Sexual and Reproductive Health Working Group Bulletin

Rohingya Refugee Response, Cox's Bazar

April – June 2022

Introduction

According to the Joint Response Plan 2022, there are about 918,841 Rohingya refugees and 541,021 host community members living in camps in the Ukhiya and Teknaf Upazilas and surrounding host communities respectively in the Cox's Bazar District of Bangladesh. In addition, the JRP 2022 identifies gaps, obstacles, and possibilities for addressing Sexual and Reproductive Health and Rights [SRHR] and other humanitarian needs of Rohingya refugees and neighboring host communities.

SRH Working Group partners contribute to the implementation of the JRP 2022 by providing both basic and comprehensive SRHR services to the target population. This involves providing specific SRH needs for adolescents and young adults. In general, integrated SRHR/GBV services are provided through health facilities and GBV women safe spaces [Women Friendly Spaces and Multi-Purpose Women Centers].

Strategically, UNFPA, as the coordinating agency for the SRH working group, led and coordinated with Government partners and SRH stakeholders the creation of a Cox's Bazar family planning strategy document (2021-2023). The strategy document that has been endorsed by the Cox's Bazar Government authorities in October 2021 and is currently undergoing final clearance by the Ministry of Health of Bangladesh in Dhaka will now be extended to 2025 and include a family planning strategy for the relocated Rohingya refugees in Bhasan Char. The adoption of the strategy implementation action plan that will be developed along with the strategy will go a long way toward improving access to family planning and minimizing unmet family planning needs among the Rohingya and surrounding host communities.

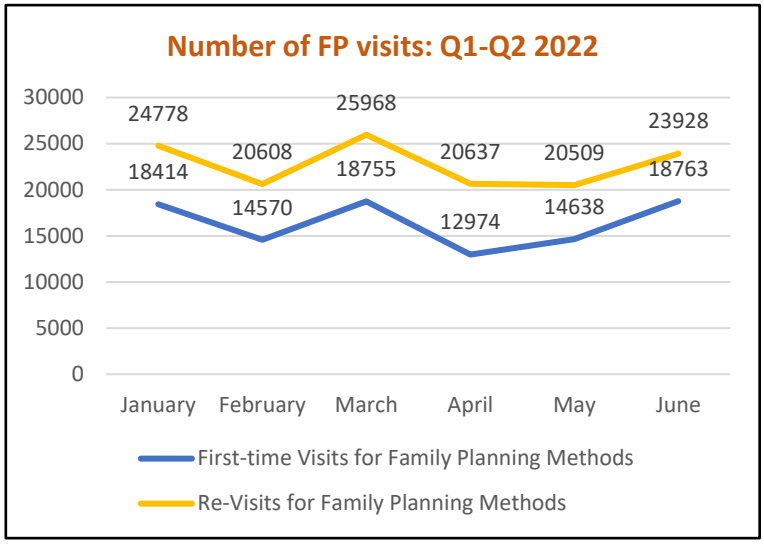
This report is based on data supplied by partners of the SRH Working Group between April and June 2022. The average number of SRH Working Group partners reporting over the time was 42, with 100 percent reporting completion.

Data Overview

Family Planning

Figures based on reports by SRH Partners

A total of 111,449 (Rohingya: 79.91 percent, Host: 20.09 percent) family planning consultations were conducted between April-June 2022 across SRHR facilities in Ukhia and Teknaf, with at least 46,375 (41.61 percent of total) being first-time visits and 65,074 (58.39 percent of total) re-visits. From the first to the second quarter of 2022, the use of Long-Acting Reversible Contraceptives [LARC] among Rohingya refugees and host communities increased by 3.71 percent. In the second quarter, however, oral contraceptives remained by far the most popular way of contemporary Family Planning (59.91 percent), followed by injectable and condom methods. The accomplishments may be attributed to the partners of the SRH Working Group's persistent efforts, which include community participation and awareness-raising. 1.39 percent of all family planning visits were provided to girls under 18 years of age. The SRHWG reiterates its commitment to improving access and availability to voluntary family planning services.



Antenatal Care [ANC] and Postnatal Care [PNC]

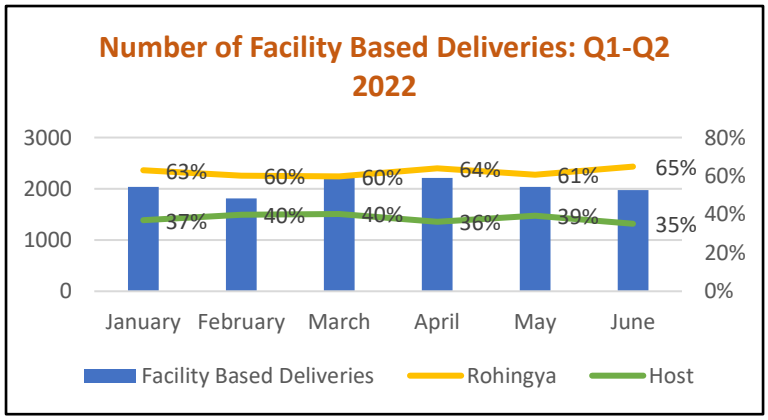
Figures based on reports by SRH Partners

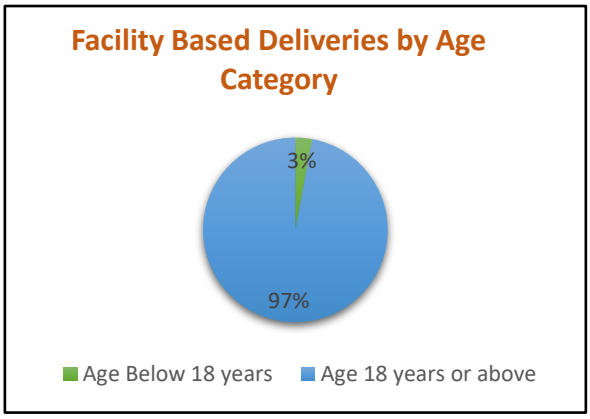
During the period under review, a total of 90,182 ANC visits by pregnant women seeking pregnancy care from skilled health professionals were recorded (Rohingya: 73.89 percent; Host: 26.11 percent), comprising 39,025 First ANC visits and 51,157 ANC revisits. 6.23 percent of the visits were made by girls under the age of 18. In contrast, there were 22,340 PNC visits (Rohingya: 77.42 percent, Host: 22.58 percent), of which more than 4 percent were from girls under the age of 18. Counseling and referrals to health facilities were still provided by Community Health Workers (CHW) to women and girls in need.

Pregnant women receiving ANC at a health facility from a midwife

Facility-Based Deliveries

Figures based on reports by SRH Partners





A total of 6,217 deliveries by women and girls from Rohingya refugee camps and host communities occurred at health facilities and were attended to by Skilled Birth Attendants [SBAs]. Girls less than 18 years age accounted for 2.93 percent of the facility-based deliveries. As a whole, facility-based

deliveries increased by 2.32 percent in Q2 compared to Q1, while the increase among Rohingya refugees was 5.69 percent. Increased facility-based deliveries are attributable to the deployment and mentoring of midwives, medical doctors, and other health-workers, the provision of ambulance services, the procurement of supplies to ensure reproductive health commodity security, the development and provision of Standard Operating Procedures [SOP], information management, and the SRH Working Group's supportive supervision. This was supplemented by advocacy, community participation, and awareness-raising efforts.

Emergency Obstetric Care

Figures based on reports by SRH Partners

The number of obstetric complications reported and managed in the quarter increased by 9.54 percent, from 1,551 in Q1 to 1,699 in Q2 of 2022. Postpartum Hemorrhage, Severe pre-eclampsia/eclampsia, Obstructed/Prolonged Labor, and Puerperal Sepsis were the leading causes of complications. As we move into a protracted phase of the crisis, accessibility and sustainability of Emergency Obstetric and Newborn Care [EmONC], Respectful Maternity Care [RMC], and overall Quality of Care [QoC] becomes paramount. Efforts to fully equip health facilities at all levels and increase the competence of health workers to offer quality basic and comprehensive emergency obstetric care will continue. In addition, continuous community engagement and strengthening the ability of community health workers to identify and refer mothers with danger signs and obstetric complications in a timely manner are emphasized, as are effective emergency referral systems at the community level and between facility levels.

Capacity Building Trainings

Figures based on reports by SRH Partners

SRH Working Group and the Health Sector identified gaps and needs in SRHR and related areas and coordinated training sessions for 400 [247 Female: 153 Male] health workers [see table below];

Training/Orientation		Number Trained		Target group
		Female	Male	
Capacity building of Service Providers to provide LARC services to the Rohingya Refugees	17-19, 21-23 May	17	6	Doctors, Mid-Level Providers
Adolescent Sexual Reproductive Health (ASRH) in Humanitarian Settings	23 May	19	8	SRH or ASRH Manager/Officer/ Programme Level Staff
Clinical Management of Rape and Intimate Partner Violence (CMR-IPV) training for midwives	22-25 May	20	1	Health care workers
2 Days Capacity building of service providers to provide counseling services on FP MR PAC to the Rohingya Refugees	25-26 May	12	0	Mid-Level Providers
Training Including Theory and Onsite Clinical Session on PPIUD & PAIUD with Quality MR & PAC service for Midwives	28 May-2 June	10	0	Mid-Level Providers
Adolescent Sexual Reproductive Health (ASRH) in Humanitarian Settings	29 May-31 May	20	5	Clinical Staff (Doctor/Midwife/Nurse/ Medical Assistant)
Workshop on Strengthening the family planning service through the evidence-based guidelines & best practice	31 May	23	2	Midwife, Medical Officer, Paramedic, CHW, MIS Officer, Field Coordinator
4 days TOT on Comprehensive Sexual and Reproductive Health Package for CHW Supervisor	13-16 June	14	25	CHW Supervisor
Clinical Management of Rape and Intimate Partner Violence (CMR-IPV) training for midwives working in Teknaf and Ukhia camps	19-22 June	22	0	Midwife
Training on 2nd Trimester Post Abortion Care	19-23 June	12	1	Doctors
4 days TOT on Comprehensive Sexual and Reproductive Health Package for CHW Supervisor	20-23 June	13	25	CHW Supervisor
2 days of Capacity building of service providers to provide counseling services on FP MR PAC to the Rohingya Refugees	25-28 June	22	0	Mid-Level Providers
Clinical Management of Rape and Intimate Partner Violence (CMR-IPV)	26-30 June	14	12	Health care workers
4 days TOT on Comprehensive Sexual and Reproductive Health Package for CHW Supervisor	27-30 June	11	29	CHW Supervisor
The Dissemination of learning for future preparedness of Quality SRH Service Provision	28 June	18	39	Program Managers
TOTAL		**247**	**153**	**400**

Feature Article | Maternal and Perinatal Mortality Surveillance and Response (MPMSR)

Courtesy of the inter-agency MPMSR team

To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to high quality care provided by competent skilled health professionals during pregnancy (antenatal care), during childbirth (intrapartum care), and care and support in the weeks after childbirth (postnatal and postpartum care). As timely management and treatment can make the difference between life and death, it is particularly important that all births take place in health facilities and are attended to by skilled health professionals.

Despite the fact that Bangladesh implemented MPDSR into its national system in 2010, the humanitarian situation always presents a unique scenario. Subsequently, the SRH Working Group, chaired by UNFPA and collaborating with the Community Health Worker Working Group and the Epidemiology Working Group, established the Maternal and Perinatal Mortality Surveillance and Response for Rohingya refugee in September 2019. This event was followed by the formation of the MPMSR Committee, which is essential for the coordination and implementation of surveillance within the response.

MPMSR is described as an ongoing cycle of identification, notification, and assessment of maternal and perinatal mortalities, followed by measures to enhance the quality of treatment and prevent future deaths. The surveillance systems work by involving stakeholders at all levels in the process of identifying maternal deaths, determining why they occurred, and taking action to prevent similar deaths from occurring in the future, adhering to the fundamental principle of "No Name, No Blame, and No Shame" with an anonymous and non-punitive approach.

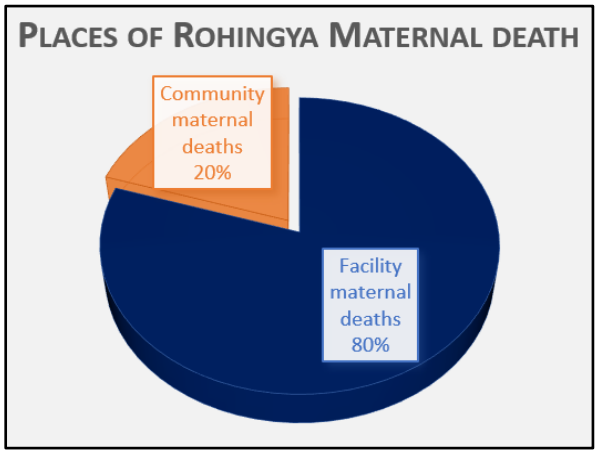
The objectives of Maternal and Perinatal Mortality Surveillance and Response (MPMSR) for Rohingya refugee response are as follows:

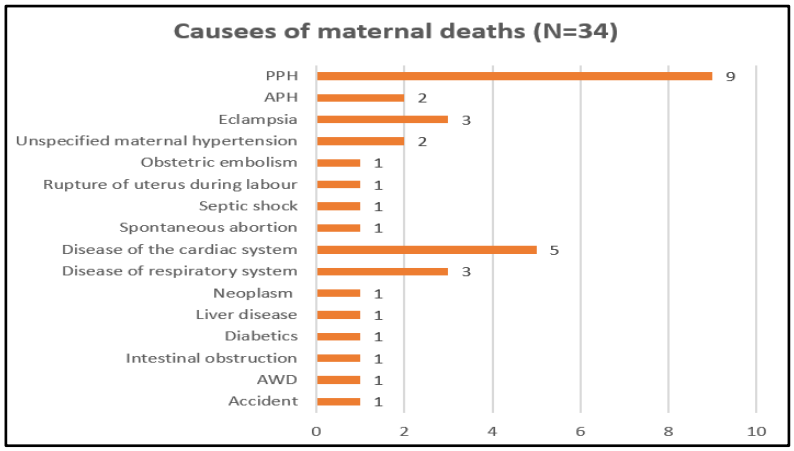
- To identify all factors that led to the deaths in order to address those factors and prevent future deaths of a similar nature;
- To understand the circumstances around the deaths;
- To precisely identify the causes of deaths;
- To improve access and quality of safe motherhood programming (i.e., antenatal care, delivery, postnatal care, post-abortion care), with particular focus on Emergency Obstetric Care to prevent future maternal and neonatal morbidity and mortality.

MPMSR is applied on two levels in Rohingya refugee camps: community and facility.

The MPMSR for Rohingya refugees in Cox's Bazar, Bangladesh, includes community-based surveillance as a distinguishing component. In this technique, all mortalities of women of reproductive age (WRA) are reviewed through verbal autopsy, irrespective of the site of death. The objective of facility-based maternal mortality surveillance and response is to improve the quality of care delivered by facilities through facility-based maternal death audits. A facility-based maternal death audit is undertaken for every death during pregnancy, labor, and the postpartum that occurs at the institution or during referral in order to learn from the previous set of events in order to prevent such mortalities in the future.

Facility based maternal death audit in a camp CEmONC facility





The MPMSR reported 116 Rohingya WRA deaths from January to June 2022. 33.1% of WRA deaths were maternal over these six months. Post-Partum Hemorrhage (PPH) was the leading cause of maternal death, followed by non-obstetric complications.

Various delays contributed to maternal deaths. Most delays occurred at the community level owing to preference for home birth through Traditional Birth Attendants', lack of knowledge of pregnancy risk symptoms and their repercussions, and neglect of women's health etc. Delay is also caused by inaccessibility to hard-to-reach areas. Facility level delays also contributed to maternal deaths. Non-compliance with the referral process and protocol, poor skills of some healthcare personnel in making judgments and diagnosing, lack of facility staff coordination, etc. are major delays at the facility level.

Based on the findings, MPMSR team made the following suggestions to prevent future maternal deaths. Capacity building of the CHWs is key to provide meaningful counseling at the community level. In addition, CHW counseling at the field level has to be monitored and improved, including Estimated Date of Delivery (EDD) tracking, high-risk women' identification and tracking, and promoting family planning and birth planning. Some facilities require midwives and healthcare personnel to receive appropriate training. The referral channel must be followed by facilities, blood, and other medicinal goods. As community mobilization is a long-term method, it is critical for quality of care at facilities to be emphasized for an immediate benefit.

SRH Working Group Coordination

The Sexual and Reproductive Health [SRH) Working Group, under the umbrella of the Health Sector and the Inter Sector Coordination Group [ISCG), provides leadership, coordination and information management on sexual and reproductive health and rights services provision to Rohingya refugees and host communities in Cox's Bazar district, Bangladesh. The Working Group chaired by UNFPA and currently has over 40 members including UN agencies, non-governmental organizations, and local health authorities.

Meetings are held fortnightly on Thursdays from 10.30 am – 12.00 pm UNFPA Office, Hotel Sea Palace. Currently meetings are being held online to maintain social distancing in the context of the COVID-19 pandemic. To find the next meeting date, visit Humanitarian response website.

For more information, please reach us at srh-wg-cxb+owners@unfpa.org or contact SRHR Information Management Analyst, Nafiul Azim azim@unfpa.org.

Acknowledgement to SRH Working Group Partners

AMAN, Bandhu Social Welfare Society, BBC Media Action, BDRCS- QRC, BDRCS-CRC, BDRCS-IFRC, BDRCS-JRCS, BDRCS-SRC, BDRCS-TRC, BRAC, CARE Bangladesh, Christian Aid, CIS, MM and DCHT, CWFD, DDFP, DSK, FH/MTI, Friendship, Global One, Gonoshasthaya Kendra [GK] - Malteser International, Green Hill-CPI, Handicap International- Humanity & Inclusion, Health and Education for All[HAEFA], Health Sector, HMBD Foundation, HOPE Foundation, Integrated Social Development Effort[ISDE] Bangladesh, IOM, Ipas Bangladesh [GAC + PACKARD], Ipas Bangladesh [UNFPA], IRC SRH, LIGHT HOUSE, MedGlobal, MoH CC, MSF Belgium, MSF OCP, MSF-OCA, MSF-OCBA, Partners in Health and Development, Peace Winds Japan, Prantic Unnayan Society, Qatar Charity, Relief International, RRRC, RTMI Pathfinder, RTMI-IOM, RTMI-UNFPA, RTMI-UNHCR, RTMI-UNICEF, Save the Children, TDH, UNFPA, UNHCR, UNICEF, WHO

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