HEALTH SECTOR COX'S BAZAR

Health Sector coordinator ,Health coordinator – RRRC office,Ministry of Health Coordination cell, and icddr,b, and WASH partners during an AWD response visit in Teknaf.
Photo by WHO

HEALTH SECTOR BULLETIN # 11
November 2019

Bangladesh

Emergency: Rohingya Refugee Crisis in Cox's Bazar District
Reporting period: 21 July 2019 – 26 October 2019

1.24 MILLION PEOPLE IN NEED

914 998 REFUGEES

146 PARTNERS

HIGHLIGHTS

- Between 5 September and end of October 2019, there have been 120 cases of acute watery diarrhoea (AWD) reported from host (36%) and Rohingya refugee camps (64%). These cases have tested positive by cholera Rapid Diagnostic Tests (RDTs), or culture, or are linked to these cases (data as of 5 November 2019). Most of the cases, 83%, were reported from Teknaf.
- A total of 90 facilities from Ukhiya and Teknaf and other Upazilas of Cox's Bazar district were assessed using a facility-based Health Care Provider Interview Questionnaire based on *WHO Package of Essential Noncommunicable (PEN) Diseases Interventions for primary care in low resource settings*. Preliminary finding indicates 100% diagnostic capacity for hypertension in all categories of hospital and 10% of health posts, 10% of community clinics and 14% of Upazilla Health Complexes had limited capacity to diagnose diabetes mellitus.
- An estimated 47% of all deliveries were conducted in health facilities, a remarkable increase from 32% at the end of 2018. Significant differences between camps are however observed, ranging from 11.8% to 100%. Long established camps, such as the registered camps, have the highest institutional delivery rates.

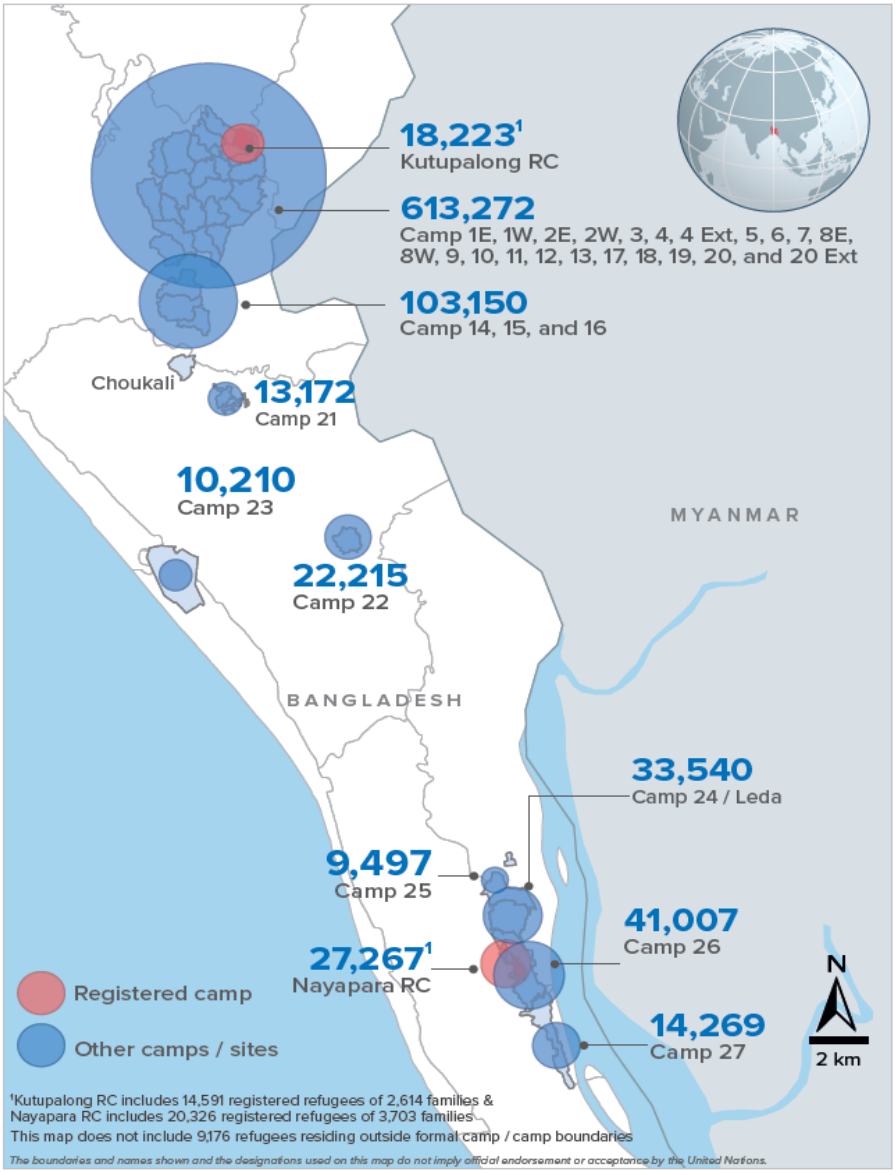
HEALTH SECTOR

1.2 M	PEOPLE TARGETED FOR ASSISTANCE
MEDICINES AND SUPPLIES DELIVERED TO HEALTH FACILITIES/PARTNERS*	
113	IEHK AND TRAUMA KITS
11	NCD KITS
14	CHOLERA KITS
36 700 PIECES	DIPTHERIA AND ASSORTED ARI MEDICINES
HEALTH FACILITIES	
32	PRIMARY HEALTH CENTERS
129	HEALTH POSTS
HEALTH ACTION	
1 514 988	CONSULTATIONS
3 998	ASSISTED DELIVERIES
8 829	REFERRALS
VACCINATION AGAINST	
12 750	POLIO
6 953	MEASLES*
EWARS	
167	SENTINEL SITES
FUNDING $US	
36	% FUNDED (AS OF 04 DEC 2019, FTS)
88.7 M	REQUESTED

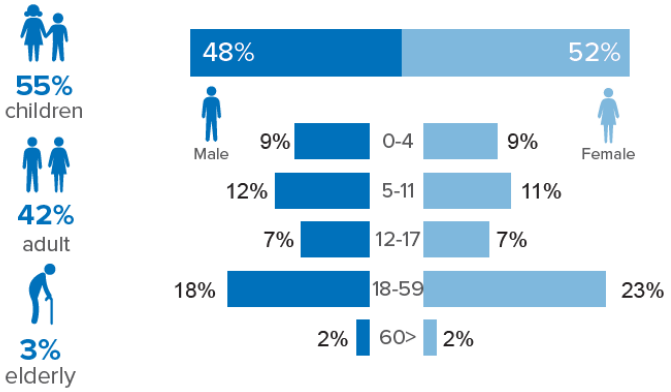
Situation update

The number of Rohingya refuges in Cox's Bazar, Bangladesh now stands at 914 998, according the recent Inter-Sector Coordination Group (ISCG) situation report (October 2019). Of these are 744 000 refugees who have fled violence from Mynamar's Rakhine state since August 2017. About 52% are women and girls while 55% are children. As of 31 October 2019, 757 440 had been registered through the government of Bangladesh-UNHCR registration exercise. The process is still ongoing.

Map of Rohingya Refugee population density**



Demography**



**According to UNHCR factsheet (as of 30 September 2019)

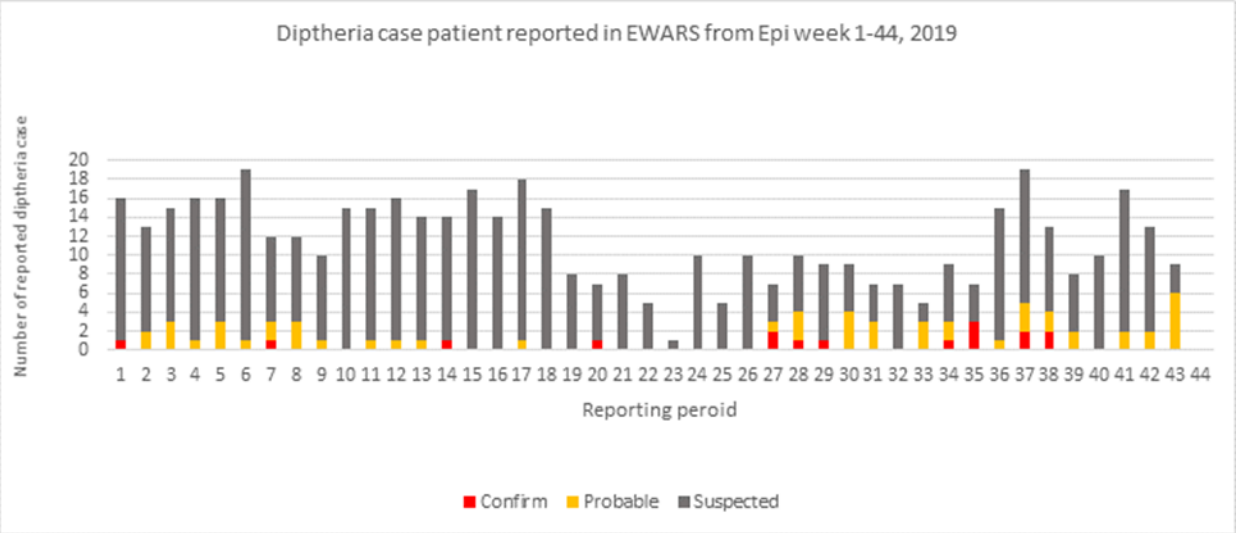
Public health risks, priorities, needs and gaps

Communicable diseases

Diphtheria

A total of 8841 diphtheria cases were reported in Early warning and Response System (EWARS) since the beginning of the outbreak, with 227 cases from the host community. In 2019, a total 489 diphtheria cases were reported in EWARS. Of these, 16 were confirmed, 54 were probable and 419 were suspected. A total of 45 deaths were reported due to diphtheria since the beginning of the outbreak. So far, no deaths have been reported in 2019.

Figure 1: Epidemic curve of diphtheria cases among Rohingya refugees (W1 – W44, 2019), EWARS

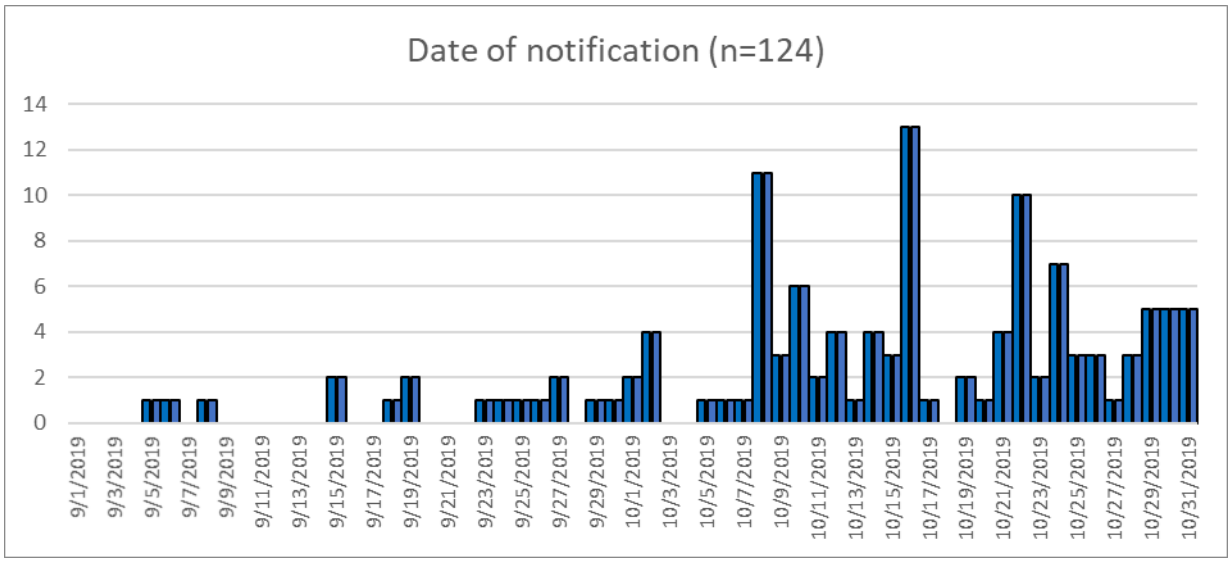


Acute watery diarrhoea

A total of 5837 diarrhoeal diseases cases have been reported in EWARS. Among these, 4135 cases were reported with acute watery diarrhoea (AWD), 448 cases with bloody diarrhoea and 1254 cases with other diarrhoea. Diarrhoeal diseases are lately showing an increasing trend.

Between 5 September and end of October 2019, there have been 120 cases of AWD that have tested positive by cholera Rapid Diagnostic Tests (RDTs), or culture, or are linked to these cases (data as of 5 November 2019). Most of cases, 83%, were reported from Teknaf; 64% of cases are reported in Rohingya camps. 45% of cases are aged over 15 years and 56% are females. Institute of Epidemiology, Disease Control and Research (IEDCR) field laboratory has tested 25 stool samples from Teknaf children under 5 years of age for rotavirus. Of these 16 samples were positive confirming co-circulation of rotavirus in young children.

Figure 2: Epidemic curve of Suspected and confirmed cases by date of notification, 1 September to 3 November 2019.



Child health

Routine immunization against Vaccine Preventable Diseases (VPDs) through the outreach sites and fixed sites, is now more established, following one year of implementation. However, it requires further strengthening by improving access by increasing the number of days for sessions at fixed sites, having more sustainable cold chain systems and reduction of dropout rates for vaccines with doses received at intervals especially Pentavalent, Oral Polio Vaccine, Pneumococcal Conjugate Vaccine, Measles Rubella vaccines remain a priority for the health sector.

Reproductive health

Sphere guidelines require a minimum of five basic emergency obstetric and neonatal care (BeMONC) facilities per 500 000 population. There are currently an appropriate number across the camps as the minimum essential service package requires that primary health care facilities provide these services. However, continuous support and monitoring is required to ensure that women and neonates receive the emergency stabilisation and management that is needed to limit morbidity and mortality, that providers are well trained to perform procedures and that resources for emergency medical care are always available. Similarly, with comprehensive emergency obstetric and neonatal care (CeMONC) facilities, one facility is required per 500 000 population and there are currently four field hospitals that provide obstetric emergency care including surgical intervention and blood transfusion. However, there are facility limitations in the provision of 24/7 services, and as a result, a rotational obstetric referral plan has been created to fill the current gap. Further Health Sector support is required.

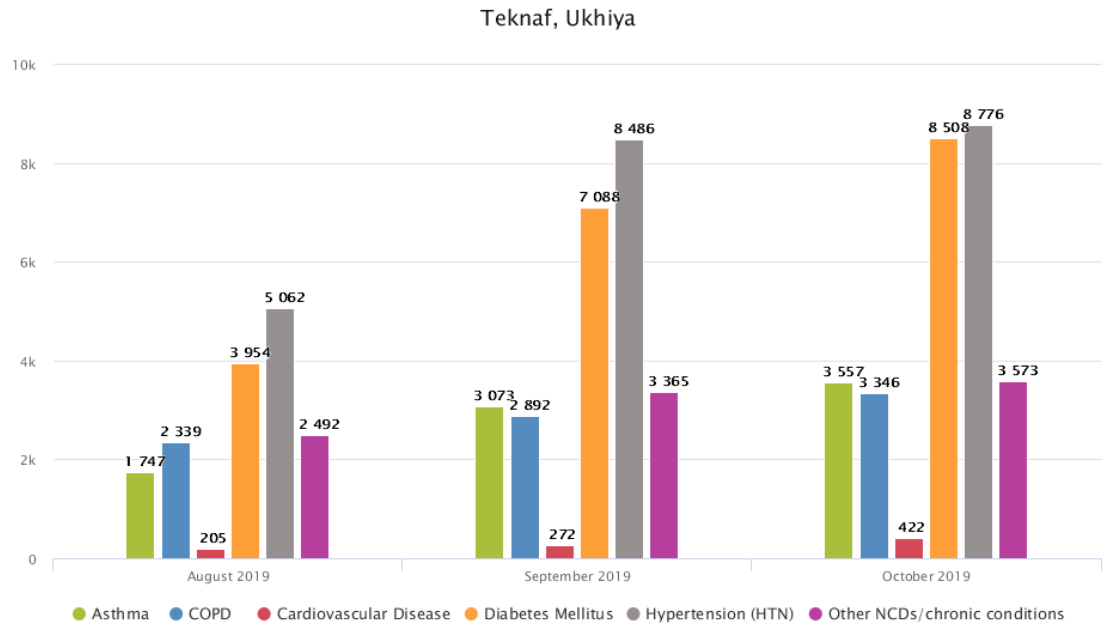
Non-communicable diseases and mental health

The Noncommunicable Disease Core group conducted the first ever NCD assessment in the Rohingya camp. A total of 90 facilities from Ukhiya and Teknaf and other Upazilas of Cox's Bazar district were assessed using a facility-based Health Care Provider Interview Questionnaire based on *WHO Package of Essential Noncommunicable (PEN) Diseases Interventions for primary care in low resource settings*. A tenth (10%) of health posts, 10% of community clinics and 14% of Upazilla Health Complexes had limited capacity to diagnose diabetes mellitus. The capacity for diagnosis of diabetes mellitus needs improvement in union sub-centres. Less than 50% of all centres assessed lacked printed diagnostic and treatment guidelines on the day of assessment. Urine ketone test strips was found low in many health facilities

Among the drugs of national protocol, Amlodipine, Losartan, Aspirin and Metformin were available in more than 75% camp level secondary health facilities and 50% primary health centres (PHCs). Insulin, a key emergency medicine was found in only 46% of PHCs. There is need to improve skills and

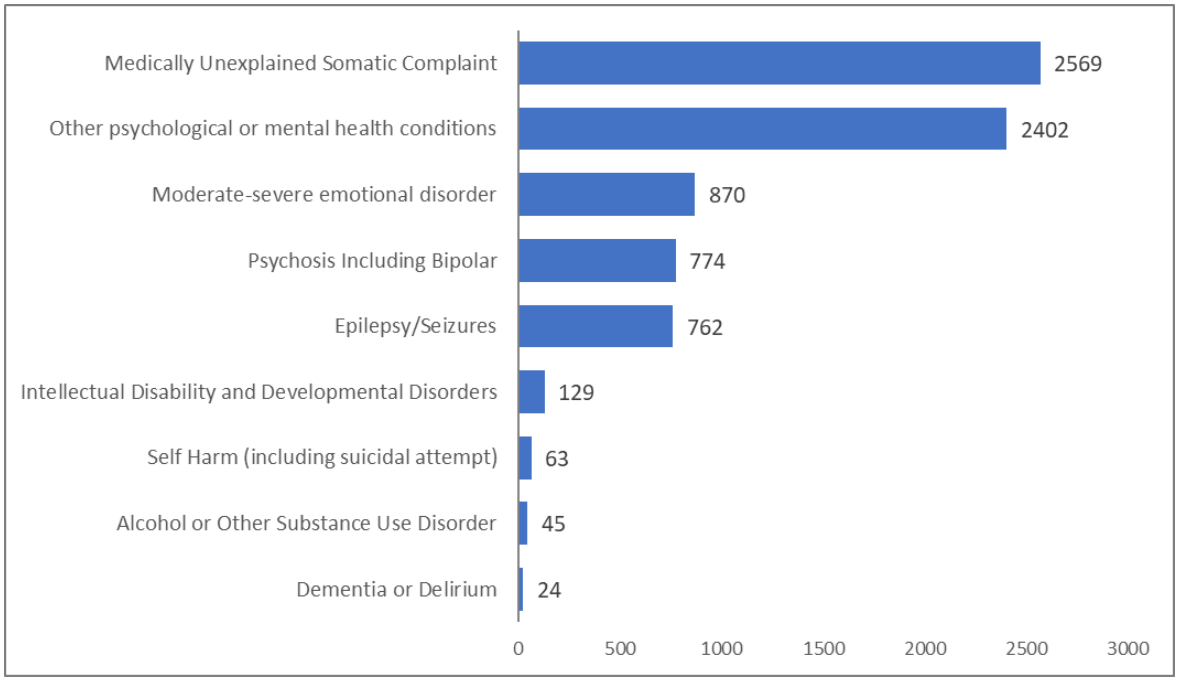
knowledge on WHO PEN and national protocols for PHCs and higher-level facilities. Screening and health promotion on NCD risk factors for lower level cadres is also necessary. Printed copies of National Protocols for NCD Management in health facilities should be disseminated.

Figure 3: Number of reported NCD Cases in Health Facilities (August – October 2019)



The figure below indicates the MHPSS morbidity trends as reported in DHIS2 during the reporting period. Somatic complaints account for the largest proportional morbidity, followed by 'other psychological or mental health conditions', psychosis, epilepsy and emotional disorders. The total cases were 7638.

Figure 4: MHPSS morbidity as reported in FDMN DHIS-2 weeks 20-29, 2019 (Teknaf and Ukhia combined)



Functionality of health facilities

The health sector partners are running 129 health posts in the Rohingya refugee camps; as well as 32 primary health care centers providing 24/7 services. Gaps in PHCs persist, and an additional 13 PHCs needed to meet the minimum standards, as indicated in the table below.

Table 1: Gaps in the PHCs in the Camps

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

Numerous government-run health facilities in the host community are supported by partners, including 10 community clinics, six union sub-centres and six Health and Family Welfare Centres, two Upazila health complexes and District-level Sadar Hospital.

Health Sector Action

Health sector coordination

Overall, the health sector partners are coordinated under the leadership of Civil Surgeon's Office of Cox's Bazar, the Directorate General Health Services Coordination Center and the World Health Organization (WHO), for better planning and implementation of a coordinated emergency response. The health sector benefits from the support 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, 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:

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

The health sector is firmly committed to improving quality of services through improved monitoring and strengthened field coordination. One Field Health Sector Coordinator at Cox's Bazar level, two health sector field coordinators at Upazilla levels and 10 Camp Health Focal Points (CHFPs) at camp level are deployed to support, strengthen field coordination and liaison between Cox's Bazar, Ukhia and Tenaf Upazillas and Camps. During the reporting period, Upazilla level coordination meetings and Camp level coordination meetings have been held to regularly review health activities and situation in camps and the host population. Under the leadership of Camp in Charges periodic camp level reviews mechanism has been institutionalized with support of CHFPs.

Assessments

Camp Health Focal Points (CHFPs) with support from Field Coordinators and health Sector Coordination team, conducted quarter 3 (Q3) monitoring assessment of all PHCs and health posts in the camps. This exercise is intended to help the sector track several JRP and non-JRP progress indicators and will guide supportive supervision activities. Some key findings are presented in the figure below.

Figure 5: Available medicine at the PHCs (at the time of survey)

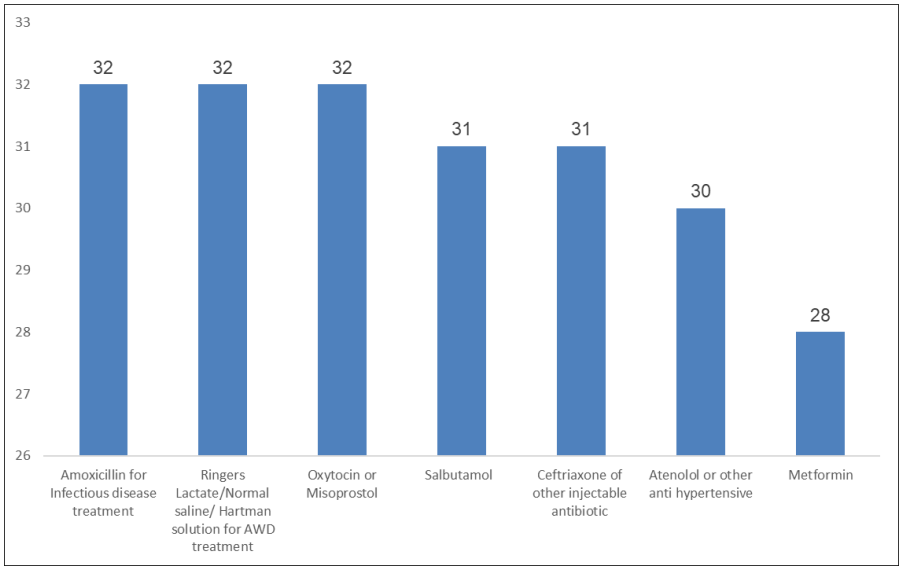
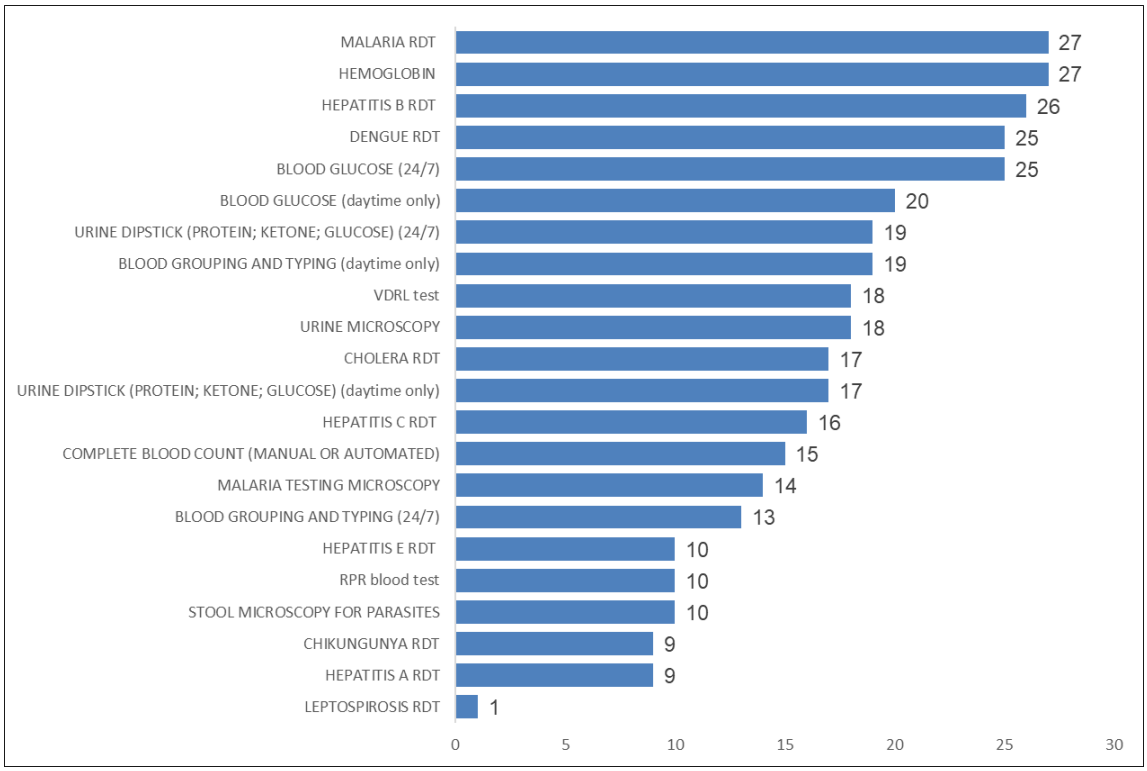


Figure 6: Available laboratory tests by PHCs (at the time of survey)



Support to health service delivery

From July to October 2019, a total of 1 514 988 outpatient consultations have been reported to the sector by 38 implementing partners respectively. Among these, 42% were provided to males and 58% to females.

Community level

During the beginning of the reporting period, the Community Health Working Group (CHWG) partners focused on dengue prevention in response to a general increase in reported cases in Cox's Bazar district. Messages were shared during courtyard sessions, meetings with community leaders and in community facilities. Altogether 5665 sessions were conducted for 43 357 participants, in addition messages were shared through door-to-door visits with all households.

From September onwards, an increase in Acute Watery Diarrhoea cases including suspected cholera cases was observed especially in Teknaf upazilla. A coordinated response between health and WASH actors was strengthened, hygiene and community health volunteers jointly visited all houses in the most affected camps 26 and 27 to provide quick messages on AWD prevention and hygiene promotion and refer patients with diarrhoea to health facilities. CHWs conducted 10 282 household visits and reached 31 345 refugees with messages. Four hundred and twelve patients with diarrhoea were identified and referred to health facilities.
Detailed discussions were held with the SRH working group and community health partners to understand differences between camps. In the same time, partners working in camps with high institutional delivery rates are sharing their best practices during the working group meetings to support other partners.

Vaccinations

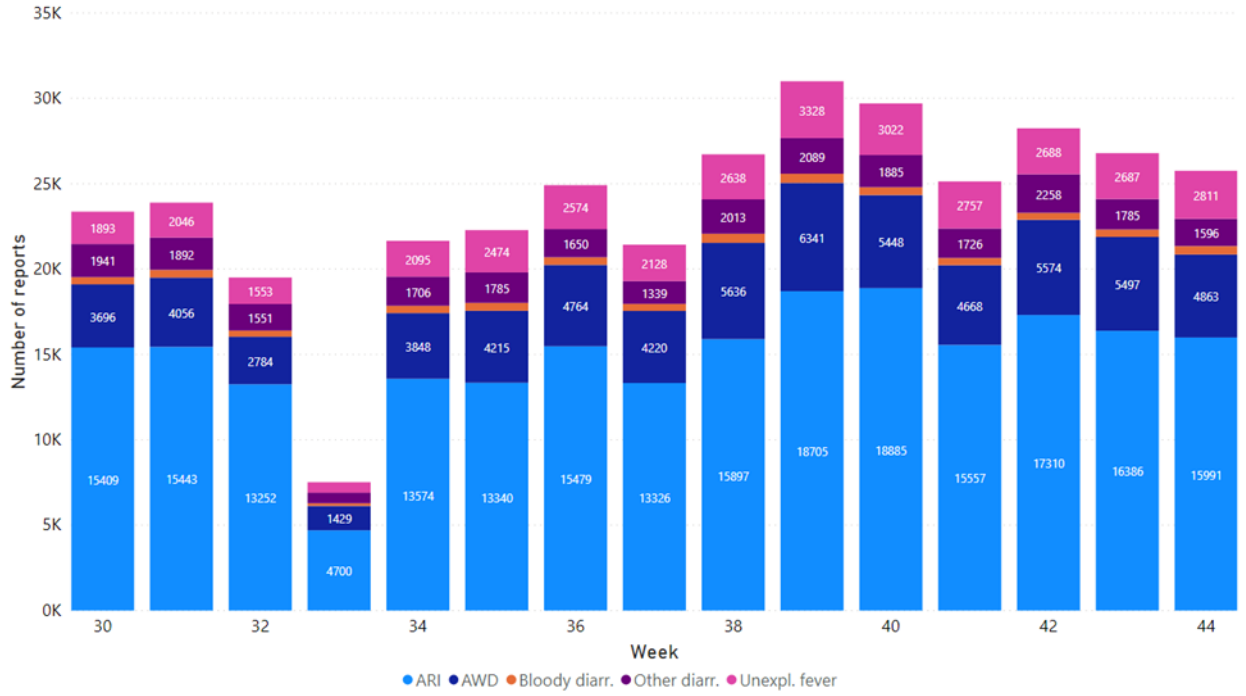
From the beginning of July to end of October 2019, 24 529 doses of BCG vaccine were administered among children 0-11 months of age; 17 090 doses of Pentavalent vaccine at first dose (Penta 1) and 14 004 Penta 3; 15 644 doses of Measles Rubella vaccine at 9 months (MR1) and 10 418 doses between 15-18 months (MR2); and 9 046 pregnant women received two doses of Tetanus Diphtheria.

Surveillance /Early Warning Alerts and Response System (EWARS)

A total of 167 (86%) health facilities are currently registered and reporting in EWARS. The cumulative reporting completeness is 88% and timeliness is 83% for 2019. A total of 680 alerts were generated between 21 July and 3 Nov 2019 (epidemiology weeks 30 to 44), of which 8 (2%) alerts were field investigated for risk assessment, 192 (58%) are being monitored and 135 (41%) were discarded. All these alerts were reviewed and verified within the required 48-hours timeframe.

Between epidemiological weeks 30 and 44, a total of 1 165 856 weekly consultations have been reported through EWARS since start of 21 July 2019.

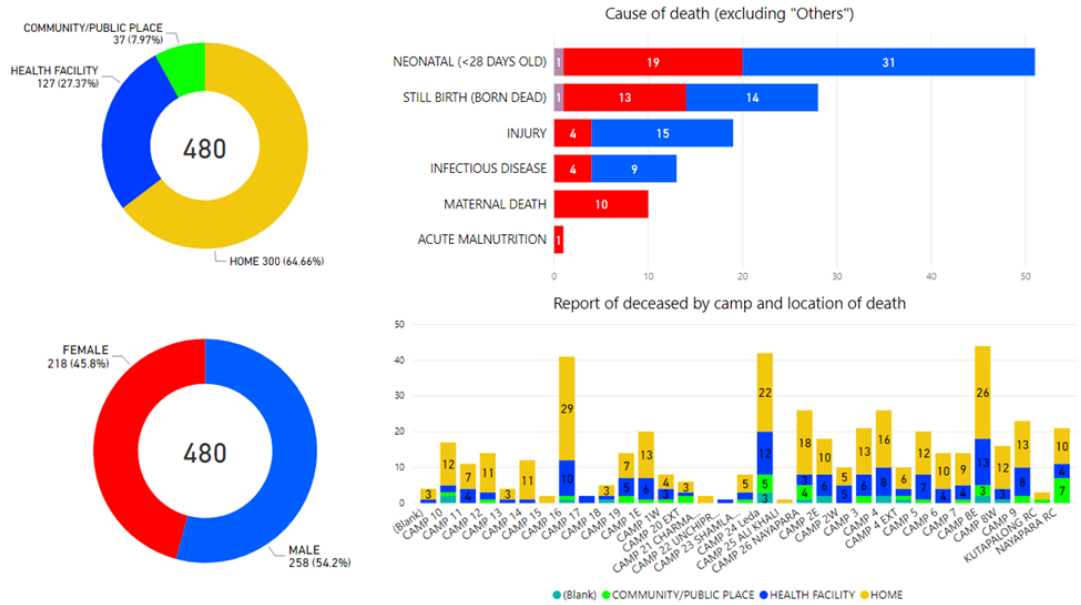
Figure 7: Reported cases of priority disease consultations between weeks 30 and 44 in 2019, EWARS



Community based mortality surveillance

A total of 480 mortalities were reported between weeks 30 to 44. A total of 218 female mortalities and 258 male mortalities were reported in this reporting period. Of the 218 female mortalities, 125 were reported to be women of reproductive age (ages 12 to 49) of which 10 were re-classified as maternal mortalities following verbal autopsy. A total of 28 still-births and 51 neonatal deaths were also reported. The average age of reported mortalities are 36.9 years of age for females and 35.1 years of age for males. Of the deaths reported, majority (64.7%) occurred in the home, 27.4% in the health facility and 7.9% in the community/public spaces. See figures below for more details.

Figure 8: Cause of deaths reported in EWARS through community based mortality surveillance, by sex (week 30-44)



Communicable disease control

To ensure that cases receive adequate clinical management, the Health Sector recommended that all cases of AWD that present to health facilities with any dehydration should be referred to diarrhoea treatment centres (DTCs), or, if there are no DTCs nearby, to PHCs with isolation facilities.

The Risk Communication Taskforce has been activated. A targeted oral cholera vaccine (OCV) campaign is being considered utilizing the 49 000 remaining doses in Cox's Bazar. A request to access the global oral cholera vaccination stockpile for 1.2 million doses was submitted on 31 October 2019 was approved.

Reproductive Health

Family planning: Data from the SRHWG data collection tool, which captures new and repeat family planning visits, shows an increase to 96 004 total facility visits in Q3 2019, and increase of 17 624 visits from Q2 (78 380).

Safe delivery: Across the 32 primary health care (PHC) facilities in the camps, there are 98 maternity beds available 24/7. A total of 3 998 facility-based deliveries occurred between July 21 to October 26th by skilled birth attendants. On average, 47% of all deliveries were conducted in health facilities, a remarkable increase from 32% at the end of 2018. Significant differences between camps are however observed, with institutional deliveries ranging from 12% to 100%. Long established camps, such as the registered camps, have the highest institutional delivery rates. Partners working in camps with high institutional delivery rates are sharing their best practices during the working group meetings to support other partners. None-the-less, continued efforts are being made to effect community preference to deliver at home. A traditional birth attendant (TBA) position statement has been drafted as a guidance note to clarify their scope of non-clinical work that can be done, including referral and labour support, further promoting safe facility-based deliveries.

Gender-based violence

The global health cluster project implementation on strengthening the capacity of Health Cluster partners to coordinate and deliver GBV services continued throughout the period. Key outputs included intensified follow-up that resulted in 80% of the 16 Primary Health care facilities assessed earlier submitting their action plans in response to facility feedbacks on identified gaps and the revision of the health component of the GBV referral pathways for 34 camps by the SRH and MHPSS partners to specify package of health services available for GBV survivors. Trainings were also conducted during the reporting period which included two batches of joint trainings on Clinical Management of Rape/Intimate Partner Violence (CMR/IPV) organized and supported by health sector, UNFPA, RTMI and IPAS for 43 frontline medical staff and two batches of training supported by WHO and health sector on first line support for 56 medical staff from nine health posts to address service availability gaps. Further, a draft Standard Operating Procedure (SOP) on health service delivery to GBV survivors was development and has since been included in the GBV SOP and will be finalized in the coming period.

Mental health and psychological support, non-communicable diseases

By the end of October, 54 healthcare professionals (medical officer, nurses and medical assistants) from 8 agencies representing 18 PHCs received training on WHO Package of Essential Noncommunicable Disease Interventions (PEN). The development and printing of Behaviour Change Communication (BCC) materials, with technical assistance of CHWG, are in final stages. A total of 16 partners have been supported by WHO with essential medicines and devices to manage NCDs.

During the reporting period, the MHPSS WG updated the 4Ws mapping of MHPSS activities and this was shared on October 1st including 54 organizations out of 77 identified with mental health and psychosocial activities. Numerous trainings were completed on Mental health (MhGAP) and according to monitoring data from Q3 2019, 81% of 32 PHCs have at least one healthcare worker trained to provide mental health services.

Water, sanitation and hygiene and environmental health

The 11th, 12th and 13th Water Quality Surveillance (WQS) were concluded and reports shared with the WASH sector. WQS is a regular monitoring exercise, in collaboration with UNICEF and the Department of public health (DPHE), in which the physio-chemical and microbial contamination of tube wells is assessed. The three consecutive reports revealed that 51%, 52% and 36% of water sources were contaminated with *E. coli* respectively. Whereas, the respective WQS rounds revealed 85%, 91% and 87% of drinking water at household level were contaminated with *E-coli* and not safe for drinking as per the WHO water quality guideline or standards. The second round of water quality test and WASH facility monitoring was conducted in 152 functional health facilities and the report released for implementation. Findings indicated the need for strong emphasis on water quality and safety in the facilities. Hand washing and excreta disposal in facilities showed good coverage.

Supportive supervision and Health Care Waste Management (HCWM) situation assessment were done in three health posts, three primary health centres and seven secondary health care facilities and the necessary advice and reports shared for improvement with the partners. Following the rapid health care waste management assessment conducted in Teknaf and Ukhiya Rogingya settlements, WHO in collaboration with two international consultancy firms, Health Care Without Harm, and Health Care Foundation Nepal, started the district-wide comprehensive Health-care Waste Management assessment and planning for the sustainable improvement of medical waste management in Cox's Bazar district. The assignment is scheduled to be completed by end of December 2019

WHO in partnership with HEKS/EPER had conducted the fact-finding evaluation on 22 health care facilities. The findings of the assessment revealed significant improvement of WASH services in most of the health care facilities.

Contingency planning

In the reporting period, health sector reviewed its contingency plan with a focus on monsoon and cyclone seasons planning. During the reporting period, there were several days of heavy monsoon rains, however the impact on health was relatively minimal. The table below summarizes the number of events; affected individuals and injuries as reported from the site management daily incident report during the reporting period.

Table 2: Summary of incidents reported in Rohingya camps from 12 May-14 July 2019 (source: site management incident reporting)

Type of Incident	Number of incidents	Number of Affected individuals	Number of Injured individuals
Fire	10	10	8
Flood	17	17	12
Landslide	111	105	100
Wind-Storm	173	166	147
Total	**311**	**298**	**267**

Four Medical Mobile Teams (MMTs) were on standby after Heavy rainfall warning by Bangladesh meteorological department on 10 September 2019. One MMT provided triage and referral services to the incident where 200 families in host areas in Teknaf were evacuated due to landslides after Flash flood in the second week of September 2019. From 7th July 2019, the Civil Surgeon's office health emergency operations centre (HEOC) was activated in response to landslides in Chittagong region/division, under the guidance of Ministry of Health (MoH), activated the health emergency operation center (HEOC) at Civil Surgeon Office.

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