

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

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Location: Bangladesh

Emergency type: Rohingya Crisis



Health Sector Rationalization Task Team in the field conducting focus group discussions with beneficiaries



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.

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911 000 Rohingya
refugees in need of
humanitarian
assistance



740 993
New arrivals
since
25 Aug 2017



714 843 outpatient
consultations from
30 December 2018-
09 March 2019



126 health sector
partners

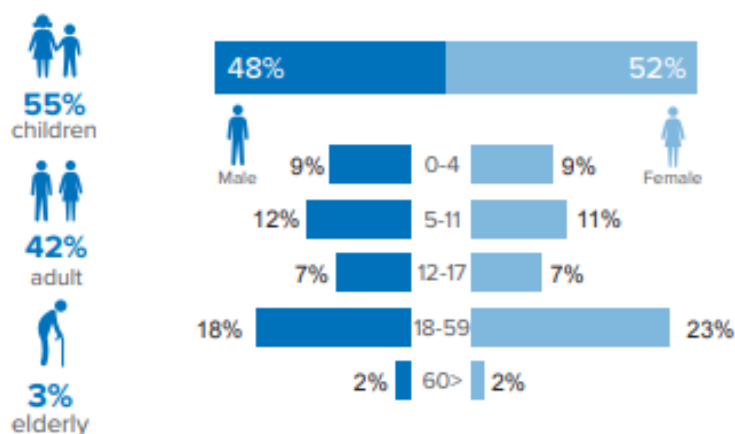


1.3 million People
in Need for the
Health Sector
Response

1. SITUATION OVERVIEW

As of end January 2019, the total number of Rohingya refugees became 911 000 (ISCG situation report; 13 December 2018), including 740 993 new arrivals since 25 August 2017. 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 (28 February 2019).

Figure 1 Demographic breakdown among FDMN (UNHCR population factsheet as of 28 February 2019) (n=908,840)



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 has 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 sector partners, serves an advisory role to the health sector coordinator based on priority needs. Since the start of 2019, the health coordination structure was formalized the following working groups, which meet on a regular basis:

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

In addition, coordination of support to the District hospital (Sadar) continues through the Sadar Roundtable meetings (one meeting held in reporting period) and upazila level health sector coordination continues (one meeting held in each Ukhia and Teknaf during reporting period).

A time bound emergency preparedness taskforce was activated in early March for monsoon and cyclone preparedness. All other ad-hoc issues not directly related to the above are addressed through health services strengthening taskforce under the health sector.

The health sector benefits from support of over 100 partners who have responded to the needs in numerous ways including through direct service delivery from primary, secondary and specialized 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.

2.2 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 0.4% of its needs.

2.3 Key coordination activities in reporting period

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. This was also a key recommendation from the external evaluation of health services. It is noted that fewer health facilities that qualify the minimum standard package and provide higher quality services is a preferable modality. For these reasons, the health sector initiated the rationalization process through an inter-agency task team, endorsed by the Civil Surgeon. On 29 January 2019, the health sector convened a half day workshop for this rationalization task team in which camp wise gap analysis was conducted. A total of 22 priority camps were identified for decongestion, and a scoring matrix was developed (partly based on the minimum service package) which will be used as the basis for recommendations for health facility closures and/or relocations. On 12 February, a follow up workshop was held in which the task team members were trained on how to score the health facilities and the rationalization scoring toolkit. Shortly after, the health sector coordination team briefed all Camp in Charges (CiCs) in the priority camps on the rationalization process, on a one-to-one basis to ensure adequate buy-in for the process. Once completed, the rationalization task team members proceeded with their field exercise

in which they scored each health facility in each priority camp (based on the agreed scoring criteria); conducted interviews with CiCs and obtained qualitative feedback from Rohingya refugees on their experience of health care provision in their respective camps.

Minimum service package and self-assessment

In late 2018, the health sector finalized a minimum standards document for health posts and primary health centers; outlining what services need to be provided. Further to this, the Health Sector launched an online self-assessment questionnaire, for all partners to complete and self-assess their own compliance with the minimum standards. This was accompanied by a training in January on the online tool as well as the minimum standards, to ensure adequate engagement by partners. Partners were encouraged to use the results from the self-assessment to develop 3-month action plans for improvement towards attaining minimum standards, and those who are unable to meet the minimum standards were given the option to volunteer to decommission their facilities.

Emergency preparedness

In February, the health sector conducted three meetings to review 2018 health sector monsoon and cyclone season contingency plan and have way forward planning process for 2019 health sector contingency plan. Two meetings were conducted for After Action Review, one among health sector and another among inter sectoral sector leads. The third meeting focused on sharing preliminary findings of After Action Review (AAR) and deciding the way forward for 2019 health sector emergency preparedness planning. Health sector will work with health sector partners, other sectors and ISCG to update and implement a robust 2019 health sector contingency plan. There are discussions with other sectors to also focus on having camp level plans.

Support to strengthening DHIS-2

DHIS2 is the National HMIS tool in Bangladesh, and the DGHS developed in 2017 a “FDMN server” for reporting by partners working in the Rohingya refugee response. The health sector is committed to strengthening the reporting and use of DHIS2 in this context in support of the DGHS. In response to concerns raised from implementing partners that the DHIS2 in its current state is not optimal, health sector initiated a review of the variable list and developed recommendations to improve reporting and usage of DHIS2 information in this response. This process involved wide consultation workshop with key stakeholders; technical review by SAG members, and field piloting the draft revised DHIS-2 variable list. A final draft, with recommendations, was submitted to the relevant Ministry of Health Authorities for review; pending endorsement.

2.4 Upcoming coordination priorities

There are several immediate and longer term upcoming priorities for the health sector in the next few months. First, the rationalization exercise will need to be concluded through a plenary workshop in which task team members and SAG members will develop a set of camp wise suggestions, to be submitted to the Government Authorities for further action. The sector must also draft a strategic plan for HIV/AIDS, starting with a technical workshop with the SAG members. To reduce avoidable deaths, much work is needed to improve the referrals systems. The health sector will continue its

efforts to address issues of referral funding support; referral documentation and forms; hospital coordination to ensure 24/7 emergency service availability; and blood availability. The referral committee, for review of exceptional cases, must be initiated at the earliest possible.

Regarding field coordination the health sector remains committed to improving quality of services through improved monitoring and strengthening field coordination. Two health sector field coordinators will join to support the coordination at Upazila level. Furthermore, the new camp health focal points structure is expected to be established in the next month, such that each camp will receive dedicated coordination support for one day/week to monitor health facilities; build linkages with other sectors at the camp level; strengthen two-way information sharing at the camp level; conduct basic monitoring of health activities; coordinate meetings with all relevant stakeholder at camp level; and collect field information to inform the response. These camp health focal points and field coordinators will receive an in-depth induction training.

Upon completion of the rationalization exercise, the sector will implement joint supportive supervision visits to all health facilities through inter-agency teams, in line with the Joint Response Plan commitments. These visits will cover different thematic areas including information management and reporting; Gender Based Violence; SRH and MHPSS and will provide feedback and recommendation to facilities on quality improvement measures.

In terms of information management, upon receipt of approval for the new DHIS2 variable list, the sector will support the rollout of this list through capacity building, monitoring reporting, conducting regular data reviews. Community based mortality surveillance will also be rolled out in the coming months, using EWARS platform to aggregate mortality data received from Community Health Workers. Partners will be trained on the tools and reporting platform. By generating alerts of mortality among women of reproductive age, maternal mortality surveillance will be strengthened. As part of the health sector's commitment to knowledge sharing, a workshop will be organized for partners to showcase best practices from the past year. In addition, the health sector will roll-out a new 4Ws reporting system to strengthen knowledge of service delivery in the camps.

Finally, the sector will develop and update its cyclone and monsoon preparedness plan in the coming months, with support of the different working groups.

3. HEALTH RISKS, NEEDS AND RESPONSE

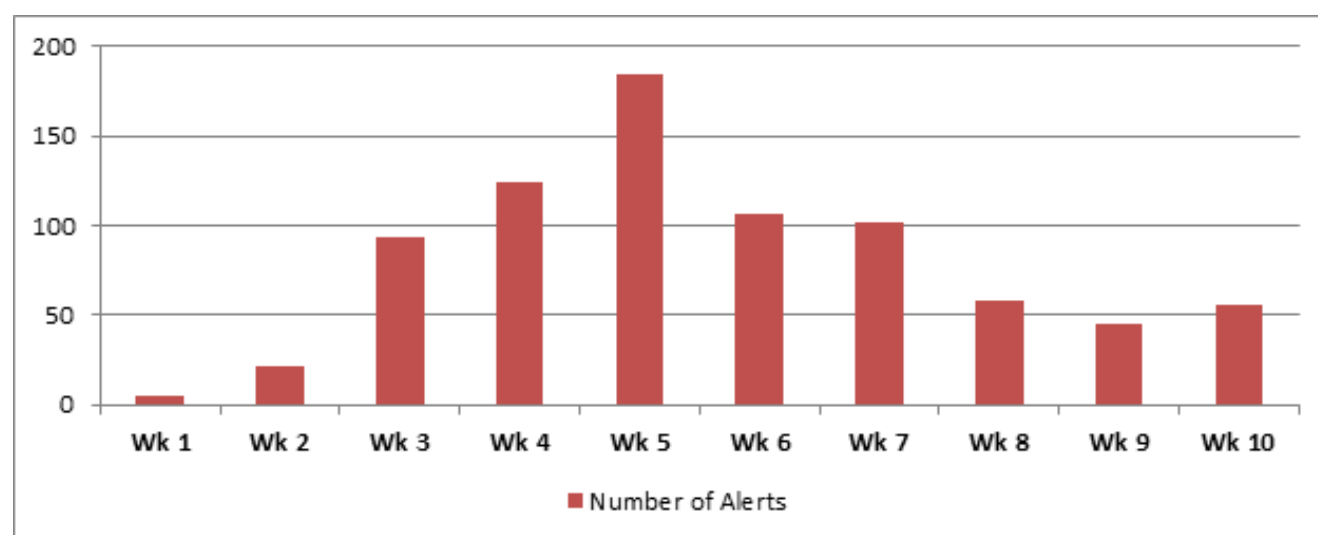
3.1 Epidemiology and Case Management

Surveillance

In total, 81% (171/212) 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 registered with the Early Warning, Alert and Response System (EWARS) for weekly reporting; while 19% are not registered. Of these sites, 118 submitted their weekly reports (67%) by 09 March 2019 resulting in a cumulative completeness of 76 % for 2019.

During the reporting period, an increased number of suspected varicella cases were reported through EWARS, in response to which suspected varicella was added to the EWARS disease reporting list. As of epidemiological week 10, a total of 714 843 consultations have been reported through EWARS since beginning end of December 2018. 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 cumulatively in 2019 were acute respiratory infections (ARI) contributing the highest percentage (14.9%), followed by suspected varicella (7.8%), acute watery diarrhea (AWD) (4.2%), unexplained fever (3.9%), other diarrhea (2.5%), injuries and wounds (2%) and bloody diarrhea (0.4%) and Suspected Malaria (0%). 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 827 alerts were generated from 30 December 2018- 09 March 2019 and 100% reviewed and verified. As indicated in the figure below, the number of reports increased in week 5 due to inclusion of Varicella in the indicator based system.

Figure 2 Total weekly alerts reported through EWARS from weeks 1-10 2019



The EWARS surveillance system is complemented by an ongoing project to strengthen laboratory surveillance. Through health sector partner support, laboratory capacity especially in the diagnosis of infectious diseases was increased with strengthening of the IEDCR Field laboratory at Cox's Bazar Medical College with addition of a new autoclave facility and distilled water plant. Work is ongoing to add a microbiology culture facility expected to be completed March. Reagents, consumables and equipment as per needs are being procured and supplied to both the IEDCR Field laboratory and the Sadar Hospital Laboratory to enable operations for the whole year of 2019 with the initial batch of these procurements already supplied. The IEDCR Field laboratory will be participating in a surveillance effort on the prevalent causes of unexplained fever given the high reporting on EWARS last year. This effort has been submitted, approved and supported by IEDCR, Dhaka and the laboratory has been equipped to do the tests defined in the protocol by incorporating capability to

carry out limited conventional blood cultures. A referral system has been planned and approved by IEDCR, Dhaka for the transfer of samples from health facilities and Sadar Hospital to the IEDCR Field Laboratory. This effort will allow better utilization of facilities. Rapid Diagnostic Test (RDT) kits, PPE for laboratories and other consumables like biohazard bags are being stocked and will be disseminated to laboratories at health facilities (camp level) as per requirement. This will ensure that the health facilities meet the requirements set out for laboratories in the Minimum Services for Essential Health Services document as well as prepare for the possible increase in infectious diseases during the monsoon period.

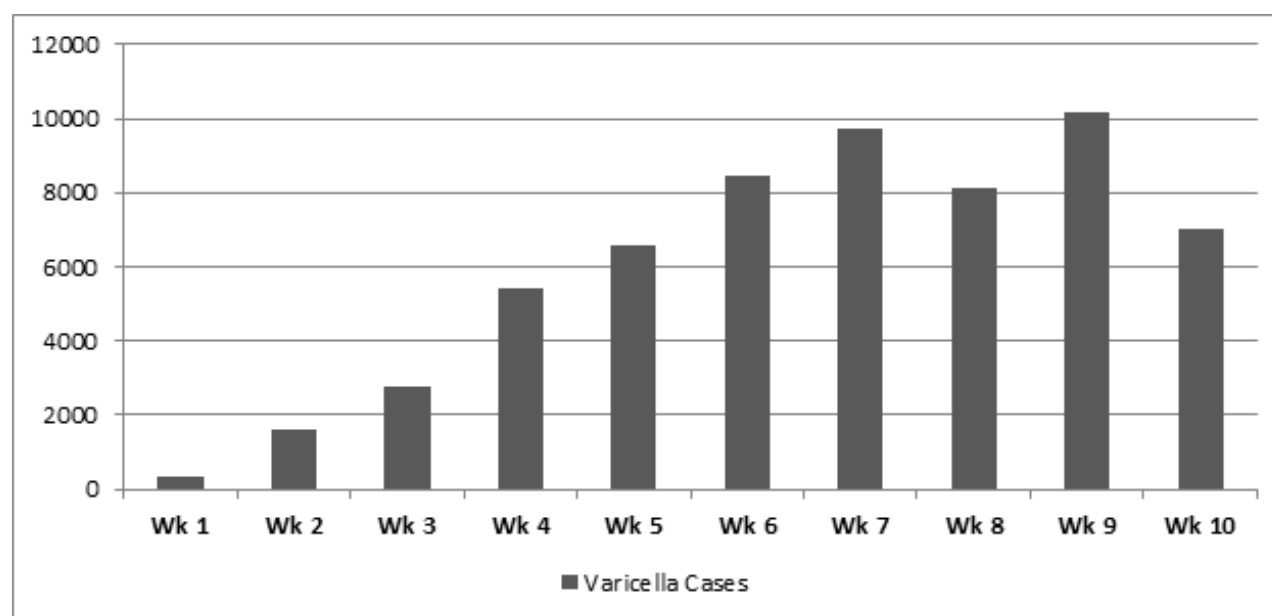
Immunization

Increasing immunization coverage among the host and refugee population 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). Since February 2018 the focus has been on routine EPI targeting children 0-23 months of age. This is being implemented through 804 outreach session sites monthly run by 67 outreach mobile teams (12 sessions in a month) consisted of 2 MoH vaccinators and 58 fixed sites (672 sessions) in-built in HFs run by different agencies by their own vaccinators across the camps. Since beginning of February 2018 to date, the following antigen doses were delivered to children through routine immunization: 53 932 BCG doses; 76 381 pentavalent doses; 78 797 Oral Polio Vaccine (OPV) doses; 74 788 PCV doses; 42 590 Measles/Rubella (MR) doses. Pregnant women are targeted for Td (40 183 doses delivered from February to date 28 February 2019).

Varicella

From late 2018 and early 2019, an increased number of suspected varicella cases were reported in EWARS. Total number of suspected cases reported in EWARS from week 1-10 2019 is 60 227 (of which 49.7% are under five and 50.3% are over five years) as indicated in the figure below.

Figure 3 Epidemic curve of suspected varicella cases among Rohingya refugees (W01 – W10, 2019)

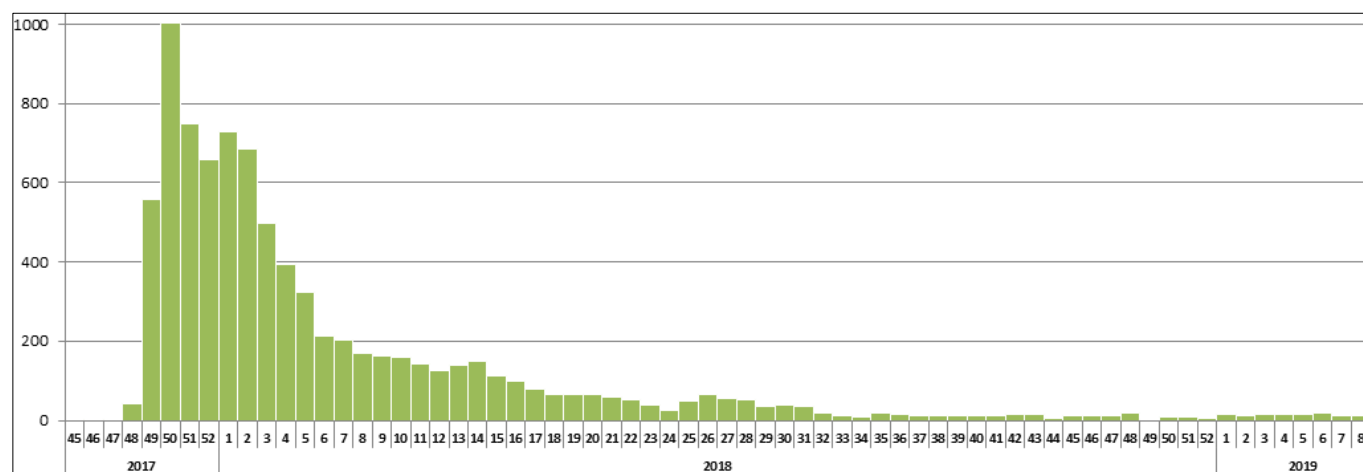


In response to the increased number of cases, several actions were taken, starting with an emergency meeting with health partners at Civil Surgeon Office on 3 January 2019 and followed by an inter-agency (WHO, MoH, DGHS & health partners) field investigation in the most affected camps to verify the alerts on the next day. Disease surveillance was strengthened by including varicella to the list of diseases under surveillance in EWARS and partners were requested to be on heightened alert of varicella disease and to report in EWARS. Risk communication materials (including posted and radio messages) were rapidly developed and disseminated to different target groups including community members, learning centers, and mosques. A simple one page guidance note for clinicians was finalized by the epidemiology and case management working group and was disseminated to health facilities along with a one-page map with information on referral sites for complicated cases/cases in high risk groups. Camp health focal points and immunisation field monitors received orientation on their respective roles and 197 healthcare workers were trained on triaging; clinical management of varicella cases; how to differentiate between measles and chickenpox; and EWARS reporting. A follow up field investigation visit was conducted by Institute of Epidemiology Disease Control and Research (IEDCR) after which a simple line-list template was shared with partners for daily reporting to IEDCR until end of February 2019. The community health working group conducted a Training of Trainers (ToT) for 182 supervisors (4 batches) of community health workers/volunteers (CHW/Vs) who in turn trained 1744 community health workers.

Diphtheria

While the number of Diphtheria cases has been steadily decreasing since the vaccination campaigns and with continuous contact tracing, there are still several cases reported each week as illustrated in the figure below. In 2019, a total of 128 case patients were reported in EWARS, all of which are managed by one Diphtheria treatment center.

Figure 4 Epidemic curve of diphtheria cases among Rohingya refugees (W45, 2017 – W09, 2019)

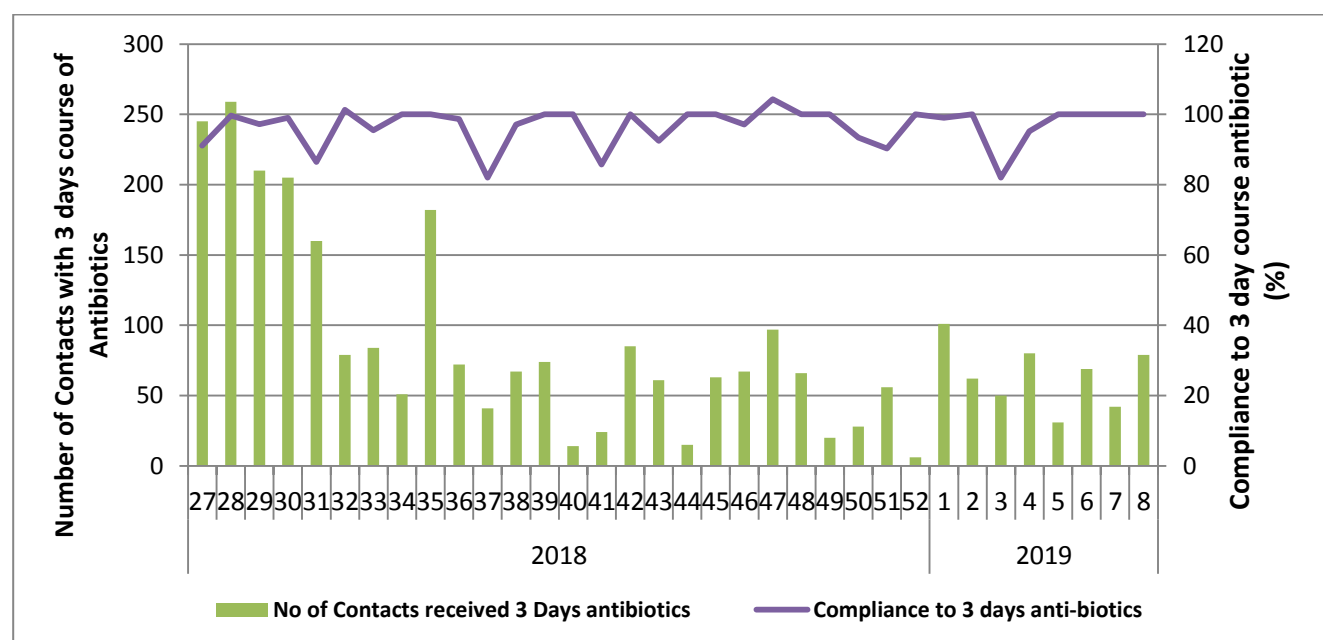


In week 09 2019, a total of 9 cases new diphtheria case-patients (all suspected) were reported bringing the cumulative total case-patients reported in EWARS to 8474. Of these, 294 case patients tested positive on PCR, with the last confirmed case reported on 12 February 2019. Of the remaining cases 2724 were classified as probable and 5456 as suspected. The total number of deaths remains

45 with the last death reported on 15 January 2019. A total of 208 case-patients were reported from host community since the beginning of the outbreak. Of these, 30 case-patients were confirmed on PCR testing while 65 cases were categorized as probable and 113 as suspected. No death has been reported from the host community.

The graph below indicates the compliance with three-day course of antibiotics for contacts of Diphtheria cases since directly observed treatment was introduced in July 2018. As compared to the average compliance of 79% from week 1-26, compliance continues to remain strong with an average 96.7% compliance during week 27 2018 to week 8 2019 as shown in the figure below.

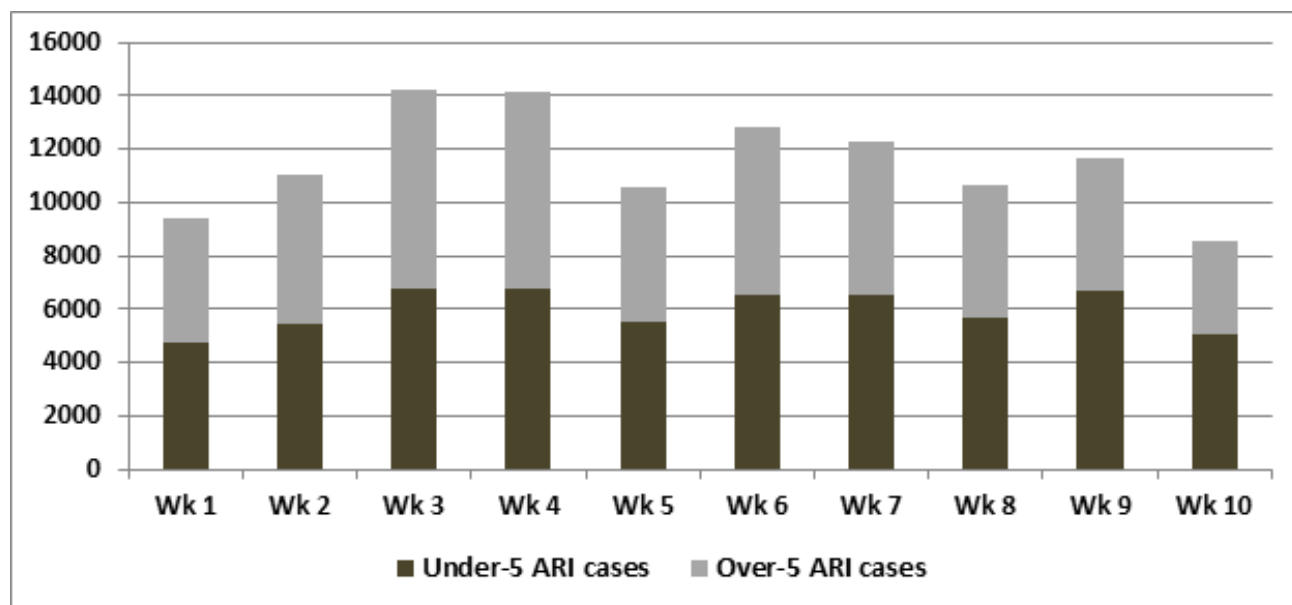
Figure 5 Diphtheria household contacts compliance with antibiotics from Week 27 2018 to Week 8 2019 (after DOT Implementation)



Acute Respiratory Infections (ARI)

Acute respiratory infections (ARI) remains the highest contributor both in under-5 (22.4%) and overall (14.9%) proportional morbidity. From week 1-10, total 115 435 ARI cases were reported, and no major fluctuations were observed. An assessment will begin in March to obtain prevalence estimates for ARI related diseases and estimate the level of transmission of influenza, vector borne diseases among Rohingya and host community population in Cox's Bazar, Bangladesh.

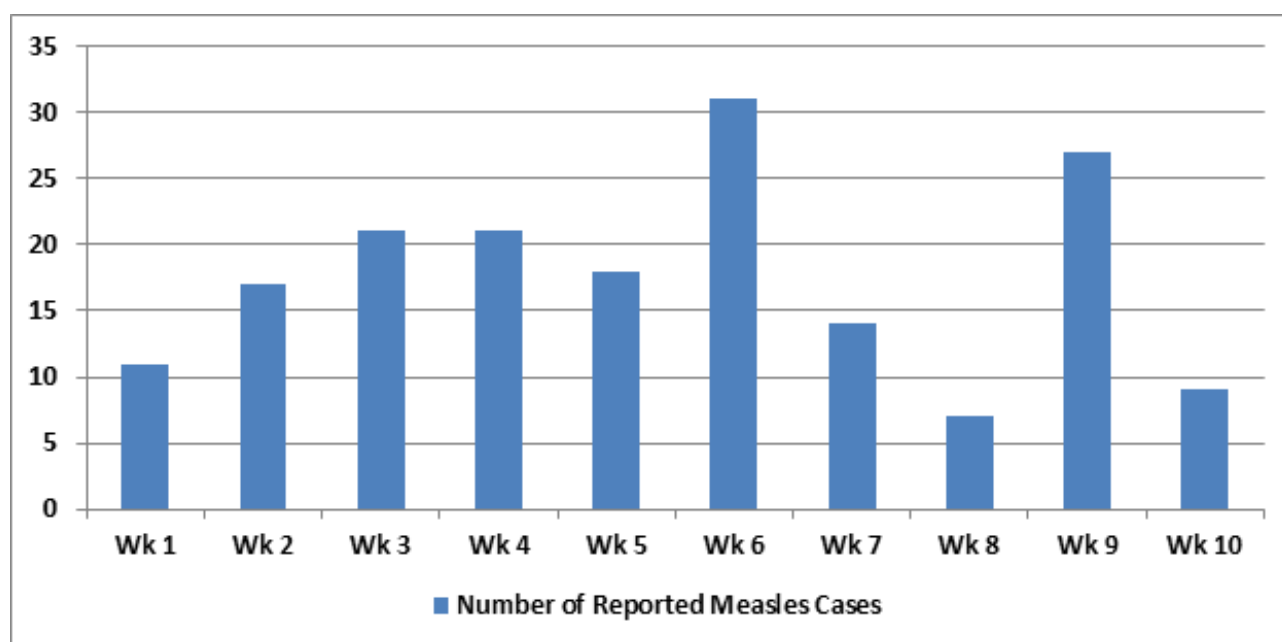
Figure 6 Number of Under-5 & Over-5 ARI cases reported among Rohingya refugees from week 1 to week 10 2019



Measles

A total of 176 suspected measles/rubella cases were reported in weeks 1-10 2019, with the trend indicated in the figure below.

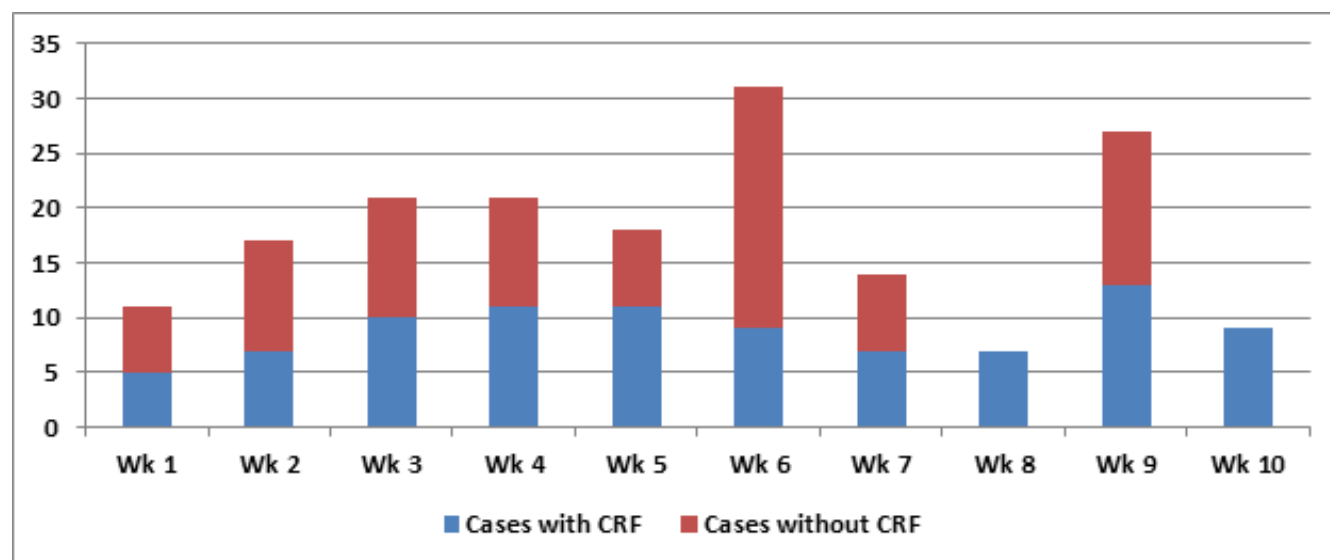
Figure 7 Trend of EWARS reported suspected measles cases among Rohingya refugees W01- W10 2019



National measles surveillance program has been expanded into the refugee camps since September 2018. Under this, all suspected cases are laboratory tested through the National surveillance system (in Dhaka) subject to completion of a case report form (CRF) in EWARS. Of the 179 cases reported in EWARS from week 1-10 2019, only 89 (51%) completed a CRF. Out of these, 65 were traced and 42 cases were laboratory tested. Of the 35 results available, 30 were laboratory confirmed negative, 1

was laboratory confirmed rubella and 4 were laboratory confirmed measles (other laboratory results are pending). Sample collection from the field remains a challenge, as does the compliance with the completion of CRF; however, improvement was observed in CRF completion in weeks 8 and 10 2019 as indicated in the figure below.

Figure 8 Suspected measles/rubella CRF completion in EWARS for W01- W10 2019



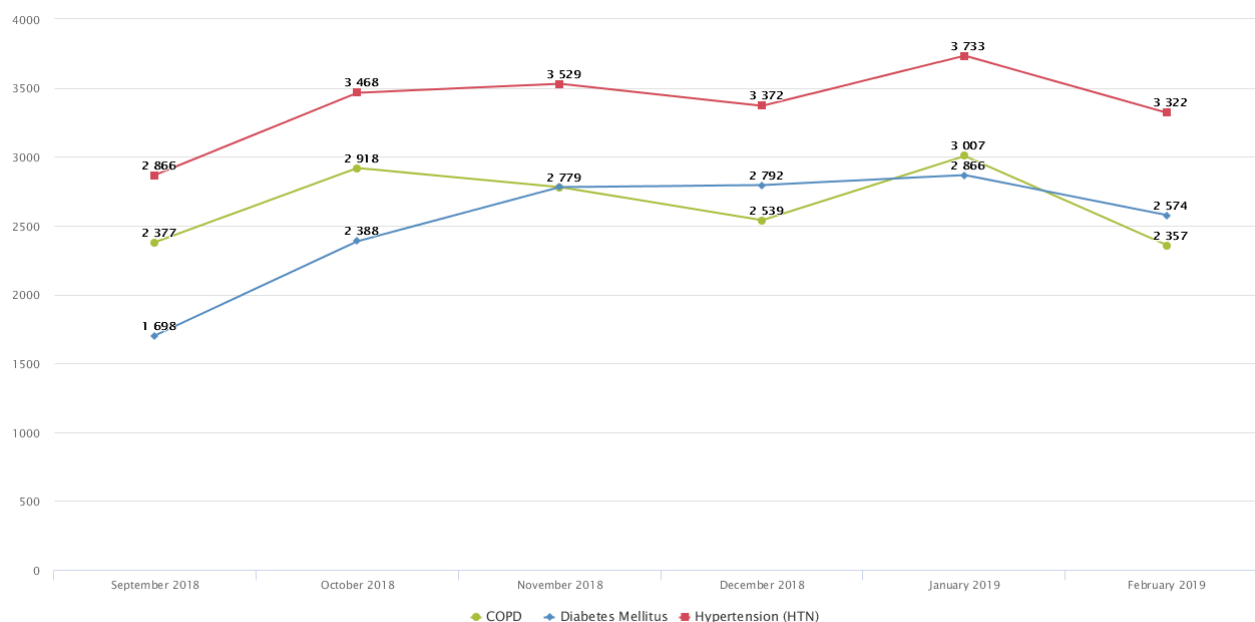
3.2 Mental Health and Psychosocial Support (MHPSS); Non-communicable diseases (NCDs); and other specialized services

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. In January 2019, both IOM and UNHCR started to lead the MHPSS WG and together with the group members, they drafted an annual work plan for the group. Three taskforces were launched to scale up mental health and psychosocial interventions; 1) MH-PHC integration taskforce, 2) tools translation and adaptation taskforce, and 3) emergency preparedness and response taskforce. These taskforces aim to provide operational guidance for organizations planning to integrate mental health interventions into primary health care services, translate and adapt psychometric tools and scales into local language, and draft & implement the MHPSS emergency preparedness and response plan for Monsoon related events. The WG is reactivating regular local coordination meetings at the field level to strengthen different level coordination mechanisms and to engage the affected communities in decision making about services provided.

The WG reached out to more than 50 organizations providing mental health and psychosocial support services to update the 4Ws mapping, and will keep updating it on quarterly basis. Also, the WG is planning to organize the first MHPSS conference in Cox's Bazar in April 2019, and will support the publication of a special section on Rohingya mental health in Intervention Journal during the second half of 2019.

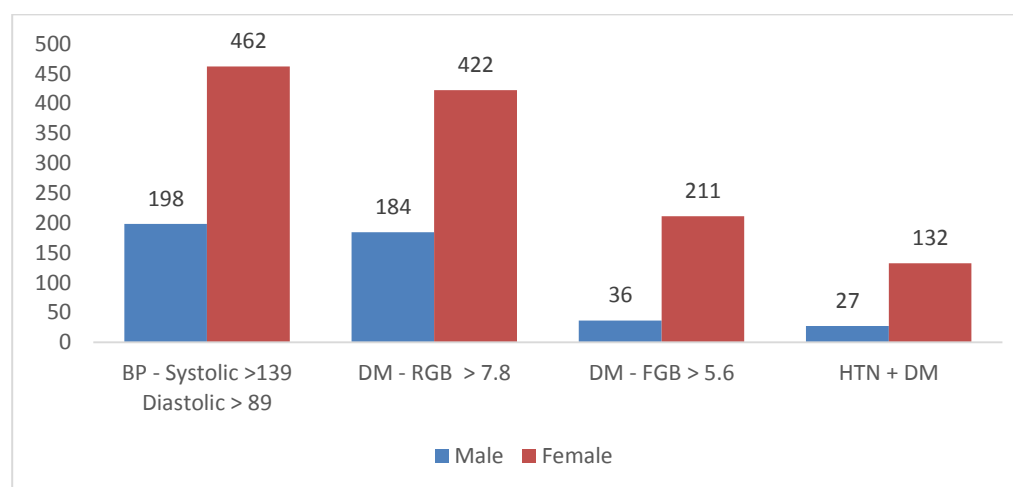
Regarding NCDs, reliable morbidity data is not currently available for the Rohingya refugee population. However, DHIS-2 data on hypertension, Diabetes Mellitus (DM) and COPD consultations among Rohingya refugees suggests that hypertension is the largest contributor to the NCD disease burden in this population, followed by COPD and DM. The morbidity trend has remained relatively consistent over the past 6 months, with a slight observed increase in January 2019.

Figure 9 Trends in NCD consultations from September 2018-February 2019



Data from HAEFA, USA one health care provider who systematically screens for NCDs in camps 1W and 9, shows a higher prevalence of hypertension than diabetes (n=10 992) as indicated in the Figure below. It should be noted that the observed higher prevalence among women can partly be attributed to a higher proportion of women seeking care (62% of outpatient consultations were women).

Figure 10 Patient status for NCDs from Camps 1W and 9



Regarding eyecare services, during the reporting period, 13 017 persons underwent eye screening, 3 139 received medicine for eyecare; 372 eye surgeries were performed and 2 026 spectacles were provided by the main eye care provider in this response (Orbis eyecare). The table below shows the breakdown by refugee and host community.

Table 1 Eye care services rendered by the main eyecare provider in this response

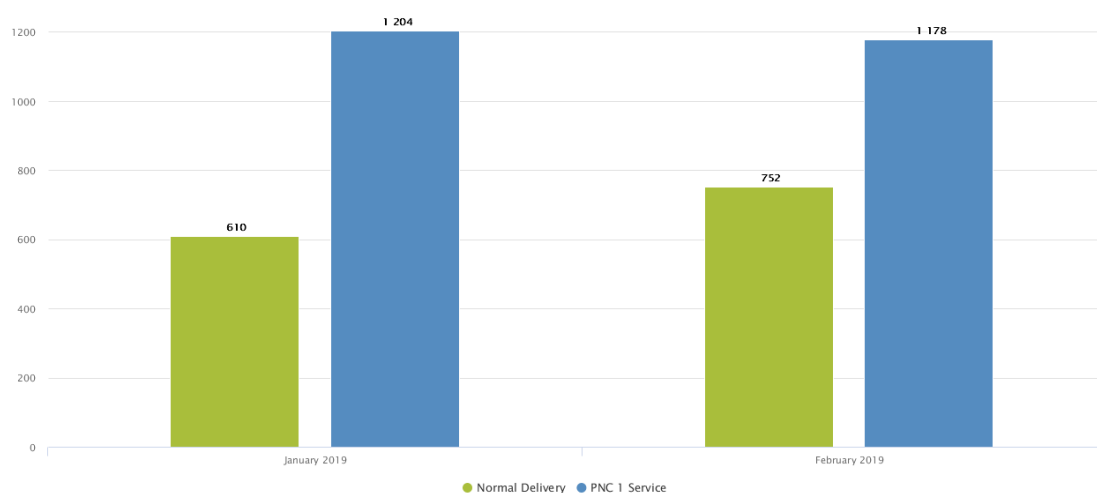
Number of people screened	Refugees	11,113
	Host Community	1,904
	Total	13,017
Number of persons received medicine	Refugees	1,898
	Host Community	1,241
	Total	3,139
Number persons received spectacles	Refugees	1,289
	Host Community	737
	Total	2,026
Number of surgeries performed	Refugees	297
	Host Community	75
	Total	372

3.3 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 services.

From the start of the crisis up to January 2019 , a total of 16,519 deliveries were reported from health facilities in the SRH WG data collection tool. While estimates on proportion of institutional deliveries among the refugees vary, the figure below from DHIS-2 shows higher numbers of first PNC consultations recorded than the number of live births (in both Ukhia and Teknaf) suggesting that large number of deliveries are taking place outside of health facilities.

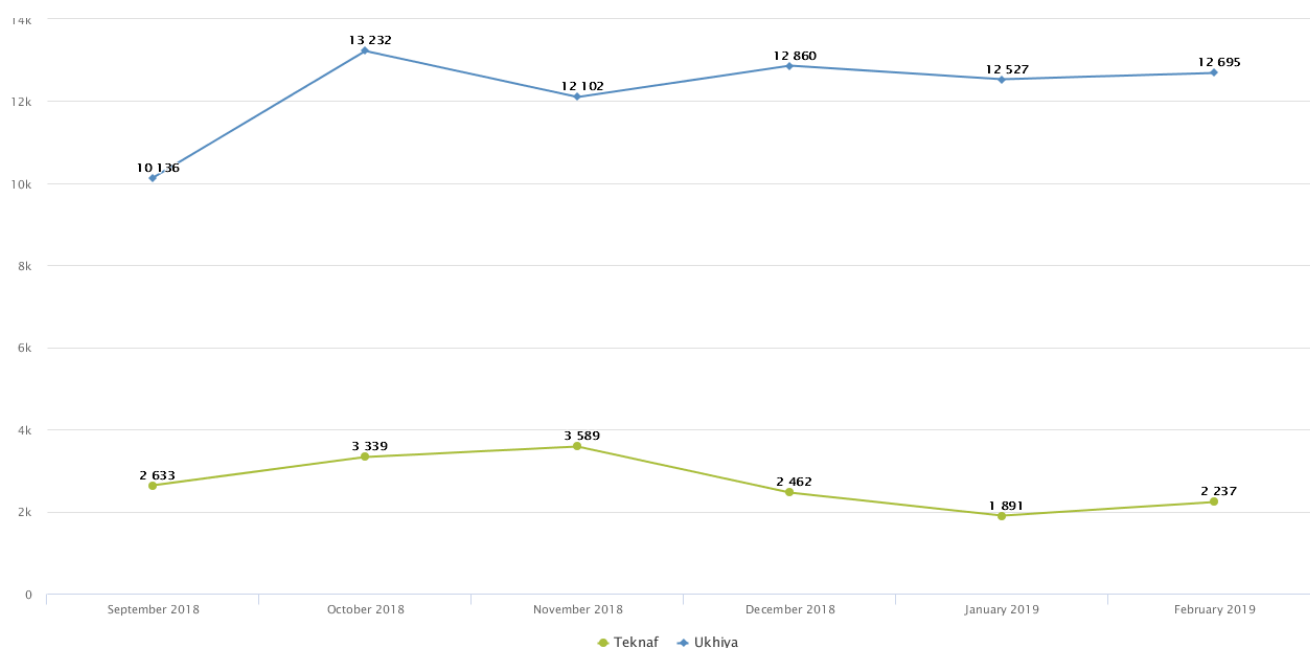
Figure 11 Normal deliveries vs 1st PNC consultations in DHIS2 FDMN server in January and February 2019 (total for Ukhia and Teknaf)



Attainment of the 2019 JRP target of > 55% of deliveries occurring in health facilities assisted by a skilled attendant will require considerable effort and better understanding of access barriers and demand-side barriers. Similar issues are present among the host community according to data from the January 2019 multi sector needs assessment (MSNA) in the host community which showed that 53% of children born in the past year who were delivered at home in Ukhia, and 68% in Teknaf (REACH, ACAPS, NPM).

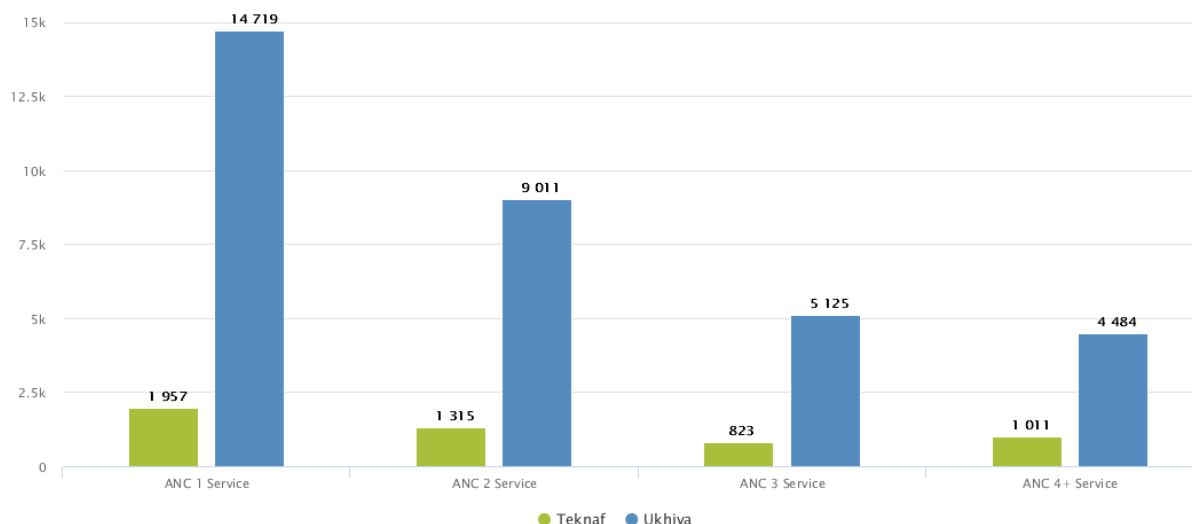
Regarding family planning, gaps in service provision and uptake remain. According to data from the recently conducted self-assessment survey, while 95% of primary health centers self-report to fully provide short-acting methods, only 58% self-report to fully provide long-acting methods (n=38). Similarly, 80% of health posts self-report to fully provide short-acting methods, while just 58% self-report to fully provide long-acting methods (n=108). In total, 90 221 family planning services are recorded from September 2018 to February 2019 in DHIS-2 from facilities serving Rohingya refugees. While the data (see graph below) may not be complete, it nevertheless shows sustained levels of family planning service provision in Ukhia, and slight decrease in Teknaf.

Figure 12 Family Planning services rendered in Ukhia and Teknaf, Sept 2018-Febr 2019, DHIS-2 FDMN server, Ukhia and Teknaf



Regarding uptake of ANC, total cumulative data from DHIS-2 for January and February 2019 (see figure below) shows clear progressive drop off in ANC visits in both Ukhia and Teknaf, suggesting that the number of pregnant women receiving the recommended 4 ANC consultations remains below standards.

Figure 13 ANC services recorded in DHIS2 FDMN server in January and February 2019, Teknaf and Ukhiya



To address some of the critical gaps, SRH Working Group (SRH WG) facilitated and completed the first round of inter-agency field monitoring visit in 2019. The primary objective of these assessments was to monitor the facilities and provide direct supportive supervision including suggested recommendations/actions, which could be taken to improve in identified areas. In the initial stage, most of the Primary Health Care centers (PHC) are targeted for supervision. A monitoring checklist was developed based on the minimal initial service package (MISP) and finalized after receiving feedbacks from the SRH WG partners. A total of 12 teams from inter-agencies were formed with a plan to monitor 15 PHCs in the camps. To date, 13 PHCs have been visited. The data is currently being reviewed and analyzed by the SRH Coordination team and a report will be compiled upon completion of analysis.

In a similar manner, a GBV monitoring quality assurance tool is being drafted under the health sector GBV project, to help address identified gaps in provision of clinical management of rape (CMR) and other GBV services. Several rounds of review and contextualization of the tool were undertaken jointly with the GBV subsector and child protection subsector, and a planning meeting was held with for the roll out of this tool in March, to assess and support all PHCs (who are expected to provide CMR).

Improved sexual and reproductive health community based messages and pictorials are being developed through jointly by the community health working and SRH partners, to support community health workers SRH-related tasks. In addition, a standard training module for ToT for community health supervisors is being developed for use in a series of planned trainings in April 2019.

Finally, the SRH working group has developed a training calendar which has been shared with SRH WG partners for inputs and review. The plan includes trainings on Emergency obstetric care, High risk identification in ANC and Long Acting Reversible Contraceptives (LARC). From early 2019 to date, three batches of STI trainings were completed for midwives along with one batch of LARC training for medical doctors.

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 working group responded quickly to the chicken pox outbreak by conducting a Training of Trainers (ToT) for 182 supervisors (4 batches) of Community Health Workers/Volunteers (CHW/Vs), which in turn allowed 697,010 community members to be reached with chicken pox messaging by CHW/Vs. The co-chair team assisted the health sector in conducting a rapid assessment in the field, and contributed to the standardized health messages (posters and FAQs) developed and distributed by the Health Risk Communication Task Force led by UNICEF.

The CHWG prioritized two training packages in the first quarter of 2019: SRH and data collection. The co-chair team collaborated with UNFPA to develop a comprehensive training package for CHW/Vs on Sexual and Reproductive Health (SRH), which will be delivered during April using the Training of the Trainer (ToT) model. CHWG piloted bi-weekly Kobo reporting during January and February. From January to March 10, the CHWs of reporting partners made 243,557 home visit carrying health education and promotion messages. Based on the pilot, working group mainstreamed the indicators through a consultative session, and conducted a feedback session with the M&E units of all CHWG partner agencies to fine-tune the tools. Data collection training will be held through March and April 2019.

The working group is actively coordinating with partners to minimize gaps and rationalize CHW/Vs. The mapping exercise conducted in late 2018 identified 1,782 existing CHW/Vs among partners. However, based on population targets (1:750), there is only need for 1,181 CHW/Vs. Several camps are being re-mapped to resolve the excess.

3.5 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. In total, 43 emergency health kits were distributed by WHO to health sector partners, 7950 Rapid Diagnostic Tests (Cholera, Dengue, Chikungunya and Malaria), 320 mosquito nets and 1200 oxytocin ampoules. In addition, 136,080 azithromycin tablets were donated to Civil Surgeon's Office. New additional supplies were received for health sector partners' use including 25 Personal deployment kits, 35 Defibrillators, 40 oxygen cylinders and 30 Trauma bags; 7 Trauma A kits, 6 Trauma B kits, 7 Surgical Kits, 8 sample collection kits to help fill identified gaps and as a contingency plan during the monsoon season. And Calamine lotion and other drugs for Varicella were ordered on a priority basis on 15th January in response to the Varicella situation. Meanwhile, to address the inevitable expiry of medicines, a mechanism to destroy expired drugs through a third-party agency was put in place and approximately 650 kg of expired drugs are ready to be sent to Dhaka for destruction. During the

reporting period, 612 Diphtheria anti-toxin treatments (DAT) were sent to support emergency response in Yemen, based on the identified need.

The health sector has prepositioned three containers stocked with essential medicines, for health sector partners' use in case of emergency. These stocks are continually replenished and a further five containers have been procured and land and permits preparations and underway for scaling up prepositioning within the camps. Finally, to strengthen 24/7 health care provision, generators and solar systems were procured for partners running 24/7 primary health centers. In total, twelve facilities were identified and assessments are completed now so installation will begin from March 2019.

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. During the reporting meeting, two meetings were held with important discussions and coordination outcomes to improve synergies between partners and UN agencies, for example to support each other in case of stock rupture.