Iraqi refugees in Jordan research their own living conditions
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Iraqi refugees in Jordan research their own living conditions: *'we only have our faith and families to hold on to'*

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Thirty-six Iraqi refugees designed and conducted a community survey among their fellow refugees in Amman/Jordan in July 2007, as part of the 2007/08 CARE International Refugee Programme in Jordan[1]. The survey aimed to capture their living conditions from a community mental health perspective, with a special focus on gender based violence, and to identify resources for community development initiatives. Three hundred and fifty-four Iraqis, between the age of 10 and 86 years, were interviewed through a mixture of institution based and 'snowball' sampling.

This article highlights the general challenges to studying temporary communities under distress, and the special obstacles to gathering valid and reliable information on sensitive topics, such as violence, in a situation of pervasive fear and mistrust. The main findings are presented and discussed with regard to projects and activities that can strengthen refugee communities' mental health.

Keywords: Community mental health, Community empowerment, Researching temporary communities under distress, Training lay people in research, gender based violence

Background

Numerous Iraqis fled their country between 1990 and 2003, often under traumatizing circumstances, due to crippling international economic sanctions, periodic air attacks by the Coalition Forces, ethnic discrimination and internal political persecution. Since 2003, the military and civil violence that has accompanied the occupation of Iraq by American and other forces, has led to a high percentage of internal displacements and cross border migration. Emigration has intensified since the bombing of the Al Askari mosque in Samarra in early 2006, which also unleashed heavy sectarian violence. Syria and Jordan have absorbed the largest numbers of refugees. Estimates of the number of Iraqi refugees in Jordan fluctuates between 450 000 and 750 000 (International Organization for Migration (IOM), 2008).

According to the Norwegian Research Institute FaFo report 2007, most refugees come from central Iraq, in particular Baghdad. The majority of them have emigrated together with other family members. Most refugees live in rented apartments in urban settlements and survive on the transfer of money from Iraq or abroad. Their financial resources are, however, becoming depleted with increasing length of stay, in the absence of work opportunities in Jordan, and due to the sociopolitical instability of the region.

Jordan is not a signatory to the United Nations Convention relating to the Status of Refugees of 1951. Refugees consequently do not enjoy legal protection. They are not allowed to work and have limited access to health and social services. At the time of the survey Iraqi children were only able to attend public schools in Jordan if they had

residency status. As of August 2007, the Jordanian government has opened the schools for all Iraqi children. Their numbers attending have, however, been repeatedly found to be comparatively low.

Until the end of 2007, less than 10% of the estimated refugee population had registered with the United Nations High Commissioner for Refugees (UNHCR) for refugee status determination (Duncan, Schiesher & Khalil, 2007). Around 20 national and international nongovernmental organizations (NGOs and INGOs, respectively) provide psychological, health, social and educational services specifically to Iraqi refugees, but reach only a fraction of them. Services lack referral and coordination mechanisms (Ventevogel, 2008). In particular, mental health and psychosocial support services are not integrated within the Jordanian public services.

Principal challenges

With the exception of the FaFo study, all studies about the situation of Iraqi refugees in Jordan conducted in 2007 by IOM, the International Catholic Migration Commission (ICMC) and the Community Development Centre Sweileh were primarily qualitative, and based on convenience samples. All reports mention difficulties in outreach to the refugees. This is due to hiding and moving within the urban environment because of fear of abuse, exploitation and maltreatment by others, political persecution and assassination, as well as the depletion of their financial resources. Lack of communication and support structures within the refugee community itself has also been repeatedly mentioned. The exceptions are small seeds of self organization among Christians, and some minority groups, as well as refugee committees that have been initiated by some of the NGOs and INGOs.

Conceptual framework and related research

The development of the survey was based, among others, on considerations that have been summarized lately in the *Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007) and the conceptual work of the Psychosocial Working Group (Psychosocial Working Group, 2003)[2]. The survey topics were elaborated in detail according to the competence/control and stress/coping models of mental health (White, 1959; Seligman, 1975; Rotter, 1975; Rutter & Garmezy, 1983)[3]. Recent studies have indeed shown that, in general, the refugee experience increases both physical and mental health risks (Iglesias et al., 2003), as listed below.

- Arabic refugee communities often experience an increase in mental health problems and gender-based violence (Douki et al., 2003; Khawaja & Twetel-Salem, 2004; Khawaja & Barazi, 2005; Hammoury & Khawaja, 2007; Meffert & Marmar, 2008);
- Humiliation as an experience of unjust and debasing treatment during and after violent conflicts is significantly related to subjective physical and psychological health complaints (Giacaman et al., 2007);
- Long processes of asylum seeking and postmigration living problems impact negatively on refugees' quality of life, overall functioning and physical well-being (Laban et al., 2008).

Participatory training and survey development[4]

Characteristics of the participants CARE announced the research project in the Iraqi refugee community committee by word of mouth. All applicants were accepted on the

condition that they committed themselves to the whole of the training and the ethics and obligations of the field research. Two thirds of the 36 volunteers had university degrees. Their age ranged from 27 to 53 years, except for four teenagers who were between 14 and 16 years old. The latter participated together with adult family members and in the spirit of a Child-to-Child Approach.[5] Males and females participated in equal numbers. Prior to the data collection phase, 80% of the researchers had completed three of four peer counselling training workshops. These focused on understanding and dealing with refugees' psychosocial problems, communication skills and group leadership. Those researchers who were not concurrently involved in such training were supervised and coached by the master trainer and the co-trainer throughout the survey preparation. This was done in order to ensure that they owned the necessary communication skills before going out into the field.

Training programme The survey design and questionnaire were developed in two interactive, five-day training workshops which were attended by all researchers. The training addressed the following topics, outlined below.

Outline of the training workshops

I. Orientation

- **Key problems** of the Iraqi refugee community in Jordan
- **Goals of the survey:**
  a) General living conditions, physical and psychological well being
  b) Gender based violence: incidence, perpetrators and victims
  c) Resources for community development: knowledge, skills, communication networks, community activities, facilities, activists, resource persons, and supporters from the Jordanian community
- Learning about research processes:
  a) Exploration and background information
  b) Guiding questions
  c) Quantitative and qualitative research methods
  d) Standards and protocols
  e) Interviewing skills
  f) Pre-test, data collection, processing and analysis
  g) Dissemination of results
  h) Practical implications
- Challenges in community research:
  a) Sensitive topics and populations
  b) Trust building
  c) Protection of interviewees and data
  d) Obtaining valid and representative data

II. Composition of research teams:

- Profile of researchers
- Principles of team work and group leadership
- Composition of research teams

III. Development of the survey questionnaire:

- Brainstorming of questions
- Testing of questions through researchers' knowledge of their local community
- Working groups on guiding questions
- Testing of questions across research groups
- Interviewing skills and recording
- Pre-test and finalization of questionnaire

IV. Survey design:

- Sampling strategies
- Identification of sampling procedure
- Logistics

Overcoming fear and suspicion Establishing trust between the participants, building functioning research teams, agreeing on an effective sampling strategy with minimum bias and maximum safety for the researchers, and reaching a common understanding of violence, proved to be the biggest challenges in the preparation phase. Transparency, democratic dialogue and sound reasoning were introduced from the beginning as basic training values and strategies. They helped to create an atmosphere of self-responsibility and mutual respect.

After CARE explained the general background, rationale and purpose of the survey, the researchers met according to their area of residence in Amman and compiled information about the living conditions, mental health situation and incidents of violence in their areas. It became clear that the social relations between the refugees were not determined by living in the same area in Amman, but by family, neighbourhood and other networks that had already existed in Iraq. Beyond these, refugees were generally cautious, suspicious, and sometimes even hostile, towards each other and their host community. The researchers feared that they would not be welcomed and accepted in the area in which they were living. For these reasons, the idea was abolished to compose research teams and draw samples according to the refugees' area of residence. Instead, a mixture of institution based and social network snowball sampling was chosen[6].

Composition of research teams The researchers finally agreed to work in teams of two, according to their choice for safety, practicality and quality control reasons. A total of 18 teams went out into the field. Each four – five teams formed a network, and met at least once a week with their self assigned coordinator in order to discuss research related questions, and for the coordinator to collect the completed questionnaires. All researchers also met once a week at the CARE premises in order to discuss the progress and problems of fieldwork.

Sampling strategy Due to the absence of comprehensive demographic information about Iraqi refugees in Jordan, the following sampling strategy was selected: each research team interviewed 20 refugees. Gender parity had to be strictly considered. Special attention was also given to the various age groups (10–17 years, 18–24 years, 25–45 years, and more than 45 years old). These were interviewed according to the ratio 2:3:3:2. Half of the interviews were conducted at the CARE and CARITAS premises that were approached by many refugees for social, psychological and medical services, and the other half through snowball sampling (Heckathorn, 1997) across the researchers' personal communication networks, but excluded family members[6].

Survey questionnaire and its application The survey questionnaire was developed cooperatively, over the several steps that are described above. It proved to be difficult to achieve a common understanding of abuse and violence, as most researchers had little awareness of these issues in the beginning of the training. A patient, cross cultural dialogue and discussion resulted in the adoption of the World Health Organization (WHO) definitions for the purpose of the survey (WHO, 2005)[7]. The final questionnaire crystallized through several pre tests that involved self application, mutual interviews and supervised random interviews with

users of the CARE community centre. It included the following main sections: demographic information, current living conditions, physical and psychological health, social relationships, community communication and resources, as well as violence affecting the Iraqi refugee community. Ten of the 53 questions were of an exploratory nature and open ended. They focused particularly on the interviewees' ideas how to improve the wellbeing of the community as a whole. The answers to the other questions were formatted as multiple choices, or rating scales[8]. The interviewees were, however, always encouraged to provide additional information according to need. Each interview lasted around 50 minutes. One researcher conducted the interview while the second team member wrote the answers down.

Data collection and processing The field phase lasted from July 10–31, 2007. The quantitative data were coded by two refugees according to a predetermined key, and entered into an SPSS (Statistical Package for the Social Sciences) spreadsheet. These entries underwent several control procedures for accuracy and consistency before they were analyzed further by using SPSS 10. The qualitative answers were translated, and consequently content-analyzed by the principal researcher. A draft report was submitted to CARE in October 2007, and a final report in January 2008.

Main results[9]

General sample characteristics Three hundred and fifty-four refugees were interviewed. Females and the age group of the 25 – 45 years old were slightly overrepresented in comparison to the original sampling key. Approximately 90% had registered with UNHCR for refugee status determination. This indicates a level of awareness and initiative that marks the sample as a somewhat positive selection. Sample characteristics are shown below.

Sample characteristics	N	%
Total sample size	354	
Males	164	46.3
Females	190	53.7
10 – 17 years	66	18.6
18 – 24 years	78	22.0
25 – 45 years	144	40.7
More than 45 years	66	18.6

Two thirds of the interviewees were Moslems, 13% Christians, and 20% adhered to other faiths (Sabeans, Mandeans, Yezidis, etc.). Half of the sample had left Iraq in 2005 and 2006. Their average level of education was high school (*tawjihi*). Both the percentage of illiterate respondnts and those with higher education increased with age.

Around two thirds of the respondents indicated that they had worked previously in Iraq (54% of the males and 75% of the females). Nearly all minors and 90% of the 18 – 24 years old said that they had work experience. These data may reflect the economic pressure on families in Iraq that has forced more minors and women into the work force in recent years.

Current living conditions Four out of five respondents lived with their immediate family, and another 10% together with members of their extended family. Six percent of the adults lived alone. Separation, divorce or widowhood affected almost exclusively women, and particularly those older than 45 years.

Around 11% of the interviewees, most of them 25–45 years, admitted that they were working illegally. Slightly more men than women worked. Savings and support by family members were the most important financial resources for the refugees. Only

every seventh refugee received assistance from UNHCR or CARE. Of those interviewees who had children of school age, 40% admitted that their children did not participate in any educational activities.

As personal wellbeing is very much influenced by people's own perceptions, the interviewees were asked to rate basic aspects of their life: the quality of food, their financial situation, the general housing conditions, as well as their physical and psychological health. Although the average ratings all turned out to be fair, they ranged from very bad to very good.

Physical and psychological health Physical health rated lowest among all of the above components, particularly among the male respondents. Quality of food had the second lowest overall rating. Fifty-nine percent of the interviewees indicated that they suffered from physical health problems. The most frequently mentioned were illnesses that are, among others, related to stress, such as head and back pain, high blood pressure, ulcer, diabetes, irritable colon, etc. (33%), degenerative musculoskeletal diseases (16%), injuries sustained in Iraq (6%) and coronary heart diseases (5%) [10].

When asked about their physical ailments, 14% mentioned, in fact, primarily psychological problems such as anxiety, depression, and *'going mad'*. In a specific qualitative inquiry, 78% of all respondents described their psychological health problems further. They did this mostly in terms of the perceived causes.

These were:

- Financial problems (18.8%)
- Bad physical health (15.2%)
- Difficult living conditions (13.0%)
- Loneliness (12.3%)
- Instability (11.9%)
- No future (11.6%)
- Lack of protection and residency, and fear of deportation (10.5%)
- No access to education (10.5%)
- No job (9.7%)
- Being away from home (9.7%)
- Traumatic experiences in Iraq (8.7%)
- Worries (8.7%)

Eighteen percent of the total sample indicated, in addition, that they lived with at least one other family member who had physical health problems, and 16% said that at least one other family member was suffering from psychological problems.

Stressful experiences in Jordan: One open-ended question of the survey asked; *'what is the most difficult situation that you have experienced since you came to Jordan that still causes you worries and fears when you remember it?'* Fifty-eight percent of the interviewees answered positively. The following were the most frequently mentioned incidents:

- Residency and border police controls, arrest, abuse in custody, threat and execution of deportation (35.3%)
- Problems with landlords, neighbours and children of the vicinity (9.3%)
- Serious health problems, accidents, bad health services (9.3%)
- Difficulties with the residency permit (8.3%)
- Public violence, humiliation, harassment and abuse (8.3%)
- Deception, exploitation and robbery (8.3%)
- Separation or loss of family members (6.9%)
- Difficulties at the Jordanian–Iraqi border (6.4%)
- Deprivation of school attendance, and school based abuse and rejection (5.9%)
- Threats (5.4%)

- Lack of work and financial resources to meet basic needs (5.4%)

Perceived obstacles to the normalization of life Nearly all respondents answered an open-ended question about what they thought were the three biggest obstacles to a normal and healthy life for Iraqi refugees in Amman.
They identified the following main obstacles:

- Difficulties in obtaining residency (68.7%)
- No work permit (52.5%)
- Limited financial resources and high costs of living (41.8%)
- No access to education (31.6%)
- Insufficient health services (30.8%)
- Harsh and inappropriate living conditions, particularly regarding accommodation (19.5%)
- Instability and stress (8.5%)
- Lack of legal protection and threat of deportation (7.6%)
- Practices of the resident police (5.6%)
- Restricted freedom of movement (4.0%)
- Lack of acceptance by the host community (3.7%)

All respondents were aware that these factors caused psychological distress and led to violence within the Iraqi refugee community.
Incidents of violence Community violence is commonly gravely underreported in surveys (Ellsberg & Heise, 2005). Researchers on violence usually have to gain the trust of their target communities through patient and long term, community based work before they can access the whole fabric and dynamic of it (Lee, 1993). This research aimed, therefore, only at obtaining first information about patterns of violence that affect the Iraqi refugee community in Jordan. As for the pre test phase it became obvious that respondents would be reluctant to share their experiences. The researchers were consequently asked to keep a final note in each survey questionnaire whenever they observed that the participants obviously knew of incidents of violence, but were hesitant to speak about them. This affected a total of 5.4% of the interviewees, and especially the 10 – 24 year olds. No gender differences appeared in this respect. All interviewees were asked to indicate incidents of violence that they had heard of, observed, been subjected to, or that they themselves had actually perpetrated within the last four weeks. They were asked to describe what kind of violence had happened, where it had happened, and who had been the perpetrator(s) and the victim(s). The provided responses were sparse, frequently incomplete and consequently did not allow further detailed analysis.
Within the last four weeks, nearly every tenth refugee reported to have been exposed to violent incidents, either directly as a victim, or through learning about the incidents. Every 15th refugee had observed situations of violence during this period. One out of 20 refugees also admitted to have acted violently towards others. Verbal and sexual violence dominated in all accounts. Most violent situations had happened in refugees' homes, or in a public place. According to the data, the different forms of violence seemed to affect all age groups and both genders, and both victims and perpetrators were found in each of them.
Coping strategies All refugees were asked what they did in order to protect and improve their psychological wellbeing. Every tenth refugee did nothing in this respect. Praying and reading the Qur'an or the Bible were the most preferred strategies of handling psychological distress and enhancing psychological wellbeing, followed by talking

to others, going out, sleeping, taking medication or doing sports.
These activities are shown in the table below.

Activities to improve psychological wellbeing (multiple choices)			
Pray	49.7%	Do sports	11.9%
Read the Qur'an or Bible	42.1%	Doing nothing	10.2%
Talk to somebody	28.5%	Other	8.2%
Go out	28.5%	Listen to music	6.5%
Sleep	21.5%	Relaxation exercises or yoga	3.1%
Take medication	14.1%		

Social support systems The researchers asked also questions about whom the respondents would turn to if they needed information, comfort in times of emotional distress, or practical help. The interviewees also had to evaluate who had been most and least helpful to them since they had come to Jordan. The following table gives a summary of the findings.

Neighbours and friends from Iraq were considered as primary sources of information, followed by refugee relief organizations and parents. It should be noted that 14.1% of the respondents indicated that they did not know of anyone who could help them get the necessary information. When asked about whom they would turn to if they needed practical help, around a quarter of the respondents indicated that they did not know of any one. Another 23% would turn to relief organizations for help. Practical help was often sought from within the immediate

Supporters to turn to for (multiple choices)	Information	Practical help	Emotional support and comfort	People who have in fact been most helpful[11]
No one	14.1%	24.9%	8.5%	39.5%
My spouse	16.9%	12.4%	36.7%	8.2%
My children	2.8%	2.5%	18.9%	2.3%
My parents	24.3%	20.9%	35.9%	19.8%
My brothers and sisters	18.1%	19.8%	32.8%	16.4%
Other family members	14.1%	13.6%	17.8%	7.1%
Neighbours and friends from Iraq	36.2%	13.3%	11.3%	6.2%
Current neighbours	9.9%	9.3%	9.0%	4.5%
Iraqis I met in Amman	18.1%	19.2%	15.8%	10.2%
Jordanians I got to know	18.1%	13.3%	5.7%	14.4%
Staff of organizations in Amman that help refugees	28.8%	23.2%	7.6%	14.7%

and extended family. Every fifth respondent would also ask other Iraqis for practical help, and every seventh respondent would ask Jordanians. Members of the immediate family were primary emotional comfort resources for all respondents. All other members of their social network ranked less.

However, when asked to evaluate who had really been helpful to them since they had come to Jordan, nearly 40% of all respondents said that no one had really been helpful since they had come to Jordan. In contrast to the frequency with which they would seek help from the various groups of their social network, the actual help provided appears to be much less. These findings highlight that present support structures might, in fact, be limited in their efficiency.

The interviewees reported mostly negative experiences with landlords (36.7%), followed by Jordanians who they had met (21.5%), staff of relief organizations (20.3%), current neighbours (18.8%), Jordanian authorities (13.6%), other Iraqis who they had met in Amman (10.2%), and employers (9.0%).

Knowledge of community resources Around one third of the interviewees indicated that they knew of other particularly skilled, helpful, or well informed Iraqi refugees. They thought that some of them would be able to help organize community activities. In contrast, only 11% of them knew of equally resourceful members from the Jordanian host community. Every fifth survey respondent also wanted to help other Iraqi refugees in Amman themselves.

Suggested interventions to improve the situation of Iraqi refugees in Amman Many respondents also saw a huge need to explain the situation in Iraq and of Iraqi refugees in Jordan, through the international organizations and the media, to the government and the general Jordanian public. '*We wish the Jordanian community to understand our situation*' was frequently expressed. They also advocated better human rights and legal protection, especially in regard to residency, work, and protection from abuse, and asked the government to take the initiative. They also appealed to their Jordanian and Iraqi brothers to promote mutual understanding and respect, and to establish cordial relations. Some suggested cultural and educational activities for both Jordanians and Iraqis.

When asked what they thought could help to reduce the violence that affects the Iraqi refugee community from both inside and outside, respondents mentioned, in addition the improvement of refugees' living conditions particularly with regard to financial income, health and educational services. They strongly appealed to their own community to apply patience, wisdom, mutual respect, forgiveness and love, and to improve cooperation between each other in order to solve internal violent conflicts. They thought that awareness raising, educational and cultural activities, as well as individual and family counselling, could help in promoting a stronger sense of community.

With regard to addressing domestic violence within their community, most respondents appeared somewhat helpless. Staying silent was particularly suggested to women and children. Praying and reading the Qur'an or Bible were most frequently recommended as active ways of coping with such situations, followed by talking to others.

Responding to situations of violence in public places appeared to be particularly difficult for the refugees. Besides acting correctly and trying to calm the situation down, the predominant advice was to *'accept the situation, keep silent because you do not have residency, and go away.'* Only a very few respondents suggested self-defence, or turning to

the police. Similar advice was given for situations of violence at work places. Few respondents suggested that refugees should speak to their managers, yet many suggested *'run away because you do not have a work permit.'* In cases of violence in public institutions, the majority of respondents also advised their fellow-citizens to behave well, keep out of the situation as much as possible, and leave. Few recommended that others to speak up for themselves and complain.

Gender differences Gender differences appeared in several areas of investigation[12]. Female respondents seemed to suffer somewhat more from disadvantages in financial means, housing and food than men, but saw their physical and psychological health slightly more positively than their male counterparts. Men and women also used different psychological coping mechanisms. Females resorted to praying, reading the Qur'an or the Bible, and taking medication much more often than males. Males, on the other hand, went out more often, talked to others more, and used sports more frequently than females in order to achieve psychological wellbeing. In regard to their social support networks, female participants had somewhat less access to relevant information than males, but used both other family members and the relief organizations more often than the men as information sources. In comparison to the female refugees, a higher percentage of the male respondents had no one to turn to for practical help. However, male respondents were, on the whole, more active in seeking practical help from both within and outside the family than female refugees. More female than male respondents indicated that they had no one to turn to for emotional comfort. This affected the elderly in particular. Male respondents reported, however, more disappointing experiences with people who they had approached for help than females.

Age differences The age groups of the 10–24 year olds rated their overall living conditions as more negative than the older respondents, with physical health being the most distressing life aspect. They were also least connected to sources of information and least aware of the role of refugee relief organizations in providing guidance and support. This age group also had the highest percentage of respondents who indicated that they do not have any one to turn to if they are in need of information.

Vulnerable groups Twenty-nine respondents (8.2% of the sample) were found to rate both their physical and psychological health as bad, or very bad. Poor housing and financial conditions were significantly correlated with the perception of poor physical and/or mental health. Further analysis found that respondents with bad or very bad psychological health ratings were more inclined to stay at home, do nothing, or watch TV than refugees who felt that they were in fair, good or very good psychological health. They also turned more often than others to family members for information, emotional support and practical help. Additionally, they hardly ever approached staff of organizations who care for refugees for help.

Discussion

The aim of the survey was to describe the living conditions of Iraqi refugees in Amman from a community mental health perspective with a special focus on gender based violence, and to identify resources that can contribute to community development initiatives. The sampling strategy strived to achieve a balance between the need to make use of safe and trustworthy places and channels of communication, and the requirements of random sampling in order

to achieve maximum representation of the data. The fact that 90% of the interviewees were registered with UNHCR, while UNHCR had only reached 10% of the estimated total refugee population in Jordan at the time of the survey, shows that even the peer researchers were only able to reach a special sector of their community. Due to the lack of appropriate reference data it is impossible to say how representative the findings truly are for the total Iraqi refugee population in Amman. Some similar general demographic information has, however, been obtained in the other studies (see also Gilbert, this issue).

The research process as described above generated much useful information on the target population's general psychological distress, coping mechanisms, support needs and resources, yet fell short of gaining access to the reality of violence, let alone gender based violence.

The poor data quality in this respect can currently be explained only by some hypotheses that the author has drawn from observations throughout years of work in the field of (gender based) violence in Jordan and neighbouring countries, and within refugee populations:

- Gender based violence is a sensitive concept introduced in the Middle East by western oriented scholars, practitioners and agencies. It touches the power relationship between the genders, as still traditionally enshrined in many families. Researching gender based violence questions, and thus potentially threatens, traditional patterns of social relationships. Interviewees might have felt that they needed to protect their social life from any interference, particularly given the distressing living conditions.
- They might have been afraid of talking about violence within the public sphere due to fear of reprisals and lack of legal protection. In the course of the survey preparation, the author listened to numerous accounts of verbal and physical violence against Iraqi men, women, youth and children by neighbours, taxi drivers, shop owners, bosses, officials, teachers and fellow students.
- Coming from the same community, the peer researchers might have shared some of these reservations. They might, consequently, have not been very proactive in their inquiries. Lack of interview experience might have also added to this problem.

The following discussion concentrates, therefore, mostly on implications of the survey findings for the general protection and enhancement of refugees' psychosocial wellbeing.

1. *Fulfilling basic human needs in a cooperative Jordanian/Iraqi effort* The interviewees considered their insecure legal status, prejudice, discrimination, harassment and abuse, sparse financial resources, the absence of work opportunities and limited access to health and educational services as major causes of their current psychological distress and obstacles to achieving a '*normal*' life. In the spirit of the IASC guidelines, these findings call for psychosocial support interventions that secure, first of all, basic human needs and rights. Surely this can only be achieved through a cooperative effort of both the Jordanian and the Iraqi community, based on listening and learning from and with each other, and through continuous financial support by the international community until a durable

solution is reached. The interviewees contributed many valuable ideas how to facilitate this process. These could supplement similar national and international NGO initiatives that were started in the course of 2007 under the leadership of the Jordanian government.[13]

2. *Strengthening families' psychosocial competence and creating multipurpose community centres* Refugees' social networks consists primarily of their family, but also neighbours and friends from Iraq, staff of refugee relief organizations and Iraqis and Jordanians they met in Amman. The family is the prime source for emotional support, particularly for refugees with mental health problems, while the others are more often approached for information and practical help. The efficiency of help seems to be generally limited. Many interviewees and, in particular, adolescents, have no support. These findings highlight the need to empower families to take better care of the psychosocial support needs of their members. With additional training in culturally sensitive family counselling strategies the peer counsellors could, for example, become family educators. Through outreach programmes, they could also approach those community members who are – for different reasons – unable to join more centralized community activities. The findings also call for pooling the available refugee community resources, in order to create better sources of practical help by connecting them with the previously mentioned social activity centres. Such centres also need to develop specific programmes for girls and women, adolescents and men.
3. *Addressing physical and mental health problems in an integrated manner* The responses of the many affected interviewees show that they do not differentiate between physical and mental health problems. Physical and mental health education and service provision need, therefore, to be delivered in the primary health care level in an integrated way, and also, eventually as an outreach service through the above mentioned community centres.
4. *Strengthening the communion between spiritual and psychological coping skills* The data show how important spiritual guidance is for most of the interviewees, in order to deal with their difficult living conditions. Psychosocial support interventions need, therefore, to include much space for a respectful dialogue between faith based wisdom and western science based knowledge, about stress and trauma management, and to integrate both in a joined effort of finding meaning and purpose for hardship that is often difficult to bear.
5. *Combating violence that affects the refugee community* Violence from both within and outside the Iraqi refugee community remains a challenging topic of psychosocial intervention. It seems to affect nearly all age groups and both genders as victims and as perpetrators, yet the obtained data is far from satisfying. Violence is, by far, not always understood as a threat to mental health. It is often accepted within families, feared from the side of the host community, and paired with a profound sense of helplessness when it occurs in the public sphere. Trustworthy and well accepted advocates need to embark on patient anti violence awareness raising and education campaigns, for both the Iraqi refugee community and the Jordanian public.

On the whole, the survey documents the continuous high distress among the contemporary Iraqi refugee community in Amman, and the destructive potential that the current living conditions contain in the long run for the wellbeing and development of hundreds of thousands of human beings.

Afterthoughts

What has the survey given to the peer researchers? In an evaluation meeting at the end of the field research phase, the researchers expressed the following:

- '*We have made friends and learnt to work together.*'
- '*We have learnt to do research and study a situation before we take action.*'
- '*We know the situation of our community better and can, therefore, help more efficiently.*'
- '*We have met with so many people who are so much worse off than we are, so that we really learnt to appreciate what we still have.*'
- '*We need to speak out for all Iraqi refugees and lobby for a better understanding between Iraqis and Jordanians.*'

References

Community Development Centre Sweileh (2007). *East Amman Survey of Iraqis. Final report.*

Douki, S., Nacef, F., Belhadj, A., Bouasker, A. & Ghachem, R. (2003). Violence against women in Arabic and Islamic Countries. *Archive of Women's Mental Health, 6,* 165-171.

Duncan, J., Schiesher, D. & Khalil A. (2007). Iraqi Asylum Seekers in Jordan. A Report of the *ICMC-USCCB Mission to Assess the Protection Needs of Iraqi Asylum Seekers in Jordan.* International Catholic Migration Commission.

Ellsberg, M. & Heise, L. (2005). *Researching violence against women: a practical guide for researchers and activists.*. Washington, DC: World Health Organization.

Giacaman, R., Abu-Rumeileh, N., Husseini, A., Saab, H. & Boyce, W. (2007). Humiliation: the invisible trauma of war for Palestinian youth. *Public Health, 121,* 563-571 www.elsevier health.com/journals/pubh.

Gilbert, J. (2009). Power and ethics in psychosocial counselling: reflections on the experience of an international NGO providing services for Iraqi refugees in Jordan. *Intervention* 7 (this issue).

Hammoury, N. & Khawaja, M. (2007). Injuries, Violence, Disasters. Screening for domestic violence during pregnancy in an antenatal clinic in Lebanon. *European Journal of Public Health,* Vol. 16, No. 6, 605–606.

Heckathorn, D. D. (1997). Respondent-driven sampling: a new approach to the study of hidden populations. *CALIBER journals of the University of California Press, 44,* 174-199.

Iglesias, E., Robertson, E., Johansson, S.-E., Engfeldt, P. & Sundquist, J. (2003). Women, international migration and self-reported health. A population-based study of women in reproductive age. *Social Science and Medicine, 56,* 111-124 www.elsevier.com/locate/soscimed.

Inter-Agency Standing Committee (IASC 2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: IASC.

International Organization for Migration (2008). *Assessment on Psychosocial Needs of Iraqis Displaced in Jordan and Lebanon.*

Khawaja, M. & Barazi, R. (2005). Prevalence of wife beating in Jordanian refugee camps:

reports by men and women. *Journal of Epidemiology and Community Mental Health, 59,* 840-841.

Khawaja, M. & Twetel-Salem, M. (2004). Agreement between husband and wife reports of domestic violence: evidence from poor refugee communities in Lebanon. *International Journal of Epidemiology, 33,* 526-533.

Laban, C. J., Komproe, I. H., Gernaat, , & deJong, (2008). The impact of long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands. *Social Psychiatry & Psychiatric Epidemiology, 43,* 507-515.

Lee, R.B. (1993). *Doing Research on Sensitive Topics.* London: SAGE Publications.

Meffert, S.M. & Marmar, L.C. (2008). Darfur Refugees in Cairo: Mental Health and Interpersonal Conflict in the Aftermath of Genocide. *Journal of Interpersonal Conflict Online First. Sage Publications.* http://jiv.sagepub.com.

Norwegian Research Institute FaFo, UNFPA, Department of Statistics Jordan (2007). *Iraqis in Jordan 2007. Their Number and Characteristics.*

Psychosocial Working Group (2003). *Psychosocial intervention in complex emergencies: A concept paper.* Edinburgh: Psychosocial Working Group.

Rotter, J.B. (1975). Some problems and misconceptions related to the construct of internal versus external control of reinforcement. *Journal of Consulting and Clinical Psychology, 43,* 36-67.

Rutter, M. & Garmezy, N. (1983). *Stress, coping and development in children.* New York: McGraw-Hill.

Seligman, M.E.P. (1975). *Helplessness.* San Francisco: Freeman.

United Nations (1951). *United Nations Convention relating to the Status of Refugees.* Geneva: United Nations.

Ventevogel, P. (2008). *Mental Health and Psychosocial Support for Displaced Iraqis in Jordan. A Brief Assessment of Needs and Services.* Unpublished Report. WHO Jordan.

White, R.W. (1959). Motivation reconsidered: the Concept of Competence. *Psychological Review, 66,* 297-333.

World Health Organization (2005). *WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses.* Geneva: World Health Organization.

[1] Many people worked together to make the survey a success. Special thanks go to CARE project manager Reema Masoud, for her organizational skills and technical input; Samar Al Nashy, MA Demographics, and Ihssan Ali, BA Biology, for the data entry; Sana Ramadan, MA System Analysis and Computer Programming, for the quantitative data analysis; volunteers Nour Haj Hassan and Remah Ali Milhem for their Arabic-English translations during the training workshops, and finally to Khalid Hashim Al Rawi, M.B.CH.B./Diploma in Public Health, for his professional translation skills and the analysis of the medical data. This report presents the views of its author who was the principal researcher and trainer, and not necessarily of CARE International in Jordan.

[2] According to the Psychosocial Working Group, traumatic events such as war and expulsion affect communities in three domains: their human capacity/capital (household livelihoods, skills and knowledge, health and well-being); their social ecology/capital (social relations with families and peers, religious and cultural institutions, links with civic and political authorities);

and their culture and values/cultural capital. The effect can be a disruption and depletion of such community resources, but also a strengthening. Psychosocial interventions aim at strengthening the capacity of communities for coping successfully with changing circumstances.

[3] The competence/control and stress/coping models of mental health assume that threats to personal wellbeing result from the absence or insecurity of the fulfilment of basic human needs, previous and/or ongoing experiences of losses, as well as discrepancies between situational demands and individual capabilities to act competently with regard to personally meaningful and developmentally relevant aspects of life. Individuals' general resources, such as health, education, work and communication skills, specific coping skills for stressful situations, and the amount of social support moderate the consequent personal experiences of stress and eventual trauma. Ongoing personal distress increases the risk of developing more serious mental health problems over time. The mental health of a community is characterized by its collective past stressful and traumatizing experiences, the ongoing deprivation and threats that it encounters, its material, human and organizational resources and coping strategies, its social support structures, as well as its self organization and control over living conditions.

[4] The principles and strategies of developing refugees' competences as researchers and the development of the survey design and instrument will be elaborated in detail in a future article.

[5] The Child to Child Approach encourages and enables children and young people to promote the holistic health, wellbeing and development of themselves, their families and communities worldwide. See http://www.child-to-child.org/.

[6] In a snowball sampling approach, additional survey participants are identified according to set criteria upon the recommendations of initial participants. This sampling along with social structures is often used in the study of populations that are difficult to reach.

[7] Verbal violence was defined as any use of language that disrespects, insults and humiliates another person and hurts his/her feelings. Physical violence was defined as any threat of inflicting physical pain and injury to another person, and/or the execution of it. Sexual violence was defined as any action that forces a person into a sexual behaviour against his/her will, through the use of force, power and/or authority. Exploitation was defined as any misuse of power and authority for personal gain of emotional, physical or material gratification at the expense of others.

[8] The full questionnaire can be requested from CARE International in Jordan.

[9] More detailed data can be obtained from the internal document that was submitted to CARE International on January 4, 2008.

[10] According to the WHO world data table, in 2000, diabetes rates in Jordan were 8.1% and in Iraq 6% for all over 20 year olds.

[11] Well-to-do Iraqi families who reside in Amman were also mentioned by 7.6% of the respondents as benefactors.

[12] Both gender and age differences were assessed by comparing the proportions of responses within, and between, the subgroups.

[13] At the time of this report (June 2008) CARE International in Jordan, for example, is providing an estimated 7000 Iraqi refugee families in Amman with material and financial assistance, as well as social counselling. It offers various activities (skills training, discussion groups and leisure time activities) in two social activity centres. As far as possible, these are run by refugees. Their goal is to promote a sense of confidence and competence among the refugees, to strengthen their ability to recover from stress and trauma, and to cope with the daily hardships. CARE also currently works with four local NGOs on including Iraqi refugees in the services that they have been offering for a long time to the Jordanian population. In the absence of legal protection it

seems, however, to take time to develop a sense of commitment towards the Iraqi population from within these NGOs.

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