



World Health Organization

Bangladesh

Weekly Situation Report # 24

Date of issue: 3 May 2018

Period covered: 24 April – 30 May 2

Location: Bangladesh

Emergency type: Rohingya Refugee Crisis



905 000

total Rohingya
in Bangladesh



693 000

new arrivals since
25 Aug 2017



984 906

Rohingya people and the
host community targeted for
the next round of OCV
campaign



728 786

people are being
monitored for diseases



1.3 million

people targeted for health
assistance

KEY HIGHLIGHTS

- From 8 November 2017, a total 6 822 suspected cases of diphtheria have been reported. Cases continue to be reported amongst children aged 5-14 years.
- According to Early Warning Alert and Response System (EWARS), in 2018, acute respiratory infections and AWD are the two leading syndromes with highest proportional morbidity of 11.8% and 5.3%, respectively. Both diseases and mosquito-borne diseases are at risk of causing severe outbreaks during monsoons and are being monitored by WHO team.
- About 984 906 people are being targeted in the Oral Cholera Vaccine (OCV) campaign scheduled to commence on 6 May 2018 including 135 000 from the host community.

SITUATION OVERVIEW

- Since 25 August 2017, an estimated 693 000 Rohingya have crossed over from Myanmar into Cox's Bazar, Bangladesh, joining approximately 212 500 others who had fled in earlier waves of displacement. There have been 7 885 new arrivals since January 2018.
- 52% of Rohingya refugees are women; high proportions of births are reported as home deliveries. Traditional birth attendants have been trained and provided with incentives to facilitate the referral of pregnant women for facility-based deliveries to reduce maternal deaths due to complications. Family planning services are also available at selected health facilities.
- The psychological impacts of displacement continue to affect large numbers of the Rohingya community. 15 agencies and actors are providing mental health and psychosocial support services (MHPSS) to the affected population; there is an urgent need for more investment particularly in psychiatric care.

MONSOON PREPAREDNESS

- Mobile Medical Teams (MMT) trainings were completed and the MMTs will be ready to deploy as of next week.
- A simple emergency response summary draft was developed to inform partners on the coordination structures, and respective roles and responsibilities within different categories of events. Once finalized, an orientation is planned for partners.
- An agreement was reached that WHO and Health Sector's role in dead body management (DBM) will be limited to technical support in management of dead bodies related to an infectious disease event. For all other dead body management, WHO/health sector will have no further role.
- A coordination mechanism for centralized management of response resources was developed. A proposal for a centralized referral and ambulance dispatch unit is being discussed with Government authorities to facilitate both ambulance and mobile medical team dispatch.
- As a part of monsoon preparedness, the second phase of malaria training on RDTs is scheduled in the following week. The Revised National Treatment Regimen for malaria was disseminated to the Partner organization that took part in the malaria training on 21 April 2018.
- The AWD technical group is close to finalizing the multi-sectoral Acute Watery Diarrhea response plan as part of preparedness for potential AWD outbreak response ahead of the upcoming monsoon and flooding season. The multi-sectoral plan is scenario based and includes actors from Health, WASH and Nutrition sectors.

RESPONSE

EPIDEMIOLOGICAL UPDATE

- To date, 157 health facilities are currently registered as active Early Warning Alert and Response System (EWARS) reporting sites. For week 17, 102 reporting sites have sent their weekly reports by 1 May 2018, resulting in a cumulative completeness of 68% for 2018. Twelve new MoH sites were registered this week and will start reporting in week 18.
- In week 17, a total of 59 alerts were triggered. All alerts went through initial verification within 72 hours of being triggered. Of the 59 alerts, 13 alerts are currently being monitored by the WHO epidemiology team.
- In week 17, there were 14 new suspected measles case-patients bringing the total number of cases reported in 2018 to 1 222, a decline from the previous weeks. Measles sampling strategy to assess viral transmission was implemented on 15 April 2018. Last sample collection date was 23 April 2018.
- In week 17, 3 503 Acute Watery Diarrhea (AWD) case-patients were notified through Indicator Based Surveillance (IBS). The number of cases is steady in comparison to previous weeks. The total number of AWD case-patients is now 81 479.
- In 2018, acute respiratory infections and AWD are the two leading syndromes with highest proportional morbidity of 11.8% and 5.3%, respectively. Both diseases are at risk of causing severe outbreaks during monsoons and are being monitored by WHO team.
- WHO team is in the process of mapping EWARS sites and transitioning reporting by zones to camps to better align with other health sector activities. This process is expected to be completed in the coming weeks.
- Public Health Situation Analysis 2018, assessing major public health threats faced by the affected populations is currently being finalized.

DIPHTHERIA UPDATE

- From 8 November 2017, there have been a total of 6 822 (excluding 556 lab negative cases) diphtheria cases reported through EWARS. In week 17, there were 100 (1 confirmed, 35 probable and 64 suspected) new case-patients reported through EWARS. To date, 222 (28.5%) cases have been laboratory confirmed. Cases continue to be reported amongst children aged 5-14 years. An updated epidemic curve is presented in Figure 1.
- As of 28 April 2018, there were 42 deaths (case-fatality proportion <1.0%). No deaths were reported in week 17.
- In week 17, two (one probable and one suspected) case-patients were reported from the host community, bringing the total to 56 case-patients (84 case-patients were excluded after laboratory result came negative) since week 49, 2017. Among the host community 19 case-patients were laboratory confirmed, 27 were probable and 10 were suspected. No deaths have been reported within the host community.

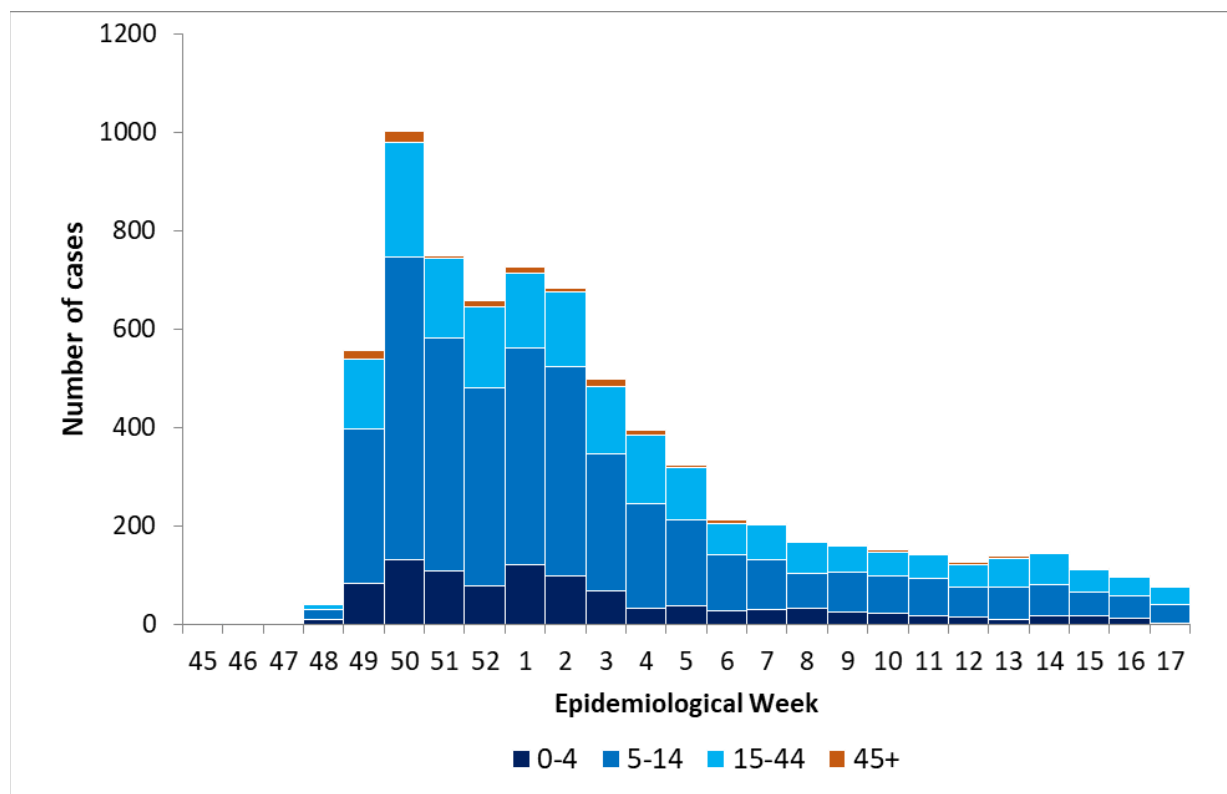


Figure 1: Epidemic curve of diphtheria cases by age groups, W50 2017 to W16 2018, Cox's Bazar

VACCINATION CAMPAIGNS AND ROUTINE IMMUNIZATION

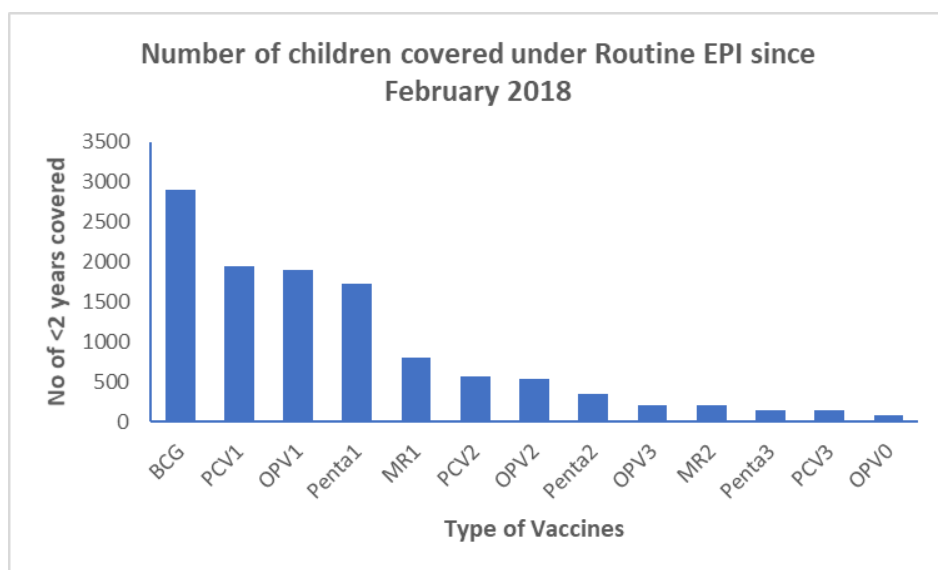


Figure2: EPI Routine vaccination

To sustain the efforts started by Bangladesh government eight months ago in carrying out vaccination campaigns within the Rohingya community, WHO established 25 fixed Routine EPI sites in February 2018. 672 Outreach EPI sessions were prepared in March to ensure that every new born baby was reached. Vaccinations through these sessions has commenced in Teknaf and will be implemented in Ukhiya in two weeks' time.

WATER QUALITY SURVEILLANCE ANALYSIS (APRIL 2018)

- The analysis revealed that water from 42% of sources and 32% of households are at low risk requiring no immediate action. Around 8% of the sources and 13% of the households are at high risk necessitating urgent remedial action.
- The fourth round of water quality survey in comparison to previous rounds further revealed that the safe water coverage in terms of *E. Coli* contamination at household's storage water and source is improving. Improvement of sanitary condition of at source and households' storage is also improving. The water quality surveillance risks of all settlements at source level and at household level is decreasing.

E. Coli contamination of Water Source and Household

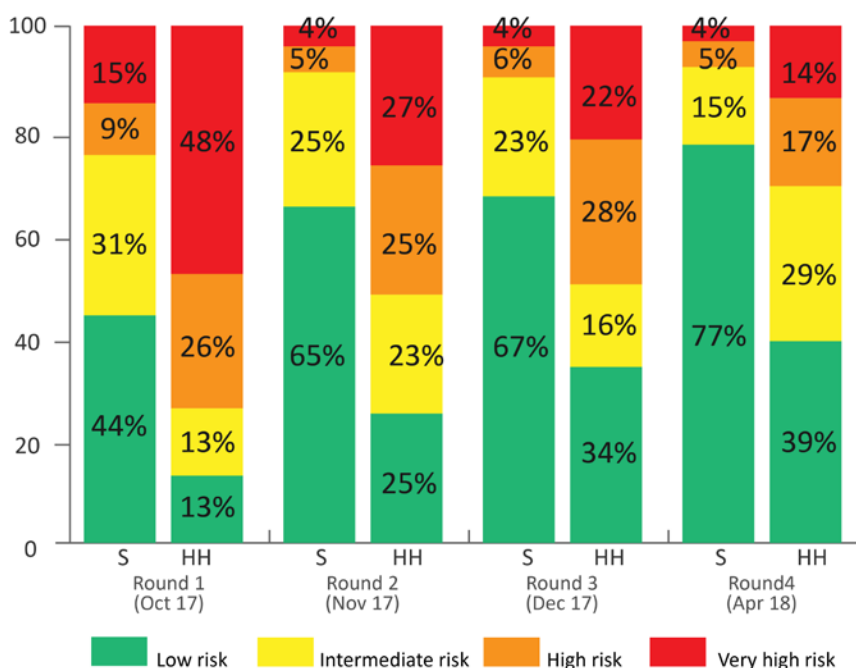


Figure 3: Results of water quality surveillance

HEALTH OPERATIONS

- The health systems strengthening mission from WCO was in Cox's Bazar to review the immediate needs on health systems strengthening and initiated support on the areas of blood safety, referral mechanism, infection prevention-control, community health services and performance targets. The mission proposed several recommendations on the above areas including standardizing the quality of services and reducing potential health related hazards.
- The MHPSS 4W's data verification has been completed, mapping will be finalized and shared with the partners and other stakeholders.
- WHO continued to co-train Rohingya community health workers and health worker supervisors in both diphtheria symptoms/prevention/treatment, and in deeper participatory communication in their communities on health issues before, during and after weather emergencies. More than 100 Rohingya community health workers in Kutupalong camp who are affiliated with UNHCR and its partners have received training. Hundreds more will be trained over the next few weeks.
- The IEDCR Laboratory at the Medical College in Cox Bazar, is partially functional with the diphtheria testing capacity of up to 40 specimens per day. The diphtheria molecular testing is carried out with essential quality control to ensure the quality of results. The total turnaround time for the diphtheria testing and communication is targeted to be 48hours.
- As part of monsoon preparedness, the second phase of malaria training on RDTs is scheduled in the following week. The Revised National Treatment Regimen for malaria was disseminated to the partner organization that took part in the malaria training on 21 April 2018.

LOGISTICS

- Local procurement for air conditioners was prioritized, to upgrade the prepositioned containers to cold storage in the camps. The air conditioners should be fitted this week and prepositioned stocks loaded by next week. WHO will pre-position 20 Cholera drug kits and 10 cholera renewable kits in Kutupalong on 3 May.
- Local procurement of the final laboratory items to ensure the Medical College Laboratory is fully operational by 10 May was prioritised this week. Diphtheria specimens are now being analysed at the CXB lab.
- WHO is on standby to provide a tent to the first operational Mobile Medical Team for a possible static health facility in Camp 20. This will help provide more accessible health services to newly relocated Rohingya people within the camp. WHO logistics will assist to transport and provide guidance on assembly of the tent.
- Logistics is assisting to develop Infection Prevention and Control (IPC) training for health workers and will assist in the delivery of the training in the coming weeks.

COORDINATION

- The health sector is putting in place three levels of coordination. For this purpose, camp-level focal points are being assigned to ensure coordination and overview of the health sector emergency response per camp, under the guidance of the Health Sector Field Coordinator. Selection of these camp-level focal agencies is being finalized; and training is planned.
- The health sector is developing standard operating procedures for referrals (ongoing). A proposal for a centralized referral and ambulance dispatch unit is being discussed to facilitate both ambulance and mobile medical team dispatch. This is envisaged to operate throughout the monsoon season and will facilitate easy scale-up when required.
- WHO will be undertaking a project to address Sexual and Reproductive Health (SRH) through the Global Health Cluster. This is supported by the Dutch government as part of a multi-country project. Focus is on

procurement, capacity building and data management. Experts from WHO Headquarters will visit Cox's Bazar this week.

- A project to strengthen the capacity of the Health Sector and WHO's Emergency Work to address Gender-Based Violence (GBV) is planned to commence in May. The main objectives of this project are to enhance the capacity of the health sector/health care providers to deliver essential services to survivors/victims of GBV in crises (including survivors/victims amongst refugees), and to enhance prevention of GBV. Experts from WHO Headquarters will visit Cox's Bazar this week.
- Key indicators for feasible monitoring and evaluation of the response process and its outcomes and impacts are being refined. These include elements to examine coordination, information flow and implementation of plans as well as response outcomes and humanitarian impacts. This is to inform continued effective and efficient decision making. The health sector is working in collaboration with the DGHS to access data to evaluate levels of health and clinical services provided in order to ensure at least minimum standards of care are delivered and there is no negative impact on the host community.

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