







PHOTO: WHO has been supporting the Government of Bangladesh through the Civil Surgeon's office to develop a protocol for COVID-19 Antigen RDT pilot testing in Cox's Bazar to accelerate COVID-19 testing in the district.

HIGHLIGHTS

- In coordination with Civil Surgeon's Office, WHO and Health Sector partners are working on the reactivation of stand-by SARI ITC beds to respond the increase trend of confirmed COVID-19 cases among the host community and the Rohingya population. Currently, a total of 572 active beds are functional.
- WHO has been supporting the Government of Bangladesh through the Civil Surgeon's office to develop a protocol for COVID-19 Antigen RDT pilot testing in the Cox's Bazar district.
- WHO and IOM have prepared an assessment report capturing best practices and lessons learnt and a plenary discussion on the overarching strategic issues with the Mobile Medical Team Working Group (MMT TWG) has been scheduled for 9 June 2021.
- **SUBJECT IN FOCUS:** Risk Communication during public health emergencies: the Cox's Bazar experience

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	9 429	1 354
 Total cases in isolation in Cox's Bazar	230	129
 Total number of tests conducted	94 975	44 834
 Total deaths due to COVID-19	96	18

**Updated as of 6 June 2021 / *FDMN = Forcibly Displaced Myanmar Nationals*

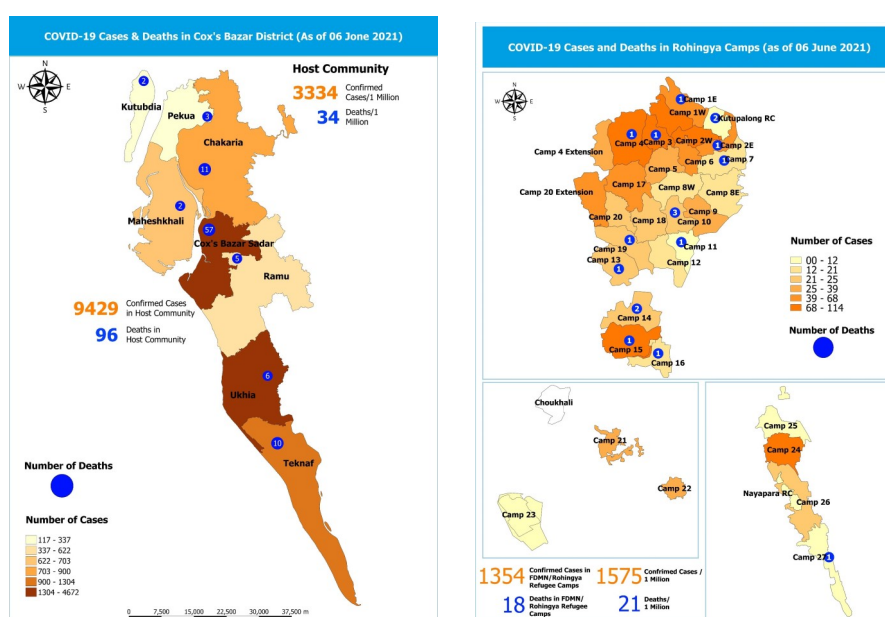
WHO, together with the Ministry of Health and Family Welfare (MoHFW) and office of Refugee Relief & Repatriation Commissioner (RRRC) continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the COVID-19 response and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

Restrictions continue to be in place for movement as communicated by the RRRC and have undergone various extensions. Selected camps with detected high rates of COVID-19 are under stricter restrictions.

During the past weeks, Health Sector, led by WHO, has been closely monitoring the increase of COVID-19 positive cases in Cox's Bazar. The surge of COVID-19 cases resulted in increased admissions to the Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs) in the district. As an integral part of COVID-19 preparedness and response, the Health Sector in coordination with the Civil Surgeon's Office, Cox's Bazar, continues to work with partners running SARI ITCs in the camps to increase the number of functional beds in order to manage moderate/severe cases and minimize excess mortality. Currently, a total of 572 active beds are functional. Discussions are ongoing with partners on an effective evidence-based approach for management of mild cases considering the operational and resources implications of various solutions.

Health Sector continues to work on updating the 'Health Sector Strategic Plan-2019' to adapt to the changing circumstances and meet current and future needs to propose a common way forward for health for the coming years. In addition, Health Sector partners are currently revising the Standard Operating Procedures for referrals in a collaborative process under the Health Sector Strategic Advisory Group. This process is expected to be completed in the coming weeks. The Health Sector SAG is also developing an Accountability to Affected Populations framework which is expected to be complete shortly as well.

Between weeks 21 and 22, a total of 12 (07 in person, 05 online) camp-level Health Sector Coordination Meetings were held in Rohingya Camps, engaging respective government agencies, UN agencies and NGOs. Key challenges, achievements, and areas requiring support, strengthening coordination, collaboration, and liaison among partners and government authorities were discussed. In the meetings, Camp-in-Charges advocated preventive measures like hand washing, wearing of masks, prohibition of mass gathering, etc. to all the health partners. In addition, RIRT coordination meetings were conducted in five camps to strengthen the COVID-19 response through coordination among SMSD, Camp Health & Disease Surveillance Officer (CHDSO) and CHW Supervisors.



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 6 June 2021, a total of 9429 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 7804 in Chokoria, 117 in Kutubdia, 626 in Moheshkhali, 281 in Pekua, 620 in Ramu, 4 672 in Sadar, 960 in Teknaf and 1 373 in Ukhiya.

While the overall positivity of the samples tested in the district is 9.9%, a decreasing trend in the positive cases among the host community has been observed in the past few weeks. In week 22, 290 cases tested positive, with a test positivity rate of 11.1%, in comparison with week 20 when 432 positive cases were registered. To date, a total of 96 deaths have been reported in the host community, with a case fatality ratio of 1.0%.

Among the Rohingya refugee population, the number of confirmed COVID-19 cases remains stable in the last two weeks. In week 21, 175 positive cases were registered in the Rohingya refugee camps, similarly to the 166 confirmed cases in week 22, with a test positivity rate of 14.5% both weeks. As of 6 June 2021, a total of 1354 COVID-19 cases have been reported among Rohingya. With a total of 111 cases,

Camp 2W has the highest number of cases to date further ahead from Camp 24 with 101, camp 3 and 4 reported 96 cases each and Camps 15 with 87 cases. To date, 76 cases have been reported from Camp 1W, 60 from Camp 2E and 20 Ext each and 55 each from Camp 1E, and 6. Camps 13, 14, 16, 17, 18, 19, 20, Nayapara Registered Camp (NRC), 21, 22, 23, 25, 26, and 27 have so far had less than 30 cases.

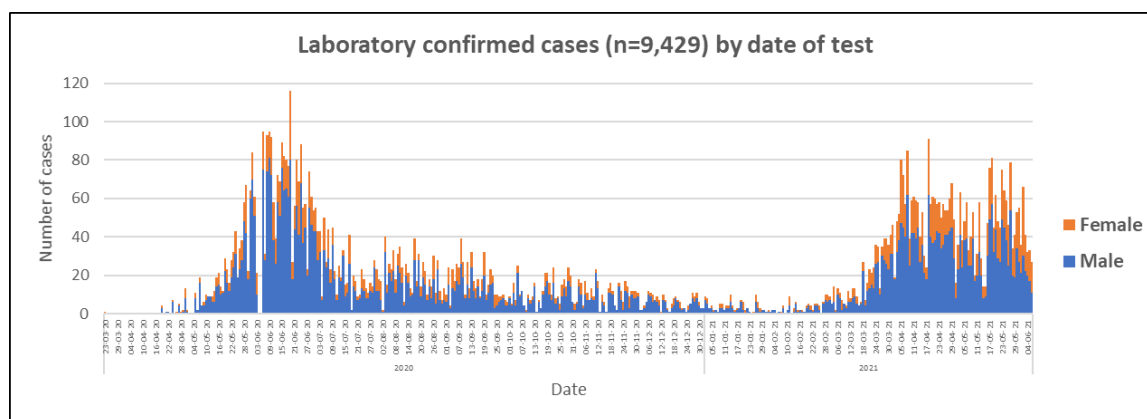


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

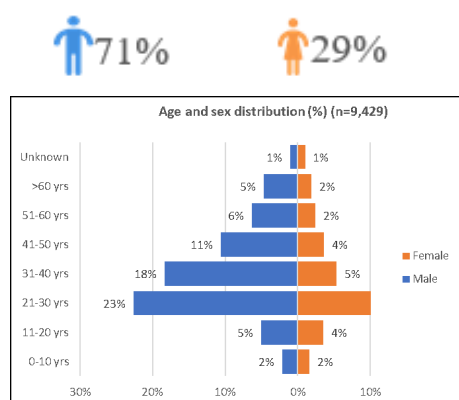


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

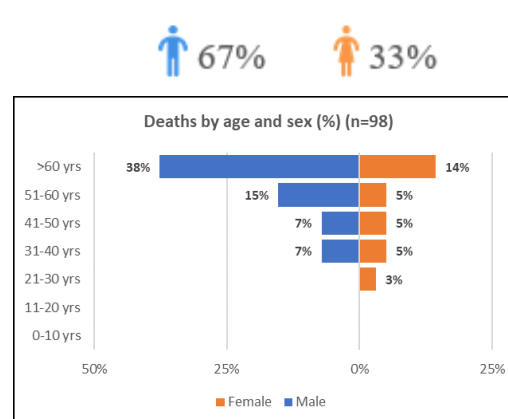


Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

Movement restriction and other mitigation measures in district and camp areas imposed by the Government of Bangladesh and the Office of the Refugee Relief and Repatriation Commissioner (RCCC) in Cox's Bazar in response to the upward trend of cases in the district continue until 16 June. Additionally, to enhance SARI ITC preparedness and response, the Civil Surgeon office in Cox's Bazar issued a directive to activate the SARI ITC stand-by beds. Currently, 556 general isolation beds are functional in 12 Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centers (ITCs) with provision of oxygen to assist both the Rohingya refugee population and the nearby host communities of Cox's Bazar. The current bed occupancy of these SARI ITCs is 56% at the end of the reporting period. Moreover, the capacity of general isolation beds in the district is 376. The Intensive Care Unit/High Dependency Unit (ICU/HDU) at the Cox's Bazar Sadar Hospital has a capacity of 38 beds for severe and critical patients. During the past weeks, an increase in the bed occupancy has been observed, indicating the increased demand of hospitalization due to severe disease presentation at admission.

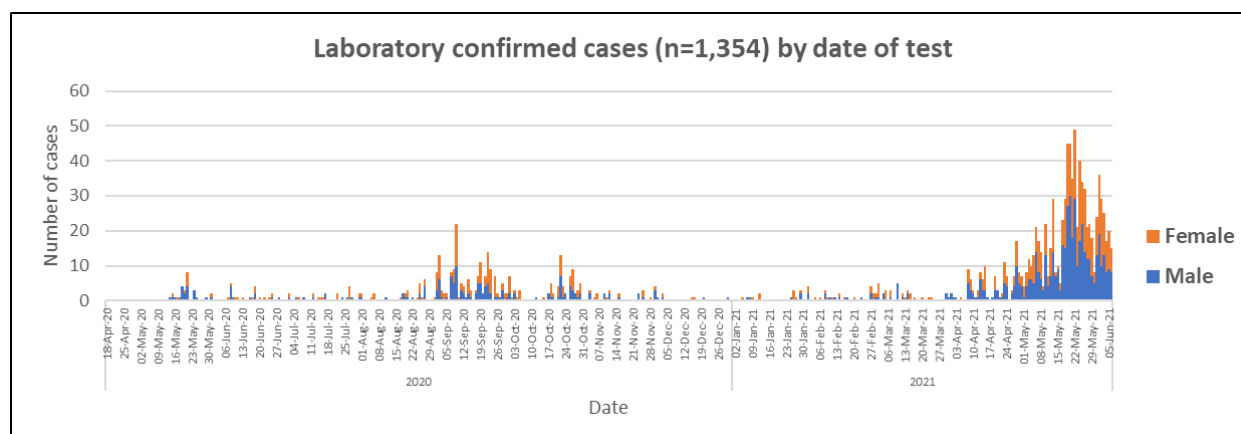


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

52%

48%

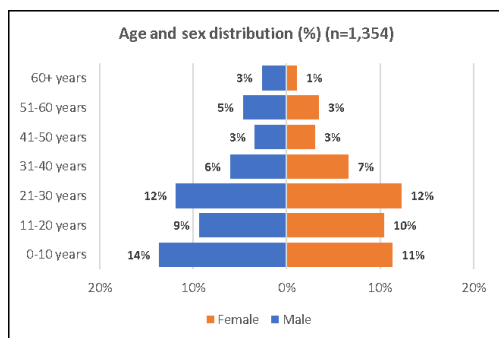


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

39%

61%

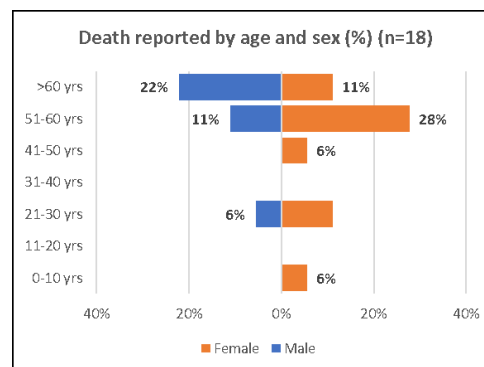


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Between weeks 21-22, 341 new confirmed cases were detected from 2351 samples tested, the test positivity was therefore 14.5%. As of 6 June 2021, the cumulative incidence is 157.5 per 100 000 people. The overall positivity of samples tested is 3.0%. Among the cases, 3.3% showed severe symptoms at the time of admission while 5.9% reported at least one co-morbidity. The median age of tested and confirmed cases was 11 (0-120) & 23 (0-100) years, respectively and ratio of females among tested and confirmed cases was 54% and 48%, respectively. Though the median age of tested samples remained below 11 years, a significant proportion has been tested among 50+ years: 613 per 10 000 population, following that of 0-9 years with 761 tests per 10 000 population as highest number. The test positivity was highest 5.5% in 30-39 years age cohort and the age specific mortality 1.9 per 10 000 population observed among 50+ years during the period. In total, and since the outbreak began, 18 deaths due to confirmed COVID-19 have been reported in the camps with a case fatality ratio of 1.3%.

A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) has been embedded in the Rapid Investigation and Response Teams (RIRTs) for COVID-19. A total of 1045 confirmed cases (out of 1354 to date) have been investigated by RIRTs by 6 June, with contact tracing activities being conducted and captured through Go.data, including the 2605 contacts to be followed up. Out of these, 1918 (73.6%) contacts have seen their follow up visits completed and were released from quarantine. 104 (5.4%) tested positive cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

Three (03) Rapid Diagnostic Test (RDT) positive cases for Acute Water Diarrhea (AWD) were reported in the reporting period. The total number of cases reported so far is 42 in 2021: 24 from the refugee camps and 18 from host communities. Out of these, nine (09) were culture confirmed, 29 tested negative by culture and remaining four (04) culture results are awaited. In 2020, a total of 28 RDT positive cases for Cholera were detected through sentinel testing, five (05) of which were confirmed by culture - two from Ukhiya host community, one from Teknaf host community and two from the refugee camps. It is important to note that a Cholera outbreak occurred in late 2019 with a reported number of 239 RDT/culture positive cases and in response a mass Oral Cholera Vaccine (OCV) vaccination campaign was conducted with over 160 000 children of 1-<5 years being vaccinated with a 2- doses regimen.

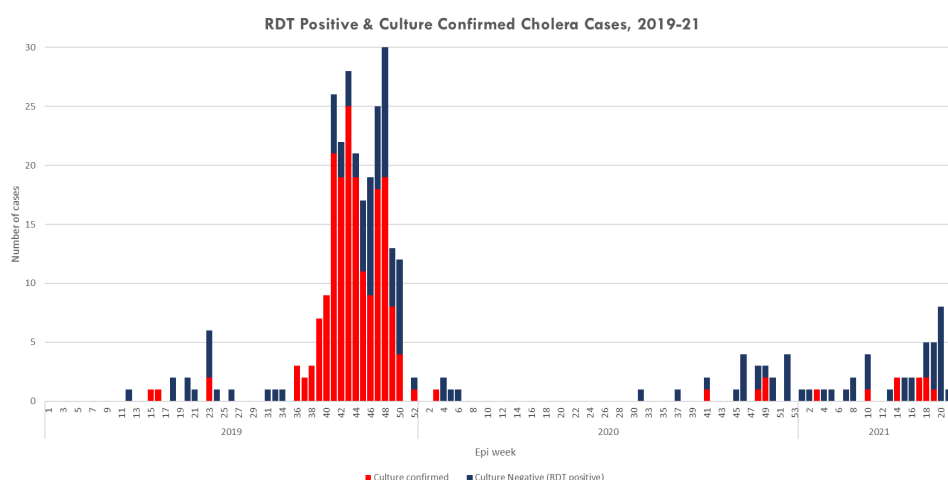
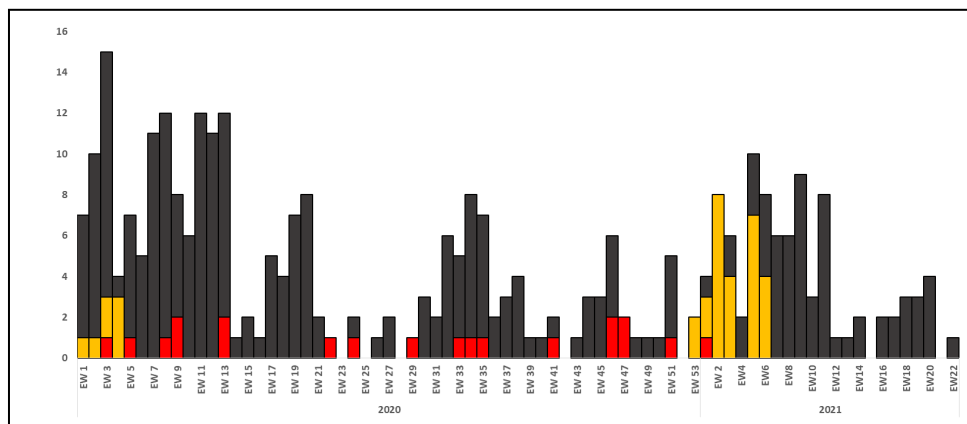


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9275 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 89 as of week 20, 2021). In total, 9030 cases were reported in the camps and 245 from the host community, with 47 deaths registered in the refugee camps and none in the host community. While the first Diphtheria case was detected on 10 November 2017, the first death occurred on 29 December 2017 and the last death on 25 October 2019.



In week 21-22, four (04) suspected Severe Acute Respiratory Infection (SARI) deaths were reported. In total 44 deaths have been reported in 2021. All deaths have been investigated by RIRT as a part of COVID-19. Nine (09) deaths have been reclassified as COVID-19 probable death cause. In 2020, a total 49 suspected SARI deaths were reported through community-based mortality surveillance. Of these, all were verified and two (02) considered death due to probable COVID-19. During the reporting period, seven (07) new probable maternal death have been reported. In total 51 probable maternal/deaths of women of reproductive age (WRA,12-49 years) have been reported in 2021, of which fourteen (14) deaths have been reported from facilities and directly undergone review by Maternal and Perinatal Mortality Surveillance and Response (MPMSR). Investigation of mortality due to suspected potential infectious causes i.e. SARI, Measles, Cholera, Diphtheria etc. is ongoing in the camps along with death due to maternal causes as high priority.

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, quarantine, isolation, and treatment centres, among others. Through its involvement in the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), WHO 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.

During the reporting period, RCCE WG and WHO disseminated public health messages on COVID-19 variants and mutations among health care professionals and humanitarian workers for feedback. During the reporting period WHO shared with the RCCE WG Information Education and Communication (IEC) materials developed by WHO about safety and mitigation measures required while handling medical oxygen. WHO and UNICEF continue providing English and Bangla versions of the weekly radio script on COVID-19 confirmed cases and number of tests conducted among refugee and host communities. These messages were shared with partners to be widely disseminated among the Rohingya community through radio broadcasting.

During the reporting period CHWs conducted 282 027 household visits in which 6 219 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 63 patients with moderate/severe symptoms. The cumulative number of patients with mild symptoms is 144 969, and 751 patients with moderate/ severe symptoms. To date, 74 618 persons with COVID-19 like symptoms have been referred to health facilities, 4183 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 544 926 persons between weeks 21 and 22. Since the beginning of the response, CHWs have conducted more than 8 million household visits and had a cumulative number of more than 20 million contacts with adult household members. Through the CwC WG, 61 777 people were engaged in 25 312 small group sessions.

DISTRICT LABORATORY

WHO continues its support to the Institute of Epidemiology, Disease Control and Research (IEDCR) Field Laboratory at the Cox's Bazar Medical College comprising human resources, equipment, supplies/consumables and technical and operational expertise.

Between early April 2020 and 23 May 2021, a total of 158 008 tests for COVID-19 have been conducted of which 139 809 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A slight decrease in the number of tests conducted among the Rohingya refugees was observed in weeks 21-22-19 as compared to weeks 19-2017-18, from 2484 to 2351 tests. However, among the host community an increased number was tested: from 5290 tests in weeks 19-20 to 5936 tests in week 21-22. Currently, 33 sample collection sites are operating for suspected COVID-19 patients.

During the reporting period, WHO has been supporting the Government of Bangladesh through the Civil Surgeon's office to develop a protocol for COVID-19 Antigen RDT pilot testing in the Cox's Bazar district. The protocol is currently under review and will be used to guide the subsequent training of lab personnel at selected SARI ITCs in the Rohingya refugee camps. Additionally, in weeks 21 and 22

WHO has conducted refresher training on COVID-19 sample collection and handling for four (04) sentinel sites in Camp 20 Extension, Camp 2W, TDH and Nayapara registered camp.

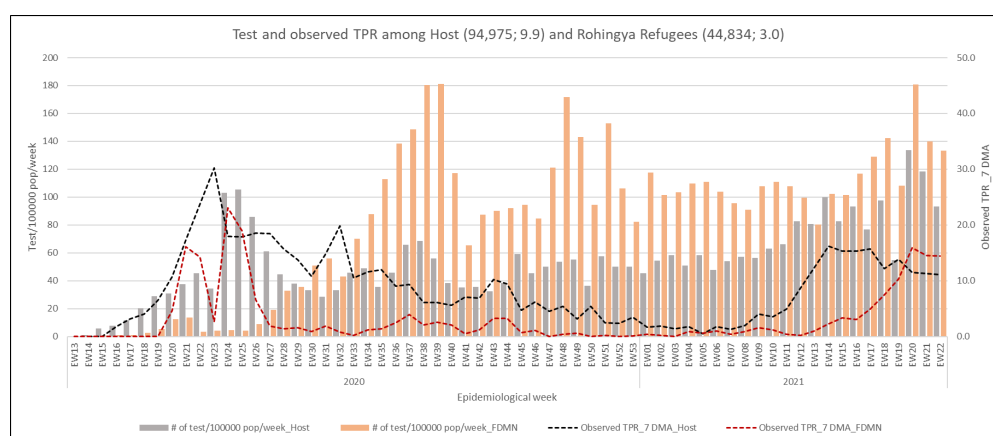


Figure 9: Number of tests conducted per million among the host population and the Rohingya refugees/FDMN

*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.

INFECTION PREVENTION AND CONTROL

To enhance preparedness for COVID-19 in Cox’s Bazar, WHO has been training healthcare workers on Infection Prevention and Control (IPC) from Severe Acute Respiratory Infection (SARI) ITC partners and Government facilities. To date, training for Infection Prevention and Control (IPC) has been provided to 2 390 humanitarian health care workers and government staff from Severe Acute Respiratory Infection (SARI) ITC partners and government facilities.

During the reporting period, WHO conducted IPC Supportive supervision visit to one Field Hospital and all 12 functional SARI ITCs in the Rohingya refugee camps. These technical visits are part of quality assurance and quality control efforts by the IPC TWG for all health facilities in the camp to aid continuous capacity building for improved health workers and patient safety as well as better quality of healthcare.

On 31 May 2021, the IPC Technical Working Group (ICP TWG) held its 12th coordination meeting. During the meeting, WHO emphasized the need to set up IPC Structures in the healthcare facilities in order to keep health workers and patients safe amidst increasing COVID-19 cases in the Rohingya camps. The formation of IPC structures at health care facilities is currently ongoing as part of efforts to institutionalize IPC in camps. Currently a total of 119 (87%) health facilities (91 HPs, 27 PHCC and 1 FH) have reported the creation of IPC structures which include IPC focal persons for health posts and IPC committees and focal persons for the primary healthcare centers and the field hospitals. The IPC focal persons and committees will play a pivotal role in planning for IPC activities as well as daily oversight of implementation of IPC in their facilities.

CLINICAL CASE MANAGEMENT

Since the onset of the outbreak, WHO is coordinating regular weekly Operational, Clinical and Critical care online forums; each with a multidisciplinary panel of health care providers with experience in the clinical management of patients with COVID-19 and other viral infections to foster peer to peer support and knowledge exchange. With the guidance provided by WHO experts, the initiative is serving as a foundation for optimized clinical care to ensure the best possible outcome for patients in Cox’s Bazar. During the reporting period, two working group meetings along with two case conferences for SARI ITCs and two case conferences for ICU were conducted. As of 6 June 2021, there are 12 operational SARI ITCs in the camps with a total of 545 functional beds open and 348 on stand by. The SARI ITC bed occupancy is currently 61% (334 beds). At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 8 beds and the Severe Care Unit (SCU) 20 functional beds. At the moment, 22 beds are occupied.

ESSENTIAL HEALTH SERVICES

Ensuring the provision of essential health services remains a priority in Cox’s Bazar. Under the coordination of WHO and the Civil Surgeon, Cox’s Bazar, the Health Sector is providing health care to nearly 890 000 Rohingya refugees and 472 000 Bangladeshi living in the surrounding areas of the refugee camps. The health facilities run by Health Sector partners to provide services to the population include 38 primary health care centers (PHCs), 97 Health Posts (HPs), 23 special facilities and three field hospitals.

WHO and Health Sector partners continue supporting the Government of Bangladesh (GoB) in the preparation of the COVID-19 vaccination campaign for the Rohingya community, scheduled to start in the coming weeks, pending the revised arrival date of the allocation of



Photo: On 27th May 2021, the Health Sector team held an extraordinary coordination meeting to enhance the emergency health response given the increase of COVID-19 cases in Cox's Bazar.

vaccines from the COVAX facility for Bangladesh. COVAX is a global initiative aimed at equitable procurement and distribution of COVID-19 vaccines led by WHO, Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations.

The WHO Immunization and Vaccine Development (IVD) team designed a community preparedness assessment tool to measure the awareness of Rohingya refugees regarding the upcoming COVID-19 vaccination campaign in the camps. This tool will help the Government and partners better implement the risk communications strategy in the field to encourage vaccinations and ensure that no one is left behind. Through a multi-channel strategy which includes community radio, interpersonal communication and digital media, WHO is tracking vaccine hesitancy and rumors in the field and promotes community mobilization.

Despite the lockdown situation in Cox's Bazar, routine immunization (RI) sessions continue, both fixed and outreach, with WHO's guidance on the operation and sustaining of immunization programs during the COVID-19 pandemic, and a revised strategy and

microplan having been reviewed by the Government with technical assistance from WHO and other partners, based on data collected in 2020. Currently, 59 health facilities are working as immunization fixed sites and another 66 vaccination teams are conducting outreach sessions both in community and healthcare facilities. During the reporting period, the IVD team continued monitoring and following up with children who missed their vaccines at the healthcare facilities. Assessment of the vaccination list is currently ongoing through the work of WHO Health Field Monitors. WHO is continuously monitoring Acute Flaccid Paralysis (AFP) and vaccine-preventable diseases (VPDs) despite the lockdown.

As part of the Non-communicable Diseases (NCDs) program, WHO is supporting the Government to enhance the accessibility to reliable information on NCDs and quality of care for people diagnosed with any Non-communicable Diseases, such as hypertension or diabetes. During the reporting period, a total of 8453 patients from the Rohingya refugee camps and adjacent host communities of Ukhiya and Teknaf Upazila seek medical care for Non-communicable Diseases (NCDs) and were reported through DHIS-2. Out of the total patients, 34% had or were newly diagnosed with diabetes mellitus and the same percentage of 34% with hypertension. A total of 9671 patients from the host community and Rohingya refugee camps seek medical attention for communicable diseases in weeks 21 and 22. Out of the total consultations, Acute Watery Diarrhoea was reported by 42.5% of the patients.

In May 2021, WHO Tuberculosis (TB) field assistants conducted five (05) sessions and visited approximately 250 households to raise awareness on tuberculosis among the Rohingya refugees and the nearby host community. They distributed sputum collection pots and referred suspected TB patients for further evaluation. During the reporting period Medical technologists performed 183 and 120 GXP tests and 230 and 150 routine microscopy tests for TB diagnosis in Ukhiya and Teknaf UHC respectively. Radiographers conducted a total of 50 X-rays including Chest X-rays for referred patients in Teknaf UHC for TB & COVID-19 suspect cases and other respiratory illnesses.

MONSOON AND CYCLONE PREPAREDNESS

The Health Sector, with 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 the list of camp health focal points is maintained and updated regularly. During the reporting period, WHO and IOM, as chair and co-chair of the Emergency Preparedness and Response Technical Committee continue with the After-Action Review for the major fire that occurred in the camps on 22nd March 2021 in order to assess the Mobile Medical Teams (MMTs) emergency response. In previous weeks, several interviews with MMT members deployed during the incident were conducted. Based on these key informant interviews, WHO and IOM have prepared an assessment report capturing best practices and lessons learnt and a plenary discussion on the overarching strategic issues with the Mobile Medical Team Working Group (MMT TWG) has been scheduled for 9 June 2021. This After-Action Review will help the standardization of future response interventions and it serves to remap the MMTs' intervention areas, so that interested new partners can join for better coverage and response. Capacity building activities will be organized in the next few weeks to capacitate the new and existing MMTs on response procedures based on the learnings from the After-Action Review.

Additionally, in weeks 21 and 22, the Health Sector Emergency Preparedness and Response Technical Committee maintained communication with the EPR TWG in preparation for the cyclone Yass and kept the MMTs alert for immediate deployment, if needed. WHO stockpiled Inter Agency Emergency Health Kits (IEHK) and Trauma and Emergency Surgery (TESK) kits at strategic points in and around the camp to support any post cyclone health response in coordination with relevant authorities.

WHO continues to ensure timely provision of quality and adequate supplies, equipment and consumables for the health emergency operations in Cox's Bazar.

To reinforce the public health response to COVID-19, WHO supported partners in Cox's Bazar, including the Health Management BD (HMBD) Foundation, Prantic Unnayan Society and Médecins Sans Frontières (MSF) with the delivery of 9000 Personal Protective Equipment (PPE) items, including isolation gowns, gloves, boots, face shields and surgical masks.

During the reporting period, a total of 1.3 MT total volume 6.23 Cubic meters of medicines and supplies were deployed to Cox's Bazar including medicines, PPE and sample collection kits for the diagnosis of COVID-19. WHO continues its logistic support to the IEDCR Field Laboratory with two vehicles providing transportation of COVID-19 sample collection in the camps. Further to this, WHO Cox's Bazar provided logistics support to send COVID-19 sample collection for quality assurance from Cox's Bazar and Chattogram districts to IEDCR Dhaka. In weeks 21-22, WHO has received 10 000 VTM from IEDCR Dhaka to support IEDCR lab Cox's Bazar.

SUBJECT IN FOCUS: Risk Communication during public health emergencies: the Cox's Bazar experience

Effective Risk Communication and Community Engagement (RCCE) relies on timely and transparent information sharing, coordination, information delivery, and public and stakeholder participation in the emergency response.

Risk Communication

Risk communication used to be viewed primarily as the dissemination of information to the public about health risks and events, such as disease outbreaks, and instructions on how to change behaviour to mitigate those risks. Today, it has evolved as social science evidence and integrates new communications, media technologies and practices.

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

Community engagement in public health emergency response

Risk Communication and Community Engagement (RCCE) is an essential part of humanitarian health emergency responses. During disease outbreaks and public health emergencies, individuals are in dire need of information. At the same time, these situations are characterized by an overload of information coming through different channels and sources which may hamper emergency management, while increasing the stress and uncertainty among the affected populations.

Effective Risk Communication and Community Engagement (RCCE) relies on timely and transparent information sharing, coordination, information delivery, and public and stakeholder participation in the emergency response. The early engagement of risk managers, stakeholders and affected communities during a disease outbreak or emergency can make a difference for an effective disaster response. Additionally, a well-established RCCE network helps build trust among the communities and contributes to the crisis management.

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, to foster positive behaviour change and to ensure the



Photo: A Rohingya refugee, 22-year-old Siraj is sharing key information on health promotion, referrals and communication from the Health Sector and RCCE WG while addressing fears, misinformation and rumours.

maintenance of trust between humanitarian aid and communities. Additionally, it ensures quick, timely community outreach to affected populations while providing correct information in the right language, appropriately communicated.

Rohingya Crisis: 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.

Risk Communication and Community Engagement during the COVID-19 pandemic

COVID-19 has proved that successful community engagement at individual and societal level helps the health system actors to contain the crisis through non-health interventions.

Before the first case of COVID-19 was detected in Cox's Bazar district, the Communications with Communities Working Group (CwC WG) and the Inter Sector Coordination Group (ISCG) activated a Risk Communication and Community Engagement Working Group (RCCE WG) to enable real-time exchange of relevant information between the experts, emergency health service providers and the communities. Together with CwC WG agencies, other RCCE WG partners –including Translators Without Borders, BBC Media Action, UNICEF, UNHCR, WHO, and representatives from Health Sector, Community Health Working Group and the WASH Sector– have been working to prepare the population, mitigate misinformation and rumors, and promote health and well-being of the Rohingya people and the host communities. 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 have since being 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.

The role of Community Health Workers (CHWs) in RCCE

WHO works with UNHCR and the Community Health Working Group (CHWG) to help implementing the strategy while supporting the 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.



Photo: WHO National Consultant, Dr Tasnova Sadneen, participated in a video production led by BBC Media Action to increase awareness on Sexual and Reproductive Health (SHR) among the Rohingya population.

Since the beginning of the COVID-19 response, CHWs have conducted over 8 million household visits and had contacts with a cumulative number of 20 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.

Vaccination campaign preparedness for the Rohingya

An extensive communication and engagement campaign involving key community members and religious leaders is currently on going in all the camps to raise confidence and acceptance among the Rohingya refugees. Through a multi-channel strategy which includes community radio, interpersonal communication and digital media, WHO is tracking vaccine hesitancy and rumors in the field and promoting community mobilization.



Photo: A Community Health Worker is helping her community fight the coronavirus in the densely populated refugee camps. She received training and communication tools to pass on important message to other refugees.

WHO has also provided technical assistance in the designing of Information, Education and Communication (IEC) materials on COVID-19 vaccination awareness for the Rohingya community in the refugee camps. Additionally, the WHO Immunization Vaccine Development (IVD) team has designed a community preparedness assessment tool to measure the awareness of Rohingya refugees regarding the upcoming COVID-19 vaccination campaign in the camps. This tool will help the Government and partners better drive the risk communications strategy in the field to encourage vaccinations and ensure that no one is left behind.

RCCE during the major fire incident in the Rohingya refugee camps on 22 March 2021

On 22 March 2021 afternoon a massive fire spread through camps 8E, 8W and 9 in the Rohingya refugee camp in Cox's Bazar, resulting in eleven deaths confirmed by government authorities and a significant number of injured.

In close coordination with the Risk Communication and Community Engagement Working Group (RCCE WG) under the Communications with Communities Working Group (CwC WG), WHO developed public health messages on preventive measures against fire hazard and management of burn wounds. Additionally, WHO provided support and coordination to partner agencies to ensure that post-fire health messages were accurate and easily understandable by the community, including the technical assistance to BBC Media Action for the production of Public Service Announcement (PSAs) on burn wound care. Interactive Voice Response (IVR), a set of standardized voice recorded messages that can be accessed by refugees with questions over telephone, containing health messaging encouraging the use of essential health services, referrals, among other urgent health needs were provided by the Health Sector.

In the immediate aftermath of the fire over 300 community health workers (CHWs) were deployed to provide emergency first aid and referral services. The CHWs had been trained on fire incident response earlier. Subsequently, CHWs have initiated door-to-door messaging on essential public health messages.

Training

WHO and Translators Without Borders (TWB) organized five batches of communication training and cultural awareness sessions in Rohingya language for humanitarian workers in the camps (including programme manager, programme officer, communication officer and health service providers) . The training, provided in Rohingya language, was engaged by 35 health care workers and helped them improve their communication skills while dealing with the Rohingya community

NATIONAL LEVEL HIGHLIGHTS, 10 June 2021 (BANGLADESH)

	Last 24 hours	Total
COVID-19 tests conducted	19 447	6 126 238
COVID-19 positive cases	2576	820 395
Number of people released/recovered	2061	759 630
COVID-19 deaths	40	12 989

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 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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