



**RESIDENT / HUMANITARIAN COORDINATOR  
REPORT ON THE USE OF CERF FUNDS  
IRAQ  
RAPID RESPONSE  
CHOLERA 2015**

**RESIDENT/HUMANITARIAN COORDINATOR**

**Ms. Lise Grande**

## REPORTING PROCESS AND CONSULTATION SUMMARY

- a. Please indicate when the After Action Review (AAR) was conducted and who participated.

*AAR was conducted in two steps: 1) Consultative meetings followed by a workshop on lessons learned on 23-24 March 2016 in Baghdad attended by relevant ministries, municipalities, UNICEF, WHO and Health and Wash Cluster' members; 2) Meeting between UNICEF and WHO facilitated by OCHA HFU held on 7 June 2016 in Erbil.*

- b. Please confirm that the Resident Coordinator and/or Humanitarian Coordinator (RC/HC) Report was discussed in the Humanitarian and/or UN Country Team and by cluster/sector coordinators as outlined in the guidelines.

YES ☒ NO ☐

*The CERF report was discussed at the HCT meeting 12 Aug and no comments were shared.*

- c. Was the final version of the RC/HC Report shared for review with in-country stakeholders as recommended in the guidelines (i.e. the CERF recipient agencies and their implementing partners, cluster/sector coordinators and members and relevant government counterparts)?

YES ☒ NO ☐

*The final version of the CERF report was shared with the implementing partners, Cluster Coordinators as well as the HCT.*

## I. HUMANITARIAN CONTEXT

TABLE 1: EMERGENCY ALLOCATION OVERVIEW (US\$)		
Total amount required for the humanitarian response:		
Breakdown of total response funding received by source	Source	Amount
	CERF	4,490,040
	COUNTRY-BASED POOL FUND ( <i>if applicable</i> )	395,500
	OTHER (bilateral/multilateral)	3,716,381
	<b>TOTAL</b>	<b>8,601,921</b>

TABLE 2: CERF EMERGENCY FUNDING BY ALLOCATION AND PROJECT (US\$)			
Allocation 1 – date of official submission: 13 October 2015			
Agency	Project code	Cluster/Sector	Amount
UNICEF	15-RR-CEF-125	Water, Sanitation and Hygiene	2,295,299
WHO	15-RR-WHO-046	Health	2,194,741
<b>TOTAL</b>			<b>4,490,040</b>

TABLE 3: BREAKDOWN OF CERF FUNDS BY TYPE OF IMPLEMENTATION MODALITY (US\$)	
Type of implementation modality	Amount
Direct UN agencies/IOM implementation	3,920,789
Funds forwarded to NGOs and Red Cross / Red Crescent for implementation	107,745 378,800
Funds forwarded to government partners	461,506300,000
<b>TOTAL</b>	<b>4,490,040</b>

### HUMANITARIAN NEEDS

The CERF projects were developed in response to an unusual, sudden increase of acute watery diarrhoea cases in September 2015, which finally was identified as an outbreak of cholera, with clinically and laboratory confirmed cases. Following this confirmation, the Iraqi Ministry of Health (MoH), in consultation with the World Health Organization (WHO), declared the cholera outbreak on 15 September 2015 and stepped up measures to stop the transmission and prevent further spread of the disease. Tests from the Central Public Health Laboratory confirmed *Vibrio cholerae* in 38 of 106 tested stool samples. The outbreak subsequently spread rapidly. By 18 October, the number of laboratory confirmed cholera cases had risen to 1,748, according to the MoH and WHO. Over 50,000 people sought treatment for acute diarrhoea at various hospitals in the affected governorates. Based on WHO's case definition for cholera, out of 53,238 acute diarrhoea cases between 1 September and 18 October, 1,748 cases were confirmed for *Vibrio cholerae* in 15 governorates: Baghdad,

Babylon, Basrah, Kerbala, Missan, Muthanna, Najaf, Qadissiya, Salah Al Din, Kirkuk, Thi Qar, Wassit, Erbil, Dahuk and Diyala. Out of the 1,748 confirmed cases, 53 per cent were males and 47 per cent females confirmed; the MoH also confirmed two deaths. The range between 0.01 per cent to 0.05 per cent attack rates was used for the off-camp population and host community, hence it was estimated that there were up to 7,140 cases in this epidemic.

Cholera is endemic in Iraq, and analysis showed that over the last 15 years, major cholera epidemics have occurred every two-to-three years. The main accelerators of the outbreak in 2015 were broken water supply systems and the lack of sufficient amounts of chlorine in the country to provide clean water. The endemicity of cholera in Iraq was also compounded by decades of wars and embargos that have severely damaged Iraq's water supply and sanitation infrastructure and weakened the Government's capacity at all levels to manage water, sanitation and hygiene services. One third of the country is under the control of non-government-allied armed groups, limiting the access of the humanitarian community and the Government. The situation was further aggravated in 2014–2015 by armed groups using water resources as a weapon (unilaterally regulating water flow through upstream dams). This led to serious water shortages in governorates located downstream. At the time of the outbreak, the Euphrates River was only getting 10 per cent of its normal seasonal flow, which increased turbidity and led to inefficient treatment of water. There was also shortage of water purification materials resulting from the interrupted supply chain.

This cholera outbreak amidst a large-scale humanitarian emergency highlighted the need for a rapid response to control and prevent its further spread to areas with a high concentration of displaced people and refugees who were especially vulnerable to infectious diseases. Health facilities were overburdened, and medicines and supplies were running short. In four of the most severely affected areas in the country, 14 hospitals and more than 170 health facilities have been damaged or destroyed. Public health services, water and sanitation infrastructure in areas of displacement were already fragile and overloaded.

The humanitarian crisis, including the cholera outbreak, had occurred at a time when the country is facing a major budgetary crisis. The Government of Iraq (GoI) had lost more than 40 per cent of its public revenues as a result of dropping oil prices. Public institutions were doing what they could to provide assistance across the country, but capacities were limited. The Government had publicly requested international assistance to be increased until its revenues and capacities recovered.

The water, sanitation and hygiene response had also scaled back due to lack of resources. Only 40 per cent of the funding required for the most critical priorities had been received. This left 1.3 million people in need of clean water, improved sanitation and basic hygiene-promotion items without essential support, heightening their vulnerability.

Decades of war and embargos have severely damaged Iraq's water supply and sanitation infrastructure and weakened the Government's capacity at all levels to manage Water, Sanitation and Hygiene (WASH) services. The Tigris and Euphrates and their tributaries, together with some smaller rivers and boreholes, are the major water resources shared among domestic, agricultural, and industrial use. Improper management of raw water resources has severely depleted underground aquifers. Current WASH legislation, policies and standards, developed decades ago, are outdated. Although about 94 per cent of the Iraqi population theoretically have access to a water supply network, according to the 2015 "Knowledge, Attitude and Practices" (2015 KAP) survey, only 60 per cent of the surveyed households had access to drinking-quality water, leaving two in five households at risk of water-borne diseases.

Only 23 per cent of households have access to a sewage network (33 per cent in urban areas, 4 per cent in rural areas). Nationwide, over half (53 per cent) of households in the highest wealth quintile have access to a sewage network, compared to nine per cent in the lowest quintile. Globally, only 17 per cent of wastewater is treated before it is discharged into the environment. This translates into about a million tons of raw sewage discharged daily into the Tigris River in Baghdad only, leading to water-borne diseases, including frequent cholera outbreaks. Diarrhoea is the second-largest cause of death for Iraqi children under five, after acute respiratory infections.

Climate change, population growth, and limited environmental awareness limits water resource management in Iraq. The destruction of vital infrastructure as a consequence of conflict and a lack of capital investment have resulted in the lack of access to potable water and basic sanitation facilities. Insufficient operating budgets are exacerbated by poorly trained personnel, ineffective supply chains for water purification products and a tendency to look for quick fixes rather than long-term solutions to structural problems. Iraq depends mainly on Euphrates and Tigris Rivers for its water demands.

## II. FOCUS AREAS AND PRIORITIZATION

WASH responses have not been easy to articulate for large numbers of highly mobile, displaced populations in host communities with already over-stretched WASH services, in camps and, especially, those in informal settlements beyond the reach of existing municipal services. WASH interventions, especially provision of large-scale infrastructure, represent a very high-cost investment. Maintenance of these services represents a significant concern, when considering infrastructure work.

In coordination and agreement with the Health Cluster led by WHO and GoI, UNICEF WASH interventions prioritized the following:

- **Target areas:** Not only communities reporting cholera cases, but also those potentially vulnerable to the outbreak, particularly IDP camps and host communities where minimum requirements for safe water supply and sanitation were not fully met.
- **Water supply response approach:** The first line of response focused on immediate delivery of safe drinking water through water trucking and provision of bottled water, followed by more durable interventions by connecting communities to safe water supply networks.
- **Household water treatment and safe storage (HWTS):** Due to poor performance of water treatment plants, UNICEF enhanced the capacity of communities on treatment and storage of safe water at household level. House water treatment systems were promoted in areas where high levels of water turbidity were noted, making water chlorination methods less effective.
- **Water quality test campaigns:** These were carried out in close collaboration with the Directorate of Water and the Directorate of Environment. Basic tests such as turbidity measurements and coliform presence were conducted in affected areas.
- **IDP camps and settlements:** Following closely the guidance provided within the Cholera Preparedness Plan Iraq WASH-Health Clusters (September 2015) for cholera prevention and control in camps, specific activities with the community were carried out, including support to camp outbreak-control teams, community-based surveillance, WASH facilities, etc. to safeguard the needs of this highly vulnerable group.
- In contribution with other funds (namely provided by: ECHO (\$1,047,741), OFDA/Office of U.S. Foreign Disaster Assistance (\$1,318,140) and the Iraq Humanitarian Pooled Fund (\$395,500) ), CERF funds were utilized to provide lifesaving WASH supplies and services to affected communities within the epidemic area, focusing on the epicentre of the outbreak within the sub-districts targeting directly 150,000 people (25,000 families).
- Age, gender and diversity mainstreaming (particularly for persons with disabilities, children and the elderly) throughout all actions assured the privacy, dignity and security of the affected population in the use and management of WASH facilities and services. Gender is central and key to equitable provision of WASH services. For sanitation, gender-divided and gender-sensitive facilities are part of standard installation, offering girls, boys, women and men separate, secure, private and appropriately designed spaces for bathing. Gender-sensitive items such as sanitary towels are a core component of hygiene kits in order to meet the basic menstrual hygiene needs of girls and women.

The CERF-funded cholera response project's WASH component aimed at:

- Ensuring effective WASH information/communication;
- Improving effective use of sanitation facilities;
- Strengthening community mobilization and participation;
- Increasing the demand for quality services by enabling the capacity of local authorities and communities to provide equitable, affordable and sufficient services.

Prioritization of immediate WASH interventions to supply temporary safe water to the worst-affected locations was managed through the WASH cluster and its partners, with support from the ten WASH Service Centres established by UNICEF (through support from other donors) in 2015.

**WHO:** The need to respond to the cholera outbreak as a priority was discussed in detail with Cholera Task Force during the C4 coordination meetings which were conducted three times a week. The strategies agreed through C4 consultation meetings included 8 main components: (1) Case management; (2) Active/Passive Surveillance; (3) Laboratory strengthening; (4) Health and Hygiene

promotion; (5) Coordination; (6) Monitoring of water quality and safety of food and sanitation resources; and (8) Vaccination and Logistics. The areas were prioritized based on analysis of epidemiological data and laboratory results confirmed by Central Public Health Laboratory (CPHL). As funds made available through CERF mechanism was not enough to address all the strategic components, it was agreed that funds provided through CERF will only address the vaccination component. It was also agreed that the Oral Cholera Vaccines would target the most vulnerable population who were not yet exposed to the cholera bacteria so as to create protective immunity to this exposed population. The targeting was based on the most up-to-date Displacement Tracking Matrix (DTM) database maintained by IOM. In total 247,319 (77,669 refugees and 169,650 IDPs) were targeted, in 62 selected camps in locations at the highest risk of cholera outbreak. Of the total number, 148,865 were under the age of 18, with 117,414 women. The camp and collective centre locations were spread throughout the country, including Baghdad, Babylon, Basrah, Dahuk, Diyala, Erbil, Kerbala, Kirkuk, Najaf, Salah Al Din, Sulaymaniyah, , and Wassit. The remaining strategic components were supported from other resources.

### III. CERF PROCESS

At the onset of the outbreak, the Government of Iraq activated the Cholera Task Force (CTF), a decision-making body chaired by the Prime Minister, and the Cholera Control and Command Centre (C4) led by the Ministry of Health (MoH). At the interagency level, UNICEF as WASH Cluster lead and WHO as Health Cluster lead held regular meetings to discuss new data and to streamline response.

In the original project proposal, the main implementing NGO partners were stated as Rebuild Iraq Recruitment Programme (RIRP); Jannet el Ferdows (JF) and United Iraq Medical Services (UIMS). While negotiating with CERF for funding, UNICEF was simultaneously engaging with other current donors to gauge their interest in supporting cholera response; prior to receipt of CERF funds in November 2015, UNICEF had already received approval from ECHO to temporarily re-programme a portion of a pre-existing contribution in order to facilitate cholera response; therefore, although RIRP, JF and UIMS did support the response, they did so with the support of ECHO funds, among other sources. Directly through CERF, national NGO partners Civil Development Organisation (CDO) and Iraqi Centre for Women and Child Rights (ICRWC), and the local authority GDW (General Directorate of Sewage/Ministry of Municipality and Public Works) were engaged through Small-Scale Funding Agreements (SSFAs) to ensure more comprehensive coverage of affected areas.

### IV. CERF RESULTS AND ADDED VALUE

TABLE 4: AFFECTED INDIVIDUALS AND REACHED DIRECT BENEFICIARIES BY SECTOR <sup>1</sup>									
Total number of individuals affected by the crisis:									
Cluster/Sector	Female			Male			Total		
	Girls (< 18)	Women (≥ 18)	Total	Boys (< 18)	Men (≥ 18)	Total	Children (< 18)	Adults (≥ 18)	Total
Health (WHO)	67,648	50,945	<b>118,593</b>	70,362	45,728	<b>116,090</b>	138,010	96,673	<b>234,683</b>
Water, Sanitation and Hygiene (UNICEF)	103,974	103,974	<b>207,948</b>	85,070	85,070	<b>170,140</b>	189,044	189,044	<b>378,088</b>
Total	171,622	154,919	<b>326,541</b>	155,432	130,798	<b>286,230</b>	327,054	285,717	<b>612,771</b>

<sup>1</sup> Best estimate of the number of individuals (girls, women, boys, and men) directly supported through CERF funding by cluster/sector.

## **BENEFICIARY ESTIMATION**

WASH interventions can be specific to a camp, a community or other location, reaching the same beneficiaries once (e.g. hygiene kit distribution with hard components); reaching the same beneficiaries multiple times with repeated resources (e.g. regular daily water trucking serving a targeted population in a specific location or repeated distribution of hygiene items with soft components). Certain WASH interventions can be specific to a location (e.g. a city or municipal area) but can be considered as benefitting the entire population within that location (e.g. provision of water treatment materials for use in the main water source used by the population).

Within one project, multiple types of activity can be implemented supporting the achievement of one overall WASH result. In estimating beneficiaries, and to avoid double-counting, UNICEF reports only the largest beneficiary figure achieved within a WASH project. Given that provision of safe water is a critical and central preventative measure in cholera response, the figure reported as beneficiaries reached through the CERF-funded actions is that for beneficiaries reached through provision of safe water supply. Geographic location of activities has been taken into account in the estimation and overall calculation.

The last national level data gathered in Iraq was in 2011, with the UNICEF-supported Multiple Indicator Cluster Survey (MICS). Given the lapse in time and the potential changes in demographic caused by the Syrian refugee crisis, internal mass displacement in Iraq, and continuing reports of migration of Iraqis from Iraq to other countries, UNICEF uses a standardised gender and age breakdown when estimating beneficiaries for proposals. In reporting for WASH, where the largest 'catchment' of beneficiaries is used, as described above, the same breakdowns are used. In detail, these are as follows:

**Gender breakdown used in the Kurdistan Region of Iraq (KRI):** Males – 49 per cent; females 51 per cent

**Gender breakdown used in central and southern Iraq:** Males – 45 per cent; females – 55 per cent

**Age disaggregation:** 50 per cent children under 18 years of age

It was agreed that the Oral Cholera Vaccine (OCV) will target the most vulnerable population who were not yet exposed to the cholera bacteria so as to create protective immunity to this exposed population. The number of beneficiaries was computed based on the most recent data from the Displacement Tracking Matrix (DTM) database maintained by IOM.

<b>TABLE 5: TOTAL DIRECT BENEFICIARIES REACHED THROUGH CERF FUNDING<sup>2</sup></b>			
	<b>Children (<math>&lt; 18</math>)</b>	<b>Adults (<math>\geq 18</math>)</b>	<b>Total</b>
<b>Female</b>	171,622	154,919	326,541
<b>Male</b>	155,432	130,798	286,230
<b>Total individuals (Female and male)</b>	<b>327,054</b>	<b>285,717</b>	<b>612,771</b>

## **CERF RESULTS**

### **WASH (UNICEF)**

378,088 beneficiaries were reached with access to safe water against the target of 150,000 (55 per cent female), through a combination of water trucking, distribution of water tabs (33 mg for household level use and 167 mg for community-level use), as well as other water purification materials. Water of acceptable quality for drinking and cooking was supported through provision of chemical and biological water tests. Ninety per cent of all water tests taken by partners during the project period at targeted sites were deemed to be satisfactory. In addition, 265 water tanks were installed via partners Rebuild Iraq Recruitment Programme (RIRP) and Jannet al Ferdaws.

A total of 70,692 households (target 50,000) were reached with hygiene-promotion messages (on average, six people per household; therefore, with a proxy estimate over 424,000 people received hygiene-promotion messages) through a combination of community-level mobilization, information-sharing and the decision to leverage an already-planned nationwide door-to-door polio vaccination campaign, which targets more than 5.7 million children under 5 for polio vaccination. Polio vaccination teams operating in the worst of the cholera-affected locations were given Information, Education, and Communication (IEC) materials and basic training on prevention of transmission of waterborne diseases, to share during the polio campaign.

A total of 70,692 hygiene kits (target 50,000) were distributed, containing basic but critical household items such as soap to help support the uptake and adoption of good hygiene practices in the home.

Five thousand five hundred community members (target 2,000) in project sites were engaged in the community mobilization activities specifically for cholera/prevention of transmission of waterborne diseases. These individuals played a key part in ensuring that overall messages reached the most in need and vulnerable of the populations, especially those who may not have had access to mass media such as TV or radio, or own a mobile phone. 61,948 school children (target 15,000) were reached with hygiene-promotion messages.

The outbreak coincided with the 'Ashura and 'Arba'een' religious pilgrimages (Ashura, 23 October and Arba'een on 3 December) in Iraq. With more than 15 million people expected to travel, surveillance, preparedness and awareness-raising activities were crucial to prevent the spread of the virus. Accordingly, with support from CERF, the pilgrims were targeted with proper hygiene awareness messages regarding the transmission and control of cholera. In this regard, UNICEF signed a Memorandum of Understanding (MoU) with the Ministry of Youth and Sport (MoYS) so that volunteers in over 200 youth centres covering central and south governorates worked jointly with UNICEF in carrying out public awareness and disseminating key messages on cholera outbreak prevention. T-shirts, flyers, brochures, leaflets and tents were dispatched for this purpose. The MoYS assigned 150 volunteers from the Directorates of Youth (DoY) in the selected governorates for this task in liaison with UNICEF WASH facilitators and a UNICEF communication unit. Through community assessments, 77 per cent of the surveyed population had heard of cholera, 66 per cent considered cholera a significant health problem and 97 per cent of the surveyed population said that they had heard of public messages on cholera in the past month.

### **Health (WHO)**

Almost 234,682 displaced populations were vaccinated during the first and second Oral Cholera Vaccine rounds. This is more than 95 per cent of the target population. To reach the herd immunity among the vaccinated population and ensure quality, the plan was to reach 90 per cent by vaccination, which the campaigns achieved. Cards were distributed to those who received the first dose to reduce the risk of getting the vaccine twice during the same round, as well as to document that the person received the two doses in the second round.

The cholera outbreak was contained through a combination of seven strategic interventions, including the OCV campaign. The first index case reported with a date of onset on 30 August was from Diwaniya governorate. The most affected governorates during the outbreak were Babylon, Baghdad, Diwaniya and Muthanna, as shown in Figure 1 below.

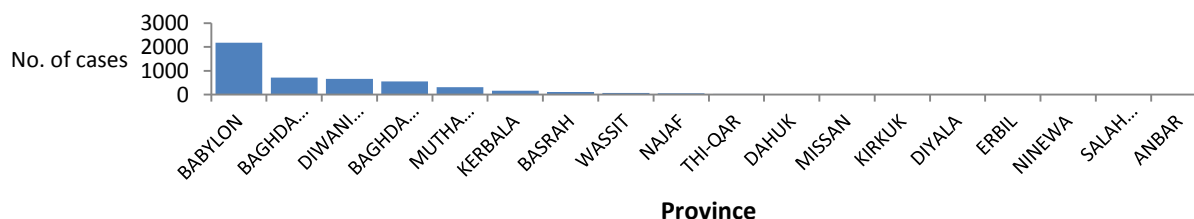
The Iraq Ministry of Health, with the support of WHO, conducted an Oral Cholera Vaccine (OCV) mass preventive immunization campaign targeting the vulnerable populations in refugee and internally displaced person (IDP) camps and collective centres all over the country. It is the first time that Iraq introduced the OCV vaccine (Shanchol). In addition, the fixed centre vaccination strategy had been applied after using the house-to-house strategy for more than 20 years. A total of 510,020 doses were dispatched by ICG to Baghdad (first batch arrived 22 October and the second batch arrived 23 October). The first round was planned to start from 31 October for two days while the second round was scheduled to start from 7 December. The delay gap between the first round and the second round was due to the Oral Polio Vaccinations NIDs (National Immunization Days).

The estimated target population for the OCV campaign was selected from the vulnerable group of the displaced populations in Iraq. Due to the global shortage of the vaccine and the limited amount of the fund, 247,319 displaced persons were selected from IDPs, refugees camps and collective centres to be provided with the two doses of OCV.



Due to heavy rain while conducting the first round, especially in central governorates of Iraq, people moved from their camps to temporary settlements which caused delays. Annex 2 to this report is an infographic showing areas affected by the floods. Despite this hardship, MoH medical teams administered OCV to 234,682 displaced people. After the second round, 95 per cent of the target displaced population had received two doses of OCV.

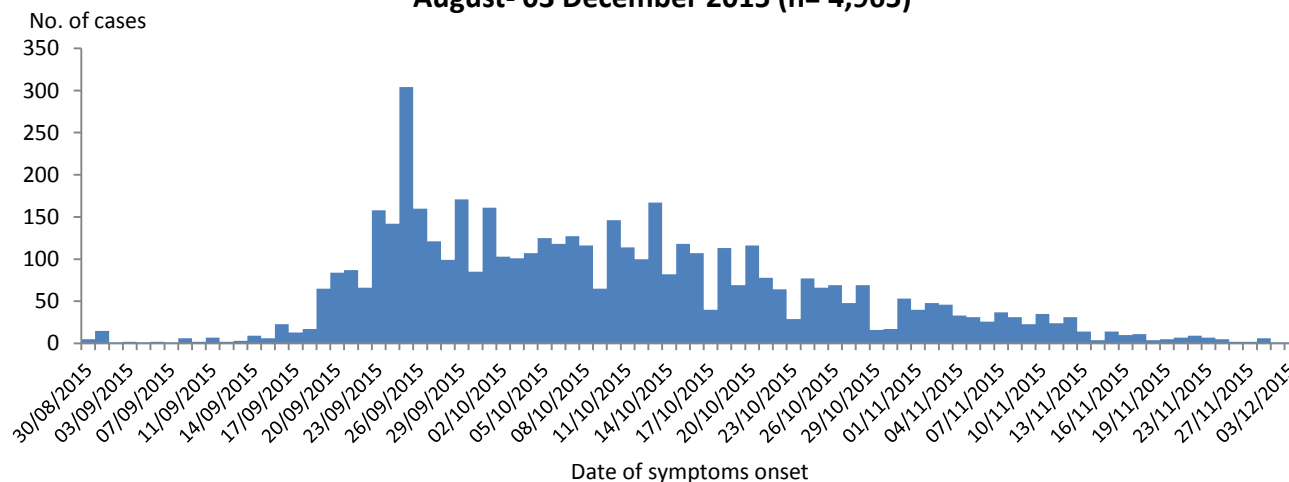
**Figure 1: Distribution of reported cholera cases by province in Iraq, 2015**



The total reported cases exceed 4,965 from all over Iraq, including two reported deaths, from 30 August up to 3 December 2015. The low mortality rate indicates that the health system still has resilience through the existing PHC network in Iraq.

Figure 2 below is an epidemic curve that shows the trend of cases until the outbreak was totally contained. The attached Annex 3 (Time series map) shows how the outbreak evolved over time.

**Figure 2: Epidemic Curve of cholera cases by date of symptoms onset in Iraq, 30 August- 03 December 2015 (n= 4,965)**



Coverage survey conducted after the second round to monitor shows good immunization coverage. EWARN surveillance was used to monitor the reported cholera cases, including those who received OCV.

### **CERF's ADDED VALUE**

a) Did CERF funds lead to a fast delivery of assistance to beneficiaries?

YES ☐ PARTIALLY ☒ NO ☐

**UNICEF:** CERF funding and collaborative support from other donors (including ECHO and OFDA) enabled UNICEF to provide life-saving WASH supplies and services to the targeted population. In actuality, UNICEF received permission from ECHO to partially re-programme a portion of an existing WASH grant to support cholera-specific activities on the understanding that once additional cholera-specific funding arrived, UNICEF would ensure a complementary response. UNICEF utilised ECHO funding from September to October, until CERF funds were received by November 2015. Later, cholera-specific funding was also received from ECHO itself, in addition to the pre-existing ECHO WASH grant held by UNICEF.

**WHO:** The process of the proposal submission exceeded more than two weeks, so there was a delay in conducting the campaign from early October to end of the month. The first round was planned to start on 31 October for two days while the second round was postponed until 7 December. The delay gap between the first round and the second round was due to the fact that the scheduled Oral Polio Vaccinations (National Immunization Days-NIDS) overlapped with OCV campaign, and the OCV vaccination should not be used in combination with Polio drops. This required a gap of another two weeks was required, hence the second round started on 7 December.

**b) Did CERF funds help respond to time critical needs<sup>1</sup>?**

YES ☒ PARTIALLY ☐ NO ☐

**UNICEF:** CERF funds supported UNICEF to ensure rapid and continued availability of core relief lifesaving items, the availability of a pipeline of WASH stocks to fill critical gaps, and the continuation of services to assure a critical cluster accountability to ensure a stock of contingency supplies to meet needs.

**WHO:** The OCV campaign was the first time preventive measures were applied in Iraq. The target population for the OCV was selected from displaced population throughout Iraq.

**c) Did CERF funds help improve resource mobilization from other sources?**

YES ☒ PARTIALLY ☐ NO ☐

**UNICEF:** Knowledge that CERF funding was on its way helped to form part of a wider funding and resource mobilization effort that allowed UNICEF to reach out to additional donors (including ECHO, OFDA, and the Iraq Humanitarian Pooled Fund) to raise resources for scaling-up a WASH response for the targeted population..

**WHO:** As a result of CERF support, technical assistance from regional and headquarters offices was leveraged as an indirect source of funding (in-kind funding). In addition, specialist consultants from International Centre for Diarrheal Diseases and Research, Bangladesh (ICDDR,B) participated in building the capacity of health staff and assessing the response activities. Financial support was received from HQ and EMRO in addition to other resources from the country office to cover the remaining response components in health other than the OCV campaign covered by CERF. In total \$955,000 was received from other funding included in table 1

**d) Did CERF improve coordination amongst the humanitarian community?**

YES ☒ PARTIALLY ☐ NO ☐

**UNICEF:** Designing and submitting a joint proposal for funding between the key humanitarian partners involved – UNICEF for WASH and WHO for Health – helped establish and strengthen the ongoing coordination among the CTF, the C4 and other key stakeholders. Rapid disbursement of funds through CERF allowed UNICEF to organize and prioritize the WASH response in coordination with other WASH Cluster partners.

**WHO:** Several coordination meetings conducted during the cholera outbreak facilitated the response activities.

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<sup>1</sup> Time-critical response refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of lives and damage to social and economic assets (e.g. emergency vaccination campaigns, locust control, etc.).

e) If applicable, please highlight other ways in which CERF has added value to the humanitarian response

**UNICEF:** CERF enabled UNICEF to respond to the ongoing IDPs crisis in addition to Cholera outbreak

**WHO:** CERF's support on vaccination component has helped to raise attention to the need to address other components at the same time. Also it should be noted that there were no reported cholera cases among the vaccinated population during the cholera outbreak in 2015 due to the immunity received by the two doses immunization.

## V. LESSONS LEARNED

TABLE 6: OBSERVATIONS FOR THE <u>CERF SECRETARIAT</u>		
Lessons learned	Suggestion for follow-up/improvement	Responsible entity
While cholera response was an acute emergency phase in the final quarter of 2015, there remains an ongoing and urgent need to provide funding to humanitarian emergency response in Iraq	CERF to consider providing funding on longer timeframes to ensure that connections between first / second / third lines of humanitarian response can be more deeply engaged in context of multiple and complex humanitarian response in situations of protracted crisis.	CERF secretariat
Slow disbursement of funds	Determining mechanisms to accelerate the disbursement of funds would have helped the programme. If disbursement is very slow, the time frame for the programming may need to be refigured to take this into account.	CERF secretariat
Narrow scope limited to cholera <i>vaccination</i> as opposed to other strategies to limit the spread of the outbreak	In case of disease outbreak, the funds provided by CERF should be flexible to address comprehensively or take action required to control the outbreak. This was not the case for the current cholera outbreak in Iraq.	CERF secretariat

TABLE 7: OBSERVATIONS FOR <u>COUNTRY TEAMS</u>		
Lessons learned	Suggestion for follow-up/improvement	Responsible entity
Shortage of water purification materials (chlorine/alum) and spare parts (pumps/water test tools) made organization of response harder, as breaking the 'contamination chain' became more difficult	Shortage in chlorine and other inputs for water treatment was one of the biggest contributing factors leading to the spread of the disease in most of the governorates	Before the cholera period, the MoH and the Ministry of Housing, Reconstruction, and Municipalities / DoW should procure and pre-position chlorine, alum, spare parts, water testing materials etc. in sufficient quantities (to be determined at outbreak) in at-risk districts/areas  The DoW should train staff in charge of the water

**TABLE 7: OBSERVATIONS FOR COUNTRY TEAMS**

Lessons learned	Suggestion for follow-up/improvement	Responsible entity
		<p>treatment plant</p> <p>WASH and Health cluster partners can support with supplies and technical guidance to a certain degree; however, the overall impetus must come from the concerned Ministries</p>
When a major stakeholder like the Directorate of Water (DoW) is missing, the effectiveness of the cholera response is negatively impacted.	It is suggested that the Government of Iraq (GoI) ensures that all stakeholders from relevant sectors are represented in Cholera Task Force.	GoI, WHO, UNICEF
The shortage of chlorine, and other inputs for water treatment was one of the biggest contributing factors leading to the spread of the disease in most of the governorates.	<p>Before the cholera season, the MoH and the DoW should procure chlorine and other inputs for water treatment, including water testing materials.</p> <p>It is suggested that the DoW train the staff in charge of the water treatment plant.</p>	MoH, DoW
Appropriate use of the sewage system could have prevented the spread of bacteria from excreta to contaminate the drinking water system.	It is suggested that the DoH, DoW and Governorates team up to monitor the sewage management.	DoH, DoW, Governorates
The absence of skilled staff in cholera case management in the community health centres had a negative impact on the care provided to patients.	It is suggested that the MoH train staff serving the community health centres in cholera case management.	MoH
Starting to procure the vaccine earlier would ensure that it is available in adequate quantity and vaccinate people before the cholera season.	Make the Oral Cholera Vaccine (OCV) available at global level with adequate amount to meet the demand.	ICG (International Coordination Group)

*Note: Detailed Lessons Learned document was finalised by and agreed with all key cholera response stakeholders in the first quarter of 2016. The full Lessons Learned document is submitted alongside this report as a supporting document. A small number of recommendations are reflected in the tabulation above, for information purposes; however the full and final document shall act as the comprehensive list for Country Teams engaging in future cholera responses in Iraq.*

## VI. PROJECT RESULTS

TABLE 8: PROJECT RESULTS							
<b>CERF project information</b>							
<b>1. Agency:</b>	UNICEF		<b>5. CERF grant period:</b>	01/10/2015 – 31/03/2016			
<b>2. CERF project code:</b>	15-RR-CEF-125		<b>6. Status of CERF grant:</b>	<input type="checkbox"/> Ongoing			
<b>3. Cluster/Sector:</b>	Water, Sanitation and Hygiene			<input checked="" type="checkbox"/> Concluded			
<b>4. Project title:</b>	Immediate UNICEF WASH and Health responses for Cholera Outbreak						
<b>7. Funding</b>	a. Total funding requirements <sup>2</sup> :			d. CERF funds forwarded to implementing partners:			
	US\$ 4,000,000			▪ NGO partners and Red Cross/Crescent:			
	b. Total funding received <sup>3</sup> :			US\$ 79,555			
	US\$ 5,056,680,000			▪ Government Partners:			
	c. Amount received from CERF:			US\$ 315,705			
	US\$ 2,295,299						
<b>Beneficiaries</b>							
<b>8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) <u>directly</u> through CERF funding (provide a breakdown by sex and age).</b>							
<b>Direct Beneficiaries</b>		<b>Planned</b>			<b>Reached</b>		
		<b>Female</b>	<b>Male</b>	<b>Total</b>	<b>Female</b>	<b>Male</b>	<b>Total</b>
Children (< 18)		41,250	33,750	75,000	103,974	85,070	189,044
Adults (≥ 18)		41,250	33,750	75,000	103,974	85,070	189,044
<b>Total</b>		<b>82,500</b>	<b>67,500</b>	<b>150,000</b>	<b>207,948</b>	<b>170,140</b>	<b>378,088</b>
<b>8b. Beneficiary Profile</b>							
<b>Category</b>		<b>Number of people (Planned)</b>			<b>Number of people (Reached)</b>		
Refugees							
IDPs		50,000			88,000		
Host population		50,000			200,000		
Other affected people		50,000			90,088		

<sup>2</sup> This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

<sup>3</sup> This should include both funding received from CERF and from other donors.

<b>Total (same as in 8a)</b>	<b>150,000</b>	<b>378,088</b>
<i>In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:</i>	Due to the acute shortage of purification materials, and after consultation with relevant members of the Cholera Task Force, the WASH cluster and Health cluster, UNICEF utilized the CERF fund to procure double the planned quantity of water purification materials; as a result, this benefitted more than the originally targeted number of beneficiaries. In addition, due to the Arbayeen occasion (religious pilgrimage to the city of Kerbala which brings millions of people to Iraq, many of whom cross international borders from Iran, Kuwait, and Saudi Arabia among others) that occurred during the CERF-funded project period, activities were able to reach more than the originally planned targets.	

CERF Result Framework			
9. Project objective	Reduce mortality and morbidity associated with cholera and other water-borne diseases through improved water, sanitation, hygiene, and health services among people affected in Iraq.		
10. Outcome statement	Populations in Iraq affected by cholera and those at increased risk of cholera have access to equitable, affordable and sufficient safe water supply and sanitations services and engage in hygiene practices.		
11. Outputs			
Output 1	Cholera-affected populations and those at increased risk have access to safe water to the agreed standards and maintained water supply systems (targeted areas: 8 affected governorates of Central and South Iraq).		
Output 1 Indicators	Description	Target	Reached
Indicator 1.1	# of beneficiaries with access to safe water	150,000 (55% female)	378,088
Indicator 1.2	# of satisfactory water tests	100%	90%
Indicator 1.3	# of water tanks installed	200	265
Indicator 1.4	% of affected sites with regular water trucking in M3	100%	50%
Indicator 1.5	# of Cholera cells established and trained	10	One central Cholera Control and Command Centre (C4) established, and led by MoH – guided by the decision-making body of the Cholera Task Force (CTF); it was found in the lessons learned from the cholera response that the existence of ad hoc coordination bodies working parallel to the C4 and CTF was not conducive

			to an effective response
Indicator 1.6	# of beneficiaries with access to safe water	150,000 (55% female)	378,088
<b>Output 1 Activities</b>	<b>Description</b>	<b>Implemented by (Planned)</b>	<b>Implemented by (Actual)</b>
Activity 1.1	Water trucking	UNICEF LTA	UNICEF LTA with Iraqi supplier (Al-Shad Company)
Activity 1.2	Distribution of water tanks with tab stands and steel shades	Procured by UNICEF, Distributed by RIRP, JF	Procured by UNICEF, Distributed by RIRP, JF
Activity 1.3	Distribution of Household Aqua tabs through PHCs	Procured by UNICEF, Distributed by RIRP, JF, UMIS, PHCs	Procured by UNICEF, Distributed by RIRP, JF, UMIS, PHCs
Activity 1.4	Distribution of Community 1.67g purification tablets	Procured by UNICEF, Distributed by RIRP, JF	Procured by UNICEF, Distributed by RIRP, JF
Activity 1.5	Provision of purification chemical materials (Alum & Bleaching powder)	UNICEF LTA	UNICEF LTA with Turkish supplier (Tekkon)
Activity 1.6	Support chemical and biological water tests from source to household	UNICEF IPs (RIRP, JF, UMIS), GDW, MoEnv, MoH	UNICEF IPs (RIRP, JF, UMIS), GDW
Activity 1.7	Establish Cholera cells at governorate levels	UNICEF	UNICEF & WHO in coordination with MoH, MHCPM, MoB
<b>Output 2</b>	Cholera-affected populations and those at risk have reduced risk of cholera contamination through improvement, upgrading/constructions and disinfection of sanitation facilities in infected households, schools, and health facilities (targeted areas include eight governorates of Central and South Iraq).		
<b>Output 2 Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Reached</b>
Indicator 2.1	# of functioning latrines installed	400	414
Indicator 2.2	# of functioning showers installed	200	396
Indicator 2.3	# of Septic tanks disinfected	100	66
Indicator 2.4	Quantity of waste water de-sludge (M3)	1000	1500
Indicator 2.5	# of schools with sanitation facilities upgraded	30	9
Indicator 2.6	# of health centres with sanitation facilities upgraded	10	1

Output 2 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 2.1	Installation of latrines for IDPs in camps and informal settlements.	UNICEF, Distributed by RIRP, JF	UNICEF, Distributed by RIRP, JF & ICWCR (activities carried out by the partners RIRP and JF were supported through complementary contribution from ECHO; while partners C4DO, ICWRC and GDW were supported through CERF funds)
Activity 2.2	Installation of showers for IDPs in camps and informal settlements.	UNICEF, Distributed by RIRP, JF	UNICEF, Distributed by RIRP, JF
Activity 2.3	Disinfectant of waste water sub structure in high epidemic areas (Hospital)	UNICEF/ICRC	UNICEF/ICRC
Activity 2.4	Desludging of waste water	UNICEF through RIRP, JF	UNICEF through RIRP, JF
Activity 2.5	Upgrading of Sanitation facilities in 10 Schools	UNICEF through IPs & DoE	UNICEF through private contractor in Babel and NGO partner JF in Abu Ghraib-Baghdad
Activity 2.6	Upgrading of Sanitation facilities in four Health centres	UNICEF through IPs & DoH	UNICEF through IPs (JF)
<b>Output 3</b>	Cholera-affected populations and those at risk are enabled to adopt appropriate hygiene practices and have access to culturally appropriate and gender sensitive sanitation facilities and services, in particular ensuring adequate access for women and girls, including in displacement settings (targeted areas include eight governorates of Central and South Iraq).		
Output 3 Indicators	Description	Target	Reached
Indicator 3.1	# of households reached with hygiene promotion messages (families within the epidemic areas through UNICEF/IP hygiene mobilizers, volunteers within promotion campaigns along with the distribution of hygiene materials)	42,000	70,692
Indicator 3.2	Quantity of Hygiene kits distributed	50,000	70,692
Indicator 3.3	Quantity of water family kits/Jerry cans, Buckets distributed	50,000	70,692
Indicator 3.4	% of households demonstrating household water treatment and safe storage	100	168
Indicator 3.5	# of community members in project sires involved in community mobilization activities	2,000	5,500



Indicator 3.6	# of school children (girls and boys) reached with hygiene promotion messages	15,000	61,948
<b>Output 3 Activities</b>	<b>Description</b>	<b>Implemented by (Planned)</b>	<b>Implemented by (Actual)</b>
Activity 3.1	Distribution of Hygiene kits	Procured by UNICEF, Distributed by RIRP, JF, UMIS, PHCs	Procured by UNICEF, Distributed by RIRP, JF, UMIS & PHCs,
Activity 3.2	Distribution of water family kits /Jerry cans, Buckets	Procured by UNICEF, Distributed by RIRP, JF, UMIS, PHCs	Procured by UNICEF, Distributed by RIRP, JF, UMIS & PHCs,
Activity 3.3	Distribution of disinfectant	Procured by UNICEF, Distributed by RIRP, JF, UMIS, PHCs	Procured by UNICEF, Distributed by RIRP, JF, UMIS & PHCs,
Activity 3.4	Distribution of soap	Procured by UNICEF, Distributed by RIRP, JF, UMIS, PHCs	UNICEF IPs, Staff, Media companies, Facilitators & Volunteers,
Activity 3.5	Development and dissemination of key public messages on Cholera prevention (production of printed materials, radio and TV spots, SMS messages, refresher training of communicators)	UNICEF IPs, Staff, Media companies, Facilitators & Volunteers	UNICEF IPs, Staff, Media companies, Facilitators & Volunteers
<b>Output 4</b>	Cholera-affected populations and those at risk have access to diarrheal diseases case management services to the agreed standards (targeted areas include 8 governorates of Central and South Iraq).		
<b>Output 4 Indicators</b>	<b>Description</b>	<b>Target</b>	<b>Reached</b>
Indicator 4.1	# of cases with severe dehydration managed at the tertiary hospitals	1,428	2,001
Indicator 4.2	# of cases with some dehydration managed at the PHCs with ORT	7,140	724 children under 5 (MoH Data)
<b>Output 4 Activities</b>	<b>Description</b>	<b>Implemented by (Planned)</b>	<b>Implemented by (Actual)</b>
Activity 4.1	Establishment of referral mechanisms between ORPs and PHC	MoH/DoH with support of UNICEF	MoH/DoH with support of WHO
Activity 4.2	Ensure treatment of all diarrhoea cases at the PHC per existing protocol	MoH/DoH with support of UNICEF	MoH/DoH with support of WHO
Activity 4.3	Cases requiring hospitalizations to be referred to General hospital (adults/children)	MoH/DoH with support of UNICEF	MoH/DoH with support of WHO
<b>Output 5</b>	Service providers and households at cholera-affected areas and those at risk have enhanced skills to provide adequate case management of diarrheal diseases cases (targeted areas include 8 governorates of Central and South Iraq).		

Output 5 Indicators	Description	Target	Reached
Indicator 5.1	# of service providers oriented on case management of cholera	400	1,321
Indicator 5.2	# of households provided with orientation on community case management	2,000	3,750
Indicator 5.3	# of households reached with health-seeking behaviour messages	42,000	70,692
Indicator 5.4	# of school children (girls and boys) reached with health-seeking behaviour messages	15,000	61,948
Output 5 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 5.1	Orientation on case management for the clinicians/support personnel working in the health facilities/camps	MoH/DoH with support of UNICEF	WHO
Activity 5.2	Orientation on community case management of diarrhoea at household level	MoH/DoH with support of UNICEF	Not Done – Ministry did not have the capacity (time; available human resources) to work on this within the time frame of the grant

**12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:**

Under the WASH Cluster component of the cholera response led by UNICEF with support of CERF funding, higher numbers of beneficiaries were reached than originally planned as the number of the affected communities increased subsequent to the submission of the proposal. A higher number of supplies (especially water purification materials, of which double the planned amount was procured) was distributed than originally planned in the CERF proposal which led to an over achievement in beneficiaries reached.

**13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:**

WASH activities led by UNICEF in coordination with the WASH cluster included community assessments. UNICEF community assessments gathered key information to guide the response i.e. on the level of knowledge among communities on waterborne disease transmission while also offering affected populations the opportunity to feedback on their situation, their needs, and their suggestions for required actions.

UNICEF through the university of Baghdad's Administration Institute carried out community assessments in three high epidemic governorates (Baghdad, Babylon and Diwaniya). CERF fund supported UNICEF to ensure rapid and continued availability of core relief lifesaving items, and availability of a pipeline of WASH stocks to fill critical gaps and ensure continuation of services and assure a critical Cluster accountability to ensure a stock of contingency supplies to meet needs.

<b>14. Evaluation: Has this project been evaluated or is an evaluation pending?</b>	EVALUATION CARRIED OUT <input type="checkbox"/>
Detailed review of the cholera response has been carried out across an extended period by all stakeholders including the relevant line Ministries, WASH Cluster; Health Cluster and others. While this is not a formal evaluation as such, it has formed a common and shared understanding of the strengths and weaknesses of the 2015 cholera outbreak response in Iraq, which has resulted in the Lessons Learned document as a key output	EVALUATION PENDING <input type="checkbox"/>
	NO EVALUATION PLANNED <input checked="" type="checkbox"/>

**TABLE 8: PROJECT RESULTS**

CERF project information							
<b>1. Agency:</b>	WHO		<b>5. CERF grant period:</b>	01/10/2015 – 31/03/2016			
<b>2. CERF project code:</b>	15-RR-WHO-046		<b>6. Status of CERF grant:</b>	<input type="checkbox"/> Ongoing			
<b>3. Cluster/Sector:</b>	Health			<input checked="" type="checkbox"/> Concluded			
<b>4. Project title:</b>	Reinforcement of the emergency rapid response to cholera outbreak in Iraq						
<b>7. Funding</b>	a. Total funding requirements <sup>4</sup> :			d. CERF funds forwarded to implementing partners:			
	US\$ 8.5m			▪ NGO partners and Red Cross/Crescent:			
	b. Total funding received <sup>5</sup> :			US\$ 28,190			
	US\$ 3,149,741			▪ Government Partners:			
	c. Amount received from CERF:			US\$ 145,801			
	US\$ 2,194,741						
Beneficiaries							
<b>8a. Total number (planned and actually reached) of individuals (girls, boys, women and men) <u>directly</u> through CERF funding (provide a breakdown by sex and age).</b>							
Direct Beneficiaries		Planned			Reached		
		Female	Male	Total	Female	Male	Total
Children (< 18)		70,723	78,142	148,865	67,648	70,362	138,009
Adults (≥ 18)		46,691	51,763	98,454	50,945	45,728	96,673
<b>Total</b>		<b>117,414</b>	<b>129,905</b>	<b>247,319</b>	<b>118,593</b>	<b>116,089</b>	<b>234,682</b>
8b. Beneficiary Profile							
Category	Number of people (Planned)			Number of people (Reached)			
Refugees	77,669			67,865			
IDPs	169,650			166,817			
Host population							
Other affected people							
<b>Total (same as in 8a)</b>	<b>247,319</b>			<b>234,682</b>			
In case of significant discrepancy between planned and reached beneficiaries, either the total numbers or the age, sex or category distribution, please describe reasons:		Not applicable as there were no major discrepancies					

<sup>4</sup> This refers to the funding requirements of the requesting agency (agencies in case of joint projects) in the prioritized sector for this specific emergency.

<sup>5</sup> This should include both funding received from CERF and from other donors.

CERF Result Framework			
9. Project objective	To contain the spread of cholera outbreak in the high risk population groups, IDPs and Refugees; and create long term population immunity through two short-spaced vaccination rounds in October and November 2015.		
10. Outcome statement	Risk of cholera outbreak in targeted populations minimized.		
11. Outputs			
Output 1	Risk of cholera outbreak among IDPs and refugees reduced through increased immunity among targeted population		
Output 1 Indicators	Description	Target	Reached
Indicator 1.1	At least 90 per cent of the total targeted population vaccinated in each round of the cholera vaccination campaign	247,319	234,682
Indicator 1.2	Number of visits conducted by the social mobilisers (n=651)	1,200	1,061
Indicator 1.3	Number of vaccinators trained	1,953	1623
Output 1 Activities	Description	Implemented by (Planned)	Implemented by (Actual)
Activity 1.1	Procurement and shipping of vaccines	WHO	WHO
Activity 1.2	Transportation, clearance and warehousing of vaccines	WHO	WHO
Activity 1.3	Distribution of vaccines to targeted governorates and camps	WHO and MoH	WHO and MoH
Activity 1.4	Supporting cold chain at central and peripheral levels	WHO, MoH	WHO, MoH
Activity 1.5	Technical Support for preparation and implementation of campaign	WHO	WHO
Activity 1.6	Developing micro-planning for teams and areas assignment	MoH, DoH	MoH, DoH
Activity 1.7	Printing of vaccination cards	MoH	MoH
Activity 1.8	Developing and printing training materials and forms	MoH, WHO	MoH, WHO
Activity 1.9	Training of the campaign staff	MoH, DoH	MoH, DoH
Activity 1.10	Targeted and locally appropriate social mobilization	MoH, DoH	MoH, DoH
Activity 1.11	Conducting Vaccination Campaigns	MoH, DoH with WHO technical and financial support	MoH, DoH with WHO technical and financial support
Activity 1.12	Monitoring campaign activities and Adverse Events Following Immunization (AEFI) Surveillance	WHO in collaboration with, partners	WHO in collaboration with , partners
Activity 1.13	Coverage survey	WHO in collaboration with IRCS	WHO in collaboration with IRCS (Iraqi Red Crescent Society)

<b>12. Please provide here additional information on project's outcomes and in case of any significant discrepancy between planned and actual outcomes, outputs and activities, please describe reasons:</b>	
<p>Almost 95 per cent of the target displaced population received two doses of the OCV vaccine. The operation was conducted in all targeted governorates. South and central governorates were operationally covered from Baghdad while the operation of Northern governorates was controlled from Erbil. Northern governorates added one extra day to the days of the campaign and reduced the number of vaccinators. Details of the coverage are provided in Infographic shown as Annex 6.</p>	
<b>13. Please describe how accountability to affected populations (AAP) has been ensured during project design, implementation and monitoring:</b>	
<p>The selection of IDPs and Refugee camps was done in consultation with camp management and community leaders which were kept informed of the process. The benefits of the campaign were explained through awareness raising campaigns. Most of the target population received two doses of the OCV.</p>	
<b>14. Evaluation: Has this project been evaluated or is an evaluation pending?</b>	EVALUATION CARRIED OUT <input checked="" type="checkbox"/>
Coverage survey was conducted against the OCV campaigns by IRCS.	EVALUATION PENDING <input type="checkbox"/>
	NO EVALUATION PLANNED <input type="checkbox"/>

## ANNEX 1: CERF FUNDS DISBURSED TO IMPLEMENTING PARTNERS

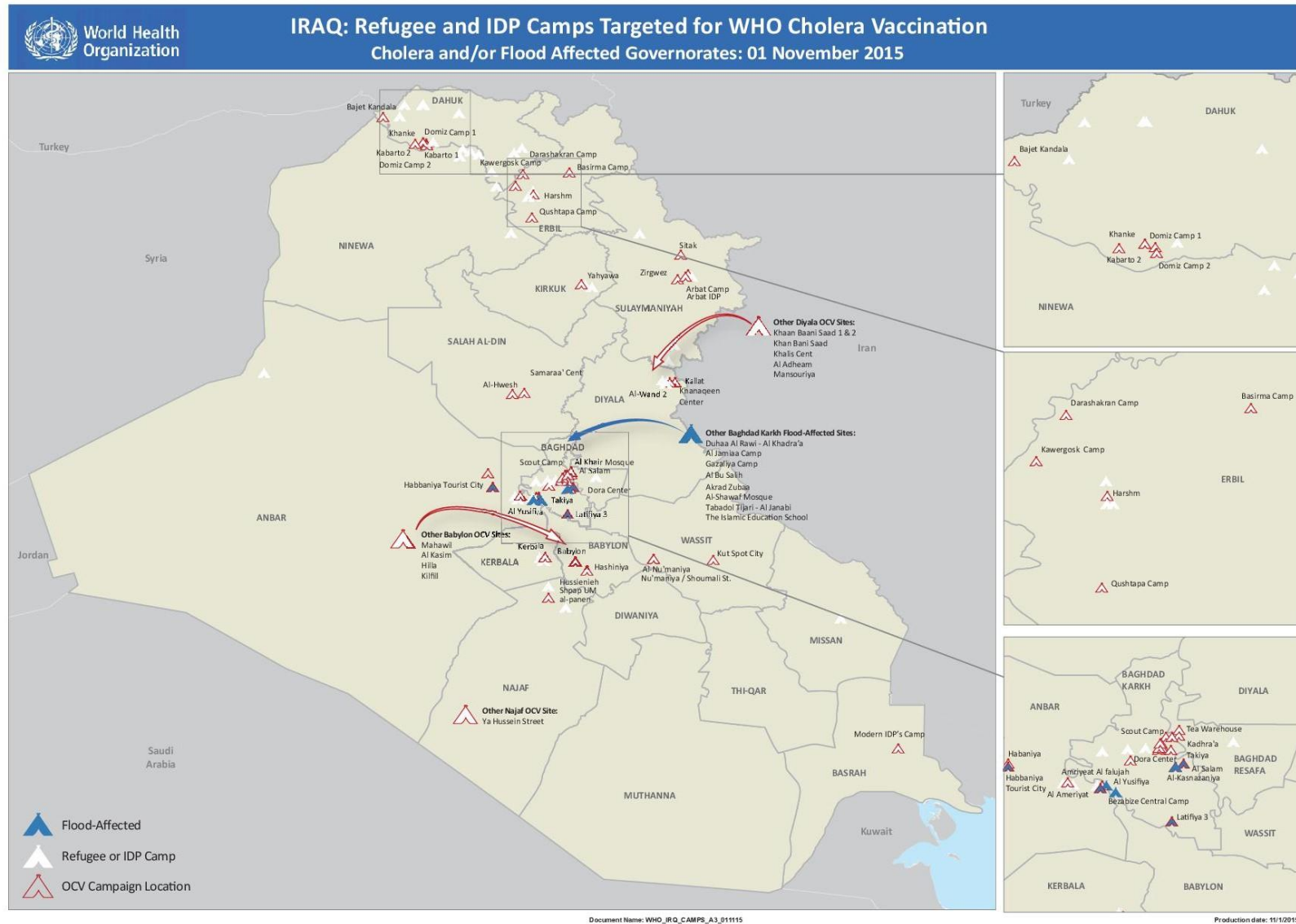
CERF Project Code	Cluster/Sector	Agency	Partner Type	Total CERF Funds Transferred to Partner US\$
15-RR-CEF-125	Water, Sanitation and Hygiene	UNICEF	GOV	\$39,950
15-RR-CEF-125	Water, Sanitation and Hygiene	UNICEF	GOV	\$239,490
15-RR-CEF-125	Water, Sanitation and Hygiene	UNICEF	NNGO	\$31,280
15-RR-CEF-125	Water, Sanitation and Hygiene	UNICEF	NNGO	\$48,275
15-RR-WHO-046	Heath	WHO	RedC	\$28,190
15-RR-WHO-046	Health	WHO	GOV	\$145,801
15-RR-CEF-125	Health	UNICEF	GOV	\$36,265

## ANNEX 2: ACRONYMS AND ABBREVIATIONS (Alphabetical)

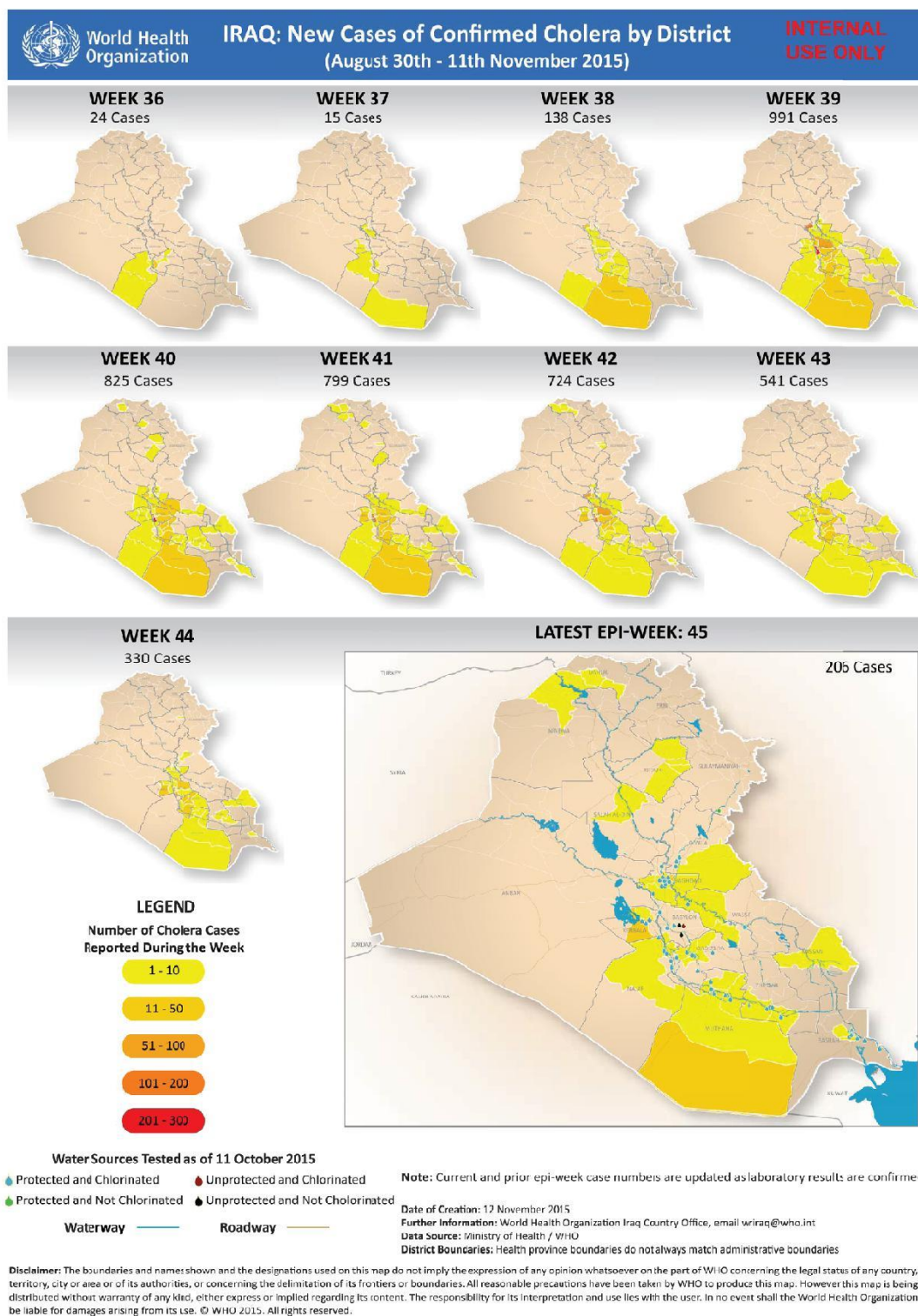
AEFI	Adverse Events Following Immunization
AWD	Acute Watery Diarrhoea
CDO	Civil Development Organisation
C4	Cholera Command and Control Centre
CPHL	Central Public Health Laboratory
CTC	Cholera Treatment Centre
CTF	Cholera Task Force
DoH	District of Health
DoW	Directorate of Water
DoY	Diretorate of Youth
DTM	Displacement Tracking Matrix
ECHO	European Commission's Humanitarian Aid and Civil Protection
GDW	General Directorate of Sewerage / Ministry of Municipality and Public Works (GDW)
Gol	Government of Iraq
HWTS	Household Water Treatment and Safe storage
ICG	International Coordinating Group
ICDDR,B	International Centre for Diarrheal Diseases and Research, Bangladesh
ICRC	International Committee of the Red Cross
ICWCR	Iraqi Centre for Women and Child Rights
IDP	Internally Displaced People
IOM	International Organisation for Migration
JF	Jannet el Ferdows
KRI	Kurdistan Region of Iraq
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MOYS	Ministry of Youth and Sport
NGO	Non-Governmental Organisation
NIDs	National Immunization Days
OCV	Oral Cholera Vaccine
OFDA	Office of U.S. Foreign Disaster Assistance
ORPs	Oral Rehydration Posts
PHC	Public Health Clinics
PIF	Packing, Insurance and Freight
RIRP	Rebuild Iraq Recruitment Programme
SSFAs	Small-scale Funding Agreements
UIMS	The United Iraq Medical Socceity for Relief and Development
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation



### Annex 3



## Annex 4



## Cholera Outbreak Response Activities and Supplies

August - December 2015



### 1 RESPONSE COORDINATION

#### CHOLERA COMMAND AND CONTROL CENTRE (C4) CHOLERA TASK FORCE

13 SEPTEMBER - 06 DECEMBER 2015

C4 Meetings with Ministry of Health: 3 times weekly, Baghdad (36 total)  
Regional Strategy Meeting: 16 - 17 October 2015, Beirut Lebanon  
Lessons Learned Meeting: 17 - 19 November 2015, Amman Jordan  
Ad-Hoc Cluster Meeting for Cholera: 3 times throughout response

### 2 SURGE CAPACITY



12 STAFF MEMBERS



CENTER FOR DISEASE CONTROL



CENTRE FOR ENVIRONMENTAL HEALTH ACTION



ICCD, B



WHO HEADQUARTERS AND EASTERN MEDITERRANEAN  
REGIONAL OFFICE

### 3 VACCINATION CAMPAIGN

#### TARGET POPULATION: 250,000 IDPS AND REFUGEES

##### ROUND ONE

229,216 Individuals in camps and collective centers received 1 of 2 doses  
93% of targeted population reached

##### ROUND TWO

Northern Governorates (Sulaymaniyah, Dahuk, Erbil): 89% reached  
In Remaining Governorates: Pending Data

### 4 SURVEILLANCE AND MANAGEMENT

130 PARTICIPANTS Training for Trainers: Case Detection / Management

325 PARTICIPANTS Paramedics Orientation

325 PARTICIPANTS Doctors Training

14 TEAMS OF 2 Mobile Teams for Revitalization of ORT Centers

6 TEAMS OF 3 Mobile Teams for Data Management and Analysis

13 SUPERVISORS Provincial Supervision through Mobile Teams

65 VISITS Central Supervision from MOH to Governorates

• 26 Cholera Treatment Centres

• 39 Oral Rehydration Therapy

Date of Creation: 10 January 2016

File Name: WHO\_IRO\_CHOLERA\_RESPONSE\_A3\_10012016

Further Information: World Health Organization Iraq Country Office, email: musana@who.int

Data Source: Ministry of Health / WHO

District Boundaries: Health province boundaries do not always match administrative boundaries

Disclaimer: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. All reasonable precautions have been taken by WHO to produce this map. However this map is being distributed without warranty of any kind, either express or implied regarding its content. The responsibility for its interpretation and use lies with the user. In no event shall the World Health Organization be liable for damages arising from its use.

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### DISTRIBUTION OF CHOLERA RESPONSE SUPPLIES



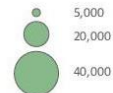
504,350

ORAL CHOLERA  
VACCINES (OCV)

Delivered by Vaccination Teams

OCV Targeted District

Number of Vaccines Provided  
per Distribution Site



10 WATER TESTING KITS  
Provided by WHO to Baghdad  
Ministry of Health (MOH)



4,396,000 AQUATABS  
Managed By Provincial DOHs



450,563 ORAL REHYDRATION SOLUTION (ORS)  
At Primary Health Centers and Government Warehouses

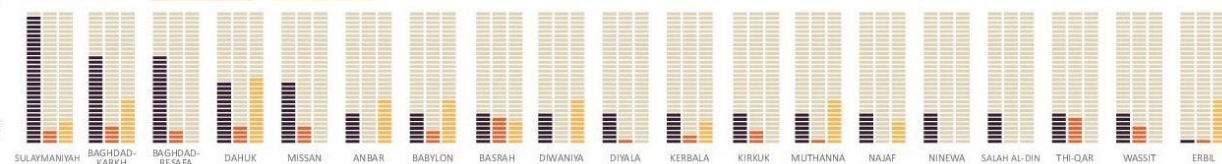


11,000 RAPID DIAGNOSTIC TESTS (RDT)  
Distributed From WHO to Provincial DOHs

100,000 AQUATABS

10,000 ORS

10 RDT



97 INTERAGENCY DIARRHOEAL  
DISEASE KIT (IDDK) MODULES  
Including Stock, Pipeline, and Deliveries from WHO

DAHUK IDDK STOCK	DELIVERED TO DOH DAHUK
Diarrhoeal ORS: 1	Diarrhoeal ORS: 3
Diarrhoeal Support: 1	Diarrhoeal Support: 3
Diarrhoeal Infusion: 1	Diarrhoeal Infusion: 3
Diarrhoeal Basic: 1	Diarrhoeal Basic: 3

ERBIL IDDK STOCK	DELIVERED TO IMC
Diarrhoeal ORS: 11	Diarrhoeal ORS: 1
Diarrhoeal Support: 6	Diarrhoeal Support: 1
Diarrhoeal Infusion: 7	Diarrhoeal Infusion: 0
Diarrhoeal Basic: 11	Diarrhoeal Basic: 0

SULAYMANIYAH IDDK STOCK	DELIVERED TO MOH BAGHDAD
Diarrhoeal ORS: 4	Diarrhoeal ORS: 15
Diarrhoeal Support: 4	Diarrhoeal Support: 15
Diarrhoeal Infusion: 1	Diarrhoeal Infusion: 15
Diarrhoeal Basic: 1	Diarrhoeal Basic: 15

BAGHDAD IDDK STOCK	DELIVERED TO MOH BAGHDAD
Diarrhoeal ORS: 0	Diarrhoeal ORS: 15
Diarrhoeal Support: 1	Diarrhoeal Support: 15
Diarrhoeal Infusion: 0	Diarrhoeal Infusion: 15
Diarrhoeal Basic: 0	Diarrhoeal Basic: 15

#### IDDK PIPELINE

##### VIA DUBAI

Diarrhoeal ORS: 15

Diarrhoeal Support: 15

Diarrhoeal Infusion: 15

Diarrhoeal Basic: 15

##### VIA JORDAN (FROM RUWAIL)

Diarrhoeal ORS: 5

Diarrhoeal Support: 5

Diarrhoeal Infusion: 5

Diarrhoeal Basic: 5



