COVID in Eastern Mediterranean and North Africa Region: An Update

#COVIDEastMedNorthAf
HOUSEKEEPING

This session is being recorded

Attendees may not unmute

Chat is off, Q&A is on and moderated

Only host and panelists can screen share

#COVIDEastMedNorthAf
AGENDA

Welcome
Youssef Cherif, CGC | Tunis

Introduction
Wafaa El-Sadr, ICAP

Panelists
Rana Hajjeh, WHO/EMRO
Hechmi Louzir, Institut Pasteur in Tunis
Gerardo Noto, UNDP Libya

Q&A
INTRODUCTION

Wafaa El-Sadr, ICAP
ICAP Webinar for MENA:

Update on COVID-19 Situation and Response in the EMR

3 June 2020

Rana A. Hajjeh, M.D.
Director, Program Management
Regional Eastern Mediterranean Office, WHO
Cairo, Egypt
Cumulative
Total confirmed: 6,057,853
Total deaths: 371,166 (6.1%)

USA: 1,734,040 (deaths: 102,640)
Brazil: 498,440 (deaths: 28,834)
Russia: 414,878 (deaths: 4,855)

33,274 new cases reported in Brazil
Epidemic curve by region (cases reported to WHO as of 31 May 18H)

Epi-curve based on date of report (n=5,938,493)

Note: Different scale on y-axes for all epi curves shown.

“International conveyance (Diamond Princess) 741 COVID-19 cases and 13 deaths not included in the epi curves above”
Daily distribution of cases of COVID-19 in EMR countries
29 January – 01 June 2020 (6:00 PM)

Cumulative:
Total cases: 529,163
Total deaths: 12,752 (CFR 2.4%)
Countries reported cases: 22
Distribution of COVID-19, confirmed cases and deaths in the Eastern Mediterranean Region (EMR) as of June 1st 2020, 06:00 PM (GM+2)

Total cases
- 123 - 5026
- 5027 - 15750
- 15751 - 34557
- 34558 - 87142
- 87143 - 154445

Total cases: 529163
Total deaths: 12752

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data source: World Health Organization
Map production: Health Emergency Information and Risk Assessment (HIM) Unit
World Health Organization

WHO 2020, All rights reserved
Regional update of COVID-19 outbreak
31 May, 2020 (6:00 PM)

<table>
<thead>
<tr>
<th>Country</th>
<th>New cases</th>
<th>New deaths</th>
<th>Total cases</th>
<th>Recovered</th>
<th>Total deaths</th>
<th>CFR</th>
<th>Tests/100,000</th>
<th>Positivity %</th>
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<td>1976</td>
<td>348</td>
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<td>Med= 2.2</td>
<td>Med= 884</td>
<td>Med= 9.2</td>
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</table>
Daily distribution of COVID-19 cases and cumulative CFR% in EMR countries
29 January – 30 May 2020 (6:00 PM) (n= 505 001)

Eid vacation?
Epidemiology Summary

- No explosive outbreaks
  - all countries with local / community transmission
  - 3 countries with >20,000 cases
  - One country in “top 10” – Iran (45% cases)

- Range of epidemiological trends
  - Difficult to interpret without additional data

- Amplifying events and settings
  - Religious events, e.g. Iran
  - Migrant workers, e.g. Gulf
  - Hospitals, e.g. Egypt

- Window of opportunity to intervene remains – urgency to scale up proven PH measures
WHO’s overall strategy

Slow down the transmission and reduce mortality

- **Mobilize** all sectors and communities to ensure that everyone takes ownership of and participates in the response

- **Control** sporadic cases and clusters and prevent community transmission by rapidly finding and isolating all cases, and tracing, quarantining, and supporting all contacts

- **Suppress** community transmission through physical distancing measures and restrictions on travel

- **Reduce** mortality by providing clinical care for those affected by ensuring the continuity of essential health services, and protecting frontline workers and vulnerable populations

- **Develop** safe and effective vaccines and therapeutics that can be delivered at scale and that are accessible based on need
Response Pillars

- Partnership and Coordination
- Health Information/Surveillance
- IMST
- Health Operations and technical expertise
- Knowledge Management
- Operations Support and Logistics
- IHR/Points of Entry

Other Supportive Functions:
- Finance and Administration
- Resource Mobilization

Country Support
Key Areas of WHO/EMRO Support

**Country Offices**
- Planning & Coordination
- Technical assistance
- Epi analysis and information management
- Logistics support
- Resource mobilization
- Research & development

**Regional Office**
- 7 technical support missions
- 22 country support teams
- Epidemiological analysis
- Adoption of tech guidance
- Political engagement
- Partnership network – daily updates and weekly calls
- Essential health services
Infection Prevention and Control - 10/22 EMRO countries do not have national IPC programs

- Early on, HCWs over-reacting & using full attire PPEs (global shortage of PPE)
- IPC restricted to just PPE use which is the most visible intervention
  - Policies, staff/patient ratio, infrastructure, environmental cleaning, distancing, HH, waste management, triage, ventilation, isolation facilities, standard precautions
- 10 countries have no national and hospital IPC focal point to lead the response
- Many infections among HCWs
Impact of COVID on Health Workers

- Increased workload, leading the shortages
- Need for updated knowledge, skills
- High risk for contracting infection
- Fatigue and psychosocial stress
- Violence and stigma against health workers
<table>
<thead>
<tr>
<th>Countries</th>
<th>Infected HWs</th>
<th>% of infected HWs</th>
<th>Total deaths among HWs</th>
<th>Date</th>
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<td>13</td>
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<td>8</td>
<td>13</td>
<td>20/05/2020</td>
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<tr>
<td>IRQ</td>
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<td>3</td>
<td>27/05/2020</td>
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<tr>
<td>YEM</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>26/05/2020</td>
</tr>
</tbody>
</table>
Infected healthcare workers by profession

Afghanistan: 10% Physicians, 11% Nurses, 4% Other

Egypt: 0% Physicians, 2% Nurses, 4% Other

Iraq: 4% Physicians, 2% Nurses, 10% Other

Pakistan: 15% Physicians, 0% Nurses, 0% Other

Other: 29% Physicians, 0% Nurses, 0% Other
## Research Updates – EMRO - Solidarity trial

<table>
<thead>
<tr>
<th>Country status update</th>
<th>Patients recruited since</th>
<th>No of hospitals</th>
<th>Patient recruited so far</th>
<th>Weekly average</th>
</tr>
</thead>
<tbody>
<tr>
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<td>25</td>
<td>&gt;900</td>
<td>~150</td>
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<td>100</td>
<td>~40</td>
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<tr>
<td>Lebanon</td>
<td>4 May</td>
<td>1</td>
<td>10</td>
<td>~1</td>
</tr>
<tr>
<td>Kuwait</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>Expected</td>
<td></td>
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</tr>
</tbody>
</table>
Communications and Community Engagement

**Weekly FB overview**
- 50 million people reached
- 895,000 post engagements
- 452,000 video views

**Weekly Twitter overview**
- 3M impressions
- 1.3K retweets
- 3.1K likes

**Topics covered:**
- Walk the Talk
- FB Live on physical distancing
- Myth busters
- World Health assembly
- Physical activity at home
- Feeding young children during COVID-19
- Photo essay: gathering & testing samples
- Joint tweets showing #WHOImpact
- Donor visibility: KSA

**Facebook Live with RD**
- 1.1 M people reached
- 235,000 views

**Twitter post with highest interaction in last 7 days**
- 225,700 impressions
- 3,600 engagements

**Physical activity at home**
- 201x255 impressions
- 3,600 engagements

**ORGANIC Facebook post with highest interactions in last 7 days**
- Walk the Talk
- 326,700 people reached
- 28,000 engagements
Logistics & Supply Chain

• 102 Countries across all 6 WHO Regions have received support.
  • EMR (18): Afghanistan, Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Kuwait, Morocco, Oman, Pakistan, Saudi Arabia, Somalia, Syria, Sudan, Tunisia, Yemen
Special Considerations in the region

- Humanitarian emergencies, including countries with territorial divisions – political, operational, reporting problems, etc.
- Migrant workers in the Gulf countries
- Refugee camps – vulnerabilities, but also represent opportunities to prevent and control
- Managing mass gatherings across the region – vital role of religious and community leaders
- Acceptability of social distancing measures- with considerations for social and economic impact
Access essential supplies, medicines and equipment is limited because of global market collapse.

Ongoing humanitarian crisis operations outside of COVID-19 will be affected.

Continuity of non COVID-19 health services such as immunization activities.

Weak health systems and limited capacity to offset the economic and social costs of population-level shut-downs.

Vulnerable populations with poor nutrition, underlying conditions and disease prevalence which complicate the diagnosis and treatment.

High-risk groups include those displaced, living in camps, overcrowded sites such as slums have restricted movement and cannot physically distance.
Mass Gatherings

- Major religious gatherings in the region
- Can amplify epidemic
- Initial outbreak in Iran started in Qom
- Early interventions focused on limiting mass gatherings, in particular in religious sites and houses of worship
- Ramadan Guidance, including Eid Holiday
- Hajj Pilgrimage?
## Main Challenges – COVID-19 response

<table>
<thead>
<tr>
<th>Challenges</th>
</tr>
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<tbody>
<tr>
<td>• Deficiencies in epidemiological data collection, analysis and use</td>
</tr>
<tr>
<td>• Testing capacities</td>
</tr>
<tr>
<td>• Availability of PPE and Lab supplies</td>
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<tr>
<td>• Poor IPC - infections among HCWs</td>
</tr>
<tr>
<td>• Divided governments and politicization of response</td>
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</table>

<table>
<thead>
<tr>
<th>Gaps in other elements of response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk communications and community engagement</td>
</tr>
<tr>
<td>• Capacities to isolate, quarantine, contact trace</td>
</tr>
<tr>
<td>• Adherence to social and physical distancing</td>
</tr>
<tr>
<td>• International travel – pause on tech support missions</td>
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</table>
**Additional Challenges**

- Weak/disrupted health systems in a high number of countries in the region
- Disruption in supply chain: difficulties for patients to get medicines
- Limited capacity: staffing during the pandemic and limited public resources to be allocated to the health sectors
- Unemployment and impoverishment resulting in increased burden on public facilities, and reduced capacity for mobilizing public resources.
- Limited attention to critical health conditions/services and increased morbidity and mortality (NCDs, EPI, CDs, etc)
- Efforts have focused primarily on hospital settings, with less attention given to PHC, particularly that around 80% of COVID-19 patients are expected to experience mild illness
- Limited peer reviewed literature
How to Adjust Public Health Control Measures?

1. **Control community transmission** to a level that the health system can manage cases

2. **Capacity to find, test, isolate** and care for cases and identify, trace, quarantine and support contacts are in place

3. **Risks in high-vulnerability settings** such as health care facilities and residential care settings are minimized

4. **Risks in work and public places** are reduced through infection prevention and control and physical distancing

5. **Risks of imported cases** are reduced by identifying likely transit routes and measures to rapidly detect and manage suspected cases among travelers

6. **Communities are fully engaged** and understand that there is a need for a managed transition to a "new" normal

Considerations in adjusting public health and social measures in the context of COVID-19

Interim guidance
16 April 2020

**Background**

Across the globe, countries have implemented a number of control measures to comprehensively prepare for and respond to COVID-19. The overarching goal of the WHO global COVID-19 response strategy is for all countries to control the pandemic by slowing down transmission and reducing overall mortality, including through minimizing deaths and avoiding saturation of health-care systems. The objectives of reaching and maintaining a state of low-level or no transmission. Based on local epidemiology, some countries are in the process of scaling up public health and social measures, while others are or currently considering standing down these measures.

Although the goal in all countries is to suppress transmission and provide care for all patients, the intensity of implementation of control measures to achieve this — including identification, testing, isolation and care for all cases, contact tracing and quarantine of close contacts, public health and social measures, and management of community transmission — varies based on the transmission scenario and country in question.

**Public health and social measures**

Public health measures include personal protective measures (hand hygiene, respiratory etiquette), environmental hygiene, social distancing, social gatherings, communication, and community mobilization. Physical distancing measures apply to individuals (e.g., isolation, quarantine) as well as communities, specific segments of the population, or to the population as a whole. These measures are not mutually exclusive.

WHO recommends that all suspected cases be isolated, treated, traced, and quarantined (if necessary). Additional large-scale public health social measures (PHSM), including movement restrictions, closure of schools and businesses, geographic area quarantine, and closure of borders, are sometimes implemented at a national or regional level. These are sometimes referred to as “lockdowns” or “virus-attacking” measures.

**An assessment of the public health impact of PHSM for COVID-19 is not yet available but is needed.** This assessment needs to take into account the social consequences and potential harms of such measures as well as their potential benefits and risks. As such, a careful risk assessment and risk management approach is needed to balance the benefits and potential harms of adjusting these measures, as to not to trigger a resurgence of COVID-19 cases and jeopardize the health of the population. Until specific and effective pharmaceutical interventions (e.g., therapies and vaccines) are available, countries may need to continue to invest in or re-engage the measures described above.

Decisions to tighten or loosen or re-implement PHSM should be based on scientific evidence and real-world experience and take into account other critical factors, such as economic factors, severity-related factors, human rights, food security, and public sentiment and adherence to measures.

**Decisions to tighten or loosen or re-implement PHSM should be based on scientific evidence and real-world experience and take into account other critical factors, such as economic factors, severity-related factors, human rights, food security, and public sentiment and adherence to measures.**

Individual measures, including medical masks for symptomatic people, isolation and treatment of all individuals, and hygiene measures (hand hygiene, respiratory etiquette) should be sustained.

This document is intended for national authorities and decision-makers in countries that have introduced large-scale PHSM and are considering adjusting them. It offers guidance for adjusting public health and social measures, while managing the risk of resurgence of cases.

**Scenarios**

WHO has previously defined four transmission scenarios to describe the dynamics of the epidemic: no reported cases (whether true or not as a result of asymptomatic cases, clusters of cases, and community transmission). A summary or one can move from one transmission situation to another (e.g., from asymptomatic waves to community transmission) at a subnational level. Each transmission scenario requires a different approach to control measures.

Although it is unknown how the pandemic will continue to evolve, three scenarios can be envisioned:

1. Complete interruption of human-to-human transmission;
2. Avert epidemic waves (large or small); and
3. Continuous low-level transmission.

Based on current evidence, the most plausible scenario may involve recurring epidemic waves, interposed with periods of low-level transmission. This guidance has been developed to fit within these scenarios and will be updated as knowledge of the dynamics of the pandemic evolves.
Overall Strategic Opportunities and Success Stories

- Global & Regional Leadership
- Solidarity and partnership
- Pandemic Preparedness
- Strong Risk Communication
- Effective Diagnostic Capacities
- Digital Innovations and Tele-Medicine
- Working with GOARN partners
- Service continuity
Thank You
 شكراً جزيلاً
PRESENTATION

Hechmi Louzir, Institut Pasteur in Tunis
Data from Tunisia

All data are actualized by June 1st, and obtained from Dr Ben Alaya, ONMNE, MoH

• The first phase of COVID-19 pandemic was achieved by slowing down the progression of SARS-CoV-2 avoiding overshooting the health system.
• Since May 04, Tunisia began a transition to a new phase in the management of the COVID-19 pandemic: progressive target containment.
• We have to avoid a rebound by the ability of detect, isolate and treat all new cases early (imported).
• As of June 01, 2020, the cumulative number of confirmed COVID-19 cases is 1,086 cases (out of a total of 52,874 samples)
  • cumulative is 9.16 / 100,000 inhabitants. Among the screening cases, 73 (6.7%) are still active.
• New cases registered in recent days are imported cases diagnosed among returnees and placed directly in compulsory confinement.
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<th>Count</th>
<th>Percentage</th>
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<tr>
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<td>Autochtones</td>
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<tr>
<td>Guéris</td>
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<td>88.9%</td>
</tr>
<tr>
<td>Décès</td>
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<td>4.4%</td>
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<tr>
<td>Encore actifs</td>
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<td>6.7%</td>
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<td>Personnels de santé</td>
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<td>13%</td>
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<tr>
<td>Importés</td>
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<td></td>
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<tr>
<td>Autochtones</td>
<td>131</td>
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</tbody>
</table>
Courbes épidémiques journalière des cas confirmés COVID-19-Tunisie
Why Tunisia has been relatively spared

• The Tunisian health system is among the most developed in the region (basic health care centers that cover the country, preventive medicine, good immunization program)
• Previous vaccinations
• The climate
• The circulation of other members of the Coronavirus family
• The relatively young population
• Anticipation in relation to crisis management and the mobilization of experienced and disciplined teams.
• Team preparation through their involvement in a major flu project funded by “the Centers for Disease Control and Prevention”, USA (Grant number 1U51IP00822).
PRESENTATION

Gerardo Noto, UNDP Libya

#COVIDEastMedNorthAf
Q&A

Moderated by Wafaa El-Sadr