The meeting started with introduction of new comers along with health safety advice to them. The new comer humanitarian staff was advised to consult their project managers for receiving vaccination against Diphtheria from the field vaccination booth sites as per the vaccination schedule plan if they could not get it during pre-departure preparation from their home country.

Opening remarks: Dr Nilesh Buddh, Incident Manager of WHO opened the meeting. Welcome address was given by Md. Shiraz Islam, Chief Coordinator, DGHS Coordinating Cell. He commented that Diphtheria response is still very crucial because it is a disease which was not seen in Bangladesh in the last 3 decades. The acting Civil Surgeon Dr. Md. Alamgir welcomes and expressed special thanks to all the partners from national and international NGOs, and UN agencies. He expressed special thanks for major contribution of MSF in Diphtheria cases management and to WHO in coordinating, providing technical assistance and mobilizing resources in management of health emergency response.

Overall situation update: The IOM presented updates on the overall situation in the Cox’s Bazar refugee camps. According to latest NPM total influx is 655000 since 25 August (IOM Needs and Population Monitoring round 7). No change since last week updates. There are around 547,000 refugees in Kutupalong-Balukhali, 242,000 in other settlements and camps and 79,000 in host communities. Total population of refugees including pre-existing refugees (prior to 25th August 2017) has reached to 866000. Some crucial info from NPM are presented on needs analysis. Coverage of health facilities is still ongoing in areas where these are not present yet such as ZZ and the rest of the western areas of the settlements. Major road access is almost complete.

Updates on Diphtheria outbreak: The District Core Committee on Diphtheria Response is closely monitoring the outbreak and response interventions. As on 26th December 2017, cumulative number of suspected Diphtheria cases has reached to 2526 including 96 cases from yesterday and 1 deaths making cumulative number of deaths to 27. Majority (34%) of cases have been in the age range 05-09 years although under 15 years of ages contributes to 74% of caseload. Over the last week, the epicurve seems to have plateaued with gradual declining of reported cases. Case fatality rate is very low.

As the usage of the clinical case definition in the camps health clinics has improved and it has enhanced specificity in the diagnosis cases indicated that 40.9% of the total cases reported were diagnosed with pseudo-membrane formation in the throat of patients. Contact tracing of diphtheria cases has been implemented and streamlined over last 5 days. For each diphtheria case, there has been contacts ranging from 5- 20. It is much better tracing of contacts over last two days but there are challenges in tracing contacts in particularly in Kutupalong area as it is difficult for people as they do not know exact description of residential address where they live. MSF suggested that volunteers involved in contact tracing need to speak to patients to understand the location about signs and address system.
**Epidemiology updates:** Morbidity and Mortality Weekly Bulletin (MMWB) No. 9 has been shared and published on WHO Bangladesh website. Partners were encouraged to visit the website.

**WASH Situation:** Results of the 3rd Water Quality Monitoring Surveillance were shared. The WASH situation in camps is still worrisome. Under round 3, 686 samples from water sources, and 1108 samples from households were collected for water quality testing. The analysis of 686 source samples showed that 70% of water sources in the camps are free from *E. coli* contamination. In Roikong/Uchiprang camp, 33% of the water sources are contaminated. At household levels, 81% of the water samples collected were found contaminated with *E. coli*. The detailed report will be soon shared. Partners were urged to focus more on promotion of hands hygiene and raising awareness on methods of disinfecting water at “Point-of-Use” at household levels. The enhanced linkage between Health and WASH Coordination groups was also accepted and highlighted.

**Early Warning And Response System:** Understanding the importance of early detection of public health risks for guiding timely investigation, preventive and control interventions, the significance and importance of EWARS was flagged. It supports MOHs, local health systems and health partners through the provision of technical support, training and field-based tools.

Presently, a lot of work is ongoing on manually filling excel based forms. Current version of EWARS is fairly doing a good job on the early warning side. The alert side would need more systematization. However, a mechanism is needed to improve the EWARS tapping on mobile-based technology. Proposed changes are to be discussed with the local health authorities. As currently, most of the reporting is daily but it may not be necessary because of lack of existing capacity of doing daily analysis. One recommendation would be to shift on weekly report. There is also need to review the list of diseases for prioritization on reporting. It will be complemented with event-based surveillance which means that if any significant outbreak event is reporting during the week then also it will be captured despite weekly-based fixed reporting date. Strengthening the data analysis would be the next step. Training for the revamped EWARS model is proposed on Saturday (30 December). First epi-week of 2018 can be the 1st week to adopt the improved EWARS system.

There should be a specific list of facilities with complete names or complete codes but yet to understand how to identify and allot codes to these facilities (in want of proper geographical or catchment areas based boundaries in the camps).

SRH Working Group informed that hepatitis E in pregnancies is being detected. The group asked if the improved EWARS considering also particular groups such as Pregnant women. Such alerts which are important and should not be ignored due to weekly-based reporting will definitely be captured as part of event-based reporting and alert system inbuilt in the

**Diphtheria response:** MSF has been major partner in treatment and care of diphtheria case management since the beginning of identification of suspected cases. New partners; BARC (in Kutupalong), IOM (in Leda), Samaritan Purse and Japanese Red Cross are joining hands in diphtheria case management. The Emergency Medical Teams from UK and Australia will soon arrive in support of the MOH in managing diphtheria case management. There will be around 600 bed capacities soon including adequate capacity for Red Beds for the severe diphtheria cases.

WHO is conducting training for staff from different partners on 27 and 31st December 2017 and on 02 January 2018 on clinical case management of diphtheria. The target is to train around 100 staff from different partnering agencies. There is also a plan to train health facilities (150 staff) in first weeks of January 2018. These trainings will cover the gap on lack of adequate number of staff and will refresh the technical skills of staff in management of Diphtheria cases.
The DGHS in coordination with WHO and RRRC are striving to equitable distribution of health facilities in across different zones in the camps and settlements so the all the refugees get access to essential emergency health services. The MOH also has a plan to establish 20 government health facilities to cover the zones/block needing health facilities which can be supported by the health partners. The RRRC will have a 11 members’ committee to oversee the equitable distribution of health facilities across the refugees’ camps.

On the question of any set timeframe for the additional 20 government health facilities in the camp sites, the DGHS Chief Coordinator Ms Shiraz Islam explained that it was difficult to quote any specific agreed time-frame because on ongoing development and process for voluntary repatriation of Rohingya under the bilateral agreement between Bangladesh and Myanmar but we are dedicated to providing essential health services in camp areas taking into account the practical aspects that it may take some significant time (months to year/s) to implement the procedures of repatriation.

The problems of lack of ambulance transport systems, referral mechanism and SOP were put forth for discussion. There is need of nurses for care of in-ward patients. The expressed need of nurses touched the figure of 100+. The Nursing Training Institute in Cox’s Bazar has offered deployment of nurses (newly gradates or about to graduate) to which MSF asked for facilitation by the Civil Surgeon Office and DGHS Coordination Cell if the Nursing Council could issue provisional license to these nurses. MSF can train these nurses and induct into case management. Health partners also considered the rights of the host community on nurses’ availability as there is already a shortage of nurses in Bangladesh hence do not prefer deployment of experienced nurses from host community hospitals to the camps but it depends on the Civil Surgeon Office if the competent Authority decided to spare some nurses.

Mass Vaccination against Diphtheria: A brief was provided on the mass vaccination campaign against diphtheria, target population and strategies adopted. The mass vaccination campaign started on 12th December and will be completed on 03rd January. For children of age 6 weeks to <7 years of age, OPV, Pentavalent and PCV are being provided. Td vaccine as booster dose was added on 17th December to the campaign for the age group 7 to <15 years. There are 61 teams vaccinating in Ukhiya and 20 teams in Teknaf areas. Vaccination cards are being provided to all vaccine recipients. Social mobilization is being done through Mazhis, and community volunteers. One female vaccinator is included on mandatory-basis in each team. During the period 12-26 December 2017, the cumulative coverage of penta vaccine has been 56.16% and for Td 64.2%. It is estimated that by 31st December, overall coverage could be around 90% which will be complemented during 01-03 January 2018 through mop-up campaign to achieve the target of 95% coverage.

A total of 12000 humanitarian health workers have been vaccinated against Diphtheria by 26 December 2017.

The Government of Bangladesh is planning to vaccinate all school children (6 years to 15 years) in the host community with Td vaccine starting from 01 January 2018. As the school enrolment rate is around 97% hence it is expected that 95% of the children will be covered.

It was highlighted that Mazhis has so many other responsibilities so sometimes it has been difficult to avail their services.

Risk communications: The risk communication package has been shared. Key thematic messages are available in English, Bangla and Burmese, to address and minimize rumours circulating and avert any panic in the Rohingya and host population. A rumour tracking mechanism has been established: based on current feedback, rumours so far do not appear to be widespread nor impacting health-seeking behaviours (social mobilisation for vaccine is quite successful)
A training package jointly developed by GoB, UNICEF, WHO and UNHCR was shared with health partners. It also included guidance for child learning centres and child friendly spaces.

**Humanitarian Response Plan:** The draft Health Strategy evolved in consultation with health partners was shared with the ISCG. A joint planning workshop will be conducted on 14th January 2017 to further discuss humanitarian needs overview and Humanitarian Response Plan with health partners.

**Nutrition Coordination Group:** Nutritional status of the Rohingya population is poor. Around 50% of the general population of Rohingya are malnourished. Acute malnutrition rate among under-5 children is 25%. It is estimated that 40% of the under-5 children could get diarrhoeal diseases. The linkages between nutritional data and health response plan need to be strengthened. The nutritional working group also requested to including Severe Acute Malnutrition to the EWARS.

**Sexual and Reproductive Health Coordination Group:** The SRH Working Group informed about the establishment of a Task Force for defining referral pathways on pregnancy related complications. A SRH data collection tool has been developed. SRH group was requested to share the baseline information available in the database with them with the Health Sector Coordination Group on complicated pregnancies, pre-term deliveries, and peri-natal mortality etc. Hepatitis E was found among 4 pregnant women. The updated on incentives to promote ANC check-ups and visits to health facilities were shared. At first ANC visit a torch-light, 2nd ANC visit a voucher for referral, 3rd ANC visit a clean delivery kit and on 4th visit to health facility a mamma kit will be provided. Information on upcoming SRH trainings during January-March: “helping Mothers Survive” and “Helping Babies Breath” was provided.

**Mental health and Psychosocial Support Coordination Group:** The group shared their activities on individual and group counseling, recreational and therapeutic activities and psychiatric support in Ukhiya, Teknaf and Cox’s Bazar areas. Currently, 13 organizations are providing MHPSS services on ground. MHPSS-IOM and ACF are conducting mental health needs assessment. IOM is conducting FGDs and interview in Ukhiya and Teknaf. Quantitative assessment has been done by ACF in Ukhiya, Teknaf and Cox’s Bazar. The MHPSS Task Force is developing technical tools and SOPs.

**AOB:** Some doctor in Bangladesh are appearing in civil examination for recruitment therefore may not be available for next 3 days.

**Workshops/meetings**

- Sexual and Reproductive Health Working Group meeting: tomorrow 28th December at 10 am at Sayeman Hotel
- MHPSS Coordination Group meeting at BRAC office on 28th December at 2:00 pm at BRAC learning centre.
- Acute Watery Diarrhoea meeting: Tuesday 2nd January 2018 at 2pm at WHO office, Allegro Suites Hotel

**ACTION POINTS**

1. Health partners are to focus more on promotion of hands hygiene and raising awareness on methods of disinfecting drinking water at ‘Point-of-Use’ at household levels.
2. Improved version of EWARS need to consider inclusion of Severe Acute Malnutrition, hepatitis E and B among pregnant women under event-based surveillance component of EWARS. Training date on new EWARS need to be communicated to the participants by the Health Sector Coordination Group.
3. Need of strengthening referral mechanism and ambulance transport system and requirements of nurses need to be discussed in the next Strategic Advisory Group Meeting.
4. The SRH Coordination Group to share the baseline information on key indicators with the Health Sector Coordination Group
5. The MHPSS Coordination Group to share the findings of the mental health needs assessment with the Health Sector Coordination Group
6. Partners running health facilities are requested to share disease morbidity and mortality data/line lists in time on the designated email (healthcxb.info@gmail.com)
7. Partners wishing to establish new facilities were reminded not to approach the Civil Surgeon’s office nor the RRRC directly, but should get in touch with the health sector first who will work with the relevant authorities to review the proposal.

CONTACT

Flavio Salio - Health Sector Coordinator: salio@who.int, healthcxb.coord@gmail.com