



1.2 MILLION PEOPLE IN NEED



655 500 ARRIVALS







Forcibly Displaced Myanmar Nationals (FDMNs) in Cox's Bazar, Bangladesh: Health Sector Bulletin

16 November – 31 December 2017



GK, SHED, GODOCs, PWJ, Malaysia Field Hospitals, HMBDF, FHM, CPI, Swiss Red Cross

ICRC

HIGHLIGHTS	HEALTH SECTOR	
<p>Since 25 August 2017:</p> <ul style="list-style-type: none"> 655 500 FDMNs are estimated to have arrived in Cox's Bazar, Bangladesh as of 31 December 2017 There are around 124 national and international health partners providing services through 169 health facilities (including 7 hospitals) that are increasing in number as more partners are joining for strengthening emergency response Cumulative number of clinical consultations provided until 27 December 2017 are 1 916 262 In response to diphtheria outbreak, children aged 6 weeks to <7 years old were vaccinated with bOPV, pentavalent and PCV. Td vaccine as booster was given to children with age group 7 years to <15 years. A total of 315 889 out of targeted 357 467 children were vaccinated (88% coverage). 	124	HEALTH SECTOR PARTNERS
	1.2MIL	TARGETED POPULATION
	MEDICINES DELIVERED TO HEALTH FACILITIES/PARTNERS*	
	 >342 000	ANTIBIOTIC TABLETS FOR DIPHTHERIA CHEMOPROPHYLAXIS
	HEALTH FACILITIES	
	 >169	TOTAL NUMBER OF HEALTH FACILITIES OPERATIONAL
	7	HOSPITALS FUNCTIONING
	HEALTH ACTION	
	 1 916 262	CONSULTATIONS
	3,193	ASSISTED DELIVERIES**
	VACCINATION AGAINST	
	 149 962	BOPV, PENTAVLENT AND OCV AND
	165 952	TD BOOSTER
	EWARS	
	 139	SENTINEL SITES
	34.6 % FUNDED	
	 \$48 MILLION	TOTAL FUNDS NEEDED

1. CONTEXTUAL SITUATION

The state of Rakhine in Myanmar has been undergoing civil strife for many years. There had been incidences of clashes and conflicts between the Rohingya community and other communities in Rakhine that resulted in internal displacement as well as displacement of Rohingya in bordering areas of Bangladesh. But the violence on 25 August 2017 in Rakhine state, especially in Maungdaw and Buthidaung provinces, led to exodus of an estimated 655 500 Rohingya across the border into Cox's Bazar, Bangladesh. 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. Basic services available prior to influx became over-strained due to massive demands on the systems and services. The Government of Bangladesh called for external assistance to meet the needs of population-in-crisis and prevent humanitarian catastrophe.

All the operational partners joined hands in organizing a combined emergency response. Following public health situation analysis published on 10 October 2017, WHO rated this crisis as a grade 3 emergency. 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 Government of Bangladesh allocated 3 000 acres for a new camp in Kutupalong. New roads were constructed by the Bangladesh Army and temporary shelters were provided along with basic amenities. Health facilities and services were initially concentrated in easy to reach areas, leading to inequitable access. Site management and equitable distribution of an essential health service package across all camps and settlements became a priority. The demographic profile of the 655 500 FDMNs is presented in the table below¹.

Table: Demographic Proportions	
Males	48%
Females	52%
Elderly	3.4%
Infants	3.6%
1-4 years	15.1%
Under 18 years	55.0%
Single Mothers	16.3%
Pregnant Women	4.9%
Un-accompanied Children	1.0%
Disabled	3.9%

¹ UNHCR Factsheet- Family Counting. Available at: <http://data2.unhcr.org/en/dataviz/10?sv=34&geo=0>

2. PUBLIC HEALTH RISKS, PRIORITIES, NEEDS AND GAPS

2.1 Communicable diseases

Over-crowding in camps, high malnutrition prevalence in the general community, low or unknown immune-protection and poor general sanitation conditions present risk factors for various communicable diseases. The multiplicity of health facilities providing services and the heavy reporting burden has made measurement of morbidity and mortality burden a difficult and challenging task.

Based on EWARS reports from epidemiological week 45-52, fever of unexplained origin, acute respiratory infections, acute watery diarrhoea and bloody diarrhoea have contributed significantly to overall consultations in all reporting camps and settlements.

Condition	Cases <5	Cases 5+	Deaths <5	Deaths 5+	CFR (#/10 000)
Acute watery diarrhoea	25 468	37 286	7	3	1.59
Bloody diarrhoea	2 239	1 808	0	0	0.00
Other diarrhoea	5 708	4 571	2	6	7.78
Acute respiratory infection	33 976	31 314	14	1	2.30
Suspected measles/rubella	1 639	453	3	0	14.34
Suspected meningitis	6	16	0	1	454.55
Acute jaundice syndrome	95	339	1	1	46.08
Neonatal tetanus	2	NA	0	NA	NA
Adult tetanus	1	56	30	0	5 263.16
Suspected malaria	682	7 397	2	0	2.48
Confirmed malaria	67	249	0	0	0.00
Severe malnutrition	1 050	159	9	11	165.43
Unexplained fever	31 943	69 268	3	0	0.30
Skin diseases	6 499	22 449	0	0	0.00
Eye infection	2 354	5 964	0	0	0.00
Injuries	1 595	6 815	12	7	22.59
Other	52 997	272 311	11	31	1.29
TOTAL	166 321	460 455	94	61	2.47

However, as the completeness of reporting and ascertainment of catchment population by reporting health facilities had been a constant challenge, the proportional morbidity trends as given in Fig 2 below better reflect the prevalent burden of communicable diseases:

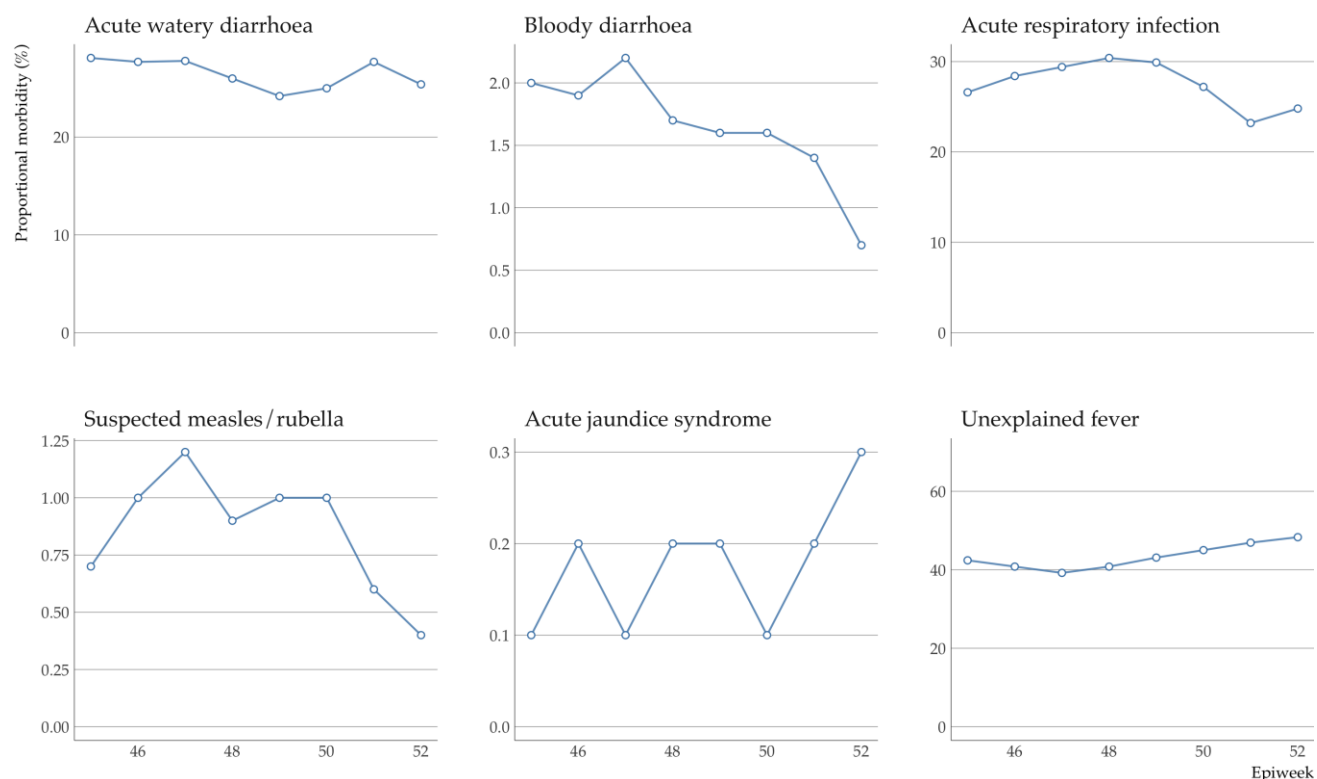
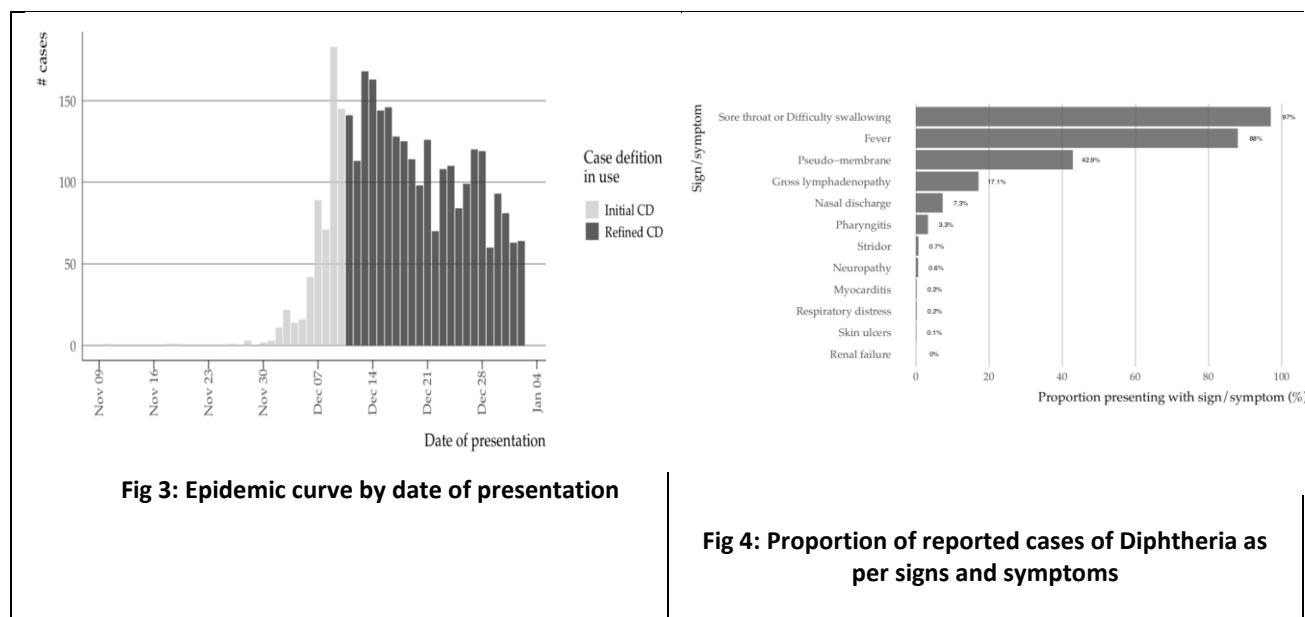


Fig 2: Proportional morbidity of key conditions under surveillance through EWARS, epidemiological weeks 45-52, 2017

2.1.1 Diphtheria Outbreak

Diphtheria outbreak detected on 8 November 2017 continued, reached its peak in mid November 2017 (Fig 3) and plateaued with implementation of multi-pronged response strategy comprehending: enhanced surveillance, early detection and treatment, contact tracing, risk communication and mass vaccination campaign with pentavalent (diphtheria, tetanus, pertussis, hepatitis B and haemophilus Influenza). Between 8 November and 31 December 2017, 3014 suspected cases and 28 deaths were reported in camps and settlements. Out of the 3014 suspected cases, 42.9% cases reported to be presented with pseudo-membrane formation in throat (Fig 4). Out of 470 swab samples taken from patients that were tested in laboratory since 17 December 2017, 26% were found positive on PCR. Nine suspected cases of diphtheria were reported from host community in the month of December 2017, which led to strategic plan of providing immune-protection to host community school children as well.



2.2 Water, Sanitation and Hygiene

Supply of water has increased over last 6 weeks with some improvement in the quality of water at the source. According to the Needs and Population Monitoring Survey no. 7 published at the end of December 2017, 86% of all locations report that half or less of the population has access to sufficient water to meet the basic needs. However, as per the 3rd water quality monitoring surveillance, 81% of the water samples collected (1 108) from household were found to be contaminated with E.coli. Many of the water sources built in the early phase of the response were shallow and constructed close to latrines, which increases their risk of being contaminated. The sanitary toilets need de-slugging and some of them even need de-commissioning.

At household level, practices around purification of drinking water at 'Point-of Use' are still inadequate. Soap for handwashing is scarce, and boiling drinking water is uncommon. All these factors present a high risk of household water contamination.

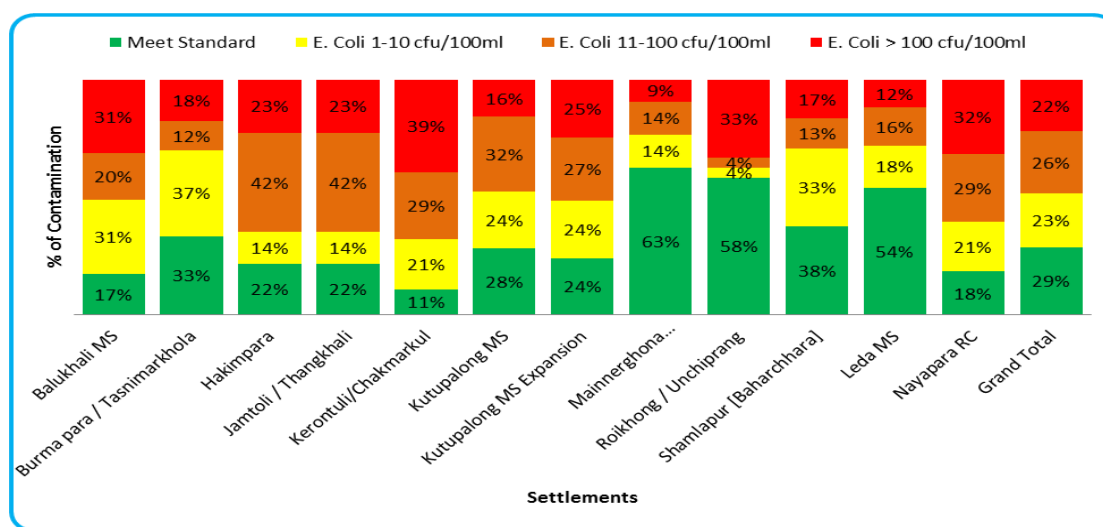


Fig 5: Analysis of 1108 household water samples in round 3 showing that only 29% are free of E. Coli contamination.

2.3 Nutrition

The affected population settled in camps is afflicted with high malnutrition rates especially among adolescents, pregnant women and children. Around 50% of the FDMN child population is anemic. An estimated 564 000 people are in need of nutrition assistance (including new and previous FDMN and host community). Around 19 729 children (0-59 months aged) suffer Severe Acute Malnutrition (SAM), 45 846 children (6-59 months aged) suffer moderate acute malnutrition and 240 000 children are in urgent need of vitamin A supplementation².

2.4 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, especially in the new settlements and hard to reach areas. Only seven health facilities are in a position to provide 24/7 services³. As of end December 2017, 3 193 have been assisted by skilled attendants. There are an estimated 58 700 pregnant women among the FDMN with 15 480 expectant deliveries over the next 3 months. As per the Sexual Health and Reproductive Task Force, about 2 322 pregnancies are expected with obstetrical complications. Home deliveries have anecdotally been reported to be high in several camp areas. Health facilities based deliveries are estimated to be only 22%. There is no standardization of the community health volunteers (CHV) network programme to ensure that home visits to pregnant women, newborn and children take place routinely to support the continuum of care. Lastly, several agencies have reported high levels of SGBV, but only a few women are reported to have visited health facilities for care.

2.5 Mental health and psychosocial support (MHPSS)

The mental and psychosocial impacts of being forcibly displaced are vast, with the affected populations facing daily stressors associated with reliance on humanitarian assistance for food and other life-saving needs. This is compounded by reports of traumatic experiences including SGBV and physical violence in Rakhine State. Health Sector partners preliminary assessments results show that needs on MPHSS are similar both in FDMN and host community. However less adaptive distress show a general lower prevalence in host community if compared to more chronic problems related to pervasive sense of hopelessness in registered and makeshift camp populations. Many needs have been identified, among these: identified disrupted social support and self-help, particularly in the newly arrived parts of the populations, massive distress, lack of awareness on mental health problems with associated lack of adequate assistance and stigma. Finally the high levels of malnutrition and lack of adequate education related stimulation are considered as risk condition for child psychosocial development.

3. HEALTH SECTOR RESPONSE

3.1 Service delivery planning

² Inter-sectoral Coordination Group Weekly Sitrep 31 December 2018

³ Health sector meeting 27th December 2017

Currently, approximately 169 health care facilities providing different levels and types of health services are known to be operating across all settlement areas. Measures have been taken to de-congest areas with a surplus of facilities and distribute newer health facilities in zones/areas still uncovered in order to meet the needs of the population. A committee constituting the Refugee Relief and Repatriation Commissioner Office (RRRC), District Civil Surgeon Office, Director General Coordination Cell/MOHFW and Health Sector Coordination Group is being formed to oversee the equitable distribution of health services across geographical regions. A referral mechanism and SOPs have been proposed by the DGHS and Health Sector Coordination Group so as to optimally utilize existing transport (ambulances) resources and reduce the case load from Hospitals to peripheral health facilities and making services available nearer to the community-in-need.

The health sector has designed a recommended package of minimum basic health services for health posts and health care centers, based on the MOHFW's service delivery package and UNHCR and Sphere standard based guideline. The package has been approved by MOHFW and shared with all health sector partners to inform their programming several activities implemented by partners to strengthen primary health care.

Health sector partners are implementing activities in the field. UNHCR supports five partners namely, Refugee Health Unit of the RRRC, Gonoshastaya Kendra (GK), Research Training and Management International (RTMI), Medical Teams International (FH/MTI) and Relief International/IRC, to provide primary care services through Health Posts, Primary Health Centres and Diarrhea Treatment Units in 14 locations. Relief International established five static primary health care posts (OPDs in AA1, AA2, RR Zone with UNHCR Assistance; and in PP & WW Zones with UNICEF Assistance). Peace Winds Japan (PWJ) is implementing one mobile clinic and one static clinic, cooperating with a local partner, the Dhaka Community Hospital Trust (DCHT). The mobile clinic rotates several places: Balukhali, Jamtoli and Baghona while the static clinic is in Hakimpara. Health and Education for All (HAEFA) has established an effective referral system for diagnosis and treatment of TB with the support of NTP and BRAC, treatment of malnutrition with the support of WFP, and hospitalization of serious illnesses including gunshot injuries. IRC has established 7 health posts, 2 integrated women's centres, 1 comprehensive women's centre that includes 24-hour Basic Emergency Obstetric Care and 3 inpatient Nutrition Stabilization Centres.

An assessment of service delivery and quality was conducted by WHO, UNHCR, IOM, SDC and UNFPA in Sadar district hospital, Ukhia Upazilla Health Centre and Teknaf Upazilla Health centers to ascertain adequacy and quality of existing capacities. Gaps in physical infrastructure, equipment and laboratory logistics, human resources, healthcare waste management and infection control practices were identified and need improvement. WHO has provided supplies and Inter-agency Emergency Health Kits to both government and NGO-run health facilities. Scale up of support to the overburdened government-managed facilities is still needed.

3.2 Vaccines and Immunization

In response to the diphtheria outbreak the District level Diphtheria Core Committee was constituted under the chair of District Civil Surgeon that closely monitors the outbreak situation. A mass vaccination with pentavalent, PCV and BOPV and Td was conducted during 12-31 December 2017. For children aged 6 weeks to <7 years of age, pentavalent, PCV and OPV were given. Td vaccine as booster was given to

children with age group 7 years to <15 years. A total of 315 889 out of the targeted 357 467 children were vaccinated (88% coverage). Partners have rapidly strengthened social mobilization efforts for the vaccination campaign in Ukhia and Teknaf upazilas. More than 88% targeted children have been provided immune-protection against Diphtheria, Pertussis, Tetanus, Haemophilus influenza and hepatitis B, Poliomyelitis and meningococcal meningitis.

Mass vaccination using pentavalent vaccine among host community school children (6-15 years) are scheduled to be launched on 1 January 2018, targeting 130 000 children in 395 schools in the host population. More than 85% of the households of diphtheria patients have been traced and 10 594 contacts have been put on chemoprophylaxis with the collaboration of nine implementing partners.

As of 26 December, 11 734 aid workers were also provided immune-protection using Td vaccine. Currently the dT campaign has been expanded to school age children in the host community of Teknaf and Ukhia upazilas. Risk communication and community engagement materials were developed for the vaccination campaign. These will be pretested in coming weeks. The first vaccination campaigns in host community schools in Ukhia will take place in January 2018 with a target of approximately 29 500 children.

A second round is then planned to take place in Ukhia and Teknaf upazilas in mid-January, targeting 132 000 children. Meanwhile the next vaccination campaign among FDMN population is planned for late January.

3.3 Diphtheria case management and capacity building

Diphtheria cases were initially managed by MSF and later were supported by other health partners, notably IOM, BRAC and Samaritan's Purse, with the opening of more Diphtheria Treatment Centres. An urgent call was sent to Emergency Medical Teams and the Japanese Red Cross and UK EMTs responded and have joined the effort to control and manage the outbreak. Australian EMT has also expressed willingness to assist if needed. Overall, a total of 144 red beds for serious cases and 275 orange beds for moderate and mild cases are now available.

A sufficient supply of Diphtheria Anti-Toxin (DAT) is available to save lives. As of 31 December, a total of 66 patients have received DAT treatment. To respond to shortage of health work force, the DGHS Coordination Cell mobilized 60 nurses to be recruited by health partner agencies involved in delivery of clinical care services.

Training on clinical case management of diphtheria was conducted in the last week of December to augment the existing capacity of government and NGO staff. In addition, the health sector continues to support the MOHFW's efforts to strengthen routine vaccination. Since November, 970 children (6 months-15 years) passing through the two transit sites have been vaccinated against measles and rubella (MR) and 1 038 children under five years received oral polio vaccine (bOPV). Establishing the routine Expanded Programme on Immunization (EPI) in camps and settlements and setting up vaccination posts at entry points into Bangladesh are both key to controlling measles and other diseases. However, in response to the significant increase in measles cases, MoHFW and health sector have agreed to rapidly initiate a measles campaign targeting 360 000 children under 15 for MR vaccination. The campaign took

place in November where 354 982 (>95%) children between 6 months and 15 years of age have been reached by 94 teams of vaccinators.

3.4 Water, sanitation and hygiene promotion

Improving water quality is a joint health and WASH sector priority. Representatives from both the sectors meet in the Acute Watery Diarrhea (AWD) Working Group Meetings on a weekly basis. During the last meeting of the AWD Working Group, the need to further strengthen and scale up drinking water monitoring surveillance and field sentinel surveillance was identified. The group also geared up to implement the AWD Preparedness and Response Plan interventions considering the likelihood of cyclone and rains in the coming months.

WASH partners have distributed 199 708 hygiene kits/NFIs in the major spontaneous sites, makeshift settlements, and camps as well as in some nearby host communities. A large-scale sludge treatment unit has been identified which will initially cover over half a million people in Kutupalong mega site. De-slugging of latrines is being conducted by WASH partners. To improve the sanitation condition of the sites, the Bangladesh Army has completed construction of over 9 000 latrines.

Following the results from the third round of the water quality monitoring survey, WASH sector has prioritized hygiene promotion and household level water treatment.

Partners implemented several activities. UNICEF facilitated reaching out to 276 488 people with critical and life-saving messages through different community level activities and radio broadcasts. A 25-minute live phone-in programme titled 'For Everyone' on hygiene promotion was broadcast by Cox's Bazar's regional Betar Radio Station, covering around 200 000 listeners and magazine programmes on hygiene promotion were broadcast. A total of 4 963 people in makeshift camps provided feedback through 8 Information and Feedback Centres.

25 "model mothers" were identified as ambassadors to reach communities with key preventive lifesaving messages on IPC skills and were provided job aids such as flash cards, bags and umbrellas. FH/MTI implemented over 1 289 household public health education visits and 4 151 household visits in December in Kutupalong, whereas 766 patients in November and 481 in December were treated in Diarrhoeal Treatment Units (DTUs). Similarly, 848 patients were treated in Nayapara DTU in November and 975 patients throughout December. IFRC-BDRC conducted training on ORP for 30 volunteers. In Hakimpara, 57 community volunteers were trained in collaboration with Canadian Red Cross on diarrhoeal disease prevention and control. Agrajatra Health NGO has facilitated the supply of a total of 180 000 liters of pure drinking water by water truck since 1 October 2017 for 3 500 families as of 15 December, 2017. They are also distributing halogen tab among 2 000 families for water purification.

3.5 Nutrition

Addressing the alarming high rates of severe acute malnutrition is a multi-sectoral priority and nutritional services are included in the package of minimum health services. WHO is providing technical support to the preparation of a multi-sectoral plan led by the Nutrition sector with the involvement of the Food Security, Shelter, Health and WASH sectors. In addition, the Health Sector Coordination Group is supporting the Nutrition sector to standardize the management of children in Outpatient Therapeutic Program (OTPs) in collaboration with different organizations. A rapid mapping of all health and nutrition services centers is being done regularly to update partners on the actual situation in the field.

The information yielded has enabled the identification of gaps and oversupply and the health sector is now supporting the process of reassigning health care facilities to under-served areas, and allocating sites for new facilities. MOHFW has planned establishment of government health facilities that can be further supported and strengthened by the partners for provisions of quality health services. Nutrition therapeutic programmes have been implemented to provide treatment, care and nutritional care to children suffering from malnutrition. More specifically, a total of 19 729 children (aged 0-59 months) suffering from Severe Acute Malnutrition (SAM) were treated by the health partners, 1 476 boys and girls (6-59 months) were identified as affected by MAM and were admitted to outpatient settings for treatment (cumulative: 12 527). A significant number of MAM children who were identified during screening were admitted to a Blanket Supplementary Feeding Program.



Partners are also implementing other activities. UNICEF supported Public Service Announcements (PSAs) to raise awareness on the Nutrition Action Week (NAW). Save the Children provided 16 714 OPD consultations (6 747 children screened with MUAC and 689 children identified as SAM). Terres des Hommes opened 5 Outpatient Therapeutic Feeding Program (OTP) sites. A total of 80 Community Health Volunteers have been identified and trained on nutrition screening using Community Bases Management of Acute Malnutrition. World Concern International implemented cooking demonstrations before distribution of supplementary food at centre level.

3.6 Sexual and reproductive health

Sexual and Reproductive health (SRH) services have been further streamlined. A SRH Task Force led by UNFPA is developing the referral protocol and mechanism and data collection tools. Referral pathways for

Gender-based violence (GBV) were also set up and clinics providing health services for the clinical management of rape (CMR) have been mapped and shared. To improve referrals, information on ambulances has been collected and shared, but needs to be updated regularly and distributed more widely. Hygiene kits for women (13-49 years) have been distributed (target of 4000 in first six months). Cash vouchers as well as “mama and baby kits” are being distributed as to promote health facility based deliveries.

Partners are also implementing other activities. IOM provided 4 111 pregnancy related services (3 331 antenatal care, 503 post-natal care and 277 deliveries). BRAC identified 9 010 pregnant women, provided 21 645 ANC and 2227 PNC consultations and conducted 312 facilities-based deliveries. BRAC also distributed 9406 oral contraceptive pills and 4032 condoms. Save the children (SCI) is working closely with child protection team to integrate adolescents sexual and reproductive health activities with the adolescent safe space program. Relief International provided treatment and support for SGBV survivors including the Clinical Management of Rape and referral to Psycho-social support. Health and Education for All (HAEFA) has also established an effective referral system for sexual violence victims and safe delivery of pregnant women. HOPE Foundation, with the support of UNFPA, conducted 12 Deliveries, 7207 ANCs, 320 PNCs and Family Planning counseling to 2430. The Dhaka Ahsania Mission (DAM) provided HIV pre & post-test counseling to 160 patients in Ukhia and 188 in Jamtoli.

3.7 Mental health and psychosocial support (MHPSS)

Integration of service provision for mental health and psychosocial support services into the primary and secondary healthcare services is a crucial need. Further strengthening of information management is expected to better understand the non-communicable diseases burden and better address the response. MHPSS Working Group has conducted mental health needs assessment in Ukhia and Teknaf Upazilas. Results will be available by mid January 2018. The Working Group is developing technical guidelines and SOPs on provisions of mental health services in the camps. In the last two months ACF has provided Psychological First Aid between for more than 37 895 beneficiaries. UNHCR conducted training on mhGAP for primary care doctors to integrate mental health in primary health services. IOM provided psychosocial support to 1499 people.

3.8 Palliative care and non-communicable diseases

Integrated management of treatment of non-communicable Diseases is considered by Health Sector as essential particularly in ensuring screening and continuation of care. World Child Cancer (WCC) and Fasiuddin Khan Research Foundation (FKRF) are providing palliative care support in Ukhia camps based on a rapid palliative care situation analysis was conducted at the end of November 2017 and allowing the training of ten “palliative care assistants” at the end of December. A systematization of reporting of non-communicable disease treatment reporting is ongoing and will be functional in the next months. So far, information from Sajida Foundation report delivery of treatment to 60 cases of diabetes, 92 cases of hypertension and 63 cases of kidney related diseases in Ukhia.

3.8 Provision of essential drugs and supplies

WHO continued to transfer essential medical logistics to partners based on requests received. A total of 137 IEHK basic medical kits were distributed; together with more than 416 000 units of personal protective equipment (PPE) related items (e.g. gloves, face masks). Medical equipment distribution is proceeding according to need with supply of 27 000 units (packs of disposable syringes, needle, IV sets, oxygen sets and tubing, bio-hazard waste bag etc). Diphtheria Anti-toxin (DAT) vials has been provided to MSF and other partners for management of severe diphtheria cases. More than 342 000 antibiotic tablets (erythromycin and azithromycin) were distributed for chemoprophylaxis through contact tracing.

3.9 EWARS

In collaboration with MOHFW, during the final week of December 2017 Health Sector revamped and revised the Early Warning, Alert and Response System (EWARS) in the camps. A new, innovative system has been implemented allowing partners to submit reports online or using mobile phones, allowing for more real-time sharing of information and triggering of alerts. This system also reduces the burden of paper-based reporting. The alerts generated are also being linked to the Upazila Rapid Response Teams, so prompt action can be taken to investigate potential outbreaks and initiate appropriate public health action where needed. The system will begin reporting from epidemiological week 1, 2018 and regular bulletins will be shared with all partners and at the health sector coordination meetings.

4. HEALTH SECTOR COORDINATION

Health Sector Coordination Group is working to bridge the gaps between the health and health-related sectors; notably, WASH, Nutrition, SRH, MHPSS and Civil-Military Coordination. Regular weekly meetings with these sub-sector working groups had been conducted and information and decisions for public health actions were also shared during inter-sectoral working group (ISCG) meetings every week.

A Host Community Working Group has been established under the lead of the district commissioner to address the concerns and needs of the host community. Inter-sectoral linkages between health and nutrition, WASH, SRH, and MHPSS are being strengthened through weekly coordination meetings. Health Sector is also actively involved in coordinating with ISCG for preparedness towards the possibility of running of a multi-inter sector rapid assessment in case of natural disaster.

The Health Sector Coordination Group has actively pursued the Civil Surgeon Office, DGHS Coordination Cell and the RRRC for formalization of the permission for 24/7 emergency health services equitably distributed across all population in need. In the meantime, mechanisms and procedures for land allocation and construction of health facilities as the MOHFW and RRRC are gradually moving towards systematic regulation and control on presence and construction of health facilities by the NGOs/INGOS or UN agencies so as to match the health needs of FDMNs and host community.

On the operational front, regular health updates on public health risks and vulnerabilities, assessments, ongoing diphtheria outbreak, immunization coverage and challenges in implementation of services by the health sector partners were regularly shared in the routine Health sector Partners meeting, Civil-Military Coordination Group meetings and other forums every week.

The draft of the Health Sector need overview and strategy under the Joint Response Plan for 2018 has been developed through a participative and consultative workshop on 19 December 2017. A further consultation workshop is being planned for mid-January to refine the health sector operational plan and develop a budget and donor proposal for resource mobilization.

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