

Forcibly Displaced Myanmar Nationals (FDMN's) to Bangladesh- Health Sector Response & Challenges

The humanitarian crisis caused by escalating violence in Myanmar's Rakhine State is causing human suffering on a catastrophic scale. An estimated 693,000 Rohingyas have crossed over to Bangladesh following violence in Myanmar's Rakhine state since 25 August 2017.¹ The ongoing challenges in providing safe water, sanitation and hygiene (WaSH), together with the upcoming rainy season, risk of outbreaks of waterborne diseases transmitted through the fecal-oral route, as well as vectorborne diseases among others. Before this crisis began, the country was already hosting a verified population of well over 212,500 Rohingya from Myanmar - and likely many more. The new arrivals are adding massive pressure to services in existing refugee camps and in makeshift settlements. Basic services are now badly outstripped, including water, health, and particularly shelter and sanitation. The crowded living conditions in camps and settlements expose the refugees to further risks of public and individual health. Basic services available prior to influx became overstrained due to massive demands on the systems and services.

The health sector's 150 national and international partners have responded to the needs through health service delivery in more than 270 static (147) and mobile health facilities in both Ukhiya, and Teknaf. The total estimated population in need which the health sector is targeting is 1.3 million including new arrivals, existing refugees, host community and contingency. The sector is responding to the population needs through provision of health services in camps as well as strengthening of the health system as a whole through supporting existing health facilities, the health workforce and the surveillance system. Overall, the health sector partners are coordinated under the leadership of WHO and the Civil Surgeon's Office of Cox's Bazar for better planning and coordinated emergency response. The current health sector focus is strengthening preparedness for the impending rainy season for which there is a high likelihood of floods, landslides and associated health threats, including epidemics.

There are a number of key infectious diseases which pose significant risk to the public health of the target population. These include vector-borne disease such as chikungunya, dengue and malaria in addition to AWD, measles, diphtheria, ARI & shigellosis, which are currently being monitored by the Early Warning Alert and Response System (EWARS). There have been a total of 5121 cases of suspected malaria, of which 27 cases were confirmed as Malaria. There have been no suspected cases of Dengue or Chikungunya fevers reported in the EWARS. However with the onset of the rainy season, these vector-borne diseases remain a risk.

The top ten diseases among the MDMN population were reported by health posts are Diarrhoea (31.9%), Respiratory Tract Infection (7.4%), Skin Disease (14.6%), Injury (3.8%), Abscess (1.6%), Cough & Cold no Pneumonia (31.4%), Eye Infection (3.4%), Severe Acute Malnutrition (SAM) (0.5%) & Moderate Acute Malnutrition (MAM) (5.5%)².

Acute jaundice syndrome (AJS) continues to be reported to EWARS, 2000 cases up to 10 May 2018. Among the AJS cases, 34% (292/864) were less than five years old. Detailed surveillance through case-based reporting has started, which alongside enhanced laboratory testing will improve epidemiological understanding and monitoring. Measles were suspected in 1258 cases in 2018. Trends of suspected measles/rubella cases have steadily declined in 2018. These trends are based on syndromic reporting (no laboratory confirmation). Eighty percent of cases were aged under 5 years. Acute watery diarrhoea (AWD) contributes significantly to overall consultations in all reporting camps, though there is no indication of severe disease or clustering of cases. A diphtheria outbreak was announced on 8 Nov 2017. The outbreak peaked in December 2017, and a steady decline in reported cases after implementation of a multi-pronged response strategy comprising of enhanced surveillance, early detection and treatment, contact tracing, risk communication and mass vaccination campaigns. The latest campaign targeting children aged 6 months – 7 years (pentavalent vaccine) and 8 – 14 years (Td

vaccine) finished in February 2018. Forty two deaths were reported (total cases 6 149, case fatality proportion < 1 %) with other complications (pneumonia, mumps and/or stridor). Contact tracing is ongoing, and includes post-exposure prophylaxis of close contacts with antibiotics and vaccination, regardless of age. A major outbreak of cholera was averted by quick deployment of oral cholera vaccine coordinated by International Coordinating Group (ICG) and WHO.³

Service package of sexual and reproductive health (SRH), access to essential reproductive, maternal and newborn health services remains a major concern. In some of the new facilities, high-quality SRH services are beginning to operate in hard-to-reach areas, and SRH partners continue to construct additional clinics with fixed structures that can provide high-quality SRH services even during the rainy season. Within Ukhiya and Teknaf, approximately 100 000 births are expected in 2018, with 2,322 pregnant women expected to experience obstetric complications, where now only 22% are giving birth at health facilities. The difficulty of transporting patients for safe facility-based births continues to be an under-recognized factor for the high rate of home deliveries, especially for night time deliveries.

Although much progress has been made in the provisioning of WaSH services to the large influx of Rohingya refugees, several key challenges remain. The emergency facilities that were constructed in the first phase response have been of poor quality and require decommissioning. A WHO-led assessment of WASH and IPC in 146 health facilities also revealed large gaps such as 22% of surveyed facilities do not have adequate functional latrines or improved toilets, as well as one-third of surveyed facilities did not have functioning hand washing stations. This is a potential threat to health of the refugees, hosts, staff of HCFs or any other people in that area. Lastly, there are no primary collection centers for solid waste with many disposing of waste in narrow spaces between shelters. Finding suitable land for solid waste management remains a primary challenge for partners. Together with the upcoming rainy season, the ongoing challenges in WaSH raise the real possibility of a resurgence of severe acute watery diarrhea which is endemic in Bangladesh.

There are an estimated 403,889 people among Rohingya refugees and host communities in need of emergency nutrition interventions. These high levels

of under nutrition are in part a result of existing vulnerabilities such as stunting (above 40%), food insecurity, poor hygiene and sanitation conditions and disease outbreaks. Additionally extremely high levels of anaemia amongst children in refugee settlements indicate high prevalence of micronutrient deficiencies. The mental and psychosocial impacts of being forcibly displaced continue to affect large numbers of Rohingya refugees. This is compounded by reports of traumatic experiences, and the daily stressors associated with reliance on humanitarian assistance for food and other life-saving needs. There is therefore a need to increase availability and access to specialized mental health services as well as to increase the capacity of the health care workforce to manage common mental disorders in primary health care settings.

In the initial phase of the response, existing host community facilities were severely overwhelmed with the influx of patients leading to difficulties in accessing care by host communities. However as the Rohingya settlements have grown, many new facilities were constructed in an effort to lessen the strain on existing facilities and increase access for the new arrivals. Access to Trauma care in the camps is limited with only two hospitals in the camp with surgical capacity (1 operating theater and surgeon each). Referrals remain an ongoing challenge with no comprehensive referral mechanism in place, standard operating procedures for referral is ongoing yet to be finalized. In the absence of such a mechanism, referrals have been on an ad-hoc basis with many partners entering into bilateral Memoranda of Understanding. For referral facilities there was strengthening of Upazilla Hospitals at Ukhiya & Teknaf, and Coxsbazar District Hospital besides other hospitals run by MSF, Malaysia, Turkey, Iran. Initially injury cases were predominant, currently some of the illness in the referral facility at Coxsbazar UHCs, District hospital are chronic liver diseases, pregnancy complications, psychiatric conditions, injury, TB, HIV, hepatitis, NCDs.⁴

Major challenges still remains in strengthening communicable disease prevention, detection and control by improving disease surveillance and immunization coverage to contain any potential outbreaks of life-threatening communicable diseases. Timely access to essential life-saving health services requires to be evolved for a potentially long-term problem with the HDMN population.

A large number of populations in a limited area transformed it into a large 'rural slum'. Due to use of

green forested land for housing the FDMN additional environmental aspects are likely to be considered; social dimension including prevention of substance abuse for example 'yaba' are also a concern. There might be an impact on the local community as well- on job, food cost, environmental effect on water level, deforestation, psycho-social effect. A major concern will be continuation/sustainability of health care if the RDMN are not migrated to home country in due time⁵⁻⁸.

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