



*PHOTO: Partners conducting Rapid Diagnostic Tests (RDTs) in Cox's Bazar. Every week, health facilities report aggregated numbers of Acute Watery Diarrhoea (AWD) cases through the Early Warning and Response System (EWARS) which is managed by the World Health Organization (WHO).*





## HIGHLIGHTS

During the reporting period, 3 new COVID-19 cases were confirmed in the Rohingya refugee camps. Currently, 25 sample collection sites (including 1 new site) are operating for COVID-19 sample collection.

A "special" case management meeting was held together with SARI ITC information management focal persons to review the new streamlined data collection protocol and tool. The Health Sector developed and shared a referral pathway for obstetric patients who are confirmed or suspected to have COVID-19.

In preparation for a possible outbreak, a Joint Assessment Team (JAT) Training for AWD Outbreak Response is planned to start in the last week of October 2020.

**SUBJECT IN FOCUS: A Multi-sectoral Acute Watery Diarrhoea (AWD) Preparedness & Response Plan for Cox's Bazar.**

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	4609	276
 Total cases in isolation in Cox's Bazar	267	123
 Total number of tests conducted	33 548	12 043
 Total deaths due to COVID-19	70	8

*\*Updated as of 11 October 2020 / \*FDMN = Forcibly Displaced Myanmar Nationals*

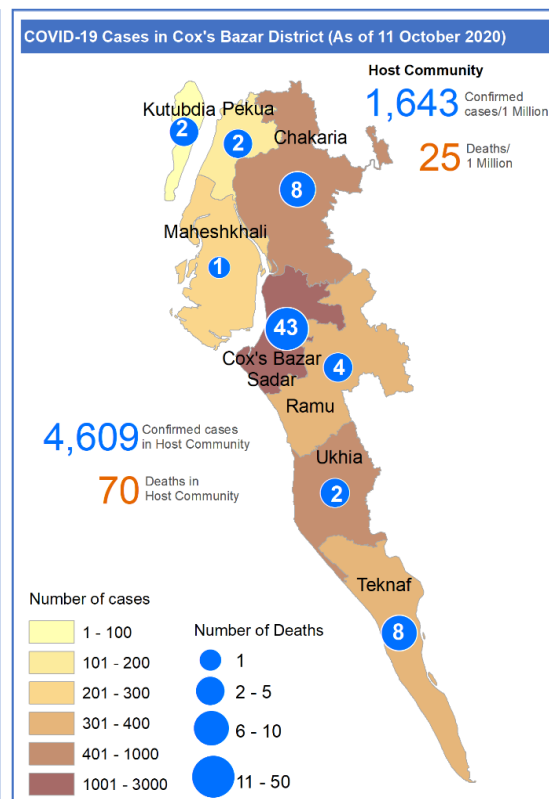
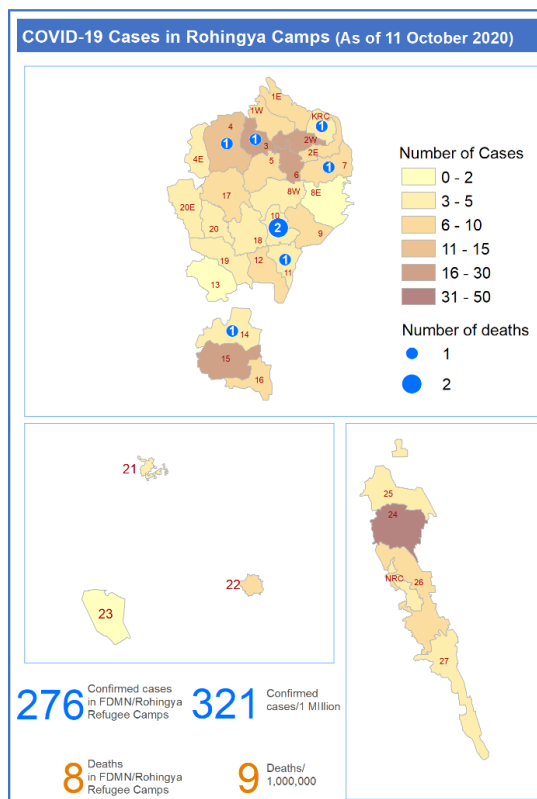
WHO, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC), continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the COVID-19 emergency.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

The biweekly Camp Health Focal Point meeting was held in Cox's Bazar with Health Sector Field Coordinators, Health Sector field level coordinators and representation from RRRC. Discussions continue between Health Sector, WHO and WASH to ensure rapid response of Joint Assessment Teams (JAT) in the case of Acute Watery Diarrhea (AWD).

Special SAG meeting held to discuss planning for isolation facilities for AWD with representation from organizations currently involved with isolation for respiratory disease/COVID-19. Representatives from the Civil Surgeon Officer and MOHFW were present.

Collaboration with ISCG Emergency and Response Plan Working Group to ensure alignment between overall sector planning and provision of health services and rapid response during cyclone and monsoon events.

The Health Sector developed and shared a referral pathway for obstetric patients who are confirmed or suspected to have COVID-19.



## 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.

Following the analysis of a survey conducted across all camps between 5-10 September WHO has started working with partners on community engagement around the importance of mask wearing when outside the home. Particular emphasis will be given to women, some of whom surveyed said that they do not need to wear masks as they wear veils or scarves over their nose and mouth outside the home.

WHO continues working and promoting the RCCE WG routine immunization month long strategy (started 1 October). This response-wide strategy is encouraging parents and guardians to get follow up shots, as well taking children not yet vaccinated to start their vaccine programme. WHO is providing medical experts where needed for community engagement, as well as technical advice and support.

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 132 663 household visits in which 2948 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and one patient with moderate/severe symptoms. The cumulative number of mild patients is 39 803, and 176 moderate/ severe patients. 1376 persons with COVID-19 symptoms were referred to health facilities from a total of 18 703 to date.

COVID-19 messages reached 287 360 persons between 05-11 October. Since the beginning of the response, CHWG conducted more than 3 Million household visits and had contacts with a cumulative number of more than 5.8 million adult household members.

Through the Communications with Communities (CwC) working group, another 57 552 people were engaged in 10 385 communication sessions conducted by religious leaders. Additionally, 35 288 Rohingya refugees received COVID-19 key messages through 12 673 community consultation meetings. And finally, 5034 community people participated in 681 group sessions and watched 632 videos about the new virus. Among host communities, 5493 people participated in 2096 community awareness meetings and 626 participated in 126 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 11 October 2020, a total of 4609 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 478 in Chokoria, 367 in Teknaf, 280 in Maheshkhali, 2388 in Sadar, 497 in Ukhiya, 320 in Ramu, 180 in Pekua and 99 in Kutubdia.

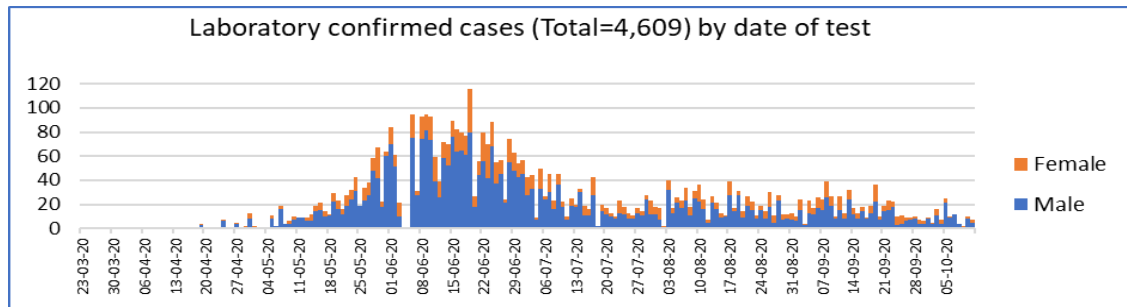


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

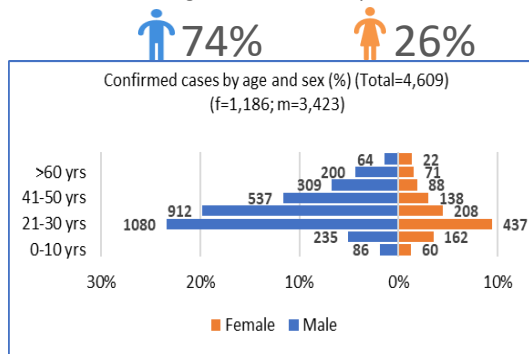


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

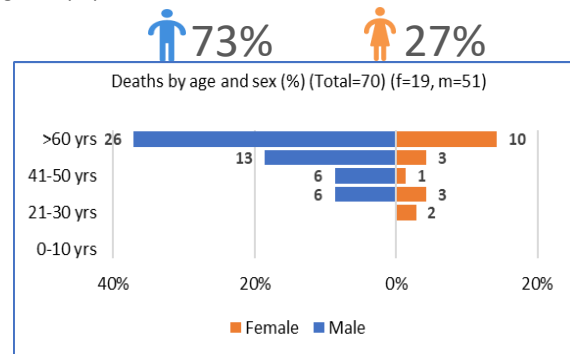


Figure 3: COVID-19 deaths by age and sex among host population in Cox's Bazar

As of 11 October 2020, a total of 276 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 and 3 with 24 and 20 cases respectively and camp 15 with 22 cases. To date, 16 cases were reported from Camps 6 and 12 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 had so far less than 5 cases.

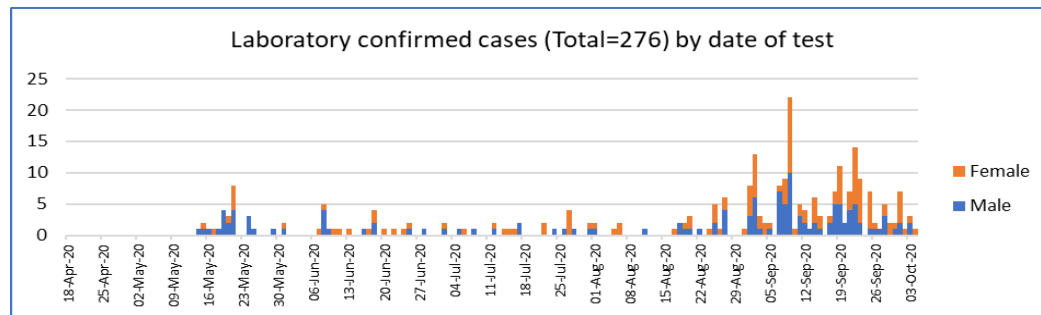


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

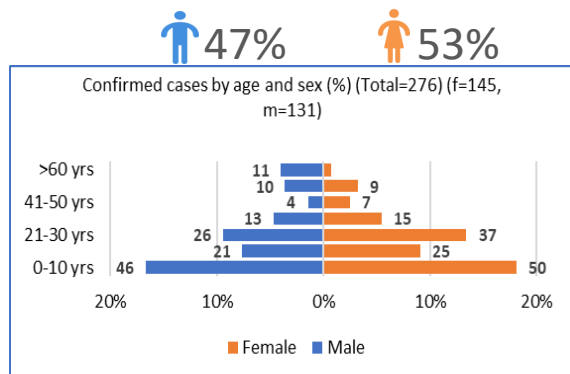


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

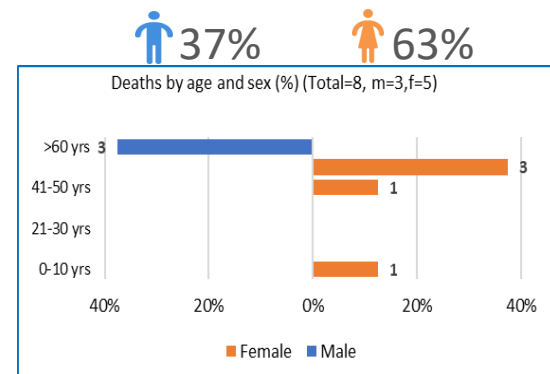


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

During the reporting period, 3 new COVID-19 cases were confirmed in the Rohingya refugee camps. Currently, 25 sample collection sites (including 1 new site) are operating for suspected COVID-19 sample collection. A training in Community Based Mortality Reporting is ongoing with a total of four batches planned to reach 150 medical doctors, reporting officers and community health workers are expected to participate in this capacity building. A refresh training has been conducted with all site focal persons to reemphasize the current data management and introduce a pilot initiative to capture data using kobo platform. A Joint Assessment Team (JAT) Training for AWD Outbreak Response is planned for the last week of October 2020.



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 11 October 2020, a total of 52 897 tests for COVID-19 have been conducted of which 45 591 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A significant decrease in the number of tests conducted among the Rohingya was observed in the last two weeks (1810, 1172 and 652 tests per one million population in weeks 39, 40 and 41 respectively). Similarly, the number of tests decreased among the host community population (561, 382 and 353 tests per one million population in weeks 39, 40 and 41 respectively).

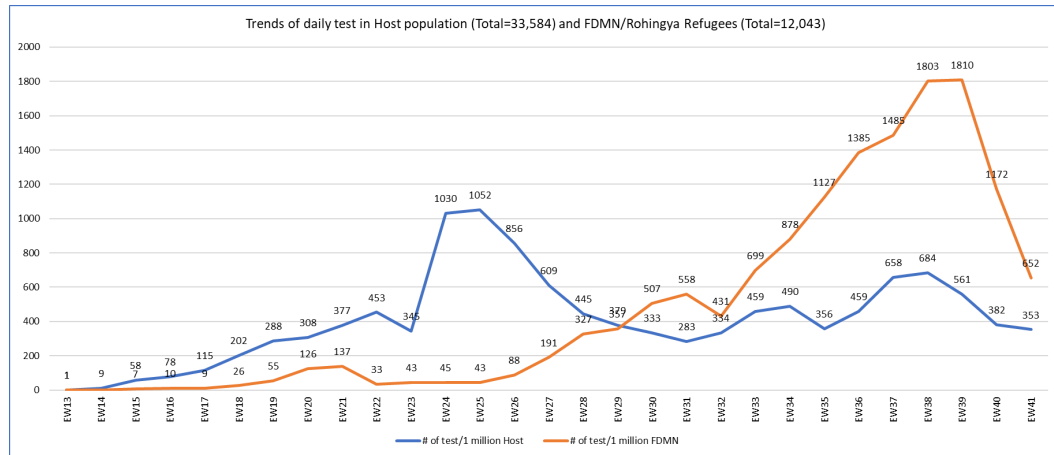


Figure 7: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees

## 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 1831 humanitarian health care workers and 814 government staff from Severe Acute Respiratory Infection (SARI) ITC partners and government facilities, respectively.

A planning and advocacy meeting for WASH FIT was held in Cox's Bazar bringing together over 11 organizations implementing WASH FIT in their facilities. This is a follow up to a 4-days training on Water and Sanitation in Health care facilities Improvement Tool (WASH FIT) which was completed for 104 health care workers from 105 health facilities. 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. Preliminary findings from 184 facilities against standard WASH FIT indicators were presented and discussed for a joint way forward. 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 two facilities in camps 16 and 21. In total, 16 SARI ITCs have been visited. IPC supportive supervision was conducted at eight health facilities. Since September, 67 health care facilities, including 17 SARI ITCs and Isolation Units, have been visited in 25 camps.

Photo: After attending WHO WASH FIT training, Medical Assistant Samira Chakma improved the cleaning protocol, hand washing and water pipes at the IOM Health Post, in Teknaf, where she works. Engaging her team was key for a successful implementation.



## 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-three mobile medical teams and 19 dispatch and referral unit ambulances stand ready to respond to the adverse effects of cyclone and monsoon season. IOM has 30 ambulances in the pool and 11 ambulances dedicated for the MMT. 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.

## CLINICAL CASE MANAGEMENT

To date, 14 SARI ITCs are established with a total of 878 beds. Of these, 546 are ready to receive patients and another 327 are in place and held on standby. Five isolation facilities provide additional 72 beds. Also operational is the Intensive Care Unit/High Dependency Unit Facility at Sadar Hospital with ten ICU and eight HDU beds. Construction of SARI ITC sites is expected to be completed by November 2020 with three more facilities bringing 279 new beds to the overall count. The low occupancy rate is reason for partners to plan ahead for the medium and longer term usage of the SARI ITCs and moving beds from "open" to "stand by" status. A consolidated, streamlined data reporting tool is going to be implemented aiming to reduce reporting efforts and limiting the potential for conflicting data. The resulting data will aid the monitoring of bed availability across the SARI ITCs.

Continued case management meetings (operational and clinical) take place once weekly. A "special" case management meeting was held together with SARI ITC information management focal persons to review new streamlined data collection protocol and tool.



Photo: WHO supportive supervision visit at the Care Unit/High Dependency Unit Facility at Sadar Hospital, Cox's Bazar.

## ESSENTIAL HEALTH SERVICES

**Routine immunization:** 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, a new strategy and microplan has been 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 (HFM)s 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. HFMs are instructed to collect the updated eligible children line listing which will be provided by Community Health Workers and their supervisors. Based on the updates, the EPI registration book will be reformed to find out the missed/drop out and left out children.

**Sexual and Reproductive Health (SRH):** Discussions held with WHO, Health Sector, UNFPA/SRH WG coordination, and CHWG to review SRH messaging and strategize the most effective means of dissemination and community engagement, including for male involvement in maternal health care. Collaborated with OSL to ensure that essential supplies are available in prepositioned containers for continued and uninterrupted provision of health services in the event of an emergency.

Held preliminary discussions with health partners at "special" SAG meeting to discuss future planning of facilities in the camps post-COVID -19, to ensure a collaborative approach to covering essential health services including maternal child health, nutrition, while continuing surveillance and responding to infectious diseases.

## OPERATIONAL SUPPORT AND LOGISTICS

Technical support to the CERF funded Friendship SARI ITC is ongoing, including facility layout, patients and staff flow, bed spacing, ventilation and waste management. Preposition containers at Camps 9 and 12 in Ukhiya were restocked with contingency supplies, IEHK and Trauma kits. During the reporting period, a total of 8000 Kg of supplies were distributed including COVID-19 related items, SRH kits and medical equipment to five partners, WASH supplies to five government agencies and other implementing partners, and 56 waste bins as part of the World Bank funding.

## 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 11 October 2020, a total of 593 479 individuals have been screened. The teams continue working to identify febrile passengers and pedestrians for education and referral to health facilities.



## SUBJECT IN FOCUS: A Multi-sectoral Acute Watery Diarrhoea Preparedness & Response Plan for Cox's Bazar

Globally, diarrhoeal disease is the second leading cause of death in children under five years old and as such is responsible for taking the lives of thousands of children every year. Acute Watery Diarrhea (AWD) is one of the most reported diseases in the Rohingya refugee camps and host communities in Cox's Bazar. According to the case definition, it is defined as the passage of three or more loose/fluid stools over the past 24 hours with or without symptoms of dehydration. One of the causes of AWD is Cholera, a diarrhoeal disease that starts with the bacterium *Vibrio cholerae*, either type O1 or O139, infecting the intestine.

### Context

Living under fragile conditions, the Rohingya refugees in Cox's bazar experience poor sanitation, unsafe drinking water and densely populated areas, being therefore exposed to contamination of food and drinking water. However, the situation has improved over the past 2 years and a half with the support provided by the Health, WASH and Shelter sectors who work relentlessly to improve the situation. Still, there are a few aspects requiring to be addressed as the risk of AWD remains.

#### AWD & vulnerable populations

Cholera is known for being a threat to vulnerable populations but that is especially true in communities affected by crisis and emergencies. If not prevented and timely contained, AWD has the potential to become an epidemic with a high death toll if treatment is not initiated during the early phase of the disease transmission. Critical measures to reduce the risk of AWD outbreaks include ensuring the provision of clean water and proper sanitation, educating the at-risk population to adopt good personal and food hygiene as the risk of infection significantly reduces when people apply hand-washing practices before preparing food and eating and after using the washroom. A good coordination of the Health, Water, Nutrition, Sanitation and Hygiene (WASH) sectors as well as Communications with Communities (CwC) has been critical to prevent AWD outbreaks in Cox's Bazar with 444 000 host communities and 860 494 Rohingya refugees.

#### Oral Cholera Vaccine

WHO recommended that inactivated oral cholera vaccines (OCVs), in conjunction with provision of appropriate rehydration therapy, clean water and sanitation, are available in humanitarian and emergency settings at high risk for cholera. In Cox's Bazar, six rounds of preventive and reactive Oral Cholera Vaccine (OCV) campaigns were conducted in October and November 2017, May and December 2018, in December 2019 and in February 2020 in response to the increasing number of Cholera cases. The campaigns included continuous health promotion and WASH related interventions. Between September and December 2019, 239 RDT positive cases were reported in the refugee camps, the majority from Teknaf areas. Of these, 178 cases were found with cholera.



Photo: In December 2019, 635 000 refugees and host communities were vaccinated against diarrheal diseases in Cox's Bazar.

The engagement of multidisciplinary partners was key to develop a strategic plan following which the implementation was carried out by a Joint Assessment Team (JAT) to break the chain of transmission and control the outbreak.

#### Diarrhoea Treatment Centre

A Diarrhoea Treatment Centre (DTC) with 20 beds is currently operational at Leda Camp 24 in the Rohingya Refugee camps, where treatment for AWD patients with signs of severe dehydration can be admitted. In December 2019, during Epidemiology week 52, the number of cases declined significantly as a result of the action taken by different actors and supported by the successful administration of two rounds of OCV campaign in the camps, targeting the most vulnerable, including one round of OCV in the host community. However, the second round of OCV campaign in the host community was delayed due to COVID-19 and it is expected to be implemented by December 2020. This year, between week 1 and 33, a total of 83 509 AWD cases were reported through EWARS from different health facilities across the 34 camps.

#### A response plan for Cox's Bazar

The multi-sectoral acute watery diarrhoea response plan was initiated in October 2017 by the Cox's Bazar Health Sector in consultation with the WASH and Nutrition sectors, the Communications with Communities Working Group (CwC WG) and relevant units.

The plan was revised in 2019 and is expected to be updated this year in line with the Global Action Plan for Pneumonia and Diarrhoea (GAPPD) taking into consideration the recommendations drawn from the After Action Review (AAR) of AWD/cholera outbreak in February 2020.

The purpose of this document is to ensure a proactive and coordinated approach to AWD outbreak plan and response across sectors and stakeholders with the objective of reducing morbidity and mortality. It focuses on preparedness, prevention and control activities agreed upon between the sectors and departments preventing the impact of AWD outbreaks in the refugee camps and the surrounding areas of the host population. Although the plan was developed to respond to a AWD/ cholera outbreak, the framework can be adapted to prepare for and respond to other water-borne and fecal-oral transmitted diseases. AWD preparedness is expected to improve coordination and response interventions, enhance cholera surveillance for immediate public health control measures (case management, WASH and use of OCV, if justified) and monitoring, establish and implement standard operating procedures for early detection of cases and laboratory confirmation of cholera outbreaks.



Photo: Conducting a rapid diagnostic test (RDT) at the host community in Teknaf, Cox's Bazar.

Additionally, the document recommends adequate case management and infection prevention and control during an outbreak, while enhancing environmental control procedures in response to outbreaks, strengthening public health Communications with Communities (CwC) and ensuring that regular Hygiene Promotion (HP) activities are implemented. In preparation for a successful implementation, 300 health care workers were trained in 2019 to respond to the AWD outbreak in the host community and the camps. This year, the first training targeted 160 health care workers from the Upazilas of Ukhiya and Teknaf as part of preparedness for AWD case management.

## Enhancing Preparedness

Based on the characteristics of previous large AWD outbreaks in Cox's Bazar, two possible scenarios, "worst-case" and "best-case", were taken into consideration to estimate the need for treatment facilities and supplies during the peak of the outbreak, when the maximum number of resources will be required.

Every week, health facilities report aggregated numbers of AWD cases through the Early Warning and Response System (EWARS) which is managed by the World Health Organization (WHO). In addition to regular reporting of health events through Indicator-Based Surveillance (IBS), EWARS has also an Event-Based Surveillance (EBS) component for immediate reporting of important issues related to AWD. Health facilities with isolation capacity and DTCs will conduct Rapid Diagnostic Tests (RDTs) for all suspected cholera cases and share the results in EWARS through the notification in EBS and update the case report form. All samples tested positive are re-tested using culture confirmed procedure in laboratory.

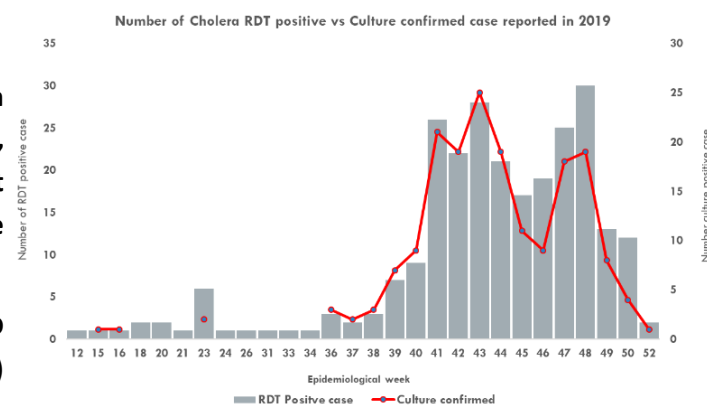


Figure 8: Number of Cholera RDT positive vs Culture confirmed cases reported in 2019.

The JAT mechanism was crucial during the last outbreak and will be used for any confirmed diarrheal disease alert in the future. Together with epidemiological investigations, an environmental assessment of Health & WASH conditions around the alert location and collection of water/environmental samples should be conducted followed by immediate health and WASH education sessions in the community. The goal of the JAT is to develop the capacities of the health and WASH sectors in order to respond in a coordinated and systematic manner to any confirmed AWD alert investigation in a routine / non-outbreak setting. The roster will rely on partners from the Health and WASH sectors that could be mobilized to assist in joint case investigation, response and follow-up activities at field level.

The Ministry of Health & Family Welfare (MoH&FW) has the sole authorization to declare a Cholera outbreak after a thorough assessment of the magnitude and risk considering the exiting context and available resources.

	Last 24 hours	Total
COVID-19 tests conducted	13 227	2 084 222
COVID-19 positive cases	1472	379 738
Number of people released/recovered	1531	294 391
COVID-19 deaths	31	5555

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](mailto: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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