Appendix 1 – Detailed problem statements

1. **Target Psychosocial Problems**: Depression, Overthinking/Anxiety, Sadness, Isolation/Loneliness and Fear of Shame were the top five psychosocial problems identified by women, adolescent girls and GBV survivors in NCA's centers in Iraq. These problems are interrelated and at times co-occurring. And they are caused, exacerbated and/or maintained by systemic issues, such as gender inequality, the difficult economic situation in Iraq, and mental health stigma. Among the five psychosocial problems, depression was most often ranked at the highest priority issue. Please refer to the Needs Assessment Report for more details on each psychosocial problem. *How may a VR-based experience/program help alleviate one or more of these psychosocial problems among individual GBV survivors?*

2. **Service Delivery**: In most humanitarian contexts, social service and health infrastructures are damaged and/or underdeveloped and often rely heavily on paraprofessionals. Thus, specialized mental health and psychosocial support (MHPSS) services and trained providers are not widely available. NCA's caseworkers provide lifesaving care for survivors of GBV, including basic psychosocial support, a trusting and caring relationship, referral to other essential services, and client advocacy. They are well-placed to provide more in-depth therapeutic support; however, caseworkers are paraprofessionals who lack in-depth training and knowledge to deliver specialized MHPSS that addresses survivors' more intractable psychological issues, such as those in problem 1 above. Furthermore, high staff turnover rates are endemic in emergency contexts and threaten continuity of care for survivors, knowledge retention within teams, and the overall sustainability of projects. *How may a therapeutic, VR-based experience/program be safely delivered by paraprofessionals and continue to be used easily by newly hired staff?*

3. **Therapeutic Appropriateness:** Where specialized MHPSS services do exist, providers do not always use approaches that are in line with the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming—particularly, approaches that are feminist, survivor-centered and empowerment-based.[1] Moreover, efficacy of MHPSS interventions relies on the degree to which the intervention is culturally relevant. Each culture has its own explanatory models of illness, idioms of distress, ways of expression, and other MHPSS considerations. Also, NCA supports both adult women and adolescent girls and would like a VR experience/program that is appropriate for use for ages 14 and up and/or adapted for each age group. *How may a VR-based experience/program address the target psychosocial problems in a way that is culturally relevant, age-appropriate, in line with GBV minimum standards, and usable by survivors with diverse experiences?*

4. **Monitoring and Evaluation:** A therapeutic VR experience/program should result in a measurable change in indicators related to survivors' wellbeing, depression, overthinking/anxiety, sadness, fear of shame, and/or isolation/loneliness. *How can therapeutic outcomes and changes from the VR experience/program be measured? And how can this data be easily collected and safely stored?*

5. **Technological Accessibility and Appropriateness:** NCA's office in Iraq has sufficient bandwidth to download and update VR experiences; however, internet access is not consistent in the Family Support Centers (FSC) where the VR headsets will be used. Electricity is available in the FSCs to charge the VR headsets. Most clients will not have experienced VR before their introduction to this therapeutic VR experience, and may likely require an orientation to VR. Clients will experience the VR program in a center with limited space. Similarly, caseworkers will not have had prior exposure to VR, and will require training to assist their clients with VR onboarding and incorporating the VR experience into their case management work. Based on findings from a small

[1] The global *Interagency Minimum Standards for GBV in Emergencies Programming* can be found at https://gbvaor.net/gbviems. The global GBV Area of Responsibility's learning brief on feminist MHPSS practices can be found at https://gbvaor.net/node/798.

sample size of experts, caseworkers and clients, perceptions toward trying VR are positive. *Given these conditions, what are the most appropriate and accessible VR hardware options (i.e., headsets) and what VR experience design decisions should be taken?*

6. **Sustainability:** The VR solution will need to be maintained after the project period. What kind of maintenance will be required over time? *How can it be updated or changed, if needed? How can any maintenance needs be addressed locally in Iraq rather than from an international source? How may future technological advancements in VR hardware impact an experience built for today's headset? How can any maintenance needs be accounted for in the design?*
7. **Scalability:** At present, the opportunities for scaling are wide-ranging and will, in part, depend on the solution. And upon demonstrating a successful pilot, further funding opportunities are accessible. Regardless of how we scale, a solution needs to be amenable to scaling in a cost-effective manner. There may be software/tech requirements that are applicable here. NCA is considering many ways to scale for impact, including: increase new users within target group, expand to new programmatic contexts (e.g., support groups) and/or geographic contexts (e.g., another country or another site within Iraq), and increase the length and frequency of use by building out the solution further (e.g., add more VR experiences or functions). *What may be important design and technology considerations at this pilot stage that will later impact scaling (e.g., adding language options, changing environments and/or avatars, or even the VR experience itself)?*