

<b>DREF Operation MDRIQ015</b>	<b>GLIDE n° <a href="#">OT-2022-000241-IRQ</a></b>
<b>Operation start date: 06 July 2022</b>	<b>Operation end date: 28 February 2023</b>
<b>Host National Society(ies): Iraqi Red Crescent Society (IRCS)</b>	<b>Operation budget: CHF 362,606</b>
<b>Number of people affected: 18,000 (3,000 families)</b>	<b>Number of people assisted: 69,562 people (11,594 families)</b>
<b>Red Cross Red Crescent Movement partners currently actively involved in the operation:</b> The International Federation of Red Cross and Red Crescent Societies (IFRC), The International Committee of the Red Cross (ICRC), in-country Participating National Societies (PNSs).	
<b>Other partner organizations actively involved in the operation:</b> Ministry of Health in Baghdad and Kurdish Region of Iraq (KRI), Directorates of Health at Sulaymaniyah, Al Muthanna, World Health Organization (WHO), Médecins Sans Frontières (MSF), and other humanitarian organizations.	

*The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, German, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.*

## A. SITUATION ANALYSIS

### Description of the disaster

Cholera outbreak is an extremely virulent disease in Iraq these days. In the outbreak of 2022, Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel, Thi Qar, and Al Qadisiyyah have been the most affected governorates. The consistent lack of safe water and limited sanitation facilities due to the protracted crisis. Moreover, Iraq's location along the Tigris and Euphrates, whose contaminated water supply with frequent disease outbreaks increases Iraq's vulnerability to waterborne and infectious diseases. Therefore, cholera outbreak is more possible in other governorates if the contaminated water of the river is not treated well at the water treatment plants. In addition, it is observed that domestic and urban sewage is used by farmers to irrigate ready-to-use vegetables. This presumably increased the scale of the epidemics of acute watery diarrhea, including cholera in the Kurdistan region. Experts say that the irrigation of vegetables with sewage water, an increasingly common practice due to water shortages in both the Euphrates and Tigris rivers, is the reason behind the outbreak. The situation is further exacerbated by the COVID-19 pandemic, along with the already weak state of the overly stretched national health infrastructure. Neglect also plays a key role in the crisis, poorly maintained water and sewage systems, lack of proper sewage disposal, open defecation, and poor sanitation systems put millions at risk of contracting water-



*Orientation of MMU team on Cholera outbreak operation (Photo by: IRCS)*

borne diseases, including Cholera. Since last summer in Iraq, experts have warned that deficiencies in local sewage systems, together with the bad quality of drinking water, could result in an outbreak of water-borne diseases.

Previously, Iraq experienced several cholera outbreaks that usually occurred between September and December. In 2022, a new Cholera outbreak unexpectedly started in the summer months. On 19 June 2022, Iraq's health authorities announced a cholera outbreak after at least 13 cases were confirmed across the country and thousands of hospital admissions for acute diarrhea were reported. Ten of the confirmed cases were in the northern city of Sulaymaniyah and many other cases were confirmed in the southern governorates, Al Muthanna, and the other in Kirkuk, north of Baghdad. There had also been a spike in hospital admissions because of diarrhea in the nearby cities of Erbil and Duhok. The number of diarrhea cases kept increasing well beyond the normal ranges witnessed in previous years. As of 2 November 2022, there was a total of 3,063 confirmed cholera cases and 19 deaths across the country.

#### Division of cholera cases during the cholera outbreak

Province	Confirmed cases	Confirmed deaths
Kirkuk	937	3
Baghdad – Resafa & Karkh	726	6
Erbil	443	3
Sulaymaniya	385	-
Babylon	167	3
Diyala	135	2
Wasit	88	-
Thi Qar	80	1
Najaf	42	-
Kerbala	19	-
Diwaniya	19	2
Al Muthanna	14	-
Salah Al-Din	8	-
<b>Total (as of Nov. 2)</b>	<b>3,063</b>	<b>19</b>

Source: Iraqi MoH and Operational Update, 29 November 2022

Many drivers are contributing to the resurgence of cholera in Iraq, including the protracted crisis, climate change, weak health systems, poor water and sanitation infrastructure, and low awareness among the general public. As of 28 February 2023, the highest number of suspected AWD/cholera cases were reported from Iraq (11,097, CFR 0.23%)<sup>1</sup>. Cholera remains a threat to public health and an indicator of inequity and lack of awareness in communities. During the health cluster meeting held in Sulaymaniyah on 21 June, the Directorate of Health (DOH) highlighted the challenges to the health department and requested support for providing medicine and medical supplies, including intravenous (IV) fluid (ringer lactate), infusion sets, and Infection Prevention and Control (IPC) materials. The DOH also requested logistic support, such as hiring vehicles to facilitate the activities of rapid response teams, water quality monitoring, and disease surveillance teams. Further, the Ministry of Health in both Baghdad and the Kurdistan region requested in-country humanitarian actors' support to deal with this outbreak.

## Summary of current response

### Overview of Operating National Society

IRCS has an auxiliary role to the government in the humanitarian field and is one of the leading humanitarian organizations in the country with eighteen governorate branches, as well as activities that cover the entire nation. IRCS is a major national player in disasters and crisis response and works closely with authorities at national and local levels. IRCS has well-trained and experienced staff and volunteers and different tools and mechanisms in place. IRCS has a long history of providing life-saving assistance to people in need in Iraq. IRCS's presence and local networks across the country are exceptionally well established, which enables IRCS to reach vulnerable

<sup>1</sup> <https://www.emro.who.int/pandemic-epidemic-diseases>

populations who are not served by other humanitarian actors, including those in highly remote and hard-to-reach areas. IRCS has vast expertise with different types of programming through multilateral projects supported by IFRC, as well as through bilateral programs with Red Cross Red Crescent Movement partners and with ICRC. This includes youth development, disaster risk management, community-based health, and first aid, restoring family links, community resilience (including Water, Sanitation, and Hygiene (WASH) and livelihoods, etc.), dissemination of international humanitarian law (IHL), humanitarian values and Red Cross/Red Crescent principles, and rehabilitation for the physically disabled among IDPs. IRCS volunteers play a critical role at all stages of the organization's programs. This includes assessment, identification, and registration of target communities and IDPs.

The Cholera outbreak operation targeted a total of 22,951 individuals, equally divided in Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel, and Al Qadisiyyah governorates. The IRCS aimed at providing basic health services through the deployment of two (2) Mobile Medical Units (MMUs), in Sulaymaniyah and Al Muthanna. Hygiene kits (2,000) have also been distributed to the households most in need. Further, health, hygiene promotion, and Infection, Prevention, and Control (IPC) activities were implemented in Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel, and Al Qadisiyyah governorates.

**IRCS Cholera outbreak response:** IRCS has coordinated regularly with the MOH in Baghdad and KRI, as well as DOH in Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel, and Al Qadisiyyah governorates, since the outbreak of Cholera and the emergence of the diarrhea cases. The National Society's branches were participating in MOH meetings within the governorates. IRCS national headquarters directed its governorate branches to share the information reports of the cholera outbreak and diarrhea cases from respective governorates. IRCS governorate branch mobilized its branch-trained staff and volunteers to organize awareness-raising sessions in the communities and public places and distribute information, education, and communication (IEC) materials with the support of the National Society's headquarters.

### **Overview of Red Cross Red Crescent Movement in Country**

IRCS kept all partners updated on the situation, existing needs, and response plan through coordination meetings. The IFRC country delegation provided technical support through MENA RO to the NS in preparing for and responding to the Cholera outbreak operation. RO provided real-time technical guidance on the operations from the early phase of the response and supported the set-up of the operation. The IRCS Headquarters maintains a regular flow of communication with the IFRC Iraq Country Delegation in Baghdad and with other Movement partners. Coordination and consultation with Movement partners in the country led to the launch of a DREF operation to avoid the duplication of support. The Movement partners present in Iraq include the ICRC and the German, Norwegian, Danish, and Swedish Red Cross Societies.

The National Society had a well-coordinated mechanism with the full involvement of the HQ staff, branch, and community leadership. Coordination meetings were regularly held in the country within the National Society departments and the IFRC delegate and weekly updates on the outbreaks were shared through situation reports. Similarly, coordination meetings were held virtually between technical departments of the National Society and Health and WASH clusters and government authorities. The IFRC Iraq delegation has contacted the leadership and technical departments of the IRCS and the regional office to share information about the Sulaymaniyah and Al Muthanna outbreak impact, emergency plans, and rapid response, as well as to provide technical support for the DREF.

### **Overview of non-RCRC actors in the country**

The Iraqi Government, through the MOH in Baghdad and KRI, coordinates health interventions performed by the other humanitarian agencies. The Ministry of Health is leading the health cluster with the support of the WHO in Iraq. The government and WHO are working together to effectively improve the public health situation in the country, with special emphasis on health security and prevention and control of communicable diseases, non-communicable diseases, mental health, promoting health through the life-course, health systems strengthening and preparedness, surveillance, and response.

The WASH and Health clusters coordination mechanism operates at national and sub-national levels by clarifying the roles and responsibilities of each partner, including Non-Governmental Organizations (NGOs), United Nations (UN) agencies, and government authorities of the Government of Iraq, among other stakeholders. The WASH cluster and sector response in Iraq are primarily targeting ten governorates: Duhok, Erbil, and Sulaymaniyah in the Kurdish Region of Iraq; and Ninewa, Kirkuk, Salah al-Din, Diyala, Anbar, Baghdad, and Basra in the Federal Region of Iraq. WASH partners are working in these areas to meet the needs of IDPs in camp, IDPs out of camp, returnees, and refugees. The response aims to meet the minimum WASH service provision needs of affected populations and look at durable solutions for returnees and out-of-camp IDP populations to facilitate resilience and cluster transition. Cluster meetings occur monthly and are coordinated by the respective cluster lead agencies through cluster coordinators. Meetings are attended by cluster partners, members, and observers and aim to strategize and coordinate humanitarian activities at the cluster or sector level, as well as to share information on challenges and bottlenecks faced at the operational level.

The WHO dispatched an urgent consignment of medicines and medical supplies to Sulaymaniyah governorate Iraq to support the regional MoH in stepping up its response to the sudden cholera outbreak in the Region. The consignment comprised medicines and medical supplies, including infusion sets, antibiotics, and IV fluid (ringer lactate) to cover the needs of a population of approximately 5,000 people.

IRCS ensured its participation in all coordination meetings in clusters, technical working groups, health, and WASH, including in government-led or other humanitarian organization meetings. Other agencies implementing humanitarian activities related to the health response, include UN Agencies and other International NGOs implementing health and water and sanitation activities in the country.

## **Needs analysis and scenario planning**

### **Needs analysis**

In the early stages of the outbreak, the Government through the MOH shared gaps that required attention, and this provided the basis for designing response activities. The Ministry of Health, in collaboration with the WHO, shared information on the cholera response as well as the outbreak situation. The increase in new cases, especially in Kirkuk, Bagdad, Erbil, Al Muthana and Sulaymaniyah, is a reason for concern for WHO and the MOH, as it is coming against the backdrop of the COVID-19 pandemic and other outbreaks that the country is still battling. However, WHO in Iraq has committed to supporting MoH both in Baghdad and in the Kurdistan Region to respond to the outbreak and lower the impact on the population, including on the vulnerable groups of women, children, and low-income communities. The capacity of the national health system became severely overstretched and had difficulties in meeting the health needs of the country. The limited availability of primary healthcare services, the lack of sufficient trained health personnel, the destroyed or inadequate healthcare infrastructure, and shortages of medicines and medical supplies.

The Directorate of Health has also noted that they are facing a shortage of medicine in their response and have requested support from the international community. Mental health has been identified as a priority. The risk of communicable diseases is very high in displacement camps, as well as an increase in acute diarrhea cases in Sulaymaniyah and a few other Iraqi governorates. Cholera is a waterborne bacterial infection that can spread quickly through a population. This is an acute diarrheal infection caused by eating food or drinking water that is contaminated with the bacterium vibrio cholera. Cases of acute watery diarrhea are affecting the households in displaced sites. Acute Watery Diarrhea (AWD) and the Crimean Congo Hemorrhagic Fever (CCHF) are more prevalent than previously reported. Existing health services are unable to cope with the increased demand in the areas of origin and are now out of essential medicines and supplies.

WHO Representative and Head of Mission in Iraq mentioned during the meeting that they are calling upon their funding partners, stakeholders, WASH sector, and health cluster members to enhance collaboration with the local health authorities to ensure a proactive and coordinated approach to the cholera response across Iraq. Daily updates and summaries provided by the MOH in collaboration with WHO in KRI, highlight the extent and trends of the outbreaks. Health cluster coordination meetings in Sulaymaniyah at the regional level have helped to

outline the gaps that require partners' attention for a coordinated response to the outbreak. Among these gaps identified at the last cluster meetings held on 21 June 2022, the key ones include:

- Inadequate access to basic social services in the areas where the outbreak occurred.
- Inadequate funding and logistics/supplies for a rapid response to the outbreak.
- Inadequate community-based surveillance in place for early detection of cases and sharing information to assist investigations and responses.
- Insufficient capacity of staff supporting case management.
- Need to scale up WASH interventions to increase common access to safe water.

Through this DREF operation, the National Society has addressed some of these gaps to effectively respond to the Cholera outbreak. The outbreak, which was initially located in the northern regions of Sulaymaniyah and Kirkuk in south Al Muthanna at the beginning, has spread to other governorates due to the persistent movement of the people across the country. The tourists, who may be carriers or recently recovered, are more likely to shed Cholera into the sewage system and then into the streams and rivers in the tourist areas. Moreover, Sulaymaniyah and Kirkuk governorates usually depend on the Little Zab River as a main source of drinking water in the Dukan and Dubz districts respectively. The contamination of the Little Zab River in Dukan, an attractive touristic district, causes a cholera outbreak in Sulaymaniyah and Kirkuk and then circulates in the neighboring governorates.

The target population is found mostly in areas where no other organization is providing the much-needed support for health services and outbreak response. Other drivers of the epidemic to be considered are contaminated water, lack of access to safe water for daily usage in remote areas that are currently affecting the country, and especially cholera-affecting areas and the perception of some communities not to consume water treated with chlorine (natural denatured taste), the use of traditional treatment, the lack of information on the disease and prevention measures, and the lack of early case detection and management system. The affected areas are also known to be affected by the protracted crisis, COVID-19, food insecurity, and malnutrition, especially at this time of lean period due to the consecutive drought spells in the country. Lastly, many citizens cannot afford the high cost of buying water and instead must rely on untreated water sources, further leading to poor health outcomes.

### **Operation Risk Assessment**

The situation in Iraq is punctuated with episodes of extreme violence, which requires the implementation of stringent security measures for IRCS to operate. Iraq still faces threats of disease outbreaks like cholera especially in endemic areas, these situations have negatively affected the people in the country. The cholera outbreak posed a further risk of crippling the life survival system by depriving and disrupting most livelihood activities if the situation worsened. In addressing these risks, IRCS through social media and awareness-raising programs outlined specific problematic concerns from the public where specific institution representatives were invited to discuss how to mitigate some of the risk vices within the cholera hotspots. This helped in addressing risk behaviors and was further emphasized through door-to-door activities. For more details on the analysis, targeting, scenario planning, and risk analysis refer to the EPOA.

Besides the complex humanitarian situation compounded with AWD and Cholera, there are several risks directly associated with the outbreak, including COVID-19, protracted droughts, and CCHF, affecting the whole country in general, as well as the weak community-based surveillance and health management information systems (HMIS). Potential resurgence and new waves of COVID-19, predictable during these days, could potentially further overstrain the fragile health system. While Iraq continues to steadily recover from years of conflict, thousands of vulnerable families across the country remain displaced and in acute need of protection and assistance for IDPs, returnees, and Syrian refugees who live in Iraq and KRI governorates, Erbil, Duhok, and Sulaymaniyah. Affected families may relocate to other areas, and proper tools and good understanding need to be considered. IRCS is working closely with the government to find the best approach to ensure humanitarian assistance is provided to displaced families. Community perception of water treated with chlorine or Aqua tabs can equally affect the successful implementation of planned interventions under the DREF operation. Generally, the community has some hesitation in drinking water treated with Aqua tabs with the complaint that the natural taste is lost.

Sustained community sensitization in weighing heavily on the derived benefits from chlorinated water would help change the perception of water treated with chlorine or Aqua tabs.

The IRCS continues to apply all necessary measures to ensure the safety and security of staff and volunteers engaged in this operation with a heavy reliance on its strong acceptance within the community. IRCS will continue to monitor the security situation and liaise closely with the security institutions to reduce identified risks in the field. The staff and volunteers involved in the operation may be at risk of contracting other diseases, including COVID-19 and water-borne diseases. Exposure is reduced through strict observation of the COVID-19 national guidelines, where required, to ensure good hygiene practices. The current DREF operation and its operational strategy are aligned with the IFRC global emergency appeal, which supports National Societies to deliver assistance and support to affected communities or the communities at risk of being affected by the COVID-19 pandemic. IRCS has been incorporating hygiene and health promotion activities in this operation in line with the IRCS COVID-19 action plan and hygiene promotion activities, to ensure government measures are complied with.

## B. OPERATIONAL STRATEGY

### Proposed strategy

The overall strategy of this DREF operation was to reduce the immediate risk of the cholera outbreak to the health of the affected population with interventions including improved surveillance for early case detection, timely response, including effective case management to curb the outbreak and contribute to preventing further outbreaks of cholera in target areas. The interventions included:

**Health:** i) deployment of two Mobile Medical Units (MMUs) in Sulaymaniyah and Al Muthanna; ii) awareness-raising sessions at the community level in six target governorates - Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel and Al Qadisiyyah; iii) training of volunteers on Oral Rehydration Therapy (ORT) usage; vi) training community leaders on cholera and its treatments and, ii) creation and dissemination of Information, Education and Communication (IEC) material.

**WASH:** i) conducted awareness sessions on personal hygiene promotion and, ii) distributed hygiene kits to the 2,000 households, iii) trained targeted communities in the use of distributed hygiene kits, and iv) carried out IPC activities with MMUs teams and hotspot areas.

During the operation, continuous needs assessments and analyses were carried out to adapt the response to the most vulnerable people in need of support. Although the cholera outbreak evolved quickly, the team monitored the epidemiological situation to ensure the efficacy of the response. The IRCS collaborated closely with the MoH on different levels to respond to the priorities defined and to strengthen the health system. Following the initial assessments, the implementation strategy was adapted to the epidemiological situation and in line with the request of the Ministry of Health (MoH).

IRCS response is aimed at enhancing the overall well-being of the affected families through a comprehensive **WASH** and **Health** response. IRCS' approach includes awareness, disability support, social cohesion, and protection, gender, and inclusion (PGI), considering them vital components for enhancing the resilience of the target population. IRCS was working closely with other stakeholders to ensure no duplication of work and efforts. IRCS has a trained eCBHFA team, community health workers, and trained volunteers and staff who were the main technical focal points. By providing this support, IRCS aimed to reduce the initial distress caused by traumatic events and to foster short and long - term adaptive functioning and coping strategies.

## C. DETAILED OPERATIONAL PLAN



## Health

People reached: 18,000

Male: 9,108

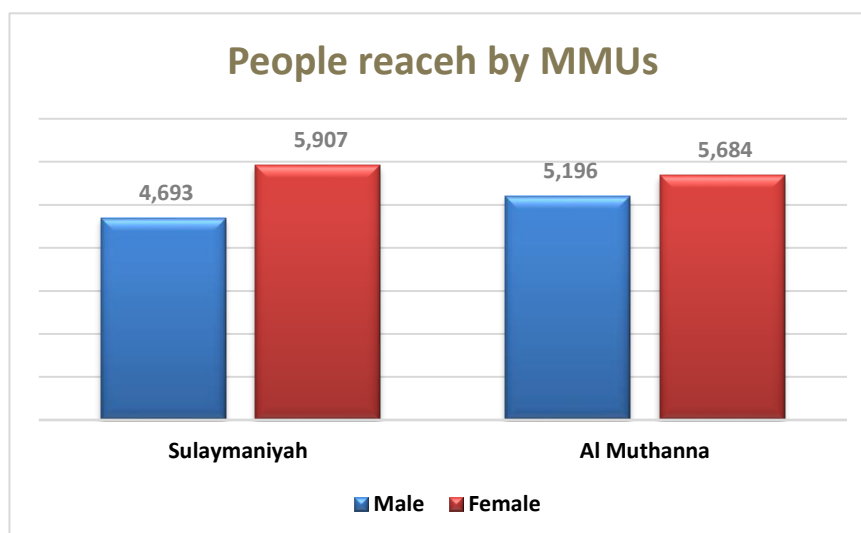
Female: 8,892

Indicators:	Target	Actual
# of people reached by NS with services to reduce relevant health risk factors	18,000	21,480
# of Mobile Medical Units deployed to provide health services support	2	2
# of targeted population reached with awareness-raising activities	18,000	22,951
# of awareness-raising sessions conducted	300	340
% reduction of cholera cases in the affected areas	100%	100%
# of volunteers trained on ORT/ORP	40	40
# of community leaders trained	60	60
# of people supported through the ORPs	50%	50%
# of cases identified through community-based surveillance referred	Yes	Yes
% of the target population that have access to information about the cholera epidemic prevention	100%	100%
# of videos produced for the cholera epidemic	5	5

### Progress towards outcomes

After approval of the DREF operation, an assessment of the situation was carried out by analyzing primary and secondary data. IRCS organized a meeting with the Movement partners, and MoH, and participated in the coordination meetings of Health and WASH Clusters. Based on these meetings, the areas of intervention were further specified in the affected governorates. IRCS deployed two Mobile Medical Units (MMUs), one each in Sulaymaniyah and Al Muthanna, to provide basic health services to those in need. Each mobile unit team consisted of two doctors (one: male and one: female), two nurses, one pharmacist, and one data collector. The main purpose of these clinics was to provide primary healthcare and free medication to populations suffering from health conditions related to the Cholera outbreak in target areas. People displaced within the country were particularly affected by the outbreak, thought to be caused by vegetables irrigated with sewage water due to drought in major rivers.

The targets of the above activities' indicators were exceeded due to the extension of the project and the ability of the volunteers to increase the reach of the covered areas. IRCS was able to cover targets from Erbil and Sulaimaneya and to the south of the country "Dikhar" as well to expand the reach as some citizens were internally displaced to these areas.



A total of **21,480** individuals were reached (male: **9,889** and female: **11,591**) through the Mobile Medical Units (MMUs) during the operation. The number reached exceeds the initial target by 18,000 individuals, mainly due to the high need for medical services in the affected areas.



*Healthcare services provision through Mobile Medical Units (Photo by: IRCS)*

IRCS conducted a two-day training on ORP/ORT training for 40 volunteers (male: 23 and female: 17). An ORP serves as the primary point of care for cholera in communities recognized as hotspots of infection. Six governorates were hotspots, identified among eighteen in the governorates, according to the MoH. DREF operation was initiated in July 2022, responding to the escalating cholera cases claiming over 3,063 confirmed cholera cases and 19 deaths across the country. IRCS has taken the opportunity to initiate the CEA activities to set up a feedback mechanism and rumors collection. Therefore, it was decided to train all volunteers during on CEA and RCCE on top of the information provided on these topics in the ORP/ORT training. As part of the training, the volunteers were taught basic knowledge of the CEA / RCCE module on community mobilization and stigmatization. In these modules, volunteers learned the importance of community mobilization, risk perception, and well-prepared community, different methods for social mobilization, the danger of rumors, management of rumors. A roadmap was then designed for the implementation of CEA within IRCS, which shall continue after the DREF operation.

IEC material was developed according to the Ministry of Health guidelines, including 5 videos, which were distributed through various mediums in the target governorates. The other aspect of information dissemination was through the printing of information education materials containing cholera prevention messages. The IRCS planned to print **13,500** posters, flyers, leaflets, brochures, social media posts posters, etc. The IEC material was printed and posted in designated public areas such as schools, clinics, markets, malls, and public places. It is estimated that 22,000 individuals had access to and read through the poster as evidenced through the door-to-door visits. The volunteers practiced household visits in simulation using the IEC materials.



Information, Education, and Communication Material for Cholera (By: IRCS)

Besides sensitization using public address systems in the communities, the response also incorporated the use of media engagement in target governorates. The topics covered included general hygiene promotion in the prevention of Cholera, the importance of safe water and good sanitation, and the importance of waste management in the prevention of diarrheal diseases.

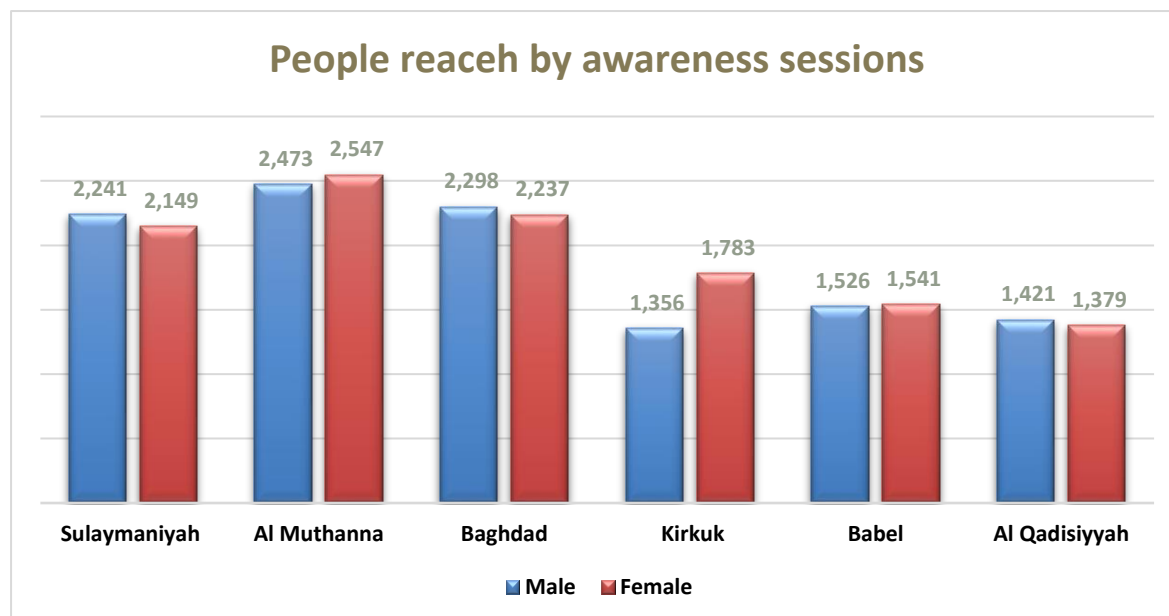
In addition, the community case was defined based on directives of the Ministry of Health and the existing ORP training materials as; any person with an episode of three or more watery stools in a single day, accompanied by dehydration (persistent skinfold test or sunken eyes). This information was shared with all volunteers during the ORP/ORT training so that they could recognize suspected cholera cases in their activities and make referrals. Since its inception, the ORP has logged 257 of suspected cholera incidents, referring these cases to the nearest public health facility in Sulamaniyah and Al Muthana for advanced treatment.



Community awareness raising sessions in target areas (Photo by: IRCS)

The number of community leaders trained surpassed the initial target as both the IRCS, health department, and communities showed great interest in this activity. IRCS conducted one-day training for 60 participants (male: 31 and female: 29) one training at each in six target governorates, primarily for community leaders, health workers, and any relevant person within the community in a defined catchment area who may play a critical role in implementing of operation activities at the community level. Under Risk Communication and Community Engagement (RCCE), activities IRCS engaged traditional leaders to promote community-based disease control and health promotion. Further, communication and engagement with target communities related to case detection and referral systems were established and are well functioning. Community leaders have a significant

impact on accelerating behavior change as they are respected by the community. This training also served to introduce the important concepts and key terms that are used in environmental health and hygiene, the importance and scope of environmental health, and links between hygiene, sanitation, human health, and their role in the management of hygiene and environmental health at the community level. Participants were also trained on disease occurrence and the environmental conditions related to disease which is a basic community right-to-know issue for both community residents and public health professionals.



Monitoring teams continued to assess progress made in achieving expected results, to spot bottlenecks in implementation, and to highlight whether there were any unintended effects from the project. A total of 6 monitoring teams were formed to conduct field visits in the target areas. IRCS trained volunteers with the support of community leaders and further conducted awareness-raising activities with local communities and schools' children, a total of **340** sessions were conducted in Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel, and Al Qadisiyyah to reach out to **22,951** individuals (female: **11,315** and male: **11,636**).

### Challenges

- There were some delays in the deployment of Mobile Medical Units (MMUs), mainly due to the security situation and administrative approvals with the Kurdistan regional authorities for field-level activities in Sulaymaniyah, and the Arba'een activities held in the country in the month of October.
- Further delays in the procurement of hygiene kits and medications were faced, leading IRCS to use materials already available in its contingency stocks. Therefore, a two-month extension has been requested to complete the activities as per the set operational plan.
- Low number of medical cadres within the MMUs where in the south, female doctors were recruited through the HQ.
- Lack of gender balance among volunteers and MMU doctors, affecting the ability to reach/aid females and males equally within the teams. Recruiting female doctors was a challenge in the south and Sulaymaniyah due to security issues in the north.
- Delays from the health laboratory in Kurdistan in sending Cholera diagnoses to the central laboratory in Baghdad, leading to inaccurate nationwide cholera case figures.
- Lengthy organizational processes which led to delays in getting the needed approvals for IRCS to access school grounds (2 to 3 weeks at least).
- Didactic material including videos, posters, and flyers in both Arabic and Kurdish was low in number which was readily available at the beginning of the operation, which caused some delays in awareness-raising activities in communities.

## Lessons Learned

- To ensure the timely completion of the operation activities within the extended timeframe, the IFRC Iraq country delegation has revised the M&E plan with the NS followed daily with the technical teams, and organized weekly meetings. The delegation was also following up with the management to expedite the processes for approvals and avoid any unnecessary delays to achieve the operation targets on time.
- Allocating more financial support and increasing the medical cadres for MMUs in the operations budget.
- Conducting regular meetings and follow-ups with the NS management to ensure a more efficient and swift process.
- Encouraging both men and women to volunteer within affected communities and hiring more female doctors for health care services for operations.
- Allocation of more funding to acquire large-level human resource teams according to the operation needs.
- Preparing posters/flyers beforehand to ensure immediate dissemination of awareness material in Arabic and Kurdish language.



## Water, sanitation, and hygiene

People reached: **18,000**

Male: 9,108

Female: 8,892

Indicators:	Target	Actual
# of the targeted people who have access to clean water, and sanitation	18,000	22,744
% change in knowledge and practice of personal hygiene according to Sphere standards	80%	80%
# of assessment of water, sanitation, and hygiene situations in targeted communities are carried out	10	10
# of hygiene promotion sessions conducted	200	220
# of IPC activities organized with MMU teams	200	200
# of hygiene kits distributed to target communities	2,000	2,000

### Progress towards outcomes

As per the Iraqi Ministry of Health, cholera spread quickly through a population in six governorates, and the major cause lack of clean water supply, sanitation, and hygiene for the spread of waterborne diseases in a community. Since Iraq is considered an extremely water-stressed country, achieving the crucial mandate of water for all will be a challenge. Water scarcity and rising turbidity are increasingly understood to pose vital threats. Compounding this is the fact that there is no existing mechanism in the country to obtain updated information on key WASH needs and gaps in Iraqi communities. Very little data is available on the WASH conditions and on the ability of Water Treatment Plants (WTPs) to function effectively, thus hindering the accuracy of a response that has yet to yield any impactful results against the ongoing water crisis.

Under the Water, Sanitation, and Hygiene (WASH) component, before implementation, IRCS assessed to identify the hygiene situation in the targeted communities, along with water and sanitation quality and needs of the most vulnerable population. Based on the assessment, a WASH activity plan was developed for local communities, aiming to promote good personal and environmental hygiene to protect health and facilitate access to water resources. IRCS engaged its trained volunteers to conduct awareness-raising sessions for delivering key promotional messages about personal hygiene, cholera causes, routes of cholera transmission, and ways of cholera prevention, with the distribution of posters, and brochures delivering important key messages about cholera prevention. A total of **420** (hygiene promotion and IPC) sessions were conducted in six target governorates to reach out to **22,744** individuals (male: **11,981** and female: **10,763**).

Overachieving this target was due to the fact the team was able to extend their coverage area using the allocated budget.



*Awareness-raising sessions for school children in target areas (Photo by: IRCS)*

As school children were also at risk of cholera, the education sector specifically targeted schools that were at risk through the provision of clean water, improved sanitation, and hygiene promotion interventions. The IRCS-trained volunteers implemented Cholera operation activities at the household level and in community-shared spaces such as markets and schools. Teams of 40 volunteers delivered awareness sessions on Cholera with **2,387** school children.

IRCS teams assessed the hospital's readiness to deal with the Cholera outbreak and started providing hospital staff with training sessions on infection prevention and control (IPC) and triage management. These preparations ensured that cholera-infected patients received proper treatment, while still protecting other patients and staff from infection. IRCS volunteers also delivered sessions on hygiene promotion, focusing mainly on the use of latrines, handwashing, and Infection Prevention and Control (IPC) activities with MMU teams and in target governorates.



*Infection Prevention and Control (IPC) training sessions (Photo by: IRCS)*

2,000 hygiene kits were distributed to cholera case-households have previously shown an effect in reducing cholera incidence and were recommended by the MoH for distribution to the affected households. The integration of a hygiene kits intervention to case households was effective in reducing cholera transmission among household contacts and environmental contamination within the household. The distribution of

hygiene kits maintains hygiene levels and a sense of dignity for communities and families. Those who received kits were trained on how to use them, and IRCS continuously monitored the water, sanitation, and hygiene situation in the targeted communities.



*Hygiene kits distribution in the communities (Photo by: IRCS)*

A WASH Knowledge Attitude Practice (KAP) survey was conducted both pre- and post-operation to understand the current Knowledge, attitudes, practices, and behaviors in target governorates, to guide the design and packaging of interventions, and to measure the progress of the operation. The post-KAP survey demonstrated the positive impact of the prevention action and education sessions on the communities. The findings on knowledge levels regarding Cholera revealed that people had already good knowledge of the transmission and prevention of cholera after IRCS activities. NS has strengthened the educational session, covering knowledge on the disease but also prevention and homemade practical sanitation and water potabilization.



*Knowledge Attitude Practice (KAP) survey (Photo: IRCS)*

IRCS maintains coordinates and collaborates with health clusters and other stockholders to monitor, evaluate, and conduct health needs assessments if required, for supporting integrated WASH and Health intervention in target governorates.



*Health and WASH Clusters meeting with the stockholders (Photo: IRCS)*

### Challenges

- Lack of data at the inception of operation, there was no multi-sectoral assessment carried out by the MoH and/or any other humanitarian organizations in the country.
- More frequent visits were requested by the communities, but the team could not cover them.
- Inability to account for remote areas and hotspots due to lack of adequate transportation for staff and volunteers.
- Insufficient funds to cover volunteer and staff transportation to implementation areas.
- Safe water/drinking access is not included in the plan.
- Inability to cover the needs of the whole community with distributions. The limited amount of hygiene kits against the number of affected families led the community to demand more. lag in the procurement process. Beneficiaries were approaching the CFRM. No proper system in place to record the feedback. Branches used to deal with the community case by case. No serious concerns were recorded.
- Ongoing requests from the targeted communities for hygiene kits and other services despite the end of the operation.

### Lessons Learned

- Regular meetings and coordination with the MoH and participation in Clusters level meetings in target governorates.
- Scheduling more awareness-raising sessions.
- Coordinating with certain authorities (health, civil defense, police, and community leaders) for easier accessibility.
- Increasing volunteers' per diem and staff allowances to account for high transportation costs.
- 
- Upscaling the response and increasing the number of hygiene kits.
- Attempting to provide as many services as possible for communities throughout the operation timeframe.

## Strengthen National Society

Indicators:	Target	Actual
# of IRCS branches that are well functioning (for the operation)	6	6
# of insured volunteers	40	40
# of volunteers who know their roles and responsibilities	40	40
# of volunteers properly trained	40	40
<b>Progress towards outcomes</b>		

IRCS has a strong network in the country with all 18 governorate branches, which are well capable of providing support during times of emergency operations. Several staff and volunteers are trained in disaster response, specializing in health, MHPSS, and hygiene promotion. These members are well-trained in life-saving techniques to assist rescue operations in times of need. The IRCS implemented this operation through its six governorate branches, supported by the National Headquarters and national/branch response teams. They were directly supporting the Cholera DREF operation activities through 40 insured volunteers. Furthermore, implementation is supported by both IRCS HQ and IFRC delegation in Iraq and MENA technical teams.

## International Disaster Response

Indicators:	Target	Actual
<i>Effective and coordinated international disaster response ensured</i>	Yes	Yes
<i># of surge deployments in support of the operation</i>	1	1
<i>% of feedback received and acted on</i>	50%	50%

### Progress towards outcomes

IFRC delegation in Iraq was providing constant support to IRCS with the support of the MENA Regional Health, Disasters, Climate, and Crises (HDCC) team and in regular coordination with the National Society. In addition, PMER support from the MENA Regional Office was also deployed.

Regular meetings took place with the National Society to discuss progress and challenges faced by the operation. Appropriate mitigation actions are being identified and carried out to address challenges.

Due to the high transparency of the IRCS, people were greatly encouraged to reach out to the branches to express their thoughts and ideas and provide suggestions. IRCS members were there to listen and tackle any issue on the spot. This was also reflected in the PDM exercise done for the hygiene kits where respondents stated that they were aware of the CFRM mechanism in place and that they would report any incident through the branches.

## Influence others as a leading strategic partner

Indicators:	Target	Actual
<i>IFRC and NS are visible, trusted, and effective advocates of humanitarian issues</i>	Yes	Yes
<i># of lessons learned workshop conducted</i>	1	1

### Progress towards outcomes

IRCS has earned the acceptance of local communities, as it is present in all governorates and is assisting vulnerable people.

#### Communications materials produced (social media)

IRCS posts regular updates on social media, including Facebook and Twitter. Furthermore, the IRCS website is regularly updated to share updates on the operation.

#### Post-Distribution Monitoring (PDM)

Post-distribution monitoring is set to take place under the WASH component once all hygiene kits are distributed. The surveys were filled with 30% of the population targeted with hygiene kits distribution. Respondents stated that they were satisfied with the provided kits, that it was relevant to their needs, and that they found the items useful.

#### Disaster Response Emergency Fund (DREF) training for IRCS

Two-day DREF training was conducted for IRCS staff to understand the mechanism of the DREF and financing the operations of the IFRC. Explained the overall objective and concept of an emergency fund for disaster response, roles and responsibilities of the NS, and criteria for the launching of DREF operation. Proactive action, including preparedness, early action early response preparedness, and operational updates through

the GO platform appropriately. NS has been trained on procedures and processes related to procurement within the operations of the IFRC.

**Lesson Learned Workshop (LLW)**

A lessons-learned workshop was organized at the end of the operation. During the workshop, Cholera response approaches were presented and IRCS response was assessed, with key learnings captured for future actions. IRCS staff from the HQ and its governorate branches took part in the lessons learned workshop.

## D. Financial Report

**CHF 362,606** has been allocated for IRCS to respond to the immediate needs of 69,562 people (11,594 families) in Sulaymaniyah, Al Muthanna, Baghdad, Kirkuk, Babel, and Al Qadisiyyah. ***The final financial report is found below.***

### DREF Operation

Selected Parameters			
Reporting Timeframe	2022/7-2023/10	Operation	MDRIQ015
Budget Timeframe	*	Budget	APPROVED

#### FINAL FINANCIAL REPORT

Prepared on 27/Nov/2023

All figures are in Swiss Francs (CHF)

#### MDRIQ015 - Iraq - Cholera Outbreak

Operating Timeframe: 06 Jul 2022 to 28 Feb 2023

#### I. Summary

Opening Balance	0
<b>Funds &amp; Other Income</b>	<b>362,606</b>
DREF Response Pillar	362,606
<b>Expenditure</b>	<b>-362,548</b>
Closing Balance	58

#### II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			0
PO02 - Livelihoods			0
PO03 - Multi-purpose Cash			0
PO04 - Health	163,474	300,157	-136,684
PO05 - Water, Sanitation & Hygiene	95,156	11,004	84,153
PO06 - Protection, Gender and Inclusion			0
PO07 - Education			0
PO08 - Migration			0
PO09 - Risk Reduction, Climate Adaptation and Recovery	9,353		9,353
PO10 - Community Engagement and Accountability			0
PO11 - Environmental Sustainability			0
<b>Planned Operations Total</b>	<b>267,983</b>	<b>311,161</b>	<b>-43,178</b>
EA01 - Coordination and Partnerships	3,253		3,253
EA02 - Secretariat Services	25,716	22,880	2,836
EA03 - National Society Strengthening	65,654	28,507	37,146
<b>Enabling Approaches Total</b>	<b>94,623</b>	<b>51,387</b>	<b>43,236</b>
<b>Grand Total</b>	<b>362,606</b>	<b>362,548</b>	<b>58</b>

# DREF Operation

## FINAL FINANCIAL REPORT

### MDRIQ015 - Iraq - Cholera Outbreak

Operating Timeframe: 06 Jul 2022 to 28 Feb 2023

Selected Parameters			
Reporting Timeframe	2022/7-2023/10	Operation	MDRIQ015
Budget Timeframe	*	Budget	APPROVED

Prepared on 27/Nov/2023

All figures are in Swiss Francs (CHF)

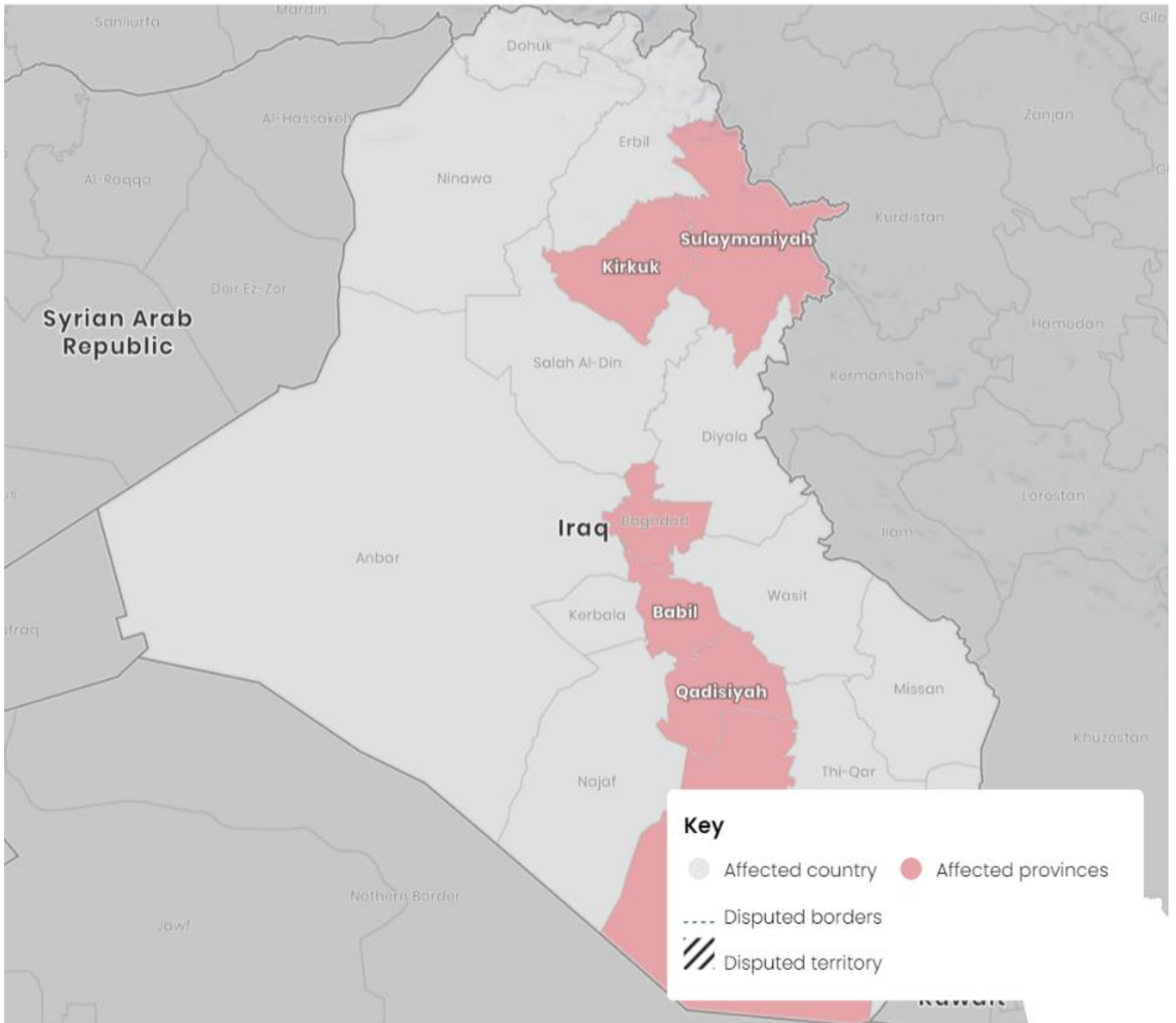
### III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
<b>Relief items, Construction, Supplies</b>	<b>152,733</b>	<b>6,303</b>	<b>146,430</b>
Water, Sanitation & Hygiene	57,275		57,275
Medical & First Aid	95,458	6,303	89,155
<b>Logistics, Transport &amp; Storage</b>		<b>116</b>	<b>-116</b>
Transport & Vehicles Costs		116	-116
<b>Personnel</b>	<b>65,656</b>	<b>30,347</b>	<b>35,309</b>
International Staff	4,296		4,296
National Staff	4,009	10,358	-6,348
National Society Staff		7,966	-7,966
Volunteers	57,351	12,023	45,328
<b>Workshops &amp; Training</b>	<b>58,420</b>	<b>226,292</b>	<b>-167,872</b>
Workshops & Training	58,420	226,292	-167,872
<b>General Expenditure</b>	<b>63,666</b>	<b>77,363</b>	<b>-13,697</b>
Travel	9,601	4,782	4,819
Information & Public Relations	33,410	46,136	-12,726
Office Costs		1,284	-1,284
Communications	3,055	74	2,981
Financial Charges		1,199	-1,199
Other General Expenses	17,601	17,601	0
Shared Office and Services Costs		6,288	-6,288
<b>Indirect Costs</b>	<b>22,131</b>	<b>22,127</b>	<b>4</b>
Programme & Services Support Recover	22,131	22,127	4
<b>Grand Total</b>	<b>362,606</b>	<b>362,548</b>	<b>58</b>



# IRQ: Other - 2022-06 - The response of the Iraqi Red Crescent Society to the outbreak of cholera

June 30, 2022



The maps used do not imply the expression of any opinion on the part of the International Federation of Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities, Data sources: IFRC, OSM contributors, Map box.

## Contact Information

### Reference documents



Click [here](#) for:

- Previous Appeals and updates
- Emergency Plan of Action (EPoA)

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## How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere)** in delivering assistance to the most vulnerable. The IFRC's vision is to inspire, **encourage, facilitate, and promote at all times all forms of humanitarian activities** by National Societies, to prevent and alleviate **human suffering**, thereby contributing to the maintenance and promotion of human dignity and peace in the world.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:



**Save lives,**  
protect livelihoods,  
and strengthen recovery  
from disaster and crises.



Enable **healthy**  
and **safe** living.



Promote social inclusion  
and a culture of  
**non-violence** and **peace**.