



Short Update 17b COVID-19 Coronavirus Disease 1st of May 2020



GLOBALLY
3 221 477
Confirmed cases
1 014 916
recovered
233 416 deaths

USA
(x2 in 22.0 d ↗)
1 067 910
confirmed cases
153 947 recovered
62 900 deaths

Brazil
(x2 in 8.0 d ↗)
87 187
confirmed cases
35 935 recovered
6 006 deaths

Russia
(x2 in 9.0 d ↗)
106 498
confirmed cases
11 619 recovered
1 073 deaths

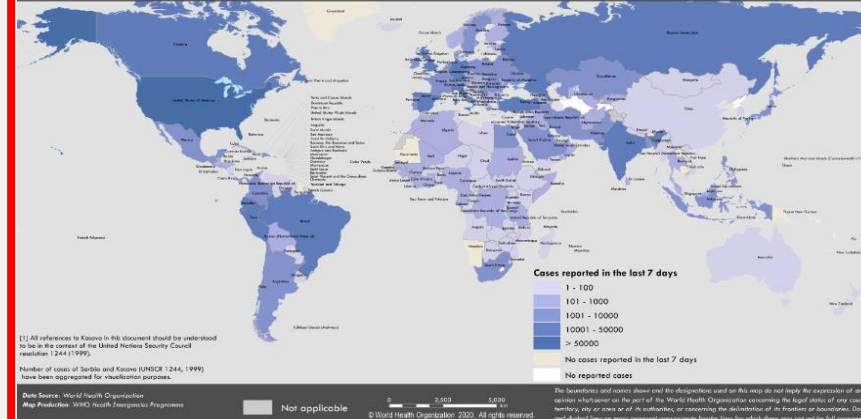
News:

- Today it is three months since WHO declared a public health emergency of international concern over the outbreak of novel coronavirus.
- **WHO Director:** "From the beginning, WHO has acted quickly and decisively to respond and to warn the world. We sounded the alarm early, and we sounded it often. We said repeatedly that the world had a window of opportunity to prepare and to prevent widespread community transmission. WHO is committed to transparency and accountability."
- **International Energy Agency (IEA):** The coronavirus pandemic paralyzed the economy, and that is leading to the largest drop in greenhouse gas emissions ever. CO2 emissions are expected to decrease by a good eight percent in 2020, as the IEA predicts in its annual world energy report. IEA expects a decrease of six percent in global energy requirements and urged all governments to move post-pandemic reconstruction towards greener energies.
- **WHO:** The COVID-19 Health Systems Response Monitor (HSRM) collects and organizes information on how countries' health systems are responding to the crisis. It currently includes information for most of the countries in the WHO European Region, including all EU Member States, and is updated regularly. Information find [here](#).
- **WHO SEARO:** Organized a meeting yesterday with vaccine manufacturers and national regulatory authorities to discuss future COVID-19 vaccine manufacturing in the Region. An article on this is available [here](#).
- 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_74RJnkC57W6UsgRUQVhUViK4TUUzM1IERONDuZE1MzSSDVOSi4u

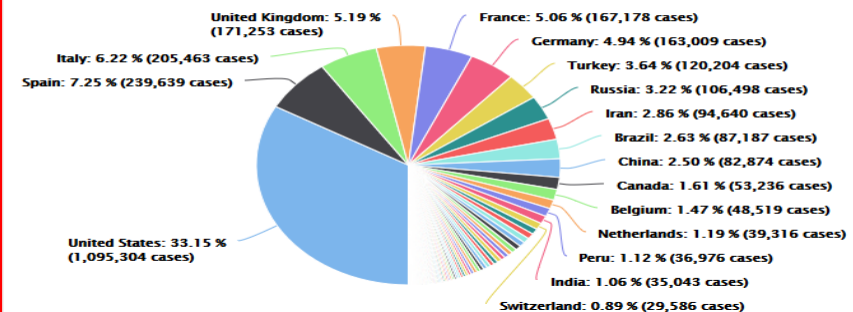
Topics:

- Subject in Focus: Considerations for epidemiological criteria and indicators to plan and monitor the adjustment of community level physical distancing measures, ECDC
- Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK—ninth update
- Mask Facts
- Conflict & Health

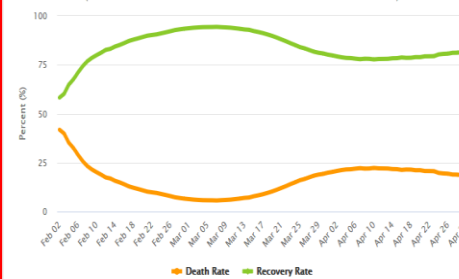
Countries, areas or territories with COVID-19 cases reported in the last 7 days



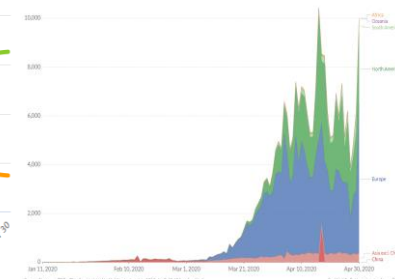
Distribution of cases



Outcome of total closed cases (recovery rate vs death rate)



Daily confirmed COVID-19 deaths



EUROPE

1 430 732
confirmed cases
526 013 recovered
138 396 deaths

SPAIN

(x2 in 41.0 d ↘)
213 435
confirmed cases

112 050 recovered
24 543 deaths

ITALY

(x2 in 62.0 d ↘)
205 463
confirmed cases
75 945 recovered
27 967 deaths

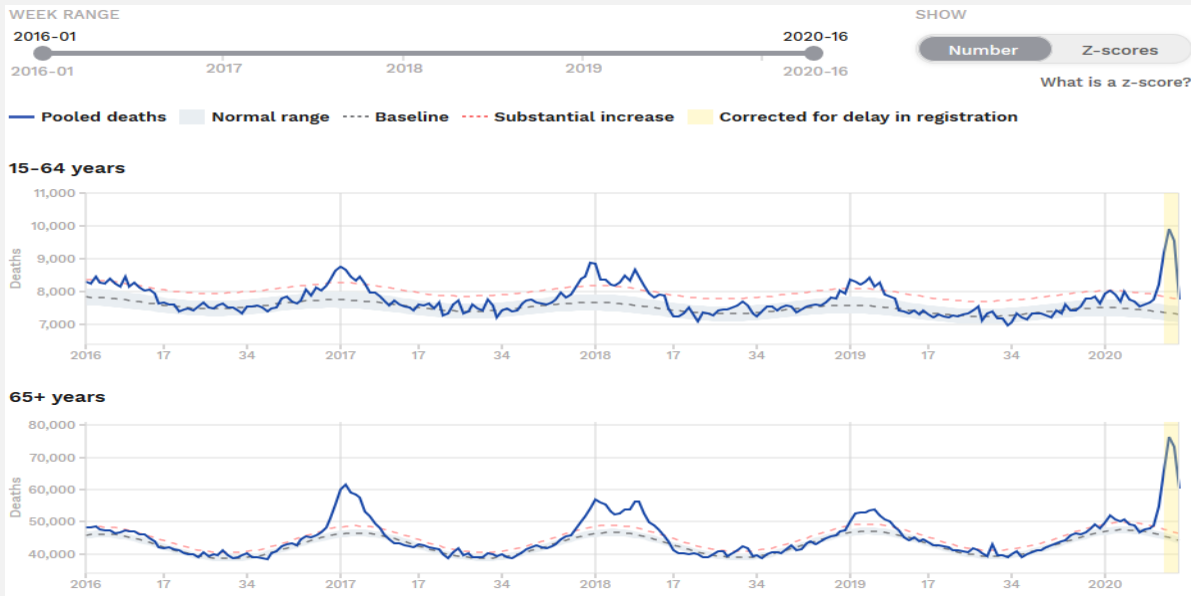
UK

(x2 in 22.5 d ↗)
171 253
confirmed cases
recovered not reported
26 771 deaths

Situation in Europe

EUROPE and rise in mortality

In Europe, tens of thousands more people died within four weeks than in the same period in previous years. The so-called over-mortality rate among the over 65-year-olds was almost 50,000. The latest information on so-called over-mortality in 24 European countries shows how drastically the number of deaths increased in Europe between March 16 and April 12. The development is particularly dramatic among people older than 65: According to Euro Momo (European Mortality Monitoring, see graphic), the mortality rate in the evaluated European countries was almost 50,000 people within four weeks. That means, in these four calendar weeks, tens of thousands more people over the age of 65 died more than on average during this period. The figures are particularly drastic in the age group of over 65-year-olds in Belgium, England, France, Italy, the Netherlands, Spain, Scotland, Sweden, Switzerland and Wales. Figures from the Swedish statistical authority SCB also document that significantly more older men have died in the past few weeks; the Stockholm region is particularly affected: many more people died here every day than in previous years. In the UK, according to a Financial Times report, the pandemic may have killed twice as many people as expected - around 41,000. The Ministry of Health estimates that fewer than 20,000 people have died of lung disease in hospitals. This does not include deaths in nursing homes and private households. This information is also missing from the official statistics of other countries.



Sources: <https://www.euromomo.eu/graphs-and-maps>
<https://www.tagesschau.de/faktenfinder/corona-uebersterblichkeit-101.html>

Global Situation

Source: <https://acleddata.com/analysis/covid-19-disorder-tracker/#1585775314361-2ee40e97-5aec>

Strick lockdown measures to prevent COVID-19 lead to a lot of protest and riots globally.

IRA: Around 36 prisoners in Iran are feared to have been killed by security forces after the use of lethal force to control protests over COVID-19 safety fears (Amnesty International). Dozens of protests were held by farmers and labor groups over a range of issues, including unpaid salaries and benefits as well as farming water supplies. At least eight labor protests were related to problems for workers and businesses caused by the spread of the coronavirus.

MEX: The growing number of Covid-19 cases has brought a wave of violence against nurses and doctors who are wrongly accused of spreading the disease. According to the head of nursing at the Mexican Social Security Institute, at least 21 medical workers were attacked in 12 states across the country.

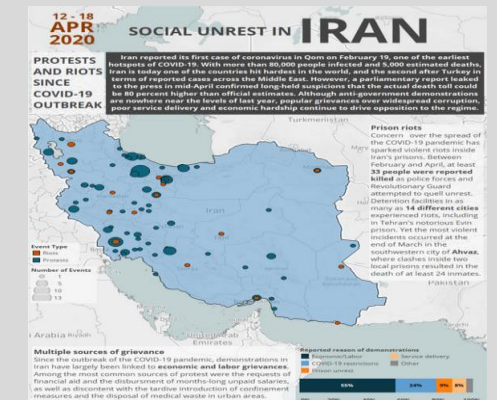
Malawi: Violent protests hit several parts of Malawi when vendors complained that a 21-day nationwide ban on COVID-19 would "starve them," according to local media. In protests in Blantyre, Mangochi, Karogna, Zomba, Kasungu and Mzuzu, demonstrators have petitioned government-related city councils or district commissioners, the Nyasa Times reported.

USA: Anti-lockdown rallies have been seen in states including Colorado, Pennsylvania, Texas, Wisconsin, Ohio, California and Minnesota. As healthcare workers in Colorado and Pennsylvania staged counter-protests against right wing anti-quarantine rallies.

KOR: Protests continued to focus on government measures to support groups suffering from the economic downturn, including students, contract workers, artists, school drivers, and pilots, among others.

Hong Kong: Also continued to protest and call on the government to increase financial assistance for industries affected by the coronavirus outbreak. Though demonstrations remain small due to the ban on public gatherings of more than four people, there was a slight rise in events last week.

LEB: Last week saw the highest number of demonstrations since the beginning of the coronavirus lockdown. Protesters gathered in defiance of the stay-at-home order and called attention to the country's worsening economic, health, and living conditions.



Subject in Focus:

Considerations for epidemiological criteria and indicators to plan and monitor the adjustment of community level physical distancing measures

When planning and deciding to adjust community level physical distancing measures, the following criteria and approaches could be considered:

- Start monitoring epidemiological indicators before the planned change to create a baseline (at least two weeks is recommended) and when measures are adjusted differentially at a sub-national level, establish monitoring information at subnational level.
- Start adjusting measures (if conditions allow, one at a time), in smaller or localised geographical areas, in order to minimise the impact, should the lifting/easing of that measure result in a significant surge of cases.
- Allow sufficient time after lifting/easing one measure to evaluate its impact on virus circulation and on consequent COVID-19 related morbidity and mortality (evidence to-date indicates that the impact of adjusting measures may take at least two to four weeks to become apparent in epidemiological monitoring systems).
- When deciding which measures can be lifted first, choose those measures targeted to specific age groups where evidence shows continued limited disease transmission is less likely to result in major public health impact. So far, this may apply only to children younger than 10 years of age (who are not also members of high-risk groups). CAVE: there is still limited data on the role of children in transmitting the disease.
- When adjusting physical distancing measures, identify measures that could be maintained for longer periods of time with some adjustments: For example, consider allowing people to leave their homes but require them to keep a two meter distance from one another or allowing activities where physical distance can be guaranteed or allowing access to open spaces where people can easily keep distance, allowing outdoor activities and access to open or indoor spaces where people can easily keep distance from one another. Also allowing those measures with little societal impact (e.g. teleworking) can be considered.

For these approaches to be successful, it is necessary that they are accompanied by a thorough monitoring of the epidemiological situation following the adjustment of a measure. Enhanced monitoring should take place at the lowest geographical level possible corresponding to the area where a given measure is modified. Such ad hoc systems overcome the lack of sensitivity of existing sentinel surveillance systems, and ensure that an upsurge of cases following the lift of a measure is detected in a timely manner in different settings. These systems also provide data on the effectiveness of various measures thus allowing further optimisation of the public health response.

Regardless of the measures modified, people at risk of severe clinical outcomes from contracting COVID-19 must remain protected from infection, irrespective of age and occupation, until an effective vaccine or treatment is available. All indirect consequences of lifting measures should be assessed prior to their modification, such as effects on public transportation usage and overcrowding of public spaces where high rates of viral transmission may occur, or specific mixing patterns such as between children and elderly individuals.

Prior to modifying measures, each country should have appropriate and adequate testing of COVID-19 implemented that is capable of detecting and closely monitoring changes in disease transmission at the population level over a longer time and within and between communities. All suspected cases should be included in the monitoring system, and ideally all cases should be tested for COVID-19.

Table 4. Suggestions for monitoring the effect of modifying or lifting public health measures

Data source	Methods	Epidemiological indicators ¹	Comment
Community (citizens)	<p>Participative reporting of COVID-19 compatible symptoms through:</p> <ul style="list-style-type: none"> • Online questionnaires • Hotlines • Mobile apps <p>Requested reporting of COVID-19 compatible symptoms through:</p> <ul style="list-style-type: none"> • Telephone surveys • Random surveys in public transport system <p>Depending on test availability, ideally local authorities should organise testing of all suspect cases and their contacts, or, if not possible, testing of a random number of them. Availability of self-testing would facilitate this.</p>	<p>Daily % of people with suspected COVID-19, by lowest administrative unit</p> <p>Weekly % of confirmed COVID-19 cases, by age group and week</p> <p>% cases with unknown source of infection (data from contact tracing)</p>	<p>Data are assessed by local public health authorities.</p> <p>Consumer associations may help with carrying out the telephone surveys or organise online questionnaires.</p>
Employers/companies	<p>Daily surveillance system of suspected cases in major employers in the geographic area, along with contact tracing in organisation. Reach out to employees requesting sick leave and verify symptoms. (Employees on leave to care for sick family members should be excluded from the numerator.)</p>	<p>Weekly % of total employees in the geographical area absent for suspected COVID-19</p>	
Schools	<p>Reach out to students and teachers absent for illness and verify symptoms.</p>	<p>Weekly % of students and teachers absent for suspected COVID-19</p>	
Administrators of institutions where people live (e.g. nursing homes, prisons, long-term care facilities, and psychiatric clinics)	<p>Check daily health status of institutionalised people and staff. Notify public health authorities of suspected COVID-19 cases (nonspecific symptoms also need to be monitored). Collect information on institutional practices for preventing introduction of the virus from staff and visitors</p>	<p>Number of suspected and confirmed cases, including fatal cases</p>	<p>Every suspected case should be tested for COVID-19.</p> <p>Considering the risk of large outbreaks with a high impact, testing could be extended to asymptomatic contacts (two tests, five days apart), or to all residents and staff once a case is identified.</p>
General practice (GP)/primary care	<p>Record and report daily or weekly number of suspect cases:</p> <ul style="list-style-type: none"> • Seen at GP practice • Calling GP practice • Notified by mobile app <p>Test GP workers if they report COVID-19 symptoms</p>	<p>Daily (weekly) number of:</p> <ul style="list-style-type: none"> • Cases/consultations • Cases/registered patients • Cases/calchment area <p>Weekly % of confirmed by age group and week</p> <p>Weekly number of GP workers tested and % positive</p>	<p>Data are assessed by local public health authorities. Depending on test availability local authorities should organise testing of all suspect cases or of a proportion (ideally representative) of them.</p> <p>Self-sampling for PCR-testing would be helpful.</p>
Hospital	<p>Record and report daily or weekly number of SARI cases</p> <p>Test all SARI for COVID-19 Calculate % SARI positive for COVID-19</p> <p>Testing all HCWs developing COVID-19 compatible symptoms Weekly serologic surveys of all HCWs Monitor bed occupancy daily, by type of ward</p>	<p>Daily /weekly number of SARI admitted by severity criteria at admission/all admissions</p> <p>% of SARI cases admitted who are working outside of the home and/or using public transportation</p> <p>% confirmed SARI by severity criteria at admission</p> <p>Weekly new and cumulative % of HCWs infected (PCR & serology)</p> <p>% of bed occupation by type of ward</p>	<p>Strict adherence to infection prevention and control practices should continue to be enforced</p>
Office of statistics	<p>Retrieve and report weekly/monthly number of death certificates with underlying cause of death coded as ICDU7.1 and U07.2 in ICD-10 or RA01.0 and RA01.1 in ICD-11, by age Monitor all-cause mortality and detect departure from expected.</p>	<p>Weekly/monthly number of deaths attributed to COVID-19, by age</p> <p>Excess all-cause mortality, by age and week</p>	<p>Statistical methods can be applied to test significance of weekly/monthly variations</p>

In the absence of reliable and representative data from surveillance systems it will be difficult for countries to decide when it is possible for certain measures to be adjusted. Some surveillance systems currently in use may not be sufficiently sensitive and accurate. Therefore, decision-making on public health measures should not be based only on incidence data and trends from current surveillance systems, but should be supported by additional data such as those described in Table on the left. There should be clear policies on what actions should be taken if or when the trend for an indicator is observed to rise or fall following the adjustment of a measure. These might include, in the case of an adverse trend, reinforcing other measures, reintroducing the modified/lifted measures, or considerations to change/lift a different measure; whereas, in the case of a positive trend, these might include continuation with the adjusted measure and adjustment (easing) of another measure after a suitable period of time.

Source: Extract from ECDC RAPID RISK ASSESSMENT Coronavirus disease 2019 in the EU/EEA and the UK—ninth update; Point 4. Considerations when planning for adjusting ‘stay-at-home’ policies and physical distancing measures, page 17 as of 23 April 2020. Document find [here](#).

Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK—ninth update

Source: ECDC; document including all references can be found [here](#) (Nr. 140 – 146)

Considerations when planning for adjusting ‘stay-at-home’ policies and physical distancing measures

To date, most countries are still experiencing widespread sustained transmission and, following large-scale interventions, a few countries are transitioning to or have reached a situation where transmission is reduced to localised clusters. The five scenarios describing the possible progression of the COVID-19 outbreak in EU/EEA countries were described in [ECDC’s fifth Rapid Risk Assessment on COVID-19](#).

As of Monday 20 April 2020, all 31 EU countries and the UK had a measure in place to cancel mass gatherings (31/31, 100%). Generic measures to close public spaces are currently ongoing in 30 countries (30/31, 97%). Most countries had measures in place to close educational institutions including the closure of secondary schools or higher education (31/31, 100%), the closure of primary schools (28/31, 90%) and the closure of day care or nursery schools (23/31, 74%). Enforced or recommended ‘stay-at-home’ policies for the general population are currently in place in more than half of EU countries (17/31, 55%). Eighteen countries have ‘stay-at-home’ recommendations for risk groups (18/31, 58%).

Such measures are highly disruptive to society and there is therefore significant interest in defining a sound approach to phase out ‘stay-at-home’ policies and to adjust community and physical distancing measures. Several Member States have started to ease measures such as re-opening primary schools and kindergartens (e.g. Denmark, Czech Republic, Norway) and small retail shops, hairdressers, and independent shops (e.g. Austria, Germany, Italy).

Lifting too many measures at once without appropriate systems and capacities in place may cause a rapid resurgence of transmission. The question is how Member States can restart economic and social activities while minimising the impact of COVID-19 on citizen’s health and healthcare systems. [The Joint European Roadmap](#) towards lifting COVID-19 containment measures addresses this question by providing the frame work for a comprehensive economic and social recovery plan for the EU, with public health actions at its core.

In the current situation, measures in Member States should continue to be aimed at the containment and mitigation of further transmission of the virus, and its impact, including infection prevention and control, community-level physical distancing, measures in hospital settings, surveillance and testing. A focus on vulnerable groups and populations with defined risk criteria is paramount.

General considerations

The reduction in the rate of incident reported cases in many EU Member States is almost certainly due to the introduction of stringent control measures. A modelling study of Île-de-France, France estimated that entering ‘lockdown’ had reduced the effective reproduction

number from 3.0 to 0.68, and a similar study in Vo’, Italy estimated a reduction from 3.0 to 0.24. Modelling studies show that lifting interventions too rapidly will cause a sudden upsurge in case incidence. However, a progressive strategy to phase out measures, where an increasing proportion of the population returns to work, could mitigate the risk of significant upsurges, and maintain incidence at a rate within hospital capacity and allow monitoring systems to identify the need for re-introduction of specific measures if there is a sharp resurgence.

The relative effectiveness of different measures is, as yet, still unclear since many countries around the world introduced interventions *en bloc*. Nonetheless, the considered refinement of control measures may help mitigate the negative impact on society and the economy, while continuing to protect the health of those most at risk of developing severe disease.

In summary, if control measures are to be lifted, conscious efforts to protect the vulnerable and careful choices by all in their interactions with others will help to moderate the increased risk of transmission.

Public health objectives

While phasing out of the ‘stay-at-home’ policies and adjusting community and physical distancing measures, the EU/EEA actions should support the following public health objectives:

- Reduce morbidity, severe disease and mortality in the population through proportionate non-medical countermeasures, until effective vaccines, treatments and medicines become available.
- Limit and control virus circulation and transmission in the general population now (flattening the curve) and for the months to come to maintain the number of new SARS-CoV-2 infections at manageable levels for the healthcare system.
- Understand the public health effectiveness of specific measures while also identifying the best measures that are sustainable long-term during the ongoing COVID-19 pandemic.
- Minimise the indirect effects that the current healthcare response to COVID-19 may have on other diseases (the increased risk of depression and other mental health conditions etc).
- Restart activities while minimising any impact on people’s health and the healthcare system in a coordinated fashion within countries and between EU Member.

To reach these public health objectives, when planning to phase out the ‘stay-at-home’ policies and adjust community and physical distancing measures, criteria, indicators, monitoring systems and accompanying measures, must be in place as described below:

- A robust surveillance strategy
- A framework for contact tracing
- An expanded testing capacity and harmonised testing methodologies
- Sufficient health system capacity and resilience
- A strong risk communication strategy



Mask Facts

It is important to distinguish between the two types of protection that masks provide and are designed to prevent the virus from being transmitted. Because not every type of mask creates the same protection, which is why different masks are the means of choice in different situations.

The function of securely protecting yourself against infection is called **SELF-PROTECTION**. To do this, a mask must filter out the nanoscopically small viruses from the air we breathe. Due to the small size of the particles, this can only be achieved with certain materials. To prevent the spread of the pandemic, however, it is not necessary to protect the population completely. This principle only applies to people who have been proven to have permanent contact with infected people. B. Medical staff. Self-protection can only be created by particle-filtering half masks, the so-called FFP2 or 3 masks. They reliably prevent the virus particles from being inhaled. Since the filter material makes breathing difficult, this type of mask is also available with an exhalation valve. However, it must be noted that this valve allows the exhaled air to flow out unhindered / unfiltered and therefore offers no external protection! In addition, these protective masks have been in short supply for the medical sector since the pandemic began, which is why medical personnel often do not have enough protective equipment available to adequately protect themselves against infection. One reason for this deficiency is unreflected panic buying by private individuals who are not actually dependent on these protective masks.

On the other hand, the principle of **THIRD PARTY PROTECTION** is the reason for the general public mask requirement. The purpose of this is to assume that the wearer is considered a potential source of infection; the mask is intended to protect all contact persons from infection. This works primarily by preventing "droplet ejection", which is currently the most likely and most common transmission path for SARS-Corona Virus-2 (SARS-CoV-2). Anything that completely covers the mouth and nose is generally suitable for this barrier function, which is why there are now various types of "community" masks (also called "everyday masks"). From surgical mouth and nose protection to the self-sewn fabric mask to simple scarves - each of these tissue materials represents an obstacle to the transmission of the virus and protects others. Which type of one you prefer is up to you.

Even if everyone adheres to the obligation to wear a mask and we, as a society based on solidarity, want to protect each other from infection, it does not mean that we can go back to the usual forms of contact. The obligation to wear a mask is just another, albeit important, building block in the concept of social distancing! Even with a mask, the public must continue to keep their distance, which means that all measures taken so far are still in force! Therefore:

- Regular hand washing, especially after a stay in public spaces such as B. Shopping.
- Keep a safe distance! Observe a distance of 1.5 to 2 m to other people.
- Sneeze and cough etiquette (ONLY in the crook of the arm and whenever possible, turn away from people nearby in good time beforehand!). This also includes not putting your hands on your face or under your mask.
- Avoiding all contacts that are not essential. In particular, encounters with members of the risk groups should be avoided!

How to make your own face covering:

CDC: <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html>

<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>



A **medical face mask** (also known as surgical or procedure mask) creates a barrier between hospital staff and patients by covering the mouth, nose and chin. It is used by healthcare workers to prevent large respiratory droplets and splashes from reaching the mouth and nose of the wearer. It also reduces and/or controls the spread of large respiratory droplets from the person wearing it.

Non-medical face masks (or 'community' masks) include various forms of self-made or commercial masks and face covers made of cloth, other textiles or other materials (e.g. paper). They are not standardised and not intended for use in healthcare settings or by healthcare professionals.

A **respirator** or a filtering face piece is designed to protect the wearer from exposure to airborne contaminants and is classified as personal protective equipment. Filtering face pieces are mainly used by healthcare workers, especially during aerosol-generating procedures. Valved respirators are not appropriate for use as a means of infection control, as they do not prevent the release of respiratory particles from the wearer into the environment.

Remember! Proper use of face masks is key for their effectiveness and safety.



Make sure the face mask completely covers your face from the bridge of your nose down to your chin.



If your face mask is disposable, dispose of it in a safe way.



Clean your hands with soap and water or an alcohol-based hand sanitiser before putting the face mask on or taking it off.



If your mask is reusable, wash it as soon as possible after each use with common detergent at 60 °C.



When taking your face mask off, remove it from behind - be sure not to touch the front of it.



Campaigns showing the appropriate use of face masks by the public may improve their effective and safe use.

Global Health Index (GHS Index)



The Global Health Security Index presents the results of an assessment of global health security capabilities in 195 countries prepared by the Johns Hopkins Center for Health Security, the Nuclear Threat Initiative (NTI) and the Economist Intelligence Unit (EIU). It was first published in 2019. It shows that "no country is fully prepared for epidemics or pandemics, and every country has important gaps to address". In 2019, the countries in the category "most prepared" were - in alphabetical order - Australia, Canada, Finland, France, the Netherlands, South Korea, Sweden, Thailand, the United Kingdom and the United States. The United States was ranked first with an index value of 83.5 out of 100. The largest number of countries in the category "least prepared" was in Western and Central Africa.

The GHS Index relies entirely on open-source information: data that a country has published on its own or has reported to or been reported by an international entity. The GHS Index was created in this way with a firm belief that all countries are safer and more secure when their populations are able to access information about their country's existing capacities and plans and when countries understand each other's gaps in epidemic and pandemic preparedness so they can take concrete steps to finance and fill them. The indicators and questions that compose the GHS Index framework also prioritize analysis of health security capacity in the context of a country's broader national health system and other national risk factors.

The 140 GHS Index questions are organized across six categories:

- Prevention:** Prevention of the emergence or release of pathogens
- Detection and Reporting:** Early detection and reporting for epidemics of potential international concern
- Rapid Response:** Rapid response to and mitigation of the spread of an epidemic
- Health System:** Sufficient and robust health system to treat the sick and protect health workers
- Compliance with International Norms:** Commitments to improving national capacity, financing plans to address gaps, and adhering to global norms
- Risk Environment:** Overall risk environment and country vulnerability to biological threats

Among its 140 questions, the GHS Index prioritizes not only countries' capacities, but also the existence of functional, tested, proven capabilities for stopping outbreaks at the source. Several questions in the GHS Index are designed to determine not only whether a capacity exists, but also whether that capacity is regularly—for example, annually—tested and shown to be functional in exercises or real-world events.

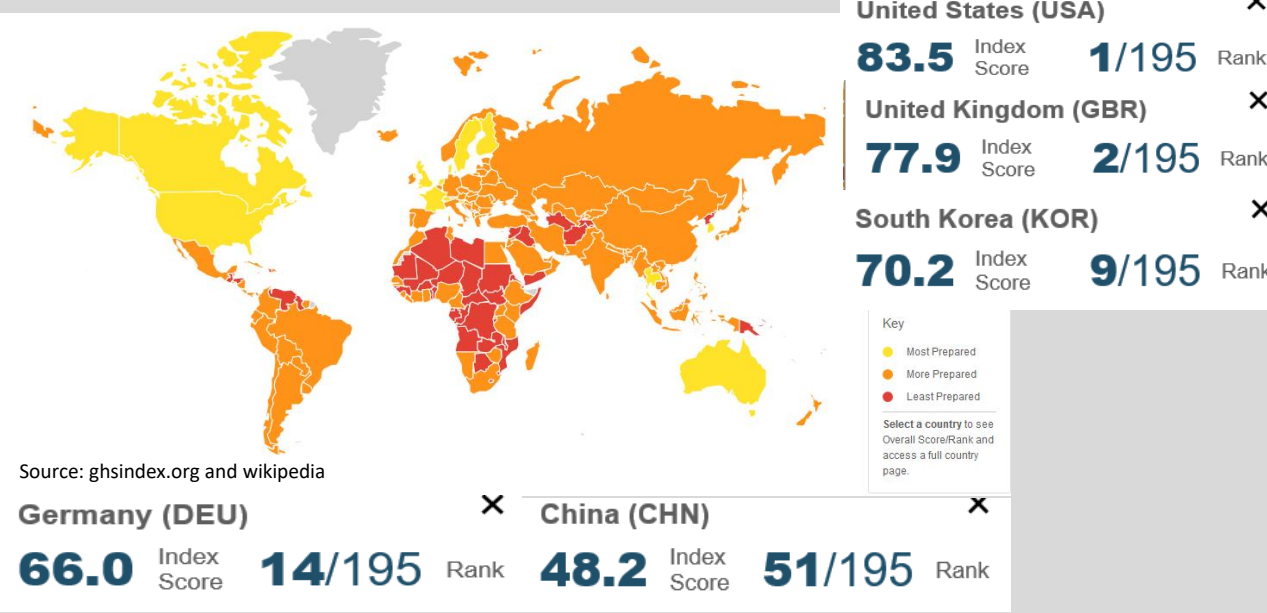
The GHS Index also includes indicators of nations' capacities and capabilities to reduce Global Catastrophic Biological Risks (GCBRs), which are biological risks of unprecedented scale that could cause severe damage to human civilization at a global level, potentially undermining civilization's long-term potential. These are events that could wipe out gains in sustainable development and global health because of their potential to cause national and regional instability, global economic consequences, and widespread morbidity and mortality. The GHS index came to prominence during the outbreak of the current pandemic. On February 27, 2020, US President held up a map based on the GHS index showing the United States was "the best prepared country in the world for a pandemic". However, one of the consultants working on the project, pointed out that "even though the US does rank at the top of the index, there are areas where there is room for improvement", notably access to healthcare.

The GHS index has also faced criticism regarding whether it overestimated the capacity of the healthcare systems in historically rich states, countries ranked the most prepared, such as the UK fared worse than those ranked lower amid the pandemic, such as China or South Korea. Although Germany was only ranked as a more prepared country it saw significant lower case mortality rates than even best ranked countries and finally was able to offer ICU capacity to most prepared countries in Europe.

Why is the GHS Index Needed?

It is likely that the world will continue to face outbreaks that most countries are ill positioned to combat. In addition to climate change and urbanization, international mass displacement and migration—now happening in nearly every corner of the world—create ideal conditions for the emergence and spread of pathogens. Countries also face an increased potential threat of accidental or deliberate release of a deadly engineered pathogen, which could cause even greater harm than a naturally occurring pandemic. The same scientific advances that help fight epidemic disease also have allowed pathogens to be engineered or recreated in laboratories. Meanwhile, disparities in capacity and inattention to biological threats among leaders have exacerbated preparedness gaps. The 2014 West Africa Ebola epidemic was a wake-up call. It prompted global leaders and the World Health Organization to realize that it's not clear where the gaps are – or how to fill them. It also highlighted that leaders need better ways to understand and measure improvement in global capability to prevent, detect, and respond to infectious disease threats.

The GHS Index seeks to illuminate preparedness and capacity gaps to increase both political will and financing to fill them at the national and international levels.





In cooperation with Bundeswehr HQ of Military Medicine
Translated by FHPB NATO MILMED COE

Conflict & Health ROYINGYA

Cox's Bazar District: 2.6 million inhabitants
Until now 5 COVID-19 cases, 859,161 refugees in 11 camps
High population density, large households, insufficient WASH-capacities, no possibilities to isolate infected people
Capacities within Cox's Bazar:
590 beds (thereof 340 beds in Kutupalong camp)
10 ICU beds, no ventilators



Bangladesh

35.0 Index Score 113/195



	COUNTRY SCORE	AVERAGE SCORE*		COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	27.3	34.8	HEALTH SYSTEM	14.7	26.4
Antimicrobial resistance (AMR)	16.7	42.4	Health capacity in clinics, hospitals and community care centers	27.4	24.4
Zoonotic disease	35.4	27.1	Medical countermeasures and personnel deployment	33.3	21.2
Biosecurity	0	16.0	Healthcare access	23.6	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	93.9	85.0	Capacity to test and approve new medical countermeasures	0	42.2
DETECTION AND REPORTING	50.9	41.9	COMPLIANCE WITH INTERNATIONAL NORMS	52.5	48.5
Laboratory systems	100	54.4	IHR reporting compliance and disaster risk reduction	50	62.3
Real-time surveillance and reporting	45	39.1	Cross-border agreements on public and animal health emergency response	0	54.4
Epidemiology workforce	50	42.3	International commitments	75	53.4
Data integration between human/ animal/environmental health sectors	0	29.7	JEE and PVS	75	17.7
RAPID RESPONSE	23.1	38.4	Financing	50	36.4
Emergency preparedness and response planning	12.5	16.9	Commitment to sharing of genetic & biological data & specimens	66.7	68.1
Exercising response plans	0	16.2	RISK ENVIRONMENT	44.0	55.0
Emergency response operation	0	23.6	Political and security risks	53.6	60.4
Linking public health and security authorities	0	22.6	Socio-economic resilience	69	66.1
Risk communication	25	39.4	Infrastructure adequacy	16.7	49.0
Access to communications infrastructure	45	72.7	Environmental risks	43	52.9
Trade and travel restrictions	100	97.4	Public health vulnerabilities	38.5	46.9

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

The **Rohingya people** are officially not recognized as an independent ethnic group by the state of Myanmar. The United Nations classify them as the "most persecuted minority in the world". As they are stateless, they aren't granted any rights. They are not allowed to vote, have no access to higher education and they are not allowed to officially leave the country. In addition, travel restrictions apply to them even within the country. A law dating back to 1982 denies the Rohingya people their citizenship and corresponding documents. Lands owned by Rohingya people is impounded and private property is destroyed or robbed. The objective of the government is said to be the transformation of the Rakhine State into a solely Buddhist region making Muslims an either unimportant or at least manageable minority. Furthermore, Buddhist monasteries and pagodas were built at sites that were formerly Muslim. Extra taxes, forced labour, restrictions on marriage and manipulations during the registration of births and deaths restrict daily life. This is accompanied by illegal detention, torture, rape and assassinations. **It is estimated that approximately 1.5 million stateless Rohingya people live in exile**, but also there, they are subject to repressions. Most of those living in exile are living in Bangladesh (esp. Chittagong), Pakistan and Saudi Arabia, smaller groups are also living in the United Arab Emirates, Thailand and Malaysia.

At the instigation of Myanmar Rohingya people are illegally arrested in numerous states, e.g. in Bangladesh, India, Pakistan, Saudi Arabia, United Arab Emirates, Thailand and Malaysia. Since Myanmar's independence (granted on 4th January 1948) the government led twenty military operations against the Rohingya people. The consequences of those operations were the death of many Rohingya people, the devastation of their settlement areas and sanctuaries and the (partly) systematic destruction of their infrastructure.

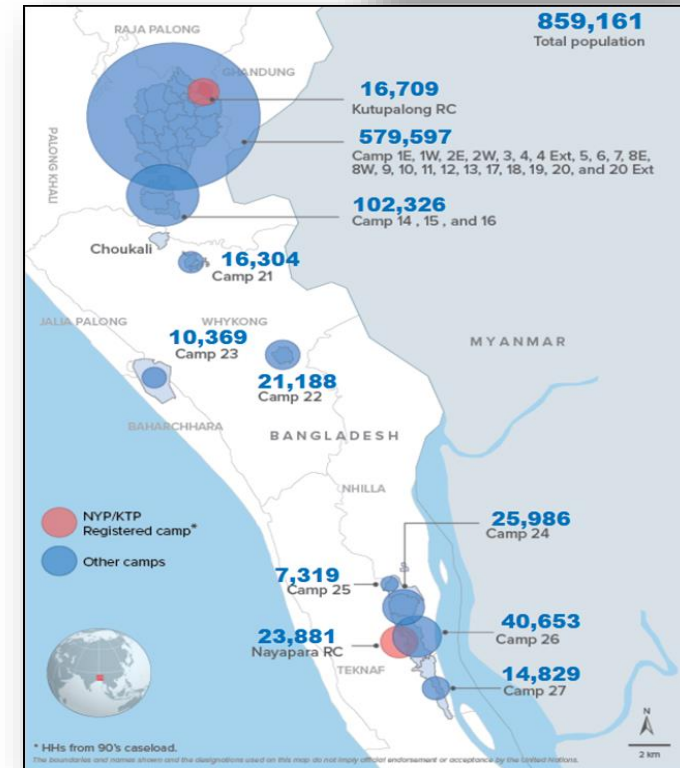
An extraordinary number of **refugee flows** was observed in 1942, 1962, 1978 and 1991. In the year 1978 approximately 200,000 Rohingya people sought protection in the neighbouring country Bangladesh, in 1991 250,000 refugees followed, in recent years the number rose again notably. Even though some of them returned, eventually many of them stayed in the refugee camps in the district **Cox's Bazar**. On 25th August 2017 another escalation took place as various targets in Myanmar were simultaneously hit and Arakan Rohingya Salvation Army (ARSA) assumed full responsibility for those attacks. A counteroffensive conducted by the armed forces and the police as well as the fear of raids undertaken by the rebels initiated a refugee movement during which Buddhists fled or were evacuated from Islamt warriors, whereas people belonging to the Muslim minority of Myanmar overran the border with Bangladesh to seek for protection. The situation deteriorated quickly and observers deduced that Myanmar's army used those attacks as a justification for a large-scale offensive. In the two months after 25th August 2017 approximately 604,000 Rohingya people fled to Bangladesh. In total by the end of October 2017 almost one million Rohingya refugees lived there.

In November 2017 Myanmar's ministry for foreign affairs announced that it has signed a joint memorandum with Bangladesh, allowing to repatriate the Rohingya that fled Myanmar. According to the government of Bangladesh the repatriation should start within two months. The overall situation in the overcrowded refugee camps in Bangladesh is seen as catastrophic. The number of refugees living there was estimated to be around 700,000 Rohingya people in March 2018. According to the memorandum there has to be a "safe" return to Myanmar, which is illusory for most of the affected people given the fact that Myanmar's army has destroyed certain villages.

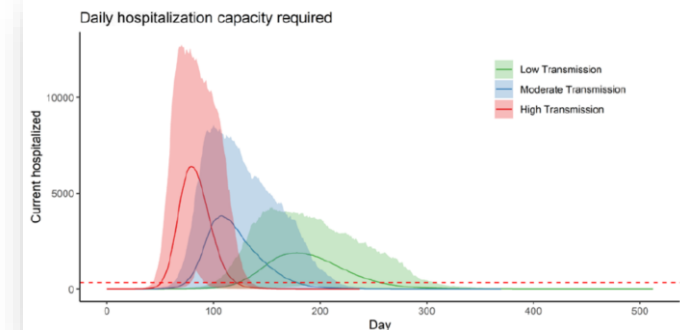
For April 2019 Bangladesh's government announced the beginning of a resettlement of Rohingya people to the previously uninhabited island Bhasan Char. In previous years infrastructure and houses were built on this island. Approximately 100,000 people should settle on this remote island.

Bangladesh's health system is more or less within the global average (see graphic on the left); even though there are usable laboratory capacities, they are undersized for the current outbreak. Nevertheless the whole outbreak management system (beside of travel and business restrictions) has to be seen as undersized. Almost all individual aspects of patient care (see Health System table on the left) will be overwhelmed as soon as the number of COVID-19 cases increases according to almost every modelling variant.

Some parts are taken from: <https://de.wikipedia.org/wiki/Rohingya>



Red line: available capacities
Modelling with various reproduction rates: (scenario 1 $R_0=1.5-2.0$; scenario 2 $R_0=2.0-3.0$; scenario 3 $R_0=3.3-5.0$)
Cases within the first 30 days: 119-504; Cases within one year: 424,798 – 591,349.



<https://www.medrxiv.org/content/10.1101/2020.03.27.20045500v1.full.pdf.html>



Ramadan and COVID-19

Ramadan:

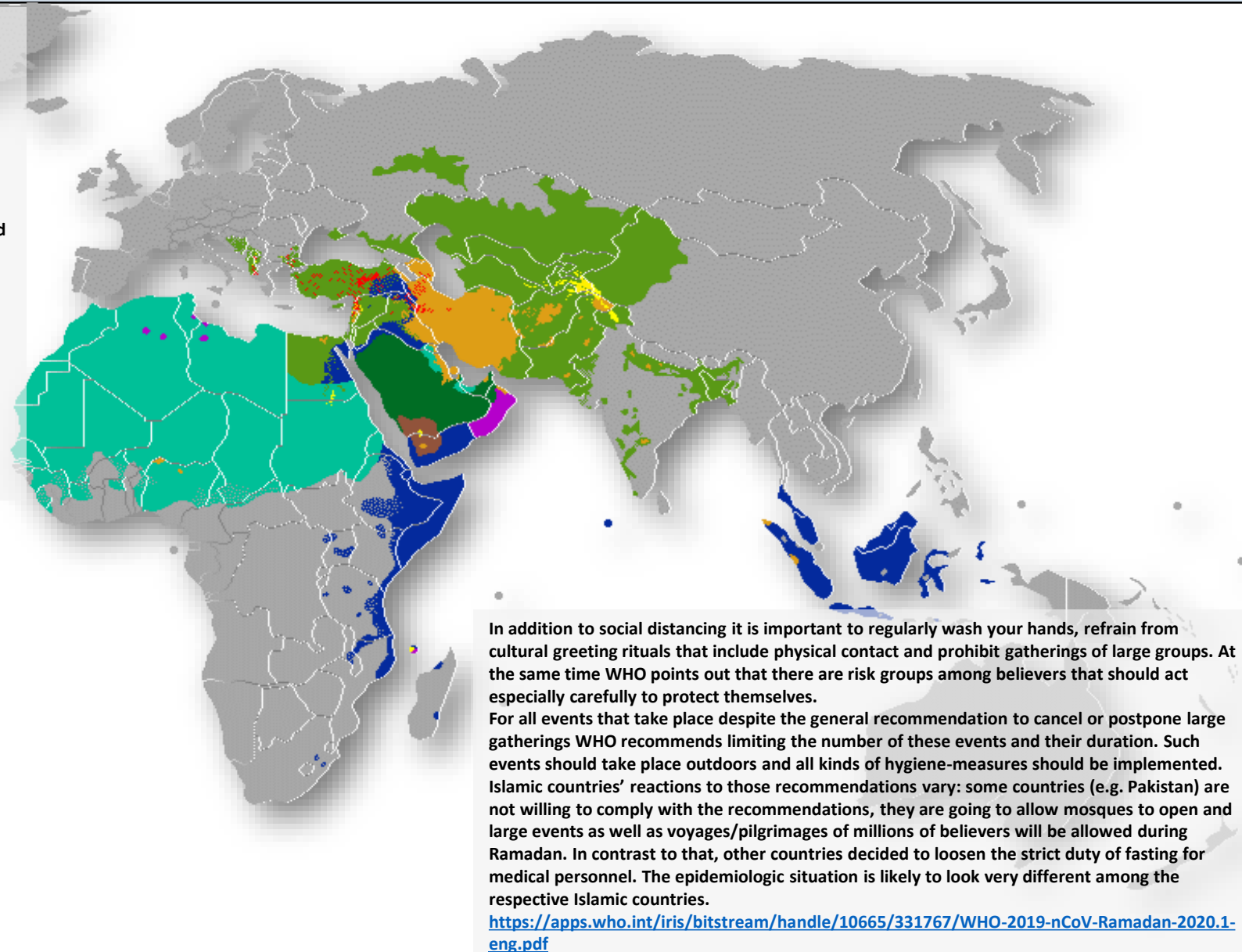
The Ramadan, the month of fasting for the Muslims and the subsequent Fast-Breaking ("Iftar") are two important events in the Islamic calendar. As one of the five pillars of Islam fasting during Ramadan is conducted by 1.8 billion people (approx. ¼ of global population). Like many other cultural and religious 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>