



Health Sector Strategic Plan 2026 - 2027

Acknowledgements

The Health Sector Strategic Plan 2026–2027 is the result of a collective effort by the institutions, organizations, and technical groups contributing to the humanitarian health response for Rohingya refugees in Cox's Bazar. The Health Sector acknowledges the leadership and support of the **Government of Bangladesh** and the relevant health and refugee-response authorities in guiding and facilitating the health response.

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Thank you

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Executive Summary

The Health Sector Strategic Plan 2026–2027 provides the common strategic direction for the humanitarian health response for Rohingya refugees in Cox's Bazar. It has been developed through an evidence-informed and consultative process involving Health Sector partners, the Strategic Advisory Group (SAG), Technical Working Groups (TWGs), and existing Health Sector coordination mechanisms. The plan is informed principally by the Public Health Needs Assessments (PHNA) 2024 and 2025, routine surveillance, Essential Package of Health Services (EPHS) assessments, referral and Health Management Information System (HMIS) assessments, WaSH and Infection Prevention and Control (IPC) monitoring, community health data, pharmaceutical information, costing analyses, and technical program evidence.

The strategy responds to a protracted humanitarian context characterized by a high burden of communicable and non-communicable diseases (NCDs), persistent maternal and mental health needs, overcrowding, inadequate WaSH conditions, limited health literacy, barriers to healthcare access, medicine and supply constraints, fragmented referral and Health Information System (HIS), and recurring risks from outbreaks, monsoons, cyclones, fires, and other emergencies.

The overall goal of the strategy is to reduce the prevalence and incidence of priority health conditions through two interconnected approaches: addressing public health determinants through prevention and health promotion, and systematic strengthening of the health system. The strategy is guided by three overarching objectives: promoting equity and accessibility in healthcare services, strengthening the resilience and capacity of the health system, and enhancing EPR.

The plan identifies eight priority public health areas: mental health, acute respiratory infections (ARI), maternal health, NCDs, dengue, hepatitis C, AWI/cholera, and skin diseases. These priorities were selected based on the PHNA 2024 & 2025 findings in consultation with the Health Sector partners according to the magnitude and trend of health problems, morbidity and mortality risks, vulnerability and inequity, outbreak potential, service availability, health-system gaps, opportunities for prevention, and alignment with EPHS and applicable technical standards.

Seven health-system priorities complement these public health objectives: essential medicines, HIS, referral systems, WaSH and IPC, quality of services, costing standardization, and the Community Health Program. These areas address structural constraints that affect access, continuity, quality, efficiency, preparedness, and the ability of the Health Sector to achieve measurable public health outcomes.

A central feature of the strategy is its outcome-indicator approach. Strategic performance will be assessed primarily through measurable changes in disease burden, access, quality, equity, continuity of care, health-seeking behavior, and health-system functionality rather than through activity completion or service-delivery outputs alone. Outcome indicators are linked to strategic objectives through the Consolidated Results Framework, including baselines, 2027 targets, data sources, monitoring frequency, and responsible technical mechanisms.

Community health is positioned as a core health-system function and a principal bridge between households and Health Facilities (HFs). The Community Health Program will support prevention, Risk Communication and Community Engagement (RCCE), early identification of cases, referral, follow-up, community surveillance, and improved uptake of preventive and essential health services. The outreach program is considered particularly important under funding constraints and during changes in service delivery arrangements.

The strategy is implemented in an increasingly constrained humanitarian financing environment. Resource allocation and service prioritization will therefore be guided by population needs, public health impact, service criticality, EPHS functionality, geographic accessibility, costing evidence, and the wider consequences for the health system rather than the financial needs of individual implementing partners. Where rationalization is required, decisions should protect quality, patient safety, continuity of care, referral pathways, and equitable access.

The Health Sector SAG provides the collective mechanism for prioritization under constrained resources. Priority Level 1 activities will receive preference, with advocacy for Priority Level 2 activities once Priority Level 1 funding reaches at least 65% by mid-year. The Community Health Program is treated as a strategic exception because of its system-wide role in the response.

Emergency Preparedness and Response (EPR) is integrated across the strategy. Preparedness measures include maintaining multi-hazard and outbreak contingency plans, strengthening surveillance and early warning, protecting referral and ambulance capacity, maintaining emergency stocks, integrating community health program into preparedness and early response, and conducting simulation exercises and after-action reviews. These measures are particularly relevant to recurrent monsoons, cyclones, floods, landslides, fires, disease outbreaks, and disruptions to health service delivery.

Implementation will use the existing Health Sector coordination architecture rather than creating parallel structures. The Health Sector coordination team will provide strategic oversight, and TWGs will lead technical implementation and performance review. Additionally, the sector partners will implement agreed interventions and report through harmonized mechanisms, and SAG will support strategic prioritization. Monitoring, Evaluation, Accountability and Learning (MEAL) will support routine performance review, data quality, corrective action, community accountability, and adaptive management.

Risk management is embedded throughout implementation. Particular attention will be given to funding reductions, outbreaks, natural hazards, supply-chain disruptions, health workforce constraints, service rationalization, health information gaps, inequitable access, and deterioration in quality or continuity of essential services.

Sustainability is defined within the specific humanitarian and policy context of the Rohingya response. The plan does not assume a conventional humanitarian-to-development transition or formal employment of Rohingya refugees. Instead, sustainability focuses on maintaining essential health functions, strengthening national and local actors, reducing fragmentation, standardizing systems, preserving institutional knowledge, and maintaining authorized community-volunteer mechanisms.

The Consolidated Results Framework will provide the principal mechanism for assessing achievement by the end of 2027. It brings together public health, health-system, and cross-cutting indicators and will support annual strategic review, corrective action, resource prioritization, and final assessment of whether the strategy

has contributed to reduced preventable morbidity and mortality, improved access and quality of care, greater equity, and a more preventive, coordinated, resilient, and accountable humanitarian health response in Cox's Bazar.

List of Abbreviations

Abbreviation	Full Term
ANC	Antenatal Care
ARI	Acute Respiratory Infection
AWD	Acute Watery Diarrhea
CHW	Community Health Worker
CS	Civil Surgeon
CFR	Case Fatality Rate
DHIS2	District Health Information Software 2
DM	Diabetes Mellitus
DRU	Dispatch and Referral Unit
E-card	Electronic Health Card
EML	Essential Medicines List
Epi	Epidemiology
EPHS	Essential Package of Health Services
EPR	Emergency Preparedness and Response
EWARS	Early Warning, Alert and Response System
FRC	Free Residual Chlorine
HeRAMS	Health Resources and Services Availability Monitoring System
HF	Health Facility
HCV	Hepatitis C Virus
HIS	Health Information System
HMIS	Health Management Information System
HP	Health Post
IPC	Infection Prevention and Control
IVD	Immunization and Vaccine Department
JRP	Joint Response Plan
KAP	Knowledge, Attitudes and Practices
LSD	Livelihoods and Skills Development
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psychosocial Support
MRC	Medical Referral Committee
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
OPD	Outpatient Department
ORS	Oral Rehydration Solution

Abbreviation	Full Term
PEN	Package of Essential Noncommunicable Disease Interventions
PHC	Primary Health Centre
PHNA	Public Health Needs Assessment
PNC	Postnatal Care
PPE	Personal Protective Equipment
PwD	Person with Disability
RCCE	Risk Communication and Community Engagement
RDT	Rapid Diagnostic Test
RNA	Ribonucleic Acid
RRRC	Refugee Relief and Repatriation Commissioner
SAG	Strategic Advisory Group
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
TF	Task Force
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WaSH	Water, Sanitation and Hygiene
WASH-FIT	Water and Sanitation for Health Facility Improvement Tool
WHO	World Health Organization

Introduction

The Rohingya refugee crisis in Cox's Bazar, Bangladesh, represents one of the most protracted humanitarian emergencies of the 21st century. Since 2017, over one million Rohingya refugees have fled violence and persecution in Myanmar to seek shelter in the densely populated camps of Ukhiya and Teknaf. With limited resources, overcrowded conditions, and recurring environmental challenges such as monsoons and cyclones, the camps face a range of public health challenges that threaten the well-being of this vulnerable population.

The health system in the camps has been largely dependent on humanitarian assistance coordinated by the Office of the Refugee Relief and Repatriation Commissioner (RRRC), Civil Surgeons (CS), and the Health Sector under the leadership of the World Health Organization (WHO). Despite significant efforts by WHO and its partners, the health needs of the Rohingya refugees remain immense, further compounded by high levels of poverty, malnutrition, and limited access to essential health services. Public health concerns such as communicable and NCDs, maternal and neonatal health complications, mental health, and inadequate WaSH and IPC standards are exacerbated by systemic gaps in the health system, including shortages of medicines, fragmented referral services, and ununified HIS.

A critical factor driving these challenges is the impact of public health determinants, including overcrowding, inadequate water and sanitation infrastructure, including within Primary Health Centers (PHCs) and Health Posts (HPs), environmental problems, low educational levels, and behavioral factors. Overcrowding alone has been linked to 32% of ARI, 30% of diarrhea cases, and 33% of skin diseases. Behavioral and lifestyle factors contribute significantly to the burden of chronic diseases such as hypertension and diabetes, affecting 33% of households. Additionally, poor WaSH services are another challenge in the health system. Based on the PHNA 2025, 41% of HFs lack adequate sanitation, and 33% insufficient waste management systems, which increases the risk of waterborne diseases such as cholera and AWD. Environmental factors, including extreme weather events and crowded settings, further exacerbate respiratory and skin conditions, while limited health literacy undermines prevention efforts and health-seeking behavior.

Recognizing the scale and complexity of these challenges, the Health Sector Strategy 2026 – 2027 outlines a comprehensive, multi-sectoral approach to address pressing public health concerns, in addition to strengthening the health system. The strategy prioritizes interventions to reduce disease burden, enhance health system resilience, and improve access to equitable and quality health services for the Rohingya population. Guided by evidence-based assessments and informed by lessons learned from previous responses, the strategy reflects the collective commitment of WHO and its partners under the coordination umbrella of the health sector coordination structure to meet both immediate and long-term health needs.

This strategy also considers the unique vulnerabilities of the Rohingya population, including living conditions, cultural context, and limited self-reliance, while emphasizing the importance of sustainability. It aligns with global health priorities, including universal health coverage (UHC) and the Sustainable Development Goals (SDGs), and underscores the need for continued support to address funding gaps and ensure a robust response.

Through this strategy, the Health Sector aims to transition from emergency health service delivery to a more integrated and sustainable healthcare system. By focusing on disease prevention, health promotion, public health determinants, and capacity building, the strategy seeks to empower both health workers and the community to create a resilient and inclusive health system that safeguards the well-being of the Rohingya refugees and their host communities.

Strategy Development Methodology and Planning Process

The Health Sector Strategic Plan 2026–2027 was developed through an evidence-informed and consultative planning process with the sector partners and the Health Sector SAG and designed to link identified public health needs with health-system priorities, technical recommendations, operational feasibility, and the evolving humanitarian context. The planning process built primarily on evidence generated during 2024–2025 and on priorities identified through existing Health Sector coordination and technical mechanisms. The methodology followed a problem-oriented approach. Public health conditions and their underlying determinants were

first identified and assessed in a consultative workshop with the sector partners, followed by analysis of health-system constraints that influence prevention, access, quality, continuity of care, and emergency response. Strategic objectives, activities, and outcome indicators were subsequently defined, in consultation with TWGs, to address these two interconnected dimensions: i) public health determinants and priority health conditions, and ii) systematic strengthening of the health system. This approach is consistent with the Theory of Change of this strategy.

Evidence Base

The PHNA 2024 and 2025 served as a principal evidence source for defining population-level health priorities, health-seeking behavior, access barriers, health literacy, perceived disease burden, and vulnerabilities affecting different population groups. The strategy explicitly uses PHNA findings as the basis for the public health and health-system objectives and establishes December 2027 as the principal implementation timeline before the subsequent assessment cycle. PHNA findings were complemented by routine and thematic Health Sector information, including:

- Routine surveillance and disease-trend information.
- EPHS assessments.
- WaSH in HFIs and IPC assessments.
- Referral-system assessments.
- HMIS assessments.
- Community Health Program reporting.
- TWG monitoring and program data.
- Pharmaceutical and essential medicine information.
- Costing and expenditure analyses.

The MEAL framework further establishes these information streams as the principal sources for monitoring strategy implementation and evaluating changes in disease burden, access, quality, equity, and health-system performance.

Existing Health Sector coordination structures were used as the principal mechanisms for technical review and refinement of the strategy. Relevant TWGs and sector partners contributed to this plan by providing technical priorities, program experience, technical standards, and proposed interventions within their respective

areas of responsibility. The final strategy therefore reflects both population-level evidence and operational knowledge generated by partners and technical mechanisms working within the response. The role of TWGs continues during implementation, including translation of strategic objectives into technical actions, development and updating of guidance, monitoring of performance, identification of implementation gaps, and recommendation of corrective measures.

Prioritization Criteria

The selection and prioritization of objectives and interventions considered several complementary criteria:

- Magnitude and trend of the public health problem.
- Severity and potential consequences for morbidity and mortality.
- Vulnerability and inequities affecting specific population groups.
- Potential for outbreaks or rapid deterioration.
- Availability and functionality of existing health services.
- Identified gaps in quality, access, referral, medicines, information, or infrastructure.
- Potential for prevention and reduction of avoidable disease burden.
- Alignment with EPHS and applicable technical standards.

Resource prioritization was considered separately from partner-specific financial needs. The strategy establishes that funding and service prioritization should be driven primarily by population needs, public health evidence, service criticality, EPHS functionality, geographic access, and the wider consequences for the health system.

For financing decisions requiring prioritization among activity groups, the Health Sector SAG provides the collective mechanism for determining priority levels and guiding advocacy under constrained funding conditions.

Development of Strategic Objectives and Activities

Following identification of the priority problems, objectives were formulated by the TWGs and Health Sector to describe the intended change expected by the end of the strategy timeline. Activities were then identified as the principal interventions required to contribute to the achievement of those objectives.

Outcome indicators were linked to strategic objectives to enable measurement of progress through 2027. Existing indicators and baselines were retained where reliable data were available from PHNA, routine surveillance, EPHS assessments, technical program, or other established sector mechanisms. Where reliable baselines were unavailable, the strategy identifies the need to establish them through the relevant monitoring system before performance assessment. The Consolidated Results Framework provides the common structure for linking each strategic objective to its indicator, baseline, target, data source, monitoring frequency, and responsible mechanism.

Indicator selection was guided by the principle that indicators should measure meaningful changes in public health status, access, quality, equity, health-system functionality, or strategic implementation rather than merely documenting completion of activities.

Consideration of the Operational and Policy Context

The planning process considered the specific humanitarian and policy environment governing the Rohingya response. This includes declining and uncertain humanitarian financing, restrictions affecting long-term development approaches, limitations on formal employment of Rohingya refugees, reliance on authorized volunteer mechanisms, and continued dependence on coordinated humanitarian service delivery. Consequently, objectives related to sustainability, transition, localization, and capacity strengthening were framed within the existing Government of Bangladesh policy environment rather than assuming a conventional humanitarian-to-development transition. The strategy therefore emphasizes continuity of essential health functions, strengthening of national and local partners, standardization, efficiency, institutional knowledge, and resilience of humanitarian systems.

Vision and Goals

Vision: A strengthened health system built on cooperation, prioritizing prevention, and equitable health promotion and service delivery for improved public health outcomes.

Goal: The goal of the Health Sector Strategy 2026 - 2027 is to reduce the prevalence and incidence rates of the most common health conditions. This will be achieved by focusing primarily on i) a preventive approach to health determinants and ii) a systematic strengthening of the health system.

The health sector's strategic objectives to address these conditions and underlying public health determinants, as well as strengthen the health system, are in line with the Joint Response Plan (JRP) objectives:

1- Promote Equity and Accessibility in Healthcare Services

Rationale: Vulnerable groups, including Persons with Disabilities (PWD), women, children, NCD patients, and elderly individuals, face disproportionate barriers to accessing healthcare. Addressing these inequities is essential to achieving UHC. Additionally, the functionality of HFs, as recommended by the sector, is essential.

2- Strengthen the Resilience and Capacity of the Health System

Rationale: Persistent challenges such as medicine shortages, insufficient referral systems, fragmented HIS, and inadequate WaSH and IPC standards have weakened the health system's ability to respond effectively to the population's needs.

3- Enhance Emergency Preparedness and Response

Rationale: The Rohingya camps face recurring emergencies, including cholera outbreaks, fires, monsoons, and cyclones, which disrupt healthcare delivery and increase health risks. Strengthening EPR is critical to minimizing the impact of these hazards on public health.

Public health conditions and determinants

The health conditions and public health determinants that have been prioritized by the sector members based on the PHNA 2025 results are:

- 1- Mental health: 32% of households report emotional distress or trauma, with the prevalence rising to 48% among PwD. Additionally, 52% of PwD experiencing emotional distress lack access to mental health or psychosocial support services. The underlying determinants are inadequate healthcare access,

malnutrition and food insecurity, restricted movement and livelihood opportunities, and stigma.

- 2- ARI: chronic conditions are very prevalent, and the acute cases are seasonal. These infections are caused or exacerbated by behavioral and lifestyle factors, as well as overcrowded living conditions.
- 3- Maternal health: discrepancies in reporting the home vs facility-based delivery rates, besides reports on limited access to Sexual and Reproductive Health (SRH) services. The underlying factors include community and cultural factors, education and awareness, as well as poor socioeconomic conditions.
- 4- NCD: 33% prevalence rate of hypertension and DM 2, disproportionately impacting PwD, where the prevalence rises to 60%. These conditions are attributed to behavioral and lifestyle factors, as well as inadequate education and awareness, and limited access to healthcare services for these cases.
- 5- Dengue: A seasonal condition that is exacerbated due to poor WaSH conditions and lack of preparedness.
- 6- Hepatitis C: 30% prevalence rate mainly due to the lack of awareness, unsafe medical practices, and vulnerable health.
- 7- AWD: among the most reported conditions by households and is exacerbated by inadequate WaSH services.
- 8- Skin diseases: Scabies is endemic in the camps. The underlying factors are inadequate WaSH services and overcrowded living conditions.

The other operational priorities of the health sector include:

- 9- Essential Medicine List: Address disruptions in pharmaceutical availability by establishing a pharmaceutical and supply platform and revising the Essential Medicine List (EML).
- 10- HIS: Initiating the Electronic Health Card (E-card) and online data reporting platforms to address the challenges related to the fragmented HIS.
- 11- Referral System: Revisit and update the referral system guidelines, and establish an overarching referral system in the camps.
- 12- WaSH and IPC functions: Enhance partners' adherence to WHO health facility standards for WaSH and IPC.

- 13- Quality of services: With the standardization of costing and the defunding crisis facing the humanitarian system globally, quality assurance has emerged as a key system-level priority to prevent any potential compromise in service delivery resulting from changes in funding mechanisms and models.
- 14- Costing standardization: Costing and standardization: The defunding crisis has increased the need for harmonized costing and expenditure tracking for health services to ensure the rational allocation of available resources and preserve the key functions of the health system.
- 15- Community health program: This program is the backbone of the health system in the camps. The sector strategy should focus on strengthening and institutionalizing this program to support the achievement of the plan's objectives and reduce the burden on HFs.

Indicator Definitions and Metadata

To ensure consistency in monitoring and interpretation across Health Sector partners, the indicators included in the Consolidated Results Framework will be supported by standardized indicator definitions and metadata. As this strategy adopts an “outcome-indicator approach”, particular attention will be given to ensuring that indicators measure meaningful changes in public health status, access to services, quality of care, equity, health-seeking behavior, continuity of care, and health-system performance, rather than relying primarily on activity completion or service-delivery outputs.

For each strategic indicator, the Health Sector will define, as applicable, the indicator definition, numerator, denominator, calculation method, unit of measurement, baseline and baseline year, 2027 target, data source, reporting frequency, required disaggregation, responsible technical mechanism, and any methodological limitations. Indicator definitions will be harmonized across partners before routine monitoring begins. Where an indicator definition, numerator, denominator, data source, or measurement method changes during implementation, the corresponding baseline and target will be reviewed to preserve comparability over time.

The detailed indicator metadata sheet will be maintained as a technical annex or companion document to the strategy and managed through the Health Sector MEAL

and Health Information Management mechanisms. This will support consistent reporting, improve data quality, and ensure that progress reported against the strategy reflects genuine changes in health outcomes and health system.

Indicator metadata will define, at minimum:

- Indicator name
- Strategic objective
- Indicator definition
- Numerator and denominator, where applicable
- Unit of measurement
- Baseline and baseline year
- 2027 target
- Data source
- Reporting frequency
- Required disaggregation, where applicable

Guiding Principles

Implementation of the Health Sector Strategic Plan 2026–2027 will be guided by the following principles, reflecting the specific operational realities of the Rohingya response in Cox's Bazar. These principles will guide implementation across all strategic priorities and support a more preventive, coordinated, equitable, efficient, and resilient humanitarian health response in Cox's Bazar.

1- Evidence-Based Prioritization

Planning and resource allocation will be guided by PHNA findings, surveillance, EPHS assessments, service utilization, referral data, medicine availability, costing analysis, and other Health Sector evidence. Priorities should reflect population needs and public health impact rather than individual partner funding requirements.

2- Outcome-Oriented Performance Measurement

The strategy adopts an outcome-indicator approach to assess whether Health Sector interventions are contributing to measurable changes in public health and health-system performance, rather than focusing primarily on activity completion or service-

delivery outputs. Accordingly, monitoring will emphasize changes in disease burden, access, quality, equity, continuity of care, health-seeking behavior, and health-system functionality.

3- Prevention Alongside Service Delivery

The strategy will address both priority health conditions and their underlying determinants, particularly overcrowding, inadequate WaSH, low health literacy, delayed care-seeking, stigma, and behavioral risks. Community-based prevention, early detection, referral, and health promotion will complement facility-based care.

4- Equity and Accessibility

Service planning will prioritize groups facing greater barriers or health risks, particularly PwD, women, children, older persons, people with chronic conditions, and populations living in underserved locations. Equity implications will be considered when rationalizing facilities, changing services, or allocating resources.

5- Protection of Essential Health-System Functions

Funding reductions or service reconfiguration should not compromise Level 1 prioritized activities. A particular focus should be given to the community health program to make sure that it is sufficiently funded.

6- Harmonization and Reduction of Fragmentation

The Health Sector will promote common standards, tools, reporting systems, referral mechanisms, costing approaches, and technical guidance across partners. Parallel systems should be reduced where shared sector mechanisms can improve continuity, efficiency, and accountability.

7- Community Health as a Core System Function

The Community Health Program will remain central to prevention, health promotion, early detection, referral, follow-up, RCCE, and connection between households and HFs. Its strategic role will be protected even under funding constraints. The strategy already identifies the program as the backbone of the health response.

8- Quality and Efficiency Together

Efforts to reduce costs, rationalize facilities, or change service-delivery models must preserve EPHS standards, quality of care, patient safety, geographic accessibility, and continuity of treatment. Efficiency will be pursued through harmonization, evidence-based service mapping, costing standardization, and reduction of unnecessary duplication.

9- Adaptive Humanitarian Response

Implementation will remain flexible in response to outbreaks, monsoons, cyclones, population movements, funding reductions, supply disruptions, and changes in health-facility functionality. Adjustments will be made through existing Health Sector, TWG, SAG, MEAL, and risk-management mechanisms while maintaining the overall strategic direction of the plan.

Theory of change

If the Health Sector strengthens prevention, early detection, timely referral, quality case management, and integrated service delivery, while addressing key public health determinants such as overcrowding, poor WASH conditions, low health literacy, stigma, and barriers faced by vulnerable groups, then the burden of priority health conditions among Rohingya refugees will decrease and health outcomes will improve¹ (figure 1). This change will be achieved through a coordinated approach that links community-based action with facility-level quality improvement. Community Health Workers (CHWs) will strengthen household-level awareness, surveillance, referral, and follow-up, while HFs will improve adherence to EPHS standards, clinical guidelines, IPC measures, and the availability of essential medicines. At the same time, strong intersectoral coordination will address the environmental and social drivers of disease.

¹ The inter-sectoral approach presented in the Theory of Change recognizes that several important determinants of health in the Rohingya camps, including WaSH, nutrition, shelter, site management, and other environmental or social factors, fall outside the direct mandate and operational control of the Health Sector. Consequently, achievement of some intended outcomes will depend on the engagement, capacity, priorities, and resources of other sectors. This may create implementation challenges and should be considered when interpreting Health Sector accountability for results that require substantial inter-sectoral action.

System strengthening is central to this plan, including community health, emergency preparedness, health information, referral systems, WaSH infrastructure, and quality of services. Through this approach, the Health Sector will move from reactive service delivery toward a more preventive, resilient, and accountable health system performance.

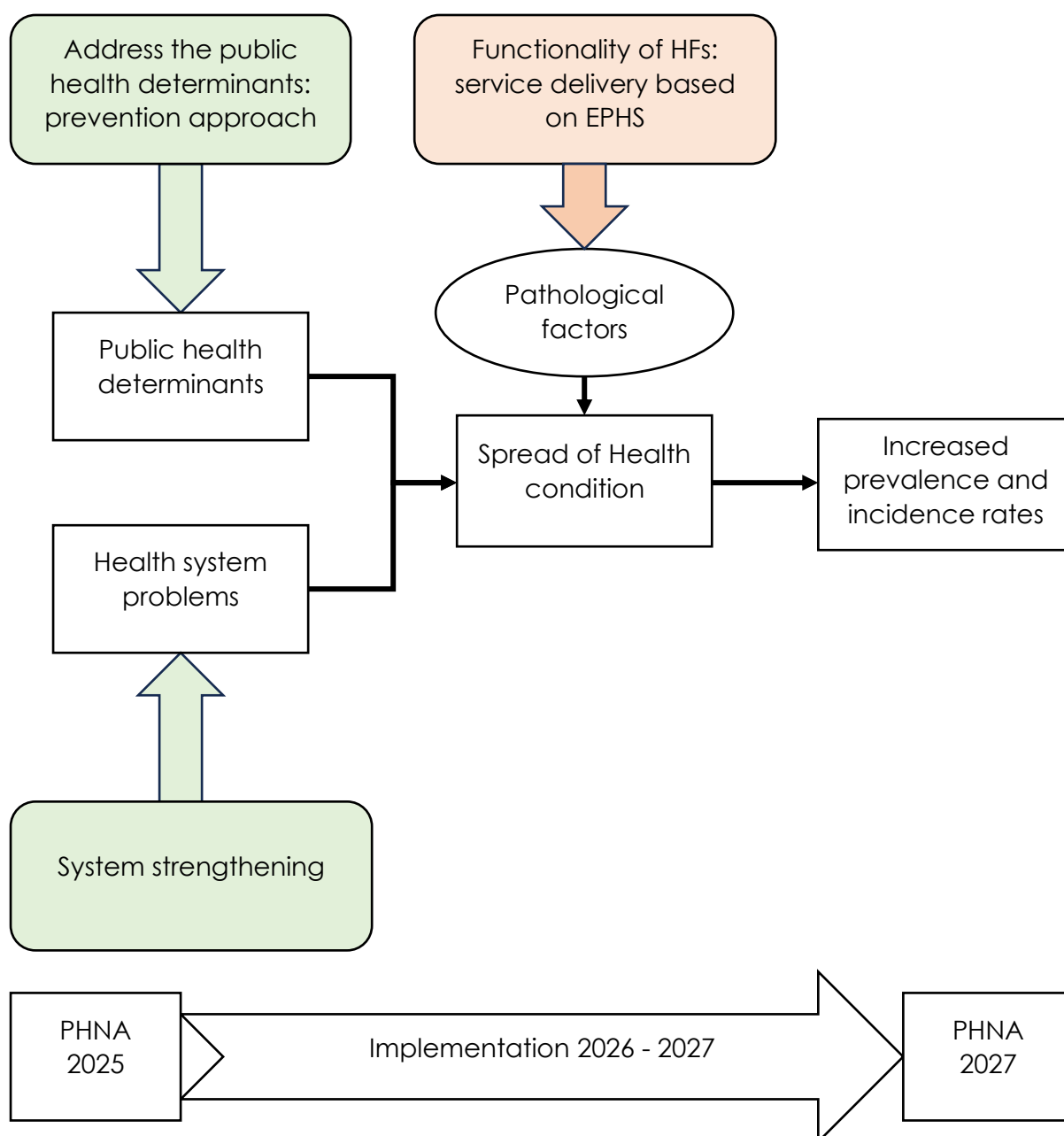


Figure 1: Theory of change: the health sector for the Rohingya refugees response plan 2026 - 2027

Public health and health system objectives

These objectives are based on the PHNA 2025 findings and align with the health sector's and TWGs' plans to address public health and health system issues. The timeline of these objectives is December 2027, when the PHNA 2027 will be planned and implemented.

1. Mental health

32% of households report emotional distress or trauma, with the prevalence rising to 48% among PwD. Additionally, 52% of PwD experiencing emotional distress lack access to mental health or psychosocial support services. The underlying determinants are inadequate healthcare access, malnutrition and food insecurity, restricted movement and livelihood opportunities, and stigma.

From 2024 to 2025, mental health findings show remarkable progress. The proportion of HHs reporting emotional distress or trauma declined from 31.9% to 21.6%, suggesting a reduction in perceived psychosocial hardship. Besides, distress among HHs with PwD also decreased from 47.5% to 38.1%. However, this group remains disproportionately affected. At the same time, access to Mental Health and Psychosocial Support (MHPSS) services improved from 39.3% in 2024 to 48.4% in 2025, and access among PwD increased from 48.3% to 58.3%. Nevertheless, mental health services remain significantly needed. In 2025, nearly one in five households (19%) still reported severe emotional distress affecting daily functioning, and adolescents and adults continue to carry a substantial burden.

Objectives

- 1.1. Reduce the prevalence of households reporting MH problems, especially among families of PwD.
- 1.2. Increase PwD access to MHPSS services.

Activities

- 1.1.1. Expand capacity building and technical support to outreach Rohingya volunteers on delivery of MHPSS interventions, including targeted home-based one-to-one counselling.

- 1.1.2. Build and strengthen the capacity of front-line Livelihoods and Skills Development (LSD) staff to provide basic MHPSS and strengthen cross-sectoral referrals between MHPSS and LSD services.
- 1.2.1. Conduct accessibility assessment of all MHPSS service points.
- 1.2.2. Assess the availability of assistive devices and other accessibility provisions within HFs providing MHPSS services.
- 1.2.3. Adapt facilities, IEC material, and communication methods for different disabilities.

Outcome indicators

- 1.1.1. Percentage of households reporting emotional distress and MHPSS issues.
Baseline: 21.6%. Target by 2027: 15%
- 1.1.2. Percentage of households with PwD reporting emotional distress and MHPSS issues.
Baseline: 38.1%. Target by 2027: 25%
- 1.2.1. Percentage of PwD with access to MHPSS services.
Baseline: 58.3%. Target by 2027: 70%
- 1.2.2. Percentage of PwD receiving support from LSD.
Baseline: NA. Target by 2027: 10%.
- 1.2.3. Percentage outreach volunteers trained and supervised on delivering structured, adapted, and contextualized low intensity psychotherapy interventions.
Baseline: NA. Target by 2027: 100%.

2. Maternal health

Discrepancies in reporting the home vs facility-based delivery rates, besides reports on limited access to SRH services and high maternal mortality rates. The underlying factors include community and cultural factors, education and awareness, as well as poor socioeconomic conditions.

Home deliveries and delays associated with reliance on Traditional Birth Attendants (TBAs) remain significant challenges. Strengthening localization innovative approaches, including the repurposing and engagement of TBAs as community reproductive health, referral agents as well as training them as Rohingya midwifery

aides, is therefore critical. Encouragingly, social autopsies and expert technical reviews have improved understanding of the root causes of maternal and newborn deaths and helped identify and address key technical gaps.

Adolescent pregnancy remains a major concern, accounting for 4% of maternal deaths among girls aged 15–19 years. Targeted interventions addressing child marriage, poor health-seeking behavior, and limited adolescent access to SRH information and services are essential. Access to emergency obstetric care is further constrained by weak and uncoordinated referral systems, as well as insecurity at night, both of which contribute to delays in receiving life-saving care.

Joint monitoring and PHNA findings confirm that SRH services are generally available; however, long waiting times, inadequate laboratory and blood transfusion capacity, and inconsistent adherence to SRH protocols continue to affect service quality.

Objectives

- 2.1. A unified reporting mechanism for deliveries.
- 2.2. Improved facility-based delivery rate.
- 2.3. Declined maternal mortality rate per 100,000 population.

Activities

- 2.1.1. The health sector, in coordination with SRH and CHW TWGs, will revise the reporting mechanism and develop a unified mechanism.
- 2.2.1. Enhance the quality of SRH service delivery to reduce the maternal mortality rate.
- 2.2.2. Ensure the integration of TBA into outreach health services in line with UNFPA plan to reduce community-based delivery by TBA.
- 2.3.1. Design an RCCE program to target males, addressing the importance of Antenatal Care (ANC), PNC, and skilled service delivery for pregnant women, healthy nutrition habits for mothers and infants, and referral services.

Outcome indicators

- 2.1.1. The number of unified reporting mechanisms for deliveries across the health sector
Baseline: 0 – Target by 2027: 1

1.1.1. Facility-based delivery rate.

Baseline: 90%. Target by 2027: 93%

1.1.2. Maternal mortality ratio among Rohingya refugees in Cox's Bazar and Bhasan Char reduced by at least 10% annually

Baseline: 66/100,000 – Target by 2027 < 53/100,000

1.1.3. Percentage of males who have a positive attitude towards facility-based delivery by skilled health workers.

Baseline: NA – Target by 2027: 80%.

3. Hepatitis C

The Health Sector Hepatitis C Response Plan (2024–2025) was developed in coordination with the hepatitis C Task Force (TF) and in line with the Global Health Sector Strategy on Viral Hepatitis (2022–2030). The plan aims to target the high burden of hepatitis C virus (HCV) among the Rohingya refugee population. A prevalence rate of 30% among adults has been adopted for planning purposes, based on WHO surveillance data (38% Rapid Diagnostic Test (RDT) positivity, 74% Ribonucleic Acid (RNA) confirmation) and the 2023 MSF survey findings (29.7% HCV seropositivity and 19.6% active infection). The prevalence is notably higher among women and older adults, with mother-to-child transmission identified as a potential concern due to a 77.5% RNA positivity rate among pregnant women. The main drivers of transmission are unsafe healthcare practices and low community awareness.

Objectives

- 3.1. Declined hepatitis C prevalence rate among adults by the end of 2027, as measured by a follow-up representative survey.
- 3.2. Universal hepatitis C screening coverage among the eligible refugee population aged ≥11 years, in accordance with Scenario 2 of the response plan.
- 3.3. A unified hepatitis C patient database established and operational for tracking cases, treatment status, and treatment progress.

Activities

- 3.1.1. Procure and distribute lab test kits and medicine for hepatitis C patients.

- 3.1.2. Operationalize treatment sites in the camps, and integrate HCV treatment into existing partner services to provide hepatitis C treatment and lab tests.
- 3.2.1. Conduct phased mass screening of adults using RDTs, followed by confirmatory RNA testing for all RDT-positive cases.
- 3.3.1. Develop a unified information platform for hepatitis C patients and treatments.

Outcome indicators

- 3.1.1. Hepatitis C prevalence rate
Baseline: 30%, Target: 10%
- 3.1.1. Percentage of screened adults using RDTs.
Baseline: 35%. Target: 100%.
- 3.2.2. Percentage of drug courses procured or secured for hepatitis patients
Baseline: NA, Target: 100%
- 3.3.1. The percentage of health partners sharing information using the information platform.
Baseline: 0, Target: 100%

4. Non-communicable diseases

According to the PHNA 2024 findings, NCDs, particularly hypertension and type 2 DM, affect 33% of households in Rohingya refugee camps, with this rate rising to 60% among households that include a PwD. These conditions significantly impact health functioning, including mobility, social roles, and energy levels, and are exacerbated by behavioral and lifestyle factors, limited awareness, and insufficient access to continuous care and essential medicines. 27% of the HFs reported disruptions in the availability of NCD medications, leading people to seek treatment from private pharmacies or unregulated providers.

Progress on the NCDs objectives shows partial improvement but a continued need for scale-up in 2026. PHNA 2025 findings indicate that the proportion of households reporting long-term health conditions increased to 32.5% (a 0.5% decrease), confirming that chronic diseases such as hypertension and diabetes remain a major public health burden. NCD medicines also remain among the most frequently needed, and some HFs still report medicine supply gaps, which may affect treatment continuity.

Against the objective to reduce household-reported hypertension and diabetes from 33% to 25%, progress appears limited, as the 2025 findings remain close to the baseline. The objective to improve access to regular NCDs services PwD remains highly relevant, as PwD continue to face significant access barriers. However, community-based screening and follow-up are being strengthened through CHW-led NCDs activities, including screening, counseling, referral, and medicine adherence support.

Objectives

- 4.1. Reduced household-reported prevalence of hypertension and DM2 through strengthened early detection, health promotion, and continuity of care.
- 4.2. Increased access of PwD to regular NCD services, including screening, treatment, and follow-up.
- 4.3. Uninterrupted availability of essential NCD medicines across all recommended HFs.

Activities

- 4.1.1. Integrate regular blood pressure and blood glucose screening into PHC services and outreach campaigns, prioritizing PwD and persons over the age of 40 years.
- 4.1.2. Implement an NCD training Package of Essential Noncommunicable Disease Interventions (PEN) for frontline health workers to improve case identification, counseling, and management.
- 4.2.1. Ensure that health education materials are adapted for low-literacy populations and culturally tailored, especially for PwD and female caregivers.
- 4.3.1. Revise the EML to include a full range of antihypertensives and antidiabetics and establish buffer stocks to address recurrent disruptions.

Outcome indicators

- 4.1.1. Percentage of adults over 40 years of age screened for hypertension and diabetes through PHC facilities and outreach services who are linked to follow-up care and treatment.
Baseline: not known, Target by 2027: >90%.
- 4.1.2. Percentage of households reporting prevalence of hypertension and DM2.
Baseline 33%, Target by 2027: 25%.

4.1.3. Percentage of individuals diagnosed with hypertension or diabetes who report regular adherence to treatment and follow-up visits.

Baseline: not known, Target by 2027: >90%.

4.2.1. Percentage of PwD with access to NCD services

Baseline: 40%, Target by 2027: 70%

4.3.1. Percentage of HFs reporting drug availability and consumption on a collective platform (the next plan will focus on the percentage of HFs reporting NCD medicine stock-out)

Baseline: NA, Target by 2027: 100%.

5. Acute Respiratory Infections

Based on PHNA 2024, ARI were among the key health concerns reported by Rohingya refugee households, ranking fifth among household-reported health conditions. The burden was likely linked to overcrowded shelters, seasonal weather changes, poor ventilation, limited health awareness, and delayed care-seeking, particularly among children under five, elderly persons, PwD, and households living in congested areas.

In 2025, respiratory infections became a more prominent concern, moving from rank 5 to rank 3 among reported household health conditions. ARIs were also identified as the top-ranked health problem when households were asked to list their five main health concerns. This indicates that respiratory infections have not improved compared to 2024, instead, their relative burden appears to have increased. The 2025 findings suggest the need to strengthen prevention messaging, early detection, timely referral, and quality case management, especially for high-risk groups.

Objectives

5.1. Reduced burden and complications of ARI.

Activities

5.1.1. Strengthen CHW-led household education on ARI prevention, early danger signs, hygiene, ventilation, and timely care-seeking.

5.1.2. Integrate ARI screening and referral into routine CHW household visits and outreach activities.

5.1.3. Conduct seasonal RCCE campaigns before winter and cyclone periods.

Outcome indicators

5.1.1. The annualized ARI incidence rate per 1,000 population

Baseline: 178/1,000, Target by 2027: < 143/1,000

6. Dengue

In 2024, dengue was reported as a seasonal public health concern among Rohingya refugees, linked to poor WASH conditions, stagnant water, overcrowding, and limited vector-control coverage. While at present, it ranked lower among household-reported health problems, indicating a comparatively smaller perceived burden than respiratory infections, diarrhea, and skin diseases.

In 2025, dengue became a more prominent household health concern, rising from rank 8 to rank 4 among the top health problems reported by households. This suggests that dengue risk has increased compared to 2024, likely due to continued vector-breeding conditions, seasonal exposure, and gaps in prevention and early detection. The 2025 findings indicate the need to strengthen dengue preparedness, RCCE, early case detection, referral, and coordination with WASH and vector-control actors. Although the PHNA 2025 shows dengue rising from eighth to fourth among household-reported health problems, routine surveillance indicates that mortality remained under control, with a 0.17% case fatality rate reported earlier in 2025. This suggests that the dengue burden is driven primarily by morbidity, including consultations, hospital admissions, and treatment needs.

Objectives

6.1. Reduced dengue morbidity and risk of outbreaks among Rohingya refugees.

Activities

- 6.1.1. Strengthen CHW-led household education on dengue symptoms, danger signs, and prevention.
- 6.1.2. Conduct targeted RCCE campaigns in high-risk blocks and areas with reported dengue clusters.
- 6.1.3. Coordinate with WASH and Site Management actors to reduce mosquito-breeding sites.

- 6.1.4. Ensure HFs have updated dengue case management guidance and referral pathways.

Outcome indicators

- 6.1.1. A 15% reduction in severe dengue cases among confirmed and suspected dengue cases.

Baseline: 829. Target by 2027: 705

- 6.1.2. Declined CFR

Baseline: <1% - Target by 2027: <=1%

7. Acute Watery Diarrhea

In 2024, AWD and cholera remained major WASH-linked public health risks in the camps. The Cholera Knowledge, Attitude, and Practices (KAP) survey 2024 found strong general awareness: around 90% of respondents had heard of cholera, and 86% knew that untreated cholera can be fatal. However, important knowledge and practice gaps persisted: 59.5% did not know the cause of cholera, only 31.6% fully understood transmission routes, 35% were uncertain about using ORS for diarrhea or cholera, and 32.5% used unsafe methods or lacked information on safe drinking water. Sanitation gaps were also significant, with 12.1% reporting no access to latrines, 61.7% reporting that latrines were not sex-separated, and 38% of PwD reporting inaccessible latrines. In 2025, diarrhea remained a persistent, high-priority health concern, ranked second among household-reported health conditions in the PHNA. This shows limited progress in reducing the relative burden compared with 2024. While awareness of cholera and ORS was already relatively high in the KAP findings, the continued high ranking of diarrhea in 2025 suggests that prevention gaps remain linked to unsafe water practices, sanitation barriers, incomplete knowledge of transmission, and delayed or inconsistent use of ORS. Additionally, basic water service in the facilities remains a concern. However, improvements were observed, increasing from 8% in 2024 to 43% in 2025, though significant gaps still remain.

Objectives

- 7.1. Improved access to safe and reliable basic water services in the facilities
- 7.2. Improved KAP among Rohingya households

Activities

- 7.1.1. Conduct routine water quality monitoring and provide technical support to ensure compliance with water safety standards at HFs.
- 7.1.2. Conduct targeted household and group awareness sessions on AWD and cholera transmission, symptoms, fatal risks, ORS preparation/use, and early care-seeking, prioritizing Teknaf, low-literacy households, older persons, and male caregivers.

Outcome indicators

- 7.1.1. Percentage of facilities maintaining water safety standard compliance.
Baseline: 43%. Target by 2027: 80%.
- 7.1.2. Percentage of households with correct knowledge of cholera transmission.
Baseline: 31.6%. Target by 2027: 60%.
- 7.1.3. Percentage of respondents aware that ORS is the first-line treatment for cholera/AWD.
Baseline: 70.2%. Target by 2027: 85%.

8. Skin Diseases

In 2024, skin diseases were the most reported health condition among Rohingya refugee households, ranking first in the PHNA. The burden was mainly associated with overcrowding, poor hygiene conditions, limited access to water and sanitation, and close household contact, making skin infections and scabies persistent community-level health concerns. In 2025, skin diseases continued to rank first among reported household health conditions, showing no major improvement in relative burden compared with 2024. Skin diseases also remained among the top public health concerns identified by health workers and Non-Governmental Organization (NGOs), confirming that the issue persists at both household and service-delivery levels. The continued high ranking indicates the need for stronger prevention, early identification, treatment adherence, household-level hygiene promotion, and closer coordination with WASH actors.

Objectives

- 8.1. Reduced public health burden and community transmission of skin infections, including scabies, through timely detection, appropriate case management, and management of contacts in the camps.
- 8.2. Strengthened surveillance, technical guidance, and coordinated response to changing transmission patterns, upsurges, and outbreaks of skin infections in the camps.

Activities

- 8.1.1. Review and update the community awareness and RCCE approach on prevention, early care-seeking, treatment adherence, and transmission reduction.
- 8.1.2. Implement targeted or community-wide interventions during identified upsurges or outbreaks.
- 8.2.1. Monitor the intervention coverage, implementation quality, and epidemiological impact.

Outcome indicators

- 8.1.1. Decreased annual case consultation of skin infections in camps by 20%.
Baseline: 652,341. Target by 2027: 521,873.
- 8.1.2. Increased household contact identification and targeted treatment of skin infection in 10 high-burden camps.
Baseline: 17%. Target by 2027: 40%.

9. Essential Medicine List

Access to essential medicines remains a critical component of the Health Sector response in the Rohingya camps. Although PHNA 2025 findings indicate overall improvement in medicine access, important gaps persist in medicine availability, continuity of supply, and rational use. Approximately 27% of HFs reported regular medicine stock gaps in 2025, compared with 23% in 2024, highlighting persistent supply-chain and distribution challenges. In addition, households continue to rely on private pharmacies and informal providers when medicines are unavailable through formal channels, particularly for NCD, pediatric, and gynecologic medicines. To address these gaps, the Health Sector will continue strengthening the implementation

and monitoring of the EML in alignment with EPHS standards and national guidelines. The EML approach in 2026 will focus on developing the required infrastructure to monitor and report on drug consumption, demand, and stock-outs. After that, the focus must shift to ensuring the uninterrupted availability of priority medicines, promoting rational prescribing and use, improving forecasting and stock-monitoring systems, and strengthening coordination among health partners, pharmacies, and supply-chain actors. Particular attention will be given to medicines for communicable diseases, NCDs, maternal and child health, mental health, and outbreak-prone conditions.

Objective

9.1. A unified monitoring and reporting mechanism and tool for medicine.

Activities

9.1.1. Review and update the EML in line with the national initiative in coordination with WHO and other partners.

9.1.2. Develop a reporting and monitoring online tool.

9.1.3. Provide capacity building to the partners to utilize the tool.

Outcome indicators

9.1.1. Percentage of HFs reporting medicine consumption, stock-in, and stock-out on time using the unified reporting tool.

Baseline: 0%, Target by 2027: 65%

10. Health Management Information System

Health Information Management is one of the six core functions of the Health Sector, as effective management of health information is crucial for ensuring that healthcare needs are met efficiently and that resources are allocated appropriately. Since the establishment of the sector, the core Public Health Information Services (PHIS) standards and tools have been slowly introduced, such as 4Ws (Who, What, Where, When), Early Warning, Alert, and Response System (EWARS), DHIS-2, and Health Resources and Services Availability Monitoring System (HeRAMS) in order to streamline humanitarian coordination, ensure evidence-based decision-making, and provide a unified operational picture as per the global standards.

The current system is characterized by heavy reliance on hard-copy tools. A HMIS assessment of 45 HFs identified 32 different types of registers being used to capture data, with no standard system in place. Approximately 93% of data collection is manual, which has led to significant data duplication; for example, the Outpatient Department (OPD) register captures 73% of the same information already present on a patient's health card. Furthermore, doctors are overburdened by being involved in filling out 20 different kinds of registers, diverting them from clinical care. Furthermore, similar to the facility, the patient-level records such as General Health Cards, Maternal and Child Health (MCH) Cards, NCD booklets, etc. are also fully reliant on hard copies despite being harmonized, posing two significant problems – a) the system is not financially sustainable in its current form; since each card only records about 10–12 consultations, they require reprinting every 2–3 years. Given the current and projected funding shortages, the recurring annual cost of \$350,000 USD for paper cards is no longer tenable. b) The information captured in the patient-level cards is largely unused and not being analyzed, and there is no linkage between the facility-level register and patient-level cards, creating a critical gap that leads to a lack of a proper monitoring system that ensures quality of care and identifies needs and gaps. On the other hand, the existing system focuses on recording consultations and program outputs rather than patient outcomes. There is currently no effective system to capture or monitor treatment success rates for major health conditions. Furthermore, critical quality markers, such as whether a patient recovered after treatment or was referred safely, are not systematically tracked.

The current problem in the HMIS is that it is an unharmonized, offline, paper-based, fragmented, and non-integrated HIS that lacks linkage between service delivery and beneficiary data, resulting in poor-quality, delayed response, and unreliable health information for decision-making, as well as being cost-ineffective. Additionally, there is a critical lack of adequate outcome indicators to measure the actual clinical and programmatic impact of the health response.

Objectives

- 10.1. A sustained, optimized, and routinely maintained HIS that ensures the continuity of established global standards (4Ws, EWARS, DHIS-2, and HeRAMS).

- 10.2. A digitalized, harmonized, and integrated HIS that creates a clear linkage between service delivery and beneficiary data and replaces the manual paper-based system and cards.
- 10.3. A systematic framework for monitoring outcome indicators to measure the impact of health interventions in the camp and inform the Health Sector strategy.

Activities

- 10.1. Digitalization of Health Records – The E-card Initiatives: Replace paper-based health cards with an E-card initiative to reduce recurrent costs and improve data quality and portability.
- 10.2. Create and install specialized software in HFs to capture facility-level data online, capable of reading E-cards.
- 10.3. Provide training to the partners and stakeholders on using the E-card and develop step-by-step instructions, SOPs, documentation, and IEC materials on utilizing the system.

Outcome indicators

- 10.1. Percentage of HFs that have successfully transitioned from using different types of manual registers to standardized digital reporting.
Baseline: 0%, Target by 2027: 80%
- 10.2. Proportion of refugees using the E-card instead of the paper-based General Health Card
Baseline: 0%, Target by 2027: 80%

11. Referral System

In 2024, referral services remained a critical component of healthcare delivery for Rohingya refugees, particularly for obstetric emergencies, acute medical conditions, trauma, and complex cases requiring secondary or specialized care. However, referral pathways faced major operational and coordination challenges, including fragmented Medical Referral Committee (MRC) processes, inconsistent follow-up mechanisms, delays in emergency transportation, limited availability of blood donors, incomplete referral documentation, and a lack of standardized referral guidelines in

some facilities. These gaps affected the timeliness, continuity, and quality of patient care, especially in Teknaf.

In 2025, the Referral System Assessment confirmed that referral demand remains very high, with approximately 80% of HFs providing referral services daily, and nearly 50% of the referral burden linked to emergency cases, particularly obstetric and acute medical emergencies. While referral pathways generally follow sector guidance, important gaps persist in communication, standardization, and follow-up. The assessment found that 45% of health staff in Teknaf lacked information about receiving facilities, 60% of facilities lacked clear clinical referral guidelines or relied solely on physician judgment, and 60% of facilities in Teknaf had no follow-up mechanism for referred cases. Delays in ambulance transport, fragmented MRC processes, referral refusal by patients or families, and inconsistent coordination continue to affect access to timely care. The findings highlight the need to strengthen referral governance, digital coordination systems, emergency transport management, referral documentation, and community awareness regarding referral services.

Objectives

- 11.1. A unified overarching referral system.
- 11.2. Blood bank services are timely available in the camps.

Activities

- 11.2.1. Review and update the referral guidelines and medical protocols.
- 11.2.2. Develop an online monitoring and information tool for referral and service capacity.
- 11.2.3. Establish an overarching back-up Dispatch and Referral Unit (DRU).
- 11.2.4. Establish two blood banks.

Outcome indicators

- 11.1.1. Percentage of HFs with standardized referral guidelines and protocols.
Baseline: 40%. Target by 2027: 80%.
- 11.1.2. Percentage of HFs with utilized access to the referral capacity online tool.
Baseline: 0%. Target by 2027: 80%.
- 11.1.3. Average waiting time for access to blood services.

Baseline: 100%. Target by 2027: 50%.

12. WaSH and IPC

In 2024 and 2025, the WaSH in HFs Assessment identified major gaps in water, sanitation, and waste management across camp HFs. In 2024, 104 facilities (95% coverage) were assessed, while in 2025, 80 facilities (85% coverage) were assessed. In 2024, only 8% had basic water services, and 90% had no water service according to minimum standards. In 2025, the situation improved, with 43% of facilities achieving basic water service levels. However, a considerable number of facilities remain below the minimum standard. Hygiene and environmental cleaning services remained comparatively strong in both years, with 98% of facilities meeting the hygiene standards in 2024 and 99% in 2025. Environmental cleaning services also improved, rising from 71% in 2024 to 84% in 2025. But for sanitation and waste management, it remained weaker: Basic sanitation service coverage increased only slightly from 54% in 2024 to 59% in 2025. Similarly, basic healthcare waste management services improved from 52% in 2024 to 58% in 2025, indicating that significant gaps remain. Accessibility of sanitation facilities for PwD remains a major gap within HFs. In both 2024 and 2025, the assessment found that almost one-third of HFs still lacked accessibility and sanitation features for PwD. These gaps increase risks of healthcare-associated infections, cholera transmission, poor IPC compliance, and reduced quality of care.

The 2025 EPHS assessment confirmed that WaSH in HFs remained below the required benchmark. WaSH in HFs scored below the 80% EPHS adherence threshold, with only 15 of 42 (35.7%) PHCs and 25% of the HPs meeting or exceeding the benchmark. This shows that despite good hand hygiene coverage in 2024, broader WaSH infrastructure and service quality gaps persisted into 2025, particularly around water quality, sanitation accessibility, medical waste management, and facility-level IPC support.

In 2025, a comprehensive IPC assessment in HFs identified major gaps in isolation rooms, sterilization processes, and the supply of Personal Protective Equipment (PPE) across camp HFs. Out of 80 assessed facilities, only 56.2% had isolation rooms for infectious diseases, while 43.75% lacked adequate isolation space according to minimum standards. The decontamination and sterilization processes were inadequate, with only 63.25% of facilities equipped for basic procedures, while 36.75%

lacked functional sterilization capabilities. Additionally, 18.75% of facilities did not regularly use chlorine solution for decontamination, and 32.5% reported insufficient supplies of PPE and hygiene materials. These deficiencies increase the risk of nosocomial infections and poor IPC compliance, compromising the overall quality of patient care.

Objectives

- 12.1. Availability of safe drinking water in HFIs in compliance with Water and Sanitation for Health Facility Improvement Tool (WASH-FIT) standards.
- 12.2. Compliance with standardized healthcare waste management practices.
- 12.3. Improved compliance with EPHS WaSH standards.
- 12.4. Reduced nosocomial infections and strengthened IPC practices in HFIs facilities, in compliance with the IPC standards.

Activities

- 12.1.1. Improve basic water service availability and quality by ensuring functional improved water sources on facility premises, routine Free Residual Chlorine (FRC) monitoring, and corrective action for facilities outside acceptable water-quality standards.
- 12.2.1. Strengthen healthcare waste management systems by ensuring three-bin segregation, safe sharps and infectious waste disposal, and regular monitoring of waste treatment practices.
- 12.3.1. Monitor and improve adherence to EPHS WaSH standards.
- 12.4.1. Strengthen IPC practices in HFIs by implementing a daily IPC checklist and regularly monitoring adherence to IPC best practices.
- 12.4.2. Improve sterilization processes by ensuring the availability of adequate supplies and maintaining functional sterilization equipment.

Outcome indicators

- 12.1.1. Percentage of HFIs with basic water services and access to safe drinkable water.
Baseline: 43%. Target by 2027: 80%
- 12.1.2. Percentage of HFIs with basic waste management services.
Baseline: 52%. Target by 2027: 65%

12.1.3. Percentage of PHCs meeting the EPHS benchmark (80%) for WaSH in HFs.

Baseline: 35.7%. Target by 2027: 75%.

12.1.4. Percentage of PHCs and HPs meeting the EPHS benchmark (80%) for WaSH in HFs.

Baseline: 25%. Target by 2027: 65%

12.1.5. Percentage of HFs with minimum standards of IPC practices.

Baseline: 67%. Target by 2027: 80%

13. Service Quality

The 2025 EPHS assessment shows that quality of services remains below the agreed benchmark in many HFs. Across 42 PHCs, average adherence to EPHS standards was 77%, below the 80% acceptable threshold, with 17 PHCs below benchmark. Among 26 HPs, average adherence was lower at 67%, with 21 HPs below benchmark. Key quality gaps were identified in referrals, WaSH in HFs, drug management, AAP, laboratory/radiology, and accessibility for PwD.

Objective

13.1. Improved consistency of essential health services.

Activities

13.1.1. Conduct facility-specific EPHS improvement plans for PHCs and HPs scoring below the 80% benchmark.

13.1.2. Strengthen supportive supervision, mentorship, and quality audits focused on low-performing EPHS domains.

Outcome indicators

13.1.1. Percentage of PHCs meeting the $\geq 80\%$ EPHS adherence benchmark.

Baseline: 60%. Target by 2027: 80%.

13.1.2. Percentage of HPs meeting the $\geq 80\%$ EPHS adherence benchmark.

Baseline: 19%. Target by 2027: 60%.

14. Costing Standardization

Costing standardization has become a critical priority in the context of the defunding crisis and the need to preserve essential health services. The Health Sector initiated a structured costing exercise to identify standard costs for key activity groups through

bilateral discussions with partners, surveys, and email consultations. A costing unit was defined for each activity, and both top-down and bottom-up approaches were used to estimate costs based on actual budgets and technical guidance. This process supports the rational allocation of available resources, improves comparability across partners, and helps identify areas where cost efficiencies can be achieved without compromising the core functions of the health system. The analysis also highlights the importance of clear activity definitions, as misreporting was identified during the mid-year funding review, including medicine costs being reported under stockpiling instead of PHCs and HPs. Costing standardization will therefore support planning, prioritization, donor engagement, and partner accountability by ensuring that health sector resources are allocated based on agreed service models, standardized units, and evidence-informed cost assumptions.

Objectives

- 14.1. Evidence-based resource allocation and financial efficiency in the Health Sector.
- 14.2. Improved compliance with standardized costing guidance across Health Sector partners

Activities

- 14.1.1. Develop and validate standardized costing units, reference costs, activity definitions, and costing assumptions for key Health Sector activity groups through partner consultations, budget reviews, surveys, and technical guidance.
- 14.1.2. Disseminate and promote the use of the standardized costing guidance among Health Sector partners to improve consistency in JRP planning, reduce misreporting, and ensure costs are reported under the correct activity groups.
- 14.1.3. Monitor compliance with standardized costing guidance and communicate the compliance data with relevant stakeholders.

Outcome indicators

- 14.1.1. Percentage of priority Health Sector activity groups with agreed standardized costing units and reference costs.
Baseline: NA. Target by 2027: 100%.

14.1.2. Percentage of HFs aligned at least 80% with the costing standards.

Baseline: NA. Target by 2027: 100%.

15. Community Health Program

The Community Health Program remains a core platform for linking households with health services, improving health literacy, supporting early detection of priority conditions, and strengthening referrals. In 2025, CHWs remained the dominant source of health information, reaching 96% of households, underscoring their critical role in community-level prevention and health promotion. In 2026, the program should be strengthened to support RCCE, outbreak preparedness, maternal and child health promotion, immunization defaulter tracing, NCD follow-up, MHPSS awareness, nutrition screening, and referral facilitation, with priority focus on underserved blocks, new arrivals, PwD, women, children, and elderly persons.

Rohingya communities continue to face a sustained burden of infectious and epidemic-prone diseases, requiring stronger CHW-led case detection, RCCE, referral, and EWARS. Preventive and maternal health gaps also remain critical.

Objectives

15.1. Expanded community-based management of chronic and nutritional conditions.

15.2. Improved uptake of maternal and preventive health services.

Activities

15.1.1. Support screening, counseling, and follow-up for NCDs and acute malnutrition.

15.1.2. Increase community mobilization for prenatal care, facility-based delivery, and immunization.

Outcome indicators

15.1.1. Proportion of mothers aware of nutrition services in HFs.

Baseline: NA, Target by 2027: 80%.

15.1.2. Proportion of individuals >40 aware of hypertension and DM type 2 risk factors.

Baseline: NA. Target by 2027: 80%

15.2.1. Prenatal care coverage.

Baseline: 35%. Target by 2027: 70%.

15.2.2. Full immunization coverage for children under 2.

Baseline: 64%. Target by 2027: 80%.

Monitoring, Evaluation, Accountability and Learning

MEAL will provide the framework for tracking implementation of the Health Sector Strategic Plan 2026–2027, measuring progress toward its public health and health system objectives, and ensuring that evidence is systematically used to improve the response. The MEAL approach will build on existing Health Sector information systems, including routine health information and surveillance data, PHNA findings, EPHS assessments, TWG monitoring mechanisms, community health reporting, and other sector assessments. Particular emphasis will be placed on measuring outcomes and changes in disease burden, access, quality, equity, and health system performance, rather than relying only on activity and service-delivery outputs. This approach is consistent with the strategy's proposed strengthening of the Health System and development of a systematic outcome-monitoring framework by addressing the identified public health determinants.

Monitoring

Progress against the strategy will be monitored through the outcome indicators and targets defined under each public health and health system priority. Where reliable baselines are available from PHNA 2025, EPHS assessments, routine surveillance, or other sector assessments, these will serve as the reference point for measuring progress. Where baselines are not yet available, the target of 2027 will be the baseline for the next strategic plan.

Monitoring will focus particularly on trends in morbidity and mortality, access to essential services, service quality and EPHS adherence, availability of essential medicines, referral performance, WaSH and IPC standards, community-level health outcomes, and disparities affecting vulnerable groups, including PwD, women, children, adolescents, and older persons. Data will be disaggregated where possible by age, sex, disability status, location, and other relevant vulnerability characteristics to identify inequities in health outcomes and access to services.

The Health Sector will progressively strengthen and harmonize information systems, including the proposed E-card and online reporting platforms, to reduce fragmentation, improve data quality, and facilitate timely analysis and evidence-based decision-making.

Evaluation

A strategic review will be conducted by the end of 2027 to assess whether implementation was contributing to the intended results described in the Theory of Change: reduced burden of priority health conditions, improved access and quality of care, and a more preventive, resilient, inclusive, and accountable health system.

PHNA findings will remain a key mechanism for assessing changes in HH-reported health conditions, health-seeking behavior, access barriers, health literacy, and other public health determinants. These findings will be triangulated with routine surveillance, Health Sector reporting, EPHS assessments, and thematic assessments to distinguish changes in perceived health needs from changes observed through health-facility and surveillance data.

The strategic reviews will assess progress against objectives and targets and identify areas requiring corrective action or reprioritization. The review of the strategy should assess achievement against the 2025 baselines and agreed 2027 targets and inform development of the subsequent Health Sector strategy.

Accountability

Accountability will be strengthened at both community and partner levels. Health partners will be responsible for timely and accurate reporting against agreed indicators and for implementing corrective actions identified through monitoring, supportive supervision, EPHS assessments, and TWG reviews.

At community level, the Community Health Program will provide an important link between HHs, HF, and the Health Sector. CHWs will support two-way communication by disseminating health information, identifying barriers to care, facilitating referrals, and communicating community concerns and feedback to service providers and coordination mechanisms. The strategy will promote accessible and inclusive

feedback mechanisms, particularly for PwD and other groups experiencing barriers to health services.

Community feedback and perceptions should be triangulated with quantitative service data and incorporated into program review and decision-making so that service improvements respond to both measured health outcomes and community priorities.

Learning and Adaptive Management

Findings from PHNA, routine surveillance, outbreak investigations, EPHS monitoring, TWG reviews, community feedback, referral assessments, WaSH assessments, and other thematic studies will be used to identify emerging risks, document effective interventions, and adapt activities accordingly.

The Health Sector and TWGs will periodically review indicator trends and implementation progress to identify interventions that should be continued, strengthened, modified, scaled up, or discontinued. Lessons from outbreaks, emergencies, changes in disease patterns, funding constraints, and implementation challenges will inform subsequent operational planning and resource prioritization.

MEAL Responsibilities

The Health Sector coordination team will oversee strategic-level monitoring and consolidate progress against the plan. Relevant TWGs will provide technical oversight for indicators within their areas of responsibility, while health partners will collect, validate, and report data through agreed sector mechanisms. The Health Information Management function will support data harmonization, analysis, visualization, and dissemination.

Progress against the strategy should be reviewed through existing Health Sector and TWG coordination mechanisms, with identified gaps translated into time-bound corrective actions. Results should also inform decision-making, prioritization services, resource allocation, and revision of targets where changes in the operational context require adjustment.

Key MEAL Activities

- Establish a consolidated results framework linking each strategic objective to its outcome indicator, baseline, target, data source, reporting frequency, and responsible entity.
- Harmonize indicators and reporting mechanisms across Health Sector partners and TWGs and progressively integrate them into the unified HIS.
- Conduct periodic data-quality reviews and strengthen partner capacity for accurate, timely, and disaggregated reporting.
- Conduct annual reviews of progress against strategic objectives and use PHNA and other assessments to measure changes in public health outcomes.
- Strengthen community feedback and accountability mechanisms and ensure that findings are systematically incorporated into program improvement.
- Document lessons learned, good practices, implementation challenges, and corrective actions and use these findings to inform subsequent planning and strategic decisions.

Risk Management and Mitigation

Implementation of the Health Sector Strategic Plan 2026–2027 takes place in a complex and rapidly changing humanitarian environment. Public health outcomes and continuity of essential health services may be affected by funding constraints, disease outbreaks, natural hazards, insecurity, supply-chain disruptions, health workforce limitations, influx, and persistent gaps in health system capacity. These risks may disproportionately affect vulnerable groups, including PwD, women, children, older persons, and people with chronic health conditions.

Risk management will therefore be integrated into implementation of the strategy and linked to Health Sector coordination, EPR, surveillance, HIS, community health, referral systems, essential medicines, WaSH and IPC, and quality-of-care mechanisms. The Health Sector and TWGs will periodically identify and monitor emerging risks and adopt interventions to protect essential health services and priority public health outcomes.

1. Funding Constraints and Reduction in Health Service Capacity

The ongoing humanitarian funding crisis represents a major strategic risk to the continuity and quality of health services. Reduced funding may lead to rationalization or closure of HFs, reductions in health workforce, interruptions to outreach activities, shortages of medicines and supplies, and increased pressure on remaining facilities. Changes in funding mechanisms and service-delivery models may also compromise adherence to EPHS standards and increase inequities in access to care.

Mitigation measures will include:

- Prioritize essential and life-saving services in accordance with EPHS and identified public health needs.
- Use standardized costing and expenditure tracking to support evidence-based resource allocation and identify efficiency opportunities.
- Monitor the impact of funding reductions and health-facility rationalization on accessibility, utilization, workload, and quality of services.
- Strengthen advocacy and resource mobilization using the health sector strategy, PHNA, EPHS, surveillance, and service-utilization evidence.
- Protect critical functions, including emergency care, maternal and newborn health, outbreak management, essential medicines, referrals, surveillance, and community health.

2. Communicable Disease Outbreaks and Emerging Public Health Threats

The camps remain vulnerable to outbreaks and seasonal increases in communicable diseases, including dengue, AWD/cholera, ARI, skin diseases, and other epidemic-prone conditions. Overcrowding, inadequate WaSH conditions, environmental factors, and gaps in health literacy may increase transmission risks. The strategy also identifies preparedness and response to outbreaks as a core health system priority.

Mitigation measures will include:

- Strengthen EWARS, alert investigation, and rapid response mechanisms.
- Maintain preparedness and contingency plans for priority epidemic-prone diseases.

- Strengthen CHW-led community surveillance, RCCE, early identification, and referral.
- Ensure HFs maintain appropriate IPC practices, case-management capacity, referral pathways, and essential emergency supplies.
- Strengthen intersectoral coordination, particularly with WaSH and other relevant sectors, to address environmental and community-level determinants of outbreaks.

3. Natural Hazards and Disruption of Health Services

Monsoons, cyclones, floods, landslides, fires, and other environmental hazards can disrupt access to HFs, damage infrastructure, interrupt referral routes and supply chains, and increase the risk of communicable diseases and injuries. EPR is therefore one of the overarching strategic objectives of this plan.

Mitigation measures will include:

- Maintain and periodically update multi-hazard health contingency and preparedness plans.
- Identify HFs and communities at greatest risk of service disruption.
- Strengthen Mobile Medical Teams, emergency referral, ambulance coordination, and alternative referral arrangements.
- Maintain contingency stocks of essential medicines, medical supplies, and emergency equipment.
- Integrate CHWs into community-level emergency preparedness, EWARS, first response, and referral.
- Conduct periodic simulation exercises and after-action reviews to identify and address preparedness gaps.

4. Essential Medicine and Supply-Chain Disruptions

The strategy identifies interruptions in pharmaceutical availability as an important health system challenge, particularly for chronic conditions requiring continuity of treatment. Supply disruptions may contribute to treatment interruption and increase reliance on private pharmacies or unregulated providers.

Mitigation measures will include:

- Strengthen forecasting, procurement planning, stock monitoring, and redistribution mechanisms.
- Revise and maintain the Essential Medicines List based on EPHS requirements and priority disease burden.
- Establish appropriate buffer stocks for priority and life-saving medicines.
- Strengthen collective reporting on medicine availability and consumption to identify potential shortages early.
- Coordinate among health partners to facilitate redistribution and continuity of essential treatment when stock gaps occur.

5. Referral Delays and Limited Access to Secondary and Emergency Care

Weaknesses in referral coordination, transportation, communication between facilities, and access to specialized services may result in delays in receiving life-saving care. These risks are particularly important for obstetric emergencies, severe acute illness, trauma, and patients requiring secondary or specialized services.

Mitigation measures will include:

- Standardize referral guidelines, pathways, documentation, and communication mechanisms.
- Strengthen ambulance coordination and emergency transport arrangements.
- Improve communication between referring and receiving facilities.
- Establish mechanisms for referral tracking and follow-up.
- Monitor referral delays and use findings to identify bottlenecks and implement corrective actions.

6. Decline in Quality of Care

Resource constraints, workforce pressures, medicine shortages, infrastructure gaps, and changes in service-delivery arrangements may negatively affect the quality and safety of care. The EPHS assessment provides the principal framework within the strategy for monitoring health-facility functionality and adherence to agreed service standards.

Mitigation measures will include:

- Continue periodic assessment of PHCs and HPs against EPHS standards.

- Develop corrective action plans for facilities and service domains performing below agreed benchmarks.
- Strengthen supportive supervision, clinical mentorship, adherence to standard treatment guidelines, and quality-improvement mechanisms.
- Monitor WaSH, IPC, referral, drug management, accessibility, and other identified quality gaps.
- Prioritize patient safety and continuity of essential services during facility rationalization or changes in service-delivery models.

7. Health Information Fragmentation and Data Quality Risks

Fragmented reporting systems and inconsistent data may limit the Health Sector's ability to identify emerging public health risks, monitor outcomes, and make timely evidence-based decisions. The strategy therefore prioritizes development of E-card and online reporting platforms and strengthening of an integrated HIS.

Mitigation measures will include:

- Harmonize indicators, reporting tools, and data standards across partners.
- Progressively operationalize unified digital reporting and patient information systems.
- Conduct routine data-quality reviews and strengthen partner reporting capacity.
- Triangulate PHNA, surveillance, facility, community health, EPHS, and thematic assessment data.
- Use dashboards and routine analysis to identify emerging risks and trigger corrective actions.

8. Inequitable Access and Exclusion of Vulnerable Groups

PwD, women, children, older persons, people with MHPSS and NCD conditions, and other vulnerable groups may experience disproportionate barriers to healthcare. Funding reductions, changes in facility locations, inaccessible infrastructure, transportation barriers, stigma, and inadequate communication may further increase these inequities. Promoting equitable and accessible healthcare is therefore a core strategic objective of the plan.

Mitigation measures will include:

- Monitor access and health outcomes using disaggregated data wherever possible.
- Maintain targeted outreach and CHW support for vulnerable and underserved households.
- Improve physical accessibility and disability-inclusive WaSH and health services.
- Adapt health information and RCCE materials for low-literacy populations and people with specific communication needs.
- Assess equity implications before major changes to health-facility coverage or service-delivery arrangements.

9. Community Trust, Health Literacy, and Health-Seeking Behavior

Limited health literacy, stigma, cultural factors, misinformation, and delayed care-seeking may reduce uptake of preventive and curative services and contribute to continued disease transmission and avoidable complications. The Community Health Program is therefore central to reducing these risks and connecting households with the formal health system.

Mitigation measures will include:

- Strengthen CHW-led RCCE, household counseling, early detection, referral, and follow-up.
- Engage communities in identifying barriers to care and designing appropriate communication approaches.
- Strengthen community feedback mechanisms and incorporate findings into service improvement.
- Tailor communication to priority groups and identified health risks.
- Monitor changes in health knowledge, perceptions, service utilization, and health-seeking behavior through PHNA and other sector mechanisms.

Risk Monitoring and Adaptive Management

Risk monitoring will be incorporated into routine Health Sector and TWG coordination mechanisms. Priority risks should be reviewed periodically according to their likelihood,

potential public health impact, and implications for continuity and quality of essential services. Emerging risks identified through surveillance, PHNA, EPHS monitoring, community feedback, partner reporting, and emergency assessments will inform adjustments to implementation priorities.

Where significant changes occur in the operational environment, including major outbreaks, funding reductions, population movements, natural hazards, or changes in health-facility functionality, the Health Sector will review relevant objectives, activities, and resource priorities. Corrective measures will be documented and monitored through the strategy's MEAL framework.

This approach will enable the Health Sector to anticipate and manage risks while maintaining focus on the strategy's overarching goals of reducing preventable morbidity and mortality, protecting equitable access to essential health services, and strengthening the resilience of the health system.

Implementation and Coordination Framework

Implementation of the Health Sector Strategic Plan 2026–2027 will be undertaken through the existing Health Sector coordination architecture and in close collaboration with government authorities, TWGs, health partners, communities, and relevant sectors. The framework is intended to translate the strategic objectives and technical priorities of the plan into coordinated, measurable, and adaptive action while avoiding duplication and parallel implementation structures.

Governance and Strategic Oversight

Overall strategic oversight will be provided through the Health Sector coordination mechanism, in collaboration with the RRRC, CS office, and other relevant government authorities. The Health Sector coordination team will facilitate implementation of the strategy, monitor overall progress, identify cross-cutting constraints, promote harmonization among partners, and ensure that emerging priorities are addressed through appropriate coordination mechanisms.

Major strategic or operational issues affecting multiple partners or technical areas will be discussed through Health Sector coordination mechanisms and, where required, referred to relevant government authorities or other coordination platforms for action.

Role of Technical Working Groups

TWGs will provide technical leadership for the implementation of priorities falling within their respective areas of responsibility. Their functions will include:

- Translating strategic objectives into technical and operational actions.
- Developing or updating technical guidance, standards, tools, and protocols.
- Supporting implementation and technical capacity development among partners.
- Reviewing progress against agreed indicators and identifying implementation gaps.
- Providing technical recommendations and corrective actions when performance is below agreed standards.
- Supporting harmonization of technical approaches across health partners.
- Identifying emerging technical priorities and proposing adjustments to implementation where necessary.

Where priorities cut across several technical areas, joint planning and review between TWGs and relevant Health Sector functions will be encouraged.

Role of Health Partners

Health partners will be responsible for implementing agreed strategic activities within their respective geographic and technical areas of operation. Partners will align their programs, workplans, and service-delivery approaches with strategic objectives, EPHS, technical guidance, and standards endorsed by the Health Sector and relevant authorities.

Partners will also be responsible for timely and accurate reporting against agreed indicators, participation in coordination and technical mechanisms, implementation of corrective actions, and communication of operational challenges that may affect achievement of strategic objectives.

Implementation Planning

The strategic objectives and activities of this plan are translated into operational workplans through existing Health Sector and TWG mechanisms. Implementation planning should define where relevant:

- Priority activities and expected outputs.
- Responsible and supporting entities.
- Geographic areas or population groups requiring particular attention.
- Implementation timelines and milestones.
- Required technical, human, logistical, and financial resources.
- Relevant indicators and monitoring arrangements.

Implementation priorities may be adjusted according to changes in disease burden, population needs, available resources, health-facility functionality, emergency conditions, and findings from PHNA, surveillance, EPHS assessments, and other monitoring mechanisms.

Coordination Across Levels of the Health System

Implementation will promote stronger linkages between community-level, primary healthcare, referral, and secondary-care functions. CHWs will support health promotion, RCCE, early identification, referral, follow-up, and communication of community concerns, while HFs will provide standardized preventive, diagnostic, treatment, and referral services in accordance with EPHS and relevant technical standards.

Coordination between community and facility-based services will be strengthened to improve continuity of care, reduce delays in seeking treatment, increase uptake of preventive services, and identify barriers affecting vulnerable and underserved populations.

Intersectoral Coordination

Many of the public health determinants identified in this strategy fall beyond the direct mandate of the Health Sector. Implementation will therefore require coordinated action with relevant sectors and technical actors, particularly in areas related to WaSH, nutrition, protection, site management, food security and livelihoods, education, and emergency preparedness.

Intersectoral engagement will focus on specific public health risks and measurable actions rather than parallel coordination structures. Priority areas may include outbreak prevention, environmental health, nutrition, disability inclusion, health

literacy, community engagement, emergency preparedness, and barriers affecting access to healthcare.

Adaptive Implementation

Given the changing humanitarian and funding environment, implementation of the strategy will remain adaptive. Changes in disease patterns, outbreaks, population movements, natural hazards, funding availability, health-facility functionality, supply-chain conditions, or other major contextual factors may require modification of activities or reprioritization of resources.

Such adjustments should remain consistent with the strategy's approach (addressing public health determinants and strengthening the health system). The Health Sector will therefore use existing coordination, monitoring, risk-management, and technical mechanisms to ensure that implementation remains evidence-informed, coordinated, accountable, and responsive throughout 2026–2027.

Financing and Resource Prioritization

The Health Sector Strategic Plan 2026–2027 is being implemented in an increasingly constrained humanitarian financing environment. Declining and uncertain funding may affect the availability, accessibility, quality, and continuity of essential health services and may require adjustments to service-delivery arrangements, partner coverage, staffing, and health-facility functionality. Financing decisions must therefore be guided by public health needs, equity, service criticality, efficiency, and the protection of essential health-system functions.

The Health Sector will promote a coordinated approach to resource prioritization that links available financing with the strategic objectives of this plan, the EPHS, PHNA findings, disease burden, health-facility capacity, geographic accessibility, and identified risks to continuity of care.

Strategic Resource Prioritization

Where available resources are insufficient to maintain all existing activities at the same level, prioritization will focus first on interventions necessary to prevent avoidable mortality, severe morbidity, outbreaks, and disruption of essential healthcare.

Priority of activity groups will be identified collectively through the Health Sector SAG. Prioritization decisions should consider both immediate service-delivery needs and the potential system-wide consequences of reducing or discontinuing particular functions, taking into account the Health Sector prioritization exercise, recommended HFs, available funds, and costing analysis.

Evidence-Based Allocation of Resources

Resource allocation will be informed by available evidence rather than historical funding patterns alone. The Health Sector will use the costing analysis findings, costing norms, PHNA findings, routine health information, surveillance data, EPHS assessments, health-facility utilization, geographic coverage, referral information, community feedback, and relevant technical assessments to identify areas where resources are likely to generate the greatest public health benefit.

Costing and Expenditure Visibility

Standardized costing and expenditure tracking will provide an important foundation for resource prioritization. The Health Sector will promote greater consistency in defining, calculating, and reporting the costs of health services and operational functions across partners.

Improved costing information should enable the Sector to:

- Compare the resource requirements of similar services and facilities.
- Identify major cost drivers and opportunities for efficiency.
- Improve understanding of the resources required to maintain essential services.
- Support planning for health-facility rationalization or changes in service delivery models.
- Estimate funding gaps more accurately.
- Strengthen financial advocacy with donors and other stakeholders.
- Link available resources more closely to strategic priorities and expected results.

Cost comparisons should nevertheless be interpreted alongside differences in service scope, workload, partners' feedback, geographic context, quality standards, organizational arrangements, and population needs.

Protecting Critical Health-System Functions

Funding reductions should not be assessed solely according to the number of facilities, projects, or activities affected. Particular attention should be given to functions whose disruption could have disproportionate consequences for the wider health system. Before significant reduction or discontinuation of such functions, the potential consequences for service continuity, disease detection, patient safety, referral pathways, and overall health-system performance should be assessed jointly.

Health-Facility Rationalization and Service Mapping

Where funding constraints require consolidation, rationalization, or changes in health-facility coverage, decisions should be made jointly based on systematic assessment of priorities rather than funding availability alone. The Health Sector should consider distance and accessibility, service utilization, funding availability, facility workload, EPHS functionality, referral capacity, risks, availability of alternative facilities, and the needs of vulnerable populations. The financial needs or funding gaps of implementing partners is not a basis for any prioritization or service mapping. Rather, the core basis is the needs of affected populations.

Any major service relocation should aim to avoid creating overlapping, excessive workload in remaining facilities, increased referral delays, deterioration in quality of care, or disproportionate barriers for vulnerable populations. The impact of major changes should be monitored after implementation so that unintended consequences can be identified and addressed.

Efficiency and Reduction of Duplication

Resource constraints increase the importance of maximizing the value generated by available resources. Health partners will therefore be encouraged to identify opportunities for efficiency through coordination, harmonization, and shared approaches where appropriate. The Health Sector's reference in this regard is the cost analysis, costing norms, and prioritization of services and HFs. Efficiency measures should not compromise quality, accessibility, patient safety, or adherence to EPHS standards.

Resource Mobilization and Advocacy

Evidence generated through implementation of this strategy will be used to strengthen resource mobilization and advocacy. Funding requests should clearly demonstrate the relationship between identified health needs, proposed interventions, expected results, funding gaps, and the consequences of underfunding. The Health Sector will support collective advocacy by consolidating evidence on disease burden, service utilization, health-facility functionality, geographic coverage, quality gaps, medicine availability, referral capacity, and other strategic priorities. Particular emphasis should be placed on demonstrating the consequences of funding gaps for essential services and critical health-system functions rather than relying only on overall financial requirements.

Coordination of Financing Decisions

Strategic resource prioritization will be coordinated through the SAG of Health Sector. Partners will be encouraged to communicate major funding changes that may affect service continuity, geographic coverage, staffing, or essential system functions sufficiently early to allow coordinated assessment and mitigation. Where significant funding gaps or service reductions are identified, the Health Sector and relevant technical mechanisms will assess the potential public health implications and identify possible measures, including reprioritization, redistribution of responsibilities, service integration, referral arrangements, or targeted advocacy. Financing decisions with major implications for the response should be considered alongside the Implementation and Coordination Framework, MEAL findings, and Risk Management and Mitigation framework.

Monitoring Financing and Resource Allocation

The Health Sector will periodically monitor major funding and resource constraints affecting implementation of the strategy. Monitoring should focus on the funding gap and operational consequences. The partners are encouraged to report funding gaps regularly and on timely-basis using the health sector reporting platforms. The Health Sector will present the funding gap status on the sector dashboard for timely access. Findings will inform resource advocacy, implementation adjustments, risk mitigation, and subsequent prioritization decisions.

Sustainability, Transition and Localization

The Health Sector Strategic Plan 2026–2027 is being implemented within a protracted humanitarian context in which the Rohingya response remains governed by national policies that limit the application of a conventional development approach. Rohingya refugees do not have access to formal employment and may participate in selected humanitarian activities only within the volunteer arrangements permitted by the Government of Bangladesh. Sustainability must therefore be understood within these policies and operational parameters.

In this context, sustainability does not imply integration of Rohingya refugees into the national labor market, establishment of refugee-led employment structures, or a transition from humanitarian assistance to a conventional development model. Rather, it refers to maintaining essential health services and critical health system functions as effectively, efficiently, and consistently as possible. Additionally, sustainability must aim at strengthening local authorities and partners capacity, reducing fragmentation, preserving technical systems and institutional knowledge, and ensuring that service-delivery arrangements remain resilient under changing funding and operational conditions.

Strategic Approach to Sustainability

The Health Sector will pursue sustainability through strengthening the systems and functions that support continuity of humanitarian health services rather than through development-oriented transformation of the response. Donor engagement is a key in this approach to ensure rationalized and efficient allocation of resources since the planning phase.

Localization within the Humanitarian Response

Localization will primarily focus on strengthening the role, capacity, and leadership of local actors participating in the response, including local NGOs, national health professionals and staff, and relevant government institutions. Localization should not be interpreted as transferring formal employment or institutional responsibility to the Rohingya refugee population where this is inconsistent with national policy. Rohingya participation will continue through authorized community and volunteer mechanisms. Where partners reduce their operational presence or transfer responsibilities, transition

arrangements should prioritize capable national and local organizations, subject to government approval, technical standards, operational capacity, and continuity-of-care requirements. The health sector will prioritize assigning a co-coordinator from the local partners.

Role of Rohingya Community Volunteers

Rohingya community participation remains essential to the effectiveness of the health response, particularly for health promotion, early detection, referral, follow-up, community surveillance, and communication between households and HFs. Rohingya community members may support health activities as volunteers rather than as formal employees. The Health Sector will therefore strengthen and harmonize volunteer-based community health functions while ensuring that roles remain consistent with applicable government policies.

Institutionalization of the Community Health Program

The Community Health Program is a critical operational component of the humanitarian health response and should be strengthened as a standardized sector mechanism. Institutionalization in this context refers to harmonization and continuity of community health functions across implementing partners rather than establishment of a formal refugee health workforce. The aim of this approach is to strengthen continuity and efficiency while remaining consistent with the humanitarian and regulatory context.

The Health Sector will therefore work toward:

- Standardized volunteer roles and responsibilities.
- Harmonized training packages and technical guidance.
- Standardized supervision arrangements.
- Common referral and reporting mechanisms.
- Integration of community health information into the wider HIS.
- Stronger links between community volunteers and HFs.
- Reduced duplication of parallel community structures.

- Consistent approaches to incentives or volunteer support in accordance with applicable policies.
- Preservation of essential community health functions when implementing partners change.

Managed Transition between Implementing Partners

Major transitions should be planned sufficiently in advance to minimize service interruption and allow coordinated redistribution of responsibilities. Within this strategy, transition will mainly refer to changes in implementing organizations, funding arrangements, health-facility coverage, or service-delivery modalities rather than transition from humanitarian response to development programming. Where partner withdrawal, funding reductions, or service rationalization require changes, transition plans should address:

- Continuity of essential services.
- Geographic accessibility and population coverage.
- Transfer of operational responsibilities where appropriate.
- Availability and capacity of receiving partners.
- Continuity of medicines and treatment.
- Referral arrangements.
- Health information and patient records.
- Transfer or handover of equipment and supplies where applicable.
- Continuity of community volunteer mechanisms.
- Communication with affected communities.
- Potential effects on vulnerable groups.

Institutional Knowledge

The protracted nature of the response and frequent changes in partners, staff, and funding create a risk of losing technical knowledge and repeatedly rebuilding systems. The Health Sector will therefore promote systematic documentation and preservation of:

- Technical guidelines and standard operating procedures (SOPs).

- Referral guidelines and pathways.
- Facility and service mapping.
- Assessment methodologies and tools.
- Training packages.
- Indicator definitions and reporting standards.
- Emergency preparedness plans.
- Lessons learned and after-action reviews.
- Handover documentation.
- Decisions taken through technical and coordination mechanisms.

These resources should be maintained in accessible sector-level systems wherever feasible rather than remaining dependent on individual organizations.

Workforce Sustainability

The humanitarian health response depends heavily on Bangladeshi health professionals, technical staff, support staff, and partner personnel. Fund reductions and turnover can lead to loss of experienced personnel and deterioration in service quality. Workforce sustainability measures should remain consistent with applicable national labor regulations and the policy framework governing Rohingya participation in the response.

The Health Sector will promote:

- Retention of critical technical competencies where resources permit.
- Standardized competency requirements.
- Continuous professional development.
- Supportive supervision and mentorship.
- Development of national staff for technical and managerial responsibilities.
- Workforce planning informed by workload and service needs.
- Protection of critical clinical, surveillance, information, referral, and coordination functions.
- Knowledge transfer during staff and partner transitions.

Sustainable Health Information and Digital Systems

Unified health information and digital systems can improve sustainability by reducing dependence on organization-specific tools and maintaining continuity when partners change. The development of shared systems such as E-card and unified reporting platforms should therefore consider:

- Common data standards.
- Interoperability.
- Government requirements.
- Data governance and confidentiality.
- Technical maintenance.
- User training.
- Access and authorization arrangements.
- Ownership and continuity when implementing partners change.
- Long-term operating costs.
- Use of information for coordination and strategic decision-making.
- Engagement of outreach workers in the information system.

Digitalization should simplify the information environment and reduce fragmentation rather than create additional parallel platforms.

Sustainability under Funding Constraints

The principal sustainability challenge during 2026–2027 is likely to be maintaining essential health outcomes under increasingly limited humanitarian resources. Advocacy and preference should be given to interventions identified by the Health Sector according to the prioritization levels agreed through the Sector SAG. The Sector will advocate for the prioritization of Priority Level 2 activities once funding for Priority Level 1 activities has reached at least 65% by mid-year.

The Community Health Program will be treated as an exception, given its critical role as the backbone of the response. The Health Sector will therefore continue to advocate for sustained support to this program regardless of the broader prioritization threshold.

Consolidated Results Framework

The Consolidated Results Framework translates the strategic objectives of the Health Sector Strategic Plan 2026–2027 into a common structure for monitoring progress and assessing achievement by the end of 2027. It categorizes and consolidates the outcome indicators defined across the public health, health-system, and cross-cutting strategic priorities and provides a basis for annual review, corrective action, resource prioritization, and the final strategic review.

The framework should be interpreted together with the MEAL framework. Where baseline values are not yet available, they should be established through the identified information system, assessment, or technical mechanism before routine performance assessment begins.

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
A. Public Health Priorities	MHPSS	Reduce household-reported emotional distress and MHPSS problems	Percentage of households reporting emotional distress and MHPSS issues	21.6%	15%	PHNA	Annual / PHNA cycle	Health Sector	
A. Public Health Priorities	MHPSS	Reduce disproportionate MHPSS burden among households with PwD	Percentage of households with PwD reporting emotional distress and MHPSS issues	38.1%	25%	PHNA	Annual / PHNA cycle	Health Sector	
A. Public Health Priorities	MHPSS	Increase PwD access to MHPSS services	Percentage of PwD with access to MHPSS services	58.3%	70%	PHNA	Annual / PHNA cycle	Health Sector	
A. Public Health Priorities	MHPSS	Increase PwD access to MHPSS services	Percentage of outreach volunteers trained on low intensity psychotherapy interventions	NA	100%	MHPSS TWG	Annual	MHPSS TWG	
A. Public Health Priorities	MHPSS	Strengthen cross-sectoral support for PwD	Percentage of PwD receiving support from LSD	NA	10%	MHPSS TWG	Annual	MHPSS TWG	
A. Public Health Priorities	Maternal health	Establish a unified reporting mechanism for deliveries	Number of unified sector-wide delivery-reporting mechanisms operational	0	1	Health Sector reporting platforms	Annual	Health Sector	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
A. Public Health Priorities	Maternal health	Achieve facility-based delivery of 93%	Facility-based delivery rate	90%	93%	Health Sector reporting platforms	Quarterly	Health Sector	
A. Public Health Priorities	Maternal health	Reduce maternal mortality	Maternal mortality ratio among Rohingya refugees in Cox's Bazar and Bhasan Char	66 per 100,000	<53 per 100,000	Health Sector reporting platforms	Annual	Health Sector	
A. Public Health Priorities	Maternal health	Improve community support for skilled facility-based delivery	Percentage of males with a positive attitude toward facility-based delivery by skilled health workers	NA	80%	PHNA / KAP assessment	Annual	CHW TWG / SRH TWG	
A. Public Health Priorities	Hepatitis C	Reduce HCV prevalence among adults	Hepatitis C prevalence rate	30%	10%	HCV survey	Endline 2027	HCV TF	
A. Public Health Priorities	Hepatitis C	Screen 100% of the eligible adult refugee population	Percentage of eligible adults screened using RDTs	35%	100%	HCV program database	Quarterly	HCV TF	
A. Public Health Priorities	Hepatitis C	Ensure treatment availability	Percentage of required drug courses procured or secured	NA	100%	HCV program data	Quarterly	HCV TF	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
A. Public Health Priorities	Hepatitis C	Develop a unified database for HCV patients and treatment progress	Percentage of health partners sharing information through the unified platform	0%	100%	Health Sector reporting platforms	Quarterly	Health Sector	
A. Public Health Priorities	NCD	Reduce household-reported prevalence of hypertension and DM2	Percentage of households reporting prevalence of hypertension and DM2	33%	25%	PHNA	Annual / PHNA cycle	Health Sector	
A. Public Health Priorities	NCD	Strengthen screening and continuity of care	Percentage of adults >40 screened for hypertension/DM who are linked to follow-up care and treatment	NA	>90%	PHNA	Annual / PHNA cycle	Health Sector	
A. Public Health Priorities	NCD	Improve continuity of treatment	Percentage of diagnosed hypertension/DM patients reporting regular treatment adherence and follow-up	NA	>90%	PHNA	Annual / PHNA cycle	Health Sector	
A. Public Health Priorities	NCD	Increase PwD access to regular NCD services	Percentage of PwD with access to NCD services	40%	70%	PHNA	Annual / PHNA cycle	Health Sector	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
A. Public Health Priorities	NCD	Establish medicine monitoring	Percentage of HF's reporting NCD medicine availability and consumption	NA	100%	Health Sector reporting platforms	Monthly	Health Sector	
A. Public Health Priorities	ARI	Reduce ARI burden and complications	Annualized ARI incidence rate per 1,000 population	178 per 1,000	<143 per 1,000	EWARS	Annual	Epi TWG	
A. Public Health Priorities	Dengue	Reduce dengue morbidity	Percentage of severe dengue cases.	829	705	EWARS	Annual	Epi TWG	
A. Public Health Priorities	Dengue	Prevent dengue mortality	Dengue case fatality rate	0.17%	0%	Surveillance	Annual	Epi TWG	
A. Public Health Priorities	AWD / Cholera	Improve access to safe and reliable basic water services in HF's	Percentage of HF's maintaining the agreed basic safe-water service standard	43%	80%	WaSH in HF's assessment	Annual	Health Sector	
A. Public Health Priorities	AWD / Cholera	Improve household knowledge of cholera transmission	Percentage of households with correct knowledge of cholera transmission	31.6%	60%	KAP	Annual	CHW TWG	
A. Public Health Priorities	AWD / Cholera	Improve appropriate early-management knowledge	Percentage of respondents identifying ORS as first-line treatment for AWD/cholera	70.2%	85%	KAP	Annual	CHW TWG	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
A. Public Health Priorities	Skin diseases	Reduce public health burden of skin infections	Annual number of skin-infection consultations	652,341	521,873	Health Sector 4Ws	Annual	Health Sector	
A. Public Health Priorities	Skin diseases	Improve household contact identification and targeted treatment	Percentage of household contacts identified and receiving targeted treatment in 10 high-burden camps	17%	40%	Program / surveillance data	Quarterly	Epi TWG	
B. Health-System Strengthening	EML	Establish a unified monitoring and reporting mechanism and tool for medicines	Percentage of HFs reporting medicine consumption, stock-in and stock-out on time using the unified reporting tool	0%	65%	Unified EML reporting platform	Every six months	Health Sector	
B. Health-System Strengthening	HMIS	Digitalize and harmonize facility reporting	Percentage of HFs transitioned from multiple manual registers to standardized digital reporting	0%	80%	A unified digital HIS	Quarterly	Health Sector	
B. Health-System Strengthening	HMIS	Replace paper patient cards with E-card	Proportion of refugees using E-card instead of the paper-based	0%	80%	E-card system	Quarterly	Health Sector	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
			General Health Card						
B. Health-System Strengthening	Referral system	Establish a unified overarching referral system	Percentage of HFs with standardized referral guidelines and protocols	40%	80%	Referral assessment / monitoring	Annual	Referral mechanism / Health Sector	
B. Health-System Strengthening	Referral system	Establish real-time referral-capacity information	Percentage of HFs actively using the referral-capacity online tool	0%	80%	Health Sector reporting platforms	Quarterly	Health sector	
B. Health-System Strengthening	Referral system	Improve timely access to blood services	Average waiting time for access to blood services	100%	50%	FGD	Annual	Health Sector	
B. Health-System Strengthening	WaSH and IPC	Provide safe drinking water in HFs in compliance with WASH-FIT	Percentage of HFs with basic water services and access to safe drinking water	43%	80%	WaSH in HFs assessment	Annual	Health Sector	
B. Health-System Strengthening	WaSH and IPC	Comply with standardized healthcare waste-management practices	Percentage of HFs with basic healthcare waste-management services	52%	65%	WaSH in HFs assessment	Annual	Health Sector	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
B. Health-System Strengthening	WaSH and IPC	Improve compliance with EPHS WaSH standards	Percentage of PHCs meeting ≥80% WaSH benchmark	35.7%	75%	EPHS assessment	Annual	Health Sector	
B. Health-System Strengthening	WaSH and IPC	Improve compliance with EPHS WaSH standards	Percentage of HPs meeting ≥80% WaSH benchmark	25%	65%	EPHS assessment	Annual	Health Sector	
B. Health-System Strengthening	WaSH and IPC	Reduce nosocomial infections and strengthen IPC practices	Percentage of HFs meeting minimum IPC standards	67%	80%	EPHS / IPC assessment	Annual	Health Sector	
B. Health-System Strengthening	Quality of services	Improve consistency and quality of essential services	Percentage of PHCs meeting ≥80% EPHS adherence benchmark	60%	80%	EPHS assessment	Annual	Health Sector	
B. Health-System Strengthening	Quality of services	Improve consistency and quality of essential services	Percentage of HPs meeting ≥80% EPHS adherence benchmark	19%	60%	EPHS assessment	Annual	Health Sector	
B. Health-System Strengthening	Costing standardization	Establish standardized costing architecture	Percentage of priority Health Sector activity groups with agreed standardized costing units and reference costs	NA	100%	Health Sector costing exercise	Annual / JRP cycle	Health Sector	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
B. Health-System Strengthening	Costing standardization	Improve compliance with standardized costing	Percentage of HFs aligned at least 80% with the costing standards	NA	100%	Costing compliance monitoring	Annual	Health Sector	
B. Health-System Strengthening	Community Health Program	Expand community-based management of chronic and nutritional conditions	Proportion of mothers aware of nutrition services in HFs	NA	80%	Community workers reporting	Quarterly	CHW TWG	
B. Health-System Strengthening	Community Health Program	Expand community-based management of chronic and nutritional conditions	Proportion of individuals >40 aware of hypertension and DM2 risk factors	NA	80%	Community workers reporting	Quarterly	CHW TWG	
B. Health-System Strengthening	Community Health Program	Improve uptake of maternal and preventive health services	Prenatal care coverage	35%	70%	Community workers reporting	Quarterly	CHW TWG	
B. Health-System Strengthening	Community Health Program	Improve uptake of maternal and preventive health services	Full immunization coverage among children under 2	64%	80%	IVD / CHW reporting	Quarterly	IVD / CHW TWG	
C. Cross-Cutting Strategic Functions	Implementation and Coordination	Ensure follow-up of agreed corrective actions	Percentage of time-bound corrective actions arising from strategic	NA	80%	Health Sector tracker	Quarterly	Health Sector / TWGs	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
			reviews completed within the agreed timeframe						
C. Cross-Cutting Strategic Functions	Financing and Resource Prioritization	Strengthen visibility of financing and funding gaps	Percentage of Health Sector partners reporting received funding and funding gaps through the agreed reporting mechanism	100%	100%	RCP / Health Sector funding platform / dashboard	Mid-year	Health Sector	
C. Cross-Cutting Strategic Functions	Financing and Resource Prioritization	Prioritize Priority Level 1 activities before expanding advocacy to Priority Level 2	Funding coverage of Priority Level 1 activities at mid-year	≥65% by mid-year	≥65% by mid-year	RCP / Health Sector funding dashboard	Mid-year	Health Sector / RCP	
C. Cross-Cutting Strategic Functions	Financing and Resource Prioritization	Protect the Community Health Program as a strategic exception	Funding coverage of the community health program at mid-year	≥65% by mid-year	≥65% by mid-year	RCP / Health Sector funding dashboard	Mid-year	Health Sector / RCP	
C. Cross-Cutting Strategic Functions	Sustainability, Transition and Localization	Strengthen local participation in coordination within the applicable	Local partner co-coordination established within the Health Sector	0	1	Health Sector records	Annual	Health Sector	

Group	Strategic Area	Strategic Objective	Outcome Indicator	Baseline	Target by 2027	Principal Data Source	Monitoring Frequency	Lead Mechanism	Status as of 2027
		policy framework	coordination mechanism						
C. Cross-Cutting Strategic Functions	EPR	Maintain updated preparedness and contingency arrangements	Percentage of priority multi-hazard/outbreak contingency plans reviewed and updated according to schedule	100%	100%	EPR / Health Sector records	Annual	Health Sector	

Use of the Results Framework

The Health Sector coordination team will maintain the consolidated framework and coordinate annual strategic performance reviews. TWGs and designated technical mechanisms will validate technical indicator results within their respective areas, while partners will provide required data through agreed Health Sector reporting systems. Indicators should not be added solely because data are available. Indicators retained in the framework should demonstrate a direct relationship with a strategic objective and measure a meaningful change in public health status, access, quality, equity, health-system functionality, or strategic implementation.

Baseline values identified as “to be established” should be confirmed before the relevant indicator is used for performance assessment. Where an indicator definition, numerator, denominator, or measurement method is modified, the corresponding baseline and target should be recalculated using the same definition.

The framework will be reviewed at least annually and may be adjusted where changes in disease burden, funding, government policy, emergency conditions, service-delivery arrangements, or data availability materially affect implementation. Any substantive changes to indicators, baselines, or targets should be documented to preserve comparability and accountability throughout the strategy period.