

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

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Location: Bangladesh

Emergency type: Rohingya Crisis



Government—led inter-agency assessment team during training on health facility assessment (June 2018)



HMBDF, FDSR, Coast Trust, CZM, DCHT, Humanity First, ISDE, OBAT Helpers, Prottayashi, Pulse Bangladesh, RPN, SALT, DSK, Moonlight Development Society, RISDA, Muslim Hands International, Al Markazul



919 000
Rohingya in
need of
humanitarian
assistance



725 000
New arrivals
since
25 Aug 2017



3,387,920
outpatient
consultations since
25 August 2017



126 health sector
partners



1.3 million People
in Need for the
Health Sector
Response

1. SITUATION OVERVIEW

Since 25 August 2017, an estimated number of 725,000 Rohingya refugees have crossed over from Myanmar into Bangladesh, joining 194 000 who had fled in earlier waves of displacement. As of July 22 2018, the total number of Rohingya refugees became 919,000 (ISCG situation report; 5 September 2018). The overall population in need for the health sector, including the host communities, remains 1.3 million. Figure 1 below illustrates the demographic breakdown based on UNHCR population data.

Figure 1 Demographic breakdown among FDMN (UNHCR population factsheet) (n=894 262)

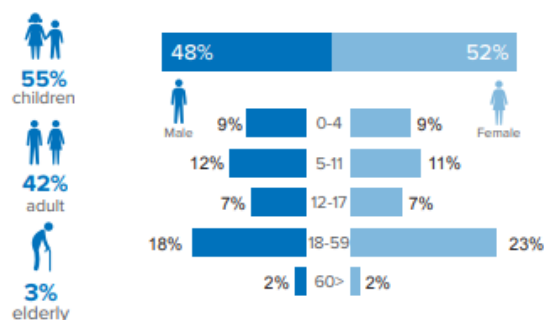
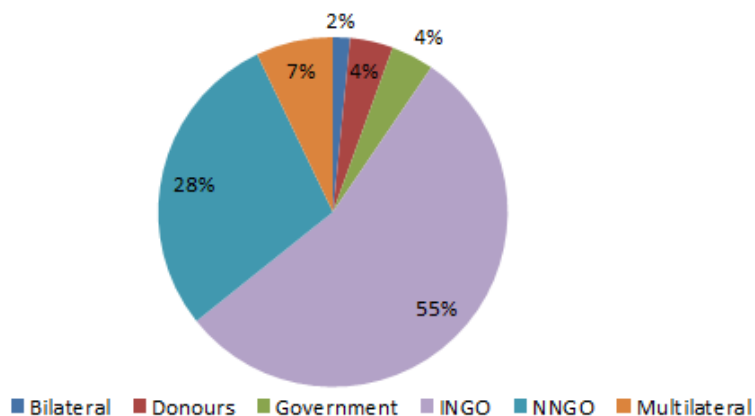


Figure 2 Type of health sector partner (n=126)



The health sector benefits from support of 126 partners who have responded to the needs in numerous ways including through direct service delivery from primary, secondary and specialized health facilities (both static and mobile health facilities in both Ukhia, and Teknaf); establishing expansive community health worker networks and developing risk communication materials; supporting government health facilities with human resources, renovations and medical supplies; ensuring availability of essential medicines and other supplies through logistics support; maintaining a strong disease surveillance system; delivering vaccination campaigns and strengthening routine immunizations; improving morbidity/mortality reporting from health facilities and from the community; strengthening laboratory diagnostic capacity; monitoring and improving water quality in health facilities; capacity building of medical personnel; and preparing for disease outbreaks.

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 are assigned from health partner agencies, for better two-way information sharing under the guidance of the Health Sector Field Coordinator. Field coordinators participate in relevant upazila and camp level meetings and the health camp focal points represent health sector in the camp-level CIC meetings. At the end of August, a workshop was held with all camp health focal points for strengthening of health sector coordination in the camps. The objective was to improve the health intelligence and information sharing in and from the field and to empower Health Camp Focal Points. Gaps and challenges were identified and the field coordinators are working to address these.

The health sector continues to benefit from strong support and engagement by Government authorities, most recently evidence by a joint initiative by the offices of the Civil Surgeon, Refugee Repatriation and Relief Commissioner and DGHS coordination cell to undertake an assessment in June 2018, to monitor health facilities in the FDMN camps with the aim of improving accountability by health sector partners. Data collection was under-taken by inter-agency teams.

2 PUBLIC HEALTH RISKS, NEEDS , AND RESPONSE

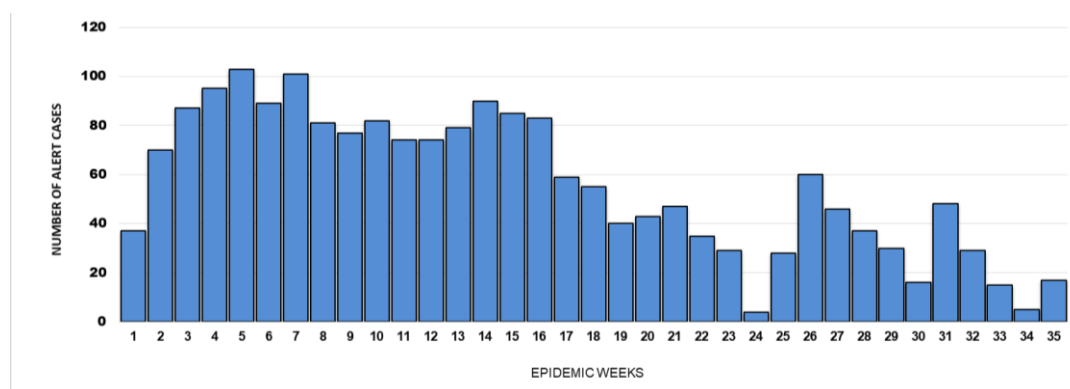
2.1 Communicable diseases

Surveillance

In total, 38% (84/223) of functional health facilities (Community Clinics, Health and Family Welfare Centers; Health Posts fixed and mobile; primary health centers; sub-centers; upazila health complexes; and secondary facilities) are not registered with EWARS for weekly reporting; while 62% are registered. In addition, mobile medical teams are registered in EWARS for weekly reporting with 7 teams reporting on a rotational basis.

As of Week 35, a total of 3 387 920 million consultations have been reported through an Early Warning, Alert and Response System (EWARS) since beginning of August 2017. These included clinically defined syndromes of communicable diseases, vaccine preventable and vector borne diseases as well as water borne and related diseases. The majority reported cases were acute respiratory infections (ARI) contributing the highest percentage (12.8%), followed by unexplained fever (11.5%), Acute watery diarrhea (AWD) (5.7%), other diarrhea (2.8%), injuries and wounds (1.8%), bloody diarrhea (1.3%), and Suspected Malaria (1.2%). Other reported illnesses included diphtheria, severe acute malnutrition (SAM), acute jaundice syndrome (AJS), Measles/Rubella, suspected hemorrhagic fever, confirmed malaria, meningitis, suspected acute flaccid paralysis (AFP), adult and neonatal tetanus, suspected and confirmed dengue and other consultations. A total of 1950 alerts were generated from January – September, 2018 and investigated.

Figure 3 Total alerts reported through EWARS from January – September, 2018



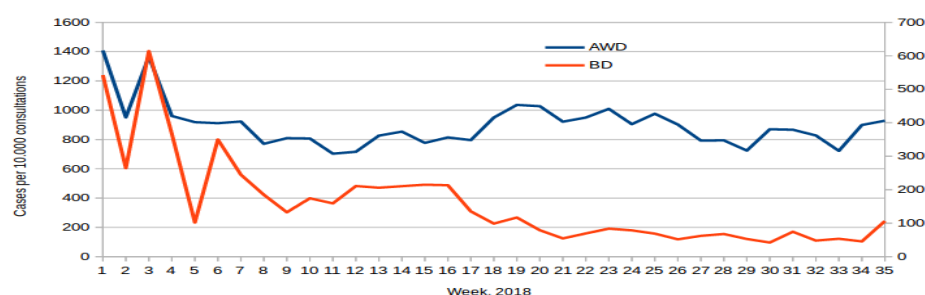
The EWARS surveillance system is complemented by an ongoing project to strengthen laboratory surveillance. Through health sector partner support, a field laboratory is now functional (since 21st April 2018) in the Cox's Bazar District with capacity for molecular technique diagnostic including DNA extraction, master mix preparation (clean room), template addition and PCR amplification. All Diphtheria samples are now processed at this laboratory. Laboratory diagnostics are scarce in the camp areas, but suspected cases of measles and acute flaccid paralysis are traced back as a part of national response by Immunization team from all partner organizations. Furthermore, rapid diagnostic tests (RDT) for suspected AWD cases are used in large and referral health facilities. Based

on the laboratory diagnosis, cases were classified and treated by the Ministry of Health and partner organizations. No confirmed cases of polio or cholera have been identified from the camps to date.

Acute Watery Diarrhea and Water and Sanitation

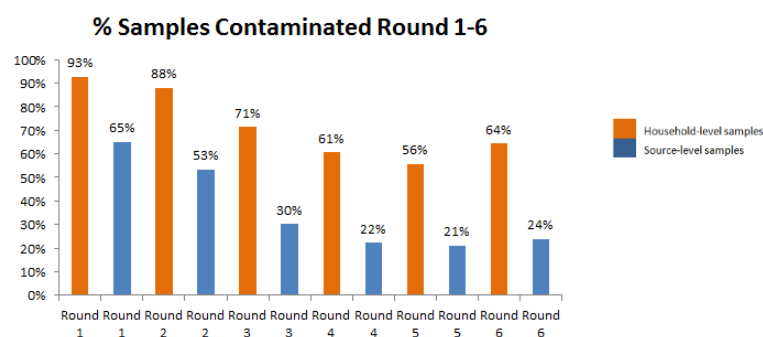
Diarrheal diseases are common in refugee camp settings, and a total of 109 730 acute watery diarrhea (AWD) cases were reported through EWARS between weeks 1 and 35, 2018, as shown in the figure below. Although there has been no indication of severe disease or clustering of cases to date, there has been a slight observed increase in the trend and all alerts are being assessed and investigated if needed. Several hotspot areas have been identified in the camp areas which were shared with WASH partners for further follow up. The recently completed multi-sector needs assessment (MSNA) found that 16% of all households with children under 5 reported a child had been ill with diarrhea in the two weeks period prior collection (UNHCR/REACH; September 2018). Of these, 95% of boys and 97% of girls reported to have received oral rehydration salts (ORS). There have not been any confirmed any cholera outbreaks or clusters in the FDMN camps to date.

Figure 4 Acute Watery Diarrhea (AWD) and bloody diarrhea (BD) EWARS reported among FDMN < 5 years cases (week 1 – 35, 2018)



AWD prevention interventions overlap closely with the WASH sector activities and strong collaboration exists between the two sectors. Six rounds of water quality surveillance were completed from August 2017 to June 2018. Previous rounds of water quality monitoring have shown high levels of *E.Coli* contamination of water particularly at the household level as shown in the figure below. An increase in contamination proportions was seen in the latest round (June 2018) during the monsoon season. These results were reported to the WASH sector for remedial measures to undertaken as they pose a significant public health risk. Round 7 will continue in September 2018.

Figure 5 Percentage of contaminated source and household-level samples among 6 rounds of water surveillance

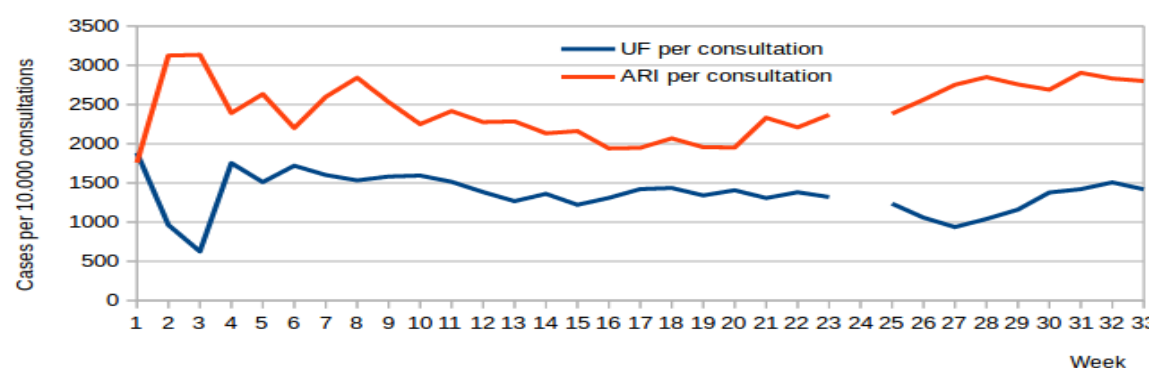


To help address water quality in health facilities, a three day “water and sanitation for health facility improvement tool (WASH-FIT)” training was conducted in September with 20 participants from health sector partners. The training supported partners to make sustainable change to the standard of WASH and IPC in their respective health facilities. It also promoted development of skills in WASH and IPC among junior managers to enable them to manage their facilities in efficiently and sustainably. Monitoring through WASHFIT surveys of the camps is to be integrated, and interventions will be tailored to address the needs and gaps identified through the survey. In addition, 72 community and 1142 family water filters were distributed to health facilities and households with pregnant women, respectively. This was accompanied by a training of trainers on the installation, maintenance and safe keep of the water filters, so that partners can train the pregnant mothers and health providers in the facilities provided with Community water filters. The impact of water filters will be evaluated in the coming months.

Acute Respiratory Infections (ARI)

Acute respiratory infections (ARI) and unexplained fever (UF) contribute about half of the consultations in the health facilities among children < 5 years of age in the Rohingya camps. There has been a recent upsurge of cases in ARI consultations, also some concerns regarding increase in level of UF. Influenza season is somewhat regular in Bangladesh, usually starting around May-June. This year, influenza cases were detected from sentinel surveillance from around June. Majority of cases were influenza A, predominantly H1N1pdm09, some H3N2 cases have also been detected. Influenza cases have also been detected from Cox's Bazar area, most notably H3N2. One RDT positive influenza A case has been identified from camp 25 (Leda) area. Support and strengthening of laboratory diagnostics for influenza continues. There were recent alerts of both ARI and UF from a number of health facilities. As these clinical syndromes overlap, health facility visits were carried out to determine the situation and it was determined that the increase is mainly due to ARI. Some Rapid Diagnostic Tests (RDT) were distributed to health facilities and more accurate PCR diagnostics is currently under way. Supporting appropriate diagnosis is important to reduce large-scale and inappropriate use of antibiotics in the camps with accompanying antimicrobial resistance especially among children.

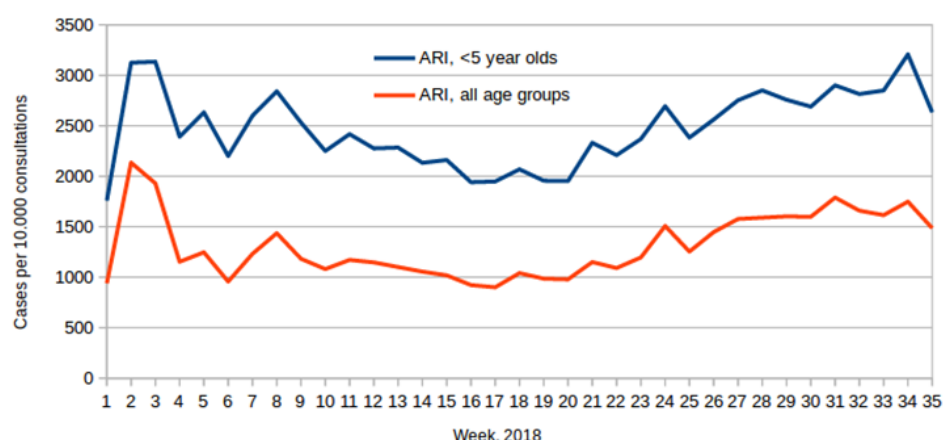
Figure 6 ARI and UF cases/10,000 consultations reported through EWARS among FDMN less than 5 years of age



Further local risk assessment were undertaken to identify likely infectious disease syndromes possible in Cox's Bazar, Bangladesh. This unexplained fever scenario could represent variety of

illnesses, possibly corresponding to a common cold or viral syndrome but also to the beginning of a severe disease outbreak. Different diseases with human-to-human transmission as influenza, or vector-borne diseases as Malaria, Dengue, Chikungunya or Zika or arthropod-borne diseases as Rickettsial illnesses are possible. An assessment study is to address the increasing trend of unexplained fever, to obtain a comprehensive prevalence estimates for diseases in question and to estimate the level of transmission of influenza, vector borne diseases (malaria, dengue) or arthropod-borne diseases (rickettsia) among Rohingya and host community population in Cox's Bazar, Bangladesh. The assessment will also consider the burden of neglected viral, tropical infections as a potential outbreak causing organisms.

Figure 7 ARI cases/10,000 consultation reported through EWARS among FDMN <5 year old and all aged patients



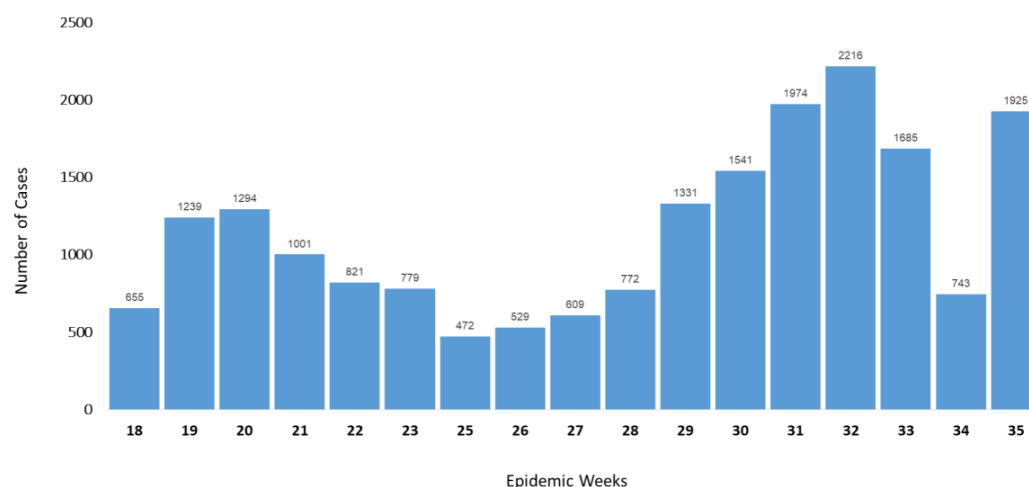
Vector Borne Diseases

A total of 34 355 Malaria suspected cases were reported through EWARS surveillance from week 1 to week 35, 2018. Of these, 59 cases were found to be malaria confirmed cases through rapid diagnosis test (RDT) in the field. The below trend of suspected malaria cases shows that cases have been increasing during the monsoon season and these are expected to peak when rainy season is approaching an end. However, further follow up with health facilities suggests that some of this increase is due to increased awareness and more testing. The number of confirmed malaria cases remains low. No confirmed dengue cases have been reported in the year 2018, but the diagnostics are scarce. From the historical Bangladesh disease surveillance data, dengue cases have usually peaked between July and September predominantly in Dhaka area. For intervention and control activities 300,000 mosquito nets have been distributed since the onset of the crisis. The recently completed multi-sector needs assessment (MSNA) found that 97% of all households with children under 5 reported all children sleeping under a mosquito net the night prior to data collection (UNHCR/REACH; September 2018).

High population density and environmental contamination over time may increase the risks from vector borne diseases. The environmental context in the camp appears to be favorable for vector borne diseases. Entomological assessment were undertaken with the conclusion that post monsoon period could possess a risk for mosquito proliferation.

The health risk communication task force developed a ‘communicating with communities’ campaign about vector-borne diseases, including creating flash cards on symptoms and preventive measures that community health workers will use, and audio messages to be played through microphones.

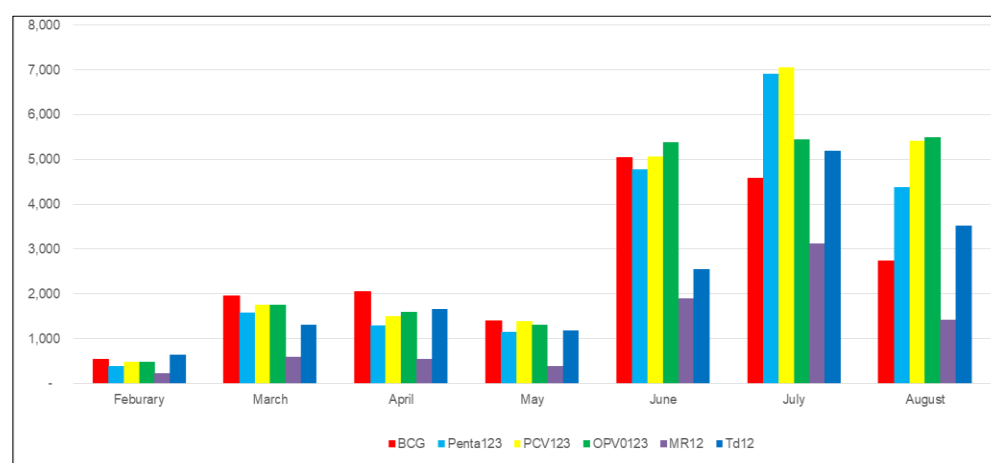
Figure 8 EWARS reported Suspected Malaria cases among FDMN from week 18 – 35, 2018



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). While another OCV campaign is planned for the second week of October 2018 (targeting 327 364 individuals), in the past three months the focus has been on routine EPI targeting children 0-23 months of age. This is being implemented through 780 fixed session site and 70 outreach mobile teams (65 for FDMN, 5 for host community) across the camps. From beginning of February to end of August 2018, the following antigen doses were delivered to children: 18,327 BCG doses; 20,522 pentavalent doses; 21 501 oral polio vaccine (OPV) doses; 22 697 PCV doses; 8214 Measles/Rubella (MR) doses. Pregnant women are targeted for Td (16 077 doses delivered from February to August, 2018). A two day ToT refresher training for the vaccinators and for the supervisors was conducted.

Figure 9 Vaccination doses administered to FDMN aged 0-23 and pregnant women, Feb. – August 2018 (n=83,047)



Current overall estimated EPI coverage, averages 89%. Meanwhile the MSNA found that 79% of all households with children under 5 reported all children under 5 having immunization cards (UNHCR/REACH; September 2018).

Diphtheria

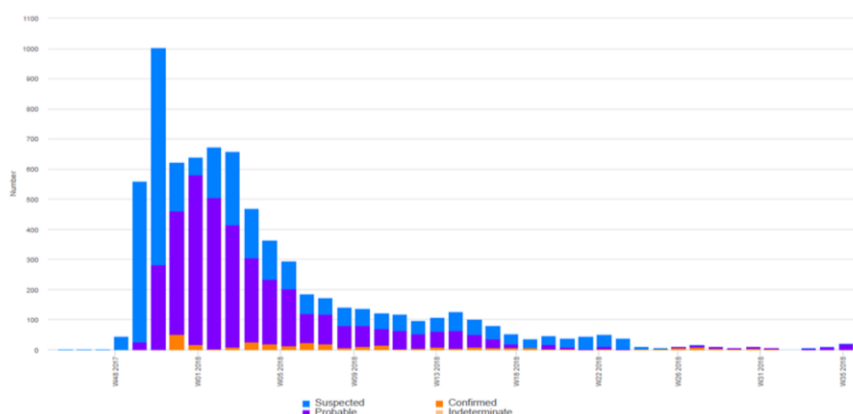
An unprecedented diphtheria outbreak began among FDMN in Cox's Bazar in November 2017. A vaccination campaign among FDMN aged <15 year was undertaken during December 2017 to March 2018 and from January to February 2018 among the host community of the same age. About 80-90 % of <15 year old age group have been vaccinated at least twice against diphtheria. Both Rohingya and host population groups were given three doses of vaccine. This resulted in a rapid decline in number of diphtheria cases. As of August 19 2018, a total of 8135 diphtheria case-patients were reported through EWARS, including 268 with a positive lab test (PCR) and 1011 with a negative lab test. Total number of deaths reported due to diphtheria was 44 (case-fatality proportion <1.0 %). During the past four weeks (weeks 30-33), 86/100 case patients have been PCR-tested and 7 % (6) tested positive. The latest confirmed case was on August 3rd, 2018. Case management is ongoing for all diphtheria patients including contact tracing and chemoprophylaxis. As the case numbers are low, more efforts may be given for the remaining clusters. This will hopefully further reduce the burden of illness among this highly vulnerable group of people. Routine EPI is the key to success.

The long tail- end of the outbreak over the last three months has highlighted some problematic areas in diphtheria prevention effort. The adult Rohingya population (>15 years old, except pregnant women) are not protected against diphtheria. Also the vaccine coverage within the newly arrived population is low. Furthermore, a number of Rohingya children (<15 years old) have not received the full three doses of Penta/Td vaccine. It has been estimated during vaccine coverage surveys that about 70-90 % of the children have received all three doses. Issues with vaccination refusal still exist for various reasons including fear of adverse effects following immunization. The documentation of vaccination in the Rohingya population is based on hand-written cards. Also the host community requires adequate protection against diphtheria given their proximity to the Rohingya population. Due to previous differences in clinical case definition, a number of patients who met the probable case definition for diphtheria subsequently test negative for PCR, and some patients having only mild respiratory illness and tested PCR positive. Systematic culture and subsequent antibiotic susceptibility testing of clinical specimens has not been done, therefore the true proportion of positives in the population remains somewhat unclear. Lack of information on genotyping of outbreak strains is limiting comprehensive understanding of the disease in this outbreak scenario. Diphtheria transmissions to close contacts are continuing despite active contact tracing and chemoprophylaxis.

An international consultation on diphtheria was undertaken in Cox's Bazar one 30th July, 2018 to tackle these issues on. As a result, several recommendations were made. It was suggested to seek government concurrence to increase the age for routine immunization to 5 years and specify the antigens for immunization and the target group. Furthermore, a technical guideline to vaccinate the

entire block in case of diphtheria cluster would be needed. A diphtheria cluster is now defined as: two suspected cases in a household OR three suspected cases in the same block OR one laboratory confirmed case within four weeks. Furthermore, case definitions are now standardized in line with WHO standard definitions. Vaccine card retention should be enforced as well as vaccination policy for new arrivals. Recognizing that women caring for children are at greater risk for diphtheria, more data would be needed to consider if all adult women (15-49 years) should be vaccinated. Overall, better documentation and data for microbiology, epidemiology, vaccination history and modelling on cases above 15 years is needed to qualify decisions for immunizing this age group. Laboratory diagnosis should be strengthened as well as contact tracing.

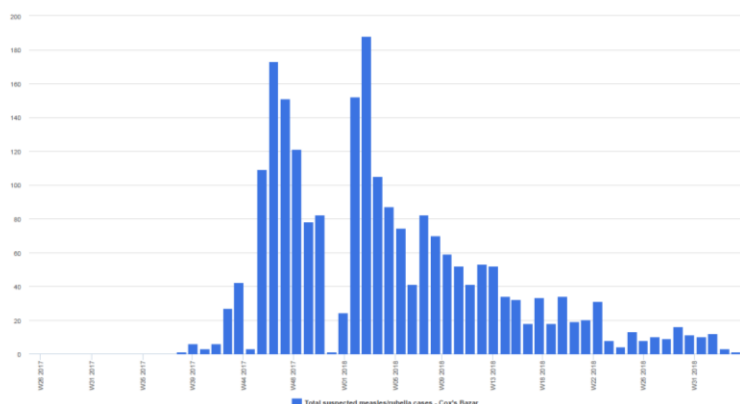
Figure 10 Epidemic curve of diphtheria cases among FDMN (W44, 2017 – W35, 2018)



Measles

A total of 1483 suspected measles/rubella cases were reported through 152 EWARS sites between weeks 1 and 35, 2018 (From January – September 02, 2018). In the last reporting period of week 35, only 1 confirmed Measles case was reported compared to week 34 (1 case) and week 33 (3 cases). Trends of suspected measles/rubella cases have been progressively declining in 2018 as vaccination coverage have increased. These trends are based on syndromic reporting (no laboratory confirmation). National laboratory surveillance is taking place also in the camp areas by suspected cases.

Figure 11 Trend of EWARS reported suspected measles cases among FDMN as of Week 38 2017- Week 35 2018



2.2 Sexual and Reproductive Health

Based on the recent surveys the proportion of pregnant women has been estimated to be 2.4 % of the total FDMN population. The Sexual and Reproductive Health Working Group 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 new-born health services remain a major concern. 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. Findings from the MSNA indicate that 41% of households reported fear of sexual violence for girls aged under 18 (UNHCR/REACH; September 2018).

Although access to and coverage of family planning services has improved slightly over the past 6 months (March-August 2018), family planning needs remain inadequately addressed for these very vulnerable populations. SRH Sub sector data from health facilities indicates an improvement in provision of Family Planning from a baseline of 12% to 28% of the facilities providing at least 3 short acting and 1 long acting method as per the Joint Response Plan (JRP) standard. Nevertheless, the contraceptive prevalence rate is estimated to be just 33.7 % (iccd, survey July 2018) which suggests that gaps in service provision and uptake remain. Similarly, in the past 6 months, there has been an increase in the proportion of facility-based delivery (from a baseline of 22% to 43% among total population in need and 32% among FDMN only according to SRH monthly data collection tool). MSNA results indicate that 72% of pregnant women interviewed reported to have attended an NGO or government clinic at least once since the start of their pregnancy, to get advice or treatment about their pregnancy (UNHCR/REACH; September 2018). Nevertheless, attainment of the JRP target of 50% of deliveries taking place in health facilities assisted by a skilled attendant will require considerable effort and better understanding of access barriers and demand-side barriers. Critically, it is important that quality sexual and reproductive health information and services are available near the communities including outreach services for the hardest-to-reach.

To help address the gaps large quantities of emergency reproductive health kits were distributed to implementing partners and government facilities. Importantly, the SRH sub-sector successfully reached a collaborative agreement 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'. The SRHR WG has for many months advocated for the scale up of family planning (FP) services in all camps and settlements for newly arrived FDMN population. SRH partners are working on scaling up family planning services in the camp to include wide range of right based FP methods availability to address the unmet need for FP.

Other key achievements of the subs-sector in the past three months include the development of a service quality monitoring checklists developed to guide on-site mentoring of health providers

alongside the launch of a series of trainings to improve the quality of care provided to FDMNs and the local population with a focus on SRH/maternal health and neonatal care. A total of 460 health care practitioners received various SRH related training on Helping Babies Breathe, Emergency Response, Helping Mothers Survive, Family planning (LARC), Menstrual Regulation & Post-Abortion Cared and Clinical Management of Rape. The Health Sector has developed a short-term action plan until December 2018 to strengthen health responses to Gender-based Violence (GBV) among health partners including first line responses, Clinical Management of Rape, referrals and community outreach. On September 4, 2018, a pilot program for cervical cancer screening was introduced to Balukhali camp.

Currently there are no systems in place to track community-based births, but to date a total of 7504 deliveries were reported from health facilities and 86 505 people have been reached with various method of FP. A community-based retrospective assessment of maternal mortality is planned in September, and prospective community mortality surveillance will be piloted in September.

2.3 Nutrition

From early June to end August, a total of 184 220 nutrition screenings were reported from the Nutrition Sector. Based on monthly reported data, the table below summarises key nutrition treatment and preventing services provided in the previous three months.

Table 1 Total nutrition services provided by Nutrition sector partners June-August 2018

- SAM Admissions: 11 596
- MAM [Child] Admission: 11 216
- MAM [Pregnant and Lactating Women] Admission: 3233
- BSFP [Child] Admission: 35 812
- BSFP [Pregnant and Lactating Women] Admission: 10 287
- IYCF Counselling: 16 829
- Vitamin A distribution: 147 167
- Deworming: 88 888
- Iron and Folic Acid supplementation [adolescent girls]: 8377
- Iron and Folic Acid supplementation [Pregnant and Lactating Women]: 15 888

In July and August 2018, an assessment (quantitative and qualitative) was conducted by the Nutrition Sector in Community Management of Acute Malnutrition (CMAM) treatment of coverage including SAM services (OTPs) and MAM services (TSFPs). A total of 10 742 cases were screened from five zones within the refugees camp. Results indicate that, despite considerable efforts, approximately 30% of children diagnosed with SAM did not attend OTP for various reasons (main reason: “carer does not think the child is sick”); and approximately 34% of children diagnosed with MAM did not attend a TSFP for various reasons (main reason: “carer unaware of TSFP). Qualitative results indicated

several misconceptions, awareness and knowledge gaps among FDMN which Nutrition sector plans to address through developing appropriate risk communications materials.

Encouragingly, a recently completed Government-led health facility assessment (June 2018) found that >90% of interviewed health facilities reported that they are within a 10 minute walk from a nutritional facility (facilities who responded “No” are in Camps 5, 6, 7, 8W, 8E, 13, 17). Nevertheless, strengthening of referrals by health facilities to nutrition facilities needs improvement to help address treatment coverage gaps.

2.4 Mental Health and Psychosocial Support (MHPSS) and Non-communicable diseases (NCDs).

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.

Continuous MHPSS capacity building is conducted by the MHPSS partners. In the past 6 months, numerous trainings were undertaken including psychological first aid trainings (approximately 80 trainings), mhGAP (approximately 50 medical doctors trained), and numerous trainings on basic counselling skills. Importantly, the number of psychiatrists has increased from 2 to 5 over the past 6 months. However, in-camp management of mental health conditions remains a gap. To help address this, at Task Force on Integration of Mental Health (MH) into Primary Healthcare (PHC) was initiated to help ensure effective, coordinated and focused inter-agency and government approach among all stakeholders in Cox’s Bazar in their efforts to integrate MH into PHC services and to strengthen capacities to do so through mhGAP training as well as to help build existing government capacities.

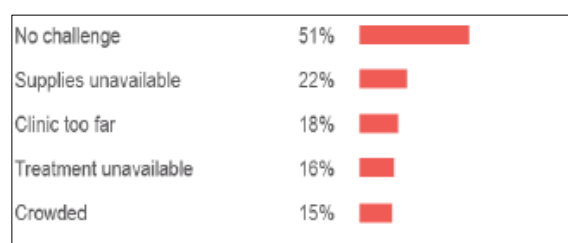
Regarding NCDs, reliable morbidity data is not currently available for the Rohingya population. However, in Kutupalong (Camp 1W) and Balukhali (Camp 9), a systematic approach for health screening programs to identify NCD with special emphasis on hypertension and diabetes has been carried out since October 2017 by one partner. Out of 45,000 patients screened, 7.1% and 4.9% were diagnosed to have hypertension and diabetes (DM), respectively. Approximately 12% of diabetics are insulin-dependent. At present, there are at least 265 diagnosed cases of insulin-dependent (Type 1 and Type 2) diabetes and gestational diabetes that require injectable insulin in these two camps. A cold-chain provision and in-patient monitoring system are in need to initiate treatment and follow up for the insulin-dependent diabetic cases.

2.5 Health service access and delivery

Since the beginning of the crisis up to end August 2018, health partners have reportedly provided 3 387 000 out-patient consultations (Health sector 4Ws). Not all of these consultations are gender/age disaggregated. However of the consultations reported, 3 000 192 (78%) are gender disaggregated of which 38% were male patients and 62% were female patients. Overall, 2 587 946 (67%) of the total outpatient consultations are age disaggregated of which 938 878 (36%) are <5 years of age.

Based the MSNA, 30% of male and 33% of female individuals interviewed reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection. Of these, 96% of males and 95% of females reported to have sought treatment (82% from NGO clinic; 31% from pharmacy; 5% from Government clinics). Although 51% of households reported no challenges to accessing NGO-run clinics since arriving in the camp, some challenges were documented as shown in the figure below.

Figure 12 Percentage households reported challenges in accessing NGO –run clinics since arriving in the camps, by challenge (MSNA-UNHCR/REACH)



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 262 functional facilities known to the health sector, with a further 18 planned or under construction.

Table 2 Current health facilities serving population in need, by type and functionality

Facility Type	Functional	On standby	Planned	Under construction	Grand Total
Community Clinic (MOH)	14				14
Health and Family Welfare Center (MOH)	5				5
Health Post (fixed and mobile)	173		6	4	183
Labour Room or specialized SRH facility	12				12
Other specialized clinics	18				18
Primary Health Center	15		5	2	21
Secondary Health Facility	11				11
Specialized Infectious Disease Facility	8	5		1	14
Sub-center (MOH)	3				3
Tertiary Health Facility	1				1
Upazila Health Complex (MOH)	2				2
Grand Total	262	5	11	7	284

Other specialized clinics include providers of eye-care services and physical and functional rehabilitation services. Regarding eye-care, an assessment completed in June 2018 (Orbis International) recommended that a minimum initial service package of eye care for FDMNs be developed including addressing preventable forms of blindness as needed; setting up emergency eye referral processes as feasible; integrating primary eye care (PEC) into the primary health care (PHC) system and; providing basic eye services (cataract surgery and provision of eyeglasses) without discrimination, as resources allow. The main NGO providing eye-care services in the camp has screened 27, 155 individuals (82% children and 18% adults).

Regarding infectious disease outbreak preparedness; several facilities have dedicated isolation beds in addition to the dedicated infectious disease isolation facilities. Overall; there are 509 beds specifically for AWD isolation plus 11 beds for isolation of other diseases including AWD which totals 520 beds in case of an AWD outbreak. Some of these are on 'standby' in case of disease outbreak; meaning that the facility infrastructure is in place and can be set-up with staff and supplies with 24-48 hours of an outbreak being declared. An additional 42 isolation beds are available for non-AWD diseases such as measles etc. Finally, 10 isolation beds are available for Diphtheria patients.

The total number of in-patient beds among health facilities serving the FDMN (excluding upazila health complexes; Sadar Hospital and private facilities) is 769, in addition, to 143 maternity beds. The total of 912 corresponds to a ratio of approximately 1 in-patient or maternity bed/1000 FDMN, excluding the Government Secondary Health Facilities.

In June 2018, 25 Doctors, 40 Nurses, 15 Cleaners and 6 Guards were recruited at Sadar (District) Hospital through partner support. Standard operating procedures and standardized forms for medical referrals to Government secondary/tertiary health facilities were also finalized in June 2018 and were signed off by Government authorities, to facilitate medical referrals outside of the camps. Nevertheless, findings from the recent Government-led health facility assessment indicated that just 65% of reporting facilities have a referral mechanism in place for medical referrals for secondary/tertiary care, and only one third reported they could cover referral costs to Government facilities.

Based on the data available, the below table summarizes current status of ratio of health facility to the population in need ratios, vis-a-vis the SPHERE standards. Broadly speaking, there are a sufficient number of health posts and other basic health units; but the shortage in primary health centers (24/7 health facilities) persists. This is supported by the findings that while only 6% of assessed locations reported reduced access to health facilities (> than 30 mins walking or no access), 66% reported difficulties accessing health services at night (IOM Needs and Population Monitoring Round 11). Health sector has been supporting health facilities to obtain the necessary approvals to establish 24/7 services but the gap persists.

Table 3 Current aggregated status of health facility coverage against SPHERE standards

Basic Health Units (health posts fixed/mobile and community clinics):

Current number of basic health units: 186 (1:6,989 people in need)

SPHERE standards target is one basic health unit/10,000 population so this standard is **met**.

Health Centres (Primary Health Centres and Sub-centres):

Current number of health centers: 19 (1:68,421 people in need)

SPHERE standards target: one health centre/50,000 population so this is currently **not yet met** because it requires 24/7 services for primary health centers. However, an additional 14 facilities are in the process of upgrading to 24/7 (by end October 2018 (which will bring the total to 33 fully functional 24/7 PHCs (1: 39,393 people in need), so there is no need to construct additional sites but simply to support the smooth transition into 24/7 services.

Hospital facilities:

Current number of hospital facilities: 11 (1:116,700 people in need)

SPHERE standards target: one district or rural hospital/250,000 people so this standard is **met**.

In terms of geographic distribution and coverage, there are discrepancies by camps. The below maps show the projected coverage/camp for health posts and primary health centers based on camp-wise populations, and assuming all primary health center upgrades are completed by end October as expected. Gaps were identified in Teknaf area and a meeting was coordinated by health sector with all relevant partners to mobilize resources to urgently fill these gaps which should be filled in the next months.

Figure 13 Projected map of health posts coverage by end October, based on population size

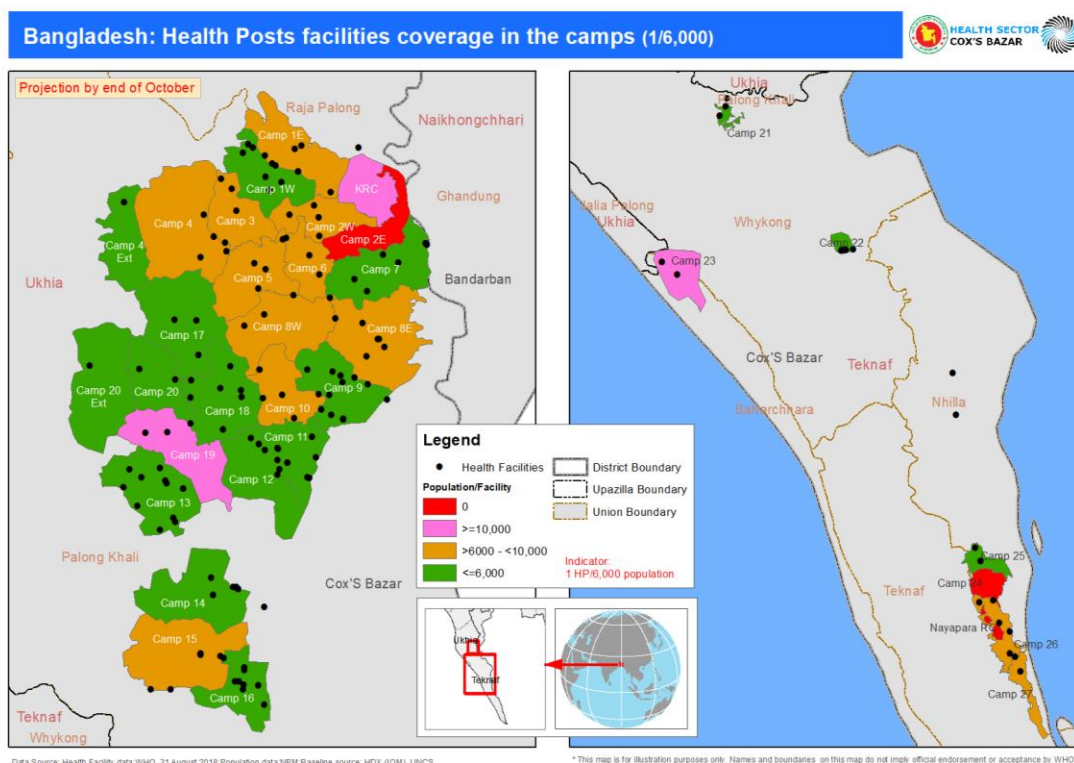
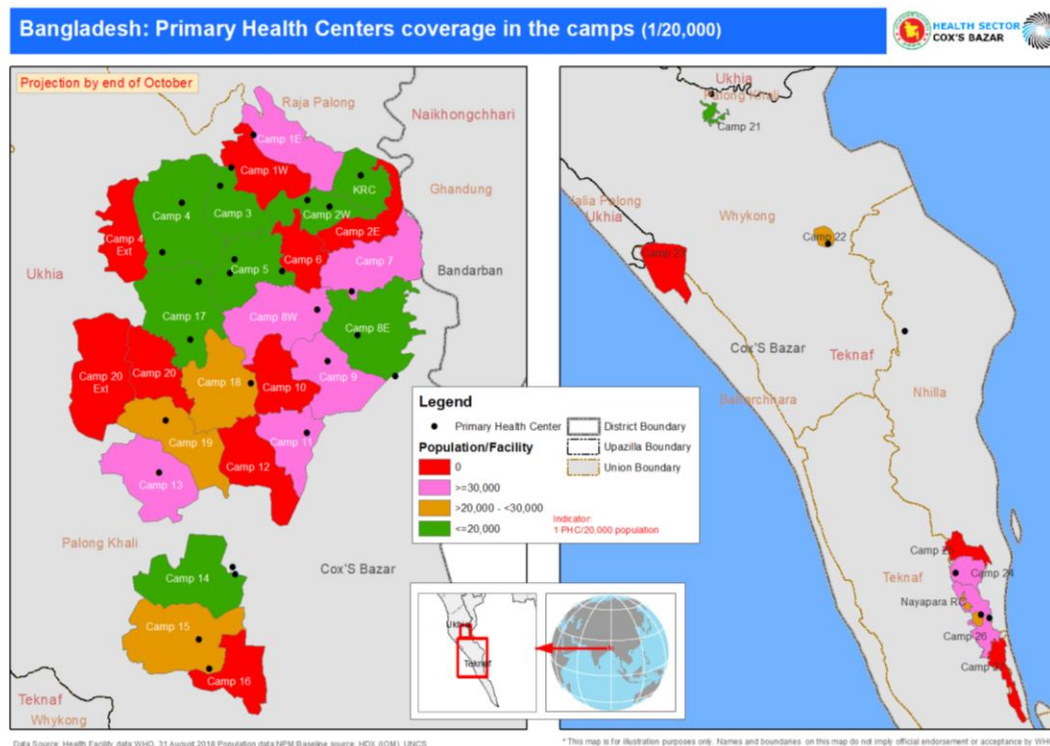


Figure 14 Projected map of fully functional 24/7 PHCs coverage (excluding planned facilities) by end October, based on population size



2.6 Monsoon season

During monsoon season, a total of 605 category 1 level incidents were reported through the site management sector daily incident report (11 May 2018 up to date). Table 4 below summarizes the incident types and scale of impact, as reported by site management sector.

Table 4: Summary of Category 11 incidents and their impacts, 11 May-06 September 2018

Incident type	Number of Incidents	Affected Households	Affected individuals	Casualties (individuals)	Injured individuals
Fire	15	55	213	0	10
Flood	42	1419	5742	0	0
Landslide	317	3567	15639	1	28
Water-logging	41	763	3356	0	2
Wind-Storm	190	5487	25861	0	6
Total	605	11291	50811	1	46

During the same period, the health sector registered 37 instances of temporary facility closures due to weather-related incidents. On a daily basis throughout monsoon season, the health sector emailed partners with updates on facility closures; logistics/road access issues; and other important topics.

¹ A localized event that caused minor to moderate damage and that has little or no impact outside the locally affected area. Situation is managed by local stakeholders with existing resources.

Throughout the monsoon season, to address foreseen disruptions to health services provision, Mobile Medical Teams (MMTs) deployed daily. A total of 5 core teams and 14 surge teams are currently ready for deployment and a centralized Dispatch and Referral Unit (DRU) in place and coordinating the deployment of the MMTs. Core MMTs deploy daily to provide Primary Health Care support in the absence of an emergency deployment. These core teams see an average of approximately 1,200 patients in strategically focused areas of the camp where health services are limited, relocations have occurred or static facilities have limited functionality. Ambulance availability has been mapped and the DRU and MMTs work in close contact with available ambulances when additional support is required. Currently the DRU is mapping referral needs to strengthen 24/7 referral systems in the hard to reach areas of the camp.

2.7 Upcoming priorities

As monsoon season ends, the focus of the health sector is now shifting to cyclone preparedness ahead of the cyclone season in November. The emergency preparedness working group has been reactivated for this purpose with a focus on trauma/mass casualty planning; surgical capacities; outbreak preparedness and dead body management. Meanwhile, planning for longer term is a key priority for the sector including ensuring a core minimum number of health facilities which are committed to remain for the medium-term. At the half-way point through the current Joint Response Plan, a mid-term review was finalized by the health sector in which priorities for the next 6 months are articulated. This will be published soon.

4. HEALTH SECTOR FUNDING

JRP for the Rohingya Crisis was launched in March 2018, for the period 1st March- 31 December 2018. A total of 50 project proposals were submitted for the health sector, with \$113,086,292 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 19.9% of its needs. The sector is significantly under-funded and requires additional funds to support its objective of offering lifesaving assistance.

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