World Health Organization
Bangladesh

Rohingya Crisis Situation Report #31

Date of issue: 10 November 2020

Week 45
2 - 8 November
Location: Cox's Bazar

PHOTO: On 14 May 2020, Nur Alam, a Rohingya refugee, was the first person testing positive for COVID-19 at the refugee camps in Cox's Bazar. He has fully recovered and is selling facial masks at his stall to help other refugees reduce the risk of getting infected.

HIGHLIGHTS

- **Six months ago, on 14 May 2020, a 35-year-old Rohingya became the first patient (of 342 to date) testing positive for COVID-19 at the Cox's Bazar Refugee camps. Through Clinical Case Management forums, WHO continues fostering peer to peer support and knowledge exchange on the full spectrum of the COVID-19 illness, from screening to rehabilitation, to optimize clinical health care in Cox's Bazar. 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 Dispatch and Referral Unit (DRU).**
- **Currently under preparation, the 2021 Joint Response Plan for the Rohingya Humanitarian Crisis will be shared soon with Strategic Advisory Group (SAG) members, including government officials, for their contributions.**
- **SUBJECT IN FOCUS: Communicating Risk - Working with vulnerable communities to promote health in emergencies**

	Host Community	Rohingya refugees
Total confirmed COVID-19 cases in Cox's Bazar	4955	342
Total cases in isolation in Cox's Bazar	230	77
Total number of tests conducted	38 197	15 175
Total deaths due to COVID-19	72	10

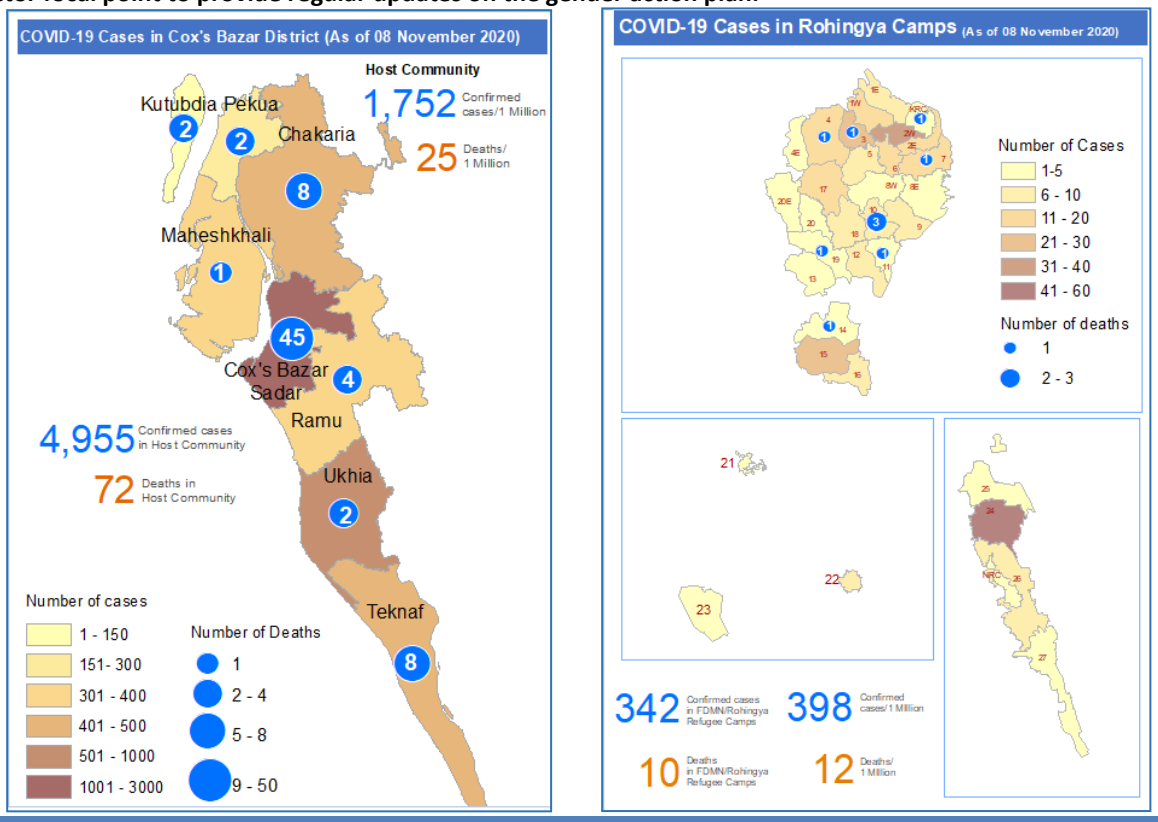
**Updated as of 8 November 2020* / *FDMN = Forcibly Displaced Myanmar Nationals

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. During the reporting period, seven camp level health partners coordination meetings were held at Ukhiya and Teknaf Upazilas. The Health Sector Field Coordinator visited six priority health facilities and four Camps-in-Charge (CiC) in Teknaf. WHO Head of Sub-Office and Health Sector Coordinator (Ag) met with Refugee Relief and Repatriation Commissioner and RRRC Health Coordinator to review health services in the camps and host community, and to ensure strong collaboration between Health Sector and government officials. Topics included continuation of surveillance and case management for infectious diseases, public health measures to safely support the gradual resumption of non-critical services and strengthening family planning services. Quarter 3 (Q3) facility monitoring continues through the camp health focal points. Completion is expected by mid-November.

2021 JRP preparation continues. The zero draft narrative will soon be completed and shared with Strategic Advisory Group (SAG) members, including government officials, for their contributions. Health Sector coordinator (Ag) and partner representation from UNFPA, Save the Children and UNICEF visited the Civil Surgeon office to discuss an upcoming maternal health workshop to address issues with referral pathways, comprehensive emergency maternal and neonatal health care (CEmONC) services. Under the government's leadership, provision of maternal health will be further strengthened in the camps and in the affected host communities.

The health sector re-circulated through WHO a Request for Proposals (RFP) for the planned in-depth assessment on impact of COVID-19 on Gender-Based Violence (GBV) health services to invite more applications. Health partners continued to collect printed copies of Health Sector SOP on GBV, Clinical Management of Rape flowcharts, GBV registers and posters from the WHO warehouse in Sea Palace. Following a request by one of the partners, an orientation session was also held by health sector with frontline medical staff from the partner agency on the use of the GBV registers. The Health Sector was represented in the bi-weekly Gender in Humanitarian Action (GIHA) Working Group meeting by the sector focal point to provide regular updates on the gender action plan.



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 08 November 2020, a total of 4955 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 500 in Chokoria, 403 in Teknaf, 313 in Maheshkhali, 2579 in Sadar, 517 in Ukhiya, 336 in Ramu, 202 in Pekua and 103 in Kutubdia.

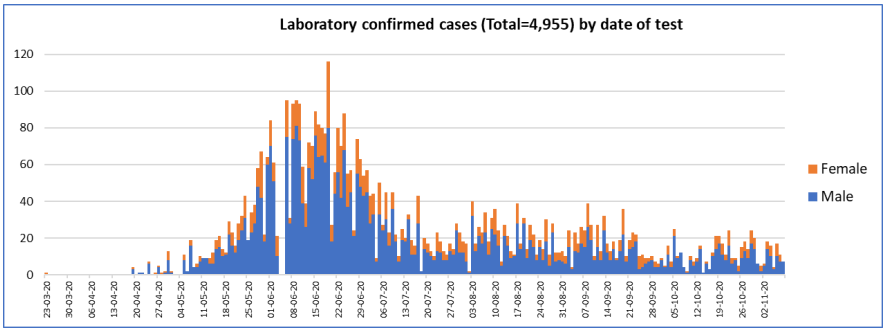


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

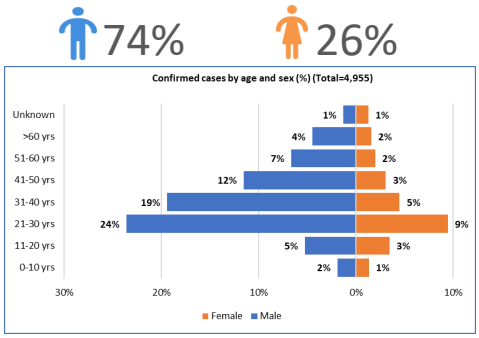


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

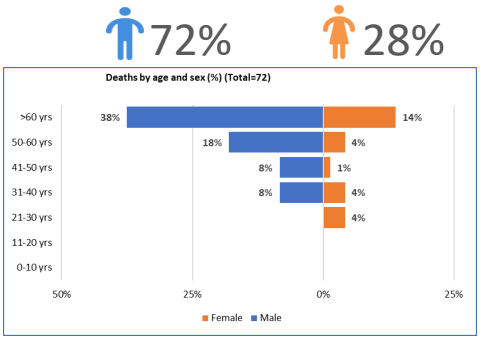


Figure 3: COVID-19 deaths by age and sex among host population in Cox's Bazar

As of 08 November 2020, a total of 342 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 50 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 33 and Camps 3 and 15 with 27 and 24 cases respectively. To date, 20 cases were reported from Camps 6 and 15 from Camp 2E. Camps 1W, 4 and 7 had 12 cases each. Camp 17 registered 11 cases and Camps 1E and 10, identified 10 each while Camps 18 and 26 reported 9 cases. As for Camps 5 and 9, 8 cases were reported. Camps 12, 16 and 22 registered to date 7 cases each. Camps 8W, 11, 19, 20 Extension and Nayapara RC identified 5 cases. The remainder Camps (27, 25, 4 extension, 14, 21, 8E, 23, 13, 20, 20 and Kutupalong RC) had so far less than 5 cases.

Camp-wise Rapid Investigation and Response Teams (RIRTs), 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 Dispatch and Referral Unit (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 (34 supervisors and 311 volunteers) are embedded in the RIRT for contact tracing having identified 80% of the contact persons (1001/1283) and 2.2% of new cases during the reporting period (6/342).

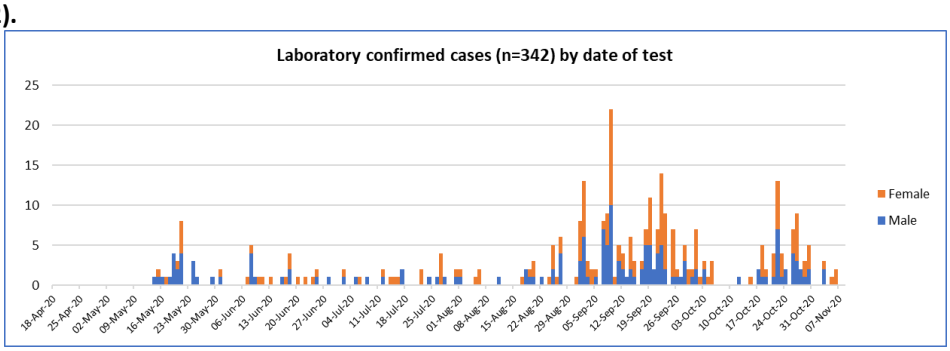


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

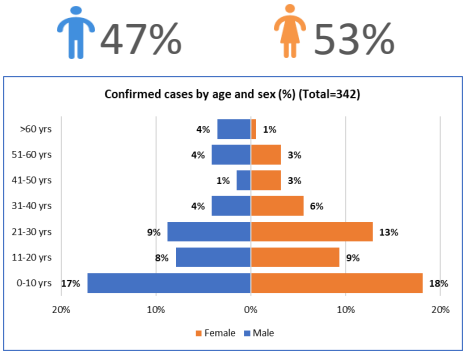


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

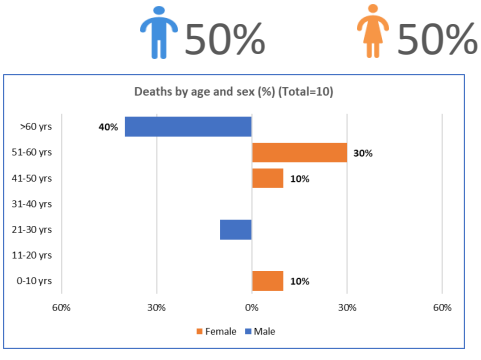


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Between 1 - 8 November, 6 new COVID-19 cases were confirmed in the Rohingya refugee camps. The cumulative share of positive tests is 2.2%, with 10 deaths hence a fatality rate of 2.9%. The incidence rate is 39.8 per 100 000 people, 8.4% of the cases showed severe symptoms at the time of admission while 7.6% of the cases report at least one co-morbidity. Although the main age of tested samples is below 12 years, a significant proportion has been tested among 40+ years (158 per 10 000 people), however the highest number is 246 tests per 10 000 population among patients aged 0-9 years. The test positivity was highest in the 50+ cohorts with 3.1% and the age specific mortality of 0.99% per 10 000 people. So far, 45% (589) of contacts have seen their follow up completed after which they were released from quarantine, while 1.2% of known contacts have tested positive for COVID-19. Existing 25 sentinel sites have been followed up by digital data entry of all tested samples using Kobo platform. Currently this activity uses a paper-based lab request form and excel-based data sharing and management. A strategic document on CoVAX (Coronavirus Vaccine Alliance) for Rohingya refugees is under development and will soon be shared with the GoB. The Epidemiology unit is engaging in prioritization, targeting risk groups while continuing COVID-19 surveillance. A JAT (Joint Assessment Team) Training for AWD Outbreak Response is planned for 16-22 November 2020.

*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.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

WHO is engaging communities, health partners and other key stakeholders to develop, implement and monitor an action plan to effectively help prepare populations and protect them from COVID-19. Mixed-media messages include general information on COVID-19, hand washing, physical distancing and mask wearing, risks and vulnerabilities, safe and dignified burials, home-based care, quarantine, isolation, and treatment centres, etc. WHO, through its involvement in Communications with Communities Working Group, (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), 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. Results from the September WHO/UNHCR survey around mask wearing, COVID-19 testing and health clinic visits, showed that among women who do not wear a mask at all times 83% said that it was because they wore a veil or niqab. In response, the RCCE WG and health sector have started working on outreach to women around the necessity of wearing the more protective face mask. A total of 1416 community health workers (CHWs) have been trained and are coordinated by the Community Health Working Group (CHWG) 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 155 197 household visits in which 3277 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 3 patients with moderate/severe symptoms. The cumulative number of mild patients is 52 362, and 205 moderate/severe patients. Additionally, 1353 persons with COVID like symptoms were referred to health facilities from a total of 23 908 to date. Through coordination by the CHWG, COVID-19 messages reached 276 922 persons between 2 and 8 November. Since the beginning of the response, community health workers have conducted more than 3.6 million household visits and had contacts with a cumulative number of more than 11.68 million adult household members. Through the CwC WG, another 30 697 people were engaged in 9778 small group sessions.

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 08 November 2020, a total of 62 303 tests for COVID-19 have been conducted of which 53 372 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A slight increase in the number of tests conducted among the Rohingya was observed in week 45 (from 922 to 944 tests per one million population). An increase was observed among the host community population (from 384 to 592 tests per one million population). Currently, 25 sample collection sites are operating for suspected COVID-19 patients.

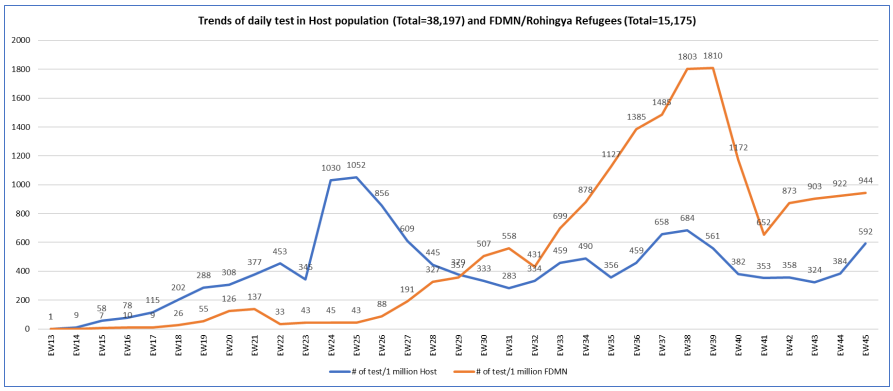


Figure 7: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees

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 new colleague has joined WHO to support the IPC team health care waste management activities in the camps. Supervisory visits have taken place with technical support provided to health care facilities in several camps including SARI ITCs. The visits addressed issues relevant to WASH, HCWM and WQS and solutions recommended to respective facility in charge(s). To date, 208 health workers from 179 health care facilities in Cox's Bazar have been trained on WASH FIT to support improvements on IPC, WASH and health care waste management at their respective facilities. WASH FIT assessment for SARI ITCs was conducted at 18 SARI ITCs including Sadar HDU/ICU.

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. The Emergency Preparedness Response (EPR) working group met this week to review general plans for emergency response, activation phases, 72-hour pre and post landfall plans, overview of MMT function, and catchment area organization. The biweekly camp health focal point (CHFP) meeting was held and CHFPs are encouraged to join the EPR WG as they will play a significant role in the event of an emergency or natural disaster occurs. The Health Sector planning continues with updates and additional details will be shared with partners soon.

CLINICAL CASE MANAGEMENT

Photo: First Aid training participants "rescuing" a patient in a simulated road accident.

The number of operational SARI ITC beds continue to fluctuate with additional bed capacity coming "live" in Teknaf and one SARI ITC site in Camp 26 having transitioned fully into stand by modus due to the currently low transmission scenario. Therefore the current SARI ITC bed capacity stands at 625 operational beds, 560 stand by beds with additional 44 beds currently under construction of which 25 will be operational towards the end of November. All partners with stand by bed capacity are capable of immediate re-opening of their beds in case the number of patients increases.

Clinical case presentations at the Sadar ICU are bringing to light the need to strengthen rehabilitation skills among the ICU staff to ensure appropriate rehabilitation activities for patients recovering from their severe health conditions in the ICU. A network of technical experts in physical rehabilitation from WHO and partner organisations joined the case presentation calls over the past two weeks and are currently jointly developing a concept to support the ICU team to address their needs. The first batch of Basic First Aid training for SARI ITC driver/nurse teams finished during the reporting period and the second batch has started. Initially, participants showed some hesitancy to engage in the practical activities, especially from the non-medical personnel (i.e. drivers). However, over the course of the three days this has changed notably. The Basic First Aid training is a starting point to build stronger emergency care and referral capacity in the context of Cox's Bazar.

ESSENTIAL HEALTH SERVICES

The monthly 4W (Who, What, Where, When) reporting has been completed: 1500 deliveries, 1314 dental services and 18 615 community psychosocial activities completed in October 2020. In total, there are 96 health posts, 38 primary care centers, 4 field hospitals, 23 specialized facilities and 56 sexual and reproductive health specific facilities.

Photo: A Dentist in the Rohingya refugee camps, Dr Jonayed is providing dental care services to refugees and host communities in Cox's Bazar.

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. To that end, a new strategy and microplan has been implemented and coverage data has started showing 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 Active Surveillance, WHO SIMOs are visiting surveillance sites for the VPD case searching. Suspected VPD cases are being investigated regularly by SIMOs. Updated line listing information of children under 2 years old has been collected and will be shared with vaccinators to streamline the information in the registered book for missed and left out children. WHO-IVD team has started working on COVID-19 vaccination planning and strategy under the leadership of the Government of Bangladesh following the modality of NVDP (National Vaccine Deployment Plan) and CoVAX.

WHO/James P Grant School of Public Health (JPGSPH) completed a 3-days Training of Trainers (ToT) on risk factors of noncommunicable diseases (NCDs) and behavioural interventions for 54 community health worker supervisors working at the Rohingya refugee camps of Ukhiya and Teknaf.

OPERATIONAL SUPPORT AND LOGISTICS

During the reporting period, a total of 10 982 Kg and 24.81 CBM of Lab supplies, Medicines, Flip Charts, VTM, GBV stationary and medical equipment were distributed to implementing partners in the camps. Distribution of the SRH kits for the contingency stock in preposition containers in the camps has been finalized. As part of the supply management activity, the supplies stock card inventory has been concluded while obsolete items for disposal are currently in process. A technical proposal of 19 bidding suppliers for the laboratory and blood transfusion facilities has been finalized. WHO continues to support DRU and sample collection activities in the camps with four vehicles.

POINTS OF ENTRY

Seventeen out of 19 Points of Entry are functional in different strategic locations around the camps. A total of 53 928 individuals have been screened during the aforesaid reporting period. Support is ongoing to identify febrile passengers and pedestrians for education and referrals to health facilities.

SUBJECT IN FOCUS

Communicating Risk - Working with vulnerable communities to promote health in emergencies

When COVID-19 hit globally, in Bangladesh and in Cox's Bazar, the Communications with Communities Working Group (CwC WG) and the ISCG activated a Risk Communication and Community Engagement Working Group (RCCE WG) consisting of CWC WG member agencies, Translators without Borders, BBC Media Action, UNICEF and WHO and representatives from Health/Community Health Working Group and WASH sector to provide technical advice in the COVID-19 response.

Photo: A Rohingya refugee, Md Ayub works as a Volunteer Supervisor in Cox's Bazar since 2018. He is responsible for 15 other volunteers. Together, they are supporting the COVID-19 response in the camps.

Communicating Risks: hand in hand with communities

Risk communication consists in real-time exchange of information, advice and opinions between experts or officials and people who face a threat (hazard) to their survival, health or economic or social well-being. Its ultimate purpose is that everyone at risk is able to make informed decisions to mitigate the effects of the threat (hazard), such as a disease outbreak, and to take protective and preventive action for themselves, their families, and their community.

To that end, and as an essential part of humanitarian health emergency responses, Risk Communication and Community Engagement (RCCE) includes a range of tools that enhances preparedness, response and recovery phases in the contexts where it is most needed: to address serious public health events, to encourage informed decision making, positive behaviour change and the maintenance of trust between humanitarian aid and communities. It ensures quick, timely community outreach to affected populations while providing correct information in the right language, appropriately communicated.

Rohingya Crisis: three years on, the value of community proximity

In Cox's Bazar, risk communication is about working with communities with the emphasis on face to face communication and utilizing the resources already in the community to the greatest benefit. Community health workers, and social and community mobilizers play a significant and irreplaceable role in working with communication and information. Having fled Myanmar's Rakhine State in August 2017, where they missed educational opportunities, the Rohingya people greatly benefits from language and culturally inclusive information.

Preparing vulnerable groups for COVID-19 Pandemic

In early March, the RCCE WG developed an RCCE plan outlining key initial steps for the COVID-19 emergency response, including launching key messages (approved by the Civil Surgeon) for the Rohingya community in written Bangla and Burmese. At the same time, audio messages were delivered across all 34 refugee camps in Rohingya language. These first communications outlined the symptoms of COVID-19 and how to seek help for any concerning signs of the disease. Messages also included preventive measures of hand washing, physical distancing, and other appropriate approaches to general hygiene.

The in-depth Joint Health Sector and CWCWG Strategy on Strengthening Community Engagement was launched in June. The strategy aims at community health workers, health facility staff and others who interact directly with at-risk people to communicate prevention measures: how, where and why to seek out COVID-19 testing, contact tracing, treatment and availability of health facilities such as quarantine and isolation centres, designed with the purpose of "allowing people to take practical and pro-active steps for themselves, [that] could bring a sense of empowerment and ownership to a frightening time which is not often in their control".

The strategy also encourages community members to plan what to do in case someone in their family has symptoms or becomes sick with COVID-19. Furthermore, it helps communities in identifying the nearest health facility, how to transport family members if they are very ill, who would look after children or support the elderly or disabled people who stay home, what to tell children if family members are extremely ill, how to manage home isolation, keeping the shelter secure and safe in case of absences due to isolation, and how would your family plan to get food, other relief items and LPG gas if the responsible family members are sick.

Through this strategy, to date over 225 multisectoral, needs-based, actionable and culturally appropriate communication materials have been developed and delivered in different formats, including posters, flyers, radio dramas, podcasts, loudspeakers, narrowcasts and broadcasts, videos and animations, WhatsApp forums, radio listening groups (with physical distancing), and community-based discussions.

WHO works with UNHCR and the Community Health Working Group (CHWG) to help implementing the strategy while supporting the 1515 community health workers (CHWs) who visit over 140 000 households per week. Their mission is to share correct, up-to-date and appropriate health information around COVID-19 including community-based surveillance and information on home-based care. Since the beginning of the COVID-19 response, CHWs have conducted 3.6 million household visits and had contacts with a cumulative number of 11.6 million adult household members. CHWs also counsel on testing, quarantine and patient referral to isolation facilities. The Rohingya community health workers represent best practice in risk communicators and community engagement. They are trusted members of their community who share key information on health promotion, referrals and communication from the Health Sector and RCCE WG while responding to fears, misinformation, and rumours.

Photo: Nur Asina, a Rohingya volunteer, is helping her community fight the coronavirus in the densely populated refugee camps. To that end, she received training and communication tools to pass on important message to other refugees.

Assessing results to enhance effectiveness

Three months since the strategy was launched, in September, WHO and UNHCR decided to survey the effectiveness of the intense community engagement that has been done among the Rohingya population; whether people were absorbing and developing good knowledge from the risk communication outreach, and whether they were responding (through behaviour change) to the information they were receiving.

The findings concluded that there is a good knowledge of COVID-19 related issues: indicating a strong understanding of the processes of COVID-19 prevention by always wearing masks outside the house, and symptoms of COVID-19. For trustworthy sources information around the COVID-19 test, NGOs scored highly (over 80%) among both women and men respondents. The survey results were presented to the Health Sector, the CHWG, the CwC Working Group and circulated to all partners.

The RCCE WG, responding to evidence outlined in the survey that 83% of women who say they do not wear a mask at all times because they feel protected by a face veil or niqab, is currently working on information that highlights that even if a female wears a niqab, for the sake of protection, they should also wear a face mask.

Addressing COVID-19 impacts in the camps: one month to increase Routine Immunization

Concerns around COVID-19 has led to a drop off in families returning to clinics for follow up vaccinations. In October, the RCCE Working Group launched a one-month strategy in the Rohingya camps and host communities promoting routine vaccination and outlining the risk to children's health when they miss out vaccines. The project involves a concerted and intense outreach to every family and guardian in the camps, through health clinics, community sessions, Imams and Mahjis, and audio messaging, outlining the importance of keeping up with the vaccinations schedule and addresses concerns and vaccine hesitancy, assuring families that vaccines are safe.

WHO continues to make its technical experts and RCCE expertise available for communications with host communities, by working with radio stations and community outreach groups on such topics as maintaining routine immunization during the COVID-19 period. Since August, WHO has delivered 15 weekly radio scripts to the widely listened government radio station Bangladesh Betar for community awareness around COVID-19.

All COVID-19 risk communication tools are made available to anyone to download on the Bangladesh National Communication with Communities national website Shongjoghttp://www.shongjog.org.bd/.

	Last 24 hours	Total
COVID-19 tests conducted	12 760	2 442 602
COVID-19 positive cases	1474	420 238
Number of people released/recovered	1577	338 145
COVID-19 deaths	18	6067

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"

World Health Organization
Bangladesh

CONTACTS

Dr Bardan Jung RANA
WHO Representative
WHO Bangladesh
Email: ranab@who.int

Dr Kai VON HARBOU
Head of Sub-Office
WHO CXB Sub-Office
Email: vonharbouk@who.int