







PHOTO: The Health Sector team holds a weekly online meeting to coordinate the emergency health response of over 80 partners and support the Government of Bangladesh in its response to the Rohingya crisis.

HIGHLIGHTS

- With the support of the Immunization and Vaccines Development and Risk Communication units, the Health Sector Coordination team conducted a briefing session for the vaccination focal points and interested Bangladeshi humanitarians on COVID-19 vaccination.
- Following the request of the Government of Bangladesh (GoB), WHO carried out the preparatory work for the “National level Training of Trainers on Infection Prevention and Control (IPC)” aimed at creating a pool of master trainers that will be held in Dhaka from 8 - 17 March 2021.
- WHO and BRAC field assistants conducted 10 sessions in approximately 800 household visits for community awareness on Tuberculosis (TB) in the refugee camps and host community. They carried out TB case identification and notification among communities and referred TB suspected cases to near-by facilities for further evaluation.
- WHO and IOM jointly organized a mhGAP refresher training for 34 health service providers in the refugee camps including doctors, nurses, psychologists and counsellors from different partner organizations.
- **SUBJECT IN FOCUS:** People-centred surveillance mechanisms - mortality surveillance in crisis affected populations to curb disease outbreaks.

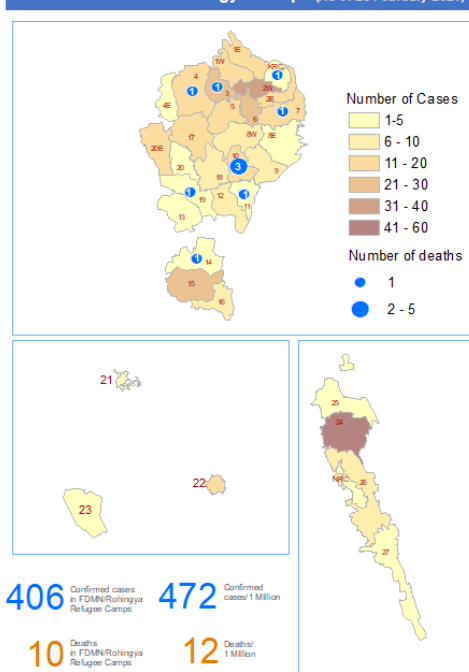
	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	5 593	406
 Total cases in isolation in Cox's Bazar	38	11
 Total number of tests conducted	61 344	30 561
 Total deaths due to COVID-19	73	10

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 nine (09) camp level Health Sector coordination meetings were held at Ukhiya and Teknaf Upazilas. The Health Sector Coordination team also facilitated two (02) Upazila coordination meetings in Ukhiya and Teknaf with the aim of strengthening coordination, collaboration and liaison among partners and government authorities. A total of 45 partner agencies, including Government bodies, UN agencies and NGOs, participated in these coordination meetings where key challenges, achievements and areas requiring support were addressed. The first draft of the Health Sector Gender Action Plan for 2021 is underway with inputs from the Health Sector strategic advisory group members. The plan is in line with the four (04) health objectives described in the Joint Response Plan (JRP) 2021 and addresses COVID-19 related measures while considering essential health services.

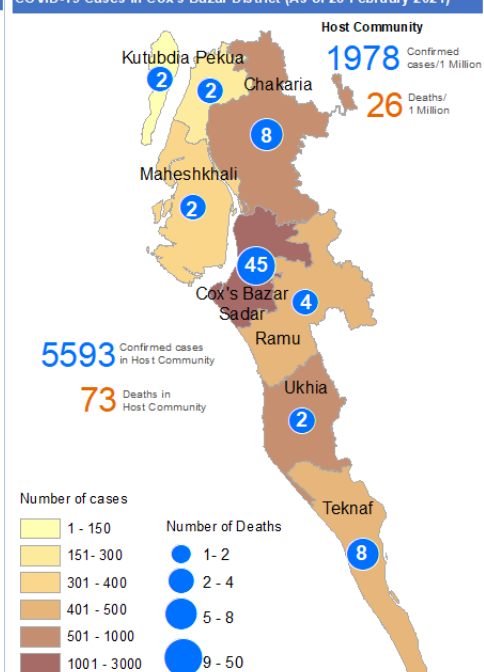
With the support of the Immunization and Vaccines Development and Risk Communication units, the Health Sector Coordination team conducted a briefing session for the vaccination focal points and interested Bangladeshi humanitarians on COVID-19 vaccination. Conducted in Bangla, the session included a demonstration of the registration process through the *Sorukkha* App, which is currently the platform where people can apply to get vaccinated.

Additionally, to monitor the uptake of COVID-19 vaccines, WHO/Health Sector has started tracking the vaccination status among humanitarian workers in Cox's Bazar by compiling data from all agencies and organizations. The data is being collected through the existing weekly reporting tool for humanitarian surveillance.

COVID-19 Cases in Rohingya Camps (As of 28 February 2021)



COVID-19 Cases in Cox's Bazar District (As of 28 February 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 28 February 2021, a total of 5593 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 539 in Chokoria, 105 in Kutubdia, 367 in Moheshkhali, 221 in Pekua, 405 in Ramu, 2923 in Sadar, 457 in Teknaf and 576 in Ukhiya.

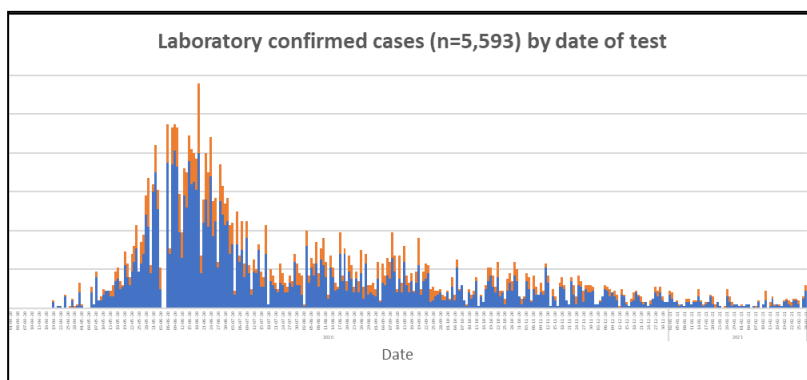


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

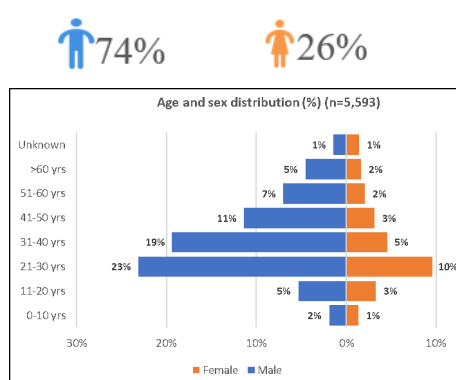


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

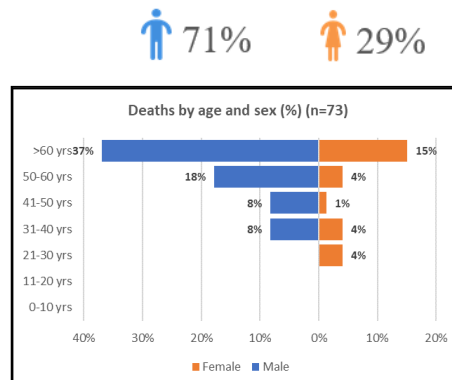


Figure 3: Age and sex distribution of COVID-19 positive cases among host population in Cox's Bazar District

As of 28 February 2021, a total of 406 COVID-19 cases have been reported among Rohingya/FDMN. With a total of 56 cases, Camp 24 has the highest number of cases to date further ahead from Camp 2W with 40 and Camps 3 and 15 with 30 and 27 cases, respectively. To date, 25 cases were reported from Camp 6, twenty from Camp 2E and 18 from Camp 4. Camps 1W and 5 had 14 and 13 cases, respectively and camp 7 and 20 Extension have had twelve cases each. Camps 1E, Camp 10 and 22 registered 11 cases each. As for Camps 9, 16, 18 and 26 nine cases were reported to date; and eight cases from Camp 8W. Camps 12 registered 7 cases while Camps 11, 19, and Nayapara RC have recorded 5 cases. The remainder Camps (Kutupalong RC, 4 Extension, 8E, 14, 20, 21, 23, 25 and 27) have so far had less than 5 cases.

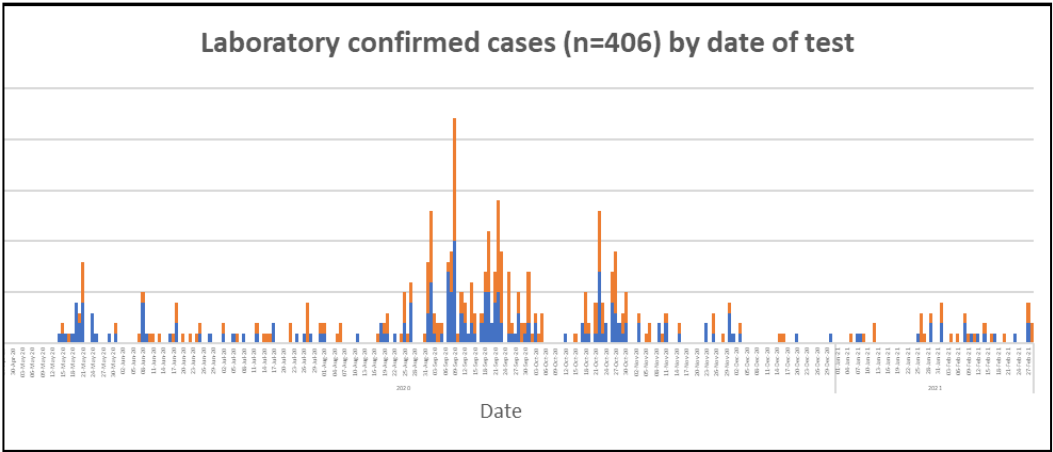


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

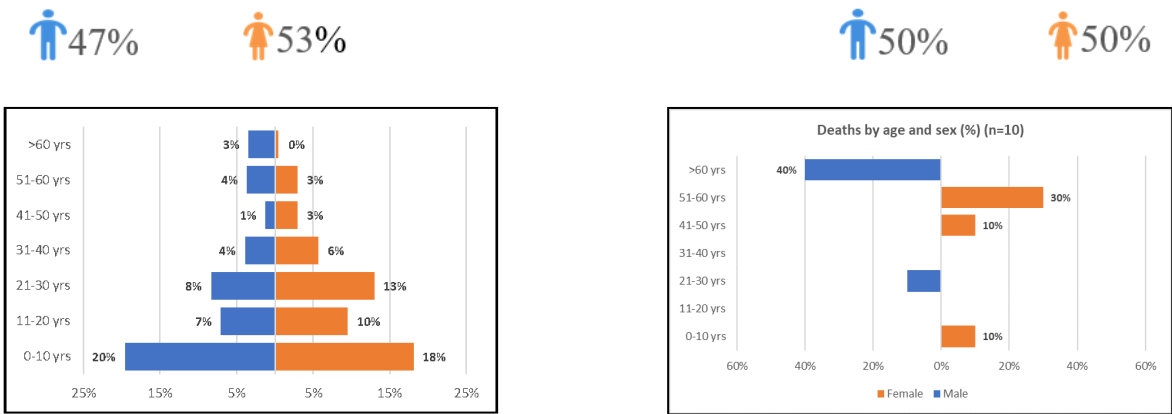


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

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

Between weeks 07-08, ten (10) new confirmed cases were detected from 1603 samples tested, the test positivity was therefore 0.6%. As of 28 February 2021, the cumulative incidence is 47.2 per 100 000 people. The overall positivity of samples tested is 1.3%. Among the cases, 6.7% showed severe symptoms at the time of admission while 6.2% reported at least one co-morbidity. The median age of tested and confirmed cases was 10 (0-120) and 18 (0-90) years, respectively and ratio of females among tested and confirmed cases was 55% and 53%, respectively. Though the median age of tested samples remained below 10 years, a significant proportion of people has been tested among those older than 40 years: 361 per 10 000 population, following that of 0-9 years with 517 tests per 10 000 population as highest number. The test positivity was highest (1.9%) in the 30-39 years age cohort followed by 1.6% in 40+ years and the age specific mortality was 0.67 per 10 000 population observed among 40+ years during the period. In total, and since the outbreak began, ten deaths due to confirmed COVID-19 have been reported in the camps with a case fatality rate of 2.5%.

A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) has been embedded in the Rapid Investigation and Response Team (RIRT) for COVID-19. A total of 404 confirmed cases (out of 406 to date) have been investigated by RIRTs by 28 February, with contact tracing activities being conducted and captured through Go.data, including the 1553 contacts to be followed up. Out of these, 1324 (85%) contacts have seen their follow up visits completed and were released from quarantine. Thirteen contacts (1%) became confirmed cases during the follow up period. WHO is closely supporting contact tracing activities through the Camp Health & Disease Surveillance Officers (CHDSOs).

Two (2) Rapid Diagnostic Test (RDT) positive cases for Acute Water Diarrhoea (AWD) were identified during the reporting period. The total number of cases reported so far is eight in 2021. Out of these, one was culture confirmed, six tested negative by culture and one result is pending 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. Currently 22 sentinel testing sites are functional in camp setting including Ukhiya and Teknaf Upazila Health Complexes. 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 2 doses regimen.

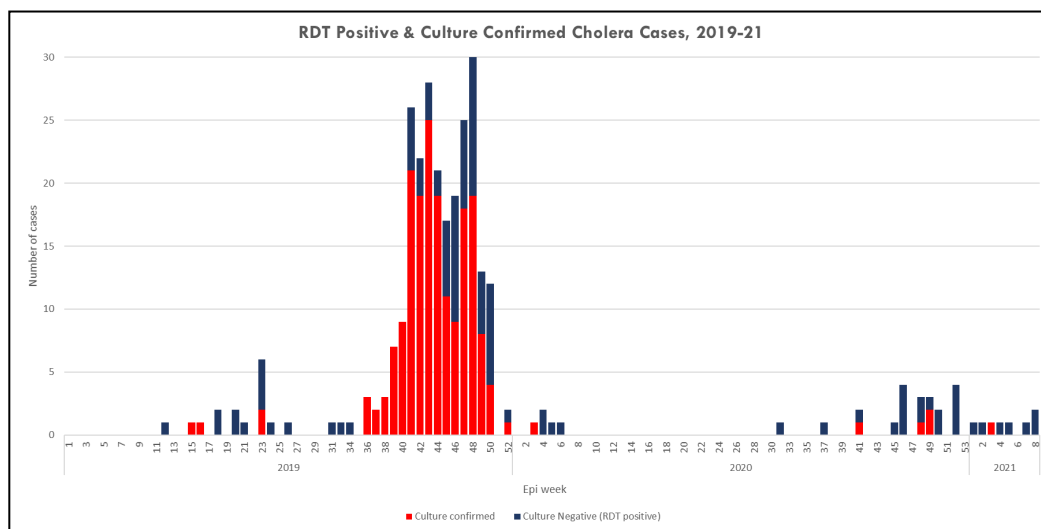


Figure 7: RDT positive and culture confirmed for Cholera cases in 2019-21.

In weeks 07-08 of 2021, a total of six (06) suspected SARI death have been reported. In total 21 deaths have been reported in 2021. All deaths have been investigated by RIRTs for COVID-19 response. Seven (07) deaths have been reclassified as COVID-19 probable death causes. In total 49 suspected SARI deaths were reported in 2020, of these all were verified and 45 underwent investigation, one (01) death was confirmed for COVID-19 and two (02) considered probable.

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. During the reporting period, six (06) new suspected maternal deaths have been reported. In total 19 suspected and confirmed maternal/deaths of Women of Reproductive Age (WRA), i.e. between 12-49 years have been reported in 2021, of which five (05) deaths have been reported from facilities having directly undergone review by MPMSR (Maternal and Perinatal Mortality Surveillance and Response).

On 28 February 2021, WHO started a one-week training programme on “Mortality Surveillance and Reporting” with the revised protocol for mortality surveillance to further include facility death and death occurring during referral. Over 200 persons engaged in surveillance and reporting (i.e. Medical Team Lead, Medical Doctor, Reporting Officer, SRH Focal Person & CHW Supervisor) are expected to attend the training to improve mortality surveillance and data available for improved decision making.

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 drafted public health messages on COVID-19 Frequently Asked Questions (FAQs) to be disseminated between the Rohingya refugees and the host communities. The messages are undergoing relevant approval processes. 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. These messages were shared with partners to be widely disseminated by the Rohingya community through radio broadcasting. Based on the findings of the Informal Health Survey conducted by WHO and UNHCR, appropriate risk communication messages have been drafted for the Rohingya Refugees and shared with relevant authorities for feedback. Communication messages on COVID-19 vaccination for humanitarian health workers have been approved by the Civil Surgeon’s Office and disseminated through various channels. In addition, WHO in partnership with Translators Without Borders (TWB) conducted a communication training session to humanitarian workers in the camps (including programme manager, programme officer, communication officer and health service providers). The training, provided in Rohingya language, will help health care workers improve their communication skills while dealing with the Rohingya community.

During the reporting period CHWs conducted 306 574 household visits in which 6 012 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and 33 patients with moderate/severe symptoms. The cumulative number of mild patients is 107 714, and 403 moderate/ severe patients. To date, 48 973 persons with COVID-19 like symptoms have been referred to health facilities, 3 986 of which during the reporting period. Through coordination by the CHWG, COVID-19 messages reached 594 756 persons between 16-28 February 2021. Since the beginning of the response, CHWs have conducted more than 6 million household visits and had contacts with a cumulative number of more than 16.3 million adult household members. Through the CwC WG, 71 638 people were engaged in 21 961 small group sessions.

WHO continues its support to the Institute of Epidemiology, Disease Control and Research (IEDCR) Field Laboratory at the Cox's Bazar Medical College comprising human resources, equipment, supplies/consumables and technical and operational expertise. Between early April 2020 and 28 February 2021, a total of 107 408 tests for COVID-19 have been conducted of which 91 905 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 refugees was observed in weeks 07-08 as compared to weeks 05-06, from 1845 to 1603. However, the number of tests has slightly increased among the host community: from 2971 in weeks 05-06 to 3125 tests in weeks 07-08. Currently, 26 sample collection sites are operating for suspected COVID-19 patients.

The refurbishment works at the Blood Bank and Transfusion Centres at Ukhiya and Teknaf Health complexes, which were newly established with the support of WHO, has been completed. This is part of the wider effort to increase availability of blood, and lifesaving commodities when dealing with shock due to excess bleeding, obstetric hemorrhages during childbirth and other conditions. Procurement of additional supportive equipment and supplies is ongoing to support full operationalization.

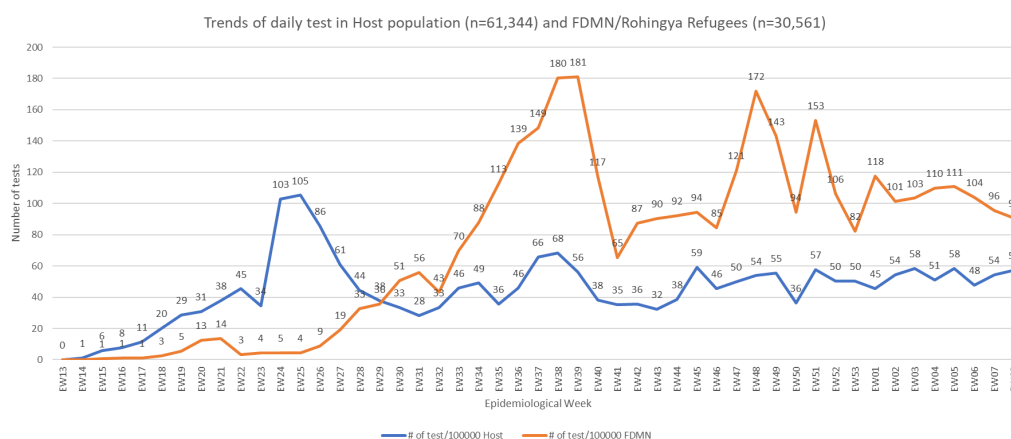


Figure 8: Number of tests conducted per million among the host population and the Rohingya refugees/FDMN

*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.

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) Isolation and Treatment Centre (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 in Cox's Bazar. During the reporting period, the IPC Technical Working Group continued with the preparations for the workshop on “Infection Prevention and Control Program for Cox's Bazar District” that will be held on 3 March. This workshop is part of WHO's support to the government to build consensus on the institutionalization of IPC in the health system in Cox's Bazar envisioning improved patient and healthcare workforce safety. In addition, following the request of the Government of Bangladesh, WHO carried out the preparatory work for the “National level ToT on Infection Prevention and Control” aimed at creating a pool of master trainers. The training will be held in Dhaka from 8-17 March 2021. Supportive supervision was conducted on water sample collection activities at different health facilities in camps 13 and 14, and on water sample analysis at the laboratory of the Department of Public Health Engineering (DPHE). A total of 710 samples from 349 health facilities were collected and analyzed during the reporting period. WHO and UNICEF monitored the activities in accordance with the Standard Operating Procedures (SOP) and relevant technical recommendations were made on sanitary inspection and water sample collection. WHO, UNDP and ICRC agreed upon several actions for further collaboration and information sharing for streamlining healthcare waste management in Cox's Bazar including increasing awareness on waste management among private health facilities in the district.

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 chance for survival of patients in Cox's Bazar. During the reporting period, one (01) working group meeting along with two (02) case conferences for SARI ITCs and two (02) case conferences for ICU were conducted. On 15 and 16 February 2021, the Health Sector in collaboration with WHO and IOM organized two webinars on Fire Safety and Burns Care for healthcare managers and clinical staff working in the camps. The trainings conducted by ARUP Fire Engineering Consultants and the Australian Medical Assistance Teams (AUSMAT) covered topics related to fire safety of health facilities and the clinical care of burnt, and gathered 125 and 85 participants, respectively.

As of 28 February, there are 13 operational SARI ITCs in the camps with a total of 502 functional beds open and 415 on standby. The SARI ITC bed occupancy is currently of 119. 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.

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 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 centers (PHCs), 97 Health Posts (HPs), 23 special facilities and three field hospitals. WHO, in collaboration with UNFPA and the Sexual Reproductive Health working group (SRH WG), organized two training courses on “Clinical Management of Rape and Intimate Partner Violence” for frontline health workers from health facilities in the camps. A total of 55 healthcare professionals including doctors, nurses, midwives and medical assistants from primary health care services working with partner organizations joined the sessions. The training helped these healthcare workers improve their clinical knowledge to support survivors of gender-based violence in the context of the COVID-19 pandemic. In February 2021, WHO and BRAC field assistants conducted 10 sessions visiting approximately 800 households for community awareness on Tuberculosis (TB) in the refugee camps and host community. They carried out TB case identification and notification among communities and referred TB suspected cases to near-by facilities for further evaluation and definitive diagnosis of TB. Supported by WHO, medical technologists conducted 194 and 150 GeneXpert tests in Ukhiya and Teknaf Upazila Health Complexes (UHC), respectively. They also carried out 109 and 130 routine microscopy tests for TB diagnosis in Ukhiya and Teknaf UHC. A total of 57 X-ray examinations were performed at Teknaf UHC for tuberculosis and other respiratory illnesses.



Photo: Healthcare professionals actively engaged in interactive activities conducted during the training on “Clinical Management of Rape and Intimate Partner Violence” organized by WHO, UNFPA and SRH WG.

WHO in collaboration with UNHCR, organized two mhGAP training sessions for primary health care services working at the Intensive Care Unit (ICU) and High Dependency Unit (HDU) at Sadar Hospital in Cox’s Bazar. During this round, 16 doctors and 19 nurses were trained and cumulatively all 27 doctors and 39 nurses working at the facility have been reached. The training helped these healthcare professionals who often handle high-pressure situations to better cope with the stress and to improve psychosocial support to beneficiaries. In addition, WHO carried out supportive supervision sessions at Ukhiya and Teknaf to assist staff trained on mhGAP to better integrate mental health services and psychosocial support in primary health care services. Further trainings on mhGAP are scheduled for the upcoming weeks with the aim of reaching at least one trained clinician in each health care facility in the camps. On 23 February, WHO and IOM jointly organized a mhGAP refresher training for 34 healthcare professionals including doctors, nurses, psychologists and counsellors working with different partner organizations in the camps.

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, shared the pre-final version of the Health Sector Preparedness and Response Plan to Monsoon and Cyclone and received feedback from Health Sector partners. This plan is currently in the final reviewing stage and its finalization is expected by next week. In addition, the Emergency Preparedness and Response Technical Committee is also working on the Preparedness and Response Plan to Mass Casualty Events in the refugee camp. A draft plan will be shared in the next two weeks among critical partners for their feedback to embark on its finalization.

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 902.95 Kg and 4.17 Cubic meters of Medicines were deployed to Cox’s Bazar including medicines, PPE and sample collection kits for the diagnosis of COVID-19. WHO received 568.95 Kg of medicines, RDT and kits for gap filling. WHO continues its support to the sample collection in the camps with two vehicles and is supporting the refurbishment work for the IEDCR Field Lab expansion in the Cox’s Bazar Medical College. In addition, WHO continued to make arrangements for connection to the Blood Bank and Transfusion to an already existing generator at Ukhiya Upazila Health Complex (UHC).

POINTS OF ENTRY

As of 28th February, the designated points of entry (PoE) for temperature screening and hygiene promotion have been closed. From now on, hygiene education activities related to COVID-19 health awareness will be carried out under routine activities of the WASH sector.

SUBJECT IN FOCUS: People-centred Surveillance Mechanisms

Mortality Surveillance in crisis affected populations to curb disease outbreaks

Humanitarian crises and forced migration disrupt public health systems and increase the risk of the emergence and transmission of infectious diseases. Outbreaks can reach widespread geographical scales when undetected by surveillance and transmission is unmitigated by public health systems. The direct effect can be substantial morbidity and mortality.

Context

Community-based surveillance (CBS) has been widely used in the Cox's Bazar refugee camps, and across camp and non-camp settings around the world as an instrument to enhance the early detection of disease outbreaks to systematically collect real time data on the health status of populations. In the context of a pandemic, community-based and mortality surveillance may provide crucial information to formulate an effective and evidence-based response. Such has been the case of the COVID-19 response in Cox's Bazar where all efforts have been employed to break the chains of transmission and reduce mortality and morbidity associated with the infection which has largely increased around the world.

Community-based mortality surveillance in Cox's Bazar refugee camps

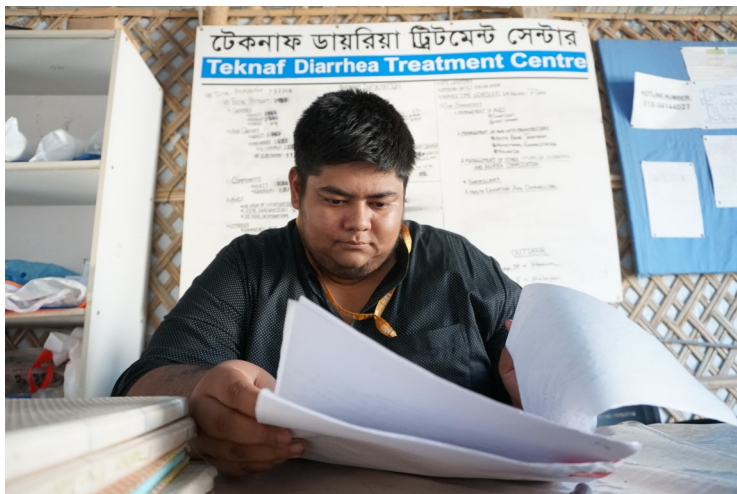
Community-based surveillance is an active process of community participation in detecting, reporting, responding to and monitoring health events in the community. Since 2018, WHO has been supporting the establishment of a community-based mortality surveillance system to enhance early detection of potentially epidemical diseases while capturing mortality data across all 34 refugee camps in Cox's Bazar. Community-based surveillance was finally established in Cox's Bazar in 2019 with a special emphasis on maternal mortality surveillance. The roll-out of mortality surveillance is aimed at establishing a baseline trend of deaths associated with diseases/health events among the population to: identify any unusual change over time/place, identify areas and groups with higher mortality rates, inform public health interventions, detect potential hotspots and clusters in a timely manner, inform rapid public health action, supplement the existing early warning system for causes of death of particular relevance and concern among vulnerable populations. In 2019, community-based surveillance was included in the Early Warning, Alert and Response System (EWARS) for an integral response of outbreaks in the Rohingya emergency response.

Mortality surveillance during COVID-19 pandemic

As a result of the COVID-19 pandemic, delivery of essential health services in the Rohingya refugee camps has been disrupted. In this context, community-based mortality surveillance may provide crucial information related to COVID-19 at community level while helping to understand the impact of the outbreak. However, the mortality reporting system had to be adjusted to the new circumstances. Fears and stigma associated to COVID-19 affected the health-seeking behaviours among the Rohingya population. This has resulted in growing concerns that the existing surveillance system would not be able to detect any early warning signs of COVID-19. WHO in collaboration with the Community Health Workers Group and Health Sector partners agreed to set up additional measures to detect any change on mortality and morbidity rates by adding "Suspected Severe Acute Respiratory Infection (SARI)" as a cause of death to be captured through mortality surveillance mechanisms. In addition, the system remains flexible for the inclusion of other potential and relevant causes of death should they increase. Under the enhanced community-based surveillance, Community Health Workers (CHWs) also work towards identifying individuals with symptoms associated with COVID-19. Persons with symptoms are then referred to the nearest health facility or directly to one of the 26 sample collection sites. Through strengthening community-based surveillance, it is possible to better understand 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 movement restrictions. Since mid-2020, every death occurring at a given Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centre (ITCs) has been alerted through EWARS in order to ascertain the probable cause of death. In 2020, at community level, a total of 49 suspected SARI deaths were reported, two deaths were considered as probable to probable COVID-19 through Rapid Investigation and Response Teams (RIRT). In order to further promote the timeliness of the identification and notification of death cases, as well as to maximize the efficiency of mortality data information flow, several updates have been made to enhance mortality reporting mechanisms. Such updates include the addition of a facility-based mortality reporting tool for all health facilities which was launched in January 2021 to make facility-based mortality reporting easier and more reliable. Additionally, an updated protocol for reporting facility-based maternal mortality has been established through using event-based surveillance followed by retrospective data entry. This new protocol will help improve reporting compliance, timeliness of maternal death reporting (and subsequent death review), and ongoing actions to enhance the quality of care for women of reproductive age (WRA).



Photo: Community-based surveillance has helped mitigate the transmission of infectious diseases and therefore reduce morbidity and mortality among Cox's Bazar vulnerable populations.



The existing strategy has been developed and implemented collaboratively by WHO, CHWG, and SRH WG. The CHWG network and its supporting reporting agencies are responsible for collecting, collating, and reporting the CBS system's functions which are coordinated by the CHWG. Meanwhile, the Maternal and Perinatal Mortality Surveillance and Response (MPMSR) committee under the SRH-WG is responsible for coordinating the activities focused on maternal and neonatal mortality. The MPMSR committee will primarily facilitate the identification, notification, review and response of all facility based maternal and perinatal mortalities with support from the relevant SRH-WG partners. The WHO epidemiology team ensures that overall coordination and data management are overseen. This includes managing alert verification at facility level and timely dissemination of notified mortality cases to the relevant actors and stakeholders.

Photo: Partner's support and engagement through EWARS and Go.data has been key to enhance disease surveillance in Cox's Bazar.

A year without precedent

In 2020, a total of 1880 deaths were reported (Crude Mortality Ratio-2.2 per 1000 population) of these 733 were under 5 years old (Under 5 Mortality ratio-U5MR of 5.5 per 1000 population). The reported all-cause mortality was highest in November-December 2020 with 27% of the year's deaths having been reported in those two months. For 290 of these (67%), the cause of death was classified as "others" due to insufficient information provided to healthcare and Community Health Workers. Among these, no further information has been provided regarding 80% of the cases. The next most prevalent deaths were those of still-births (13%) and neonatal deaths (11%).

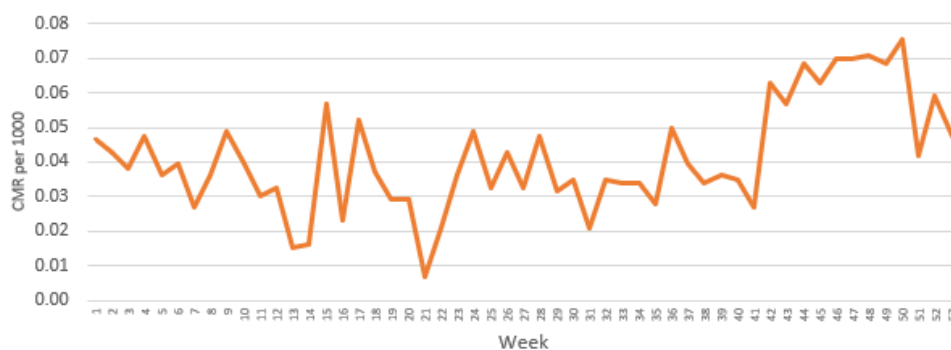


Figure 9: Weekly crude mortality rates per 1000 population, 2020

Capacity building on Mortality Surveillance

Since the integration of community-based surveillance through EWARS in 2019, WHO created several capacity building opportunities for health care workers in Cox's Bazar envisioning a more efficient mortality surveillance in the refugee camps. In 2020 alone, more than 1300 health care workers were engaged in a variety of training opportunities including EWARS, Go.data, contact tracing, community-based mortality, among others to increase the reliability of the information collected by the CHWG network and address issues created by the significant turnover of staff among health partners. Since the onset of the COVID-19 pandemic, WHO implemented a suspected SARI mortality surveillance strategy using the existing CBS of care for Women of Reproductive Age (WRA).

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Photo: WHO National Technical Officer, Dr Umme Asma Absari, conducting the Community Based Mortality Surveillance Training in Cox's Bazar, October 2020.

	Last 24 hours	Total
COVID-19 tests conducted	13 411	4 089 336
COVID-19 positive cases	385	547 930
Number of people released/recovered	641	499 327
COVID-19 deaths	8	8428

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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