



*PHOTO: An extensive network of Rapid Investigation and Response Teams (RIRTs) is closely monitoring the COVID-19 situation in the refugee camps and provides counselling to patients and family members for proper isolation and quarantine*

## HIGHLIGHTS

- AWD surveillance has been enhanced through EWARS and 22 sentinel sites. Joint Assessment Teams (JAT) comprising of actors from Health and WASH sectors are investigating in and around the household of any RDT/culture-positive case and ensuring necessary public health measures.
- The analysis of Health Facility Quarterly Monitoring (Q2/2021) data is ongoing and will soon be shared with relevant actors and partners. The monitoring exercise aims to review adherence to the minimum package of essential health services, applicable for Health Posts and Primary Health Care Centers in the Rohingya camps.
- The COVID-19 vaccination campaign for Rohingya refugees >55 years will be taking place from 10 August, starting with community leaders >55 years, followed by all persons over 55 years in the Rohingya camps.
- A total of 5.5 million COVID-19 Moderna vaccines have arrived in the country through the COVAX facility, along with 4 million COVID-19 Sinopharm vaccines supplied through a bilateral agreement with China.
- **SUBJECT IN FOCUS:** Minimum package of Essential Health Services for Primary Healthcare Facilities in the FDMN/Refugee camps, Cox's Bazar (February 2020)

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	12 200	2 287
 Total cases in isolation in Cox's Bazar	700	419
 Total number of tests conducted	111 888	52 092
 Total deaths due to COVID-19	126	25

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 essential health services.

In response to a high occupancy rate and high proportion (~80%) of mild cases isolated in the SARI ITCs over the last weeks a contingency plan for home-based Isolation for mild cases' when bed occupancy in SARI ITC reaches more than 75% was advocated to authorities. The COVID-19 vaccination campaign for Rohingya refugees >55 years will be taking place from 10 August, starting with community leaders >55 years, followed by all persons over 55 years in the Rohingya camps. As a part of the preparedness, a mapping exercise of responsible Human Resources (HR) and facility preparedness has been recently completed.

Analysis of the Health Facility Quarterly Monitoring (Q2/2021) data is ongoing and will soon be shared with relevant actors and partners. The monitoring exercise aims to review adherence to the minimum package of essential health services, applicable for Health Posts and Primary Health Care Centers in the Rohingya camps. Revised Standard Operating Procedures (SOP) for Referrals and an Accountability to Affected Population (AAP) framework are expected to be endorsed shortly.

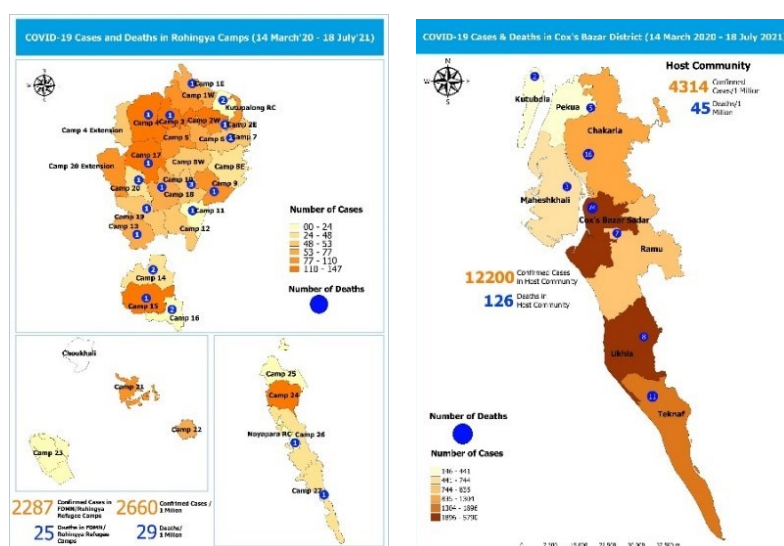
Indicators of the upcoming Multi-Sector Needs Assessment (MSNA) have been finalized for Health and training of enumerators has been completed. The findings will serve to guide response planning for 2022.

For AWD preparedness and response, enhanced surveillance is ongoing utilizing EWARS and 22 sentinel testing sites. Meanwhile in the field, Joint Assessment Team (JAT) comprising of actors from Health and WASH sectors are investigating in and around the household of any RDT/culture-positive Cholera case and ensuring necessary public health measures, in line with the Multisectoral AWD Preparedness and Response Plan (August 2020). Coordination meetings take place daily with WASH and CWC actors to ensure collective action relating to the implementation of agreed interventions under the Multisectoral AWD Preparedness and Response Plan.

At present, over 1400 Community Health Workers (CHW) are undertaking active case finding and referral, disseminating key health messages and distributing ORS/Zinc in households reporting symptoms. A General Health Card for Rohingya refugees is currently being compiled by the Health Sector Strategic Advisory Group. A pilot will take place prior to full scale roll-out of the card in the camps.

An After-Action Review (AAR) in response to the fire incident on 22 March 2021 in camp 8E, 8W and 9 by the Emergency Preparedness and Response Technical Committee (EPR TC) chaired by WHO and co-chaired by IOM, and the Mobile Medical Team Technical Working Group (MMT WG) led by IOM has been completed and a report is being compiled documenting lessons learned. In addition, they are also mapping hazards in Cox's Bazar and required logistics in strategic locations.

During the reporting weeks, a total of 8 camp-level Health Sector Coordination Meetings were held in Rohingya refugee camps, maintaining proper precautions against COVID-19. Key COVID-19 issues requiring support, coordination and collaboration among different partners and working groups were extensively discussed along with monsoon preparedness measures. In addition, Rapid Investigation Response Teams (RIRTs) coordination meetings are ongoing in the camps to strengthen the COVID-19 enhanced surveillance.





Among the Rohingya refugee population, the number of confirmed COVID-19 cases has also increased over the past weeks. In week 28, a total of 184 positive cases were registered in the Rohingya refugee camps with a test positivity rate of 14.8%, in comparison to the 123 confirmed cases in week 26, with a test positivity rate 10.0%. As of 18 July 2021, a total of 2 287 COVID-19 cases have been reported among Rohingya.

With a total of 147 cases, Camp 3 has the highest number of cases to date further ahead from Camp 2W with 137 cases, Camp 24 with 136 cases, Camp 15 with 130 cases, Camp 4 with 124 cases and Camp 17 with 116 cases. To date, 107 cases have been reported from Camp 1W, 103 cases have been reported from Camp 21, 95 cases from Camp 9 and 90 cases from Camp 20 Ext. 87 cases have been registered from Camp 5, 78 cases in Camp 2E, 76 cases in Camp 6. Both Camp 13 and 18 have registered 69 cases each, where Camp 1E has 65 cases. Camp 22, Camp 4 Ext, Camp 8W, Camp 7, Camp 19, Camp 12. Camp 10, Camp 26, Camp 8E, Camp 20, Camp 27, Camp 14, Camp 16, Nayapara RC, Kutupalang RC, Camp 11, Camp 25 and Camp 23 have so far had less than 60 cases. 7 cases have been registered from Zero Point and 2 are from new arrivals.

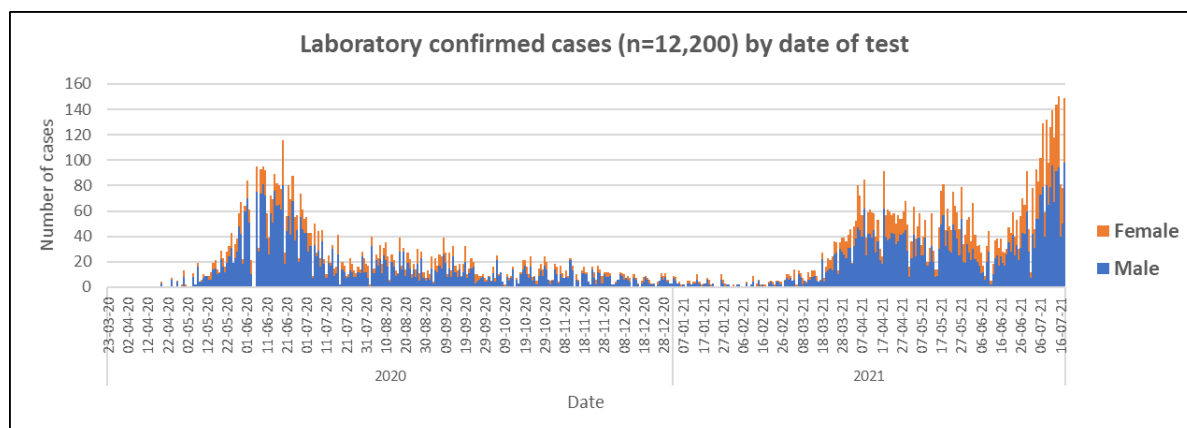


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

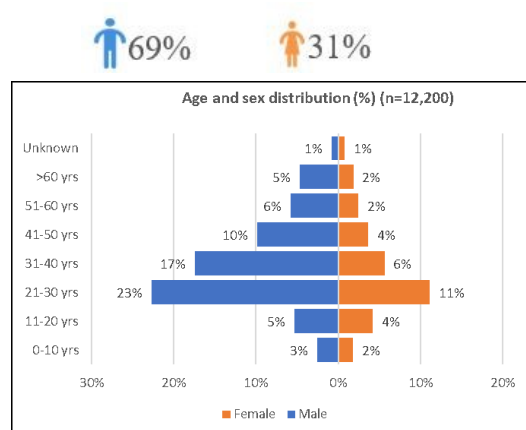


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

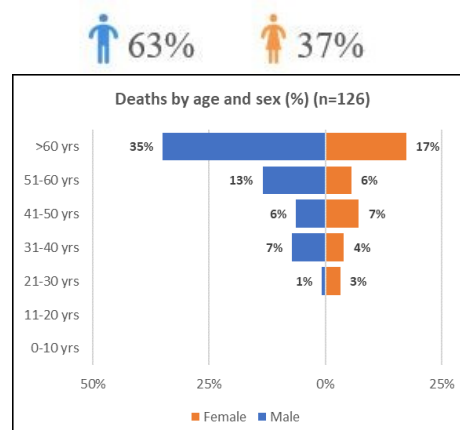


Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

To enhance Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITC) preparedness and respond to the upward trend of cases, the Civil Surgeon's office in Cox's Bazar issued a directive to activate all SARI ITC stand-by beds. Currently, 625 general isolation beds are functional in 12 SARI ITCs with provision of oxygen to assist both the Rohingya refugee population and the nearby host communities of Cox's Bazar. The bed occupancy of these SARI ITCs is 65% at the end of the reporting period. Moreover, the capacity of general isolation beds in the district is 405. The Intensive Care Unit/High Dependency Unit (ICU/HDU) at the Cox's Bazar Sadar Hospital has a capacity of 43 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.

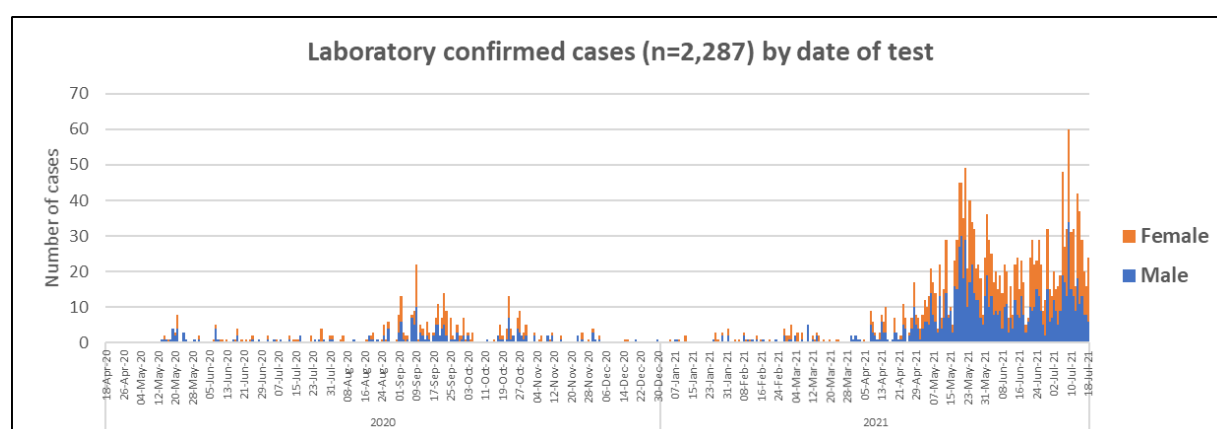


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

49% 51%

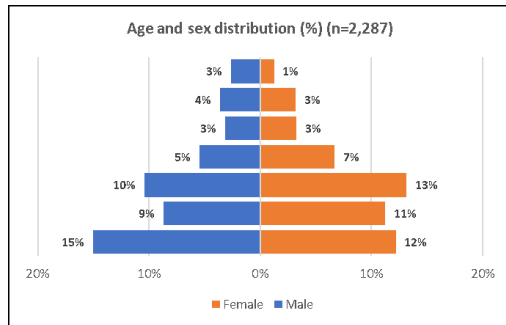


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

42% 58%

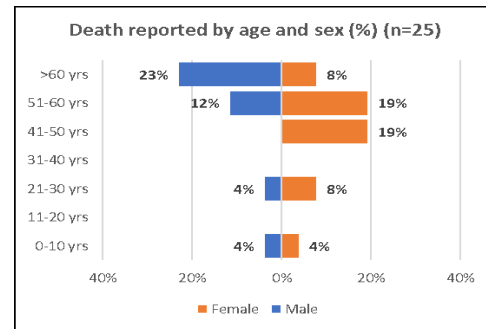


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Between weeks 27-28, 433 new confirmed cases were detected from 2 544 samples tested, the test positivity was therefore 17.0%. As of 18 July 2021, the cumulative incidence is 214.0 per 100 000 people. The overall positivity of samples tested is 4.4%. Among the cases, 1.9% showed severe symptoms at the time of admission while 3.8% reported at least one co-morbidity. The median age of tested and confirmed cases was 11 (0-120) & 22 (0-100) years, respectively and ratio of females among tested and confirmed cases was 54% and 51%, respectively. Though the median age of tested samples remained below 11 years, a significant proportion has been tested among 50+ years: 684 per 10 000 population, following that of 0-9 years with 843 tests per 10 000 population as highest number. The test positivity was highest 7.1% in 30-39 years age cohort and the age specific mortality 2.6 per 10 000 population observed among 50+ years during the period. In total, and since the outbreak began, 25 deaths due to confirmed COVID-19 have been reported in the camps with a case fatality ratio of 1.1%.

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 1 854 confirmed cases (out of 2 287 to date) have been investigated by RIRTs by 18 July 2021, with contact tracing activities being conducted and captured through Go.data, including 4 104 contacts. Out of these, 2 517 (61%) contacts have seen their follow up visits completed and were released from quarantine. 221 (8.8%) tested positive cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health and Disease Surveillance Officers (CHDSOs).

Since 1 May 2021, there have been 107 cases (88 from Rohingya refugees and 19 from host community) of AWD that have test-ed positive by Rapid Diagnostic Tests (RDTs)/bacteriological culture confirmed cases for cholera (data as of 18 July 2021) bringing the total to 127 (95 from Rohingya refugees and 32 from host community) in 2021. Of the 107 cases, 40 (35 from Rohingya refugees and 5 from host community) have been culture confirmed. In the past three weeks (week 26-28) the total number of culture confirmed cases was 20.

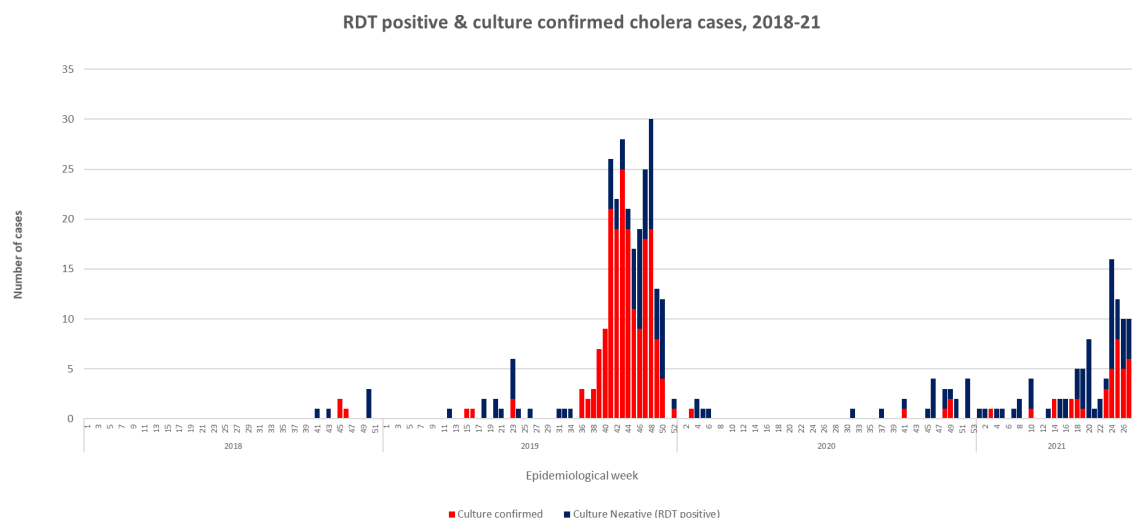


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

In week 28 (12-18 July 2021), 24 Rapid Diagnostic Test (RDT) positive cases were reported. All 24 RDT positive samples are undergoing culture for confirmation. In addition, 9 cases were culture confirmed from RDT negative samples. In week 27 (5-11 July), 10 RDT positive cases reported (6 were culture positive, 2 discarded and 2 result are yet to be received) and no additional culture confirmed cases from RDT negative samples were received so the total culture confirmed cases is 6 for that week. In week 26 (28 June-4 July) 8 RDT positive cases were reported (2 were culture positive and 6 discarded) and 2 more were culture con-firmed from RDT negative samples. Total culture confirmed cases for that week is 4.

In line with the Multisectoral AWD response plan, for each case a joint Health and WASH investigation takes place and implements household level measures. Areas of focused intervention have been identified based on at least one culture confirmed case in camp in last 30

days and/or 2 or more RDT positive cases from same sub-block in last 14 days, where WASH, Health and Community Engagement activities are undertaken/intensified at sub block/camp level as appropriate. In 2021, at least one confirmed cholera case was reported in last 30 days, from camp 1E, 1W, 2E, 2W, 3, 7, 8E, 8W, 9, 10, 13, 17, 18, 20, 20 extension and Kutupalong Registered Camp as of now, out of these culture confirmed few camps have reported more than one case i.e. 7, 13 and 18. Two or more RDT positive cases have been identified in same subblocks from camp 17 (7 cases from sub-block H109), camp 10 (3 cases from sub-block F39), camp 19 (2 cases from sub-block) and camp 20 Extension (2 cases from sub-block S2B4).

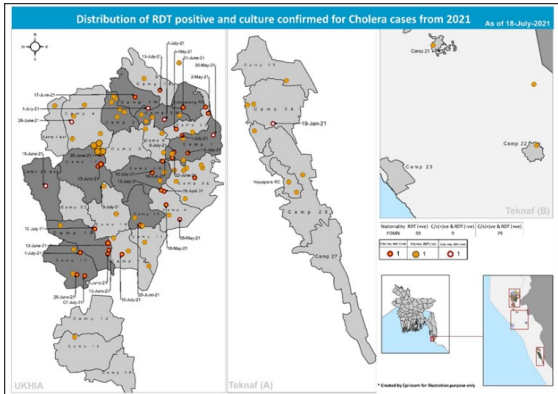


Figure 8: Geographic distribution of all RDT Positive and Culture Confirmed Cholera Cases in 2021

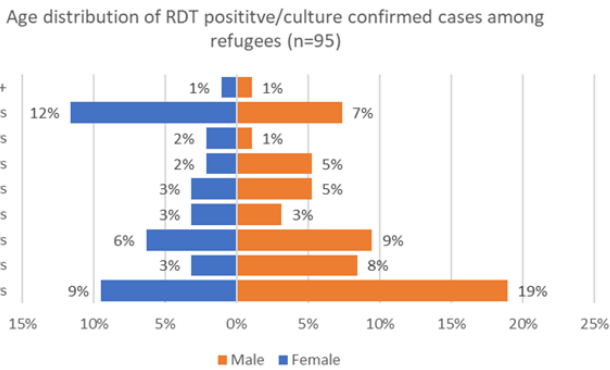


Figure 9: Age group distribution of RDT Positive and Culture Confirmed Cholera Cases among refugees from May to 7 July 2021

In response to the surge of Acute Watery Diarrhea (AWD) cases in Cox’s Bazar, a rapid mapping conducted by WHO and partners in line with the Multisectoral Acute Watery Diarrhea Response Plan (August 2020) has identified Seventy-two (72) isolation beds for AWD are functional at this time, with additional 400 beds on standby that could be activated on short notice. (Of these standby beds, 160 are SARI ITC standby capacity beds that could be repurposed for AWD if the epidemiological situation required. See Figure below for further details.) Diarrhea Treatment Centers (DTC) in Leda remain open for strengthened case management of AWD patients and are ready to expand the capacity.

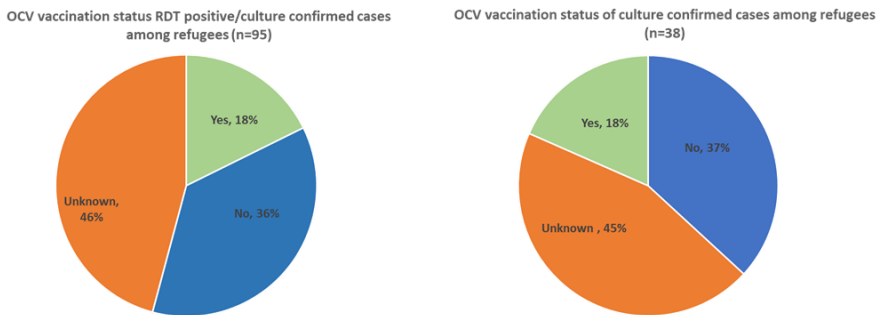


Figure 10: OCV vaccination status among RDT Positive and Culture Confirmed Cases among refugees

The situation continues to be closely monitored by WHO epidemiology team in order to respond accordingly. During the reporting period, WHO has conducted AWD clinical management training for healthcare workers in the camps. In total, 254 Healthcare workers mainly from the affected Upazilas and the camps attended a half day online training, in batches over three days, on clinical management of AWD organized by Civil Surgeon of Cox’s Bazar, WHO/Health Sector in collaboration with icdr,b. In the month of July 2021 until 18 July, there have so far been 71 admissions to the isolation facilities and the Diarrhea Treatment Centers (DTC). No deaths have been reported at the isolation facilities so far.

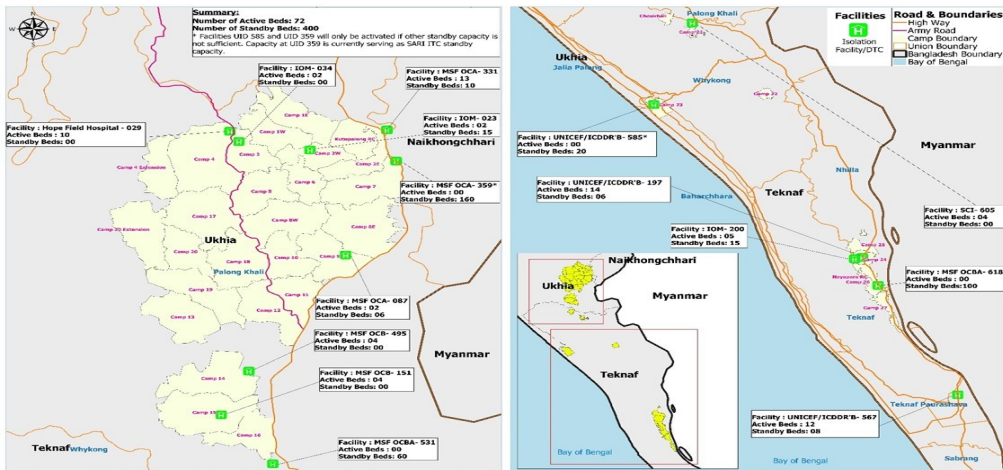


Figure 11: Acute Watery Diarrhea Isolation & Diarrhea Treatment Center Bed Capacity Mapping, as of 1 July 2021.

A total of 401 refugee cases were admitted to DTC and other health facilities with AWD isolation capacity. Out of the cases, 22% were severely dehydrate, 30% with some dehydration and 47% showed no sign of dehydration at the time of admission among refugees.

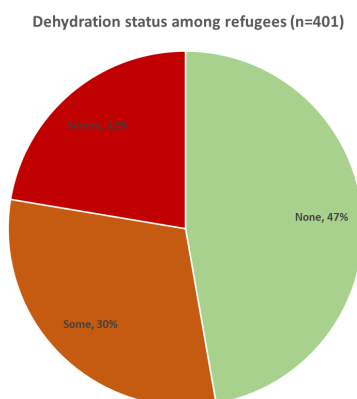


Figure 12: Dehydration status of admitted cases reported from Leda DTC and other health facilities with isolation capacity in camps from week 1-28, 2021

As of 18 July 2021, around 1400 Community Health Workers (CHWs) have been trained on key messages on health/hygiene promotion and prevention of acute watery diarrhea, following a training of 120 CHW supervisors and managers in previous weeks. UNHCR, as chair of the Community Health Working Group (CHWG), has organized and facilitated the training. UNHCR is also supporting with printing of hygiene promotion and AWD prevention IEC materials to help enhance awareness and prevention measures in the camps, other agencies are providing support as well. Active case finding with a uniform line list is being rolled out by CHWG partners from early July, in support of community-based surveillance. CHWG with Health Sector support developed AWD surveillance which was rolled out as of week 27 (4th July). As of 17th July, over 270,000 household visits have been conducted, out of which over 2900 AWD cases were referred to the health facility for further case management. Furthermore, over 10,000 ORS sachets and over 9700 zinc tablets have been distributed at community level.

Throughout the camps, CHWs have re-enforced community engagement activities through weekly visits to every household in the camps. This includes community-based surveillance; health education on hygiene promotion and prevention of Acute Watery Diarrhea (AWD) through house to house visits and small group sessions and active finding of cases with AWD and subsequent referrals to health facilities. Specific emphasis is being placed on “target camps”. In 2020, a total of 28 RDT positive cases for Cholera were detected through sentinel testing, 5 of which were confirmed by culture – 2 from Ukhiya host community, 1 from Teknaf host community and 2 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.

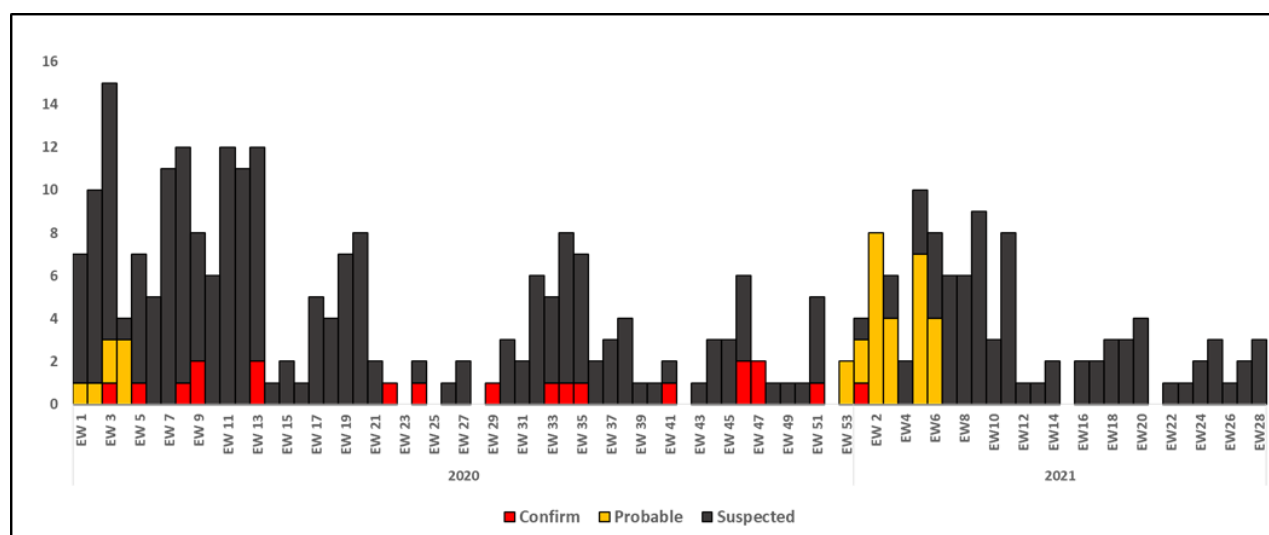


Figure 13: Total number of diphtheria case reported in EWARS from 2020-2021

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9287 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 101 as of week 28, 2021). In total, 9041 cases were reported in the camps and 246 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.

During the reporting period, 3 new probable maternal death have been reported. In total 68 probable maternal/deaths of women of reproductive age (WRA, 12-49 years) have been reported in 2021, of which 19 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. In week 26-27, 2 suspected Severe Acute Respiratory Infection (SARI) deaths were reported. In total 54 deaths have been reported in 2021. All deaths have been investigated by RIRT as a part of COVID-19 response and 9 were considered as death due to probable COVID-19. In 2020, a total 49 suspected SARI deaths were reported through community-based mortality surveillance.

Of these, all were verified and 2 considered death due to probable COVID-19. So far in 2021, 2 suspected deaths were investigated under this task and considered as death due to suspected cholera.

## 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. 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. 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.

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 (Bangladesh Betar and Community radio Naf 99.2 FM)

During the reporting period, the first draft of the virtual roundtable discussion on Community Engagement, Coordination and Healthcare Seeking Behaviours in Cox’s Bazar was developed. For the upcoming COVID-19 Vaccination campaign among Rohingya Refugees, Frequently Asked Questions (FAQ) and Public Health messages were reviewed and finalized.

Under the study on “Knowledge, Attitude and Practice on Minimum Invasive Procedure in the Non-Healthcare Settings among Rohingya Refugees in Cox’s Bazar” that is jointly undertaken by WHO, UNHCR and the Community Health Working Group, English translation and quality assurance of the Key Informant Interview (KII) and Focused Group Discussion (FGD) previously conducted by Community Health Workers (CHWs) have been completed.

In addition, to address different health issues like Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health (SRMNCAH), Gender-Based Violence (GBV), Nutrition, Sexually transmitted infections (STI) and Noncommunicable Diseases (NCDs) as well as improving health-seeking behaviour; facilitating to produce a series of Audio Visual (AV) and podcast materials in association with BBC Media Action.

During the reporting period, CHWs conducted 286 471 household visits in which 3806 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 45 patients with moderate/severe symptoms. The cumulative number of patients with mild symptoms is 159 235, and 932 patients with moderate/ severe symptoms. To date, 84 648 persons with COVID-19 like symptoms have been referred to health facilities, 2606 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 604 797 persons between weeks 27 and 28. Since the beginning of the response, CHWs have conducted more than 8.8 million household visits and had a cumulative number of more than 22 million contacts with adult household members. Through the CwC WG, 53 175 people were engaged in 25 844 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 18 July 2021, a total of 183 535 tests for COVID-19 have been conducted, of which 163 980 are from Cox’s Bazar district and the remainder from Bandarban and Chittagong districts. An increase in the number of tests conducted among the Rohingya refugees was observed in weeks 27-28 as compared to weeks 25-26, from 2 451 to 2 544 tests. Among the host community an increased number was tested either: from 5 391 tests in weeks 25-26 to 6 709 tests in week 27-28. Currently, 35 sample collection sites are operating for suspected COVID-19 patients.

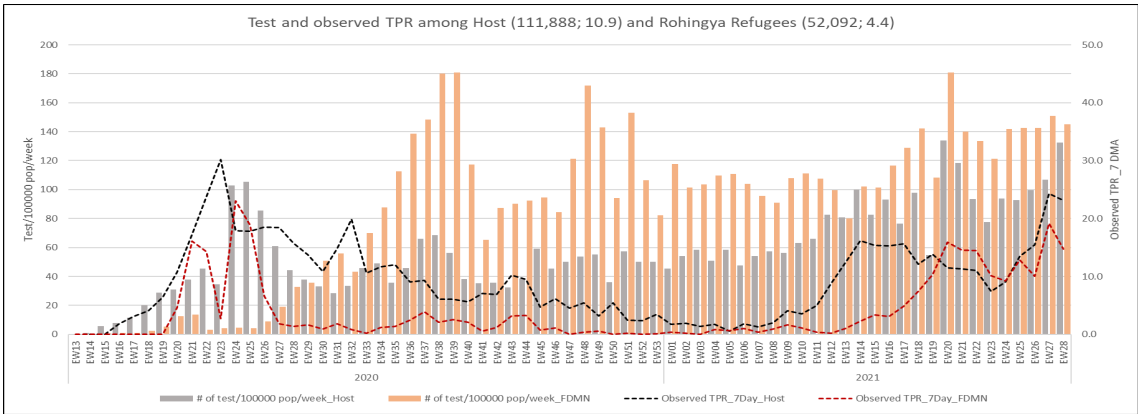


Figure 14: Number of tests conducted and observed test positivity per million among the host population and the Rohingya refugees/FDMN

\*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



WHO continues supporting Health partners in capacity building through providing trainings. As part of this effort, WHO conducted two hands-on trainings on “Use and analysis of COVID-19 Ag RDT at camp level” to IOM SARI ITC camp 24 and MSF OCBA Goyalmara where 12 and 11 health care workers received the training respectively. In addition, the WHO Lab team provided hands-on trainings on “COVID-19 sample collection and transportation” to Gonoshasthya Kendra (GK) PHCC at camp 4 Ext and IRC PHC at camp 23 to 12 and 8 health care workers respectively. These facilities will initiate COVID-19 sample collection in their respective camps of work. Additionally, COVID-19 Ag RDT were provided to five healthcare facilities in camp 2W, 20 Ext, HOPE SARI ITC, Camp 24 IOM SARI ITC and MSF OCBA Goyalmara. The team also finished monitoring RDT test procedures in those five facilities.

Following a request from IRC camp 23 PHC, the WHO lab team assessed the facility to facilitate opening of a COVID-19 sample collection site for that camp. Finally, WHO concluded the laboratory supportive supervision for 45 World Bank funded health facilities last week.

### INFECTION PREVENTION 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 IPC has been provided to 3600 humanitarian health care workers and government staff from healthcare facilities and SARI ITCs in Cox’s Bazar.

In the past weeks, WHO and some partners from the IPC Technical Working Group (IPC TWG) completed a two-week hands-on mentorship on the use of the recently developed kobo reporting tool for monthly IPC scorecard. In total 17 IPC dedicated staff from 9 healthcare facilities (8 SARI ITCs and 1 ICU/HDU) in Cox’s Bazar were mentored with the aim to improve IPC data management and data sharing.

In addition, envisioning the safety of healthcare workers and patients during this COVID-19 pandemic, WHO and the IPC TWG are jointly conducting supportive supervision visits to specialized services facilities (SRH, dental, disability, eye care, etc.) in the Rohingya refugee camps. So far, 13 facilities have been covered in this activity that is anticipated to last for at least one month.

### 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 health sector case management working group meetings along with one case conference call for SARI ITCs and one case conference calls for ICU/HDU of Cox’s Bazar District Hospital were conducted.

Until the reporting week, there are 12 operational SARI ITCs in Cox’s Bazar with a total of 625 beds functional and 292 on stand by. The SARI ITC bed occupancy rate is currently 71% (Ukhiya 83% and Teknaf 55%). For the admitted patients, 81% of them are categorized as mild patients, 11% as moderate and 8% as severe cases. At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 15 beds and the Severe Care Unit (SCU) has 13 beds (all of the beds are functional). As of 5<sup>th</sup> July, 31 beds are occupied with COVID-19 patients in total.

On 6th July 2021, ‘Online Refresher Session on DRU Operations’ was arranged through collaboration of Health Sector, WHO and IOM. More than 180 healthcare workers including Rapid Investigation and Response Team (RIRTs) coordinators, camp health focal points, camp health disease surveillance officers and health sector partners joined this 2-hours session.

### 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. During the reporting period, the Directorate General of Health Services (DGHS) issued an official communication announcing vaccine prioritization for Rohingya refugees over 55 years-old. To build trust and community engagement, WHO IVD team proposed to start the vaccination campaign on 10 August with community and religious leaders along with the frontline volunteers who are above 55 years of age. From 16 August, the full campaign will be rolled out. The Civil Surgeon and the technical committee on Immunization for FDMNs has accepted the proposal to start the campaign with the planned date. To that end, WHO Immunization and Vaccine Development (IVD) team initiated the development of an updated micro plan based on most recent population breakdown and a complete training package for supervisors, AEFI focal points, vaccinators and volunteers

During the reporting period, Bangladesh has received 3 million vaccine doses of Moderna COVID-19 vaccine through COVAX, 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. In total, 5.5 million doses of Moderna have been received through COVAX, in addition to the 4 million vaccine doses of Sinopharm COVID-19 vaccine received through a bilateral procurement agreement with China. The Government of Bangladesh has resumed COVID-19 vaccine registration through the national Surokkha portal for Bangladeshi citizens over 30 years-old and other priority groups.

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 75 vaccination teams are conducting outreach sessions both in community and healthcare facilities. Vaccination sites and surveillance health facilities will be reassessed by Government authorities with the technical support of Surveillance and Immunization Medical Officers (SIMOs) based on data from 1<sup>st</sup> half of 2021.

An immunization microplan for the upcoming six months is currently under review by the Upazila Health Complexes (UHC) in Teknaf and Ukhiya with the technical assistance from WHO and health partners. Additionally, the IVD team is completing the preparatory work and planning to conduct basic routine immunization trainings for vaccinators and supervisors. During the reporting period, the IVD team continues 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, during the reporting period, a total of 9930 patients from the Rohingya refugee camps and adjacent host communities of Ukhiya and Teknaf Upazila sought medical care for NCDs and were reported through DHIS-2. Out of the total patients, Hypertension was reported with highest percentage of 33% followed by 32% for Diabetes Mellitus among all NCD patients.

Regarding Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), WHO is upholding and promoting policies and practices on prevention and response to sexual exploitation, abuse and harassment (PRSEAH). WHO is continuously coordinating with global and local Protection from Sexual Exploitation and Abuse (PSEA) network to provide technical assistance in Cox's Bazar. WHO is also collaborating with the Child Protection Sub-Sector (CP SS), Gender-Based Violence Sub-Sector (GBV SS), Gender in Humanitarian Action (GiHA) Working Group and GBV in Emergency (GBViE) Global Peer Group to assist the platforms with technical support.

WHO is also contributing to developing strategies and action plans to reduce Maternal and newborn mortality across camps and host communities and supporting partners with sustainable solutions to the challenges faced through conducting Maternal and perinatal death reviews along with MPMSR sub-committee members.



Photo: Routine Immunization is conducted and monitoring in the refugee camps by WHO HFMs .

## 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, findings and observations generated through the After-Action Review of the Mobile Medical Teams (MMTs) response to the fire incident on 22 March 2021 were disseminated by the Emergency Preparedness and Response Technical Committee and the MMT Technical Working Group in the SAG meeting. In addition to that, the agenda of the EPR TC meeting was discussed among the chairs and scheduled for the first week of August 2021.

## OPERATIONAL SUPPORT AND LOGISTICS

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 Hope Foundation with the delivery of 11 132 Personal Protective Equipment (PPE) items, including isolation gowns, gloves, boots and face shields. Logistical support for COVID-19 sample collection at 33 sentinel sites continues with the supply of vacutainer, swab sticks and zip lock bag, among others. During the reporting period, a total of 3.38 MT total volume 16.16 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 donated 10 TESK 2019 Gloves module kits to the MSF-Paris and continues its logistics support to the IEDCR Field Laboratory with two vehicles providing transportation of COVID-19 sample collection in the camps.

## SUBJECT IN FOCUS: Minimum package of Essential Health Services for Primary Healthcare Facilities in the FDMN/ Refugee camps, Cox's Bazar (February 2020)

On 25 August 2017, an unprecedented influx of Rohingya refugees began from Rakhine State in Myanmar into Bangladesh's district of Cox's Bazar. The scale and acuteness of this humanitarian crisis was unprecedented and unique globally, requiring strong coordination of a multitude of actors.

As part of the Intersectoral Coordination Group (ISCG) in Cox's Bazar, the Health Sector coordination team led by the World Health Organization (WHO) is tasked to ensure minimum standards of health care for Rohingya refugees. To this end, several technical working groups operate under the umbrella of the Health Sector: Sexual Reproductive Health (SRH) led by UNFPA; Community Health led by UNHCR and Medair; Mental Health and Psychosocial Support (MHPSS) led by IOM and UNHCR; Emergency Preparedness and Response (EPR) led by WHO and IOM; Epidemiology led by WHO; and Clinical Case Management also led by WHO.

Since November 2017, the health sector has been led by a Health Sector Strategic Advisory Group (HSSAG), constituting representatives from government, the UN bodies and selected national and international NGOs. Health Sector partners in Cox's Bazar are coordinated under the leadership of the Civil Surgeon, the Ministry of Health and Family Welfare coordination cell (MoHFW CC) and the Refugee Relief and Repatriation Center (RRRC) for better planning and implementation of a coordinated emergency response by humanitarian agencies.

#### Access to primary health care and referrals for secondary facilities in the Rohingya refugee camps

Numerous health facilities are operating in Cox's Bazar District including the camps providing health care to refugees as well as nearby host communities, many with varying levels of services and quality of care. There are 175 functional healthcare facilities in the Rohingya refugee camps offering a range of general healthcare services to nearly 884 000 Rohingya refugees and 472 000 Bangladeshi living in the surrounding areas. This includes primary healthcare centers, health posts, special facilities and field hospitals.

Additionally, as part of the COVID-19 pandemic response, in March 2020 WHO and partners established 14 Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs) to provide quality clinical care to COVID-19 patients within this complex setting. With a capacity of nearly 1200 beds, these healthcare facilities can provide treatment for mild, moderate and severe cases of COVID-19 and ensure access to a secure oxygen supply 24 hours a day.

Healthcare facilities in the camps submit weekly reports to the WHO Early Warning, Alert and Response System (EWARS), an application for outbreak detection and response in emergency settings which enables systematic collection of real time data for disease surveillance. The use of EWARS provides an overview of the health status of the refugee population and becomes crucial in developing a more targeted and coordinated public health response, particularly in complex humanitarian settings such as Cox's Bazar where a wide range of government and humanitarian actors are involved.

Additionally, partner-led healthcare centers in the camps coordinate efforts with the existing government facilities to ensure early access to life-saving treatment. In the case of the SARI ITCs, a well-established referral pathway enables the transfer of critical COVID-19 patients or patients with other serious pathologies to the ICU/HDU at Cox's Bazar district Sadar Hospital, established months ago with the support of Government, UNHCR and WHO.

#### Minimum package of Essential Health Services for Primary Healthcare Facilities in the Rohingya Refugee Camps (February 2020)

The Health Sector aims to improve the health and nutrition status and overall wellbeing of refugees. To achieve this, a standard package of evidence based, essential health services should be delivered by health partners in an equitable manner, while ensuring accessibility and quality.

At the start of the crisis, as many health partner agencies sought to establish health facilities, standardization and distribution of health services was a challenge. One key priority was to rapidly develop minimum standards for health facilities in the refugee camps to provide a benchmark against which the health sector could monitor health facilities and to institute a basic level of equity in service provision. This was done by defining two levels of primary health care: health posts (broadly equivalent to government community clinics and counted as a basic health unit according to sphere standards) and primary health centres (broadly equivalent to government union-level sub-centres and counted as a 'health centre' according to sphere standards).



Photo: An integrated system has been established in primary healthcare facilities to the prevention and control of Noncommunicable Diseases (NCDs) in the refugee camps



Photo: An extensive network of Government and partner-led healthcare facilities offer a range of general healthcare services to the Rohingya refugees, including 38 Primary Healthcare Centers (PHC)

Minimum standards for each level were developed by the HSSAG members based on national and global standards including. With the endorsement from the government health authorities, these were published and shared with all health partner agencies as February 2020. This revised package builds up on the earlier Essential Service Package developed in 2017 and revised in December 2018 by Health Sector under the leadership of MOHFW and RRRC.

The purpose of the Essential Minimal Health Care Package is to demarcate the said minimal standards and services availed through the primary health care facilities. The package has considered SPHERE standards, UNHCR Global Health strategy and contextual realities. It is expected to facilitate Health Posts (HP), and Primary Health Centers (PHC) to provide person centered, comprehensive health care in a continuous, coordinated and integrated manner, as first contact points of health care for refugees.

The primary health facilities will avail health promotion, preventive services, curative services and access to secondary/tertiary referrals. Systematic community level health promotion and preventive services are being rolled out through the Community



Health Workers linked to the primary health facilities. Curative services encompass IMNCI, SRHR and MHPSS in addition to general communicable and non-communicable diseases curative services. Referral services are sustained to ensure intra-camp and out-side camp referrals for secondary and tertiary care.

Other services such as oral and eye care will be explored to be provided in an integrated manner in close collaboration with Primary and Secondary Health Care Providers. An important focus will be on the vulnerable groups including pregnant and post-natal women, newborns, the under-fives, including those with malnutrition and persons with disabilities.

The scope of this guideline limits to the general primary health care facilities only. However, links to secondary health care and special care services will also be explored as and when feasible/possible.

#### NATIONAL LEVEL HIGHLIGHTS, 22 July 2021 (BANGLADESH)

	Last 24 hours	Total
COVID-19 tests conducted	11486	7 376 374
COVID-19 positive cases	3697	1 140 200
Number of people released/recovered	8566	969 610
COVID-19 deaths	187	18 625

WHO global situation report: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>

WHO interim guideline on Preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings: [https://www.who.int/publications-detail/preparedness-prevention-and-control-of-coronavirus-disease-\(covid-19\)-for-refugees-and-migrants-in-non-camp-settings](https://www.who.int/publications-detail/preparedness-prevention-and-control-of-coronavirus-disease-(covid-19)-for-refugees-and-migrants-in-non-camp-settings)

Institute of Epidemiology, Disease Control and Research (IEDCR) for COVID-19 updates in Bangladesh : <https://www.iedcr.gov.bd/>  
COVID-19 Bangladesh situation reports: [https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update/coronavirus-disease-\(covid-2019\)-bangladesh-situation-reports](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/coronavirus-disease-(covid-2019)-bangladesh-situation-reports)

WHO Bangladesh awareness and risk communication materials in Bengali:  
[https://www.who.int/bangladesh/emergencies/coronavirus-disease-\(covid-19\)-update](https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update)

Previous issues of this Situation Report:  
<https://www.who.int/bangladesh/emergencies/Rohingyacrisis/bulletin-and-reports>

COVID-19 Dashboard under WHO Cox's Bazar Data Hub can be accessed here: <https://cxb-epi.netlify.app/>

Write to [coord\\_cxb@who.int](mailto:coord_cxb@who.int) to receive COVID-19 updates and situation reports from Cox's Bazar with the subject "Add me to the situation reports and updates mailing list"



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