Final Whole of Syria Cholera Operational Review Report

Health and WASH Clusters

WHO – UNICEF

July 2023

Contents

Abbreviations and Acronyms

AAR	After-Action Review
AWD	Acute Watery Diarrhea
CATI	Case-area targeted intervention
CHW	Community health worker
CTC	Cholera Treatment Centre
CTF	Cholera Treatment Facility
CTU	Cholera Treatment Unit
EWARN	Early Warning Alert and Response Network
EWARS	Early Warning Alert and Response System
FGDs	Focus Group Discussions
FRC	Free residual chlorine
GoS	Government of Syria
GTFCC	Global Taskforce for Cholera Control
HC	Health Cluster
HCT	Syria Humanitarian Country Team
IAR	Intra-Action Review
IEC	Information Education Communication material
IMS	Incident Management System
IPC	Infection Prevention and Control
KPI	Key Performance Indicators
MoH	Ministry of Health
NES	Northeast Syria
OCHA	Office for the Coordination of Humanitarian Affairs

OCV	Oral Cholera Vaccine
ORP	Oral Rehydration Point
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
NWS	Northwest Syria
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Team
SBC	Social and Behavior Change
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WoS	Whole of Syria

Executive summary

The operational review (IAR) was conducted over two days, May 15th & 16th, 2023 in Amman, Jordan, under the leadership and facilitation of Whole of Syria (WoS) health and WASH clusters. The review used a qualitative participatory approach guided by WHO guidance for after-action review[1]. The 3 Response areas prepared detailed accounts of the response to the outbreak which were used for discussions.

The meeting was attended by a total of 55 participants representing WoS Health, WASH, and RCCE coordinators and hub representatives from the Syria response areas of Damascus, Northwest Syria (NWS), and Northeast Syria (NES). In addition, technical officers from WHO and UNICEF, and partners from national and international organizations supporting cholera response operations also attended the meeting.

Participants reviewed the ongoing cholera outbreak, discussed actions taken to date, identified key challenges, and recommended actions moving forward. This report will therefore highlight what went well, not well, gaps/challenges during the last 8 months, and will identify corrective actions both in the short t and ahead of the summer season where a second wave is expected, and strategic actions that will contribute to eliminating cholera from Syria in the longer term.

Key recommended actions

Leadership and Multi-Sectoral Coordination.

1. Prepare the WoS Cholera Intra-Action Review (IAR) report to inform future actions, and strategies and to update July-December 2023 Cholera response plan.
2. Identify high-risk areas for preparedness, prevention, and response actions, and develop targeted prioritization activities plan accordingly.
3. Jointly revise Key Performance Indicators (KPIs), apply well-defined Monitoring and Evaluation (M&E) indicators, and work on the integration of reporting across all hubs.
4. Organize a follow-up meeting with the global health and WASH cluster team on intersectoral collaboration, operational review report recommendations, and learning documentation.
5. Enhance governmental, local authorities, and local partners' engagement in response operations.
6. Support and advocate for cross-hub resource prepositioning and mobilization.
7. Support conducting joint health, RCCE, and WASH coordination meetings and integrated response programming at hub levels.

[1] WHO, Guidance for after action review (AAR), https://www.who.int/publications/i/item/WHO-WHE-CPI-2019.4

Surveillance and Laboratory

8. Enhance surveillance and address its gaps mainly in NES; finalize the Surveillance (Early Warning Alert and Response Network/ Early Warning Alert and Response System) (EWARN/EWARS) synchronization exercise.
9. Integration of reporting forms to enable easier interpretation of data.
10. Expansion, capacitation, and operationalization, of planned laboratories in Syria HCT and NES, with the enhancement of reporting from across all hubs.

Case management and Infection Prevention and Control (IPC)

11. Scale up the referral system from hotspot areas.
12. Address WASH and IPC gaps in Cholera Treatment Facilities.
13. Advocate for IPC guideline implementation and supervision.
14. Advocate for (Oral Rehydration Therapy) ORT reporting at community and Primary health care level.

Supply and Logistics.

15. Strengthen Supply chain planning, coordination, monitoring, and sharing between response actors.

Water, Sanitation, and Hygiene (WASH)

16. Advocate for supporting the rehabilitation and operation and maintenance of water and sanitation infrastructures and for WASH system recovery adapted to climate change and water scarcity crises.
17. Continue to advocate to avoid the use of “access to water” for political reasons and ensure the right to safe water for everyone (Alouk, Al Bab) is maintained.
18. Develop a strategy to better engage the private sector to ensure water quality monitoring and increase water quality investigations at the field level.
19. Advocate for and support the solarization of water and electricity systems to address challenges surrounding the availability of safe water and the inadequacy of power supply/gas.

Risk communication and Community Engagement (RCCE)

20.
21. Foster community ownership, participation, and inclusion in the different phases of programming and implementation of Cholera response interventions to ensure the effectiveness and sustainability of interventions.
22. Emphasize the importance of adopting and sustaining specific behaviors that would prevent cholera and other water- and food-borne diseases, to significantly mitigate cholera transmission and new outbreaks
23. Develop messages and interventions that are culturally acceptable within localized contexts, employing a variety of communication channels to reach

different targeted populations, with a special focus on high-risk and impacted communities

24. Unify messaging, education, supply distribution, as well as surveillance mechanisms, and social investigation methodology across all hubs and partners by integrating the activities of CHW and social mobilizers. This will streamline efforts, ensure consistent messaging, and enhance the overall effectiveness of the response.

Research

25. Identify Research/best practice topics and document these practices/lessons learnt from the response operations.
26. Conduct 2 documentations/best practices from the response before the end of 2023

Background on Emergency

After 12 years of conflicts, Syria is experiencing a protracted complex political and socio-economic crisis that has resulted in severe deterioration of living conditions, with 6.9 million people internally displaced and up to 90% of the population estimated to live under the poverty line: a 10% increase compared to previous years. The country has been grappling with unprecedented various and recurrent epidemics and outbreaks, most recently a cholera outbreak started in August 2022 and was declared on the 10th of September 2022 by the Syria Ministry of Health (MoH).

As of the 20th of May 2023, 132,782 suspected cholera cases have been reported from all 14 governorates, including 104 associated deaths to date at a case fatality rate of 0.08%[2]. Across all affected areas of Syria, at least 8 million people are at elevated risk for acute watery diarrhea due to the ongoing water crisis, damaged water, and sanitation networks, overcrowded IDP sites, and insufficient access to WASH services. The recent devastating earthquake in February 2023, caused significant disruption to the cholera response as well as exacerbating cholera risks with sometimes overcrowded reception centers, damage to already fragile water, sanitation, and health infrastructure, and reduced access and capacity of responding partners.

[2] WoS CHOLERA OUTBREAK SITUATION REPORT NO. 17, 18th June 2023

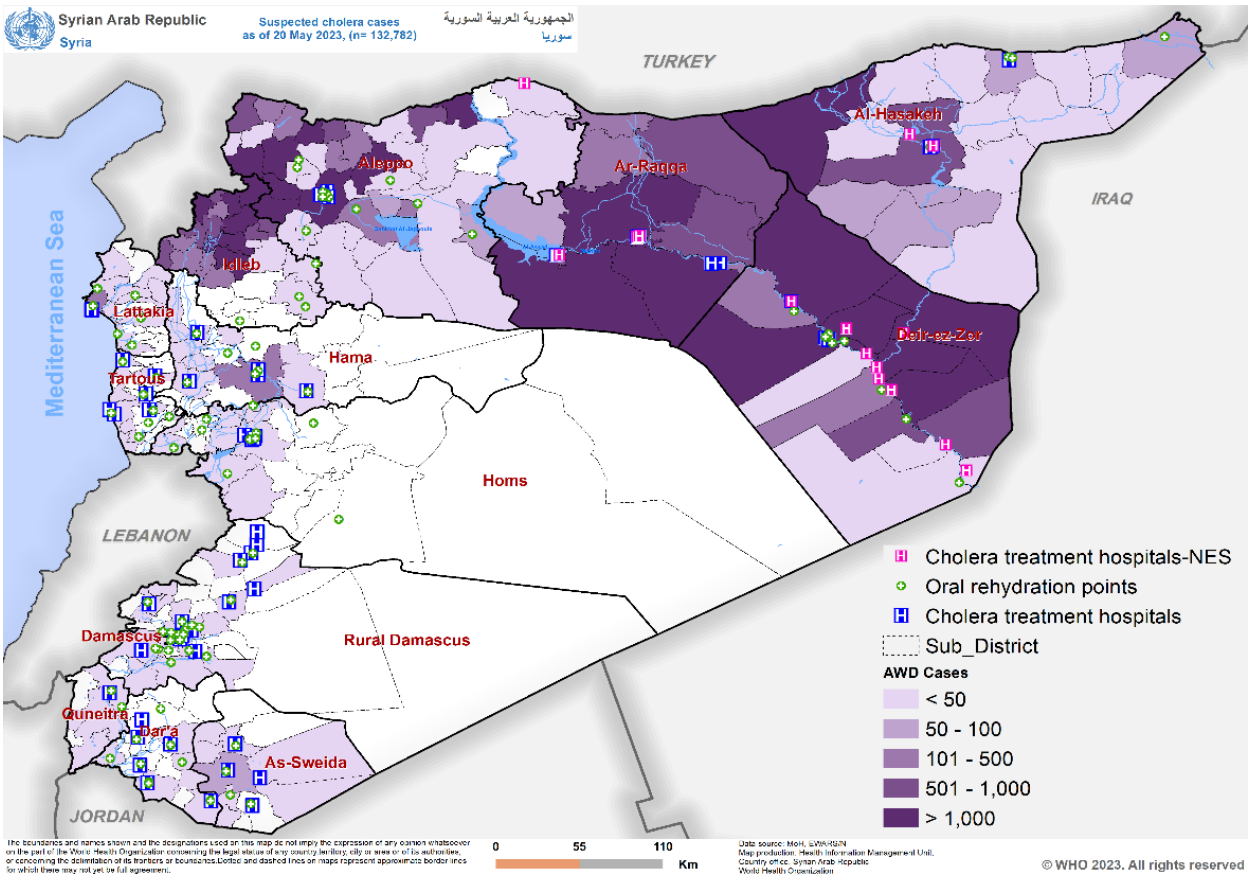


Figure 1. Distribution of suspected cholera cases by date of onset as of 20 May 2023

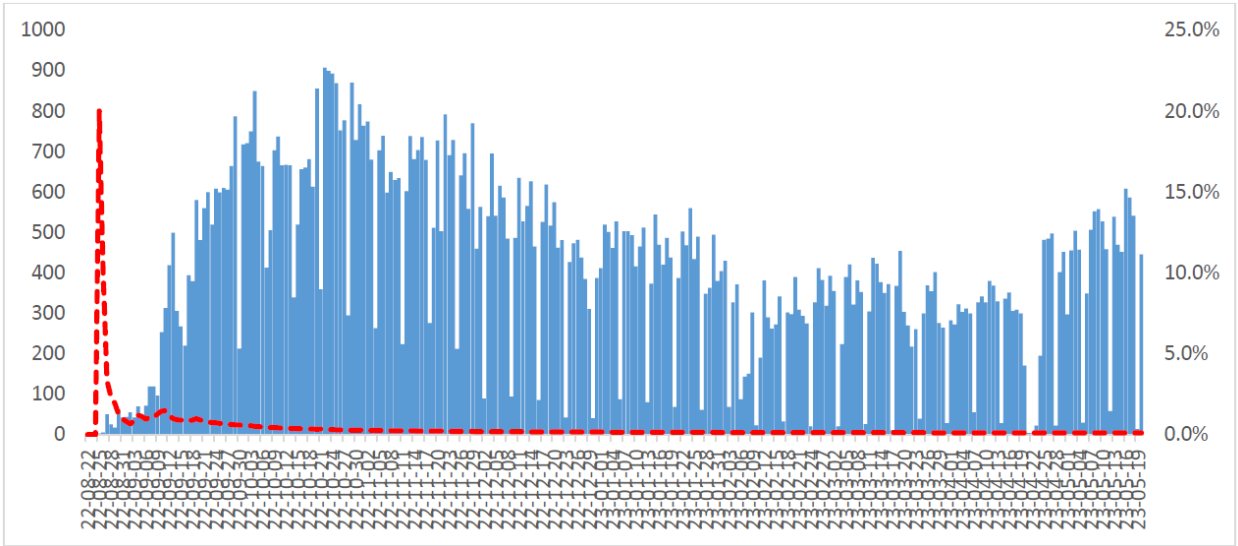


Figure 2. Distribution of suspected cholera cases by date of onset, as of 20 May 2023. In red, are the associated deaths.

Since the outbreak was declared, collective efforts at WoS level and across all operational response areas have been made to contain and respond to the cholera outbreak across Syria, with health, RCCE, and WASH partners supporting several activities based on the response pillars. This IAR aims at refining the ongoing response activities in the short term, ensuring a

coherent response is carried out across WoS, and looking at actions taken so far within the response, to build on lessons learned and lay the foundation to prepare medium- to long-term strategic plans for the elimination of cholera from Syria.

Following the outbreak declaration, a joint coordination cell was established at WoS level and Incident Management System (IMS) was activated at Syria Humanitarian Country Team (HCT), and NWS levels led by WHO/Health Clusters with the support of UNICEF/WASH cluster. A cholera coordination working group was also formed under the leadership of the NES forum.

Intra-Action Review (IAR)

Objectives

1. Document major progress achievements, and challenges and compile lessons learned by various stakeholders across response areas.
2. Review communications, coordination, and information sharing between hubs and sectors to enhance data harmonization and response coherence.
3. Identify priority preparedness actions that need to be implemented immediately, to ensure a better response in the subsequent waves.
4. Identify short-term actions needed to strengthen the necessary capabilities of the public health system and WASH services.
5. Outline long-term strategies for the elimination of cholera through multi-sectoral and integrated response mechanisms.

Methodology

The IAR used a qualitative participatory approach guided by the standardized WHO AAR guidance[3]. Over the two days of the IAR, participants discussed through focus groups the 8 response pillars of the cholera outbreak in Syria; what went well, what didn't go well, challenges, and recommendations during the previous period of the outbreak from August 2022 - May 2023 using the Global Taskforce for Cholera Control (GTFCC) Cholera Preparedness and Response Framework[4] and the previous WoS Response Plans[5].

[3] WHO, Guidance for after action review (AAR), https://www.who.int/publications/i/item/WHO-WHE-CPI-2019.4
[4] GTFCC, Cholera Outbreak Response Field Manual, Section 3: Organization of the Response, https://choleraoutbreak.org/book-page/section-3-organization-response
[5] Wos September – December 2022 Cholera Preparedness and Response Plan, and WoS January - June 2023 Cholera Response Plan.

In addition to presentations, the following groups had in-depth discussions on each response pillar and took notes on what went well, not well, and what corrective actions needed moving forward.

Group 1- Leadership and Multi-Sectoral Coordination.

Group 2- Surveillance and Laboratory

Group 3- Case management and IPC

Group 4- Supply and Logistics.

Group 5- Water, Sanitation, and Hygiene (WASH)

Group 6- Risk Communication and Community Engagement

Group 7- Oral Cholera Vaccination

Group 8- Research

Key Findings

Timeline of the outbreak

Event	**Timeline**
date of start of outbreak or event	25th August 2022
date of detection of outbreak or event	25th August 2022
date of notification of outbreak or event	10th September 2022
date of verification of outbreak or event	22nd August 2022
date of laboratory confirmation	25th August 2022
date of an outbreak or event intervention	22nd August 2022
date of public communication	10th September 2022

date outbreak or event declared over	Ongoing
Cholera operational review period	May 15th -16th, 2023

Pillar 1- Leadership and Multi-Sectoral Coordination.

The pillar ensures leadership and coordination of the cholera outbreak preparedness, readiness, response, and early recovery. The pillar promotes multisectoral coordination mechanisms and integrated response programming, unified response operations, enhancing advocacy and resource mobilization for the outbreak.

What Went Well

1. Immediate Risk Assessment and immediate notification to IHR and declaration of emergency.
2. WoS Joint Response planning – An initial 4-month joint health and WASH sectors response plan was developed and later revised and extended until June 2023. These also include RCCE.
3. An operational response plan developed per hub aligned with overall WoS plan.
4. Weekly/and bi-weekly WoS joint health and WASH cholera coordination meetings, with RCCE participation.
5. Two joint KPIs were developed at WoS level to track progress against targets across all hubs.
6. Operational Cholera Taskforces were formed in NES and NWS.
7. A RCCE Working Group was established in NWS and Syria HCT (One voice- One strategy)
8. 17 Regular and Joint WoS Situation reports were produced from September 2022 to June 2023. They were released weekly initially and later bi-weekly[6]
9. Over 6 WoS donor briefings were conducted and updated donors on the progress, gaps, and resources required from September 2022 to April 2023.
10. Inclusion of Cholera plan in HRP to facilitate resource mobilization.
11. Weekly briefing to high-level coordination meetings in – UNHCT, and UNCT on status, key achievements, and obstacles.
12. Inclusion of Prevention of Sexual Exploitation, Abuse, and Harassment (PRSEAH) in programmatic planning.

[6] WoS Situation Reports https://reliefweb.int/updates?advanced-search=%28PC226%29_%28S1275%29_%28T4595%29_%28F10%29&search=title%3A%22cholera+outbreak%22+AND+%22whole+of+syria%22&_gl=1*l6qxwx*_ga*MTA5MjYyNDEzMS4xNjg2MTI0NjU1*_ga_E60ZNX2F68*MTY4NjEyNDY1NC4xLjEuMTY4NjEyNDkzMC40MS4wLjA.

13. Collaborative coordination mechanism during planning and implementing the Cholera Vaccination campaign leveraged relationship with government and local authorities implementors.

What didn't go well/Gaps and Challenges?

1. Minimal hub and health cluster partners' involvement in KPI selection, with irregular feedback from hubs.
2. Poor supply coordination between WHO and UNICEF especially regarding distribution and monitoring across hubs
3. Fragmented governance in NWS and NES has led to weak leadership and ownership of the response.
4. Limited financial resources to scale up response operations.
5. Limitations around unified and strong accountability measures across all hubs to monitor funds and supplies.

Corrective recommended actions

1. Improve regular intersectoral coordination at the hub level – Conduct joint Health and WASH cluster and RCCE regular coordination meetings at the operational level (hubs and sub-national level) with follow-up of the action points.
2. Resource mobilization – Continue to conduct regular donor briefings and enhance advocacy efforts at all levels.
3. Improving involvement of national authorities and local partners in coordination – Engage MoH and local authorities on medium to long-term cholera/AWD preparedness and response strategy.
4. Syria HCT to advocate with GoS for the introduction of a long-term National Cholera Plan according to the Global Taskforce for Cholera Control (GTFCC) roadmap.
5. Re-activate the Operations Support and Logistics (OSL) pillar co-led by WHO and UNICEF at WoS and hubs level, by identifying focal persons and holding coordination meetings with clear actions.
6. Identify high-risk areas for preparedness, prevention, and response, and develop targeted prioritization activities plan accordingly.

Pillar 2- Surveillance and Laboratory

To ensure timely and structured disease detection and investigation of cholera alerts enable rapid emergency response and ensure control measures are put in place. Rapid information sharing through established communication channels is essential to ensure data consolidation, analysis and inform strategic decision-making.

And to strengthen and maintain the capacity to test and confirm samples including samples from suspected cholera cases and monitor drinking water quality promptly to guide response and surveillance actions.

What Went Well

1. Detection and confirmation of the outbreak through existing EWARN and EWARS systems.
2. Utilization of standard case definition and sampling strategies as per GTFCC guidelines and sampling strategy across all response areas.
3. Existing EWARN and EWARS surveillance involvement in the cholera response, rapid initiation of training of RRT teams across all areas, and integration of data from all three hubs at WoS level.
4. Early identification of key Indicators for follow-up of the outbreak.
5. 7 labs in Syria HCT controlled areas, 3 in NWS and 1 in NES have been supported and provided with testing capacities including culture and sensitivity.
6. Provision and wide distribution of RDTs in the affected areas to EWARN and EWARS labs and operational partners running CTCs/CTUs.
7. Communication of surveillance data between health and WASH RRTs was adapted to each hub context and surveillance system.
8. Utilization and communication of surveillance data for effective RCCE and WASH at the community level.
9. Up-to-date information on hotspot areas and analysis of epidemiology to develop OCV proposal.

What didn't go well/Gaps and Challenges

1. Fragmented surveillance systems and tools across the three response areas (EWARN, EWARS, MoH/Cholera hospital-based surveillance).
2. Despite the preexisting EWARN and EWARS systems, the overall surveillance and lab performance was weak and fragmented across all hubs especially in NES, with overlapping and duplication of surveillance data in some geographical areas and inconsistency of reporting by all 3 sources of information.
3. Delays in epidemiologic data provision (timeliness) and absence of Community and event-based surveillance.
4. Delays from data sources to support all aspects of operational response at the local level.
5. Inaccessibility and presence of large hard-to-reach areas pose difficulties in the operational response capacity of case investigation and sample transportation.
6. Lack of specificity of the suspected cholera case definition that overwhelmed the RRT in charge to investigate the cases and led to a dilution of the WASH interventions
7. Insufficient RRTs personnel to investigate cases reported at PHCs.
8. Logistic difficulties to transport samples from some governorates due to fuel shortages.
9. Unavailability of microbiology labs in some governorates for necessary culture testing. Linkage of laboratory reports to cases.
10. Unavailability of alternative lab diagnosis of AWD in some areas (i.e., Rotavirus.)

Corrective recommended actions

1. Enhance field-level operational response monitoring – Conduct monthly/Quarterly joint supervision and monitoring.
2. Necessity for investment into data management control at all levels to enhance data quality.
3. Set up Community-based and Event-based surveillance systems across all hubs.
4. Scale up RRTs coverage and integrate WASH and Health RRTs.
5. Timely and regular data sharing and synchronization of surveillance systems across all three hubs and scale-up surveillance coverage in NES.
6. Assign data collectors to inform WASH partners CATI/CORT approach.
7. Integration of reporting forms to enable easier interpretation of data.
8. Enlarge the scope of enteric pathogens tests available (rotavirus, etc.) to improve the diagnosis of AWD.

Pillar 3- Case management and IPC

To ensure rapid access to quality treatment to reduce preventable morbidity and mortality (CFR <1%). And to ensure that robust systems and capacities are in place at all levels to reduce the risk of healthcare-associated infections. Enable functional and hygienic healthcare environments to ensure the quality of care of patients and staff safety within health facilities through the establishment and reinforcement of IPC standards and transmission-based precautions. Reduce the risk of health and care facilities amplifying transmission of cholera and initiating clusters and outbreaks of other infections transmissible in health and care facilities when managing acute caseloads.

What Went Well

1. Overall Case fatality rate was kept below the threshold across all hubs – in May the CFR stood at 0.09% which is below the threshold.
2. Setting up 53 CTCs/CTUs in HCT areas, 9 in NWS, and 1 CTC/CTU in NES across response areas since the declaration of the outbreak, in addition to 31 Oral rehydration points (ORS) at community and PHC level.
3. Adaptation and contextualization of GTFCC guidelines to the local context.
4. Over 5,000 care healthcare staff have been trained on case management protocols and guidelines; the training contributed to the reduction of the case fatality ratio from 0.78 % to 0.1 % between September 2022 and January 2023.
5. AWD posters including updated case management flow charts and ORS been printed and distributed to all CTCs/CTUs.
6. Integrated standard IPC/WASH measures in the context of outbreaks including AWD in draft for updated national IPC guideline.

What didn't go well/Gaps and Challenges

1. Adherence to case definitions by health staff and weak reporting mechanisms from treatment centers.
2. Poor community acceptance of CTCs and CTUs.
3. Not enough facilities to meet the number of patients in NES and referral gaps across all hubs.
4. Delays in issuing context-specific cholera and malnutrition guidelines
5. Poor IPC and WASH in health facilities, especially regarding fecal sludge management.
6. Chronic staff shortage and high turnover across all areas.
7. Short-term funding of health facilities and phasing out of many partners in the middle of the response.
8. Setting up of CTCs/CTUs that were not fully guided by epi data/hotspot identification.
9. Key issues around infrastructure and SOPs limitations at CTCs, including:
    - Deficient standard liquid medical waste management infrastructure inside CTCs/CTUs to disinfect AWD secretions before pouring into sewage.
    - Standard Cholera beds.
    - Designated CTCs/CTUs laundry unit.
    - Designated room to handle deceased Cholera cases inside some CTCs/CTUs especially those at PHC.
    - Bathrooms for AWD patients inside CTCs/CTUs compared to bed capacity.
    - Standard CTC is designed to isolate Cholera cases from clean/other units; triage and first-line treatment for suspected moderate and severe cases are usually conducted in ER, and severe cases are isolated at CTCs/CTUs.
    - Designated sterilization equipment in CTCs/CTUs; however, samples and lab consumables are treated at the central sterilization unit.
    - Segregation of solid medical waste management which is under Municipality tasks outside the CTCs.
    - High turnover for some trained staff/or staff being overwhelmed with other tasks entails the need for continuous training to sustain the facility readiness and HCWs capacity.
    - Insufficient training and monitoring of standard IPC and PPE measures during Cholera outbreaks for cleaning and maintenance staff working at CTCs/CTUs.
    - Limited supervision capacity due to shortage in fuel supplies, to monitor quality of care and fulfil gaps.
    - Insufficient funds to support IPC activities, such as procurement of IPC supplies to sustain best practices with a focus on environmental cleaning and medical equipment disinfection at public hospitals in general and CTCs/CTUs in specific.

Corrective recommended actions

1. Improve WASH and IPC in health facilities including fecal sludge management, especially at CTCs/CTUs and those receiving a high flow of cholera patients.
2. Provide resources to maintain cholera treatment facilities in hotspots and maintain health workforce support.
3. Translate and contextualize training materials and guidelines to local languages.
4. Improve preparedness and readiness by training more healthcare workers and prepositioning supplies to health facilities, especially in target hotspots.
5. Track case management training through the database, monitor, and coach trained personnel.
6. Address CTC/CTU infrastructure gaps in accordance with the SOPs and guidelines.

Pillar 4- Supply and Logistics.

To ensure supplies, equipment, and lifesaving goods are made available in appropriate quantities and quality to at-risk communities to ensure structured and capable preparedness and response activities.

What Went Well

1. Over 32 tons of cholera supplies have been distributed across all hubs.
2. The supply distribution was targeted mainly to hotspots and affected facilities in the target areas.
3. Storage and distribution capacity in HCT and NWS was effective.

What didn't go well/Gaps and Challenges

1. Weak coordination, monitoring, and tracking of supplies.
2. Global shortage of cholera supply and global shipping delays affected response operations in the initial phase specifically in NES – cholera kits, lab supplies, Aquatabs, chlorine.
3. Difficulty in chlorine transfer cross-border and crossline.
4. Shortage of funds to procure supplies both external and local.
5. Sanctions and wavering exchange rates affected the availability of procurement of items in the country.
6. In the HCT area, general conditions of lack of reliable banking systems led to difficulty in transferring payments to beneficiaries; Lebanon's economic crisis closed the only window that was used for securing urgently needed supplies; the fuel crisis that affected inland transport including MoH/DoH distribution capacity; local currency devaluation and the withdrawal of key local suppliers and service providers; delays in receiving documentation from the global suppliers and approvals from the local authorities delayed GL approvals; all together contributed to impairments in supplies and logistics provision.

Corrective recommended actions

1. Strengthen the coordination of the Operational Supply and Logistics (OSL) pillar led by WHO and UNICEF across all hubs.
2. Prepositioning of WASH, Lab, and treatment supplies ahead of the expected second wave.
3. Provide resources to procure supplies, based on the response plan identified, needs, and prioritized geographic and priority groups.
4. Monitor supply use and distribution for better accountability across all hubs through a common tracking system/Dashboard.

Pillar 5 – Water, Sanitation, and Hygiene (WASH)

Ensuring appropriate lifesaving WASH prevention and response measures with special attention to the at-risk populations and improving IPC WASH interventions in cholera health facilities are key to controlling the spread of AWD/cholera and reducing morbidity and mortality.

What Went Well

1. Use and rehabilitation of existing local WASH systems.
2. Contributed to preventing big outbreaks in camps by ensuring and scaling up continued access to WASH services, and water quality monitoring with a focus on free residual chlorine (FRC) and hygiene promotion activities.
3. Soft components, adapted hygiene promotion activity in collaboration with RCCE
4. Internal and external coordination: good coordination of the WASH pillar among WoS and Hubs level, with regular meetings held, guidance developed (WASH/IPC in school, SOP, etc.), and contribution to the development of multisectoral response plans, sitreps, advocacy messages, lessons learned and other documents.
5. WASH pillar collaborated with RCCE, Education Cluster, and Health Cluster for specific tasks and with the GWC and UNICEF at HQ, regional, and country offices for specific programmatic aspects.
6. Supported the set-up of sustainable solar panel systems and private water tankers in NES.

What didn't go well/Gaps and Challenges

1. Few organizations were involved in the response.
2. Sharing household positive cases and water testing information within 24 hours.
3. Weak water quality surveillance and monitoring.
4. Inadequate IPC in schools.
5. Limited adaptation of CATI/CORT approach.
6. Limited coordination and duplication/overlapping in community information development, sharing, and engagement between WASH, health promotion, and RCCE teams.
7. Limited funds to rehabilitate WASH systems.

8. Open sewage and poor WASH infrastructure and energy crisis specifically after the earthquake
9. Uncontrolled private water trucking in many parts of the country.

Corrective recommended actions

1. Develop a targeting prioritization plan to identify high-risk areas, with the support of the health Cluster.
2. Advocate for rehabilitating infrastructure and for WASH system recovery adapted to climate change and water scarcity crises.
3. Longer-term strategies and sustainable solutions to maintain WASH networks.
4. Strategy to engage with the private sector to ensure water quality monitoring and increase water quality investigations at the field level, based also on a survey to understand the water trucking landscape.
5. Finalization and context specific adaptation of the SoPs developed at WoS level and dissemination of the SOP to all involved partners at hub level A.S.A.P.
6. Engaging and supporting farmers on irrigation water sources.
7. Continue to advocate to avoid the use of “access to water” as a political and war weapon and ensure the right to safe water for everyone (Alouk, Al Bab) is maintained.
8. Ensure the availability of chlorine and people’s acceptance of chlorinated water.

Pillar 6 – Risk Communication and Community Engagement (RCCE)

The goals of the RCCE pillar are to (I) ensure that structures are in place at both, the national and sub-national levels, to plan, resource, coordinate, and manage RCCE activities to facilitate engagement, information sharing, and inclusion of affected and at-risk communities in the planning implementation and evaluation of all relevant components of outbreak readiness and response. (ii) Create an environment that enables effective communication and dissemination of RCCE messaging in a timely and appropriate manner and through trusted channels to encourage the adoption of preventative, protective, and care-seeking behaviors within the affected communities. (iii) address rumors and misinformation that may circulate within at-risk communities and establish appropriate channels that are accessible and trusted by these communities to address and counteract false information, and finally, (iv) ensure that RCCE activities are informed and regularly updated by socio-behavioral data and the evolving needs of the affected communities.

What Went Well

1. Existing RCCE coordination mechanisms, strategies, and action plans were in place to guide the response under the interagency RCCE working group.

2. Existing networks and channels were used to disseminate information to communities; for example, using existing COVID-19 coordination mechanisms and networks and previous RCCE partners and CHWs mapping exercises.
3. Evidence-based approaches to RCCE were applied, by using behavioral insights, social listening, and community feedback
4. Tailored and targeted training packages and resources for prompt training and deployment of existing community health workers (CHWs) were rapidly developed to disseminate cholera messages after the outbreak.
5. RCCE products were developed based on specific identified needs; followed by sharing and reusing materials across the three hubs.
6. Innovative methods were utilized.
    - Use of PwD material - IEC materials were made in accessible formats to include people with disabilities like the use of sign language in videos in NWS
    - Joint RCCE, WASH, and health in RRT in NWS.
    - Optimization of the allocation and use of scarce resources to meet implementation needs in the absence of funding.
    - RCCE activities were adapted to suit different population contexts, utilizing impactful channels (such as the Farmer's Union addressing people working in agriculture), to ensure the accurate and clear conveyance of the message
7. Integration of RCCE activities with WASH and Health interventions, including messaging on Oral Rehydration Solution (ORS), Oral Cholera Vaccine (OCV), health referrals, and WASH practices, etc.
8. Unifying and coordinating all messages and utilization of common tools across RCCE partners (WoS).

What didn’t go well/Gaps and challenges

1. Irregular sharing of RCCE data across clusters, and between partners
2. Weak Monitoring and Evaluation (M&E).
3. Fragmentation and duplication of RCCE messaging, supplies, and community interventions.
4. Linking messaging with supply availability.
5. Poor household targeted messages.
6. Meagre activities during the early response phase, which led to an increasing number of cases.
7. Duplication of effort with WASH hygiene promoters conducting health/hygiene promotion, which is also being undertaken under by RCCE pillar.
8. Limited availability of assessments to inform about community perceptions and behavioral insights Lack of preexisting Arabic material. Time and effort were needed to translate and contextualize material to the Syrian needs and specificity of each region.
9. Limited dedicated funding sources and restricted allocations and disbursement measures for resources available.

10. Lack of initial social norms analysis before setting the cholera interventions that led to inefficient actions.

Corrective recommended actions

1. Integrate RCCE with all operational pillars and incorporate it in the national response plan and structures to support the collection of behavioral insights and community feedback to inform further investment.
2. Conduct baseline KAP surveys and other assessments to inform continued response efforts, including conducting baseline KAP surveys.
3. Go beyond information sharing and prioritize behavior change, focusing on shifting social norms around water safety and hygiene to promote sustainable behavior change.
4. Identify specific training needs of the different categories of community workforce and ensure continuous monitoring and on-ground coaching to ensure needs-specific capacity-building activities of CHWs and health staff.
5. Empower the RCCE group to lead qualitative M&E and qualitative research, in the form of field focus group discussions, surveys, and social norm analysis.
6. Map and mobilize community influencers and active grassroots organizations to ensure the involvement of local influential actors across all hubs in the decision-making process and to enhance the community's sense of partnership and ownership.
7. Strengthen coordination and collaboration between WASH and RCCE pillars for the joint co-design and implementation of community-led WASH interventions to address cholera effectively.
8. Address funding gaps within RCCE by embedding it as a standalone budget line item in different proposals, noting it is a cross-cutting function that supports all operational pillars of the response.
9. Integrate social and behavioral data into risk assessment and routine monitoring, to inform decision-making and continued operational response strategies.
10. Enhance coordination between RCCE partners and NGOs/CSOs at the subnational level, including the establishment and coordination of subnational RCCE/cholera working groups to support coordinated local action and address emerging issues.
11. Work within high-risk communities in partnership with WASH and Health pillars, to co-design local solutions to persistent cholera risks e.g., sanitation services; water monitoring; agricultural practices adaptation to address identified risks.
12. Establish mechanisms to actively involve communities in disease surveillance efforts by training and equipping community members to identify and report cholera cases promptly
13. Develop communication campaigns that are tailored for high-risk communities to address their unique challenges and barriers

Pillar 7 – Oral Cholera Vaccination

To ensure effective and early implementation of oral cholera vaccine (OCV) campaigns in strategic high-risk communities identified by active surveillance to help mitigate the impact of cholera outbreaks. OCV should be used in conjunction with other cholera prevention and control strategies and activities.

What Went Well

1. Early development of OCV plan and multi-agency/multi-forum advocacy resulted in immediate approval, fund granting, and timely delivery of 3.8 M vaccines despite the global shortage.
2. In the first round of the OCV campaign, a total of 1,944,807 and 1,762,383 people were vaccinated representing 98% of the target population in GOS/NES and NWS respectively.
3. Crossline vaccination supply to NES.
4. Priority RCCE covered with proper social mobilization which contributed to increased community acceptance, and high vaccine uptake.
5. Existing agreement of prioritization of vaccine administration in GoS-controlled areas and non-GOS-controlled areas ensured equity in vaccine distribution and accessibility by affected populations.
6. Day-to-day follow-up in the implementation of the vaccination campaign complemented by independent monitoring and the concurrent post-campaign survey was conducted to inform future campaigns.

What didn't go well/Gaps and Challenges

1. Weakness around campaign planning and coordination with other sectors mainly in NES
2. The campaign started late considering the beginning of the outbreak.
3. Global Vaccine shortage led to adopting one dose instead of two to accommodate the limited OCV quantities.
4. Planning and targeting in HCT areas:
   a. Difficult to target, population figures based upon the census conducted in 2004.
   b. The high uptake for vaccines in untargeted areas especially in cities.
   c. Continuous population movement internally.
   d. Reluctance in providing very few vaccines to avoid public comments that would reflect bias.
5. Operations in HCT areas: Difficulty in the transportation of vaccines to the affected areas, Experienced delays for OCV in eastern Deir-Ez-Zor and Hassakeh governorates.

Corrective recommended actions

1. Plan to conduct the 2nd dose of OCV in targeted hotspots to increase its efficiency.

2. Perform community perception surveys and evaluate OCV campaign efficiency.
3. Inclusion of community stakeholders: grassroots organizations, influencers, school educators, youth organizations, media, and religious leaders in the planning and implementation of future OCV campaigns.
4. Integrated activities package of health and wash information and messages in OCV/RCCE campaigns.
5. Advocate for Rotavirus vaccination for children under 5.

Pillar 8 – Research and Learning

To support WoS, hubs, and partners in learning from the response and documenting lessons learned and best practices. Also, for global information sharing between operations.

What Went Well

1. Having research and learning pillars as part of the response plan.
2. Conducting lessons learned exercises and documenting the best practices per pillar after the first wave of the outbreak.
3. Conducting this cholera operational review process.
4. Ongoing WASH study in NES and a health study in Aleppo.

What didn't go well/Gaps and Challenges

1. Using/documenting available data to inform ongoing response operations and also formally document and publish.
2. Funding gaps to support research, documentation, and best practices from the ongoing response operations.
3. Capacity gaps to conduct operational research at WoS and across all hubs.

Corrective recommended actions

1. Identify priority research areas jointly and document best practices and learning.
2. Collaborate with relevant academic institutions and organizations to conduct operation studies and research.
3. Develop future short – long-term plans based on evidence and learnings from the response operation.
4. Establish a national repository and a process for constantly exchanging and receiving resources and material that can be contextualized to meet the needs.

Overall Immediate Actions and next steps

The following action points were identified by the working groups as follow-up points, it was agreed that several multi-level meetings are needed to strategies and plan for the implementation of these action points.

SN	Actions	Responsibility	Time frame
1.	Revise KPIs jointly and work on the integration of reporting.	All Hubs/WoS	June
2.	Identify research/best practice documentation topics and implement research.	WoS	May-Dec
3.	Updating Cholera response plan to cover July – Dec 2023	WoS	June/July
4.	Finalize Cholera operational review report	WoS	End of June
5.	Follow-up meeting with global health and WASH cluster team on intersectoral collaboration/operational review report finalization/ documentation and learning	WoS and Global Health & Wash Cluster	June/July
6.	Finalize Surveillance synchronization exercise in NES and address its gaps across all hubs.	WHO	May-June
7.	Conduct integrated health and WASH coordination meetings at the hub level	Hub coordinators	May-June
8.	Enhancing governmental/authority involvement and community ownership and inclusion in programming for Cholera's second wave.	Health clusters, WASH, and RCCE interagency working group	May-June

9.	Prioritizing advocacy for WASH infrastructure rehabilitation	WoS WASH	May-June
10.	Address WASH and IPC gaps in Cholera Treatment Facilities.	WASH/Health	May-June
11.	Scale up Referral support in hotspots	Hubs	ASAP
12.	Strengthen Supply planning, coordination, and monitoring	WoS	May-June
13.	Integrating CHWs and Social mobilizers activities through unifying messaging, education, supply distribution, and surveillance mechanisms across all hubs and partners.	RCCE, WASH, & Education	May-June
14.	Enhance advocacy and resources mobilization efforts at all levels	All	

Annexes

Mentimeter-based survey results, and Agenda.

Agenda - Whole of Syria
Health and WASH Joint Cholera Operational Review (Intra-Action Review)
May 15 – 16 2023 Amman, Jordan

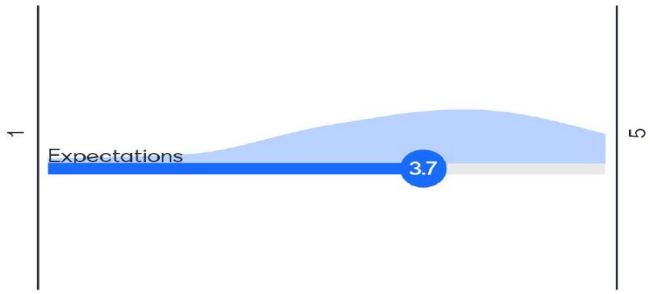
Time	Subject	Presenter
DAY 1		
8:30 - 9:00	Registration	
9:00 – 9:20	Opening remarks	WHO, UNICEF
9:20- 9:35	Introduction, objectives, and Expectations of the meeting	WoS Health and WASH
9:35- 10:15	Overview of high-level (strategic) actions taken so far and achievements made since the cholera outbreak was declared.	WoS Health / WASH
10:15 - 10:30	**Coffee/tea break**	
10:30-11:00	Overview of AWD/cholera epidemic situation in the last two years 2021/ 2022 and Trend Analysis	WHO WoS
11:00- 11:30	WASH– Current situation, risks, and challenges	UNICEF WASH
11:30- 01:00	Cholera Integrated Operational response including the recent impact of earthquake– What went well, not well, challenges. • Syria HCT • GZT HLG • NES Forum	Response Area health and WASH cluster coordinators
01:00 – 2:00	**Lunch break**	
02:00- 02:30	Improving Integrated & Coordinated Cholera Preparedness and Response within Humanitarian Crises - Joint Operational Framework	Global Health and WASH cluster
02:30- 02:45	WoS cholera response – Specific actions to strengthen inter-sectoral collaboration and integrated response programming at all levels	All
02:45- 03:45	World Café on tables based on Pillars – The groups based on the response pillar will review what went well, and not well, lessons learned, challenges, and propose recommendations. • Leadership and Multisectoral coordination, • Surveillance and Laboratory. • Case management including IPC. • RCCE • WASH • OCV • Research and learning • Operational support, supplies, and logistics	
03:45 - 4:15	Group feedback and Wrap-up	
DAY 2		
8:30- 9:00	Recap of First Day	
9:00 – 9:30	WoS Cholera response Information management and monitoring – IM Products status, progress against targets	WoS IMOs
09:30- 10:30	RCCE strategies: Intersectoral operational and SBC effective strategies	UNICEF
10:30 - 10:45	**Coffee/tea break**	
	Group Work	

10:45- 11:45	• Group 1 – Immediate corrective actions to strengthen preparedness and reinforce ongoing response operations. • Group 2 – Medium to long-term strategic actions toward cholera elimination in Syria • Group 3 – Enhancing advocacy and resource mobilization. • Group 4 – Priority actions to strengthen info-sharing and response monitoring. • Group 5 – Specific actions to improve intersectoral collaboration and integration. • programming • Group 6 – Strengthening cross-cutting elements within the response including protection, GBV, education, etc.	
11:45- 1:00	Group feedback	
1:00 – 2:00	Lunch break	
02.00 – 02.30	Priority Areas for Documentation and Learning for cholera response	
2:45 – 3.00	Summary of key actions agreed with timelines and next steps	
03.00 – 3:15	Wrap up and closure	

Mentimeter results

On a scale from 1 to 5 (1 lower limit – 5 upper limit), Did the workshop meet its expectations?

Mentimeter



What would you highlight and recommend for the next joint WoS cholera response workshop?

29 Answers

Mentimeter

Less presentations	Fewer slides.	More field partners involvement
More partners	More time to hub specific updates.	Much more practical session
More time for group discussions	Dream world	Involve more partners from field level

What would you highlight and recommend for the next joint WoS cholera response workshop?

29 Answers

Mentimeter

More time for discussions	Involve remote colleagues more on working groups	More involvement of the partners
Stop the defensive attitude between WHO and UNICEF.	More time to discuss issue widely	More schaduled topics with cleqrer expectation and time
Ensure better participation of the online participants	More practical, operational lessons learnt sharing	I would recommend that people gather informally on the first day and meet each other it will support sharing ideas and understanding each and everyone role that was played in the response

What would you highlight and recommend for the next joint WoS cholera response workshop?

29 Answers

Mentimeter

- Better illustrations to what worked and what did not work. Analyze.
- To be more detailed on the area level to highlight for each region and sector
- Invite the WHE team leads
- Group work could focus on hubs than mixing it up. There is vast difference between syria nes and nws
- Good methodology and collaborative
- adequate time for sessions; refresher / health breaks between sessions
- Add more interactive group work, more concise presentations
- Donor Advocacy as a subsequent meeting with clear asks - Chatham House Rules - Joint Donor meeting dedicated to Cholera Resource mobilization
- Extend invitations to more partners who have presence on the ground. Focus on case studies and success stories Engage partners in drafting the agenda items

If you have the power to change something in the joint cholera response, what it would be?

28 Answers

Mentimeter

- Nothing
- More preparedness for future
- Invest more in prevention measures to avoid such a pandemic
- The national team to show ownership and leadership of the response
- Advocate for and implement full WASH Rehabilitation
- Build hospitals capacity.
- Real integration, especially bringing RCCE into the middle of the response.
- Surveillance and Vaccination data quality monitoring
- Should be inside the hotspot areas

If you have the power to change something in the joint cholera response, what it would be?

28 Answers

Mentimeter

- Need more Syrian voices
- Mobilize more OCV to reach more people
- Tools for ease of reporting to avoid additional reporting burden to field partners
- Could have done it before and would repeat it and focus on most important topics
- More time to RCCE
- Increase the funding
- Increase focus / investment on addressing root cause(s)
- Response plan AWD
- Frequent joints monitoring field visits

If you have the power to change something in the joint cholera response, what it would be?

28 Answers

Mentimeter

- Not taking too long for the response plan to be implemented and Focus on the long term solutions rather than only preventive measures (infrastructure)
- Less cooks in the kitchen
- have a reliable decision makers In the taskforce
- Nothing
- A joint effort in NES between NES F and HCT Qamishli
- Build a digital information response platform for information sharing
- I was expecting to get an answer for this question from this workshop. What is the answer for this question based on the outputs?
- Extend for extra day to have more tangable plan not only action points
- Better knowledge of transmission context