







*PHOTO: The COVID-19 Seroprevalence Study has started: Dr Fahmida Sultana, a supervisor from BDRCS and Nahida, a data collector from Food for the Hungry (FH), at Sheikh Hasina's shelter at the Rohingya refugee camps. As a head of household, Sheikh Hasina is one of the first 1000 voluntary participants in the study.*

## HIGHLIGHTS

- Sample collection for a COVID-19 seroprevalence study started on 02 December 2020 in the camps. The aim of this study is to estimate the population-level exposure to SARS-CoV-2 across the Rohingya camps. This will be measured by visiting randomly selected households and selecting one participant from the household to provide a blood sample. The study is based on WHO's "UNITY protocol" for standardized sero-epidemiological investigations and aims to inform an evidence-based planning for the COVID-19 response in 2021. It is led by the Institute of Epidemiology Disease Control and Research (IEDCR) and supported by WHO, UNHCR, BDRCS, FH, RI, RTMI, BRAC and IOM. More than 1000 refugees participated in the study to date. The IEDCR Field Laboratory is playing a key role in testing the samples collected for the seroprevalence study in the Rohingya camps. Testing was initiated this week after deployment of ELISA kits for detection of antibodies against COVID-19.
- The health sector coordination team with support from a peer review team, formed by representatives from key national and international NGOs and UN agencies, recommended 26 projects from 26 partners for the Joint Response Plan (JRP) 2021.
- **SUBJECT IN FOCUS:** Setting up Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) in a complex setting

	Host Community	Rohingya refugees
 Total confirmed COVID-19 cases in Cox's Bazar	5 229	363
 Total cases in isolation in Cox's Bazar	187	28
 Total number of tests conducted	43 941	19 651
 Total deaths due to COVID-19	73	10

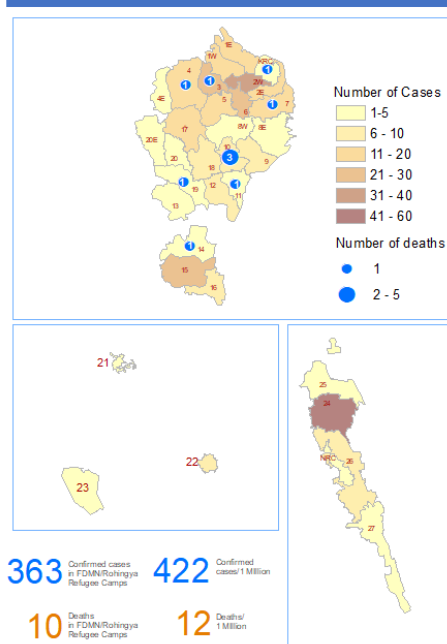
*\*Updated as of 06 December 2020 / \*FDMN = Forcibly Displaced Myanmar Nationals*

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, eight camp level health coordination meetings were held at Ukhiya and Teknaf Upazilas. Additionally, two Upazila level health sector coordination meetings were held at Ukhiya and Teknaf. The biweekly Camp Health Focal Point (CHFP) meeting was held, where updates, challenges and field achievements were shared with the Health Sector coordination team based in Cox's Bazar. The health sector coordination team with support from a peer review team, formed by representatives from key national and international NGOs and UN agencies, recommended 26 projects from 26 partners for the Joint Response Plan (JRP) 2021. A total of 36 projects were submitted for consideration. The Health Sector continues to publish weekly COVID-19 updates highlighting key activities of health sector partners to curb the spread of COVID-19 among host and Rohingya communities in Cox's Bazar. Planning for interviews and other activities to document lessons learnt on integrating Gender-Based Violence (GBV) in health sector emergency response is at advanced stage. The interviews with relevant health partners are scheduled for the second week of December 2020.

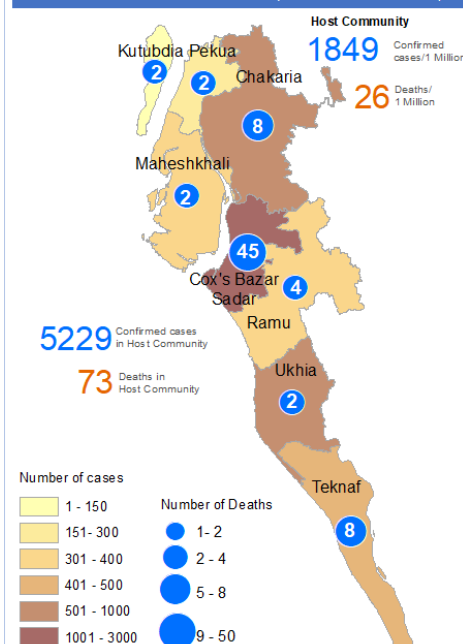
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COVID-19 Cases in Rohingya Camps (As of 06 December 2020)



COVID-19 Cases in Cox's Bazar District (As of 06 December 2020)



## 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 06 December 2020, a total of 5229 individuals from the host community in Cox's Bazar district have tested positive for COVID-19: 522 in Chokoria, 104 in Kutubdia, 331 in Maheshkhali, 210 in Pekua, 350 in Ramu, 2732 in Sadar, 430 in Teknaf and 550 in Ukhiya.

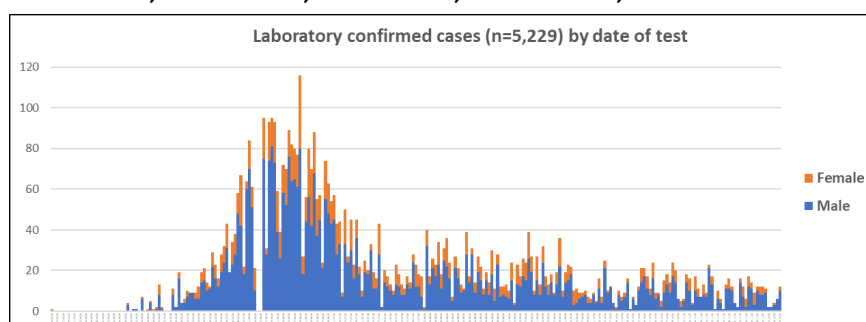


Figure 1: COVID-19 positive cases in among host population in Cox's Bazar District

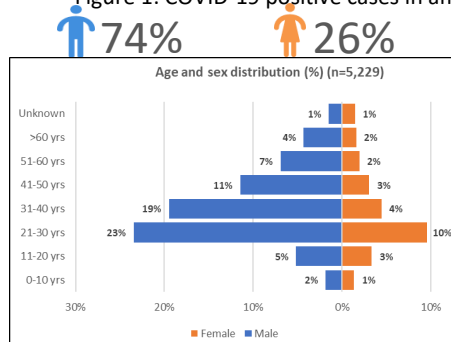


Figure 2: COVID-19 positive cases by age and sex among host population in Cox's Bazar District

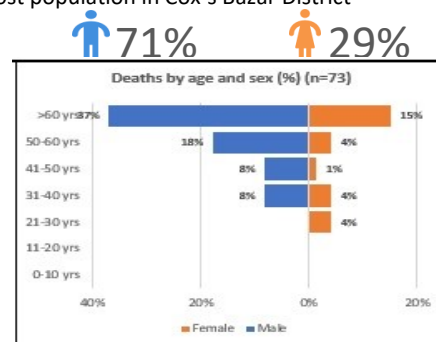


Figure 3: COVID-19 deaths by age and sex among host population in Cox's Bazar

As of 06 December 2020, a total of 363 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 36 and Camps 3 and 15 with 27 and 25 cases respectively. To date, 22 cases were reported from Camp 6, 17 from Camp 2E and 14 from camp 4. Camps 1W, 7 and 17 had 12 cases each. Camp 1E and Camp 5 registered 11 cases each and Camp 10 identified 10 cases while Camps 18 and 26 reported 9 cases.



As for Camps 9, 16 and 22, 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.

A camp wise dedicated Contact Tracing (CT) network (34 supervisors and 311 volunteers) has been embedded in the RIRT in camps, having captured 91% (1242/1362) of the contacts in the go.data, 79% of contacts have completed their follow up, while 1.1% (13) of known contacts became positive COVID-19 cases and 4.8% (13/269) cases have contacted with a suspected or confirmed COVID-19 case. WHO is closely supporting the CT activity through the field surveillance network. During epidemiology week 49, between 30 November - 06 December, seven new COVID-19 cases were confirmed in the Rohingya refugee camps.

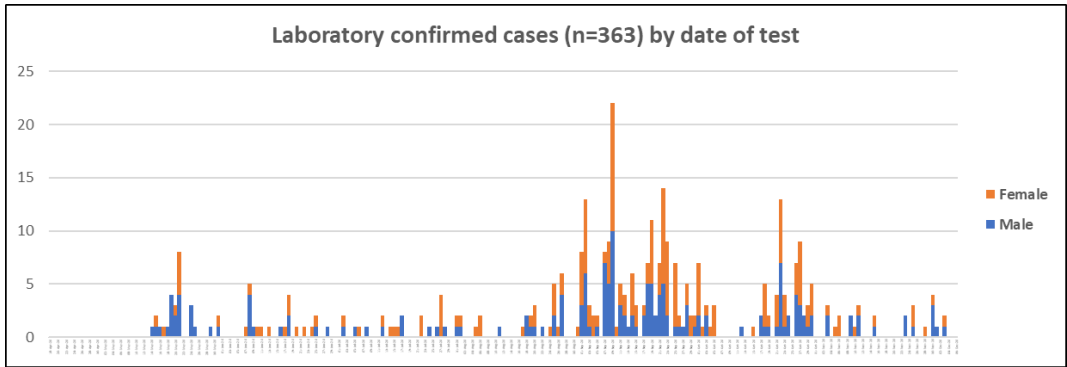


Figure 4: COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

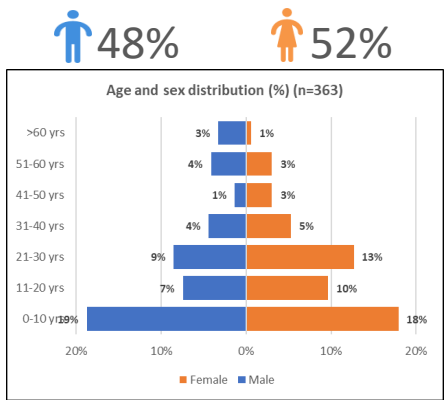


Figure 5: Age and sex distribution of COVID-19 positive cases among Rohingya refugees/FDMN in Cox’s Bazar

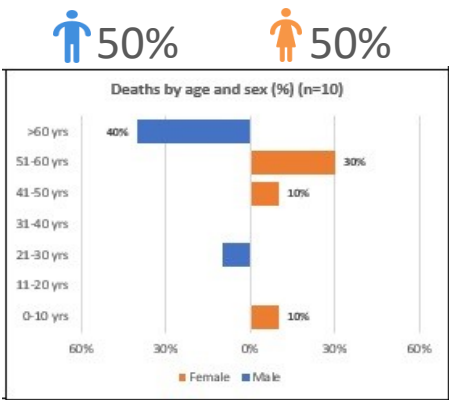


Figure 6: Age and sex distribution of COVID-19 deaths among Rohingya refugees/FDMN in Cox’s Bazar

The cumulative share of positive tests is 1.8%. In total, there were 363 confirmed cases of COVID-19 (SARS-CoV-2) detected out of 19 651 samples tested. The total number of deaths reported is 10 with case fatality rate of 2.8%. The incidence rate is 42.2 per 100 000 people. So far, 8.67% of the cases showed severe symptoms at the time of admission while 4.8% reported at least one co-morbidity. Although the median age of tested samples is 11 years, a significant proportion has been tested among 40+ years (223 per 10 000 people), however the highest number is 329 tests per 10 000 people among patients aged 0-9 years. The test positivity was highest in the 30-39 age cohorts with 2.7% and then 50+ years age cohort with 2.5% and the age specific mortality among 50+ years is 0.9% per 10 000 people.

Three new sample collection sites, out of 25, are functional for sample collection of suspected COVID-19 cases and followed up for digital data entry using Kobo platform. A slight decrease in the number of tests conducted among Rohingya was observed in week 49 (from 1477 to 1230) but an increase was observed in the host community population (from 1509 to 1553).

Since mid-October 2020, JAT investigation started to be rolled out and so far 19 assessments were done for Cholera RDT positive cases including three in the reported week (Week 49). In total, three cases were confirmed for Cholera, one from Ukhiya host community, one from Teknaf host community and one from Camp 16 in the refugee camps. Two (2) results are still pending, and others tested negative for culture. Twenty (out of 23) sentinel sites for cholera surveillance are functional including two UHCs and one DTC (located at Leda near camp 24) in Ukhiya and Teknaf testing over 200 samples on a random basis in a month. WHO is supporting with RDT kits to the testing sites.

Mortality due to suspected SARI, Measles or Cholera causes are being investigated by WHO Epi Surveillance network. In the previous epidemiology week 48, three suspected SARI deaths were investigated and discarded. In total, 46 deaths due to SARI were reported this year, 42 could have been identified and investigated, three deaths were due to COVID-19 and responded to accordingly. Similarly, four deaths due to suspected AWD with severe dehydration and three deaths due to suspected Measles were investigated and reclassified in 2020. October-December 2020 quarterly EWARS health facilities supportive supervision is being conducted and expected to be finalized by end of December 2020 with 146 visits currently registered in EWARS health facilities in camps and outside camps. So far, around 50% of the facilities were visited for supervision.

\*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.

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. With UNICEF and UNHCR, WHO is working on a community engagement plan to prepare for a potential upcoming COVID-19 vaccination for the Rohingya and host communities in Cox's Bazar. A camp wide survey into the informal health sector started. In the Cox's Bazar setting, the informal health sector is defined as any practitioners working outside of the formal and traditional medical and health structures within the camps (eg: informally trained pharmacists, medicine shop owners and dispensers, "quack doctors", and faith, spirit or traditional healers). Enumerators have started collecting information, interviewing over 600 people across all camps, as well as doing interviews with members of the informal health sector. The survey is being conducted in partnership with UNHCR and results will be available in early January 2021. Major community engagement outreach is part of the COVID-19 seroprevalence study. The study will help understand the total number of infections in the camps and aid in future planning of the response. This will be done by interviewing and requesting blood samples from over 6000 residents from the camps. The community engagement strategy includes outreach by Camp Health Focal Points to camp-based CiC's, Imams, Mahjis, site management field workers, to share information with them about the process and reason behind the project and to ask them to share the information with their communities. Community Health Workers (CHWs) will accompany the medical teams as they visit randomly selected households. Community engagement materials such as audio explanations in Rohingya, animation and flipcharts have been created by BBC Media Action, based on technical information supplied by WHO. During the reporting period CHWs conducted 151 025 household visits in which 4963 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and four patients were identified with moderate/severe symptoms. The cumulative number of mild patients is 67 092, and 217 moderate/ severe patients. 1246 persons with COVID like symptoms were referred to health facilities from a total of 29 284 to date. Through coordination by the CHWG, COVID-19 messages reached 301 763 persons between 30 November and 6 December. Since the beginning of the response, CHWs have conducted 4.17 million household visits and had contacts with a cumulative number of more than 12.8 million adult household members. Through the CwC WG, another 37 043 people were engaged in 12 460 small group sessions. Furthermore, 113 CHW supervisors have been trained on Routine immunization while 1416 CHWs have been oriented on seroprevalence study with 136 currently supporting the study by obtaining consent and helping navigate sample collection activities, among others.

## 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 6 December 2020, a total of 74 530 tests for COVID-19 have been conducted of which 63 592 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 49 (from 1477 to 1230 tests per one million population) but a slight increase was observed in the host community population (from 1509 to 1553 tests per one million population). Currently, 25 sample collection sites are operating for suspected COVID-19 patients. The Field Laboratory is playing a key role in testing the samples collected in the Rohingya camps for the COVID-19 seroprevalence study. To date, more than 1000 refugees participated in the study. Testing was initiated this week after deployment of ELISA kits for detection of antibodies against COVID-19.

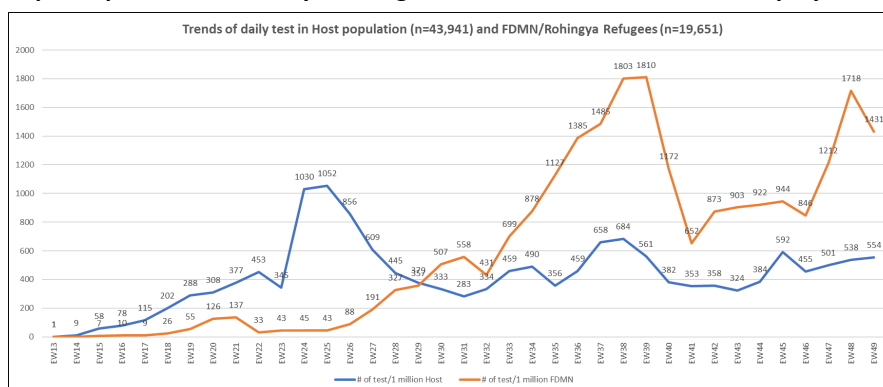


Figure 7: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees

## INFECTION PREVENTION AND CONTROL

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. The WHO WASH and Health Care Waste Management (HCWM) team supported a health sector partner (GK-Malteser Int) with a training on WASH & Health Care Waste Management for 41 health post based staffs at Camp 1E, Camp 11 and Camp 22 in Ukhiya and Teknaf between 1-3 December with hands on skills to ensure capacity in health post staff on safe and standardized management of clinical health care waste and WASH practices in the context of COVID-19. Relevant technical issues regarding WASH & HCWM at these different health facilities were addressed and on site recommendations were provided to the respective facility management.

SARI ITC case management meetings have moved to a bi-weekly rotation as of last week, allowing partners to focus on patient care and planning for 2021 during this period of low case prevalence across most SARI ITCs. The uncertainty on the trend of COVID-19 complicates the planning processes and partners are reporting that phased approaches are being considered with frequent analysis of the situation to ensure that vigilance remains high and capacity is maintained to rapidly scale up a response if and when needed. Bed capacity remains as before at close to 640 operational beds and additional 550 beds on standby. Bed utilization is at 9% at the time of reporting with mostly mild/moderate cases being treated. During the reporting period the first two Basic Emergency Care trainings were provided to 16 SARI ITC nurses and clinicians in emergency care procedures. This is a second step to build critical care capacity among health care providers within the SARI ITC network to ensure safe transfer of critically ill COVID-19 patients to the ICU at Sadar Hospital.

## ESSENTIAL HEALTH SERVICES

WHO organized one supervision session for mhGAP trained personnel where four individuals, including two doctors from partner agencies, received the supportive visit of WHO MHPSS Consultant. WHO actively participated in the MHPSS working group and suicide prevention subgroup's biweekly meetings and organized a new round of mhGAP training for 26 health care professionals (doctors, nurses, psychologists and MHPSS coordinators) from Government and partner agencies. The mhGAP approach consists of interventions for prevention and management of priority MNS (Mental, Neurological and Substance) conditions, identified on the basis of evidence about the effectiveness and feasibility of scaling up these interventions in low- and middle-income communities.

Supportive supervision visits were conducted following trainings on "Clinical management of rape" and "Adolescent sexual and reproductive health and rights in Humanitarian crisis" as a follow up for primary health care centers of PHD-UNICEF and Relief International.

Routine immunization sessions continue, both fixed and outreach, with WHO's guidance regarding the operation and sustaining of immunization programs during the COVID-19 pandemic based on a strategy and microplan which have been implemented. To strengthen Routine Immunization and VPD surveillance through fixed vaccination sites, WHO IVD team has completed a Training on IPC modules of COVID-19 for vaccinators in Teknaf. Vaccine-Preventable Disease surveillance is being closely monitored by government authorities with WHO's technical support. WHO SIMOs and Health field monitors (HFMs) continue to visit health facilities for surveillance, monitoring and investigation to contribute to the National AFP & VPD surveillance system. As part of the Active Surveillance, SIMOs are visiting surveillance sites for VPD case investigation. During the reporting period, two laboratory confirmed Rubella cases have been shared by the National Polio and Measles Laboratory (NPML). SIMOs & HFMs have taken the necessary steps to activate case search inside the block and around the household. No other suspect cases were found, and the confirmed cases have recovered with no complications.

Coverage of antigens in Routine Immunization has further increased in November compared to previous months thanks to the efforts to harmonize line listing in EPI registration books by vaccinators with the most updated child data from Community Health Workers. WHO Health Field Monitors are continuously monitoring the process. The Antigen dropout rate has also decreased. Enhanced risk communication activities including regular meetings with community leaders have contributed to the increased acceptance of Routine immunization by beneficiaries.

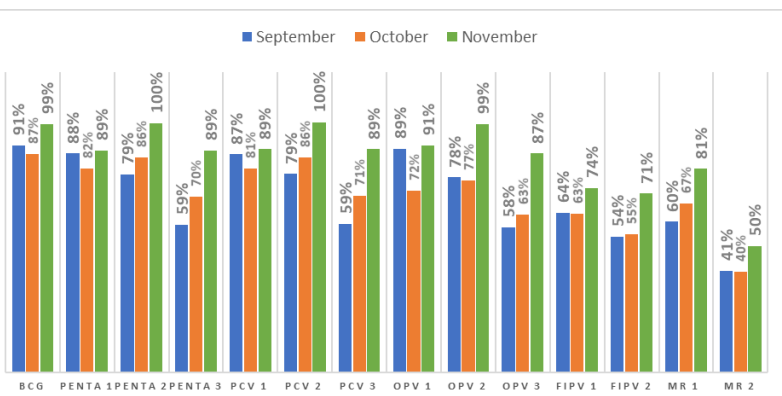


Figure 8: Antigen coverage rate has increased in November

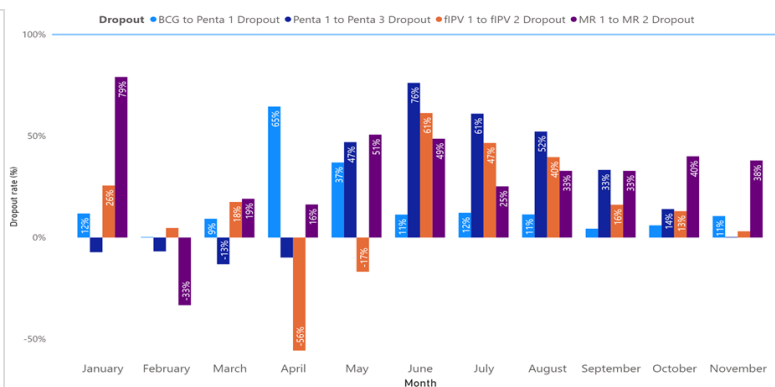


Figure 9: Antigen dropout rate in 2020

## MONSOON AND CYCLONE PREPAREDNESS

The Health Sector and 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, a review of the emergency and preparedness plan was shared focusing on how the catchment areas will function and how CHFPs respond to cyclones or other emergency. A second field visit was made by Health, Shelter and Site Management Sector members to evaluate the structure at SARI ITCs for the purposes of patient evacuation during natural disasters. Three SARI ITCs were visited, including UNHCR/ RI, IRC and UNICEF/ icddr,b. A report by the attending engineers will be shared with the partners operating the isolation facilities, and recommendations will be added to the Health Sector emergency and preparedness plan.

During the reporting period, a total of 1680 Kg and 19.7 CBM of Medicines, VTM, GBV stationary and medical equipment were distributed to implementing partners in the camps. In support to the COVID-19 seroprevalence study currently being conducted in the camps, 300 packages including PPE and sample collection tools were transported to Uhkiya and Teknaf, and three vehicles are supporting the teams in the field. Beds were transported to the Skills Laboratory at the Cox's Bazar Medical college.

A plan was developed to distribute spare parts of 300 oxygen concentrators to the government and partners in the coming week. WHO continues its support to DRU activities and sample collection in the camps with four vehicles.



Photo: Three hundred packages including PPE and sample collection tools were transported to the refugee camps.

## POINTS OF ENTRY

Sixteen out of nineteen points of entry (POE) have been functional in different strategic locations around the camps. A total of 34 054 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 with fever. Three POE are closed as a result of Education Sector staff returning to their regular duties, but efforts are ongoing to replace staff for continued screening.

## SUBJECT IN FOCUS: Setting up Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) in a complex setting

Under the leadership and technical expertise of WHO, health partners collaborated to establish 15 Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centers (ITCs) to provide quality care for COVID-19 patients, in an admirable example of collaboration by UNHCR, IOM, UNICEF/ icddr, Save the Children, IRC, Hope Foundation, Relief International, FH-MTI, IFRC, and MSF, creating nearly 1200 beds with capacity to provide care for severely ill patients, including provision of oxygen therapy, by November 2020.

### Context

Internal WHO discussions on potential outbreak scenarios of COVID-19 in the Rohingya refugee camps commenced in February, rapidly expanding to engage multiple UN and NGO partners in the planning and operationalization of specialized dedicated treatment centers and targeted clinical treatment options required to mount an effective response to a COVID-19 outbreak within the means feasible in the Cox's Bazar context, and largely utilizing local capacity. Early modelling projections from renowned academic institutions suggested that a large-scale outbreak was very likely in the Cox's Bazar setting after the virus had entered the world's largest refugee camp.



Photo: The densely populated refugee camps is Cox's Bazar are sheltering 860 000 Rohingya. Early this year, humanitarian organizations come together to find ways to effectively respond to COVID-19 infections.

Projections indicated alarming rates of infection, with up to over 90% of the population that could become infected within the first three months, depending on the transmission scenario. Daily numbers of severe patients requiring hospitalization were expected to reach 1000s within a short time and over 2000 deaths were expected within 12 months, even under the best scenarios. This was expected to vastly overwhelm the capacity of the existing health services. Based on the study findings, key planning assumptions were used to calculate surge specialist health care needs, dedicated bed capacity, increased staffing requirements, IPC measures for frontline health care workers; and specific medical equipment, supplies and medicines already in critically high demand around the globe - such as oxygen and Personal Protective Equipment (PPE).

### Establishing Specialized Care & Bed Capacity

In March, WHO developed a concept of operations for the "Establishment of COVID-19 Temporary Treatment Centres near the Rohingya Camps in Ukhiya and Teknaf", outlining the required minimum standards for Severe Acute Respiratory Infection (SARI) Isolation and Treatment Centres (ITCs). WHO worked closely with Government and partners throughout design, construction and implementation phases of SARI ITCs providing valuable technical SARI expertise in optimal site selection, aspects of layout and construction, clinical equipment, drugs, oxygen, laboratory support services, staffing plans and IPC considerations for both patient care and health care workers, and safe clinical infectious waste management/disposal.



In addition, WHO has been facilitating ongoing training support and supportive supervision visits to ensure safe quality standards of care are being delivered across the Case Management Working Group of the Health Sector. To date, 509 and 188 doctors and nurses mainly from SARI ITC partners and Government facilities were trained on COVID-19 clinical case management. Leading a Technical needs assessment, WHO helped guide the development of an oxygen surge and continuity plan, calculating the life-saving and vital estimated oxygen requirements, including the advocacy and facilitation of the delivery of 6 field oxygen plants for 50 beds each, capable of generating up to 303L per min/436 320L in a day and making linkages to help partners procure oxygen through local supply chains. Based on the technical guidance and with the continuous support from WHO Health Sector partners, 15 facilities with nearly 1200 dedicated beds were established and evenly distributed across the camps, providing specialist clinical management of COVID-19 patients to refugees and surrounding host community. Due to the significant resources and limited availability of specialist skill sets of health staff, the maximum level of care available in the SARI ITCs is restricted to severe COVID-19 cases but could not be provided for critical patients. In response, a referral pathway has been established - and is currently strengthened - to allow for the safe transfer of critically ill COVID-19 patients to the newly established Intensive Care Unit at the Cox's Bazar District Sadar Hospital. Across the SARI Network, each ITC reports their daily clinical service activity data using a KOBO form, a tool that is used for data collection in other contexts of the Rohingya response.



Photo: WHO supportive supervision visits were conducted throughout all stages of establishing the SARI ITC facilities.



Photo: To date, WHO provided infection prevention and control (IPC) trainings to nearly 3000 health care workers.

### Preparing for COVID-19: IPC and a culture of patient safety

In the months prior to the first COVID-19 patient in Cox's Bazar (March 2020) and in the Rohingya refugee camps (May 2020), WHO organized sensitization sessions to prepare humanitarian and government staff from all sectors to prevent transmission of the disease through infection prevention and control (IPC) measures to be undertaken at individual, organization and community levels. To date, over 3000 humanitarian workers from all sectors were trained. Together, WHO and health partners prepared for COVID-19 in the many fronts of the health care system to ensure patient safety and health care workers' safety amidst the greatest pandemic of our times. By engaging different stakeholders including government, donor agencies, ISCG, UN, INGOs, Bangladeshi NGOs, Rohingya and host communities, WHO coordination meetings where partners shared

the understanding of the desired response in terms the projected case loads and burden to the healthcare system at the peak of the outbreak and therefore bed capacity, medical oxygen capacity requirements for mobilization of resources, acceptability, trust and security of the would-be SARI facilities. Different partners expressed interest in operating SARI facilities to increase bed capacities that would meet the anticipated demand at the peak of the outbreak, and in record time SARI ITCs were established across the camps.

### SARI facility design: considerations and requirements

WHO with a team of relevant technical expertise including engineers, and experts in emergency and disaster preparedness, public health, infectious diseases, among others, visited several sites to select the most suitable for construction of the SARI facilities that would accommodate projected total bed capacity to serve the Rohingya refugees and immediate host community in Cox's Bazar. WHO provided partners with the appropriate designs for SARI facility guided by the Practical manual to set up and manage a SARI treatment centre and a SARI screening facility in health care facilities that could be easily adaptable using locally available materials of the partners choice including bamboo, clay bricks and any other materials. The designs generally considered: adequate ventilation, security, water and water storage, wastewater and drainage, sanitation and hygiene, dead body management, waste management and cyclone resistance. COVID-19 being an infectious disease, the following spaces were adequately provided for in SARI facility designs for infection prevention and control (IPC): separate entry and exit for patients, visitors and staff, screening points at all entries, changing rooms, designated room for putting on Personal Protective Equipment (PPE), designated room for putting off PPE, separate wards for suspected and confirmed patients (also separated by gender), PPE free observation area for nurses and doctors, chlorine mixing areas, laundry rooms, sterilization rooms and waste management zone. WHO continued to visit the sites and engage site engineers and partners during construction to give appropriate guidance whenever necessary throughout the construction process.

### At the heart of patient care: human resources

WHO led the estimation of staff that SARI facilities needed depending on the capacity of the facility using experience of management of other infectious diseases. Clinical staff, including doctors, nurses, nurse assistants, pharmacist, IPC lead, laboratory staff, would constitute approximately 60 % of the total staff. The logistical staff (WASH officers, supply staff, construction staff, fleet staff, hygiene officers, cleaners, laundry and cooks constituted 30% while operation support staff (leadership and management, external coordination, human resource, monitoring & evaluation staff, data manager) constituted 10% of the total staff at the SARI facilities. For some tasks positions like IPC that were relatively new to the partners, WHO provided an organogram and description of activities for each level to help partners in recruitment and appropriate utilization of the recruited staff.

Following the WHO disease commodities packages for COVID-19 and the WHO COVID-19 Essential Supplies Forecasting Tool (ESFT), WHO Cox's Bazar Emergency Sub-Office also helped partners to estimate the quantities of PPE, medicines and supplies and other equipment that would be needed to run the SARI facilities depending on the anticipated bed capacities. For example, to estimate PPE requirement, the following considerations were made: level of PPE required for a given activity being undertaken (one whole set), number of expected entry and exit times per shift, number shifts per 24hrs, number of staff per shift and total number of days. Considering the global shortage of PPE and other essential supplies and equipment related to COVID-19, WHO accessed large quantities through centralized procurement mechanisms, and provided these to partners, in particular to local Government facilities, to ensure safety of patients and staff and the best possible clinical case management.



Photo: In 2020, WHO distributed 1.5 million PPE items among government-led facilities and health partners in Cox's Bazar.



Photo: WHO has been providing trainings for adequate management of patients with COVID-19 through cost-effective strategies to empower health workers responding to the pandemic.

### Training and Standard Operating Procedures (SOP) for SARI facilities

In the complex health setting of Cox's Bazar, caring for COVID-19 patients is not an easy feat. With the increasing number of COVID-19 cases around the world, WHO has been providing trainings for adequate management of patients with COVID-19 through cost-effective strategies to empower health workers responding to the pandemic in a district hosting nearly one million refugees. WHO led trainings in the following modules: IPC, clinical case management, case alert and surveillance, laboratory, protection, duty of care, operational leadership, risk communication and community engagement and conveyance of patients and decontamination of ambulances. WHO rolled out trainings in form of Training of trainers making sure that each facility had at least two trainers who then cascaded training to the rest of the staff in the facility. WHO staff also went to each facility to reinforce the training through continuous education sessions with different cadres of staff at the SARI ITC facilities.

After training, WHO facilitated partners with SOP for IPC, clinical case management, and COVID-19 sample collection to guide the work of the staff. Before receiving patients in each SARI ITC, WHO facilitated dry runs with different cadres of staff right from doctors to cleaners and waste handlers on how their typical day with COVID-19 patients should be with emphasis to proper IPC adherence. To this day, WHO is ensuring continuous capacity building through the coaching and individual case reviews that the case management team offer to the ICU and SARI ITC staff.

### Addressing community fears towards the newly established facilities

With the SARI facility construction complete and equipment, supplies, consumables and staff in place, community engagement was the next very important step to familiarize the communities with the newly established facilities. WHO encouraged all SARI facilities to invite representatives and community leaders of both refugee and host communities to visit the facilities to better understand the layout, operations, and interact with the leadership and staff of the facilities. This community engagement contributed towards acceptability of the facilities by the community who was understandably worried about the COVID-19 situation.

### Patient transfers

The COVID-19 response, required the coordination of patient transfers through a centralized Dispatch and Referral Unit (DRU) managed by the International Organization of Migration (IOM) with a total of 21 ambulances. Various health partners, including those running SARI ITCs, contributed with ambulances to transport COVID-19 patients. All health facilities in the camp have been provided with the COVID-19 referral pathway algorithm which has the DRU telephone numbers to call in case of a suspected COVID-19 patient. The DRU also has a centralized ambulance decontamination system.

### Quality assurance and continuous improvement

Good quality of healthcare does not only accelerate acceptability of services provided but also safety of the patients and health care workers. To that end, WHO developed quality assurance tools including: daily IPC checklists, monthly IPC scorecard, environmental and equipment cleaning schedule, and daily stock taking. WHO also carries out continuous medical education sessions, weekly clinical case management meetings, monthly IPC technical meetings and Quarterly Supportive supervision visits to all SARI facilities in order to promote maintenance of high quality of services delivered by the SARI facility partners. To date, 15 SARI facilities with a total bed capacity of 1185 were established, 638 of which are operational and 547 currently on standby. Six SARI facilities are located in Teknaf, 10 in Ukhiya and 03 in Sadar Upazilas (including 1 Intensive Care Unit (ICU)/High Dependency Unit (HDU) respectively.

Through promoting coordinated health action and best practices in Cox's Bazar, WHO and health sector partners have been instrumental to prevent excess morbidity and mortality as a result of coronavirus infections



	Last 24 hours	Total
COVID-19 tests conducted	17 084	2 894 622
COVID-19 positive cases	2202	481 945
Number of people released/recovered	2571	400 110
COVID-19 deaths	32	6906

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](mailto: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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