

Rohingya Crisis in Cox's Bazar, Bangladesh: Health Sector Bulletin

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Location: Bangladesh

Emergency type: **Rohingya Crisis**



Photo Credit: Catalin Berbaru





883 868
total Rohingya
in Bangladesh



671 500
new arrivals since
25 Aug 2017



431 448 Rohingya children
were vaccinated in the 3rd
round of diphtheria
vaccination



155 facilities reporting
through the Early Warning
Alert and Response System
for surveillance



1.3 million
people targeted for
health assistance

HIGHLIGHTS

- An estimated 671 500 Rohingya have fled to Bangladesh following violence in Myanmar's Rakhine state on 25 August 2017. There are now a total of 883 868 Forcibly Displaced Myanmar National (FDMN) in Bangladesh. The total population in need of health sector assistance is 1.3 million including approximately 300,000 from the host community population.
- The most pressing concern is the upcoming monsoon/cyclone season, and the effects of flooding, landslides and cyclones, which can cut off access within camps/settlements and affect provision of health services. Heavy rains are expected to exacerbate health needs significantly. Areas may become temporarily uninhabitable due to flooding, further degrading living conditions and increasing risks of water and vector borne outbreaks. Landslides and cyclones will damage and disrupt health facility service provision. Increasing need for flexible service delivery mechanisms, management capacity for trauma / mass casualty / emergency obstetric care, and targeted Mental Health and Psychosocial Support. Health sector partners are actively engaged in emergency preparedness and mitigation efforts.
- The third round of vaccination campaign against diphtheria concluded on 25 March with 431 448 children (104% of estimated target) vaccinated.

1. SITUATION OVERVIEW

Since 25 August 2017, an estimated 671 500 Rohingya have crossed over from Myanmar into Bangladesh, joining approximately 212 000 others who had fled in earlier waves of displacement. As of 15 March 2018¹ over 584 000 arrivals are in Kutupalong expansion site, 187 000 in other camps and settlements, and 113 000 arrivals in host communities, impacting the already congested health response. The scale of influx into Cox's Bazar district and the scarcity of resources resulted in a critical humanitarian emergency that exceeded the coping capacity of the local communities and systems. The crowded living conditions in camps and settlements, particularly the Kutupalong expansion sites, expose the FDMNs to further risks of public and individual health. Basic services available prior to influx became over-strained due to massive demands on the health systems and services.

The health sector's 107 national and international partners have responded to the needs through health service delivery in both static and mobile health facilities in both Ukhia, and Teknaf as well as through expansive community health worker networks. The sector is responding to the population needs through provision of health services in camps as well as strengthening of the health system as

¹ ISCG Situation Report: Rohingya Refugee Crisis Cox's Bazar | 25 March 2018

a whole through supporting existing health facilities, the health workforce and the surveillance system. The current health sector focus is strengthening preparedness for the upcoming monsoon/cyclone season for which there is a high likelihood of floods, landslides and associated health threats, including epidemics.

2. HEALTH SECTOR COORDINATION

Overall, the health sector partners are coordinated under the leadership of Civil Surgeon’s Office of Cox’s Bazar, the Directorate General Health Services Coordination Center and the World Health Organization (WHO), for better planning and implementation of a coordinated emergency response.

The health sector is aiming for a multiple-tiered coordination structure, as illustrated in the figure below. A strategic advisory group (SAG), constituting the main health sector partners, serves an advisory role to the health sector coordination based on priority needs. Health Sector Field coordinators have begun to be placed at Upazila level, to strengthen the linkages between the health sector coordinator and camp/settlement level activities. At camp level, focal agencies have been identified in support of the Camp in Charges (CICs) and under the guidance of the Health Sector Field Coordinator to ensure coordination of the Health Sector response. They are tasked with centralizing and circulating relevant information among health partners operating in the same camp and coordinating with other sectors. Briefing and trainings in support of camp lead agencies’ new roles will be underway for mid-April.

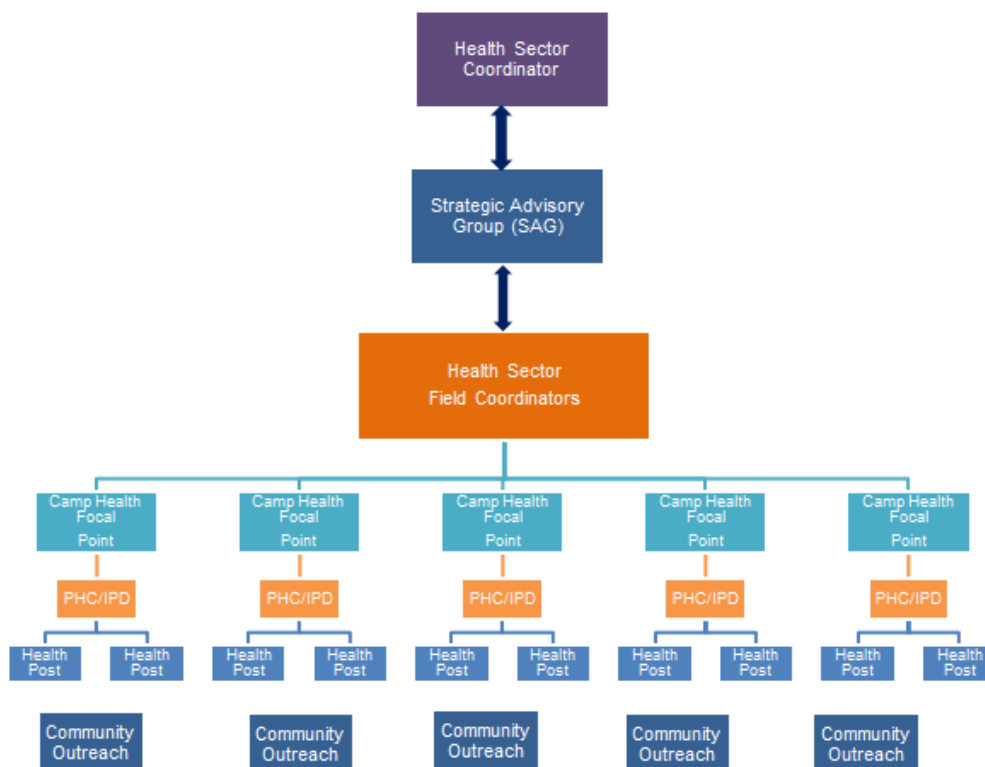


Figure 1- Health Sector coordination structure

Under the health sector coordination there are several active working groups with strong representation from the health sector partners. These groups evolve based on current needs, and meet at differing frequencies depending on the priorities. At present, the active working groups include:

- Mental Health and Psychosocial Support (MHPSS)
- Sexual and Reproductive Health (SRH)
- Community Health
- Health Sector Emergency Preparedness and Response
- Acute Watery Diarrhea
- Vector Borne Diseases

The health sector priority over the past six weeks has been emergency preparedness for the upcoming monsoon/cyclone season. A preparedness action plan has been drafted, implemented by nine “subgroups” (Coordination; Relocation of Health facilities; Logistics; Mobile Medical Teams; Community preparedness; Outbreak preparedness and response; Trauma / Mass Casualty Incident; Dead Body Management; Mental Health and Psychosocial support).

On the 22nd of March, A 1day simulation exercise was conducted for cyclone/monsoon season emergency preparedness and response, and attended by health partners, other sector focal points, and government agencies including Ministry of Health and Family Welfare, Camp in Charge, Cyclone Preparedness Programme, Refugee Relief and Repatriation Commission and the Bangladesh Military. Objectives of the exercise included: (1) orienting participants with content the Health Sector Emergency Preparedness and Response Plan. (2) Validating procedures for incident verification, coordination and communication across sectors and stakeholders. (3) Verifying roles, responsibilities and actions of communication, coordination, and referral systems during a natural disaster event and the mass casualty and/or major outbreak consequences. (4) Building relationships among partners. The exercise was successful in highlighting gaps and areas for renewed focus where more defined roles and responsibilities are required and the health sector continues to coordinate with partners and government authorities to enhance preparedness. Activities related to emergency preparedness are described in the below sections, where relevant.

2 PUBLIC HEALTH RISKS, NEEDS , AND RESPONSE

2.1 Communicable diseases

Surveillance

Although immunization rates have increased with successive vaccination campaigns, continued congested living conditions, inadequate drinking water quality, and poor nutritional status continue to exacerbate existing public health risks. Diseases of concern are vector and water borne, including malaria, dengue and chikungunya, AWD, Shigella, Typhoid, and Hepatitis A and E. Continued concerns exist regarding presence of vaccine- preventable diseases such as measles and diphtheria. Numerous

conditions are being monitored through an Early Warning Alert and Response System (EWARS) which is an online, integrated data collection, analytics, alerting, and automated reporting system. In total, 155 registered health facilities report on a weekly basis, for indicator based and event-based surveillance. From January 1st to 31 March 2018, a total of 1 127 alerts were raised of which 99% were verified and assessed by a joint Ministry of Health and partner response unit. Table 1 summarizes the main diseases that have been reported through EWARS since epidemiological week 1 up to week 13 (ending 31 March 2018).

Condition	Cases <5	Cases 5+	Total
Unexplained fever ²	44 402 (30%)	101 198 (70%)	145 600
Acute respiratory infection	74 897 (51%)	71 666 (49%)	146 563
Acute watery diarrhoea ³	27 632 (43%)	36 784 (57%)	64 416
Bloody diarrhea	7954 (32%)	16 675 (68%)	24 629
Other diarrhea	13 634 (55%)	10 984 (45%)	24 618
Suspected malaria ⁴	349 (4%)	9269 (96%)	9618
Acute jaundice syndrome	508 (32%)	1087 (68%)	1595
Suspected measles/rubella	910 (80%)	226 (20%)	1136
Mumps	1344 (34%)	2606 (66%)	3950

Table 1 Main morbidities reported to EWARS between weeks 1-13, 2018 (cumulative figures)

1. Diphtheria cases are omitted from this table, and described in detail in the following subchapter. 2. Defined as fever >38.5°C/101°F for more than 48 hours in persons for which all obvious causes of fever have been excluded, which captures a range of febrile syndromes of multiple aetiologies. 3. Alerts are verified and investigated for any cluster, cases of severe dehydration, or deaths (see below). 4. Of which 27 cases were confirmed (3 cases in <5 year olds).

The surveillance system is complemented by an ongoing project to strengthen laboratory capacity for diphtheria diagnosis and other key tests in proximity to affected populations and treatment centers for communicable diseases. Through health sector partner support, a laboratory is in final stages of set up in the Cox's Bazar Medical College with capacity for molecular diagnostic testing including DNA extraction, master mix preparation (clean room), template addition and PCR amplification. The objective is to ensure timely detection and response to outbreaks in Cox Bazar. The laboratory is expected to be functional by end April 2018.

Meanwhile, a proposal for community based surveillance of mortality and unusual severe events among FDMN was submitted and approved for implementation by the Ministry of Health authorities.

Outbreak preparedness

Outbreak preparedness is a critical Health Sector consideration for the upcoming monsoon season. A select group of partners is tasked with this aspect under the coordination of the health sector emergency preparedness working group. Contextualized disease risks were assessed in the event of a natural disaster and scenarios were developed for these, outlining background profile data, estimation of burden, alert and verification thresholds, case definitions for post emergency surveillance etc. Disease specific toolkits are being developed for Cholera, Hepatitis A/E, Malaria, and

Dengue, as well as SoPs and training package for Rapid Response Teams to be deployed in the event of an outbreak. Furthermore, the health sector actively participates in the “Communicating with Communities” Working group and, as part of risk communication, is working to finalize key community health messages for each of these diseases.

Water Borne Diseases

Previous rounds of water quality monitoring have shown high levels of contamination of water both at the source and at household level, posing a significant public health risk.

The fourth round of water quality surveillance is currently underway, led by health sector partners. So far, 21% of the targeted water samples have been collected from tube wells and surrounding household water storage containers. Additionally, 220 sanitary inspections of latrines in surrounding tube well areas have been conducted. Analysis is ongoing with results expected at the end of April. An assessment of microbiological water quality) is also being done at the District Government Hospital (Sadar). These will help to identify areas with high levels of water contamination, for action and follow up by the WASH sector. WASH sector is also working to construct deeper tube-wells within the camps, with a minimum of 10 meters between latrines and wells to reduce contamination.

To help address contamination of household water, the health sector is working with the WASH sector hygiene promotion working group to develop key community messages. Trainings are scheduled for early April for community health workers on hygiene promotion with specific focus on acute watery diarrhea (AWD) and Hepatitis E. Distribution of water purification tabs is ongoing and the Health Sector has requested scaled up blanket distribution. There is a plan to distribute comprehensive protection water filters to all households with pregnant women in the near future.

Acute Watery Diarrhea

Diarrhoeal diseases are common in refugee camp settings, and a total of 63 497 acute watery diarrhea cases have been reported between weeks 1 and 13 2018. Although there has been no indication of severe disease or unusual clustering of cases to date, all alerts are being investigated and vigilance is warranted particularly with the upcoming monsoon season.

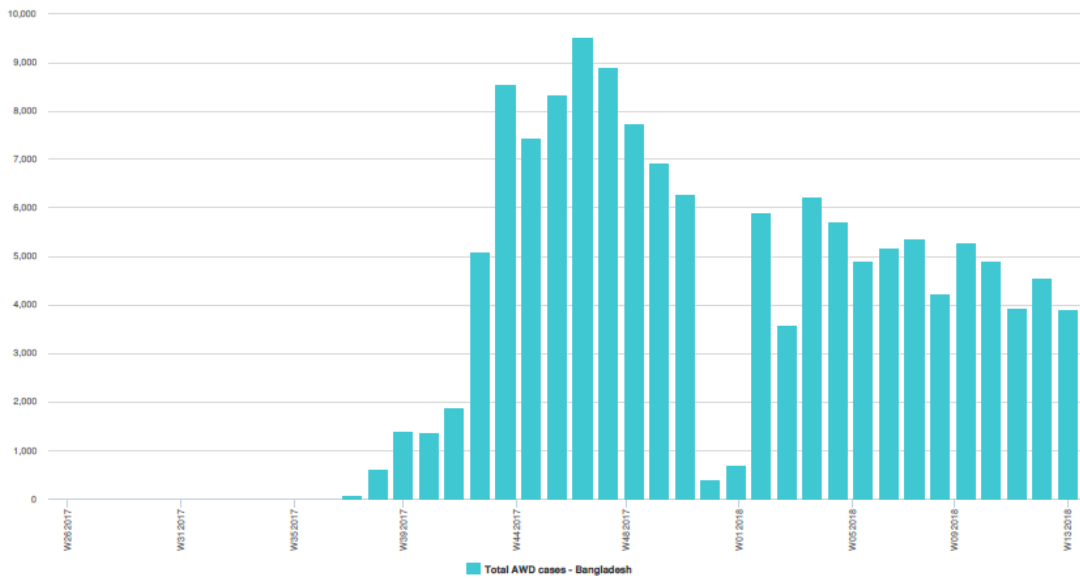


Figure 2- Number of acute watery diarrhea cases reported to EWARS between weeks 1 and 13

Coordination and implementation of the Acute Watery Diarrhea (AWD) preparedness plan is jointly executed by the Health and WASH sectors and their key implementing partners. Twenty (20) planned Diarrhea Treatment Centers were assessed late February to determine level of operational “readiness” with medical, logistic, and WASH technical support provided to ensure implementation to standard. In addition, critical AWD stocks (sufficient for the worst case outbreak scenario) are stockpiled and are being prepositioned. Health facilities with isolation capacity (non-AWD) have been mapped out together with total bed numbers to guide partners in patient referral pathways.

Acute Jaundice Syndrome

A total of 1591 cases of acute jaundice syndrome (AJS) have been reported to EWARS between weeks 1 and 13 of 2018 – ranging from 90 to 170 per week. EWARS Bangladesh case definition for Acute Jaundice Syndrome is: Any person with acute onset of jaundice with or without fever and absence of any known precipitating factors. Following an initial rapid investigation conducted in February and revealing 10/27 cases of Hepatitis A, 2/27 cases of Hepatitis B, and 1/27 case of Hepatitis E, an exhaustive and systematic sampling campaign was launched 28 February - 26 March 2018. In total 269 samples from AJS cases were taken and tested for Hepatitis A, B, C, E, and Leptospirosis. Final samples are still being processed and a summary report is underway. Initial findings from the first 150 samples reveal an underlying prevalence of Hepatitis A similar to the initial rapid investigation and in line with national prevalence of Hepatitis A in Bangladesh. Less than 1% of samples have tested for Leptospirosis and 0 cases of Hepatitis E have so far been detected.

Response actions are underway between the Community Health TWG and Hygiene Promotion TWG to reinforce community prevention and health education. Including (1) the Hygiene Promotion working group has initiated Training of Trainers trainings for AWD and Hepatitis A & E among Hygiene Promoters and CHWs across all camps and settlements, (2) a program for hygiene promotion among

food vendors is being worked on, (3) WASH sector plans aqua tab distributions, and in complement Health Sector partners have begun procurement of “ultrafiltration” community water filters providing comprehensive protection for households with pregnant women. For case management: there is no specific treatment for Hepatitis A, and almost everyone recovers fully with lifelong immunity. Most important is the avoidance of Acetaminophen / Paracetamol and medication against vomiting should not be given. Hospitalization is unnecessary in the absence of acute liver failure. In countries where Hepatitis A may be widespread, large-scale vaccination programs may not be recommended due to high numbers of naturally immune persons.

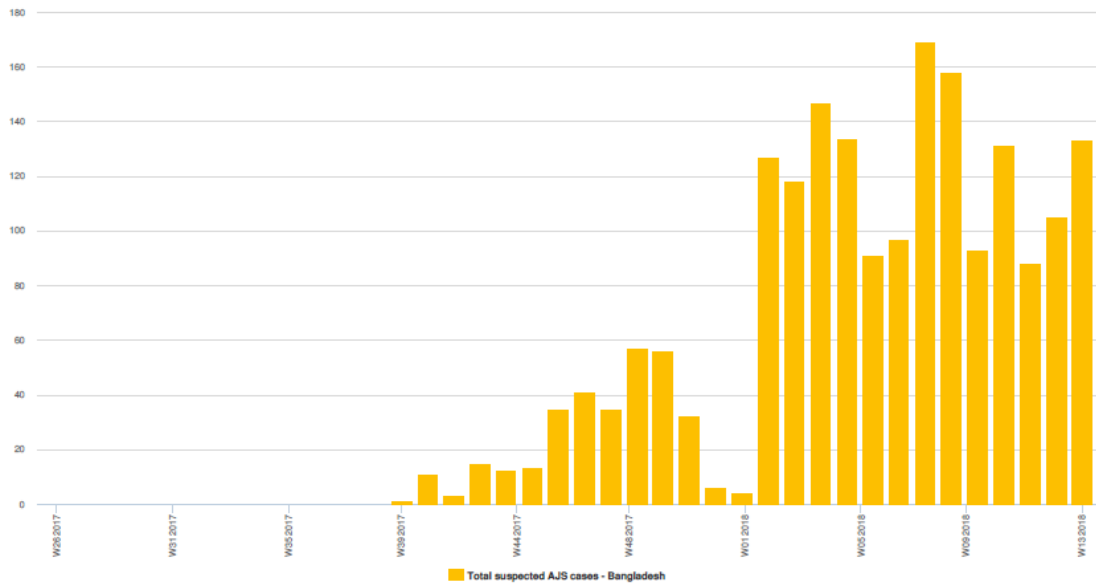


Figure 3- Number of cases of suspected AJS reported to EWARS between weeks 1 and 13 of 2018

Vector Borne Diseases

As of 31 March, a total of 9611 cases of suspected malaria have been reported from week 1 to week 13 2018, of which 40 cases were confirmed. Although there have been no suspected cases of Dengue or Chikungunya, fevers reported through EWARS event based surveillance in 2018, with the onset of the rainy season these vector borne diseases remain a risk.

Through partner support, international technical experts were deployed to undertake an assessment of risk for vector-borne diseases for the coming monsoon season, with special emphasis on Dengue, and Malaria. A report detailing the key recommendations is pending finalization, and will guide action plans. Meanwhile a preliminary laboratory service availability assessment was also undertaken, with a view to mapping out laboratory capacities within the camps in the near future.

Other Vaccine Preventable Diseases

Increasing immunization coverage among the FDMN against vaccine preventable diseases is a priority for the health sector, both through vaccination campaigns and through strengthening of routine immunization. In the past 6 weeks, the 3rd and final round of Diphtheria vaccination campaign was completed. Targeting children <2 years of age, routine immunization has been initiated, with BCG

(2491 vaccinate to date), Pentavalent (1975 vaccinated to date); bOPV (2239 vaccinated to date); PCV (2247 vaccinated to date); MR (830 vaccinated to date). Trainings of vaccinators were completed through health sector partner support, and routine EPI is now being implemented through 25 fixed session site and 64 outreach session sites across the camps.

Measles

A total of 1105 suspected measles cases were reported between weeks 1 and 13 in 2018. In week 13, 43 new suspected measles cases were reported, compared to 50 cases in week 12. Trends of suspected measles/rubella cases have steadily declined in 2018. To assess ongoing transmission and circulation of measles virus, sampling has been re-launched as per national protocols using both serum and swab sampling techniques. Results will be analyzed at national level by NMRL, and tested for presence of Measles IgM followed by Rubella. Swab samples will allow for viral genotyping in order to confirm continuity of previous outbreak or identify if any new source of cases.

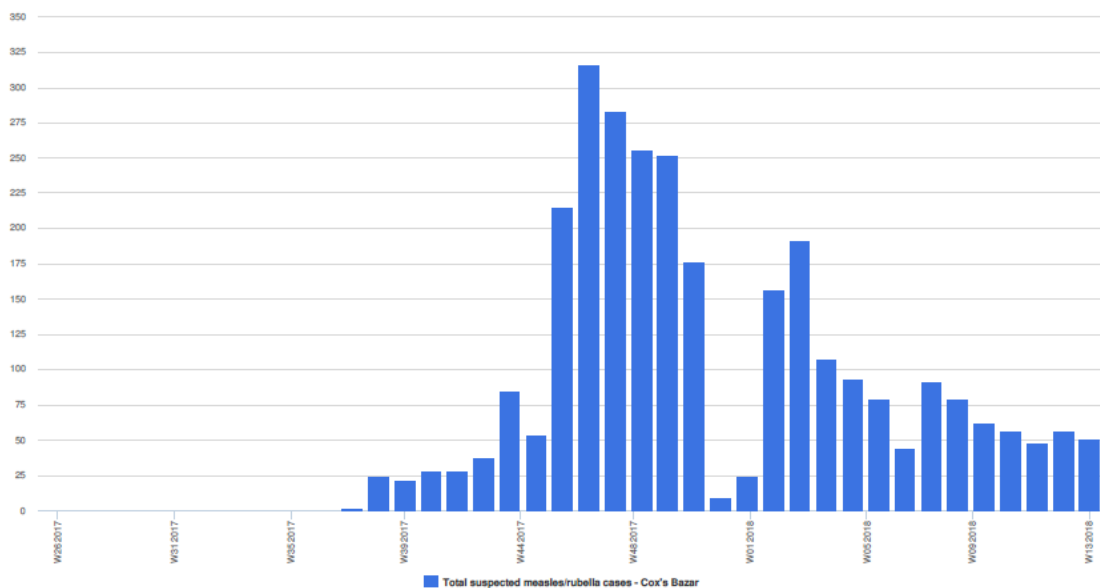


Figure 4- Number of suspected measles/rubella cases reported to EWARS between weeks 1 and 13

Diphtheria

Since the announcement of a Diphtheria outbreak on 8 Nov 2017 and up to 31 March 2018, 6 460 diphtheria case-patients were reported through EWARS of which 2 837 (44 %) were suspected, 3 422 (53 %) were probable. There have been a total of 40 deaths (case-fatality proportion <1.0%), the most recent death occurring in W12 2018 in a child aged 3 years. As illustrated by the epidemiological curve (Figure 4), the outbreak peaked in December 2017, and a steady decline in reported cases has been observed since week 1 of 2018. The age distribution of cases has remained constant with decreasing incidence.

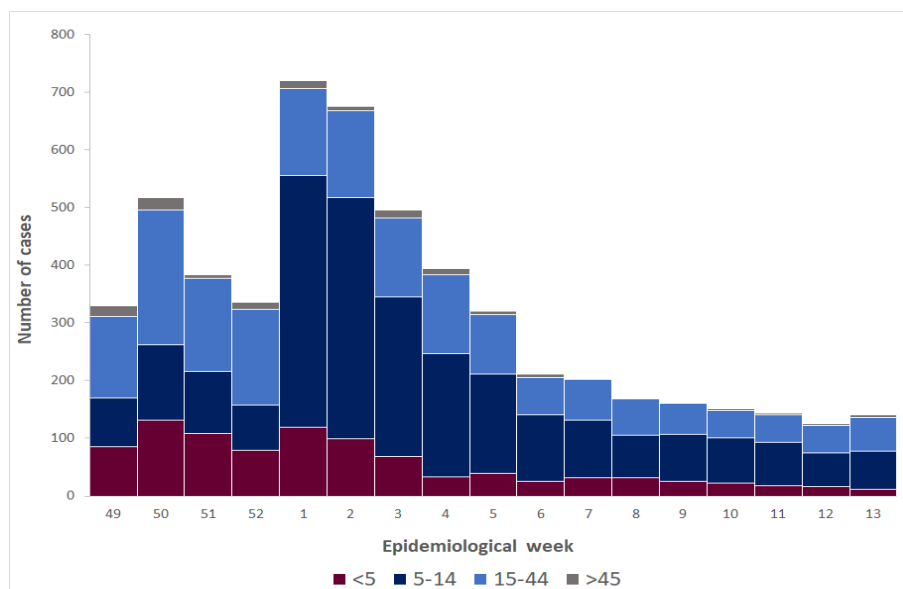


Figure 5-Total number of suspected, probable or confirmed cases reported by week between 1 November 2017 and 31 March 2018

Among the host community case reports remain limited but continuous. In-depth investigation to improve understanding of transmission patterns is ongoing. As of 31 March, a total of 58 suspected diphtheria case-patients and no deaths have been reported since the start of 2018. The risk of further spread has been assessed to be moderate in younger age groups as the routine vaccination coverage for Diphtheria is reportedly sufficient in the Bangladeshi community.

A multi-pronged response strategy was implemented comprised of enhanced surveillance, early detection and treatment, contact tracing, risk communication and mass vaccination campaigns. The third and final campaign targeting children aged 6 months – 7 years (pentavalent vaccine) and 8 – 14 years (Td vaccine) finished on 25 March 2018 with 431 448 children vaccinated. Rapid coverage assessment of 10,000 children (eligible for diphtheria vaccination) estimated the coverage to be approximately 90%. While the impact of this robust response is evident from the decreased incidence, the outbreak continues with 169 cases reported in week 13 2018. A large proportion of these cases are in the age group ≥ 15 years. Further investigation is currently underway to understand transmission dynamics and design strategies for further reduction in cases, towards a goal of reaching zero cases.

Health sector partners continue to provide patient care from 2 active Diphtheria Treatment Centers and have begun systematically following up all patients 30 days after discharge. Patients with diphtheria can develop “late complications” (e.g. cardiac, renal, neurological) several days/weeks after the initial acute phase of the illness. A clinic physiotherapist has been organized for patients with support being sought for speech and language therapists.

2.2 Sexual and Reproductive Health

Based on the latest UNHCR family counting exercise demographic data, an estimated 52% of FDMNs are women, including more than 205,000 women aged 18-59 years². The Sexual and Reproductive Health Working Group is coordinated by UNFPA and includes approximately 50 partners.

Although some partners are providing the minimum initial service package of sexual reproductive health (SRH), access to essential comprehensive reproductive, maternal and newborn health services remains a major concern. Based on the latest available NPM data³, it was reported that FDMNs face problems accessing antenatal care in 28% of locations surveyed, either because the service was not available, or because it was available but not easily accessible. In 36% of assessed locations, it was reported that women do not give birth in health facilities. Based on data reported by SRH partners, an estimated 14%⁴ of deliveries occurred in SRH facilities which may reflect a combination of both demand and access issues. The difficulty of transporting patients for safe facility-based births continues to be a challenge, especially for night time deliveries, as 24/7 facilities with birthing units are scarcely located within the camps, and arranging for an emergency patient transport at night remains a major challenge, resulting in avoidable maternal and infant mortalities.

Nevertheless, several facilities are providing SRH services in hard-to-reach areas, and SRH partners continue to construct additional clinics with sturdy structures that can provide high-quality services even during the rainy season. To date, 2 980 safe delivery kits were provided to key health I facilities. In response to the high proportion of home deliveries cash-based project is being piloted to incentivize facility-based deliveries and traditional birth attendants are being trained as safe motherhood promoters.

A total of 280 health care practitioners received training on Helping Babies Breathe, Emergency Response, Helping Mothers Survive and Clinical Management of Rape. To address the need for emergency obstetric services, 3 obstetrics/gynecology consultants were deployed to Ukhia health complex for support of 24/7 emergency obstetric services. In March 2018, Hepatitis B vaccination for healthcare workers was launched by the Civil Surgeon's office, and a national task force of HIV visited Cox's Bazar to assess support needed to begin implementation of HIV/AIDS activities in certain health facilities in particular as it relates to PMTCT. From December 2017-February 2018, 1 593 deliveries took place in a health facility, at least 16 592 women were reached with family planning methods and 29 654 antenatal care visits were reported.

² Latest report published on 18 March.

³ Round 9 assessment was conducted between 7 and 25 February 2018.

⁴ Note that this figure is based on reported data; it is likely that data on deliveries is underreported.

2.3 Mental Health and Psychosocial Support (MHPSS)

The psychological impacts of being forcibly displaced continue to affect large numbers of FDMNs. To help coordinate the response, an MHPSS working group exists with fifteen agencies and actors providing mental health and psychosocial support to the affected population.

A qualitative and quantitative Mental Health and Psychosocial needs assessment was recently completed by MHPSS WG partner. Of the 327 individuals surveyed during February, 45% reported experiencing some distress indicators and other negative feelings mainly among children and youth. Specifically, 47% felt sad always, 29% of participants reported to feel tense always and 27% of participants manifested feeling grief always for their lost family members and their previous life⁵. Identified stressors include unemployment, lack of health care, lack of clean water and separation from family. These mental and psychosocial needs will only be compounded by any natural disaster resulting from monsoon/cyclone season. Furthermore, MHPSS actors have identified concerns of increased intimate partner violence, domestic violence and rape victims who were impregnated coming to full-term.

The working group is addressing both long and short term issues arising. In the short-term, efforts are directed towards emergency preparedness, and the MHPSS Task Force has been shifted to focus on this. MHPSS Emergency Preparedness and Response Action Plan includes (1) Psychological First Aid trainings for Mobile Medical Teams and community focal points within the Safety Units, (2) weekly workshops for both national and international staff on self-care, (3) technical guidance on management and prioritization of persons with severe mental health conditions, (4) workshops and key messages on “do no harm” principle, (5) technical guidance and support to MHPSS actors on emergency response and (6) functional links established with protection sector.

On an ongoing and longer term basis, the MHPSS partners continue to advocate for access of specialized psychiatric services at camp and settlement levels to ensure better support to the beneficiaries. Structured supervision is provided to the psychological care practitioners to build capacity as well as mitigate further harm. In late March, 15 psychologists attended an in-depth training on Child Clinical Skills. A detailed mapping of services is in process to help identify gaps, facilitate referrals, and encourage partners to collaborate and coordinate. Information is being captured following the four layers of service provision: Specialized Services, Focused non-specialized support, Community & Family supports, Social Considerations in basic services & security. This information will also inform the 6 month work plan which the group is finalizing.

However, despite continued advocacy, a gap in available psychiatric care persists. Only two partners offer psychiatric care within the camps, as well as one psychiatrist is working within the District of Cox’s Bazar Hospital. This issue has been raised within the Health Sector and mhGAP trainings are launched and planning to be increased in the near future. Finally, a detailed 4W’s MHPSS workshop

⁵IOM. Assessment of Mental Health and Psychosocial Needs of displaced Rohingya Refugees. March 2018.

held and the mapping will be finalized soon which will help clarifying the ongoing challenge of referral pathways.

2.4 Nutrition

The Nutrition Sector estimates that more than 208 000 0-59 month-old infants, 107,000 pregnant and lactating women (PLW) and 88 000 adolescent girls among the FDMN and host communities are in need life-saving nutrition interventions. These high levels of under nutrition are in part a result of existing vulnerabilities such as stunting (above 40%), food insecurity, poor hygiene and sanitation conditions, and disease outbreaks. Additionally, extremely high levels of anemia among FDMN children indicate high prevalence of micronutrient deficiencies⁶. Results from the Standardized Monitoring Assessment for Relief and Transition (SMART) Surveys conducted last year suggest that the prevalence of Global Acute Malnutrition (GAM) among Rohingya children is above the WHO emergency threshold levels.

In the past 6 weeks, an estimated 4 886 children were admitted for Severe Acute Malnutrition (SAM) and 6 053 for Moderate Acute Malnutrition (MAM). A total of 17 635 children were reached through blanket supplementary feeding programs (BSFP) and 80 870 pregnant and lactating women were counseled on Infant and Young Child Feeding (IYCF).

Many Health Sector partners continue to provide nutrition services in their health facilities such as screening of children as well as pregnant and lactating women for malnutrition. Additionally, many partners are also providing therapeutic supplementary food provision and referrals to Targeted Supplementary Feeding Programs (TSFP). Partners have been utilizing community health workers to provide joint health and nutrition messaging to the community and there is collaboration between Nutrition and Health Sectors through training of health staff on nutrition and provision of health nutrition equipment to health facilities as well as training of nutrition staff on common infectious disease.

The nutrition sector recently undertook a review to identify areas of work that require improvement. One recommendation is to ensure continuum of care for all acutely malnourished and following the agreed road map to identify and prioritize locations where nutrition services need to be established. In addition, discussions were held with other sectors including the health sector, to identify core integration actions that can be implemented through multi sectorial approaches. Treatment protocols for the management of acute malnutrition (SAM, MAM) as well as BSFP were reviewed.

The nutrition sector has also worked on preparedness and response planning for the monsoon/cyclone season, to review and estimate nutrition supplies needed for the flood response, their procurement and prepositioning and to present changing approaches and modalities based on different emergency scenarios. Work is ongoing to update the number of nutrition sites in light of the new flood and landslides risk map and either relocate facilities at high risk or reinforce others that are at lower risks. Follow up with specific partners to understand their level of readiness is also ongoing.

⁶Joint Response Plan for the Rohingya crisis, March-December 2018

Lack of understanding of planned relocation sites currently hamper the efforts to prepare contingencies in order to ensure continuity of nutrition services for all during the monsoon season.

2.5. Health service access and delivery

Regarding health service access and delivery, the health sector is committed to meeting both the needs within the camps as well as outside the camps.

The health sector maintains an up to date dataset of all health facilities within the camps and the surrounding areas, including facilities implemented by NGOs and Government. Each facility has now been assigned a unique identifying number to simplify any facility-based reporting. Currently, there are 265 functional facilities known to the health sector including isolation facilities, specialized facilities, health posts, primary health centers, and secondary care facilities. A further 16 are planned or under construction. Facility maps are developed on a routine basis and shared with health sector partners for improved coordination. Based on the data available, overall coverage meets the Sphere minimum requirements. There are an estimated 152 basic health units (Health posts) which corresponds to 1: 8852 people in need⁷; 40 primary health center facilities (1:32 500 people in need) and 10 secondary care facilities (1:130 000 people in need). Approximately 900 hospital beds are available to the people in need, of which 290 are in Government run facilities.

However, there are inconsistencies in the quality of services provided, and varying implementation of the established minimum package health of services which was endorsed by relevant authorities, for primary health service delivery within the camps (Primary Health Centers and Health Posts). Notably, non-communicable diseases (NCD) management capacities are limited, and the health sector held an exploratory meeting to identify how best to move the NCD agenda forward. Furthermore, there are gaps in secondary care services in Teknaf upazila, as the three main field hospitals are all clustered in Ukhia upazila.

Referrals remain an ongoing challenge with no comprehensive referral mechanism in place. The health sector regularly updates maps on secondary care facilities; with admission criteria, bed capacities and emergency contact details to facilitate referrals. A map was also produced for rehabilitation services to facilitate specialized care referrals, and there are plans to map out other specialized services as needed. Furthermore, a taskforce is working to finalize an SOP for referrals which will standardize the pathways as well as referrals forms and criteria.

Outside of the camps, the health sector is committed to health system strengthening through support to the Government facilities. Following the assessment of the District Hospital and the two upazila health complexes in December 2017, several health sector partners committed to provide support to these facilities. Critical gaps identified include human resources, physical infrastructure, equipments, laboratory, Water and Sanitation, Healthcare Waste Management Capacity, and Infection Prevention and Control. In March 2018, the health sector convened 2 round table discussions among 11 health actors and donors currently investing in the District Hospital to

⁷ Total population in need as per the current JRP is 1.3 million including FDMN and Bangladeshi host community.

coordinate the support and set common goals. In particular, working to achieve the priority of ensuring 24/7 functionality of key emergency services. Through this coordination mechanism, areas of overlap were identified and collaborations were formed to avoid duplication. The same exercise is planned for the two upazila health complexes in coming weeks.

The health sector is also planning for medium-term options for health infrastructures among the affected population. The Directorate General of Health Services is committed to identifying several semi-permanent structures, with a view to providing services on a longer term basis. Several partners have offered their support in this regard, and one “model” primary health center was officially inaugurated by the Director General of Health Services in March, setting an important standard for future investments.

2.6. Monsoon / Cyclone preparedness and response

In the context of emergency preparedness, a concerted effort and planning is needed to ensure sustained health service access and delivery of critical, life-saving health support throughout sudden onset of emergency events including flooding, landslides and cyclones. There are many concerns with regards to the effects of small and larger scale flooding and landslides which can and will cut off access within certain parts of the camps/settlements as well as to the camps and settlements themselves. Health needs are expected to exacerbate significantly as certain areas of the camp may become temporarily uninhabitable forcing people to crowd further into non-affected areas, increasing strain on health services as well as even denser living conditions. Access to the interior of Kutupalong will become difficult and vehicular access will again be compromised with regards to transport of staff and supplies. Some of the Teknaf camps may become heavily flooded and Rohingya, if not relocated, will likely move to adjacent areas and/or disperse among the host community.

The health sector has convened an Emergency Preparedness and Response Working Group since January 2018, and has been actively working on contingency planning and response mechanisms. Based on risk mapping, 54 health facilities are at risk of flooding and 15 are at risk of landslides in Ukhia upazila (Teknaf upazila risk mapping remains to be completed). This could lead to considerable gaps in service provision and, due to land shortages options are very limited for relocation. The Health Sector is encouraging partners to meet minimum standards for service provision and reduce number of outpatient facilities in the northern camps and settlements of Kutupalong, Balukhali, and Jamtoli. Partners have been asked to consolidate service provision and partner together to ensure the minimum package of services is provided, particularly in flood/landslide safe areas. Several health sector partners also participated in a training run by the shelter sector in early April on strengthening community infrastructures. The Ministry of Health and Family Welfare and the Health Sector have been encouraging partners to invest in stronger semi-permanent structures or at very least in reinforcing structures for high winds and rain. Partners located in high risk landslide areas will be asked to take down their facilities.

The logistics subgroup of the Health Emergency Preparedness and Response working group has been working to ensure the necessary critical supplies are available to maintain health service delivery as well as respond to potential outbreaks and mass casualty events. Sites have been identified around the camps and settlements in Ukhia and Teknaf for prepositioning of six containers for medical and logistical “buffer stocks”. Guidance has also been developed for implementing partners regarding stock management, protection of medical supplies, and transport, as well as communications. Challenges are foreseen regarding emergency communication given restrictions on use of VHF radios.

In order to ensure ability of health facilities to respond to increased and changed health needs after floods throughout the monsoon season, outbreak preparedness and response was initiated with the objective to minimize disruptions to disease monitoring and prepare for outbreak response in the context of a natural disaster. Contextualized risk of predominantly water and vector borne disease outbreaks have been identified, and scenarios developed; outlining disease profile, estimated burden, alert and response thresholds, patient care protocols, supplies list, HR training packages, and rapid response teams.

To address potential disruptions to health service provision, Mobile Medical Teams will be deployed comprised of volunteers from numerous health sector partners. Volunteers have now been identified for 5 core teams, 15 surge teams and >20 supplementary teams with full operational plan developed. MMTs will undergo a full training in April (covering personal safety awareness and risk assessment; first aid; mass casualty triage and management; key protection issues; and psychological first aid). Meanwhile, the Trauma and Mass Casualty management sub-group of the emergency preparedness working group has been working with the main secondary care facilities to ensure mass casualty plans are in place and to map ambulance capacities. However, gaps remain in health care waste management, dead body management and decentralized availability of safe blood in sufficient quantity.

4. HEALTH SECTOR FUNDING

The Joint Response Plan (JRP) for the Rohingya Crisis was launched in March 2018, for the period 1st March- 31 December 2018. A total of 35 project proposals were submitted and validated for the health sector, with a \$113.1 million appeal budget.

Since the launch of the JRP, investment in the Health Sector’s strategy and needs has not been enough of a priority. Great difficulties will be faced to adequately scale up to meet the requirements of ongoing activities as well as the challenges of the upcoming monsoon/cyclone season due to lack of funding.

Support provided from donors from October 2017 to February 2018 enabled Health Sector partners to:

- exponentially increase Health Facilities in the camps and settlements from the few existing in August 2017 to almost 270 structures covering majority of camps / settlements in March 2018;
- carry out 7 timely and to-scale mass vaccination campaigns in under 6 months;
- successfully set up and maintain surveillance systems and respond to Diphtheria and Measles outbreaks;
- Deliver life-saving health kits, medicines and other commodities to government and NGO health facilities;
- and a variety of other achievements

Work must continue for health service delivery, and epidemic response, underpinned by continued programming and activities to avoid further degradation of the health context.

Support is urgently needed to enable Health Sector Partners to deliver the JRP and adequately respond to the monsoon/cyclone season.

CONTACTS

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