World Health Organization
Bangladesh

Rohingya Crisis Situation Report #16

Date of issue: 19 August 2021

Weeks 31 - 32
2 - 15 August 2021
Location: Cox's Bazar

Under the leadership of the Government of Bangladesh and with the technical support of WHO and Health Sector partners, on August 10, 2021 COVID-19 vaccination campaign started in the world's largest refugee camp targeting Rohingya refugees of 55 years and above.

HIGHLIGHTS

- **The first round of COVID-19 vaccination campaign for Rohingya refugees/FDMN aged 55 years and older started on 10 August 2021 and is currently ongoing. As of 18 August 2021,a total of 34 429 Rohingya people has been vaccinated out of 43 093. WHO together with CWC partners has been providing additional support and to the WHO Immunization and Vaccine Development (IVD) team for the documentation and monitoring of COVID-19 vaccination in the refugee camps. Similarly, technical assistance has been provided to BBC Media Action to review and finalize the script and during the recording.**
- **Quarterly and bi-annual IPC supportive supervision has been completed in all the SARI ITCs, Primary Healthcare centers, secondary facilities and field hospitals showing considerable progress.**
- **The final report of water quality surveillance (January to April 2021) has been completed and shared with partners. A total of 4212 water samples were collected and analyzed comprising 1053 unsterile sources, 1053 sterile sources and 2106 household's storage water samples.**
- **SUBJECT IN FOCUS: COVID-19 vaccination in the world's largest refugee camp**

	Host Community	Rohingya refugees
Total confirmed COVID-19 cases in Cox's Bazar	15 778	2 677
Total cases in isolation in Cox's Bazar	238	158
Total number of tests conducted	127 582	56 109
Total deaths due to COVID-19	212	29

**Updated as of 15 August 2021* / **FDMN = Forcibly Displaced Myanmar Nationals*

COORDINATION, PLANNING AND MONITORING

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.

The first round of COVID-19 vaccination campaign for Rohingya refugees/FDMN aged 55 years and older started on 10 August 2021 and is currently ongoing. The campaign will be followed by mop-up days, to be confirmed by Government authorities.

At present, Community Health Workers (CHW) are undertaking active case finding for AWD, referring persons with symptoms, disseminating key health messages and distributing Oral Rehydration Solution (ORS) packets /Zinc tablets in households with persons reporting AWD symptoms. In addition, enhanced surveillance is ongoing utilizing EWARS and 22 sentinel testing sites. Joint Assessment Team (JAT)s are investigating in and around the household of any Cholera case and ensuring necessary public health measures. A total of 72 active and close to 400 standby beds are dedicated for AWD management. A coordination meeting among Health, WASH & CwC actors takes place twice a week.

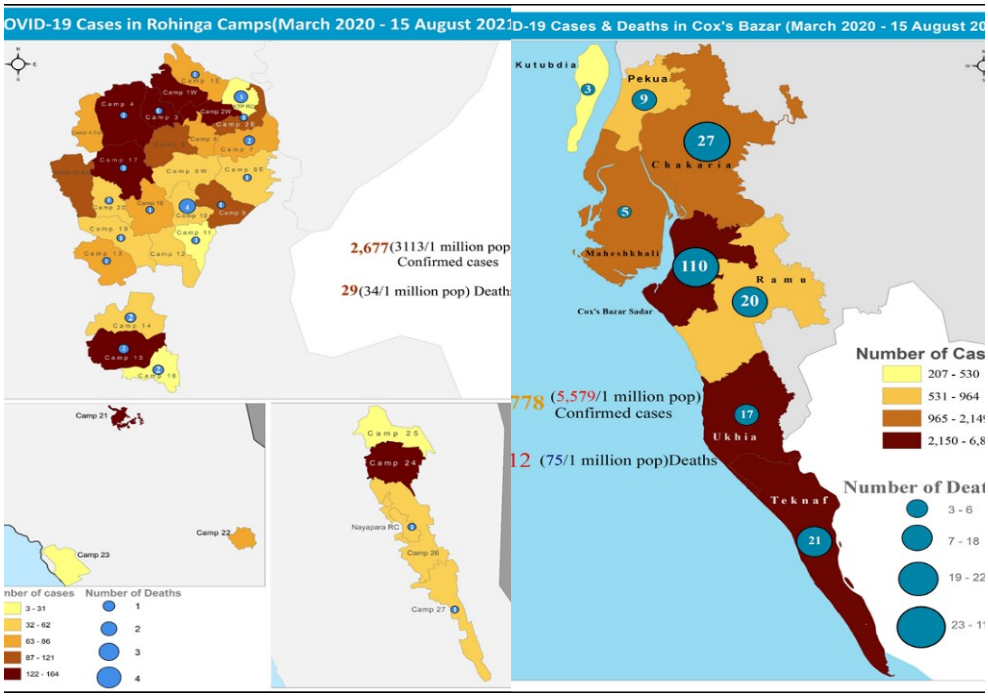
There are 42 COVID-19 sentinel sample collection sites in Rohingya camps, as compared to 26 at the beginning of the year. Meanwhile, a majority of admitted cases in SARI ITCs are mild with a slight increase in number of moderate & severe cases.

Camp-wise Quarterly Health Facility Monitoring (Q2/2021) undertaken by Health Sector Camp Health Focal Points have been finalized and findings are being disseminated among relevant authorities and health partners.

Health Facilities in the camps have shared updates on the incident, damage, injuries and deaths as an aftermath of monsoon heavy rainfall since 28 July 2021. So far, Health Sector has contributed to 4 ISCG compiled Monsoon Response Flash Reports which have been shared with all health partners.

Currently, Civil Surgeon Office is reviewing the 'Referral SOP'. Simultaneously, Health Sector partners are finalizing the 'General Health Card' for Rohingya refugees. This will be the record of health services utilization by an individual- with the aim to minimize the duplication of services and to optimize the chronic case monitoring.

During the reporting weeks, a total of 5 camp-level Health Sector Coordination Meetings were held (while maintaining precautions against COVID-19). Strengthening COVID-19 and monsoon response was extensively discussed among different working group partners. In addition, Rapid Investigation Response Team (RIRT) coordination meetings are ongoing in the camps to strengthen the COVID-19 enhanced surveillance.



SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION

WHO continues to provide epidemiological data to support operational decision making for the COVID-19 response in Cox's Bazar. As of 15 August 2021, a total of 15 778 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 1199 in Chokoria,238 in Kutubdia, 1027 in Moheshkhali, 563 in Pekua, 951 in Ramu, 6819 in Sadar, 2308 in Teknaf and 2 673 in Ukhiya.

While the overall positivity of samples tested in the district is 12.4%, a decreasing trend in cases among the host community has been ob-

served in recent weeks. In week 32, 718 cases tested positive, with a test positivity rate of 19.4%, in comparison with week 30 when 1177 positive cases were registered with a test positivity rate of 24.3%. To date, a total of 212 deaths have been reported in the host community, with a case fatality ratio of 1.3%.

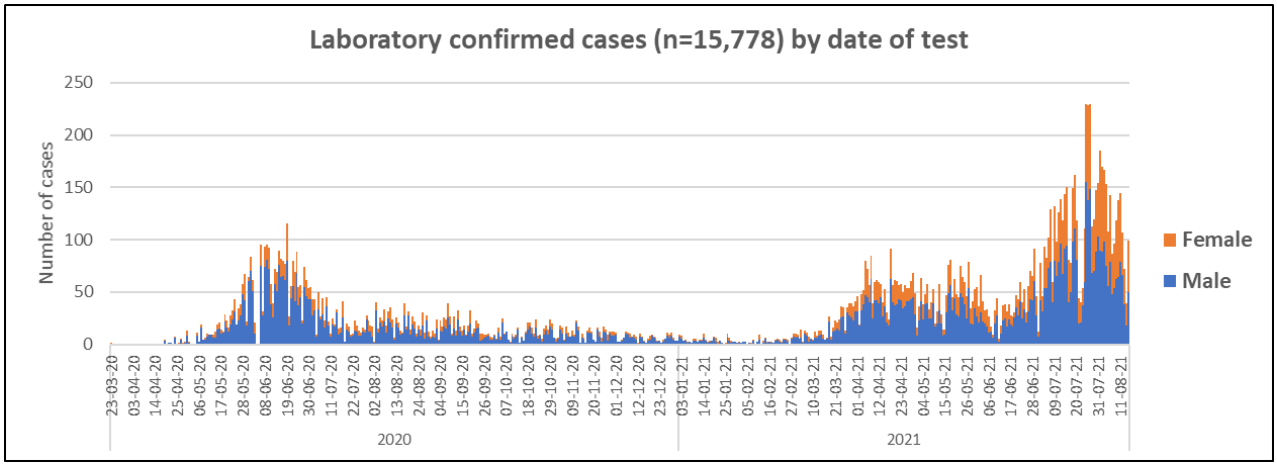


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

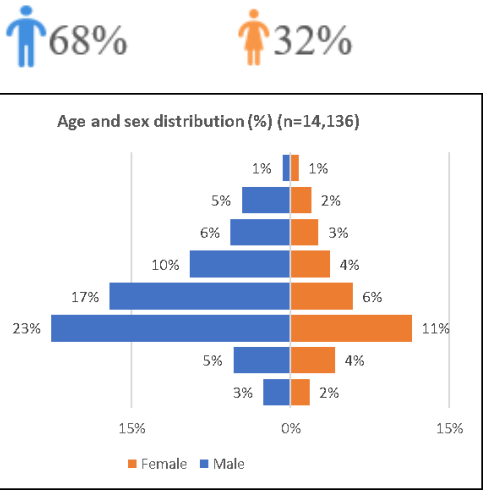


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

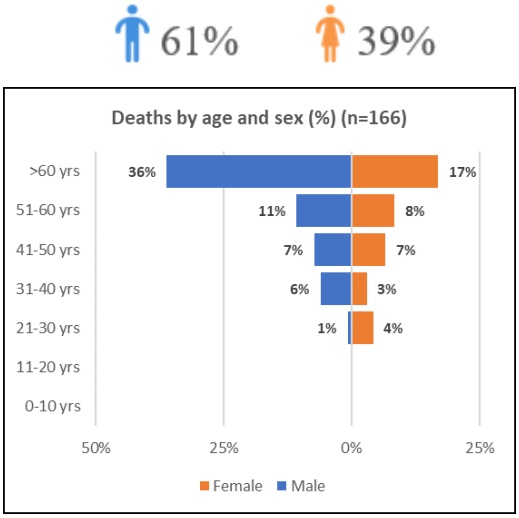


Figure 3: Age and sex distribution of COVID-19 deaths among host population in Cox's Bazar District

Among the Rohingya refugee population, the number of confirmed COVID-19 cases has decreased the past weeks. In week 32, a total of 100 positive cases were registered in the Rohingya refugee camps with a test positivity rate of 7.6%, in comparation to the 120 confirmed cases in week 32, with a test positivity rate 12.0%. As of 15 August 2021, a total of 2 677 COVID-19 cases have been reported among Rohingya.

With a total of 164 cases, Camp 3 has the highest number of cases to date ahead of Camp 2W and 24 with 156 cases, , Camp 15 with 147 cases, Camp 17 with 144 cases and Camp 4 with 143 cases. To date, 127 cases have been reported from Camp 21, 123 cases have been reported from Camp 1W, 108 cases from Camp 20 extension and 105 cases from Camp 9. In Camp 5, 100 cases have been registered. Camp 1E, 2E, 4 Ext, 6, 7, 8E, 8W, 10, 11, 12, 13, 14, 16, 18, 19, 20, 22, 23, 25, 26, 27, Kutupalong RC and Nayapara RC so far had less than 100 cases. 7 cases have been registered from Zero Point and 4 amongst new arrivals.

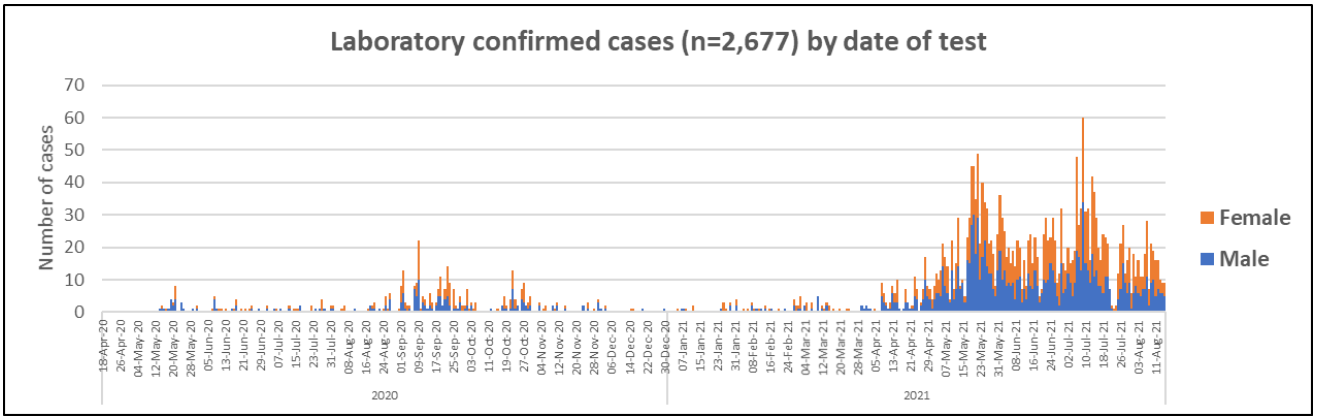


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

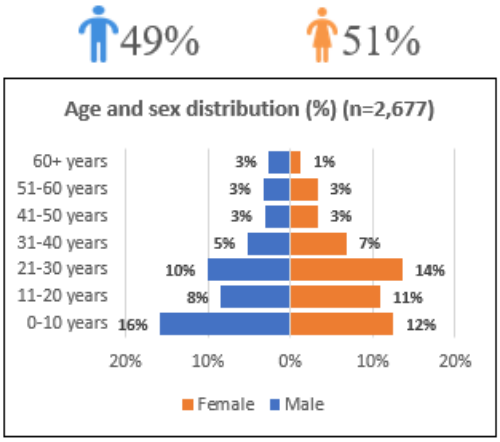


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

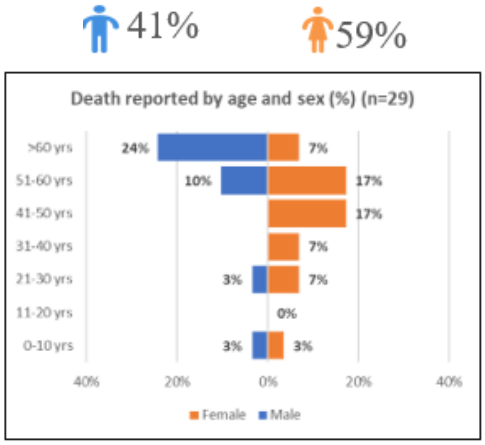


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

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 reactivating SARI ITC stand-by beds over the past weeks following instructions from 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 52% at the end of the reporting period. Moreover, the capacity of general isolation beds in the district is 517. 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 at the ICU has been observed, indicating the increased demand of hospitalization due to severe disease presentation at admission.

Between weeks 31-32, 202 new confirmed cases were detected from 2 493 samples tested, the test positivity was therefore 7.6%. As of 15 August 2021, the cumulative incidence is 116.3 per 100 000 people. The overall positivity of samples tested is 4.8%. Among the cases, 1.8% showed severe symptoms at the time of admission while 4.5% 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 867 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 ratio of 1.1%.

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 2 477 confirmed cases (out of 2 677 to date) have been investigated by RIRTs by 15 August 2021, with contact tracing activities being conducted and captured through Go.data, including 5 562 contacts. Out of these, 3 252 (58%) contacts have seen their follow up visits completed and were released from quarantine. 266 (8.1%) 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 143 cases (118 from Rohingya refugees and 25 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 15 August 2021) bringing the total to 163 (125 from Rohingya refugees and 38 from host community) in 2021. Of the 143 cases, 56 (47 from Rohingya refugees and 9 from host community) have been culture confirmed. In the past three weeks (week 30-32) the total number of culture confirmed cases was 8.

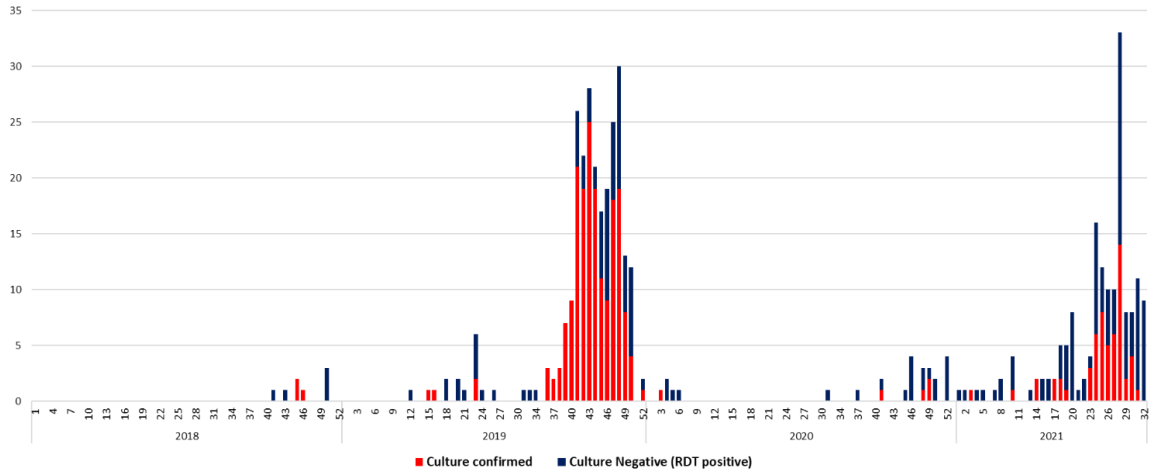


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

In week 32 (9-15 August), 9 Rapid Diagnostic Test (RDT) positive cases were reported (1 culture positive, 4 discarded and 4 awaiting for culture. In week 31 (2-8 August), 10 RDT positive cases were reported (2 were culture confirmed and 8 were discarded), in addition 1 case was culture confirmed from RDT negative sample. In week 29 (25 July- 1 August) 7 RDT positive cases were reported (3 were culture positive and 4 were discarded) and 1 was culture confirmed from RDT negative samples. Total culture confirmed cases for that week is 4.

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 and sub block 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 camps 1E, 5, 8E, and 13. Out of these camps with culture confirmed cases, few camps have reported more than one case namely:1E, 8E and 13.

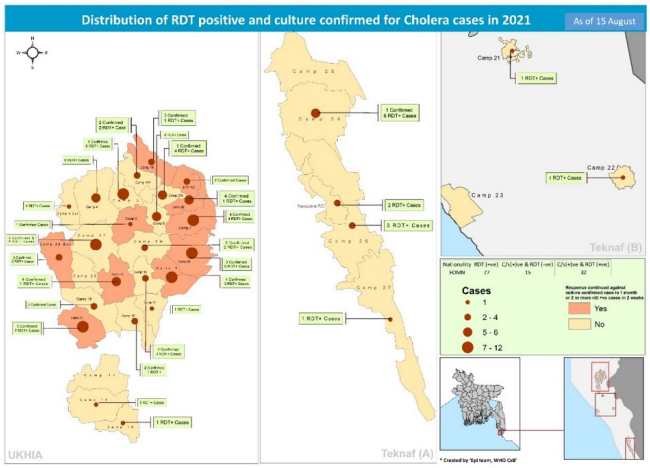


Figure 8: Geographic distribution of all RDT Positive and Culture Confirmed Cholera Cases in 2021

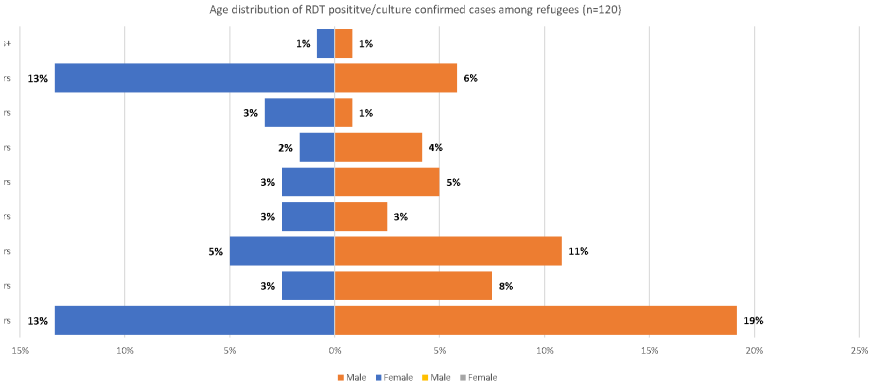


Figure 9: Age group distribution of RDT Positive and Culture Confirmed Cholera Cases among refugees from May to 7 July 2021

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 72 isolation beds for AWD are functional at this time, with additional 400 beds on stand-by that could be activated on short notice. Out of these standby beds, 160 are SARI ITC standby capacity beds that could be repurposed for AWD if the epidemiological situation required. 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. WHO 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 August 2021, 47 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.

A total of 688 refugee were admitted to DTC and other health facilities with AWD isolation capacity. Out of the cases, 22% were severely dehydrated, 29% had some dehydration and 49% showed no sign of dehydration at the time of admission among refugees.

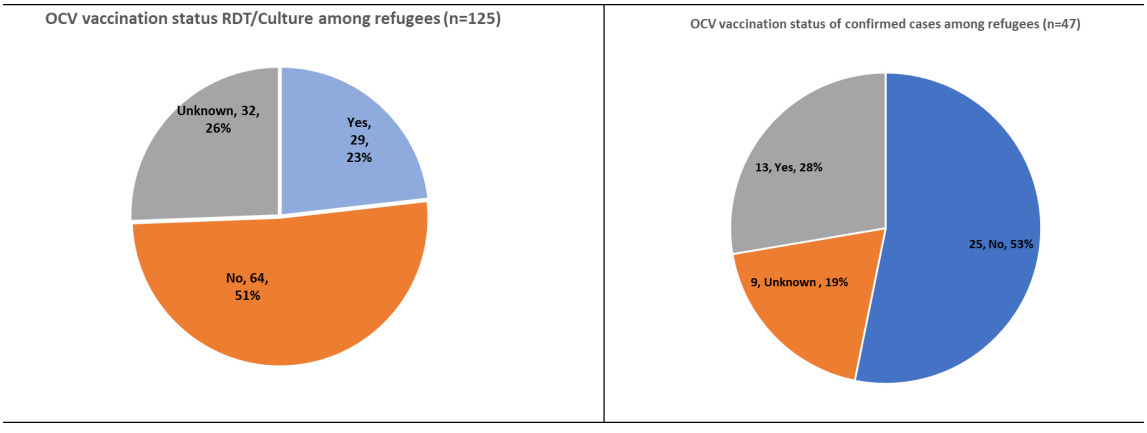


Figure 10: OCV vaccination status among RDT Positive and Culture Confirmed Cases among refugees

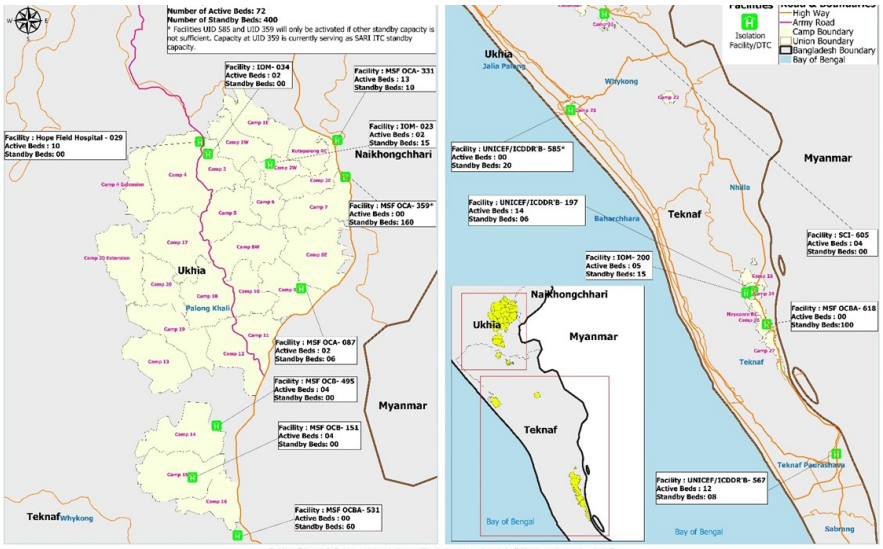


Figure 11: Acute Watery Diarrhea Isolation & Diarrhea Treatment Center Bed Capacity Mapping, as of 1 July 2021.

As of 11 August 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.

Active case finding with a uniform line list has been rolled out by CHWG partners since early July, in support of community-based surveillance. CHWG with Health Sector support developed AWD surveillance tool which was rolled out as of week 27 (4th July). At the end of the reporting period, 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.

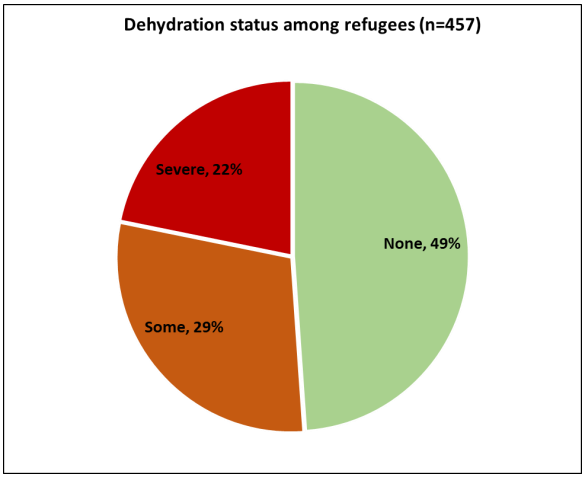


Figure 12: Dehydration status of admitted cases reported from Leda DTC and other health facilities with isolation

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".

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 9296 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 110 as of week 32, 2021). In total, 9050 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, no 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 31-32, 5 suspected Severe Acute Respiratory Infection (SARI) deaths were reported. In total 60 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 deaths at community level were investigated that were eventually considered as death due to suspected cholera.

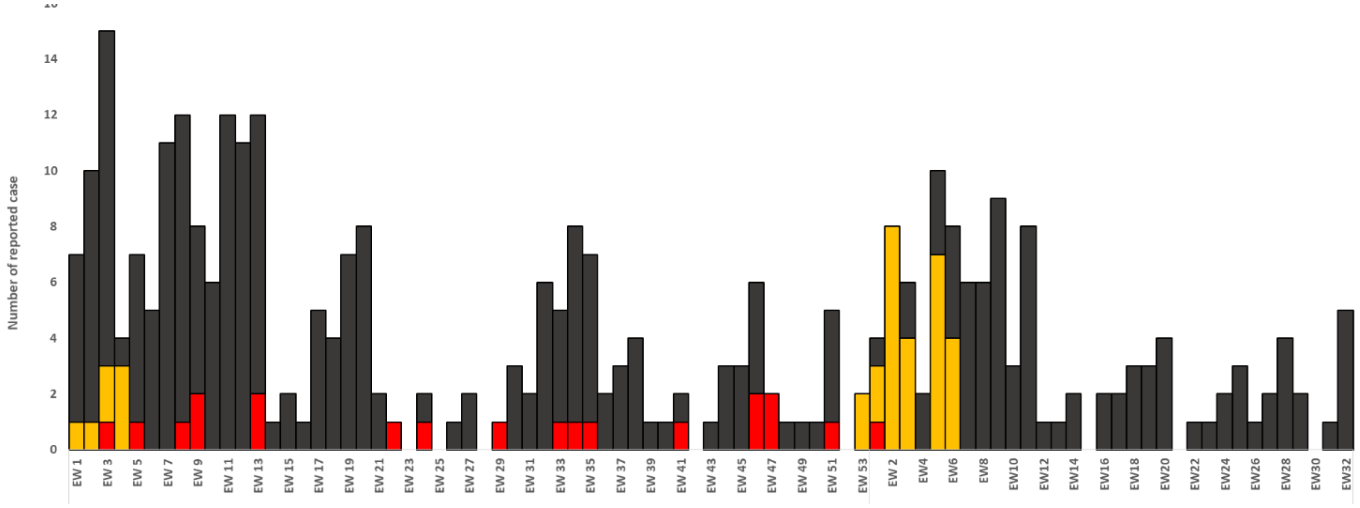


Figure 13: Total number of diphtheria case reported in EWARS from 2020-2021

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 and reviewed the Frequently Asked Question (FAQ) and Public Health (PH) messages on the COVID-19 vaccination 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. WHO has been providing additional support for the documentation and monitoring of COVID-19 vaccination in the refugee camps and supporting social mobilization efforts. Similarly, technical assistance has been provided to BBC Media Action to review and finalize the script and during the recording.

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), among others, as well as improving health-seeking behaviour among Rohingya refugees, the WHO has been working closely with BBC Media Action in the production of audio-visual and podcast materials.

Following a number of reports of infections caused by razors, needles, scissors and/or other tools in the refugee setting, WHO and UNHCR are finalizing a study on "Knowledge, Attitude and Practice on Minimum Invasive Procedure in the Non-Healthcare Settings among Rohingya Refugees in Cox's Bazar". Data collected through key informant interviews and focus group discussions during the past weeks has been included in the draft report.

During the last week (EPI week 32) CHWs conducted 115 503 household visits in which 1084 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 27 patients with moderate/severe symptoms. The cumulative number of patients with mild symptoms is 166 523, and 1017 patients with moderate/ severe symptoms. To date, 89 381 persons with COVID-19 like symptoms have been referred to health facilities, 1085 of which during week 32. Since the beginning of the response, CHWs have conducted more than 9.14 million household visits and had a cumulative number of more than 24.6 million contacts with adult household members.

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 204 103 tests for COVID-19 have been conducted, of which 183 691 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 31-32 as compared to weeks 29-30, from 2493 to 1 524 tests. Among the host community an increased number was tested as well; from 7 578 tests in weeks 29-30 to 8 107 tests in week 31-32. Currently, 42 sample collection sites are operating for suspected COVID-19 patients.

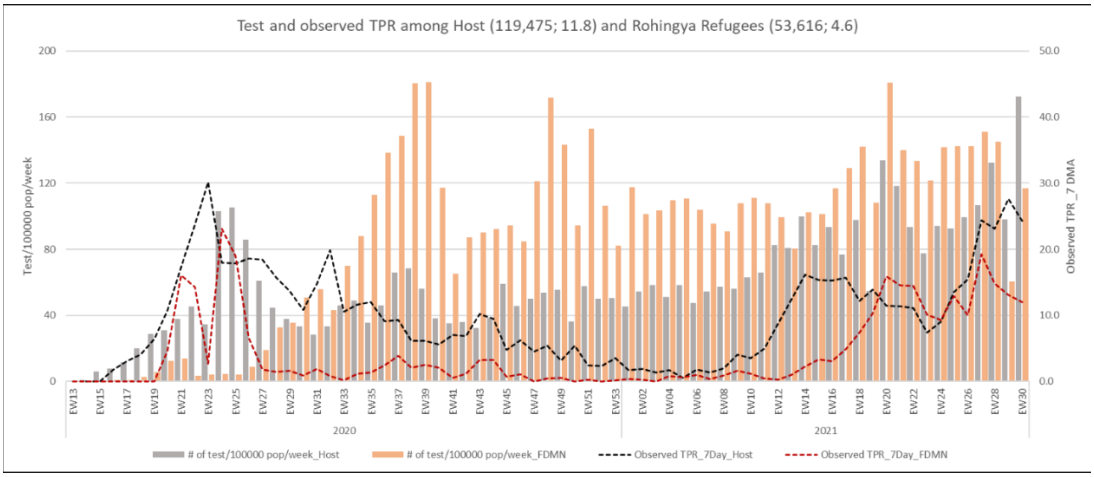


Figure 14: Number of tests conducted and observed test positivity per million among the host population and the Rohingya refugees/FDMN

*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.

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.

Quarterly supportive supervision visits for SARI ITCs for quarter two that commenced on the 25th July was completed in 13 functional SARI facilities. The technical visits ensure quality of IPC services in the SARI ITCs for safety of patients and healthcare workers. The facilities have generally showed continued improvement in IPC activities compared to the previous quarter.

The bi-annual IPC supportive supervision in PHCs, secondary health facilities and field hospitals conducted by the IPC TWG which started on 01 August 2021 was also completed for all (41) PHCs, secondary facilities and all (5) field hospitals in the Rohingya camps. The supportive supervision aimed at continuous improvement of patient and health care worker safety in the Rohingya refugee camps.

WHO IPC TWG and health sector have completed the joint supportive supervision visits to specialized services facilities (ASRH, dental, disability, eye care, women friendly, aged people's spaces, etc.) in the Rohingya camps. A total of 20 facilities were covered during this activity which resulted in recognition of progress and identification of areas for improvement. A report has been compiled and will be disseminated for management at higher levels to refer to as they follow up on recommended improvements.

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, one health sector case management working group meeting along with two case conference call for SARI ITCs and one case conference call for ICU/HDU of Cox's Bazar District Hospital 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 ocupancy rate for the last two weeks dropped from 55% to the current 52% (Ukhiya 59% and Teknaf 38%). For the admitted patients, 76% of them are categorized as mild patients, 12% moderate and 12% 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 15 August 2021, 28 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 operated by Health Sector partners to provide services to the population include 41 primary health care centers (PHCs), 90 Health Posts (HPs), 23 special facilities and three field hospitals.

Under the leadership of the Government of Bangladesh and with the technical support of WHO and Health Sector partners, on August 10, 2021 COVID-19 vaccination campaign started in the world's largest refugee camp targeting Rohingya refugees of 55 years and above. In

total, 56 health facilities with 58 vaccination teams, each comprising 2 vaccinators and 4 volunteers ,are conducting vaccination sessions. Every healthcare facility has 1 supervisor, 2 AEFI focal person and 1 verifier for better vaccine management and monitoring. As of 17 August 2021, 30 628 Rohingya people has been vaccinated out of 43 093. WHO is supporting the Government with training of the human resources for the vaccination campaign, micro planning of vaccination session, vaccine distribution, developing the training packages and required forms in the line of National level, monitoring of the sessions and evaluation of the campaign, house to house mobilization along with other partners. In total, 25 Health Field Monitors of IVD team with 2 SIMOs and other 10 technical staff of WHO are in the field continuously for program monitoring.

Regarding COVID-19 vaccination for Bangladeshi host community, the Government of Bangladesh has revised the age limit for the vaccination registration to 25 years-old and other priority groups. Pregnant women and lactating mothers are now also eligible for the vaccination as per decision of Bangladesh Government.

Photo: As part of the Non-communicable Diseases (NCDs) program WHO distributed insulin kits at Teknaf Upazila Health Complex

During the COVID-19 vaccination campaign routine immunization (RI) sessions are continuing, 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 1st half of 2021.

Currently, WHO is completing the preparatory work and planning to conduct basic routine immunization trainings for vaccinators and supervisors after the campaign. During the reporting period, WHO 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 (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 35% followed by Diabetes Mellitus with 31% of all NCD patients. The NCD Core Group conducted supportive supervision visits on implementation of the national protocol on hypertension and diabetes mellitus in 3 health facilities ; 1 Upazila Health Complex, 1 union health and family welfare center and 1 health post of Teknaf Upazila. Healthcare staff in these facilities were provided with essential job aids and refreshed with critical technical aspects of the national protocol to accelerate implementation. As part of gap filling support, WHO handed over insulin kit to Upazila Health & Family Planning Officer, Teknaf for strengthening management of Diabetes Mellitus in Teknaf Upazila on 8 August 2021. The amount donated is estimated to serve about 360 diabetic patients requiring insulin for four weeks.

During the reporting period, the final report of Water Quality Surveillance (WQS)- January to April 2021 has been completed and shared with partners. A total of 4212 water samples has been collected and analyzed comprising 1053 unsterile sources, 1053 sterile sources and 2106 household's storage water samples. The quality water surveillance also covered 167 healthcare facilities including 8 field hospital, 112 health posts and 47 primary healthcare centres across different camps in Ukhiya and Teknaf. Samples from 28 pipelines water supply systems across Ukhiya and Teknaf was also collected for the surveillance. In each of the pipeline water supply system, WQS was performed at pump house, 3 stand points of each of the pump house and 2 user household's water storage for each of the standpoints. Additionally, 327 functional water sources from learning and other purpose centers were considered in the final report, including 212 deep/ shallow tube wells, 1 mechanized pump with reservoir and 114 tap stands.

As a part of RMNCAH program, WHO actively engaged in the session monitoring at health facilities during the last week. Also provided audio interview to BBC media action to raise awareness among Rohingya beneficiaries regarding COVID 19 vaccination campaign. The session was conducted in Rohingya language.

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, co-chairs and partners from the Emergency Preparedness and Response Technical Committee (EPR TC) have conducted several discussions for the creation of a subcommittee for safety and resilience assessment in the camp. The EPR TC nominated UNFPA, UNOPS, UNHCR, UNICEF, MOAS, IOM, and WHO as member of this subcommittee, which will start with a pilot programme in the coming weeks. In addition, a sub committee comprised of health sector partners was formed under the EPR TC to review and contextualize the Emergency Health Logistics and Medical Supplies of the Mobile Medical Teams (MMTs) as a part of the follow up of the recommendations identified through the After Action Review (AAR) of the MMTs response to the fire incident on 22nd March 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 has distributed 400 pieces of COVID-19 Rapid Antigen Testing kits to Relief International and the Hope Foundation in the Rohingya refugee camps. WHO has also supported Ukhiya Upazila Health Complex (UHC) with the supply of 3000 test swab and 3000 red cap vacutainers for COVID-19 sample collection. Moreover, WHO continues providing support to the sentinel sites in the camps with the provision of 2200 red cap vacutainer and 2200 throat swabs.

During the COVID-19 vaccination campaign that is currently ongoing in the camps, WHO has been supporting the Civil Surgeon's office with the provision of 600 hand sanitizers, 3000 pieces of surgical masks and 1200 zip lock bags.

During the reporting period, a total of 6.67 Metric ton total volume 165.71 Cubic meters of 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: COVID-19 Vaccination in the world's largest refugee camp

Ensuring equitable access to safe and effective COVID-19 among the poorer countries and vulnerable populations has been part of WHO's core mission since the onset of the pandemic. As such, the inclusion of the Rohingya refugee population in the Bangladesh national vaccination plan has been one of the Health Sector's priorities for Cox's Bazar.

Leaving no one behind: inclusion of the Rohingya refugees in the national vaccination plan

In early February 2021, coinciding with the national campaign roll-out, the Government of Bangladesh signed a revised version of the National Deployment and Vaccination Plan (NDVP) which included the Rohingya refugee population as a target group, with a similar phased approach as used for the host community. WHO and Health Sector partners have been since supporting the Government in COVID-19 vaccination campaign preparations for the Rohingya community, which was pending the arrival of the allocation of vaccines from the COVID-19 Vaccines Global Access (COVAX)* facility for Bangladesh.

The critical situation in the neighboring country affected the vaccination plan in the Rohingya refugee setting as vaccine supplies were redirected to meet urgent domestic needs bringing uncertainty to the refugees' vaccination roll-out.

Under the leadership of the Government of Bangladesh and with the technical support of WHO and Health Sector partners, on August 10, 2021 COVID-19 vaccination campaign started in the world's largest refugee camp targeting Rohingya refugees of 55 years and above.

A multi-sector approach

Due to the complexity of Cox's Bazar humanitarian context, the Operational Guidelines for the Rohingya community had to be adjusted and developed through a consultative process with the Civil Surgeon, the Ministry of Health and Family Welfare - Coordination Center (MoHFW-CC), the Refugee Relief and Repatriation Commissioner (RRRC) and key humanitarian partners such as WHO, UNICEF and UNHCR. Aspects such as Adverse Event Following Immunization (AEFI) management capability, transport and storage of vaccines and geographical distribution in the camps, as well as health facility-based vaccination, were addressed to ensure a realistic roll-out framework in the world's largest refugee camp.

The vaccination strategy in Cox's Bazar involves a multi-sector approach that goes beyond the health sector coordination. WHO as a lead agency of the Health Sector has been working closely with Government and humanitarian partners to adjust the national parameters to the Rohingya's complex setting.

Photo: WHO staff is closely monitoring and supporting the Government of Bangladesh in the first round of COVID-19 vaccination among the Rohingya population.

At least one vaccination site was identified in each camp to ease accessibility, and an extensive community awareness and engagement plan was put in place to effectively prepare the Rohingya population for COVID-19 vaccination.

In total, 56 health facilities with 58 vaccination teams, each comprising 2 vaccinators and 4 volunteers, are conducting vaccination sessions. Every healthcare facility has 1 supervisor, 2 AEFI focal person and 1 verifier for better vaccine management and monitoring. As of 18 August 2021, a total of 34 429 Rohingya people has been vaccinated out of 43 093.

Photo: In total, 56 health facilities with 58 vaccination teams, each comprising 2 vaccinators and 4 volunteers, are conducting vaccination sessions.

WHO support for the COVID-19 vaccination in the Rohingya refugee camps

WHO is supporting the Government with training of the human resources for the vaccination campaign, micro planning of vaccination session, vaccine distribution, developing the training packages and required forms in the line of National level, monitoring of the sessions and evaluation of the campaign, house to house mobilization along with other partners. In total, 25 Health Field Monitors of IVD team with 2 SIMOs and other 10 technical staff of WHO are in the field continuously for program monitoring.

The preparations of the COVID-19 campaign in the Rohingya refugee camps also provided a unique opportunity to continue building capacities among healthcare workers in Cox's Bazar. Over 450 health professionals from Government and partner-led facilities in Ukhiya and Teknaf Upazilas have received training on operational guidelines and Adverse Events Following Immunization (AEFI) for COVID-19 vaccination through an interactive methodology which combined informative content, problem-solving scenarios and active trainee participation. Additionally, WHO has designed a community preparedness assessment tool to measure the awareness of Rohingya refugees regarding the COVID-19 vaccination campaign in the camps. This tool will help the Government and partners better drive the risk communications strategy in the field to encourage vaccinations and ensure that no one is left behind.

RCCE strategy for COVID-19 vaccination

Just like elsewhere in the world, COVID-19 vaccine hesitancy and related fears and anxiety have impacted Rohingya refugee's health care seeking behavior. In collaboration with the Risk Communications and Community Engagement Working Group (RCCE WG), WHO together with other UN agencies and humanitarian partners have been engaging communities, health sector partners and stakeholders to create awareness among the population about the benefits of COVID-19 vaccination and dispel rumors and misconceptions for better uptake of COVID-19 vaccine provided by the Government of Bangladesh.

To effectively prepare the Rohingya population for the COVID-19 vaccination campaign, an extensive communication and engagement campaign involving key community members and religious leaders was put in place in all the camps to raise confidence and acceptance among the Rohingya refugees. Through a multi-channel strategy which includes community radio, interpersonal communication and digital media, WHO is tracking vaccine hesitancy and rumors in the field and promoting community mobilization. WHO experts have also provided technical assistance in drafting the technical messages for the Information, Education and Communication (IEC) materials on COVID-19 vaccination awareness for the Rohingya community in the refugee camps.

The role of Community Health Workers

Risk Communication and Community Engagement (RCCE) is an essential pillar of health emergency responses. In the humanitarian context of Cox's Bazar, risk communication is about working with communities with special focus on interpersonal communication and expected behavioral change.

Community Health Workers (CHWs) have played a significant and irreplaceable role in the COVID-19 vaccination campaign which recently started in August 10. WHO provides technical assistance to UNHCR and the Community Health Working Group (CHWG) which lead a skilled team of 1 447 Community Health Workers (CHWs) – of which 868 are Rohingya refugees – who conduct over 140 000 households visits per week sharing important information to targeted members of the family through door-to-door visit on COVID-19 prevention, referring people for testing and treatment, combatting negative rumors and documenting observations and queries to tailor appropriate messages to combat infodemics. During this campaign, the CHWs have also played a very important role in supporting access to the registration cards for the eligible population.

Without losing sight of routine immunization

While preparations were ongoing to guarantee a successful deployment in the world's largest refugee camp, the Rohingya population continued to be at risk of vaccine-preventable diseases, such as polio and measles. Upholding the routine immunization programmes continues being a priority for WHO in Cox's Bazar as part of the essential health service delivery provided to nearly 890 000 Rohingya refu-

gees in the camps. The pandemic highly impacted the immunization services in the refugee settlement due to the movement restrictions and the subsequent impact on essential health services, along with raised fears from the community. In response, WHO in close coordination with the Government of Bangladesh and a group of immunization experts developed a health facility-based transitional strategy to resume the routine immunization services. 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 to guarantee the continuation of routine immunization programs in the Rohingya camps. 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 1st half of 2021.

NATIONAL LEVEL HIGHLIGHTS, 20 August 2021 (BANGLADESH)

	Last 24 hours	Total
COVID-19 tests conducted	23 882	8 617 828
COVID-19 positive cases	3991	1 457 194
Number of people released/recovered	7666	1 355 421
COVID-19 deaths	120	25 143

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

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

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

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

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

Write to coord_cxb@who.int to receive COVID-19 updates and situation reports from Cox's Bazar with the subject "Add me to the situation reports and updates mailing list"

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Bangladesh

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