







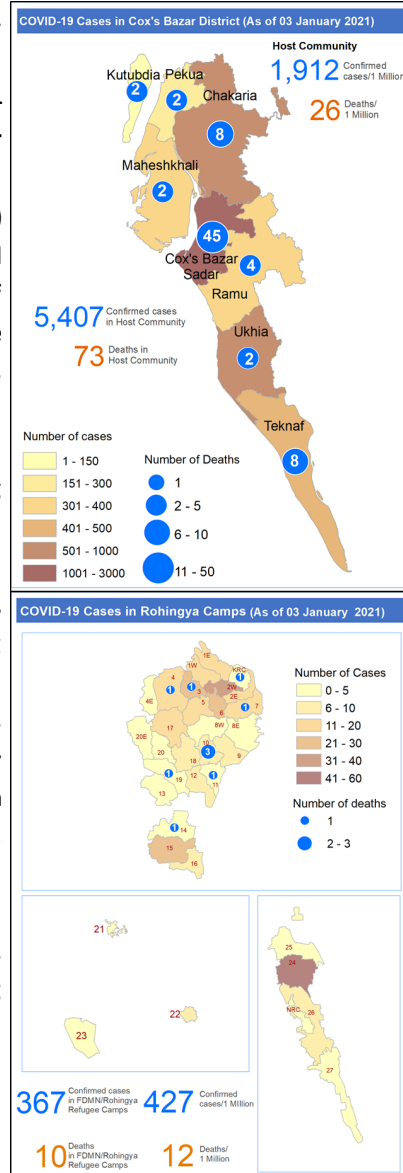
PHOTO: The COVID-19 Seroprevalence Study was concluded on 30 December 2020. The findings of the first seroprevalence study in Bangladesh will provide important information for the future provision of healthcare services across the camps.

HIGHLIGHTS

- During the reporting period, the sample collection for a COVID-19 seroprevalence study was completed, with a total of 3699 blood samples having been collected in the Rohingya refugee camps. Blood samples collected will be analyzed for the presence of antibodies against SARS CoV-2 (total antibodies) in the WHO supported IEDCR Field Laboratory in Cox's Bazar. The testing of the samples has started and will be completed by early January 2021.
- The Health Sector through the Sexual and Reproductive Health (SRH) Working Group conducted a follow-up meeting on Maternal and Perinatal Mortality Surveillance and Response (MPMSR) and decided upon a rapid assessment of continuation of SRHR services, to ensure 24/7 emergency referrals and to develop strategies to enhance community mobilization and sensitization for uptake of SRH services.
- WHO and partners have established - and further strengthened through trainings on emergency care - a referral pathway to allow for the safe transfer of critically ill COVID-19 patients to the newly established Intensive Care Unit (ICU) at the Cox's Bazar District Sadar Hospital.
- **SUBJECT IN FOCUS:** Breaking the chains of COVID-19 transmission: the key role of Camp-wise Rapid Investigation and Response Teams in Cox's Bazar

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	5 407	367
 Total cases in isolation in Cox's Bazar	18	1
 Total number of tests conducted	49 386	23 398
 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, the COVID-19 seroprevalence study was completed (30 December 2020), with a total of 3699 blood samples having been collected in the Rohingya refugee camps. Blood samples collected will be analyzed for the presence of antibodies against SARS CoV-2 (total antibodies) in the WHO supported IEDCR Field Laboratory in Cox's Bazar. The testing of the samples has started and will be completed by early January 2021. The Civil Surgeon has approved the 2020 Minimum Package of Essential Health Services for Primary Health Facilities for use in the Cox's Bazar Rohingya camps by the Health Sector partners. A Traditional Birth Attendant (TBA) guidance note was also approved and has been circulated to health partners. Operationalization of the principles outlined in the guidance note will ensure better use of TBA's as a supportive workforce. A total of nineteen (19) camp level Health Sector partners coordination meetings were held at Ukhiya and Teknaf Upazilas during the reporting period. Upazila level coordination meetings were held in Ukhiya and Teknaf last week. Two Upazila level Health Sector coordination meetings were held at Ukhiya and Teknaf with the participation of 35 partner agencies in both meetings. Among the issues discussed were partners' updates, key challenges, achievement and areas requiring support, strengthening coordination, collaboration and liaison among partners and government authorities. In the year 2020, a total of 25 health coordination meetings were held at district level, 18 at Upazila level and 305 at camp level. The sector also participates in meetings conducted by Upazila Nirbahi Officers (UNOs) in both Ukhiya and Teknaf Upazilas. The Health Sector through the Sexual and Reproductive Health (SRH) Working Group conducted a follow-up meeting on Maternal and Perinatal Mortality Surveillance and Response (MPMSR) on 22 December 2020. It was agreed that: a rapid assessment of continuation of SRHR services and current status of the facilities will be conducted; a the 24/7 Comprehensive Emergency Obstetric and Newborn Care (CEmONC) rotational plan for the camp facilities will be formulated, it will be ensured that contact details of the focal points for EMOnc are provided to all Basic emergency obstetric and newborn care (BEmONC) and CEmONC sites and the field hospital coordination meeting platform will be revived to improve the coordination for 24/7 emergency referrals; and finally practical strategies to enhance community mobilization and sensitization for improved awareness and uptake of SRH services will be put in place Progress against these agreed directions will be reported regularly.



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 03 Jan 2021, a total of 5407 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 533 in Chokoria, 105 in Kutubdia, 349 in Maheshkhali, 217 in Pekua, 380 in Ramu, 2825 in Sadar, 438 in Teknaf and 560 in Ukhiya.

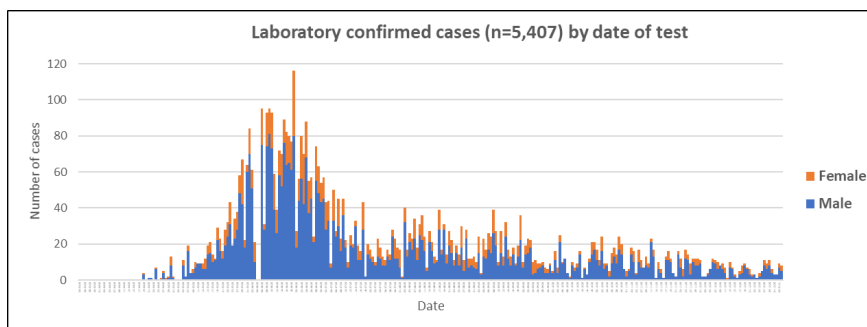


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

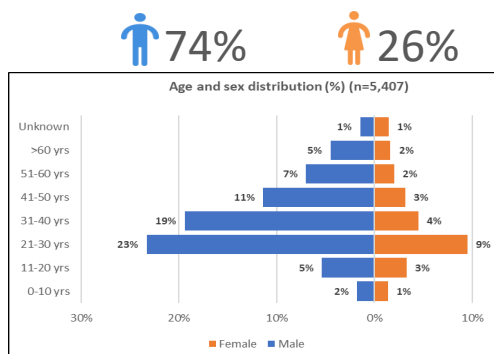


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

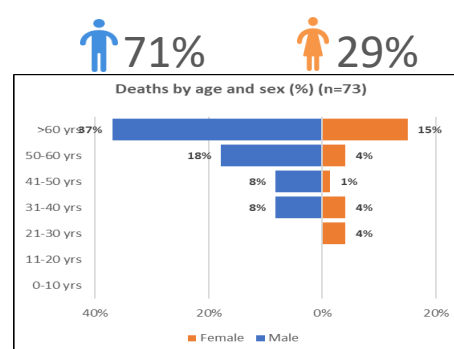


Figure 3: COVID-19 deaths by age and sex among host population in Cox's Bazar

As of 03 January 2021, a total of 367 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, 18 from Camp 2E and 15 from Camp 4. Camps 1W, 7 and 17 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, 8 cases were reported. Camp 12 registered to date 7 cases. Camps 8W, 11, 19, 20 Extension and Nayapara RC identified 5 cases. The remainder Camps (Kutupalong RC, 4 Extension, 8E, 13, 14, 20, 21, 23, 25 and 27) had so far less than 5 cases.

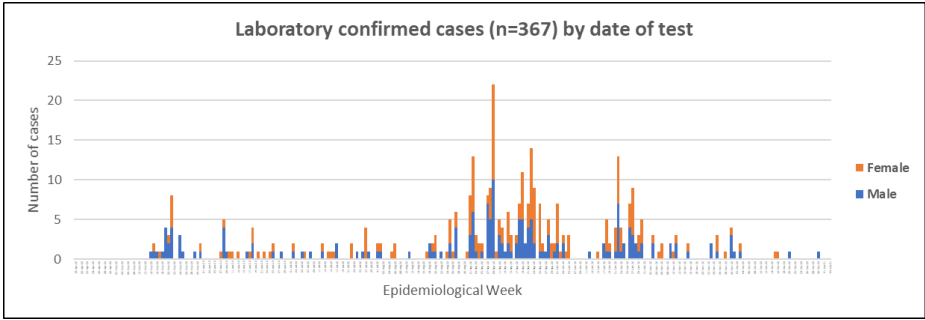


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

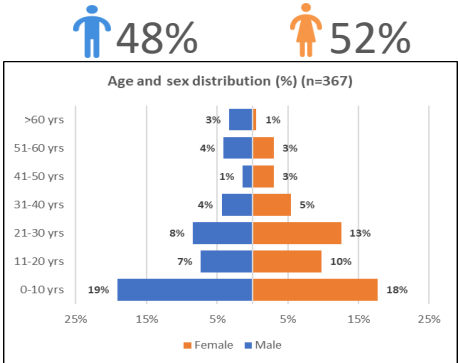


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

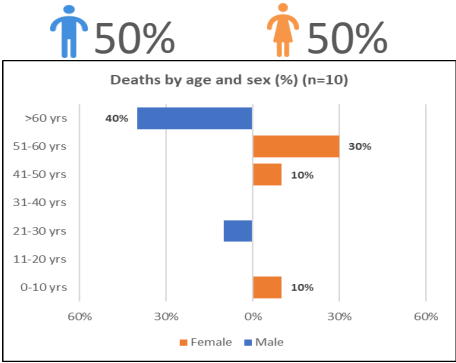


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox’s Bazar

Between weeks 51-53, four (4) new confirmed cases were detected from 2936 samples tested, the test positivity was 0.1%. As of 03 January 2021, the cumulative incidence is 42.7 per 100 000 people. The overall positivity of samples tested is 1.6%. Among the cases, 7.7% 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 fatality rate of 2.7%. Although the median age of tested samples is 10 years, a significant proportion has been tested among 40+ years (258 per 10 000 people), however the highest number with 394 tests per 10 000 people is among patients aged 0-9 years. The test positivity was highest in the 30-39 age cohorts with 2.3% and then the 40+ age cohort with 2.1%. The age specific mortality was highest among 50+ years with 0.9% per 10 000 people. Currently, 26 sample collection sites are operating for suspected COVID-19 patients. A decrease in the number of tests conducted among the Rohingya refugees was observed on week 53, from 914 to 706 tests and remains the same in the host community population from 1407 to 1409. A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) have been embedded in the RIRT for COVID-19. A total of 339 confirmed cases (out of 367 to date) has been investigated by Rapid Investigation and Response team (RIRT) during the reporting period, with contact tracing activities being conducted and captured through Go.data, including the 1238 (91%) contacts to be followed up. Out of these, 1033 (83%) 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 the contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

Four (4) new Cholera RDT positive cases were reported between weeks 51-53. Since October 2020, 18 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 Rohingya Refugees. The remaining tested negative under culture. In 2020, 26 AWD RDT positive for Cholera cases were verified and 20 qualified for JAT investigation. Diphtheria surveillance is ongoing in the camps since the onset of the outbreak in 2017. The total number of diphtheria cases reported is 9190 to date; 3016 in 2017, 5334 in 2018, 617 in 2019 and 223 in 2020. The last case was reported on 01 Jan 2021. In total, 8949 cases were reported from FDMN/Rohingya Refugees and 241 from the host population; 47 deaths were registered in the refugee camps and none in the host community.

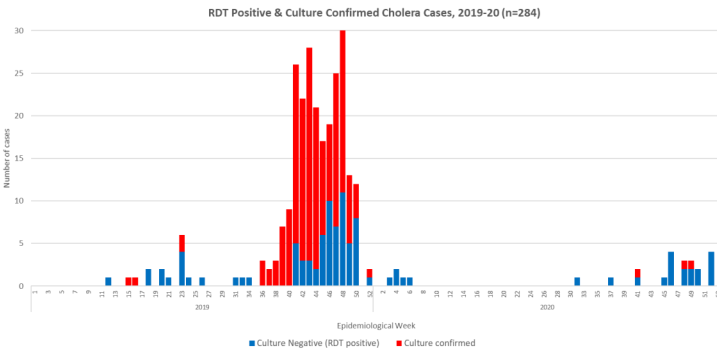


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-20

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. is ongoing in Cox’s Bazar.

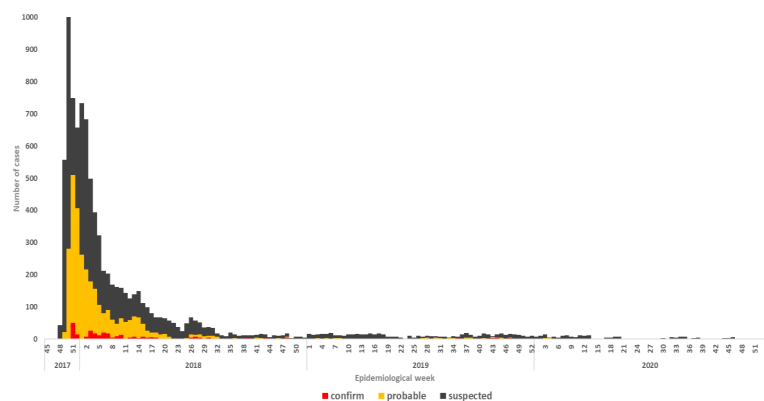


Figure 8: Number of Diphtheria cases between 2017 and 2020.

Last week (week 52), one suspected SARI death has been investigated by RIRT. A total of 48 suspected SARI deaths were reported in 2020, all were verified and 44 qualified for detailed investigation. Three (3) deaths were considered as confirmed and probable of COVID-19 and responded to accordingly. Additionally, alerts on four (4) deaths due to suspected AWD with severe dehydration and three (3) deaths from suspected Measles were received in 2020 through mortality surveillance. EWARS supportive supervision for health facilities is ongoing. So far, 127 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 2021.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

WHO is engaging communities, health partners and other key stakeholders to develop, implement and monitor an action plan to effectively help prepare populations and protect them from COVID-19. 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 continued populating and sharing the English and Bangla version of a radio script with critical information on confirmed cases, laboratory tests and deaths among the refugee and host population based on updated epidemiological and laboratory information received from the Civil Surgeon's Office for broadcasting messages to the target population for better sensitization on attrition to IPC practices and other public health interventions. During the reporting period CHWs conducted 445 928 household visits in which 10 024 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 31 patients were identified with moderate/severe symptoms. The cumulative number of mild patients is 77 565, and 254 moderate/ severe patients. To date, 33 556 persons with COVID like symptoms were referred to health facilities. Through coordination by the CHWG, COVID-19 messages reached 857 933 persons between 14 December 2020 and 3 January 2021. Since the beginning of the response, CHWs have conducted more than 4.6 million household visits and had contacts with a cumulative number of more than 13.7 million adult household members. Through the CwC WG, another 117 387 people were engaged in 38 078 small group sessions. Furthermore, 1416 CHWs have been oriented on Seroprevalance study, where 136 CHWs supported the study as a team member to aid in obtaining consent and all other CHWs have helped in navigating the sample collection team to identify the Household.

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. From early April until 3 January 2021, a total of 85 267 tests for COVID-19 have been conducted of which 72 784 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. A decrease in the number of tests conducted among the Rohingya was observed in week 53, from 914 to 706 tests, and remains the same in the host community population with a slight change from 1407 to 1409. 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. The testing of the samples has started and will be completed by early January 2021.

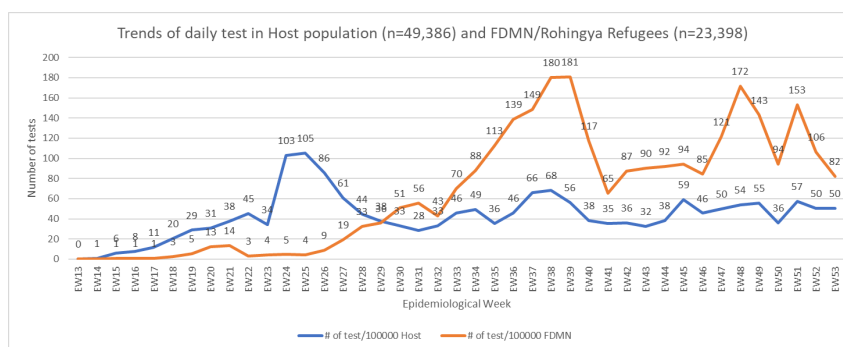


Figure 9: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees

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, supportive supervision was conducted in eight (8) health care facilities across Ukhiya and Teknaf (1 Health Post, 3 Community Clinics, 1 PHC, 1 SARI ITC and 2 UHCs).

Relevant technical issues regarding WASH & HCWM at these different health facilities were addressed and on-site recommendations were provided to the respective facility managements. Phase-2 distribution of color-coded waste bins were completed during this period of time. A total of 894 color coded waste bins have been distributed to 31 World Bank funded health care facilities catering the health needs of both Rohingya refugees and host population to support sustainable healthcare waste management services. Quarterly IPC supportive supervision and monthly IPC scorecard monitoring was conducted for all SARI ITCs to strengthen infection prevention and control activities in facilities, quality control and assurance to ensure better quality services for COVID-19 patients in the Rohingya and host communities.

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. 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 15 operational SARI ITCs in the camps with a total of 652 open and 579 stand by beds. One more SARI ITC is being constructed. Case load among the SARI ITCs have further decreased over the holiday period with currently 6% of the available bed capacity being used. Most cases are mild to moderate, however severe cases continue to occur with some deteriorating to critical status, requiring transfer to Sadar ICU, the only facility in Cox's Bazar who can appropriately manage critical COVID-19 cases. In the Rohingya refugee camps in Cox's Bazar, WHO and partners have established - and further strengthened - a referral pathway to allow for the safe transfer of critically ill COVID-19 patients to the newly established Intensive Care Unit (ICU) at the Cox's Bazar District Sadar Hospital. All Basic Emergency Care (BEC) trainings have been completed in December meeting the target set and ensuring a total of 64 Basic First Aid staff trained among SARI ITCs, 32 of which had the additional BEC training. The increased staff capacity is allowing for improved management of critically ill patients and their timely referral to Sadar hospital ICU. Case presentation conference calls have taken a week's pause over the holidays and are resuming as of this week with continuation on a weekly basis throughout at least the first quarter of 2021. Case management meetings took a week's break and are now resuming the bi-weekly agenda on 10th January.

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 860 000 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. 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. WHO has actively participated with other UN agencies to develop and implement psychosocial services in the Sadar Hospital in Cox's Bazar. TB activities at Upazila and camp levels are regularly monitored and updated. In December, medical technologists performed 300 and 160 GXP tests at Ukhiya and Teknaf Upazilas and conducted 150 routine microscopy tests for TB diagnosis, having helped collecting samples for COVID-19. Radiographers conducted a total of 75 X-rays including chest X-rays for referred patients in Teknaf UHC for TB and COVID-19 suspect cases and other respiratory illnesses. WHO TB field assistants conducted 14 sessions and visited 1200 households for TB community awareness in the refugee camps and host community in December 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. A refresher training on Basic EPI for all Vaccinators has started with WHO's technical support. 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.

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. The Health Sector in collaboration with WHO, IOM, UK EMT and Australian RedR facilitated a 3-day hands on training for 20 doctors from 17 partners representing the medical hubs on emergency and trauma management on 20 December 2020. A medical hub is a medical focal point in the Emergency Preparedness and Response (EPR) catchment area and would receive referrals from the field and possibly other facilities in the aftermath of a disaster. Additionally, in the event that there is limited/ no communication, the medical hub would receive reports from the field and other organizations, and report to the health emergency operations center (HEOC), or to the catchment area coordination hub.

*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.

During the reporting period, a total of 7336.67 Kg and 28.65 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. In support to the seroprevalence study in the camps, 300 packages including Personal Protective Equipment (PPE) and sample collection tools were transported to Ukhiya and Teknaf Upazilas. Three vehicles are supporting the teams in the field. A total of 1416 waste bins were distributed to health facilities supported by the World Bank. Following a plan to distribute spare parts of 300 oxygen concentrators to the government and partner, 95 of these were distributed in the reporting period, in the coming week 50 more will be delivered at Friendship Hospital including spare parts. WHO continues its support to the Dispatch and Referral Unit (DRU) activities and sample collection in the camps with four vehicles. The refurbishment work for the blood transfusion centres in Ukhiya and Teknaf UHC is currently in process.

POINTS OF ENTRY

Fifteen out of 19 points of entry (POE) have been functional in different strategic locations around the camps. A total of 111 745 individuals have been screened during the 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: Breaking the chains of COVID-19 transmission: the key role of Camp-wise Rapid Investigation and Response Teams in Cox's Bazar

As 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. In health emergencies, the mission of the World Health Organization (WHO) is to support countries to coordinate actions to prevent, prepare for, detect, rapidly respond to, and recover from outbreaks and emergencies.

Context

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 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 Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centers (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.

COVID-19 Surveillance with Syndromic Surveillance of Acute Respiratory Infections (ARI)

It has been eight months since the humanitarian health care workers at the world largest refugee camp in Cox's Bazar found themselves at arms with the coronavirus disease 2019 (COVID-19). The condition is caused by SARS-CoV-2, a newly emerged coronavirus, and reached the refugee camps on 14 May 2020 when the first Rohingya patient tested positive. Those living in the camps are particularly vulnerable to outbreaks of communicable diseases, due to high population densities, poor WASH conditions and low immunization. WHO supported the establishment of a disease surveillance system and Rapid Response. Teams for outbreak investigation to ensure a meaningful integration of facility and community-based disease surveillance systems to enhance early detection of epidemical potential diseases in Cox's Bazar. Additionally, in response to the COVID-19 pandemic, WHO deployed seven Camp Health and Disease Surveillance Officers (CHDSOs) for further enhanced disease surveillance, outbreak investigation and appropriate response. A site-level surveillance SOP outlines the surveillance strategy for the COVID-19 response in Cox's Bazar.

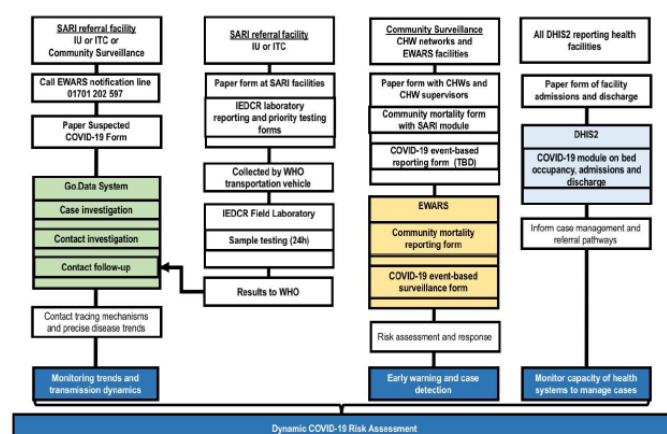


Figure 10: Key elements of the surveillance strategy integrated within a COVID-19 risk assessment .

In addition to the pillars established for the COVID-19 response, existing syndromic surveillance of ARI data and sentinel testing of ARI cases is also forming a part of the surveillance system response. With this in mind, a new protocol for sentinel surveillance of ARI cases has been designed to strengthen surveillance and testing among refugees with compromised health seeking behavior.

COVID-19 Testing: WHO continues its support to the sentinel testing for COVID-19 Acute Respiratory Infections (ARI) through sample collection sites in the camps and testing being ensured by 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.

To prioritize testing, the WHO standard case definition has been adapted for the camp setting through a revised strategy with a special concurrence from the Government of Bangladesh (GoB). Since early April 2020, all samples are being processed at the Cox's Bazar Medical College (IEDCR Field Laboratory). Between April 2020 and the first days of January 2021, a total of 85 267 tests for COVID-19 have been conducted of which 72 784 are from Cox's Bazar district and the remainder from Bandarban and Chittagong districts. Currently, 26 sample collection sites are operating for suspected COVID-19 patients in camps along with regular government sites in upazilas. As of Week 53 (03 Jan 2021), there are 367 confirmed cases of COVID-19 in the Rohingya refugee camps. The detection of the majority of cases (304, i.e. 83%) through ARI sentinel surveillance, with most cases lacking known epidemiological links suggest that there are focus of community transmission. Important to note, there have been no observed increase in SARI cases or community mortality that would indicate a more advanced-stage outbreak.

Community Based Surveillance: Community mortality reporting: All deaths that occur in a community setting are individually reported by community health workers (CHWs) through the Early Warning, Alert and Response System (EWARS). Community mortality surveillance may provide crucial information related to COVID-19 at community-level and also provide insight into the impact of the outbreak. To date, there aren't any signs of increased mortality or adult mortality despite all efforts to enhance community mortality surveillance. Since mid-2020 every death occurred at the SARI ITCs has been alerted through EWARS in order to ascertain the probable cause of death and required responses. So far 48 likely deaths have been investigated and responses took place as per the established protocol. Enhanced Community Based Surveillance: Additionally, under Enhanced Community Based Surveillance, CHWs also work to identify individuals with symptoms associated with COVID-19. Symptomatic people are then referred to the nearest health facility or directly to the sample collection sites. Through strengthening community-based surveillance, we can understand more about the number of people reporting COVID-19 associated symptoms while strengthening all-cause mortality surveillance systems. This has provided timely information during the critical phase of the outbreak, particularly when outpatient consultations decreased due to lockdown and consequently changes in health seeking behavior.

Rapid Investigation and Response Teams (RIRTs): The WHO epidemiology team, in collaboration with the Ministry of Health (MoH) and health sector partners, identified a group of qualified people who are responsible for the investigation and public health response for COVID-19 in the camps. These teams are known as "Rapid Investigation and Response Teams" (RIRT) - a dedicated team for each camp providing additional support in investigating and responding to any COVID-19-related health event thoroughly to avoid straining the existing health system which is already overwhelmed by this crisis. The camp level RIRT is to ensure that partners conduct case detection, contact identification, contact tracing and implement camp level public health intervention in a coordinated and systematic way while ensuring that the trust between humanitarian actors and affected communities remain unaffected. The establishment and continued operationalization of the laboratory has been made possible with the generous support from various donors, including the World Bank, UK Department for International Development (DFID), the Bureau of Population, Refugees, and Migration in the US (BPRM), the European Commission Directorate General of Humanitarian Aid and Civil Protection (ECHO), including funding from the UN, among others.



Photo: Dr Morshad Ahmad, a WHO Camp Health and Disease Surveillance Officer (CHDSO) verifying with the mother of a confirmed COVID-19 patient the family members who have been in contact with the patient.

Case Investigation and contact tracing: The Contact Tracing network at the Rohingya refugee camps is comprised of 34 supervisors and 311 volunteers and closely facilitated by seven Camp Health and Disease Surveillance Officers (CHDSOs) from WHO. The rapid investigation focuses on identifying cases with their contacts and referral to the dedicated facilities according to the COVID-19 surveillance SOP. The rapid response team helps to locate the case and their contacts while implementing public health measure, technically supporting and guiding authorities for suspected/confirmed COVID-19 dead body management, and engaging with communities. Each RIRT team consists of one RIRT coordinator (from health sector partners/CHFP), one contact tracing supervisor and one site management sector focal person. Under the direct supervision of the WHO Epidemiology Team and COVID-19 response cell, following any COVID-19 related event and subsequent trigger, a camp level RIRT is activated.



Photo: Acting as a Contact Tracing Supervisor from NGO Mukti Cox's Bazar, Mina Akter is working at the Rohingya refugee camps since the onset of the COVID-19 outbreak.

Isolation unit focal points as one of the RIRT team members are ensuring that case and contact details are registered in the Go.Data Application and are providing overall support and supervision of contact tracing and contact follow-up activities in the camps.

Contact tracing supervisors, on the other hand rapidly locate and trace suspected or confirmed COVID-19 cases and enter information in Go.data to ensure counselling to clinical case management cases and referral pathways through contact tracers, by following the guidance from RIRT coordinators and completing the referral form provided by the DRU (Dispatch and Referral Unit). Twelve isolation units along with the camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) have been engaged in the RIRT structure for COVID-19. In total 339 (out of 367) confirmed cases have been investigated by Rapid Investigation and Response teams and 1238 (91%) contacts were captured through Go.data to be followed up. Among those, 1033 (83%) contacts have seen their follow up visits completed and were released from quarantine. To date, thirteen contacts (1.3%) became confirmed cases during the follow up period. WHO is closely supporting and supervising contact tracing through the Camp Health & Disease Surveillance Officers (CHDSOs).

Over the past three years, disease surveillance and outbreak investigation has been paramount to enhance early detection and treatment and 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.

NATIONAL LEVEL HIGHLIGHTS, 7 January 2021 (BANGLADESH)

	Last 24 hours	Total
COVID-19 tests conducted	15 381	3 317 810
COVID-19 positive cases	1007	519 905
Number of people released/recovered	966	463 362
COVID-19 deaths	31	7718

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"



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