







*Since early 2021, WHO and Health Sector partners have been supporting the Government in COVID-19 vaccination campaign preparations for the Rohingya community*

## HIGHLIGHTS

- 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 with the revision of inclusion of all Rohingya volunteers > 18 years of age.
- The Health Sector completed its Quarter 2 (April-June 2021) health facility quarterly monitoring exercises and the findings being disseminated to the different stake holders and Technical Working Groups. 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.
- Currently over 95% of healthcare facilities in the Rohingya camps have established IPC structures to facilitate proper implementation of IPC in the health facilities.
- **SUBJECT IN FOCUS: Tuberculosis (TB).**

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	14 136	2 475
 Total cases in isolation in Cox's Bazar	448	204
 Total number of tests conducted	119 475	53 616
 Total deaths due to COVID-19	166	28

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, SARI ITC partners have increased their bed capacity. At present, across 13 SARI ITCs, there are 641 functional and 276 standby beds. As of 01 August 2021, there are 40 COVID-19 sentinel sites in Rohingya camps. Each of 34 camps has at least one sentinel site – except Camp 1E & 8E- in order to increase the number of tests as requested by Civil Surgeon, Cox's Bazar.

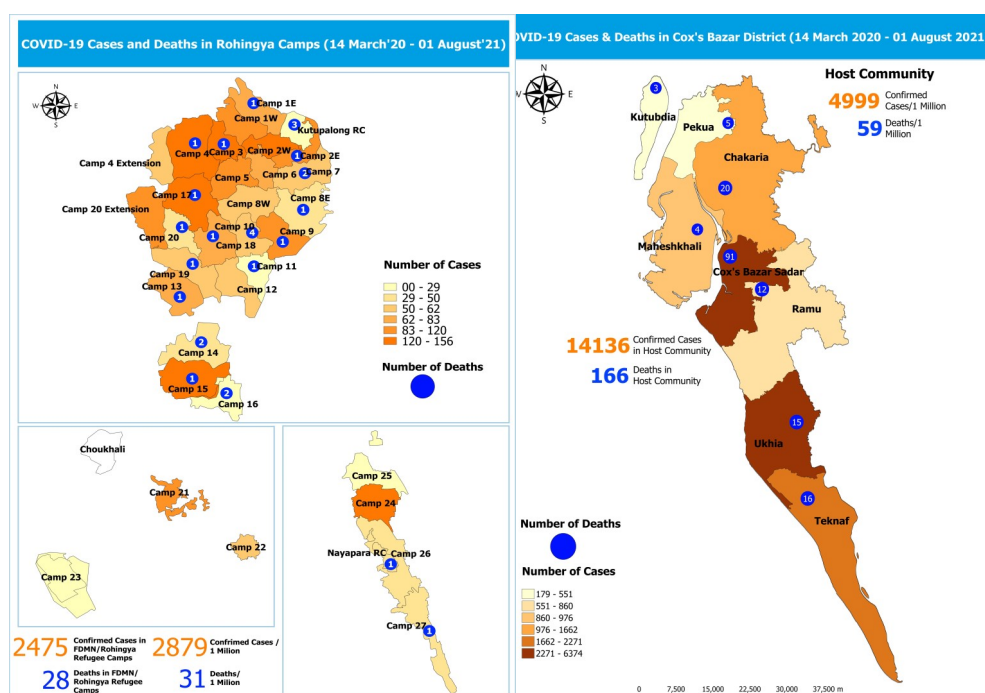
A COVID-19 vaccination campaign for Rohingya refugees will commence on 10 August 2021 with the community leaders aged 55 years and above, followed by population over 55 years on 16 August 2021. The Rohingya frontline volunteers >18 years have recently been included in the campaign as per the directive from GoB- the registration is going on. As a part of the preparedness, trainings for Vaccination Site Supervisors, CHW Supervisors and Adverse Events Following Immunization (AEFI) Focal Persons have been completed. In addition, Camp-in-Charges (CiC) were oriented on the COVID-19 Vaccination Campaign for FDMN. Age limit of COVID-19 vaccination registration for Bangladesh nationals was lowered to 25 years as indicated in the Surokha web portal. In relationship to this, 1<sup>st</sup> phase of data collection for COVID-19 vaccination registration for national humanitarian workers in Cox's Bazar aged 18- 34 years is complete. Around 7000 workers are expected to be registered in this process to national database

One week-long heavy rainfall in Cox's Bazar disrupted the essential health services provision in the camps. A rapid assessment tool developed by the Health Sector is being used in collecting information. Health Facilities in the camps are sharing updates on the incident, damage, injuries and deaths daily since 28 July 2021. Based on these information, Health sector has contributed to 02 Monsoon Response Flash reports, compiled by ISCG, which have been shared with all health partners recently. At the field level, 07 Mobile Medical Teams (MMT) are on standby to support the affected facilities. Six out of 135 health facilities were affected.

The Health Sector completed its Quarter 2 (April-June 2021) health facility quarterly monitoring exercises and the findings are being disseminated to the different stake holders and Technical Working Groups. The monitoring exercise assessed facility compliance with the Minimum Package of Essential Health Services, applicable for both Health Post and Primary Health Care Center in the Rohingya camps. Civil Surgeon, Cox's Bazar is currently reviewing the revised Standard Operating Procedure (SOP) of Referrals in Rohingya camps. Also, SAG members are finalizing the first draft of General Health Card for Rohingya refugees.

At present, over 1400 Community Health Workers (CHW) are undertaking active case finding for Acute Watery Diarrhea (AWD) & COVID-19, referring persons with symptoms, disseminating key health messages and distributing Oral Rehydration Solution (ORS) sachets /Zinc tablets in households with persons reporting AWD symptoms. For AWD preparedness and response, enhanced surveillance is ongoing utilizing Early Warning Alert and Response System (EWARS) and 22 sentinel testing sites. Meanwhile, Joint Assessment Team (JAT) is investigating in and around the household of any Cholera case and ensuring necessary public health measures are instituted through WASH and Health Sector partners. Seventy-two (72) beds are active and dedicated to AWD management. A coordination meeting with Health, CHW WG, WASH & CwC WG actors takes place daily to ensure collective action to implement interventions under the Multisectoral AWD Preparedness and Response plan

Despite the lock down, Health Sector Coordination meetings in Rohingya refugee camps are continuing with appropriate precautions against COVID-19. Key discussion points included areas requiring support, coordination and collaboration among different partners and working groups as well as monsoon response measures. In addition, Rapid Investigation & Response Team (RIRT) coordination meetings are ongoing in the camps to strengthen the COVID-19 enhanced surveillance.



WHO continues to provide epidemiological data to support operational decision making for the COVID-19 response in Cox's Bazar. As of 18 July 2021, a total of 12 200 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 918 in Chokoria, 146 in Kutubdia, 740 in Moheshkhali, 381 in Pekua, 752 in Ramu, 5790 in Sadar, 1 497 in Teknaf and 1 976 in Ukhiya.

While the overall positivity of samples tested in the district is 11.8%, an increasing trend in cases among the host community has been observed in recent weeks. In week 30, 1177 cases tested positive, with a test positivity rate of 24.3%, in comparison with week 28 when 859 positive cases were registered with a test positivity rate of 23.1%. To date, a total of 166 deaths have been reported in the host community, with a case fatality ratio of 1.1%.

Among the Rohingya refugee population, the number of confirmed COVID-19 cases has decreased the past weeks. In week 30, a total of 120 positive cases were registered in the Rohingya refugee camps with a test positivity rate of 12.0%, in comparison to the 184 confirmed cases in week 28, with a test positivity rate 14.8%. As of 1 August 2021, a total of 2 475 COVID-19 cases have been reported among Rohingya.

With a total of 156 cases, Camp 3 has the highest number of cases to date ahead of Camp 2W with 150 cases, Camp 24 with 144 cases, Camp 15 with 138 cases, Camp 4 with 130 cases and Camp 17 with 127 cases. To date, 117 cases have been reported from Camp 1W, 115 cases have been reported from Camp 21, 99 cases from Camp 9 and 96 cases from Camp 20 Ext. 87 cases have been registered from Camp 5, 95 cases in Camp 2E. Camp 1E, 2E, 4 Ext, 6, 7, 8E, 8W, 10, 11, 12, 13, 14, 16, 18, 19, 20, 22, 23, 35, 26, 27, Kutupalong RC and Nayapara RC so far had less than 90 cases. 7 cases have been registered from Zero Point and 3 is from new arrivals.

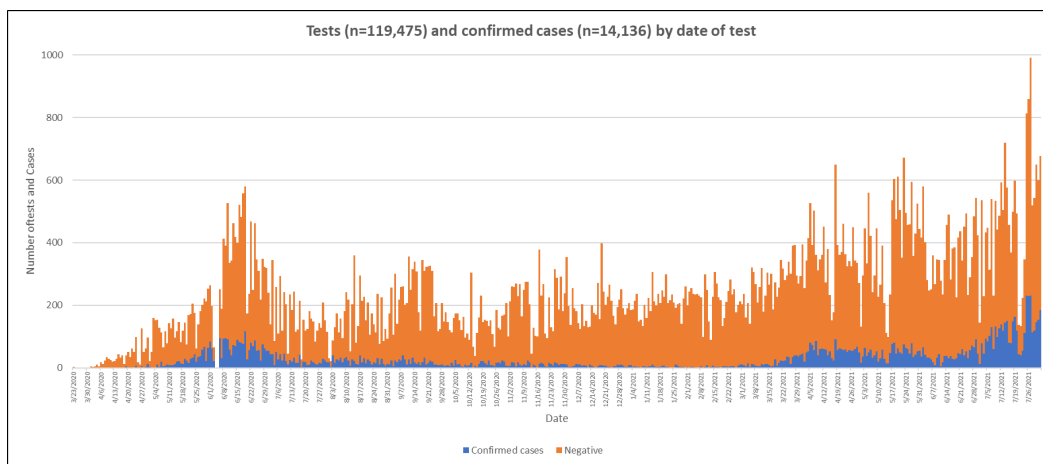


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

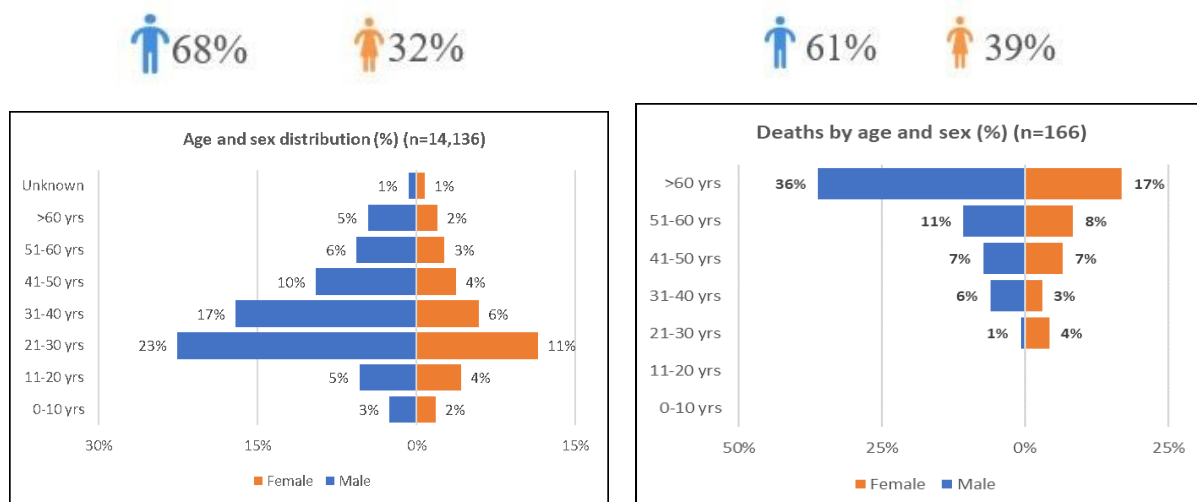


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

3: Age and sex distribution of COVID-19 positive cases

To enhance Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITC) preparedness and respond to the upward trend of cases, WHO and humanitarian partners have been activating SARI ITC stand-by beds over the past weeks as per requested by the Civil Surgeon's office. Currently, 641 SARI beds are functional in 13 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 56% at the end of the reporting period. Moreover, the capacity of general isolation beds in the district is 467. 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.



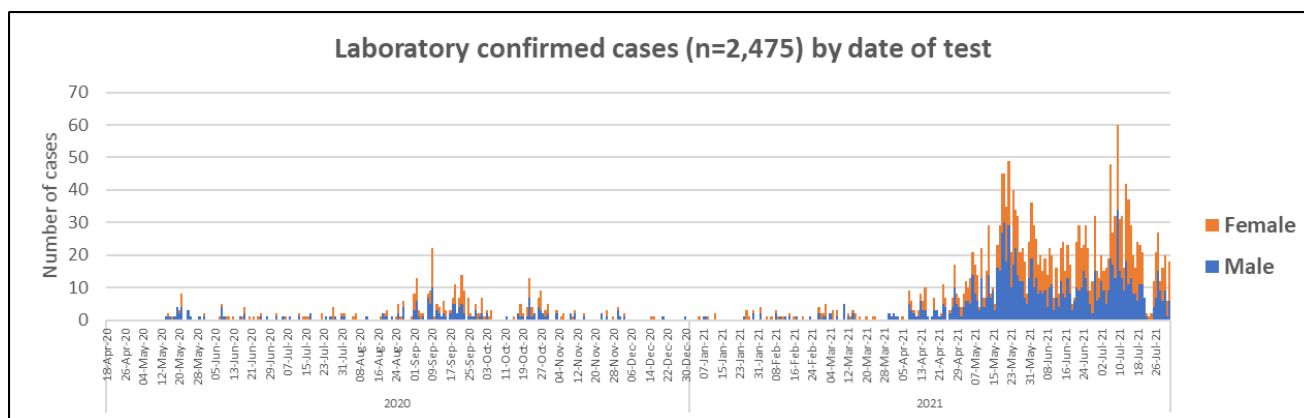


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

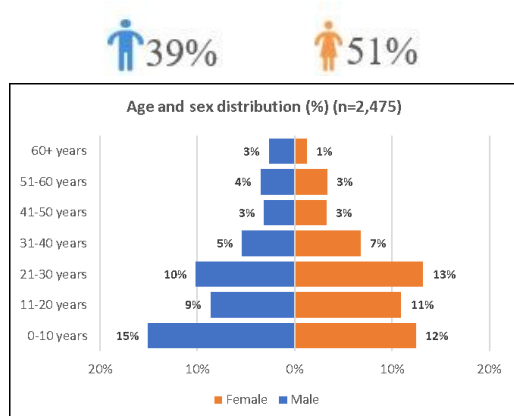


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

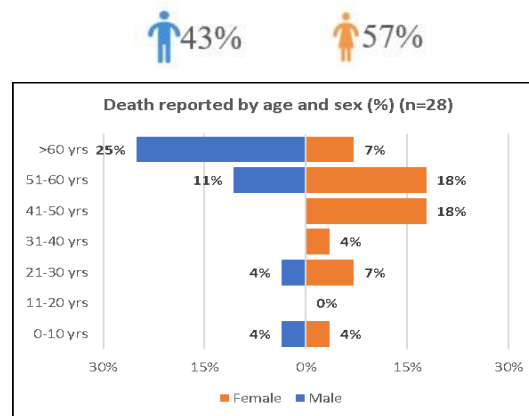


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

During week 29 and 30, 188 new confirmed cases were detected from 1 524 samples tested, the test positivity was therefore 12.5%. As of 1 August 2021, the cumulative incidence is 139.6 per 100 000 people. The overall positivity of samples tested is 4.6%. Among the cases, 1.8% showed severe symptoms at the time of admission while 3.5% 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 10 years, a significant proportion has been tested among 50+ years: 706 per 10 000 population, following that of 0-9 years with 868 tests per 10 000 population as highest number. The test positivity was highest 7.7% 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, 28 deaths due to confirmed COVID-19 have been reported in the camps with a case fatality 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 2 034 confirmed cases (out of 2 475 to date) have been investigated by RIRTs by 1 August 2021, with contact tracing activities being conducted and captured through Go.data, including 4 356 contacts. Out of these, 2 677 (61.4%) contacts have seen their follow up visits completed and were released from quarantine. 248 (9.2%) 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 123 cases (102 from Rohingya refugees and 21 from host community) of Acute Watery Diarrhea (AWD) that have tested positive by Rapid Diagnostic Tests (RDTs)/bacteriological culture confirmed cases for cholera (data as of 18 July 2021) bringing the total to 143 (109 from Rohingya refugees and 34 from host community) in 2021. Of the 123 cases, 46 (39 from Rohingya refugees and 7 from host community) have been culture confirmed. In the past three weeks (week 28-30) the total number of culture confirmed cases was 15.

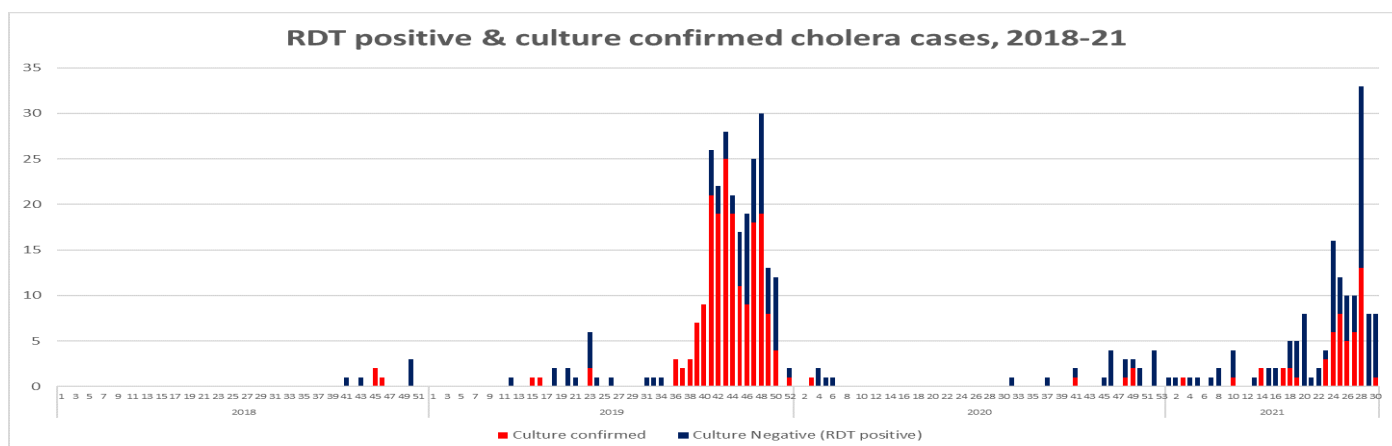


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

In week 30 (26 July- 1 August), 7 Rapid Diagnostic Test (RDT) positive cases were reported. All 7 RDT positive samples are undergoing culture for confirmation. In addition, 1 case was culture confirmed from RDT negative samples. In week 29 (5-11 July), 8 RDT positive cases were reported . All 8 RDT positive samples are undergoing culture for confirmation) and no additional culture confirmed cases from RDT negative samples were received. In week 28 (12-18 July) 24 RDT positive cases were reported (4 were culture positive ,7 discarded and 13 awaited for culture result) .9 more were culture confirmed from RDT negative samples. Total culture confirmed cases for that week is 13.

In line with the Multisectoral AWD response plan, a joint Health and WASH Sector investigation takes place for each case, followed by the implementation of 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, 2E, 2W, , 7, 8E, 8W, 9,12, 13, 18, 20 Extension and Kutupalong Registered Camp as of now, out of these culture confirmed few camps have reported more than one case (7, 13 and 18). Two or more RDT positive cases have been identified in last 14 days period in subblocks D3 from camp 13 .

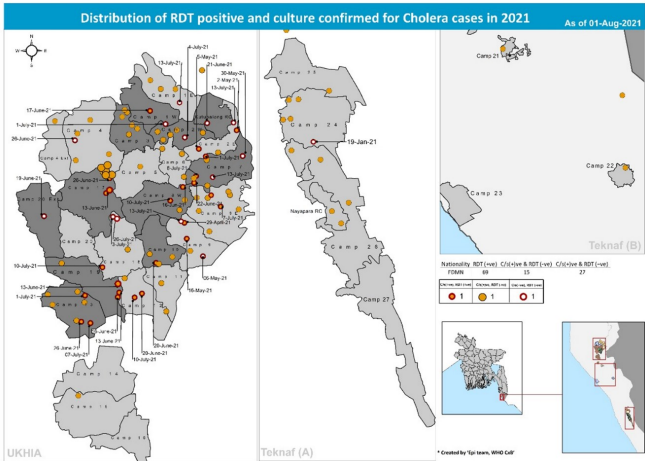


Figure 8: Geographic distribution of all RDT Positive and Culture Confirmed Cholera Cases in 2021

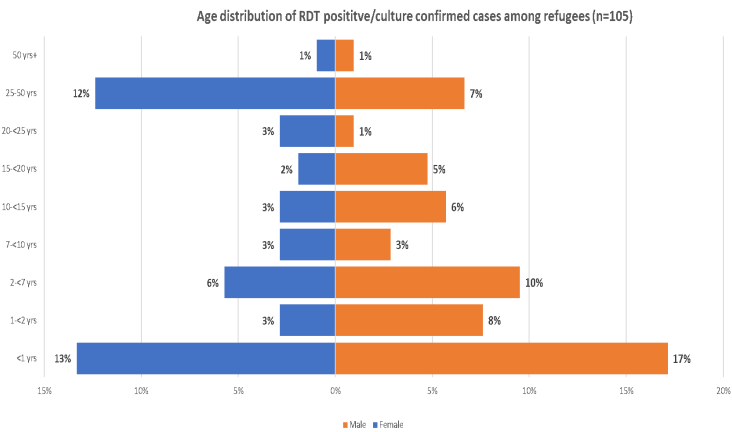


Figure 9: Age group distribution of RDT Positive and Culture Confirmed Cholera Cases among refugees from May to 7 July 2021

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.

The situation continues to be closely monitored by WHO 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 three-day online training on clinical management of AWD organized by Civil Surgeon of Cox’s Bazar, WHO/Health Sector in collaboration with iccdr,b. In the month of July 2021, 104 admissions to the isolation facilities and the Diarrhea Treatment Centers (DTC) have been registered. No deaths have been reported at the isolation facilities so far.

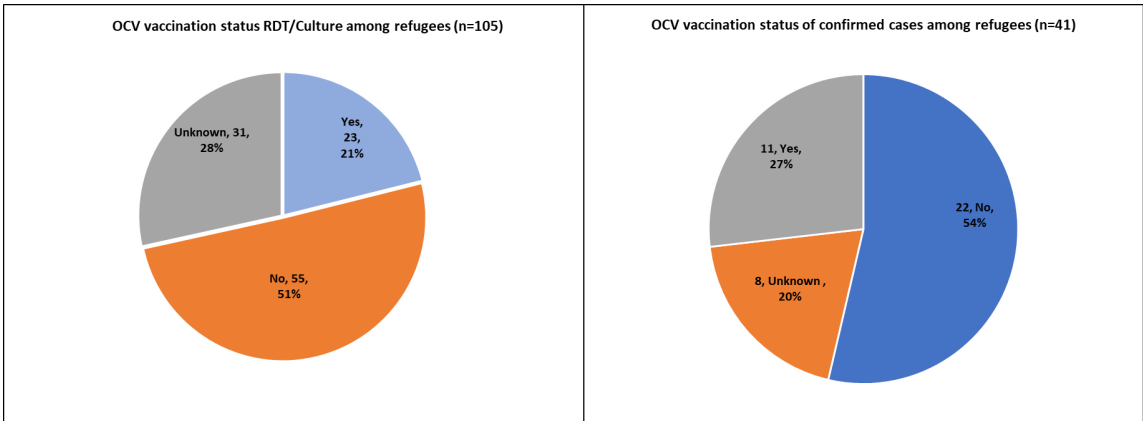


Figure 10: OCV vaccination status among RDT Positive and Culture Confirmed Cases among refugees

A total of 428 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.

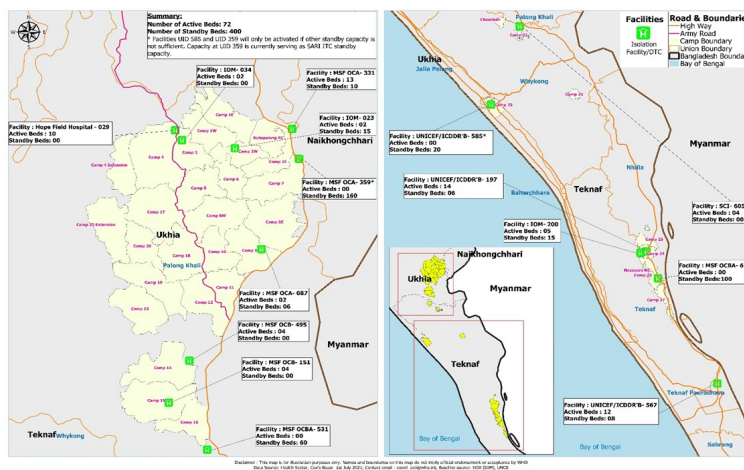


Figure 11: Acute Watery Diarrhea Isolation & Diarrhea Treatment Center Bed Capacity Mapping, as of 1 July 2021.

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 and distribution 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.

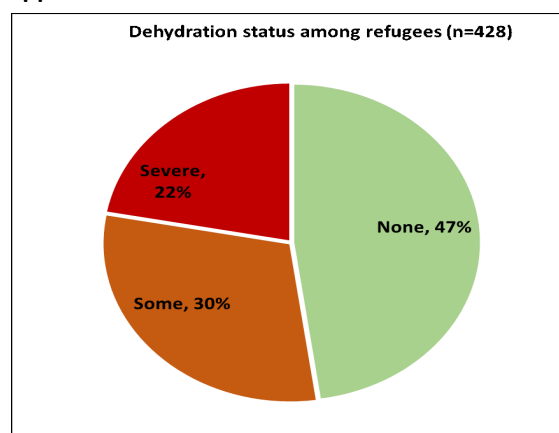


Figure 12: Dehydration status of admitted cases reported from Leda DTC and other health facilities with isolation capacity in camps from week 1-28, 2021

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 2 900 AWD cases were referred to the health facility for further case management. Furthermore, over 10 000 Oral Rehydration Solution (ORS) sachets and over 9 700 zinc tablets have been distributed at community level.

Throughout the camps, CHWs have reinforced 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 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”

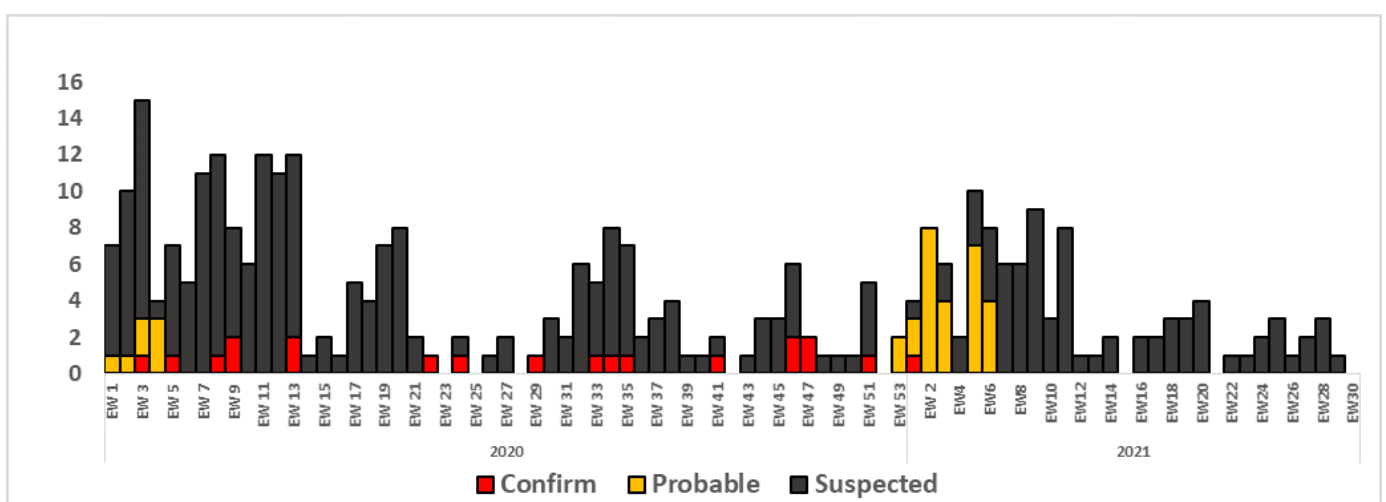


Figure 13: Total number of diphtheria case reported in EWARS from 2020-2021

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.

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9288 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 102 as of week 30, 2021). In total, 9042 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, 5 new probable maternal death has been reported. In total 74 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 29-30, 3 suspected Severe Acute Respiratory Infection (SARI) deaths were reported. In total 57 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 63 suspected SARI deaths were reported through community-based mortality surveillance. Of these, all were verified and 3 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 updated 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, RCCE WG and WHO maintained regular communications on the COVID-19 vaccination campaign for the Rohingya community with partners as well as reviewed and finalized the Frequently Asked Question (FAQ) and Public Health (PH) messages on the COVID-19 vaccination program for the Rohingya refugees. Moreover, the RCCE WG supported preparing Information, Education, and Communication (IEC) materials on the COVID-19 vaccination campaign for the Rohingya community. Oxygen Cylinder Safety messages were reviewed and shared among partners for wider dissemination. Similarly, public health messages for Health Card was developed and shared with partners for their review.

In addition, RCCE WG completed training on Rohingya language and culture to 125 humanitarian workers. 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 and podcast materials in association with BBC Media Action.

During the reporting period CHWs conducted 234 747 household visits in which 3275 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 30 patients with moderate/severe symptoms. The cumulative number of patients with mild symptoms is 163 210, and 965 patients with moderate/ severe symptoms. To date, 86 982 persons with COVID-19 like symptoms have been referred to health facilities, 1870 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 493 085 persons between weeks 29 and 30. Since the beginning of the response, CHWs have conducted more than 9 million household visits and had a cumulative number of more than 24.3 million contacts with adult household members. Through the CwC WG, 43 384 people were engaged in 26 618 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 August 2021, a total of 192 876 tests for COVID-19 have been conducted, of which 173 091 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. An decrease in the number of tests conducted among the Rohingya refugees was observed in weeks 29-30 as compared to weeks 27-28, from 1 524 to 2 451 tests. Among the host community an increased number was tested either: from 6 709 tests in weeks 27-28 to 7 587 tests in week 29-30. Currently, 40 sample collection sites are operating for suspected COVID-19 patients.

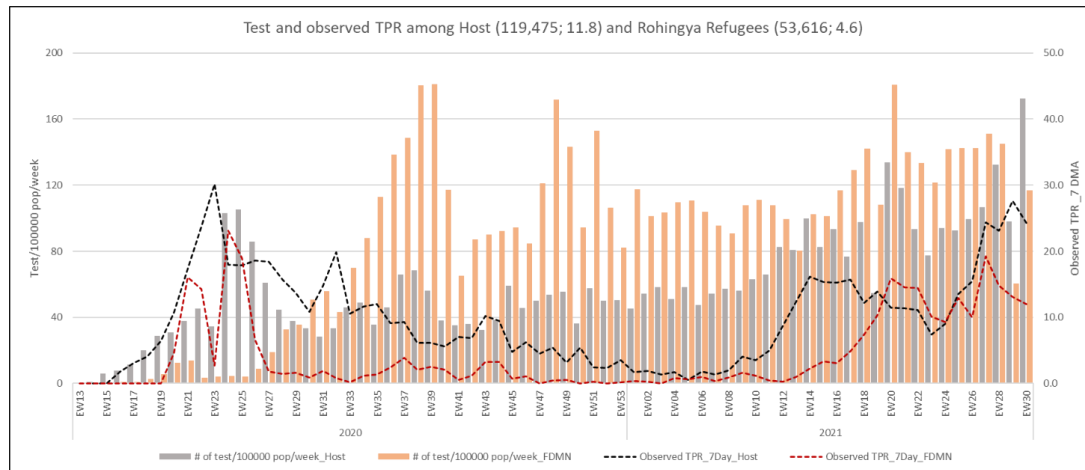


Figure 14: Number of tests conducted and observed test positivity per million among the host population and the Rohingya refugees/FDMN

\*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 population.

WHO continues supporting the Government of Bangladesh through the Civil Surgeon’s office to develop a protocol for COVID-19 Antigen Rapid Diagnostic Test (RDT) pilot testing in the Cox’s Bazar district. During the reporting period, WHO conducted hands-on training on “Use and analysis of COVID-19 Ag RDT at camp level” to Médecins Sans Frontieres (MSF) OCP in Camp 8W

## 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.

The IPC TWG and WHO are jointly conducting bi-annual supportive supervision of all PHCs and secondary healthcare facilities in the Rohingya refugee camps with at least 13 facilities reached so far. The objective of the technical visit is continuous capacity building on IPC and therefore improvement of patient and health worker safety. Similarly, WHO is also currently conducting Quarterly supportive supervision visits for SARI ITCs for quarter two 2021. So far 7 out of 13 SARI ITCs have been reached with the aim of completion of supervision in the following two weeks. The technical visits continue to ensure quality of IPC services in the SARI ITCs for safety of patients and healthcare workers. The 14<sup>th</sup> IPC TWG meeting was conducted online on the 29<sup>th</sup> July 2021. The forum which acts as a platform of deliberations and steering of IPC activities in the Rohingya camp on behalf of the health sector has gained grounds since its establishment in May 2020 with decisions including joint visits for capacity building being decided on the last meetings. Currently over 95% of healthcare facilities in the Rohingya camps have established IPC structures to facilitate proper implementation of IPC in the health facilities. The structures which include IPC focal persons and IPC committees will go a long way in planning, budgeting and implementing IPC in their respective 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 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.

During the reporting period, two health sector case management working group meetings along with one case conference call for SARI ITCs were conducted. There are currently 13 operational SARI ITCs in Cox’s Bazar with a total of 641 beds functional and 276 on stand by. The SARI ITC bed occupancy rate is currently 52% (Ukhiya 53% and Teknaf 53%). For the admitted patients, 75% of them are categorized as mild patients, 15% moderate, 9% severe and 1% as critical 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 1 August 2021, 34 beds are occupied with COVID-19 patients in total.

## 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 with the revision of inclusion of all Rohingya volunteers > 18 years of age. To build trust and community engagement, Government has agreed to start the vaccination campaign on 10 August with all the community and religious leaders along with the frontline volunteers from Health, Wash and Communication with community. 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 microplan based on most recent population breakdown and a complete training package for supervisors, AEFI focal points, vaccinators and volunteers. Total 56 health facilities has been identified as potential vaccination centers where 58 vaccination teams will conduct the vaccination. In regard to COVID-19 vaccination of host community, the Government of Bangladesh has revised the age limit for the vaccination registration to 25 years-old and other priority groups.



Photo: Orientation of vaccinators on COVID-19 vaccination for Rohingya refugees

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 5721 patients (host community and Rohingya refugees) from Ukhiya and Teknaf were reported in DHIS-2 to have sought care with noncommunicable diseases. Hypertension was reported with the highest percentage of 37% followed by Diabetes Mellitus with 33% of all NCD patients. With technical assistance from WHO, on 27 July 2021 5th NCD Core group meeting took place where 21 NCD technical focal persons joined from different health partners. During this coordination meeting Summary of NCD related operations coordinated by NCD Core group, update of NCD component in 'Minimum Package of Essential Health Services for Primary Healthcare Facilities in the FDMN/Refugee Camps', MSF support in NCD service delivery at camp level and on-field challenges were discussed.

In July 2021, WHO Tuberculosis (TB) field assistants conducted 4 sessions and visited approximately 200 households to raise awareness on tuberculosis among the Rohingya refugees and the nearby host community. They also distributed sputum collection pots and referred suspected TB patients for further assessment. Cumulatively, during the month of July, medical technologists performed 172 and 150 GXP tests and 273 and 350 routine microscopy tests for TB diagnosis in Ukhiya and Teknaf UHC respectively. Furthermore, the radiographer conducted a total of 65 X-rays including Chest X-rays for referred patients in Teknaf UHC for TB & COVID-19 suspect cases and other respiratory illnesses.

In preparation for WASH In Health Facilities assessments against WASH FIT indicators expected later this year, WHO and UNICEF undertook Training of Trainers (TOT) session on 25,27 and 29 July.

## 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, the findings and observations of the After-Action Review on response by the Mobile Medical Teams were shared in the health sector meeting. In addition to that, the Mobile Medical Team Technical Working Group coordinated the deployment of few MMTs to the flood affected site to support the health facilities affected by the monsoon.

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, WHO has received 2,000 Pcs COVID-19 Rapid Antigen Testing kit and started distribution to the partners in FDMN camp. Logistical support for COVID-19 sample collection at 40 sentinel sites continues with the supply of 2 900 pcs vacutainer, 5 800 pcs swab sticks and zip lock bag, among those sites. During the reporting period, a total of 286.85 kg total volume 1.67 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 logistics support to the IEDCR Field Laboratory with two vehicles providing transportation of COVID-19 sample collection in the camps.

## SUBJECT IN FOCUS: Tuberculosis (TB)

Tuberculosis (TB) is a communicable disease that is a major cause of ill health, one of the top 10 causes of death worldwide and the leading cause of death from a single infectious agent. TB is a disease of poverty, and economic distress, vulnerability, marginalization, stigma and discrimination are often faced by people affected by TB. Most of the people infected with TB live in low and middle-income countries.

### Background

Globally, countries have made substantial progress in the fight against tuberculosis (TB) to reduce the prevalence, enhance specialized care and raise public awareness of this preventable and curable disease. Through a multisectoral strategic approach which includes the involvement of high-level representatives, the World Health Organization (WHO) has been closely working with countries, partners and civil society all around the world in scaling up the TB response and translate commitments into actions. Much has been achieved in recent decades to end the tuberculosis epidemic. Global efforts to combat TB have saved an estimated 63 million lives since the year 2000. However, TB remains a public health threat, affecting vulnerable populations and killing almost 4 000 people every day.

Tuberculosis occurs in every part of the world, however over 95% of cases and deaths are registered in developing countries. In 2019, 87% of new TB cases occurred in the 30 high TB burden countries, with eight countries accounting for two thirds of the new TB cases, including Bangladesh.

### Tuberculosis in Bangladesh

Tuberculosis (TB) is considered one of the major public health problems in Bangladesh. The World Health Organization (WHO) has been supporting the Government of Bangladesh through the Directorate General of Health Services (DGHS), Ministry of Health & Family Welfare (MOHFW), to address unreached populations with early diagnosis and provide appropriate treatment to patients suffering from various forms of TB. Over the past years, the Government of Bangladesh has committed to provide TB diagnosis and treatment services completely free of cost to all citizens. It strives to make services equally available to all people of Bangladesh, with special focus on the most vulnerable populations. Under the Ministry of Health and Family Welfare, the National Tuberculosis Programme (NTP) closely coordinates with various Ministries, civil society, non-governmental organizations, development agencies, private sector and WHO to end TB.

### The National TB Control Programme and Rohingya refugees

The Rohingya have faced statelessness, systematic discrimination and bouts of targeted violence in Rakhine State for decades, forcing them over the border into Bangladesh multiple times in recent decades. Since the massive influx of Rohingya refugees arrived in Cox's Bazar in August 2017, the National TB control program (NTP) of Bangladesh was extended to the refugee camps and strengthened among host communities in Cox's Bazar. The program includes early TB detection, Drug-resistant (DR) Tuberculosis and timely and quality treatment to all patients. WHO is also providing human resources, technical and logistic support to strengthen TB control in the district.

### Joining forces to end Tuberculosis

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 40 primary health care centers (PHCs), 90 Health Posts (HPs), 23 special facilities and three field hospitals.

WHO has been working with the NTP and other implementing and collaborating partners to design key interventions linked to diagno-



Photo: WHO TB field assistant supplying the TB sample collection box at the household level.

sis and treatment of TB. Through an extensive partnership aimed to end tuberculosis in Bangladesh, BRAC (Bangladesh Rural Advancement Committee) is supporting the TB activities in Cox's Bazar developed under the National TB control program (NTP). There are five Gene-X-Pert machines for Cox's Bazar district and microscope facilities in each Upazila Health Complex (UHC) to increase testing which were made available to both Rohingya and host communities. Within the camps, there are eight TB laboratories and two GeneXpert machines for diagnosis of TB. Sputum samples from highly suspected persons (patients who experienced TB symptoms like, weight loss, no appetite, low grade fever and coughing) are being transported to Upazila Health Complexes (UHC) of Ukhiya or Teknaf for further testing.

According to the National protocol, treatment (1st line/ 2nd line of anti TB drug) is also available through the UHCs. Health sector partners such as IOM, Médecins Sans Frontières, Save the children and other humanitarian organizations are referring TB suspect cases to BRAC TB center for definitive diagnosis by testing. Treatment is ensured under Direct Observation Treatment (DOT) from UHCs.

#### WHO TB Activities in Cox's Bazar

WHO's TB team is comprised by a district Medical officer, two field supervisors, a radiographer, two Medical Technologists for laboratory and ten junior field assistants. Together, they support the existing health workforce in Cox's Bazar in accelerating TB service delivery in Ukhiya and Teknaf. Additionally, the health workers give support at the UHC TB activities such as detect cases, follow up and engage communities for increased public awareness. The team is coordinated by the district TB medical officer who supervises the activities and liaises with the Civil Surgeon office, other health facilities and NGO partners in Cox's Bazar.

The medical technologists conduct the Gene X-pert diagnosis and carry out supervisory activities on TB laboratory services, that includes sputum collection and smear preparation in the refugee camps to provide technical support and supervision to ensure the quality of TB diagnosis. To improve diagnostic services, a digital X-ray machine and an X-ray printer were installed in Ukhiya and Teknaf UHCs. WHO recruited a Radiographer who was supported the Upazila Health Complex in conducting more than 80 x-ray examinations per month.

Furthermore, community engagement sessions were also being conducted in PHC, health post and at different small community gatherings. About 1000 people were reached on a monthly basis for community health education on TB control. These community sessions were followed by distribution of sputum collection pot and referral of suspected TB patients to the near-by BRAC facility for further evaluation and diagnosis. Gene X pert (GXP) service and routine microscopic tests were approximately 200 and 250 per month respectively. Capacity building, regular feedback and supportive supervision helped improve NTP's performance at Upazila Health Complexes level as well as coordination efforts between partners and UHCs towards quality TB services delivery.

At household level, field teams are identifying TB suspect cases and referring them to the respective TB clinic for further investigation and health education. A field supervisor in each Upazila is working with five junior field assistants and up to 700 household visits are conducted on a monthly basis among the different camps to deliver TB awareness messages before COVID situation. In each Upazila Health Complex (UHC), there is a radiographer and a medical technologist dedicated to case detection. This team communicates regularly with a network of field staff supporting NTP partners.

#### Statistics

In each quarter, 11 000 -12 000 TB suspects and 900-1000 confirmed cases were reported for the host community. As for the cure rate, it was more than 95% for TB patients. Among Rohingya refugees, TB suspect and confirmed cases were 161 440 and 9963 respectively from September 2017 to March 2021. Only five MDR-TB cases were reported in refugees since September 2017 and three were under treatment. Only 2.2% of TB cases occurred in children. TB treatment was provided for more than 88% of confirmed patients with a cure rate of 97-99%.

#### TB services during COVID-19

The COVID-19 pandemic has impacted the TB program in Cox's Bazar, hindering its progresses among host and refugee communities due to the stigma associated to both conditions and fears among the populations. Community engagement sessions for TB awareness were adjusted to this new scenario and continue in the host communities and refugee camps led by exceptional frontline health care workers highly committed with ensuring prevention and care services to the vulnerable populations of Cox's Bazar.

In the period of April- June 2021, medical technologists performed a total of 1099 (557 in Ukhiya and 542 in Teknaf) GeneXpert (GXP) tests. They also conducted up to 1050 routine microscopy tests (468-Ukhiya and 582 in Teknaf) for TB diagnosis. During this period, a total



Photo: WHO TB medical technologist performing TB test. As part of the National TB Control Programme and Rohingya refugees in Cox's Bazar



of 170 X-ray examinations were conducted for patients referred to Teknaf UHC. Despite the COVID-19 Outbreak, field teams continued their work in about 1000 households to follow up around 200 TB patients as part of the TB contact tracing process in this time period.

## NATIONAL LEVEL HIGHLIGHTS, 5 August 2021 (BANGLADESH)

	Last 24 hours	Total
COVID-19 tests conducted	49 514	7 948 683
COVID-19 positive cases	13 817	1 309 110
Number of people released/recovered	16 112	1 141 157
COVID-19 deaths	241	21 638

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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