

Faith and MHPSS among displaced Muslim women

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With religious identity, practices and beliefs having a profound impact on mental health, faith sensitivity in aid and MHPSS is essential.

“Prayer was the rope of survival.” “Religious needs are my primary needs.” “I wish I had been asked.” These statements were shared by displaced women in Iraq, Syria, Tunisia and Turkey in three independent, coordinated research studies in 2019 led by University of Birmingham, Queen Margaret University and Syria Bright Future in collaboration with Islamic Relief Worldwide and the Humanitarian Academy for Development. The studies examined the role of faith in coping and recovery of women in forced migration and conflict contexts.¹

The women in this study, like many forced migrants, suffered unspeakable hardships, experiencing loss of relatives and belongings, war and violence (including sexual and gender-based violence), life-threatening journeys, separation from family, and powerlessness. Having once belonged to a local faith community, now, on the move, they had held onto the religion, faith and spirituality that move with them. Faith resilience and spiritual suffering – often difficult to comprehend

for outsiders – influenced women’s well-being in varied ways. Throughout their experiences, religious identity, religious practices and religious beliefs had a profound impact on mental health, both buffering and contributing to psychological distress.

Faith moves with them

The findings from the study indicate that the women drew widely upon their faith narratives to find meaning in their suffering and inform critical decision-making, including decisions regarding divorce and suicide. They employed a variety of faith practices as primary coping mechanisms, and valued guidance from informal and formal, female and male faith leaders and access to religious spaces and resources. Women described their religious practices as providing comfort, as a conduit of protection from danger, as a means to reduce anxiety, and as a pathway to receive direction for decision-making. “It’s just like pouring water on fire,” shared Jinan, a 51-year-old woman living in an IDP camp in Iraq, referring



A Syrian refugee woman reading the Qur'an at home in Turkey.

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to her practices of prayer and reading the Qur'an. Religious beliefs similarly formed a primary framework through which the majority of the women in the three studies interpreted life and sought to understand their experiences. A sense of continuing spiritual intimacy with God helped women to persevere through their ongoing struggles.

The women in camps and shelters, however, struggled with logistical barriers to practising their faith, including the lack of privacy and lack of a dedicated space for prayer in their crowded accommodation. In countries of transit and refuge, some felt too tired or preoccupied with daily stresses to perform their individual worship, and lacked opportunities to exercise communal faith practices. They had lost or had to leave behind religious accessories such as sacred texts, prayer beads and prayer mats. Some lost mobile phones in which they kept religious applications or were unable to charge their phones to access religious applications.

Some intimated that their religious practices had declined as a result of their struggle to reconcile their experiences with their belief in God. For some, the decline in their faith was only temporary but for those who were unable to resolve the dissonance between their experiences and their faith, or to restore the stability of their former practice, the decline was linked with symptoms of anxiety and depression. They needed reassurance from sacred knowledge – which felt out of their reach – to help process internalised beliefs associated with abuses they had experienced, as well as self-blame.

Disrupted support

Some of the women in the study shared the desire to speak about spiritual struggles in a formal counselling setting but felt that they were not meant to talk about faith issues. One respondent in Iraq shared: "It is clear, because when they talk to us they never mention anything about religion." Similarly, a study participant from Syria said that she wished that "religious sayings and examples...can be used in treatment, because my personality is inclined to faith and religion."

International and local service providers tended to avoid engaging with religion and did so only when explicitly requested by the women. However, staff attitudes and organisational policies shaped what the women considered safe to disclose. For instance, the religious profile of migrants crossing borders in Tunisia was often assumed based on their appearances, and accounting for religious needs was not embedded in reception screening procedures, nor in medical checks or psychosocial support activities. Most women across the four countries spoke of a desire for a broader type of aid engagement focused on increasing or restoring access to external supports related to faith that had been severely disrupted. Many wished for access to spaces where they might gather with other women to pray as they had done before. For women in transit, the locations of prayer spaces or faith leaders were unknown or remote and, unable to locate spiritual leaders, many were left with unresolved emotional turmoil.

The support that was accessible to the women from aid and MHPSS providers largely did not account for the impact of faith on psychological distress nor the relevance of facilitating access to faith resources for coping, instead assuming local faith leaders would take responsibility for such needs. The reasoning was frequently linked to concerns for neutrality and impartiality. In many of these contexts however – transit towns, detention centres, camps and resettlement locations – the women had limited access to such persons or resources, or had been overlooked or estranged from support due to their gender. Those with a humanitarian mandate who could have brokered equal access did not ask the women in the study about their needs related to faith and avoided discussion of faith in assessments and response plans. As a result, many of the women in this study lacked external support for their coping strategies.

Faith-sensitive MHPSS with Muslim women

While marginalising faith concerns of displaced populations can create harm,

over-emphasising the importance of faith to a population or making assumptions about faith needs based on the majority religion may also create harm. Aid should be responsive to persons who both do and do not wish to be engaged in any way with faith. Thus faith sensitivity in aid and MHPSS begins with asking the displaced population: what they believe the causes of their problems are, what they feel the solutions should be and what role, if any, they would like for faith language, faith actors and spiritual practices to be a part of that process.

The foundations for faith sensitivity in MHPSS are rooted in the principles and directives set forth in the *IASC Guidelines on MHPSS in Emergency Settings*.² These provide guidance on engaging religious supports and on undertaking assessments that take faith issues and actors into account, and emphasise the importance of building on available resources and capacity, participation, integrated support systems and human rights. Further practical guidance on faith sensitivity in MHPSS was developed in 2018.³ Drawing on this guidance and the data in this study, we offer a number of recommendations for working specifically with Muslim women.

MHPSS and other aid actors should take responsibility for assessing, facilitating and monitoring equal access to faith resources and spaces for women and men, working closely with formal and informal faith leaders, and recognising that access to religious resources is gendered. It is important to identify informal female faith leaders in the local context to whom other women turn for spiritual and emotional support. Engage those women in PSS programme design and implementation, including in Psychological First Aid trainings.

MHPSS staff should be made aware of the existence and relevance of key faith teachings and local proverbs that are utilised for coping by individuals and communities. In addition, identification with Prophets and female role models in faith narratives can be a source of comfort as they too experienced displacement, persecution and loss. Heightening staff awareness of these coping methods may enhance the effectiveness of the programmes.

Mental health tools should take into account local idioms of distress that often infuse faith language into descriptions of symptoms of mental health disorders; for example, in Iraq “tired soul” was used to describe the experience of depression.

The role of adverse experiences related to religious identity should be considered when assessing root causes of distress, especially for populations exposed to war atrocities and religious persecutions, and religious and racial discrimination. Increased understanding of the positive and negative functions of local beliefs regarding guilt and divine punishment, and their impact on distress levels and coping mechanisms, can help providers tailor effective care responses.

Women’s peer-to-peer psychosocial support groups designed and led by women can be particularly potent in improving well-being, especially when integrated with educational and income-generation projects. These initiatives may also include religious coping activities such as providing peer support to re-establish rituals and space for discussion related to faith and other concerns.

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1. Involving 246 women, most Muslim (96%), with the remainder Christian, ages ranging from 18-64. The study also included 22 interviews with humanitarian and MHPSS practitioners.

2. IASC (2007) *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* bit.ly/IASC-MHPSS-guidelines

3. Islamic Relief Worldwide and Lutheran World Federation (2018) *A faith-sensitive approach in humanitarian response: Guidance on mental health and psychosocial programming*. bit.ly/IRW-LWF-faith-sensitive-MHPSS-2018