Update 21 (25th of May 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
25th 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

- **GAVI, WHO and UNICEF**: At least 80 million children under one at risk of diseases such as diphtheria, measles and polio as COVID-19 disrupts routine vaccination efforts. Agencies call for joint effort to safely deliver routine immunization and proceed with vaccination campaigns against deadly vaccine-preventable diseases. WHO published an interim guidance on Framework for decision-making: implementation of mass vaccination campaigns in the context of COVID-19.
- **WHO and partners**: Have produced guidance on laboratory biosafety related to the testing of clinical specimens and guidance on the repatriation of COVID-19 human remains by air as of 22 May.
- **WHO** has published a COVID-19 Monitoring and Evaluation Framework listing the key public health and essential health services and systems indicators to monitor preparedness, response, and situations during the COVID-19 pandemic.
- **WHO** has published an interim guidance on Controlling the spread of COVID-19 at ground crossings advising countries to reduce the spread of COVID-19 resulting from travel, transportation, and trade on and around ground crossings.
- **WHO**: The organization sees no reason to avoid or stop breastfeeding. This recommendation was made on WHO homepage after German scientist detect coronavirus in the breast milk of a woman suffering from COVID-19.
- **FHP Branch** started to organize a weekly VTC on "COVID-19 response" next VTC will take place on Wednesday,20th of May focusing on **"Immunity map, national strategies to measure and evaluate the immunity level"**

Find articles and other materials at the MilMed CoE homepage: click here

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

GLOBALLY
5 375 511 confirmed cases 2 171 315 recovered 345 159 deaths
EU/EEA and the UK
1 974 937 confirmed cases **955 308** recovered **174 082** deaths
USA ↗ (new cases/day 21 271)
1 639 901 confirmed cases **366 524** recovered **97 579** deaths
Brazil ↗ (new cases/day 14 527)
363 211 confirmed cases **149 911** recovered **22 666** deaths
Russia ↘ (new cases/day 9 120)
344 481 confirmed cases **113 299** recovered **3 541** deaths
UK ↘ (new cases/day 2 428)
259 559 confirmed cases **not reproted** recovered **36 793** deaths
Spain ↗ (new cases/day 656)
235 772 confirmed cases **150 376** recovered **28 752** deaths

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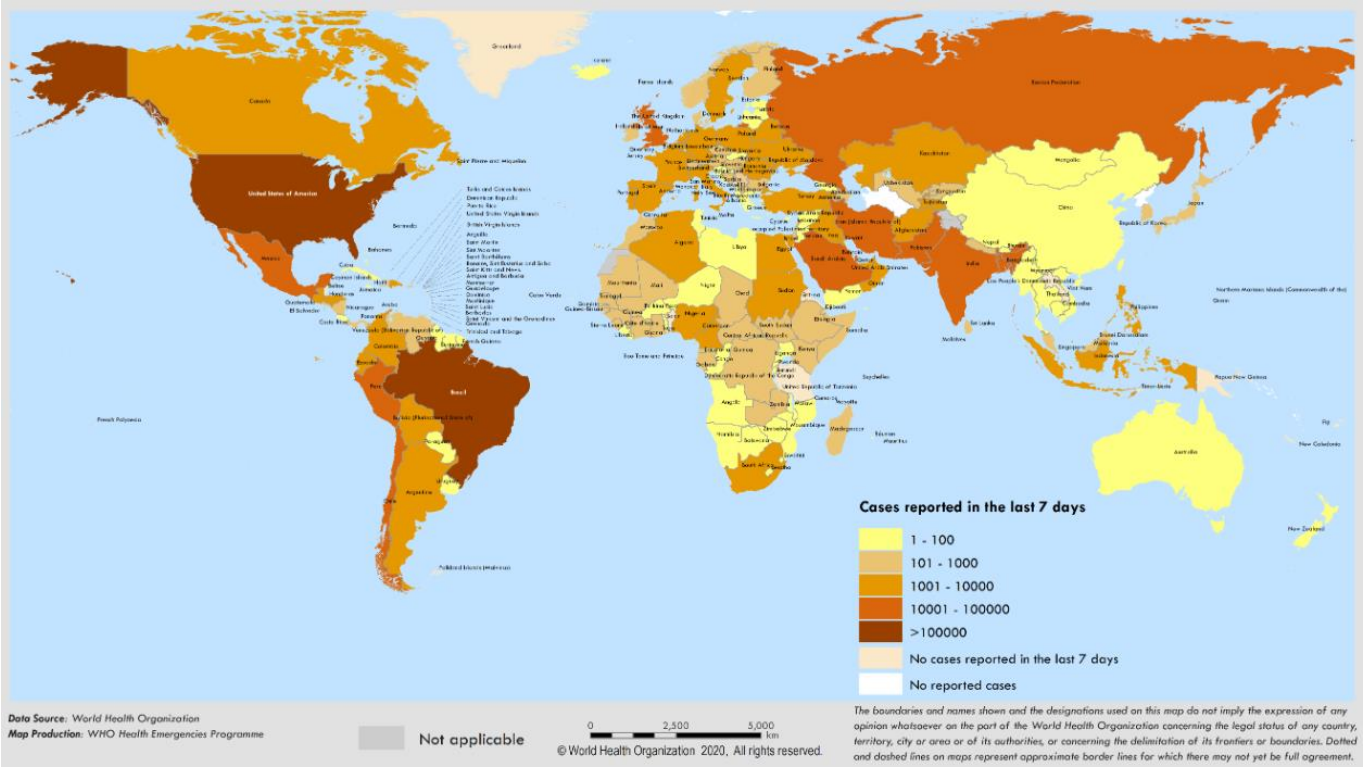
Map of countries with reported COVID-19 cases (last 7 days)



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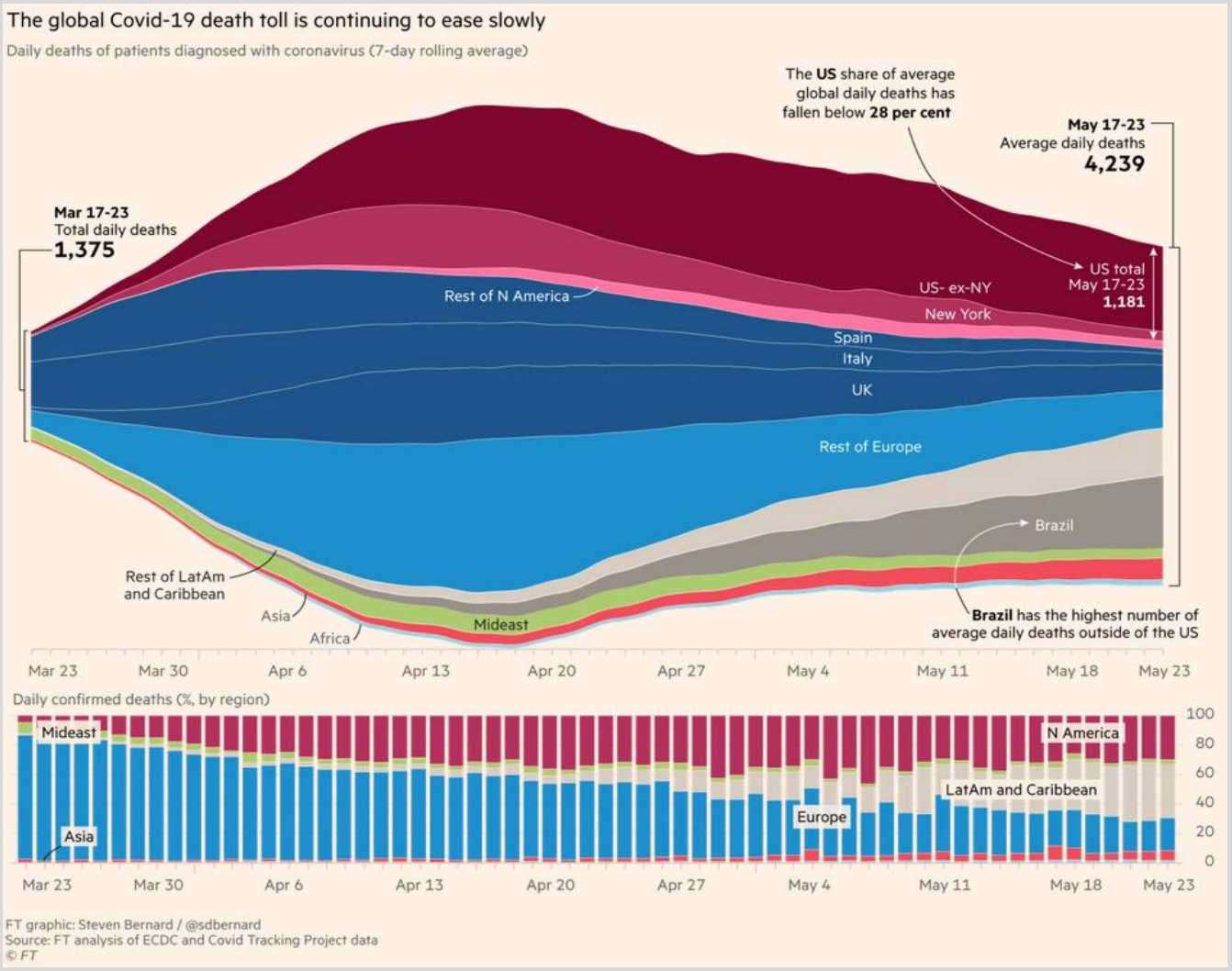
Worldwide Situation

Global Situation

Latin America: The number of deaths registered by the corona pandemic in Latin America and the Caribbean has increased to more than 40,000. This was the result of a count by the AFP news agency on the night of Monday based on official data. In just two weeks, the total number of corona deaths recorded in this region of the world has doubled.
Brazil is the region most affected by the pandemic. By today, 22,666 deaths and 363,211 cases of infection had been counted. Peru (3,456 dead and 119,959 infected) and Chile (718 dead and 69,102 infected) and are behind. Given the scale of infection rates in Brazil, the U.S. government announced a ban on entries from the South American country on Sunday.
CHN: International flights will severely restrict until at least October. While air traffic within China has again reached half of the pre-crisis level according to a report by the business magazine "Caixin" on Saturday, the aviation authority is holding on to the restrictions on flights from abroad. Since the end of March, a “five-one rule” has been in place that only allows one airline to fly one route to one country per week.



In early March Europe´s average count to coronavirus-related death overtook Asia´s. At that time Italy, Spain and the UK become the new global hotspots. The US, where the number´s of death remained very high until now, became the hotspot in mid-April, accounting for 28% of global deaths. Recently the Caribbean and Latin America showed its shared increase to more than a third pf new deaths, with the focus on the COVID-19 fatalities in Brazil.

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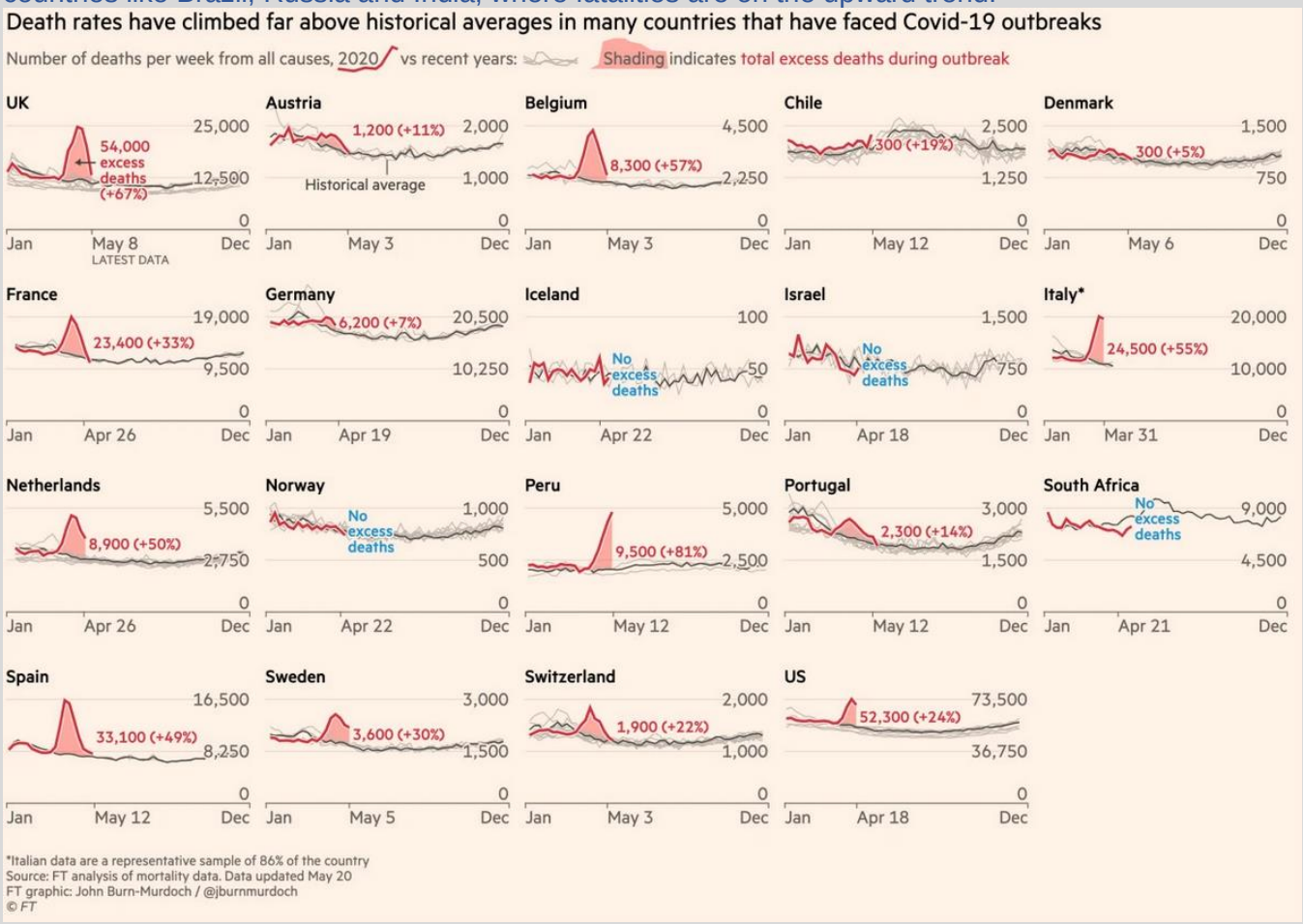
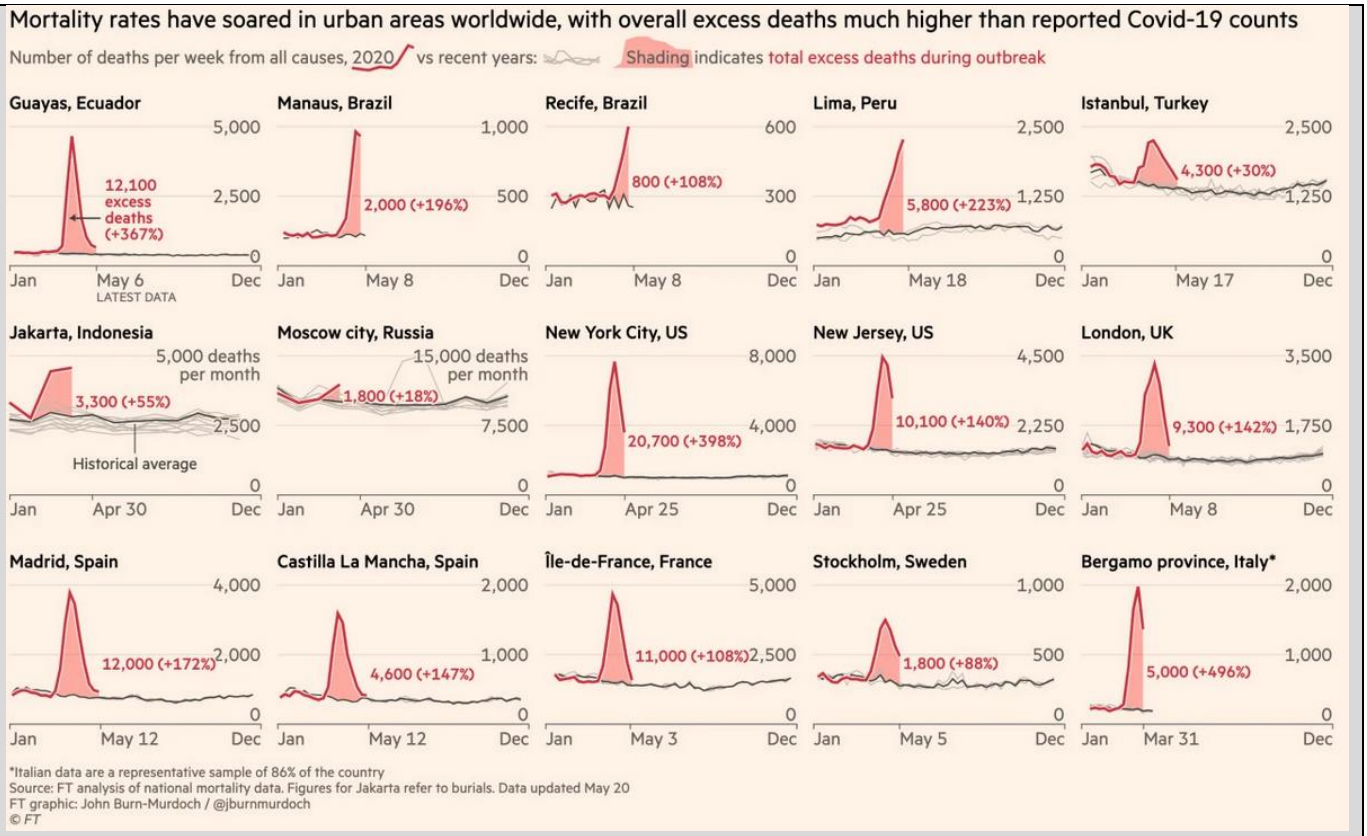
After the pandemic shifted to Europe, Italy became the country hardest hit by Coronavirus. A lot of other countries faced also a high amount of fatalities in the first month of the crisis. Only a few countries worldwide, like Australia, could keep their death tolls from ever reaching double digits. Still there are countries like Brazil, Russia and India, where fatalities are on the upward trend.



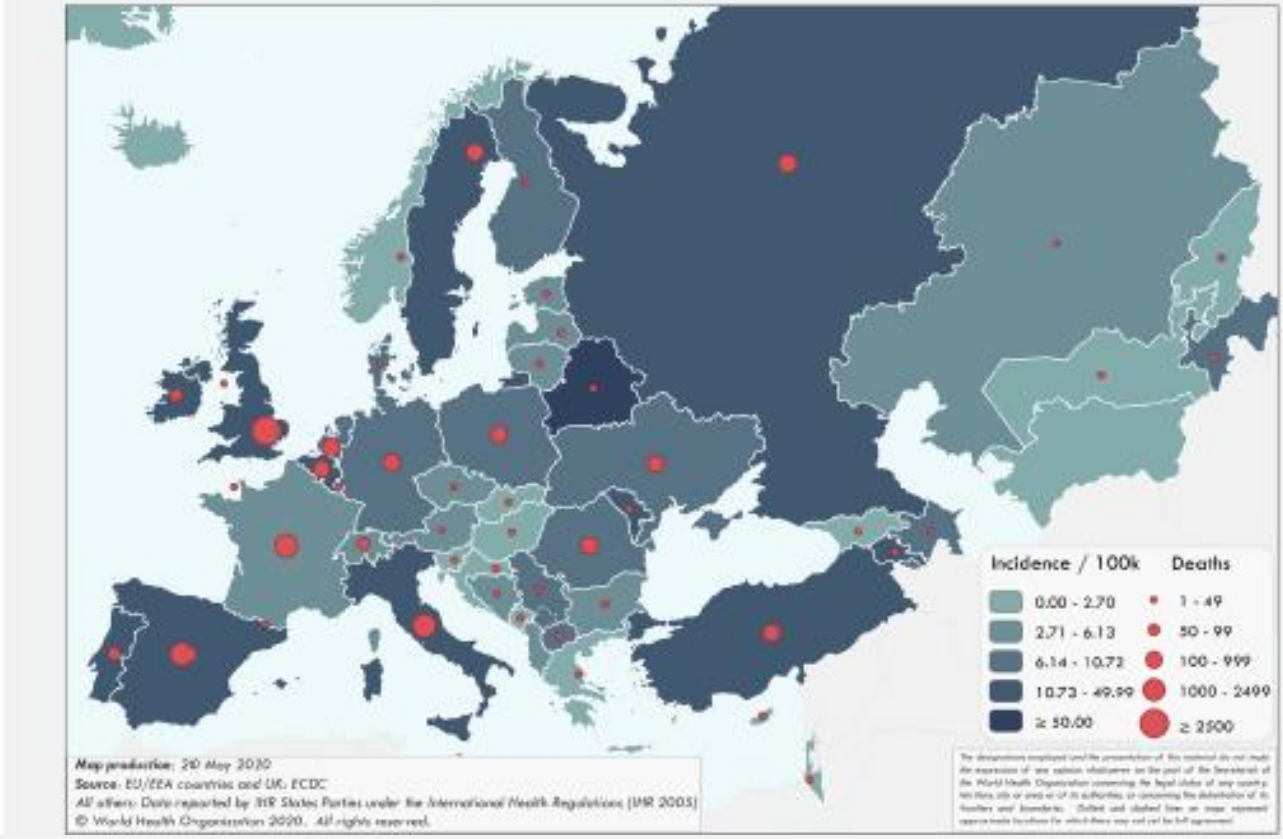
There are questions if the reported COVID-19 deaths are capturing the true impact of coronavirus on mortality around the world. For the shown pictures the Financial Times gathered and analysed data on excess mortality – the number of deaths over and above the historical average – worldwide and has found that death tolls in some countries are more than 50% higher than usual.

The Euromomo network gathers data from various European countries on mortality and the gathered data show the same outcome.



The picture is even starker in the hardest-hit cities and regions. Like in Ecuador´s Guayas province where there have been 10,000 more death than normal since the start of March, means an increase of more than 300%. London has seen overall deaths more than double, and New York City´s total death number since mid-March are more than four times the norm.
Source: https://www.ft.com/content/a26fbf7e-48f8-11ea-aeb3-955839e06441

Source: ECDC

Situation in Europe	**AUT:** Doctors at the medical university in Vienna have successfully completed a lung transplant in connection with COVID-19 disease. The university announced that it was the first of its kind in Europe. The 45-year-old patient was infected with the coronavirus eight weeks ago, and developed a total lung failure. **ITA:** For the first time since the lifting of the corona restrictions in Italy, the Pope has given his Sunday blessing to pilgrims who were standing on St. Peter's Square. The square in front of St. Peter's Basilica had been closed since March and only opened again this Monday. An antibody test study with around 150,000 participants started this Monday to determine the undisclosed number of corona infected people. The Ministry of Health and the statistical office together with the national Red Cross want to take blood tests of people from 2,000 locations. **GBR**: Will make international air travelers isolate themselves for 14 days as of June 8, but is exempting truck drivers, seasonal farm workers and medical staff. In a reciprocal move, **FRA** will require visitors from Britain to isolate for 14 days starting on June 8, and air travelers from Spain starting Monday. COVID-19 incidence per 100,000 population and number of deaths by country for week 20 

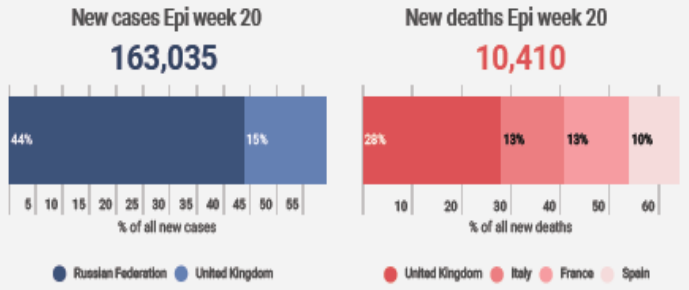
COVID-19 situation update for the WHO European Region (11 May - 17 May 2020 Epi week 20)

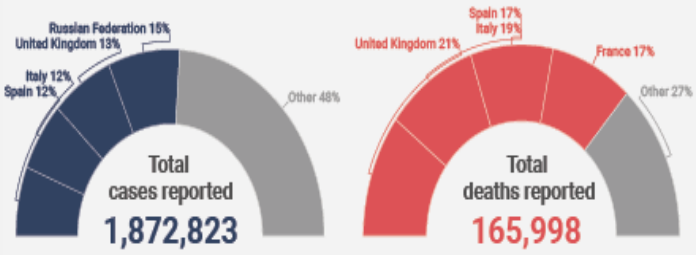
Week 20/2020 (11 - 17 May 2020)

- The number of cases reported in week 20/2020 in the Region has declined by 37% since week 14/2020
- 59% of the cases reported in week 20/2020 were from the Russian Federation and the United Kingdom
- Two countries had a crude incidence of ≥50 per 100,000 in week 20/2020: Belarus and San Marino
- In nine countries, the 14-day cumulative incidence increased by ≥10% in week 20/2020 compared to the previous week: Tajikistan, Azerbaijan, Malta, Armenia, the Russian Federation, Kyrgyzstan, Belarus, Lithuania and the Republic of Moldova. (see EURO COVID-19 Dashboard for recent trends).
- 64% of the deaths reported in week 20/2020 were from the United Kingdom, Italy, France and Spain
- The proportion of reported cases that died decreased from 6.8% in week 19/2020 to 6.4% in week 20/2020, a change that is likely due to a range of factors

Summary overview

- Seven countries in the Region each reported a cumulative incidence of ≥400 cases per 100,000 population: San Marino, Andorra, Luxemburg, Iceland, Spain, Ireland and Belgium.
- 19% of all reported infections with information available were in a health care worker
- 79% of all ICU admissions were in persons aged 50-79 years of age, with 70% of all ICU admissions in men
- 94% of all deaths were in persons aged ≥60 years and 59% of all deaths were in men
- 97% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (66%)
- 73% of cumulative deaths were reported from the United Kingdom, Italy, Spain and France
- From week 10, 2020 and as of week 20, there were more than 159,000 excess deaths reported from 24 countries/regions. Primarily in the age group ≥65 years with over 143,000 excess deaths, but also in the 15-64 years age group with over 13,000 excess deaths. 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 20/2020, five countries reported a total of 211 tests and five COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 19/2020 was 4.3% (8 countries) compared to 9.5% (7 countries) in week 18/2020. The highest positivity was 18.6%, seen in week 15/2020.





19%
of all people infected were health care workers

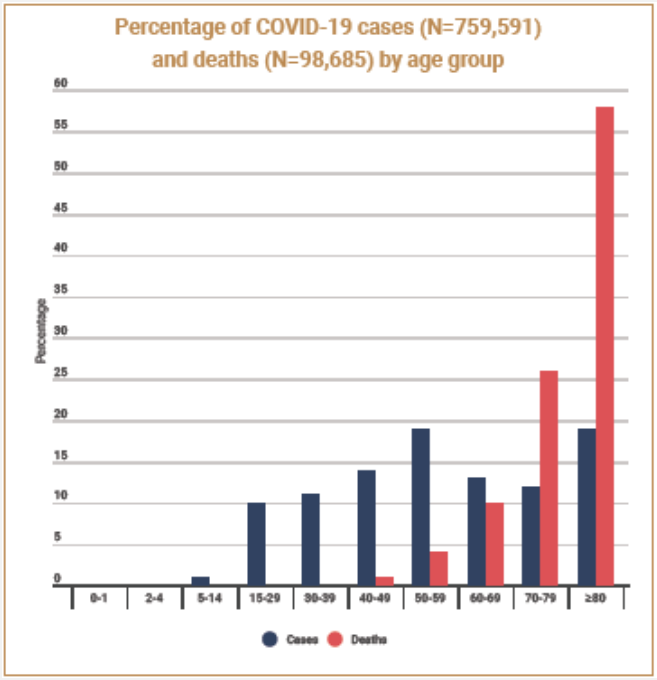
97%
of all deaths
had at least 1 underlying condition

59%
of all deaths
were in men

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

94%
of all deaths
were in persons aged 60+

66%
of all deaths
had cardiovascular disease



Characteristics of COVID-19 cases and deaths

	Characteristics	n	%	Total records with data available
Cases	Age in years, median (range)*	55 (1-105)		526,722
	Sex, male*	243,697	47	524,000
	Travelled*	16,957	12	142,264
	Recovered*	184,166	90	204,852
	Health care workers*	83,084	19	426,848
	Hospitalization*	127,278	30	425,744
	Intensive care unit admissions*	9,607	3	319,797
Deaths	Age in years, median (range)^	81 (0-108)		98,685
	Sex, male^	57,662	59	97,691
	At least one underlying condition^	26,125	97	26,984
	• cardiovascular disease	15,340	66	23,327
	• diabetes	7,546	34	22,394
	• lung disease	5,247	23	22,616
	• neurological disease / dementia	1,929	26	7,491
	• renal disease	1,367	20	6,758
	• malignancy	827	26	3,228
	• obesity	524	9	5,759
	• liver disease	320	5	6,689
	• immune disease	234	4	5,779
	• other	11,066	50	22,241

*Case report forms (n=528,541);
^Case report forms and aggregated data from Italy (14/15 May) and Spain (14 May 2020) (n=792,555);
Health care workers refer to occupation and not to the place of exposure
^Case report forms, mortality survey, aggregated data from Italy (14 May 2020) and Spain (14 May 2020) (n=98,698)

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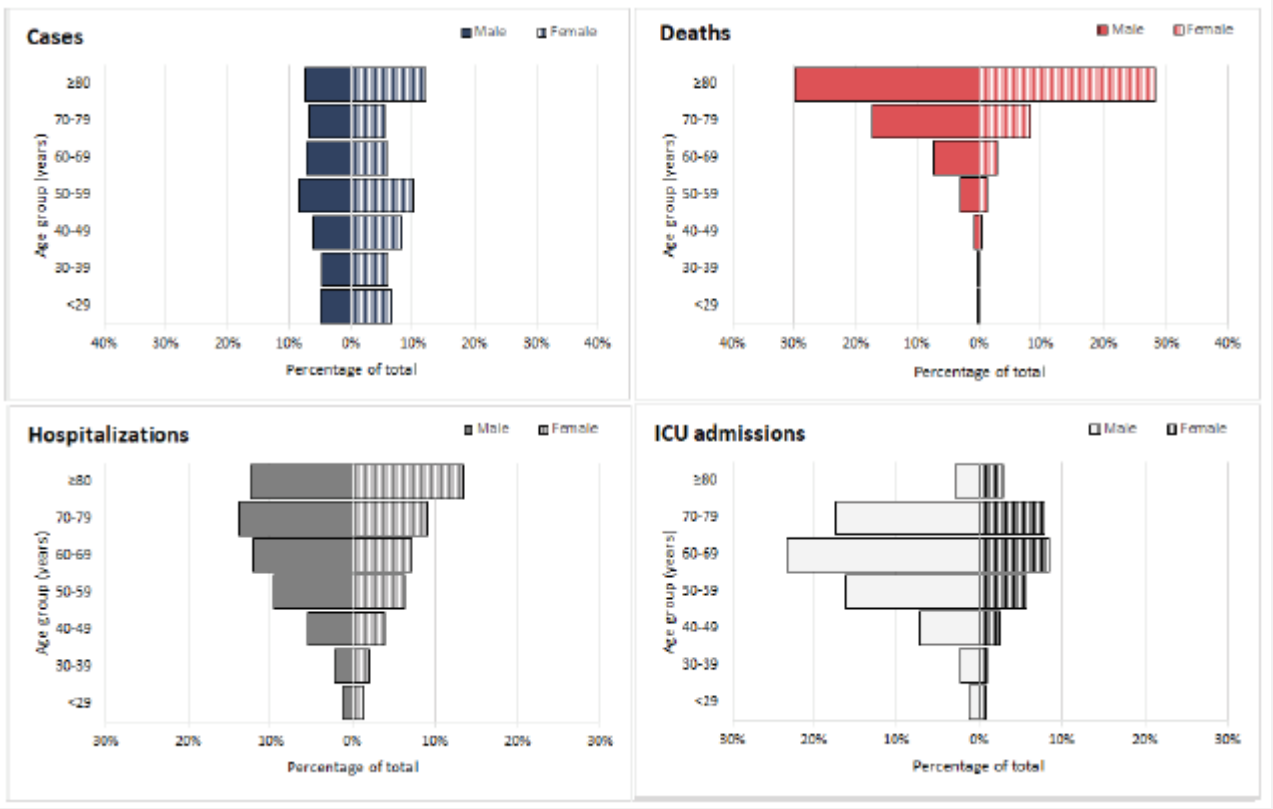
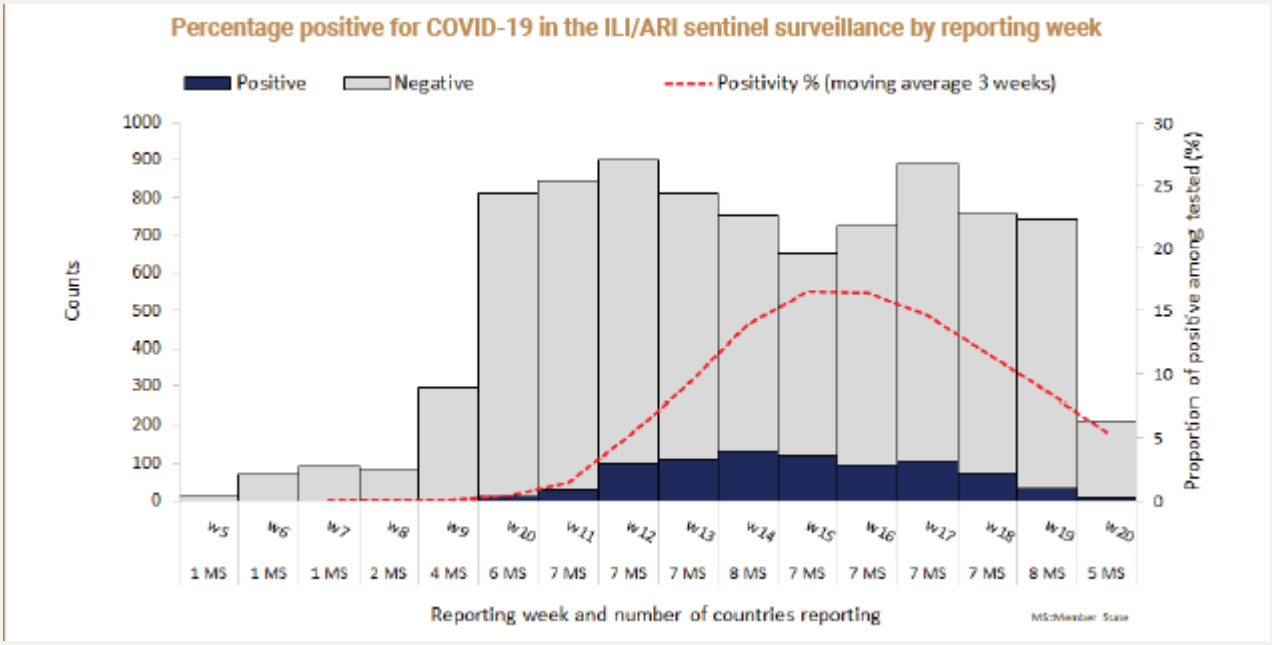
Percentage of COVID-19 cases (N=763,258), hospitalizations (N=126,177), ICU admissions (N=11,696) and deaths (N=93,401) by age group and sex





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Subject in Focus

Pandemic Emergency Financing Facility (PEF)

Background:
Infectious diseases pose a constant threat to people's health and wellbeing as well as to countries' economies and development. While developed countries usually have the technology, personnel and money available to combat epidemic outbreaks and contain them at an early stage, developing and emerging countries are often not able to do the same. The population of poor countries is usually more vulnerable to the consequences of infectious diseases and environmental conditions and other circumstances in those countries usually foster the spread of infections. In addition, many well-known tropical diseases are endemic in those countries.

It is estimated that moderately severe to severe pandemics could lead to annual costs of about USD 570 bn (0.7% of global Gross Domestic Product (GDP)). A very severe pandemic (comparable to the Spanish flu in 1918) is expected to cost up to USD 4 trillion (5% of global GDP).

In the light of the Ebola outbreak in Western Africa that hit Guinea, Liberia and Sierra Leone and led to a combined loss in GDP of USD 2.6 bn and with the idea in mind that the early availability of some money to fight an outbreak at its beginning could have the same (or an even bigger) effect compared to a larger amount of money that is available at a later stage, the G7 asked the World Bank Group to develop a solution to make money available at the early stage of a concerning outbreak.

About one year later on 21st May 2016 the World Bank announced the start of the Pandemic Emergency Financing Facility (PEF).

The overall objective of the PEF is to make money available at the early stage of an outbreak and at the same time not only disbursing money donated by countries, but also involving the capital market into fighting an outbreak. It was estimated that – if PEF would have been in place prior to the Ebola outbreak in 2014 - approximately USD 100 m would have been available as early as July 2014 and the outbreak might have been contained rather quickly. Without PEF the outbreak grew and eventually claimed more than 11,300 lives and costed at least USD 10 bn (which were partly covered by a total of USD 7 bn of international assistance).

PEF – just another catastrophe bond?

PEF was setup and structured in close collaboration with the World Health Organisation and the private sector.
It shares some similarities with so called "catastrophe bonds" (cat bonds) that are already well-established instruments to insure quick pay-outs after natural catastrophes (e.g. Hurricanes). Those bonds are basically following a rather simple scheme to transfer the (financial) risk of a catastrophe from a so-called "sponsor" to investors.

Some important terms are now briefly described:

- Sponsor: Someone who currently is "at risk" of the (financial) consequences of a natural catastrophe and is willing to pay money to transfer the risk to someone else
- Investor: Someone who is willing to bear the financial risk of a natural catastrophe, if he receives an adequate amount of money for this "service"
- Catastrophe: An event that (can) meet all triggers and could lead to a pay-out
- Parametric Trigger(s): Pre-agreed requirements that lead to a pay-out if met (e.g. geographical area where a hurricane has to occur in order to receive a pay-out). Little to no room for subjective decisions whether a trigger is met or not.
- Coupon: Annual premium paid by the sponsor (comparable to interest rates)
- Principal: The amount of money that is paid to the sponsor by the investors in case all triggers are met

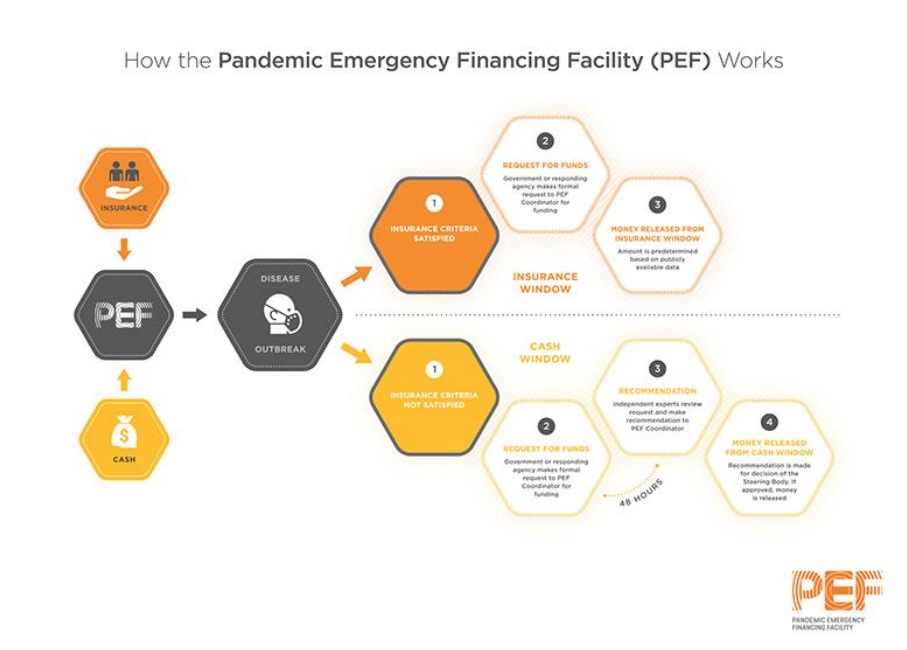
The bond is issued via an investment bank and the sponsor pays a coupon to the investors.
In case a predefined catastrophe occurs, which meets all triggers, the investors must pay the principal to the sponsor. If there is no catastrophe until the time of the bond's maturity (pre-agreed duration of the bond's existence) no payment is made from the investor to the sponsor.

In other words:
If a catastrophe happens during the bond's existence, the sponsor receives money and the investors lose money and if no catastrophe happens the investors earn money, while the sponsor loses money.
Catastrophe bonds are usually considered as being a risky investment and are therefore usually rather expensive (3%-20% above inter-bank rates like LIBOR). It is important to know that those bonds usually use "parametric triggers" to determine whether a catastrophe has occurred or not. Parametric triggers usually leave no room for subjectivity and are either met or not at any specific point in time.
As soon as all triggers are met a pay-out is made.

With PEF the World Bank uses this mechanism for the first time to combat infectious diseases.

The general structure of the PEF consists of two so called "windows" an insurance window that uses the previously described mechanism and a "cash window" that can pay out money that was previously made available by donors (e.g. developed countries). In total the insurance window can pay out several hundred million of USD. The main idea was that PEF should close the gap between the funding of immediate mitigation measures (usually funded by the affected countries and international organisations like the WHO with their regular budget) and the availability of large-scale international assistance.
The interest payments for PEF's insurance window are made by two donor countries (Germany, Japan). As described above a series of triggers must be met in order to make the PEF pay-out.

It was also agreed that not all infectious diseases can lead to a pay-out and not every disease can lead to the same amount of money being paid out. The diseases that are covered under PEF are the ones that are deemed to be likely causes of large-scale outbreaks within poor countries. Especially flu (max insurance window pay-out of USD 275 m), Coronaviruses (USD 195.83 m) and Filoviruses like the Ebolavirus (USD 150 m) were addressed.



https://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility

No pay-out during Ebola in the Democratic Republic of the Congo:
After being praised for its innovative concept and capital market involvement that transfers a share of the financial costs of international assistance from the donating countries to the private sector in the beginning, PEF was criticized by some experts, politicians and the public for not paying out during the next outbreak of Ebola in Africa. As the trigger design is parametric and therefore no subjectivity of decision makers was involved, the criticism aimed at the general trigger structure which was believed as being too strict and making a pay-out almost impossible by setting to high hurdles. Former world bank economist Lawrence Summers even called the PEF "an embarrassing mistake". The World Bank was criticized for essentially allowing investors to earn money that could be better used to pay directly for prevention and outbreak mitigation.
It should not be forgotten that PEF was never designed to pay for the mitigation of rather local outbreaks (that's why a minimum of 20 deaths in a neighbouring country were one of the parametric trigger criteria). Only PEF's cash window paid out during the Ebola outbreak in DRC, leaving the investors unaffected.

COVID-19 leads to PEF pay-out:
After the COVID-19 epidemic evolved into a global pandemic there were calls for PEF to pay out. Most trigger criteria were met early (e.g. the number of deaths, and number of affected countries) and SARS-CoV-2 qualified as a pathogen that is covered by the PEF. But due to its initial objective of closing the gap between immediate financing and large-scale international assistance the remaining unmet criterion was that the first pay-out could only be made if all triggers are met 12 weeks after the initial declaration of the outbreak. It took approximately 3 and a half months between official recognition of the outbreak and the pay-out of nearly USD 196 m. It can be said that the overall goal of PEF, to pay out at a specific point during an outbreak was achieved. Critics pointed out that an earlier pay-out would have been beneficial, but it was acknowledged that the overall structure has worked. The COVID-19 pay-out also showed that the triggers involved were effective in "timing" the pay-out, so that it happened at a specific point in time when local budgets were expected to be exhausted.

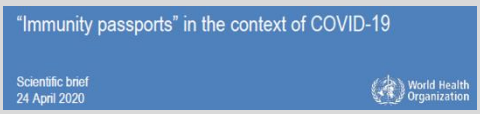
Conclusion and future developments:
Even though the usefulness of the existence and the mechanism behind this innovative solution are not undisputed, PEF demonstrated its potential in fighting future outbreaks. Involving the private sector creates a win-win situation for both: private investors that can invest into a so called "uncorrelated asset" diversifying their investment portfolio and the society that profits from quick availability of money to fight the outbreak at an early stage. Further evaluations are necessary to determine if adjustments to the structure and trigger design are necessary to improve PEF's performance and societies benefits. However, it must be clear that loosening or dropping triggers (e.g. reducing the number of deaths that have to happen until a pay-out is possible or the necessity of a certain number of deaths in a neighbouring country) will increase the price that has to be paid by funding countries as this directly affects the likelihood of a pay-out and subsequently the likelihood of a total loss for the investors.

The creation of PEF (and its potential successors) is also an important step forward on the way of creating an insurance market for epidemic risks which would allow companies to protect themselves against the consequences of pandemics and epidemic outbreaks of various scales. While some people see this solely as an insurers' idea to make profit, research suggests that the availability of insurance against epidemic risks can help making the economy and the society more resilient against infectious diseases and might help to mitigate consequences such as increased unemployment rates which would have numerous positive effects on (mental) health and wellbeing.

Sources:
https://www.worldbank.org/en/news/press-release/2016/05/21/world-bank-group-launches-groundbreaking-financing-facility-to-protect-poorest-countries-against-pandemics
https://en.wikipedia.org/wiki/Pandemic_Emergency_Financing_Facility
https://www.worldbank.org/en/topic/pandemics/brief/fact-sheet-pandemic-emergency-financing-facility
https://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility

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. **Topics former VTCs:** • Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities. • Testing strategies • Aeromedical evacuation • De-escalation strategy and measures • Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases • Immunity map, national strategies to measure and evaluate the immunity level"
Immunity map, national strategies to measure and evaluate the immunity level	**Summary last VTC "Immunity map, national strategies to measure and evaluate the immunity level"** Immunity is the capacity of resistance in developing a disease. There are several types of immunity. In the case of COVID-19 the question is re-infection. South Korea, 286 positive cases of people who were already tested negative before, seems to suggest otherwise. The importance of IgG antibodies: the accuracy as a diagnostic tool is debated but using the result as immunity status documentation can be useful. For diagnostic purposes real-time PCR is the only accepted method of testing. Pooling method can be used in case of large numbers of possible patients. Most nations are only testing symptomatic patients. For asymptomatic patients (after incubation period) IgM/IgG can be used. Body temperature is also a symptom, but not a diagnosis. To diagnose the immunity, IgG is the only method. Immune status: real time PCR negative, IgM negative and IgG positive is the result in case of a patient who is recovered from the virus (symptomatic or asymptomatic). Antibody detection is essential for the positive diagnosis of the immune status. Measuring immunity is also a tool to measure the effectiveness of the de-escalation measures. Currently 325 serology tests are commercially available. FDA authorised 12 out of 325. Serology criteria: Good specificity (more than 98%) Good sensitivity (more than 95%) If the sensitivity is between 90-94% the test can be used for collective testing. Out of the 12 authorised tests, 3 are point of care tests and 9 are ELISA tests. As of right now, only 2 tests are up to the quality requirement. Both tests are blood sample based. Hundreds of tests can be done per day and the results are ready in 12 hours. The con is that the tests are a robot-based method, to carry out the testing, lab robot and professional personnel is needed. The results can't be used as an immunity passport. So far there is no proven correlation between positive serology and COVID-19 protection. Herd immunity is also far away yet. Measuring the antibodies can prove that the patient met with the virus. But antibody response is different between people. This is the reason why the results can't be used as immunity passport. WHO Immunity passport in the context of COVID-19



	Vaccination: About search for vaccine -irrational optimism. The actual vaccine is not as developed at the making as we might think. There are more than 100 vaccine candidates and maybe 10 of it will go to trial. But still it's not sure when and if we get a vaccine. Until an effective and reliable vaccine is developed, non-pharmaceutical measures are the only available mitigation methods. **Topic next VTC:** • Mental Health response

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 Ukraine

UKRAINE

DEMOGRAPHIC

AREA: 603.628 km^2
POPULATION: 42.030.832
CAPITAL: Kiev
AGE STRUCTURE:
0-14 years: 15.95%
15-24 years: 9.57%
25-54 years: 44.03%
55-64 years: 13.96%
65 years and over: 16.49%

NUMBERS AT A GLANCE

3.4 million people requiring Humanitarian Assistance

1.4 million IDPs in Ukraine

1 million food-insecure people in Eastern Ukraine

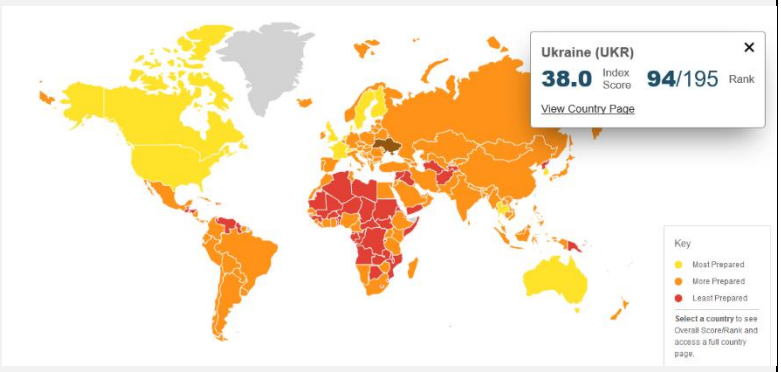
480,156 Ukrainians seeking asylum in nearby countries

21.245 confirmed COVID-19 cases in Ukraine

623 COVID-19 related deaths were reported

SHORT HISTORY

After World War II the Western part of Ukraine merged into the Ukrainian Soviet Socialist Republic, and the whole country became a part of the Soviet Union as a single state entity. Ukraine gained its independence in 1991, following the dissolution of the Soviet Union at the end of the Cold War. Following its independence, Ukraine declared itself a neutral state, it formed a limited military partnership with Russia and other Commonwealth of Independet States (CIS; post-Soviet) countries while also establishing a partnership with NATO in 1994. In 2013, after the government of President Viktor Yanukovych had decided to suspend the Ukraine-European Union Association Agreement and seek closer economic ties with Russia, a several-months-long wave of demonstrations and protests known as the Euromaidan began, which later escalated into the 2014 Ukrainian revolution that led to the overthrow of Yanukovych and the establishment of a new government. These events formed the background for the annexation of Crimea by Russia in March 2014, and the War in Donbass in April 2014. On 1 January 2016, Ukraine applied the economic component of the Deep and Comprehensive Free Trade Area with the European Union.



COVID-19 IMPACT AND RESPONSE

The COVID-19 pandemic and resultant containment measures have hampered humanitarian activities, as well as limited access to essential services, for conflict-affected populations in eastern Ukraine, according to the UN. Following the first reported COVID-19 case in Chernivtsi Oblast in early March, the Government and self-proclaimed Non-Governmental Controlled Areas (NGCA) authorities implemented regulations—including border closures, movement restrictions, and public gathering prohibitions—to reduce disease transmission in Ukraine. As of late April, most travel across the line of contact connecting Government Controlled Areas (GCA) and NGCAs in eastern Ukraine remained prohibited, and all border crossing points remained closed. Consequently approximately 300,000 NGCA residents have lost access to the Government pensions on which they rely, and an additional 163,000 people experience difficulties accessing ATMs in GCAs, limiting their access to cash and hindering their ability to purchase essential goods.

In addition, restrictions imposed by self-proclaimed NGCA authorities have limited humanitarian commodity and staff movement from GCAs to NGCAs. As of mid-April, self-proclaimed authorities had prohibited all humanitarian staff from entering NGCAs, allowing for limited and unevenly applied exemptions for International Committee of the Red Cross (ICRC). Self-proclaimed authorities also restricted humanitarian convoy movements.

While COVID-19 cases in Ukraine continue to increase, conflict-affected populations remain at acute risk, as containment measures disrupt access to basic services. As of today, nearly 21.245 confirmed COVID-19 cases has been reported—including more than 900 in Luhansk NGCA; more than 800 in Donetsk NGCA; and more than 500 and 300 in Donetsk and Luhansk GCAs, respectively—and 623 associated deaths in Ukraine. More than 40 percent of the population residing along the contact line are older persons, often at higher risk of COVID-19 complications, while prolonged conflict continues to adversely affect eastern Ukraine's health care system. On both sides of the contact line, a shortage of medical personnel and supplies, as well as limited public transport has complicated response efforts.

Prior to the COVID-19 outbreak, approximately 2.8 million people already required water, sanitation, and hygiene (WASH) support in eastern Ukraine, hindering hygiene practices critical to minimizing the risks of disease transmission. Nearly 120 GCA settlements surveyed on the COVID-19-related needs in late March, approximately 90 percent lacked ambulance services, and more than 60 percent lacked medical facilities.

In response to the COVID-19 outbreak, the UN released the Ukraine COVID-19 Emergency Response Plan, requesting money for COVID-19 prevention and response activities countrywide, as well as for health activities and to address the socioeconomic impact. In March UNHCR mobilized more than 10 Community Support Initiatives —assisting displaced and other conflict-affected communities —to produce medical masks for distribution to GCA community members and health facilities in response to the COVID-19 pandemic.

INSECURITY AND POPULATION MOVEMENT

Ongoing insecurity—including armed clashes, as well as explosive remnants of war and mine-related incidents—resulted in two civilian deaths and injury to 17 civilians only in March. From April 2014 to March 2020, the conflict resulted in an estimated 3,353 civilian deaths and injury to more than 7,000 people.

From January to March, armed actors attacked more than 10 education facilities in eastern Ukraine, according to the Education Cluster. On February 18, shelling near a lot of settlements along the contact line prompted at least one school to evacuate to a nearby bomb shelter, contributing to a 70 percent increase in child psychosocial support service requests from schools in affected areas. In 2019, approximately 50 incidents damaged school infrastructure in conflict-affected areas of Ukraine.

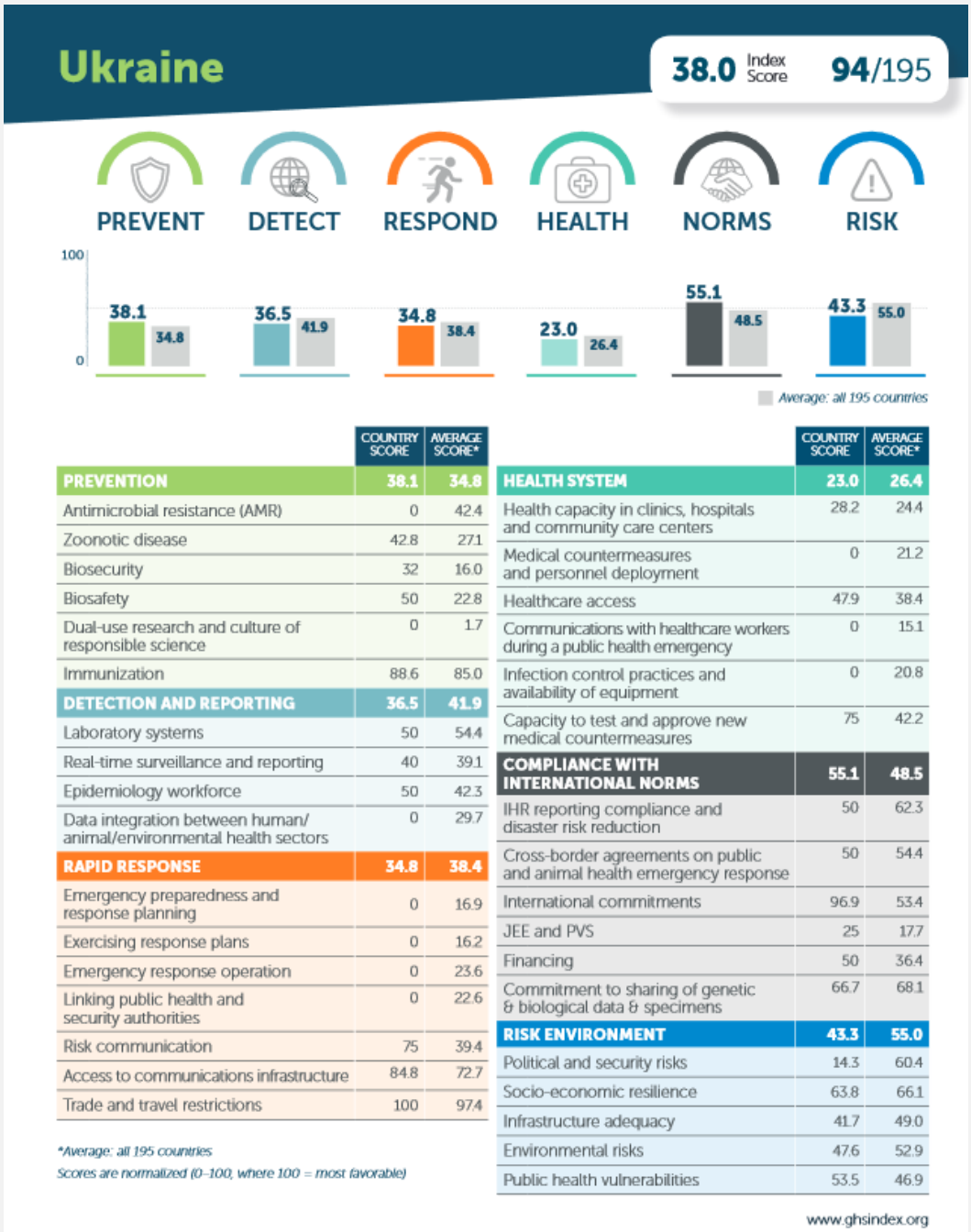
During March, humanitarian monitors recorded 593,000 contact line crossings—representing a nearly 40 percent decrease from the 979,000 crossings recorded during February—due to the mid-March COVID-19-related closure of all border crossing points.

PROTECTION

During January and February, humanitarian actors provided psychosocial support services to nearly 3,200 older people in Donetsk and Luhansk and provided mental health services to conflict-affected people in GCAs during March.

SHELTER, WASH, AND WINTERIZATION

From January to March, approximately 14 armed attacks affected critical WASH facilities in conflict-affected areas of eastern Ukraine. Furthermore, Donetsk Filter Station—which supplies safe drinking water to an estimated 380,000 people on both sides of the contact line—ceased operations in late March due to a lack of personnel security assurances from parties to the conflict. A three days later the station resumed activities.



	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**38.1**	**34.8**
Antimicrobial resistance (AMR)	0	42.4
Zoonotic disease	42.8	27.1
Biosecurity	32	16.0
Biosafety	50	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	88.6	85.0
DETECTION AND REPORTING	**36.5**	**41.9**
Laboratory systems	50	54.4
Real-time surveillance and reporting	40	39.1
Epidemiology workforce	50	42.3
Data integration between human/ animal/environmental health sectors	0	29.7
RAPID RESPONSE	**34.8**	**38.4**
Emergency preparedness and response planning	0	16.9
Exercising response plans	0	16.2
Emergency response operation	0	23.6
Linking public health and security authorities	0	22.6
Risk communication	75	39.4
Access to communications infrastructure	84.8	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**23.0**	**26.4**
Health capacity in clinics, hospitals and community care centers	28.2	24.4
Medical countermeasures and personnel deployment	0	21.2
Healthcare access	47.9	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	0	20.8
Capacity to test and approve new medical countermeasures	75	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**55.1**	**48.5**
IHR reporting compliance and disaster risk reduction	50	62.3
Cross-border agreements on public and animal health emergency response	50	54.4
International commitments	96.9	53.4
JEE and PVS	25	17.7
Financing	50	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	**43.3**	**55.0**
Political and security risks	14.3	60.4
Socio-economic resilience	63.8	66.1
Infrastructure adequacy	41.7	49.0
Environmental risks	47.6	52.9
Public health vulnerabilities	53.5	46.9

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

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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 and De-escalation strategy measures 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

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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