World Health Organization
Bangladesh

COVID-19
Situation Report No. **#11**
11 May 2020

https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/coronavirus-disease-(covid-2019)-bangladesh-situation-reports

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Tested	Confirmed	Recovered	Dead	Isolated
129,865	15,691	2,902	239	2,276

Test/1 million	AR/1 million	Recovery Rate	CFR%	Isolation Beds
759	92.13	18.5%	1.52%	7,064

Laboratories	Gender	PPE Stock	PoEs Screening
37 COVID-19 Labs / 7 Days / 40,949 Samples	68% / 32%	1,249,872	328,336
14.5% IEDCR Positive %		2,305,872	17,358
11.7% Other laboratories Positive %		696,973	7,029
12.1% Overall Positive Test %		204,195	330,363

1. Highlights

As of 11 May 2020, according to the Institute of Epidemiology, Disease Control and Research (IEDCR), there are 15,691 confirmed COVID-19 cases in Bangladesh, including 239 related deaths; Case Fatality Rate (CFR) is 1.52%.

Bangladesh Civil Aviation Authority extended flight restriction till 16 May 2020. This restriction applies for all flights to and from Bahrain, Bhutan, Hong Kong, India, Kuwait, Malaysia, Maldives, Nepal, Oman, Qatar, Saudi Arabia, Sri Lanka, Singapore, Thailand, Turkey, UAE and UK. All domestic flights are also restricted till 16 May 2020. Only cargo, relief, air ambulance, emergency landing and special flights will be allowed.

The ongoing general holiday has been extended in Bangladesh till 16 May 2020 with important instructions to be followed: no movement outside from 8 pm to 6 am; shopping malls can operate on a limited scale from 10 May ensuring precautions (physical distancing, arrangement for sanitization and hygiene rules etc.) and operating hours are limited to 10 am to 4 pm; during Eid Holiday, all government officials are to remain in the duty station. No inter-city transport and commuting during the Eid holiday. The restrictions do not apply to emergency transport services including food products, supplies for factories, government projects, fuels, baby foods, aid materials, agricultural goods, fertilizers and insecticides, goods related to livestock and fisheries, milk and dairy products, daily necessities, medicine and pharmaceutical industries, medical services.

2. Coordination

On 9 May, the DGHS announced that prevalence of dengue in the country has increased. Since fever may be present both in dengue and COVID-19 cases, dengue testing will be conducted in addition to COVID-91 test in all patients presenting to health facilities with fever. COVID-19 hotline in every District/Upazilla are to include Dengue reporting. Dengue Rapid Diagnostic tests kits were distributed by the National Malaria Eradication Programme to all districts.

The DGHS held a video conference on Dengue management with 64 civil surgeons of the districts and most of the Upazilla Health and Family Planning Officers, who were instructed to provide all dengue-related information to the DGHS control room; and to make ready the Dengue corner in every district Hospital and upazila hospital, established during the last year outbreak.
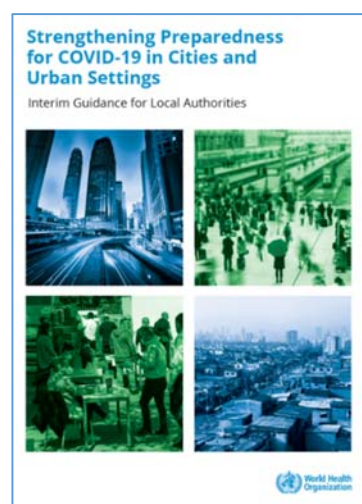

The World Health Organization released an Interim guidance to local authorities "Strengthening Preparedness for COVID-19 in Cities and Urban Settings". This document aims to support local authorities, leaders and policy-makers in cities and other urban settlements world-wide in identifying effective approaches and implementing recommended actions that enhance the prevention, preparedness and readiness for COVID-19 in urban settings, to ensure a robust response and eventual recovery. It covers factors unique to cities and urban settings, considerations in urban preparedness, key areas of focus and preparing for future emergencies.

Preparedness in cities and other urban settlements is critical for effective national, regional and global responses to COVID-19. These settings face unique dynamics that affect preparedness – they serve as travel hubs, have a higher risk of disease spread due to high population densities, and many have extensive public transport networks. Diverse subpopulations have different sociocultural needs and contain vulnerable groups. Some live in crowded and substandard housing, lack. access to safe water, sanitation and hygiene facilities, and those in informal settlements are also more often unemployed or dependent on informal economies. Cities also have centres for advanced medical care and are critical to broader health systems. These issues and other related issues will be addressed in the continued dialogue with local authorities with regard to their important role throughout the emergency management cycle – from preparedness and readiness to response to and eventual recovery from COVID-19.

3. Surveillance and Laboratory

Between 8 March and 11 May 2020, according to the Institute of Epidemiology, Disease Control and Research (IEDCR) there were fifteen-thousand-six-hundred-nighty-one (**15,691**) COVID-19[1] confirmed by rt-PCR, including two-hundred-thirty-eight (**238**) related death cases (**CFR 1.52**%). Two-thousand-nine-hundred-nifty-two (**2,902**) or **18%** of all reported cases recovered. Sixty-eight (**68**) percent of all confirmed cases were males.

The figures below are showing the daily distribution of reported confirmed COVID-19 cases, outcome and CFR, 08 March – 11 May 2020, Bangladesh.

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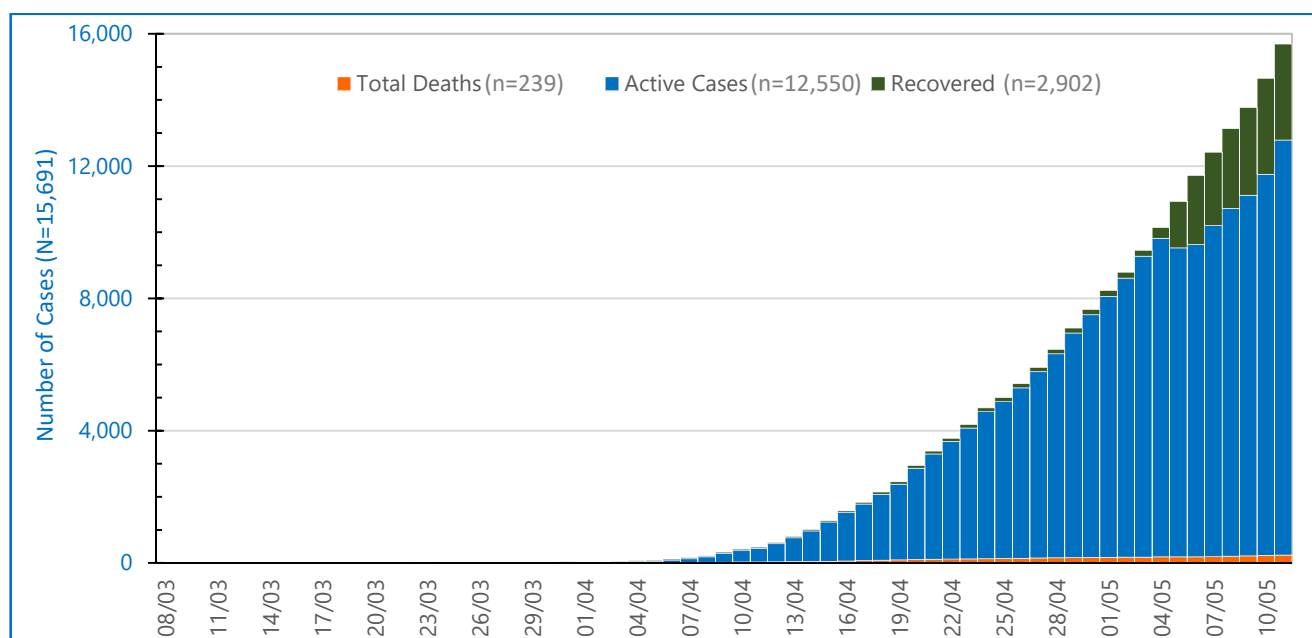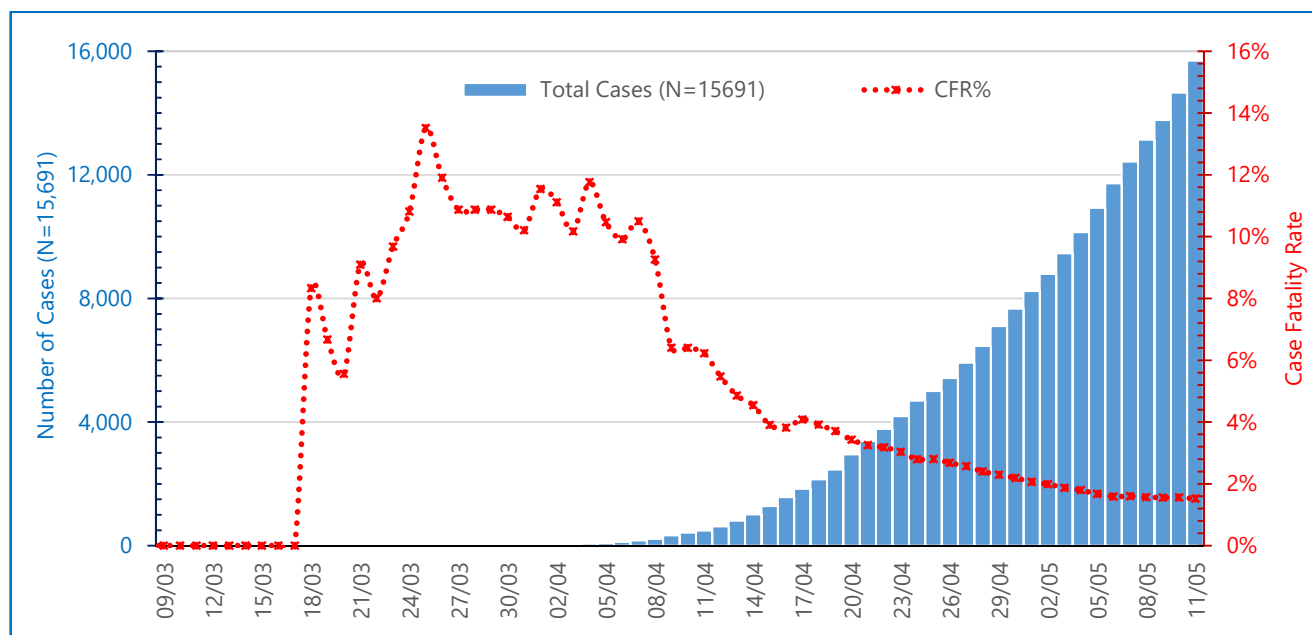
[1] *WHO Bangladesh COVID-19 Situation Reports present official counts of confirmed COVID-19 as announced by the IEDCR on the indicated date. Difference in data between the WHO reports and other sources can result from using different cutoff times for the aggregation and reporting of the total number of new cases in the country.*

Since 4 April 2020 to date, the overall COVID-19 attack rate (the total number of cases divided by the total population) in Bangladesh[2] has been showing a steady increase. On 11 May, Bangladesh attack rate (**AR**) is **92.1** per 1 million.

The highest AR was observed in **Dhaka division** (**527.0**/1,000,000). Within Dhaka division, **Dhaka city** has the highest AR (**874.9**/1,000,000), followed by **Narayanganj** (**356.6**/1,000,000), **Munshigan**j (**126.4**/1,000,000), **Gazipur** (**84.0**/1,000,000) and **Narshingdi** (**65.4**/1000,000).

The second highest COVID-19 Attack Rate was reported from **Mymensingh** division **(34.8/**1,000,000**).** Within Mymensingh division, Jamalpur district city has the highest AR (**40.6**/1,000,000), followed by **Mymensingh** district (**38.6**/1,000,000), Netrokona district (**26.6**/1,000,000) and Sherpur District (**24.3**/1,000,000).

A rise in Chattogram division is visible since 06 May 2020 at AR of **23.3**/1,000,000. Within the division, Cox's Bazar district reported highest AR (**35.1**/1,000,000) followed by Chaootgram (**29.5**/1,000,000), Lakshmipur (**28.9**/1,000,000), Cumilla (28.6/1,000,000) and Chandpur (**19.6**/1,000,000).

Barisal division reported overall AR of (**14.8**/1,000,000) with the highest AR in **Barguna** district at (**35.1**/1,000,000). Although Attack Rate for **Rasjsahi** division is relatively low at **07.5**/1,000,00, the AR for **Joypurhat** district is as high as **38.9.3**/1,000,000.

To date, **100% (64**/64) of districts and cities with the total population of 170,306,468 people have confirmed COVID-19 cases. The latest district reporting its first COVID-19 cases was Rangamati district in Chattogram division on 06 May 2020.

The following figure is showing the attack rate per 1,000,000 population of reported confirmed COVID-19 cases in selected divisions, 08 March - 11 May 2020, Bangladesh.
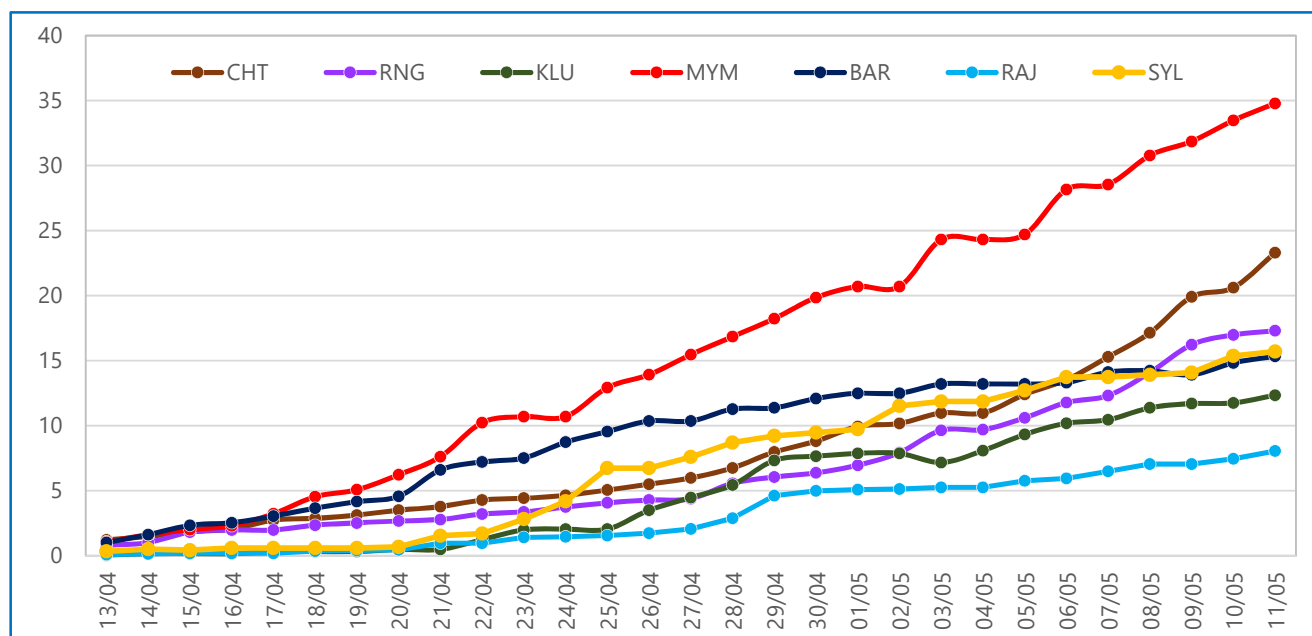
As of 11 May 2020, geographical distribution of conformed reported COVID-19 cases was available on **80%** (**12,275**/15,391)**;** of them **81%** (9,977/12,275) were from **Dhaka** division**, Chattogram** division **6%** (783)**, Mymensingh** division **4%** (452), **Rangpur** division **3%** (323), **Khulna** division **2%** (229), **Sylhet** division **1%** (184), **Rajshahi** division **1%** (176) and **Barisal** division **1%** (151).

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[2] Source: Population projection from 2011 Census, Bangladesh Bureau of Statistics

The figures below are showing the daily distribution of reported confirmed COVID-19 cases per division, 13 April–11 May 2020, Bangladesh
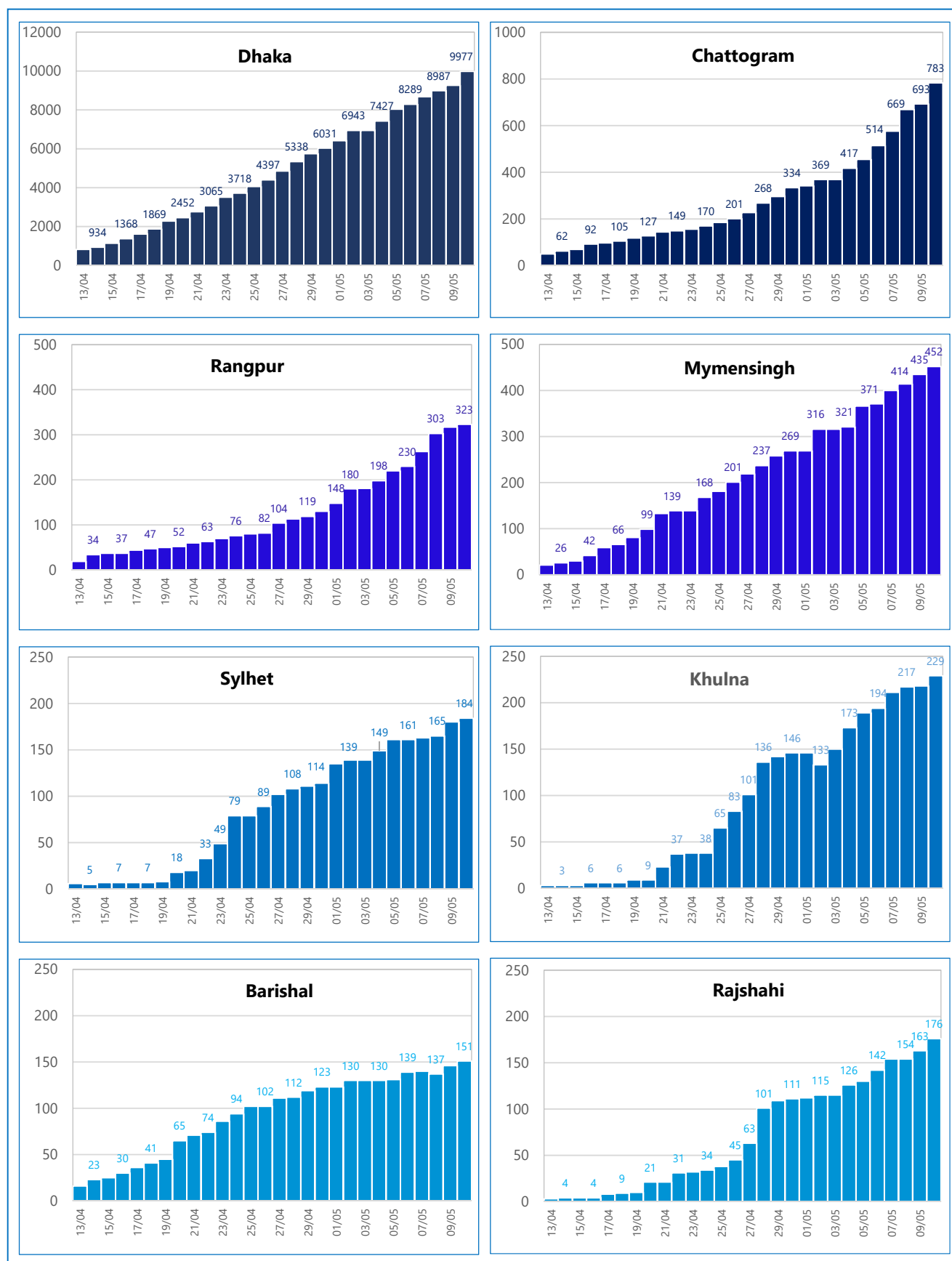
Bangladesh reported its first confirmed COVID-19 case on 08 March 2020, reached 100 cases on 9 April, and exceeded 200 cases within the next two (2) days (Case Doubling Time). The case doubling of new cases continued for 14 days, and then on the 15th day after reaching 100 cases, the case doubling changed to three (3) day time and has been slowing down further.
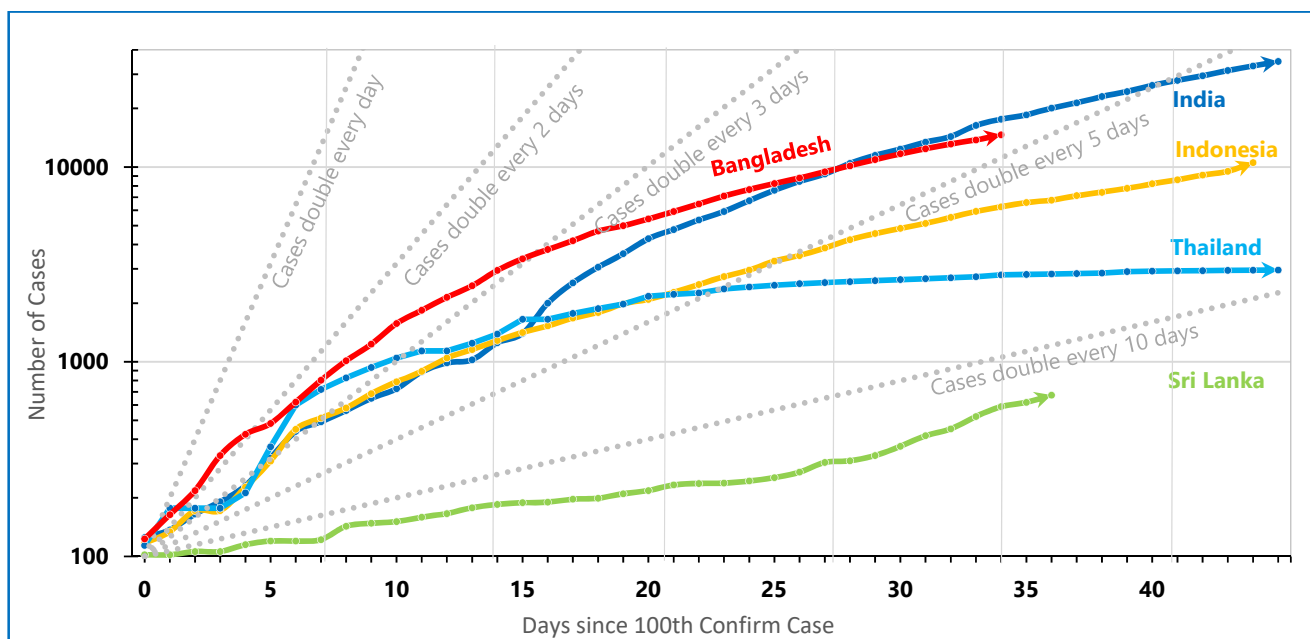
Available data allows us to see how quickly the number of confirmed cases increased in Bangladesh and some other countries in the WHO South-East Asia region: India, Indonesia, Thailand and Sri Lanka.

The figure below is showing the growth of COVID-19 confirmed cases in selected South East Asian countries starting from the day they reported 100 confirmed cases.

In the chart above we used the total number of COVID-19 confirmed cases; in the chart below, we use data of daily reported cases adjusted for the size of the population (AR/1,000,000).

The figure below is showing the **daily reported confirmed COVID-19 cases per million people** ***in selected South East Asian countries starting from the day they reported 30 confirmed cases.***
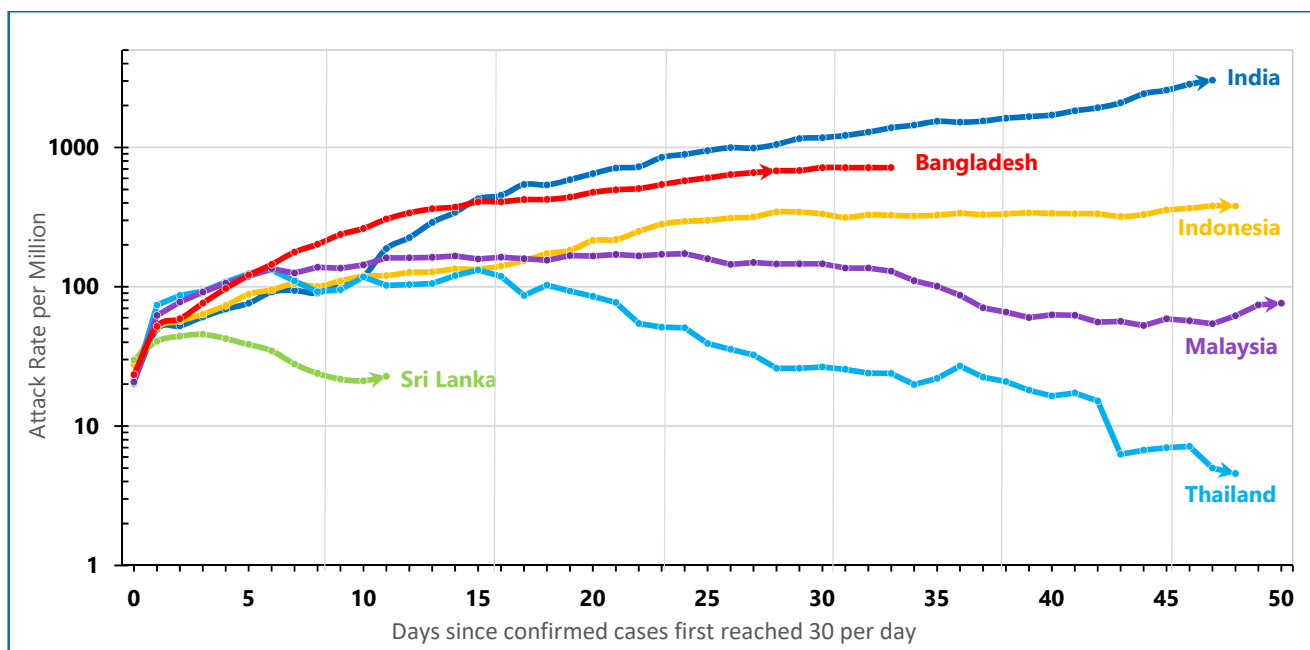
On April 3, **Growth factor (GF)** for COVID-19 cases (every day's new cases / new cases on the previous day) reached the highest of **2.5**, on 12 April it was **2.3**, after dropping to 1.6 on 20 April to date the Growth Factor has been less than **1.5** and occasionally below **1**. **Growth factor** (GF) between 0 and 1 indicates a decline; when it is above 1 it signals an increase, and if is persistently above 1 this could signify exponential growth.
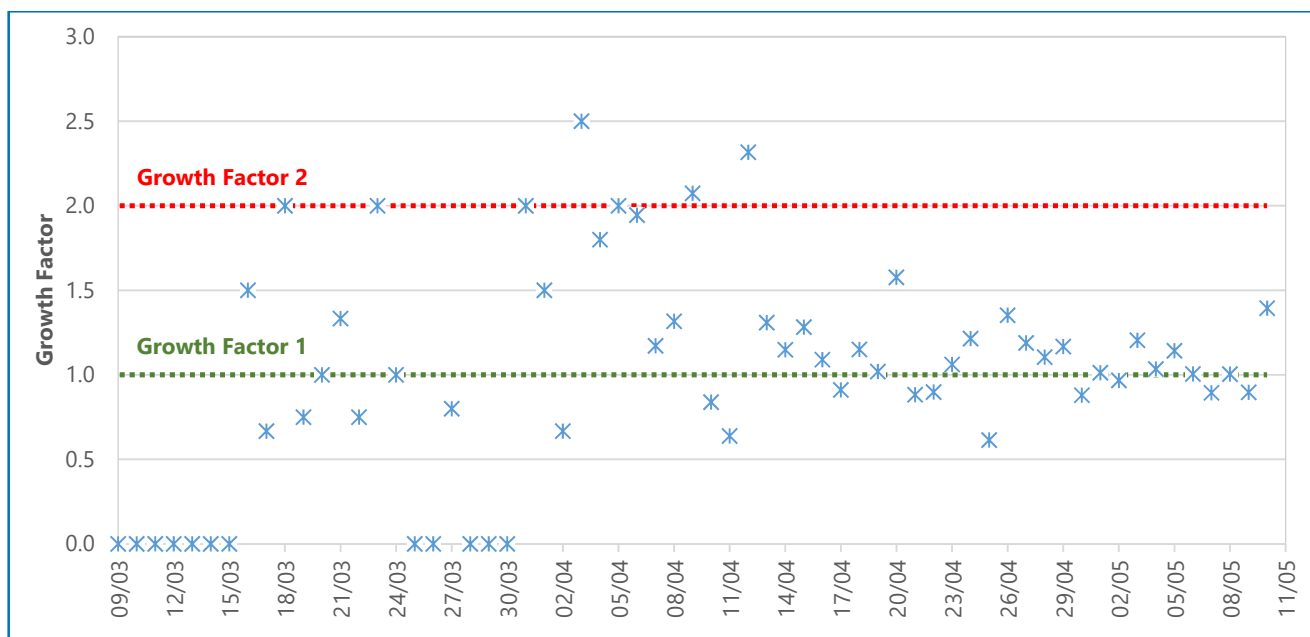
The figure below is showing the Growth Factor of daily confirmed COVID-19 cases, 08 March – 11 May 2020, Bangladesh

As of 11 May 2020, there were **3,141** COVID-19 cases with known outcome (closed cases) of them **92.4%** (2,902/3,143) of which were cured and **7.6%** (228) died.

Accordingly, the death rate on closed cases in Bangladesh has been lower than the **17.9%** global average.

The figure below is showing the death and recovery rates over cumulative on closed reported confirmed COVID-19 cases, 08 March – 11 May 2020, Bangladesh.
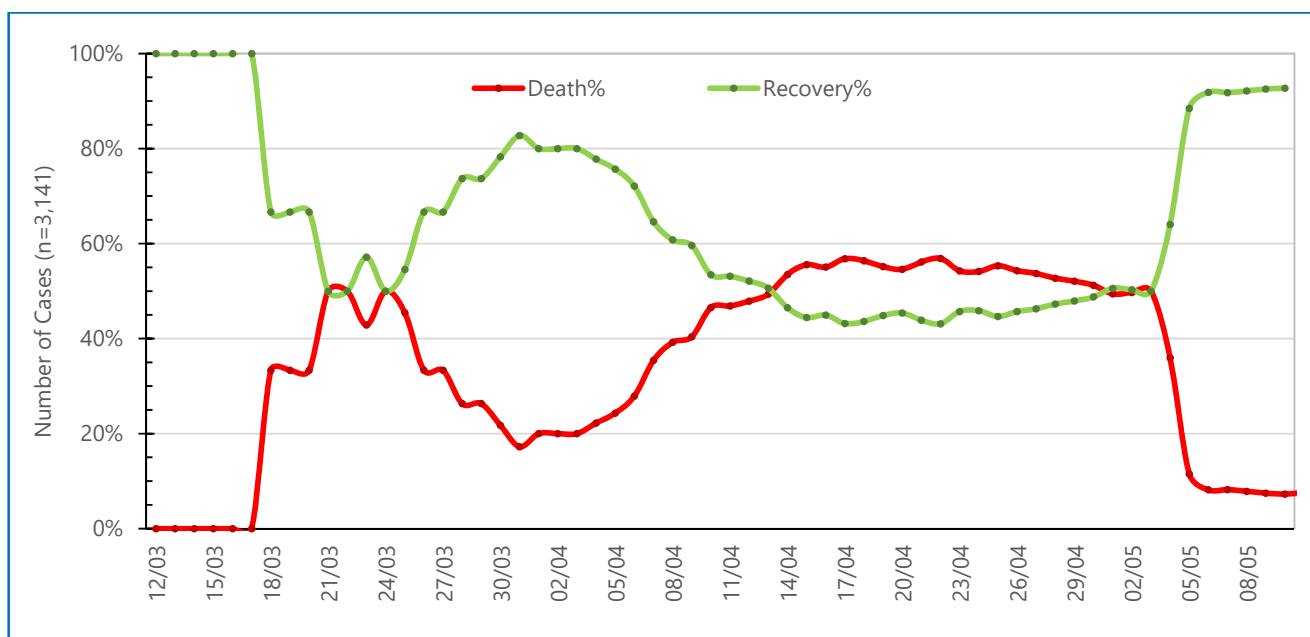
Bangladesh reported its first confirmed COVID-19 death on 18 March 2020 (10 days after reporting the first COVID-19 confirmed case). Between 9 April and 11 May COVID-19 Case Fatality Rate (the number of deaths divided by the number of confirmed cases) in Bangladesh showed a decline from **10%** down to **1.52%**.

According to data available as of 11 May, the death count doubling in Bangladesh has been slower than in India and Indonesia, but faster than in Malaysia, Thailand and especially Sri Lanka.

The figure below is showing the growth of COVID-19 confirmed deaths in selected South East Asian countries starting from the day they reported the 5th confirmed death.
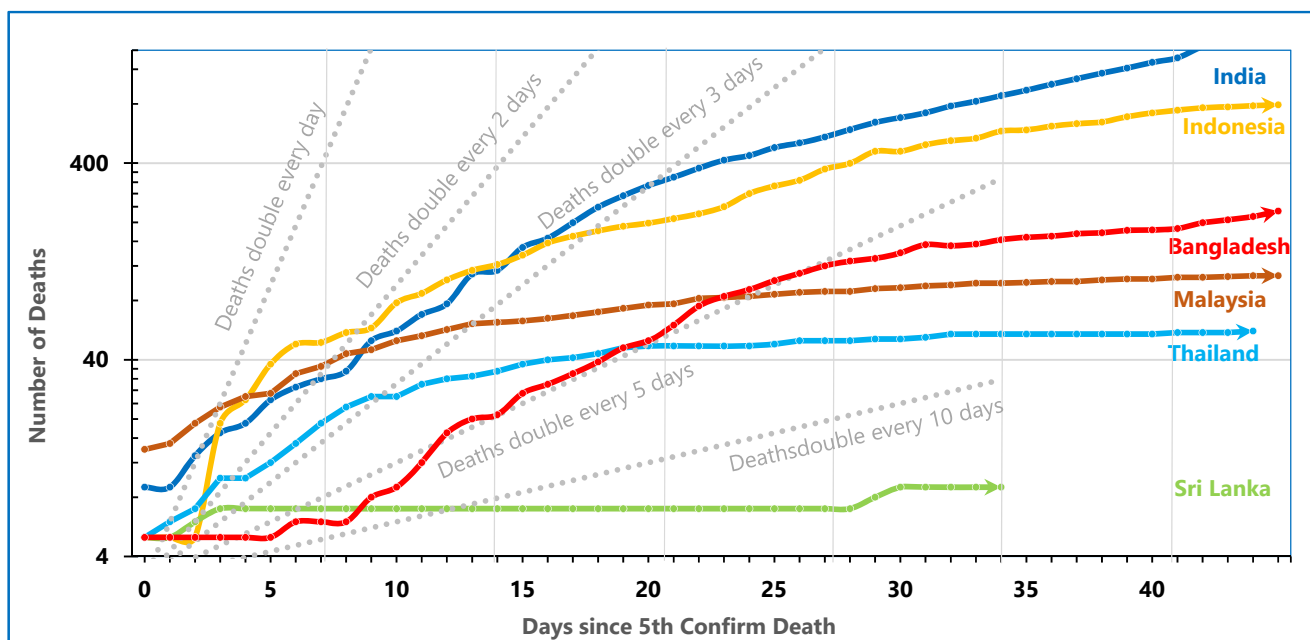
Due to death reporting protocols and possible delays, the reported death figure on a given date does not necessarily represent the number of new deaths on that day. And since daily reporting can very, it is also helpful to see the three-day rolling average of the daily figures.

The figure below is showing daily confirmed COVID-19 deaths, rolling 3 days average in selected South East Asian countries, 11 May 2020.
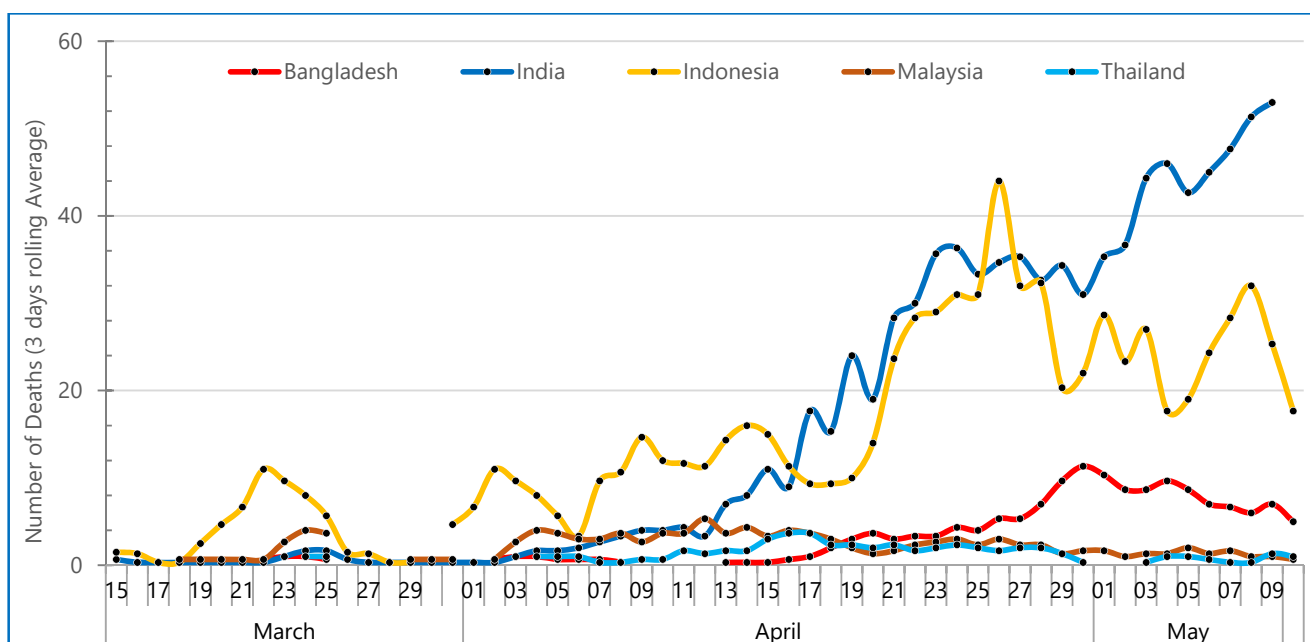
As of 11 May 2020, according to IEDCR, a total of 129,865 COVID-19 tests were conducted in Bangladesh (by 37 laboratories, of them 18 laboratories in Dhaka and 19 laboratories in other districts of the country. Since the last WHO update on 04 May, 4 additional laboratories stating testing of them 1 in Dhaka (Centre for Advanced Research in Sciences (CARS), Dhaka University and 3 outside Dhaka (300 Bed Hospital Khanpur, Narayanganj, Chattogram Medical College, Chattogram and Abdul Malek Ukil Medial College, Noakhali).

Of the total **129,865** COVID-19 tests conducted between 08 March to 11 May, **15,691** were positive for COVID-19; overall positivity rate of the conducted tests now is **12.1%** (15,691/129,280). Within Dhaka laboratories IEDCR laboratory conducted **12%** (15,723/129,280) with positivity rate **14.5%** (2,280/15,723) which is highest among all the laboratories).

The COVID-19 testing coverage has been gradually increasing in Bangladesh, reaching now **759**/1,000,000 but is still lower than in Thailand (**1,390**/1000,000), India (**1,170**/1000,000).

The graphs below are showing the weekly accumulative number of COVIS-19 testing and positivity rate, and tests per 1,000,000, 08 March – 11 May 2020, Bangladesh
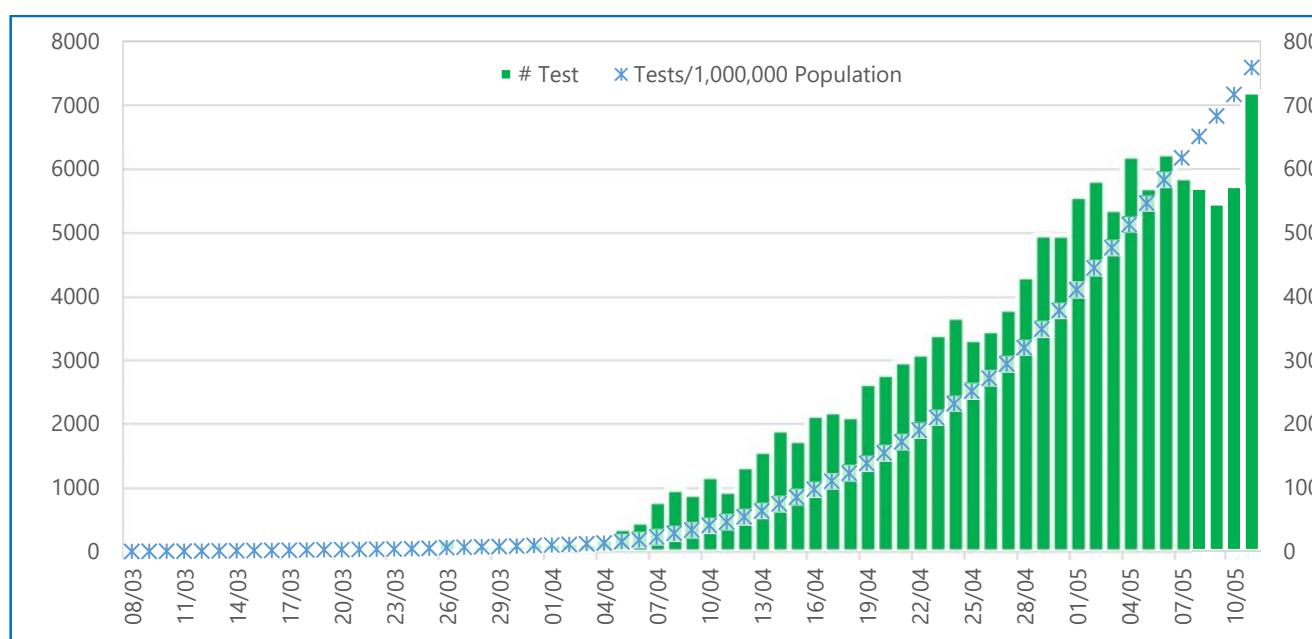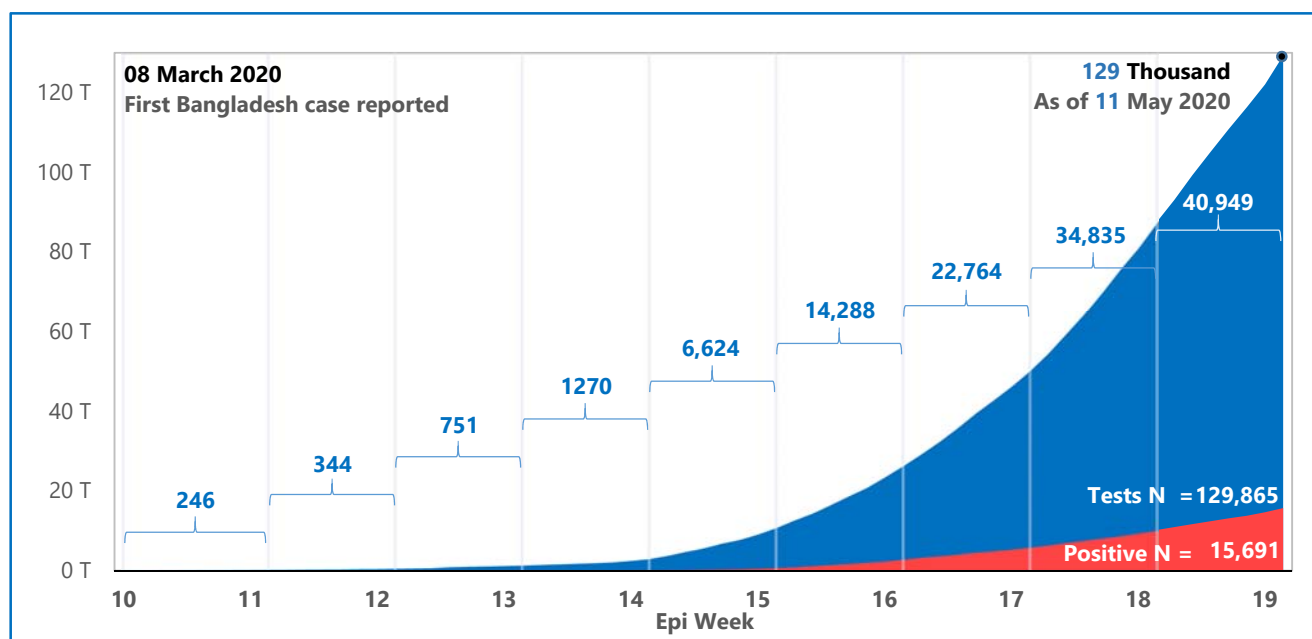
4. Contact Tracing, Points of Entry (PoEs) and Quarantine

According to the DGHS, as of 11 May 2020, the current institutional quarantine capacity in the country is represented by **615** centres across **64** districts, which can receive **30,955** people.
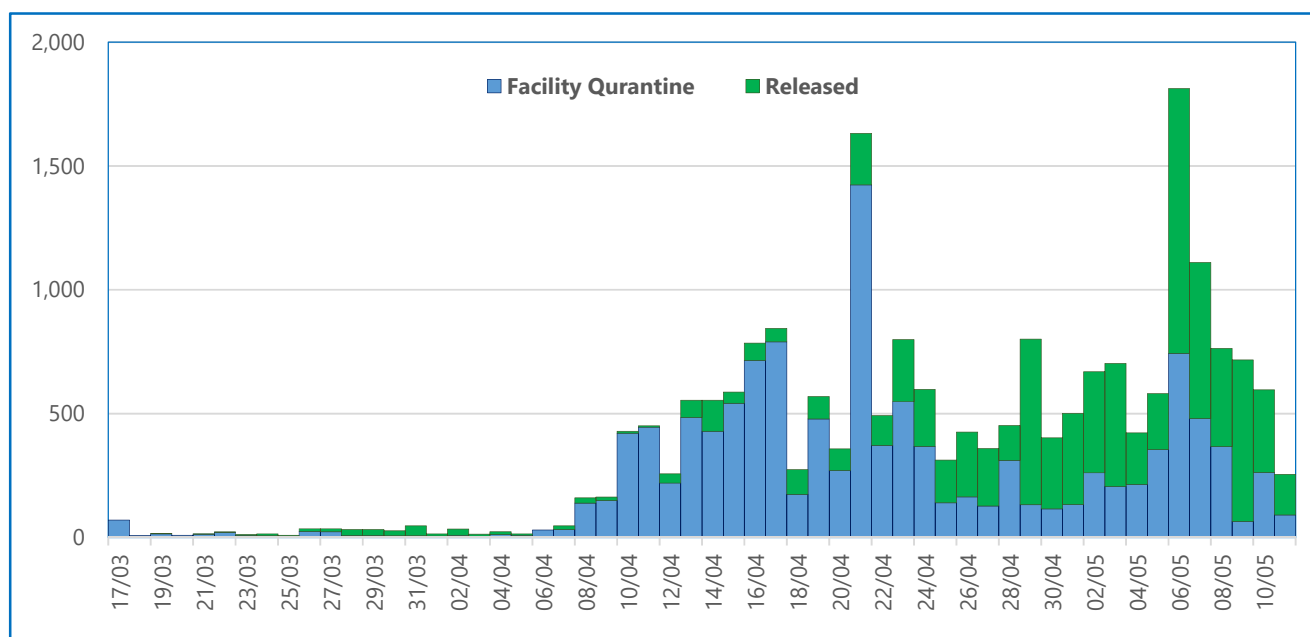
Between 17 March to 11 May 2020, total 212,983 individuals were placed under home quarantine all the over the county, and to date 83% (176,640) have been already released.

The figure below is showing the number of individuals in facility quarantine and individuals released, 17 Mach – 11 May 2020, Bangladesh

As of 11 May 2020, there were 12,366 individuals isolated in designated health facilitates all over the country, of then 8,120 were released. There was an increase in the number of individuals placed under facility quarantine since 12 April 2020. A total 295 passengers quarantined from Hazart Shah Jalal International Airport are accommodating in BRAC Learning Centre (188) and in Ashkona Hagi Camp Dhaka (107).

The other large centers are Gazi Darga Madrasa in Jashore with 367 passengers and none in Benapole Community Centre who entered through the Benapole land port.

The figure below is showing the distribution of available isolation beds in hospitals and isolation individuals, 11 May 2020, Bangladesh.

Division	Number of Isolation Beds	% of total beds in the country	Individuals in Isolation	% of total isolated in the country
Barisal	683	10%	228	10%
Chattogram	1,313	19%	394	17%
Dhaka	1,229	17%	815	36%
Khulna	938	13%	288	13%
Mymensingh	522	7%	101	4%
Rajshahi	815	12%	52	2%
Rangpur	585	8%	280	12%
Sylhet	979	14%	118	5%
Total	**7,064**	**100%**	**2,276**	**100%**

5. Case Management and infection Control

On 4 May, a meeting was held at DGDA to discuss the draft visual inspection checklist for personal protective equipment (PPE). The checklist is being developed by Japanese inspection firm K2 and supported by JICA. Feedback from DGDA technical staff and stakeholders was solicited by the K2 experts to be incorporated into the tool. The purpose of the exercise is to develop a guide to procurement agencies, regulators and industries on visual inspection techniques for PPE for quality control. The exercise is important for both imported and locally produced PPE to ascertain that the products being delivered comply with the specifications mentioned in the technical data sheet and the conditions agreed with the competent authorities. On 5 and 7 May, the Technical Working Group on PPE Quality Control convened at WHO office. The meeting included TWG experts from BUET, K2, ICDDR,b and USAID. The main focus of the meeting was addressing information gaps in parameters for pass/fail against several tests in the relevant PPE standards. Available information was reviewed, and decisions made on alternate parameters to use where the pass/fail were not available.

On Sunday 10 May, DGDA issued a notice announcing approval of the minimum parameters for testing quality of PPE at the following link https://www.dgda.gov.bd/index.php/news/item/50. The parameters were set based on the WHO specifications for PPE, as outlined in the disease commodity package for COVID-19. Account was taken of the local laboratory capacity and the availability of accredited, non-accredited and/or equivalent testing methods. The decided parameters are accepted by DGDA for PPE quality control during the emergency. Previously, DGDA had circulated a list of 5 laboratories which were approved to perform the tests on PPE. The tests performed at the approved laboratories will be the basis for DGDA to issue no-objection-certificate (NOC) for both imported and locally produced PPE. Also, the parameters will be used to classify the PPE as fit for use in Level 1-4, according to the approved standards.

On 4 May, a webinar, hosted by IFC was held to support local garments industries in converting their production lines to manufacture priority PPE items. Speakers included IFC Principal and Global Sector Lead for Light Manufacturing, IFC Textile Industry Specialist, WHO and leading companies in PPE manufacturing solutions. Around 16 local industries participated in the webinar as well as interested manufacturers from other countries in the region. The topics presented in the workshop included an introduction to COVID-19 and how is the virus transmitted, What is needed from PPE to protect, Material properties for protection, Alternatives to nonwovens and 3-layer structures, Material sourcing, ultrasonic welding or cut & sew machinery, demo videos, patterns, cut files, and technical package for conversion of garments industries to PPE manufacturing. The Q&A session was dynamic and focused mainly on achieving the WHO specifications for PPE.

On 6 May, a meeting took place at the DGHS control room with the expanded committee for PPE protection of health workers against COVID-10. In addition to the DGHS members, WHO and DGDA were present, for the first time. The meeting was presided by DGHS, ADG Administration. Member secretary of the PPE taskforce committee briefed the terms of references of the committee and explained the achievements of the committee so far in the COVID-19 context. He asked the committee to prepare a forecast on the PPE requirements and to support for WHO to provide technical support in preparing country-specific guidelines on the reuse of respirators, especially during the acute shortages. WHO updated the committee on current DP efforts to provide a consolidated estimate of country needs and to address main quality concerns over PPE. Other issues discussed included the global shortages in commodities for COVID-19 management, the reuse of PPE and necessity of decontamination protocols, technical specifications of KIOSKS for sample collection, and expansion of lab testing.

On 7 May, a meeting of the South East Asia Regulatory Network (SEARN) was hosted by WHO SEARO and attended by DGDA officials remotely. The meeting provided regulatory updates on key issues facing countries in the Context of COVD-19. Issues tackled included post-market surveillance for substandard and falsified products, in-vitro diagnostics, PPE, vaccines development, solidarity trial and off label use of medicines. Regarding off-label use of medicines WHO/HQ strongly advised countries to encourage clinicians to engage in clinical trials for using existing medicines such as Remdesivir, chloroquine/hydroxychloroquine, Favipiravir and others, rather than off label use.

6.   Risk Communication and Public Awareness

WHO has been working for producing communication materials adapted to the current phase of the pandemic to reduce stigma and discrimination towards people affected by COVID-19 or towards frontline health workers.

Within Risk Communication and Community Engagement pillar co-led by DGHS and UNICEF, WHO has been working with partners for producing accurate messages, in line with national guidelines for better informing communities and individuals how to stay protected and to protect others.

Messages have been created addressed to worshippers and Mosque Management Committees and Imams on the prevention measures that have to be followed and implemented with the reopening of the mosques for prayers. In this regard people are requested to follow personal hygiene advices, to wear masks, sick and elderly people are requested to pray from home while management of the mosques must conduct regular disinfection of the praying areas, to ensure physical distance between the worshippers or to refrain from preparations for Sehri and Iftaar in the mosques.

WHO will continue working with partners on developing additional messages for different sectors of activity for reinforcing prevention measures and awareness towards COVID-19.

Useful COVID-19 links:

WHO Bangladesh COVID-19 Situation Reports: https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update/coronavirus-disease-(covid-2019)-bangladesh-situation-reports

The latest global WHO Situation Report # 112 as of 11 May 2020: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200511-covid-19-sitrep-112.pdf?sfvrsn=813f2669_2

WHO Bangladesh awareness and risk communication materials in Bengali: https://www.who.int/bangladesh/emergencies/coronavirus-disease-(covid-19)-update

For timely, accurate, and easy-to-understand advice and information on COVID-19 for different types of audiences (e.g. individuals and communities, health sector, employers and workers, faith-based organizations and faith leaders, etc): https://www.who.int/teams/risk-communication

For the information from the IEDCR: https://www.iedcr.gov.bd/index.php/component/content/article/73-ncov-2019

Directorate General of Health services, Ministry of Health and Family Welfare, Government of The People's Republic of Bangladesh: https://dghs.gov.bd/index.php/en/home/5343-covid-19-update

Strengthening Preparedness for COVID-19 in Cities and Urban Settings: https://www.who.int/publications-detail/strengthening-preparedness-for-covid-19-in-cities-and-urban-settings

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