World Health Organization
Bangladesh

Rohingya Crisis Situation Report #18

Date of issue: 17 September 2021

Weeks 35 - 36
30 Aug - 12 Sep 2021
Location: Cox's Bazar

On 16 September 2021, WHO and UN partner agencies met with the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MoHFW) to monitor the progress and achievements of the "Health Sector Support Project" (HSSP) funded by the Government of Bangladesh through the World Bank grant, and to discuss priorities for the upcoming period.

HIGHLIGHTS

- **Following the successful completion of the 1st round of the COVID-19 vaccination campaign on 10- 23 August 2021, the 2nd round will commence on 18 September 2021 for Rohingya refugees aged 55 years and above.**
- **The International Coordination Group (ICG) on Vaccine Provision has approved the Government of Bangladesh's application for a 02-dose Oral Cholera Vaccine (OCV) campaign for Rohingya refugees and nearby host population above 1 year (approximately 1.4 million) in Ukhia and Teknaf. The start date of the campaign is expected to be in October.**
- **On 6-9 September, WHO and IOM, as co-chairs of the Emergency Preparedness and Response Technical Committee in Cox's Bazar, conducted a 4-day training course on "Emergency & Trauma Care" to equip frontline health providers with basic trauma and surgical skills, as well as knowledge and understand of an effective incident command system for emergency response.**
- **SUBJECT IN FOCUS: Strengthening Noncommunicable Disease Prevention & Management in Humanitarian Settings - Reviewing the Cox's Bazar approach**

	Host Community	Rohingya refugees
Total confirmed COVID-19 cases in Cox's Bazar	16 974	2 975
Total cases in isolation in Cox's Bazar	78	153
Total number of tests conducted	137 891	61 366
Total deaths due to COVID-19	247	32

**Updated as of 12 September 2021* / *FDMN = Forcibly Displaced Myanmar Nationals

COORDINATION, PLANNING AND MONITORING

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

Following the successful completion of the 1st round of the COVID-19 vaccination campaign on 10- 23 August 2021, the 2nd round will commence on 18 September 2021 for Rohingya refugees aged 55 years and above.

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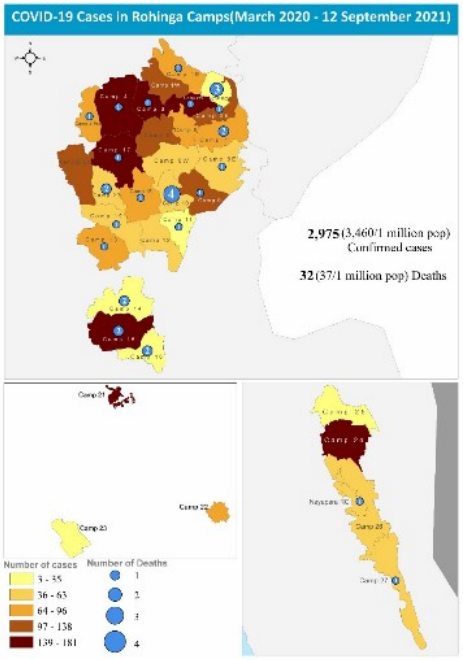
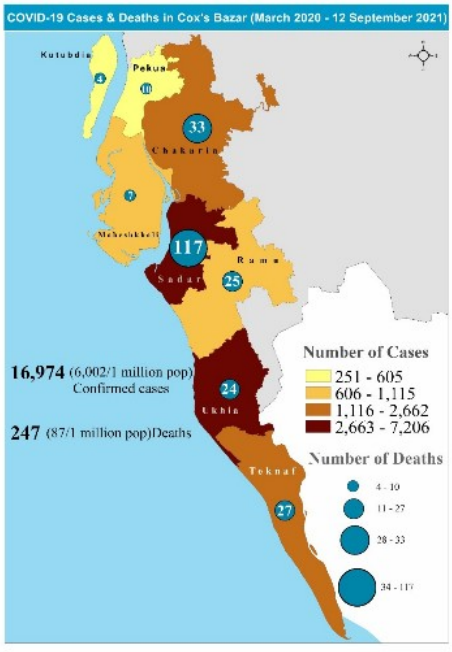
The Health Sector Strategic Advisory Group (SAG) has agreed to a General Health Card design taking into consideration all the inputs from different health partners. This person-specific card- a booklet recording individual Rohingya's formal consultation data- is awaiting final Government endorsement. As per the concurrence from the SAG members, this card will be piloted in 05 camps for more than 01 month, followed by a post-pilot assessment. The general roll-out for all the Rohingya refugees will depend on the analysis report.

At present, Community Health Workers (CHW) are undertaking active case finding for AWD, referring persons with symptoms, disseminating key health messages, and distributing ORS/Zinc in households reporting symptoms. In addition, enhanced surveillance is ongoing utilizing EWARS and 22 sentinel testing sites. In the field, Joint Assessment Team (JAT)s are investigating in and around the household of any Cholera case and ensuring necessary public health measures. At present, 72 active and 400 standby beds are dedicated to AWD management. A coordination meeting among Health, WASH & CwC actors takes place in quick succession.

The Quarterly Health Facility Monitoring (Q3/2021) is expected to be started by the end of September 2021. Health Sector is presently working on the comprehensiveness of assessment focusing on the Minimum Package of Essential Health Services (MPEHS).

During the reporting weeks, a total of 12 camp-level Health Sector Coordination Meetings were held (maintaining precautions against COVID-19). Strengthening Essential Health Services, COVID-19 and monsoon responses were discussed among the different working group partners. At present, the Health Sector Field Coordinators are conducting supportive supervision visits to the facilities whose quarterly assessment (Q2/2021) didn't reflect the minimum standard of service quality as guided by the Minimum Package of Essential Health Services (MPEHS). In addition, Rapid Investigation and Response Team (RIRT) coordination meetings are ongoing in the camps to strengthen the COVID-19 enhanced surveillance.





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 12 September 2021, a total of 16 974 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 1265 in Chokoria, 251 in Kutubdia, 1115 in Moheshkhali, 605 in Pekua, 993 in Ramu, 7206 in Sadar, 2662 in Teknaf and 2877 in Ukhiya.

While the overall positivity of samples tested in the district is 7.9%, a considerable decrease of positive cases has been observed among the host community in recent weeks. In week 36, 204 cases tested positive, with a test positivity rate of 7.9%, in comparison with week 34 when 329 positive cases were registered with a test positivity rate of 12.8%. To date, a total of 247 deaths have been reported in the host community, with a case fatality ratio of 1.4%.

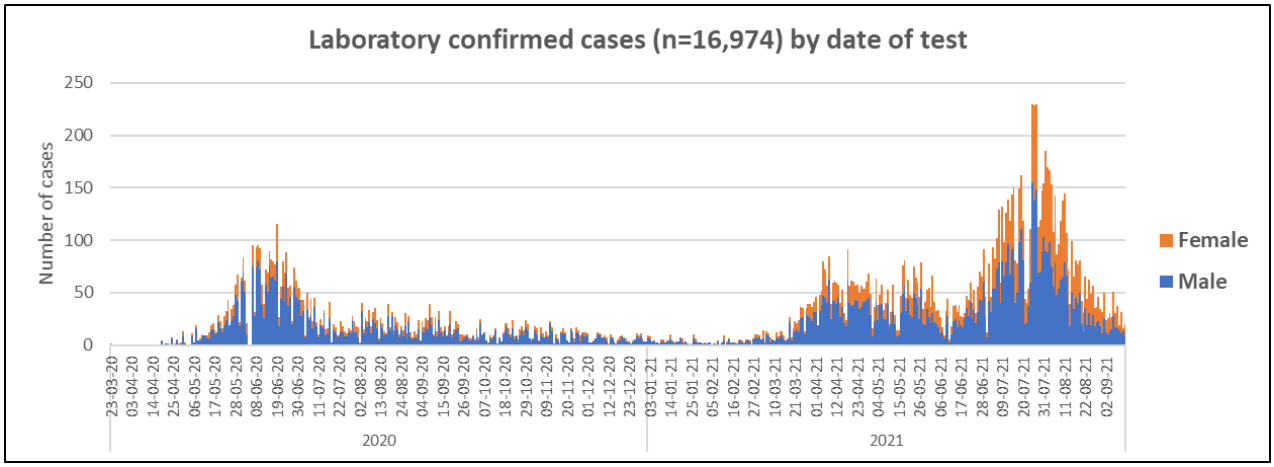


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

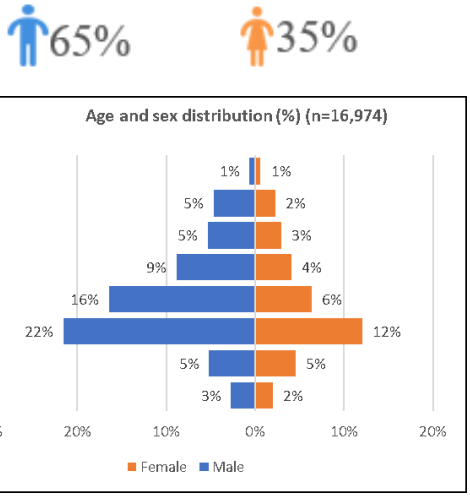


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

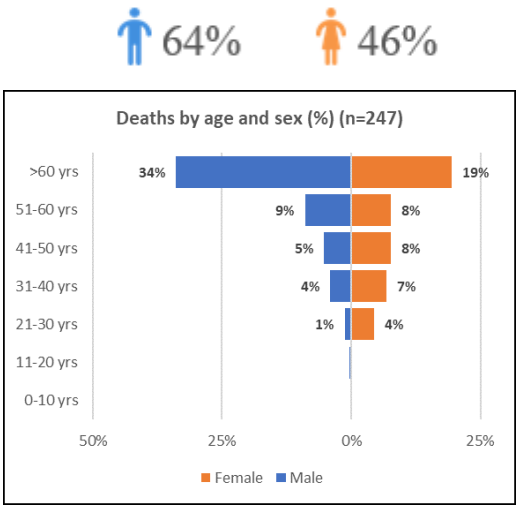


Figure 3: Age and sex distribution of COVID-19 deaths among host population in Cox's Bazar District

Among the Rohingya refugee population, the number of confirmed COVID-19 cases has also decreased in the past weeks. In week 36, a total of 53 positive cases were registered in the Rohingya refugee camps with a test positivity rate of 4.1%, in comparation to the 105 confirmed cases in week 34, with a test positivity rate 7.0%. As of 12 September 2021, a total of 2975 COVID-19 cases have been reported among the Rohingya population.

With a total of 181 cases, Camp 24 has the highest number of cases to date ahead of Camp 3 with 180 cases, Camp 2W with 164 cases, Camp 15 with 162 cases and Camp 21 with 161 cases. To date, 158 cases have been reported from Camp 158, 156 cases have been reported from Camp 4, 138 cases from Camp 1W and 125 cases from Camp 20 extension. In Camp 5 and 9, 112 cases have been registered. Camp 2E has 109 cases reported. Camp 1E, 4 Ext, 6, 7, 8E, 8W, 10, 11, 12, 13, 14, 16, 18, 19, 20, 22, 23, 25, 26, 27, Kutupalong RC and Nayapara RC so far had less than 100 cases. 7 cases have been registered from Zero Point and 5 amongst new arrivals.

Currently, 641 beds are functional in 13 Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs) in the camps with provision of oxygen to assist both the Rohingya refugee population and the nearby host communities of Cox's Bazar. The bed occupancy of these SARI ITCs is 45% at the end of the reporting period. Moreover, the capacity of general isolation beds in the district is 517. The Intensive Care Unit/High Dependency Unit (ICU/HDU) at the Cox's Bazar Sadar Hospital has a capacity of 43 beds for severe and critical patients.

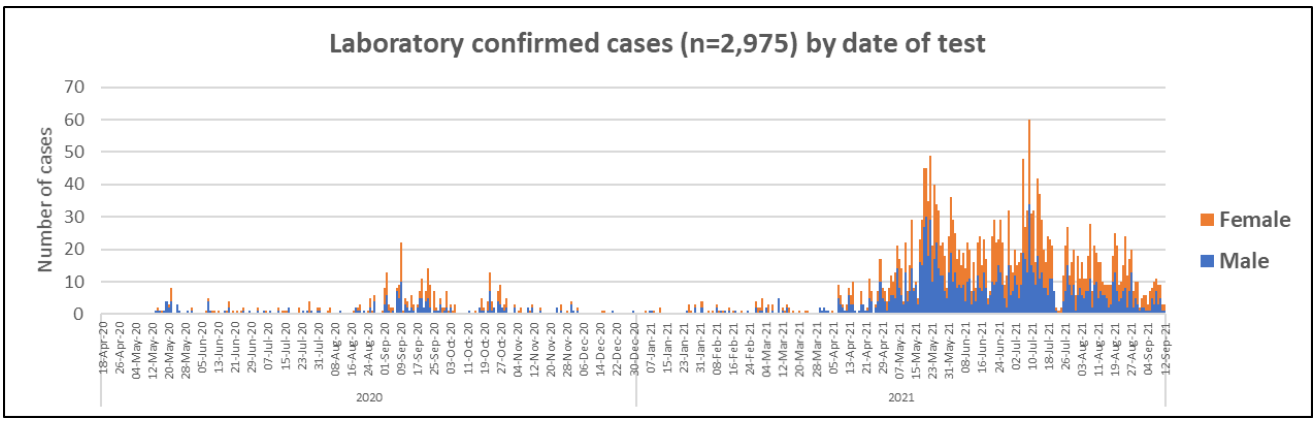


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

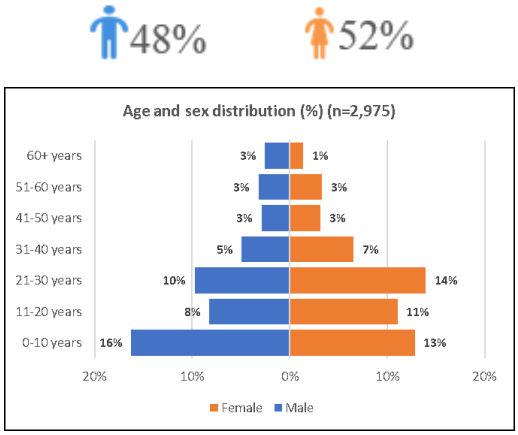


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

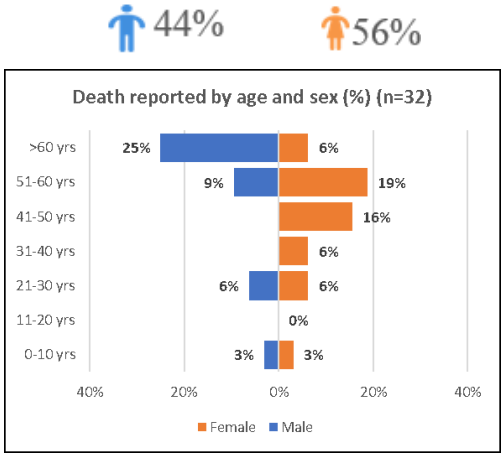


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Between weeks 35-36, 92 new confirmed cases were detected from 2 413 samples tested, the test positivity was therefore 4.1%. As of 12 September 2021, the cumulative incidence is 61.6 per 100 000 people. The overall positivity of samples tested is 4.8%. Among the cases, 1.8% showed severe symptoms at the time of admission while 4.3% reported at least one co-morbidity. The median age of tested and confirmed cases was 11 (0-120) & 21 (0-100) years, respectively and ratio of females among tested and confirmed cases was 54% and 52%, respectively. Though the median age of tested samples remained below 10 years, a significant proportion has been tested among 50+ years: 706 per 10 000 population, following that of 0-9 years with 867 tests per 10 000 population as highest number. The test positivity was highest 7.7% in 30-39 years age cohort and the age specific mortality 2.6 per 10 000 population observed among 50+ years during the period. In total, and since the outbreak began, 32 deaths due to confirmed COVID-19 have been reported in the camps with a case fatality ratio of 1.0%.

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 2 786 confirmed cases (out of 2 975 to date) have been investigated by RIRTs by 12 September 2021, with contact tracing activities being conducted and captured through Go.data, including 6 710 contacts. Out of these, 3 953 (59%) contacts have seen their follow up visits completed and were released from quarantine. 289 (7.3%) tested positive cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health and Disease Surveillance Officers (CHDSOs).

Since 1 January, there have been 194 cases (150 from Rohingya refugees and 44 from host community) of Acute Watery Diarrhoea (AWD) that have been tested positive Rapid Diagnostic Tests (RDTs)/bacteriological culture confirmed cases for cholera (data as of 12 September), of these 70 were culture confirmed, 93 negative and 31 awaited for culture result. In the past three weeks (week 34-36) the total number of culture confirmed cases 8.

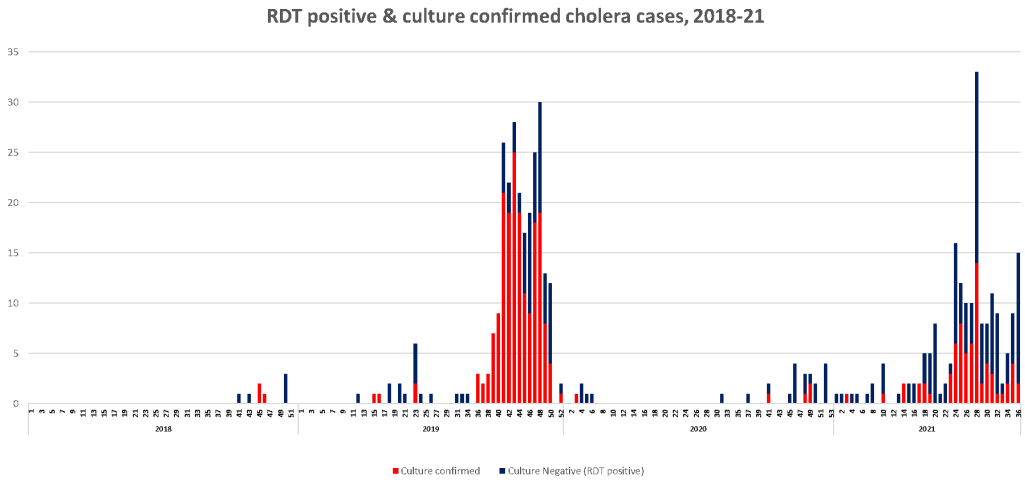


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

In week 36 (6-12 September)- a total of 13 RDT positive cases were reported, all samples are waiting for culture result and 2 additional culture positive cases were identified from RDT negative sample. In week 35 (30 August- 5 September)- a total of 8 RDT positive cases were reported (3 were culture confirmed and 5 waiting for culture result), 1 additional culture positive casewas identified from RDT negative samples. In week 34 (23-29 August)- a ttal of 4 RDT positive cases were reported (1 was culture confirmed, 2 discarded and 1 waiting for culture result), 1 additional culture positive casewas identified from a RDT negative sample.

In line with the Multisectoral AWD response plan, a joint Health and WASH Sector investigation takes place for each case, followed by the implementation of household and sub block level measures. Areas of focused intervention have been identified based on at least one culture confirmed case in camp in last 30 days and/or 2 or more RDT positive cases from same sub-block in last 14 days, where WASH, health

and community engagement activities are undertaken/intensified at sub block/camp level as appropriate. In 2021, at least one confirmed cholera case was reported in last 30 days, from camps 1E, 4, 7 and 15. Out of these camps with culture confirmed cases, only Camp 15 has reported more than one case.

In response to the surge of Acute Watery Diarrhea (AWD) cases in Cox's Bazar, a rapid mapping conducted by WHO and partners in line with the Multisectoral Acute Watery Diarrhea Response Plan (August 2020) has identified 72 isolation beds for AWD are functional at this time, with additional 400 beds on stand-by that could be activated on short notice. Out of these standby beds, 160 are SARI ITC standby capacity beds that could be repurposed for AWD if the epidemiological situation requires. Diarrhea Treatment Centers (DTC) in Leda remain open for strengthened case management of AWD patients and are ready to expand the capacity.

The situation continues to be closely monitored by WHO in order to respond accordingly. WHO conducted AWD clinical management training for healthcare workers in the camps. In total, 254 Healthcare workers mainly from the affected Upazilas and the camps attended a three -day online training on clinical management of AWD organized by Civil Surgeon of Cox's Bazar, WHO/Health Sector in collaboration with iccdr,b. In the month of August 2021, 47 admissions to the isolation facilities and the Diarrhea Treatment Centers (DTC) have been registered. No deaths have been reported at the isolation facilities so far.

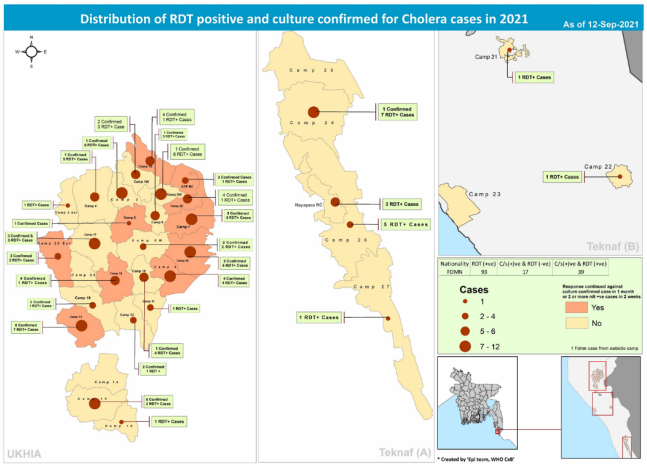


Figure 8: Geographic distribution of all RDT Positive and Culture Confirmed Cholera Cases in 2021

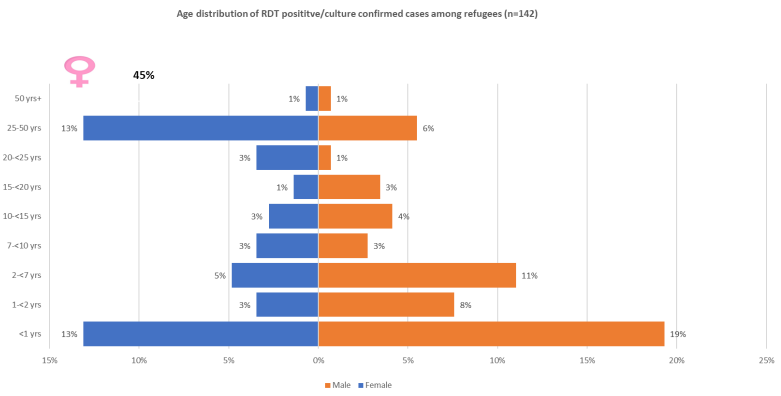


Figure 9: Age group distribution of RDT Positive and Culture Confirmed Cholera Cases among refugees from May to 7 July 2021

A total of 863 refugee cases were admitted to DTC and other health facilities with AWD isolation capacity. Out of the cases, 22% were severely dehydrated, 30% had some dehydration and 46% showed no sign of dehydration at the time of admission among refugees. As of 11 August 2021, around 1400 Community Health Workers (CHWs) have been trained on key messages on health/hygiene promotion and prevention of acute watery diarrhea, following a training of 120 CHW supervisors and managers in previous weeks. UNHCR, as chair of the Community Health Working Group (CHWG), has organized and facilitated the training. UNHCR is also supporting with printing and distribution of hygiene promotion and AWD prevention IEC materials to help enhance awareness and prevention measures in the camps, other agencies are providing support as well.

Active case finding with a uniform line list has been rolled out by CHWG partners since early July, in support of community-based surveillance. CHWG with Health Sector support developed AWD surveillance which was rolled out as of week 27 (4th July). At the end of the reporting period, over 270 000 household visits have been conducted, out of which over 2 900 AWD cases were referred to the health facility for further case management. Furthermore, over 10 000 Oral Rehydration Solution (ORS) sachets and over 9 700 zinc tablets have been distributed at community level.

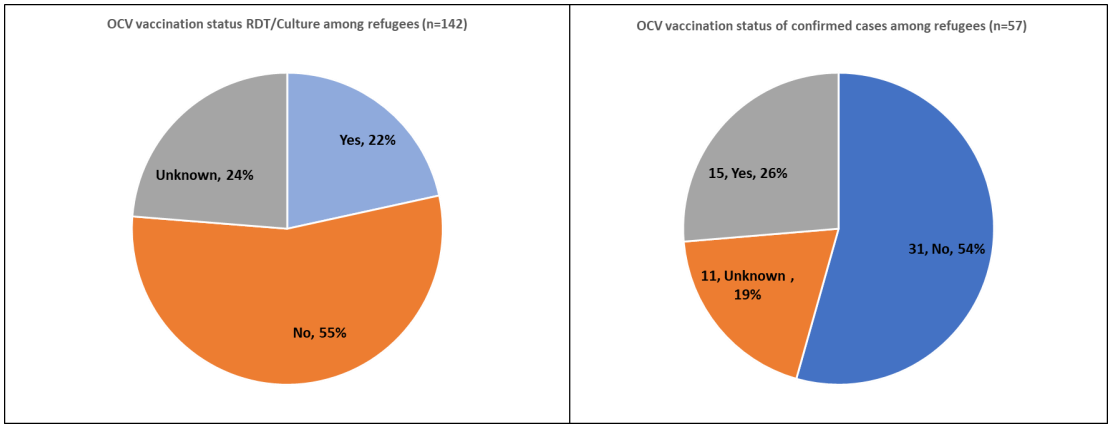


Figure 10: OCV vaccination status among RDT Positive and Culture Confirmed Cases among refugees

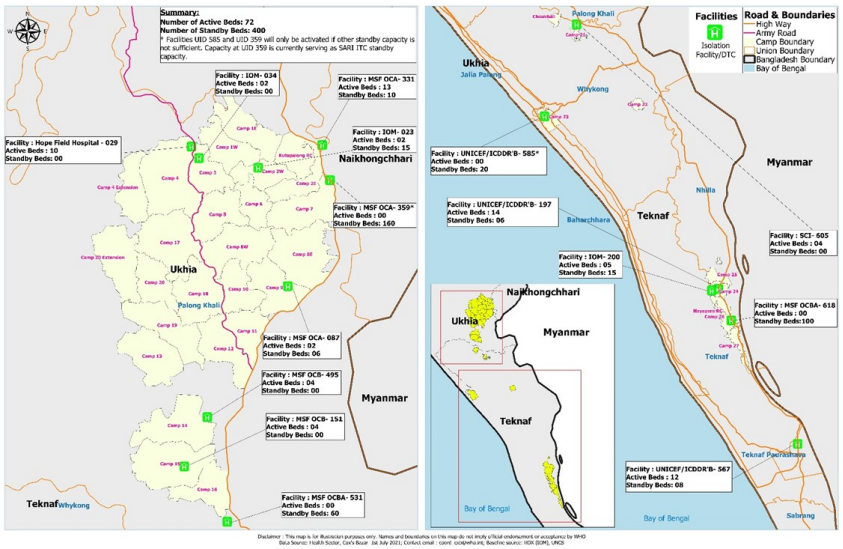


Figure 11: Acute Watery Diarrhea Isolation & Diarrhea Treatment Center Bed Capacity Mapping, as of 1 July 2021.

Throughout the camps, CHWs have reinforced community engagement activities through weekly visits to every household in the camps. This includes community-based surveillance; health education on hygiene promotion and prevention of AWD through house to house visits and small group sessions and active finding of cases with AWD and subsequent referrals to health facilities. Specific emphasis is being placed on "target camps".

In 2020, a total of 28 RDT positive cases for Cholera were detected through sentinel testing, 5 of which were confirmed by culture – 2 from Ukhiya host community, 1 from Teknaf host community and 2 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.

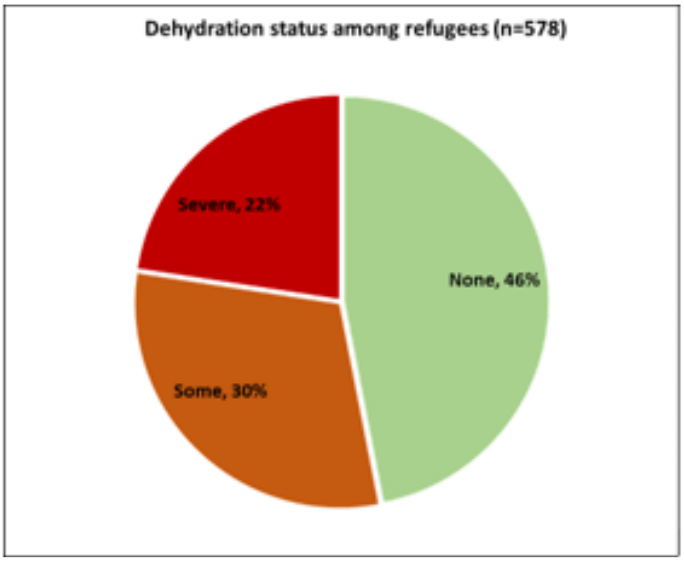


Figure 12: Dehydration status of admitted cases reported from Leda DTC and other health facilities with isolation capacity in camps from week 1-28, 2021

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9304 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 118 as of week 36, 2021). In total, 9058 cases were reported in the camps and 246 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.

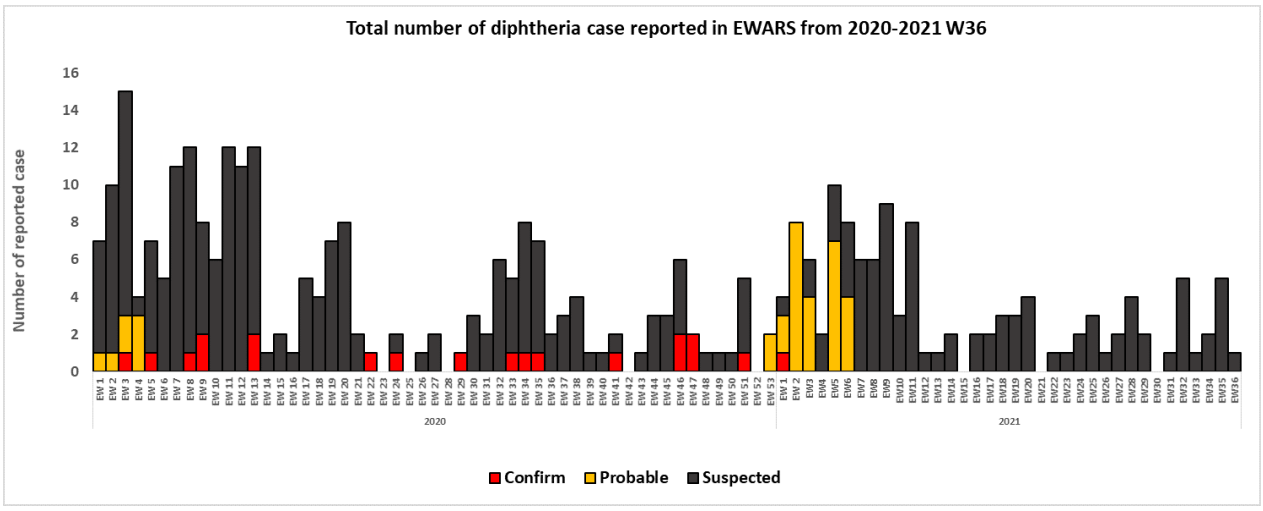


Figure 13: Total number of diphtheria case reported in EWARS from 2020-2021

During the reporting period, one new probable maternal death has been reported. In total 94 probable maternal/deaths of women of reproductive age (WRA, 12-49 years) have been reported in 2021, of which 23deaths 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. In week 35-36, 5 suspected Severe Acute Respiratory Infection (SARI) deaths were reported. In total 69 deaths have been reported in 2021. All deaths have been investigated by RIRT as a part of COVID-19 response and 9 were considered as death due to probable COVID-19. In 2020, a total 85 suspected SARI deaths were reported through community-based mortality surveillance. Of these, all were verified and 9 considered death due to probable COVID-19. So far in 2021, 2 deaths at community level were investigated that were eventually considered as death due to suspected cholera.

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. 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. 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.

WHO and UNICEF continue providing English and Bangla versions of the updated 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 (Bangladesh Betar and Community radio Naf 99.2 FM).

During the reporting period, RCCE WG and WHO maintained regular communications with other humanitarian partners on the COVID-19 vaccination campaign for the Rohingya community. WHO supported the technical clearance of Public Health messages on COVID-19 awareness before the reopening of educational institutions. Additionally, Information, Education and Communication (IEC) materials on Dengue awareness and preventions were developed during week 35-36.

Currently, Technical focal points from WHO and UNHCR are reviewing the draft report of the joint WHO and UNHCR study on "Knowledge, Attitude and Practice on Minimum Invasive Procedure in the Non-Healthcare Settings among Rohingya Refugees in Cox's Bazar".

During the reporting period CHWs conducted 288 227 household visits in which 3533 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 46 patients with moderate/severe symptoms. The cumulative number of patients with mild symptoms is 175 414, and 1109 patients with moderate/ severe symptoms. To date, 95 144 persons with COVID-19 like symptoms have been referred to health facilities, 2794 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 569 430 persons between weeks 35 and 36. Since the beginning of the response, CHWs have conducted more than 9.78 million household visits and had a cumulative number of more than 25.77 million contacts with adult household members. Through the CwC WG, 97 744 people were engaged in 36 608 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 August 2021, a total of 220 447 tests for COVID-19 have been conducted, of which 199 257 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. An decreased in the number of tests conducted among the Rohingya refugees was observed in weeks 35-36 as compared to weeks 33-34, from 2 413 to 2 546tests. Among the host community an increased number was tested as well; from 4 797 tests in weeks 33-34 to 4 316tests in week 33-34. Currently, 42 sample collection sites are operating for suspected COVID-19 patients.

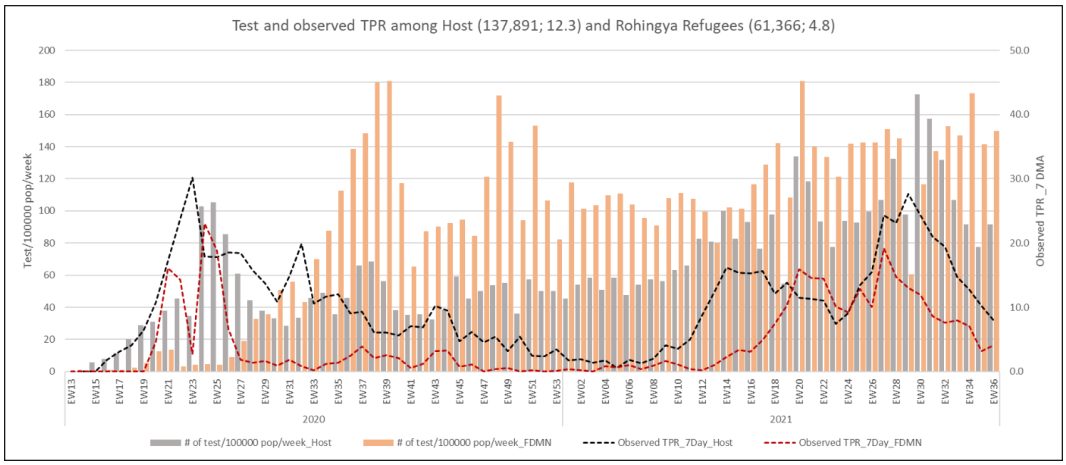


Figure 14: Number of tests conducted and observed test positivity per million among the host population and the Rohingya refugees/FDMN

WHO continues supporting the Government of Bangladesh through the Civil Surgeon's office in the implementation of standard laboratory procedures in the Cox's Bazar district. During the reporting period WHO conducted a training on basic laboratory techniques and quality management for a total of 45 laboratory personnel from different facilities in the Rohingya camps.

INFECTION PREVENTION 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 IPC has been provided to 3600 humanitarian health care workers and government staff from healthcare facilities and SARI ITCs in Cox's Bazar.

During the reporting period, WHO IPC team conducted a three-day training to 32 healthcare workers at the newly established COVID-19 isolation center run by CARE International in Camp 4 Extension. Clinical and non-clinical staff were targeted within this training, including doctors, nurses, laboratory and pharmacy staff, cleaners, guards, cooks and other volunteers.

On 9th September 2021, the monthly IPC Technical Working Group was held to share IPC experiences from different facilities and discuss improvement of IPC in the camp and host community.

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, two health sector case management working group meeting along with two case conference calls for SARI ITCs and two case conference calls for ICU/HDU of Cox's Bazar District Hospital were conducted. The SARI ITC bed ocupancy rate is currently 46% (Ukhiya 50% and Teknaf 41%). For the admitted patients, 73% of them are categorized as mild patients, 16% moderate, 10% severe and 1% as critical cases. At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 15 beds and the Severe Care Unit (SCU) has 13 beds (all of the beds are functional). At the end of the reporting period, 20 beds are occupied with suspected and confirmed COVID-19 patients.

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 operated by Health Sector partners to provide services to the population include 41 primary health care centers (PHCs), 90 Health Posts (HPs), 23 special facilities and three field hospitals.

Under the leadership of the Government of Bangladesh and with the technical support of WHO and Health Sector partners, the COVID-19 vaccination campaign started on 10 August targeting Rohingya refugees of 55 years and above. During the first round of vaccination, a total of 36 943 people received the first dose of COVID-19 vaccine during a 9-day vaccine roll out which reached 86% of the target population. On 18 September 2021, the second dose of vaccine will start to be administrated to Rohingya refugees of 55 years and above.

Photo: WHO and IOM conducted a 4-day training course on Emergency and Trauma care to enhance emergency response in Cox's Bazar

In total, 56 health facilities with 58 vaccination teams, each comprising 2 vaccinators and 4 volunteers, are conducting vaccination sessions. Every healthcare facility has 1 supervisor, 2 AEFI focal person and 1 verifier for better vaccine management and monitoring. WHO has supported the Government with training of the human resources for the vaccination campaign, micro planning of vaccination session, vaccine distribution, developing the training packages and required forms in the line of National level, monitoring of the sessions and evaluation of the campaign, house to house mobilization along with other partners. In total, 25 Health Field Monitors of IVD team with 2 SIMOs and 10 other technical staff of WHO are in the field continuously for program monitoring. Currently, WHO is finalizing the micro plan for 2nd round vaccination which is expected to be started from second week of September.

Regarding COVID-19 vaccination for Bangladeshi host community, the Government of Bangladesh has revised the age limit for the vaccination registration to 25 years-old, students above 18 years and other priority groups. Pregnant women and lactating mothers are now also eligible for the vaccination as per decision of Bangladesh Government.

During the COVID-19 vaccination campaign, routine immunization (RI) sessions are continuing, 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 the 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 75 vaccination teams are conducting outreach sessions both in community and healthcare facilities. Vaccination sites and surveillance health facilities will be reassessed by Government authorities with the technical support of Surveillance and Immunization Medical Officers (SIMOs) based on data from 1st half of 2021.

Photo: On 9th September 2021, the monthly IPC Technical Working Group was held to share IPC experiences from different facilities and discuss improvement of IPC in the camp and host community.

Currently, WHO is completing the preparatory work and planning to conduct basic routine immunization trainings for vaccinators and supervisors after the campaign. During the reporting period, WHO continues monitoring and following up with children who missed their vaccines at the healthcare facilities. Assessment of the vaccination list is currently ongoing through the work of WHO Health Field Monitors. WHO is continuously monitoring Acute Flaccid Paralysis (AFP) and vaccine-preventable diseases (VPDs) despite the lockdown.

WHO has conducted 6 supportive supervision sessions in Ukhiya for continued capacity building of healthcare professionals who were previously trained in mhGAP to better integrate Mental Health and Psychosocial Support (MHPSS) at primary care level. Further mhGAP trainings will be organized in the coming weeks. Additionally, ongoing remote supportive supervision is carried out through online platform, where the mhGAP trained doctors and staff can reach out to the WHO psychiatrist for active advice regarding patient management. During these two weeks more than ten consultations were conducted online. This initiative is part of a group for mhGAP personnel that has been previously trained by WHO the last two years.

During the reporting period, WHO Health Care Waste Management (HCWM) team completed baseline assessment at 9 health care facilities –7 Upazila Health Complexes (UHC), the Cox's Bazar Sadar Hospital and Mother & Child Welfare Centre (MCWC) – supported by the Health and Gender Support Project (HGSP) funded by the Government of Bangladesh through the World Bank grant.

EMERGENCY PREPAREDNESS AND RESPONSE

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.

On 6-9 September, WHO and IOM, as co-chairs of the Emergency Preparedness and Response Technical Committee in Cox's Bazar, conducted a 4-day training course on "Emergency & Trauma Care" for healthcare workers responding to the health needs of the Rohingya refugees and host population. The course, carried out with the support of emergency medicine experts from the International Committee of the Red Cross (ICRC), aimed to equip frontline health providers with basic trauma and surgical skills, as well as effective incident command system for emergency response.

OPERATIONAL SUPPORT AND LOGISTICS

WHO continues to ensure timely provision of quality and adequate supplies, equipment and consumables for the health emergency operations in Cox's Bazar. During the reporting period, WHO has supported the sentinel sites in the camps with the provision of 1700 red cap vacutainer, 6800 throat swab stick, 5800 nasal swab stick and 2500 Zip Lock bag to reinforce the public health response to COVID-19.

WHO continues supporting the establishment of decentralized blood transfusion centers and blood banks in Cox's Bazar and has supplied a hot air oven, microscope, centrifuge for tube, RDTs and other laboratory items to Ukhia and Teknaf Upazila Health Complexes (UHCs).

During the reporting period WHO donated 4259.76 kg with volume of 16.22 cubic meter of kits, medicines, PPE and medical equipment to 19 partners in the Rohingya refugee camp. Logistics support to the IEDCR Field Laboratory is ongoing with two vehicles providing transportation of COVID-19 sample collection in the camps.

SUBJECT IN FOCUS: Strengthening Noncommunicable Disease Prevention & Management in Humanitarian Settings - Reviewing the Cox's Bazar approach

Addressing the burden of Noncommunicable diseases (NCDs) among refugees and migrants remains a major challenge. While communicable diseases continue to be an overriding concern among displaced populations, the increasing burden of NCDs is leading to a shift of focus in public health interventions in humanitarian settings.

In the Rohingya refugee camps of Cox's Bazar, the most densely populated in the world, WHO is supporting Government health authorities and humanitarian partners to better integrate NCD services, and thus prevent premature deaths among the refugee population.

Through a holistic approach at primary health care level, various efforts to support the NCD response have taken place including coordination, capacity building, health education, provision of emergency medicines and supplies, and monitoring/supportive supervision, which have continued despite the constraints imposed by the COVID-19 pandemic.

The successful outcomes reached within the NCD delivery programme in the Rohingya refugee camp have been acknowledged in several occasions, leading to the identification of standardized practices that can be replicated in other humanitarian settings.

International Webinar on Noncommunicable Diseases in Humanitarian Settings

On 14th September 2021, WHO Bangladesh in coordination with the WHO Regional Office for outh-East Asia (SEARO) and WHO Headquarters, held a webinar on "Strengthening Noncommunicable Disease Prevention & Management in Humanitarian Settings - Reviewing the Cox's Bazar approach".

Experts on Noncommunicable Diseases (NCDs) from international and Bangladeshi national organizations – namely UNHCR, Save the Children International and RTM International – participated in this international webinar which aimed to discuss the NCD programme in the Rohingya refugee camps, highlighting collaborative efforts with partners to deliver care and reflecting practical lessons from its implementation.

Organized in close coordination with the Government of Bangladesh (GoB), the webinar addressed NCD delivery in emergencies, from community-based interventions up to primary health care facilities. Additionally, Professor Dr Mahammad Robed Amin, Line Director on Noncommunicable Diseases Control (NCDC) at the Directorate General of Health Services (DGHS) of the GoBs gave a presentation on "NCD Surveillance and Patient Monitoring Systems in Bangladesh".

The productive discussions among the speakers enabled a deeper comprehension of the NCD delivery programme carried out at the Rohingya refugee camp, while helping to identify key common aspects that can be replicated in similar settlements around the world.

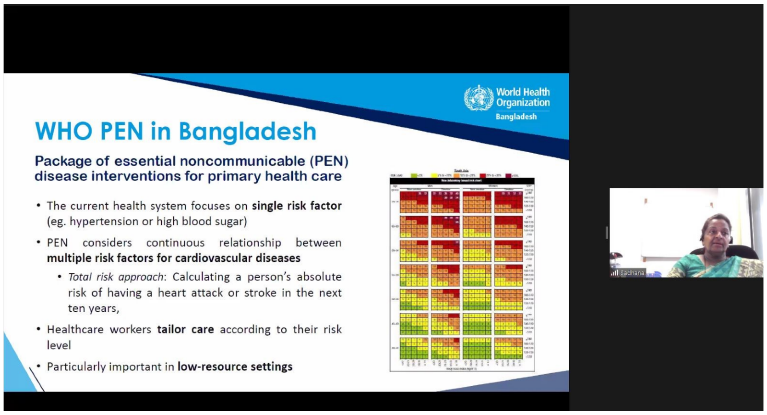


Photo: Experts on Noncommunicable Diseases from international and Bangladeshi national organizations actively participated in sereral panel discussions on "NCD Delivery in Emergencies" and "Community-based interventions & Partnerships for Prevention of NCDs in Refugee Settings".

NCD service delivery in the world's largest refugee camp

Under the leadership of the Ministry of Health and Family Welfare (MoHFW), WHO is supporting the Civil Surgeon's office in the roll out of national protocols for integrated management of hypertension and diabetes using a total cardiovascular risk approach in Primary Health Care (PHC) facilities serving Cox's Bazar vulnerable populations. Based on the WHO Package of Essential Noncommunicable (PEN) disease interventions, this approach includes capacity building for primary health care staff and community outreach workers, health promotion activities on NCD risk factors, supply of essential NCD commodities with gap-filling purpose, supportive supervision as well as strengthening NCD surveillance and monitoring in the district.

Photo: WHO continued to provide gap-filling support to health care facilities during the COVID-19 pandemic when shortages of essential NCD medications and basic diagnostic equipment and supplies occurred.

Coordination

Following national protocols developed in line with the WHO Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource setting, an integrated system has been established in primary healthcare facilities for the prevention and control of NCDs in the refugee camps, where an extensive network of 175 Government and partner-led healthcare facilities caters the health needs of over 884 000 Rohingya refugees settled in 189 660 households, along with 472 000 Bangladeshi host population living in the adjacent area.

Over 80 partners coordinated under the Health Sector provide NCD related services in the refugee camps, such as screening, diagnosis, treatment, counselling, referral or healthy lifestyle promotion. In total, 93 health posts, 41 primary health care centers and 4 field hospitals are providing NCD services focusing on priority non-communicable diseases among the Rohingya refugees such as hypertension, diabetes and chronic respiratory diseases.

WHO is also leading the coordination of a NCD Core Group which relies on the active participation of 17 health partner organizations as well as Government counterparts to ensure standardized NCD service delivery in the Rohingya refugee camps. The NCD Core Group conducted 47 on-site supportive supervision visits in collaboration with Ministry of Health and Family Welfare Coordination Cell (MOH&FWCC) to strengthen NCD screening and treatment strategies in Primary Health Care during the COVID-19 pandemic.

Capacity building: WHO PEN training on NCD interventions

Since 2019, a total of 283 primary healthcare workers from 64 Primary Health Care Centers (17 Government facilities and 47 partners-led centers) along with 8 Upazila Health Complexes have participated in the WHO PEN training in Cox's Bazar. These training sessions, implemented in close collaboration with the Directorate General of Health Services (DGHS) and the BRAC James P Grant School of Public Health, aimed to help healthcare professionals better respond to an increasing prevalence of NCDs in the camp setting.

NCD surveillance and monitoring

Essential disease components of NCDs have been incorporated in the District Health Information System (DHIS-2) that monitors disease burden in Cox's Bazar. The systematic collection of real time data for NCDs surveillance provides a comprehensive overview of the health status of the refugee population and becomes crucial in developing a more targeted and coordinated public health response to NCDs, particularly in the complex humanitarian setting of Cox's Bazar where the coordination of a wide range of government and humanitarian actors is required for a standardized and effective response.

In addition, NCDs surveillance allows to track population-level health-seeking behavior and ensure a meaningful follow-up of Rohingya patients who have a history of poor prompt health care seeking behavior and undiagnosed NCDs in their country of origin. The progress achieved in the prevention and control of non-communicable diseases is evident. According to DHIS-2, the number of patients seeking medical care for NCDs has considerable increased over the past years.

Gap-filling support on Essential NCD commodities

WHO continued to provide gap-filling support to health care facilities during the COVID-19 pandemic when shortages of essential NCD medications and basic diagnostic equipment and supplies occurred. Essential NCD medications and basic equipment –including insulin, x-ray films, stethoscope, digital blood pressure machines, glucometer with strips, urine strips, weight machines and height scales commodity supplies and equipment – were supplied to 123 health care facilities in Cox's Bazar.

Health promotion strategies

WHO is also undertaking health promotion strategies on healthy lifestyle and behavioral changes to prevent deaths and complications associated to NCDs. Risk communication materials on NCDs and its associated risk factors have been developed in coordination with health humanitarian partners and disseminated in Bengali and English languages for facility and community-based health education. Based on these materials, community engagement initiatives were put in place involving 68 staff working in Government facilities – including community health care providers, health inspectors, and health assistants– and 361 Rohingya Community Health Workers (CHWs) who received training on NCDs risk factors identification and behavioral interventions for healthy lifestyle.

	Last 24 hours	Total
COVID-19 tests conducted	19 668	9 413 033
COVID-19 positive cases	1190	1 541 300
Number of people released/recovered	1645	1 498 654
COVID-19 deaths	35	27 182

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

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

WHO Bangladesh awareness and risk communication materials in Bengali:
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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