
Rohingya refugees in Bangladesh: Health Sector Bulletin No.1

Period:
01 October - 15 November 2017



KEY FIGURES

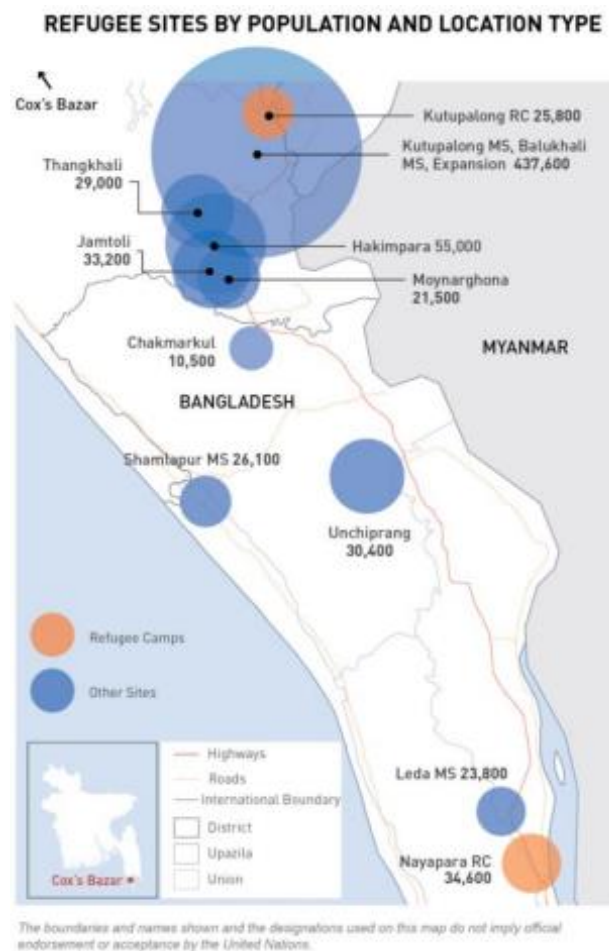
- 618 000 Rohingyas from Myanmar are estimated to have arrived in Cox's Bazar, Bangladesh since 25 August 2017.
- 1.2 million (both new arrivals and their host communities) have been targeted by the health sector .
- Since 25 August 2017:
 - 1.2 million in need of health service support
 - 653 755 health care service consultations delivered
 - 712 797 people aged one year and above given oral cholera vaccine.
 - 199 472 children aged one to five years vaccinated with second dose of oral cholera vaccine.
- At least 65 national and international health sector partners operational.

1. HEALTH SITUATION

Around 1.2 million people are estimated to be in need of health assistance. This number includes both newly arrived Rohingyas from Myanmar since 25 August, and their host communities. Based on the public health situation analysis published on 10 October 2017, WHO has graded this crisis as a level 3 emergency, the highest possible rating.

The ongoing challenges and needs faced by the health sector include:

- **Overburdened government health care facilities:** Sadar Hospital in Cox's Bazar and Teknaf and Ukhaia upazilla health complexes and primary health care (PHC) units are not equipped to handle the huge influx of Rohingya refugees, and are running substantially over capacity to meet the needs of both the new arrivals and the host populations in the area.
- **Rates of severe acute malnutrition (SAM)** are running at 7.5% (well over the emergency threshold). Local health care facilities and NGOs have limited capacity to treat children with SAM with complications.
- **Inequitable access to services:**
 - Although the Government of Bangladesh has allocated 2000 acres for a settlement area for the new arrivals, the earmarked land consists of remote, hilly terrain that has no established infrastructures and no roads linking it to Cox's Bazar or other towns.



- Health care services are currently concentrated in the more accessible areas of the camps. As a result, some areas are over-served while in other areas have no or very limited access to health care.
- **Communicable disease risks:** crowded living conditions, inadequate water and sanitation (WASH) facilities and low vaccination coverage present significant risks of communicable disease outbreaks. As of 11 November, 611 suspected cases of measles were reported.
- **Seasonal threats:** The Cox’s Bazar area is prone to cyclones that can potentially destroy temporary shelters and displace large segments of population. The incidence of acute respiratory infections (ARIs) is expected to rise with the onset of winter. Due to complete deforestation and topography of the camps, there is a risk of landslides in the next rainy seasons.
- **Sexual and Reproductive Health:** Essential reproductive health/maternal, child and newborn health services, particularly obstetric services, are inadequate either due to insufficient bed space or lack of facilities in hard-to-reach areas. Home deliveries are anecdotally reported to be high.
- **Mental and psychosocial health:** The needs are immense. Many Rohingya are reported to have been physically and mentally traumatized by the violence, including sexual and gender-based violence (SGBV).

2. HEALTH SECTOR RESPONSE PLANNING

A multi-sectoral humanitarian response plan covering the period September 2017 to February 2018¹ was published in early October 2017. The plan focuses on three strategic objectives: 1) provide life-saving basic assistance in settlements, camps and host communities; 2) improve conditions in and management of both existing and new settlements, including infrastructure and site planning; and 3) promote safety, dignity and respect for the individual rights of the affected population.. The health sector has set a target of reaching **1.2 million people in need**, with the following objectives:

1. Improve access to essential life-saving primary and secondary health services for crisis-affected populations, aimed at reducing avoidable morbidity and mortality;
2. Provide life-saving reproductive, maternal, neonatal and child health care to reduce maternal and neonatal mortality and morbidity;
3. Ensure the prevention of, preparation for and response to outbreaks of diseases with epidemic potential and other health emergencies.

Humanitarian sectors are currently preparing a revised response plan covering the period February to December 2018.

3. HEALTH SECTOR FUNDING

- Funding required for health sector response: \$48.3 million.
- Funding received (based on what has been reported/shared with WHO): \$4.4 million
 - The UN Central Emergency Response Fund has released US\$2 million for the health response.
 - Several health partners have mobilized internal resources to cover their response (\$2.4 million reported).

¹ <https://reliefweb.int/report/bangladesh/bangladesh-humanitarian-response-plan-september-2017-february-2018-rohingya>

4. HEALTH SECTOR COORDINATION

The health sector coordination is led by WHO since 1 October 2017. With the support of IOM, weekly coordination meetings are organized. WHO also represents the health sector during Inter-Sector Coordination Group (ISCG) meetings in Cox's Bazar and also acts as the secretariat for the Emergency Coordination Committee set up by the government to lead the health response. In addition WHO is also coordinating and supporting disease surveillance, providing significant logistics support to partners. Information management is handled jointly by IOM, UNFPA and WHO

There are now at least 65 health partners known to the health sector. To address crucial health issues that required urgent attention, a Strategic Advisory Group (SAG) was established comprised of WHO, the MOHFW and selected health partners such as BRAC, IFRC, MSF, IOM, UNFPA and UNHCR have set up. The group met for the first time on 14 November and will continue to meet on a weekly basis.

There are two health sector sub-groups: one on sexual and reproductive health (SRH) led by UNFPA, and one on mental health and psychosocial support (MHPSS) led by ACF. A multi-sectoral acute watery diarrhea preparedness and response plan working group (AWD-PRP WG) was established and meets regularly. The health sector actively collaborates with the Nutrition, WASH and Logistic sectors.

5. HEALTH SECTOR RESPONSE

5.1 Service delivery planning

Challenges

Currently, approximately 200 health care facilities are providing different levels and types of health services across all settlement areas. However, their distribution is far from equitable due to the limited land available, poor road access and high densities of populations in some areas. Many health care services in the camps are concentrated in easily accessible areas and unavailable elsewhere. Moreover, the services provided are not standardized and the quality of health care services varies considerably. Government hospital facilities are overcrowded and do not have the resources to cope with the high volumes of referral patients.

Health Sector Response

The health sector has designed a recommended package of minimum basic health services for health posts and health care centres, based on the MOHFW's service delivery package and UNHCR/SPHERE guidelines. The package has been approved by MOHFW and shared with all health sector partners to inform their programming.

A rapid mapping of all health and nutrition services available in camps and settlements was done from 8 to 14 November. This information has helped identify gaps and oversupply. The health sector is now reassigning health care facilities to under-served areas, and allocating sites for new facilities. With very limited land space available, it is estimated that the process of assigning and reallocating facilities will take around six weeks. Dispensaries without medical doctors will be phased out and implementing partners have been asked to partner with each other to expand the level of services provided in line with minimum package of essential primary health services. Secondary-level health care facilities are likely to remain outside the camp areas for the immediate future, and implementing partners have been encouraged to scale up their support to Government hospitals to alleviate the strain on resources.

To help improve coordination, health sector will work with the government to assign specific responsibilities to one health organization per “block”. Each designated organization will be responsible for (1) providing information on available health services (including referrals) to WHO to enable it to monitor the overall health response, and (2) establishing a mechanism to register and address complaints.

WHO has provided supplies and Inter-agency Emergency Health Kits to both government and NGO-run health facilities. There is an urgent need to scale up support to the overburdened government–managed facilities.

5.2 Disease surveillance

Challenges

In humanitarian emergencies, where the risk of transmission of infectious diseases increases, an effective disease surveillance system is essential to rapidly detect and respond to disease alerts and outbreaks.

Health Sector Response

WHO and the Ministry of Health and Family Welfare (MOHFW) have established an Early Warning, Alert and Response System (EWARS). WHO has trained health care workers on disease surveillance, standard case definitions and how to complete the EWARS reporting form. A total of 39 sentinel surveillance sites in camps are now reporting daily on diseases with outbreak potential such as malaria, diarrhoea and acute respiratory infections. This facilitates rapid case investigations and active case finding.

EWARS data is compiled with the analysis provided in a Mortality and Morbidity Weekly Bulletin (MMWB) that is published online and widely shared. Monitoring of morbidity and mortality trends supports decision-making for a more targeted response. Data from the five weekly bulletins issued by WHO to date (period 25 August-11 November 2017), showed that fevers of unexplained origin accounted for 29% of the overall 169,233 consultations for diseases under surveillance, followed by acute respiratory infections (27%), acute watery diarrhoea (21%) and skin diseases (9%). See Figure 1 below. Between 6 September and 11 November 2017, a total of **611** suspected cases of measles including two related death (**CFR, 0.33%**) were reported from Cox’s Bazar.

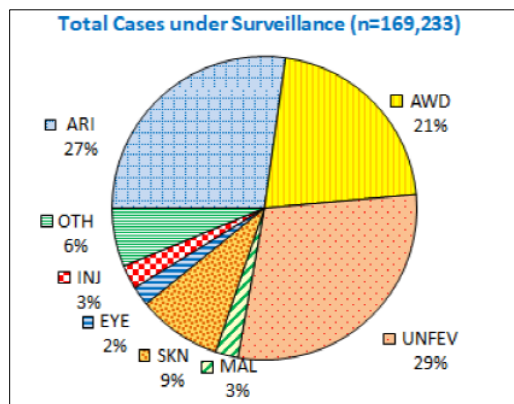


Figure 1: Proportion of primary causes for all reported cases, Cox’s Bazar, Bangladesh, 25 August -21 October 2017.

ARI: acute respiratory infection, AWD: acute watery diarrhoea, BD: bloody diarrhoea, INJ: injuries, MAL: malaria, ND: neonatal diseases, OTH: Other diseases, SKN: skin disease, UNFEV: fever of unexplained origin, EIN: eye infections, UNK: unknown causes

A total of 199 deaths have been reported through EWARS, most of which (28%) are attributed to acute respiratory infections, followed by injuries (10%).

5.3 Health and WASH

Challenges

Many of the water sources built in the early phase of the response are situated close to latrines, which increases their risk of being contaminated. Moreover, many households are storing water in uncovered containers that are wide enough to allow users to immerse their hands, greatly increasing the risk of contamination. Soap for handwashing is scarce, and boiling drinking water is uncommon. All these factors present a high risk of household water contamination.

Health Sector Response

Improving water quality is a joint health and WASH sector priority. WHO has been working with the government to test water samples from sources and households on a daily basis, using membrane filtration techniques to measure *E. coli* contamination. WHO has trained 12 newly recruited water sample collectors from the Department of Public Health Engineering (DPHE) on sample collection and sanitary inspections. In this first round, 624 source and 1 248 household water samples were collected and tested between 24 October and 12 November. Of these, just 35% and 7% were free from *E. coli* contamination, respectively. Sanitary Inspections (SI) were also conducted, whereby WHO and DPHE teams inspected water sources and household storage containers and observed household hygiene practices. Based on the scoring system used, 68% of surveyed households were considered at high risk of water contamination, necessitating urgent remedial action. The second round of water quality testing began on 13 November and water sample collection and testing is ongoing on a daily basis. The analysis report was shared with the WASH sector to inform actions to improve sanitary conditions and prevent the further deterioration of drinking water quality.

5.4 Vaccines and Immunization

Challenges

The baseline coverage for routine immunization is low. This, combined with crowded living conditions, lack of adequate water and sanitation and reported levels of high malnutrition, represents a public health risk to both the new arrivals and the host population.

Health Sector Response

The health sector has conducted several vaccination campaigns. In the first campaign, which ended on 3 October 2017, 135 519 children under 15 years of age were vaccinated against measles and rubella, 72 334 children under 5 years of age were vaccinated against polio and 72 064 children received Vitamin A.

To mitigate the outbreak of cholera, the International Coordinating Group (ICG) on Vaccine Provision mobilized 900 000 doses of oral cholera vaccine (OCV) for a large-scale cholera vaccination campaign among recently arrived Rohingyas and their host communities. The health sector worked with the MOHFW to plan, train volunteers, fund, implement and monitor this campaign. The campaign to administer the first dose (targeting 650 000 individuals over one year of age) was successfully implemented from 10 to 18 October 2017. It reached a total of 712 797 people, 179 848 of whom were children aged from one to five years old. To help improve personal hygiene, vaccinators handed out soap to each person vaccinated.

From 4 to 9 November 2017, the health sector supported the MOHFW in implementing the second phase of a cholera and polio vaccination campaign for children. A total of 199 472 children aged between one and five years received a second dose of oral cholera vaccine for added protection (estimated target population:

180 000), and 236 696 children under five years received oral polio vaccine (estimated target population: 210 000). The number of people reached per camp is shown in Figure 2.

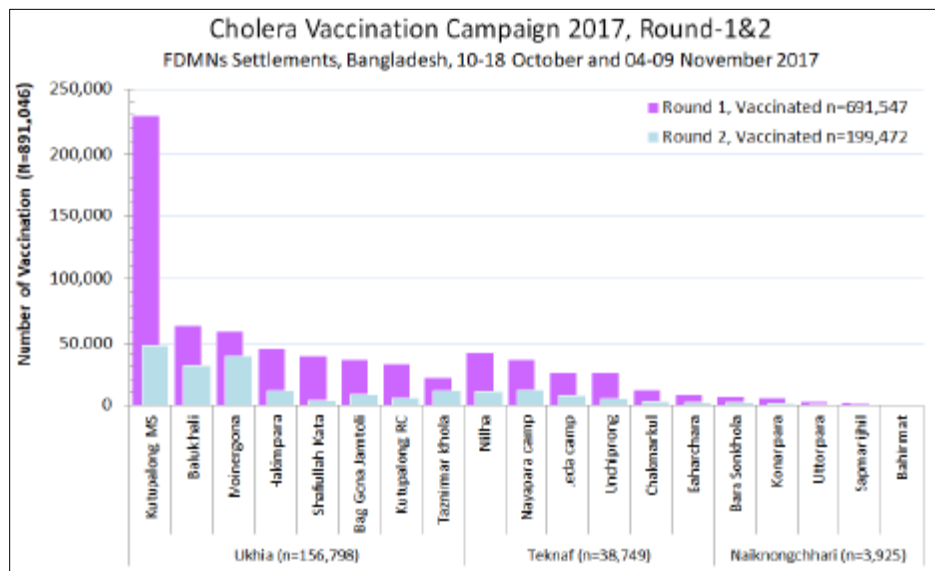


Figure 2: Number of people vaccinated with OCV, by camp/settlement

In addition, the health sector continues to support the MOHFW’s efforts to strengthen routine vaccination. Approximately 100 vaccinators have been trained on the current routine Expanded Programme on Immunization (EPI) schedule, key EPI messages, the importance of maintaining the cold chain, monitoring vaccine vials, injection safety, registration, reporting and waste management. Polio, measles and tetanus immunization began on 11 November from static sites within the camps. Through these static sites, to date 719 children have been vaccinated against polio, 589 children against measles and 476 pregnant women against tetanus.

Additionally, since 1 November, 970 children (6 months - 15 years) passing through the two transit sites have been vaccinated against measles and rubella (MR) and 1038 children under five years received oral polio vaccine (bOPV).

Establishing the routine Expanded Programme on Immunization (EPI) in camps and settlements and setting up vaccination posts at entry points into Bangladesh are both key to controlling measles and other diseases. However, in response to the significant increase in measles cases, MoHFW and health sector have agreed to rapidly initiate a measles campaign targeting 360 000 children under 15 for MR vaccination. In view of the urgency of the situation, the campaign is planned to start on 18 November and microplanning has begun.

5.5 Nutrition

Challenges

Preliminary results of a recent inter-agency assessment conducted in Kutupalong refugee camp from 22 to 28 October 2017 show that severe acute malnutrition rates are running at 7.5% (well above emergency thresholds). Local health care facilities and NGOs have limited capacity to treat children with SAM with complications.

Health Sector Response

Addressing the alarmingly high rates of severe acute malnutrition is a multi-sectoral priority, and nutritional services are included in the package of minimum health services. WHO is providing technical support to the preparation of a multi-sectoral plan led by the Nutrition sector with the involvement of the Food Security, Shelter, Health and WASH sectors. In addition, WHO will support the nutrition sector to standardize the management of children in Outpatient Therapeutic Program (OTPs) supported by different organizations.

5.6 Contingency planning

Challenges

The affected population is vulnerable to diarrhoeal diseases linked to the squalid conditions in the camps and settlements. Moreover, the strong risk of cyclones brings additional vulnerabilities. These two risks require the health sector to prepare and implement contingency measures.

Health Sector Response

WHO and UNICEF drafted a preparedness and action plan for acute watery diarrhoea (AWD), based on a worst-case scenario of 37 000 cases with inputs from all health partners. A gap analysis was conducted to review the availability of diarrhoea treatment centres (DTCs), oral rehydration points, and contingency supplies. A multi-sectoral AWD preparedness and response has been established and, through joint efforts, the level of preparedness has considerably improved. Health sector partners are prepositioning life-saving supplies, and will shortly begin training health care workers on the case management of AWD. Several suitable DTC sites have been identified in spite of land constraints.

Given that Cox's Bazar is prone to cyclones, the health sector is also preparing a cyclone preparedness plan. This plan, which will be finalized in November, will cover the period from 48 hours before a cyclone hits to the immediate 72-hour aftermath. It will feed into a larger inter-sectoral cyclone preparedness plan.

5.6 Sexual and reproductive health

Challenges

Although some partners are providing the minimum initial service package of sexual reproductive health (SRH), access to essential reproductive, maternal, newborn and child health services remains a major concern, especially in the new settlements and hardest-to-reach areas. Home deliveries have anecdotally been reported to be high in several areas. There is also insufficient access to basic and comprehensive emergency obstetric and newborn care (CEmOC), including referral services. There is no standardization of the community health volunteers (CHV) network programme to ensure that home visits to pregnant women, newborn and children take place routinely to support the continuum of care. Lastly, several agencies have reported high levels of SGBV, but only a few women are reported to have visited health facilities for care.

Response

Reproductive health kits have been distributed to facilities providing reproductive health care, and clean delivery kits have been distributed to pregnant women. In addition to the three public hospitals, an additional comprehensive emergency obstetric (CEmOC) and newborn care facility in Kutupalong is now up and running. Standardization of the community health volunteer network has been initiated as an inter-agency effort. Referral pathways for GBV are being set up and clinics providing health services for the clinical management of rape (CMR) have been mapped and shared. The aim is to ensure that all health service points are able to provide high-quality and timely CMR services to survivors of sexual violence. To improve referrals, information on ambulances has been collected and shared, but needs to be updated regularly and

distributed more widely. Several trainings on “Helping Babies Breathe” were completed. A new plan for HIV prevention has been developed and will be implemented soon.

5.7 Mental and Psychosocial health

Challenges

The mental and psychosocial impacts of being forcibly displaced are vast, with the FDMNs facing daily stressors associated with reliance on humanitarian assistance for food and other life-saving needs. This is compounded by reports of traumatic experiences including SGBV and physical violence in Rakhine State.

Response

A critical component of the response has been to train volunteers, outreach workers and para-counsellors in basic psychosocial support; thus far, at least 400 individuals have been trained. In addition, 120 child-friendly spaces have been built and are reportedly much appreciated by caregivers. Currently, MHPSS services are available in child-friendly spaces and static health clinics as well as through group support sessions and outreach activities. However, capacities remain limited, especially for referrals to mental health specialists. The MHPSS sub-group will continue to scale up services for FDMNs through 1) capacity building on emergency psychosocial issues; 2) regular centre- and home-based psychosocial support by para-counsellors, with professional supervision and follow-up; 3) the establishment of 80 more child-friendly spaces; and 4) raising awareness in the community on various emergency psychosocial issues. The MOHFW has recruited a full-time psychiatrist in Sadar district hospital.