HEALTH SECTOR BULLETIN: March 2024

Cox's Bazar District, Bangladesh
Emergency: Rohingya Refugee – Protracted Grade 2 Emergency[1]
Reporting period: 1 - 31 Mar 2024

1.48 million People in Need (PiN, ISCG JRP 2024)

978,204[2] Rohingya Refugees living in camps. Health Sector Target 1.07 million (JRP2024)*

HIGHLIGHTS

- During the holy month of Ramadan within 3 weeks of the month of March, the health service utilization maintained a normal trend, unlike the prior years when a drastic decline was observed in the number of medical consultations.
- The prevailing issue of maternal mortality remains a cause for grave concern.
- Three catch-up vaccinations campaigns were conducted with the support of WHO in camps 5, 21 and 27,, aimed at reducing dropout rates and reaching zero-dose children within the Rohingya population.
- A post-MDA cross-sectional survey to estimate the Prevalence of Scabies in Cox's Bazar Rohingya Camps was carried out, more than 800 samples were gathered from the 33 camps in Ukhiya and Teknaf.
- WHO in collaboration with Health Sector Partners initiated the agency's first Hepatitis C surveillance program linked to treatment in the South-East Asia Region at Cox's Bazar, Bangladesh, addressing the disease's high prevalence among Rohingya refugees.

THE HEALTH SECTOR

56	ACTIVE HEALTH SECTOR (HS) PARTNERS
17	#APPEALING PARTNERS JRP 2024

REGISTERED HEALTH FACILITIES

58	HEALTH POSTS
46	PRIMARY HEALTH CENTRES
01	FACILITIES WITH CEmONC SERVICES
06	FIELD HOSPITALS
490	#MEDICAL DOCTOR
372	#NURSES
466	#MIDWIVES

HEALTH ACTION

403K	OPD CONSULTATIONS
9,020	INPATIENT ADMISSIONS
3,028	FACILITY-BASED BIRTHS (Host & Rohingya)
98%	% LIVE BIRTHS
2%	% STILLBIRTHS
9	MATERNAL DEATHS
0%	COVID-19 CASE FATALITY RATIO

DISEASE SURVEILLANCE

0.72	CRUDE DEATHS/1,000 Pop (Jan-Mar 24)
18	COVID-19 SENTINEL SITES
24	AWD SENTINEL SITES
122	EWARS REPORTING SITES

HEALTH FUNDING $USD (JRP 2024)

UN OCHA Financial Tracking System

USD	
86.8 M	Requested
19 M	Received
65.6 M	Funding gap **76 %**

**100% of the Rohingya Refugees living in camps and 25% of the Host Community have been targeted in JRP 2024*

Situation Update

General Situation

The month of March 2024 was marked by uninterrupted routine service delivery and unimpeded access to essential healthcare services. During the holy month of Ramadan, the health service utilization rate was almost similar to the previous months following the launch of General Health card last August 2023. This is notable to mention that, in the previous years during Ramadan observance, the utilization of Health Services showed a noticeable decreasing trend which was not evident during this year. The data also reflects that there is an increment of host community population receiving services, a population not been monitored by the health card usage.

Health Services Delivery

In the month of March around 403,000 OPD consultations were recorded which is slightly less than the average number of OPD consultations recorded Jan & Feb 2024 but notable higher than previous years Ramadan Period. As per DHIS-2, the average number of consultations for morbidity distribution among the refugees throughout the month of March was highlighted by Acute Respiratory Infections (ARI), Other acute conditions, and Skin diseases. Skin Diseases were the number one reason for medical consultations through the year 2023, however, appears the Scabies MDA campaign immediate impact in reducing the burden of skin disease consultations which also contributed to reducing the overall number of consultations.

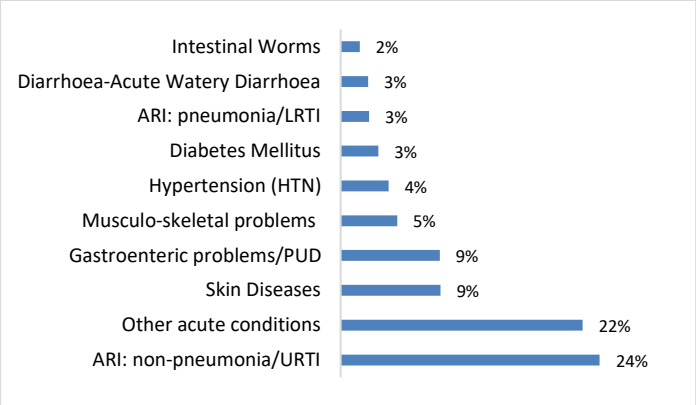


Figure 1: Top Morbidity Reported in DHIS2

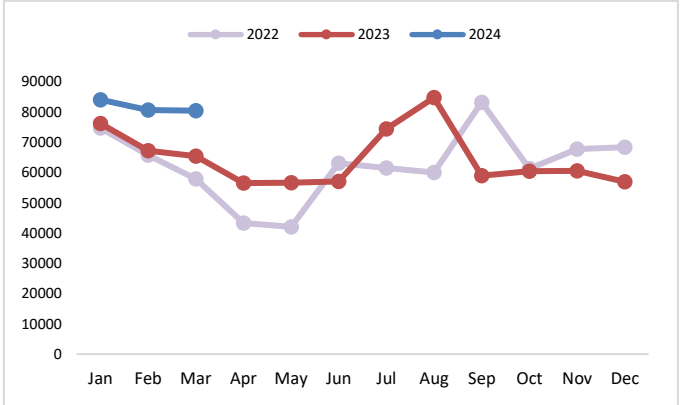


Figure 2: Non-pneumonia/URTI ARI trends

Acute Respiratory Infection (ARI) cases contributed 24% of the consultations for diseases (Fig-1) during the reporting period with more than 80,000 consultations for non-pneumonia infections. The trend is higher compared to any period of the last couple of years as seen in Figure 2 which sets an alarm to analyze the underlying causes. Seasonal variations and shifts in weather patterns may contribute to the observed increase in ARI consultations. However, this factor alone does not suffice to fully account for the heightened caseload, given that the numbers exceed those recorded during the corresponding seasons of the previous year. Notably, the current data indicates the highest incidence of ARI consultations within a three-month period (January to March 2024). It is notable to mention that the incidence of COVID-19 cases is still low in camps, not likely the reason for the increased ARI cases. This might be associated with other flu-like diseases which might be a concern if not detected. Both WHO and Epidemiology, case management, and IPC WG led by the WHO under the Health Sector are closely monitoring the situation.

Mortality Surveillance

The prevailing issue of maternal mortality remains a cause for grave concern, as evidenced by the recent report of nine maternal deaths within the camp during March 2024. Since the outset of the year until March 2024, a total of 24 confirmed maternal deaths have been documented, signifying a disturbing trend of deterioration. Of the nine deaths reported in March, four occurred within health facilities, while the remaining five transpired within the community. These fatalities were attributed to various causes, categorized according to the ICD10MM major groups, including non-obstetric complications (six deaths),

obstetric hemorrhage (one death), other obstetric complications (one death), and hypertensive disorders in pregnancy, childbirth, and the puerperium (one death). Noteworthy is the fact that 33.3% of deaths occurred during the referral process. Among the fatalities, 55.56% transpired during pregnancy, while 33.33% transpired within 42 days of delivery. For comprehensive insights, further details are available within the Maternal and Perinatal Mortality Surveillance and Response (MPMSR) Dashboard.

The discrepancy between reported data and the actual situation is disconcerting, particularly considering the reported facility-based delivery rate exceeding 80% and ANC 4 coverage hovering around 77%, as per data from the Community Health Workers Working Group (CHW-WG) and Health Sector 4W data, respectively. However, findings from WHO concurrent monitoring of immunization from 2023 to 24* reveal a conflicting reality: of the 35,264 children under three years of age monitored, only 43% were born in health facilities. A thorough analysis is warranted to elucidate the underlying factors contributing to this incongruity, including a meticulous examination of data collection and reporting methodologies.

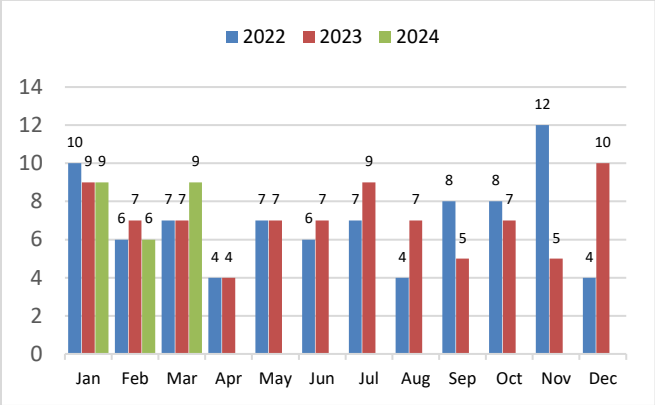


Figure 3: Number of Confirmed maternal deaths in camps

Both the Health Sector and WHO remain diligently engaged in monitoring the situation to facilitate the implementation of requisite interventions and enhance the standard of care.

Furthermore, the incidence of infant and under-five mortality remains distressingly high, with 46 infant deaths and 49 under-five deaths recorded in March alone. Regarding perinatal fatalities, nine cases were reported, encompassing five early neonatal deaths, two fresh stillbirths, and two macerated stillbirths.

Table 1: Selected Health System Performance Data

Indicator	Target	Jan-24	Feb-24	Mar-24	Cumulative in year 2024	Baseline-2023	Progress against target
Total number of OPD Consultations (Host and Rohingya)	>2 per person	416,679	431,065	403,242	**1,250,986**	**5,546,581**	23%
Total number of Inpatient Admissions (Host and Rohingya)	Measuring Trends	8,945	9,427	9,020	**27,392**	**104,680**	26%
Total Number of Patients referred out	Measuring Trends	4,002	4,294	3,936	**12,232**	**43,727**	28%
Total number of first-time users (Host and Rohingya)	Measuring Trends	11,529	11,126	11,183	**33,838**	**138,152**	24%
Total number of ANC 1 Visit (Rohingya)	Measuring Trends	8,992	7,511	6,588	**23,091**	**156,397**	15%
Total number of Live births at the facility (Host + Rohingya)	Measuring Trends	3,202	2,933	2,984	**9,119**	**NA**	
Total number of Still births at the facility (Host + Rohingya)	Measuring Trends	52	52	44	**148**	**NA**	
Of the births, number of mothers who had ANC 4 or above visits (Rohingya)	>80% ANC4 Coverage	1,652	1,553	1,322	**4,527**	**26,008**	17%
Cesarean Section: Total number of C-Section at the facility	Measuring Trends	292	216	279	**787**	**1,919**	41%
Total Number of Post Abortion Care provided (Host and Rohingya)	Measuring Trends	283	316	271	**870**	**2,858**	30%
Total number of beneficaries newly diagnosed with Hypertension (Host and Rohingya)	Measuring Trends	11,929	11,803	8,767	**32,499**	**142,322**	23%
Total Number of beneficaries newly diagnosed with Diabetes Mellitus (Host & Rohingya)	Measuring Trends	5,870	7,070	5,413	**18,353**	**123,677**	15%
Total Number of NEW clinical mental health consultations done by psychiatrist and/or mh-GAP doctor(Host and Rohingya)	Measuring Trends	2,039	1,688	1,119	**4,846**	**61,221**	8%
Number of NEW focused counselling done by psychologist or counsellor (Host & Rohingya)	Measuring Trends	3,012	3,173	3,657	**9,842**	**NA**	
Number of Health staff trained on mhGAP under the facility	Measuring Trends	58	227	86	**371**	**2,449**	15%
Total number of Minor surgeries conducted (Host and Rohingya)	Measuring Trends	5,262	4,976	5,338	**15,576**	**59,483**	26%
Total number of Major surgeries conducted (Host and Rohingya)	Measuring Trends	467	374	382	**1,223**	**4,401**	28%
Total number of Post Natal Care (PNC) visit after discharge from health facility following birth/delivery or first visit after home delivery (Host and Rohingya)	Measuring Trends	4,529	4,362	4,004	**12,895**	**58,881**	22%
Sum of Malnutrition cases referred: Total number of children 6-59 months referred for nutrition services	Measuring Trends	676	959	584	**2,219**	**18,284**	12%

Public health risks, priorities, needs, and gaps

1. Communicable Disease Control and Surveillance

Dengue

Dengue fever cases were observed on the rise throughout March 2024, with a 108% increase over the previous month. Nationally, in March 2024 lowest number of confirmed cases were observed comparing to the other months of the year with 311 cases and 5 deaths (Source: HEOC, DGHS). As part of prevention and control efforts, WHO is collaborating with the Community Health Working Group (CHWG) and RCCE to increase risk communication and awareness creation messages at the camp level.

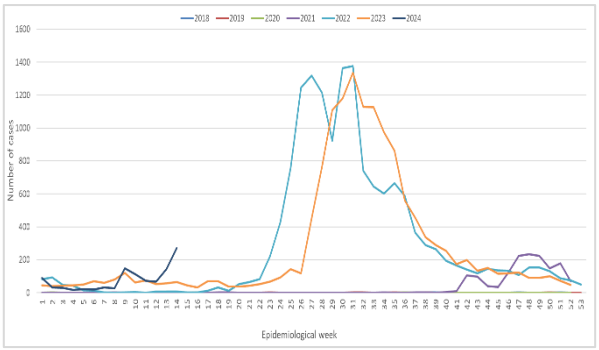


Fig 4: Dengue Trends among the Refugees (WHO, Cox's Bazar)

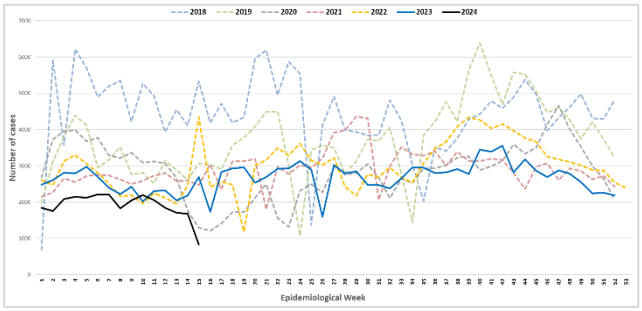


Figure 5: Trends of Culture confirmed Cholera cases 2018-2024.

AWD/Cholera

Despite no culture test being done since September 2023, the trends of AWD cases from syndromic surveillance data in 2024 are similar to that of the previous year though lowest for the same period as seen in Figure 5 graph.

COVID-19:

There has been a static pattern of COVID-19 infection observed among Rohingya Refugees with sub-optimal transmission in host population settings. Overall, the rising level of transmission in the early part of 2024 is still low compared to the past waves of upsurges reported in the past four years since the pandemic began.

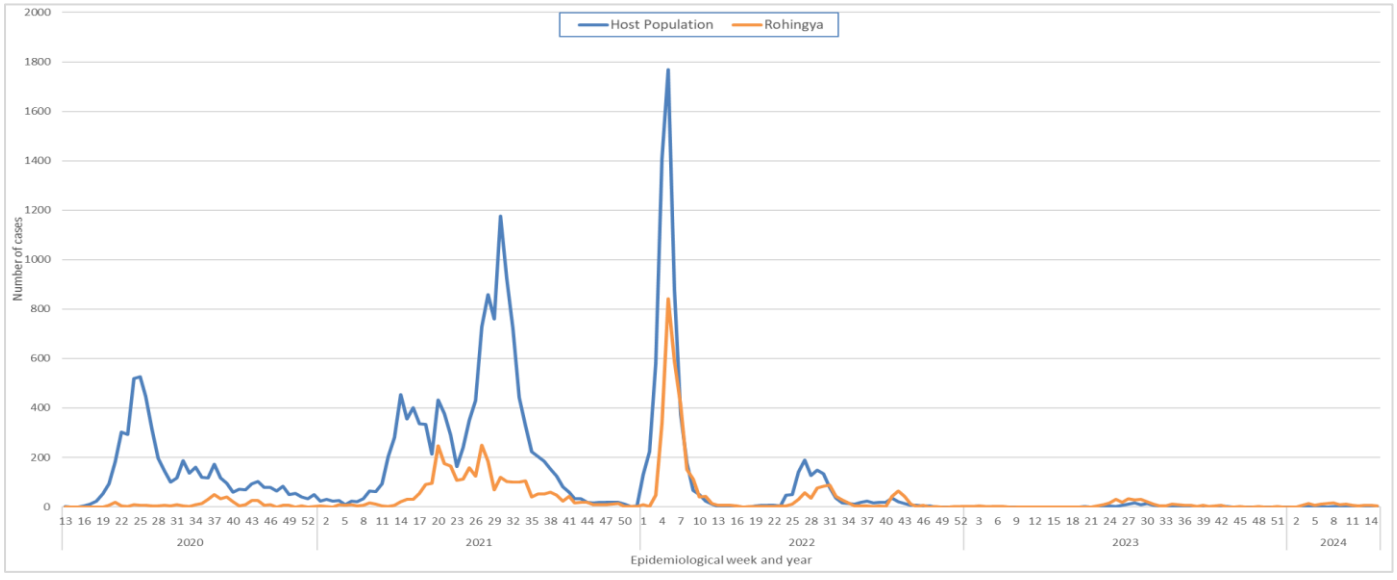


Figure 6: Epi-week COVID-19 cases reported in Rohingya refugees and host population.

2. Routine Immunization and AFP & VPD surveillance

In March 2024, more than 48,000 doses of different antigens were administered targeting less than 2 years of children. This includes 17,213 doses of the Polio vaccine (OPV one to 3rd dose and fIPV 1st & 2nd dose) and 3,656 doses of Measles vaccine (MR 1st and 2nd dose).

The WHO IVD team did a house-to-house survey to assess the vaccination status of <5 children in Ukhiya and Teknaf Camps. The Oral Polio Virus (OPV) vaccination status of <5 children was found to be 98%, 87%, and 80% for 1st, 2nd, and 3rd doses respectively (n=213). Though the overall coverage appears to be satisfactory, some camps showed very poor coverage e.g., in Camp 13, OPV-2 coverage was observed at 64% and OPV-3 was 49%.

The same goes for f-IPV coverage as well, Camp-13 showed 39% Coverage; overall coverage for f-IPV for 1st dose was 94%, and 2nd dose was 75%. The situation is still of concern considering the fact that the OPV vaccine had no shortage, and the consequence of such gaps increases the chance of vaccine-derived Polio. The WHO-IVD team requested partners to increase mobilization for Routine Immunization, especially to critically look at the risk communication to reduce the Polio dropout.

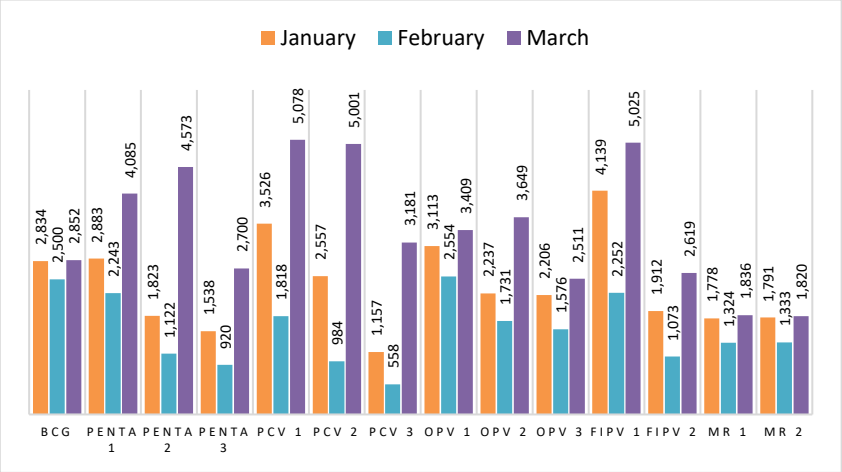


Figure 7: Number of doses Administered in 2024

During March 2024, three catch-up vaccinations were conducted with the support of WHO in camps 21, 27, and 5, aimed at reducing dropout rates and reaching zero-dose children within the Rohingya population. These efforts resulted in the administration of over 1700 doses of various antigens to children under two years old.

Health Sector Action

1. Coordination, Collaboration, and Strategic Guidance

Post-MDA Campaign Assessment to determine the impact of MDA in the transmission of Scabies in Rohingya Camps: The Mass Drug Administration (MDA) to interrupt the transmission of scabies in Rohingya Camps was successfully implemented with the leadership, technical support, and logistic support of WHO and close collaboration with the UNHCR-led community Health Working Group in November- December 2023 at Cox's Bazar Camps and in January-February 2024 at Bhasan Char. In both Cox's Bazar Camps and Bhasan Char the coverage of MDA was more than 100% for both doses. The MDA was conducted based on findings of the baseline community prevalence survey conducted in May 2023 where the prevalence of scabies was determined to be 39.6% which surpasses the WHO's recommended threshold for MDA which is set at 10% in such settings.

Though number of consultations for Scabies appears to have reduced drastically after the MDA, a post-MDA assessment/survey was necessary to provide important evidence for public health decisions regarding the immediate impact of MDA among the Rohingya population in terms of changes in transmission level, determination of the actual coverage, and uptake of the MDA medicines by the targeted population. In light of the above situation, under the Health Sector, the Epidemiology, Case Management, and IPC WG led by

WHO planned a post-MDA cross-sectional survey to estimate the Prevalence of Scabies in Cox's Bazar Rohingya Camps.

With the support of all Health Partners Working in the Camps, the survey was carried out in March 2024 to identify the impact of MDA to interrupt the transmission of Scabies and the current prevalence of scabies in camps. More than 800 samples were gathered from the 33 camps in Ukhiya and Teknaf. The qualitative portion of the study is ongoing, and following completion of the analysis, recommendations for interrupting the Scabies transmission will be made.

Figure 8: An enumerator from WHO is collecting data for the post-MDA survey to determine Scabies prevalence and Impact of MDA

Adapting the WHO Package of High Priority Health Services for Humanitarian Settings (H3 Package) to update the Minimum Package of Essential Health Services for Primary and Secondary Health Care in response to the Rohingya Refugee Crisis: In March 2023, the World Health Organization (WHO) introduced the H3P guidance, delineating a set of evidence-based services deemed suitable for most humanitarian contexts. This guidance establishes a benchmark, indicating the minimum standard toward which humanitarian partners should strive as they deliver health services to vulnerable populations. To tailor this global framework to the specific needs of Cox's Bazar, a comprehensive two-day meeting was convened by the health sector, gathering multidisciplinary experts from academic institutions, healthcare clinicians spanning tertiary, secondary, and primary care facilities within the camps, as well as leaders, managers, and policymakers from the Ministry of Health, UN agencies, international non-governmental organizations (INGOs), and local partners.

This collaborative effort culminated in the formulation of a preliminary version of the Cox's Bazar Minimum Package of Essential Health Services for Primary and Secondary Health Care in response to the refugee crisis. This draft package was crafted based on a thorough assessment of existing local practice standards and policies, available capacity and resources, and other context-specific considerations. Subsequently, the Package underwent rigorous scrutiny by the health sector's Strategic Advisory Group and thematic technical personnel, who provided invaluable feedback. Notably, the Strategic Advisory Group addressed the absence of minimum staffing norms in the H3 Package.

Following the review process, the draft package garnered endorsement from governmental counterparts, including the Refugee Relief and Repatriation Commissioner (RRRC) and the Civil Surgeon Office of the local Ministry of Health. With their approval, the Health Sector team disseminated the package to the Global Health Cluster and the H3 package team, facilitating the incorporation of feedback into the Service Provision Decision Instrument (SPDI) tool. Collaboratively, efforts were directed toward producing a revised version of the distributable booklet outlining the updated Minimum Essential Health Service Packages.

Cluster Coordination Performance Monitoring (CCPM): Cluster Coordination Performance Monitoring (CCPM) is an IASC-mandated self-assessment of cluster performance against the six core cluster functions plus Accountability to Affected populations. The CCPM is a cluster responsibility. CCPM can be applied by both clusters and sectors and assists in taking stock of which coordination functions work well, and which areas need improvement. Global Health Cluster (GHC) provides the clusters with practical orientation, a survey system, and technical support.

The Health Sector Cox's Bazar with the Global Health Cluster initiated a CCPM survey for the year 2023. , A questionnaire and the survey tool was shared with active sector partner's focal point and was finalise the 1st week of March with only25 Partners responded among 56 active partners. The draft results were then produced, and the report was generated by the GHC team dedicated to CCPM and reviewed by the Health Sector Cox's Bazar. The final report will go through the SAG before disseminating to the partners. The next step will be to arrange a session with the partners to discuss the findings and feedback to improve the sector's performance and participation.

Health Resources and Services Availability Monitoring System (HeRAMS) report: Throughout March the reports produced by the WHO HQ HeRAMS initiative team were reviewed, feedback was provided, and necessary corrections were made. The report is now waiting for final check and approval.

2. Working Groups (WGs)

Sexual and Reproductive Health Working Group (SRH-WG)

Workshop Minimum Initial Services Package for Reproductive Health (MISP) Readiness assessment: The SRH Working Group under the leadership of UNFPA Cox's Bazar and in collaboration with the RRRC organized a two-day MISP Readiness Assessment (MRA) workshop involving multiple sectors and Health partners.

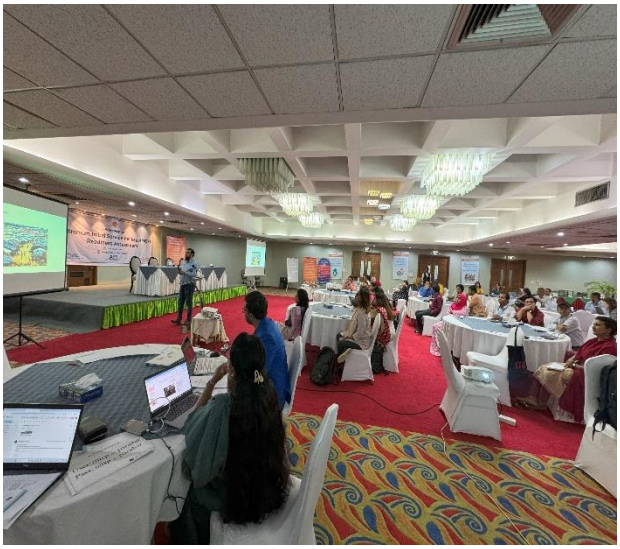


Figure 9: RRRC Health coordinator coordinating a session at the MRA workshop

The MRA aimed to provide a snapshot of the readiness and capacity to access essential SRH services during emergencies, as outlined in the MISP framework. The assessment helps identify and prioritize key areas that need to be strengthened to improve the delivery of SRH services/MISP, especially in emergencies. The assessment also prompts action to address the continuum of preparedness, response, and recovery phase following a crisis. The MRA tool refers to the standard digital MRA questionnaire. The responses to the 58 questions are structured to produce the assessment of the six MISP components. The questionnaire looks at "readiness" from different perspectives including policy, coordination, health services, data, resources, and access to service delivery, in particular trained human resources, equipment, medicines, and referrals.

The MRA workshop in Bangladesh engaged multi-stakeholder participation from government sectors (including Health, social welfare, and Disaster management) and CSOs to harness a more engaging collaboration and planning among key players during disaster preparedness, response, and recovery in times of emergencies.

Developing an MISP action plan was one of the essential components of the MRA. The action plan was developed with the team that completed the MRA Questionnaire. Based on the priority gaps identified from all the MISP objectives, the group identified interventions for each action, and defined the resources required and the timeliness of implementation. If additional resources need to be mobilized, this was clearly marked. Once the action plan was finalized, participants agreed on the following points; a) who will monitor the action plan's implementation b)at what frequency c) When the group will reconvene to look at the progress made collectively. A detailed action plan will be shared as soon as it is finalized by all stakeholders.

In conclusion, the development of a comprehensive report and action plan marks a significant step forward in enhancing Cox's Bazar's readiness to implement the Minimum Initial Service Package (MISP) framework during emergencies. Through the collaborative efforts of all stakeholders involved in the MRA process, led by the enhanced RRRC and government leadership, key priority areas have been identified and agreed upon for strengthening.

By fostering a unified approach and commitment from all parties, the envisioned outcome is to ensure the effective and efficient implementation of MISP in crisis situations. This includes bolstering preparedness, response mechanisms, and coordination strategies to address the urgent reproductive health needs of Rohingya refugees and affected populations in Cox's Bazar.

Moving forward, the concerted efforts outlined in the action plan will pave the way for a more resilient and responsive system, capable of mitigating the adverse impact of emergencies on sexual and reproductive health services. With a shared vision and collective determination, we are poised to make tangible progress in safeguarding the health and well-being of vulnerable populations, reaffirming our commitment to upholding human dignity and rights in times of crisis.

Community Health Workers Working Group (CHW-WG)

Head Lice Infestation Survey: Trained CHWs conducted a survey revealing a 35% Head Lice infestation rate among Rohingya refugees, with higher rates among female children under 5 years old and all-aged females.

Chickenpox: Few camps reported higher chickenpox cases. CHWG shared prevention messages and scaled up prevention activities, along with case identification and referral.

Epidemiology, Case Management, and IPC Working Group (Epi-WG)

With the support of the WHO, the Working Group trained 70 data enumerators to collect data for Estimating Community Prevalence of Scabies Infestation among Rohingya Refugees Post Mass Drug Administration (MDA) Campaign in Cox’s Bazar, Bangladesh. Nominated Physicians, nurses, and medical assistants attended the training.

Due to concomitant ongoing skin infections. a headlice assessment was undertaken among the Rohingya Population through Community-Based Surveillance implemented routinely through Community health workers. The findings of the assessment will guide the community-based treatment of Headlice.

3. Health Sector Partners Update

Health and Education for All (HAEFA)

At the Refugee Camp health post, Health and Education for All (HAEFA) has implemented a separate common toilet for common gender in addition to individual male and female facilities. This move aligns with their commitment to providing inclusive services. Furthermore, there are plans underway to establish a common waiting room, ensuring equitable access and a welcoming environment for all individuals seeking healthcare.

Figure 11: Common Toilet for common gender

Save the Children International (SCI)

Save the Children (SC) PHCC, Camp-21 is one of the healthcare facilities in the Rohingya Response that remains open around the clock, even during the critical hours of the natural disaster, with its experienced staff and volunteers. Previous experiences in the country suggest that a pre-monsoon natural disaster typically occurs in early summer (April–May). Considering this, SC PHCC and MMT staff received quarterly refresher training.

Figure 12: Training on EPR and BFA

In this continuation, on March 21st, SC took the early initiative to train Facility Volunteers and CHWs (Community Health Workers) on Emergency Preparedness and Response (EPR) with Basic First Aid (BFA) through different practical demonstrations and techniques. The aim of this training was to develop coordination and communication skills in order to respond to an emergency safely, quickly, and effectively. The training will enable them to take personal protective measures as well as respond to and serve acute emergencies more swiftly and effectively during critical periods.

Médecins Sans Frontières (MSF)

In mid-2023, Médecins Sans Frontières (MSF) conducted a survey to assess the prevalence of active Hepatitis C Virus (HCV) infection and its associated factors within the Rohingya Camps. Given the absence of recent representative data specifically addressing active HCV infection, this survey aimed to fill this crucial gap. During the February Health Sector meeting, the survey findings were presented to partners, highlighting the following key insights:

- Approximately one-third of adults within the camps have been exposed to HCV infection, with an estimated seropositivity rate of 29.7% (95% CI: 26.0-33.8).
- The estimated prevalence of active HCV infection stands at 19.6% (95% CI: 16.4-23.2).
- Factors associated with HCV seroprevalence were identified, revealing nearly double the odds of HCV seropositivity among women compared to men (adjusted odds ratio (aOR)=1.8; 95% CI: 1.2-2.9), and more than double the odds (with aORs between 2.3-2.9) among individuals aged over 18-25 years. For further granularity, breakdowns by age and gender are available for reference (please refer to the shared slides for detailed information).

A concerning observation was made regarding the high viraemic rate (66.6%) among HCV seropositive

individuals, indicating a significant gap in HCV treatment coverage within the camps. Among those identified as HCV seropositive, only 38.2% reported a previous diagnosis of HCV infection, with a mere 10.5% indicating prior HCV treatment.

The Health Sector expressed a need for a critical examination of the findings, particularly concerning the notably high odds ratios observed in certain instances. For instance, the reported odds of HCV seropositivity being five times higher among those who underwent surgery raise questions, considering the relatively low percentage (3.3%) of individuals who reported surgical history. It is acknowledged that such discrepancies may stem from limitations inherent in the data collection process and warrant further investigation.

Fig. 13: Head of WHO Cox's Bazar Sub Office reiterates WHO's unwavering commitment to alleviate the impacts of viral hepatitis on the Rohingya and, eventually, on the surrounding host communities.

World Health Organization (WHO)

Hepatitis C surveillance program: WHO in coordination and addressing the findings from MSF, has initiated the agency' first Hepatitis C surveillance program in the South-East Asia Region at Cox's Bazar, Bangladesh, to address the disease's high prevalence among Rohingya refugees. This program, launched on March 6, 2024, is supported by national and regional experts, and includes two treatment centers. Preceding launch, 185 healthcare workers received comprehensive training from March 3-5, 2024. The program involves RT PCR diagnostics at the IEDCR Field Lab, followed by treatment at designated centers. WHO has distributed 30,000 RDTs for Hepatitis B and 15,000 for Hepatitis C across camp health facilities and will provide medication for 900 confirmed cases.

Fig. 14: Supportive supervision of NCD service delivery

WHO laboratory team is also oriented 32 laboratory personnel from 18 sentinel sites for Hepatitis C on Sample Collection, Storage, and Transportation related to Hepatitis C Surveillance and Service Care. In addition, the laboratory team also arranged hands-on training for the IEDCR field laboratory staff to set up the Hepatitis C RT PCR to detect the viral load.

Supportive supervision visits on NCD Services: WHO conducted supportive supervision visits on NCD service delivery in seven primary health care facilities placed in multiple Rohingya camps (Camp 1 East, 1 West, and 13). During these visits, different components of NCD service delivery including technical capacity of human resources, methodologies of blood pressure and anthropometric measurements, functionality of diagnostic equipment, availability of medicines, stock management in the warehouse, as well as reporting and recording mechanisms were supported in alignment with national protocols.

Routine Immunization and VPD Surveillance: Between March 25 and March 28, the WHO IVD team conducted regular EPI refresher training sessions for vaccinators, with over 250 outreach and fixed-site vaccinators participating in the training.

Prevention and response to sexual exploitation, abuse, and Harassment: To mainstream the SEA zero-tolerance policy, WHO aspires to reinforce workforce capacity on prevention, early detection, mitigation, and response to sexual misconduct and other abusive behaviours. With this aim, from 19-21 March, WHO trained 121 third-party contractual staff to create and raise awareness and strengthen their capacity while holding them accountable for protecting beneficiaries from any form of abusive behaviours.

Bhasan Char Health and Nutrition Sector (Led by UNHCR) update

Training Sessions: March featured valuable training sessions, including a four-day session on lifesaving midwifery skills for 25 midwives and a two-day training on Acute Flaccid Paralysis (AFP) and Vaccine Preventable Disease (VPD) for 96 healthcare providers.

Medical Campaigns: Two extensive five-day medical campaigns addressed specific needs, providing consultations to 325 patients for ear, nose, and throat (ENT) issues, as well as dermatology consultations for 318 patients, including 11 minor surgeries.

Routine Immunization: In March, 590 children (307 male, 283 female) up to 23 months old received routine vaccinations, while 180 pregnant women received Tetanus and diphtheria (Td) vaccine.

Newborn Health and Stabilization Center (SC) Services: Notably, 150 newborns received treatment at the Special Care Newborn Unit (SCANU), and 87 severely malnourished children with medical complications were treated at the stabilization center (SC) in a 20-bed government hospital.

*New Medical Officer*s: The Ministry of Health (MOH) assigned six medical officers to work on a rotational basis at the 20-bed hospital.

Closure of Health Project: GK_Malteser plans to close their health project in the 20-bed hospital by the end of April due to insufficient funds.

Mental Health and Psychosocial Support (MHPSS) Capacity Building: Psychologists underwent training on counselling and mentoring, while 40 community health and nutrition workers (CHNW) and 20 community psychosocial volunteers (CPV) received training on stress management and psychological first aid (PFA).

Treatment of Acute Malnutrition: Efforts in March led to the admission of 24 children with severe acute malnutrition (SAM) and 183 with moderate acute malnutrition (MAM) to the nutrition treatment program.

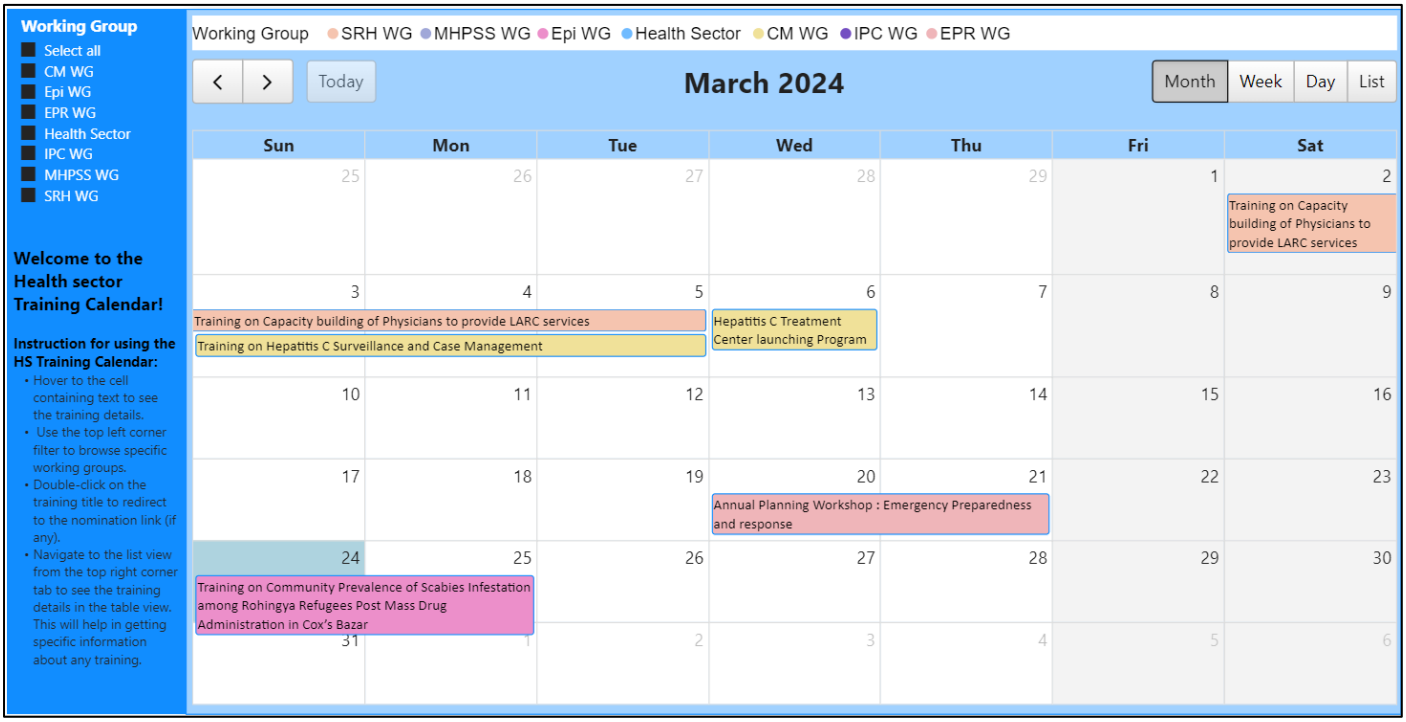
Prevention of Malnutrition: Supplementary food was distributed to 6,082 children and 1,474 pregnant and lactating women (PLWs), with 123 PLWs receiving counselling on infant and young child feeding practices. Additionally, over 48.648 MT of supplementary food and 0.758 MT of fortified vegetable oil were distributed.

Vitamin A Campaign and Mass MUAC Screening: A significant number of children, exceeding 6,370, received vitamin A supplementation, and mass screening identified 16 children with MAM who were referred for treatment.

Needs, Gaps, Challenges

Shortage of Medicines: Two health posts (RTMI and HAEFA) on Bhasan Char are currently facing challenges due to a shortage of medicines.

Upcoming Events / Training Calendar



([*LINK TO TRAINING CALENDAR)*])

References:

1. Emergency response framework – 2nd ed. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO.
2. Joint Government of Bangladesh - UNHCR Population Factsheet as of Feb 2024. UNHCR Operational Data Portal (ODP).
3. https://healthcluster.who.int/publications/m/item/health-cluster-dashboard-q1-march-2023
4. Please visit the Health Sector Webpage available here to access the following: Health Sector HeRAMS, Health Sector 4W, Health Sector Training Planner, and Sector strategic documents
5. Health Service Performance Indicators Data Source: Health Sector Monthly 4W report and, HeRAMS (Data Extracted on 20 February 2024)

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