HEALTH CLUSTER IRAQ

ANNUAL REPORT

2017

Bartella Field Hospital in the frontlines of Mosul
Photo© Samaritan Purse

Health Cluster - Iraq

The humanitarian crisis in Iraq remains one of the largest and most volatile in the world. The pace of displacement over the past three years is almost without precedent. In 2014, over 2.5 million civilians were displaced in Iraq; an additional 1 million were forced to flee their homes in 2015 while in 2016, nearly 700,000 people were displaced in areas impacted by the Iraq crisis. As the Mosul crisis reached its peak in 2017, more than 3 million people were displaced.

During 2017, the Iraq Health Cluster consisted of 40 partners (24 International nongoverment organizations (NGOs), 12 local NGOs and 4 United Nations (UN) agencies).

There were four working groups under the Health Cluster: reproductive health; nutrition; mental health and psychosocial services (MHPSS) and trauma.

The Cluster requested US$ 110 million and was fully funded against the Humanitarian Response Plan (HRP) 2017.

6.2 million people affected by the conflict were reached during 2017, primarily through life-saving interventions, including trauma management, emergency primary healthcare services and sustaining a steady supply of essential medicines and supplies.

Health Cluster partners attend a cluster meeting in Erbil Photo © Health cluster

More than
2.5
million civillians displaced in 2014

Nearly
7 0 0 0 0 0
people newly displaced in 2016

6.2
million people reached in 2017

US$ **110**
million requested for the HRP in 2017

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1. Leadership

The Health Cluster was instrumental in advocating for the health needs of the conflict-affected population in Iraq on international, national and sub-national levels, with the relevant stakeholders including donors (United States Agency for International Development/US Foreign Disaster Assistance, European Civil Protection and Humanitarian Aid Operations, Department for International Development, Government of Kuwait, Government of Japan and Humanitarian Pooled Fund (HPF), government stakeholders (Ministry of Health (MoH) and the Departments of Health (DoH) of the different governorates), other humanitarian clusters (mainly Protection, Camp Coordination and Camp Management (CCCM), Water Sanitation and Hygiene (WASH), Food Security and Logistics clusters), Inter-Cluster Coordination Mechanism, Civil-Military Coordination Unit, 31 United Nations and International NGO partners and 9 local NGO partners.

Within the cluster, there were four working groups: trauma, reproductive health, nutrition and mental health & psychosocial support services. These working groups are supported by the Health Cluster in terms of information management and mapping, coordination and facilitation of meetings,addressing gaps and issues and advocacy.

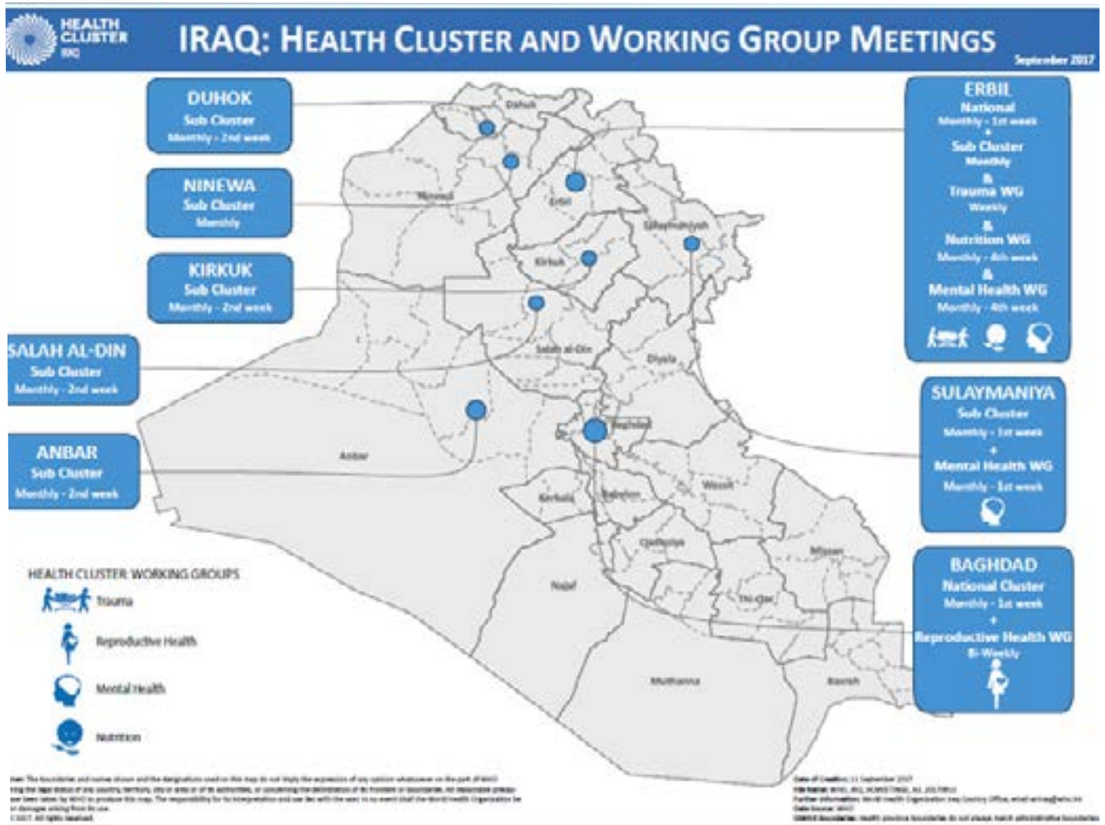
The Health Cluster activated the Strategic Advisory Group (SAG) in April 2017, whose function was to decide on priorities and actively shape the Health Cluster's orientation, keeping in line with the Humanitarian Response Plan. The SAG consisted of up to 10 representatives that reflected the major partner groups and priority areas of operation of the Cluster, i.e., United Nations agencies, international and national NGOs, agencies specialized in providing trauma and/or primary health care services, agencies specialized in providing reproductive health services, agencies specialized in providing MHPSS services, agencies addressing the needs of internally displaced people (IDPs), agencies supporting healthcare services or refugees and those serving migrants.

The SAG was instrumental in the strategic and technical reviews of the projects submitted under the Humanitarian Pooled Fund (HPF) that had three allocations during 2017 (First Standard, Reserve and Hawija). This is in addition to supporting the development of the health component of the HRP 2018, including both the Humanitarian Needs Overview (HNO) and the Response Plan.

Communicable disease investigation at Hasansham camp in Erbil
Photo©WHO

2. Coordination and partnership

The Health Cluster Coordination team consists of an international Health Cluster Coordinator (WHO), a Co-Coordinator (IMC), a national officer (WHO), an information management officer (WHO) and a sub-national Cluster Coordinator (Medair). The Health Cluster convened one national (Baghdad) and seven sub-national (Erbil, Dohuk, Sulaymaniyah, Ninewah, Kirkuk, Anbar and Salah al-Din) cluster meetings monthly during 2017. At the height of the Mosul crisis, the meetings in Erbil, being the nearest hub to the operation, were conducted twice a month. Overall, during the year, 75 meetings were conducted. WHO has assigned each of the sub-national hubs with a dedicated Area Coordinator who conducted meetings and coordinated with the DoH on the operational side of the health interventions. In addition, the four working groups held their own meetings at national and sub-national levels, providing feedback to the Health Cluster on the action points, achievements and any challenges they may have come across which needed guidance and assistance.



2.1 Reproductive Health Working Group

The Reproductive health working group, which was established in 2016 and led by United Nations Population Fund (UNFPA), was able to secure reproductive health services during the different phases of the Iraq crises in 2017, providing services to more than 650 000 women in reproductive age. Most effectively, during the Mosul crisis UNFPA established two field maternity hospitals in the outskirts of Mosul, attached to the WHO field hospitals, in addition to facilitating the revitalization and running of two maternity hospitals in east and west Mosul. Overall, more than 70 reproductive health services were established and running during the Mosul crisis, including nine mobile delivery units and six mobile reproductive health clinics, with more than 25 service-delivery points inside Mosul city.

These services served populations both in and out of camps, as well as those coming across screening and transit sites. The working group worked to ensure that intact referral pathways existed between the reproductive health clinics and both basic emergency obstetric and neonatal (BEmONC) facilities providing normal deliveries and comprehensive emergency obstetric and neonatal (CEmONC) facilities providing caesarian sections.

UNFPA provided 13 ambulances to ensure the effectiveness of the referral pathways, most of which served in west Mosul.

Reproductive health services were also rapidly deployed and provided across the referral pathways established in Hawija (Kirkuk), Telafar (Ninewa) and west Anbar. Services continued to be provided to the IDP camps and the most vulnerable populations in urban areas.

The working group was able to support the Ministry of Health's endorsement of the Clinical Management of Rape (CMR) MoH website subsequently. The link to this document is as follows: *http://www.phd.iq/News_Details.php?ID=1495.*

UNFPA also provided training on the Minimum Initial Service Package (MISP) in reproductive health to different health actors, training more than 150 providers in 2017, as well as trainings on clinical managment of rape. Additionally, UNFPA provided emergency reproductive health kits to the different RH working group partners. The working group also endorsed the guidelines to work towards the harmonization of services among different actors.

A medical personnel attends to a new born baby in one of the UNFPA supported health facilities Photo©UNFPA

More than

650 000 women provided with RH services

70 RH services established

9 Mobile delivery units procured

6 RH clinics set up

26 service points established

13 ambulances for RH procured

2.2 Nutrition Working Group

The Nutrition working group was reactivated in March 2017 as part of the Health Cluster and led by UNICEF. Some of the accomplishments:

- supported the Ministry of Health to move forward in preventing the blanket distribution of infant formula as part of promoting, supporting and protecting breast-feeding.
- 352 699 children under five were provided nutrition services; 23373 children with moderate acute malnutrition cases and 3381 children with severe acute malnutrition were identified and treated;
- 71 137 women/caregivers of children aged 0-23 months received Infant and Young Child Feeding (IYCF) counseling. In addition, more than 500 health professionals were trained on community management of malnutrition and IYCF counseling;
- 207 522 children aged 9-59 months were reached with vitamin A supplementation;
- ensured the use of universal treatment protocols on severe acute malnutrition, moderate acute malnutrition and IYCF for children under 6 months;
- ensured the inclusion of high energy biscuits with the Rapid Response Mechanism (RRM) kits for newly displaced people in the retaken areas;
- supported partners and the DOH in screening children for early case identification, referral of identified moderate acute malnutrition and severe acute malnutritioncases to primary health care centers and/or nutrition rehabilitation units for treatment, micronutrients supplementation for children under five;
- pregnant and lactating women were supported to practice IYCF feeding in safe havens through counselling and confidence building for breastfeeding.

A Health Cluster partner takes a growth monitoring measurement of a displaced child Photo©UNICEF

207 522 children received Vitamin A supplementation

352 699 provided with nutrition services

71 137 provided with IYCF counseling

2.3 Mental Health and Psychosocial Social Support Services Working Group

The MHPSS working group was established at a sub-national level in Ninewa and Erbil in 2016. During 2017, the group reported on the following in terms of achievements:

- The group managed to identify key issues pertaining to mental health and psychosocial support services in Erbil such as the management of emergency cases, the need to work with children affiliated with the armed groups among other issues.
- Conducted and updated the service mapping.
- Established formal linkages with other coordination bodies such as the clusters and sub-clusters.
- Conducted a series of trainings on mental health GAP, psycological first aid among other trainings

There were also some challenges, including:

- economic situation affecting staff retention
- funding remained a priorities for organizations and donors
- commitment of training participants and PHCC staff to retain skills at community-based level
- weak or absent support and supervision after trainings
- commitment of authorities to address mental health issues; only one person in was Erbil working part-time

Mental health and psycosocial services outreach worker visiting Jedaa camp: Photo©International Medical Corps.

2991
Mental Health Consultations provided

4138
Psychosocial consultations provided

148
Physicians recieved Mental Health GAP

2.4 Trauma Working Group

As the military operations to retake Mosul were ongoing, WHO worked with national health authorities to ensure that people with war-related trauma injuries had access to life-saving medical care. For this purpose, the trauma working group was established in October 2016 to coordinate the activities of the partner agencies who were providing front-line trauma care.

The following are some achievements of the working group:

- Overall, 8 trauma stabilization points (TSPs) were established.
- Trauma referral pathways were drawn up and updated based on the changing situation.
- A total of five field hospitals were established one each in Bartella and Athba and three in Hammam Al Alil.
- 96 ambulances were deployed to refer the stabilized patients to secondary care.
- A total of about 25 000 individuals received trauma care through the above mechanisms
- 206 patients with toxic chemical exposure were also treated.

Subsequent to the conclusion of the military operations in Mosul, Hawija and west Anbar, the working group shifted focus of the field hospitals to the delivery of comprehensive secondary health care services, relocating and handing off he hospitals to the government as soon as they had the capacity to run them.

An injured child recieves emergency trauma care at trauma stabilization point near the frontlines of Mosul Photo ©CADUS

8
TSPs established

5
FHs established

96
Ambulances deployed

25 000
Trauma patients treated in FHs

206
patients exposed to toxic substances treated

2.5 Inter Cluster Coordination Mechanism

The cholera taskforce was jointly reactivated by the Health, Water Hygiene and Sanitation (WASH) and Camp Coordination and Camp Managment (CCCM) clusters to facilitate the surveillance of acute watery diarrhea (AWD) cases as well as to have a coordinated response to any confirmed cholera cases during summer of every year.

In addition, the Health Cluster played an active role in the Inter-Cluster Coordination Group (ICCG), participating in all the national and sub-national ICCG meetings. This participation helped to facilitate the prioritization of the overall needs and mobilization of available resources by providing information regarding health needs. The Cluster also coordinated with other clusters, mainly Protection, CCCM, WASH, Food Security and Logistics and the Civil-Military Coordination Unit. This was not only during the response to the front-line conflict situation but also in addressing the needs of the IDPs in camps and out of camp locations.

The Cluster was able to ensure adequate service provision supported by health partners in the different IDP camps and non-camp locations in the affected governorates while coordinating to avoid duplication of service-provision. During the course of the year, the Cluster facilitated the deployment of partners with proven capacity to emergency locations to support service-delivery as per need.

HEALTH CLUSTER PARTNERS	
CATEGORIES	**PARTNERS**
National	AMF, AMAR, CDO, DAMA, DARY, HEEVIE, HTN, IHAO,KFD, TAJDED, UIMS, ZHIAN
International	ACF, ADRA, ASB, CORDAID, DAI, EMERGENCY, HI, Human Appeal, IMC, INTERSOS, IRW, MALTESER, MDM-France, MEDAIR, Nuture Project, PUI, PWJ, QRC, RI, SP, Step-In, UPP, WAHA, WVI
UN Agencies	IOM, UNFPA, UNICEF, WHO

A displaced person recieving primary health care service in WHO supported clinic that is run by Heevi in Dohuk Governorate Photo © WHO/P Ajello

Medecins Du Monde pharmacists dispensing medicines to IDPs Photo © MDM

3. Planning and strategy development

The Health Cluster developed and disseminated the following guidance documents to health partners, OCHA and Camp Management:

- Standard Operating Procedures (SOPs) for trauma and non-trauma emergency referrals
- Harmonized health workers incentives scale of 2015, was re-endorsed in August 2016 in coordination with the MOH and DoH. The incentive scale will be reviewed again by end of 2018.
- Fve Keys to Safe Food Handling
- information, education and communication (IEC) material on prevention and treatment of snake and scorpion bites, in coordination with CWC-IOM
- IEC material on prevention and management of scabies, in coordination with CWC-IOM
- Cost per beneficiary breakdown for areas of intervention under Primary and Secondary Health Care
- Minimum health services to be provided in IDP camps

The cluster actively participated in developing the Mosul Flash Appeal, which was launched in July 2016, in response to the then imminent military operation in Ninewah to reclaim both East and West Mosul. This document was the basis for developing the Humanitarian Response Plan (HRP) 2017.

The health cluster had requested USD 109.6 million under the HRP 2017 and, by the end of the year, was fully funded.In order to develop the health section of the HNO and HRP 2018, the cluster used a participatory approach, incorporating feedback from the SAG members. In addition, the cluster conducted a workshop for all partners on 14th November, in which the objectives, activities and indicators to be included, monitored and reported against for 2018 were discussed and finalized.

Health cluster partners discussing the indicators for HRP 2018 in Erbil photo © WHO/P.Ajello

4. Health Emergency Response

The year 2017 witnessed several military operations in Iraq, including the Mosul crisis, the Anbar campaign, the Hawija crisis and the Telafer operations. It has been estimated that over 1.7 million individuals were newly displaced in 2017, bringing the overall total of displaced population to above 6 million from 2014. However, while hundreds of thousands of people were fleeing their homes, several were returning to newly-retaken areas.

Under the HRP 2017, the Cluster had targeted 6.2 million people residing in 88 IDP camps and among the host community, nearly all of whom were reached through mobile and static Primary Health Care units. More than 25,000 severely injured people were served by front-line trauma services; 2.9 million medical consultations were provided at mustering/screening sites and IDP camps alone, not to mention the other 3.7 million consultations that were provided to displaced people in informal settlements and among host communities; 6,000 emergency deliveries were conducted; 99% of the children targeted were vaccinated, which is close to 3.1 million doses of vaccine in Ninewah, Anbar and Kirkuk alone.

During the operation, an overall of 64 Mobile Medical Clinics (MMCs) were deployed which provided more than 750 thousand consultations. A single partner deployed 96 ambulances to refer emergency complicated cases to higher-level services, while another was instrumental in referring cold cases.

Despite the main focus of the emergency response being on life-saving services, state-of-the-art knowledge was transferred from international health actors to local partners; an example would be the Field Hospitals. In addition, 29 partially damaged health facilities were reactivated in Ninewah governorate. In addition, the UNDP Funding Facilities for Stabilization (FFS) Program is targeting a number of hospitals and major Primary Health Care Centers (see Annex) that were affected during the conflict to conduct rehabilitation of the infrastructure and provide equipment.

Meanwhile, the cluster also monitored the interventions of the partners through participating in Multi-sectoral Initial Rapid Assessments (MIRA), conducting regular field monitoring missions and working in coordination with Protection/CCCM clusters and the Civil-Military Coordination Unit who monitored the interventions in camps and on the front-lines respectively.

The ambulances donated by WHO were monitored by the trauma working group lead a daily basis through DOH focal points in order to know where they were as well as to shift them upon short notice to locations with a sudden need, e.g., if IDPs were being moved to a mustering/screening point along a particular route.

A phramcist dispenses medicine to displaced patients in static primary heath care centre in Ninewa Governorate Photo © WHO

A food-borne illness incident occurred in Hasansham U2 camp on the 12th of June; health Cluster partners responded swiftly in coordination with DOH Ninewah and Erbil. Partners provided immediate life-saving response to manage patients with severe vomiting and through referral to their PHCC in Hasansham U3 camp). Of the 825 reported cases, 638 were referred to various health facilities, 386 cases having been admitted to hospitals within Erbil.

5. Achievements

A staff of Handicap Internation assessing a patient's limb for a possible prosthetic fitting Photo © Handicap International

The Cluster conducted the Health Resource Availability Mapping System (HeRAMS) in Ninewa governorate in order to assess the available health services and gaps so that adequate health services were made available as families began eturning back to their homes in East and West Mosul.

In addition, the Monitoring of Events Against Safe Use and Running of Health Services (MEASURES) assessment tool, which was developed by WHO as a smartphone application, came into use in Iraq for the purpose of collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with all relevant stakeholders, while avoiding duplicated efforts.

Throughout the year, the Health Cluster Information Management Unit had produced several maps and info-graphics, based on partners' reporting. The following were the products prepared and disseminated by the Cluster, in addition to having been put in the public domain

- Health Cluster Emergency Response – monthly and for the entire year (Jan to Dec 2017) *https://www.humanitarianresponse.info/en/operations/iraq/infographic/iraq-health-cluster-emergency-response-jan-dec-2017*

- Nutrition Working Group – 4Ws *https://www.humanitarianresponse.info/en/operations/iraq/infographic/nutrition-partners-coverage-4w-who-what-where-and-when-june-2017*

- 4Ws (Who is doing What, Where and When) maps of health partners per governorate *https://www.humanitarianresponse.info/en/operations/iraq/infographic/irq3wpartnersperhealth-facility-servicesjanuary-2018*

- Scheduled Health Delivery Point Closure *https://www.humanitarianresponse.info/en/operations/iraq/infographic/iraq-scheduled-health-delivery-point-closures-july-sep-2017.*

- Health Cluster and Working Group meeting schedule *https://www.humanitarianresponse.info/en/operations/iraq/infographic/iraq-health-cluster-and-working-group-meetings.*

Achievements - contd.

A vaccine monitor checks the quality of polio vaccines during an immunization campaign in an IDP camp Photo © WHO

- Health Cluster and working group meeting schedule
https://www.humanitarianresponse.info/en/operations/iraq/infographic/iraq-health-cluster-and-working-group-meetings

- Scheduled health delivery point closure
https://www.humanitarianresponse.info/en/operations/iraq/infographic/iraq-scheduled-health-delivery-point-closures-july-sep-2017

- Health service availability in west Mosul
https://www.humanitarianresponse.info/en/operations/iraq/infographic/health-service-availability-west-mosul-neighborhoods-25-july-2017

- Mobile medical services distribution
https://www.humanitarianresponse.info/en/operations/iraq/infographic/iraq-mobile-medical-services-mobile-medical-clinic-distribution

- Daily Activity Report for Mosul
https://www.humanitarianresponse.info/en/operations/iraq/infographic/daily-activty-report-mosul-17-october-2016-4-september-2017

The Cluster Coordination Performance Monitoring (CCPM) assessment was rolled out in December, 2017. The number of participants in the survey were 52, including representatives of the MInistry of Health, 6 DoHs, 4 United Nations agencies, 6 national and 27 international NGOs, 3 donors and 5 observers.

The aim of the survey was to monitor the coordination performance at the national and sub-national level to ensure that the cluster is efficient and effective in coordination mechanisms, fulfilling the core cluster functions, meeting the needs of constituent health partners and supporting health service delivery to affected people. The survey aimed to assess the performance of the Cluster in achieving its six core functions, as determined by Inter Agency Standing Committee (IASC); which are: supporting service delivery; informing strategic decision-making of the Humanitarian Coordinator /Humanitarian Country Team for the humanitarian response; Planning and strategy development; Advocacy; Monitoring and reporting the implementation of the cluster strategy and results and Preparedness for recurrent disasters whenever feasible and relevant.

6. Challenges

The Health Cluster had some constraints in achieving some of its objectives during 2017. The following is a brief of the issues faced and areas where improvement is required:

- Delays in the pipeline of medicines into the country. WHO, as the provider of last resort, supported the operation by sustaining a steady flow of essential, life-saving medicines and supplies for health authorities and partners.

- Mental health needs were not addressed as they should have been, mainly due to inadequate technical expertise on ground, competing priorities (trauma and life-saving primary care versus MHPSS, the latter often being a subtle problem and not always obvious), etc. This is not to say that the survival centres and integration of psychological frst aid in school programmes were not conducted. However, more needs to be done in this area, with particular focus on the clinical side of mental health services.

- Access was the main issue for cluster partners, mainly in terms of displaced people being too near the frontlines, partners not reaching those that were kept in “transition sites, etc.

As soon as partners were able to access people, services were provided. This had some issues with the quality of care such as increased number of patients being seen by a limited number of health personnel through mobile services, resulting in limited patient satisfaction; issues with proper referral of complicated cases due to inaccessibility/unavailability of secondary health facilities, etc. Despite the repeated monitoring assessments conducted by the cluster, limited capacity of some partners with accessibility to some conflict-affected areas resulted in inadequate standards of service provision.

- Iraq is endemic for cholera. In 2017, sporadic cases were recorded but were managed through close coordination between the Health, Water, Sanitation and Hygiene cluster and Ministry of Health. In camps however, under suitable contions, there should not have been any cases, but these were still recorded due to some under causative factors that have since been dealt with through the national cholera taskforce. Furthermore a cholera lessons learnt workshop was conducted to focus on the preparedness and response activities for cholera for the next year.

In the picture: Ibn-sina hospital which was completly damaged during the Mosul crisis. Six major hospitals were damaged or destroyed and remain closed Photo © WHO/P.Ajello

7. Way forward 2018

During 2018, the Health Cluster will remain as the coordinating mechanism for interventions or technical guidance and work closely with the Ministry of Health to ensure that there will be no parallel coordinating mechanisms.

The focus will be on continuation of care, transition/handover of services to the government and transfer of knowledge from international/local partners to the Department of Health.

This is in line with the Health Cluster objectives in the HRP 2018 which are as follows:

- Providing access to quality essential healthcare services, including psychosocial support to highly vulnerable persons, according to need

- Ensuring access to critical lifesaving healthcare services and specialized services to newly displaced and currently accessible families by engaging with local authorities and humanitarian partners

- Promoting and strengthening the healthcare services in crisis affected areas by facilitating transition and recovery.

In this regard, the Cluster has been able to streamline:

the activities and indicators under the Response Plan; where there were 79 health service output indicators under HRP 2017, there are now 54, i.e. 25% reduction in the number of indicators. This is envisaged to facilitate appropriate monitoring of partners' projects.

The Health Cluster aims to provide short-term support to health facilities in newly-retaken areas in coordination with the UNDP Stabilization Program, which will focus on revitalization through equipping and enabling initial operations/service delivery in areas with gaps.

In addition, the health cluster is aiming to enhance the quality of health services provided by partners. In this regard, the cluster is developing a Quality of Care (QoC) assessment tool which will be used to assess services provided by partners in all the IDP camps.

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8. Health cluster partners and donors

Throughout 2017, Health Cluster partners swiftly responded to the largest humanitarian crisis in the world because of the generous contributions of our donors and partners, without whom, the response to the healthcare needs of the Iraqi people would not have been met. Thank you and we look forward to your continued generosity to the people of this country.