The COVID-19 seroprevalence study was launched at a Coordination meeting held on November 29th by Representatives from IEDCR, WHO, UNHCR, BDRCS, FH, RI, BRAC & FMTI. The meeting aimed to provide an overview of the study allowing time for discussions drawing on the experience of the partner organisations in running activities across the camps. The study has started and will be completed by the end of December.

The Health Sector peer review team (PRT) met to evaluate the 38 projects submitted for 2021. The complex process of project reviews is only possible thanks to the efforts from the PRT (IRC, BRAC, Save the Children, UNFPA, WHO, UNHCR, IOM and UNICEF). Results will be shared next week.

During the reporting period WHO collected data in reference to TB activities in November. Medical technologists performed 220 and 180 GXP tests in Ukhiya and Teknaf UHC, respectively; 185 routine microscopy tests for TB diagnosis; and helped collect samples for COVID-19. WHO TB field assistants conducted 12 sessions on TB community awareness in the refugee camps.

SUBJECT IN FOCUS: Achievements to date in the area of Points of Entry screening for COVID-19 in Cox’s Bazar - A proactive and collaborative effort to keep coronavirus at bay in Cox’s Bazar.

<table>
<thead>
<tr>
<th></th>
<th>Host Community</th>
<th>Rohingya refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total confirmed COVID-19 cases in Cox’s Bazar</td>
<td>5 180</td>
<td>356</td>
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<tr>
<td>Total cases in isolation in Cox’s Bazar</td>
<td>229</td>
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<tr>
<td>Total number of tests conducted</td>
<td>42 388</td>
<td>18 421</td>
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<tr>
<td>Total deaths due to COVID-19</td>
<td>73</td>
<td>10</td>
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</table>

*Updated as of 29 November 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, seven 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 chaired by Upazila Health & Family Planning Officer under MOHFW. Both meetings were facilitated by Health Sector Field Coordinator where participants from 39 partner agencies (UN agencies, INGOs, NGOs, Government, RRRC, MOHFW Coordination cell) debated on organizational updates and key challenges and achievements. The meetings are an effort to strengthen coordination, collaboration and liaison among partners (government and non-governmental) for on-going implementation of health services activities in the refugee camps and nearby host communities. In addition, five camp level health partners coordination meetings took place during the reporting period. The Health Sector Coordination meeting was held this week with 47 participants, addressing the standard agenda topics (epidemiology, case management and IPC and immunization), and also reviewing results from the Cluster Coordination Performance Monitoring (CCPM), EPR updates, and information about vacancy for a gender hub health focal point. The Health Sector peer review team (PRT) met to evaluate the 38 projects submitted for 2021. The final date for JRP project submissions was November 26th and on November 28-29th the peer review team (PRT) met to evaluate projects. The complex process of project reviews is only possible thanks to the efforts from the PRT (IRC, BRAC, Save the Children, UNFPA, WHO, UNHCR, IOM and UNICEF). Results will be shared next week and final submission for approval to the Humanitarian Program Cycle (HPC) module will be December 6. Conversations continue around the impact of the fencing on health services for both host and refugee communities. Mapping of health care facilities and feedback from stakeholders will be collected and shared with ISCG.

WHO continues to provide epidemiological data to support operational decision making for the COVID-19 response in Cox’s Bazar. As of 29 November 2020, a total of 5180 individuals from the host community in Cox’s Bazar district have tested positive for COVID-19: 520 in Chokoria, 104 in Kutubdia, 329 in Maheshkhali, 209 in Pekua, 346 in Ramu, 2707 in Sadar, 429 in Teknaf and 548 in Ukhiya. 

As of 29 November 2020, a total of 356 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 33 and Camps 3 and 15 with 27 and 25 cases respectively. To date, 21 cases were reported from Camp 6, 16 from Camp 2E and 14 from camp 4. Camps 1W, 7 and 17 had 12 cases each. Camp 1E registered 11 cases and Camp 10 and 5 identified 10 cases while Camps 18 and 26 reported 9 cases. 

SURVEILLANCE, RAPID RESPONSE TEAMS, AND CASE INVESTIGATION

![COVID-19 Cases in Cox’s Bazar District](image)

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

![COVID-19 positive cases by age and sex among host population in Cox’s Bazar District](image)

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

![COVID-19 deaths by age and sex among host population in Cox’s Bazar](image)

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

As of 29 November 2020, a total of 356 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 33 and Camps 3 and 15 with 27 and 25 cases respectively. To date, 21 cases were reported from Camp 6, 16 from Camp 2E and 14 from camp 4. Camps 1W, 7 and 17 had 12 cases each. Camp 1E registered 11 cases and Camp 10 and 5 identified 10 cases while Camps 18 and 26 reported 9 cases.
As for Camps 9 and 16, 8 cases were reported. Camps 12 and 22 registered to date 7 cases each. 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.

Camp-wise Rapid Investigation and Response Teams (RIRT), composed of one coordinator, one clinical supervisor and one contact tracing supervisor, have been responding to alerts within 24 hours and referring patients to SARI ITCs with the help of the Dispatch and Referral Unit (DRU). Contact tracing and referral to quarantine facilities and follow up during the period of at-home quarantine has been facilitated in coordination with other sectors and camp administration. A camp wise dedicated Contact Tracing network (34 supervisors and 311 volunteers) are embedded in the RIRT for contact tracing, having captured 91% of the contacts (1223/1343) in go.data. So far, 79% (964/1223) of contacts have seen their follow up completed and were released from quarantine, while 1.1% (13) of known contacts have tested positive for COVID-19.

As of week 48, between 23 - 29 November, 6 new COVID-19 cases were confirmed in the Rohingya refugee camps. The cumulative share of positive tests is 1.9%. In total, there are 356 confirmed cases of COVID-19 (SARS-CoV-2) detected out of 18 421 samples tested. Ten is the total number of deaths reported with case fatality rate of 2.9%. The incidence rate is 40.7 per 100 000 people. 8.7% of the cases showed severe symptoms at the time of admission while 6.8% reported at least one co-morbidity. Although the main age of tested samples is below 12 years, a significant proportion has been tested among 40+ years (198 per 10 000 people), however the highest number is 280 tests per 10 000 people among patients aged 0-9 years. The test positivity was highest in the 30-39 age cohorts with 2.9% and the age specific mortality of 0.9% per 10 000 people. The testing of contacts of confirmed cases has started this week regardless of being symptomatic or asymptomatic in selected sample collection sites. This week (week 48), seven contacts of confirmed cases were tested and one was COVID-19 positive. Three new sample collection sites out of existing 25, are now functional for suspected COVID-19 sample collection and follow up for digital data entry using Kobo platform. An increase in the number of tests conducted among the Rohingya was observed in week 48 (from 1042 to 1477 tests per one million population) as well as in the host community population (from 1405 to 1509 tests per one million population). Since mid-October 2020, JAT investigation was conducted for 11 cases that have tested positive for RDT including 2 in the reported week. Out of those, one was confirmed for Cholera in the Ukhia host Community. Two results are pending and others testing confirmed culture. Twenty (20) sentinel sites for cholera surveillance are functional including 2 UHCs and 1 DTC (located at Leda near camp 24), testing over 200 samples on a random basis in a month. WHO is providing support with RDT kits to testing sites. All suspected mortality due to specific causes (maternal, neonatal, SARI and other infectious diseases) continue being investigated by assigned teams i.e. MPDSR team, RIRT, JAT or CHDSO. So far 15 suspected SARI death investigation were conducted, three reclassified as probable and confirmed COVID-19 deaths according to the protocol. October-December 2020 quarterly EWARS health facilities supportive supervision continued, expected to end by 31st of December 2020. Currently, 146 visits have taken place in health facilities in camps and outside camps. A migration is planned for Early Warning, Alert & Response System (EWARS) to countries/contexts using EWARS-in-a-Box in order to adapt the upgrading of the system. The migration process has started on 30 November and took 24 hours to upgrade the system which is expected to be available on 3 December. Web users with log for the new system with existing network and mobile users must now uninstall their existing mobile application and download the new smartphone application.

*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 of Cox’s Bazar. Planning for the strategy is ongoing in order to be ready for vaccine delivery. The broadest possible community outreach is being prepared. A camp wide survey into the informal health sector has 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). The survey, in partnership with UNHCR will investigate how the informal sector works within camps, interviewing both users and practitioners. Training for enumerators started on 29 November, with the survey results expected in early January 2021. A total of 1416 community health workers (CHWs) have been trained and are coordinated by the Community Health Working Group (CHWG) to provide enhanced Community Based Surveillance and Home-Based Care which includes counselling on testing, quarantine and patients’ referral to isolation facilities. During the reporting period CHWs conducted 157 817 household visits in which 3600 patients were identified with mild respiratory symptoms (fever, sore throat, cough) and two patients were identified with moderate/severe symptoms. The cumulative number of mild patients is 62 128, and 213 moderate/ severe patients. 1474 persons with COVID like symptoms were referred to health facilities from a total of 28 037 to date. Through coordination by the CHWG, COVID-19 messages reached 293 322 persons between 23 and 29 November. Since the beginning of the response, community health workers have conducted more than 4 million household visits and had contacts with a cumulative number of more than 12.5 million adult household members. Through the CwC WG, another 37 217 people were engaged in 11 554 small group sessions. Furthermore, 113 CHW supervisors have been trained on Routine immunization.

**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 29 November 2020, a total of 71 197 tests for COVID-19 have been conducted of which 60 809 are from Cox’s Bazar district and the remainder from Bandarban and Chittagong districts. An increase in the number of tests conducted among the Rohingya was observed on week 48 (from 1042 to 1477 tests per one million population) as well as in the host community population (from 1405 to 1507 tests per one million population). Currently, 25 sample collection sites are operating for suspected COVID-19 patients. The COVID-19 seroprevalence study was launched at the Cooperation meeting on November 29th by Representatives from IEDCR, WHO, UNHCR, CBHCS, FH, RI, BRAC & FMTI. The meeting aimed to provide an overview of the study allowing time for discussions drawing on the experience of the partner organisations in running activities in the camps. Dr Mahbubur Rahman from IEDCR gave a presentation outlining the planning and training required to train over 100 field workers to collect blood samples from approximately 6200 households. Prof Dr Meerjady Sabrina Flora ADG, the chief guest, mentioned the importance of the study for the people living in the Rohingya camps and for future seroprevalence studies planned across Bangladesh. The study has started and will be completed by the end of December.

![Figure 7: WHO Head of Sub-Office, Dr Kai von Harbou; IEDCR Principal Scientific Officer Dr Asm Alamgir; and Additional Director General DGHS, Dr Meerjady Sabrina Flora, at the Seroprevalence Study Coordination meeting.](image)

**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. Supportive supervision visits were conducted in health care facilities across Ukhiya and Teknaf (03 PHC and 04 Health Posts) with several COVID-19 related IPC, WASH and HCWM related issues being identified. Relevant technical recommendations were provided on site and issues communicated to different stakeholders for further collaboration.

![Figure 7: Number of tests conducted per million among the host population and the FDMN/Rohingya refugees.](image)
MONSOON AND CYCLONE PREPAREDNESS

The Health Sector (HS) 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. The EPR WG met to review catchment areas and medical hubs confirmed to date, flood mapping and EPR updates with consideration to COVID-19. A preliminary draft was shared of the tiered response for emergencies based on their severity. EPR WG partners were very keen to help finalize the plan with more detail in the coming weeks. A first field assessment was made at SARI ITCs (Hope Foundation, IOM Camp 20 ext. and Save the Children) for cyclone evacuation. IOM SMS and Caritas shelter engineers accompanied HS coordination to ensure technical oversight and standardized assessments. Another three SARI ITCs will be assessed next week.

CLINICAL CASE MANAGEMENT

A new SARI ITC has opened this week in Cox’s Bazar with the support of WHO, Action Contre la Faim and IOM. The current SARI ITC bed capacity in the camps remains stable at 638 operational beds and 547 stand by beds respectively. Equally, the occupancy remains low with 1.0% of the operational beds being utilized mostly for mild and moderate but also some severe cases. The past weeks SARI ITC partners have discussed and planned for the need to strengthen critical patient referrals between SARI ITCs and the Sadar Hospital Intensive Care Unit. The four Basic First Aid (BFA) trainings that took place in November were a first step towards building the capacity of health staff to safely accompany critical patients during transport. Further steps have now been taken to ensure a number of ambulances are being upgraded with technical equipment and supplies. Planning and administrative steps have taken place to commence the next step in building critically needed emergency care skills among SARI ITC staffs. The Basic Emergency Care training will be conducted in December and is again a collaborative endeavour between ICRC and WHO, benefitting from a highly motivated and active SARI ITC partner network. The weekly clinical case presentations continue to be held with 20 - 25 active participants from SARI ITCs who share the responsibility to present cases on rotational basis which are summarized and reviewed by WHOs clinical expert and discussed between peers. In both SARI ITC settings and the ICU presentations the medium and long term consequences of COVID 19 infections are becoming more visible now and follow up treatment and rehabilitative care are under discussion. Differential diagnosis often highlight not only the impact of comorbidities on the progression of the cases but also the critical need to include all possible diagnosis and not be drawn too quickly into settling for COVID-19 infections. Such differential diagnosis is often complicated by the lack of essential diagnostic tools like x-ray, ultrasound or specific laboratory capacity. Inauguration of the CERF funded Friendship/ACF SARI ITC in Bahachara, Cox’s Bazar, took place on November 26th. It is a project initiated by the District Commissioners Office, ensuring equitable access to isolation services for the host community. The ceremony was attended by many respected official representatives from the government and donor organizations, in recognition of the isolation and treatment center which is considered an extension of the isolation capacity available at Sadar Hospital.

ESSENTIAL HEALTH SERVICES

WHO organized two supervision sessions for mhGAP trained personnel where six individuals, including four 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 committed to organize a new round of mhGAP training for 25 health care workers in the coming weeks. TB activities are regularly conducted at different designated places including UHC and camp level. During the reporting period WHO collected data in reference to TB activities in November: 220 and 180 GXP tests conducted at Ukhiya and Teknaf UHC, respectively; 185 microscopy tests for TB diagnosis; samples collected for COVID-19. Additionally, 95 X-rays for referred patients in Teknaf UHC, including TB, COVID-19 and other respiratory illnesses. WHO TB field assistants conducted 12 sessions on TB community awareness in the refugee camps to date. Surgery tests for TB diagnosis; samples collected for COVID-19. Additionally, 95 X-rays for referred patients in Teknaf UHC, including TB, COVID-19 and other respiratory illnesses. WHO TB field assistants conducted 12 sessions on TB community awareness in the refugee camps to date.

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 social mobilization with the support from Community Health Workers (CHWs), WHO IVD team completed a Training of Trainers for 150 CHW supervisors and coordinators on Basic EPI, AFP & VPD surveillance system who will be able to notify any suspected VPD case. Vaccine-Preventable Disease surveillance is being closely monitored by government authorities with WHO’s technical support. WHO SIMOs and Health field monitors (HFM) 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 cases investigation with no laboratory confirmed Measles, Diphtheria or any other VPD in the refugee camps to date.

**WHO WASH and HCWM team also attended the WASH-FIT training at the Maheshkhali UHC and conducted a supportive supervision visit at the newly built health care waste processing zone at the Maheshkhali UHC. Supportive supervision on WASH Fit is an on-going activity. During the reporting period WHO visited one Upazila Health Complex, one Community Hospital, two community clinics and one community dispensary. The visits were an opportunity to provide technical support, assess WASH related gaps that could hinder IPC processes in health care service delivery. A WASH FIT training was provided for 28 health care workers of various cadres from various health facilities in Maheshalkali Upazila. The training funded by SDC and implemented by HEKS/EPER aims to build the capacities of health care workers in the government funded health facilities in order to identify WASH related gaps at their respective facilities and use the resources available to improve services at their respective facilities.**
During the reporting period, a total of 1243 Kg and 6.81 CBM of Medicines, VTM, GBV stationary and medical equipment were distributed to implementing partners in the camps. The technical proposal of 19 bidding suppliers for the laboratory and blood transfusion facilities has been finalized. Anaesthesia machine and accessories for endoscopy machine for Sadar Hospital are currently operational while transport of beds and bed sheets to Sadar Hospital and Medical College is complete. Three hundred packages including PPE and sample collection tools were prepared to support the seroprevalence study in the refugee camps. WHO continues its support to DRU activities and sample collection in the camps with four vehicles.

**POINTS OF ENTRY**

Sixteen out of 19 points of entry (POE) have been functional in different strategic locations across the 34 camps in Ukhiya and Teknaf. A total of 43 302 individuals have been screened during the reporting period. Screeners, WASH staff and educators continue to identify febrile passengers and pedestrians to provide COVID-19 sensitization including hygiene education and referrals to nearby health facilities for symptomatic individuals. As discussions are underway to plan for the gradual opening of expanded non-COVID humanitarian services in the camps, staff at the POE will be eventually shifted back to their regular tasks. Continued efforts will be made to maintain POE while there are still infections in the camps. Four supportive supervision visits made to PoE sites this week by members of the Health Sector coordination.

**SUBJECT IN FOCUS: Achievements to date in the area of Points of Entry screening for CoVID-19 in Cox’s Bazar - a proactive and collaborative effort to keep coronavirus at bay in Cox’s Bazar**

To mitigate the risk of rapid transmission of COVID-19 in the Rohingya camps, WHO coordinated the establishment of 19 Points of Entry to proactively identify those who may be sick, refer them to health care, and prevent them from crossing a defined boundary in the camps from where it would be difficult to deter the virus should they be infected.

**Context**

In early February, the World Health Organization (WHO) published a 2019 Novel Coronavirus Strategic Preparedness and Response Plan that outlined the public health measures required to address potential global transmission of, then called, 2019-nCoV. The framework was highly useful in planning national level and local (district, county, province) level preparedness to the threat of epidemic or pandemic, and the resources and structure needed to rapidly detect and respond to identified cases, with flexibility for adaptations based on country context. In general, eight pillars were identified to structure the framework, including: coordination, surveillance, rapid response, and case investigation, points of entry, case management, laboratories, infection prevention and control, logistics and supplies, and risk communications and community engagement.

**Preparing for COVID-19**

In Bangladesh, a national strategy was developed based on the WHO framework to be used in each of the districts. In Cox’s Bazar, the presence of a large population of Rohingya refugees and given the vulnerabilities of both Rohingya and the affected host communities, a separate and specialized plan was made for the response inside the camps and in the surrounding host community.

**Defined boundaries to stop de spread of coronavirus:** While the pillar structure was relevant to the planning process in Cox’s Bazar, one pillar - points of entry - seemed to be less applicable. The points of entry pillar is intended to guide the national government to scale up monitoring at international borders, including airports, land crossing and sea ports. Those who are identified as being suspect for COVID-19 during entry and screening, can be prevented from unrestricted entry to the country, and officials can use the opportunity to isolate and test. This measure can reduce the threat of transmission from international travellers to a national-level community transmission. However, given the defined border around the camps, and the daily high volume of national and international humanitarian workers, it was believed that operating points of entry at strategic sites into the camps may help to reduce transmission to the vulnerable refugee population.

**Establishing Points of Entry in Cox’s Bazar:** In April 2020, the Health Sector reached out to the WASH sector to initiate conversations around the implementation of Points of Entry. An interim guidance note was created, and the WASH sector partners dedicated their efforts to providing both material and human resources for hand washing stations at each point of entry. Roads leading into the camps needed to be identified and designated as strategic sites for temperature screening and handwashing. Several joint visits were made with the Health Sector field coordinators and WASH colleagues, with guidance from the Site Management sector (SMS), in order to choose the screening areas that would see the highest volume of humanitarian workers coming into the camps.
Establishing Points of Entry in Cox’s Bazar: In April 2020, the Health Sector reached out to the WASH sector to initiate conversations around the implementation of Points of Entry. An interim guidance note was created, and the WASH sector partners dedicated their efforts to providing both material and human resources for hand washing stations at each point of entry. Roads leading into the camps needed to be identified and designated as strategic sites for temperature screening and handwashing. Several joint visits were made with the Health Sector field coordinators and WASH colleagues, with guidance from the Site Management sector (SMS), in order to choose the screening areas that would see the highest volume of humanitarian workers coming into the camps.

In addition, any pedestrian, or host community member walking or taking local transport into the camps were also targets for screening; while sites close to open markets and main roads were prioritized. There was an effort made to ensure that the screening areas would have geographic placement so that the same vehicle would not be stopped more than once between the host and camp locations. Once hygiene support was established and locations identified, the Health Sector needed to ensure that safe structures could be established from which the screeners could operate. The Shelter sector agreed to support the initiative and first created a standardized draft of a structure that could be used by all partners. They then asked their partners to assist in the building of the structures at each strategic site (19 Points of Entry) across Teknaf and Ukhiya. This undertaking was also done with support from the Site Management sector (SMS), who helped to identify the exact location to build, navigate host community interactions and liaise with the camp in charges (CIC) for approval and consensus.

A proactive and collaborative effort by humanitarian partners: Human resource was a challenge given that no one sector was the sole driver of the points of entry initiative. Eventually, staffing of screeners became a truly multisectoral approach, including the Site Management, Protection, and WASH sectors. Health provided the training and equipment (donated by several organizations including WHO, UNCHR and Community Partners International), and PPE were donated by the Food Security sector, through several partners from the livelihoods program. In total, there have been 74 screeners trained to take temperatures of individuals at the entry points to the camps. They were instructed, when identifying a high temperature (over 38.0°C), to take one of two actions. Any person who lives inside the camps with fever is to be referred to a primary care center (PHC) or sentinel site for follow up evaluation by a medical provider and possible testing. Any person who lives outside of the camps - national or international - with a fever is not allowed entry and is to be referred to their supervisor and medical provider for follow up evaluation and possible testing.

The Health Sector coordination team made “fever sheets” for screeners to give to febrile individuals with specific information about symptoms of COVID-19, what to do as follow up, and including self-care and IPC measures. English and Bangla versions were made for non-camp residents, and English and Bangla versions were made, with pictures, for camp residents who might also need pictorial cues.

To capitalize on sensitization and messaging, the Education Sector partners were brought on board to have volunteers also stationed at the points of entry and provide reassurance and advice to persons found with fever. Additionally, twenty teachers were trained to counsel those found with fever by using the fever sheets and COVID-19 flipchart produced by BBC Media Action with UNHCR and WHO support. When teachers are not busy with symptomatic individuals, they are able to advise mask wearing, distancing, and to reach out to the families with children to discuss school closures and ways to mitigate the effects on children.

The point of entry temperature screening and hand washing initiative was presented at many meetings, including the health and the site management coordination meetings. In addition, CICs were informed of planning for the points of entry concept early on so that they could fully support the implementation of the activity. This could not have been successful without a tremendous multisectoral effort, orchestrated by health, and contributing towards early identification and referral for sick community members and opportunity for sensitization and education for COVID-19.
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Institute of Epidemiology, Disease Control and Research (IEDCR) for COVID-19 updates in Bangladesh: [https://www.iedcr.gov.bd/](https://www.iedcr.gov.bd/)


Previous issues of this Situation Report: [https://www.who.int/bangladesh/emergencies/Rohingyacrisis/bulletin-and-reports](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/](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”