Update 19 (11th of May 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
11th 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**: On 8 May the world celebrates the 40th anniversary of the declaration of smallpox eradication. The eradication of smallpox laid the foundation for immunization programmes worldwide, underpinning the establishment of primary healthcare in many countries. Vaccines work, and vaccination continues to save up to 3 million lives every year from polio, measles and other infectious and chronic diseases, beyond the millions of deaths averted thanks to the discovery and adoption of the smallpox vaccine.
- **WHO** has released a video summarising key moments in the response so far.
- A newly released **WHO** scientific brief summarizes the current evidence on the impact of angiotensin-converting enzyme (ACE) inhibitors and receptor blockers on severe acute respiratory illness due to COVID-19.
- **WHO-Europe:** Member States are reporting up to a 60% increase in emergency calls by women subjected to violence by their intimate partners in April this year, compared to last. Online enquiries to violence prevention support hotlines have increased up to 5 times. The UN partner UNFPA has sounded the alarm loud and clear – if lockdowns were to continue for 6 months, we would expect an extra 31 million cases of gender-based violence globally. Beyond the figures, only a fraction of cases is ever reported.
- **UN**: Restrictions against humanitarians who rescue migrant boats in the central Mediterranean are putting lives at risk and must be lifted immediately, the UN human rights office said on Friday.
- **CDC**: Has launched a site about testing in the U.S. Including public health laboratories with complete verification to offering testing as well as current numbers.
- FHP Branch started to organize a weekly VTC on "COVID-19 response" next VTC will take place on Wednesday,13th of May focusing on **"Collateral damage of COVID-19 emphasising Mental Health Aspects and other diseases, which were negatively affected by the COVID crisis."**

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GLOBALLY
4 066 992 confirmed cases 1 412 774 recovered 282 758 deaths
EU/EEA and the UK
1 689 824 confirmed cases **711 584** recovered **156 506** deaths
USA (x2 in 34.5 d ↘) **1 327 213** confirmed cases **216 169** recovered **79 403** deaths
Spain (x2 in 137.5 d ↘) **224 350** confirmed cases **136 166** recovered **26 621** deaths
UK (x2 in 30.0 d ↘) **219 183** confirmed cases **not reproted** recovered **31 855** deaths
Russia (x2 in 11.0 d →) **209 688** confirmed cases **34 306** recovered **1 915** deaths
Brazil (x2 in 11.0 d →) **162 699** confirmed cases **64 957** recovered **11 123** deaths

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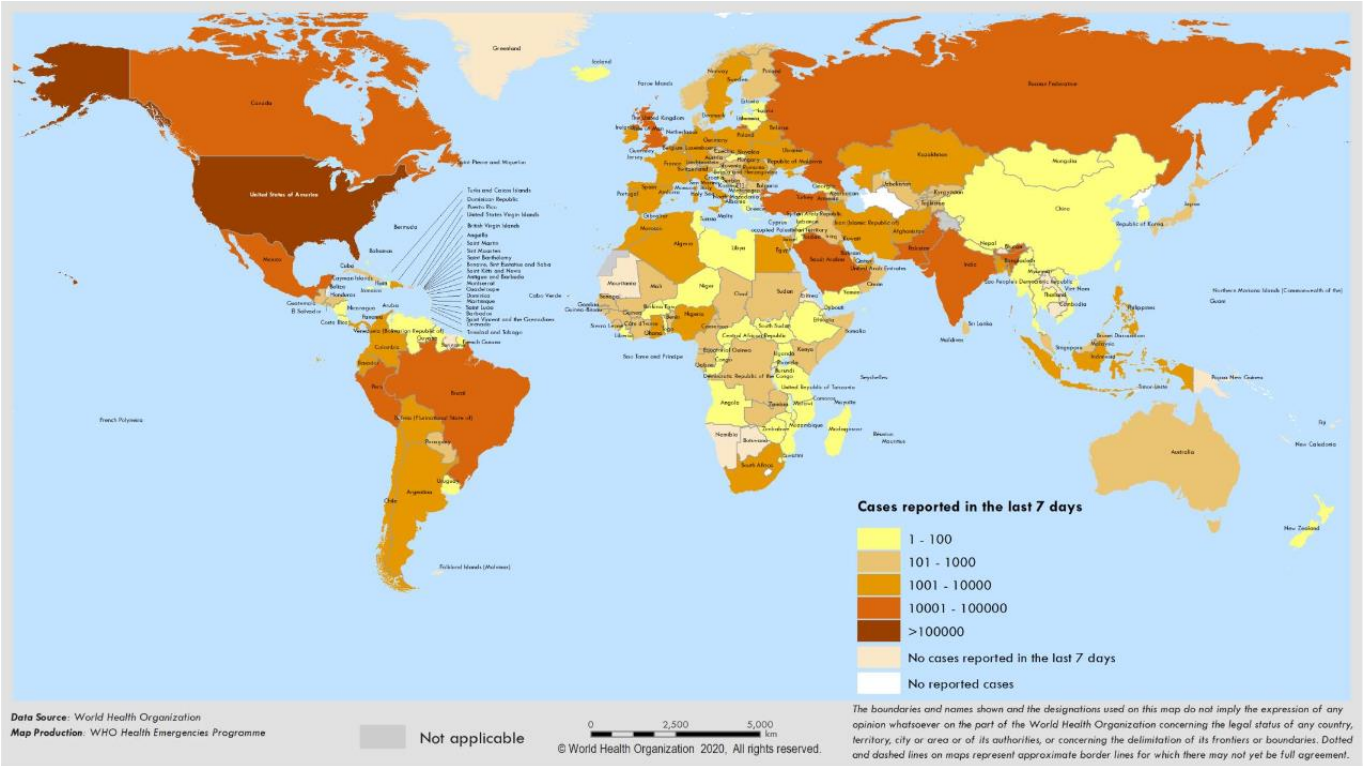
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation

World Health Organization

COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PLAN
Country Preparedness and Response Status for COVID-19
as of 7 May 2020

Table 1: COVID-19 Preparedness and Response Status for Countries, Territories, and Areas,[2] as of 7 May 2020

Response Category	Country Preparedness Capacity									
	Level 5		Level 4		Level 3		Level 2		Level 1	
5- Community transmission	Belgium Canada Germany Iceland Italy Lithuania Netherlands Portugal	Slovenia Spain Sweden Switzerland United Kingdom of Great Britain and Northern Ireland United States of America	Algeria Andorra Austria Brazil Chile Croatia Czechia France Greece	Iran (Islamic Republic of) Ireland Latvia Mauritius Mexico Poland Romania San Marino Turkey	Argentina Colombia Dominican Republic Ecuador Georgia Guinea	Indonesia Nigeria Panama Peru Qatar South Africa Tunisia	Bosnia and Herzegovina Burkina Faso Honduras Paraguay Syrian Arab Republic Ukraine			
4- >=10 cases	Australia China Denmark Finland Israel Japan Malaysia Monaco	New Zealand Norway Republic of Korea Singapore United Arab Emirates	Bahrain Brunei Darussalam Bulgaria Costa Rica Cyprus Egypt Estonia Hungary	Kuwait Luxembourg Malta Oman Russian Federation Saudi Arabia Slovakia Thailand Viet Nam	Albania Angola Antigua and Barbuda Armenia Azerbaijan Bahamas Bangladesh Barbados Belarus Belize Cambodia Cameroon Congo Côte d'Ivoire Cuba Democratic Republic of the Congo Dominica El Salvador Eswatini Ethiopia Ghana Grenada Guyana India Jamaica Jordan Kazakhstan Kenya Lebanon Liberia	Malawi Maldives Mali Mongolia Montenegro Morocco Mozambique Myanmar Nepal Niger North Macedonia Philippines Republic of Moldova Rwanda Saint Kitts and Nevis Saint Lucia Saint Vincent and the Grenadines Senegal Serbia Seychelles Sierra Leone Sri Lanka Sudan Suriname Trinidad-Tobago Uganda United Republic of Tanzania Uruguay Zimbabwe	Afghanistan Benin Bolivia (Plurinational State of) Botswana Burundi Cabo Verde Chad Djibouti Equatorial Guinea Eritrea Fiji Gabon Gambia Guatemala Guinea-Bissau Haiti Honduras Iraq Kyrgyzstan Lao People's Democratic Republic Libya Madagascar	Namibia Nicaragua occupied Palestinian territory, including east Jerusalem Pakistan Sao Tome and Principe Somalia South Sudan Tajikistan Timor-Leste Togo Uzbekistan Venezuela (Bolivarian Republic of) Yemen Zambia	Central African Republic

Response Category	Country Preparedness Capacity				
	Level 5	Level 4	Level 3	Level 2	Level 1
3- <10 cases			Bhutan	Mauritania Papua New Guinea	Comoros
2- High risk of imported cases			Democratic People's Republic of Korea Turkmenistan	Kiribati Marshall Islands Micronesia (Federated States of) Samoa Solomon Islands Tonga Tuvalu Vanuatu	
1- Preparedness				Cook Islands Lesotho Nauru Niue Palau	

2 The categorization will be updated periodically through capacity and risk assessments based on the evolving COVID-19 situation. The operational readiness index (levels 1-5) was aligned with the WHO SPAR benchmarks capacity levels: Level 1 ≤20%, Level 2 ≤40%, Level 3 ≤60%, Level 4 ≤80%, and Level 5 >80%. The categorization itself takes into consideration additional factors relevant for managing the risk of COVID-19.

Source: https://www.who.int/who-documents-detail/updated-country-preparedness-and-response-status-for-covid-19-as-of-7-may-2020

Global Pandemic Preparedness by country

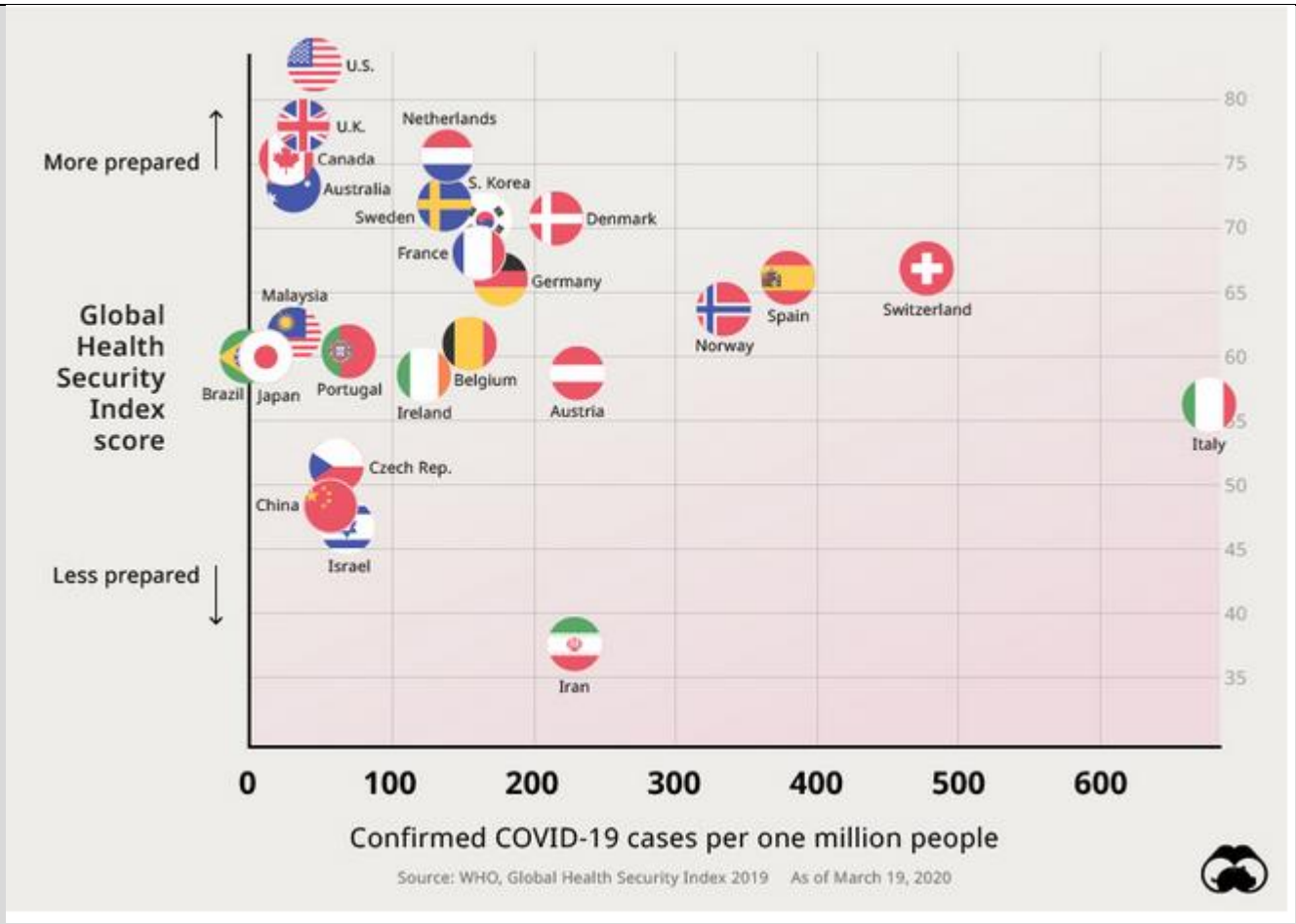
Data from the 2019 Global Health Security Index, which ranks 195 countries on health security, reveals that while there were top performers, healthcare systems around the world on average are fundamentally weak—and not prepared for new disease outbreaks. That assessment could be confirmed with the current COVID-19 outbreak situation where a lot of countries failed in preventing and respond.

Today's health care systems mainly look inward, towards national populations, with less of a focus on integrating what is happening with the outside world.

The Global Health Security (GHS) Index is the first comprehensive effort to assess and benchmark health security and related capabilities by nation, and it tracks six key factors to come up with an overall score for each of the 195 countries in the ranking:

1. Prevention
   Prevention of the emergence or release of pathogens
2. Detection and Reporting
   Early detection and reporting for epidemics of potential international concern
3. Rapid Response
   Capability of rapidly responding to and mitigating the spread of an epidemic
4. Health System
   Enough and robust and health system to treat the sick and protect health workers
5. Compliance with Global Norms
   Compliance with international norms by improving national capacity, financing plans to address gaps
6. Risk Environment
   Risk environment and country vulnerability to biological threats


Here's how countries scored in terms of health security:
Countries with a population of over 5 million
Global Health Security Index score
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
Average score
U.S. 83.5
The U.S. ranked first in the world in a number of indicators including: Epidemiology Workforce, Biosecurity, and Emergency Preparedness and Response Planning.
U.K. 77.9
Canada 75.3
Australia 75.5
Netherlands 75.6
Thailand 73.2
Sweden 72.1
Denmark 70.4
S. Korea 70.2
Finland 68.7
Switzerland 67.0
France 68.2
Germany 66.0
Spain 65.9
Japan 59.8
Singapore 58.7
Prior to the COVID-19 outbreak, China had a plan in place to deal with communicable diseases with pandemic potential.
Mexico 57.6
Brazil 59.7
Argentina 58.6
Malaysia
Portugal 60.3
Belgium 60.1
Italy ranked 126th in the Emergency Response Operation indicator, and 59th in Emergency Preparedness and Response Planning.
Indonesia 56.6
Poland 55.4
Italy 56.2
Austria 58.5
Chile 58.3
S. Africa 54.8
Turkey 52.4
Israel 47.3
Vietnam 49.1
Czech 52.0
China 48.2
Peru 49.2
Philippines 47.6
Saudi
India 46.5
Colombia 44.2
Russia 44.3
Egypt 39.9
Iran 37.7
Pakistan 35.5
Nigeria 37.8
Bangladesh 35.0
Afgan. 32.3
Côte d'Ivoire 35.5
Haiti 31.5
Tunisia 33.7
Cameroon 34.4
Sudan 26.2
Angola 25.2
D.R.C. 26.5
Venezuela 23.0
Iraq 25.8
Iran ranked 108th in Emergency Preparedness and Response Planning.
A cholera outbreak has infected over 2.2 million people in Yemen since 2016.
Yemen 18.5
Somalia 16.6
North Korea 17.5
Syria 19.9
Global Health Security Index score
73% of the world's population lives in countries that scored below 50 in the Health Security Index.
The report found that most countries lack foundational health systems capacities vital for epidemic and pandemic response.



Looking at the overall ranking, global preparedness for both epidemics and pandemics is weak, with the average score in the index sitting at 40.2 out of 100.The countries with the highest scores have effective governance and politics systems in place, while those with the lowest scores fall down for their inadequate healthcare systems—even among high-income countries.
81% of countries score in the bottom tier for indicators related to biosecurity—and worse, 85% of countries show no evidence of having completed a biological threat-focused simulation exercise in conjunction with the World Health Organization (WHO) in the past year.

The report outlined eight critical insights about global health security in 2019 that reveal some of the problems countries are now facing.

1. National health security is fundamentally weak globally. No country is fully prepared for epidemics or pandemics, and every country has important gaps to address.
2. Countries are not prepared for a globally catastrophic biological event.
3. There is little evidence that most countries have tested important health security capacities or shown that they would be functional in a crisis.
4. Most countries have not allocated funding from national budgets to fill identified preparedness gaps.
5. More than half of countries face major political and security risks that could undermine national capability to combat biological threats.
6. Most countries lack basic health systems capacities critical for epidemic and pandemic response.
7. Coordination and training are inadequate among veterinary, wildlife, and public health professionals and policymakers.
8. Improving country compliance with international health and security norms is essential.

The intention of the Global Health Security Index is to encourage improvements in the planning and response to one of the world's most omnipresent risks–infectious disease outbreaks. When this report was released in 2019, it revealed that even the highest-ranking nations still had gaps to fill in preparing for a pandemic.

Looking at the graphs we can see even if nations ranked in the upper part like USA or GBR they failed in the responds to the current outbreak.
The COVID-19 outbreak has hopefully served as a wake-up call to health organizations and governments around the world. Once all the curves have been flattened, the next version of this report will undoubtedly be viewed with renewed interest and maybe needs an adjustment of the parameters.

China is one of the first countries openly reporting the recognized weaknesses in its health care system. The coronavirus outbreak revealed "shortcomings in preventing major epidemics," said deputy head of the National Health Committee, Li Bin. He announced stricter controls and better provisions. The health authority will build a "centralized, uniform and efficient" system, with which one can react faster to crises, said Li. For this the use of artificial intelligence and other technologies is under discussion. International cooperation should also be strengthened.

Reinforcing emergency response against COVID-19 in Africa:
In an expanded pool of expertise, the World Health Organization (WHO) is supporting several African countries to coordinate the work of external emergency medical teams deployed to support the efforts to contain the spread of COVID-19 pandemic.
So far, United Kingdom EMTs have been working in South Africa, Ghana and Zambia. Chinese teams have been working in Ethiopia and Burkina Faso. Despite not being classified as a formal EMT, the teams from Cuba (Cuban Medicale Brigade) is deployed in South Africa and Togo. The EMT from China and the United Kingdom are in the pipeline to six more countries in Africa.
The work of these EMTs is varied: it involves everything from high level coordination meetings with Ministry of Health officials to training front-line health workers and response staff in areas like infection prevention and control, to community engagement and beefing up treatment capacity in areas that have been identified as COVID-19 hotspots.

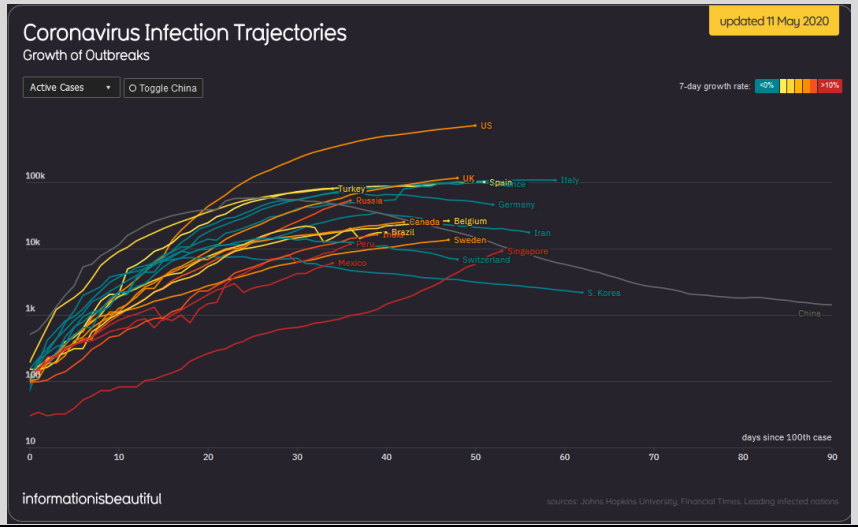
BRA: A provisional hospital has opened in Rio de Janeiro on the site of the legendary Maracanã stadium. This was announced by the state government. The clinic was built in 38 days, 170 beds were initially put into operation. The aim is to increase capacities in the healthcare system.

KOR: According to the authorities, the number of new infections in South Korea increases by 34, the highest level since April 9. Eight of them were imported. Many of the new cases are believed to be due to an infected person who infected people in clubs in Seoul before testing positive. Last Friday, the authorities spoke of 15 people. No details were given in the current figures, except that there were 14 new infections in Seoul. The easing of corona protection measures has been partially reversed due to the recent surge in new infections. For the capital Seoul, the neighboring province of Gyeonggi and the cities of Incheon and Daegu, orders have been given to close all clubs and bars. In addition, the opening of some of the schools planned for next Wednesday has been postponed.

CHN: In Wuhan, the authorities are reporting the first corona case in more than a month. For the first time since April 3, contagion has been found, according to the National Health Commission.

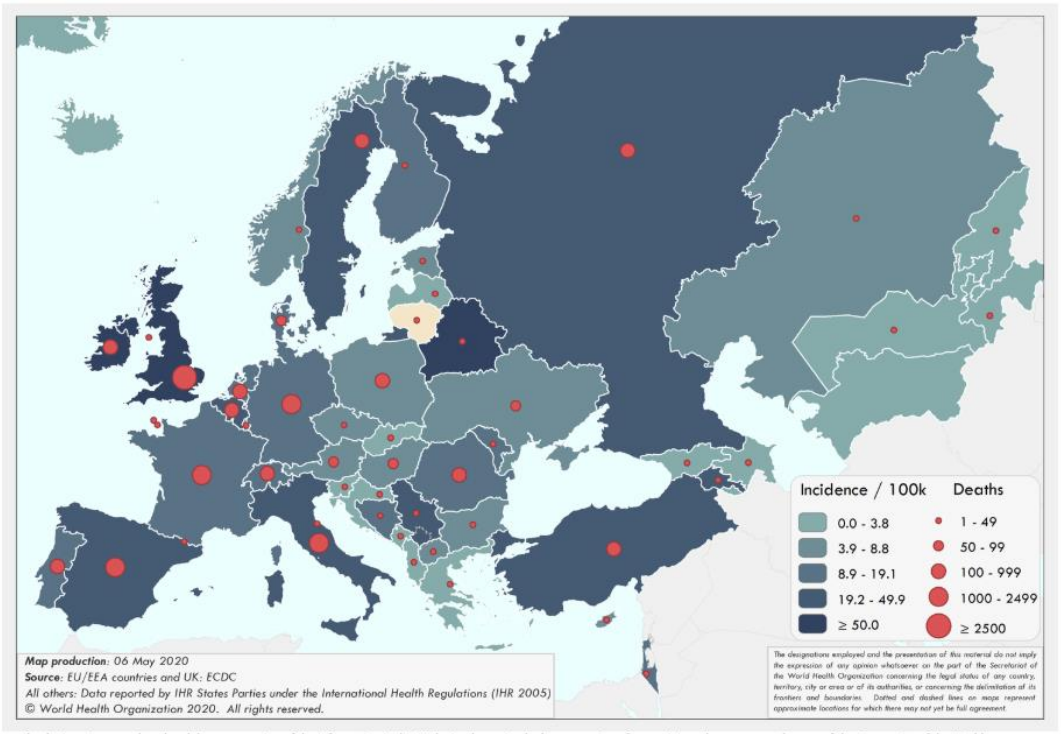
AFG: At a demonstration in the Afghan province of Ghor, the police fired on demonstrators and shot an Afghan journalist. According to a report by the German Press Agency, the reason for the demonstration were the major shortages in supply due to the lockdown in the corona pandemic.

IND: A pharmacist died after drinking a supposedly mixed corona remedy. The chief of the pharmacist, who also tried the mixture, was taken to the hospital with poisoning, said the police chief in Chennai in southern India. It was a mixture of nitrogen oxide and sodium nitrate. Both men reportedly worked for a company that makes herbal medicines and initially wanted to test their brew on themselves.



Situation in Europe	A new Corona test center will open its doors in the European Parliament in Strasbourg from Monday. The competent prefecture, the city, the health authority and the parliament said it would have a capacity of 2000 people per day. In the Louise Weiss building, an area for the screening center should be made available free of charge, residents from the Bas-Rhin department and in particular from Strasbourg should be able to be tested there.

COVID-19 incidence per 100,000 population and number of deaths by country for week 18



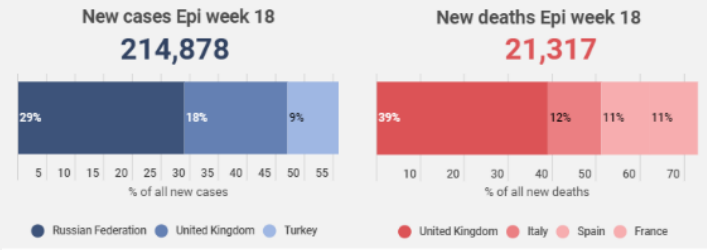
COVID-19 situation update for the WHO European Region (27 April – 03 May 2020 Epi week 18)

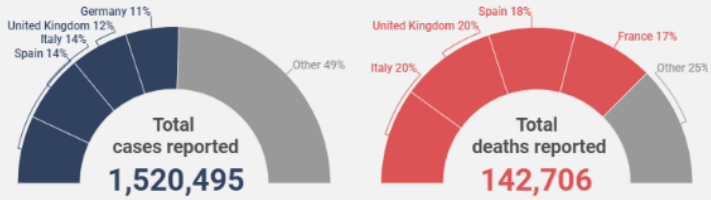
Week 18/2020 (27 April-3 May 2020)

- The number of cases reported in week 18/2020 in the Region has declined by 29% since week 14/2020
- 56% of the cases reported in week 18/2020 were from the Russian Federation, United Kingdom and Turkey
- Three countries had a crude incidence of ≥50 per 100,000 in week 18/2020: Belarus, Ireland and the United Kingdom
- The number of cases in week 18/2020 increased by ≥50% in two countries compared to week 17/2020 (the Russian Federation and Belarus) (see EURO COVID-19 Dashboard for recent trends)
- 72% of the deaths reported in week 18/2020 were from the United Kingdom, Italy, Spain and France
- The proportion of reported cases that died increased from 2.2% in week 9/2020 to 10.8% in week 18/2020, a change that is likely due to a range of factors

Summary overview

- 75% of cumulative deaths were reported from Italy, Spain, France and United Kingdom
- 18% 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 71% of all ICU admissions in men
- 94% of all deaths were in persons aged ≥60 years and 60% of all deaths were in men
- 96% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (66%)
- Nine countries and territories in the Region each reported a cumulative incidence of ≥400 cases per 100,000 population
- From week 10/2020 and as of week 18, there were 149,447 excess deaths reported from 24 countries/regions, primarily in the age group ≥65 years (137,524), but also in the 15-64 years age group (11,573). 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 18/2020, two countries reported a total of 36 tests and no COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 17/2020 was 10% (7 countries) compared to 9.3% (6 countries) in week 16/2020





94% of all deaths were in persons aged 60+

96% of all deaths had at least 1 underlying condition

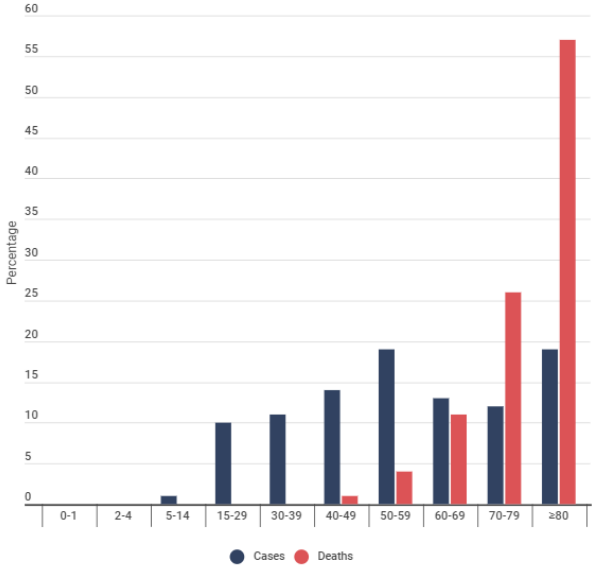
60% of all deaths were in men

79% of all ICU admissions were people aged 50-79 years

18% of all people infected were health care workers

9% of all reported cases resulted in deaths

Percentage of COVID-19 cases (N=723,096) and deaths (N=83,037) 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)		515,506
	Sex, male*	238,008	47	510,893
	Travelled*	17,095	13	130,206
	Recovered*	172,847	86	200,462
	Health care workers#	68,360	18	376,987
	Hospitalization#	124,606	32	383,443
	Intensive care unit admissions#	11,584	4	277,639
Deaths	Age in years, median (range)^	81 (0-106)		83,037
	Sex, male^	47,871	60	80,054
	At least one underlying condition^	21,710	96	22,698
	• cardiovascular disease	12,650	66	19,060
	• diabetes	6,256	34	18,298
	• lung disease	4,358	23	18,778
	• neurological disease / dementia	1,388	26	5,250
	• renal disease	934	20	4,651
	• malignancy	702	26	2,669
	• obesity	384	10	3,826
	• liver disease	221	5	4,601
	• immune disease	162	4	4,578
	• other	9,091	50	18,232

Source:
*Case report forms (n=515,506);
#Case report forms and aggregated data from Italy (29/30 April and 4 May 2020) and Spain (4 May 2020) (n=731,382); Health care workers refer to ocupation and not to the place of exposure
^Case report forms, mortality survey, aggregated data from Italy (30 April 2020) and Spain (4 May 2020) (n=83,061)

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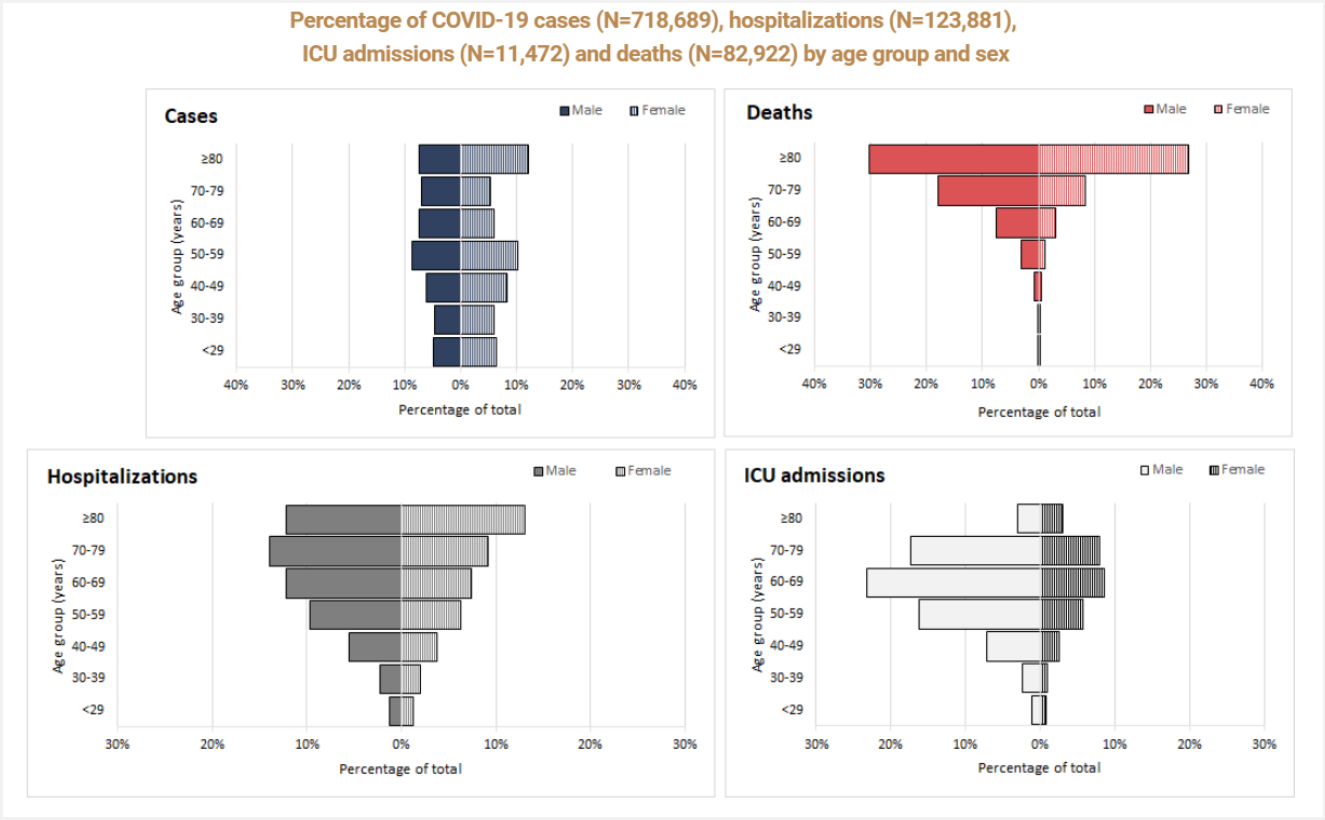
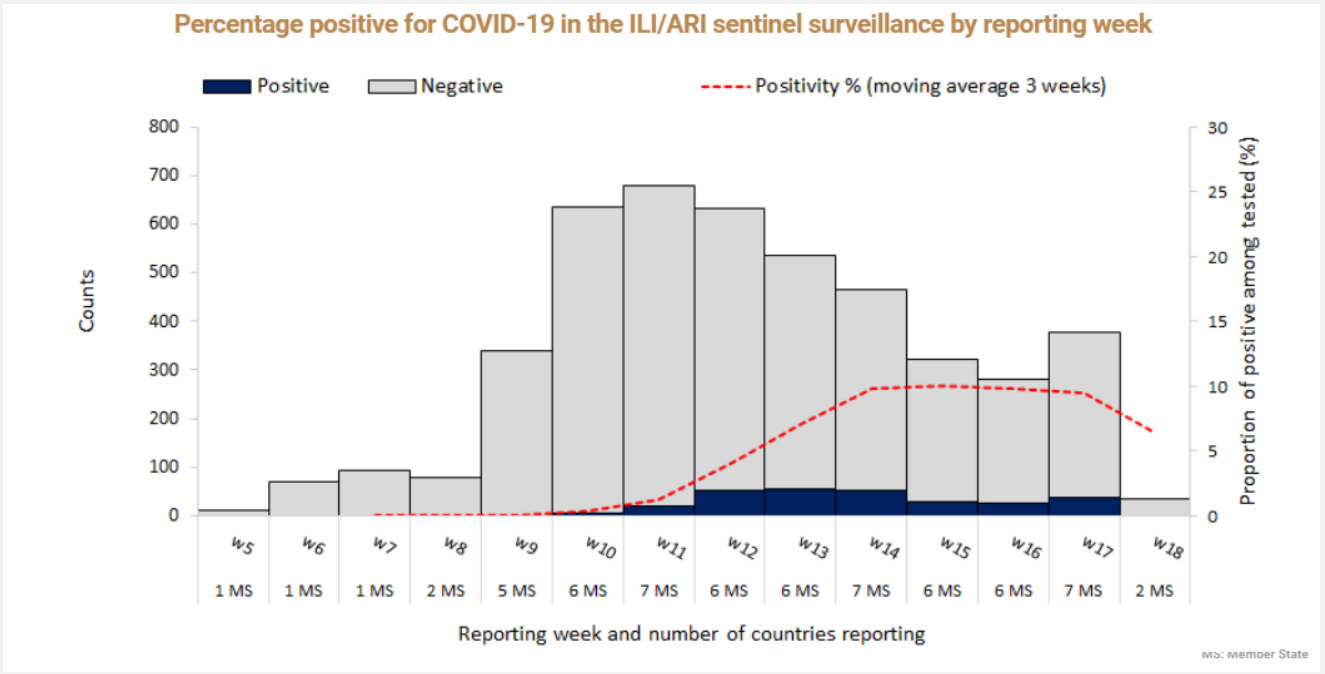

Percentage of COVID-19 cases (N=718,689), hospitalizations (N=123,881),
ICU admissions (N=11,472) and deaths (N=82,922) by age group and sex
Cases
Male
Female
Age group (years)
≥80
70-79
60-69
50-59
40-49
30-39
<29
40% 30% 20% 10% 0% 10% 20% 30% 40%
Percentage of total
Deaths
Male
Female
Age group (years)
≥80
70-79
60-69
50-59
40-49
30-39
<29
40% 30% 20% 10% 0% 10% 20% 30% 40%
Percentage of total
Hospitalizations
Male
Female
Age group (years)
≥80
70-79
60-69
50-59
40-49
30-39
<29
30% 20% 10% 0% 10% 20% 30%
Percentage of total
ICU admissions
Male
Female
Age group (years)
≥80
70-79
60-69
50-59
40-49
30-39
<29
30% 20% 10% 0% 10% 20% 30%
Percentage of total


Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week
Positive
Negative
Positivity % (moving average 3 weeks)
Counts
800
700
600
500
400
300
200
100
0
Proportion of positive among tested (%)
30
25
20
15
10
5
0
w5 w6 w7 w8 w9 w10 w11 w12 w13 w14 w15 w16 w17 w18
1 MS 1 MS 1 MS 2 MS 5 MS 6 MS 7 MS 6 MS 6 MS 7 MS 6 MS 6 MS 7 MS 2 MS
Reporting week and number of countries reporting
MS: Member State

	RUS: Origin of virus strains - Most Russian samples apparently come from European virus lines. Only individual genomes are more comparable to known cases from Asia. This is particularly evident in Moscow. Variants of the corona virus that circulate there are hardly related to each other. This suggests that a large part of the infections is due to imports from other countries, especially from Western Europe **DEU:** The autopsies of 65 deceased COVID-19 patients from Hamburg show that all had previous illnesses such as high blood pressure, heart attacks and arteriosclerosis. Previous respiratory and lung diseases were reported, and other organ damage or patients had had transplanted organs. At the Institute of Forensic Medicine in the University Medical Center Hamburg-Eppendorf, post-mortem surveys have brought new insights into the course of the disease of COVID-19. Around 170 deceased COVID-19 patients have been examined there in the past few weeks in Hamburg. Thromboses and fatal pulmonary embolisms were found frequently in the autopsies. **CHE**: Autopsy results show that microscopically severe disturbances in the microcirculation of the lungs were visible. This means that the oxygen exchange no longer works. This would be a possible explanation for the difficulties with the ventilation of COVID-19 patients in the intensive care units. All autopsied patients had high blood pressure, many of whom were severely obese. More than 2/3 of the predominantly male patients had previously damaged coronary arteries, 1/3 had diabetes. There is growing evidence that SARS-CoV-2 affects much more than just the lungs. Zurich researchers recently reported in The Lancet that the virus also causes severe inflammation in the vascular endothelium. This could explain why patients who do not have to be ventilated are also dying. **GRB**: Prime Minister Boris Johnson plans to extend the country's seven-week Corona curfew until June. As of June 1st, classes at primary schools could be gradually resumed and some shops reopened. **ROM**: Viorel Catarama, Vice President of the Romanian Red Cross and ex-politician, has demonstratively tried to become infected with the corona virus. He wanted to prove that the corona precautionary measures that were also applicable in his country were superfluous. Catarama hugged a man suffering from Covid-19 in the village of Barbulesti and thereby violated the law to prevent the spread of epidemics, said the prosecutor in the city of Urziceni.

Subject in Focus

COVID-19 Economic impact

The SARS-CoV-2 outbreak is primarily a human tragedy that affects millions of people around the world. The crisis has demonstrated not only the vulnerability of global public health but also the fragility of an integrated world's economy to shocks, as just-in-time supply chains begin to crack and the world edges toward recession, or even depression.

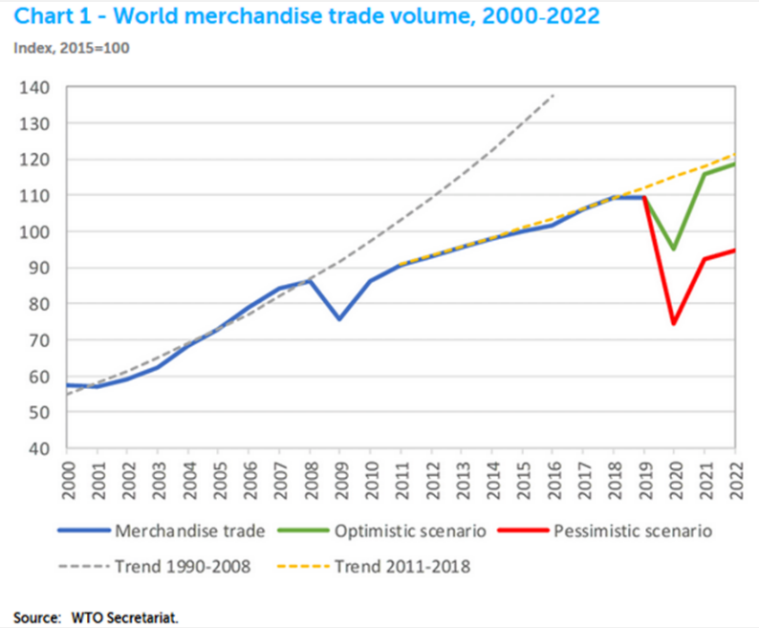
The outbreak of COVID-19 has firstly disrupted the Chinese economy and subsequently spread globally. The future course of the disease and its economic impact are still uncertain which makes it difficult for policymakers to formulate an appropriate (political) macroeconomic response.

The coronavirus crisis has escalated around the world, with stay-at-home orders in almost all countries, following school closures, event cancellations, restaurant and bar closures, travel restrictions and mandatory work-from-home policies. A severe world recession is likely to be inevitable.

The pandemic has affected different sectors of the countries' economies to various extents. Below a brief overview is given.

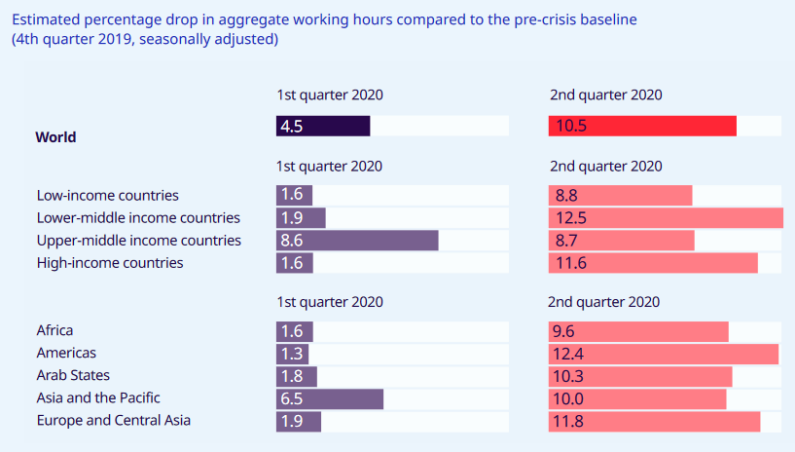
All major stock indices, from S&P 500 to Eurostoxx 50 and Nikkei 225 experienced significant drops during the last months.
The International Monetary Fund (IMF) estimates global growth to fall to -3 percent in 2020, a downturn of 6.3 percentage points from previous estimates in January 2020. Global growth is projected to rebound to 5.8 percent in 2021, assuming the pandemic fades during the second half of 2020 and that mitigation measures and political action implemented around the world are effective. Over the next two years, cumulative output loss from the pandemic could reach 9 trillion dollars.
According to the Organization for Economic Cooperation and Development (OECD) forecast:
The greatest impact of the restrictions will be on retail and wholesale business, and in professional and real estate services, although there are notable differences between countries.
Business closures could reduce economic output in advanced and major emerging economies by 15% or more; other emerging economies could experience a decline in output of 25%.
Countries dependent on tourism could be affected more severely, while countries with large agricultural and mining sectors could experience less severe effects.
Economic effects likely will vary across countries reflecting differences in the timing and degree of containment measures.

Global Trade:
In accordance with a forecast from World Trade Organization (WTO), global trade volumes are projected to decline between 13% and 32% in 2020 as a result of the economic impact of COVID-19. The WTO argues that the wide range of variation in this forecast represents the high degree of uncertainty concerning the length and economic impact of the pandemic. The WTO's more optimistic scenario assumes that trade volumes recover quickly in the second half of 2020 to their pre-pandemic trend. The more pessimistic scenario assumes a partial recovery that lasts into 2021. The WTO concludes that the COVID-19 impact on global trade volumes could exceed the drop in global trade during the height of the 2008-2009 financial crisis.



Labour market:

Undoubtedly, the impact of the epidemic can be seen in the employment market. The number of people who lose their jobs as a result of economic stagnation caused by COVID-19 increases from month to month. The International Labour Organization (ILO) estimates that COVID-19 will wipe out 6.7 percent of working hours globally in the second quarter of 2020 – equivalent to 195 million full-time workers. It is projected that a quarter of all private sector employments could be affected by the current situation. The crisis will inevitable hit some sectors harder than others, especially jobs in the sectors of food and accommodation, arts and entertainment, retail and wholesale, tourism and transportation are at high risk. Contrary to that, jobs in professional services are presumably less affected. Some countries' unemployment rate could double by next year and would be unlikely to return to pre-crisis levels until 2024.



Source: ILO nowcasting model

Tourism:

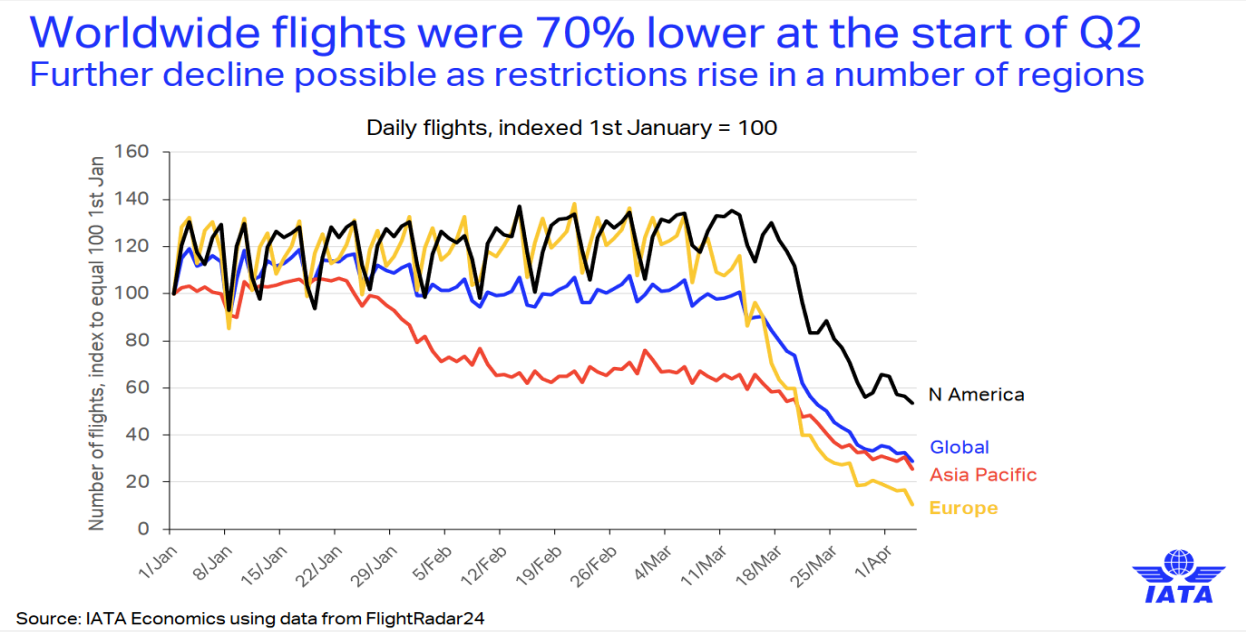
The Tourism sector is currently one of the hardest-hit by the COVID-19 outbreak, with impacts on the demand and supply side, particularly in China, the world's leading outbound market, and other key Asian and European destinations such as Italy. Many destinations will experience severe economic impacts from the effects of COVID-19. The reduced number of tourists visiting a country can have severe effects, especially for smaller businesses (e.g. family-owned single hotels) that often don't have the liquidity necessary to financially survive the outbreak. As in other sectors many tourist companies complain that governmental aid is either not provided or not paid-out in a timely manner. In countries that are highly dependant on their tourism sector the sectors' problems that come along with the COVID-19 pandemic can quickly evolve into a large-scale problem with major consequences for the country's GDP and society.

Currently, around 120 countries in the world have closed their borders or introduced restrictions for travellers from pandemic regions. As the world slowly turns back to normal it is very likely that international travel restrictions will linger on to avoid importing new COVID-19 cases. In accordance with the World Tourism Organization's opinion it is estimated that international tourist movement could decline by 20% to 30% in 2020. This would translate into a loss of 300 to 450 US$ billion in international tourism income. In case it becomes evident that COVID-19 survivors become immune to subsequent infections and transmissions, an immunity certificate (like Yellow Fever booklet) may become a requirement for both outward and inward travel creating a new barrier for tourists when deciding for a travel abroad.

Restaurants and bars:
The tourists are either not visiting (or are not allowed to visit) a country anymore and/or the residents are prohibited from staying in restaurants and bars as part of the outbreak mitigation measures. This leads to massive reduction of turnover for each affected enterprise (in many cases turnover drops to zero, while fixed costs like rent and wages (in some countries) still have to be paid). Currently the regular restaurants and bars are closed, only take-aways can maintain (and sometimes even expand) their regular business. Many restaurants undertook efforts to quickly setup a take-away business. Searches for food delivery services increased by 56% on average - depending on the company.

Air Transport:
The spread of COVID-19 has important implications for airlines and their customers. The International Air Transport Association (IATA) predicts 2020 global revenue losses for the passenger business between $63 billion and $113 billion. No estimates are available for the impact on cargo operations yet. Airlines' share prices have fallen nearly 25% since the outbreak began, some 21 percentage points more than the decline that occurred at a similar point during the SARS crisis in 2003. In addition, almost all trade lanes across the world are seeing declines in air cargo capacity of approximately 31% compared to last year.

Ins



Insurance:
A sector that is often not mentioned in the list of affected sectors is the (re)insurance industry. One of this industry's goals is to take risk off companies that would face severe economic damage when hit by a so-called loss scenario (e.g. a fire, hailstorm, flood etc) and receive an insurance premium for this service.
While business operations carry on as usual in the banking/insurance sector where working-from-home policies are easy to implement, the sector faces numerous challenges imposed by the outbreak. Large (re)insurance companies have to deal with losses that will arise on the "life-side" meaning that an increased number of "excess deaths" (deaths above the expected annual average) lead to higher pay-outs and subsequently losses in the field of life- and health- insurances. On the so called "non-life" side (covering topics such as insurance against physical damage and liability insurance) additional losses are possible. In recent years special covers against the consequences of an epidemic outbreak were developed but only a very limited number of companies bought these expensive products. While – from a financial view-point – this is advantageous for the insurance companies at the moment, not buying these products backfires now for affected companies. Without an insurance every company has to bear its own risk posed by a pandemic and insolvency caused by a governmental ordered shut- or lockdown might be inevitable despite governmental aid is granted (and received in a timely manner).

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.

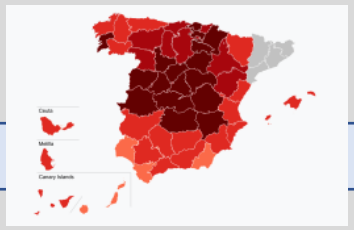
Topics last VTCs:

- 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

Spain de-escalation strategy and measures

Spain de-escalation:

Now PHASE 0 → PHASE 1 → PHASE 2 → PHASE 3



Now its phase 0 – time and age-related restrictions
Phase 1 - some businesses can reopen with restrictions in place.
Phase2 – cafes and restaurants will reopen
Phase 3 – All shops, museum, theatres and larger businesses can reopen with limited capacity social
distancing measures must still be adhered to as well as wearing of masks.

- The date of changing the phases will be determined by epidemiologic markers as well as socio-economic markers.
- Bed capacity of hospitals are better, Routine procedures are conducted again.
- Schools are still closed. Teleworking is encouraged. Virtual schooling is working well for most.
- Impact of de-escalation: government set up testing, volunteer based, randomized.

Daily evaluation of epidemiological parameters may lead to an extension of the respective phase or even downgrading.

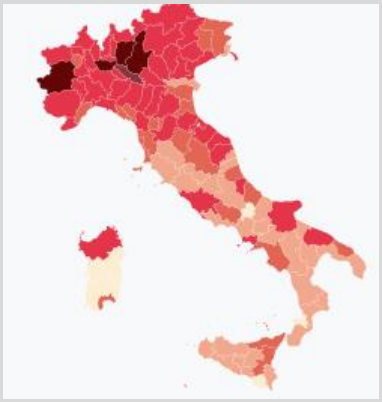
- Each phase lasts at least 2 weeks;
- A new phase can only be called if the region meets fixed criteria

Impact on Military:
The MIL regulations are following the CIV regulations. Few cases of differences: such as academy students/cadets are still conducting some of their training if authorised.

Impact on Missions:
Some contingents/rotations are prolonged. Quarantine is enforced with deployments.

Italy de-escalation strategy and measures

Italy de-escalation:

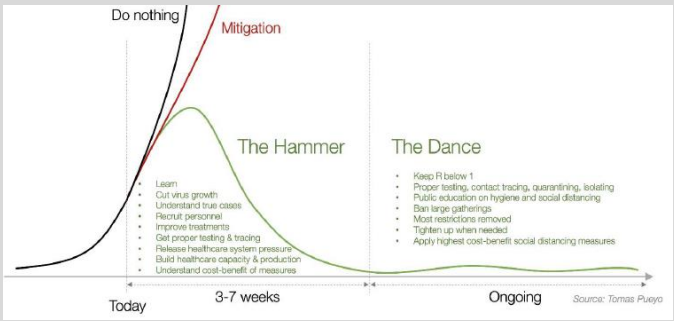


First wave was called "**The Hammer phase**"

- **04.05.2020**
  - public parks and garden reopen
  - Factories, construction sites and wholesale supply business can resume activity
- **18.05.2020**
  -retail shops reopen
  -libraries,
  -museums and art exhibitions reopen

If all goes well, restaurants, cafes, barber shops and hair salons will be allowed to reopen on 1 June

Schools will remain closed for this semester!



"The curve of contagion can rise again, it will go out of control, deaths will climb and we'll have irreparable damage" to the economy if the people do not carefully adhere to the guidelines.

- Some previously imposed measures are staying in place. Important to train and advise the population to be more responsible for themselves.
- Investigation of new infections and strict quarantining, to prevent the forming of new clusters.
- Larger scale testing is also planned. (PCR testing mainly).

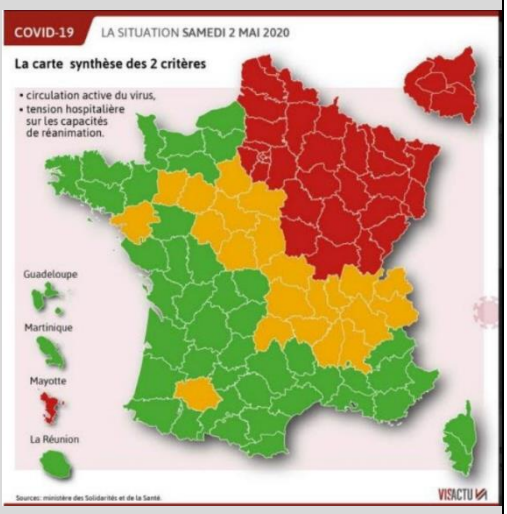
The task is now to keep the infection in the „**Dance phase**". But also ensure financial and economic survival of families.

Impacts on Military:
All restrictions during phase 1 is still in place. Many MIL personnel are deployed all over the country, especially specialists. Military logistics capabilities are used to help CIV efforts too. Rome based MIL hospital was „deployed" to help with the region's shortage in healthcare facilities.

France de-escalation strategy and measures

France de-escalation:

- De-escalation will start from 11th of May, three weeks tiers. Inpatient cases are reducing slowly, fewer ICU cases.
- The reopening is to be both a medical and a political decision. The two must be merged.
- FRA is not uniformly impacted, NE is red, SW is orange, rest is green.
- Medical masks are reserved for medical professionals. The population is encouraged to use cloth face covers.
- A program is in place to train non-medical people to aid epidemiologic efforts.
- Larger case testing starts soon.



Graduality of these measures are important to avoid an unmanageable second wave.

	De-escalation is still discussed; a step back is also possible. The situation is constantly evaluated. The intensity and the profile of de-escalation will be regionally decided based on local capacities. Schools will be reopened gradually. **MIL side of the strategy:** 4 objectives: • Protect • Prevent • Prevention to become a vector/carrier of the virus (Don't export or import the virus) • Ensure all duties are conducted Starts from the 11th of May. All measures are reversible. Both self and mutual responsibility. Offices are spaced out. Shifts created if possible. Medical masks are used only by military medical professionals, the rest of the MIL wears cloth masks. **Topic next VTC:** • „Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases"

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 publics 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 Central Syria

SYRIA – IN COMPLEX EMERGENCY SITUATION

AREA OF SYRIA	185,180 km^2
POPULATION	17,500,657
RELIGION	87% Islam
	10% Christian
	3% Durzis

AGE STRUCTURE

0-14 years: 33.47% (male 3,323,072/female 3,170,444)
15-24 years: 19.34% (male 1,872,903/female 1,879,564)
25-54 years: 37.31% (male 3,558,241/female 3,679,596)
55-64 years: 5.41% (male 516,209/female 534,189)
65 years and over: 4.46% (male 404,813/female 459,417)
(2020 est.)

NUMBERS AT A GLANCE

11.7 million people - in need of humanitarian assistance in Syria
6.2 million - IDPs in Syria
4 million people reached per month by USAID assistance in Syria

5.6 million Syrian refugees in neighbouring countries
- 3.6 million Syrian refugees in Turkey
- 910,256 Syrian refugees in Lebanon
- 656,213 Syrian refugees in Jordan
- 247,440 Syrian refugees in Iraq

438,000 Palestinian refugees in Syria

As of today, there are 47 confirmed COVID-19 cases and 3 COVID-19 related death. Data about testing (if any) is not available.

HIGHEST CONCERN FOR COVID-19

The UN reports that densely populated urban areas; overcrowded collective shelters, displacement camps, and informal settlements, and locations with active hostilities remain the areas of highest concern for COVID-19 in Syria. In addition to *older persons* and those with *underlying health issues*, *internally displaced persons* (IDPs – 6,2 million people) are considered **particularly at risk** due to the insufficient water, sanitation, and hygiene (WASH) infrastructure and debilitated health care system in Syria.

COVID-19 IMPACT AND RESPONSE

Regional COVID-19-related border closures and movement restrictions have impacted the delivery and provision of humanitarian assistance to some parts of Syria, **particularly for northeast Syria**. In northwest Syria, COVID-19 restrictions have not significantly affected the provision of cross-border humanitarian assistance.

COVID-19 policies vary by location throughout Syria due to several areas of influence and control existing within the country, creating a complex and dynamic operating environment. In Government-controlled areas, policies include a ban on travel between and within governorates; a curfew in effect from 6:00 p.m. to 6:00 a.m. daily; and the closure of schools, parks, restaurants, and various public institutions since mid-March.

A limited quantity of COVID-19 testing kits and a weak health system nationwide—further complicated by ongoing conflict and shifting lines of control—could present **significant COVID-19 response challenges in Syria**. Densely populated sites and areas experiencing hostilities remain primary areas of concern for COVID-19 infection. Despite the obstacles, relief organizations, in close coordination with health authorities, **continue to enhance infection prevention and control measures** countrywide.

COVID-19 testing began in northwest Syria on March 24, following WHO's initial delivery of testing kits. With the technical support of WHO, the MoH has commenced **active disease surveillance across 13 of 14 governorates in Syria**; however, the loss of UN cross-border access to northeast Syria in January is likely to significantly hinder the COVID-19 response in the northeast.

The UN released a COVID-19 Global Humanitarian Response Plan which includes Syria as a priority country, citing the high risk for COVID-19 due to continued displacements, overcrowded IDP sites, and a fragile health care system. The UN estimates that **90 percent of Syrians live under the poverty line**, and a COVID-19 outbreak would disproportionately impact the most vulnerable populations.

Syria is particularly vulnerable to the COVID-19 pandemic due to a weak health care system resulting from more than nine years of hostilities and deliberate attacks on health care facilities. From 2016 to 2019, WHO **confirmed nearly 500 attacks on health care facilities and personnel in Syria**, resulting in 470 deaths and injuring at least 970 people. WHO reports that **only 64 percent of**

hospitals and 52 percent of primary health care centres were functional in Syria and **70 percent of the health workforce had left the country** as of late 2019.

DISPLACEMENT

A Government of Turkey and Government of Russia negotiated **ceasefire took effect in northwest Syria** on March 6. **Prior to the ceasefire**, from early December to late February, a Syrian Government and Russian offensive—including increased airstrikes, shelling, and ground attacks—**displaced as many as 961,000 people**. Due to relatively improved security conditions as a result of the ceasefire, more than 32,000 people had returned to areas of origin in northwest Syria as of early April. However, **up to 940,000** of those who fled the offensive **remained displaced**. As of early March, nearly 2.9 million IDPs were sheltering in northwest Syria.

On April 2, artillery shelling struck damaging the pipeline that links Alouk water-cleaning station cutting off the water flow. Water shortages heighten the risk of COVID-19 transmission by reducing the ability of populations to practice adequate handwashing and sanitation habits. During the intermittent service, humanitarian actors have provided emergency water trucking services to vulnerable populations; however, actors note this is an unsustainable solution.

FOOD SECURITY AND NUTRITION

UN World Food Program (WFP) continues to provide emergency food assistance to people throughout Syria, reaching approximately 4.3 million people in February. WFP delivered food assistance to people, distributed ready-to-eat rations (RTEs). Since late 2019, purchasing commodities on credit increased up to 60 percent in urban areas and up to 100 percent in rural areas, according to the WFP analysis.

In partnership with the UN Children's Fund (UNICEF), WFP began distributing soap and informational brochures alongside food assistance packages in April. WHO recently delivered approximately 50,000 brochures containing information related to COVID-19 prevention.

HEALTH AND WASH

Humanitarian organisations have increased the distribution of WASH (Water, Sanitations and Hygiene) supplies and integrated COVID-19 information into existing hygiene promotion campaigns. USAID partners conducting water trucking for IDPs have also increased the quantity of safe drinking water delivered daily per person to accommodate increased handwashing. Relief actors have temporarily suspended some services, such as group-based education and protection activities, per public health guidance for social distancing.

During February, Humanitarian organisations conducted more than 1,600 hygiene promotion sessions, reaching approximately 49,200 people in northwest Syria. Additionally, the NGOs rehabilitated water stations in 16 communities in the northwest, reaching more than 241,300 people, and delivered safe drinking water to nearly 373,600 people during the month. The NGOs also established 81 water distribution points in informal settlements in northwest Syria

Recommendations

Recommendation for international business travellers

As of 11 April 2020, 167 countries, territories and areas have implemented additional health measures that significantly interfere with international traffic.
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.

In the case of non-deferrable trips, please note the following

- 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 you can find at IATA and International SOS.

Most countries implemented strikt rules of contact reduction:

- 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.

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:

- 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
- 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.
- WHO information for people who are in or have recently visited (past 14 days) areas where COVID-19 is spreading, you will find here.

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.**

Source: WHO

WHO recommendation

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.
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.

Further information: https://www.who.int/news-room/commentaries/detail/immunity-passports-in-the-context-of-covid-19

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	• 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	ECDC assessment for EU/EEA, UK: • **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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