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### Acronyms

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On 22nd May, Iraqi Security Forces (ISF) and Iraqi Militia (IM), supported by Coalition Forces (CF), engaged in an offensive against Islamic State (IS) in Falluja to retake the city and surrounding areas. After a month of fighting, resulting in the displacement of some 14,000 HH’s, Iraqi and Coalition Forces entered the urban area of Falluja and took the city. This resulted in an increase in the number of HHs displaced to AAF, Habbaniyah Tourist City (HTC) and Khaldiyyah to hundreds or new arrivals per day.

Displacement is strictly controlled by ISF, with transition centres to screen people for possible collusion with terrorist groups and checkpoints to limit the movement of IDPs to the Anbar Governorate.

With camps at full capacity and congested, and IDPs being prevented from getting into Baghdad and other Governorates in Iraq, it is plausible to contemplate a scenario where camps won’t be able to host the estimated 10,000 HHs coming from Falluja City and the other thousands already displaced from surrounding areas. It is likely that IDPs will therefore find refuge either in informal settlements around existing camps or amongst the Host Community (HC).

GOAL, in partnership with local NGO Afkar, has assessed out-of-camp situations in order to understand current needs and the absorption capacity of host communities.

The findings highlight that the three communities assessed, to different degrees and along different sectors, have reached their breaking point, with facilities already congested and struggling to cope with the current burden; services overstretched and systems dysfunctional. Further, IDPs and HC’s coping mechanisms are exhausted and giving way to discontent and social tensions.

With a focus on health, WASH and protection, this rapid assessment points out that urgent humanitarian work and expanded capacity are needed to increase services and strengthen the structures that are currently addressing needs. An inadequate response in this complex environment will result in the loss of lives and destruction of already weak social connections. A comprehensive and integrated approach is needed in order to respond to the current emergency, whilst preventing an escalation of the current crisis and the ensuing further damage.
In January 2014, IS took the city of Falluja and started the territorial expansion which brought the militant group to occupy the Central-Western Governorates of Iraq. IS still controls significant portions of the Iraqi territory, including the Anbar corridor, Mosul corridor and Mosul City. Military operations scaled up to retake territories under IS control. In January 2015, Iraqi and Coalition Forces (CF) retook Ramadi (Anbar Governorate) but the city sustained significant damage and was unsafe for civilians to return to due to booby-traps and other mines. Iraqi and Coalition Forces then retook the city of Heet (Anbar Governorate) and started to reclaim territories along the Anbar corridor. Similarly, military operations have started along the Mosul corridor, with fighting ongoing around Makhmur and Northern Ninewa. The city of Falluja (Anbar Governorate) is currently under fire, with ISF and Militia, supported by CF, progressively gaining ground.

IDPs from Anbar have largely remained within the Governorate, moving towards the east in the hope of getting across the Euphrates and into Baghdad. However, with movements severely restricted only a few people (who managed to get the required sponsors and permits) managed to get to Baghdad; the remainder are concentrated in the Eastern Districts with more than 45% of Anbar IDPs in Falluja District (IOM).

On 22nd May 2016, military operations to reclaim Falluja City started on a large scale and the urban centre was taken between 18th and 19th June; ISF is now controlling the city with the exception of a few areas in the north still held by IS.

The Government of Iraq (GoI) policy on migration and prevention of terrorism sanctions complete control over population movements from Falluja, with security screenings to identify potential IS affiliates within the IDP population. GoI strategy is to keep IDPs in camps as much as possible and to limit IDP movements within Anbar Governorate, with a strict checkpoint on Bezeibiz Bridge preventing IDPs from crossing into Baghdad Governorate.

As of 20th June 2016, the number of IDP HHs who have been displaced following the start of military operations is 11,608 in Falluja District and 1,900 in Ramadi District (Khaldiyah) according to IOM. At the beginning of this current wave of migration related to Falluja city, people fleeing the rural areas surrounding the city were transported south; men and boys were then sent to Al Wafa and K18 transitional centres (Heet and Ramadi District respectively), where they were detained for a minimum of 3 days while the rest of the family continued the journey towards Amiriyat Al-Falluja (AAF) camps. After a few weeks, screenings for men were moved to transitional centres south of Falluja City, with women and children continuing to move towards AAF camps. Currently, IDPs are also directed towards Khaldiyah and HTC.

Several new camps were established in AAF as a contingency before the start of the new migration wave. Standard camp capacity is 1,394 HHs on average (8,364 individuals, assuming 6 people per HH) (OCHA). These camps filled very quickly, leading to the opening of new, additional camps in AAF. At the date of writing, camps are at full capacity and services are
struggling to scale up to meet the needs of the growing camp population.

Under attack, IS is increasingly reverting to asymmetrical tactics with vehicle and body-borne explosive devices and Improvised Explosive Device (IED) detonations. Reports from inside Falluja City for the past few months have reported dire humanitarian needs, with people close to starvation, eating dried dates and grass, as the limited stocks of food available are unaffordable for most HHs (for example, 1Kg of flour costs $20 inside Falluja City, an 800% increase compared to pre-war prices, according to WFP). Other security threats to the civilian population include: violence and torture; prolonged detention of men causing family separation and increasing the exposure of vulnerable members; restricted freedom of movement and lack of identification and other documents, such as permits to cross Bezeibiz Bridge into Baghdad.

In addition, sectarian tensions are increasing, triggered by the shift of powers from the Sunni to the majority Shia since the end of Saddam’s regime and increased by the presence of the Shia Militia in Anbar, traditionally a Sunni stronghold.

This extremely complex situation is deeply connected to both new and historical grievances, previous conflicts and regional dynamics. All of these factors create intricate linkages which influence displacement patterns, impose limitations and ultimately defines the context of operation for humanitarian actors.
Methodology

GOAL has collected data and qualitative information for this assessment through a team of shelter, WASH, health and protection experts from Afkar Society for Development and Relief (Afkar). Afkar’s connections and presence in the target areas facilitated access to the affected population and mitigated against assessment-fatigue.

The assessment was carried out from 30th May to 9th June 2016, with follow up visits, in three locations:

AAF (Amiriya Falluja town; AAF Residential Complex; Western Alankur; Eastern Alankur; Heramat; Alpoorkt; Seora; Alhimidian; Owesat; Tel Ghattas); HTC; Khalidiyah (Habbaniyah; East Husaybah; Cooley Camp; Khalidiya Center; Alsidikah; Abu-Flese; Khalidiya).

The team spent a minimum of 2 days in each area.

Assessment methodology included:

- Key Informant Interviews (KII) with at least one community leader/representative and one health expert/authority per location;
- Group Interviews (GIs), one for females and one for males per location, to capture the views of the wider community of IDPs in the areas. Group Interviews included a less rigidly structured Focus Group Discussion (FGD) methodology, asking the participants open questions about their fears and concerns;
- Direct observations of sector experts (WASH, health, shelter and protection);
- HH Survey methodology was kept to a minimum and used to triangulate findings and integrate them with information coming from the single HH perspective. The team collected a minimum of three HH surveys per location visited.

The majority of respondents for HHs Surveys and KII (with the exception of one female doctor in AAF) are adult men. Female FGD/GIs conducted by women surveyors were the most effective modality to gather women’s opinions and narrative on IDP conditions and needs, in a way accepted by their families and communities.

Population Profile

GOAL’s assessment focused on IDPs out of camps. IDPs in non-camp situations are less visible (or do not wish to be seen) and as a consequence receive less services. In addition, with current displacement from Falluja increasing, it was imperative to assess the conditions of existing infrastructures, and the capacity of communities to cope with an increased number of IDPs.

IDPs out of camps find shelter in informal settlements, unfinished buildings, in rented houses, host families and communal and/or religious buildings (schools; mosques; etc.).
The three areas assessed have been impacted by successive waves of displacement. AAF has seen displacement following IS’ seizure of Falluja in January 2014 and all three areas have hosted IDPs from towns placed along the Anbar corridor in the following months. The second major wave of migration arrived in 2015 when Ramadi was taken by IS and then reclaimed by Iraq forces. The military operations in 2016 saw the seizure of Heet City increasing the number of IDPs in the areas around Khaldiayah, HTC and AAF. AAF has been, until now, the destination of the majority of IDPs escaping the fighting around Falluja City after military operations resumed on 22nd May 2016. According to IOM (18th June 2016) about 80% of new displacement was channelled to AAF. Trends have recently started to change, and more HHs are directed towards HTC and Khaldiayah.

The linguistic, religious and ethnic homogeneity facilitates the relationships between IDPs and HC and mitigates tensions. Possible threats to social cohesion are along tribal lines, although to date this has not culminated in open hostility or discriminatory behaviour. The difficult economic situation, the restrictions imposed on IDPs, overstretched resources and damage to infrastructure caused by years of conflict and emergency have resulted in critically low levels of coping mechanisms.

Limitations

Due to time constraints and the limited availability of resources on the ground, the number of HH Surveys was intentionally set to a few units and used to triangulate data collected during Key Informants Interviews (KII) and Focus Group Discussions/Group Interviews (FGDs/GIs). As a consequence, this assessment does not offer statistics. This assessment provides an understanding of the current situation on the ground, from the point of view of displaced families living out of camps, community leaders and key medical personnel. Key informants and experts are also the main sources of primary quantitative data.

This is a rapid multisector assessment, with a particular focus on Health, WASH and Protection. Whilst information on markets, shelter and nutrition were collected, the scope is limited to aspects correlated to the three main sectors, and in no way provides exhaustive coverage of those sectors.
Findings

Amiriyah Al Falluja (AAF)

Until April 2016, almost 14,000 IDP HHs were hosted in AAF, with 86% having been displaced since April 2015. To date, the total number of IDP HHs in AAF has increased to 25,500, including more than 11,000 newly displaced HHs (IOM DTM), who have fled Falluja surrounding areas over the past 4 weeks.

Prior to the new wave of displacement, 37% of the IDP population in AAF was located in camps; 30% in informal settlements and 21% living with host families (IOM). The remaining families were mainly living in unfinished or abandoned buildings, with only a few HHs finding shelter in school buildings. The newly displaced are notably staying in camps, increasing the figure for camp population to an estimated 55% at the date of writing.

The significant proportion of people accommodated with host families is a phenomenon specific to AAF and suggests IDPs have a stronger networks of kinship and connections in AAF compared to the other areas assessed.

KII for the community, in particular community leaders and respondents for the HH interviews, are adult male, between 35 and 60 years old. The KI for the health facilities in AAF is a female doctor working at the hospital. The Focus group Discussion/Group Interviews were separated between men and women and had between 8 and 10 participants each.

The rapid assessment took place in small communities in AAF area and covered 370 IDP HHs.

Health

The main hospital in the area is Al Amiriyah General Hospital, located south-west of the Residential Complex, with a capacity of 64 beds. In addition to the hospital, Al Amiriyah and Al Ekhha health clinics provide basic health services. There are also two private and one mobile
clinic in the area providing primary healthcare. The health facilities, far away from the frontline and out of the reach of fire, have not reported significant damage from the conflict, and the buildings are intact and functioning.

Patients pay for consultations and procure their own drugs. The public health service is cheaper than the private health service, but much less efficient: both Group Interviews (GIs) and HHs Surveys indicate that patients prefer private healthcare because of the attention dedicated to the patient, with more qualified practitioners and services available. The public health service on the other hand is reportedly understaffed, offering limited services and with long queues to see a doctor. The higher cost of private healthcare was mentioned as the single reason for choosing the public system. However, the price for health services has recently been increased by the Ministry of Health (MoH), reducing the price difference between private and public health services. This could result in changes in preference in favour of private healthcare, but it could also mean that the poorest and most vulnerable in the community, who are less able to pay for consultations and drugs, might be cut out of the system. In contrast to the host community, IDPs in AAF receive free consultations and drugs from the public health service. This new policy, combined with an already overburdened system, has the potential to undermine social cohesion and result in tensions between HC and IDP populations.

Health facilities are supported by the Government of Iraq (GoI) and the international community, with INGOs and LNGOs currently supporting health facilities in AAF. Medicines are available 24/7 at the hospital, while the pharmacy is open from morning until midnight. Sometimes, AAF experiences shortages due to the closure of Bezeibiz Bridge; also, capacity store adequate quantities of drugs is limited. Health Key Informant (KI) specifically reports frequent shortages in dermatological drugs. HHs and KIs consistently ranked medical assistance among the top priorities, highlighting the urgent need for medicines to treat chronic conditions such as diabetes, heart disease, blood pressure and dermatological problems. Expanded Programme of Immunization (EPI) vaccines are currently available (list of full vaccines for Iraq can be found in Annex B); the HH surveys report children being regularly vaccinated against Polio and Measles. Displacement has resulted in staffing problems, with many practitioners and qualified health staff leaving Falluja. The problem is mitigated by hiring skilled and experienced IDPs. However, gaps remain and one of the consequences is the reduced capacity to offer secondary healthcare services, in particular mental health (psychological trauma), reproductive health and dentistry. These gaps were consistently mentioned by the participants in the Group Interviews, both male and female.

Ambulance services have been reduced, but are still running with 3 functioning ambulances covering the AAF area. Before the conflict, one bus line used to connect villages to the hospital; now patients reach the hospital by car (IDPs reported renting vehicles as they need them), with the distance not exceeding one hour drive. HHs surveys and GIs indicate that fever, cold and rash are the most diffuse health problems in the community. Rash and skin diseases can be connected to WASH conditions and limited availability of water in the arid desert climate. The Al Amiriyah General Hospital has records of trauma and injury, with only 3 cases on record in the past 30 days, according to the health informant. The hospital started keeping records on trauma about 6 months ago, with no available data for the previous period. The most common
cases managed at the hospital in the last 30 days are Diabetes (92), Bloody Diarrhoea (85) and Watery Diarrhoea (82), followed by Malnutrition (36). The majority of Diarrhoea cases (58%) are reported in children under the age of 5 (U5s). The high number of Diarrhoea cases raises significant concerns over potential outbreaks: overcrowded settlements, water sources at risk of contamination, poor management of latrines and reduced capacity to store water safely all contribute towards increased prevalence of water-borne diseases, including cholera. The significant number of Diarrhoea cases also raises concerns around malnutrition, connected to reduced absorption of nutrients, as well as insufficient quantity of food.

The hospital has standardised case management for Diarrhoea and Respiratory Tract Infections, but lacks standardised case management for other diseases and trauma.

In Al Amiriyah General Hospital patient records are duly kept and available. Al Amiriyah General Hospital offers surgical operations and, in addition to being the main health provider in an area including AAF town, residential complex and villages (Western Alankur; Eastern Alankur; Alpoukrti; Seora; Alhimidian; Owesat; Tel Ghattas; Al Enkoor; Al Huremaat; Al Bukretee; Albuhooree; Albjasim) it also receives referrals from the hospital in Khalidiyah. This is challenging the ability of the system to cope with increasing caseload linked to the new displacement.

The doctor serving as Health KI observed that more attention should be given to staff development and quality of drugs available at the health facility and distributed to patients, raising concerns around staff capacity and challenges in the procurement of drugs. Another key threat identified was the potential for epidemic outbreaks due to the high concentration of IDPs in a limited space and lack of essential services.

Mental Health

All Group Interviews, across different villages, have reported cases of vulnerable individuals in need of mental health and psychosocial support (PSS). Vulnerable individuals in need of support include, ranked according to the number of cases identified: orphans; pregnant women; widows and dependent elderly. IDPs have witnessed or endured violence; now they face loss and alienation in their new communities, with anecdotal cases of parents having lost all their children to the conflict. In addition, there are many cases of single-parent HHs and orphans in each of the villages assessed.

Participants of the Group Interviews also report a number of people in their communities who have become incapacitated as a result of conflict and displacement. IDPs have lost their homes, are removed from the duties they felt were fulfilling their lives before displacement and find themselves frustrated and helpless.

HH surveys, FGDs and KIIIs report that those who suffer most from this specific type of trauma are young men who find themselves frustrated at being unable to support their families or those young adults who have been recruited for combat, or experienced violence either under IS or during detention and security screenings.
Another type of psychological trauma in need of attention is the result of violence experienced by women, either domestically or as a result of conflict and increased lawlessness and insecurity. Due to traditional norms, restricted freedom of movement and the sensitivity of the topic, this often remains underreported and unaddressed. The difficulties in approaching this topic are well known, and only during one Group Interview the 9 women involved felt at ease discussing the issue, with one of them reporting that “there is a big amount of violence against the women, [especially] from their husbands, but they cannot talk or say anything to anyone”. Victims of GBV need targeted, integrated support from their families, communities and specialised personnel; because of the nature of the issue and the traditional norms of the society, this is as difficult to achieve as it is needed.

Women’s Health

Women involved in the Group Interviews reported that they can access healthcare thanks to the presence of female doctors and pharmacists. Women can access public primary healthcare services as well as family planning and Maternal and Child Healthcare (MCH). Obstetric, ANC and PNC skills seem to be available amongst the female staff at the public facilities (women reported having delivered at the public health facility), respondents do not indicate the presence of a dedicated service within the public healthcare system.

In addition to what is noted above on GBV, health clinics and the hospital in AAF do not have reports on sexual violence or offer clinical management of GBV. As is often the case, GBV is hugely underreported, especially in situations of conflict when, despite the significant increase in the number of cases, the reports drop due to lawlessness and changes in social dynamics. PSS and mental health services related to this issue are also non-existent.

WASH

Water sources are in close proximity to the IDP houses, with the farthest harvesting point located a 20 minute walk from the HH’s accommodation. Neither women nor men reported any significant security concerns around water collection.

Communal water networks are the main source of water in the communities assessed. IDPs report that they use water from the mains to shower, wash clothes and clean kitchen items and the water purified through the Reverse Osmosis (RO) system for drinking. Respondents report having from 2 to 5 litres of drinking water per person per day, with 5 litres being the minimum amount according to WASH cluster recommendations.

In general, villages in AAF receive sufficient quantities of water, however participants of the GIs noted accidental discontinuity of the service, with the network remaining dysfunctional for 2 to 3 days in a row. This raises concerns in the hot summer weather with temperatures reaching 50°C and suggests the critical need for safe water storage facilities, at both HH and community level.
Latrines are reported to be overcrowded, with IDP HHs living in the same unfinished buildings, sharing the same toilet; one HH survey suggested that latrines and showers were shared with neighbours as well as HHs inhabiting the same building, the sanitation unit being located in the common courtyard. According to interviewees, on average, 18 people share the same latrine.

Toilets and showers are not segregated by gender with men and women, girls and boys sharing the same unit. In addition, latrines are reportedly dark at night as they are not connected to the mains electricity. This was highlighted as a major security concern in both men and women Group Interviews. Although sanitation units and showers have doors, in some cases doors cannot be locked from the inside. Toilet and shower buildings were reported as in need of significant repair; informants showed the assessment team holes in the walls of toilets and shower facilities, highlighting the feeling of insecurity and violation of privacy and dignity.

38% of interviewees noted that the area needs additional water tanks with increased capacity, for both latrines and showers. Also, the quantity of toilets and showers is not adequate for the number of people using the service and additional WASH units with extra taps are needed. Facilities are in need of repair and upgrading to ensure preservation of safety, privacy and dignity.

IDPs in unfinished buildings and informal settlements in AAF do not currently face the level of congestion characterising camps hosting newly displaced IDPs from Falluja. Nevertheless, these settlements do not meet minimum standards and expose vulnerable people to increased risks, including safety. In addition, as described above, services are already overstretched and covering a disproportionate amount of people, whilst the system has completely exhausted its coping capacity. IDPs seeking shelter out of camps, coupled with HCs with little or no resources to meet immediate needs, poses risks ranging from rapid spread of epidemics to social tensions and widespread insecurity.

Respondents reported receiving WASH assistance (including hygiene kits, jerry cans, and water) in the past. The recurrence of this support in the past three months changes considerably from one village to another, but no respondent has received support from NGOs after mid-April 2016.

As is the case for other WASH items (including soap), female specific hygiene items are available on the market, but IDP women state they cannot access them because of high prices. During menstruation, women use cloth and disposable napkins and report not having the quantities needed.

Protection

HHs reported direct threats to family and generalised violence and armed conflict as the two main reasons for fleeing, followed by destruction of their homes and lack of access to basic services. AAF is the first or second area of displacement for the interviewees. Respondents reported feeling ‘very’ or ‘fairly’ safe in the new location.
The most vulnerable IDPs in need of specific attention are: survivors of violence under IS, both women and men; people suffering from severe medical conditions; people with limited access to social support including orphans, widows, unaccompanied elderly and single-parents.

Families reported their children were currently going to school; however point out the challenges to keep them in school given overcrowding of the education services, the unstable security situation and financial conditions of the HH. Respondents point out that worsening of any one of the three indicators could result in withdrawing children from school. While the quantitative data collected reports single-parent HHs, it does not indicate any unaccompanied children, with orphans being hosted by the next of kin.

Between 25-35% of HHs are currently referring to friends and family in the area of displacement for support, including financial support. This highlights the relations between the HC and IDPs and accounts for the relatively high degree of social cohesion in AAF. IDPs do not feel discriminated against and have direct interaction with the host community, rating this interaction as ‘positive’ or ‘neutral’.

During FGDs, women indicated widespread insecurity and lawlessness as the main form of insecurity, with domestic violence highlighted as the main form of violence experienced by women in their community. Other forms of GBV outside of the HH were not mentioned. Men FGDs reported violence perpetrated by IS and some security forces as the main violence experienced by men. Men FGDs also discussed main forms of violence experienced by women and girls, identifying violence perpetrated by husbands and parents.

As mentioned in the WASH section above, some form of insecurity comes from forced proximity to strangers, namely sharing shelter, latrines and showers with other HHs. This feeling of insecurity combined with the poor structural condition of WASH facilities, and non-segregation of services, contributes to perceived reduction of privacy and threat to dignity and safety.

Another protection concern is represented by lack of identification papers. During the assessment, some of the IDPs reported not being in possession of an ID. This has a number of implications for further migration, access to services and money transfers.

Multisector

The communities surveyed live out of camps, and more specifically in informal settlements, unfinished houses and other types of shelter such as government buildings or abandoned structures, including ex-industrial units (in one village in AAF, the FGD pointed out people were living in a decommissioned poultry farm). Building are shared between 2 or 3 HHs who generally don’t know each other. According to respondents, buildings need rehabilitation. IDPs, who pay rent for the buildings they occupy, also need cash support. In addition, IDPs out of camps need kitchenware, cookers, carpets, clothing and female hygiene items. Building are usually connected to public electricity and in close proximity to communal water sources.
IDPs in AAF report that most of the items they need on a daily basis can be found in the markets. Depending on the closure of Bezeibiz Bridge, restocking supplies can be a slow process, but in general traders are reportedly able to import goods. Virtually all KI (community leaders) are confident that markets can provide the needed supplies. Market are also within easy reach, and KI did not raise any access concerns relating to the status of IDPs or gender. Nevertheless, people state they do not have enough food and they are eating relief food. The main obstacles are the price of the items (with inflation estimated at 15-25%) combined with the eroded financial capacity of HHs, who are incurring debts in order to meet basic needs.

When asked about money transfers, IDPs report that the traditional money transfer system, the Hawala, is working. However, IDPs may be unable to access the services as they are not in possession of the required documents. Or, very simply, they don’t need the service as they don’t have any funds to access.

IDPs depend mostly on humanitarian aid and their network of family and friends in order to address their primary needs. Some respondents mentioned receiving some help from the community and sometimes the GoI. Only 10-20% of the HH’s resources come from a source of employment. IDPs who reported earning an income were employed as daily workers, for a few days a month. IDPs admit that the competition for jobs is harsh and increasing, and that the majority of IDPs lack the necessary skills to earn a better living.
Key Findings

- Public healthcare is currently incapable of meeting the demand for primary healthcare, and secondary healthcare is not provided. Health services are overburdened, with long queues to see a doctor.
- Healthcare and drugs are free for IDPs in AAF but not for HCs. The recent increase in costs for public healthcare for the HCs may result in the exclusion of the most vulnerable people in the community.
- Availability of drugs is limited and there are severe shortages in basic drugs and medications.
- High prevalence of diarrhoea hints to poor water and WASH facilities management; this raises a red flag over potential outbreak of water-borne diseases, including cholera. Severe gaps exist in the provision of mental health, PSS and GBV case management, including clinical management.
- WASH facilities require rehabilitation and an increase in the number of units. WASH facilities are shared amongst an average of 3 HHs, and structural damages, lack of illumination and overcrowding lead to poor perception of privacy, dignity and security. Increased amounts of water, safe water storage and female hygiene items are among the most urgent needs.
- Vulnerable categories in need of protection are: survivors of violence under IS, both women and men; people suffering from severe medical conditions; victims of domestic violence; people with limited access to social support, including orphans, widows, unaccompanied elderly and single-parents.
- Buildings are generally connected to the electricity mains and in proximity to water sources; however, IDPs lack essential NFIs such as bedding materials, cooking items and summer-specific supplies (coolers, fans).
- HCs provide some support to IDPs and social cohesion has not yet been compromised by the difficult conditions. AAF is the only area of the three assessed with a high percentage of people finding shelter with host families, highlighting some level of trust between HCs and IDPs.
Habbaniyah Tourist City (HTC)

Over 6,600 IDP HHs live in HTC. The bulk of migration occurred in the spring of 2015, adding to the numbers of people displaced during 2014 and contributing to an increase of medium to long term displacement in the area. Since May 2016, approximately 2,000 HHs have arrived in HTC, fleeing active fighting around Falluja City. As the camps in AAF fill up and face congestion, the numbers of IDPs directed towards the western part of Falluja District is increasing, with further increases expected in the next few weeks.

IDPs interviewed during HHs Surveys and KIIs are men between 42 and 55 years of age. The team conducted 2 FGD/GIs, one with men (4 participants) and one with women (6 participants). 45% of IDPs in HTC have found shelter in informal settlements, while 39% are hosted in the IDP camp in the area. The remaining HHs are either staying in unfinished buildings, rented houses or community buildings such as schools and mosques. No IDP HHs are staying with host families.

Health

The only functioning health services in HTC are a public health facility (Al Habbaniyah health facility), one private clinic, one pharmacy and a mobile clinic, with a total of 16 beds for in-patient care. These facilities offer primary healthcare, but do not offer specialised services, reportedly due to lack of specialised personnel. The services which are most needed, and not currently provided, are surgery, reproductive services and dentistry. The HTC health facility has only 2 functioning ambulances.

When a patient requires specialist treatment, they are either referred to the closest hospital or opt to attend a private doctor. The two main hospitals in the area are Khaldiyyah hospital (30Km
northwest) or AAF hospital (40Km east). The health facility in HTC refers a minimum of 40 cases per month to the hospitals in the area. Patients reach the hospital by car, which is often rented. Respondents reported that healthcare fees are very high and often unaffordable; however, if patients can afford the expensive private fees, or need treatment that neither hospital can offer, then they seek healthcare at the private clinic in HTC. Before conflict resumed in 2014, in the event of the local private doctor or clinic not offering the specialised service needed, patients who could afford it, attended hospitals Baghdad. In the last two years, this has been nearly impossible due to security and the restriction of movement for people coming from Anbar (reportedly unable to obtain the permit to cross Bezeibiz Bridge into Baghdad governorate).

Drugs are normally supplied by DoH, however, due to shortages, most essential supplies are provided by international organisations. Availability of supplies follows trends in the security situation, including the closure of Bezeibz Bridge, and the rough conditions of the roads to reach the area. The main shortages are drugs to treat hypertension, diabetes and dermatology drugs. Some drugs, like oncology medicines, are never available because of their high price and limited demand.

Patients need to pay for their prescriptions. A cost example is the hypertension treatment, bought at pharmacies for USD3. As per AAF, drugs are free for the IDPs.

The majority of cases managed by the health facility in the past month were diarrhoea (80 cases, 24% severe) and diabetes (79 cases). The facility received 34 cases of malnutrition and assisted 40 deliveries. The FGDs identified fever, diarrhoea and skin diseases as the main health problems in the community.

The health facility had only 6 reported cases of trauma and injuries in the past month, 17 in the past 6 months and 32 in the past year. The health facility in HTC has standardised case management of Diarrhoea and Respiratory Tract Infection, but not for IMCI (Integrated Management of Childhood Illness) and GBV.

According to the KI-doctor in the infection and disease department at the health facility in HTC, the greatest threat to public health, in particular in the upcoming summer months, is represented by a lack of services and of appropriate awareness and preventative behaviour, including cleaning of cooking tools and treatment of water for drinking. The KI recognises the work of the humanitarian actors in supporting the health facilities, but highlights that that is not enough at present and the support provided will need significant scale up to face the new displacement from Falluja City.

The limited services offered together with a lack of personnel are sources of complaint for the patients. The community leaders interviewed stated that since the health services were opened to IDPs, the health facility is always too crowded. They added that ‘the number of IDPs is higher than the number of people in the HC’. This increased competition for services has been identified as a possible breaking point in the social cohesion between the two different communities, in particular with the ongoing displacement from Falluja.
Mental Health

Following patterns similar to those identified in AAF, orphaned children are identified as the most in need of PSS and mental health, followed by pregnant women and dependant elderly and widows. The children who have lost their mothers are all under the age of 12.

Mental health services are needed for victims of violence, in particular women. The 6 participants in the female FGD say that women suffer two types of violence, in the family ‘where they are beaten by their husbands’ and in their communities ‘preventing women to take part in work and social activities’. This inevitably leads to feelings of isolation and helplessness which frequently culminates in depression, and highlights the need for both mental health services for the victims and PSS for better, and culturally acceptable, integration of women in the event of displacement.

Despite the increased and increasing IDP caseload, the capacity of the system to deliver services remains unchanged, causing frustrations and stress among the population, and possible tensions between IDPs and HCs. In addition, forced proximity to other HHs is felt to be a problem and reason for concern, and likely to introduce conflict among IDPs.

Women’s Health

Health facilities in HTC offer family planning and MCH. Although assisted delivery is offered by
both private and public services, women prefer delivering at private clinics, with two thirds of respondents reporting that they delivered at the private health facilities in the last pregnancy. Considering that the price of the private healthcare is higher than the public, and that most of the private health services offered are considered ‘unaffordable’, this result should raise concerns of the quality of services at the public healthcare facility.

The health facility in HTC offer treatment for women and girls victims of violence, including sexual violence. However, cases are not recognised or reported as GBV cases. The informant notes that from inception of the conflict, the number of GBV cases reported dropped to zero. This does not indicate a drop in cases, but else an increased fear of reporting abuses and unacceptability of the topic. This is confirmed by health facilities treating cases, without formally recognising them as GBV or keeping any reports on them.

**WASH**

Restricted quantities of drinking water is a significant threat identified for HTC. Families are allowed 20 litres of drinking water per day and people report having 1.5 to 2 litres per head per day; this is consistent with the average number of HH members. The drinking water comes from the RO system, whereas the water for other uses comes from Habbaniyah Lake.

IDPs in HTC have received in-kind support in the past three months, with supplies including soap and hygiene kits as well as water. IDPs say that soap comes from donations, none of them reported buying it in the market. The WASH expert from the assessment team recommends an increased amount of water for the latrines both for the tanks and for their maintenance.

In this community, latrines and showers are public, with a minimum of 2 HHs using the same unit. Women and men share the same unit. Individuals interviewed mention long queues in the sun in order to use latrines or showers. Also, they report feeling uncomfortable using the WASH facilities, ‘with all the people very close, waiting’. This undermines the privacy and dignity of IDPs who live in these conditions. Interviewees also complained about children using the latrines ‘improperly’. In addition, crowded WASH facilities with limited water for the unit’s cleaning and maintenance pose a considerable risk for disease outbreak. Water shortage also means that there is not enough water for showers, as FGD have reported; this has an impact in the prevalence of skin diseases.

Electricity in HTC is supplied by a generator, which only runs for a few hours a day, and only during the day. As a consequence, latrines are dark at night. Both men and women report feeling safer if somebody else accompanies them, in particular during night hours.

Hygiene items are available on the market, but very expensive. This include female hygiene items. IDP women reported using disposable napkins or cloth during menstruation. Participants to the female GI say that they need to take the family budget into consideration when they need to purchase these specific items and sometimes they cannot afford to buy what they need.
Protection

HTC is the only community where one of the KI openly admitted that there is a problem related to sexual violence, in particular VAWG.

There are orphans in the community, but none of them were reported to be unaccompanied. Children are currently enrolled in school, although parents interviewed point out that, if the family is forced to move again due to lack of services or livelihoods opportunities and insecurity, then that might change. Also, HHs point out that their children do not feel comfortable going to school, complaining about the situation in the classrooms; as per other services, education is overcrowded and sees a lot of people from different parts of Anbar gathered together with limited or no activities encouraging integration.

HHs are concerned that lack of, or poor quality, services (including education) and the harsh economic situation will have a negative impact in the longer term on the future of their children and feel frustrated because they feel there is nothing they can do to help it.

Social cohesion is a concern which comes across clearly from the answers provided for each sector, for example when speaking about overcrowded WASH services or shared shelter, distrust is expressed. Parents are uncomfortable with their children spending time with strangers and phrases like our children ‘learn more things that our parents did not accept’, portray a sense of alienation and suspicion towards the new society. This could fuel tensions and conflict, and certainly prevents the creation of a cohesive network which could withstand the worsening situation.

IDPs report receiving little help from the community, even though the respondents recognise that the HC is ‘poor too’. This points out that the social capacity, and arguably willingness, to cope with more migration is exhausted and calls for support from other actors to increase the level of services and resources in the community, both material and social.

Although direct discrimination was never mentioned, relationships with the HC and between IDPs themselves is ‘neutral’, suggesting a co-existence with little social connection and weak networks. This situation could be exasperated by the arrival of significant numbers of IDPs.

The HHs interviewed reported having two or more members of their family with at least one of the following vulnerabilities: serious medical conditions, disability, missing relative, survivors or at risk of violence and pregnant/lactating woman. People in the community are often missing identification documents, reducing their access to services and freedom of movement and further increasing their vulnerability. The high level of debt in IDP HHs is also a concern from a protection perspective, inducing members to adopt negative coping mechanisms and increasing the level of frustration and conflict within the HH.

The community leader highlighted that the community faces a serious problem for the cases of unaccompanied people, in particular elderly and people suffering from illness or disability.
Multisector

The IDP population surveyed lives in informal settlements, mostly in unfinished buildings which they rent for a monthly fee. Buildings need rehabilitation; in addition, IDPs report being in need of NFIs such as women’s hygiene items, pots and pans to cook, cooker, bedding materials and items for the summer, like coolers and fans.

The market is functioning relatively well; goods are arriving from Baghdad with the main obstacles being the crossing of Bezeibiz Bridge, which closes when the security situation deteriorates, and the poor condition of the roads towards HTC. Shops are generally open from morning to evening and provide most of the items needed by HHs on a daily basis. Gender or status do not prevent access to the market, which is located within walking distance for the HHs in the villages assessed.

From the consumers’ side, the main barrier to access the market is the price of items, approximately 30% more expensive compared to the pre-war period.

In the absence of a significant or stable source of income (maximum 20% of IDP HHs’ income comes from employment, which is limited to daily work) and with the majority of HHs being in debt, the inflated price of goods constitutes a barrier which can prevent HHs from accessing specific items; for example, IDPs say they depend on distribution of soap from NGOs and UN.
Key Findings

- There are no hospitals in HTC.
- Health facilities offer primary healthcare, but don’t have the capacity to scale up coverage.
- Secondary services are non-existent. Most needed services are mental health and PSS. The health facility in HTC offers treatment for women and girl victims of violence, including sexual violence. However, cases are not recognised or reported as GBV cases.
- Lack of services and appropriate awareness and preventative behaviour, including cleaning of cooking tools and treatment of water for drinking, are the greatest concerns for public health.
- There is a high competition for services, with IDPs almost outnumbering HC members. This has been identified as a key factor which could compromise the already fragile social cohesion. In addition, IDPs have access to consultations and drugs free of charge.
- Water is a crucial need in HTC. People have between 1.5 to 2 litres drinking water per head per day. IDPs also report not having enough water to shower and maintain the WASH facilities, with serious consequences for their, and the community’s, health.
- A generator provides power to HTC, but only runs a few hours a day. HTC is left in the dark at night.
- Critical lack of female hygiene and dignity items; available on the market, but unaffordable.
- In addition to victims of VAWG, unaccompanied people, in particular elderly and people suffering from illness or disability are of particular concern for protection.
- Markets function inconsistently due to poor road conditions and the security situation affecting the closure of the main bridge into Anbar; however, basic items seem to be available in shops and inflated prices are the main reason why IDPs cannot access basic items.
Khaldiyyah

Ramadi City and surrounding areas have seen fighting throughout 2015 with significant displacement from Ramadi City, almost completely destroyed and not safe for civilians to return to (mines, UXOs, booby-trapped houses). When the area was retaken from IS, IDPs - unable to go home - decided to stay in proximity to their area of origin, settling around Khaldiyyah city, in an area which hosts over 2,000 HHs in informal settlements.

South of Khaldiyyah city centre there is a camp which to date has received 1,900 extra HHs since the military operations around Falluja started in May 2016.

The villages surveyed in this rapid assessment are located between Khaldiyyah and Habbaniyah, in Ramadi District. The number of IDP HHs hosted in those communities and targeted in the assessment are approximately 100.

With the exception of the 14 women consulted in the FGD/GIs, respondents are men, between 36 and 55 years old.

Health

In Khaldiyyah, there is one central hospital (Al Rasheed Al Ahly Al Badeel) with a capacity of 75 beds, and various clinics, both private and public, in the surrounding area, including two clinics with in-patient capacity (Al Shuhadaa and Al khalidya Al Qadim) of a total of 19 beds. Al Madiq health facility was completely destroyed by the conflict in December 2015 and has not been repaired to date. The hospital can be easily accessed and provides affordable services. However, patients are not satisfied with the services, saying that they receive appropriate care; the main issue is the lack of drugs and medical equipment.

Since the closure of the hospital in Ramadi, the caseload at Al Rasheed Al Ahly Al Badeel has considerably increased and will continue to be congested until the hospital in Ramadi is fully rehabilitated. In addition to the current situation, the number of people covered by the existing hospital and clinics is going to increase as newly displaced from Falluja are directed towards Khaldiyyah and Habbaniyah areas.

Al Rasheed Al Ahly Al Badeel refers cases to the hospital in AAF, in particular for surgery and intensive care. Last month, the hospital in Khaldiyyah referred 70 cases to the hospital in AAF; this raises clear concerns around capacity to scale up and manage the extra burden.

Private healthcare reportedly offers more and better services, however, they are considered unaffordable by both male and female respondents. When ill, people prefer to go to the pharmacy rather than to the hospital (seen as too crowded and offering poor levels of services) or the private doctor (too expensive); however, in case of emergency, the hospital is the first point of contact. The ambulance service is reported to be functioning, although not at the required scale.
The Group Interviews reported that people seek healthcare mainly for diarrhoea and rashes. The community leader reported that diseases affecting the IDPs are chronic diseases, such as diabetes and hypertension; diarrhoea, in particular amongst U5s; Respiratory Tract Infection and Skin diseases. In the last 30 days, the hospital has treated 93 cases of Watery Diarrhoea; statistics on more severe forms of diarrhoea are not kept by the hospital. A high number of cases have also been observed for diabetes in adults, both male and female, respiratory diseases and fever, with a higher prevalence of cases in the U5s. The hospital has received 92 serious injuries and 60 cases of malnutrition. The main gaps identified by the doctor interviewed regard surgery (kidney and brain).

The hospital does not have reports on trauma, injury or sexual violence. GBV clinical management is not offered at Al Rasheed Al Ahly Al Badeel. In addition, the hospital does not have standardised case management of diarrhoea, Respiratory Tract Infection or IMCI. Patient records are not kept at the hospital in Khaldiyyah.

Gol through the DoH procure required drugs and medications and distribute them to the hospital, which then provides them to the patients. The patients pay for drugs and the price per prescription is IQD 2,000 on average. There are no reports of drugs provided to the IDP population free of charge in Khaldiyyah. Pharmacies offer the main drugs as well, but they do not offer a 24/7 service. Shortages are often experienced for antibiotics, cough syrup and imperazol (or omeprazole, to cure gastroesophageal reflux disease, or GERD).HHs surveyed state that there are not enough medicines at the hospital/health facilities, and not enough staff. EPI vaccines are available in Khaldiyyah and the positive outcome of the vaccinations campaign confirmed by the HH Surveys, with IDPs reporting that their children have received immunisation against both polio and measles. Respondents in Khaldiyyah have been displaced for a year, therefore it needs to be noted that for vaccines, the answers might not be representative of the current situation and cannot confirm whether vaccines are currently available. These people are believed to be two years behind with vaccinations. This issue needs follow up to assess whether the system was able to extend coverage to the new arrivals.

According to the health informant, at present, there are no organisations supporting the health facilities in Khaldiyyah.

Mental Health

Some of the categories at risk are pregnant women, orphans, elderly and widows. Compared to other geographies, unaccompanied elderly are more numerous in Khaldiyyah. GI point out that in addition to the above, many people have been injured and have lost eyes and limbs due to the conflict. Their diminished physical capacity, together with the constraints of displaced life (competition for a job; difficult economic conditions; limited social networks), contributes to feelings of helplessness and depression.

There are no specialised services for mental health and PSS.
Women's Health

Contrary to the other two locations assessed, public healthcare offers a range of reproductive and maternal and child healthcare (MCH) services, including delivery, ANC and PNC and has dedicated female personnel. With a dedicated service at the hospital and the public healthcare cheaper than the private, the number of women delivering at the hospital is higher than the number of women delivering at the private clinics, according to the focus group.

As mentioned above, the hospital does not have specialised staff, equipment to address cases of rape, or a dedicated system to file cases of GBV. There are no indications of specific services to treat cases of sexual violence.

WASH

meeting the minimum standard recommended by the WASH Cluster. IDPs buy their water at the RO, where they collect water in 20 litre jerry cans. Paying for this service may result in HHs limiting the amount of drinking water per person per day, or lead to them using the water from the communal main for drinking after some sort of purification which, if done incorrectly, can risk diseases such as diarrhoea. There are no reports of disruptions in the system or limits in the availability of drinking water. The RO station can be reached by car and the journey takes half an hour. This can be a serious access concern for IDPs who do not own, or cannot access or drive, a vehicle.

Both obstacles highlighted above pose questions on the suitability of this system for IDPs recently displaced from Falluja (with no cash or possessions) in case an increased number of IDPs are displaced outside of the camps in the peri-urban area between Khaldiyyah and Habbaniyah.

The water for showering and washing comes from the municipal mains, and is accessible from IDP houses, with taps in close proximity to the building. However the system is reported to be functioning only a few days a week.

IDPs in this community use public toilets, shared by men and women. On average, this community has one toilet per HH and the cases of queues for accessing toilets and showers are not present in this area, eliminating a great part of frustrations connected to service congestion. Latrines are located outside the main building and dark at night, as there is no connection to electricity. Similarly, showers are located outside the house and are shared. IDPs do not report feeling unsafe, but stress the need for lights to be able to access latrines in safety at night. The main concern for both men and women is privacy, latrines and showers are all in the same location and organised in clusters, and the quality of water. According to the community representative, the latrines are in need of some repair. He also confirmed the need to improve the quality of the water available in the WASH facilities, namely, water should be chlorinated.

Soap can be purchased in the local shops; similarly, female hygiene items are available in the market, although reported to be very expensive (since inception of the crisis, prices have
increased by 50%).

IDPs have been in displaced in Khaldiya for more than 2 years. In that timeframe, they have received WASH support from the international community and local NGOs, in particular hygiene kits, jerry cans, water and cash. However, they state that the support was very basic and did not meet their needs. Nevertheless, families only rank hygiene items between 3rd and 6th when listing priorities, with NFIs, and in particular summer-related items, scoring higher in the list.

Protection

The most common form of violence experienced by men is related to terrorism, their life in areas under IS control and the direct threat posed by the fighting and widespread insecurity on their families. While the type of violence experienced by men comes from external circumstances, for women, the threat comes from within the HH, and is violence (specifically beating) from their husbands. It is not clear if women do not talk about abuses perpetrated by armed forces because they refer, in their FGD, to current fears and current lives in the situation of displacement, or because the topic is even more sensitive than domestic violence and would entail more damage to their reputation and safety within the community; the only possible observation is that VAWG outside the HH is not listed in the security concerns of either men or women.

In the current area of displacement IDPs feel fairly safe. IDPs don’t feel discriminated against and although the help offered by the HC is admittedly limited, interactions between the two groups are frequent and peaceful. However, the level of connection between HC and IDPs registered in AAF is not observed in Khaldiya, with IDPs mainly going to NGOs for help. For example, HHs in Khaldiya consistently report not having access to food and only having a few days/weeks of food in stock. When asked when their will find the money or food when they finish their stocks, only rarely do they mention friends and family.

However, one area of tension and stress worth highlighting is between the different IDP HHs living in the same building, in close proximity, who do not know or trust each other. This distinction does not follow religious or ethnic differences, but is likely to be along tribal lines, although more research on the topic is needed. This is felt to be a threat to children as well, with parents becoming more protective and watchful of their children’s network of friends. This increased attention does not seem to impact, at present, children’s education, with parents reporting that if the situation remains stable their children will continue to go to school. The tension between IDP HHs sharing living spaces is a potential threat for social cohesion in view of increased displacement.

In this community, there is a serious problem with the number of IDPs missing identification documents. This constrains their movement, access to aid, services (such as money transfer) and rights, making them more vulnerable.

Unaccompanied elderly are viewed as the category most at risk in the community, with particular reference to older women.
Multisector

The IDP community surveyed lives in an informal settlement, in unfinished buildings. Buildings report minor damages, but need rehabilitation. The unfinished buildings where IDP HHs found shelter are extremely crowded, with numerous cases of 5 families living in the same building; this means that each family is confined to one room, with on average 11 HH members.

While drinking water is located a 30 min car journey from the habitation, non-drinking water taps are located near the house. However, buildings are not connected to electricity.

Access to the market is limited by unavailability of cash, with restocking problems due to poor roads, bridge closures and insecurity only mentioned as side problems. Prices in the market have increased 50% compared to pre-crisis levels and people are forced to prioritise their needs. The Hawala is reported to be working and accessible to IDPs as well as HC, provided they present an ID - which is not possible for many people. It is not clear if IDPs could potentially access money transferred by relatives and friends, but what is clearly indicated is that HHs have exhausted their finances and are in debt. HHs interviewed have not had an income since they were displaced, with most of the HHs in the community having been displaced since 2015. IDP HHs largely depend on NGOs. IDPs’ exhausted coping capacity and resorting to negative coping mechanisms to meet critical needs, and the limited support the HC can offer, will result in increased competition for limited resources and create harsher circumstances for the newly displaced.
The hospital in Khaldiayah offers only basic services and has a caseload well above its capacity. Last month, the hospital in Khaldiayah referred 70 cases to the hospital in AAF. In particular, surgery is missing; Khaldiayah does not offer any GBV treatment, formal or informal. Similarly, specialised services such as mental health are not available. Unlike HTC and AAF, there are no reports of drugs provided to the IDP population free of charge in Khaldiayah. Health facilities in Khaldiayah are receiving minimal or no support from the NGO community. Public healthcare offers a range of reproductive and maternal and child healthcare (MCH) services, including delivery, ANC and PNC and has dedicated female personnel. These are not available in the other two geographies. IDPs access non-drinking water for free from the mains, but need to pay for drinking water from the RO system. In addition, the RO station can only be accessed by car. Although WASH facilities are all concentrated in the same area, with concerns for privacy, IDPs have one latrine and one shower per HH. Latrines are not connected to the electricity and are dark at night. Men experience, or have experienced, violence outside of HH, at the hands of armed groups. In contrast, violence for women is primarily domestic violence, from husbands and parents. Lack of IDs is a big problem in Khaldiayah according to the community leader, with consequential protection issues. HHs in Khaldiayah are often in debt.
Conclusions

Before the Falluja crisis, the majority of IDPs had found shelter in informal settlements, unfinished buildings, with host families or in public buildings. The strictly controlled displacement from Falluja City and the surrounding area has increased the percentage of IDPs in camps. However, the limited capacity of camps, with the congestion of existing camps and new camps already at full capacity, the scenario where significant portions of displacement will revert to informal settlements or surrounding areas is likely.

At present, systems are under significant pressure, with HC and IDPs competing for resources and services currently unable to meet their needs.

Public healthcare has increased the price HC members have to pay, making the difference between private and public healthcare negligible and making it harder for HC members to access services. At the same time, a new policy is providing free drugs and consultations for IDPs, lending to tension within the HC. Long queues to see doctors are reported and some drugs are not available. In general, health facilities can provide primary healthcare, with hospitals providing additional services such as surgery. However, only AAF hospital seems to be equipped for operations, with dozens of cases per months getting referred to Al Amiriyah General Hospital. Lack of specialised personnel, drugs and equipment are the main problems. Critical gaps are provision of mental health, PSS and clinical management of GBV.

Water supply and management is a severe problem especially in the western part of Falluja district, with quantities of drinking water per person per day far below Sphere standards. Scarcity of water for personal hygiene and maintenance of WASH facilities has severe consequences on health and wellbeing of displaced communities, which report significantly higher cases of diarrhoea and skin diseases.

Systems which are currently congested and incapable of delivering at scale are likely to collapse under a suddenly increased caseload if not duly supported.

Vulnerabilities are multiple and affect women and men, boys and girls differently. For men, the threats come from the external environment and are connected with violence perpetrated by armed groups. For women, the greatest threat is violence within the HHs, perpetrated by parents or husbands. This kind of violence is hidden, due to tradition, sensitivity of the topic and a rigidly patriarchal society that discourages public discussion of the topic. For this reason, during conflict, when the level of violence against women inevitably increases, reports of sexual violence decrease. Some hospitals treat GBV survivors, but do not file cases or have reports. No hospital or health facility offers standardised case management of GBV or services such as mental health and PSS to support and rehabilitate the victims, highlighting the overwhelming need to address this critical gaps in the present situation.
Annex A

List of EPI for Iraq

BCG birth DT 2, 4, 6, 18 months; 4-6 years
DTwP (Diptheria, Tetanus, with Polio) 2, 4, 6, 18 months; 4-6 years
DTwPHib 4, 18 months (subnational)
DTwPHibHep 2, 6 months (subnational)
Hepatitis A 2, 2.5 years;
Hepatitis B birth; 2, 6 months
IPV birth; 2, 4, 6, 18 months; 4-6 years
Measles 9 months
MenACWY 7, 12 years;
MMR 15 months; 4-6 years
OPV birth; 2, 4, 6, 18 months; 4-6 years
Pneumonia_ps 2 years; high-risk groups
Rotavirus 2, 4, 6 months
Td >6 years
Tetanus Toxoid Women of Child bearing age and pregnancy; 1st contact; +1, +6 months; +1, +2 years
Typhoid 4 years;
Vitamin A 9, 15 months; 4-6 years
Yellow fever 4 years