World Health Organization
Bangladesh

Rohingya Crisis Situation Report #26

Date of issue: 7 October 2020

Week 40
28 September - 04 October
Location: Cox's Bazar

PHOTO: World Mental Health Day - Mental Health and psychosocial support is a priority in the humanitarian crisis in Cox's Bazar. WHO mhGAP training is helping health care workers address mental health conditions in an empathic and proactive way.

HIGHLIGHTS

During the reporting period, 21 new COVID-19 cases were confirmed in the Rohingya refugee camps. Since early April until 04 October 2020, a total of 51 135 tests have been conducted in the Field laboratory of the Cox's Bazar Medical College.

With a total of 41 cases, Camp 24 has the highest number of cases to date in the Refugee camps, further ahead from Camps 2W, 15 and 3 with 24, 21 and 20 cases respectively.

A training in Community Based Mortality Reporting has been launched during the reporting period. With a total of four batches, around 150 medical doctors, reporting officers and community health workers are expected to participate in this capacity building.

SUBJECT IN FOCUS: Three years of Surveillance and Outbreak investigation in the Rohingya Refugee camps

	Host Community	Rohingya refugees
Total confirmed COVID-19 cases in Cox's Bazar	4539	273
Total cases in isolation in Cox's Bazar	329	146
Total number of tests conducted	32 559	11 482
Total deaths due to COVID-19	68	8

**Updated as of 04 October 2020* / *FDMN = Forcibly Displaced Myanmar Nationals

COORDINATION, PLANNING AND MONITORING

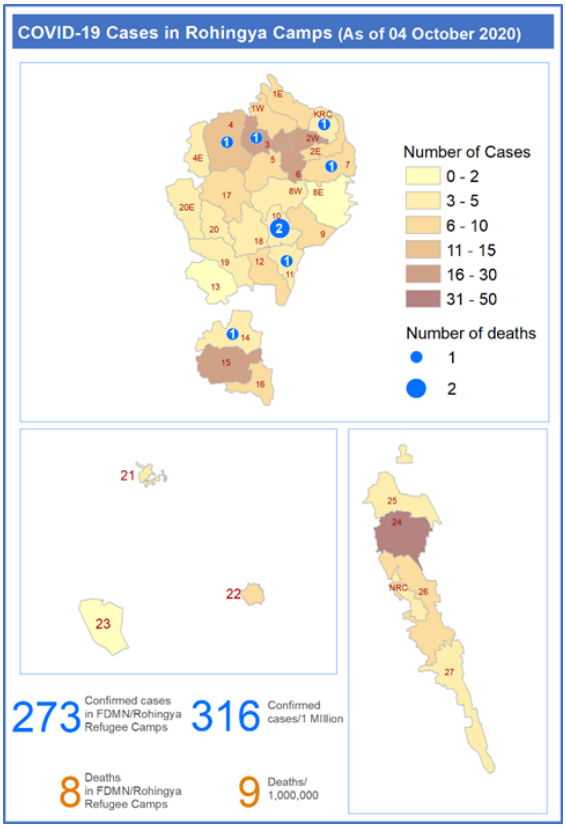
WHO, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC), continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the COVID-19 emergency. Camp health Focal Points, Field Coordinators and Health Sector team meet bi-weekly to discuss the current COVID-19 response and Cyclone Preparedness including immunization and cyclone and monsoon preparedness at camp level.

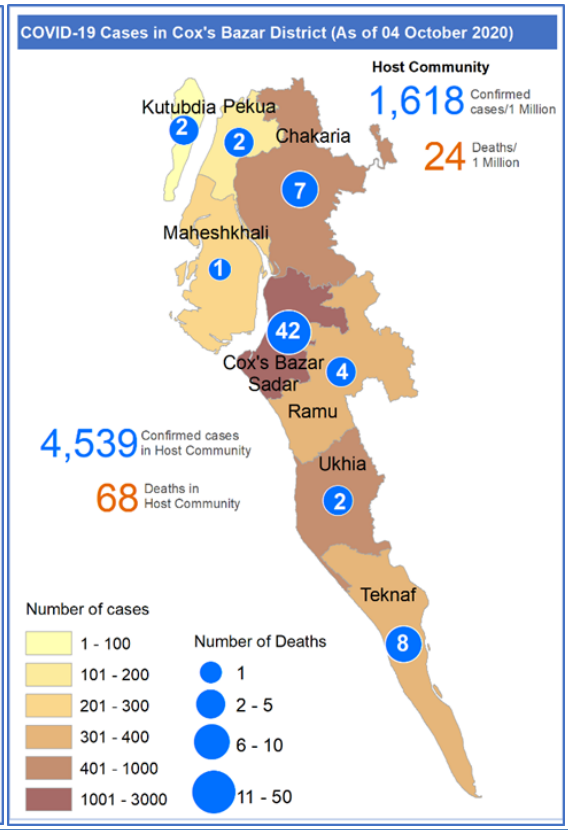
During the reporting period, two meetings with health partners and eight meetings at camp level took place in Ukhiya and Teknaf, Cox's Bazar.

Weekly clinical case management meetings continue enabling discussions on operational aspects and exchange of experiences between peers to improve clinical treatment for COVID-19 patients in Cox's Bazar.

SARI ITCs take turns in case presentation which includes treatment decisions and progression of the patients' condition with peers discussing alternative options.

Often times other clinical areas, including health and psychosocial support and protection, are mentioned as they are necessary to comprehensively address the clinical condition of COVID-19 patients.





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, risks and vulnerabilities, safe and dignified burials, home-based care, quarantine, isolation and treatment centres, use of masks, etc.

Analysis of a survey conducted across all camps between 5-10 September has been completed and presented to the Health Sector. The survey assessed the population's knowledge of COVID-19 as well as attitudes towards mask wearing and testing. The survey indicated a good knowledge among the refugee population of COVID-19 symptoms and testing, as well as the importance of mask wearing. However, the survey results also indicated that work needs to be done to assist the Rohingya population in following the recommendations.

Photo: A Rohingya Refugee, Nur Hasina became a Community Health Volunteer to help fight COVID-19 in Cox's Bazar.

A total of 1416 community health workers (CHWs) were trained to provide enhanced Community Based Surveillance and Home-Based Care which includes counselling on testing, quarantine and patients' referral to isolation facilities. During the reporting period CHWs conducted 150 464 household visits in which 3676 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 13 patients with moderate/severe symptoms. The cumulative number of mild patients is 36 855, and 175 moderate/ severe patients. 1690 persons with COVID symptoms were referred to health facilities from a total of 17 307 to date.

COVID-19 messages reached 275 122 persons between 27 September - 04 October. Since the beginning of the response, CHWG conducted more than 2.9 Million household visits and had contacts with a cumulative number of more than 5.5 million adult household members.

Through the Communicating with Communities (CwC) working group, another 51 925 people were engaged in 8664 communication sessions conducted by religious leaders. Additionally, 33 810 Rohingya refugees received COVID-19 key messages through 13 162 community consultation meetings. And finally, 4339 community people participated in 645 group sessions and watched 414 videos about the new virus. Among host communities, 6018 people participated in 2005 community awareness meetings and 19 416 participated in 91 listener group sessions on COVID-19.

*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.

WHO continues to provide epidemiological data to support operational decision making for the COVID-19 response in Cox's Bazar. As of 04 October 2020, a total of 4539 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 466 in Chokoria, 363 in Teknaf, 276 in Maheshkhali, 2351 in Sadar, 489 in Ukhiya, 316 in Ramu, 180 in Pekua and 98 in Kutubdia.

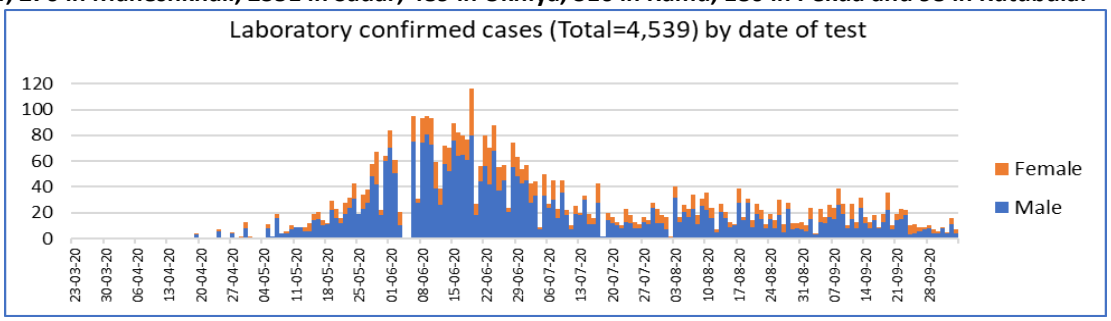


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

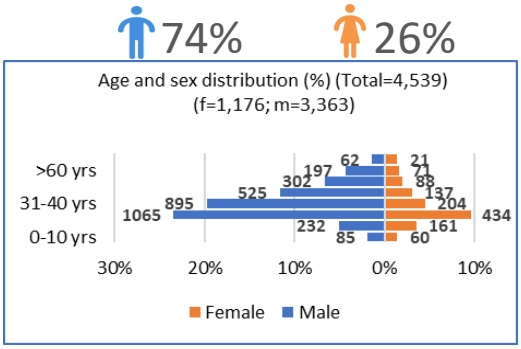


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

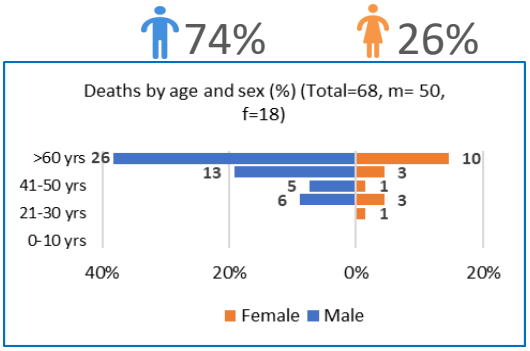


Figure 3: COVID-19 deaths by age and sex among host population in Cox's Bazar

As of 04 October 2020, a total of 273 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 41 cases, Camp 24 has the highest number of cases to date, further ahead from Camps 2W, 15 and 3 with 24, 21 and 20 cases respectively. To date 16 cases were reported from Camps 6 and 11 from Camp 4. Camps 1W, 2E and 7 had 10 cases each while Camp 17 reported 9 cases. As for Camp 9, 8 cases were reported to date. Camps 1E, 5 and 12 registered 7 cases each. Camps 16, 22 and 26 registered 6. Niapara RC and Camps 10 and 18 identified 5 cases each. The remainder Camps, 19, 27, 25, 4 extension, 8W, 11, 14, 21, 8 E, 23, 13, 20 Extension and Kutupalong have so far less than 5 cases.

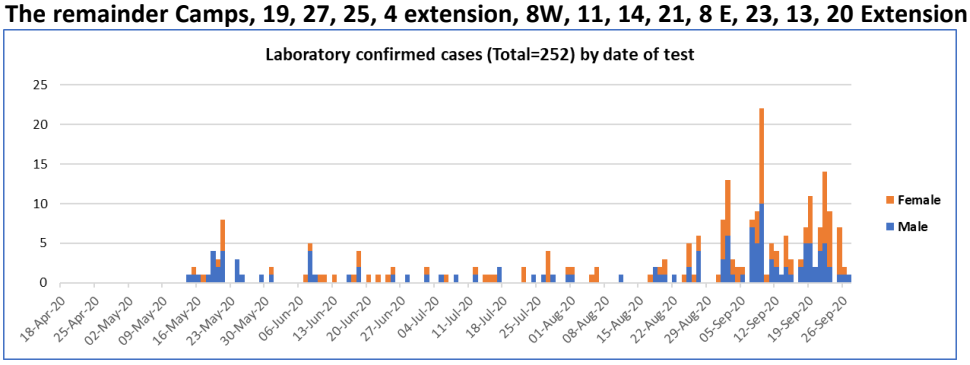


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

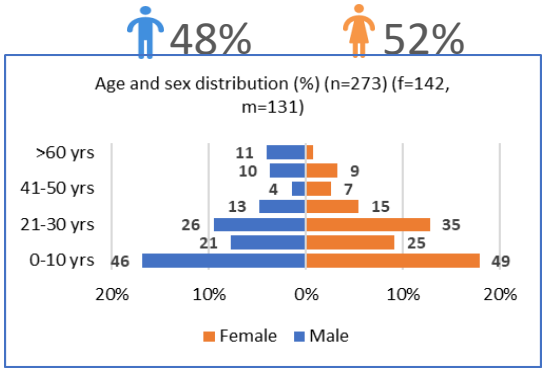


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

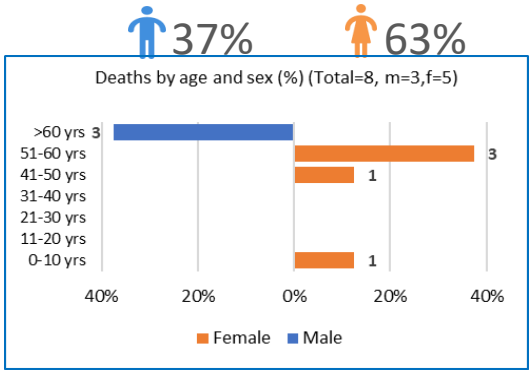


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

During the reporting period, 21 new COVID-19 cases were confirmed in the Rohingya refugee camps. Currently, 24 sample collection sites (including 1 new site) are operating and another 13 camps are under consideration to become sentinel sites. A training in Community Based Mortality Reporting has been launched during the reporting period. With a total of four batches, around 150 medical doctors, reporting officers and community health workers are expected to participate in this capacity building. In preparation for eventual AWD cases in the coming months, a training for Acute Watery Diarrhea (AWD) Outbreak Response started on 4 October. A total of 160 health care workers from Ukhiya and Teknaf Upazilas are expected to attend. Two batches of GoData refresher training was provided to 50 staff from Isolation and Treatment Centers (ITCs) and 60 from Isolation Units (ISOUs) in Cox's Bazar.

DISTRICT LABORATORY

WHO continues its support to the Field Laboratory of the Institute of Epidemiology, Disease Control and Research (IEDCR) in the Cox's Bazar Medical College comprising human resources, equipment, supplies/consumables and technical and operational expertise. From early April until 04 October 2020, a total of 51 135 tests for COVID-19 have been conducted of which 44 041 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A decrease in the number of tests conducted among the Rohingya was observed in week 40 (1172 tests per one million compared to 1810 in week 39). Similarly, the number of tests decreased among the host community population (382 tests per one million compared to 561 in week 39).

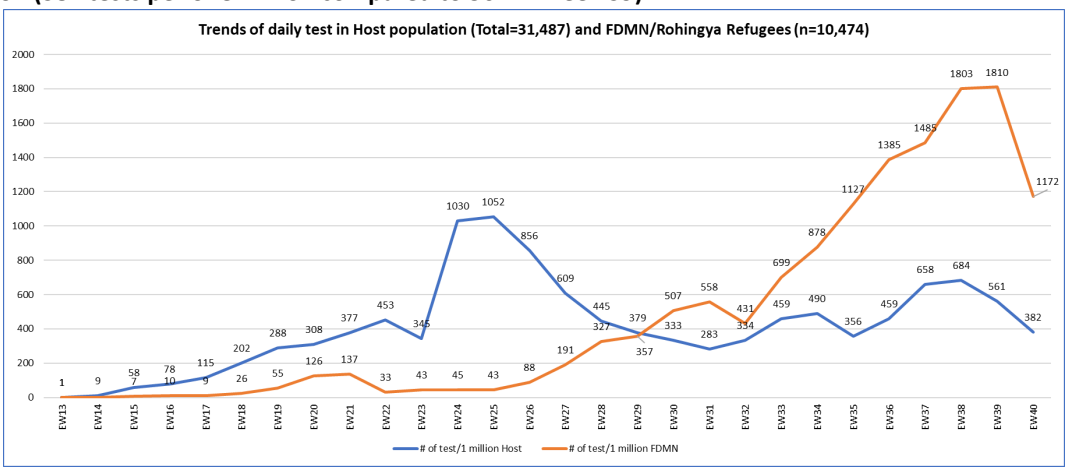


Figure 7: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees

INFECTION PREVENTION AND CONTROL

WHO continues to support partners as co-facilitators on a cascade of trainings conducted remotely and on-site to enhance COVID-19 preparedness. To date, training for Infection, Prevention and Control (IPC) has been provided to 1727 humanitarian health care workers from Severe Acute Respiratory Infection (SARI) ITC partners and 800 government facilities.

A 4-days training on Water and Sanitation in Health care facilities Improvement Tool (WASH FIT) has been completed for 104 health care workers from 105 health facilities this year. The training included field visits and assessment with participants drawing action plans for improvements in general IPC, WASH, health care waste management at their respective facilities delivering essential health services. 184 facilities have so far been assessed against standard WASH FIT indicators. To date, 208 health professionals from 179 health care facilities in Cox's Bazar have been trained on WASH FIT.

WASH FIT assessment for SARI ITCs was conducted in the reporting period at four facilities in camps 2W, 7 and Kutupalong. In total, 9 SARI ITCS have been visited, so far IPC supportive supervision was conducted at three health facilities. Since September, 40 health care facilities, including three SARI ITCs, have been visited in 15 camps.

MONSOON AND CYCLONE PREPAREDNESS

The Health Sector and 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 list of camp health focal points is accessible through the health sector Google drive. Contingency supplies such as Inter-Agency Emergency Health Kits (IEHK), trauma kits, surgical kits, cholera kits, SRH kits and other supplies have been stored at 20 locations in the districts and camps. Thirty-nine 24/7 priority health facilities have been identified in the camps. Twenty-one mobile medical teams and 29 dispatch and referral unit ambulances stand ready to respond to the adverse effects of cyclone and monsoon season. Camp wise contingency plans have been completed at 34 refugee camps to guide response to natural disasters about cyclone hazards. The Health Sector team continues to conduct monthly meetings to raise awareness on cyclone hazards. Camp level Health Sector Teams remain in close contact with trained volunteers and site management agency.

Photo: Cyclone and monsoon preparedness remains a priority in the refugee camps in Cox's Bazar, 144 health facilities and many shelters are at risk of being affected by the upcoming cyclone season.

CLINICAL CASE MANAGEMENT

To date, 14 SARI ITCs are established with a total of 946 beds. Of these, 578 are ready to receive patients and another 368 are in place and held on standby. Five isolation facilities provide additional 61 beds. Also operational is the Intensive Care Unit/High Dependency Unit Facility at Sadar Hospital with ten ICU and eight HDU beds. Twenty additional SARI ITC beds will open on the 3rd floor of the hospital this week with capacity to scale up to high dependency units (HDU) when needed. Construction of SARI ITC sites is expected to be completed by November 2020. WHO is currently conducting supervisory support visits to the SARI ITCs, offering technical and clinical guidance and exploring further SARI ITC support requirements.

Photo: Host community COVID-19 positive patients recovering at a Upazila Health Complex, in Cox's Bazar.

ESSENTIAL HEALTH SERVICES

As routine immunization sessions continue, both fixed and outreach, WHO continues to provide guidance regarding the operation and sustaining of immunization programs in the context of the COVID-19 pandemic. In this context, the new strategy and microplan are currently being implemented. Coverage data shows an increasing trend but due to the slow pace of tracking and mobilization of unvaccinated and under vaccinated children, immunization coverage remains low.

Vaccine-Preventable Disease surveillance is being closely monitored by government authorities with WHO's technical support. SIMOs and Health field monitors (HFMs) continue to visit health facilities for surveillance, monitoring and investigation while contributing to the National AFP & VPD surveillance system. As part of this system, 13 health facilities have been identified as very high priority (VHP) sites and 38 high priority (HP) as active surveillance sites. VHP and HP sites are visited weekly and bi-weekly respectively. Since the establishment of active surveillance, on 18 August 2020, more AFP and measles cases were reported than in the first seven months of the year showing increase in surveillance sensitivity. WHO health field monitors and Emergency Immunization and Surveillance Officers (E-SIMOs) are monitoring the program in order to ensure vaccines and logistics distribution, cold chain management and proper field management.

After the successful deployment of the Session monitoring tool, an ODK-based House to House monitoring tool has been deployed. On 4 October HFMs received training to initiate this monitoring modality and will follow the line list of missed children and pregnant women provided by vaccinators and CHWs. WHO Health Field Monitors (HFMs) monitored 1058 immunization sessions having shared the collected data with government and partners. Monitoring data shows that engagement with Community Health Workers (CHWs) is increasing. WHO HFMs interviewed 1374 care-givers and 63% referred that CHWs asked them to attend vaccination sessions. WHO HFMs monitored 1058 vaccination sessions to see that 97% of vaccinators were wearing face masks while 89% of caregivers were maintaining physical distancing. HFMs also interviewed 662 Imams to find that 52% had low levels of engagement in the immunization program.

SRH continued supportive supervision alongside UNFPA to tertiary and secondary health facilities and PHCs in the camps following the Non-pneumatic Anti-Shock Garment (NASG) Training of Trainers (ToT) and the subsequent distribution of this life-saving tool to address excessive bleeding, including postpartum haemorrhage. The trainers are progressing with the roll out of NASG theory, demonstration and practice to other clinical staff on site.

OPERATIONAL SUPPORT AND LOGISTICS

During the reporting period WHO assessed the work in progress of the CERF funded Friendship SARI ITC in regard to facility layout, patients and staff flow, bed spacing, ventilation, waste management, etc. WHO provided additional changes to the layout design and bill of quantities of the IEDCR Field Laboratory and summarized the stockpile of contingency supplies for the preposition of containers in the camps. 1200 Kg of NCD supplies were distributed by WHO to the World Bank supported IOM health facilities in the camps, as well as 45 waste bins and NCD, SRH, PPE and medical kits and equipment to ten implementing partner organizations.

POINTS OF ENTRY

Sixteen out of 19 Points of Entry are functional in different strategic points of entry into the camps. Efforts are ongoing to identify partners who can support three PoEs with human resources. As of 4 October 2020, a total of 550 256 individuals have been screened. The teams continue working to identify febrile passengers and pedestrians for education and referral to health facilities.

SUBJECT IN FOCUS: Three years of Surveillance and Outbreak investigation in the Rohingya Refugee camps

Disease outbreaks can have substantial health, economic and social costs. The public health imperative during an outbreak is therefore to control the event as quickly as possible in order to minimize morbidity, mortality and other negative impacts. Outbreaks are frequently characterized by uncertainty and a sense of urgency, and timing is critical. The mission of WHO's Health Emergencies Programme (WHE) is to help countries and to coordinate international action, to prevent, prepare for, detect, rapidly respond to, and recover from outbreaks and emergencies.

Context

Fleeing from violence in the Rakhine State of Myanmar in August 2017, 860 000 Rohingya refugees found generous host communities in Cox's Bazar. However, those living in the camps are particularly vulnerable to outbreaks of communicable diseases, due to high population densities, poor WASH conditions and low immunization. Outbreaks in the past years have included diarrhoeal diseases, measles, diphtheria, chickenpox and respiratory infections like COVID-19.

WHO supported the establishment of a disease surveillance system and Rapid Response Teams for outbreak investigation to ensure a meaningful integration of communicable and noncommunicable disease surveillance systems to enhance early detection of diseases among the affected populations. This includes the development of an effective mechanism for outbreak investigation with strong laboratory support and immediate intervention.

Over the past three years, disease surveillance and outbreak investigation has been paramount to collect information on mortality and morbidity with an acceptable degree of precision and accuracy for the effective planning, monitoring and evaluation of disease control programmes in Cox's Bazar.

Early Warning, Alert and Response System (EWARS)

The rapid implementation of an early warning, alert and response system at the temporary health facilities catering to the critical health needs of the Rohingya refugees is key to the early detection of potential infectious disease outbreaks. Further to this, under the leadership of the Government of Bangladesh (GoB) and in close collaboration with WHO and other health partners, an outbreak investigation mechanism was implemented in Cox's Bazar to generate rapid response drive and effective control measures. During the last 3 years in different large-scale outbreaks in the Rohingya settlement a considerable number of deaths have been averted where outbreak investigation played a critical role and guided health authorities in implementing control and prevention measures.

Photo: Diphtheria outbreak investigation in the host community in Cox's Bazar, 2018.

These tools were particularly important during the diphtheria and measles outbreaks and other surge health events that were rapidly mitigated and averted including Cholera, Varicella and Acute Jaundice Syndrome. Rapid Investigation and Response teams (RIRTs) and Joint Assessment Teams (JATs) for AWD outbreaks have been mapped and capacitated to conduct a thorough epidemiologic and environmental investigation whenever necessary. Additionally, in response to the COVID-19 pandemic, the deployment of Camp Health and Disease Surveillance Officers (CHDSOs) by WHO is enhancing community-based disease surveillance activities.

SUBJECT IN FOCUS: Three years of Surveillance and Outbreak investigation in the Rohingya Refugee camps

COVID-19 Outbreak response

Testing: Currently 24 sample collection sites are operating for collecting samples from people with suspected COVID-19 symptoms. Additional testing facilities in 13 camps are under review. To prioritise testing, the WHO standard case definition has been adapted for the camp setting. Since early April 2020, samples are being processed in the IEDCR field laboratory at the Cox's Bazar Medical College. So far 11 482 samples have been collected among the Rohingya refugees, transported and tested. Additional 4597 samples of the host population have been collected in camp facilities. The median age of samples remains low as most are been from people under 18 years.

Confirmed COVID-19 cases: 273 Rohingya refugees have tested positive to COVID-19. The cumulative share of positive tests is 2.6%. Samples from the 0-9 years age group have the lowest test positivity but there is little variation between the age groups. Eight deaths have been reported, meaning that case fatality risk is 2.9%. More Rohingya women have tested positive 143 (52%) and only 21 (8%) are 60 years or older. The average age of cases is 23. In terms of clinical management, with the support from the Dispatch and Referral Unit (DRU), all positive cases have been sent to SARI ITCs for isolation/ treatment. To date, 119 patients were successfully treated with a recovery rate of 44%. Among the admitted patients (n=226), 44 (22%) experienced moderate/severe symptoms and 16 (7%) had at least one comorbidity. The most common symptoms at the time of admission were cough and fever.

RIRT & Contact Tracing: Camp-wise Rapid Investigation and Response Teams (RIRT), including one coordinator, one clinical supervisor and one contact tracing supervisor, have been responding to alerts within 24 hours and referring patients to SARI ITCs with the help of the DRU. Contact tracing and referral to quarantine facilities and follow up during the period of at-home quarantine has been facilitated in coordination with other sectors and camp administration. A camp wise dedicated Contact Tracing network (10 supervisors and volunteers per camp) are embedded in the RIRT for contact tracing having identified 996 contacts to date.

Photo: WHO CHDSOs talking with a Rohingya man after his successful recovery from COVID-19.

Data Management & Dissemination: Go.data has been used to collect detailed information on cases and contacts. All Contact Tracing Supervisors and SARI ITC focal persons have been trained on Go.Data and equipped with a tablet. The activity is supervised by WHO Epidemiology Unit & Surveillance Network (CHDSOs). Under the WHO Cox's Bazar Data Hub (https://cxbhealth.info/), the Cox's Bazar Rohingya Camps Epidemiological Summary provides an in-depth analysis of the last weeks, and the COVID-19 Dashboard provides an overview of COVID-19 surveillance based on information from Go.data, Field Laboratory, EWARS and the Community Health Working Group (CHWG).

Community Based Surveillance: With the help of the CHWG, Community Based Mortality Surveillance has been strengthened through information collected by SARI ITCs on probable cause of deaths. The WHO Surveillance network is assisting the reclassification of deaths through detailed investigation of events by the CHWG and mortality data. So far 9 deaths have been reviewed and reclassified. CHWs also work to identify individuals with symptoms associated with COVID-19. Symptomatic people are referred to the nearest health facility or directed to sample collection sites. Through strengthening community-based surveillance, we can better understand the number of people reporting COVID-associated symptoms while strengthening all-cause mortality surveillance systems. This provides timely information during critical phases of the outbreak.

Capacity Building: Since the beginning of the COVID-19 outbreak a significant number of trainings (online and in-person) has been organized and conducted in order to effectively respond to the COVID-19 outbreak having reached nearly 1000 participants.

	Last 24 hours	Total
COVID-19 tests conducted	9859	1 989 664
COVID-19 positive cases	1125	368 690
Number of people released/recovered	1587	281 656
COVID-19 deaths	23	5348

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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