



# Short Update 18a COVID-19 Coronavirus Disease 6<sup>th</sup> of May 2020



## GLOBALLY

3 627 943

Confirmed cases

1 200 425  
recovered  
257 321 deaths

## USA

(x2 in 28.0 d →)

1 202 174  
confirmed cases  
189 791 recovered  
70 965 deaths

## Brazil

(x2 in 11.5 d ↘)

115 953  
confirmed cases  
48 221 recovered  
7 958 deaths

## Russia

(x2 in 9.5 d ↗)

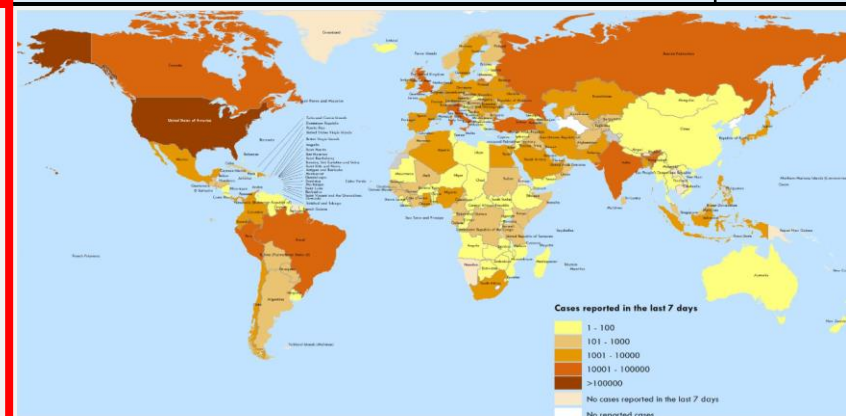
155 370  
confirmed cases  
19 865 recovered  
1 451 deaths

## News:

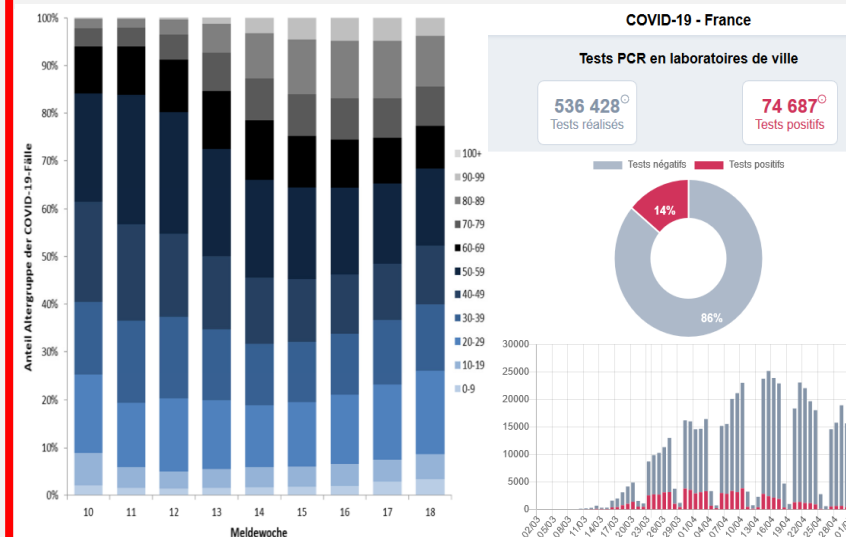
- GAVI:** the global alliance against the corona virus has raised 7.4 billion euros for the search for vaccines and medicines. "The world is united against the corona virus and the world will win," said EU Commission chief Ursula von der Leyen after a donor conference organized by the Brussels authorities with several countries and organizations. More information [here](#).
- WHO:** 127 Emergency Medical Teams (EMTs) are registered in the Global Classification of which 29 are already classified and 98 under the classification process. To date, a total of 19 EMTs have been deployed internationally and another 36 EMTs are supporting national operations in the response to COVID-19, providing support to 15 countries. In particular, large EMTs have been deployed to Italy, Cambodia, Mongolia and Kyrgyzstan. 58 training sessions have been conducted with more than 3100 front line responders trained. More information can be found [here](#).
- WHO:** May 5 is Hand Hygiene Day, around the world, fewer than two-thirds of healthcare facilities are equipped with hand hygiene stations, and 3 billion people lack soap and water at home.
- IFRC, UNICEF and WHO,** in close coordination with **GOARN** and support from the Bill and Melinda Gates Foundation, are working towards the establishment of a RCCE Global Collective Service to assist the public health and humanitarian response.
- Find Articles and other materials about COVID-19 at our website <https://www.coemed.org/resources/COVID19>
- Please use our online observation form to report your lessons learned observations as soon as possible. [https://forms.office.com/Pages/ResponsePage.aspx?id=Ada59cF6jUaZ\\_fZxuxzAAVLXriN\\_74RJnkC57W6UsgRUQVhUVik4TUUzM1IERONDUzE1MzSSSDVOSi4u](https://forms.office.com/Pages/ResponsePage.aspx?id=Ada59cF6jUaZ_fZxuxzAAVLXriN_74RJnkC57W6UsgRUQVhUVik4TUUzM1IERONDUzE1MzSSSDVOSi4u)

## Topics:

- Subject in Focus: COVID-19 impact on domestic violence and child abuse
- COVID-19 Case-Cluster-Study –
- How do COVID-19 testing criteria differ across countries?
- WHO's response during the early stage of the COVID-19 outbreak
- Conflict & Health – BURUNDI -



Source: World Health Organization  
Map Produced: WHO Health Emergencies Programme  
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## EUROPE

1 555 511  
confirmed cases

610 268 recovered  
147 600 deaths

## SPAIN

(x2 in 122.0 d →)

219 329  
confirmed cases

123 486 recovered  
25 613 deaths

## ITALY

(x2 in 87.5 d ↘)

213 013  
confirmed cases

85 231 recovered  
29 315 deaths

## UK

(x2 in 25.5 d ↗)

194 990  
confirmed cases

recovered not reported  
29 427 deaths

# Situation in Europe

Participants in an **international donor conference** organized by the EU pledged 7.4 billion euros on Monday for a vaccine and the fight against the novel corona virus. The event narrowly missed the stated goal of 7.5 billion euros. According to the EU Commission, FRA made the largest contribution with around 1.5 billion euros in commitments and credit guarantees. The Brussels authorities themselves contributed a similar amount. Japan, Canada, Great Britain, Germany and Saudi Arabia were also particularly generous. Pop icon Madonna has also donated a million euros, said von der Leyen. USA and RUS denied to conference.

The money will primarily go to recognized global health organizations such as the international vaccine alliances Cepi and Gavi. Four billion euros of this will flow into the development of a vaccine and the treatment options will be expanded worldwide with two billion euros and test capacities with 1.5 billion euros. Info find [here](#).

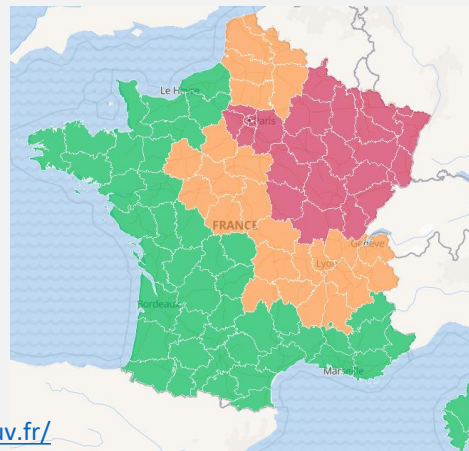
**DEU:** According to a study by researchers around Bonn's virologist Hendrik Streeck, the number of corona infected people in DEU is estimated to be at least 1.8 million people - that would be ten times as many infected people as previously reported by the Robert Koch Institute.

**TUR:** President Erdogan has announced a gradual relaxation of restrictions. Accordingly, seniors as well as children and young people will be allowed to leave their homes for four hours on fixed days in the future.

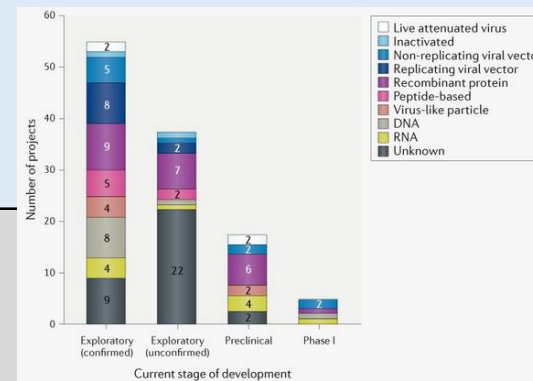
**GRE:** Restaurants, cafés and hotels are said to be reopened in June, subject to conditions. The Greek Prime Minister Mitsotakis expressed the hope that the tourism industry would still be able to make part of the holiday season possible.

**ITA:** According to the authorities, the number of virus deaths is significantly higher than previously reported. Between the first officially registered Covid-19 death on February 21 and the end of March, there were 39 percent or 25,354 more deaths in the country than the average of the previous five years. However, only 13,710 of these were attributed to the virus by the authorities, while the remaining 11,600 were not. The majority of the death come from the north of Italy and thus from the most affected part of the country.

**FRA:** The first corona infection appeared in France in December. Old samples from patients at the time with breathing difficulties had been re-evaluated. The sample was taken at the end of 2019 from a man who had symptoms and had been sick for 15 days. Where he got infected is unclear. It was possible to trace back that he had not traveled. "The only contact he had was with his wife," said Cohen. This worked next to a sushi stand near colleagues with Chinese origin. However, it is unclear whether these colleagues have traveled to China



Repartition of cases in FRA as per severity;  
Source: <https://dashboard.covid19.data.gouv.fr/>



## Vaccine Research:

The London School of Hygiene & Tropical Medicine (LSHTM) lists almost 120 projects worldwide that are researching a vaccine. See: [https://vac-lshtm.shinyapps.io/ncov\\_vaccine\\_landscape/](https://vac-lshtm.shinyapps.io/ncov_vaccine_landscape/)

A few of the possible vaccines are already being tested in phase I clinical trials in humans. This means that a small number of healthy volunteers are vaccinated to primarily test safety and tolerability, and to a lesser extent, effectiveness.

Research is most advanced at CanSino, a Hong Kong-listed company whose vaccine is already being tested in clinical phase II. This means that it is being tested for the first time in a larger test group whether the vaccination works. Large-scale phase III studies must be successful before a possible market approval.

In Germany, the first test phase with the vaccine candidate of the Mainz biotechnology company BioNTech on 200 subjects just started. The first findings on tolerability are expected by the beginning of July at the latest. BioNTech is working with the US pharmaceutical company Pfizer and hopes to test its corona vaccine in the USA as well.

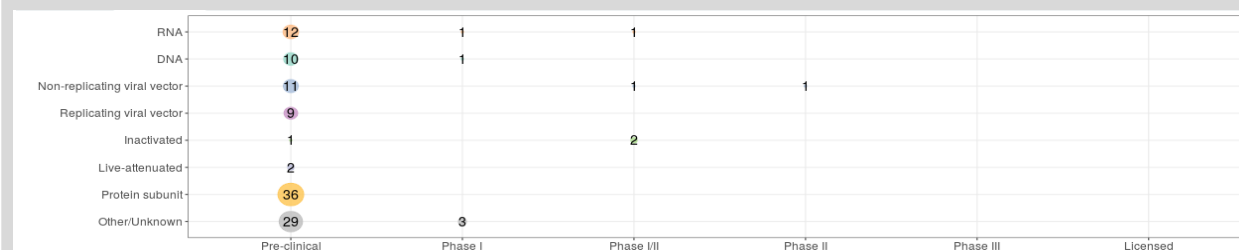
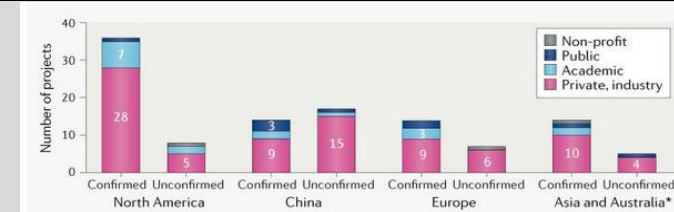
According to LSHTM, three Chinese projects are in phase I of the clinical tests: that of the pharmaceutical giant Sinovac and two of the medical institute in Shenzhen. According to information from the WHO, the vaccine is already being tested by the Institute for Biological Products in Beijing and that of the Virological Institute in Wuhan.

In the UK, Oxford University's vaccine project has reached the first test phase. Two developments from the USA are at the same stage: the vaccine candidate from the biotechnology company Inovio Pharmaceuticals and the one that the Moderna company developed together with the health authority NIH.

In order to bring the pandemic to a standstill with vaccinations and thus to be able to permanently do without safety measures such as exit and contact restrictions, the vaccine must be produced in huge quantities and administered in bulk. The WHO and large pharmaceutical laboratories assume that it will take twelve to 18 months for a vaccine to be ready for the market.

# Global Situation

Source: <https://www.nature.com/articles/d41573-020-00073-5>





# Subject in Focus:

## COVID-19 impact on domestic violence and child abuse

### Introduction:

As nations grapple with the spread of COVID-19, citizens are being told to stay home, for their safety and everyone else's. But for victims and survivors of domestic violence, including children exposed to it, being home may not be a safe option — and the unprecedented stress of the pandemic could breed unsafety in homes where violence may not have been an issue before.

### Steps and measures:

Experts also encourages clinicians to adopt a long-term view and be prepared for an uptick in demand for care and social services related to domestic violence and child abuse. The countries may not feel the full weight of the ramifications of the pandemic for months or years to come.

Other health-care providers should also be on the lookout for patients potentially in crisis.

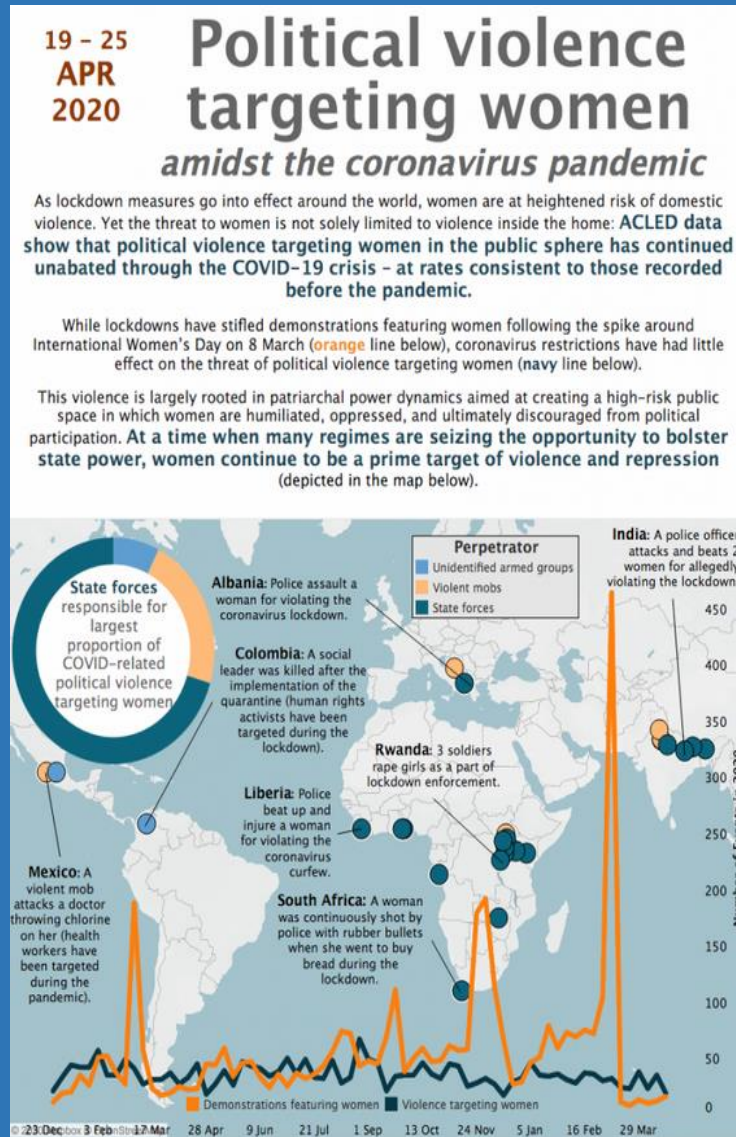
### Marginalized groups:

Researches show that approximately 1 in 3 women and 1 in 4 men have experienced violence from an intimate partner in their lifetime. About 41% of female intimate partner violence survivors and 14% of male intimate partner violence survivors sustain a physical injury from their abusers, and about 1 in 6 homicide victims are killed by their intimate partners.

Now, experts worry that all these numbers could increase dramatically during this period of social distancing and quarantine.

Research shows race and age play a role in a person's likelihood to experience abuse from an intimate partner, with minorities and older women at particular risk.

Sexual and gender minorities are also at an increased risk for domestic violence during the COVID-19 pandemic, partly because of the stressors they already experience as marginalized members of society.



### Similar stressors:

A previous study on how Hurricane Harvey affected families that had already experienced domestic violence, researchers have found the stress associated with the disaster led to higher rates of both domestic violence and child abuse during and after the hurricane. Researchers have found social factors that put people more at risk for violence are reduced access to resources, increased stress due to job loss or strained finances, and disconnection from social support systems. With this pandemic, similar things can happen, which unfortunately leads to circumstances that can foster violence.

### Risk of children:

Research shows that increased stress levels among parents is often a major predictor of physical abuse and neglect of children, she says.

And the resources many at-risk parents rely on — extended family, childcare and schools, religious groups and other community organizations — are no longer available in many areas.

To add to the tension, children are also experiencing their own stress and uncertainty about the pandemic. Stressed parents may be more likely to respond to their children's anxious behaviours or demands in aggressive or abusive ways.

### Source:

<https://www.theguardian.com/society/2020/apr/12/domestic-violence-surges-seven-hundred-per-cent-uk-coronavirus>  
<https://www.apa.org/topics/covid-19/domestic-violence-child-abuse>  
<https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html>

# Study outcome: Infection fatality rate of SARS-CoV-2 infection in a German community with a super-spreading event – COVID-19 Case-Cluster-Study -

The district of Heinsberg in North Rhine-Westphalia is the focal point for the novel coronavirus SARS-CoV-2 in Germany. After a carnival session there was an early and massive spread of the pathogen. As part of the study, a large number of residents in the village of Gangelt were interviewed, samples were taken and analysed. Among other things, the mortality rate of the infection was precisely determined for the first time.

A total of 600 randomly selected households in Gangelt were contacted and asked to participate in the study. From March 30 to April 6, 919 study participants from 405 households were interviewed and tested six weeks after the outbreak of the Gangelt infection. The scientists took throat swabs and blood samples. A combination of PCR and ELISA tests was able to detect both acute and past infections. The focus of the study was the infection fatality rate (IFR), which indicates the proportion of deaths among those infected. With the available data it is now possible for the first time to estimate very well how many people have been infected after an outbreak event. In the study, that was 15 percent for the community of Gangelt. Infection mortality (IFR) can be determined from the total number of all infected. For SARS-CoV-2 it is 0.37 percent for the outbreak in the community of Gangelt.

With the IFR, the number of people who have died can be used to estimate how many people are infected in other places with other infection rates. The comparison of this number with the number of officially reported infected leads to the estimated number of undetected cases. In Gangelt this is around 5 times higher than the officially reported number of people who tested positive. If one extrapolates the number of almost 6,700 SARS-CoV-2-related deaths in Germany, the estimated total would be around 1.8 million infected. This undisclosed figure is 10 times larger than the total number of officially reported cases.

The results of the study can be used to further improve model calculations on the spreading behaviour of the virus - so far the data basis for this has been comparatively uncertain.

The study also provides important information for further research on SARS-CoV-2, such as the risk of infection depending on age, gender and previous illnesses, the higher severity of the disease under the special conditions of a massive infection event such as Gangelt, or the risk of infection within families . The description of symptoms is also an aspect of the study. The most noticeable symptom complex for this infection is the loss of smell and taste. In addition, a total of 22 percent of all infected people in Gangelt showed no symptoms at all.

In the multi-person households examined, the risk of catching another person was surprisingly low. Infection rates were very similar in children, adults and the elderly and do not appear to depend on age. There were also no significant differences between the sexes.

**Abstract of the study manuscript:**

**Method:**  
A sero-epidemiological GCP-and GEP-compliant study was performed in a small German town which was exposed to a super-spreading event (carnival festivities) followed by strict social distancing measures causing a transient wave of infections. Questionnaire-based information and biomaterials were collected from a random, household-based study population within a seven-day period, six weeks after the outbreak. The number of present and past infections was determined by integrating results from anti-SARS-CoV-2 IgG analyses in blood, PCR testing for viral RNA in pharyngeal swabs and reported previous positive PCR tests.

**Results:**  
Of the 919 individuals with evaluable infection status 15.5% were infected. This is 5-fold higher than the number of officially reported cases for this community (3.1%). Infection was associated with characteristic symptoms such as loss of smell and taste. 22.2% of all infected individuals were asymptomatic. With the seven SARS-CoV-2-associated reported deaths the estimated IFR was 0.36%. Age and sex were not found to be associated with the infection rate. Participation in carnival festivities increased both the infection rate (21.3% vs. 9.5%) and the number of symptoms in the infected. The secondary infection risk for study participants living in the same household increased from 15.5% to 43.6%, to 35.5% and to 18.3% households with two, three or four people respectively.

**Conclusions:**  
While the number of infections in this high prevalence community is not representative for other parts of the world, the IFR calculated based on the infection rate in this community can be utilized to estimate the percentage of infected based on the number of reported fatalities in other places with similar population characteristics. The unexpectedly low secondary infection risk among persons living in the same household has important implications for measures installed to contain the SARS-CoV-2 virus pandemic.

Full version can be found [here](#).

# How do COVID-19 testing criteria differ across countries?

Source: HSRM as of 16 April; <https://analysis.covid19healthsystem.org/index.php/2020/04/16/how-do-covid-19-testing-criteria-differ-across-countries/>

Since the start of the COVID-19 pandemic, countries have been advised by WHO to expand testing in order to detect COVID-19 cases early, ensure their isolation, trace and isolate their contacts, and determine the epidemiological situation as accurately as possible.

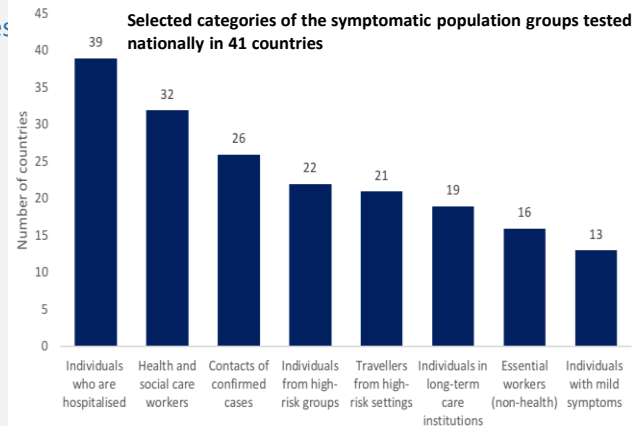
However, for a number of reasons, including the stage of the epidemic, the national response strategy, and differences in the capacity for testing, countries have used different criteria to decide who to test.

Details on current testing criteria as of 16th April for a selection of countries in the WHO European region are available from the COVID-19 Health Systems Response Monitor (HSRM) and summarized in the figure below, with data for 41 countries available. These countries are at various stages of the pandemic, and this might explain some of their differences in testing strategies. Initially, as a few imported cases were detected, the testing was primarily focussed on symptomatic travellers arriving from high-risk areas (with the geography of what were considered high-risk areas progressively expanding) and their symptomatic contacts. This focus on imported cases has shifted in most countries, as they started registering community spread.

As of 16th April, among symptomatic population groups, most countries test people with severe symptoms (mainly those needing hospitalisation). The testing of symptomatic cases in groups at high risk and among health- and social care staff is also done quite broadly, although not in all countries, and testing in social care seems to lag behind. For example, in the NLD, symptomatic health care staff are required to self-isolate if they display symptoms of COVID-19, but they are not tested routinely. Strategies also vary widely in terms of testing residents of long-term care institutions, with some countries testing all residents with symptoms, while others (e.g. FRA, NLD, GBR) only test few or selected cases in order to determine if there is an outbreak in an institution. When interpreting the figure, it is important to bear in mind that countries differ in details of strategies (e.g. there may be regional differences as well as set priorities depending on laboratory capacity) as well as in the scale of implementation.

As testing capacity in countries expands, more countries start to pilot areas with community-wide testing (e.g. Cyprus and the Veneto region in Italy), however none of the 41 countries reviewed have implemented this at the national level.

In countries with community spread that have restricted testing capacity, WHO recommends to prioritise testing of at-risk and vulnerable groups, all symptomatic health care workers, and at first symptomatic cases in closed settings, such as long-term care institutions.



## Testing strategy in FRA:

The policy on testing has been evolving in FRA in line with the evolution of the spread of the coronavirus. Systematic testing was long limited to individuals with symptoms similar to those of Covid-19 who also have one of the following characteristics: signs of severity, health professionals or fragile and at-risk individuals, the first three individuals living in institutions for vulnerable populations, hospitalized patients, pregnant women and organ donors. For hospitalized patients, testing is carried out within hospitals, while others can be tested in the community upon medical prescription. Early April, the government has finally decided to launch large-scale testing in nursing homes and institutions for disabled individuals, both for residents and staff, using biomedical laboratories, the medical care reserve and mobile testing buses. The Ministry in charge of health has estimated the number of available tests per day at around 5,000 but expect to increase this capacity quickly. Mobile drive-through clinics have not been implemented at a large scale in France, but there are some similar local initiatives developed by biomedical laboratories.

On April 13, the president announced that the relaxation of the lock-down policy by May 11 would be accompanied by the systematic testing of health professionals, older people and vulnerable individuals as well as, progressively, of all persons presenting symptoms of the Covid-19 virus or in contact with an infected case.

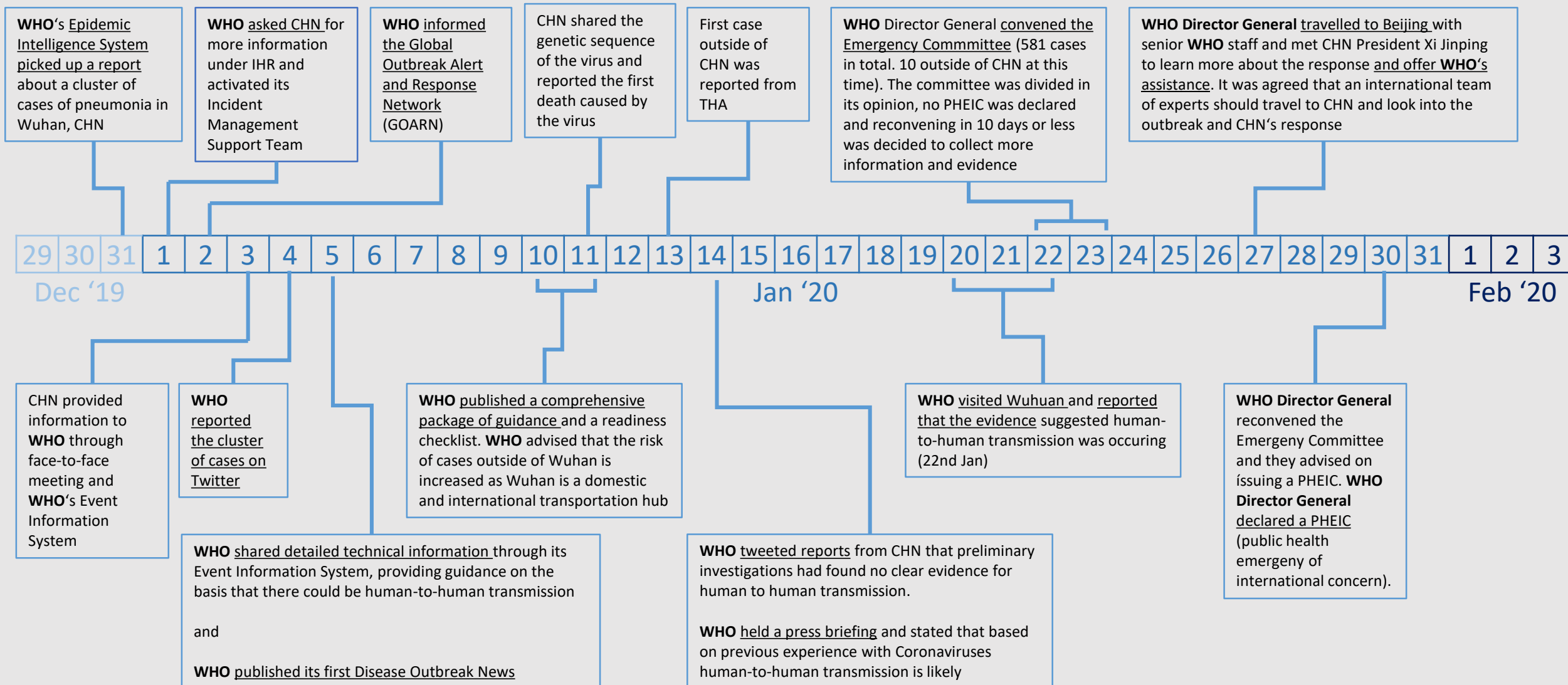
## Testing strategy NLD since 25 March:

- Patients admitted into hospitals with (severe) acute respiratory infections are tested to ensure proper treatment and to protect hospital personnel and other patients.
- Patients presenting at GP practices and patients that receive home care are in principle not tested, with the exception of patients with intensive care demands, requiring many care related contact moments (potentially with different care professionals) per day. They can be tested when they present themselves with symptoms. GPs that would like to have a patient tested have to organize this themselves.
- Nursing homes and homes for disabled: one or two patients per department or location may be tested when they become symptomatic to assess a possible outbreak in order to protect those living and working in these facilities and to optimize individual patient care.
- Practices of the Nivel Primary Care Database: these are GP practices (40) where all patients with influenza-like illnesses and symptoms are tested for surveillance purposes. Since early February, the collected swabs are also tested for COVID-19.
- Healthcare personnel are not tested. Symptomatic personnel with a fever >38°C should stay at home until 24 hours symptom free. In all other cases, when there has been unprotected contact with a confirmed patient and the healthcare worker has symptoms, he/she should either stay at home up to 24 hours symptom free or be tested.

Testing is not available upon request for individual citizens. There are about 34 laboratories that can perform COVID-19 testing. Together they can handle about 10,000 tests per day. To confirm COVID-19, two tests are performed independently. As of 31 March, the actual testing capacity is about 4000 tests per day. By the middle of April, this should increase to 17,500 per day and later on to 29,000 per day.

# WHO's response during the early stage of the COVID-19 outbreak

According to: <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---29-april-2020>







# Conflict & Health BURUNDI

## 2019 GHS Index Country Profile for Burundi

### Burundi

22.8 Index Score 177/195



	COUNTRY SCORE	AVERAGE SCORE*		COUNTRY SCORE	AVERAGE SCORE*
<b>PREVENTION</b>	<b>25.1</b>	<b>34.8</b>	<b>HEALTH SYSTEM</b>	<b>8.9</b>	<b>26.4</b>
Antimicrobial resistance (AMR)	33.3	42.4	Health capacity in clinics, hospitals and community care centers	1.4	24.4
Zoonotic disease	9.9	27.1	Medical countermeasures and personnel deployment	0	21.2
Biosecurity	0	16.0	Healthcare access	30.5	38.4
Biosafety	0	22.8	Communications with healthcare workers during a public health emergency	0	15.1
Dual-use research and culture of responsible science	0	1.7	Infection control practices and availability of equipment	0	20.8
Immunization	92.1	85.0	Capacity to test and approve new medical countermeasures	25	42.2
<b>DETECTION AND REPORTING</b>	<b>11.4</b>	<b>41.9</b>	<b>COMPLIANCE WITH INTERNATIONAL NORMS</b>	<b>37.6</b>	<b>48.5</b>
Laboratory systems	33.3	54.4	IHR reporting compliance and disaster risk reduction	50	62.3
Real-time surveillance and reporting	10	39.1	Cross-border agreements on public and animal health emergency response	0	54.4
Epidemiology workforce	0	42.3	International commitments	25	53.4
Data integration between human/animal/environmental health sectors	0	29.7	JEE and PVS	25	17.7
<b>RAPID RESPONSE</b>	<b>28.4</b>	<b>38.4</b>	Financing	50	36.4
Emergency preparedness and response planning	0	16.9	Commitment to sharing of genetic & biological data & specimens	66.7	68.1
Exercising response plans	50	16.2	<b>RISK ENVIRONMENT</b>	<b>28.3</b>	<b>55.0</b>
Emergency response operation	0	23.6	Political and security risks	14.3	60.4
Linking public health and security authorities	0	22.6	Socio-economic resilience	33.8	66.1
Risk communication	25	39.4	Infrastructure adequacy	16.7	49.0
Access to communications infrastructure	48.4	72.7	Environmental risks	66.4	52.9
Trade and travel restrictions	100	97.4	Public health vulnerabilities	17.3	46.9

\*Average: all 195 countries  
Scores are normalized (0-100, where 100 = most favorable)

## Soccer and elections during the pandemic

Burundi is one the smallest countries on the African Continent (approximately the size of the German state Brandenburg) and among the poorest in the world. Nevertheless, with its approximately 11 million inhabitants it is one of most densely populated countries. The average age is at 16.9 years and the share of people over the age of 65 is at only 2.5 percent. Burundi is a landlocked country and borders the conflictful eastern part of DRC, Rwanda and Tanzania. The Burundian people all belong to a single ethnic group and share a common culture and history. Irrespective of this there are various social and religious groups (approximately 62% of the population are Catholics, 5% are Protestants, 10% are Sunni Muslims and 23% follow traditional African religions). The Burundian people see themselves either as part of the Hutu (rural population with a share of 85% of the total population) or the Tutsi (urban population, 14%). Since Burundi gained independence in 1962 the country is dominated by conflicts that are constantly flaring up again. They are based on the tensions between political and social groups and claimed approximately 300,000 (mostly civilian) lives. Violence peaked during the mass murders in 1972 and 1993, which were reported as genocides to the United Nations Security Council. Even though the excess of violence of past decades declined during the last years, there are still barriers remaining that prohibit ending the conflict and creating (inner) peace in Burundi. Extreme poverty, missing safety and legal structures as well as the permanent violation of human rights play a big role. The integration of former conflict parties/rebels into the state apparatus is also a still unresolved but essential task and challenge.

In April 2015 President Nkurunziza caused a still on-going political, economical and humanitarian crisis. After he announced to stay in office for a third tenure (not allowed by the constitution at that time) violent conflicts between the government and the opposition broke out. These conflicts claimed hundreds of lives and displaced hundreds of thousands internally or to the neighbouring countries. The fragmented opposition and the media are very restricted. Burundi, which is on the lower end of every humanitarian and conflict ranking has to fight with an almost non-existing health system against diseases that are widespread in the region, including intestinal infections, amoebiasis, hepatitis A, typhus, bilharzia, hepatitis B and C, STDs, HIV/AIDS, rabies and sleeping sickness. Malaria is endemic in the whole country and there is a year-round alarming high risk for Malaria. In total a number of 8.3 million infections is estimated. Given the population size of 11 million people this means a country-wide extremely high risk for malaria-transmission. In May 2019 the malaria epidemic breached the fatality-threshold of the Ebola epidemic in eastern DRC. One of the reasons for the high number of deaths is the missing immunity of people that fled or were forced out of malaria-free areas of Burundi. The government strictly refused to acknowledge this outbreak as an epidemic.

This is the breeding ground for a possible new humanitarian catastrophe due to COVID-19. Beside of quarantining incoming individuals, giving advice on good hygiene and banning all air traffic the government took no action to protect the population. It was reported that humanitarian organizations were denied access to the people that were quarantined after entering the country and are held prisoner under inhumane conditions. As there were only two imported cases of COVID-19 reported, until last week the soccer league took place regularly, but it was ended prematurely because of elections that are scheduled to take place in May. It is planned to use the stadiums for election rallies. The President's speaker announced that Burundi is an exception from the community of states and is chosen and sustained by God.

Conclusion: The government's ignorance and denial of the corona pandemic will likely not prevent the pandemic from entering Burundi. If COVID-19 spreads within Burundi, fostered by the socioeconomic and political circumstances, the number of false-positive as well as true cases of malaria will rise, as there are almost no testing capacities for COVID-19 available. Whether the small size of the high-risk group aged 65 and above or the high number of pre-existing conditions within the population will lead to a decisive change in mortality remains unknown at the moment.



## Burundi

Select Country to View  
Burundi

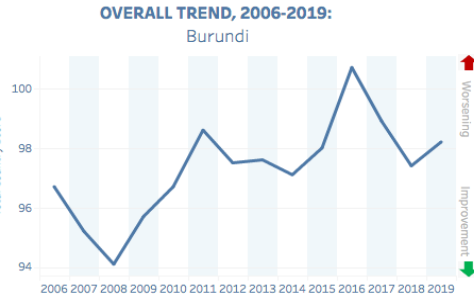
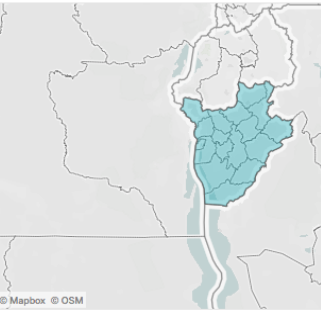
98.2  
FSI Score in 2019  
(Maximum 120)

15th  
FSI Rank in 2019  
(178 Countries)

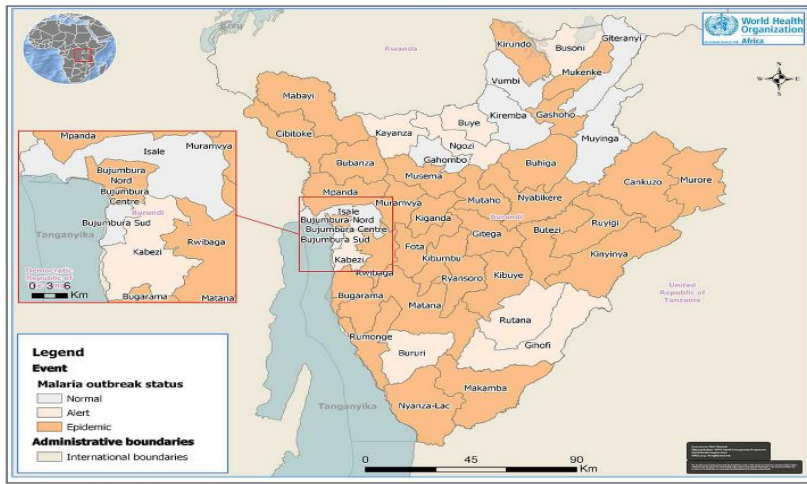
0.8  
Points Change from  
Last Year

1.1  
Points Change Over  
Five Years

2.5  
Points Change Over  
Ten Years



## Geographical distribution of malaria cases and deaths in Burundi, week 1 - 21, 2019



<https://www.usip.org/sites/default/files/file/resources/collections/commissions/Burundi-Report.pdf>  
<https://www.timeslive.co.za/news/africa/2020-04-28-burundi-elections-going-ahead-despite-covid-19-fears/>  
<https://www.theneuehumanitarian.org/news/2020/04/02/burundi-coronavirus-aid>  
<https://www.ihacu-burundi.org/covid-19-le-burundi-est-une-exception-car-cest-un-pays-qui-a-donne-a-dieu-la-premiere-place/>  
<http://de.worldatlas.info/Africa/Burundi>  
<https://apps.who.int/iris/bitstream/handle/10665/325162/OEW23-0309062019.pdf?sequence=5&isAllowed=y>



# Ramadan and COVID-19






## Ramadan:

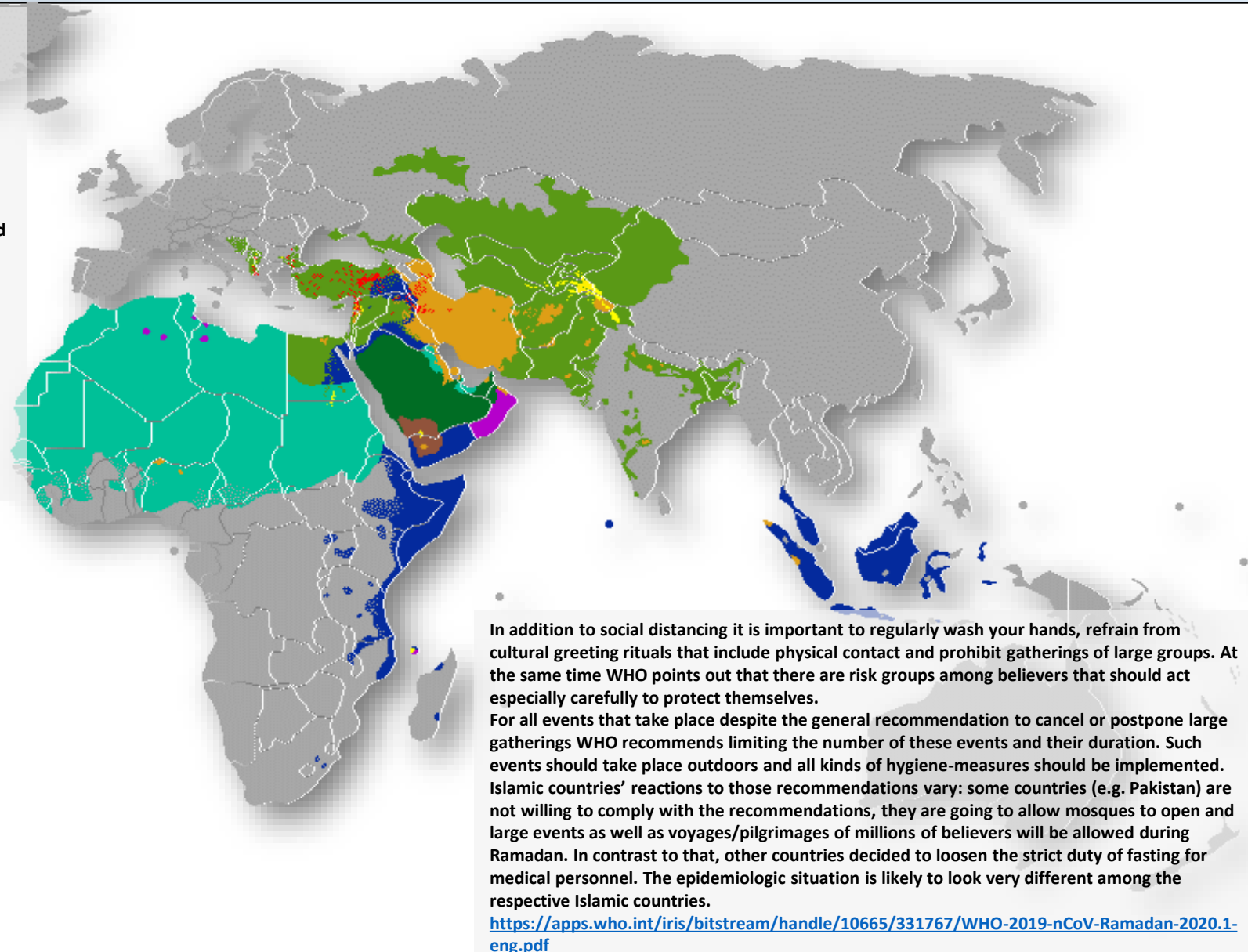
The Ramadan, the month of fasting for the Muslims and the subsequent Fast-Breaking ("Iftar") are two important events in the Islamic calendar. As one of the five pillars of Islam fasting during Ramadan is conducted by 1.8 billion people (approx. ¼ of global population). Like many other cultural and religious festivities and events worldwide, the Ramadan, starting at the end of April and lasting until the end of May is affected by the pandemic.

During Ramadan/fasting numerous social and physical contacts take place for religious reasons (e.g. increased and intensive visits to the mosques, pilgrimages and celebrations with the family). The usual way of conducting these activities are often not compliant with the rules of social distancing and other prevention measures. Therefore, WHO has published recommendations for celebrating a safe Ramadan. These recommendations should enable believers to fulfil their religious duties while at the same time complying with medical and epidemiological prevention measures to contain the deadly virus.

The most effective measures are the postponement or cancellation of social and religious gatherings, as recommended by the WHO whenever possible. It is recommended to use all available virtual/digital ways of communication to replace physical gatherings for religious interaction to the maximum possible extent.

A strong communication strategy has to be implemented by the authorities (especially national health authorities) to make believers understand, accept and comply with the necessary measures. In order to protect yourself and other from infection WHO still recommends the following:

SUNNI	
	HANAFI
	HANBALI
	MALIKI
	SHAFI'I
SHIA	
	ISMAILI
	JAFARI
	ZAIDI
	OTHER
OTHER	
	IBADI



In addition to social distancing it is important to regularly wash your hands, refrain from cultural greeting rituals that include physical contact and prohibit gatherings of large groups. At the same time WHO points out that there are risk groups among believers that should act especially carefully to protect themselves.

For all events that take place despite the general recommendation to cancel or postpone large gatherings WHO recommends limiting the number of these events and their duration. Such events should take place outdoors and all kinds of hygiene-measures should be implemented. Islamic countries' reactions to those recommendations vary: some countries (e.g. Pakistan) are not willing to comply with the recommendations, they are going to allow mosques to open and large events as well as voyages/pilgrimages of millions of believers will be allowed during Ramadan. In contrast to that, other countries decided to loosen the strict duty of fasting for medical personnel. The epidemiologic situation is likely to look very different among the respective Islamic countries.

<https://apps.who.int/iris/bitstream/handle/10665/331767/WHO-2019-nCoV-Ramadan-2020.1-eng.pdf>