

Rohingya Refugee Crisis in Cox's Bazar, Bangladesh: Health Sector Bulletin

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Location: Bangladesh

Emergency type: **Rohingya Refugee Crisis**



Photo Credit: WHO/M. Sethi



, SHED, HMBDF, CPI, GODOCS



900 377
total Rohingya
in Bangladesh



688 000
new arrivals since
25 Aug 2017



391 678 Rohingya children
were vaccinated in the 2nd
round of diphtheria
vaccination



An estimated **728 786** people
are being monitored for
epidemic-prone diseases



1.3 million
people targeted for health
assistance

HIGHLIGHTS

- An estimated 688 000 Rohingya have crossed over to Bangladesh following violence in Myanmar's Rakhine state on 25 August 2017.
- The ongoing challenges in safe water, sanitation and hygiene raise, together with the upcoming rainy season, risk of outbreaks of waterborne and diseases transmitted through the fecal-oral route, as well as vectorborne diseases among others.
- The second round of vaccination campaign against diphtheria concluded on 10 February with 391 678 children (109% of estimated target) immunized.
- Health sector partners are actively engaged in emergency preparedness and mitigation efforts ahead of the expected rainy season

HEALTH SECTOR

150 Health cluster partners

HEALTH FACILITIES

270 TOTAL NUMBER OF HEALTH FACILITIES

10 HOSPITALS FUNCTIONING

HEALTH ACTION

1 949 508 CONSULTATIONS*

VACCINATIONS PROVIDED

169 241 pentavalent and bOPV

222 437 Td Vaccine

EWARS

149 Reporting sites

*Figure extracted from the latest 4w, actual consultations may be higher

1. SITUATION OVERVIEW

Since 25 August 2017, an estimated 688 000 Rohingya have crossed over from Myanmar into Cox's Bazar, Bangladesh, joining approximately 212 000 others who had fled in earlier waves of displacement. Rohingya continue to cross into Bangladesh, but at a decreased rate with only 801 new arrivals from 1-9 February. As of 9 February 2018 over 585 000 arrivals are in Kutupalong expansion site, 237 000 in other camps and settlements, and 79 000 arrivals in host communities, impacting the already congested health response. Pre-existing camps and settlements as well as new spontaneous settlements have expanded with the new influx. The scale of influx into Cox's Bazar district and the scarcity of resources resulted in a critical humanitarian emergency that exceeded the coping capacity of the local communities and systems. The crowded living conditions in camps and settlements expose the refugees to further risks of public and individual health. Basic services available prior to influx became over-strained due to massive demands on the systems and services.

To date the health sector's 150 national and international partners have responded to the needs through health service delivery in more than 270 static and mobile health facilities in both Ukhia, and Teknaf. The total estimated population in need which the health sector is targeting is 1.3 million including new arrivals, existing refugees, host community and 100,000 contingency. The sector is responding to the population needs through provision of health services in camps as well as strengthening of the health system as a whole through supporting existing health facilities, the health workforce and the surveillance system. Overall, the health sector partners are coordinated under the leadership of WHO and the Civil Surgeon's Office of Cox's Bazar for better planning and coordinated emergency response. The current health sector focus is strengthening preparedness for the impending rainy season for which there is a high likelihood of floods, landslides and associated health threats, including epidemics.

2 PUBLIC HEALTH RISKS, NEEDS AND GAPS

2.1 Infectious Diseases

2.1.1 Early Warning Alert and Response System (EWARS)

There are a number of key infectious diseases which pose significant risk to the public health of the target population. These include vectorborne disease such as chikungunya, dengue and malaria in addition to AWD, measles, and diphtheria which are currently being monitored on the Early Warning Alert and Response System. There have been a total of 5121 cases of suspected malaria have been reported from week 1 to week 7, of which 27 cases were confirmed as Malaria. There have been no suspected cases of Dengue or Chikungunya fevers reported in the EWARS. However with the onset of the rainy season, these vectorborne diseases remain a risk. Figure 1 provides the trends for some of the key conditions that have been reported through EWARS since epidemiological week 1, when EWARS was set up, to week 7 (ending 17th February 2018).

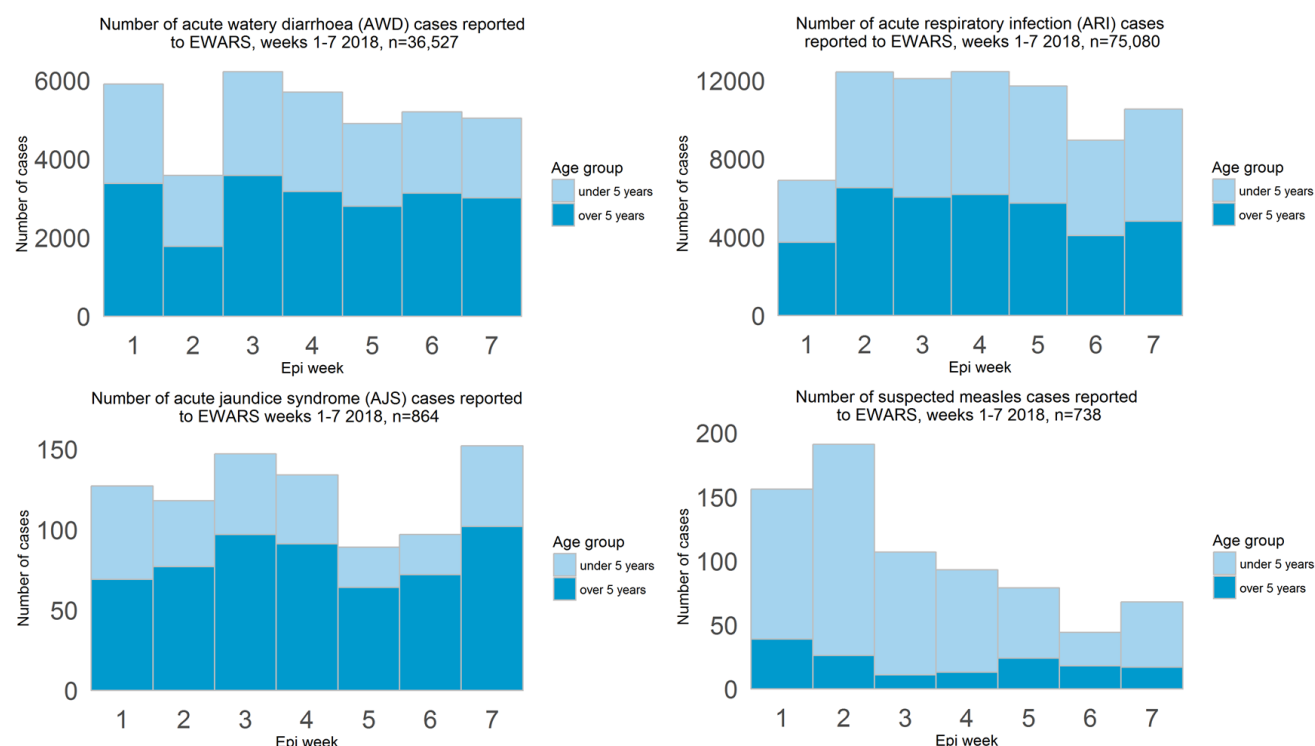


Figure 1- Number of cases of some of the main conditions reported to EWARS between weeks 1 and 7 of 2018 (Please note that diphtheria trends are reported separately in the chapter below).

Table 1 Main morbidities reported to EWARS between weeks 1-7, 2018 (cumulative figures) 1

Condition	Cases <5	Cases 5+	Total
Unexplained fever ²	22053	56326	78379
Acute respiratory infection	37962	37118	75080
Acute watery diarrhoea ³	15677	20850	36527
Bloody diarrhea	5211	9528	14739
Other diarrhea	7284	4771	12055

Suspected malaria ⁴	184	4928	5112
Acute jaundice syndrome	292	572	864
Suspected measles/rubella	590	148	738
Mumps	206	305	511

1. Diphtheria cases are omitted from this table, and described in detail in the following subchapter. 2. Defined as fever $>38.5^{\circ}\text{C}/101^{\circ}\text{F}$ for more than 48 hours in persons with which all obvious causes of fever have been excluded, which captures a range of febrile syndromes of multiple aetiologies. 3. Alerts are verified and investigated for any cluster, cases of severe dehydration, or deaths (see below). 4. Of which 27 cases were confirmed (3 cases in <5 year olds).

Acute Jaundice Syndrome: 864 cases of acute jaundice syndrome (AJS) continue to be reported to EWARS between weeks 1 and 7 of 2018 – ranging from 90 to 100 per week. Among the AJS cases, 34% (292/864) were less than five years old. Detailed surveillance through case-based reporting has started in week 7, which alongside enhanced laboratory testing from week 8 will improve epidemiological understanding and monitoring.

Measles: 738 suspected measles cases were reported between weeks 1 and 7, 2018. Trends of suspected measles/rubella cases have steadily declined in 2018. These trends are based on syndromic reporting (no laboratory confirmation). Eighty percent of cases were aged under 5 years.

Acute watery diarrhoea (AWD): AWD contributes significantly to overall consultations in all reporting camps and settlements with 36 527 cases reported between weeks 1 and 7. There is no indication of severe disease or clustering of cases, however all alerts are being investigated and vigilance is warranted, particularly with the upcoming monsoon season.

2.1.2 Diphtheria

A diphtheria outbreak was announced on 8 Nov 2017. The outbreak peaked in December 2017, and a steady decline in reported cases has been observed between weeks 1 to 7 of 2018 (Figure 2) after implementation of a multi-pronged response strategy comprising of enhanced surveillance, early detection and treatment, contact tracing, risk communication and mass vaccination campaigns. The latest campaign targeting children aged 6 months – 7 years (pentavalent vaccine) and 8 – 14 years (Td vaccine) finished on 12th February 2018. During the period between 1 January and 17 February 2018, 2637 cases were reported in total, of which, 913 (35 %) were suspected, 1 671 (63 %) were probable and 53 (2 %) were confirmed. During that period, five deaths were reported (case fatality proportion $<1\%$) and Diphtheria anti-toxin (DAT) was administered for 604 (23%) of the cases. Out of 144 swab samples that were tested in the laboratory during that same period of time, 53 (37 %) were positive on PCR and 91 (63 %) were negative and excluded from the total reported number of cases. Of the 2637 cases reported between week 1 – 7, 2018, 890 (34 %) presented with pseudo membrane and 3 ($< 1\%$) with other complications (pneumonia, mumps and/or stridor). Contact tracing is ongoing, and includes post-exposure prophylaxis of close contacts with antibiotics and vaccination, regardless of age. Figure 2 shows the epidemic curve for the entire epidemic period, up to week 7, 2018.

Epidemic curve of diphtheria cases in Cox's Bazar,
by date of examination (W45 2017 - W7 2018), n=5834

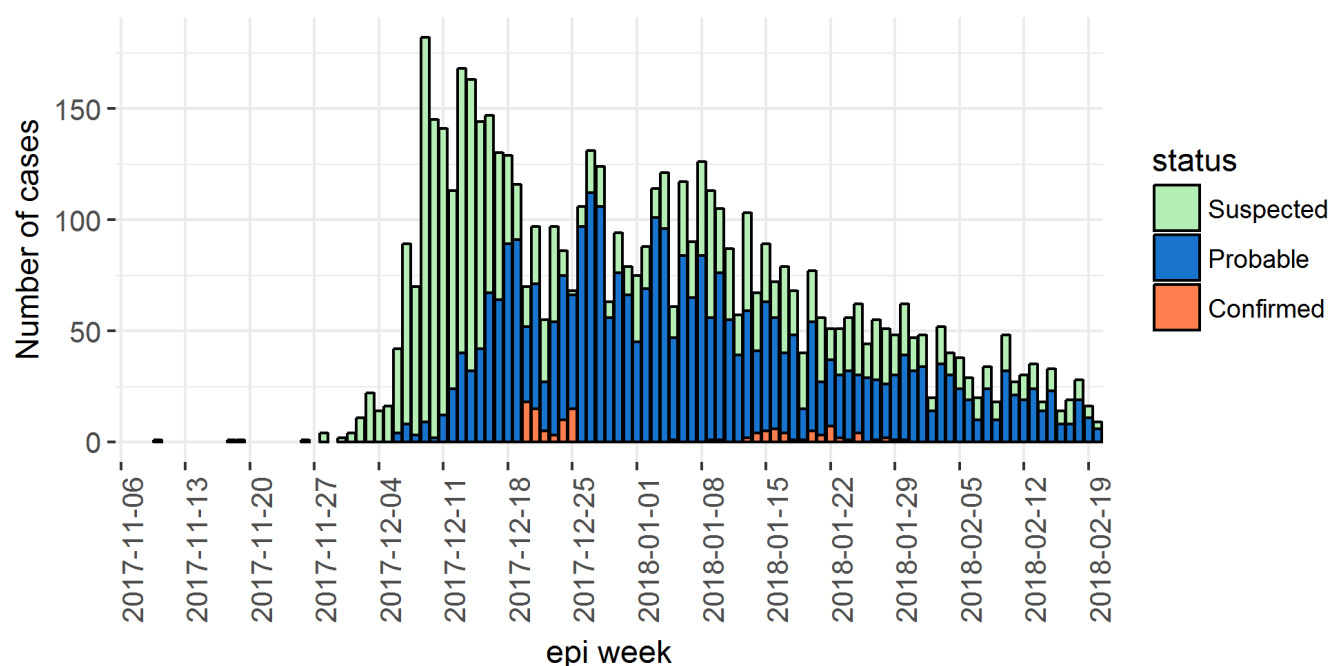


Figure 2-Total number of suspected, probable or confirmed cases reported by week between 1 November 2017 and 17 February 2018

A total of 34 suspected cases have been reported among the host community since the start of 2018. Of these, 4 (11 %) cases were laboratory-confirmed, 25 (74 %) were probable and 5 (15 %) were suspected. The risk of further spread in the host population has been assessed to be moderate as the routine vaccination coverage for DTP is high in the Bangladeshi community.

2.2 Sexual and Reproductive Health

Although some partners are providing the minimum initial service package of sexual reproductive health (SRH), access to essential reproductive, maternal and newborn health services remains a major concern. On-site blood and urine testing, as well as tetanus vaccination capacity, continue to lack in many SRH clinics. Nevertheless, some new facilities with high-quality SRH services are beginning to operate in hard-to-reach areas, and SRH partners continue to construct additional clinics with sturdy structures that can provide high-quality SRH services even during the rainy season. Within Ukhiya and Teknaf, currently 15 facilities are in a position to provide 24/7 SRH services, which is an improvement since the December 2017.

As of end of February 2018, there are an estimated 53 266 pregnant women among the Rohingya refugees with 16 513 expectant deliveries over the next 3 months. As per the Sexual Health and Reproductive Task Force, about 2 477 pregnancies are expected with obstetrical complications.

By the end of January 2018, 4 350 facility based births by skilled birth attendants have been reported, but it is suspected that home deliveries continue to be high. The difficulty of transporting patients for safe facility-based births continues to be an under-recognized factor for the high rate of home deliveries, especially for night time deliveries, as 24/7 facilities with birthing units are scarcely located within the Rohingya community, and arranging for an emergency patient transport at night remains a massive challenge, resulting in loss of life-saving time.

2.3 WASH

Although much progress has been made in the provisioning of water sanitation and hygiene services to the large influx of Rohingya refugees, several key challenges remain. In the initial phase of the emergency and in response to the speed of arrivals, partners and private contributors rushed to provide latrines and water points. However emergency facilities that were constructed in the first phase response have been of poor quality and require decommissioning. Of the approximately 5700 tube-wells, some 21% require rehabilitation or replacement due to their proximity to latrines or position which significantly increases the likelihood of contamination.¹

Additionally there is growing pressure on the aquifer in Ukhia which will require alternative sourcing of safe water. Prior to the August influx, assessments have shown that 92% of Rohingya in host communities had no access to safe water illustrating the need to scale up services to both host and new arrivals.

The WHO water quality testing also identified household water contamination as an ongoing public health risk with water being contaminated due to improper storage and handling. A WHO-led assessment of WASH and IPC in 146 health facilities also revealed large gaps such as 22% of surveyed facilities do not have adequate functional latrines or improved toilets. As well as one-third of surveyed facilities did not have functioning hand washing stations. This is a potential threat to health of the refugees, hosts, staff of HCFs or any other people in that area. Furthermore, water quality testing in 79 facilities revealed that 5 facilities had very unsafe water.

¹ Rohingya Refugee Joint Response Plan 2018- Draft

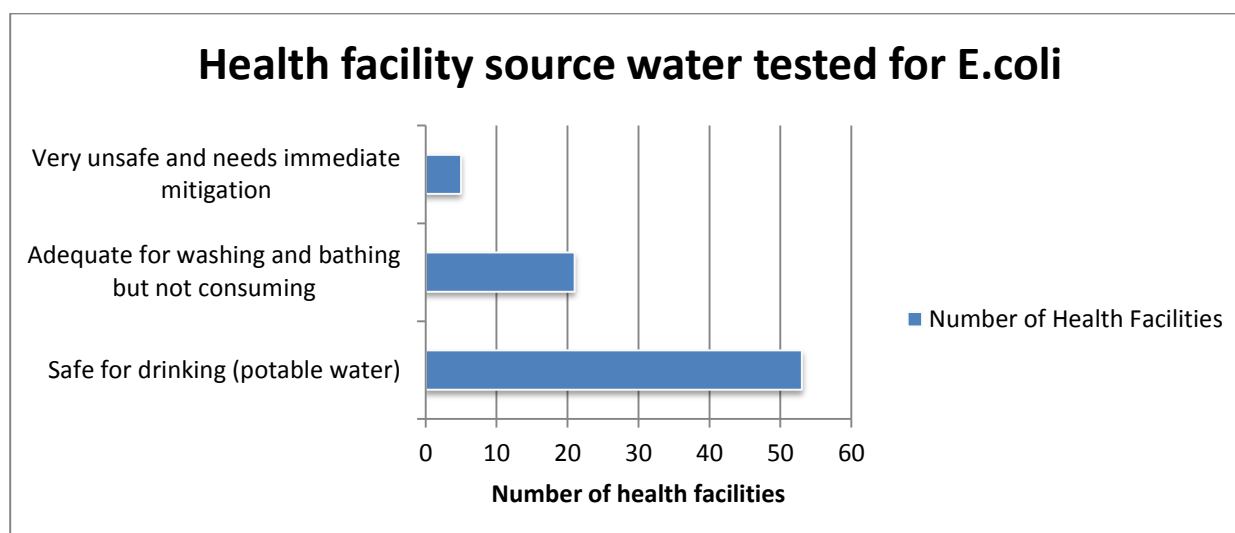


Figure 3 Availability of safe water in 79 assessed health facilities

Lastly, there are no primary collection centers for solid waste with many disposing of waste in narrow spaces between shelters. Finding suitable land for solid waste management remains a primary challenge for partners. Together with the upcoming rainy season, the ongoing challenges in safe water, sanitation and hygiene raise the real possibility of a resurgence of severe acute watery diarrhea which is endemic in Bangladesh.

2.4 Nutrition

There are an estimated 403 889 people among Rohingya refugees and host communities in need of emergency nutrition interventions. These high levels of undernutrition are in part a result of existing vulnerabilities such as stunting (above 40%), food insecurity, poor hygiene and sanitation conditions and disease outbreaks. Additionally extremely high levels of anemia amongst children in refugee settlements indicate high prevalence of micronutrient deficiencies. Based on nutrition sector estimates, approximately 148 935 children aged 0-59 months will suffer from acute malnutrition unless nutrition interventions are urgently scaled up.

2.5 Mental Health and Psychosocial Support

The mental and psychosocial impacts of being forcibly displaced continue to affect large numbers of Rohingya refugees. This is compounded by reports of traumatic experiences including SGBV and physical violence in Rakhine State. Many refugees also face the daily stressors associated with reliance on humanitarian assistance for food and other life-saving needs. There is therefore a need to increase availability and access to specialized mental health services as well as to increase the capacity of the health care workforce to manage common mental disorders in primary health care settings. As with the broader health response, there is also an ongoing need to establish effective forward and back referral mechanisms.

2.6 Health service access and delivery

In the initial phase of the response, existing host community facilities were severely overwhelmed with the influx of patients leading to difficulties in accessing care by host communities. However as the Rohingya settlements have grown, many new facilities were constructed in an effort to lessen the strain on existing facilities and increase access for the new arrivals. WHO mapped and collected the geo-coordinates of 270 health facilities (figure 3), which span 34 different camps and settlement areas. Among them, 246 are functional, 14 are under construction and 10 are planned. In terms of facility types, approximately half of them (48%) are health posts, followed by primary health centers (22%) and secondary health facilities (4%). Access to Trauma care in the camps is limited with only two hospitals in the camp with surgical capacity (1 operating theater and surgeon each)

Health sector partners conducted a survey from 27 January to 5 February on the availability of 12 main areas of health services, including curative care, maternal and newborn, child health, adolescent health, family planning, gender based violence (GBV), nutrition, communicable diseases, mental health and psychosocial services, non-communicable diseases (NCD), basic laboratory, information management. The results highlighted a continuing gap in communicable disease treatment (malaria, HIV and TB) and a lack of inpatient care and beds as well as a shortage of delivery beds.

Referrals remain an ongoing challenge with no comprehensive referral mechanism in place. In the absence of such a mechanism, referrals have been on an ad-hoc basis with many partners entering into bilateral Memoranda of Understanding. There has also been an underutilization of in-camp referrals as many partners refer patients to facilities outside the camp. This has also led partners to report difficulties in transporting patients across checkpoints for referrals outside the camp.

Rohingya Response: Health Services mapping (Ukhia)

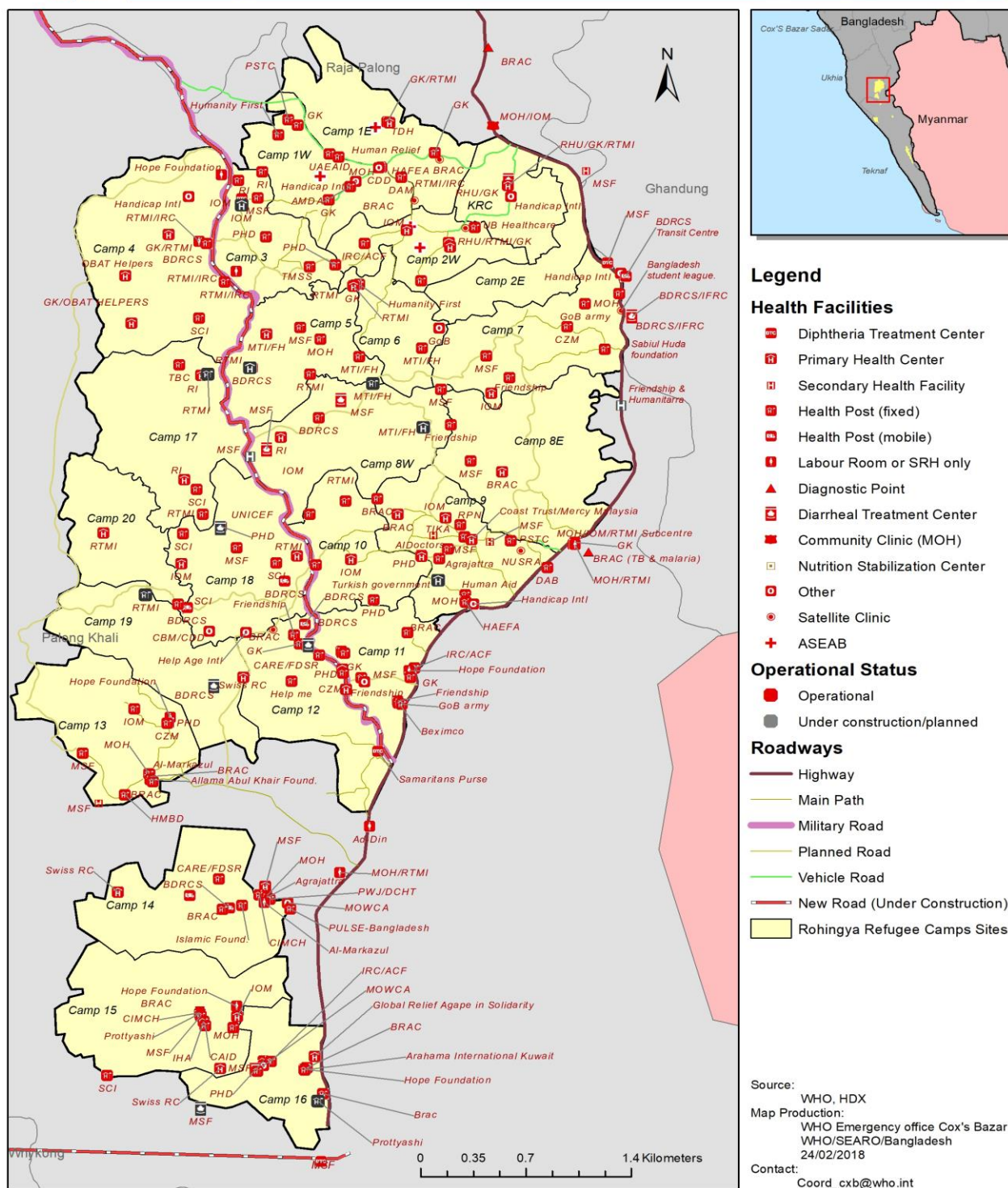


Figure 4 Health facilities in Ukhia Upazila

3. HEALTH SECTOR RESPONSE

3.1 Infectious Diseases including Diphtheria

3.1.1 Disease Surveillance

The current EWARS platform is a novel WHO-developed, online, integrated data collection, analytics, alerting, and automated reporting system. Daily (event-based) and weekly (indicator-based) alerts are being verified on a continuous basis by the WHO rapid response team, and acted upon as needs be. The number of facilities reporting through EWARS expanded and all reporting partners received training on the EWARS system. By week 7 of 2018, 94% (149/158) of health facilities were set up to report on EWARS. This provides surveillance for an estimated 728 786 people (84% of the estimated population).

Health facilities began reporting weekly aggregate data for a number of conditions through EWARS during the first week of 2018. Since 1 January 2018, a total of 619 alerts were raised in the EWARS. 97% of the alerts were assessed by the joint MoHFW- IEDCR-WHO response. In order to strengthen laboratory surveillance, WHO in conjunction with the local authorities and IECDR will set up a laboratory in the district hospital. This lab will have dedicated spaces for molecular technique diagnostic including DNA extraction, master mix preparation (clean room), template addition and PCR amplification. The necessary supplies and materials have been procured and the physical infrastructure is nearing completion.

3.1.2 Diphtheria contact tracing and case management

The Diphtheria epidemiology and case management task forces continue to meet twice per week, to ensure coordination of activities and troubleshoot problems arising in the field. Under health sector coordination, contact tracing activities were strengthened and expanded. Fixed vaccination sites were established for vaccination of contacts of all ages and vaccination on exit from treatment facilities was facilitated for all cases. Having scaled up the number of Diphtheria Treatment centers to six to ensure sufficient bed capacity and equitable distribution of beds across the camps, the process of scaling down has now begun. The UK Emergency Medical Team departed Cox's Bazar and transition plans were agreed for several of the sites. Some sites will be transformed into isolation facilities for other diseases.

Detailed case investigations of the host cases are ongoing with collaboration between MoHFW, IEDCR and WHO. IOM, MoHFW and the clinical partners will be responsible for the contact tracing of case-patients from the host community

The results of a WHO-led assessment of the Ukhia upazilla health complex indicated a need for a triage area to manage suspected diphtheria cases. Health sector partners are currently supporting the procurement of the necessary supplies and materials to operationalize the triage area.

3.1.3 Vaccines and Immunization

A vaccination campaign targeting children in the host community was conducted on 02 January during free book distribution day across 104 schools in Ukhia. A total of 29 377 children were vaccinated. These included 6 514 children 6 weeks to under 7 vaccinated with pentavalent vaccine and 22 823 children 7 to 15 years were vaccinated with Td. School vaccination for host community children was postponed in Ukhia and Teknaf due to a nationwide strike of health assistants in the country. The Penta/Td vaccination campaign in schools resumed for the remaining educational institutions from 13-17 January 2018. The vaccination campaign targeting 178 183 host national children under 15 years. The school vaccination campaign was completed in the host community from 13-17 January in which 168 842 children aged 6 weeks to 15 years were vaccinated against diphtheria.

The second round of vaccination campaign against diphtheria concluded on 10 February with a coverage of 391 678 children (109% of estimated target). Of them, 169 241 children aged 6 weeks to 7 years were administered Pentavalent and bOPV vaccines and 222 437 children aged 7 years to 15 years were administered Td vaccine. Vaccination at entry point (Sabrang, Teknaf) is ongoing with 151 children vaccinated between 1 Jan to 31 Jan 2018. All children passing through entry point are being vaccinated with Penta/Td, bOPV, PCV and MR vaccines.

In January, vaccines for humanitarian aid workers were made available again in Cox's Bazar and several thousand workers were vaccinated. Field based humanitarian aid workers also received vaccines from field vaccination sites during the duration of the vaccination campaign. In total more than 15 000 humanitarian aid workers were vaccinated against diphtheria. Although immunization rates have increased with successive vaccination campaigns, crowded living conditions and poor nutritional status still pose a danger for outbreak of a number of communicable disease particularly measles, vectorborne diseases, hepatitis E and AWD.

3.2 Sexual & Reproductive Health (SRH)

Members of the SRH working group continue to support the distribution of emergency and live-saving Reproductive health kits to Government and partner health facilities. In response to the high percentage of home deliveries, UNFPA launched an incentive program on 23 January to encourage institutional deliveries. As part of partner capacity building, UNFPA, through the SRHR Resource Centre, has been conducting a series of sexual and reproductive health and rights training to all partners. The trainings target mostly clinical health providers, midwives and doctors. Participation in these trainings has been extended to all SRHR partners. To date, two batches of helping babies breathe trainings (5-6 & 12-13 Jan.), two emergency response trainings (19-20 & 22-23 Jan.) and two

helping mothers survive trainings (12-13 & 14-15 Feb.) have been conducted. A total of 210 health care providers have been trained.

In addition, through the SRH working group, UNFPA facilitated an interactive Inter-Agency Working Group (IAWG) workshop on 1 February 2018 where resources, guidelines and tools related to MIS and SRH in crisis were shared, and current SRH gaps were explored. A map of all health facilities providing clinical management of rape, menstrual regulation and post-abortion care sites was developed and shared with partners in January 2018. Service data from facilities for the month of January reported 700 facility deliveries, and increased cases of pre-eclampsia and eclampsia which have since stabilized. As part of the response, health care providers were alerted of the trends, sufficient stocks of medicines were ensured in the facilities and proper referral pathways were defined. UNFPA & ICDDR, conducted an assessment from 12 January to 20 February on the needs of maternal and child health care for Rohingya refugee populations.

3.3 WASH

A joint assessment was carried out to review WASH and Infection Prevention and Control (IPC) in health facilities inside the camps. A total of 20 survey teams, constituting volunteers from the Health and WASH sectors, were trained on the data collection tool and the field data collection began on 27 January 2018 with a plan to survey all health facilities serving Rohingya refugees in Ukhia and Teknaf. A total of 189 facilities were surveyed, data cleaning is ongoing and a report with recommendations will be drafted. The initial findings and recommendations have been presented in the WASH sector meeting. As a result of the assessment, training materials for hospital staff to ensure WASH and IPC standards in health facilities inside the camps have been developed.

The acute watery diarrhea working group of the health sector met jointly with the WASH sector and agreed on priority activities. As a priority, all existing diarrhea treatment centers will undergo an assessment to determine level of readiness in relation to agreed minimum standards, and what support is needed. Members of the AWD working group have developed a comprehensive checklist for assessing the DTC and assessments are currently underway. WHO has made available three cholera kits as part of AWD preparedness and ordered an additional 20 Central Cholera kits and 40 peripheral kits as part of the preparedness activities for the upcoming rainy season. A fourth round of training of health care workers was conducted ICDDR.

Hygiene education and provision of kits is ongoing in order to confront the issue of household water contamination. Additionally in order to minimize risk of contamination of tube-wells by over-flowing latrines, new deeper tube-wells are being constructed with a minimum of 10 meters between latrines and wells.

A plan for the fourth round of water quality monitoring (surveillance strategy, refresher training on water sampling and sanitary survey, implementation of survey, analysis of survey data, result dissemination and follow-up plan) has been prepared and is expected to be implemented from 26th February. Health sector partners have undertaken mapping of essential AWD medical supplies and it

has been determined that there are enough fluids (ORS and Ringer Lactate) in Cox Bazar to cover the worst scenario.

3.4 Mental Health and Psychosocial Support (MHPSS)

There are currently many agencies and actors addressing mental health and psychosocial support (MHPSS) for the Rohingya refugees and host community members. The MHPSS working group has provided 52 243 consultations and services in the past month. In particular, there have been more than 11 680 basic psychosocial support sessions as well as 313 psychological first aid sessions, 409 individual counselling consultations and 100 group counselling sessions delivered. The MHPSS community continues to prioritize trainings in psychological first aid (PFA), stress management and mhGap in order to strengthen the capacity of individuals providing mental health and psychosocial services, especially in planning and preparing for the upcoming monsoon season. The MHPSS working group explains that psychological first aid is a supportive and evidence based intervention for use in the immediate aftermath of disasters. Components include listening but not forcing individuals to talk; assessing needs and concerns; ensuring basic needs are met; linking people to loved ones, services and information; helping people to feel calm; encouraging the use of positive coping strategies and protecting people from further harm.

MHPSS actors are conducting assessments, providing specialized mental health services to those needing individual counseling and support as well as identifying needs. As well, the MHPSS community is also prioritizing the recruitment and advocacy for more specialized mental health service providers, as the needs continue to be immense. Psychiatric support is available, but building the capacity of health service providers continues to be priority as well.

3.5 Nutrition

Many health Sector partners continue to provide nutrition services in their health facilities such as screening of children as well as pregnant and lactating women for malnutrition. Additionally, many partners are also providing therapeutic supplementary food provision and referrals to Targeted Supplementary Feeding Programme (TSFP). Partners have also been utilizing community health workers to provide joint health and nutrition messaging to the community. There is also close collaboration and integration between nutrition and health sectors through training of health staff on nutrition and provision of health nutrition equipment to health facilities as well as training of nutrition staff on common infectious disease. Nutrition corners will also be integrated into health. Additionally the collaboration between sectors will be strengthened through referral of nutrition screened patients such as those with severe malnutrition with medical complications to the appropriate health facilities. In preparations for the rainy season, health and nutrition facilities at risk of flooding and require relocation will be relocated together so as to ensure unbroken access to both health and nutrition services to the population.

3.6 Health Service Access and Delivery

Currently, coverage of health facilities remains sufficient in both Ukhia and Teknaf (Table 1). As of 08 February, health sector partners reported they have provided a total of 1 949 508 health consultations since August 25 2017, in response to the crisis. This includes health services to outpatients, inpatients as well as community health and outreach activities.

Table 2-Health Facility Coverage

Type	Current Number of Facilities	Sphere Standard Ratio	Current Ratio
Health Post	129	1 per 10,000 population	1 per 10, 077
Health Centre	56	1 per 50,0000 population	1 per 24,074
Hospital	10	1 per 250,000	1 per 130,000

In anticipation of the upcoming rainy season, the health sector mapped out flood prone health facilities and identified priority facilities for relocation, based on an agreed set of criteria. The health sector is working closely with the site management sector to minimize the disruptions to essential health service delivery during the monsoons.

To help facilitate referrals for secondary health care, the health sector produced a map of available secondary facilities indicating the services offered, as well as the contact details and bed capacities. The map has been circulated to partners and guidelines and tools to facilitate and standardize referrals in the camp are under development.

4. HEALTH SECTOR COORDINATION

The Health section of the Joint Response Plan (JRP) was developed based on the humanitarian needs overview and key priorities identified by all health sector partners, the Directorate General of Health Services (DGHS) in Dhaka and district level government representatives. A total of 38 project proposals were submitted for review by the sector review team. After review a total of 33 Project proposals with an estimated \$113 million appeal budget were approved for inclusion in the health sector Joint Response Plan.

Health sector partners are conducting emergency preparedness planning for the rainy season. A Working Group was formed and key priority activities were identified. Mapping of resources (medical supplies and mobile medical teams) was conducted. Eleven high priority facilities at risk of

flooding were selected for relocation based on a transparent and accountable process using criteria endorsed by the Health Sector.

WHO coordinated with agencies in charge of site management to allocate land for health facilities as per identified needs. Most site allocations are complete and partners have been informed where their facilities will be located. Decongestion and related relocation of health facilities will support more equitable health care coverage and improve access, prioritizing the most vulnerable populations

A Multi-sectoral Vector Borne Diseases (VBD) Working Group was established to ensure interagency coordination among different actors and enhance preparedness for an outbreak of VBDs within the FDMN camps/settlements and the surrounding host population. Additionally, the Health Sector is working closely with the WASH sector to align plans for addressing acute watery diarrhea (AWD) and AJS through a joint AWD preparedness Working Group.

The referral system for patients who have suffered Gender based violence was strengthened and Health sector partners were briefed on the process. A community health programmes working group was created to improve coordination of community based health activities. The Health Sector Coordination Group continued to collect analyse and disseminate relevant information on public health needs, priorities and gaps to all partners and strengthened collaboration with health related sectors, including WASH, Nutrition, Protection, Site-management, SRH, MHPSS , Civil-Military Coordination and the Inter-sectoral Coordination Group (ISCG).

Health Sector Meetings

Name	Frequency	Location
Health Sector Meeting	Weekly	Wednesday 10:00-12:00. IOM meeting room
AWD Working Group	Bi-Weekly	Tuesdays 14:00- 15:00. WHO Office
Vector Borne Disease Working Group	Bi Weekly	Tuesdays 14:00- 15:00. WHO Office
Health Sector Strategic Advisory Group	Weekly	Mondays 16:00-17:00 WHO Office
Sexual & Reproductive Health Working Group	Weekly	Thursdays 10:00-11:30 Sayeman Hotel
MHPSS Working Group	Weekly	Thursdays 14:00-15:30 ACF Office

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