Update 53 (19th of January 2021)

Information about infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
19th of January 2021
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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**: Again warns of "catastrophic moral failure" in vaccine distribution. The countries and manufacturers should distribute the vaccine against the corona virus more fairly worldwide. While 39 million doses have now been administered in at least 49 wealthy countries, the number of doses in poor countries is just 25. "This me-first approach not only endangers the poorest and weakest in the world, it is also self-destructive" says WHO Director General. Ultimately, that will only prolong the pandemic.
- **G7 summit:** The summit will be hosted by Great Britain this year, is to take place from June 11th to 13th in Carbis Bay on the coast of Cornwall. It will be the first face-to-face meeting of the G7 heads of state and government for two years and since the new US President Joe Biden took office. The main topics are likely to be the fight against the corona pandemic and climate change. Australia, India and South Korea have also been invited to the G7 summit.
- **ECDC**: is building a system to collect early data on the distribution and administration of corona vaccines in Europe. The data collection is intended to cover, on the one hand, the vaccine doses delivered per country per week and, on the other hand, the number of people who have been vaccinated against the coronavirus so far. Among other things, the authority wants to provide information on the efficiency of the national vaccination campaigns and identify possible deficiencies in the distribution of the batches.
- **WHO:** Published the statement on the sixth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic.
- **ECDC**: Published a technical guidance on sequencing of SARS-CoV-2 to provide guidelines to laboratories and relevant stakeholders in making decisions on establishing sequencing capacities and capabilities and on which technologies to use and/or in deciding on the role of sequencing for SARS-CoV-2 diagnostics, research, outbreak investigations and surveillance. It addresses the most used sequencing technologies and their applications and proposes a central standardization process to analyse and report the findings of SARS-CoV-2 genetic characterisations.
- **CoronaNet:** The Research Project compiles a database on government responses to the coronavirus. The main focus is to collect information about the various fine-grained actions governments are taking to address the effects of the COVID-19 pandemic. It includes 50,000 entries, 195 countries, 500+ researchers.
- **ECDC:** Published a technical note for the sequencing of SARS-CoV-2 to provide guidelines to laboratories in the EU.
- **ECDC:** In an effort to continuously improve its performance, the Centre commissioned an external assessment of its response to the COVID-19 pandemic for the period January - September 2020.

GLOBALLY ↘ 95 585 471 confirmed cases 62 200 050 recovered 2 041 477 deaths
EU/EEA and the UK ↘ 30 191 883 confirmed cases 15 802 200 recovered 656 785 deaths
USA ↘ **(new cases/day 148 246)** 23 980 818 confirmed cases **9 401 194** recovered 397 146 deaths
India ↘ **(new cases/day 13 788)** **10 581 823** confirmed cases **10 228 753** recovered **152 556** deaths
Brazil → **(new cases/day)** **8 511 770** confirmed cases **7 560 460** recovered **210 299** deaths
Russia → **(new cases/day 22 509)** **3 552 888** confirmed cases **2 947 479** recovered **65 059** deaths
UK ↘ **(new cases/day 37 535)** **3 433 494** confirmed cases -not reported- recovered **89 860** deaths

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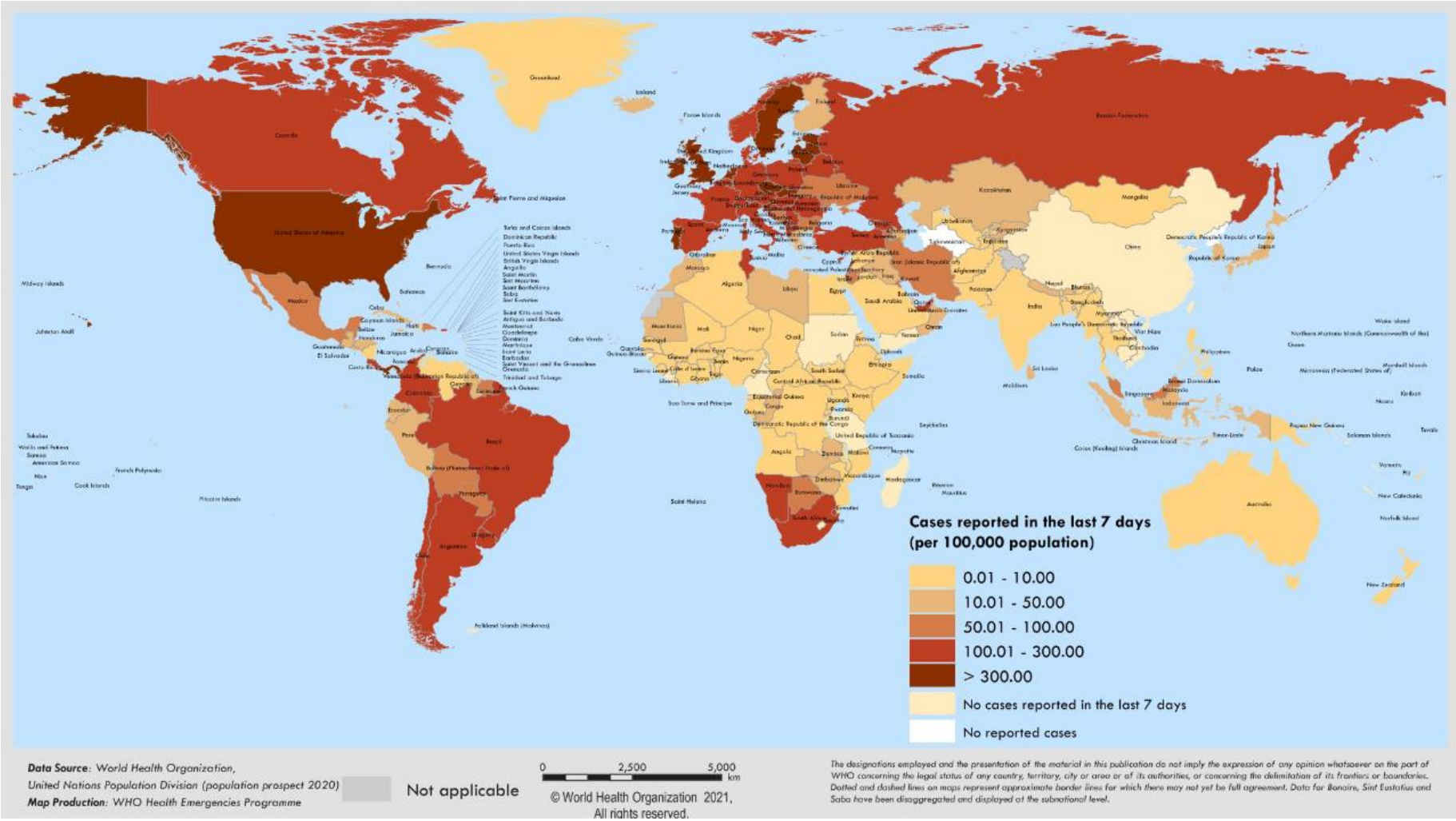
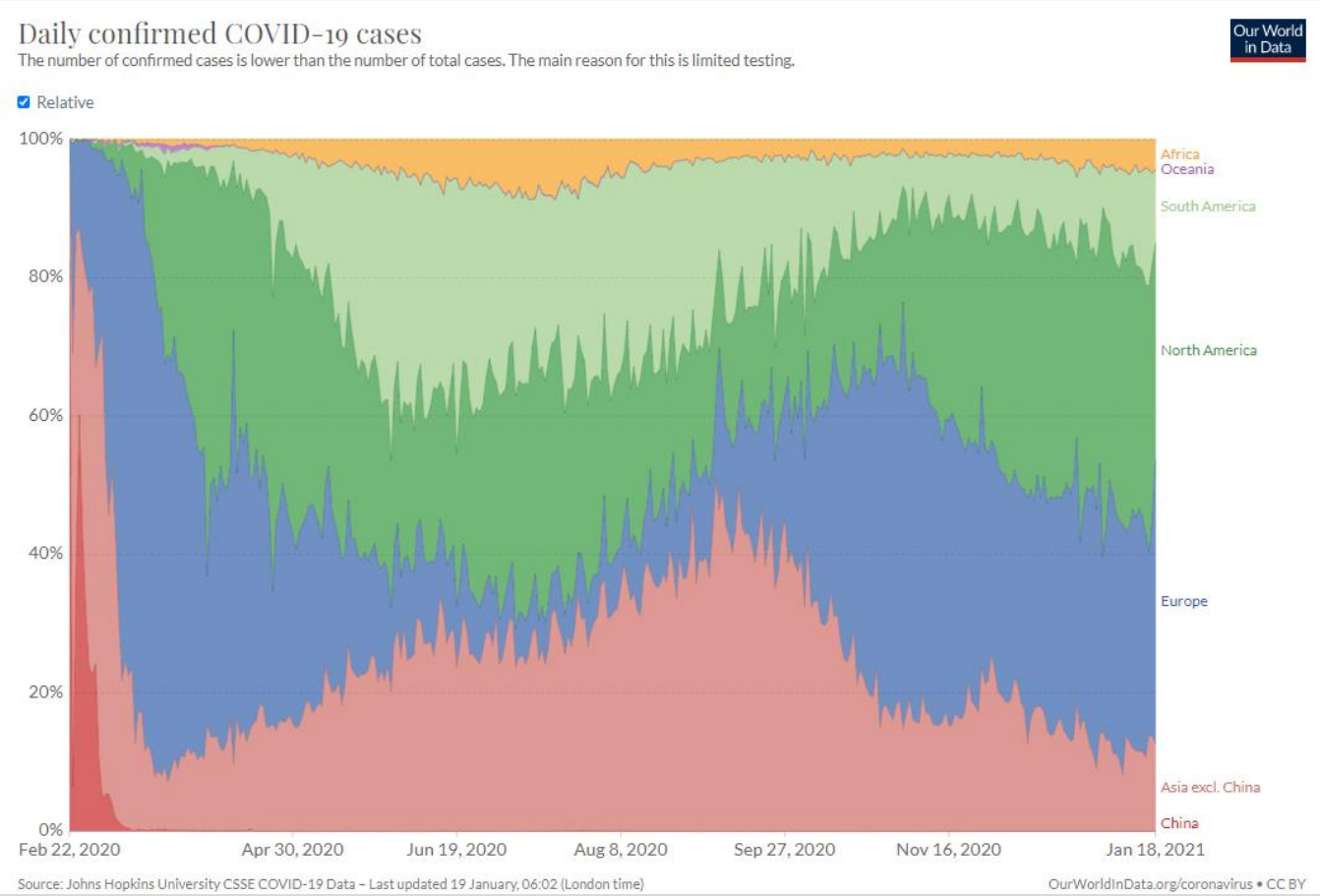
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation



An **independent commission of inquiry** into the global response to the pandemic criticizes the initial measures by China and the WHO as being to slow. The Beijing government could have taken more decisive action in January 2020, said the group of experts, led by former New Zealand Prime Minister Helen Clark and Liberia's ex-President Ellen Johnson Sirleaf. The WHO, for its part, should not have waited until January 30th to declare an international emergency.

Furthermore the commission called for the World Health Organization (WHO) in Geneva to be strengthened and financed. The Commission warned that the WHO has too few competencies and insufficient budgetary resources to take decisive action against the outbreak of pandemics. The WHO could not order the 194 member countries and they could not start an independent investigation. A thorough modernization of international health structures is also required.

A final report should follow in May.

Statement on the sixth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic, as of January 15

Advice of the Committee to the WHO Secretary:

SARS-CoV-2 Variants

1. Continue to work with partners to develop standardized definitions and nomenclature of SARS-CoV-2 virus variants, based on their genetic sequence, that avoids stigmatization and is geographically and politically neutral. Provide clear information to State Parties on what constitutes a variant of concern.
2. Continue to increase worldwide capacities for SARS-CoV-2 molecular testing and genetic sequencing, in line with WHO guidance, and encourage rapid sharing of sequences and meta-data to strengthen monitoring of virus evolution and to increase global understanding of variants and their effects on vaccine, therapeutics and diagnostic efficacy.

3. Strengthen the SARS-CoV-2 risk monitoring framework for variants by accelerating collaboration and harmonizing research to answer critical unknowns about specific mutations and variants, through relevant networks and expert groups such as WHO SARS-CoV-2 Virus Evolution Working Group and the WHO R&D Blueprint for Epidemics.

COVID-19 Vaccines

4. Accelerate research on critical unknowns about COVID-19 vaccination efficacy on transmission, duration of protection against severe disease and asymptomatic infection, duration of immunity (following infection or vaccination), long-term protection after using different vaccination intervals, protection after a single dose, and vaccination regimes, in line with the SAGE and the Research and Development Blueprint recommendations.
5. Promote global solidarity and equitable vaccine access by encouraging States Parties and manufacturers to donate resources and provide support to the COVAX Facility.
6. Promote technology transfer to low- and middle- income countries with the potential capacity to accelerate global production of COVID-19 vaccines.
7. Support State Parties, including fragile states, in preparing for COVID-19 vaccine introduction by developing a national deployment and vaccination plan, in line with WHO guidance, that addresses barriers to COVID-19 vaccine readiness. Such planning should include prioritization of populations, regulatory authorization, supply and logistics preparation, indemnification and liability, health workforce planning, and access for humanitarian and vulnerable population.

Health Measures in Relation to International Traffic

8. Lead development of risk-based international standards and guidance for reducing SARS-CoV-2 transmission related to international travel (by air, land, and sea) based on current science and good practices that include clear recommendations for testing approaches and quarantine duration as appropriate. The guidance should additionally include advice on adapting those measure to specific risk settings, including movements of migrants, temporary workers, travellers and conveyance operators.
9. Rapidly develop and disseminate the WHO policy position on the legal, ethical, scientific, and technological considerations related to requirements for proof of COVID-19 vaccination for international travelers, in accordance with relevant IHR provisions.
10. Coordinate with relevant stakeholders the development of standards for digital documentation of COVID-19 travel-related risk reduction measures ,that can be implemented on interoperable digital platforms. This should include vaccination status in preparation for widespread vaccine access.
11. Encourage States Parties to implement coordinated, time-limited, risk-based, and evidence-based approaches for health measures in relation to international travel.

Evidence-Based Response Strategies

12. Continue to rapidly provide and regularly update evidence-based advice; guidance; tools; and resources, including regular dissemination of resources to combat misinformation for COVID-19, to enhance evidence-based COVID-19 preparedness and response strategies and implementation of such strategies.

Surveillance

13. Continue to actively support countries to further strengthen their SARS-CoV-2 surveillance systems, including strategic use of genetic sequencing, by leveraging existing systems such as the Global Influenza Surveillance and Response System (GISRS) and relevant networks for systematic sharing of data and specimens.

Strengthening Health Systems

14. Provide strategic insight on how State Parties can sustain the public health infrastructure, capacities, and functions developed for COVID-19 response to support strengthened health systems and universal health coverage in the long-term.

Additional Temporary Recommendations to State Parties

SARS-CoV-2 Variants

1. Increase molecular testing and genetic sequencing and share sequences and meta-data with WHO and through publicly accessible databases to enhance global understanding of the virus evolution and inform response efforts.

2. Support coordinated global research efforts to better understand critical unknowns about SARS-CoV-2 specific mutations and variants.

COVID-19 Vaccines

3. Engage in technology transfer to accelerate global production and deployment of COVID-19 vaccines and ancillary supplies.
4. Prepare for COVID-19 vaccine introduction and post-introduction evaluation using the guidance, tools, and trainings for national/subnational focal points and health workers developed by the Access to COVID-19 Tools (ACT) Accelerator's Country Readiness and Delivery workstream.
5. Incorporate, as necessary and appropriate, the private sector into the COVID-19 vaccine planning and introduction to supplement existing service provision and vaccination capacity.
6. Encourage and facilitate vaccine acceptance and uptake by providing credible information on vaccine safety and the benefits of vaccination to address concerns.

Health Measures in Relation to International Traffic

7. At the present time, do not introduce requirements of proof of vaccination or immunity for international travel as a condition of entry as there are still critical unknowns regarding the efficacy of vaccination in reducing transmission and limited availability of vaccines. Proof of vaccination should not exempt international travellers from complying with other travel risk reduction measures.
8. Implement coordinated, time-limited, risk-based, and evidence-based approaches for health measures in relation to international traffic in line with WHO guidance and IHR provisions. Careful consideration should be given to when and if travel bans should or should not be used as tools to reduce spread. Such decisions should be based on the best available evidence.
9. Share information with WHO on the effects of health measures in minimizing transmission of SARS-CoV-2 during international travel to inform WHO's development of evidence-based guidance.

Evidence-Based Response Strategies

10. Refine evidence-based strategies according to WHO guidance to control the spread of SARS-CoV-2 using appropriate public health and social measures, including strategies that address pandemic fatigue.

Surveillance

11. Increase investment in surveillance and sequencing capacities to detect and report early emergence of variants and assess abrupt changes in transmission or disease severity to increase understanding of the evolution of the pandemic.
12. Utilize the WHO SARS-CoV-2 global laboratory network, leverage GISRS and other laboratory networks for timely reporting and sharing of samples; support other State Parties, where needed, in timely sequencing of SARS-CoV-2 virus specimens.

Strengthening Health Systems

13. Continue to strengthen public health infrastructure, system capacities, and functions for COVID-19 response and to enhance universal health coverage.

Source: https://www.who.int/news/item/15-01-2021-statement-on-the-sixth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic

https://www.who.int/news/item/15-01-2021-emergency-committee-on-covid-19-advises-on-variants-vaccines

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ECDC rapid assessment of laboratory practices and needs related to COVID-19, as of January 18

Executive summary

- EU/EEA Member States and the UK have increased their laboratory capacity tremendously over the past 11 months as the majority of the Member States reported sufficient testing capacity until March 2021.
- Many countries are adding rapid antigen detection tests (RADT) to their testing strategies in order to reduce pressure on RT-PCR testing.
- Some Member States have already included RADT in their case definition.
- The main bottlenecks, such as shortages of laboratory consumables and human resources, as well as sample storing facilities, continue to exist and may affect the overall laboratory response to COVID-19.

Source: https://www.ecdc.europa.eu/en/publications-data/covid-19-rapid-assessment-laboratory-practices-and-needs

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Vaccination report

EU: The Commission plans to vaccinate 70 percent of adults in the EU by the summer. According to information from the dpa news agency, the interim goal by March is to immunize 80 percent of people over the age of 80 and of those working in the healthcare sector.
At the EU video summit on Thursday, the question of whether there should be an EU vaccination pass and, if applicable, associated privileges will be discussed. In view of the particularly contagious mutations of the coronavirus, the EU Commission wants to urge the member states to do more to detect the new virus forms. This requires the so-called sequencing of the virus samples taken during tests. Most EU countries are far from the desirable numbers for sequencing, it was said in Brussels. Virus variants would thus be discovered more by chance - unlike in Great Britain, where searches were carried out more systematically.

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The EU plans to dispose of excess vaccine doses to poorer countries, for example to countries in Africa. A corresponding European mechanism is being examined. The EU, home to around 450 million people, has secured nearly 2.3 billion doses of vaccines and vaccine candidates from six manufacturers.

Africa: In Africa the states are preparing for the first vaccination campaigns. In view of the spread of a new virus variant in the south of the continent, they hope that this will gradually return to normal. An initiative of the African Union (AU) called AVATT serves as the procurement instrument. According to the South African AU presidency, 270 million vaccine doses were procured through them.

BioNTech: As updated recommendations for action show, the vaccine can also be transported as a finished dose in the syringe for up to six hours at 2 to 8 degrees. That would have resulted in new data on the stability of the vaccine. This will make the vaccine easier to use in the future. According to BioNTech, the diluted vaccine can be stored for a maximum of six hours at 2 to 30 degrees. If necessary, it can already be diluted at the vaccination center and then carefully transported as a prepared dose in the syringe.

ISR: One month after the start of the extensive corona vaccination campaign in Israel, the first study results show that the vaccine significantly reduces the number of new infections. Just two weeks after the first dose of the Biontech vaccine, the number of positive corona tests in people over 60 was significantly lower, according to a study by the country's largest health insurance company. A group of around 200,000 vaccinated people over 60 was compared with a group of non-vaccinated people of the same size and of the same age.

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The Israeli judicial authorities have also announced corona vaccinations for Palestinian prisoners. The vaccination campaign for all prison inmates should start next week after the vaccination of the medical staff. According to the Association of Palestinian Prisoners, at least 250 of the 4400 Palestinian prisoners in Israeli prisons tested positive for the corona virus.

GBR: Wants to start vaccinating the second vaccination group of 70-year-olds and people who are particularly medically at risk. There are more than five million people in this group. More than half of people over 80 in the UK have already received their first dose of vaccine, according to government figures. The rest should continue to enjoy priority during appointments, as should staff in nursing homes or medical professions. The government has set itself the ambitious goal of vaccinating 15 million people - and thus the groups most at risk from COVID-19 - by mid-February. Ten more vaccination centers are due to open in England today, and soldiers are on duty in Scotland to prepare another 80. A 24-hour center will also be tested in London from the end of the month. By Sunday evening, more than 3.8 million people in the UK had been vaccinated. According to the NHS and the government, an average of 140 people are vaccinated every minute. Corona immunization is to be offered to every adult in the UK by September.

RUS: Plans to vaccinate more than 20 million people in the first three months of the year. The approval of a third vaccine is also planned for February 16. Since Monday, all 146 million citizens have been able to be vaccinated against the corona virus voluntarily and without prior notification. The risk groups had already started in December.

BRA: After two vaccines received emergency approval on Sunday, the nationwide vaccination campaign started two days earlier than planned. The drug CoronaVac from the Chinese manufacturer Sinovac and the vaccine from the British-Swedish pharmaceutical company AstraZeneca have been approved. For the time being, only the CoronaVac vaccine is available in Brazil.

VEN: Is sending six trucks with a total of 107,000 cubic meters of oxygen to hospitals in Manaus, Brazil. As reported, in Manaus the oxygen supplies in hospitals are running out due to the second coronavirus wave in Brazil.

USA: In California, more than 330,000 coronavirus vaccinations with a vaccine variant from the manufacturer Moderna are to be put on hold for the time being. The top epidemiologist in the US state, Erica S. Pan, recommended that Moderna vaccine 41L20A should be discontinued for the time being in order to investigate potentially serious allergic reactions.
In the period from January 5 to January 12, more than 330,000 doses of the drug arrived in California and were distributed to 287 locations that administer the vaccine. Less than ten people would have needed medical attention within 24 hours; all of them were given the drug in the same community center.
Further connections were not found, said Pan. "Extreme caution" is the reason why a stop of vaccinations is recommended and one should rather fall back on other available vaccines.
The Moderna company said it was not aware of any comparable events from other vaccination centers that might also have received vaccine from the batch.

IND: The start of the vaccination campaign did not go as planned. From Saturday to Monday, with around 380,000 residents, significantly fewer vaccinations than expected were vaccinated. In the Indian capital New Delhi, less than half of the people who had a vaccination appointment actually attended it. In addition, the smartphone app used to contact those eligible for vaccination caused problems. The automatic notification did not materialize in some cases, so that the vaccination centers had to confirm the appointments by telephone. In the southern state of Tamil Nadu, only about 16 percent of those entitled showed up.

Vaccine development:

COVID-19 Vaccination in GBR, as of 18th January

The vaccinations against the corona virus started on 08th December 2020 across GBR – as of 17th January 2021 a total of 3,947,442 doses have been vaccinated all over GBR as reported by the NHS.

Region of residence	1st dose	2nd dose	Cumulative Total Doses to Date
Total	3,520,056	427,386	3,947,442
East Of England	370,989	53,146	424,135
London	367,209	50,016	417,225
Midlands	681,042	65,445	746,487
North East And Yorkshire	610,684	70,633	681,317
North West	480,227	60,918	541,145
South East	578,287	74,063	652,350
South West	409,060	52,732	461,792

Statistics showing data of vaccinated doses between 8th December 2020 and 10th January 2021 report also the number of people who have been vaccinated for COVID-19 by age group.

Region of residence	1st dose		2nd dose		Cumulative Total Doses to Date
	Under 80	80+	Under 80	80+	
Total	960,699	1,036,605	81,228	292,875	2,371,407
East Of England	81,604	104,687	6,891	42,841	236,023
London	107,588	92,398	9,198	28,340	237,524
Midlands	194,628	193,019	14,803	44,879	447,329
North East And Yorkshire	166,554	204,140	12,226	50,125	433,045
North West	135,178	131,407	14,146	37,714	318,445
South East	165,564	183,299	14,147	48,247	411,257
South West	108,212	126,896	9,655	40,569	285,332
Other	1,371	759	162	160	2,452

The UK has so far secured access to 367 million doses from seven vaccine developers with four different vaccine types (viral vectored vaccines, recombinant protein-based adjuvanted vaccines, whole inactivated viral vaccines and mRNA vaccines), with an expected cost of £2.9bn across the five final contracts signed to date. The UK was the first country in the world to buy the Pfizer/BioNTech vaccine, ordering 40 million doses – enough for a third of the UK population – the first to authorise it and the first to begin vaccinating people with it. The UK was also the first country in the world to buy, authorise and provide the Oxford/AstraZeneca vaccine.

Vaccine Type	Vaccine	# of Doses	Status
Adenovirus	Oxford/AstraZeneca	100 million	Approved and in deployment
	Janssen	30 million	Phase 3 trials
mRNA	Pfizer/BioNTech	40 million	Approved and in deployment
	Moderna	17 million	Approved
Protein Adjuvant	GlaxoSmithKline/Sanofi Pasteur	60 million	Phase 1/2 trials
	Novavax	60 million	Phase 3 trials
Inactivated whole virus	Valneva	60 million	Phase 1/2 trials

Vaccination groups

Priority groups for vaccination in this initial phase were determined by Government following advice from the Joint Committee on Vaccination and Immunisation (JCVI) by 15 February GBR aims to have offered a first vaccine dose to everyone in the top four priority groups:

- all residents in a care home for older adults and their carers,
- all those 80 years of age and over and frontline health and social care workers,
- all those 75 years of age and over,
- all those 70 years of age and over and clinically extremely vulnerable individuals.

Priority groups:

JCVI Cohort	Priority Group	England	UK
Care Home Residents	1	0.3m	0.3m
Residential Care Workers	1	0.4m	0.5m
80+	2	2.8m	3.3m
Healthcare Workers	2	2.0m	2.4m
Social Care Workers	2	1.2m	1.4m
75-79	3	1.9m	2.3m
70-74	4	2.7m	3.2m
Clinically Extremely Vulnerable (under 70)	4	1.0m	1.2m
Total priority cohorts 1-4		**~12m**	**~15m**
65-69	5	2.4m	2.9m
At Risk (under 65)	6	6.1m	7.3m
60-64	7	1.5m	1.8m
55-59	8	2.0m	2.4m
50-54	9	2.3m	2.8m
Total priority cohorts 5-9		**~14m**	**~17m**
Total priority group population		**~27m**	**~32m**
Rest of adult population		~18m	~21m
Total		~44m	~53m

As of the 10th of January, of the vaccinations provided over this time,1,329,480 were provided to people aged 80 years old or over, which is 56% of the total vaccinations given.

Until the 29thDecember, all vaccinations received for COVID-19 were 1st vaccinations. Between the 29th December and 10th January, 374,1032nd vaccinations were given.

All vaccinations during the week of the 7th to 13th December were administered in NHS hospital hubs. Between the 14th December and 10th January vaccinations were also administered through local vaccination services such as GP practices. In total there were 207 hospital hubs and 788 local vaccination sites providing the vaccine over this time period.

In the end there are three types of vaccination site planed:

- Vaccination centres, using large-scale venues, such as football stadiums and accessed by a national booking service;
- Hospital hubs, using NHS Trusts across the country; and
- Local vaccination services, made up of sites led by general practice teams working together in already established primary care networks and pharmacy teams through community pharmacies

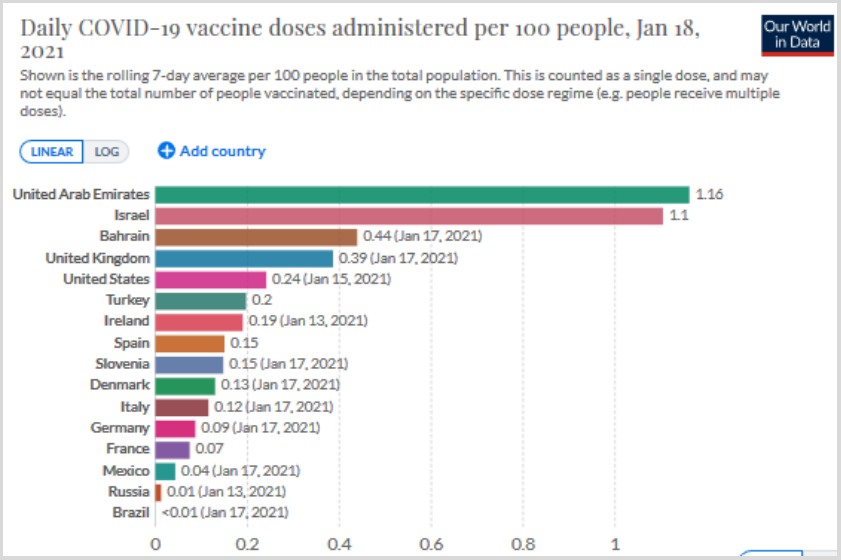
Investments:

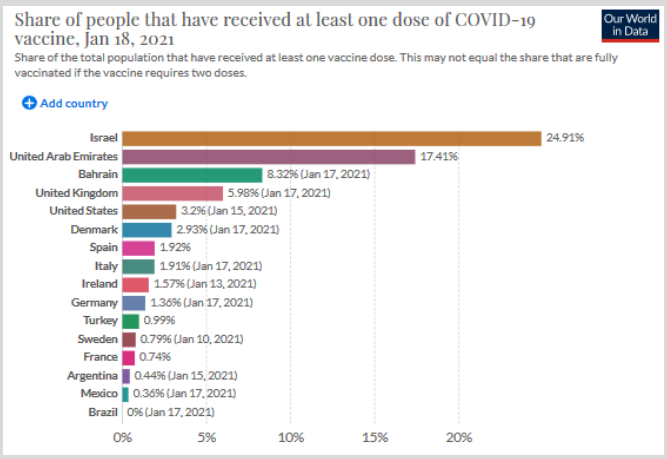
The UK government took concerted and coordinated action to invest £120m between 2016 and 2021 for the development of new vaccines, in line with the expert advice provided by the UKVN, made up of leading experts from academia, industry and policy. The UKVN funded Oxford University £1.87m to develop a MERS (another coronavirus) vaccine. This MERS vaccine technology was rapidly repurposed to develop a COVID-19 vaccine using initial funding from an NIHR and UKRI research call launched in February. In April the government announced £20m of further funding so that the Oxford clinical trials could commence immediately.

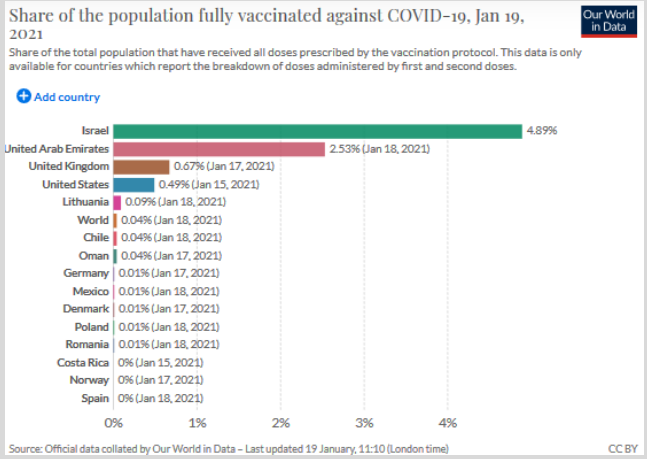
The UK Government's Vaccine Taskforce (VTF) was established in April 2020 to ensure that the UK population would have access to a safe and effective vaccine against COVID-19. The VTF's approach enabled different stages of the vaccine development process to take place quickly and in parallel, without ever compromising strict safety, quality and effectiveness standards. The MHRA have been

constantly reviewing data from vaccine clinical trials, rather than waiting for delivery of all the data at the end of the process.

Global numbers:







Source:

https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/01/COVID-19-weekly-announced-vaccinations-14-January-2021.pdf
https://www.health.org.uk/publications/long-reads/the-covid-19-vaccine-who-gets-
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951928/uk-covid-19-vaccines-delivery-plan-final.pdf
https://ourworldindata.org/covid-vaccinations

Country reports:

ZAF: According to experts, the corona variant first discovered in South Africa is more contagious, but apparently no more deadly than the original form of the virus. The mutation is 50 percent more contagious than the original virus, but the death rate has not changed. A large amount of data from the nationwide virus clusters were analyzed for the investigation.

BRA: Despite the further increase in the corona numbers, the streets along the beaches of Rio were closed to vehicle traffic on Sunday and converted into leisure areas for the residents of Rio. The visitors huddled close together, many of them wearing no masks. Rio de Janeiro is one of the most affected states.

After the Chinese vaccine CoronaVac received emergency approval on Sunday, the nationwide vaccination campaign has now started.

AUS: It is unlikely that borders will open to travelers this year. According to the government, free travel is not expected in 2021 despite the early start of the vaccination campaign against the corona virus.

USA: The outgoing US President Donald Trump announces an end to the corona entry bans for Europeans. Travelers from the Schengen area, Great Britain, Ireland and also Brazil are likely to return to the USA from January 26th. A negative corona test is required.
However, the new government immediately made it clear that the restrictions should not be lifted. Instead, security measures should be strengthened when traveling internationally. With the pandemic worsening and the emergence of more contagious virus mutants, now is not the time to lift restrictions.

Olympic Games: Japan does not plan to make corona vaccination a prerequisite for participating in the Summer Olympics 2021. However, the organizers are promoting that as many athletes as possible get vaccinated in advance.

Chinese President Xi Jinping is convinced that the postponed Winter Olympics can take place next year. China will "hold successful Olympic and Paralympic Winter Games in 2022".

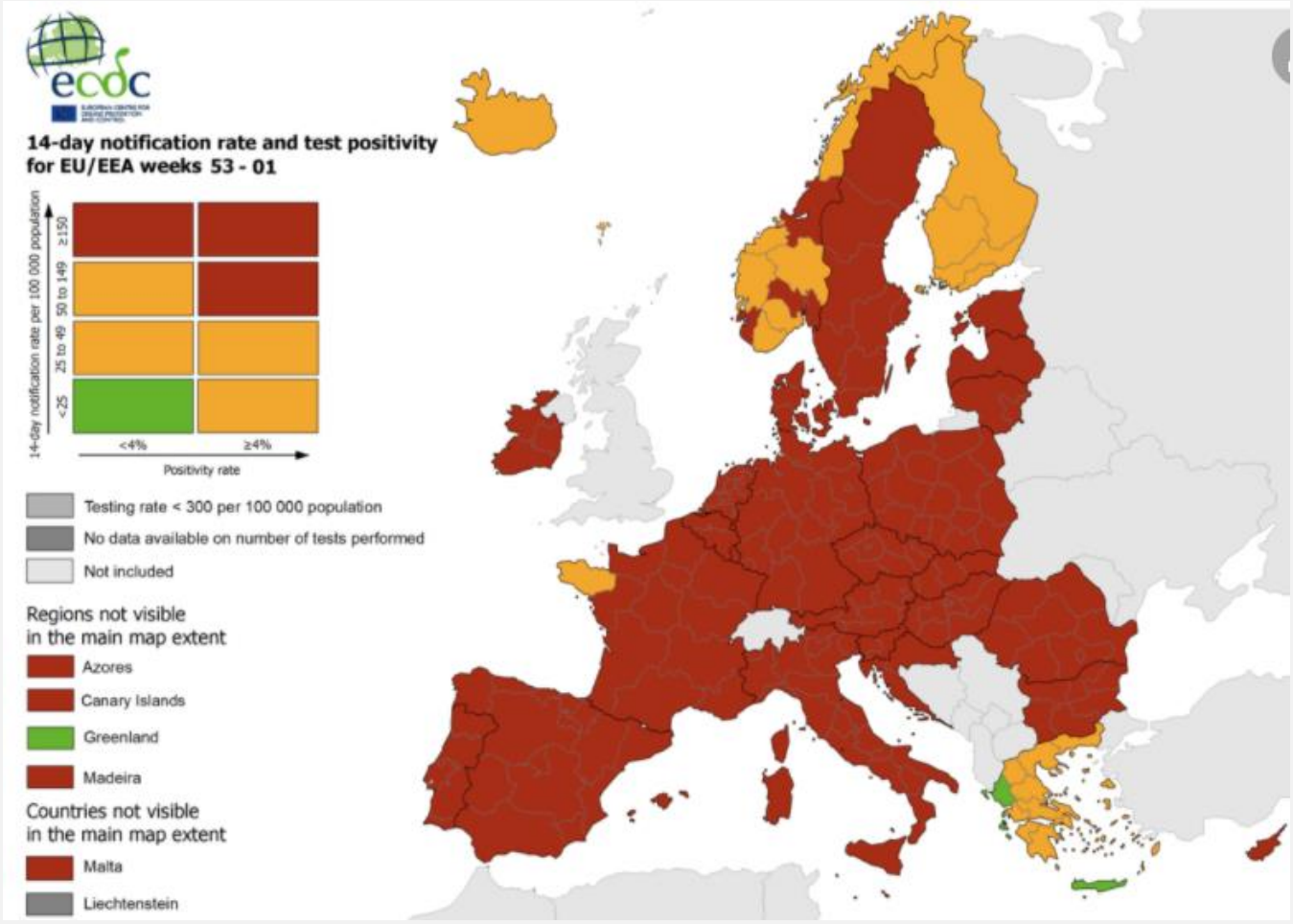
ISR: According to the Israeli Corona Commissioner, the country's health authorities recorded more than 10,000 new infections within one day - more than ever since the outbreak of the pandemic. There is currently a strict lockdown with massive exit restrictions. At the same time, the nationwide vaccination campaign against the pandemic is running. About 186,000 people were vaccinated yesterday. So far, around 2.2 million people in Israel have received the vaccine.

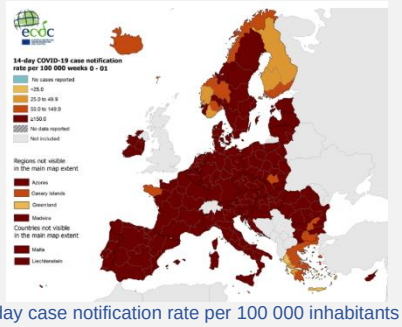
CHN: reports 118 new infections. This means that the number of infections is over 100 for the seventh day in a row. This is the worst outbreak of the epidemic since March. Most new infections are registered in Jilin City, with 43 cases. Authorities said the cause was a businessman from neighboring Heilongjiang Province, where infections had occurred in some places.

HKG: is extending the contact restrictions, which should expire this week. The reason is that the number of infections has increased again to three-digit levels. Details of the measures will be announced during this week.

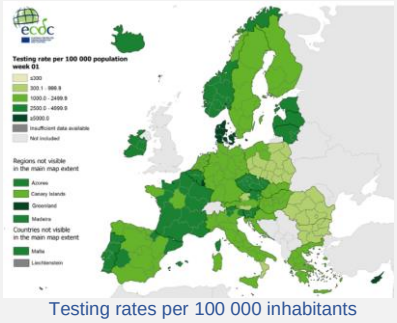
Situation in Europe

[Maps in support of the Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic in the EU](), as of 14 January 2021

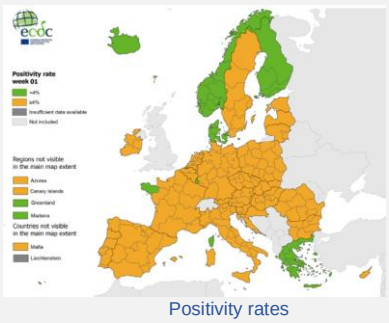




14-day case notification rate per 100 000 inhabitants



Testing rates per 100 000 inhabitants



Positivity rates

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ECDC COVID-19 surveillance report Week 01, as of 14 January 2021

Weekly surveillance summary

Overall situation

By the end of week 1 (ending Sunday 10 January 2021), 13 countries observed increasing case rates (compared to six countries in week 53) and nine reported increasing hospital or ICU admissions and/or occupancy due to COVID-19 (compared to 10 in the previous week). Case rates among older age groups increased in 11 countries and 10 countries reported increasing death rates. Absolute values of the indicators remain high in all countries, including those with stable or decreasing trends in these indicators, suggesting that transmission is still widespread. The larger number of countries reporting increasing case trends suggest that hospitalisations and ICU admissions, and potentially deaths, are likely to increase in the coming weeks.

Data reported over the holiday period must be interpreted with care as they may be subject to reporting delays. Testing rates also decreased during weeks 52 and 53, although there was an increase during week 1.

Trends in reported cases and testing

- By the end of week 1, the 14-day case notification rate for the EU/EEA, based on data collected by ECDC from official national sources from 30 countries, was 425 (country range: 48–1 513) per 100 000 population. The rate has been increasing for one week.
- Among 29 countries with high case notification rates (at least 60 per 100 000), increases were observed in 13 countries (Cyprus, Czechia, France, Hungary, Ireland, Italy, Latvia, Malta, Portugal, Romania, Slovakia, Slovenia and Spain). Stable or decreasing trends in case rates of 1–4 weeks' duration were observed in 16 countries (Austria, Belgium, Bulgaria, Croatia, Denmark, Estonia, Finland, Germany, Greece, Liechtenstein, Lithuania, Luxembourg, the Netherlands, Norway, Poland and Sweden).
- Based on data reported to the European Surveillance System (TESSy) from 26 countries, among people over 65 years of age, high levels (at least 60 per 100 000) or increases in the 14-day COVID-19 case notification rates compared with last week have been observed in 24 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 1, available for 28 countries, varied from 533 to 12 511 tests per 100 000 population. Luxembourg had the highest testing rate for week 1, followed by Denmark, Cyprus, Slovenia and Malta.
- Among 23 countries in which weekly test positivity was high (at least 3%), seven countries (France, Germany, Ireland, Malta, the Netherlands, Portugal and Spain) observed an increase in test positivity compared with the previous week. Test positivity remained stable or had decreased in 16 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Italy, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia and Sweden).

Hospitalisation and ICU

- Pooled data from 20 countries for week 1 show that there were 1.6 patients per 100 000 population in ICU due to COVID-19, which is 78% of the peak ICU occupancy observed during the pandemic. Pooled weekly ICU admissions based on data from 15 countries were 3.7 new admissions per 100 000, which is 44% of the peak rate to date.
- Hospital and/or ICU occupancy and/or new admissions due to COVID-19 were high (at least 25% of the peak level during the pandemic) or had increased compared with the previous week in 29 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden). No other increases have been observed, although data availability varies.

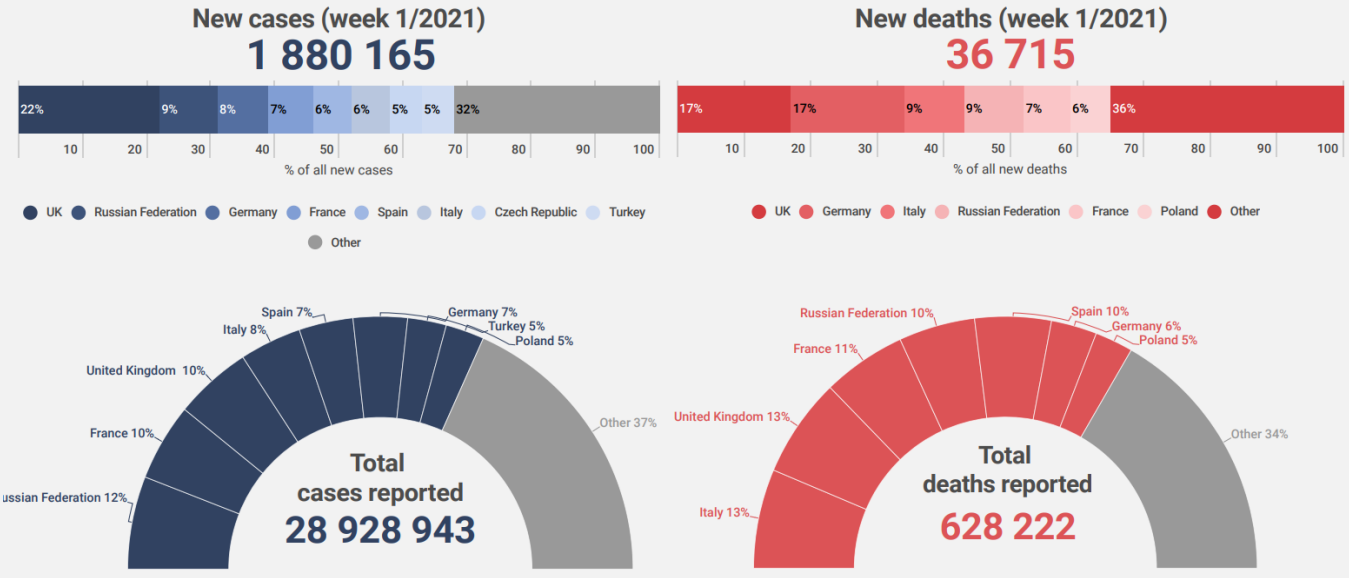
Mortality

- The 14-day COVID-19 death rate for the EU/EEA, based on data collected by ECDC from official national sources from 30 countries, was 97.2 (country range: 2.8–573.2) per million population. The rate has been stable for seven weeks.
- Among 27 countries with high 14-day COVID-19 death rates (at least 10 per million), increases were observed in 10 countries (Czechia, Denmark, Germany, Ireland, Latvia, Liechtenstein, the Netherlands, Portugal, Slovakia and Spain). Stable or decreasing trends in death rates of 1–4 weeks' duration were observed in 17 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Estonia, France, Greece, Hungary, Italy, Lithuania, Luxembourg, Malta, Poland, Romania, Slovenia and Sweden).

Notes

- ECDC produces two separate weekly COVID-19 surveillance outputs (COVID-19 country overview and COVID-19 surveillance report) using data from a range of sources. The data behind most of the figures in the COVID-19 country overview are available to download in open data formats on ECDC's website.
- Additional weekly surveillance bulletins relevant to the COVID-19 pandemic in Europe include EuroMOMO (estimates of all-cause mortality) and Flu News Europe (including primary care sentinel and hospital-based surveillance for respiratory disease), which are published every Thursday and Friday, respectively.

COVID-19 situation update for the WHO European Region (04 Jan – 10 Jan 2021 Epi week 01)



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Country Reports:
GRE: After a month-long lockdown, the shops open again, but only one person per 25 square meters of shop space can be received. In regions with higher corona numbers, shops are only allowed to sell through "Click Away".

ITA: Despite extended corona restrictions, museums and exhibitions in some regions of the country can open again from Monday to Friday since yesterday. This rule applies to the so-called yellow zones.
……
Brazil flights will be cancelled because of a new Corona variant. Anyone who was in transit in Brazil in the last 14 days is no longer allowed to enter Italy. People arriving from Brazil would have to be tested.

ESP: The number of new infections rose to a high of 84,287 in one weekend. From Friday to Monday, 455 people died from or with Corona at the same time. The number of new infections per 100,000 inhabitants within seven days rose to just under 380. Restrictions had been strengthened on Monday.

DEU: From Sunday on, Brazil will also be considered an area in which new virus variants are circulating with probably special risks and thus stricter entry regulations apply. Great Britain, Ireland and South Africa have already been considered such areas. Anyone who was in such an area in the last ten days before entering the country must have a negative corona test result before entering the country and be able to present it to the airline.
In general, a regulation that recently came into force stipulates stricter test obligations for entries from Corona risk areas with many infections - this now includes numerous countries. Anyone who has been in a risk area must show a negative test no later than 48 hours after entry. Basically, travelers from risk areas are obliged to go into quarantine after their return.
……
The federal government is meeting today to discuss stricter measures. The lockdown is expected to be extended to February 15. The regulations for the home office are also to be tightened. The Federal Ministry of Economics is planning a regulation that obliges employers to "wherever possible to enable employees to work in the home office". Schools should remain closed. A working group will develop concepts for possible relaxation if an incidence value of 50 new infections per 100,000 inhabitants per week is reached. A tightening of the mask requirement is apparently not intended.

GBR: According to an antibody study by the British statistics agency, around twelve percent of people in England had had a coronavirus infection by December. That corresponds roughly to every eighth. In November the rate was just under nine percent. However, analyzes have shown that the amount of antibodies can quickly decrease after an infection - the actual value could therefore be higher. Samples from thousands of people aged 16 and over from private households are analyzed for the evaluation. People cared for in nursing and old people's homes are not included in the study.

AUT: Austria extends the corona lockdown until the beginning of February. The aim is to reopen shops and museums under strict security precautions from February 8th. However, the new infections reported daily must decrease significantly by then. So long, exit restrictions and distance learning schools remained in place. In addition, the safety distance that people should keep will be extended from one to two meters. FFP2 masks must now be worn in shops and public transport. The government also appealed to companies to let employees work from home whenever possible.

SVN: Starts a new round of mass tests. The population can be tested from today until January 26th. The tests are not mandatory, but only those who have a negative test result can continue to work afterwards, according to government circles. The aim is also that the schools can reopen in February and other restrictions can be shut down again. A third round of mass tests is to take place later in the worst affected regions. In the first round, 1.06% of those tested were positive.
Exit restrictions are currently in place in Slovakia around the clock. There are exceptions, for example, for the way to work, visits to the doctor or shopping in the immediate vicinity of the home address.

UKR: Reported the lowest number of cases since September on Monday. The number of deaths also fell from 116 the previous day to 67. The lockdown is now set to end on January 25th. On January 8th, facilities such as schools, restaurants and gyms had to remain closed.

Subject in Focus

COVID-19 Trends Among Persons Aged 0–24 Years

Studies have consistently shown that children, adolescents, and young adults are susceptible to SARS-CoV-2 infections. Children and adolescents have had lower incidence and fewer severe COVID-19 outcomes than adults.

In this study done by the CDC children, adolescents, and young adults were stratified into five age groups: 0–4, 5–10, 11–13, 14–17, and 18–24 years to align with educational groupings (i.e., pre-, elementary, middle, and high schools, and institutions of higher education), and trends in these groups were compared with those in adults aged ≥25 years. Data was identified by individual-level case reports submitted by state and territorial health departments during March 1–December 12, 2020. COVID-19 case data for all confirmed cases were analyzed to examine demographic characteristics, underlying health conditions, and outcomes. Trends in COVID-19 incidence were analyzed using a daily 7-day moving average, aggregated by week, and expressed as cases per 100,000 persons.

Results

During March 1–December 12, 2020, a total of 2,871,828 laboratory-confirmed cases of COVID-19 in children, adolescents, and young adults aged 0–24 years were reported in the United States. Among these cases,

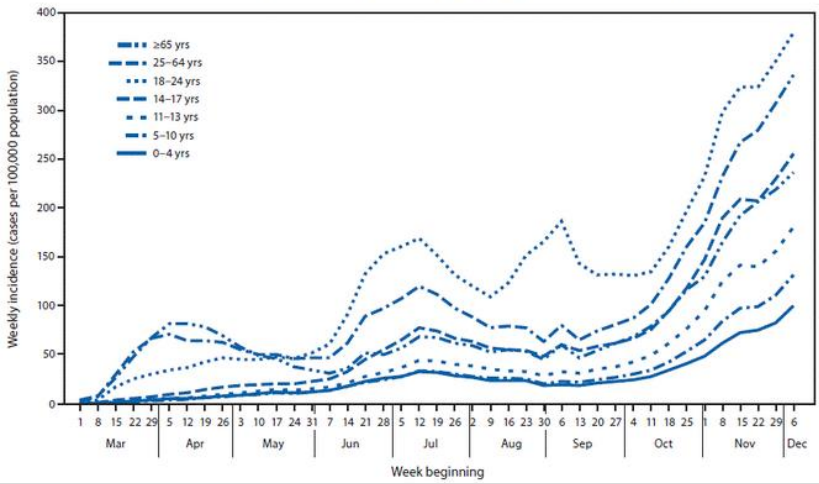
- 57.4% occurred among young adults aged 18–24 years;
- 16.3% in children and adolescents aged 14–17 years,
- 10.9% in those 5–10 years,
- 7.9% in those 11–13 years, and
- 7.4% in those 0–4 years.

Overall, 51.8% of cases occurred in females.

Among the 1,504,165 (52.4%) children, adolescents, and young adults with COVID-19 with complete information on race/ethnicity, 50.2% were non-Hispanic White, 27.4% were Hispanic/Latino (Hispanic), and 11.7% were non-Hispanic Black. The proportion of cases among Hispanic persons decreased with increasing age from 34.4% among those aged 0–4 years to 24.6% among those aged 18–24 years.

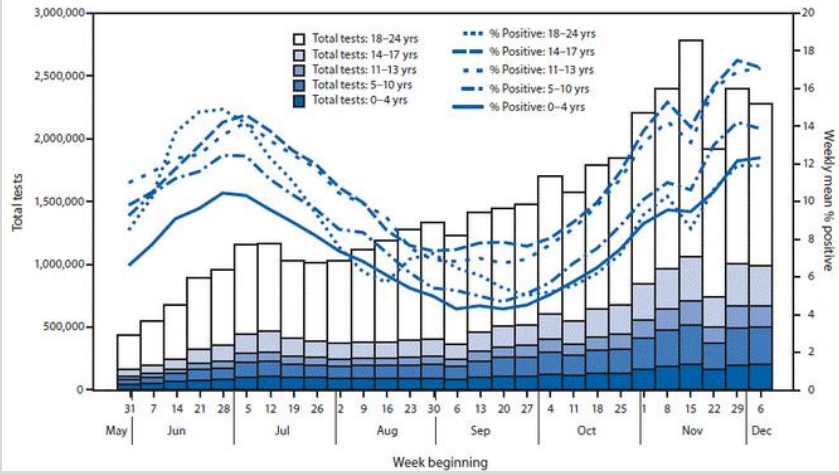
Among persons aged 0–24 years, weekly incidence was higher in each successively increasing age group; weekly incidence among adults aged 25–64 years and ≥65 years exceeded that among children and adolescents aged 0–13 years throughout the review period. Weekly incidence was highest during the final week of the review period (the week of December 6) in all age groups: 99.9 per 100,000 (0–4 years), 131.4 (5–10 years), 180.6 (11–13 years), 255.6 (14–17 years), and 379.3 (18–24 years). Trends in weekly incidence for all age groups aged 0–17 years paralleled those observed among adults since June. The trend in incidence among young adults aged 18–24 years had a distinct and more prominent peak during the week of September 6.

FIGURE 1. COVID-19 weekly incidence,*,† by age group — United States, March 1–December 12, 2020



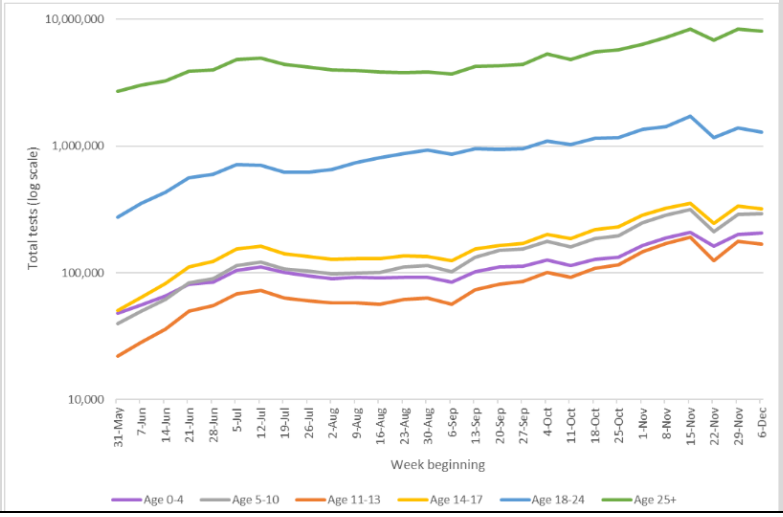
Weekly SARS-CoV-2 laboratory testing among children, adolescents, and young adults increased 423.3% from 435,434 tests during the week beginning May 31 to 2,278,688 tests during the week beginning December 6.

FIGURE 2. Weekly test volume and percentage of SARS-CoV-2-positive test results* among persons aged 0–24 years, by age group — United States, May 31–December 12, 2020†



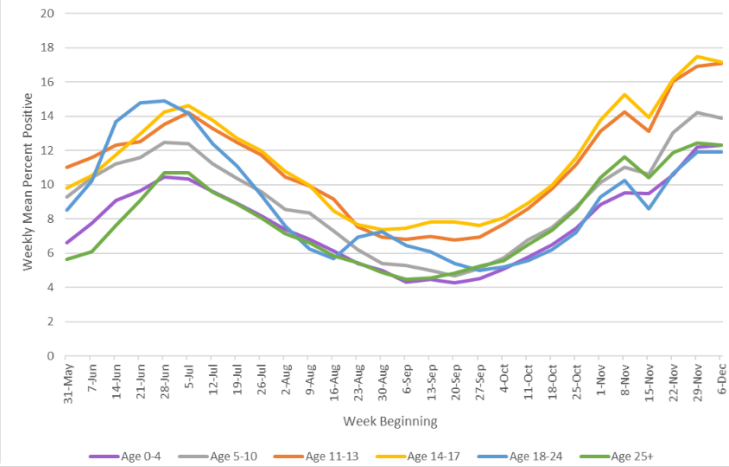
At their peak during the week of November 15, tests conducted among children and adolescents aged 0–17 years represented 9.5% of all tests performed, and tests among young adults aged 18–24 years represented 15.3%.

SUPPLEMENTARY FIGURE 1: Volume of SARS-CoV-2 reverse transcription–polymerase chain reaction (RT-PCR)* tests, by week and age group — United States, May 31–December 12, 2020†



As observed in trends in incidence, weekly percentage of positive test results among children and adolescents paralleled those of adults, declining between July and September, and then increasing through December.

SUPPLEMENTARY FIGURE 2. Percentage of SARS-CoV-2 reverse transcription–polymerase chain reaction (RT-PCR)* tests with positive results, by week and by age group — United States, May 31–December 12, 2020†



Percentage of positive test results among young adults aged 18–24 years peaked earlier in June and increased slightly in late August; this was not observed among other age groups.

In contrast to incidence, percentage of positive test results among children and adolescents aged 11–17 years exceeded that among younger children for all weeks and that of all age groups since the week beginning September 6; test volumes over time were lowest among children and adolescents aged 11–13 years, suggesting incidence among these age groups might be underestimated.

Among cases reviewed, data were available for 41.9%, 8.9%, and 49.1% of cases for hospitalizations, intensive care unit (ICU) admissions, and deaths, respectively.
Among children, adolescents, and young adults with available data for these outcomes, 30,229 (2.5%) were hospitalized, 1,973 (0.8%) required ICU admission, and 654 (<0.1%) died, compared with 16.6%, 8.6%, and 5.0% among adults aged ≥25 years, respectively. Among children, adolescents, and young adults, the largest percentage of hospitalizations (4.6%) and ICU admissions (1.8%) occurred among children aged 0–4 years. Among 379,247 (13.2%) children, adolescents, and young adults with COVID-19 and available data on underlying conditions, at least one underlying condition or underlying health condition was reported for 114,934 (30.3%), compared with 836,774 (60.4%) among adults aged ≥25 years.

TABLE. Demographic characteristics and underlying conditions among persons aged 0–24 years with positive test results for SARS-CoV-2 — United States, March 1–December 12, 2020

	Age group, yrs, no. (%)						
Characteristic	**0–24**	**0–17**	**0–4**	**5–10**	**11–13**	**14–17**	**18–24**
Total	**2,871,828 (100)**	**1,222,023 (42.6)**	**212,879 (7.4)**	**313,913 (10.9)**	**227,238 (7.9)**	**467,993 (16.3)**	**1,649,805 (57.4)**
Symptom Status							
Yes	1,247,552 (94.1)	524,390 (91.9)	87,646 (90.4)	126,010 (88.9)	97,831 (91.8)	212,903 (94.5)	723,162 (95.8)
No	77,899 (5.9)	46,166 (8.1)	9,281 (9.6)	15,720 (11.1)	8,736 (8.2)	12,429 (5.5)	31,733 (4.2)
Missing/Unknown*	1,546,377 (N/A)	651,467 (N/A)	115,952 (N/A)	172,183 (N/A)	120,671 (N/A)	242,661 (N/A)	894,910 (N/A)
Underlying condition†							
Any	114,934 (30.3)	43,388 (27.6)	6,334 (23.7)	10,203 (26.4)	8,206 (28.8)	18,645 (29.5)	71,546 (32.2)
None	264,313 (69.7)	113,621 (72.4)	20,426 (76.3)	28,386 (73.6)	20,280 (71.2)	44,529 (70.5)	150,692 (67.8)
Missing/Unknown*	2,492,581 (N/A)	1,065,014 (N/A)	186,119 (N/A)	275,324 (N/A)	198,752 (N/A)	404,819 (N/A)	1,427,567 (N/A)
Known condition¶	421,078 (14.7)	176,766 (14.5)	30,665 (14.4)	43,765 (13.9)	32,122 (14.1)	70,214 (15.0)	244,312 (14.8)
Chronic lung disease	26,937 (6.4)	10,521 (6)	786 (2.6)	2,495 (5.7)	2,316 (7.2)	4,924 (7.0)	16,416 (6.7)
Disability**	4,162 (1.0)	1,992 (1.1)	243 (0.8)	497 (1.1)	411 (1.3)	841 (1.2)	2,170 (0.9)
Immunosuppression	3,495 (0.8)	1,373 (0.8)	196 (0.6)	323 (0.7)	237 (0.7)	617 (0.9)	2,122 (0.9)
Diabetes mellitus	4,030 (1.0)	1,104 (0.6)	63 (0.2)	133 (0.3)	237 (0.7)	671 (1.0)	2,926 (1.2)
Psychological	3,055 (0.7)	1,176 (0.7)	23 (0.1)	153 (0.3)	231 (0.7)	769 (1.1)	1,879 (0.8)
Cardiovascular disease	3,103 (0.7)	1,133 (0.6)	266 (0.9)	239 (0.5)	163 (0.5)	465 (0.7)	1,970 (0.8)
Current/Former smoker	15,362 (3.6)	798 (0.5)	37 (0.1)	42 (0.1)	39 (0.1)	680 (1.0)	14,564 (6.0)
Severe obesity††	1,865 (0.4)	566 (0.3)	32 (0.1)	109 (0.2)	121 (0.4)	304 (0.4)	1,299 (0.5)
Chronic kidney disease	796 (0.2)	336 (0.2)	80 (0.3)	77 (0.2)	44 (0.1)	135 (0.2)	460 (0.2)
Hypertension	1,788 (0.4)	272 (0.2)	43 (0.1)	20 (0)	29 (0.1)	180 (0.3)	1,516 (0.6)
Autoimmune disease	919 (0.2)	305 (0.2)	17 (0.1)	45 (0.1)	56 (0.2)	187 (0.3)	614 (0.3)
Chronic liver disease	407 (0.1)	137 (0.1)	22 (0.1)	24 (0.1)	22 (0.1)	69 (0.1)	270 (0.1)
Substance abuse/use	355 (0.1)	72 (<0.1)	1 (<0.1)	1 (<0.1)	6 (<0.1)	64 (0.1)	283 (0.1)
Other	10,100 (2.4)	3,511 (2.0)	665 (2.2)	725 (1.7)	581 (1.8)	1,540 (2.2)	6,589 (2.7)
Outcome							
Hospitalized							
Yes	30,229 (2.5)	11,882 (2.3)	4,294 (4.6)	1,983 (1.5)	1,598 (1.6)	4,007 (2.0)	18,347 (2.7)
No	1,172,310 (97.5)	514,834 (97.7)	88,786 (95.4)	132,108 (98.5)	96,021 (98.4)	197,919 (98.0)	657,476 (97.3)
Missing/Unknown*	1,669,289 (N/A)	695,307 (N/A)	119,799 (N/A)	179,822 (N/A)	129,619 (N/A)	266,067 (N/A)	973,982 (N/A)
ICU admission							
Yes	1,973 (0.8)	866 (0.8)	288 (1.8)	168 (0.6)	131 (0.6)	279 (0.6)	1,107 (0.8)
No	252,961 (99.2)	109,234 (99.2)	16,091 (98.2)	25,968 (99.4)	20,574 (99.4)	46,601 (99.4)	143,727 (99.2)
Missing/Unknown*	2,616,894 (N/A)	1,111,923 (N/A)	196,500 (N/A)	287,777 (N/A)	206,533 (N/A)	421,113 (N/A)	1,504,971 (N/A)
Died							
Yes	654 (<0.1)	178 (<0.1)	52 (<0.1)	30 (<0.1)	27 (<0.1)	69 (<0.1)	476 (0.1)
No	1,409,626 (100)	620,989 (100)	111,437 (100)	162,971 (100)	115,664 (100)	230,917 (100)	788,637 (99.9)
Missing/Unknown*	1,461,548 (N/A)	600,856 (N/A)	101,390 (N/A)	150,912 (N/A)	111,547 (N/A)	237,007 (N/A)	860,692 (N/A)

Discussion

Reported weekly incidence of COVID-19 and percentage of positive test results among children, increased during the review period, with spikes in early summer, followed by a decline and then steeply increased in October through December.

In general, trends in incidence and percentage of positive test results among preschool-aged children (0–4 years) and school-aged children and adolescents (5–17 years) paralleled those among adults throughout the summer and fall, including during the months that some schools were reopening or open for in-person education.

In addition, reported incidence among children, adolescents, and young adults increased with age; among children aged 0–10 years, incidence and percentage of positive test results were consistently lower than they were among older age groups.

Incidence among young adults (aged 18–24 years) was higher than that in other age groups throughout the summer and fall, with peaks in mid-July and early September that preceded increases among other age groups, suggesting that young adults might contribute more to community transmission than do younger children.

Findings from national case and laboratory surveillance data complement available evidence regarding risk for transmission in school settings. Despite the level of in-person learning (62% of U.S. kindergarten through grade 12 (K-2) school districts), reports to CDC of outbreaks within K–12 schools have been limited.
COVID-19 incidence among the general population in counties where K–12 schools offer in-person education was similar to that in counties offering only virtual/online education. A recent study found no increase in COVID-19 hospitalization rates associated with in-person education.

In contrast to the evidence regarding K–12 school reopenings, previous studies provide evidence for increased community incidence in counties where institutions of higher education reopened for in-person instruction, and presented case surveillance data showed unique trends.

Success in preventing introduction and transmission of SARS-CoV-2 in schools depends upon both adherence to mitigation strategies in schools and controlling transmission in communities. When community transmission is high, cases in schools should be expected, and as with any group setting, schools can contribute to COVID-19 transmission, especially when mitigation measures, such as universal and proper masking, are not implemented or followed.

The findings in the CDC report are subject to at least four limitations:

1. COVID-19 incidence is likely underestimated among children and adolescents because testing volume among these age groups was lower than that for adults, the rate of positive test results was generally higher among children and adolescents (particularly those aged 11–17 years) than that among adults, and testing frequently prioritized persons with symptoms; asymptomatic infection in children and adolescents occurs frequently.
2. Data on race/ethnicity, symptom status, underlying conditions, and outcomes are incomplete, and completeness varied by jurisdiction; therefore, results for these variables might be subject to reporting biases and should be interpreted with caution. Future reporting would be enhanced by prioritizing completeness of these indicators for all case surveillance efforts.
3. The reporting of laboratory data differs by jurisdiction and might underrepresent the actual volume of laboratory tests performed; as well, reporting of laboratory and case data are not uniform.
4. The presented analysis explores case surveillance data for children, adolescents, and young adults; trends in cases among teachers and school staff members are not available because cases are not routinely reported nationally by occupations other than health care workers.

Lower incidence among younger children and evidence from available studies suggest that the risk for COVID-19 introduction and transmission among children associated with reopening child care centers and elementary schools might be lower than that for reopening high schools and institutions of higher education.

	However, for schools to operate safely to accommodate in-person learning, communities should fully implement and strictly adhere to multiple mitigation strategies, especially universal and proper masking, to reduce COVID-19 incidence within the community as well as within schools to protect students, teachers, and staff members. Source: https://www.cdc.gov/mmwr/volumes/70/wr/mm7003e1.htm?s_cid=mm7003e1_w https://stacks.cdc.gov/view/cdc/100246 https://www.reachcentered.org/publications/the-effects-of-school-reopenings-on-covid-19-hospitalizations https://pubmed.ncbi.nlm.nih.gov/32758454/ https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30882-3/fulltext

COVID-19 Crisis in Mozambique

In cooperation with Bundeswehr HQ of Military Medicine

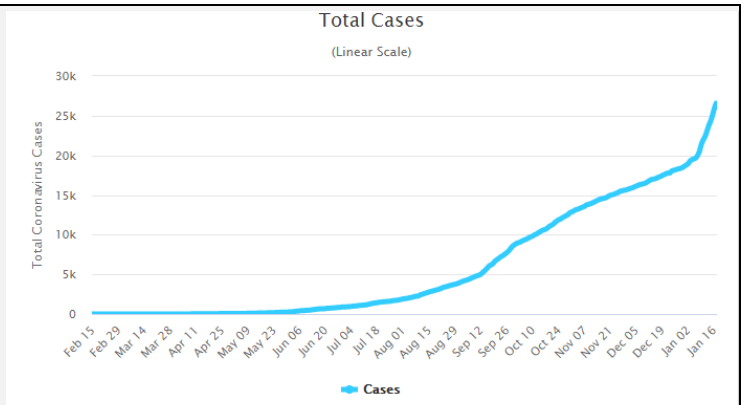
Mozambique

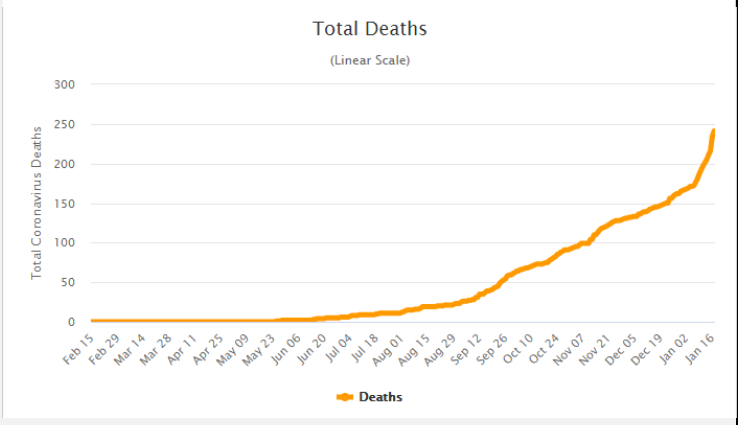
Area:	801,590 km^2
Population:	30,066,648
Capital:	Maputo
Age structure:	
0-14 years:	45,57%
15-24 years:	19,91%
25-54 years:	28,28%
55-64 years:	3,31%
65 years and over:	2,93%

CONFLICT:
Since March 2020, a dramatic increase in attacks by militant Islamists has been reported from the province of Cabo Delgado in northern Mozambique, which has existed since 2017. Since test drillings off the Rovuma Basin in the north of the MOZ coast demonstrated considerable natural gas reserves in 2007 and numerous international corporations are preparing for the start of natural gas production scheduled for 2020, the next coastal town to the production facilities, Mocímba da Praia, has been the goal Become a jihadist-motivated insurgent. Some of the companies involved in the natural gas project are already planning to evacuate some of their staff if they have not already left the city due to the COVID-19 pandemic. ("Total" has recently evacuated its employees after attacks by the insurgents and stopped work.) The attackers, who acted in the spirit of the so-called Islamic State, led by Ahlu-Sunnah Wal Jama'at (Al-Sunnah) met their first raid on the city was met with little resistance from the MOZ government troops. The armed attackers destroyed government property, including buildings and military facilities, but largely refrained from attacking the civilian population, unlike at the beginning of the uprising two years ago. Instead, the attackers distributed food before leaving the city. Lt. Joseph Hanlon, an expert on Mozambique at the London School of Economics, the insurgents are pursuing a new strategy in which they attract the urban population to their side ("winning hearts and minds"), but in return drive the population out of the urban and rural areas . For decades the local population has enjoyed little government support. Although MOZ has considerable natural resources, including the world's largest explored natural gas field (estimated value 50 billion US $), the predominantly Muslim province of Cabo Delgado is still the poorest of the 11 MOZ provinces. The attempt by the government to resettlement parts of the population in the north for the purpose of less resistance to the exploitation of local raw material deposits (including precious stones, natural gas) failed. The loss of livelihoods of thousands of farmers and fishermen exacerbated dissatisfaction with the state. Some now see their enemy in the government and less in the insurgents. In the meantime, Al-Sunnah is taking advantage of the situation by promoting himself and his followers as the better alternative that takes care of the needs of the people. In the meantime, the new strategy began to bear fruit, as in 2019 the population began to use force against soldiers and government employees with the accusation that they were denying the population the satisfaction of even basic needs. The recent attacks against the government are believed to be an attempt to remove control of the province from the government. It is feared that a self-sustaining guerrilla organization might be set up to support the goals of the conservative opposition party RENAMO (Resistência National Moçambicana). This suspicion, confirmed by Amnesty International, is reinforced by a recently released video of the Islamists saying they want to replace the ruling government with Sharia. RENAMO, which emerged from a rebel organization at the time, is still not

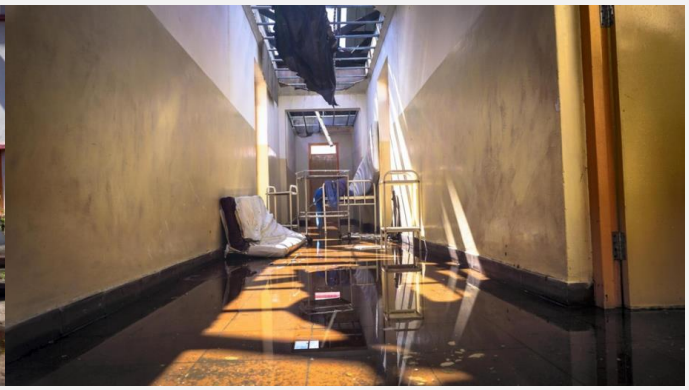
	fully disarmed after the end of the civil war almost 30 years ago. In the wake of extremist activities, the situation in northern Mozambique is worsening due to an increase in organized crime. Many levels of government have been infiltrated by mafia-like actors to such an extent that they are now said to have a significant influence on politics, including the ability to finance political campaigns and elections. The widespread trafficking in heroin and other illicit drugs is seen as a major source of funding for the insurgents. In addition, the latest attacks reflect a growing propensity for violence in the country. According to the “Armed Conflict Location & Event Data Project” (ACLED), more than 900 people have lost their lives since the uprising began in late 2017. According to ACLED data from March 21, 2020, more than 100 deaths have been registered in over 80 attacks in 2020 alone. In its response to terrorism and violent extremism, MOZ follows the well-known African script after the problem is initially negated. If this is no longer possible, one declares the situation as an internal matter and invokes one's own state sovereignty before attempting to control the situation with military force. Realizing that MOZ alone cannot control terrorism, MOZ finally asked the African Union (AU) for support. However, international cooperation with RUS, FRA and PAK only had a minor impact on the country's improved military equipment, and even RUS mercenary troops could not change the situation in the country. Meanwhile the government under President Filipe Nyusi is considering non-military solutions and is considering negotiations with the terrorist groups and has announced a development program for the north. Nevertheless, it is expected that the measures will come significantly too late in view of the power that the insurgent groups have now achieved. **HEALTH:** The medical care structure in the north of the country, which is considerably below the international average, is poorly effective due to long-term neglect on the part of the government and can only provide extremely inadequate care for the internally displaced persons of the failed resettlement program. Mozambique, severely poor and where 54% of the population lives in absolute poverty, has inadequate facilities in its public health system. Health care is rather simple, limited and inadequate. In a country severely affected by diseases such as malaria and cholera, it is vital to have adequate infrastructure in place to meet the health needs of its citizens. Malnutrition among children and babies is also at a critical point in Mozambique. The situation is even worse in rural areas, where people are forced to walk for more than an hour to reach a hospital / health center. According to the United States Agency for International Development (USAID), about 30% of the population are unable to access health services at all, and only about 50% have access to an "acceptable" level of health care. The differences between people with coverage in rural and urban regions are enormous. There are only 3 doctors per 100,000 people. The devastation and floods caused by the storm events "Kenneth" and "Idai" in 2019, from which the population has still not recovered, are making matters worse. Some of the emergency housing built with international aid has already become uninhabitable again due to storms and heavy rainfall. At the end of March 2019, as a result of the floods in Sofala province, there was also an outbreak of cholera with as far as reported 6,768 cases (8 deaths).

COVID-19 current Situation: On March 23, 2020, the first case of infection by SARS-CoV-2 was confirmed. On April 1, 2020, the president declared a state of emergency and then a disaster. As of 01/19/21, the "Instituto Nacional de Saúde" in Maputo (INS) carried out a total of 296,922 corona tests, of which 27446 people tested positive and 249 died. Since January 7th, 21, however, the daily new infections have increased up to fourfold, which represents an exponential growth that Mozambique has not yet experienced during the pandemic (see graphic on the right). This exponential development can be seen as a direct consequence of the easing over the holidays. In addition to the Relaxation for the population, these attracted masses of tourists from South Africa who populated the beaches over the holidays. Mozambique probably imported an entry that caused the first big wave in Mozambique. Against the background of this worrying development, the President and the Ministry of Health warned of a collapse of the health system, especially in Maputo, and the overloading of ICU capacities and imposed tightened measures on the population from January 15, 21st. In addition, Mozambique, as the current chairman of the "Southern African Development Community (SADC)", canceled the summit for conflict resolution in the north of the country on January 21, 21 due to the infection situation.





CONCLUSION:
Mozambique, with its limited health system, its existing severe poverty and its increasing armed conflicts, is now feeling the pandemic more clearly for the first time. Presumably the exponential increase due to the limited possibilities (e.g. limited test possibilities, large part of the population in large families in a confined space, severely limited hygiene measures) in Mozambique will hardly be slowed down and it must be assumed that the number of unreported cases is large and growing. The already bad overall situation will worsen significantly in the coming months in the conflict and health sectors.



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Mozambique

28.1 Index Score **153**/195

	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**26.5**	**34.8**
Antimicrobial resistance (AMR)	33.3	42.4
Zoonotic disease	8.8	27.1
Biosecurity	0	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	100	85.0
DETECTION AND REPORTING	**29.3**	**41.9**
Laboratory systems	50	54.4
Real-time surveillance and reporting	36.7	39.1
Epidemiology workforce	25	42.3
Data integration between human/ animal/environmental health sectors	0	29.7
RAPID RESPONSE	**18.2**	**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	0	39.4
Access to communications infrastructure	57.7	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**17.0**	**26.4**
Health capacity in clinics, hospitals and community care centers	18.1	24.4
Medical countermeasures and personnel deployment	0	21.2
Healthcare access	41.6	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	50	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**43.8**	**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	12.5	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	**38.4**	**55.0**
Political and security risks	53.6	60.4
Socio-economic resilience	31.5	66.1
Infrastructure adequacy	41.7	49.0
Environmental risks	55.4	52.9
Public health vulnerabilities	11.2	46.9

*Average: all 195 countries

Scores are normalized (0–100, where 100 = most favorable)

www.ghsindex.org

Source:
https://reliefweb.int/report/mozambique/mozambique-insurgency-requires-urgent-response-sadc-and-au
https://allafrica.com/stories/202101070474.html
https://covid19.ins.gov.mz/
https://www.energymixreport.com/total-stops-work-at-afungi-in-mozambique/
https://www.humanium.org/de/gesundheitssystem-in-mosambik/
https://www.thenational.ae/world/africa/battered-mozambique-hospitals-in-race-against-time-to-prevent-epidemic-after-cyclone-idai-1.842127
https://www.allianzworldwidecare.com/en/support/health-and-wellness/national-healthcare-systems/healthcare-in-mozambique/
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https://www.who.int/patientsafety/implementation/apps/first_wave/beira_ipswich/en/
https://www.worldometers.info/coronavirus/country/mozambique/
https://reliefweb.int/report/mozambique/mozambique-s-crisis-requires-new-playbook-fight-extremism
https://www.crisisgroup.org/index.php?q=crisiswatch/database&location%5B0%5D=125&crisis_=
https://www.indexmundi.com/mozambique/

MilMed CoE VTC COVID-19 response

Topics former VTCs	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" • Mental Health • Treatment of mild symptomatic cases of COVID-19 • Transition home office back to the office • COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation • Perspectives of the current COVID-19 vaccine development • National overview on current COVID-19 situation • Long term effects of COVID-19 and the impact on force capability • Overview on current COVID-19 situation in Missions • Civil – military cooperation in view of COVID-19 • Immunity development versus reinfections of COVID-19 • The current status of SARS-CoV-2 vaccine development **Next VTC will be 27th of January 2021 with the Topic "Resilience strategies from the private sector"**

Recommendations

Recommendation for international business travellers As of 19th October 2020 Updated 2nd December 2020 by ECDC and 12th January by CDC	Many countries have halted some or all international travel since the onset of the COVID-19 pandemic but now have re-open travel some already closed public-travel again. This document outlines key considerations for national health authorities when considering or implementing the gradual return to international travel operations. The decision-making process should be multisectoral and ensure coordination of the measures implemented by national and international transport authorities and other relevant sectors and be aligned with the overall national strategies for adjusting public health and social measures. WHO Public health considerations while resuming international travel. **Travel has been shown to facilitate the spread of COVID-19 from affected to unaffected areas. Travel and trade restrictions during a public health event of international concern (PHEIC) are regulated under the International Health Regulations (IHR), part III.** The majority of measures taken by WHO Member States relate to the denial of entry of passengers from countries experiencing outbreaks, followed by flight suspensions, visa restrictions, border closures, and quarantine measures. Currently there are exceptions foreseen for travellers with an essential function or need. **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. For Europe you will find more information here. For the US here. **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. **Risk of infection when travelling by plane:** The risk of being infected on an airplane cannot be excluded, but is currently considered to be low for an individual traveller. The risk of being infected in an airport is similar to that of any other place where many people gather. If it is established that a COVID-19 case has been on an airplane, other passengers who were at risk (as defined by how near they were seated to the infected passenger) will be contacted by public health authorities. Should you have questions about a flight you have taken, please contact your local health authority for advice. **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 • 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.

Travellers who develop any symptoms during or after travel should self-isolate; those developing acute respiratory symptoms within 14 days upon return should be advised to seek immediate medical advice, ideally by phone first to their national healthcare provider.
Source: WHO and ECDC

Information on COVID-19 testing and quarantine of air travellers in the EU and the US you can find following the link:
https://www.ecdc.europa.eu/en/publications-data/guidelines-covid-19-testing-and-quarantine-air-travellers
https://www.cdc.gov/coronavirus/2019-ncov/travelers/testing-air-travel.html

More information about traveling you can find here.
- National regulation regarding travel restrictions, flight operation and screening for single countries you will find here (US) and here (EU).
- Official IATA travel restrictions. You will find here.

European Commission:

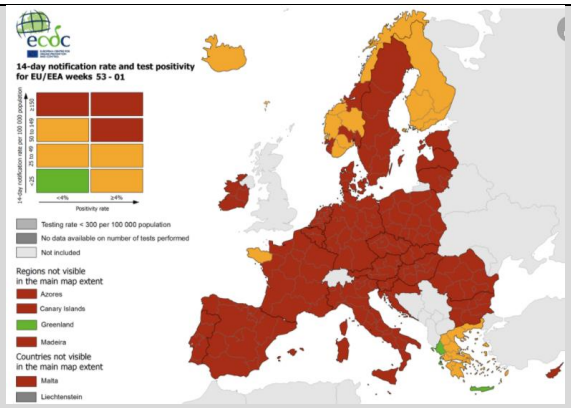
On 13 May, the European Commission presented guidelines and recommendations to help Member States gradually lift travel restrictions, with all the necessary safety and precautionary means in place.

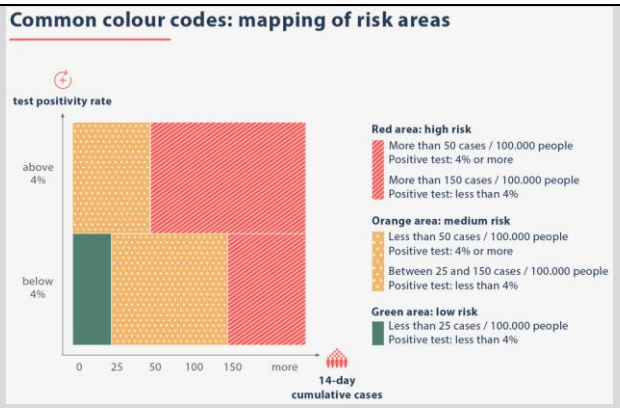
On 13 October, EU Member States adopted a Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic.

1. Common criteria
- **the notification rate** (the total number of newly notified COVID-19 cases per 100 000 population in *the last 14* days at regional level)
- **the test positivity rate** (the percentage of positive tests among all tests for COVID-19 infection carried out during the last week)
- **the testing rate** (the number of tests for COVID-19 infection per 100 000 population carried out during the *last week*)

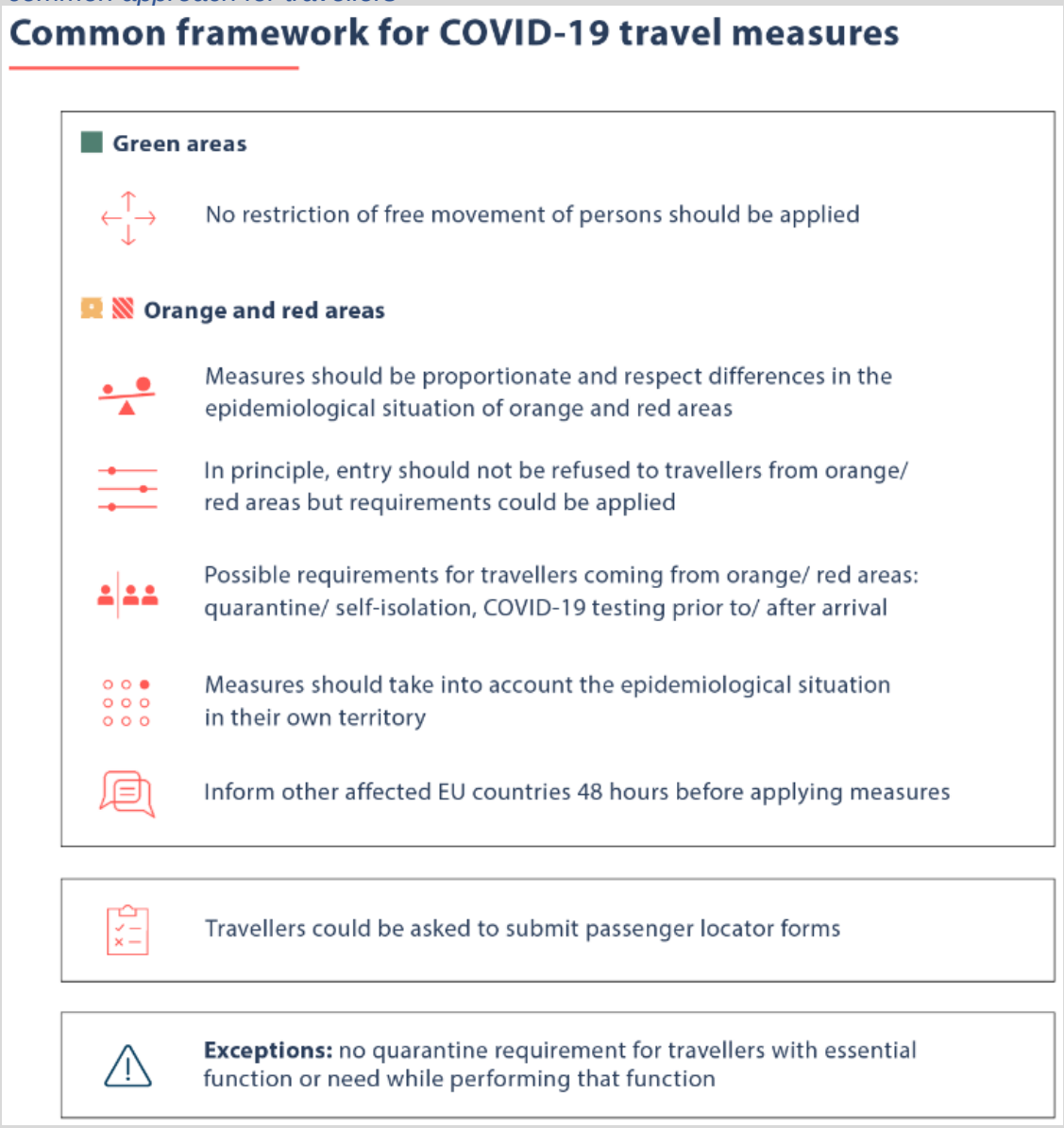
2. A common map
The ECDC will publish a map of EU Member States, broken down by regions, which will show the risk levels across the regions in Europe using a traffic light system. See also "Situation in Europe".

Areas are marked in the following colours:
- **green** if the 14-day notification rate is lower than 25 cases per 100 000 and the test positivity rate below 4%;
- **orange** if the 14-day notification rate is lower than 50 cases per 100 000 but the test positivity rate is 4% or higher or, if the 14-day notification rate is between 25 and 150 cases per 100 000 and the test positivity rate is below 4%;
- **red** if the 14-day notification rate is 50 cases per 100 000 or higher and the test positivity rate is 4% or higher or if the 14-day notification rate is higher than 150 cases per 100 000;
- **grey** if there is insufficient information or if the testing rate is lower than 300 cases per 100 000.





3. A common approach for travellers



4. Clear and timely information to the public about any restriction

As a general rule, information on new measures will be published 24 hours before they come into effect.

All information should also be made available on Re-open EU, which should contain a cross-reference to the map published regularly by the European Centre for Disease Prevention and Control.

	More information about traveling in the EU by the European Commission you will find here: https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en https://www.consilium.europa.eu/en/policies/coronavirus/covid-19-travel-and-transport/

Risk Assessment	
Global	• Because of global spread and the human-to-human transmission the **moderate to high** risk of further transmission persists. • Travellers are at 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 and 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. • 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 As of 23rd of October 2020	ECDC assessment for EU/EEA, UK as of 23 October 2020: Under the current classification system, based on epidemiological indicators, the epidemiological situation in countries is classified as *stable*, *of concern* or of *serious concern*. The majority of countries in the European region are currently classified as experiencing an epidemiological situation of **serious concern** due to the increasing case notification rates and/or test positivity≥3% as well as the high notification rates in the older age groups and/or high mortality rates. Countries have implemented various non-pharmaceutical interventions, but these have not been sufficiently effective in controlling transmission due to several factors: • adherence to the measures was sub-optimal; • the measures were not implemented quickly enough; • or the measures were insufficient to reduce exposure. As a result, the epidemiological situation is now rapidly deteriorating in most countries. **There are currently only six countries in the region that are classified as experiencing a *stable epidemiological situation*.** • In countries where the epidemiological situation is stable: • the **probability of infection** for the population is **generally low** but **the impact of infection** still **varies** depending on the individuals affected; • the risk for the **general population** in these countries is **low;** • for **vulnerable individuals**, including the elderly and people with underlying medical conditions, the risk is **moderate**. Nevertheless, in these six countries, there is still ongoing transmission and the situation must be closely monitored. **Based on the latest available data to ECDC, there are currently no countries categorised as having an epidemiological situation '*of concern*'.** **In countries where the epidemiological situation is of serious concern:** • there is a **high risk** to the **general population**, • and for **vulnerable individuals** the COVID-19 epidemiological situation represents a **very high risk**. In these countries the continuously increasing trend in notification rates calls for strong public health action in order to prevent the imminent risk that health care systems will be overwhelmed, rendering them unable to provide safe, adequate care.
As of 29th of December 2020	**ECDC** assessed the risk of the two new variants of SARS-CoV-2, as well as the risk of spreading in the EU and the increased impact on health systems in the risk assessment of 29th Dec 2020. **Risks associated with new variants of current concern:** • The probability of introduction and further spread in the EU is currently assessed as **high**. • The impact of COVID-19 disease in terms of hospitalisations and deaths is assessed as **high**, particularly for those in older age groups or with co-morbidities. • The overall risk associated with the introduction and further spread of SARS-CoV-2 VOC 202012/01 and 501.V2 is therefore assessed as **high**. • The probability of placing greater pressure on health systems in the coming weeks is considered to be **high** • The impact of this increased pressure on health systems is considered to be **high** even if current public health measures are maintained. • Therefore, the overall risk of an increased impact on health systems in the coming weeks is assessed as **high**. Therefore, States are recommended to continue to advise their citizens of the need for non-pharmaceutical interventions in accordance with their local epidemiological situation and national policies and, in particular, to consider guidance on the avoidance of non-essential travel and social activities.

	Source: https://www.ecdc.europa.eu/en/publications-data/covid-19-risk-assessment-spread-new-sars-cov-2-variants-eueea

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
- European Commission; https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en
- Our World in Data; https://ourworldindata.org/coronavirus
- Morgenpost; https://interaktiv.morgenpost.de/corona-virus-karte-infektionen-deutschland-weltweit/

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