

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

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Health Sector Field Coordinator during a field visit

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1.24 million
People in Need
for the Health
Sector
Response



913 316
Rohingya
refugees in Cox's
Bazar District



335 930 host
community in
need of
humanitarian
support



2 621 525
outpatient
consultations
provided in 2019

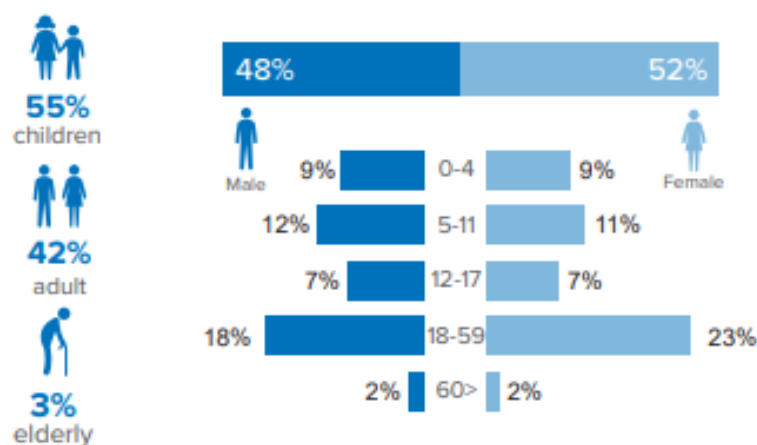


119 health
sector partners

1. SITUATION OVERVIEW

As of end January 2019, the total number of Rohingya refugees residing in Cox's Bazar is 911 316 (ISCG situation report; June 2019). The overall population in need for the health sector, including the host communities, is 1.24 million for Joint Response Plan 2019, including (335 930) host community affected populations. Figure 1 below illustrates the demographic breakdown based on latest available UNHCR population data (15 July 2019).

Figure 1 Demographic breakdown among refugees¹ (UNHCR population factsheet as of 15 July 2019; n=912 114)



2. HEALTH SECTOR COORDINATION

2.1 Overall 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 benefits from the support of over 100 partners who continue to respond to the needs of the affected populations. This includes 62 international partners, 49 National NGOs, 8 UN agencies. The health sector adopted a three-tiered coordination structure at District, sub-district (Upazila) and union levels. At the District level, a strategic advisory group, constituting the main health

¹ <https://data2.unhcr.org/en/documents/download/70356>

sector partners, serves an advisory role to the health sector coordinator based on priority needs. For 2019, the health is coordinated through the following working groups, which meet on a regular basis:

- Mental Health and Psychosocial Support (MHPSS): chaired by IOM and UNHCR
- Sexual and Reproductive Health (SRH): chaired by UNFPA
- Community Health (CH): chaired by UNHCR and co-chaired by CPI
- Epidemiology and Case Management (ECM): chaired by WHO

In addition, coordination of support to the District hospital (Sadar) continues through the Sadar Roundtable meetings (one meetings were held during the reporting period) and Upazila level health sector coordination continues (one meeting held in Teknaf during the reporting period). A time bound emergency preparedness taskforce, which is co-chaired by International Rescue Committee (IRC), was activated in early March for monsoon and cyclone preparedness.

All other issues not directly related to the above are addressed through ad-hoc groups. For example, an NCD core group has now been established (comprised of nominees from health partners working on NCDs). Similarly, laboratory personnel of interested partner organizations have been invited to form an informal platform, under the leadership of the National Institute of Epidemiology Disease Control and Research (IEDCR), for sharing of technical expertise, building of capacity and dissemination of available regulatory information related to clinical laboratories.

To strengthen intersectoral collaborations, the health sector also holds regular meetings with the WASH sector to review data, identify priority camps for interventions, and develop joint action plans. In addition, the health sector convenes a group of GBV and Child Protection sub-sectors as well as SRH, CH and MHPSS working group leads. This group meets on an ad-hoc basis review action plans and respective responsibilities. to improve coordination and provide technical input and guidance, health logistics meetings are held with health partner stakeholders, co-chaired by WHO and Logistics sector. One area that requires improvement is further integration between health sector and protection sector in this setting. Although some efforts have already taken place; fresh impetus is expected as result of the Global Health and Protection Clusters joint decisions to undertake a global analysis of the existing barriers and gaps in response coordination. From this global-level initiative, it is expected that operational guidance materials for Health and Protection Clusters/Sectors, sub-clusters and working groups for child protection (CP), reproductive health (RH), GBV, Mine Action (MA) and MHPSS will be developed for country level implementation.

2.2 Health Sector Funding

The 2019 JRP for the Rohingya Crisis was formally launched on 14 February 2019, for the period 1st January- 31 December 2019. A total of 28 sector projects from were submitted for the health sector, with an \$88.8 million appeal budget. To date, the health sector has been funded at 13.1% of its needs according to the financial tracking system (FTS) with a total of \$11.6 million funded. However, when factoring in other funding received by partners but not reported in FTS, the sector is funded at 35.4%.

2.3 Key coordination activities in reporting period and upcoming priorities

Mid-term review of Joint Response Plan 2019

The health sector underwent a mid-term review process through a review workshop with SAG members to reflect on achievements and challenges from the past 6 months. There has been considerable progress made on availability of 24/7 primary health centers in the camps, coverage of Pentavalent among <1-year old increased to 78%, 69% of PHCs have one healthcare worker trained to provide mental health services, 425 AWD isolation beds are on standby in case of outbreak (exceeding the target), 23603 community health sessions were held (51% of target) and 100 % of verified and confirmed EWARS alerts investigated within 48 hours. However, there is still need for improvement in the sector target on achieving training of community health workers with just 803 out of a targeted 1208 CHWs trained on two out of three essential training modules (AWD/Hygiene; first aid; and SRH). Very modest improvements were seen in percentage of deliveries assisted by a skilled birth attendant (facility-based), with 35% in June 2019 (against a target of 55%). To improve quality of health service, the sector targeted to provide at least two supportive supervisions to each HPs/PHCs/Hospitals, however only achieved 27% by June 2019. This review process was therefore a useful exercise to help identify gaps and reprioritize efforts towards achieving the JRP 2019 health sector targets.

Emergency preparedness

In the reporting period, health sector reviewed its contingency plan with a focus on monsoon season planning. Emergency preparedness and response remained a standing agenda item for all health sector working groups meeting during this period. Further trainings for Mobile Medical Teams (MMTs) were conducted and an additional prepositioned container was stocked with essential medical supplies, bringing the total number to six out of a targeted eight.

During the reporting period, there were several days of heavy monsoon rains, however the impact on health was relatively minimal. The table below summarizes the number of events; affected individuals and injuries as reported from the site management daily incident report during the reporting period. There were 7 reported casualties' in the reporting period due to drowning (3), lightning (2), landslide (1) and unknown reasons (1). No MMTs were requested or deployed during this period.

Table 1 Summary of incidents reported in Rohingya camps from 12 May-14 July 2019 (source: site management incident reporting)

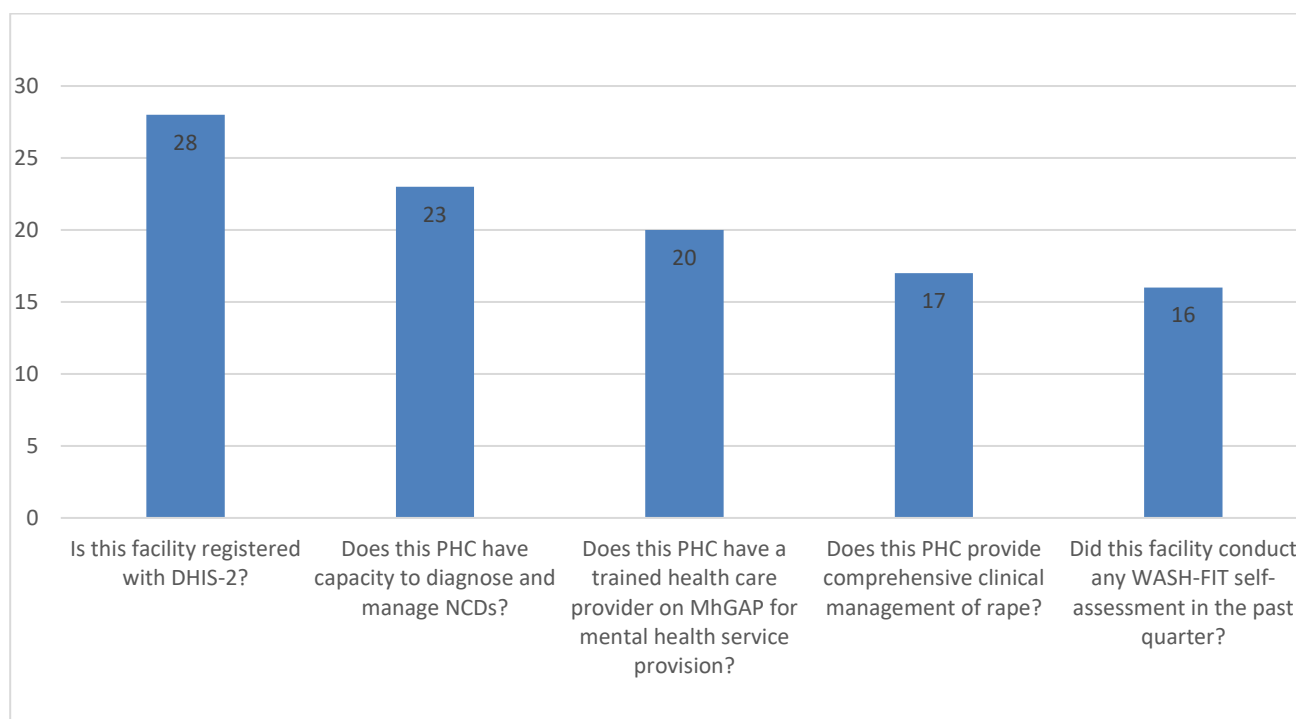
Type of Incident	Number of incidents	Number of affected individuals	Number of Injured individuals
Fire	11	55	4
Flood	49	1143	0
Landslide/soil erosions	1013	11711	18
Lightning	2	8	6
Wind-Storm	267	33820	14
Total	1342	46737	42

Daily monsoon updates are provided to partners, with information on incidents, health facility closures, MMT deployments, and alerts of outbreak importance requiring investigation. From 7th July 2019, the Civil Surgeon's office health emergency operations center (HEOC) was activated in response to landslides in Chittagong region/division, under the guidance of Ministry of Health (MoH), activated the health emergency operation center (HEOC) at Civil Surgeon Office. A hotline was established for reporting events in the host community; and the usual reporting channels were reinforced for reporting events in the refugee population. An intensified two-week messaging campaign on hygiene and acute watery diarrhea in the refugee camps was initiated by DGHS in early July.

Field coordination

The health sector is firmly committed to improving quality of services through improved monitoring and strengthening field coordination. Two health sector field coordinators are responsible for supporting coordination at the Upazila level and dedicated camp health focal points are now in place since May 2019. Through this new structure, each camp receives dedicated coordination support for one day per week. During the reporting period, the camp health focal points met with each Camp in Charge (CIC), having completed their induction training, and conduct regular camp health coordination meetings with partners in the camps. They also supported the health sector with conducting a quarter 2 (Q2) monitoring assessment of all PHCs and health posts in the camps, which will be repeated after completion of quarter 3. This exercise is intended to help the sector track several JRP and non-JRP progress indicators and will guide supportive supervision activities in the upcoming months. Some key findings are presented in the figure below.

Figure 2 Findings from Q2 monitoring assessment of Primary Health Centers (n=29)



Health systems strengthening on Gender Based Violence

Under the global objective to strengthen the capacity of Health Cluster partners and health providers to coordinate and deliver GBV services, the health sector in collaboration with SRH and GBV subsector partners completed a 10-day inter-agency GBV service quality assessment in 16 Primary Health Care (PHC) facilities where Clinical Management of Rape (CMR) services were available (May 20 - 30th, 2019). The purpose of the assessment was to establish service delivery standards for the quality of post GBV care in clinical settings, identify gaps and challenges in service provision and create action plan to improve service quality. Key findings are presented in the table below. Facility-specific feedback was shared with respective agencies to develop improvement plans based on identified gaps.

Table 2 Overall findings from GBV service quality assessment among PHCs (n=16)

- None of the facilities had any visible Information Education and Communication materials to inform patients of GBV service availability or what to do in case of GBV or benefits of reporting.
- Nearly 75% of facilities lacked some of the essential infrastructure, equipment and commodities to provide appropriate care; confidential space where GBV clinical services are provided, lockable cabinets, relevant hepatitis B or tetanus vaccines, Emergency Contraceptives, HIV prophylaxis, treatment protocols or GBV registers
- 80% of facilities did not have appropriate systems in place for providers to identify patients who have experienced sexual or intimate partner violence based on suspicion of violence; and only a few had received some training on how to ask about it or identify signs and symptoms.
- Some facilities had inadequate skills on child friendly communication techniques and did not understand the concept of informed assent for child survivors.
- In nearly half of the facilities, Intra Uterine Device was not provided as a family planning option for survivors who may choose the service over other methods (primarily due to lack of trained staff)
- Nearly 70% of facilities had no referral system in place to ensure patients are connected to necessary services or follow-up systems, including GBV referral pathway.
- 80% of facilities had staff trained on CMR. However, most of the staff trained were those working in the maternity/delivery section. In most cases, outpatient staff were not trained to identify when patients present with signs and symptoms of GBV beyond chronic conditions thus missing opportunities to provide timely support
- Although clinical management of Rape (CMR) services were available in all 16 assessed facilities, only 37% (6) had attended to survivors of rape. This can be attributed to the limited number of facility-level staff trained on how to identify patients with signs and symptoms of GBV and the lack of systems to inform stakeholders about GBV service availability by the facilities. All these factors affect the capacity of facilities to deliver GBV services.

Information Management and operational research

To improve reporting on 'Who is doing What, Where and When' (4Ws), the health sector has now transitioned from excel-based 4Ws reporting to an online reporting tool known as 'Report Hub'. This has greatly improved the quality and depth of information reported on partners' activities for refugees and host community. Two trainings were held for partners during the reporting period, and Report Hub was used for May and June 2019 4Ws reporting and will be used exclusively from now on.

To strengthen information sharing of best practices, a knowledge sharing symposium was organized by the health sector in on 24th June 2019, with participation from Line Director of Planning, Monitoring and Research (PMR), DGHS. The health sector received and reviewed 35 abstracts and selected 16 of the best ones to be presented at the symposium. A total of 15 oral presentations were presented by 12 partners, followed by plenary discussions across 4 different thematic areas.

The health sector information management team participated in the ISCG 'facility barcoding exercise'. Under this exercise, health facilities in the camps were 'tagged' with a weather-proof label with information on the facility ID and type, as well as a barcode which can be scanned for other facility information. This is expected to facilitate data collection exercises/assessments of health facilities in the future.

Rationalization

Going into 2019, it was agreed that the health sector should rationalize and consolidate services to reduce duplication of health services, ensure appropriate geographic distribution of health facilities and to free up land for shelters and road infrastructure projects. The health sector initiated the rationalization process through an inter-agency task team which assessed all health post and PHCs in 22 priority camps. In March 2019, a workshop was held for all task team members and SAG members to review the findings from the field assessments, during which preliminary suggestions were made for each health facility to either i) decommission; ii) upgrade to a PHC; iii) relocate; or iv) keep in current location. These suggestions were reviewed by the Cox's Bazar Civil Surgeon and recommended for RRRC approval; which was obtained. Preliminary suggestions were then shared with CICs and with all 'affected' health facilities' focal points in early June 2019 along with an invitation to 'appeal' the decision. An appeal committee was established under the RRRC's office with representation from Civil Surgeon's Office and the SAG members. A total of 26 health facilities appealed the decision and their cases were heard on 13, 16 and 17 June and documented by the committee. Following the appeal, a final set of recommendations was compiled considering the recommendations of the appeal committee and this shared with RRRC for final endorsement which is pending. It is expected that this exercise will be completed by end of 2019 as partners would be given 4 months to decommission to ensure sufficient notice.

3. HEALTH RISKS, NEEDS AND RESPONSE

3.1 Health Service delivery

The health sector partners are running 134 health posts in the Rohingya refugee camps; as well as 29 primary health centers providing 24/7 services. Gaps in PHCs persist, and an additional 11 PHCs needed to meet the minimum standards, as indicated in the table below.

Table 3 PHCs gaps in the Rohingya refugee camps

Camps	PHC needed	PHCs functional/planned	PHC Gap
Camp 13	3	1	2
Camp 16	1	0	1
Camp 20	1	0	1
Camp 6	1	0	1
Camp 27	1	0	1
Camp 11	2	1	1
Camp 9	2	1	1
Camp 8W	2	1	1
Camp 1E	2	1	1
Camp 1W	2	1	1

During the months of May and June 2019, a total of 610 709 outpatient consultations have been reported to the sector by 33 and 36 implementing partners respectively. Among these, 35% were provided to males and 65% to females. Majority (70%) of these consultations were provided to children and adults aged 5 and above, and 30% to children less than 5 years of age.

The health sector partners also run field hospitals, diarrhea treatment centers, specialized SRH and/or delivery facilities, and other specialized health facilities including eye-care facilities, rehabilitation facilities, age friendly centers, and diphtheria treatment center. However, some of these specialized services are not widely available.

Numerous Government-run health facilities in the host community are supported by partners, including 10 community clinics 6 union-sub-centers; and 6 Health and Family Welfare Centers, 2 Upazila health complexes and District-level Sadar Hospital.

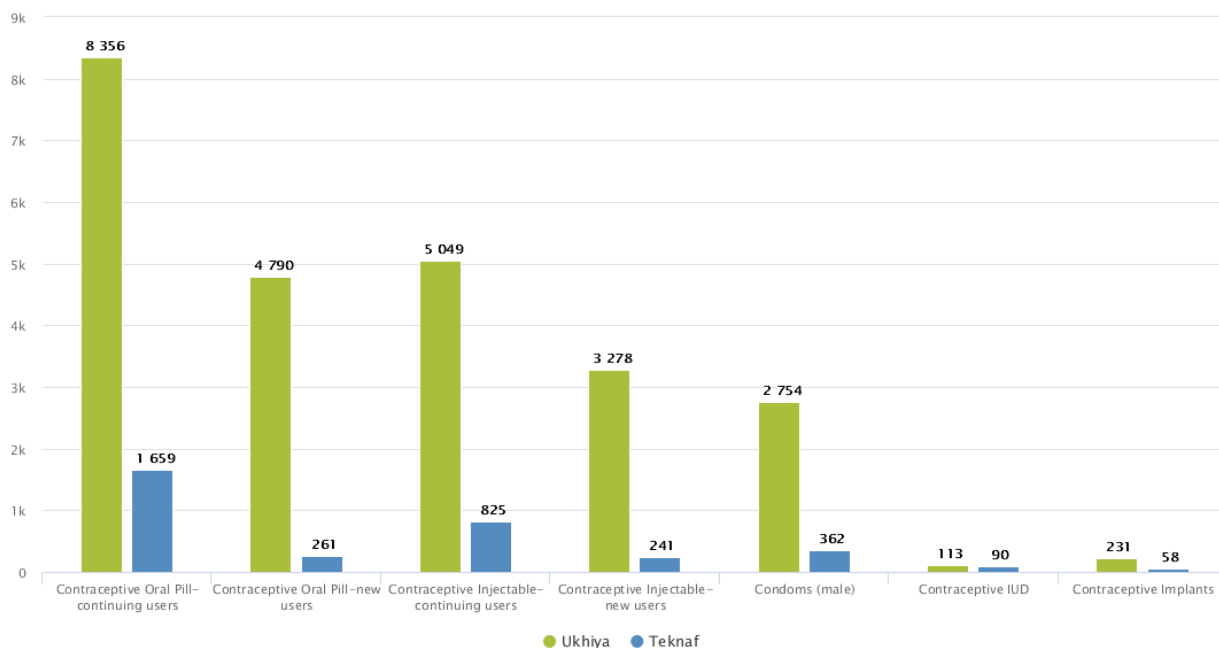
3.2 Sexual and Reproductive Health

The Sexual and Reproductive Health Working Group is coordinated by UNFPA and includes more than 50 partners. In addition, two global projects are being implemented under the health sector in Cox's Bazar: one on strengthening SRH services; and one of strengthening GBV health response.

In quarter two of 2019, a total of 3494 facility based deliveries were reported from health facilities using the SRH WG data collection tool. Estimates on proportion of institutional deliveries among the refugees vary, but are known to be low. The most recent data from the community health working group tool shows the institutional delivery proportion in June 2019 was just 35%, suggesting very little improvement since the beginning of the year. Across the 29 PHCs, 98 maternity beds are available 24/7 in the camps (based on health sector Q2 monitoring data). Nevertheless, community preferences to deliver at home prevail. The working group is developing a guidance note on traditional birth attendants (TBAs), to clarify for the partners how TBAs can be used to promote facility-based deliveries.

Data from the SRHWG data collection tools, which captures new versus repeat family planning visits, shows a decrease to 78 380 new plus revisits in Q2 2019 from Q1 (90 109). Looking at the DHIS2 data for the reporting period, the uptake of short-acting contraceptives (oral pills, injectables and condoms) remains considerably higher than long acting reversible contraceptives (LARC).

Figure 3 Family Planning method uptake reported in FDMN DHIS-2 weeks 20-29, 2019, by Upazila



Data from the Q2 PHC monitoring of all primary health care centers in the camps shows the following availability of FP services among the 29 PHCs. While availability of short term methods is very high (93% of PHCs had pills, injectables and condoms available), availability LARC is considerably lower (76% for implants and 52% for IUDs). On balance, given that we know that gaps in method choice remain, FP service delivery efforts need to be sustained and strengthened, particularly in Teknaf, to reduce unmet need.

The SRHWG continues to advocate for transition from a minimal initial service package to comprehensive SRH service delivery. Capacity building of healthcare workers is a major priority and several trainings were conducted by the SRH WG in May and June including five batches of DMPA-SC

training for 60 mid-level service providers, 3 batches of training on emergency obstetric and newborn care training for government and other NGO partners, Helping Baby Breath (HBB) ToT, followed by HBB training held for around 200 health service providers. Several new born care trainings were also coordinated for SRH sub sector partners – 3 days KMC (Kangaroo Mother Care) training for 40 health service providers, 2 batches of three day CNCP (Comprehensive New Born Care Package) training for around 240 participants, 2 batches of ETAT (Emergency Triage Assessment and Treatment) training for 40 mid-level service providers. Training materials for community health workers on comprehensive SRH that were piloted in April will be printed in the coming weeks.

The SRHWG strives to reduce avoidable maternal mortality and 100% of reported maternal deaths in Q2 2019 were investigated (Maternal death reviews) within 48 hours. A preliminary maternal death review committee has been formed through the SRH Working Group and the TOR is currently in the process of finalization. A meeting for the committee will be convened very soon. Notification of suspected maternal mortalities (as recorded by CHWs) is being rolled out through EWARS.

Inter-agency field monitoring visits are being planned for the next quarter, towards achieving of the health sector target of quality improvement through supportive supervision. Based on the pilot visits that were conducted in 14 PHCs in Q1 2019, the next round of visits will focus particularly on the health posts. A draft monitoring checklist and plan regarding this will be shared with the SRH Working Group for their feedback before roll-out.

3.3 Epidemiology and Case Management

Surveillance

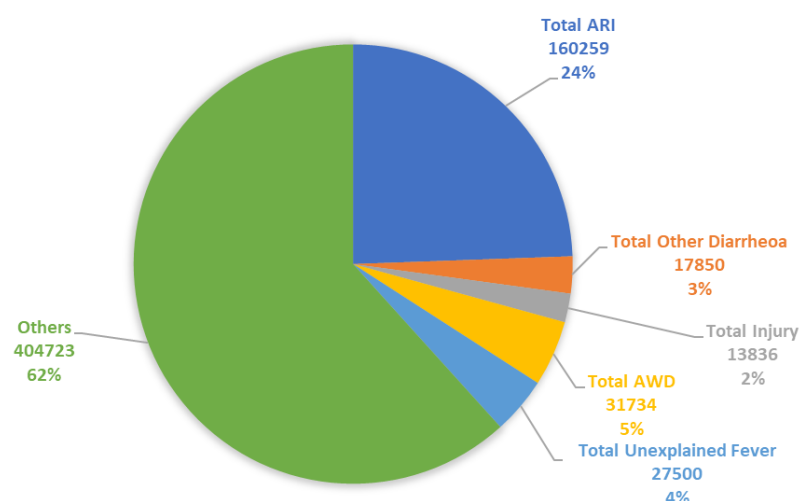
A total 190 health facilities are currently working to support the humanitarian crisis and host community needs in Ukhia, Teknaf and Cox's Bazar. Out of which 148 (78%) health facilities are currently registered and reporting in EWARS. The cumulative reporting completeness is 89% and timeliness is 84% for 2019. WHO with health sector is monitoring to improve the reporting completeness and timeliness by following-up with health partners.

Between epidemiological weeks 20 and 29, a total of 655 902 weekly consultations have been reported through EWARS since start of 12 May 2019. These weekly consultations included clinically defined communicable diseases, vaccine preventable diseases (VPDs), vector borne diseases, injuries & malnutrition. All other diseases including non-communicable diseases are reported as "Others". Disease specific surveillance for acute watery diarrhoea (AWD), Measles, diphtheria and acute jaundice syndrome (AJS) are also part of EWARS surveillance.

A total of 332 alerts were generated between 12 May 2019 and 20 July 2019 (epidemiology weeks 20 to 29), of which 8 (2%) alerts were field investigated for risk assessment, 192 (58%) are being monitored and 135 (41%) were discarded. All these alerts were reviewed and verified within the required 48-hours timeframe.

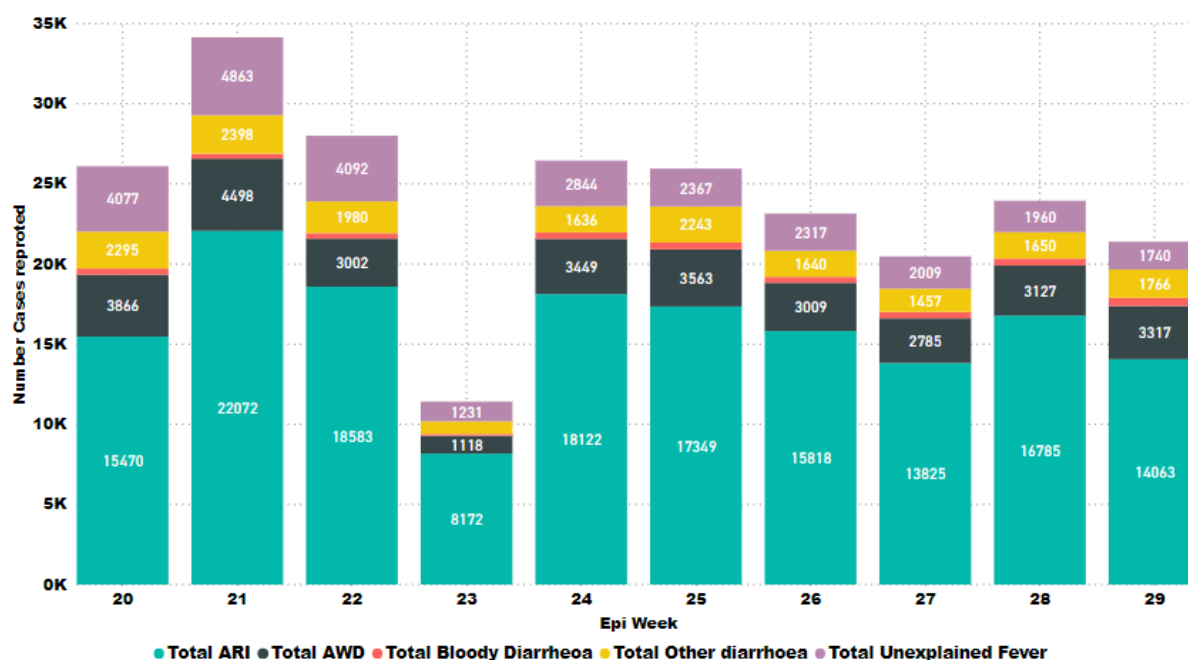
Acute respiratory infection (18.6%), acute watery diarrhea (4.6%), suspected varicella (4%), unexplained fever (3.9%) and other diarrhea (2.6%) are the disease with highest proportional morbidity reported in 2019 in EWARS out of 2 028 258 total consultations (cumulative). In the reporting period, the top five reported syndromes acute respiratory infections (ARI) (24.4%), followed by acute watery diarrhea (4.8%), unexplained fever (4.2%), other diarrhea (2.7%), and injuries (2.1%); as shown in the figure below.

Figure 4 Syndromic surveillance (reported cases) by top 5 conditions, W20 -29, EWARS



The total number of cases of top five diseases reported in EWARS from week 20 to week 29 in 2019 are shown in the figure below. In addition, measles and acute flaccid paralysis (AFP) are priority vaccine preventable disease (VPDs) being monitored in the camps.

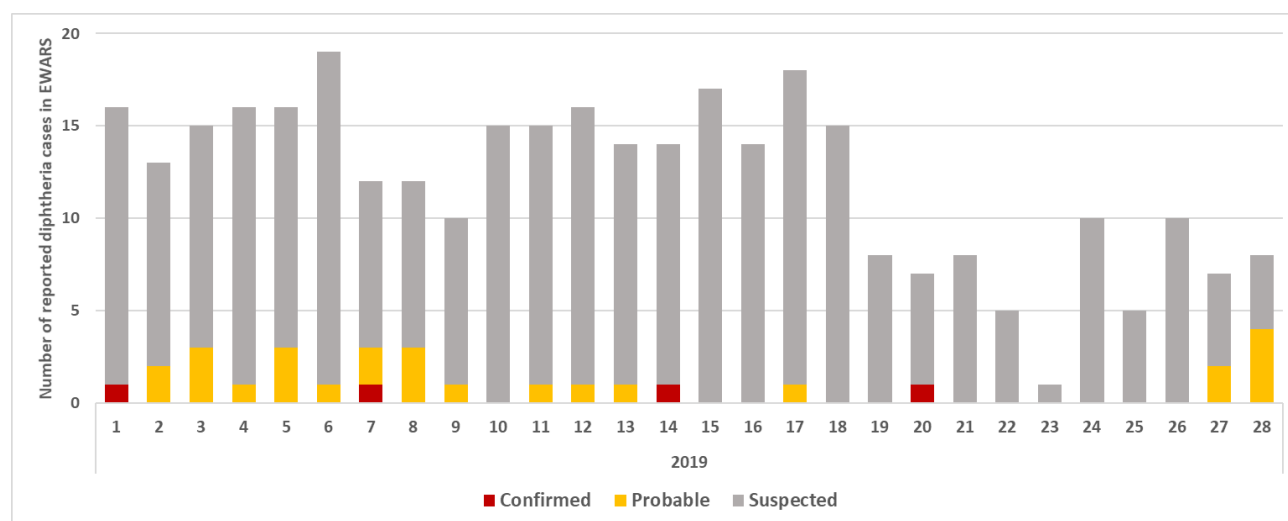
Figure 5: Reported cases of priority disease consultations between weeks 20 and 29 in 2019, EWARS



Diphtheria

A total of 8 682 diphtheria cases were reported in EWARS since the beginning of the outbreak, among which 206 cases from the host community. Between week 20 to week 29, a total of 61 cases of diphtheria were reported in EWARS. In the reporting period, only one confirmed case was reported in Week 20 and the rest were probable (6 cases) and suspected (54 cases). From week 1 to week 28 in 2019, a total of 336 diphtheria cases were reported in EWARS. Of which 4 were confirmed, 26 were probable and 306 were suspected. A total 45 deaths were reported in EWARS to date. No death was reported from the host community so far.

Figure 6 Epidemic curve of diphtheria cases among Rohingya refugees (W1 – W28, 2019), EWARS



Measles

Between epidemiological Week 20 to week 29, 2019, a total of 49 suspected measles/rubella cases were reported. In addition, another 45 cases of suspected measles/rubella cases were reported via measles case based surveillance in EWARS. Based on the laboratory surveillance report available, a total of 13 samples were collected within week 20 to 22 in 2019 (more recent date not yet available). Out of these 12 cases were discarded after being tested negative for both measles and rubella and one was confirmed positive for rubella.

Acute watery diarrhoea

As we are now in the monsoon season, the acute watery diarrhoea surveillance has been strengthened in the camps. All acute watery diarrhoea alerts (both case alerts and trend alerts) are now being investigated by joint assessment team (JAT) within 24 hours. Health sector and WASH sector are working closely to improve the diarrhea disease awareness, health seeking behaviors and water and sanitation conditions in the camps. A total 16 diarrhoeal disease alerts have been investigated during the reporting period (week 20 to week 29). Although there have been some sporadic cases in the camps, no evidence of local transmission or epidemiological linkage was found between these cases. To strengthen the diarrhoeal disease investigation a 2nd round of joint assessment team (JAT) training

was held in Cox's Bazar, Teknaf and Ukhia on 28, 30 May and 18 June respectively. A total of 79 participants from health and WASH sector partners were trained in 3 days. Meanwhile, laboratory surveillance for acute watery diarrhoea (AWD) cases was strengthened with partner support. Samples are now being collected from all reported cases and are sent to Dhaka for culture and sensitivity testing.

Water quality-round 11 reports shared for WASH sector

The 11th round water quality surveillance data collection started on 7th of May 2019 and concluded in 2 June 2019. A total of 5412 water samples were collected from water sources and households and analyzed in the DPHE water quality laboratory in Cox's Bazar.

Findings revealed that only 15% of the water sources in the refugee households are E-coli free (0-cfu/100ml). By contrast, significant portions of the water source from source are safe for drinking. The findings highlighted that the contamination mainly happens at the household level and at the spouts; the following recommendations have been forwarded for the WASH sector and implementing partners for action: disinfect the tube well spout by burning with fire and methyl alcohol regularly, perform spot chlorination for the contaminated sources/boreholes, remove the source of fecal matter within 30ft distant from the tube wells, continue intensive hygiene promotion and behavioral changes activities, motivate households to use narrow mouth container where hand cannot be inserted and clean water storages; and consider using point of use water treatment facilities/chemicals.

Rapid health- care waste management assessment in the settlement

A rapid healthcare waste management (HCWM) assessment was conducted in health care facilities in the camps of Ukhia and Teknaf. The main purpose of the assessment was to review and understand the present medical waste management situation and highlight potential areas of improvement to reduce the risks of infection on staff, patients, and communities. 172 health facilities (110 health posts, 34 PHC and 28-other types of facilities) were assessed. This rapid assessment will be followed by a comprehensive assessment which will cover facilities outside of the camps, in Cox's Bazar district, and will ultimately support the development of a district wide Health Care Waste Management plan.

The assessment found on average 250 bins (20 liter bins) of health care waste are generated every working day in the camps (estimated around 5M³/day). Only around 36% of healthcare facilities segregate waste at the source of generation with color coded waste bins. A significant number of facilities (~58%) disposed waste on-site, without going through proper treatment and disposal methods: either using temporary or barrel incinerators to burn infectious waste or indiscriminately disposed in the communal dustbins. Others transfer waste to nearby incineration areas using publicly available transport (Tomtom and/or Rikshaw). This practice potentially poses occupational health risks for clinical and non-clinical staffs and endangers patients and standers-by including children. The coverage and quality of incineration is low. Investment in the improvement of health-care waste management in the settlement is essential due to suboptimal management of infectious wastes in the settlement and associated public health and environmental risks. The final version of this rapid assessment will be shared with Health Sector partners.

Rapid Laboratory Review

A total of 50 facilities were reviewed for their adherence to different aspects of the Minimum Package of Essential Health Services. This included 28 Primary Health Centers (PHCs), 2 Secondary Health Centers and 20 Health Posts (HPs). The assessment was carried out through visits to individual facilities using a questionnaire developed to capture various parameters of laboratory testing capability.

Areas for improvement included the low (0 to 50%) presence of rapid diagnostic kits to test for Hepatitis A, Dengue, Chikungunya, Leptospirosis, Cholera and Urine ketone in PHCs. Only 3 of the 28 PHCs had on-call personnel to conduct tests 24/7. Of the 10 tests mandated for Health Posts, 9 were present in less than 50% Health Posts. Positive aspects included the availability of necessary personnel protective equipment (PPE) and equipment for phlebotomy in all laboratories however lack of adequate infrastructure was observed in many laboratories.

Further details are provided in the figures below.

Figure 7 Adherence (in percentage) to components of Minimum Package of Essential Health Services among Primary Health Centers

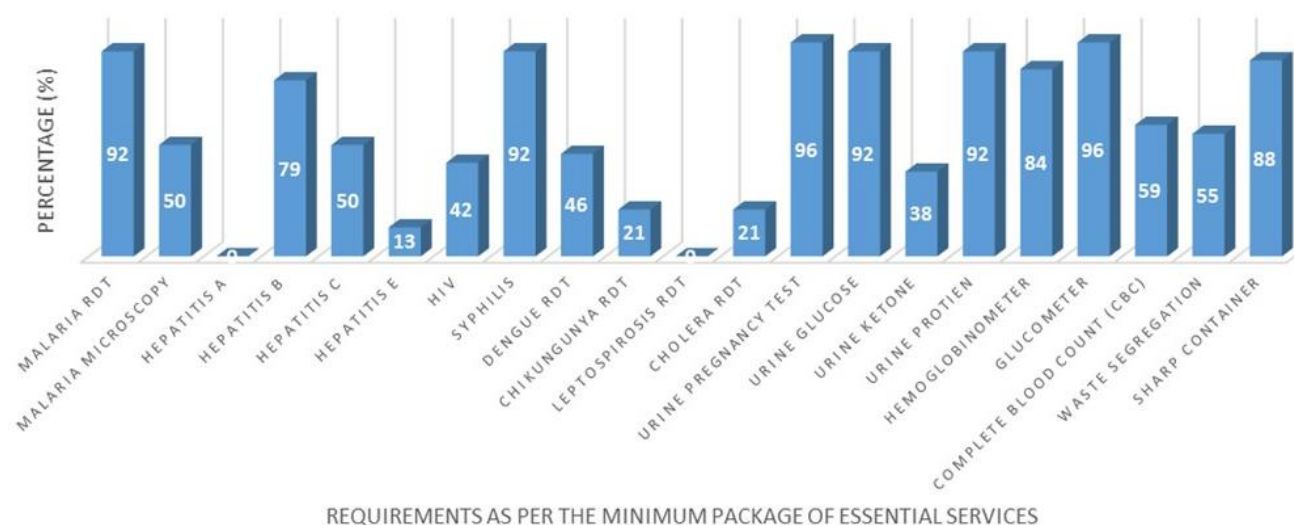
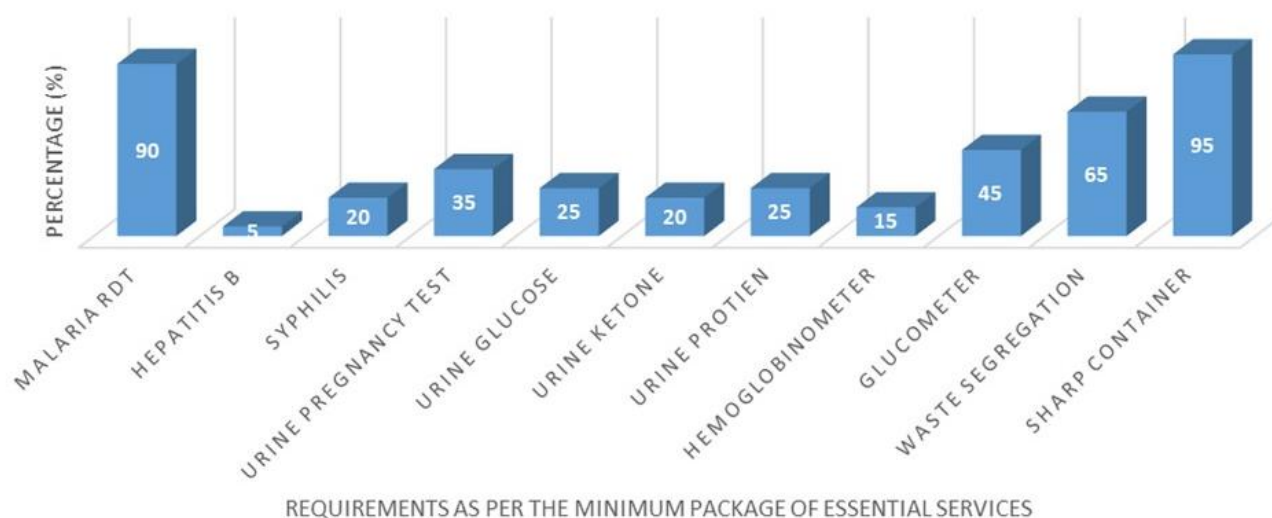


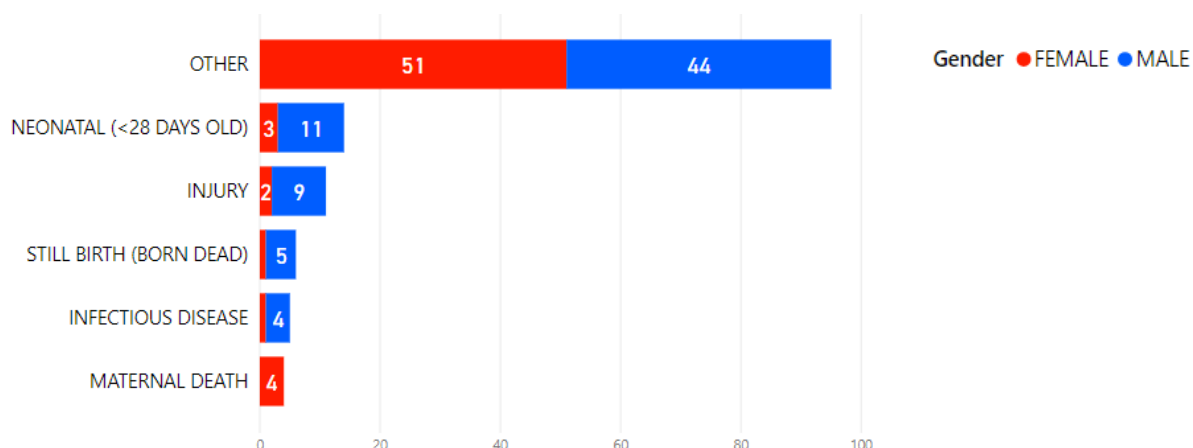
Figure 8 Adherence (in percentage) to components of the Minimum Package of Essential Health Services among Health Posts



Community based mortality surveillance

A total of 135 mortalities were reported between from weeks 14 to 26 (more recent data still pending validation). A total of 62 female mortalities and 73 male mortalities were reported in this reporting period. Of the 62 female mortalities, 15 were reported to be women of reproductive age (ages 12 to 49) of which 4 were re-classified as maternal mortalities following verbal autopsy. A total of 6 stillbirths and 14 neonatal deaths were also reported. See figures below for more details.

Figure 9 Cause of deaths reported in EWARS through community based mortality surveillance, by sex (week 14-26)



Overall, 25.9% of the total deaths within this reporting period were women of reproductive age, still births and neonatal deaths. The average age of reported mortalities are 45.3 years of age for females and 35.5 years of age for males. Of the deaths reported, majority (73%) occurred in the home, 16% in the health facility and 11% in the community/public spaces. The current number of reporting agencies cover 28 facilities across 24 camps. Further coordination between the partners and future enhanced training is needed to improve reporting rates.

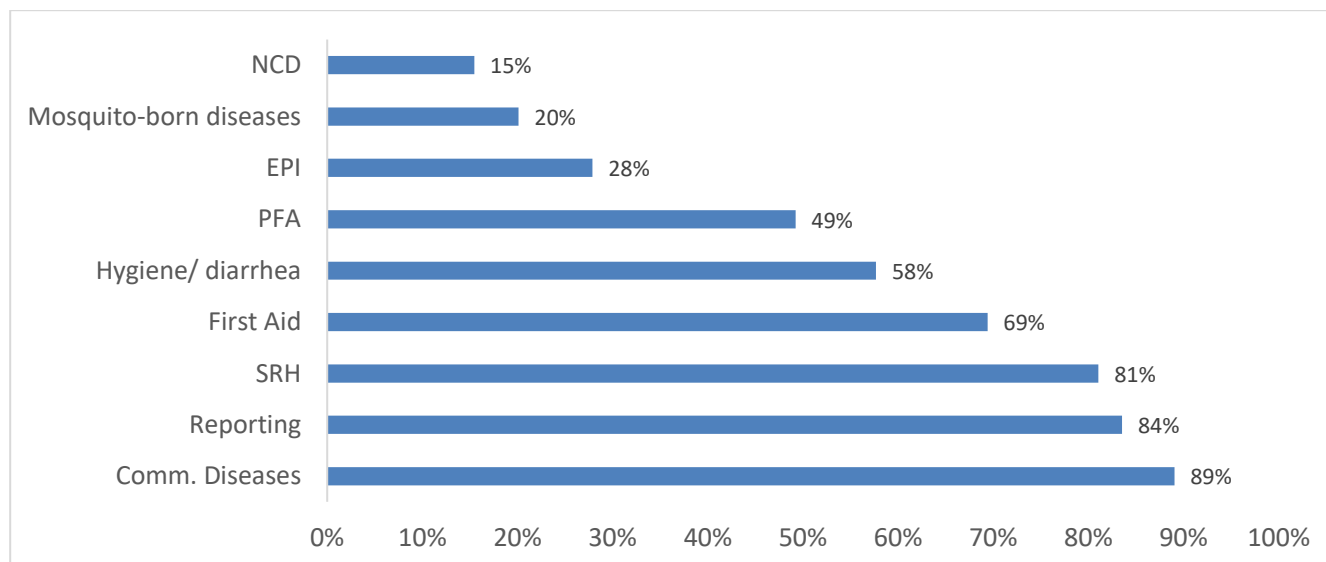
3.4 Community Health

Community health is critical component to the health response. Nearly 30 health sector partners implement community outreach activities. These activities are coordinated through a Community Health Working Group (CHWG) under the health sector, responsible for strengthening and standardizing health outreach activities. The co-chair team includes UNHCR, and Community Partners International (CPI).

During the reporting period, the CHWG partners focused on preparedness for the monsoon season with special focus on increasing awareness on hygiene awareness and diarrhea prevention, enhancing first and psychological first aid capacities of the CHWs. Partners also took part in a two-week long intensified messaging on acute watery diarrhea, initiated by the Civil Surgeon from 1st of July. Altogether 4749 courtyard sessions on hygiene awareness and diarrhea prevention were conducted during the reporting period for 48 457 refugees.

In the previous reporting period, trainings of trainers (ToT) were conducted on Sexual and Reproductive Health, First Aid and Psychological First Aid (PFA). During this current reporting period, these trainings were cascaded down to CHWs. The CHWG conducted a review exercise of the implementation of ToT trainings in 2019 to determine how well they have reached the CHWs. Results from the assessment showed a good uptake on the communicable diseases trainings (chickenpox, diphtheria etc.) with 89% of CHWs being trained. A total of 84% and 81% of CHWs were trained on reporting and SRH respectively. The uptake of first aid trainings reached 69% however PFA reached only 49% so far. Detailed breakdowns are provided in the figure below.

Figure 10 Percentage of CHWs trained, by training topic

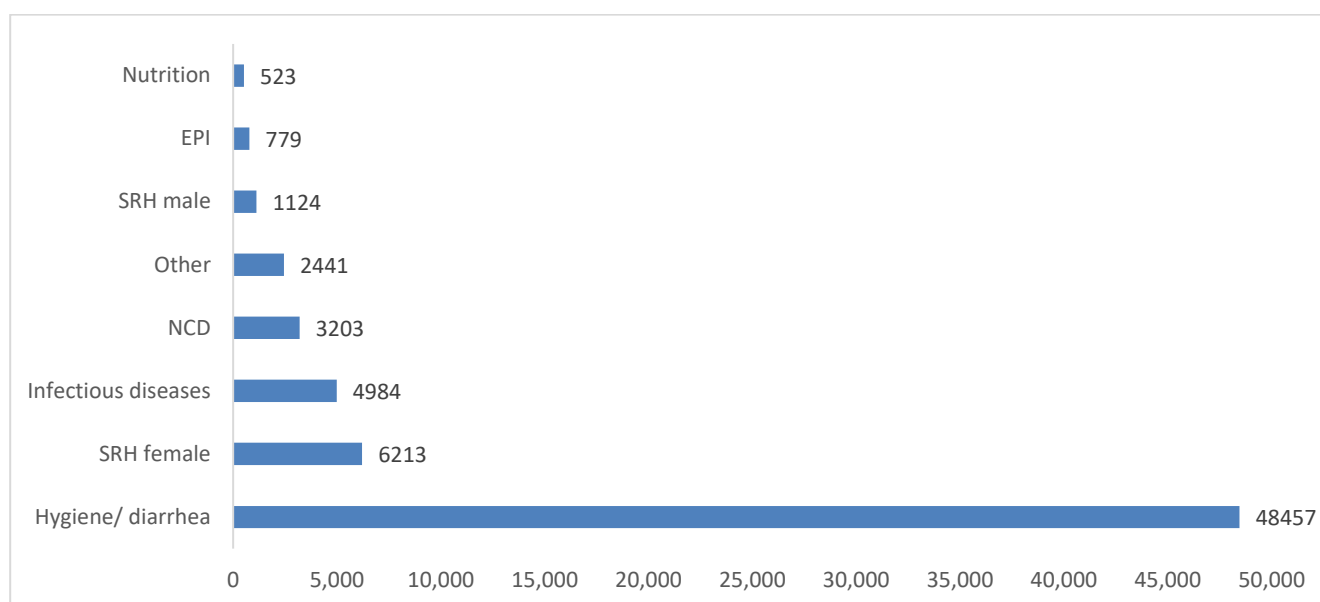


CHWG partners discussed on how to increase the uptake of trainings in the areas where there are gaps and agreed to include more field based staff as trainers (e.g. CHW supervisors) and to avail training opportunities to other organizations where possible. The need for additional training packages on non-

communicable diseases (NCSs) and EPI is evident from the low training coverage, only 15% and 28% of CHWs are trained on these topics respectively.

The number of partners sharing regular reports to the CHWG has increased to more than 70%. CHWs are requested to visits every household twice a month and a total of 532 564 household visits were conducted during the reporting period. In addition, CHWs conducted 7017 community sessions for 70 703 participants. The breakdown by topic are presented in the figure below.

Figure 11 Number of participants in community health sessions held during the reporting period, by session topic



The CHWG has started to review its 4Ws and to remap Community Health Workers areas of work within each camp. During the process, the number of active CHWs from all organizations was verified and new organizations were added. According to the available CHWs, each organization was assigned specific blocks for operation in the camp. The remapping aims to reduce overlapping of activities in the camps and ensure that no area remains uncovered. This two-month long exercise will be completed in the second half of July.

3.5 Mental Health and Psychosocial Support and Non-communicable diseases

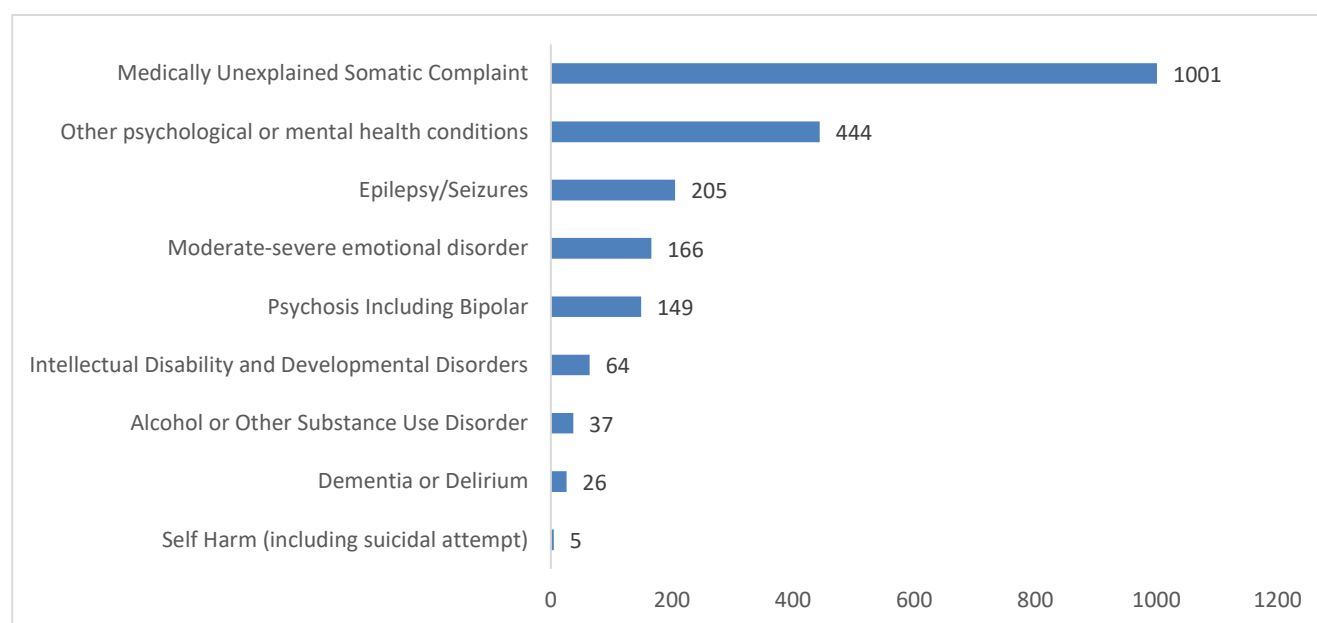
The psychological impacts of being forcibly displaced continue to affect large numbers of refugees and the coordination of mental health and psychosocial support services across different sectors remains a crucial domain for effective provision of accessible, acceptable and culturally sensitive services. The Mental health and Psychosocial Support Working group (MHPSSWG), co-chaired by UNHCR and IOM, continues to support the coordination of MHPSS activities together with provision of technical guidance for partners in different sectors working to scale up MHPSS activities.

During the reporting period, the WG updated the 4Ws mapping of MHPSS activities and this was shared on June 1st including 48 organizations out of 77 identified with mental health and psychosocial

activities. The next version of the mapping will be shared by the first week of August 2019 with aim of reaching more actors providing MHPSS services. The MHPSS Emergency Preparedness is ongoing with scaling up of activities like capacity building, strengthening referral pathways and field level coordination. The MHPSS Emergency Preparedness and Response planning is led by a dedicated taskforce that works closely with the MHPSS WG and the health EPRP taskforce. The MHPSS WG organized a workshop to develop a framework for suicide prevention in Rohingya refugees' camps. The framework is intended to provide a comprehensive, inter-sectoral and consensus based action plan that can be further adopted by different actors to mitigate the risk of suicide. The final version is expected to be completed by end of August 2019. Numerous trainings were completed on Mental health (MhGAP) and according to monitoring data from Q2 2019, 69% of 29 PHCs have at least one healthcare worker trained to provide mental health services.

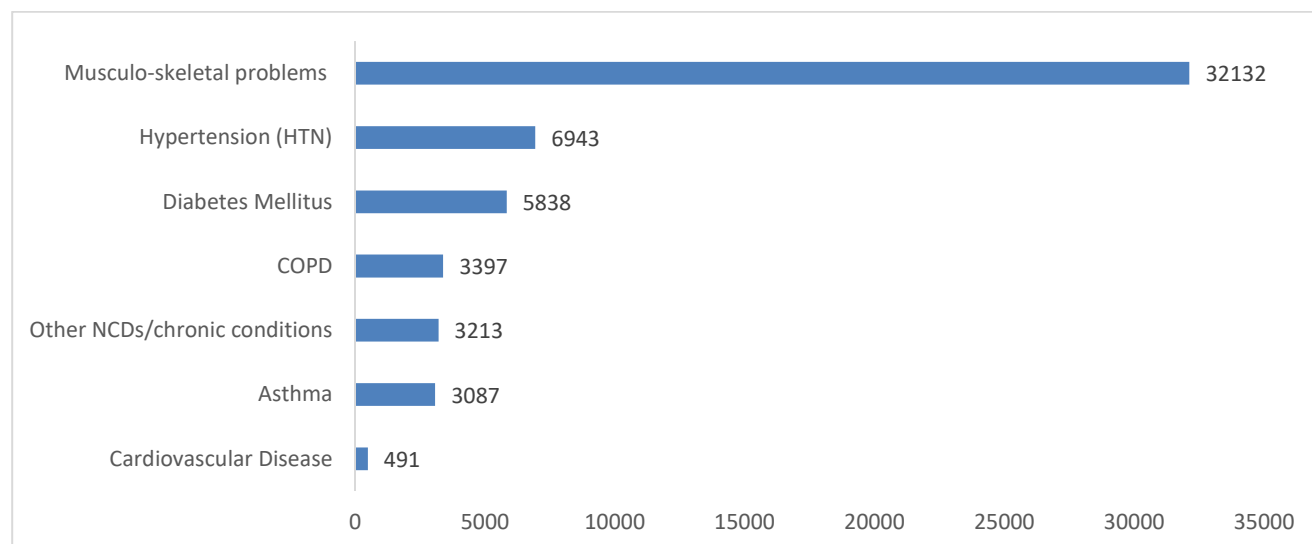
The figure below indicates the MHPSS morbidity trends as reported in DHIS2 during the reporting period. Somatic complaints account for the largest proportional morbidity, followed by 'other psychological or mental health conditions', psychosis, epilepsy and emotional disorders.

Figure 12 MHPSS morbidity as reported in FDMN DHIS-2 weeks 20-29, 2019 (Teknaf and Ukhia combined)



Regarding non-communicable diseases (NCDs), complete morbidity data is not currently available for the Rohingya refugee population. However, DHIS-2 data based on patient consultations during the reporting period shows the top three NCD morbidities are musculoskeletal problems, hypertension, and Diabetes Mellitus (DM) among the refugee population (see figure below). According to monitoring data from Q2 2019, 79% of 29 PHCs have capacity to diagnose and manage NCDs, however the levels of service provision vary. Gaps remain, such as availability of insulin and laboratory capacity to diagnose NCDs. A detailed NCD assessment, led by the NCD core group is expected to identify specific areas for improvement and supportive supervisions will be held thereafter.

Figure 13 NCD consultations reported in FDMN DHIS-2 weeks 20-29, 2019 (Teknaf and Ukhia combined)



3.6 Health Logistics

Health logistics is a critical component to the health sector response. In the reporting period, several critical health commodities were procured and distributed to partners. Fifteen PCR hoods were procured and distributed to health facilities in the camps; as well as 4000 (out of 4136) Calamine lotion bottles. Distribution is ongoing for 8080 cholera RDTs and 6350 malaria RDTs. A total of 50 000 ampoules of oxytocin arrived for the SRH project and were distributed. In support of the MMT training (25 to 26 June) for monsoon and cyclone season, 8 Trauma bags, 9 AED and 10 Personal deployment kits were distributed to MMTs. The main health partners have been sharing their overstocks, and this is being coordinated to enable donations among each other, to cover critical gaps.

The health sector now has six containers prepositioned, and these are stocked with essential medicines, for health sector partners use in case of emergency. These stocks are continually replenished and a further two containers are stock with Logistics items and tents. In addition to this, several partner agencies have prepositioned emergency stocks in the camps and in their respective warehouses; and these have been mapped out for emergency preparedness. The project to strengthen 24/7 health care provision through provision of generators and solar systems for partners running 24/7 primary health centers is progressing well. In total, twelve facilities were identified for this support. Generators and solar lighting have already been installed in all of 12 these, and solar AC has been installed in 9. Refurbishment and upgrading of the medical storage in Teknaf Health Complex was done, to keep the temperature control medicine in a proper condition (25°C).

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