

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

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Photo Credit: Razzaque Khan- Health Sector Meeting 30 May 2018



ASEAB, SHED, HMBDF, GODOCS, SKB, FDSR, Coast Trust, CZM, DAM, Dalit, DCHT, Humanity First, ISDE, OBAT Helpers, Protyyashi, Pulse Bangladesh, RPN, SALT, UAEAID



915 000
total Rohingya
in Bangladesh



702 160
new arrivals since
25 Aug 2017



879 273 Rohingya people
and the host community
were vaccinated during
OCV campaign



107 health sector partners



1.3 million
people targeted for
health assistance

HIGHLIGHTS

- The oral vaccination campaign for acute watery diarrhea was successfully completed on 13th May 2018. A total of 901,810 people were vaccinated in this campaign including Rohingya and host community.
- According to incident report (as of 12 May 2018) by Site Management Sector in Cox's Bazar, 27 incidents have been reported as a result of current rains. A total of 1 551 households have been affected including 7 112 individuals. WHO and health sector partners continue to put in place mechanisms to respond to health needs those likely to be affected.
- The health sector has received 10.9% of the US\$113.1 million requested through Rohingya Refugee Crisis Joint Response Plan 2018 (<https://fts.unocha.org/appeals/656/summary> as of 10 June 2018). Additional funding is required to cater for the health needs of the Rohingya community as well as strengthening the health system in Cox's Bazar.

1. SITUATION OVERVIEW

Since 25 August 2017, an estimated 702 160 Rohingya have crossed over from Myanmar into Bangladesh, joining 212 840 others who had fled in earlier waves of displacement. As of 24 May 2018¹ over 607 096 arrivals are in Kutupalong expansion site, 292 505 in other camps and settlements, and 15,000 in the host community, 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 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 a whole through supporting existing health facilities, the health workforce and the surveillance system. The current health sector focus is strengthening preparedness for the ongoing monsoon/cyclone season for which there is a high likelihood of floods, landslides and associated health threats, including epidemics.

¹ ISCG Situation Report: Rohingya Refugee Crisis Cox's Bazar | 24 May 2018

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 has adopted a three-tiered coordination structure at District, sub-district (upazila) and camp-levels. At the District level, a strategic advisory group, constituting the main health sector partners, serves an advisory role to the health sector coordinator based on priority needs. 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
- Emergency Preparedness
- Acute Watery Diarrhea

To ensure three levels of coordination, field coordinators were recruited to strengthen the linkages with the field-level activities. At a camp level, camp-level focal points were assigned from health partner agencies, for better two-way information sharing under the guidance of the Health Sector Field Coordinator. Selection of these camp-level focal agencies was finalized and orientations were conducted. Field coordinators participate in relevant upazila and camp level meetings. The health camp focal points have been engaged in the following ways so far:

- Preparedness planning for the monsoon season including dead body management at community level and possible acceptable communication channels and responsibilities at camp level. The Health Focal Points are working closely with Site Management, WASH and other camp actors in organizing and mobilizing burial groups
- Participated in a WASH-sector led collaborative workshop on Acute Watery Diarrhea coordination between WASH, Health and Site Management in each camp including communications flow chart in case of Death from AWD at community and health facility levels

2 PUBLIC HEALTH RISKS, NEEDS , AND RESPONSE

2.1 Communicable diseases

Surveillance

Although immunization rates have increased with successive vaccination campaigns, crowded living conditions, inadequate drinking water quality and poor nutritional status still pose risk to the public health of the target population, with risks of vector borne disease such as chikungunya, dengue and

malaria in addition to water-borne diseases, and other 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, 170 registered health facilities are registered and an average of 77 report each week, for indicator based and event-based surveillance. From January 1st to 03 June 2018, a total of 1721 alerts were raised of which 100% were verified and assessed by the joint Ministry of Health and partner response unit. As part of the emergency preparedness, an EWARS helpline phone number has been activated.

Table 1 summarizes the main diseases that have been reported through EWARS since epidemiological week 1 up to week 22 (ending 03 June 2018).

Diseases/Syndromes ¹	<5 Cases	5+ Cases	Total Cases
Unexplained fever ²	70621	157307	227928
Acute respiratory infection	115026	108625	223651
Acute watery diarrhoea ³	45085	64860	109945
Bloody diarrhea	24687	25027	49714
Other diarrhea	10475	22426	32901
Suspected malaria ⁴	528	19232	19760
Acute jaundice syndrome	5020	7822	12842
Suspected measles/rubella	687	1566	2253
Mumps	1110	264	1374

Table 1 Main morbidities reported to EWARS between weeks 1-22, 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 etiologies. 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 EWARS surveillance system is complemented by an ongoing project to strengthen laboratory surveillance. Through health sector partner support, a new field laboratory is now functional (since 21st April 2018) in the Cox's Bazar District with capacity for molecular technique diagnostic including DNA extraction, master mix preparation (clean room), template addition and PCR amplification. All Diphtheria samples are now processed at this laboratory.

A proposal for enhanced community based mortality surveillance is being rolled out, in which community health care workers will collect mortality data from households on a rotational basis, and this will be entered and analyzed through the EWARS information platform.

Outbreak preparedness

Outbreak preparedness is a critical health sector consideration for the current 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 were developed for Cholera (Acute Watery Diarrhea), Shigella, Typhoid, Hepatitis A/E, Malaria, and Dengue including case management material, epidemiology investigation protocols and tools, and community messaging. Work is ongoing to finalize a toolkit for Influenza.

A proposal is being finalized for the several formations of rapid response teams (RRTs) with responsibilities for outbreak investigation and response. Deployment of the RRTs will be activated by the Civil Surgeon's office based on information from the WHO EWARS team or other community-based alerts requiring investigation. RRTs will be formed from partner agencies and consist of field epidemiologists/WASH experts /IPC experts/Infectious disease specialists/lab sampling technicians.

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.

Two rounds of water quality surveillance were completed in the past 8 weeks by health sector partners, with a focus on Teknaf and southern part of Ukhia. From 31 March to 14 May, 1126 samples from water sources and 2252 samples from households were tested using Membrane Filtration Technique to determine *E. coli* contamination. Of the total number of samples tested in these two rounds, 41.5% of household-level samples and 78.5% of source-level samples matched the Bangladeshi standards for drinking water quality. There is a high probability of deterioration trend in both at the source and household's water storage in the ongoing monsoon and the WASH sector is continuing its efforts to chlorinate contaminated shallow tube-wells and decommission/relocate latrines near shallow tube wells. Household chlorination tablets and water purification filters are being distributed.

Aside from the water-contamination focused interventions, a project is also being launched by the WASH sector to address issues of food hygiene in the camp,

Acute Watery Diarrhea

Diarrhoeal diseases are common in refugee camp settings, and a total of 109 730 acute watery diarrhea cases were reported through EWARS between weeks 1 and 22 2018, as shown in the figure below. Although there has been no indication of severe disease or clustering of cases to date, there has been a slight observed increase in the trend and all alerts are being investigated. Vigilance is warranted in view of the ongoing monsoon season.

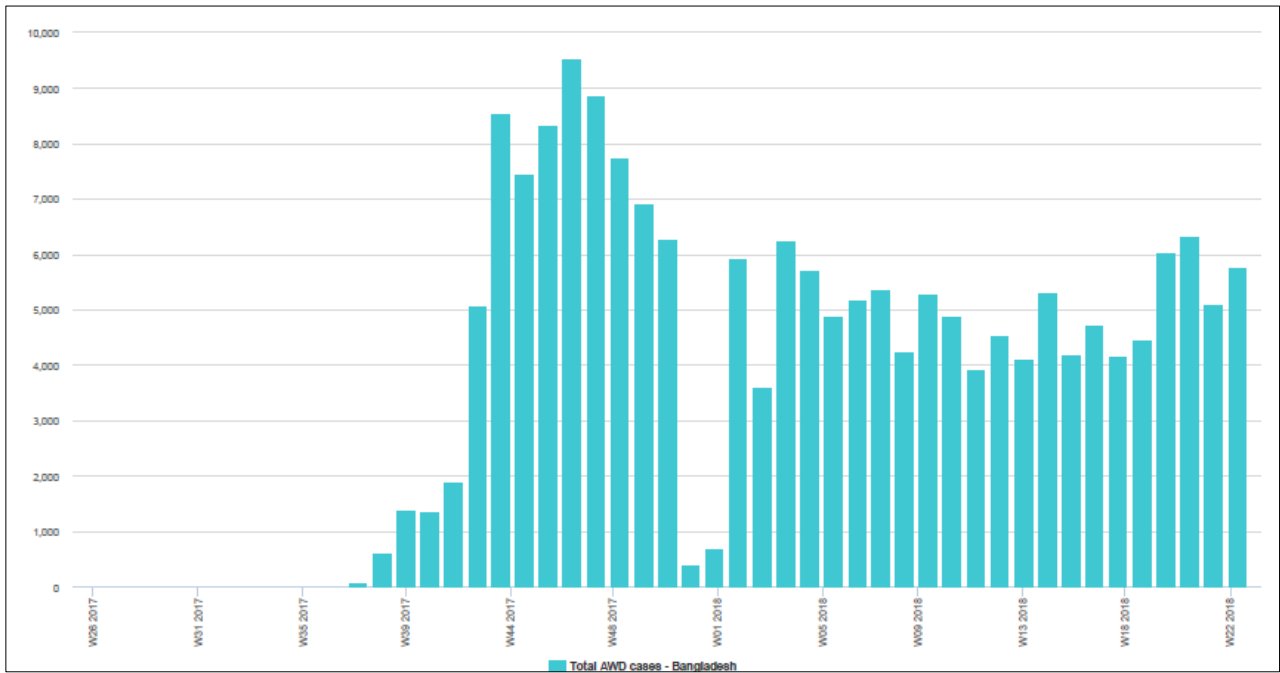


Figure 1- Number of acute watery diarrhea cases reported to EWARS from week 1 – 22 2018

A multi-sectoral Acute Watery Diarrhea (AWD) preparedness response plan was finalized. Implementation of this plan is jointly executed by the Health and WASH sectors with active support from WASH and Health sector partners. Diarrhea Treatment Centers (DTCs) continue to be assessed to determine level or readiness in relation to agreed minimum standards and technical and logistical support are being offered as needed. Critical AWD stocks (sufficient for the worst case outbreak scenario) are stockpiled and prepositioned. The DTCs are enrolling in the EWARS surveillance system and an outbreak line list form has been created.

The Oral Cholera Vaccination (OCV) campaign was successfully completed on 13 May, 2018. A total of 901 810 beneficiaries were vaccinated in this campaign. Rapid Convenience Monitoring of a sample of 8 745 individuals indicates an overall coverage of 94%, as described in the below figure.

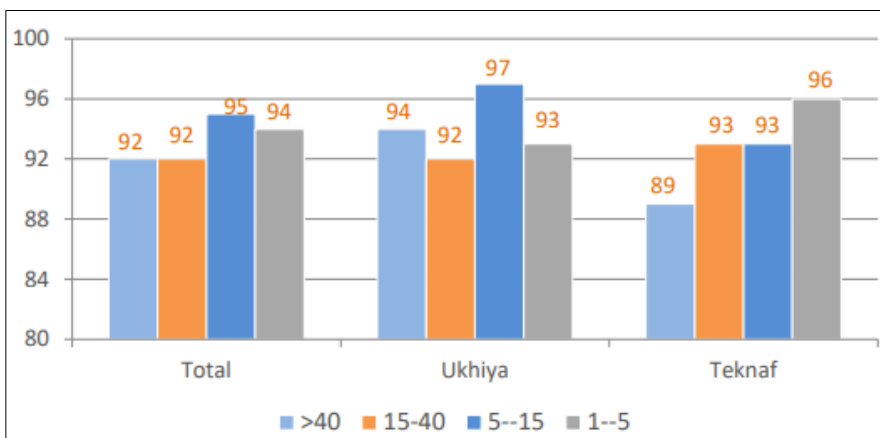


Figure 2- OCV Campaign: vaccination coverage by age

Acute Jaundice Syndrome

Since January 2018, there have been a total of 2 253 cases of acute jaundice syndrome (AJS) reported through EWARS. To investigate this further, an exhaustive laboratory sampling campaign was conducted from 28 February - 26 March 2018 to identify etiologies associated with AJS in the camps. Of particular concern was the possibility of a Hepatitis E outbreak which, given the water and sanitation conditions and overcrowding, could easily spread in a relatively susceptible population. All samples were tested for IgM against HAV, HCV, HEV and for HBsAg (all using ELISA) and for IgM against *Leptospira* using rapid immunochromatographic test (ICT). Of the 269 samples collected, 147 (56%) were positive for Hepatitis A, 1 (0.4%) was positive for Hepatitis E, 35 (13%) were positive for Hepatitis B, 14 (9%) were positive for Hepatitis C and 13 (5%) were positive for Leptospirosis. The report concluded that, although there has been a declining trend, AJS cases are still being reported and are likely to be an undercount of the actual situation in the camps. The true incidence of Hepatitis A virus infection is likely to be larger, in particular among people in the youngest age-groups, which are often asymptomatic, but still represent the highest proportion of symptomatic patients seen. To help protect pregnant women who constitute a 'high risk group' for AJS, water purification filters are being distributed to households with pregnant women. The figure below shows the trend of AJS cases reported through EWARS from week 1 to week 22, 2018.

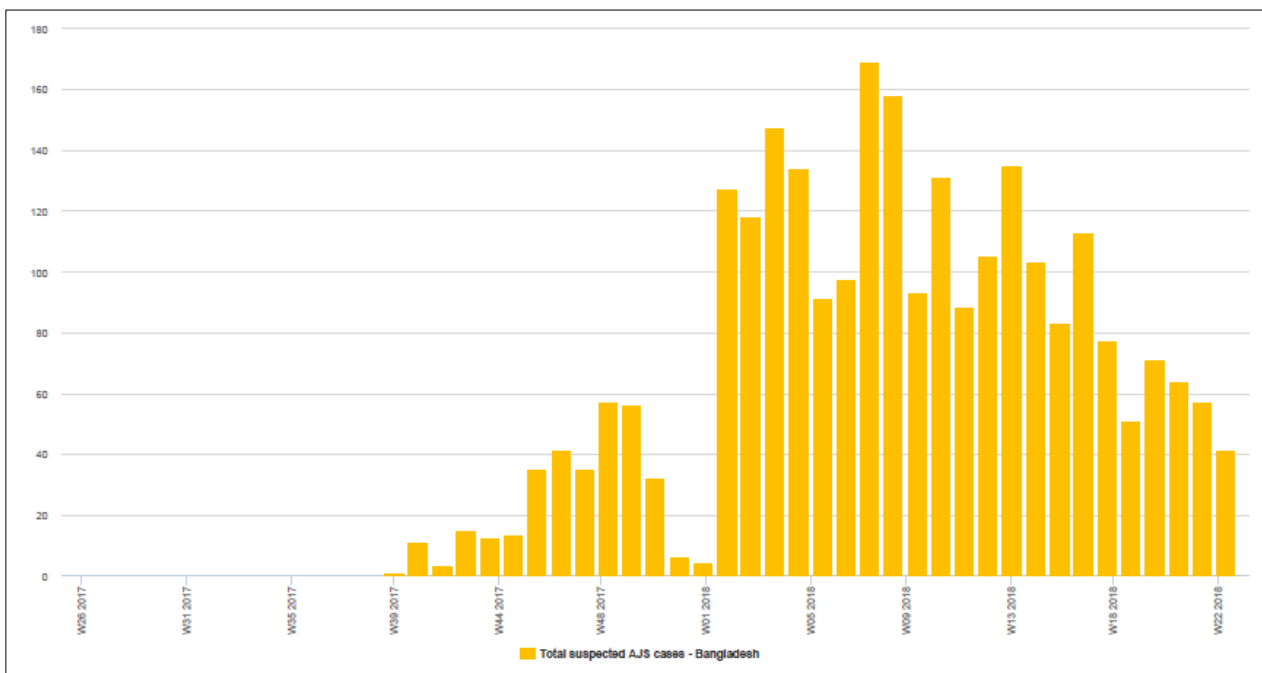


Figure 3- Number of cases of suspected AJS reported to EWARS from week 1 - 22 2018

Vector Borne Diseases

A total of 19 760 cases of suspected malaria were reported through EWARS from week 1 to week 22 2018, of which 53 cases were confirmed as Malaria. Although there have been no suspected cases of Dengue fever reported through EWARS event based surveillance in 2018, with the onset of the rainy

season these vector borne diseases remain a risk. Dengue peak season in Bangladesh is July-August/September.

Preliminary vector surveillance activities have started and a Malaria and Dengue epidemic preparedness and response has been drafted which includes enhanced surveillance along with prevention, enhanced and active case detection, treatment activities.

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 expanded program of immunization (EPI). Following completion of the OCV campaign, routine EPI activities continue, targeting children <2 years of age BCG (5950 total doses delivered as of 1st June), Pentavalent (4432 total doses delivered as of 1st June); OPV (5155 total doses delivered as of 1st June), PCV (5148 total doses delivered as of 1st June), MR (1761 total doses delivered as of 1st June). Pregnant women are targeted for Td (4796 doses delivered as of 1st June). Trainings of vaccinators were completed through health sector partner support, and routine EPI is now being implemented through 31 fixed session site and 64 outreach session sites across the camps.

Measles

A total of 1374 suspected measles cases were reported through EWARS between weeks 1 and 22, 2018. In week 22, there were 32 new suspected measles cases compared to 50 cases in week 12. Trends of suspected measles/rubella cases have steadily declined in 2018. These trends are based on syndromic reporting (no laboratory confirmation).

Diphtheria

As of 02 June 2018, there were 7 682 diphtheria case-patients reported through EWARS of which 686 were tested negative by PCR. During week 22, 51 new case-patients were reported which is slightly lower than the previous week (57 case-patients in week 21). A total of 42 deaths were reported in EWARS (case-fatality proportion <1.0%), with the last death recorded on 9 April 2018. In week 22, one (probable) case-patient was reported from the host community, bringing the total to 63 case-patients of which 20 were laboratory confirmed, 30 were probable and 13 were suspected. No deaths have been reported within the host community.

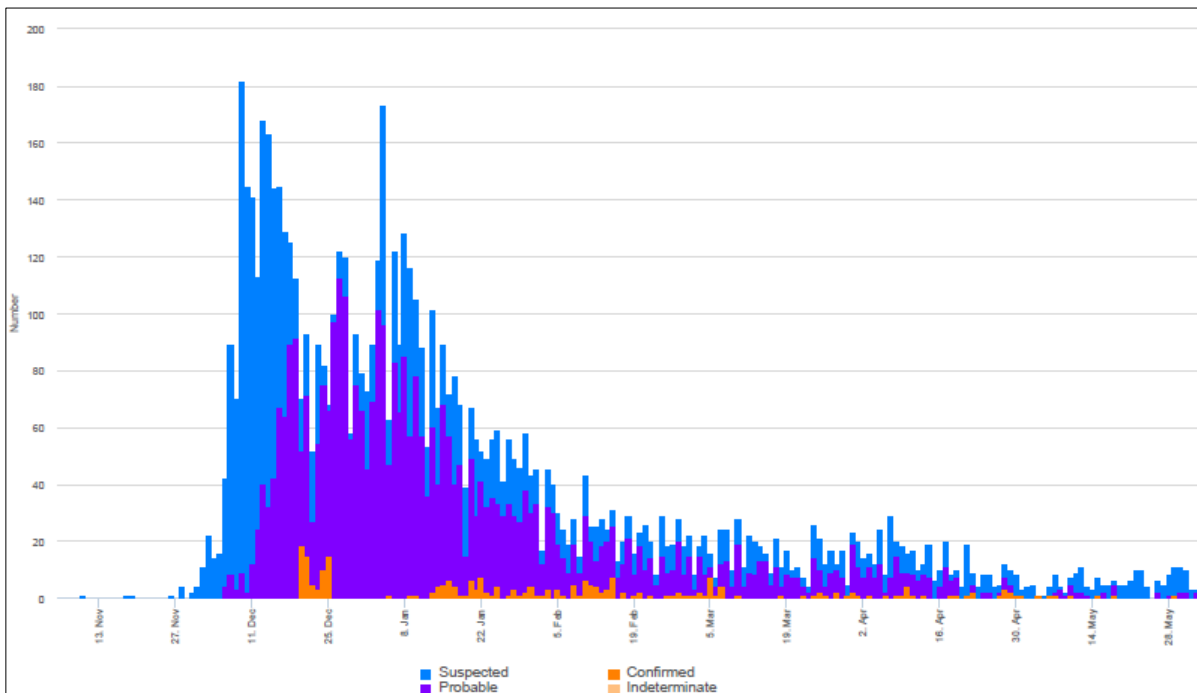


Figure 4-Epidemic cases of diphtheria in Cox's Bazar by date of admission, (Week 44 2017 – Week 22 2018)

In response to the decreasing case load, all cases are now being treated from a single Diphtheria treatment center and the other facilities are being converted in diarrhea treatment centers or oral rehydration points. Contact tracing activities continue however the Directly Observed Treatment strategy (1 dose/day of Azithromycin at 20mg/kg) could not be continued during the Ramadan period which has negatively impacted compliance. Further analysis of the contact tracing data showed that, of a total of 7 250 households requiring contact tracing follow up since November 2017, 5 002 were found (69%), 932 were not found (13%) and information is missing on 1,316 (18%).

2.2 Sexual and Reproductive Health

Based on the latest UNHCR family counting exercise demographic data, an estimated 52% of FDMNs are women and girls, including approximately 316,000 women of reproductive age. The Sexual and Reproductive sub sector is coordinated by UNFPA and includes approximately 53 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 data, 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 less than 22% 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, 10,630 safe delivery kits were distributed to key health facilities. In response to the high proportion of home deliveries traditional birth attendants are being trained as safe motherhood promoters (*NOTE: not to conduct home deliveries*) and are integrated into community health workers. Community maternal mortality surveillance still remains weak and the SRH subsector is working on establishing the surveillance system.

A total of 400 health care practitioners have received various SRH related training on Helping Babies Breathe, Emergency Response, Helping Mothers Survive, Family planning, Menstrual Regulation, Post Abortion Care and Clinical Management of Rape. To address the need for emergency obstetric services, 4 obstetrics/gynecology consultants were deployed to Ukhia Health Complex and Cox's Bazar district hospital for support of 24/7 emergency obstetric services. Since December 2017, at least 39,212 women were reached with various forms of family planning methods and 77,896 antenatal care visits were reported.

After many months of advocacy by the SRH subsector for the scale up of FP services in all camps and settlements for newly arrived Rohingya population, a collaborative agreement was reached with the Government's Directorate General of Family Planning (DGFP) to establish access to long acting and reversible contraceptives (LARC) services to all 'unregistered refugees'.

As part of the monsoon season contingency planning prepositioning of emergency RH kits, all partners have been provided with stocks to ensure timely support to the facilities and the mobile medical teams (MMT).

To mark the "*International Day of the Midwife*", on May 5th SRH subsector carried out SRHR promotional activities in the refugee camps and settlements. Rallies, a midwifery fair, interactive sessions with midwives and cultural shows representing midwifery contributions were organized for this occasion.

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 which is chaired by ACF and co-chaired by BRAC with over twenty partners and actors providing mental health and psychosocial support to the affected population.

In the past 8 weeks, the MHPSS working group (WG) has been focused on developing an emergency and implementing its preparedness plan (EPRP) which has been incorporated in the WG's six month work plan. Training on Psychological First Aid for sector front line staffs, and a guidance note was developed to guide organizations' response to persons with severe mental conditions. An orientation on MHPSS basics is planned for early June.

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.

The IASC MHPSS reference group Co-Chairs visited Cox's Bazar to support the MHPSS WG during which they led a workshop to discuss practical considerations in using the IASC MHPSS guidelines. Under their guidance, a detailed mapping of services was started and information has been captured on the four layers of service provision: Specialized Services, Focused non-specialized support, Community & Family supports, Social Considerations in basic services & security. This information is being verified and will be mapped soon to help identify gaps, facilitate referrals, and encourage partners to collaborate and coordinate.

To mitigate the gap of holistic mental health support in the field level, the WG has a plan to develop a model team of psychiatrist, psychologist and social workers which is in process. Furthermore, to improve the access of specialized support "MH-Gap" trainers started providing psychiatric support in Ukhia and Teknaf health facilities with follow up.

2.4 Nutrition

In the past 8 weeks, an estimated 189,023 children under-five have been screened out of which 7,796 children were identified and treated for severe acute malnutrition (SAM), while 7,854 presented moderate acute malnutrition (MAM) and treated. Under the malnutrition prevention interventions overall 127,273 children are currently enrolled in blanket supplementary feeding programs (BSFP) an initiative that is aimed at malnutrition prevention among the most vulnerable.

In addition nutrition surveys that are aimed at monitoring the evolution of the nutrition status of the forcefully displaced Rohingya nationals also commenced in the first week of May and data collection for the makeshift camp and Nayapara has been completed. Currently data analysis is going on and results of the nutrition surveys will be realized in the second week of June.

The sector team continued to support initiatives aimed strengthening nutrition service delivery through harmonization of Infant and young child feeding and CMAM monitoring and reporting tools. Plans are underway to have the tools printed and rolled out for use after the trainer of trainers training that is scheduled to take place in the 3rd week of June.

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 Programme (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 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 partner to understand their level of readiness is also ongoing. 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

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 is assigned a unique identifying number to simplify any facility-based reporting. Currently, there are 278 functional facilities known to the health sector, with a further 37 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 minimum requirements. There are an estimated 170 basic health units (1: 7 647 people in need); 33 primary health center facilities (1:39 394 people in need) and 10 secondary care facilities (1: 130 000 people in need). Approximately 910 hospital beds are available to the people in need, of which 290 are in Government run facilities. Since the beginning of the crisis on 25 August 2018, a total of 1 876 908 outpatient consultations were reported. According to the mapping of community health volunteers, there are approximately 1400 teams operating across the camps.

However, there are inconsistencies in the quality of services provided, and varying implementation of the full minimum package health 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. 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. 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. A referral pathway was developed and shared with partners, and an SOP and standardize referral forms are in finalization.

In the context of emergency preparedness, concerted effort and planning is needed to ensure sustained health service access and delivery of critical, life-saving health support throughout unplanned emergency events including flooding; landslides and cyclones. Consequentially, the health

sector has actively been planning for such events. Based on risk mapping, 60 health facilities are at risk of flooding and 15 are at risk of landslides. Assuming worst case scenario, this could lead to considerable gaps in service provision and, due to land shortages, only a few selected facilities have been identified for relocation. The health sector has requested each and every partner to conduct a facility structural assessment to determine whether facilities need to be upgraded or decommissioned. Several health sector partners also participated in a training run by the shelter sector on strengthening community infrastructures. Partners are encouraged to make use of the community infrastructure strengthening guidance or decommissioning guidance from the Shelter sector. Of the 70 facilities who have reported so far, three were marked for decommissioning, and 54 are undergoing upgrading.

To address foreseen disruptions to health services provision, mobile medical teams have undergone training (covering personal safety awareness and risk assessment; first aid; mass casualty triage and management; key protection issues; and psychological first aid). A total of 5 core teams and 14 surge teams are currently ready for deployment and a centralized dispatch coordinator is in place. For safety and security reasons, the MMTs will only deploy during daylight hours, however the Bangladesh Army also has mobile medical teams which can be called upon during night time hours. The ambulance availability has been mapped and discussions are ongoing regarding how best to distribute and make use of these available resources. To help prepare for mass casualty incidents, trauma and mass casualty event capacities are in the process of being mapped out. From the community preparedness side, community health workers are receiving certified first aid training (1200 trained to date).

Beyond the emergency preparedness work and the health system strengthening work, the health sector is also planning for medium-term options for health infrastructures for the affected population. The Directorate General of Health Services has a plan to build structurally reinforced health facilities in each camp, with a view to providing services on a longer term basis. Several partners have offered their support in this regard and three model primary health centers have now opened, setting an important standard for future investments.

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 33 project proposals were submitted for the health sector, with a \$113.1 million appeal budget. The health sector is committed to meeting with donors and partners to increase the commitment to the health sector. Currently, the health sector has been funded 10.9% of its needs. The sector is significantly under-funded and requires additional funds to support its objective of offering lifesaving assistance

CONTACTS

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