UAC/Alternative Care Guidance for the COVID-19 Situation – Iraq Child Protection Sub-Cluster

Introduction:

Children are particularly vulnerable during infectious disease outbreaks for three main reasons: 1. Children have **specific susceptibilities** to infection during infectious disease outbreaks; 2. Infectious diseases can **disrupt the environments** in which children grow and develop and 3. Measures used to prevent and control the spread of infectious diseases can **expose children to protection risks**[1]. This guidance provides an overview of the risks assosciated with disease outbreak that could **cause children to be left without appropriate parental care,** and provides scenearios for where children may be identified **as separated in Iraq** due to issues related to COVID-19.

Based on these scenarios, and the **current and potential impacts of the COVID-19 situation** on forms of alternative care in Iraq outlined in the *Guidance Note Alternative Care – CMWG Iraq 2018,* this guidance provides **practical steps and actions** for child protection case management actors to follow in order to **identify and provide safe and appropriate forms of alternative care** for children identified as seperated in and outside of camps as well as at hospitals assigned for referrals of suspected COVID-19 cases[2].

a). COVID-19 Scenarios, Risks and Criteria for UAC in need of Alternative Care:

Scenarios	**Risks Associated**
1. Child separated from caregiver in and outside of camps	Children whose caregivers fall ill, are quarantined, hospitalized or die are at high risk of being left without protection and care. Children whose family members are sick are likely to be stigmatized, socially excluded and discriminated against.
2. Child identified as separated in hospital or health/quarantine facility at the camp level[3]	Young children who caregivers are hospitalized may remain with the caregiver and be exposed to the virus. Children under quarantine and treatment may be deprived by parental care. Abandonment of children after they have received treatment or have been quarantined. Risks may exist for children who remain at the hospital e.g. risks of abuse. Quarantine facilities may be established at the camp level which could be another location where children become separated.
3. Children in institutions	Children in detention, state homes and children with their parents in prison may be exposed to the virus. Measures taken to prevent the spread of COVID-19 could impact scheduled activities and visitations in the institutions. Children

[1] The Alliance for Child Protection in Humanitarian Action, *Guidance Note on the Protection of Children During Infectious Disease Outbreaks*, 2018.

[2] The situation of COVID-19 and impacts to children and the forms of alternative care available in Iraq is constantly evolving. This guidnace is correct as of the 19th March, and will be updated as necessary depending on major changes.

[3] On the 5th March, 2020 an action point from the 1st COVID-19 Operations Cell meeting was that quarantine locations must be set up in camps – however currently suspected cases in IDP camps are being referred to local hospitals for testing. In this case, the priority is currently to plan for referrals for children identified as separated at the hospital level for scenario 2.

	with their parents in prison may require alternative care if parent undergoes quarantine or treatment.

b). COVID-19 Situation and Impact to available forms of Alternative Care

The first recorded case of COVID-19 (also colloquially known as "coronavirus") was recorded in Iraq on 24th February 2020, in the city of Najaf. Since then, 73 additional cases have been confirmed, with the majority of affected persons in Federal Iraq and approximately one-quarter of confirmed cases in the Kurdistan Region of Iraq. Eight fatalities due to COVID-19 have been confirmed as of the 12th March, 2020. The World Health Organization has declared COVID-19 to be a global pandemic.[4] Whlist there is currently no known cases of adults or children contracting COVID-19 in the IDP or refugee camps in Iraq, 3 suspected cases were recetly identified in Salamiyah IDP camp in Ninewa governorate which were found to be negative[5]. Preparedness planning for COVID-19 outbreak has become a priority, under the leadership of the COVID-19 Operational Cell appointed by the HCT to make programmatic decisions about the humanitarian response. Case management and alternative care has been prioritised as a life-saving activity in relation to the COVID-19 situation by the CPSC, particularly due to the risks which the COVID-19 presents for children as outlined above[6].

Current impacts of the COVID-19 situation on the child protection response include: Limitation of child protection services being delivered due to the closure of government offices, humanitarian access issues in Ninewa governorate, misinformation and rumors amongst the community creating fear, limitations to activities in instutions such as the stopping of family visits in detention centres.

Of major concern is the potential impacts of loss of access to camps if a case is identified in or around the camp locations (e.g. camps being unaccessile to humantiarian actors). This has been given particular consideration in providing guidance for the scenarios below, with planning covering if child protection actors have access to the affected population in and outside of the camps or not. Another concern is the potential stigmatization of adults and children who have, or who are suspected to have, contracted the virus. In this case, both kinship care and foster families as forms of alternative care have not been identified initially as highly viable options for the COVID-19 response in Iraq due to the stigmatization being assessed as a barrier for the families to agree to look after the children[7]. Awareness raising messaging will be developed in order sensitize families however this may take time to coordinate and implement in the current scenario of limited access and movement in the country.

Based on the current and potential impacts of the COVID-19 situation, the following forms of alternative care in Iraq as outlined in the *Guidance Note Alternative Care – CMWG Iraq 2018* are assessed as follows in Table 1.

[4] OCHA, *IRAQ: COVID-19, Situation Report No. 5*, 12 March 2020.
[5] Ibid.
[6] For further information regarding the prioritised CP activities please refer to document: *NPC Priority HRP Activities during COVID-19 (as of 13 March 2020).*
[7] Iraq UASC TF - Alternative Care for COVID-19 Preparedness Meeting Minutes, 12th March, 2020

Table 1: The Viability of forms of Alternative Care in Iraq in Emergency & Post-Emergency Settings in the situation of COVID-19 in Iraq

Alternative Care Modalities	**Viability for COVID-19 situation**	**Guidance**
Kinship	Based on Assessment	Based on the assessment of care arrangements and interview with the child's caregiver or with the child themselves, there may be the option of the extended family to provide kinship care for the child. If this placement takes place, this will not be under the supervision of CP actors due to the potential large-scale response possibly required by actors to support other alternative care arrangements due to COVID-19. It is important to note that in the context of COVID-19 the possibility of kindship care arrangement could be limited as a child's extended family or close friends of the family known to the child may not be willing to provide the care, due to the stigma associated with the children being separated from an infected caregiver.
Foster care	No	Placement with foster care arrangements is predicted to be difficult due to the stigma associated with the children being separated from an infected caregiver and the fear and misinformation that currently exists in the community around possible transmission of the disease.
Supported (semi-) Independent Living Arrangements	Yes	In the case of a child being separated from their caregiver when they are quarantined or hospitalized, if the CP actor or community-based CP focal point are available to mentor the children 24/7 and provide for their basic needs, the supported (semi-) independent living arrangement- adolescent headed household is considered to be a viable form of alternative care.
Residential care	No	Due to the high number children already in residential care in KRI and Federal Iraq there is currently no capacity to host additional children who have been separated from their caregiver in state homes.
Small Group-Home based Care	Yes	This modality refers to a small group of generally maximum 8 children placed together in a home in a 'family-like environment', who receive 24/7 care by designated caretakers and other staff for both in and out of camp locations. If community-based CP focal points as well as CP actors will be available to mentor the children with the support of camp management where applicable to provide the required resources such as shelter (tents), and food and non-food items, then this is a viable form of alternative care.
Emergency Transit Shelters/ Centers	Yes	In emergencies, interim or emergency shelter to temporarily host unaccompanied children in need of short-term interim care, may be necessary and appropriate in some circumstances for in and out of camp locations. Interim care is provided for unaccompanied children for the shortest period possible, until the child can be reunified.

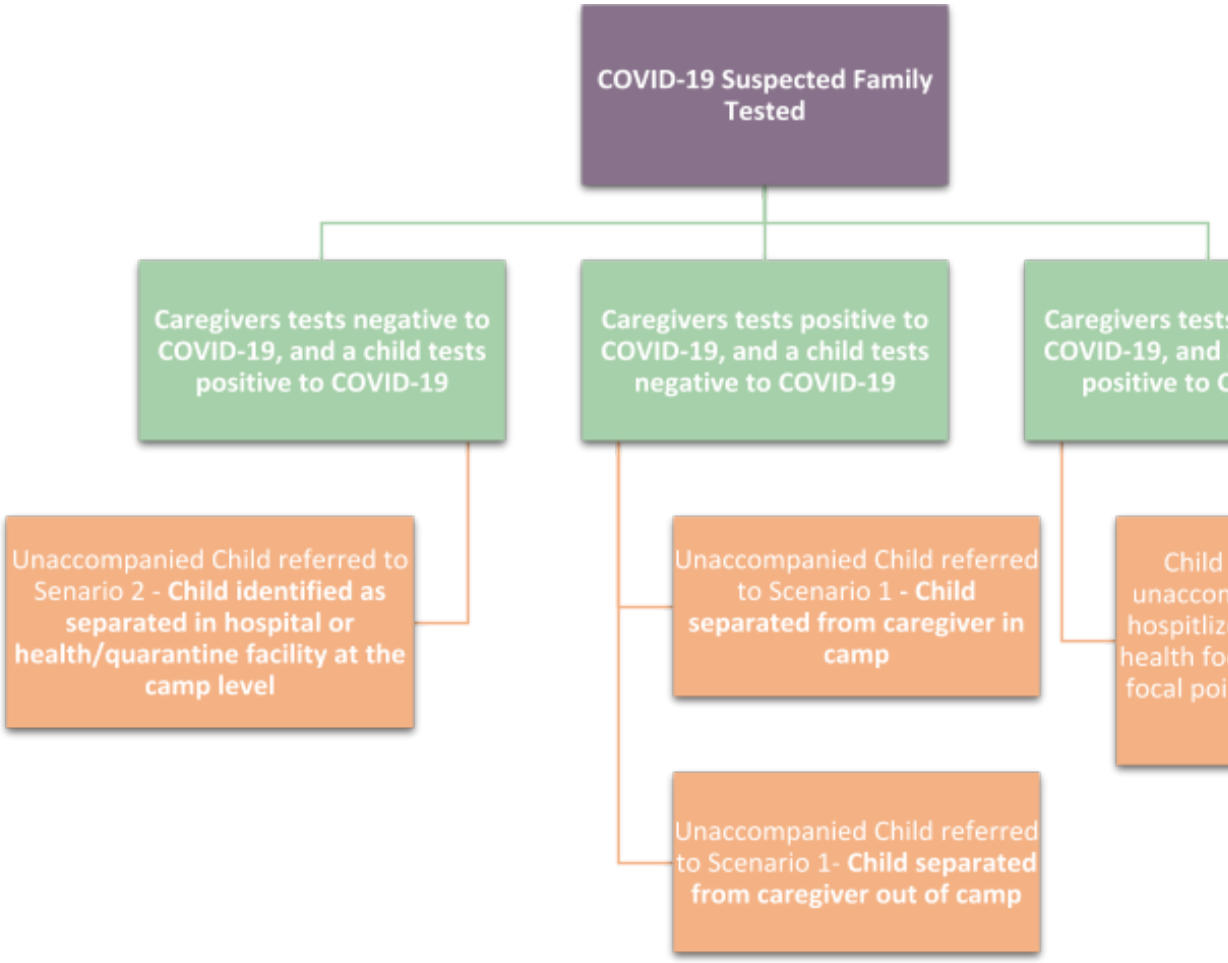
In reference to all forms of alternative care assessed as viable in regards to the COVID-19 situation, MoLSA and DoSA should be involved in the planning and implementation if they have the capacity to support where possible.

c). Coordination & Engagement with Key Stakeholders

Coordination and engagement with the Ministry of Labour and Social Affairs (MoLSA) and the Ministry of Health will be a key part of the planning process for identification of opportunities for alternative care for children in each of the agreed scenarios. In addition, coordination with the CCCM Cluster about possible need for support particulary at the camp level will be necessary. Coordination will be required at both the national, governorate and site levels. This will be facilitated by the Case Management Working Group, supported by the National Child Protection Sub-Cluster. At the governorate level the Child Protection Working Group Coordinators and the agency focal points to be assigned through the Case Management Working Group will lead on this engagement and localised operational planning.

d). Alternative Care Scenarios for COVID-19 in Iraq

Flow Chart: Referral of cases per scenario for Alternative Care Arrangment for COVID-19



Scenario 1. Child separated from caregiver in and outside of camps

Scenario 1. Child separated from caregiver in and outside of camps Children whose caregivers fall ill, are quarantined, hospitalized or die are at high risk of being left without prote whose family members are sick are likely to be stigmatized, socially excluded and discriminated against.		
	In the Camp	**Outside the**
Modalities	*If a child tests negative to COVID-19 and is without appropriate parental care then the following forms of alternative care are considered relevant depending on the age of the child including: emergency transit shelter, supported semi-independent living arrangements and child-headed household. These activities will need to be implemented in coordination with the community-based child protection mechanisms (CBCPMs) which exist in the camp as well as Camp Management, Shelter/NFI and Food Security Clusters.*	*If a child tests negative to COVI appropriate parental care, ther alternative care are considered the age of the child: Emergency semi-independent living arrang household.*
Small Group-Home based Care	Small Group Care Arrangements generally refer to a small group of generally maximum 8 children placed together in a home in 'family-like environment', who receive 24/7 care by designated caretakers and other staff. Placement or set-up of small group home care can be considered as kinship or foster care or supported independent living is not possible in case of COVID-19 or advisable. Care and protection, access to basic services, and daily activities is provided by skilled, trained staff during day and night shifts. In the camp CP actor with coordination with the CBCPCM and Camp Magamgement will set-up small 'emergency group homes' in tents in IDP/refugee camp settings, often for boys between 13 and 17 years old, where there should be 24/7 care and guards at night, which provide a viable interim care solution, until they could be reunified with their family or other relatives. DoLSA and MoLSA will be inform about the interventions by the relevant actors.	Small Group Care Arrangements g group of generally maximum 8 ch home in 'family-like environment' designated caretakers and other s small group home care can be con care or supported independent liv COVID-19 or advisable. Care and services, and daily activities is pro staff during day and night shifts. C DoSA and CBCPM if it exists to set homes' in identified shelter (e.g. h settings, often for boys between 1 there should be 24/7 care and gua a viable interim care solution, unt with their family or other relatives play a major role in the implemen care modality.
Emergency Transit Shelters/ Centers	In emergencies, interim or emergency shelter to temporarily host unaccompanied children in need of short term interim care, may be necessary and appropriate in some circumstances such as Scenario 1 of COVID-19 Iraq. Emergency transit shelters or centers will set-up and used to provide interim care for children separated from their families due to disease outbreak. Interim care is provided for unaccompanied children for the shortest period possible, until the child can be reunified. In disease outbreak context child protection actors set-up transit shelters for UAC during the emergency, which provided a viable short term care solution for the high numbers of UAC,	In emergencies, interim or emerg host unaccompanied children in n care, may be necessary and appro circumstances such as Scenario 1 Emergency transit shelters or cen during an emergency Based on Sc will aiming to provide interim care from their families due to disease provided for unaccompanied child possible, until the child can be reu

	who could generally be reunified very quickly, generally varying from a few days to a few weeks. DoLSA will need to be engaged in the planning of these facilities and coordination will also be required with the camp management and CBCPMs.	Child protection actors or the Gov transit shelters for UAC during the provided a viable short term care numbers of UAC, who could gener quickly, generally varying from a f CP actor or the Government can i hotel or other shelter could be set Coordination will be required with food and non-food items.
Supported (semi-) Independent Living Arrangements, especially Supported Child Headed Households	In some circumstances, unaccompanied children live in "child or peer-headed household", it can be a children that are otherwise related to each other. They may be informally supported by extended fam members, CP or DoSA, who do not live in the same household. It means that children have to fulfill r normally attributed to adults. Children, especially girls in child-headed households can be exposed to exploitation and need to be thoroughly assessed, closely monitored and supported and alternative a found, when this living arrangement is not in their best interests. Generally, child-headed household family or 'mentor' in the community. CP actors or DoSA staff can play this role - assisting with daily ta support and act as a point of reference for the children.	

Roles and Responsibilities

In the Camp	**Outside the Cam**
Child Protection actors: ● Conduct assessment to ensure the resources and capacities are available to provide alternative care within the camps (refer to Annex A Checklist). ● Ensure that there is CBCPM established in the camp ● Identify CPCBM focal point to ensure the possibility of mentoring children in alternative care arrangements 24/7. ● Provide support to CPCBM focal points with relevant resources and materials (incentives, phone credit), ● Ensure that CPCBM focal points have been trained on Child Protection core concept and this alternative care guidance note. ● Ensure the CP staff will be available physically or remotely in case there is no access to support the CPCMB focal points to address the needs of unaccompanied minors and alternative care arrangements. ● Coordinate with DoSA, Camp Management and other relevant stakeholders regarding the establishment of alternative care arrangements in the camps and to ensure that services are provides including food and non-food items for unaccompanied children. **Community-based Child Protection Focal Point:** ● Be availability and willingness to support the alternative care arrangements in the camp.	**Child Protection actors:** (where CBCPMs are location) ● Conduct assessment to ensure the r available to provide alternative care coordination with DoSA (refer to An ● Coordinate with DoSAs to assess the UAC emergency shelter and identify capacities exist and what is the gap. ● Child Protection need to train DoSA specifically emergency transit shelte semi-independent living arrangeme household. ● Ensure that there is CBCPM establis ● Identify CPCBM focal point to ensur mentoring children in alternative ca ● Provide support to CPCBM focal poi and materials (incentives, phone cre ● Ensure that CPCBM focal points hav Protection core concept and this alt ● Ensure the CP staff will be available case there is not access to support t address the needs of unaccompanie care arrangements.

- Be aware of CP core concepts and alternative care arrangments guidance related to COVID-19 specifically for emergency transit shelter and supported semi-independent living arrangements and child-headed household.
- Be avaliable to mentor UC in alternative care arrangments 24/7 and provide support to children who have been separated from their caregivers due to COVID-19 in the different scenarios that may arise in the camp.
- Communicate regularly with CP actor to allow remote monitoring of alternative care arrangement if CP actor is unable to access the camp.

Camp Managament:

- Ensure that planning and resource distribution in the camp includes children in alternative care arrangements
- Coordinate with CP actors, CBCPMs and CP focal points and DoSA on issues related to case management and alternative care related to COVID-19, including the supervision of alternative care arrangements where required.
- Camp Management able to provide resources for alternative care arrangments.

- Coordinate with Camp Management stakeholders regarding the establish arrangements in the camps and to e provides including food and non-foo children.

Community-based Child Protection Focal Po

- Willing to be part of this alternative Support CP and DoSA if needed.
- To get training of CP core concept a arrangments specifically emergency supported semi-independent living a child-headed household.
- CPCBM FP will be avaliable to mento arrangments 24/7.
- To communicate with CP focal point

DoSAs:

- DoSAs have the capacity to support
- DoSAs can provide resources for alt based on their capacity.
- DoSAs maintain coordination with C points to ensure the care arrangeme appropriate, safe and positive exper
- In the case of CBCPM FP does not ex avaliable to mentor UC in alternativ

<u>Points to be considered when implementing the above:</u>

- Case management registration forms should be completed with basic child information to register separated chil
- Database of UAC should be filled by CM actors and be updated regularly
- Ensure procedures are put in place to support continued remote or virtual contact between children and caregive separated due to quarantine, isolation or treatment
- Reunification will take place after the caregivers is considered recovered form COVID-19, the reunification forms caregiver and be approved by CP actor, especially for the 'in camp' context.
- Any change of care arrangement should be completed after consulting and gaining the permission of CP actors, e context.
- If the child is unable to to be reunified with family after 12 weeks of separation due to the caregiver has died as a reunification with their caregiver is no longer an option, case management actors should refer to *the Guidance N CMWG Iraq 2018* for identification of longer-term solutions and processes to follow.

Scenario 2. Child identified as separated in hospital

Scenario 2. Child identified as separated in hospital Young children who caregivers are hospitalized may remain with the caregiver and be exposed to the virus. Chi and treatment may be deprived by parental care. Abandonment of children after they have received treatment quarantined. Risks may exist for children who remain at the hospital e.g. risks of abuse. Quarantine facilities ma camp level which could be another location where children become separated.	
Key Actions	- Establishment of referral pathway between hospitals assigned to treat COVID-19 cases (including ide point in each) and Case Management actors. List of hospitals assigned for referral for COVID-19 cases i - Training and orientation of health focal points by Case Management actors including: 1). Rapid registration form for non-case management actors and process of communication with the C identified 2). PSEA and Child Safeguarding 3). Confirmation of methods of communication between child and family (e.g. safe options for visiting place), phone calls etc. 4). PSS and awareness raising materials/resources available from the CPSC. - See Checklist C in Annex for case management actors who will be the focal point for the hospital per current needs and resources available, and key proccesses to be in place.

Scenario 3. Children in Insitutions

Scenario 2. Child identified as separated in hospital Young children who caregivers are hospitalized may remain with the caregiver and be exposed to the virus. Children under quarantine and treatment may be deprived by

parental care. Abandonment of children after they have received treatment or have been quarantined. Risks may exist for children who remain at the hospital e.g. risks of abuse. Quarantine facilities may be established at the camp level which could be another location where children become separated.	
Scenario 3. Children in institutions Children in detention, state homes and children with their parents in prison may be exposed to the virus. Meas spread of COVID-19 could impact scheduled activities and visitations in the institutions. Children with their pare alternative care if parent undergoes quarantine or treatment.	
Key Actions	- Children in detention, state homes and with their parents in prison are already under the care o Government will provide the response to any needs for alternative care related to COVID-19 preparedness and response for this scenario and is in communication with the Government and will s requests for assistance that will be made.

Child Protection
Iraq Child Protection Sub-Cluster

Checklist

ANNEX A - COVID -19 Alernative Care Arrangement- In Camps

This Checklist will enable Child Protection actors to define alternative care arrangment modalities at the camp level as well as identify existing resources and gaps that needs to be addressed in order to provide safe and appropriate forms of alternative care for children left without appropriate care due to COVID-19.

Name of Camp: _____ Organization: _____ Date: _____

Checklist Questions	Yes	No	Comments
Do Child Protection actors have access to the camp?			*If CP actor does not have access to the camp, then remote follow-up is required*
Is there trained Case Management staff to follow-up children at risk?			*If no, alternative care arrangement is not possible*
Have CP staff been trained on alternative care arrangements including emergency shelter?			*If not, please request training from UASC TF*
Are CP staff available to monitor alternative care arrangement (physical or remote)?			*If staff are not availale, additoinal staff need ot be identified or alternative care is not possible*
Is there any community-based Child Protection mechanisms (e.g. groups, focal points)			*If no, focal point from community needs to be identified*
Has a community-based CP focal point been identify to support (if CP actor has access) or monitor (if CP actor does not have access) Alternative Care Arrangement?			
Has the community-based CP focal point been trained on CP core concepts?			*If no, provide training*
Has the community-based CP focal point been briefed on COVID-19 Alternative care arrangment guidence note?			*If no, conduct the briefing*
Are there community-based CP focal points available and willing to monitor the 24/7 emergency shelter for unaccompanied children due to COVID-19 in the camp?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for this camp*
Are there female community-based CP focal points available and willing to monitor the 24/7 emergency shelter for under-5 years unaccompanied children due to COVID-19 in the camp?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for children under 5 years for this camp*
Is the Camp Management agency ready and willing to support alternative care arragements identified in this camp? (Please ensure that you discuss this with the agency)?			*Please provide the contact details of the camp management agency*
Does Camp Managament have any additional tents at the camp level to support accomodation arranagements (emergency shelters, CHHs shelter)?			*If not, please look for opportunities to source these*
Is camp management willing to install the tents used to accommodate the unaccompanied children near by the Camp Management officeÉ			*If not, please identify safe location near community-based CP focal point's shelter*
Is camp management able to support unaccompanied children in emergency shelter by providing non-food items?			*If not, please look for opportunities to source these*

Is camp managemnt able to support unaccomapnied children in emergency shelter by providing food items?			*If not, please look for opportunities to source these*

ANNEX B - COVID -19 Alernative Care Arrangement- Out of Camps Checklist

This Checklist will enable Child Protection actors to define alternative care arrangment modalities in locations out of camps and urban areas as well as identify existing resources and gaps that needs to be addressed in order to provide safe and appropriate forms of alternative care for children left without appropriate care due to COVID-19. In this context coordination with Government and DoSA is required in the identification of alternative care arrangement for IDP, refugees and host community children.

Name of Location: _____ Organization: _____ Date: _____

Checklist Questions	Yes	No	Comments
Child Protection actors have access into the mentioned location?			*If CP actor does not have access to the mentioned location, then remote follow-up is required*
Is there trained Case Management staff to follow-up children at risk?			*If no, alternative care arrangement is not possible*
Have CP staff been trained on alternative care arrangements including emergency shelter?			*If not, please request training from UASC TF*
Are CP staff available to monitor alternative care arrangements (physical or remote)?			*If staff are not availale, additoinal staff need ot be identified or alternative care is not possible*
Is there any community-based Child Protection mechanisms (e.g. groups, focal points) at this location?			*If no, focal point from community or DoSA staff needs to be identified*
Has a community-based CP focal point or DoSA staff been identified to support (if CP actor has access) or monitor (if CP actor does not have access) alternative care arrangement?			
Has the community-based CP focal point been trained on CP core concepts?			*If no, provide training*
Has the community-based CP focal point been or DoSA briefed on COVID-19 Alternative care arrangment guidence note?			*If no, conduct the briefing*
Are there community-based CP focal points or DoSA available and willing to monitor the 24/7 emergency shelter for unaccompanied children due to COVID-19 in the camp?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for this location*
Are there female community-based CP focal points or female staff from DoSA available and willing to monitor the 24/7 emergency shelter for under-5 years unaccompanied children due to COVID-19 in this location?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for children under 5 years for this location*
Is the Government/DoSA ready and willing to support alternative care arragements identified in this location? (Please ensure that you discuss this with the agency)?			*Please provide the contact details of the DoSA Focal point in this location*

Does Government/DoSA have any idintefied building in mentioned location to support accomodation arranagements (emergency shelters, CHHs)?			*If not, please look for opportunities to source these*
Is Government/DoSA able to support unaccompanied children in emergency shelter by providing non-food items?			*If not, please look for opportunities to source these*
Is Government/DoSA able to support unaccomapnied children in emergency shelter by providing food items?			*If not, please look for opportunities to source these*

Annex C - COVID -19 Alernative Care Arrangement- Hospital/Heath Facilitlies

This Checklist will enable Child Protection actors to assess the current arrangements and capacity at the hospital or health facility in relation to providing care to separated children, as well as to establish a referral pathway between appointed health and child protection actors to coordinate on child protection issues such as family tracing and alternative care.

Name of Hospital/Health Facility: _____ Organization: _____ Date: _____

Checklist Questions	Yes	No	Comments
Do Child Protection actors have access to the Hospital/Health Facility?			*If no, please advise why* *If CP actor does not have access to the mentioned location, then remote follow-up is required*
Is there a health focal point available to coordinate with?			*If yes, please record the details of the focal point:* *If no, what actions needs to be taken in order to have this focal point nominated?*
Is there trained Case Management staff available to follow-up children at risk and provide support to health staff focal point?			*If no, case management and alternative care arrangement is not possible*
Have CP staff been trained on alternative care arrangement, and are able to provide this technical support to the health staff focal point?			*If not, please request training from UASC TF*
Has a discussion on the process of communication following the referral pathway occurred with the Health focal point – particularly how the case will be referred if a separated child is identified?			*If not, please have this discussion so it is clear the mode of communication with the health actor.*
Has the Health Focal Point been trained on the Rapid registration form for non-case management actors?			*If not, please provide training or request support from UASC TF*
Are CP staff available to support the Health focal point to receive referrals?			*If staff are not availale, additoinal staff need to be identified*

Has the Health focal point been trained on CP core concepts? Has the Health focal point attended PSEA and Child Safeguarding training? (With the health focal point spend time discussing the possible CP risks that may exist for particularly separated children at the hospital (e.g. abuse) and identify ways to mitigate this).			*If the health focal point has not received training, please refer the DoLSA focal point in that location to provide support.* *Please details any risks and mitigation strategies discussed*
Has the Health staff CP focal point been briefed on COVID-19 Alternative care arrangement guidence note?			*If no, conduct the briefing*
What are the methods of communication between child and family being used at the hosptial or health facility (e.g. safe options for visiting (if proper precautions are in place), phone calls etc.			*Please detail the methods that will be used:*

List of referral hospitals for management of COVID-19 cases crisis-affected governorates

No	Governate	Hospital name	Contact information name	Phone number
1	Dahuk	Burn and Plastic Surgery Hospital	Dr. Mohammad Salih	07504057510
			Mr. Kader	07512145797
2	Kirkuk	Epidemic center	Dr Dhahid Naji	07702301379
3	Kirkuk	Kirkuk General Hospital	Dr muhamamd Faryadon	07701271366
4	Kirkuk	Azadi Teaching Hospital	Dr Gaylan Qadir	07701343134
5	Kirkuk	Pediatric Hospital	Dr Shahin Kamil	07722374852
6	Kirkuk	Maternity, Gynecology & Pediatric	Dr Hussin Muhamad	07706110150
7	Erbil	Central Emergency Hospital	Dr. Hassan Hamza	07504470058
8	Erbil	Peshmarga Hospital	Dr. Haval Sarezh	07514346616
9	Erbil	Attaya Emirates hospital	Dr. Shakhawan	07504488944
10	Sulaymaniyah	Sarchnar Hospital	Dr. Hersh haider hama	07701556202
11	Ninawa	Al-Shefaa Hospital	Dr. Salih Sabri	07701741254
			Dr. Salih Suleman	07703861696
12	Baghdad Al-Karkh	Al-Forat Hospital	Dr. Mohammed Al-Zobaee,	07901349378
13	Baghdad Al-Rusafa	Ibn Al-Khateeb hospital	Dr. Salman Hamid Ali,	07725855252
			Dr. Jafar Naser	07703945900
14	Al-Anbar	Isolation hospital	Dr. Adil Ftekhan	07825966727
15	Diyala	Baquba general hospital	Dr. Haider Jasim & Dr. Firas Raad	
16	Salahadeen	Tikrit Emergency hospital	Dr. Mohammed Sabah Sabir	07721307478