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“I’m restlessly eager to breastfeed”: breastfeeding narratives of internally displaced Yazidi genocide survivors in the Kurdistan Region of Iraq

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**Abstract**

Breastfeeding is one of the most important public health interventions that supports infant and young child survival in humanitarian crises. Yet, breastfeeding in these settings is often difficult and challenges are not always easy to address. The purpose of this study was to understand breastfeeding decisions and experiences among a population of internally displaced Yazidi women living in IDP camps across the Kurdistan Region of Iraq. This mixed-methods, multi-sited study was designed to document Yazidi women's breastfeeding experiences while living in an IDP camp in the KRI. Qualitative and quantitative data were collected November 2018-December 2019 in five IDP camps throughout Sulaymaniya Province to which Yazidi families had been resettled. Mental Health screening data were collected with 30 pregnant and postpartum women. Semi-structured interviews were conducted with these same 30 women as well as some spouses (n=7) and aid workers (n=5). Thematic narrative analysis was used to analyze the data and develop themes and interpretations. Breastfeeding decisions and practices are strongly circumscribed by living conditions in the camp, pregnancy and birth experiences, poverty, lack of mental health care, social support, and cultural beliefs regarding the importance of breastfeeding. There is a critical need for increased investment in delivering mental health support in camps, specifically for people experiencing pregnancy, childbirth, and breastfeeding and those who are supporting these populations, with an emphasis on culturally sensitive, trauma-informed care. Doing so has the potential to promote more humane, holistic, and human-rights-based approaches to perinatal and postpartum care for Yazidis and for IYCF-E programs globally.

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## Background

An estimated 180 million people across 72 countries are in need of humanitarian assistance (1). Despite United Nations Human Rights Declarations and International Humanitarian Law (2), women and children are disproportionately impacted during armed conflicts (3,4). Conflict exacerbates health risks during pregnancy, childbirth, postpartum, and infancy and early childhood. The impacts of conflict reverberate across the life course and generations, shaping immediate and long-term health outcomes and resilience of families, communities, and societies (5-8). The costs of conflict are embodied through acts of gender-based violence, child marriage, human trafficking, neglect, and suffering due to intractable constraints on being able to access basic needs to survive (9).

Nutrition is a critical sector of humanitarian response that is vital to the survival of infants and young children in conflict zones (10). Armed conflict disrupts access to food aid, food systems and food security, constrains mobility, undermines livelihoods, and fragments networks of social support, protection, and mutual aid, all of which are factors associated with heightened risk of maternal undernutrition, fetal growth restriction, low infant birthweight, pre-term birth, and malnutrition in infants and young children (11,12). The weaponization of food insecurity and hunger in conflict settings is a form of gender-based violence that inflicts profound suffering upon adult women and adolescents who are pregnant, newborns, infants, and young children.

Recommendations put forward in the Operational Guidance for Infant and Young Child Feeding in Emergencies (IYCF-E) provide practical guidance for providing adequate nutrition during pregnancy and lactation and for mitigating

nutrition-related infant morbidity and mortality during conflict (13,14).

Implementation of evidence-based nutrition interventions to support pregnancy and lactation are particularly vital for infant and young child survival and well-being (15). Breastfeeding is prioritized as a critical infant feeding intervention. However, breastfeeding is often difficult to support in emergencies.

Breastfeeding is a complex, multi-dimensional, biocultural process (16-18). For example, it is affected by many factors, including, cultural knowledge and norms, previous breastfeeding experiences, pregnancy complications, interventions used during labor and delivery, birth experiences, postpartum health of mother and infant, early interventions to support breastfeeding immediately postpartum, and numerous biopsychosocial factors. Breastfeeding is simultaneously physiologically and emotionally related to the postpartum transition, and adequate support systems, mental health care, and resources are essential for effective breastfeeding, particularly in conflict settings (11). Situational and social contextual factors, such as trauma, displacement, and lack of resources complicate individuals' decisions to breastfeed and access to resources that are supportive of breastfeeding (19,20). Thus, understanding how and why mothers decide to breastfeed or not to breastfeed in emergencies should consider their histories, pregnancy and birthing experiences, and the broader sociocultural and political economic context of their situation. Doing so has potential to promote more humane, holistic, and human-rights based approaches to IYCF-E globally (2,21,22).

### **Yazidi Survivors of Genocide**

It is estimated that there have been 74 genocides of the Yazidi people in the last 800 years (23). It is well documented that there is a high prevalence of mental

health disorders in the Yazidi community. The most reported disorders are Post-Traumatic Stress Disorder (PTSD) and major depression (MD) (23–26). However, the literature emphasizes that Yazidis suffer from more than just PTSD and MD. Other relevant disorders include Complex PTSD (CPTSD), adjustment disorder (AD), insomnia, anxiety, and somatoform disorder (26–29).

The 2014 genocide was systematically gendered (30). Men were either killed or forced to become “Islamic State” (IS) fighters. Women and girls were captured and sold into sexual slavery. Yazidi women have suffered unimaginable harm during this genocide, and the targeting of Yazidi women and girls are reflected in the mental health burden of Yazidis. In almost all the mental health literature on Yazidis, women experience a higher prevalence of mental health disorders compared to men. PTSD, MD, and comorbidity of the two were higher in women than men across several studies (25,31,32). Women were more likely to report feelings of guilt, shame, and worthlessness than men (33). Additionally, perceived social rejection was found to play a mediating role between trauma exposure and depression in women (34). Yazidi women also suffer from psychosomatic disorders where they experience chronic physical pain without a determined physical origin. These disorders are known to be predictors of PTSD (27). Given the Yazidis’ history of repeated life course exposures to armed conflict, collective stress and transgenerational trauma is significant among the Yazidi people.

Unfortunately, the mental health needs of this population are not aligned with mental health services to which they have access. There is a severe lack of mental health services and resources for both resettled and internally displaced Yazidis in Iraq. The humanitarian health literature emphasizes the urgent need for

transcultural psychiatry and culturally relevant mental health care for Yazidis (27,32,35). While most studies highlight the lack of adequate resources and treatments, few offer potential solutions. One exception is a pilot study, which showed promising results when using Thought Field Therapy (TFT) compared to Cognitive Behavioral Therapy (CBT) (36). This study posits that conventional biomedical modes of mental health care emanating from U.S. and European psychiatric traditions may be inappropriate and irrelevant for this population. For example, because Yazidis favor supernatural concepts and traditional healers, TFT is more culturally relevant than the classic CBT(36) .

Despite the well documented mental health disparities among Yazidis, there are major gaps in knowledge related to maternal and child health among Yazidi survivors of the 2014 genocide, in particular. Likewise, little is known about the role and impact of social support networks on post-conflict mental health and wellbeing and sexual and reproductive health. Few studies have examined how Yazidi survivors narrate their experiences with breastfeeding during conflict and post-conflict displacement. Little is known about the extent to which life in humanitarian camps for Yazidi Internally Displaced Persons (IDP) has shaped women's breastfeeding decisions and experiences nor how pregnancy and childbirth also shape breastfeeding outcomes. The current report seeks to fill these gaps through humanistic social science inquiry.

Previously we reported on the unmet mental health care needs of internally displaced persons, including adults and pregnant and postpartum Yazidi women (37,38). The purpose of the present study was to gain an understanding of Yazidi women's experiences with breastfeeding while living in camps for IDPs. We examine

participants' narratives to explore how biological, sociocultural, historical, political-economic, and environmental factors circumscribe Yazidi women's breastfeeding decisions and experiences. We use critical biocultural theory as a framework with which to scrutinize how power dynamics, identities, structural, and policy influences shape breastfeeding outcomes and experiences, revealing broader implications for health equity and protections of human rights in humanitarian settings. Finally, in this report Yazidi women's narratives serve as both a dataset, but more importantly, as an archive of Yazidi women's stories of surviving genocide and nurturing a new generation, even amidst the ongoing distress and grief of internal displacement.

## **Methods**

### Setting

The Yazidi people are a Kurdish ethnic minority who mostly live in Iraq, Syria, and Turkey. In August 2014, Yazidis in Sinjar, Iraq were systematically and brutally targeted by the so-called "Islamic State." In just a few days, 2.5% of the Yazidi population was either kidnapped (6,800) or killed (3,100) (39). The 2014 massacre is now globally recognized as a genocide. While some Yazidis fled to neighboring Turkey and others were resettled in Germany, there are approximately 400,000 Yazidis internally displaced in Iraq, 3,000 men and elderly women were killed, and 2,700 Yazidis still missing, likely being held in IS captivity (40).

A 2018 UNICEF report indicates that the total number of IDPs throughout Iraq during this period was 1.8 million people, including 900,000 children, with the majority in Western and Central Iraq (41). As a result of over 15 years of chronic conflict, no child in Iraq has known continuous peace. The years since 2014 have

led to the displacement of nearly 6 million Iraqis, including 3 million children under the age of 18 (42). Around 70% of IDP families live outside of camp settings.

### Study Design

This cross-sectional, multi-sited, mixed-methods pilot study was designed to (i) assess the feasibility and appropriateness of utilizing the validated Kurdish version of the Edinburgh Postnatal Depression Scale (EPDS) (43) with this population; and (ii) document Yazidi women's perinatal experiences while living in an IDP camp in the Kurdistan Region of Iraq (KRI). Data were collected November 2018-December 2019 in five IDP camps throughout remote Sulaymaniyah Province to which Yazidi families have been displaced. The total IDP population within these camps during the study period was as follows: 10,260 in Ashti; 26,469 in Chamishku; 13,470 in Kabarto 1 camp; 13,681 in Kabarto 2; and 15,217 in Shariya (44).

### Participant Characteristics

Participants were at least 18 years of age and able to speak or read either Kurdish or Arabic. The primary focus of the study was to explore the lived experiences of adult Yazidi women who were currently pregnant or within 1 year of delivery and living in an IDP camp in the KRI. Additional participants were recruited to provide diverse perspectives on the state of reproductive and pediatric health care in the IDP camps. A convenience sample was identified through non-random sampling, based on convenience and voluntary interest in the study. After introducing the investigators, the ethical considerations of the study were explained

by the social worker. Participants provided verbal consent to participate in the study, per the approved IRB protocol.

### Data Collection and Analysis

#### *Qualitative Data*

Qualitative data were collected using in-person using semi-structured interviews. All interviews were conducted by a highly skilled team, led by an experienced PhD-trained Psychology researcher (PS) and psychiatric nurse (NQ) with logistical support from a local Kurdish-speaking social worker who had developed rapport with Yazidis living in the camps. PS and NQ provided training for the social worker and oversight for the interviews. Interviews were conducted in-person by PS and NQ, with Kurdish translation provided by the social worker. All participants gave their verbal consent to participate in the study and to have their interviews audio recorded.

Participants were asked to respond to open-ended questions related to pregnancy, birthing, and breastfeeding, concerns about maternal nutrition and milk supply, cross-nursing or sharing human milk, formula feeding, lack of maternity services, maternal mental health, and IDP camp conditions. Spouses of respondents answered questions about their role in caring for their family, their concerns about the mother and the children, and their hopes for the future. Humanitarian aid worker respondents were asked about their experiences working in the camps, challenges to providing services, recommendations for improving care, and their perception of mental health issues among Yazidi mothers and children.

Interview recordings were transcribed in Kurdish by fluent Kurdish-speakers and then transcribed into English by bi-lingual members of our research team. The English language transcripts were shared with the U.S. research team for analysis. Each English-language transcript was assigned a random participant ID, de-identified, and imported into Dedoose (45) for qualitative analysis conducted by AP, LS, and RD. First, a constant comparison method was used to complete line-by-line coding of each transcript, generating a coding framework and codebook in Dedoose. Then, codes were grouped together as major themes and sub-themes organized around the semi-structured interview guides. Finally, these themes were further refined through group discussions and review of preliminary analyses and thematic tables. Illustrative quotes were selected to demonstrate both cohesion and diversity of responses within each theme and to support the authors' interpretations of the data.

#### *Demographic Data*

Minimal demographic and background information was requested from participants due to the vulnerability of the population and to maximize participants' privacy and confidentiality. Basic demographic characteristics were collected for each participant. This information included camp location, age, gender, marital status, and pregnancy status. Demographic data were analyzed simply for descriptive purposes and to further ground the interpretation of interviews within the context of this study.

#### *EPDS Scores [Kurdish]*

Each participant provided verbal responses to a structured EPDS survey that was administered by PS or NQ. The EPDS consists of 10 items, each item has four possible answers scored on a four-point scale (from 0-3). The instrument has been translated and validated in Arabic and Kurdish for Iraq (43) and we used it in a separate study with a larger cohort of IDP women in KRI, which we have published previously (37). Individual EPDS results were aggregated for inclusion in the present analysis. These results were triangulated with the interview responses regarding mental health care needs of pregnant and postpartum Yazidi women.

#### Ethics Approval and Funding Statement

Ethics reviews and approvals for conducting research with Human Subjects were completed by the Institutional Review Board and Office of Research Ethics at the University of North Carolina at Chapel Hill (IRB 18-0640) and the University of Garmian, respectively in accordance with the Declaration of Helsinki. Additional approval to conduct the research was granted from the central office of camp managements in Sulaymaniyah Province. Funding for this research was made possible by a Faculty Research and Development award by the Department of Maternal and Child Health and the Gillings School of Global Public Health, University of North Carolina at Chapel Hill.

## **Results**

#### Participant characteristics

Study participants included 30 Yazidi pregnant or postpartum women 21-46 years of age (mean age 30.6). Twenty of the participants were currently pregnant at the time of interview and 10 were <1 year postpartum. Complementary interviews

(n=12) were conducted with a purposive sample of participants' spouses (n=7), humanitarian aid and health care workers (n=5), who provided additional perspectives on the care of pregnant and postpartum Yazidi women in the IDP camps. Table 1 provides an overview of the breastfeeding histories of pregnant and postpartum participants.

INSERT TABLE 1 HERE

### Prevalence of Depression Risk and Self-Harm or Suicide Ideation [Kurdish]

Thirty of the pregnant or postpartum Yazidi women provided responses to a verbally administered EPDS survey. For the present study, responses to the surveys were aggregated and provide data regarding the risk of depression and self-harm among all study participants. Of the 30 participants who were interviewed, 50% had a score of  $12 <$  indicating probable depression, 13% had a score 9-11 indicating possible depression, and 37% had a score of  $<8$  indicating that depression was not likely.

Item 10 in the EPDS screens for risk of self-harm or suicidal ideation. For this item, 80% of participants indicated that they "never" had a thought of self-harm in the past 7 days, 10% indicated "hardly ever", 3% indicated "sometimes", and 7% indicated "quite often." Among the participants with a positive screen for suicide ideation (n=6), 4 were currently pregnant and 2 were postpartum.

### Themes from the qualitative analysis

*Content disclosure: genocide; sexual violence; obstetric violence; pregnancy loss; miscarriage; infant death; suicide; family separation; war-related trauma*

## ***Pregnancy***

Pregnant and postpartum participants were asked to share their thoughts about what women need to have a healthy pregnancy. Participants shared a range of needs that were common for Yazidi women in the different camp sites. The five most common things that they mentioned included: (i) being able to have rest and good sleep; (ii) eating healthy, nutritious foods and having enough water; (iii) having assistance with doing housework, taking care of other children, and being relieved of tasks that required physical exertion; (iv) having a peaceful, comfortable, happy life; (v) health care, medicines, vaccines, and vitamins (Table 2). Some mentioned other needs such as money to be able to afford food, medicines, vitamins, warm clothing especially after delivery, psychological and mental health support, and opportunities for healthy physical activity. Several simply responded with, "*We need everything.*"

[INSERT TABLE 2 HERE]

Yazidi women were asked to describe some of the barriers they faced, which made it difficult for them to find what they needed while pregnant in the IDP camps. The most common barriers that they described included: (i) psychological and emotional distress; (ii) lack of assistance and support for household responsibilities and caring for children; (iii) lack of social support to help them care for themselves during pregnancy; (iv) poverty and lack of financial assistance; and (v) barriers related to living in an IDP camp (Table 3).

[INSERT TABLE 3 HERE]

A common challenge was related to poor nutrition during pregnancy, including lack of appetite, not being able to afford extra food, or having cravings for cultural foods but not being able to afford or find them. One woman explained, “*We are poor and it is not easy to prepare appropriate foods.* [P11]” Other issues during pregnancy included exhaustion, back and leg pain, dizziness, nausea, difficulty breathing, difficulty sleeping, and worries and anxiety. Some participants noted how an unhealthy pregnancy might affect their child’s future health:

*I am always worried about the growth and healthiness of the baby during pregnancy and also after that. At 9 months of pregnancy, I always had no appetite, and I was feeling nausea. Now I am worried about milk. I am worried that my child will not grow up.*[P12]

Only four participants, most of whom were in early pregnancy, said that they still felt comfortable, did not have any problems, other than feeling tired or bored. Nearly all participants described pregnancy in the IDP camp as difficult:

*In my opinion the most important problem is living at the camp. None of these could be done at the camp: resting, not having stress, and so on.* [P12]

Primary sources of information and support during pregnancy came from family members within the household, such as a spouse, in-laws, and siblings. Family members living elsewhere, and neighbors were less frequently mentioned. Participants whose spouses worked for extended periods outside of the camps, whose spouse had been killed and were alone, or who was a primary caregiver to other children and family members mentioned struggling to find help when they needed it. One participant shared,

*My second child born in the camp hospital, I was feeling so bad and had so much difficulty during the birth, but I had my mother and sister-in-law with me, and they were so supportive.”*

This same participant goes on to say,

*Giving birth here in the camp is very difficult, like what happened to me with my second child. There are limited facilities in the camp hospital, and it is very risky for the women if something goes wrong. It might be difficult to save their lives, because driving way to Duhok city hospital is very bad and very far. I would prefer a normal delivery in Duhok hospital, but I think it would be hard for normal delivery, because I have a twin pregnancy, so I might go for Cesarean section. [P17]*

Pregnant participants were acutely aware that hospital care required difficult travel, and that if a transfer were required, it was usually because there was a life-threatening emergency, which heightened worries about delivery during pregnancy:

*I would like to give birth here at the camp, because it would be hard to drive to Duhok. I wish the hospital will be well prepared by then so I will not have to go out of the camp. [P16]*

The difficulties in meeting basic needs, the hard conditions of living in an IDP camp, and lack of quality prenatal care compounded women’s worries and anxiety during pregnancy, which provides context for understanding the prevalence of risk for depression, anxiety, and self-harm in this population. For example,

*It is really difficult for me to visit the doctor. I had to visit Dr. X regularly, due to a cyst in my uterus and sepsis. These issues made pregnancy more difficult for me. I have to take a spectrum of drugs, and it's annoying. I am really worried about my parturition, and our health (my baby and I). I'm worried about insufficient facilities in the camp which may endanger my baby's health. We haven't had any problem in the camp, but I still feel worried. I prefer to go to Sulaymaniyah Hospital for giving birth.[P5]*

Participants who had experienced pregnancy or childbirth prior to genocide-associated displacement often used those experiences to anchor comparisons with their current situations:

*I'm about 6 months pregnant. This is my fourth pregnancy. I am in a difficult situation. I am alone and I have to work. My heart, back, and legs are always in pain. I'm sleepy and I have lack of appetite. It wasn't hard for my first two kids, but it was hard for the third one and the one in my belly. Pregnancy in the camp is very difficult. The first time I was pregnant I had a caring neighbor, I wasn't alone. But I'm alone here.[P11]*

Stories of past pregnancy loss or infant loss also were integrated into concerns that women voiced during current pregnancies, along with reflections on differences in the type of support systems they had in the past as compared with social support available in the camps:

*It is very hard. My previous pregnancies were very difficult, and I was sick the whole time. I had a risk of miscarriage. A week after giving birth, my son died, and I was destroyed. This experience happened to me two more times*

*later. I lost three children, a few days after giving birth. We were in [Shingal] at that time, my mother and husband were with me.[P16]*

### **Birth**

Pregnant and postpartum participants alike, who had delivered an infant after a previous displacement (n=19) responded to interview questions regarding any psychosocial and medical support they received, or needed but did not receive, during labor and delivery. Participants described personal experiences with labor and delivery. They reported stories of experiencing labor followed by unmedicated vaginal delivery in the camp hospital; labor that began in the camp but ended with an emergency transfer to a city hospital in Sulaymaniyah or Duhok for delivery or postpartum critical care; or a planned labor in Sulaymaniyah or Duhok hospital.

Overwhelmingly, participants spoke about a desire to experience “*natural birth*” and to receive support during labor and postpartum by family members. Not being able to have support from trusted family members during labor and delivery was a source of worry during pregnancy, especially for women who were pregnant for the first time, or whose previous pregnancy and birthing experiences were difficult or traumatic. One participant, who was the mother of 7 children, shared her experience with pregnancy loss, and the difficulty in coping with that experience without social support:

Participant 29: *...for that one who died, it was very hard for me. I needed empathy. I was so sad.*

Interviewer: Who helped you, how did they help you?

Participant 29: *No one. I was alone.*

Thirty-two percent of the study participants who had delivered an infant while displaced to an IDP camp reported a Cesarean delivery. Three of the 9 participants who were pregnant at the time of the study, and who also had other children, reported that their youngest infant was born via Cesarean delivery. Three of the 10 postpartum participants reported Cesarean delivery of their youngest infant. Cesarean delivery and recovery from the surgery in the camp was a cause of worry and anxiety for many of the pregnant participants, including one participant who had a traumatic birth and postpartum experience with her most recent Cesarean delivery:

*I have needed help many times, but no one has helped me. For example, one of the times was my son's birth. I gave birth to my son with Cesarean section. I got 16 stitches and couldn't take care of myself, because I was alone, and my kids were small. Three times my sutures were opened, and I bled. I got a severe infection and got sick. I was so tormented that I would not forget until my death. I have no family. My parents are dead, and I have no siblings. My husband's family didn't help me either. My three-year-old daughter stayed in the dirt (urinating) for hours. Or the kids got hungry, but no one helped them. Once I got up to eat, and my sutures opened all the way down, but there was no one to help. Kids were small and weak; I had to feed and clean them. [crying]. I will never ever forget. There is no one to help me except my daughter [motions to the six-year-old girl sitting next to her]. It was very easy for my two daughters. Both pregnancy and childbirth were very easy. I was comfortable giving birth to both naturally and only had one*

*day of pain. But, as I said, I was very upset with my son. I was asking one of my neighbors because I didn't have anyone. No one was with me. Last time I went alone with my husband. Once the person in charge of the camp realized that I was alone and had no one, even though it was forbidden for men to enter the camp, when they saw me alone, they let my husband and other children accompany me and gave me a room alone. That little girl [her granddaughter] was taking care of me. I had a very difficult birth. The doctor told us that if I did not have a Cesarean section, either myself or the baby would die. I hope, God kill me, but not have Cesarean again [laughing]. I just want to give birth naturally. [P11]*

The 2014 attack in Sinjar was not specifically mentioned by most Yazidi women, but a few alluded to these events when mentioning that they were separated from family, recalling previous experiences with home births in Sinjar, or reiterating the psychological difficulties of camp life. One participant shared that she had delivered her youngest child while escaping from the ISIS attack in Sinjar:

*When we fled our homes in August 2014, we arrived in [city name] and I gave birth to my second child at that time. It was the worst day of my life and the worst birth experience. I was with my husband, and a woman from [another village] helped us with the labor. [P15]*

Several others noted that they had to seek support during labor, delivery, and postpartum from their spouse's family or neighbors, since they were far away from their own mother, sisters, aunts, or other relatives, for example:

*The birth experience is difficult, painful, and scary, but I had the wife of my brother-in-law with me. She is my neighbor, and she is so helpful and supportive with me and my children. [P4]*

A younger woman, described her maltreatment at the city hospital in Duhok, where she did not have social support during her labor:

*It was hard for me. I am too young for such an experience. I had a bad pain. My mother-in-law took me to the health center, and they sent me to the city as I was in an emergency. I wish the hospital staff - the nurses, gynecologists, and others - behaved in a more friendly manner. They were impatient with me. I was scared and they yelled at me to push... push! [P29]*

Participants had varied perspectives on the quality of care in the camp as compared to the city hospitals. Some perspectives were based on personal experiences and others were based on hearsay or stories they had heard from others. One woman noted that the care in the camp for her sixth delivery was better than her experience in the Shingal hospital:

*I gave birth to 5 of my children in Shingal hospitals, but the last one in this camp hospital, I think the camp hospital is better than Shingal hospitals. There are good services in the camp hospital. [P4]*

More commonly, however, participants noted concerns with lack of specialized supplies and services available in the camps as compared with the nearby hospitals. The two quotes below illustrate:

*My previous child was born in the camp hospital. I lost so much blood, so they referred me to Duhok hospital to get blood. I was with my husband and his family. They were very supportive and helped me with taking care of my child after birth. I would prefer a normal delivery in Duhok hospital because it is better than the camp hospital. [P19]*

*I gave birth to two of my children in Shingal, two here. I gave birth to my last baby, who is now 6 months old, very easily. The facilities here at the camp were very good. I gave birth to the last one in the camp, but at the time it wasn't as it is now. I needed blood, and there was no blood in the hospital of the camp. They took my baby to the hospital in the city, and I was on my way to Dohuk, and it was really bad. [P20]*

### ***Breastfeeding***

Participants with young infants were asked open- and closed-ended questions about current infant feeding practices, and participants who were pregnant and did not have any other children were asked about their future infant feeding preferences and plans. All pregnant and postpartum women stated that breastfeeding was their preferred infant feeding method. However, only 9 out of 19 (47%) participants who had an infant reported exclusively breastfeeding in the first 6 months after delivery. Figure 1 below illustrates participants' breastfeeding decisions stratified by parity and pregnancy, birth, lactation, and social support characteristics.

Insert Figure 1 - spectrum diagram here

*Breastfeeding Knowledge, Attitudes, and Practices*

Overall, participants were knowledgeable about the importance of breastfeeding for an infant's health, growth, and development, with many responding similarly to this participant, a young women who was expecting her first child:

*I'm restlessly eager to breastfeed. I have made all provisions for its birth. Although, I don't know its gender, I've bought girl clothes [she laughs]. I will try to breastfeed as much as possible....Breastfeeding boosts natural growth of babies. There is no replacement for breastmilk.[5]*

Most noted that colostrum is very important for the infant: *The first milk is great for the babies. It is even better than a vaccine and it makes the baby grow well and be healthy.* [P11] Although colostrum taboos are commonly cited in the literature for delays in immediate postpartum breastfeeding or use of prelacteal feeds, just one participant mentioned that feeding an infant with colostrum should be avoided: *Colostrum is the first milk in the mother's breast. I think it is very bad, not good for the child.* [P18]

We identified four sub-themes in women's descriptions of breastfeeding experiences, that reflect cultural knowledge and beliefs about breastfeeding: (i) the importance of breastfeeding; (ii) experiences with insufficient milk; (iii) other breastfeeding difficulties; (iv) influences on the quality and quantity of milk. Within each of these sub-theme groups were a range of responses (Table 4).

Insert Table 4

The importance of breastfeeding was described in terms of its contribution to infant health, growth, resistance to illness, and strength not only in infancy but as

they grow into early childhood. Participants mentioned the convenience and safety of breastfeeding as compared to bottle feeding with commercial infant formula milk, as well as the nurturing and emotional bonding that breastfeeding provided.

Experiences with insufficient milk production during lactation were common and the most prominent reason mothers explained breastfeeding for a shorter duration than they had wished or for having to use formula. Twenty-six percent of participants who had ever breastfed described need to begin supplementing their milk after their own milk began to dry up specifically around “40 days” postpartum. Other breastfeeding difficulties included women’s challenges balancing breastfeeding with caring for the household and other children, often on their own; the pain of breastfeeding while recovering from surgical delivery and disruption of lactation due to blood loss and illness; difficulty breastfeeding during illness. Interventions for insufficient milk included medication (“pills”), vitamins, and improving the quality of nutrition during lactation, however, most mothers who tried these interventions indicated that they did not lead to increased milk supply.

Participants provided interesting cultural insights regarding the quality and quantity of breast milk, particularly why some women struggled to make enough milk and behaviors or environmental factors that can change the quality of breast milk. Poor appetite, malnutrition, genetics, lack of interest in breastfeeding, chance or destiny, and eating inappropriate foods were some of the reasons given for insufficient milk and for formula feeding. Diet, a woman’s mental state, nutritional status, and overall physical health were mentioned as affecting the composition of milk. However, many participants were skeptical that medical or nutritional interventions could improve the quality of milk or increase how much milk a woman

could produce. Several of the responses reflect cultural beliefs regarding milk sufficiency and milk composition (see Table 4).

Several participants who had breastfeeding experiences prior to their displacement reflected on how their current situation had disrupted their ability to meet their breastfeeding goals. Two participants who had given birth during their displacement noted that they were not able to breastfeed their youngest infant due to complications at birth, which required exclusive formula feeding starting immediately postpartum. Just as the study participants described positive home birth experiences before the attack, many who had experienced breastfeeding difficulties explained that they did not have any problems breastfeeding prior to their displacement. For example:

*I have breastfed two of my children, and it was amazing experience. It was easy for me and creates a great bond with the baby. But, with my other two children, I had no milk and do not know why, I tried very hard, but it did not work.[P19]*

Participants reported learning how to breastfeed and gaining information and assistance with breastfeeding from their spouses, mothers and sisters, elder women, mothers-in-law and sisters-in-law, camp doctors, and from observing other women breastfeeding. One participant explained that she relied on herself and Google searches: *I can find anything on Google. No need to ask others.* [P28] None of the participants mentioned that they received lactation support from doctors or health care providers. Some noted they were supported by family members and other trusted women in the camp.

### Delegated Nursing and Milk Kinship

Participants were asked open-ended questions regarding knowledge, attitudes, and experiences with delegated nursing (46), defined in the study as “when a woman breastfeeds a baby to whom she did not give birth.” All participants were familiar with this practice. They had mostly positive attitudes about allowing another woman to breastfeed their infant and about breastfeeding someone else’s infant. However, there were also strong objections by a smaller number of participants regarding any type of delegated nursing. Sub-themes that emerged from these questions included stories about personal experiences with shared breastfeeding, the notion that breastfeeding someone else’s infant was an act of kindness and benevolence to be admired, concerns about marriage associated with milk kinship practices, concerns about the health implications, and it would only be considered as a very last resort (Table 5).

Insert Table 5

While two participants mentioned that they would consider speaking with their husband about a decision to allow another women to breastfeed their baby if it were needed, most noted that this decision was their own to make: *I will decide about this on my own, because I am the mother, and it is my decision.*[P1] Another woman noted that she would make the decision on her own, because her husband “*did not talk about such things.*”

### Use of Commercial Infant Formula

Despite strong intentions to breastfeed among women pregnant for the first time and experienced breastfeeding mothers, less than half of these participants

were able to exclusively breastfeed. The most common reason for supplementation with infant formula prior to 6 months was having insufficient breast milk. Among the 11 pregnant Yazidi women who had never given birth, two indicated that they would use infant formula if they had insufficient breast milk.

Formula feeding involved a range of challenges, including not being able to find sources of clean water, feeding bottles, and formula powder; not being able to afford powdered infant formula and supplies required to prepare and feed it; and the inconvenience of preparing feeds and washing the feeding supplies. Mothers reported that these challenges led to severe consequences including serious newborn and infant illness and child malnutrition. When participants were asked what they would do if they could not find clean water, formula, or feeding bottles, about half said they did not know, while others thought that they would consider asking another woman to breastfeed their baby or that they would feed with some other kind of food, until a proper source of nutrition were available: *In such cases, we have to feed them something else like a soup.*[P3]

Participants shared their perceptions regarding why some women fed their infants with formula instead of breastfeeding them. These responses also varied, from explanations about insufficient breast milk, maternal illness, or a doctor's orders to more moralized explanations, such as laziness, selfishness, or personal preference (Table 6).

#### INSERT TABLE 6

We also asked mothers if they had been taught how to prepare infant formula. The responses were varied. Mothers with formula feeding experience were familiar with

the importance of measuring the feeds and not over diluting them. Mothers without any formula feeding experience often said they had no idea how to prepare or feed formula, because they had only ever breastfed their infants. Approximately two-thirds of participants describe formula as not very safe or a perception that only some types of formula were safe, while others were less safe. None of the participants said that they continued breastfeeding once they began bottle feeding with infant formula.

### ***Fathers' perspectives***

Seven fathers ages 19-34 from three of the five IDP camps were interviewed for this study. Four were expectant fathers and three had other children, including at least one child that was delivered in the last year. One was expecting his first child, the others had 2-6 children. While only a small number of fathers were interviewed across three different camps, their concerns and perspectives were consistent. They were all concerned about the well-being of their wives during pregnancy, the effects of stress associated with camp conditions on pregnancy, a lack of quality health services and resources in the camps, poverty and financial stability, and the uncertainty of long-term well-being for their family and community. Worry about their wives' physical and psychological health contributed to fathers' own stress and anxiety during their spouses' pregnancies (Table 7).

When asked about their role in supporting their spouse during pregnancy, birth, or breastfeeding, they described their main role as being responsible for providing financial stability for the family and doing whatever they could to help create a better future for them. Most fathers mentioned that these were "*feminine matters*" and something that other women in the family and community would

provide education, support, and assistance. However, one participant noted that he wished there was more education and support provided to fathers: *“Someone should teach us to take care of the babies. We think it is a feminine work, but it is not true.[34]”*

A strong theme of cultivating self-reliance, along with a return to Shingal, emerged across the fathers’ interviews. There was a clear lack of confidence and shared frustration in the camp health and social services the government and NGOs were providing.

Insert Table 7

### ***Aid Workers’ Perspectives***

Five aid workers from two camps were interviewed for the study as well. Their positions included camp management, social worker, and NGO leader or volunteer. Three participants were Yazidi and two were Kurdish. They each responded to specific questions about their motivation for working in the IDP camp, their experience working with families in the IDP camp, and some of the main challenges they see regarding perinatal and newborn health and health care. These participants also provided important context on broader issues that negatively affect Yazidi families as well as their perspectives on needs to improve care for Yazidi IDPs. Among the most important perinatal and newborn specific challenges were psychological issues, barriers in access to care, lack of education and information about pregnancy, birth, and breastfeeding provided to Yazidi women and their families, and cultural challenges. Additional issues that were raised included sexual violence resulting in pregnancies among unmarried women and

girls, intimate partner physical and sexual violence, alcoholism, self-harm, and suicide (Table 8).

Insert Table 8

Aid workers' responses were consistent with mothers' and fathers' responses in terms of the serious need for psychological support, a lack of adequate services for pregnancy and postpartum medical care, and the difficulties that pose barriers to accessing available services and fulfilling needs. However, there were some important differences. A new theme that emerged from the aid workers' interviews was the additional need for specialized mental health screening and psychiatric care for Yazidi women who have been traumatized or re-traumatized through sexual violence in the IDP camps, including women and adolescents who had unwanted pregnancies resulting from rape, women and children who experienced domestic violence, and women who attempted suicide. Aid workers also addressed cultural barriers to accessing mental health care or perinatal services. They mentioned shyness, shame, embarrassment, and lack of privacy or confidentiality that made it difficult for Yazidis to report sexual and physical violence. Moreover, they all noted that there was a lack of awareness among Yazidis and other IDPs that there were services available to women to assist them. Aid workers were not asked specifically about breastfeeding support, and none of them specifically discussed breastfeeding as one of the pregnancy or postpartum needs of women in IDP camps.

## **Discussion**

There are consequences of conflict that are ignored in calculations of “civilian casualties of war.” These include, for example, perinatal maternal and infant morbidity and disability, a lifetime burden of sexual and reproductive health issues, loss of educational and economic opportunities, a lifetime of poverty, and psychological trauma (3,47,48). Civilian women and children are forced to bear especially acute harm in situations of genocide, where they are targeted in acts of physical, sexual, and psychological violence (30,49). One way to foreground these costs of war is through the personal stories of women who have survived such atrocities. In the present study, breastfeeding is an entree to a narrative archive of the incalculable burden of genocide against Yazidi women as they navigate pregnancy, birth, and mothering while living in IDP camps.

Breastfeeding is an important focus of infant and young child feeding in emergencies (IYCF-E) research. This study contributes to a growing literature on IYCF-E in a few ways. While the main focus of the research was to understand breastfeeding knowledge, attitudes, and practices among internally displaced Yazidi women, it is significant that pregnancy, birth, and postpartum transitions figure prominently into the ways they narrate their breastfeeding experiences. Participants who had children prior to the 2014 attack and subsequent displacement often compared those past pregnancy, birthing, and breastfeeding experiences, as a way to create perspective to the extraordinary hardships they were had encountered in the camps and to convey that they understood things could be different. For these women, the relationships, resources, and coping strategies that had supported them when having children in the past were no longer available to them, leaving many feeling hopeless and lost in grief. Nonetheless, some women were able to

access new friendships and relationships in the camps, and this provided important sources of breastfeeding education and practical support.

One common reason that breastfeeding rates are low in conflict settings is a widespread belief among humanitarian actors, aid workers, and affected populations alike that psychological trauma and stress make it physiologically impossible for women to produce enough milk or that maternal stress will be passed to infants during breastfeeding (50–52). Indeed, there is a high burden of mental health disorders and mental health needs generally among adult IDPs living in protracted conflict settings. Moreover, we have previously published findings describing the mental health burdens of IDPs as well as the high prevalence of unmet perinatal health services for pregnant and postpartum Yazidi women living in IDP camps (37). For the present mixed-methods investigation, we also found a high burden of untreated perinatal mood disorders among Yazidi IDPs. At the same time, Yazidi women overwhelmingly indicated a prenatal intention and desire to breastfeed and/or reported at least initiating breastfeeding. The reasoning underlying these strong intentions to breastfeed are longstanding cultural beliefs about the importance of breastfeeding and breastmilk along with education that women have received from trusted health care providers, family members, and friends about the value of breastfeeding. These findings are important because they show that preconceived notions about the intrinsic inability or lack of desire to breastfeed among women in traumatized populations may hinder breastfeeding. Investing in comprehensive mental health care in IDP camps (53), with special programs for perinatal mental health needs, may have a significantly positive impact on breastfeeding rates.

We were also able to explore Yazidi women's cultural belief systems and attitudes about breastfeeding, including the perceived importance of breastfeeding, the value of human milk, women's knowledge of recommended infant feeding practices, and acceptability of delegated breastfeeding practices like cross-nursing or co-nursing. The insights that they shared contribute to the IYCF-E literature on "wet nursing in emergencies" (54,55), and illustrate that even if delegated nursing practices are not visible, or even universally accepted, that offering culturally appropriate counseling and practical support for these practices in post-conflict camp settings is feasible and a critical intervention that may prevent infant malnutrition and death (56).

In conflict settings, implementing the global recommendations and operational guidance for IYCF-E is critical to postpartum and newborn health and maternal-infant well-being and survival. Recent analyses emphasize the importance of integrating mental health services with maternal-newborn services to optimize breastfeeding. While not exclusively focused on Yazidis, one published study describes a negative association between conflict and breastfeeding in Iraq (57). Diwakar et al. found that as violent conflict increases, the probability an infant is exclusively breastfed decreases. Interestingly, this association differed by religious majority and education level. The Shia area of Iraq was more likely to report higher breastfeeding rates than Sunni and Kurdish areas. Additionally, the study found that humanitarian distribution of breastmilk substitutes deterred breastfeeding and increased infant malnutrition (57). Other reports have found that women often use water and sugar to feed infants when breastfeeding is difficult or not possible, leading to high prevalence of malnourishment in infants (58,59). These reports support the findings of Diwakar et al., 2019, which demonstrates an association

between formula distribution and infant malnutrition. As Corley has noted, “armed conflict is an important driver of malnutrition” (11). Participants in the present study also noted that if formula was needed, it was difficult to find, and that they had to resort to feeding infants with foods that they recognized were not ideal, because they were left with no other options.

In these cases, it is clear that the systems in place to support women and children who have survived war and genocide are, in fact, inadequate in providing the basic care and essential resources needed to keep themselves and their children alive and thriving (53). Interventions to improve breastfeeding outcomes in post-conflict settings must prioritize strengthening systems to support Yazidi IDPs, rather than investing only in interventions focused on breastfeeding education. Interventions that improve the material conditions of life in IDP camps, that attend to the psychiatric and mental health needs of traumatized people, and that offer economic opportunities with financially solvent pathways to economic stability are likely to be more impactful and effective in improving breastfeeding rates than individual breastfeeding counseling and education.

The mixed-methods approach undertaken for this study provides important information with which to contextualize Yazidi women’s perinatal mental health concerns and needs. Even though Yazidis were living in camps ostensibly set up to protect them from harm, women expressed concern over lacking the basic necessities to survive and care for themselves, their infants, and other young children. A high proportion of Yazidi women in the study reported thoughts of self-harm and suicide ideation during pregnancy and postpartum. We know from the published literature, humanitarian relief briefs and reports, and the media that

Yazidi survivors are at increased risk of obstetric violence, neglect, and re-traumatization in IDP camps (41,42). Financial constraints of living in IDP camps are a primary factor that is consistently named as exacerbating negative family dynamics and weaker support systems for women in the perinatal and postpartum period.

Health care workers serving the Yazidi population also face their own set of challenges. The literature suggests that Iraq's public sector is weakening, leading any physicians to spend more time in private clinics to supplement their incomes (39). This exacerbates the shortages of care providers in PHCC's and IDP camps. Additionally, given the severity and brutality of atrocities experienced by the Yazidi population, secondary traumatization of health care workers has been documented. One study found that nearly a quarter of caregivers working with Yazidis through Germany's Humanitarian Admission Program (HAP) experienced secondary traumatization (60). Of those with secondary traumatization, nearly 10% showed a severe symptom load. Secondary traumatization not only affects the caregivers themselves but also can hinder their ability to provide care. Improving systems of maternal-newborn care within IDP camps should include improving access and utilization of mental health services among health care workers, too.

Our study findings resonate with others calling for increased scrutiny of settling survivors of conflict and displacement to camps for protracted periods of time (26,61,62). Reports from IDP camps in KRI document malnourishment in infants under six months old (58). Squalid living conditions in Iraq's seasonal climate extremes exacerbate the pre-existing stress and mental health conditions of Yazidi mothers, many of whom survived multiple traumatic experiences including

sexual slavery, rape, forced religious conversion, and deaths of their husbands, families, and children (41). It is evident that for many Yazidis in our study, surviving in IDP camps is embodied as prolonged suffering due to chronic exposures to structural violence and deprivation. Their stories that highlight a comprehensive need for psychosocial support and economic resources to preserve their cultural heritage while addressing the long-term effects of their suffering (34,53). Insights gained from interviews with Yazidi women, their spouses, and aid workers should be used to improve the conditions of life in IDP camps for women, children, and families.

### **Limitations**

There are limitations of the study that restrict its applicability to other contexts in which complex humanitarian crises and genocide occur. This study is a cross-sectional study conducted with a non-random sample of participants. The number of participants, and the integration of both pregnant and postpartum participants in the dataset, do not allow for adequate power to use survey data in predictive models for infant feeding or mental health outcomes. Lack of more detailed comprehensive data on each participant with which to conduct quantitative analyses means that several relevant and significant research questions may not be answerable using our dataset.

### **Conclusions**

Breastfeeding saves lives in conflict and post-conflict settings. However, breastfeeding is often difficult in these circumstances. Yazidis have been living in IDP camps for over ten years, and there is a substantial unmet need for integrated

mental health and maternity-newborn care services in the camps. Too often the human rights of these populations are overlooked and ignored, perpetuating violations of rights for generations in terms of mental health trauma, physiological trauma, and intergenerational trauma. There is a critical need for increased investment in delivering mental health support in camps, specifically for people experiencing pregnancy, childbirth, and breastfeeding and those who are supporting these populations, with an emphasis on culturally sensitive, trauma-informed care. IDP camp conditions are inadequate to support IDP livelihoods, health, and well-being. These camps create numerous barriers to economic opportunities, education, access to health services, and well-being. Efforts to allow safe return of Yazidis to their ancestral homelands must be supported and protected. Human rights-based solutions must be used to advocate against prolonged residence in camp settings and to protect and advance maternal and child health as a foundation of healthy populations today and in years to come.

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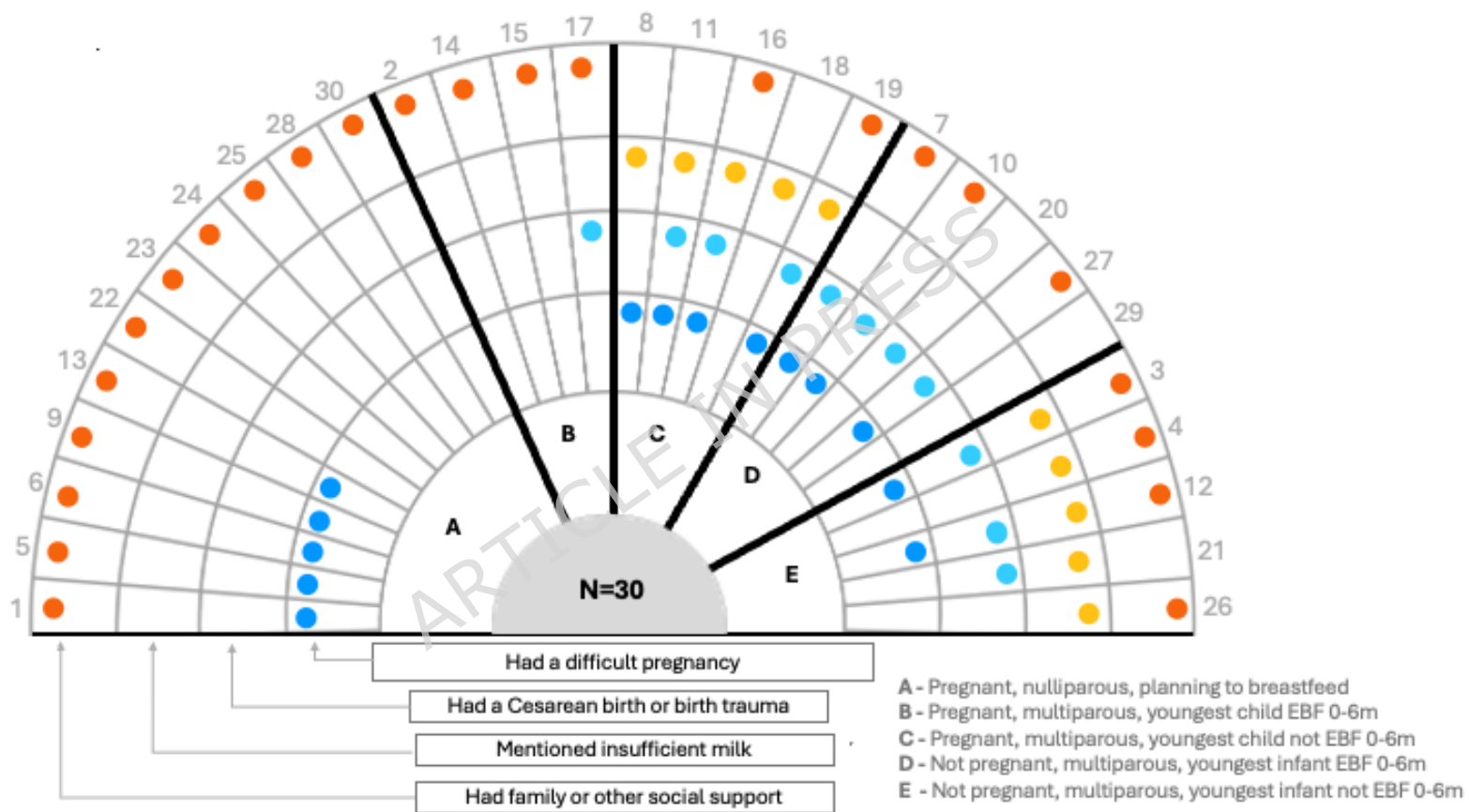
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**Table 1. Participant Characteristics: Breastfeeding Experiences and Intentions**

<b>Participant Groups</b>	<b>N (% of total sample = 30)</b>
<b>Any breastfeeding experience</b>	<b>17 (57%)</b>
Postpartum	10 (33%)
Pregnant, at least one other child	7 (23%)
<b>No breastfeeding experience</b>	<b>11 (55%)</b>
Pregnant, no breastfeeding experience	11 (55%)
<b>Youngest infant was exclusively breastfed</b>	<b>9 (30%)</b>
Postpartum	5 (17%)
Pregnant, at least one other child	4 (13%)
<b>Expectant mother's intention to breastfeed</b>	<b>20 (67%)</b>
Pregnant, at least one other child	(30%)
Pregnant, no other children	11 (37%)

**Table 2: Summary of Themes, Sub-Themes, and Illustrative Quotes Regarding Women's Needs for a Healthy Pregnancy**

<b>Theme</b>	<b>Sub-Themes</b>	<b>Illustrative Quotes</b>	
Yazidi women's perceptions of women's needs for a healthy pregnancy	Plenty of rest and sleep	<i>It is very important to rest. The mother must have enough time to take care of herself. Take the time to walk. Hard work has a lot of pressure on the baby. [11]</i>	
	Eat healthy foods and drink plenty of water	<i>Nutrition is the top priority. A pregnant woman should follow a suitable diet.[5]</i>	
	Help with housework, caring for other children in the home, and doing strenuous tasks	<i>Mothers need everything, but the most important is help and support in taking care of house and children, we need help with that it is hard for us, we have a lot of work to do every day. We need help from our families, neighbors, and friends because it is not easy to work alone when you have five children. [4]</i>	
	Peaceful, comfortable, happy life		<i>Mothers need psychological calmness.[16]</i>
			<i>Peace, calmness, no sadness or crying. No sadness or being bored. [10]</i>
			<i>I think stress and anxiety are the worst thing for a pregnant woman.[23]</i>
	Health care, medications, vaccinations, vitamins		<i>Clinical and medical facilities are also very important for a pregnant woman, since she should always be supervised by a doctor. Nutrition is important too. Her health is the most important concern. [5a]</i>
			<i>Mothers need to visit doctors and they need psychological rest.[14]</i>
			<i>Mothers need investigations, ultrasound, vaccination, medications, and supplementary vitamins. They also need rest.[1]</i>
			<i>Medications and money to buy the medications would help to have a healthy pregnancy. [2]</i>

**Table 3: Summary of Themes, Sub-Themes, and Illustrative Quotes Regarding Barriers to Meeting Women’s Needs during Pregnancy**

<b>Theme</b>	<b>Sub-Themes</b>	<b>Illustrative Quotes</b>
Barriers and challenges to fulfilling Yazidi women’s needs during pregnancy	Trauma, stress, worry, anxiety, fear, and loneliness	<i>Our life is a tragedy.</i> [21]
		<i>The camp experience is very hard. We will never forget the difficulties that we have been through.</i> [8]
		<i>I am worried that my child will grow up in the camp</i> [26.]
		<i>I have some concerns because I am not well psychologically. Two of my sisters are still in captivity with ISIS, and a few days ago we heard that one of them has died. The camp environment is very difficult and has destroyed our mental health</i> [16]
		<i>I need someone to take care of me. I am afraid of giving birth.</i> [27]
		<i>I'm very worried. I always think about it. Now, while I'm pregnant, I go to work on others' farms and work to raise money for my children. Two of my daughters also come and work with me. We work in the evening and earn 20,000 dinars. Not growing children is due to malnutrition and lack of care.</i> [11]
	Lack of assistance for household responsibilities and caring for children	<i>I need help with taking care of my children and house, my husband is working outside the camp, and he stays a week at work and another week at home, so most of the time I am alone and have so much work to do by my own.</i> [8]
		<i>Sometimes I need financial support, other times I need help with my work at home because I am alone and have three kids, so I have so much work to do. Sometimes I need help, but it is not easy to find it.</i> [14]
	Lack of social support to help them care for themselves	<i>Sure, I needed help at the house and for taking care of myself. I had difficulties with my pregnancy, I was vomiting, not eating well, dizziness, and fatigue.</i> [3]
		<i>I have concerns because I am sick most of the time, I feel tied and I have a lot of housework, too much housework, taking care of other children....</i> [15]
		<i>I need a lot of help, but I only got help from my mother when I gave birth. Most of the time I need help, but I cannot get it.</i> [16]
		<i>I'm single-handed. My mother-in-law is dead, and I have to work at their home, too. No one can help me when I need help.</i> [20]
	Challenges related to living in an IDP camp	<i>Sometimes there is no physician at the clinic, no electricity, no investigations so it is hard to follow up their health.</i> [1]
<i>Also, there is no ultrasound in the hospital for pregnant mothers, which is bad.</i> [17]		
<i>It's hard, the weather is freezing.</i> [6]		

		<i>Being at the camp is difficult for everything, pregnancy is not that much difficult, but childbirth is very difficult. Once, a woman in the family got infection after giving birth because the camp is not clean and safe.[1]</i>
		<i>Sometimes I need some rest and sleep, but I cannot because I do not trust the tent, it is not safe, so I am always worried about my children, and I have to watch them in case of a fire or insects. [17]</i>
		<i>.... no hospital at the camp and the camp is so far from the city center. [15]</i>
	Poverty and lack of financial support	<i>Yes, actually poverty is the greatest concern that I have because in order to take care of your child you need enough money. Financial hardship. Most of us experience poverty. [23]</i>
		<i>After birth is difficult because of financial difficulties. [15]</i>

**Table 4: Summary of Themes, Sub-Themes, and Illustrative Quotes Breastfeeding Experiences**

<b>Theme</b>	<b>Sub-Themes</b>	<b>Illustrative Quotes</b>
Yazidi women's breastfeeding experiences	Importance of breastfeeding	<i>My children have always taken my own milk. I have never used formula before.[20]</i>
		<i>It is healthier for baby and easier for mom. You do not need boiled water for formula and so on. Breastfeeding is always ready. [27]</i>
		<i>People told me a child who is fed with formula is not as healthy as other children.[26]</i>
		<i>Yes, I did, it was nice, felt the bond with my daughter and enjoyed holding her while I was feeding her.[3]</i>
		<i>Thanks to God, with my two other children I used my breast milk; it was very easy and comfortable for me, and I had no problem.[17]</i>
		<i>My kids are weak because they don't breastfeed, and they don't grow well.[11]</i>
		<i>I would rather breastfeed my baby. I prefer it because it is safe, healthy, and better than bottle milk.[1]</i>
		<i>I will breastfeed my baby. I will never give him or her formula. [22]</i>
		<i>The first milk is extremely useful, I always give this milk to my children. First, I wash my breast cleanly with water, then I let them drink from both breasts.... Children who drink breast milk get sick less than others.[12]</i>
	Experiences with insufficient milk	<i>I would prefer breastfeeding, but I have milk only 40 days, after that I have no milk so I depend on formula milk. I visited a doctor and they gave me some pills, but did not work. I asked my mother-in-law, and she said, 'you cannot do anything about it, you have to use formula.' I do not know the reason, but for both of my children I had milk only 40 days.[8]</i>
		<i>After forty days I had no milk.[11]</i>
		<i>Yes, they told me give them my milk and also formula because my milk is not insufficient. They were true my milk was too insufficient...Yes, I am so worried because my milk is not sufficient. Take a look at the baby, he is too small even for this age, it is like he never grew up....I am just worried about my baby's insufficient growth. [12]</i>
		<i>I have six children, for all of them I had milk only one month after birth, I had no milk after one month and I had to use formula milk. I was wishing to give them my breast milk, but I could not.[4]</i>
		<i>I was willing to keep feeding breast milk for 2 years, but I had no milk after 45 days.[3]</i>

Other breastfeeding difficulties	<i>It is difficult when I have so much work at home, and I am busy.[17]</i>
	<i>Now it is difficult. Doctors told me to rest for 9 months. Because of some problem. I am not still comfortable with stitches. I can't give milk to my children because I feel pain in my back and sides of my body. I always bend when I give milk and I get backache.[12]</i>
	<i>After the birth of my first child, I tried to breastfeed my baby, but my family members told me that I should not because I was very sick, and they said it is not good to feed my baby because he will be sick. I did not feed my other children either, because I had no milk, but this time I am planning to breastfeed my baby.[16]</i>
	<i>All of my children are breastfed.... It was hard and challenging. When I get sick, it's hard to breastfeed. I encouraged myself to breastfeed. It was challenging at first, but now it is fine.[7]</i>
	<i>When my breast milk stopped in a month after labor I asked for the reason from my mother-in-law, and she told me that because I am so thin, skinny, and because I am not eating well. So she told me that I cannot do anything about it and I have to use formula for my baby. I was surprised because I have never seen other women stop having breast milk a month after labor. [4]</i>
Influences on the quality and quantity of milk	<i>I have a poor appetite, so it affects my breast milk.[3]</i>
	<i>Yes, mental situation and diet can change it.[29]</i>
	<i>Breastfeeding boosts natural growth of babies. Mothers should avoid some types of food, for example, wheat makes milk heavy, causing constipation. Also, when a mother is pregnant, she should not breastfeed. It is harmful for both mother and baby.[5]</i>
	<i>I think there is nothing harmful if the mother does not take medicine, for example. By eating, we change the quality of our milk. [28]</i>
	<i>The quality of mother's milk does not change.[24]</i>
	<i>It's an inheritance.[23]</i>
	<i>There is such a lot of women [with insufficient milk]. I think it is because of the nature of the mother. Some women have a lot of milk and others have no milk or little milk. There is nothing serious that women could do to get good results and increase their milk, because I tried a lot, but it did not work at all. [19]</i>
	<i>I think it is a different reason for each parent. It could be disease, having no milk, or just the desire of the parents.[16]</i>

		<i>In my opinion we shouldn't change it, even if we can. I have a neighbor who went to the doctor, he gave her medicine to increase her milk, to have enough milk for her baby.[9]</i>
		<i>By eating healthful foods, breast milk will change. [21]</i>
		<i>Maybe because of malnutrition.... By eating honey and milk, mothers' breast milk will be better.[13]</i>
		<i>I have heard [some mothers do not have enough milk]. I think this is about chance and destiny. Some are not blessed.[12]</i>
		<i>Breastmilk is totally good, but eating some kind of foods leaves bad effects on breastmilk.[12]</i>
		<i>Fat women's milk is not good quality. Thin women's milk has more vitamins. Fat women keep their weight for themselves...Good food provides good milk. Cracked wheat, sweets, and so forth [10].</i>

**Table 5: Summary of Themes, Sub-Themes, and Illustrative Quotes Regarded Delegated Nursing and Milk Kinship**

<b>Theme</b>	<b>Sub-Themes</b>	<b>Illustrative Quotes</b>
Yazidi women's knowledge, attitudes, and experiences with shared breastfeeding	Knowledge of the practice	<i>I know many people have done this.[25]</i>
	Positive attitudes	<i>By the way, it is better than formula.[27]</i>
		<i>Yes, I have heard of it, if the mother is not there, another woman will breastfeed the baby until the mom is back. If I am sick, that's fine with me. I would breastfeed another baby too, because I feel sorry not to, since the baby is hungry and I have milk to give, why not?[9]</i>
		<i>If mother's breastmilk is not sufficient, someone else may feed the baby.[13]</i>
		<i>If I had to, I would do that. I think it's healthy.[4]</i>
		<i>I would only ask my sister if it was necessary.[28]</i>
		<i>I have heard it, but I don't like to do it.[29]</i>
	Negative attitudes	<i>I have heard about it, but I will not allow another woman to feed my baby.[2]</i>
		<i>If I can't give my baby my milk, what's the point of someone else's milk? What's the benefit?[6]</i>
		<i>I was one of those women. I breastfeed others' babies and someone breastfed my babies many times.[26]</i>
	Personal experience	<i>I have seen my mother breastfeed my cousin after his mom passed away.[1]</i>
		<i>Yes. If mother's breast produces no or little milk, someone else may breastfeed the baby. In our family, my sister-in-law and my sister breastfed one another's babies. Of course, it was just for the first two days after the birth. My sister-in-law had pain due to cesarean birth, consequently my sister breastfed the baby. If I can't breastfeed my baby due to illness or on the first few days after delivery, I'll have someone else to breastfeed it, but I'll try to breastfeed my baby by myself. I'll tolerate any difficulties. I love to feed my baby with my own milk. Except for the first few days, I prefer infant formula in case I have no milk. Of course, my husband and I should think over this issue.[5]</i>
		<i>Now the baby is very little, if I have no milk, it's fine with me if another mother breastfeeds my baby. My brother-in-law's wife has a 6 month old baby, and she breastfed my baby for two days until my milk started to come in.[10]</i>

		<i>I didn't have milk for my first baby for three days, and the same neighbor as I said gave my daughter milk.[11]</i>
		<i>Once I tried to give milk to someone's child, but he didn't drink. I thought that every baby likes to drink his or her own mother's milk.[12]</i>
		<i>I have been hearing about this a lot. It is common nowadays. Once I was sick and spent a night at the hospital. Our neighbor fed my baby that day.[19]</i>
		<i>When someone has no milk, they can give the baby the milk of someone else. I did it when I was sick.[20]</i>
	Benevolence	<i>Yes, I would do this, this is a humanitarian sense. My mother-in-law proposed it the first time.[27]</i>
		<i>I have heard that some mothers feed babies when they have a lot of milk. I do agree to allow another woman to breastfeed my baby if she has a lot of milk. I do not mind helping and feeding another baby. It is like alms.[15]</i>
		<i>I do not mind feeding other babies if I could, because it's like benevolence.[19]</i>
	Marriage concerns	<i>I have heard that mothers feed other women's children when their mothers have little milk. I won't allow that for my daughter because of future consequences, because it will lead to marriage difficulties in the future, if two non-sibling children fed the same women's milk they will be considered siblings and so do their other siblings as well, which means they can't marry.[3]</i>
		<i>I have seen our neighbors doing that, but I would not allow any woman to breastfeed my children because of future consequences, because the children of both families will become siblings and they cannot marry, we have such thing in our relatives and now they are unable to marry because they fed from the same woman breast milk.[4]</i>
		<i>I would agree for another woman to breastfeed my baby, but I do not agree to feed another baby. It will cause problems with marriage when they grow up, they will be brothers and sisters with each other.[17]</i>
	Health Concerns	<i>I need to know that the mother is a clean mom.[1]</i>
		<i>I'm afraid they might be sick, or not providing good milk.[6]</i>
		<i>No, I don't like to, because I don't know if that woman is clean or healthy or not. If I have to I just let a woman whom I know.[12]</i>
	Last resort	<i>I have heard that some mothers feed babies when they have a lot of milk. I do not really like to allow another woman to breastfeed my baby, but I would agree if I had no choice. I would like to help and feed another baby if I have so much milk.[14]</i>

		<i>I would agree only if I had no choice.</i> [18]
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**Table 6. Summary of Themes, Sub-themes, and Illustrative Quotes Regarding Formula Feeding experiences**

Theme	Sub-Themes	Illustrative Quotes
Yazidi women's formula feeding experiences	Challenges with formula feeding	<i>We were in Shingal mountain for 7 days, and my son was so young, I had to feed him with formula, we did not have enough milk and no clean bottle or water. At that time, I felt so bad; I wished I had had fed him with my milk. A few days later, when we arrived to Duhok, my son got very sick.[16]</i>
		<i>I had to use formula for my children, because I had no breast milk. Formula costs us and also requires a lot of work. I have to prepare the water, bottles, formula powder, and clean the bottle. It is an annoying routine, and formula is not good as breast milk.... Formula milk costs a lot, each month we buy 10 cans of milk, each cost 5,000 dinars [\$4].[4]</i>
		<i>... once I forgot to buy her formula. At night they went to camp markets, and they did not have any formula. Another time I heated water for the milk while she was hungry and forgot to stop the fire, so it boiled a lot, and I had to wait more to cool it.[3]</i>
		<i>Once I wanted to make formula, but I could not find clean water, my baby cried all the night. [21]</i>
		<i>It can cause diarrhea or constipation in infants. Furthermore, people are poor, and this leads to malnutrition. [5]</i>
		<i>I think it is not safe. The baby who feeds by formula usually does not grow up well. [24]</i>
		<i>My younger child could not suck the bottle, he felt suffocated. It was really hard for us.[26]</i>
		<i>Breastmilk is healthy, clean, makes the baby strong and healthy. The temperature is suitable, it won't get hot or cold. While bottled formula milk you need to take care of it by cleaning the bottle well, the water must be very clean, besides buying the formula milk.[9]</i>
		Reasons for formula feeding
	<i>I think those mothers are lazy or selfish. I think only some brands are safe, not all formula brands.[22]</i>	
	<i>I have no concerns, because the formula is not bad. Breastmilk is very good, but formula is not bad as well. I gave my other kids formula, and they are fine now.[8]</i>	
	<i>The first time my daughters were four to five days old was eating formula. It is not good at all. I don't give up until I have to, but some moms do it out of laziness.[11]</i>	
	<i>They do that because the mother has no milk or only because they like using it. I think the formula is not very safe for children. [18]</i>	

		<i>If a physician tells me, I will give him formula.</i> [25]
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**Table 7. Summary of Themes, Sub-Themes, and Illustrative Quotes Regarding Yazidi Fathers' Perspectives**

<b>Theme</b>	<b>Sub-Themes</b>	<b>Illustrative Quotes</b>
Yazidi Fathers' perspectives	Psychological trauma, stress, worry, anxiety, and uncertainty	<i>Yes, I am worried, she got a lot of difficulties when she gave birth to our last child. I am worried about the child too. ...Last week, my wife had pain, and I was so worried for my wife not to give birth to the child earlier than its time. My brother's child is always sick due to the earlier birth.[31]</i>
		<i>Yes, my wife is very young and weak, and I am worried that she wouldn't give birth easily. She lost her brother and father in the attack of ISIS, and she still has a terrible mental condition. ...I am always anxious. [32]</i>
		<i>I'm not worried at all [about the pregnancy]. My wife is an experienced mother. But I'm worried about the future, because we are homeless, and our future is ambiguous.[33]</i>
		<i>My wife is not pregnant, but I'm worried about our future. ...our future is not clear, and our past is full of sadness. ...When my older child was born, my wife suffered much pain and no one came to help us.... It was the weekend and there were no doctors in the camp.... My family tried to help us, but the situation was complicated. I wish we had an obstetrician in the camp.[34]</i>
		<i>My wife gets tired a lot. We have six children, and she is very sad, because of our older son, he has brain tumor. My wife is crying and sad for him. ...the only worry we have is my 11 years old son ... I was so worried when we flee our home in Shingal, I was so worried and scared. Now I am worried about my son and my wife. [36]</i>
		<i>I don't know. I will do whatever they tell me.[32]</i>
Yazidi father's role in caring for a new baby		<i>I am not home most of the day, and my wife takes care of the children alone. But, if there is a problem, like when they're sick or we have to go to the city, I will go with them.[33]</i>
		<i>I spend most of time at work, so I am not home a lot. But when I am home I try to help my wife. I usually take care of the children when they play outside. I take them to the hospital when they need, and buy them their needs.[36]</i>
		<i>I usually ask my mom to help my wife.[35]</i>
		<i>I am working for them. I do not want anything for myself.[34]</i>
		<i>I work outside of the camp all day, and my role is to earn money for the family.[31]</i>
		<i>I don't know. I will do whatever they tell me.[32]</i>
Barriers in access to care		<i>Not too much, the NGOs are not providing a lot, I have asked them to help us find good specialist for my son, but they did not help us, and I cannot afford his treatment.[36]</i>
		<i>It would be better if we had a hospital here.[35]</i>
		<i>There is a lady in the camp who calls the hospital or the emergency if it's needed. It would be better if we had a doctor here all the time. It isn't easy for us to go to the cities.[31]</i>
		<i>Most of the organizations work until noon and after that there are people who don't know anything.</i>

Challenges in living in the IDP camp for Yazidi pregnant and postpartum women, children, families	It's very hard. It's not the place you are used to living in. It's not like being home.[37]
	<i>My biggest anxiety is living in the camps. ... This winter, my children became sick a lot. That's my biggest anxiety</i> [33]
	I am worried for our future, I wish I could set a plan for our future and we could have more children.[34]
	<i>I am worried about raising them, because we are homeless and living in the camps is very hard.</i> [31]
Knowledge and attitudes about breastfeeding	<i>I think the mother needs to be well fed and calm in order to feed the baby. Certainly, breastfeeding, because it not only feeds the baby, it also increases the body's resistance. I would encourage my wife to breastfeed, because I do not want my baby to eat formula. It's okay in times of need, but it's better not to do it all the time. Breast milk is much better. </i> [33]
	<i>I think it is better for a child to breastfeed, but by the way formula is another safe option.</i> [34]
	<i>I have never thought about it. [laughs] No, why should I have thought about it? [laughing] It's not my business.</i> [31]
Poverty	<i>It's hard to go back [to Shingal]. The government won't give me anything, and I had a house that was bombed. How can I make a better life? My daily income is only 20,000 Iraqi dinnar. It's hard to make a good life.</i> [37]
	<i>I am worried about the cost of living. I work in the amp in the mornings and in the evenings outside of the camp. But, I am still worried. </i> [33]
	<i>We have financial hardship and I am worried about the cost of living.</i> [31]
Social support for internally displaced Yazidi fathers	<i>Actually, my father and my brothers are always my support, they always help me, I depend on them when I need help.</i> [36]
	<i>I consulted the physicians several times with my wife, and my little boy was hospitalized for a few days.</i> [33]
	<i>Myself [laughs] and of course my wife, kids, and family are important too.</i> [33]
	<i>... family and most of my brothers.</i> [31]
What is needed to help Yazidi IDP families	<i>I do not have any idea.</i> [34]
	<i>it would be better if we had a doctor so that we could solve our psychological problems. We all need it. Our past is painful.</i> [32]
	<i>We should have a permanent hygiene center so as to help us whenever we need... "or maybe it would be better to help us learn how to take care of ourselves.</i> [31]
	<i>I hope we can treat my son and go back to our home in Shingal, we need to go back with a guarantee that we will be safe this time, but with this government unfortunately we have no guarantee. ... There is not much that could be done while we are in camp, but the government and the NGOs could provide more support for families to meet their need, especially medical support.</i> [36]
	<i>People need to be informed. We don't know much. The importance of health, good nutrition, and education. Not many people know about this. In some cases, our people do not know how to wash their hands! [laughing].... For me awareness is the most</i>

		<p><i>important thing, and teaching families to take care of themselves and their children. As education is scares, our people are illiterate and sometimes unknowingly hurt their own relatives. We have to come out of isolation so that we can take care of ourselves.[33]</i></p>
		<p><i>There is not much that could be done while we are in the camp, but the government and the NGOs could provide more support for families to meet their needs, specially medical support.[36]</i></p>

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**Table 8: Summary of Themes- Sub-Themes, and Illustrative Quotes Regarding Aid Workers' Experiences with Yazidi IDPs living in the KRI**

<b>Theme</b>	<b>Sub-Theme</b>	<b>Illustrative Quotes</b>
Perspectives of aid workers' experiences in IDP camps located in the KRI	Mental health needs of Yazidi IDPs	<i>The Yazidis have psychological problems and their mental health is very bad, since they became refugees and the Islamic State [ISIS] took many of their relatives. We have families where most of them were kidnapped by ISIS. Some of them came back lately during the last few years, that's affecting their psychological condition" [42]</i>
		<i>We have a woman that her daughter and kids got kidnapped by (ISIS) she is always crying and hoping to see them again on day. Those are the problems, they are very devastated and broken psychologically.[42]</i>
		<i>Yazidis have no desire to openly express their problems due to their specific cultural conditions. So there may be cases of sexual violence or illegitimate pregnancies that have already happened and remained silent.[39]</i>
		<i>Depression and anxiety are very common here. There are many instances of committing suicide with drugs or pills. Mourning among them is very common and most have sad faces. In addition, the ambiguous future and unknown fate have caused stress. For this reason and insecurity, despite the fact that their town - Shingal- has been liberated, they dared not return.[39]</i>
		<i>Psychological problems are very common among us all, not just mothers and children. We have been in very bad conditions. Of course, mothers who have children killed or kidnapped are the worse of all, and they often cry and grieve. Others are mostly anxious or thinking about those days.[38]</i>
		<i>They wish they could get back to their home city and live safe. Yazidis are always in danger.[40]</i>
		<i>Depression. They cry a lot, they try to hurt themselves, those types of issues. Some cases like swallowing pills or cleaner detergent, they try something strong to end their lives. [42]</i>
		<i>Mental health issues are highly common. None of us, I emphasize NONE are normal. [41]</i>
	Challenges facing Yazidi women during pregnancy, birth, and postpartum	<i>Pregnant women generally have many difficulties. Not just in childbirth, but during pregnancy. The centers inside the camp do not have any ultrasound devices, for example, and many women have to do it outside the camp, so everyone can't afford it. Since birth, many mothers have to go outside the camp because of certain conditions, which are a lot of financial burden for them. In addition, there are difficulties in childbirth and post - pregnancy, due to their lack of education. Like the constant infection and the reopening of the female stitching or even heating and cooling the tents that can cause illness in the baby.[39]</i>

		<p><i>Yazidis are reserved and private. I don't remember them asking for anything.[39]</i></p> <p><i>The main problem is financial instability and lack of facilities in the camp. In many cases mothers have to go to the city and the cost of a doctor and labs are high.[38]</i></p> <p><i>One of my worst experiences was with a camp kid. When I was working at Camp Hospital, one early morning in the morning I was brought in by a sick little girl who was short of breath. It was less than a year. His mother had bathed him in cold water and had become ill because of the cold weather. When they arrived, the camp doctors had not arrived. I prayed for him to get to the doctors. Half an hour later the doctors arrived and less than half an hour later I heard the baby was dead. It had a very bad effect on me. It had been in my mind for a long time. She was a very cute and sweet girl.[38]</i></p> <p><i>There are a lot of problems like limitation in access to healthcare, financial hardship, and lack of knowledge about self-care, domestic violence, and so on.[30]</i></p> <p><i>Mental health issues are common, not only among mothers and children, but all of us. We experienced terrible things..[40]</i></p> <p><i>I think the greatest challenge is that people usually do not know how vital this stage is. Our men are ashamed to help their wife, and our women are ashamed to ask questions about their problems.[41]</i></p> <p><i>We have some problems, for example, in our hospital we don't have ultrasound. For pregnant women, we have the healthy deliveries, since we don't have ultrasound the pregnant women have to go to Arbat or Sulaymaniya on her cost, which causes financial problems. It will be very good to have ultrasound to serve them. You know when the circumstances were very hard the hospitals in Sulaymaniyah were not free, because of the economic situation in Kurdistan in general. The woman has to pay to deliver her baby, so she has to have an amount of money before going to the hospital, also after delivery she has to take care of the baby which needs getting milk, new clothes, and a warm place, those are all problems and challenges.[42]</i></p>
	<p>Challenges for Yazidi families in IDP camps of the KRI: poverty, domestic violence, mental health, alcohol misuse</p>	<p><i>As a matter of fact, most of the cases are domestic violence. The families have many problems because of the difficult conditions in which they are exposed. For example, most of them have economic problems. In addition, families are highly crowded. For instance, we have families with 15 people; well, how does a 15 - member family live in tents? While some have been living in these conditions for more than four years. ... The reason for domestic violence in them is poverty and sometimes the alcoholism of the man of the family. In these families, the men spend the small amount of money they have earned, on buying wine to forget their troubles for a few hours, and in that mood of drunkenness and lack of</i></p>

		<p><i>reasoning, do agitated and violent treatments. If we want to label a problem as a major problem of Yazadis, we would say the mental problem. The issue of violence and poverty is common in both groups, but Yezidis have psychological problems in many cases. Most families have loved ones who have been killed or kidnapped by ISIL. In some families, there are members who have been captives or slaves of ISIL and have just been freed. Therefore, naturally they have an adverse psychological condition. For example, I know a lady whose children have been kidnapped by ISIL. One of them was a teenage girl. Despite the past four years, he still mourns for his children and is in the hope of meeting them again. These are the problems that, I mentioned before, leads men to alcoholism. The man whose wife, his sister, or mother was a prisoner of ISIL, is looking for a way not to think about their painful experiences as these are very important and vital issues. As a result of alcohol consumption, violent behaviors are becoming more and more, and family conflicts arise.[39]</i></p>
		<p><i>For me, personally, another challenge is the longer administrative process, the longer and the scope of service delivery. For example, if we decide to hold a training course, a long administrative process must be made to obtain permission. Or, for instance, when I want to record a case of violence, I should take the victim to the police center to complain. In many cases, they are not willing to do so. Because the person who acts in violence is their family. For instance, when a woman is sexually assaulted, she first has to go to forensic medicine and then testify and go to police until they arrest the person. Many women don't do it because of their specific cultural conditions.[39]</i></p>
		<p><i>Most families are in need of financial assistance because they are very poor.[38]</i></p>
		<p><i>I am a volunteer and I work with both families and camp management here. Most of the Yazidi families know me and trust me, that's why the camp management ask me to work with them. In fact, our people are reluctant to contact non-Yazidis, so camp management usually asks us to help. [40]</i></p>
		<p><i>One of the hardest times for me is when a person asks me for financial assistance, and I am not able to help them. I usually explain to them that I can just deliver the request related to the organization, and nothing else." 40]</i></p>
		<p><i>Also men are jobless and no other work to do so they go toward alcohol and getting drunk which is common especially among the Yezidi's men. It's very bad and leads to domestic violence. For example, a wife is asking her drunk husband to quit and stop spending money on alcohol, his response is; he is jobless and wants to forget about his problems...etc. then arguments and conflict will take place. Most of them are like that.[42]</i></p>
Available services to Yazidi IDPs in the KRI		<p><i>We have a special Staff, who sometimes visit and inform the tents. We bring special cases to the center and provide them with support services.[39]</i></p>

		<p><i>First, they are formally identified and their information is recorded. Then they are referred to the doctor to receive medicine. There are meetings to be held for their empathy and emotional support, and we refer some of the cases to Zhiyan Foundation on which have support services for them. ...It seems to be effective because we had a couple of patients who kept coming regularly. Previously, the institute was lodging with us, but now they are transferred to the hospital, and their number has become very low. [39]</i></p> <p><i>Here we file forms for pregnant women, checking their health. We also have another organization working on emotional and social support for women.[38]</i></p> <p><i>There are support centers for them, but not everyone comes. Plus, the service is not for everyone. Very acute cases are referred to a psychiatrist for medication. We have special groups to support women. Of course, those groups have now been taken to the hospital and fewer women are referred to them. I don't know if they've been useful or not because I haven't heard anything from anyone. [38]</i></p> <p><i>I remember there was an Israeli organization which had some programs for Yazidi mothers, young women, and widows. [40]</i></p> <p><i>I think in the health center, we have some women who give mothers information about self-care, vaccination, and things like this. I am not sure.[40]</i></p> <p><i>We have staff for different sectors for GBV women, we have nutrition and distributing food, also protection sector that is responsible for whoever has a problem like protection the NGO will get involved to solve it. It's like coordination to make it easier on many sides.[42]</i></p> <p><i>Most of the time we try to facilitate and keep it easier for them, for example, the pregnant woman who has such a case like I mentioned earlier, we would help her by collaborating with a hospital that she can have her C-section and deliver her baby for free, besides that we have funds set aside for these cases for those types of emergencies, we provide them with it. [42]</i></p> <p><i>The Yazidi women won't announce it [rape and domestic violence], they cannot. I can say all cases from both sides [Yazidi and Arab] are the same, they don't want to announce it. But, since this organization has been here in the last 4 years to provide help, they feel secure and safe, once they know there is confidentiality. They trust, and are not afraid of people to know and talk about it. [42]</i></p> <p><i>We as an organization are funded by UNFPA so that doctors and the staff that delivery health care can education women and raise awareness that we have services by visiting the tents, and also patients who visit the hospital, we do the same. We do meetings by collaborating with doctors to gather and talk to the people.[42]</i></p> <p><i>We register her [a woman attempting suicide] case and give her some sessions and psychological support. But, if we see the case needs more care than the</i></p>
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		<p>psychosocial support sessions we have, and since I am not a psychiatrist, I can't give the patient a complete evaluation, so we send them to a special organization for mental health issues to take care of the case. .. they have a psychiatrist. It's Zhyan foundation and OCHA and they are responsible for mental health problems.[42]</p>
	<p>Improving access to and quality of care for Yazidi IDPs in the KRI</p>	<p><i>In many of these cases we are trying to solve these problems. For example, when the birth surgery is essential, we accept the cost that is used in a projected budget called sexual issue. Or the referring the cases to those who accompany us.</i> [39]</p> <p><i>These organizations I think should raise awareness of the dangers of mental illness and pay more attention to poor families with sick children. Because we have lost everything after ISIS and left our homes and our lives in fear and almost all of us have psychological symptoms.</i>[38]</p> <p><i>Of course [mental health services] are helpful, but it would be better if some of our people worked in this field, and if our religious leaders encouraged people to use these services.</i>[40]</p> <p><i>Many things. Money, health facilities, education, even hobbies. They sometimes ask for something they have never had, for example, a car.</i>[41]</p> <p><i>I think [mental health services] are not helpful, at least at this time, because people usually do not even know that they exist.</i>[41]</p> <p><i>If I want to manage a case, we first have to have an agreement paper for it, like if you have a woman she a case-based violence you have to take her to the police to register her, but she won't go or she can't go. Also, another case [a rape case] requires that a doctor examines her at a forensic medicine department, which again needs registration at the police office, and the woman doesn't want to go through many peoples and people to do that. These are all problems for us. It would be great to have privacy for some cases, for example, those who got pregnant because of rape or those who got pregnant out-of-marriage, should be considered as a private case, since it is a problem.</i>[42]</p> <p><i>For those patients who are improving mentally, they try to go visit the organizations for treatment. For example, if they ask them to go visit once a week, they would do so, they are comfortable and happy to go. Once Zhyan foundation came here once a week to check on the cases and to meet with the patients, since here is a place for women and nobody would see them, so it was comfortable for them to meet here. They were visiting on a regular basis. ... They now have their services in the hospital.</i>[42]</p>