HEALTH SECTOR COX'S BAZAR

The RRRC health coordinator and the health sector coordinator during supportive supervision visit to Camp 26

HEALTH SECTOR BULLETIN # 12

Bangladesh
Emergency: Rohingya Refugee Crisis in Cox's Bazar District
Reporting period: January – June 2020

1.27 MILLION PEOPLE IN NEED

8860 356 REFUGEES

146 PARTNERS

HIGHLIGHTS

- With facility-based deliveries increasing to 53.2%, 0.5% more as compared to end of 2019, there are now 7 446 facility-based deliveries reported in the Rohingya refugee camps. In addition, 64 143 women of reproductive age received family planning contraceptive methods, in spite of a decline in accessing family planning services between March-May 2020 due to the decline in people seeking health service during COVID-19.
- There are 2 519 COVID-19 confirmed cases in host community (77% male and 23% female) and 50 confirmed cases from FDMN/Rohingya camps (60% male and 40% female).
- Six severe acute respiratory infection isolation and treatment centres (SARI ITCs) were active and ready to receive patients including the intensive care unit/high dependency unit (ICU/HDU) facility at Sadar Hospital with ten ICU and eight HDU beds. There were 267 and 112 active SARI and isolation beds respectively in the camps.
- The majority of PHCs, 69%, had at least one health personnel trained on Mental Health Gap Action Programme (MhGAP).
- 1 400 community health workers (CHWs) continued to provide community health services. The under-five mortality rate was 0.35/1,000/month and the crude mortality rate was 0.55/10,000/day.

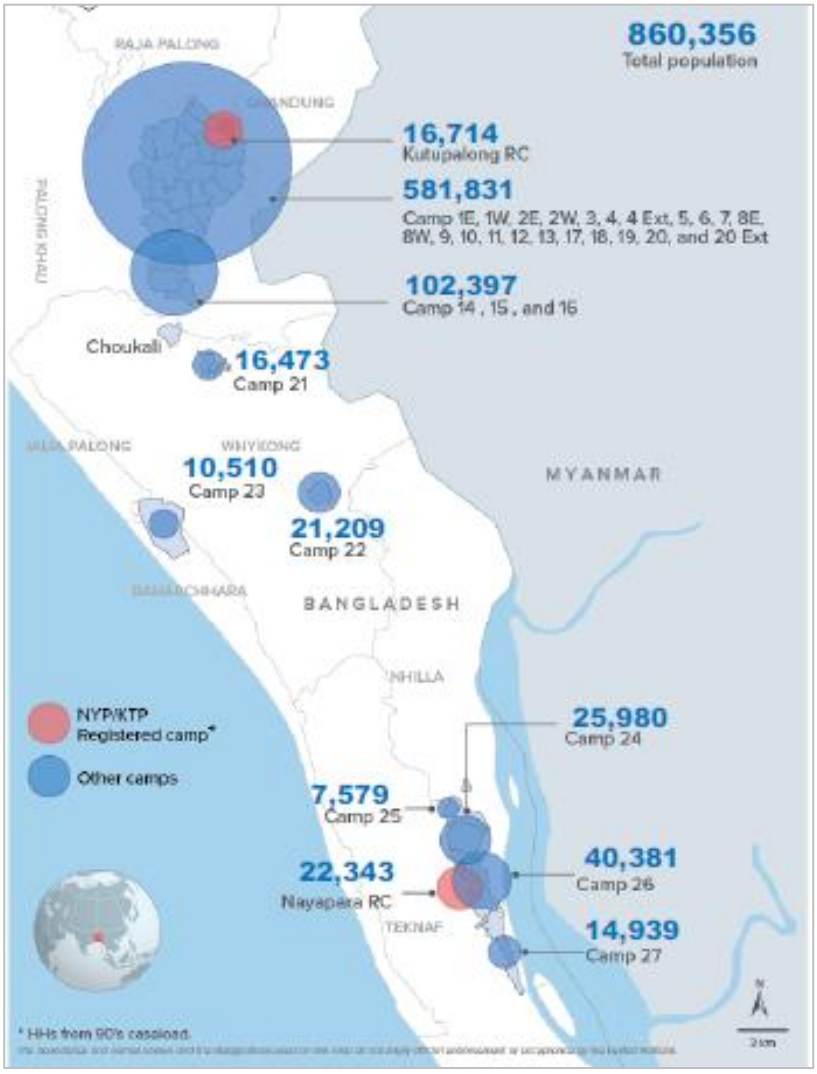
HEALTH SECTOR

1.2 M	PEOPLE TARGETED FOR ASSISTANCE
MEDICINES AND SUPPLIES DELIVERED TO HEALTH FACILITIES/PARTNERS*	
15	TRAUMA KITS
11	IEHK KITS
1	CHOLERA KITS
HEALTH FACILITIES	
37	PRIMARY HEALTH CENTERS
96	HEALTH POSTS
HEALTH ACTION	
1 486 719	OPD CONSULTATIONS
6473	ASSISTED DELIVERIES
8 872	REFERRALS
VACCINATION AGAINST	
12 750	POLIO
6 953	MEASLES*
EWARS	
138	SENTINEL SITES
FUNDING $US	
10.5	% FUNDED (AS OF 08 SEPTEMBER 2020, FTS)
172 M	REQUESTED

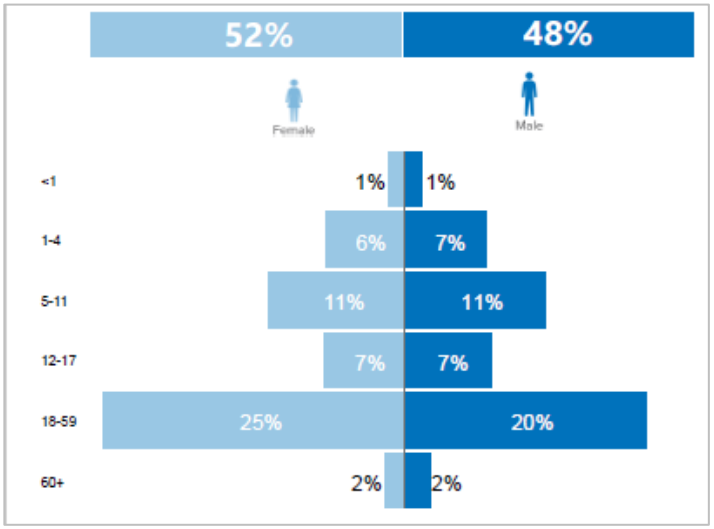
Situation update

The number of Rohingya refuges in Cox's Bazar, Bangladesh, now stands at 860 356, according to the recent joint Government of Bangladesh – UNHCR factsheet (30 June 2020). About 52% are women and girls while more than half are children. Less than 1% -- 0.91% -- are estimated to be persons with disability while 0.5% have serious medical conditions. Unaccompanied/separated children are approximately 0.4%. The average family size of the total registered population is 4.6 persons.

UNHCR Map of Rohingya Refugee population by location**



Demography**



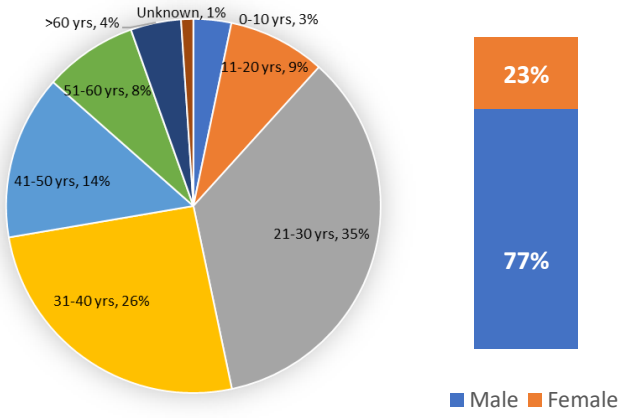
***SOURCE: GoB - UNHCR Joint Registration Exercise (as of 30 June 2020)*

Public health risks, priorities, needs and gaps

Communicable diseases

1. COVID-19

WHO declared COVID-19 outbreak pandemic on 11 March 2020. The first COVID-19 case was reported in Cox's Bazar district on 23 March 2020 in the host community, and on 14 May 2020 Rohingya refugee was confirmed as a COVID-19 patient. On 29 June 2020, the host community had 2519 COVID-19 laboratory confirmed positive cases (77% male and 23% female) with a total of 15 154 tests conducted.



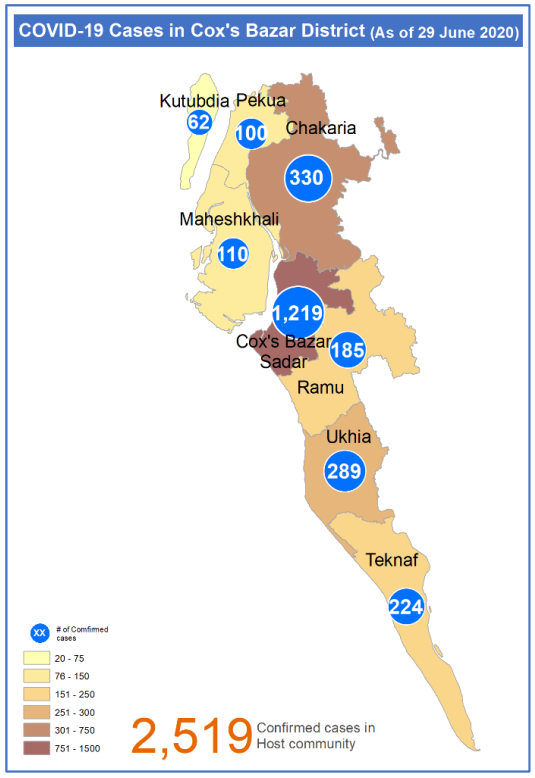
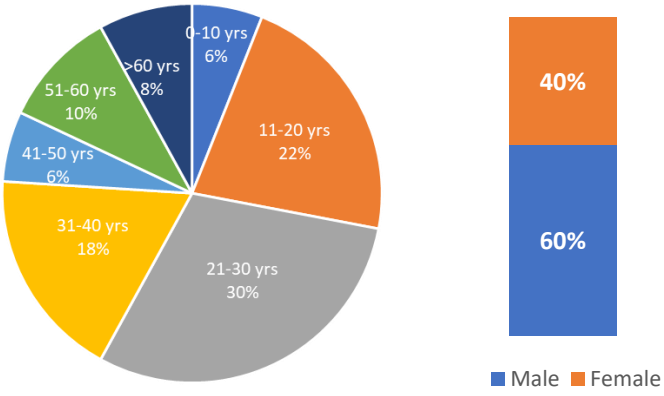


Figure 1: COVID-19 Laboratory Confirmed Cases among Host Population

Among the Rohingya refugees, 538 tests had been conducted and 50 had tested positive for COVID-19 (60% male and 40% female).



The number of fatalities in the host community was 34, and five among the Rohingya/FDMN community. The case fatality ratio was 1.34% among the host community in Cox's Bazar district and 10.0% among the Rohingya refugees.

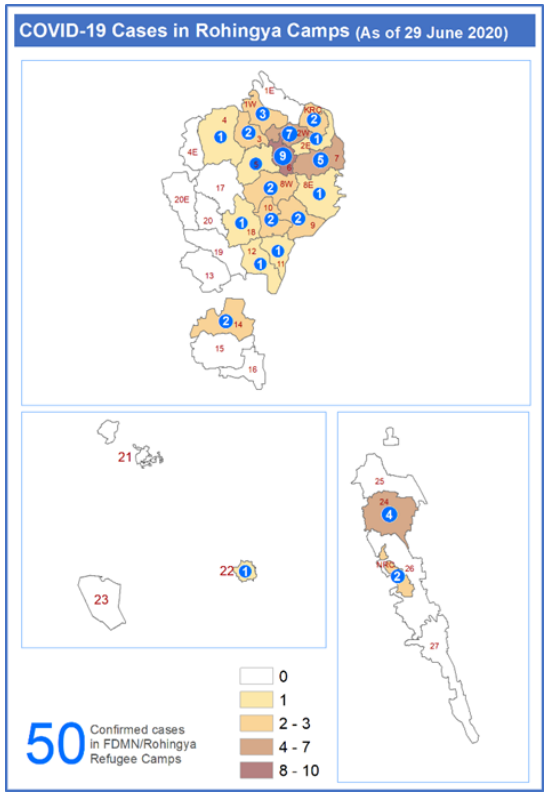


Figure 2: COVID-19 of Laboratory Confirmed Cases among FDMN/Rohingya Refugees

2. Diphtheria

A total of 9118 diphtheria cases (223 from host community) were reported in the Early warning and Response System (EWARS) since December 2017and a total of 46 diphtheria related deaths were reported in the same period. Between January and June 2020 157 cases between were reported. No deaths were reported in this period (last death reported in 25 October 2019).

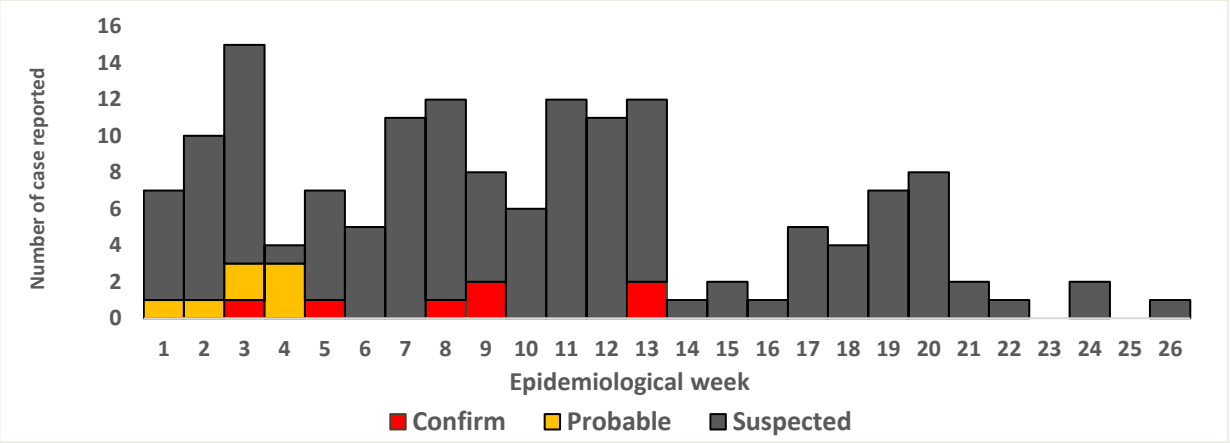


Figure 3: Epidemic curve of diphtheria cases among Rohingya refugees (W1 – W26, 2020), EWARS

3. Acute Respiratory Infection (ARI)

During the reporting period, a total of 315 977 ARI cases were reported in EWARS; 168 102 referring to children under five and 147 875 over five years of age. The graphic below illustrates a decline in the reporting trends from week 13 as compared to the same period in 2018 and 2019 due to the low rates on health seeking services in the Rohingya refugee camps due to COVID-19.

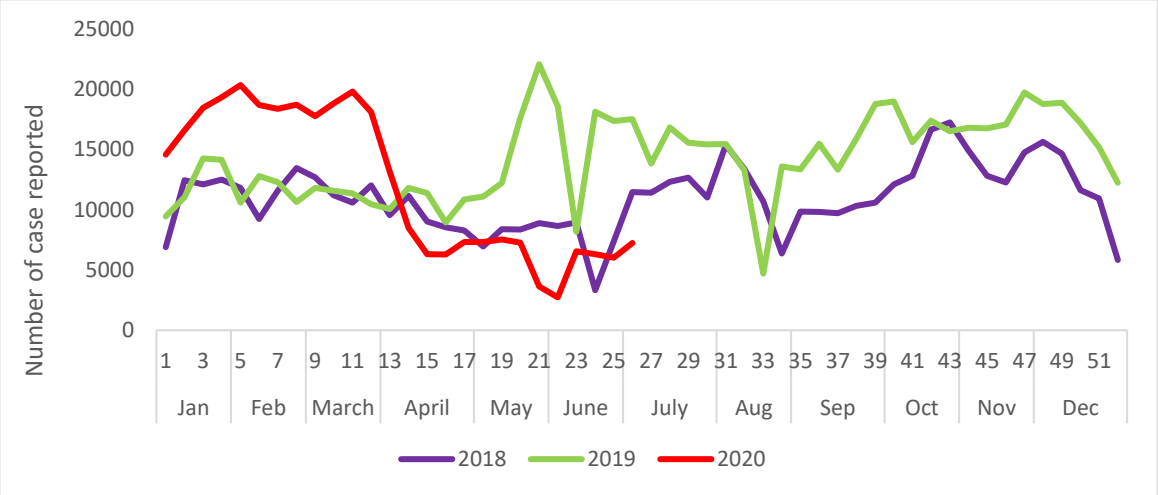


Figure 4: Total number of ARI case reported in EWARS from 2018-2020.

Non-communicable diseases and mental health

i) Non-Communicable Diseases (NCD)

The health sector trained twenty-four healthcare workers on Package of Essential Interventions of non-communicable diseases (PEN) in limited resource settings. Out of the 32 PHCs, 94% can now manage diabetes, cardiovascular diseases and chronic respiratory diseases. The health sector has also supported Ukhiya and Teknaf health complexes with the delivery of NCDs screening equipment.

Assessment of the blood transfusion services was conducted in February and a consultative meeting took place to discuss the findings. The implementation of blood transfusion centres in Ukhia and Teknaf Upazila Health Centres in currently underway.

ii) Mental Health

Mental health Gap Action Plan (MhGAP) trainings that began in 2019 continued in 2020. As of end of June 2020, 69% of the 35 monitored PHCs have at least one person trained on site at the time of supervision. Common mental health conditions reported and managed by mental health personnel are stated in the graphic below.

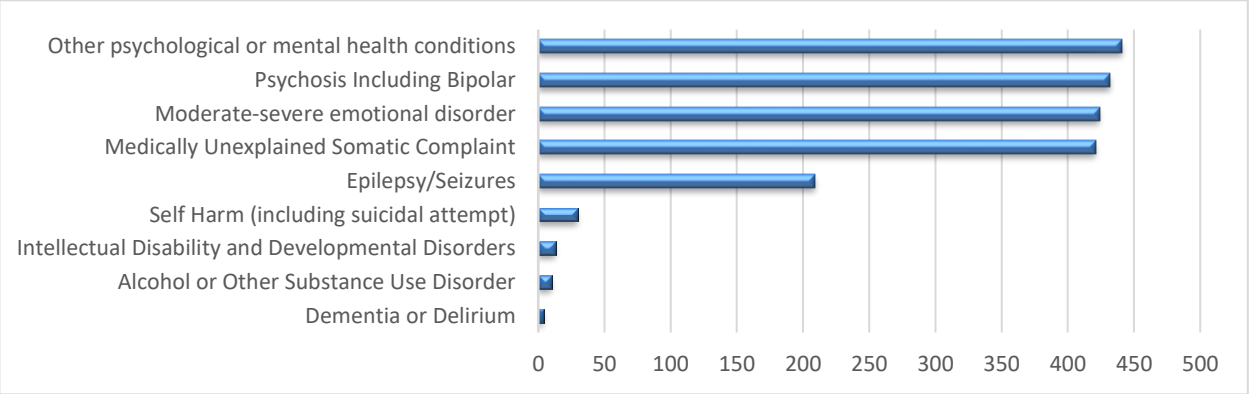


Figure 5. MHPSS conditions. Source: DHIS2

Health sector coordination

WHO, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC), continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the Rohingya crisis and COVID-19 emergency. The Health sector is comprised of over 100 partners who continue to respond to the needs of the affected populations, this includes 62 international partners, 59 National NGOs and 8 UN agencies. The health sector adopted a three-tiered coordination structure at District, sub-district (Upazila) and union levels. At the District level, a strategic advisory group, with representatives from Ministry of Health, Director General of Health Services (MOHDGHS), RRRC Health unit, Health sector working group coordinators, INGO and NGO health agencies serves as an advisory to the health sector. Since the COVID-19 outbreak in March 2020, one additional working group was formed for effective monitoring and coordination of COVID-19 response activities:

- Sexual and Reproductive Health (SRH): chaired by UNFPA
- Community Health (CH): chaired by UNHCR and co-chaired by CPI
- Epidemiology (ECM): chaired by WHO
- Surge Case Management-Chaired by WHO
- Mental Health and Psychosocial Support (MHPSS): chaired by IOM and UNHCR
- Emergency preparedness response (EPR) working group (chaired by WHO)

Functionality of health facilities

The health sector partners are running 97 health posts in the Rohingya refugee camps; and 38 primary health care centres providing 24/7 services. Gaps in PHCs persist, and additional nine PHCs need to meet the minimum standards, as indicated in the table below. Numerous government-run health facilities in the host community are supported by partners, that includes 10 community clinics, six union sub-centres and six Health and Family Welfare Centres, two Upazila health complexes and District-level Sadar Hospital.

Table 1: Gaps in the PHCs in the Camps

Camp	Number of PHC required	Functional / planned PHC available	Gap in required PHC
Camp 01 W	2	0	2
Camp 27	1	0	1
Camp 01 E	2	1	1
Camp 10	1	0	1
Camp 06	1	0	1
Camp 20	1	0	1
Camp 08 W	2	1	1
Camp 07	2	1	1
Camp 09	2	1	1
Camp 13	3	1	2
Camp 11	2	1	1

Health Sector Action

The health sector developed a preparedness and response plan on COVID-19 to address pillar-based priorities and needs:

Coordination, collaboration and monitoring

The health sector, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC), continued to provide leadership in coordinating health partners actions in response to COVID-19 health emergency. The RRRC's office, Civil Surgeon's office and health sector partners have conducted supportive supervision visits to the camps. The visits aimed at supporting facilities in COVID-19 response and assess community engagement. The need for enhanced messaging on mask wearing was observed.

Risk communication and community engagement

In collaboration with Communicating with Communities working group and WASH sector, the health sector developed a risk communication strategy, the messages focus on COVID-19 symptoms, risk factors and quarantine and isolation/ treatment centres. The Health sector has also translated essential messages into local languages and continued its dissemination through multiple outlets including Community Health workers.

A cumulative number of 2 423 610 household visits were conducted for health promotion, referral and routine surveillance. Health promotion topics included the promotion of sexual and reproductive health services, hygiene and diarrhoea prevention, immunization, prevention of non-communicable diseases, healthy living as well as seasonal acute health conditions. In addition, CHWs conducted 90 689 small group sessions for 765 056 persons. From June onwards enhanced community-based surveillance (CBS) was started by CHWG partners to identify patients with respiratory symptoms and provide targeted counselling on testing, treatment and quarantine. Flipcharts with photographs from camp facilities are used in the counselling to overcome fears and concerns of the unknown concepts of quarantine and SARI ITCs. More than 630,000 HH visits were conducted in the first 6 weeks of introducing the system, resulting in the identification of more than 10,300 patients with respiratory symptoms.

Surveillance, rapid response and case investigation

The health sector adapted the surveillance strategy in response to COVID-19. Expansion of sentinel sites for COVID-19 sample collection remains a key priority to at least one site per camp in addition to the 20 sites currently operational. Camp wise Rapid Investigation and Response teams were formed, and protocol developed with the support of the site management sector. Additional 20 camp level disease surveillance officers (CHDSO) were recruited to support the outbreak investigation and

response. Contact tracing and Go.data implementation remains a priority to capture essential information on COVID-19 response in camps. The MOH oversees contact tracing activities of the trained 60 supervisors and 300 volunteers for COVID-19 response. COVID-19 Epi Dashboard was also developed to provide live updates on testing, epidemiology, mortality, home based care, clinical management and service utilization.

Laboratory

The health sector continued to support the Institute of Epidemiology, Disease Control and Research (IEDCR) Field Laboratory in the Cox's Bazar Medical College with human resources, equipment, supplies/consumables, technical and operational expertise for testing COVID-19 samples. Within the reporting date, the testing capacity had improved to 500 samples per day. Increasing the capacity of the field lab to carry out more sample tests remains a priority.

Infection prevention and control

The health sector continued to address needs on staff training, supplies and technical guidance on Infection Prevention and Control (IPC) to minimize risks of infection from COVID-19 for patients, staff and the community. An IPC Response and quality assurance plan was developed to address COVID-19 infectious disease. Between January and June, 22 health care facilities received supportive supervision on IPC. 43 master trainers were trained in May 2020. During the intensive four-day training, the participants were provided IPC guidelines and procedures on how to receive, provide triage, care and treatment to patients in the Acute Respiratory Infection (SARI) Isolation and Treatment Centers (ITC). Participants of the training continue to train other health care workers in the camps and the upazila health facilities. A total of 1140 people had been trained as of end of June 2020

Case management

As of 29 June 2020, six SARI ITCs were active and ready to admit patients, including the ICU/HDU facility at Sadar Hospital with ten ICU and eight HDU beds. Within the reporting period, 267 and 112 active SARI and isolation beds respectively in the camps and more are being established in the preparation for the event of high community transmission. By 30 June 202, 197 Health professionals had received training on clinical case management of COVID-19. There is continued need to strengthen MHPSS support and response to stressors in relation to COVID-19. Nine facilities received supportive supervision visits at the time of reporting.

Essential health services

Based on the latest WHO guidance, Health Sector drafted an Essential Health Services plan and strategy and was presented to Health Sector's Strategic Advisory Group for review prior to its implementation. Continuity of essential health services during the pandemic based on existing minimum essential service package remains a priority for the health sector. Following the interruption of routine immunizations sessions due to COVID-19 restrictions with low numbers in immunization coverage being observed, WHO provided technical support to the Civil Surgeon and Upazila health and Family Planning Officers to revise routine immunization microplan.

Points of Entry

In order to minimize the transmission of COVID-19 in the Rohingya camps, the health sector in collaboration with WASH, Site Management, and Protection Sector partners established temperature screening and hand washing stations at 14 points of entry out of the 19 planned.

Assessments

Camp Health Focal Points (CHFPs) with the support from Field Coordinators and health Sector Coordination team, conducted Quarter-2 (Q2) 2020 monitoring assessment covering 35 PHCs and 79 health posts in the camps. This exercise is intended to help the sector track several JRP and non-JRP progress indicators as well as readiness for COVID-19 response and will guide supportive supervision activities. Some key findings are presented in the figures below.

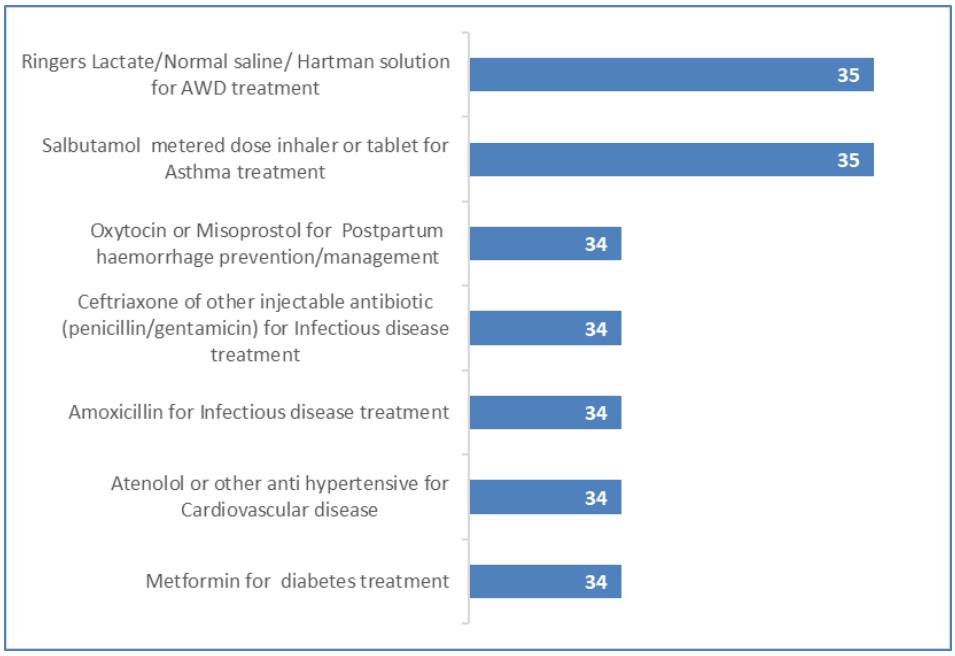


Figure 7: Available medicine at the PHCs (at the time of survey)

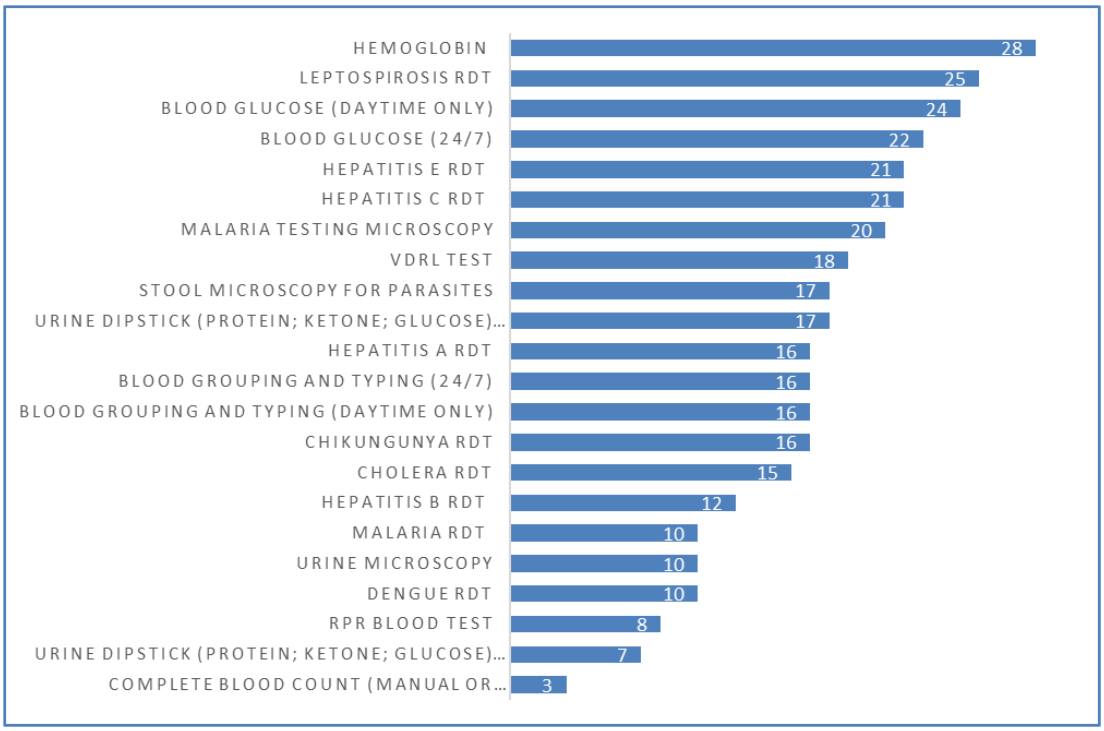


Figure 8: Available laboratory services in PHCs (at the time of survey)

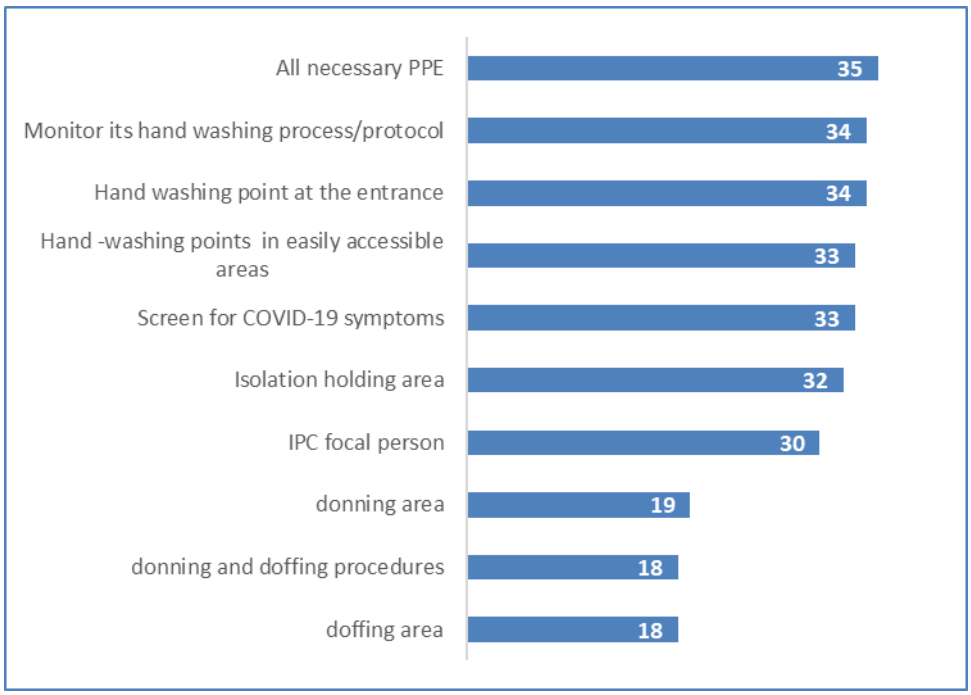


Figure 9: Infection Prevention and Control (IPC) situation at the PHCs (at the time of survey)

Child Health

From mid-April, the routine immunization services were suspended in FDMN/Rohingya refugee camps due to COVID-19 constrains. However, some fixed sites continued to provide the services in a limited scale. The reduced coverage of immunization sessions is illustrated in the below graph during the suspension period. To minimize the impact of COVID-19 on vaccine preventable diseases, the health sector in collaboration with MOH developed a routine Immunization strategy and micro plan in the context of COVID-19.

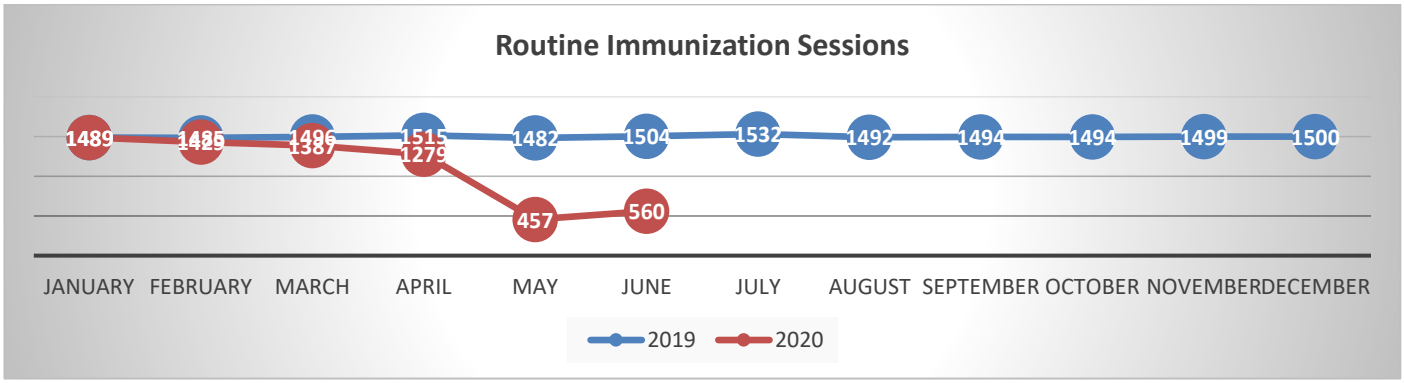


Figure 10: Routine Immunization Sessions in 2020 compared to 2019

Antigen coverage

The graph below further illustrates the impact on antigen coverage between April and May due to the temporary suspension of RI services. However, in June the health sector started the implementation of the new RI strategy and micro plan.

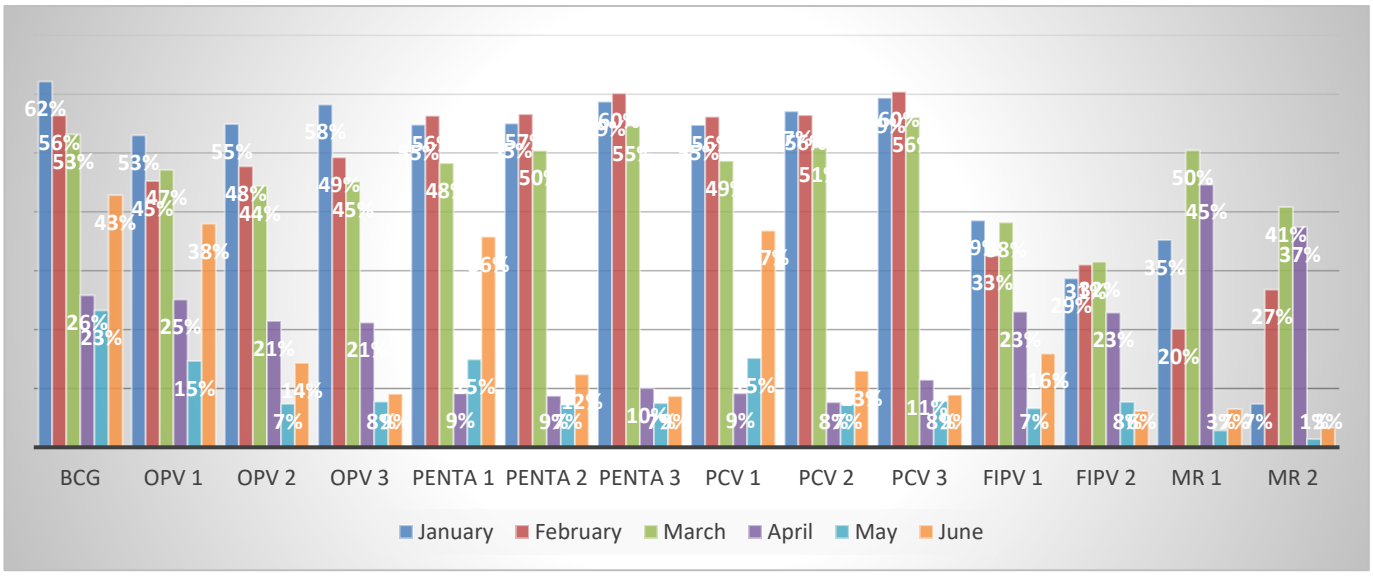


Figure 11: Antigen coverage in FDMN/Rohingya Camps (Jan-June 2020). Source; DHIS2

Surveillance /Early Warning Alerts and Response System (EWARS)

As of 30 June 2020, a total of 141 (85%) health facilities were registered and reporting in EWARS. Reporting completeness was 87% and timeliness was 79%. The health sector received 1652 alerts; 1216 or (74%) monitored and 435 (26%) discarded. All alerts were reviewed and verified within the required 48-hours timeframe. A total of 1,476,833 weekly consultations were reported within the reporting time. However, from the below graph, health facilities witnessed a declining trend in weekly consultations from week 13 that may be attributed to fears, stigma, rumours and misinformation associated with COVID-19. The health sector is finalizing a plan to increase health seeking behaviour through rumour tracking and other mechanisms.

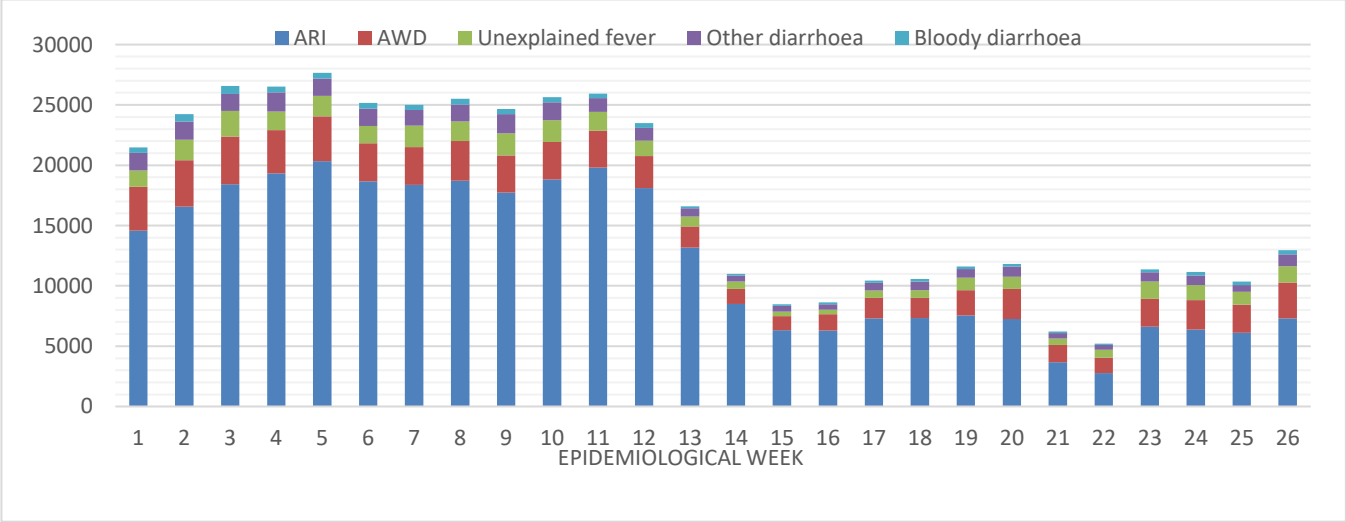


Figure 12: Reported cases of priority disease consultations between weeks 1 and 26 in 2020. Source; EWARS

Community based mortality surveillance

The below charts provide breakdown of all mortalities reported by camp, sex, place and causes of death. In total, 767 mortalities were reported (343 female and 424 male). Among the female diseased 22 were women of reproductive age (12 to 49). Still births were 108 and neonatal deaths 77. The average age

of reported mortalities was 35.85 years for females and 35 years for males. The highest number of deaths occurred at home (64.02%) followed by health facilities (28.9%) and community/public spaces (4.3%). Under 5 mortality rates were as follows: 0.29/ 1,000/ month (female: 0.23, male 0.33), crude mortality 0.15/ 1,000/ month (female: 0.16, male 0.14).

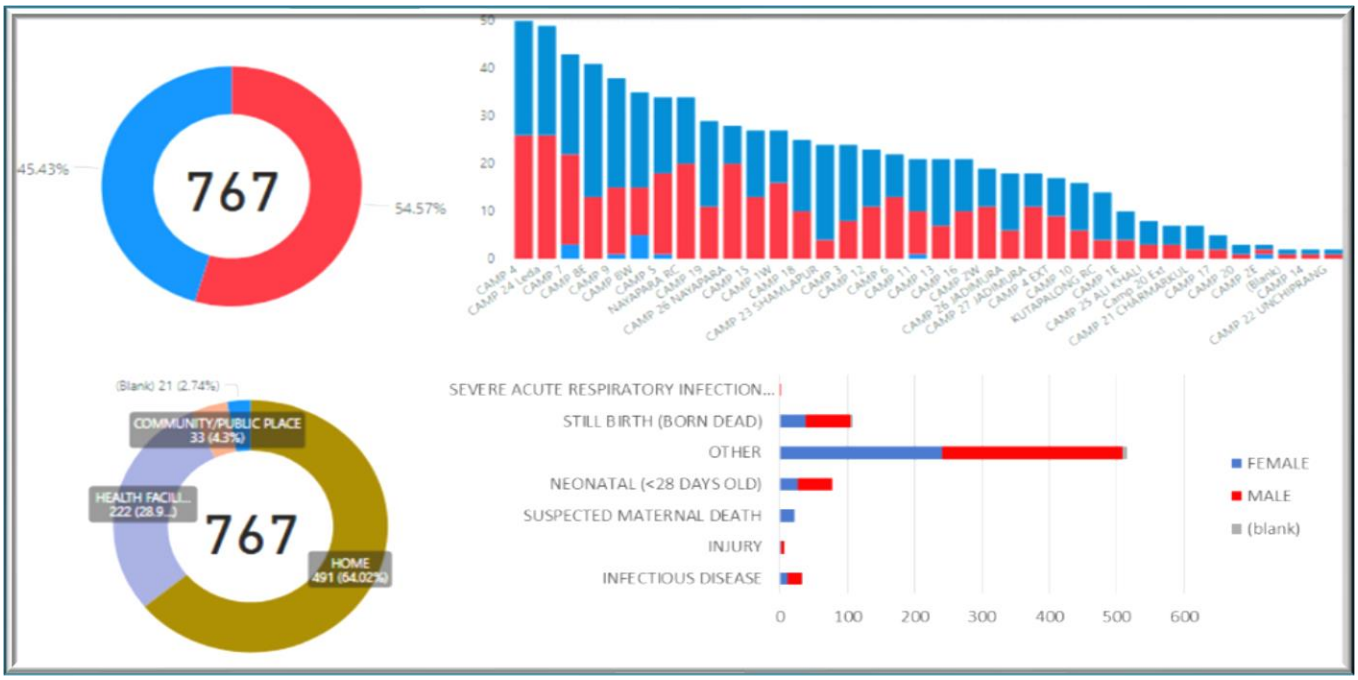


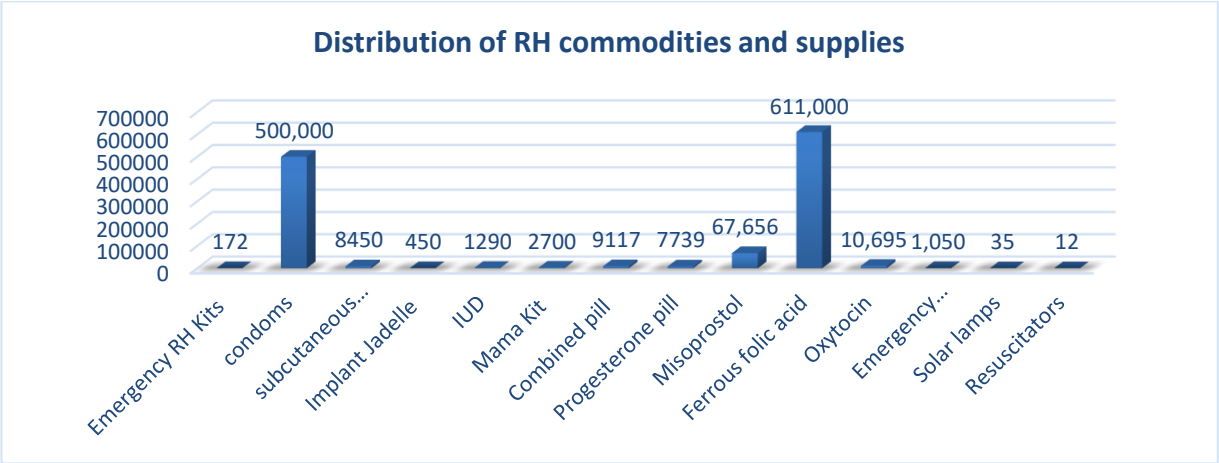
Figure 13: Community based mortality surveillance by camp, sex, cause and place; Source; week 1-26, EWARS

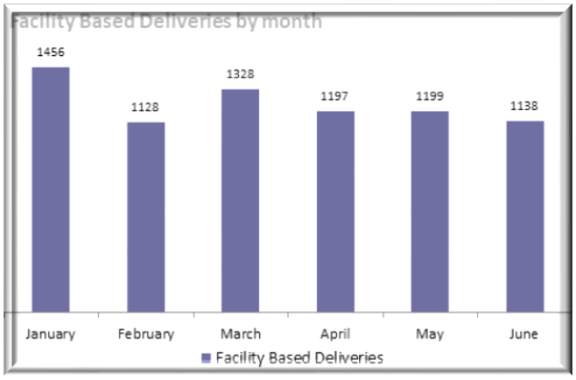
Reproductive Health

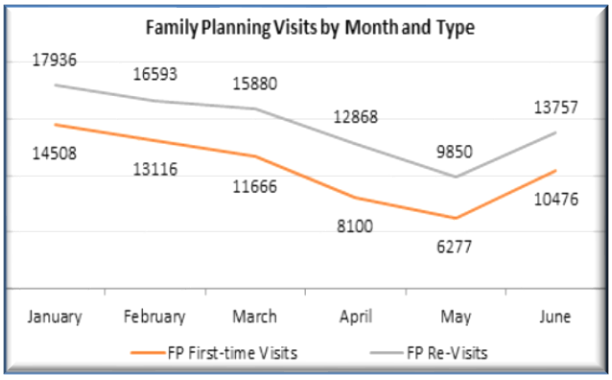
SRHR services continued in both Rohingya refugee camps and surrounding host communities in Ukhiya and Teknaf. Maternity Red Zones[1] were established in 18 out of the 43 facilities. According to the information available, COVID-19 does not represent a direct risk factor for pregnant and lactating women. However, it may affect the ability of communities to access Sexual and Reproductive Health (SRH) facilities and services.

The health care facilities supported 7,446 facility-based deliveries and 64 143 women of reproductive age (WRA) received family planning contraceptive methods. In addition, a functional Maternal and Perinatal Mortality Surveillance and Response (MPMSR) system was rolled out in all the 34 camps. Standard Operating Procedure (SOP) on Antenatal, Intrapartum, Postpartum, and EmONC during COVID-19 was produced alongside guideline on Basic emergency obstetric and neonatal care (BEmONC) and comprehensive emergency obstetric and neonatal care (CEmONC) on the management of eclampsia and hepatitis at primary and secondary health care facilities. In addition, two batches of Long Acting Reversible Contraceptive (LARC) Training of trainers (ToT) training was conducted in February 2020 with a total of 16 Medical Officers. The SRH working group has also distributed a range of reproductive health commodities and supplies to SRH Partners as shown. The below graphics illustrate the uptake of SRH services.

[1] designated isolation area for COVID-19 suspected and confirmed pregnant women to address emergency cases before referral to SARI/ITCs as per maternal health SOP







Gender Equality and Gender-based violence

The health sector in collaboration with SRH WG continued to implement the global health cluster project on strengthening the capacity of health providers to coordinate and deliver gender-based violence (GBV) services. Key actions included the interagency GBV quality assurance assessment conducted in seven PHCs in March 2020 that revealed lack of service availability in four of the PHCs, implementation of action plans to address service gaps from the quality assurance such as the distribution of lockable cabinets to 80 health facilities in support of ethical and safe storage of survivor's information and civil surgeon's approval of the health sector SOP on GBV. Trainings are planned for PHCs with no GBV services.

Collaboration between health sector and working groups on protection, Child protection, PSEA and gender was strengthened in response to COVID-19; development of an orientation package on the cross cutting themes integrated in health sector trainings on COVID-19, cross-sectoral sharing of guidance documents for review and inputs, and development and implementation of Health Sector Gender action plan with inputs from ISCG gender hub.

Water, sanitation and hygiene and environmental health

The coordination mechanism between Health and WASH Sector was reactivated in response to COVID-19. The two sectors collaborated in developing risk communication to curb the spread of COVID-19. Guidelines on medical waste management, disinfection and chlorination were shared with health sector partners. In collaboration with two international consultancy firms, Health Care Without Harm, and Health Care Foundation Nepal, completed the district-wide comprehensive Health-care Waste Management assessment and submitted final reports and waste management plan for improvement of medical waste management in Cox's Bazar district. The bidding process for capacity building agency on WASH FIT is complete. The sector also coordinated with the WASH sector in establishing hand washing points at all 19 points of entry in the camps. On-site health care waste management trainings were conducted to support SARI ITC facilities established to receive COVID-19 patients.

Contingency planning

Health Sector regularly updated its contingency plan for cyclone (April-May) and monsoon (Jun-July) seasons. Updated information related to health facility functionality, contingency supplies and locations, mobile medical teams, ambulance network and systems to respond to emergencies and list of camp health focal points is available in the health sector google drive. In addition, contingency supplies such as IEHK, trauma kits, surgical kits, cholera kits, SRH kits and other supplies are currently stored in 20 sites in the district and camps. Thirty-nine 24/7 priority health facilities across the camps have been identified. Twenty-one mobile medical teams and 29 dispatch and referral unit ambulances stand ready to respond to the adverse effects of cyclone and monsoon season. The Health Sector is updating monsoon and cyclone contingency plan in preparation for the upcoming cyclone season (September-December). Camp wise contingency plan is under development for all 34 refugee camps. The sector is collaborating with the local administration to identify potential locations for evacuation of patients and equipment from SARI facilities in case of severe cyclone in the camps.

Contacts:

Dr Prajapati Mukeshkumar
Health Sector Coordinator
Email: coord_cxb@who.int

Bernard Oduor
Health Sector IMO
Email: oduorb@who.int