



Update 20 (18th of May 2020)

Information about Infection disease COVID-19 (novel coronavirus)



Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE
in Munich

18th of May 2020

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In December 2019, a novel coronavirus emerged in Wuhan City, China. Since then the virus spread to 65 countries including Europe and America. Since then the virus showed evidence for human-to-human transmission as well as evidence of asymptomatic transmission. At 30th January 2020 WHO declared a Public Health Emergency of International Concern. The disease was formally named COVID-19 on 11th of February. The virus itself has been named SARS-CoV-2. On 11th of March 2020 WHO characterized the disease as a pandemic.

HIGHLIGHTS/NEWS

- **WHO and ECDC:** Have published a new scientific brief on “Multisystem inflammatory syndrome in children and adolescents with COVID-19”, given the reported clusters of children and adolescents who require admission to intensive care units with a multisystem inflammatory condition. There is an urgent need for collecting standardized data describing epidemiology, clinical presentations, severity, and outcomes. Find more information in [Subject in Focus](#)
- **WHO** has published new guidance on “[Cleaning and disinfection of environmental surfaces in the context of COVID-19](#)”, intended for healthcare professionals, public health professionals and health authorities that are developing and implementing cleaning and disinfection policies and standard operating procedures.
- **WHO and UNICEF** have published a document on [frequently asked questions](#) (FAQs) about immunization in the context of the COVID-19 pandemic. These FAQs accompany WHO’s [Guiding principles for immunization activities](#) during the COVID-19 pandemic.
- A UN [policy brief](#) on COVID-19 and mental health warns that [substantial investment is needed to avert a mental health crisis](#). Reports already indicate an increase in symptoms of depression and anxiety in several countries.
- **FHP Branch** started to organize a weekly VTC on “COVID-19 response” next VTC will take place on Wednesday, 20th of May focusing on “**Immunity map, national strategies to measure and evaluate the immunity level**”

Find articles and other materials at the MilMed CoE homepage: [click here](#)

Please use our online observation form to report your lessons learned observations as soon as possible.

[Click here to submit your lessons learned observations online](#)

GLOBALLY

4 681 684
confirmed cases
1 735 884 recovered
315 271 deaths

EU/EEA and the UK

1 846 724
confirmed cases
830 652 recovered
166 784 deaths

USA

(x2 in 43.5 d →)

1 483 715
confirmed cases
272 265 recovered
89 423 deaths

Russia

(x2 in 16.5 d ↘)

281 752
confirmed cases
67 373 recovered
2 631 deaths

UK

(x2 in 46.0 d ↘)

243 695
confirmed cases
not reported recovered
34 636 deaths

Brazil

(x2 in 12.0 d ↘)

241 080
confirmed cases
94 122 recovered
16 122 deaths

Spain

(x2 in 174.0 d ↘)

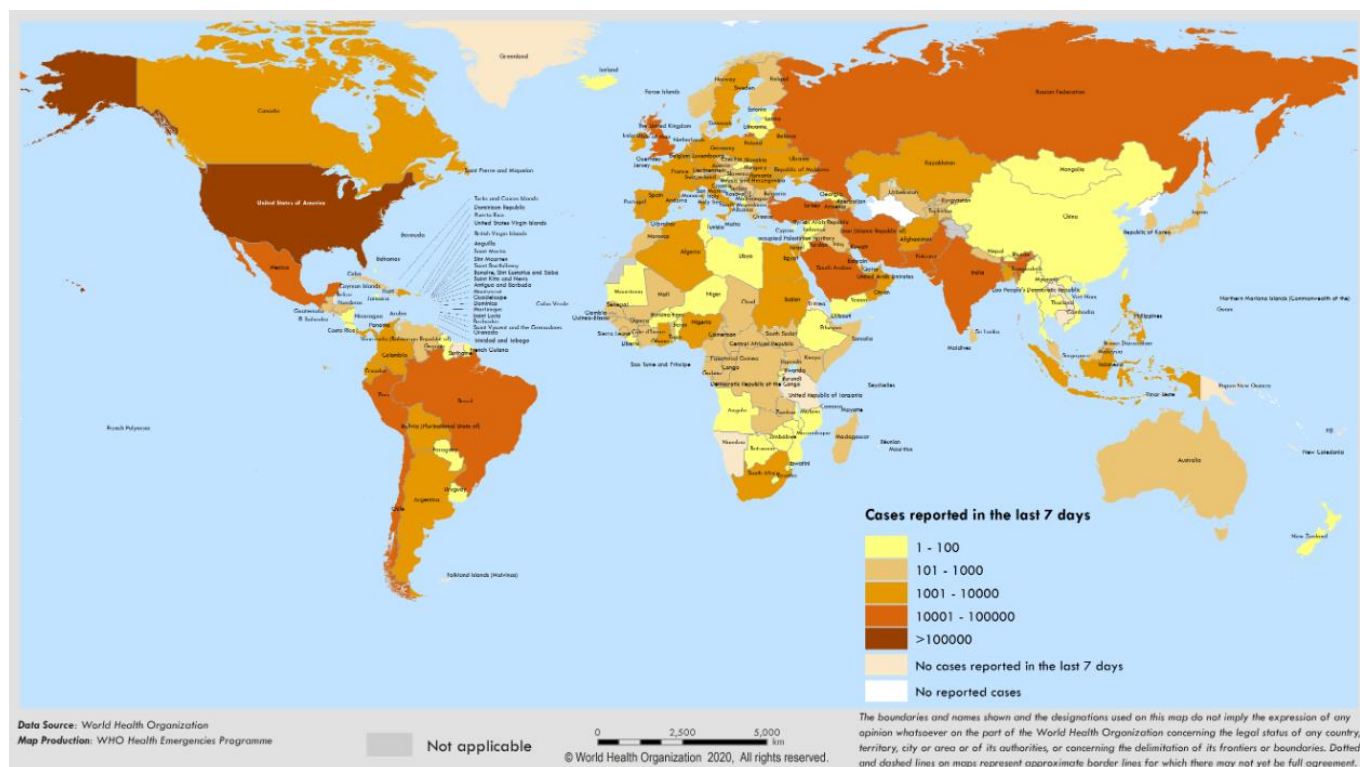
230 698
confirmed cases
146 446 recovered
27 563 deaths

Please click on the headlines to jump into the document

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Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation

JPN: Japan has agreed to contribute over US\$2.7 million to help nine countries in the Americas strengthen their capacities to detect cases, monitor, and control outbreaks of COVID-19, as well as ensure that reliable public health information on the COVID-19 pandemic is available to people involved in the response and the general public.

CHN: The government health advisor in Beijing fears a second wave of coronavirus in China. Due to a lack of immunity, the majority of Chinese are still susceptible to the virus. There is fear of a possible second wave, as new infection clusters have recently appeared in north eastern provinces and the central Chinese city of Wuhan

QAT: Anyone traveling in public without a mask has to face up to three years in prison and a fine of up to \$ 55,000 (50,800 euros) since Sunday. The desert state is struggling with one of the highest infection rates in the world. More than 30,000 people in the small Gulf state have been infected with the new corona virus - this corresponds to 1.1 percent of the 2.75 million inhabitants.

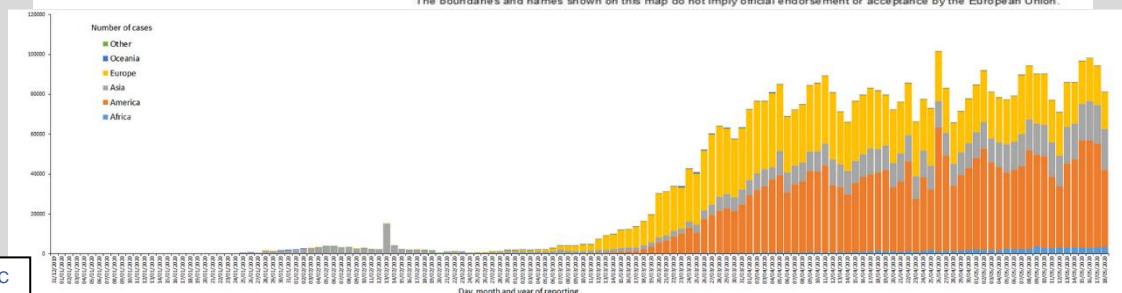
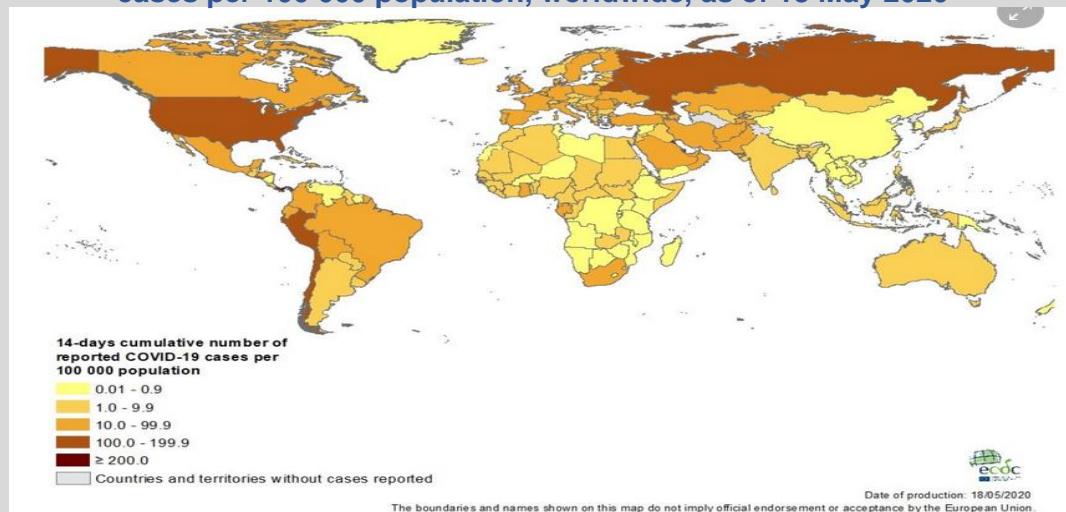
THA: Thailand has extended the stop for international passenger flights to the Southeast Asian country by one month until June 30. Exceptions apply to freight, auxiliary and military flights as well as emergency landings. A 14-day quarantine is planned for passengers on board such flights.

BRA: Large increase in confirmed cases, pushing Brazil to be the fourth most affected country for confirmed cases, and the fifth for deaths. The hospital bed capacity is around 90% in Sao Paulo and growing, estimated to reach capacity within a fortnight. Debates about enforcing a state-wide lock down continue.

SNP: At least 305 new cases have been reported in the last 24 hours, mostly Work Permit holders staying in foreign worker dormitories. This is the lowest number of new cases from early May. This reduction is due to fewer tests being done as one of the testing laboratories is reviewing its process due to an earlier calibration issue.

AFG: The government announced extension of the nationwide lockdown until 24 May. However, a number of provinces began easing lockdowns with the arrival of Ramadan.

Geographic distribution of 14-day cumulative number of reported COVID-19 cases per 100 000 population, worldwide, as of 18 May 2020



Source: ECDC

Situation in Europe

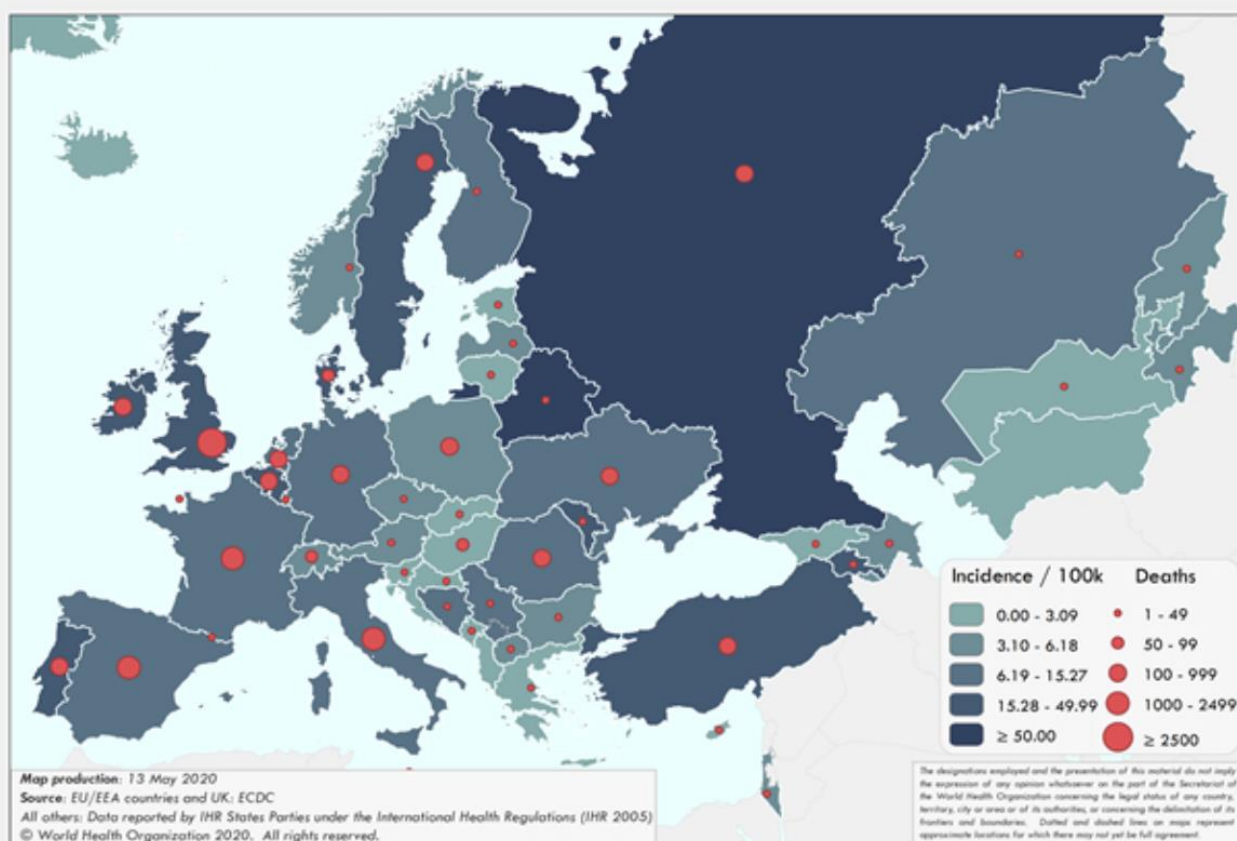
ESP: For the first time in two months, fewer than 100 new corona deaths were reported in one day in Spain on Sunday. According to the health authorities, 87 people died within 24 hours. At the height of the epidemic in early April, 950 deaths had been registered within one day. The state of emergency due to the coronavirus pandemic will be extended by around a month.

ITA: Wants to allow entry for foreigners again from June 3rd. In addition, travel between regions in Italy should be allowed again.

FRA: France's State Secretary for Tourism has spoken out in favor of reopening as many sights as possible by the end of June. The first beaches and tourist destinations such as the pilgrimage to the Virgin Mary in Lourdes or the famous island of Mont Saint-Michel opened this weekend.

DEU: The Public Health Agency (RKI) contradict temperature controls at airports. Many corona infected people would not be recognized: for example, less than half of those affected, about whom the RKI has data, had a fever at all. Travelers could also mask their temperature by taking antipyretic agents. Some infected people have no or generally no symptoms but could still be contagious. For airports, the experts consider behavioural instructions for the suspected Corona case in several languages to be appropriate and sensible, as well as electronic recording of the contact details of the travelers so that they can be contacted quickly by health authorities in the event of an emergency. In addition to maintaining distance and hygiene rules, the RKI advocates making laboratory tests and medical care accessible to all patients.

COVID-19 incidence per 100,000 population and number of deaths by country for week 19



COVID-19 situation update for the WHO European Region (04 May - 10 May 2020 Epi week 19)

Week 19/2020 (4 - 10 May 2020)

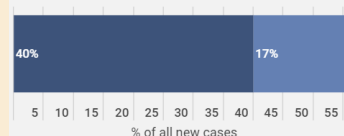
- The number of cases reported in week 19/2020 in the Region has declined by 27% since week 14/2020
- 57% of the cases reported in week 19/2020 were from Russian Federation and the United Kingdom
- Three countries had a crude incidence of ≥ 50 per 100,000 in week 19/2020: San Marino, Belarus and the Russian Federation
- In three countries, the number of cases increased by $\geq 50\%$ in week 19/2020 compared to week 18/2020: Azerbaijan, Kyrgyzstan and Tajikistan (see [EURO COVID-19 Dashboard](#) for recent trends)
- 63% of the deaths reported in week 19/2020 were from the United Kingdom, Italy, France and Spain
- The proportion of reported cases that died decreased from 10.8% in week 18/2020 to 6.8% in week 19/2020, a change that is likely due to a range of factors

Summary overview

- 74% of cumulative deaths were reported from the United Kingdom, Italy, Spain and France
- 19% of all reported infections with information available were in a health care worker
- 79% of all ICU admissions were in persons aged 50-79 years of age, with 70% of all ICU admissions in men
- 94% of all deaths were in persons aged ≥ 60 years and 59% of all deaths were in men
- 95% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (65%)
- Seven countries in the Region each reported a cumulative incidence of ≥ 400 cases per 100,000 population: San Marino, Andorra, Luxemburg, Iceland, Spain, Ireland and Belgium.
- From week 10, 2020 and as of week 19, there were over 152,000 excess deaths reported from 24 countries/regions, primarily in the age group ≥ 65 years (140,000), but also in the 15-64 years age group (12,000). This time period includes part of the influenza season as well as the start of the COVID-19 pandemic. See [European Mortality Bulletin](#)
- In week 19/2020, three countries reported a total of 76 tests and no COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 18/2020 was 7.6% (6 countries) compared to 9.9% (6 countries) in week 17/2020

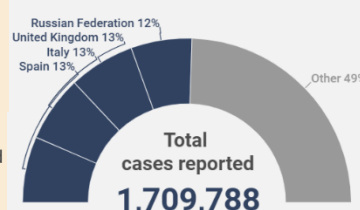
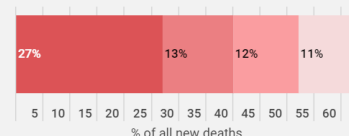
New cases Epi week 19

189,381

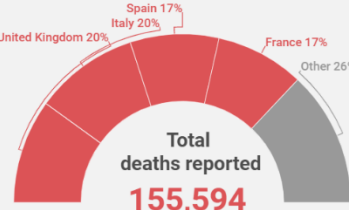


New deaths Epi week 19

12,888



Total cases reported
1,709,788



Total deaths reported
155,594

19%

of all people infected were health care workers

95%

of all deaths had at least 1 underlying condition

59%

of all deaths were in men

79%

of all ICU admissions were people aged 50-79 years

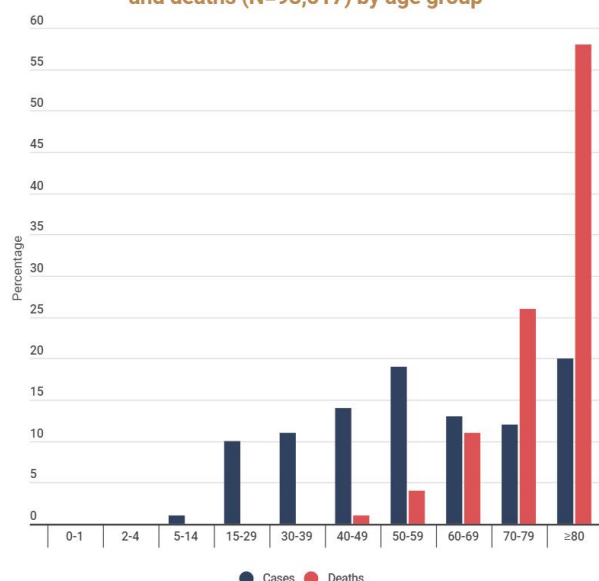
94%

of all deaths were in persons aged 60+

65%

of all deaths had cardiovascular disease

Percentage of COVID-19 cases (N=767,727) and deaths (N=93,517) by age group



Characteristics of COVID-19 cases and deaths

Characteristics		n	%	Total records with data available
Cases	Age in years, median (range)*	55 (1-105)		554,504
	Sex, male*	253,568	46	549,795
	Travelled*	17,647	12	142,569
	Recovered*	182,920	86	212,558
	Health care workers*	77,156	19	407,954
	Hospitalization*	129,430	32	407,031
	Intensive care unit admissions*	9,392	3	300,195
Deaths	Age in years, median (range)^	81 (0-108)		93,517
	Sex, male^	55,035	59	93,424
	At least one underlying condition^	23,217	95	24,430
	• cardiovascular disease	13,631	65	20,817
	• diabetes	6,740	33	20,169
	• lung disease	4,682	23	20,315
	• neurological disease / dementia	1,683	29	5,806
	• renal disease	1,081	20	5,411
	• malignancy	781	26	2,981
	• obesity	438	10	4,585
	• liver disease	247	5	5,339
	• immune disease	187	4	5,052
	• other	9,840	50	19,502

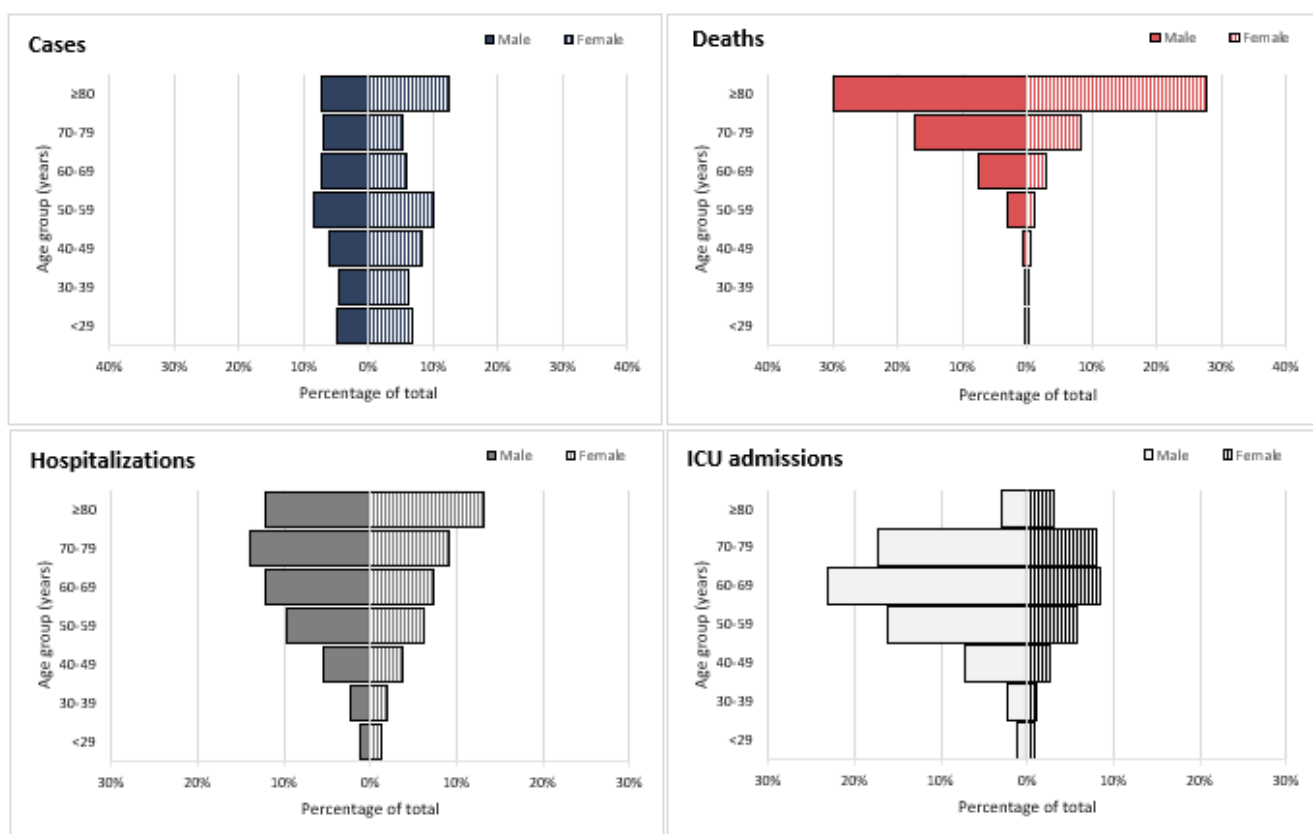
*Case report forms (n=554,504);

^Case report forms and aggregated data from Italy (7/8 May) and Spain (7 May 2020) (n=791,479);

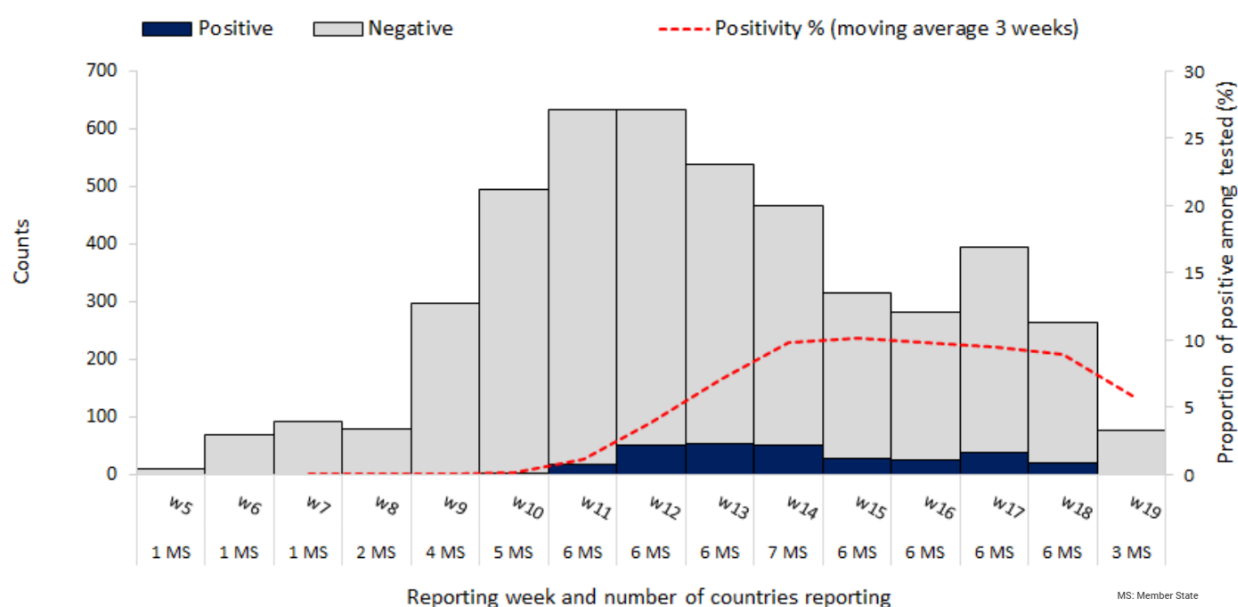
Health care workers refer to occupation and not to the place of exposure

^Case report forms, mortality survey, aggregated data from Italy (7 May 2020) and Spain (7 May 2020) (n=93,549)

Percentage of COVID-19 cases (N=763,258), hospitalizations (N=126,177), ICU admissions (N=11,696) and deaths (N=93,401) by age group and sex



Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



Subject in Focus

Multisystem inflammatory syndrome in children and adolescents with COVID-19 by WHO/ECDC

Background

As of 15 May 2020, more than 4 million confirmed cases of COVID-19, including more than 285,000 deaths have been reported to WHO. The risk of severe disease and death has been highest in older people and in persons with underlying noncommunicable diseases (NCDs), such as hypertension, cardiac disease, chronic lung disease and cancer. Limited data describe clinical manifestations of COVID-19 that are generally milder in children compared with adults, but also show that some children do require hospitalization and intensive care.

Relatively few cases of infants confirmed to have COVID-19 have been reported; those who are infected have experienced mild illness. Robust evidence associating underlying conditions with severe illness in children is still lacking. Among 345 children with laboratory-confirmed COVID-19 and complete information about underlying conditions, 23% had an underlying condition, with chronic lung disease (including asthma), cardiovascular disease, and immunosuppression most commonly reported.

Recently, however, reports from Europe and North America have described clusters of children and adolescents requiring admission to intensive care units with a multisystem inflammatory condition with some features similar to those of Kawasaki disease (KD) and toxic shock syndrome (TSS). Please find the more detailed Article “Paediatric inflammatory multisystem syndrome and SARS-CoV-2 infection in children” from ECDC [here](#).

Case reports and small series have described a presentation of acute illness accompanied by a hyperinflammatory syndrome, leading to multiorgan failure and shock. Initial hypotheses are that this syndrome may be related to COVID-19 based on initial laboratory testing. Children have been treated with anti-inflammatory treatment, including parenteral immunoglobulin and steroids.

It is essential to characterize this syndrome and its risk factors, to understand causality, and describe treatment interventions. It is not yet clear the full spectrum of disease, and whether the geographical distribution in Europe and North America reflects a true pattern, or if the condition has simply not been recognized elsewhere.

There is therefore an urgent need for collection of standardized data describing clinical presentations, severity, outcomes, and epidemiology.

WHO has developed a preliminary case definition and case report form for **multisystem inflammatory disorder in children and adolescents**.

The preliminary case definition reflects the clinical and laboratory features observed in children reported to date, and serves to identify suspected or confirmed cases both for the purpose of providing treatment and for provisional reporting and surveillance.

The case definition will be revised as more data become available.

Preliminary case definition

Children and adolescents 0–19 years of age with fever > 3 days

AND two of the following:

- Rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands or feet).
- Hypotension or shock.
- Features of myocardial dysfunction, pericarditis, valvulitis, or coronary abnormalities (including ECHO findings or elevated Troponin/NT-proBNP),
- Evidence of coagulopathy (by PT, PTT, elevated d-Dimers).
- Acute gastrointestinal problems (diarrhoea, vomiting, or abdominal pain).

AND

Elevated markers of inflammation such as ESR, C-reactive protein, or procalcitonin. a Consider this syndrome in children with features of typical or atypical Kawasaki disease or toxic shock syndrome. Multisystem inflammatory syndrome in children and adolescents with COVID-19: Scientific brief -2-

AND

No other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes.

AND

Evidence of COVID-19 (RT-PCR, antigen test or serology positive), or likely contact with patients with COVID-19.

Global COVID-19 Clinical Data Platform

WHO has an established platform for standardized, anonymized clinical data. Contributors can enter data into the web-based WHO COVID-19 Clinical Data Platform, which captures all COVID-19 variables listed in the case report forms (CRFs).

Using the WHO platform facilitates aggregation, tabulation, and analysis across different settings globally and provides a secure, access-limited, password-protected, electronic database hosted in a secure server at WHO. WHO will maintain appropriate technical and organizational security measures to protect confidentiality and prevent the unauthorized disclosure of the anonymized COVID-19 data.

Note: Contributors will retain control of their data. Health facilities will have access to their dataset in an analyzable format.

How to become a contributor: please email COVID_ClinPlatform@who.int and request log-in credentials. The data management team will contact you with instructions for data entry and will assign you a 5-digit site code at that time.

Each CRF has two modules:

- 1) Module 1 to be completed when multisystem inflammatory syndrome is suspected, and results of tests included in the case definition.
- 2) Module 2 to be completed at discharge or death.

If the patient is transferred from one ward to another within the same hospital, the CRF should be updated throughout the hospital stay, from the date of admission in the hospital, until the date of transfer to another hospital, discharge from the hospital, or death.

In settings where COVID-19 CRF data have been already entered in databases other than the WHO COVID-19 Clinical Data Platform, WHO will work with health facilities to transfer data from the original databases to the WHO platform. Please email COVID_ClinPlatform@who.int to request support. As the COVID data collection is not considered a research study, but rather surveillance of public health importance, patient or parent/guardian consent is not expected to be required in most settings; additionally, information is likely to be collected retrospectively through extraction from medical records in most cases.

More information about WG Members and WHO's References find [here](#)

Please find the whole rapid risk assessment "Paediatric inflammatory multisystem syndrome and SARS-CoV-2 infection in children" [here](#).

This assessment is based on information available to ECDC at the time of publication and unless otherwise stated, the assessment of risk refers to the risk that existed at the time of writing. It follows the ECDC rapid risk assessment methodology, with relevant adaptations. The overall risk is determined by a combination of risk of the probability of an event occurring and of its consequences (impact) to individuals or the population.

**ECDC risk
assessment
for the
EU/EEA**

Risk of CoVID-19in children in the EU/EEA and UK:

In recent months, SARS-CoV-2 has been circulating and spreading in the EU/EEA and the UK through human-to-human transmission. SARS-CoV-2 proved to be highly transmissible among a virtually fully susceptible population. However, children were reported in relatively low numbers and with mostly asymptomatic or mild infection. There is no consensus yet whether the low proportion of cases reported in children is due to a low probability of infection or a low probability of developing severe symptoms (which makes getting tested for the disease less likely). SARS-CoV-2 does not appear to be highly transmissible in children, particularly in younger children, and school outbreaks or school transmission instances have been rarely reported. However, due to mild symptoms and the fact that school closures were among the first physical distancing measures implemented in most countries, outbreaks may have remained undetected.

After reaching a peak at the end of March or in April, most EU/EEA countries have observed decreases in the daily number of newly reported cases in the last weeks. Consequently, although transmission persists, children are currently experiencing decreased opportunities for infection and, therefore, the likelihood of seeing large number of COVID-19 cases in children in the coming weeks is very small. In countries where community transmission keeps occurring at high rate, opportunities for infection in children are similar to the previous months.

In summary, the **probability of COVID-19 in children** is currently assessed as **low**.

The **impact** of such disease is assessed as **moderate**, therefore the **overall risk of COVID-19 in children** is assessed as **low**.

MilMed CoE VTC response

Topic

The NATO Centre of Excellence for Military Medicine is putting its expertise and manpower to aid in any way possible during the pandemic. The VTC is for interested participants (experts) to exchange experiences, management regulations and restrictions due to COVID-19. We would like to propose just one of the most important topics in the next iteration. We will have some experts giving a short briefing and then afterward we will have time for questions and experiences as well as a fruitful discussion.

Topics last VTCs:

- Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities.
- Testing strategies
- Aeromedical evacuation
- De-escalation strategy and measures
- Collateral damage of COVID-19 emphasizing Mental Health Aspects and other non COVID related diseases

Collateral damage of COVID-19 emphasising Mental Health Aspects and other non COVID related diseases

Summary last VTC “Collateral damage of COVID-1

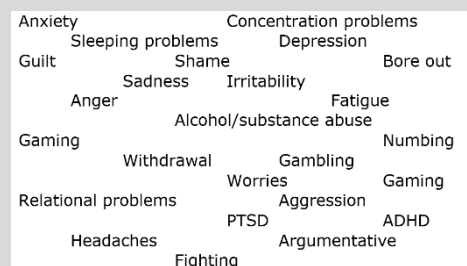
- All nations facing challenges to bring medical service to their soldiers
- Telemedicine showed a good opportunity to fill the gap
- Telemedicine needs to be trained to the doctors as they are reluctant to use the new tools
- There is a need to prove interoperability and the use in a big exercise will be beneficial. The COMEDS Planery already endorsed the use of Telemedicine.
- It has been provided a lot of examples of psychological problems which are cause by COVID-19 restrictions among civilian society and soldiers. Mental health is extremely crucial to keep servicemen in good condition especially during deployment.

Mental Health

Mental health is an important issue that should not be neglected and is becoming increasingly important during this crisis.

Couple of common issues:

- Bore out
- Irritability
- Relational problems
- Excessive gaming/gambling
- Guilt over „I can't do my job”
- Shame and feeling of uselessness



In many cases COVID-19 acts as a critical event. For such an event unit would usually train their troops. Now it was not possible. After such a critical event, there is a period of processing that stress. If there are still symptoms after this, then it is a disturbed processing of stressor. Prolonged display of processing of abnormal situation. If it doesn't get better, it can turn into PTSD.

- „I'm Fine” can mean otherwise.
- Help seeking behaviour of MIL personnel:
 - Mostly seeking help from peers
 - With family mostly the positive things are discussed
 - Low reporting to commanders, only about 12-15%
 - Even lower reporting to medical staff, only about 6%

Psychosocial support plan is important.

Maslow's pyramid:

- Physical needs
- Safety needs: physical safety is one aspect, but safety from the threat of the infection, safety of loved ones is also a threat.
- Belonging and love: a unit is like a family. When some of them are isolated because of the virus, the „family dynamics” are disturbed.
- Esteem: try to keep working if possible. Try to let the soldiers socialize with people they would normally socialize with. (Social bubble)



Telemedicine:

The field of telemedicine is also becoming increasingly important. This was made very clear by the Briefing from United States during the VTC.

The challenges are the same for all NATO nations and missions.

This presents a challenge for healthcare delivery. This challenge is not new for the military, but now unprecedented IT support is available.

First challenges:

- Telephones – phonelines collapsed or got overwhelmed
- Huge demand on training on virtual health providing.
- The IT system is not up to virtual healthcare as a routine

Email and phone consultations are used in some cases, but they are not as effective as video calling (face-to-face).



Topic next VTC:

- "Immunity map, national strategies to measure and evaluate the immunity level"

Telemedicine

Conflict and Health

Conflict and Health

(Public) Health is a topic that is often neglected during times of conflicts and civil unrest. While military personnel regularly have access to medical supplies and a dedicated military health service, the public often suffers from a lack of supply with medical equipment and basic goods (e.g. clean water), low number of health-care professionals and an increased burden on the individuals' mental and physical wellbeing.

During conflicts an increased probability of the emergence of infectious diseases can be observed (e.g. in refugee-camps or in war zones with numerous unburied corpses). Given those circumstances public authorities are seldom capable of maintaining surveillance networks and enforcing mitigation and containment measures (e.g. contact tracing) which are key for preventing large-scale outbreaks within an already highly vulnerable and challenged population. If a disease like COVID-19 is introduced into such a population an uncontrolled spread and devastating consequences for the society are highly likely. In addition, in some conflict areas external/international help is either unwanted by the public (due to previous bad subjective experience or disinformation campaigns) or prohibited by local authorities/conflict parties. In certain conflicts the emergence of an infectious disease might also be used as a "natural" bioweapon by only protecting selected (ethnic/political) groups or not protecting the population of opponent's areas.

If countries want to help areas with on-going conflicts, they should keep in mind aspects like:

- Necessity and difficulty of maintaining **clear and transparent communication** (e.g. cultural/social barriers, distrust in existing governmental structures, disinformation campaigns orchestrated by conflict parties, the disease might be considered a less important problem compared to everyday risks within a warzone)
- Necessity of a **minimum stability** within the area to send civil personnel. A robust mission with mostly military personnel comes with additional difficulties and is usually not possible without major political consequences and planning. In addition, a military operation can negatively affect the public's willingness to accept foreign help.
- Allowing a virus to spread within war zones can on the one hand put an unbearable burden on already heavily challenged populations, on the other hand it can foil the plan of global containment of the pandemic if the virus is allowed to become **endemic** in the affected population due to possible **global re-infections**.

Country in Focus Somalia

SOMALIA – COMPLEX EMERGENCY

DEMOGRAPHIC

AREA:	637.657 km ²
POPULATION:	11.031.386
CAPITAL:	Mogadishu
AGE STRUCTURE:	0-14 years: 42.87%
	15-24 years: 19.35%
	25-54 years: 31.23%
	55-64 years: 4.35%
	65 years and over: 2.19%



Area controlled by Somalia shown in dark green; claimed but uncontrolled Somaliland (a self-declared but unrecognized state) shown in light green. n.b., zones of control are approximate at this time.

SMALL HISTORY

After the Middle Ages Sultanates in the late 19th century, Somalia was colonized by European powers, first by Germany, and then later by Britain and Italy when the Germans abandoned their efforts in 1890. The British and Italians established the colonies of *British Somaliland* and *Italian Somaliland*. In 1960, the two regions united to form the independent Somali Republic under a civilian government. The Supreme Revolutionary Council seized power in 1969 and established the Somali Democratic Republic, which collapsed 22 years later, in 1991, with the onset of the Somali Civil War. The Transitional Federal Government (TFG) was established in 2004, which reestablished the military. In 2006, the TFG assumed control of most of the nation's southern conflict zones from the newly formed Islamic Courts Union (ICU). These radical groups such as Al-Shabaab battled the TFG and its allies for control of the region. By mid-2012, the insurgents had lost most of the territory that they had seized, in

the same year the Federal Government of Somalia was formed and a period of reconstruction began in Mogadishu. (*Source. Wikipedia*)

POLITICAL BACKGROUND

The first cases of infection have also appeared at a time of heightened political tension over forthcoming parliamentary and presidential election in November 2020. Opponents of the president worry that he might exploit virus fears to put off elections, as a way of staying in office past his term's expiry. The coronavirus's onset risks undermining Somalia's recent progress toward debt relief, and it could also tempt the Al-Shabaab insurgency to step up attacks and might pose the renewal of civil war. The Somali government should take care not to add a political crisis to the public health emergency.

NUMBERS AT A GLANCE

5.2 million People in Somalia requiring humanitarian assistance

1.6 million People in Somalia likely to experience crisis or emergency levels of acute food insecurity

2.6 million number of IDPs in Somalia

763,936 Somali refugees in neighboring countries

As of today **1421** people infected with COVID 19, and **56** COVID 19 related deaths were reported.

COVID-19 IMPACT AND RESPONSE

Following the first laboratory-confirmed case of COVID-19 in mid-March, the Government began introducing policies aimed at curbing the spread of the disease, such as closing the country's borders with Ethiopia and Kenya, suspending domestic passenger flights and international travel, restricting large gatherings of people, and shuttering schools, according to international media reports.

On April 23, the UN released a COVID-19 Country Preparedness and Response Plan to scale up public health preparedness and response activities and respond to the humanitarian and socioeconomic impacts of COVID-19 in Somalia during the next six to nine months. These require \$232.000.000 for the public health preparedness and response and immediate humanitarian response components of the plan. In accordance with the plan, the Government and relief actors started to train health workers, strengthen infection prevention and control protocols, establish isolation centers, deploy health providers to ports of entry, and implement risk communication and community engagement activities.

Given that the majority of confirmed COVID-19 cases have been attributed to community transmission, public health specialists are also scaling up testing, diagnosis, and contact tracing to contain the spread of the disease. Despite COVID-19 preparedness and response efforts to date, only one laboratory in Somalia's capital city of Mogadishu had sufficient capacity for COVID-19 testing and diagnosis. Additionally, less than 20 percent of health facilities have adequate supplies to manage a COVID-19 outbreak, and only two health workers are available per 100,000 people in Somalia, according to the UN.

The significant IDP populations, especially IDPs sheltering in overcrowded, makeshift camps face limited access to health care services, safe drinking water, and hygiene supplies, increasing transmission risks could contribute to the spread of COVID-19 across Somalia. Therefore, Relief actors continue to coordinate with government authorities to respond to acute health and WASH (water, sanitation and hygiene) needs across Somalia.

Additionally, they are continuously working on to ensure ongoing emergency food and nutrition needs in Somalia are met, including pivoting resources to incorporate appropriate COVID-19 prevention measures.

FLOODING

Since April 20, heavy seasonal rainfall has significantly elevated river levels and resulted in flash floods and riverine flooding in southern Somalia, including for instance in parts of Mogadishu and the semi-autonomous region of Puntland. As of April 24, floods had destroyed the shelters of 81,000 people in more than 70 IDP camps across Somalia. Flooding has also damaged property, destroyed crops in low-lying areas, and damaged or flooded latrines in affected areas, increasing the risk of cholera and other waterborne diseases. Emergency needs among affected populations include access to food, health care services, and safe drinking water, as well as livelihoods, shelter, and WASH assistance.

Experts anticipate further moderate-to-heavy rainfall in the highlands of south-eastern Ethiopia and south-central Somalia in the coming weeks, increasing the risk of additional riverine flooding along parts of the rivers.

FOOD SECURITY AND NUTRITION

Despite above-average crop yields and an improvement in livestock production, more than 1.6 million people in Somalia will likely experience higher levels of acute food insecurity from June through September. The increase is due to the impact of seasonal flooding during the gu rains, as well as locust-related damage to crops and pastureland. The estimate does not account for the effects of COVID-19 on food security. In addition, approximately 963,000 children younger than five years of age could face acute malnutrition.

As of mid-February, desert locusts had caused 2 percent of main season crop losses, though off-season crops remained unaffected. While the impact of locust infestations remained limited and localized as of mid-April, new

swarms of locust could threaten food security in northern Somalia and in south-central areas located along the country's borders with Ethiopia and Kenya in the coming months. Overall, locusts could damage up to 19,000 metric tons (MT) of cereal crops produced during the harvest—an amount of food sufficient to support an estimated 281,000 people for six months.

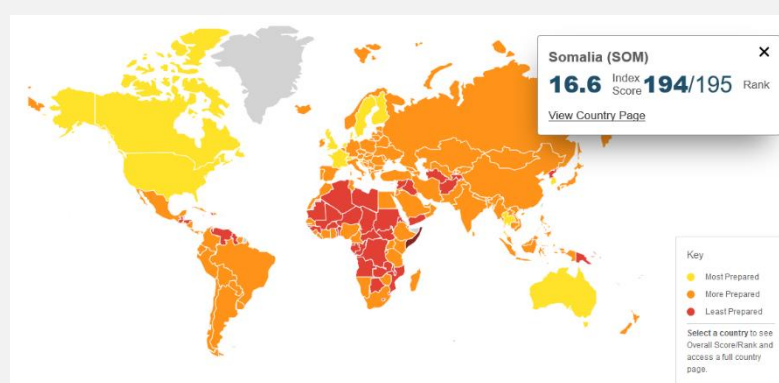
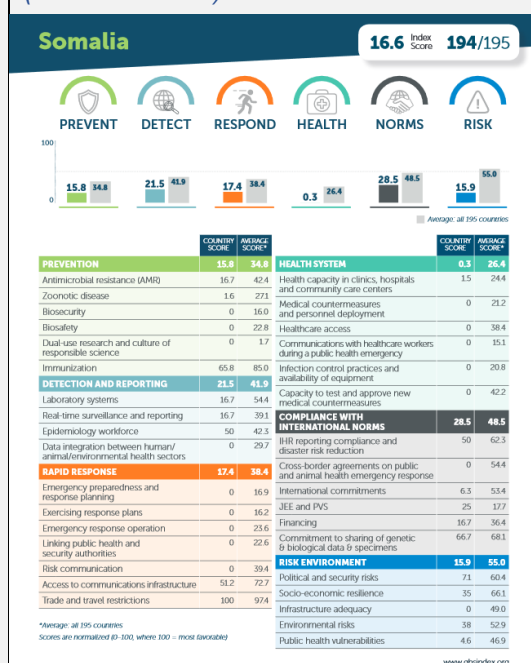
Meanwhile, the COVID-19 pandemic could further exacerbate food insecurity in Somalia by disrupting domestic market supply chains and household food and income sources.

INSECURITY AND POPULATION DISPLACEMENT

Conflict continues to drive displacement in Somalia, with armed clashes displacing approximately 56,000 people. Most displaced individuals fled to nearby villages, sheltering in makeshift dwellings or with relatives or clan members. Separately, clashes between the Somali National Army (SNA) and al-Shabaab displaced approximately 8,000 people from Janaale town in mid-March.

Overall, an estimated 2.6 million people remain displaced across Somalia due to ongoing conflict, as well as the effects of climatic shocks, including recurrent drought and flooding.

(Source: USAID)



Recommendations	
Recommendation for international business travellers	<p>As of 11 April 2020, 167 countries, territories and areas have implemented additional health measures that significantly interfere with international traffic.</p> <p>The majority of measures taken by WHO Member States relate to the denial of entry of passengers from countries experiencing outbreaks, followed by flight suspensions, visa restrictions, border closures, and quarantine measures.</p> <p><u>In the case of non-deferrable trips, please note the following</u></p> <ul style="list-style-type: none"> • Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules. • Check your national foreign office advices for regulations of the countries you're traveling or regulations concerning your country. • Information's about the latest travel regulations and De-escalation strategy measures you can find at IATA and International SOS. <p><u>Most countries implemented strikt rules of contact reduction:</u></p> <ul style="list-style-type: none"> • Everyone is urged to reduce contacts with other people outside the members of their own household to an absolutely necessary minimum. • In public, a minimum distance of 1.5 m must be maintained wherever possible. • Staying in the public space is only permitted alone, with another person not living in the household or in the company of members of the own household (for most countries, please check bevor traveling). • Follow the instructions of the local authorities. <p>General recommendations for personal hygiene, cough etiquette and keeping a distance of at least one metre from persons showing symptoms remain particularly important for all travellers. These include:</p> <ul style="list-style-type: none"> • Perform hand hygiene frequently. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if hands are not visibly soiled; wash hands with soap and water when they are visibly soiled; • Cover your nose and mouth with a flexed elbow or paper tissue when coughing or sneezing and disposing immediately of the tissue and performing hand hygiene; • Refrain from touching mouth and nose; See also: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public • <u>A medical mask is not required if exhibiting no symptoms, as there is no evidence that wearing a mask – of any type – protects non-sick persons.</u> If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal. • WHO information for people who are in or have recently visited (past 14 days) areas where COVID-19 is spreading, you will find here. <p>People returning from affected areas (= countries, provinces, territories or cities experiencing ongoing transmission of COVID-19, in contrast to areas reporting only imported cases) should self-monitor for symptoms for 14 days and follow national protocols of receiving countries. Some countries may require returning travellers to enter quarantine. If symptoms occur, such as fever, or cough or difficulty breathing, persons are advised to contact local health care providers, preferably by phone, and inform them of their symptoms and their travel history.</p> <p>Source: WHO</p>
WHO recommendation	<p>WHO has published guidance on adjusting public health and social measures for the next phase of the COVID-19 response. Some governments have suggested that the detection of antibodies to the SARS-CoV-2, the virus that causes COVID-19, could serve as the basis for an "immunity passport" or "risk-free certificate" that would enable individuals to travel or to return to work assuming that they are protected against re-infection. There is currently no evidence that people who have recovered from COVID-19 and have antibodies are protected from a second infection.</p> <p>At this point in the pandemic, there is not enough evidence about the effectiveness of antibody-mediated immunity to guarantee the accuracy of an "immunity passport" or "risk-free certificate." People who assume that they are immune to a second infection because they have received a positive test result may ignore public health advice. The use of such certificates may therefore increase the risks of continued transmission. As new evidence becomes available, WHO will update this scientific brief.</p> <p>Further information: https://www.who.int/news-room/commentaries/detail/immunity-passports-in-the-context-of-covid-19</p>

EU recommendations	The European Commission released a guideline with “ EU recommendations for testing strategies ” and “ EU recommendations for community measures ”. The first document talks about whom to test in the EU and the Do and Don’t. The latter give a guiding when to initiate and when to end community measures as well talks about social distancing and infection and control measures and when to introduce lockdown measures. A third guidance talks about safe return to workplaces; “ EU guidance for a safe return to the workplace ”.
US recommendations	United States Department of Defence released a guideline with COVID-19 practice Management for Clinical management of COVID-19 find here .

Risk Assessment	
Global	<ul style="list-style-type: none"> Because of global spread and the human-to-human transmission the high risk of further transmission persists. Travellers are at high risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks. Individual risk is dependent on exposure. National regulation regarding travel restrictions, flight operation and screening for single countries you will find here. Official IATA changed their travel documents with new travel restrictions. You will find the documents here. Public health and healthcare systems are in high vulnerability as they already become overloaded in some areas with elevated rates of hospitalizations and deaths. Other critical infrastructure, such as law enforcement, emergency medical services, and transportation industry may also be affected. Health care providers and hospitals may be overwhelmed. Appropriate to the global trend of transmission of SARS-CoV-2 an extensive circulation of the virus is expectable. At this moment of time, asymptomatic persons as well as infected but not sickened persons could be a source of spreading the virus. Therefore, no certain disease-free area could be named globally.
Europe	<p>ECDC assessment for EU/EEA, UK:</p> <ul style="list-style-type: none"> Risk of sever disease associated with SARS-CoV-2 infection for general population: currently considered low in areas where appropriate physical distancing measures are in place and/or where community transmission has been reduced and/or maintained at low levels and moderate in areas where appropriate physical distancing measures are not in place and/or where community transmission is still high and ongoing. and very high for older adults and individuals with chronic underlying conditions. Risk of sever disease associated with SARS-CoV-2 infection in populations with defined factors associated with elevated risk for COVID-19: currently considered moderate in areas where appropriate physical distancing measures are in place and/or where community transmission has been reduced or maintained at low levels and very high in areas where appropriate physical distancing measures are not in place and/or where community transmission is still high and ongoing. Risk of resurgence of sustained community transmission: currently considered moderate if measures are phased out gradually and accompanied by appropriate monitoring systems and capacities, with the option to reintroduce measures if needed, and remains very high if measures are phased out without appropriate systems and capacities in place, with a likely rapid increase in population morbidity and mortality.

References:

- European Centre for Disease Prevention and Control www.ecdc.europe.eu
- World Health Organization WHO; www.who.int
- Centres for Disease Control and Prevention CDC; www.cdc.gov

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