







PHOTO: Given the increase of COVID-19 positive cases in the refugee camps and surrounding communities, a circular note dated 23 May 2021 was sent by the Civil Surgeon Office to Health Sector partners for the activation of the stand-by beds in the Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs). In the picture, health care workers at the UNICEF/icddr, b SARI ITC in Teknaf.

HIGHLIGHTS

- In coordination with Civil Surgeon's Office, WHO and Health Sector partners are working on the reactivation of stand-by SARI ITC beds to respond the increase trend of confirmed COVID-19 cases among the host community and the Rohingya population.
- With funding from the World Bank, WHO initiated efforts to establish blood banks and transfusion centers in all Upazila Health Complexes in Cox's Bazar.
- As part of Government and WHO efforts to institutionalize IPC in camps, a total of 119 (87%) health facilities (91 HPs, 27 PHCC and 1 FH) have reported the creation of IPC structures which include IPC focal persons for health posts and IPC committees and focal persons for the primary healthcare centres and the field hospitals.
- On 10th and 11th May, with the coordination support from WHO and Health Sector, 90 medical doctors from SARI ITCs and ICU/HDU at Cox's Bazar District Sadar Hospital joined the 2nd and 3rd batch of a national level online training on Updated Management and Treatment Protocol for COVID-19 arranged by the Bangladesh Doctors Foundation.
- **SUBJECT IN FOCUS:** Menstrual Hygiene Management in the Rohingya Refugee Camps.

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	8 763	1 013
 Total cases in isolation in Cox's Bazar	332	325
 Total number of tests conducted	89 039	42 483
 Total deaths due to COVID-19	95	16

WHO, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC) continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the COVID-19 emergency.

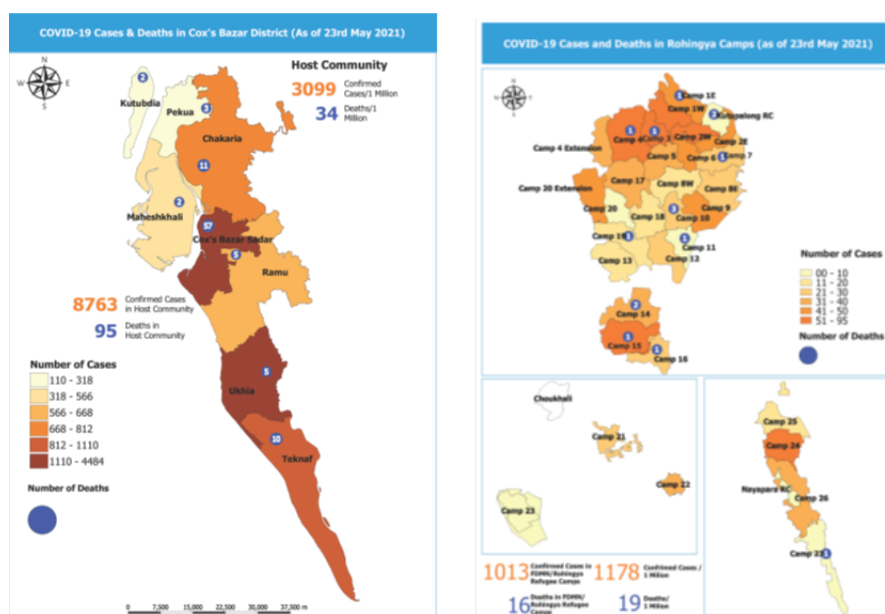
During the reporting period, Health Sector Coordination Team has analyzed the data obtained through the Quarterly Monitoring (Q1/2021) of Health Posts (HP) and Primary Health Care Centers (PHCs) in the Rohingya Refugee camps. Camp-wise analysis depicting the performance of each health facility against different indicators from the Minimal Package of Essential Health Services has been shared with the respective Camp-in-Charges (CiCs). Following the results dissemination, WHO and partners agreed to reinforce coherent quarterly quality assessments to ensure timely response to any flagged issues.

WHO and IOM, as co-chairs of the Emergency Preparedness and Response Technical Committee have completed the After-Action Review of the Mobile Medical Teams (MMTs) emergency response during the major fire occurred on 22nd March 2021. A plenary discussion session on overarching strategic issues has been scheduled in the coming weeks with the Emergency Preparedness and Response Technical Working Group (EPR TWG).

Meanwhile, all the damaged or destroyed health facilities in fire affected camps have resumed essential health services to a large extent, including the delivery of emergency health services in the Turkish Field Hospital. Integration of nutrition and health services in these health facilities remains a priority for the Health Sector. In addition, Health Sector is following up on funds for the reconstruction in the camp-level facilities.

During the past weeks, Health Sector led by WHO, has been closely monitoring the increase of COVID-19 positive cases in Cox's Bazar. The recent surge of COVID-19 cases has resulted in increased admissions to the Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs) in the district. In coordination with Civil Surgeon's Office, the Health Sector in Cox's Bazar is working on the reactivation of stand-by SARI ITC beds to respond the increasing trend of cases among the host community and the Rohingya population. This crucial action will enhance COVID-19 preparedness and response by increasing capacity for clinical case management.

Efforts to increase field level coordination has been curtailed in some camps due to additional lockdown and restriction measure enforced by the local authorities. Additionally, the final reviews of the Mass Casualty Management Plan and the COVID-19 Action Plan 2021 are ongoing.



SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION

WHO continues to provide epidemiological data to support operational decision making for the COVID-19 response in Cox's Bazar. As of 23 May 2021, a total of 8763 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 754 in Chokoria, 110 in Kutubdia, 559 in Moheshkhali, 270 in Pekua, 581 in Ramu, 4484 in Sadar, 841 in Teknaf and 1164 in Ukhiya.

While the overall positivity of the samples tested in the district is 9.8%, an increasing trend in the positive cases among the host community has been observed in the past few weeks. In week 20, 432 cases tested positive, with a test positivity rate of 11.5%, in comparison with week 18 when 333 positive cases were registered. Most cases have been reported in the municipality and Sadar Upazila area, with a 2-fold rise of new cases contributed by the other upazilas collectively in the district. Case distribution by age and sex remains similar to 2020. To date, a total of 95 deaths have been reported in the host community, with a case fatality ratio of 1.0%.

A significant increase in number of confirmed COVID-18 cases has been registered among the Rohingya refugee population in the last weeks, from 96 positive cases registered in week 18 to 247 cases in week 20. As of 23 May 2021, a total of 1013 COVID-19 cases have been

reported among Rohingya/FDMN. With a total of 91 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 89, camp 4 reported 80 cases and Camps 3 and 15 with 70 cases, respectively. To date, 66 cases have been reported from Camp 2W, 50 from Camp 1E and 46 from Camp 2E, 43 and 42 from camp 6 and camp 20 Ext. Camps 13, 14, 16, 17, 18, 19, 20, Nayapara Registered Camp (NRC), 21, 22, 23, 25, 26, and 27 have so far had less than 30 cases.

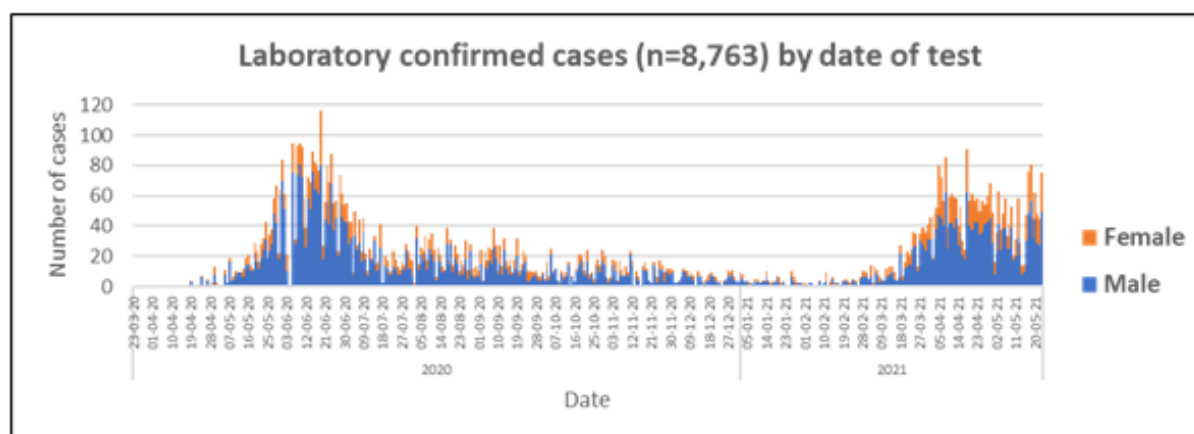


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

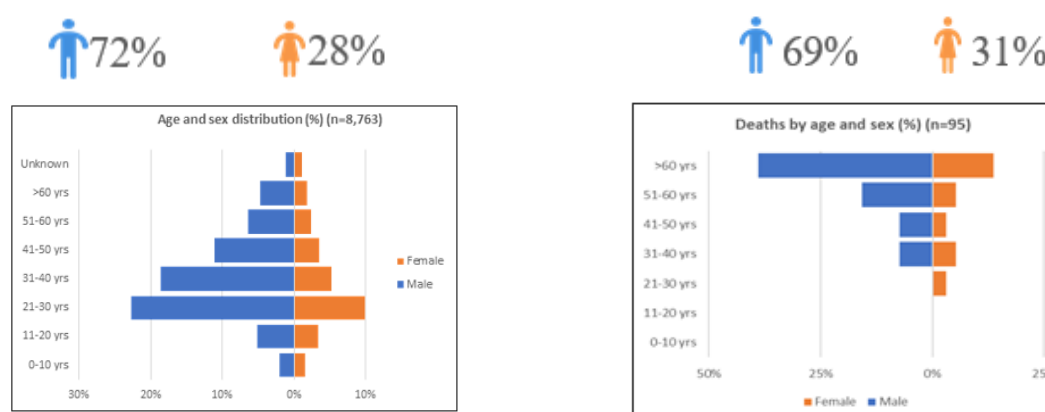


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

In response to the recent increase in number of cases among the host community and refugee populations, the Government of Bangladesh and the Office of the Refugee Relief and Repatriation Commissioner (RCCC) in Cox's Bazar have imposed movement restrictions and other mitigation measures in district and camp areas. Additionally, to enhance SARI ITC preparedness and response the Civil Surgeon office in Cox's Bazar issued a directive to activate the SARI ITC stand-by beds.

Currently, 478 general isolation beds are functional in 12 Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centers (ITCs) with provision of oxygen to assist both the Rohingya refugee population and the nearby host communities of Cox's Bazar. The current bed occupancy of these SARI ITCs is 69% at the end of the reporting period.

Moreover, the capacity of general isolation beds in the district is 418. The Intensive Care Unit/High Dependency Unit (ICU/HDU) at the Cox's Bazar Sadar Hospital has a capacity of 38 beds for severe and critical patients. During the past three weeks, a considerable increase in the bed occupancy has been observed, indicating the increased demand of hospitalization due to severe disease presentation at admission.

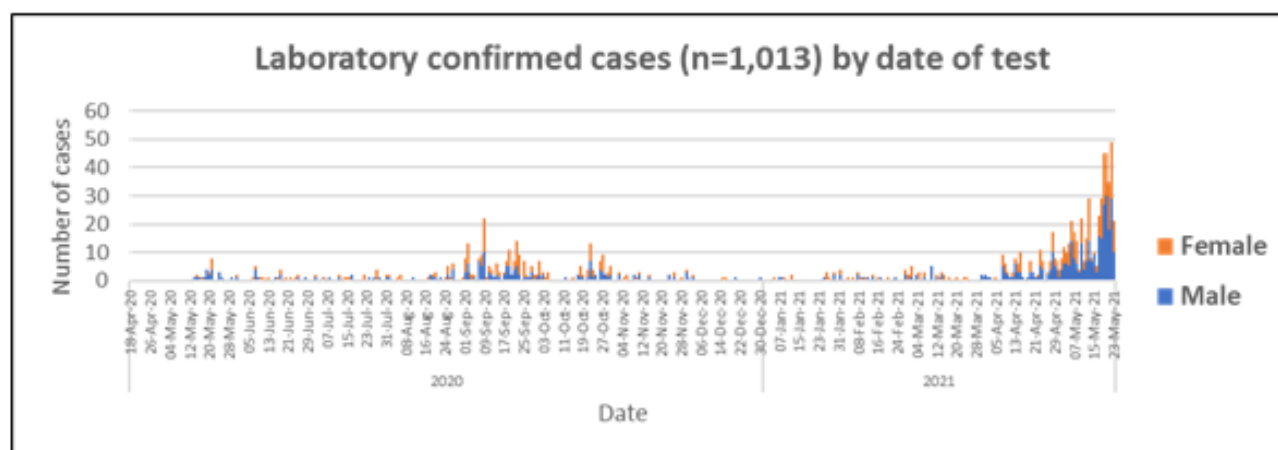


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

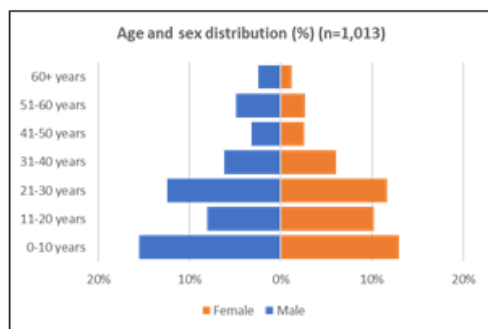
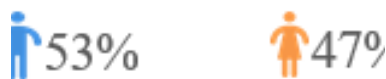


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

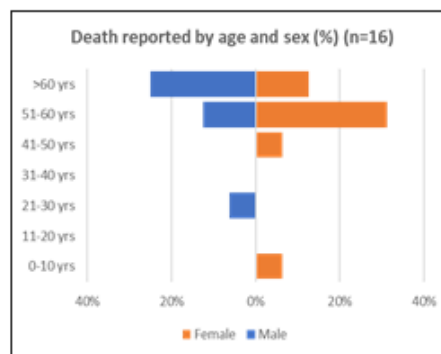


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Between weeks 19-20, 343 new confirmed cases were detected from 2,484 samples tested, the test positivity was therefore 13.8%. As of 23 May 2021, the cumulative incidence is 117.8 per 100 000 people. The overall positivity of samples tested is 2.3%. Among the cases, 3.2% showed severe symptoms at the time of admission while 5.7% reported at least one co-morbidity. The median age of tested and confirmed cases was not changed 10 (0-120) & 20 (0-90) years, respectively and ratio of females among tested and confirmed cases was 54% and 47%, respectively. Though the median age of tested samples remained below 10 years, a significant proportion has been tested among 50+ years: 584 per 10 000 population, following that of 0-9 years with 727 tests per 10 000 population as highest number. The test positivity was highest 4.3% in 30-39 years age cohort and the age specific mortality 1.17 per 10 000 population observed among 40+ years during the period. In total, and since the outbreak began, 16 deaths due to confirmed COVID-19 have been reported in the camps with a case fatality ratio of 1.5%.

A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) has been embedded in the Rapid Investigation and Response Teams (RIRTs) for COVID-19. A total of 777 confirmed cases (out of 1013 to date) have been investigated by RIRTs by 23 May, with contact tracing activities being conducted and captured through Go.data, including the 2364 contacts to be followed up. Out of these, 1758 (74%) contacts have seen their follow up visits completed and were released from quarantine. Fifty-three (3.0%) tested positive cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

Thirteen (13) Rapid Diagnostic Test (RDT) positive cases for Acute Water Diarrhea (AWD) were reported in the reporting period. The total number of cases reported so far is 39 in 2021: twenty-two (22) from the refugee camps and seventeen (17) from host communities. Out of these, nine (09) were culture confirmed, twenty-one (21) tested negative by culture and remaining nine (09) culture results are awaited. In 2020, a total of 28 RDT positive cases for Cholera were detected through sentinel testing, five (05) of which were confirmed by culture - two from Ukhiya host community, one from Teknaf host community and two from the refugee camps. It is important to note that a Cholera outbreak occurred in late 2019 with a reported number of 239 RDT/culture positive cases and in response a mass Oral Cholera Vaccine (OCV) vaccination campaign was conducted with over 160 000 children of 1-<5 years being vaccinated with a 2- doses regimen.

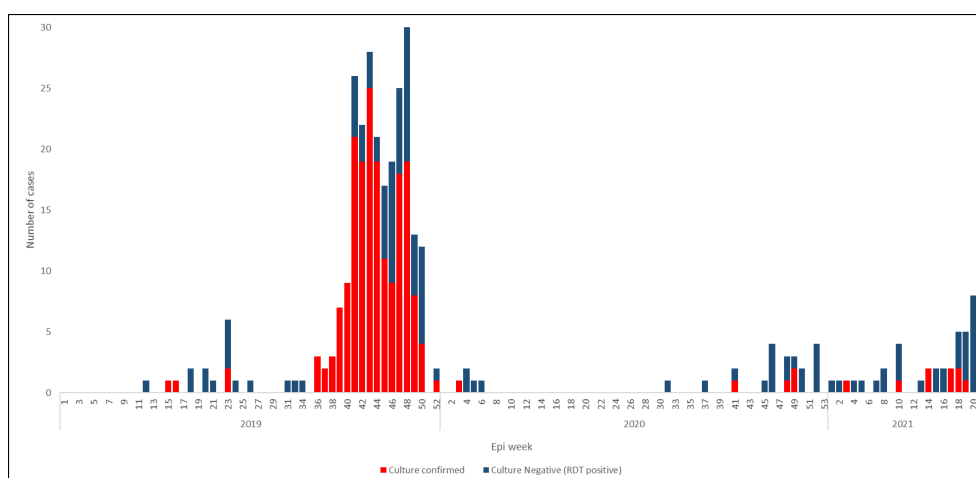


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9274 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 88 as of week 20, 2021). In total, 9029 cases were reported in the camps and 245 from the host community, with 47 deaths registered in the refugee camps and none in the host community. While the first Diphtheria case was detected on 10 November 2017, the first death occurred on 29 December 2017 and the last death on 25 October 2019.

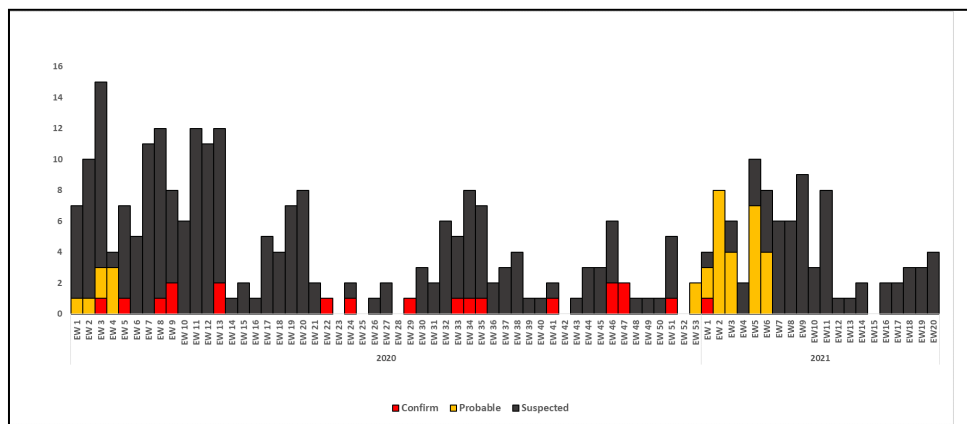


Figure 8: Total number of diphtheria case reported in EWARS from 2020—2021

In week 19-20, five (05) suspected Severe Acute Respiratory Infection (SARI) death were reported. In total 49 deaths have been reported in 2021. All deaths have been investigated by RIRT as a part of COVID-19. Eight (08) deaths have been reclassified as COVID-19 probable death cause. In 2020, a total 49 suspected SARI deaths were reported through community-based mortality surveillance. Of these, all were verified and two (02) considered probable. During the reporting period, one (01) new probable maternal death has been reported. In total 44 probable maternal/deaths of women of reproductive age (WRA,12-49 years) have been reported in 2021, of which eleven (11) deaths have been reported from facilities and directly undergone review by Maternal and Perinatal Mortality Surveillance and Response (MPMSR). Investigation of mortality due to suspected potential infectious causes i.e. SARI, Measles, Cholera, Diphtheria etc. is ongoing in the camps along with death due to maternal causes as high priority.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

WHO is engaging communities, health partners and other key stakeholders to develop, implement and monitor an action plan to effectively help prepare populations and protect them from COVID-19. Mixed-media messages include general information on COVID-19, hand washing, physical distancing and mask wearing, risks and vulnerabilities, safe and dignified burials, quarantine, isolation, and treatment centres, among others. Through its involvement in the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), WHO continues to coordinate with agencies across the response to ensure that all information around COVID-19 and health issues are of high quality, technically correct and easily understandable by communities.

During the reporting period, RCCE WG and WHO finalized the development of public health messages on the COVID-19 variants and mutations to be disseminated among health care professionals and humanitarian workers. In addition, Information and Education and Communication (IEC) materials on COVID-19 awareness during Eid-ul Fitr were finalized and disseminated among partners. Topics such as COVID-19 sample collection and testing, isolation, quarantine process, psychosocial support, Infection Prevention and Control and safe religious practices during the Holy Month of Ramadan, among others, were covered to raise awareness among the Rohingya population and adjacent host communities. Similarly, technical inputs were provided for the preparation of Public Service Announcements (PSAs) on COVID-19 vaccinations developed by BBC Media Action. During the reporting period WHO and UNHCR also prepared a concept note on minor invasive procedures which will be submitted for approval in the coming days.

WHO and UNICEF continue providing English and Bangla versions of the weekly radio script on COVID-19 confirmed cases and number of tests conducted among refugee and host communities. These messages were shared with partners to be widely disseminated among the Rohingya community through radio broadcasting.

During the reporting period CHWs conducted 252 020 household visits in which 4 179 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 69 patients with moderate/severe symptoms. The cumulative number of patients with mild symptoms is 138 272, and 674 patients with moderate/ severe symptoms. To date, 70 017 persons with COVID-19 like symptoms have been referred to health facilities, 2921 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 492 386 persons between weeks 19 and 20. Since the beginning of the response, CHWs have conducted more than 7.7 million household visits and had a cumulative number of more than 19.5 million contacts with adult household members. Through the CwC WG, 60 506 people were engaged in 22 517 small group sessions.

DISTRICT LABORATORY

WHO continues its support to the Institute of Epidemiology, Disease Control and Research (IEDCR) Field Laboratory at the Cox's Bazar Medical College comprising human resources, equipment, supplies/consumables and technical and operational expertise.

Between early April 2020 and 23 May 2021, a total of 149 223 tests for COVID-19 have been conducted of which 131 522 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A sharp increase in the number of tests conducted among the Rohingya refugees was observed in weeks 18-19 as compared to weeks 17-18, from 2484 to 2332 tests. However, among the host com-

munity a slight increase was tested: from 4892 tests in weeks 16-17 to 5290 tests in week 19-20. Currently, 33 sample collection sites are operating for suspected COVID-19 patients.

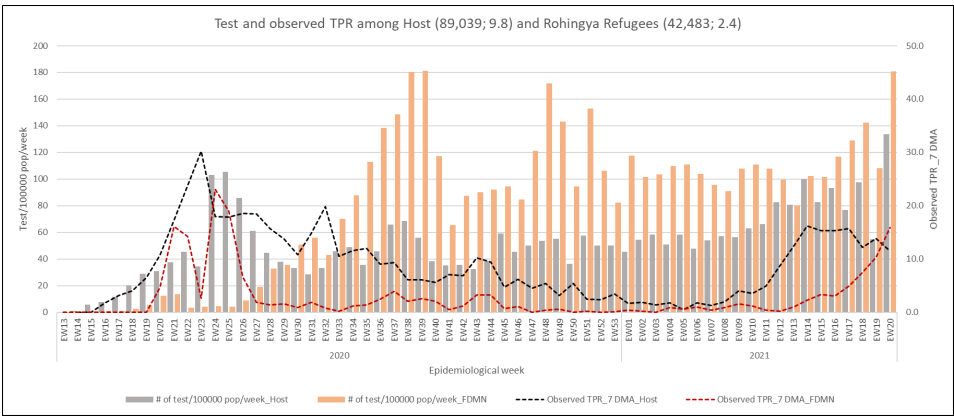


Figure 9: Number of tests conducted per million among the host population and the Rohingya refugees/FDMN

*The Government of Bangladesh refers to Rohingya as “Forcibly Displaced Myanmar Nationals”. The UN system refers to this population as Rohingya refugees, in line with the applicable international framework. In this document both terms are used, as appropriate, to refer to the same population.

INFECTION PREVENTION AND CONTROL

To enhance preparedness for COVID-19 in Cox’s Bazar, WHO has been training healthcare workers on Infection, Prevention and Control (IPC) from Severe Acute Respiratory Infection (SARI) ITC partners and Government facilities. To date, training for Infection, Prevention and Control (IPC) has been provided to 2 390 humanitarian health care workers and government staff from Severe Acute Respiratory Infection (SARI) ITC partners and government facilities.

The formation of IPC structures at the health care facilities is currently ongoing as part of efforts to institutionalize IPC in camps. Currently a total of 119 (87%) health facilities (91 HPs, 27 PHCC and 1 FH) have reported the creation of IPC structures which include IPC focal persons for health posts and IPC committees and focal persons for the primary healthcare centers and the field hospitals. The IPC focal persons and committees will play a pivotal role in planning for IPC activities as well as daily oversight of implementation of IPC in their facilities.

CLINICAL CASE MANAGEMENT

Since the onset of the outbreak, WHO is coordinating regular weekly Operational, Clinical and Critical care online forums; each with a multidisciplinary panel of health care providers with experience in the clinical management of patients with COVID-19 and other viral infections to foster peer to peer support and knowledge exchange. With the guidance provided by WHO experts, the initiative is serving as a foundation for optimized clinical care to ensure the best possible outcome for patients in Cox’s Bazar.

During the reporting period, one working group meeting along with one case conference for SARI ITCs and two case conferences for ICU were conducted. As of 23 May 2021, there are 12 operational SARI ITCs in the camps with a total of 478 functional beds open and 415 on stand by. The SARI ITC bed occupancy is currently 68%. At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 8 beds and the Severe Care Unit (SCU) 20 beds functional beds. At the moment, 25 beds are occupied.

On 10th and 11th May, with the coordination support from WHO and Health Sector, 90 medical doctors from SARI ITCs and ICU/HDU at Cox’s Bazar District Sadar Hospital joined the 2nd and 3rd batch of a national level online training on Updated Management and Treatment Protocol for COVID-19 arranged by the Bangladesh Doctors Foundation. Members of the COVID-19 Clinical Management & Guidelines Preparation Committee shared their latest technical knowledge during the training and their clinical experience in the implementation of national guidelines of COVID-19 in hospital settings in Bangladesh.

ESSENTIAL HEALTH SERVICES

Ensuring the provision of essential health services remains a priority in Cox’s Bazar. Under the coordination of WHO and the Civil Surgeon, Cox’s Bazar, the Health Sector is providing health care to nearly 890 000 Rohingya refugees and 472 000 Bangladeshi living in the surrounding areas of the refugee camps. The health facilities run by Health Sector partners to provide services to the population include 38 primary health care centers (PHCs), 97 Health Posts (HPs), 23 special facilities and three field hospitals.

WHO and Health Sector partners continue supporting the Government of Bangladesh (GoB) in the preparation of the COVID-19 vaccination campaign for the Rohingya community, scheduled to start in the coming weeks, pending the revised arrival date of the allocation of



Photo: Dr Abu Toha M.R.H Bhuiyan, Health Coordinator of RRRC office visited the IOM SARI ITC in Camp 20 Ext as part of WHO and Health Sector rapid assessment of COVID-19 treatment centers in the refugee camps

vaccines from the COVAX facility for Bangladesh. COVAX is a global initiative aimed at equitable procurement and distribution of COVID-19 vaccines led by WHO, Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations.

WHO Immunization and Vaccine Development (IVD) team designed a community preparedness assessment tool to measure the awareness of Rohingya refugees regarding the upcoming COVID-19 vaccination campaign in the camps. This tool will help the Government and partners better implement the risk communications strategy in the field to encourage vaccinations and ensure that no one is left behind. An extensive communication and engagement campaign involving key community members and religious leaders is currently ongoing in all the camps to raise confidence and acceptance among the Rohingya refugees. Through a multi-channel strategy which includes community radio, interpersonal communication and digital media, WHO is tracking vaccine hesitancy and rumors in the field and promotes community mobilization.

Despite the lockdown situation in Cox's Bazar, routine immunization (RI) sessions continue, both fixed and outreach, with WHO's guidance on the operation and sustaining of immunization programs during the COVID-19 pandemic, and a revised strategy and microplan having been reviewed by Government with technical assistance from WHO and other partners based on data collected in 2020. Currently, 59 health facilities are working as immunization fixed sites and another 66 vaccination teams are conducting outreach sessions both in community and healthcare facilities. During the reporting period, the Immunization and Vaccine Development (IVD) team continues monitoring and following up with children who missed their vaccines at the healthcare facilities. WHO is continuously monitoring Acute Flaccid Paralysis (AFP) and vaccine-preventable diseases (VPDs) despite the lockdown.

With funding from the World Bank, WHO initiated efforts to establish blood banks and transfusion centers in all Upazila Health Complexes in Cox's Bazar as part of the wider effort to increase availability of blood and lifesaving commodities when dealing with shock due to excess bleeding, obstetric hemorrhages during childbirth and other conditions. An initial assessment has been conducted to identify gaps and requirements in order to establish and operationalize the blood banks. Obtained data is currently under analysis for subsequent intervention.

As part of the Non-communicable Diseases (NCDs) program, WHO is supporting the Government to enhance the accessibility to reliable information on NCDs and quality of care for people diagnosed with any Non-communicable Diseases, such as hypertension or diabetes. During the reporting period, a total of 8033 patients from the Rohingya refugee camps and adjacent host communities of Ukhiya and Teknaf Upazila consulted for medical care with Non-communicable Diseases (NCDs) and reported through DHIS-2. Out of the total patients, 34% had or were newly diagnosed with diabetes mellitus and 31% with hypertension.

MONSOON AND CYCLONE PREPAREDNESS

The Health Sector, with respective working groups and partners regularly updates its contingency plan for cyclone (March-June) and monsoon (September-November) seasons. Information related to health facility functionality, contingency supplies and locations, mobile medical teams (MMT), ambulance network systems to respond to emergencies, and the list of camp health focal points is maintained and updated regularly.

During the reporting period, WHO and IOM, as co-chairs of the Emergency Preparedness and Response Technical Committee continue with the After-Action Review for the major fire that occurred in the camps on 22nd March 2021 in order to assess the Mobile Medical Teams (MMTs) emergency response. In weeks 17-18, several interviews of MMT members deployed during the incident were conducted. Based on these key informant interviews, WHO and IOM have prepared an assessment report capturing best practices and lessons learnt and a plenary discussion on the overarching strategic issues with the Emergency Preparedness and Response Technical Working Group (EPR TWG) has been scheduled for the coming weeks. This After-Action Review will help the standardization of future response interventions and it serves to remap the MMTs' intervention areas, so that interested new partners can join for better coverage and response. Capacity building activities will be organized in the next few weeks to capacitate the new and existing MMTs on response procedures based on the learnings from the After-Action Review.

Additionally, the Health Sector Emergency Preparedness and Response Technical Committee maintained regular communication with the EPR TWG in preparation for the cyclone Yass expected in the coming weeks. WHO has stockpiled Inter Agency Emergency Health Kits (IEHK) and Trauma and Emergency Surgery (TESK) kits at strategic points in and around the camp to support any after cyclone health response in coordination with relevant authorities.

WHO continues to ensure timely provision of quality and adequate supplies, equipment and consumables for the health emergency operations in Cox's Bazar.

To reinforce the public health response to COVID-19, WHO supported partners in Cox's Bazar, including the Refugee Relief and Repatriation Commissioner office (RRRC), Gonoshstha Kendra (GK), Médecins Sans Frontières (MSF) and Research, Training and Management (RTM) International with the delivery of 16 600 Personal Protective Equipment (PPE) items, including isolation gowns, gloves, boots, face shields and surgical masks.

During the reporting period, a total of 2.6 MT total volume 12.19 Cubic meters of medicines and supplies were deployed to Cox's Bazar including medicines, PPE and sample collection kits for the diagnosis of COVID-19. WHO continues its logistic support to the IEDCR Field Laboratory with two vehicles providing transportation of COVID-19 sample collection in the camps. Further to this, WHO in Cox's Bazar provided operation support to the IEDCR Field Laboratory to install two-biosafety cabinets.

SUBJECT IN FOCUS: Menstrual Hygiene Management (MHM) in the Rohingya Refugee Camps

Hundreds of millions of girls and women around the world are menstruating, yet a substantial proportion of them lack the knowledge and the means to manage their menstrual health safely and with dignity, the result of gender inequality, cultural taboos, poverty, and a lack of basic sanitation and hygiene.

Context

In the refugee camps in Cox's Bazar, menstrual hygiene is a personal topic and often women and girls do not want to share their experiences with others. Taboos and stigma regarding menstruation is common in the Rohingya setting, having an impact in the daily life of the female refugee populations and limiting their access to information on Menstrual Hygiene Management (MHM).

According to the Government of Bangladesh and UNHCR, women of reproductive age represent around the 31% of the whole refugee population in the Rohingya refugee camps. Cultural beliefs regarding menstruation are largely reported in the Rohingya camps. Both women and men consider monthly periods to be an illness and menstruating women to be dirty. These stigmatizing beliefs often lead to women being isolated during the onset of menarche and limiting their access to public spaces.

Lack of access to basic hygiene product has also lead women in the refugee camps to use unhygienic materials leading to an increased risk of reproductive and urinary infections. Further to this, lack of adapted and MHM responsive sanitation designs are an obstacle in promoting good MHM behavior. When it comes to disposal of menstrual materials, women do not have many choices to dispose used pads or cloths in a safe a dignified way.

Menstrual Hygiene Management (MHM) in the Rohingya Refugee Camps

Menstrual Hygiene Management (MHM) refers to access to menstrual hygiene products to absorb or collect the flow of blood during menstruation, privacy to change the materials, and access to facilities to dispose of used menstrual management materials.

MHM is a key area of intervention for WHO in Cox's Bazar to address the needs of the Rohingya women and girls in the camps, in partnership with other key partners such as UNFPA and UNICEF. Through the WASH Sector and the work of midwives, medical officers and Community Healthcare Workers (CHWs), among others, WHO and humanitarian partners implement a wide range of activities to raise awareness about Menstrual Hygiene Management (MHM) among the Rohingya population and create safe spaces for women and girls.



Photo: Midwives and Community Health Workers (CHWs) play an instrumental role raising awareness on Menstrual Hygiene Management among the Rohingya refugees.

MHM interventions by WASH actors have included distribution of menstrual hygiene materials and dissemination of information regarding menstrual hygiene through group awareness sessions. Additionally, there have been efforts to make latrines and bathing facilities MHM-friendly by providing washing platforms to hygienically wash menstrual items and inbuilt chutes (pipes) for disposal of used menstrual cloth and pads.

In this regard, the Water and Sanitation for Health Facility Improvement Tool (WASH FIT) developed by WHO and UNICEF includes an essential indicator on Menstrual Hygiene Management. This practical guide for improving quality of care through water, sanitation and hygiene in health care facilities states that “at least one toilet or improved latrine provides the means to manage menstrual hygiene needs” and that “toilets should have a bin for disposal of waste or an area for washing, with available water”.

The work of the midwives has become instrumental to break the silence and build awareness about the fundamental role that good menstrual hygiene plays in enabling women and girls to reach their full potential. Through appropriate counselling, midwives convey the community that periods need to be accepted as a normal biological occurrence, and not as an illness or shameful experience. WHO and key partners as UNFPA also developed flipcharts and other Information Education and Communication (IEC) materials to increase the access to trustful information. Additionally, the Rohingya Community Health Workers (CHWs) have played a fundamental role when it comes to community engagement through house-to-house visits. Distribution of menstrual hygiene materials in the healthcare facilities in the camps is also part of the WHO and partners’ intervention on MHM.

MHM in emergencies

In November 2020, the WASH Sector/Hygiene Promotion technical working group (HP TWiG) agreed on the fundamental need to add menstrual hygiene materials in the emergency kits distributed in case of cyclone, floods, fires, landslides and similar events, within the first 72 hours from the onset of the disaster, to affected population identified.

Training

In the complex setting of a refugee camp where resources are strained and institutional capacity is limited, women and girls face disproportionate impacts. Building the capacities of all individuals involved in the health emergency response in Cox’s Bazar has been a priority for WHO since the onset of the Rohingya humanitarian crisis. This vision was strengthened when the pandemic broke out in the refugee camps, with the aim of ensuring a safe place where women and girls can seek quality health services and to stop the cycle of violence.

WHO along with key partners such as UNFPA and UNICEF and in collaboration with technical working groups from protection, Gender, Gender-based Violence (GBV), Child protection and Protection from Sexual Exploitation and Abuse (PSEA) developed an orientation package on cross-cutting themes to accompany health sector trainings on COVID-19.



Photo: According to WASH FIT, health care facilities should establish at least one sex-separated toilet with menstrual hygiene facilities.



Photo: In 2020, 360 healthcare workers and partners received 8 training sessions on gender mainstreaming, PSEA, GBV, protection and child protection through the ISCG Gender Hub.

	Last 24 hours	Total
COVID-19 tests conducted	14 606	5 901 874
COVID-19 positive cases	1358	796 343
Number of people released/recovered	1064	736 221
COVID-19 deaths	31	12 511

WHO global situation report: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>

WHO interim guideline on Preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings: [https://www.who.int/publications-detail/preparedness-prevention-and-control-of-coronavirus-disease-\(covid-19\)-for-refugees-and-migrants-in-non-camp-settings](https://www.who.int/publications-detail/preparedness-prevention-and-control-of-coronavirus-disease-(covid-19)-for-refugees-and-migrants-in-non-camp-settings)

Institute of Epidemiology, Disease Control and Research (IEDCR) for COVID-19 updates in Bangladesh : <https://www.iedcr.gov.bd/>

COVID-19 Bangladesh situation reports: [https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update/coronavirus-disease-\(covid-2019\)-bangladesh-situation-reports](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/coronavirus-disease-(covid-2019)-bangladesh-situation-reports)

WHO Bangladesh awareness and risk communication materials in Bengali:
[https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update)

Previous issues of this Situation Report:
<https://www.who.int/bangladesh/emergencies/Rohingyacrisis/bulletin-and-reports>

COVID-19 Dashboard under WHO Cox's Bazar Data Hub can be accessed here: <https://cxb-epi.netlify.app/>

Write to coord_cxb@who.int to receive COVID-19 updates and situation reports from Cox's Bazar with the subject "Add me to the situation reports and updates mailing list"



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