World Health Organization
Bangladesh

Rohingya Crisis Situation Report #9

Date of issue: 14 May 2021

Weeks 17-18
26 April - 9 May 2021
Location: Cox's Bazar

PHOTO: Despite the movement restrictions, WHO is closely monitoring epidemiological data to support operational decision making for the COVID-19 response in Cox's Bazar while ensuring the provision of essential health services for the Rohingya refugees and nearby host populations.

HIGHLIGHTS

- **Camp Health Focal Points (CHFPs) under the guidance of WHO and Health Sector have completed Quarterly Monitoring (Q1/2021) of Health Posts (HP) and Primary Health Care Centers (PHCs) in the Rohingya Refugee camps.**
- **A total of 115 (84%) health facilities (91 HPs, 23 PHCC and 1 FH) have created Infection Prevention and Control (IPC) structures as part of WHO and Government efforts to institutionalize IPC in camps.**
- **WHO and partners develop a Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) assessment tool to improve health service delivery in the SARI ITCs.**
- **An extensive communication and engagement campaign involving key community members and religious leaders is currently ongoing in all the camps to raise confidence and acceptance on COVID-19 vaccination among Rohingya refugees.**
- **SUBJECT IN FOCUS: Responding to a pandemic in a refugee camp - the key role of contact tracing to break the chains of COVID-19 transmission**

	Host Community	Rohingya refugees
Total confirmed COVID-19 cases in Cox's Bazar	8 118	670
Total cases in isolation in Cox's Bazar	813	151
Total number of tests conducted	83 749	39 999
Total deaths due to COVID-19	89	11

**Updated as of 9 May 2021* / **FDMN = Forcibly Displaced Myanmar Nationals*

COORDINATION, PLANNING AND MONITORING

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.

During the reporting period, WHO and IOM, as co-chairs of the Emergency Preparedness and Response Technical Committee initiated an After-Action Review for the major fire occurred on 22nd March in order to assess the Mobile Medical Teams (MMTs) emergency response. To date, all the damaged or destroyed health facilities have recommenced essential health services to some extent, including the restarting of Turkish Field Hospital emergency services from 16 April 2021.

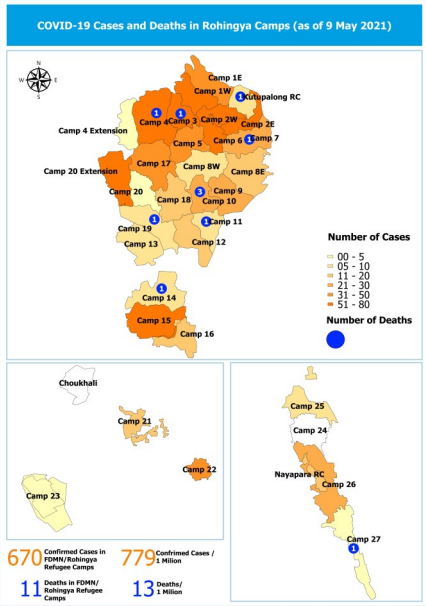
Following a Government request, Health Sector partners also mapped the support provided within the COVID-19 response by different humanitarian partners to government facilities in Cox's Bazar, namely Sadar Hospital and Upazila Health Complexes.

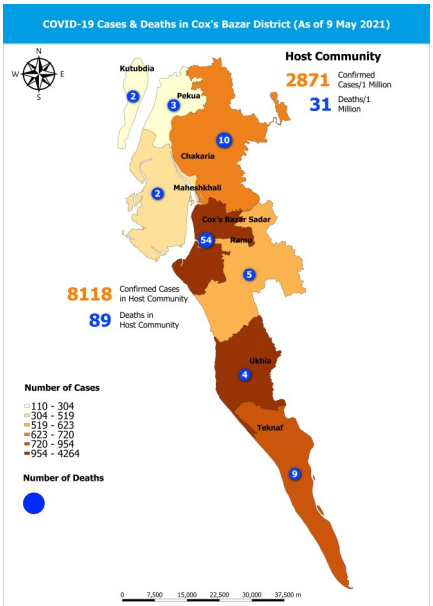
On 29th April 2021, Health Sector partners resumed Sadar Hospital round table meetings to encourage information sharing and collective planning, as well as accountability on the hospital support. The meeting, that will be held on a monthly basis, was chaired by the Superintendent of Cox's Bazar Sadar Hospital and attended by all UN partners supporting the hospital, INGOs and the MOHFW Coordination Cell.

Camp Health Focal Points (CHFPs) under the guidance of the Health Sector Coordination Team have completed Quarterly Monitoring (Q1/2021) of Health Posts (HP) and Primary Health Care Centers (PHCs) in the FDMN/Rohingya Refugee camps. The collected data is now undergoing analysis to advocate further adherence to prescribed minimum standards despite the lockdown.

Between weeks 17 and 18, a total of nine (09) camp level Health Sector coordination meetings were held at Ukhiya and Teknaf Upazilas. These meetings were engaged 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 core 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.

In this regard, the office of Refugee Relief and Repatriation Commissioner (RRRC) issued an official authorization on Minimum Package of Essential Health Services (January to December 2021) outlining the minimum service to be provided in primary health care.





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 9 May 2021, a total of 8118 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 711 in Chokoria, 110 in Kutubdia, 511 in Moheshkhali, 263 in Pekua, 535 in Ramu, 4264 in Sadar,724 in Teknaf and 1000 in Ukhiya.

While the overall positivity of the samples tested in the district is 9.6%, a decreasing trend in the positive cases among the host community has been observed in the past few weeks. In week 16, 400 cases tested positive in comparison with 453 positive cases registered in week 14. The number of cases has slightly decreased to 333 in week 18, with a test rate positivity of 12.1%. 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.To date, a total of 89 deaths have been reported in the host community, with a

case fatality ratio of 1.0%. In the past week, a decreasing trend in the number of deaths has also been registered across the country. The highest weekly count case was registered in week 16 with 668 cases. In week 18 the number of cases decreased to 355. The cumulative total number of positive cases registered at national level is 777 397 and 12 045 deaths.

In response to the recent 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.

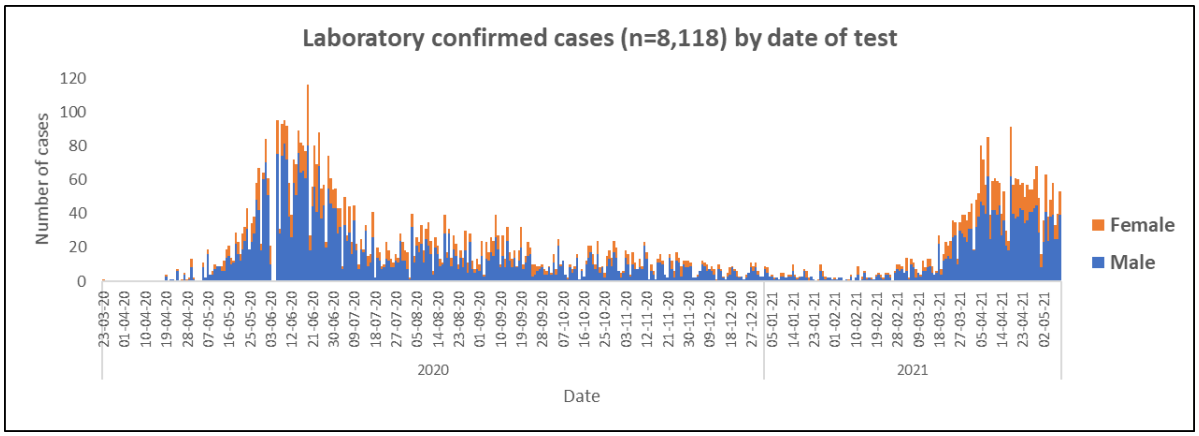


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

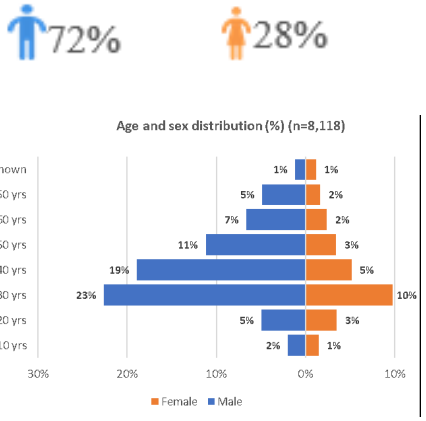


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

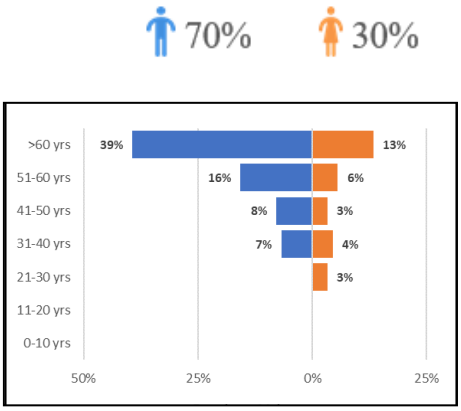


Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

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 29%.

Moreover, the 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.

As of 9 May 2021, a total of 670 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 84 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 64 and Camps 3 and 15 with 48 cases, respectively. To date, 45 cases were reported from Camp 4, 35 from Camp 6 and 30 from Camp 2E, 5 and 20Ext. Camp 22 had 24 cases and camps 1E and 5 reported 22 and 20 cases. The reminder camps (Camp 4 Ext, Kutupalong RC, 7, 8E, 8W, 9, 10, 11, 12, 13, 14, 16, 17, 18 ,19, 20, 21, Nayapara RC, 23, 25, 25 AND 27) have so far had less than 20 cases.

Between weeks 17-18, 145 new confirmed cases were detected from 2,332 samples tested, the test positivity was therefore 6.2%. As of 9 May 2021, the cumulative incidence is 77.9 per 100 000 people. The overall positivity of samples tested is 1.7%. Among the cases, 4.8% showed severe symptoms at the time of admission while 5.9% reported at least one co-morbidity. The median age of tested and confirmed cases was not changed 10 (0-120) & 20 (0-90) years, respectively and ratio of females among tested and confirmed cases was 55% and 50%, respectively. Though the median age of tested samples remained below 10 years, a significant proportion has been tested among 50+ years: 542 per 10 000 population, following that of 0-9 years with 676 tests per 10 000 population as highest number. The test positivity was highest 2% in 40-49-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 1.6%.

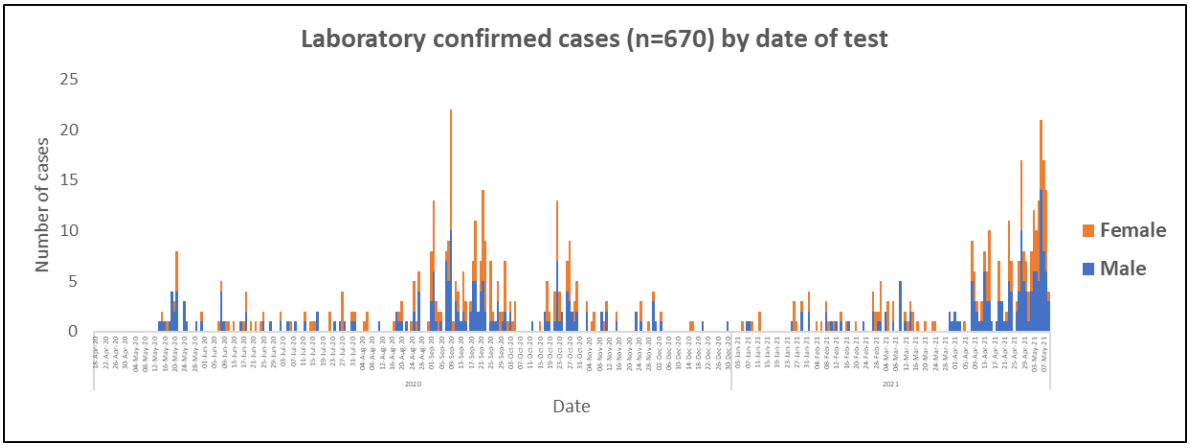


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

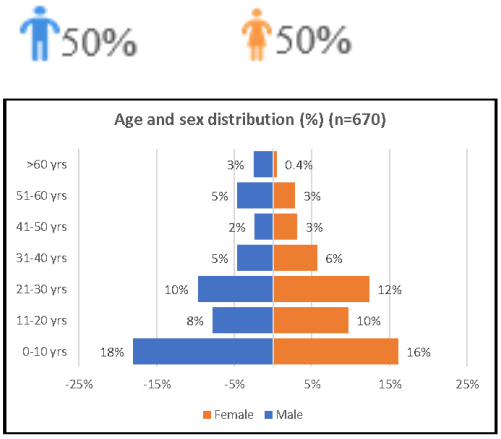


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

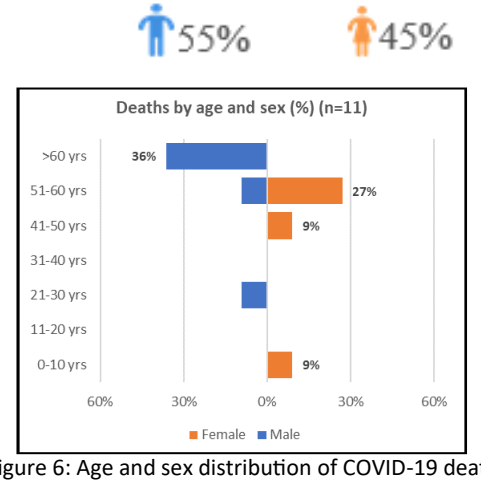


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

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 604 confirmed cases (out of 670 to date) have been investigated by RIRTs by 9 May, with contact tracing activities being conducted and captured through Go.data, including the 2103 contacts to be followed up. Out of these, 1647 (78%) contacts have seen their follow up visits completed and were released from quarantine. Twenty-six (1.6%) tested positive cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

Seven (07) 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 26 in 2021: twelve (12) from the refugee camps and fourteen (14) from host communities. Out of these, seven (07) were culture confirmed, fifteen (15) tested negative by culture and remaining four 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 9266 to date (3016 in 2017; 5330 in 2018; 614 in 2019; 226 in 2020 and 80 as of week 18, 2021). In total, 9023 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

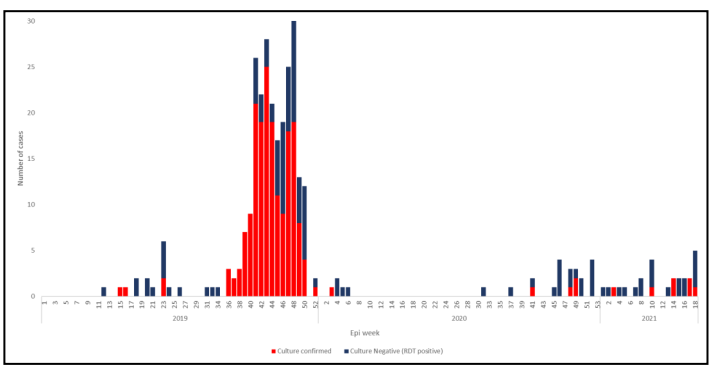


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

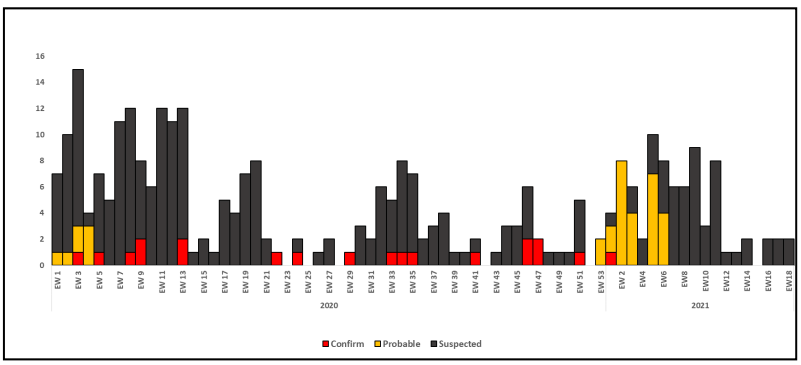


Figure 8: Total number of diphtheria case reported in EWARS from 2020—2021

In week 17-18, two (02) suspected Severe Acute Respiratory Infection (SARI) death were reported. In total 39 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, one (01) new probable maternal deaths has been reported. In total 44 probable 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, RCCE WG and WHO submitted public health messages on COVID-19 awareness to the Civil Surgeon Office for feedback. Topics such as lab testing, isolation, quarantine process, MHPSS, Infection Prevention and Control and safe religious practices during the Holy Month of Ramadan, among others, were covered to raise awareness among the Rohingya population and adjacent host communities. Similarly, technical inputs were provided for the preparation of Public Service Announcements (PSAs) on COVID-19 vaccinations developed by BBC Media Action. During the reporting period WHO and UNHCR also prepared a concept note on minor invasive procedures which will be submitted for approval in the coming days.

WHO and UNICEF continue providing English and Bangla versions of the weekly radio script on COVID-19 confirmed cases and number of tests conducted among refugee and host communities. These messages were shared with partners to be widely disseminated among the Rohingya community through radio broadcasting.

During the reporting period CHWs conducted 280 137 household visits in which 4 279 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 48 patients with moderate/severe symptoms. The cumulative number of mild patients is 133 847, and 601 moderate/ severe patients. To date, 66 894 persons with COVID-19 like symptoms have been referred to health facilities, 3 051 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 565 966 persons between weeks 17 and 18. Since the beginning of the response, CHWs have conducted more than 7.4 million household visits and had contacts with a cumulative number of more than 19 million adult household members. Through the CwC WG, 56 625 people were engaged in 22 617 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.

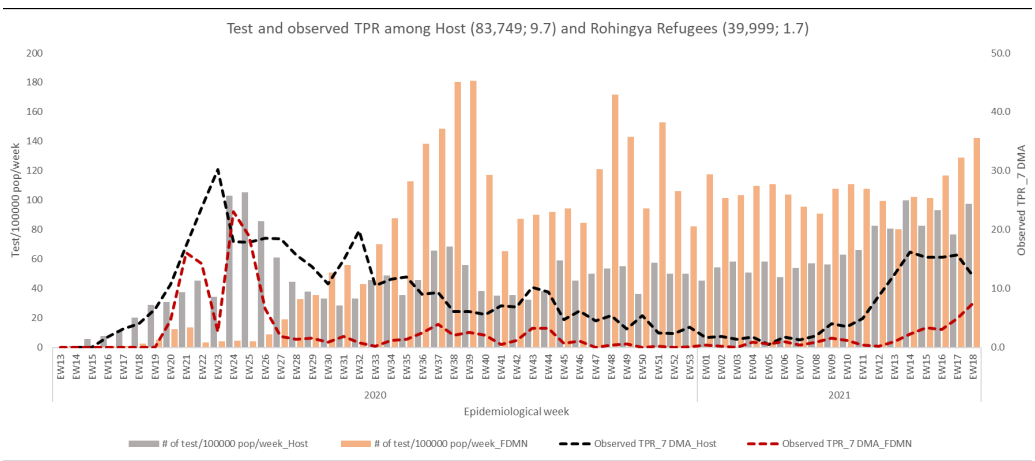


Figure 9: Number of tests conducted per million among the host population and the Rohingya refugees/FDMN

*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.

Between early April 2020 and 9 May 2021, a total of 141 079 tests for COVID-19 have been conducted of which 123 748 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A sharp increase in the number of tests conducted among the Rohingya refugees was observed in weeks 17-18 as compared to weeks 15-16 , from 2332 to 1875 tests. However, among the host community a slight decrease was tested: from 4930 tests in weeks 15-16 to 4892 tests in week 16-17. Currently, 31 sample collection sites are operating for suspected COVID-19 patients.

During the reporting period, two biosafety cabinets were delivered to the IEDCR field lab at Cox's Bazar medical college by UNOPS through the Foreign Commonwealth and Development Office (FCDO) in-kind procurement. The cabinets will be used for handling of COVID-19 as well as other infectious diseases samples from Rohingya refugees and the host population. Additionally, WHO provided consumable items and equipment to Ukhiya and Teknaf Upazila Health Complexes and blood transfusion centers, such as blood bags, blood transfusion sets, weighing machines, autoclaves, glucometers, and rapid diagnostic test for blood screening. The equipment and consumables will be used to facilitate safe blood transfusion for the Rohingya and host community.

INFECTION PREVENTION AND CONTROL

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

During the reporting period, IPC supportive supervision visits were conducted in two (02) 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, in coordination with Health Sector Partners and the Inter-Sector Coordination Group (ISCG) for the Rohingya response, conducted four Q&A sessions on IPC for humanitarian workers in Cox's Bazar. The sessions were conducted separately in Bangla and English language to ensure comprehension of concepts among the participants and were attended by 145 and 85 IPC focal points, respectively.

Further to this, WHO and the IPC Technical Working Group (IPC-TWG) finalized the pilot implementation of a daily IPC checklist tool and monthly IPC score card in Health Posts (HP), Primary Health Care (PHC) centers, Field Hospitals (FHs) and specialized facilities. A total of five health facilities from the Refugee camps, including one FH, one PHCC, one HP, one Maternity center and one dental care facility, participated in this pilot experience which aims 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.

The formation of IPC structures at the health care facilities is currently ongoing as part of efforts to institutionalize IPC in camps. Currently a total of 115 (84%) health facilities (91 HPs, 23 PHCC and 1 FH) have reported the creation of IPC structures which include IPC focal persons for health posts and IPC committees and focal persons for the primary healthcare centres and the field hospitals. The IPC focal persons and committees will play a pivotal role in planning for IPC activities as well as daily oversight of implementation of IPC in their facilities.

Photo: WHO distributed PPE items in all SARI ITCs and regular supportive supervision visits are conducted by IPC specialists to equip healthcare workers with preventive strategies against further spread of COVID-19

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 10 May 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 ocupancy is currently 27%. 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, 15 beds are occupied.

On 9th May, with the coordination support from WHO and Health Sector, 18 medical doctors from SARI ITCs and ICU/HDU at Cox's Bazar District Sadar Hospital joined the 1st batch of a national level online training on Updated Management and Treatment Protocol for COVID-19 arranged by the Bangladesh Doctors Foundation. Members of the COVID-19 Clinical Management & Guidelines Preparation Committee shared their latest technical knowledge during the training and their clinical experience in the implementation of national guidelines of COVID-19 in hospital settings in Bangladesh.

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.

WHO Immunization and Vaccine Development (IVD) team designed a community preparedness assessment tool to measure the awareness of Rohingya refugees regarding the upcoming COVID-19 vaccination campaign in the camps. This tool will help the Government and partners better implement the risk communications strategy in the field to encourage vaccinations and ensure that no one is left behind. An extensive communication and engagement campaign involving key community members and religious leaders is currently ongoing 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 promotes community mobilization.

Despite the lockdown situation in Cox's Bazar, routine immunization (RI) sessions continue, both fixed and outreach, with WHO's guidance on the operation and sustaining of immunization programs during the COVID-19 pandemic, and a revised strategy and microplan having been reviewed by Government with technical assistance from WHO and other partners based on data collected in 2020. Currently, 59 health facilities are working as immunization fixed sites and another 66 vaccination teams are conducting outreach sessions both in community and healthcare facilities. During the reporting period, the Immunization and Vaccine Development (IVD) team continues monitoring and following up with children who missed their vaccines at the healthcare facilities. WHO Emergency Immunization and Surveillance Officers (e-SIMOs) and Health Field Monitors (HFMs) will conduct house-to-house surveys in the coming days to update the list of vaccination and mobilize parents to bring their children to regular immunization sessions. WHO is continuously monitoring Acute Flaccid Paralysis (AFP) and vaccine-preventable diseases (VPDs) despite the lockdown.

Photo: WHO Emergency Immunization and Surveillance Officers (e-SIMOs) check the registration sheets in all healthcare facilities to follow -up with children who missed their vaccines.

As part of the Non-communicable Diseases (NCDs) program, WHO is supporting the Government to enhance the accessibility to reliable information on NCDs and quality of care for people diagnosed with any Non-communicable Diseases, such as hypertension or diabetes. During the reporting period, a total of 9802 patients from the Rohingya refu-

refugee camps and adjacent host communities of Ukhiya and Teknaf Upazila were diagnosed with Non-communicable Diseases (NCDs) and reported through DHIS-2. Out of the total of patients, 34% were diagnosed with diabetes mellitus, 31% with hypertension and 18% with chronic respiratory diseases. WHO and MOHFW-CC continue conducting feedback session at the health facilities in the camps. In weeks 17 and 18, three (03) Primary Health Care (PHC) centers, one (01) Heath Post and one (01) Union Heath & Family Welfare Center in Ukhiya and Teknaf were visited.

WHO continues supporting Sexual and Reproductive Health (SHR) in the camps. A Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) assessment tool is being developed to improve health service delivery in the SARI ITCs. This tool will help understand the current situation, demands and existent SRH barriers of vulnerable groups such as pregnant and lactating women (PLWs), newborn, child and adolescents during the pandemic. The survey will be conducted in collaboration with several Health Sector working groups such as the Case Management Working Group, Gender in Humanitarian Action Working Group (GiHA WG), Sexual and Reproductive Working Group (SRH WG) and other partners.

During the reporting period, WHO organized three (03) supportive supervision visits in Ukhiya and Teknaf camps to assist staff trained on mhGAP to better integrate mental health services and psychosocial support in primary health care services.

In April 2021, WHO Tuberculosis (TB) field assistants conducted six (06) sessions and visited approximately 300 households to raise awareness on tuberculosis among the Rohingya refugees and the nearby host community. They distributed sputum collection pots and referred suspected TB patients for further evaluation. During the reporting period Medical technologists performed 150 and 100 GXP tests and 90 and 100 routine microscopy tests for TB diagnosis in Ukhiya and Teknaf UHC respectively. Radiographers conducted a total of 40 X-rays including Chest X-rays for referred patients in Teknaf UHC for TB & COVID-19 suspect cases & other respiratory illnesses.

MONSOON AND CYCLONE PREPAREDNESS

The Health Sector, with respective working groups and partners regularly updates its contingency plan for cyclone (March-June) and monsoon (September-November) seasons. Information related to health facility functionality, contingency supplies and locations, mobile medical teams (MMT), ambulance network systems to respond to emergencies and 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 IOM initiated an After-Action Review for the major fire that occurred in the camps on 22nd March in order to assess the Mobile Medical Teams (MMTs) emergency response. In weeks 17-18, several interviews of MMT members deployed during the incident were conducted and the preparation of an assessment report capturing best practices and lessons learnt is currently ongoing. This After-Action Review will help the standardization of future response interventions and it serves to remap the MMTs' intervention areas, so that interested new partners can join for better coverage and response. Capacity building activities will be organized in the next few weeks to capacitate the new and existing MMTs on response procedures based on the learnings from the After-Action Review.

OPERATIONAL SUPPORT AND LOGISTICS

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

To reinforce the public health response to COVID-19, WHO supported partners in Cox's Bazar, including the UN Clinic, MSF, Hope Foundation, BDRCS and the Turkish Field Hospital with the delivery of 50 pulse oximeter, 34 infrared thermometers and over 100.000 Personal Protective Equipment (PPE) items, including isolation gowns, gloves, boots, face shields and surgical masks.

During the reporting period, a total of 5.74 MT total volume 38.71 Cubic meters of Medicines 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. Further to this, WHO in Cox's Bazar brought four oxygen concentrators to WHO Country Office in Dhaka in case of emergency support.

SUBJECT IN FOCUS: Responding to a pandemic in a refugee camp: the key role of contact tracing to break the chains of COVID-19 transmission

Because outbreaks are frequently characterized by uncertainty, early detection and timely response mechanisms to break the chains of transmission are critical to protect vulnerable and most-at-risk populations.

Context

In health emergencies, the mission of the World Health Organization is to support countries to coordinate actions to prevent, prepare for, detect, rapidly respond to, and recover from outbreaks and emergencies. In Cox's Bazar, after three years successfully averting disease outbreaks such as Measles, Diphtheria and Cholera, the public health imperative is to control COVID-19 as quickly as possible in order to minimize morbidity, mortality and other social and economic impacts that may compromise important health outcomes.

Under the overall supervision and coordination from WHO, camp-wise Rapid Investigation and Response Teams (RIRT) have been responding to alerts within 24 hours and referring COVID-19 patients to SARI ITCs with the help of the Dispatch and Referral Unit (DRU), in an effort that has been instrumental to slow down the spread of the virus in the world's largest refugee camp.

Surveillance and Outbreak Investigation

According to WHO, contact tracing is the process of identifying, assessing, and managing people who have been exposed to a disease to prevent onward transmission.

Since the onset of the pandemic, contact tracing has become a key strategy for interrupting chains of transmission of SARS-CoV-2 and reducing COVID-19-associated mortality. Governments and partners all over the world have been implementing public health strategies focused on identifying, educating and monitoring individuals who have had closed contact with the virus.

In the complex setting of the Rohingya refugee camp, the impact of the pandemic was expected to vastly overwhelm the capacity of the existing health services and compromise important outcomes achieved in the four year of the humanitarian response. Given this scenario, WHO in close coordination with the Government of Bangladesh and other key health partners immediately started a surveillance and outbreak investigation response for the effective planning, monitoring and evaluation of COVID-19 in Cox's Bazar.

Contact tracing and Case Investigation in the Rohingya refugee camps

Over the past three years, disease surveillance and outbreak investigation has been paramount to collect information on mortality and morbidity with an acceptable degree of precision and accuracy for the effective planning, monitoring and evaluation of disease control programmes in Cox's Bazar.

In preparation for the COVID-19 surveillance response, site-level surveillance SOPs were prepared outlining the surveillance strategy in line with a risk assessment for the COVID-19 response. In addition, existing syndromic surveillance of ARI data and sentinel testing of ARI cases have also been incorporated in the surveillance system response in order to strengthen surveillance and testing among refugees.

The WHO Epidemiology Team, in collaboration with the Ministry of Health and Family Welfare (MoHFW) and Health Sector partners in Cox's Bazar, established Rapid Investigation and Response Teams (RIRTs) to conduct investigations and public health response to COVID-19 cases in the camps. These teams consist of one RIRT coordinator (from health sector partners/CHFP), one contact tracing supervisor and one site management sector focal person. The contact tracing network at the Rohingya refugee camps is comprised of 34 supervisors, 311 volunteers and nine WHO Camp Health and Disease Surveillance Officers (CHDSOs).

Photo: The Rapid Investigation and Response Teams' conduct house-to-house visits to identify individuals with symptoms associated with COVID-19 and refer them to the nearest healthcare facilty.

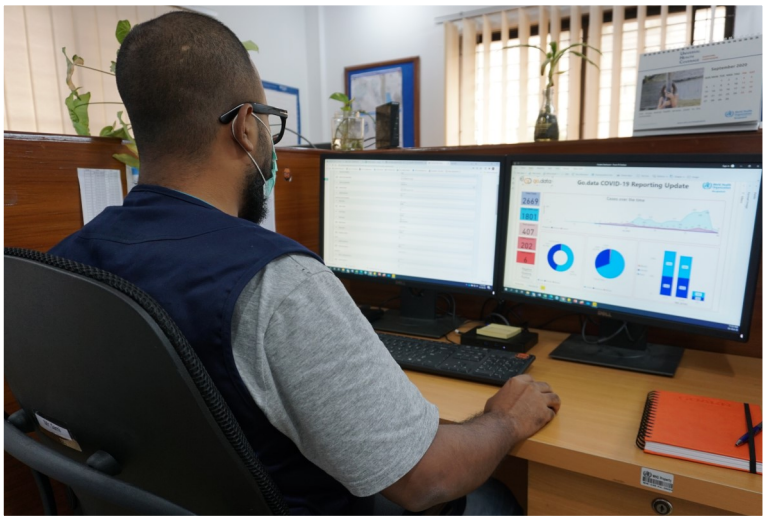


Photo: Go.data generates daily contact follow-up lists which enable a comprehensive visualization of chains of transmission of COVID-19 and other diseases in Cox's Bazar

The Rapid Investigation and Response Teams' role focuses on identifying individuals with symptoms associates with COVID-19 and to refer them to Severe Acute Respiratory Infection Isolation and Treatment Centers (SARI ITCs) established in the camps with the help of the Dispatch and Referral Unit (DRU). Additionally, RIRTs help define and identify possible contacts, while supporting the governments public health strategy by engaging with communities and providing technical support to local authorities in case of suspected or confirmed COVID-19 deaths.

In the last year, under the overall supervision and coordination of WHO, camp-wise Rapid Investigation and Response Teams (RIRTs) have been responding to alerts within 24 hours, becoming instrumental to slow down the spread of the virus in the world's largest refugee camp.

Go.data: managing data in disease outbreaks

Go.Data is an outbreak investigation tool for field data collection during public health emergencies. The tool includes functionality for case investigation, contact follow-up, visualization of chains of transmission including secure data exchange and is designed for flexibility in the field, to adapt to the wide range of outbreak scenarios.

Go.data was launched in 2019 in Cox's Bazar having played an important role throughout 2020 on COVID-19 outbreak investigation in the refugee camps. As for the existing EWARS system, the platform ensured surveillance to other diseases in Cox's Bazar for appropriate early response to other potential outbreaks.

RIRTs performance

To date, a total of 541 (out of 579) COVID-19 confirmed cases have been investigated by RIRTs. Out of the total of 1,990 contacts registered in Go.data, 1,624 (82%) have successfully completed their follow-ups. As of 2 May 2021, 26 (1.6%) contacts have become cases during their follow-up period. No geo cluster, except household-level clusters, could be mapped in the Rohingya refugee camps and the average number of contacts per case is ~4.

Despite the strong performance achieved by the RIRTs, WHO is closely supporting and supervising them in order to address common challenges around quality of data, technical skills, poor network in camps, and proper community engagement skills, among others.

Infection Prevention and Control (IPC) protocol

Ensuring the safety of all the individuals involved in the surveillance and case investigation network is crucial to ensure the proper functioning of the Rapid Investigation and Response Teams. In this regard, all RIRTs strictly adhere to WHO Infection Prevention and Control (IPC) protocols to maintain preventive measures and reduce the risks of getting infected. Further to this, the network is supported with the supply of appropriate Personal Protective Equipment (PPE) and regular health check-ups by the assigned medical supervisor. WHO draws particular attention on IPC Guidelines in case of contact with any suspected or confirmed case.

Training

Since the beginning of the COVID-19 outbreak a significant number of trainings (online and in-person) has been organized and conducted related to COVID-19, including for other diseases' surveillance, outbreak investigation and relevant data management (EWARS and Go.Data) in order to keep participants oriented and refreshed on the topics and to effectively respond to the COVID-19 emergency.

WHO arranges periodical trainings on Go.data for all the contact tracing supervisors in the camps. Moreover, CHDSOs provide regular supportive supervision to all the supervisors and volunteers at camp level to ensure the quality of contact tracing process and data management. Under the coordination of the WHO Epidemiology Team, biweekly COVID-19 contact tracing meetings aim to enhance the case investigation through information sharing and experts' opinions

	Last 24 hours	Total
COVID-19 tests conducted	15296	5 677 222
COVID-19 positive cases	1140	777 397
Number of people released/recovered	2928	718 249
COVID-19 deaths	40	12 045

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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