

Editorial

Infectious Diseases among the Forcibly Displaced Myanmar Nationals, a Public Health Concern for Bangladesh

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Since August 2017 nearly 700,000 Forcibly Displaced Myanmar Nationals (FDMN) arrived in Bangladesh and were housed in a selected green forested area of the sub-districts (Upazilla) Ukhiya and Teknaf of Coxsbazar district. The makeshift residential accommodation for this one of the largest displaced population within short time were associated with compromised housing, water & sanitation-hygiene facility and provision of basic support including essential health care. The FDMNs includes vulnerable population women, children, elderly and displaced from a location in Myanmar, Rakhine state having very limited education, and primary health care facility for example very low rate of vaccination.¹ Despite very quick and large exodus of population initial preventive health care delivery by the Ministry of Health and Family Welfare, Government of Bangladesh with technical assistance from WHO and other development partners was exemplary in rapid vaccination against measles, and diarrhoeal diseases. Considering the prevalence of cholera in the area across the border International Coordinating Group (ICG) promptly delivered an unprecedented 900,000 doses of oral cholera vaccine (OCVs) to the population.² Although more than 100,000 acute watery diarrhoea (AWD) were notified in 2018 through indicator based surveillance in active Early Warning Alert and Response System (EWARS) it is noteworthy that cholera outbreak seems to be contained.³ Due to close habitation of concentrated people respiratory pathogens were likely to be quickly transmitted. To surprise the health policy group (coordinating cell) a large outbreak of diphtheria happened

with nearly 7000 cases (238 laboratory confirmed) and 42 deaths even not sparing the host community which was diphtheria free.³ Fever with acute onset sorethroat with suspected faucial membrane were clinical indicators to suspect by clinicians in the field. Potential complications in vital organs, cardiac, renal, respiratory necessitated purposefully managed facilities with specialist input provided. Initial management with ADS and penicillin was difficult particularly in absence of reduced local expertise and isolation facility to deal with such infections.

A large health promotion initiative for prevention of infections was made by deploying health ‘promoters’ in the camps and regular radio talk in local language.

The prevalence of circulating water born pathogen including hepatitis E, typhoid in an inadequate sanitary environment with community having little knowledge in health promotion and disease prevention was the possible reason for outbreak of jaundice syndrome, 2210 cases since January 2018.³

Bangladesh was struggling to combat TB and HIV infection with reasonable success in containment. Deployment of GenXpert in Coxsbazar district hospital, and at Upazilla Hospital at Ulhiya and Teknaf was made, support of BRAC in setting up 10 labs in the camps was taken. Within short time (September 2017-6 June 2018) 40212 presumptives were tested with detection of more than 1000 cases of TB with few MDR (personal communication, Dr. Shah Jahan, Tropical Medicine expert, Coxsbazar district Hospital). The seroprevalance of hepatitis C is higher than that of host community indicated by a large number of hepatitis C associated chronic liver disease among admitted cases at Coxsbazar district Sadar Hospital.⁴ It was not surprising if one considers prevailing practice of multiple shaving using same razor in the traditional community saloon in the camps and using same syringe for delivering injectables by the ‘traditional healers’ still practicing in the camps having faith/practice for long at Rakhine state. It was not surprising to have a large number of HIV cases among the FDMNs (190 till now). It would be wise to have universal precaution of injection and blood safety in the health facilities to avoid a disaster of big outbreak in the area.

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Initial concern of outbreak of malaria was raised with threat of potential artemisinin resistance among the FDMN. More than 300,000 LLINs were distributed to FDMNs from country allocation of Global Fund to Bangladesh. Nearly 50,000 tests were performed to detect 11 cases of malaria, 3 falciparum and 8 vivax. A continuous surveillance on the outbreak of malaria and other vector born diseases is essential for early containment (Parasitic and Aedis Born Disease Control program, GOB).

Currently infections in the FDMN are diagnosed and treated with syndromic approach through a primary health care set up by large number of partners under the supervision of the GOB with very limited facility of investigation virtually no microbiological detection except for TB and malaria in the existing health set up and limited capacity. The outbreak of diphtheria is an example how quickly respiratory pathogen can be transmitted in the FDMNs with potential of spill over to the host community. It is essential to have a continuous surveillance of microbial diseases using quick point of care diagnostics in the field, options of other modern quick laboratory facility for detection and characterization of the

organisms is warranted through assistance and collaboration with technical and development partners. A constant watch on the pattern of cases by surveillance and proper documentation at referral facilities will be essential, so also to have a dedicated infectious diseases hospital in the close vicinity.

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