



Bangladesh Health Watch Report 2018 - 2019

BANGLADESH  
HEALTH WATCH

Humanitarian Crisis in Rohingya Camps  
A Health Perspective



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# **Humanitarian Crisis in Rohingya Camps A Health Perspective**

**BANGLADESH**  
**HEALTH WATCH**

*Dedicated to*  
**Sir Fazle Hasan Abed KCMG**  
**(1936-2019)**

Visionary, and Founder of  
BRAC

**Publisher**

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# CONTENT

|         |           |   |            |
|---------|-----------|---|------------|
| Chapter | <b>1</b>  | <b>Introduction</b>   | <b>1</b>   |
|         |           | Muhammad Musa   |            |
| Chapter | <b>2</b>  | <b>Management of Infectious Diseases</b>  | <b>11</b>  |
|         |           | A M Zakir Hussain, Md. Akramul Islam, M. Moktadir Kabir,<br>Zarfisha Alam, Isbat Azmary Rifat, and Shayla Islam |            |
| Chapter | <b>3</b>  | <b>The Nutrition Response</b>   | <b>23</b>  |
|         |           | Malay Kanti Mridha and Rina Rani Paul   |            |
| Chapter | <b>4</b>  | <b>WASH, Ecology and Environment</b>  | <b>41</b>  |
|         |           | Mahbubur Rahman, Mahfuza Islam and Mehjabin Tishan Mahfuz   |            |
| Chapter | <b>5</b>  | <b>Reproductive Health Care in Rohingya Refugee Camps</b>   | <b>53</b>  |
|         |           | Bachera Aktar, Rushdia Ahmed, Md Tanvir Hasan,<br>Zahidul Quayyum and Sabina Faiz Rashid                        |            |
| Chapter | <b>6</b>  | <b>Mental Health and Trauma</b>   | <b>69</b>  |
|         |           | Nargis Islam, Nishat F. Rahman and Naila Z. Khan  |            |
| Chapter | <b>7</b>  | <b>Trafficking, Migration and Gender Based Violence</b>   | <b>91</b>  |
|         |           | Shaila Shahid, Md Zakir Hossain and Shuvra Rahman Basunia   |            |
| Chapter | <b>8</b>  | <b>Coordination of Health Interventions</b>   | <b>108</b> |
|         |           | Be-Nazir Ahmed and Progga Zaman   |            |
| Chapter | <b>9</b>  | <b>Mobilization of Resources for the Rohingya Humanitarian Crisis</b>   | <b>120</b> |
|         |           | Zahidul Quayyum, Mahmud Muntasir Homsi, Syed Abdul Hamid<br>and Atonu Rabbani                                   |            |
| Chapter | <b>10</b> | <b>Summary and Conclusion: The Future of Rohingya Refugees in Bangladesh</b>                                    | <b>138</b> |
|         |           | Mushtaque Chowdhury   |            |
| Annex   | <b>1</b>  | <b>Acronyms</b>   | <b>145</b> |
| Annex   | <b>2</b>  | <b>List of Working Group and Advisory Group</b>   | <b>149</b> |
| Annex   | <b>3</b>  | <b>Contributors</b>   | <b>150</b> |

# FOREWORD

This report of the Bangladesh Health Watch (BHW) titled, Health Sector Response to the Rohingya Crisis, is a unique attempt to document multiple facets of health-related challenges of one of the world's largest humanitarian crises. From its outset, the Rohingya situation was a perfect breeding ground for a major health crisis. During August-September 2017 an estimated 1.2 million Rohingyas took shelter in Bangladesh fleeing a genocidal persecution in their own country in the Rakhine state of Myanmar. Immediately after their crossing into Bangladesh, there were tens of thousands of people sleeping out in the open or under makeshift shelters in Ukhia and Teknafupazilas of Cox's Bazar district. This had huge implications and risks in terms of public health services, as well as for surveillance and response capacity. The forced migration driven by violence influenced the broader aspects of the health of the affected people, including the concomitant burden of chronic or latent diseases (both infectious and noninfectious) and patterns of preexisting immunity. It also had implications for the use and uptake of disease prevention and health promotion interventions, and health-care service utilization in general.

The sudden influx of Rohingya refugees in the two upazilas of Cox's Bazar which are home to another half a million people put massive pressure both on the host communities and on the local health services. The cramped living conditions of the refugees presented significant public health risks. The high population density, poorly ventilated houses and environmental contamination over time increased the risks from vector-borne diseases as well as other infectious diseases such as diarrhea, TB, ARI, and so on.

The vulnerable displaced people are still today dependent on limited primary and secondary health services, including reproductive, maternal and neonatal health care (RMNCH), care for

communicable diseases, mental health services and psychosocial support. The existing facilities in Cox's Bazar and surrounding areas have reported an increase in patients, overwhelming the current capacity and resources. Since the surge of Rohingyas in 2017, the health sector has seen a major increase in engagement of international and national partners to meet the increasing demand for health in the context of this complex emergency.

The BHW report presents snapshots of selected health-related issues faced by this persecuted and deprived community focusing on specific issues and describes how they have evolved over time. The report covers eight health-related issues of the Rohingya crisis including the management of infectious diseases; mental health and trauma; nutrition response; reproductive health care; trafficking, migration and gender based violence; water and sanitation; resource mobilization and coordination.

The BHW report puts forward five major overall recommendations, in addition to sub-sector wide recommendations. The first overall recommendation is the need for a primary health care (PHC) approach that includes empowering the people and communities (here, the refugees and host communities); multi-sectoral policy and action for health and good-quality, integrated health services based on primary care supported by essential public health functions.

The second recommendation is for an integrated information system. The various chapters in this report have pointed to an important gap in the response efforts which is the lack of an integrated and credible information system. A few challenges are identified including lack of coordination on data; limited learning from short-term data during project implementation and limited dialogue with local actors.

The third recommendation is to recognize the importance of bringing the needs and perspectives of the host community in the overall planning for the future. The host communities have extended their full support to the refugees but our knowledge and understanding of the kind of problems they face as a result of the sudden influx is rudimentary at best. There is a need to look at this and map out a comprehensive plan for the overall development of the entire district.

The fourth recommendation is on the mobilization of resources. The Rohingya crisis raised a lot of international concerns leading to mobilization of substantive resources. History has shown that as such crises linger, there is a continuous decline in international interest and synchronized funding. The Bangladesh government and donor agencies need to develop a longer-term plan on how to mobilize resources in order to meet the needs of the refugees in the foreseeable future.

The fifth and final recommendation is on the imperative to clearly define policy decisions towards the Rohingya refugees. As time passes, there will be need to provide them with the basic minimum needs as recognized through different international agreements and charters including human rights. There will be need to set up educational institutions. Sustainable livelihood opportunities and a full-fledged primary health care system will also have to be readily available.

The range of the issues covered by this report are wide and the perspectives presented in each of the chapters are far-reaching additions to our current humanitarian programming knowledge base. While each of the chapters stands out on its own, because they are broadly related to the health sector and to the same crisis—there are interesting complementarities. Hence, this compilation was prepared in the expectation that the bigger picture presented would be more useful and a more revealing account than the mere sum of the picture presented by the individual.

This is the 7th report of the BHW which has worked since 2006 as a network of Bangladesh's civil society who are interested in policy advocacy related to health and health care. The previous six reports of BHW have highlighted different challenges faced by the health sector such as equity, workforce, governance, universal health coverage (UHC), urbanization, and non-communicable diseases.

I hope like the earlier reports, this report will also be widely discussed and disseminated and the concerned stakeholders will make good use of the information and accompanying recommendations contained in this report.

**Professor Rounaq Jahan**

Convenor,  
Advisory Group, Bangladesh Health Watch

## ACKNOWLEDGEMENTS

This report of Bangladesh Health Watch (2018-19) is the culmination of relentless work of the study team comprising of the lead authors, co-authors, the reviewers, and the editors. The chapter authors and co-authors have given dedicated time from their busy schedules in repeated revisions of their respective chapters until these met the editorial rigor. Without their hard work, intellectual input and sincere cooperation, this would not have been possible! We take this opportunity to graciously acknowledge their contributions in bringing out this report.

Thanks are due to members of the Working Group (WG) of the Bangladesh Health Watch, who guided and supported us with their experiences, insights and wisdom. The Advisory Group under the convenership of Professor Rounaq Jahan provided overall guidance. Mushtaque Chowdhury (convener of the WG and formerly Vice Chair of BRAC) and Syed Masud Ahmed (Professor and Director, Center of Excellence, Health Systems and Universal Health Coverage at the BRAC James P Grant School of Public Health, BRAC University) deserve special mention for their painstaking review, feedback and advise in developing and finalizing the intellectual contents of the chapters.

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The enthusiasm of Late Sir Fazle Hasan Abed KCMG will always remain as a constant source of inspiration to us. He was a great encouragement and support to the Watch since its inception and this report is dedicated to his memory.

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We are grateful to different agencies working in Cox's Bazar refugee camps and host communities including the Government of Bangladesh, UN agencies, NGOs and other civil society organizations, local governments and the affected communities for supporting the authors of different chapters in collecting the relevant data and providing their perspectives on the refugee situation.

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## CHAPTER ONE

# INTRODUCTION

Muhammad Musa

## THE EXODUS

Since 25 August 2017, more than 700,000<sup>1,2,3</sup> Rohingya refugees have fled extremely violent “clearance” operations by the Myanmar army in the northern Rakhine State to neighboring Bangladesh. The United Nations High Commissioner for Refugees (UNHCR) has dubbed this crisis as a “textbook example of ethnic cleansing.” The UN fact-finding mission portrays a horrendous picture of 1.1 million people subjected to indiscriminate mass killings, torture, gang-rape, children being forced into burning houses, entire villages being burned down, and landmines placed at escape routes from villages<sup>4</sup>. Community after community, mostly women and children, had to risk death to cross the sea, river, or mine-infested inaccessible terrains to reach the relative safety of Bangladesh. The majority of the Rohingya arrived at the border district of Cox’s Bazar, and some at the hill district of Bandarban.

When Bangladesh opened her borders to the mass of people fleeing, no one predicted the scale of the crisis to come, and no one was prepared for hosting an influx of such massive proportions. Nonetheless, the Rohingya were welcomed into Bangladesh with positivity and genuine humanitarian outreach from both the government, the civil society and the local communities. Numerous Bangladeshi citizens played a critical role in providing hands-on support and volunteering in the first two months of the influx.

The torture and trauma and the long treacherous journey took its toll on the health of the Rohingya refugees. So did the years of systematic discrimination that restricted this community’s access to health and other basic services. A study conducted jointly by Harvard University and BRAC revealed that around 60 percent of the Rohingya

children never received any vaccine<sup>5</sup>. Most reported lack of availability and access to critical medical care for adults. Similarly, the same study revealed that more than half of the Rohingya refugees never went to any school or Madrasah (religious school). Accessing the market was reported as a challenge. The Rohingya talked about their inability to go out of their village without permission from the authority, and were not even able to get married without permits. Overall, this is a deprived community of poor health, subjected to extreme conditions and health risks.

This Health Watch report presents snapshots of selected health-related issues faced by this deprived community. Each article covers specific issues from the start and describes how it evolved over time. This introduction highlights the common features of this evolution by dividing the time into three distinct phases.

## THE EVOLVING SITUATION

The Rohingya crisis, like most crises, has been an evolving one. In retrospect, the state of the crisis seems to have had three distinct phases: the most chaotic and acute initial phase, the transitional phase when the newly arrived Rohingya people began to take refuge in makeshift settlements, and the current phase of relatively organized living.

### THE INITIAL PHASE (PHASE 1)

The initial phase started with the influx in August 2017 and continued till November of the same year. Most of the Rohingya arrived during this phase; they arrived visibly exhausted, injured, traumatized, hungry, and thirsty. Many arrivals had serious medical needs, such as violence-related injuries, severely infected wounds, acute infections including respiratory infections, and diarrheal diseases. A significant number of pregnant women arrived with advanced obstetric complications. A few aspects of this phase are worth mentioning. First, the speed of the influx was unprecedented globally. More than 400,000 new Rohingya joined the existing 211,000 by 24th September 2017<sup>6</sup>. Second, the refugees entered Bangladesh with very few material possessions. They could recover next to

nothing from their burning houses before fleeing, and what was saved was mostly used to pay for transportation to Bangladesh. A few had some savings left to construct a shelter, often out of no more than tree branches and a thin sheet of plastic. Others could not even manage such shelter, and simply slept on the ground, exposed to the elements. Third, though most of the refugees eventually moved into the makeshift camps, thanks to the praiseworthy efforts by Bangladesh Army, the camps did not and still do not meet the minimum standards for human settlement. Given the number of people who were affected and the quantum of land available for the camps, some of the camps became the most densely populated inhabitation in the world, with no real facilities for water and sanitation. The continued rain and muddy terrain also made the situation challenging from a public health perspective. Due to lack of potable water, people were collecting water from paddy fields, puddles and hand-dug shallow wells which were often contaminated with excreta, leading to increasingly higher incidence of diarrhea and creating a public health scare about an infectious disease outbreak.

### GAPS AND CHALLENGES

During this phase, the most critical need was to stand beside these persecuted communities, who had lost all hope and even, it seemed, the survival instinct. Supplying food and water to people amongst whom the prevalence of severely acute malnutrition (SAM) and moderately acute malnutrition (MAM) were alarmingly above threshold levels was the first priority. About 40,000 children were at imminent risk of starvation<sup>7</sup>. An estimated 204,000 adolescent girls and 240,000 children needed nutritional support.

The second priority was to supply emergency medical care to the injured and the physically distressed people. Humanitarian agencies also reported a high number of acute respiratory infections (ARI), diarrhea and skin diseases. For critical secondary or tertiary care, the existing facilities were overwhelmed by added caseloads and were struggling to offer proper and acceptable quality care. Most Rohingya women, who were either sick or were pregnant, were unwilling to come out of their shelters and seek medical support, possibly due to trauma, cultural taboos or just fear of the unknown. Hence, one of the important priorities was to convince people to come out and seek medical help, or to provide basic care at their tents.

Third, as many as 24,000<sup>8</sup> pregnant and lactating mothers needed maternal health care support as of October 2017—many of whom gave birth just before the exodus, during the stressful journey or just after arrival in Cox's Bazar in dangerously unhygienic conditions. In addition to maternal health care, all of them needed nutritional support to avoid catastrophic consequences for them, their newborns and other children.

The fourth priority was mental health. High levels of stress and serious protection concerns amid insufficient mental health and psychological support services (MHPSS) was alarming<sup>9</sup>. At the same time, of the 380,800 children that arrived, many were separated from their parents and faced diverse physical and mental health issues.

The fifth priority was the need for vaccination. Given the incredibly low level of immunization coverage among the refugees, all children were vulnerable to diseases such as cholera, measles, and other infectious diseases.

Finally, arranging minimum sanitation facilities for the ever-growing Rohingya community, already crammed for space by the roadside or inside congested and inaccessible settlements, was a race against time to prevent cholera and other waterborne disease outbreaks.

During the first phase, the initial need assessment of the crisis was conducted by the Inter Sector Coordination Group (ISCG) and published on October 1, 2017. It revealed important gaps in water, sanitation, and food security. Approximately 3,150 cubic meters of safe water was needed per day, and 18,000 emergency latrines were needed to meet the first phase of the emergency to meet basic sanitation standards for the targeted population. Over 10 million rations of food were also needed to meet the immediate food and nutritional requirement of the population. Based on this assessment, a pledging conference took place in Geneva later in October 2017 . Against the goal of US \$450 million, the conference successfully raised \$360 million for the period of September 2017 to February 2018.

## RESPONSE

During the first half of the initial phase, amid the large influx of refugees, the primary response was to supply shelter, food, water, health care, and toilets to the

refugees. However, no institutional respondent was prepared for the crisis. Instead, the first response could be characterized as an outpouring of emotionally driven humanitarian response from all over the country. Bangladeshis rushed into Cox's Bazar following a call from the Prime Minister of Bangladesh. Several thousand individuals, club members, professional associations, local and national civil society groups mobilized funds, clothes, shelter materials, health services, and basic family packs to help the Rohingya refugees. This response, however, was much uncoordinated. While the government agencies were fully active, it was quite difficult at this stage to bring discipline into the chaotic situation. Doctors and medical students, individually or in groups, were seen opening up makeshift 'medical stands' to give away medicines.

After about three weeks of sheer chaos with the traumatized Rohingya in the midst, the Bangladeshi Army started to coordinate the support. The government's Health Directorates opened medical camps too, and prescribed emergency medicine. The Bangladesh Army also responded with more organized medical clinics. With the support and guidance of the government agencies (Refugee Relief and Repatriation Committee (RRRC), District Administration), UN and NGOs slowly opened mobile clinics. It took almost one month until the processes were centralized, and the civil society organization partners reduced their inefficient ad hoc operations.

At this phase, the response by local and international agencies was mostly targeted towards the erection of tents, provision of food and drinking water, as well as emergency medical care for injured and wounded and basic ailments like fever, ARI, fungal infections of skins and eyes, indigestion, and watery diarrhea.

During the same time, several other responders deployed health workers who visited shelter to shelter to offer outreach health care. This fulfilled the critical need of those who required health care, but did not want to travel to nearby medical camps. These outreach health workers were quite effective in providing basic maternal, neonatal, and reproductive health services. Additionally, the outreach health workers also played a key role in bringing back relative normalcy by reaching out and giving the community courage and hope. These outreach workers soon became the first 'human to human' bridge between the Rohingya and the local host community and helped the refugees, especially women, to come out of their tents.

The first organized joint health intervention was the vaccination drive for cholera. The government, UN agencies, icddr,b and non-government agencies undertook this massive campaign of reaching every child with two shots of cholera vaccination in two stages. The resultant program was not only highly successful in attaining high coverage (some estimates suggest an 85% coverage) but also created one of the first platforms for government-UN-NGO collaboration of such a magnitude.

During the first phase, a sizeable number of emergency pit latrines were established, and many shallow tubewells were sunk to address the need. However, the demand and supply gaps created an early crisis in keeping the toilets in workable condition. The insistent rain also led to further deterioration of the situation. However, once the number of toilets increased and some of the agencies started sludge management interventions, the situation gradually improved.

## THE TRANSITIONAL PHASE (PHASE 2)

The second phase started around December 2017 and continued till May 2018. During this phase, the settlements became more stable; refugees started to settle in the camps and getting into a routine for relief distribution. By May 2018, more than 690,000 Rohingya had crossed the border and taken refuge in one of the 25+ odd camps set up for them.

During this time, many of the refugees started taking part in some ‘community’ activities while exploring the best opportunities available for themselves and their children in terms of livelihood and future prospect, including education. Especially the child-friendly centres (initially termed as Child Friendly Spaces) and women-friendly centres were successful in bringing back trust and hope among the refugees and making the refugees interested to seek better services.

In fact, to the surprise of many, the refugee community as whole responded quite rapidly to the positive stimulus from the Government of Bangladesh, UN, and humanitarian organizations. The rate of contraceptive prevalence, for example, which was nearly zero at the outset, started to show slow but steady increase progress. Vaccination of newcomers and new-borns gradually became less challenging. The health workers and the ‘Communication for Development (C4D)’

volunteers were largely successful in convincing an increasing number of Rohingya refugees, including the mothers, to start seeking services such as antenatal care and postnatal care (ANC/PNC). In fact, at one stage, the entire community of humanitarian respondents were struggling with whether to increase supply of services or to boost demand.

The most critical concern of this phase that cut across all issues was the preparation for the monsoon season that typically starts in April. Everybody reached a chilling consensus – if nothing were done to prepare, the upcoming monsoon could kill thousands of the refugees in massive landslides, and potential disease outbreaks.

## GAPS AND CHALLENGES

Many of the health-related challenges of the earlier phase continued during this phase as well. The lack of potable water became particularly acute due to drying up of the underground water table, partially because the transitional phase coincided with the dry season in Bangladesh and partly due to heavy extraction during the early phase. This caused concerns about increased burden of endemic infectious diseases. Contamination of the groundwater tables by the large number of pit latrines was worrisome too.

A major outbreak of diphtheria was reported at the end of November 2017, and continued till December 2017. Of the total reported 6,687 diphtheria cases, 42 died. The outbreak was managed quite successfully through the effective partnership of government, UN, and NGOs in case finding, isolation and treatment, contact tracing, administration of preventive antibiotics to close contacts of identified cases, and mass-scale awareness raising through a coordinated campaign of multiple actors.

As of April 2018, a total of 1,231 cases of measles were reported, of which 81 percent of the patients were in under-5 age group<sup>10</sup>. Though the number of cases decreased significantly by April, the transmission appeared to continue. Intensification of routine immunization in the clinics within the camps, particularly measles vaccination, had probably helped in the reduction of cases.

During this phase, more and more refugees started to come forward to medical facilities with their everyday ailments like ARI. High degree of particle-pollution from indoor smoke and burning fire-woods and

overcrowding contributed to increased transmission of respiratory pathogens, resulting in such a high rate of ARI. Other ailments like chronic obstructive pulmonary diseases (COPD), particularly in men, started to be reported too<sup>10</sup>. A BRAC-Harvard study in April 2018 revealed the prevalence of other non-communicable diseases (NCD) such as hypertension, arthritis of various forms, and mental health problems. Slowly but surely, the refugees also started to report incidences of sexually transmitted diseases, and associated complications too.

One of the major lackings was in comprehensive sexual and reproductive health care. Although some humanitarian responders started offering the minimal initial service package of sexual reproductive health (SRH), access to essential comprehensive sexual, reproductive, maternal, neonatal and child health (RMNCH), as well as education and counselling services were inadequate. Awareness of family planning methods and the prevalence of contraceptive were extremely low.

Reporting of violence against women and rape began to increase in this phase. Adolescent and young adults appeared as a critical group to support, not only with sexual and reproductive health care, but also psychosocial care –both of which were inadequate at the beginning of this phase.

Lack of adequate medical facilities, insufficient referral system, quality of and accessibility to secondary, tertiary and critical health care remained high in the list of gaps. The need for 24x7 clinics and primary health care centres emerged as one of the critical gaps too. The continued funding crisis in the health sector worsened the gap.

The health-seeking behaviors of the Rohingya community also were highlighted as one of the challenges, despite some visible improvement over time. It was estimated that only 14 percent of deliveries took place in SRH centres due to both lack of centres and lack of awareness of the need for delivery in presence of skilled birth attendants. Hygiene education, including menstrual hygiene, appeared to be limited among the Rohingya community. As it appeared from an April 2018 survey, hygiene practices remained low within the Rohingya community, evidenced by the lack of soap for hand washing among a third of the households, and evidence of open defecation, especially by children in 65 percent of households.

Finally, regarding the upcoming monsoon season, it was identified that the health services would simply become inaccessible due to landslide and flash flooding. Additionally, there was hardly any preparation to help the patients reach health facilities in case of a prolonged flood.

## RESPONSE

In response to the increased risk of waterborne diseases, many humanitarian responders started distributing water purification tablets. Several agencies started fecal sludge management and took up the responsibility of maintenance of the latrines built during the first phase, often by unidentified individuals. This interim response was highly effective to prevent potential waterborne disease outbreak. Agencies started testing newer models of latrines, including the double-pit latrines that were more suitable to the situation.

There was a marked improvement in the nutritional status of children under 5 years. Nutrition indicators reflected improvement since the beginning of the crisis, with global acute malnutrition (GAM) dropping from 19.3 percent in October/November 2017 to 12.0 percent in April/May 2018<sup>11</sup>.

The second vaccination drive to administer the diphtheria vaccine and set up diphtheria isolation centres not only strengthened the collaborative nature of the health response, but also created much-needed trust between the refugee community and humanitarian responders. The outbreak also highlighted the risk to the adjacent host community of the spread of such outbreaks outside of the camp, which motivated some humanitarian and development programming actors to intensify public health interventions in the host communities too.

Medical facilities offered by the humanitarian agencies started to look more like formal clinics with proper private diagnosis rooms, mini diagnostic labs, medicine dispensaries, etc. The range of ailments covered by these centres extended to include a few non-communicable diseases (NCDs), though the number of such facilities remained largely limited. Continued dialogue with the government health services providers and district health administration enabled a new referral system to be established for critical patients.

During the second phase, several responders started an obstetric centre to offer a safe delivery facility for pregnant women — but the shortage of facilities and restriction to keeping the facility open after dusk limited the impact. To address this shortage, nearly 300 health-care practitioners were given training on critical maternity and newborn care. The capacity of the Upazila health complex was also bolstered. In total, 33 primary health centres, 11 field hospitals and 186 health posts were made available to refugees and host communities during this phase.

Ambulance services became more available and started to be used more regularly by the refugee community, especially pregnant mothers. The health workers started to offer more comprehensive ANC/PNC services to pregnant and lactating mothers, both at the community level and in clinics. Some of the services for newborns, like vaccination, started to take shape. As a result of all these efforts during this phase, the rate of delivery at the centres started to show signs of improvement.

The women-friendly spaces and community-based protection groups offered some tools to help women deal with the growing incidence of violence against women and rapes. However, lack of proper facilities and continuing social taboo, as well as pressures on, and unavailability of, medical services at night meant the health response to such incidences were limited. Encouraged by preliminary results, the multipronged community outreach program was extended in this phase. Health and nutrition education were mainstreamed in most community interaction programs. However, nutrition education continued to suffer from a funding crisis.

Probably the most impressive response was to prepare the refugees and the humanitarian respondents to address any seasonal floods and landslides. Bamboo bridges were built to ensure accessibility to the health centres, clinics, and hospitals inside and outside the camps. Quick training on disaster response including cardiopulmonary resuscitation (CPR) was organized for early respondents. The refugees were made aware of the potential risks and trained on ways to manage such risks. As a result, there was only one fatality reported from the series of landslides of varying severity that hit the camps.

## THE ORGANIZED LIVING PHASE (PHASE 3)

This is the current phase in which the Rohingya refugees are living now. This phase started from around June 2018, when not only the refugees had settled in the shelters, but the humanitarian responders/organizations had also largely settled into their response activities. The key discussion point of this phase has been the options for longer-term measures for the Rohingya population, and the probable time duration of the crisis. Having lived in a camp setting for nine months, the Rohingya community began reporting a range of diseases that are expected in any normal community—which is not very different to the host community in the two sub-districts of Cox's Bazar. Hence, the need for and efficacy of a separately designed health care system, different from that for the host community, has started being debated. Need for strengthening local health systems is being suggested as a focus area.

The other critical issue in the discussion is livelihood opportunities for the refugees. Currently, Rohingyas are entirely dependent on the humanitarian agencies for their every need, including food. Such situation restricts their food choices and hampers nutrition. One positive trait noticed among Rohingyas was their entrepreneurial spirit. Many of them began setting up of small businesses within the camps on their own initiative, which made some of the food items and medicines of their choice and knowledge available to them through a market-based approach. However, a large number of refugees could not afford those services. So, there has been a growing tendency of Rohingyas becoming involved in work.

Not being able to work has its mental health consequence too. Uncertainty about the future, especially about the future of their children, adolescents, and young adults is also affecting their disposition.

It is visible that in this phase, the community has started to 'redesign' their culture, influenced by their interaction with the host community and relief workers. The new role of women inside the camp life, which is actively supported by the humanitarian agencies, is also profoundly affecting the new 'culture.' Finally, the freedom of movement and expression of opinion in group setting has also begun to emerge as part of the new paradigm with which the refugee

community, especially in monitoring the services they receive, as well as in assessing their role in shaping their future.

## GAPS AND CHALLENGES

One of the key gaps identified in this phase was sustainability of the infrastructure that was put in place during the second phase. Especially in view of the next cyclone season, the focus has now moved to promoting preparedness, sustaining life-saving services, and increasing the robustness and quality of facilities as well as basic services, including health care services. For example, it is agreed that all agencies should replace their service delivery and program management structures which used untreated bamboo with more stable treated ones, not only to ensure safety but also to ensure cost efficiency. One of the key challenges for this phase has been to ensure sustainable provision of water for both refugees and host communities. Similarly, sustainable sanitation systems that do not contaminate water sources, as well as the wider environment, were considered a priority.

Health needs assessments conducted during this phase continued to point to increased risk of vector-borne and waterborne diseases such as dengue, chikungunya, typhoid fever, hepatitis E, leptospirosis, malaria, dysentery, acute upper and lower respiratory tract infections, including seasonal influenza. Acute watery diarrhea (AWD) is still another commonly reported ailment in the camps. Varying degrees of mental health illnesses, which are considered to be the impact of violence and displacement suffered, as well as daily stresses, were reported.

As in any development programming situation, there has also been a lot of focus on keeping minimum acceptable standards in service delivery to Rohingya refugees. For example, there has been a sector-wide agreement to move towards an agreed minimum service package, with a focus on maternal and child health, an effective referral system, and the inclusion of mental health into the service mix. All of these show a definite move from the ‘crisis mode’ of humanitarian programming to ‘development mode’ of programming. This shift in programming thinking has also been reflected in adjustments being made in the delivery approaches to upgrade health care services to the community.

While the Rohingya community has become readier to engage in planning, organizing, and managing the services that are delivered by the humanitarian agencies, as well as express their opinion on service relevance and quality, the community involvement in the design and delivery of health services has remained limited. Lack of community platform, long-term vision, and widely accepted leadership among Rohingya communities also pose an obstacle for the agencies for effective engagement in program design, delivery and management processes. Holding agencies/organizations accountable to the refugee communities as well as to the host communities for the services delivered have also been affected by the absence of community-based organizations.

There has been a growing recognition of the need to focus on host community services too, simultaneously with that for refugees, including the needs arising out of their heightened risk of infectious diseases, which had been virtually eliminated from Bangladesh.

## RESPONSE

Amidst the uncertainties that are prevailing in Cox’s Bazar about resettlement and repatriation of the refugees, most humanitarian agencies started the process of evaluating and adjusting their mid-term strategy to ensure service effectiveness, efficiency, and efficacy. Everyone has been looking into the issue of monsoon/cyclone preparedness as a cyclic/seasonal issue, rather than a one-time event. The new generation of double-pit latrines that are being built by the agencies is designed to sustain with minimum maintenance. These double-pit latrines have gradually been replacing the first generation of ordinary pit-latrines that were built in the first phase. As of mid-2019, 12,565 bathing facilities, 40,382 functional latrines and 107 small and mid-size fecal sludge management sites were operational in the camps<sup>12</sup>. There have been notable improvements in the drinking water provision in the camps too - an average of 31 litres per person per day. Already a few camps have been brought under piped water system – slowly but surely, a significant proportion of refugees and people in the host community will benefit from such piped water system soon. Deep tube wells have also been installed in many locations as the water table in refugee camps has begun to go down. However, questions about the environmental sustainability of such deep tube wells have been raised by many development and environmental professionals. A long-term plan is being prepared to

sustainably maintain the water system by a number of refugee communities.

There has been a plethora of work on-going in almost every sector to define the minimum standard of service for both the refugee population and host communities. For example, the education sector has been working on a unified curriculum, the health sector has been focusing on minimum service package, etc. These standards are focused on the holistic need of the refugee and the host communities rather than an interim solution for a community in distress. Issues such as mental health and other NCDs are being considered in line with Bangladesh's national standard applicable for a Bangladeshi citizen. Livelihood support and cash-based programs have been designed in the context of food/nutritional security—with an emphasis on promoting the ability of the refugee community to buy food from local markets and thereby ensure diversity and income for the local sellers/producers. Expectedly, when implemented along with proper awareness campaign, such cash-based programs will also allow the refugees to reach the minimum food diversity needed to sustain for the mid-term.

There were already attempts to hold an internal election in a few camps to bootstrap the leadership development process. In addition, many agencies have been 'employing' Rohingya volunteers to deliver services for the refugee communities. Both initiatives seem to have had some positive impact in helping the Rohingya community to gradually take charge of their own lives and pursue a positive vision for their own communities. In fact, this has been one of the most critical elements that could help the response process enormously by supporting meaningful engagement between the refugee community, the host community, and the humanitarian agencies to ensure the effectiveness of humanitarian services.

Humanitarian actors have made progress addressing the health needs of the refugees since the beginning of the crisis, but as the needs of the population are changing from acute emergency to ongoing health and protection needs, the situation is still very critical and major gaps remain evident and unaddressed. The health sector remains one of the highly underfunded sectors, with only 24 percent of the total requested funding of \$113 million covered.

This third phase is when the humanitarian response sector should be developing a mid- to long-term strategy to prepare for as well as address upcoming

and unforeseen challenges. There is no doubt that the root cause of the crisis is in Myanmar, and it must end at Myanmar too. Like the position of Bangladesh government, humanitarian sector actors believe that a safe, voluntary, dignified, and sustainable return of the refugees to their homeland will end this humanitarian crisis. However, until such goals are accomplished, the minimum standard of humanitarian services in general, and health services for a humane living, would remain a critical priority.

## MANY FACETS OF A HEALTH CRISIS

This Health Watch Report is a unique attempt to portray multiple facets of health-related challenges of one of the world's largest humanitarian crisis within the confine of two covers. This is a unique way to capture its specific history as it has been unfolding in front of our very eyes. The range of the issues covered are wide and the perspectives presented in each of the articles are far-reaching additions to the humanitarian programming knowledge base. While each of the articles stands out on its own, because they are broadly related to the health sector and to the same crisis—there were interesting complementarities. Hence, the bigger picture presented by the compilation could be useful and interesting, and a more revealing account than the mere sum of the picture presented by the individual pieces.



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## NOTES

- a. The Government of Bangladesh refers to the Rohingya as “Forcibly Displaced Myanmar National (FDMN)”. The UN system, however, refers to this population as refugees. In this report, we use the term ‘Rohingya refugees’.
- b. The conference was hosted by the European Union and the Government of Kuwait. It was co-organized by the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration (IOM), and UN Office for the Coordination of Humanitarian Affairs (OCHA).



## CHAPTER TWO

# MANAGEMENT OF INFECTIOUS DISEASES

A M Zakir Hussain, Md. Akramul Islam, M. Moktadir Kabir, Zarfisha Alam, Isbat Azmary Rifat, and Shayla Islam

## BACKGROUND AND INTRODUCTION

In late August 2017, the world witnessed an influx of hundreds of thousands of Rohingya populations from Myanmar into Bangladesh. This resulted in a massive struggle on the part of the government of Bangladesh, local population and aid workers to secure shelter and life-saving commodities. In the first few weeks, the camps and extended sites established for these refugees had virtually no access to water and sanitation facilities. They were forced to collect water from paddy fields, ditches and shallow tubewells which were contaminated with human excreta, leading to high incidence of diarrheal diseases. This created apprehension for an infectious disease outbreak. In this emerging public health crisis, a health sector working group, then consisting of thirteen implementing partners, with the technical leadership of the World Health Organization (WHO), was formed to support a Joint Response Plan (JRP). As the number of partners

added up, they provided regular updates on public health risks and vulnerabilities, and conducted assessments and resource mapping. The primary objective was to provide emergency life-saving services by setting up mobile camps and referring complex cases to district hospitals in order to prevent any potential outbreak and reduce morbidity and mortality.

The health sector response was spearheaded by the Directorate General of Health Services (DGHS) of the government and district level health authorities under the leadership of the Civil Surgeon of Cox's Bazar. WHO maintained surveillance and coordination between the NGOs and supported key interventions and vaccination campaigns, such as the oral cholera vaccine. The health sector working group organized multiple immunization campaigns and provided vaccines for diphtheria and polio.

Other services provided were standardized management of illnesses, management of diseases with potential of outbreak (e.g. diphtheria); and conduction of community mobilization to destigmatize fear and apprehensions regarding vaccines, in addition to providing other relevant information such as the benefits and necessity of vaccines and the importance of good hygiene practices like hand washing. All these interventions helped to ward off major epidemics in the camps and the neighboring communities (popularly known as host communities), who were also at risk because of their close geographical proximity and frequent religious, social and economic interactions.

Health facilities were established by both the Government of Bangladesh, and national and international non-government organizations (NGOs and INGOs) to cover a wide range of functions such as community clinics, health posts (fixed/mobile), labor room, sexual and reproductive health (SRH) care, communicable diseases treatment facilities (such as the diarrheal treatment centers, diphtheria treatment centers, TB, HIV and malaria treatment etc.), primary health care centers, secondary health facilities, and diagnostic points.

As of November 2018, a total of 185 health facilities were supporting the humanitarian crisis in Ukhia, Teknaf and Cox's Bazar. Of this, 152 were basic health units, each targeting a population of 10,000 people. Additionally, there were 25 primary health centers which operated 24/7, and eight hospitals, with a functional capacity of one per 50,000 and one per 250,000 people respectively. These health facilities are largely managed by the UN and NGOs.

## ROHINGYAS' VULNERABILITY TO INFECTIOUS DISEASES

Throughout history, people who became internally displaced, especially due to wars and conflicts, were inflicted with infectious diseases, particularly typhus<sup>1</sup>, malaria, relapsing fever, tuberculosis<sup>2,3</sup>, and dysentery<sup>4</sup>. Migrations lead to emergence of diseases as people are more prone to or have reduced immunity because of malnutrition or harsh living conditions.

Even prior to the military atrocities, all communities in the Rakhine state of Myanmar suffered from poverty,

poor social services and limited livelihood opportunities, with a poverty rate of 78 percent<sup>4</sup>, making it one of the poorest and deprived regions of the country. Furthermore, access to healthcare was limited across the Rakhine population in general. The health system was incapacitated infrastructurally and otherwise. Immunization coverage in Rakhine was amongst the lowest in Myanmar. The state suffered from multiple outbreaks<sup>3</sup> of vaccine-preventable diseases in recent years, predominantly in the northern part of the state.

As the Rakhine state had a critical shortage of qualified medical staff, many villages lacked full-time access to a health worker. Health workers displayed reluctance to spend time in Muslim Rohingya villages and hard-to-reach areas. Moreover, the Rohingyas faced institutionalized discrimination and obstacles, such as movement restrictions even within the state, communal segregation, as well as refusal of some health facilities to treat Rohingya patients<sup>5</sup>.

## DISEASE OUTBREAK, SURVEILLANCE AND CASE MANAGEMENT

During the earliest days of the influx, health sector partners established mobile health facilities across the temporary settlements to provide first aid and treatment of common ailments, and referred complicated cases to the upazila health complexes, district hospitals and the Cox's Bazar Medical College Hospital, which provided secondary and tertiary care for the local population.

Three suspected measles cases were reported within a month of the first arrival of the Rohingyas. During the initial period (between 25 August and 10 October 2017) of the response, higher incidence of acute respiratory infections (ARI), lower respiratory tract infections (LRTI), diarrhea and skin diseases<sup>6</sup> were recorded. However, due to inadequate referral and limited disease surveillance systems, many patients could not be provided appropriate care initially.

The WHO established a web-based *Early Warning, Alert and Response System (EWARS)*, developed in 2015, to strengthen disease surveillance and detect outbreaks in the camps in time. A EWARS kit contains equipment needed to establish surveillance and response activities. This included 60 mobile phones,

tablets, a local server, a solar generator and solar chargers. A single kit costs approximately US\$15,000 and can support surveillance through up to 60 fixed or mobile clinics, serving nearly 500,000 persons. EWARS<sup>6</sup> includes an analytic and alert module that signals outbreak at early stages and incorporates a risk assessment framework and matrix.

Provision of two EWARS kits, followed by a series of workshops and field visits to train aid workers in 151 health facilities, were ensured by WHO, and these became fully operational from December 2017. Within one week of establishing EWARS, health facilities started registering and reporting the cases, by age and site of the patients. A team from the Institute of Epidemiology, Disease Control and Research (IEDCR) of the Government of Bangladesh collected samples for etiology of outbreaks. This practice resulted in prompt detection of an outbreak of hepatitis A, allowing early measures to curb the outbreak<sup>7</sup>.

EWARS generated automated weekly bulletins that included reporting performance, trend and location of reported diseases, and summary of alerts. The weekly bulletins were disseminated among 125 partners<sup>8</sup>, which swelled from the initial 13. The weekly bulletin was also posted on WHO and Ministry of Health and Family Welfare (MoHFW) websites.

The diseases considered as potential threat and included in the reporting system were acute watery diarrhea, bloody diarrhea, acute respiratory tract infection, measles/rubella, acute flaccid paralysis, suspected meningitis, acute jaundice syndrome, neonatal tetanus, adult tetanus, malaria, and fever of unknown origin. Dengue and varicella (chicken pox) were added later. More specific details on the infectious diseases are given below.

## Epidemiology of infectious diseases

### **Measles**

Bangladesh nationally reached a vaccination rate of over 90 percent against measles in 2016. As a result, the incidence of measles decreased by 82 percent - from 34.2 to 6.1 cases per million populations from 2000 to 2016<sup>9</sup>.

Within ten weeks of the first case of measles in the Rohingya camps, reported on 6 September 2017 from Kutupalong settlement, a total of 1,714 suspected cases of measles were reported from the Rohingya settlements, including two related deaths. By end of July 2018, a total of 4,500 suspected cases of

measles and rubella were reported by the office of the Civil Surgeon of Cox's Bazar. Of the total suspected cases, 83 percent were amongst children less than five years of age. Routine measles vaccination was provided to children less than five years of age. However, a mass immunization campaign which began in November 2017 reached all children aged 6 to 15 years.

### **Tuberculosis**

To prevent a potential epidemic, the National Tuberculosis Programme (NTP) of DGHS along with BRAC as its key implementing partner established TB control services in the Rohingya refugee camps in September 2017. Also, a reinforced intervention in the host communities under the same strategic plan was launched.

Community mobilization was a key activity in the plan to enhance case findings, treatment and follow up. If anyone presented symptoms of TB at health centers or during community visits by mobile health workers, they were referred to BRAC health centers for sputum collection. The sputum samples were sent to the nearest designated diagnostic facilities operated by BRAC and NTP. Upon confirmation of the disease, patients were treated with Directly Observed Treatment Schedule (DOTS) and routine follow-up visits were undertaken in cooperation with the Majhis (informal leader/representative of a number of houses in a camp), community, and partners. All children less than five years of age who lived in close contact with bacteriologically confirmed patients received prophylactic isoniazid therapy.

Community health workers conducted regular visits to households (at least two visits per week to each household) in the camps for: 1) active searching of presumptive TB cases and, 2) follow-up of treatment side-effects and follow-up sputum collection from suspected cases, in addition to the cases in health centers. The test results were collated by the laboratory under the supervision of the program organizers and final verification was ensured by medical officers deployed by BRAC. Data pertaining to TB was collected on NTP provided forms. All 68,982 people presenting symptoms of TB were tested from September 2017 till November 2018, and 2,779 people who tested positive (4.0% among the suspected) received treatment. Out of these 2,779, 58 were relapsed cases (2%).

Among those 2,779 identified TB cases, 1,418 (51%) were female and 1,361 were male (49%). To identify

TB/HIV co-infection, 1,861 people were tested, revealing 13 HIV cases (0.7% among the suspected). It may be noted that the HIV infection rate among the high risk population in Bangladesh is about one percent, although in some categories it is higher<sup>10</sup>.

Table 2.1: Distribution of TB/HIV co-infection

| <b>TB/HIV REPORT</b> |              |            |
|----------------------|--------------|------------|
| Total HIV Tested     | HIV Positive | Percentage |
| 1861                 | 13           | 0.7%       |

Source: AIDS/STD Program, PIACT and SSMF. End Line Survey 2018

### Malaria

The borders of Bangladesh and Myanmar are the most endemic<sup>11</sup> and high-risk areas for malaria. The Myanmar-India border and the Myanmar-Thailand border have also demonstrated high mortality and morbidity rates from malaria in the region. Bangladesh follows the WHO recommended Artemisinin-based combination therapy (ACT) as the first line of treatment. The influx of the migrant population from the Rakhine, an area of high prevalence of the disease, coupled with reduced susceptibility to ACT<sup>11</sup> posed a high threat to malaria control in Bangladesh.

The National Malaria Elimination Programme (NMEP) of DGHS developed a National Strategic Plan for Malaria Elimination (NMEP 2017-2021), which also included the Rohingya refugee camps. Major services under Malaria Elimination Programme included early detection with rapid diagnostic tests, prompt treatment with ACT, and prevention by distribution of long-acting insecticidal bed-nets, as well as community awareness activities. From September 2017 to November 2018, the program tested 101,163 refugees within the camps and treated 17 cases that were identified (0.0168% of the tested/ suspected). However, from July 2018 to November, out of the 49,649 cases tested, 10 were found with malaria (three were plasmodium falciparum and seven plasmodium vivax – 30% and 70% respectively). All were male. It seems that the number of cases of malaria currently remains static in the camps.

### HIV

Services for managing the transmission, providing care, and appropriate treatment of HIV were being coordinated and executed under the AIDS/STD Programme (ASP) of the Ministry of Health and Family Welfare (MoHFW). The Rohingya refugees were considered vulnerable to HIV infections due to the high

prevalence of STI in the region, and with Rakhine posing the highest prevalence of HIV in Myanmar<sup>12</sup>. Additionally, multiple reports of gender-based violence were reported by women and girls. By as early as October 2017, 21 cases of HIV were identified, and NGOs such as IOM and MSF raised concerns over the risks.

The emergency HIV response in the refugee camps aimed to ensure HIV prevention, care and support as well as STI management for those affected. The services offered as a package included counseling, testing, treatment initiation and maintenance, and a follow up model to ensure that patients adhered to the drugs. Furthermore, no independent health facilities were set up for the treatment of HIV and STIs, and services were integrated with certain components of health such as tuberculosis and antenatal care centers (ANCs). While the National AIDS/STI Programme provided diagnosis and treatment facilities, and bore the cost of testing and medicines, the role of the civil society organizations was to carry out primary screening of suspected HIV carriers from risk-based groups. Patients presenting positive results on the primary tests were referred to the government's District Hospital for confirmatory tests, and all diagnosed patients were registered for anti-retroviral therapy (ARV). The ASP program identified 358 HIV patients in Cox's Bazar within a year. Of them, 238 were from the Rohingya camps while 120 from the host communities (reported by the office of the Civil Surgeon of Cox's Bazar). Among the 358 cases, 155 and 154 were men and women respectively; and 23 and 25 were male and female children respectively. Of the 13 HIV cases among the TB patients, five were female and eight were male.

### Acute Respiratory Infections (ARI)

ARI was highly prevalent amongst the Rohingya refugee population and constituted a significant proportion of the total cases reported. Between 25 August and 11 November 2017, 27 percent (46,077) of the total consultations (332,973) reported under EWARS were attributed to ARIs. The disease was of particular concern amongst children. Of the 46,077 ARI cases, nearly 47 percent were from children under five years of age. During the same time, ARI caused 27 deaths in under-five children<sup>13</sup>. The disease escalated rapidly through many areas, especially the Jamtoli and Kutupalong camps, and peaked at the settlements at Moynarghna where the infection rate was 147 per 1,000 population from late October to mid-November 2017. Overcrowding, indoor cooking practices, and sub-optimal shelters constructed with air-impermeable

plastic sheets contributed to poor indoor air quality and the proliferation of respiratory infections. However, as most ARIs were treated following the standardized WHO protocol, the symptoms subsided with time.

### Acute Watery Diarrhea (AWD)

Diarrheal diseases are common in refugee camps and acute watery diarrhea (AWD) was one of the five most frequently reported diseases in the early days of the crisis. In 2017, nearly 81,000 cases of acute watery diarrhea were reported to EWARS, affecting mainly children aged less than five years. The total number of AWD cases reported by the Civil Surgeon's office for the period of July 2017 to July 2018 was 916,538. The number reported by the Civil Surgeon's office includes the host population as well. The incidence rates presented in the figures found from the Civil Surgeon's office show a corresponding spike during the time of the massive influx.

A multi-sector AWD preparedness response plan was jointly executed by the Health and WASH sectors with active support from the relevant partners. Diarrhoea Treatment Centres (DTC) were set up to treat cases that would require oral and intravenous rehydration 24 hours a day. These centers also had provisions for several isolated emergency admissions at a time for dehydration cases, and with stockpiles of necessary logistics. DTCs were distributed in all big camps in adequate numbers<sup>14</sup>. Health facilities and DTCs jointly reported AWD cases.

### Acute Jaundice Syndrome (AJS)

A high number of AJS cases amongst the refugees living in Cox's Bazar were reported through EWARS since early 2018.

In 2018, 2,730 cases of AJS were recorded (as of September 2017). Following the sudden increase, exhaustive laboratory sampling was initiated as part of response activities to determine the etiologies. In all health facilities across the camps, more than 50 percent of the AJS cases were positive for Hepatitis A, with more than half the cases being children less than 10 years of age.

### Diphtheria

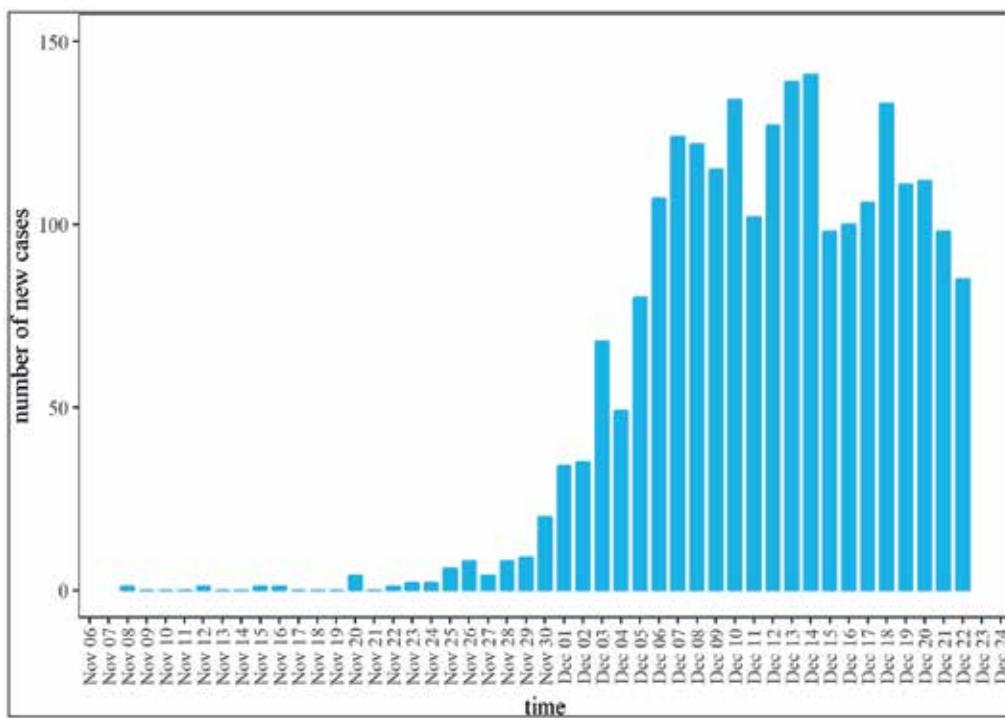
The first case of diphtheria was reported on 8 November 2017 by a Médecins Sans Frontières (MSF) clinic, located in the Balukhali makeshift settlement. The case was a 30 year-old woman who had primarily received antibiotics for her symptoms from MSF, but returned 5 weeks later with complaints of numbness in her arms, not being able to stand or walk and

difficulty swallowing. However, it was too late to give her diphtheria antitoxin (DAT) at that stage. A suspected case of diphtheria was reported later to an International Federation of Red Cross and Red Crescent Societies (IFRC) clinic with a three-day history of fever, sore throat, difficulty swallowing, and a swollen neck.

In the six weeks since the index case of 8 November 2017, the number of diphtheria cases rose to 2,526, causing 27 deaths. The disease escalated rapidly, reaching almost 150 suspected cases a day (Figure 2.1)<sup>15</sup>. Until December 11th 2017, the number of suspected diphtheria cases was too high as all cases displaying clinical suspicion of diphtheria were reported. Later the definition was revised by the WHO, and mainly probable cases (cases with upper respiratory tract illness with laryngitis or nasopharyngitis or tonsillitis AND sore throat or difficulty swallowing and an adherent membrane (pseudomembrane) OR gross cervical lymphadenopathy) were advised to be reported<sup>16</sup>. Due to vaccination efforts and other countermeasures, including contact tracing and hospital admission of cases, the epidemic had been brought under control, with incidences beginning to decline by the end of December 2017.

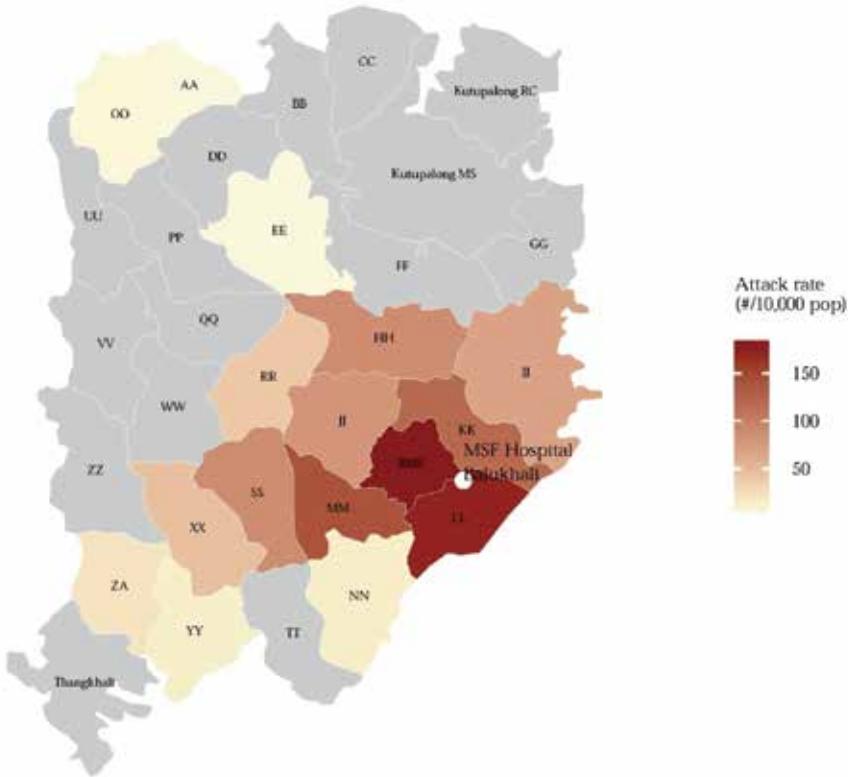
Fatality rate was high (19.8%), as patients presented themselves too late unless severe symptoms developed; many with near-airway obstruction on arrival. A total of 8,262 diphtheria cases were reported through EWARS until September 2018, of which 278 cases were confirmed, 2,706 cases were classified as probable and 5,205 as suspected<sup>17</sup>. Geographically, the outbreak extended from Balukhali settlement within the Kutupalong camp to other smaller refugee camps (Figure 2.2)<sup>18</sup>.

Figure 2.1: Daily incidence of diphtheria in refugee camps, November 6- December 24, 2017



Source: WHO. Diphtheria Outbreak Response Update Cox's Bazar, Bangladesh Update#2. 2017.

Figure 2.2: Diphtheria disease burden amongst the Rohingyas (December 2017)



Source: World Health Organization. Minutes of Health Sector Meeting, 13 December 2017

# INTERVENTIONS IMPLEMENTED

## Management activities

A core committee, made of six sub-groups was formed by the Civil Surgeon's Office of Cox's Bazaar, was assigned to coordinate between partners, create a standard guideline for case detection and treatment, triage, streamline logistical operations, manage outbreaks, and communicate with the target population.

The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) oversaw the coordination and information management, as well as management of allocated funds<sup>19</sup>.

## Activities to control diphtheria

A response strategy to manage the diphtheria outbreak was developed by the Directorate General of Health Services (DGHS) and district health authorities (Civil Surgeon), together with health sector partners. Improvement of community and facility-based surveillance, early detection, and preventing the spread of diphtheria along with provision of treatment and isolation for those affected were critical components of the strategy. Standardization of case management, infection prevention and control protocols, and establishment of rapid response teams were among the other strategies. A mass vaccination campaign for preventing the spread of diphtheria was the key intervention. Community mobilization approach was adopted for tracing those in close contact with the suspected patients to provide prophylactic drugs and vaccination. The model was also used to disseminate messages on diphtheria, improve positive health-seeking behavior, and remove traditional beliefs against vaccines. WHO, UNICEF, UNHCR, IOM, WFP, MSF, ISCG, Save the Children, BRAC, OBAT Helpers, RTM International, Samaritan's Purse, Medicals Team International, HOPE, CODEC, and IFRC were the key implementing partners.

## Activities to control acute watery diarrhea

Cholera is a threat to vulnerable populations caught in such humanitarian emergencies. On October 10, 2017, the Government of Bangladesh launched an oral cholera vaccination (OCV) campaign supported by WHO, targeting over 650,000 people in eleven camps, settlements and host communities in Cox's Bazar, for everyone aged less than or equal to one year. A follow-up campaign, targeting children aged one to

four years, was conducted between 4th and 9th November 2017, with support from key implementing partners – IOM, UNICEF and MSF. IOM deployed more than 200 mobile vaccination teams, each with five members, across 12 FDMN camps and makeshift settlements to administer the vaccines as a door-to-door service. In the second round of the campaign, 250,000 children between the ages of one to five years were given a booster dose between 14 days and 3 months after they received the previous dosage.

The third oral cholera vaccination (OCV) campaign was successfully completed on 16 May 2018 including the three day-long sweep activity, i.e., vaccinating the missed cases. The sweep teams reached 20,361 through repeat activity in some grey areas, identified through Rapid Convenience Monitoring (RCM). The RCM strategy involved supervisors and local workers to check 20 children in the target age group, in neighborhoods at greatest risk due to poor coverage during mass vaccination campaigns, through house to house surveys. If more than one unvaccinated child was found, teams revisited the area and vaccinated the children who were missed. As per the RCM data, coverage was 95 percent. A total of 871 areas were monitored by checking 8,146 beneficiaries, and 33 areas were reached through repeat vaccinations by sweep teams. A total of 1,317 OCV sites were checked by WHO monitors. In total, 879,237 doses of OCVs were administered by July 2018, as per the office of Civil Surgeon, Cox's Bazar<sup>20</sup>.

The fourth round of oral cholera vaccine campaign was launched on 17 November 2018, targeting about 330,000 people, under the leadership of DGHS and in collaboration with WHO, UNICEF and other health sector partners. The campaign aimed to ensure a two dose vaccination programme for the target population in the camps, along with host communities at risk. A total of 700 volunteer vaccinators along with 2,000 Majhee and 2,000 community health workers were involved in this campaign.

The vaccine cold chain was maintained, and vaccines were transported using a sufficient number of vaccine carriers and ice packs for a door-to-door strategy. The vaccination campaign was preceded by extensive social mobilization efforts to inform the community of the benefits, availability, and necessity of the vaccine in addition to breaking the stigma regarding vaccinations. It included capacity building on treatment protocol of acute watery diarrhea and included case management, malnutrition

management, infant and young child feeding (IYCF), waste management and infection control. Treatment points at various levels of the ‘health system’ were planned for oral rehydration solutions (ORS)/zinc distribution, as well as standard treatment at health centers, as per national protocol developed by ICDDR,B. Coverage with at least one OCV dose was high in Nayapara and makeshift settlements (>81%). However, coverage in Kutupalong was lower (72.6% and 78.9% in children aged 1–4 years and persons aged ≥5 years, respectively) because of the low coverage among unregistered refugees. OCV coverage within camps was similar among children aged 1–4 years and persons aged ≥5 years in all groups (overall, registered, and unregistered refugees), except in Nayapara where coverage among children aged 1–4 years was approximately 10 percentage points higher than that among persons aged ≥5 years in all groups.

### Other immunizations

Given the rapid spread and the sheer magnitude of the outbreaks, the Ministry of Health and Family Welfare with support from UNICEF, WHO, GAVI, and the Vaccine Alliance launched a mass vaccination campaign for children 15 years and younger in the refugee camps, temporary settlements and host communities. Children aged six weeks to seven years received a triad vaccine of Penta, PVC and bOPV to protect the vulnerable from a number of infectious diseases, including diphtheria, hepatitis B, pneumonia and polio. Children from ages 7-15 received the tetanus-diphtheria (TD) vaccine. The campaign, which began on 12th December 2017, was planned to provide three rounds of the vaccines four weeks apart, and had a target to cover 95 percent of the Rohingya children. The vaccination campaign was preceded by extensive social mobilization efforts to inform the community of the benefits, and availability and necessity of the vaccine. The vaccination strategy included a combination of fixed sites and mobile teams for door-to-door vaccine delivery.

During the first round, 81 percent children less than seven years of age and 96.4 percent children from 7-15 years of age were immunized, respectively. Soon after the first round, vaccination at border entry camps began on 23rd December 2017. Vaccination rounds for 20,000 aid workers and close contacts were completed. During the second round, a school vaccination campaign reaching 168,842 children had been conducted in the host community. The third round of diphtheria vaccination campaign ended in May 2018 covering 431,448 (104%) children six weeks to 15 years of age in Ukhia, Teknaf and

Naikhongchhari upazilas. During each month, 12 days were allocated for door-to-door registration of the children and pregnant woman, and the other twelve days were assigned for vaccinating them. In nine months, three campaigns were delivered with more than 4,000,000 doses of vaccines.

The vaccines given by July 2017, as per the Civil Surgeon’s office were as follows:

- bOPV: 69,539 doses (first round) and 208,729 doses (second round)
- DT: 169,127 doses (first round), and 120,895 doses (school campaign).

### Experience gained

For an improved standardized case detection of diphtheria, the standard definition was revised to include the probable cases also as possible diphtheria. Under the improved definitions, the number of reported cases showed an upswing.

In 2013, WHO established a stockpile of oral cholera vaccine (OCV), with funding from Gavi and the Vaccine Alliance, primarily for emergency responses. Considering the precarious water and sanitation situation in the Rohingya refugee camps, 900,000 doses of OCV were mobilized by WHO from the international stockpile in October 2017 to prevent cholera outbreaks, before cholera cases were reported. The Director General of Health Services (DGHS) in collaboration with the health sector partners formed a taskforce and an AWD preparedness plan was rolled out and jointly executed by the Health and WASH sectors and their key implementing partners. Twenty planned Diarrhoea Treatment Centres (DTCs) were assessed to determine the level of operational “readiness” with medical, logistic, and WASH technical support provided to ensure implementation to standard.

## LOGISTICS AND FUND FLOW

WHO provided support to partners through the provision of surveillance and medical supplies. Twenty one Immunization Field Monitors (IFM) of WHO monitored and provided technical guidance for the whole vaccination process. The IFM oversaw timely arrival and distribution of vaccines, compliance with cold chain guidelines, assisted vaccinators in registration and vaccination, and facilitated community mobilization. Additionally, IOM, IFRC,

Canadian RC, BRAC, Save the Children International (SCI), OBAT Helpers, Medical Teams International (MTI), MSF, and WHO collectively reported on contact tracing.

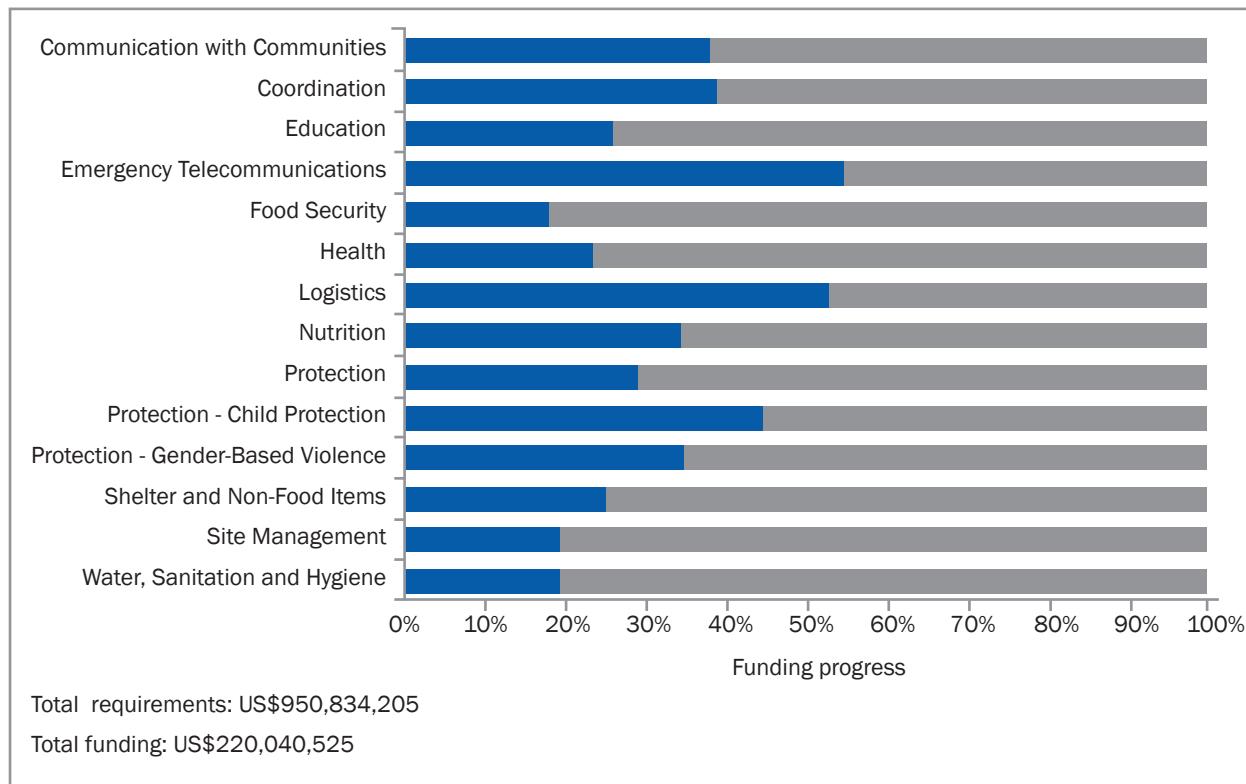
IOM, MSF, Japanese Red Cross, and BRAC established diphtheria treatment centers and provided treatment with Diphtheria Antitoxin (DAT) and antibiotics, depending on severity of cases along with isolation centres. WHO and UNICEF worked with communities to disseminate messages and build awareness on the signs and symptoms of diphtheria, and to seek prompt treatment, with continued efforts on improvement to encourage vaccination, including consideration of cultural and gender specific sensitivities. The management of the diphtheria epidemic was largely funded by the Government of UK (US\$ 2,079,223), the Government of Australia (AUD 1,500,000), as well as the European Union.

### Funding for the Health Sector Response

An initial allocation of US\$ 1.5 million allowed WHO to rapidly expand its response and quickly get the required personnel and critical medical supplies on ground. Since September 2017, Contingency Fund for Emergencies (CFE) funding supported the administration of 900,000 doses of oral cholera vaccines. The amount available for OCV vaccination to UNICEF was US\$ 462,963.

In 2018, the joint response plan pledged US\$ 113.3 million for health sector response (Fig 2.3). Total of US\$ 46.47 million (41.1%) was received against the appeal funding, which was in sufficient to provide health coverage to the planned beneficiaries. The largest funders to the health sector were the government of Australia, Denmark, Canada, Japan, and Norway; Islamic Development Bank; European Commission's Humanitarian Aid and Civil Protection Department; UNICEF National Committee and various European countries.

Figure 2.3: Fund flow to the Rohingya health sector response, grouped by cluster



Source: Bangladesh: Rohingya Refugee Crisis Joint Response Plan, Financial Tracking Service, 2018.

## WAY FORWARD

Health sector partners continue to prioritize life-saving needs and as the situation evolves, relevant plans will be adopted to suit the changing contexts. So far, the health sector remains inadequately funded. This places the Rohingya population and the neighboring population in a vulnerable situation. High population density, poorly ventilated houses and environmental contamination over time may increase the risks from vector-borne diseases and other infectious diseases such as TB, ARI, and so on. Major priorities that remain for the sector include ensuring sustained funding to continue and expand surveillance of morbidity,

mortality and diseases; efficient and effective preventive and control measures including skilled community mobilization and awareness interventions; establishing sufficient surgical capacity; a functional referral system; life-saving medical logistics; and maintaining collaboration and coordination, in particular with local government institutions and relevant sectors<sup>21</sup>. Finally, efficient planning and monitoring will be imperative along with assurance that the health facilities report their performance to the public health department (Civil Surgeon's office). It is also imperative that sufficient human resources for health are provided as per the WHO standard, i.e., 123 service providers per 100,000 beneficiaries.

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## NOTES

- a. WHO, Médecins Sans Frontières (MSF), International Organization for Migration (IOM), United Nations High Commissioner for Refugees (UNHCR), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), Action Contre la Faim Bangladesh (ACF), International Federation of Red Cross and Red Crescent Societies (IFRC), International Committee of the Red Cross (ICRC), BRAC, Bangladesh Red Crescent Society (BDRCS), International Committee of the Red Cross (ICRC), MUKTI and International Centre for Diarrheal Disease Research (ICDDR,B).





## CHAPTER THREE

# THE NUTRITION RESPONSE

Malay Kanti Mridha and Rina Rani Paul

## INTRODUCTION

Rohingya, an ethnic group of Myanmar, has been a target of attacks and violence since 1977. As Bangladesh has a border with Myanmar, there were influxes of Rohingya community to Bangladesh. The first massive influx took place in 1978, followed by another influx in 1991-1992. The third and the largest influx occurred in 2017-2018. Almost all the members of this forcibly displaced community from Myanmar live in 34 camps in two sub-districts (Ukhiya and Teknaf) of Cox's Bazar district of Bangladesh. Before the 2017-2018 influx, an estimated 200,000 persons from the Rohingya community were living in Bangladesh. The 2017-2018 influx added nearly 700,000 more people. As a response to the latest influx, the Government of Bangladesh, development partners,

different non-profit and for-profit organizations came forward to help them. However, this forcibly displaced community, like other refugee communities in the world faces a number of health and nutrition issues. The aim of this chapter of the Bangladesh Health Watch (BHW) is to report the nutrition situation, ongoing nutrition interventions, resource requirement for the nutrition interventions, current coordination and accountability system, lessons learnt so far and way forward for improving the nutrition situation. Therefore, this chapter of BHW will capture the nutrition situation as existed during the data collection in 2019, and status of nutrition programs so that policy and programmatic actions can be taken to further improve the nutrition situation of the Rohingya refugees.

## METHODS

This report is based on the literature (indexed and grey) available in the public domains. We searched for literature in the Pubmed database, google scholar database, the websites of the key organizations, e.g., Humanitarian Response and nutrition sector google drive with key words 'Rohingya' and 'Nutrition'. From the Pubmed database, we identified 49 published articles. There were 1,780 hits on the Google Scholar database including 774 hits since 2015. We finally reviewed 49 published articles from index journals and 168 reports and documents (grey literatures). We created an EndNote database of these articles and documents. Only the articles or reports published in English were included. Before the review of the articles and documents, we deleted the duplicate articles using 'Find Duplicates' option of EndNote software.

Table 3.1: Rohingya population living in Bangladesh by age and gender

| <b>Age group</b> | <b>Female</b> | <b>Male</b> | <b>Total</b> |
|------------------|---------------|-------------|--------------|
| 0-1 years        | 15,367        | 15,347      | 30,714       |
| 1-4 years        | 67,774        | 70,607      | 138,381      |
| 5-11 years       | 99,747        | 105,126     | 204,873      |
| 12-17 years      | 61,379        | 61,974      | 123,353      |
| 18-59 years      | 215,033       | 167,450     | 382,483      |
| 60+ years        | 15,937        | 14,127      | 30,064       |
| Total            | 475,237       | 434,631     | 909,868      |

A recently published report from icddr,b shared findings on socio-demographic profile of the Rohingya population in Bangladesh. The study collected data from 16,588 persons in 3,050 households living in 337 randomly selected sampling clusters in the camps. Table 3.2 shows key demographic characteristics of the population. The table also shows

## RESULTS

### Demographic and social profiles

As per United Nations High Commissioner for Refugees (UNHCR) population factsheet updated on 31<sup>st</sup> March 2019<sup>1</sup>, there was a total of 909,868 forcibly displaced Rohingya persons living in Bangladesh. Most of them were living in 34 camps and only 7,658 were reported to live outside the camp boundaries. Among the camps, Nayapara and Kutupalong are known as 'permanent' refugee camps, whereas the other camps are known as makeshift settlements. Table 3.1 presents a breakdown of these persons by gender and age. It is pertinent to mention that there were 49,393 more adult females than their adult male counterparts living in these camps.

that there was a high crude birth rate, low contraceptive prevalence rate among the Rohingya population. The icddr,b study also reported that 31.2 percent of Rohingya population did not have any formal education, 37.7 percent had some religious education and less than 1 percent had secondary or higher education.

Table 3.2: Key demographic characteristics of the Rohingya population living in Bangladesh

| <b>Demographic characteristics</b>                  | <b>Mean ± SD/Percentage</b> |
|---|-----------------------------|
| Mean household size                                 | 5.3 ± 2.25                  |
| Mean age at 1st marriage (years)                    | 16.8 ± 2.2                  |
| Mean age at first pregnancy (years)                 | 18 ± 2.4                    |
| Women of reproductive age (%)                       | 24.5                        |
| Crude Birth Rate                                    | 35.6/1000 population        |
| Prevalence of stillbirth                            | 18/1000 live births         |
| Pregnant women among total population (%)           | 2.3                         |
| Pregnant women among women of reproductive age (%)  | 10.1                        |
| Adolescent pregnancy of total pregnancies (%)       | 18.4                        |
| Pregnant among adolescent girls (%)                 | 5.4                         |
| Lactating women of total population (%)             | 6.0                         |
| Lactating women among women of reproductive age (%) | 26.4                        |
| Contraceptive prevalence rate (%)                   | 33.7                        |

Source: Demographic profiling and needs assessment MCH care for the Rohingya refugee population in Cox's Bazar, Bangladesh 2018.

# NUTRITION SITUATION

Since the latest influx in 2017-2018, three rounds of emergency nutrition and health assessment have been conducted in the Rohingya camps by Action Against Hunger (ACF) on behalf of the Nutrition Sector, in collaboration with the Government of Bangladesh, the United Nations High Commissioner for Refugees (UNHCR), the World Food Programme (WFP), the United Nations Children's Fund (UNICEF), Save the Children International (SCI), Swedish International Development Cooperation (SIDA) and the Center for Disease Control and Prevention (CDC). Data collection for the first, second and third round was carried out during October to November 2017, April to May 2018 and October to November 2018 respectively. During the 2nd and 3rd round, the researchers could not collect data from Kutupalong Camp (KC) due to a high rate of household level refusals. These assessments captured data only on women and child nutrition situation. Though there is a large number of adolescents, adult men and elderly women and men living in the camps, the nutrition status of these population groups is unavailable. The following paragraphs, therefore, highlights on the nutrition situation of only the women and children. The data are mostly from the Makeshift Settlements (MS) and the Nayapara Camp (NC) since information KC was largely unavailable.

## Women's nutrition

The emergency nutrition and health assessments

Table 3.3: Key nutrition indicators of 15-49 years old women living in MS and NC

| Indicators                      | Makeshift Settlements (MS) |                     |                     | Nayapara Camp (NC)  |                     |                     |
|---------------------------------|----------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|                                 | Round 1                    | Round 2             | Round 3             | Round 1             | Round 2             | Round 3             |
|                                 | %, (95% CI)                |                     |                     | %,(95% CI)          |                     |                     |
| 15-49 years women in the sample | 23.7<br>(23.0-24.5)        | 23.9<br>(22.8-25.0) | 23.2<br>(22.2-24.1) | 24.4<br>(22.9-25.9) | 25.1<br>(23.5-26.9) | 26.5<br>(25.0-28.1) |
| Pregnant women                  | 3.2<br>(2.7-3.6)           | 3.0<br>(2.5-3.6)    | 2.8*                | 2.2<br>(1.7-2.7)    | 2.3<br>(1.8-3.0)    | 2.1*                |
| Lactating women                 | 6.7<br>(6.2-7.2)           | 6.4<br>(5.7-7.1)    | 6.3*                | 4.9<br>(4.2-5.7)    | 4.8<br>(4.0-5.7)    | 4.6*                |
| Low MUAC (all)<br>[< 210mm]     | 8.7<br>(6.7-11.1)          | 2.6<br>(1.6-4.2)    | 3.0<br>(2.0-4.6)    | 3.5<br>(2.3-5.1)    | 2.4<br>(1.5-3.9)    | 1.3<br>(0.7-2.4)    |
| Low MUAC among PLW<br>[< 210mm] | 12.2<br>(8.6-17.1)         | 3.4<br>(1.2-7.8)    | 2.8<br>(1.0-7.3)    | 3.5<br>(1.3-8.9)    | 6.5<br>(2.9-13.9)   | 1.9<br>(0.5-6.7)    |
| Mean MUAC All                   | 247 mm<br>(±31.8)          | 254 mm<br>(±29.1)   | 256 mm<br>(±31.7)   | 257 mm<br>(± 34.6)  | 271 mm<br>(± 38.2)  | 271 mm<br>(± 35.3)  |

Source: Action Against Hunger. Emergency nutrition assessment final report cox's bazar, bangladesh 2017, april-may 2018 and october-november 2018

reported percentage of low Mid-Upper Arm Circumference (MUAC) among all 15 to 49 years old women and the pregnant and lactating Women (PLW) in all three rounds. In the third, prevalence of anemia among a subset of non-pregnant and non-lactating women was also reported.

Table 3.3 displays data on women's nutrition status. In the first, second and third round 23.7 percent, 23.9 percent and 23.2 percent of the respondents in the MS and 24.4 percent, 25.1 percent and 26.5 percent of the respondents in the NC were women in the 15-49 years age group. Percentage of pregnant women dropped in both MS and NC between Round 1 and Round 3 (from 3.2% to 2.8% in MS and from 2.2% to 2.1% in NC). In the MS, 8.7 percent women were with a low MUAC (<210 mm) in Round 1; the proportion became 2.6 percent in Round 2; and 3.0 percent in Round 3. Whereas, in the NC, the proportion of women with a low MUAC (<210 mm) was 3.5 percent in Round 1; 2.4 percent in Round 2; and 1.3 percent in Round 3. Among the pregnant and lactating women, proportion with low MUAC dropped from 12.2 percent to 2.8 percent in MS and from 3.5 percent to 1.9 percent in NC between Rounds 1 and 3. Between Rounds 1 and 3, the mean mid-upper arm circumference (MUAC) of 15 to 49 years old women increased from 247 mm to 256 mm in the MS. On the other hand, between Rounds 1 and 3, MUAC of 15 to 49 years old women increased from 257 mm to 271 mm in NC. A similar increase of MUAC was noticed among the PLW in both MS and NC.

| Indicators   | Makeshift Settlements (MS) |                    |                     | Nayapara Camp (NC) |                    |                     |
|--|----------------------------|--------------------|---------------------|--------------------|--------------------|---------------------|
|  | Round 1                    | Round 2            | Round 3             | Round 1            | Round 2            | Round 3             |
|  | %, (95% CI)                |                    |                     | %,(95% CI)         |                    |                     |
| Mean MUAC PLW  | 241 mm<br>(±28.0)          | 246 mm<br>(±25.5)  | 252 mm<br>(±30.1)   | 246 mm<br>(± 29.6) | 259 mm<br>(±35.2)  | 257 mm<br>(± 29.4)  |
| Anemia among a subset of non-pregnant and non-lactating women [Hb<12.0 g/dL] | Data not collected         | Data not collected | 22.6<br>(16.7-28.5) | Data not collected | Data not collected | 22.8<br>(18.2-28.2) |

\* 95% CI not reported

During Round 3, a sub-sample of non-pregnant and non-lactating women was assessed for hemoglobin status. The anemia prevalence was 22.6 percent (95% CI: 16.7%-28.5%, n=217) in the MS and 22.8 percent (95% CI: 18.0-28.2%, n=276) in the NC.

In the KC, in Round 1, 24.3 percent (95% CI: 22.6%-26.2%) women in the sample were in the 15-49 years age group, 2.0 percent (95% CI: 1.5%-2.7%) were pregnant, and 6.2 percent (95% CI: 5.2%-7.3%) were lactating. Among the 15-49 years old women, the prevalence of low MUAC (<210 mm) was 7.3 percent (95% CI: 5.2%-10.1%) and mean MUAC was 257 mm (± 36.4). The low MUAC among the PLW was 9.9 percent (6.2%-15.6%). As mentioned earlier, data from this camp was not available for Rounds 2 and 3<sup>2</sup>.

### Child nutrition

The aforementioned three rounds of emergency nutrition assessments also collected data on nutrition status of the children in the 6-59 months age group. The indicators included in these assessments were wasting, stunting, MUAC and anemia. Table 4 compares the status of different child nutrition indicators in Rounds 1, 2 and 3. The data from these assessments showed that between Rounds 1 and 3, global acute malnutrition and severe acute malnutrition (SAM) declined in both the MS and NC. Table 4 also presents data on stunting and anemia, which are also displayed in the subsequent sections using age disaggregated data.

Table 3.4: Wasting, stunting and anemia among 6-59 months old children in MS and NC

| Indicators                                      | Makeshift Settlements (MS) |                     |                     | Nayapara Camp (NC)  |                     |                     |
|---|----------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | Round 1                    | Round 2             | Round 3             | Round 1             | Round 2             | Round 3             |
|   | %, (95% CI)                |                     |                     | %,(95% CI)          |                     |                     |
| 0-59 months old children in the sample          | 20.3<br>(19.3-21.4)        | 20.2<br>(18.9-21.5) | 20.7<br>(19.2-22.2) | 15.0<br>(13.8-16.3) | 12.4<br>(11.2-13.8) | 12.8<br>(11.7-14.1) |
| Global acute malnutrition (WHZ <-2±edema)       | 19.3<br>(16.7-22.2)        | 12<br>(9.4-15.9)    | 11<br>(8.4-14.2)    | 14.3<br>(11.2-18.1) | 13.6<br>(10.1-18.1) | 12.1<br>(9.1-15.9)  |
| Severe acute malnutrition (WHZ <-3±edema)       | 3.0<br>(2.2-4.2)           | 2.0<br>(1.1-3.6)    | 1.1<br>(0.4-2.8)    | 1.3<br>(0.5-2.9)    | 1.4<br>(0.6-3.6)    | 0.9<br>(0.3-2.5)    |
| Global acute malnutrition (MUAC <125 mm ±edema) | 8.6<br>(6.8-10.7)          | 4.3<br>(3.2-5.9)    | 3.1<br>(1.9-5.0)    | 7.0<br>(4.9-9.9)    | 3.6<br>(2.0-6.5)    | 3.7<br>(2.2-6.2)    |
| Severe acute malnutrition (MUAC <115 mm ±edema) | 1.3<br>(0.8-2.1)           | 0.5<br>(0.2-1.6)    | 0<br>(0.0-0.0)      | 1.8<br>(0.9-3.6)    | 0.4<br>(0.1-2.0)    | 0.3<br>(0.1-1.6)    |

Source: Action Against Hunger. Emergency nutrition assessment final report cox's bazar, bangladesh 2017, april-may 2018 and october-november 2018

| Indicators                                  | Makeshift Settlements (MS) |                     |                     | Nayapara Camp (NC)  |                     |                     |
|---|----------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | Round 1                    | Round 2             | Round 3             | Round 1             | Round 2             | Round 3             |
|   | %, (95% CI)                |                     |                     | %,(95% CI)          |                     |                     |
| Global chronic malnutrition (HAZ<-2 ±edema) | 44.1<br>(40.7-47.5)        | 37.7<br>(33.0-42.5) | 26.9<br>(22.4-31.9) | 44.4<br>(39.5-49.3) | 40.4<br>(34.7-46.3) | 38.3<br>(33.4-43.5) |
| Severe chronic malnutrition (HAZ<-3 ±edema) | 12<br>(10.1-14.3)          | 7.9<br>(5.8-10.8)   | 5.9<br>(4.0-8.5)    | 12.5<br>(9.6-16.1)  | 7.6<br>(5.0-11.4)   | 8.1<br>(5.6-11.4)   |
| Any anemia (Hb <11.0 g/dL)                  | 47.9<br>(44.1-51.7)        | 32.3<br>(27.8-37.1) | 39.8<br>(34.1-45.4) | 46.6<br>(41.8-51.5) | 29.4<br>(24.3-35.0) | 38.1<br>(33.2-43.3) |
| Mild anemia (Hb10.0 to <11.0 g/dL)          | 30.8<br>(27.7-34.0)        | 19.6<br>(16.7-22.8) | 21.5<br>(18.4-24.7) | 31.1<br>(26.7-35.8) | 18.6<br>(14.5-23.7) | 19.5<br>(15.7-24.0) |
| Moderate anemia(Hb 7.0 to <10.0 g/dL)       | 16.9<br>(14.5-19.7)        | 12.5<br>(9.8-15.9)  | 18.1<br>(13.5-22.6) | 15.5<br>(12.3-19.4) | 10.4<br>(7.3-14.6)  | 18.1<br>(14.4-22.4) |
| Severe anemia (Hb<7.0 g/dL)                 | 0.2<br>(0.1-0.7)           | 0.2<br>(0.1-1.2)    | 0.2<br>(0.0-0.5)    | -                   | 0.4<br>(0.1-2.5)    | 0.5<br>(0.2-2.1)    |

Though KC was not included in the Rounds 2 and 3 assessments mentioned above, the child nutrition situation in the camp was available from an article published by Leidman et al. The data analyzed for the paper was collected in October 2017. According to the paper, among the children registered in the camp, the prevalence of global acute malnutrition (WHZ <-2±edema) was 21.8 percent (95% CI: 15.9-29.1), severe acute malnutrition (WHZ <-3±edema) was 8.2 percent (95% CI: 4.7-13.7), global acute malnutrition (MUAC <125 mm ±edema) was 6.1 percent (95% CI: 3.2-11.2), severe acute malnutrition (MUAC <115 mm ±edema) was 0 percent, and global chronic malnutrition (HAZ<-2) was 40.1 percent (95% CI: 32.6-48.2). The authors of the paper also reported prevalence of anemia and minimum dietary diversity

which were 44.2 percent (95% CI: 36.4-52.3) and 14.8 percent (95% CI: 7.7-26.6) respectively<sup>2</sup>.

Figure 3.1 displays data on prevalence of stunting by age group in the MS. As presented in Table 4, between Rounds 1 and 3, there was a decrease in the prevalence of stunting in all age groups. However, a gradual declining trend in all the 3 rounds was noticed in four age groups (18-23 months, 24-29 months, 36-41 months and 48-53 months). In Round 1, the highest prevalence of stunting was noticed in 24-29 months age group. However, in Round 3, the prevalence of stunting was the highest in 18-23 months age group. Between Rounds 1 and 3, the highest absolute decline in the prevalence of stunting was noticed in the 36-41 months old group.

Figure 3.1: Prevalence of stunting by age in makeshift settlements

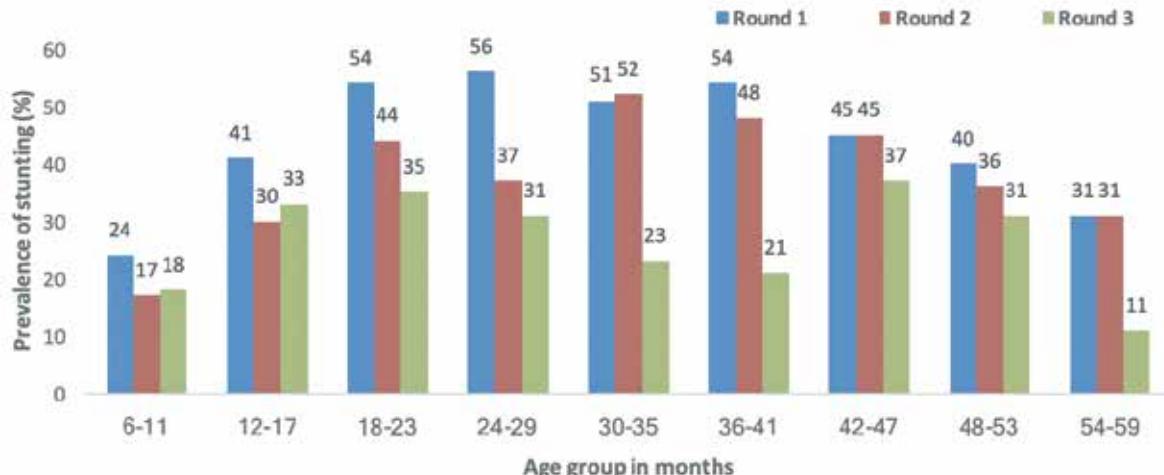


Figure 3.2 displays data on prevalence of stunting by age group in the NC. A gradual declining trend continued in all the three rounds in two age groups only (6-11 months, 36-41 months). On the other hand, in the other two age groups (30-35 months and 54-54 months), the prevalence of stunting increased

gradually. In Round 1, the highest rate of stunting was noticed in 18-23 months age group. However, in Round 3, the prevalence of stunting was the highest in 54-59 months age group. Between Rounds 1 and 3, the highest absolute decline in the prevalence of stunting was noticed in the 18-23 months old group.

Figure 3.2: Prevalence of stunting by age in Nayapara camp

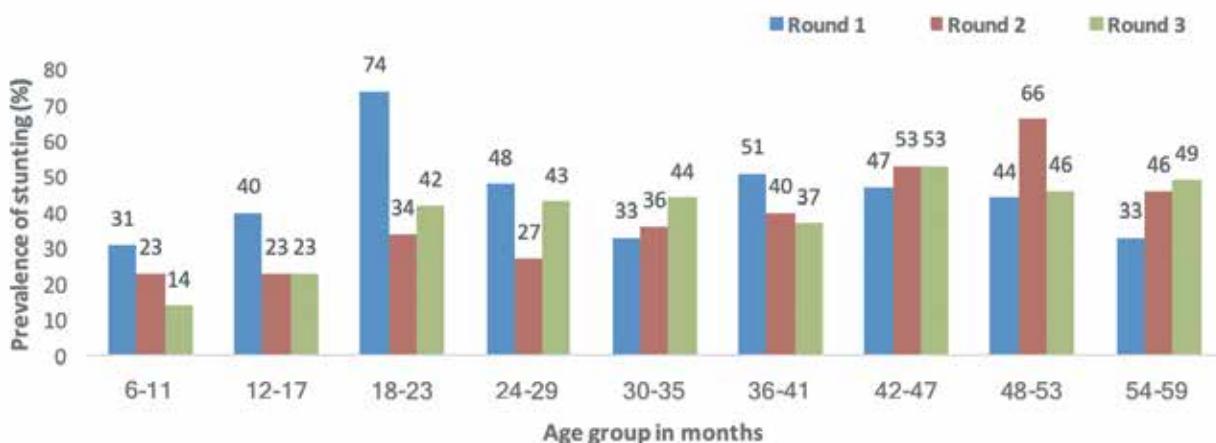


Figure 3.3 represents age-disaggregated data on anemia in MS. Though data in Table 4 showed a decline between Rounds 1 and 3, this decline was not obvious in all the age groups. Moreover, between Rounds 2 and 3, there was a significant increase in the prevalence of anemia in the MS. The data also

revealed that except the children in 12-17 months age group, prevalence of anemia increased in all age groups between Rounds 2 and 3. Between Rounds 1 and 3, the highest absolute decrease in the prevalence of anemia was noticed in the 36-41 months old group.

Figure 3.3: Prevalence of any anemia by age in makeshift settlements

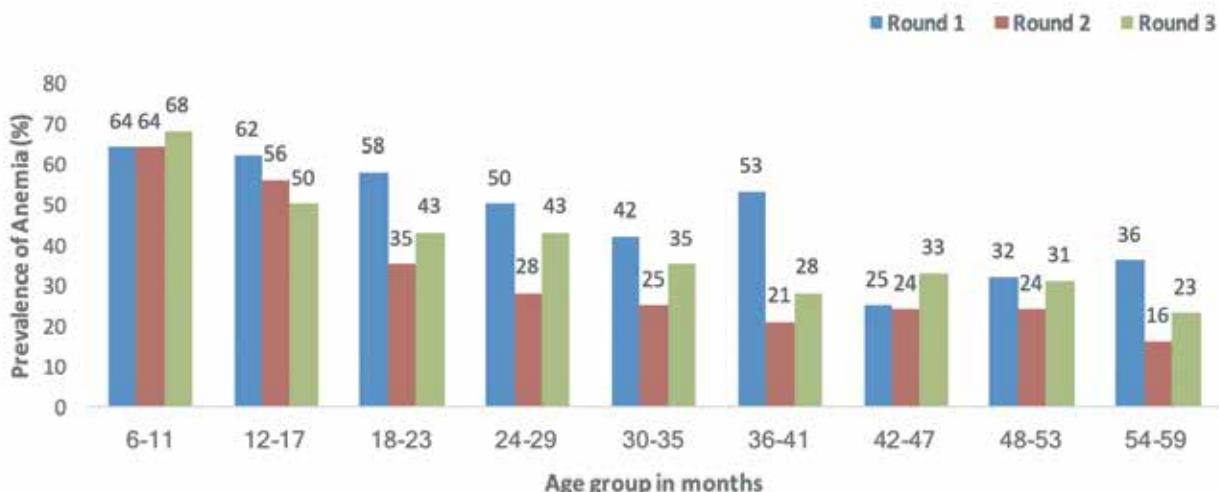
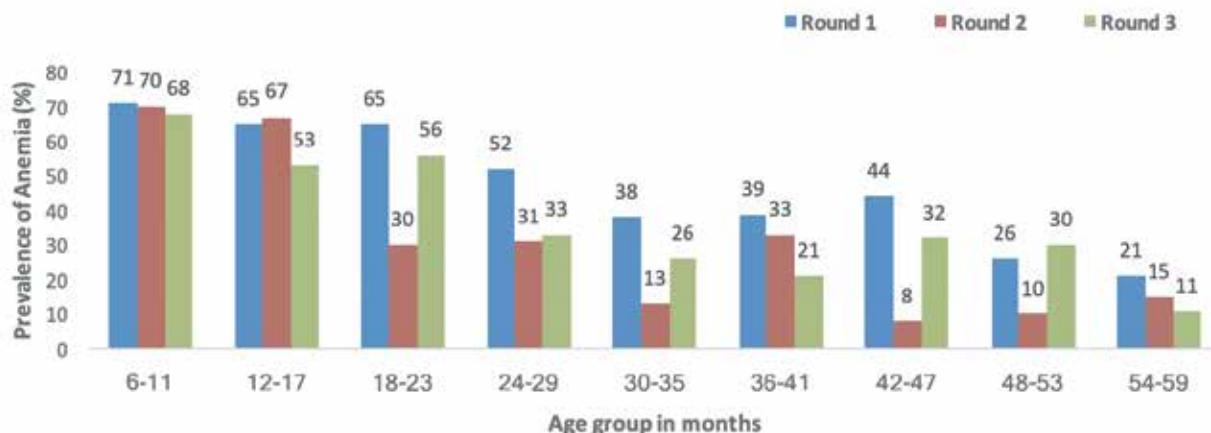


Figure 3.4 represents age-disaggregated data on anemia in NC. Overall, between Rounds 2 and 3, there was a significant increase in the prevalence of anemia in NC. Data from NC revealed there was a gradual decline in the prevalence of anemia in three age

groups (6-11 months, 36-41 months, 54-59 months). Between Rounds 2 and 3, the absolute increase in the prevalence of anemia was the highest in 18-23 months age group.

Figure 3.4: Prevalence of anemia by age in Nayapara camp



Malnutrition and infection create a vicious cycle. It is also evident from the data from Rounds 1, 2 and 3. Table 3.5 presents data on infectious morbidity of the children. The prevalence of infectious morbidity was

higher in both MS and NC during the Round 1. However, between Rounds 2 and 3, there was no significant improvement in the rate of infectious morbidity except the prevalence Diphtheria in the MS.

Table 3.5: Infectious morbidity among 6-59 months old children living in MS and NC

| Indicators                           | Makeshift Settlements (MS) |                     |                     | Nayapara Camp (NC)  |                     |                     |
|--------------------------------------|----------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|                                      | Round 1                    | Round 2             | Round 3             | Round 1             | Round 2             | Round 3             |
|                                      | %, (95% CI)                |                     |                     | %,(95% CI)          |                     |                     |
| Diarrhea                             | 41.3<br>(36.5-46.2)        | 20.9<br>(17.4-24.8) | 28.4<br>(24.5-32.4) | 34.3<br>(29.9-39.1) | 23.9<br>(19.3-29.3) | 25.2<br>(20.0-30.0) |
| Acute respiratory illness with fever | 57.7<br>(52.8-62.4)        | 26.1<br>(21.1-32.0) | 10.9<br>(7.1-14.6)  | 50.3<br>(45.4-55.1) | 21.5<br>(17.1-26.7) | 9.5<br>(6.9-13.0)   |
| Fever with cough                     | Data not available         | 40<br>(34.6-46.0)   | 38<br>(33.0-43.0)   | Data not available  | 40.5<br>(34.9-46.3) | 33.6<br>(28.9-38.7) |
| Fever with rash (suspected Measles)  | Data not available         | 13.9<br>(10.7-17.7) | 12.8<br>(9.8-15.7)  | Data not available  | 11.6<br>(8.4-15.9)  | 10.9<br>(8.1-15.6)  |
| Prevalence of Diphtheria*            | Data not available         | 6.2<br>(3.7-10.3)   | 2.6<br>(0.7-4.0)    | Data not available  | 0.4<br>(0.1-2.5)    | 0.0<br>(0.0-0.0)    |

Information on infant and young child feeding (IYCF) indicators were reported in Rounds 1 and 2 but not in Round 3. As shown in Table 6, the changes in these indicators were mixed with better improvement in NC

than in MS. Among all the changes, there was a significant improvement in timely initiation of breastfeeding in both MS and NC, and minimum dietary diversity and minimum acceptable diet only in NC.

Table 3.6: IYCF practices among 6-59 months old children living in MS and NC

| IYCF Indicators  | Makeshift Settlements (MS) |                      | Nayapara Camp (NC)   |                      |
|--|----------------------------|----------------------|----------------------|----------------------|
|  | Round 1                    | Round 2              | Round 1              | Round 2              |
|  | %, (95% CI)                |                      | %,(95% CI)           |                      |
| Ever breastfed (Infants 0-23 months)                               | 98.6<br>(97.2-99.3)        | 96.6<br>(93.4-98.3)  | 97.7<br>(94.0-99.1)  | 100<br>(-)           |
| Timely initiation of breastfeeding (Infants 0-23 months)           | 42.9*<br>(35.7-50.3)       | 55.5*<br>(48.3-62.4) | 48.5*<br>(41.1-56.1) | 76.0*<br>(67.7-82.7) |
| Exclusive breastfeeding (Infants 0-5 months)                       | 56.1<br>(45.2-66.3)        | 50.0<br>(34.4-65.6)  | 72.2<br>(58.6-82.7)  | 73.5<br>(56.1-85.8)  |
| Continuation breastfeeding at one year (Children 12-15 months)     | 97.1<br>(89.3-99.3)        | 97.3<br>(83.8-99.6)  | 96.4<br>(77.3-99.5)  | 100.0<br>(-)         |
| Continuation of breastfeeding at two years (Children 20-23 months) | 71.1<br>(54.8-83.3)        | 62.5<br>(44.7-77.5)  | 66.7<br>(43.8-83.7)  | 64.0<br>(43.2-80.6)  |
| Introduction of complementary Foods (Infants 6-8 months)           | 71.6<br>(57.3-82.7)        | 85.3<br>(67.8-94.1)  | 94.7<br>(68.4-99.3)  | 81.3<br>(53.6-94.2)  |
| Minimum dietary diversity (Children 6-23 months)                   | 8.3<br>(5.2-13.0)          | 12.6<br>(8.4-18.3)   | 15.7*<br>(10.2-23.4) | 37.4*<br>(28.0-47.8) |
| Minimum meal frequency (Children 6-23 months)                      | 61.2<br>(54.6-67.4)        | 57.5<br>(48.5-66.0)  | 65.3<br>(56.3-73.3)  | 61.5<br>(51.1-71.0)  |
| Minimum acceptable diet (Children 6-23 months)                     | 6.4<br>(3.8-10.4)          | 7.3<br>(4.1-12.4)    | 15.7*<br>(10.2-23.4) | 29.7*<br>(21.1-39.9) |

### Interventions to improve nutrition

Since the publication of the Lancet series on maternal and child nutrition in 2013, nutrition interventions are broadly classified as nutrition specific and nutrition sensitive. Nutrition specific interventions address the immediate determinants of malnutrition and promotes

good health and reduction of disease risk for both mothers and their children. Nutrition sensitive interventions address the underlying and systemic determinants of malnutrition. A list of the nutrition specific and nutrition sensitive interventions are given in the Table 3.7.

Table 3.7: Nutrition specific and sensitive interventions

| Nutrition-specific interventions   | Nutrition-sensitive interventions   |
|--|---|
| <p><b>Maternal nutrition specific interventions</b></p> <ul style="list-style-type: none"> <li>• Peri-conceptional and postpartum iron folic acid supplementation</li> <li>• Maternal multiple micronutrient supplementation</li> <li>• Maternal balanced energy protein supplementation</li> <li>• Maternal calcium supplementation</li> </ul> <p><b>Child nutrition specific interventions</b></p> <ul style="list-style-type: none"> <li>• Management of severe acute malnutrition (SAM)</li> <li>• Management of moderate acute malnutrition (MAM)</li> <li>• Preventive zinc supplementation</li> <li>• Promotion of breastfeeding</li> <li>• Appropriate complementary feeding</li> <li>• Vitamin A supplementation</li> </ul> <p><b>Adolescent specific interventions</b></p> <ul style="list-style-type: none"> <li>• Iron folic acid supplementation</li> </ul> | <p><b>Nutrition-sensitive interventions</b></p> <ul style="list-style-type: none"> <li>• Family planning: healthy timing and spacing of pregnancy</li> <li>• Water, sanitation, and hygiene (WASH)</li> <li>• Nutrition-sensitive agriculture</li> <li>• Food safety and food processing</li> <li>• Girls' and women's education</li> <li>• Economic strengthening</li> <li>• Livelihoods</li> <li>• Social protection</li> </ul> |

Source: Adapted from USAID Multi-sectoral nutrition strategy monitoring and learning plan

This article will describe the availability and actors for the nutrition specific interventions in the following section of this article.

### Maternal nutrition specific interventions

Available maternal nutrition interventions in the camps include blanket supplementary feeding program for pregnant and lactating women, treatment of PLW with acute malnutrition, and Iron and Folic Acid (IFA) distribution among PLW. As per the report from the nutrition sector covering up to 7 January 2019, a total 6,188 PLW identified as suffering from moderate acute malnutrition (MAM) and admitted to outpatient settings for treatment; 55,830 PLW were admitted to blanket supplementary feeding program (BSFP); and 67,969 PLW received IFA supplementation. Some of the maternal nutrition interventions IFA and calcium distribution the PLW are integrated within the health sector programs through the maternal child health service delivery platforms.

### Child and adolescent nutrition specific interventions

Interventions for addressing childhood malnutrition includes screening and identification of malnourished children at the household level and referral to the treatment centers, treatment of severely malnourished children without complications at the community level outpatient therapeutic treatment centers or OTPs, treatment of severely malnourished children with complications at in-patient stabilization centers (SCs), treatment of moderately malnourished children at targeted supplementary feeding programmes or TSFPs, and identification and treatment of malnourished less than 6 months infants through Community Management of Acute Malnutrition for Infants or CMAMI program. Table 8 summarizes the available malnutrition intervention programs for under 5 children in the MS, NC and KC along with the implementing partners. Table 3.9 below summarizes the key activities from these centers or program components. .

Table 3.8: Interventions for malnutrition among under five children and pregnant lactating women with implementing partners

| Nutrition activity   | Makeshift Settlements (MS) | Nayapara Refugee Camp (NC) | Kutupalong Refugee Camp (KC) | Total | Implementing Organizations <sup>a</sup>  |
|--|----------------------------|----------------------------|------------------------------|-------|--|
| Stabilization centres (SCs),   | 3                          | 1                          | 1                            | 5     | MSF, IOM, ACF                            |
| Outpatient therapeutic programmes (OTPs) including screening and referral              | 55                         | 1                          | 1                            | 57    | SHED, SARPV, TDH, BRAC, ACF, CWW, SCI,   |
| Targeted supplementary feeding programmes (TSFPs)                                      | 31                         | 2                          | 2                            | 35    | SHED, SARPV, BRAC, ACF, SCI, WVI, WC, GK |
| Blanket supplementary feeding programmes (BSFPs)                                       | 31                         | 2                          | 2                            | 35    | SHED, SARPV, BRAC, ACF, SCI, WVI, WC, GK |
| Community Management of Acute Malnutrition for Infants (CMAMI) aged less than 6 months | 6                          | -                          | -                            | 6     | SCI                                      |

Source: Nutrition Sector facility database

As of 7 January 2019, the nutrition sector reported that a total 32,082 children aged 0-59 months were identified with SAM through screening programs and admitted to nutrition programs for therapeutic treatment; 37,546 children aged 6-59 months were identified with moderate acute malnutrition (MAM)

and admitted to targeted supplementary feeding programs for treatment; and 198,997 children aged 6-59 months admitted to blanket supplementary feeding programs. The nutrition sector also reported that no breast-milk substitute violations were reported.

Table 3.9: Key activities by centers or program components

| Nutrition Centre                                  | Key activity   |
|---|--|
| Stabilization centres (SCs)                       | <ul style="list-style-type: none"> <li>In-patient treatment of acute malnutrition with medical complications</li> <li>Enrolls 6-59 months old children with SAM and with medical complications, children with WHZ/WLZ &lt;-3Z Score, infants not gaining weight after serial measurements, too weak to suckle</li> </ul>   |
| Outpatient therapeutic programmes (OTPs)          | <ul style="list-style-type: none"> <li>Outpatient treatment of Severe Acute Malnutrition (SAM)</li> <li>Enroll 6-59 months old children with SAM without medical complications</li> </ul>  |
| Targeted supplementary feeding programmes (TSFPs) | <ul style="list-style-type: none"> <li>Outpatient treatment of moderate acute malnutrition (MAM)</li> <li>Enroll 6-59 months old children with MAM.</li> <li>Provide ration or RUSF with key messages,</li> <li>Bi weekly follow-up of MUAC, weight, height/length</li> <li>Refer to the health care providers Vitamin A supplementation, deworming and Iron/folate and measles vaccine</li> </ul> |
| Blanket supplementary feeding programmes (BSFPs)  | <ul style="list-style-type: none"> <li>Prevention of acute malnutrition</li> <li>Enrolls all children 6 to 59 months, pregnant and lactating women and chronically ill patients such as with TB, HIV, cancer</li> <li>Provide food supplement to all children under 5 years and all pregnant and lactating women.</li> </ul>   |

Infant and Young Child Feeding in Emergencies (IYCF-E) support, deworming and immunization campaigns, and micronutrient supplementation interventions are also implemented in these camps. SCI provides technical assistance to the IYCF-E programming led by UNICEF. As of 7 January 2019, nutrition sector reported that a total of 225,886 counselling sessions on complementary feeding of infants and young children and promotion of breastfeeding were carried out with the lactating women.

Nutrition sector also reported that as of 7 January 2019, 45,150 adolescent girls received Iron and Folic Acid supplementation from different agencies.

### Coverage of the maternal and child nutrition interventions

The Round 2 and Round 3 emergency nutrition assessments reported key program coverage in the MS and NC. Due to unavailability of data for the same indicators in both round 2 and round 3, it is impossible to make comments on the progress made with respect to coverage. However, there was a significant improvement with respect to the proportion of children received at least 1 sachet of micronutrient powder (MNP) in both MS and NC. Moreover, the coverage of most of the interventions was higher in NC than in NS (Table 3.10).

Table 3.10: Coverage of some key Nutrition specific interventions in the MS and NC

| Indicators  | Makeshift Settlements (MS) |              | Nayapara Camp (NC) |              |
|---|----------------------------|--------------|--------------------|--------------|
|   | Round 2                    | Round 3      | Round 2            | Round 3      |
| Proportion of children enrolled in an OTP                                       | 9.4%                       | Not reported | 2.5%               | Not reported |
| Proportion of children overall enrolled in a TSFP or BSFP                       | 49.8%                      | Not reported | 82.8%              | Not reported |
| Proportion of children identified as SAM (WHZ or MUAC) enrolled in an OTP       | 23.1%                      | Not reported | 40.0%              | Not reported |
| Proportion of children identified as MAM (WHZ or MUAC) enrolled in TSFP or BSFP | 53.4%                      | Not reported | 77.5%              | Not reported |
| Proportion of children that received at least 1 sachet of MNP                   | 29.9%                      | 58.7%*       | 58.5%              | 83.8%*       |

| Indicators  | Makeshift Settlements (MS) |         | Nayapara Camp (NC) |         |
|---|----------------------------|---------|--------------------|---------|
|   | Round 2                    | Round 3 | Round 2            | Round 3 |
|   |                            |         |                    |         |
| Proportion of children that received Vitamin A in past 6 months | Not available              | 92.1%   | Not available      | 93.6%   |
| Proportion of pregnant women enrolled in ANC program            | Not available              | 53.9%   | Not available      | 80.0%   |
| Proportion of pregnant women currently receiving IFA tablets    | Not available              | 47.1%   | Not available      | 76.9%   |

### Food assistance

Food assistance to the camps is mostly supported by the World Food Programme (WFP) either as General Food Distribution (GFD) or e-voucher program. OXFAM also covers a small population with GFD program. International Federation of Red Cross (IFRC) provides

dry food assistance in some areas. Turkish Cooperation and Coordination Agency (TIKA) and ACF provide cooked meal to households not otherwise covered. Table 3.11 lists different food assistance program with implementing partners.

Table 3.11: Coverage of different types of food assistance in the MS and NC

| Type of food assistance         | Composition  | Agencies     |
|---------------------------------|--|--------------|
| General Food Distribution (GFD) | Rice, pulses and vegetable oil                     | WFP, OXFAM   |
| E-voucher programme             | E-voucher to purchase food from a list of 18 items | WFP          |
| Dry food assistance             | Rice, lentils, oil, chickpeas, sugar, and salt     | IFRC         |
| Cooked meals                    | NA   | ACF and TIKA |

Table 3.12 below shows the coverage of food assistance in the MS and NC as reported in round 3.

Coverage of food assistance was found to be almost universal.

Table 3.12: Coverage of different types of food assistance program in the MS and NC

| Indicators  | Makeshift Settlements (MS) | Nayapara Refugee Camp (NC) |
|---|----------------------------|----------------------------|
| Proportion of households with a general food distribution (GFD) ration card and/or e-voucher card | 94.9%<br>(89.8-100)        | 98.2%<br>(96.7-99.0)       |
| Proportion of households with a GFD ration card   | 77.3%<br>(66.5-88.0)       | 1.4%<br>(0.7-2.8)          |
| Proportion of households with a e-voucher (SCOPE) card for food rations                           | 18.5%<br>(8.7-28.3)        | 96.8%<br>(94.9-97.9)       |

## RESOURCES TO ADDRESS MALNUTRITION

The United Nations agencies and the international and national NGOs responded immediately after the influx that started in August 2017. The partners who had pre-existing programs in the area before the influx (ACF, Society for Environment and Human Development and SARPV) mobilized their staff and

other resources immediately to support. UNICEF, WFP and UNHCR quickly engaged international and national NGOs to implement the life-saving nutrition programs. By November 2017, the nutrition sector had received 70 percent of the funding needed, but, considering the volume of the influx, the capacity of the partners to respond was a major concern. In 2018, a funding requirement was identified by the nutrition sector by priority activities (Table 3.13)<sup>8</sup>.

Table 3.13: Nutrition sector funding needs by priority activities for 2018

| <b>Priority Activities</b>   | <b>Funding required (USD)</b> | <b>Number of affected children</b>           |
|--|-------------------------------|--|
| Provide life-saving interventions to treat SAM among children under-5 and other vulnerable groups through Stabilization Centers (SCs) and Out Patient Therapeutic care Programs (OTPs) | 21.8 million                  | 24,004 children under 5 years with SAM       |
| Provide life-saving interventions to treat MAM among children under-5, PLWs and other vulnerable groups through Targeted Supplementary Feeding programs (TSFPs)                        | 11.3 million                  | 70,981 children under 5 years with MAM       |
| Strengthen malnutrition prevention interventions (IYCF plus MNP and BSFP)  | 23.5 million                  | 95,008 children under 5 years and 58,794 PLW |

Source: Intersectoral coordination group. One Year On: Urgent Funding Priorities - Cox's Bazar Rohingya Refugee Crisis 2018 - Bangladesh

Though the funding pledge was for a total USD 56.6 million in 2018, USD 37.1 million was received by different agencies (65%)<sup>4</sup>. Table 3.14 lists major donors with funding for nutrition in 2018.

Table 3.14: Major funding for nutrition in 2018 by source

| <b>Organization/Country/Private</b>                    | <b>Amount in USD</b> |
|--|----------------------|
| World Food Program*                                    | 13,149,989           |
| UNICEF   | 9,172,697            |
| Central Emergency Response Fund                        | 5,500,008            |
| Government of Japan                                    | 2,915,905            |
| Government of United Arab Emirates                     | 1,869,159            |
| European Commission, European Countries                | 1,600,204            |
| Government of United States of America fund for UNICEF | 963,995              |
| Government of Canada**                                 | 590,681              |
| Frontiers, Ruwad Association*                          | 429,448              |
| United Kingdom   | 414,096              |
| World Vision International                             | 353,232              |
| Private (individuals & organizations)                  | 54,807               |
| Others   | 62,474               |
| Total  | 37,076,695           |

\*For Food Security and Nutrition; \*\*For WASH and Nutrition

Source: UNOCHA. Bangladesh: 2019 Joint Response Plan for Rohingya Humanitarian Crisis

For 2019, the nutrition sector identified the objectives and priority activities and estimated a funding requirement of 48 million USD<sup>6</sup>. The nutrition sector had targeted a total of 347,590 people including 44,254 Bangladeshi host community people. Unfortunately, by 11th May 2019, the nutrition sector secured only USD 413,000, which was less than one percent of the total requirement<sup>5</sup>.

### Funds mobilization and government approval

Majority of funding for nutrition activities came through the UN agencies requiring no approval from the NGO Affairs Bureau in Bangladesh. Some international and national NGOs also raised independent funding, and required approval from the NGO Affairs Bureau. Initially, the Bureau had been

providing 3 months approval through FD7, but later started providing approval for 6 months. The process, is sometime time consuming, and can hamper emergency health and nutrition activities. As a result, the approval system was further relaxed and approval for long term funding is now possible.

### Human resources

In-country capacity to respond with quality emergency nutrition programming was limited and partners with pre-existing programs (ACF, SHED and SARPV) before the recent influx lost many of their staff to other UN agencies and NGOs. The UN agencies, the international and national NGOs were competing with each other to attract and retain trained staff. This competition resulted in unusual pay hike and thereby

raised the overall implementation cost. The humanitarian response attracted both recent nutrition graduates and professionals from all over the country and also from abroad. However, most of the staff employed had no training or experience to deliver nutrition program in a humanitarian context. Appropriate training and on the job support is crucial to achieve quality in nutrition programming.

## COORDINATION, REPORTING, ACCOUNTABILITY

### Coordination

The Nutrition Sector in Cox's Bazar is jointly led by UNICEF and the office of the Civil Surgeon or a representative of the Institute of Public Health Nutrition (IPHN), National Nutrition Services (NNS), under the Ministry of Health and Family Welfare (MOHFW). The Nutrition Sector in Cox's Bazar coordinates joint assessments, capacity development, planning and implementation of nutrition services by different humanitarian actors based on an agreed Terms of Reference<sup>7</sup> that clarifies the overall engagement of this collective partnership with clear role and responsibility between the sector coordination team, the partners and the government. UNICEF, the nutrition sector lead agency, also provides Information management support and ensures sufficient support to monitoring and reporting requirements to fulfill the sectoral obligations. A Strategic Advisory Group (SAG) was also established to provide strategic advice and vision for the entire response, ensure adherence to the sector Strategic Response Plan (SRP) and facilitate review of sector performance and progress against the agreed objectives.

Different Technical Working Groups (TWGs) had been established for Community based Management of Acute Malnutrition (CMAM), IYCF-E and assessment. These TWGs are translating national guideline into practice and supporting the adaptation of national and international guidance for use in Cox's Bazar. Programs for treatment of acute malnutrition among 6 to 59 months old children is guided by the CMAM and facility based in-patient management of SAM guidelines developed at the national level. A Supply Task Force (STF) has also been established to streamline supply needs, establish coordination for

the various pipelines and agree on the supply related standards for the sector.

The frequency of nutrition sector meeting has been reduced from every week to every alternative week as the response to the situation became stable. High turnover of coordination staff both for the sector and for the partners caused loss of institutional memory affecting the coordination.

### Reporting flow of information

All implementing partners report back to the nutrition sector every week using standardized reporting tools. The reports are then analyzed and made available for monitoring the progress. This reporting is additional to the reporting required from the NGOs to meet the contractual requirement of the funding organizations. A process to develop a web based reporting system has also been initiated. The sector also reports to the Inter Sector Coordination Group (ISCG) every fortnight. Steps have been taken to include the nutrition information into the Health Information System (DHIS 2) of Bangladesh.

The sector has standardized different reporting tools working through different TWGs. The standardized tools, guidelines, training modules and other relevant documents can be accessed in the Google drive maintained by the sector using the link below: [https://drive.google.com/drive/folders/1ck-gNR2N3fJ3kGkgta\\_8FnTYy6nEchEt](https://drive.google.com/drive/folders/1ck-gNR2N3fJ3kGkgta_8FnTYy6nEchEt)

### Accountability mechanism

The agencies implementing the nutrition interventions are responsible to the Refugee Relief and Repatriation Commission (RRRC) for ensuring satisfactory functioning of the sector. Each Nutrition sector member needs to adhere to internationally accepted code of ethics, such as humanity, neutrality, impartiality, independence and humanitarian core standards. The sector members also agreed to ensure they remain accountable, transparent in their operations and adhere to the agreements, decisions and commitments agreed to within the nutrition sector. Each sector member is also committed to ensure effective cooperation and collaboration, and not compete or negatively affect other partners in order to achieve the maximum humanitarian impact and relieve the sufferings of the Rohingya and affected host communities. Moreover, the Nutrition Sector also upholds the principles of Accountability to Affected Populations<sup>8</sup>, and Protection from Sexual Exploitation and Abuse (AAP/PSEA).

## Lessons learnt

The nutrition sector achieved a lot during the latest influx of Rohingya community. The nutrition sector could establish various facilities to provide essential nutrition services to all Rohingya and host communities (HC). In November 2017, a rapid assessment exercise using tools developed by the CMAM TWG of the Sector, facilitated early organization of the nutrition services that minimized duplication and maximized coverage. In addition, different nutrition services were integrated with health facilities.

The nutrition sector felt the need to harmonize the reporting tools. Accordingly, most reporting tools were standardized across different partners. Standardized tools to support nutrition services have been developed and are now used by all partners. The nutrition sector also felt that services to treat moderate and acute malnutrition as well as prevention of malnutrition should be given emphasis. Therefore, in addition to the screening and treatment of acute malnutrition, activities to prevent micronutrient deficiencies, anemia and promote dietary diversification were implemented by the nutrition sector partners. Nutrition campaigns such as the Nutrition Action Week was successfully implemented in 2017 and 2018 by the sectoral partners.

The quality of nutrition services provided by the sector was also deemed important. Accordingly, CMAM and IYCF capacity building activities were undertaken to enhance the quality of nutrition services and address human resource challenge. The monsoon season posed new challenges to the sector. Therefore, an Emergency Preparedness & Response Plan was implemented which mitigated the impact of monsoon season to a certain extent.

For a better coordination, regular coordination meetings were conducted by the nutrition sector TWG and SAG. In order to monitor the progress a functional monitoring and reporting system was necessary. Therefore, a functioning data collection and reporting system was established for all sector partners and it is used to check the validity and quality of data. This system is now able to make recommendations and decisions for the individual sector partners in order to improve the delivery of the programs. Moreover, the sector did a commendable job by carrying out regular surveys and assessments to provide evidence for planning and guidance of nutrition services.

## CHALLENGES AND GAPS

Despite a well-coordinated nutrition program run by the nutrition sector, the sector faced a number of challenges. The Nutrition Sector remained underfunded in 2018 (65% of the required fund was raised). In 2019, only 1 percent of the funding identified in the joint response plan (JRP) was mobilized by the time of data collection for this research (May 2019). The efforts of the partners to access non-JRP funding may not compensate for this massive shortfalls in future. Availability of appropriate human resource to deliver quality nutrition programs still remains a huge challenge. High staff turnover makes it difficult to recruit, train and maintain a skilled workforce. Due to uneven competition with the international NGOs and UN organizations, the local NGOs struggle to retain trained staffs and volunteers. There are still significant gaps in terms of skills and training among the large number of volunteers and staff used by nutrition sector partners.

Referral and follow up between different nutrition facilities such as OTPs, TSFPs, BSFPs and SCs need further improvement. Restructuring of the nutrition facilities is needed to improve coordination and thereby increase effectiveness of nutrition interventions. However, space constraints imposes great challenge to such a restructuring. Proper demarcation of catchment areas and effective communication and referral between facilities and services are required for further improvement of the delivery of nutrition services.

Service integration with other sectors has been tried but still needs improvement. Coordination and cooperation with other sectors and at camp level remained as a challenge. Prevention of malnutrition intervention is still not strong or effective enough compared to efforts and investments into the treatment. There is a room for improving the behavior change communication for IYCF, breast-feeding, dietary diversity, etc.

Poor utilization of the Stabilization Centers (SCs) due to low acceptance of overnight stay by the community is resulting in a lower number of SAM children with medical complications being treated properly. Support for non-breastfed children is a problem due to lack of a clear national policy. Moreover, some vulnerable groups (people with disabilities, elderly, malnourished adolescents and adults) are not covered by the nutrition sector and the current nutrition assessments do not include nutritional assessment of adolescents, adult men and elderly population. Moreover, there is

need to provide nutrition services not only for the women and children but also for other population groups including adolescents, adult men and elderly population.

## SUSTAINING THE OPERATIONS

Though there was a massive influx in 2017-2018 and the incoming Rohingya population suffered from acute and chronic malnutrition, there has been remarkable improvement in the nutrition situation among the Rohingya population. Further improvement of the nutrition situation as well as sustenance of the achievements will need coordinated effort from the different actors. There is a need for overcoming the shortfalls with respect to financial and human resources. Moreover, the host community is not adequately reached through current nutrition programming and this can increase tension between the Rohingya population and the host community and thereby threatens the overall response. The Nutrition sector is thus encouraging specific programming targeted towards host community. Integration of host community in the nutrition programming is an immediate requirement. In the intermediate and longer term, the sector needs a continuous flow of financial resources to support and improve the existing operations, expand the operations in other population groups and a plan to develop skilled human resources. In the long-term, it may not be possible for the government of Bangladesh and other agencies to support such a huge population. Therefore, a coordinated effort between the Government of Bangladesh and the Government of Myanmar is required for repatriation of this forcibly displaced community to their own country.

## CONCLUSION AND RECOMMENDATIONS

### Conclusion

In conclusion it can be inferred that the level of education among the Rohingya population is very poor, although over a third of them have some religious education. The proportion of population with secondary or higher education is only 1 percent. The crude birth rate among the camp residents is very high in comparison with Bangladeshi population. The crude birth rate among the Rohingya population is

35.6/1000 population, compared to 22 in Bangladesh.

Nutrition status data is available only for women in reproductive age and 0-5 year old children. There is no data available for other population groups including adolescents, adult men and geriatric population. Based on the available data, we found that between October-November 2017 and October-November 2018, nutrition status of the 15-49 years old women and PLW improved. In MS, among the 15-49 years old women and LLW, the percentage of women with Low MUAC declined from 8.7 percent to 3.0 percent and from 12.2 percent to 2.8 percent respectively. Therefore, women in reproductive age group were more malnourished when they came to Bangladesh. Their condition improved gradually. However, comparable data collected in Rounds 1, 2 and 3 also indicates that the improvement has plateaued as the improvement of nutrition status between Round 2 and Round 3 was negligible. There should be a review of the existing programs and possible reasons that can be responsible for this plateau. If needed, the current programmatic approach should be changed.

During October-November 2018, the prevalence of anemia among the non-pregnant and non-lactating women was 22.6 percent in the MS and 22.8 percent in the NC. Both these proportions are well below the WHO threshold of 40 percent for anemia in emergency situation. However, the anemia situation should be further improved.

Between October-November 2017 and October-November 2018, nutrition status of 6-59 years old children showed mixed improvements. In the MS and NC, global acute malnutrition, severe acute malnutrition, global chronic malnutrition, severe chronic malnutrition declined. In the MS, the prevalence of anemia declined from 47.9 percent to 32.3 percent between Round 1 and Round 2; but increased to 39.8 percent in Round 3. A similar trend was visible in NC with respect to the prevalence of anemia.

The improvement in nutrition status with respect to anthropometric indicators was more pronounced in the MS than in NC. For example, in the MS, the prevalence of stunting declined from 44.1 percent to 26.9 percent; whereas, in the NC, the prevalence of stunting declined from 44.4 percent to 38.3 percent. Age disaggregated data from the MS and NC show that the trends of improvement or worsening in nutrition status were variable in different age groups. There can be inadequate resource allocation for NC as the camp is

more stable and was established a long time back.

The prevalence of infectious morbidities among the 6-59 months old children also decreased. The most notable improvement was in the prevalence of acute respiratory illness with fever (decreased from 57.7% to 10.9% in the MS and from 50.3% to 9.5% in the NC). There was a very high prevalence of diarrhea among these children though it decreased in both the MS (41.3% to 28.4%) and NC (34.3% to 25.2%) between Round 1 and Round 3.

A number of international and national NGOs and development partners are working to improve nutrition situation. There are 5 stabilization centers, 5 out-patient therapeutic programs, 35 targeted supplementary feeding programs, 35 blanket supplementary feeding programs and 6 community management of acute malnutrition of infants programs (only in the MS) in the MS, NC and KC. Some of the coverage data was available from Round 2 (March-April 2018) and Round 3. Comparison of Rounds 2 and 3 data shows that the coverage of all the indicators was better in NC than the MS.

There are different kinds of food assistance programs in the camps including general food distribution (distribution of rice, pulses and vegetable oil), e-voucher program (e-voucher to purchase from a list of 18 food items), dry food assistance (rice, lentil, oil, chickpeas, sugar and salt), and cooked meals. Not all the households are eligible for all the food assistance schemes mentioned above. The coverage data show that almost all the households are under at least one type of food assistance scheme.

Since the beginning, the nutrition sector suffered from lack of resources. For example, the resource need for the nutrition sector was 57 million USD in 2018 but only 65 percent of the required resources was made available. The funding situation continued to look dismal, as of May 11, 2019, the nutrition sector was able to secure only 423,000 USD against a pledge for 48 million USD. The nutrition sector also suffered from lack of skilled human resources. As Bangladesh had an existing shortage of skilled manpower for nutrition activities, the Rohingya crisis worsened the situation.

As noted, the Nutrition Sector coordinates joint assessments, capacity development, planning and implementation of nutrition services by different humanitarian organizations based on an agreed terms of reference that clarifies the overall engagement of this collective partnership with clear role and responsibility

between the sector coordination team, the partners and the government. UNICEF as sector lead also provides information management support and ensures sufficient support to monitoring and reporting requirements to fulfill the sectoral obligations. The sector now has web-based reporting as part of the District Health Information System 2 (DHIS 2) of the Directorate General of Health Services of the Government of Bangladesh.

## Recommendations

The chapter is based on secondary data and information as well as considering our understanding of the local, national and global contexts. Since the recent influx in 2017, the situation is becoming stable and therefore the response with respect to nutrition needs to adequately focus the preventive nutrition interventions along with continuation of the treatment of acute malnutrition among different vulnerable groups. In the context of shrinking resources, there can be more emphasis on preventive nutrition and strengthening of community mobilization, nutrition mainstreaming, integration and multi-sectoral programming can improve efficiency and coverage facilitating sustainability of the nutrition interventions. One of the ways to nutrition mainstreaming can be tried by integrating nutrition information within different relevant sectors, such as health, WASH, food security, education, gender-based violence, shelter, livelihood for behavioral change etc. The areas in which nutrition messaging can be developed for integration should include exclusive breast feeding, continuation of breast feeding, complementary feeding, dietary diversity, iron and folic acid supplements during pregnancy, adolescent nutrition etc. Moreover, mainstreaming nutrition can work well only if nutrition sensitive and nutrition specific interventions are implemented simultaneously. When nutrition sector collaborates with other sectors to foster cross learning, resource utilization can be more efficient and more services will be delivered. Ensuring better nutrition services necessitates a continuum of care. Strengthening of referral system between different facilities through facilitating collaboration and coordination between different agencies and providers at the camp level can create a continuum of care.

Providing nutrition services can only be done efficiently when the service providers are adequately trained. Therefore, investment on local capacity building is needed to address the human resource issues as well as quality improvement. Innovative approach to capacity building through mentoring and on the job training can be useful. There is effort to standardize the quality

of response and services. However, there is still differences in quality of services between the agencies. Communication with Rohingya community continues to be a challenge due to socio-cultural, religious and linguistic barriers. Nutrition sector needs to improve understanding of knowledge, attitude, and belief patterns of the Rohingya refugees so that culturally appropriate services can be provided and the staff can develop cultural competence.

In future nutrition assessments, the nutrition status of population groups other than women and children

should be explored. These population groups include adolescents, adult men and geriatric population. Be it services, capacity building or research, the government and donor agencies should consider a continuous flow of fund for the nutrition sectors so that the nutrition status of all the populations groups in the Rohingya camp can be improved.

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## CHAPTER FOUR

# WASH, ECOLOGY AND ENVIRONMENT

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## INTRODUCTION

Water, sanitation and hygiene (WASH) are critical in any humanitarian emergency to reduce public health risks from the spread of infectious diseases such as diarrhea and cholera<sup>1</sup>. From the beginning of the influx of Rohingya refugees into Bangladesh, the speed and scale of the crisis and the chaotic spread of shelters that were established almost overnight meant that WASH assumed a singular importance both for the refugee population, as well as the agencies responding to the situation. Incoming refugees created makeshift settlements in Kutuplaong camp area, extending the original boundaries of the existing refugee camp, and in Balukhali. Near Teknaf, makeshift camps sprung up in Leda, and around the Nayapara refugee camp. The sudden influx also profoundly altered the

surrounding environment, creating further challenges around managing the camp environment and limiting losses to the local ecology, alongside continuing public health concerns.

The very initial response to water, sanitation and hygiene needs within the camp were often hurried, poorly planned and designed for the short term. However, these interventions presented their own challenges in time, which led to a gradual evolution in WASH programming in the area. This chapter traces this evolution, highlighting key challenges and lessons learned in the early and latter stages, as well as issues of particular importance to the wider environment and ecology of the affected areas.

# WATER, SANITATION AND HYGIENE (WASH) RESPONSE

The onset of the crisis marked the growth of spontaneous settlements built by clearing forest and scrubland, with little scope to consider the health and environmental implications. Initial Inter Sector Coordination Group (ISCG) situation reports cite overcrowding from the start, noting how existing camp areas and madrasa, maktab, schools, and community centers were all being used to host new arrivals, along with construction of huts in existing refugee camps and in makeshift settlements<sup>2</sup>. Intense overcrowding, coupled with a lack of basic infrastructure, created health and sanitation conditions that doctors cited as ‘a perfect storm in the making’, as cited in an early mission report of the Office of the United Nations High Commissioner for Human Rights (OHCHR)<sup>3</sup>.

In the makeshift settlements, the limited existing WASH facilities were under immense pressure at the initial phase. There were reports of an average of 100 people using one latrine in one site. Refugees themselves built some latrines, which posed a health risk because they were too shallow or too close to a water source, and poorly protected by cheap plastic sheeting<sup>4</sup>. This is a trend that continued for some time, with many families still using latrines that were built by a member of the household, without due consideration of safety standards<sup>5</sup>.

Given the urgency of the situation, the initial focus of WASH interventions by different organizations in the area was on volume of infrastructure, particularly shallow tubewells and pit latrines with a minimum number of rings. By December of 2017, ISCG was already reporting a large number nonfunctional latrines and tubewells that needed to be decommissioned and/or repaired/relocated, with 30 percent of 5,338 tubewells and 36 percent of 33,650 latrines no longer operating<sup>6</sup>. A Devex report published in November 2017 asked the question whether emergency latrines were being built for the refugees or for donors, given that many were going out of order from lack of maintenance, regular desludging and poor quality of construction. Similarly, in early stage of the crisis, thousands of shallow wells (about 40 meters deep) were dug, but after excessive drawing of water, many of the sources started to dry up<sup>7</sup>.

With time, the initial rush to provide some level of services shifted to a longer-term approach that factors in operation and maintenance, quality of construction and community engagement<sup>8</sup>. The rest of this chapter provides an overview of the situation in the camps that prevailed at the time of writing this report in 2019, as well as an account of the ecological and environmental impact of the crisis.

## WATER

As many of the shallow tubewells installed in the very initial stages began to dry up, there was a sector-wide call for more deep tubewells<sup>9</sup>, and development partners began to shift funding to deep wells to reduce the water crisis<sup>10</sup>. Decommissioning and replacing unsafe water sources, especially in the southern camps in Teknaf, became a priority for the WASH sector in the second half of 2018<sup>11</sup>. A REACH study found that 99 percent of refugee households were using improved water sources, with tubewells being the most common source (73%), followed by tapstands (20%), tanks (5%), and a small percentage using protected dug wells (<1%)<sup>11</sup>. Overall, the study shows that Kutupalong camp area fared better than the southern camps when it comes to water, with over 2 percent of households in Teknaf using unprotected water sources as their primary source, and 5 percent as their secondary source. Teknaf is identified as a “critical zone” in terms of underground water, as boring of water pipes is almost impossible in its stony land<sup>11</sup>. The sector is also providing drinking water through trucks in the remote and unserved areas that reaches about 10 percent of the population<sup>12</sup>. A mid-term review of the Joint Response Plan for the crisis estimates that overall, over 720,000 people have been reached with safe water, meeting agreed standards for drinking and domestic purposes, which is approximately 68 percent of the population in question<sup>13</sup>.

While the REACH study found only 2 percent of households had a travel time and 5 percent of households had a waiting time of over 60 minutes to collect water. An August 2018 gender analysis had found that over 20 percent of households spent over 60 minutes to collect water. As the water storage capacity of households were very low compared to emergency standards 11, it necessitating multiple trips to collect water in a day, and queuing for water was an ongoing problem across most camps. Other issues included the lack of consideration in design for people with mobility issues. A gender, gender-based

violence (GBV) and inclusion audit conducted in early 2019 cites a study by Handicap International in Jadura camp where the majority of 63 respondents with disability reported “a lot of difficulty” in accessing drinking water (39%), or said they “cannot do it at all” (43%)<sup>14</sup>.

Water contamination has been a concerning issue from the beginning of the crisis. The World Health Organization (WHO) and the Department of Public Health Engineering (DPHE) of the government tested over 1000 samples from tubewells and households in the Kutupalong and Balukhali extension sites between September and November of 2018, which found that more than 86 percent were contaminated by E. coli<sup>15</sup>. However, the practice of water treatment improved following focused interventions on behavior change and distribution of water purification tablets and chlorine powder, as well as regular water quality testing and decontamination of water points by organizations including International Migration organization (IOM), BRAC, ACF, CARE and Dustho Shasthya Kendra (DSK)<sup>16</sup>. The REACH studies found almost a doubling of water treatment, from 17 percent to 38 percent of households, over a six month period. Precautionary measures to stave off any potential epidemics were also taken, and UNICEF and its partners in the health sector conducted a massive oral cholera vaccination campaign in Ukhia and Teknaf, administering 900,000 doses of the cholera vaccine, in October 2017<sup>17</sup>.

## SANITATION

Alongside water, sanitary latrines and the safe disposal of waste became urgent priorities, as evidenced by a situation report from ISCG, which highlighted the need to decommission non-functional latrines. Fecal sludge management also became a pressing concern within a few months of the start of the crisis, as will be discussed below.

Though at the beginning of the crisis, emergency latrines were being built with bamboo and tarpaulin<sup>18</sup>, over time construction patterns shifted towards block latrines with permanent bases.

As of early 2018, there were 49,323 latrines in functional order<sup>19</sup>, of which communal latrines and shared latrines were used by most refugees – 55 percent and 44 percent respectively<sup>20</sup>. The Joint Response Plan (JRP) mid-term review found 66 percent of men, women and children were benefiting

from functional latrines built to agreed standards<sup>21</sup>.

The REACH study found that 53 percent of households reported problems with access to latrine, with the most common complaint being overcrowding (35%), followed by distance (22%). In addition, the gender analysis found that girls (both children and adolescents) were concerned about a lack of segregation and privacy in latrines. Girls also complained about long queues, overcrowding and the lack of lighting at night, all of which inhibited their ability to use latrines. Boys (both children and adolescents) raised concerns around the proper maintenance of latrines (e.g., bad smell, full pit) and lack of lighting<sup>22</sup>.

Issues around accessibility are a concern in sanitation services as with water, and the 2019 gender audit found a lack of inclusion and consultation with people with disabilities, leading many to being excluded from access. The audit also cites a study by Handicap International conducted in Jadura camp, which found that 56 percent of people with disabilities faced “a lot of difficulty” in accessing latrines, while 8 percent “cannot do it at all”, and the study found cases where people urinate on the floor and defecate in a bucket.

The audit also reported that many women and girls were urinating, and possibly defecating, inside their shelters due to concerns around fear and shame in accessing communal toilets, and one of the key barriers in access for women is the lack of gender segregation during queuing<sup>23</sup>.

Although open defecation was almost nil amongst adults, the most commonly reported practice for children under five was open defecation. Even though this reduced over time – down from 65 percent in April 2019 to 53 percent in May – this is still an extremely concerning figure given the health risk this represents. At the time of data collection in 2018, only 36 percent of households reported children’s feces as disposed in latrines, and 24 percent reported disposing it in unsafe ways. This indicates a high possibility of fecal contamination of the environment, and pointed to an additional challenge for hygiene behavior change interventions within the camps<sup>24</sup>.

## FECAL SLUDGE MANAGEMENT

Given the sheer number of people in the camps and

the limited facilities that could be accommodated within these spaces, safe management of fecal sludge to prevent contamination of surrounding environment assumed paramount importance within a short time. Many toilets built in the early phase had filled up and overflowed, and the presence of *E. coli* in water signaled the possibility of a major public health crisis<sup>25</sup>. By December 2017, a technical group for sludge management had already been formed, and several partners were building small scale aerobic treatment systems, while some were venturing into larger anaerobic treatment systems<sup>26</sup>. These included some agencies with specialized experience in fecal sludge management (FSM) such as WaterAid and Practical Action, who designed contextualized FSM operations that would work within the constraints of the camps. The key challenges for these organizations were the hilly terrain and the restricted space in the camps, along with the logistical issues of finding skilled labor to construct these plants. However, innovative designs shaped by the context and terrain overcame these challenges, including portable FSM units using simple up flow filtration systems by Practical Action, and a gravity flow based system which utilizes the hilly terrain to automatically shift sludge from an intermediate transfer station to the treatment unit by WaterAid. Other practices included lime treatment of sludge either on site, or in treatment plants where sludge is collected and deposited manually.

Currently, a number of organizations such as ACF, Oxfam and Tearfund are also working on FSM, and Oxfam was in the process of building a large FSM plant that aims to treat waste from 100,000 refugees. In addition, VERC, BRAC, NGO Forum, CARE, and DSK were also working on desludging of latrines through lime treatment. On the knowledge and capacity side, UNHCR worked to train WASH partners from UN sister agencies and non-governmental organizations through a series on sanitation technologies and fecal sludge management<sup>27</sup>.

## HYGIENE AND HANDWASHING

Alongside the immediate interventions of latrines and water points, hygiene was essential both to maintaining the health of the vulnerable refugees, as well as maintaining the cleanliness of the newly installed water and sanitation facilities. Partners are responsible for providing their hygiene interventions in

a coordinated and thoughtful method to encourage the beneficiaries to adopt and maintain safe and hygienic practices, including providing menstruating girls and women with products and facilities for safe practice<sup>28</sup>. The health promotion strategies of WASH partners included targeted interventions, promotion of community management, information management, onsite capacity building and coordination<sup>29</sup>.

Many organizations including BRAC, DSK, Agrajatra and ACF are working on community hygiene promotion sessions on cleanliness and maintenance of latrines, safe drinking water, handwashing with soap, menstrual hygiene management, and households waste disposal management<sup>30</sup>. The effects of these programmes can be seen in the increase in soap availability in the camps between the REACH studies in April and October 2018, with 93 percent of households reporting possessing a soap in the follow-up compared to 65 percent during the baseline. However, challenges remain, and practice is far from adequate. Overall, 46 percent of respondents in the REACH study were able to mention at least three critical handwashing times, with a much larger proportion of men being able to answer correctly than women (55% vs. 34%). Only 26 percent of women could identify 'before feeding child' as a critical time, compared to 46 percent of men. This may be attributed to the fact that more men were participating in hygiene sessions, with 62 percent of male respondents reporting participating in at least one hygiene session, compared to 39 percent of female respondents<sup>31</sup>. In the Joint Response Plan mid-term review, 56 percent of respondents were able to demonstrate at least three critical hygiene practices. Overall, there are significant challenges to involving women in hygiene sessions and finding ways to effectively transfer hygiene knowledge to the Rohingya population given language and other barriers<sup>32</sup>.

## BATHING PLACES

New arrivals initially had very limited access to bathing facilities. Gradually the Rohingya refugees availed communal bathing facilities constructed by BRAC, DSK, AAB and ACF, amongst others<sup>33</sup>. Separate bathing cubicles were installed in the camps for both men and women. Although there is no direct water connection in the cubicles, the sites were selected considering easy access to the water source, e.g., tubewell<sup>23</sup>. However, the majority of women (52%) still use makeshift spaces within their shelter to bathe, while 23 percent used communal or public bathing

facilities. This preference for bathing at home may indicate a need for privacy that is yet to be fulfilled by facilities built by agencies, or cultural preferences that require further research. One possible reason is the lack of gender segregation during queuing, which is reported as one of the most distressing aspects for users in different focus group discussions<sup>23</sup>.

## MENSTRUAL HYGIENE MANAGEMENT

Menstrual hygiene management (MHM) is an essential but often neglected aspect of health and hygiene during humanitarian emergencies. In this context, it took on particularly challenging proportions due to confined spaces women and girls had to live in, the lack of latrines, and the powerful social stigma around periods. An adolescent needs assessment done by Save the Children as part of the joint agency research on gender analysis found that only 25 percent of girls were able to meet their menstrual hygiene needs in the camps, most of whom were in Ukhia, either through distributions (92%), or buying sanitary materials in local stores<sup>34</sup>. Specific difficulties mentioned included insufficient water to wash the menstrual cloths, lack of areas for a drying menstrual hygiene items and various restrictions during their periods. The mid-term review of the Joint Response Plan found a slightly improved scenario, with 56 percent of women and girls of reproductive age reporting their menstrual hygiene needs met.

According to REACH, women who consented to respond to menstrual hygiene question reported reusable pads (57%) as the most commonly used material for menstrual hygiene management, followed by cloth (41%), and disposable pads (35%). These figures showed interesting changes from the baseline, with a jump in the use of both reusable and disposable pads. The vast majority of those using reusable pads washed and dried these pads in their homes. While disposal was mainly done through burying, a quarter of the respondents reported disposing of the materials in latrines, which can lead to clogging issues. Almost one-third (31%) of women reported facing problems with accessing materials during their period. However, 85 percent reported being satisfied with access to materials, indicating that these problems may be intermittent in nature.

In terms of the sectoral response, while there has been coordination on some fronts, such as the

agreement between different actors to supply cloth or reusable materials, and an informal MHM working group is in place, there is duplication of efforts in multiple efforts to develop related materials, where one common set would be ideal<sup>23</sup>.

## SOLID WASTE MANAGEMENT AND ENVIRONMENTAL HYGIENE

In case of solid waste, it is estimated that over 10,000 tons or around 22,000 cubic meters of waste is being produced per month in the refugee camps, posing health and environment hazards<sup>35</sup>. VERC, BRAC and Sajeda Foundation provided waste bins to the Rohingya households and a number of garbage pits have been constructed by VERC, BRAC, IOM, NGO Forum, Plan, DSK and UNHCR in the camps to ease the waste management activity. Some incinerators have also been provided considering the space constraints in the camps, but these are inadequate in number.

The October 2018 survey found that most households either dump their waste in designated open areas (46%) or in communal pits (26%), which represents an improvement in solid waste management practices compared to the previous scenario, when rampant dumping of waste in undesignated open areas was common<sup>36</sup>. Amongst the different solid waste management methods introduced, sets of sanitation kits (spade, hoe, wheelbarrow, broom etc.) have been provided in the camps by CARE, DSK, BRAC, Bangladesh Red Crescent Society (BDRCS), and ACF<sup>37</sup>. United Nations Development Programme (UNDP) and Sweden has launched a separate project worth USD 4.8 million on solid waste management, indicating its prioritization by the sector and development partners. However, drainage seems to be an overlooked issue, and most people in the camps are not clear where responsibility lies to ensure proper drainage, impacting public health and well-being<sup>23</sup>.

## IMPACT ON LOCAL ENVIRONMENT AND ECOLOGY

The scale and speed of the exodus to Cox's Bazar has

had profound environmental and ecological impact. The immediate need for shelter led to the clearing of large areas of forest and levelling of hills. UNDP estimated that by 2018 a total of 4,300 acres of hills and forests were cut down by the Rohingyas<sup>38</sup>. Since the initial damage, the ongoing need for fuel has led to further deforestation, affecting Cox's Bazar already vulnerable ecology. The risk of landslides has increased as hills have lost their natural topography, and wildlife in the area is at threat from loss of habitation and encroachment of human settlements.

The urgent need for water and fuel perhaps had the biggest impact on the landscape. Nearly 6,800 tons of fuelwood is estimated to be collected each month. As a result, around 90 percent of forest land are expected to be cleared within a 10 kilometer buffer zone if the current rate of deforestation continues. The relief material being distributed among the Rohingyas did not include firewood, forcing the refugees to cut down trees from government forests. An ISCG report estimated that the refugees need about 700 tons of firewood every day for fuel<sup>39</sup>. Related to this, further environmental degradation is caused by the spike in air pollution from burning firewood, as well as increased traffic in the area.

Indoor air pollution can affect health and people in the camps are highly dependent on inefficient stoves. An estimated 200,000 households need to replace their cooking facilities. Steps were taken to address the issue and about 11,000 LPG gas cylinders were supplied in the camps<sup>41</sup> by 2018. However, covering all the households will take a long time, and the damage already done will require serious efforts at land reclamation and reforestation, which seem a remote possibility given the current situation.

The initial humanitarian response consisted of unplanned sinking of thousands of shallow wells, which depleted the shallow aquifer in many places. In the following phase of the response, while many agencies switched to deep wells to ensure safe water supply, the associated risk of depleting precious groundwater reserves increased. There was no initial comprehensive assessment of groundwater resources to ensure safe, affordable and sustainable water supply. Upon request of DPHE, different aid agencies, development partners and NGOs agreed to an integrated study of both surface water and groundwater resources not only to inform the Rohingya response, but to also support the host community who were also reliant on the groundwater sources being

depleted and the freshwater streams becoming contaminated.

## COORDINATION, REPORTING AND ACCOUNTABILITY

The humanitarian response for the Rohingya influx are monitored and coordinated by an Inter-Sector Coordination Group (ISCG), which was established in October 2017 to manage the influx of refugees. The ISCG is the central coordination body for humanitarian agencies serving Rohingya refugees. It is organized into 12 thematic sectors and sub-sectors, including child protection, nutrition, food security, gender-based violence, site management and health, amongst others. Strategic guidance is provided by a UN/NGO/Donor Policy Group, chaired by the Resident Coordinator of IOM, and the group's remit covers field coordination, information management, reporting/communications and NGO coordination functions<sup>40</sup>.

The DPHE and the District Civil Surgeon have established mechanisms in Cox's Bazar to improve coordination with implementing agencies on WASH and health respectively. The WASH Sector Coordination Unit, a sub-sector of ISCG, was set up under the authority of DPHE<sup>41</sup>. The Ministry of Disaster Management and Relief (MoDMR) district level has engaged in coordination on camp site establishments.

On the public side, the Government of Bangladesh formed an office of the Refugee Relief and Repatriation Commission (RRRC) in 1992 following the arrival of 250,000 Rohingya Muslims who fled across the border into Bangladesh from Rakhine State, in Myanmar. The RRRC is the governing body that is responsible for providing the refugees with humanitarian assistance, with the support of the United Nations (UN) and the international community. Among the many activities of RRRC, it is responsible for ensuring that agencies only work with the Rohingyas after receiving prior approval from the RRRC along with a list of activities, the budget and the area of operation. They are responsible for preparing datasheets with facilities, organizing weekly coordination meetings of government, non-government and international agencies working in the camp and submission of these proceedings, and submitting weekly progress reports<sup>28,29</sup>.

Each organization needs approval from RRRC before beginning their activities in the camps. The approval process requires details about the source of funding, the type of activities, the intended services to be provided and the specific location of their services. Once the approval is received, the organizations report to the Camp-in-Charge (CiC), the Bangladeshi government's administrative head of the refugee camps who is responsible for designated camps and oversees the camp activities. The CiCs also allocate and collaborate with other organizations to ensure that the activities are conducted according to the plans set by the RRRC. Once inside the camps, the organizations' work is overseen by the CiC and reported back to the technical meetings by ISCG and their respective organizations.

In general, besides the overseeing by the CiCs, there is little accountability of organization activities in the camps, the field workers are accountable for their respective organizations and their reporting during the technical meetings.

#### **Financing of the initiatives**

According to ISCG, there is a need for USD 920.5 million to finance the Joint Response Plan for 2019. Of this need, only about 8 percent was met till February 2019, most of which has gone to education, shelter and non-food items<sup>42</sup>.

According to Financial Tracking Service, the largest donors of the Rohingya crisis are governments (72.9%), NGOs (0.9%), pooled funds (6.8%) and private organizations or foundations (8.4%). The national governments that contributed included the United States of America (27.6%), Government of United Kingdom (52.4%), Government of Australia (22.2%), Central Emergency Response Fund (21.6%), European Commission (21%). Private sources (individuals and organizations) contributed to about 13.2 percent of the total amount. The health sector benefits from 126 partners who are responding in numerous ways. The major organizations through which the international government funds are channeled are World Vision International, WHO, World Food Programme, and International Organization for Migration, Action Contre la Faim, United Nations Children's Fund and BRAC, amongst others.

According to RRRC Joint Response Plan for Rohingya Humanitarian Crisis from March to December 2018, there were about 1.3 million people in need – 172,200 in Bangladeshi host communities, 591,800 refugees in camps and settlements, and 224,400 refugees in

host communities. There are a total 16 organizations working to meet the WASH needs and the expected required money is over USD 136 million.

## **SUSTAINING THE OPERATIONS**

Sustainability of the WASH options would require close coordination with authorities, tracking the infrastructure installed, and taking actions to protect natural resources. To address the WASH needs in the Rohingya camps, the WASH partners, namely Christian Aid, Action Against Hunger, BRAC, Care International, IOM, Oxfam, Save the Children, and various UN organizations, have agreed that five minimum commitments would be observed that includes accessibility, ensure dignity and safety, a strong monitoring and evaluation system, include women and girls to conduct need assessment, and ensure that the latrines are in the right location.

## **CHALLENGES AND GAPS**

Based on the current situational analysis and the multiple reports of different agencies and the ISCG, some primary conclusions can be drawn. WASH was correctly identified as a priority from the early days of the crisis, and was met with an initially haphazard but increasingly coordinated and contextualized response that has seen most of the refugees gain access to improved water and sanitation. Despite cases of waterborne diseases including diphtheria and diarrhea, initial fears of a widespread epidemic, especially of cholera, were allayed, without any large-scale disaster in the form of disease outbreaks, landslides or major loss of life.

However, manifold challenges remain, as described above, especially as the sector shifts towards issues of quality and sustainability, at least in the medium-term, from the initial focus on immediate life-saving operations. These include water quality first and foremost, especially at the household level, and the related issues of fecal sludge management of such a huge population within such constrained spaces.

One of the major limitations of the refugee camps in Bangladesh is unavailability of space. Due to limited space it was not possible to design all the facilities properly following the guidelines. The alignment of the shelters, location of the latrines, bathing cubicles,

garbage pits etc. were not always done following proper standards. The current number of facilities are still not being able to adequately cover the whole population, especially persons with disabilities, the elderly, and children. Another hidden issue is that of incontinence, which may be affecting a wide range of people including women with fistula after giving birth, older people, people with disabilities and GBV survivors, which cannot be dealt with through usual WASH facilities. HelpAge has been giving older people urine containers, but there is need to research how others may also benefit from such a service.

Menstruating women and girls face an additional challenge in finding a private space for cleaning and using the latrines, properly washing and drying of their menstrual absorbents, and disposal of menstrual absorbents. There is a lack of extensive social and behavioral interventions to reduce the taboos surrounding menstruation that often restricts of movement and activities. In addition, there is a lack of data on the practices and health impacts of MHM among Rohingya women.

Solid waste handling and disposal is localized and indiscriminate due to space and technological

restrictions. There is a lack of wide-scale and functioning solid and liquid waste management systems, which poses both health and environmental hazards. In addition, lack of access to fuel for cooking and inefficient stoves are making the indoor air quality worse and increasing risks to human health in the camps. These issues can be addressed by better planning, resetting and improvement of minimal living standards.

In terms of programmatic approaches and ways of working, meaningful consultations with a wider range of stakeholders, prioritizing accessibility and integrating WASH with other sectors including ageing and disability are needed. Monitoring, reporting and accountability mechanisms also have their limitations given the vast operations underway in the camps, and the activities and accountability of small local organizations are often overlooked. However, all of these require both capable human and financial resources, in a situation where sector funding remains low. In particular, the following activities are seriously limited by funding shortfall: needed scale-up in WASH operations and infrastructure maintenance, fecal sludge management in underserved areas, and human resources for hygiene promotion activities.

## CONCLUSION

The WASH sector under the leadership of the Bangladesh government mounted an impressive WASH response to the large onset of Rohingya crisis that commented in August 2017. Overcoming significant challenges in terms of congestion, terrain, physical access, and providing services to the Rohingya population that was profoundly stressed, with different social norms and language as well as low levels of education, the WASH sector was instrumental in ensuring there was no outbreak of waterborne diseases, and was able to stabilize diarrhea rates during the wet seasons. Acute watery diarrhea and monsoon preparedness initiatives were generally effective. The WASH emergency response has also been an incubator of innovation with impressive technologies and approaches developed to respond to challenges in fecal sludge management, safe drinking water and hygiene promotion.

Despite these significant efforts, the facilities in settlements are still under strain. Following the initial

rounds of construction, operation and maintenance, quality, accessibility and gender-sensitivity have become major issues. Addressing gender equality and ensuring safe and adequate access to potable water, latrines and other facilities, such as menstrual hygiene materials to menstruating women and girls, is a major concern in the overcrowded settings. Most of the facilities lack gender segregation and locations are often not accessible, especially to women. The long term impact of the influx on the local ecosystem and water resources requires further study and evidence-based planning. The WASH sector clearly needs a long-term strategy to meet the continuous needs of the Rohingya as well as to ensure limited environmental consequence and plan for restoration of the damaged ecosystem.

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## CHAPTER FIVE

# REPRODUCTIVE HEALTH CARE IN ROHINGYA REFUGEE CAMPS

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Zahidul Quayyum and Sabina Faiz Rashid

## INTRODUCTION

During humanitarian crisis situations such as the Rohingya, women and children stand as the most vulnerable and most at-risk groups. Women of reproductive age suffer immensely in such situations as reproductive health services including prenatal care, assisted delivery and emergency obstetric care often become scarcely available and many young and older women lose access to family planning services, exposing themselves to unwanted pregnancy<sup>1,2</sup>. Cultural and social norms, and living in new unfamiliar spaces and fear of safety lead to adolescent girls experiencing restrictions on their freedom of movement. This in turn results in limited access to health care, education, quality food, clean water, and hygiene facilities<sup>3</sup>. They remain vulnerable to gender-based violence and lack access to sexual and reproductive health (SRH) services because of their gender, refugee status and ethnic affiliation<sup>4</sup>. Unless

ensured, lack of these basic SRH services can lead to higher risk of morbidity and mortality related to complicated pregnancy from home deliveries, exploitation, violence and diseases for these most vulnerable groups<sup>5</sup>. In such precarious humanitarian emergency conditions, delivering comprehensive sexual and reproductive health and rights (SRHR) services for women and adolescents is critical for better health outcomes.

This chapter outlines the demographic profile of the Forcibly Displaced Myanmar Nationals (FDMNs, referred to as Rohingya population hereafter) who are in-need of SRH services, and a brief overview on the sexual and reproductive health (SRH) situation including maternal health, adolescent SRH, family planning, gender-based violence including sexual abuse, sexually transmitted infections including HIV/AIDS and SRH of neglected groups (adolescent

boys and adult males) in the refugee camps of Ukhiya and Teknaf upazilas (sub-districts) in Cox's Bazar district of Bangladesh. It also highlights major interventions to address SRH needs of different population groups, availability of necessary amount of

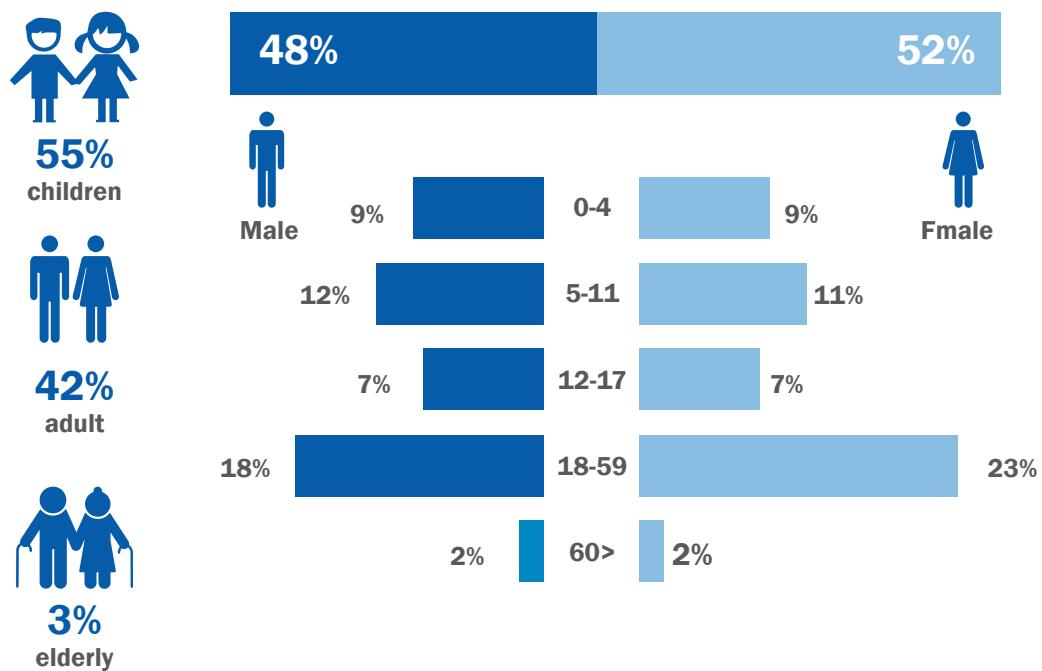
resources to fulfill those needs, coordination, reporting and accountability of the SRH sector, and role of the Government of Bangladesh and non-government actors including national and international partner organizations.

## DEMOGRAPHIC PROFILE OF THE ROHINGYA POPULATION IN NEED OF SRH SERVICES

The Health Sector Bulletin #10 provided a demographic profiling of the Rohingya refugee population based on UNHCR population data as of July 15, 2019<sup>5</sup> which indicates that 14 percent of the population belong to the age group 12-17 years, and 41 percent to the age group 18-59 years. Hence, the two groups that are most in need of SRH services comprise of 55 percent of the total Rohingya population residing in the refugee camps in Cox's Bazar. The United Nations Population Fund (UNFPA)

estimates that there are around 304,388 women of reproductive age (15-49 years)<sup>6</sup> which is 24% of the total refugee population<sup>6</sup>. Another demographic profiling and needs assessment of maternal and child health (MCH) care by icddr,b on 16,588 people from 3,050 Rohingya refugee households found that approximately 46 percent Rohingya women were 13-49 years old and 70 percent of reproductive aged women were below 30 years old<sup>7</sup>.

Figure 5.1: Demographic breakdown among FDMN (UNHCR population factsheet) (n=904,373)



Source: Health Sector Bulletin #10: Rohingya Crisis in Cox's Bazar, Bangladesh, July 2019

# OVERVIEW OF THE REPRODUCTIVE HEALTH AND MATERNAL HEALTH SITUATION

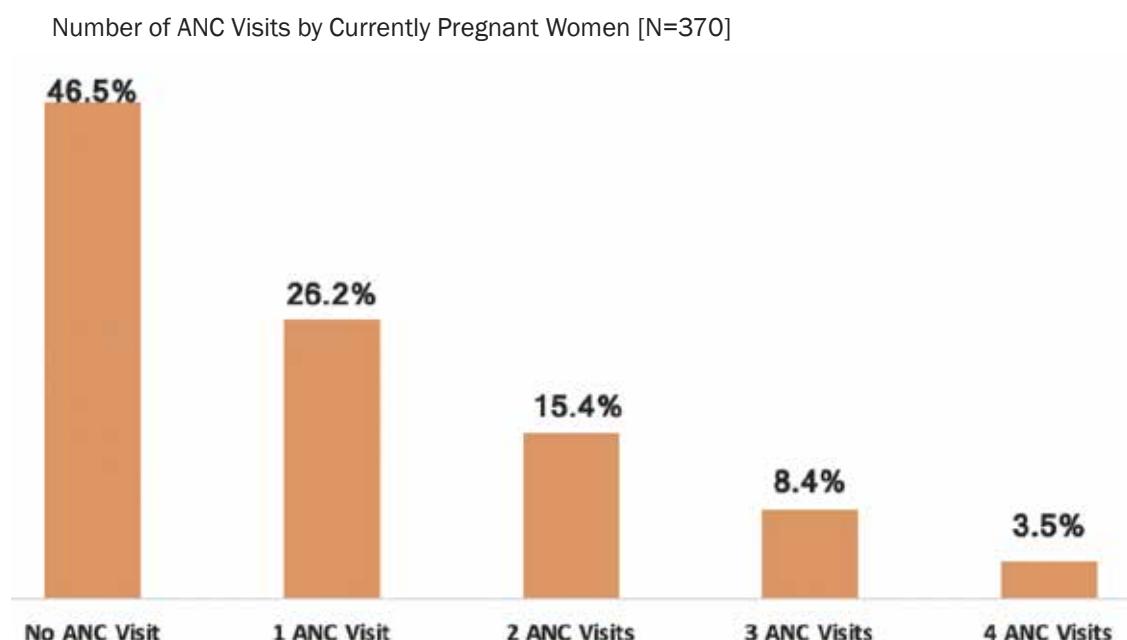
This section discusses the current conditions of the reproductive health and maternal health in refugee camps of Ukhia and Teknaf sub-districts.

**Maternal health:** In October 2019, UNFPA estimated that around 2.4 percent (29,818) of the Rohingya population were pregnant and lactating mothers, which was almost double the figure (58,800) from a year back, in November 2017. The calculation also projects that around 1,200 mothers were at risk of experiencing obstetric complications in the following

three months' time, whereas the estimation a year ago was more than 1,500 mothers<sup>8</sup>. The interesting fact about the 2.4 percent pregnant mothers among the total population is that around 13 percent of them are aged 18 years or below and more than 80 percent of them are below 30 years of age<sup>9</sup>. The icddr,b needs assessment study reported the pregnancy rate to be 10.1 percent in reproductive age women<sup>7</sup>.

In terms of antenatal care (ANC) visits, 53.5 percent of currently pregnant women had at least one ANC visit whereas 46.5 percent had no such visits at all (Figure 2)<sup>7</sup>. Reasons for avoiding ANC visits included Rohingya cultural and community perceptions restricting mobility, misconception regarding health facilities, overcrowding, long waiting time, lack of privacy, inability to trust providers, un-uniformed services, and gender of providers, amongst others<sup>7</sup>.

Figure 5.2: Number of ANC visits by currently pregnant women



Source: icddr,b needs assessment study, July 2018

Due to their cultural and social norms, restricted mobility, hard geographical terrain and difficulty in transportation to health facilities, pregnant Rohingya mothers face barriers in accessing services resulting in a preference for home deliveries (78%)<sup>10</sup>. However, there is lack of availability of 24/7 Emergency Obstetric and Newborn Care (EmONC) services. Deliveries are conducted by local traditional birth attendants in

unsafe and unhygienic conditions<sup>11</sup>. The icddr,b needs assessment study estimates that 6 percent of the study population were lactating mothers whose median duration of lactation was 13 months<sup>7</sup>.

Maternal morbidities or complications during last pregnancy reportedly included excessive vaginal bleeding, high fever, severe headache, foul-smelling

discharge, greenish vaginal discharge, convulsion, swelling of feet or face, cord prolapse, retained placenta, etc<sup>7</sup>.

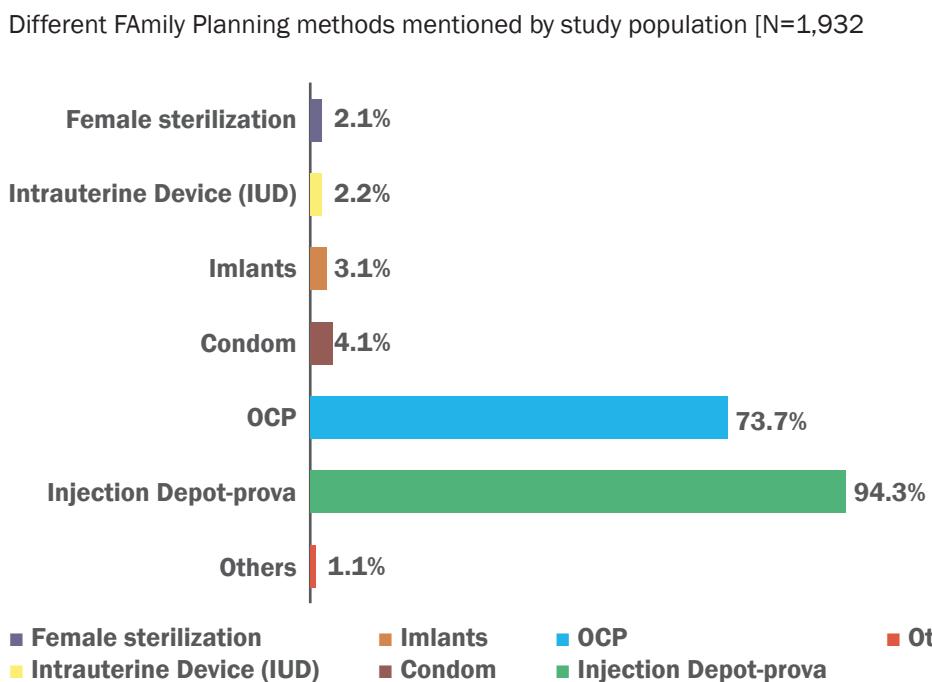
**Adolescent SRH:** Alongside the reproductive aged women, adolescent girls are also in need of urgent access to SRH services. Inter-Agency Working Group on reproductive health in crisis (IAWG) partners on the ground identifies escalation in child marriage within camps including very young adolescent girls<sup>11</sup>. Adolescent girls in Rohingya camps are reportedly having early pregnancies, low-birth weight for newborns, stillbirths, irregular menstruation, and leucorrhoea (whitish or yellowish discharge of mucus from the vagina)<sup>12</sup>. Around 5.4 percent of adolescent girls are estimated to be currently pregnant<sup>7</sup>, and 18.4 percent adolescent pregnancies are identified amongst the total pregnancies in the camps. Menstrual hygiene practices of adolescent girls are barely reported due to sensitivity of the issue. However, the knowledge on menstrual hygiene these adolescent girls acquire are mostly from their elder female family members or peers. Due to security issues, restrictions on their movements are very apparent, impacting their access to information and SRH services.

**Family Planning:** Regarding family planning (FP), the contraceptive prevalence rate (CPR) among currently married women has been reported as 33.7 percent<sup>7</sup>.

Recent Health Sector Bulletin reported increased uptake of short-acting contraceptives (oral pills and injectable) over long-acting and reversible contraceptives (LARC)<sup>5</sup>. Availability of contraceptives in all healthcare centres maybe a reason of increased uptake<sup>5</sup>. Frequently used family planning methods by Rohingya women of reproductive age includes Injection Depot-Provera (70.5%) and Oral Contraceptive Pill/OCP (28.9%) according to icddr,b<sup>7</sup>. Uptake of FP methods found lower in Teknaf sub-district compared to Ukhiya<sup>5</sup>.

In terms of their knowledge on FP methods, 86.3 percent of respondents had heard about at least one method of family planning. The two most common methods they mentioned were Injection Depot-Provera (94.3%) and Oral Contraceptive Pills (73.7%) (Figure 3)<sup>7</sup>. Even though approximately 49 percent of currently married women reported knowledge of the service delivery place for FP methods, almost 50 percent were not interested to use any method due to disapproval of partners, religious prohibition, not liking FP methods, wanting more children, fear of side effects, perception of FP methods interfering with their physiological process and social pressure<sup>7</sup>. Thus, to meet the family planning needs of this vulnerable population, their knowledge and perception along with adequate service provision need to be targeted for elevation in service uptake.

Figure 5.3: Various Family Planning methods mentioned by currently married women



Source: icddr,b needs assessment study, July 2018

**Gender-based violence:** One major factor in terms of determining the condition of the sexual and reproductive health of the Rohingya community is gender-based violence (GBV). Reportedly, many female Rohingyas have experienced severe forms of gender-based violence. They are at high-risk of domestic and intimate partner violence in the refugee camps<sup>10</sup>. Over 2,000 GBV cases were reported through November 2017<sup>13</sup>. As of October 2019, only 21.9% of the rape cases were reported<sup>14</sup>.

A qualitative study with 148 adult Rohingya men and women in the two registered camps in Cox's Bazar revealed 12.8 percent had been exposed to sexual abuse, humiliation or exploitation, 8.1 percent were raped (forced or unwanted sex with a stranger, acquaintance, or family member) and 6.1 percent reported witnessing physical or sexual abuse<sup>15</sup>. While this is the condition in the registered camps, concern has been raised on the bigger gender-based violence risk to Rohingya women and adolescent girls residing in the unregistered camps<sup>16</sup>.

The Multi-sector Needs Assessment reported that 41 percent of households fear for sexual violence towards girls aged under 18<sup>17</sup>. Other problems such as forced marriage, survival sex, trafficking for commercial sexual exploitation, drug smuggling and forced labor exploits adolescent girls and women, violating their sexual and human rights<sup>13</sup>. Alongside the legal protection and appropriate healthcare, mental health problems arising from these violence-related experiences need to be screened and managed through specific mental health facilities<sup>4</sup>.

**Sexually transmitted infections including HIV/AIDS:** HIV prevalence in the Rakhine state was the highest in Myanmar<sup>18</sup>. Sexual violence, especially towards women and adolescent girls, during the predicament in August 2017 increased the risk of sexually transmitted infections and transmission of HIV among the Rohingyas who migrated to Cox's Bazar<sup>19</sup>. A qualitative study by Population Council found that Rohingya adolescents and youth had limited knowledge regarding STI and HIV, and have misconceptions regarding spreading of such diseases<sup>12</sup>.

### **Most neglected group – men and adolescent boys:**

The Rohingya men and adolescent boys are almost entirely overlooked for any kind of sexual and reproductive healthcare services in the refugee camps – whereas the risk of STIs, including HIV, are perceived to be high among boys due to higher risk of sexual abuse and violence<sup>12</sup>. Therefore, urgent attention and action from partner organizations are required as the reproductive health needs of men and boys and related service provision are as important as that of women and adolescent girls.

## SRHR SERVICES IN HUMANITARIAN CRISIS

Just after the onset of the crisis in August 2017, Bangladesh government and other local and international organizations came forward to provide SRH services to the Rohingya population. Initially, the focus was on emergency case management, including managing rape survivors and screening the population for STIs including HIV/AIDS. With support from UNFPA and WHO, the minimum initial service package (MISP) for reproductive health was introduced immediately. The MISP is considered to be the most evidence-based standard guideline for SRHR services in humanitarian crisis situation. The Inter-agency Working Group (IAWG) on Reproductive Health in Crisis has developed this guideline, which is basically a set of priority activities that need to be implemented ideally within 48 hours of the onset of a humanitarian crisis to meet the immediate SRH needs of the displaced population, mostly women and adolescent girls<sup>20</sup>. The MISP includes emergency obstetric care, clinical management of rape, prevention and treatment of STI/HIV, and referrals<sup>21</sup>. Once the emergency situation becomes stable, MISP is expanded to comprehensive service package. In addition to the services under MISP, the comprehensive service package also includes family planning; antenatal, intrapartum, postpartum and newborn care; cervical cancer screening, menstrual regulation (MR); and referrals<sup>21</sup>. The services under MISP and comprehensive RH service package are listed in Table 5.1.

Table 5.1: Recommended minimum RH service package and comprehensive RH service package

| <b>Subject Area</b>                                  | <b>Minimum (MISP) RH Services</b>   | <b>Comprehensive RH Services</b>   |
|--|---|--|
| <b>Family Planning</b>                               | <ul style="list-style-type: none"> <li>Provide contraceptives, such as condoms, pills, injectables and IUDs, to meet demand</li> </ul>  | <ul style="list-style-type: none"> <li>Source and procure contraceptives supplies</li> <li>Provide staff training</li> <li>Establish comprehensive family planning programs</li> <li>Provide community education</li> </ul>  |
| <b>Gender-based Violence</b>                         | <ul style="list-style-type: none"> <li>Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters</li> <li>Provide clinical care for survivors of rape</li> <li>Inform community about services</li> </ul>   | <ul style="list-style-type: none"> <li>Expand medical, psychological, social and legal care for survivors</li> <li>Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting</li> <li>Provide community education</li> <li>Engage men and boys in GBV programming</li> </ul>  |
| <b>Maternal and Newborn Care</b>                     | <ul style="list-style-type: none"> <li>Ensure availability of emergency obstetric and newborn care services</li> <li>Establish 24/7 referral system for obstetric and newborn emergencies</li> <li>Provide clean delivery packages to visibly pregnant women and birth attendants</li> <li>Inform community about services</li> </ul>   | <ul style="list-style-type: none"> <li>Provide antenatal care</li> <li>Provide postnatal care</li> <li>Train skilled attendants (midwives, nurses, doctors) in performing emergency obstetric and newborn care</li> <li>Increase access to basic and comprehensive emergency obstetric and newborn care</li> </ul>   |
| <b>STIs, including HIV, prevention and treatment</b> | <ul style="list-style-type: none"> <li>Ensure safe and rational blood transfusion practices</li> <li>Ensure adherence to standard precautions</li> <li>Guarantee the availability of free condoms</li> <li>Provide syndromic treatment as part of routine clinical services for patients presenting for care</li> <li>Provide ARV treatment for patients already taking ARVs, including for PMTCT, as soon as possible</li> </ul> | <ul style="list-style-type: none"> <li>Establish comprehensive STI prevention and treatment services, including STI surveillance systems</li> <li>Collaborate in establishing comprehensive HIV services as appropriate</li> <li>Provide care, support and treatment for people living with HIV/AIDS</li> <li>Raise awareness of prevention, care, treatment services of STIs</li> </ul> |

Source: Women Refugee Commission, 2009

As of January 2019, all components of MISP were being provided, with few exceptions, in some of the refugee camps by some partner organizations<sup>10</sup>. However, delivery of comprehensive RH package was still in the planning phase. Thus, access to comprehensive RH service package for the Rohingya community is still a major area of concern.

## SRHR SERVICES FOR ROHINGYA COMMUNITY IN COX'S BAZAR

As of July 2019, the available SRH services for the Rohingya refugees in Cox's Bazar include short- and long-acting family planning methods; maternal care – antenatal, safe delivery and postnatal care; basic and comprehensive emergency obstetric and neonatal care (BEmONC and CEmONC); menstrual regulation (MR) and post-abortion care; clinical management of rape cases and psychological support to the victims of sexual and gender-based violence; fistula care; and screening and treatment of STD and HIV/AIDS<sup>5,14</sup>. Some organizations also operate mobile clinics where medical doctors and midwives provide SRH services at the household level in hard-to-reach areas<sup>22</sup>.

SRH services are mainly provided by different NGO/INGO (non-government organization / international non-government organization) run health centers established inside the camps or in the vicinity of the camps. The type of health facilities that provide SRH services include: health post, primary healthcare center, comprehensive/integrated maternity center, labor room/SRH only center, INGO run secondary hospitals, Upazila Health Complexes in Ukhya and Teknaf and Cox's Bazar Sadar Hospital (Table 5.2). The current influx has created tremendous pressure on the existing health facilities in Cox's Bazar. A public health

situation analysis conducted by WHO in October 2017 reported an increase of 150-200 percent patient flow in the existing health facilities in Cox's Bazar, especially in Sadar, Ukhya and Teknaf upazilas where most of the new arrivals are staying<sup>19</sup>. As of September 2018, more than 600 health facilities were serving Rohingya refugee population, and among those approximately 281 health facilities were providing SRH services. Of those, only 48 facilities had 24/7 service available and 11 facilities planned to start 24/7 service between end of October 2018 to January 2019<sup>23</sup>.

Table 5.2: Health facilities providing SRH services to the Rohingya refugees (as of September 2018)

| Facility type                          | Functional | Planned | Under construction | Grand total |
|--|------------|---------|--------------------|-------------|
| Community clinic (MOH)                 | 14         |         |                    | 14          |
| Health and Family Welfare Center (MOH) | 5          |         |                    | 5           |
| Health Post (fixed and mobile)         | 166        | 9       | 3                  | 178         |
| Labor room or specialized SRH facility | 12         |         |                    | 12          |
| Primary Health Center                  | 17         | 6       | 2                  | 25          |
| Secondary Health Facility              | 13         |         |                    | 13          |
| Upazila Health Complex (MOH)           | 2          |         |                    | 2           |
| Tertiary Health Facility               | 1          |         |                    | 1           |

Source: Health Facility Registry, WHO, September 2018

Distribution of health facilities within the camps is inequitable. Most of the health facilities are concentrated in camps which are geographically easy to access. The western part of Ukhya upazila and southern part of Teknaf have fewer number of health facilities, mostly because of scarcity of available lands and poor road conditions<sup>24</sup>. Table 5.3 shows the distribution of health facilities in different camps in Ukhya and Teknaf upazilas<sup>23</sup>. Most of the health facilities are concentrated in the Kutupalong and

Balukahali Expansion sites in Ukhya upazila where population density is high<sup>22</sup>. Camps in Teknaf are under-served compared to the camps in Ukhya. Even within the camps, health facilities are built mostly at the roadside or at the entrance to the camp. Very few facilities are built in remote areas located inside the camp. As a result, access to health facilities, especially for pregnant women and adolescent girls, remains a great challenge because of either unavailability of or inaccessibility to the services<sup>25</sup>.

Table 5.3: Distribution of health facilities in the camps

| Upazila | Camp             | Heath post (fixed and mobile) | Primary Health Center | Labor room / Specialized SRH facility | Community Clinic | Health & Family Welfare Centerv | Secondary Health Facility |
|---------|------------------|-------------------------------|-----------------------|---------------------------------------|------------------|---------------------------------|---------------------------|
| Ukhya   | Camp 1E          | 5                             | 1                     | 1                                     |                  |                                 |                           |
|         | Camp 1W          | 9                             |                       |                                       |                  |                                 |                           |
|         | Camp 2E          | 1                             |                       |                                       |                  |                                 |                           |
|         | Camp 2W          | 4                             | 2                     |                                       |                  |                                 |                           |
|         | Camp 3           | 9                             |                       | 1                                     |                  |                                 |                           |
|         | Camp 4           | 5                             | 3                     | 2                                     |                  |                                 |                           |
|         | Camp 4 Extension | 1                             | 1                     |                                       |                  |                                 |                           |

| Upazila | Camp          | Health post<br>(fixed and mobile) | Primary Health Center | Labor room / Specialized SRH facility | Community Clinic | Health & Family Welfare Center | Secondary Health Facility |
|---------|---------------|-----------------------------------|-----------------------|---------------------------------------|------------------|--------------------------------|---------------------------|
| Ukhiya  | Camp 5        | 6                                 | 1                     |                                       |                  |                                |                           |
|         | Camp 6        | 6                                 | 1                     |                                       |                  |                                |                           |
|         | Camp 7        | 9                                 |                       |                                       |                  |                                |                           |
|         | Camp 8E       | 6                                 |                       |                                       |                  |                                |                           |
|         | Camp 8W       | 7                                 | 1                     |                                       |                  |                                | 1                         |
|         | Camp 9        | 10                                |                       |                                       |                  |                                | 2                         |
|         | Camp 10       | 6                                 |                       |                                       |                  |                                |                           |
|         | Camp 11       | 12                                |                       | 1                                     |                  |                                |                           |
|         | Camp 12       | 4                                 | 1                     | 1                                     | 1                |                                |                           |
|         | Camp 13       | 11                                |                       | 1                                     | 1                |                                |                           |
|         | Camp 14       | 6                                 | 1                     | 1                                     |                  |                                |                           |
|         | Camp 15       | 7                                 | 1                     |                                       |                  |                                |                           |
|         | Camp 16       | 10                                | 3                     | 1                                     |                  |                                | 1                         |
|         | Camp 17       | 7                                 |                       |                                       |                  |                                |                           |
|         | Camp 18       | 6                                 | 1                     |                                       |                  |                                |                           |
|         | Camp 19       | 2                                 |                       |                                       |                  |                                |                           |
|         | Camp 20       | 4                                 |                       |                                       |                  |                                |                           |
|         | Camp 20       | 1                                 |                       |                                       |                  |                                |                           |
|         | Extension     |                                   |                       |                                       |                  |                                |                           |
|         | Kutupalong RC | 1                                 |                       |                                       |                  |                                |                           |
| Teknaf  | Camp 21       | 2                                 | 1                     |                                       |                  |                                |                           |
|         | Camp 22       | 7                                 | 1                     |                                       |                  |                                |                           |
|         | Camp 23       | 2                                 |                       |                                       |                  | 1                              |                           |
|         | Camp 24       | 1                                 |                       |                                       |                  |                                |                           |
|         | Camp 25       | 1                                 |                       |                                       | 1                |                                |                           |
|         | Camp 26       | 5                                 | 1                     |                                       | 1                |                                |                           |
|         | Camp 27       | 3                                 |                       |                                       |                  |                                |                           |
|         | Nayapara RC   | 1                                 |                       |                                       |                  |                                |                           |

**Maternal health:** Antenatal and postnatal care services are provided both at health facility and community levels, mostly by community health workers (CHWs) and midwives. Some 24/7 PHCs including all secondary hospitals, UHCs and Sadar Hospital, have normal vaginal delivery facility, and some secondary hospitals and Sadar hospital have facilities for C-section. However, home delivery is very common among the Rohingya refugees. As of end-2018, only 32 percent deliveries occurred at health facilities<sup>26</sup>. From January to September 2018, a total of 9,945 deliveries were conducted in the health facilities<sup>22</sup>. However, the utilization of ANC services was quite impressive. According to DHIS-2 data, total 28,612 Rohingya refugee pregnant women received at

least one ANC services from health facilities from September to November 2018<sup>10</sup>. However, looking at the prevailing choice for home deliveries over facility-based deliveries, SRH WG has developed a guideline for engaging traditional birth attendants through all the partners and promote institutional deliveries amongst the Rohingya refugee community<sup>5</sup>.

**Adolescent SRH:** ASRH issues are mostly unaddressed. There is no focused SRH services available for adolescents. Some NGOs and INGOs distributed disposable sanitary napkins at the early stage of the crisis. After six months of the influx, some organizations have started providing sanitary pads and some are also teaching refugee adolescent girls to

make reusable pads. However, disposal of disposable sanitary napkins is a great challenge in the camp context.

**Family planning services:** Providing family planning services to the Rohingya refugees is one of the priorities of the organizations providing SRH services. However, providing family planning services and acceptance of the family planning methods among this population are major challenges due to their cultural and religious conservatism. UNFPA along with SRHR working group partners have been advocating for the scaling up of FP services in all camps with a special focus on long-acting and reversible contraceptives (LARC). A collaborative agreement has been established with the Directorate General of Family Planning (DGFP) of the Government of Bangladesh for promoting and improving the access to LARC services for the Rohingya refugees<sup>26</sup>. As reported in the Mid-term Review of the Joint Response Plan (July 2018), 28 percent facilities provided at least 3 short acting and 1 long acting FP methods as of July 2018, which was a good improvement from the baseline of 12 percent<sup>27</sup>. DHIS-2 data also showed an upward trend in family planning service utilization. About 5,856 couples received FP services in June 2018, which increased to 15,687 in November 2018<sup>10</sup>.

**Sexually transmitted infections including HIV/AIDS:** The treatment of STIs is available at some selected healthcare facilities, mostly run by INGOs like MSF, Save the Children International, RTMI, and PHD, and in Teknaf and Ukhia upazila health complexes and Cox's Bazar district hospital. But the treatment of HIV/AIDS is available only in the district hospital. Some NGOs and INGOs have facilities for screening suspected HIV and STI cases. When suspected cases are identified, they are referred to the specific facilities where treatment services are available. But due to the lack of awareness, cultural conservatism and movement restrictions, especially for women, the number of case identification and treatment is still low.

**Most neglected group –adolescent boys and adult males:** There are very few interventions targeting adolescents. The NGOs mostly target adolescent girls, and few interventions in 2019 are also targeting adolescent boys<sup>28</sup>. However, adolescent boys and adult males are still the most neglected segment of the population in terms of sexual and reproductive health services. There are no specific services available to address the SRH needs of adolescent boys and adult males.

## COMMUNITY-BASED SRH SERVICES

Some organizations also have community health workers/volunteers (CHW/CHV), selected mostly from the Rohingya refugees as a linkage between the refugee community and health facilities. Their main responsibilities include health education and awareness-building, and community mobilization for increasing service utilization among the Rohingya refugees. A separate community health working group was formed under the health sector to coordinate and standardize the community-based activities. The working group developed monitoring and information collection tools to track the community-based services, such as ANC/PNC services provided by the CHWs, and deliveries occurring at home<sup>5</sup>.

Promoting Behaviour Change Communication (BCC) interventions within the Rohingya community to establish two-way engagement for SRH health-related concerns and solutions development is identified as an important aspect in the context of this humanitarian crisis<sup>13,28</sup>. To protect adolescent girls and boys from violence including gender-based violence and other forms of abuse (i.e., sexual abuse), protective behaviour trainings are conducted in the camps<sup>13</sup>. It is also important that other SRH issues this community faces in the camps be brought under the BCC intervention campaigns or communicating with communities (CwC) activities.

## SRHR TRAINING FOR THE PROVIDERS

UNFPA and its partner organizations have been providing series of trainings on SRHR topics to the healthcare providers. As of October 2018, more than 600 healthcare practitioners including midwives, medical doctors, and paramedics received training on LARC family planning methods, Helping Babies Breathe, Helping Mothers Survive, Clinical Management of Rape, Menstrual Regulation and post abortion care<sup>10,22</sup>. The SRH working group has also developed a pool of master trainers to help the partner organizations in rolling out the trainings to healthcare providers<sup>10</sup>. In addition, partner organizations also have their own system for training healthcare providers.

## SRHR INTERVENTION COORDINATION

The Bangladesh government and different national and international NGOs provide SRH services to the Rohingya refugee population. The services are mostly provided at the health facility level although some NGOs also have community health workers/volunteers working at the household level inside the camps. A

total of 55 organizations (Box 1), who are the key SRHR service implementers in Cox's Bazar, have joined the SRHR Working Group under the Health Sector and the Inter Sector Coordination Group (ISCG) with a common goal to improve SRH condition of the refugee population by providing best available services. UNFPA is leading the SRHR Working Group, and along with partner organizations has been trying to improve the service coverage and address the gaps in service provision and quality.

### **Box 5.1: SRHR Working Group partners**

Action Contre la Faim (ACF), AID Station Bangladesh (MOAS), Alliance of International Doctors, Bangladesh Red Crescent Society, BRAC, Canadian Red Cross, CARE International, Centre for Disease Control and Prevention (CDC) Bangladesh, Christian Aid (CA), Community Partners International (CPI), Direct Relief, DocMobile, emBOLDen Alliance, Family Planning Association of Bangladesh (FPAB), Field Hospital Malaysia (FHM), Friends in Village Development, Bangladesh, Friendship, Gonoshasthaya Kendra (GK), HelpAge, HOPE Foundation, HumaniTerra, Humanity Heroes, IFRC, International Committee of the Red Cross (ICRC), International Planned Parenthood Federation (IPPF), International Rescue Committee (IRC), IOM, Ipas, Malteser International, Management & Training International (MTI), Marie Stopes, Mastul Foundation, Medair, Medco Bangladesh (FH/MTI), Médecins du Monde (MDM-F), MedGlobal, Medical Teams International, Mercy Malaysia, MSF, OBAT Helpers, Partners in Health and Development (PHD), Peace Winds Japan (PWJ), People in Need, PUI, Relief International (RI), Research, Training and Management (RTM) International, SAMS Global Response, Save the Children, Terre des Hommes, Turkish Field Hospital, UNAIDS, UNHCR, UNICEF, WHO

Source: Sexual and Reproductive Health Working Group – Quarterly Bulletin, Issue 2, March-May 2018.

## GAPS AND CHALLENGES

- Available SRHR services are not fully standardized and the quality of services is questionable. Health cluster and SRHR working group are trying to establish a joint monitoring system, but the progress has been very slow.
- Transporting patients at night, especially women, to the health facilities for delivery is a great challenge due to the unavailability of transports and most of the 24/7 facilities being located outside the camps<sup>8,26</sup>.
- High turnover of skilled and experienced healthcare providers remains a big challenge. As a result, continuation of SRH services and maintaining service quality have become matter of great concern<sup>8</sup>.
- Due to the scarcity of skilled healthcare providers and inadequate number of health facilities, the existing facilities have become over-crowded, resulting in less consultation time per patient, which ultimately compromises quality of care.
- Managing emergency obstetric cases on time is a great challenge due to the insufficient number of

health facilities having fully functional 24/7 BEmONC and CEmONC facilities<sup>22</sup>. There is also a lack of blood transfusion and inadequate lab facilities in the health centers serving the refugee population.

- Due to the scarcity of space in health facilities, maintaining privacy and confidentiality of the female patients, especially for providing GBV, services is a huge concern<sup>8</sup>.

## RESOURCES

In February 2018, the IAWG came up with recommendations for the steps to be taken by the Bangladesh government, implementing agencies, and the donors to strengthen the SRH of the displaced Rohingya population. Soon, the JRP was released for the Rohingya humanitarian crisis outlining plans for a coordinated response to meet the needs of refugees and host communities<sup>29</sup> and allowing them having access to free-of-charge SRH services. The MISP is designed to guarantee the access to services that have the most impact in reducing RH-related morbidity

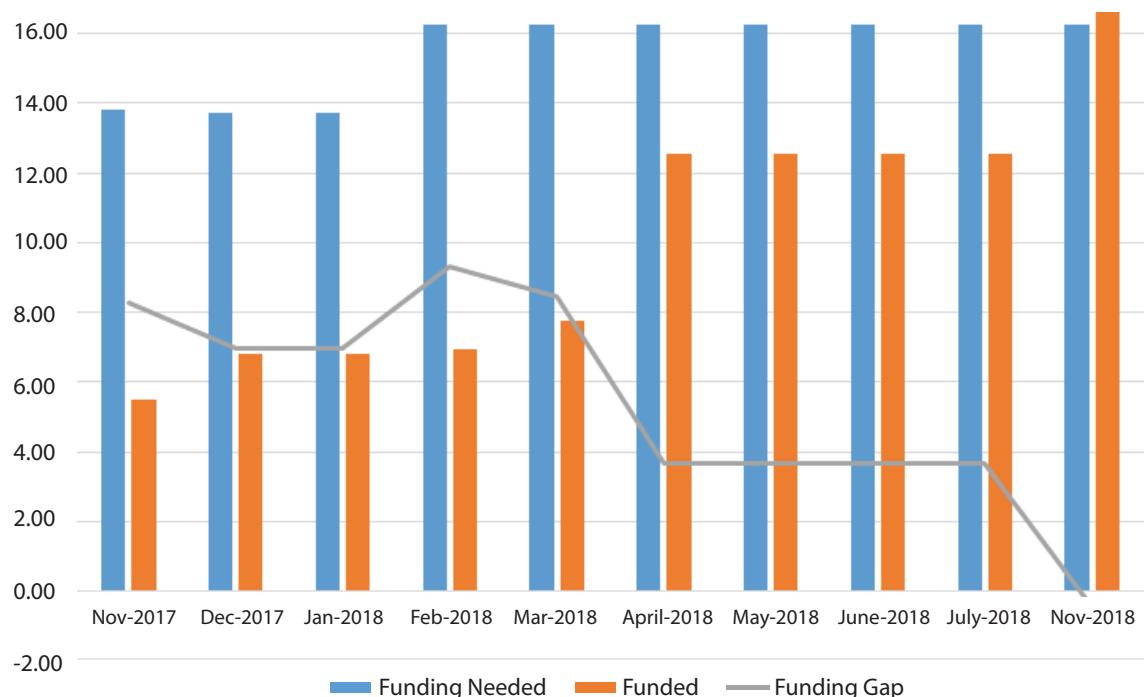
and mortality often found during the early stages of emergencies; and implementing the priority RH services<sup>30</sup> including the coverage of HIV/AIDS control and prevention, and responding to GBV and women's health risks such as sexually transmitted infections<sup>28</sup>. In order to avoid dreadful consequences such as increases in mortality and morbidity, sexually transmitted infections, unintended pregnancies, and unsafe abortions, the UNFPA and partners made implementing this protocol an immediate priority, and have been playing a major role in the JRP in mobilizing the funds to ensure service provision, and providing critical training in SRH care to the health workers.

## FUNDING AND RELATED GAPS

The JRP has estimated its resource requirement and requested to donors to fund SRH service, or more

specifically the MISP, to serve 325,000 women of reproductive age, attend approximately 60,000 pregnant women requiring basic ANC, and delivery care or comprehensive emergency obstetric care for approximately 2,500 women. Among these women, so far, only 22 percent are reported to be using health facilities to give birth (Huang and Schnabel, 2018). The resource requirement for SRH, which is part of the total resource that is mobilized for the health sector, was estimated at \$ 13.8 million in November 2017. This was later revised to \$ 16.24 million in February 2018 with the JRP's initiative. It is important to note that the health sector funding appeal within the JRP (US\$ 113 million) constitutes only 12 percent of the total, and only 13.49 percent was funded, which is lowest compared to the under-funding levels for all the other sectors. The trend of the request, funding level and funding gap for SRH provided by the UNFPA monthly situation reports are shown in Fig 5.4 below.

Figure 5.4: Funding Needed, Funding Level and Funding Gaps for SRH



Source: UNFPA Situation Report: Rohingya Refugee Response February 2017 - November 2018. Several Issues.

The funding gap remained quite substantial until March 2018, when only 47.9 percent of the total funding appeal was available. It improved to 70.4 percent in April 2018, and gradually to 103 percent. However, more recent information suggests that the total JRP 2019 funding requirements for SRHR and

GBV sectors is USD 20,000,000. The sector wise funding requirements that the SRHR sector requirement is estimated at USD 13,500,000, and for GBV, it is USD 6,500,000. The funding gap as in October 2019 has been recorded at USD 6,660,674.74.

## MAJOR SOURCES OF FUNDING

The major donors for the SRH sector in April 2018 included Australia, Canada, Denmark, Japan, Republic of Korea, New Zealand, Sweden, UK, and UNFPA. The

donors at the beginning of the emergencies were different from what we found recently, it changed at the time when JRP was launched (Table 5.4).

Table 5.4: Major donors for SRH

|                   | <b>Nov-2017 (USD)</b> | <b>Feb-2018 (USD)</b> | <b>April 2018 (USD)</b> | <b>Nov-2018 (USD)</b> |
|-------------------|-----------------------|-----------------------|-------------------------|-----------------------|
| Australia         |                       |                       | 2,300,000               | 2,300,000             |
| Canada            | 856,405               | 856,405               | 856,405                 | 1,906,405             |
| CERF              | 1,294,356             | 1,294,356             |                         | 1,294,356             |
| China             | 300,000               | 300,000               | 300,000                 |                       |
| DFAT              |                       |                       |                         |                       |
| DFID/UK&IRE       | 634,500               | 634,500               | 634,500                 | 2,561,000             |
| ECHO              |                       |                       |                         | 1,165,000             |
| ERF               | 300,000               | 300,000               |                         |                       |
| Friends of UNFPA  | 56,245                | 56,245                | 60,000                  | 60,000                |
| New Zealand       | 685,600               | 685,600               | 685,600                 | 685,600               |
| Republic of Korea | 500,000               | 500,000               | 500,000                 | 150,000               |
| UNFPA APR0        | 150,000               | 150,000               |                         |                       |
| UNFPA Bangladesh  | 70,000                | 70,000                |                         | 70,000                |
| CSTF              | 140,000               | 140,000               |                         |                       |
| Denmark           | 430,000               | 430,000               | 2,670,000               | 430,000               |
| vDANIDA/Denmark   |                       |                       |                         | 2,485,500             |
| SIDA              | 500,000               | 500,000               | 500,000                 | 500,000               |
| UNA Sweden        | 346,075               | 346,075               | 346,075                 | 346,000               |
| Japan             | 2,772,727             | 2,772,727             | 2,772,727               | 2,772,727             |
| UNFPA HQ          | 1000000               | 1000000               | 1000000                 | 1000000               |
| Total             | 10,035,908            | 10,035,908            | 12,625,307              | 17,726,588            |

Source: UNFPA Monthly Situation Report - April 2018

## CONCLUSION

This chapter summarizes the sexual and reproductive health condition, related services and actors, and associated challenges in the refugee camps of Cox's Bazar, Bangladesh, as of end-2018 and early 2019. The major challenges faced by the Rohingya community in terms of accessing essential reproductive, maternal, newborn and child health services are diverse. The majority of reproductive-aged Rohingya women and adolescent girls undergo home based delivery—only 22 percent are reported to use health facilities for giving births<sup>10</sup> due to accessibility, transport and service availability issues. This is resulting in avoidable maternal and infant mortalities<sup>10</sup>. On the other hand, knowledge and utilization of contraceptive methods are also restricted

(contraceptive prevalence rate – 33.7%) in this community due to various cultural and religious barriers<sup>7,12</sup>. Fears of gender-based violence including sexual violence and abuse are also evident in the Rohingya community despite efforts from various national and international organizations and actors to provide SRH services and support at the population level (in some cases, including the host community). Misinformation, rumors and lack of understanding on SRH issues and service importance hinder this population from accessing the available services in the camps<sup>12</sup>. Restricted mobility of women and adolescent girls, absence of services targeting Rohingya males and adolescent boys, lack of community awareness and overall knowledge regarding the importance of sexual and reproductive health contributes to underutilization of SRH services, and overall deprivation in SRH condition of this community.

Ensuring service coverage and utilization through community awareness for sexually transmitted diseases and infections control and prevention methods including HIV/AIDS, and attention to preventing and responding to gender-based violence, are also critical and important.

On other hand, though the funding gaps came to an end in November 2018, it is important to evaluate whether the resources are being utilized efficiently. Lack of evaluation data on the effectiveness of the programs/interventions is a common problem in humanitarian crisis situations. It is important that proper monitoring and evaluation activities are undertaken for each program/intervention to improve accountability and performance of the system<sup>31</sup>.

We need to ensure that there is efficient utilization of resources. It is important to upgrade and improve the capacity of the existing health facilities which would enable to provide multi-disciplinary health care, including integrated comprehensive SRH services envisaged under MISP. The focus should also be on expanding to 24/7 service provision. However, the attempts to implement the MISP, ensuring the

allocations of resources/funding and looking at the supply side only would not be enough; there were other factors that acted as barriers that may lead to underutilization of resources and create inefficiency. Along with the effort to mobilize resources, effort should be made to improve the access by removing cultural barriers and restrictions on mobility, and improving community awareness of services. There is also a need to engage males in SRH interventions since they influence health-seeking behavior of women and in most cases they are the main decision makers in the family. Further, adolescent boys should not be put aside as this is a time when teenagers would like to experiment with drugs, get engaged with risky sexual behavior and are at higher risk of contracting STIs such as HIV/AIDS due to exposure to sexual abuse or malpractices.

The other supply-side interventions that have been planned or initiated include UNFPA's provision of critical trainings in sexual and reproductive health care, including health workers' caring for survivors of sexual violence, and establishing emergency obstetric and newborn care services and referral mechanisms, with the aim of reducing maternal illness, disability, and early deaths.

## RECOMMENDATION

Considering the situation of SRHR of the Rohingya taking shelters in the refugee camps in Cox's Bazar, Bangladesh, few short and long term action points are recommended here.

### **Short-term recommendations:**

- More emphasis needs to be given on community mobilization to make them aware of the importance and availability of SRH services. Community-based strategies need to involve husbands/ male community members as they are one of the main barriers in SRH service access and utilization
- Orientation training can be arranged for informal health care providers, such as traditional healers, traditional birth attendants and Burmese doctors to encourage them for referring patients to health facilities.
- Provision of remote consultancy by medical doctors through telemedicine/video-conferencing can be an immediate alternate strategy for dealing with shortage of medical service providers in the health facilities.

### **Longer term recommendations:**

- Unequal distribution of health facilities is one of the barriers in accessing services from the remote locations of the camps. Therefore, distribution of health facilities across and within the camps is crucial to make facilities accessible in the challenging geographical landscapes. More health facilities with key SRH services need to be established to increase coverage and service utilization.
- It is important to make SRH services available for Rohingya men and adolescents in addition to engaging them in GBV awareness campaigns. Considering the sensitivity of the services and conservative nature of the community, male-only service points can be introduced where male providers will serve ensuring privacy and confidentiality.
- Frequent high turnover of human resources is a major challenge for the continuation of quality SRH services. Recruiting more healthcare providers from host community as well as provision of secure accommodation and incentives (monetary or non-monetary, such as opportunities for higher study or training to acquire new skills) can be a strategy for retaining and motivating staff.

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## CHAPTER SIX

# MENTAL HEALTH AND TRAUMA

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## INTRODUCTION

The United Nations High Commissioner for Refugees (UNHCR) estimates that globally 65.6 million people have been forcibly displaced as a direct result of conflict, human rights violations and persecution, with 85 percent of displaced people being hosted in developing countries<sup>1</sup>. The Rohingya people are recognized as one of the most persecuted minority groups in the world, experiencing appalling personal and geopolitical traumas. Their difficulties are well-documented, particularly following the recent systemic campaign of extreme violence by the Myanmar authorities in August 2017. Over 700,000 Rohingyas fled over the border into the Cox's Bazar district of Bangladesh, joining the 200,000 Rohingya people who were already residents from previous campaigns. The Rohingya experiences of conflict, torture, genocide and gender-based sexual violence are recognized as having serious and severe consequences on mental health and

well-being. How the experience of resettlement impacts on their mental health is less understood. However, it is likely to involve a complex interaction between the individual and their community, their identity, and the wider local and international community and systems of disaster management.

The construct of mental health is itself complex, involving consideration of multiple factors to accurately understand, assess and treat distress in culturally meaningful and effective ways. This chapter will outline the relevant theoretical and clinical issues pertaining to a critical understanding of mental health needs and provisions for the experiences of the Rohingya since August 2017. A summary of current provisions and the challenges of managing a humanitarian crisis of this magnitude will be discussed with attention paid to areas of gains and hope, the gaps and future needs.

# WHAT IS MENTAL HEALTH?

The World Health Organization (WHO) defines mental health as ‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’<sup>2</sup>. The American Psychiatric Association (APA) understands mental health as ‘processes that involve effective functioning in daily activities resulting in productive activities (work, school, caregiving), healthy relationships, ability to adapt to change and cope with adversity’. In humanitarian crises, there is a much higher incidence of mental health difficulties due to the mass exposure to extreme and traumatic stressors than in a ‘normal’ and relatively stable population<sup>2</sup>.

It is important to note that most mental health difficulties are understandable, or ‘normal’ responses to longstanding acute or traumatic life events. Indeed, in most cases, it would be unusual if there were no negative emotional reactions to adverse circumstances. As such, mental well-being and distress can be understood to exist on a spectrum, along which we move throughout our lives. Mental health difficulties occur when person’s mental state has undergone changes in emotion, thinking and behaviors, or a combination of these, resulting in psychological distress, which in turn impacts on their functioning in social, community, employment and family activities<sup>3</sup>. Mental health is understood to be an interaction between biology, individual characteristics and the social environment (i.e., biopsychosocial approach). Significant stigma and shame are attached to mental health difficulties regardless of culture and social norms. Culture is an important component in understanding how individuals make sense of their experiences from birth, and displays of distress are culturally influenced and informed. For example, in some cultures the hallucinatory experiences associated with a diagnosis of ‘psychosis’ can be understood within a spiritual framework as ancestral communications of wisdom, whereas in Western cultures the same experience is understood as a symptom of severe and enduring mental health difficulties. As such, the cultural meaning ascribed to the experience is crucial.

The inclusion of mental health in the 2030 Agenda for Sustainable Development Goals (SDG) is an important recognition that mental health is ‘one of the most pressing development issues of our time’<sup>4</sup>. This is

significant given the SDGs’ influence on priority setting and funding at national and international levels<sup>5</sup> which recognize universality of mental health and well-being across all human experiences. Improvements in mental health services therefore play a significant role in facilitating safe and sustainable human settlements experience<sup>6</sup>. Historically there have been distinctions between the remits and overarching goals of humanitarian and development bodies<sup>5</sup>. In the Rohingya context, therefore, development organizations focus on long term systemic and sustainable change, while humanitarian principles rooted in international humanitarian law focus on immediate needs of saving lives and alleviating suffering. The principles of humanity, neutrality, impartiality and independence are devised to guide the work of humanitarian actors. Much like poverty, mental health discourses in SDGs’ run the risk of being exclusively individual pathologies and are therefore conceptualized as a barrier to development that needs ‘fixing’. The reality is likely to be that it is a much more nuanced and complex process, involving a multifactor understanding of the positive and negative consequences of development initiatives in the populations they seek to serve<sup>5</sup>.

An overview of common mental health problems in a refugee population is presented below to aid a critical understanding of the experiences and service provision in the Rohingya camps.

## Depression

Depression is one of the main causes of disability worldwide<sup>7</sup> and is the term used to describe chronic and enduring feelings of sadness, hopelessness, feeling stuck, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. It can present as reactive (response to a particular life event or life stage), long-lasting, or recurrent, and can substantially impair people’s ability to function at work or school and to cope with daily life. At its most severe, depressive processes can lead to suicide.

## Anxiety

Feeling afraid is an essential part of the human experience and generally occurs in response to anticipated danger. As a survival instinct, a fear response is important as it initiates a series of physical and behavioural changes that ultimately serve to

protect us, e.g., our system receives an adrenaline boost to enable us to cope with any immediate survival action, i.e., fight or flight. Anxiety is differentiated from fear, which is usually a response to a real or perceived immediate threat<sup>8</sup>. Anxiety is understood as an emotional and physiological experience of uneasiness and worry, usually generalized and unfocused, often accompanied by muscular tension, restlessness, fatigue and problems in concentration and rumination (over-thinking or perpetual worry cycle)<sup>9</sup>. It is understood to be experienced as subjectively unpleasant feelings of dread over anticipated events and can be profoundly debilitating to everyday and long-term functioning. Anxiety can be appropriate, (for example, before an exam or job interview) as it has strengths in enabling focus and concentration for short bursts, but when experienced regularly the individual may suffer from an anxiety disorder. Difficulties arise when the anxiety is disproportionate or incongruent to the reality of threat in the environment, e.g. feeling anxious about a social situation, or getting back into a car after a road traffic accident.

## Trauma

Trauma is the psychological and physiological reaction that an individual can experience in response to an event or a situation that is threat-based and deeply disturbing. Trauma experiences can involve single incident e.g., an accident, sexual assault or bereavement, and/or longstanding and damaging experiences such as wartime rape or torture. As experiences are essentially subjective, a broad trauma definition is more of a guideline and as such there are various categories of trauma. Among them are post-traumatic stress disorder (PTSD), complex trauma, and transgenerational trauma.

## SOCIAL DETERMINANTS OF MENTAL HEALTH

It is increasingly recognized that the determinants of mental health and illness involve not just individual factors, but also social and socio-political factors, and their interaction with each other<sup>10</sup>. People are made vulnerable by poverty, social inequality, persecution and discrimination<sup>10,11,12</sup>. The WHO (2014)<sup>2</sup> ‘Social Determinants of Mental Health’ report recognizes that mental health and many common mental disorders are shaped by these social, economic and physical

environments. Patel et al. (2010)<sup>13</sup> and other researchers have added to a growing body of evidence that social inequalities are associated with increased risk of mental health difficulties<sup>14,15,16</sup>. For example, occupying a ‘stateless’ status for the Rohingya has an impact on their sense of safety and security in terms of legal frameworks, which in turn has an impact on their internal state in terms of sense of belonging, recognition of trauma, feelings of safety and recognition of self-worth in addition to availability of future support and opportunity to thrive.

Despite recognition that social structures can negatively impact on mental health<sup>17,8,19</sup>, there is a lack of mental health interventions that are sensitive to social influences in humanitarian settings. The interventional research upon which guidelines and services are developed tend to be conceptualized in individualistic Western models of mental distress, reducing the impact of social complexity by locating the ‘problem’ in the individual. Individuals are then expected to ‘take responsibility’ for their own health, often in circumstances that present almost overwhelming structural barriers to the effective accomplishment of such goals<sup>5</sup>. Such reductionist approaches are unlikely to produce sustainable psychological and indeed economic gains in the long term, although further research is required to assess the economic impact of individualized treatment when compared to those that address social determinants of mental distress. It is important to note that structural approaches do not dismiss the importance of the individuals’ unique experience of and reactions to traumatic experiences, but rather recognize that these experiences are a manifestation of individual reactions to adverse life events that are impacted on and influenced by their social context. The social ecology of individual experience therefore pays explicit attention to the social, institutional, and cultural contexts of people-environment relations, and provides a useful conceptual bridge between social, anthropological, psychological and medical disciplines<sup>20,21</sup>. The Rohingya people with their history of persecution already experience significant barriers to achieving positive mental health and well-being<sup>22,23</sup>. In recognising the impact of social and political structures, power and responsibility within social society and geopolitics also play a significant role<sup>24</sup>.

The experience of psychological and emotional distress therefore cannot be analysed based on individual factors alone given the systemic influence of power. The analysis of power dynamics indicates the adverse influence of certain groups in social,

economic and material factors on well-being and how language is constructed, 'producing dominant social discourses, with particular consequences'<sup>25</sup>. Such influences are uncomfortably apparent, when observing the impact of social media on the rise of nationalism globally and the consequences on targeted groups of people. Explanations of mental health arise from those with the geopolitical power; these in turn determine the types of psychological and mental health symptoms which constitute mental illness and distress, and thus which assessment, interventions and services are made available to the population. Therefore, 'individualizing the distress of refugee people and 'treating' them by focusing on symptom alleviation'<sup>25</sup> is likely to be a benefit for those in therapeutic engagement with a compassionate professional, but danger lies in services overlooking, being unaware of, or dismissing the social and material causation of refugee people's distress while holding an individualistic trauma discourse<sup>25</sup>. To quote Lund et al (2018)<sup>18</sup> who cited the words from the WHO report on the social determinants of health in 2008: "Why treat people only to send them back to the conditions that made them sick in the first place?"

## MENTAL HEALTH INTERVENTIONS FOR DISPLACED PEOPLE AND REFUGEES

### Current evidence

One of the major challenges in addressing the mental distress experienced by refugee people in humanitarian settings lies in the complexities of providing interventions that are effective, culturally appropriate and that are ethically deliverable in low resource settings.

When compared to a general population, refugees have been shown to experience considerably higher levels of psychological distress, higher levels of mental health conditions and higher levels of social distress in different domains, i.e., demographics, economic, neighbourhood, environmental events and socio-cultural domains<sup>26,18</sup>. There is epidemiological evidence that post-displacement stressors and acute, cumulative and daily stressors are disproportionately experienced by refugees and asylum seekers, before

and during displacement<sup>27,28,19</sup>. Post displacement stressors include resettlement, language barriers and perceived stigma and discrimination<sup>29,30</sup>.

Recent reviews indicate high incidences of depression, anxiety and PTSD, with the surprising finding that depression and anxiety are almost equally experienced to PTSD<sup>31,32,33</sup>. This finding is of particular relevance to epidemiological relevance of common mental disorders in this group, but also to specifically underline that depression and anxiety disorders present a significant mental health challenge for refugees and services that support them. The importance of this finding lies in the fact that the refugee mental health field is currently dominated by programs and research activities that focus predominantly on PTSD.

Published reviews on interventions for refugee people show differing efficacy outcomes. Turrini et al. (2019)<sup>34</sup> found that psychological interventions had a significant beneficial effect on PTSD, with the most supportive evidence coming from trauma-informed CBT reducing PTSD and anxiety symptoms, with Eye Movement Desensitized Reprocessing (EMDR) showing efficacy in lowering symptoms of depressive difficulties, but with little support for Narrative Exposure Therapy<sup>34</sup>. Conversely, Tribe et al. (2017)<sup>35</sup> found medium to high quality evidence to support the use of NET in the treatment of PTSD, with less evidence to support CBT and EMDR, citing a lack of cultural adaptation in these interventions. These differences highlight the continuing need to have overarching strategies for researching effective treatments in diverse settings.

There are significantly fewer published studies on mental health issues in refugee children and adolescents. Fazel et al (2012)<sup>36</sup> found that exposure to pre-trauma violence, gender, settlement in refugee camps, repatriation issues and internal displacement were all associated with mental health difficulties in children and adolescents. Vossoughi et al. (2018)<sup>37</sup> found that prevalence of mental health disorders in children and adolescents was variable in their systematic review of the evidence base, with some studies reporting low percentages for mental health disorders like PTSD, and others reporting high prevalence rates for the same disorder. Similar prevalence variances were observed across the studies in the reported levels of anxiety, somatic symptoms, depression, and aggression. These results suggest a considerable need for more research on the mental health of children and adolescents residing in refugee camps.

A significant challenge lies in concerns about the reliability of the published data on prevalence rates and efficacy for interventions<sup>34,31</sup>. What is apparent is that data from comparison and global prevalence studies should be approached with caution, due predominantly to the variability and heterogeneity in approaches, study designs, and differing cultural groups from different countries<sup>31</sup>. In addition to this, the instruments used to measure prevalence and efficacy of mental health disorders and interventions were based on and normed against Western conceptualizations of mental health which may have misrepresented symptoms experienced by non-Western populations<sup>38</sup>. Indeed, Weissbecker et al. (2019)<sup>39</sup> argue that prevalence surveys in humanitarian settings are inefficient and potentially misleading, coming with their own set of challenges. Such surveys are not part of a routine assessment in emergencies and lack the sensitivity to distinguish between normal stress reactions (expected human responses to adversity) and mental disorders. Weissbecker et al (2019)<sup>39</sup> suggest that this leads to potentially inflated estimates of mental disorders; it is also likely that the measurement criteria of Western conceptualization of distress might misclassify or overlook important indigenous expressions of distress. In addition to this, a focus on psychopathology largely overlooks the strengths of the individual experience, i.e. the resilient processes that drive positive adaptation such as religion, hope, social connections and resourcefulness<sup>39,40</sup>. Clinically speaking, the reviews highlighted that any study comparisons were problematic given they were based in very different clinical cultural groups from different countries. In addition to this, studies were on refugees who had resettled in different host countries with different reasons for migration, different exposure to post-migration stressors and very different lengths of stay in the host countries. The recognition here is that while these factors and their complex interaction may have a crucial role in shaping individuals' behaviour and mental health, comparing and pooling data for over-arching evidence is fundamentally problematic<sup>41</sup>.

In summary, it seems clear that the current evidence base requires more robust and rigorous studies focusing not only on PTSD but also on a wider range of outcomes, including depression and anxiety, and taking into considerations cultural idioms of distress. In addition to this, new research is required to assess efficacy of psychosocial interventions and an evaluation of factors and adaptations that contribute to positive treatment outcomes based on refugee needs. Specific evidence guidelines should be

developed for cultural contexts which could be applicable and modified for the range of mental health services in low- and middle-income countries as well as high-income countries.

## MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)

Mental health and psychosocial support (MHPSS) refer to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Support may include interventions in health, education, or interventions that are community-based. The term 'MHPSS problems' covers social problems, emotional distress, common mental disorders (such as depression and posttraumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual disability<sup>1</sup>. MHPSS are based on Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings which provides a consensus framework and detailed guidance for humanitarian organizations to plan, establish and coordinate minimum multi-sectoral responses to protect and improve mental health and psychosocial well-being in an emergency<sup>42,39</sup>. While this model is useful in its potential low cost and ability to provide support for large numbers of people, and the successful linking of mental health and psychosocial actors<sup>43</sup>, there are challenges identified in the lack of specificity and heterogeneity in interventions across settings, a lack of measurement of outcomes, lack of cultural sensitivity in service delivery and potential ethical issues around consent<sup>44</sup>.

## HUMAN RIGHTS AND ETHICAL ISSUES

Human rights violations are inextricably linked with humanitarian crises, the trajectory of which can result in people being denied opportunities to seek and receive help for mental health difficulties<sup>39</sup>. We have already highlighted the evidence about the influence of social factors on mental health, e.g., housing, employment; and freedom from discrimination, all of which are also enshrined in international human rights law. What is more complex is the relationship between

mental health and human rights violations such as torture and displacement, denial of access to adequate resources, and coercive treatment practices. Such vulnerabilities are particularly salient in the Rohingya experience. Human rights violations can impact on mental health and conversely, respecting a person's human rights can improve mental health<sup>45</sup>. In the context of the Rohingya people's experiences, Wali et al (2018)<sup>46</sup> reviewed documentation on the human rights related health issues, finding that significant structural barriers, poor living conditions, restricted mobility, and lack of working rights for extended periods of time collectively contribute to poor physical and mental health outcomes for the Rohingya refugees. They concluded that in the camps, a better understanding of the complex interplay of the underlying and immediate human rights of refugees would aid positive well-being. Parallel and related to human rights advocacy is the issue of ethical practice in mental health intervention work. Ethical principles form the basis of intent for any health interventions, and are grouped in principles of beneficence (promoting well-being and doing good) and non-maleficence (striving to prevent harm), autonomy (recognizing that individuals have rights to freedom of action and choice), fidelity (being faithful, honest and transparent regarding plans for intervention, and trust in practitioner), respect for the person, justice (ensuring people are treated fairly and impartially), fairness (equitable treatment irrespective of individual differences) and self-respect (fostering the practitioner's self-knowledge and care for self). Weissbecker et al (2019)<sup>39</sup> note the importance of MHPSS practitioners following human rights and ethical principles as narrowly defined clinical approaches and stigmatizing assumptions and language can have harmful effects on a vulnerable individual and communities.

## GENDER BASED VIOLENCE (GBV)

GBV involves men and women, in which the female is usually the target, and is derived from unequal power relationships between men and women. It is understood to be rooted in and reinforced by gender inequalities, and the gender norms and social structures that support and justify it. The impact of GBV is far reaching, affecting women, girls, families, communities and societies. It is recognized as a human rights violation and one of the most pervasive forms of gender-based inequality. GBV includes, but is

not limited to, physical, sexual, and psychological harm, with the most pervasive form is in the abuse of a woman by intimate male partners. Forms of GBV also include battering, intimate partner violence, sexual violence, bride price-related violence, sexual abuse of female children in the household, honor crimes, early and forced marriage, female genital mutilation (FGM), sexual harassment and intimidation in social experiences, commercial sexual exploitation, and trafficking of girls and women.

There is substantial evidence of the use of sexual violence by the Myanmar forces as a strategy of oppression and ethnic cleansing, including rape, gang rape and sexual torture of Rohingya women before and during the August 2017 atrocities (Sultana, 2018)<sup>47</sup>. Rohingya women are frequently subjected to multiple forms of abuse including harassment, economic deprivations and psychological and physical violence perpetrated by men<sup>48,47</sup>. High rates of exposure to sexual and gender-based violence (SGBV) have been reported by a range of humanitarian agencies and human rights organizations amongst Rohingya communities in Myanmar and countries of displacement, but accurate rates of SGBV are difficult to establish given the associated stigma and fear of retaliation, resulting in low reporting rates amongst survivors. The social impact of rape is profound; stigmatizing and discriminatory social factors mean that Rohingya women and their families often deny SGBV for fear of social ostracization. Additionally, husbands are reluctant to accept wives who had been raped or are thought to have been raped<sup>48</sup>.

The constraints on camp living and movement have also placed women in vulnerable positions regarding SGBV, as restrictions in the camps are more focused on the movements of men. As such, women are more able to travel outside the camps to earn money, and in many cases take domestic work in local host communities where they are at further risk of sexual and physical abuse. Trafficking is also a serious issue in the camps, and as a result, many Rohingya girls are forced into early marriages as a means of protecting them from SGBV.

# MENTAL HEALTH IN ROHINGYA CAMPS POST-AUGUST 2017

## Overview

There are few published studies on mental health of the Rohingya following the August 2017 crisis. Reasons for this may be partly due to the focus on immediate and emergency delivery of public health and social structure support systems, the ethical parameters of researching vulnerable populations in refugee camps, and due to the time and resources required to plan, develop and implement research projects.

Riley et al. (2017)<sup>19</sup> found that while trauma symptoms were present, high levels of daily environmental stressors were associated with life in the camps, i.e., lack of food, restrictions on movement outside the camps and safety concerns. Symptoms of depression were associated with these daily stressors rather than prior experiences of trauma.

Tay et al. (2018)<sup>49</sup> published a UNHCR commissioned comprehensive review of mental health and cultural needs of the Rohingya people in recognition of a serious lack and need of available information in this area. The review made important contributions to Rohingya conceptualizations and idioms of mental distress, for example, the use of restlessness or lack of peace to denote a range of distress. Importantly, the review established that the Rohingya people have a limited familiarity with Western concepts of mental distress; their expressions of distress stem from cultural rather than global descriptors. The review also highlights Rohingya beliefs in spirit possession for issues such as erratic behaviour, visual and auditory hallucinations and paranoid delusions, implying that psychological formulations should consider incorporating such cultural beliefs around spirit possession, psychotic experiences and neurological conditions such as epilepsy. Religiosity was highlighted as a source of finding meaning about traumatic experiences, and support through community affiliation and belonging. Tay et al (2018)<sup>49</sup> identified key cultural barriers to the access and uptake of services; finding that in general, the Rohingya people tend not to seek formal support for mental health difficulties but connect with services when there is a physical complaint. Social stigma and

shame are associated with mental health problems, and most people experiencing such difficulties are supported within the family. With regards to psychosocial interventions for the Rohingya people, Tay et al. (2018)<sup>49</sup> noted the importance of combining community-based approaches with evidence based clinical interventions that address the unique trajectory of the Rohingya migration experiences.

Khan et al (2019)<sup>50</sup> examined neurodevelopmental difficulties in children presenting at a clinic in the Rohingya camps, assessing mental health as a component of their screening process. Using standardized measures normed for a Bangladeshi population, they found that over half of the 622 children included in the study reported to be in the clinical range for emotional symptoms, and 25 percent for peer problems. Overall, they found that the children's mental health difficulties were significantly associated with being parentless, in terms of emotional problems and peer problems. Strengths were noted in the commitment and caregiving of Rohingya mothers and caregivers. While parental mental health was not assessed in this study, they posit that problems in caregivers are also likely to affect the children, in particular those who are older and more aware of the circumstances and experiences of the past year.

In summary, while there is a dearth of evidence of prevalence rates of mental health difficulties and an absence of outcome data regarding current psychosocial interventions in the camps, there is reason to assume that anxiety, depression and PTSD are some of the main issues present. The social environment plays a key role in the development and maintenance of mental health difficulties and gaining an understanding of individual experiences requires an understanding of the structural and individual factors at play. Such understanding also requires an understanding of the cultural descriptors and idioms of mental distress, in line with guidelines with appropriate and effective interventions of displaced and traumatized people.

## IMPACT ON HOST COMMUNITIES

Another important aspect of the Rohingya experience and its context is the impact of and on the host communities in Cox's Bazar. During the initial influx in August 2017, the Rohingyas experienced of

oppression, genocide and dislocation resonated deeply with the people of Bangladesh, particularly for those who were in the locations nearest to the Myanmar border. There were accounts of great humanity, empathy and compassion displayed by local people: “their condition was deplorable. Most of them were women and children. They had no food, clothes, or shelter. They roamed like refugees. Their face was “horror of death”. I was shocked to see this disaster in humanity. I saw a Rohingya girl who was just eating rice with water. This scene made me cry. Then I decided to build a volunteer team”<sup>51</sup>. As time has gone on, the impact has become more complex and nuanced. The responses of the host community to the vast presence of the Rohingya are varied. While they appeared to be affected by humanitarian instincts for the traumatic experiences and difficult condition of the Rohingyas, there are also concerns about economic impact on work and job security and concerns about links with extremist religious organizations<sup>52</sup>.

## CURRENT PROVISION OF MHPSS INTERVENTIONS IN THE ROHINGYA CAMPS

### Overview

The responsibility for the general health care provision for Rohingya refugees, and more recently, the host communities, are held by a combination of local governmental organizations, United Nations agencies and national and international non-governmental organizations. Over 126 organizations and stakeholders are involved in direct and indirect support of the MHPSS provision in the camps. The need to effectively manage and co-ordinate the work of this range of organizations became apparent and to aid this, a MHPSS Working Group was established in 2009, with over twenty partners and actors providing mental health and psychosocial support to the affected population<sup>53</sup>.

Table 6.1: Current staffing provision

| MHPSS Staff Across Organizations and Camps* |   |  |
|---|---|--|
|   | Name of the Organization                              | MHPSS Staff +  |
| 1   | Directorate General of Health Services (DGHS)         | 1 psychiatrist, 4 Mental Health Gap Action Programme (mhGAP) trained doctors,  |
| 2   | International Organization for Migration (IOM)        | 5 Psychologists; 4 Clinical Psychologists; 6 Psychosocial counsellors; 1 Social worker; 2 Psychosocial volunteers; 1 Assistant project officer; 1 Clinical Psychologist; 8 Case management workers; 6 Community mobilizers team leaders; 1 Community volunteer; Designated MHPSS staff in child protection teams; 3 Para-counselors; 6 Community volunteers. |
| 3   | United Nations High Commissioner for Refugees (UNHCR) | 5 MHPSS managers and assistant managers for Cox's Bazar office. Supports technical staff via NGOs working on MHPSS in the camps.   |
| 4   | United Nations Population Fund (UNFPA)                | 5 GBV Managers in Cox's Bazar office. Funds the technical staff of NGOs working for GBV/protection in camps.   |
| 5   | Action contre la Faim (ACF)                           | 5 Clinical Psychologists; 12 Psychologists; 4 Assistants to Psychologist; 18 Assistant project officers.   |
| 6   | World Health Organization (WHO)                       | Large operation with technical officers and monitoring staff.  |
| 7   | Building Resources Across Communities (BRAC)          | 16 Psychologists (13 on call); 60 Para counselors, 350 Barefoot Counselors   |
| 8   | Medecins Sans Frontieres (MSF), Netherlands           | 1 Mental Health Activities Manager (MHAM- ex-pat) 1 NS Psychologist Supervisor, 1 Psychologist, 12 Counsellors;  |
| 9   | Research Training and Management International (RTMI) | 2 Psychologist; 6 Counsellors; 1 Social worker; 2 Psychosocial volunteers; 8 Case management workers   |

| <b>MHPSS Staff Across Organizations and Camps*</b> |  |  |
|--|--|--|
|  | <b>Name of the Organization</b>  | <b>MHPSS Staff +</b>   |
| 10   | CARE Bangladesh  | 3 Psychologists; 4 WFS assistants; 13 Volunteers; 13 Community mobilizers  |
| 11   | Ministry of Health (MoH)/ Directorate General of Health services (DGHS)/Ministry of Women and Children Affairs (MoWCA) | 6 Clinical Psychologists; 12 Psychosocial counsellors; 12 Psychosocial volunteers  |
| 12   | World Concern  | 20 Psychosocial Outreach Workers, 35 PSS volunteers, 1 Educational supervisor  |
| 13   | Danish Refugee Council (DRC)   | 38 case workers; 75 Volunteers   |
| 14   | IFRC through the Bangladesh Red Crescent Society (BDRCS)   | 1 Psychosocial Support (PSS) delegate, 1 BDRCS PS officer, 4 Psychologist; 3 Social workers; 28 Community volunteers; 17 BDRCS volunteers; 8 Psychosocial volunteers |
| 15   | Technical Assistance Inc. (TAI)  | 6 Psychosocial Counselors  |
| 16   | Mukti Cox's Bazar  | 16 Case Managers, 64 Case Workers  |
| 17   | Refugee Health Unit  | 2 Psychiatrists, 2 General Practitioners (GP)  |
| 18   | Save the Children International  | 5 Psychologists, 1 Expert  |
| 19   | Ganaswastha Kendra (GK)  | 5 Psychologists, 5 Social Mobilizers, 50 Community Volunteers  |
| 20   | Handicap International   | 6 Psychologists, 8 Social Workers  |
| 21   | Relief International   | 1 Psychiatrist, 1 GP   |
| 22   | Friendship   | 1 Project Coordinator, 6 Educational Supervisors, 16 Teachers, 16 Volunteers   |
| 23   | Medecins Sans Frontieres (MSF) France  | 2 Psychiatrists, 2 clinical psychologists, 4 psychosocial counselors, 4 interpreters, 16 community health workers  |
| 24   | Medecins Sans Frontieres (MSF), Belgium  | 3 psychologist, 7 Counselors   |
| 25   | Centre for Disability in development (CDD)   | 3 psychologists  |
| 26   | Medecins Sans Frontieres (MSF), Spain  | 1 mhGAP Doctor, 1 Clinical Psychologist, 2 Psychosocial Workers, 1 Social Worker, 2 Lay Counselors, 1 MH Educator, 7 MH Community Workers, 1 Interpreter             |

\* Data gathered from MHPSS Working Group (December 2018)

+ numbers denote posts. As it is not known whether these posts are full- or part-time, accurate numbers of total professionals and volunteers are difficult to calculate.

## MHPSS INTERVENTIONS ACROSS AGENCIES

The speed and scale of the influx over the course of the three-month period from August 2017 placed an enormous strain on host communities and Bangladesh as a whole, making it one of the world's largest and worst refugee crises. The sheer volume of the humanitarian crisis required immediate responses with the available resource structure, with priority placed on addressing basic needs of food, shelter and public health management. Here, the Bangladesh Army, with its significant experience in UN peacekeeping forces, were able to mobilize and put in

place shelter and provisions for initial and basic needs, alongside first response teams from international and local humanitarian organizations interventions.

With over 700,000 individuals joining the already resident 200,000 Rohingya refugees, humanitarian and government agencies were required to provide immediate care to the sudden appearance of a population the equivalent size of Stockholm in Sweden (744,000) or Rajshahi in Bangladesh (700,133). Adequate physical and mental health services for a population of these proportions are typically developed over long periods of time, with stable and established social, governmental and financial infrastructures that enable a system to respond to the physical, social and psychological needs of the

population within a culturally congruent context. The Rohingya crisis awarded none of these opportunities to aid agencies and the government of Bangladesh. The political history of the Rohingya meant that very little information was in the public sphere about their culture and unique needs, and together with their immediate experiences of torture and genocide, meant that humanitarian and government agencies faced an exceptionally daunting task of prioritizing and addressing the multiple needs.

## UNHCR

UNHCR has had an established presence in Cox's Bazar since 2014, developing a pilot project for psychosocial support in the two registered refugee camps in Bangladesh<sup>49</sup>. This pilot was initiated with the purpose of streamlining MHPSS across different stakeholder agencies and organizations charged with the humanitarian response<sup>1</sup>. Key components of the programme were to strengthen self-help mechanisms at the community level and awareness raising activities around psychological well-being and coping skills. Additional recreational activities aimed to improving confidence, leadership, and creativity amongst young adults. MHPSS was substantially scaled up by UNHCR in 2018 focusing on two main priorities:

1. Strengthening community-based psychosocial support (through training of community volunteers),
2. Introducing scalable psychological interventions such as Integrated ADAPT Therapy<sup>54</sup> and Group Interpersonal Therapy for Depression<sup>55</sup>.

The UNHCR MHPSS team consists of six mental health professionals (four psychologists and two psychiatrists) who focus on capacity building and support to UNHCR's partners such as NGOs and the government.

## INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)

The IOM's remit is to support the expansion of primary, reproductive and secondary healthcare services, in addition to providing the infrastructural support required for effective healthcare to function.

The immediate interventions following the August 2017 humanitarian crises were to respond to the 'emergency and primary healthcare needs of the Rohingya and affected host communities'<sup>56</sup> while continuing to assess, develop and integrate healthcare systems in response to the needs of the Rohingya. The capacity development with regard to MHPSS interventions is reported to have begun from January 2018, where training of 20 health promoters was completed in psychosocial approach and the Belief Model, and Focus Group Discussions, in order to ascertain the 'perceptions of mental health and psychosocial well-being' for the provision of MHPSS<sup>56</sup>. Over the period of January and February 2018, trainings on a range of therapeutic skills such as active listening and empathy continued<sup>57</sup>. While the training is reported to have commenced from January 2018, the IOM Situation Report (23 Feb, 2018)<sup>58</sup> reports that 4,487 individuals had received support MHPSS services since the influx in August 2017. The details of the nature of the interventions prior the training strategy and numbers and competencies of staff to deliver MHPSS interventions were not reported.

Their current MHPSS programme includes provisions such as 'individual counselling, inpatient care, patient referrals and community mobilization'<sup>49</sup>.

Table 6.2: IOM MHPSS and community interventions

| <b>IOM MHPSS and community interventions*</b> |  |  |  |
|---|--|--|--|
|   | <b>Extremely Vulnerable Individuals (EVI)** +</b>  | <b>Gender Based Violence (GBV)** +</b> | <b>Psychological First Aid (PFA)**</b> |
| Sept 2017                                     | 4,901  | 180                                    | 1,259                                  |
| Oct 2017                                      | 6,174  | 203                                    | 1,584                                  |
| <b>MHPSS individual interventions</b>         |  |  |  |
| 9-15 Feb 2018                                 | No data reported   |  |  |
| 16-22 Feb 2018                                | 1,300 Children received psychosocial support+  |  |  |
| 23 Feb – 22 Mar 2018                          | 4,487 received MHPSS since Aug 2017+   |  |  |
| 30 Mar – 30 April                             | No data reported   |  |  |
| 13 April - 31 May 2018                        | MHPSS support to 228, case management for 47 beneficiaries+  |  |  |
| 8 – 14 June 2018                              | No data reported   |  |  |
| 15 June – 26 Jul 2018                         | MHPSS specialized psychological support for 704+   |  |  |
| 3 – 9 Aug 2018                                | 4 group sessions with at risk populations+, MHPSS = 123+   |  |  |
| 14 – 30 Aug 2018                              | 2 group sessions, 70 pregnant women on self-care and attachment, MHPSS specialized psychological support for 310+  |  |  |
| 31 Aug – 6 Sept 2018                          | MHPSS specialized psychological support for 184+, Group session for adolescent girls on self-efficacy and confidence, art work competition for unaccompanied children.<br>8,707 people received MHPSS since Aug 2017   |  |  |
| 7 - 13 Sept 2018                              | MHPSS specialized psychological support for 230: individual counselling, positive parenting skills, emotional support, self-care during pregnancy.<br>Total 8,937 received MHPSS since Aug 2017  |  |  |
| 13 – 20 Sept 2018                             | MHPSS specialized psychological support for 381+<br>2 group sessions on self-care and mental health awareness, follow up sessions with families who have lost children including non-formal education lessons, positive parenting skills, awareness sessions for pregnant women, conflict resolution and livelihood activities.  |  |  |
| 21 – 27 Sept 2018                             | MHPSS specialized psychological support for 305+   |  |  |
| 28 Sept – 10 Oct 2018                         | MHPSS specialized psychological support for 448: developing understanding of own resources, and emotional, cognitive and physical skills to manage current situation and increase resilience.<br>Skills building with adolescent girls and women to increase community awareness, self-awareness and key roles they have in their community to increase cohesion and participation |  |  |
| 12-25 Oct 2018                                | MHPSS specialized psychological support for 1050+  |  |  |
| November 2018                                 | No data reported   |  |  |
| December 2018                                 | 176 beneficiaries participated in friendship sport activities. No individual MHPSS data reported.  |  |  |

\* Data extracted from IOM Weekly External Situation Reports between Sept 2017 – Dec 2018 (<https://www.iom.int/rohingya-response>)

\*\* Total numbers provided, which are assumed to be cumulative

+ Details and nature of intervention not reported.

The available data from IOM suggests that there has been development of a needs-targeted approach to MHPSS interventions over the course of the time, since the initial influx in August 2017, which would be appropriate given the general lack of cultural understanding of the Rohingya perspectives on mental

health and their relationship to help-seeking. However, what is less clear from the available data are the details of what form MHPSS interventions are taking and whether there are any clinical outcomes being collected.

## MÉDECINS SANS FRONTIÈRES (MSF)

MSF have identified that addressing and treating the psychological effects of traumatic experience is a priority from the outset. The MSF website reports that between August 2017 and December 2018,<sup>49</sup> mental health consultations and group mental health sessions have been provided across the camps, representing 4.7% of their total consultations. All MSF health facilities provide mental health services, and both psychological and psychiatric services are available at all inpatient facilities and some primary health centres. MSF reports it has 4 inpatient health facilities (hospitals), 5 primary health centres, 8 health posts and 1 outbreak response centre. It is not, however, clear what proportion of the overall health provision and resources are allocated for mental health/psychiatric care.

The website also reports that MSF teams ‘provide individual and group sessions, do psychosocial stimulation for malnourished children, and treat people for psychiatric conditions’ (MSF, 2018)<sup>50</sup>. There is, however, no detail provided on the models that inform their interventions, or how they are measuring the efficacy of their interventions through outcome measurement processes. They instead have reported attendance rates and state that success rates are based on a low incidence of drop-out from interventions; and that the high discharge rates imply improvements to people’s mental health, presumably as a result of the intervention (MSF, 2018)<sup>50</sup>. Furthermore, a breakdown of demographic information, incidence and prevalence data on mental health symptoms and presenting difficulties would add to an understanding of the nature of the psychological distress the Rohingya are experiencing. There is also a recognition of the stigma surrounding mental health difficulties and initiatives also include creating awareness of the availability of safe spaces. To this aim, MSF notes that as the Rohingya have particularly negative perspectives on having a ‘label’ of ‘mental ill health’, they made a commitment to use non-labelling terms, e.g. the psychological support space has been renamed ‘Shanti Khana’ or ‘Place of Peace’ rather than ‘Mental Health centre’.

## BRAC

BRAC is one of the largest NGOs in the world. Their model for MHPSS implementation involved multidisciplinary teams developed in BRAC Institute of Educational Development of BRAC University. Their significant work and experience in child development enabled them to take the lead in child protection and MHPSS provided by BRAC to the Rohingya refugees at Cox’s Bazar. They identified the significant vulnerability of women and children to abuse, violence and trafficking, due to high population density in camps and the makeshift nature of shelters. In addition to these safety issues, BIED identified an ongoing need for integrated early childhood education and psychosocial support for the refugee population. To address this gap, BRAC and the BRAC Institute of Educational Development (BIED) have partnered with UNICEF to design and deliver 200 Child-Friendly Spaces (CFS) across 11 camps in the Ukhiya and Teknaf areas of Cox’s Bazar, as well as 15 for local Bangladeshi communities. MHPSS support has been offered centring the child friendly spaces catering to 40,000 children and their families.

BRAC-IED provides psychosocial support to the Rohingya community by implementing a four-tier psychosocial model through group sessions based in the CFS, as well as individual sessions for cases identified during routine home visits. This delivery approach involves four levels of staff. As of April 2018, BIED has deployed 308 barefoot counsellors and 38 para-counsellors at Cox’s Bazar to provide psychosocial support to children, adolescents and their families of BRAC CFSs through individual and group session at centres and at homes. This frontline staffs are supervised by eight counselling psychologists based in Cox’s Bazar and two experts who make routine trips to Cox’s Bazar and manage more complex cases. Brief statistics are provided below.

Table 6.3: Mental Health and Psychosocial Support Service (MHPSS)

| <b>Mental Health and Psychosocial Support Service (MHPSS)*</b>        | <b>Total Number</b> | <b>Male</b> | <b>Female</b> |
|---|---------------------|-------------|---------------|
| PSS Cases Identified  | 1,683               | 271         | 1,412         |
| Client Ages 0-10  | 186                 | 97          | 89            |
| Client Ages 11-18   | 365                 | 83          | 282           |
| Client Ages 19 and above  | 1,132               | 91          | 1,041         |
| Client Referred to Psychiatrist/Medical Support                       | 199                 | 53          | 146           |
| GBV Client Received Individual PSS Session                            | 292                 | n/a         | n/a           |
| Sexual Abuse Client Received PSS Services                             | 42                  | 1           | 41            |
| One to One (O2O) PSS Sessions Conducted by Para/Peer Counsellor       | 4950                | n/a         | n/a           |
| PSS Group Session for Adolescents Facilitated by Para/Peer Counsellor | 12,483              | 2,185       | 10,298        |
| Unaccompanied and Separated Children (UASC) received PSS service      | 294                 | n/a         | n/a           |
| Pregnant Women Received PSS Services                                  | 262                 | -           | n/a           |

Source: BRAC Institute of Educational Development (BIED), MHPSS Service (January 2019)

However, BRAC's 10 health centres at Rohingya camps do not provide pharmacological or psychiatric interventions or mental health medicines, although some health centres have para-counsellors who will refer more severe cases to a clinical psychologist, the MSF Psychiatrists or government hospitals for psychiatric support.

As with other organizations, BRAC has not published outcome data to establish the efficacy of their model.

## CURRENT CHALLENGES AND GAPS IN NEED

From the available information, it is apparent that training and capacity building for direct responders is an ongoing process. Currently, there is no or very little reliable published data or literature on the efficacy of these skills training on the Rohingya population's mental health, nor whether the clinicians and workers who had the training feel it has contributed positively to their MHPSS work.

Although the MHPSS working group conducts service mapping in different camps, there is inconsistency in such provisions across the camps. Many organizations have psychosocial service centres; however, Rohingya people are often reluctant to seek mental health and psychosocial services due to the stigma associated

with the term and cultural narrative<sup>1</sup>. To address this, organizations have worked hard to find ways of making MHPSS services more accessible, for example BRAC offer MHPSS services through home visits of para professionals which ensures coverage. What is apparent is that through these interactions over time, the community has become more comfortable with the idea of a psychologically supportive space and are less distrustful of MHPSS provisions Engagement through outreach services is a potential method of addressing uptake of support systems. Given the large geographical area, the distances from home to health centres are sometimes substantial, presenting a further challenge for MHPSS service provision. Outreach services are beneficial for engagement, although there are issues around management and treatment of more severe mental health difficulties, including confidentiality in client disclosure when conversations within shelters can be overheard by family members and neighbours; and safety of the para-counsellors particularly during the monsoon season when road travel becomes extremely hazardous.

### Language barriers

Language is the key to ensure effective MHPSS service. Unfortunately, although key differences in language and dialect, despite the similarities in the Rohingya language the host community (Chatgaon), there continue to be significant challenges in communication. This is of particular concern with

regards to talking therapies and MHPSS provision, which generally relies on verbal communication to engage people in a helpful therapeutic relationship. Currently most organizations provide MHPSS services through para professionals hired from the host community due to the similarity in dialects. However a recent research by Translators without Borders Report illustrates that almost 60 percent of the surveyed Rohingya people found it difficult to understand the host community language, in particular the women who have low literacy rates<sup>60</sup>. Considering the language barriers and sustainability issues, it is important that service providers develop capacity of Rohingya people to ensure effective MHPSS services through intensive training and effective referral pathways.

### Cultural and religious knowledge

As outlined early in this chapter, understanding Rohingya culture is of unique importance with regard to being able to deliver appropriate treatments in a method that is accessible and non-stigmatizing. Unlike western and westernized cultures, seeking mental health and psychosocial services in stress is uncommon amongst the Rohingya community. MHPSS providers need to engage with the wider community to introduce creative and non-traditional methods that are non-stigmatizing with regard to mental health support practices. It is not clear whether the need for cultural awareness is currently informing MHPSS providers, but Tay et al.'s (2018)<sup>49</sup> report provides a framework within which to implement such considerations, and it is hoped that this will instigate a better understanding of the culture and articulation of mental distress in the Rohingya people.

### Changes in family culture

Due to the structural challenges discussed earlier in the chapter, incidences of polygamy across the host and Rohingya communities are rising. The impact of the complex and multiple family relationships and tensions within and between the host and Rohingya communities are unclear, but it is plausible to assume that there will be concomitant stressors around uncertainty, emotional and economic resource allocation and SGBV. The impact is predominantly on wives and children, and increasing the already substantial gender-based vulnerabilities they face. In the context of such structural and social barriers, MHPSS is fundamentally limited in promoting psychosocial gains in well-being beyond the therapeutic companionship experienced in individual sessions. The more pressing issue is the appropriateness and ethicality of providing therapeutic

coping strategies for women and children that ostensibly and implicitly condone the acceptance of uncertain, violent and abusive living conditions. Conversely, providing empowerment support for women which encourage the development of autonomy and 'zero-tolerance' to violence and uncertainty is also inappropriate without infrastructural support such as provision of safe living spaces. This is particularly challenging in a refugee camp environment. Community, security and legal systems and process are therefore the most effective method of addressing these structural challenges.

### Relationship with the host communities

The current MHPSS provision is limited to the Rohingya communities, but there are understandably pre-existing and ongoing mental health needs in the host community. These host communities responded with great humanity and compassion to the arrival of the initial influx of traumatised Rohingya people, and subsequently sacrificing their lands and resources to help the Rohingya community. Since 2017, challenges in the form of shortage of resources, shortage of work, high prices of commodities and intermarriages have created tensions through a perceived 'battle for resources' between the host community and the Rohingya in the camps. Tensions arising from intermarriages and polygamy is a cause of distress for women and children in terms of psychological and economic impact. Some of these issues can be addressed through the provision of MHPSS services for host community members. However the structural issues of intermarriage, inflation of commodities and workforce issues require intervention on a public health and economic policy level.

### Quality and monitoring of training

There is little information available on the quality assurance processes in the development of MHPSS and mental health professionals, presenting a serious issue for the ethical delivery of MHPSS interventions. Practitioners have an obligation to provide care that is non-judgemental and sensitive to the impact of subtle prejudices, personal opinions and perspectives on individual experiences. In any therapeutic context, there is an embedded process of accountability and transparency, usually through regular group or individual supervision, and through case note auditing and clinical outcome measures. It is of utmost importance that any psychosocial intervention within MHPSS provision has these structures at its core, and indeed that such accountability structures should extend to all who have contact with the Rohingya people in a support capacity or research capacity.

Anecdotal evidence suggests that some organizations have employed men and women with little or no mental health training to gather information pertaining to gender-sensitive issues such as SGBV. The implications of this in terms of the pre-existing vulnerabilities of the Rohingya people and the lack of accountability of humanitarian actors could have serious consequences from a human rights and ethical practice perspective<sup>39</sup>.

#### **Clinical outcome measures, quality assurance and efficacy of MHPSS interventions**

Related to the above point, there are few details available as to the composition of the various MHPSS interventions provided in the camps, and it remains unclear whether there are any measures being used to assess the efficacy of the interventions themselves. It is therefore unclear whether there are discernible psychological gains from these interventions. There is an assumption from the data that continued attendance implies psychological gains, which is problematic with regard to evidence-based therapeutic practice. Culturally sensitive outcome measures need to be utilized to have a thorough understanding of how MHPSS interventions are effective in promoting psychological well-being and, importantly, whether elements require modification, or further development to maximise mental well-being for the recipients.

need for further research and evaluation studies on the Rohingya. In particular, data on the composition, nature and efficacy of current MHPSS and other psychological interventions are essential to developing culturally sensitive and effective interventions. Related to this is the continuing need for accurate estimates of numbers of people seen across the camps, and numbers of health professionals employed, in order to aid workforce planning and to develop strategies that support the well-being of staff who are working in often highly pressurized contexts. Recognizing what is realistically accomplishable in each context would address the potential negative impact of these experiences. Finally, the evaluation of training and the monitoring of ethical practice in MHPSS and in the wider context of humanitarian action is required to ensure that work continues to be in accordance with the human rights of this vulnerable and disempowered group of people.

## **GAPS IN KNOWLEDGE AND MENTAL HEALTH NEEDS**

The difficulties and pressures of providing MHPSS in the Rohingya context is recognized as being substantial. Given this, it is unsurprising that there are areas that would benefit from more scrutiny, consideration and development.

A review of the international research on refugee mental health difficulties and interventions highlights the gaps in the evidence base due to heterogeneity in available studies and in some cases, problematic research designs. The research base for culturally appropriate and sensitive data on the mental health experiences of refugee populations suffers from similar difficulties. The lack of reliable data on this area compromises the effectiveness of mental health focused humanitarian work. As might be expected, mental health provisions in the Rohingya context also reflect these gaps in understanding and highlight the

## CONCLUSIONS AND RECOMMENDATION

This chapter aimed to give an overview and understanding of mental health difficulties in the Rohingya context, specifically following the mass migration of over 700,000 Rohingya people into Bangladesh from August 2017. At the centre of these experiences reside a people like any other. They want to live in a place of safety, where they have access to opportunities to work and for personal fulfilment, to be able to follow their religion in peace and to be able to nurture and support their children to lead safe and fulfilled lives.

The psychological theories of mental health difficulties discussed highlights the complex social and individualized aspects of the mental health experience, while also noting the challenges of understanding cultural manifestations of distress within a predominantly Western mental health paradigm. While most mainstream discourses on mental health focus on the individual, we now know that an unhealthy, unsupportive or conflict-ridden environment on mental health is equally if not more significant in the development and maintenance mental health difficulties in the individual.

In addition to the role of socio-political power, the social structures that form such environments is highlighted. Such structural barriers are recognized in the Rohingya experiences of historical and ongoing persecution, oppression and genocide. Being rendered stateless disallows the protection and support that constitutes a further structural barrier to their well-being, thereby also affecting their right to make choices about life style, movement and employment, and justice for the atrocities they have endured. As such, they occupy a place of disempowerment and subjugation despite concerted international efforts to remediate their plight. Theories and clinical models underpin the importance of personal agency and opportunity for human beings to feel fulfilled and enjoy positive psychological well-being. The geopolitical context similarly contributes to service provision and ultimately individual well-being in terms of what is made available for refugee and displaced people. The inclusion of mental health in SDGs is seen as a positive move that indicates a prioritization of mental health service provision through funding allocation. While there are ongoing challenges within this process, it marks a welcome departure from the focus

solely on physical well-being. What is clear is that no one profession, service or organization can address all levels of influence and power, and as such, it will require collaborative interagency and intergovernmental work to move forward.

Forcibly displaced people experience higher levels of mental health difficulties than those in the general population, with some studies suggesting that the impact continues in subsequent generations via trans-generational trauma. Refugee research suggests that difficulties with depression, anxiety and trauma symptoms are the most common difficulties experienced in humanitarian settings. Studies suggest that trauma-focused interventions such as CBT, EMDR and NET are moderately effective in reducing symptoms of PTSD in the appropriate settings. However, finding a safe and confidential space is problematic in the Rohingya camps, in addition to the requirement of specialist training for such interventions.

MHPSS interventions provide a space for people to connect to a supportive professional, with various psychosocial skills interventions that potential benefits for developing coping strategies of the Rohingya people in the camps. MHPSS interventions present a low-cost option to maximise accessibility for more people, and can be delivered by staff who require less specialized training. Anecdotal evidence suggests that the Rohingya communities appreciate this space to discuss their distress and feel a sense of ‘peace’ from this process. The challenge here is to ensure adequate training to deliver MHPSS interventions with transparency and accountability with regards to their therapeutic interactions. Such safeguards here are important given the vulnerability of the population. Clinical supervision models provide a mechanism through which counsellors can discuss their experiences in a safe and supportive environment, with clarity around the therapeutic models and techniques used in the interventions being essential. Finally, a clear training and skills assessment process for MHPSS workers is necessary. Gender based violence is an issue that exponentially affects refugees in their insecure and uncertain contexts, with women and children at more risk of sexual and physical violence and exploitation. For the Rohingya people, SGBV formed a core strategy of persecution and expulsion by the Myanmar army. Managing the impact of these profound traumas will require deep sensitivity, research and practice-based evidence interventions, and a recognition that the predominantly patriarchal context presents significant

barriers to the survivors achieving positive mental health.

A major challenge is the accurate collection of outcome data for MHPSS interventions in the camps. In line with a human rights framework, it is necessary to establish that these interventions are helpful and not unwittingly causing harm. Challenges are the form of workforce resourcing and lack of sensitive and validated outcome measurement tools. It is imperative that the efficacy of interventions are evaluated for cultural congruence and clinical efficacy, so as to identify both positive aspects of the MHPSS work and also to identify areas of development or potential harm. Based on theories and principles of individual and community resilience, research interventions that develop individual strengths through community participation and support structures are likely to be efficacious, but data is needed to support this hypothesis.

Another challenge is the Rohingya people's conceptualization of mental distress, which is conceptually different from mainstream mental health paradigms. Entrenched stigma associated with mental health in the Rohingya community severely affects their uptake of available services. Community and outreach services appear to have greater relevance to the Rohingya people's acceptance of mental health difficulties, as does a reconceptualization of para counsellor and mental health professionals as 'dil-er doctor' (heart doctor) and clinics as 'Shanti Khanas' rather than counsellors and mental health clinics. Much can be learned by humanitarian, development and clinical actors from such examples in terms of introducing flexible and creative methods of describing mental distress and delivering accessible services that are culturally sensitive and appropriate.

While the challenges of providing effective mental health interventions for the Rohingya people can feel overwhelming, it is important to recognize the significant gains since August 2017. Multi-agency work has established a range of MHPSS interventions to address psychological well-being in dedicated spaces (e.g., MSF psychiatric assessment service) as well as outreach services, e.g. BRAC MHPSS service. While initial services provided host country MHPSS workers, plans are now underway to enable Rohingya community members to provide these services within their communities. This will not only increase the cultural relevance of future interventions, but more importantly will recognize the autonomy and rights of the Rohingya community in providing and

self-developing support structures that are best placed to address their cultural and psychological needs. Furthermore, by encouraging a creative and open approach to mental health and well-being, the host and international communities have a rich opportunity to learn new strategies and interventions which can enrich global understandings of mental health. In addition to this, while much of the discourse is around the needs and deficits prevalent in the camps, there is also the recognition of the significant resilience and strength the Rohingya community possess following decades if not centuries of oppression. It is likely that their experiences will have strengths in their shared and distinct cultural values, ideologies, and identity which include the human need for belonging and pride in their group affiliations. We should be further encouraged by the humanity and empathy exhibited by host community members at the outset of the crisis, and the national response to the humanitarian needs of the Rohingya, which resonates with Bangladesh's own experience during the Liberation War.

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## CHAPTER SEVEN

# TRAFFICKING, MIGRATION AND GENDER BASED VIOLENCE

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## INTRODUCTION

In any humanitarian crisis and refugee settings, those most at risk are often women, children and young girls. They are vulnerable to various types of sexual assaults such as rape, forced or coerced prostitution, other forms of sexual exploitation, sex trafficking, early or forced marriage, intimate partner abuse, and child sexual abuse.

Globally, 80 percent of the refugee and internally displaced people are children and women, which leaves them in a vulnerable position<sup>1</sup>. This includes vulnerability to physical attacks, sexual assaults, and transactional sex<sup>2</sup>. Moreover, during conflict, victims experience further stigmatization and humiliation, which can lead to discrimination, exclusion, and inequality<sup>3</sup>. Stigma significantly impacts people's mental health; which can devalue and demean the assaulted person<sup>4</sup>. Therefore, by emphasising the continuum of violence, it becomes

clear that women are vulnerable in these settings<sup>5</sup>. This means that these are not isolated cases, but a phenomenon that needs to be researched in a deeper and more comprehensive manner, in order for the system of support and protection to be able to respond adequately<sup>6</sup>.

The recent refugee crisis in Cox's Bazar has created various forms of vulnerability and insecurity, particularly for refugee women, including multiple forms of sexual and gender-based violence. A large number of women, either alone or with their families, reached Cox's Bazar to seek refuge from the rampant violence in the Rakhine state in Myanmar. Many of these women were subjected to heinous violence before or during their movement, and in some cases on arrival at the destination.

# HUMAN TRAFFICKING SITUATION IN ROHINGYA CAMPS

The stranded Rohingya refugees, particularly young women and girls, who have landed in Bangladesh since late August 2017 escaping the brutal military crackdown in Myanmar's Rakhine state, are now facing new threats, like human trafficking. Their life and livelihood in the overcrowded camps are tough, and many of the Rohingyas are trying to escape the camps to build a better future for themselves and for their families. Human traffickers are taking advantage of this situation. The data on human trafficking of Rohingya refugees is scarce, but it appears that the risks are high for women, young girls, and children. While trafficking networks have been active within Rohingya refugee camps for years, reports depict a substantial increase since the current influx of refugees that began in August 2017<sup>6</sup>. There is also the threat of being kidnapped inside the camps while going out to use the toilets at night.

Different newspapers and media sources have reported that traffickers lure men, women, and children with false job offers and different livelihood opportunities like fishing and begging; and for girls, offering domestic work. Once an offer is accepted, victims are usually trapped, abused, and not paid the agreed amount, if at all. Various forms of physical and sexual abuse and assaults are common for women and girls. According to information from the Human Trafficking Search organisation,<sup>6</sup> traffickers prey on the vulnerability and helplessness of the families who are struggling to collect food for their survival and also target those children that have travelled alone after losing their parents. According to information received from Save the Children and United Nations Population Fund (UNFPA), traffickers usually pay a small amount of money to the struggling families with the promise of work for their daughters, though many of these girls are never seen again<sup>7</sup>. While much of the trafficking occurs within Bangladesh, International Organization for Migration (IOM) has reported that there is evidence of trafficking of Rohingya refugees to India, Nepal and other regional countries.

The anarchy, poverty, and insecurity in the Rohingya camps has also led to an increase in forced and child marriage as families often consider marriage as a way to protect their daughters and reduce their economic

burden<sup>8</sup>. Sources from different NGOs revealed that families are also selling their children into bonded labor, particularly in fish drying and other works in frozen fish industries. To combat this practice and encourage families to keep children in school, UNICEF has provided 400 families with the same amount of money they would receive from selling a child into bonded labor till 2018. There are some exemplary initiatives taken by few Rohingya refugees living in the camps who have also made efforts to prevent trafficking and reunite lost or missing children with their families. In fall 2017, the Thomson Reuters Foundation visited the Kutupalong refugee camp and discovered the work of Nazir Ahmed, a Rohingya refugee in the camp who set up an information center to connect parents with their missing children<sup>9</sup>. He keeps a watch on the children to ensure that they are not taken by traffickers, and has trained some of the adults on how to return the children to their original parents. Till the end of 2017, Mr. Nazir claimed that he had already reunited some 1,800 lost children with their parents<sup>10</sup>. Despite its important role, the center's only logistic is a wooden table and a megaphone. The center, usually from early morning, is inundated with people looking for their loved ones<sup>11</sup>.

Global experience and evidence suggest that the risk of human trafficking increases during migration crises<sup>12</sup>. In the continuing disarray and expansion of camps, there is a lack of reporting mechanisms and human trafficking often goes unnoticed or unaddressed. As globally forced migration continues to rise, governments, international agencies, networks and institutions should take adequate measures and be capacitated to combat human trafficking and modern-day slavery. Addressing the added vulnerability of statelessness can be the starting point to curb human trafficking<sup>6</sup>

## REASONS FOR TRAFFICKING

The trafficking of Rohingya people started with the oppression, adversities, and sheer human rights abuses happening on the ground, particularly while in Myanmar. They were forced to seek ways to escape from the dangers they faced, which started to push them toward criminal networks that operate as part of the trafficking rings within their shelter and livelihood areas.

Various web-based reports and media blogs suggests that the whole process basically starts with traffickers operating inside Rakhine State of Myanmar, who usually promise an escape route to the Rohingya. The

fee is often about 2,000-3,000 US dollars, usually with one payment made on the spot, and the promises of the remaining payment when they finally arrive at the destination<sup>13</sup>. However, due to the poverty-stricken situation of the Rohingya, in reality it is often impossible for them to actually make the final payment, so they end up in a kind of bondage agreement with the traffickers.

When it comes to the situation of trafficking of women and girls, most of the literature suggests that sexual violence is very common. Women and girls are often raped by traffickers or sold to brothels. Since the recent influx of Rohingya, there have been more cases of refugees being trafficked into slave-like work or the sex industry, lured by the promise of money or a better future for their children. Till the writing of this report in 2018, around 80 trafficking cases were reported in the refugee camps since the latest influx started, according to an unofficial source of Save the Children<sup>14</sup>. The information could not be verified independently, but given the sheer number of the refugees – more than a million – the number of cases seems credible.

According to a BBC report based on an undercover investigation alongside Foundation Sentinel, a non-profit group established to train and assist law enforcement agencies combating child exploitation, the chaos of the camps offers opportunities to bring children into the sex industry. Offering a chance of a better life to desperate families is a cruel tactic deployed by traffickers. The report also revealed that Rohingya children have been taken to Chittagong and Dhaka in Bangladesh, Kathmandu in Nepal and Kolkata in India. In Kolkata's booming sex industry, they are given Indian identity cards and absorbed into the system, their identities lost. At the Cyber Crime Unit in Dhaka, police explained how traffickers trade girls for sex over the internet. Open and closed Facebook groups offer a gateway to a child sex industry out of sight. Both online and offline in Bangladesh, a network of traffickers, pimps, brokers and transporters continue to supply women and children for sex. The Rohingya crisis did not create a sex industry in Bangladesh, but it has increased the supply of women and children, forcing the price of prostitution down and keeping demand as strong as ever<sup>15</sup>.

## ROLE OF SECURITY FORCES IN PREVENTING TRAFFICKING

According to different national and local media reports and key informant interviews, Bangladeshi law enforcement agencies have prioritized the prevention of trafficking. Heavy security checks have been imposed in all vehicles and exit points by law enforcement agencies. However, experts say the risk remains high. *"It actually goes back several years. The grand crisis is just part of a longer story. Many of them (Rohingyas) have been trafficked to Thailand for prostitution. Traffickers took advantage of the recent exodus and trafficked girls to India or other parts of Bangladesh. It is a horrible scenario. I do not have that much faith in the repatriation process,"* human trafficking expert Siddharth Kara told a Dhaka Tribune correspondent. Taposhi Rabaya, an Assistant Director for Mediation in BLAST, a rights NGO, said in the report that people are trafficking children for domestic work. She said, they just hold the hand of a child and take him or her with them. No one knows what happens at the camps after sunset as outsiders (NGOs or aid workers) are not allowed to stay<sup>14</sup>.

Various organizations have taken steps to raise awareness about trafficking among the refugees. The United Nations Population Fund (UNPFA) responded by creating 19 Women-Friendly Spaces till June 2018. These are facilities where women can gather and seek health advice and referrals, as well as psychosocial counselling. Rohingya women call this space 'shanti khana' or a 'home of peace'<sup>16</sup>.

The women's centers or women's safe spaces cater to hundreds-of-thousands of women and girls, providing healthcare and counselling, as well as professional case management for survivors of violence<sup>17</sup>. UNFPA provides information on trafficking, how people end up being a victim, and how they can understand when someone is trying to traffic them. Furthermore, Save the Children is running a Child Club in the camps to raise awareness about such issues. They usually ask the children (and their parents) not to trust people offering gifts or jobs. It is also identifying at-risk groups so they can be transferred to safety, and forming community watch groups from among refugee and host community women to locate those who are pregnant—often as a result of rape. Vulnerable women and girls are taken to more secure settlements or places with facilities designed to help them cope with

trauma and loss.

Age-friendly spaces have also been established. The HelpAge Global Network in Bangladesh through their partners, Resource Integration Centre (RIC) and Bangladesh Association for the Aged and Institute of Geriatric Medicine, are helping those most at risk, including older people, through three age-friendly spaces in one of the permanent camps in Cox's Bazar. They provide health screenings and home-based care in the camp community, access to age-friendly latrines, and ensure older people reach the services they need<sup>18</sup>.

IOM is the lead agency coordinating the fight against human trafficking in Cox's Bazar. It launched its program in September 2017, and has been working since then through a three-pronged approach of protection, prevention and prosecution to fight trafficking. In 2018, seventy-eight victims of trafficking were identified and supported by IOM in Cox's Bazar, although this is likely to be a major under-estimation given the clandestine nature of the crime.

According to IOM, without access to proper livelihood opportunities, people frequently fall victim to exploitation while seeking labor for survival, and exploitation can only be tackled if authorities, local and international agencies, and communities work together. Women and girls are at particular risk of trafficking into the sex trade and associated gender-based violence (GBV)<sup>14</sup>. IOM is already working in all three areas in Cox's Bazar, and is also working closely with the authorities to significantly increase activities over the coming months and in the longer term to prevent trafficking in person.

## IMPACT OF SEXUAL AND GENDER-BASED VIOLENCE

Given the circumstances of the mass influx and rapid movement of Rohingya refugees in Cox's Bazar area, initially it was difficult to recognize, analyze and adequately respond to the occurrence of risks of exploitation and its impacts over refugee women as well as to the host community in a timely manner. A Rapid Gender Analysis (RGA) conducted by CARE (see Figure 7.1) reported that, in one camp, every woman and girl was either a survivor of sexual assault or a witness to it from their time in Myanmar, but those women felt relatively safe in camps in Bangladesh<sup>19,20</sup>. However, various reports have shown that crowded settlements, a lack of appropriate WASH facilities and increased vulnerability are putting women and girls at risk of GBV, including sexual harassment, assault and sexual violence, with hundreds of incidents of GBV reported weekly<sup>21</sup>.

A lack of adequate lighting and availability of electricity is affecting refugees' mobility at night and is of particular concern in relation to risks of GBV. Women's mobility is also restricted by the observance of purdah, and limited knowledge of reporting GBV prevents them from accessing aid or GBV services, a problem compounded by the stigma faced by GBV survivors<sup>22</sup>. Adolescent girls are highly vulnerable to GBV threats and have very restricted mobility outside the home, so their access to services and information is even more limited<sup>23</sup>. Information dissemination still needs to be improved, as does access to GBV services and to sexual and reproductive health (SRH) services, which are hampered by an insufficient number of female doctors and a lack of gender-segregated facilities<sup>24</sup>. The Joint Response Programme (JRP) reported that 62 percent of refugees are unable to communicate with aid providers. This figure is likely to be higher for women, given the traditional expectation that they should stay at home and perform care work<sup>24</sup>. Child marriage and domestic violence is very common in both Rohingya refugees and host community.

Figure 7.1: Rapid Gender Analysis: Gender-Based Violence (GBV)

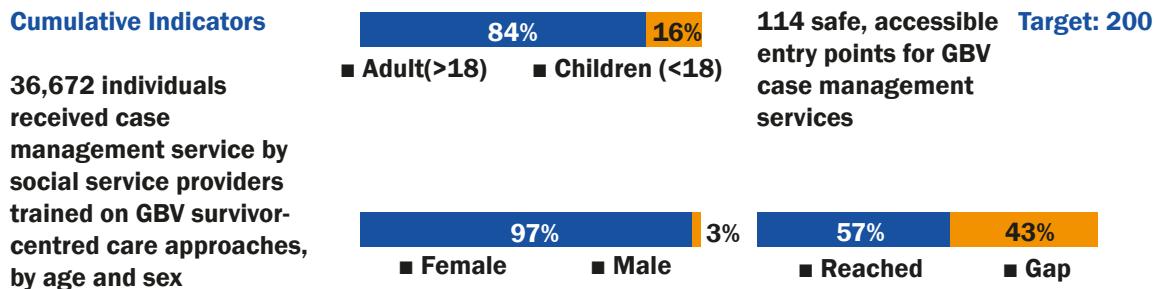


Table 7.1: Availability of Services for GBV Survivors<sup>25</sup>

| <b>Target population</b>  | <b>Availability of services</b>  |
|---|--|
| Documented refugee population   | <p>Camp in Charge (CIC) provides legal support</p> <p><b>TAI</b> (Technical Assistance Incorporated): Provides counselling and follow-up of GBV</p> <p><b>RTMI</b> (Research, Training and Management International):</p> <ul style="list-style-type: none"> <li>Post-exposure prophylaxis (PEP ) for rape survivors which are prevention against tetanus, Hepatitis-B, HIV, STI and pregnancy,</li> </ul> <p><b>United Nations High Commissioner for Refugees (UNHCR):</b></p> <ul style="list-style-type: none"> <li>Ensures access to justice and legal support. UNHCR works with the police, judiciary, government officials and refugee community leaders.</li> <li>UNHCR is working to increase awareness and improve reporting on the frequent incidence of sexual and gender-based violence (SGBV) among the camp community</li> </ul> |
| Undocumented refugee population<br>(Both temporary camp and scattered refugee population) | <p>IOM provides some services for them. They also refer to GOB facilities for services.</p> <p>In Ukhya, both IOM and MSF are providing overall health service. But their community leaders (Chairman) are handling the issues locally.</p>  |
| Host population   | <p>One-Stop Crisis Centre (OCC), assisted by the Ministry of Women and Child Affairs (MOWCA) and UNFPA in Cox's Bazar is providing services for survivors of GBV. There is one OCC in the UHC of Teknaf also. The OCC provides the following services:</p> <ul style="list-style-type: none"> <li>Health care</li> <li>Police assistance</li> <li>Social services</li> <li>Legal assistance</li> <li>Psychological counselling</li> </ul> <p>Women Support Centre (WSC), also assisted by MOWCA and UNFPA, is providing services for GBV. The major responsibilities of WSC include:</p> <ul style="list-style-type: none"> <li>Women shelter centre</li> <li>Legal aid support</li> <li>Psychological counselling</li> <li>Help line service</li> </ul> <p>Child and aged education</p>   |

The IOM's Needs and Population Monitoring (NPM) report estimates that 12 percent of households in the Rohingya community are likely to be female-headed and that 17.35 percent of the Rohingya mothers are single mothers. Research for the ACAPS Host Community Review found that, as of December 2017, 45 percent of female-headed households in the host community were vulnerable or very vulnerable, compared with 35 percent of male-headed households<sup>26</sup>.

## HOW VIOLENCE IS TAKING PLACE IN ROHINGYA REFUGEE CAMPS

The major findings on SGBV reveals that the occurrences of violence is the actual exercising of masculine power or the perpetuation of those oppressive roles and subjugation which are dictated by

the male-dominant values of a patriarchal society. The Rohingya population in Bangladesh are driven by their loss of nationality and citizenship to steer themselves into assimilation with the dominant community in Bangladesh, and customary Islamic marriage practices have helped them in this respect. However, women enter these relations at a disadvantage given gendered stereotyping of their roles in the family and their dependent relationship with the male. Such oppressive structures make women more susceptible to violence than others in the community<sup>27</sup>.

The lack of social awareness with respect to fundamental rights of the woman is quite evident in the locality in general and in the case of the Rohingya in particular. The concept of violence itself seems to have been normalized in the region to the extent that certain kinds of violence such as wife battering seem not to affect the general public except for those directly affected<sup>28</sup>.

Apparently, in Bangladesh, domestic violence does not necessarily constitute a criminal offence. Justice, therefore, has to be sought in arbitration which in turn is constituted by inter and intra community power politics and corruption. The conventional practice is that only when it reaches the stage of rape or murder in public spaces does it reach the level of court proceedings or police investigation. But there is evidence of the legal system failing to address such complaints<sup>29</sup>.

There are various levels of child abuse in the Rohingya camps and within the host community. Therefore, child welfare is an important part of an overall protection strategy for Rohingyas. Children suffer impact of SGBV directly when they are married off at an early age and are ill-equipped to handle power relationships in their in-law's house or with their husbands. Because of insolvency in the family, especially in families where the male income-earner has abandoned the wife with the children, many have to sell their labor under difficult conditions. Children when uncared for can be driven into conditions that create juvenile delinquency, truancy and even into the machinations of trafficking and terror networks<sup>28</sup>.

The Humanitarian Response Plan for 2018 predicts that there are at least 1.2 million people who will require humanitarian assistance in the area of response, with women and children comprising the majority of the population. UNHCR's family counting exercise identified that 31 percent of Rohingya families participating in the exercise as of early 2018

had one or more persons with vulnerabilities, including older persons at risk, persons with disability, child-headed families, single mothers, and separated or unaccompanied children<sup>28</sup>. The majority of these persons are at heightened risk of different forms of violence, including GBV.

## LEGAL AND SOCIAL PROTECTION OF REFUGEES AND UMNs

The Undocumented Myanmar Nationals (UMN) fall under the Foreigners Act (FA) of 1946, in the absence of any specific national legislation and administrative framework in Bangladesh to manage possible new refugees and asylum-seekers. Under this Act, UMNs can be subjected to imprisonment for up to five years and fines. Lack of access to basic services and formal livelihood opportunities also make them vulnerable to severe labor abuse. In light of this reality, UMNs avoid approaching law enforcement agencies even when serious human rights violations have been committed against them. This means even in cases of serious abuse, such as SGBV, trafficking, torture and even killings, crimes can be committed against this population with impunity for the perpetrators<sup>30</sup>.

Bangladesh has acceded to a number of international human rights treaties, whose provisions indirectly promote the rights of refugees. Some of these are:

- Universal Declaration of Human Rights (UDHR) 1948
- Geneva Convention relative to the Protection of Civilian Persons in Time of War (1949)
- Convention Relating to the Status of Refugees (1951)
- International Covenant on Civil and Political Rights (1966)
- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1948)
- Convention on the Rights of the Child (1989).

However, in reality, the international human rights are not enforceable in Bangladesh's courts of law unless specific provisions are incorporated into existing municipal laws or given effect through separate legislations.

The above-mentioned instruments have some provisions which obligates states to provide protection to asylum seekers and refugees. Bangladesh is a member of the UNHCR's Executive Committee and it

honors the principle of non-refoulement and ensures protection of refugees. As per UNHCR, the definition of non-refoulement is a principle of international law providing a refugee or asylum seeker with the right to freedom from expulsion from a territory in which he or she seeks refuge or from forcible return to a country or territory where he or she faces threats to life or freedom because of race, religion, nationality, membership in a particular social group, or political opinion. Moreover, there are certain provisions under the Constitution of Bangladesh which can be cited as being also relevant to the protection of refugees.

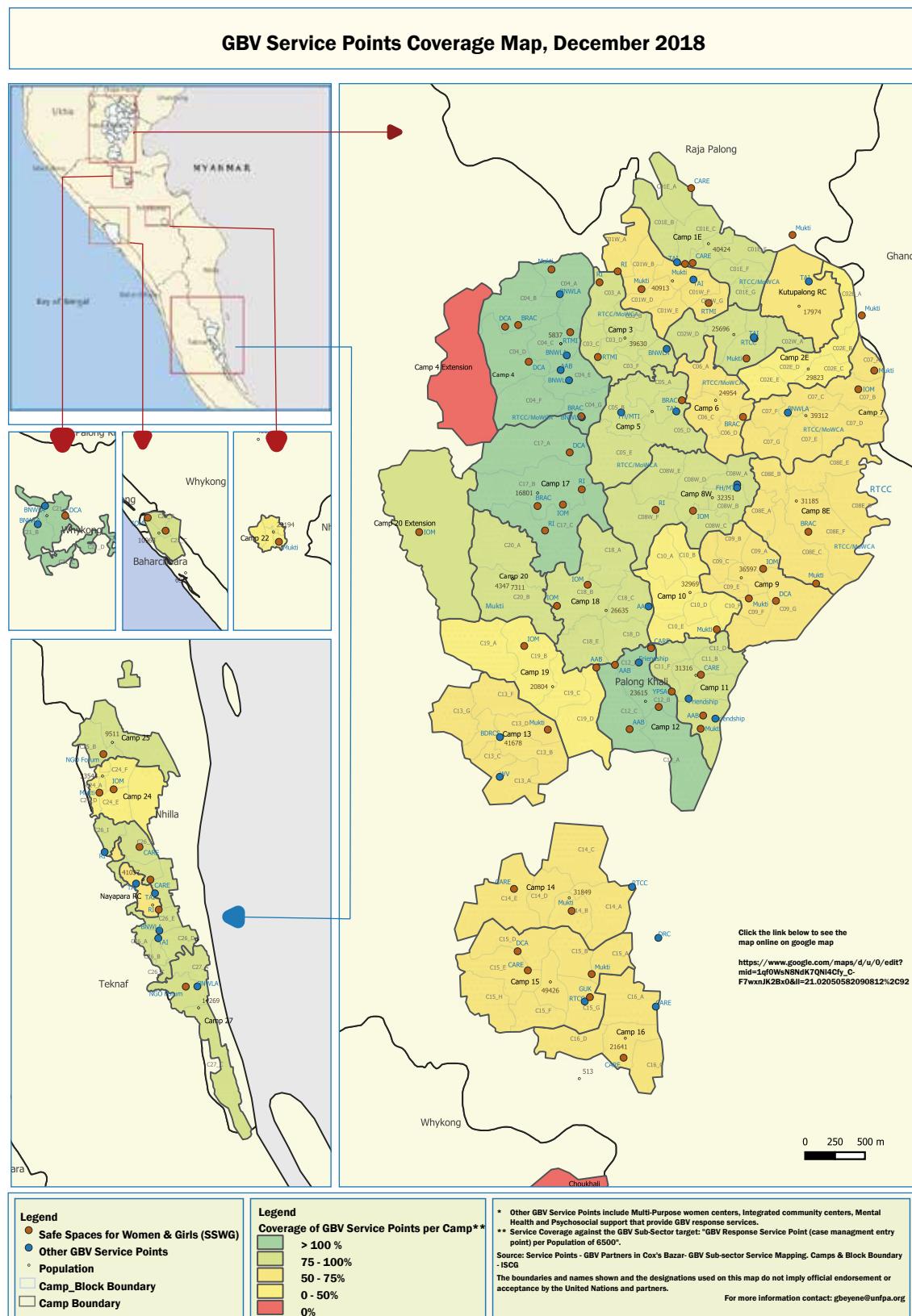
## REFUGEE PROTECTION UNDER STATUTORY LAWS INCLUDING PROTECTION AGAINST GBV

In Bangladesh, there are some statutory laws like civil and criminal laws with provisions to provide legal protection to refugees. Civil and criminal courts are also endowed with the task of looking into the interests of the refugees. The Government of Bangladesh through the Legal Aid Act, 2000 (Act 6 of 2000), is also trying to reach out to the refugees. In addition, articles 28 and 29 of the Constitution, the

Prevention of Violence against Women and Children Act (last amended in 2003), Dowry Prohibition Act 1980, Cruelty to Women (Deterrent Punishment) Ordinance 1983, and some sections of the Penal Code provide procedures for the protection from violence against women. At present, Bangladesh is acting as a host country for refugees from Myanmar. Although some of them have formal refugee status, i.e., registered refugees in camps run by the government and UNHCR, majority have remained undocumented, i.e., those living in unidentified makeshift sites or among the local population. Initially, the government had not taken cognizance of this population, dismissing them as illegal migrants. However, in a strategy declared in 2015, the government has given this population the name of UMNPs and hence brought them under a policy regime that is still evolving.

The legal protection outlined above should also in fact be relevant for this latter group as well. If the basic rights of the refugees get infringed due to any internal clash or conflict between the refugees and citizens, they can go to the court and seek justice. However, refugees are not financially solvent to continue their suit in most scenario and struggle to engage or hire a lawyer for court proceedings. According to the Legal Aid Act, 2000 (Act 6 of 2000), the refugees who are parties in any litigation, may take advantage of the Act as a poor litigant and get justice.

Figure 7.2: Cox's Bazar GBV Sub-Sector



Source: UNFPA January 2018

## HEALTH ASPECTS OF GBV

SGBV is an important part in the health component of the humanitarian assistance that has been incorporated in the protocols of many international organizations such as United Nations Office for the Coordination of Humanitarian Affairs (OCHA), UNHCR, UNFPA, World Health Organization (WHO), and IOM. This concept is particularly applicable to the understanding of the physical, mental and social integrity related challenges of the UMN who are residing in Bangladesh and is intrinsically linked to their humanitarian needs.

A study to assess the prevalence of malnutrition among children aged 6-59 months and anemia among different age groups was conducted by World Food Programme (WFP) and UNHCR in 2012 in the two official registered camps of Kutupalong and Nayapara. The report stated that because specific parts of the Cox's Bazar district are poverty-ridden, food insecurity is a general problem which also affects nutritional status of women in family and makes them vulnerable in power relationships<sup>31</sup>. This has great relevance for making women and children vulnerable to

Figure 7.3: Active Sector Partners (in Cumulative Indicators and outside JRP)



Source: ISCG Situation Report Rohingya Refugee Crisis, January 2019

gender-based violence. In patriarchal societies, it is often women who eat last and hence gets the scraps or the less nutritious part of food, even during pregnancy. Hence, as the report stated, one of the methods of coping was actual starvation. Food deprivation itself became a form of violence. Considering the current Rohingya influx and its complexity, the humanitarian crisis regarding health as well as water and sanitation needs reached crisis level

### Health situation assessment in relations to Migration, Trafficking, GBV and available services

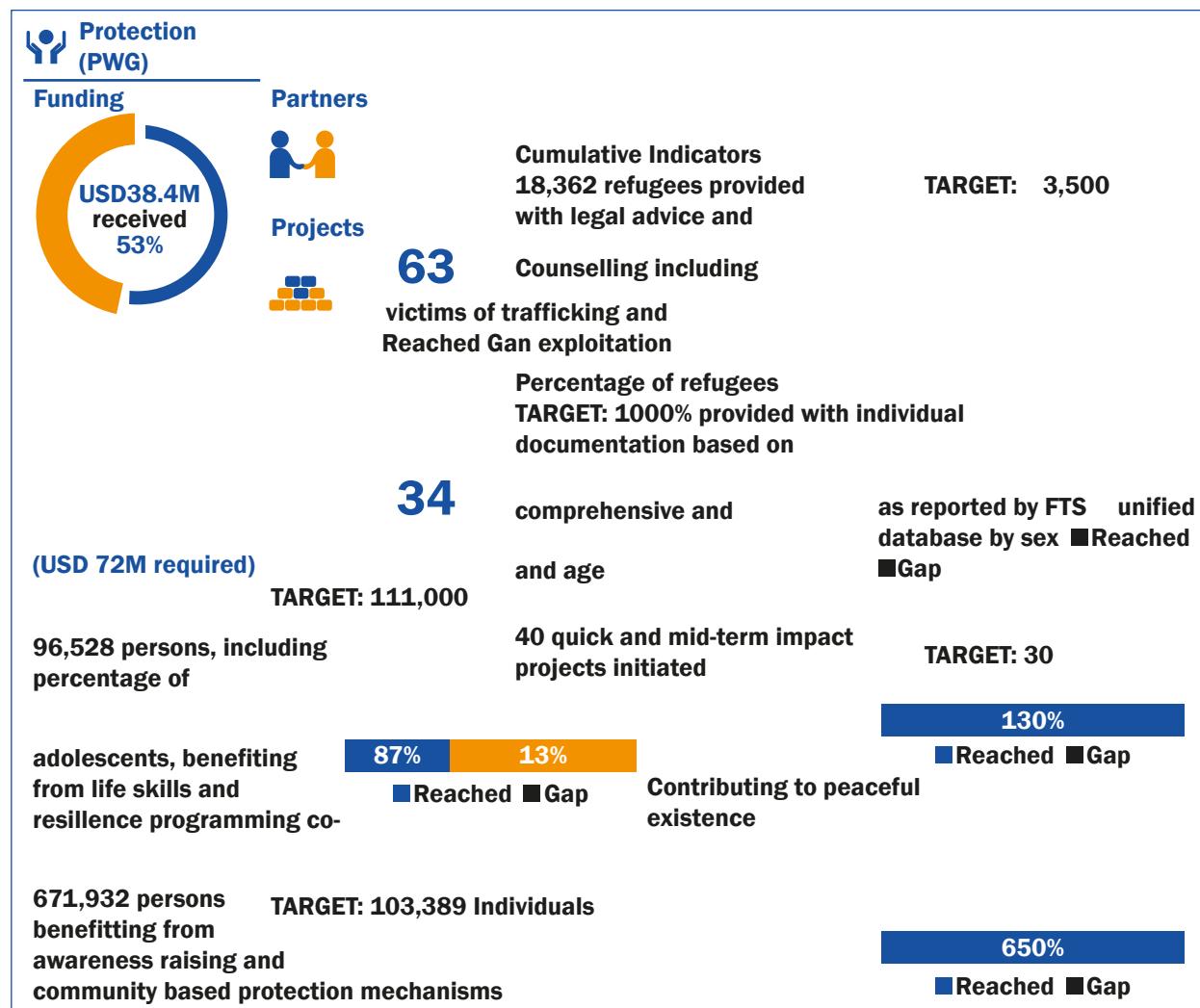
Overall, the health sector partners are coordinated under the leadership of Civil Surgeon's Office of Cox's Bazar, the Directorate General Health Services Coordination Center and the WHO, for better planning and implementation of a coordinated emergency

response. The health sector has adopted a three-tiered coordination structure at District, sub-district (upazila) and union levels. At the District level, a strategic advisory group, constituting the main health sector partners, serves an advisory role to the health sector coordinator based on priority needs. For 2019, the health is coordinated through the following working groups, which meet on a regular basis:

- Mental Health and Psychosocial Support (chaired by IOM and UNHCR)
- Sexual and Reproductive Health (chaired by UNFPA)
- Community Health (chaired by UNHCR and co-chaired by CPI)
- Epidemiology and Case Management (chaired by WHO)

In addition, coordination of support to the District

Figure 7.4: Sector and Sub-Sector Achievements and Gaps



hospital (Sadar) continues through the Sadar Roundtable meetings, and upazila level health sector coordination continues through Upazila level meeting. A time bound emergency preparedness taskforce, which is co-chaired by International Rescue Committee (IRC), was activated in early March for monsoon and cyclone preparedness.

The report from various field visits made by Medicins Sans Frontiers (MSF) staff revealed that, it was clearly visible during camp visits that health conditions in the refugee camps were alarming and various deadly outbreaks of communicable diseases and water-borne diseases had already occurred, such as acute watery diarrhea, typhoid, hepatitis, malaria and dengue. Further, the situation worsened due to environmental degradation, and deforestation. This changed the

topography of the camps thereby increasing the risk of mudslides and flooding during the rainy season. The majority of the hastily-constructed latrines and wells required decommissioning or rehabilitation as flooding contaminated the drinking water<sup>32</sup>.

A MSF report revealed that female-headed households, unmarried women, and unaccompanied children were particularly vulnerable to different forms of violence including human trafficking. The report said that in 2017, the majority of women and girls who sought post-rape medical and psychological care in the MSF facility were abused in Myanmar<sup>32,19</sup>. The day-to-day stress in the camp to survive and collect food as well as livelihood is also making their lives miserable. Furthermore, there is little awareness and realisation about when to take medical or counselling

related support due to stigma, shame, fear and lack of proper information available in the camp. To date, 230 survivors of sexual violence have been treated at MSF's clinic, but because many never seek medical care, the number of survivors is likely to be much higher.

## GBV AND HEALTH SYSTEMS STRENGTHENING

As per the WHO Health Sector Bulletin on Rohingya crisis in Cox's Bazar district (Bulletin published on 20th May 2019) under the global health cluster, the health sector coordinates implementation of a specialized project on institutionalizing and strengthening the capacity of health sector partners to coordinate and deliver GBV services. This is part of a multi-country project implemented in close coordination with the SRH Working Group and GBV and Child Protection (CP) sub-sectors.

The health sector developed a comprehensive plan of action to address critical gaps in health response to GBV. The priority actions aim at ensuring that health related GBV services are available and accessible, and that referral pathways are understood and utilized by facility staff. One of the priorities in the annual plan is assessing the quality of GBV services in primary health care facilities using GBV quality assurance tool. The tool seeks to ensure that post GBV care is accessible, and available; essential infrastructure, equipment and services are in place, providers have appropriate training to deliver services, and relevant policies and procedures are followed. Several rounds of review and contextualization of the global GBV Quality Assurance tool were undertaken jointly with SRH, GBV and CP sub-sectors, and the tool was piloted by the multisector team in two facilities.

## MENTAL HEALTH AND PSYCHO-SOCIAL SITUATION

As expected, the mental health impact on the forcibly displaced refugees is significant. Refugees suffer from flashbacks of the massacre, anxiety, acute stress, recurring nightmares, sleep deprivation, eating or even

speaking disorder<sup>33</sup>. Rape on women and girls and violent deaths of family members have compounded the mental health situation of the survivors of this physical violence. There has been an increase in the incidence of sexual violence among the refugees in Bangladesh which was exacerbated by the unavailability and low quality of post-rape care services. Children face the danger of long-term psychological and social distress. Since refugees are dependent on the humanitarian assistance for their survival and struggle daily for food assistance, this acts as a stressor for majority of them as well<sup>34</sup>.

## CHALLENGES AND LESSONS LEARNED

There are numerous challenges to deal with the situation of the GBV in the refugee shelter as well as with the condition of the women who had suffered the horrifying physical violations. Inter-Sector Coordination Group (ISCG) Gender Profile (No.2, 01 Oct 2018 to 30 Jan 2019) for Rohingya Refugee Response report reveals that Rohingya refugee crisis has had a particularly gendered nature. Fifty two percent of the total refugee population are women and girls , while 85 per cent are women and children and 16 percent of households are female headed . Girls, who represent a larger proportion (57%) of the vulnerable group, are particularly at risk of child marriage, sexual exploitation, abuse and neglect . The facts on the ground present unique challenges as well as opportunities for saving lives, protecting the basic human rights of the affected populations and for gender transformative programming. Horrific accounts of rape and sexual assault happened against the Rohingya women and girls which is a real humanitarian crisis to overcome the situation and provide proper counselling as well as medical support to this traumatic state.

The scale of violence experienced by Rohingya women required a massive deployment of GBV and SRH related capacity support and services. However, the availability of quality GBV and SRH services and in terms of quantity still remains grossly inadequate even months into the response. Ironically, though Rohingya women in Cox's Bazar are apparently safe from the violence that they had encountered in Myanmar, GBV continues in refuge, with hundreds of incidents reported regularly at various stages. There are efforts for further funding and programs to support survivors, but the proper steps to take them to scaling up have

led to serious quality concerns.

The international community and Bangladesh government need to address the vulnerability of these refugees by providing humanitarian and financial assistance. There is need to scale up health services and increase access to essential reproductive health and neonatal care, especially for Rohingyas living in hard-to-reach areas. Community health workers need to be effectively trained to ensure adequate health and hygiene promotion, and home visits to pregnant women. Scaling up of mental health service provision in primary health care settings is needed. Information needs to be adequately provided to the refugees. Furthermore, in the case of epidemics, rapid response is necessary and to ensure that reliable health statistics remain paramount<sup>35</sup>. Thus, organizations need to give more attention to the collection and dissemination of data. As refugees, their condition has aggravated because of limited financial aids and overcrowded unhealthy living conditions in settlements and camps. All of which will exacerbate their access to health care services, predisposing them to numerous health risks and increase the chance of disease outbreak. Thus along with the government, private sectors and international communities must collaborate to assist the refugees in their dire condition for the improvement of their health status<sup>35</sup>. The current focus on physical trauma and diseases also needs to expand to consider GBV and issues of security and access to basic amenities as a way to reduce exposure to risk<sup>35</sup>.

## RECOMMENDATIONS

A recent Joint Agency Research Report on Gender Analysis of the Rohnigya Refugee Response, led by Oxfam in partnership with Action against Hunger and Save the Children, produced a comprehensive report on the overall gender scenario of the refugee crisis with analysis, comments and recommendations from CARE, UNHCR, ISCG and UN Women. The work aimed to identify the different needs, concerns, risks and vulnerabilities of women, girls, boys and men in both Rohingya refugee communities and host communities in the Cox's Bazar district of Bangladesh. The analysis shows various gaps in the humanitarian response for both communities, especially in terms of accountability, communication with affected communities and disaster preparedness, but also in equitable access to services, in particular for women and girls, and especially for the Rohingya community.<sup>34</sup>

### Drawing on the overall scenario the study focused on the following key recommendations:

- To ensure that dissemination of information on GBV referral systems trickles down to communities, especially women and girls. Engage men and boys, women and girls and community leaders in behavior change activities around gender equality and GBV.
- Engage men and boys positively in addressing GBV, especially domestic violence, sexual harassment against women and girls and polygamy (as a contributing factor to GBV).
- Ensure that all field staff and key local leaders (including informal women leaders) are trained on key principles around GBV and are familiar with GBV referral systems.
- Address GBV with the aim of changing harmful social and traditional norms through awareness-raising campaigns in both refugee and host communities, especially to remove stigma for survivors of GBV.
- Work with religious and community leaders and key persons within the community, such as school teachers, who are informal leaders other than majhis, ensuring both male and female leadership.
- Utilize these informal leaders in the community such as women members of the Union Parishad and their alternative views on gender roles to decentralize power at different level.
- Empower informal women leaders in the Rohingya community and engage with formal women leaders in the host community.
- Promote the active involvement of women and adolescent boys and girls in decision making processes, especially within existing structures created by the wider humanitarian response.

## CONCLUSION

To summarize, GBV exists everywhere, but when the social and moral structure breaks down, women become more vulnerable. Women migrants and refugees should have unrestricted access to rights and all the issues relating to women's rights, SRH, and services in the receiving communities. It is necessary to create services intended for women and girls separately, as their needs are different. The difficult position of women refugees requires special attention of actors in the protection system, and sensitized approach in the provision of necessary forms of assistance, creation of support programmes, but also

devising policies for potential and substantial integration in the process of rehabilitation. We also hope to slowly pave the path for all the relevant actors, but for us as a society in a whole as well, to take equal responsibility and help those girls and women in need of our assistance in the best possible way.

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## CHAPTER EIGHT

# COORDINATION OF HEALTH INTERVENTIONS

Be-Nazir Ahmed and Progga Zaman

## INTRODUCTION AND HISTORICAL BACKGROUND

The Rohingya, described by the United Nations in 2013 as one of the most persecuted minorities in the world and historically also termed Arakanese Indians, are a stateless Indo-Aryan people from Rakhine State, Myanmar. An estimated 1.3 million Rohingyas are residents of Myanmar, while another 1.5 million form a diaspora, with many refugees. The majority are Muslim while a minority is Hindu. The Rohingya population is denied citizenship under the 1982 Burmese citizenship law. According to Human

Rights Watch, the law "effectively denies to the Rohingya the possibility of acquiring a nationality. Despite being able to trace Rohingya history to the 8th century, Burmese law does not recognize the ethnic minority as one of the national races". They are also restricted from freedom of movement, state education and civil service jobs. The Rohingyas have faced military crackdowns in 1978, 1991–1992, 2012, 2015 and 2016–2017 and recently ongoing one<sup>1</sup>.

Figure 8.1: Map showing location of the Rakhine state in Myanmar and location of Rohingya refugees in Bangladesh

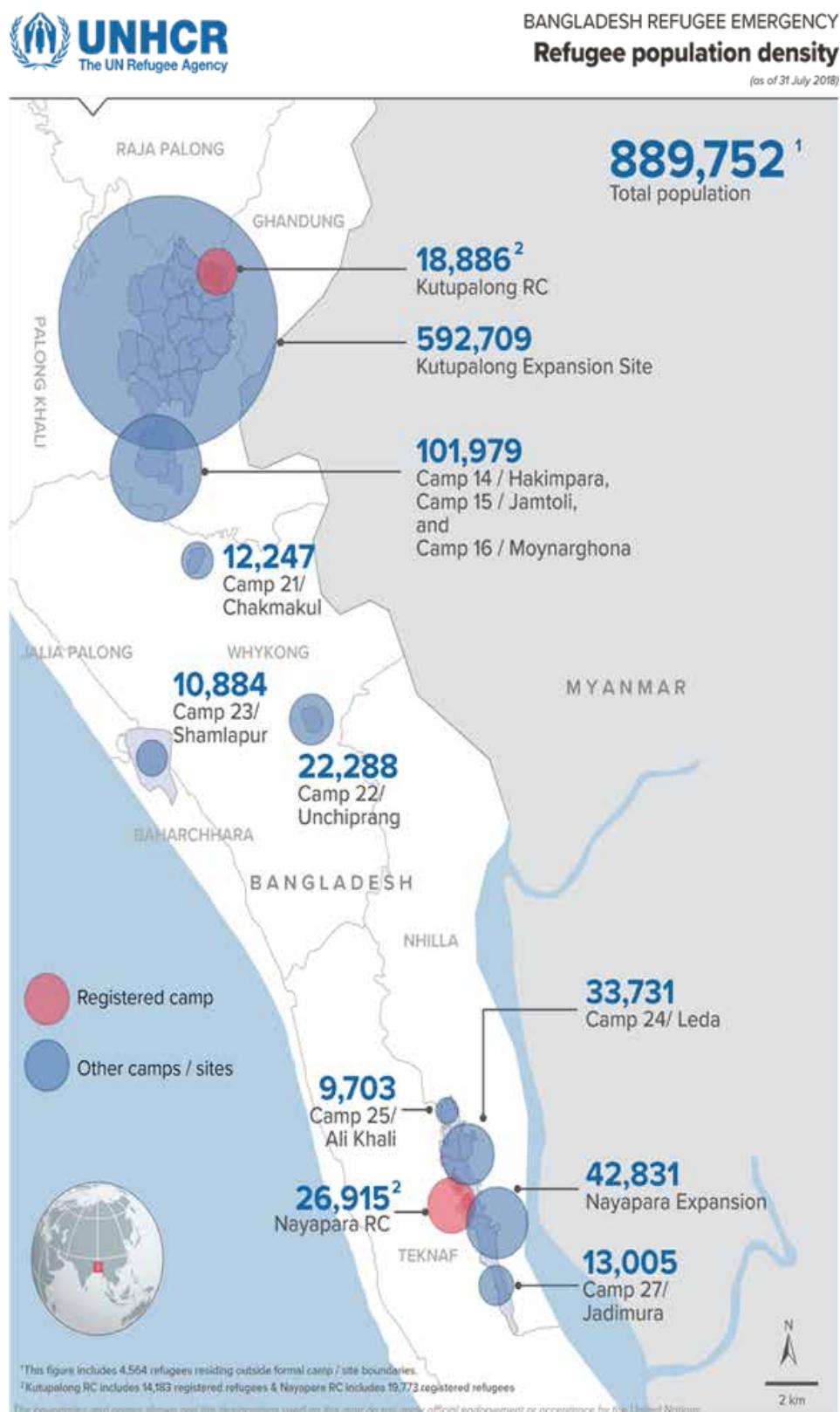


## RECENT INFLUX

The violence in Rakhine State in Myanmar in August 2017 was one of the gravest humanitarian crises in the world. The genocide, as termed by U.S. Senator Ben Cardin, Ranking Member of the Senate Foreign Relations Committee, triggered forcible displacement of ethnic minority of Myanmar nationals namely Rohingya population to Bangladesh<sup>2</sup>. During the massive influx of this Forcibly Displaced Myanmar Nationals (FDMN) since August 2017, an estimated 708,400 people arrived in Bangladesh according to the Needs and Population Monitoring (NPM) round 12 exercise; amongst them 617,000 in the Kutupalong Expansion site and another 256,000 in other

settlements and camps. Furthermore, there are 15,000 Rohingya refugees in host communities. There are now an estimated 920,900 Rohingya refugees (215,796 families) in Cox's Bazar<sup>3,4</sup>. The majority of these Rohingya refugees are living in unsafe and unhygienic conditions in two mega camps (Kutupalong and Balukhali); however, there are a few other clusters of small and big settlements between Teknaf and Ukhia. It is estimated that 52 percent of Rohingya refugees are women and girls, and about 15 percent of them are pregnant and lactating. Some women gave birth during their journey to Bangladesh and children died during the perilous border crossing. About 12 percent of households are female-headed<sup>3,4,5</sup>.

Figure 8.2: Distribution of the FDMN (Rohingya refugees)



Creation date: 31 July 2018, Source: UNHCR, ISCG, RRRC, Feedback: bgdcoim@unhcr.org

## DEMOGRAPHIC PROFILE

According to the Joint Response Plan (JRP) midterm review March-Dec 2018<sup>4</sup> as well as data provided by the DGHS Coordination Cell, a total of 800,000 Rohingya refugees are currently counted as residing in the camps on the Bangladesh side by the Myanmar border in Ukhia and Teknaf districts<sup>4</sup>. Over two thirds (631,000) reside in the Kutupalong and Balukhali Expansion sites whereas the rest of the refugees are dispersed over some 20 smaller camps. A recent Linking Exercise that was conducted from December 2017 until February 2018 between the Government of Bangladesh and UN High Commissioner for Refugees (UNHCR) aimed at merging family-based data with data on Rohingya individuals estimates a total number of 206,845 families are currently present in the camps. The updated JRP estimates a total of 215,796 families during its most recent Mid-term review<sup>4</sup>. Over half (57%) of this current population is under 18, while 43 percent is adult. The most recent JRP data indicates 52 percent of the refugee population living in camps are female and 48 percent are male<sup>4</sup>.

## HEALTH NEEDS AND CHALLENGES

The total population in need of health services has been calculated for the 2018 Joint Response Plan (JRP) as 1.3 million people including 336,000 people of the host community<sup>4</sup>. The sheer magnitude of refugee numbers has put massive pressure on all health services, and the cramped living conditions present significant public health risks. Poverty-ridden and without access to resources, the vulnerable displaced people are dependent on limited primary and secondary health care, including reproductive, maternal and neonatal health care (RMNCH), communicable diseases, mental health services and psychosocial support. The existing facilities in Cox's Bazar and surrounding areas have reported an increase in patients<sup>3</sup>, overwhelming the current capacity and resources<sup>5</sup>. Since the recent surge, the health sector has seen a major increase in engagement of international and national partners to meet the increasing demand for health in the context of this complex emergency. It is now over a year later and the health sector response is in the process of shifting from the mode of emergency response to a more sustained and rationalized approach. It is in the next of the change from an ad-hoc response to major

influx to the management of the population's health in the now drastically expanded camp sites<sup>3,4,5,6</sup>.

## START OF THE RESPONSE

During the initial phase, the focus was on urgent establishment of life saving primary health care provision to new arrivals, with prioritization to ensure coverage of new spontaneous settlements where there were no pre-existing facilities as well as increasing capacity of existing facilities in and near camps and settlements. Initially mobile teams were deployed in temporary fixed health posts to provide basic health care provision for newly arrived populations. Urgent support was required to enhance the capacity of existing health facilities, both those operated by partners in pre-existing camps/settlements as well as government facilities at local, Upazila and district levels. Bi-directional emergency referral systems were strengthened to refer urgent and emergency cases, support their treatment in secondary care, and assist in discharge and follow up planning. Immunization for key vaccine preventable diseases was essential to cover all newly arrived children under age 15 and was supported by all sector partners and under the leadership of the Ministry of Health and Family Welfare.

The Critical Early Warning and Response Systems (EWARS) was established with the high likelihood of diseases outbreak, and these systems needed to be linked with government health authorities and information systems for sector-wide surveillance. With serious and significant public health risks, an active approach to outbreak preparedness and response was taken to mobilize pre-positioned stocks, rapidly expand community health education and awareness in collaboration with WASH sector partners and pre-emptively establish precautionary outbreak treatment capacity. Large number of women including pregnant and lactating mothers, and children were provided with specific reproductive, maternal and child health with implementation of Minimum Initial Service Package.

## COORDINATION OF HEALTH INTERVENTIONS

The Government of Bangladesh, along with national and international non-government organizations (NGO, INGO), UN and other development partners,

responded promptly at that time to address the emergency health need of these population along with the host community residing in those areas. Initially, the response was spontaneous and there was a lack of overall coordination. Different organizations, professional bodies, philanthropic groups and individuals were providing health services on urgent need basis based on their own capacity and plan. After about a week or so, the health sector coordination started under guidance and stewardship of the Directorate General of Health Services and Ministry of Health and Family Welfare through monitoring and supervision by the ministers and the Director General and other high officials of the ministry and the directorates. The coordination was extended from the national level with the Task Force at the Ministry of Foreign Affairs and National Coordination and Monitoring Cell at the office of the Directorate General of Health Servicers down to the district and below level with Relief Rehabilitation and Repatriation Commissioner (RRRC), District Commissioner, DGHS Coordination Cell and Civil Surgeon involving the stakeholders. The Inter Sector Coordination Group (ISCG) was formed and kept functioning from the onset of the massive influx and the Director General himself presided some of the meetings held in the offices of International migration Organization (IOM) and the Civil Surgeon in Cox's Bazar.

The coordination was maintained through planning, functional coordination committees, meeting, workshops and training. The stakeholders' meetings assessed the humanitarian situation, inventoried different situations and guided drafting the health service guidelines in coordination with the local government, Refugee, RRRC's office, Civil Surgeons of Cox's Bazar and Bandarban districts, District Commissioners and other stakeholders including UN agencies alongside different INGOs and NGOs.

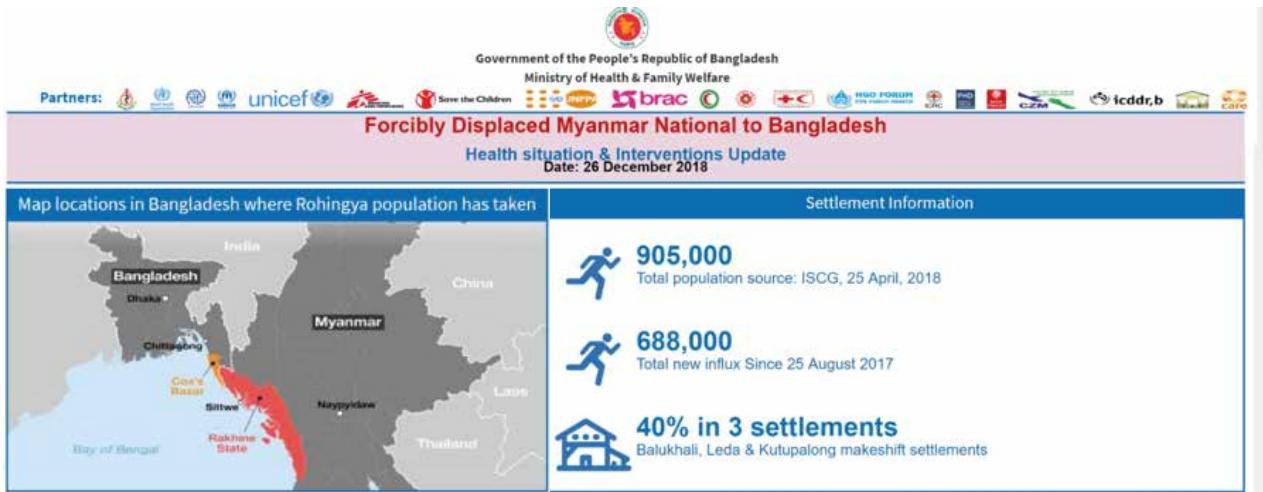
## TYPES OF COORDINATION

Coordination was exercised on different aspects of the health interventions for the FDMN based on the type of services provided. Three types of coordination were instrumental at the field level for functioning health care service.

### COORDINATION OF INFORMATION

Information for coordination was one of the great challenges in the initial phases due to involvement of huge number of health care providers from diverse background without information of each other and lack of a common system for data generation and system and a common platform for accumulation, analysis and use of report for coordinated interventions. Measures were taken to develop a common system to gather, manage and analyse data for evidence-based intervention. A control room with strong ICT support was established in the office of the Civil Surgeon to collect data from different sources and respond accordingly. The Directorate General of Health Services started to gather information through their DHIS2 software on health services from all the centers working in these camps. A dash board was developed in the website of DGHS which made visualization of the demographic, epidemiological and service data establishing it as a good portal for updating, monitoring and supervision of the health interventions. All the health organizations had access to DHIS2 where they could upload and update health service related data which subsequently portrayed the overall health situation of the Rohingya population on Health Dashboard ([http://103.247.238.81/webportal/pages/controlroom\\_rohingya.php](http://103.247.238.81/webportal/pages/controlroom_rohingya.php)). This portal was operated, controlled, monitored and supervised by the Management Information System (MIS) department of the Directorate General of Health Services (DGHS).

Figure 8.3: Dash board in DGHS website



Source: Forcibly Displaced Myanmar National to Bangladesh, Health situation & Interventions Update, Govt. of Bangladesh, Dec 2018

### Service coordination

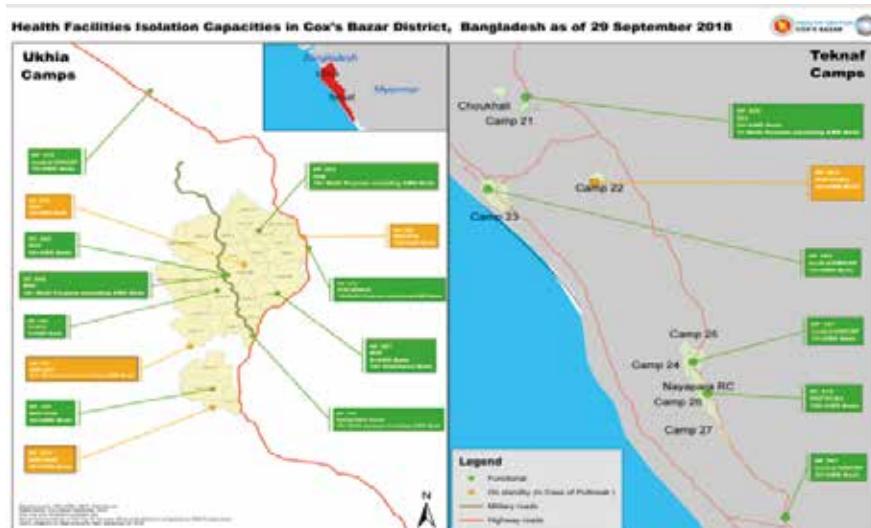
It was near impossible to coordinate the services at the initial chaotic time when thousands and thousands of the Rohingya were entering and starting to select settlements on their own choice and health interventions were agreed by any one at any place. The senior Officers deputed by DGHS started to develop some guidelines, norms and standard for the

organizations and persons offering medical service and developing a system to seek permission to start a health intervention and also to follow set guidelines and standard. Those officers played stewardship role in bringing all partners under the same umbrella and start of coordinated health interventions.

Figure 8.4: Bringing all partners under the umbrella of Health Ministry



Figure 8.5: Coordinated plan for distribution of health facilities



The Oral Cholera Vaccine (OCV) campaign and management of diphtheria epidemic may be regarded as the best examples for coordination of health interventions for the FDMN. To prevent the impending cholera epidemic the daunting OCV campaign was one of the greatest challenges that needed huge collaboration and coordination and also tested the vaccination capability of the country. Allocating around 2 million doses, transporting them from abroad, inland

transport, storage, macro-micro planning, resource mobilization and ultimately successful campaign with significant coverage overcoming linguistic and taboo, cultural barriers would not be possible without the impressive coordination done by DGHS and supported by all organizations, large and small, and from the highest to the lowest level officials, personnel and workers.

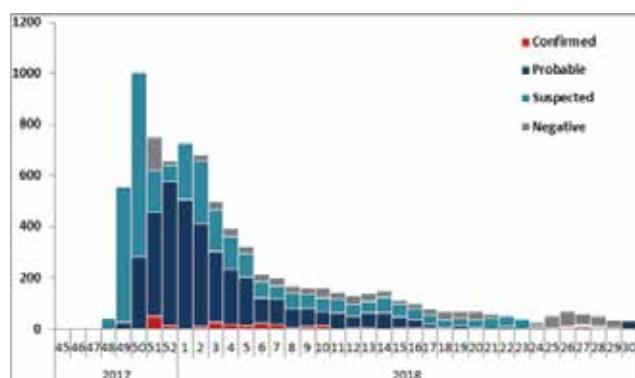
Figure 8.6: Immunization Campaigns

| Health Interventions  |   |   |   |   |   |
|---|---|---|---|---|---|
|                                |  |  |  |  |  |
| <b>MR Vaccine</b>   | <b>Oral Polio Vaccine</b>   | <b>Vitamin A</b>  | <b>Oral Cholera Vaccine</b>   | <b>Td</b>   | <b>Penta, PCV, bOPV</b>   |
| <b>Total: 490,501</b>   | <b>Total: 242,432</b>   | <b>Total: 72,064</b>  | <b>Total: 2101,553</b>  | <b>Total: 648,008</b>   | <b>Total: 492,011</b>   |
| <b>1st Round = 135,519<br/>(16 Sep - 03 Oct, 2017)</b>  | <b>1st Round = 72,334 (16 Sep - 03 Oct, 2017)</b>                                 | <b>68,941 (16 Sep - 03 Oct, 2017)</b>   | <b>1st Round = 700,487 (10 - 18 October 2017)</b>                                 | <b>1st Round = 165,927 (12 - 31 December 2017)</b>                                  | <b>Penta, PCV, bOPV=149,962 (12 - 31 December 2017)</b>                             |
| <b>2nd Round =354,982<br/>(18 Nov - 05 Dec, 2017)</b>   | <b>2nd Round = 236,696<br/>(4 - 09 Nov, 2017)</b>                                 | <b>Campaign = 156,505<br/>(NAW November, 2017)</b>                                | <b>2nd Round = 199,472<br/>(04 - 09 November 2017)</b>                            | <b>2nd Round = 223,065<br/>(27 Jan - 10 Feb, 2018)</b>                              | <b>Penta, bOPV=169,617<br/>(27 Jan - 10 Feb, 2018)</b>                              |
|   |   |   | <b>Special round = 879,273 (06 - 13 May 2018)</b>                                 | <b>3rd Round=259,016 (10 - 31 March 2018)</b>                                       | <b>Penta = 172,432 (10 - 31 March 2018)</b>   |
|   |   |   | <b>4th round = 364,686<br/>(17 Nov - 13 Dec 2018)</b>                             |   |   |
| <b>Cumulative number of medical consultations given for different diseases (24 Oct, 2017- 26 December 2018)</b> |   |   |   |   |   |

Management of the diphtheria epidemic was another good example of good coordination with successful end result. The epidemic was unexpected in Bangladesh. There was no such outbreak since long leading to diminishing experience of the service providers, scarcity of antibiotics and serum and limited

isolation and high care health facilities. Through concerted efforts and coordination, that epidemic was handled successfully. The coordination for OCV campaign and management of the diphtheria outbreak extended from international level down to national and field levels.

Figure 8.7: Controlling of Diphtheria Epidemic



## LOGISTICS COORDINATION

Supply and coordination of logistics were disorganized and uncoordinated creating inefficient logistic management. Though at the initial phase, measure was taken to rent a dedicated warehouse for the healthcare logistics of the FDMN to ensure coordinated and need based distribution, but it did not happen; not all partners participated actively in the coordination mechanism for the logistics.

## LEVELS OF COORDINATION

A four-tiered coordination structure was adopted by the health sector starting at national level and subsequently at District, sub-district (Upazila) and camp levels. At the national level, primary responsibility was assigned to the Additional Director General (ADG) Planning of Health Services to work on policy and guidelines for health interventions to FDMN and host community residing in the area. To supplement his (ADG) duty, a Coordination Center was established in November 2017 with offices in Dhaka and Cox's Bazar with a view to providing legal, logistic and human resources support to ensure health interventions to these populations as well as coordinating between government and other agencies. At the district level, a strategic advisory group comprising of the main health sector partners provides advisory role to the health sector coordinator based on priority needs. Under the health sector coordination there are several working groups with strong representation from the health sector partners, e.g. Multi-sectoral Vector Borne Diseases (VBD), Epidemiology and Case Management, Mental Health and Psychosocial Support (MHPSS), Sexual and Reproductive Health (SRH), Community Health, Emergency Preparedness, Acute Watery Diarrhea and so on.

### THE DGHS COORDINATION CENTER

The DGHS under the Ministry of Health and Family Welfare in Bangladesh has been working relentlessly for the Forcibly Displaced Myanmar Nationals (FDMN) (Rohingya refugees) since August 2017. DGHS established a Coordination Center at Cox's Bazar in November 2017 with a view to coordinate between government, UN Partners, NGOs and INGOs regarding health interventions to FDMN population and host community in Cox's Bazar with the following objectives:

- i. Cooperating and collaborating with other groups, sectors and organizations working for FDMN to scale up response;
- ii. Coordinating, facilitating and monitoring health instructions to FDMN including host community;
- iii. Conducting disease surveillance for epidemic prone diseases and health events;
- iv. Ensuring equitable humanitarian health response for the affected population;
- v. Providing regular, timely and accurate information to support evidence-based humanitarian actions;
- vi. Coordinating and liaising the work of the Multipurpose Health Centers, Primary Health Care centers, Upazila Health Complexes in Ukhiya, Teknaf and Naikhonchari as per the TOR;
- vii. Organising workshop/training for the members providing health care support to the FDMN and host community.

The following describes the mechanism for the Coordination Center

- i. There are different levels of coordination group working in the health sector starting from Inter Sector Coordination Group based in Cox's Bazar to camp-wise health sector coordination group coordinated by Camp in Charge in every camp.
- ii. The health sector partners are coordinated under the leadership of Civil Surgeon's Office of Cox's Bazar, the Directorate General of Health Services Coordination Center and the World Health Organization (WHO), for better planning and implementation of a coordinated emergency response.
- iii. The health sector has adopted three-tiered coordination structure at District, sub-district (Upazila) and camp levels. At the District level, a strategic advisory group, constituting the main health sector partners provides advisory role to the health sector coordinator based on priority needs.
- iv. Under the health sector coordination there are several working groups with strong representation from the health sector partners:
  - a. Multi-sectoral Vector Borne Diseases (VBD)
  - b. Epidemiology and Case Management
  - c. Mental Health and Psychosocial Support (MHPSS)
  - d. Sexual and Reproductive Health (SRH)
  - e. Community Health
  - f. Emergency Preparedness
  - g. Acute Watery Diarrhea.

## STRATEGIC ADVISORY GROUP

There are currently over 70 national and international organizations present in the Cox's Bazar area engaged in delivering health services to the displaced population. The scale and number of health-related issues along with the number of partners presents us with a coordination challenge. In order to streamline efforts and in line with a number of other sectors it established a Strategic Advisory Group (SAG) comprised of the MOHFW and key health actors to better support the MOHFW and health sector in addressing the most crucial issues at hand. The remit/objectives of this group is to advise the wider health sector on provision of timely, appropriate support to the MOHFW response in line with priority needs and at a quality that attains minimum standards as far as is possible in the given circumstances as below:

### **Support to health sector strategy and planning**

- Assist in developing the health component of the Strategic Plan
- Develop road map and process to engage health sector members and MOHFW in strategy development
- Support on-going needs assessments and gap analysis
- Support developing of costing and budget
- Establishing a clear and transparent process for gauging quality and maintaining oversight of project proposals for the strategy.

### **Support to coordination and delivery of high quality health services**

- Ensure an adequate package of health service is agreed, supported and monitored
- Support to site planning process and rational distribution / re-location of current health services and location of future services
- Support to developing and maintaining reporting on key health activities to MOHFW.

### **Surveillance, preparedness planning and response coordination**

- Support to preparedness and contingency planning for outbreaks and natural disasters
- Active support to and promotion of early warning and surveillance systems
- Support coordination of outbreak investigation and response.

The following were the initial inclusion criteria for SAG:

- i. Capacity to contribute meaningfully and knowledgeably in terms of time and expertise
- ii. Scale of health operations
- iii. Intention and clear capacity to scale up rapidly in case of outbreak, or other health related crisis
- iv. Engagement in / scale of cross sector operations – especially WASH and nutrition
- v. Experience of health service delivery in camp settings
- vi. Experience of the context
- vii. Long-term commitment to the context

### **The following is the composition of the SAG:**

- Chair – WHO;
- Members: IOM, UNFPA (SRH Subgroup), ACF (MHPSS Subgroup), UNICEF, UNHCR, MSF, BRAC, Save the Children, IFRC / Bangladeshi Red Crescent, Inter-sector advisors / observers - WASH cluster representative and Nutrition cluster representative

## HEALTH SECTOR COORDINATION AT CAMP LEVEL

In light of the monsoon and cyclone, where flooding and landslides were anticipated to disrupt health services, the health sector strengthened and streamlined the coordination and disease surveillance in the camps by assigning a health sector camp focal point in each camp. The responsibility of the Health Sector Camp Focal Person (CFP) is to support coordination and disease surveillance among health sector partners and the community in the camp he/she is responsible for. The CFP also works closely with the Camps in Charge (CiCs) and under the guidance of his/her agency and the Health Sector Field Coordinator (HSFC) to centralize and circulate relevant health information among all public health related partners operating in the same camp. This role was critical to the smooth running of health services, community liaison and information, identification of emerging needs and gaps, surveillance and outbreak response.

## NGO COORDINATION

NGOs have played an outstanding role in the response to this humanitarian crisis under the leadership of the Government of Bangladesh. Although many of them lacked experience in humanitarian crisis response and management, local NGOs brought valuable experience of working with local communities on social and economic issues, and were among the first to help

meet the immediate needs of refugees. The main roles of the NGOs were field level implementation and community mobilization. Through community mobilization, various messages were delivered to the affected population in their local language and dialect. One example of the effectiveness of community mobilization was that it helped to organize multiple immunization campaigns and de-stigmatize fear regarding vaccines. NGOs deploy Community Health Workers (CHWs) who conduct regular household visits to identify the sick, refer them to nearest treatment centers and follow-up on the treatment.

Local organizations have successfully established networks and coalitions including the NGO Coordination Support Cell and the Cox's Bazar Civil Society Organization NGO Forum (CCNF), which have helped establish common positions and increased their visibility. Besides, the Heads of Sub-Office Group (HoSOG) has played an active role in bringing together the heads of all UN agencies and representatives of the international NGOs, local NGOs and donor representatives to establish a well-coordinated response targeting the affected and the host community. HoSOG is headed by a Senior Coordinator who also chairs the ISCG and guides the response with the support of secretariat in Cox's Bazar.

During the early phase of the humanitarian response, the ISCG Secretariat organized an NGO liaison function and encouraged the independent Bangladesh Rohingya Response NGO forum. To increase coordination, advocacy, and partnership as well as broaden the humanitarian space in the response, the NGO Platform facilitates more than one hundred local, national and international NGOs and helps them work in a coordinated way. Moreover, the NGO Platform Coordinator plays a significant role in decision making and agenda-setting in the coordination forum at all levels including the Strategic Executive Group, the HoSOG and the ISCG. This platform also participates in government-led coordination mechanisms and helps coordinate with the Government's NGO Affairs Bureau.

## CHALLENGES IN COORDINATION AND SUPERVISION

### Horizontal coordination

Many service providers and clients are not well aware of the services provided in the camps. For example, staff at one Health Post may not be aware that another Health Post that provides the same or similar services. Also, there may be facilities having specialists or providing specialized care within or near the camps but it may not be known to other providers<sup>3</sup>.

### VERTICAL COORDINATION AND SUPERVISION

Lack of coordination is a hindrance in better utilization of services such as ambulance for referral of patients. This in many cases led to delays in care giving due to overburdening of the referral system. It is found that supervisory visits are not always up to the mark. Most of these supervisory visits are administrative in nature. The health providers want more technical or supportive supervision where they could receive some technical guidance to the challenges they faced<sup>3</sup>.

### RECOMMENDATIONS FOR IMPROVING COORDINATION

#### Integrate health services and improve horizontal coordination

- Reassess the geographic distribution of health posts according to minimum standards and based on needs.
- Review the approval process for health facility localization and types of services, especially in terms of localization of health posts and types of services provided.
- Ensure that specialized NCD, MHPSS, dental and eye care facilities are established to meet growing demand for these types of services, and these are also provided in comprehensive clinics.
- Continuously update mapping of facilities and services provided per facility, and strengthen the coordination role of the national government and the health sector in the camps
- Consider introduction of compulsory “Health/Service Card” in order to maintain health service records and to streamline the health service provision<sup>3</sup>.

## **Strengthen vertical integration**

In the context of moving from a more ad-hoc, emergency situation to a more coordinated effort in health service provision, the following measures have been recommended to improve coordination between the first, second and third level of care, specifically in reducing delays during referral:

- Designation of specialized centers for referrals and continuous monitoring of capacity
- Communicate HP / PHC and Referral mapping and guidelines
- Assess quality of care after hours in 24/7 facilities
- Increase capacity of supportive technical supervision.

## **Reduce duplication through rationalization and optimizing the geographical distribution of health facilities**

In order to reduce the duplication of services, scaling up of rationalization of localization, licensing, assignment and deployment of health services are recommended. This needs to be done especially at the level of health posts, but also at the level of health facilities. Duplication can be reduced to a minimum with strong support from health sector coordination<sup>3</sup>.

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## CHAPTER NINE

# MOBILIZATION OF RESOURCES FOR THE ROHINGYA HUMANITARIAN CRISIS

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## INTRODUCTION

The humanitarian crises across the world affect more people and last longer on average than ever before, and making efforts to reach all the vulnerable people, the need for the amount of resource to tackle this challenge is more than what it used to be<sup>1</sup>.

One of the important aspects of handling a humanitarian crisis is to effectively mobilize and manage the resource required to face its challenges. Tracking down the resources and the efforts made in mobilizing the resources for these programs and activities enable us planning for efficient use and develop a sustainable mechanism to support the displaced population in a specific context. This is particularly important as vast majority of the refugees often live in low and low-middle income countries with their own public finance limitations.

Today, there are more than one million Rohingya refugees live in and around the Cox's Bazar district

of Bangladesh. They are now one of the largest stateless population in the world, and with such a huge number of displaced population living in makeshift settlement camps in Ukhia and Teknaf, the population density has reached to 9,041 per square mile. The extreme level of influx of refugees during August-October 2017, estimated at 723,000, has contributed to this number and this has been described as one of the worst humanitarian crises in recent history.

This chapter contains a background on the resource mobilization and financing the humanitarian crisis, the need assessment for resource mobilization, the level and estimated amount of funding requirement against the actual amount of funding obtained during 2018 and in 2019, and the major partners/implementing organizations who mobilized the funding during the period. It also looks at resource requirements for the future and its fiscal implications.

## RESPONSE TO THE CRISIS: THE BACKDROP OF THE CHALLENGE

A humanitarian crisis is dealt with by a response plan that emerges as a result of collaborative efforts amongst the different stakeholders such as the government, the UN and international aid agencies. These agencies, with commonly shared information and analysis of the need of the affected people following some protocols and guidelines, come up with an operational plan with detailed costs for different parts of the humanitarian responses and make a formal appeal to the international community and donors. Different UN and international agencies, donor countries and development partners respond to this appeal. The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), a United Nations body formed in December 1991 by General Assembly Resolution 46/182, and the United Nations High Commissioner for Refugees (UNHCR) play an important role in coordinating the response plan and mobilizing the resource required, where UNOCHA plays the role of the Humanitarian arm of the United Nations Secretariat. The Secretary General of the United Nations takes the leadership role to strengthen and warrant well groundwork for a coherent response to emergencies, and has also established the role of the Emergency Relief Coordinator (ERC). The ERC works with the Secretary General and the Inter-Agency Standing Committee (IASC) in leading, coordinating and facilitating humanitarian assistance. UNOCHA, as the Secretariat, provides support to the ERC and the Secretary General to meet the leadership and coordination responsibilities recorded in GA resolution 46/182.<sup>12</sup>.

Humanitarian response plans are the products of collaborative efforts among most aid organizations and the government of host countries working in a major crisis. They are based on shared information and analysis of affected people's needs, and embody a unified strategic and prioritized result, the world's forcibly displaced population reached yet again at a record high. This has made approach to meeting those needs and helping people out of crisis. Furthermore, they entail operational planning, division of labor, and detailed costs for each part of the humanitarian response—thus also forming an appeal. Increasingly, for protracted crises, they take a multi-year view and involve development actors accordingly.

The year 2017 was marked by record humanitarian need due to stretched and complex crises resulting from the intensification of conflicts in several countries, climate change-induced vulnerability and a series of natural disasters. Globally, the forcibly displaced population increased in 2017 by 2.9 million<sup>3</sup>. By the end of the year 2017, a total of 68.5 million individuals were forcibly displaced worldwide as a result of persecution, conflict, or generalized violence or human rights violations, recording a 4.4 percent increase from the previous year<sup>4</sup>. The UNOCHA's humanitarian appeal asked for a record level of \$23.5 billion to support 141 million of the most vulnerable people around the world (\$166 per person per year). By the end of the year, OCHA was able to raise \$13 billion to provide life-saving aid and protection<sup>5</sup>. In 2018, the funding required to meeting the demand for shelter, food, education and health and social care has been more than that has been used ever before<sup>2,6</sup>. In their 2018 Global Humanitarian Overview, UNCHR have estimated that the total funding requirement in 2018 for the 135 million people needing support at \$25.2 billion, of which only \$14.1 billion were actually funded (55.95%), and \$11.1 billion remained unfunded. It is within this circumstance that the efforts on funding and resources mobilization are being made. UNOCHA mobilizes and engages several financing instruments, mechanisms and partners to ensure that growing humanitarian needs are met. At the country level, UNOCHA helps partners to build common strategies and implementation plans and to appeal for funds as a group. This ensures that resource mobilization and financing are handled collectively and are based on a thorough needs evaluation, making aid more effective, efficient and predictable. At a global level, this work culminates in the Global Humanitarian Overview, which is launched every year in December<sup>2</sup>. This review is considered to be the most comprehensive and evidence-based assessment of priority for global humanitarian needs. It provides a sufficiently accurate assessment of needs and recommends the means to meet them, and to ensure that the resources are targeted to the people needing them most for effective and efficient utilization.

## NEEDS ASSESSMENT FOR RESOURCE MOBILIZATION

The efforts made for coordinating needs assessments is important, as this provides a complete understanding of the crisis situation and the needs of

different groups of people facing the crisis. Such coordinated effort with the use of evidence-based information enable the development of effective protocols and guidelines for designing and implementing responses that save lives and restore people's livelihoods under emergencies.

A coordinated assessment for an effective humanitarian response consists either of a single assessment exercise including various sectors, or of the combination of various sectoral assessments analyzed together. Such coordinated assessments are carried out in partnership with the partners and actors involved in dealing with humanitarian crisis. This forms the basis for needs-based strategic planning and system-wide monitoring, the key first phase of the Humanitarian Programme Cycle<sup>7</sup>. UNHCR have identified several tools and guidance that have been developed and followed to support and strengthen coordinated assessments in humanitarian contexts<sup>7</sup>. These are:

- i) **Humanitarian Needs Overview (HNO)**, a template that compiles results from various sectoral and multi-sectoral assessments to identify priority humanitarian needs to be addressed and feeds the next stage of the programme cycle, strategic planning. It also highlights information gaps and country plans to address these gaps.
- ii) **Operational Guidance for Coordinated Assessments**, which describes how to plan and carry out coordinated multi-sectoral assessments.
- iii) **Humanitarian Indicator Registry**, which lists the primary needs and response monitoring indicators for each sector/cluster and provides a unique identifier for every indicator.
- iv) **The Humanitarian Dashboard** is an OCHA information product and is an IASC agreed tool that offers a brief and primarily graphic overview of progress towards meeting needs in a humanitarian response. It helps to quickly comprehend the strategic priorities of a response to the key figures portraying the crisis, and the most important humanitarian needs related to different sectors.
- v) **The Multi-Cluster/Sector Initial Rapid Assessment<sup>8</sup>** guidance that explains how to jointly design and execute a multi-sectoral/cluster needs assessment at early stage of an emergency, including IASC system-wide level 3 emergency responses (L3).
- vi) **Kobo Toolbox**: an open source software for field

mobile data collection and analysis, which can be used in needs assessments to promote a standardized, reliable, simple and efficient approach.

- vii) **Other assessments by different actors and sectors**: Sector specific assessment such as SMART surveys

Apart from those tools and guidelines, guidance and support are provided by the Coordinated Assessment Support Section (CASS) within the Programme Support Branch (PBS) of OCHA in Geneva, so that the humanitarian actors can reach common understanding of the situation and needs in order to formulate strategic planning, monitoring and resource-mobilization. CASS also leads internal efforts to build OCHA and partners' capacity to coordinate multi-sectoral assessments and analysis<sup>9</sup>.

The resource mobilization for the different defined sectors are guided by the work based on the application of the different need assessment tools which has been developed, tested and are used widely under humanitarian crisis to develop projects and programmes. For example, for sexual and reproductive health, it is the Inter-Agency Working Group (IAWG) on Reproductive Health in Crisis which works to expand and strengthen access to quality sexual and reproductive health (SRH) services for people affected by conflict and natural disaster and help to assess situation and recommend measures to be taken by the UN agencies, government, and the implementing agencies and also estimate resource requirements. To respond to that, the Joint Response Plan (JRP) worked through a coordinated approach to meet the needs of refugees and host communities<sup>10</sup>, so that they can have access to free SRH services and formed the basis for resource mobilization. For estimating the amount of resource required the evidence-based guidance on SRH became the standard of care in humanitarian situations. The Minimum Initial Services Package, or MISP, which was developed in the late 1990s by the IAWG on Reproductive Health in Crisis (a multi-agency coalition hosted by the Women's Refugee Commission) was based on such guidance.

This package was designed to guarantee the access to services that have most impact in reducing the RH-related morbidity and mortality often found during the early stages of dealing with the emergencies and implementing the priority reproductive health (RH) services<sup>8</sup> including the coverage of HIV/AIDS control and prevention and responding to gender-based violence (GBV) and women's health risks such as

sexually transmitted infections<sup>6</sup>. In order to avoid dreadful consequences such as increases in mortality and morbidity, sexually transmitted infections, unintended pregnancies, and unsafe abortions, the UNFPA and partners have made implementing this MISP protocol an immediate priority and was playing a major role to the JRP in mobilizing the funds to ensure service provision and providing critical training in sexual and reproductive health care to the health workers.

The Plan has estimated resource requirement and appealed to donors to fund the SRH service, or more specifically the MISP, to serve 325,000 women of reproductive age in the camps, attend approximately 60,000 pregnant women (initially estimated according to MISP, revised later on to 22,000 pregnant women) requiring basic ANC, delivery care or comprehensive emergency obstetric care for approximately for 2,500 women.

The resource requirement for SRH, which is part of the total resource that is mobilized for the health sector, was estimated at \$13.8 million in November 2017. This was later revised to \$16.2 million in February 2018 with the JRP's initiative. The funding gap remained quite substantial until March 2018, when only 47.9 percent of the total funding appeal was available. It improved to 70.4 percent in April 2018, and gradually increased to 103 percent.

The major donors of funding for the sexual and reproductive health in April 2018 included Australia, Canada, Denmark, Japan, Republic of Korea, New Zealand, Sweden, UK, and UNFPA. The donors at the beginning of the emergencies were different from what we found recently, it changed at the time when JRP was launched.

OCHA mobilizes and engages a number of financing instruments, and mechanisms for partners to guarantee that increasing humanitarian needs are met. At the country level, OCHA helps the partners responding to the crisis to shape common strategies and implementation plans and to appeal for funds as a group. This ensures that resource mobilization and financing are handled collectively and are based on a thorough needs evaluation, making aid more effective, efficient and predictable.

## PLANNING, MANAGEMENT AND OPERATIONS FOR RESOURCE MOBILIZATION

The Government of Bangladesh leads the Rohingya response, providing close guidance to the development of the JRP and its mid-term reviews. Over the period, the partnership between the Government of Bangladesh and the Inter Sector Coordination Group (ISCG) has significantly strengthened and improved as the coordination and communication channels were established with the Refugee Relief and Repatriation Commissioner (RRRC), local public administration, the military, the line ministries and government agencies. These channels include regular coordination meetings co-chaired by the ISCG Secretariat and the Upazila Nirbahi Officers, the ISCG Secretariat and the Military at the Upazila levels, and by the Senior Coordinator and the RRRC at the Cox's Bazar district level. The Co-Chairs of the Strategic Executive Group and Senior Coordinator are also regular contributors to inter-ministerial meetings, including the National Task Force in Dhaka<sup>11</sup>.

## RESOURCE MOBILIZATION AND UTILIZATION IN 2018

Mobilization of resources for the Rohingya population since 2017, the year considered as the worst year for humanitarian crisis for the world, has been a colossal task. Resources had to be mobilized to cater to the needs of an estimated 921,000 Rohingya refugees (as on September 2018) in Cox's Bazar<sup>11</sup>. Over 700,000 refugees, including more than 380,000 children, followed those first arrivals (during August 2017) over the subsequent four months, and this became the largest and also the fastest refugee influx into Bangladesh ever. The majority arrived between August and December 2017, however, it continued even until August 2018, with over 13,000 refugees arriving during January – August 2018.

The first JRP for the Rohingya Humanitarian Crisis, launched in February/March 2018, covered the period March to December 2018, with a requirement of US\$ 950.8 million which was assessed on the basis of the prioritized programs and activities in the major areas/sectors. There were 101 implementing partners involved in it which raised \$682.1 million as of end December 2018<sup>6</sup>.

Since the JRP was launched, the focus of the response has been on addressing priority gaps in services for both the refugees and the affected host communities in need in Cox's Bazar district. Building resilience and addressing environmental concerns are also core objectives of the JRP<sup>11</sup>. JRP is a report for both the affected and the host populations' needs in Cox's Bazar District, i.e., consider the Rohingya refugees and heavily impacted host communities in the seven Unions in Ukhia and Teknaf Upazilas of Cox's Bazar District, hosting the highest numbers of refugees. The 2018 JRP targeted 336,000 affected Bangladeshi nationals living in the host community, 26 percent of the total 1.3 million in need.

A donor or individual can appeal through the country-based pool fund Central Emergency Response Fund (UNCF) or through UNOCHA to mobilize resources for a humanitarian crisis. The CERF emphasizes on programs and activities that are very critical and life-saving, and as the UN General Assembly extended its funding target to US\$1 billion, as a result of which emergency funding were available immediately without waiting for the response to the appeal. In 2018, US\$18 million of emergency funding to Bangladesh were channeled by CERF<sup>12</sup>.

The major contributors of significant funds mobilized outside of the JRP for the Rohingya refugee crisis included but not limited to the Government of Bangladesh, MSF and Red Cross movement's contributions, have formed critical elements of the overall response<sup>11</sup>. The Government of Bangladesh is

playing a key role in the support and utilization of resources through the government health facilities, including community clinics and union-level health facilities. The hospitals are provided additional resources to cope with the increased patient volumes. In particular, the Sadar District Hospital in Cox's Bazar benefitted from human resources support (nurses, medical doctors, and medical specialists) as well as various types of supplies and equipment<sup>11</sup>. There are also a large number of grassroots local community charitable projects and initiatives, such as a number of health clinics that are donated and opened by direct contributions, particularly at the beginning of the crisis.

The estimated requirements of funding for different sectors through JRP, and amount funded for the different sectors of Rohingya Crisis are provided in Table 9.1.

The table shows the level of required and funded amount for the period until 2018 in different major sectors that are identified to be the basis of managing the crisis. The activities and services of three major sectors that directly contribute to the health and health care of the Rohingya population are 'Health', 'Nutrition' and 'Water, Sanitation and Hygiene,' and an understanding of the amount of resources being mobilized both within the JRP and outside JRP in these sectors is useful. The table also provides the situation on the total amount of resources required, total funding and the funding gaps in different sectors.

Table 9.1: Funding Requirement (US\$) and Funding Coverage by Sectors in 2018

| <b>Cluster/Sector</b>          | <b>Original requirements</b> | <b>Current requirements</b> | <b>Funding received</b> | <b>% funded</b> | <b>Funding as % of the Total Funding received</b> |
|--------------------------------|------------------------------|-----------------------------|-------------------------|-----------------|---|
| Communication with Communities | 5,869,715                    | 5,869,715                   | 4,264,402               | 72.7            | 0.65  |
| Coordination                   | 5,557,568                    | 5,557,568                   | 2,229,059               | 40.1            | 0.34  |
| Education                      | 47,319,607                   | 47,319,607                  | 23,691,838              | 48.6            | 3.59  |
| Emergency Telecommunications   | 1,200,000                    | 1,200,000                   | 520,000                 | 43.3            | 0.08  |
| Food Security                  | 240,856,565                  | 240,856,565                 | 169,973,261             | 68.7            | 25.75   |
| Health                         | 113,086,292                  | 113,086,292                 | 45,316,937              | 39.7            | 6.86  |
| Logistics                      | 3,626,042                    | 3,626,042                   | 3,956,554               | 109.1           | 0.60  |
| Not reported                   | 0                            | 0                           | 204,511,099             | 0               | 30.98   |
| Nutrition                      | 56,722,102                   | 56,722,102                  | 35,772,687              | 63.1            | 5.42  |
| Protection                     | 34,414,853                   | 34,414,853                  | 13,832,797              | 40.2            | 2.10  |

| <b>Cluster/Sector</b>              | <b>Original requirements</b> | <b>Current requirements</b> | <b>Funding received</b> | <b>% funded</b> | <b>Funding as % of the Total Funding received</b> |
|------------------------------------|------------------------------|-----------------------------|-------------------------|-----------------|---|
| Protection - Child Protection      | 19,047,953                   | 19,047,953                  | 15,824,617              | 83.1            | 2.40  |
| Protection - Gender-Based Violence | 18,373,631                   | 18,373,631                  | 9,441,016               | 47.7            | 1.43  |
| Refugee Response (Multi-Sector)    | 0                            | 0                           | 353,232                 | 0               | 0.05  |
| Shelter and Non-Food Items         | 136,626,254                  | 136,626,254                 | 33,892,612              | 25.1            | 5.13  |
| Site Management                    | 131,444,984                  | 131,444,984                 | 43,555,530              | 32.2            | 6.60  |
| Water, Sanitation and Hygiene      | 136,688,639                  | 136,688,639                 | 36,160,721              | 33.1            | 5.48  |
| Multiple Field clusters (shared)   |                              |                             | 16,911,026              | 27.5            | 2.56  |
| <b>Total</b>                       | <b>950,834,205</b>           | <b>950,834,205</b>          | <b>660,207,388</b>      | <b>69.43</b>    | <b>100.00</b>                                     |

Source : UNOCHA, 2018

The total appeal for overall funding was US\$950.83 million, and at the end of the year 2018, the total amount committed were US\$ 748.68 million, but the actual funded amount stood at US\$660.21 million, with a shortfall of 290.62 million. The food security sectors received almost 26 percent of the total funded amount, while about 31 percent of the total funded amount could not be assigned to the listed sectors making it difficult to assess sector wise distribution of funding.

The funding coverage (total funded amount as a proportion of estimated requirements) ranges from as low as 25.7 percent to as high as 109 percent. It is understandable why logistics, communication with communities, and the food security sectors have high proportion of funded amount. The communication with communities sector has been well funded.

The three sectors which we have considered to be directly contributing to health and public health of the population could obtain only 39.7 percent of the total requirement. The “Health Sector” collaboratively with the partners developed a guideline set of Essential Service Packages (ESP) that aims to ensure that for every 20,000 refugees, there is one primary health center, that shall be able to provide 24-hour health care with inpatient and laboratory capacity, and three health posts providing daytime basic care (equivalent to 1 health post for every 6,000 population). This can

be used to give an estimate on the amount of resource that will be required to provide basic health services to the Rohingya refugees across the different camps.

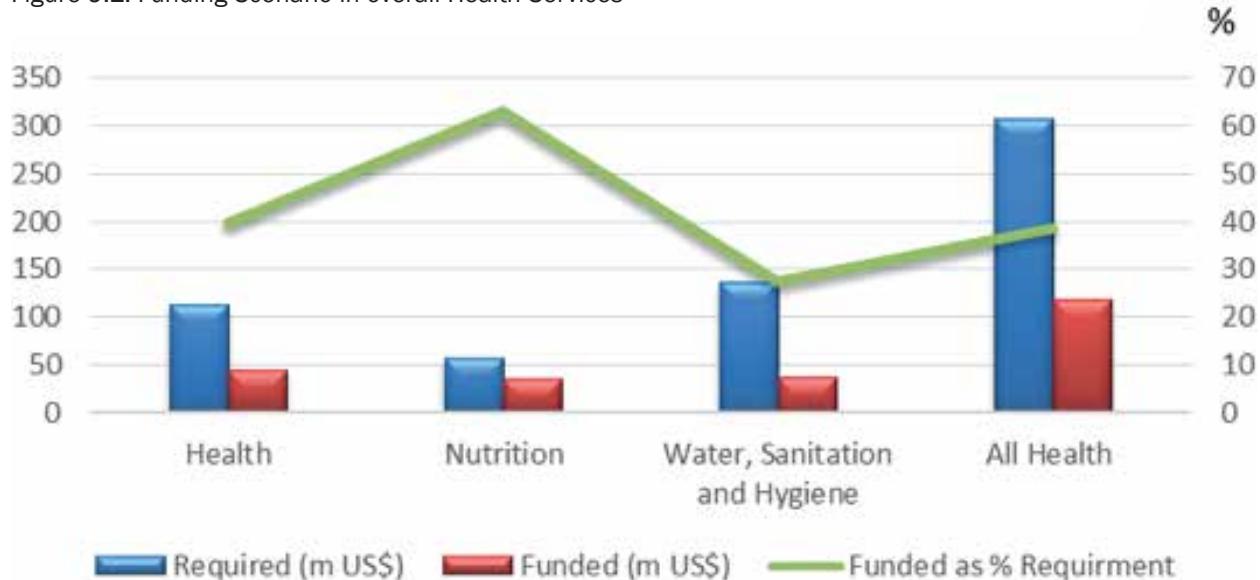
The funding realization as against the target, as noted in JRP 2018, changed over the year 2019 for some specific sectors and for others remaining the same as was observed at the end of December 2018. As on 28 November 2019, the proportion of actually realized to required amount in the education sector has increased by 32.9 percentage points (from 48.6 % to 81.5%; US\$ 23.7 million to US\$ 38.6 million). Besides, the funding coverage in food security increased to 72.1 percent from 68.7 percent. Unfortunately, the coverage increased marginally in case of health sector (71.5% in November 2019 as against to 69.43% in December 2018).

As of end of 2018, if we consider all the three sectors, the nutrition sector seems to have been funded better getting more than 60 percent of the requirement. WASH remains at the lower end, with the funded amount covering only 27.5 percent of the total estimated requirement (Fig 9.1). If we take all the three sectors together (i.e., health, nutrition, and WASH), we can see that of the total amount of the funding requirement of US\$306.5 million, only about 39 percent is funded. Though the share of WASH in the total estimated funding requirement for the three health sectors has been the highest, the total

proportion of funded amount for it remains the lowest. The level of funding obtained for the nutrition sector remained highest (63.1%) for the JRP (March-December, 2018), the health sector funded

amount was nearly 40 percent of the requirement (Figure 9.1).

Figure 9.1: Funding Scenario in overall Health Services



Source: JRP, 2018

There are about 107 national and international partners in the health sector who have responded to the needs and have been delivering health services in both static and mobile health facilities in both Ukhia, and Teknaf as well as through expansive community health worker networks. Efforts and resources are in place to strengthen the health system as a whole through supporting existing health facilities, the health workforce and the surveillance system.

It is important to note that during 2018, the health sector funding appeal (US\$ 113 million) within the JRP constitutes only 12 percent of the total for all the sectors, and only 13.5 percent was funded, the lowest compared to the underfunding levels for all the other sectors.

## SOURCES OF FUNDS

A large number of donors, international organizations, UN agencies, bilateral donors contributed to the funding that has been realized during the JRP period 2018. The two main contributors are the United States of America and the UK, who are contributing 36.50 percent and 12.8 percent of the total funds respectively, or together close to half of all contributions (Table 9.2).

Table 9.2: Sources of Funds during the JRP Period 2018

| <b>Donor Government and Funding Organization</b>                       | <b>Amount (US\$)</b> | <b>% of response plan/appeal funding</b> |
|--|----------------------|--|
| Australia, Government of   | 24,336,949           | 3.70                                     |
| Bangladesh, Government of  | 154,027              | *  |
| Canada, Government of  | 21,320,404           | 3.20                                     |
| Central Emergency Response Fund  | 18,002,515           | 2.70                                     |
| Denmark, Government of   | 8,671,163            | 1.30                                     |
| Education Above All Foundation   | 2,882,834            | 0.40                                     |
| Education Cannot Wait Fund   | 264,306              | *  |
| Estonia, Government of   | 61,728               | *  |
| European Commission  | 10,206,043           | 1.50                                     |
| European Commission's Humanitarian Aid and Civil Protection Department | 39,389,527           | 6.00                                     |
| France, Government of  | 1,799,943            | 0.30                                     |
| Friends of UNFPA   | 4,949                | *  |
| Frontiers, Ruwad Association   | 429,448              | 0.10                                     |
| Germany, Government of   | 11,694,014           | 1.80                                     |
| International Organization for Migration                               | 1,006,666            | 0.20                                     |
| Ireland, Government of   | 1,260,248            | 0.20                                     |
| Islamic Development Bank   | 5,819,314            | 0.90                                     |
| Japan, Government of   | 43,153,716           | 6.50                                     |
| Korea, Republic of, Government of                                      | 4,200,000            | 0.60                                     |
| Kuwait, Government of  | 1,000,000            | 0.20                                     |
| Luxembourg, Government of  | 674,380              | 0.10                                     |
| Netherlands, Government of   | 800,000              | 0.10                                     |
| New Zealand, Government of   | 2,087,609            | 0.30                                     |
| Norway, Government of  | 10,001,836           | 1.50                                     |
| Not specified  | 10,561,667           | 1.60                                     |
| Portugal, Government of  | 11,848               | 0.00                                     |
| Private (individuals & organizations)                                  | 33,293,258           | 5.00                                     |
| Qatar, Government of   | 2,621,242            | 0.40                                     |
| Russian Federation, Government of                                      | 1,000,000            | 0.20                                     |
| Saudi Arabia (Kingdom of), Government of                               | 7,344,987            | 1.10                                     |
| Spain, Government of   | 701,235              | 0.10                                     |
| Sweden, Government of  | 10,143,280           | 1.50                                     |
| Swiss Solidarity   | 2,464,426            | 0.40                                     |
| Switzerland, Government of   | 9,721,279            | 1.50                                     |
| Thailand, Government of  | 100,000              | 0.00                                     |
| UN Foundation  | 100,000              | *  |
| UNICEF National Committee/Australia                                    | 741,031              | 0.10                                     |
| UNICEF National Committee/Belgium                                      | 3,288                | *  |
| UNICEF National Committee/Canada                                       | 139,660              | *  |
| UNICEF National Committee/Denmark                                      | 123,923              | *  |
| UNICEF National Committee/France                                       | 116,906              | *  |
| UNICEF National Committee/Germany                                      | 241,772              | *  |

| <b>Donor Government and Funding Organization</b> | <b>Amount (US\$)</b> | <b>% of response plan/appeal funding</b> |
|--|----------------------|--|
| UNICEF National Committee/Hong Kong              | 4,053                | *  |
| UNICEF National Committee/Iceland                | 3,577                | *  |
| UNICEF National Committee/Italy                  | 5,938                | *  |
| UNICEF National Committee/Japan                  | 3,658,042            | 0.60                                     |
| UNICEF National Committee/Netherlands            | 516,200              | 0.10                                     |
| UNICEF National Committee/Portugal               | 17,921               | *  |
| UNICEF National Committee/Spain                  | 427,828              | 0.10                                     |
| UNICEF National Committee/United Kingdom         | 904,160              | 0.10                                     |
| US Fund for UNICEF                               | 1,137,698            | 0.20                                     |
| United Arab Emirates, Government of              | 3,953,859            | 0.60                                     |
| United Kingdom, Government of                    | 84,398,080           | 12.80                                    |
| United Nations Children's Fund                   | 34,347,220           | 5.20                                     |
| United Nations Office for Project Services       | 34,734               | *  |
| United Nations Population Fund                   | 324,000              | *  |
| United States of America, Government of          | 240,869,425          | 36.50                                    |
| World Bank                                       | 600,000              | 0.10                                     |
| World Vision International                       | 353,232              | 0.10                                     |
|  | <b>660,207,388</b>   | <b>99.9</b>                              |

Source: UNOCHA, 2018

\*Less than .01%

Some additional donors have raised funds for this humanitarian crisis beyond the previous donors like Disasters Emergency Committee (UK), Global Partnership for Education, Norwegian Refugee Council, UNICEF National Committee/Luxembourg, and UNICEF National Committee/United Kingdom. Besides, Government of Kuwait is contributing more US\$ 1.2 million. Thus, contributing to the raise in funding amount total US\$ 679.53 million from the previous US\$ 660.21 million (as on 28th November, 2019).

Out of the total requirement of US\$113.1 million estimated for the JRP for Health sector for the year 2018, about 43.4 percent were obtained, and the UN agencies (WHO, IOM, UNFPA, UNCHR, UNICEF), and international NGOs like Save the Children, Care International, Relief International and Terre des Hommes were the major recipients. The major recipients of the funds under the JRP in the health sector are given in the following table (Table 9.3).

Table 9.3: Destination of Funds Raised through Joint Response in the Health Sector in 2018 and 2019

| <b>Destination organization</b>                                   | <b>Requirements<br/>(US\$)</b> |             | <b>Funding<br/>Obtained (US\$)</b> |             | <b>Coverage %</b> |             |
|---|--------------------------------|-------------|------------------------------------|-------------|-------------------|-------------|
|   | <b>2018</b>                    | <b>2019</b> | <b>2018</b>                        | <b>2019</b> | <b>2018</b>       | <b>2019</b> |
| ACT Alliance / Christian Commission for Development in Bangladesh | 1,600,000                      | 400,398\    | -                                  | -           | 0                 | 0           |
| Action Against Hunger   | 755,042                        | 1,091,603   | -                                  | 9852217     | 0                 | 902.5       |
| Agrajattra  | 794,528                        |             | -                                  |             | 0                 | 14.3        |

| <b>Destination organization</b>                                       | <b>Requirements<br/>(US\$)</b> |                   | <b>Funding<br/>Obtained (US\$)</b> |                   | <b>Coverage %</b> |             |
|---|--------------------------------|-------------------|------------------------------------|-------------------|-------------------|-------------|
|   | <b>2018</b>                    | <b>2019</b>       | <b>2018</b>                        | <b>2019</b>       | <b>2018</b>       | <b>2019</b> |
| BRAC  | 8,884,177                      | 5,281,098         | -                                  | 757002            | 0                 | 14.3        |
| CARE International  | 1,800,000                      | 500,000           | 901,107                            | -                 | 50.1              | 0           |
| CBM International (formerly Christian Blind Mission)                  |                                | 1,332,615         |                                    | 868,687           |                   | 65.2        |
| COAST Trust   | 726,667                        |                   | -                                  |                   | 0                 |             |
| Fasiuddin Khan Research Foundation                                    | 170,000                        |                   | -                                  |                   | 0                 |             |
| Friendship  |                                | 1,856,500         | -                                  | 112,553           |                   | 6.1         |
| Gonoshasthaya Kendra  | 642,570                        |                   | -                                  |                   | 0                 |             |
| HOPE Foundation for Woman and Children of Bangladesh                  | 238,500                        | 500,000           | -                                  | -                 | 0                 | 0           |
|   | 725,250                        |                   |                                    |                   |                   |             |
| Handicap International / Humanity & Inclusion                         |                                | 1,314,075         |                                    | -                 | 0                 | 0           |
| Health and Education for All  |                                | 757,810           | -                                  |                   | 0                 | 116.5       |
| HelpAge International UK  | 1,130,437                      | 570,000           | 601,953                            | 664,238           | 53.2              |             |
| HumaniTerra International   | 586,025                        |                   | -                                  |                   | 0                 |             |
| Integrated Social Development Effort Bangladesh                       | 134,145                        |                   | -                                  |                   |                   | 27.2        |
|   | 17,792,307                     |                   |                                    |                   | 0                 |             |
| International Organization for Migration                              |                                | 12,455,876        | 10,869,907                         | 3,389,365         | 61.1              | 0           |
|   | 1,205,000                      |                   |                                    |                   |                   |             |
| Migrant Offshore Aid Station  |                                | -                 | -                                  |                   | 0                 | 0           |
| Mercy Malaysia  |                                | 400,000           | -                                  |                   | 0                 |             |
| N/a   |                                | 149,883           | -                                  |                   |                   |             |
| OBAT Helpers  |                                | 839,686           |                                    |                   |                   | 346.1       |
| PULSE – Bangladesh  | 275,000                        |                   | -                                  |                   | 0                 | 0           |
| Peace Winds Japan   | 495,000                        | 400,000           | -                                  | 1,384,485         | 0                 |             |
| Première Urgence Internationale                                       |                                | 1,000,000         |                                    | -                 |                   | 0           |
| Protyashi   | 550,000                        |                   |                                    | -                 | 0                 |             |
| Qatar Charity   |                                | 400,000           | -                                  |                   | 0                 |             |
| Relief International  | 3,000,000                      | 975,549           | 932,111                            |                   | 31.1              | 0           |
| Resource Integration and Social Development Association in Bangladesh | 145,000                        | 255,372           |                                    | -                 | 0                 |             |
| Rokeya Foundation - Rohingya Women Welfare Society                    |                                |                   | -                                  |                   |                   |             |
| Samaritan's Purse   | 2,266,615                      |                   | 2,318,675                          |                   | 0                 |             |
| Save the Children   | 6,549,307                      | 3,055,440         |                                    | 940,783           | 35.4              | 30.8        |
| Terre des Hommes – Lausanne   | 748,926                        | 924,296           | 1,290,081                          | 308,960           | 172.3             | 33.4        |
| United Nations Children's Fund  | 21,302,016                     | 15,608,320        | 14,131,426                         | 9,309,265         | 66.3              | 59.6        |
| United Nations High Commissioner for Refugees                         | 13,823,477                     | 14,779,200        | 3,889,706                          | 614,026           | 28.1              | 4.2         |
| United Nations Population Fund  | 10,000,000                     | 13,000,000        | 3,850,145                          | 4,322,545         | 38.5              | 33.3        |
| World Concern   | 477,650                        | 568,233           |                                    | -                 | 0                 | 0           |
| World Health Organization   | 14,954,578                     | 11,646,707        | 10,345,795                         | 1,645,544         | 69.2              | 14.1        |
|   | <b>113,086,292</b>             | <b>88,748,586</b> | <b>49,130,906</b>                  | <b>34,169,670</b> |                   |             |

Source: UNOCHA, 2018 &amp; UNOCHA, 2019

The table suggests that some of the organizations did not receive any funding during 2018. But this is not the case, as they have actually received funding and have been implementing their programmes with funding from donor agencies (e.g UN agencies and international agencies) listed in this table. So, the destination of funding has not been accounted against such organizations in this table. As for example, BRAC's total spending in different programmes and interventions was about US\$ 2.96 million for the year 2018, this was mainly obtained from different UN and international organizations, viz IOM, UNICEF, Global Funds to fight AIDS, TB and Malaria (GFATM) and WMO.

The health cluster supported by WHO and the government of Bangladesh, leads and coordinates the efforts of over 100 partners managing more than 270 health facilities in the camps and in Cox's Bazar district and also provide medicines and medical equipment, diagnostics, guidelines and trainings and building laboratory capacity. The WHO plays a crucial role in keeping the population protected against preventable infectious diseases and respond to any possible disease outbreak, and takes the main responsibility for maintaining the Early Warning and Response Systems (EWARS), supporting routine immunization program, and checking on the water quality in the camps. The immunization is run by the Government's EPI program supported by UNICEF and WHO.

The existing facilities in and around Cox's Bazar have reported a 150-200 percent increase in patients, overwhelming current capacity and resources available from the government (DG Health and DG FP) Services<sup>13</sup>. The King Salman Humanitarian Aid and Relief Centre" which committed a US\$2 million grant to the WHO for improvement of the Sadar District Hospital in Cox's Bazar, Bangladesh, to enhance health care services for Rohingyas and their host communities. This relief fund is available to increase the bed capacity, by doubling the number of in-patient beds from 250 to 500, and to improve trauma and emergency obstetric care<sup>13</sup>.

As of 31 October 2018, UNICEF had received US\$116.7 million against the US\$149.8 million appeal (78% funded), and this include US\$77.2 million received against the 2018 appeal and US\$39.5 million carried forward from the previous year for the different sectors where UNICEF has programs and activities.

The scenario of funding requirement obtained has changed for the JRP plan for the year 2019. The total funding requirement for health sector for 2019 was about US\$ 88.7 million (compared to US\$ 113 million in 2018), where 38.5 percent funds obtained through the year. Among the recipients, 'Action against Hunger' received almost 9 times of their original requirement (US\$ 9 million against US\$ 1 million). Similarly, Peace Winds Japan and HelpAge International UK received funds more than their original requirements. Other than these, the major recipients of the health sector fund were WHO, UNICEF, UNFP, IOM, Terre des Hommes and Save the Children. In 2019, BRAC also received a significant amount of fund for the health sector. BRAC got a fund of about US\$ 757,000 from Canadian government for Health sector which was about 14.3% of their original requirement. Other than BRAC, CBM international and Friendship also received funds for health (Table 9.3).

## SUCCESS IN MOBILIZING RESOURCES IN 2019

The JRP for January- December 2019 has been drawn up. The total amount of resource requirement has been revised to US\$920.50 million for the 1.24 million population (which include the host population), with reduction in allocation from \$113.08 m to \$88.70m in health and from \$56.72m to \$48.10 in nutrition sector. However the increased amount of requirement in the food security sector will be able to supplement the partial need for the nutrition sector. The proposed level of requirement for the water and sanitation sector remain almost unchanged at \$136.69 million. The increase in proposed funding requirement in the protection sector, including its sub-sectors (child protection, and gender based violence) for the period January - December 2019 JRP can be noticed due to increased attention to this aspect. Almost one-third of the refugee families have at least one definite protection susceptibility that requires specialized protection attention. The funding requirement for the communication with communities has been proposed to be at higher level compared with what was proposed for the period February to December 2018. The education sector has also received an increased attention for the period, and it has been proposed that \$59.50 million needs to be raised to cater to the need of the population of 462,400 (which include 120,131 host population), and increase by 25.7 percent. This suggests that the donors and funding agencies are giving more importance to other long term needs like

investing in education and skill development, rather than the short term need of the population, and the associated level funding requirement. The changing attention to these sectors, which have been given

more importance, suggest that a new perspective of the response is there and emphasis is on long term outcomes (Table 9.4).

Table 9.4: Sector-wise Mobilization of Funds in 2019

| <b>Cluster/Sector</b>            | <b>Amount (US\$)</b> | <b>Funded (US\$)</b> | <b>Coverage (%)</b> |
|----------------------------------|----------------------|----------------------|---------------------|
| Child Protection                 | 23,535,186           | 13,398,901           | 56.9                |
| Communication with Communities   | 11,010,134           | 3,216,584            | 29.2                |
| Coordination                     | 4,200,000            | 512,821              | 12.2                |
| Education                        | 59,499,950           | 31,662,341           | 53.2                |
| Emergency Telecomm               | 1,100,000            |                      |                     |
| Food Security                    | 254,070,856          | 190,919,747          | 75.1                |
| Gender Based Violence            | 23,471,108           | 10,597,879           | 45.2                |
| Health                           | 88,748,586           | 32,195,904           | 36.3                |
| Logistics                        | 2,800,000            | 0726,982             | 026.0               |
| Not reported                     | 0                    | 190,476,626          | 0                   |
| Nutrition                        | 48,050,143           | 16,860,588           | 35.1                |
| Protection                       | 38,864,154           | 11,397,453           | 29.3                |
| Shelter                          | 128,800,001          | 44,629,920           | 34.7                |
| Site Management                  | 98,736,503           | 024,243,251          | 024.6               |
| WASH                             | 136,645,508          | 39,244,317           | 28.7                |
| Not specified                    |                      | 6,853,167            |                     |
| Multiple Field clusters (shared) |                      |                      |                     |
| <b>Total</b>                     | <b>919,532,129</b>   | <b>616,936,481</b>   |                     |

Source: UNOCHA, 2019

## LAND AS A RESOURCE FOR THE ROHINGYA POPULATION

Before the large influx which started in August 2017, about 3,000 acres of land was available for the displaced population who were living in the registered camps. With the influx of huge additional people, the Government of Bangladesh made more land available in the two upazilas of Ukhia and Teknaf, and the total amount of land today stands at 6,500 acres, which include 3,700 acres for the Kutupalong-Balukhali Expansion Site. It needs to be mentioned that the overall land resources in the country is scarce, and more so in these two upazilas. The congested camps in these sites do not meet basic international humanitarian standards with respect to locations that are safe from weather emergencies, and are easily accessible for improved living conditions. The present aim is to achieve the population density of 20 square

meters per person with the use of 6,500 acres, though this remains far below the international minimum standard of 45 square meters per person.

The land resource being used, which increased by 774 percent during the period 2016 to 2107, has a high cost, particularly to the environment of the region. A joint study, conducted by the United Nations Development Programme and UN Women with the support from Ministry of Environment, Forests and Climate Change<sup>14</sup>, found that about 4,300 acres of hills and forests were levelled down to make temporary shelters, facilities and used for cooking fuel in the camps. A report suggest that the financial loss due to the destruction of forest in Ukhia and Teknaf stands to about Bangladesh Taka 1,865 crore (US\$ 219.68 million), and the long term effect are more environmental than only financial<sup>15</sup>. Today, there is not enough land area that are available to reduce the congestions in the settlements and to make space available for building and learning facilities. A report suggested that an additional 68 acres of land should be made available to build learning facilities that has

become essential for providing education services to this displaced population<sup>16</sup>. This is a threat to the biodiversity of the ecologically-critical areas of the country and has already triggered ecological problem and disturbed wildlife habitats. An UNDP report<sup>14</sup> identified the key cause for the encroachment of green and forest land. This is due to the fact that nearly 6,800 tons of fuel wood is collected each month. Apart from that, each Rohingya family uses on an average 60 bamboo culms to construct their temporary shelters. All these are resulting in a serious damage to environmental resources<sup>14</sup>.

The Bangladesh government plans to start relocating Rohingya refugees to a remote island in the Bay of Bengal called Bhashanchar. The area, declared as a forest reserve in 2013, is 10,000 acres at high tide and 15,000 acres at low tide. According to the plan, 103,200 Rohingyas out of more than a million who are living in the cramped camps of Cox's Bazar will be re-located to Bhashanchar under a project that is being implemented by Bangladesh Navy, with an estimated cost of over Tk 2,312 crore (US\$280 million), funded out of the government's own funds. This is built in an area of 6.7 square kilometers. However, there has not been any real sign of relocation in spite of the fact that there are about 1,440 houses built already. This small island which has emerged from the sea in 2006 could be vulnerable to extreme weather, even though the buildings for the houses are designed to be protected from cyclone and tidal waves<sup>17</sup>. There are also concerns that Rohingya refugees will not be able to leave the island even for medical treatment as only available mode of communication for residents is located 30 kilometer away from the mainland. According to the report<sup>18</sup> the process to relocate more than 100,000 Rohingya refugees to the Bhashanchar island from camps in Cox's Bazar was supposed to start by mid-April 2019 but it did not happen.

## THE ECONOMIC BURDEN OF THE ROHINGYA REFUGEES FOR BANGLADESH

A study by the Centre for Policy Dialogue (CPD) predicted a few fiscal implications for Bangladesh under different scenarios<sup>19</sup>. Based on the estimates of 2018-19 requirement of \$1.21 billion, and assuming

300 Rohingya repatriated per day from January 2019, and assuming no population growth and no inflation, the time needed for the repatriation will be 11 months. There is being no sign of repatriation now, and the country is bearing some of the direct and many indirect costs of the burden of accommodating the nearly a million additional population in land scarce areas with substantial environmental damage. The study presented another scenario, where the inflation and population growth at the prevailing rate is possible, then the repatriation will take 12 years. If 100 Rohingyas are repatriated per day instead of 200, and the inflation rates and population growth assumed unchanged at the current rate, total repatriation period will be 42 years. Under the three scenarios above, the resource requirement will be US\$ 6,348 million, US\$ 9,197 million and US\$ 75,011 million, respectively. The study presented another scenario, which seems to be quite a likely situation where there is no repatriation, but population growth and inflation are included, the cost of hosting the Rohingya people during the first five years will stand to US\$ 7,046 million<sup>19</sup>. In considering these research findings it needs to be mentioned here that the study was based on UNHCR estimated funded requirement of UD\$ 951 million (the level for the year 2018), which may not remain the same over the years (e.g., reducing to \$920 million for the year 2019). Nevertheless, this study results provide indication of the fiscal implications for the government.

In terms of the indirect economic burden on Bangladesh, the governmental healthcare system, namely in the affected areas will now have to accommodate the health needs of the Rohingya refugees, which means the increase in the human resources for health care, such as doctors, specialists, lab technicians, midwives, etc. and non-human resources such as bed capacity, medical drugs and consumables and the depreciation of the health infrastructures itself will persist until this displaced population is repatriated. Prior to the crisis most of the governmental health facilities in the region were already stretched thin and had major human resources gaps. For example, the Sadar hospital has 40 percent of the positions vacant<sup>20</sup> and the same applies to Ukhia and Teknaf health complexes. To cope with this the government of Bangladesh will have to reallocate and increase its resources / budget allocation of health in this area to at least maintain a pre-crisis levels of services and quality.

## DISCUSSION AND CONCLUDING REMARKS

Assuming that there will be continued funding support from donor agencies and the government continues to contribute to the resource pot that would still stretch the available resources for the provision of health care and other development inputs. There is also a cost of policing these population apart from the provision of humanitarian assistance which has indirect resource implications on the part of the Bangladesh government. With an appeal for more than US\$900 million, representing one of the largest humanitarian appeals during 2018, the scenario if not very positive as it remains mostly underfunded affecting adversely much of the health care provision and its quality.

The response plan should concentrate more on the long-term goals in addition to the more immediate short-term objectives. At the same time, the future of the Rohingyas in Bangladesh is intimately tied to the government itself, which is in charge of the humanitarian response but is also attempts to work on diplomatic frontiers so that the refugees must return home before long.

The environment of humanitarian assistance changes as the partners in humanitarian assistance are becoming diverse. This brings in new perspectives, experiences, and capacities under which today's humanitarian system is taking a new shape. The communities are now more connected and informed that is changing the way the work is organized. Also, many development actors are slowly changing their focus of attention as new fragile and conflict-affected situations come up<sup>11</sup>. However, the crucial thing to note is that the funders' likelihood or intention to respond to the call for humanitarian assistance is often governed by factors such as media coverage, political interest assigning importance to security, the presence of humanitarian NGOs and international organizations operating in countries where the humanitarian emergencies occur. The last two factors perhaps play a greater role<sup>21</sup> and security being important should not be on our way in providing the best possible humanitarian support.

The OCHA, the humanitarian arm of the United Nations Secretariat is attempting to be committed to becoming "a more accountable, agile, decentralized, effective, transparent and, crucially, collaborative organization" and they are streamlining their activities and

refocusing on their role as a coordinator and believes that to be effective, they must be perceived by others to be, collaborative<sup>16</sup>.

Regarding the damage on the environment, the Bangladesh government and international humanitarian organizations need to develop better plans to protect the ecologically sensitive forested land and wildlife habitats surrounding the refugee camps, enable more informed management of the settlements, and assist in more sustainable resource mobilization for the Rohingya refugees<sup>22</sup>.

Both the refugees and the host community are competing for the resources and is exacerbating tensions due to perceived loss of livelihood and deteriorating living conditions in immediate surroundings of the camps, despite some assistance aimed at host communities. Community representation is limited in most of the camps. For an efficient and effective effort on resource mobilization, the priority remains continuing to invest in and strengthen the relationships, as well as to streamline and clarify the coordination structure in order to provide coherent and unified support to the Government of Bangladesh in its response to this crisis.

There are acute gaps that exist in health service provision including surgical capacity, 24/7 health service provisions including obstetric emergencies, and mental and psychological supports. Sufficient resource mobilization need to be supplemented by efforts made to providing incentives, motivation, necessary logistics and administrative support for the health human resources to work at the camps, as absence of this factor may even lead to closure of field hospitals or facilities at the camps, as has happened at the end of 2018. The health sector is urgently reviewing this situation to identify means of mitigating the risks. The new effort to mobilize resources need to emphasize on the programming for non-communicable diseases (NCD), malaria, TB, and HIV/AIDS which remains insufficient<sup>23</sup>. It is also vital to strengthen service provision by integrating health services and improving horizontal and vertical coordination and reduction of duplication of efforts through rationalization and optimizing the geographical distribution of health facilities, enabling efficient allocation and utilization of resources, which the WHO is said to help implement during 2019<sup>23</sup>.

There are concerns that many organizations working in the camps may begin to reduce their activities

because of funding crisis. While some amalgamation of activities is necessary to avoid duplication or overlap, any substantial lessening of activities in the near future would bring in serious gaps and potentially overwhelm the capacity at the hospitals and secondary care levels.

The World Bank and the Asian Development Bank pledged a longer term more development and resilience centered funding<sup>24,25</sup>. However, the reality is that most of the initial funds mobilized into the response are one-time grants, not recurring funds and will not be renewed. As a result, the question of sustainability and long-term planning for this refugee crisis when allocating resources becomes crucial, and this situation puts more pressure on the different stakeholders to prioritize their interventions. For example, the WHO-administered King Salman Humanitarian Aid and Relief Centre which supported the expansion of the much needed services at Sadar Hospital by increasing the bed capacity and services and providing human resources support for 86 extra staff, including 25 medical officers expired on the 28th of February 2019. Now the upgraded hospital with the increased equipment and bed capacity faces a major shortage of human resources and the new services and upgrade will be underutilized<sup>13</sup>.

The growing humanitarian needs are outdoing available funding and current capacity for humanitarian response. There has been steady decline in the level of overall funding for humanitarian appeals as a percentage of total in the last 20 years, ominously restraining the humanitarian system's ability to meet intensifying needs. About US\$24.2 billion of humanitarian appeal was made during 2018. Despite the generosity of donors, the funding gap remained wide as the needs outpacing available funding as the drivers of needs are changing as well with the average length of humanitarian crisis are longer, lasting for more than nine years. However there are some positive circumstances, e.g., the local, national, regional and international capacity to prepare for and manage crises has developed and grown over time, and humanitarian partners are more diverse, carrying new perspectives, experiences and capacities to the international humanitarian system, and OCHA has taken important steps in recent years in bringing many of these actors on board for its effort to increase the commitments towards humanitarian financing. The uncertainty about the future will remain to be the major concern for the refugees and continues to affect their health, and the effort on return of the refugees to Myanmar must be voluntary,

safe and dignified. This has to be complemented by calls on governments to influence Myanmar to implement measures to stop violence and discrimination against Rohingyas and to let the refugees to be able to return to their place of origin. There are also growing demand for granting the Rohingyas a refugee status. Highly criticized plans to begin refugee returns to Myanmar last year were called off when they refused to return. The government's plan to resettle some Rohingyas on Bhashanchar, a disaster-prone island, that rights groups say, would be even more precarious than the refugees' current camp shelters. All these efforts have different resource implications that has to be dealt with nationally and internationally by the government.

## RECOMMENDATIONS

Drawing upon the above situation of funding gaps, there should be some short term and long term measures that need to be addressed. It is essential to make all efforts to mobilize the resources needed for the Rohingya settlements in Cox's Bazar Bangladesh. The question of the sustainability and mid-to-long term goals when mobilizing resources should be considered carefully even when planning for urgent short-term needs, and although the capitalization on short term funding to meet urgent short needs is understandable, it is important not to forget the long-term impact of those funds and projects. This makes the current scarce resources even more valuable.

In the short run, efforts need to be made to improve the efficiency in utilization of resources. Firstly, there is a need to look at the possibility of making the donor funding more flexible, cost-effective and to have greater transparency. The donor funding for programs and interventions should have cost-consciousness. We do not have sufficient information about the gain in health and development outcomes. Secondly, the efficiency of resources used within the cluster/sector should be looked at to examine the possibility of achieving higher outcomes with the given resources for all the programs, and efforts should be made to avoid duplications of efforts to release any additional resources. Thirdly, an integrated approach of looking at the programs and activities across clusters/sectors would be a useful exercise to exploit the efficient utilization of resources.

There are attempts on repatriation deal, however, discussion are at premature stage, and there exist insufficient political and diplomatic progress on it.

Myanmar government's reluctance to create a conducive environment for the return of the Rohingya and the problem like China and Russia blocking action at the UN, and the Association of South-East Asian Nations (ASEAN) has been unable to develop a coherent position. As a result the displacement is now protracted, and we should look at the impact of long-term displacement and its impact on the host community and the economy. Firstly we should continue to respond to urgent needs of services like protections and security, education and health care and long term planning for the different sectors using more of the improved data being collected by different agencies. These services should get priority and we should ensure that funding to this sector should not fall. Secondly, we should continue efforts for the mobilization of resources to support a longer-term developmental response emphasizing on the need for providing education and child development services, skill development of the productive labor forces for

men and women. Thirdly, Bangladesh should look at the possibility to mobilize their internal resources. The country, with its limited resources that are needed for its own development programs, has already a significant contribution to the total resource pot. Attempts should be made to consider the country-based pooled funds (CBPFs, an option that permit governments facing the humanitarian crisis to mobilize resources) and the private donors to pool financial contributions to finance response to the crisis. The local population and the local government, the central government and the Bangladesh Army has been contributing directly to the crisis management and providing services for the different sectors/clusters. The government should have a thorough estimates of all these, and this will help to show the international donor and funding agencies what is the government contribution and enable to attract matching funds from potential donors and international agencies.

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## CHAPTER TEN

# SUMMARY AND CONCLUSIONS: THE FUTURE OF ROHINGYA REFUGEES IN BANGLADESH

Mushtaque Chowdhury

## INTRODUCTION AND SUMMARY

Bangladesh has been acclaimed and appreciated for its generosity in hosting the Rohingya refugees from Myanmar. The refugee issue is a major contentious subject in global discourses. The world is aware of refugee problems in Palestine, the Balkans, Sub-Saharan Africa, Latin America or Southeast Asia but the Rohingya issue of Bangladesh is markedly different. Although the bulk of the influx happened in August-September of 2017, the country has been hosting these refugees since the 1980s. Between these two points of time, there was another influx that happened in the early 1990s. However, what happened in 2017 exceeded all proportions. There is hardly any example of such movement of so many distressed and persecuted people in such a short period of time. It is estimated that as many as 1.2 million Rohingya refugees are sheltered in Ukhiya and Teknaf upazilas of Cox's Bazar district, which outnumbers the combined host population of the

two upazilas by a factor of two. This in fact is more than the total population of Bhutan. Bangladesh itself is the most densely populated country in the world and the impact of this new sudden addition can only be conjectured.

The Rohingya community of Myanmar's Rakhine State is one of the most persecuted in the world. Ever since the latest influx, a lot has been published internationally on the kind of atrocities they went through in their own country. The kind of life they lived could be visualized from the various accounts that have been reported. According to the refugees themselves, the highly packed and congested refugee camps with minimum facilities in Cox's Bazar where they are housed temporarily are better than what they had in their own country! They lived a poor life by any standard, with dependence on primitive agriculture. Access to social services was

very restricted. Very few children attended even the primary schools. The health condition was worse with little or no access to basic services such as immunization, reproductive health, or family planning.

Now that they are in Bangladesh what are they getting in the camps? How is their health and what kind of healthcare are they experiencing? Do they have access to reliable and safe water and sanitation services? What is the nutrition situation? Are their women and girls safer here? Are there enough money to pay for all the services they need indefinitely? How are camp operations coordinated and managed? What is in store for the refugees in future? These are some of the issues that the Bangladesh Health Watch looked into in this report. Due to our mandate, this report deals with only the health and health-related aspects of the Rohingya refugee story. A note of caution, however. The different chapters included in this report were done over the last two years. As such some of the data and analysis presented here may look somewhat outdated. But the messages coming out of this are still largely relevant.

In the introductory chapter, Muhammad Musa recounted the story of the influx and Bangladesh's initial responses by dividing it into three phases. The first phase, which he called the 'Chaotic condition', was marked by the unprecedented speed at which the refugees arrived. Neither the government nor the local communities were prepared for this and, as a result, many found themselves on the roads, open grounds, schools or even alleys of agricultural fields. The immediate need was to stand beside them and give them the feeling of a safer environment with no one out there to kill, harass, molest or abuse, and more importantly, give them hope. There was need for emergency medical and pregnancy care, food and nutritional support, mental health care, water and sanitation, and protection for women and children. The second phase was transitional in which the government started to respond more effectively and resolutely with the Bangladesh Army in coordination. The settlements became more stable and the national and international refugee community started to get engaged in providing succour to the refugees. Preparation to meet the challenges of the monsoon was also on the agenda. The third phase which he called the 'organized living phase', started about the middle of 2018, about ten months into the beginning of the tragedy. In this phase which still continues, both the refugees and their helpers such as the government agencies and NGOs are more settled and organised. This is the time when they both started wondering

about the future. Would the Rohingyas ever be returning to their homes in Myanmar? If not, what's there for them in the future? Would their children be allowed educational opportunities? Would they be allowed to work and would there be a minimum healthcare system to cater to their needs? Would the Bangladesh government keep them confined to the camps here or ship them to Bhashanchar? The transition from a crisis situation to a more 'development' oriented approach without much hiccup is an important positive aspect of the Rohingya refugee story.

Bachera Aktar and her colleagues studied the reproductive health and related issues pertaining to the refugees. They reported poor health status of the women, particularly delivery care. Because of various reasons such as availability and access to quality care and cultural issues such as beliefs and taboos about childbirth, only about a quarter of the deliveries were carried out in clinics/hospitals. A third of eligible couples used some contraceptive devices for family planning which was higher than previously believed. They also reported the vulnerability particularly faced by adolescent girls to accessing reproductive health services. As of September 2018, there were about 300 facilities providing reproductive health services to the refugees.

Mahbubur Rahman and his colleagues acknowledged the mounting tasks faced by the government and implementing NGOs in providing safe water and sanitation services to the refugees. Starting with a minimalist approach of providing such services overnight as the floods of people poured in, the facilities were gradually improved to cater to more quality and safer services. There still remains questions about water quality and management of latrine sludge. Here also, the particular vulnerability of women and girls in terms of maintaining privacy is highlighted. The authors also point to the special problems faced by physically challenged groups in accessing the available water and sanitation services. Innovations in the water and sanitation sector were tried and the authors emphasised the need to evaluate their effectiveness and efficiency. One of such innovations is the urine container that was recommended for use by elderly people but its utility in the given situation had not been assessed when the chapter was written.

A M Zakir Hussain, Akramul Islam and their colleagues described the status of infectious diseases in the Rohingya camps. Due to the sudden influx of so many

people, there were apprehensions of disease outbreaks. But timely and effective actions taken by the government and other service providers prevented potential disasters. The response was well organized and effectively coordinated with the Directorate General of Health Services of the government with the Civil Surgeon of Cox's Bazar in the lead. Apart from the government, the efforts also included the implementing NGOs. With technical support from WHO, a web-based Early Warning, Alert, and Response (EWARS) system was developed to strengthen surveillance and detect and manage the outbreaks in the camps instantly. The responders faced a major challenge when several cases of diphtheria were reported. Thanks to a near universal vaccination programme, Bangladesh had been spared of the scourge for many years and, as a result, the local medics were less equipped to detect and manage it. There was a total of 271 confirmed cases of which 42 died. Fortunately this was contained before it went out of hand. Among the major preventive actions, a massive vaccination campaign against specific diseases including cholera, diphtheria, and jaundice was done. To protect children from a number of other infections, a triad of vaccines was given to almost all children aged 0-7 years and 7-15 years. The campaign also included children from the host communities.

Nargis Islam and colleagues researched the issue of mental health in the context of the Rohingya crisis. Including the mental health of the host communities. A major challenge in addressing mental distress is the complexity in understanding and developing interventions that are effective, culturally appropriate and ethically acceptable in a low resource setting. It is easy to comprehend that the refugees experience considerably higher levels of psychological, mental and social distress than the general population. Post displacement stressors that have been flagged include resettlement, language barriers and perceived stigma and discriminations. A review of the mental health issues in the Rohingya population highlighted 'beliefs in spirit possession for issues such as erratic behavior, visual and auditory hallucinations and paranoid delusions'. The authors identified 126 organizations and stakeholders who were involved in providing one or the other kind of mental health and psychosocial support (MHPSS) in the camps, along with the work of a MHPSS Working Group which has been working since 2009, well before the current exodus began. Through the services provided by Medecins Sans Frontieres (MSF), for example, a total of 49,401 patients were seen between August 2017 and December 2018. The BRAC University Institute of

Educational Development (BUIED) developed a four-tier integrated model which included designing and running of hundreds of child friendly spaces and training and posting of barefoot counselors. The interventions run by the International Organization on Migration (IOM) included individual counseling, inpatient care, referrals and community mobilization. The authors identified a dearth of evidence on prevalence rates of mental health problems and outcome data regarding current interventions.

Malay Mridha and colleagues reviewed the nutrition situation in the camps and host communities. Contrasting the popular beliefs (and rumors) about the dismal situation, the chapter found a somewhat positive scenario particularly due to a barrage of interventions mounted by the government and different organizations. However, the authors also found that the improvements had somewhat plateaued recently. For example, the MUAC of women 15-49 years and that of pregnant and lactating women declined from 8.7 percent and 12.2 percent respectively in October-November 2017 to 3 percent and 2.8 percent a year later (October- November 2018). However, improvements afterwards were marginal leading to the conclusion that more needed to be done to improve the nutrition situation further. Emphasis was placed in moving more from treatment of malnutrition to its prevention. The authors also identified a lack of data availability for selected groups in the population including the adolescents, adult men and the elderly.

Shaila Shahid and colleagues reminded us that the population at highest risk in refugee and conflict situations are the women, children, and young girls. The authors note that these vulnerable groups who escaped the brutal military crackdown in Myanmar faced new threats in Bangladesh like human trafficking. While the trafficking networks were active well before the recent influx, their activities increased substantially since August 2017. While bulk of the trafficking occurs within Bangladesh, the authors report trafficking of Rohingya population groups to neighboring countries of India and Nepal. In 2018 alone, one of the agencies identified 78 victims of trafficking which, according to the authors, was a major under-estimation of the actual situation. Various agencies have initiated interventions to prevent trafficking which include creation of safe spaces for women and girls. The authors also discuss the issue of gender-based violence (GBV) in the camps. A lack of adequate lighting in camps restricting mobility, cultural taboos like purdah, language barrier, and limited

knowledge on reporting GBV prevent the victims from accessing aid and relevant available services. In Bangladesh where the refugees have taken refuge, domestic violence does not constitute a criminal offence and as such these offences are mostly dealt with through arbitration which often favors the perpetrators. Only the cases of rape and murder reach the level of court proceedings or police investigation. To meet the challenges the authors made certain specific recommendations.

Be-Nazir Ahmed and his colleague describe the different mechanisms that have been established to coordinate the responses in the health sector. Three types of coordination efforts for information system, services provision, and logistics have been identified, being implemented at different levels. For example, the Directorate General of Health Services (DGHS) has established a center in Cox's Bazar for coordinating the interventions of the government, UN agencies, and non-governmental organizations (NGOs). It has adopted a three-tiered coordination structure at District, Upazila and Camp levels and works through several working groups based on different health-related issues. The authors identified several challenges in the health sector response and provide specific recommendations to address the bottlenecks which include integration of health services through a health system approach, strengthening vertical integration, and avoidance of duplication through rationalizing and optimizing geographical distribution of health facilities in the camps and host communities.

Zahidul Quayyum and colleagues trace the history of resource mobilization and financing for the Rohingya crisis and discuss its current (2019) status. The process of fund raising starts with an appeal against which the donor communities commit their share. The donors' commitments are then matched with sector-wide requirements. The third in the process is the funds that are actually received. Up to 2018 (including 2017), the appeal for a total funding was US\$ 950.83 million against which the donors committed US\$ 748.68 (79%). Of the commitment, the amount actually received was US\$ 660.21 (88%). This was a satisfactory outcome given the crisis in global development financing. Sector-wise, the three items which may be considered to be overall Health (health, nutrition, and water& sanitation), the funding coverage varied. The total requirement for Health was US\$ 306.5 million of which 39 percent was funded. The coverage for nutrition was the highest (60%); the coverage for the water & sanitation sub-sector was the lowest (27%). The overall health sector funding

situation worsened in 2018 and 2019. In 2018, the funding actually received was 43 percent (US\$ 49 million against the requirement of US\$ 113 million) and in 2019, it declined further to 38 percent (US\$ 34 million against the requirement of US\$ 88 million). Bilateral donors such as the governments of USA and UK shared about half of the total funding. The authors recommend a longer-term view of the situation, particularly in terms of financing given that the likelihood of repatriation is as bleak as ever. There will be need for more sustained investments to cater to the growing needs of this population. They also recommend a more efficient use of the resources and improving the information and research systems so that more cost-effective interventions can be identified.

## CONCLUSION AND RECOMMENDATIONS

It is now 30 months since the most recent and massive influx began in August 2017. Over this period, Bangladesh the host country, local communities and national and international responders have shown unprecedented empathy and support to the Rohingya refugees in mitigating their woes and sufferings. Unfortunately, the hope for this crisis coming to an end through safe and voluntary repatriation of the refugees to their own country seems a far cry. It looks like that the crisis will be protracted with them staying in this country for the foreseeable future. Under the circumstances, all the stakeholders - the government, UN agencies, NGO community, the hosts and the refugees themselves - need to plan both short- as well as longer-term strategies on how to deal with this continuing crisis. In terms of the health sector, which is the main concern for this report, there are a few aspects that require attention of the relevant stakeholders.

### Need for a primary health care (PHC) approach

The three pillars of primary health care (PHC) are vital to address the health needs of the Rohingya refugees and their host communities. These include<sup>1</sup>.

- Empowered people and communities
- Multisectoral policy and action for health and
- Good-quality, integrated health services based on primary care supported by essential public health functions.

A recent WHO publication has reemphasized the need to integrate the PHC principles in emergency situations ‘in order to prevent, mitigate and withstand emergencies’<sup>2</sup>. The chapters in this volume have documented how the situation in respect of different health sub-sectors needs to be improved through a systematic overhaul of the various systems that are in place. These will include not only the services in the camps but also improved quality services for the host communities.

### The host community

The host communities in the upazilas of Cox’s Bazar district extended their all-out empathy and support to the refugees when they arrived and still continue to host them without any major resistance. However, our knowledge and understanding of the kind of problems faced by them as a result of the influx is still rudimentary at best. There is a need to look at this and chalk out a comprehensive plan for the overall development of the entire district. It is heartening to note that the government along with development partners including the World Bank is developing such plans. It is hoped that such a plan would encompass the development agenda in all sectors in a coordinated way.

### An integrated information system

The various chapters have pointed to an important gap in the response efforts which is the lack of an integrated information system. Because of this we have seen various agencies reporting differently on the same issues. A workshop convened by the World Bank in Dhaka on November 12, 2019 discussed the need for such a system in informing the medium- to longer-term responses. It identified a few challenges including:

- Lack of coordination on data
- Limited learning from short-term data during project implementation
- Limited dialogue with local actors.

The workshop acknowledged that the data production and research have so far been led by international actors and that there was a critical need to have a local and national agenda. This calls for developing local research capacities in the area of humanitarian crisis. Bangladesh should seriously consider setting up *Centers of Excellence* on humanitarian research. The BRAC University James P Grant School of Public Health, which hosts the Bangladesh Health Watch, has been active on selected issues of humanitarian research, particularly related to the Rohingya crisis.

### Mobilization of resources

The Rohingya crisis raised a lot of international concerns leading to mobilization of substantive resources. However, as we have seen in this volume, there is a depletion of such interests and consequent funding. In 2019, Bangladesh was able to mobilize only 38 percent of the resources needed to look after the needs of the refugees. With the uncertainty in repatriation, there will be need for more investment in the social and livelihood sectors which will require substantial amount of additional resources. History has shown that as such crises lingers, there is a continuous and secular decline in international interest and synchronized funding. The Bangladesh government and donor agencies need to develop a long-term (10-20 years) plan on how to mobilize resources in order to meet the needs of the refugees.

### Need clear policy decisions towards the Rohingya refugees

As has been argued repeatedly, the Rohingya refugees are here for a long haul. The Bangladesh government has been refusing to accept them as refugees as this binds the country to certain international regulations on how to treat refugees. As time passes, we must prepare ourselves to provide them with the basic minimum needs as recognized in different international agreements and charters including the one on human rights. For example, there will be need to set up educational institutions that provide not only primary education but also secondary and technical education. Sustainable livelihood opportunities will also have to be created. A full-fledged primary health care system will also have to be readily available. The government needs to make its policy transparent and clear on such issues through giving refugee status to the Rohingyas. It maybe pertinent to remember here what the Hon’ble Prime Minister had said when opening our doors to them. She is on record to having said that Bangladesh is a nation of 160 million and it can easily absorb another million of such perpetrated humans. The onus is on the government to take the next step. In a recent book, Imtiaz Ahmed and colleagues lamented at the little interest on the Rohingyas in Bangladesh’s capital city of Dhaka. They are subjects of discussion neither in civil society platforms nor in the mainstream media<sup>3</sup>. Hope this report brings this mainly forgotten issue high on the agenda again.

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## ANNEX 1

# ACRONYMS

|        |   |
|--------|---|
| AAB    | ActionAid Bangladesh                                |
| AAH    | Action Against Hunger                               |
| AAP    | Accountability to Affected Populations              |
| ACAPS  | The Assessment Capacities Project                   |
| ACF    | Action Contre la Faim                               |
| ACT    | Artemisinin-based Combination Therapy               |
| ADG    | Additional Director General                         |
| AJS    | Acute Jaundice Syndrome                             |
| ANC    | Antenatal Care                                      |
| APA    | American Psychiatric Association                    |
| ARI    | Acute Respiratory Infections                        |
| ARV    | Anti-Retroviral Therapy                             |
| ASEAN  | Association of South-East Asian Nations             |
| ASP    | AIDS/STD Programme                                  |
| ASRH   | Adolescent Sexual and Reproductive Health           |
| AWD    | Acute Watery Diarrhea                               |
| BBC    | British Broadcasting Corporation                    |
| BCC    | Behaviour Change Communication                      |
| BDRCS  | Bangladesh Red Crescent Society                     |
| BEmONC | Basic Emergency Obstetric and Neonatal Care         |
| BIED   | BRAC Institute of Educational Development           |
| BLAST  | Bangladesh Legal Aid and Services Trust             |
| BRAC   | Formerly Bangladesh Rural Advancement Committee     |
| BSFPs  | Blanket Supplementary Feeding Programmes            |
| C4D    | Communication for Development                       |
| CA     | Christian Aid                                       |
| CASS   | Coordinated Assessment Support Section              |
| CBT    | Cognitive Behavioral Therapy                        |
| CCNF   | Cox's Bazar Civil Society Organization NGO Forum    |
| CDC    | Centre for Disease Control and Prevention           |
| CDD    | Centre for Disability in development                |
| CEmONC | Comprehensive Emergency Obstetric and Neonatal care |
| CFE    | Contingency Fund for Emergencies                    |
| CFP    | Camp Focal Person                                   |
| CFS    | Child-Friendly Spaces                               |

|         |  |
|---------|--|
| CHV     | Community Health Volunteer                                       |
| CHW     | Community Health Worker  |
| CiC     | Camp-in-Charge   |
| CMAM    | Community based Management of Acute Malnutrition                 |
| CMAMI   | Community Management of Acute Malnutrition for Infants           |
| CODEC   | Community Development Centre (NGO)                               |
| COPD    | Chronic Obstructive Pulmonary Disease                            |
| CPI     | Community Partners International                                 |
| CPR     | Cardiopulmonary Resuscitation                                    |
| CPR     | Contraceptive Prevalence Rate                                    |
| CS      | Civil Surgeon  |
| CwC     | Communicating with Communities                                   |
| DAT     | Diphtheria Antitoxin   |
| DGFP    | Directorate General of Family Planning (GoB)                     |
| DGHS    | Directorate General of Health Services (GoB)                     |
| DOTS    | Directly Observed Treatment Schedule (for TB)                    |
| DPHE    | Directorate of Public Health Engineering                         |
| DRC     | Danish Refugee Council   |
| DSK     | Dustho Shasthya Kendra (NGO)                                     |
| DTC     | Diarrhoea Treatment Centre                                       |
| EMDR    | Eye Movement Desensitized Reprocessing                           |
| ERC     | Emergency Relief Coordinator                                     |
| EVI     | Extremely Vulnerable Individuals                                 |
| EWARS   | Early Warning, Alert and Response System                         |
| FDMN    | Forcibly Displaced Myanmar Nationals                             |
| FGM     | Female Genital Mutilation  |
| FHM     | Field Hospital Malaysia  |
| FIVDB   | Friends in Village Development Bangladesh                        |
| FP      | Family Planning  |
| FPAB    | Family Planning Association of Bangladesh                        |
| FSM     | Fecal Sludge Management  |
| GAVI    | Global Alliance for Vaccines and Immunization                    |
| GBV     | Gender Based Violence  |
| GFD     | General Food Distribution  |
| GK      | Gonoshasthaya Kendra   |
| GoB     | Government of Bangladesh   |
| GP      | General Practitioner   |
| HC      | Health Center  |
| HI      | Health Information   |
| HIV     | Human Immunodeficiency Virus                                     |
| HNO     | Humanitarian Needs Overview                                      |
| HOPE    | HOPE International (NGO)   |
| HoSOG   | Head of Sub-Office Group   |
| HP      | Health Professional  |
| HSFC    | Health Sector Field Coordinator                                  |
| IASC    | Inter-Agency Standing Committee                                  |
| IAWG    | Inter-Agency Working Group on Reproductive Health in Crisis      |
| icddr,b | International Centre for Diarrhoeal Disease Research, Bangladesh |
| ICRC    | International Committee of the Red Cross                         |

|       |  |
|-------|--|
| ICT   | Information and Communications Technology                        |
| IEDCR | Institute of Epidemiology, Disease Control and Research (GoB)    |
| IFA   | Iron and Folic Acid  |
| IFM   | Immunization Field Monitors                                      |
| IFRC  | International Federation of Red Cross and Red Crescent Societies |
| INGO  | (International) Non-Government Organization                      |
| IOM   | International Organization for Migration                         |
| IPHN  | Institute of Public Health Nutrition                             |
| IPPF  | International Planned Parenthood Federation                      |
| IRC   | International Rescue Committee                                   |
| ISCG  | Inter Sector Coordination Group                                  |
| IYCF  | Infant and Young Child Feeding                                   |
| JRP   | Joint Response Plan  |
| KC    | Kutupalong Camp  |
| LARC  | Long-Acting and Reversible Contraceptives                        |
| LRTI  | Lower Respiratory Tract Infections                               |
| MAM   | Moderately Acute Malnutrition                                    |
| mhGAP | Mental Health Gap Action Programme                               |
| MHM   | Menstrual Hygiene Management                                     |
| MHPSS | Mental Health and Psychosocial Support Services                  |
| MIS   | Management Information System                                    |
| MISP  | Minimum Initial Services Package                                 |
| MNP   | Micronutrient Powder   |
| MoDMR | Ministry of Disaster Management and Relief                       |
| MOHFW | Ministry of Health and Family Welfare                            |
| MoWCA | Ministry of Women and Children Affairs                           |
| MR    | Menstrual Regulation   |
| MS    | Makeshift Settlements  |
| MSF   | Médecins Sans Frontières   |
| MTI   | Medical Teams International                                      |
| MTI   | Management & Training International                              |
| MUAC  | Mid-Upper Arm Circumference                                      |
| NC    | Nayapara Camp  |
| NCD   | Non-Communicable Diseases  |
| NET   | Narrative Exposure Therapy                                       |
| NGO   | Non-Governmental Organization                                    |
| NMEP  | The National Malaria Elimination Programme                       |
| NNS   | National Nutrition Services                                      |
| NPM   | Needs and Population Monitoring                                  |
| NTP   | National Tuberculosis Control Programme                          |
| OBAT  | Office-Based Addiction Treatment                                 |
| OCC   | One-Stop Crisis Centre   |
| OCHA  | UN Office for the Coordination of Humanitarian Affairs           |
| OCP   | Oral Contraceptive Pill  |
| OCV   | Oral Cholera Vaccine   |
| ORS   | Oral Rehydration Solution  |
| OTP   | Outpatient Therapeutic Treatment Centers                         |
| PEP   | Post-Exposure Prophylaxis  |
| PFA   | Psychological First Aid  |
| PHC   | Primary Health Care  |

|        |  |
|--------|--|
| PHD    | Partners in Health and Development                                     |
| PLW    | Pregnant and Lactating Women   |
| PNC    | Postnatal Care   |
| PSB    | Programme Support Branch   |
| PSEA   | Protection from Sexual Exploitation and Abuse                          |
| PSS    | Psychosocial Support   |
| PTSD   | Post-traumatic Stress Disorder   |
| PVC    | Triad Vaccine of Penta   |
| PWJ    | Peace Winds Japan  |
| RCM    | The Rapid Convenience Monitoring                                       |
| RGA    | Rapid Gender Analysis  |
| RH     | Reproductive Health  |
| RI     | Relief International   |
| RMNCH  | Reproductive, Maternal, Neonatal and Child Health                      |
| RRRC   | Refugee Relief and Repatriation Committee                              |
| RTMI   | Research Training and Management International                         |
| SAG    | Strategic Advisory Group   |
| SAM    | Severely Acute Malnutrition  |
| SC     | Stabilization Center   |
| SCI    | Save the Children International  |
| SDG    | Sustainable Development Goals  |
| SGBV   | Sexual and Gender-Based Violence                                       |
| SHED   | Society for Health Extension and Development (NGO)                     |
| SIDA   | Swedish International Development Authority                            |
| SMART  | Specific, Measurable, Attainable, Relevant, Time-based                 |
| SRH    | Sexual and Reproductive Health   |
| SRHR   | Sexual and Reproductive Health Rights                                  |
| SRP    | Strategic Response Plan  |
| STF    | Supply Task Force  |
| STI    | Sexually Transmitted Infection   |
| TAI    | Technical Assistance Inc.  |
| TB     | Tuberculosis   |
| TD     | Tetanus-Diphtheria   |
| TSFP   | Targeted Supplementary Feeding Programme                               |
| TWG    | Technical Working Group  |
| UASC   | Unaccompanied and Separated Children                                   |
| UDHR   | Universal Declaration of Human Rights                                  |
| UDMN   | Undocumented Myanmar National  |
| UN     | United Nations   |
| UNFPA  | United Nations Population Fund   |
| UNHCR  | United Nations High Commissioner for Refugees                          |
| UNICEF | United Nations Children's Fund   |
| UNOCHA | The United Nations Office for the Coordination of Humanitarian Affairs |
| VBD    | Vector Borne Disease   |
| VERC   | Village Education Resource Centre (NGO)                                |
| WASH   | Water, Sanitation, and Hygiene   |
| WFP    | World Food Programme   |
| WHO    | World Health Organization  |
| WSC    | Women Support Centre   |

## ANNEX 2

# LIST OF WORKING GROUP AND ADVISORY GROUP MEMBERS

### **Working Group**

- 1 Ms. Samia Afrin, nominated representative from Naripokkho
- 2 Dr. Syed Masud Ahmed, Professor and Director, Centre of Excellence for Health Systems and Universal Health Coverage, BRAC James P Grant School of Public Health, BRAC University
- 3 Dr. Ahmed Al Sabir, Independent Consultant and former Director of Research, NIPORT
- 4 Dr. AMR Chowdhury (Convener), Advisor, James P Grant School of Public Health and Former Vice Chairperson, BRAC
- 5 Dr. AJ Faisel, Independent Consultant, Former Country Director, Engender Health
- 6 Dr. Rumana Huque, Professor of Economics, Dhaka University
- 7 Dr. A M Zakir Hussain, Independent Consultant and Former Director, Primary Health Care, Directorate General of Health Services
- 8 Dr. Md. Khairul Islam, Regional Director, WaterAid
- 8 Dr. Sayeedur Rahman Khasru, Professor and Head, Department of Pharmacology, BSSMU
- 9 Dr. Sabina Faiz Rashid, Dean and Professor, James P Grant School of Public Health, BRAC University
- 10 Dr. Ubaidur Rob, Country Director, Population Council

### **Advisory Group**

- 1 Dr. Jahiruddin Ahmed, Member Board of Directors, SMC and Former Director of Directorate General of Family Planning
- 2 Mr. Faruque Ahmed, Former Executive Director, BRAC International
- 3 Mr. Mahfuz Anam, Editor, The Daily Star
- 4 Ms. Maleka Banu, General Secretary, Bangladesh Mohila Parishad
- 5 Dr. Zafrullah Chowdhury, Founder, Gonoshasthaya Kendra
- 6 Professor Jamilur Reza Chowdhury, Vice Chancellor, University of Asia Pacific
- 7 Professor Rounaq Jahan, Distinguished Fellow, Center for Policy Dialogue and Chair of the Advisory Group
- 8 Dr. Naila Zaman Khan, Former Professor, Department of Pediatric Neuroscience, Dhaka Shishu Hospital and Bangladesh Institute of Child Health (BICH) and Director, Clinical Neurosciences Center, Bangladesh Protibondhi Foundation
- 9 Dr. Hossain Zillur Rahman, Executive Chairman, Power and Participation Research Center and Chairperson, BRAC



## ANNEX 3

# CONTRIBUTORS

**Be-Nazir Ahmed**, MBBS, MPH, PhD, worked as the Director Disease Control and Line Director, Communicable Disease Control of the Government of Bangladesh during 2011 to 2015. Prof. Be-Nazir coordinated the health interventions for the 1 million FDMN for over two years on behalf of (Directorate General) DG Health, Government of Bangladesh.

**Rushdia Ahmed**, MPH, worked as a Senior Research Fellow at BRAC JPGSPH. She also worked in the Health Systems and Population Studies Division of icddr,b. She is currently pursuing an MA in Health Policy & Equity at York University in Canada.

**Bachera Aktar**, MPH, is an Assistant Director at the Center of Excellence for Gender, Sexual and Reproductive Health Rights of BRAC James P Grant School of Public Health (JPGSPH), BRAC University. She oversees research projects on sexual and reproductive health, urban health system and humanitarian response to Rohingya refugees, and also a course coordinator and Faculty. Previously, she worked for BRAC.

**Zarfisha Alam** is a Knowledge Management and Communication Specialist under the Water, Sanitation and Hygiene (WASH) Programme at BRAC. She is an analytical writer and has over five years of experience in social and corporate communications. Zarfisha holds a Bachelor's degree in Pharmacy from North South University.

**Shuvra Rahman Basunia** was graduated from the Jahangirnagar University. He has worked with the Inter Sector Coordination Group in Cox's Bazar as part of the communications group for humanitarian response.

**Mushtaque Chowdhury**, PhD, is a professor of population and family health at Columbia University in New York. He is an adviser and founding Dean of BRAC JPG School of Public Health and the former Vice Chair of BRAC.

**Md Tanvir Hasan**, PhD, is an Assistant Professor and Co-Director of Centre of Excellence for Urban Equity and Health (CUEH) at BRAC JPGSPH. He teaches Biostatistics and Quantitative Research Methods in the Master of Public Health (MPH) Program. His expertise is in advanced statistical analysis, mixed methods research, implementation research and spatial epidemiological research.

**Mahmoud Muntasir Homsi** was a member of BRAC's health and nutrition team responding to the Rohingya crisis. He is a Jordanian medical doctor and a public health practitioner and worked as an aid worker in different humanitarian crises in Yemen, Syria, Iraq, Turkey and Bangladesh. Currently, Dr Homsi is pursuing post-graduate studies in public health and epidemiology at Karolinska Institutet in Stockholm, Sweden.

**A M Zakir Hussain**, MBBS, PhD, is a former Director, Primary Health Care & Diseases Control, and IEDCR, Government of Bangladesh. He was one of the drafters of the health and population sector strategy in 1997 and the national health policy of 2000 and 2011. Dr Hussain also worked for the Urban Health Care Project-I as the team leader and for WHO at national and Regional levels.

**Zakir Hossain** is a graduate in Ecological Farming from Wageningen University, The Netherlands. Returning home, he established the Farmers' Research Institute 'Krisoker Sor' (Farmers' Voice). With more than 17

years of practical and pragmatic experience he became a strong voice of pursuing local people's agenda in the policy uptake.

**Md Akramul Islam**, PhD, is the Director of Communicable Diseases and Water, Sanitation and Hygiene (WASH) Programme, BRAC. He also served as interim Director for Humanitarian Response, Disaster Management and Climate Change Programmes of BRAC during 2014-2018, overseeing the BRAC Rohingya response. He is an adjunct professor of BRAC James P Grant School of Public Health at BRAC University and served as visiting lecturer at the University of Tokyo and Harvard University.

**Mahfuza Islam**, MSc, is an Assistant Scientist in icddr,b. and has 13 years of experience in public health and research in Bangladesh. She has led several studies including large trials on WASH and other environmental issues in Bangladesh both in urban and rural settings and has published in many international peer reviewed journals.

**Nargis Islam** is a Clinical Psychologist and Tutor on the Professional Doctorate in Clinical Psychology Programme at the University of East London. Dr Islam has worked in the NHS in inpatient and community adult mental health and child services in Oxford. Dr Islam is a Trustee of the Oxfordshire Sexual Abuse and Rape Crisis Centre, and is Deputy Chair of British Psychological Society's Accreditation Committee for Training in Clinical Psychology.

**Shayla Islam**, MBBS, is the Programme Head for BRAC Communicable Disease Programme. She also worked as Senior Advisor, Programmatic Management of Drug Resistant tuberculosis in IRD (Interactive Research Development), Bangladesh, a global health delivery and research organization for one and half years.

**Mohammad Moktadir Kabir**, MBBS, is the Programme Head of Water, Sanitation and Hygiene (WASH) and Malaria Control Programmes of BRAC. He has worked as a focal person of WASH, malaria and tuberculosis programmes for BRAC at Rohingya refugee camps in Cox's Bazar. He has also represented BRAC as a founding member and country focal point for Global Civil Society for Malaria Elimination (CS4ME).

**Mehjabin Tishan Mahfuz**, MBBS, is a Research Investigator at the Environmental Interventions Unit at icddr,b. She is currently working to improve menstrual hygiene management among women and girls in urban slums and schools. She is currently working for

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**Malay Kanti Mridha**, MBBS, PhD, is a Professor of the BRAC James P Grant School of Public Health of BRAC University. He is also the Director of the Center of Excellence for Non-communicable Diseases and Nutrition. He received MBBS from Chittagong University, MSc in Nutrition and Health Economics from Dhaka University, and Ph.D. in Nutritional Biology from the University of California, Davis.

**Muhammad Musa**, MBBS, MPH, is the Executive Director of BRAC International. He has an extensive background in leading humanitarian, social development, and public health organizations in international, cross-cultural settings. Before joining BRAC Bangladesh as its Executive Director in 2015, he worked for 32 years with CARE International as one of its senior international management professionals.

**Rina Rani Paul**, MBBS, is a public health professional and physician. She supported the emergency response of CARE-Bangladesh in Cox's Bazar for Rohingya refugees. She worked for different reputed research organizations in Bangladesh including Johns Hopkins University, icddr,b, JiVitA (a research site of Johns Hopkins University) and U-Chicago Research in Bangladesh.

**Zahidul Quayum**, PhD, is a Professor & Co-Director Research at James P Grant School of Public Health (JPGSPH), BRAC University. He is a health economist and has worked on a wide range of national and global health research projects and economic evaluation models, impact assessment of health systems and health financing policies.

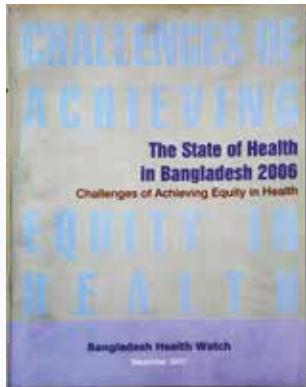
**Atonu Rabbani**, PhD, is an Associate Professor in the Department of Economics at the University of Dhaka and an Associate Scientist with the BRAC James P Grant School of Public Health. He is an applied microeconomist with interest in health, labor and organization economics and is involved in a number of research projects.

**Md Mahbubur Rahman**, MBBS, MSc is leading the Environmental Interventions Unit at icddr,b. He has been managing and implementing large trial on WASH and other environmental issues in Bangladesh. He led the "WASH Benefits trial" which contributed to a better understanding of the impact of WASH interventions on child growth and development.

**Sabina F. Rashid**, PhD, a medical anthropologist, is Dean and Professor at the BRAC School of Public Health. Her areas of expertise are ethnographic and qualitative research focusing on gender, sexual and reproductive health, emotional health, well-being, sexuality and rights of adolescents, young women and men.

**Isbat Azmary Rifat** is a Senior Sector Specialist-Knowledge Management, Communicable Diseases & WASH programme of BRAC. He did his Bachelors from North South University, and Masters from Indiana State University, USA. Isbat Participated into the 50th World Conference on Lung Health and presented an abstract titled, “Shasthya Shebika: Changing the Scenario of TB in Bangladesh” in Hyderabad, India.

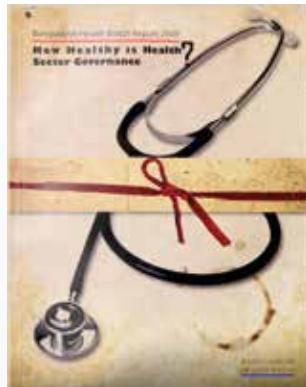
**Shaila Shahid** is Senior Advisor- Climate Change, DRR and Gender at International Centre for Climate Change and Development (ICCCAD). She is Advisory Board Member of Stakeholder Engagement Mechanism (SEM), UNDRR Geneva. She is the winner of Mary Fran Myers Disaster Scholarship award for 2019 from the Natural Hazards Centre, Colorado University, USA.



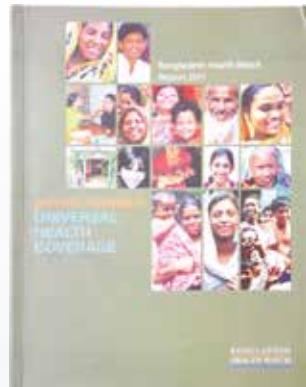
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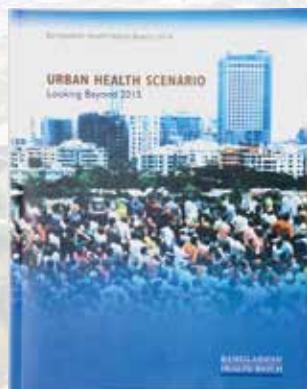
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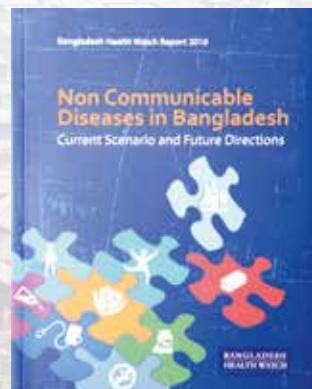
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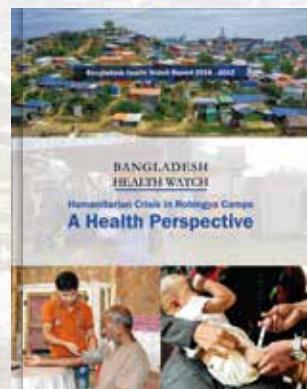
2011



2015



2016



2018-2019

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