







Emergency: Rohingya Crisis

Period covered:

1 NOV 2021 – 31 JAN 2022

Location: Cox's Bazar, Bangladesh

Population	 Total confirmed COVID-19 cases	 Total cases in isolation	 Total number of tests conducted	 Total deaths due to COVID-19
Rohingya refugees	3 703	379	86201	35
Host Community	20 101	1 895	184 737	257

*Updated as of 30 January 2022; Cumulative number.

COORDINATION, PLANNING AND MONITORING:

Leadership and Coordination: WHO in collaboration with the Ministry of Health and Family Welfare (MoHFW) and office of Refugee Relief & Repatriation Commissioner (RRRC) continues to provide effective leadership and coordination of the health response- ensuring access to essential and life-saving health services and COVID-19 response.

Strategy development and planning: As part of the Joint Response Plan 2022, the health sector reviewed and endorsed 27 projects (estimated at USD 110.8 million) from 40 partners. The JRP launch-initially planned for late February 2022- has now been rescheduled to March 2022 pending review and approval from Ministry of Foreign Affairs (MoFA), Bangladesh.

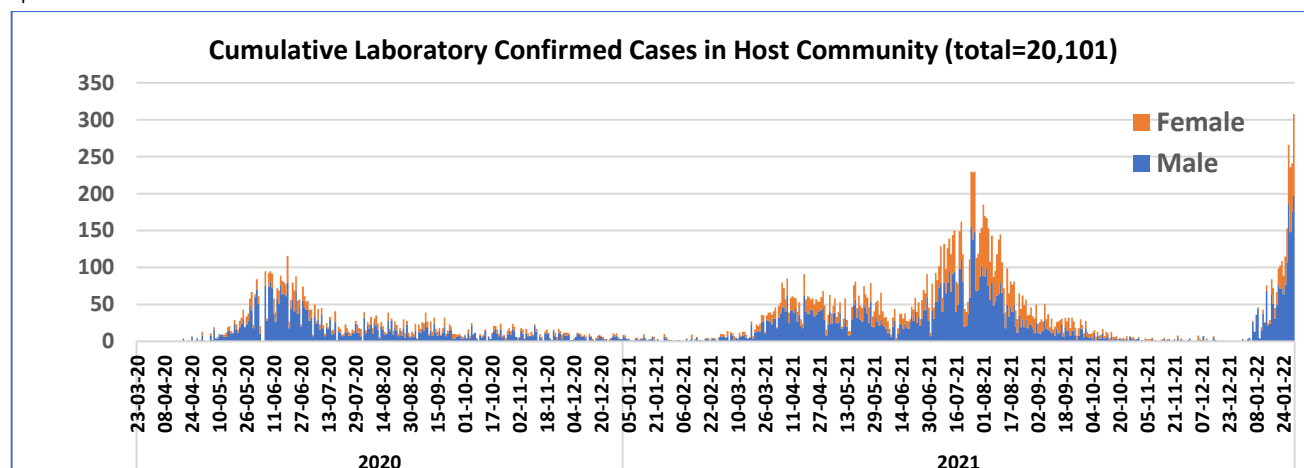
Health resources and service availability monitoring: To track health resource and service availability, the health sector continues to conduct the Quarterly Health Facility Monitoring. The 4th Quarterly monitoring for 2021 was completed- covering a total of 133 facilities (89 Health Posts and 44 PHCs) in Rohingya camps. The findings from this exercise is widely disseminated to donors, partners and government to inform operational and strategic decision for prioritization, quality improvement among others. Findings are disseminated through the WHO Cox's Bazar Data and Information Hub [interactive dashboard](#).

Health Service Quality Improvement: The health sector continues to push forward the agenda on the [General Health Card](#)- intended to ensure systematic and harmonized tool for communicating continuity of care across the camps. It is further anticipated to improve patient follow-up information, better communication on patient's medical and treatment history amongst clinicians involved in the patient care and avoid duplications. The draft has been endorsed by government thus far. A piloting exercise was planned for February- with feedback being compiled at the time of writing.

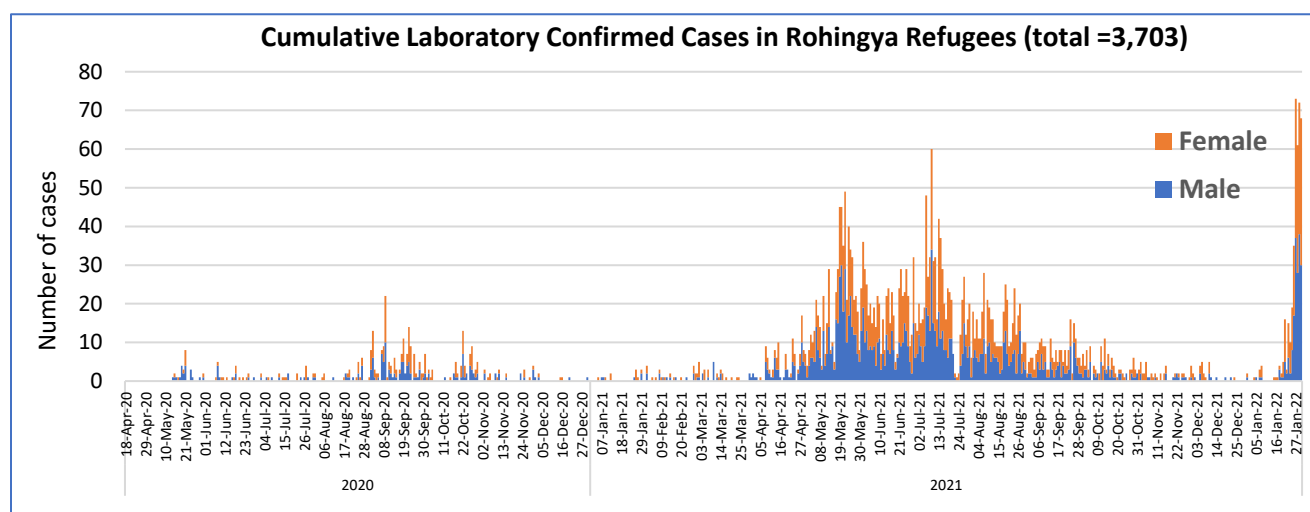
Access to health care: Provision of essential health care services through a network of 130 primary health care facilities continues with support from more than 90 partners. Fires remains a key threat to health service delivery in the camps. The health sector continues to engage with key partners to ensure health facilities are prepared and equipped to mitigate the rampant risk of fires in health facilities. There is an ongoing policy discussion to harmonize and streamline response wide engagement of volunteers.

SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION:

WHO is guiding the operational decision-making for the COVID-19 response in Cox's Bazar, with epidemiological data. The relevant data has been made available to partners through a [dynamic dashboard](#) that is regularly updated



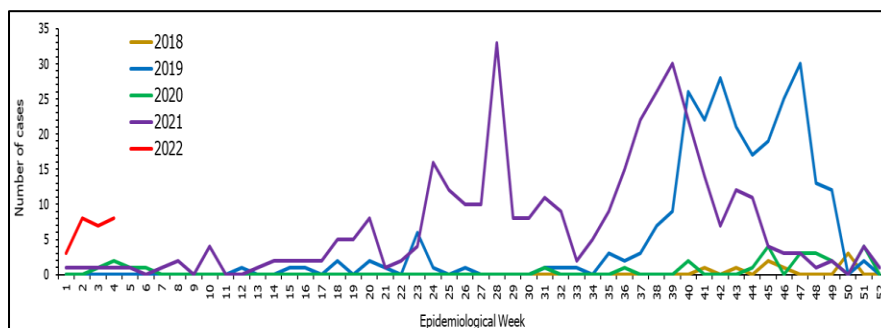
By 30 January 2022, a total 20,101 cases (65% male and 35% female) were reported in the Cox's Bazar host community- with a Test Positivity of 14.3%. Among the Rohingya refugees, a total of 3,703 (Females- 53%, Males- 52%) COVID-19 cases were reported. In Epi-week 4, a total of 338 positive cases were registered in the Rohingya refugee camps with a TPR of 21.0%- a dramatic rise from 3.3% in week 03. More young people appear to get infected, the median age of population got tested 11 (0-120) & 21 (0-100) tested positive. Since the outbreak began, 35 COVID-19 deaths among Rohingya refugees had been recorded by the time of reporting. WHO is closely supporting contact tracing through the Camp Health and Disease Surveillance Officers (CHDSOs).



Contact tracing continues across the camps through a network of 34 supervisors and 311 volunteers working within the COVID-19 Rapid Investigation and Response Teams (RIRTs) for COVID-19.

Acute Watery Diarrhea

In the reporting period 1 November 2021- 31 January 2022, there were 55 RDT confirmed cholera cases in host and refugee population; of these 6 were culture confirmed. The refugee population bears the number of cases as it accounts for 60% of cumulative RDT confirmed cases and 83% of the cultured confirmed cholera cases from the host community.



Dengue

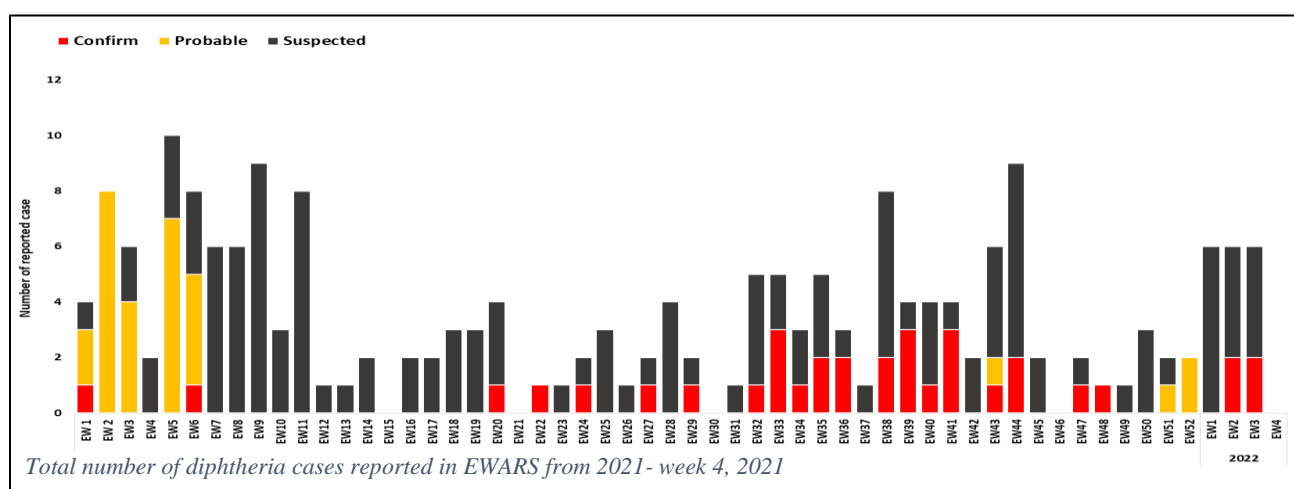
An upsurge of Dengue cases was detected among Rohingya Refugees with a total of 1,698 confirmed cases so far reported from Epi week 1, 2021 to epidemiological week 4, 2022. The highest increase was reported in the month of October-December 2021 which accounts for 89% (1,503/1,699) of total cases. Majority of the cases, 89% (1,516/1,699) were reported among the Rohingya Refugee population while 11% (181/1,699) were reported in the host community. 3 death were so far reported.

Three camps (Camp 3, Kutupalong RC and Naypara RC) account for most of the reported cases, (42%, 723/1699) among the Rohingya refugee population. Teenagers and adults of both genders, above 15 years seem most affected as they contribute 75% (1,280/1,699) of total cases so far reported. Males were most affected across all age groups and accounted for nearly 56% of total cases.

Diphtheria

Between 1 November 2021 to 31 January 2022, a total of 40 Diphtheria cases were reported, of these 8 were confirmed, 3 probable and 29 suspected cases.

In 2020, coverage of the pentavalent vaccination among infants less than 1-year-old had experience decline among the Rohingya refugees due the COVID-19 pandemic – hence the recent confirmed cases heightened the risk of resurgence.



Mortality Surveillance

Between 1st November 2021- 31st January 2022, 11 confirmed maternal deaths had occurred in health facilities with additional 26 probable maternal/WRA (12-49 years) deaths recorded through Community Based Mortality

Surveillance. 32 suspected SARI deaths were reported including 02 deaths due to probable COVID-19. All deaths have been investigated by RIRT as a part of COVID-19 response.

CLINICAL CASE MANAGEMENT

WHO led health sector case management working group conducted six (06) meetings to update the health partner managers on case management situation, epidemiological analysis related to case management, and provide operational guidance in alignment with government and health sector strategy. WHO also coordinated regular online clinical case conferences for health sector partners through which technical assistance on clinical management of patients with COVID-19 and other viral infections was provided to foster peer to peer support and knowledge exchange with the remote support of international panel of infectious disease experts.

During the reporting period, 12 online case conferences for SARI ITCs were conducted focusing on COVID-19 and underlying conditions which included Hypertension, Diabetes Mellitus, Bronchial Asthma, Chronic Obstructive Pulmonary Disease, Ischemic Heart Disease and Pregnancy. Clinicians from partner organizations of the WHO coordinated case management working group from International Organization for Migration (IOM), Save The Children International (SCI), Food for Hunger (FH) and Relief International (RI) presented the clinical cases with average audience of 20-25 Clinicians and nurses. In addition, 10 online case conferences were also arranged for clinical staff working in ICU/HDU department of Cox's Bazar District Hospital on management of Critical COVID-19 cases with participation of 10-15 healthcare professionals on each call.

SARI ITC facilities

There are 13 operational SARI ITCs in the Rohingya camps with 543 functional and 292 on standby beds with the capacity to provide oxygen for both Rohingya refugees and nearby host communities of Cox's Bazar. SARI ITC bed occupancy rate was 19% at the time of report.

In the 13 functional SARI ITCs, WHO-supported Infection Prevention and Control (IPC) Technical Working Group (TWG) conducted quarterly IPC supportive supervision in December 2021 as a part of quality assurance and quality control efforts for continuous capacity building.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

As an integral member of the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Technical Working Group (RCCE TWG), WHO spearheads the drafting of the technical products on priority health issues and validates the technical products shared by the RCCE TWG members for further approval from the Civil Surgeon Office to facilitate its dissemination. The approved products are shared with Community Health Working Group led by UNHCR and Communication For Development network led by UNICEF for mobilizing their field network/partners for effective community engagement COVID-19 related public health & social measures including the vaccination campaign.

This has helped to ensure high quality, technically correct and easily understandable information on COVID-19 and health issues. Furthermore, WHO RCCE team played a vital role in tackling vaccine hesitancy as well as increasing acceptance during OCV and COVID-19 vaccination.

With the aim to develop Public Health messages to reduce minor infection, a joint WHO/UNHCR report on "Knowledge, Attitude and Practices on Minor Invasive Procedures among Rohingya Refugee Camps in Cox's Bazar" was prepared. The study helped us to understand the cultural aspect among the Rohingya population for undergoing circumcision and piercing of nose/ear through Informal Health Care Providers due to lack of surgical services in the health facilities. RCCE team also developed and shared IEC materials on COVID-19 breast feeding awareness, 72 hours reporting for rape survivors, World AIDS Days 2021 and various other infectious disease

topics (Dengue, AWD etc.). Besides, training materials on Enhancing Basic Competencies on Smart Phone Photography for Official Communication has organized for 28 participants (1 female and 27 male).

As mass communication support, WHO has been providing support to develop English and Bangla radio script weekly on COVID-19 and the updates were broadcasted by Bangladesh Betar and Radio Naf 99.2 FM among Host and Rohingya communities. A 15-minute video reportage for the “WHO Global School on Migrant and Refugee health” was developed at the end of October. The video depicted the reality at the Rohingya refugee camps throughout the COVID-19 pandemic and showcased the health emergency response among the Rohingya community involving first-hand testimonies from health sector partners, WHO and the Government of Bangladesh.

DISTRICT LABORATORY

WHO continues to support the Institute of Epidemiology, Disease Control and Research (IEDCR) Field Laboratory at the Cox’s Bazar Medical College with human resources, equipment, supplies/consumables and technical and operational expertise.

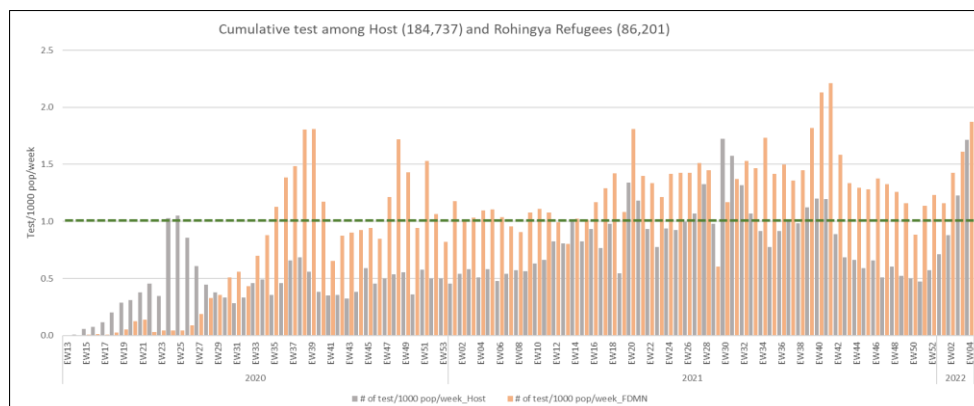


Fig 3: Number of tests conducted and observed test positivity per million among the host population and the Rohingya refugees

Establishment of Diphtheria surveillance sites

In December 2021, four facilities in the Rohingya camps were assessed for the establishment of Diphtheria sentinel surveillance alongside the COVID 19 sample collection happening at these sites. The facilities that were assessed include IOM camp 3, camp 20 Ext SARI ITC, IOM camp 24 and new site- Turkish Field Hospital. Establishment of sentinel surveillance for Diphtheria will facilitate early detection of cases and outbreaks in the camps for quick control actions.

Capacity building for laboratory professionals

In November 2021, WHO conducted a training on basic laboratory techniques and quality management for 42 laboratory health workers working in the Rohingya camps. The training is part of continuous capacity building to enhance staff safety during collection and transportation of COVID-19 samples as well as ensuring viability of samples.

COVID-19 sample testing

The IEDCR Field laboratory at Cox’s Bazar Medical College with support from WHO continues to conduct COVID-19 testing for samples collected from the Rohingya camps and host community.

By 31 January 2022, a total of 294,637 COVID 19 tests had been conducted by the lab since the start of the pandemic with 43,359 samples being tested in the months of Nov 2021 to Jan 2022. Specifically, for the FDMN since the start of the pandemic until 31 Jan 2022, a total of 86,281 samples had been tested with 14,904 samples being tested in the period Nov 2021 to Jan 2022.

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 IPC has been provided to 3600 humanitarian health care workers and government staff from healthcare facilities and SARI ITCs in Cox's Bazar.

Quarterly Supportive supervision for SARI ITCs

The IPC TWG supported by WHO and health sector conducted the fourth quarterly IPC supportive supervision for year 2021 for all 13 functional SARI ITCs in December 2021. These technical visits are part of quality assurance and quality control efforts by WHO and the IPC TWG for all SARI ITCs and for continuous capacity building aimed at improved health worker and patient safety.

IPC training

The IPC TWG with technical support from WHO conducted a training on the use of daily IPC checklist and monthly score card for IPC focal persons from all healthcare facilities in the Rohingya camps. The training which was carried out in seven batches reached 164 IPC focal persons covering all facilities in the Rohingya camps and immediate host community. The implementation of the daily IPC checklist will improve IPC performance through regular self-monitoring and timely intervention by different healthcare facilities

Implementation of IPC monitoring in health facilities

The daily IPC checklist and monthly score card was introduced by the WHO and IPC TWG in November 2021 to facilitate monitoring of IPC daily activities and, in general, trigger continuous improvement of IPC practices in the health care facilities in the Rohingya camps. Within three months of implementation, sixty per cent (60%) of the facilities in the camp are using the monthly score card for monitoring of the IPC practices in different departments of the facilities.

Steering IPC in the Rohingya camps

The IPC TWG conducted three monthly IPC TWG meetings in November 2021 to January 2022. Chaired by different partners each month; the meetings brought together all health workers working in infection prevention and control to discuss issues pertaining improvement of IPC in the camps but also sharing knowledge and good practices. Emphasis is being put on using the daily IPC checklists for monitoring IPC practices in the facilities and use of monthly score cards for visualization of performance and triggering action for improvement of IPC practices among health workers.

Institutionalization of infection prevention and control

As the year 2021 closed, the health sector efforts to institutionalize IPC in the health system in the Rohingya refugee camps has seen great progress. By 31 January 2022, all (100%) healthcare facilities at all levels in the Rohingya camp have formed these structures. The IPC focal persons and committees will play a pivotal role in planning for IPC activities as well as daily oversight of implementation of IPC in their facilities. All the committees and IPC focal points will be trained on their roles and responsibilities in the first quarter of 2022 to ensure efficiency of the structures.

Water Quality Surveillance

During the reporting period, WHO, in collaboration with UNICEF and the Department of Public Health Engineering (DPHE) completed the third round of water quality surveillance (August – November 2021) in the FDMN settlements. Water samples from 158 functional health care facilities, 1,053 community water source points including 2,106 household, storage water and drinking water samples (4,212 in total), 338 Learning Centres/ Multiple Centres and 28 Pipeline Water Supply Systems tested for physical parameters (pH, Turbidity) and being analyzed for the presence of E. coli and metals (As, Fe, Mn). Additionally, sanitary inspections were conducted using observation methods.

92% of the community water source points are free of E. Coli contamination and matched the WHO guideline value as well as Bangladesh standard (0 cfu/100ml). The remaining 3%, 4% and 1% have 1-10 cfu/100ml, 11-100 cfu/100ml and > 100 cfu/100ml E. Coli contamination respectively. 111, 38, and 9 HCF have no/low risk, intermediate risk, and high risk of E. Coli contamination, respectively.

Out of 158 functional Health care facilities (HCF). 151 (95.57%), 4 (2.53%), and 3 (1.9%) HCF have E. Coli contamination levels of 0 cfu/100ml (Bangladesh standard), 1-10 cfu/100ml (intermediate risk), and 11-99 cfu/100ml (high risk), respectively. The results revealed that out of 158 HCFs the source water of 106, 40, and 12 have no/low risk, intermediate risk, and high risk of providing safe water, respectively, according to the WHO guideline.

The analysis of unsterile source water samples from 338 Learning Centres/ Multiple Centres showed that 89% are free from E. Coli contamination and matched WHO guideline value and Bangladesh standard. Additionally, all pipeline water delivery systems provided E. Coli-free water from source. Some pipelines had E. coli contamination at the domestic storage level that needed to be cleaned up via hygiene education.

The pH and turbidity of the water tests along the pipeline met Bangladesh standards (pH 6.5 – 8.5 and turbidity 10 JTU). However, the users must be educated about the proper use of chlorine tablets/solutions because some domestic storage water contains a high quantity of residual chlorine.

Technical reports with tailored recommendations were prepared after completion of the third round and shared with WASH and health sector stakeholders.

During the reporting period, sample collection and analysis of the 4th round of WQS (cumulative round of 18) were completed. In this round, sanitary inspection, E. coli, pH and turbidity, chlorine testing were conducted at 1044 sterile and 1044 unsterile community water sources and 2088 households, 156 health care facilities, 342 Learning/ Multiple Centres and 28 pipeline water supply systems.



WQS personnel is collecting storage water sample from a Rohingya household

Health Care Waste Management:

A 2—day Comprehensive Health Care Waste Management Training of Trainers (ToT) in the 09 HGSP Supported Health Facilities of Cox's Bazar District was held on 17-18 November 2021 at Cox's Bazar with 15 (8 Male and 7 Female) participants. Medical Officers from the Civil Surgeon Office, WHO Environmental Health experts, IPC Specialist and Communicable Disease Officer facilitated different sessions of the training.

WHO is supporting health care waste management of 45 HSSP supported health care facilities by supplying Coveralls, Safety Shoes, Safety Goggles, Kevlar Gloves, Anti-Needlestick gloves, Logistics gloves, Water & Chemical Resistant Aprons and Portable fire extinguishers.

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. The 49 primary health care centers (PHCs), 93 Health Posts (HPs), 25 other specialized facilities and three field hospitals supported by Health Sector partners continues to extend essential health services to over 900,000 Rohingya refugees and 541,021 Bangladeshi living in the surrounding areas of the refugee camps.

To ensure full accordance with WHO's commitment for "Zero Tolerance on Sexual Exploitation, abuse and harassment" WHO is conducting refresher trainings for all WHO staff to ensure proper sensitization and awareness regarding prevention of sexual misconduct as well as development of contextualized IEC materials. In collaboration with Gender in Humanitarian Action Working Group (GIHA WG) and UN Women, Health Sector also trained senior level management officers of partner agencies in Gender and PSEA mainstreaming into Health System and intends to roll out the training for Health Actors working in the camps further.

A Skill lab has been established in Cox's Bazar Medical College to capacitate health care service providers working in the camps and medical students to harness the basic and advanced competencies for the management of cases related to emergency Reproductive, Maternal, Newborn, Child, and Adolescent health issues.

WHO continued providing technical support as a resource to SRH WG through facilitation of capacity buildup initiatives and technical inputs in drafting knowledge products. During this reporting period, WHO collaboratively facilitated a ToT on "ANC and Life savings Protocol" targeted for health actors (midwives, doctors, and clinical supervisors). WHO technically supported the SRH Technical Working Group which is following up on the recommendations from recent HS quarterly HF assessment to scale up service availability and the Visual Inspection With Acetic Acid (VIA) taskforce led by UNFPA for early detection and prevention of cervical cancer. The VIA taskforce will also address the issues regarding VIA screening & follow up in CXB, especially within the refugee camps.

Availing blood to Rohingya refugees and Cox's Bazar population

Accessibility to blood as a lifesaving commodity for different segments of the population has been a concern of the health sector in the Rohingya response.

WHO under the Health and Gender Support Project (HGSP), has since the 2nd quarter continued to support the ongoing efforts to establish blood banks in all Upazila health Complexes in Cox's Bazar.


- Completed an assessment of the gaps and requirements needed to establish and operationalize the blood banks
- Organized a one-day consultative meeting with 40 participants, a workshop with 20 participants and 3-days training on safe blood transfusion Programme for Upazila Health and Family Planning Officers (UHFPOs) and 8 Medical Laboratory technologist of all Upazila in Cox's Bazar district have been accomplished.
- Procured and installed two refrigerators, for blood preservation in Teknaf and Ukhiya Upazila Health Complexes. Blood donation is anticipated to start in the first quarter of 2022 which will be a great relief on shortage of blood for patients in Cox's Bazar and will reduce time and lives lost due to referral of patients because of lack of blood.



WHO team deliver the refrigerator in Teknaf Upazila Health

Immunization

Under the leadership of the Government of Bangladesh and with the technical support of WHO and Health Sector partners, COVID-19 Vaccination for refugees continued. By 31st December 2022, 85% of the 432,462 targeted people above 18yrs of age had received at least one dose of COVID-19 vaccine (Sinopharm®), while 73% had received 2 doses.

 COVID-19 Vaccination Campaign for FDMNs / Rohingya Refugees -Summary									
Phase	Target Age group	Target population	1st dose administered	% of population received 1st dose against target population	Total population*	% of population received 1st dose against total population	2nd dose administered	% of population received 2nd dose against target population	% of population received 2nd dose against total population
Phase 1 (Aug- Sep 2021)	55 and above years of age	43,093	36,943	86%	907,766	38%	33,386	77%	4%
Phase 2 (December 2021) **	18 years and above (excluding those who have completed both doses in 1st phase)	389,369	306,727	79%			0	0%	
Total	18 years and above (1st+2nd phase - 6150)***	426,312	343,670	81%			33,386	8%	

* Population Source: Joint Government of Bangladesh - UNHCR Population Factsheet as of 31 October 2021

** Camp 23 and Bhasan Char population has been excluded in 2nd phase target.

** Estimated number of pregnant women is included in 2nd phase target population, however as per Government decision they were not vaccinated.

*** 6150 those who did not receive 1st dose in 1st phase, was included in 2nd phase

Fig 5: COVID-19 vaccination summary of both phases

Both fixed and outreach routine immunization (RI) sessions are being continued with the technical support of WHO. Active surveillance sites were reassessed by Upazila Government authorities with the technical support of Surveillance and Immunization Medical Officers (SIMOs) and approved by Civil Surgeon. Based on new surveillance site lists, active surveillance for AFP and VPD cases have been continued by WHO's Emergency Surveillance and Immunization Medical Officers (E-SIMOs).

Non-Communicable Diseases (NCD)

WHO PEN training

WHO Bangladesh together with Directorate General of Health Services conducted Six batches of a 4-days training on Package of Essential Noncommunicable Diseases Interventions for Primary Healthcare Providers in the months of November and December 2021. A total of 150 health workers (76 Female and 74 Male) including medical officers, nurses, and medical assistants from 7 Upazila Health Complexes and camp level primary health care centres of Cox's Bazar attended the trainings. The PEN training is aimed at building the capacity of health workers to provide better NCD prevention and control to non NCD patients and management to patients with NCDs following risk-based approach.

Orientation on National Protocol for Hypertension and Diabetes Mellitus

WHO and Health Sector also conducted 5 batches Orientation sessions on the National Protocol for Hypertension and Diabetes Mellitus for Health sector partners from 1 – 7 November 2021. In total, 160 facility in-charges, mid-level managers and Camp Health Focal Persons (42 Female and 118 Male) from 134 health facilities including health posts, primary healthcare centres and field hospitals in the Rohingya response attended. The orientation served to bring all health sector partners to speed with the current treatment protocols for better quality assurance of the services provided to patients in the camps.

NCD Prevention and Control Coordination Committee (NCDPCCC)

The Cox's Bazar District office of the Civil Surgeon Office with technical assistance WHO formed a district NCDPCCC to tackle the fast-growing problem of NCDs in the district. The 1st meeting of Cox's Bazar NCD Prevention and Control Coordination Committee (NCDPCCC) was held on 23 December 2021. Chaired by the Civil Surgeon of Cox's Bazar with participation of representatives of all Upazila Health and Family Planning Officers and other members of NCDPCCC, emphasis was laid on health promotion at all levels of health care and community.

Supportive supervision

NCD supportive supervision visits were conducted in 7 Upazila health complexes and 7 community clinics and 1 Union Sub Centre of Cox's Bazar district for strengthening the implementation of WHO PEN and national protocol in primary health care settings. During these visits, on-site training and relevant job aids were provided to healthcare staff of NCD corners.

Mental Health and Psychosocial Support (MHPSS)

mhGAP Supportive supervision and mentorship

WHO in collaboration with health partners provided supportive supervision to 65 (35 female and 21 Male) mental healthcare workers in Rohingya camps and Cox's Bazar district Sadar hospital with the aims to improve the quality of mhGAP services offered by trained clinicians and to better integrate mental health and psychosocial support services.

Three 5-day long mhGAP trainings were conducted in presence of 100 participants including Doctors, Nurses, and Medical Assistant (53 Male and 47 Female) from national NGOs, INGOs and government facilities to reach the target of aim of the trainings is to ensure that all facilities in the camps have at least one mhGAP trained clinician for better support of patients with mental health conditions in the Rohingya camps. Additionally, two one day refresher training sessions on mhGAP were also conducted for 23 previously trained mhGAP health workers to rejuvenate their knowledge.

Mental health patient management technical support to health workers in the Rohingya camps.

WHO has taken an innovative approach in providing mental health services where the mhGAP trained doctors receive remote technical support from WHO psychiatrist on patient management through social media platform (WhatsApp). Since November 2021, 60 consultations (42 Female and 38 Male) were directly assisted through this innovation.

Communicable diseases

Entomological survey

The WHO together with the National Malaria Elimination Program (NMEP), DGHS conducted an entomological survey of mosquito fauna in the FDMN camp areas to understand the present malaria and dengue vector status and biology to take appropriate control interventions. The entomological survey has completed on 29th November 2021 found Dengue and Chikungunya vectors in 07 FDMN camps. The highest numbers of vectors and vector breeding sites were found in Kutupalong registered camp which coincidentally also had been reported to have the highest dengue patients at that time. Additionally, the entomological teams also found one primary malaria vector species *Anopheles annularis* yet the previous surveys, did not find any primary malaria vector in the camps. NMEP recommended regular monitoring through surveys of malaria, dengue, and chikungunya vectors, and individual Aedes survey three times a year (pre-monsoon, monsoon, and post-monsoon).

Malaria training

WHO also conducted three batches of training on prevention, control and treatment of malaria in November 2021. A total of 151 health workers (91 Male: 60 Female) participated in the training from different INGOs, NGOs, UN agencies and government.

EMERGENCY PREPAREDNESS AND RESPONSE

WHO, IOM and UNFPA, conducted joint field visits to healthcare facilities in order to pilot the "Health Safety and Resilience Tool" The inputs from different functions and agencies will be compiled and the tool will be further reviewed for use in the field.

EPR Technical Committee and Mobile Medical Team (MMT) Technical Working Group facilitated a 2-day long multi-stakeholder workshop involving the MMT partners, health sector partners and protection sector. The workshop was organized to facilitate the review of the existing MMT operational and logistic plan; and generate concrete recommendations for updating the plans and improve coordinate between MMT TWG and other working groups and sectors. The partners recommended reviewing the existing MMT kit and considering response to multiple hazards prevailing in the camps (e.g. cyclone, monsoon heavy rain and flooding, fire, landslide and violence).

As part of the MMT kit review, a kit should have – a) common kit of medicines; b) a common kit for trauma management, c) a common personal and team deployment kit, d) a kit reserved for burn management and e) an extended package for response for 2 weeks after first 72 hours.

It was also highlighted for the strengthening of partners activity monitoring, capacity building, organizing camp level drill involving relevant health and non-health stakeholders, including but not limited to MMTs, incident commander, CHWs, DMUs, DRU, PERU and SMSD, GIS mapping of the MMTs, night deployment, equipping the MMTs with VHF as well as the participation of the MMT partners in Joint Need Assessments, CiC meetings and SRH, CHW, MHPSS and Protection sector mainstreaming.

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, WHO has supported the sentinel sites in the camps with the provision of 10,300 viral transport medium and 11,800 Zip Lock bag to reinforce the public health response to COVID-19.

As part of the efforts to strengthening the blood transfusion facility at Upazila and District level, WHO has refurbished the room and installed 2 blood bank refrigerators in Ukhia Upazila Health Complex.

WHO is also providing support of laboratory supplies including Rapid Diagnostic Kits (RDTs) for Dengue, Malaria, Hepatitis B & C, HIV, Cholera and Pregnancy Test), equipment for estimation of anaemia (Hemocue machines) and waste management supplies to the 45 health facilities.

During the reporting period WHO donated 13,666.56kg with volume of 96.59 cubic meter of kits, medicines, PPE and medical equipment to government health facilities and 10 partners in the Rohingya refugee camp. Logistics support to the IEDCR Field Laboratory is ongoing with transportation of COVID-19 sample collection in the camps.

ONLINE COVID-19 Resources:

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 can be accessed under the following link:

<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://www.humanitarianresponse.info/en/operations/bangladesh/health>

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 COVID-19 updates mailing list"

CONTACTS

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