HEALTH SECTOR COX'S BAZAR

WHO/IPC TWG members mentoring IPC staff of IOM Leda SARI ITC on Kobo toolbox. Photo by WHO

HEALTH SECTOR BULLETIN #15

Bangladesh
Emergency: Rohingya Refugee Crisis in Cox's Bazar District
Reporting period: April to June 2021

1.4M PEOPLE IN NEED

889,708* REFUGEES

1.4M PEOPLE TARGETED

80 PARTNERS

HIGHLIGHTS

- In Bangladesh overall, quarter two was characterized by a surge in COVID-19 infections. Similarly, a significant surge in infections was recorded in the Rohingya refugee/Forcibly Displaced Myanmar Nationals (FDMN) camps.
- Among the Rohingya refugees, 1,368 (47 percent-female, 53 percent-male) new infections were recorded during the reporting period, compared to 74 in the first quarter. Testing rate increased by 29 percent due to an increase in testing sites and use of Antigen Rapid Diagnostic Tests (Ag-RDT) in some facilities.
- Health sector partners, at the request of government, scaled up operational capacity at the 11 Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) in the refugee camps. They activated 87 additional COVID-19 case management beds, bringing the total to 572 beds by the end of June. In addition, approximately 400 additional standby beds were available to be activated based on epidemiological indications.
- A decline in Out Patient Department (OPD) consultation among Rohingya refugees and host communities was recorded towards the end of the quarter. Facility-based delivery rate sustained at 67 percent in June 2021. Month-by-month, utilization slightly declined, most likely due to movement restrictions related to COVID-19 control measures.

HEALTH SECTOR

80	HEALTH SECTOR PARTNERS
1.4M	TARGETED POPULATION

MEDICINES DELIVERED TO HEALTH FACILITIES/PARTNERS

HEALTH FACILITIES

42	PRIMARY HEALTH CENTRES
93	HEALTH POSTS

HEALTH ACTION

903,951	OPD CONSULTATIONS
5,222	ASSISTED DELIVERIES
6,152	REFERRALS

VACCINATION AGAINST

30,564	POLIO
14,588	MEASLES

SURVEILLANCE

35	COVID-19 SENTINEL SITES
22	AWD SENTINEL SITES
174	EWARS REPORTING SITES

FUNDING $US

135M	REQUESTED
12,424,503 (9.2%) **	RECEIVED

* Rohingya Refugee Response/Bangladesh- Joint Government of Bangladesh -UNHCR Population Fact Sheet- June 20, 2021. Available at: https://data2.unhcr.org/en/documents/details/87997 Accessed on August 28th 2021. **https://fts.unocha.org/appeals/906/clusters

Situation update

As per UNHCR registration data, the Rohingya population in Cox's Bazar camps is estimated at 889,704 people (52 percent-women and girls, and 52 percent-children). Persons with disabilities constitute around one percent. The average household size is 4.7 persons per household[1]

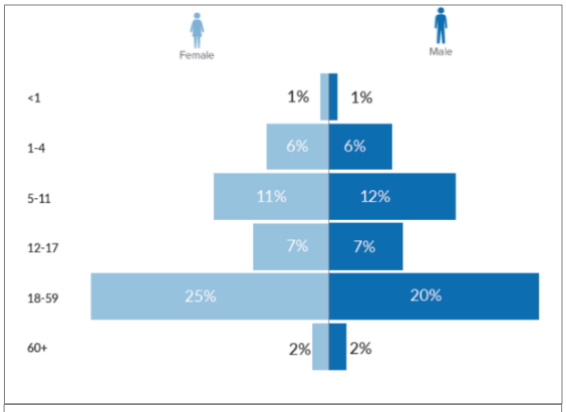
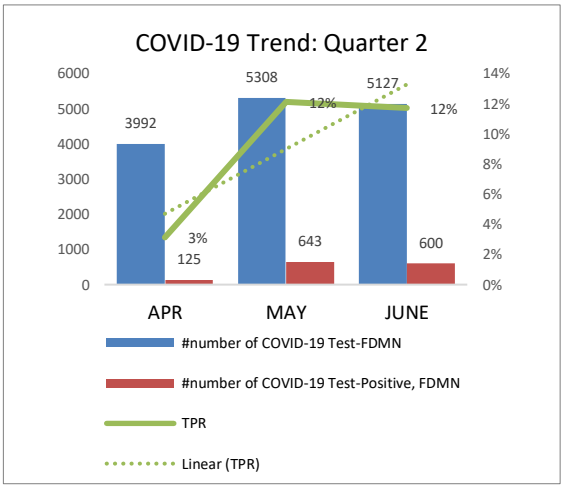


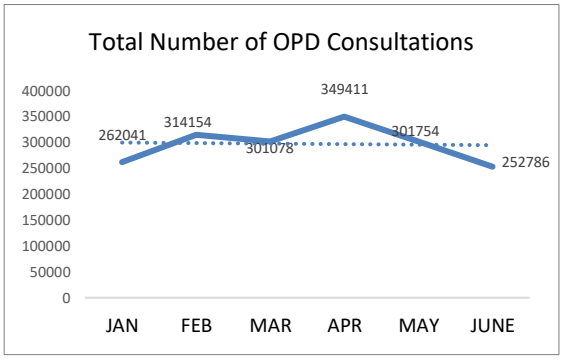
Figure 1: Rohingya Population distribution (UNHCR Joint Government of Bangladesh (Population Factsheet, March 2021)

The second quarter of 2021 was characterized by an increase in COVID-19 infections. The increase was first observed among host communities followed by the camps where a rising infection was also observed by epidemiological week 14. Like elsewhere, COVID-19 infections in the camps rose dramatically in April and May 2021. The trend stabilized in June. Results for SARS-Cov-2 genomic sequencing for samples from the camps were not available as of the end of June. At national level, the Delta variant has been shown to play a significant role in transmission. With improved access to testing services due to increased sentinel sites, from 33 to 35, and use of Ag RDTs, more cases and contacts were identified. In quarter two, 14,427 (47 percent-female, 53 percent-male) tests were conducted amongst the Rohingya, up from 11,143 in the first quarter.

By the end of June, partners supporting SARI ITCs (UNHCR/RI, UNHCR/FH/MTI, IOM, SCI, MSF, UNICEF/ICDDRB, Hope Foundation, IFRC/BDRCS) had expanded total active bed capacity to 572. While bed occupancy peaked in June with individual SARI ITCs at times reaching 90 percent, the majority of the SARI ITC admissions were mild cases. Another 10 to 13 percent were moderate and seven to 10 percent were severe while over one percent were critical. These numbers indicate that home isolation, rather than institutional isolation for mild cases from both the Rohingya and host community would free up substantial bed capacity which could be focussed more on moderate and severe cases, in line with the national clinical case management guidelines. The Health Sector will continue to engage with stakeholders on developing this further. At present, home isolation for Rohingya/FDMN is not permitted.



Although cumulative quarterly OPD consultations have remained steady (835,672 in quarter one against 903,951 in quarter two), a monthly analysis showed a decline in May and June after a peak in April. Despite health services being exempted from movement restrictions, the trend suggests that other factors, likely including transportation and access issues, may be affecting health seeking behaviour. Unrestricted access continues to be required for all components of the health response. In addition, continued community engagement is needed to address information gaps and fears in a timely fashion.

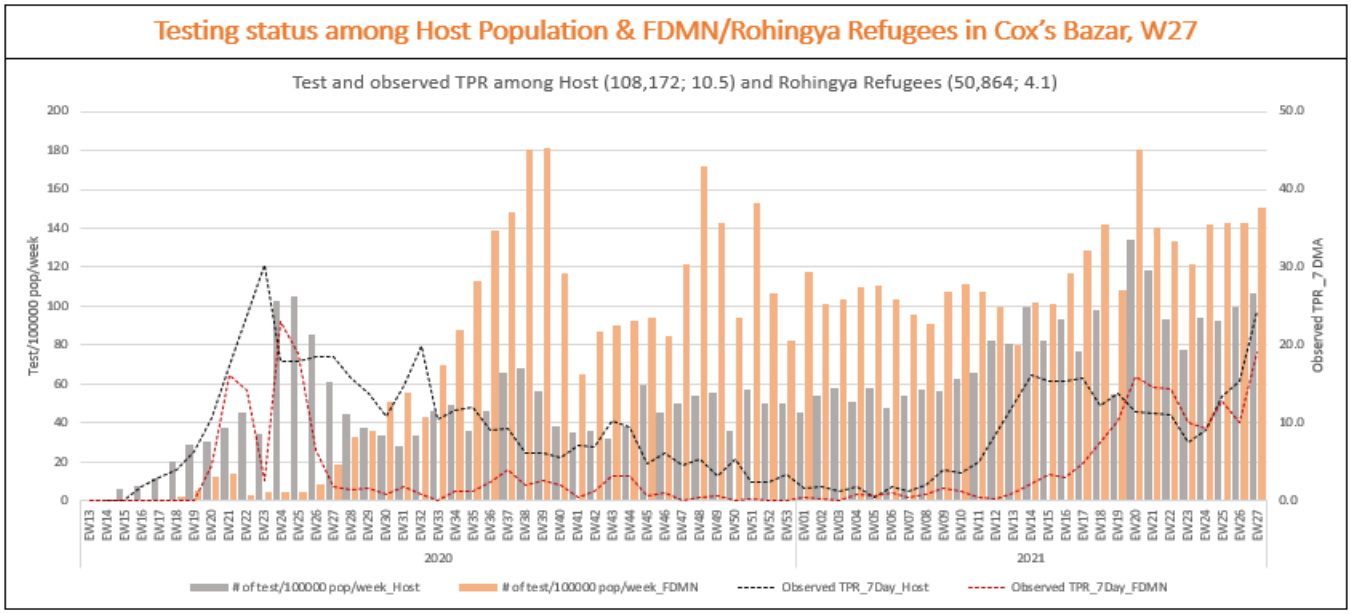


[1]Rohingya Refugee Response/Bangladesh- Joint Government of Bangladesh -UNHCR Population Fact Sheet- June 20, 2021. Available at: https://data2.unhcr.org/en/documents/details/87997 Accessed on August 28th 2021.

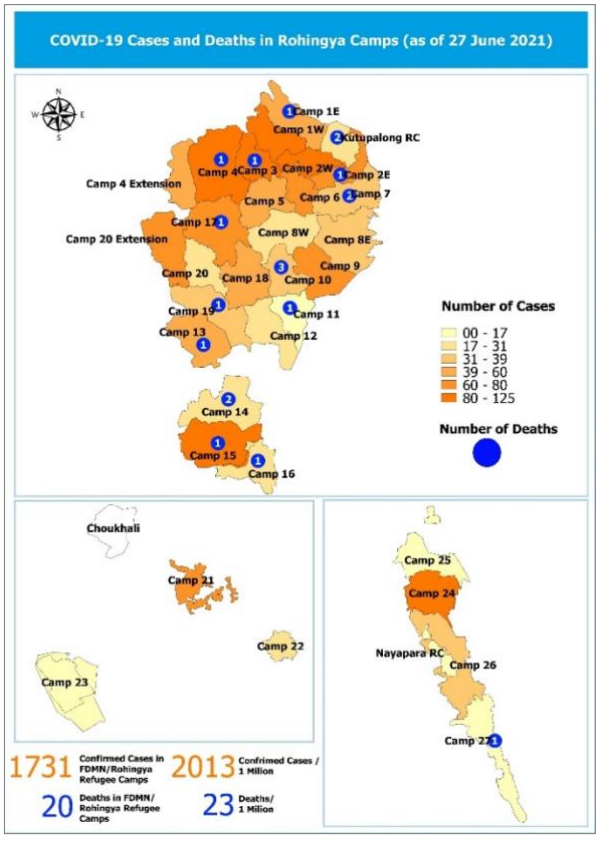
Public health risks, priorities, needs and gaps

Communicable Disease Control and Surveillance

COVID-19



- **Trend**: By end of June, of the total 10,337 (70 percent-male, 30 percent-female) infections were recorded in the host community since the beginning of the pandemic, 13 percent (1,383) of those took place in quarter two. In the camps, 77 percent (1,368) of the total infections (1,775) were recorded in quarter two alone. In quarter one, only 74 cases were recorded in the FDMN camps. This points to widespread community transmission of SARS-Cov-2 in the host and camp populations.
- **Fatality**: The COVID-19 wave ongoing at the time of this report has been associated with more deaths, with 35 deaths occurring in the host community in quarter two compared to just one in quarter one. Similarly, in the refugee camps, 50 percent (10 out of 20) of the deaths recorded during the pandemic (by June 2021) were in quarter two. Most of the deaths have been recorded in the elderly and those with comorbidities (WHO Surveillance Data, April-June, 2021)
- **Acute Respiratory Infection (ARI):** A 61 percent decline in incidence of ARI in facility based EWARS reports was observed in quarter two where 82,601 (52 percent-male, 48 percent-female) cases were reported compared to 211,122 in quarter one. This is likely due to seasonal variations, as has been observed in previous years.



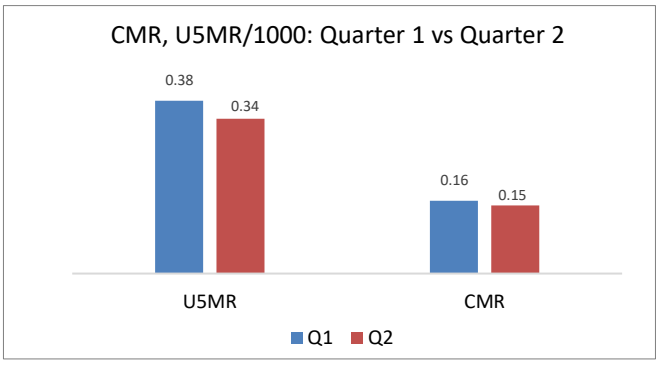
- **Diphtheria**: According to WHO Surveillance Data, from April-June, there was a 67 percent decline in reported cases of Diphtheria in quarter two. No fatalities were recorded. In quarter one, 72 cases were reported compared to 24 (35 percent-male, 65 percent-female) in quarter two.

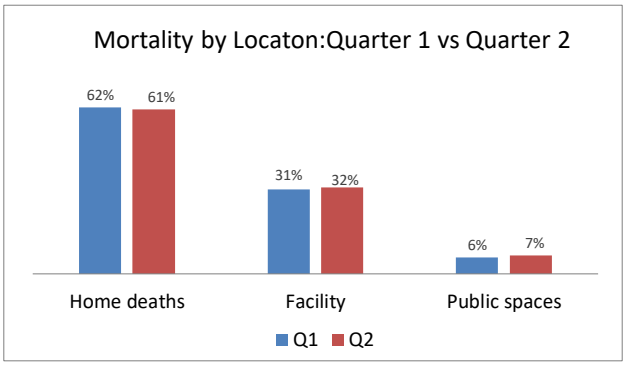
Acute Watery Diarrhoea (AWD)

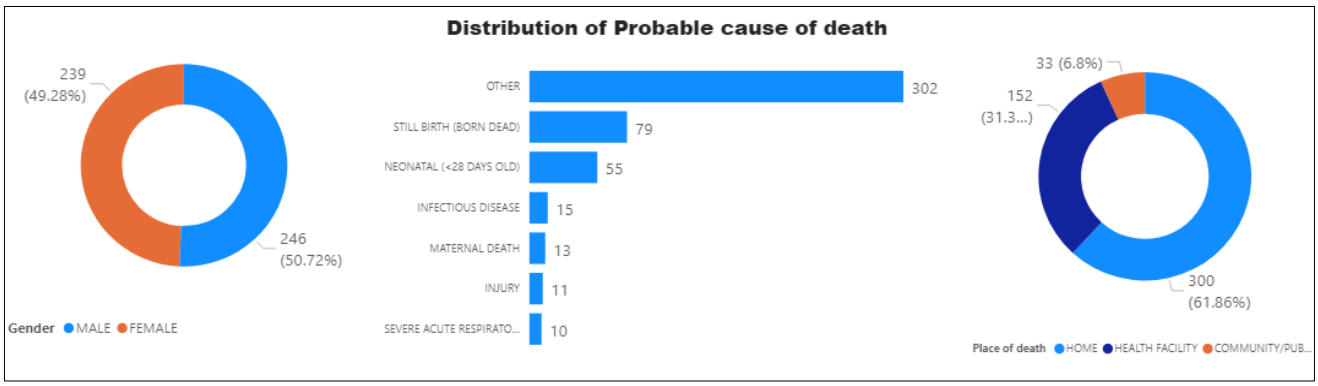
- In this period, a total of 712 RDT test were conducted- 24 were culture confirmed for cholera. Health and WASH partners have been responding to individual cases in line with the Multisectoral AWD Preparedness and Response Plan (2020). A Daily meeting has been instituted between Health, WASH and CWC representatives to facilitate implementation of the plan's components. Joint Assessment Teams (JAT), a joint team of Health and WASH experts, investigate all RDT/culture positive cases.
- 22 sentinel sites for Cholera surveillance were fully functional during the reporting period, testing a total of 712 samples.
- By end of Q2, there were 11 facilities, including diarrhoea treatment centres (DTCs) with a total of 72 active beds reserved for cholera response and 400 standby beds operated by Health Sector Partners (SCI, MSF, UNICEF/ICDDRB, Hope, and IOM).
- A total of 124 CHW supervisors / managers were trained on "Hygiene promotion and AWD prevention" and cascaded the training to 1440 CHWs to ensure active case finding for effective AWD surveillance and referral, provision of ORS and zinc at community, and reinforce messaging on prevention at community. CHWs conduct visits to every household in the camps every 1-2 weeks for health promotion on pertinent health issues, currently focussed on cholera and COVID-19, and community-based surveillance and promote referrals.
- Immediate action to scale up targeted integrated response is undertaken in response to the current cholera cases. The Health Sector advocates actively with authorities for unrestricted access to provide essential WASH interventions, as a key component for AWD/cholera response. The Health Sector is engaging with other relevant sectors such as WASH, Community Health Workers and Risk Communication for effective and integrated community mobilization, preparedness and response.
- Advocacy is ongoing by Health Sector partners to undertake a new round of Oral Cholera Vaccination, in addition to other preventive measures, in collaboration with WASH sector.

Community Based Mortality Surveillance

- According to EWARS (Week 13-25, 2021) no substantial change was noted on under-5 mortality and Crude Mortality Rate (CMR).







Quality of Medicines

- **Health Facility Monitoring**: In June, facilities were assessed for stock-outs[2] of essential medicines as a measure of access to lifesaving essential medicines. Stock out of essential medicines was reported frequently with 45 percent of facilities reporting lack of at least one of the tracer medicines. Most (70 percent) of the facilities reporting a stock out were Health Posts, 13 percent were Community Clinics and 16 percent Primary Health Centres. Besides capacity building on supply system management, increased supervision and service rationalization, inter-agency communication on potential shortages is encouraged through the Health Sector coordination platforms. Partners with surplus commodities, short expiry commodities may be able to relieve facilities in need therefore ensuring access and avoiding wastage. In order to ensure rational use of medicines, authorities have requested Health Sector to support the introduction of a General Health Card in 2021.

Tuberculosis (TB)

- **TB screening and diagnosis:** 600 GeneXpert (GXP) tests were conducted in Ukhiya (350) and Teknaf (250). In addition, 550 routine TB microscopy tests were conducted (300 in Ukhiya and 250 in Teknaf) while 150 X-rays including Chest X-rays for referred patients in Teknaf Upazila Health Complex (UHC) were conducted for TB and COVID-19 suspected cases and other respiratory illnesses.
- TB field assistants visited about 1,500 households, a 16 percent decline from quarter two when 1,800 households were visited in the refugee camps and host community. A total of 15 TB community awareness sessions were also conducted.
- The National Tuberculosis Control and Program (NTP) and Civil Surgeon's office organized the quarterly TB monitoring meeting with support from WHO, NGO partners and other stakeholders in Cox's Bazar.
- The Minimum Package of Essential Health Service (MPEHSP) for Primary Health Care facilities recommends minimum isolation capacity for infectious diseases. In quarter two, 60 percent of the facilities assessed, mainly Health Posts, lacked isolation beds. 79 percent of PHCs had at least one isolation bed for infectious diseases (Health Sector Health Facility Monitoring, Quarter 2, 2021).

Non-Communicable Diseases (NCD) and Mental Health

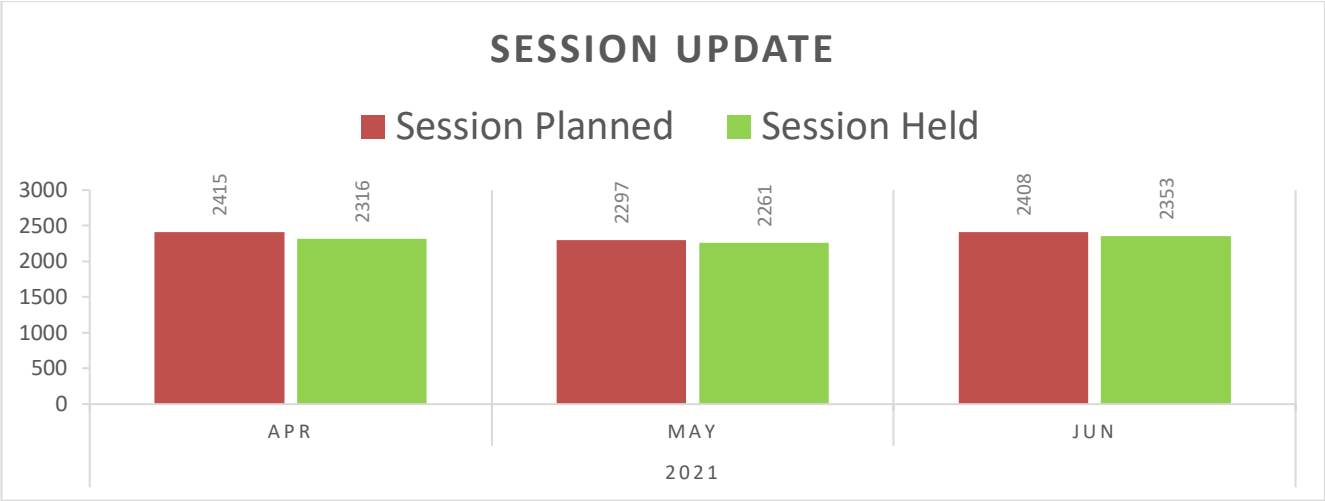
- WHO developed and piloted an NCD register in collaboration with the Civil Surgeon's Office. Ten Health facilities in Teknaf and Ukhiya Upazila participated in the piloting phase. After approval by authorities, the register will be deployed in health facilities to improve Surveillance of NCDs and promote continuity of care.
- In commemoration of World Hypertension Day 2021, WHO organized a webinar on Measurement, Management and Prevention of Hypertension for health workers. Ninety staff participated. Amongst the key panellists were Professor Dr Robed Amin, Line Director of NCD; and the Civil Surgeon, Cox's Bazar and speakers from the Refugee Relief and Repatriation Commissioner (RRRC) and Community Health Working Group (CHWG).
- According to the health sector Health Facility Monitoring (April-June, 2021), 97 percent of the health facilities provided NCD services for the priority NCDs (Hypertension, Diabetes Mellitus, Asthma, Chronic Obstructive Pulmonary Diseases). However, 12 percent of the facilities that provided NCD services reported stock-out of essential medicines for NCD case management in line with minimum standards.
- Only 32 percent of health facilities were providing glucose testing 24/7 while 63 percent offered glucose test only during the day.

Child Health

- The COVID-19 related movement restrictions temporarily interrupted Routine Immunization services in the FDMN/Rohingya refugee camps, especially community outreach. However, some fixed sites continued to provide services on a limited scale. Vaccination services were available at fixed sites (59 health facilities) and through community out-reach sessions provided by 75 vaccination teams. As reflected below, the number

[2] An essential medicine was defined as out of stock if the said medicine was not available at the facility for four or more days in the 30 days before the day of data collection.

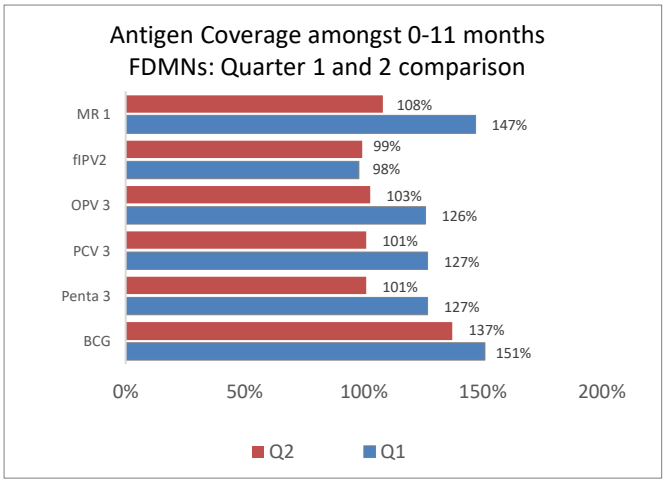
of outreach sessions dropped slightly in the second quarter.

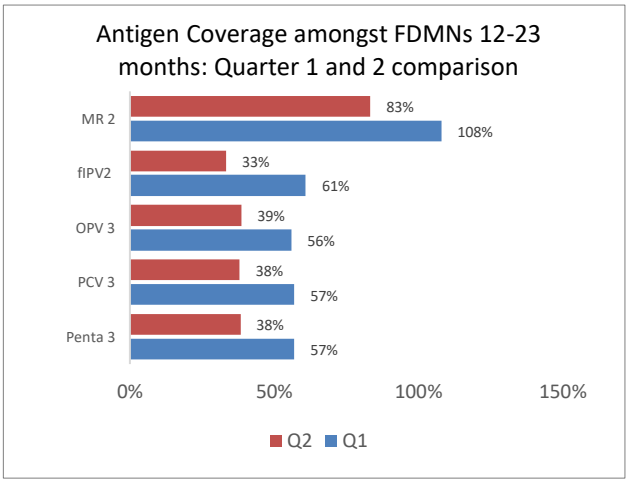


- **Integration of nutrition services**: According to the Health Sector Quarter 2 Facility Monitoring, up to 87 percent of health facilities reported conducting Mid Upper Arm Circumference (MUAC) screening while 12 percent did not have evidence of screening. There are separate ongoing efforts to escalate integration of curative nutrition services within health facilities. For instance, IOM and UNICEF are jointly exploring integration of nutrition services in Camp 9, while UNHCR is working on piloting Nutrition and Sexual Reproductive Health integration in selected facilities.

Antigen coverage

- Overall, antigen coverage dropped for both 0-11- and 12-23-month olds. Routine immunization sessions, both fixed and outreach, continue.





COVID-19 vaccination campaign for Rohingya community

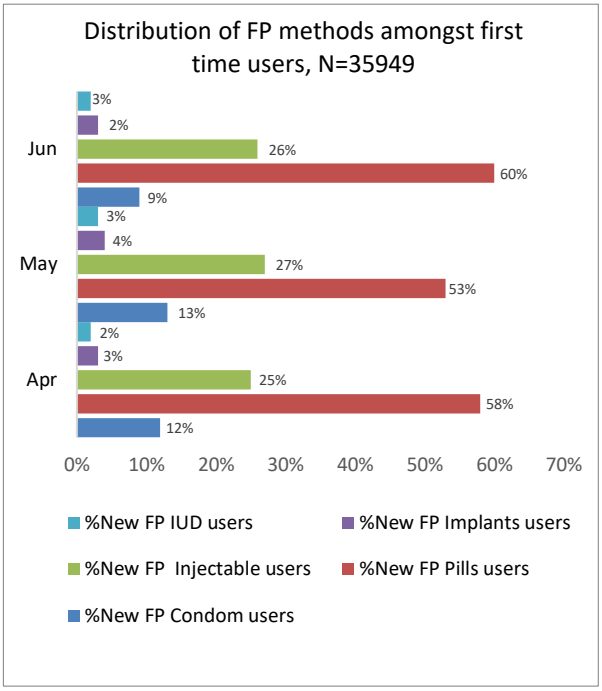
- COVID-19 vaccination campaign for the Rohingya community was initially planned to kick off in late March with a target of 129,698 people over the age of 40 years and front-line workers (Community Health Workers, Education and Nutrition volunteers) to receive the first dose. After several months of delay, the vaccination campaign for the refugees is scheduled in August, with a revised eligibility criterion targeting those 55 years and above only. Pre-printed vaccination cards were to be provided to those 55 years and above at household level. The vaccination campaign will be supported by over 450 staff from partner organizations.

Trauma and injury

- Injuries accounted for three percent (25,846) of the OPD consultations during the reporting period. Most of the injuries were reported in children under five years (70 percent). Following the fire incident reported in quarter one, of the six health facilities that were damaged or destroyed, all have resumed health services.

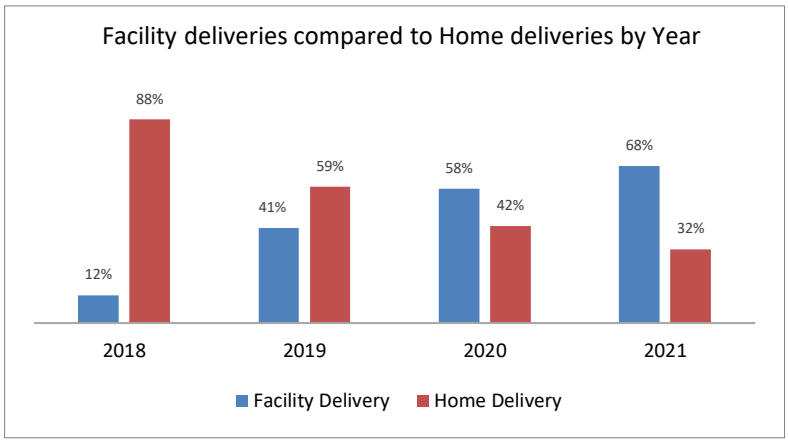
Sexual, Reproductive Health (SRH)

- **Utilization of Family Planning (FP) services**: Number of first time FP visits increased to 35,949 in quarter two compared to 24,853 in quarter one. Long Acting Reversible Contraception (LARC) uptake among first time users increased from three to five percent in quarter two. Contraceptive pills remain the most utilised FP method accounting for 60 percent of users during the reporting period. These achievements were recorded despite the surge in COVID-19 infections.



- SRH Working Group trained 20 (1-male, 19-female) service providers including doctors, midwives and paramedics on the delivery of rights-based LARC and Counselling on Family Planning, Menstrual Regulation and Post Abortion Care.
- Overall, facility-based delivery rates sustained at 67 percent as of June 2021. A total of 5,222 facility deliveries were recorded in quarter two: April (1,847), May (1,735) and June (1,640). The slight monthly decrease may be linked to restrictions in movement associated with the COVID-19 control measures which affected access and community mobilization.

  Overall - Community Health Worker reports indicate a significant reduction of home deliveries (88 percent in 2018, 59 percent in 2019, 42 percent in 2020 and approximately 30-35 percent in 2021. This trend shows a significant increase in health facility deliveries.



- The SRH working group, through the Maternal and Perinatal Mortality Surveillance and Response (MPMSR) committee, analysed maternal mortality data from 2020 and developed the 2020 Maternal and Perinatal Mortality Surveillance and Response Annual Report. The analysis showed that the majority (47 percent) of maternal deaths in the camps were due to obstetric haemorrhage and hypertensive disorder in pregnancy (eclampsia and preeclampsia). The report recommended solutions to avoid maternal deaths due to the identified barrier mainly considering the 3-Delay model. To accelerate implementation of some of the recommendations from the report, the emergency obstetrics and neonatal care referral pathway was updated to help prevent delays in accessing services and increase access to life-saving maternal care with support from field hospitals.
- To ensure improved Quality of Care, an inter-agency rapid assessment tool to evaluate the Emergency Maternal and New-born Care (EmONC) facility readiness has been adapted and translated from the global standard tool. The tool is being administered across facilities jointly by the SRH working group and Health Sector.
- The Health Sector, through the SRH working group, commemorated the 2021 International Day of the Midwife through a virtual webinar that attracted over 50 participants with keynote addresses from senior leadership from the MoHFW, WHO, UNFPA and Midwifery professional association. The commemorations were held under the theme 'Follow the Data, Invest in Midwives'.
- The quarter two Health Facility Monitoring assessed facility-based provision of the 6-signal functions for Basic Emergency Obstetric and New-born Care (BEmONC). There were 27 facilities that provide all six functions in the camps in Cox's Bazar. Of these, 89 percent are PHCs. Despite the recommendation from

Cox's Bazar Minimum Essential Service Package (MESP) for all PHCs to provide BEmONC services, only 57 percent of PHCs (24 out of 42) provide all signal functions.

Mental Health and Psychosocial Support (MHPSS)

- In response to the fire incident, MHPSS working group coordinated amongst its members to launch over 300 MHPSS staff and volunteers to provide basic level support. They reached over 9,000 individuals. Staff care support was also provided both in person and remotely by specialized staff.
- In response to the expressed needs for self/staff care, MHPSS working group conducted self/staff care workshops for the Community Health working group, Gender-based Violence (GBV) and Nutrition sectors, reaching 217 participants.
- A referral pathway for suicide related cases has been agreed. It considers the sensitivity and immediate action that the cases require and ensures proper support from the first point of referral.
- The MHPSS working group updated the terms of reference for MHPSS focal points covering overall coordination and emergency response guidance in camps. In addition, the MHPSS focal points received training to build capacity on emergency coordination amongst MHPSS actors and in between sectors at field level.
- The movement restrictions related to COVID-19 control measures at camp level negatively impacted MHPSS activities especially at community level, only health facility-based interventions are currently implemented fully as before.
- A mid-year review of the MHPSS work plan and sub- working group action plans was conducted during the reporting period.
- MHPSS working group members were panellists in this year's UN Economic and Social Council (ECOSOC) Humanitarian Affairs Segment (HAS) side event on MHPSS. In addition, advocacy to the UK/NL Donor Group was done through a presentation conducted by co-chairs of the MHPSS working group.
- Based on the reports from the 14 MHPSS agencies, 7,154 individuals received individual level support and 107,662 participants joined in community based MHPSS activities. However, this is not the full picture of MPHSS within the context as this is information based on limited reporting.
- **mhGAP supportive supervision**: Supportive supervision was conducted for nine health facilities in Rohingya camps in Ukhiya, Teknaf Upazila and Cox's Bazar district Sadar hospital to improve the quality of mhGAP services offered by trained clinicians in the PHCs, and to enhance integration of mental health and psychosocial support services in the primary health care systems. The supportive supervision directly responds to observations made in a separate review in quarter one, that while many staff had been trained on mhGAP, there was need to increase supervision to translate the knowledge to action.

Emergency Preparedness and Response/EPR

- WHO, in collaboration with IOM, led the Sector's After-Action Review of the Mobile Medical Teams (MMTs) fire response with contribution and participation from seven partners (IOM, RI, SCI, FH/MTI, BRAC, RTMI/UNFPA and Prantic). Based on the lessons drawn, the number of MMTs were increased from 24 to 32 to enable wider and prompt response.
- Health Sector partners, in collaboration with the RRRC and Civil Surgeon's office and with technical support from the EPR Technical Committee, mounted preparedness and response activities to tropical cyclone Yaas in May 2021. Partners ensured adequate capacity at the medical hubs. Dispatch and Referral Unit (DRU) and MMTs remained prepared to respond to emergencies while health sector partners prepositioned ambulances and other emergency medical supplies.
- Over 120 CHW supervisors/managers from all camps were trained on Fire Safety and Response to Fire Incidents at Community Level.

Health Sector Action

Coordination, Collaboration and Strategic Guidance.

- WHO, together with the Ministry of Health and Family Welfare (MoHFW) and the RRRC, continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors responding to the FDMN/Rohingya refugee crisis and the ongoing COVID-19 pandemic.

- **Coordination structure**: At Cox's Bazar level, a Strategic Advisory Group (SAG), with representatives from the MoHFW coordination centre, the RRRC health unit, Health Sector working group coordinators, UN, INGOs and NNGOs, serves as an advisory to the Health Sector coordinator. Currently, there are seven working groups in the sector coordinating different health activities:
    - Sexual and Reproductive Health (SRH)- chaired by UNFPA
    - Community Health (CH)- co-chaired by UNHCR and Medair
    - Epidemiology (EPI)- chaired by WHO
    - Case Management (SCM)- chaired by WHO
    - Mental Health and Psychosocial Support (MHPSS)- co-chaired by IOM and UNHCR
    - Emergency preparedness response (EPR)- chaired by WHO and IOM
    - (In light of outbreaks of communicable disease, an ad hoc working group on Infection Prevention and Control has been formed – the group is chaired by WHO.)
- At camp level, the Camp Health Focal Points (CHFPs), supported by IOM and UNHCR, undertake Health Sector coordination at field level and maintain linkages to Cox's Bazar through field coordinators.
- **Health Sector Strategic Plan (HSSP) 2022-2023:** Supported by the SAG, the Health Sector has commenced revision and update of the HSSP 2022-2023, with the aim of forging a renewed strategy that can effectively respond to the substantial changes in the context ranging from health care needs, the impact of COVID-19 on health systems, fluctuation in funding and protracted nature of the crisis in collaboration with Government counterparts and partners.
- **Health Sector Referral SOP:** To improve the quality and performance of the medical referral system, the Health Sector is in the final stages of production of an updated Referral SOP that will provide technical guidance on assessing referral needs, designing, implementing and monitoring referral services. This follows a recommendation from a referral workshop conducted in quarter one for partners to scale up respective referral capacity to support the health systems better.
- **Accountability to Affected Population (AAP) framework:** This framework, developed in line with the Global Health Cluster Operational Guidance on AAP is meant to serve as aide- memoire for health sector partners to mainstream AAP locally and expand on AAP mechanisms beyond capturing complaints and feedback as a component of their strategies to achieve AAP in health care. It outlines the core AAP components relevant to the health sectors, provides basic guidance for operationalization of AAP commitments within the Health Sector and enhances quality of health response.

Risk communication and community engagement (RCCE)

- **COVID-19 messaging:** The RCCE working group continued to provide technical oversight to ensure that information on COVID-19 and other health issues were of high quality, appropriate and effective at community level. Media messages on COVID-19 include general information on COVID-19, hand washing, physical distancing, mask wearing, risks and vulnerabilities, safe and dignified burials, quarantine, isolation and treatment centres, among others. RCCE working group disseminated public health messages on COVID-19 variants and mutations among health care professionals and humanitarian workers.
- CHWG, with RCCE and CwC working group jointly worked on developing Information, Education and Communication (IEC) materials for communication and community engagement on COVID-19 vaccination. IEC materials printing was supported by UNHCR. The materials printed include 20,000 copies of key messages in English and Bangla, 10,000 copies of key messages in English and Burmese, 215 copies of Festoon-1, 2,125 copies of Festoon-2 and 7,500 copies of Frequently Asked Questions (FAQs). The IEC materials were distributed to CHWG partners and reached over 1,440 CHWs during the second week of April 2021.
- RCCE partners continued to provide English and Bangla versions of the weekly radio programme script on COVID-19 statistics among refugee and host communities. These messages were widely disseminated among the Rohingya community through radio broadcasts.
- RCCE partners continued to use an integrated advocacy, communication and social mobilization approach aimed at raising awareness in camps in order to reduce vaccine hesitancy and to build trust between health workers and the community.
- RCCE partners collaborated in the production of a video covering various topics related to Sexual, Reproductive, Maternal, New-born, Child and Adolescent Health (SRMNCAH), Gender Based Violence (GBV),

Nutrition, and Non-communicable Diseases (NCDs) series aimed at raising awareness and improving health care seeking behaviour among Rohingya refugees.

Community Health

- Over 1,440 CHWs supported by 120 CHW supervisors continued with enhanced community-based surveillance and reporting, community engagement and prevention messaging on various health topics including SRH and re-enforcement of COVID-19 and AWD prevention messages.
- UNHCR and WHO conducted an investigation on Knowledge Attitude and Practices (KAP) on minor invasive procedures in non-healthcare settings among Rohingya Refugees Camps in Cox's Bazar. The objective of the study was to identify common minor invasive procedures, their enabling factors and the practicing sites, assess IPC compliance during minor invasive procedures in non-health care settings and to assess the role of informal healthcare providers in practicing minor invasive procedures. Study findings and recommendations will be available by quarter three, 2021.
- CHWs conducted 1.92 million household visits, reaching 3.73 million individuals. The visits include repeat visits. CHWs identified 32,924 persons with mild respiratory symptoms (fever, sore throat and cough) and 383 with moderate to severe COVID-like symptoms. CHWs also conducted 164,805 small group sessions on COVID-19 prevention. Over half a million individuals participated in the sessions which focused on symptoms, risk factors, testing, mask use, physical distancing, hand hygiene, and quarantine/isolation management.

Laboratory

- COVID-19 sample testing: As of 30 June 2021, Institute of Epidemiology, Disease Control and Research (IEDCR) laboratory had tested 171,858 samples (30 percent in quarter two alone). Of these, 71,001 were from FDMNs.
- COVID-19 Antigen RDT pilot testing: With technical assistance from WHO, the Office of the Civil Surgeon piloted COVID-19 Antigen RDT across IOM and Hope facilities in the camps. During the reporting period, 487 samples were tested (five percent were positive on RDT).
- Ease of access to testing: WHO is providing technical guidance to expand COVID-19 sentinel sites. In quarter two, two sites were added, bringing the total to 35. Technical assessment is ongoing for nine other potential sites.
- Improving availability of blood transfusion services: WHO, with funding from the World Bank, continued to work to establish blood banks in all Upazila health complexes in Cox's Bazar. A needs assessment to establish and operationalize the blood banks was completed during the reporting period. Ukhiya and Teknaf health complex received consumable items that include blood bags, blood transfusion sets and RDTs for blood screening to facilitate safe blood transfusion at the newly established blood transfusion centres.
- Capacity building for laboratory professionals: A total of 19 healthcare workers (14-male, 5-female) received training on COVID-19 sample collection and transportation.

Infection Prevention and Control (IPC)

- **Supportive supervision**: Quarterly IPC supportive supervision was conducted at all SARI ITCs as part of quality assurance and control efforts by IPC Technical Working Group (IPCTWG). IPC TWG initiated biannual IPC supportive supervision for field hospitals, Primary Health Centres and Health Posts. During the supervision, four PHCs, two Field Hospitals and one Health Post were reached. A total of 13 out of 52 specialized health facilities were visited.
- An IPC refresher training for master trainers was conducted by WHO for 51 participants from 30 Health Sector partners including Cox's Bazar Sadar hospital.
- **IPC monitoring tools**: The Health Sector and IPC TWG developed a healthcare facility daily IPC checklist and monthly IPC Score Card which has been piloted in five health facilities in the camps. An in-person training of all IPC focal persons on the tools will be scheduled when ongoing COVID-19 restrictions are lifted. In addition, the SARI ITCs IPC focal points received two weeks hands-on mentorship on the use of kobo toolbox for monthly reporting. All SARI facilities reported their IPC performance of June using Kobo and plans to create a dashboard for IPC in the third quarter are underway.

- **Institutionalization of IPC**: Currently 91 percent of health facilities in the camps (three of four field hospitals, 41 PHCs, 89 of 100 health posts and specialized service facilities) have formed IPCs committees or appointed IPC focal points.

Case Management

- Health Sector partners are currently running 97 HPs in the FDMN/Rohingya refugee camps. Of these, 42 PHCs are providing 24/7 health care services. In addition, numerous government-run health facilities in the host community are supported by health partners. The facilities include 10 community clinics, six union sub-centres and six Health and Family Welfare Centres, two Upazila health complexes and the district-level Sadar Hospital.
- As of the end of June, there were 12 operational SARI ITCs with a total of 572 active beds and 323 beds on standby. At the 250-bed Sadar district hospital, the Intensive Care Unit (ICU) has 10 beds, High Dependency Unit (HDU) has 15 beds and the Severe Care Unit (SCU) has 13 functional beds. In the Red Zone, there are 69 beds while the Yellow Zone has 38 beds
- A training on revised national guidelines for Clinical Case Management of COVID-19, supported by WHO/ Bangladesh Doctors Foundation, was conducted for 108 (77-male, 31-female) Health Sector Clinicians from nine Health Sector partners.
- 72 beds are designated in facilities for treatment of cholera, including in DTCs. An additional 400 beds could be activated if the epidemiological situation requires.

Water, Sanitation, Hygiene and Environmental Health (WASH)/Healthcare Waste Management

- A Standard Operating Procedure (SOP) for sustainable HCWM in Cox's Bazar district was developed in collaboration between WASH and Health Sector partners (WHO, UNICEF, IOM, ICRC and MOHFWCC). This SOP has been approved by the Civil Surgeon and is due for dissemination and roll out in the FDMN camps. As part of efforts to improve healthcare waste management, 288 Colour Coded waste bins were distributed to 21 health facilities in Ukhiya and Teknaf.
- UNICEF and Department of Public Health Engineering (DPHE) conducted the second round of community point source water quality surveillance (Jan-April 2021). The surveillance targeted 167 health facilities (eight field hospitals, 112 HPs and 47 PHCs. Storage water and drinking water samples from the health facilities were analysed for E. coli and ph. Sanitary inspections were also conducted using observation methods. Most (93%) of the health facilities met the Bangladesh Standard for safe drinking water (E. coli contamination 0 CFU[3]/100ml), four percent were at intermediate risk (1-10 CFU/100ml), two percent were at high risk (11-99 CFU/100ml) and 0.6 percent were at very high risk (>100 CFU/100ml). An analysis of 327 sterile and 327 unsterile water source samples showed that 96 percent of each sample are free from E. Coli contamination. This matches WHO and Bangladesh standards.

Health Sector Gender Action Plan (GAP)

- The Health Sector Gender Action Plan for 2020 provides guidance and framework for measuring the progress in Gender Mainstreaming in the Health Sector. Collectively, all partners/actors in the sector are expected to undertake appropriate actions that contribute to the overall outcome. During quarter two, the sector collected and analysed data to assess sector progress based on predetermined indicators, including the following:
  - Out of eight of the selected indicators, seven met the target set for quarter two.
  - Data was disaggregated by gender in most major reports.
  - 99 percent of health facilities having female medical personnel during the data collection period
  - Only 86 percent of health facilities had appropriate, sex-segregated latrines against a target of >95 percent for 2021.
- Additionally, 36 staff received training on Child Protection.

[3] Colony Forming Unit

Minimum Package of Essential Health Services - Monitoring

- **Health Facility Monitoring**: With the assistance of the Camp Health Focal Points (CHFPs), the Health Sector conducted quarter two (April-June) Health Facility Monitoring covering 140 health facilities in all 34 camps with 42 partners participating. The report from this exercise highlighted the following;
  - At present, in-patient capacity does not meet Sphere standards.
  - Despite the recommendation from Cox's Bazar MPEHS for all PHCs to provide BEmONC services, only 57 percent (24 out of 42) provided all signal functions at the time of the monitoring exercise.
  - Only 37 percent of the assessed facilities provided HIV Counselling and Testing while ANC and delivery services were available in more facilities, signalling an inadequate access point for screening for HIV in pregnancy for Prevention of Mother-to-Child Transmission (PMTCT) services at this time.
  - Provision of LARC (implants and Intrauterine Device (IUDs) was not common. Only 33 percent provided Implants and 20 percent provided IUDs. This may be partly explained by low demand from the community, calling for increased sensitization.
  - Despite the trainings and availability of commodities, only 46 percent of facilities had provided Clinical Management of Rape (CMR) services in the three months prior to data collection.
  - Across the response, more effort is required to improve protection mainstreaming and emphasis on improving Community Based Feedback and Response Mechanism within the health program. Up to 85 percent of health facilities used suggestion boxes as a mechanism to collect feedback despite communities indicating that this is not a preferred method for feedback.

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