HEALTH SECTOR COX'S BAZAR

Health Sector Public Health Needs Assessment Plan Rohingya Refugee Camps 2025

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World Health Organization

WHO is the sector Lead Agency and provides secretarial support.

Public Health Needs Assessment in Rohingya Refugee Camps 2024 – 2025

The Health Sector

Introduction

According to the Joint Response Plan (JRP) 2024, there are 984,591 Rohingya refugees registered in Bangladesh as part of the Government-UNHCR joint registration exercise, residing in 33 congested camps formally designated by the Government of Bangladesh in the space-constrained, densely populated and climate-vulnerable Ukhia and Teknaf Upazilas of the Cox's Bazar District/Zila[1].

The funding gap in the health sector continues to increase due to the prolonged duration of the crisis, donor fatigue, and the recurrence of multiple outbreaks and diseases, including cholera, dengue, and hepatitis C, as well as the burden due to chronic diseases among refugees. Maternity and newborn services are under significant strain, with key indicators revealing notable gaps in these services. Based on the mid-year 2024 JRP funding analysis, around 37% only of the total appeal (out of USD 86.8 M required) was received. Furthermore, less than 30% of the USD 52.3 million required for firewalled (top critical) health services in 2024 has been secured, leaving essential services, including secondary healthcare, underfunded.

Considering these challenges, and the need to rationalize available resources to prioritize the most critical services, the health sector has launched a comprehensive public health needs assessment to guide the development of the sector strategy and priorities for the JRP 2025.

This assessment is not intended to alter the current distribution or functionality of recommended health facilities by the 2022 Health Sector Rationalization exercise, as no significant changes to the 2025 sector objectives are anticipated. Instead, the assessment will guide the sector strategy on how to best utilize existing resources and appeals within the available facilities and health system to meet the needs of the target population, enhance the quality of services, and ensure cross-cutting determination of gender inclusion and Accountability to Affected People AAP.

[1] https://reliefweb.int/attachments/8f6a23be-1aed-4270-aef5-d0c89c251301/JRP%202024.pdf

Objectives

The key objectives of this assessment were:

Identify **the most pressing health concerns** among Rohingya refugees.

Evaluate the **accessibility and quality of health services** in the camps.

Assess **gaps** in the provision of **medicines**, medical **equipment**, and medical **services**.

Understand community **awareness** of health services, as well as barriers to **accessing** these services.

Provide **actionable recommendations** for improving healthcare service delivery.

Timeline and Duration

The assessment was conducted over a period of 12 weeks, including preparation, data collection, analysis, and reporting.

Table 1: PHNA 2025 phases and timeline

Phase	Duration	Timeline
Preparation (planning, resources)	3 weeks	03.09.2024 – 24.09.2024
Data collectors training	1 week	24.09.2024 – 29.09.2024
Data collection	1 week	30.09.2024 – 07.10.2024
Data cleaning and analysis	1 week	08.10.2024 – 14.10.2024
Reporting and dissemination	2 weeks	15.10.2024

Methodology

Data collection strategy

The assessment aimed to gather stakeholder input on sector priorities across various themes, including services, diseases, medicines, equipment, and access. To ensure accurate interpretation of the results and enable meaningful disaggregation and comparison across participant groups, two tailored questionnaires were developed. The first questionnaire was designed for field health workers and was slightly modified to suit health managers, sector partner coordinators, and local authorities. The second questionnaire was developed specifically for affected individuals and administered through trained data collectors. This approach facilitated comparisons across target

groups and themes, helping to identify discrepancies in perceived needs and priorities, with an emphasis on the needs identified by the affected population.

The questionnaires were devised using the WHO' Toolkit for assessing the health system's capacity to manage large influxes of refugees, asylum-seekers and migrants,[2] as well as 'the health needs assessment'[3] by the Health Development Agency as key references. The final tool is a Public Health Needs Assessment (PHNA), which represents a systematic approach to evaluating the public health challenges faced by a population. This assessment aims to establish a consensus on priorities and the allocation of resources to enhance overall public health indicators and diminish disparities in line with the JRP. The tool is useful to develop evidence about a population on which to plan services and address health inequalities. The health sector for the Rohingya response led this assessment to establish informative decision-making regarding needs and priorities in the health sector in 2025. The health sector ensured the involvement of multiple stakeholders in the assessment planning and development by targeting the service providers with the assessment questionnaire and then validating the findings with senior managerial health representatives from multiple organizations in Cox's Bazar. The initial draft of the questionnaires was validated with the WHO technical team and the Camp Health Focal Points (CHFPs). The questionnaires are available in the annex. Furthermore, this assessment allows the health sector to improve inter-cluster communication and coordination to address the root causes of morbidities and mortalities among the refugees in line with the identified public health determinants and conditions.

The questionnaires were uploaded to a Kobo toolbox, and two links were generated. The link to the first questionnaire was disseminated to field health workers via social communication groups (WhatsApp). The amended version of this questionnaire for managerial staff was emailed to the sector partners to be self-administered. The link to the second questionnaire was distributed to data collectors who administered the questionnaire with the selected participants from the affected population. Field data collectors were community health workers deployed by partners in collaboration with

[2] https://iris.who.int/bitstream/handle/10665/329419/9789289052030-eng.pdf?sequence=1
[3] https://ihub.scot/media/1841/health_needs_assessment_a_practical_guide.pdf

the Community Health Workers Working Group which was responsible for facilitating the training on questionnaire administration.

Sampling

For the first questionnaire, a convenient sampling strategy was used to ensure that the maximum number of field health workers and health managerial and coordination teams of the health sector partners and local authorities were targeted. The sampling strategy for the second questionnaire was designed to ensure representativeness across all 33 camps in Cox's Bazar. The sample size for the second group was determined based on a Confidence Interval (CI) of 95% and a margin of error of 5%.

The total population of Rohingya refugees was estimated at 958,156, excluding Bashan Char Island refugees based on UNHCR population statistics as of 31.08.2024, distributed across 33 camps. The method applied was systematic random stratified sampling, through which the target population was divided into strata (camps) and then systematically and randomly selected households within each camp for the survey. The rationale for this method was to ensure efficiency and representative coverage.

The formula for sample size calculation is:

$$S = \frac{Z^2 P\,(1-P)\,V}{e^2}$$

Where:

- S = the sample size
- Z = z value for 95% CI = 1.96
- P = estimated proportion for maximum inclusion (0.5)
- e = margin of error = 0.05
- V = sample variability = 1.5 (to account for potential non-response, non-reliable, unregistered refugees, or incomplete data, a 50% increase was recommended)

Based on the equation above, S = 577 individuals representing 577 households.

The proportional stratified sample size S_i across the camps was calculated based on the population proportion for the relevant camp.

$$S_i = \frac{N_i}{N} S$$

Where:

- Si = the sample size per camp.
- Ni = the number of populations per camp.
- N = the total number of populations in the camps.
- S = the sample size

Based on this equation, the proportional sample per camp has been calculated (table 1).

Table 2: sample size calculation (planned)

Camp	Population Si	Si/S (total population) %	# individuals to be interviewed	% females per camp	Minimum # females to be interviewed
Camp 1E	43,673	4.56%	26	51%	13
Camp 1W	40,490	4.23%	24	51%	12
Camp 2E	27,496	2.87%	17	52%	9
Camp 2W	25,725	2.68%	15	52%	8
Camp 3	38,088	3.98%	23	51%	12
Camp 4	34,910	3.64%	21	51%	11
Camp 4 E	8,895	0.93%	5	51%	3
Camp 5	28,486	2.97%	17	51%	9
Camp 6	26,931	2.81%	16	51%	8
Camp 7	40,935	4.27%	25	51%	13
Camp 8E	32,622	3.40%	20	51%	10
Camp 8W	34,441	3.59%	21	51%	11
Camp 9	36,829	3.84%	22	51%	11
Camp 10	32,335	3.37%	19	51%	10
Camp 11	33,318	3.48%	20	51%	10
Camp 12	29,686	3.10%	18	51%	9
Camp 13	46,192	4.82%	28	51%	14
Camp 14	35,993	3.76%	22	51%	11
Camp 15	59,037	6.16%	36	51%	18
Camp 16	23,004	2.40%	14	51%	7
Camp 17	19,779	2.06%	12	51%	6
Camp 18	31,445	3.28%	19	51%	10
Camp 19	27,264	2.85%	16	51%	8
Camp 20	8,807	0.92%	5	52%	3
Camp 20 E	11,786	1.23%	7	52%	4
Camp 21	17,176	1.79%	10	51%	5

Camp 22	23,904	2.49%	14	51%	7
Camp 24	27,234	2.84%	16	52%	9
Camp 25	9,108	0.95%	5	52%	3
Camp 26	41,693	4.35%	25	52%	13
Camp 27	17,866	1.86%	11	52%	6
Kutupalong	18,197	1.90%	11	51%	6
Nayapara	24,811	2.59%	15	53%	8
TOTAL	**958,156**		**577**		**296**

To ensure the meaningful involvement of women in this assessment, a minimum number of female-headed HHs was determined (296) during the planning phase to guarantee a representative sample during the data collection phase. Data analysis was performed using R and SPSS v22 statistical analysis software programs.

Data analysis

For ranked questions, choices were assigned weighted scores corresponding to their rank, with the scoring direction inversely proportional to the rank order. For example, in a 5-ranked question, the 1st choice received a score of 5, the 2nd choice received a score of 4, the 3rd choice received a score of 3, the 4th choice received a score of 2, and the 5th choice received a score of 1. Answers/choices were then ranked based on their total weighted scores.

The maximum possible score for a choice was calculated based on its theoretical frequency, assuming all respondents selected it as their 1st choice. For a 5-ranked question, this maximum score was determined by multiplying the maximum theoretical frequency for a choice by 5. The same analysis approach was applied to 3-ranked questions, with scores ranging from 1 to 3 based on the rank of each choice.

Microsoft Excel was utilized for data cleaning and processing. Data analysis and visualization were conducted using Microsoft Excel (with the Data Analysis Toolkit), SPSS (version 25), and Power BI.

To identify and exclude duplicate entries, the personal registry numbers (FCN: Family Counting Numbe: used as the primary key) were checked for household data. For medical workers and NGO respondents, contact numbers and email addresses were used to detect duplicates.

Terms and definitions

The terms outlined below are fundamental to the PHNA process detailed in this report.

- Health: Health is conceptualized as a positive notion highlighting social and personal resources in addition to physical abilities. It encompasses individuals' capacity and their self-perception of their capability to operate and manage within their social and physical surroundings, as well as to confront specific diseases and life overall (Kühn & Rieger, 2017; Saracci, 1997).
- Inequalities in health: WHO and the health sector have a mandate to bridge the disparity between the different segments of communities, according to the JRP indicators, such as access to health services and response to outbreak alerts. This assessment is important because it will establish evidence for directing services and support towards the most vulnerable groups. Substantial research indicates that various social determinants, such as education, employment status, income level, gender, and ethnicity, significantly impact an individual's health. Across countries of varying economic statuses - low, middle, and high-income - there exist pronounced disparities in the health outcomes of diverse social groups. It is consistently observed that individuals with lower socioeconomic status are at an increased risk of experiencing poorer health.

  According to WHO, health inequities refer to the systematic variations in health outcomes observed among different demographic and social groups. These disparities bear significant social and economic implications not only for individuals but also for communities at large (McCartney et al., 2019; WHO, 2018).
- Health needs: The components of the PHNA encompass a range of perspectives and considerations, including:
  - The felt and expressed needs as perceived and expected by the profiled population.
  - The viewpoints of professionals and health workers who are directly involved in providing services.
  - The insights of managers and decision-makers within humanitarian organizations, which are often based on available data regarding the magnitude and severity of health issues within a specific population. This

also involves assessing disparities in comparison to other populations, thereby identifying normative needs.

- The strategic priorities of donors, UN agencies, and the health cluster, which are typically aligned with broader national priorities based on the JRP of Rohingya refugees' response, are often referred to as corporate needs.

While the first questionnaire was designed to address the first perspective, the second questionnaire was designed to collect information about the other three perspectives.

- Health determinants: The methodology of this assessment utilized the multi-layer of factors influencing individual health or so-called public health determinants (Whitehead & Dahlgren, 1991) (figure 1). At the core are the **individual characteristics**, like age, gender, and genetic inheritance. Surrounding this are **lifestyle behaviors and patterns**, including smoking, dietary habits, and physical activity. Further out, there are factors related to **social and community networks**, such as social inclusion, social status, economic resources, and the material environment. The next layer refers **to living and working conditions**, including work environments, housing conditions, income, employment, education, and healthcare. In the most external layer, the focus

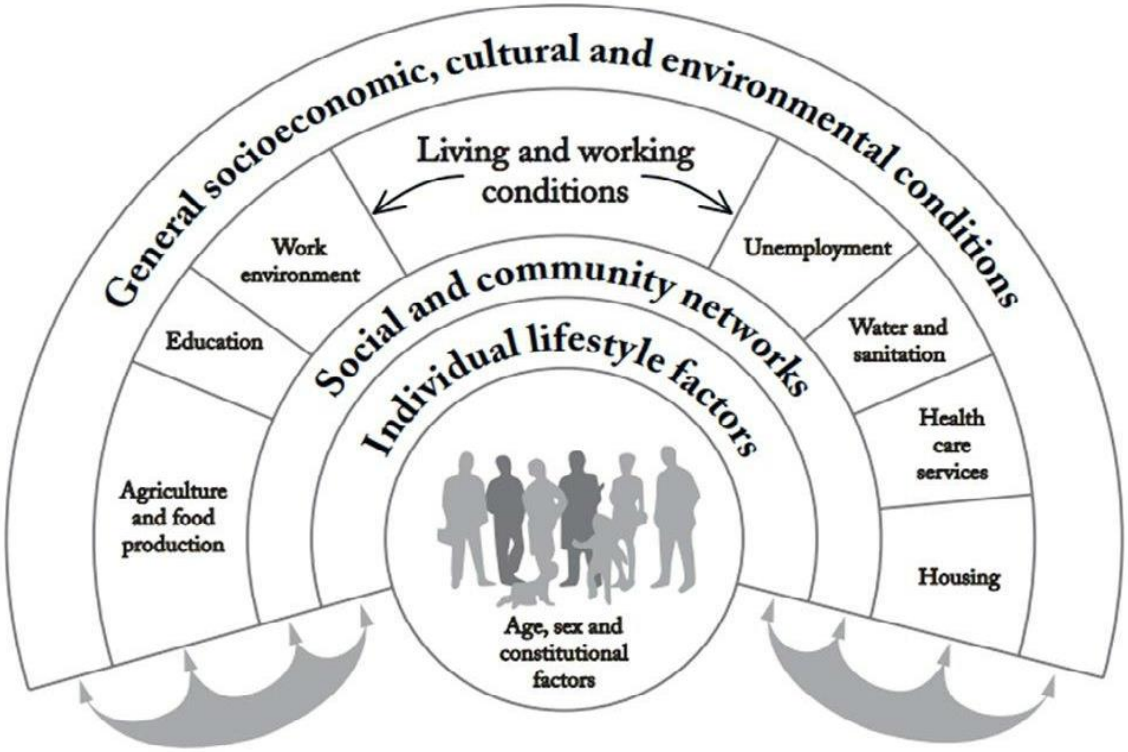

Figure 1: public health determinants of Dahlgren and Whitehead (1991).

shifts to the overarching economic, political, cultural, and environmental conditions prevalent in society. These determinants refer to **general socioeconomic, cultural, and environmental factors**.

Addressing health inequalities necessitates interventions across all these layers. PHNA serves as a critical tool for identifying, evaluating, and prioritizing areas for impactful action. Consequently, the PHNA process engaged individuals from multiple stakeholders to gather data about the needs of the target population in Rohingya camps. Through this assessment, the health sector aimed to identify the sector's pressing needs and priorities and link them to the public health determinants of Dahlgren and Whitehead.

- Diseases and health conditions: Understanding the most prevalent and impactful morbidities within a population is crucial, mainly when they influence overall health functionality and drain significant resources. These public health issues are due to certain public health determinant factors in line with the Dahlgren and Whitehead model. Therefore, in conducting PHNA, it is essential to identify public health determinants that cause or exacerbate pressing health conditions and diseases to develop relevant interventions to reduce disease and ill health. The formulation of the intervention plan should be in coordination with the humanitarian clusters. This collaborative approach is essential to develop potential programs across these clusters that are capable of addressing the underlying factors of the identified determinants. Such a strategy includes a focus on implementing prevention programs within the target population, ensuring a comprehensive and effective response.
- Health functioning: Health functioning can be described as the experience of an individual or a population with regard to the impact of the identified health condition. In the context of Rohingya refugees, health functioning has multiple dimensions, deeply influenced by the protracted crisis, which has significantly impacted the health system, access to healthcare, and social inclusion. Here, health functioning can be characterized as the experience of individuals or the population in relation to how health conditions erupted or exacerbated by ongoing conflict and instability, manifest in several critical dimensions:
    - Social Roles and Relationships: The crisis has the potential to adversely affect traditional social roles and relationships, including caregiving, partnerships, friendships, sexual relationships, and employer-employee

dynamics. The disruption of community structures and displacement may lead to changes in these roles, impacting the social fabric.

- Mobility and Physical Ability: The population's level of mobility may be negatively affected, not just by direct health conditions but also by the lack of adequate healthcare facilities, the destruction of infrastructure, and the dangers of movement in a conflict zone. This reduced mobility can further limit access to necessary health services and social interaction.
- Pain and Physical Suffering: Ongoing conflict can exacerbate physical pain, impairment, and disability, either through direct injury or due to the lack of adequate medical care for chronic conditions.
- Mental Health: The continuous stress, trauma, and loss associated with the crisis contribute significantly to mental illness, including conditions like Post-Traumatic Stress Disorder (PTSD), depression, and anxiety. The breakdown of community support systems and limited access to mental health services further compound these issues.
- Energy and Vitality: The cumulative effect of living in a protracted crisis, with its attendant uncertainties and hardships, can lead to diminished energy levels and vitality. This can be due to a combination of psychological stress, poor nutrition, disrupted sleep patterns, and general health deterioration.

More explanation about utilizing the health triangle is available in the steps of conducting this assessment.

- Health triangle: In the context of Rohingya camps, the health triangle can be a valuable framework for analyzing and addressing the region's complex health challenges (figure 2). This tool can be instrumental in several ways (Hooper & Longworth, 2002):
  - It helps identify critical health issues that are impacting the population. Given the diverse health challenges in refugee camps, from communicable diseases to the aftermath of physical trauma and mental health issues, the health triangle can highlight key areas of concern.
  - The tool facilitates an examination of the relationships between various health conditions, their determining factors, and overall health functioning. This is particularly relevant in the refugee context in Cox's Bazar, where health issues are related to factors like displacement, poor living conditions, and limited access to healthcare.

- It assists in organizing the collection and presentation of data to create a meaningful health profile. In a region where health data may be fragmented or scarce, this systematic approach is crucial for effective health planning and intervention.
- Furthermore, employing the health triangle in collaboration with the service providers, NGOs, and all major stakeholders is essential. This collaborative approach ensures a consensus on the priorities for action, which is vital for a region with diverse health needs and limited resources.
- The health triangle consists of five specified dimensions, each with a maximum score of 10. The score reflects the impact of a disease or health condition on each dimension, with higher scores indicating a greater impact. The total of these scores represents the health functioning value, providing an overall measure of the impact of health conditions on health functioning.

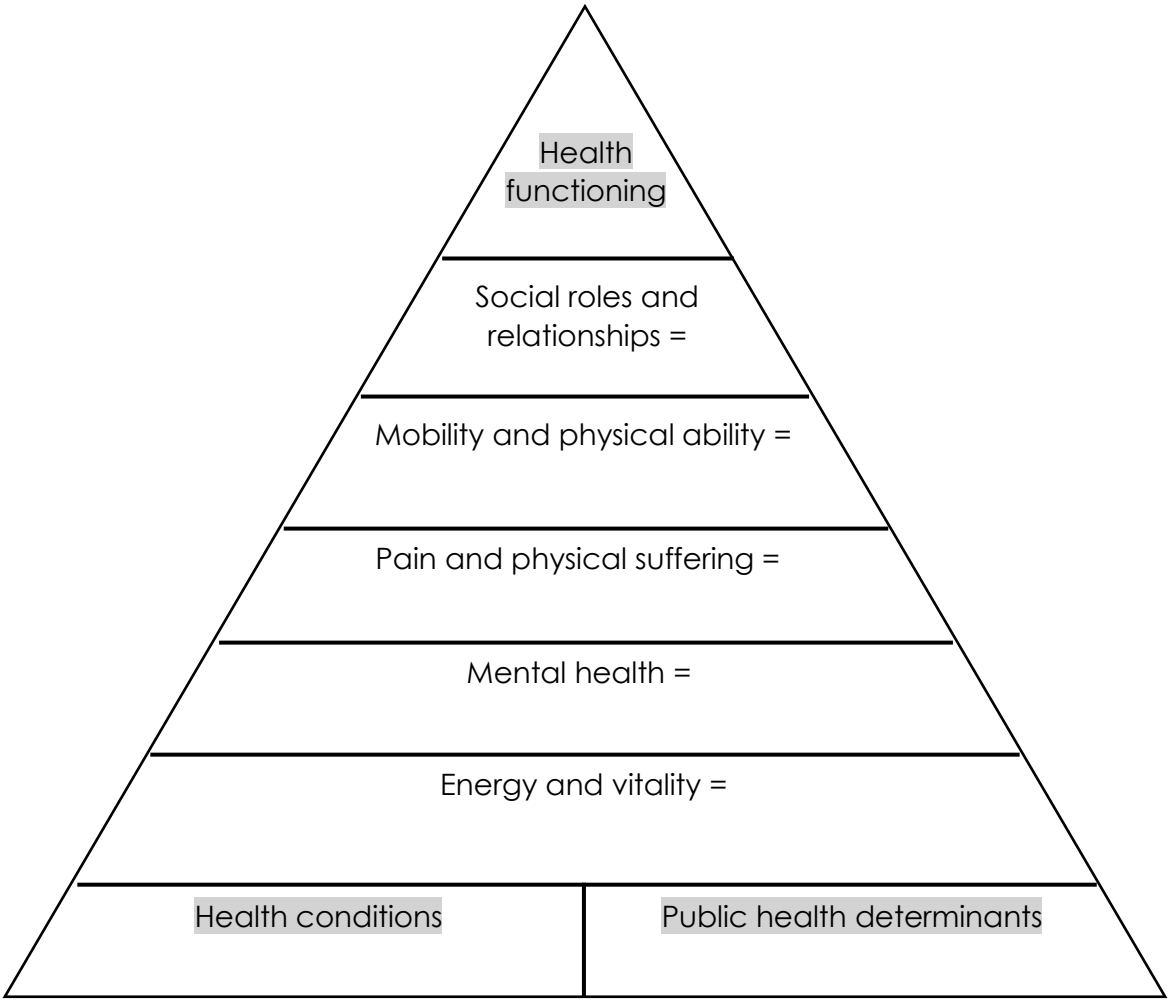

Figure 2: the health triangle of health functioning and five dimensions. Adopted from the original model used by (Hooper & Longworth, 2002).

The five steps of public health need assessment

PHNA involves a series of pragmatic steps and a combination of quantitative and qualitative evaluation methods (figure 3). This approach is designed to ensure a comprehensive and systematic assessment, revealing concrete and contextualized results. The insights gathered from this process are intended to inform the health cluster

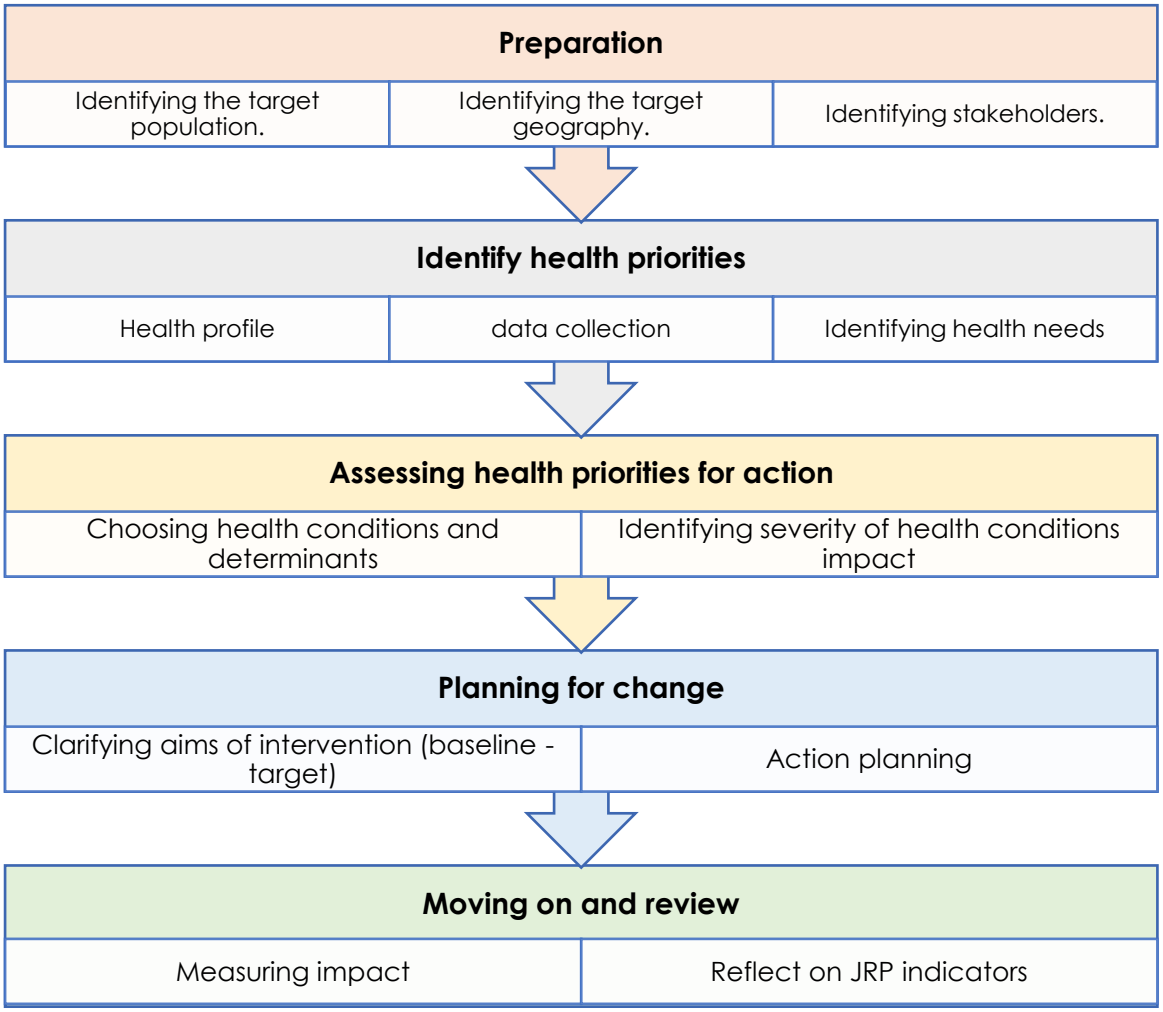

Figure 3: the five steps of PHNA 2025 – Rohingya refugees' response.

planning and decision-making regarding the delivery of healthcare services in camps in 2025, thereby enhancing health outcomes for the affected population. Additionally, this systematic approach may yield further advantages, including informing inter-cluster strategies and interventions in the region.

This document cover the health sector progress over the first three steps and the base line target of the fourth step. The health sector will coordinate with the technical working groups and other partners to develop or amend their work plans to incorporate the findings and recommendations of this assessment.

Findings

Sociodemographics

The first sample that targeted humanitarian workers (NGO and field health workers) comprised 293 respondents, 25 (9%) of whom were from managerial and coordination positions of the health sector NGOs. Of the total first sample, 148 (51%) were female participants.

A total of 670 households were targeted through the second questionnaire of this assessment, including 350 (52%) female-headed households. The majority of household heads fell within the age range of 36–59 years (45%), followed by 285 household heads aged 18–35 years (43%), and finally, 84 household heads aged 60 years and older. The median household size was 5 members, with 53% of households below this median. The sample was proportionate to the camp populations, with 560 households (84%) in Ukhia camps and 110 households (16%) in Teknaf (table 2 and figure 4).

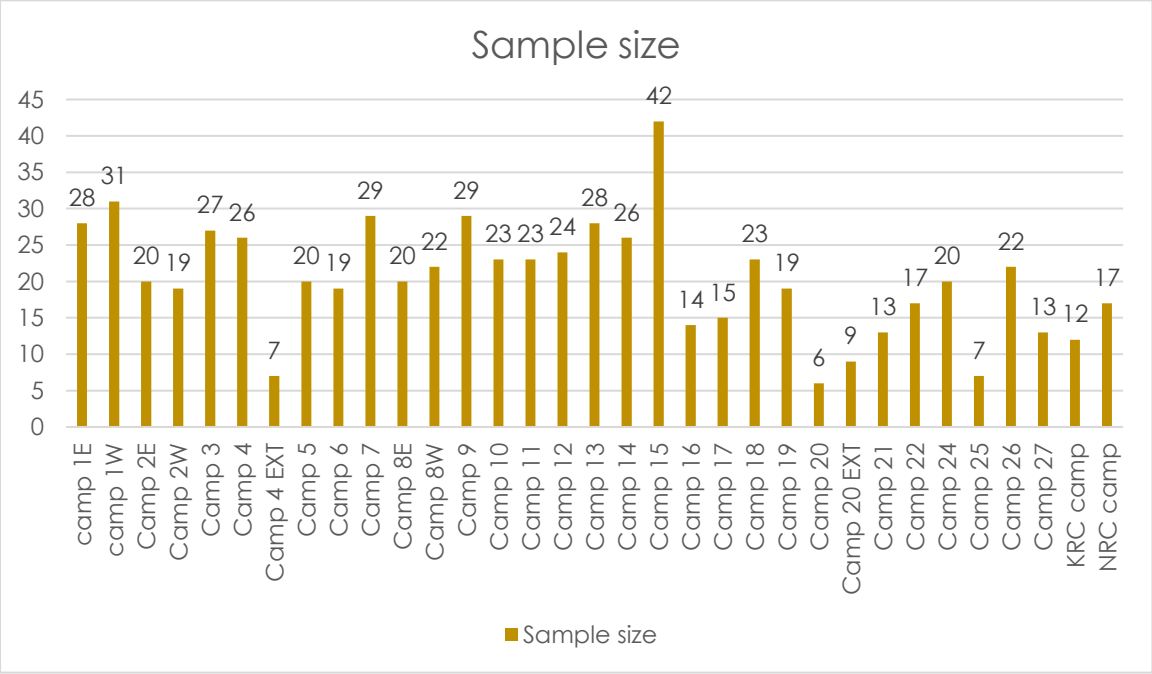

Figure 4: household visits per camp (the 2nd sample)

Table 3: gender and location-based disaggregation of the respondents (the 2nd sample)

	Respondent by sex	Respondent by disability status	Respondent by Upazila

	Male-headed HH	Female-headed HH	At least one PwD in the HH	No PwD in the HH	Ukhia	Teknaf
Number	320	350	122	548	560	110
%	48%	52%	18%	82%	84%	16%

Health Status and Concerns

Skin diseases, AWD, gastroenteric problems, hypertension, and ARI were the most common medical conditions among refugees.

The majority of respondents in the second sample indicated that, over the past three months, the most common health conditions they experienced were (ten diseases) skin diseases, particularly scabies and fungal infections, followed by acute watery diarrhea (AWD) and gastrointestinal issues, hypertension, acute respiratory infections, dengue, eye diseases, hepatitis B & C, Diabetes Mellitus type 2, chronic respiratory infections, and mental health (figure 5).

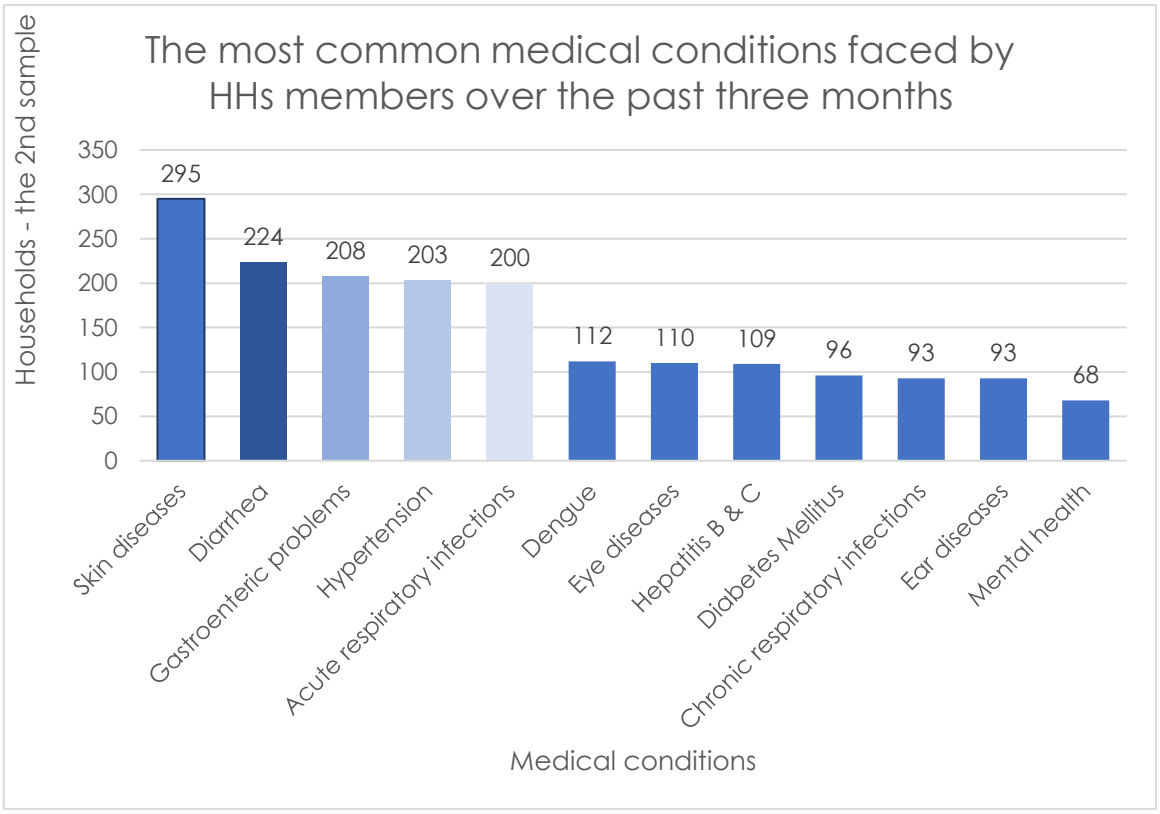

Figure 5: the most common medical conditions faced by households in the past three months (the 2nd sample)

Disaggregating the results by sex and household size showed no significant differences. However, when disaggregated by disability status, hypertension emerged as the most common health issue, followed by skin diseases, physical disabilities, diarrhea, and acute respiratory diseases. Furthermore, when the findings were disaggregated by location, a slightly different pattern of diseases emerged for people in Teknaf. While skin diseases and diarrhea were the top two medical conditions, acute respiratory infections, hypertension, and dengue were the subsequent health conditions, followed by eye, gastrointestinal, and ear diseases (figure 6).

Health issues among Rohingya refugees vary significantly by disability status and location, with hypertension most common among PwD and skin diseases and diarrhea prevalent in Teknaf camps.

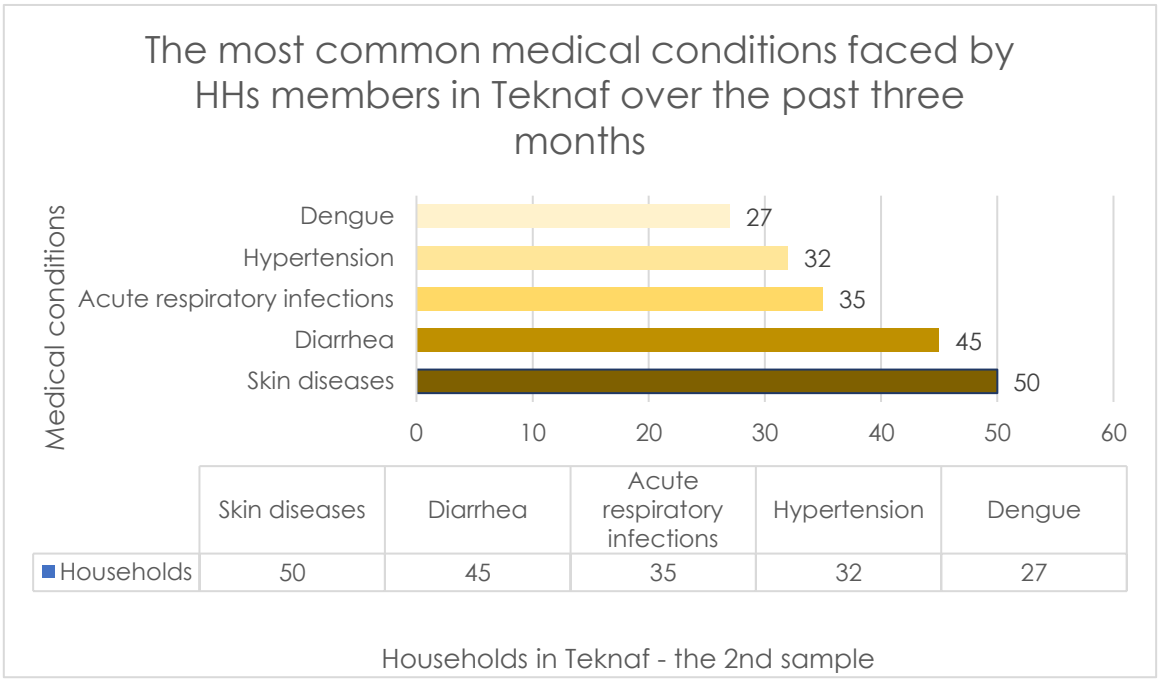

Figure 6: The most common medical conditions faced by HHs members in Teknaf over the past three months (the 2nd sample)

People were asked about the most impactful medical conditions among those they had selected in the previous question to measure the weight of the impact and criticality of these diseases besides their frequency. In fact, people said that the most impactful medical conditions were acute respiratory

The most impactful conditions identified by refugees are ARI, followed by AWD, skin diseases, gastrointestinal problems, and hypertension, with hepatitis B & C, vision impairment, and dengue also highlighted as significant.

diseases, followed by diarrhea, skin diseases, gastrointestinal problems, and hypertension. The following group was hepatitis B & C, vision impairment, and dengue (figure 7).

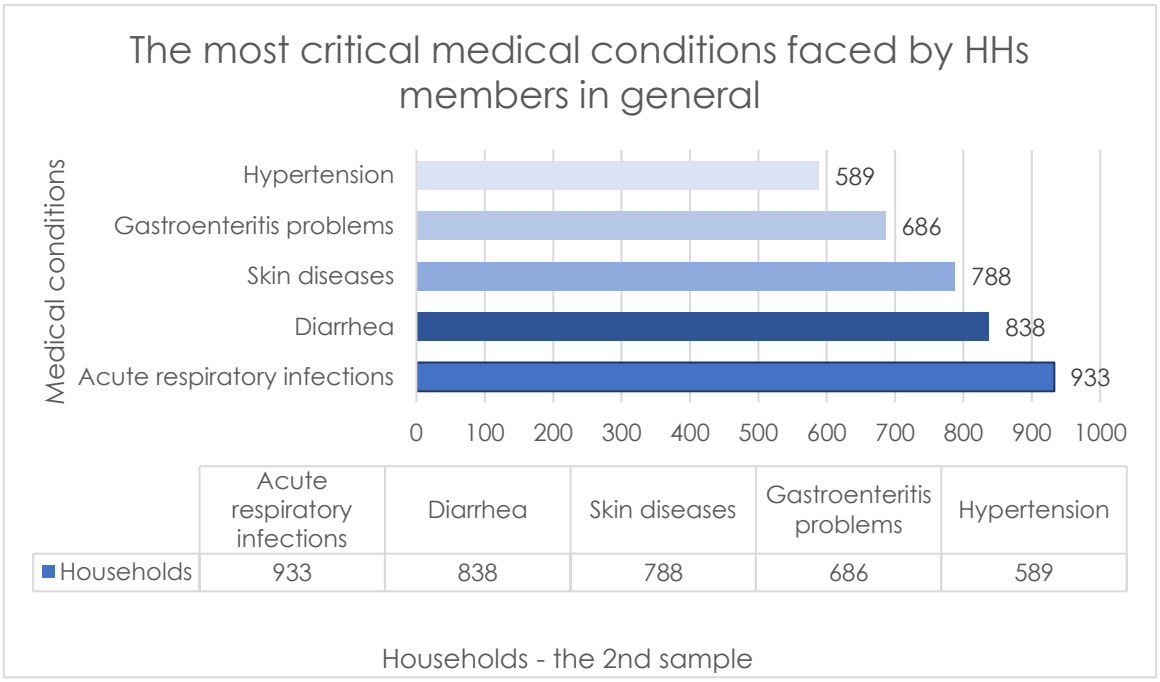

Figure 7: The most critical medical conditions faced by HHs in general (the 2nd sample)

Interstingly, disaggregating these findings based on sex did not change the order significantly. Similarly, analyzing the results based on the household size did not show remarkable variations. However, disaggregating the findings based on location, it was found that the most critical health conditions in Teknaf camps are different. For instance, diarrhea was the most impactful disease. In addition, dengue was among the five most critical health conditions. It is worth mentioning that hepatitis B & C completely disappeared from the top 10 critical health conditions based on participants' responses in Teknaf area (figure 8). Additionally, analyzing the data based on disability status revealed a high impact of vision and hearing impairment among PwD (the 3rd and 6th ranks, respectively). Physical disability was at the 9th rank.

Health priorities vary by location and disability: diarrhea and dengue are critical in Teknaf, while PwDs face high impacts from vision impairments, mental health issues, and hypertension, especially in Teknaf.

Nevertheless, data analysis based on disability status and location together revealed different figures compared to the previous findings. PwD in Teknaf critically suffered

from eye diseases, mental health conditions, physical disability, acute respiratory conditions, and hypertension (figure 9).

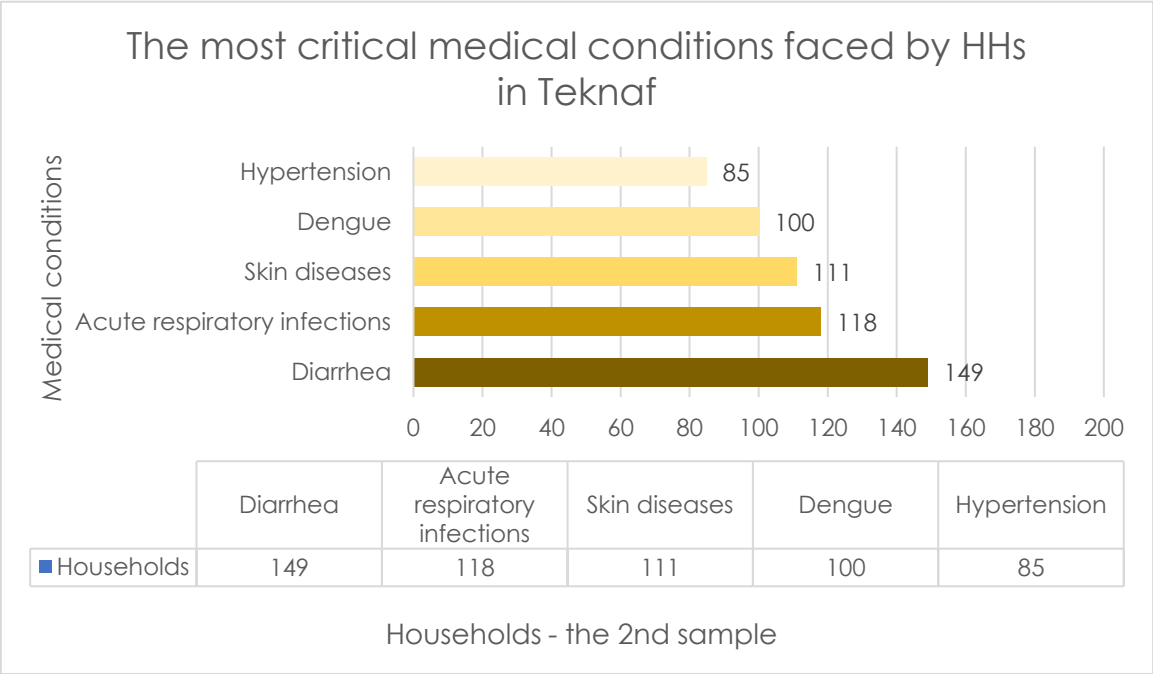

Figure 8: The most critical medical conditions faced by HHs in Teknaf (the 2nd sample)

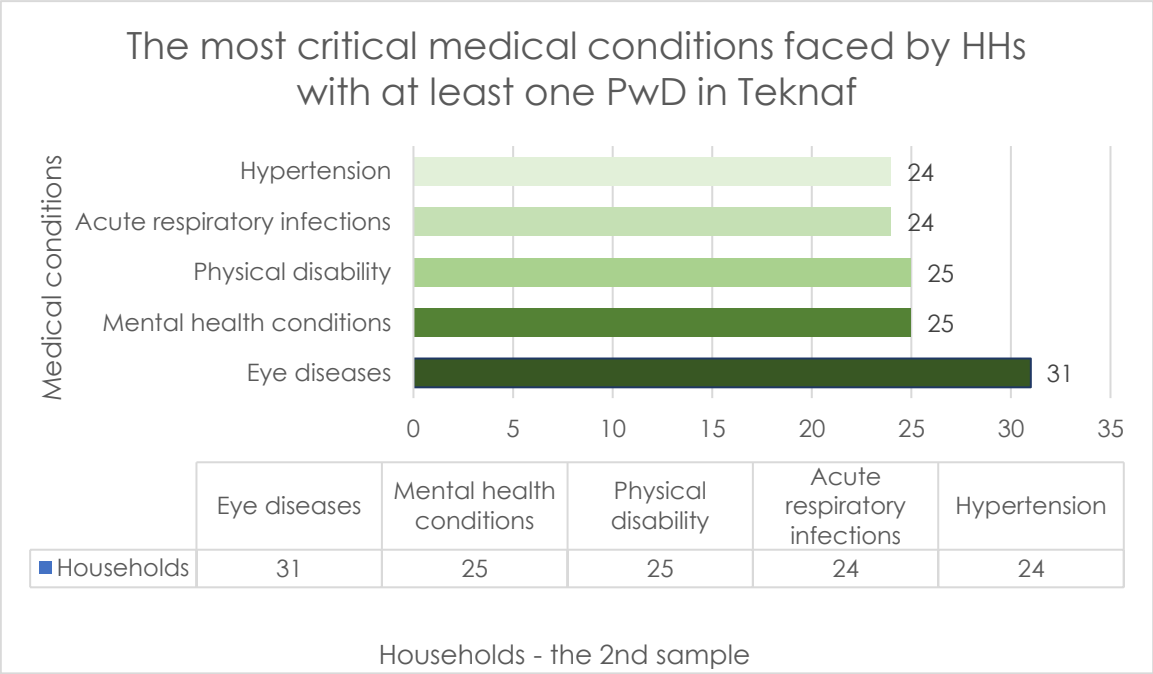

Figure 9: The most critical medical conditions faced by HHs with at least one PwD in Teknaf (the 2nd sample)

For households with at least one PwD and a size larger than the average, chronic diseases erupted to be among the top five critical conditions, especially chronic

respiratory infections and diabetes mellitus type 2. Additionally, data analysis of women-headed households in Teknaf with at least one PwD showed that eye and ear diseases, followed by chronic respiratory conditions, hypertension, and acute respiratory conditions, had the most significant impact on the household health profile (figure 10).

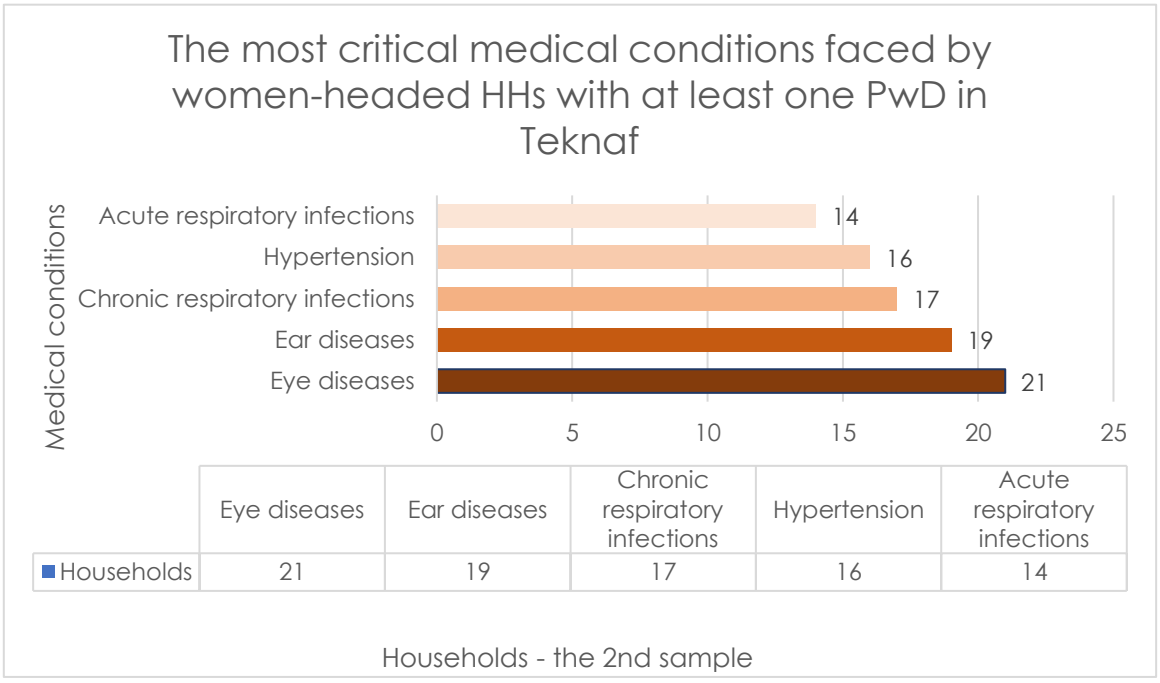

Figure 10: The most critical medical conditions faced by women-headed HHs with at least one PwD in Teknaf (the 2nd sample)

When asked about long-term health conditions, 40% of households reported having at least one member with one or more chronic diseases. Additionally, 12% indicated that at least one member had chronic renal failure. These figures were significantly higher when analyzed by disability status, with the prevalence of chronic diseases rising from 40% to 60% among households with at least one person with a disability (PwD). The prevalence further increased in households with a size greater than the median of five members (Figure 11). Sex and location did not contribute to significant variations in these results.

> Chronic diseases affect 40% of households, rising to 60% in those with a PwD and increasing further in larger households.

The same question about the most impactful diseases was directed to the 1st sample, and no major difference was noticed compared with the answers from the 2nd sample (figure 7), except for hepatitis B & C, which jumped to the 4th rank, followed by Gastroenteric problems, dengue, and hypertension on the 5th, 6th, and 7th ranks,

respectively (figure 12).

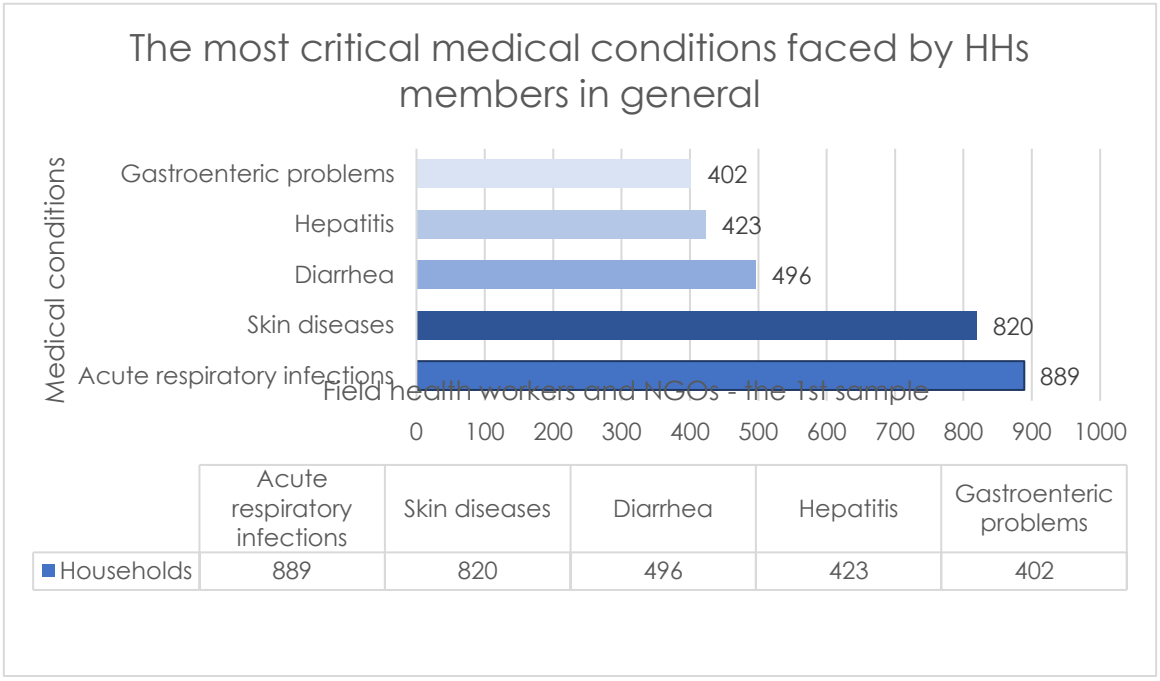

Figure 11: The most critical medical conditions faced by HHs in general (the 1st sample)

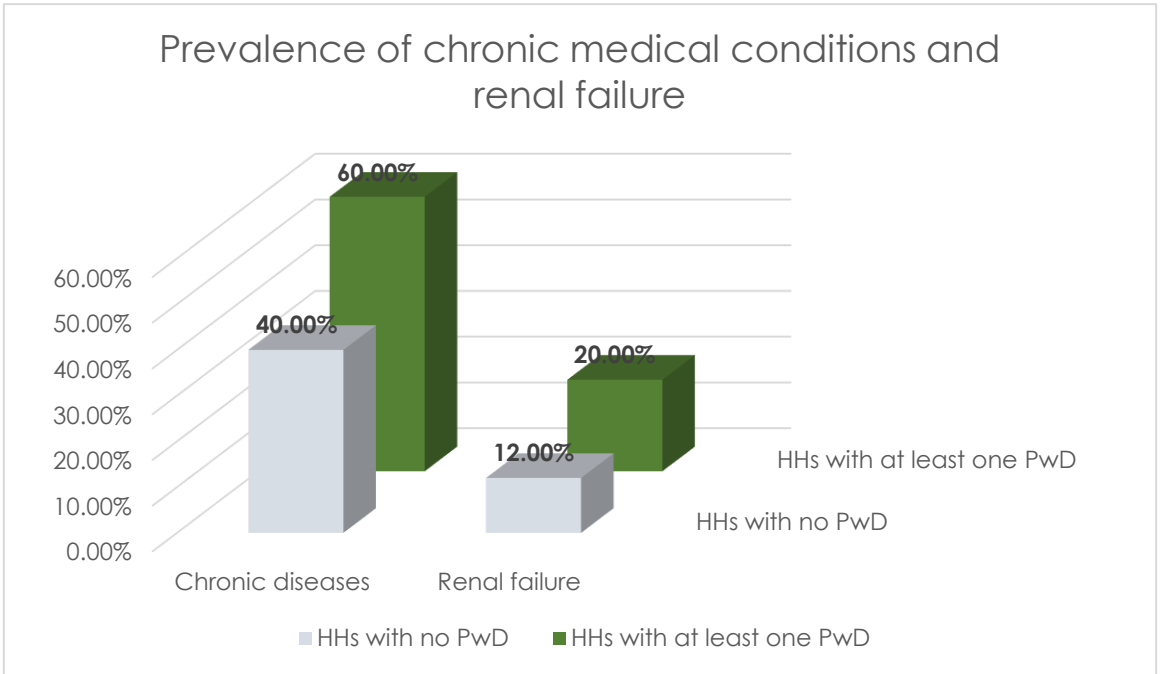

Figure 12: prevalence of chronic medical conditions and renal failures among HHs with and with no PwDs (the 2nd sample)

When the responses from the first sample were disaggregated by sex, hepatitis B and C rose to the 3rd rank, followed by diarrhea and dengue. Noticeably, responses from field health workers in Teknaf identified type 2 diabetes mellitus as one of the top five

most impactful health conditions in the camps.

Respondents from the second sample were asked whether pregnant women in their households received antenatal care (ANC), if applicable. Of those surveyed, 47% stated that pregnant women had received ANC, 29% reported that pregnant women had never received ANC, and 24% indicated that the question was not applicable to their household. Responses from Teknaf showed better outcomes, with 61% of households reporting that pregnant women had access to ANC services, compared to 45% in Ukhia. These results were consistent with vaccination rates among children, as 81% of respondents from Teknaf reported that all children in their households were fully vaccinated, compared to 70% in Ukhia.

The findings on mental health services were concerning, with 32% of respondents reporting that at least one member of their household had experienced emotional distress or trauma over the past six months. Among this group, only 39% confirmed they had access to mental health services or psychosocial support. These figures showed minimal variation by sex, location, or household size but revealed significant differences when disaggregated by disability status. Nearly half (48%) of respondents from households with at least one person with a disability (PwD) reported emotional distress or trauma, and 52% of them were unable to access mental health services or psychosocial support.

> Emotional distress and MH problems affects 32% of households, but only 39% access MHPSS services, and among households with a PwD, distress rises to 48%, with 52% lacking access to MHPSS services.

Access to Healthcare Services

The PHNA focused on four elements related to access to health services, which are **affordability** (charges for health services), **availability** or quality (full package of requisite services), **accessibility** (distance and duration), and **acceptability** (culture and gender-oriented and comfortability)[4].

The majority of respondents (93% of the second sample) reported utilizing NGO-operated health facilities, which provide free medical services. Additionally, 99% of participants indicated that they could reach the nearest health facility within 60 minutes, aligning with the Sphere 2018 guidelines (minimum of 80% population

[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC1464050/

coverage)[5]. These findings remained consistent when disaggregated by sex, disability status, location, or household size.

When asked about their perceptions of health service quality, 6% rated it as excellent, 39% as good, 35% as satisfactory, 16% as poor, and 4% as very poor (Figure 13).

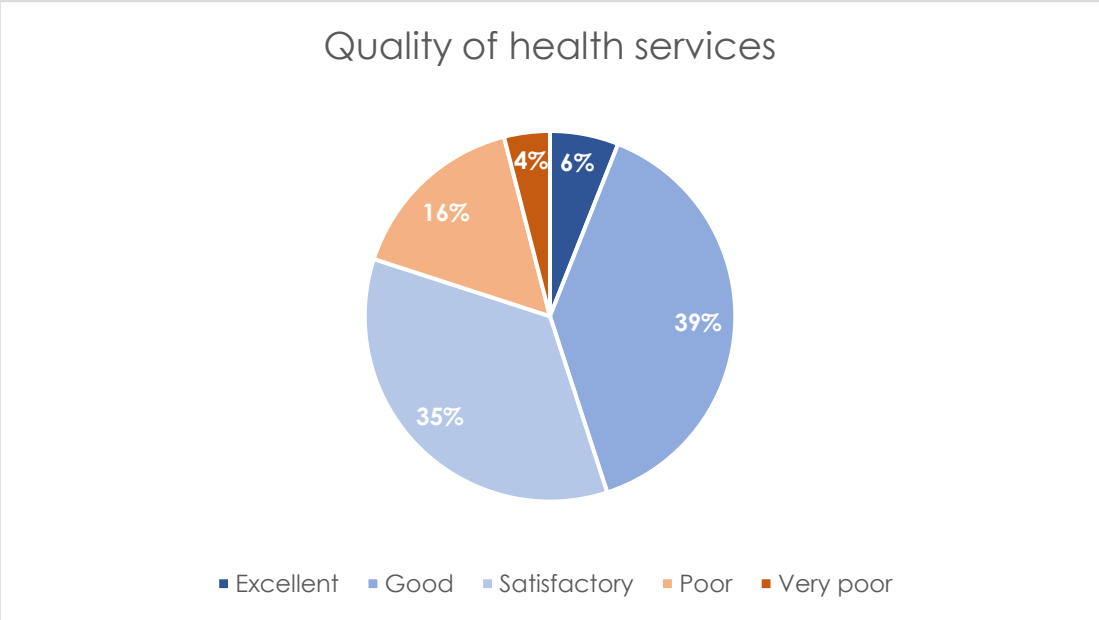

Figure 13: Perception of quality of health services (the 2nd sample)

However, 22% of respondents reported facing challenges in accessing healthcare services, particularly due to the unavailability of all required services, lack of transportation, and long waiting times. In addition, 96% of respondents reported obtaining some of their medication from health facilities within the camps. However, 32% stated that they also seek medication from private pharmacies due to the unavailability of certain drugs in NGO-operated health facilities. Additionally, 13% of respondents said they usually pay for medication from illegal drug dispensers. When asked about the reasons for resorting to illegal sources, the most common explanations included the unavailability of required drugs at NGO health centers, the lower cost of medication compared to private pharmacies, and the ability to obtain medicine without a prescription (figure 14).

Access: challenges persist with availability and affordability: 32% of patients resort to private pharmacies and 13% to illegal drug dispensers due to drug shortages and cost issues.

[5] https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf

The overall results indicate that while accessibility and acceptability metrics are encouraging, affordability and availability (quality) figures remain concerning.

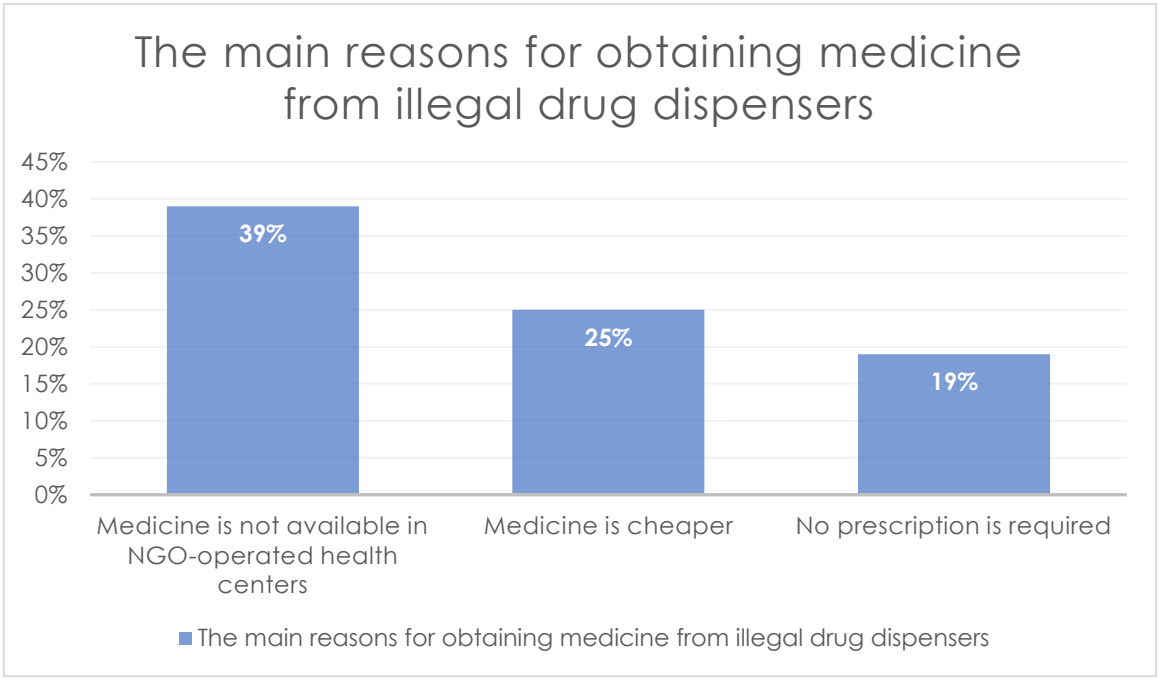

Figure 14: the main reasons for resorting to illegal drug dispensers (the 2nd sample)

Access to Medicine

As mentioned in the previous section, there are challenges among refugees in affording all the required medicine. The disaggregated analysis showed that people in Teknaf resort more to private pharmacies for their medicine, but are remarkably less dependent on illegal dispensers (figure 15).

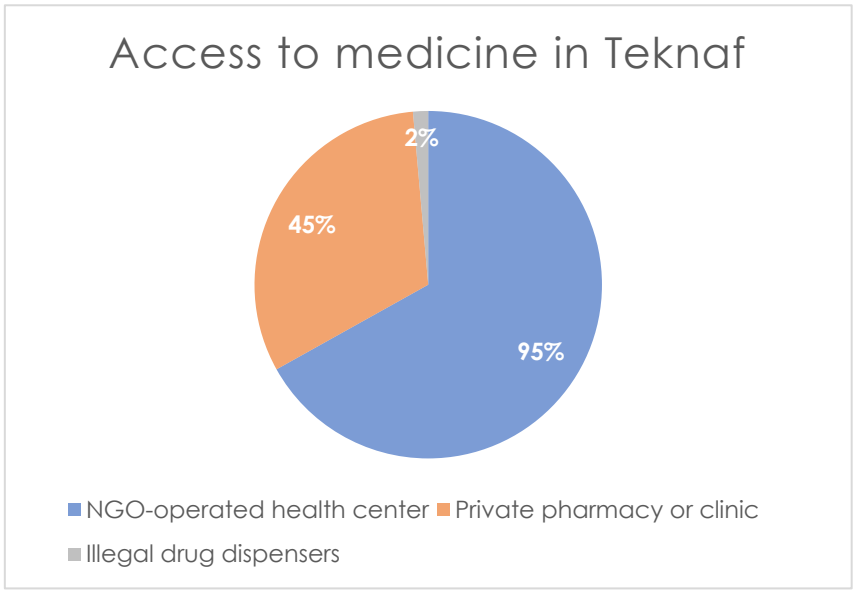

Figure 15: the main source of medicine for refugees in Teknaf (the 2nd sample)

In general, 145 (22%) participants confirmed they experienced difficulties in obtaining medicine for one of the household members in the past three months. This percentage increased significantly when analyzed by disability status, with 29% of households containing at least one PwD reporting difficulties in accessing healthcare services over the past three months (figure 16).

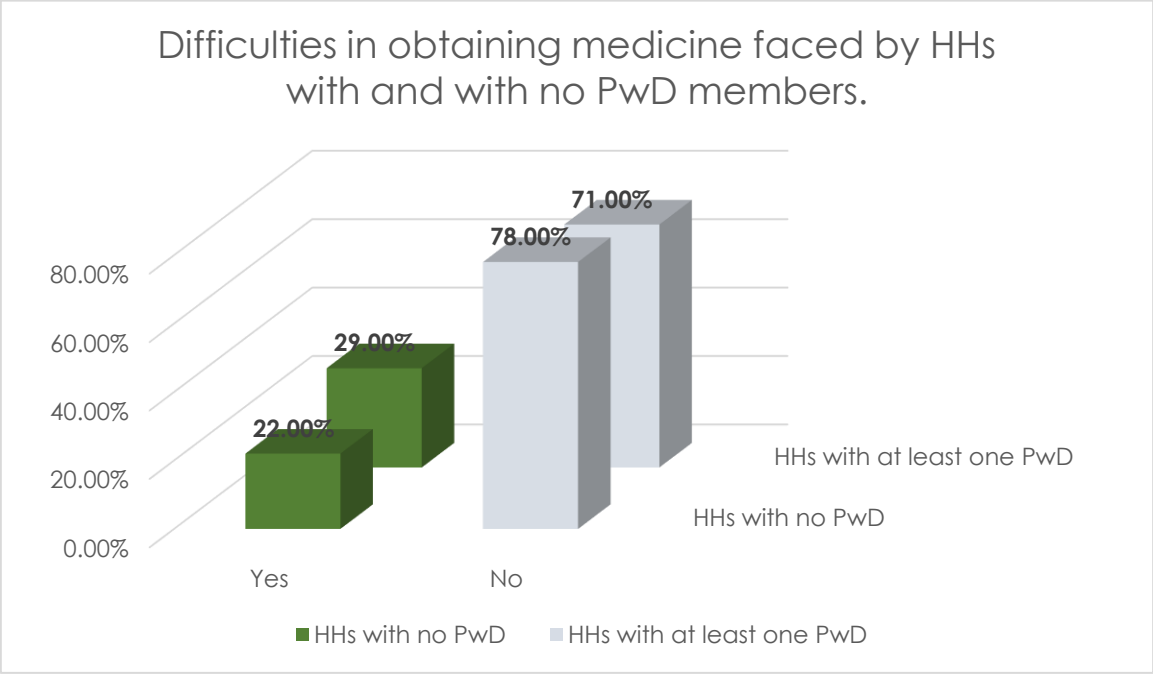

Figure 16: Difficulties in obtaining medicine among HHs with and with no PwDs (the 2nd sample)

According to responses from the second sample, the most commonly needed medicines include those for non-communicable diseases (NCDs), pediatric care, hepatitis treatment, gynecological conditions, and mental health (figure 17). These figures did not change when disaggregated based on sex. However, disaggregation based on disability status showed that mental health drugs became the 3rd rank among the most commonly needed medicines.

The second sample was asked whether they typically receive sufficient information on how to use their medication. Of the respondents, 71% said yes, 14% said no, and 15% stated that they sometimes receive adequate information. These findings did not change remarkably based on sex, location, disability status, and household size.

22% of HHs, and 29% of HHs with PwDs, reported difficulties in accessing medicines, particularly for NCDs, pediatric care, gynecological conditions, hepatitis, and mental health.

The responses regarding the most needed medicine from the first sample did not show a significant difference compared to the second sample. According to the first

sample, the most demanded drugs are those related to NCD, pediatric, gynecologic, surgery and trauma management, and mental health. In addition, 23% of respondents from the first sample reported a regular disruption in the availability of essential medicine in the health facilities.

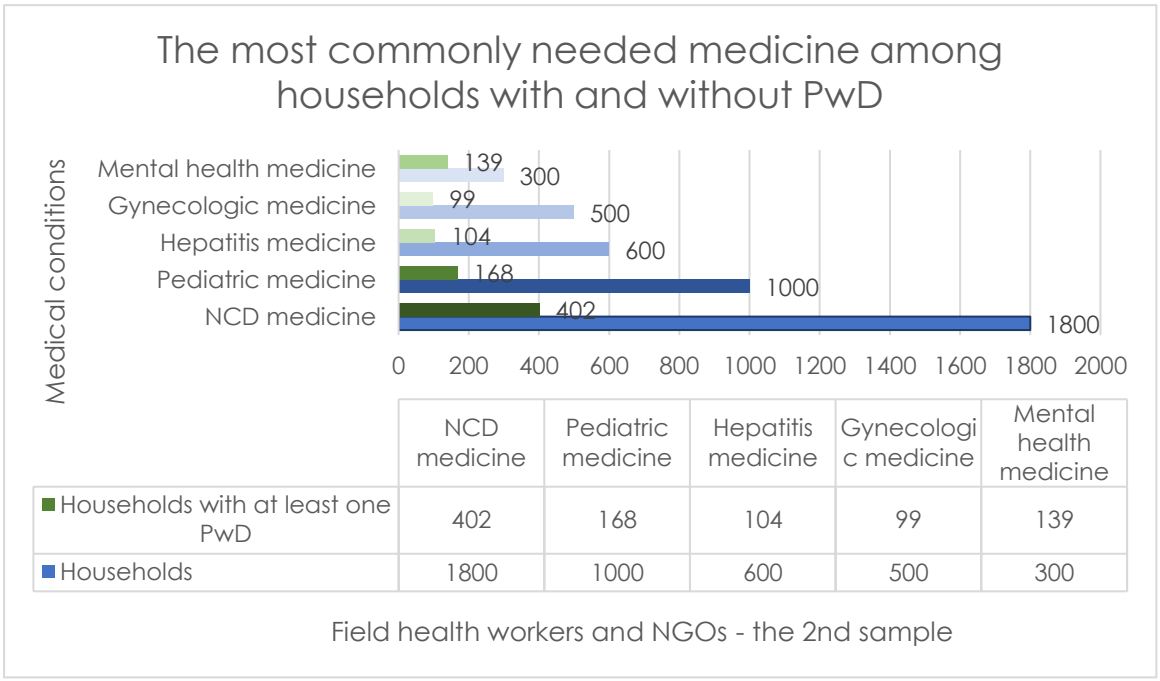

Figure 17: The most commonly needed medicine among households with and without PwD (the 2nd sample)

Health Awareness and Education

Respondents from the second sample reported receiving health awareness and education messages over the past three months on various topics, primarily from community health workers (CHWs), medical workers at health facilities, and community meetings. However, only 64% of respondents stated that they have sufficient knowledge to prevent common health problems in their households, while 20% indicated they lack sufficient information, and 17% were uncertain about their level of knowledge. These figures were even worse when the data were disaggregated based on disability status. A total of 42% of the respondents from households with at least one PwD were either without sufficient knowledge or uncertain about their level of knowledge regarding disease prevention.

Health awareness remains inadequate, with 36% of respondents lacking or unsure about knowledge to prevent diseases, rising to 42% among households with PwDs.

Data disaggregation showed less engagement of field medical workers in Ukhia in

raising awareness efforts. While 71% of people in Teknaf said that they were exposed to raising awareness messages from medical field workers, 55% of people in Ukhia said that they received awareness messages from field medical workers in the past three months.

Health Priorities

Both groups were asked to identify the health sector priorities for 2025, considering the current needs and health profile of refugees in the camps. The first group emphasized the importance of maintaining current health services, particularly primary and secondary healthcare, including immunization, maternal healthcare, non-communicable disease (NCD) management, community and outreach services, referral services and patient medical transportation, and the provision of medicines and supply chain management. The answers of the second group completely matched the first group's answers. Disaggregating the findings based on sex, location, and household size did not show remarkable disparities. People identified under-five children, pregnant and lactating women, elderly persons, and PwD as the three most vulnerable groups in camps.

The top health sector priorities for 2025 include maintaining primary and secondary healthcare services, immunization, maternal care, NCD management, outreach and referral services, patient transportation, and reliable medicine supply chains.

The first group was asked about the need for medical equipment and devices in health facilities, and 15% reported a shortage of various devices as well as issues with malfunctioning equipment. According to responses from field health workers, the following medical devices were identified as the most needed.

Table 4: medical equipment and devices that are reported to be mostly required for health facilities (the 1st sample)

Medical equipment	**The number of HFs reported a shortage in the device.**
The first group: diagnostic equipment	
Imaging Machines: X-Ray	14
Blood Gas / pH Analyzer (Lab)	14

Cardiotocography CTG (Monitoring of fetal heart frequency)	12
Pulse Oximeter	9
Bilirubinometer	8
The second group: treatment and surgical equipment	
ECG	15
Suction machine	13
DC shock machine (defibrilator)	13
Ventilator for children	11
The third group: emergency and trauma care equipment	
Crash cart	17
Infusion pump	16
Oxygen concentrator	16
Ambu bag (pediatrics and adult)	15
Oxygen generator	12
The fourth group	
Infant incubator	27
Intensive phototherapy	22
Fetal monitor	18
Neonatal resuscitation table	17
Radiant warmer	16

Gender Inclusion

The second sample was asked whether any household member had experienced difficulties accessing health services due to gender-related reasons, with 4% of respondents confirming this. Additionally, respondents were asked about their satisfaction with healthcare services at health centers in addressing gender-specific health needs. The majority reported being satisfied or very satisfied, while 4% expressed dissatisfaction or strong dissatisfaction, and 7% were neutral. When asked if field health workers were adequately sensitive to gender-specific issues, 96% of respondents agreed. However, 3% of the sample indicated that at least one household member had refrained from seeking health services due to concerns related to gender, such as violence or discrimination.

The first sample was asked if health services at facilities are managed and delivered in a manner that adequately addresses gender-specific needs, and 93% of respondents agreed. However, 45% highlighted gender-related challenges in the planning and delivery of health services in camps. Furthermore, only 34% reported receiving specific training in addressing gender-specific health issues among refugees. Nearly 24% of respondents from the first sample stated that the NGO operating their health facility was not fully aware of all the specific health needs of different gender groups.

While 93% of health workers believe health services address gender-specific needs, 45% identified gender-related challenges in planning and delivery. Additionally, only 34% reported receiving training on gender-specific health issues, and 24% felt NGOs were not fully aware of the distinct health needs of different gender groups.

Health Functioning and Triangle

The most common health concerns (Figure 5) were identified based on responses from the two samples. A health functioning approach was applied to these concerns during a consultation workshop with health sector partners. This process involved scoring and ranking the concerns based on their impact, with the health functioning value indicating the degree of impact (a higher value signifies a greater impact on public health). The potential public health determinants for each concern were identified through a thorough review of the available literature on public health issues among Rohingya refugees in Cox's Bazar. Partners were asked during the workshop to select the three most relevant public health determinants for each concern as well as to score each of the five dimensions of health functioning on a scale from 1 to 10, where 1 indicated minimal impact and 10 represented the highest impact of the health concern of interest on the health functioning dimensions (figure 2).

The next step in this process is to verify the ranking of these concerns based on their impact on public health and health functioning among refugees in collaboration with WHO. This will involve identifying the addressable public health determinants and subsequently developing a plan to address those determinants relevant to each concern.

Acute respiratory infections

Health functioning dimensions

- Social roles and relationships: 6
- Mobility and physical ability: 5
- Pain and physical suffering: 5
- Mental health: 6
- Energy and vitality: 5

Total: 27/50.

The most relevant public health determinants (figure 18):

1- Overcrowded living conditions: 32%.
2- Behavioral and lifestyle factors: 24%.
3- Education and awareness: 18%.

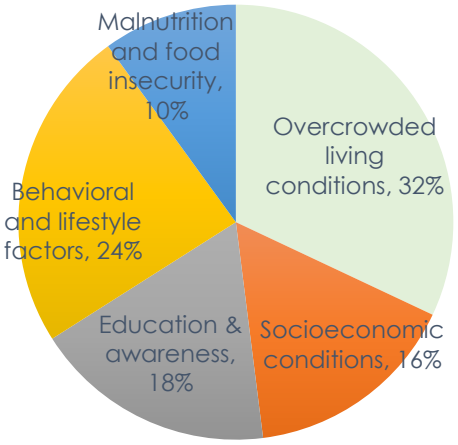

Figure 18: public health determinants: acute respiratory infections

Acute watery diarrhea

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 7
- Pain and physical suffering: 5
- Mental health: 4
- Energy and vitality: 7

Total: 30/50.

The most relevant public health determinants (figure 19):

1- Inadequate WaSH services: 32%.
2- Overcrowded living conditions: 30%.
3- Vulnerable health and compromised immunity: 20%.

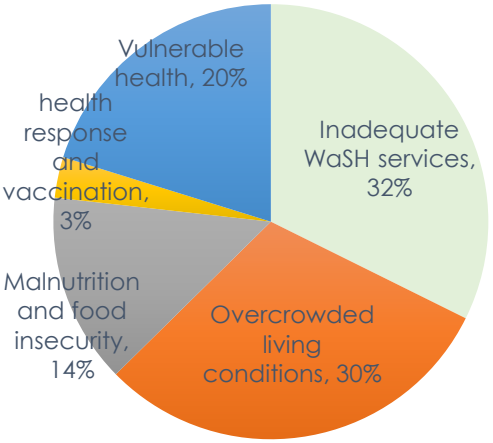

Figure 19: public health determinants: acute watery diarrhea

Skin diseases

Health functioning dimensions

- Social roles and relationships: 8
- Mobility and physical ability: 5
- Pain and physical suffering: 5
- Mental health: 7

- Energy and vitality: 5

Total: 30/50.

The most relevant public health determinants (figure 20):

1- Overcrowded living conditions: 33%.
2- Inadequate WaSH services: 30%.
3- Climate and environmental factor: 26%.

Gastroenteritis problems

Health functioning dimensions

- Social roles and relationships: 5
- Mobility and physical ability: 6
- Pain and physical suffering: 6
- Mental health: 6
- Energy and vitality: 6

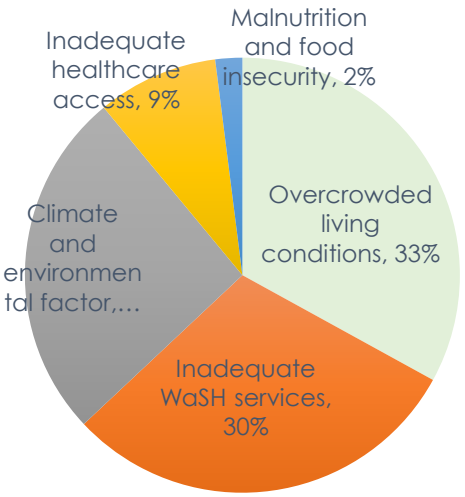

Figure 20: public health determinants: skin diseases

Total: 29/50.

The most relevant public health determinants (figure 21):

1- Malnutrition and food insecurity: 34%.
2- Inadequate healthcare access: 22%.
3- Inadequate WaSH services: 18%.

Hypertension

Health functioning dimensions

- Social roles and relationships: 6
- Mobility and physical ability: 6
- Pain and physical suffering: 5
- Mental health: 7
- Energy and vitality: 6

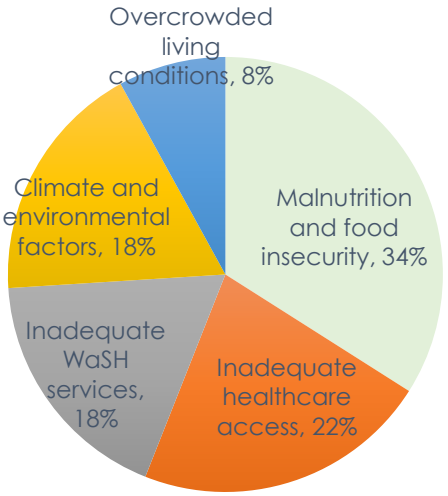

Figure 21: public health determinants: Gastroenteritis problems

Total: 30/50.

The most relevant public health determinants (figure 22):

1- Behavioral and lifestyle factors: 33%.
2- Education and awareness: 32%.
3- Poor socioeconomic conditions: 29%.

Hepatitis B & C

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 6
- Pain and physical suffering: 6
- Mental health: 8
- Energy and vitality: 7

Total: 34/50.

The most relevant public health determinants (figure 23):

1- Education and awareness: 30%.
2- Unsafe medical practices: 26%.
3- Vulnerable health and compromised immunity: 16%.

Vision impairment and eye diseases

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 8
- Pain and physical suffering: 6
- Mental health: 7
- Energy and vitality: 6

Total: 34/50.

The most relevant public health determinants (figure 24):

1- Inadequate healthcare access: 33%.
2- Malnutrition and food insecurity: 24%.

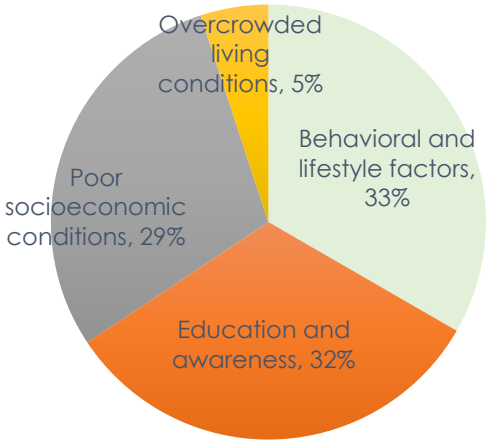

Figure 22: public health determinants: hypertension

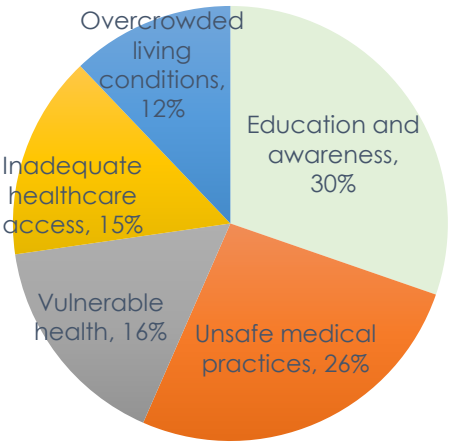

Figure 23: public health determinants: hepatitis B & C

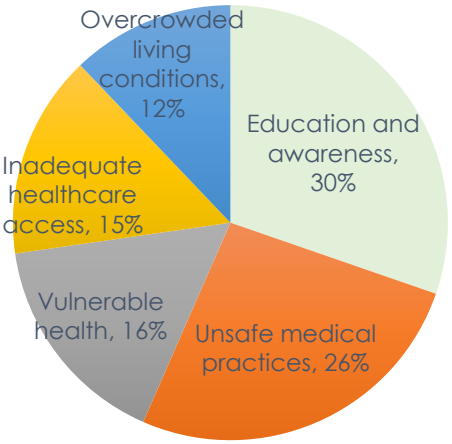

Figure 24: public health determinants: Eye diseases

3- Vulnerable health and compromised immunity: 16%.

Dengue

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 7
- Pain and physical suffering: 7
- Mental health: 6
- Energy and vitality: 7

Total: 34/50.

The most relevant public health determinants (figure 25):

1- Climate and environmental factors: 27%.
2- Inadequate WaSH services: 24%.
3- Education and awareness: 22%.

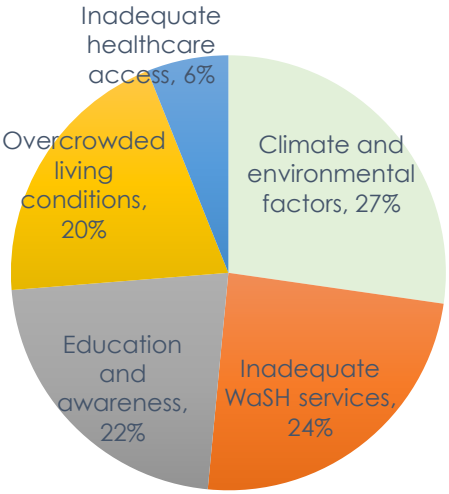

Figure 25: public health determinants: dengue

Chronic respiratory diseases

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 7
- Pain and physical suffering: 7
- Mental health: 7
- Energy and vitality: 8

Total: 36/50.

The most relevant public health determinants (figure 26):

1- Behavioral and lifestyle factors: 28%.
2- Overcrowded living conditions: 23%.
3- Climate and environmental factors: 23%.

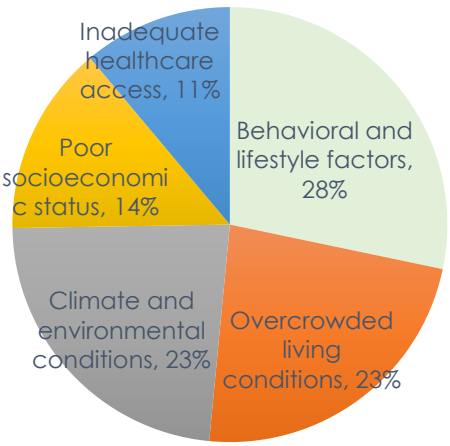

Figure 26: public health determinants: chronic respiratory diseases

Type 2 Diabetes Mellitus

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 7
- Pain and physical suffering: 6
- Mental health: 7
- Energy and vitality: 7

Total: 34/50.

The most relevant public health determinants (figure 27):

1- Behavioral and lifestyle factors: 33%.
2- Education and awareness: 27%.
3- Inadequate healthcare access: 11%.

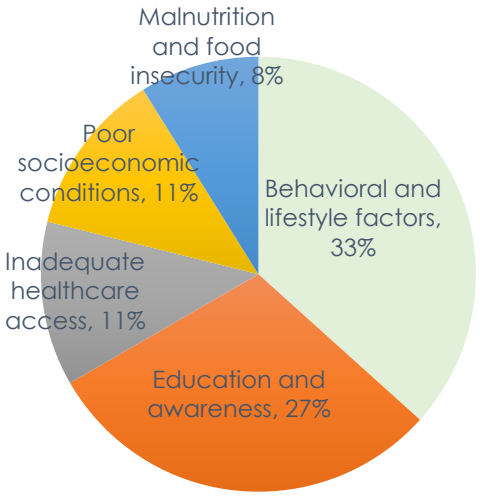

Figure 27: public health determinants: type 2 diabetes mellitus

Maternal diseases

Health functioning dimensions

- Social roles and relationships: 7
- Mobility and physical ability: 6
- Pain and physical suffering: 7
- Mental health: 7
- Energy and vitality: 7

Total: 34/50.

The most relevant public health determinants (figure 28):

1- Community and cultural factors: 30%.
2- Education and awareness: 28%.
3- Poor socioeconomic conditions: 18%.

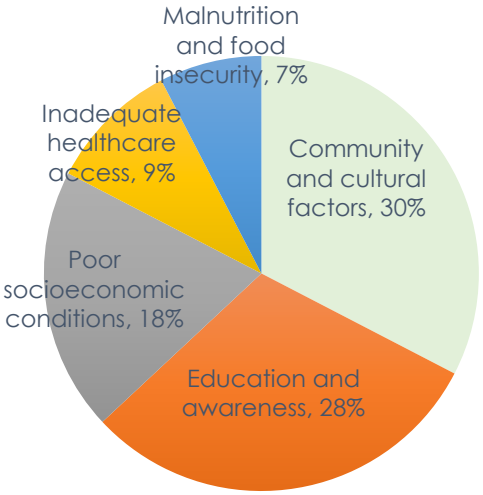

Figure 28: public health determinants: maternity diseases

Mental health

Health functioning dimensions

- Social roles and relationships: 8
- Mobility and physical ability: 7
- Pain and physical suffering: 5

- Mental health: 10
- Energy and vitality: 7

Total: 37/50.

The most relevant public health determinants (figure 29):

1- Restricted movement and livelihood opportunities: 24%.
2- Cultural stigmatization of MH issues: 24%.
3- Violence and insecurity: 20%.

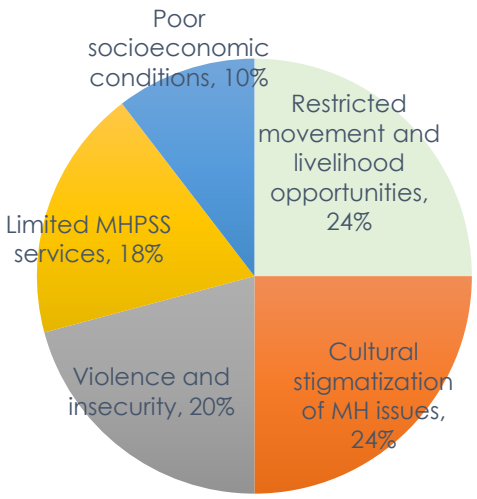

Figure 29: public health determinants: mental health

Based on the feedback from key stakeholders in the health sector during the PHNA consultation workshop, the table below presents the health conditions with the most significant impact on individual health functioning, ranked according to their health functioning values.

Table 5: Health conditions and diseases and their health functioning value

Rank	Health condition or disease	Health functioning value
1	Mental health	37/50
2	Chronic respiratory infections	36/50
3	Maternal diseases	34/50
3	Type 2 diabtetes mellitus	34/50
3	Dengue	34/50
3	Vision impairment and eye diseases	34/50
3	Hepatitis B & C	34/50
4	Hypertension	30/50
4	Acute watery diarrhea	30/50
4	Skin diseases	30/50
5	Gastroenteritis problems	29/50
5	Acute respiratory infections	27/50

An analysis of the most common public health determinants associated with these health concerns revealed significant patterns. Overcrowded living conditions were linked to acute respiratory infections (32%), acute watery diarrhea (30%), skin diseases (33%), and chronic respiratory diseases (23%). Behavioral and lifestyle factors were associated with hypertension and diabetes mellitus (33%), chronic respiratory diseases (28%), and acute respiratory infections (24%). Education and awareness were connected to various conditions, including hypertension (32%), hepatitis B & C (30%), maternal diseases (28%), and dengue (22%). Inadequate WaSH services were attributed to acute watery diarrhea (32%), skin diseases (30%), and dengue (24%). Additionally, climate and environmental factors were linked to skin diseases (26%), dengue (27%), and chronic respiratory diseases (23%).

Common public health determinants driving the most impactful health issues include overcrowded living conditions, behavioral factors, inadequate WaSH services, and climate factors.

The table below outlines the most common public health determinants and their weighted attribution to the identified health conditions. The weighted distribution represents the cumulative percentage of each public health determinant based on its relevance and contribution to the specified health conditions.

Table 6: Public health determinants based on their relevance and contribution to the health conditions.

Public health determinants	**Weight (%) = sum of total percentages**
Education and awareness	130%
Behavioral and lifestyle factors	118%
Overcrowded living conditions	118%
Inadequate WaSH services	86%
Climate and environmental factors	76%

Annexes

Annex 1: PHNA questionnaire to the field medical workers and NGOs

Health Needs Assessment 2024 - 2025 – Health Sector

- Name and surname.
- Email address.
- Phone/WhatsApp number.
- Position*
- Organization *
- Type of health facility
  - Primary Healthcare Center (PHC)
  - Health Post
  - Field Hospital
  - Other, if other, please mention: _____
- Camp number.
- Upazila: auto generated.
- Choose the Health Facility (if not in the list, please mention with UID)
- Are you directly involved in clinical medicine and patient administration?
  - Yes
  - No
- Gender
  - Male
  - Female
- What are the top five health conditions that have a high impact on the public health status among Rohingya refugees?
  Select from 1 to 5, where 1 is the most impactful.

  - Acute Respiratory Infections (URTI/LRTI)
  - Chronic respiratory diseases (e.g., asthma, chronic obstructive pulmonary disease)
  - Abscess
  - Acute Jaundice Syndrome
  - Anemia
  - Dengue (suspected/ confirmed)
  - Diarrhea (AWD/ Cholera/ Dysentery)
  - Ear Diseases
  - Eye Diseases
  - Fever of Unknown Origin
  - Gastroenteric problems/PUD
  - Hepatitis A & E
  - Hepatitis B & C
  - HIV
  - Hearing and visual disabilities
  - Intestinal Worms
  - Malaria (Suspected/ Confirmed)

- Measles/Rubella/Mumps (Suspected/ Confirmed)
- Meningitis-Suspected
- Moderate Acute Malnutrition (MAM)
- Severe Acute Malnutrition (SAM)
- Sexually Transmitted Disease/STI
- Skin diseases, including scabies and fungal infections
- TB (Suspected/ Confirmed)
- Typhoid (Suspected/ Confirmed)
- Urinary tract infection
- Varicella
- Wound infection
- Diabetes Mellitus
- Hypertension (HTN)
- Musculo-skeletal problems
- Epilepsy/Seizures
- Mental Health Conditions/ Diseases (e.g., depression, anxiety, PTSD, and substance abuse etc.)
- Trauma and injuries, including road accidents and occupational injuries.
- Assault (excluding sexual assault)
- Domestic violence-related injuries
- Bites (Dog, Snake, insects, Others)
- Burns
- Obstetrical complications / Maternal diseases and pregnancy outcomes
- Oral diseases (including dental problems)
- Pediatric and newborn diseases (Low birth weight and premature births, Infant mortality, childhood illness, etc.)
- Physical Disabilities
- Others, if other, please mention: _____

- Responding to the health conditions you prioritized in your last answer, what are the five interventions the health sector must prioritize to address these conditions?
  Select from 1 to 5, where 1 is the most prioritized intervention.
  - Support to Primary Health Care
  - Support to Secondary Health Care/Field Hospitals
  - Support to NCD Services
  - Support to Rehabilitation, Physiotherapy Center
  - Support Contingency, Stockpiling of medical commodities, etc. for Emergency Preparedness and Response
  - Strengthen Epidemiology, Surveillance, and Health Information Management
  - Support for Immunization and Vaccination
  - Support to Mobile Medical Team
  - Support to Community Health services including Health Education, mobilization, Behavior Change
  - Support to specific health services, including blood banks
  - Support referral, and medical transportation services.
  - Infrastructure and medical equipment support

  - Support to Maternal and Child health services
  - Support Mental health services
  - Procurement and distribution of medicine and medical supplies
- What are the most three vulnerable groups among Rohingya refugees in order?
  - Reproductive age women
  - Adolescent
  - Pregnant and lactating women
  - Under 5 children
  - Elderly persons
  - Persons with Disabilities
  - Gender Diverse population
- Which of the mentioned groups have the least access or difficulties in accessing health services?
  - Reproductive age women
  - Adolescent
  - Pregnant and lactating women
  - Under 5 children
  - Elderly persons
  - Persons with Disabilities
  - Gender Diverse population
- Is there a regular gap in receiving and providing medicine/drugs at your health center?
  - Yes
  - No
- Based on the medicine categorization below, what are the most five frequently used medicine categories? *Select from 1 to 5, where 1 is the most needed.*
  - Analgesics
  - Antianxiety and Antidepressant Drugs
  - Antiarrhythmics
  - Antibiotics
  - Anticoagulants and Thrombolytics
  - Anticonvulsants
  - Antifungals
  - Antihistamines
  - Antihypertensives
  - Anti-Inflammatories
  - Antineoplastics
  - Antivirals
  - Barbiturates
  - Beta-Blockers
  - Bronchodilators
  - Corticosteroids
  - Cough Suppressants
  - Decongestants

- Diuretics
- Hormones
- Hypoglycemics
- Immunosuppressives
- gastrointestinal medicine
- Vitamins and minerals

- Based on the medicine categorization below, what are the five most frequently needed medicine categories?
- *Select from 1 to 5, where 1 is the most needed*.
  - Non-communicable disease NCD
  - Pediatric medicines
  - Oncology or Cancer and blood disease medication
  - Psychiatric or Mental health medication
  - Dialysis medication
  - Hepatitis medication
  - Surgery and trauma management medication
  - Gynecologic medication
  - Thalassemia medication
  - Tuberculosis
- Are there specific pieces of medical equipment that are lacking or frequently malfunctioning in health facilities?
  - Yes
  - No
- If you answered yes to the previous question, what equipment is needed most?

The First Group: Diagnostic Equipment:

Select from 1 to 5, where 1 is the most needed.

- Auto-Refractometer Keratometer
- Bilirubinometer (Lab)
- Binocular Microscopes
- Biochemistry Analyzer
- Blood Gas / pH Analyzer (Lab)
- Bronchoscope
- Cardiotocography CTG (Monitoring of fetal heart frequency)
- Coagulometer
- Electroencephalography (EEG)
- Electrolytes Analyzer (Lab)
- Electromyography EMG
- Glucometer
- HbA1C analyzer / fine care analyzer
- Lensometers
- PCR machine (COVID-19, TB, other) PCR
- Pulse Oximeter
- Spirometer
- Stethoscope

- Thermometer
- X-ray Illustrator
- Imaging Machines: X-Ray
- Mammography
- MRI machine
- Doppler ultrasound
- Indirect Ophthalmoscope
- Direct Ophthalmoscope
- CT Scanner
- Ultrasound
- Blood Tubes Shaker (Lab)
- Combined otoscope /laryngoscope complete set
- Gastroscope, Flexible
- Hematology Analyzer Automated (Lab)
- Microhematocrit Centrifuge
- Uretero-Renoscope Flexible
- Ultrasound
- Ophthalmology Unit
- Other equipment

- If you answered yes to the previous question, what is this equipment?

The Second Group: Treatment and Surgical Equipment:

Select from 1 to 5, where 1 is the most needed.

- Anesthesia Machines
- C-arm X-ray machine (Only for orthopedics and neurosurgeries)
- Clinical Chemistry Analyzers, Automated (Lab)
- Continuous positive airway pressure (CPAP) machine
- Cryosurgical Unit
- DC Shock Machine/Defibrillator
- Drills (Orthopedic)
- ECG
- Electrosurgical Unit
- Endoscopy Surgery (General Set)
- Operating Tables
- Ophthalmic Laser, Argon
- Ophthalmic Laser, Nd: Yag
- Ophthalmic Operating Microscope
- Suction Machine
- Ventilators for adults
- Ventilators for children
- Nebulizer
- Major surgical set
- Other equipment

- If you answered yes to the previous question, what is this equipment?

The Third Group: Emergency and Trauma Care Equipment

Select from 1 to 5, where 1 is the most needed.

- Ambo Bag (Pediatric and Adult)
- Crash Cart
- Dressing Set (scissors, suture materials, needle holder, forceps, gauze)
- Hemodialysis Machine
- Oxygen concentrator
- Oxygen Cylinders
- Oxygen Generator
- Portable Operation Lamps
- Infusion pumps
- Portable V-scan
- Other equipment

- If you answered yes to the previous question, what is this equipment?

The Forth Group: Maternal and Neonatal Care Equipment:

Select from 1 to 5, where 1 is the most needed.

- Infant Incubator
- Intensive Phototherapy
- Radiant Warmer
- Obstetric Delivery Beds
- Fetal Monitor
- Neonatal Resuscitation Tables
- Other equipment

- If you answered yes to the previous question, what is this equipment?

The Fifth Group: Pharmaceutical Storage and Dispensing Equipment

Select from 1 to 2, where 1 is the most needed.

- Blood Refrigerator (Lab)
- Laboratory Refrigerator (Lab)
- Medical/Waste Incinerator
- Other equipment

- If you answered yes to the previous question, what is this equipment?

The Sixth Group: General Hospital Equipment:

Select from 1 to 5, where 1 is the most needed.

- Autoclave
- Beds for Hospitalization
- Dry Sterilizer
- Examination Couch
- Fixed Operation Lamps
- Generator
- ICU/CCU Monitors
- Physiologic Monitoring System, Stress Exercise, Cardiac
- Serum hanger

- Spectrophotometer
- Sphygmomanometer
- Step stool.
- Weight scale (children)
- Weight scale (adults)
- Measuring Tape
- Other equipment

- If you answered yes to the previous question, what is this equipment?

The Seventh Group: Communication and Information Systems:

Select from 1 to 2, where 1 is the most needed.

- Computer
- Printer
- Other equipment

- Are you aware of any referral networks in your health facilities that can refer U5 children and pregnant and lactating women to nutrition services?
  - Yes
  - No
- If a child presents to your case with symptoms of malnutrition, do you know where to refer the case?
  - Yes
  - No
- If yes, to where?

Gender inclusion

- In your opinion, do the health services provided in your facility adequately address the specific health needs of different genders (e.g., male, female, gender-diverse individuals)?
  - Yes
  - No
- If not, please specify the gaps.

- Have you received any specific training on addressing gender-specific health issues in the refugee population?
  - Yes
  - No
- If yes, how often do you apply this training in your daily work?

- Are there any gender-related challenges you face in providing healthcare services to Rohingya refugees?
  - Yes
  - No
- If yes, please describe the challenges.

- How aware do you think NGOs are of the specific health needs of different gender groups (e.g., male, female, gender-diverse individuals)?
    - Very aware
    - Somewhat aware
    - Not aware
- If not aware, what gaps do you perceive?

Annex 2: PHNA questionnaire to Rohingya refugees

Health Needs Assessment Questionnaire 2024 – 2025: Rohingya Refugees

Section 0: data collector

0.1. Name of data collector
0.2. WhatsApp number
0.3. Gender
0.4. Camp number.

Section 1: Demographics

1.1. Gender:
- Male
- Female
- Other

1.2. Age (years):
- 18-35
- 36-59
- 60+

1.3. Household size:
- 1-2
- 3-5
- 6-8
- 9+

1.4. Length of stay in Rohingya camp:
- <6 months
- 6 months - 1 year
- 1-2 years
- 2+ years

1.5. Upazila
- Ukhia
- Teknaf

1.6. Camp number:

Section 2: Health Status and Concerns

2.1. In the past month, have you or anyone in your family experienced any of the following health conditions? (Check all that apply):
- Acute Respiratory Infections (URTI/LRTI)
- Chronic respiratory diseases (e.g., asthma, chronic obstructive pulmonary disease)
- Abscess
- Acute Jaundice Syndrome
- Anemia
- Dengue (suspected/ confirmed)
- Diarrhea (AWD/ Cholera/ Dysentery)

- Ear Diseases
- Eye Diseases
- Fever of Unknown Origin
- Gastroenteric problems/PUD
- Hepatitis A & E
- Hepatitis B & C
- HIV
- Hearing and visual disabilities
- Intestinal Worms
- Malaria (Suspected/ Confirmed)
- Measles/Rubella/Mumps (Suspected/ Confirmed)
- Meningitis-Suspected
- Moderate Acute Malnutrition (MAM)
- Severe Acute Malnutrition (SAM)
- Sexually Transmitted Disease/STI
- Skin diseases, including scabies and fungal infections
- TB (Suspected/ Confirmed)
- Typhoid (Suspected/ Confirmed)
- Urinary tract infection
- Varicella
- Wound infection
- Diabetes Mellitus
- Hypertension (HTN)
- Musculo-skeletal problems
- Epilepsy/Seizures
- Mental Health Conditions/ Diseases (e.g., depression, anxiety, PTSD, and substance abuse etc.)
- Trauma and injuries, including road accidents and occupational injuries.
- Assault (excluding sexual assault)
- Domestic violence-related injuries
- Bites (Dog, Snake, insects, Others)
- Burns
- Obstetrical complications / Maternal diseases and pregnancy outcomes
- Oral diseases (including dental problems)
- Pediatric and newborn diseases (Low birth weight and premature births, Infant mortality, childhood illness, etc.)
- Physical Disabilities
- Others, if other, please mention: _____
- None

2.2. How often do children in your household suffer from these illnesses (for applicable illnesses)?

- Never
- Rarely (1-2 times in 6 months)
- Sometimes (1-2 times a month)
- Frequently (weekly)

2.3. Do you or any family member have any long-term health conditions? (e.g., diabetes, hypertension, COPD etc.)

- Yes (Specify): _____
- No

2.4. Do you or any family member have a renal failure that requests regular dialysis?
- Yes
- No

2.5. Do you or any family member have a physical or sensory disability, including movement difficulties, deafness, and blindness?
- Yes
- No

2.6. What are the top 5 health problems faced by your household? (Rank 1 to 5, 1 being the most critical):
- Acute Respiratory Infections (URTI/LRTI)
- Chronic respiratory diseases (e.g., asthma, chronic obstructive pulmonary disease)
- Abscess
- Acute Jaundice Syndrome
- Anemia
- Dengue (suspected/ confirmed)
- Diarrhea (AWD/ Cholera/ Dysentery)
- Ear Diseases
- Eye Diseases
- Fever of Unknown Origin
- Gastroenteric problems/PUD
- Hepatitis A & E
- Hepatitis B & C
- HIV
- Hearing and visual disabilities
- Intestinal Worms
- Malaria (Suspected/ Confirmed)
- Measles/Rubella/Mumps (Suspected/ Confirmed)
- Meningitis-Suspected
- Moderate Acute Malnutrition (MAM)
- Severe Acute Malnutrition (SAM)
- Sexually Transmitted Disease/STI
- Skin diseases, including scabies and fungal infections
- TB (Suspected/ Confirmed)
- Typhoid (Suspected/ Confirmed)
- Urinary tract infection
- Varicella
- Wound infection
- Diabetes Mellitus
- Hypertension (HTN)
- Musculo-skeletal problems
- Epilepsy/Seizures
- Mental Health Conditions/ Diseases (e.g., depression, anxiety, PTSD, and substance abuse etc.)

- Trauma and injuries, including road accidents and occupational injuries.
- Assault (excluding sexual assault)
- Domestic violence-related injuries
- Bites (Dog, Snake, insects, Others)
- Burns
- Obstetrical complications / Maternal diseases and pregnancy outcomes
- Oral diseases (including dental problems)
- Pediatric and newborn diseases (Low birth weight and premature births, Infant mortality, childhood illness, etc.)
- Physical Disabilities
- Others, if other, please mention: _____
- None

Section 3: Access to Healthcare

3.1. Where do you usually go when someone in your household is sick? (Select one):
- NGO health facility (HP/PHC/FH)
- Private pharmacy or clinic
- Traditional uncertified health provider
- Do not seek care.

3.1.1. If the last choice was selected, please ask why.

3.2. How long does it usually take you to reach the nearest healthcare facility from your home?
- Less than 15 minutes
- 15-30 minutes
- 30-60 minutes
- More than 1 hour

3.3. Have you faced difficulties accessing healthcare services in the last 3 months?
- Yes (If yes, please specify): _____
- No

3.3.1. If yes, what are the main 3 barriers to accessing healthcare? (Rank 1 to 3, 1 being the most critical):
- Lack of transportation
- Cost of services
- Discrimination
- Lack of available services
- Fear of authorities
- Language barriers
- Longer waiting time
- Other: _____

3.4. How would you rate the quality of care received?
- Very poor
- Poor
- Satisfactory
- Good

- Excellent

Section 4: Access to Medicines

4.1. Where do you or your household members usually obtain medicines? (Select all that apply):
- NGO-run clinic or pharmacy (HP/PHC/FH)
- Private pharmacy or clinic
- Unauthorized or informal sellers (street vendors, local markets)
- Do not use medicines.

4.1.1. If the participant selected purchase medicines from unauthorized or informal sellers, please ask: what are the main reasons? (Check all that apply):
- Medicines are cheaper.
- More convenient (closer to home)
- No prescription required.
- Medicines not available in formal facilities
- I do not trust medicine distributed by NGO health facilities.
- Other: _____

4.2. In the past 3 months, have you experienced difficulty obtaining the medicines you or your family members needed?
- Yes (Please specify the challenges): _____
- No

4.3. What types of medicine does your household most often need? (Rank 1 to 5, 1 being the most needed):
- Non-communicable disease NCD
- Pediatric medicines
- Oncology or Cancer and blood diseases medication
- Psychiatric or Mental health medication
- Dialysis medication
- Hepatitis medication
- Surgery and trauma management medication
- Gynecologic medication
- Thalassemia medication
- Tuberculosis
- Other (Please specify): _____

4.4. Do you feel you have sufficient information on how to use the medicines provided to you?
- Yes
- No
- Sometimes

Section 5: Health Awareness and Education

5.1. During the past three months, have you received health information or education from any of the following sources? (Check all that apply):
- Health workers at clinics or hospitals
- Community health workers

- Community leaders like religious figures or teachers
- Posters/visuals or brochures in the camp
- Radio or loudspeaker announcements
- Community meetings
- Other: _____

5.2. Do you feel you have enough knowledge to prevent common health problems in your household?
- Yes
- No
- Unsure

Section 6: Maternal and Child Health

6.1. For pregnant women in the household, was prenatal care/ANC received?
- Yes
- No
- Not applicable

6.2. Were there any complications during childbirth in the past year?
- Yes (Specify): _____
- No
- Not applicable

6.3. Are children in your household fully vaccinated according to the local immunization schedule? (Check vaccine card)
- Yes
- No
- Don't know.

Section 7: Nutrition

7.1. Have you received food aid in the past 3 months?
- Yes
- No

7.1.1. If yes, was the food aid sufficient for your household's needs?
- Yes
- No

7.2. Do you or anyone in your household suffer from a diagnosed malnutrition?
- Yes
- No

Section 8: Mental Health and Psychosocial Support

8.1. In the past 6 months, have you or anyone in your family experienced emotional distress or trauma?
- Yes
- No

8.2. If yes, have you received any psychological or mental health support?
- Yes

- No

8.3. What are the most common sources of stress for you and your family? (Semi-structured response): (open text)

Section 9: Health Priorities

9.1. What do you believe are the most urgent health services that should be improved or provided in your community? (Rank 1 to 3, 1 being the highest priority):
- Primary Health Care
- Secondary Health Care/Field Hospitals
- NCD Services
- Rehabilitation, Physiotherapy Center
- Contingency, Stockpiling of medical commodities, etc., for Emergency Preparedness and Response
- Strengthen Epidemiology, Surveillance, and Health Information Management
- Immunization and Vaccination services
- Mobile Medical Team
- Community Health services, including Health Education mobilization, Behavior Change
- Specific health services, including blood banks
- Referral and medical transportation services.
- Infrastructure and medical equipment
- Maternal and Child health services
- Mental health services
- Procurement and distribution of medicine and medical supplies
- Other (Specify): _____

9.2. In your opinion, what should be the top priority in improving health services in your community? (Semi-structured response):

Section 10: Inter-sector health & nutrition (specific to mothers of <5 children and PLW)

10.1. Have you or your U5 child been diagnosed with malnutrition in the past six months?
- Yes
- No

10.2. Are you aware of facilities that jointly deliver health and nutrition services in your area?
- Yes
- No

10.2.1. If yes, what is the health facility?

10.2.2. How did you know that it delivers health and nutrition services?

10.3. In the past six months, did you or your U5 child receive the joint health and nutrition services at any facility or institution?
- Yes
- No

10.3.1. What kind of health and nutrition services did you or your child receive? (open-ended question)

Gender Inclusion

- Have you or any household member faced difficulties accessing healthcare services because of your gender?
    - Yes
    - No
- If yes, please specify the type of difficulties.
- Considering your gender-specific health needs, how satisfied are you with the healthcare services?
    - Very satisfied
    - Satisfied
    - Neutral
    - Dissatisfied
    - Very dissatisfied
- Please explain your answer.
- Do you feel that healthcare providers in your area are adequately sensitive to gender-specific issues (e.g., female-specific conditions, gender-diverse needs)?
    - Yes
    - No
- If not, what improvements would you suggest?
- In the past six months, have you or anyone in your household refrained from seeking healthcare due to concerns related to gender (e.g., gender-based violence, discrimination)?
    - Yes
    - No
- If yes, please elaborate on the reasons.