







PHOTO: Cox's Bazar Civil Surgeon, Dr Md. Mahbubur Rahman, and WHO Representative in Bangladesh, Dr Bardan Jung Rana, visited host community sites in Cox's Bazar where the national vaccination Measles/Rubella campaign is taking place.

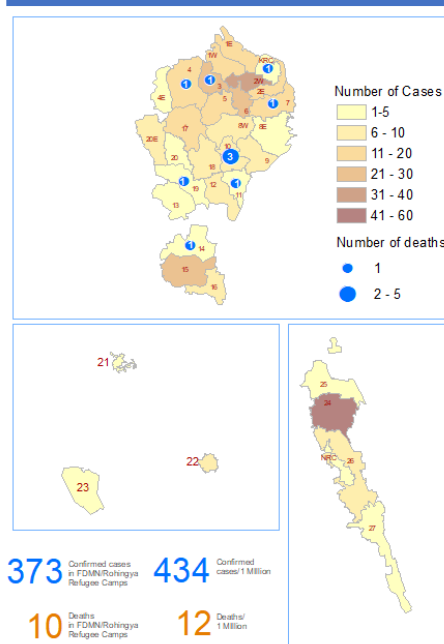
HIGHLIGHTS

- WHO together with UNHCR developed a roadmap to support the implementation of mental health and psychosocial support services at 250 Bed District Sadar Hospital in Cox's Bazar with additional focus given to the Sadar Hospital ICU. To that end, WHO will facilitate two rounds of mhGAP trainings for all doctors and nurses working at the ICU and HDU.
- The IPC Technical working group held its first meeting of 2021 where WHO emphasized the need to institutionalize IPC in the healthcare system for improved quality of health services in the camps and host community within and beyond COVID-19 pandemic. This is in line with national IPC guidance as indicated by the Civil Surgeon in Cox's Bazar and will ensure the sustainability of IPC interventions in the partner and government run facilities in the district.
- The refurbishment work of the Blood Transfusion units at Ukhiya and Teknaf Health complexes, which were newly established with the support of WHO, has been completed. This is part of the steps in increasing availability of blood, and lifesaving commodities while dealing with shock due to excess bleeding, obstetric haemorrhages during child birth, among others.
- **SUBJECT IN FOCUS:** Conducting a COVID-19 seroprevalence study in a large refugee camp setting.

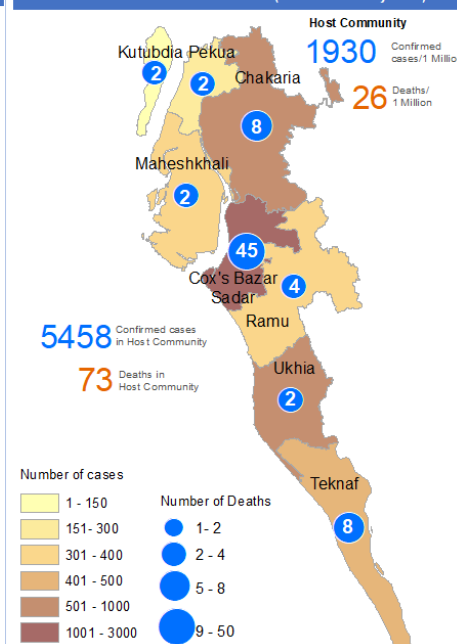
	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	5 458	373
 Total cases in isolation in Cox's Bazar	23	5
 Total number of tests conducted	52 181	25 281
 Total deaths due to COVID-19	73	10

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, a total of nineteen (19) camp level Health Sector partners coordination meetings were held at Ukhiya and Teknaf Upazilas; and a briefing on the work of Health Sector was provided to new Camp-in-Charges (CiCs) in Camp 3 and Camp 23. In order to ensure compliance with the extensive rationalization exercise that was conducted in 2019 to avoid overlaps in health service provision in facilities operating at the Rohingya refugee camps, the Health Sector continues to provide gap analysis situation to the partners. The latest gap analysis indicates that of the targeted 47 PHCs in the camps, there is a gap of 2 and 11 HPs of the 67 targeted in the camps. Following the Maternal and Perinatal Death Surveillance Review (MPMSR) meeting that took place in December 2020 and subsequent discussion during the last Health Sector coordination meeting, it was decided that the sector in collaboration with Sexual and Reproductive Health (SRH), Community Health (CH) and Epidemiology (Epi) Working Groups will join combined efforts to streamline mortality surveillance and reporting and implement the recommendations that resulted from the MPMSR meeting.

COVID-19 Cases in Rohingya Camps (As of 17 January 2021)



COVID-19 Cases in Cox's Bazar District (As of 17 January 2021)



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 17 Jan 2021, a total of 5458 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 536 in Chokoria, 105 in Kutubdia, 355 in Maheshkhali, 218 in Pekua, 390 in Ramu, 2850 in Sadar, 442 in Teknaf and 562 in Ukhiya.

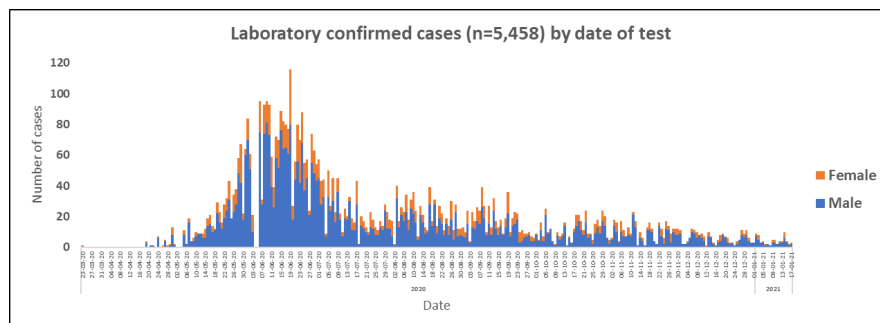


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

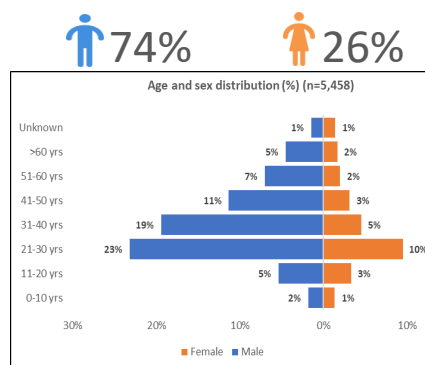


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

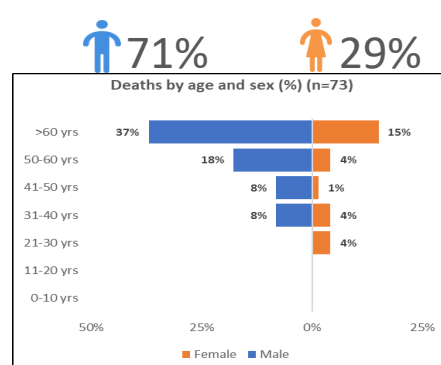


Figure 3: COVID-19 deaths by age and sex among host population in Cox's Bazar

As of 17 January 2021, a total of 373 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 54 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 37 and Camps 3 and 15 with 27 and 25 cases respectively. To date, 22 cases were reported from Camp 6, 20 from Camp 2E and 16 from Camp 4. Camps 1W, 7 and 13 had 12 cases each. Camps 1E and 5 registered 11 cases each and Camp 10 identified 10 cases while Camps 18, 22 and 26 reported 9 cases. As for Camps 9 and 16, were reported 8 cases. Camp 12 registered to date 7 cases. Camps 8W and 20 Extension identified 6 cases and Camps 11, 19, and Nayapara RC identified 5 cases. The remainder Camps (Kutupalong RC, 4 Extension, 8E, 14, 20, 21, 23, 25 and 27) had so far less than 5 cases.

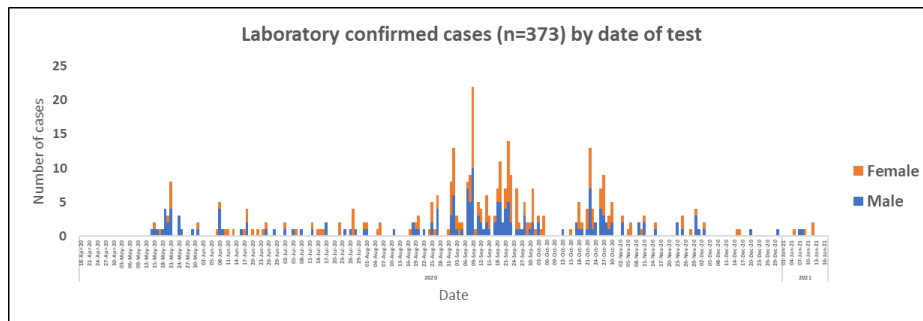


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

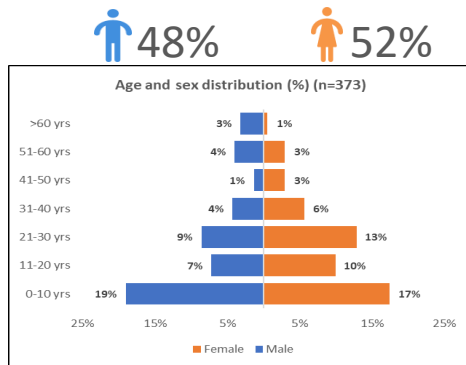


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox's Bazar

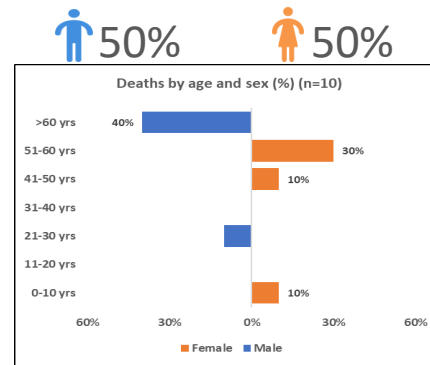


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox's Bazar

Between weeks 1-2, four (04) new confirmed cases were detected from 1973 samples tested, the test positivity is 0.3%. As of 17 January 2021, the cumulative incidence is 43.4 per 100 000 people. The overall positivity of samples tested is 1.5%. Among the cases, 5.5% showed severe symptoms at the time of admission while the same 7.7% reported at least one co-morbidity. In total, 10 deaths were reported in the camps due to COVID-19 with case a fatality rate of 2.7%. A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) has been embedded in the RIRT for COVID-19. A total of 346 confirmed cases (out of 373 to date) have been investigated by Rapid Investigation and Response Teams (RIRTs) during the reporting period, with contact tracing activities being conducted and captured through Go.data, including the 1355 (97.4%) contacts to be followed up. Out of these, 1143 (84.3%) contacts have seen their follow up visits completed and were released from quarantine. Thirteen contacts (1.3%) became confirmed cases during the follow up period. WHO is closely supporting contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

Two new Cholera RDT positive cases were reported between weeks 1-2. Since October 2020, a total of 20 RDT positive cases were detected through Cholera sentinel testing. Among these, three became confirmed by culture for Cholera, one of each from Ukhiya Host Community, Teknaf Host Community and refugee camps. The remaining tested negative under culture. In 2021, two AWD RDT positive for Cholera cases were verified and two JAT investigation were conducted and are currently waiting for culture result. Diphtheria surveillance is ongoing in the camps since the onset of the outbreak in 2017. The total number of diphtheria cases reported is 9191 to date; 3016 in 2017; 5334 in 2018; 617 in 2019; 226 in 2020 and 5 in week 1-2 of 2021. In total, 8949 cases were reported from Rohingya Refugees/ FDMN and 241 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.

Mortality investigations for SARI, Measles, Cholera, Diphtheria etc. are ongoing in Cox's Bazar. Between weeks 1-2, five suspected SARI death have been investigated by RIRT. A total of 53 suspected SARI deaths were reported to date, all were verified and 44 qualified for detailed investigation. Three (03) deaths were confirmed and probable of COVID-19 and responded to accordingly. Additionally, alerts on four (04) deaths due to suspected AWD with severe dehydration and three (03) deaths from suspected Measles were received in 2020 through mortality surveillance.

EWARS supportive supervision for health facilities is ongoing. So far, 130 out of 146 health facilities have been visited and surveillance assessment finalized. Overall findings from the supportive supervision and recommendations will be shared through a report in early February 2021.

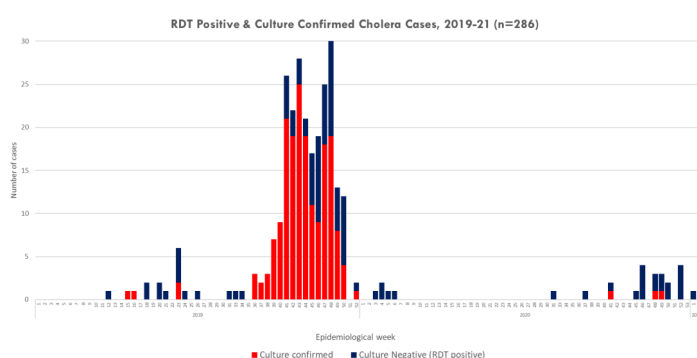


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-20

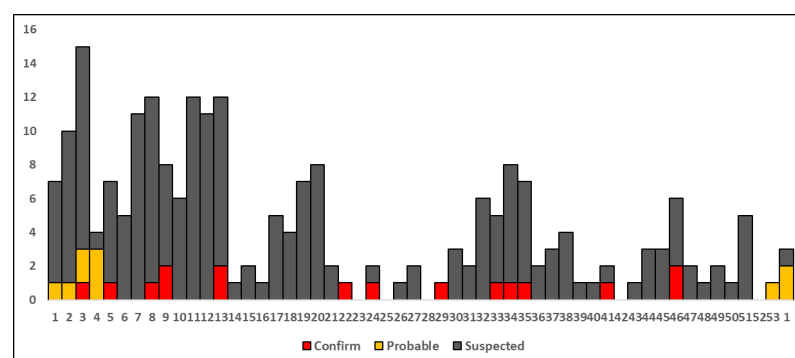


Figure 8: Total number of diphtheria case reported in EWARS from 2020/ 2021.

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, etc. WHO, through its involvement in the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), 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 inputs on the Information, Education and Communication (IEC) materials developed by UNICEF on the Use of Mask by Rohingya refugees taking in consideration the available resources in the camps. This is in response to the needs identified through the COVID-19 perception survey (2020) and aims to increase awareness about the appropriate use of mask. In addition, WHO and UNICEF provided English and Bangla versions of the weekly radio script on COVID-19 confirmed cases and number of tests conducted among refugee and host communities. The messages were shared with partners and the COVID-19 update news has been broadcasted through Bangladesh Betar (state owned radio) and Community Radio Naf 99.2fm. During the reporting period Community Health Workers (CHWs) conducted 313 021 household visits in which 7070 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 26 patients with moderate/severe symptoms. The cumulative number of mild patients is 87 009, and 286 moderate/ severe patients. To date, 37 724 persons with COVID like symptoms were referred to health facilities, 3124 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 605 494 persons between 4-17 January 2021. Since the beginning of the response, CHWs have conducted more than 5.1 million household visits and had contacts with a cumulative number of more than 14.6 million adult household members. Through the CwC WG, another 82 481 people were engaged in 25 884 small group sessions.

DISTRICT LABORATORY

WHO continues its support to the Field Laboratory of the Institute of Epidemiology, Disease Control and Research (IEDCR) in the Cox's Bazar Medical College comprising human resources, equipment, supplies/consumables and technical and operational expertise. Since early April 2020 until 17 January 2021, a total of 90 914 tests for COVID-19 have been conducted of which 77 462 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 01-02 as compared to weeks 52-53 from 1620 to 1883 tests, and a slight decrease in the host community population from 2816 in weeks 52-53 to 2795 tests in weeks 01-02. Currently, 26 sample collection sites are operating for suspected COVID-19 patients.

The IEDCR Field Laboratory is playing a key role in the COVID-19 seroprevalence study through testing and analyzing the 3699 blood samples collected in the camps for the presence of antibodies against SARS CoV-2. During the reporting period the testing of the samples has been completed and the results of the survey will be made available through IEDCR, Dhaka and the Government of Bangladesh (GoB). The expansion work at the Field Laboratory is currently in progress including serology and molecular biology laboratory and generator room. This will enable increased sample testing capacity and human resources; as well as compliance with standard requirements. The refurbishment work of the Blood Transfusion units at Ukhiya and Teknaf Health complexes, which were newly established with the support of WHO has been completed. This is part of the steps in increasing availability of blood, and lifesaving commodities while dealing with shock due to excess bleeding, obstetric haemorrhages during child birth, among other conditions. In support to strengthening laboratory capacity for Sadar Hospital, WHO and UNHCR together with the hospital's management held an inception meeting to discuss priorities for system wide support which could include procurement of selected equipment, space allocation for new laboratory at Sadar Hospital ICU, including supplies, reagents and human resources (as needed), among others.

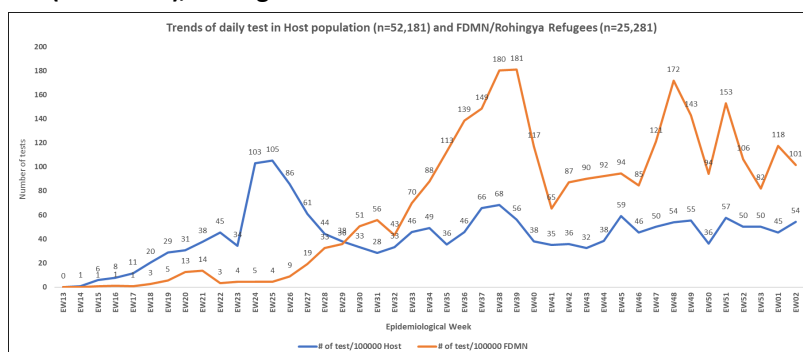


Figure 9: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees

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 2390 humanitarian health care workers and government staff from Severe Acute Respiratory Infection (SARI) ITC partners and government facilities. During the reporting period, the IPC Technical working group held its first meeting of 2021 where WHO emphasized the need to institutionalize IPC in the healthcare system for improved quality of health services in the camps and host community within and beyond COVID-19 pandemic. This is in line with national IPC guidance as indicated by the Civil Surgeon in Cox's Bazar and will ensure the sustainability of IPC interventions in the partner and government run facilities in the district.

WHO with UNICEF provided support to the Department of Public Health Engineering to conduct the second round of Water Quality Surveillance (WQS) in the refugee camps in Cox’s Bazar to monitor the water quality and sanitary risk of drinking water at source including storage at community level, learning centres, health care facilities and pipeline water. A training on Health Care Waste Management (HCWM) for health workers in priority health facilities was discussed and concurred by the Civil Surgeon’s Office and is estimated to take place in February targeting 90 HCWs from 45 WB funded health facilities in a total of five batches. Supportive supervision visits and mentoring was undertaken for three government and partner supported health facilities in the camps to enhance the effective management of health care waste. Onsite recommendations as well as technical advices were provided to the respective facility management during the visit.

CLINICAL CASE MANAGEMENT

Since the onset of the outbreak, WHO is coordinating regular weekly specialist 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 chance for survival of patients in Cox’s Bazar. During the reporting period, two case conferences for SARI ITC and two case conferences for ICU were conducted.

As of January, the number of operational and stand by beds have changed with one SARI ITC having closed down and another reducing its operational beds while keeping stand by capacity on site. Currently there are therefore 14 operational SARI ITCs in the camps with a total of 510 functional beds open and 411 on stand by. The SARI ITC bed occupancy is currently 57. At the 250 Bed District Sadar Hospital, the Intensive Care Unit (ICU) has 10 beds while the High Dependency Unit (HDU) has 10 beds and the Severe Care Unit (SCU) 20 beds functional beds. As the moment, five beds are occupied in the ICU, five beds are occupied in the HDU while three beds are occupied in the SCU.

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 centres (PHCs), 97 Health Posts (HPs), 23 special facilities and three field hospitals.

The number of consultations at the health facilities operating at the refugee camps decreased considerably between April-July 2020 due to restrictions on movement and fears of the coronavirus. However, a steady increase was observed between August-December 2020. As of December 2020, there were 2.77 consultations per person as compared to 3.36 in January 2020. During the reporting period, together with implementing partners in the refugee camps WHO provided technical inputs to the maternal death review process which is facilitated by UNFPA. In addition, WHO provided technical inputs to the maternal health and nutrition service integration pilot envisaged by UNHCR for their implementing partners to be rolled out in priority health facilities. WHO will organize a new round of mhGAP trainings for health care professionals in Cox’s Bazar in the coming weeks starting on 25th January for health care workers in the camps and government facilities targeting 30 participants. WHO together with UNHCR developed a roadmap to support the implementation of mental health and psychosocial support services at 250 Bed District Sadar Hospital in Cox’s Bazar with additional focus given to the Sadar Hospital ICU. To that end, WHO will facilitate two rounds of mhGAP trainings for all doctors and nurses working at the ICU and HDU. The plan includes two rounds of training starting on 31st January and 14th of February targeting 27 doctors and 37 nurses. The training will be organized and financed by UNHCR. WHO has organized multiple supportive supervision sessions in the field for continued capacity building of health care professionals who were trained on mhGAP to better integrate the mental health services in primary health care services. This initiative will help WHO reach the goal to train at least one clinician on mhGAP covering each of the PHCs at camp level to better integrate mental health and psychosocial support services in primary health care systems. WHO with MOHFWCC conducted supportive supervision visits to nine (09) health care facilities following trainings held in late 2020. Facilities were supported on the use of the Cardio Vascular Disease (CVD) risk Charts, essential medicines access and availability and clinical practices in line with national protocols on the management of Diabetes and Hypertension.

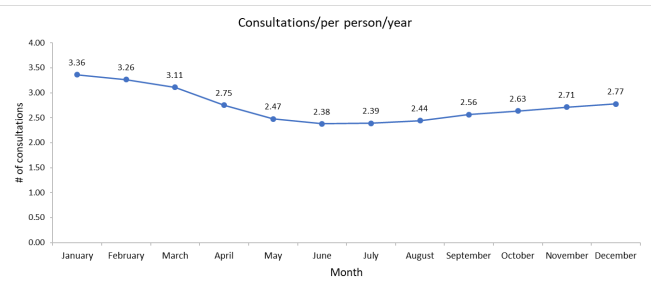


Figure 10: Number of consultations per person in the refugee camps in 2020.

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 implemented. To strengthen the Routine Immunization and Vaccine Preventable Disease (VPD) surveillance through reorganizing the vaccination sites and sessions, the Micro plan for Routine Immunization 2021 is going to be reviewed by Government with technical assistance from WHO and other partners based on data collected in 2020. During the reporting period, IVD SIMOs have completed the Basic EPI refresher training for 250 vaccinators and supervisors. Session monitoring and House to house monitoring of RI continues to be ensured by IVD teams. Vaccine-Preventable Disease surveillance is being closely monitored by government authorities with WHO's technical support. WHO teams continue to visit health facilities for surveillance, monitoring and investigation to contribute to the National Acute Flaccid Paralysis (AFP) & VPD surveillance system.

*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.

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 to the Emergency Preparedness and Response Working Group, revisited the Health Sector Preparedness and Response Plan to Monsoon and Cyclone and updated the Incident Command System of Cox's Bazar envisioned to respond to monsoon and cyclone emergencies, including the Terms of Reference of medical hubs. This updated plan will be shared with the Emergency Preparedness and Response Working Group for their inputs and validation.

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. During the reporting period, a total of 468.69 Kg and 31.10 Cubic meters of Medicines, Viral Transport Medium (VTM) for diagnosis of COVID-19, Gender Based Violence (GBV) stationary and medical equipment were distributed to implementing partners in the camps. WHO received 725.62 Kg of medicine, kits received in this period purpose of gap filling, training and strengthening support to the Rohingya refugees. A total of 50 Oxygen generators were provided to the Friendship Hospital. WHO continues its support to the sample collection in the camps with two vehicles. The refurbishment work for the blood transfusion centres in Ukhiya and Teknaf UHC is in progress with 95% of the work completed. Refurbishment and construction works for the expansion of the IEDCR field laboratory is in progress. WHO is supporting partners to ensure storage of 400 000 cloth masks.

POINTS OF ENTRY

Twelve out of 19 points of entry (PoE) have been functional in different strategic locations around the camps. A total of 70 686 individuals have been screened during the aforesaid reporting period. Staff continue to support the identification of febrile passengers and pedestrians whilst providing hygiene education related to COVID-19 health awareness and referring patients to nearby health facilities for medical assessment when having fever.

SUBJECT IN FOCUS: Conducting a COVID-19 seroprevalence study in a large refugee camp setting

The densely populated Cox's Bazar refugee camps have had confirmed COVID-19 cases since May 2020. Initial modelling predicted large numbers of infections within a short amount of time, yet PCR testing has confirmed only 373 cases to date. A seroprevalence study, undertaken in December 2020 and January 2021 by the Government of Bangladesh (GoB) with WHO support aims to investigate and find out the proportion of the population living in the camps who have been infected with COVID-19.

Context

With nearly 65 000 residents per square kilometer in some of the camps, the Rohingya camp settlement in Cox's Bazar is extremely densely populated. As such, early modelling projections from renowned academic institutions suggested that a large-scale COVID-19 outbreak was likely to take place in the world's largest refugee camp with over 90% of the Rohingya population estimated to become infected within the first months and thousands per day requiring hospitalization.

However, while Cox's Bazar presented an environment where the virus could spread rapidly - considering the densely populated and fragile setting where traditional measures to contain the virus aren't feasible - nine months since the first Rohingya patient was found positive for COVID-19, laboratory testing indicates that to date 373 refugees have tested positive for COVID-19 and 10 have died.

In search of coronavirus' antibodies

To understand more about the transmission of SARS CoV-2 in the refugee camps, the Bangladesh Institute of Epidemiology and Disease Control Research (IEDCR) with support from WHO, UNHCR and partners, the Bangladesh Red Crescent Society (BDRCS) and the UK Public Health Rapid Support Team (UKPHRS/LSHTM), conducted a seroprevalence study in all 34 camps to identify antibodies to the causative agent of COVID-19.

Serologic tests measure the antibody response in an individual. The presence of antibodies indicates that a person was infected with the COVID-19 virus, irrespective of whether the individual had severe or mild disease, or even asymptomatic infection. Surveillance of antibody



Photo: Dr Fahmida Sultana, a supervisor from BDRCS and Nahida, a data collector from Food for the Hungry (FH), at Sheikh Hasina's shelter at the Rohingya refugee camps.

seropositivity in a population can help understand the extent of the infection. Seroprevalence studies have been undertaken since the beginning of the COVID-19 pandemic in many WHO member states. Prevalence of antibodies has varied greatly across these studies, from very low prevalence, to a prevalence of over 80% indicated in one Iranian city. A large seroprevalence study conducted in Mumbai, published in November 2020 showed a prevalence after reweighting of over 54% in densely populated slum areas.

In Cox’s Bazar, the seroprevalence study aims to ascertain the population-level exposure to SARS-CoV-2 across the Rohingya refugee camps. To that end, trained teams are visiting randomly selected households and collecting a blood sample from one member of each family household. Based on WHO’s “UNITY protocol” for standardized sero-epidemiological investigations, the study aims to provide evidence-based information for the planning of the COVID-19 response in 2021. In addition, the study will also provide valuable lessons for a nationwide seroprevalence study, which will be undertaken shortly.

Planning a seroprevalence study in a large refugee camp setting

In preparation for the seroprevalence study in Cox’s Bazar, the Institute of Epidemiology and Disease Control Research (IEDCR) and the World Health Organization (WHO) conducted a training for 116 staff of the data and sample collection teams and organized sensitization sessions in the Rohingya refugee camps engaging Government and community representatives, including female leaders, Imams and Majhis to prepare the populations for informed and voluntary participation in the study.

To support the seroprevalence study, WHO coordinated daily operations, having distributed the necessary supplies to field teams (including PPE and sample collection tools), supported the IEDCR Field Laboratory and monitored data in real time as it was collected from teams.

Sample collection and data collection took place between 2-30 December 2020. Each household was asked a series of questions, including household composition, symptoms in past months, pre-existing conditions, among others, after which a blood sample was collected from a pre-identified member of the household. In total, 3699 blood samples were collected from 5411 households. The samples were then transported to the IEDCR Field Laboratory in Cox’s Bazar, where they have been tested using total antibody testing through ELISA kits (Wantai).



Photo: Sample collection from Rohingya participating voluntary was concluded on the 30th December 2020. The results will be guide important public health decisions for the new year.

Expected Outcomes

WHO is currently supporting IEDCR in conducting data analysis to inform necessary public health action in the field and provide lessons for similar contexts. The main outcome will be the measurement of seroprevalence of antibodies to SARS CoV-2 in the camp population to understand the cumulative population exposure to SARS CoV-2.



Photo: The COVID-19 seroprevalence study was launched at a coordination meeting on November 29th allowing partners, including Government representatives, to share their views on the best way forward to successfully conduct the COVID-19 seroprevalence study in Cox’s Bazar.



Photo: WHO Head of Sub-Office, Dr Kai von Harbou, with IEDCR Principal Scientific Officer Dr Asm Alamgir; and Additional Director General DGHS, Dr Meerjady Sabrina Flora, at the seroprevalence study coordination meeting.

	Last 24 hours	Total
COVID-19 tests conducted	15 097	3 470 257
COVID-19 positive cases	702	529 031
Number of people released/recovered	682	473 855
COVID-19 deaths	20	7942

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