UNITED NATIONS POPULATION FUND - IRAQ
صندوق الأمم المتحدة للسكان - العراق

Responding to the humanitarian crisis in Mosul (October2016-December 2017)

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The United Nations Population Fund (UNFPA) in Iraq thanks the donors for their trust and for supporting the humanitarian intervention benifitting thousands of women and girls in Mosul and the adjascent areas.

Foreword

The United Nations Population Fund (UNFPA) has been working with a focus on improving sexual and reproductive health service capacity, promoting gender equality, and supporting women's empowerment in Iraq since 2011. When the Islamic State in Iraq and the Levant took over the country's second largest city, Mosul in mid-2014, most maternity wards and hospitals were closed, while the ones that remained open were not easily accessible which put the lives of approximately 60,000 pregnant women at a big risk.

In October 2016, military operations were launched to retake the city and its surrounding leading to the displacement of more than one million civilians between October 2016 and June 2017. UNFPA was one of the first Agencies to intervene.

Responding to the massive displacement was an immense challenge to UNFPA. The Agency relied on a camp-centric aid approach and mobilised all its available resources to front-line areas, providing basic services to civilians still located within newly or nearly liberated Mosul neighbourhoods.

The response focused on three aspects; the planning, the coordination, and the service delivery through the Rapid Response Mechanism consortium and Protection and Health clusters, in addition to the establishment of Women Centres and the provision and support of reproductive health facilities.

Over two years, the Fund established 46 Community and Women Centres, distributed more than 220,00 dignity kits, supported 62 reproductive health facilities allowing the safe delivery of more than 33,000 babies and providing close to 500,000 consultations.

As the country enters a new phase post-conflict, UNFPA reiterates its commitments to protecting women and girls across Iraq through the regular reproductive health and gender-based violence related services as well as youth empowerment projects.

Dr. Oluremi Sogunro
UNFPA Representative to Iraq

Responding in Mosul

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Responding to the humanitarian crisis in Mosul (October 2016-December 2017)

Acronyms

ACRONYMS

ACTED	Agency for Technical Cooperation and Development
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CCSAS	Clinical Care for Sexual Assault Survivors
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CERF	UN Central Emergency Response Fund
CMCoord	Humanitarian Civil-Military Coordination
CMR	Clinical Management of Rape
DCVAW	KRG Directorate of Combating Violence against Women
DoH	Department of Health
ECHO	European Civil Protection and Humanitarian Aid Operations
GBV	Gender-Based Violence
ISF	Iraq Security Forces
ICU	Intensive Care Unit
IDP	Internally Displaced Person
IHAO	Iraq Health Access Organization
IMC	International Medical Corps
IRC	International Rescue Committee
IOM	International Organization for Migration
ISIL	Islamic State in Iraq and Levant
KRG	Kurdistan Regional Government
KRI	Kurdistan Region of Iraq
MDR	Mobile Delivery Room
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
MGC	Mobile Gynaecological Clinic
NICU	Neonatal Intensive Care Unit
NRC	Norwegian Refugee Council
OCHA	UN Office for Coordination of Humanitarian Affairs
OFDA	Office of US Foreign Disaster Assistance
PHC	Primary Health Centre
PNC	Postnatal Care
RH	Reproductive Health
RIRP	Rebuild and Relief International
RRM	Rapid Response Mechanism
RTI	Reproductive Tract Infections
SCI	Save the Children Iraq
SIF	Secours Islamique France
STI	Sexually Transmitted Infections
UIMS	United Iraqi Medical Society
UN	The United Nations
UPP	Un Ponte Per
WAHA	Women and Health Alliance International
WEO	Women Empowerment Organization
WHO	World Health Organization
WRO	Women Rehabilitation Organization

CHAPTER 1

Mosul Crisis Background

Mosul Crisis Background

In June 2014, Mosul- Iraq's second largest city, fell under the black banners of the Islamic State of Iraq and Levant (ISIL), resulting in forced displacement of an estimated half a million Iraqi civilians and necessitating a government strategy to bring the city and the surrounding areas back under the state control.

On 17 October 2016, after months of military operations across the country, a coordinated push by Iraqi Security Forces (ISF), Kurdish Peshmerga, and international partner forces commenced with the goal of wresting Mosul from ISIL domination. The ensuing conflict in and around Mosul catalysed a new humanitarian crisis with IOM figures estimating more than one million civilians displaced from their dwellings between October 2016 and June 2017. The largest share of those displaced, over 700,000, came from West Mosul owing to varied modes and intensities of the conflict that percolated in different regions of Mosul.

On 9 July 2017, after more than eight months of vicious fighting in and around Mosul, Iraqi Prime Minister Haider Al-Abadi declared victory. Although random clashes continued, the main phase of the offensive concluded and IDPs have since trickled back toward their home areas. The infrastructure for health and basic service delivery in the city took a crushing blow during the fighting, and while access has improved since, but remains uneven as of as January 2018.

A humanitarian event of this scale presented immense challenges to the aid community. In early and mid-2016, UN agencies and humanitarian clusters developed strategic plans to respond to this imminent crisis and the urgent, immediate and life-saving needs of the affected populations- vulnerable groups in particular. Humanitarian actors envisaged and prepared for the IDP flow in four primary directions out of urban Mosul toward the surrounding regions. Aid items, reception areas, camp facilities, and emergency staff were readied and pre-positioned to respond swiftly to the anticipated displacements.

One of the challenges that planning process could not fully anticipate and measure was the extent of early needs among residents of Mosul who decided to stay in their homes or only relocate to another neighbourhood or street rather than fleeing the conflict zone entirely. Rapid advances by the state-led security forces during the early weeks of the Mosul campaign opened tentative access to civilian areas – some of which had been without proper healthcare and services for more than two years under ISIL rule. Prevalence of shelter-in-place behaviour among residents in these (mostly East Mosul) neighbourhoods required on-the-fly adjustments in response strategies. In conjunction with the anticipated camp-centric aid approach, there was also an urgent need for rapid mobilization of resources to front-line areas – providing basic services to civilians still located within newly or nearly liberated Mosul neighbourhoods.

From the beginning of the liberation of Mosul campaign, UNFPA Iraq remained heavily involved in planning, situation analysis, coordination, and service delivery through the Rapid Response Mechanism (RRM) consortium, and Protection and Health clusters, as well as chairing the Gender Based Violence (GBV) sub-cluster at the national and sub-national levels.

UNFPA staff and partners were among the first among the humanitarian community to adapt and quickly respond to the staggering urgent and immediate reproductive health and protection needs inside the evolving zones of liberated Mosul, in addition to supporting significant programing in camps and IDP host communities. This report gives an account of UNFPA's efforts during the 2016-17 Mosul conflict, with an eye forward toward ongoing activities assisting those displaced or otherwise effected.

CHAPTER 2

Timeline of Key Events

Timeline of Key Events

2014

june

ISIL take-over of Mosul

2016

24 August

First Mosul response interventions: RH

19 October

First Mosul response interventions: GBV

20 October

First deployment of social workers and RH mobile team

1 November

Beginning of the state-led military offensive to retake East Mosul

28 November

30 mobile/static reproductive health services in camps and non-camps supported and operated by UNFPA, meeting the needs of 60,000 people living near front lines

8 December

First RRM distribution inside East Mosul: 42,000 people reached and 7,000 dignity kits provided

2017

23 January

Liberation of East Mosul from ISIL control

12 February

Distribution of 30,000 dignity kits distributed

18 February

Beginning of the assault on West Mosul

10 March

Revitalization and opening of gynaecology ward in Al Khansa Maternity Hospital supported by UNFPA as first functioning CEmONC facility inside East Mosul

14 March

Opening of an opens obstetric unit supported by UNFPA in Qayyarah Hospital south of Mosul

19 March

Deployment of the first mobile delivery unit inside West Mosul's Al Mamoun neighbourhood Nineveh

20 March

Provision of 9 ambulances to support referrals in West Mosul

20 May

Beginning of the first GBV service provision at Al-Mamoun PHC, West Mosul

6 July

Re-opening of the Mosul General Hospital Maternity Ward after months of closure as first CEmONC facility in West Mosul

9 July

Full retake of Mosul by the Iraqi Government

CHAPTER 3

Overview of the UNFPA Approach

Overview of the UNFPA Approach

UNFPA launched its first country programme in Iraq in 2011. Ever since, UNFPA has worked across the country with a heavy focus on improving sexual and reproductive health service capacity, promoting gender equality, and supporting women's empowerment.
In close collaboration with the Government Ministries, civil society, and other UN agencies, UNFPA has pursued development priorities through a multi- layered approach, which is inclusive, impact driven, result-oriented and that seeks to build partnership with the key stakeholders, particularly the local communities to catalyse leadership, initiatives, and empowerment, particularly in view of youth bulge and rapid population growth, viz-a-viz UNFPA strategic mandate in which youth is considered equal partner as well as agent of social change.
With the rise of ISIL in 2014 and the subsequent United Nations (UN) declaration of Iraq as a level three emergency, UNFPA pivoted to add delivery of emergency services to its portfolio.
UNFPA began responding to pressing emergency related humanitarian needs such as the provision of Reproductive Health (RH) and Gender Based Violence (GBV) services, while strategically investing in actions which would link the short and medium-term responses to longer-term sustainable development objectives, aiding resilience and recovery of the affected population.
As military forces pushed into the Mosul corridor and a major confrontation between the government forces and ISIL elements in Mosul city became imminent in 2016, UNFPA, along with partners and implementers, developed a strategy to respond to an anticipated displacement. The agreed upon approach focused on a zone-based response – anticipating IDP flow and preparing for interventions in four primary quadrants, mostly within Nineveh Governorate, where Mosul is located. Zone 1 was the area to the East of Mosul, toward Erbil. Zone 2 comprised the areas North of Mosul, toward Duhok. Zone 3 encompassed areas to the West of Mosul.
Zone 4 included areas to the South of Mosul, in the direction of Salahuddin Governorate.
During the different response, [RH & GBV] these zones had focal points who reported daily to UNFPA, allowing for the creation of consolidated information mechanism that were then shared upwards to OCHA for regular response-wide sit-reps.
As the conflict unfolded, a variety of factors including geography, military strategy, security checkpoints, and political boundaries shaped the dynamics of the displacement. Most of the civilians fleeing the conflict opted to move either to the south or east.
ISILISIL's presence in the western zones made displacement in this direction negligible.
UNFPA initiated its activities at important strategic points- such as checkpoints and screening centres where IDPs were initially held for security clearance before being allowed to move onwards toward longer-term shelter.
As days and weeks progressed, UNFPA also established services in newly set-up camps and host communities.
These interventions had been pre-planned and a range of services were in place and swiftly deployed to the relevant zones.
Military operations moved rapidly through regions of East Mosul, while the newly liberated neighbourhoods inside Mosul where 1.5 million civilians were still opting to remain or take shelter as emerged as an additional zone in urgent need of humanitarian assistance. This area became known as Zone 0 and UNFPA took a leading role in assessing and responding to the evolving needs in these conflict-stricken communities.
This report focuses on the UNFPA Mosul programing and interventions in three key areas.

1.Reproductive Health

.62Reproductive Health facilities established or supported for those affected by the Mosul conflict
.Eight CEmONC service providers created or equipped; 2 Field Hospital and 6 Traditional Hospitals
.Four Mobile Delivery Rooms
.Four Mobile RH Clinics
.12 Static Delivery Rooms
.32 Static RH Clinics
.21 medical facilities in camps
.41 medical facilities in refugee and IDP gatherings
.Financial incentives for more than 500 medical centres staff
.13 ambulances donated
.472,000 RH consultations provided
.More than 33,000 infant deliveries
.Paediatric medical services supported at Hamam al Alil Field Hospital

2.Gender-Based Violence

.286,000 IDPs reached with GBV awareness materials and activities
.Psychosocial support and/or counselling services provided to 67,000 individuals
.1,500 referrals of GBV cases were made for specialized services
.300 Yezidi women and children assisted with their return to Duhok
.26,000 attendees of GBV recreational activities and courses
.Activities provided to adolescent girls through the Adolescent Girls Toolkit
.24 Safe Spaces established in IDP camps
.22 Women's Friendly Spaces established in and around urban Mosul

3.Rapid Response Mechanism (RRM)

.More than 220,000 RRM dignity kits distributed
.Additional 49,000 dignity kits distributed through GBV programming

CHAPTER 4

Reproductive Health (RH)

-Referral Pathways

-Referral Pathways

-Phased - wise Response

-Advanced Cared

-West Mosul

-Long-term Plans

-Lessons Learned

-RH Implementers

-RH Donors

-Table: RH Interventions in Response to the Mosul Crisis

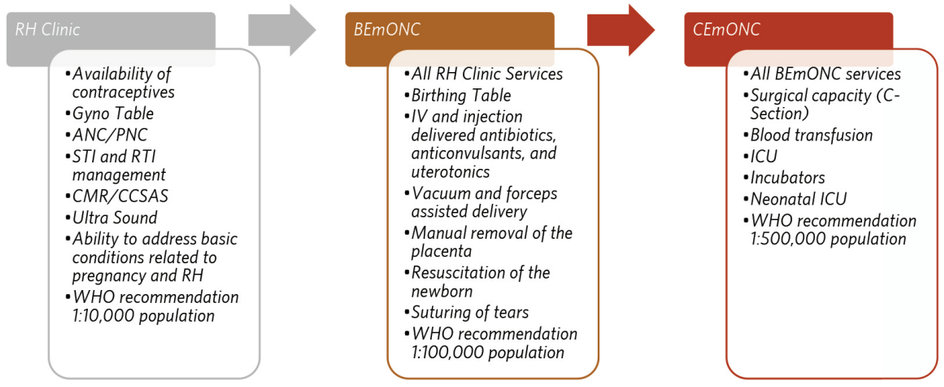
-Distribution of RH Interventions in and around Mosul

Reproductive Health (RH)

REFERRAL PATHWAYS

UNFPA's approach to reproductive health interventions is best understood in terms of medical referral pathways – a chain of care for progressively acute levels of need.
The UN health standards recommend that for every 10,000 people, there should be access to an RH Clinic, providing family planning, maternity and, reproductive health services[1] .
These service providers are the first critical link in a chain of care.
A woman who had been receiving prenatal care from an RH Clinic would be referred onward to a more advanced facility when the time arrives for her delivery.

Referral Pathways



Although some women can deliver safely within their own places of shelter, when possible most deliveries are carried out in a delivery room under the supervision of medical professionals. WHO recommendations suggest a minimum of one such BEmONC delivery room should be within reach of every 100,000 individuals. These facilities can provide all the basic services available at RH Clinics but are also equipped with birthing tables and provide a much deeper array of services in the case of any complications during normal delivery. The majority of birthing scenarios can be dealt with at such facilities, but in the event that traditional vaginal birth is impossible, or other serious medical needs arise, it is critical that all BEmONC facilities are able to refer and transport patients onward for the necessary care.

At the top of the referral pathway are CEmONC[2] facilities. Usually functioning as part of a hospital, CEmONC providers are prepared and able to deal with a full range of emergency and non-traditional birthing scenarios, from premature birth to C-Section surgical assisted deliveries, in addition to all traditional delivery needs. Requiring a much higher level of equipment, staff, and expertise, CEmONC providers are fewer in number but are an essential component of any comprehensive RH strategy.

PHASED-WISE RESPONSE

As UNFPA structured its response to the RH needs of the conflict affected population of Mosul, the priorities and investments were built around establishing and ensuring access to complete referral pathways, wherever possible. To this end, a variety of response mechanisms were deployed, to meet the critical needs of a population that had, in many cases, been deprived of proper medical care since ISIL's rise in 2014.
During this first phase of response, two of the most effective instruments in the UNFPA toolbox were MGCs and MDRs). These mobile health intervention tools allowed the immediate establishment of the first two steps of the referral pathway, even in remote and challenging locations. As security forces closed in on Mosul from the South and East, IDPs began leaving the conflict zone and passing through the front lines in search of safety. Thousands of displaced persons were held, often for days at screening sites where security services conducted background checks on individuals to ensure they had no affiliation to ISIL before allowing them to move outside the conflict zone and into the camps. MGCs and MDRs allowed UNFPA and their partners to immediately begin providing RH care to these transient populations.
From October 2016 and during the whole of the Mosul response, UNFPA deployed four MDRs and four MGCs to various sites in and around Mosul. These mobile facilities usually served as temporary measures, establishing baseline care until access to more long-term service provision could be solidified. Once alternative RH services were ensured through sustainable providers, the mobile interventions would be redeployed to other hot zones where RH gaps remained.
The modes of service provision ranged on different levels from highly mobile to semi-mobile, to permanent. Locations identified for longer-term service provision and no pre-existent health infrastructure were prioritised for the establishment of RH health facilities in the form of mobile caravans. Two types of caravans were set-up depending on the characteristics of the location. Some were mounted on wheels for continued mobility, while others were brought in on trucks and set in place with a semi-permanent design.
In-camp services:
As camps became densely populated , UNFPA realised the RH needs of the affected population and established RH Clinics in or near each camp in order to provide dignified and easy access to RH services. Larger camps required several clinics in the various sectors of the space. For larger camps, UNFPA

[1] Refer to diagram for more details on RH Clinic services

[2] CEmONC facilities are recommended at a minimum of one facility for evert 500,000 persons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UN-6540

endeavoured to establish a BEmONC delivery clinic. Each camp presented unique challenges and hence required tailored solutions to match the specific needs encountered.

UNFPA adapted its methods to suit the wide variety of scenarios.

For example, in Qayarrah Camp, to the south of Mosul, more than 120,000 IDPs took shelter. The camp's large size made it difficult for pregnant women to reach the UNFPA supported clinics, consequently a part of the RH response in that location involved securing mini-buses to facilitate transportation of patients within the camp. The intervention in the above-mentioned also included a delivery room and 5 RH clinics.

In addition to establishing new RH services, UNFPA also invested heavily in supporting and equipping the PHCs supported by the Iraqi MoH in the host communities that accommodated the IDPs. Within two weeks of the beginning of the Mosul campaign, UNFPA had already deployed 25 mobile RH teams to camps and communities around Mosul and supported 1,000 RH consultations.

Rapid movement by the government forces resulted in the opening of neighbourhoods and districts around Mosul.

Less than a month into the campaign, areas on the east side of Mosul were liberated.

UNFPA implemented a strategy that not only focused on the RH needs of those fleeing, but also provide services for those remaining in Zone 0 inside the liberated city. For assessment missions, UNFPA followed a strategic approach and positioned itself as a frontline responder through sending staff members with the initial UN OCHA CMCoord missions as they probed into and assessed the accessibility and needs of the recently liberated regions. These missions made UNFPA visible to the very front lines of the Mosul conflict, and allowed for extremely rapid response in these zones to save lives as per the UNFPA's mandate in emergencies.

UNFPA staff prioritized surveys of pre-existent MoH PHCs and hospitals in these neighbourhoods and were able to develop plans and reach agreements on the spot for the needed support that could be provided.

These missions required extreme flexibility and on-the-fly decision making. Communities had often been liberated mere days before.

The rumble of explosion was still audible from the west and a confused fog of war pervaded. Sometimes, UNFPA staff would arrive to the site of a damaged PHC only to find it locked and empty.

During one of the missions the UNFPA team arrived to a location only to find it locked; it was mere luck that they stumbled upon a passer-by who knew the holder of a key which allowed the assessment to proceed as planned.

One of the first missions took UNFPA teams to Gogjali, on the eastern outskirts of Mosul.

A PHC was available in the area and after an initial assessment mission, UNFPA began providing much-needed medications and other items to support the re-establishment of the service in that clinic. Soon after, UNFPA funded the revitalization of the PHC, including the procurement of basic items such as new doors and windows. Within days, an MDR was also deployed next to the PHC and two caravans were brought in to expand the long-term capacity of the centre. This beachhead of sorts in Gogjali served as a model for the ongoing RH interventions. As cities adjacent to Mosul were cleared of ISIL presence, UNFPA teams moved in, first assessing existent health infrastructure then providing solutions tailored to the needs of each community.

UNFPA RH Kits:

UNFPA globally has established 12 RH Kits that provide standardized equipment, medications, and RH tools appropriate to an array of different population sizes and health scenarios. During the Mosul response, these kits were utilized heavily as organized packages that could be provided quickly to establish or re-establish RH services. By mixing and matching different kits, UNFPA was able to effectively respond to the specific needs of each camp, and community.

Mobile Delivery Room (MDR)
Four deployed in and around Mosul
IV and injection delivery of antibiotics, anticonvulsants, uterotonics
Vacuum and forceps assisted delivery
Manual removal of the placenta
Resuscitation of the newborn
Ultrasound
Suturing of tears
Delivery table

Mobile Gynecological Clinic (MGC)
Two deployed in and around Mosul
Family Planning consultation
ANC/PNC
STI/RTI Management
Treatment of other conditions related to pregnancy and reproductive health
Ultra Sound
Gyno Table


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ADVANCED CARE

In the first weeks of the military campaign, nearly all emergency cases for the C-Section or other advanced care were referred to established CEmONC equipped hospitals in Erbil. The distance and logistics of those referrals proved challenging as numerous checkpoints, security permissions, and transportation mechanisms played a role in hindering the success the process. To respond to this additional challenge and provide CEmONC services to IDPs, UNFPA took a two-pronged approach.

The first pillar of this approach involved establishing Field Hospitals in secure localities outside of Mosul city. Field hospitals were established in collaboration with the WHO and implementer Aspen Medical in Athba and Hamam al-Alil – to the south of Mosul.

UNFPA funded fully equipped maternity care hospitals as part of these facilities. Opened for patients by April 2017, these facilities were equipped with operating theatres, NICUs, pharmacies, and all the tools necessary for dealing with normal and emergency birth cases.

Before their opening, it had been almost impossible for patients with complex births to access proper medical assistance in this southern region.

The second pillar involved the support and revitalization of government hospitals. Qayarrah Hospital, to the south of Mosul was one of the first hospitals with CEmONC facilities that UNFPA supported. By March 2017, a UNFPA supported 24/7 obstetric ward was reopened for service, benefitting the large number of IDPs taking shelter in and around the area.

As the state-led security forces pushed deeper into East Mosul, liberating more territory, it became possible to visit and assess what remained of the government hospitals that had previously serviced the city.

Much of the city's medical infrastructure was destroyed during ISIL occupation and this included Al Khansa hospital, previously East Mosul's largest maternity facility. Within three days of the liberation of Al Khansa's neighbourhood in mid-January 2017, a UNFPA team was on site to lay down the different scenario to restore the services at this key facility.

The whole maternity and operating areas had been burnt and were littered with booby traps and unexploded ordinance.

All told, the hospital was approximately 80 per cent destroyed. UNFPA agreed with the hospital medical staff to reopen a maternity ward in a corridor of the engineering department that had been left mostly intact by retreating ISIL forces.

UNFPA supported the hospital in restoring the water, electricity, and sewage systems in order to put a functional 24/7 operating theatre back into service.

Beginning with only a few beds and scaling up, Al Khansa reopened in late March 2017 to provide CEmONC services to Mosul residents. As the only facility of the genre accessible to thousands of people remaining in the city, the hospital faced a heavy caseload of up to was 2000 deliveries per month, including many C-sections.

The centre of ISIL control in Mosul was in the districts west of the Tigris River which bisects the city. In February 2017, security forces launched a concerted attack into these stronghold areas with a blistering array of air and ground assaults. The humanitarian situation for civilians in West Mosul was particularly reported to be severe, facing deprivations from the brutal dictates of ISIL first and later from the destruction and casualties sustained during the liberation phase.

Most medical facilities were under ISIL control and many were destroyed or shuttered, leaving dramatic and gaping health needs in the community. While actively rolling out service provision in East Mosul and surrounding communities, UNFPA actively monitored the situation in West Mosul for the first opportunity that would allow humanitarian access.

On 19 March 2017, one month into the campaign on West Mosul, the security situation in the area had been stabilized to the point that UNFPA, along with partners, was able to launch its first RH intervention in the form of an MDR.

This critical service was the first of its kind in the west of Mosul and was the first step in a quickly expanding network of service providers.

In a similar model to what has previously been described in East Mosul, UNFPA first expanded its services with mobile typologies, and then with an investment in revitalization and support of PHCs and non-mobile RH service providers. Finally, just as in the East of the city, UNFPA focused on establishing referral pathways which required identifying and empowering at least one CEmONC provider.

On 6 July 2017, Mosul General Hospital reopened in West Mosul with a functional maternity ward, once again providing a full range of advanced and emergency maternity services to the traumatized community. UNFPA was instrumental in facilitating this reopening and supported the revitalization and provided medications and equipment to the hospital. Due to the active approach of working only one step behind the front lines of security operations, Mosul General Hospital was opened several days before the Iraqi Prime Minister, Haidar Abadi's 9th of July announcement of the total victory over ISIL in Mosul city.

This accomplishment is the emblem of UNFPA unique pivot in Mosul from its usual development role towards that of a front-line emergency actor.

In addition to the tangible hard intervention components, UNFPA response also involved a variety of soft components. Particularly during the early days of the crisis, it was of utmost importance to move trained medical teams, mostly from Erbil, into areas of Nineveh Province and back, sometimes daily. This required a great deal of logistical support including scheduling, busing, and securing the proper government permission to allow regular passage through checkpoints.

UNFPA stepped in to provide this logistical support.

As more and more of the RH interventions involved former DoH facilities, it became clear that the local medical staff who has previously cared for the medical needs of the Mosul community were in need of support. In most cases, these medical professionals had been without salaries since ISIL takeover in 2014.

BEFORE

BEFORE

02/02/2017

AFTER

BEFORE

AFTER


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United Nations Population Fund
WAHA
Funded by
European Union
Humanitarian Aid
World Health Organization
Humanitarian Aid
and Civil Protection

Returning all staff to Iraqi government payroll proved to be a lengthy process. UNFPA intervened again to provide short-term financial incentives for approximately 500 health workers, allowing them to return to their posts immediately.

The day before we opened the Hamam al-Alil maternity field hospital we got a call saying they a patient was being transferred to us. A pregnant woman at full term had been shot through the abdomen. We initially prepared that we might lose both mother and child. We brought in all the staff that were pre-prepared to open the maternity hospital – ready to care for the child in the case that it was able to be saved. It was an amazing story in that this pregnant mother was shot through the uterus and the abdomen. The child was scraped by the bullet as well, but managed to somehow plug the uterus, keeping all the amniotic fluid and saving itself in the process. When we got there, the mom was okay we were able to take her straight for a C-section with the obstetrician provided by UNFPA.
– Taryn Anderson, Clinical Coordinator, Aspen Medical

LONG-TERM PLANS

In keeping with its long-term development mind set, UNFPA consistently prioritized support for sustainable medical providers. As stability and government control returns to more areas in Mosul in particular and Nineveh Governorate in general, UNFPA begins handing over many of the supported projects to the MoH for its direct management.
To meet the substantial maternity needs of the city, UNFPA is supporting a CEmONC facility and is expanding at Al Shifa Hospital in south-east Mosul.
As some of the IDPs have been able to leave camps and return to their homes, some camp facilities have become little utilized and have been closed.
In 2018, more facilities are expected to be handed over to the Government of Iraq, becoming part of the foundation for the slowly rebuilding health infrastructure of Mosul.
UNFPA will continue to invest in the clinic and hospital infrastructure of Mosul until the

During the reign of ISIL, we were in a really bad state. We had nothing. If we wanted to eat, we would eat wheat – we would cook it and eat it.
Now, thank God, things are a little better. Things are getting back to how they were before, and the way we are treated has improved.
We came here to [Mosul General Hospital] and the staff have been good to me. I was supposed to have a natural childbirth [as with my four previous children], but in the end they decided to do a caesarean section because it was best for the baby. Women in West Mosul used to go to the Batoul Maternity Hospital for deliveries, but now it is closed. If it wasn't for this hospital, we would not have had any other place to go because we don't have money. – Eman, Mother at Mosul General Hospital

LESSONS LEARNED

During the RH response in Mosul, UNFPA explored a new territory, both as an organization and also in terms of humanitarian response to the aftermath of a largely urban conflict.
During the months of the Mosul crisis, it became apparent that the best strategy for response to such a complex and varied RH crisis was the phased-wise approach described above.
Rapid assessment of existing infrastructure, accompanied by deployment of mobile response typologies, allowed the early establishment of baseline services while simultaneously allowing the Fund to secure the materials and necessary resources to establish concrete service provision.
As areas became secured, UNFPA invested in local staff capacities, in the revitalization and equipage of former providers where possible, and in the establishment of new facilities in areas where there was an absence of existing infrastructure.
This approach allowed UNFPA to consistently build on its previous investments, beginning with basic RH clinics and birthing facilities and tailoring them into growing network of referral pathways, ultimately topped by properly equipped CEmONC providers within the reach of each affected area and population.
Another main element for success was the coordination with different actors, including the trauma actors. Some of the actors such as MSF, IMC, PU-AMI etc, supported facilities in and around Mosul.
UNFPA provided RH kits and in some instances equipment and other supplies. For instance, UNFPA provided MSF-Suisse with the OT and anaesthesia machine to establish a CEmONC facility in East Mosul (Mouharebeen).
One of the main lessons learnt in an urban conflict response was to invest as much as possible in existing structures. This not only made a transition to comprehensive RH services easier, but also supported the resilience efforts at a later stage.
This approach, combined with the phased approach, leads to a rapid yet sustainable approach and was replicated by UNFPA Iraq in other areas (West Anbar, Telafar, Hawija, etc).

RH IMPLEMENTORS

Throughout its Mosul response, UNFPA worked closely with the following Reproductive Health partners:
Dary, DoH Nineveh, Harikar, IHAO, Intersos, UIMS, WAHA, Zhyan

RH DONORS

UNFPA provided life-saving RH services with generous funding assistance from ECHO, CERF, OCHA, OFDA, Japan, Australia

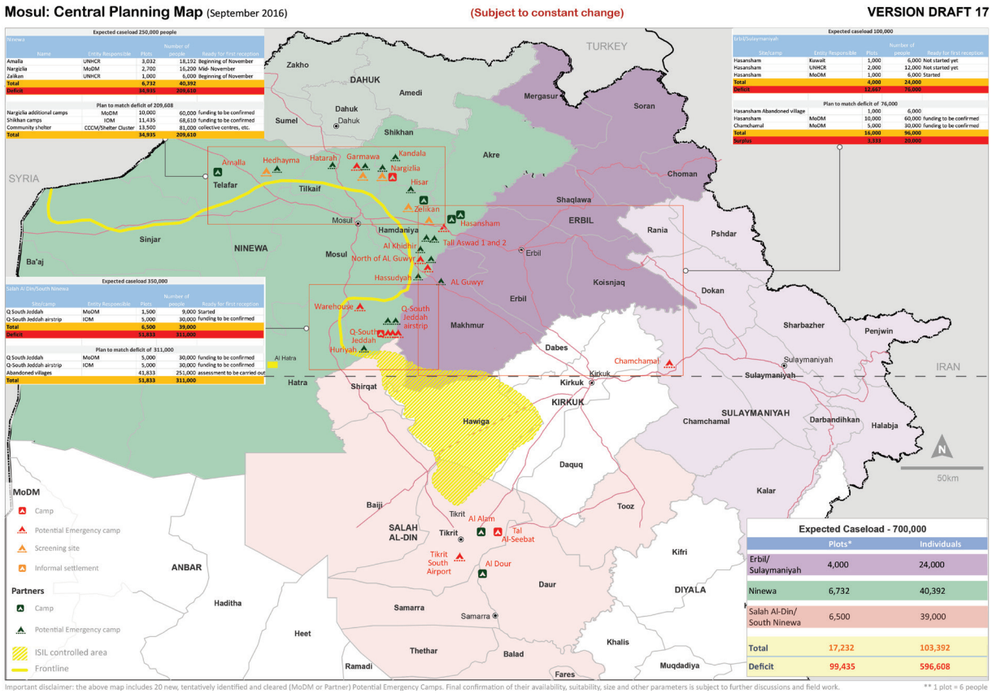
Table: Reproductive Health interventions in response to the Mosul crisis

Governorate	District	Status	Site	Type of Site	Service Typology	Partner	Type of Support
Nineveh	Qayarra	Handed over	Ijhala	Non-Camp	Static RH clinic	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Handed over	Hajj Ali	Non-Camp	Static RH clinic	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Existing	Qayarrah Center	Non-Camp	delivery room	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Existing	Jadaa 3 Camp	Camp	Static RH clinic	Zhian	Personnel, Supplies
Nineveh	Qayarra	Existing	Qayarrah Airstrip Camp	Camp	Static delivery room	IUMS	Personnel, Supplies
	Qayarra	Existing	Qayarrah Hospital	Non-Camp	CEmONC	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	Khazir	Existing	Hassan Sham Camp	Camp	Static RH clinic	WAHA	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Handed over	Gogjal	Non-camp	Static delivery room	WAHA	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Handed over	Al Qahira	Non-camp	Mobile Delivery Room	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Existing	Al Khansaa Hospital	Non-camp	CEmONC	DOH	Revitalization, Medical and Non-Medical Supplies
Nineveh	Zelkan	Existing	Zelkan Camp	Camp	Static RH clinic	DOH	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	Nargizlia	Existing	Nargizlia Camp	Camp	Static RH clinic	DOH	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Existing	Qayarrah Airstrip Camp	Camp	Static delivery room	UIMS	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Existing	Hajj Ali Camp	Camp	Static RH clinic	UIMS	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Handed over	Al Zahraa PHC	Non-camp	Static delivery room	WAHA	Personnel, Medical and Non-Medical Supplies, MDR
Nineveh	West Mosul	Existing	Hamam Al Alil 1 Camp	Camp	Static RH clinic	DARY	Personnel, Medical and Non-Medical Supplies,
Nineveh	West Mosul	Existing	Athbah Field Hospital	Non-camp	CEmONC - field hospital	ASPEN	Personnel, Medical and Non-Medical Supplies
Nineveh	Zummar	Existing	Zummar	Non-camp	Static delivery room	DOH	Personnel, Medical and Non-Medical Supplies

Governorate	District	Status	Site	Type of Site	Service Typology	Partner	Type of Support
Nineveh	Sinjar	Existing	Snuny	Non-Camp	Static delivery room	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	Telafar	Existing	Tel Abta	Non-Camp	Mobile Delivery Room	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	Al Hamdaniya	Discontinued	Al Hamdaniya Camp	Camp	Mobile Delivery Room	Zhian	Caravans, Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Handed over	Nabi Yonus	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Handed over	Rashidiyah	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Handed over	Quds	Non-Camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Mamoun	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Mansour	Non-Camp	Static RH clinic	WAHA	Supplies
Nineveh	West Mosul	Existing	Wadi Hajar	Non-camp	Mobile RH clinic	DARY	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Mosul Jadeeda	Non-Camp	Mobile RH clinic	Zhian	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Shabkhoun	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Existing	Jawsaq	Non-camp	Static RH clinic	DARY	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Existing	Mosul General Hospital	Non-camp	CEmONC	Zhian	Revitalization, Medical and Non-Medical Supplies
Nineveh	Mosul	Discontinued	Chamakor Camp	Camp	Static RH clinic	Zhian	Personnel, Medical and Non-Medical Supplies
Nineveh	Alshekhain	Existing	Nargizlia 2 Camp	Camp	Static RH clinic	DOH	Personnel, Medical and Non-Medical Supplies
Nineveh	Alshekhain	Existing	Nargizlia 2 Camp	Camp	Mobile Delivery Room	IMC	Personnel, Medical and Non-Medical Supplies
Nineveh	Mosul	Existing	Tal Kayf	Non-camp	Static delivery room	IMC	Personnel, Medical and Non-Medical Supplies
Nineveh	Mosul	Existing	Sada	Non-camp	Static RH clinic	IMC	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Yarmouk	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Heremat	Non-camp	Static RH clinic	UIMS	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	17 Tamouz	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Existing	Salamiyah Camp	Camp	Static RH clinic	UIMS	Personnel, Medical and Non-Medical Supplies

Governorate	District	Status	Site	Type of Site	Service Typology	Partner	Type of Support
Nineveh	East Mosul	Existing	Nimrud Camp	Camp	Static RH clinic	UIMS	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Discon-tinued	Mamoun	Non-Camp	Mobile Delivery Room	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Discon-tinued	Badush Screening Site	Non-camp	Mobile RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Hamam Al Alil Field Hospital	Non-camp	CEmONC - field hospital	ASPEN	Personnel, Medical and Non-Medical Supplies
Nineveh	Khazir	Existing	Hassan Sham Camp	Camp	Static delivery room	Zhian	Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Existing	Jadaa 4 Camp	Camp	Static RH clinic	Zhian	Personnel, Medical and Non-Medical Supplies
Nineveh	Qayarra	Existing	Jadaa 5/6 Camp	Camp	Static RH clinic	Zhian	Personnel, Supplies
Nineveh	Qayarra	Existing	Jadaa Village RH Clinic	Non-Camp	Static RH clinic	Zhian	Personnel, Supplies
Nineveh	Khazir	Existing	Khazir Camp	Camp	Static RH clinic	Zhian	Personnel, Medical and Non-Medical Supplies
Nineveh	Khazir	Existing	Khazir Camp	Camp	Static delivery room	WAHA	Personnel, Medical and Non-Medical Supplies
Nineveh	East Mosul	Existing	Shifa Hospital	Non-camp	CEmONC	DOH	Medical and Non-Medical Supplies
Nineveh	West Mosul	Existing	Shura	Non-camp	Static RH clinic	INTERSOS	Personnel, Medical and Non-Medical Supplies
Nineveh	Telafar	Existing	Tel Abta	Non-camp	Static RH clinic	IHAO	Personnel, Medical and Non-Medical Supplies, MDR
Nineveh	Telafar	Existing	Telafar Hospital	Non-camp	CEmONC	IHAO	Personnel, Medical and Non-Medical Supplies
Salah AlDin	Alam	Existing	Alam Camp	Camp	Static RH clinic	UIMS	Caravans, Personnel, Medical and Non-Medical Supplies
Salah AlDin	Beiji	Discon-tinued	Al Hajjaj Transit Point	Transit Point	mobile RH team	UIMS	Personnel, Supplies
Salah AlDin	Beiji	Existing	Al Hajjaj Delivery Room	Non-camp	Static delivery room	WAHA	Caravans, Personnel, Medical and Non-Medical Supplies
Salah AlDin	Shirqat	Existing	Basteen Al Sheyoukh Camp	Camp	Static RH clinic	UIMS	Caravans, Personnel, Medical and Non-Medical Supplies
Salah AlDin	Alam	Existing	Alam Delivery Room	Non-camp	Static delivery room	UIMS	Personnel, Medical and Non-Medical Supplies
Salah AlDin	Shirqat	Discon-tinued	Shirqat Screen-ing Site	Non-camp	Mbile RH Clinic	INTERSOS	Personnel, Medical and Non-Medical Supplies
Salah AlDin	Shirqat	Existing	Shirqat Hospital	Non-camp	CEmONC	IHAO	Personnel, Medical and Non-Medical Supplies

Distribution of RH Interventions in and Around Mosul



CHAPTER 5

Rapid Response Mechanism (RRM)

- Overview of RRM Activities
- Number of RRM Dignity Kits Distributed per Month
- Looking Forward
- Lessons Learned
- RRM Distribution Partners
- GBV Dignity Kit Distribution Partners
- RRM Donors

Rapid Response Mechanism (RRM)

OVERVIEW OF Rapid Response Mechanism (RRM) ACTIVITIES

In addition to distribution of RH kits, UNFPA, along with agency partners UNICEF and WFP, co-led what is now known as the Rapid Response Mechanism (RRM) consortium where a unified kit of aid items is distributed to the IDPs and similarly vulnerable families during the first 72 hours after a crisis situation is erupted. These RRM kits contain a week-long supply of items essential for a family, to tide them over until either the at-risk individuals can reach more sustained aid, or further aid can reach them in-place. Kits contained potable water, food rations, a hygiene kit, and a dignity kit.

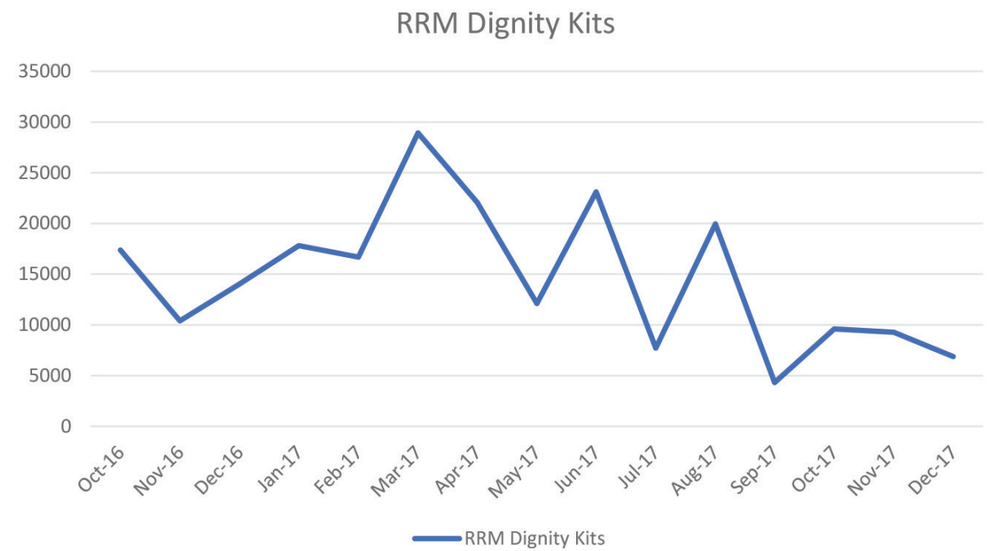
Dignity kits are a crucial tool employed by UNFPA globally and are adapted to fit the specific needs of each served population. The purpose of the kit is to provide vulnerable women with the items necessary to ensure a basic standard of personal health and hygiene even while on the move or without access to standard amenities. Each dignity kit distributed in the Iraq context is packaged in a useful and easy to carry bag containing a bath soap, an underwear, washing powder, sanitary napkins, a flashlight, toothpaste, a toothbrush, a comb, a menstrual pad set, and often an abaya and sandals.

In preparation for the Mosul displacement, UNFPA began stockpiling and pre-positioning dignity kits to be able to swiftly respond to the anticipated mass displacements. When military operations began on 17 October 2016, UNFPA had 124,000 dignity kits in the pipeline for distribution. Within the first 36 hours of the Mosul offensive, UNFPA delivered 100 RRM dignity kits to the first wave of IDP families. The fund had also prepositioned 1,700 more kits in Hajj Ali, south of Mosul, to prepare for the coming mass displacements.

By the end of October 2016, UNFPA, along with partners, had distributed more than 17,000 RRM dignity kits to women and girls flowing out of Mosul and environs. Distribution partners stood ready at government screening sites to distribute kits to every vulnerable arriving families and individuals.

Initial distributions primarily took place at IDP screening and transit sites as well as reception areas. Most initial distributions were each relatively small, ranging from tens to hundreds of kits provided on a given day at specific targeted locations. Many localized distributions were carried out, rather than large-scale single distributions.

Number of RRM Dignity Kits Distributed Per Month



Inresponse to the fluid situation on Mosul, UNFPA and RRM partners began to widen their distribution methodologies, particularly as parts of urban Mosul were liberated. In December 2016, RRM kits, carried in a convoy of trucks, became some of the very first aid items to hard-to-reach areas in East Mosul which had long been under ISIL control and severely lacking in all types of necessities. Unlike the earlier distributions, this first one in East Mosul was a large-scale event with over 7,000 dignity kits and RRM packages delivered in one single day, and an estimated 42,000 people were reached by aid items.

The volume of distribution of RRM and dignity kits ebbed and flowed over the ensuing months, in correlation with military events on the ground and the associated waves of displacement or new

access to vulnerable communities.RRM delivery volumes peaked around March of 2017 as security forces pushed into ISIL strongholds of West Mosul. Heavy military operations led to a new wave of displaced families, fleeing the city. The RRM partners responded swiftly with nearly 30,000 dignity kits distributed during March alone. These distributions were made primarily to new arrivals at camp locations like Hamam al Alil, Qayarrah Airstrip, and Hajj Ali camps to the south of Mosul and in lesser numbers to arrivals at camps to the north and east of Mosul like Hasansham, Chamakor, and Nargizlia camps.

In total, during the Mosul crisis, approximately 220,000 RRM dignity kits were contributed by UNFPA to the humanitarian response and distributed directly or through partner organizations.

LONG-TERM PLANS

Throughout 2017, as the security situation in Mosul and the surrounding Nineveh Governorate stabilized, the demand for dignity kits progressively decreased in accordance with the decrease of displacement events post July 2017. During the first months of 2018, only about 4,000 dignity kits were needed in the region while the demand for this emergency aid provision in Mosul is expected to continue tapering off in the coming months.

LESSONS LEARNED

UNFPA strategy for service delivery in Zones 1-4 was fairly well established and well-planned before the onset of the Mosul displacement. The mechanisms for response inside Mosul's Zone 0 were less defined and required some trail and error to find the best methods for reaching the impacted population. The large scale distributions, like the one in East Mosul proved not to be the most effective method for reaching out to the affected communities. Due to the extreme need in many of these communities, distribution points with large numbers of people proved difficult to manage. For most situations, UNFPA and partners found that the most effective method for disseminating these crucial aid items was on a targeted and on-going basis rather than in mass distribution events.

RRM Distribution Partners ACTED

Muslim Aid, NRC, RIRP, SCI, SFI, UIMS, WEO

GBV Dignity Kit Distribution Partners

Al-Masalla, HARIKAR, IHAO, IMC, Mercy Hands, Muslim Aid, UIMS, WEO

DONORS

ECHO, OFDA

CHAPTER 6

Gender Based Violence (GBV)

Gender Based Violence (GBV)

INTRODUCTION TO GBV

For women and girls living under ISIL reign for more than two years, the trauma sustained due to the group's misogynistic dictates was compounded by multiple displacements and loss of loved ones. UNFPA humanitarian intervention in Mosul was not limited to RH and RRM; the Agency was the lead on the response to GBV and women inclusion, including but not limited to the provision of protection, legal assistance, medical and and psychosocial support to survivors of gender-based violence.

These issues are close to the heart of UNFPA mandate and as the Mosul crisis became imminent, the Fund invested deeply in planning its response to the unique needs faced by women impacted by the crisis.

UNFPA continued to lead the GBV sub-cluster at the national and sub-national level in order to provide predictable, timely and planned GBV mitigation, prevention and response services to survivors of GBV as well as vulnerable and at-risk groups in collaboration with the government ministries, local and INGOs and other humanitarian coordination forums, including clusters.

THE AGENCY ROLE IN HUMANITARIAN COORDINATION AND PROGRAMME IMPLEMENTATION

In the lead up to the Mosul campaign, UNFPA took on the responsibility of chairing the GBV sub-cluster, ensuring coordination, communication, and effective and synchronized action between the numerous humanitarian and government actors working within the sector. Using the zone-based approach, UNFPA identified a focal point for each zone to serve as a clearing-house for information sharing in that area.

Initial coordination took place in physical meetings, but as the crisis intensified, UNFPA facilitated the use of Skype and other online messaging platforms to immediately share information between coordinating agencies and partners within each zone. If one actor identified a need that they were not equipped to respond to, they could immediately highlight the need in the zonal group-chat, alerting other parties who had the capacity or resources to respond to the situation. For example, if one agency was working in a region where newly arriving internally displaced women were lacking hygiene items or personal care products, their notification could activate another partner with stocks of dignity or hygiene kits to bring them to the area of need. Focused coordination on GBV issues allowed UNFPA and partners to consistently advocate within the humanitarian community for the specific needs of women aiming to reduce risks and exposure as well as mitigating contributing factors that may lead to acts of GBV in different sectors such as Protection, CCCM, Shelter/ NFI, WASH, Food Security and Agriculture (FSA), Health, etc.

> When I first came here I was in a bad shape. ISIL had taken my husband right out of our home, and to this day there still hasn't been any news of him. When I arrived at the camp on foot, I was staying with my parents and just sat at home. A social worker from the women's centre helped me get out of the bad condition I was in. She would sign me up for courses and ask me about my psychological state and emotional well-being. She would engage me in talk, reminding and console me to let the past go and concentrate on myself and my young son. Because of her support, my condition has improved. When I stay home I get depressed, but this centre is a place of comfort for women like me. I chat with other women and feel better. Women are at peace here. I feel strong now.
> -"Lamia", Mosul IDP

In addition to coordination responsibilities, GBV staff of UNFPA also developed a variety of interventions, ready to hit the ground immediately, in response to the first Mosul displacements. In similar fashion to the RH teams, UNFPA trained and equipped 23 mobile GBV teams, prepared to meet newly displaced IDPs and assess and respond to their needs. These teams consisted of social workers, case workers, and community mobilizers. In anticipation of the crisis, 99 individuals were trained in GBV emergency response and 105 trained on the principles of the Protection against Sexual Exploitation and Abuse (PSEA).

Within days of the beginning of the Mosul campaign, UNFPA GBV teams were in action responding to the protection-related needs of the affected population, women and girls in particular. The first team was deployed on 19 October 2016 to Qayarrah, south of Mosul and on 20 October, GBV team members accompanied the mobile RH team to Jaada Camp ready to provide Psychological First Aid (PFA) to new arrivals in compliment to the physical health services being offered.

Since screening sites were generally the first points of contact between the IDPs and the front-line humanitarian workers , the GBV teams initially focused on these locations. Prior to the advent of the Mosul displacement, UNFPA worked closely with the government to ensure access by GBV and protection staff early in the screening process. This allowed for quick identification of individuals with heightened levels of need. The previously mentioned RRM dignity kits included printed leaflets, informing international displaced women about support services available to them and provided contact options for those in need of specific health or psychological support. Members of the GBV teams accompanied the RRM distributions and used this opportunity to identify cases that called for speedy referral toward crisis counselling or other specialized services. These mobile teams also offered psychosocial support to women and girls.

As IDPs began to move into camps, UNFPA


UIMS
United Nations Population Fund
الدعم النفسي
PSYCHOLOGICAL
UIMS
وزارة الصحة العراقية
Iraqi Ministry of Health
Founded 1920
UNFPA
United Nations Population Fund
United Nations
CERF
Central
Emergency
Response
Fund
مركز النجاة لدعم النساء والفتيات في مخيم القيارة
Al-Najat Women and Girls Support Center in AL-Qayyara Camp
Supported By UNFPA تمويل صندوق الامم المتحدة للسكان
تنفيذ الجمعية الطبية العراقية الموحدة للاغاثة والتنمية
Managing By United Iraqi Medical Society for Relief and Development
VEGAPEN
ROOMS


The United Iraqi Medical Society for Relief & Development
الجمعية الطبية العراقية الموحدة للإغاثة والتنمية
UIMS
وزارة الصحة العراقية
Iraqi Ministry of Health
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دائرة صحة نينوى
UNFPA
United Nations Population Fund
صالة النجاة للولادة مخيم قاعدة القيارة
ممول من قبل منظمة الأمم المتحدة للسكان UNFPA
تنفيذ الجمعية الطبية العراقية الموحدة للإغاثة والتنمية UIMS
صالة الولادة
DELIVERY ROOM
UNFPA
United Nations Population Fund

and partners established women's centres in each camp, staffed with social workers and other team members equipped to deal with the needs of women. GBV teams were part of the reception for new arrivals, making sure that each arriving family was aware of the women's centres and services available in the camp. Once IDPs began to settle in their new surroundings, GBV teams would also conduct visits to family shelters, again, making the population aware of the services available, and using the interaction as an opportunity to identify and respond to pressing GBV risks, exposures, contributing factors and needs- both unmet as well as urgent, immediate and life-critical needs in view of the consequences of GBV.

During the Mosul response, UNFPA and partners recorded 286,000 awareness raising interactions, informing the internally displaced population about GBV issues, its harmful consequences and relevant services available for survivors of GBV. Often, during this first interaction between GBV staff and women, urgent issues would become quickly apparent and team members would immediately refer the women for specialized health, legal, and psychological support services. More than 1,500 referrals were made to specialised services. However, the actual number remains much higher given that many of the referrals happened organically during the course of conversation and were not specifically recorded.

Of heightened concern were cases of women who had suffered from sexual violence including rape. GBV staff were alert to identify such individuals and immediately refer them to the nearest facility serviced by medical professionals trained in Clinical Management of Rape (CMR). In an intersection between medical and GBV priorities, UNFPA facilitated the training of 56 medical staff in CMR, prior to the crisis, and preposition Post-Rape Kits so that medical providers would be equipped to respond to sexual violence cases.

From 24 women's centres in IDP camps, UNFPA began to provide support to women dealing with the recent traumas of their experiences and, in some cases, unhealthy or violent family dynamics pre-existent before the Mosul crisis. Women's centres began conducting regularly scheduled courses and information sessions, inviting all women to come, learn, and network. With the breakdown in social and family relationships and social cohesion as a result of continued conflict and displacement, these activities became most sought after for many women to get out of their shelters, meet other women, and enjoy their time in healthy activities. Women were given the opportunity to express themselves through art and to learn or develop skills in areas like sewing. In a conservative cultural context, where many women were expected to remain primarily in the home, organized, skill-building activities often made it easier for women to utilise spending time separate from the family shelters. In a relaxed environment facilitated by these activities, women often began to process their own experiences, reflect and share more openly with social workers about any challenges or needs they might be facing.

More than 26,000 women and girls attended recreational activities through women's centres and the positive relationships developed during these activities often formed the foundation for further action. For example, a woman might attend a session, and mention to a social worker something about domestic violence issues she would face at home. This would allow the social worker to ask more questions and when needed in case of emergency, conduct home visits.

Whether connected through the women's centre recreational activities, or as a result of women actively seeking out the GBV services, UNFPA and partners were actively providing psychosocial support to the Mosul crisis affected population. Throughout the response, UNFPA recorded more than 67,000 women receiving psychosocial support and counselling services offered as a part of the GBV programing.

As part of its GBV programming, UNFPA also distributed an additional 49,000 dignity kits directly to women that were identified as in need of aid. These additional kits were not given as part of RRM distributions, but were provided separately, and often on an continued basis as women presented themselves to centres in camps and inside Mosul. All the UNFPA responses were interconnected, and as RH facilities and Women's Centres were established, these sites became distribution points for dignity kits to women receiving other services.

URBAN MOSUL

When UNFPA began pushing into Zone 0 and interacting with the population still sheltered in Mosul, it became apparent that these communities were in need of GBV support, in addition to RH interventions and tangible aid items like various kits. Therefore, GBV staff began offering psychosocial support services and referrals. As new clinics and other health services were created or revitalized, a room or caravan was usually set aside for the GBV team to start conducting assessments and providing non-physical support services to

> We stayed a long time under ISIL rule and suffered so much. Sometimes ISIL would come to our home and harass my husband, and they threatened to blow up our house. We suffered injustice, hunger, thirst, and there was no water or electricity. Some of us got sick and we had no access to treatment. In the end, we had no choice but to leave.
>
> We fled here to this camp, but there were still many problems, both financial and family related. There were so many problems.
>
> Some relatives would provoke my husband against me and he would hit me very hard and humiliate me and would kick me out of the house. The women's centre staff make house calls, and I heard from them about the social worker at the centre, so I came to meet her. I told her my story - our problems with ISIL, and my problems here since we have arrived. She came into our lives and started visiting us at home, and I also started coming to see her as

well. She helped me so much.
The social worker talked with my husband on the phone and came to see him at our home. She told him that what he was doing was wrong. She told him that this is no way to treat your wife with whom you've spent a lifetime.
His attitude toward me has changed and now, thank God, he is much better to me.
I learned in a course at the centre about how men and woman should use dialogue when there is a problem. Beating your spouse and humiliating them is not appropriate, but instead people should help each other with kind words and attitudes. I benefited so much from this education.
My favourite women's centre activity has been the sewing. I love sewing, and the sewing course has helped me a lot. I can now improve my financial situation through sewing. The guidance they gave me has helped me to help myself.
- "Amina

On 20 May 2017, UNFPA began its first GBV service provision in newly liberated West Mosul, in conjunction with the Mamoun health centre. In total, UNFPA established 22 women's centres in and around urban Mosul, addressing the needs of IDPs who were residing outside camps. A paired operation with health facilities was an important part of the strategy for maximum reach to the population, especially to those in areas with no easy access to awareness raising.

ADOLESCENT GIRLS TOOLKIT

While many programs provided activities and programs for young children, and others focused on the needs of women, nevertheless adolescent girls were often forgotten and left without appropriate resources. In order to address this gap, UNFPA partnered with UNICEF to create a toolkit, laying out an approach and activities to effectively engage with and empower this marginalized group.
During the Mosul displacement, UNFPA and partners made solid use of this new programming focus. Many of the previously mentioned women's centres were put to double purpose, providing activities in shifts. For example, centres might provide activities targeting women during morning hours and then offer a set of courses focused and appropriate for adolescent girls in the afternoon.
This dual use approach proved effective and was used effectively during the Mosul response. More than 9,000 girls attended these courses specifically crafted to address the needs and challenges resulting during and because of displacement. Using age appropriate materials and activities, young girls were provided education on reproductive health, hygiene, personal boundaries, family relationships, safety, and other psychosocial and personal issues.

SUPPORT FOR YEZIDI WOMEN

ISIL treatment of women from the Yezidi minority community was particularly abusive, even by the dyer standards of the organization. Young Yezidi women were specifically targeted, and many were captured from their homes and forced to serve as slaves (often of a sexual nature) in ISIL controlled areas. The majority of Yezidi IDPs were forced to flee their neighbourhoods during the 2014 rise of ISIL and most sheltered in areas near the KRI city of Duhok. Upon the liberation of Mosul, UNFPA identified groups of Yezidis, mostly women and girls, who had recently escaped from enslavement by ISIL and were trying to reunite with their families and community members. Instead of going to the same IDP camps as most of those fleeing Mosul, these cases needed exceptional care. UNFPA worked closely with government actors and partners to address these unique situations. The Yezidi women needed careful legal assistance and logistical facilitation services, in order to be taken from Mosul directly to areas where they could receive the required care and support, often after experiencing severe emotional and physical trauma.
In addition to being the community where many Yezidi women could find their family groups, Duhok is also best equipped in the region to deal with difficult cases of the kind presented by these women. Since well before the Mosul displacement, UNFPA supported a specialized service centre in Duhok, offering a full range of mental, medical, and legal services tailored toward survivors of sexual violence.
During their captivity, many Yezidi women gave birth to the children of ISIL fighters, most pregnancy were the result of rape. Unfortunately, the children were to some of these mothers a reminder of a heart-breaking period, therefore, some women were unable or unwilling to return to their families and communities with them. For this reason, UNFPA and partners worked with existing orphanages to find shelter and care for the abandoned children.
In total, UNPFA facilitated the transportation and support of more than 300 Yezidis liberated from ISIL enslavement. Upon arrival to safe areas, UNFPA and partners provided accommodation, clothing, psychosocial support, medical care and legal services and when possible facilitated reunification with families.

LONG-TERM PLANS

As Mosul begins the post-ISIL rebuilding phase, IDPs begin to relocate from camps back to Mosul neighbourhoods. UNFPA remains committed to guaranteeing access to psychosocial support and advocacy services for women in the area. With its local partners, the Agency continues to support the women's centres in Nineveh Governorate both in urban contexts and the remaining IDP camps. Unlike the situation with RH facilities, the Iraqi Government does not currently have the full capacity to take over operations of such centres.
Since sustainable operations is always the goal for UNFPA interventions, developing capacity of government institutions remains part of the Fund's long-term strategy. Thus, planning is currently ongoing between the Fund and the Iraqi MoLSA with the goal of establishing a shelter in Mosul city for female survivors of GBV. A similar centre has recently been established in Baghdad, and Mosul is the target location for a second such facility in the coming months.

UNFPA is also supporting the training of government social workers and medical staff on how to appropriately respond to, advice, and treat GBV cases. Also, UNFPA continues to support a telephone helpline in KRI, providing a safe place for women in crisis situations to call and access services.
In the future, UNFPA will create a comprehensive centre in Mosul, similar to the one in Duhok. This would serve as a location for women to receive complete services in counselling, legal, medical services in addition to psychosocial support from trained professionals. This first of its kind centre in Mosul would meet critical needs of women of the community.

LESSONS LEARNED

The UNFPA GBV response to the Mosul crisis was unique in several key respects compared to the normal programing strategies employed by the Fund.
First, unlike in the normal development context where women's service provision would usually be implemented by identifying a location, establishing a centre, recruiting staff, and finally offering services, the Mosul response was best approached with an inverted structure. Mobile teams were trained and assembled first and immediately began to provide support to the transient population, wherever they might be, e.g. in screening sites, camp arrival zones, etc. As movement subsided and the vulnerable populations became settled in place, as in the case of camps, UNFPA established a physical presence through centres and women's safe spaces to continue the work that had already begun by the mobile teams.

Second, in its urban response, the close coordination with the RH teams became a unique feature of the Mosul context. RH responses were often deployed in the sites of pre-existent PHCs and faced a massive service demand which created a perfect entry point for GBV teams to add their complimentary services.
Finally, the use of leaflets and other communications channels during the RRM distribution proved a highly efficient awareness raising channel for GBV programing. Since RRM distributions were often the very first humanitarian assistance delivered to IDPs, combining GBV awareness materials with these items ensured a proper communication with those in need of services and support.

GBV IMPLEMENTORS

ACTED, Al-Mesalla, DCVAW, Harikar, IHAO, IMC, IRC, Mercy Hands, Muslim Aid, NRC, Qandil, RIRP, SCI, SFI, Tajdeed, UIMS, UPP, WAHA, WEO, WRO

GBV DONORS

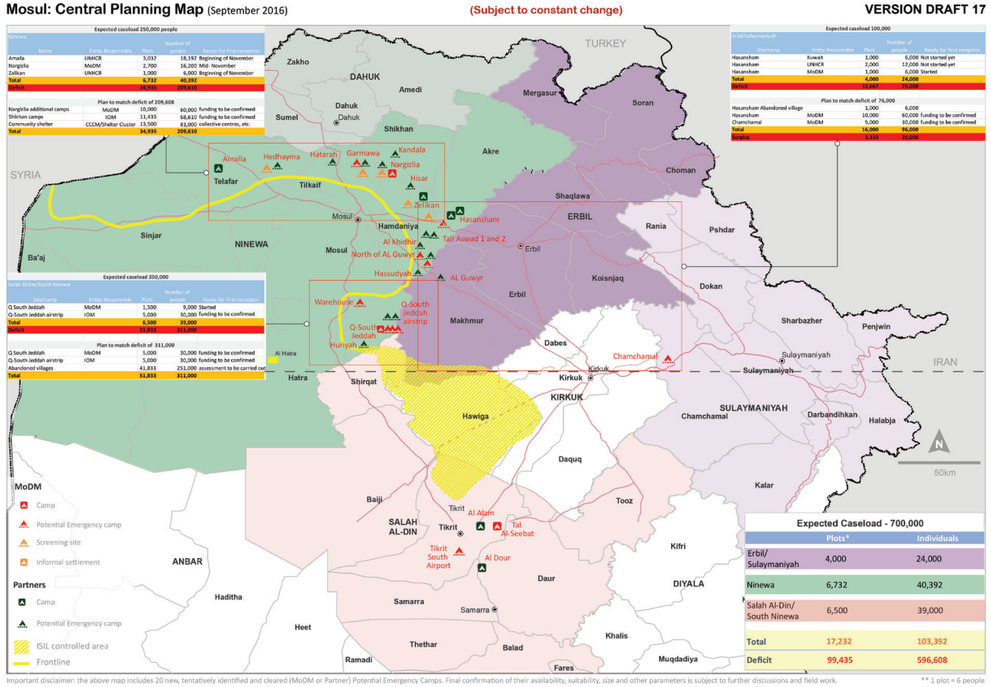
Australia, ECHO, Japan, Netherlands, Norway, OFDA, OCHA, Canada

Table: GBV interventions in response to the Mosul crisis

Governorate	NGOs Name	Name Of center	Detailed Location	Type of Facility
Nineveh	Harikar	Bardarash Camp WSC	Camp	WSC
Nineveh	AL_Mesalla	Chamakor Camp	Camp	static caravan
Nineveh	AL_Mesalla	Dibaga Camp 1	Camp	static caravan
Nineveh	AL_Mesalla	Dibaga Camp 2	Camp	static caravan
Nineveh	AL_Mesalla	Dibaga Camp stadium	Camp	static caravan
Nineveh	IHAO	17 Tamooz, West Mosul	non-camp	WSC at PHC
Nineveh	AL_Mesalla	AL_Arabi	non-camp	WSC
Nineveh	AL_Mesalla	AL_Muthana	Non-Camp	WSC
Nineveh	AL_Mesalla	AL_Noor	non-camp	WSC
Nineveh	AL_Mesalla	AL_Qahira	non-camp	WSC
Nineveh	AL_Mesalla	AL_Sukar	Non-camp	WSC
Nineveh	AL_Mesalla	AL_Zehur	non-camp	WSC
Nineveh	IMC	Garmawa Camp WSC	Camp	WSC
Nineveh	Harikar	Gawelan Camp WSC	Camp	WSC
Nineveh	UIMS	Hajj Ali Camp	Camp	caravan
Nineveh	IMC	Hamam Al Alil Camp WCC	Camp	caravan
Nineveh	AL_Mesalla	Hasan Sham Camp M2	Camp	static caravan
Nineveh	AL_Mesalla	Hasan Sham Camp U2	Camp	static caravan
Nineveh	IHAO	Al-Mamoon, West Mosul	non-camp	WSC at PHC
Nineveh	IHAO	Al-Nedaa, West Mosul	non-camp	WSC at PHC
Nineveh	UPP	Al-Nour, East Mosul	non-camp	WSC

Nineveh	AL_Mesalla	Hasan Sham Camp U3	Camp	static caravan
Nineveh	IMC	Jadaa 6 Camp	Camp	caravan
Nineveh	WRO	Jiyan WSC Shekan Camp	Camp	WSC
Nineveh	AL_Mesalla	Khazr Camp M1P1	Camp	static caravan
Nineveh	UPP	Al-Qahirah, East Mosul	non-camp	WSC at PHC
Nineveh	IHAO	Al-Qudus, East Mosul	non-camp	WSC at PHC
Nineveh	AL_Mesalla	Khazr Camp M2P2	Camp	static caravan
Nineveh	Harikar	Mamrashan Camp WSC	Camp	WSC
Nineveh	IMC	Nargizlia Camp WSC	Camp	WSC
Nineveh	UIMS	Nimrud Camp	Camp	caravan
Nineveh	Harikar	Qaymawa Camp WSC	Camp	WSC
Nineveh	UIMS	Qayyarah Airstrip Camp	Camp	caravan
Nineveh	IMC	Qayyarah Airstrip Camp	Camp	Caravan
Nineveh	UIMS	Salamiyah Camp	Camp	Caravan
Nineveh	SEWAN	Swean WSC Esian Camp	Camp	WSC
Nineveh	UPP	Al-Sommer, East Mosul	non-camp	WSC at PHC
Nineveh	IHAO	Al-Yarmok, West Mosul	non-camp	WSC at PHC
Nineveh	DoLSA	DoLSA WCC Akre Center	non-camp	WCC
Nineveh	DoLSA	DoLSA WCC Shekan Center	non-camp	WCC
Nineveh	UPP	Nabi Younis, East Mosul	non-camp	WSC at PHC
Nineveh	WAHA	Qayyarah PHC and Hospital	non-camp	PHC and hospital
Nineveh	Harikar	Sinoni WSC	non-camp	WSC
Nineveh	IHAO	Talafar/Tal Abta	non-camp	WSC
Nineveh	Harikar	Tilisquf WSC	non-camp	WSC
Nineveh	IMC	Zummar WSC	non-camp	WSC

Distribution of GBV Interventions in and Around Mosul



Important disclaimer: the above map includes 20 new, tentatively identified and cleared (MoDM or Partner) Potential Emergency Camps. Final confirmation of their availability, suitability, size and other parameters is subject to further discussions and field work.

** 1 plot = 6 people

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