	Affiliation	Camp	"What are the existing communication channels (within or among NGOS/IOs/government involved in camp)?"	"Are there any barriers to health information exchange?"	"Do the facilities inside the camp report out to the national health system or any other higher authorities, for example for disease notification?"	Are there any factors promoting the exchange of information?
Interviewer #1	IFRC Consultant	Cox's Bazaar	DHIS -2 and EWARS	Interviewer did not notice any. Info is available. How accurate it is, and how it is used, is more of an open question. Maurizio saw some discrepancies, for example, between DHIS-2 and registers in wards, though not major. Problem is ensuring the info is used for planning, etc.	Yes, thanks to UNICEF - there is a page dedicated to the health situation/activities in Rohingya camps in the national DHIS-2 reporting. Evry day, health unit/post staff are required to complete the info and send to central level.	The dedicated page in DHIS-2 and the online availability of DHIS 2 and EWARS reports.
Interviewer #2	Georgetown University	General Expert	Not answered/not applicable	Not answered/applicable	Kenya - a few years ago the government took the refugee authority and put it under the ministry of the interior. May have had an impact on how data are reported out and to whom. Normally notification was based on parallel structures not only in Kenya but in most countries. The responsibility for collecting data (and managing refugees overall) was for the international community.	Not answered / applicable

Interviewer #3	US CDC	Cox's Bazaar	Not answered/not applicable	HIS challenge- some providers weren't familiar with case definitions. Some reporting didn't make sense. Workload was so high. Seeing so many patients in one day that reporting became an afterthought. Challenge to fill out forms correctly after seein 150 pts a day.	In Cox's Bazaar, the NGOs had to report into 3 different systems: the UNHCR HIS, the WHO set up their EWARS system, and the Ministry of Health system. It was a lot of reporting for NGOs. I was trying to push for harminization for systems and use common case definitions. HIS and EWARS had common case definitions, MOH did not. There was a lot of politics involved, it did not come to fruition.	Can't think of any right now. We tried to harmonize it but it failed. There were efforts made in HIS to train people and on behalf of NGOs to hire more people and surveillance officers in addition to clinicians to get a better handle on data/recruting. NGOs made investments into CHWs and worked collaboratively with other NGOs and map out where CHWs were and not duplicate efforts.
Interviewer #4	UNICEF	Zaatari	Phone. The UNHCR HIS is not integrated/compatible with the MOH IRES. Partners also send samples from patients directly to MOH labs.	Not answered/applicable	Yes, via health surveillance system, managed by UNHCR.	Did not address this question/not applicable
Interviewer #5	Institute of Tropical Medicine, Antwerp	General Expert	Created a weekly notification services for measles and cholera (written report brought to the district capital on a weekly basis – they also had notifiers on motorbike that would communicate unusual event information before the written report was even due). No phones. This system was later dropped as it was associated with the refugee assistance program (hence why it didn't exist during the Ebola outbreak) + later, Liberians rebels in Guinea disrupted the structures in places	Not answered/applicable	They created a weekly notification services for measles and cholera. Established an EWARS for epidemic. - Created a weekly notification services for measles and cholera (written report brought to the district capital on a weekly basis – they also had notifiers on motorbike that would communicate unusual event information before the written report was even due - health posts were encouraged to be vigilant). This system was later dropped as it was associated with the refugee assistance program (hence why it didn't exist during the Ebola outbreak) + later, Liberians rebels in Guinea disrupted the structures in places	Did not address this question/not applicable

Interviewer #6	UNHCR	Dadaab	Notifiable diseases forms for the government. Integrated surveillance system. Weekly and monthly repoting to the gov (regional and national)	No challenges.	Notifiable diseases forms for the government. Integrated surveillance system. Weekly and monthly repoting to the gov (regional and national). It has become more integrated over time, and it will be even better in the future: we are remodelling our healthcare in dadaad to full unetegrated to the national system.	access to more data - gov sometimes struggles to reach the pastoral community. But the pastoral community is often close to the camp to get water for the animal. So we are actually able tp provide that data. Regional gov is always happy to et that data. Very easy to share data. Plus we have incentives to share the data as that way the gov can continue to provide support. The more we get from the gov, the more sustaibale in it is. MSF use common reporting tool as well, and attend the collbaoration meetings. Dadaab is unique in many ways.

Interviewers #7 and #8 (joint interview)	Kenya Red Cross	Dadaab	Coordination meetings "Fill out an MOH reporting tool" for reporting and communicating with sub-county - Line list if lots of cases (during outbreak) - Both paper form and electronic (share these with UNHCR) - Also a monitoring form for alerts: acute flaccid paralysis, watery diarrhea. Based on IDSR reporting tools. - Share these with sub-country teams. Online via DHIS 2 - they share the epi reports. - samples are sent to the sub-county, and then on to KEMRI in Nairobi if needed. (MOH also supports ""healthy stool"" sampling once per month. "	Yes - transportation of samples. Only have a budget for TB samples (maybe HIV but few cases). - Recently had an outbreak of Chikungunya but could only manage as suspected cases.	Yes - notifiable diseases. 36 in the region. Based on IDSR. CHWs (community health volunteers) refer these to the health clinics - then clinicians validate.	- Coordination meetings (especially during outbreaks) - UNHCR: oversees health and nutrition coordination meeting - Monthly camp coordination meeting: all camp stakeholders (actually UNHCR hosting coordination meeting that day to discuss coronavirus...). Stakeholders include county gov, camp managers, Refugee Affairs Secretariat, plus invite other stakeholders like WASH teak (CARE), SGBV, security forces, Save the Children, Hanicap Int, etc) - WhatsApp platforms, i.e. IPC task force. Sub-county level - whatsapp group, sharing epi information and trends, alerts etc. - Constant email contact with WHO - will share sitreps on relevant outbreaks - supervisory visits from WHO and MOH (WHO comes with MOH district surveillance officer, do refresher training one-on-one) - district surveillance tool. Collect surveillance data ona routine basis across all health facilities. Sometimes do it with MOH who have a similar tool

Interviewer #9	IOM	Cox's Bazaar	Not answered/not applicable	Internationally - health information and data protection challenges. A refugee undertaking a health assessment has to consent to their data being made available (but delinked).Really poor efforts made to standardize HIS in refugee contexts (KoI referenced Paul Spiegel's work.) Camps can be like the "Wild West" - everyone doing their own thing. Overall still don't have a good grasp of how humanitarian HIS work alongside or integrate with national HIS. Every NGO/partner has their own system - not integrated. Causes real problems for surveillance but also resource allocation. For NGOs: Lack of awareness of the importance of reporting individual cases to national system.	Sometimes. Very little research in this area, actually. Noted examples in Sri Lanka where NGOs proudly provided malaria medication to refugees but were not reporting those cases to the national malaria program (due to lack of awareness). IOM health assessments require notification not to host country national government, but third country governments - owners of the data are the destination countries (USA, UK, etc). Raises some interesting data protection issues - IOM's data is all anonymized but could the CDC (who they send the health data to) potentially link the case data with State Dept's immigration records and de-anonymize? Maybe. Flow of data from IOM to destination countries is part of effort to improve downstream care - CDC provides data to state and local level. Refugee should receive their own data record which serves as a "health passport". IOM works very closely with CDC due to complexity of US health system; CDC staff embedded with IOM in host countries, trying to do as much preventive care before the refugee enters the US (and may	IOM's requirement to perform the medical assessments as UN agency.

Interviewer #10	UNICEF	Cox's Bazaar	DHIS2 - national health system is ising. Each health facility can report through that system, and the whole operationg is coordnated by the coordination cell. UNICEF provide training on that. The cell is run by the gov in support of WHO.	Each of the international agency has their own reporting system back to HQ. This is the biggest problem that we face, but it's a still a good that each agency has reporting system so that you can compare different countries, but at the country level it can complicate things as it doesn't always match each other.	Sector has a coordination cell, co-chaired by WHO and the government and the diseases are reported through that system back to the national surveillance system through the national HMAS system.	Collaboration & the fact that we have a coordination cell works really well, and that people are willing to share their data so that we can make informed decisions on actions.
Interviewer #11	Danish Red Cross	Dadaab	- Use UNHCR HIS to which Danish Red X must report. Online, synced through a tablet. Just need internet. Can be real-time if internet is available. - Hard copy to government authorities --> manual transmission. Data collected are different too. Sent monthly.	No	Yes	- Government willingness to participate in surveillance has built trust with partners, increased willingness to share - Also matter of compliance obligations
Interviewer #12	Field Epidemiology Training Program, MOH, Kenya	Dadaab	Did not specifically mention modes of communication, though noted later that she was not aware of any efforts to link camps via DHIS-2. Just give the data to Dadaab county.	Everything has to go through UNHCR - can be slow and bureaucratic (lots of protocols)	NGOs (specifically IRC) reported to the Dadaab sub-country MOH post - but (or in addition?) via UNHCR. "Dotted line between between hospital and MOH" in terms of reporting. The person is charge of health at UNHCR can link to the national government. Depend on the gov for some medication (i.e. ARVs).	Did not specifically answer though said information sharing improved over time.