World Health Organization
Bangladesh

COVID-19
Situation Report No. **#12**
18 May 2020

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

Tested	Confirmed	Recovered	Dead	Hotline
185,196	23,870	4,585	349	6,028,753

Test/1 million	AR/1 million	Recovery Rate	CFR%	Isolation Beds
1,087	140.2	19.2%	1.46%	9,134

Laboratories

42 COVID-19 Labs

52,751 Samples

7 Days

15.2% IEDCR Positive Tests

12.7% Other Laboratories Positive Tests

12.6% Overall Positive Tests

Gender

68% 32%

PPE Stock

	1,375,232
	2,515,110
	691,386
	189,088

PoE Screening

	332,213
	18,362
	7,029
	332,498

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1. Highlights

As of 18 May 2020, according to the Institute of Epidemiology, Disease Control and Research (IEDCR), there are 23,870 confirmed COVID-19 cases in Bangladesh, including 349 related deaths; Case Fatality Rate (CFR) is 1.46%.

On 16 May 2020, the Ministry of Foreign Affairs informed all Diplomatic Missions and Offices of the UN Agencies and International Organizations in Dhaka on the extension of the earlier enforced suspension of the commercial flights to and from Bangladesh till 30 May 2020.

On 14 May 2020, the government decided to extend the general holidays beyond 16 May 2020 and to restrict the movement until 30 May 2020. The holiday will not be effective for those engaged in processing of agricultural products, fertilizer, pesticide, foods, industrial goods, products/equipment of government projects, kitchen markets, food shop, pharmacies, hospitals and emergency services; the inter-District and inter-Upazila movement will be controlled strictly during the holiday period. In addition, social distancing and other health related advisories should be strictly maintained during Ramadan and Eid shopping. Handwashing and sanitization facilities should be arranged at the entrance of shopping malls and should be closed by 4:00 pm.

2. Coordination

On 12 May 2020, WHO issued a new guidance for "Public health criteria to adjust public health and social measures in the context of COVID-19" as an Annex to Considerations in adjusting public health and social measures in the context of COVID-19. The criteria are grouped into three domains that should be evaluated to address three main questions: **Epidemiology** - Is the epidemic controlled? (Yes or No); **Health system** - Is the health system able to cope with a resurgence of COVID-19 cases that may arise after adapting some measures? (Yes or No); and **Public Health Surveillance** - Is the public health surveillance system able to detect and manage the cases and their contacts, and identify a resurgence of cases? (Yes or No).

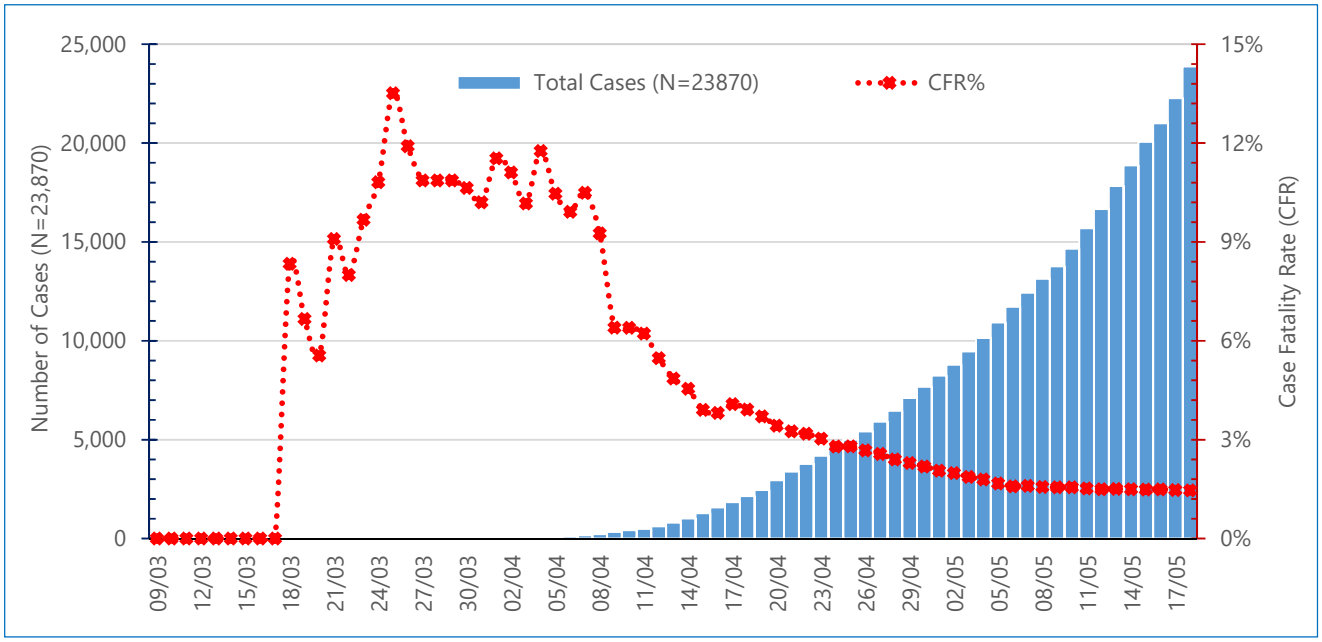
To answer the questions, the document outlines key measures and key criteria for qualitative assessment under each of the three domains. Depending on the answers to the three questions, a level of risk (high, intermediate, low) is assigned. The risk is an overall appraisal of the negative consequences resulting from loosening measures and the capacity to manage them. The risk level may be used to guide the adaptation of PHSM. In the context of the COVID-19 pandemic, finding, testing, and isolating cases, contact tracing, and quarantine remain core public health measures through all stages of the response. This document is intended for national authorities and decision makers in countries that have introduced large scale public health and social measures (PHSM) and are considering adjusting them. Full document: https://www.who.int/publications-detail/public-health-criteria-to-adjust-public-health-and-social-measures-in-the-context-of-covid-19

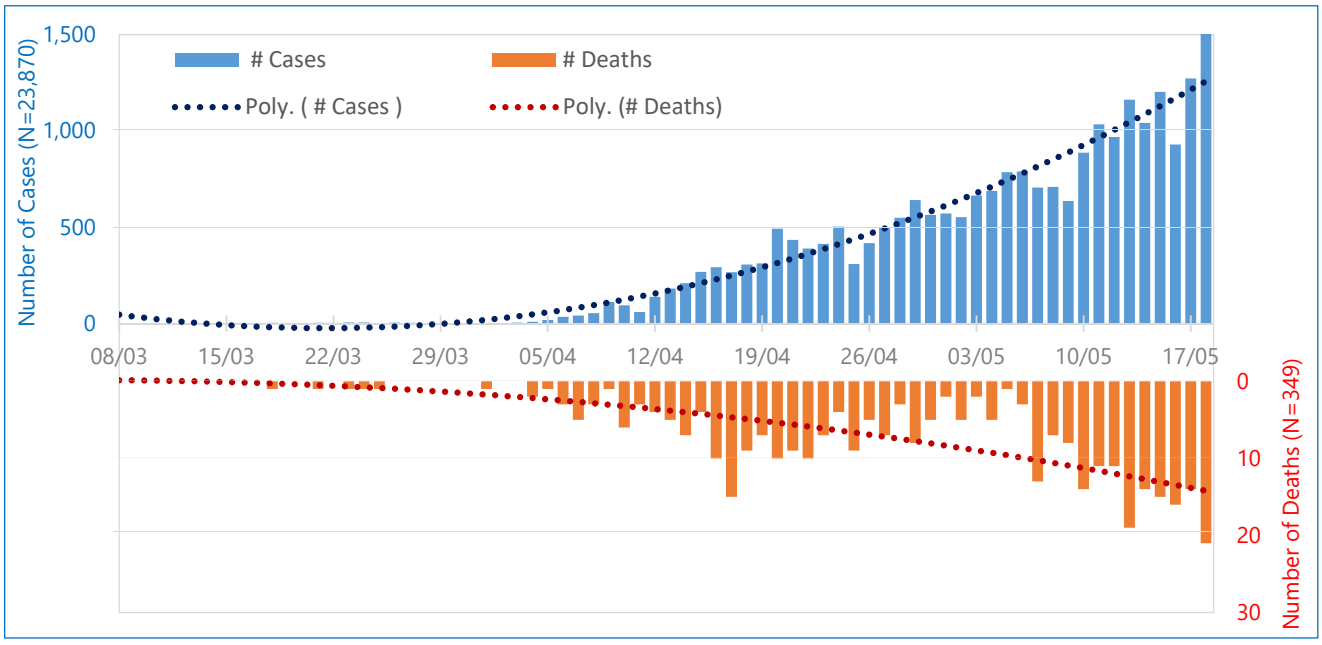
On 15 April 2020, WHO issued a new guideline for "Cleaning and disinfection of environmental surfaces in the context of COVID-19". The document addresses the principles of environmental cleaning and disinfection, issues of training in health-care settings, cleaning and disinfection techniques and supplies, products for environmental cleaning and disinfection, spraying disinfectants and other no-touch methods, health-care settings environment, non-health care settings environment, personal safety when preparing and using disinfectants. **Notably,** in indoor spaces routine application of disinfectants to environmental surfaces by spraying or fogging (also known as fumigation or misting) is **not recommended** for COVID-19; spraying or fumigation of outdoor spaces, such as streets or marketplaces, is also **not recommended** to kill the COVID-19 virus or other pathogens because disinfectant is inactivated by dirt and debris. **Spraying individuals with disinfectants** (such as in a tunnel, cabinet, or chamber) **is not recommended under any circumstances** as it could be physically and psychologically harmful and would not reduce an infected person's ability to spread the virus through droplets or contact. Moreover, spraying individuals with chlorine and other toxic chemicals could result in eye and skin irritation, bronchospasm due to inhalation, and gastrointestinal effects such as nausea and vomiting. Full document: https://www.who.int/publications-detail/cleaning-and-disinfection-of-environmental-surfaces-inthe-context-of-covid-19

1. Surveillance and Laboratory

Between 8 March and 18 May 2020, according to the Institute of Epidemiology, Disease Control and Research (IEDCR) there were Twenty-three-thousand-eight-hundred-seventy (**23,870**) COVID-19[1] confirmed by rt-PCR, including three-hundred-forty-nine (**349**) related death cases (**CFR 1.46**%).

The figures below are showing the daily distribution of reported confirmed COVID-19 cases, deaths and CFR, 08 March – 18 May 2020, Bangladesh.





[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 18 May 2020, Bangladesh attack rate (**AR**) is **140.2** per 1 million. To date, **100% (64**/64) of districts and cities with the total population of 170,306,468 people have confirmed COVID-19 cases.

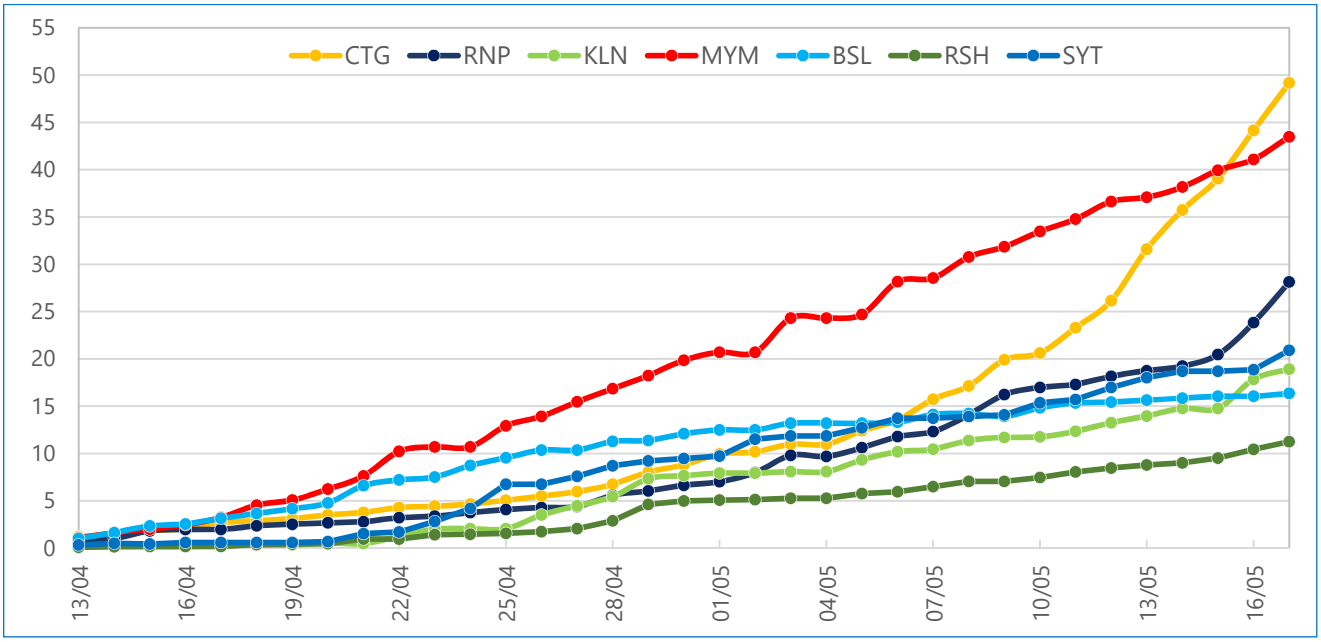
The highest AR continues to be observed in the **Dhaka division** (**300.2**/1,000,000). Within the Dhaka division, **Dhaka city** has the highest AR (**1,150.3**/1,000,000), followed by **Narayanganj** district (**419.7**/1,000,000), **Munshiganj** (**192.5**/1,000,000), **Gazipur** (**130.9**/1,000,000), **Narshingdi** (**66.1**/1000,000) and **Kishoreganj** (**60.1**/1,000,000).

The second highest COVID-19 Attack Rate is now reported from Chattogram division of **49.2**/1,000,000. Within the division, **Chattogram** reported the highest AR (**77.2**/1,000,000) followed by **Cox's Bazar** district (**68.3**/1,000,000), **Lakshmipur** (**47.9**/1,000,000), **Cumilla** (**46.8**/1,000,000). **Feni** (**44.7**/1,000,000) and **Rangamati** (**38.3**/1,000,000). Rangamati district was the last district to report COVID-19 (the first one was reported on 06 May 2020).

Although higher than in the previous week, the AR in the **Mymensingh** division (**43.5/**1,000,000) became the 3rd highest in the country. Within the Mymensingh division, **Mymensingh** district has the highest AR (**48.8**/1,000,000), followed by **Jamalpur** district (**44.3**/1,000,000), **Netrokona** district (**41.0**/1,000,000) and **Sherpur** District (**26.2**/1,000,000).

Rangpur division reported overall AR of **28.1**/1,000,000 with the highest AR in **Rangpur city** at (**79.9**/1,000,000); **Sylhet** division reported overall AR (**20.9**/1000,000) with the highest AR in Habiganj (**45.6**/1000,000), and in **Rasjsahi** division although the overall AR is relatively low at **11.3**/1,000,00, the AR for Joypurhat district is as high as 36.9/1,000,000.

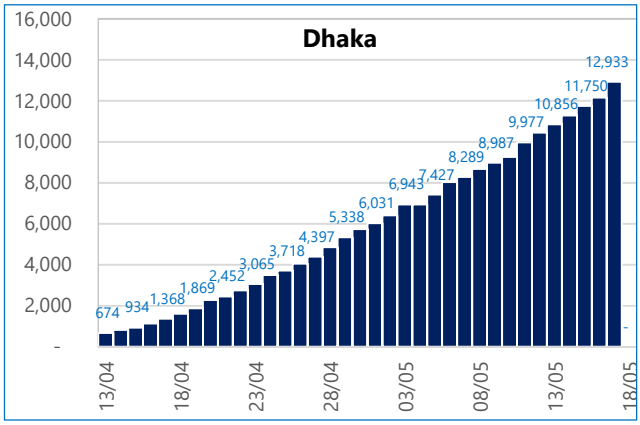
The following figure is showing the attack rate per 1,000,000 population of reported confirmed COVID-19 cases in selected divisions, 08 March - 18 May 2020, Bangladesh (except the Dhaka division.

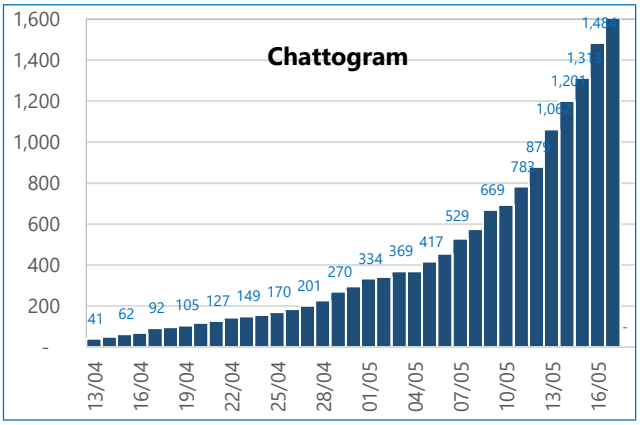


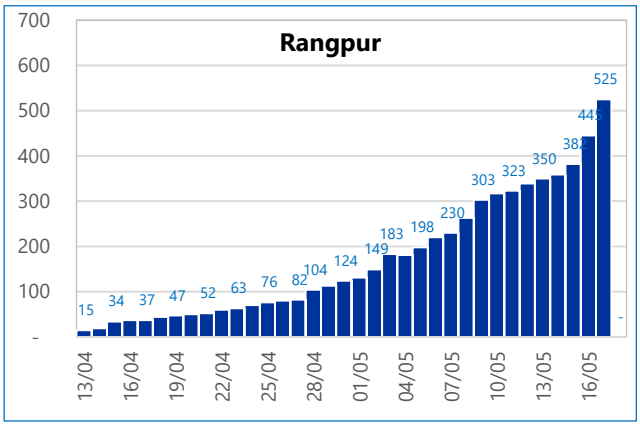
As of 18 May 2020, geographical distribution of conformed reported COVID-19 cases was available on **70%** (**16,679**/23,870)**;** of them **78%** (12,933/16,679) were from **Dhaka** division**, Chattogram** division **10%** (1,653)**, Mymensingh** division **3%** (565), **Rangpur** division **3%** (525), **Khulna** division **2%** (351), **Rajshahi** division **1.5%** (246) **Sylhet** division **1.5%** (245), and **Barisal** division **1%** (161).

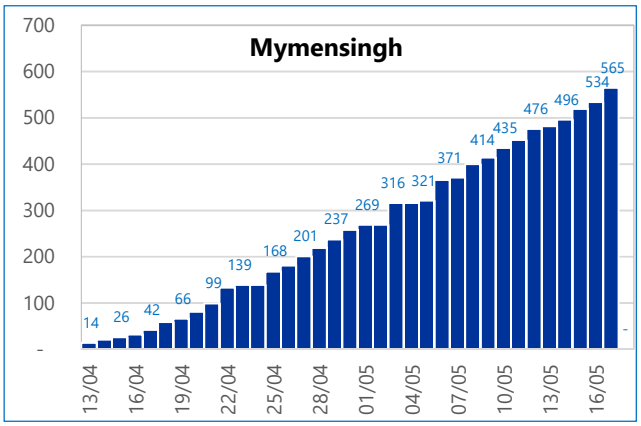
[2] Source: Population projection from 2011 Census, Bangladesh Bureau of Statistics

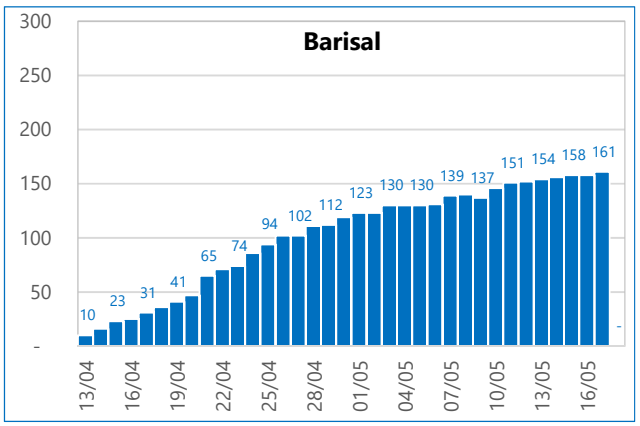
The figures below are showing the daily distribution of reported confirmed COVID-19 cases per division, 13 April–17 May 2020, Bangladesh.

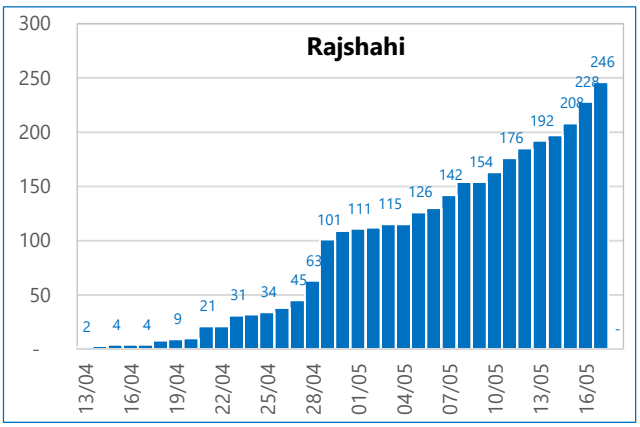


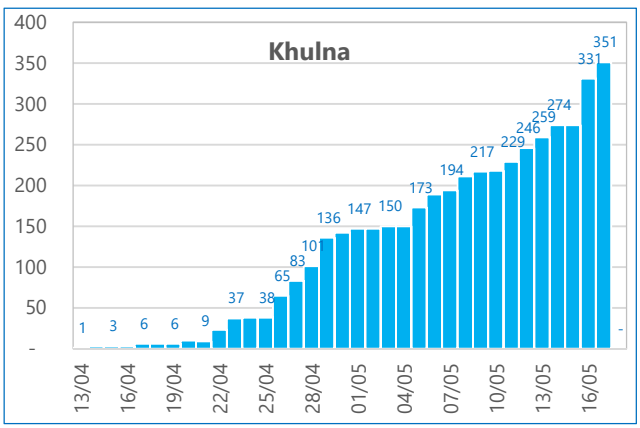


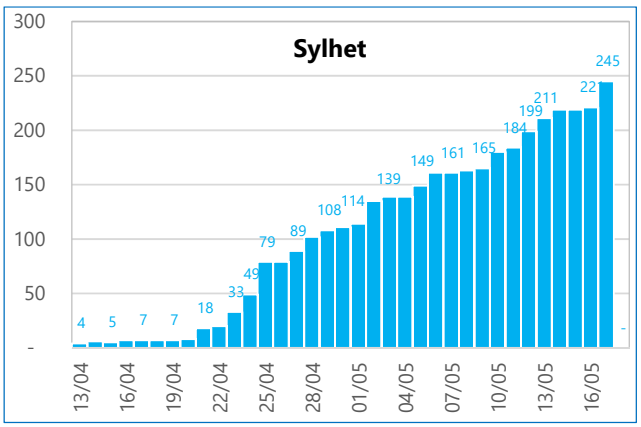






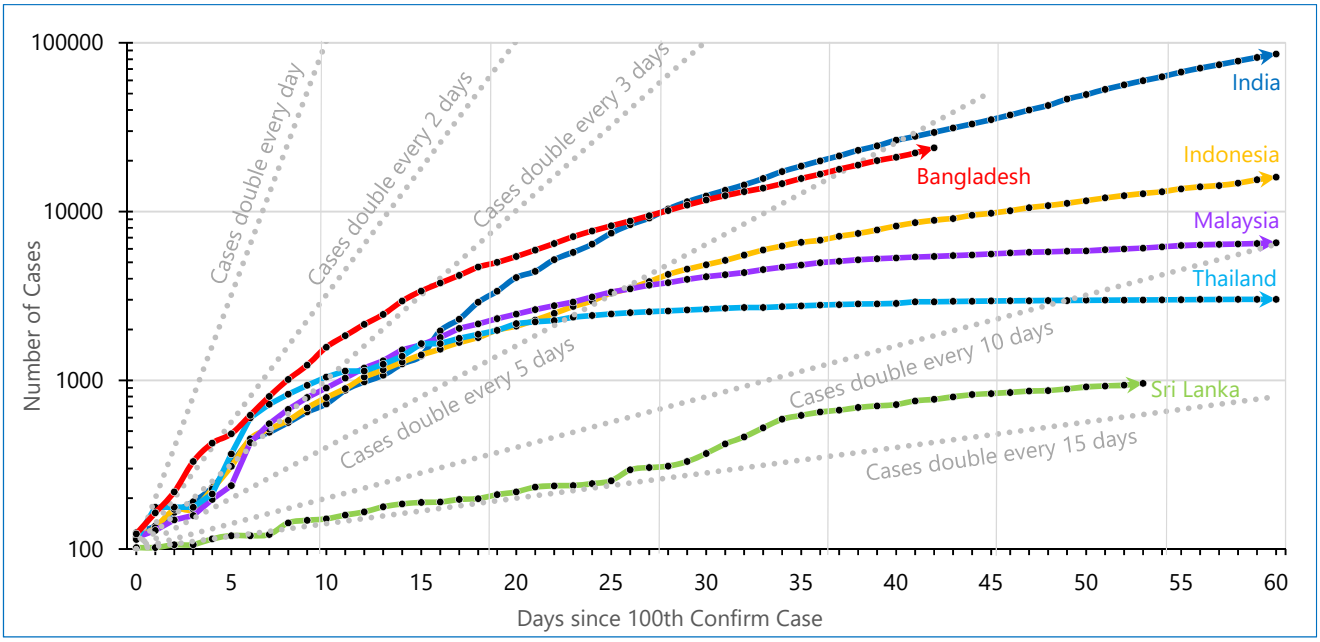






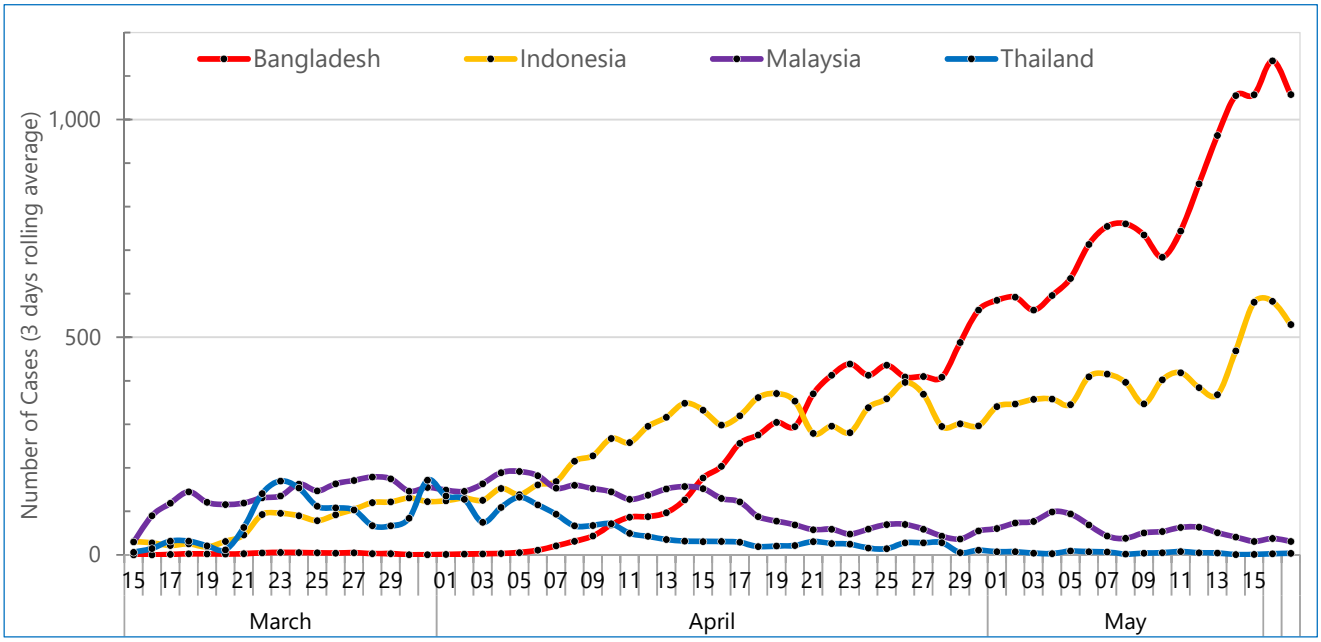
Bangladesh reported its first confirmed COVID-19 case on 08 March 2020, reached 100 cases on 9 April, and exceeded 200 cases within the next two (2) days (Case Doubling Time). The case doubling of new cases was slowing down from two to three-day time, and as of 18 May 2020, the case doubling is around five (5) day time. 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, 18 May 2020.



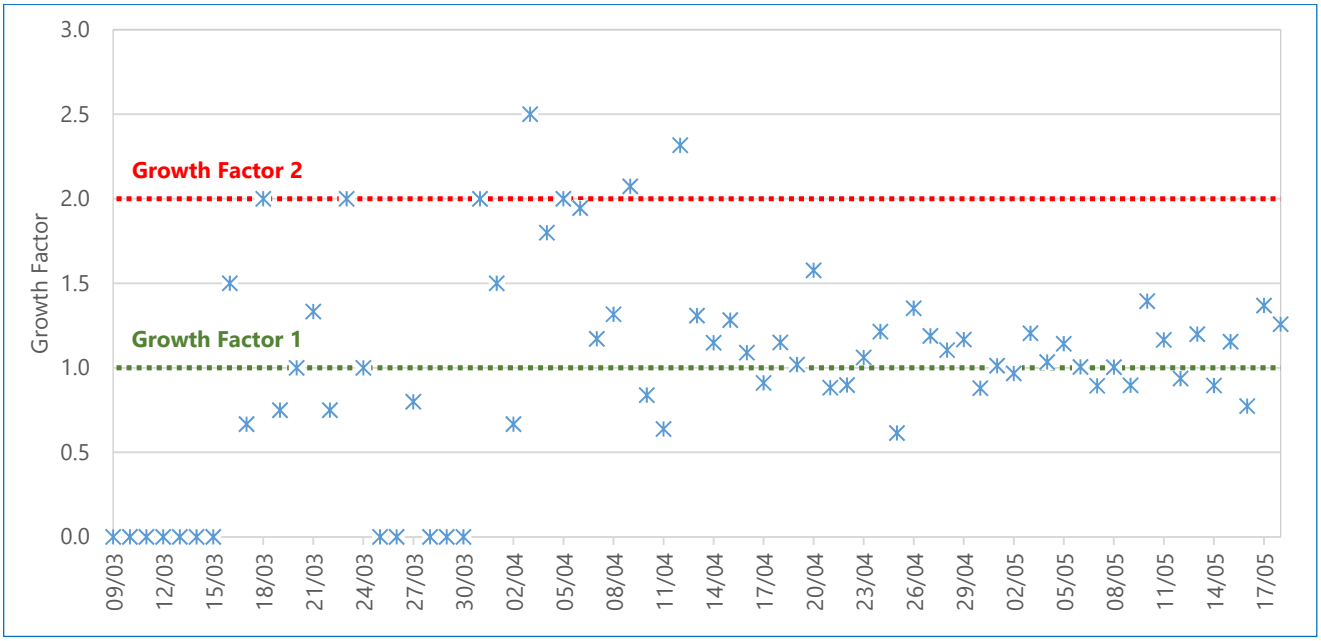
In the chart above we used the total number of COVID-19 confirmed cases; in the chart below, we used the 3 days Rolling Average of daily reported cases.

The figure below is showing the* daily reported confirmed COVID-19 3 days rolling average *in selected South East Asian countries starting from the day they reported 30 confirmed cases, 18 May 2020.



Growth factor (every day's new cases / new cases on the previous day) 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. On April 3, the **Growth factor (GF)** for COVID-19 cases in Bangladesh reached the highest of **2.5**, on 12 April it was **2.3**. Since the beginning of May 2020, the GF has been within the range of 0.8 – 1.4, and on 18 May 2020, the GF is **1.25.**

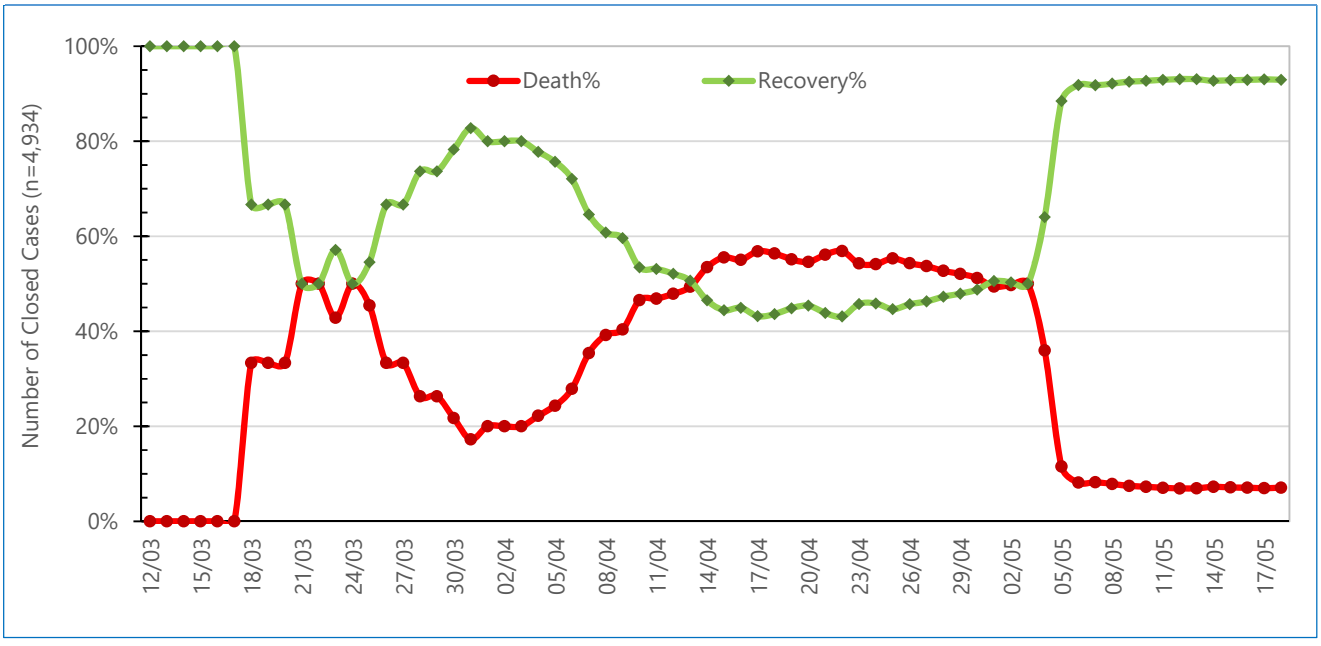
The figure below is showing the Growth Factor of daily confirmed COVID-19 cases, 08 March – 18 May 2020, Bangladesh, 08 March – 18 May 2020.



As of 18 May 2020, there were **4,934** (20.7%) COVID-19 cases with known outcome (closed cases) of them **92.9%** (**4,585**/4,934) were cured and **7.1%** (328) died.

Accordingly, the death rate on closed cases in Bangladesh is lower than the **14.5%** (318,295/2,201,439) global average as of 18 May 2020.

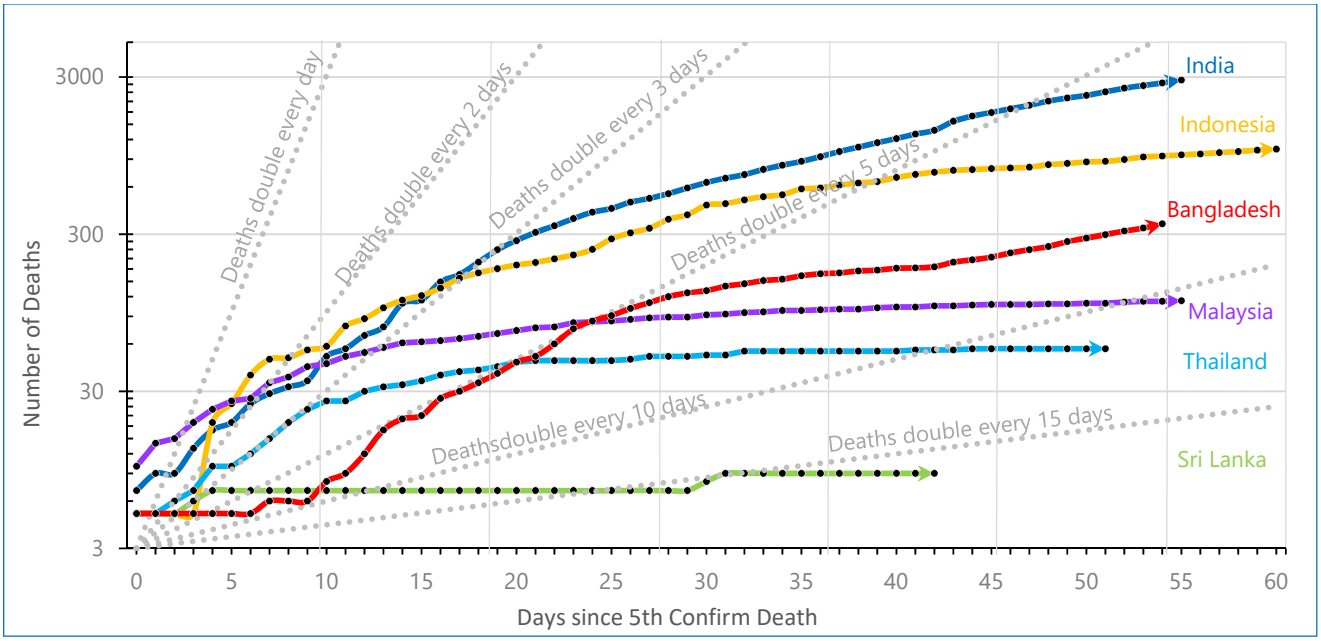
The figure below is showing the death and recovery rates over cumulative closed confirmed COVID-19 cases, 08 March – 18 May 2020, Bangladesh.



Bangladesh reported its first confirmed COVID-19 death on 18 March 2020 (10 days after reporting the first confirmed COVID-19 case). Between 6 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 **1.46%**.

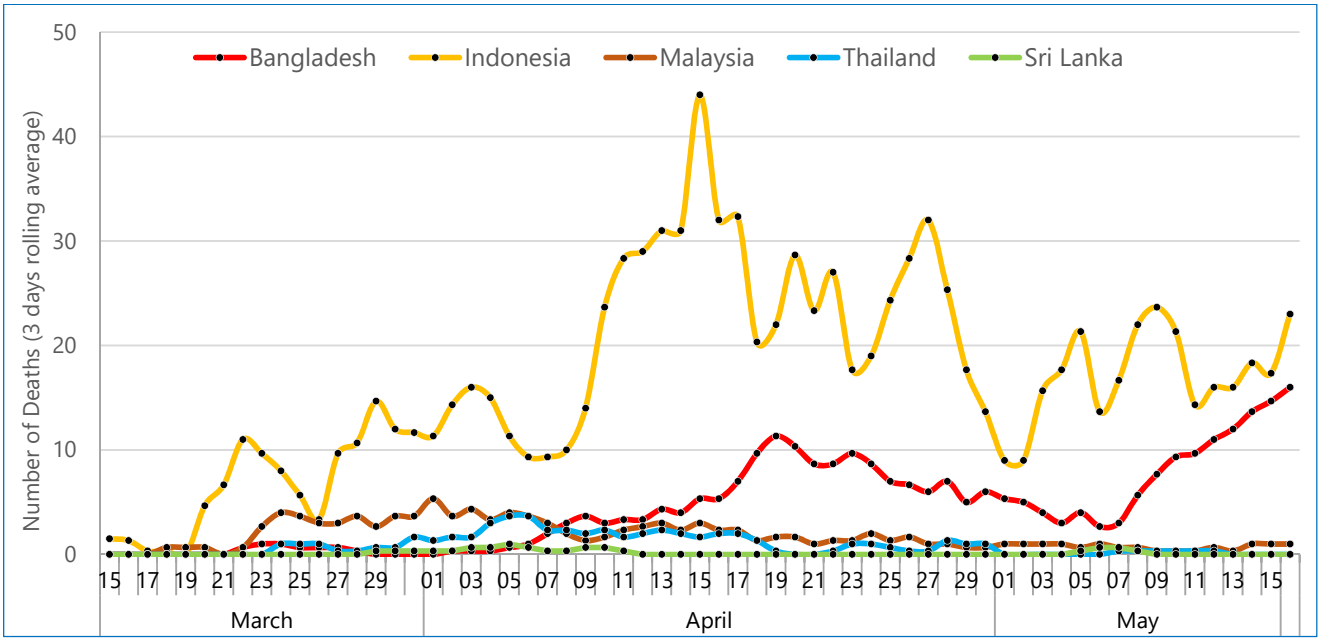
According to data available as of 18 May, the time of death count doubling in Bangladesh is slower than in India and Indonesia, but faster than in Malaysia, Thailand and especially Sri Lanka.

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, 18 May 2020.



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, 18 May 2020.

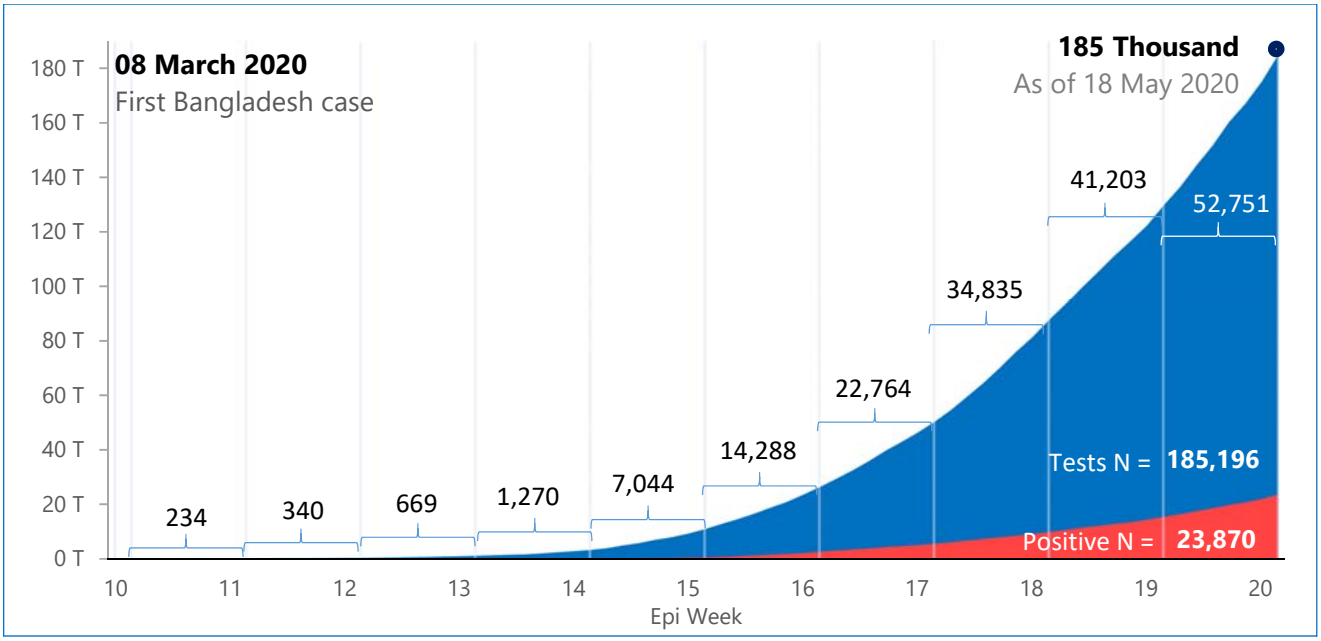


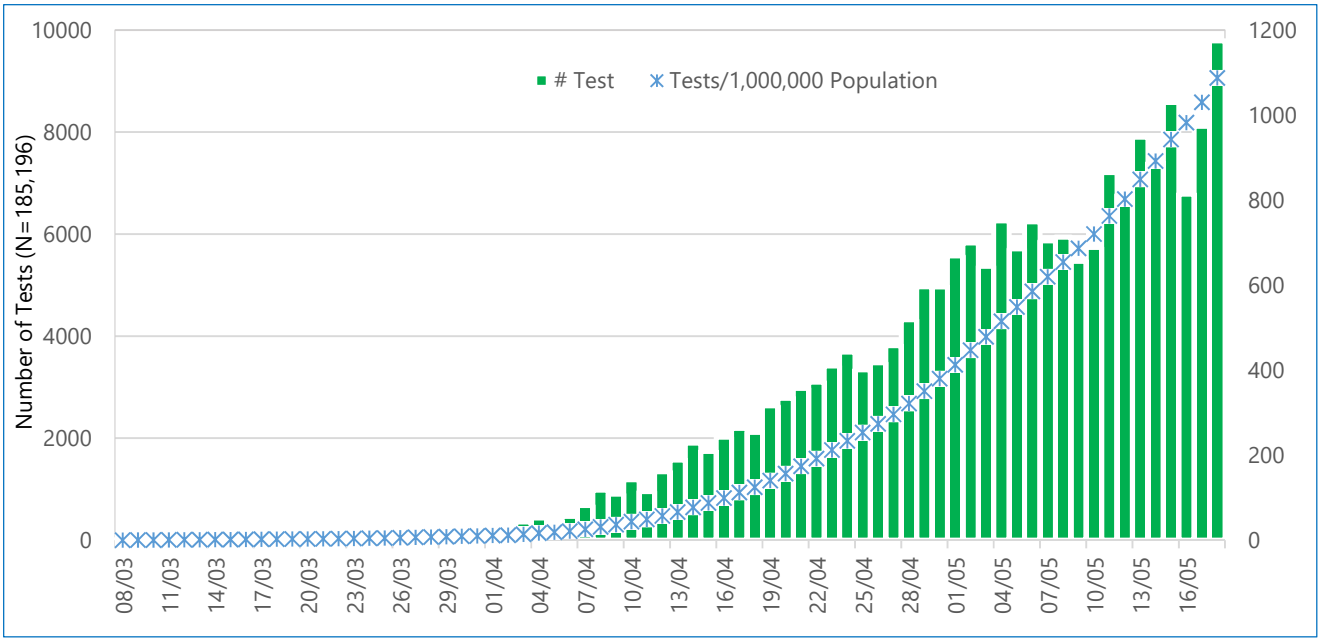
As of 18 May 2020, according to IEDCR, a total of **185,196** COVID-19 tests were conducted in Bangladesh by 42 laboratories (21 laboratories in Dhaka and 21 laboratories in other districts of the country). The latest laboratories, which have stated the testing: in Dhaka - IBN Sina Medical College Hospital, Praava Health Bangladesh Limited and Enam Medical College and Hospital, Savar, and outside Dhaka - Noakhali Science and Technology University, Noakhali and Sheikh Hasina Medical College, Jamalpur.

Of the total **185,196** COVID-19 tests conducted between 08 March to 18 May, **23,870** were positive for COVID-19; overall positivity rate of the conducted tests now is **12.9%** (23,870/185,196). Within all laboratories IEDCR laboratory conducted **9.9%** (18,412/185,196) with positivity rate **15.2%** (2,803/18,412) which is highest among all the laboratories.

The COVID-19 testing coverage has been gradually increasing in Bangladesh, reaching now **1,087**/1,000,000 but is still lower than in Thailand (**4,099**/1000,000), India (**1,671**/1000,000) and Sri Lanka (**2,074**/1,000,000).

The graphs below are showing the weekly cumulative number of COVIS-19 testing and positivity rate, and tests per 1,000,000, 08 March – 18 May 2020, Bangladesh.

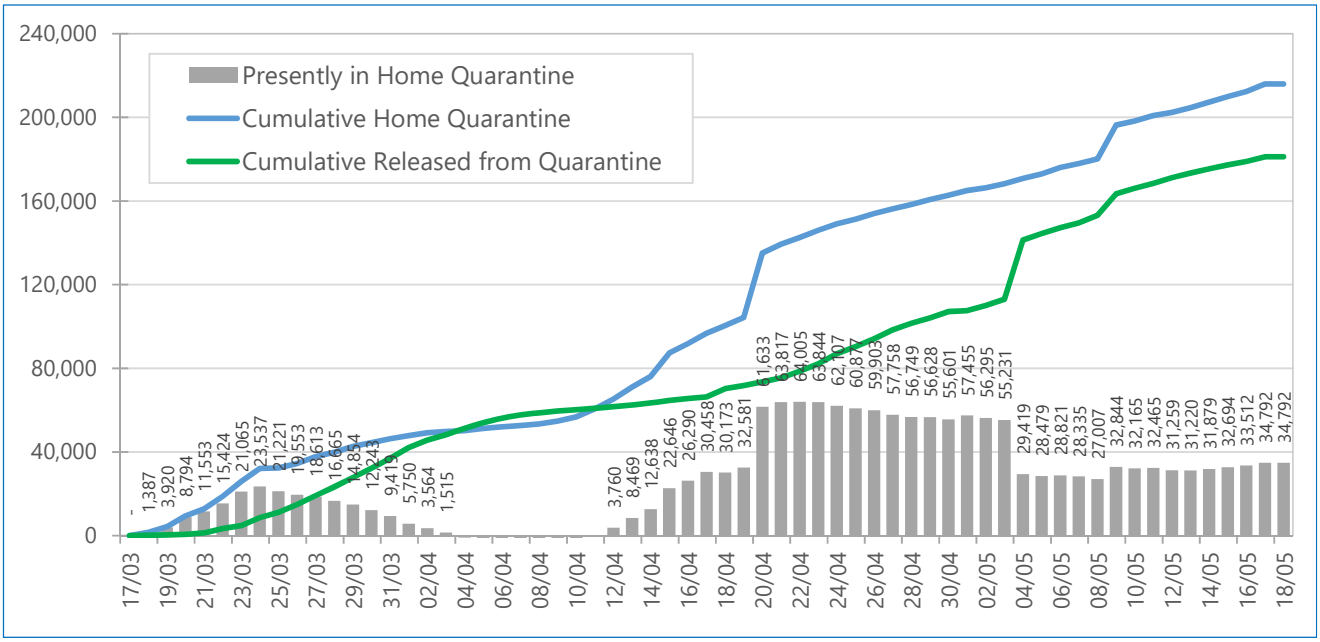




2. Contact Tracing, Points of Entry (PoEs) and Quarantine

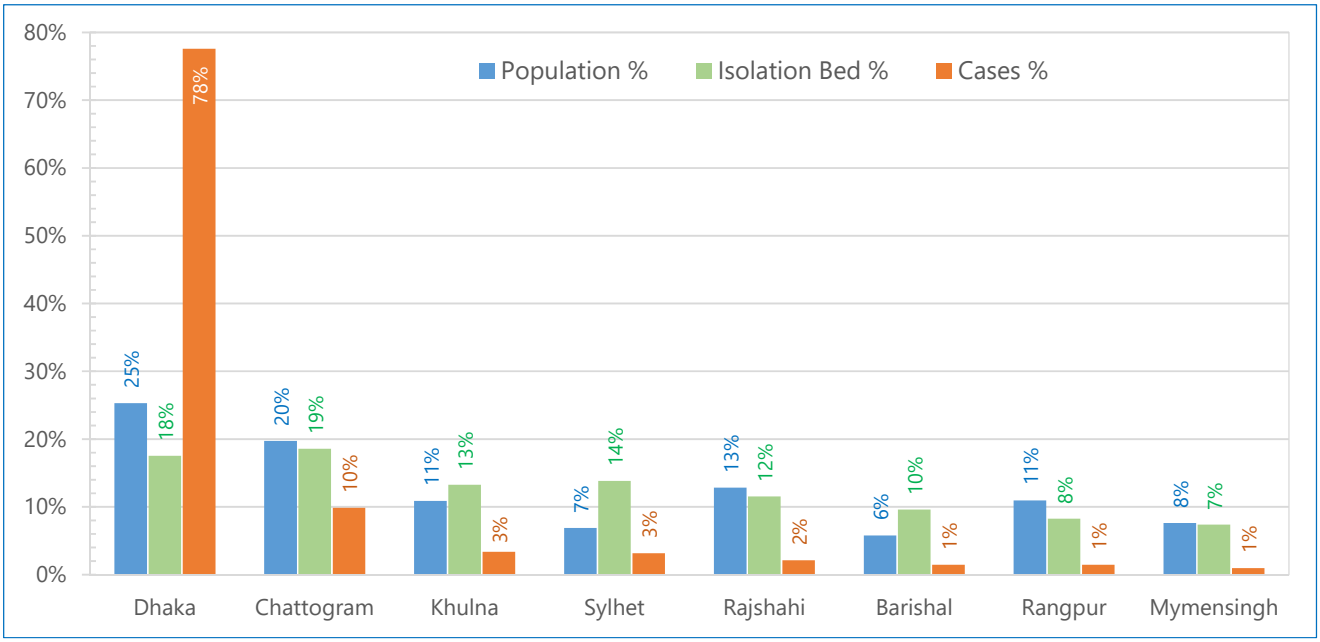
According to the DGHS, as of 18 May 2020, the current institutional quarantine capacity in the country is represented by **626** centres across **64** districts, which can receive **31,840** people. Between 17 March to 18 May 2020, total **229,818** individuals were placed under home quarantine all the over the county, and to date **80%** (183,733/229,818) have been already released.

The figure below is showing the number of individuals in home quarantine and individuals released, 17 Mach – 18 May 2020, Bangladesh.



As of 18 May 2020, there were **14,142** individuals has been isolated in designated health facilitates all over the country, of them **10,139** have been released.

The figure below is showing individuals in isolation per division as share of total population, total isolation beds and total cases, Bangladesh.



3. Case Management and infection Control

The "National Health Facility Preparedness and Readiness Rapid Assessment Checklist for COVID-19" was finalized by the Pillar partners under the leadership of USAID. The checklist contains sections on health workforce capacity, leadership/incidence management capacity, triage, infection prevention and control, case management, monitoring, surveillance and risk communication, WASH, waste management and environmental cleaning, essential support service, essential health services and patient care and equipment. On 18 May, Director of Hospital and Clinic Section of the DGHS sent a letter to all district hospitals, medical college hospitals, dedicated COVID-19 hospitals and upazilla health complexes requesting cooperation for health facility assessment as per the checklist. The assessment will help determine the requirements for the COVID-19 response and overall health system strengthening. The collected information will be also used for needs-based resource mobilization. More than 100 data collectors/ staff from different health partners were identified and oriented on the facility assessment checklist.

The DGHS issued a national guidance on "Caring for Critically Ill COVID- 19 Patient: Quick Guide for ICU Care". This document is to be used along with 'National Guidelines for Clinical Management of Coronavirus Disease 2019 (COVID-19).

On 12 May, a consultative meeting was held at DGDA on establishment of a system for visual inspection of PPE. The Japanese inspection firm K2, supported by JICA, presented the outline of a proposed national system, based on their experience with the garments industry and according to applicable standards for PPE. Feedback was collected from local inspection firms and DGDA officials for incorporation into the draft, for DGDA's consideration. The discussions focused on adapting the inspection system currently in place for the garments sector, which under normal circumstances is driven by international buyers based on the agreed specifications. In case of PPEs, the system is driven by the national regulatory authority, in order to ensure appropriate protection levels are applied to PPE as per their intended use in health care activities.

On 14 May, a virtual meeting was held with a PPE supplier in South Korea, to explore availability of PPE items which meet the WHO specifications. Market demand for PPE still exceeds supply and PPE prices continue to rise, globally. It is also increasingly difficult to secure enough quantities of PPE from overseas sources, with the export bans imposed in several source countries. The logistics and supplies pillar members are working hard to scan the market for reliable sources and source enough quantities of PPEs and other commodities for Bangladesh. Logistical challenges also persist, including export bans in some source countries and lack of feasible transport options for acquired supplies.

On 14 May, the Pillar 5 weekly meeting took place, hosted by WFP and WHO. WHO presented the global supplies portal and gave a live demonstration on how partners/government can use the portal to place requests from the global stockpile. It was also clarified that the requests do not guarantee supplies, and the final allocation would be made centrally based on country needs and available supplies. WHO also presented an orientation to the group on the testing system for PPE and how they can use the system as a quality assurance mechanism for local and imported PPE. The technical working group for PPE quality control continues to meet regularly to review developments in local testing capacity and discuss any feedback received from stakeholders.

On 14 May WHO approved a 6th Detection Kit for 2019 Novel Coronavirus (2019-nCoV) RNA (PCR- Fluorescence Probing), by Da And Gene Co., Ltd. Of Sun Yat-sen University. The kit is validated for use on two platforms, ABI 7500, LightCycler480 Ⅱ. This kit is based on one-step RT-PCR technique. In practice, 2019 Novel Coronavirus (2019-nCoV) ORF1ab and N genes are selected as amplification target regions. Specific primers and fluorescent probes are designed for the detection of 2019 Novel Coronavirus RNA in the specimens. This kit also includes an endogenous internal standard detection system, which is used for monitoring over the processes of specimen collection, RNA and PCR amplification, thereby reducing false negative results. The EUL procedure is developed to expedite the availability of in-vitro-diagnostics (IVDs) needed in public health emergency situations. It is intended to assist interested procurement agencies and Member States on the suitability for use of a specific IVD, based on a minimum set of available quality, safety, and performance data.

4. Risk Communication and Public Awareness

WHO continues to work with risk communication and community engagement (RCCE) partners for providing technical guidance and support in creating communication materials for informing individuals and communities on how to better address the challenges posed by COVID, to promote health and wellbeing as well as prevention measures during different activities impacted by the pandemic.

Within RCCE pillar co-led by UNICEF and DGHS, WHO assumed the co-leadership together with DGHS of taskforce to produce Risk Communication messages for Frontline service providers, in line with national guidelines and WHO technical advices. The taskforce will produce coordinated messages that will be further distributed within RCCE pillar for being used by any organization that is conducting information activities towards the selected target group.

WHO and ILO supported the producing of messages addressed to Tea and RMG industries, both for workers and management of the factories, taking into account the specific of the industries.

The taskforce will further work on messages for other essential sectors such as health providers, education institutions, shopping areas, transportation etc.

The different taskforces within RCCE have produced messages for a variety of segmented audiences from urban and rural areas, including men, women, youth, religious leaders and vulnerable population.

5. 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 # 119 as of 18 May 2020: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

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

Contact: Dr Bardan Jung Rana, WHO Representative to Bangladesh, ranab@who.int
Dr Hammam El Sakka, Team Leader, WHE, WHO-BAN, elsakkam@who.int