



Seroprevalence Study: Data blood sample collection in the camps between 2-30 December 2020. A total of 3699 samples obtained.
Photo by Tatiana Almeida

HEALTH SECTOR BULLETIN # 13

Bangladesh
Emergency: Rohingya Refugee Crisis in Cox's Bazar District
Reporting period: July – December 2020



**1.4 MILLION
PEOPLE IN
NEED**



**866,457
REFUGEES**



**80
PARTNERS**

HIGHLIGHTS

- Utilisation of maternity services improved between July-December 2020, compared to the period January-June 2020. The number of facility-based deliveries attended by skilled birth attendants increased by 28.2%.
- The first COVID-19 case was reported in Cox's Bazar district on 23 March 2020 in the host community, and on 14 May 2020 a FDMN/Rohingya refugee was confirmed as COVID-19 positive. As of 27 December 2020, a total of 5,358 individuals from the host community in the Cox's Bazar district have tested positive for COVID-19, and a total of 366 COVID-19 cases have been confirmed among FDMN/Rohingya refugees.
- A total of 142 509 (101.7%) first-time family planning visits were reported in 2020 against a set annual target of 140,180 visits. Generally, the number of first-time visits for family planning continued to increase steadily from July to December 2020 (23% increase in comparison to first half of the year).
- 14 Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) were active, including 652 operational beds, that have the capacity to treat severe COVID-19 cases. Additionally, 579 beds are currently kept on standby, all of which can become operable within 24-48 hours when needed.

HEALTH SECTOR

1.4 M PEOPLE TARGETED FOR ASSISTANCE
MEDICINES AND SUPPLIES DELIVERED TO HEALTH FACILITIES/PARTNERS*

23 TRAUMA KITS
130 IEHK KITS
23 CHOLERA KITS

HEALTH FACILITIES

39 PRIMARY CENTERS **HEALTH**
97 HEALTH POSTS

HEALTH ACTION

3 487 256 OPD CONSULTATIONS
15 473 ASSISTED DELIVERIES
9882 REFERRALS

VACCINATION AGAINST

18 672 POLIO
11 858 MEASLES*

EWARS

146 SENTINEL SITES

FUNDING \$US

25 % FUNDED (AS OF 23 JANUARY 2021)¹
172 M REQUESTED

¹ Source: <https://fts.unocha.org/appeals/906/summary>

Situation update



Figure 1: Population distribution in the Rohingya Camps²

According to UNHCR, the number of FDMN/Rohingya refugees in the Cox's Bazar district now stands at 866 457 (status: 31 December 2020). About 52% are women and girls, while more than half are children. Unaccompanied or separated children make up approximately 0.28%. Less than 1% are estimated to be persons with disabilities, while 0.42% have reported serious medical conditions. The average family size of the total registered population is 4.6 persons per household.

To ensure an adequate response to the COVID-19 pandemic, the Health Sector, under the leadership of the Civil Surgeon's Office and coordinated by WHO through a Case Management Working Group managed to set up 14 SARI ITCs with a total (operational and stand-by) bed capacity of 1231 (as of 31 December 2020). Health partners have indicated they will maintain SARI ITCs until there is more clarity on the trajectory of the outbreak, however some will shift their mode to "stand-by". The results of the seroprevalence study, amongst others, will guide future decision-making for the response.

COVID-19 testing capacity at the Institute of Epidemiology, Disease Control and Research (IEDCR) laboratory in Cox's Bazar is currently at 1500 tests per day. Since the first test was conducted in the laboratory 02 April 2020, 85 267 tests have been conducted in total (as of end of 2020), including 12 483 tests for the neighboring districts. 25 sentinel sites remain active to collect samples in the refugee camps. As of 27 December 2020, a total of 5358 individuals from the host community in the Cox's Bazar district have tested positive for COVID-19, and a total of 366 COVID-19 cases have been reported among FDMN/Rohingya refugees. Overall, 1.6% of all tests showed positive results, including samples from all 34 camps.

So far, 7.7% of cases showed severe symptoms at the time of admission; and 7.7% also reported at least one co-morbidity. Although the median age of individuals tested is 10 years of age, a significant proportion has been tested positive among individuals 40+ years of age (258 per 10 000 people). The highest number of positive tests was reported for individuals less than 9 years old (394 tests per 10 000 people). The age-specific mortality was highest for individuals at 50+ years of age, with 0.9% per 10 000 people.

While health facilities witnessed a decrease in weekly consultations in the first half of 2020 due to continued fears, stigma, rumors and misinformation associated with COVID-19, the second half of the year saw a steady increase for health services used by the FDMN/Rohingya refugees. In May 2020, the reported total number of consultations was 143,000, compared to December 2020 when more than 360 000 consultations were reported. An increase in deliveries assisted by skilled birth attendants was reported, from 53.1% in July to 69% by December 2020. Routine immunization efforts suffered setbacks in the first half of the year but saw some improvements in the following months.

Health Sector partners continued to advocate and promote activities geared towards improving overall health seeking behavior, including through rumor tracking. Another mechanism included collaboration efforts of the Communicating with Communities Working Group to develop messages on COVID-19, and the dissemination of such messages through various media channels. The communities, including Imams and other local leaders, were invited to tour SARI ITC facilities prior to their inauguration to better understand planned activities. Community Health Workers were engaged in several community outreach initiatives to disseminate messages on COVID-19 and essential health services. The joint efforts resulted

² Source: <https://data2.unhcr.org/en/documents/details/84360>

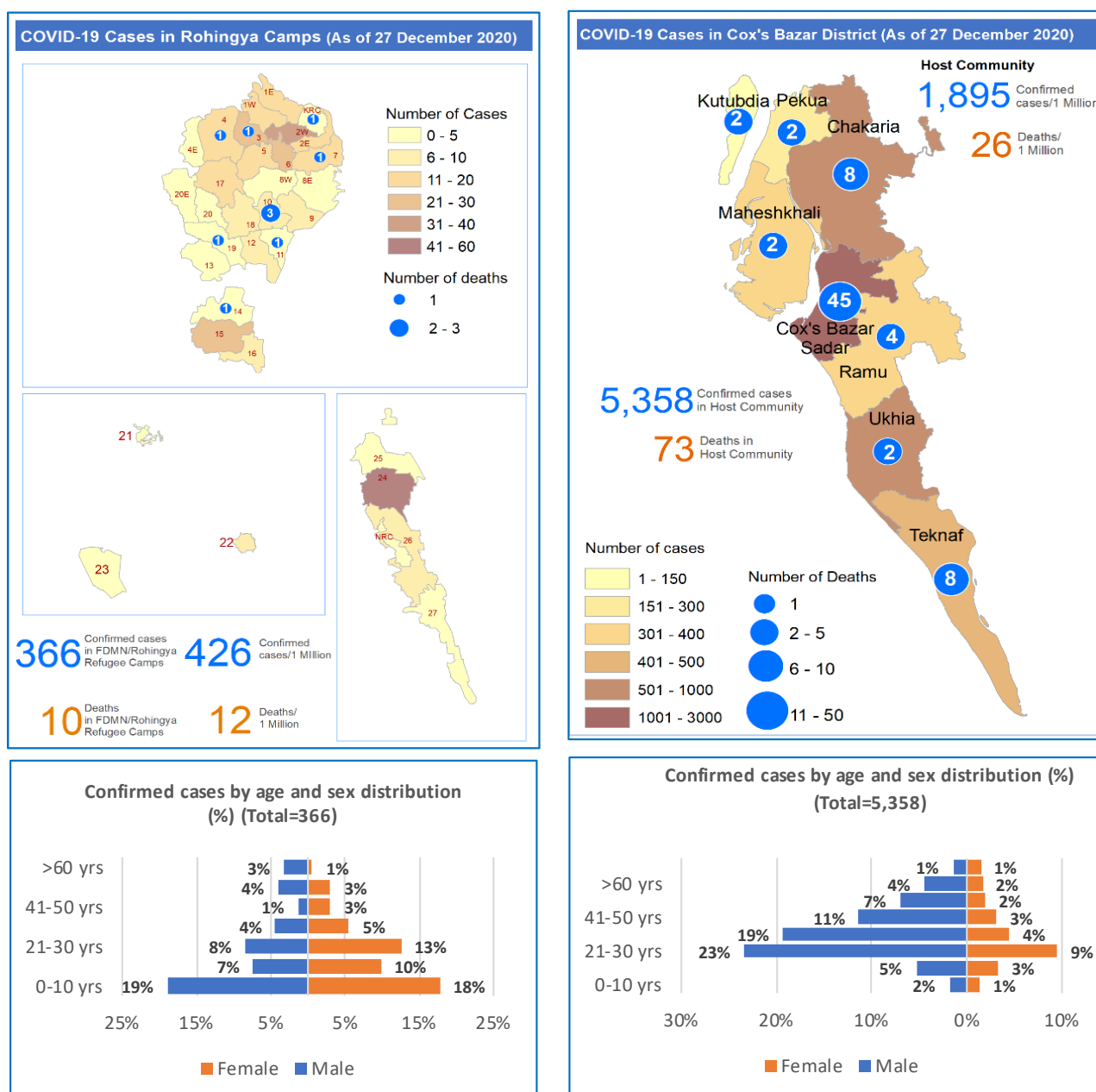
in increased daily testing rates from less than 10 to several hundreds per day during peak periods.

Public health risks, priorities, needs and gaps

Communicable diseases

I) COVID-19

WHO declared the outbreak of the COVID-19 pandemic on 11 March 2020. The first COVID-19 case was reported in the Cox's Bazar district on 23 March 2020 in the host community, and on 14 May 2020 the first FDMN/Rohingya refugee was confirmed positive. As of 27 December 2020, the host community had 5,358 COVID-19 laboratory-confirmed positive cases (74% male and 26% female) from a total of 47977 tests conducted.



Figures 2 to 5: COVID-19 laboratory-confirmed cases among host and FDMN/Rohingya refugees (disaggregated by age and sex)

Among the Rohingya refugees, 22 692 tests had been conducted and 366 had tested positive for COVID-19 (48% male and 52% female). The numbers of fatalities was 73 (host community) and ten (FDMN/Rohingya refugees) respectively. The case fatality ratio was 1.4% among the host community in the Cox's Bazar district, and 2.7% among the FDMN/Rohingya refugee.

II) Diphtheria

A total of 9 186 diphtheria cases, including 241 in the host community, have been reported through WHO's Early warning and Response System (EWARS) since December 2017, including 46 diphtheria-related deaths. Between July and December 2020, 72 cases were reported, including no deaths (last death reported in 25 October 2019).

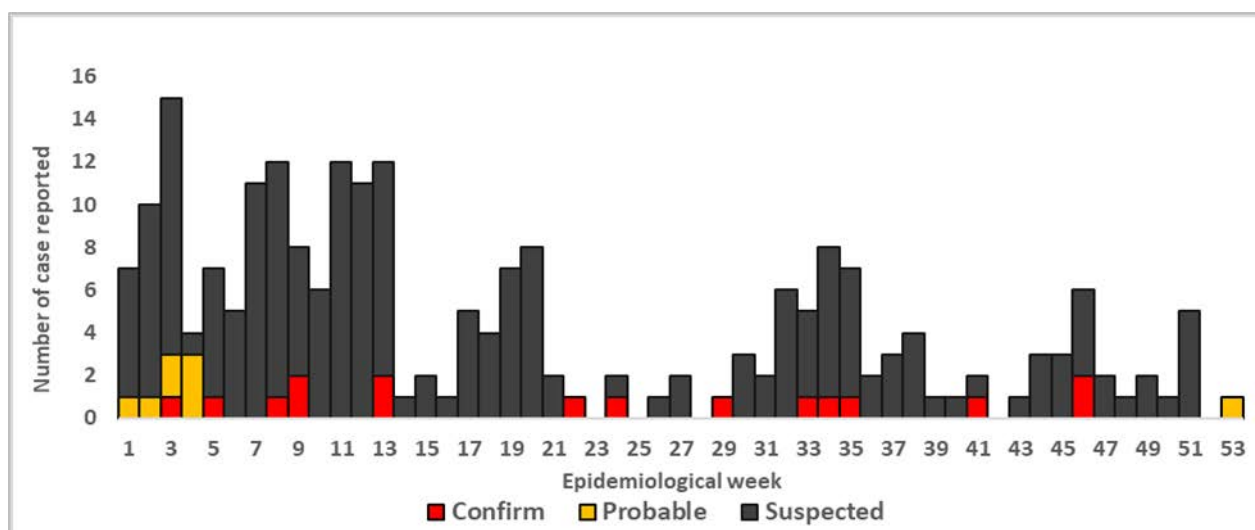


Figure 6: Epidemic curve of diphtheria cases among FDMN/Rohingya refugees (W1 – W48, 2020) (source: EWARS)

III) Acute Respiratory Infection (ARI)

Since July 2020, a total of 375 695 ARI cases were reported in EWARS, including 212 802 of those cases referring to children under five and 162 893 to children over five years of age. The graph below illustrates

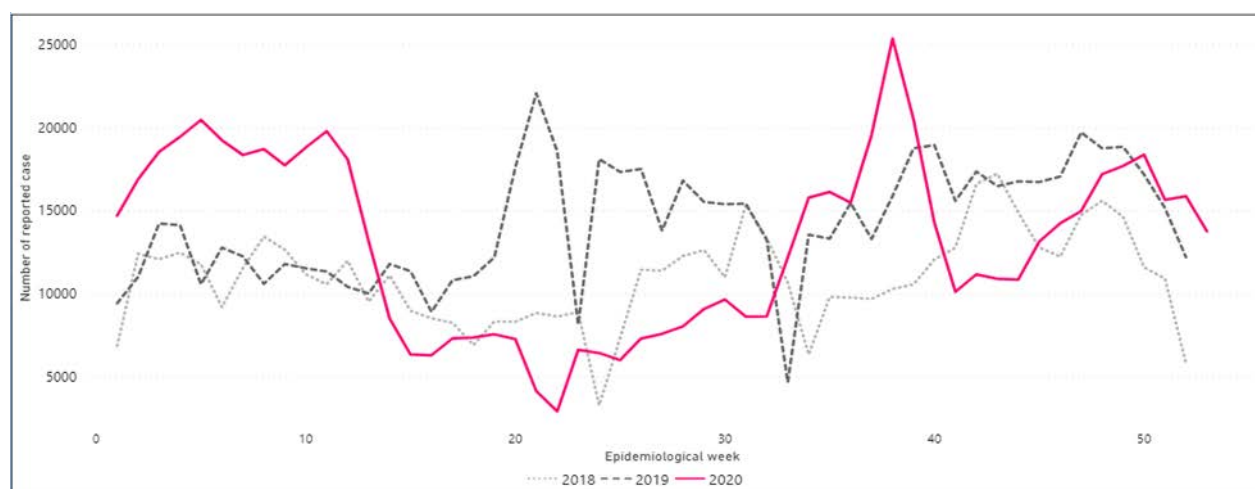


Figure 7: Total number of ARI case reported in EWARS from 2018-2020

a decline in reporting trends from week 13 as compared to the same periods in 2018 and 2019, which is due to overall low rates on health-seeking services in the FDMN/Rohingya refugee camps due to COVID-19. This rate recovers later in the year.

IV) Acute Watery Diarrhoea (AWD)

In 2020, 26 AWD Rapid Diagnostic Tests (RDTs) positive Cholera cases were reported and verified with 20 qualifying for a Joint Assessment Team (JAT) investigation. 18 of the cases were detected through sentinel testing between October and December 2020. Of these, three were confirmed for Cholera (one each in the Ukhiya and Teknaf host communities, and one in the FDMN/Rohingya refugee camps). Twenty (out of 23) sentinel sites for Cholera surveillance were fully functional during the reporting period, including two Upazila Health Complexes (UHCs) and one Diarrhoea Treatment Centre (DTC) in Camp 24. WHO is supporting the sites with RDT kits.

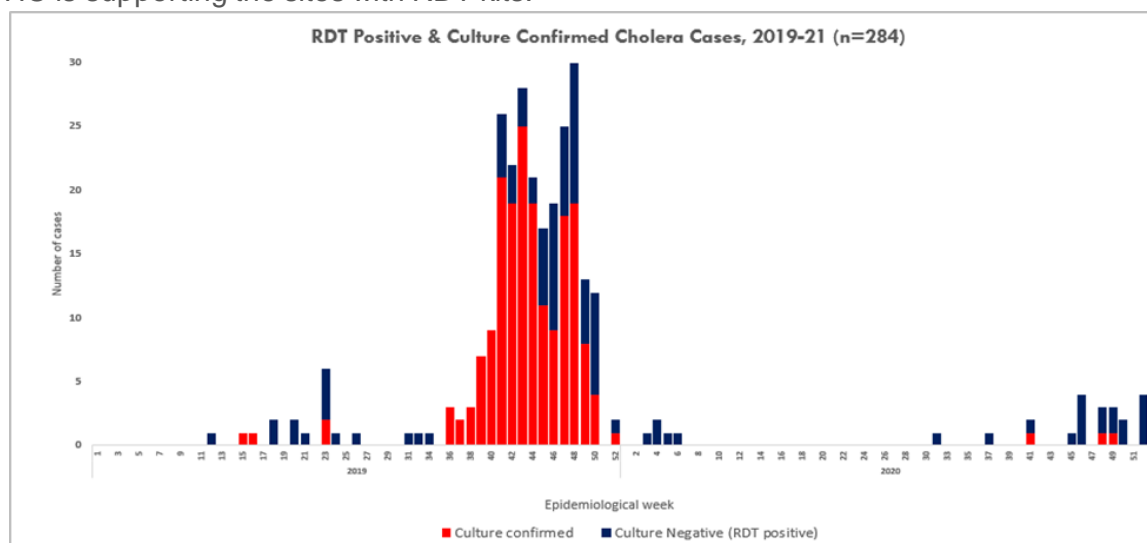


Figure 8: RDT positive and culture confirmed for Cholera cases in 2019-20

Non-communicable diseases and mental health

i) Non-Communicable Diseases (NCD)

An assessment of blood transfusion services was conducted in February 2020, with a follow-up meeting taking place to discuss the findings. In addition, the infrastructure of UHCs in Ukhiya and Teknaf were assessed for possible functioning as Blood Transfusion Centers. Refurbishment works are currently underway and support for mobilization of blood donors is being discussed.

In 2020, the majority of NCD cases reported in DHIS2 were Musculo-skeletal problems (49%), diabetes mellitus (17%) and hypertension (16%). Others include Asthma (5%), and Chronic Obstructive Pulmonary Disease and Cardiovascular Disease (1%).

Health Sector partners trained 181 Health Care Workers, including 68 from the Government, on Packages of Essential Interventions of Non-Communicable Diseases (PENs) in limited resource settings, which follow national protocols for hypertension and diabetes management and control. UHCs in Ukhiya and Teknaf received equipment to better screen and manage patients with diabetes and hypertension, and 94% of all PHCs can now manage diabetes, cardiovascular diseases and chronic respiratory diseases.

ii) Mental Health

Mental health conditions reported in DHIS2 include medically unexplained somatic complaints (22%), Psychosis, including bipolar disorder (17%), moderate to severe emotional disorders (14%), epilepsy/seizures (10%), Intellectual Disability and Developmental Disorders (1%), and other mental health conditions (35%).

The Mental Health and Psychosocial Support (MHPSS) working group conducted trainings on responsible reporting and prevention of suicide. Discussions on how to better collect data on suicide cases took place between health and protection actors were also held. The aim of these discussions was to ensure a more comprehensive and accurate recording of suicide cases. Further, trainings on Child-focused Psychosocial First Aid were conducted by the Child and Adolescent Subgroup members for service providers from various sectors in the camps.

Between July and December 2020, 155 healthcare workers were trained on Mental Health Gap Action Programme (mhGAP) to ensure that all Primary Health Centres had at least one person trained. Supportive supervision sessions in the field for hands on training were held to better integrate MHPSS services in the facilities.

Health Sector coordination

WHO, together with the Ministry of Health and Family Welfare (MoHFW) and the 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 FDMN/Rohingya refugee crisis and the ongoing COVID-19 pandemic. The Health Sector is currently comprised of more than 80 active partners, who continue to timely and effectively respond to the needs of the affected population. This includes 34 international partners, 32 National NGOs and 6 UN agencies.

At the district level, a Strategic Advisory Group, with representatives from the MoHFW Coordination Center, the RRRC Health unit, Health Sector Working Group coordinators, UN, INGOs and NNGOs, serves as an advisory to the Health Sector coordinator. There are six working groups in the sector coordinating different health activities:

- Sexual and Reproductive Health (SRH): chaired by UNFPA
- Community Health (CH): co-chaired by UNHCR and PHD
- Epidemiology (CM): chaired by WHO
- Case Management (SCM): chaired by WHO
- Mental Health and Psychosocial Support (MHPSS): co-chaired by IOM and UNHCR
- Emergency preparedness response (EPR): chaired by WHO and IOM

Two Health Sector field coordinators are responsible for supporting the coordination of health efforts at the upazila level, and collaborate with ten dedicated camp health focal points who are in place to support camp level coordination.

The Community Health Working Group (CHWG) coordinates partners implementing community health activities in the camps. There are around 1,500 CHWs and 120 Community Health Supervisors. COVID-19 is a key area of work at this time, including health education messages, as well as community based surveillance.

The Mental Health and Psychosocial Support Working Group (MHPSS WG) provides coordination and technical support to partners implementing MHPSS activities. In the period of July – December 2020, the MHPSS WG prepared and launched guidelines to ensure quality and proper integration of MHPSS activities in the SARI ITCs, among other key activities.

The Sexual Reproductive Health and Rights (SRHR) Working Group provides coordination and information management on sexual and reproductive health and rights services, and currently has close to 40 members, including UN agencies, INGOs and NNGOs, and local health authorities.

Functionality of health facilities

Health Sector partners are currently running 97 health posts in the FDMN/Rohingya refugee camps, and 39 primary health care centres providing 24/7 services. In addition, numerous government-run health facilities in the host community are supported by health partners, which include 10 community clinics, six union sub-centres and six Health and Family Welfare Centres, two Upazila health complexes and the district-level Sadar Hospital.

Health Sector Action

Coordination, collaboration and monitoring

The Health Sector, together with the MoHFW and RRRC, continued to provide leadership in coordinating health activities in response to the COVID-19 pandemic. Since the beginning of the year 2020, 25 health coordination meetings were held at the district level, 18 at upazila level, and 305 at camp level. Health Sector partners also participated in meetings conducted by Upazila Nirbahi Officers (UNOs) in both upazilas of Ukhiya and Teknaf.

Risk communication and community engagement

A COVID-19 perception survey among the FDMNs/Rohingya refugees was conducted to help better understand awareness and attitude towards COVID-19 and having to wear masks. Findings were utilized to better tailor messages and more effectively address gaps identified in the study.

The Community Health Working Group developed a community-based surveillance system to better identify COVID-19 cases for early and control transmission. Community Health Workers (CHWs) and the majority of FDMN/Rohingya refugee volunteers received trainings to identify symptoms of COVID-19-like illnesses and being able to conduct targeted counselling on testing, quarantine and treatment through door-to-door visits. Within the reporting period, CHWs identified 78 509 individuals with mild COVID-19 like symptoms and 228 individuals with moderate/severe symptoms. The cumulative number of patients identified with mild symptoms since the introduction of the activity in epidemiological week 25 is 88 887. A total of 34 585 persons with COVID-19 like symptoms were referred for testing and care. In addition, the CHWs conducted 259,306 group sessions reaching 934 787 individual refugees. In addition, the CHWs conducted a total of 4.8 million household visits with a cumulative number of more than 14 million adult members reached with COVID-19 prevention messages.

Surveillance, rapid response and case investigation



Contact tracing in the camps by CT network. Over 1,200 were identified for contact tracing and follow-up

Health Sector partners had to adapt their surveillance strategy in response to COVID-19. An expansion of sentinel sites for COVID-19 sample collection remained a key priority, to at least have one site per camp; 25 sites are currently operational. Camp-wise Rapid Investigation and Response Teams (RIRTs) were formed and protocols developed. Contact tracing mechanisms and the Go.Data platform were implemented to capture essential information on the COVID-19 response in the camps. MOHFW oversaw contact tracing activities for 60 supervisors and 300 volunteers trained for the COVID-19 response. The COVID-19 Epi Dashboard provided live updates on testing,

epidemiology, mortality, clinical management and service utilization.



Health Sector monthly coordination meeting in Ukhiya in September 2020.

A camp-wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) was embedded in the RIRT for the COVID-19 response. So far, 330 of 366 confirmed COVID-19 cases have been entered in the Go.Data system, including 1,294 (95%) contacts to be followed up by the CT network. Follow-up visits for 992 (77%) contacts was completed, with thirteen contacts being confirmed positive.

Laboratory



The Health Sector continued to support the IEDCR field laboratory in the Cox's Bazar Medical College with human resources, equipment, supplies and/or consumables, technical and operational expertise for testing of the COVID-19 samples. Within the reporting period, the testing capacity had improved to 1,500 samples per day and is currently being sustained at that level. Increasing the capacity of the field lab to conduct additional molecular and microbial culture examinations remains a priority.

Infection prevention and control

Health Sector partners continued to address needs on staff training, supplies and technical guidance on Infection Prevention and Control (IPC) to minimize the risks of infection from COVID-19 for patients, staff and the vulnerable community. The IPC Technical Working Group was endorsed by the Health Sector in mid 2020 and quickly began the operationalization of the IPC response and quality assurance plan. IPC trainings reached 814 health workers from Government facilities and 1,847 health workers from INGOs and NGOs who work in the camps.

Case management

At the end of 2020, 14 SARI ITCs, with 652 operational beds and the capacity to treat severe COVID-19 cases, are active. Additionally, 579 beds are currently kept on stand-by, and can become operative within 24-48 hours. Referral pathways have been established and continuously adjusted to allow for the safe transfer of critically ill COVID-19 patients to the Intensive Care Unit at Sadar District Hospital. Case conference calls are being conducted on a weekly basis between the SARI ITC clinical staff and international experts, during which cases are being presented and subsequently discussed among peers. While predominantly focused on the treatment of COVID-19 cases, the treatment of underlying health conditions highlights the importance of continued essential health care services to be maintained and strengthened. Case management trainings were provided to 697 health workers, including 188 government and 509 humanitarian health workers respectively.



Essential health services

The Health Sector reviewed and updated the Minimum Essential Service Package (MESP) to guide partners in their operations. The MESP was approved by the Civil Surgeon and shared with partners for use from January 2021 onwards. 38 health care workers were trained on the use of Non-Pneumatic Anti-Shock Garments and in the management of shock resulting from obstetric hemorrhages. In the same period, a training on Adolescent Sexual Reproductive Health Rights in emergency settings was conducted to support the re-establishment and utilization of quality health services for adolescents.

Camp Entry Points

In order to minimize the transmission of COVID-19 in the FDMN/Rohingya refugee camps, Health Sector partners, in collaboration with WASH, Site Management, and Protection Sector partners, established temperature screenings and hand-washing stations at 19 Camp Entry Points. Of these, fifteen are currently operational. People with febrile are identified and referred to nearby health facilities.

Assessments

The number of confirmed COVID-19 cases in the FDMN/Rohingya refugee camps remains lower than initially estimated. To understand more about COVID-19 transmission in the camps, the Bangladesh Institute of Epidemiology and Disease Control Research (IEDCR) has undertaken a seroprevalence study in all 34 camps to identify antibodies to SARS-CoV-2, the causative agent of COVID-19. During the survey conducted from 2-30 December 2020, 5498 households were visited, and 3699 blood samples obtained. Elisa testing has been completed and the results will be shared soon.

A survey on the practices of informal/traditional care for health was conducted with the objective of gaining a better understanding of informal care providers in the FDMN/Rohingya refugee camps, to enable increase their engagement on health issues, and to strengthen health literacy of FDMN/Rohingya refugees to enable them to make informed decisions about health care providers and their health. Data collection was conducted from 2-10 December 2020 and 800 responses were obtained from users. Twenty key informant interviews were conducted.

Through the support of MHPSS WG members, an assessment was conducted to better understand mental health issues faced by humanitarian workers during COVID-19 pandemic. The assessment highlighted the increased need for MHPSS support to humanitarian workers. One-on-one support is currently being continued to the humanitarian community using WhatsApp.

Camp Health Focal Points (CHFPs), with support from field coordinators and the Health Sector coordination team, conducted a Quarter-3 2020 monitoring assessment, covering 34 PHCs and 75 health posts in the camps. The exercise was intended to help the sector track several JRP and non-JRP progress indicators and the overall readiness for the COVID-19 response, resultantly guiding supportive supervision activities.

Child Health

From mid-April 2020, routine immunization services had to be suspended in the FDMN/Rohingya refugee camps due to COVID-19 constraints. However, some fixed sites continued to provide health services on a limited scale. From July 2020, routine immunization services started again, supported through a new micro plan and strategy. Session numbers and vaccination sites were increased to improve coverage gaps.

Antigen coverage

The graph below further illustrates the coverage of all antigens of routine immunization efforts through the new micro plan and strategy.

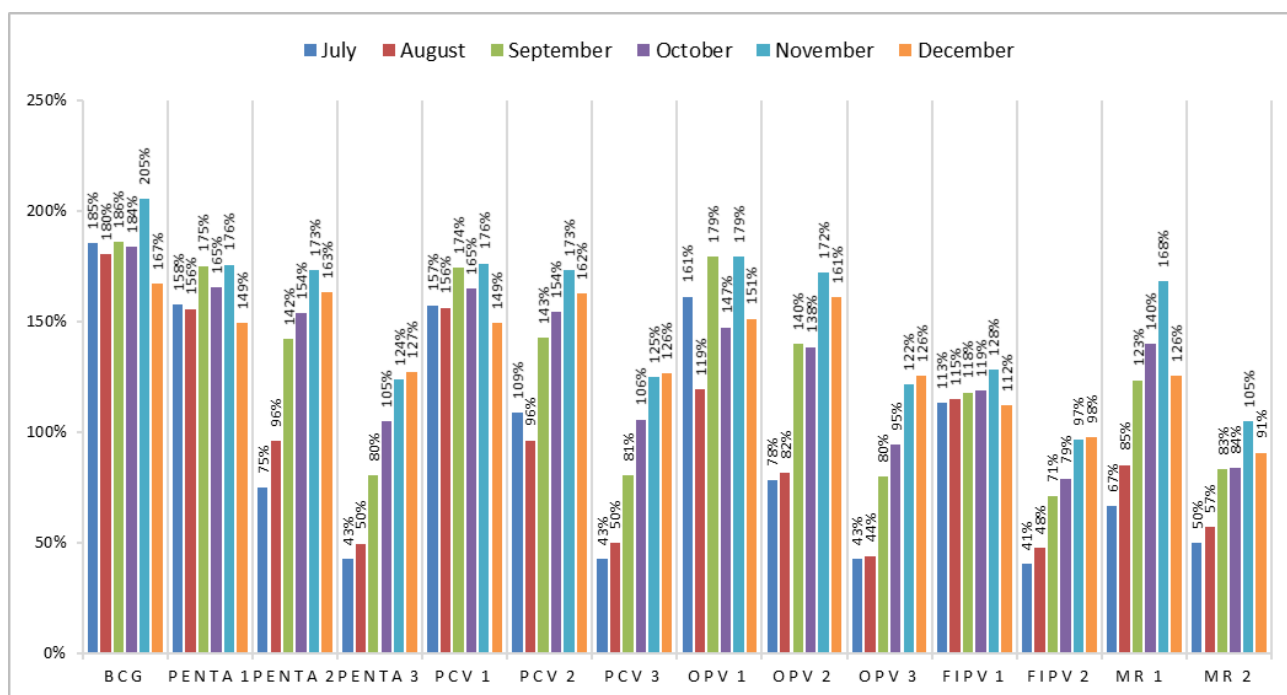


Figure 9: Antigen coverage in FDMN/Rohingya Camps (July-Nov 2020). (Source: DHIS2)

Surveillance /Early Warning Alerts and Response System (EWARS)

As of 27 December 2020, a total of 146 (88%) health facilities were registered and reporting in EWARS. Reporting completeness was 90% and timeliness was 81%. EWARS received a total of 3,382 alerts in 2020, and 2,003 alerts in the above-mentioned reporting period. All alerts were reviewed and verified within the required 48-hours timeframe.

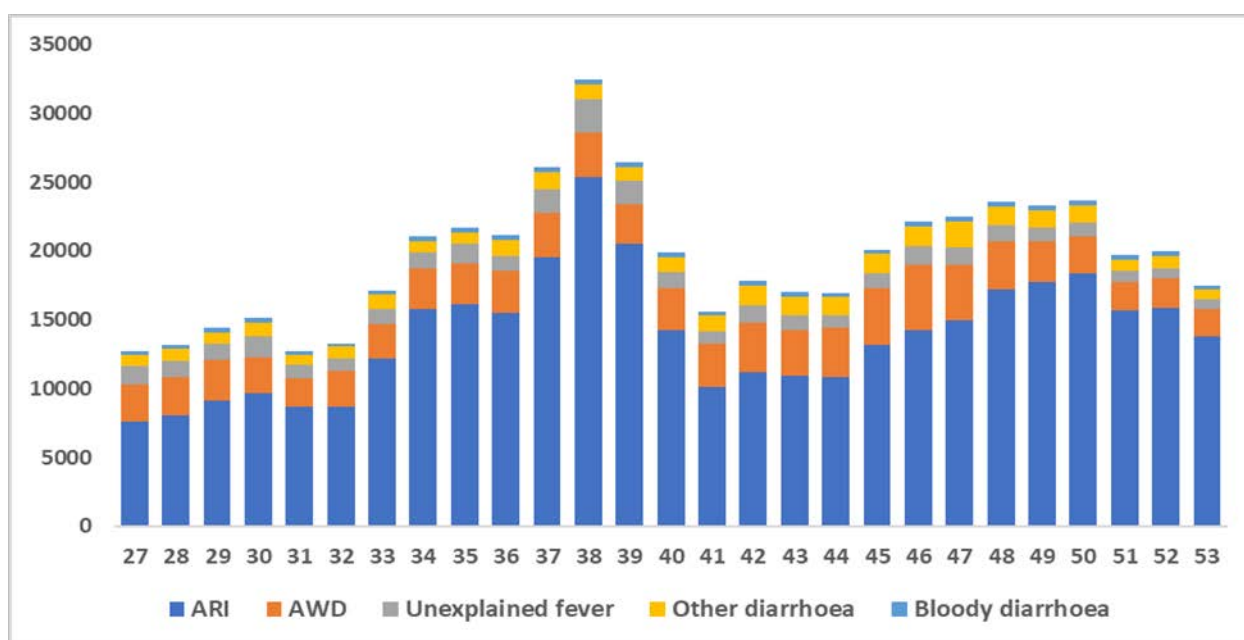


Figure 10: Reported cases of priority disease consultations between weeks 27 and 53 in 2020. (Source: EWARS)

Community based mortality surveillance

The below charts provide a breakdown of mortalities reported by camp, sex, place and causes of death. In total, 1808 (966 male and 813 female) mortalities were reported, 727 during the reporting period. In total, among female deceased, 193 were women of reproductive age (12 to 49). There were 236 still births and 205 neonatal deaths. The highest number of deaths occurred at home (62.2%), followed by health facilities (31%), and community/public spaces (5.3%). Under 5 mortality rate was calculated at: 0.29/1,000 children <5/month (female: 0.20, male 0.29), and crude mortality was calculated at 0.17/1000 population/month.

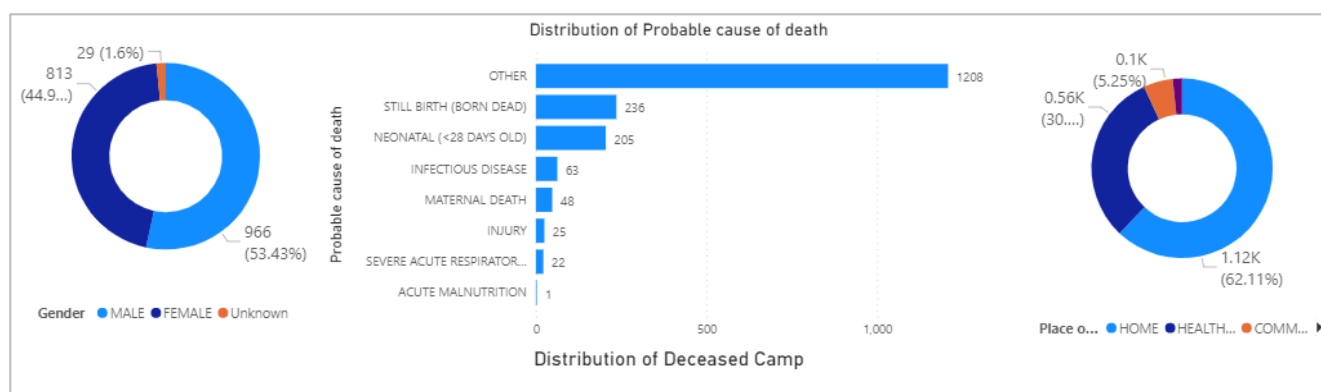


Figure 11: Community based mortality surveillance by camp, sex, cause and place; Source; week 1-53,2020. (Source: EWARS).

Reproductive Health

Family Planning

A total of 142,509 (101.7%) first-time visits were reported in 2020 against a set annual target of 140,180 visits. Generally, the number of first-time visits for family planning continued to increase steadily from July to December 2020.

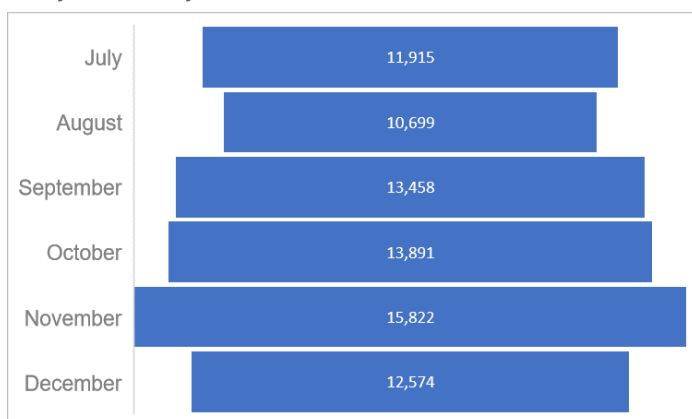
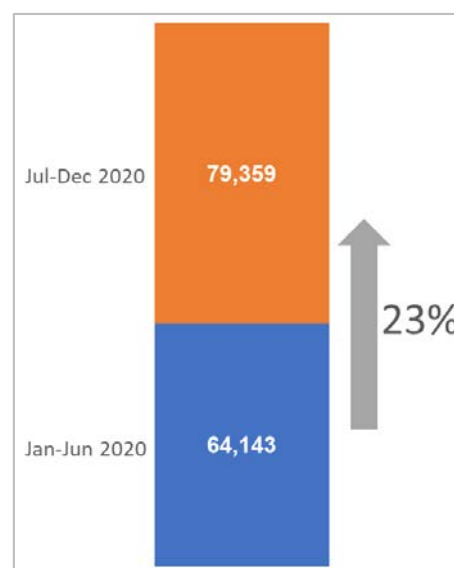


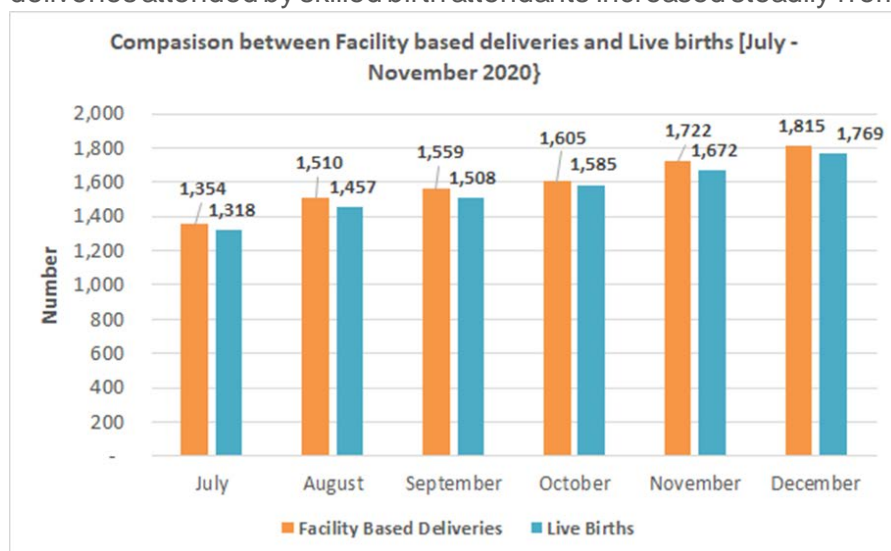
Figure 12: Family planning updates as of December 2020



These successes – recorded in the context of COVID-19 – are attributable to the availability of diverse and rights-based modern family planning methods, both including Long-Acting Reversible Contraceptives (LARC) and short-acting methods of family planning, coupled with an improved capacity of health workers to provide rights-based services.

Emergency Obstetrics and Neonatal Care (EmONC)

Utilisation of EmONC services improved in the second half of 2020. The number of facility-based deliveries attended by skilled birth attendants increased steadily from 1354 in July to 1815 in December 2020.



Overall, facility-based deliveries increased by 28.2%, with 7460 deliveries reported between January and June 2020, and 9,565 between July and December 2020. A total of 5450 women and girls, who benefitted from the facility-based delivery services, were Rohingya refugees, and 3460 were women from the host community, whilst the nationality of the remaining 655 was not reported.

Figure 13: Facility-based deliveries updates as of December 2020

SRHR commodities and supplies

Between July and December 2020, 165 Reproductive Health Kits, 10 710 Mama Kits, 24 100 Oxytocin and 59 485 Misoprostol supplies were procured and distributed. In addition, modern methods of family planning include the procurement and distribution of 801 936 condoms, 26 119 oral contraceptive pills, 10 280 implants and 600 IUDs. The commodities distributed benefitted both FDMN/Rohingya refugees and host communities in the Cox's Bazar district.

Gender Equality and Gender-based Violence

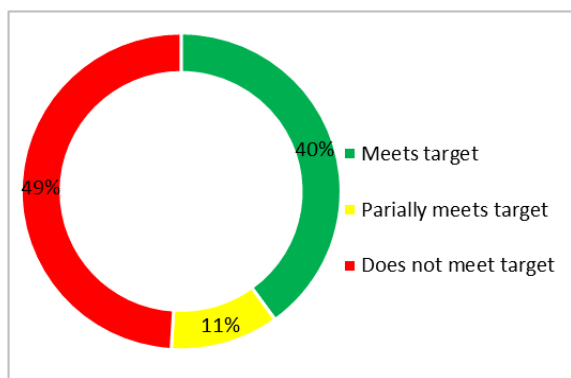
In collaboration with the SRH WG, the Health Sector continued to implement key actions to strengthen the capacity of health service providers to better coordinate and deliver Gender-Based Violence (GBV) services. Relevant resource materials were distributed to health facilities. These included GBV Standard Operating Procedures, WHO posters on violence against women and COVID-19, Clinical Management of Rape (CMR) flowcharts and GBV registers. In addition, Health Sector partners supported trainings on CMR and Intimate Partner Violence for Primary Healthcare Facilities without GBV services.

The Health Sector continued to implement gender mainstreaming actions within the COVID-19 response and regular essential health services, amongst others through the continued conduction of trainings. An online workshop on protection mainstreaming, facilitated by the Protection Sector, was held for 63 health workers. Further, a three-day face-to-face gender mainstreaming workshop, facilitated by the Inter Sector Coordination Group (ISCG) Gender hub, was conducted for 23 health partner workers.

Health Sector partners are currently in the process of documenting lessons learnt of better integrating GBV in health emergencies within the FDMN/Rohingya camps and have interviewed key stakeholders.

Water, sanitation and hygiene and environmental health

Following a delay due to COVID-19, WASH-FIT activities were implemented in the second half of the year. 103 health care workers were trained and subsequently developed improved plans as part of the



training for respective organizations. A WASH-FIT assessment was completed for 186 facilities in all 34 camps. 40% of health facilities met water-related standards, such as safe and sufficient water supply, according to national and global standards and indicators. In addition, 11% met some requirements, while 49% of the facilities need improvement.

The 15th round of the Water Quality Surveillance was completed this year, in collaboration with UNICEF and the Department of Public Health Engineering (DPHE), to assess the overall quality of water at health facilities,

point of collection at household level. 135 out of 152 facilities had no to intermediate risks on sample examination, and 149 out of 152 facilities showed intermediate to low risks of contamination. In addition, 170 Health Care Facilities (HCFs) were tested for the turbidity of source water, where 157 HCFs matched the Bangladesh standards and 13 HCFs did not. PH testing of source water was carried out for 137 HCFs, of which 33 HCFs did not match the Bangladesh standard for pH in drinking water ($6.5 < \text{pH} < 8.5$). A total of 151 HCFs stored water as per the national recommendations, whereas 19 HCFs did not. For those that did not store the water appropriately, ten kept water in water filters, while nine kept water in storage containers. The sanitary inspection of the storage containers for those health facilities indicated that seven of them had an intermediate risk of contamination, and two displayed a high risk for *E. Coli* contamination.

The assessment extended to 132 learning centers/multiple centers. This included sanitary inspection, potential *E.coli* contamination, pH and turbidity testing. Of the 325 unsterile source water samples collected and tested, 91% were free from *E.coli* contamination and matched the WHO guideline values as well as the Bangladeshi standards. Overall analysis indicated that 0% and 5% of the sources had high and very highly vulnerability to contamination, respectively. Water pH and turbidity analysis indicated that 81% and 97% of the collected source water samples matched the Bangladeshi standards, respectively.

Contingency planning

The Health Sector updated its contingency plans for the 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 a list of camp health focal points are maintained and updated regularly.

The Health Sector, in collaboration with the UK Emergency Medical Team and RedR, Australia conducted a three-day long training for clinicians of medical hubs on emergency and trauma care. A medical hub is a medical focal point in the Emergency Preparedness and Response (EPR) catchment area and would receive referrals from the field and possibly other facilities in the aftermath of a disaster. Additionally, if there is limited or no communication, the medical hub would receive reports from the field and other organizations and report to the health emergency operations center (HEOC) or to the catchment area coordination hub.

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