PATHFINDER

LEARNING BRIEF | APRIL 2023

# Advancing Sexual and Reproductive Health and Rights Among Rohingya and Host Communities in Cox's Bazar, Bangladesh

From 2019 to 2022, with support from the David & Lucile Packard Foundation, Pathfinder International partnered with the government of Bangladesh, community leaders, and local nongovernmental organization Research, Training, and Management International (RTMI) in and around Camp 22 in Teknaf to implement the Continued Sexual and Reproductive Health and Rights Support for Rohingya Refugees in Cox's Bazar project. The project worked to strengthen the provision of sexual and reproductive health (SRH) information and services for host communities and support the provision of quality essential SRH information and services where there were none for forcibly displaced Rohingya from Myanmar within Camp 22. This brief describes several valuable lessons yielded from the project.

# Context

## A district strained by crisis

Cox's Bazar—a coastal district along the Bay of Bengal in Bangladesh—has long been a hub for fishing and tourism. Yet access to basic infrastructure and services there is below the national average.[1] In recent years, existing needs have been exacerbated by an influx of forcibly displaced Rohingya from Myanmar. Beginning in 2017, violence against the ethnic Rohingya group in Myanmar drove hundreds of thousands to flee across the border to Bangladesh. Nearly one million refugees—more than half of them younger than 18—now live in sprawling camps in Cox's Bazar's southernmost sub-districts.[2] For years, they have been stateless, with limited access to basic rights like education. Without citizenship in Bangladesh or Myanmar, camp residents have no means for sustainable livelihoods or stability, and no clear pathway to return to Myanmar or integrate into Bangladesh. While a growing number of Rohingya young people are risking their lives on dangerous boat journeys to other Southeast Asian countries in hopes of the opportunity to build a life, the vast majority remain in the camps, where overcrowding and harsh conditions threaten residents' health and wellbeing.

### Challenges in Teknaf

Nearly 20% of those living in camps in Cox's Bazar are in Teknaf, one of the district's poorest upazilas (subdistricts).[3] With high levels of food insecurity and scarce access to electricity, safe drinking water, sanitation, and health facilities, the host population in Teknaf has the lowest literacy rate of any upazila in Cox's Bazar, and a high prevalence of child labor.[4] Both may have been exacerbated by the Rohingya migration, which drove some host community teachers to leave schools for better-paid work in the camps and drove some boys to drop out of school to seize work opportunities in and around camps.[5] Livelihoods among Teknaf's host communities have been severely limited by the influx of forcibly displaced Rohingya. These new residents inhabit land once used for farming, contributing to deforestation and threats to wildlife, and offer cheaper day labor than their Bangladeshi counterparts. In addition, the humanitarian situation has led both Bangladesh and Myanmar to prohibit fishing in the Naf River, which divides the two countries.

#### *Health care access for host communities*

The 171,000 Rohingya in Teknaf nearly doubled the upazila's 2017 local population of 239,000, putting enormous pressure on the already-strained health system and exacerbating health-workforce and commodity shortages.[6] In 2020, the COVID-19 pandemic brought additional strain, disrupting supply chains, client flow, and the health workforce. Clients were scared to access health care, and COVID-19 spread quickly through the crowded camps. Many health care providers got COVID-19 as they juggled challenges at the camp and at home, facing stigma and fear from their communities due to their work in the camps, seen as COVID-19 hotspots.[7] In 2021, pharmacies or drug shops were the most commonly reported sources of health care for host communities, and half of host-community households reported experiencing or expecting to experience barriers to health care access—unavailability of specific medicines, services, or treatments; long wait times; and overcrowding.[8]

#### *Health care access for Rohingya camp residents*

Just over 50% of forcibly displaced Rohingya are under age 18, many with an urgent need for SRH services. This is especially vital for adolescent girls and young women considering the harsh conditions in the camps. Their increased vulnerability to early marriage and gender-based violence (GBV) is exacerbated by the economic and other strains families face.[9] In 2021, 44% of camp households reported experiencing or expecting to experience barriers to health care access—most commonly long wait times or overcrowding; unavailability of the specific medicine, treatment, or service needed; and short operating hours, mistreatment in health centers, and unavailability of medicines onsite at health posts.[10]

## A multifaceted response

As the government of Bangladesh (GOB) family planning (FP) staff work to balance the pressing health needs of the host community with those of the people living in the camps, United Nations agencies and international and national NGOs—including Pathfinder—have worked in both the host communities and camps with donor and private-sector support to bolster the government's multisectoral response. By 2022, approximately 80 implementing partners, including health-sector partners, the UN, NGOs, and aid agencies, were supporting provision of primary and secondary health services via 93 health posts, 46 primary health centers, and 5 field hospitals within the camps, as well as via public health facilities, including community clinics, union centers, and upazila health complexes in host communities.[11]

# Implementation

From 2019 to 2022, Pathfinder worked closely with local leaders, health officials, and RTMI in and around Camp 22 in Teknaf to implement the Continued Sexual and Reproductive Health and Rights (SRHR) Support for Rohingya Refugees in Cox's Bazar project with support from the Packard Foundation. The project focused on two overarching goals:

1. Support the GOB to strengthen SRH services for host communities, which were strained before the Rohingya influx, at the Mina Bazar Community Clinic in the community of Whykong, and
2. Support the provision of quality essential SRH services where there were none for Rohingya at the health post within Camp 22.

## Partners are stronger together

Pathfinder project manager and RTMI field operation lead visit health post and clients to review feedback about services in Camp 22. Photo: Ferdous Chowdhury/Pathfinder

Pathfinder's strong expertise in SRHR; global experience in humanitarian settings; close working relationship with the camp authority and the Directorate General of Family Planning (DGFP) and the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MOHFW); and membership in technical working groups complemented RTMI's emergency-response experience; relationships with key stakeholders at Camp 22, including management from the Camp-in-Charge (CIC) office and the GOB; and knowledge of the Rohingya camp population. This helped ensure broader coverage and more efficient delivery of quality services than either partner could have provided alone. The project's multi-pronged approach blended service delivery, partnership development and maintenance, community engagement, and capacity strengthening to provide essential health information and services in direct response to the needs of community members and camp residents.

For example, during implementation, the GOB asked RTMI and Pathfinder to survey and register eligible couples for contraceptive services in blocks A, B, C, and D of Camp 22—something that had not previously been done. RTMI and Pathfinder worked together to collect the registrations and help ensure that the DGFP had up-to-date key indicator data (for example, contraceptive methods distributed) for Rohingya in the health post catchment area. This registration effort and related data helped inform the allocation of field workers in Camp 22. Not only did this strengthen service provision within the camp, but it also strengthened the relationship between the project and the government; district officials expressed appreciation for this contribution.

## Communities are served together

The strain of the influx of Rohingya on the already under-resourced host communities of Cox's Bazar caused tension between the two groups. The stressors of the pandemic, the annual monsoon season, and dwindling humanitarian assistance only exacerbated the challenges. Meeting the health needs of the host communities while simultaneously serving the camp population benefited everyone—including the project, by encouraging the efficient use of resources and strong relationships with stakeholders—and helped reduce conflict between the host and camp communities.

To this end, the project supported service delivery in the Mina Bazar Community Clinic and the Camp 22 health post and engaged in extensive outreach to the host communities and camp population through community health workers (CHWs). Pathfinder and RTMI provided on-the-job training and follow-up refresher training for service providers for provision of quality, respectful health services, including FP, maternal and child health (MCH), nutrition, postabortion care, and GBV, to Rohingya and host community members to promote better health outcomes and improve client satisfaction (Table 1).

**Table 1. Project-trained Health Workers in the Host Community and Camp**

| Site | Trained Health Workers | |
|---|---|---|
| Mina Bazar | Community Clinic | 1 Midwife |
| | Community | 2 CHWs |
| Camp 22 | Health Post | 1 Medical doctor |
| | | 1 Midwife |
| | | 1 Adolescent and youth officer |
| | Community | 8 CHWs |
| | | 1 Community health supervisor |

## Mina Bazar Community Clinic

Medical officer, midwife, and AY officer at Mina Bazar Community Clinic, Teknaf.
Photo: Ridwanul Mosrur/Pathfinder

### *Staffing*

In August 2020, Pathfinder began supporting the Mina Bazar Community Clinic in Whykong. The public health facility is a critical point of service, serving more than 300 FP clients and 100 adolescent clients per month in addition to providing general health services. One DGHS service provider delivered general health services to the clinic's large client load (community clinics typically serve a population of about 6,000), and family welfare visitors (FWVs) affiliated with the community clinic provided supplementary satellite clinics (community-based outreach services) one or two days per month. NGOs supplemented the health workforce to meet demand; for example, Pathfinder provided a dedicated midwife and two CHWs from August 2020 to November 2022, and a local NGO added CHWs to those provided by Pathfinder and RTMI.

### *Services*

The project trained the midwife on the provision of long-acting reversible contraceptives (LARCs), menstrual regulation, and postabortion services.[12] With this expanded skill-set, the midwife was able to increase MCH and FP service offerings, complementing the services FWVs offered in satellite clinics. (Her presence at the community clinic was unique; in other parts of the country, no midwife is posted at community clinics). Training providers at the community clinic and the health post helped ensure consistent, reliable services. The community clinic offered services four hours a day, six days a week; satellite clinics offered immunization services once a week; and CHWs offered complementary services, including awareness sessions for adolescents and referrals to the community clinic. While the community clinic provided primary health care and made referrals for more complex care, many clients did not seek the additional care to which they were referred due to financial, geographic, or other barriers to access. Teknaf upazila health complex, for example, was 34 kilometers away.

## Health post in Camp 22

Pathfinder began supporting service delivery in Cox's Bazar at the onset of the crisis in 2017, at a small roadside clinic funded by private donations and operated by a Bangladeshi nongovernmental organization (NGO) partner under Pathfinder's USAID-, DFID-, and Chevron-funded Smiling Sun program (2012-2018). The roadside clinic did not initially fulfill health-sector criteria for provision of the essential service package. Within a year, however, the Packard Foundation began funding the clinic, and it met the criteria to be upgraded to a formal government-approved health post in Camp 22.

### *Staffing*

The clinical team consisted of two clinical service providers (one medical doctor and one midwife), one adolescent and youth (AY) officer, and eight CHWs, and two government clinical providers were temporarily assigned. Initially, family welfare assistants—government-employed community health workers—provided home visits, but they were unable to continue due to staffing shortages in the host community.

### *Services*

The health post, managed by RTMI since 2018, offered a range of general services six hours a day, six days a week. It became a crucial access point for more than 11,000 Rohingya in blocks C and D of Camp 22 to receive MCH counseling and services, antenatal care (ANC), postnatal care (PNC), FP counseling and services, and management of sexually transmitted infections (STIs). The health post referred pregnant ANC clients to a more comprehensive primary care facility in Camp 22 for delivery, and it referred clients in need of complex care to higher-level government- and NGO-run facilities outside the camp. In addition, RTMI collaborated with the GOB to promote LARCs through an Implanon campaign, raising awareness of the method among the Rohingya and lending the organization's internal trained doctor from other projects to provide Implanon services in Camp 22.

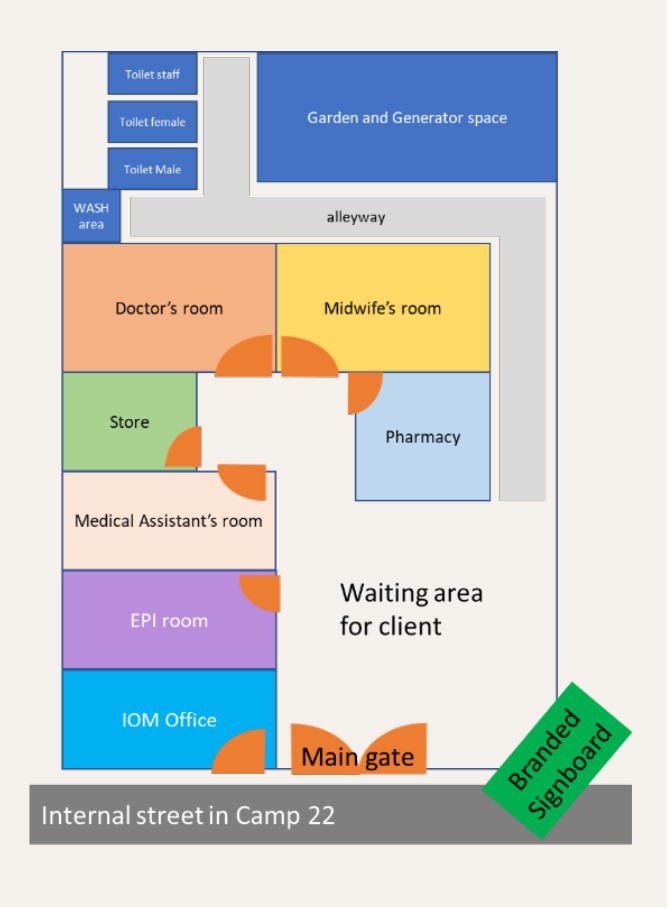
For many families who sought health services, the provision of general and curative health care services for all household members, including men and elders, generated a sense of trust in the health post and its service providers where there had been none.[13] This opened the door for the project to reach women with FP, SRH, and GBV services at the health post—something that was initially difficult due to socio-cultural barriers. Providing delivery kits was a crucial intervention to help those giving birth at home, as is customary among Rohingya. In the camp environment, getting a piece of sanitized cloth was difficult, and many clients expressed gratitude for the more than 500 delivery kits the project distributed, and the follow-up provided—including community-based postpartum FP counseling and service provision and referral.

As health post providers increasingly served pregnant women with ANC and PNC, they uncovered many cases of GBV. RTMI and Pathfinder trained the CHWs and midwives to provide gender-sensitive care, identify GBV cases, and refer them to International Rescue Committee (IRC) service providers at Family Welfare Centers (FWCs, or GOB health centers) within the host community or IRC one-stop crisis centers in the camp.

### *Location*

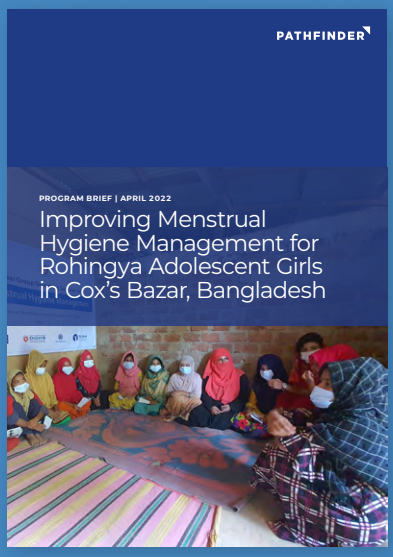
The location of the health post—deep in the camp, about a kilometer and a half from the entrance—helped it reach an otherwise unserved population. Within Camp 22, Blocks C and D are remote. For many camp residents in these blocks, the health post was closer and more convenient than the other health posts, which are located in Blocks A and B.

**Layout of Health Post in Camp 22**




### *Adapting to meet the needs of Rohingya clients*

Over the course of the project, the team made adaptations to respond to the needs of the Rohingya clients. The health post did not initially have an adequate waiting area or a dedicated space to hold forums for adolescent boys and girls, hindering privacy. In 2021, the RTMI-employed health post manager, Pathfinder, and RTMI worked with the CIC and local stakeholders to expand the structure to provide more waiting space for clients. The project also adapted information, education, and communication materials to account for low literacy among clients. While flipcharts and materials were translated into the Rohingya language, verbal communication was the most effective means of sharing health messages. In tailored sessions, the Rohingya CHWs disseminated information about puberty, early marriage, menstrual hygiene management (MHM), ANC and PNC, HIV and AIDS, STIs, and COVID-19 to encourage health care-seeking behaviors among adolescents and adults. Some of the health providers learned to speak limited Rohingya and found combining visual presentations and physical demonstrations more helpful for clients than verbal counseling alone.




## Improving Menstrual Hygiene Management for Rohingya Adolescent Girls

In the camp environment, the lack of knowledge, infrastructure, and supplies to support MHM pose serious challenges for girls and women. In 2020, Pathfinder implemented a pilot project to close this gap by increasing girls' knowledge and use of menstrual products and services; raising awareness about healthy MHM behaviors; ensuring girls can manage their menstruation in a safe, hygienic, dignified, and sustainable manner; and testing the feasibility of this model for scale-up.

**Learn More**

www.pathfinder.org/BD-MHM

Menstrual hygiene management session with adolescent girls. Photo: Pathfinder

## Community Engagement

Even with this effort, the project needed to invest deeply in community engagement to contextualize service delivery in both the community clinic and the health post to address religious and cultural beliefs, social norms, and mistrust of the GOB—whom some Rohingya believed wanted to control their population's growth—and of the health system. In the camp, providers and potential clients experienced pushback—at times so strong as to warrant safety concerns—from mothers-in-law intent on prohibiting daughters'-in-law access to FP services.

### Tailored outreach

To build trust, encourage care-seeking behaviors, and ensure the security of health workers, the project engaged Majhi (Rohingya community leaders) and influential men, including imams, in monthly stakeholder meetings and courtyard sessions on gender, FP, and couples' communication. Not only did this help expand women's access to SRH care; project and health post staff also saw it as a critical tool to prevent retaliative GBV against women seeking services. The project also facilitated courtyard sessions and home visits in host communities and camps for separate groups of women and adolescent girls and boys on MHM, puberty, FP, SRH, ANC, and PNC. The project's AY officer traveled frequently between the camp and Mina Bazar Community Clinic and conducted meetings, learning sessions, and events for groups of adolescent boys and young men to raise awareness of health-related issues. His background as a medical technician allowed him to provide valuable input on the content and format of the sessions for adolescent girls and young women, conducted by Rohingya CHWs with guidance from the AY officer.

### Roles and recruitment of community health workers

Ten CHWs led the courtyard sessions and conducted door-to-door outreach to women and adolescents with information on and referrals for MHM, pregnancy, MCH, and nutrition services. At first, the project had two Bangladeshi CHWs, but their effectiveness in reaching the Rohingya population was limited by language barriers and safety concerns. In November 2019, the project reassigned them to support the host communities surrounding the camp and recruited eight Rohingya CHWs to work within the camp to bridge the language and culture gap between the project and community, to increase acceptability of health information and services, and to help register pregnant women in blocks C and D of Camp 22.

Recruitment was challenging. The project received many applications and interviewed 50 candidates, but the positions required people who not only met project criteria (interpersonal and language skills, a literacy level high enough to effectively use project job aids, understanding of the camp context and dynamics, proactive work style) but whose gender and cultural background would help ensure social acceptability among Rohingya. Pathfinder trained and provided post-training supportive supervision for RTMI staff and the Bangladeshi and Rohingya CHWs on SRH service provision; FP counseling; infection prevention and control; GBV response and referral; camp coordination and management; STI counseling, treatment, and referral; and referrals for mental health and psychosocial support. Once in place and trained, the Rohingya CHWs' frequent interactions with the camp population generated trust, overcame language and social barriers, and eventually reduced husbands' and mothers-in-laws' efforts to block women from visiting the health post for SRH and FP services.

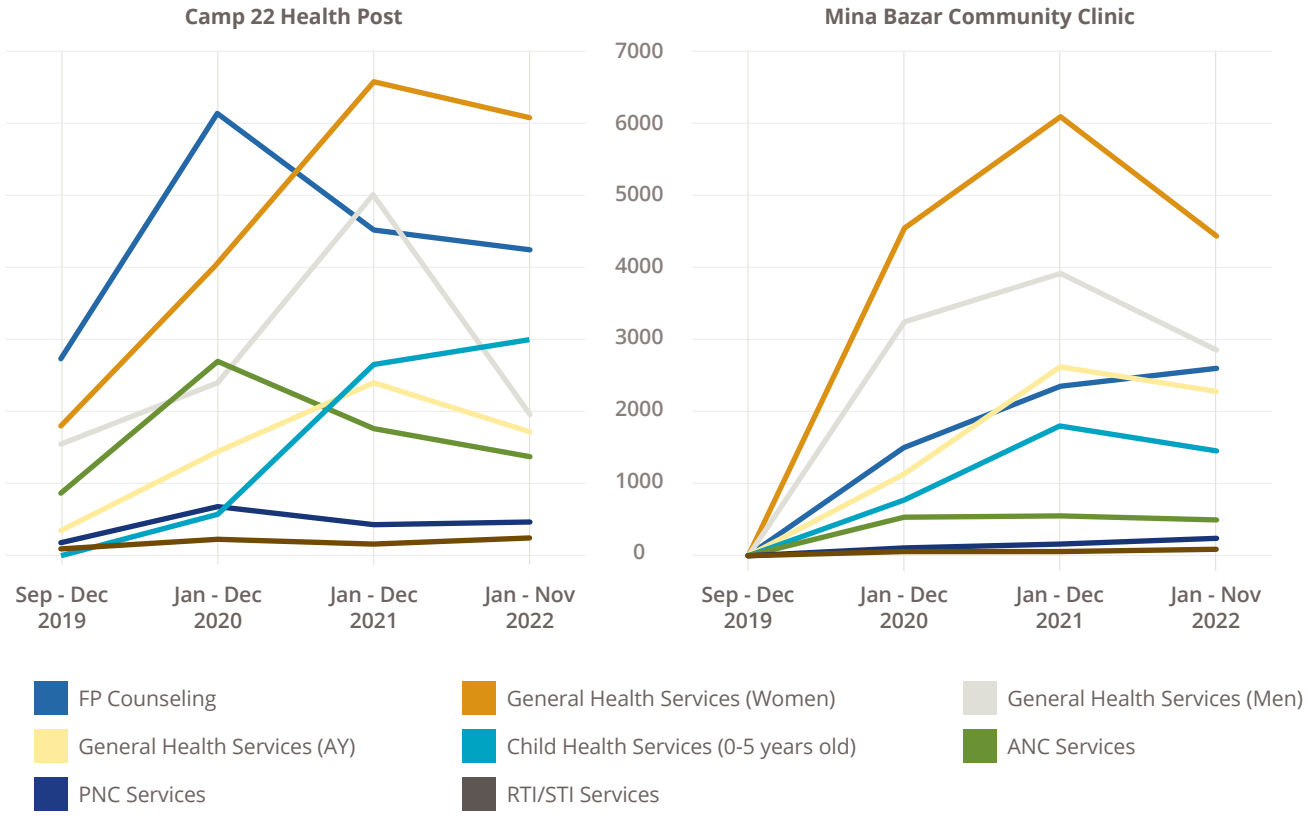
# Performance

**The project's key outcomes included provision of comprehensive training for public-sector service providers on delivery of a range of health services (especially for AY) in host communities and Camp 22; provision of FP (especially for AY), SRH, MCH, and general health services for Rohingya living in Camp 22 through the health post and for the host community through the community clinic; and increased awareness of and demand for SRH services among Rohingya women and girls.**

## Service delivery

Between September 2019 and November 2022, there were 24,338 FP counseling visits in project-supported service delivery sites, 73% of them at the health post in Camp 22. In that same period, project-supported sites received 8,465 ANC visits (80% at the health post); 2,396 PNC visits (76% at the health post); and 1,086 visits for reproductive tract infections and STIs (69% at the health post.) Visits for general health services were more evenly divided between the sites. Project-supported sites received 10,360 child health visits (60% at the health post); 12,114 AY general health visits (49% at the health post); 33,760 women's general health visits (55% at the health post); and 21,111 men's general health visits (52% at the health post) (Figure 1).

**Figure 1. Client Service Visits to Project-supported Service Delivery Sites, by Service Type, Site, and Calendar Year (Sep 2019 to Nov 2022)***



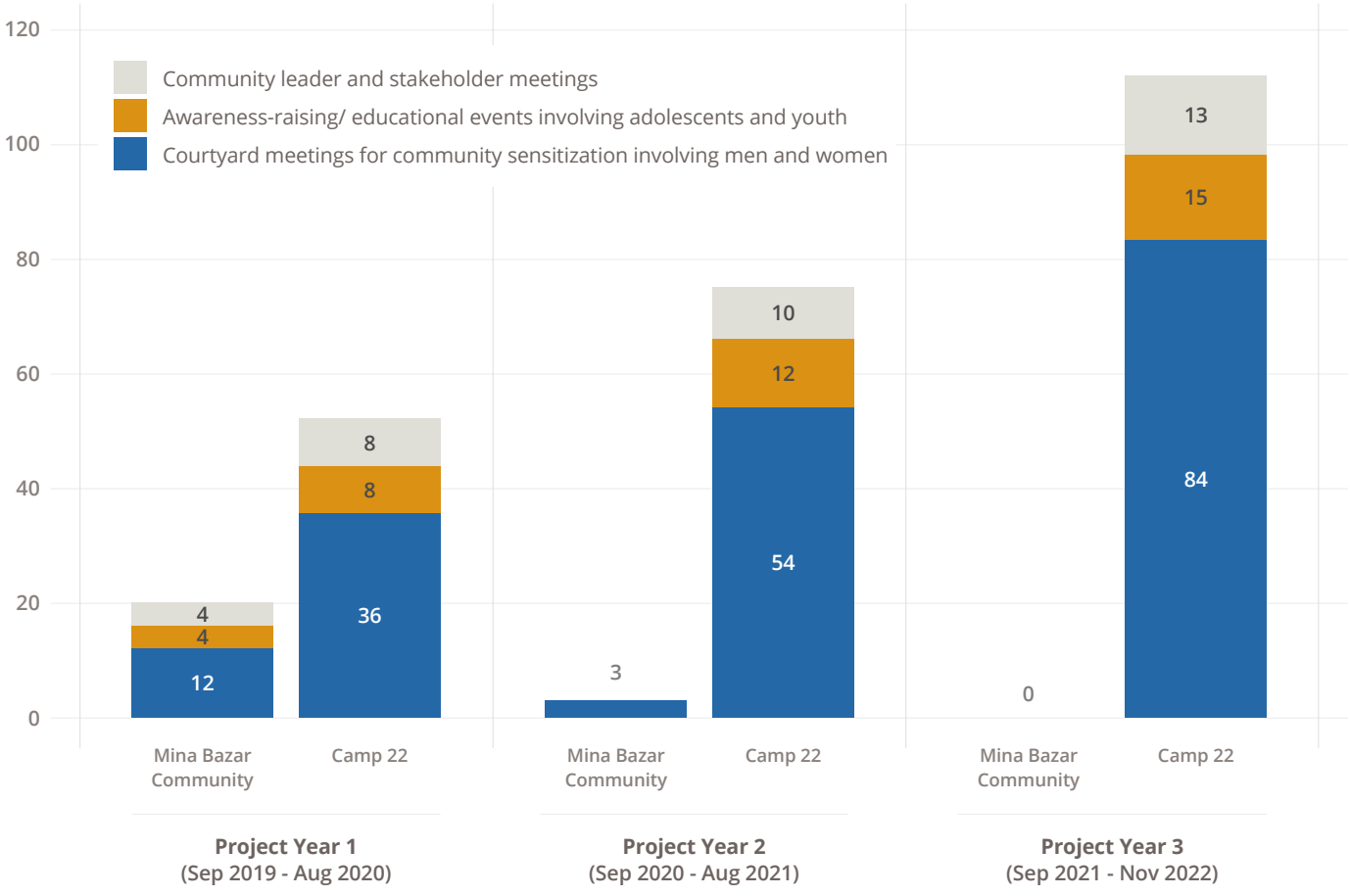

*Note that the first year (3 months) and last year (11 months) of the project are truncated and not directly comparable.

The health post in Camp 22 provided essential services to more people than anticipated. In addition to the more than 11,000 people in the intended catchment area of Blocks C and D of the camp, the health post also served many clients from Blocks A and B. In fact, a midwife reported that many clients would pass closer facilities to instead come to the project-supported health post, because they felt they received better treatment and support there. Key project-supported service providers and CHWs shared that clients expressed that the health post's service providers were friendly and attentive, taking the time to explain how and why the use of medicines or contraceptives was beneficial and encouraging clients to return for additional medical advice, consultations, and services. Providers' efforts to understand the unique needs, culture, and context of their Rohingya clients led to improved client-provider communication and trust.

## Community outreach and awareness raising

Project-supported CHWs conducted a range of community engagement and awareness-raising activities over the course of the implementation period, particularly for the community within Camp 22. In all, CHWs conducted 189 courtyard meetings for community sensitization involving men and women, 39 awareness-raising or other educational events targeting AYs, and 35 meetings with community leaders and stakeholders (Figure 2). Across community sensitization activities and individual outreach efforts, including home visits, visits with eligible couples, and group sessions, the project recorded 600 individuals reached by CHWs in the first project year (3 months), 4,500 in the second project year (12 months), and 7,800 in the final project year, which stretched from September 2021 to November 2022.

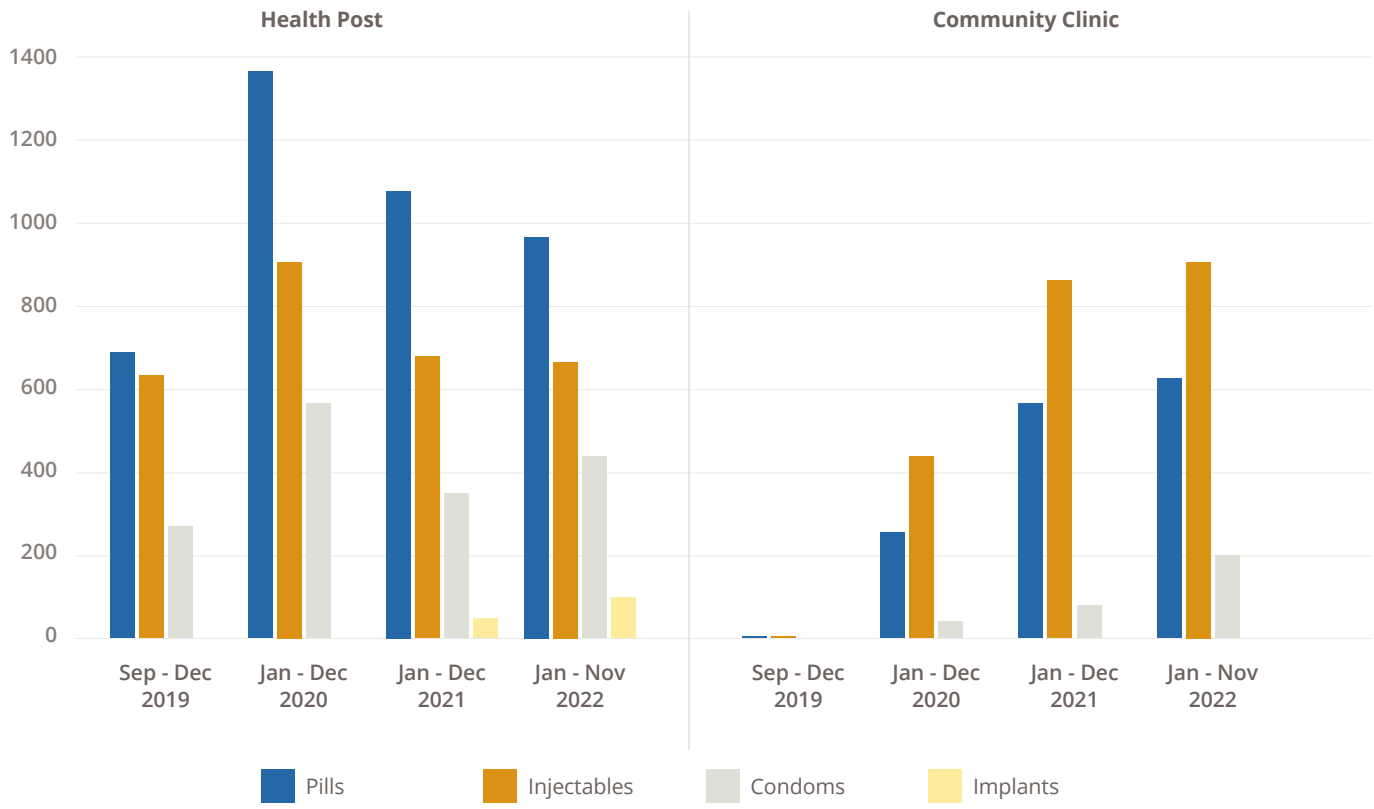
**Figure 2. Community Sensitization and Awareness-raising Activities Held by CHWs with Project Funding, by Site and Project Year**



# Contraceptive Service Delivery

The project saw large numbers of contraceptives, overwhelmingly short-acting methods, distributed to clients at its service delivery sites, with relatively high uptake at the health post from the start of the project and increasing uptake at the community clinic over time (Figure 3).

**Figure 3. Contraceptive Methods Distributed to Clients at Project-supported Service Delivery Sites, by Site, Method, and Calendar Year***

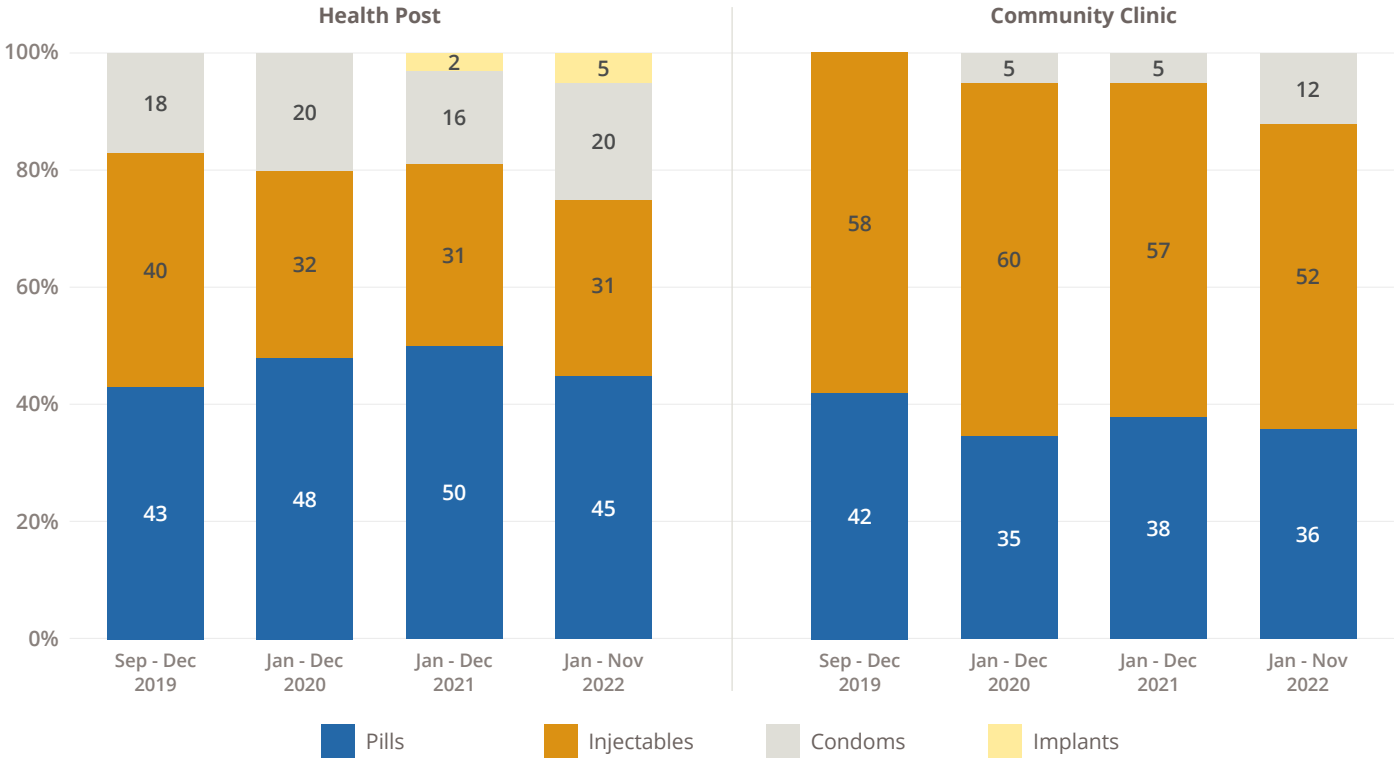



*Note that the first year (3 months) and last year (11 months) of the project are truncated and not directly comparable.

At the health post, the proportion of oral contraceptives distributed to Rohingya women who opted for FP hovered between 43% and 50% each year, while close to one third of the methods distributed were injectables after the first year, when it was 40% (Figure 4). This trend was similar to findings from a 2019 study of women in Cox's Bazar camps, which found that uptake of short-acting methods was much higher than that for LARCs (less than 2% of methods adopted), though in this study, injectables were far more popular, with 67% of Rohingya women who used FP choosing injectables, vs. 30% who chose pills.[14] Condoms were also popular at the health post (perhaps due to reductions in service availability and willingness to visit a health facility during the COVID-19 pandemic) consisting of one in five methods distributed each year. By the end of the project, when project staff had trained providers on implant insertion and removal, 5% of the methods distributed at the health post were implants.

At the community clinic, injectables (between 52% and 60% of methods distributed) were more popular than oral contraceptives (25%-42%), in contrast with findings from the 2017-2018 DHS, which found that the proportion of currently married women ages 15 to 49 in Chattogram who used pills was twice that of those using injectables.[15] The proportion of contraceptive methods distributed to clients that were condoms also increased over time, up to 12% in the final project year.

**Figure 4. Method Mix of Contraceptives Distributed to Clients at Project-supported Service Delivery Sites by Site, Method, and Calendar Year***




*Note that the first year (3 months) and last year (11 months) of the project are truncated and not directly comparable. Percentages are rounded to the nearest whole number.

Photo: Ridwanul Mosrur

**Case Study**

## Mina Bazar Community Clinic provides essential care for Bangladeshi women

Married at 17, Mahmuda Akter, 22, has been pregnant four times. She lost her first pregnancy at five months; not realizing she was pregnant, she had not sought ANC. Within months of the miscarriage, she got pregnant again and gave birth to her son, now two years old. Shortly after the birth, she got pregnant again and had a stillbirth. Weak and sick, she consulted Lija Begum, the midwife at Mina Bazar Community Clinic. After FP counseling, she decided to use injectables for six months. After discontinuing use, she got pregnant again. Receiving counseling on postpartum FP and the full range of methods, including LARCs and permanent methods, helped Mahmuda recognize the importance of healthy timing and spacing of pregnancies. In a conversation with project staff, she showed willingness to use FP after her current pregnancy.

# Lessons and Recommendations

**Projects serving populations within refugee, internally displaced persons, or other humanitarian camps should also serve the surrounding host communities, tailoring information and services to the specific context, culture, and needs of each.** RTMI's collaboration with the DGHS to make the Mina Bazar Community Clinic an FP and SRH service center to scale services for host community created a unique but replicable model for serving host communities. In Camp 22, both the strategic location of the health post and the complementing of the essential service package with community outreach activities proved an effective, replicable model for meeting the health needs of the Rohingya.

**Strong partnerships among implementers and with government and other stakeholders helps facilitate successful implementation.** Pathfinder and RTMI's complementary sharing of knowledge and resources helped the project avoid duplication of effort and minimize implementation costs. The project was proactive in its outreach and support to the GOB and other stakeholders, leading initiatives such as eligible couples' registration within the camp, that strengthened the responsiveness of the health system to the existing needs. Through RTMI, Pathfinder regularly shared updates and findings with camp management, establishing and maintaining a collaborative relationship throughout project implementation.

**While providing facility-based services is important, community outreach is essential.** The two CHWs in the host community and the eight Rohingya CHWs in the camp were instrumental on the supply side. They helped the project understand community health and language needs and cultural preferences to make services responsive and accessible to clients. These community-level actors were just as important on the demand side, generating awareness of the importance and availability of essential health services, including general health care, MHM, nutrition, FP, and MCH. The CHWs' continuous household visits, meetings with community leaders and stakeholders, and organized events for AY helped overcome some service-delivery barriers. For example, CHWs raised awareness among the Rohingya of the importance of ANC and PNC. They also held awareness-raising sessions on FP to help address the misconceptions and social norms that discouraged FP use among many Rohingya women, despite their desire to space or limit births.

**"[The midwife] is great. We get good services from this facility. It helps us a lot… It would be great if this facility and these services could continue."**

**– 22-year-old Rohingya mother of three**

## ABOUT THE PROJECT

From August 2019 to November 2022, Pathfinder worked closely with local leaders, health officials, and local NGO Research, Training, and Management International (RTMI) in and around Camp 22 in Teknaf to implement the Continued Sexual and Reproductive Health and Rights Support for Rohingya Refugees in Cox's Bazar project. With support from the David & Lucile Packard Foundation, the project focused on two overarching goals: (1) Support the government of Bangladesh to strengthen SRH services for host communities, which were strained before the Rohingya influx, at the Mina Bazar Community Clinic in the community of Whykong, and (2) Support the provision of quality essential SRH services where there were none for Rohingya at the health post within Camp 22.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**Cover**

Yesmin Ara, 21, was married in Myanmar at age 14. She had her first child in Myanmar and her second in Camp 22, where she received antenatal care, postnatal care, and consultation services from mid-wife Jannat Ara at the project-supported health post. Now pregnant with her third child, she has returned to the health post for services from Jannat. Her current pregnancy was unintended; though she was counseled on the full range of available methods, including longer-acting methods, she chose oral contraceptive pills given her religious and cultural beliefs but later discontinued use.
Photo: Ridwanul Mosrur

**Notes**


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