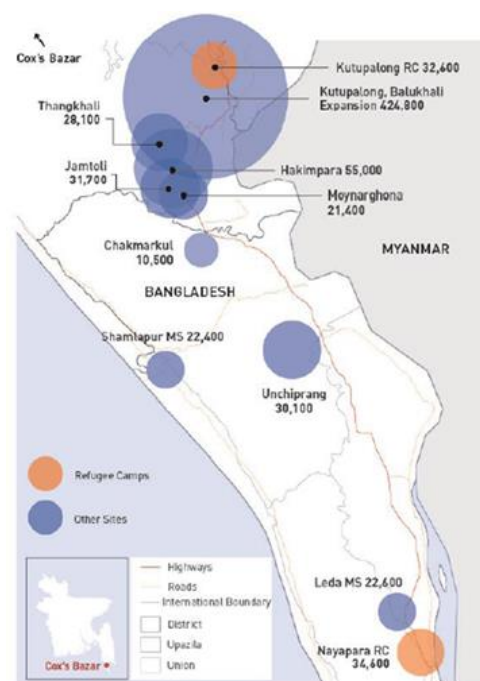


Situation Report: 01
 Date: 01 November 2017
 Emergency type: **Arrival of Rohingya population from Myanmar following conflict in Rakhine state**



607, 000
new arrivals
in BAN



300 000
previously
existing in BAN



700 487
106% OCV coverage
(1 year and above
since 10 October)



1.2 million
target population for
humanitarian action

KEY HIGHLIGHTS

- As of 31 October 2017, cumulative number of new arrivals in all sites of Ukiah, Teknaf, Cox's Bazar and Ramu are 607,000¹, including over 329, 000 arrivals in Kutupalong Balukhali Expansion site, 230, 000 in other settlements and camps and 46,000 arrivals in host communities.
- An estimated 3,000 arrivals have crossed Naf river, are currently staying in no man's land near Anjumapara border and are expected to cross into Bangladesh.
- Overall 526, 107 health services have been provided to the FDMN population since 25th August 2017
- Planning and preparations for second phase of the vaccination campaign (OCV and bOPV) was done
- The WHO Mortality and Morbidity Weekly Bulletin (27 – 29 October 2017) shows that acute respiratory infections are the most common type of disease among the vulnerable population in Cox's Bazar, with significant burden of diarrheal and skin diseases, and fever.
- Government and partners are working towards a cyclone preparedness plan

SITUATION OVERVIEW

¹ <https://reliefweb.int/report/bangladesh/isrg-situation-update-rohingya-refugee-crisis-cox-s-bazar-2-november-2017>

There are currently over 65 health sector partners operational in this response, and approximately 200 known health facilities operating across all camps and settlements, providing different levels and types of health services. However, due to the huge population size and limited available land and limited road access, the distribution of these is not equitable and there is need to systematically assess the current situation, and rationalize the site allocation process for health facilities going forward.

The epidemiological profile remains similar to previous weeks. Of the diseases monitoring in EWARS, acute respiratory infections represent the largest burden (32%) followed by unexplained fever (26%), acute watery diarrhea (20%) and skin diseases (9%) are also reported. A total of 104 deaths have been reported through EWARS, majority of which (33%) are attributed to acute respiratory infections.

In view of the increasing numbers of measles cases reported, the low immunization coverage among the FDMS and the inadequate WASH and nutritional provisions within the camps/settlements, there is need to enhance routine immunizations as well as vaccination campaigns to minimize the risk of an outbreak. It is also essential that the health sector partners be prepared in the event of an outbreak of diarrheal diseases including cholera.

In addition to the risk posed by the public health conditions within the camps, the FDMNs are susceptible to environmental risks, including cyclones. This requires that the health sector implement certain contingency measures.

WHO ACTIONS

To improve coordination within the camps/settlements, it was agreed this week that each zone will be assigned a health focal organization per block, responsible for providing information on services including referrals, and managing a complaints mechanism. WHO has drafted terms of reference and will help to coordinate this process in the coming weeks.

WHO has also set in place a plan to comprehensively map the health services available within the camps/settlements in the first week of November, to identify gaps, map referrals and ultimately support the Government in reassigning health facilities if necessary and allocating sites for new facilities.

The EWARS has now been functional for four weeks, and the number and timeliness of reports is increasing. In the latest MMWB (no. 3), the number of consultations reported throughout EWARS increased by 79% compared to the previous week (73,218 vs 40,968). This positive trend will help to provide an increasingly robust understanding of the epidemiological situation within the camps/settlements. To date, the trend has not drastically changed, and acute respiratory infections remain the most common type of disease reported. Through EWARS, a total of 139 suspected measles cases have now been reported (1 September and 29 October 2017) and case investigations were conducted.

After the initial assessment of the water quality showed high levels of contamination, WHO has continued to support the Government to conduct surveillance of household and source water contamination. In the last round of results analysis, 83% (482/580) tested positive for faecal contamination (*E. Coli*). These results were presented at the WASH and health sector meetings this week, and there is consensus that the two sectors will continue to collaborate closely to improve the water and sanitation situation.

To reduce the risk of outbreaks, one of the main priorities this week was to prepare for a second round of vaccination campaigns. WHO and UNICEF have worked with the Government to finalise plans and preparations for the next phase of the OCV campaign, which will provide a second OCV dose to 180,000 children aged

between one and five years, for added protection. This will be combined with a bOPV vaccination campaign targeting a further 210,000 children aged less than five years and will take place next week.

WHO and partners also supported the development of a routine vaccination coverage improvement plan this week. A total of 36 static vaccination sites have now been identified and a total of 95 staff were trained the current routine EPI schedule; key EPI messages; cold chain; VVM; injection safety; registration; reporting; waste management; and AEFI surveillance. The static sites will be operational from 10 November 2017.

WHO is finalizing an acute watery diarrhoea plan (based on a worst case scenario of 37,000 cases) that has a gap analysis for treatment centres and units, rehydration points, and contingency supplies. WHO and other partners are prepositioning life-saving supplies, and in November partners will begin to train health care workers on case management. However identifying suitable sites to establish oral rehydration points and diarrhoea treatment centres and units remains a challenge and is an immediate priority for the health sector which WHO will initiate next week.

WHO has begun work on a cyclone preparedness and response plan, which will be finalised in November. This will cover the period from 48 hours prior to a cyclone through to 72 hours post cyclone, and will feed into an inter-sectoral Cyclone preparedness plan.

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