority of houeholds used stress category strategies, **a relatively high proportion had used crisis or emergency strategies.** Households living in the town were more likely to use crisis strategies (20%) than households in the villages (17%), while households in the villages were more likely to use emergency coping strategies (22%) than households in the town (13%) (Figure 13). There were a number of households in the villages who reported relying on concerning emergency coping strategies such as children dropping out from school (17 responses), household members engaging in high risk behaviour (12 responses), and the whole family migrating (6 responses) (Figure 14).

These findings suggest that the use of negative food consumption strategies was high, especially for households in the villages. In addition, a relatively high proportion households from the villages seemed to have a high vulnerability profile due to the use of certain emergency coping strategies as well as a high proportion of households reporting that their food expenditure comprised half or more of their total expenditure.

Figure 11: Households by food consumption score category

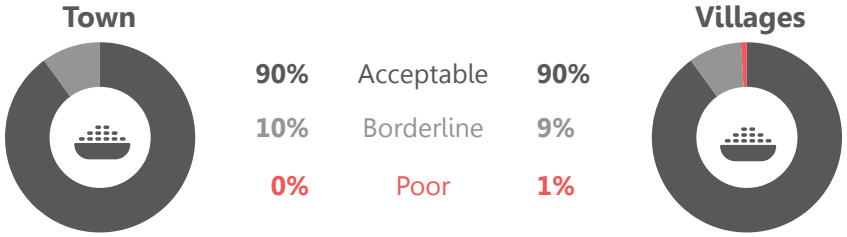


Figure 12: Households by reported food expenditure as a share of total expenditure the 30 days prior data collection

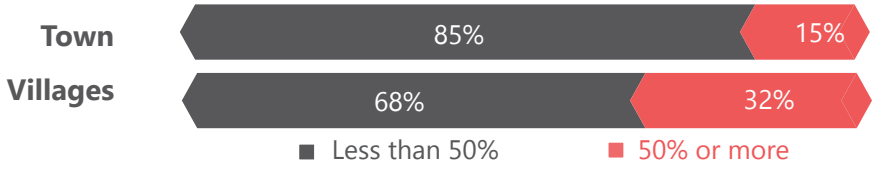


Figure 13: Households relying on stress / crisis / emergency strategies to cope with a lack of resources to afford food[13, 14]

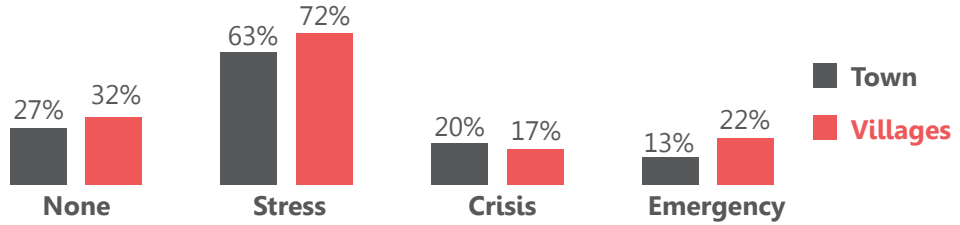
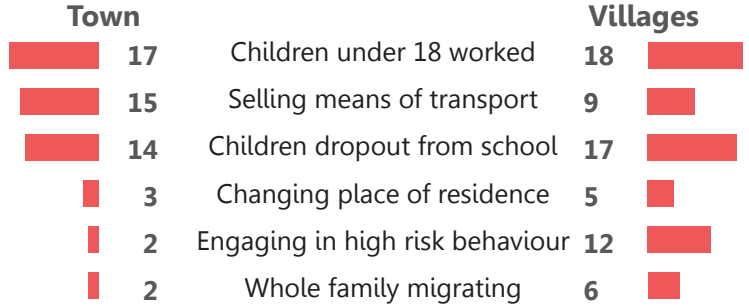


Figure 14: The most used coping strategies, out of the strategies classified as either crisis or emergency strategies, by number of responses[14]



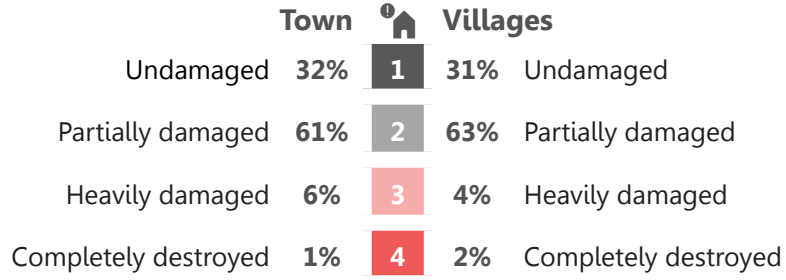
[11] REACH 2022 Multi-Cluster Needs Assessment (MCNA) X, Dataset and analysis. Available here.
[12] To know more about how FCS are calculated refer tho the following guidelines.
[13] Households were allocated to a category based on the most severe coping strategy that they used. **Stress:** sold HH assets; borrowed money; reduced spending on health/education. **Crisis:** sold means of transport; changed to cheaper accommodation; children worked. **Emergency:** withdrew children from school; engaged in high-risk activities; whole HH migrated; forced marriage.
[14] Multiple answer options could be selected for this question.

SHELTER AND NON-FOOD ITEMS (NFI)

Public infrastructure and civilian homes in the town and villages suffered substantial damages during the period of ISIL occupation and the subsequent military operations to retake the area. In addition, **the material traditionally used to build shelters in the area was found to be mud**, therefore making these shelters more vulnerable to damage while also being difficult to repair or rebuild.[15] This was reflected in households' reports on shelter damage, with **more than half reporting that their shelter was partially damaged** (61% of households in town and 63% in the villages), and a small proportion reporting their shelter was heavily damaged (6% in town and 4% in the villages) or completely destroyed (1% in town and 2% in the villages) (Figure 15). The majority of households reported that property they owned had been damaged during the conflict (85% in town and 73% in the villages), which could indicate that there has been some level of shelter reconstruction since the conflict, but that due to the materials traditionally used in the area for construction, households in the area still have shelter needs that were unmet at the time of data collection.

For these reasons many households reported issues with their shelter, such as a leaking roof with rain (58% in town and 52% in the villages), lack of insulation from the cold (53% in town and 50% in the villages), limited ventilation (40% in town and 27% in the villages), and broken windows (31% in town and 33% in the villages) (Figure 16).

Figure 15: Households reporting that their current living space is damaged, by level of damage

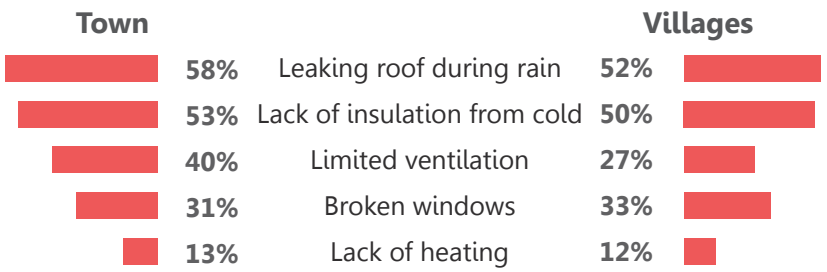


In addition, the majority of households reported needing shelter improvements (90% in town, 93% in the villages) such as improvements to the privacy and dignity of their shelters (72% in town and 73% in the villages), improvements to the safety and security of their shelters (55% in town and 54% in the villages), and protection from hazards such as contamination from explosive hazards, land at risk of flooding, solid waste dumping site or fire risks (52% in town and 46% in the villages) (Figure 18). Whereas the need for improving the security and safety of their shelters as well as from the protection from hazards could be linked to the material that the houses were built of, it could also be linked to the households reporting that their shelters needed to be cleared from explosive remnants of war (ERW) (32% in town and 27% in the villages).

In terms of type of living arrangement, th**e majority of households reported living in property they own** (81% in town and 82% in the villages), **but only a minority had ownership documents to prove ownership** (24% in town and 23% in the villages) (Table 6). The majority of households were observed to live in houses (90% and 93%), but some households were reportedly living in unfinished buildings (8% in town and 9% in the villages) or tents (3% in the villages).

More than half of the households reported needing at least one key household NFI, most commonly cooking utensils (46% in town and 42% in the villages), winter heaters or stoves (40% in town and 42% in the villages), and bedding items (38% in town and 35% in the villages).

Figure 16: Households' most reported issues with their current shelter[16]



[15] Samaritan Purse. Post-Conflict Assessment Minority Communities in Ninewa, February 2019. Available here.

[16] Multiple answer options could be selected for this question so the total result may exceed 100%

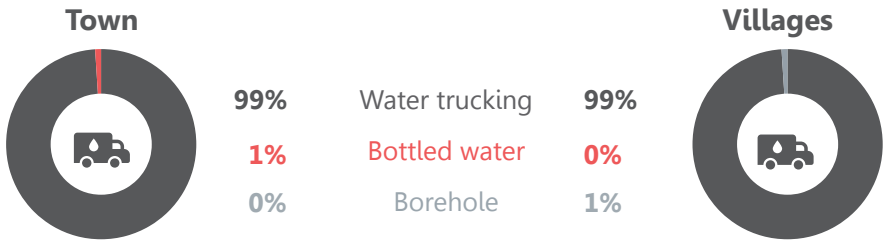
WATER, SANITATION AND HYGIENE (WASH)

The ABA findings on water, sanitation, and hygiene (WASH) indicated that **households were not connected to the public piped water network, and they were depending on water trucking for their drinking water, which may entail higher issues of accessibility, availability and quality compared to the use of piped water network.** In terms of access to sanitation facilities, a relatively high proportion of households did not have access to improved toilet facilities.[17] Nearly half of households in the town did not have access to sufficient hygiene items such as soap and feminine hygiene products.

Water

Ninety-two percent (92%) of households of both al-Qairawan town and adjacent villages reported not being connected to the piped water network, and they were **relying on water trucking as the main source of drinking water** (99% in both) (Figure 17). A relatively high proportion of households (24% in the town and 41% in the villages) reported that the water was not acceptable for drinking, cooking, and preparing food, mainly because of the water being unclear (18% in the town and 35% in the villages) and unpleasant taste (7% in the town and 9% in the villages). Still, the majority of households (79% in the town and 97% in the villages) reported never treating water before drinking. All community leaders (12/12) in the area reported that households in their neighborhood were not connected to the piped-water network. The majority of water SMEs (5/6) reported that there was less access to drinking water compared to before June 2014. To improve water access, water SMEs suggested rehabilitation of water treatment plants in the area (5/6), provision of fuel to operate water supply plants (4/6), digging new or more wells inside the area (2/6), and building new water treatment plants (2/6). Water experts (2/6) reported that the disputes between residents of the area and the communities in neighboring areas were a big barrier to repairing and reconstructing some of the water facilities that could provide the town and the villages with water.

Figure 17: Households by reported primary source of drinking water:



Sanitation and wastewater disposal

The majority of households in the town and the villages reported having access to private latrines (85% in both), but a minority reported sharing their latrine facilities (15% in town and 14% in the villages). **A majority of households were using improved toilet facilities** such as pit latrines with a slab (34% in the town and 44% in the villages) and flush toilets (17% in the town and 5% in the villages). **However, a relatively high proportion did not have access to improved toilet facilities** and used latrines without slab (35% in the town and 40% in the villages) (Figure 18). Households were reportedly using deep pits (26% in the town and 100% in villages), and septic tank (74% only in town) for wastewater drainage. A relatively high proportion of households reported that their septic tanks or deep pits were never emptied (18% in town and 34% in the villages), especially in the villages.

Figure 18: Households reporting having access to toilet, by type:

Town		Villages
Pit latrine with a slab 34%	1	44% Pit latrine with a slab
Latrine without slab 35%	2	40% Latrine without slab
Ventilated improved pit latrine 14%	3	11% Ventilated improved pit latrine
Flush toilets 17%	4	5% Flush toilets

[17] Improved toilet facilities are those designed to hygienically separate excreta from human contact. More information available here.

Solid waste

In al-Qairawan town, 26% of households in reported having access to formal solid waste removal services. However, none of the households in the adjacent villages reported having access. **The primary methods of waste removal for households were throwing in a designated open area** (33% in the town and 43% in the villages) **and open burning** (9% in the town and 21% in the villages) (Figure 19).

The majority of solid waste SMEs (4/6) and all community leaders agreed that not all households in al-Qairawan area had access to formal solid waste removal services. According to the community leaders, households who were living in specific areas (5/12) were most affected by the lack of waste removal services. Nonetheless, the majority of waste experts (4/6) reported that households had more access to formal solid waste removal services at the time of data collection compared to before June 2014 (Figure 20). Waste experts attributed this improvement mostly to the provision of more waste removal workers (2/4) and more waste removal machines (2/4). Despite this reported improvement, all community leaders reported that households in their neighborhoods were resorting to informal waste disposing methods such as open dumping (4/5 in the town and 6/7 in the villages), open burning (2/5 in the town and 5/7 in the villages) (Figure 21).

To improve solid waste disposal services in the area, waste SMEs most commonly suggested providing the municipality with more waste removal machinery (e.g., front loaders) (4/6), increasing families' awareness about preserving the environment (3/6), and hiring more waste removal workers (3/6).

Figure 19: Households by reported primary method of waste disposal[18]

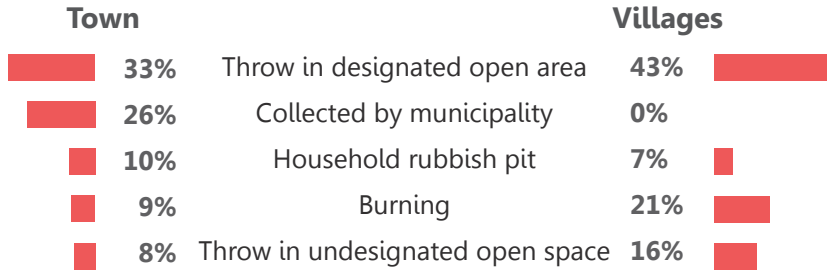


Figure 20: Access to solid waste removal services compared to before June 2014, according to SMEs:

Figure 21: Most reported informal methods of disposing waste as reported by community leaders:[15]

		Town	Villages
1	Open dumping	4/5	6/7
2	Open burning	2/5	5/7

[18] Multiple answer options could be selected for this question so the total result may exceed 100%

HEALTH

A relatively small proportion of household members reportedly needed to access health services or treatment in the 3 months prior to data collection (17% in the town and 13% in the villages) (Figure 22). Out of those, nearly a third household members were reportedly unable to access healthcare (33% in the town and 23% in the villages). **The most commonly reported barriers were the high cost of health services or medicine** (70% in the town and 76% in the villages) **and the long distances to health facilities** (35% in the town and 22% in the villages) (Figure 23).

In terms of household members with chronic diseases (hypertension, cancer, lung disease, diabetes, blood disease, or renal disease), 11% in both the town and the villages were reported to have at least one chronic disease. A majority of households (66%) in the town reported having access to the closest functioning health clinic within 2 km of their location, while only 9% of households in the villages reportedly had access within the same distance of their location (Figure 24). When assessing the distance to the closest hospital, the assessment findings revealed that only a small minority of households (10% in the town and 3% in the villages) reportedly had access to the closest hospital within 2 km, while 72% of households in the town and 80% of households in the villages reported had to travel over 5 km to the nearest hospital from their location (Figure 25).

Moreover, some households reported experiencing movement restrictions due to security issues or other access barriers to health clinics (2% only in the villages) and hospitals (2% in the town and 8% in the villages) (Figure24 and 25).

Overall, the majority of health experts (5/7) and half of the community leaders (2/5 in town and 4/7 in the villages) agreed that there was less access to healthcare services in their neighborhoods and villages compared to before

Figure 22: Proportion of household members that reported needing to access health services or treatment in the 3 months preceding data collection

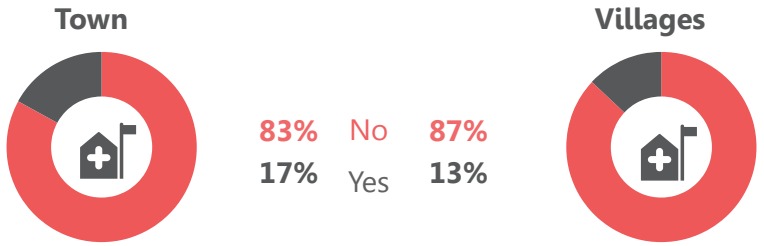


Figure 23: Most reported barriers to accessing health services, among household members that needed to access health services[19]

		Town	Villages
1	Cost of services and/or medicine was too high	70%	76%
2	The treatment center was too far away	35%	22%

Figure 24: Households by reported distance to closest functioning health clinic

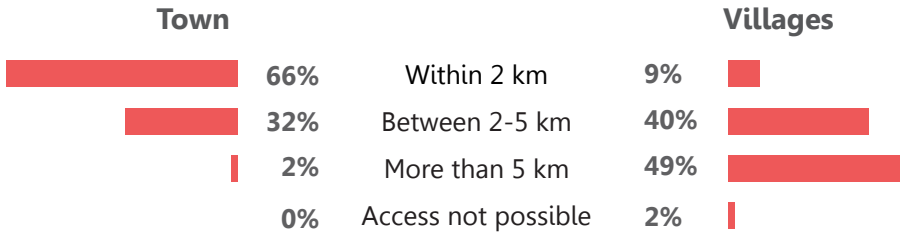
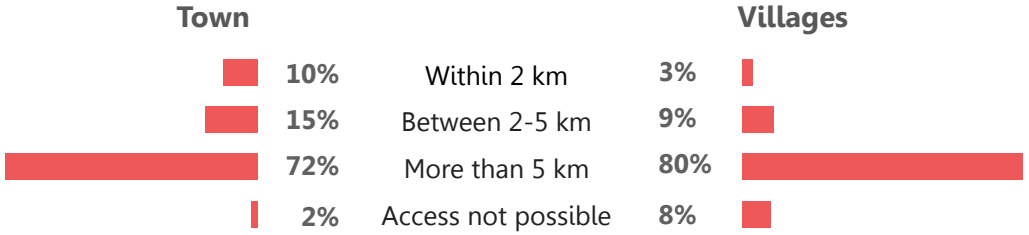


Figure 25: Households by reported distance to closest functioning hospital



[19] Multiple answer options could be selected for this question so the total result may exceed 100%

June 2014 (Figure 26). **Community leaders reported that the aspects of healthcare that were negatively changed were fewer medical personnel available (5/6), less medical equipment and medicine available (4/6), and less free healthcare available (2/6).** Community leaders stated that this negative change can be attributed to theft, damage, or destruction of health facilities, displacement of medical staff, and lack of support from the ministry of health (2/5 in the villages and 2/3 in town).

Most community leaders (4/5 in the town and 5/7 in the villages) reported that some population groups were facing unique barriers to accessing health care. These groups mostly included lower-income households (3/5 in the town and 3/7 in the villages) and female-headed households (1/5 in the town and 3/7 in the villages) (Figure 27). In the two assessed areas, the most reported barriers that these groups faced were long distances to the nearest health centre (5/5 only in the villages) and being unable to afford health costs (4/4 in the town and 4/5 in the villages).

Figure 26: Access to heathcare services compared to before June 2014, according to community leaders

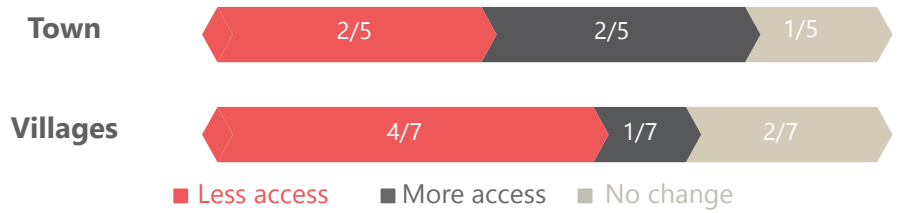


Figure 27: Population groups that were reportedly facing unique barriers to accessing healthcare[20]

		Town	Villages
1	Lower-income households	3/5	3/7
2	Female-headed households	1/5	3/7
3	Households members with chronic medical conditions	1/5	2/7
4	Households with members with disabilities	1/5	1/7

To improve healthcare in both the town and villages, health experts suggested providing more qualified/specialized medical staff (5/7), providing sufficient medicine for all kinds of diseases (5/7), building new healthcare facilities or expanding the current ones (4/7), providing healthcare facilities with ambulances (4/7), training medical staff periodically (2/7), and providing mobile health care units among villages to make access to the services easier (1/7).

Although households generally reported being able to access basic health services in al-Qairawan town and adjacent villages, the assessment findings identified a number of gaps in the health system. **The main difficulties appeared to be the cost of treatment and medication, the distance to healthcare facilities, and the lack of qualified medical staff and medicine.** Healthcare facilities in the area reportedly lacked equipment such as X-ray devices, ultrasound devices, and laboratory equipment. For advanced care, patients were reportedly traveling to far away areas such as hospitals in Markaz al-Mosul, Sinjar and Telafar to access health services.

[20] Multiple answer options could be selected for this question so the total result may exceed 100%

EDUCATION

The ABA findings revealed gaps in the education system in al-Qairawan town and adjacent villages. According to the household survey, school-age children were generally attending formal education in both areas. **However, a substantial minority reportedly was not, especially girls and children in secondary education, mainly due to high education-related costs, non-functionality of some schools, physical limitations** (e.g. no transport, no fuel available, distance too far), and parental refusal to send their children. Schools in the area generally lacked teaching equipment and supplies such as stationery, heaters or AC units, as well as uniforms. As for the distance to schools, households generally had access to primary schools within 2 km in both areas, although some children in the villages were travelling more than 5km (Figure 28). Distances to school reportedly increased for secondary school students from villages, almost a third of whom travelled more than 5km to get to school (Figure 29). This difference in access discloses the clear gap of services between the town and the villages.

Figure 28: Reported distance to closest functioning primary school

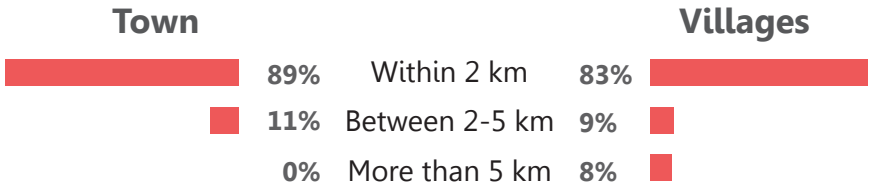
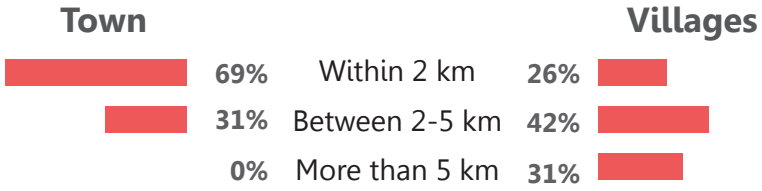


Figure 29: Reported distance to closest functioning secondary school



School Attendance

According to the household survey, a relatively high percentage of school-aged children (6-17 years old) were not attending formal education regularly (28% in the town and 23% in the villages). It was also found that girls were more likely to be not attending school (37% in town and 33% in the villages) than boys (19% in the town and 13% in the villages) (Figure 30). Overall, the vast majority of children aged 6-11 were reportedly attending school (86% of children in town and 96% in the villages), however this proportion lowered for children aged 12-17 (69% of children in town and 73% in the villages). The most commonly reported reason that children were not attending formal education was unaffordable education-related costs (35% in the town and 38% in the villages), followed by non-functionality of schools (12% in the town and 25% in the villages), physical limitations (18% in the town and 13% in the villages), and parental refusal (21% in the town and 6% in the villages) (Figure 31).

Figure 30: School-age children reportedly attending formal education by gender

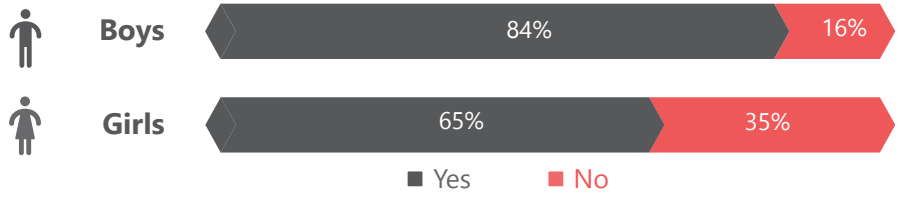


Figure 31: Households' most reported reasons why children were not attending school[21]

Town		Villages	
35% Unaffordable costs	1	38%	Unaffordable costs
21% Parental refusal	2	25%	School not functioning
18% Physical limitations	3	13%	Physical limitations

[21] Multiple answer options could be selected for this question so the total result may exceed 100%

Education gaps

The majority of community leaders in the town (3/5) and villages (6/7) reported that school-aged children in their neighbourhood/village were facing barriers to accessing education. **Among the cited barriers, the most reported were long distances or lack of transportation (1/3 in the town and 4/6 in the villages), high education-related costs (1/3 in the town and 2/6 in the villages), schools not being in good condition (1/3 in the town and 2/6 in the villages), and a lack of trained teachers in schools (1/3 in the town and 2/6 in the villages).**

The majority of community leaders in both areas (4/5 in the town and 5/7 in the villages) stated that schools in their neighbourhood **lacked equipment and supplies,** with stationary (4/4 in the town and 5/5 in the villages), heaters or AC units (3/4 in the town and 5/5 in the villages), desks (1/4 in the town and 3/5 in the villages), and uniforms (3/4 in the town and 1/5 in the villages) being the most lacking items (Figure 33). Community leaders attributed the insufficiency of equipment and supplies primarily to the lack of support by relevant authorities (e.g., Ministry of Education) (4/4 in the town and 4/5 in the villages) and theft or destruction that occurred under ISIS (1/4 in the town and 2/5 in the villages). All education experts (7/7) stated that there was a lack of trained teachers in schools as a consequence of new teachers not being appointed by the ministry of education and displaced teachers not returning.

Figure 32: Reported reasons for insufficiency of educational equipment and supplies in schools according to community leaders[22]

		Town	Villages
1	Lack of support by relevant authorities	4/4	4/5
2	Theft or destruction by ISIL	1/4	2/5

Figure 33: Stationary and equipment most commonly missing according to community leaders

Education access pre- and post-June 2014

All education SMEs stated that **fewer households had access to education compared to prior to June 2014. The experts cited the distance of schools from households' residences or the unavailability of transportation means (4/7) as the most increased barrier, followed by the lack of trained teachers (3/7), and students missing too much school due to displacement (3/7).** According to education experts (4/7), there were steps had been taken to improve education, such as the building of more schools (3/4) and provision of school desks (2/4) both the town and villages of al-Qairawan.

As new steps to improve education in al-Qairawan town and the villages, education experts suggested employing new teachers from the area (4/7), building new/more schools (3/7), opening private or summer courses (2/7), and training teachers periodically for capacity-building purposes (2/7).

The high proportion of girls missing school, alongside the refusal of some parents to send their children to school and the barriers to education according to experts (such as long distances and lack of transportation to schools) suggest that due to gender norms parents were less likely to send their girls to school, especially if they are mixed or far away from their homes.[23]

[22] Multiple answer options could be selected for this question so the total result may exceed 100%

[23] United Nations Assistance Mission for Iraq (UNAMI) and Office of the United Nations High Commissioner for Human Rights (OHCHR). The right to education in Iraq, Part II: Obstacles to girl's education after ISIL January 2021. Available here.

ELECTRICITY

According to the household survey, the vast majority of households had access to electricity in the town of al-Qairawan (92%) and adjacent villages (96%) for at least some hours a day. Most households were reportedly using the public power grid (86% in the town and 89% in the villages) as their primary source of electricity, with communal generators being the second primary source (14% in the town and 11% in the villages). **Most households (70% in the town and 58% in the villages) estimated having between 5-8 hours of electricity on average per day,** while a somewhat lower proportion (23% in the town and 35% in the villages) reported having access between 9-12 hours on average per day. This suggested that households living in the villages had more hours of public electricity than households in town.

Although the majority of the household reportedly had access to electricity, more than half of electricity experts (5/8) reported that **some areas in the town and the villages were not connected to the public grid.** Experts attributed the lack of connection in these areas to the unavailability of infrastructure to connect them (4/5) and the damage that occurred to school infrastructure (2/5). During the participatory mapping, certain areas were reported to lack public grid connection many areas in al-Qairawan town and villages had damaged electrical infrastructure and even lacking public grid connection.[22] Nearly half of electricity SMEs (3/8) reported that a minority (1-20%) of households were informally connected to the public electricity grid in the area, behavior that may lead to damage to the power grid and loss of the current. SMEs reported that this damage mainly led to weakness of current (8/8) and power cuts (7/8).

The great majority of electricity SMEs (7/8) mentioned that there were some power plants that were functional before June 2014 but that there were none at the time of data collection. Non-functional power plants were primarily reported to be al-Qairawan, Sinjar and Domiz power plants (1/7). SMEs attributed the non-functionality of these power plants to broken equipment (7/7) and broken supporting infrastructure (5/7). In terms of access to electricity compared to before 2014, although more than half of electricity SMEs (5/8) reported that there was more access to electricity at the time of data collection, half of the community leaders (6/12) in both the town and villages reported that households in their neighborhoods/villages had less access.

According to electricity SMEs, households in both al-Qairawan town and the villages had to pay for accessing the public power grid at an average cost of 60,000 IQD (41 USD) per month.[23] **According to electricity SMEs, particular categories of people were reportedly facing unique barriers to accessing electricity,** such as widows (5/7), children in lower-income households (3/7), and children in IDP or returnee households (3/5). These barriers included unaffordable bills (6/7), the public grid not reaching the residence (4/7), and the unavailability of generators in the area (3/7).

To improve access to electricity in the town and villages, electricity SMEs recommended providing power plants with sufficient transformers (6/8), wiring the power plants (6/8), vallocating funds to repair/reconstruct the power network (6/8), supplying power plants with poles (4/8), conducting awareness campaigns for people on how to save power (3/8), organizing hours of supplying electricity (3/8), or using alternative power sources like solar energy (2/8).

Table 6: Households by reported average number of hours that electrcity was available in their house per day

		Town	Villages
1	0-4 hours a day	4%	2%
2	5-8 hours a day	70%	58%
3	9-12 hours a day	23%	35%
4	13-16 hours a day	2%	5%
5	17-20 hours a day	1%	0%

[24] According to the participatory mapping there were several areas affected by lack public grid connection (areas in al-Qahra), having broken electrical poles (in al-Qahra, Hazeel Alwasti and in the northern neighbourhoods in al-Qairawan town), broken wires (Biskqi, al-Qahra, Hazeel Alwasti and in the northern neighbourhoods in al-Qairawan town), and non-functional electrical transformers (al-Qahra, Hazeel Alwasti, in the northern neighbourhoods in al-Qairawan town, Um Amer and Akhnesi). Access to the webmap here.

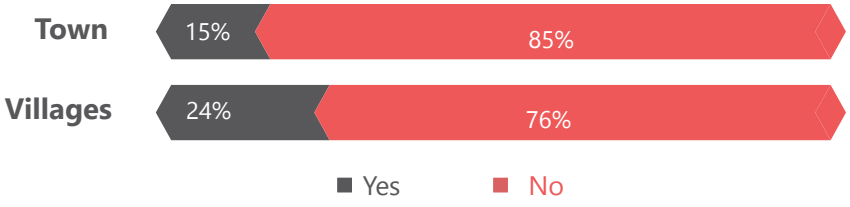
[25] Exchange rate from xe.com 1 USD equals to 1,459 IQD. Conversion rate from 14/09/2022.

PROTECTION

The major protection concern was that nearly a third of households (32% in town and 27% in the villages) reported that their shelters needed clearance from explosive remnants of war (ERW). Nevertheless, the vast majority of households (99% in the town and the villages) reported feeling safe from harm/violence in their location, and only two respondents reported having security concerns about ISIL attacks or kidnapping. Some households reported movement restrictions (15% in town and 24% in the villages), which is likely related to a multiplicity of security actors in the area, especially the areas closer to Sinjar (Figure 34).[26]

Child protection indicators suggested that children in the town and the villages were facing protection risks. As previously mentioned, a number of households reported that they used child labour (17 responses in town and 18 in the villages) and/or withdrew their children from school (14 responses in town and 17 in the villages) in order to afford food during the 30 days prior data collection. In addition, a higher proportion of girls were reportedly not attending school (37% in town and 33% in the villages) compared to boys (19% in town and 13% in the villages), especially girls from ages 12-17 (40% in town and 36% in the villages). In terms of child labour, a number of households reported children worked to provide for the family due to the lack of resources to buy food (16 responses in town and 18 responses in villages). The majority of households reported having access to the courts/formal justice systems (97%). Legal SMEs reported that the reasons why some households cannot access to courts or formal justice systems were the unaffordable costs and the inability to access the court's location.

Figure 34: Households reporting they had experienced movement restrictions in the month preceding data collection



Civil Documents

According to the household survey, **29% of households in the town and 26% in the villages were missing at least one key civil document** (Figure 35). The most commonly reported types of civil documents that were missing were the nationality certificate or unified ID for children (29% of households in town and 24% in the villages), for adults (18% in town and 8% in the villages) and adults' birth certificate (11% of households in town and 12% in the villages) (Figure 36).

The most reported reasons for missing documents in the villages were the high cost of issuing the documents (34/40 responses in the town and 34/37 in the villages) and the complexity of the process (6/40 in town and 6/37 in the villages). A few households reported to be waiting for their applications to be processed (9/40 in town and 8/37 in the villages). When lacking key documents, the most commonly reported issues that families face according to legal SMEs were the inability to access public services (education and legal) (5/6) and to access to humanitarian assistance or PDS (2/6). The groups that reportedly faced additional barriers to obtaining documentation were children from low-income families or with perceived ISIL ties.

Figure 35: Households reporting missing at least one key household or individual document

Figure 36: Most reported types of civil documents missing[27]

		Town	Villages
1	Nationality certificate / unified ID (children)	29%	24%
2	Nationality certificate / unified ID (adults)	18%	8%
3	Birth certificate (adults)	11%	12%

[26] IOM DTM, Return Index: Findings Round 15 – Iraq, March 2022. Available here. On the indicator of multiplicity of security actors, most of the assessed areas scored as high.

[27] Multiple answer options could be selected for this question so the total result may exceed 100%

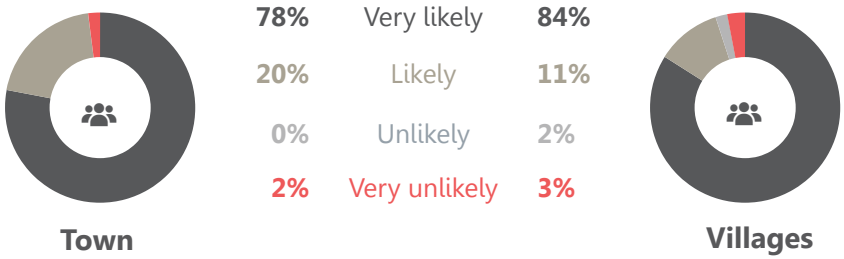
SOCIAL COHESION AND CIVIL SOCIETY

Social Cohesion, Cooperation and Disputes

According to the household survey, almost all (98%) households in al-Qairawan town and 95% in the surrounding villages reported it was likely or very likely that at least one member of the household would cooperate with other community members to solve a communal issue (e.g. flood, water shortage) (Figure 37). This finding was confirmed as all community leaders of both al-Qairawan and the villages reported it is likely or very likely that households in their neighbourhoods/villages with different backgrounds would cooperate to solve a communal problem.

A relatively low proportion of households reported being involved in a civil dispute since June 2014, only 10% of households in the town, and 13% in the villages. However, most community leaders in the town (4/5), and some in the villages (3/7) reported that households in their neighbourhood/village were involved in disputes within the community or with members of different communities. The top three reported types of disputes among those were property issues (e.g. land, housing), and family issues (e.g. divorce), which reportedly had increased compared to pre-June 2014 according to community leaders who reported disputes. To solve these disputes, the top three actors that households were reported to access to were tribal leaders/sheikhs (4/4 in town, 3/3 in the villages), mukhtars (3/4 in the town, 2/3 in the villages), and police (2/4 in town, 2/3 in the villages). All community leaders from al-Qairawan town and the villages reported that the actors provided effective dispute resolutions.

Figure 37: Households reporting it was likely at least one member of the household would cooperate with other community members to solve a communal issue



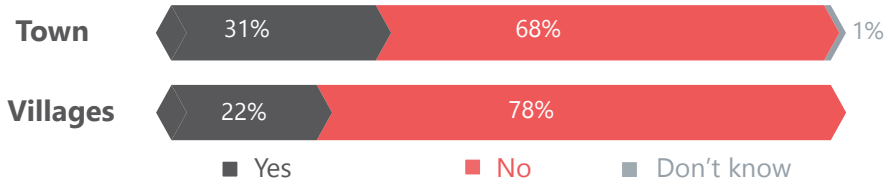
However, one community leader from al-Qairawan town, and one from the villages reported that there is a need for a reconciliation process involving groups within their neighbourhoods/villages. This community leader also reported that there were no active reconciliation, confidence-building, or peace initiatives in his area.

Political and Social Participation

Almost all households (98% in town, and 99% in the villages) reported that the head of the household voted in the 10th October 20221 elections. Only one community leader from the villages reported that **not all adults in his village were eligible or able to vote in local and national political elections, with the reported reason being that tribal and social relations put constraints on the freedom and ability to vote in his village.**

Compared to households in the villages, more households in the town reported that at least one household member participated in a community, social, political or professional organization/association in the 6 months prior to data collection (31% compared to 22% in the villages) (Figure 38). **However, some households also reported feeling unable to play a role in the decision making in their communities** (27% in the town and 22% in the villages). A similar proportion of households reported that at least one of their household members did not had access to a community leader (21% in town and 13% in the villages), which could exacerbate the feelings of being unable to participate in the decision-making for some households.

Figure 38: Households reporting that at least one HH member had participated in a community, social, political or professional organization in the 6 months prior data collection

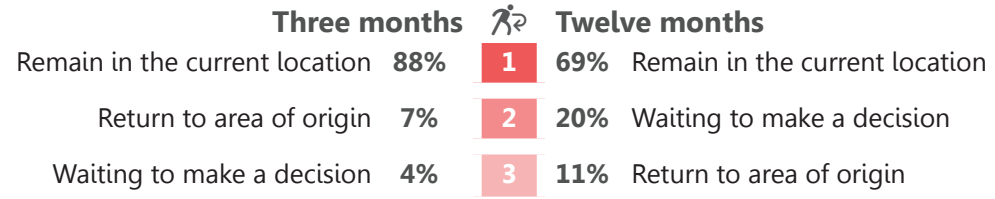


IDPS' MOVEMENT INTENTIONS

IDPs from al-Qairawan and the surrounding villages surveyed in this assessment reportedly lived in Al-Mosul and Sinjar districts. **A low percentage of these IDP households reported intending to return, both for the three months (7%) and twelve months (11%) following data collection** (Figure 39). Those intending to return to their area of origin (AoO) reported their emotional desire to return (8/12 responses), the security situation in the area of origin being stable (7/12 responses), and other family/community members have returned (4/12 responses) as reasons to return. Furthermore, around half (48%) of households reported that the security conditions in their area of origin make it more likely that they will decide to return.

The top three commonly reported reasons for households not intending to return were the lack of livelihoods/income generating activities in the AoO (75%), damaged/destroyed shelter in the AoO (67%), and no financial means to return and restart (53%) (Figure 40). These barriers highlighted the need for livelihoods opportunities and housing rehabilitation in the area to facilitate voluntary, safe, and dignified returns. Nearly half of the households reporting that their shelter was completely destroyed (51%) as a result of the conflict. A third of the households reported their shelter was heavily or highly damaged (35%) and a minority reported minor damage or no damage at all.

Figure 39: Displaced households by reported movement intentions for 3- and 12-months following data collection



The most reported conditions needed by IDP households in order to return to their area of origin were livelihood/income generating opportunities/ professional development training (86%), rehabilitation/reconstruction of homes (83%), and basic services (water, electricity, sanitation, waste removal) (75%) (Table 7). The limited availability of services in AoO was a key factor affecting the likelihood of households returning to their AoO, as almost half (48%) reported the current situation of services makes it less likely that they will decide to return.

Figure 40: Most commonly reported reasons not to return to their area of origin, among households not intending to return[28]

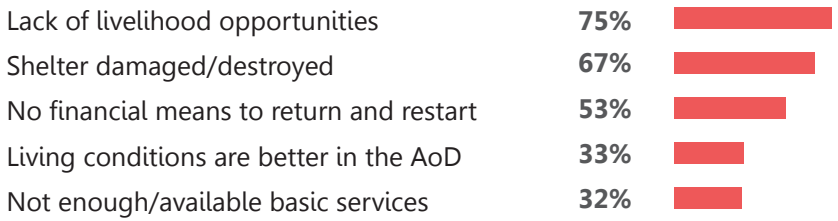


Table 7: Most commonly reported conditions needed by IDP households to return to the area of origin[29]

1	Income generating opportunities	86%
2	Rehabilitation/reconstruction of homes	83%
3	Basic services	75%
4	Psychological services	9%
5	Education services	9%
6	Healthcare services	9%

[28] Multiple answer options could be selected for this question so the total result may exceed 100%

[29] Multiple answer options could be selected for this question so the total result may exceed 100%

CONCLUSIONS & KEY TAKEAWAYS

Overall, the findings of the assessment indicate that al-Qairawan town and the surrounding villages have not recovered from the conflict, especially in terms of livelihoods, and that the provision of services had generally worsened. Livelihood opportunities, drinking water, shelter rehabilitation, education and healthcare were some of the key reported needs, and were compromising durable solutions for returnees. Below are some local stakeholder recommendations that were reported by community leaders and subject matter experts, including their opinion on how to improve the provision of services and fill existing gaps. Some key takeaways were also added, which included findings extracted from this assessment to inform local and humanitarian actors.

Food Security Issues: Household data suggested that although mostly food secure, most of the households used negative coping strategies to afford food. This situation seemed more severe in the villages due to a larger proportion of households using emergency coping strategies and directing half or more of their total expenditure towards food. This might be partially explained by their reportedly lower reliance on agriculture as a source of income, higher unemployment, and larger distances to markets in the villages.

Key Takeaways: Partners on the ground could focus their programming on addressing the underlying causes that reportedly forced households to employ negative coping strategies to afford food, such as investing in livelihood opportunities or providing direct food assistance in specific cases.

WASH Issues: Neither the vilages or the town were connected to the piped water network, and households depended on water trucking as their main drinking source at the time of data collection. Drinking water was one of the most reported priority needs by households, especially those living in the villages. In addition, over a third of the households reported not having access to improved latrine facilities.

Local Stakeholder Recommendations: Water experts suggested that, to improve the provision of water to the area, there was a need to rehabilitate the water treatment plant, provide fuel for water supply plants or connect them to the public grid, dig new wells, reconcile the communities' disputes in the area to help in repairing the water networks, build new water treatment plants, systematically regulate the distribution of water to the area, and build a piped water network in the area.

Shelter Issues: The majority of houses were built of mud, and most households reported that their houses had some level of damage. Shelter rehabilitation was the most commonly reported priority need in al-Qairawan town. In addition, community leaders reported that some households had re-displaced partly due to their shelters being damaged.

Key Takeaways: Future development interventions could focus on the rehabilitation of mud shelters, or the building of shelters made of more durable materials.

Livelihoods Issues: The findings of this assessment indicated that livelihood opportunities were scarce and had not recovered from the conflict. In addition to the effects of the conflict such as the destruction and stealing of productive assets, the most reported negative factor decreasing livelihood opportunities was water scarcity, followed by a lack of capital to invest in raw materials and productive assets, severely affecting the agriculture sector. The livelihood opportunities seemed scarcer in the villages than in the town as indicated by a reportedly higher proportion of unemployed adults and a higher reliance on community support as a source of income.

Local Stakeholder Recommendations: Livelihood experts suggested that, to improve livelihoods in the area, there was a need to invest in new business and livelihood projects, drill water wells to combat the drought, provide job opportunities for the local youth, provide vocational trainings, and provide government support for farmers, herders and new businesses via grants.

Education Issues: Findings suggested that nearly a quarter of school-aged children were not attending school. Girls and children aged between 12-17 were less likely to attend school. In addition, many households reported withdrawing their children from school or children working as a coping mechanism to afford food. In addition, community leaders and experts reported a lack of teachers.

Local Stakeholder Recommendations and Key Takeaways: Education experts provided a series of recommendations to improve education, such as employing new teachers from the area, building more schools or building new classrooms in already existing schools, opening private or summer courses, training teachers periodically for capacity building purposes, providing energy food for children in schools, providing schools with adequate stationery, and supplying schools with all necessary teaching equipment such as desks and whiteboards.

Programme strategies could be designed to improve girls' access to education (e.g., lack of awareness of the importance of education for girls, lack of gender segregated schools or schools for girls, or large distance to schools). Enhanced financial stability would likely prevent households from employing negative coping strategies related to school drop out.

Healthcare Issues: The main reported barriers for households to access healthcare were healthcare costs and the distance to health facilities. In addition, a number of households reported facing movement restriction- or security-related access barriers. Furthermore, community leaders reported that the access and quality of healthcare had diminished compared to before 2014, especially for the villages.

Local Stakeholder Recommendations: Health experts suggested increasing the number of qualified specialized medical staff, providing sufficient medicine for a wider range of diseases, building new healthcare facilities or expanding the current ones, providing healthcare facilities with ambulances, training medical staff periodically, and providing mobile health care units among villages to make access to the services easier. Community leaders also suggested adding a maternity care department to the health centre in al-Qairawan town.

Protection Issues: Although households reported feeling safe and secure in the area, around a third of households reported that their shelter needed ERW clearance.

Key Takeaways: Partners could focus on activities related to the clearance of ERW either by de-mining experts or by bringing awareness to security forces on this issue.

Displacement Issues: A low proportion of IDP households reported intending to return to their AoO in al-Qairawan subdistrict in the near future. Furthermore, community leaders reported that there had been instances of re-displacement, resulting from a lack of livelihoods, persisting shelter rehabilitation needs, and lacking access to basic services.

Key Takeaways: Governmental and non governmental organisations to coordinate projects that address the reported reasons for (re-) displacement and invest in durable solutions for households in al-Qairawan.