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

Bulletin: Number 09
Date of issue: 20 May 2019
Period covered: 10 March-11 May 2019
Location: Bangladesh
Emergency type: Rohingya Crisis

Mobile Medical Teams training on First Aid as part of Emergency Preparedness

Contents

1.24 million People in Need for the Health Sector Response

911 359 Rohingya refugees in Cox's Bazar District

335 930 host community in need of humanitarian support

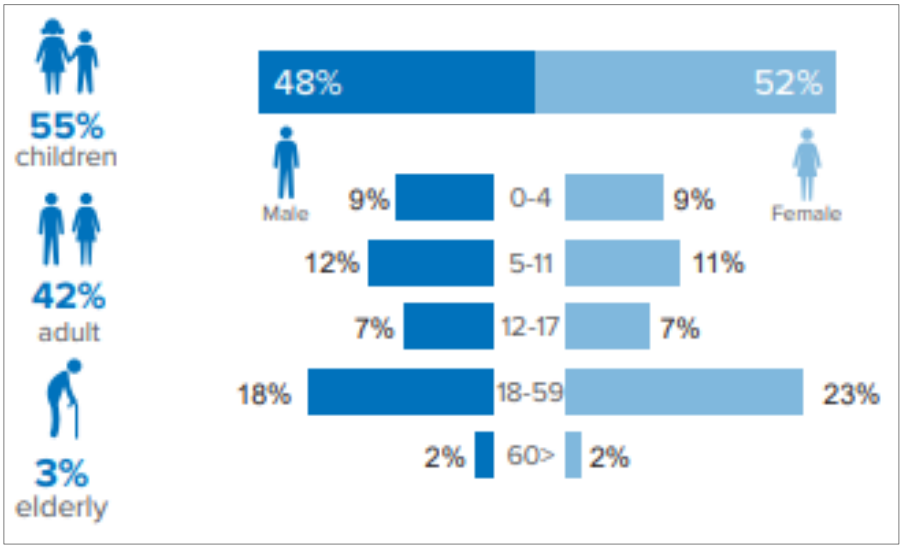
2 010 816 outpatient consultations provided in 2019

114 health sector partners

1. SITUATION OVERVIEW

As of end January 2019, the total number of Rohingya refugees residing in Cox's Bazar is 911 359 (ISCG situation report; April 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 (30 April 2019).

Figure 1 Demographic breakdown among refugees[1] (UNHCR population factsheet as of 30 April 2019) (n=910 357)



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. For 2019, the health is coordinated through the following working groups, which meet on a regular basis:

[1] https://data2.unhcr.org/en/documents/download/69298

- 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 (two meetings were 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, 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) and a first meeting was convened on 30th April 2019 with the main priority to conduct an NCD Service Availability Assessment by end of May, which will inform a baseline for further strengthening of NCD activities. The core group will meet monthly to take NCD related activities forward. Similarly, laboratory personnel of interested partner organizations are being 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 weekly meetings with the WASH sector to review data, identify priority camps for interventions, and develop joint action plans.

In addition, to promote integrated care and guide implementation of the actions, the health sector convenes a group of GBV, CP, SRH, Community Health and Mental Health and Psychosocial Support technical working group leads. The group met twice during this period to review action plans and responsibilities of each working group and have started the implementation process of the proposed actions.

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 period, two meeting 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.

The health sector benefits from the support of over 100 partners who continue to response to the needs of the affected populations. This includes 66 international NGOs, 39 National NGOs, 8 UN agencies, and 1 observer.

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 just 1.7% of its needs according to the financial tracking system. However, this likely represents an under-reporting of the true financial status of the sector, and efforts are ongoing to encourage partners to report their funding status to allow for more accurate reporting of funding gaps.

2.3 Key coordination activities in reporting period and upcoming priorities

Emergency preparedness and Cyclone Fani

In the reporting period, health sector undertook intensive contingency planning and convened four health sector emergency preparedness (EPR) taskforce meetings. Emergency preparedness and response was a standing agenda item for all health sector working groups meeting during this period. Health sector participated in the ISCG emergency preparedness process including participation to ISCG emergency and Preparedness (EPR) Working Group Meetings. A meeting was held with the military, to coordinate with their response readiness. The health sector contingency plan for 2019 was updated with inputs from all the relevant working groups and partners. Mobile Medical Teams (7 dedicated; 11 on standby from health facilities) were trained to support, triage, stabilize, refer and transport patients in case of disrupted or overwhelmed health services in the camps. MMTs were provided with Trauma bags and Personal Deployment kits. MMTs will be coordinated through the dispatch and referral unit (DRU)'s 24/7 hotline system for emergency requests. In case of need, 24 health emergency triage locations were pre-identified for mustering of the MMTs. Medical supplies were prepositioned in 23 locations in the camps (including in 5 containers; 12 warehouses and 7 Camp in Charge Offices), and locations of these were mapped and shared with partners. Community health workers are trained and aware of their roles and responsibilities during cyclone, flood or any emergency. These CHWs remained ready to bolster the immediate response until more advance support is provided. The EWARS hotline was active for reporting of disease-related incidents, in case of disruption of internet-based reporting.

In the first week of May, there was a warning for cyclone Fani and a local warning signal number 4 was raised, resulting in hoisting of the cyclone preparedness program (CPP) 1st flag in the camps and host community. In response, the health sector accelerated its measures to improve readiness. A 72-hour response plan was developed for each sector, in which the health response was a major priority. Relevant document and information was shared with partners; and a list or priority health facilities was shared with WASH sector for prioritized access to safe and clean water. The list of these facilities, which includes field hospitals, 24/7 primary health centers, and diarrhea treatment centers, was also shared with ISCG for priority access to the camps in case of access restrictions.

The Civil Surgeon's Emergency Operations Center was activated during the period of cyclone warning. Sadar hospital and Ukhia and Teknaf Upazila health complexes were asked to be on high alert. One Rapid Response Team, led by Deputy Civil Surgeon, was on standby. Ministry of Health and Family

Welfare deployed 89 medical teams for Cox's Bazar district (including 7 teams in Teknaf and 10 teams in Ukhia). Emergency room teams (6 members in each team) were on standby at Sadar Hospital.

In the end, Cyclone Fani did not make landfall in Bangladesh and the impact was very minimal in Cox's Bazar district. On 4th May the CPP 1st flag signal was taken down and normal operations resumed. Although no severe incidents arose, several lessons learned from this experience were noted and will be improved upon in the preparedness planning. The health sector EPR taskforce will continue to remain activated in the coming months and is continually improving the contingency plan, ahead of the monsoon season. Simulation exercises in the camps are being planned.

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 have now joined the health sector team to support coordination at Upazila level. In addition, the long-awaited new camp health focal points structure was established in May through support for 10 dedicated camp health focal points split between the IOM and UNHCR areas of responsibility. Through this new structure, each camp will receive dedicated coordination support for one day per 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 received a two-day induction training on their roles and responsibilities, the coordination structure (ISCG and health sector), information management and reporting requirements, site management sector, WASH, gender based violence, communication skills, minimum service standards; and the activities of the health sector working groups. Communication on this new structure has been shared with the Camp in Charges and it is expected that the coordination at the field level will be greatly improved.

Image 1 Induction of Camp Health Focal Points and Field Coordinators

Health systems strengthening on Gender Based Violence.

Under the global health cluster, the health sector coordinates implementation of a specialized project on institutionalizing and strengthening the capacity of health sector partners to coordinate and deliver Gender Based Violence (GBV) services. This is part of a multi-country project implemented in close coordination with the Sexual and Reproductive Health Working Group(SRH) and GBV and Child Protection(CP) sub-sectors.

The health sector developed a comprehensive plan of action to address critical gaps in health response to GBV. The priority actions aim at ensuring health related GBV services are available and accessible, and that referral pathways are understood and utilized by facility staff. One of the priorities in the annual plan is assessing the quality of GBV services in primary health care facilities using GBV quality assurance tool. The tool seeks to ensure that post GBV care is accessible, and available; essential infrastructure, equipment and services are in place, providers have appropriate training to deliver services, and relevant policies and procedures are followed. Several rounds of review and contextualization of the global GBV Quality Assurance tool were undertaken jointly with SRH, GBV and child protection sub-sectors, and the tool was piloted by the multisector team in two facilities. Full assessment by trained inter-agency teams is scheduled in late May 2019 targeting 24 primary health care facilities. Once completed, gaps and challenges identified will inform priority actions (including resource mobilization) for quality improvement in each of the facilities visited.

During the reporting period, the health sector coordinator and GBV officer participated in a three-day learning and knowledge sharing workshop on health systems strengthening in response to GBV held in Jordan from April 23-26, 2019. They were among 17 health cluster coordinators and their GBV counterparts from ten countries in the East Mediterranean Region (EMRO). Lessons learnt and recommendations from the workshop will be shared with health sector partners in Cox Bazar to complement existing efforts. Key among them; exploring other possible entry points for addressing GBV within the health sector such as family planning, outpatient facilities and immunization/vaccination.

Information Management and Operational research

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 of review of the variable list in early 2019, and developed a revised list which will better capture and inform on the mortality and morbidity situation of the affected population. This process involved wide consultation workshop with key stakeholders; technical review by SAG members, and field piloting the draft revised DHIS-2 variable list.

During the reporting period, this revised list was endorsed by the relevant Ministry of Health Authorities in early May, and a brief induction session was held for implementing partners’ reporting

officers, led by Civil Surgeon's Office, on 8th May 2019 for smooth transitioning into this new variable list. Tally sheets were developed by the health sector to facilitate reporting and aggregation of data at the field level. Detailed trainings for medical officers and reporting officer are planned for end of May 2019, and operational definitions for all variables will be developed. Reporting rates will be closely monitored, with the objective of attaining a robust HMIS system for this setting. Discussions regarding interoperability with other information systems are ongoing, for improved sustainability and to reduce reporting burden for partners.

To improve reporting on 'Who is doing What, Where and When' (4Ws), the health sector is transitioning from excel-based 4Ws reporting to an online reporting tool known as 'Report Hub'. This is expected to greatly improve the quality and depth of information reported on partners' activities for refugees and host community. A short pilot and feedback workshop was held on 30th April 2019, to introduce the tool to partners and adapt it to their needs. Partner feedback has now been incorporated into the tool and structured training and hands-on support are planned in the second half of May and in June.

To further strengthen information sharing of best practices, a knowledge sharing symposium will be organized by the health sector in early June 2019, with approval from the Civil Surgeon. This will be an opportunity for partners to present findings from their operational research initiatives. This will also serve as a forum to identify potential and promising research pieces for inclusion in a research supplement on the Rohingya refugee health response, in an academic journal. In preparation for this, a Q&A workshop was held on 7th May 2019 to support partners on abstract-writing and to address and queries or concerns regarding the upcoming symposium.

One upcoming activity for the health sector information management team is to participate in the ISCG 'facility barcoding exercise'. Under this exercise, each community infrastructure- including health facilities- will be '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. The health sector field coordination team will support this activity to ensure that all health facilities in the camps are tagged appropriately.

Medical Referrals

Strengthening the medical referrals system is an ongoing activity of the health sector. During the reporting period, considerable achievements were made in this regard. One of the key challenges has been that many partners running primary health centers do not have provisions to cover medical costs for emergency referrals to Government hospitals. To address this, an SOP was developed and approved whereby IOM and UNHCR financial support will be extended to partners who have no other provisions for referrals related to acute life-threatening conditions, according to the IOM and UNHCR areas of responsibility. This will be rolled out from 1st June. In addition, the health sector has printed standardized (non-duplicable) referral forms which will be distributed to partners. Meanwhile, the referral pathway was reviewed and revised by the SAG members, to clarify to referral options available

for emergency and non-emergency medical referrals. The field hospital rotation plan, which was piloted in early 2019 to ensure 24/7 availability of emergency obstetric/gynecological services, was reviewed and will continue to be implemented as a means of overcoming shortages in specialized human resources. The sector is planning to hold an orientation session on referrals with all camp in charges (CICs), to brief them on these relevant documents and processes.

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 in early 2019. This exercise, which was fully transparent to all partners, was completed in March 2019 and a workshop was held for all task team members and SAG members to review the findings from the field assessments. During this workshop, suggestions on which facilities to decommission were developed based on results from the objective scoring system and feedback from community and camp-level authorities, as well as geographic considerations. These suggestions were submitted to Civil Surgeon for endorsement, and were approved on 9th of May. The suggestions are now pending approval from RRRC after which they will be implemented in the coming months, towards achieving more equitable distribution of services and higher quality standards. An appeal process will be established, to allow partners to contest the suggestions of the rationalization task team.

3. HEALTH RISKS, NEEDS AND RESPONSE

3.1 Health Service delivery

The health sector partners are running 132 health posts in the camps; as well as 32 primary health centers of which 29 are running 24/7 services. Some gaps in PHCs persist, but additional health facilities are under construction or planned. From 1st January 2019 to 30th April 2019, more than 2 million outpatient consultations have been reported to the sector by more than 30 implementing partners. Among these, 35% were provided to males and 65% to females. Majority (69%) of these consultations were provided to children and adults aged 5 and above, and 31% 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.

Regarding eyecare services, during the reporting period, 14 129 persons underwent eye screening, 1957 received medicine for eyecare; 243 eye surgeries were performed and 1537 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 from 10 March-10 May 2019

Period: 10 March-10 May 2019		
Number of people screened	Refugees	7,899
	Host Community	6,230
	Total	**14,129**
Number of persons received medicine	Refugees	1,199
	Host Community	758
	Total	**1,957**
Number persons received spectacles	Refugees	1,251
	Host Community	286
	Total	**1,537**
Number of surgeries performed	Refugees	188
	Host Community	55
	Total	**243**

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 Epidemiology and Case Management

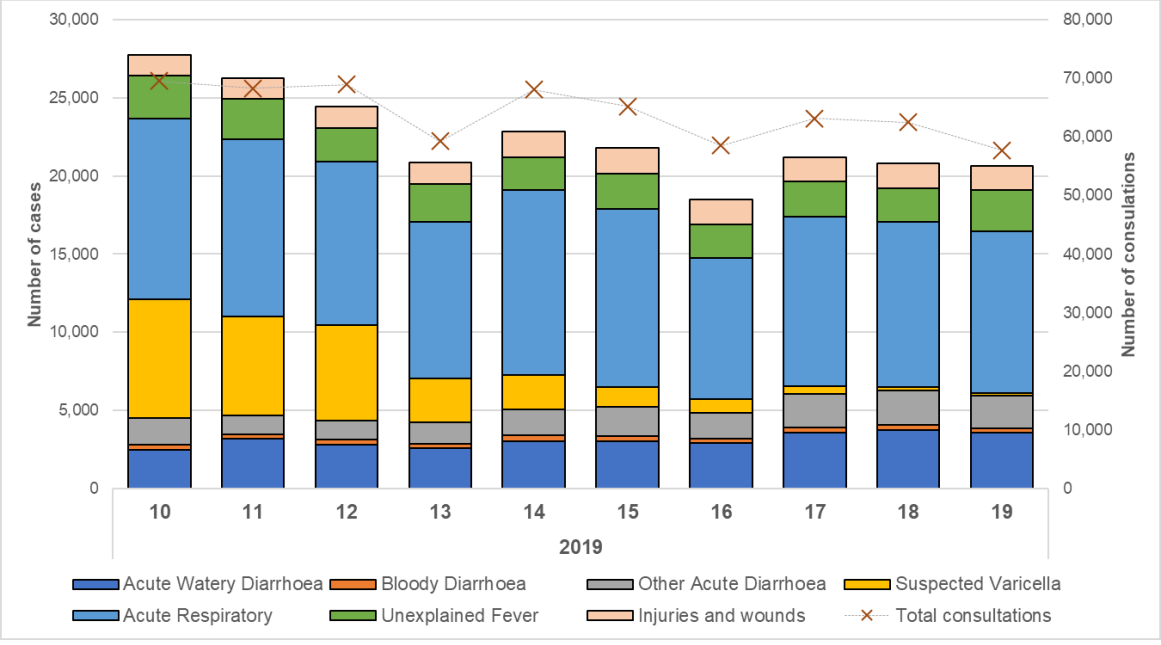
Surveillance

In total, 78% (152/196) 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 the remaining 22% are not registered. Of these sites, 120 submitted their weekly reports (78%) by 12 May 2019 resulting in a cumulative completeness of 87%, and 84% for timeliness in 2019.

Between epidemiological weeks 10 and 19, a total of 640 955 consultations have been reported through EWARS since start of March 2019. These included clinically defined syndromes of communicable diseases, vaccine preventable, vector borne and waterborne diseases. Only two diseases, malaria and confirmed dengue, require clinical testing to be reported. All others are reported through syndromic case definitions.

The majority reported cases cumulatively in 2019 were acute respiratory infections (ARI) contributing the highest percentage (16.8%), followed by acute watery diarrhea (AWD) (4.9%), suspected varicella (4.2%), unexplained fever (3.7%), other diarrhea (2.7%), injuries and wounds (2.3%) and bloody diarrhea (0.5%). Other less commonly reported illnesses included diphtheria, severe acute malnutrition (SAM), acute jaundice syndrome (AJS), measles/rubella, suspected hemorrhagic fever, confirmed malaria, meningitis, acute flaccid paralysis (AFP), adult and neonatal tetanus, suspected and confirmed dengue and other consultations. A total of 364 alerts were generated between 4 March 2019 and 12 May 2019 (epidemiology weeks 10 to 19), of which 100% were reviewed and verified with the required 48-hour timeframe.

Figure 2 Reported cases of majority reported conditions/diseases against consultations between weeks 10 and 19, EWARS



In the reporting period, the top five reported syndromes remain acute respiratory infections (ARI) (58.9%), followed by acute watery diarrhea (17.1%), unexplained fever (12.9%), other diarrhea (9.4%), and bloody diarrhea (1.75%). Disaggregation by gender and age reveals that females aged 5 years and above more commonly report experiencing unexplained fever (33.8%), acute watery diarrhea (32.8%) and other acute diarrhea (32.3%), while bloody diarrhea (60.4%) is more commonly reported in cases under the age of 5 years (see figures below).

Figure 3 Syndromic surveillance (reported cases) by (1) top 5 conditions, W10 -19, EWARS

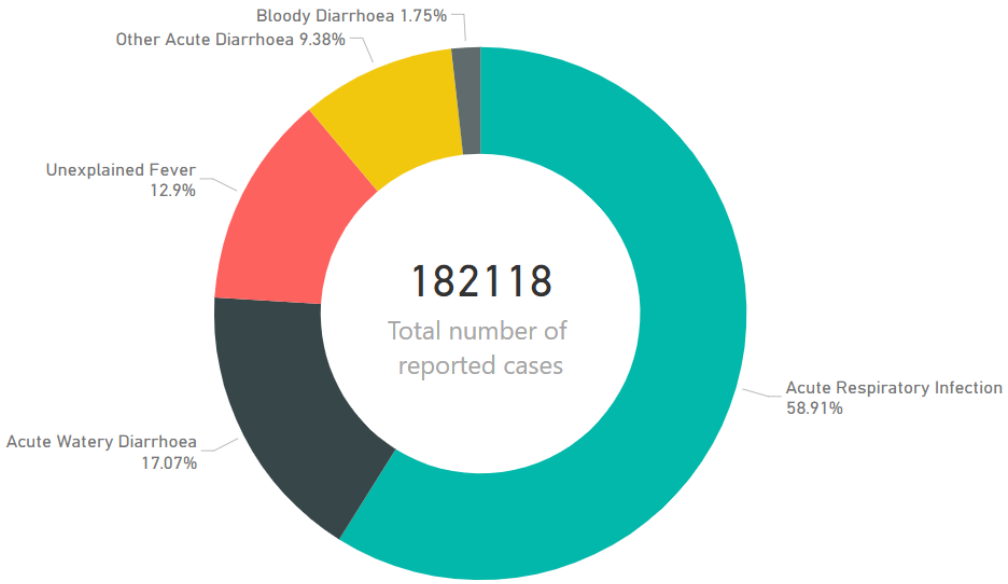
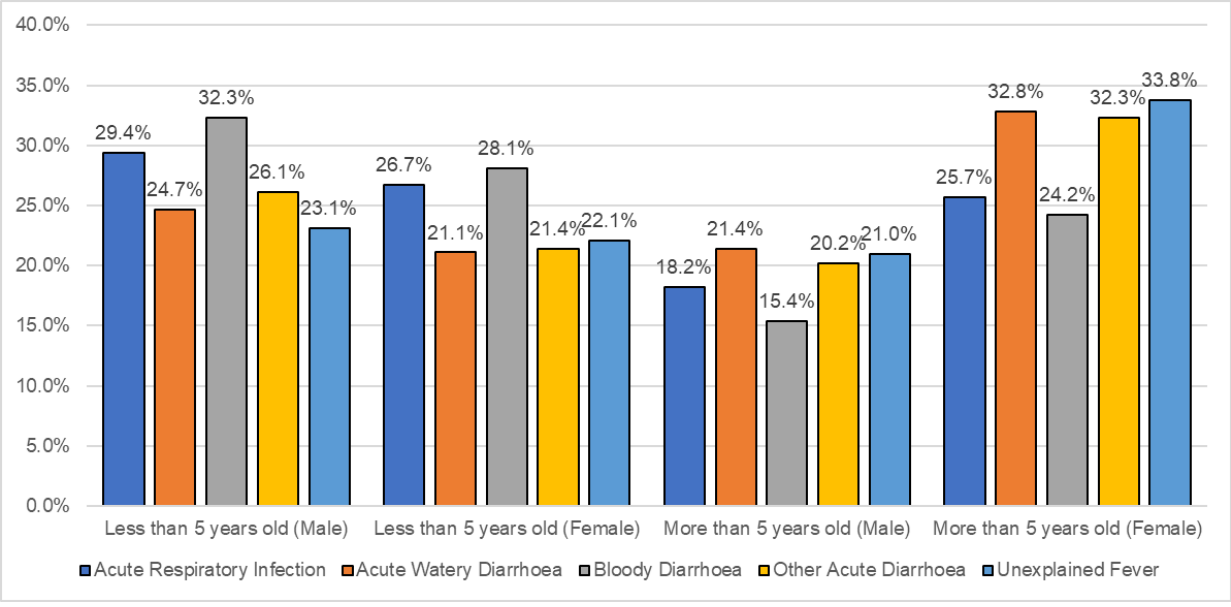


Figure 4 Syndromic surveillance (top 5 reported conditions) breakdown by age and gender between W10 -19, EWARS



The EWARS surveillance system (coordinated by WHO) is complemented by an ongoing project to strengthen laboratory surveillance. With support from partners, laboratory diagnostic capacity of IEDCR Field laboratory at Cox's Bazar Medical College was enhanced with addition of a new equipment. Training was provided for the staff on the provided equipment. Supplies to sustain operations at IEDCR Field laboratory and the Sadar Hospital Laboratory for 2019 was secured. The IEDCR Field laboratory, with partner support, embarked on a survey including testing of blood samples of patients with 'unexplained fever' to determine causes of infection. This effort was in response to surge in reported cases last year. This effort was supported by IEDCR, Dhaka which was equipped to carry out diagnostics tests for limited conventional blood cultures. With this, laboratories are better equipped to meet Minimum Services for Essential Health Services, where additional facilities will also be utilized to enhance disease surveillance in preparation for the monsoon season.

Measles

Between epidemiological Week 10 to week 19, 2019, a total of 101 suspected measles/rubella cases were reported. This is almost 50% less than the 179 alert cases reported between epidemiological period ranging from week 1 – 10, 2019. Most of the alert cases (86.2%) were less than 5 years of age and 53.5% were female. There were two peaks observed among reported cases, at week 12 and week 17, with 17 and 13 cases respectively, as shown in the figure below. Whereas some camps did not report any suspected measles/rubella case, camps 4, 16, 13, 8W and 2W reported 8 or more cases, with camp 4 reporting the highest number (17 in total). These camps need to be prioritized to ensure that the support to continue robust surveillance and subsequent response to any alert is provided. For the camps that reported zero cases for this period, there is need verify whether these were truly zero cases**.** 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. Out of 323 cases reported in EWARS from week 1-18 2019, Case Report Form were completed for 122 (41%) and 53 samples were collected (16%). Of these, 1 was laboratory confirmed rubella and 5 were laboratory confirmed measles (other laboratory results are pending).

Figure 5 Epidemic Curve of Reported Suspected Measles/Rubella, W11 – 19, EWARS

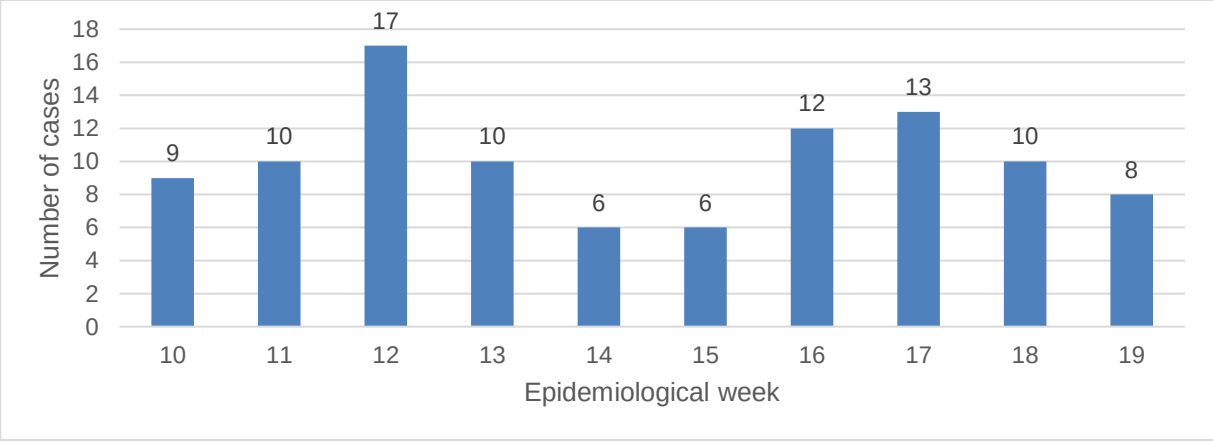
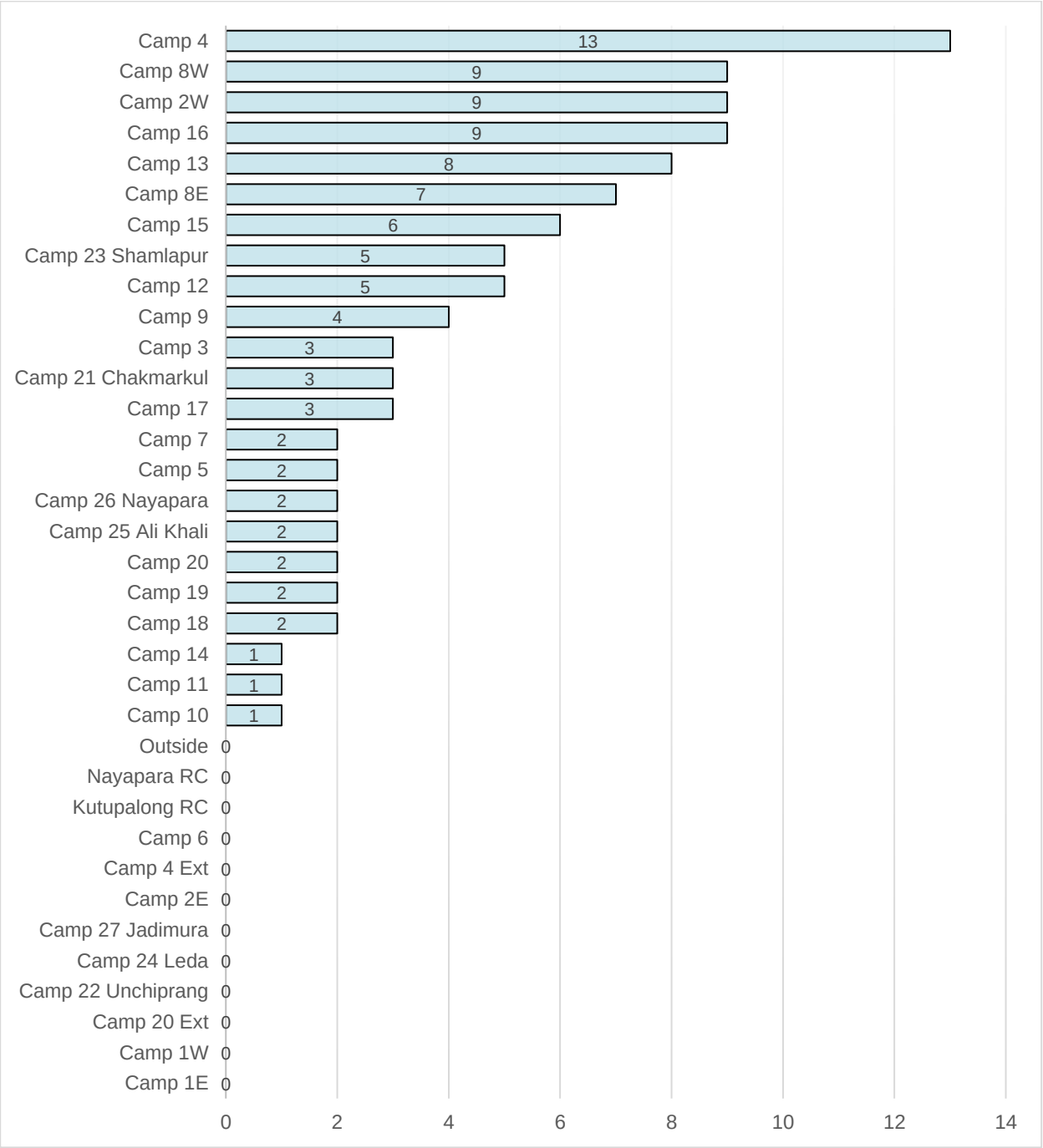


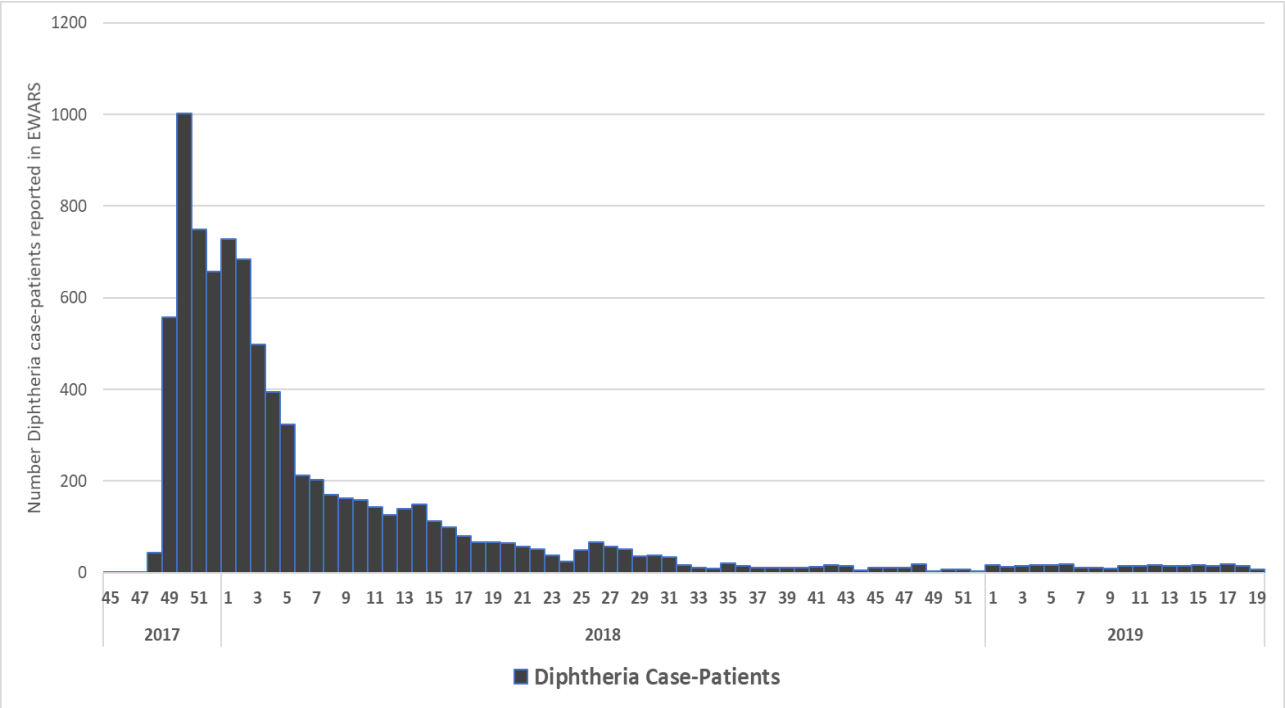
Figure 6 Suspected Measles/rubella cases reported by camp, W11 – 19, EWARS



Diphtheria

The number of reported diphtheria cases has remained consistent. Between week 10 and week 19, a total 139 cases were reported in EWARS which is similar in numbers for previous ten weeks (133 cases). Number of diphtheria cases reported since the beginning of the outbreak is illustrated in the figure below. In 2019, a total of 274 case-patients were reported in EWARS, all of which are managed by one MSF run diphtheria treatment center. Among them 3 were confirmed by PCR, 20 were reclassified as probable and others as suspected based on their clinical presentation.

Figure 7 Epidemic curve of diphtheria cases among Rohingya refugees (W45, 2017 – W19, 2019), EWARS



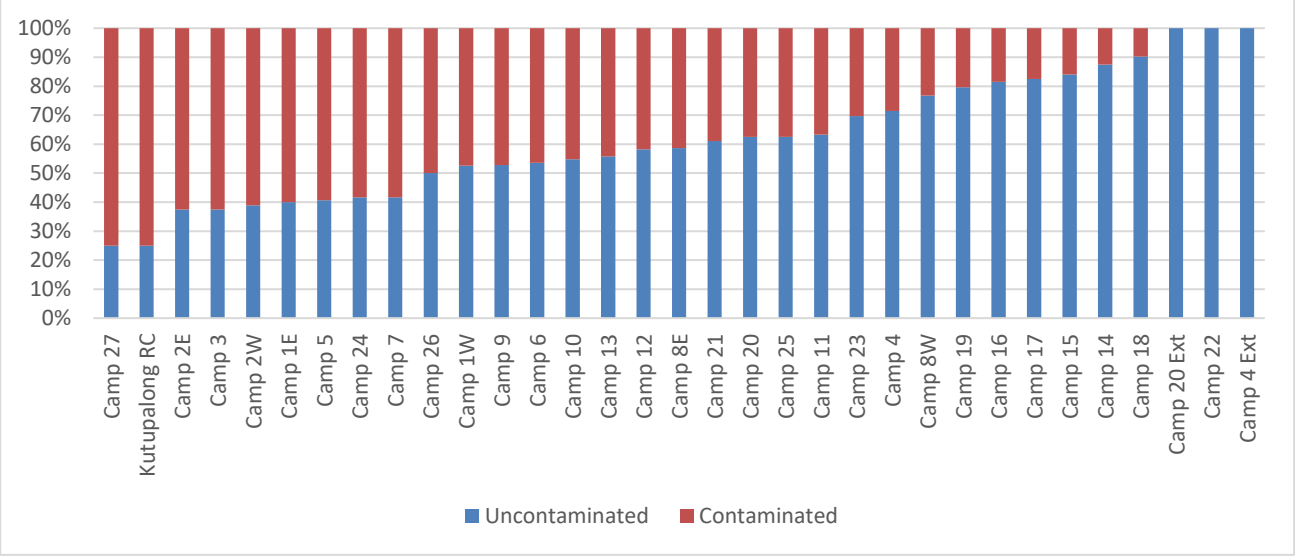
In week 19 2019, 7 new diphtheria case-patients (all suspected) were reported bringing the cumulative total case-patients reported in EWARS to 8 620. Of these, 295 case patients tested positive on PCR, with the last confirmed case reported on 3 April 2019. Of the remaining cases, 2 729 were classified as probable and 5 596 as suspected. The total number of deaths remains 45 with the last death reported on 15 January 2019. A total of 213 case-patients were reported from host community since the beginning of the outbreak. Of these, 30 case-patients were confirmed on PCR testing while 66 cases were categorized as probable and 117 as suspected. No death has been reported from the host community. As diphtheria case-patients are still being reported in the tail end of diphtheria outbreak, the Epidemiology and Case Management Working Group, along with partner agencies involved in diphtheria outbreak response activities, agreed to strengthen the outbreak response activities by implementing Go.Data software, a new outbreak tool developed by Global Outbreak Alert and Response Network (GOARN). This software will enhance and strengthen diphtheria contact tracing activity and visualization of the chains of transmission for cases. Training and workshops were organized to build capacity and sensitize the partners on Go.Data. This is the first time that Go.Data has been implemented in the field. Currently Go.Data is being piloted with two partners in the field for diphtheria contact tracing.

WASH

The 10th round of water quality surveillance in the refugee camps (WHO-UNICEF-DPHE) started on 2nd April 2019 and ended at 29th April 2019. A total of water 5280 water samples were collected and analyzed, including 1320 unsterile sources, 1320 sterile sources and 2640 household's storage water samples. The analysis of 1320 unsterile source water samples showed that 66% are free of E. Coli

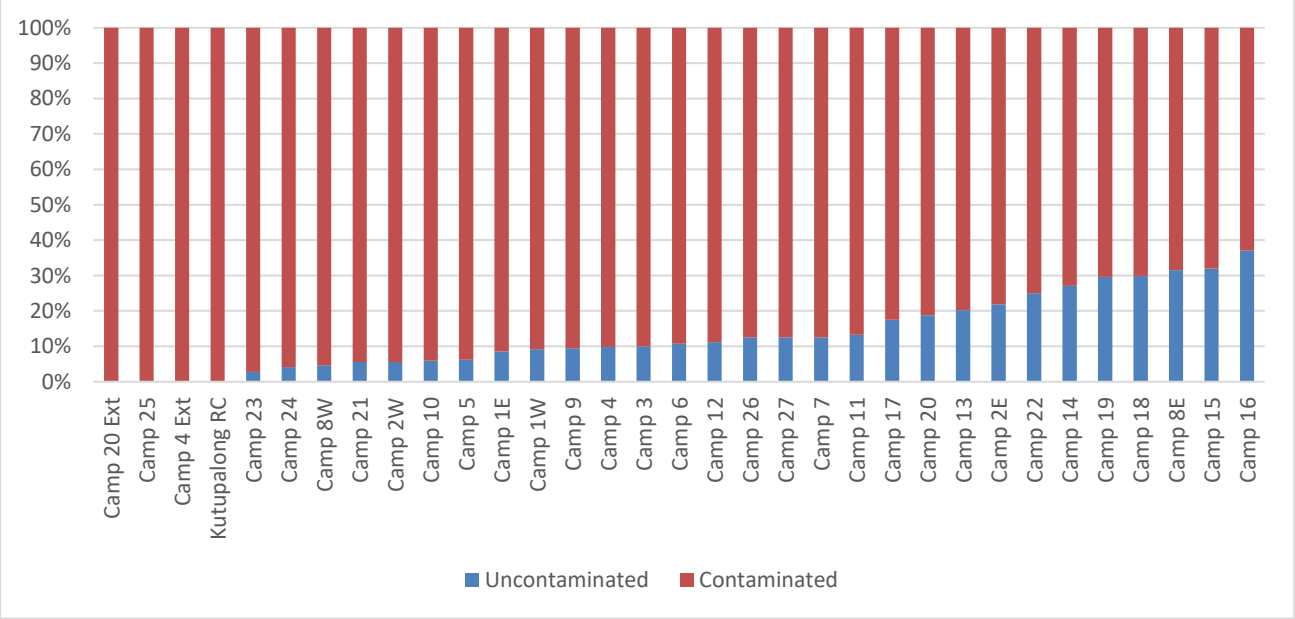
contamination and matched the WHO guideline value as well as the Bangladesh standard. See figure below for camp wise distribution.

Figure 8 Camp wise contamination from source water samples (n=1320)



By contrast, analysis of 2460 household stored water samples shows that only 17% are free of E. Coli.

Figure 9 Camp wise contamination from household water samples (n= 2460)



Significant efforts to improve WASH at the household level are needed. The health sector and WASH sectors are collaborating closely, particularly ahead of the monsoon season. Investigation of acute watery diarrhea are coordinated through the health and WASH 'Joint Assessment Teams' for investigation and response actions. Further training for health and WASH partners are planned later this month, to strengthen this mechanism.

3.3 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) 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 completed the first 4Ws MHPSS mapping for 2019 which was shared widely on April 1st including input from 37 organizations. The next updated version will be shared on June 1st with the aim of reaching and including more MHPSS actors. Also, the WG launched a new taskforce "Child MHPSS taskforce" which aims to strengthen the child focused MHPSS activities and support partners to scale up their child focused activities.

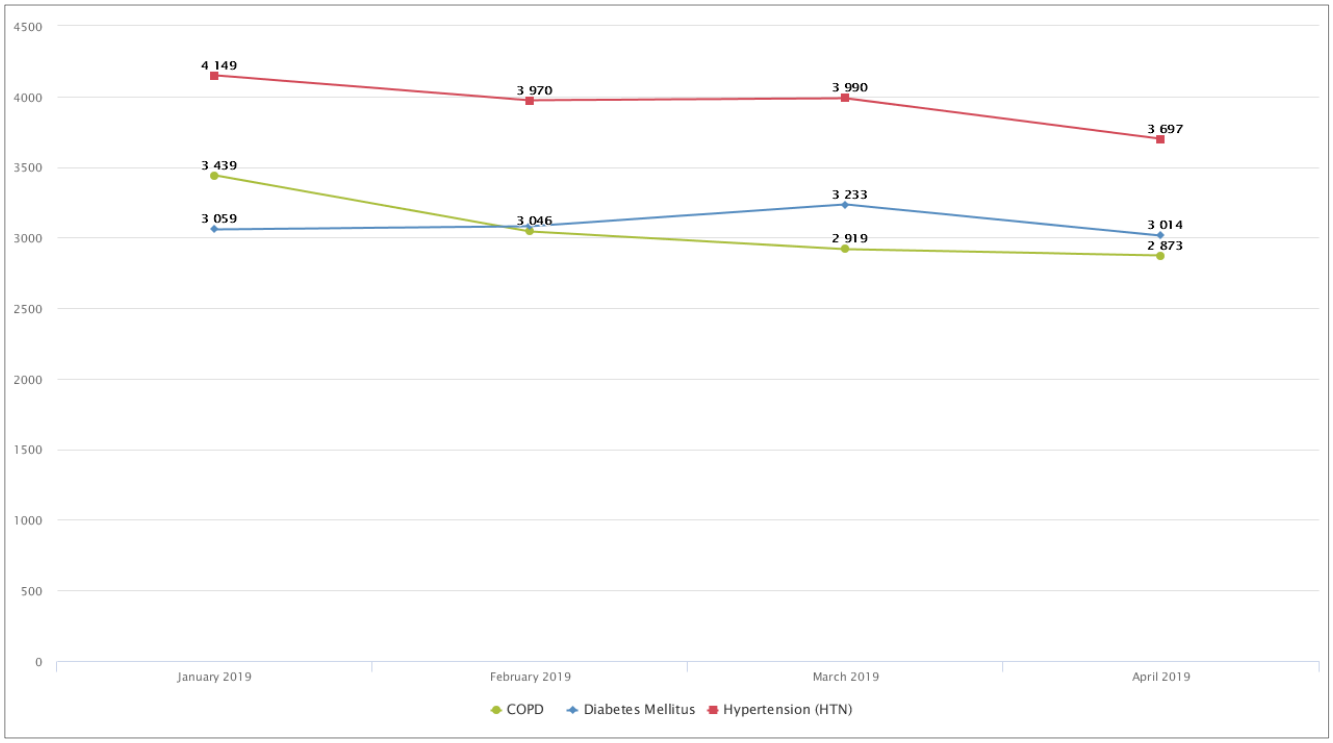
An MHPSS Emergency Preparedness and Response Plan was launched with participation of WG members. This EPRP includes several activities such as developing guidance notes, capacity building activities, field level coordination. EPRP is followed by a dedicated taskforce under the MHPSS WG, and runs in close coordination with the health sector EPRP taskforce.

A special issue of the journal of intervention on MHPSS for Rohingya refugees is planned to be published in November this year, and the call for abstracts returned 42 abstracts from different organizations and institutions in Bangladesh. The deadline for full papers submission is May 15th after which the peer review process will commence.

To strengthen the effort to integrate mental health services into primary health care, a first batch of mental health Gap Action Programme (mhGAP) training for health workers took place in early May. Participants were from Sadar Hospital and from Ukhia, Ramu and Moheskhali Upazila health complexes as well as 6 partner organizations. This training is the first of a series of four trainings, towards attaining the target of having one mhGAP trained health care worker in each of the PHCs.

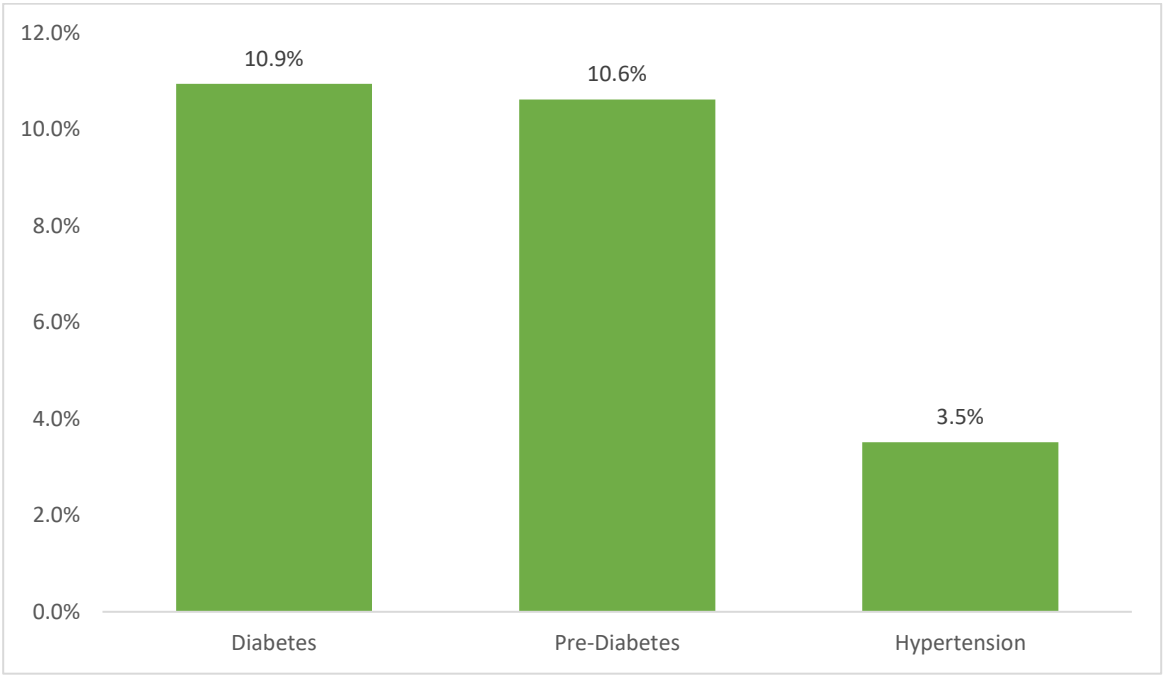
Regarding Non-Communicable Diseases (NCDs), reliable morbidity data is not currently available for the Rohingya refugee population. However, DHIS-2 data on hypertension, Diabetes Mellitus (DM) and COPD consultations among Rohingya refugees (see figure below) suggests that hypertension is the largest contributor to the NCD disease burden in this population, followed by COPD and DM (although the difference between these two is not large). The morbidity trend has reduced slightly for all three diseases from January until April 2019. Gaps in NCD service provision include availability of insulin, laboratory capacity to diagnose NCDs, knowledge gaps among health care providers, and systematic registering and recording of NCD cases at the health facility level.

Figure 10 Trends in NCD consultations as reported in FDMN DHIS-2 from January-April 2019 (Teknaf and Ukhia combined)



Data from HAEFA, USA one health care provider who systematically screens for NCDs in camps 1W and 9, shows (n=9 338) is presented in the Figure below. In contrast to DHIS-2 data, prevalence of diabetes among this cohort of screened patients is 10.9%, and pre-diabetes is 10.6%, whereas diagnosed hypertension was just 3.5%.

Figure 11 Prevalence of Diabetes, pre-Diabetes and Hypertension among screened patients from Camps 1W and 9



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 focused on enhancing community awareness on sexual and reproductive health services, preparedness for the cyclone and monsoon season and data management. Two Training of Trainer (ToT) courses on SRH were conducted for 44 participants. Trainers will subsequently provide training to CHWs to foster good SRH practices at community level, enhance uptake of SRH services and skilled delivery attendance at health facilities.

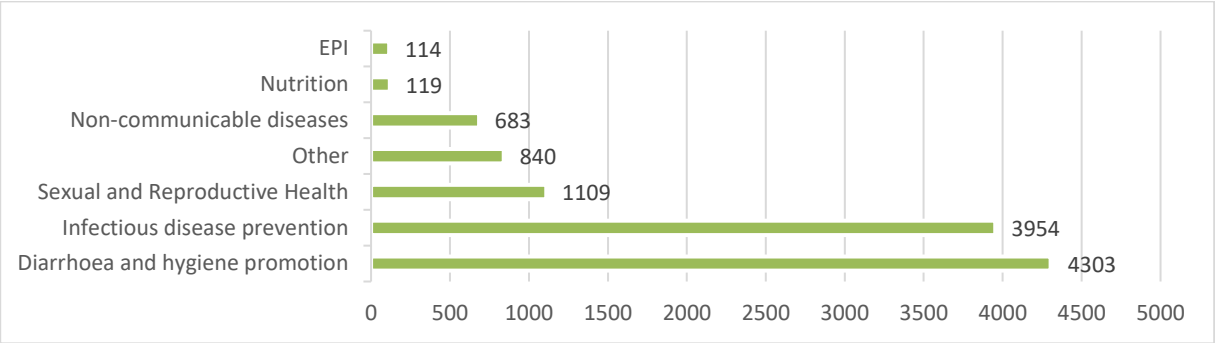
Community Health Workers play an important role in preparedness and response during monsoon and cyclone season. The working group, together with all partners, developed a guidance note to clarify the role of CHWs in emergencies. Key tasks after an event such as a strong storm or cyclone include first aid including psychological first aid (PFA), onward referral of patients, hygiene promotion and diarrhea prevention and response as well as community surveillance. Additional specific support to families whose shelter is damaged include information sharing in communal shelters and families' new homes to link refugees to the right health services. A ToT on First Aid and PFA was conducted for 39 trainers (medical staff) who will now train the CHWs. As a next step in emergency preparedness, CHWs will participate in emergency simulations in the camps which will be conducted by site management sector from the second half of May onwards.

To strengthen information management and enhance evidence based programming, the CHWG developed a reporting tool which was piloted in January and February 2019. Following the initial pilot, a workshop was conducted in March to review and revise the tools. This was followed by a series of data management trainings for all community health partners, which were attended by 110 participants. Regular reporting has been in place since April, and reporting rate is slowly increasing with 38 out of 91 reporting sites sharing data (41.2%). The WG team is reaching out to partners to enhance reporting adherence and will provide additional support sessions in the second half of May to boost reporting rate and frequency.

From available data, CHWs visited 135 428 houses during the reporting period, and 11 193 health promotion sessions were provided for 115 702 refugees. Details on the types of sessions conducted are provided in the figure below.

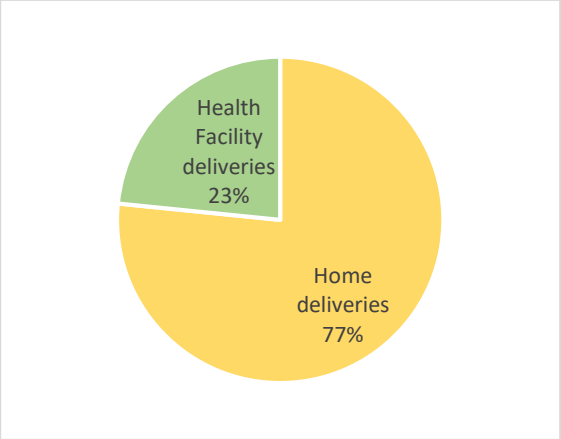
Identifying refugees in need of health and other services is among the key tasks of CHWs. During the reporting period, a total of 22 792 refugees were referred and linked to different services.

Figure 12 Number of health promotion sessions conducted by CHWs, by type (n=11 193)



CHWs also recorded a total of 731 deliveries in the months of March and April, of which only 23.4% were conducted in health facilities.

Figure 13 March and April 2019: Home vs Health Facility deliveries (n=731)



Another key activity for the CHWG in 2019 is to review existing IEC materials and develop additional materials were gaps exist. As a first step, an IEC fair was held on 9th May, to review jointly existing materials of all partners. A variety of materials around SRH, EPI and hygiene promotion exist, however key gaps were identified such as lack of materials on non-communicable diseases.

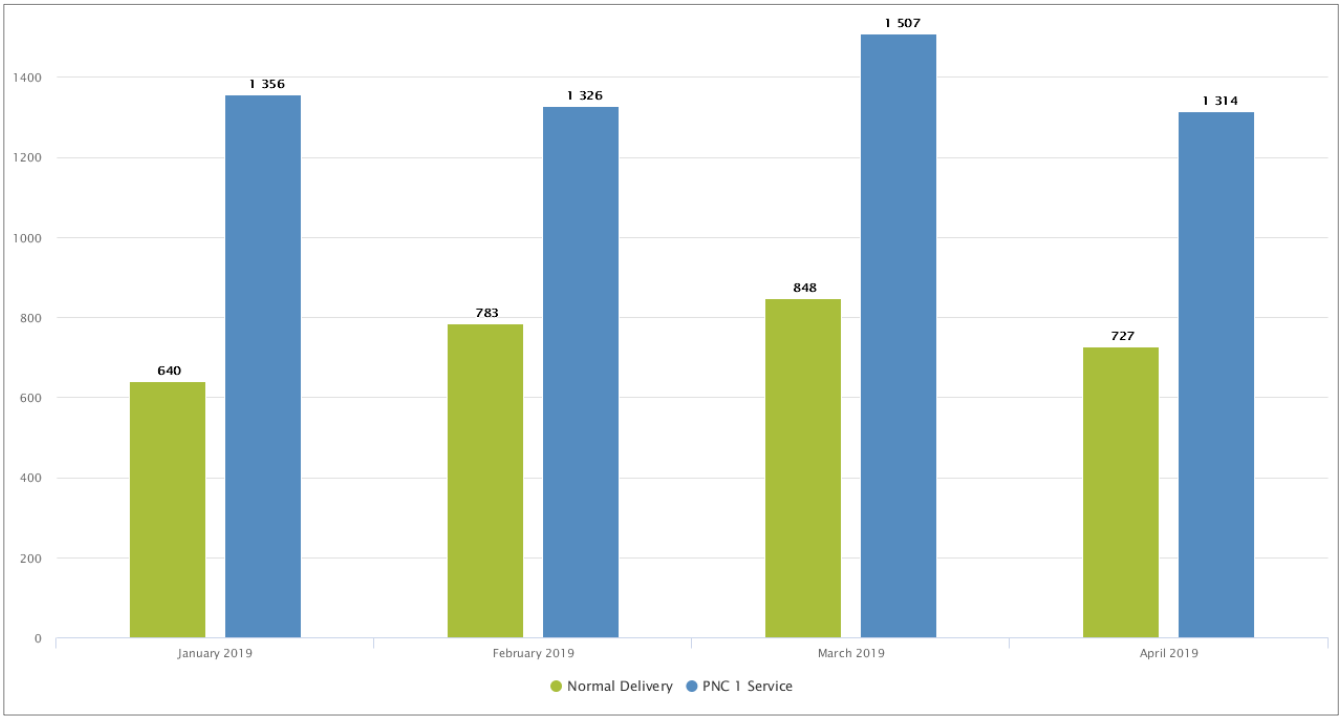
Image 2 Health IEC fair organized by Community Health Working Group

3.5 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 (previously mentioned).

In quarter one of 2019, a total of 3960 live deliveries were reported from health facilities using the SRH WG data collection tool. While estimates on proportion of institutional deliveries among the refugees vary, but are known to be low. This is supported by data from the FDMN DHIS-2 which consistently shows higher numbers of first PNC consultations reported than the number of live births (in both Ukhia and Teknaf), see figure below.

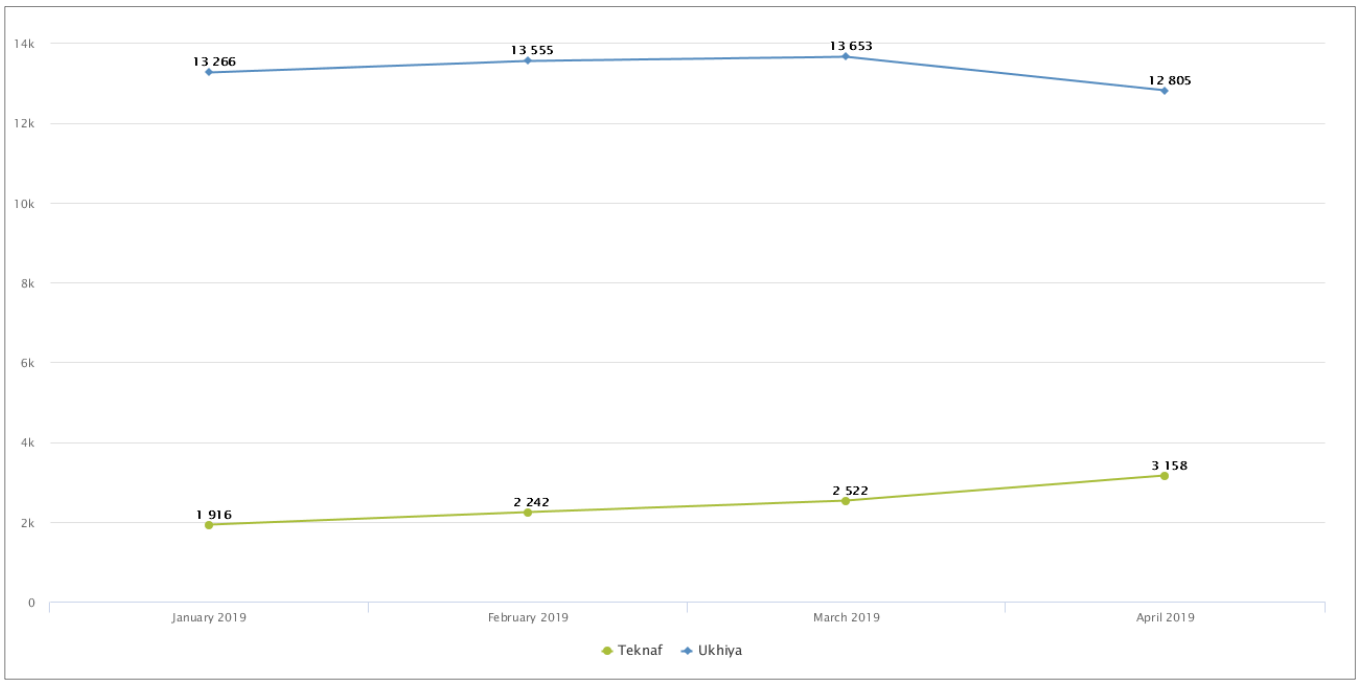
Figure 14 Normal deliveries vs 1st PNC visit as reported in FDMN DHIS-2 from January- April 2019 (Teknaf and Ukhia combined)



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).

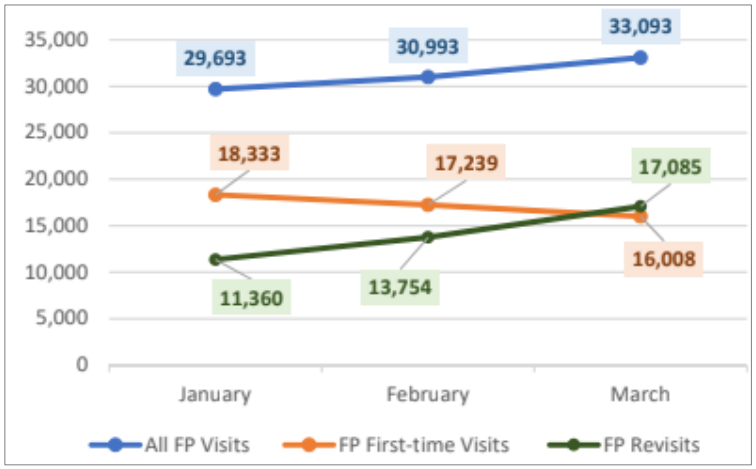
Regarding family planning (FP), no recent data on unmet need or contraceptive prevalence rate exits. However, data from FDMN DHIS-2 shows that service uptake decreased in Ukhia in April, but increased in Teknaf (see figure below).

Figure 15 Family Planning services rendered in Ukhia and Teknaf, Jan-April 2019, DHIS-2 FDMN server, Ukhia and Teknaf



Data from the SRHWG data collection tools, which captures new versus repeat FP visits, suggests that there is an overall increase in all FP visits (see figure below). However, there has been a downward trend in first time visits, with an upward trend in revisits. This could suggest that the demand for FP is being met.

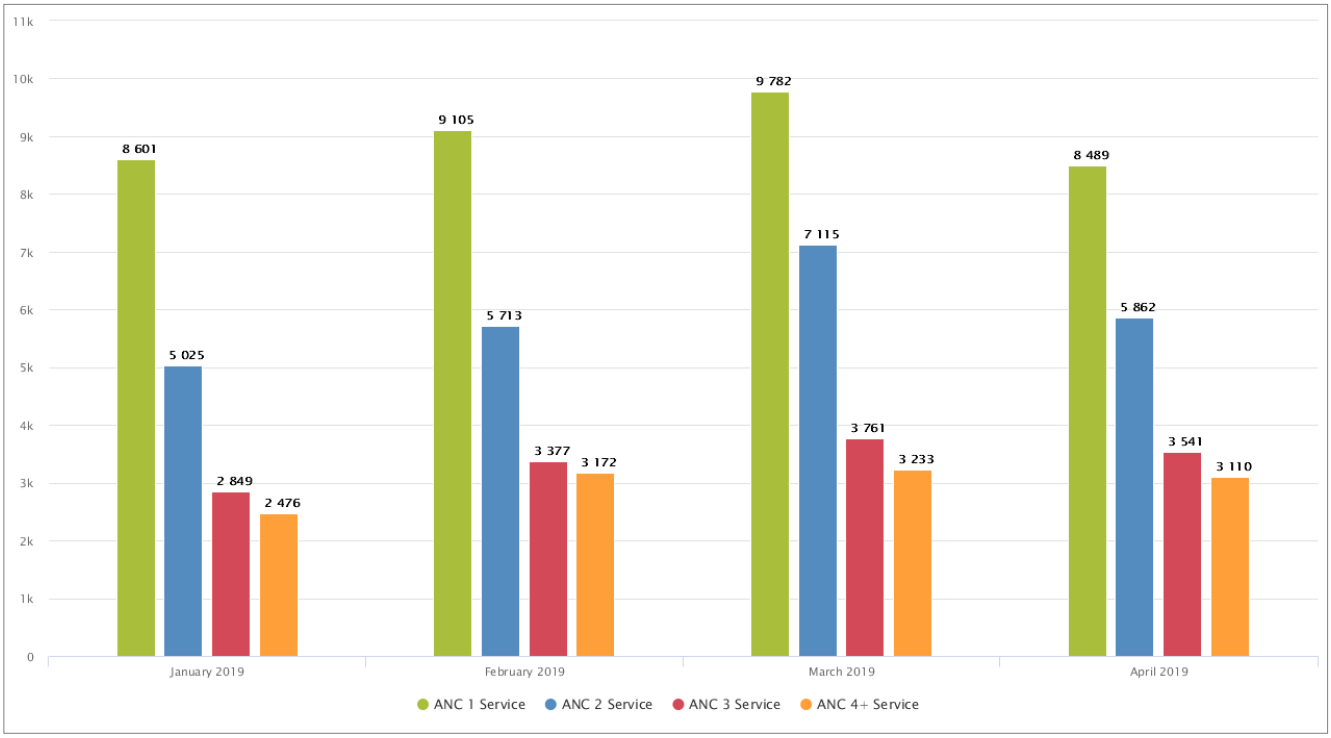
Figure 16 Family Planning Visits reported through SRH WG tool in Q1 2019, by type



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.

Regarding uptake of ANC, data from FDMN DHIS-2 for January-April 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 consistently remains below standards.

Figure 17 ANC services reported in FDMN DHIS-2 from January-April 2019 (Teknaf and Ukhia combined)



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 early May including a 5-day training of trainers on clinical management of rape/intimate partner violence (10 are now certified as a CMR trainer); and another ToT on helping mothers survive (HMS) which was attended by 8 government partners (nursing and midwifery institute; Sadar Hospital, and Ukhia/Teknaf health complexes) and 9 SRH WG partners. This will be followed by HMS "Bleeding after Birth Complete Champion Course", to train more than 100 Health Service Providers/Midwives. A training on emergency obstetric and newborn care is planned in early June and a training on post-abortion care will take place at the end of June under the SRH project of the health sector, in collaboration with SRH WG. A Helping Baby Breath (HBB) ToT, followed by HBB training is going to be held for 288 health service providers for SRH sub sector partners from 10-20 June. Training materials for community health workers on comprehensive SRH were piloted in April and were used during two batches of ToT of CHW supervisors and managers from 26 organizations, to strengthen community linkages with health service providers. Regarding commodities, SRH Kits availability and pipeline are being closely monitored, and sufficient stock is currently available at health facility level. An expected large delivery of SRH kits is being followed up.

The SRHWG strives to reduce avoidable maternal mortality, and aims to improve timely investigation (Maternal death reviews) from 83% of all the reported maternal mortalities investigated within 48 hours (Q1 2019) to 100%. A concept note for a maternal mortality review committee was drafted and is pending endorsement from Civil Surgeon's office. Notification of suspected maternal mortalities (as recorded by CHWs) is being rolled out through EWARS (trainings of CHWs and reporting officer were completed in April), although reporting is incomplete.

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. Out of a total of 80 oxygen cylinders received, 58 have been distributed to partners and to the Civil Surgeon's Office. Similarly, 3500 (out of 4136) Calamine lotion bottles have been distributed; distribution is ongoing for 3 000 Cholera RDTs and 7500 Malaria RDTs; 5 out of 7 newly received surgical kits were delivered to the field hospitals and to Teknaf and Ukhia Upazila health complexes; and 6300 amps of oxytocin arrived for the SRH project and were distributed. In support of the MMT training (23 to 26 April) for monsoon and cyclone season, 15 Trauma bags, 15 AED and 15 Personal deployment kits were distributed to MMTs. The main health partners have been sharing their overstocks on a weekly basis, and this is being coordinated to enable donations among each other, to cover critical gaps.

The health sector has prepositioned five containers stocked with essential medicines, for health sector partners' use in case of emergency. These stocks are continually replenished and a further three containers are in place and in process of being stocked up. 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. Solar lighting has already been installed in all of 12 these, and solar AC has been installed in 9.

Since a mechanism to destroy expired drugs through a third-party agency was put in place, approximately 1400 kilos of expired drugs from different partners were sent to PRISM Dhaka to be incinerated.

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