





PHOTO: To reinforce the public health response to COVID-19, WHO supported the Civil Surgeon Office and the Cox's Bazar Sadar Hospital with the delivery of commodities and medical supplies, including oxygen generators, pulse oximeters, and Personal Protective Equipment (PPE).

HIGHLIGHTS

- WHO and Health Sector partners held the first meeting of the After-Action Review following the large scale fire-incident in the camps to assess the emergency response with the aim of capturing best practices and lessons learnt, while facilitating the standardization of future response interventions.
- WHO continues to support the Government of Bangladesh (GoB) in the preparation for the COVID-19 vaccination campaign for the Rohingya community, scheduled to start in the coming weeks, pending the revised arrival date of the allocation of vaccines from the COVAX facility for Bangladesh.
- Over 250 humanitarian workers participated in three training sessions on vaccine safety, vaccine administration and FAQs in order to raise awareness, address vaccine hesitancy and rumours among the Rohingya population and promote community mobilization in favour of vaccination.
- WHO conducted IPC supportive supervision visits in six SARI ITCs in the camps as part of the quarterly quality assurance and quality control efforts to improve health workers and patient's safety and ensure quality of healthcare.
- **SUBJECT IN FOCUS:** Infection Prevention and Control (IPC) during COVID-19 pandemic in Cox's Bazar – A new paradigm of patients and healthcare workers' safety.

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	7 488	525
 Total cases in isolation in Cox's Bazar	1050	66
 Total number of tests conducted	78 857	37 667
 Total deaths due to COVID-19	84	11

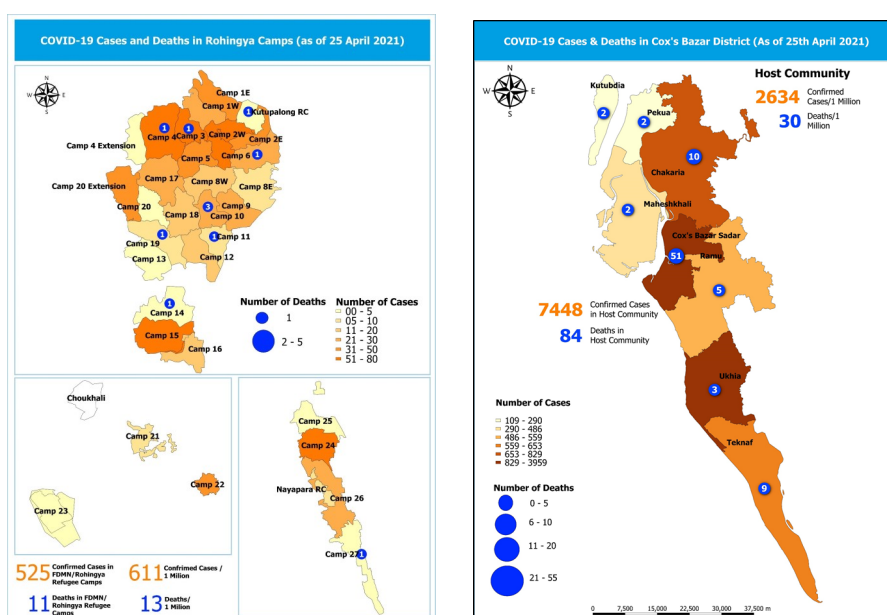
WHO, together with the Ministry of Health and Family Welfare (MoHFW) and Refugee Relief and Repatriation Commissioner office (RRRC) continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the COVID-19 emergency.

Following the large scale fire incident on 22 March 2021 in the Rohingya refugee camps 8E, 8W and 9 in Cox's Bazar, Health Sector partners continue supporting the affected population through deployment of Mobile Medical Teams (MMTs), Community Health Workers (CHWs) and Mental Health and Psychosocial Support (MHPSS) staff in the field. To date, all the damaged or destroyed health facilities have recommenced essential health services to some extent, including the re-starting of Turkish Field Hospital emergency services on 16 April 2021.

During the reporting period, the Health Sector finalized the "Gender Action Plan 2021" aligning its objectives with the draft Joint Response Plan (JRP) 2021. Progress against the objectives will be monitored in regular intervals by the Health Sector coordination team in collaboration with partners. The Health Sector also finalized the "Cyclone and Monsoon Season Contingency Plan for Cox's Bazar 2021, and an "After Action Review of the Mobile Medical Teams (MMTs)" following the fire incident is ongoing. In addition, WHO and Health Sector partners are currently finalizing a Mass Casualty Management Plan and a revised COVID-19 Action Plan for 2021.

In week 16, the Health Sector also completed its quarterly monitoring of health facilities for the first quarter of 2021 in all 34 refugee camps. Further advocacy for essential health services will be carried out to the health partners based on the monitoring outcomes, in order to ensure continued provision of quality health services despite lockdown restrictions.

Between weeks 15 and 16, a total of six (06) camp level Health Sector coordination meetings were held in Ukhiya and Teknaf Upazilas. These meetings were attended by partner agencies including Government agencies, UN agencies and NGOs. Key challenges, achievement, and areas requiring support, strengthening coordination, collaboration, and liaison among partners and government authorities were discussed. In the interim, one online health partners coordination meeting was conducted. The recent upsurge of COVID-19 positive cases among the host community as well as the Rohingya refugees was the main topic of discussions during these meetings. Health Sector partners were requested to increase their preparedness against the observed increase in COVID-19 cases and ensure advocacy on preventive measures like hand washing, wearing of masks, case management capacity strengthening, increasing sentinel testing and other COVID-19 specific measures, while also ensuring continuity of essential health services.



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 25 April 2021, a total of 7448 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 668 in Chokoria, 109 in Kutubdia, 482 in Moheshkhali, 252 in Pekua, 495 in Ramu, 3959 in Sadar, 622 in Teknaf and 861 in Ukhiya.

While the overall positivity of the sample tested in the district is 9.4%, an increasing trend in the positive cases among the host community has been observed in the past few weeks. In week 14, 453 cases tested positive in comparison with 203 positive cases registered in week 12. The number of cases has slightly decreased to 400 in week 16, with a test rate positivity of 15.3%. Most cases have been reported in the municipality and Sadar Upazila area, with a 2-fold rise of new cases contributing by the other upazilas collectively in the district. Case distribution by age and sex remains similar to 2020.

In the past weeks, an increasing trend in the number of deaths has also been registered across the country. However, this upward trend has not yet been observed in the district nor in the refugee camps. To date, a total of 84 deaths have been reported in the host communi-

ty, with a case fatality ratio of 1.1%. In response to the increase in number of cases among the host community, the Government of Bangladesh and the Office of the Refugee Relief and Repatriation Commissioner (RCCC) in Cox's Bazar have imposed movement restrictions and other mitigation measures in district and camp areas. All tourist activities remain suspended in the district for the upcoming weeks. Currently, 478 general isolation beds are functional in 12 Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centers (ITCs) with provision of oxygen to assist both the Rohingya refugee population and the nearby host communities of Cox's Bazar. The current bed occupancy of these SARI ITCs is 26%. The additional capacity of general isolation beds in the district is 418. The Intensive Care Unit/High Dependency Unit (ICU/HDU) at the Cox's Bazar Sadar Hospital has a capacity of 38 beds for severe and critical patients. During the past three weeks, a considerable increase in the bed occupancy has been observed, indicating the increased demand of hospitalization due to severe disease presentation during admission.

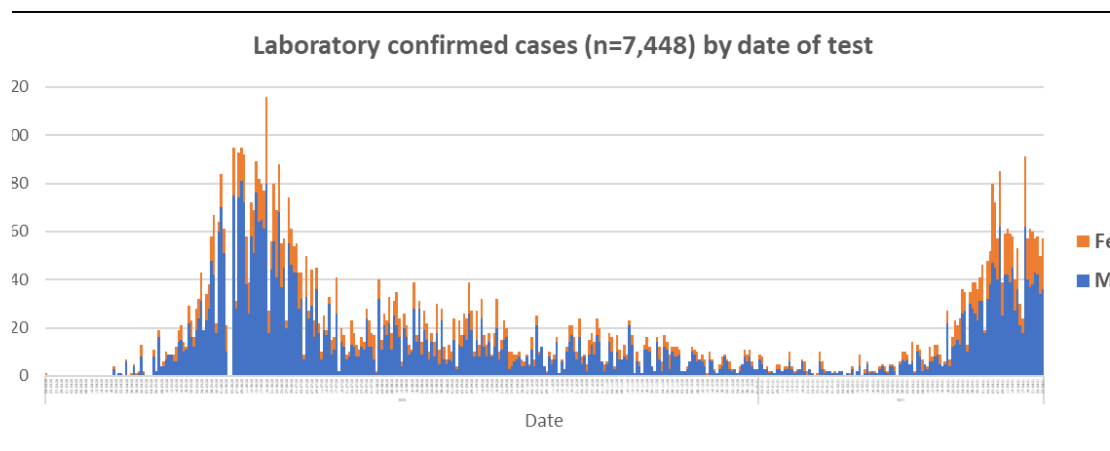


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

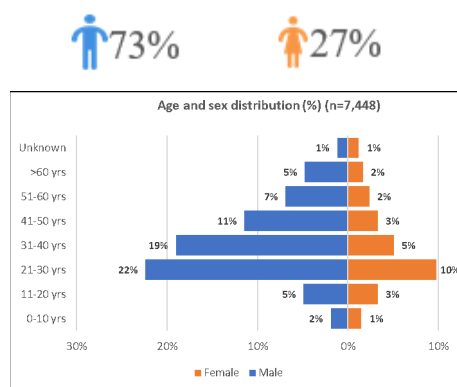


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

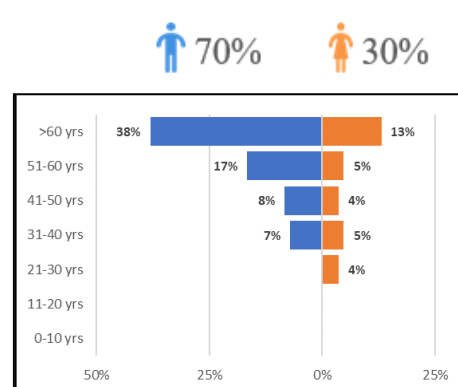


Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

As of 25 April 2021, a total of 525 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 70 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 51 and Camps 3 and 15 with 38 and 30 cases, respectively. To date, 27 cases were reported from Camp 6, 26 from Camp 2E and 28 from Camp 4. Camps 5 had 19 cases and camp 1W, camp 9 and camp 17 with 16 cases, 20Ext and 22 had 21 cases each. Camp 10 and camp 26 have 13 cases, 17 from camp 1E and 14 from camp 7 and camp 16 with 10 cases. The reminder camps (camp 4ext, 8E, 8W, 11, 12, 13, 14, 18, 19, 20, Nayapara RC, 21, 23 and 27) have so far had less than 10 cases.

Between weeks 15-16, 60 new confirmed cases were detected from 1,875 samples tested, the test positivity was therefore 3.2%. As of 25 April 2021 the cumulative incidence is 61.1 per 100 000 people. The overall positivity of samples tested is 1.3%. Among the cases, 5.5% showed severe symptoms at the time of admission while 6.5% reported at least one co-morbidity. The median age of tested and confirmed cases was not changed 10 (0-120) & 18 (0-90) years, respectively and ratio of females among tested and confirmed cases was 55% and 52%, respectively. Though the median age of tested samples remained below 10 years, a significant proportion has been tested among 50+ years: 525 per 10 000 population, following that of 0-9 years with 659 tests per 10 000 population as highest number. The test positivity was highest 1.9% in 30-39- and 20-29-years age cohort and the age specific mortality 0.99 per 10 000 population observed among 50+ years during the period. In total, and since the outbreak began, 11 deaths due to confirmed COVID-19 have been reported in the camps with a case fatality ratio of 2.1%.

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 507 confirmed cases (out of 525 to date) have been investigated by RIRTs by 25 April, with contact tracing activities being conducted and captured through Go.data, including the 1930 contacts to be followed up. Out of these, 1577 (82%) contacts have seen their follow up visits completed and were released from quarantine. Twenty-seven (1.7%) became confirmed cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

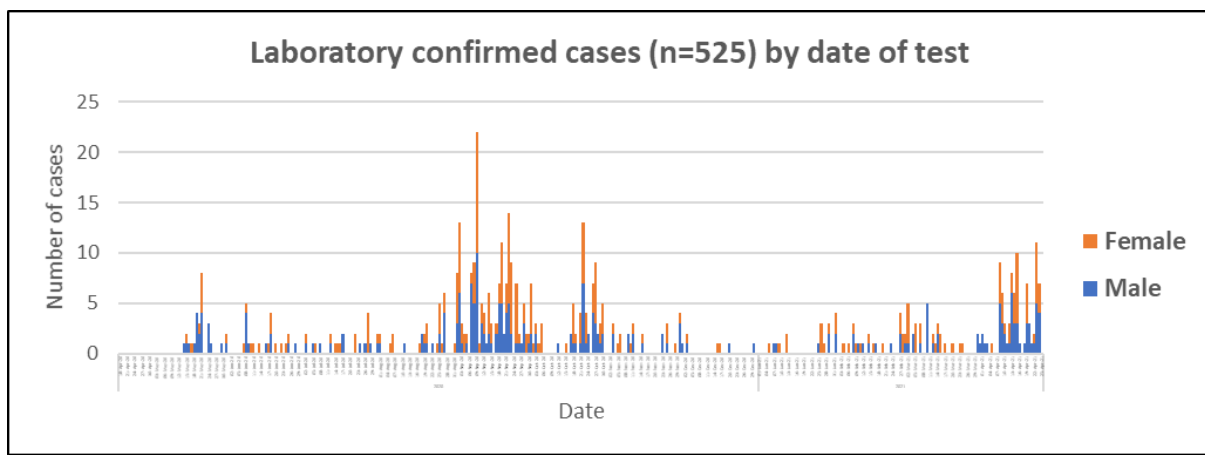


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

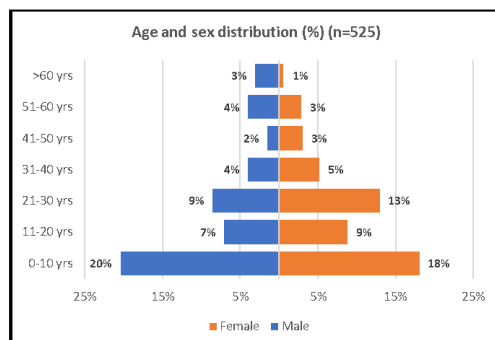


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

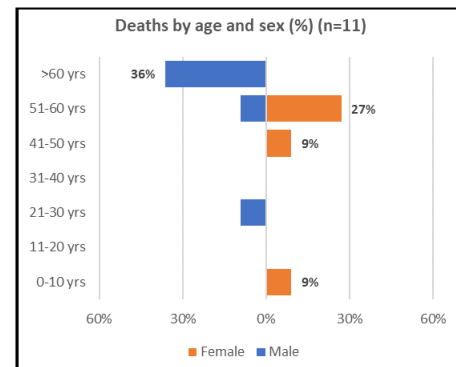
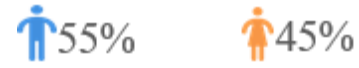


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Four (04) Rapid Diagnostic Test (RDT) positive cases for Acute Water Diarrhea (AWD) were reported in the reporting period. The total number of cases reported so far is 19 in 2021: six (06) from the refugee camps and thirteen (13) from host communities. Out of these, four (04) were culture confirmed and eleven (11) tested negative by culture and remaining for culture result awaited. In 2020, a total of 28 RDT positive cases for Cholera were detected through sentinel testing, five (05) of which were confirmed by culture - two from Ukhiya host community, one from Teknaf host community and two from the refugee camps. It is important to note that a Cholera outbreak occurred in late 2019 with a reported number of 239 RDT/culture positive cases and in response a mass Oral Cholera Vaccine (OCV) vaccination campaign was conducted with over 160 000 children of 1-<5 years being vaccinated with a 2- doses regimen.

Since the onset of the outbreak in 2017, Diphtheria surveillance is ongoing in the camps. The total number of diphtheria cases reported is 9261 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 75 as of week 16, 2021). In total, 9018 cases were reported in the camps and 243 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.

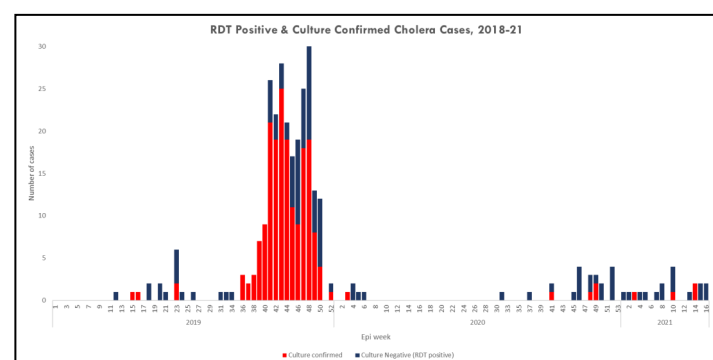


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

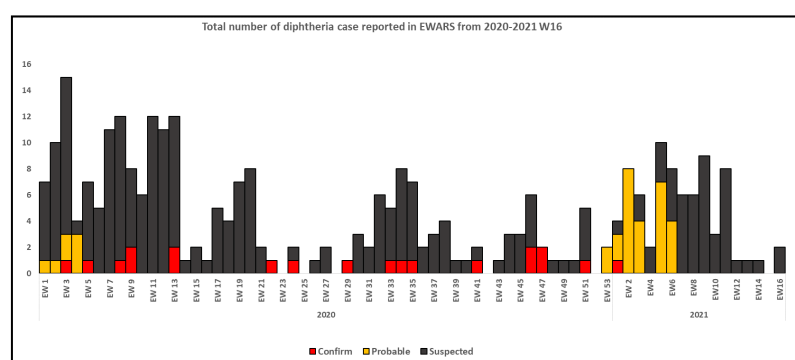


Figure 8: Total number of diphtheria case reported in EWARS from 2020—2021

In week 15-16, three (03) suspected Severe Acute Respiratory Infection (SARI) death were reported. In total 37 deaths have been reported in 2021. All deaths have been investigated by RIRT as a part of COVID-19. Seven (07) deaths have been reclassified as COVID-19 probable death cause. In 2020, a total 49 suspected SARI deaths were reported through community-based mortality surveillance. Of these, all were verified and two (02) considered probable.

During the reporting period, three (03) new suspected maternal deaths has been reported. In total 42 suspected and confirmed maternal/deaths of Women of reproductive age (WRA, 12-49 years) have been reported in 2021, of which eleven (11) 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.

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. Mixed-media messages include general information on COVID-19, hand washing, physical distancing and mask wearing, risks and vulnerabilities, safe and dignified burials, quarantine, isolation, and treatment centres, among others. Through its involvement in the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), WHO continues to coordinate with agencies across the response to ensure that all information around COVID-19 and health issues are of high quality, technically correct and easily understandable by communities.

During the reporting period, WHO provided technical assistance to review and finalize public health messages on COVID-19 awareness for the Rohingya community. Topics covered include lab testing, isolation, quarantine process, MHPSS, Infection Prevention and Control, safe religious practices during the Holy Month of Ramadan, among others. Similarly, technical inputs were provided to the COVID-19 Risk Communication and Community Engagement for critical operation. WHO and UNICEF continue providing English and Bangla versions of the weekly radio script on COVID-19 confirmed cases and number of tests conducted among refugee and host communities. These messages were shared with partners to be widely disseminated by the Rohingya community through radio broadcasting.

As part of the fire incident response, WHO in close coordination with RCCE WG and CwC WG continue disseminating public health messages on preventive measures against fire hazard and management of burn wounds. WHO continues providing support and coordination to partner agencies to update post-fire public health messages on restoration of essential health services through coordination with the Mobile Medical Teams (MMTs).

During the reporting period CHWs conducted 276 777 household visits in which 4 424 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 40 patients with moderate/severe symptoms. The cumulative number of mild patients is 129 453, and 553 moderate/ severe patients. To date, 63 787 persons with COVID-19 like symptoms have been referred to health facilities, 3 162 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 523 743 persons between 15-28 April 2021. Since the beginning of the response, CHWs have conducted more than 7.12 million household visits and had contacts with a cumulative number of more than 18.46 million adult household members. Through the CwC WG, 47,677 people were engaged in 18 776 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 25 April 2021, a total of 133 642 tests for COVID-19 have been conducted of which 116 524 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A slight increase in the number of tests conducted among the Rohingya refugees was observed in weeks 15-16 as compared to weeks 13-14, from 1875 to 1781 tests. However, among the host community a decreased number of samples was tested: from 5067 tests in weeks 13-14 to 4930 tests in week 15-16. Currently, 31 sample collection sites are operating for suspected COVID-19 patients.

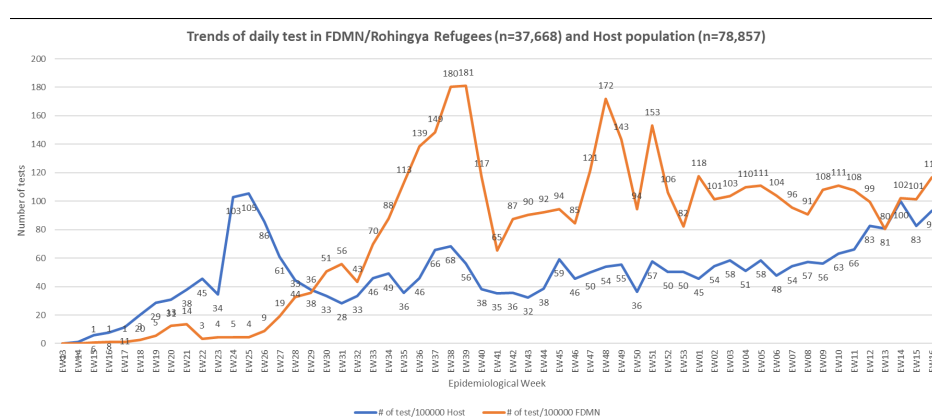


Figure 9: Number of tests conducted per million among the host population and the Rohingya refugees/FDMN

*The Government of Bangladesh refers to Rohingya as "Forcibly Displaced Myanmar Nationals". The UN system refers to this population as Rohingya refugees, in line with the applicable international framework. In this document both terms are used, as appropriate, to refer to the same population.

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

During the reporting period, IPC supportive supervision visits were conducted in five (05) SARI ITCs in the camps as part of the quarterly quality assurance and quality control efforts implemented by the Infection Prevention and Control Technical Working Group (IPC TWG) for all SARI ITCs in Cox's Bazar. These technical visits are also part of the continuous capacity building efforts employed by WHO through the Health Sector to improve health workers and patient's safety and ensure quality of healthcare.

WHO conducted a refresher webinar on Infection Prevention and Control (IPC) and quality health service delivery during the COVID-19 pandemic. A total of 51 participants from over 30 partners organizations and from the Cox's Bazar District Sadar Hospital attended the workshop facilitated by WHO-IPC team.

Further to this, WHO and the IPC Technical Working Group (IPC-TWG) designed a daily IPC checklist tool and monthly IPC score card to better monitor the performance of the healthcare facilities in the camps. This initiative will also help improve the quality of care within essential health services while identifying possible IPC gaps.

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 working group meeting along with one case conference for SARI ITCs and two case conferences for ICU were conducted. As of 26 April 2021, there are 12 operational SARI ITCs in the camps with a total of 478 functional beds open and 415 on stand by. The SARI ITC bed occupancy is currently 25.3%. At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 8 beds and the Severe Care Unit (SCU) 20 beds functional beds. At the moment, 27 beds are occupied.

ESSENTIAL HEALTH SERVICES

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

WHO and Health Sector partners continue supporting the Government of Bangladesh (GoB) in the preparation of the COVID-19 vaccination campaign for the Rohingya community, scheduled to start in the coming weeks, pending the revised arrival date of the allocation of vaccines from the COVAX facility for Bangladesh. COVAX is a global initiative aimed at equitable procurement and distribution of COVID-19 vaccines led by WHO, Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations.

The WHO Immunization and Vaccine Development (IVD) team designed a community preparedness assessment tool to ensure the timely collection, monitoring and dissemination of public health data during the COVID-19 vaccination campaign in the camps. During the reporting period, over 250 humanitarian workers received three training sessions on vaccine safety, vaccine administration and FAQs in order to raise awareness, address vaccine hesitance and rumors among the Rohingya population and promote community mobilization in favor of vaccination.

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 Government with technical assistance from WHO and other partners based on data collected in 2020. Currently, 59 health facilities are working as immunization fixed sites and another 66 vaccination teams are conducting out-



Photo: WHO and Health Sector partners conduct quarterly monitoring in every healthcare facility in the camps to ensure continued provision of quality health services, especially during the lockdown.

reach sessions both in community and healthcare facilities. During the reporting period, follow up and monitoring on missing children vaccination was conducted by vaccinators at the healthcare facilities in close coordination with WHO Emergency Immunization and Surveillance Officers (e-SIMOs) and Health Field Monitors (HFM). Acute Flaccid Paralysis (AFP) and VPD surveillance also continue during lockdown.

As part of the Non-communicable Diseases (NCDs) program, WHO is supporting the Government to enhance the accessibility to reliable information on NCDs and quality of care for people diagnosed with any non-communicable disease, such as hypertension or diabetes. WHO and MOHFW-CC conducted a feedback session at the IOM-led facilities, focused on cardio-vascular disease risk-based approach and follow-up visits.

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 list of camp health focal points is maintained and updated regularly.

During the reporting period, WHO and IOM, as co-chairs of the Emergency Preparedness and Response Technical Committee drafted the Mass Casualty Management Plan and shared it with partners for their feedback. WHO and Health Sector partners held the first meeting of the After-Action Review of the fire incident in order to assess the Mobile Medical Teams (MMTs) emergency response. This After-Action Review will help the Mobile Medical Team Working Group to capture the best practices and lessons learnt, while it will facilitate the standardization of future response interventions.

The meeting also served to remap the MMTs’ intervention area, so that interested new partners could join for better coverage and response. Capacity building activities will be organized in the coming weeks to capacitate the new and existing MMTs on response based on the learnings from the After-Action Review.

OPERATIONAL SUPPORT AND LOGISTICS

WHO continues to ensure timely provision of quality and adequate supplies, equipment and consumables for the health emergency operations in Cox’s Bazar. To reinforce the public health response to COVID-19, WHO supported the Civil Surgeon Office in Cox’s Bazar with the delivery of ten (10) oxygen generators, 30 pulse oximeter, 20 infrared thermometer and Personal Protective Equipment (PPE). As part of the operational support and logistics, WHO also supported the Cox’s Bazar 250 bed Sadar Hospital with the supply of 24 000 PPE items, including isolation gowns, gloves, respirators and surgical masks.

During the reporting period, a total of 1.48 MT total volume 11.26 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 logistic support to the IEDCR Field Laboratory with two vehicles providing transportation of COVID-19 sample collection in the camps. Further to this, WHO provided vehicle support to transport Covid-19 samples from Cox’s Bazar to Dhaka for quality testing purposes and brought 6 000 VTM from Dhaka IEDCR to Cox’s Bazar IEDCR field laboratory.

SUBJECT IN FOCUS: Infection Prevention and Control (IPC) during COVID-19 pandemic in Cox’s Bazar – Towards patient and healthcare worker safety

In the humanitarian health setting of Cox’s Bazar, caring for COVID-19 patients is not an easy feat. With the increasing number of people infected with SARS-CoV-2, including healthcare workers, WHO has been providing training for adequate management of patients with COVID-19 through cost-effective strategies to empower front-line workers responding to the pandemic.

Health care capacity in the world’s largest refugee camp

There are approximately 175 functional healthcare facilities in the Rohingya refugee camps offering a range of general healthcare services to nearly 880 000 Rohingya refugees and 472 000 Bangladeshi nationals living in the surrounding areas. This includes Primary Health Care (PHC) centers, Health Posts (HPs), special facilities and field hospitals, all of them reporting to the Early Warning, Alert and Response System (EWARS) rolled out by WHO to strengthen surveillance, and systematically collect real time data on the health status of populations.

Additionally, as part of the pandemic response, in March 2020 WHO and Health Sector partners established 14 Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs) to provide quality clinical care and ensure the best chance of survival of COVID-19 patients in the Rohingya refugee camps and adjacent host communities. With a capacity of nearly 1200 beds, an approximate number of 970 health care professionals work in these facilities which can provide treatment for mild, moderate and severe cases of COVID-19.

Infection Prevention and Control program in Cox's Bazar

Infection prevention and control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health workers. It is grounded in infectious diseases, epidemiology, social science and health system strengthening. IPC occupies a unique position in the field of patient safety and quality universal health coverage since it is relevant to health workers and patients at every single health-care encounter.

IPC has always been a priority area of work for WHO, however in the past year this has become even more apparent to reduce the risk of spread of SARS-CoV-2 in the healthcare system.

Since the onset of the pandemic, WHO has been encouraging health sector partners working in the camps to designate dedicated IPC professionals and define clear IPC objectives and workplans in each of the SARI ITCs. The successful experiences observed in these isolation and treatment centers triggered an IPC reform in Cox's Bazar district level beyond the SARI facilities. Currently, WHO and Health Sector partners are supporting the Government through the Civil Surgeon Office to build consensus on the institutionalization of Infection Prevention and Control in the health system in Cox's Bazar envisioning improved patient and healthcare workforce safety. In addition, following the request of the Government of Bangladesh, in March 2021, WHO completed a "National level ToT on Infection Prevention and Control for COVID-19" aimed at creating a pool of master trainers to support cascade of similar training through the national health care system.

Infection Prevention and Control guidelines

A wide range of IPC guidelines were provided to the SARI ITCs and other health care facilities in the camps to guide their day to day execution of clinical and non-clinical tasks with the aim of reducing not only the risk of exposure to COVID-19, but also other infectious diseases in the health care setting. Some of the topics included in these guideline documents are the use of standard precautions namely: proper use of Personal Protective Equipment (PPE), respiratory hygiene, injection safety, management of accidental injuries and exposure to blood, among others. These supportive documents also provide healthcare workers with useful information to reduce exposure to harmful pathogens and ensure safety at the workplace.

Capacity Building

To enhance preparedness for COVID-19 in Cox's Bazar, WHO has been training healthcare workers from Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) and government facilities on Infection Prevention and Control (IPC). The training covers a range of health and safety issues including the proper use of PPE, physical space requirements to limit spread of infection from patient to healthcare worker, sanitation and hygiene, injection safety, management of accidental injuries and exposure to blood, fire safety and decontamination of equipment, among others.

Trainings include theoretical and practical sessions in different forms and mediums (lectures, practical and demonstration sessions, process simulations, visual and audio visual materials...) that help build confidence of staff in handling the cases, promote the correct use of PPE and get familiar with routine procedures aimed at reducing Healthcare Associated infections.



Photo: All persons entering the SARI ITC need to be screened for possible signs and symptoms of COVID-19, this includes staff, patients and visitors.



Photo: Since the onset of the pandemic, WHO distributed 1.70 million of Personal Protective Equipment (PPE) items to partners responding to COVID-19 in Cox's Bazar.

Entry Requirements

All the isolation and treatment centers conduct daily monitoring of their healthcare workers that enable them to identify any possible symptoms and signs of COVID-19. All SARI ITCs have been supported with COVID-19 case definitions, questionnaires, registers and non-touch thermometers, and technical training has been facilitated to the staff working at the entry gates.

All persons entering the ITC need to be screened for possible signs and symptoms of COVID-19, this includes staff and patients and any visitors. If any healthcare worker is identified as having COVID-19, a WHO assessment tool for risk of exposure to COVID-19 inside the health facility is activated. This helps identify possible IPC gaps and implement responsive measures to avoid more health care workers getting infected with COVID-19.

Multimodal strategies to champion IPC measures

WHO adopts the multimodal approach for all interventions geared towards healthcare worker's safety. This approach emphasizes five key components: system change; training and education; monitoring and feedback; reminders and communication, and culture change.

The progress made in proper use of Personal Protective Equipment (PPE) also highlights this multimodal approach strategy to promote IPC measures at the SARI ITCs. Before starting to work in isolation facilities, all healthcare workers must have received training on the use of different types of PPE. The use of a trained observer in the doffing area is recommended to aid staff to slowly and carefully take off their PPE. This helps to reduce any potential mistakes in the essential steps of removal of PPE and to avoid cross contamination, which can happen when staff are tired. IPC supervisors have to monitor the proper use of PPE, to ensure that errors are identified, addressed and immediately reducing the risk of being infected.

WHO supportive supervision visits of SARI ITCs

WHO has developed checklists and other assessment materials to monitor healthcare workers' actions, identify gaps and find appropriate interventions immediately. These checklists are used to compile a monthly score card that enable easy visualization of the safety and health performance improvement efforts carried out by each SARI ITCs on a monthly basis

Additionally, monitoring and feedback are also reinforced through IPC Thematic Working Group quarterly supportive supervision visits to all SARI ITCs in the district. WHO team developed a comprehensive supportive supervision tool that explores various health and safety areas, including environmental cleaning, training, use of PPE, waste management, hand hygiene, and staff health, among other aspects.

External considerations to ensure safety in healthcare facilities

All SARI ITCs that have been set up are in line with the WHO minimum standards for an isolation and treatment center. This includes design considerations to ensure staff and patient safety, with the implementation of adequate infection prevention and control (IPC) measures.

One of the essential IPC considerations that all SARI ITCs have incorporated is adequate ventilation to enhance air flow, which is important to ensure the safety and well-being of staff and patients considering that COVID-19 is a respiratory disease. Most of the SARI ITCs in Cox's Bazar have applied natural ventilation considerations into their design planning, though some also have added in mechanical ventilation in the form of extractor fans.

Historically, Cox's Bazar has experienced and is prone to cyclones. Since 1970 they have experienced 12 cyclones. With this in mind each of the SARI ITCs in the camps were constructed with some cyclone resilience considerations like tie down structure. As the majority are bamboo-built facilities, fire health and safety considerations are in place with the use of fire extinguishers and buckets placed outside of each ward with an agreed fire evacuation plan in place.

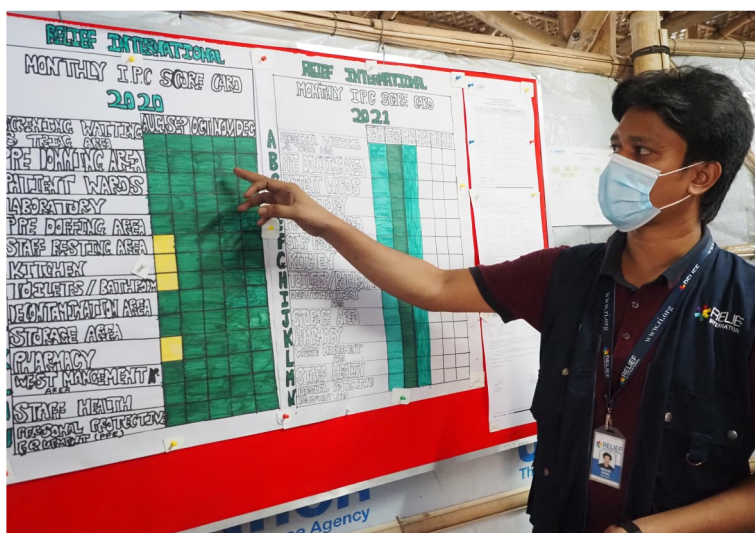


Photo: WHO and the IPC Technical Working Group (IPC-TWG) designed a daily IPC checklist tool and monthly IPC score card to better monitor the performance of the healthcare facilities in the camps.

	Last 24 hours	Total
COVID-19 tests conducted	24 928	5 448 658
COVID-19 positive cases	2341	756 955
Number of people released/recovered	4782	677 101
COVID-19 deaths	88	11 393

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

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

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

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

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

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

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



CONTACTS

Dr Bardan Jung RANA
 WHO Representative
 WHO Bangladesh
 Email: ranab@who.int

Dr Kai VON HARBOU
 Head of Sub-Office
 WHO CXB Sub-Office
 Email: vonharbouk@who.int