HEALTH SECTOR
COX'S BAZAR

HEALTH SECTOR STRATEGIC PLAN 2023-2024

Photo credit: IOM/Cox's Bazar, Bangladesh

For a Sustainable and Resilient Health System

August 2022

TABLE CONTENTS

LIST OF ACRONYMS

AAP	Accountability to Affected Population
AWD	Acute Watery Diarrhea
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CFR	Case Fatality Rate
CHFP	Camp Health Focal Points
DHIS	District Health Information System
DGHS	Director General of Health Services
EWARS	Early Warning and Alert System
HeRAMS	Health Resource and Service Availability Monitoring Systems
HSC	Health Sector Coordination
HSSP	Health Sector Strategic Plan
INGO	International Non-Governmental Organizations
IOM	International Organization for Migration
MoH CC	Ministry of Health Coordination Cell
MPEHS	Minimum Package of Essential Health Services
PHC	Primary Health Care
PSEA	Prevention of Sexual Exploitation and Abuse
SARI ITC	Severe Acute Respiratory Infection Isolation and Treatment Centers
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
SPRP	Strategic Preparedness, Readiness, and Response Plan
UHC	Upazila Health Complex
UN	United Nations
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization

EXECUTIVE SUMMARY

August 25th, 2022, marks five years since the massive displacement of 742 000 Rohingya refugees/Forcibly Displaced Myanmar Nationals (FDMN) from Rakhine state into the neighboring Cox's Bazar, Bangladesh where there are now 930 000 living in 33 camps. More than half (52%) of the refugees are young people under 18 years, and half of the whole population are female (51.5%) underscoring an inherent risk for increased vulnerability.

The government of Bangladesh, supported by the donor community and the humanitarian actors established a large-scale multisectoral response that has ensured the protection of the affected people through access to basic services including health, Water, Sanitation and Hygiene, and Food assistance that are critical determinants of health and wellbeing. The health response, coordinated by the health sector and the ministry of health and family welfare is providing access to the Minimum Package of Essential Health Services- a lifesaving essential health service through a network of primary healthcare facilities (93 health posts and 46 Primary Healthcare Clinics), and secondary care facilities (5 field hospitals). Additional community-based health promotion and referral services have been a core intervention. Partner coordination at the field level has been reinforced through Upazila/camp-based structures- the Camp Health Focal Points.

In response to the COVID-19 pandemic, since May 2020, the health sector partners collectively scaled up capacity along the core response pillars including case management, infection prevention and control, testing, risk communication, and community engagement. Thirteen COVID-19 case management centers were established, and vaccination was ramped up with more than 80% of the population 12 years and above having received at least two doses of the COVID-19 vaccine. To date, the COVID-19 case fatality is <1%. Despite the pandemic, the sector-maintained access to essential health services with more than 4 million Outpatient patient consultations provided in 2021, with about 70% of births taking place in the health facility. The public health context continues to be dynamic. Relocation of Rohingyas to Bhasan Char, substantial funding cuts, Dengue epidemics, seasonal spikes in skin diseases, and increased demand for Non-Communicable Diseases underscore the shift in context- requiring attention.

This Health Sector Strategic Plan tackles the core strategic and operational health systems issues in the domains of Human Resources, Health Service Delivery, Health Management Information, Financing, Medical Commodities, and Leadership/governance and coordination. It is informed by the situational analysis and projections of a protracted crisis requiring continued support in the short to medium term. The plan targets vulnerable refugees/FDMNs and host communities to reduce avoidable mortality, morbidity, and disability and to ensure a healthy population. This goal will be achieved through two strategic objectives 1) Strengthen the Health Systems' capacity to deliver quality health care effectively and efficiently in a sustainable manner 2) Ensure equitable access to quality essential health care (preventive, curative, rehabilitative, and palliative health care) sustainably at all levels (community, primary, secondary, and tertiary health care levels). The sector will rely on evidence-based approaches

to address prioritized needs in the most effort efficiently inter-sectoral linkages and address critical cross-cutting issues including mainstreaming of gender and Accountability to Affected Persons.

Within the leadership and strategic planning framework, the sector will embrace the evidence from the August 2022 health facility rationalization as a precondition to a prioritized availability of essential primary healthcare services and foundation to an improved quality of services. Additionally, it strives to strengthen field-level health sector coordination structures in a more localized approach from the partners.

A strong Public Health Information Management System is crucial for planning, monitoring, decision making, and communication. The sector will continue to expand on the harmonization of intra-sector reporting mechanisms, promote the use of DHIS2, and scale up the implementation of Health Resources and Services Availability Monitoring System in Year 1. In 2023, the General Health Card shall be rolled out as the first step to improving the patient medical history record system- an intervention that will strengthen information sharing during relocation or repatriation.

The Health Sector is committed to ensuring access to quality health care services that are relevant to the prioritized needs. Implementation of a nationalized health service delivery/points of care is the first step. The Minimum Package of Essential Health Services shall be revised to tackle perennial problems of increased waiting time, gaps in emerging health needs particularly Non-Communicable Diseases, Mental Health, and quality of services. Unless access is deemed compromised, the dominant mode of delivery remains to be the static (health facility-based) model supported by an extensive network of about 1400 Community Health Workers governed by the revised Volunteer policy. Access to secondary care and referral linkages is vital. Partners will ensure adequate resources to conduct medical referrals.

In the context of the COVID-19 pandemic, the sector strategy assumes a base-case scenario as defined in the WHO Strategic Preparedness Plan (2022) considering all current information and profile of the Sars-Cov-2 virus. In this scenario, the partners will specifically scale down COVID-19 dedicated resources and integrate them into the general essential health care structures. For instance, a 60% reduction in SARI ITC bed capacity is anticipated, scale down of volunteers for contact tracing and maintaining a reasonable degree of preparedness. Together with the MoH, access to COVID-19 vaccination for refugee continue to be prioritized. Beyond the availability of essential health services, the sector is focused on addressing cross-sectoral issues of common mandates

Emergency Preparedness and Response. The sector partners will ensure minimum preparedness, advanced preparedness, and contingency actions for all common hazards with the potential for public health consequences. This will include strengthening the capacity for disease surveillance and early warning systems and stockpiling essential medical commodities. The sector will leverage on complementary work of the WASH and Nutrition sectors to increase coverage for nutrition activities especially Moderate Acute Malnutrition for Pregnant and Lactating Women and responding to infectious diseases.

CHAPTER 1

BACKGROUND

In 2017, a violent military crackdown in Rakhine State, Myanmar triggered an acute massive displacement of more than 742 000 people in August 2017 resulting in the ongoing humanitarian crisis in Cox's Bazar where an estimated 913 660 Rohingya refugees [a] (Female-51.5%, Male-48.5%) people now live under very harsh conditions across 33 camps in Teknaf and Ukhiya Upazila in the Southern District of Cox's Bazar, Bangladesh. Nearly 52% of the displaced people are children under 18 years of age or younger while older people - 60 years or older account for 3.6% and 1% had a disability. Most of the people are living in camps stretching from Kutupalong and Balukhali settlements (82%) and further southwards in the Teknaf areas (18%)[1]. These camps are overcrowded with each person occupying on average 18.76sqm far from the recommended 30sqm/person[2]. Similarly, the crisis has impacted the health systems at many levels.

The influx resulted in increased health care demand that exacerbated pre-existing health systems weaknesses such as inadequate staffing and medical commodities. The Ukhiya Upazila Health Complexes (UHC) reportedly recorded a 25% increase in consultations at the onset of the crisis while in Teknaf UHC, bed occupancy rose by 40%. To alleviate the situation, the Director-General of Health Services (DGHS)- scaled up Human Resource (HR) capacity at the time through a contingency of 118 personnel (25 from the Cox's Bazar Civil Surgeon)[3].

Additionally, the Government of Bangladesh together with United Nations (UN) agencies, International Non-Governmental Organizations (INGO), and National NGOs with support from multiple donors and the private sector collectively scaled up the multi-sectoral emergency lifesaving response - providing the necessary protection assistance. In the same vein, the health sector dramatically increased its capacity, reinforcing government efforts to preserve the health system and ensure adequate access to essential health care aimed at reducing preventable excess morbidity and mortality. By end of the first quarter 2022; there were about 80 health implementing partners providing primary and secondary health care services through a network of 93 health posts, 46 Primary Health Care centers (PHCs)[4], and Field Hospitals in the camps. In the host community, community clinics, union centers, and Upazila Health Complex are receiving various types of support through the Health Sector partners. Thus far, these humanitarian actions from the Health Sector partners, aid agencies, and the government of Bangladesh have created a positive shift in the Public Health Situation.

a. The Government of Bangladesh refers to the Rohingya population in Bangladesh as "Forcibly Displaced Myanmar Nationals (FDMNs)." The United Nations (UN) system refers to this population as Rohingya refugees, in line with the relevant international framework. In this Joint Response Plan document, both terms are used, as appropriate, to refer to the same population.

OVERVIEW: COX'S BAZAR PUBLIC HEALTH SITUATION

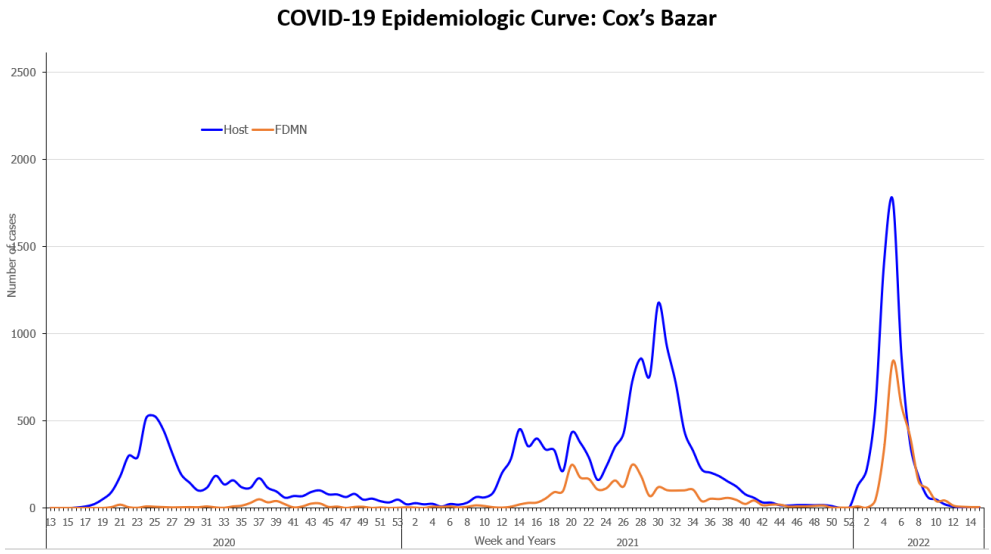
To inform the health strategic plan, this section takes stock of the current public health context guided by the strategic objectives and approaches committed in the 2019 Health Sector Strategic Plan (HSSP). It attempts to assess the extent of effectiveness achieved through the past strategy and draw key lessons to inform the subsequent approaches moving forward. On the heels of the acute phase of the crisis, the health sector's main goal was to ''minimize [excess] morbidity and mortality and improve the health and nutrition status and overall wellbeing of refugees'' through primary health care. Strategically, the Minimum Package of Essential Health Services (MPEHS) was developed as a standard guide to achieving the Sector Primary Health Care (PHC) goal. The MPEHS was to be delivered and coordinated through four broad objectives in the HSSP - all tailored to the provision of essential curative and preventive health care. The plan was forward-looking into 2022 and flexible to adaption in recognition of the rapidly changing local dynamics that include the COVID-19 pandemic, changing funding situations, local political contexts, etc.[5]. A similar standard is required for secondary care facilities in the future.

COVID-19 PANDEMIC

Approximately two years have elapsed since the COVID-19 pandemic was first declared in the first quarter of 2020. By December 2021, Bangladesh had confirmed 1 582 368 infections and 28 054 deaths[6]. By May 2022, Bangladesh had experienced recurrent surges of COVID-19 infection driven by the delta and omicron variants in June-August 2021 and Jan-Feb 2022 respectively[7]. By 24th April 2022, there were 29 369 COVID-19 infections recorded in Cox's Bazar- 20% among the refugees. A total of 311 COVID-19 deaths were reported, and 13% were among the refugees. Overall, Case Fatality Rate (CFR) among the Refugees/ FDMN was low at <2%. Despite the relatively lower absolute numbers of infected persons; the public health threat was and remains significant overcrowding, poor living, and Water Sanitation and Hygiene (WASH) conditions in the camps that limit people's capacity to adhere to the public health measures such as physical distancing.

Available data indicates a close relationship between infection rates among refugees and the host community. Infection rates among the refugees generally lagged that of the host community with the incidence rate remaining far below that in the host community. After the peak in infection rates, the refugee infection rate declined ahead of the host community[8].

To reduce excess mortality from COVID-19, partners immediately established thirteen COVID-19 Severe Acute Respiratory Infection Isolation and Treatment Centers/SARI ITCs as a field-based infrastructure for COVID-19 case management in the camp.



So far, equitable access to the COVID-19 vaccine presents one of the most viable opportunities to put an end to the pandemic. As of December 2021, more than 117 million vaccine doses had been administered in Bangladesh. The efforts of the Government of Bangladesh to include the Rohingya in the vaccine plan resulted in more than 300 000 being fully vaccinated. This is worthy of special recognition. Not only does this fulfill the central commitment of the Universal Health Coverage goal to leave no one behind but contributed immensely to reducing the risk of continued infection, and recurrent surges/waves of infection in the future for a population where delivery of health care was already a challenge.

HEALTH SYSTEMS

HEALTH SERVICES COVERAGE

In the camps, essential health services are delivered through a network of primary and secondary healthcare facilities. By April 2022, there were about 77 health partners including the MoHFW, UN, and I/NGOs that are providing a range of health services based on the government-approved minimum package of essential health services for primary health care. Through an active engagement between the government and the health sector, previous rationalization exercises have resulted in a relatively equitable distribution of health facilities. However, these gains are being eroded recently due to uncoordinated health facility establishment. For instance, by end of Q1/2022, there was an overall excess of health posts than recommended yet in 6 camps (2W,5,8W, 25, 26, NRC) there were inadequate numbers of Health Posts. This distribution pattern of health facilities demonstrates a degree of inequity and a need for continued rationalization of decisions in health facility allocation and distribution. In total, there were 90 Health Posts against 81 recommended. Based on the recommendations of the MPEHS standards, the overall number of HP has reached saturation. Instead of opening new facilities, the sector shall focus on consolidating the scope and quality of services, reallocating facilities to areas where there are true gaps.

By end of Q1/2022, four facilities were providing a mix of primary and secondary facilities in the camp. This includes Medicines Sans Frontiers (MSF), Friendship, Disaster and Emergency Management Authority/AFAD (Turkish field hospital), and Hope Women's Hospital. Despite the quantity of secondary healthcare facilities meeting the minimum standards, the quality and scope of work are limited. For instance, Friendship and Hope hospitals function predominantly as Comprehensive Emergency Obstetrics and Newborn Care (CEmONC) centers while the rest as general hospitals.

Table 1: Availability of health facilities in the Camps (April 2022)

Type	**MPEHS standard in the Refugees/FDMN camps**	**Numbers operational (August 2022)[9]**
HP	One health post per 10 000 population and within 20 minutes walking distance from patients' home	93
PHC	One PHC per 25 000 population and within 30 minutes walking distance from patients' homes.	46
Hospital	1 per 250 000	10

When accessibility was assessed based on the Sphere standards for Health, most people were found to reside within the recommended 01-hour walk from the health facility located in the camps. A survey conducted in the camps found that only 1% of households reported having to walk for more than 1 hour to the nearest health facility. Asked about the location where they sought services, 64% of the people preferred NGO-supported health facilities as their predominant health service points. Private clinics and drug shops accounted for 26% and 20% of the services respectively, indicating that a significant proportion (46%) were variably spending out-of-pocket to meet their healthcare needs. Only 6% sought services from Government facilities while traditional/community healers contributed 1%[10].

HUMAN RESOURCES

Most of the health partners continue to make progress toward filling the staffing norms stipulated in the MPEHS. From the health facility resource and service assessment conducted in April 2022, the Health Sector reported a total of 1 055 Skilled Births Attendant/SBA (392 Medical officers, 369 Nurses, and 294 Midwives)- equivalent to 23 SBA per 19 699 people compared to the Sphere standard of 23 SBA per 10 000 people. Therefore, current levels of SBA for the refugees/FDMN are only 51% of the expected 2 078. Besides the inadequacy of health workers, their inequitable distribution and quality are underlying health workforce issues that are affecting access to skilled staff hence affecting the efficiency of health service delivery. As an example, access to 24/7 CEmONC services has been difficult to attain at the Upazila Health Complexes due to a shortage of skilled staff. Contributory factors to the staff challenges

include low levels of motivation, burnout, mass enrolment into government public service, and hardship conditions - all resulting in observed high turnover.

Table 2: Distribution of selected health care workers in Cox's Bazar refugee/FDMN Camps

HR	Health Post (HP)	Primary Health Centre	Total, Jan-March 2022	Total, October-December 2021
Medical Doctors (Male)	81	180	261	227
Doctors (Female)	54	120	174	165
Nurses (Male)	23	118	141	89
Nurses (Female)	104	276	380	280
Medical Assistants (Male)	88	152	240	227
Medical Assistants (Female)	42	63	105	105
Midwives (Male)	0	0	0	0
Midwives (Female)	82	256	338	294
Dispenser (Male)	66	38	104	122
Dispenser (Female)	23	20	43	54
Total	563	1 223	1 786	1 563

COORDINATION

Under the Global Health Cluster (GHC) approach, the Health Sector (HS) is to ensure that the health response in the humanitarian setting is delivered effectively, of acceptable quality, and remains accountable to affected people. Since the onset of the crisis in Cox's Bazar, the Sector has increased its field-level coordination capacity through the Camp Health Focal Point (CHFP) - exclusively supported by UNHCR and IOM along with their respective Areas of Responsibility (AOR). The CHFPs reinforce inter-sectoral coordination at the field level, monitor the availability of health services at the camp level among other things, and function as knowledge brokers between the refugees, partners, and camp authorities. The HS is also supported by Technical Working Groups for Community Health/CH, Risk Community and Community Engagement/RCCE, Sexual and Reproductive Health/SRH, Mental Health and Psychosocial Support/MHPSS, Epidemiology, Case Management, Infection Prevention, and Control/IPC, a Gender Specialist, and Emergency Preparedness and Response/EPR. The MoHFW represented by the Civil Surgeon represents the government of Bangladesh as a co-lead to the health sector. Additionally, under the World Bank financing to the government, the Directorate of General Health Services (DGHS) Coordination Cell was established to strengthen the government's participation in coordinating the health response. The Health Sector also closely

coordinates with the RRRC on non-technical health operational matters through the Refugee Health Unit (RHU) to the delivery of health care.

With about 77 partners (40 under the Joint Response Plan/JRP) operating at different levels of the health sector, and more than 140 health facilities in the camps; a robust field-based coordination system is required to meet coordination needs on the ground. Overall, the financing model for the sub-district/field level coordination structures is delicately balanced on the availability of funds and prioritization from specific agencies (IOM/UNHCR) who fund CHFP along their AOR. With each CHFP supervising 3-4 camps, the ground presence is thinned out necessitating an augmented layer of support. Unless this model is advanced as a priority, it carries an inherent risk of interruption or collapse whenever the resourcing mechanism is destabilized. This level of risk similarly applies to other equally vital health coordination mechanisms, e.g., the Field Hospital (FH) coordination, and 250 Bed Sadar Hospital coordination, which are largely dependent WHO supported coordination structures.

Principled and committed leadership is essential in ensuring that health programs are coherent with the Health Sector strategy and priorities- to achieve a common goal through a common approach to the local health problems. In Cox's Bazar, more effective coordination is possible with a strengthened leadership engagement from the government side. To translate the health sector strategy into better programming, the use of local public health information and evidence should be enhanced. For instance, data and recommendations gathered from rationalization exercises[11], service monitoring, and public health analysis should be upheld judiciously by all stakeholders - local authorities, and donors- as a basis to inform and implement decisions without which, attaining meaningful progress for the desired health system reforms will be challenging.

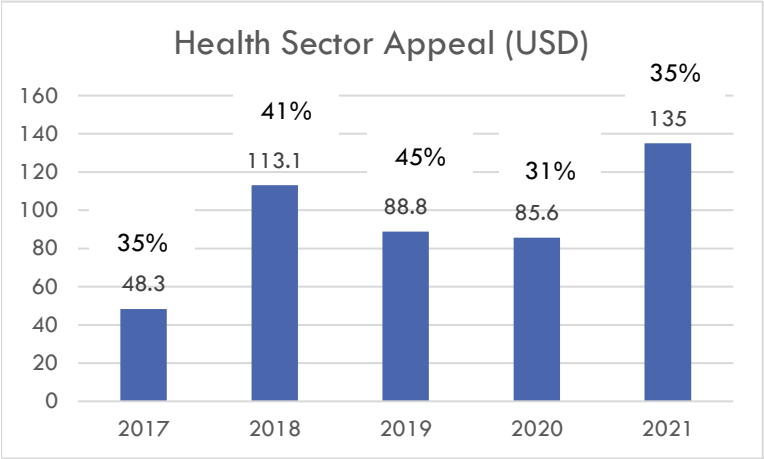
HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS)

The overall reporting rate on Early Warning, Alert, and Response Systems/EWARS has been satisfactory, with more than 80% of the sentinel 174 sites reporting on time. Reporting rate on DHIS2 reporting is poor with significant incompleteness of data. On both platforms, the quality of data and completeness of information require improvement without which the sector will fall short in measuring the health status and performance of the health systems.

A robust Health Information Management system is critical to provide the policy, decision-makers, and implementing partners the evidence base for effective decision-making, planning, and quality improvement efforts.

FINANCING

The refugee crisis in Cox's Bazar is now a protracted scenario with dwindling funding levels. An analysis of the three years of funding data (2018 to 2020) showed only partial funding for the response. In 2020, only 69% of the required USD 976 000 000 was received (all sectors). Only 59% of the required 1bn total was received in 2021 for all sectors. On the contrary, the number of people targeted for health assistance in the camps has remained high at around 850,000 (2020) to 884 000 in 2021, yet health response persistently reported less than half of its required funding through this period- only 35-45% received. The low reporting rate to the Financial Tracking System (OCHA FTS)[12] minimizes a comprehensive understanding of the funding situation.



% percentage fund received vs JRP appeal (USD/Million)

MEDICAL COMMODITIES

Most health facilities have an adequate supply of essential medicines. However, good storage practice varies and deserves attention to ensure the quality of medical commodities. Although no concrete data is available, ad-hoc reviews point to gaps in rational drug use, especially for an antibiotics. Other threats include polypharmacy, and low popularization of national and WHO treatment protocols. On the other hand, lack of information about prescriptions leads to perceived poor quality, 'shop doctors' are rampant with people resorting to alternative sources of care that may expose people to financial hardship and may be unregulated putting them in more danger.

In the context of COVID-19, the sector has ensured access to available diagnostic and therapeutic tools. The government's decision to provide access to the COVID-19 vaccine for the FDMNs is applaudable from an inclusive policy perspective. Subsequent booster doses will be necessary based on available data, to suppress community transmission.

ESSENTIAL HEALTH CARE

UTILIZATION OF ESSENTIAL PRIMARY HEALTH CARE SERVICES.

The COVID-19 pandemic hurt health service utilization initially, with a 30% decline in OPD consultations from 4 993 168 (35%-Male, and 65%-Female) in 2019 to 3 487 256 (34%-Male, 66%-Female). However, OPD consultation improved by September 2021 coinciding with a

reduced incidence of COVID-19 at the time. A total of 3.9 million OPD consultations were provided- equivalent to a utilization rate of 2-3 consultations per person per year in the year 2021. OPD consultations declined jointly with the movement of the restrictions. According to DHIS2 data, the top reasons for OPD consultations included Skin Diseases (29.1%), Upper Respiratory Tract Infection (28.3%), and Gastroenteric problems (15.1%). Other common morbidities included Unexplained Fever and Injuries[13].

The population health status measured by the mortality rates Crude Mortality Rate (CMR) and under 5 years mortality rate (U5MR) meet the Sphere threshold for an emergency. According to a nutrition survey by UNHCR and Action Against Hunger, the CDR was estimated at 0.14/10000/day in the Kutupalong mega camp- slightly higher than that in Nayapara Registered Camp at 0.08/10000/day. Similarly, the (U5MR) was higher in the Kutupalong mega camp at 0.31/10000/day compared to that in Nayapara RC estimated at < 0.0010/10 000/day[14].

The sector exceeded the target for health facility delivery of 55% in the HSSP 2019, with current estimates at 70% compared to the 80% minimum target set in Sphere standards. This performance may be attributed to better community mobilization and sensitization in conjunction with wider coverage for referral and delivery services. For instance, by September 2021, 95% of the PHCs (39/41).

According to the MPEHS, all PHCs should provide BEmONC services. However, findings from the Q1-2021 Health Facility monitoring showed some gaps with fragmented delivery. Only 21 health facilities reportedly provided BEmONC services (06 signal functions-without Assisted Vaginal Delivery), while 41 facilities provided 03 signal functions (uterotonic, i.e., antibiotics, anticonvulsants), only 22 were conducting manual placental removal, and 60 facilities provided Post Abortion Care (PAC) services. A key priority is to enhance universal coverage for BEmONC services through the PHCs.

The use of modern contraceptives remains low with an unknown retention rate. In 2019, contraceptive prevalence (CP) amongst the Rohingya was estimated at 33.7% compared to the national average of 63.1% at the time[15]. In 2021, the CP stood at 50.9%, according to a study that surveyed 493 women in the Cox's Bazar Refugees/FDMN camps[16]. The study showed that short-acting contraceptive methods were most popular (injectables/Depo-provera-67%, Oral pills- 30%) while Long-acting Reversible Contraceptive (LARC) uptake was low-Implant 1.2%, IUD-0.4%. Many factors were responsible for this utilization trend. Up to 48% of non-users cited disapproval by husbands, 17% desired future pregnancy and 15% were due to religious beliefs. Follow-up in the immediate 3 months was low with 51% not visited by CHWs. Recently, the FP strategy was developed with a focus to strengthen community mobilization with an emphasis on male partner engagement, reinforced follow-up/counseling, and capacity building for service providers[17].

Access to clinical mental health care Mental Health remains a priority gap. By Q4/2021 only 10/43 PHCs reportedly provided clinical mental health while 37/41 PHCs provided non-

specialized support MHPSS services e.g., basic mental health care, and basic emotional and practical support by community workers (IASC MHPSS intervention period)[18]. The lack of specialized staff is one of the main barriers to access to quality clinical mental health services. Although 40 out of 43 PHCs had at least one staff trained in mhGAP, with minimal supervision capacity and high staff turnover, availability for clinical care follow-upon up is scarce. In coordination with the respective line directors, access to HIV/TB diagnostic services is available at predetermined facilities. Over the last two years, there has been limited progress in expanding HIV care through a decentralized approach. There is a need to continue further engagements to agree on a local HIV framework to govern HIV services.

ACCESS TO SECONDARY AND TERTIARY CARE: A REFERRAL SYSTEM

Inadequate financing capacity for referral services is a major factor behind the lag in the progress of achieving universal referral capacity for health partners. With insufficient funding and a short-term fund cycle, most partners have had to reprioritize the available resources to meet the essential care demands. Some practical challenges include a lack of funds to cover feeding, diagnostic, and treatment cost at receiving facilities. Seldom, there are critical coordination barriers at a camp level in approval processes to permit refugees out of the camps for elective referrals. In 2019, WHO-led Health Sector coordinated the development of a Referral SOP for 'Medical Referrals for Acute Life-threatening Conditions' (MRALC) in collaboration with UNHCR and IOM, to partially respond to some of these barriers and bridge the referral gap and ensure a continuum of care. From 2020- to March 2022, IOM referred 4 570 patients to Cox's Bazar Sadar hospital (83%) and Chittagong Medical College (17%). Similarly, UNHCR supported the referral of 5 346 patients in 2021 alone-67% to Cox's Bazar Sadar hospital, and 12% to Chittagong Medical College Hospital. According to data from both UNHCR and IOM, the main indications for referrals included 1) trauma and other injuries an average of 24%, 2) Surgical cases (13.2%), and Obstetrics (13-15%). The support from IOM and UNHCR under the MRALC scheme is a temporary measure scheduled to phase out in the future. As a result, health partners/agencies will have to initiate an early plan for individual referral resources. The gains from a single agency support system are temporary and unstainable. A whole-of-sector approach is required where actors plan and establish referral infrastructures aligned to the Minimum Package of Essential Health Services/MPEHS[b] and the harmonized Referral SOP.

[b] *The minimum package of essential health services is a list of key health services that guarantee the minimum care to be provided to the population with the objective of enhancing equity and end quality. This includes but is not limited to services for Communicable Diseases, Non-Communicable Diseases, Sexual and Reproductive Health, Child Health including immunization, Infection Prevention and Control, Mental Health, General Medical Services, rehabilitation, palliative care, laboratory, and diagnostic support services.*

JUSTIFICATION

The Health Sector recognizes a safe, dignified voluntary repatriation as the most desired long-term solution to the crisis. While such a solution is sought, the sector together with the donor community and partners commits to supporting the Government of Bangladesh in delivering inclusive, cohesive, and principled health assistance through a comprehensive strategic plan targeting both FDMN and the host community.

In the context of a protracted crisis[c,19] the health interventions will go beyond establishing essential services but consolidate and improve the quality of comprehensive health care through this plan for a prioritized, efficient, and accountable response. This HSSP is a renewed, forward-looking plan that is compelled by the need to increase efficiency in the response while addressing the core public health needs of the affected population in an accountable manner.

Statement of commitment: Setting and Promoting Standards

The Health Sector leadership and stakeholders are committed to providing a comprehensive, quality health response for refugees in Cox's Bazar camps and surrounding host community as defined in the MPEHS, other all relevant SOPs and guidance documents e.g., the Referral SOP, Accountability to Affected Population framework, Health Sector Gender Action Plan, and through a unified approach as outlined in this HSSP

c. UNHCR defines a protracted refugee situation as one in which 25,000 or more refugees from the same nationality have been in exile for at least five consecutive years in a given host country

CHAPTER 2
STRATEGIC APPROACH

The HSSP aims to provide technical and strategic guidance for a cohesive, prioritized, and effective health response. It constitutes the core basis for systematic program design, implementation, monitoring, and evaluation actions that are aligned with the Core Humanitarian Standards for Quality and Accountability. It lays out the roadmap to foster an efficient strong health system that delivers quality care.

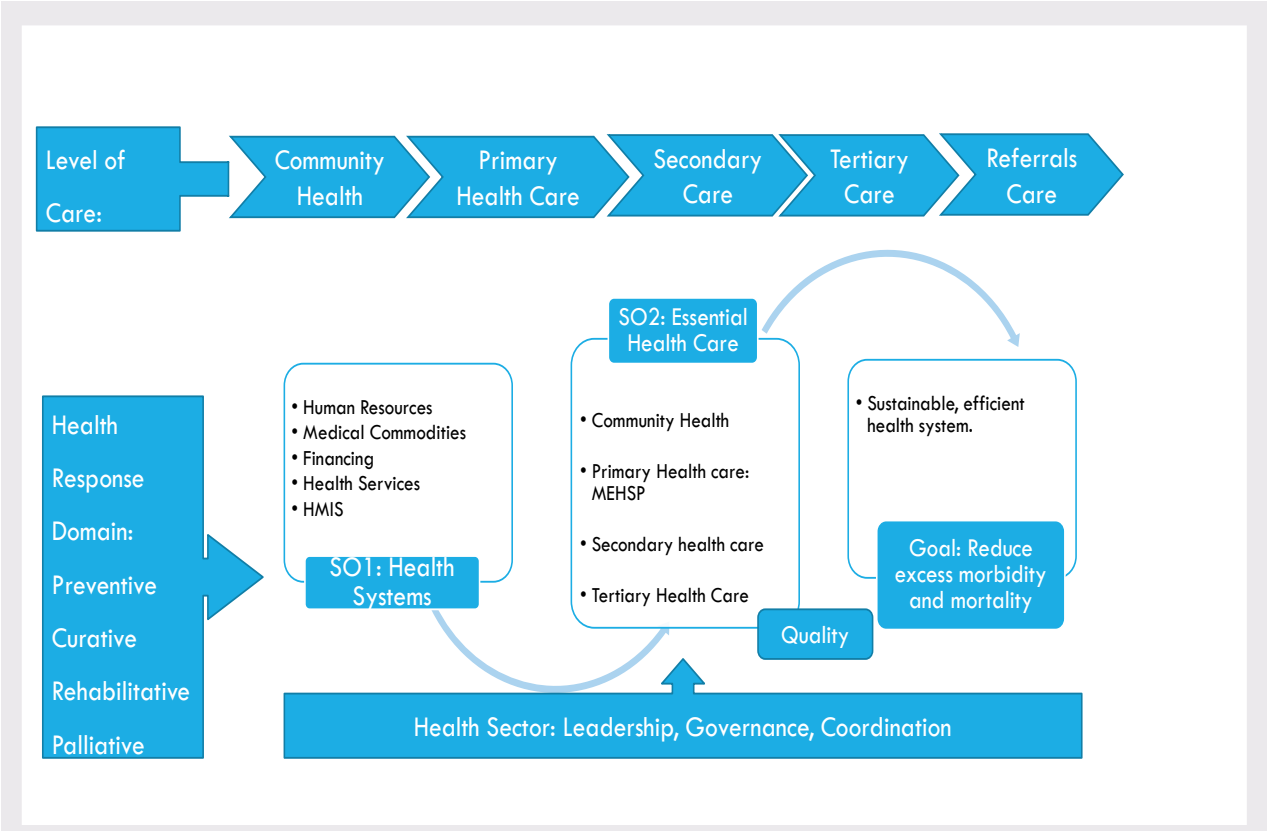
The Health Sector partners and stakeholders collectively acknowledge the plan of action outlined in this document as a roadmap to achieving the desired, acceptable health outcomes for the refugees/FDMN and host community through evidence-based and efficient approaches. The approaches below have been identified through a sector-wide consultative process and prioritization to deliver quality care in a predictable and accountable fashion for an estimated 1.4 million people (900 000 refugees/FDMN and 500 000 Host Communities) in Ukhiya and Teknaf Upazila through 2022-2024.

GOAL: TO REDUCE AVOIDABLE MORTALITY, MORBIDITY, AND DISABILITY, AND ENSURE A HEALTHY POPULATION (REFUGEE/FDMN, HOST COMMUNITY)

STRATEGIC OBJECTIVE

1. To strengthen the Health Systems' capacity to deliver quality health care effectively and efficiently in a sustainable manner. The sector will ensure a robust health system by providing strong leadership/governance/coordination as a core input to harness the full potential of all organizations, and resources (staff, financing, medical supplies) to deliver individual and public health interventions that improve health outcomes. It will strengthen monitoring systems to provide evidence for decision-making disaster risk reductions through emergency preparedness.
2. To ensure equitable access to quality essential health care (preventive, curative, rehabilitative, and palliative health care) sustainably at all levels (community, primary, secondary, and tertiary health care levels).

Fig 1: Health Sector Strategic Plan-Conceptual Framework



SO1. TO STRENGTHEN THE HEALTH SYSTEMS CAPACITY TO DELIVER EFFECTIVE AND EFFICIENT QUALITY HEALTH CARE SERVICES

The approaches outlined here provide direction on pertinent actions within each element of the health system to reinforce the health system's building blocks and ensure conducive conditions for the delivery of health services.

HEALTH SECTOR: LEADERSHIP, GOVERNANCE, AND COORDINATION.

WHO as a lead Health Sector lead agency, supported by the IASC Global Health Cluster, together with the Government of Bangladesh will continue to provide leadership, coordination, and oversight of the performance of the Health Sector in Cox's Bazar. The Health Sector Coordination (HSC), co-chaired by the Civil Surgeon will provide normative and technical oversight in collaboration with the Health Unit at the Office of the Refugee Relief & Repatriation Commission (RRRC). The HSC will continue to execute its wider and deeper technical functions supported by the Technical Working Groups/TWG, Technical Committees namely: Sexual and Reproductive (SRH), Mental Health and Psychosocial Support (MHPSS), Community Health (CH), Epidemiology, Infection Prevention and Control (IPC), Risk Communication and Community Engagement (RCCE), Emergency Preparedness and

Response, and Case Management. The priorities and strategy of these technical groups will continue to align with the HSSP. The leadership role of the health sector serves a cross-cutting function and is additionally elaborated along with relevant sections of the strategy. The Sector will also fortify its field representation by increasing capacity at the camp level.

Key interventions: Leadership, Governance, and Coordination of the Health Sector

i. Strategic Planning: Continue to provide timely strategic guidance and technical advisory role to the partners and the government. Besides developing this HSSP 2022-2024, the HS shall ensure coordinated strategic planning processes related to JRP.
ii. Rationalization and equitable distribution of health facilities: HS to ensure equitable allocation and distribution of health facilities in the camps through regular Health facility gap monitoring as a basis for prioritization of health facility allocation, among other factors. Specifically, conduct a rationalization assessment exercise in 2022 based on the rationalization principle from ISCG
iii. Cohesive Leadership: Reinforce existing mechanisms for transparent and coordinated prioritization of interventions at the camp level aiming for a cohesive and consistent decision-making process between the Health Sector-RRRC-Civil Surgeon. To this end, at least two annual consultative policy dialogues with CICs shall be organized to promote consistency and interconnectedness at a leadership and political level.
iv. Strengthen the coordination capacity of the Ministry of Health and Family Welfare, Office of the Civil Surgeon: Undertake actions to better partner with the MoHFW and increase their effective participation in the response. This will include, training, joint monitoring analysis, consultative decision-making, etc.
v. Training and Capacity Building: The Health Sector to actively engage in building the capacity of NGOs for their effective participation in the response. The sector shall deliver basic training on coordination of humanitarian health response, especially for national and new actors in the response
vi. Strengthen Field Coordination Capacity: The HS shall scale up capacity for increased field presence, monitoring, supervision, and local coordination by distributing camp-based coordination roles to competent partners. The sector will identify a camp health focal partner during the induction phase of partners into the new coordination roles at the camp level, while the CHFPs will continue to simultaneously offer oversight, support, and capacity building for the partners to strengthen camp level coordination
vii. Evaluation: The Health Sector will coordinate and lead an annual analysis of the response and progress against the targets of the HSSP. This analysis shall provide the evidence base for decision-making on remedial and mitigation reforms to achieve the

HEALTH SERVICES

The health response shall directly contribute to the fulfillment of the UN Sustainable Development Goal (SDG) 3 to promote health and well-being for everybody. Specifically, SDG 3.8 underscores the principle of Universal Health Care to ensure access to adequate essential health care without exposing individuals to financial adversity. Central to this goal is the sector's MPEHS which defines the minimum essential services to be available for everyone in the response. The MPEHS prioritizes core curative services that include Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) in line with SDG 3.1, 3.2; Communicable and Non-Communicable diseases services contributing to SDG 3.3 and 3.4 respectively; MHPSS, Palliative care among others. The Health Sector aims to ensure that the health system's input (Human resources, Financing, Medical Commodities) is organized to produce a comprehensive health service package that is appropriate and relevant in addressing the health concerns of the FDMN and Host community.

Key Interventions: Availability of Health Services

i. Health Service Delivery Model: Curative services will be provided through a static approach at designated health facilities with mobile Health approaches including community-based distribution of health kits reserved and activated by the Health Sector as a temporizing measure in emergency scenarios e.g., fires, cyclone, monsoon rain, floods where existing capacity may be overwhelmed, or access interrupted.

ii. Development and Application of Standards: The Health Sector leadership shall ensure partners fully adhere to the MPEHS standards. Similarly, it will develop standards for secondary care services.

iii. Integrated Comprehensive Services: Promote an integrated service delivery approach within the appropriate level of health care according to the MPEHS leading to a comprehensive health service contrary to siloed and fragmented services.

iv. Strengthen Referral System: Ensure continuity of care by strengthening referral systems. The HS will annually review the referral system arrangements. Partners on the other hand shall ensure adequate resources to ensure patients have access to referral services based on the MPEHS and Referral policy.

v. Ensure Safety Standard and Infection Prevention Control through WHO multimodal improvement strategy.

HUMAN RESOURCE FOR HEALTH

For the health sector response to achieve its objectives at the individual and public healthcare level, the role of knowledgeable, skilled, equitably distributed, and motivated staff is vital. A set of coordinated and complementary activities is recommended to ensure that the people have access to the right mix of health workers that are of sound professional competency and behavior. To this end, the sector will prioritize the following:

Key Interventions: Human Resource

i. Staffing Standard: Based on MPEHS, health facilities shall deploy an adequate number of qualified personnel, and ensure performance management through supervision, monitoring, and capacity building. Strengthen Information based on HR for Health for policy advocacy: Health Sector to continue to regularly track staffing levels against agreed staffing norms to assess availability and access to skilled workers.
ii. Learning and Development: Through the Working Groups and other technical bodies, the Health Sector recommends harmonized field-based in-service training with more direct supervision and monitoring for the training to achieve the desired impact. Learning needs should be determined in consultation with respective Technical Working Groups. Health Sector will work voluntarily to institutionalize learning mechanisms at the facility and wider sector level e.g., Continuous Medical Education at the facility level, and morbidity and mortality audits.
iii. Retention: Partners to share best practices on improving staff motivation and retention strategies
iv. Code of Conduct: Ensure all staff are trained on the humanitarian code of conduct, Child Safeguarding, and Prevention of Sexual Exploitation and Abuse and Harassment (PSEAH)

HEALTH MANAGEMENT INFORMATION SYSTEMS

The WHO-led Health Sector will ensure the organization and delivery of essential health care and public health intervention are driven by strong evidence derived from the analysis of health data. It will continue to conduct timely analysis and disseminate the findings through various information products to provide a picture of 1) health status/threats, 2) performance of the health system and 3) availability of resources and services. To ensure the provision of accurate and reliable public health information, the sector shall fortify the information management process by simplifying, harmonizing, and establishing more predictable reporting requirements. To take this forward, a technical task force of information management officers within the health sector shall be created for a limited period to escalate this transformative agenda. The team will identify the key challenges to HMIS and provide recommendations, implementation, and monitoring plans. Key interventions to strengthen the Public Health Information Service will include:

Major interventions HIMS

i. Strengthening reporting DHIS2, EWARS, 4Ws. Increase reporting rate on DHIS2 as the main reporting/HMIS tool, build capacity for transition to government-owned reporting platform. Increasing analysis and dissemination of data HMIS information at the camp level. Organizing DHIS2 refresher training for reporting officers, increase utilization of DHIS data, increase support supervision and monitoring
ii. Simplify routine monitoring of health resources and service availability: Reducing duplication in reporting requirements, explore and roll out Health Resources and Services Availability Monitoring System (HeRAMS) to consolidate health facility monitoring mechanism.
iii. In a timely manner, provide comprehensive public health situation analysis to partners and donors as the basis for evidence-based planning, the decision for effective response
iv. Improve the quality of documentation and record-keeping at service delivery points by introducing paper-based harmonized health booklets.
v. Develop harmonized quality monitoring tools and systems seeking input and contribution from all WG and Technical Committee under the Sector

HEALTH FINANCING

The health actions aim to ensure all affected people have access to quality essential health services without undue financial risk and hardship or erosion of basic means of survival/livelihood because of out-of-pocket payment. To achieve this, the health sector shall support efforts to mobilize adequate resources while promoting efficient resource utilization for programs aligned with the HSSP.

i. Advocate for medium to long-term financing over short-term and fragmented funding for strategic programs. In this regard, strengthening decentralized secondary care and integrated primary health care intervention is important.
ii. Resource mapping and tracking: In addition to promoting regular and timely reporting to the Financial Tracking System, the HS will consultatively work with partners to identify alternative resource indicators and reporting mechanisms.
iii. Support and prioritize the inclusion of refugee health financing into national fiscal planning for instance regarding Vaccination, and future operational support to Ukiya specialized hospital
iv. Contribute to the policy dialogue on harmonization of salary band for volunteers amongst actors while prioritizing the feasibility and impact of such policies on sector programs

v. Partners will ensure that people access health care services free of charge at the camp level and where costs are incurred, agencies should ensure adequate support to offset those costs for the refugees/FDMNs. Mechanisms to facilitate feedback and complaint mechanisms in a safe and confidential manner should be established as part of efforts to gather information on illicit payment for services, and community concerns on financial barriers to access care.

vi. Collaborate with donors to adopt innovative financing strategies that promote the rational distribution of services and alignment to HSSP. Funding allocation structures geared towards integrated service delivery should be explored at every funding opportunity. The HS and donors shall agree on a common strategy to inform donors' financing, increase partnership, and promote joint planning.

SO2: MAINTAIN EQUITABLE ACCESS TO ESSENTIAL HEALTH CARE (PREVENTIVE, CURATIVE, REHABILITATIVE, PALLIATIVE HEALTH CARE) IN A SUSTAINABLE MANNER AND OF ACCEPTABLE QUALITY AT ALL LEVELS (COMMUNITY, PRIMARY, AND SECONDARY HEALTH CARE LEVELS)

COMMUNITY ENGAGEMENT TO PROMOTE AND SUSTAIN THEIR HEALTH

Under the leadership and guidance of CHWG, partners shall prioritize health education and behavior change communication through evidence-based interventions to promote health, increase demand, and timely utilization of available health care services. The CHWs play a critical role in reducing community transmission of infectious diseases where they ensure people have access to healthcare and information (Communicable Disease Standard 2.1.1., Sphere) that promotes preventive public health measures as the first line of defense against infectious diseases including COVID-19. CHWG will target other common morbidities including Non-Communicable Diseases (NCD), continue Community Based Event Surveillance, strengthen referral systems at the community level, etc.

To the extent feasible, CHWG will continue to build the capacity of CHWs/volunteers to promote polyvalent messaging aimed at reducing message fatigue amongst beneficiaries and ensuring access to holistic and contextualized information. To this effect, the integration of health and nutrition volunteers will be explored. The health sector will strengthen the linkages between CHWG and RCCE WG to support the integration of Health, Nutrition, and WASH messages. The capacity building shall prioritize the meaningful participation of Rohingya and Bangladeshi CHWs as an effective and trusted resource by the community.

Key interventions: Community engagement to promote and sustain their health

i. Effective coordination, communication, and information sharing on health-related matters
ii. Maintain and improve access to standardized key messages and material across the camps through appropriate dissemination platforms.
iii. Implement community health outreach programs in line with the Joint Response Plan (JRP) and Health Sector Plan and adapted to evolving health priorities and emergency response needs.
iv. Continue to develop and support consultative processes that engage refugees in designing appropriate, accessible, and inclusive responses in public health including reproductive health, nutrition; Mental Health, and Psychosocial Support (MHPSS).
v. Capacity building to community health teams (CHW supervisors/managers and CHWs) on priority public health, reproductive health, MHPSS, and nutrition messages including preparedness and response to emergencies.
vi. Create linkages with MHPSS, SRH, Communicating with Communities, RCCE, and GBV Working groups as well as Nutrition and WASH sectors for joint programmatic interventions as necessary.
vii. Mobilizing and integrating community health workers and community nutrition volunteers in disseminating health and nutrition messages in the community and increasing the capacity of refugees involved in psychosocial support as volunteers to become community para-counselors.
viii. Monitoring of community health programs including community-based data collection systems.

PRIMARY HEALTH CARE SERVICES

Health care will be delivered through a primary health care approach consisting of Health Post and Primary Healthcare Centers in the camps while Secondary health care will be availed through field hospitals and the Upazila Health Complexes- Teknaf and Ukhiya. Sadar district Hospital and Chittagong Medical College hospitals shall remain the focal referral points for tertiary services accessible through the mechanism contained in the unified referral SOP. Patient movement and transfers across the different levels of care should strictly follow the referral pathway in a bid to protect the capacity of the secondary healthcare facilities.

The MPEHS will be delivered through static health facilities (HP, PHCs) prioritizing General care, Child Health, Communicable & Non-Communicable Diseases, Sexual and Reproductive Health, Infection Prevention, and Control, etc. Providers will ensure resources and systems are in place for full compliance with these MPEHS standards. In addition, the Health Sector will consultatively and timely undertake a review of the MPEHS considering the situation analysis and perspectives of service providers, aligning to this HSSP.

COVID-19 Case Management at the Primary Health Care level

The SARI ITCs remain the sector's core strategic pillar for COVID-19 case management targeting moderate and severe cases within camps. In line with the WHO recommendations for ending the acute phase of the COVID-19 pandemic, the HS will work with the partners, government, and donors to identify a safe, integrated, and scalable approach to COVID-19 clinical care[20]. The HS will lead efforts to derive alternative strategies to transition and integrate SARI ITCs into the health systems while harnessing some of the operational investment made during the last two years of the pandemic.

Under the technical guidance of the WHO-led Epidemiology Working Group, the sector will strengthen surveillance strategy and mechanisms, notably striving to achieve a consolidated adaptable surveillance system that integrates COVID-19 services during surveillance and case management.

ACCESS TO HIGHER-LEVEL CARE: SECONDARY AND TERTIARY CARE

Timely access to care is critical in saving lives during medical emergencies and improving health outcomes overall. The Health Sector has developed the SOP on medical referral SOP as a critical step to guide in strengthening the referral system. At the implementation level, the health actors will mobilize adequate resources to execute the key activities outlined in the SOP to ensure access to emergency care and non-emergency care at appropriate levels of the health system. On the other end, the sector shall continue to provide capacity to coordinate referrals and minimize access barriers, increase monitoring of the referral systems, and advocate for adequate availability of secondary care at the camp level. The scope of work for the existing and future secondary care facilities at the camp level shall be developed and aligned to the needs of the community-minimizing referrals out of the camps drastically.

The health sector will engage with the donors and partners to strengthen the capacity for secondary services within the camps or as close as possible to camps (Upazila Health Complex, field, and other specialized hospitals in the camp periphery) to provide access to referral services e.g., basic imaging and diagnostic services, Surgical care for trauma, CEmONC, cervical screening, etc.

Key activities: Primary Health Care

i. Review MPEHS* aligned to the HSSP and support partners to adhere to the standard
ii. Develop scope of work for secondary care at the field level - prioritizing needs, ensuring equitable distribution
iii. Communicable Diseases: Scale up availability and access to diagnosis and treatment of communicable diseases including HIV counseling and treatment services in a decentralized approach
iv. Non-Communicable Diseases: strengthen prevention, treatment, and follow-up.
v. SRH: Scale up uptake and retention of family planning (FP) methods based on the FP strategy
vi. MHPSS: Develop MHPSS strategy and increase technical supervision targeting mhGAP-trained staff in the provision of mental health services at the PHC level. Increase access to clinical care for MHPSS
vii. Ensure adequate coverage of EPI services
viii. Roll out and monitor implementation of the General Health Card

CROSS-CUTTING ISSUES

EMERGENCY PREPAREDNESS AND RESPONSE

The sector will ensure adequate capacity to anticipate, prepare for, respond to and reduce the impact of imminent, or current hazards or conditions in the community. Under the guidance of the Emergency Preparedness and Response (EPR) Technical Committee, the sector shall ensure adequate Emergency Preparedness capacity targeting natural disasters and artificial hazards in Cox's Bazar (Fire, Monsoon rain, Cyclone, Floods) and epidemic-prone Infectious/communicable disease (COVID-19, Diphtheria, Measles, Varicella, AWD/Cholera). Across all planning scenarios, EPR activities shall 1) ensure continuity of access to lifesaving intervention, 2) support local government capacity for preparedness and response in the host community 3) enhance local community participation in EPR activities and promote multi-sectoral integrated approaches, and 4) prepare for recurrent surge/waves of COVID-19 infection in the future.

EPR: Key Intervention

Risk Analysis and Monitoring capacity:

i. The EPR TC shall strengthen regular and timely risk analysis and monitoring, risk assessment of prevailing public health situation and timely informing of partners.

ii. Conduct After Action Review, simulation exercises for cyclone and monsoon preparedness

Minimum Preparedness Action:

iii. Ensure that health actions are adequately elaborated in the ISCG Multi-Hazard Response Plan of actions to ensure readiness to respond to disasters.

iv. Ensure and maintain the updated contingency response plans.

v. Work closely with Epidemiology WG, RCCE WG, and WASH Sector to develop and implement an integrated readiness plan for infectious disease outbreaks including COVID-19.

vi. Regularly map out existing EPR capacity (organization, staff, volunteers, equipment, supplies, etc) and promote sector-wide range participation from partners

Ensure advanced preparedness and Contingency Plans:

vii. Coordinate with HS partners to ensure adequate supplies are prepositioned for an immediate response to acute events

viii. Ensure adequate intersectoral linkages and integration, especially between RCCE, CHWG, WASH, Shelter, and SMSD on community mobilization.

PROTECTION MAINSTREAMING

The HS commits to ensuring that the response actions are delivered in a manner that protects/upholds the dignity and rights of the affected people. Regardless of a partner's protection mandate, all health actors are obligated to promote the core protection principles to 1) Enhance people's safety, dignity, and rights 2) Ensure people's access to impartial assistance, according to to need and without discrimination 3) Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion, or deliberate deprivation and 4) Help people to claim their rights (Sphere, Protection Principles)

Key Interventions: Protection Mainstreaming

i. Gender-Based Violence (GBV) Mainstreaming: Develop the HS Gender Action Plan 2022-2023

ii. Strengthen mainstreaming of Accountability to Affected Population: Design and implement health actions informed by community engagement during all phases of the health program as outlined in the Health Sector AAP framework. Partners shall mainstream Accountability to Affected People mechanisms to promote Community Communication and Transparency, Participation as a pathway to effective programming, and meaningful community engagement.

iii. Accessibility, Inclusion of People with Disability (PWD): Ensure impartial access to health by including People with disabilities. To do this, the Health Sector to develop a minimum standard to provide a technical overview and guidance to escalate the inclusion of PWD in health care and monitor implementation. Additionally, working in collaboration with the government and partners, the Health Sector Coordination will continue advocacy to reduce physical barriers to access.

iv. Prevention of Sexual Exploitation and Abuse (PSEA) Mainstreaming: Ensure that all JRP partners adhere to the minimum standards for PSEA

INTER-SECTOR COORDINATION

Under the ISCG coordination platform, the Health Sector aims to reinforce practical collaborations with other relevant sectors especially WASH, Nutrition, Education, Site Management and Site Development Sector, Communication with Communities, and Protection Sector to improve the quality of intervention by promoting synergistic interventions and avoiding duplication.

Key interventions: Strengthening Inter-sector collaboration

i. Engage relevant sectors on areas of common mandates e.g., GBV, AAP, Mental Health, Advocacy. Work collaboratively in developing the strategic response plans, and prioritization to ensure a cohesive approach to the response
ii. Coordination of GBV prevention, mitigation, and response.
iii. Actively share Early Warning information to promote multi-sector emergency preparedness and response
iv. Collaborate with SMSD through Capacity Sharing Initiative (CSI WG) and provide relevant training and information to improve coordination with CICs
v. Coordinate with SMSD on the planning of allocation of health facilities to ensure equitable physical access

Key interventions: Strengthening Inter-sector collaboration

vi. Collaborate with Nutrition Sector to increase access to services for the management of moderate acute malnutrition among Pregnant and Lactating women.

vii. Strengthen linkages with Nutrition Sector to increase access and coverage of EPI services through the annual mass MUAC screening campaigns.

viii. Maintain complementary collaboration with the WASH sector in responding to cross-cutting public health issues e.g., AWD, vector-borne diseases, etc.

CHAPTER 3
HEALTH SECTOR PERFORMANCE MONITORING FRAMEWORK

PERFORMANCE INDICATORS 2023

	Baseline	Target	Means of Verification
SO1: To Strengthen the Health Systems Capacity to Deliver Effective and Quality Health Care Services			
Health workers			
Number and Distribution of SBA at PHC and HP (Medical Officers, Midwives, Nurses) per 10 000	1 055 Skilled Births Attendant/SBA (392 Medical officers, 369 Nurses, and 294 Midwives)- equivalent to 23 SBA per 19 699 people	23 skilled birth attendants (medical doctors, nurses, midwives) per 10 000 people	4Ws
Percentage of Skilled Births (attended by skilled personnel doctors, nurses, midwives)	70%	>80%	CHWG, Health Sector
Health Management Information System			
Percentage of Health Facilities completing a report to DHIS2	<50%	>80%	DHIS 2
Percentage of complete Early Warning, Alert, and Response (EWAR)/Surveillance reports submitted on time		>80%	Epidemiology Technical Working Group
Percentage of health facilities registered and reporting on HeRAMS	0%	100%	HeRAMS Dashboard
Leadership, Governance, and Coordination			

Existence of HSSP, updated and linked to identified local needs and priorities		01	Health Sector Coordination
Availability of MEHSP for Secondary Care at camp level (Number)	0	01	Health Sector Coordination
Annual Rationalization exercise		02	Based on updated HSSP and MEHSP, Health Sector Coordination
Heath Financing			
The proportion of households reporting out-of-pocket payments for health care	30%, (approximated based on JMSNA data, June-August 2020)	<15% (>50% reduction), per year	Household Surveys
The proportion of JRP health partners reporting on the FTS		>80%	ISCG, Health Sector Coordination
Number of funding assessments and analyses conducted	1/year	2/year	Health Sector
Access to Medicines			
The proportion of health facilities with essential medicines		>80%	Assessed through the Quarterly Health Facility Monitoring. HF is to have at least 80% of 14 tracer medicines.
Referral System			
The proportion of patients referred by initiating facility and access care at receiving facility		100% for emergency referrals	Referral Databases, register, 4Ws

Number of Referral Review sessions by Health Sector	0	4/year	Quarterly review session, Health Sector Coordination
Proportion of partners with comprehensive referrals systems (transportation, cover costs related to the referral services)		For PHCs, 100%	Quarterly review session, Health Sector Coordination
SO2: Maintain equitable access to essential health care (preventive, curative, rehabilitative, palliative health care) in a sustainable manner and of acceptable quality at all levels (community, primary, secondary, and tertiary health care levels			
Number and distribution of inpatient beds per 10 000 Population, excluding maternity beds		Annual target, 18 beds per 10 000, up to 800 beds	HeRAMS
Number, OPD Consultation/person/year (segregated Male, Female, reason for consultation)	3-4 OPD Consultation/person/year (2021, a total of 4.3 million OPD consultations: 34%-Male, 66%-Female)	Annual consultation of 3-4 Consultation/person/year	4W, DHIS2 Report
Crude Mortality Rate/Month		< 0.75/1 000/month	CHWG, 4W
Under 5-year Mortality Rate	23.5/1 000 live births	<15 live births	Annual Mortality Survey, CHWG/WHO
Number of WRA using a modern contraceptive at any given time	51%	63% (approximate national CP rate)	Biannual CP The survey, SRH WG
Maternal Mortality Rates	45 (SRH WG Maternal death report))	>50% reduction/year	SRH WG
Number and distribution of Health Facilities HP that provides essential/prioritized services in the MESPH/thousand population	90 HP 44 PHC, 736 beds (18 beds per 22 099 people)	54 HP 36 PHCs (1 PHC:25 000, MPEHS) **Assumptions:** 800 IPD beds are required (18/20 330	HeRAMS

		people), the current baseline of 736 beds (18 beds/ 22 099) Sphere – 18 beds:10 0000 (General IPD beds excluding maternity) 377 IPD beds are at the field hospitals, therefore 423 are required at the PHCs 11 beds/PHC (current baseline average 10beds/PHC), 36 PHCs are required for 423 beds; This is also equivalent to 1 PHC for 25 000 as per the MPEHS If 01 PHC covers the need of 1 HP, then 54 HP, 36 PHC= 90 primary care facilities (1:10 000 sphere standard)	
Number of sessions where the Health Sector reviews the performance of Gender/ protection mainstreaming		4/year	Health Sector Coordination

ANNEXURES

i. Health Sector Strategic Plan- Work Plan
ii. IASC/Global Health Cluster Standards
iii. Health Sector AAP Framework, Cox's Bazar
iv. Health Sector Referral SOP
v. Minimum Package for Essential Health Services
vi. Emergency Preparedness Plans: AWD, Cyclone/Monsoon
vii. Health Sector Gender Action Plan
viii. Health Sector Coordination Structure
ix. List of Prioritized Health Facilities: HP, PHC following 2022 health facility rationalization

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