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WHO Health Emergency Appeal for the Rohingya crisis 2018

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health humanitarian appeal for the Rohingya crisis

2018
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SITUATION OVERVIEW

It has been described as one of the worst humanitarian crises of our time. Since 25 August 2017, an estimated 688,000 Rohingyas fleeing violence in Myanmar’s Rakhine State have crossed into Cox’s Bazar, Bangladesh. The new arrivals have joined some 213,000 Rohingyas already in Bangladesh following earlier waves of displacement. This is the second biggest exodus since the Rwanda genocide of 1994.

Now, nearly 1.3 million people are in desperate need of health assistance (nearly one million Rohingya arrivals and 300,000 in the host communities). The numbers are staggering and behind every number is a story. These people are highly vulnerable, have experienced severe trauma, and are living in extremely difficult conditions.

Cox’s Bazar is one of Bangladesh’s poorest districts; poverty is well above the national average and the sheer number of new arrivals has overwhelmed existing health services. In addition, the district is prone to natural disasters and the imminent monsoon season presents high risks of flooding, landslides and storm damage, leading to potential communicable disease outbreaks and disruptions to routine health service delivery.

However, amidst the crisis there have been stories of hope and resilience. WHO is supporting the Ministry of Health and Family Welfare (MoHFW) to meet the growing needs in Cox’s Bazar – by improving access to life-saving health services; preventing and responding to disease outbreaks; and strengthening coordination among over 100 health sector partners.

WHO remains the only actor in support of the MoHFW with the mandate and capacity to set priorities, minimum standards, and support quality health service delivery even in complex and changing contexts such as that of Cox’s Bazar. Together with local and national public health authorities, WHO is ensuring coordination at technical and sector levels to safeguard ongoing health service provision, and ensure emergency preparedness and response. This coordination is designed to strengthen local capacity and support health actors.
MAIN PUBLIC HEALTH RISKS AND CHALLENGES

Communicable diseases

With new arrivals every day, the camps in Cox’s Bazar are becoming increasingly overcrowded. After their long journey, many refugees arrive in a weakened state, and are thus more susceptible to disease. In the initial phase of the crisis, the very low vaccination coverage of the Rohingyas before displacement – coupled with malnutrition, overcrowding and a general weakened health status – put the population at high risk of epidemics. WHO and partners have been working hard to combat communicable diseases and have conducted a number of successful large vaccination campaigns.

As of 19 March 2018, there have been over 6000 cases of diphtheria reported in the settlements, of which 195 are confirmed, and 3307 probable and 2754 suspected. So far a total of 39 deaths have been reported. About 200 cases have been reported each week over the last month, and sustained efforts are required in order to control and ultimately end the epidemic. WHO has been providing technical expertise and assisting the MoHFW in coordinating outbreak response – ensuring timely detection of cases, appropriate treatment, contact tracing for preventive treatment and protecting the most vulnerable groups with vaccination.

In less than 6 months, 7 mass immunization campaigns have been successfully conducted and thousands of lives saved

WHO has actively supported MoHFW in planning and implementing multiple life-saving vaccination campaigns in Cox’s Bazar, including campaigns against Measles, Rubella, Polio, Cholera, Diphtheria, Tetanus, Whooping Cough (pertussis), Hib disease (Haemophilus influenza type b), and Pneumonia.

Since October 2017, the MoHFW and partners have ensured systematic health screenings and immunizations for children 6 months to 15 years at Sabrang and Shar Pwor Dip entry points, including administration of Penta/Td, bOPV, PCV and MR vaccines. Around 500 000 children were vaccinated against diphtheria during the first round which also covered host communities. Nearly 398 000 children aged 6 weeks—15 years were immunized during the second campaign with over 95% of the target achieved (see details in table below).

WHO established an electronic Early Warning and Response System (EWARS) to rapidly detect and respond to disease outbreaks. As of week 10 of 2018, 153 health facilities are enrolled under health-facility based surveillance (this means 728 786 people, or 84% of total Rohingya refugee population, are included). Every day, WHO and IEDCR epidemiologists and surveillance officers work to verify and investigate alerts triggered through EWARS. Teams can receive over 90 alerts per week which require verification – several of which may trigger further field investigations.
### Vaccination campaigns conducted in Cox’s Bazar from September 2017 to March 2018

<table>
<thead>
<tr>
<th>Vaccination campaigns</th>
<th>Date of campaign 2017-18</th>
<th>Age group targeted</th>
<th>Children reached</th>
<th>Remarks / achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two rounds of measles &amp; rubella campaigns conducted</td>
<td>October</td>
<td>R1*: 6 Month to &lt;15 years</td>
<td>135 519</td>
<td>At least 4000 deaths and several thousands of measles cases averted among the refugees</td>
</tr>
<tr>
<td></td>
<td>December</td>
<td>R2*: 6 Month to &lt;15 years</td>
<td>354 982</td>
<td></td>
</tr>
<tr>
<td>Two rounds of oral cholera vaccination (OCV) conducted</td>
<td>October</td>
<td>R1: All population above 1 year age</td>
<td>700 487</td>
<td>Second largest OCV campaign conducted in the world – averted an imminent cholera outbreak</td>
</tr>
<tr>
<td></td>
<td>November</td>
<td>R2: 1 to &lt;5 years</td>
<td>199 472</td>
<td></td>
</tr>
<tr>
<td>Four rounds of oral polio vaccination conducted</td>
<td>October</td>
<td>R1: 0 to &lt;5 years</td>
<td>72 334</td>
<td>Polio campaigns were integrated with other vaccination campaigns, ensuring adequate protection against polio</td>
</tr>
<tr>
<td></td>
<td>November</td>
<td>R2: 0 to &lt;5 years</td>
<td>236 696</td>
<td></td>
</tr>
<tr>
<td></td>
<td>December</td>
<td>R3*: 6 weeks to &lt;5 years</td>
<td>149 962</td>
<td></td>
</tr>
<tr>
<td></td>
<td>January</td>
<td>R4*: 6 weeks to &lt;7 years</td>
<td>171 382</td>
<td></td>
</tr>
<tr>
<td>Three rounds of pentavalent (Diphtheria, Pertussis, Tetanus, Hib &amp; Hepatitis B) campaigns conducted</td>
<td>December</td>
<td>R1: 6 weeks to &lt;7 years</td>
<td>149 962</td>
<td>Thousands of lives saved, massive spread of diphtheria outbreak averted</td>
</tr>
<tr>
<td></td>
<td>January</td>
<td>R2: 6 weeks to &lt;7 years</td>
<td>171 382</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>R3: 6 weeks to &lt;7 years</td>
<td>88 659**</td>
<td></td>
</tr>
<tr>
<td>Three rounds of Td (Tetanus &amp; diphtheria) vaccination conducted</td>
<td>December</td>
<td>R1: 7 years to &lt;15 years</td>
<td>165 927</td>
<td>Booster dose provided for higher age groups</td>
</tr>
<tr>
<td></td>
<td>January</td>
<td>R2: 7 years to &lt;15 years</td>
<td>225 993</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>R3: 7 years to &lt;15 years</td>
<td>128 526**</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- *R1=Round one; R2*=Round two; *R3=Round three; R4*=Round four
- **Coverage as of 18 March 2018 (campaign in progress)
- Around 355,000 children are protected from measles and rubella
- >700,000 people received cholera vaccines
- Around 200,000 children received bi-valent oral polio vaccines
- >170,000 children 6 weeks to <7 years are protected from diphtheria, pertussis, tetanus, haemophilus influenza type-b and hepatitis B
- >225,000 children 7 to 15 years are protected from diphtheria and tetanus
Water- and vector-borne diseases

Water-and vector-borne diseases pose a significant threat to the lives and well-being of Rohingya refugees and the host community. This is primarily due to overcrowding, lack of water and sanitation and rudimentary living conditions. Around half the population lacks access to sanitary latrines and sufficient water (70% of water samples collected from households were contaminated with E.coli), plus soap for handwashing is scarce and boiling drinking water uncommon.

The impending monsoon season brings risks of new and larger disease outbreaks. Building on the AWD/cholera preparedness work in October 2017, WHO has lead the Health Sector Outbreak Response Sub-technical Working Group in preparing most likely scenarios for emergency response (including prevention of Hepatitis A and E, Shigella/ Dysentery, Typhoid fever, and also vector-borne diseases such as Dengue and Malaria). Malaria is endemic in Chittagong District, one of the highest risk areas in Bangladesh due to the forested hill tracts. Cases of Dengue are usually reported from June to October as intermittent rains, high temperature, and humidity create ideal breeding conditions for mosquitoes.

Regarding waterborne diseases, WHO is working with the Department of Public Health Engineering (DPHE) to implement the 4th round of water quality monitoring in the camps and has already supplied 2 million chlorine tablets to disinfect drinking water, as well as enough supplies to treat 20 000 cases of AWD/Cholera. WHO leads the joint Health and WASH partner technical working group on AWD, and monitors partners’ prevention and preparedness activities e.g. providing technical advice on the implementation of Diarrhoea Treatment Facilities and Oral Rehydration Points. Furthermore, WHO is deploying risk communications specialists to help deliver messages and materials on outbreak prone diseases in affected communities.
Access to essential health services

The situation on the ground is fluid and the displaced population are constantly on the move. Humanitarian partners are providing health services through mobile outreach teams and a total of 261 health facilities and 6 field hospitals have been established so far, however, availability of services is variable. The Health Sector continues to advocate scaling up health facilities to equitably meet increasingly urgent demands of the refugee and Cox’s Bazar local population.

The priority is on consolidating and bringing to standard existing structures in order to ensure high quality service delivery. The sexual and reproductive health needs of the new arrivals require urgent attention, with approximately 60 000 women estimated to be pregnant and requiring basic or comprehensive emergency obstetric care. Among these women, so far, only 22% are reported to be using health facilities to give birth. Within the Humanitarian Response Plan (Sept 2017-Feb 2018), Phase 1 of the health sector response prioritised urgent scale-up of life-saving services for women, pregnant and lactating mothers, girls through the implementation of the Minimum Initial Services Package (MISP) and improving functional referral pathways linking health services with other sectors, such as protection/safe spaces for women and girls through community outreach. Phase 2 will prioritize upgrading health post capacity to move toward the provision of multi-disciplinary health care, including integrated comprehensive Sexual and Reproductive Health (SRH) services. Focus is also on expanding 24/7 service provision, strengthening mental health referral pathways, and extending national programmes for Malaria, TB, HIV, and NCDs into the camps in a way that meets minimum standards of care.

Coordination of the humanitarian health response

The Office of the Civil Surgeon is coordinating the health sector response with WHO’s technical and operational support. For example, WHO supported the establishment of an Emergency Operations Centre (EOC) at the WHO office in Cox’s Bazar to assist the government with the diphtheria response operations. WHO is supporting the government’s health sector team in continuing to lead and coordinate the efforts of 112 health partners managing more than 261 health facilities (including health posts, hospitals, specialised treatment centres and mobile clinics). Health interventions are being implemented in synergy with other crucial sectors such as WASH, Nutrition, Protection, Education and Site Management.

Emergency preparedness and response

Bangladesh is ranked 13\(^\text{th}\) in the world at risk of natural disasters with flooding and cyclones ranking highest. Less than 1 year ago, Cox’s Bazar and Chittagong were ravaged by Cyclone Mora which struck on 30 May 2017 bringing widespread flooding and damaging winds up to 130km/hr affecting over 3 million people.

Experts have evaluated the current landscape where refugees are residing and noted at least 102 000 people are living at risk of flooding or landslides (32% of households included are considered vulnerable with female-headed households, pregnant women, elderly or disabled people). It is anticipated that 53 health facilities will be directly affected by flooding or landslides. In addition, heavy rains will cause latrines to overflow and further infect already contaminated water.
points, and landslides at small and large scale are anticipated leaving people suddenly without shelter and needing immediate first aid and psychosocial support.

In view of this, the Health Sector convened an Emergency Preparedness and Response technical working group in early February 2018 to begin planning for a number of possible scenarios. A draft response plan was subsequently developed which includes the following focus areas: (1) coordination, (2) health facility relocation and structural reinforcement, (3) health logistics, (4) community preparedness, (5) mobile medical teams, (6) trauma and mass casualty management, (7) outbreak preparedness and response, (8) dead body management, and (9) mental health and psychosocial support. WHO is working with the government and other partners to implement the emergency preparedness plan by mapping health facilities to identify those at risk for relocation, establishing and rostering pre-trained mobile medical teams, strengthening community preparedness through risk communications, establishing culturally-appropriate dead body management system, and ensuring good linkages with intersectoral coordination mechanisms.
KEY ACHIEVEMENTS TO DATE

During the last 6 months, WHO has supported the MoHFW and 112 health partners as follows:

- **Established Early Warning and Response System (EWARS) in 153 health facilities to enable timely detection and response to disease outbreaks**
- **Supported the establishment of an Emergency Operations Centre (EOC) at the Civil Surgeon’s Office in Cox’s Bazar to assist with diphtheria response operations**
- **Led the planning and roll-out of 7 preventive and reactive mass immunization campaigns administering 2.7 million doses to children <15 years among both Rohingya and host communities**
- **Provided 100 tons of essential medical kits and equipment, laboratory reagents, consumables, equipment, and diagnostic kits, and even structural kits including tents for temporary the health facilities and mobile medical teams**
- **Supported the planning and training of MoHFW and partner-led routine immunization teams, for 76 fixed sites within the Rohingya refugee camps and settlements**
- **Defined a minimal package of health services with on-going capacity-building/training on standards such as Infection Prevention and Control (IPC), treatment and diagnosis**
- **Partnered with the national Institute of Epidemiology Disease Control and Research (IEDCR) and the Institute of Diarrheal Disease Research in Bangladesh (ICDDR,B) to ensure timely confirmation and adequate diagnostic capacity for outbreaks such as measles, diphtheria, acute jaundice syndrome, and various diarrheal diseases**
- **Surging in Emergency Medical Teams from U.K. and Samaritan’s Purse to staff, run, and build capacity of Diphtheria Treatment Facilities from December 2017 to February 2018**
- **Provided timely information and mapping on health service availability and supported functional patient referral pathways within and without the Rohingya camps and settlements as well as at Cox’s Bazar and Chittagong District levels**
- **Conducted IPC and WASH services survey in 194 out-patient and primary health care facilities in Rohingya camps and settlements, including, water quality testing, availability of water, latrines, handwashing facilities, waste management, and support staff as per minimum standards**

“We are able to save hundreds of lives during the Diphtheria outbreak at Ukhia and Teknaf with support from WHO all along. WHO has been closely supporting the Ministry of Health and Family Welfare in planning, implementing and monitoring mass vaccination campaigns and routine immunization in Rohingya camps”

Dr Misbah
Upazila Health and Family Planning Officer,
Ukhiya, Cox’s Bazar, Bangladesh
- Supported DPHE in 3 rounds of water quality surveillance and sanitary inspection across all Rohingya camps and settlements to identify water sources that are microbiologically (E Coli) contaminated, as well as potential risks of contamination, providing actionable information to WASH partners for risk reduction.

- Drafted and coordinated the Emergency Preparedness and Response Contingency Plan for the monsoon season in collaboration with key stakeholders;

- Together with MoHFW, WHO has a successful track record in coordinating and supporting the ongoing Diphtheria outbreak, providing key technical guidance in case management, surveillance and epidemiology, laboratory support and supplies.

- Procurement of essential psychiatric medicines and conducted a series of Mental Health GAP trainings for non-specialists working in Cox’s Bazar to increase the capacity of the primary health care system to manage common mental disorders and prevent tertiary hospitalization.

- Assessed 19 partner-led Diarrheal Treatment Centres for medical, logistical, and WASH-related “readiness” and provided technical guidance on planning and roll out.

- Engaged with external stakeholders to support and invest in MoHFW key hospital structures, including plans for a 250 bed scale-up of Cox Sadar District Hospital, as well as increased capacity for triage and infection, prevention, and control in Ukhia and Teknaf Health Complexes.

“\nThe support from WHO for Medical Teams International has been wonderful since we’ve been in Bangladesh. They have provided supplies for our in-patient diarrhea unit, which will treat several hundred people, and also provided most medications we’re dispensing here in our outreach clinic far from the centre of the camp”

Dr Bruce Murray
Internal Medicine Physician, Medical Teams International
### WHO’S PLANNED RESPONSE IN 2018

<table>
<thead>
<tr>
<th>Health objective</th>
<th>Key interventions</th>
</tr>
</thead>
</table>
| 1. Improve access to lifesaving and comprehensive primary and secondary health services for crisis-affected populations aimed at reducing avoidable morbidity and mortality | **Strengthen existing health facilities – primary and secondary**  
- Strengthen existing primary and secondary health facilities, specifically Sadar hospital and Ukhia and Teknaf Upazila Health Complexes – including refurbishment, upgrading equipment, and human resources capacity-building  
- Operationalize referral mechanism  
- Continue to procure and distribute essential medicines and medical supplies to fill critical gaps  
- Establish and maintain a monitoring system for medical supply needs  
- Build further capacity on infection prevention and control (IPC) and waste management in health facilities  

**Noncommunicable diseases (NCDs)**  
- Conduct assessments of NCD services in the camps and strengthen coordination, supervision and monitoring  
- Assess NCD burden and NCDs needing emergency care and routine ambulatory care and strengthen data collection by partners  
- Develop service delivery mechanism for emergency NCD conditions and improving ambulatory care services including palliative care  
- Build the capacity of care providers to manage common NCDs and operationalize/refine referral system  

**Mental Health & Psychosocial Support (MHPSS)**  
- Develop an operational plan for implementation of key MHPSS interventions and provide technical/strategic support to the working group as well as overall coordination  
- Develop and disseminate guidelines for MHPSS services, build capacity and improve access to mental health and psychosocial support services – specific to each level of care  
- Lead MHPSS related emergency preparedness activities  
- Harmonize Psychological First Aid trainings regarding emergency preparedness; train community focal points and other relevant staff  
- Support Mental Health Gap Action Program (MHGap) supervision and coaching, as well as continue to coordinate with relevant agencies and ensure provision of MHGap trainings  

**Nutrition**  
- Coordinate with the Nutrition Sector and Health Sector partners on the integration of in-patient severe acute malnutrition support at primary health care level  

**Risk communication and IEC materials**  
- Develop and disseminate IEC materials in local languages on health service availability and health promotion  
- Train community health workers on package of activities – including risk communication, health promotion and community-based surveillance  

**Mapping health units and teams to ensure equitable distribution**  
- Mapping existing health workforce and coordinate deployment of teams
<table>
<thead>
<tr>
<th>Health objective</th>
<th>Key interventions</th>
</tr>
</thead>
</table>
| **2. Ensure the prevention and response to outbreaks of diseases with epidemic potential and other health emergencies** | **EPI**  
- Develop evidence-based comprehensive immunization strategy  
- Continue to coordinate and support routine immunization and immunization campaigns  
- Continue to provide technical and logistics assistance to EPI operations  
**Surveillance**  
- Maintain the Early Warning and Response System (EWARS)  
- Build capacity of rapid response teams (RRT) for outbreak investigations  
- Train and build the capacity of different health service providers, including MoHFW, NGOs, and other humanitarian health partners, on public health surveillance and reporting  
- Enhance capacity in community-based surveillance  
**Lab and diagnostic capacity**  
- Continue to provide equipment and supplies for public health laboratories  
- Increase capacity for basic rapid diagnostic testing for key communicable diseases and specimen shipping and transport to referral laboratories  
**Water-borne diseases – especially AWD/cholera**  
- AWD preparedness and response plan developed and implemented by WHO and health sector partners  
- Support establishment of diarrhoeal treatment unit, and prepositioning of cholera kits  
- WASH sector coordination on water-quality surveillance and sanitary inspection  
- Improve WASH and waste management facilities in healthcare facilities  
**Vector-borne diseases (VBD)**  
- Scale up diagnostic capacity and quality of available diagnostic services among partners, with particular focus on malaria and dengue, including procurement of test kits  
- Partner mapping with specific roles and responsibilities relating to vector borne diseases  
- Strengthen surveillance for priority vector borne diseases  
- Undertake case investigations and focussed interventions, including case classification, parasitological screening and entomological indices  
- Develop partner capacity for treatment of priority diseases, including for complications and referrals where required  
- Respond swiftly to mitigate local transmission chains  
- Develop specific guidelines & SOPs for vector borne disease management specific to limitations of camp setting  
- Develop IEC specific messages & material for VBD prevention  
**Risk communication**  
- Develop and disseminate risk communication material on outbreak prone diseases – including water- and vector-borne diseases  
- Train health workers at all levels on risk communication |
<table>
<thead>
<tr>
<th>Health objective</th>
<th>Key interventions</th>
</tr>
</thead>
</table>
| 3. Strengthen health sector coordination to monitor response and quality of the services provided | **Health Sector Coordination**  
- Convene regular meetings with humanitarian health partners to share information and plan emergency operations  
- Strengthen health service availability and delivery monitoring and reporting (4Ws)  
- Implementation of standardized essential service package at all levels  
- Support operations at the Emergency Operations Centre  
- Support development of joint contingency and preparedness plans for disease outbreaks  
**Inter-Sectoral Coordination - WASH, Nutrition, Shelter, Site Planning**  
- Ensure coordination with Shelter and Site Planning on allocation for health facilities, including relocation in preparation for monsoon season  
- Coordinate with WASH sector on contingency planning, as part of AWD preparedness and response plan  
- Coordinate and collaborate with Nutrition sector on integration of severe acute malnutrition management at health facilities  
**Sexual and Reproductive Health (SRH)**  
- Strengthen health sector coordination on SRH to ensure upgrading access to Basic Emergency Obstetric Care (BEmOC) services and the implementation of a 24/7 available Comprehensive Emergency Obstetric Care (CEmOC) services, supported by emergency referral  
- Strengthen interlinkages with food and nutrition sectors to ensure supplementary feeding of pregnant and lactating mothers  
**Health information and epidemiology**  
- Strengthen Early Warning Alert and Response  
- Build capacity for rapid response teams in affected areas, in collaboration with MoHFW, UN, NGOs and other partners  
- Develop and strengthen outbreak preparedness tools and protocols, and ensure training of partners on those  
- Coordinate and strengthen community based surveillance for mortality and unusual events  
- Train a cadre of staff from MoHFW and other humanitarian partners on epidemic surveillance and response  
- Provide technical epidemiological expertise to inform the response  
- Develop capacity for rapid field assessments in the context of new threats, including monsoon flooding, cyclones and other disasters.  
- Working with the MoHFW and other partners, WHO aims to strengthen health information systems to better monitor morbidity in the population for all other conditions  
- Strengthen tools for the monitoring of health resources and service availability in health facilities, and ensure timely and regular monitoring |

Note: a monitoring framework with performance indicators has been developed for WHO’s planned response.
WHO’S FINANCIAL REQUIREMENTS

WHO is urgently seeking the support of donors to commit additional funds for the health sector under the Rohingya Joint Response Plan for 2018 and to quickly disburse pledges to enable WHO and partners to undertake life-saving interventions and further strengthen health services (and health infrastructure) for the affected population. The sooner health sector partners get the resources they need, the quicker they can prevent disease outbreaks and respond to the health needs of the communities affected. An early investment now will save resources and, more importantly, save lives.

WHO has released US$ 6.5 million from its life-saving Contingency Fund for Emergencies (CFE) and other internal resources to scale-up the Diphtheria response, as well as to continue to support ongoing operations to address the health needs of the displaced population. WHO wishes to recognize the support from those donors which provide funding to the CFE and those who have made direct contributions to WHO’s Rohingya response, including but not limited to: Canada, CERF, China, Estonia, France, Gavi, Germany, India, Japan, Netherlands, Republic of Korea, Saudi Arabia, Sweden, United Kingdom and the World Bank.

Additional resources are required to support the efforts of WHO, working with the government and partners, to reach almost 1.3 million people with continued provision of health services in 2018.

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost in US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources (Core staff, consultants, other personnel costs)</td>
<td>5,543,830</td>
</tr>
<tr>
<td>Capacity-building/training (Incl. health sector partners and MoHFW counterparts)</td>
<td>267,000</td>
</tr>
<tr>
<td>Medical supplies and materials (E.g. medicines, syringes, gloves)</td>
<td>6,377,822</td>
</tr>
<tr>
<td>Equipment and logistics (Cold chain, shipping costs etc.)</td>
<td>1,181,996</td>
</tr>
<tr>
<td>Contractual services (Health centre refurbishments)</td>
<td>2,111,500</td>
</tr>
<tr>
<td>Travel (Staff deployments)</td>
<td>375,000</td>
</tr>
<tr>
<td>Transfers and grants to counterparts (EOC maintenance)</td>
<td>344,429</td>
</tr>
<tr>
<td>General operating and other direct costs (WHO Field Office – rental and utilities)</td>
<td>300,000</td>
</tr>
<tr>
<td><strong>Total Budget</strong></td>
<td><strong>16,501,578</strong></td>
</tr>
</tbody>
</table>

Note: a detailed budget breakdown has been developed for WHO’s planned response.
INVESTING IN HEALTH UNDER THE JOINT RESPONSE PLAN

WHO is working with the Government of Bangladesh, UN agencies, NGOs, and other partners to plan for, and respond to, an extremely complex health emergency. Thanks to the hard work of all involved and the support of donors, to date, catastrophic disease outbreaks have been averted and the levels of immunization among the refugees have been increased. Investment in health facilities, equipment and immunization campaigns have prevented potentially high mortality rates and saved thousands of precious lives. However, potential cyclones and the unavoidable monsoon season presents significant risks of flooding, landslides and storm damage, leading to communicable disease outbreaks and disruptions to health services. There is a high risk of mass casualty, as well as an expected sharp increase in the number of maternal and newborn deaths. Therefore, WHO and partners continue to develop and deliver both emergency preparedness and response activities with the aim of serving all refugees and local populations in need, focusing on the most vulnerable. There is an urgent requirement to ensure health services are not disrupted in the coming months and therefore an investment now in preventative measures is essential. Without additional funding, WHO will be unable to meet the health necessities of the 1.3 million people in need. On behalf of all health partners on the ground, WHO urges the donor community to support the health sector under the Joint Response Plan in 2018. Together, let’s save lives and prevent further health catastrophe.
WHO health humanitarian appeal for the Rohingya crisis 2018
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