**Update 24 (16th of June 2020)**

**Information about Infection disease**
**COVID-19 (novel coronavirus)**

**Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich**
**16th of June 2020**
email: info.dhsc@coemed.org

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

- After 56 days of no reported confirmed COVID-19 cases or asymptomatic infections in Beijing, People's Republic of China, a local case of COVID-19 with no known travel history or contact with a case was reported on 11 June.
- **FDA**: has revoked its emergency use authorization for the drugs hydroxychloroquine and chloroquine for the treatment of Covid-19. After reviewing the current research available on the drugs, the FDA determined that the drugs do not meet "the statutory criteria" for emergency use authorization as they are unlikely to be effective in treating Covid-19 based on the latest scientific evidence, the agency noted on its website on Monday.
- **UN:** the corona pandemic threatens to force millions of girls and boys into child labor again. After around two decades of decline, the worldwide level of employment of minors could increase again, UN organizations warned on World Day against Child Labor. The International Labor Organization (ILO) and the child support organization Unicef emphasized that the corona pandemic is leading to increasing poverty and falling family incomes. Increased child labor is often seen in tense economic situations. Children who have already gone to work would have to do this longer or do more dangerous jobs. Worldwide, 152 million girls and boys aged between five and 17 would still have to work.
- **ECDC:** published a guidance on infection prevention and control of COVID-19 in migrant and refugee reception and detention centres in the EU/EEA and the UK. The main objective of this guidance is to provide scientific advice on public health principles and considerations for infection and prevention control of COVID-19 in migrant and refugee reception and detention centres.
- **WHO:** has also carefully investigated the risks of women transmitting COVID-19 to their babies during breastfeeding. Based on the available evidence, WHO's advice is that the benefits of breastfeeding outweigh any potential risks of transmission of COVID-19.
- **FHP Branch** started to organize a weekly VTC on "COVID-19 response" next VTC will take place on Wednesday,17th of June focusing on **"COVID 19 Second Wave prediction and preparedness base on facts/experiences, modelling and simulation".**

| GLOBALLY |
|---|
| **7 986 444** confirmed cases<br>3 847 732 recovered<br>436 467 deaths |
| **EU/EEA and the UK** |
| **2 354 046** confirmed cases<br>**1 272 876** recovered<br>**187 941** deaths |
| **USA ↘ (new cases/day 21 945)** |
| **2 107 572** confirmed cases<br>**576 082** recovered<br>**115 962** deaths |
| **Brazil ↘ (new cases/day 25 124)** |
| **888 271** confirmed cases<br>**477 709** recovered<br>**43 959** deaths |
| **Russia ↘ (new cases/day 8 634)** |
| **536 484** confirmed cases<br>**284 021** recovered<br>**7 081** deaths |
| **UK ↘ (new cases/day 1 351)** |
| **296 857** confirmed cases<br>**not reported** recovered<br>41 736 deaths |
| **India ↗ (new cases/day 9 508)** |
| **332 424** confirmed cases<br>**169 798** recovered<br>**9 520** deaths |

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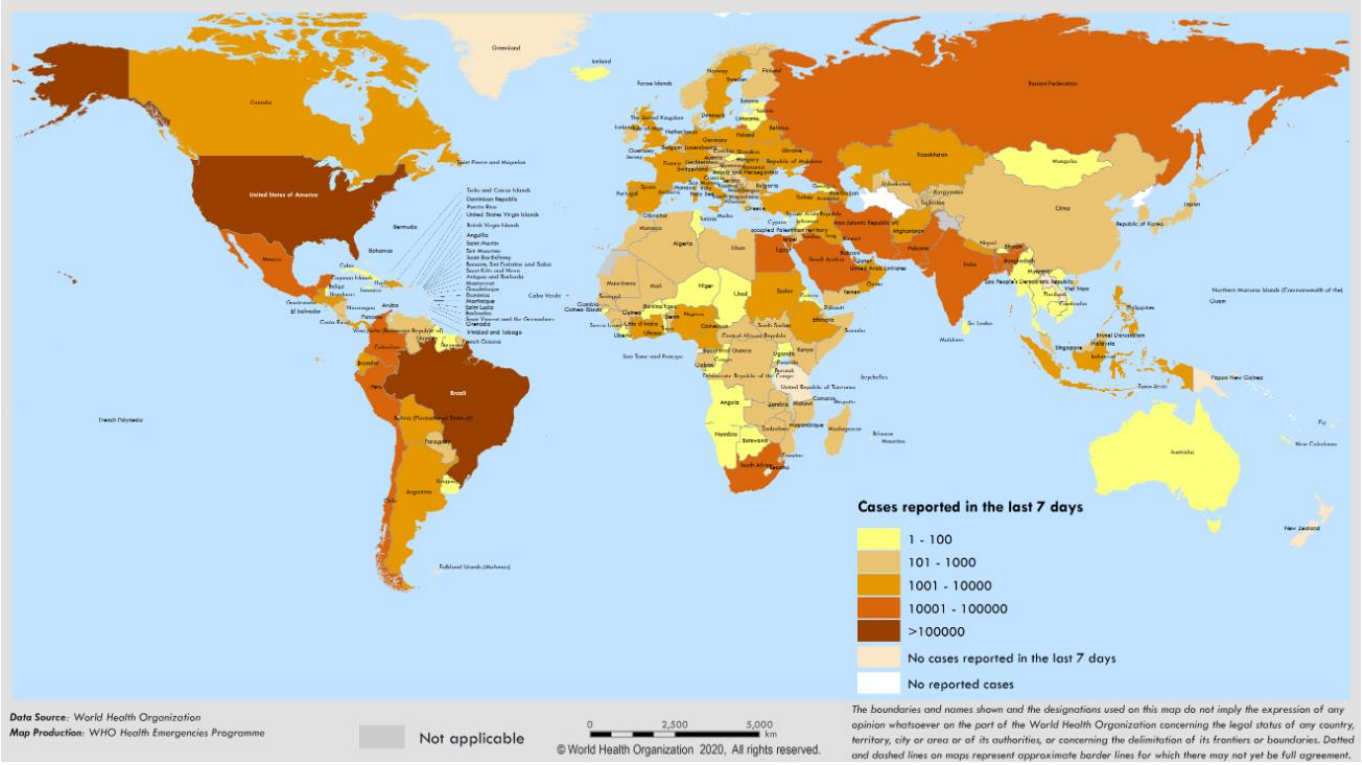
# Map of countries with reported COVID-19 cases (last 7 days)



## Worldwide Situation

Global Situation

**A cluster of COVID-19 in Beijing, People's Republic of China (WHO press release)**

After 56 days of no reported confirmed COVID-19 cases or asymptomatic infections in Beijing, People's Republic of China, a local case of COVID-19 with no known travel history or contact with a case was reported on 11 June.

From 11-14 June, 77 symptomatic laboratory-confirmed cases have been identified related to the cluster in Beijing, including two cases who travelled to Liaoning Province. An additional 46 laboratory confirmed cases, reported without symptoms, have been identified through active screening in the area. The initial symptomatic cases were identified from presentation at six fever clinics and most of the initial cases were linked to the Xinfadi Market in Beijing.

As of 14 June, WHO is aware of 40 environmental samples from the Xinfadi market, which have tested positive for SARS-CoV-2 using molecular tests (RT-PCR). Preliminary investigation continue, genetic sequencing from humans and environmental samples is ongoing.

All identified cases are currently isolated and receiving care, depending on clinical presentation, and contacts of all cases, including those without symptoms, are being followed up and tested. The public health response by Chinese officials includes:

- Tracing and monitoring of close contacts of all laboratory conformed cases (regardless of the development of symptoms).
- Six wholesale food markets in Beijing have fully or partially closed operations.
- Those working in Xinfadi Market, those living in the surrounding residential compounds, and those who have visited the Xinfadi Market in the preceding weeks are being traced and will undergo testing.
- Under the Emergency Response framework, some of the local measures that were relaxed had been re-implemented in Beijing.
- Enhanced screening measures implemented at points of entry.

WHO is closely monitoring the situation and is in close contact with national authorities in China.

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**US nursing homes and COVID-19**

As unfortunately worldwide, SARS-CoV-2 has caused many COVID-19 infections in retirement and nursing homes in the United States. By the end of May 2020, approximately 35,000 SARS-CoV-2 deaths had been reported in the facilities, making up 42% of all COVID-19 deaths in the United States.

In the study presented here, the authors not only wanted to record the extent of the infections, but also to determine whether there were different numbers of cases regarding the structure, equipment and organization of the facilities in the previous pandemic.
To this end, over 9,300 nursing homes in 30 states were examined. A good 2,900 of them (31%) had at least one documented case of COVID 19 infection. The average number of infections was just under 20 and facilities in New Jersey and Massachusetts were hardest hit. Depending on the size of the facilities, there were outbreaks of different sizes (up to 256 COVID-19 sufferers in one facility).

The following risk factors for the occurrence of a SARS-CoV-2 case were identified:

- Size of the facility,
- location in the urban environment or area,
- higher proportion of Afro-American residents,
- not a member of an association or a chain of institutions.

However, the following factors have not been associated with increased detection of COVID-19 infections:

- Classification of the institution (1 - 5, as a quality assessment),
- previous hygiene violations / infection problems,
- share of Medicaid (a type of social welfare system that works as a final protection against poverty) dependence and,
- sponsorship (private / state).

**Summary:**


- Old age and nursing homes generally have an increased risk of COVID-19 infections and related deaths due to their older age and / or proportion of underlying diseases.
- The main risks for COVID-19 infection in US nursing homes were the location in certain regions (urban) and the size of the facility.
- The impact of pre-existing hygiene problems on the risk of infection was unexpectedly low.
- Obviously, even facilities with better quality, hygiene and general equipment / personnel standards were overwhelmed by the dynamics and characteristics of the COVID-19 wave of infections.
- To protect the above-mentioned facilities and their residents, it is imperative to reduce the number of contacts / reductions, regular, also occasion-independent testing of residents and staff and a comprehensive hygiene concept with a sufficient amount of personal protective clothing / equipment.


Source: J Am Geriatr Soc. 2020 Jun 2. doi: 10.1111/jgs.16661. [Epub ahead of print], DOI: 10.1111/jgs.16661

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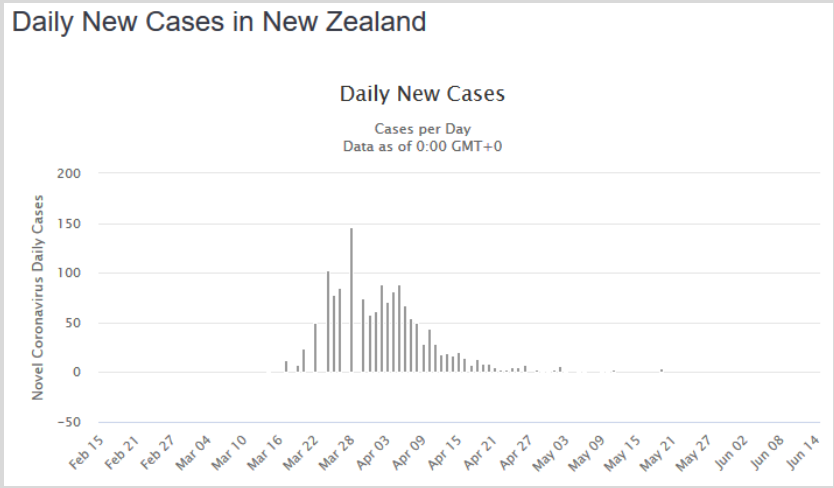
**Countries in focus**

**NEW ZEALAND**: The island nation in Oceania was one of the first countries in the world to declare itself a COVID-19 free zone last week, and there is currently no active case of SARS-CoV-2 infection in the country. In terms of population, NZE is very sparsely populated (17,46 Inhabitants/km$^2$), the extremely low number of infections (1.504), and especially deaths (22), however, are the result of a clear & well-coordinated strategy to contain the pandemic.

- *Early measures*: Strict quarantine rules were imposed in early March, although only 6 cases were reported.
- *Strict restrictions*: Shortly afterwards a 7-week lockdown began, which was one of the hardest in the world, but was always supported by the population.
- *Clear risk communication*: The government is without exception praised by the NZE population for transparent and honest communication; Value was above all emphasizing empathy and cohesion.
- *Comprehensive testing of suspected cases*: The country has rigorously tracked, tested and, if necessary, isolated contact persons for a number of 10 detected infections. As a result, asymptomatic virus carriers could be identified and prevented from spreading further. An additional positive factor was the speed with which the tests were carried out and the cost of the tests by the government.



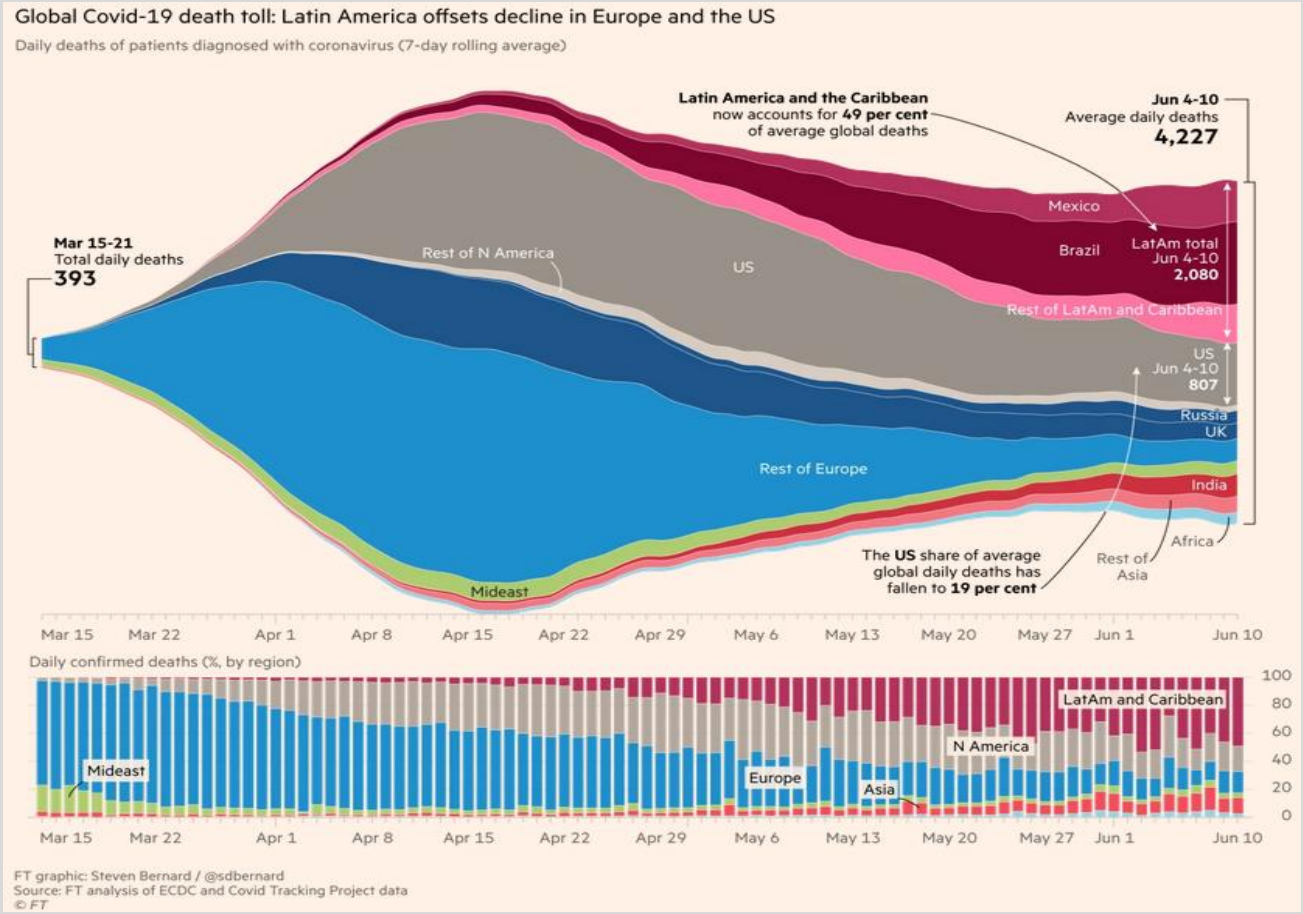

The country has thus completely stopped the transmission of the SARS-CoV-2 within 75 days. Since June all distance and assembly restrictions have been lifted; Clubs, theaters, restaurants and sporting events take place again in the usual way. The price of this success will have to be measured primarily at the economic level, the country's two most important pillars, trade and tourism, have completely come to a standstill, NZE is experiencing the worst recession in years. However, it is becoming apparent that social and public life will quickly return to normal once all restrictions have been lifted. For foreigners, the borders should still be closed in order to prevent the disease from being introduced again.

**AUS**: While AUS was on a similar path, the country experienced a setback in containing the pandemic last week. After a demonstration to support the # BlackLivesMatter movement, a participant was diagnosed with COVID-19 infection. Although the man is said to have worn a mask, it is difficult to track contacts with around 10,000 demonstration participants because the man does not use the Australian government's corona tracing app. It remains to be seen whether the event, as feared, will become the starting point for a second wave as a superspreading event.

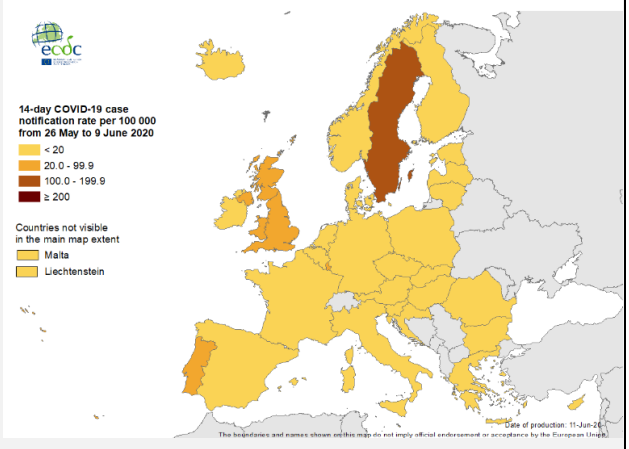
**IND:** The number of Sars-CoV-2 infections in India has increased rapidly in the past few days - with around 10,000 new cases per day. Nevertheless, the country is visibly loosening the measures - offices, religious sites, restaurants and shopping centers are now open again. The lockdown has left millions of people unemployed and many are afraid to starve. Hospital beds are running out in the capital, New Delhi, and the wealthiest city of Mumbai, and reports of people with COVID-19 symptoms have been reportedly turned away.

**Africa**: According to the World Health Organization (WHO), there are now more than 200,000 proven corona cases. In addition, more than 5600 people have died, said the WHO. South Africa is most affected with 25 percent of cases. There are more than 70 percent of deaths in just five countries: Algeria, Egypt, Nigeria, South Africa and Sudan. The Coronavirus Sars-CoV-2 has so far spread relatively slowly on the continent, the total number is still small compared to other regions. The first case occurred later in Africa than anywhere else, and most governments quickly adopted stringent measures. "But the pace of expansion is getting faster," warned WHO chief Matshidiso Moeti.

**CHN**: As of 13 June 10am (CEST), Chinese authorities reported to WHO 12 new confirmed cases, among them 6 in Beijing. The investigation of that cluster of COVID-19 in Beijing associated with a wholesale market continues. As of 14 June, 16:00 (CEST+6), Chinese authorities reported a total of 77 cases since 11 June, including 2 linked cases in Liaoning Province.



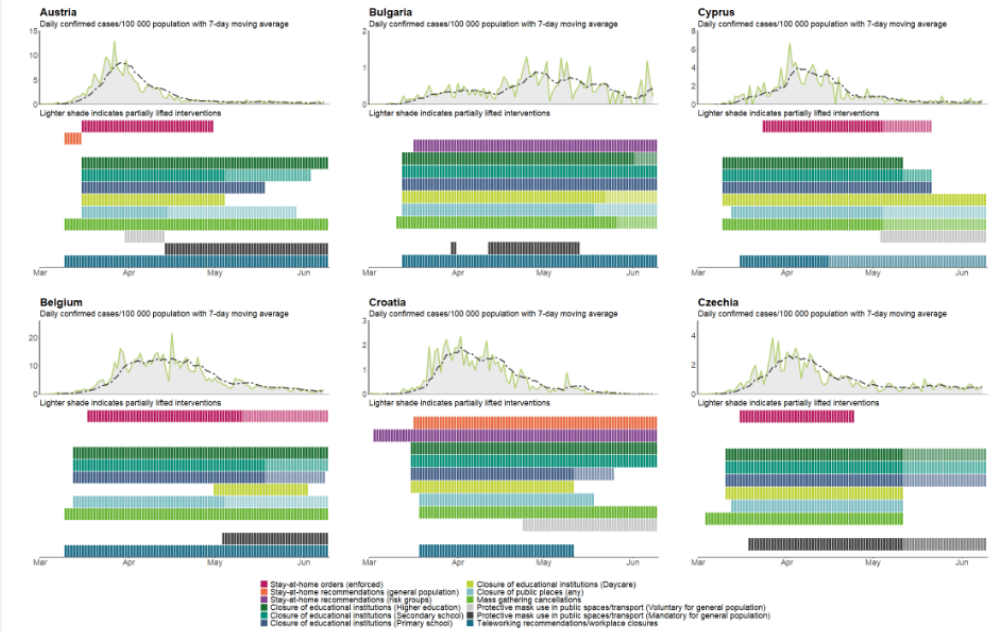
Source: Financial Times

| | |
|---|---|
| Situation in Europe | Since 31 December 2019 and as of 9 June 2020, 7 069 278 cases of COVID-19 have been reported worldwide, including 405 587 deaths. EU/EEA countries and the UK reported 1 444 710 cases (20% of all cases), including 169 207 deaths (42% of all deaths).<br><br>Rapid Risk Assessment: Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK – tenth update; ECDC Executive summary:<br><br>The COVID-19 pandemic is posing an unprecedented threat to EU/EEA countries and the UK and to countries worldwide, many of which have been experiencing widespread transmission of the virus in the community for several months. While decreasing trends in disease incidence are being observed in the EU/EEA and the UK overall, some Member States are still reporting community transmission. In addition, the information available from sero-epidemiological studies suggests that the adaptive immunity of populations remains low.<br><br>The absence of an effective treatment or vaccine, combined with an exponential growth in infections from late February, led many countries to implement non-pharmaceutical interventions, such as 'stay-at-home' policies, alongside other community and physical distancing measures, such as the cancellation of mass gatherings, and the closure of educational institutions, work places and public spaces. This approach has collectively reduced transmission and, as of 9 June 2020, the 14-day incidence in the EU/EEA and the UK overall has declined by 80% since the peak on 9 April. The initial wave of transmission has passed its peak in all countries apart from Poland and Sweden.<br><br>Although these stringent physical distancing measures have reduced transmission, they are highly disruptive to society, both economically and socially. All countries that had implemented enforced 'stay-at-home' orders for the general population have initiated full or partial relaxation of these measures, and several have begun a full or partial re-opening of small retail shops and other public spaces. At the present time, just before the summer holiday period, as Member States relax limitations, there is a risk that people will not adhere firmly to the recommended measures still in place due to 'isolation fatigue'. Therefore, continuous efforts are needed to ensure that the remaining physical distancing and infection prevention control measures continue be observed to limit the spread of the disease. The pandemic is not over, and hypothetical forecasting indicates a rise in cases is likely in the coming weeks.<br><br>• *Updated epidemiological and sero-epidemiological information*;<br>Since 23 April, the largest proportion of global cases and deaths have been in the Americas (53% of cases and 46% of deaths), with fewer in Asia (21% cases, 9% deaths) and in the EU/EEA and the UK (22% cases, 44% of deaths). The proportion of all global COVID-19 cases reported by the EU/EEA and the UK has declined from 41% on 23 April to 14% on 9 June.<br>Of the 459 913 cases reported in the EU/EEA and UK since 23April 34% (158 355) were reported from the UK, 11% (51 321) from Italy, 9% (40 984) from Spain, 8% (38 849) from Germany, 8% (36 864) from France and 6% (29 811) from Sweden.<br>The 14-day incidence remains heterogeneous across EU/EEA countries and the UK, ranging from 0.1 per 100 000 in Croatia to 110.4 per 100 000 in Sweden.<br>Deaths continue to increase in 18 countries.<br><br>Figure 2. Incidence of reported COVID-19 cases/100 000 population in EU/EEA countries and the UK in the last 14 days (26 May–9 June 2020)<br>  <br> |

- *Overview of response measures implemented in the EU/EEA countries and the UK;*

**Annex 4. Response measures in EU/EEA countries and the UK, 3 June 2020**

**Figure D. Daily incidence of reported COVID-19 cases per 100 000 population, daily reported deaths per 1 000 000 population, both with 7-day moving average, and the public health response measures at national level reported from public sources over time**




For more information on other countries click on the picture.

- *Options for response to minimise the risk of resurgence of COVID-19;*
  - A robust monitoring framework to closely monitor the epidemiological situation, rapidly detect increased transmission, assess the impact of the interventions in place and avoid a resurgence of COVID-19
  - An expanded testing strategy aiming for comprehensive testing of all individuals displaying symptoms compatible with COVID-19. In particular, a systematic or more comprehensive testing approach is suggested in high-risk populations or settings. It is suggested that testing should be ramped up and tests made easily and quickly available to all individuals displaying symptoms compatible with COVID-19, including those with mild symptoms. Member States should also consider implementing PCR-based prevalence studies and sero-epidemiological studies to monitor the spread of disease.
  - A framework for contact tracing, based on extensive testing, active case finding, early detection of cases, isolation of cases, quarantine and follow-up of contacts, possibly supported by electronic tools and applications.
  - Long-term sustainable implementation of essential non-pharmaceutical interventions, irrespective of transmission rates, and the ability to amend strategies rapidly in response to indications of increased transmission. Reinstatement or introduction of further measures could be considered at local or regional level, or for specific population groups, depending on transmission patterns. Protection of the most vulnerable and at-risk populations is of paramount importance as they have suffered most of the burden from this pandemic in terms of morbidity, mortality and need for healthcare.
  - A strong risk communication strategy should remind citizens that the pandemic is far from over. People need to be aware that the public health measures to limit the spread of the virus will continue to impact the way we move, work and travel, and our leisure activities for the foreseeable future. This is especially important as Europe moves towards the summer holidays, when changes in people's behaviour, activities and movements may cause people to switch back to pre-pandemic and potentially risky behaviour patterns. Four key risk communication messages are proposed:
    - This is a marathon, not a sprint.
    - We must not drop our guard.
    - We all need to adjust to a 'new normal'.
    - Together, our actions give us the power to control the spread of the virus.

## ECDC COVID-19 surveillance report Week 23, 2020

### Summary of key messages

**New this week**

- Hospital-based SARI surveillance data are now available from Slovenia.
- Multiple countries have updated their ILI and/or ARI syndromic surveillance data.

**Overall reported cases**

- Based on data available to ECDC on 11 June 2020, 29 out of 31 countries (EU/EEA countries and the UK) have observed COVID-19 notification rates lower than at peaks that were observed 35–71 days ago (the average rate for the EU/EEA and the UK was 81% lower than at the peak on 9 April 2020).
- Slight recent increases in COVID-19 notification rates have been observed in four countries (Bulgaria, Poland, Portugal and Sweden), some of which may reflect increases in testing.

**Primary care**

- Among five countries that reported data up to week 23 from primary care sentinel surveillance for COVID-19 using the systems established for influenza, two countries (Sweden and UK-England) have observed recent increasing trends in SARS-CoV-2 positivity among individuals with respiratory symptoms; the remaining three (Estonia, Germany, Netherlands) have observed stable or decreasing trends.
- All countries that reported ILI and/or ARI syndromic surveillance data up to week 23 using the systems established for influenza have observed low and stable recent trends in consultation rates.

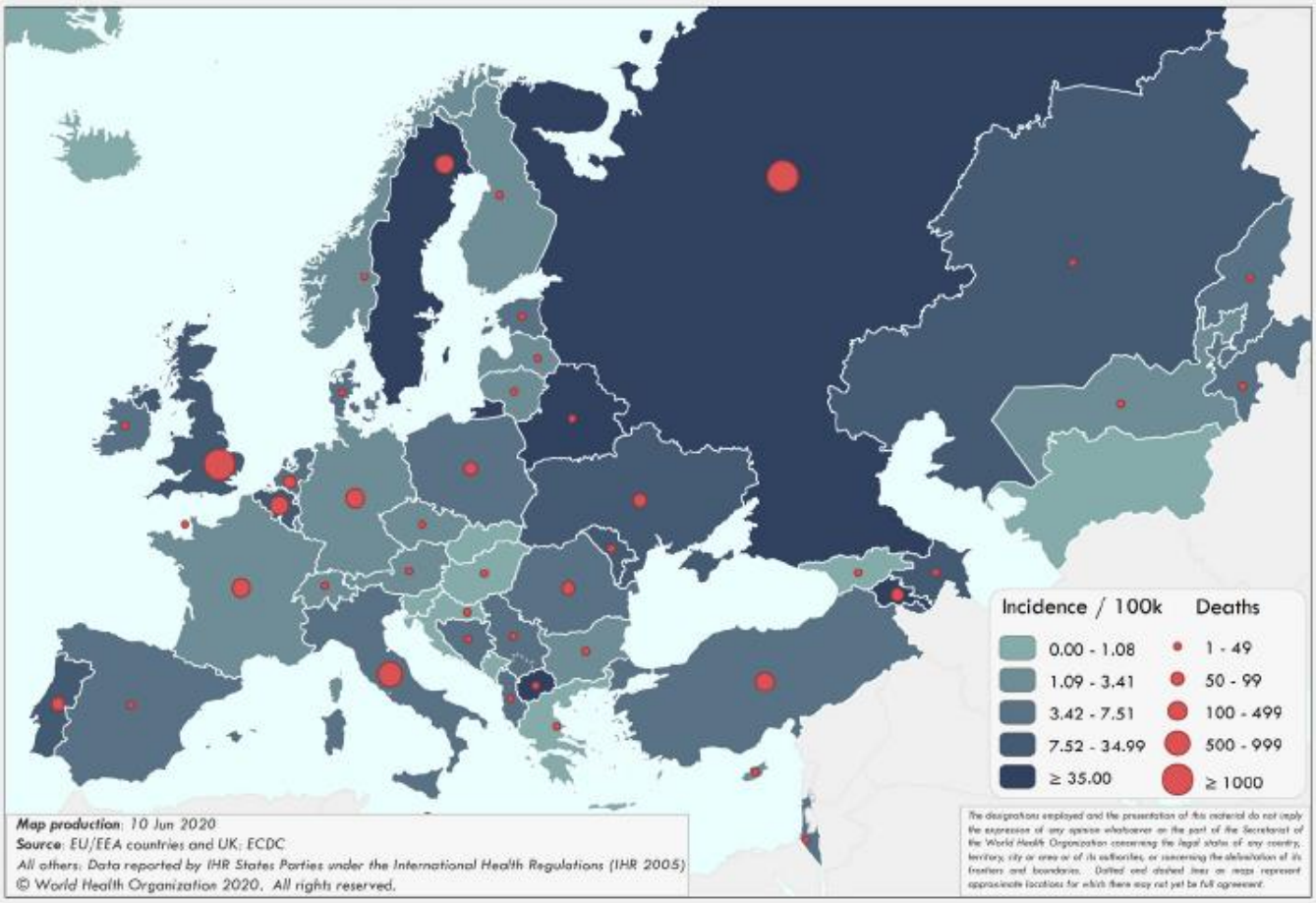
**Hospitalisation**

- Both countries that have reported recent data from in-hospital SARI surveillance (Sweden and Slovenia) have observed stable or decreasing trends in the numbers positive for SARS-CoV-2 and/or SARS-CoV-2 positivity among individuals with SARI.
- Overall, 32% of reported COVID-19 cases in the EU/EEA and the UK to date have been hospitalised; among hospitalised patients, 11% required ICU and/or respiratory support, although there is considerable variation between countries.

**Mortality**

- Reported deaths due to COVID-19 continue to increase in 16 countries, there has been no recent increase in deaths in the last five days in nine countries, and deaths have not increased for at least five days in six countries.
- We estimate that 22% of hospitalised COVID-19 cases reported to date in the EU/EEA and the UK have died.
- Pooled estimates of all-cause mortality reported by EuroMOMO are now approaching normal expected levels following a period of substantially increased excess mortality that coincided with the COVID-19 pandemic peaks. A few countries are still seeing some excess mortality.

## COVID-19 incidence per 100,000 population and number of deaths by country for week 23

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## COVID-19 situation update for the WHO European Region (01 – 07 June 2020 Epi week 23)

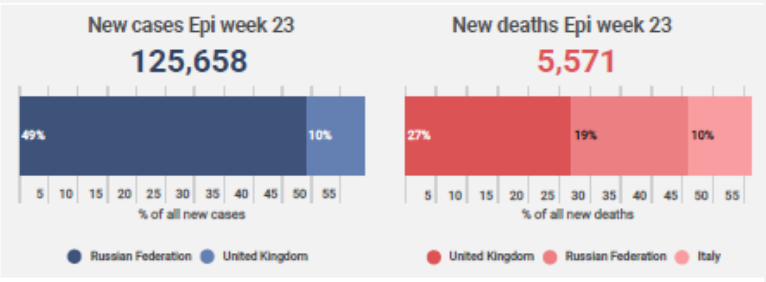
### Key points

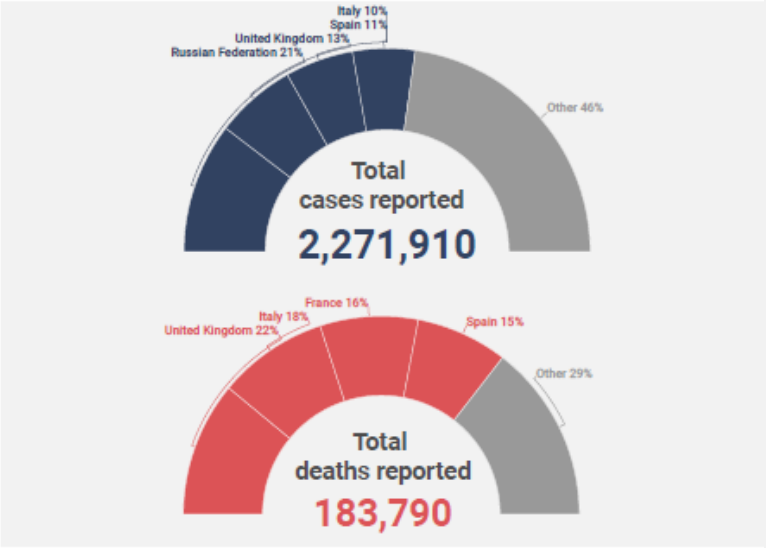
**Week 23/2020 (1 - 7 Jun 2020)**

- The number of cases reported in week 23/2020 in the Region has declined by 51% since week 14/2020
- 58% of the cases reported in week 23/2020 were from the Russian Federation and the United Kingdom
- Six countries had a crude incidence of ≥35 per 100,000 in week 23/2020: Armenia, Andorra, Sweden, Belarus, the Russian Federation, and North Macedonia.
- In 15 countries, the 14-day cumulative incidence increased by ≥10% in week 23/2020 compared to the previous week, however for some countries data was retro-adjusted by national authorities. In order of percentage increase: Andorra, Israel, North Macedonia, Albania, Slovenia, Azerbaijan, Armenia, Kyrgyzstan, France, Sweden, Uzbekistan, Kazakhstan, Portugal, Estonia and the Republic of Moldova (see EURO COVID-19 Dashboard for recent trends )
- 56% of the deaths reported in week 23/2020 were from the United Kingdom, Russian Federation and Italy
- The proportion of reported cases that died increased from 3.2% in week 22/2020 to 4.4% in week 23/2020, a change that is likely due to a range of factors

**Summary overview**

- Seven countries in the Region each reported a cumulative incidence of ≥500 cases per 100,000 population: San Marino, Andorra, Luxembourg, Iceland, Spain, Ireland and Belgium
- 22% 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
- 72% of cumulative deaths were reported from the United Kingdom, Italy, France and Spain
- 94% of all deaths were in persons aged ≥60 years and 57% 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%)
- For the EuroMOMO network as a whole, from week 10, 2020 and as of week 23, over 168,500 excess deaths have been estimated in total, including approximately 154,000 deaths in the age group ≥65 years, 12,500 deaths in the age group 45-64 years and 1,500 deaths age group 15-44 years. This time period includes part of the influenza season as well as the COVID-19 pandemic.
- In week 23/2020, five countries reported a total of 113 tests and 10 COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 22/2020 was 5.2% (7 countries) compared to 5.8% (7 countries) in week 21/2020. The highest positivity was 19.1%, seen in week 15/2020
- As of 28 May 2020, five countries in the European region had an effective reproductive number significantly over 1: Andorra, Azerbaijan, France, Israel and North Macedonia (See EpiForecasts and the CMMID COVID working group COVID-19 Global Summary for latest estimates ).




**22%** of all people infected were health care workers

**95%** of all deaths had at least 1 underlying condition

**57%** 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

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**Figure 3. Percentage of COVID-19 cases (N=795,553) and deaths (N=116,514) by age group**

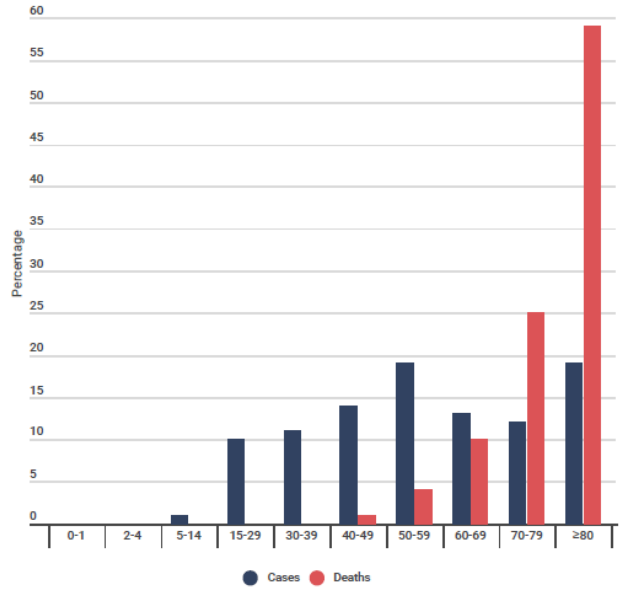


**Table 1. Characteristics of COVID-19 cases and deaths**

| | Characteristics | n | % | Total records with data available |
|---|---|---|---|---|
| Cases | Age in years, median (range)* | 55 (1-105) | | 547,942 |
| | Sex, male* | 253,631 | 46 | 545,898 |
| | Travelled* | 17,614 | 12 | 145,546 |
| | Recovered* | 204,900 | 91 | 225,860 |
| | Health care workers* | 95,361 | 22 | 438,629 |
| | Hospitalization# | 134,567 | 27 | 506,214 |
| | Intensive care unit admissions# | 10,131 | 3 | 388,799 |
| Deaths | Age in years, median (range)^ | 82 (0-108) | | 116,514 |
| | Sex, male^ | 66,682 | 59 | 116,396 |
| | At least one underlying condition^ | 56,570 | 95 | 59,656 |
| | • cardiovascular disease | 18,230 | 65 | 27,842 |
| | • diabetes | 8,868 | 33 | 26,528 |
| | • lung disease | 6,118 | 23 | 26,864 |
| | • neurological disease / dementia | 2,344 | 26 | 9,191 |
| | • renal disease | 1,673 | 20 | 8,427 |
| | • malignancy | 969 | 26 | 3,767 |
| | • obesity | 680 | 9 | 7,349 |
| | • liver disease | 417 | 5 | 8,373 |
| | • immune disease | 258 | 3 | 8,014 |
| | • other | 12,675 | 51 | 24,914 |

*Case report forms (n=550,413);
#Case report forms and aggregated data from Italy (3/4 June) and Spain (28 May 2020) (n=840,354); Health care workers refer to occupation and not to the place of exposure
^Case report forms, mortality survey, aggregated data from Italy (4 June 2020) and Spain (28 May 2020) (n=116,541)

**Figure 4. Percentage of COVID-19 cases (N=791,237), hospitalizations (N=140,630), ICU admissions (N=12,725) and deaths (N=116,378) by age group and sex**

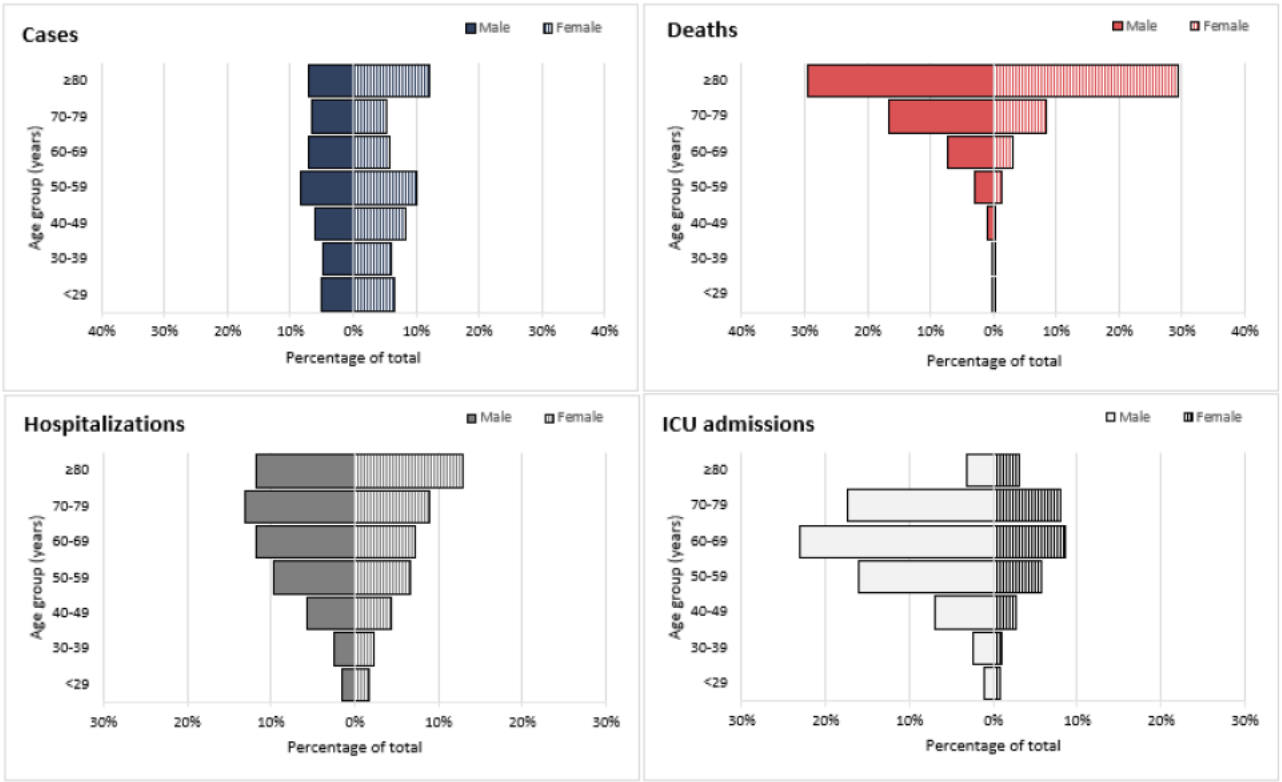


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**Figure 1: Number of COVID-19 cases (N=2,271,910) and deaths (N=183,790) by reporting week**

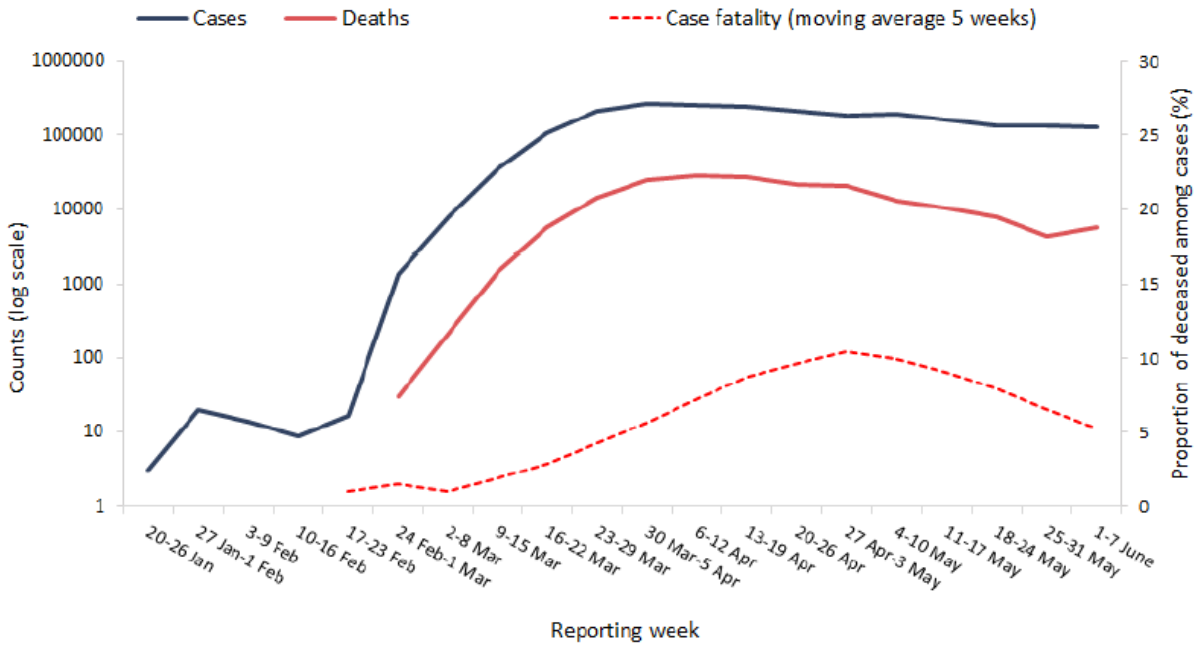
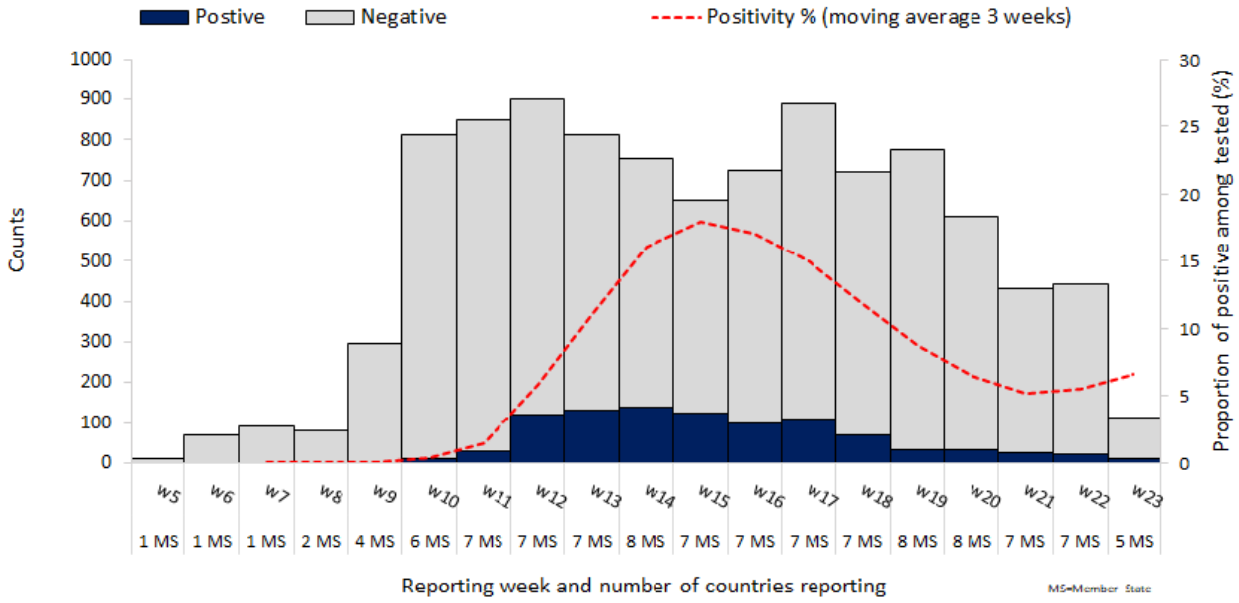
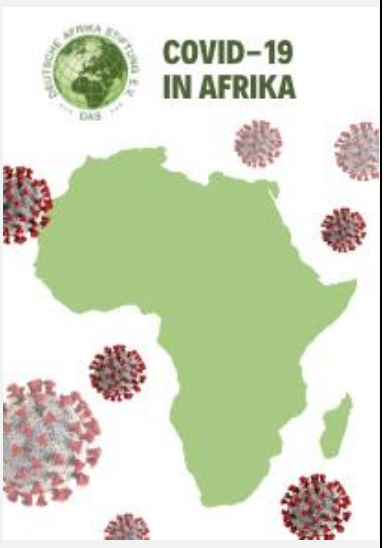



**Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week**



## Subject in Focus

COVID-19 impact in Africa




As a continent which is torn by civil wars, hunger, and diseases like AIDS and TB as well as Ebola Virus Disease Africa was expected to be the next hotspot of the Coronavirus pandemic. According to a 2016 report by the Rand Corporation, there are 25 countries most vulnerable to infectious diseases: Of these 25, 22 are African countries, only Afghanistan, Yemen, and Haiti are located elsewhere.

The African under-investment in health systems, interwoven with a multitude of underlying medical conditions, malnutrition and potential genetic risk characteristics suggests that a surge of COVID-19 cases should be anticipated. Even though the currently observed numbers on COVID-19 for Africa reflect low rates of transmission, this can be attributed to a multitude of factors, including lack of testing and attribution to other maladies. However, modelling by the World Health Organization (WHO) predicts a lower rate of transmission and viral spread across the continent than elsewhere due to lifestyle and age (younger population) factors.

There are serious concerns for African countries' ability to keep the disease under control. Some questions that have been raised:

- Is the number of cases being reported in Africa a valid representation of the situation?
- Do African health systems have the capacity to control the pandemic?
- What is next for Africa as the number of confirmed cases continues to increase albeit gradually?

There is a lack of isolation and intensive care infrastructure, ventilators, and financial resources to bankroll the fight against COVID-19 pandemic. Testing capacities are less, lockdown measures and social distancing not easy to implement. The virus has been reported in 54 African countries, and although case fatality rates remain low, the world is watching Africa's preparedness and response. But until now Africa seems to be less stricken by the pandemic than other continents.

**Current status**

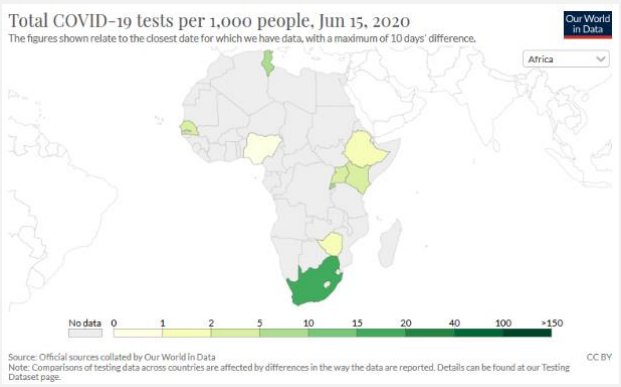
Africa confirmed the first case of COVID-19 in Egypt on 14th February 2020. Nigeria reported the first case for sub-Sahara on 27th February. The number of confirmed cases has risen to 173,000 by 15th June 2020. South Africa stands as the most affected African country with 70,038 confirmed cases with Nigeria (16,085), Ghana (11,422) and Algeria (10,919) following. The WHO has warned that potentially 83,000 to 190,000 people in Africa could die of COVID-19 and 29 million to 44 million could get infected in the pandemic's first year if containment measures fail.

**African response**

As Africa's economies are largely informal, people are living hand-to-mouth and so the imposed lockdowns affected most households as their possibilities to generate income was demolished. In addition, infrastructure in most communities does not allow for adequate social distancing and basic hygiene due to overcrowding and limited (access to) clean water. Even though the governments implemented measures like airport screening and adopted mitigation efforts like hand washing, social distancing, and stay at home lockdowns quickly and with a broad scope, they are now under increasing pressure to lift these measures and reopen economies again. In east Africa controversial political discussions, mistrust and limited epidemiological data complicate the response.

### Testing capacity

Most African countries have surveillance and laboratory capacities that are not sufficient to perform testing to the extent necessary to fight COVID-19. This is coupled with limited fiscal support to acquire external testing capacities or to build the diagnostic capacity necessary to decentralize testing. Some countries highly depend on donor aid to supplement public health budget and were only able to start testing after receiving donated kits. Additionally, testing is not universally accepted. Tanzanian authorities for example denied the validity of WHO recommended testing platforms and test kids.




### Under-funded health systems

The economic conditions of almost all African countries will have a huge impact on how far and how quickly the disease spreads. 85% of Africans survive on less than USD 5.50 per day, so there is no possibility to save some money. The lack of adequate hygiene and sanitation offers a breeding ground for the disease. There are many factors that, coupled with the weak health system, can have a huge impact on the course of the disease on the continent. Not to forget: those countries that have experience with offering help to Africa currently also struggle with controlling the pandemic and its economic impact themselves.

Health systems in some parts of Africa have been strained in the past few decades due to the high prevalence of HIV and TB. Sub-Saharan Africa accounts for more than 70% of the global burden of HIV infection. Africa has experienced infectious disease outbreaks over the last decades. In 2018, a total of 96 new infectious disease outbreaks were reported across 36 of the 47 member states of WHO Africa. The Democratic Republic of Congo (COD) had a prolonged Ebola virus disease (EVD) outbreak that hit West Africa between 2013 and 2016 and again in 2018 (which is still ongoing), aggravated by weaknesses in the health system. Currently DRC faces both a major measles outbreak and the new COVID-19 pandemic. For countries with ongoing or recently ended outbreaks managing the COVID-19 pandemic is challenging due to lack of manpower, infrastructure, and financial resources

### *African health system's capacity to contain the pandemic*

There are different problems for the African health systems. They failed in the past to contain other communicable diseases such as cholera and malaria. Accessibility to hospitals is also a major challenge. South Africa, a country with one of the best health systems in Africa, has less than 1,000 Intensive Care Unit (ICU) beds for the country's 56 million people, while Kenya, a country of nearly 50 million people, has a total of approx. 200 ICU beds. In comparison, the USA have 34 ICU beds per 100,000 people but are still struggling.


A shortage of ventilators has already been experienced by most of those African countries that are extremely affected by this pandemic. That is a special challenge as the standard reaction to COVID-19 is supportive care as there are no specific treatments yet. The same problems exist with the availability of personal protective equipment (PPE) which is necessary to adequately treat a COIVD-19 patient but is not available everywhere (and can't be easily purchased on the global market as high demand is leading to a massive increase in prices). Countries trying to focus on prevention and detection to avoid overwhelming the countries' health systems.

Another problem is that most African countries import more than 70% of all their drugs. These drugs are imported mainly from India, Europe, and from the US. With countries thinking about imposing export bans for drugs to secure their own supply, the continent may faces a shortage of basic and essential medication in the (near) future.

### *Lessons learned and preparation due to previous epidemics*

Epidemics are nothing new to Africa. HIV, Malaria or Ebola are big challenges for the society, governments and health authorities but they made the continent learn some of its lessons on how to tackles epidemics such as national and local preparedness capabilities, surveillance systems, isolation, quarantining, and diagnostic testing.

During the Ebola outbreak there was considerable infrastructure investment and the local population unlike in other countries not affected by EVD got arguably more used to public health measures and quarantines. So that in West Africa the infrastructure like diagnostic testing facilities, intensive care units, surveillance, and systems for reporting emergencies built up for the fight against EVD can be leveraged to fight the COVID-19 pandemic.

In Nigeria, local preparedness was enhanced by the availability of resources meant for fighting the wild poliovirus. The polio infrastructure includes laboratory services, surveillance, risk communication, and human resources.

### *Benefits and threats*

Data from affected other countries, among them Italy, Spain, and China, shows that people above the age of 65 are more vulnerable. Africa is the world's youngest continent; 60% of the entire continent's population is younger than 25. The median age in Africa is 19.7 years. This could act to Africa advantage in terms of lower death rates.

Another aspect that is discussed as maybe increasing the chance for a low number of total cases in Africa, is the fact that a high percentage of the African population is already using antiviral drugs due to a HIV infection or Ebola and is somehow prevented from getting the disease. The immune response to COVID-19 is improved for HIV positive persons with treatment, and it may help prevent the onset of Cytokine Release Syndrome or progression to severe respiratory failure. But at present there is no evidence that the risk of infection or complications of COVID-19 is different among HIV positive person who are clinically and immunologically stable on anti-retroviral treatment compared to the general population.

Africa has many infectious and parasitic diseases, which can co-infect and exacerbate COVID-19 infection. Non-communicable diseases are also often un-/misdiagnosed and remain untreated. Malaria and HIV share symptoms with COVID-19, increasing the rate of misdiagnosis and complicating treatment. As signs and symptoms of malaria and COVID-19 can overlap the public health messages will need to be adapted in malaria-endemic settings so that people who have a fever are encouraged to seek immediate treatment rather than stay at home. On the other hand, lymphopenia seen in patients with COVID-19 may increase vulnerability to malaria, TB and other infections.

In Some countries the impact of coronavirus on the black community and other ethnic groups has been higher than to the white community. Studies showed that the difference between ethnic groups in COVID-19 mortality is partly a result of socio-economic disadvantage and other circumstances, but the remaining difference has not yet been explained. Genetic risk factor studies that focus on ethnic groups and gender are on-going. There is a known genetic predisposition to cardiovascular disease in African Americans and these findings are being linked with an increased risk of death from COVID-19.

### Conclusion:

WHO modelling predicts slower transmission across Africa due to social-environmental factors and a younger population who may also be benefitting from well-practiced pandemic controls.

COVID-19 is therefore unlikely to be as prevalent in Africa as it has been in Europe, but once older people are infected, their outcomes are significantly less promising compared to their counterparts in Europe.

Source: COVID-19: A Perspective on Africa's Capacity and Response; Dzinamarira et al.
COVID-19 – Implications for Africa; NATO JCBRN Defence COE

## MilMed CoE VTC COVID-19 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.<br><br>**Topics former VTCs:**<br>• 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.<br>• Testing strategies<br>• Aeromedical evacuation<br>• De-escalation strategy and measures<br>• Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases<br>• Immunity map, national strategies to measure and evaluate the immunity level"<br>• Mental Health<br>• Treatment of mild symptomatic cases of COVID-19<br>• Transition home office back to the office |
| Transition home office back to the office | **Summary of the Briefings (ACO, MARCOM, NATO MILMED COE)**<br><br>**ACO:**<br>3 phases or tiers.<br>Each tier is advised to be in effect for at least 3 weeks before moving forward with the next tier.<br>The proposal to move to the next tier is following a silence procedure.<br><br>Key points:<br>• Tier 3 will be in place for quite long (probably)<br>• The summer season also accommodates this.<br>• Continuous disinfection is ongoing.<br>• Testing is reserved to trace possible contacts of positive cases.<br>• 10% of manning kept in telework as reserve personnel.<br>• Shifts in daily starting time was introduced to avoid crowds at the entrance.<br>• In big offices plexi-glass dividers are installed.<br><br>Challenges:<br>• Mask policy, distancing<br>• Summer rotation plan: over 400 families are moving in and out of SHAPE campus.<br>• SHAPE has 11 schools. All being advised but have their own regulations.<br><br>**MARCOM:**<br>Early understanding of the speciality of the COVID as a new disease.<br>In pre-pandemic period -January-February was important. Information on COVID is available and preventive measures are put in place.<br>NATO operations to recue migrants – largely falls on Navy assets.<br>Port visits are a risk – when to go to shore or when to go aboard.<br>Main concept is to avoid all unnecessary risks.<br><br>It is important not to overwhelm HN healthcare system with the HQ sick.<br>Any sick or suspected person is asked to stay at home for more than 14 days to avoid spreading of the virus. |

MARCOM HQ follows the regeneration plan of SHAPE.

**NATO MILMED COE:**
MIL MED COE located in 2 different countries (HUN, DEU).
HN regulations are followed and in addition COE regulations are applied to all personnel.
Hygiene and mitigation measures are revised constantly.

- Self-monitoring – if you feel sick, stay at home.
- Temperature is measured at the entrance of the building.
- Teleworking is advised if possible.
- Gatherings only if absolutely necessary
- Transportation: reduce number of passengers if possible or use masks.
- Sport: keep distance. Contact sports are not advised.

Individual hygiene:

- Wash your hands regularly
- Clean office surfaces regularly
- Cleaning service is organised differently than before.
- Information campaign is regularly updated

Use of meeting rooms:
reduce number of participants and hygiene requirements are important. VTCs are advised.

**Summary:**

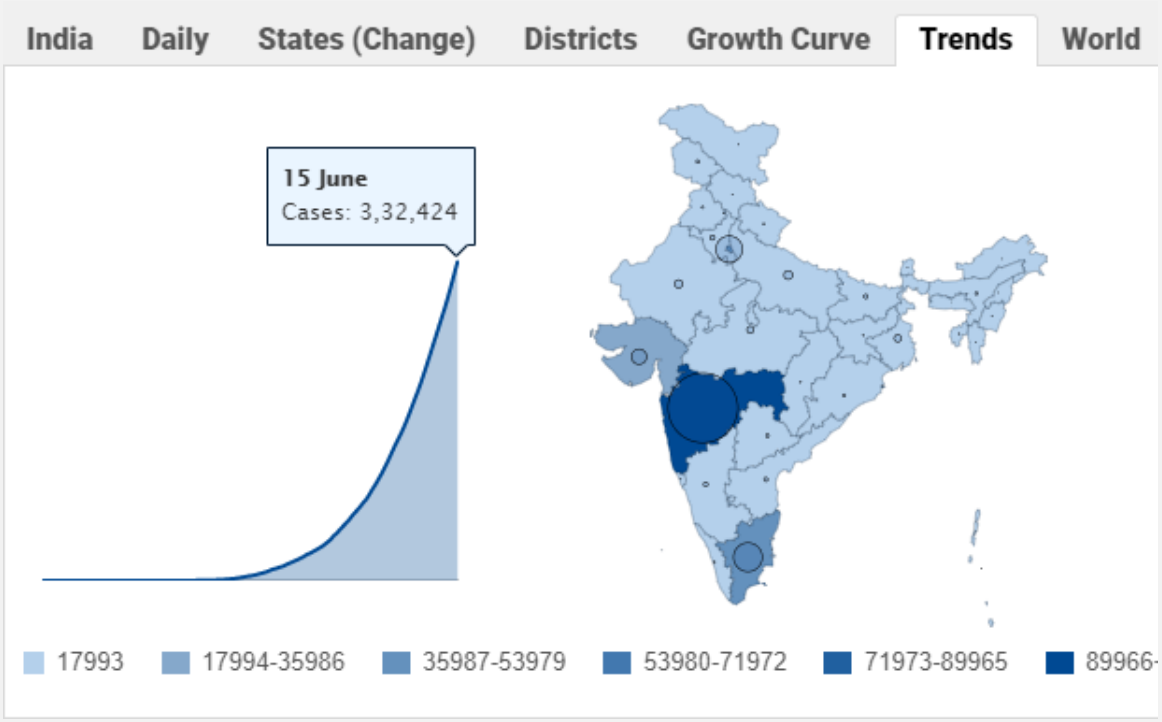
- Back to work policies are necessary and needs to be implemented reasonable to reduce the risk of COVID-19 infection spread.
- Epidemiological situations require to be screened closely
- The social distancing, avoiding crowded venues, and strict sanitary and hygiene measures are the main roles to limit transmission of SARS-CoV-2 at workplace.
- Use face mask only if the social distance is not feasible.
- It is sensitive to follow best practices – organize the quarantine of new commerce - during the rotation of personnel/staff.
- There is a risk of outbreak clusters because of people working in the same building if no measures are well implemented.

**Topic next VTC:**
COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation

## Country in Focus

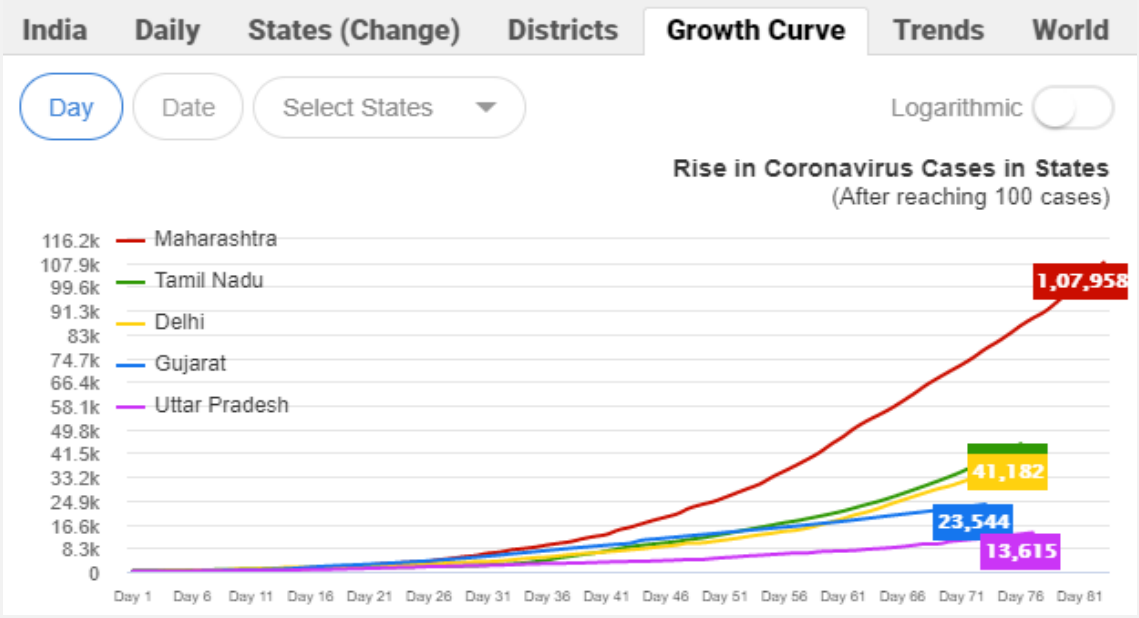
COVID 19 Crisis in India

In the past few days in India, the number of new COVID 19 infections exceeded the daily 11000 cases. As of today, India has 343.091 cases and 9900 COVID 19 related deaths. The chart below represents the increase of COVID 19 infections in India (till 15 June 2020).

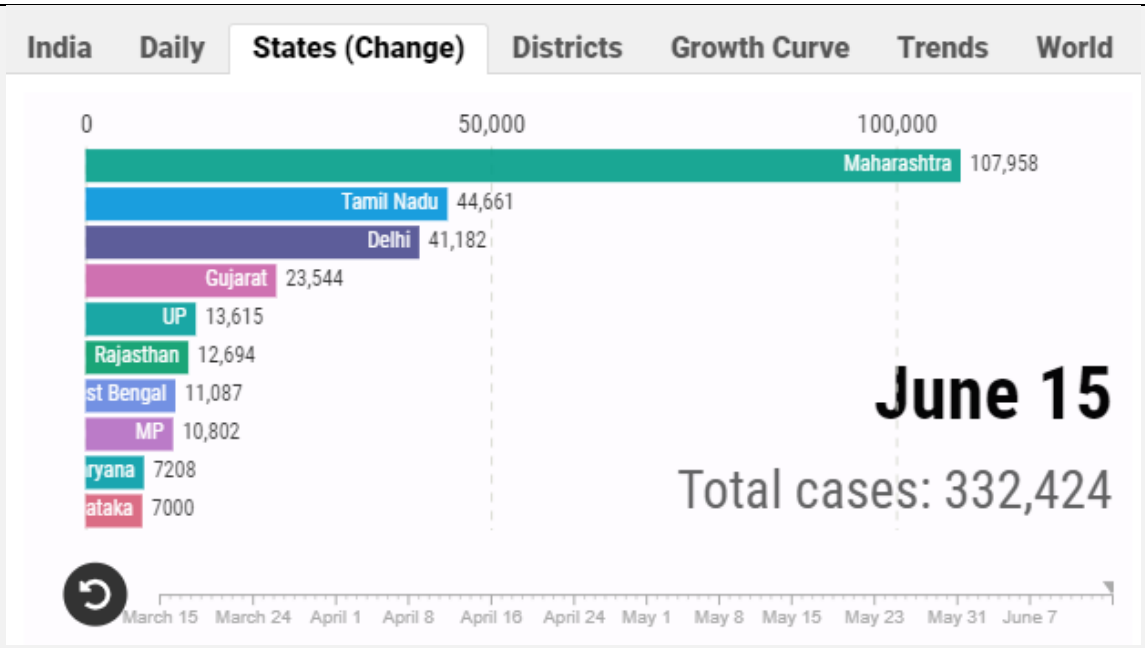



Source: https://www.ndtv.com/coronavirus

The majority (60 %) of all infections happened in 4 districts of India, but zhe lergest nunber, almost 108.000 came from one city, Maharashtra.

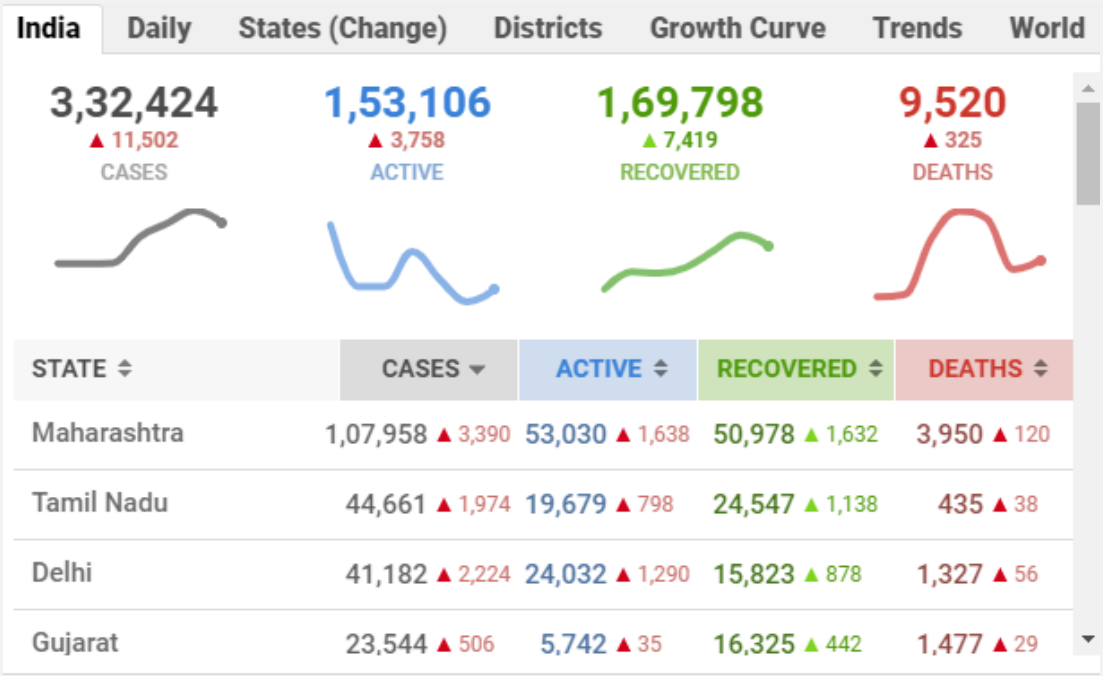



Source: https://www.ndtv.com/coronavirus




Source: https://www.ndtv.com/coronavirus

The next chart shows the growing trends in India, all parameters were higher than day before.




Source: https://www.ndtv.com/coronavirus

This continued growth has led to the government to take strict measures. In view of the rising cases of coronavirus, chief minister of Tamil Nadu district on Monday announced a maximized restricted lockdown from 19 to 30 June 2020. On the other hand, the government had no plans to impose lockdown in the national capital, Delhi.

**Background**

The first case of COVID-19 in India, which originated from China, was reported on 30 January 2020. As of 16 June 2020, the Ministry of Health and Family Welfare (MoHFW) has confirmed a total of 343,091 cases, 180,013 recoveries (including 1 migration) and 9,900 deaths in the country. India currently has the largest number of confirmed cases in Asia, and has the fourth highest number of confirmed cases in the world with the number of total confirmed cases breaching the 100,000 mark on 19 May and 200,000 on 3 June. India's case fatality rate is relatively lower at 2.80%, against the global

6.13%, as of 3 June. On June 10, India's recoveries exceeded active cases for the first time reducing 49% of total infections.

**Government responses**

On 3 March 2020, the Indian government stopped issuing of new visas. All visas were suspended on 13 March, except for diplomatic and other official visas. Indians returning from COVID-affected countries were asked to be quarantined for 14 days. On 13 March, the Government of India closed passenger traffic from all neighbouring countries other than Pakistan. The traffic from Pakistan itself was closed on 16 March.

On 24 March, PM Narendra Modi announced a complete 21-day national lockdown to contain the pandemic. By 6 April, the doubling rate had slowed to six days from earlier figure of three days. After his consultation with administrators of states on 11 April, PM Narendra Modi announced lockdown extension till 3 May in his address to nation on 14 April, with conditional relaxations in areas with lower spread from 20 April. On 1 May, the Government of India extended nationwide lockdown further by two weeks until 17 May. Then the lockdown was extended till 31 May in all indian states. Later it was announced that the ongoing lockdown would be further extended till 30 June in containment zones, with services resuming in a phased manner, starting from 8 June, in other zones.

**Food Security**

The lockdown disrupted food supplies and threatened to trigger a food crisis. By the first week of April, essential industries such as growing, harvesting and food deliveries were allowed to operate.

**Exodus of migrant workers**

The coronavirus lockdown in India has left tens of millions of migrant workers unemployed. With factories and workplaces shut down, many migrant workers were left with no livelihood. They thus decided to walk hundreds of kilometres to go back to their native villages, accompanied by their families in many cases. The central government then announced that it had asked state governments to set up immediate relief camps for the migrant workers returning to their native states, and later issued orders protecting the rights of the migrants. In its report to the Supreme Court of India on 30 March, the central government stated that the migrant workers, apprehensive about their survival, moved in the panic created by fake news that the lockdown would last for more than three months. In early May, the central government finally permitted the Indian Railways to launch special trains for the migrant workers and others stranded, but this move had a few complications. On 26 May, the Supreme Court admitted that the problems of the migrants had still not been solved and ordered the Centre and States to provide free food, shelter and transport to stranded migrant workers.

**Misinformation**

Despite evidence to the contrary, a viral rumour spread online alleging that only people who eat meat were affected by coronavirus, causing "#NoMeat_NoCoronaVirus" to trend on Twitter. Some politicians claimed that drinking cow urine and applying cow dung on the body can cure coronavirus. WHO's chief scientist rubbished such claims and criticised these politicians for spreading misinformation. Misinformation that the government is spreading "anti-corona" drug in the country during Janata curfew went viral on social media. A film actor many others shared the fake news that, the vibration generated by clapping together during Janata curfew will kill the virus.

Source: Wikipedia

## Recommendations

| | |
|---|---|
| Recommendation for international business travellers | **Travel has been shown to facilitate the spread of COVID-19 from affected to unaffected areas. Travel and trade restrictions during a public health event of international concern (PHEIC) are regulated under the International Health Regulations (IHR), part III.**<br>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. Currently there are exceptions foreseen for travellers with an essential function or need.<br><br>**In the case of non-deferrable trips, please note the following**<br>• Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules.<br>• Check your national foreign office advices for regulations of the countries you´re traveling or regulations concerning your country.<br>• Information's about the latest travel regulations and De-escalation strategy measures you can find at IATA and International SOS. For Europe you will find more information here.<br><br>**Most countries implemented strikt rules of contact reduction:**<br>• Everyone is urged to reduce contacts with other people outside the members of their own household to an absolutely necessary minimum.<br>• In public, a minimum distance of 1.5 m must be maintained wherever possible.<br>• 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).<br>• Follow the instructions of the local authorities.<br><br>**Risk of infection when travelling by plane:**<br>The risk of being infected on an airplane cannot be excluded, but is currently considered to be low for an individual traveller. The risk of being infected in an airport is similar to that of any other place where many people gather. If it is established that a COVID-19 case has been on an airplane, other passengers who were at risk (as defined by how near they were seated to the infected passenger) will be contacted by public health authorities. Should you have questions about a flight you have taken, please contact your local health authority for advice.<br><br>**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:<br>• 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;<br>• 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;<br>• Refrain from touching mouth and nose; See also: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public<br>• 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. 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.<br>• WHO information for people who are in or have recently visited (past 14 days) areas where COVID-19 is spreading, you will find here.<br><br>**Travellers who develop any symptoms during or after travel should self-isolate; those developing acute respiratory symptoms within 14 days upon return should be advised to seek immediate medical advice, ideally by phone first to their national healthcare provider.**<br>Source: WHO and ECDC |

| Risk Assessment | |
|---|---|
| Global | • Because of global spread and the human-to-human transmission the **moderate to high** risk of further transmission persists.<br>• Travellers are at risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks.<br>• Individual risk is dependent on exposure.<br>• National regulation regarding travel restrictions, flight operation and screening for single countries you will find here.<br>• Official IATA changed their travel documents with new travel restrictions. You will find the documents here.<br>• 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.<br>• 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 | ECDC assessment for EU/EEA, UK as of 11 June 2020:<br>• **Risk of COVID-19 to the general population currently assessed:**<br>**Low** in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates.<br>**Moderate** in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place.<br>• **Risk of COVID-19 to the population with defined factors associated with severe disease outcome currently assessed:**<br>**Moderate** in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates.<br>**Very high** in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place.<br>• **Risk of COVID-19 incidence rising to a level that may require the re-introduction of stricter control measures is currently assessed as:**<br>**Moderate** if measures are phased out gradually, when only sporadic or cluster transmission is reported, and when appropriate monitoring systems and capacities for extensive testing and contact tracing are in place.<br>**High** if measures are phased out when there is still ongoing community transmission, and no appropriate monitoring systems and capacities for extensive testing and contact tracing are in place. |

## References: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- World Health Organization WHO; www.who.int
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- Our World in Data; https://ourworldindata.org/coronavirus


## Disclaimer: