Update 54 (26th of January 2021)

Information about infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
26th of January 2021
email: info.dhsc@coemed.org

In December 2019, a novel coronavirus emerged in Wuhan City, China. Since then the virus spread to 65 countries including Europe and America. Since then the virus showed evidence for human-to-human transmission as well as evidence of asymptomatic transmission. At 30th January 2020 WHO declared a Public Health Emergency of International Concern. The disease was formally named COVID-19 on 11th of February. The virus itself has been named SARS-CoV-2. On 11th of March 2020 WHO characterized the disease as a pandemic.

HIGHLIGHTS/NEWS

- **COVAX** announced the signing of an advance purchase agreement for up to 40 million doses of the Pfizer-BioNTech vaccine as well as nearly 150 million doses of the AstraZeneca/Oxford candidate are anticipated to be available in Q1 2021. Means the agreement will able to deliver at least 2 billion doses by the end of the year, including at least 1.3 billion doses to 92 lower income economies in the Gavi COVAX AMC.
- **Oxfarm:** According to a report, the corona pandemic is exacerbating social inequality worldwide. The 1000 richest people could have recovered their losses in the crisis in just nine months. In contrast, it could take the poorest more than a decade to recover from the economic fallout from the pandemic. For the first time since statistical records began over a century ago, there is a threat of worsening economic inequality in almost all countries. 295 economic researchers from 79 countries were interviewed for the report.
- **MERCK**: The pharmaceutical company Merck and the French Pasteur Institute are stopping their project for a joint corona vaccine. The Pasteur Institute in Paris explained that the first tests had shown insufficient effectiveness. The remedy should be developed on the basis of a vaccine against rubella.
- **UN**: UN Secretary General António Guterres has called for a hurry to distribute corona vaccines worldwide. The global production capacities of the means to contain the COVID-19 pandemic would have to be massively expanded and licenses made available. In addition, it must be ensured that the vaccines are affordable in poorer parts of the world.
- **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 ↘ 99 727 678 confirmed cases 65 181 850 recovered 2 140 310 deaths
EU/EEA and the UK ↘ 31 632 252 confirmed cases 16 715 600 recovered 696 136 deaths
USA → **(new cases/day 136 990)** 25 191 417 confirmed cases **10 011 617** recovered 419 036 deaths
India → **(new cases/day 13 203)** **10 676 838** confirmed cases **10 345 985** recovered **153 587** deaths
Brazil → **(new cases/day xx)** **8 871 393** confirmed cases **7 864 969** recovered **217 664** deaths
Russia ↘ **(new cases/day 18 999)** **3 698 246** confirmed cases **3 117 405** recovered **68 841** deaths
UK ↘ **(new cases/day 22 195)** **3 669 658** confirmed cases -not reported- recovered **98 531** deaths

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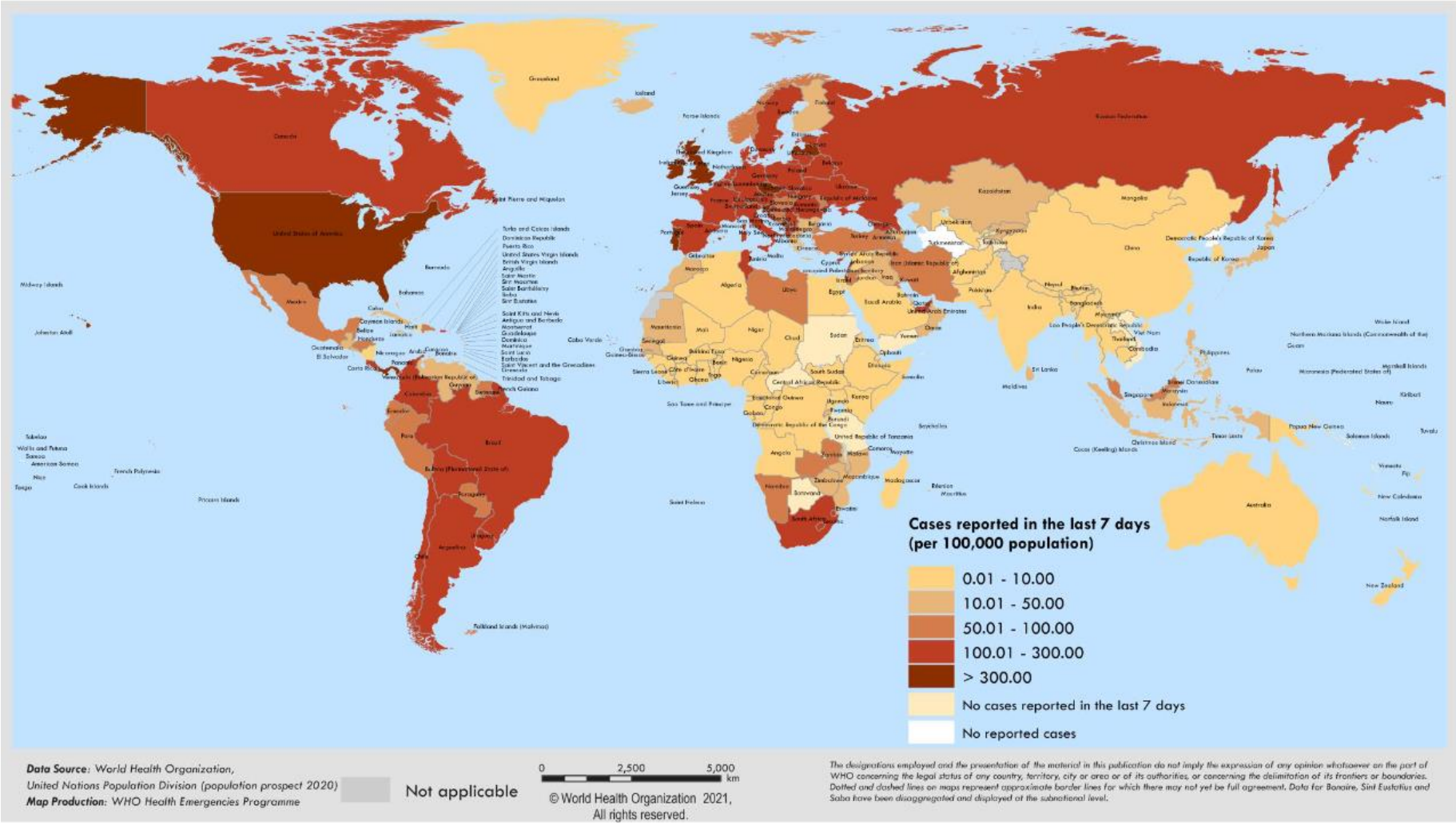
Map of countries with reported COVID-19 cases (last 7 days)



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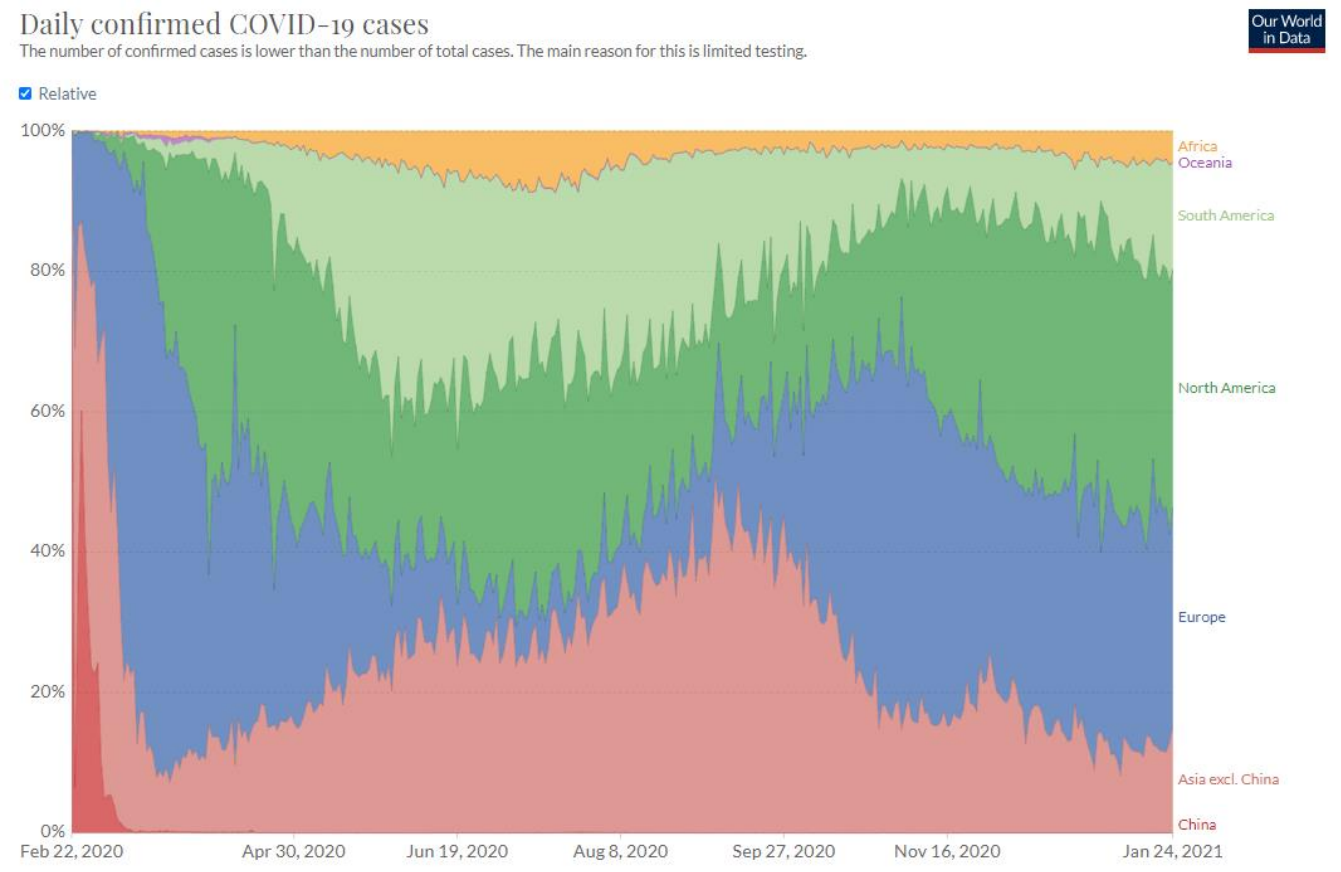
Worldwide Situation

Global Situation



Death due to vaccination with BioNTech vaccine;

At the 21 January the GACVS COVID-19 Vaccine Safety subcommittee had a meeting to review reports of deaths of very frail elderly individuals vaccinated with Pfizer BioNTech COVID-19 vaccine, BNT162b2.
Experts invited from the European Medicines Agency (EMA) and the Uppsala Monitoring Center (UMC) provided an overview of deaths reported in Europe and in the WHO global database (VigiBase) following vaccination with BNT162b2.

Based on a careful scientific review of the information made available, the subcommittee came to the following conclusions:

The current reports do not suggest any unexpected or untoward increase in fatalities in frail, elderly individuals or any unusual characteristics of adverse events following administration of BNT162b2. Reports are in line with the expected, all-cause mortality rates and causes of death in the sub-population of frail, elderly individuals, and the available information does not confirm a contributory role for the vaccine in the reported fatal events. In view of this, the committee considers that the benefit-risk balance of BNT162b2 remains favourable in the elderly, and does not suggest any revision, at present, to the recommendations around the safety of this vaccine.

Countries should continue to monitor the safety of vaccines, and promote routine after-care following immunization, consistent with good immunization practices for any vaccine. The committee recommends that data on suspected adverse events should be collected and reviewed continuously - nationally, regionally, and globally - as the COVID-19 vaccines are rolled out, world-wide.

The GACVS subcommittee will continue to monitor the safety data from these vaccines and update any advice as necessary.

The WHO COVID-19 vaccine safety surveillance manual provides guidance to countries on the safety monitoring and adverse events data sharing for the new COVID-19 vaccines and can be accessed here.

Source: https://www.who.int/news/item/22-01-2021-gacvs-review-deaths-pfizer-biontech-covid-19-vaccine-bnt162b2

Children, COVID-19, and transmission in schools, WHO as of January 19

As we already announced at last week Subject in Focus one of the most concerning questions has been the extent to which COVID-19 affects children and adolescents and the role of schools in community transmission. Research is ongoing into the factors that may put children and adolescents at risk, long-term health effects in those who have been infected, and importantly the impact of new variants of SARS-CoV-2.

WHO presents a number of research findings of 2020 in their last Weekly epidemiological report.

- Of all COVID-19 cases reported by countries, children and adolescents under 18 have represented around 8% of cases in 2020, despite comprising 29% of the global population. This may be due to the under reporting of mild and asymptomatic infections, which are more likely among children and adolescents.
- Children are also much less likely than adults to be hospitalized or have fatal outcomes. Approximately 0.2% of deaths were reported in people under the age of 20 years.
- Evidence suggests that adolescents appear to transmit the virus as often as adults, whereas children under 10 years seem to be less susceptible and less infectious than older children and adolescents. This is supported by the higher frequency of outbreaks reported in secondary/high schools compared to in primary/elementary schools.
- Large-scale community-based studies in the UK have showed higher levels of acute infection among adolescents and young adults compared to other age groups, further supporting differences in transmission patterns and susceptibility between primary and secondary-school aged children.
- A study in Norway from August to November 2020 found low levels of child-to-child and child-to-adult transmission in primary schools (children aged 5-13 years) that had infection prevention and control measures in place. Viral load studies suggest that children with symptoms carry as much virus in the nose, mouth and throat as adults, but for shorter periods with peak respiratory viral load early after symptom onset, followed by a rapid decline after the first week of illness.
- National surveillance data from the United Kingdom found that school staff are at lower risk of infection in school settings when compared to the general adult population. Another study among 57 000 caregivers at childcare facilities in the United States of America, found that there was no increased risk of infection for the caregivers.
- Several studies and reviews have shown that school re-openings have not been associated with significant increases in community transmission. The return to school of many children in mid-August, following periods of lower community transmission in many countries, does not appear to have contributed toward the rises seen in October. A United Kingdom government report found that when schools reopened in England and Wales in the summer, the infection rates among students did not increase over the existing population rate. A study in the Republic of Korea found that there was not an increase in COVID-19 cases in the two months following the resumption of classes in May, and that in most COVID-19 cases in children, the infection had been acquired from family members outside of school.
- Following the detection of new SARS-CoV-2 variants of concern (VOC), further investigations are underway to fully assess each variant and potential impacts on COVID-19 age and sex distributions. Investigations in the United Kingdom suggest that the age and sex profile of VOC 202012/01 cases are similar to other SARS-CoV-2 viruses.
- Impacts of school closures on children and adolescents:
    - The longer vulnerable children are out of school, the less likely they are to return.
    - Children from the poorest households are almost five times more likely to be out of primary school than those from the richest. Being out of school increases the risk of teenage pregnancy, sexual exploitation, child marriage, violence and other threats.
    - Prolonged closures disrupt essential school-based services such as immunization, school feeding, and mental health and psychosocial support, and disrupt the important roles school play in child protection.
    - Closures also cause stress and anxiety due to the loss of peer interaction and disrupted routines. These negative impacts are significantly higher for vulnerable children, such as those living in countries affected by conflict and other protracted crises, migrants, refugees and the forcibly displaced, minorities, children living with disabilities, and children in institutions.

- School closures affect children negatively in many ways besides their education, including equity, child health (both physical and mental health) and development and can affect the ability of parents to work, introducing other risks.

Based on available information, a number of preliminary conclusions and recommendations have been made:

- Transmission occurring in communities can be reflected in school settings: when community transmission is low and when appropriate mitigation measures are applied, schools are unlikely to be the main drivers of COVID-19 transmission. However, where there is community transmission and/or the number of new cases is rising, schools, and particularly secondary schools, may play a substantial role in community transmission.
- WHO and partners have issued guidance on the safe operation of schools during the COVID-19 pandemic. Schools should have outbreak prevention and management plans ready, including control measures to protect staff and individuals at high risk. Measures include the need for adequate ventilation, hygiene practices (such as hand cleaning, cleaning of surfaces and items), mask use (12 years and older should wear a mask under the same conditions as adults and teacher and support staff should wear masks when they cannot guarantee at least a 1-metre distance from others where there is widespread transmission in the area), physical distancing (such as by limiting the number of students per class, alternating shifts, limiting mixing of classes), and frequent communication with parents, students, teachers and staff (such as asking parents to report any cases of COVID-19 in the household, posting signs in visible locations).
- School teachers and staff need to remain vigilant to prevent exposure outside the school, where they can be infected.
- Where a student or staff tests positive for SARS-CoV-2, appropriate actions must be taken, including notifying health officials, staff and families, cooperating closely with local health authorities, quarantine, identifying and notifying close contacts and advising them to stay home for 14 days, and disinfecting school areas.
- Considerations to decide to close, partially close or reopen schools should be guided by a risk-based approach to maximize the educational and health benefit for students, teachers, staff, and the wider community, and help prevent transmission of SARS-CoV-2in the community. School closure should be implemented as a last resort, be temporary and only at a local level in areas with intense transmission.
- The time during which schools are physically closed should be used to put in place measures to prevent and respond to transmission when schools reopen.
- Health and education authorities should continue to monitor guidance based on new information and research, particularly with respect to the appearance of new and possibly more transmissible variants of SARS-CoV-2

Source: https://www.who.int/publications/m/item/weekly-epidemiological-update---19-january-2021
https://www.ecdc.europa.eu/en/publications-data/children-and-school-settings-covid-19-transmission
https://www.who.int/docs/default-source/coronaviruse/transcripts/who-audio-emergencies-coronavirus-press-conference-15sep2020.pdf?sfvrsn=580fa5f0_2
https://www.medrxiv.org/content/10.1101/2020.07.19.20157362v2
https://www.medrxiv.org/content/10.1101/2020.10.30.20223123v1
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https://www.un.org/sites/un2.un.org/files/policy_brief_on_covid_impact_on_children_16_april_2020.pdf
https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/covid-19-negative-impacts-public-health-

China tackles pandemic with mass construction once again, as of 25 January

The leadership is trying to cope with a new corona outbreak in northern China by setting up a huge quarantine center. Satellite images from the European Space Agency document the dramatic changes over the past ten days on what was once flat land in Zhengding District in Hebei Province since construction began on January 13. Rows of prefabricated houses can be seen.

As the party newspaper "Renmin Ribao" reported, more than 600 rooms were ready for occupancy by January 19. 3,600 more are to be added. According to state media, construction workers and materials have been sent from all over the country to complete the construction of the center. People who have had contact with COVID-19 patients are to be isolated there. According to the official news agency China News Service, one room per person is 18 square meters in size, equipped with bedding, a table, air conditioning, a TV and WiFi.

Zhengding is a peripheral area in the north of Shijiazhuang, a city of more than ten million people, where there was a corona outbreak. In the city of Wuhan, where the coronavirus was first discovered, the administration had two hospitals built within days to treat infected patients last year. The People's Republic has now largely brought the spread of the virus in the country under control but is struggling with outbreaks in the frosty north. On Monday, the national health commission reported 145 new cases in the previous 24 hours.

Souce: https://apnews.com/article/international-news-pandemics-beijing-coronavirus-pandemic-china-a4c4c2bdde4b3e36f814a1b853e4822c

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Vaccination report

EU: Following AstraZeneca's announcement that it will be delivering less vaccine than planned, Brussels is threatening legal action. In the responsible committee of the EU Commission, the manufacturer should now provide information on urgent questions.

AstraZeneca rejects reports of up to eight percent reduced effectiveness of its vaccine in seniors. Newspapers reported that, due to the lower effectiveness of the vaccine, the EU Medicines Agency (EMA) would only approve it for people under the age of 65. AstraZeneca called the reports "incorrect".

Moderna: Assumes its COVID-19 vaccine will also protect against the more contagious British and South African variants of the coronavirus. According to the company, the vaccine also generates virus-neutralizing antibodies against the two new variants. Nevertheless, to be on the safe side, a clinical program will be started to strengthen immunity to newly emerging variants. A reinforced vaccine is to be developed especially against the South African variant.

TUR: Received the second shipment of the corona vaccine from the Chinese company SinoVac. 6.5 million doses arrived in Istanbul on Monday. At the end of December, three million doses of the vaccine had already been delivered. The country with around 83 million inhabitants started its vaccination campaign with CoronaVac on January 14th. According to official figures, around 1.3 million people have been vaccinated since then.

GBR: Almost ten percent of the UK population - just under 6.6 million people - have received the first of two required vaccinations, according to government reports. The number of new infections rose by 22,195 and thus less than the previous day's 30,004. 592 more deaths were recorded (previous day 610).

EGY: has started vaccinating against the coronavirus. According to official information, the first doses of the vaccine produced by the Chinese state-owned company Sinopharm were given to health workers in the city of Ismailia on the Suez Canal on Sunday. The vaccination priority would be to staff from 40 hospitals across Egypt dedicated to treating and isolating COVID-19 patients. Afterwards it will go to the elderly and those suffering from chronic diseases. Two syringes would be given to each person within 21 days. The vaccine is 86 percent effective. It is believed that it can be transported at temperatures of two to eight degrees Celsius and therefore does not need such extremely low temperatures as other vaccines.

AUS: The Australian Regulatory Authority for Therapeutic Products (TGA) has approved the BioNTech Corona vaccine. According to government information, the agent can be used on at least 16-year-olds. The vaccination of prioritized groups is to begin at the end of February.

USA: According to the CDC health authority, over 18.5 million people have been vaccinated with at least one dose of BioNTech or Moderna vaccine since December 13, 2020. A second vaccination has already been given to more than 3.2 million people.

ISR: Young people between the ages of 16 and 18 should now also be vaccinated. According to the government, this is to enable them to take school exams, which are important for admission to universities. To do this, however, the young people need the consent of their parents. More than a million people in Israel have received the two necessary vaccinations against the coronavirus. The first dose has been given to around 2.6 million people so far.

Country reports:

ZWE has almost shut down the public service due to the massive increase in the number of corona cases. Otherwise overcrowded offices were orphaned today after the government sent 90 percent of officials home to prevent the virus from spreading further. Only representatives of the authorities were to be found who dealt with emergencies such as burial orders.
Zimbabwe initially had low numbers of corona cases. Recently, the number of confirmed new infections and deaths has risen sharply. While 10,000 cases and 277 deaths were registered at the beginning of December, there were already 31,320 infections last Sunday. 1005 people died in association with the virus.

BRA: For the second day in a row, thousands demonstrated for the impeachment of President Jair Bolsonaro, he is criticized for his government's handling of the corona pandemic.

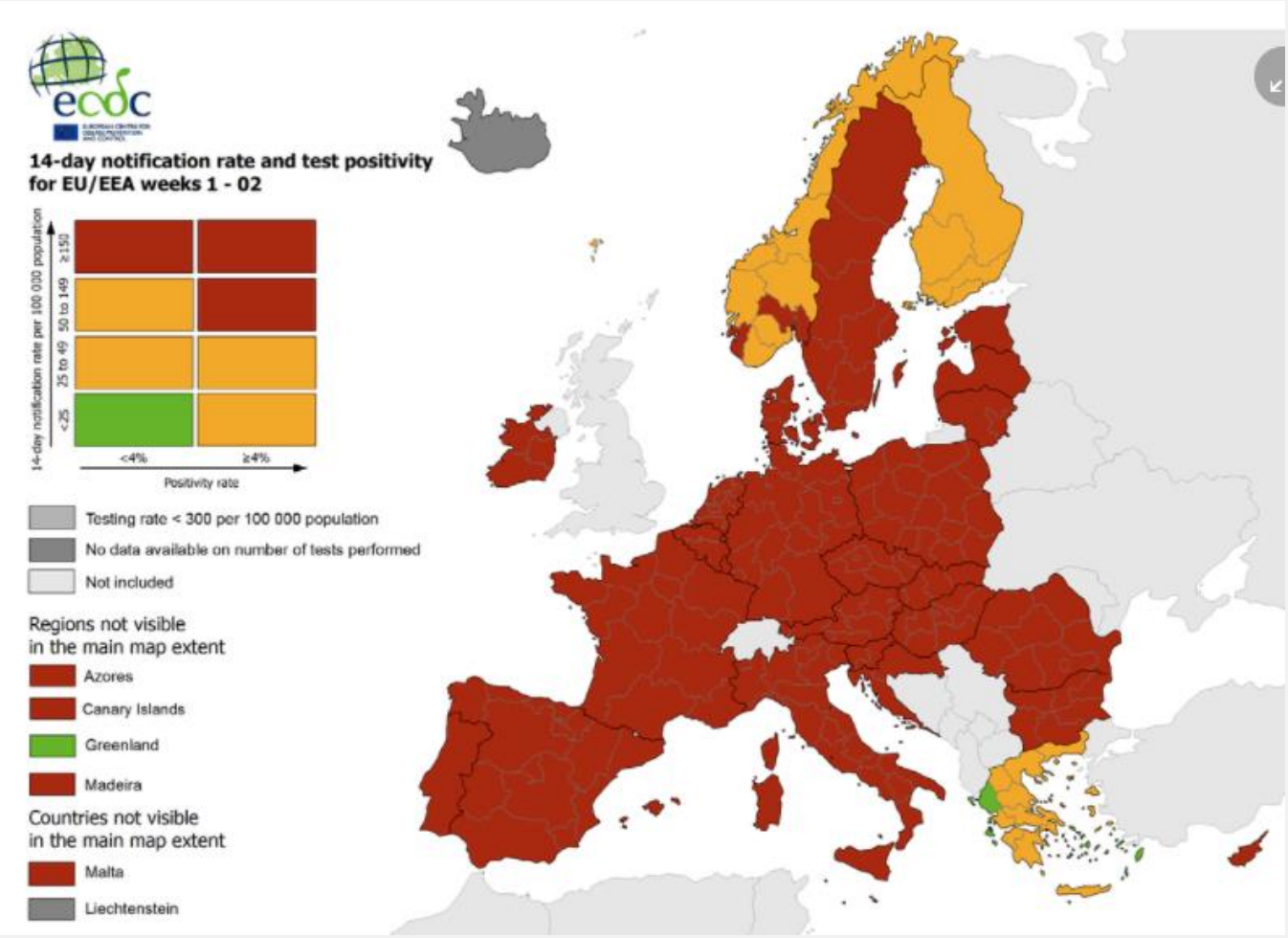
MEX: Mexico has ordered 24 million doses of the Russian anti-corona vaccine Sputnik V. The use of Sputnik V has yet to be approved by the Mexican supervisory authorities. In addition to Russia itself, according to the Russian authorities, Sputnik has already been approved for vaccination in Serbia, Belarus, Venezuela, Bolivia and Algeria.

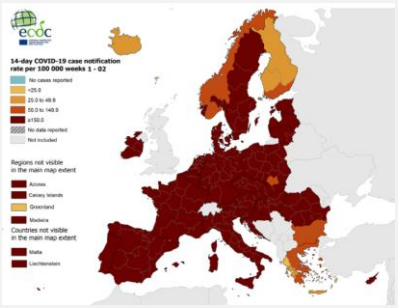
NZL: For the first time in months, a corona infection was recorded. Affected is a 56-year-old who returned from a trip abroad on December 30, as the government announced. During the two-week forced quarantine, the woman was initially tested negative twice. But after the quarantine, the South African variant of the virus was detected in another test.

	--- **USA**: According to an analysis by the AP news agency, more than 40 percent of US citizens live in an area with congested intensive care units with no more than 15 percent free beds. In view of the drastic number of corona cases in the US, hundreds of intensive care units across the country are in dire straits. There is a lack of space and accessories, and at the same time hospitals are competing for temporary employees. Facilities in the south and west of the country have been particularly hard hit. In the state of Texas alone, an average of 20,000 new infections per day were recently recorded, and more than 13,000 people are there in hospitals with symptoms of the Covid-19 disease. According to the AP, there are currently more than 80,000 corona patients in hospitals in the south and west of the USA. …….. The new US President Joe Biden has extended the entry bans for Europeans due to the corona pandemic. With the decree, travel from the 26 Schengen states, Great Britain and Ireland to the USA remains prohibited. The entry ban for people from Brazil has also been extended. South Africa was added to the prohibited list. --- **ISR:** Protests against the enforcement of the Corona rules have led to serious riots in the Israeli city of Bnei Brak, which is mainly inhabited by strictly religious people. As the police announced on Monday morning, rioters set fire to a bus, among other things. They also tried to storm a fire department building. The city police requested assistance from other districts. According to media reports, the officials used stun grenades, among other things. Four suspects were arrested, according to the police. In the city near Tel Aviv - but also in Ashdod and Jerusalem - there had been repeated confrontations between the police and ultra-Orthodox in recent days. Many strictly religious people do not follow the rules for fighting pandemics. An influential rabbi, for example, had called for schools in the ultra-Orthodox sector to be opened despite a general ban. ……. The government wants to drastically restrict international air traffic due to the high number of corona infections. According to Israeli media reports, the measure will come into effect on Monday evening at midnight (local time) and apply at least until the end of the month. There should be few exceptions to the lock. The aim is to prevent further corona mutations from being brought into Israel. According to official information, up to 40 percent of new cases can be traced back to a mutation that comes from Great Britain. The Israeli government had been sharply criticized for lax airport controls. --- **TWN:** Taiwanese authorities have ordered around 5,000 people to be quarantined after two coronavirus cases in a hospital. The action was taken after it was not clear how a patient and his visiting wife became infected with the virus. ---

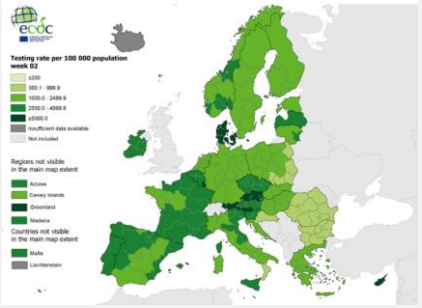
Situation in Europe

[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 21 January 2021

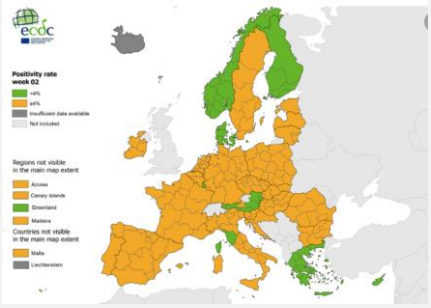




14-day case notification rate per 100 000 inhabitants



Testing rates per 100 000 inhabitants



Positivity rates

ECDC COVID-19 surveillance report Week 02, as of 21 January 2021

Weekly surveillance summary

Overall situation

By the end of week 2 (ending Sunday 17 January 2021), six countries observed increasing case rates (compared to 13 countries in week 1) and five reported increasing hospital or ICU admissions and/or occupancy due to COVID-19 (compared to nine in the previous week). Case rates among older age groups increased in seven countries and eight 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 in 2020, although there was an increase during weeks 1 and 2.

Trends in reported cases and testing

- By the end of week 2, the 14-day case notification rate for the EU/EEA, based on data collected by ECDC from official national sources from 30 countries, was 453 (country range: 61–1 444) per 100 000 population. The rate has been increasing for two weeks.
- Among 30 countries with high case notification rates (at least 60 per 100 000), increases were observed in seven countries (Belgium, France, Iceland, Ireland, Malta, Portugal and Spain). Stable or decreasing trends in case rates of 1–8 weeks' duration were observed in 23 countries (Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, Germany, Greece, Hungary, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Romania, Slovakia, Slovenia 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, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovenia, Spain and Sweden).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 2, available for 28 countries, varied from 680 to 10 326 tests per 100 000 population. Denmark had the highest testing rate for week 2, followed by Austria, Luxembourg, Cyprus and Malta.
- Among 21 countries in which weekly test positivity was high (at least 3%), two countries (France and Spain) observed an increase in test positivity compared with the previous week. Test positivity remained stable or had decreased in 19 countries (Belgium, Bulgaria, Croatia, Czechia, Estonia, Germany, Hungary, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia and Sweden).

Hospitalisation and ICU

- Pooled data from 20 countries for week 2 show that there were 1.5 patients per 100 000 population in ICU due to COVID-19, which is 74% of the peak ICU occupancy observed during the pandemic. Pooled weekly ICU admissions based on data from 15 countries were 3.6 new admissions per 100 000, which is 42% 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.

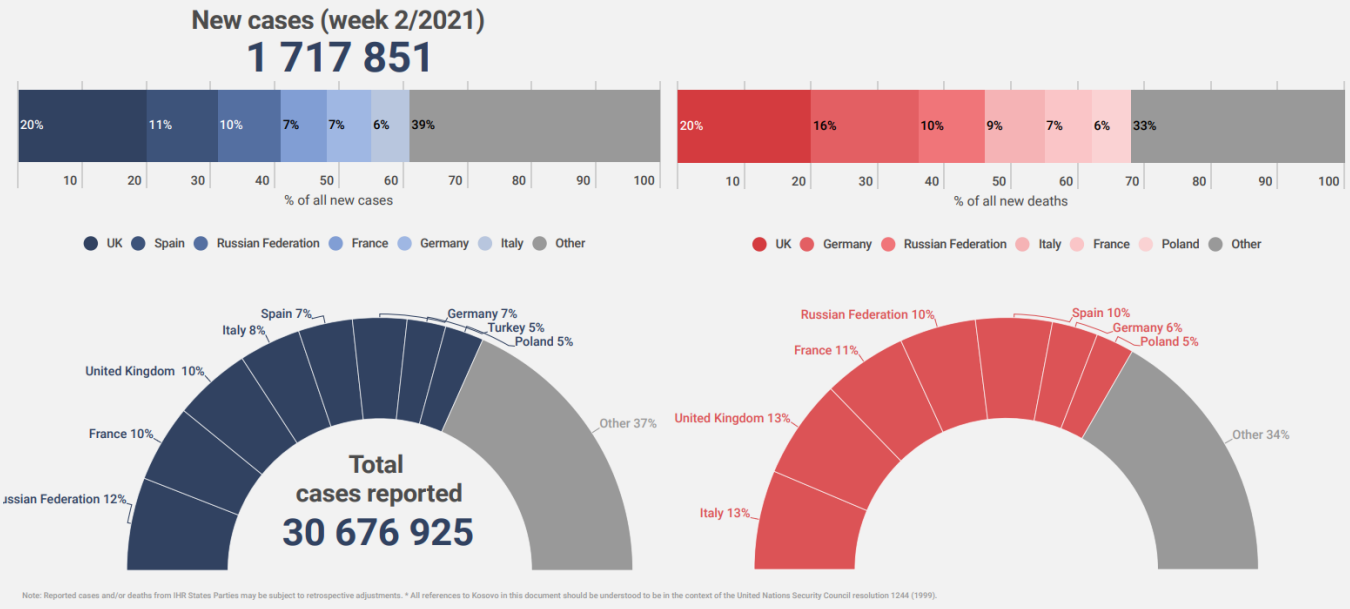
Mortality

- 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 103.6 (country range: 0.0–390.8) per million population. The rate has been stable for eight weeks.
- Among 29 countries with high 14-day COVID-19 death rates (at least 10 per million), increases were observed in eight countries (Czechia, Estonia, France, Germany, Ireland, Norway, Portugal and Spain). Stable or decreasing trends in death rates of 1–5 weeks' duration were observed in 21 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Denmark, Finland, Greece, Hungary, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Romania, Slovakia, 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 (11 Jan – 17 Jan 2021 Epi week 02)



Note: Reported cases and/or deaths from IHR States Parties may be subject to retrospective adjustments. * All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

EU:

Video conference of the members of the European Council, 21 January 2021

Main results

On 21 January 2021, EU heads of state or government met via video conference to discuss coordination on the response to the COVID-19 pandemic. They shared best practices and exchanged views on testing, vaccinations and detecting new variants of the virus.

New virus variants

The leaders noted the seriousness of the situation especially in the light of the new variants. They expressed their determination to limit the spread of the virus by adopting similar measures among the member states and highlighted the importance of increasing sequencing capacity.

Testing

Member states have agreed on a Council recommendation setting a common framework for the use of rapid antigen tests and the mutual recognition of COVID-19 test results across the EU. This is a central tool to help mitigate the spread of the virus and contribute to the smooth functioning of the internal market; the mutual recognition of test results for SARS-CoV2 infection carried by certified health bodies is essential in order to facilitate cross-border movement, cross-border contact tracing and treatment.

Key components of this recommendation include the validation and mutual recognition of rapid antigen tests and RT-PCR tests among member states, the sharing of a standardised set of data (through a digital platform), the development of a common list of COVID-19 rapid antigen tests, the prioritisation of situations for the use of such tests (e.g. contacts of confirmed cases, outbreak clusters) and more. The recommendation also includes future-proof provisions to address the challenges of the evolving pandemic: the common list of appropriate COVID-19 rapid antigen tests should be flexible enough for addition or removal of those tests whose efficacy is impacted by COVID-19 mutations.

Borders and the single market

The leaders discussed the importance of keeping borders open to ensure the functioning of the EU's single market. The leaders acknowledged that the Council may need to review its recommendations on non-essential travels into the EU in light of the risks posed by the new virus variants.
The EU heads of state and government agreed on stricter travel restrictions to contain the pandemic on Thursday. Travelers from Corona high-risk areas within the EU should always take a test before departure and be quarantined on arrival. Member States should not differentiate between cross-border and domestic travel. Furthermore, travel that is not absolutely necessary is strongly advised against, but the borders will generally remain open to cross-border commuters and the movement of goods.

Vaccinations

The leaders expressed their will to accelerate vaccination and highlighted that delivery commitments made by companies must be respected.

Vaccine certificates

The European Council members agreed to work on a standardized and inter-operable form of proof of vaccination for medical purposes.

International solidarity

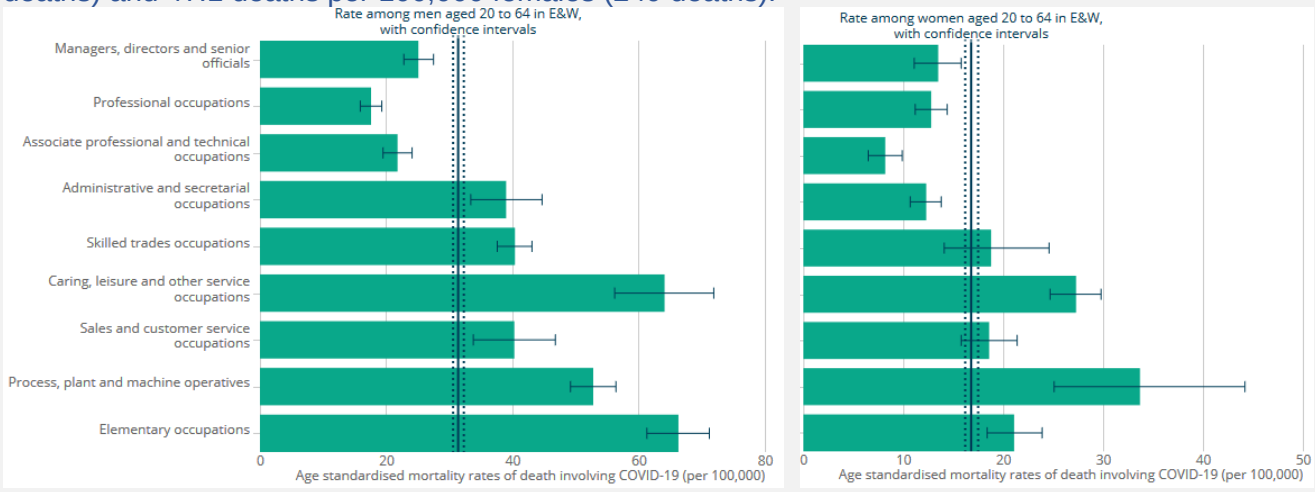
Maintaining that vaccines should be treated as a global common good, the leaders reaffirmed their solidarity with third countries. They highlighted the importance of the COVAX initiatve and Team Europe. The members of the European Council agreed that effective support should be delivered as soon as possible.

Source: https://www.consilium.europa.eu/en/meetings/european-council/2021/01/21/

Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 28 December 2020

A study by the UK statistics agency ONS shows that men in low-skilled jobs or in service sectors have a higher risk of dying from COVID-19. This is the result of an evaluation of COVID-19 deaths in England and Wales. The statisticians examined the occupation of 7,961 people who died with or from COVID-19 between March 9 and December 28, 2020. These include workers in the manufacturing industry, security forces, cooks and taxi drivers. For example, among the factory workers included in the analysis, an average of 143.2 out of 100,000 men between the ages of 20 and 64 would die. By contrast, the rate across all occupations is 31.4.
Overall, two thirds of the corona deaths in this age group are men. Assembly line workers, seamstresses and caregivers had the highest death rates among women. Mortality among

occupational groups in which people work in close proximity to one another and are regularly exposed to the virus is higher compared to the rest of the working-age population.
Almost three in four of the deaths involving COVID-19 in social care occupations (347 out of 469 deaths; 74.0%) were in care workers and home carers, with 109.9 deaths per 100,000 males (107 deaths) and 47.1 deaths per 100,000 females (240 deaths).

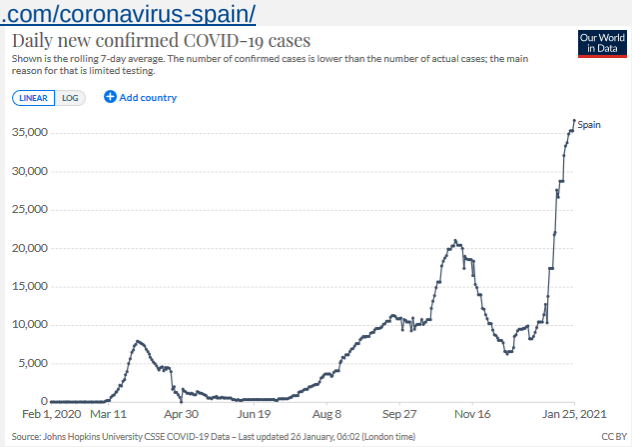


Source: https://www.ons.gov.uk/peoplepopulationandcommunity

Country Reports:

ESP: 93,822 new corona infections were registered over the weekend - more than ever before on a weekend. Thus, with an incidence value of 545.5, Spain is the fifth most affected country worldwide. The regions that are particularly affected are Castilla la Mancha, Castilla y Leon, C. Valencia, Estremadura, Madrid, Melilla, Murcia and La Rioja. All these regions have an incidence value of over 400 cases per 100,000 inhabitants in 7 days.
There are currently 30,483 people requiring hospital treatment for COVID-19 in Spain, of which 4,284 are in intensive care. This now represents over 40% occupation of intensive care units by COVID-19 patients.
Also, the variant VOC 202012/01 (B.1.1.7), is present in Spain. It has generally been sought and detected in cases with direct or indirect epidemiological links to the United Kingdom, Although cases with no apparent epidemiological link have already been detected and in wastewater, which suggests that transmission of this variant has occurred at some points in the country.
At this time the risk for Spain of new introductions and dissemination is considered **very high**.
The impact on healthcare pressure at this time is considered **low** but could reach cause a greater number of admissions in proportion to the increase in incidence.
The risk of reinfections by the variant is considered **low** and although data is awaited on the effectiveness of the vaccine in relation to this variant, so far there are no studies that conclusively indicate that it is diminished.

In Spain, an active mechanism has been put in place to integrate genomic information into the surveillance at the national level in order to identify which variants are circulating in the country and in order to detect the appearance and circulation of variants of interest, including VOC 202012/01.
Source: https://www.spainenglish.com/coronavirus-spain/



	NLD: Riots broke out in several cities for the third evening in a row. In Rotterdam, the police used water cannons against looters on Monday, and in Haarlem they used tear gas. Riots have also been reported from other cities, including Amsterdam. According to the police, around 150 people were arrested. The first riots occurred over the weekend during protests against the night curfew, which the government ordered to contain the corona virus. In the meantime, however, the motivation of the predominantly young rioters is no longer clear. --- **ITA:** After the corona numbers fell slightly, easing the COVID-19 restrictions will come into force in some parts of Italy. The economically strong Lombardy with its approximately ten million inhabitants is no longer a red zone with strict exit bans but has been lowered a risk level. Many shops are allowed to reopen there. Sicily in the south and the autonomous province of Bolzano in the north remain red high-risk areas. Most parts of Italy belong in the Orange Zone. In these areas, people should not leave their places. Restaurants and bars are no longer allowed to serve guests at the table, only temporary take-out is allowed. In the anti-corona fight, Italy introduced zoning in autumn 2020. The risk class depends on a bunch of numbers about the infection rate and the situation in the hospitals. The health authorities recently recorded moderately improved values. The R value for the number of people infected on average by an infected person has fallen "after five weeks of the increase": It is 0.97 (December 30 to January 12). --- **DEU:** The federal government has bought a new antibody-based corona drug. From next week, Germany will be the first country in the EU to use monoclonal antibody therapy initially at university clinics. For this, 200,000 doses were bought for 400 million euros. That corresponds to a price of 2000 euros per dose. --- **GBR**: According to a report by the Telegraph, the British government has extended the lockdown powers for English municipalities until the beginning of the summer holidays in mid-July. It allows municipalities to close restaurants, pubs, shops and public spaces to contain the corona pandemic. --- **SWE**: The border with Norway will be closed until February 14th after the occurrence of a corona mutation in Norway. There should be exceptions for commuters and some other groups. The shopping tourism caused by the Lockdown imposed in Norway is hope to be prevented. --- **CZE**: Since Sunday, Czech cross-border commuters have to present a negative corona test every time they travel to Germany, which must not be older than 48 hours. The background is the classification of the Czech Republic as a high-risk area. It is estimated that between 35,000 and 60,000 Czechs regularly go to work in Germany. Czech officials criticize this move because it makes life difficult for cross-border workers and their families and puts an enormous strain on the corona test system. --- **RUS**: For the first time since November 11 the authorities have registered fewer than 20,000 new infections within a day.

Subject in Focus

Pfaizer-BioNTech and Moderna mRNA vaccines versus COVID variants.

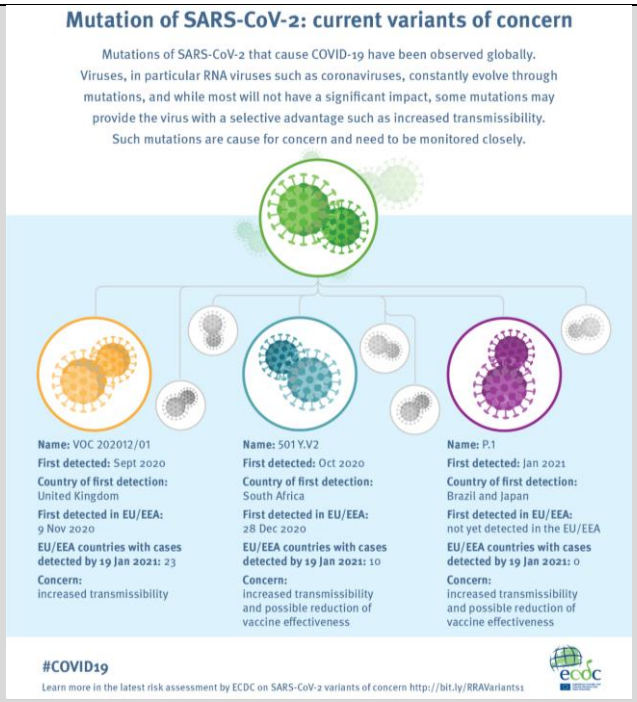
Notified deceases in Europe and US among elderly.

Pfaizer-BioNTech and Moderna mRNA vaccines versus COVID variants.

There are many thousands of different versions, or variants, of COVID circulating.
Main concerns focus on a few: UK variant, South Africa and variant from Brazil. It's not unexpected that new variants have developed - all viruses mutate as they make new copies of themselves to spread and thrive. Most of these differences are insignificant. A few can even be harmful to the virus's survival. But some can make it more infectious or threatening. Currently, there is no evidence that any of them cause much more serious illness for the vast majority of people who become infected. As with the original version, the risk is highest for people who are elderly or have significant underlying health conditions.
Due to the lack of a clear answer regarding the virulence of the new SARS-CoV – 2 variants, and in particular due to increased viral transmission, concerns have arisen as to whether currently approved vaccines could provide effective protection against these mutations. Studies are underway to check this and some early results suggest the Pfizer and Moderna vaccine protects against the new UK variant. The British variant had no effect on the levels of neutralizing antibodies produced after vaccination. But with the South African form, there was a six-fold reduction in those levels. Even so, Moderna said, those antibodies “remain above levels that are expected to be protective.”
Both, Moderna and Pfizer acknowledged that their vaccines might require alterations and boosters to fend off new and future variants of the virus. It’s a stark admission that the virus is adapting more quickly than previously thought, and that it may continue to mutate in ways that can help it evade vaccines. Nevertheless, Moderna has already begun developing a new form of the vaccine that could be used as a booster against the South African variant.
It is known that the mRNA technology used by Moderna and Pfizer-BioNTech allows the companies to create vaccines much more quickly than traditional methods. The BioNTech representative (Dr. Ugur Sahin) said that the company could develop a new variant-targeted vaccine in six weeks, though it would be up to regulators to determine the timeline for rolling it out.

UK variant:
The UK’s variant (VOC 202012/01) was first identified in Kent, southeast England in December 2020. The first sample in which it could be identified has been traced back to September 2020. Since then, it has become the predominant variant circulating in the UK. It is characterised by a significantly increased transmissibility, which has contributed to increases in incidence, hospitalisations and pressure on the healthcare system since the second half of December 2020. It is significant that while the new variant spreads more easily, it does not appear to make it deadlier. The UK’s variant is said to be currently circulating in 23 EU countries and has spread to more than 50 other countries on the globe.

South Africa variant:
The variant 501Y.V2 was first identified in South Africa in December 2020, where it is now the most prevalent variant. Preliminary results indicate that this variant may also have an increased transmissibility. However, as for VOC 202012/01, at this stage it is uncertain whether the 501Y.V2 variant causes a change in disease severity. As per 19 January 2021, 501Y.V2 has been identified in 10 EU/EEA countries. One cluster of this variant is currently being investigated in France. In addition to France, Israel and the UK have also reported cases or clusters of non-travel-related 501Y.V2 cases. The remaining cases identified in the EU/EEA have mostly been travel-related, but not only from South Africa. A South Africa variant has also been found in at least 20 other countries.



https://www.ecdc.europa.eu/en/publications-data/covid-19-infographic-mutations-current-variants-concern

Brazil variant:

The P.1 variant has only been identified in Brazil, and in travellers from Brazil (mostly from the Amazonas State) reported in Japan (it had been notified by Japan on January 9) and South Korea. The capital of Amazonas, Manaus, is currently experiencing an upsurge in COVID-19 cases, putting significant pressure on the healthcare system.

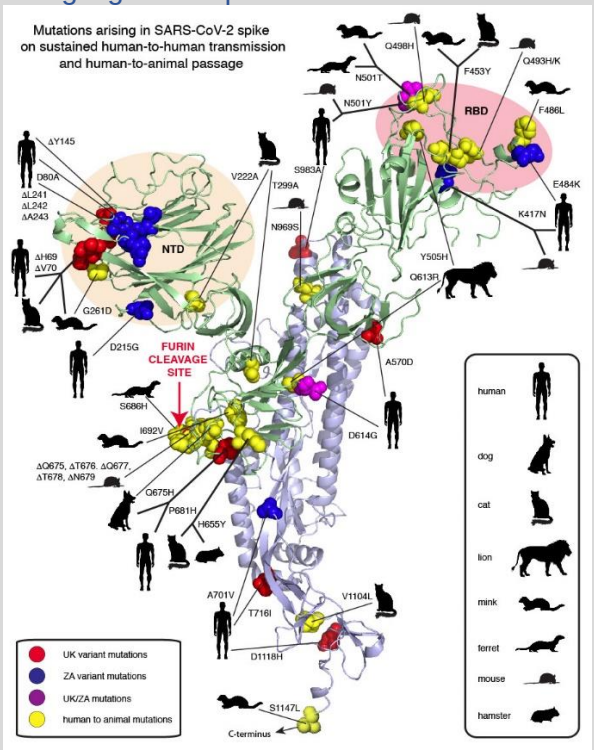


Figure 1. Compilation of SARS-CoV-2 spike mutations occurring in humans and animals. Red spheres: United Kingdom (UK) variant, Blue spheres: South African (ZA) variant, Magenta: both UK/ZA variants, Yellow spheres: animals as indicated in the inset. NTD: Amino-terminal domain. RBD: Receptor binding domain.

https://virological.org/t/mutations-arising-in-sars-cov-2-spike-on-sustained-human-to-human-transmission-and-human-to-animal-passage/578

Notified deceases in Europe and US among elderly

A small number of deaths in elderly patients across Europe and US who had received a COVID-19 vaccine has sparked concerns regarding its safety. As of January 19, there were 71 observed deaths linked to the Pfizer COVID-19 vaccine across Europe, including 16 in the UK and 12 in Germany and broadly commented 23 deaths reported by the Norwegian Medicines Agency.
In line with the WHO Global Advisory Committee on Vaccine Safety (GACVS) findings on the safety of COVID-19 vaccines on January 19, the following conclusions were drawn.

	• The current reports do not suggest any unexpected or untoward increase in fatalities in frail, elderly individuals or any unusual characteristics of adverse events following administration of BNT162b2 (Pfizer). Reports are in line with the expected, all-cause mortality rates and causes of death in the sub-population of frail, elderly individuals, and the available information does not confirm a contributory role for the vaccine in the reported fatal events. In view of this, the committee considers that the benefit-risk balance of BNT162b2 remains favourable in the elderly, and does not suggest any revision, at present, to the recommendations around the safety of this vaccine. • Countries should continue to monitor the safety of vaccines, and promote routine after-care following immunization, consistent with good immunization practices for any vaccine. The committee recommends that data on suspected adverse events should be collected and reviewed continuously - nationally, regionally, and globally - as the COVID-19 vaccines are rolled out, world-wide. Summing up, so far, there is no evidence linking the vaccine to the elderly deaths. The countries vaccines body, noted, all deaths were of seriously ill patients and it is assumed that the patients died of their underlying disease. Nevertheless, the observed demises shortly after vaccination must be very carefully analysed in order to draw long-term conclusions to ensure confidence in vaccine safety in this social group and prevent anti vaccination movement. References: • https://www.ecdc.europa.eu/en/publications-data/covid-19-risk-assessment-spread-new-variants-concern-eueea-first-update • https://www.who.int/news/item/22-01-2021-gacvs-review-deaths-pfizer-biontech-covid-19-vaccine-bnt162b2 • https://www.medscape.com/viewarticle/944478?src=WNL_dne_210122_mscpedit&uac=358037FK&impID=3146136&faf=1#vp_2

COVID-19 Crisis in Lebanon

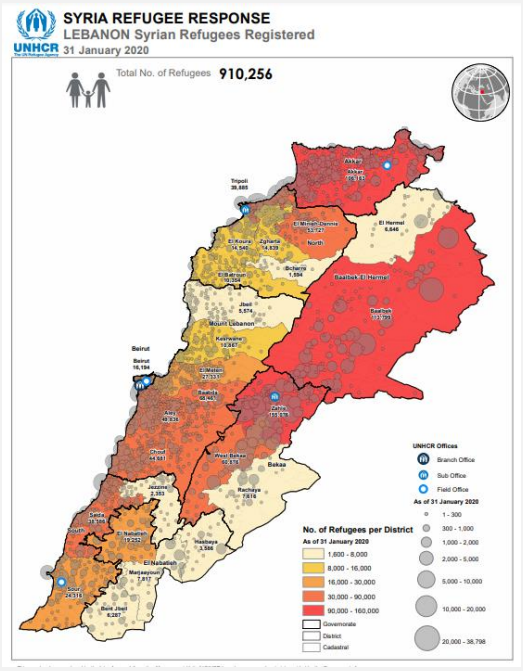
In cooperation with Bundeswehr HQ of Military Medicine

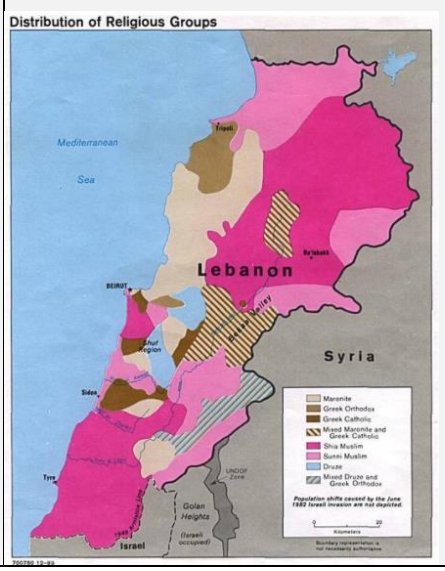
Lebanon

Area:	10,452 km^2
Population:	6,859,408
Capital:	Beirut
Age structure:	
0-14 years:	20,75%
15-24 years:	14,98%
25-54 years:	46,69%
55-64 years:	9,62%
65 years and over:	7,96%

CONFLICT:

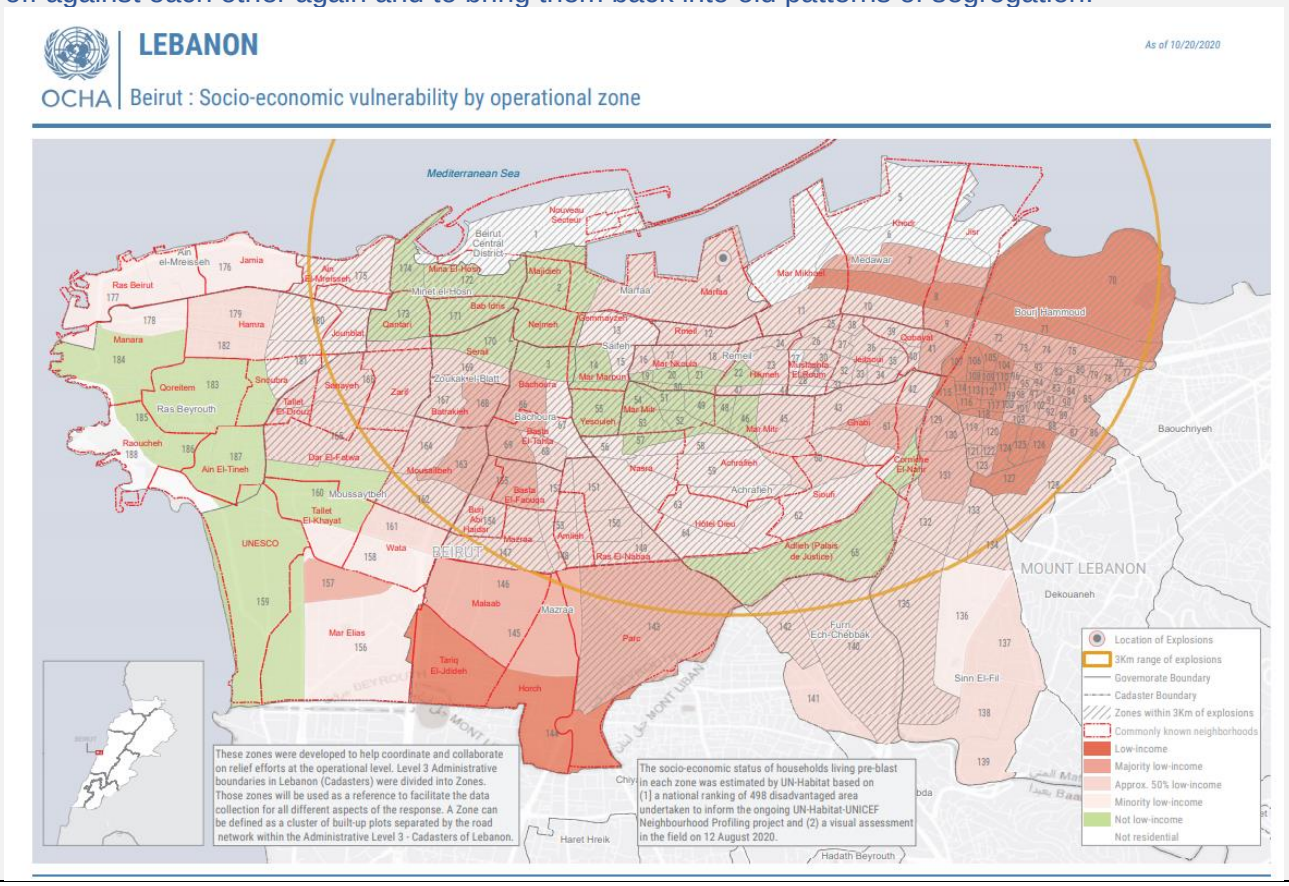
Lebanon - in free fall - a year and three crises The Lebanese Republic, formerly under the French League of Nations, gained independence in 1943. It has an estimated 6.2 million inhabitants who belong to 18 different ethnic groups and 2/3 live in an urban area. As different as the population of small Lebanon is, it is also geographically different. The country, which is one of the smallest in the world, has one of the densest settlements. It is divided into four landscape zones that run parallel to the coast. On the one hand the 225 km long, narrow, steep coastline and on the other hand the Lebanon Mountains that reach up to 3000m high. At the same time there is the fertile Bekaa plain, which is considered the breadbasket of Lebanon and which currently houses around 1.5 million Syrian refugees. The dry Anti-Lebanon mountain range and the Hermon form the border with Syria. The capital Beirut with 2.1 million inhabitants forms the multi-ethnic and multi-religious center of Lebanon.



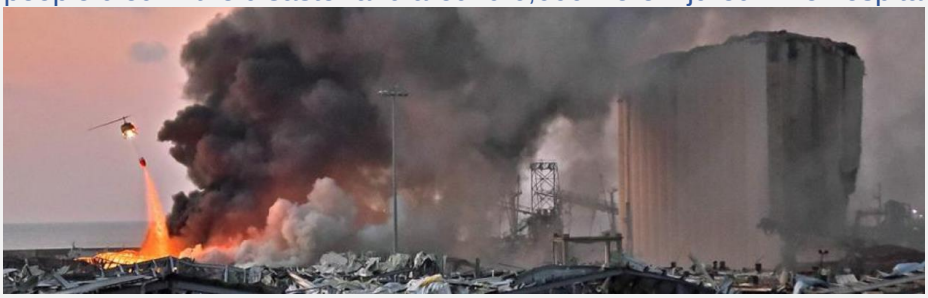


The former partial autonomy known as "Reglement Organique" is considered to be the nucleus of Lebanese statehood. The principles anchored in it have remained groundbreaking to this day: being represented and participating in power, according to a constantly controversial demographic key, primarily religious communities (Christians, Sunnis, Shiites, etc.). Since offices, jobs and social services as well as public investments are proportionally allocated to the various religious communities according to the principle of religious-denominational proportionality, economic and social struggles for distribution are always also religious-denominational disputes. Lebanese domestic politics has always been closely linked to the regional balance of power; substantial change is only possible if the latter shifts significantly. Usually it is accompanied by violence. Only with the

reorganization of the balance of power in the region after 1990 could the Lebanese civil war, which lasted for almost 25 years, be settled. In an agreement between the USA and Saudi Arabia, the neighboring state of Syria, which was deeply involved in the civil war, was entrusted with the pacification of the country and was present with troops in Lebanon until 2005. The "Document of National Understanding" of 1989 determined a moderate change in the denominational balance of power in favor of Muslims. Since 2006 the country has been politically divided into two almost equally strong camps, which define themselves politically as well as denominationally. The Sunni-dominated "March 14th Alliance" orients itself towards Saudi Arabia and its regional and western allies, supported the revolution in Syria, opposes alleged Iranian expansion efforts and sees Hezbollah as the greatest threat to democracy in Lebanon. The "March 8th Alliance" led by the Shiite Hezbollah (both alliances are named after major rival demonstrations in spring 2005), conversely, takes sides with Iran and the allegedly "secular" regime of Bashar al-Assad in Syria. It is against a supposed strategy of the USA to reorganize the region in the interests of their interests (and those of Israel) with the help of the regional powers Turkey and Saudi Arabia. The inner-Lebanese power conflict is thus directly linked to a hegemonic conflict of regional and global political importance and cannot be resolved autonomously by the Lebanese actors. This is still valid today and is particularly noticeable in the economic crisis that has ruled Lebanon since October 2019. In October, the US dollar was decoupled from the Lebanese currency, which was a guarantee of stability for decades. Since then, the Lebanese currency and economy has been in free fall. There is hardly any foreign currency in the country, the population's assets are no longer accessible and the prices are becoming unaffordable. The population has been demonstrating since October last year against the corrupt government and incapable of acting, as well as the small power elite that has enriched itself in the state and the population over decades. What is new here is that large sections of the population override the religious, political and ethnic barriers and demonstrate nationwide against the government and the power elite (these also consist of all religious, political and ethnic camps due to the demographic key). A new, first common Lebanese identity has emerged in this multi-ethnic and religious state. The political elites try, however, through political and religious propaganda to play the population off against each other again and to bring them back into old patterns of segregation.



On August 4, 2020 at 6:08 p.m. local time, experts estimate an explosion with the force of one tenth of the atomic bomb dropped on Hiroshima. The cause is 6.2 t of ammonium nitrate, which was improperly stored in the port for several years despite constant warnings and reports. According to reports, over 200 people died in the disaster and around 6,000 were injured. The hospitals in Beirut were overloaded with the onslaught of injured people. The pressure wave of the explosion also caused immense material damage: In addition to cars being thrown away and buildings destroyed in the vicinity, even houses several kilometers away were severely damaged. The pressure wave also burst windows 20 kilometers away. Three hospitals were evacuated because they were badly damaged or destroyed; two others also suffered damage. According to the Konrad-Adenauer-Stiftung's Beirut office, the power station in Beirut destroyed. Countless video recordings document devastated parts of the city. Between 200,000 and 300,000 people are said to have become homeless. According to initial estimates, the amount of property damage caused by the disaster is up to five billion US dollars (just under 4.25 billion euros and many insurance companies refuse to pay out the insurance sums. Around 85% of all goods in Lebanon were imported in the past ; the largely destroyed trading port of the Lebanese capital was one of the most important transshipment points in Lebanon. Several countries sent specially trained rescue teams to Beirut for urban missions as well as aid and supplies. International sympathy and help came from all parts of the world, even from warring Israel, if this was offered. The state development aid of Lebanon and the sympathy are very limited. Politicians fear to acknowledge their responsibility by making a public statement and being present at the site of the explosion. Almost all construction, clean-up work as well as humanitarian and relief operations are carried out by the population and NGOs. The population also calls for aid and donations not to be made available by the Lebanese government, as they fear that they will seep into the state apparatus and into corruption.



HEALTH:

The health system in Lebanon is, or until recently, considered to be one of the best in the region. Lebanon has or has had 24 public and 138 privately run hospitals. In addition, NGOs and political parties operate around 760 local clinics. According to the Ministry of Health, there are 11,186 doctors, 4,200 dentists and 4,667 pharmacists in Lebanon. Health services in Lebanon are generally of an average to good level. Lebanon has the best hospitals and doctors in the region. Nevertheless, the supply in rural areas is moderate. In addition, the qualitative differences between the public and private sectors are very large. The high number of doctors (1/270 inhabitants) and the modern, highly developed technology of the country ensure fast and comprehensive, but very expensive medical care. Only a small proportion of the Lebanese are members of the National Social Insurance Fund. The Ministry of Health spends 80% of its budget on paying private hospitals to cover the cost of medical care for patients who are not socially or privately insured and cannot pay their hospital bills. This means that the proportion of the population with access to health services is very high. Maternal and infant mortality rates are lower in Lebanon than most countries in the region. However, there is also the fact that state benefits are only available to Lebanese citizens who have had Lebanese citizenship for at least ten years. This excludes the hundreds of thousands of Palestinian refugees who have lived in the country for decades. These and the hundreds of thousands of Syrian refugees are cared for by aid organizations. As a fourth type of health care, it

remains to be mentioned that the Shiite party and militia Hezbollah operates its own social and health system for its supporters and thus also secures their loyalty (as long as it works and financial aid flows from Iran). However, the current economic development and the conflict between the population and the government have a very severe impact on the relatively good medical situation listed here. The shortage of foreign currency has an immense impact on health care as a large number of medical devices and medical infrastructure have to be paid for in foreign currency. At the same time, the state no longer has any money to pay for health services. There is not only a shortage of food, but also a shortage of medicines. In the meantime it is reported that various hospitals and around 300 pharmacies are closing. Renowned hospitals are laying off hundreds of employees and at the same time many skilled workers are leaving the country to work abroad.
These are and were not good prerequisites for confronting the COVID-19 pandemic, which has been present since March, after the first cases were registered by Shiite pilgrims from Iran. To date, 264,647 COVID-19 cases and 2084 deaths have been reported, doubling the number in the past six weeks. Case numbers have risen after the initial easing in July and led to a new lockdown in early August, which was relaxed after the explosion to allow cleanup and reconstruction work. Since the beginning of August, especially after the explosion, the numbers have increased steadily and strongly (see graphs). Various lockdowns since August tried to bring the situation back under control. The easing over the festive season at the turn of the year was dramatic for the new infections. They led to an exponential increase in positive cases as well as deaths. The current situation is causing the authorities to impose another complete lockdown, which has now been extended until February 8th. For several days there has also been a total curfew to reduce the numbers. However, the lockdown is driving the poor and newly impoverished sections of the population into famine, some of which is being attempted through humanitarian assistance. Overcrowding in hospitals and lack of resources resulted in patients being treated in their cars or not at all. Lebanon has thus de facto reached level four on the WHO scale, in which the uncontrolled spread of an epidemic meets an inadequate health system and leads to a significant increase in the death rate. Hope now rests on the vaccine, of which 2.1 million doses have been ordered and which will be financed for the first time by a World Bank loan of 34 million US dollars. The vaccinations with should be used from the beginning of February.

CONCLUSION of the last year:

- approx. 50 percent of the population slipped into poverty
- 300,000 people were left homeless in seconds
- COVID-19 cases and deaths are rising unabated, one of the highest infection rates in the world.

Health care in Lebanon, one of the best in the region, reached its limits shortly before the explosion due to rising COVID-19 cases and collapsed. The extreme economic crisis and the lack of sufficient international aid for the government, which is blocked by regional and global hegemonic conflicts and a lack of reforms, support the free fall of the entire country. Due to the catastrophic destruction of the explosion, the health system is also on the ground and, after the first emergency response, also needs short, medium and long-term support in all areas of health care in order to cope with the physical and especially mental damage of this explosion. This requires a comprehensive public health approach. A coordinated fight against the COVID-19 pandemic is currently out of the question, and the uncontrolled community spread since August has led to the highest infection rates worldwide and a currently significant death rate. It is also still unclear whether international pressure will set a process of reforms in motion that not only enables reconstruction, but also puts the population on a path towards a common future. If the old system prevails in Lebanon, Lebanon will very likely sink into sectarian chaos and corruption again and the population will continue to suffer in this tragedy.

Lebanon

43.1 Index Score **73**/195

	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**27.3**	**34.8**
Antimicrobial resistance (AMR)	41.7	42.4
Zoonotic disease	13.8	27.1
Biosecurity	0	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	93	85.0
DETECTION AND REPORTING	**62.0**	**41.9**
Laboratory systems	66.7	54.4
Real-time surveillance and reporting	61.7	39.1
Epidemiology workforce	25	42.3
Data integration between human/ animal/environmental health sectors	100	29.7
RAPID RESPONSE	**47.9**	**38.4**
Emergency preparedness and response planning	25	16.9
Exercising response plans	0	16.2
Emergency response operation	33.3	23.6
Linking public health and security authorities	100	22.6
Risk communication	25	39.4
Access to communications infrastructure	82.4	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**23.8**	**26.4**
Health capacity in clinics, hospitals and community care centers	37.4	24.4
Medical countermeasures and personnel deployment	33.3	21.2
Healthcare access	30.4	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	**49.3**	**48.5**
IHR reporting compliance and disaster risk reduction	100	62.3
Cross-border agreements on public and animal health emergency response	50	54.4
International commitments	37.5	53.4
JEE and PVS	25	17.7
Financing	16.7	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	**45.5**	**55.0**
Political and security risks	14.3	60.4
Socio-economic resilience	69.1	66.1
Infrastructure adequacy	33.3	49.0
Environmental risks	56.8	52.9
Public health vulnerabilities	59.5	46.9

*Average: all 195 countries

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

www.ghsindex.org

Source:

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https://www.indexmundi.com/lebanon/

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:

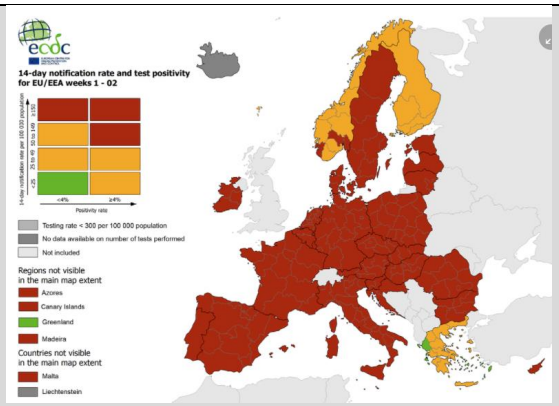
On 13 May, the European Commission presented guidelines and recommendations to help Member States gradually lift travel restrictions, with all the necessary safety and precautionary means in place.

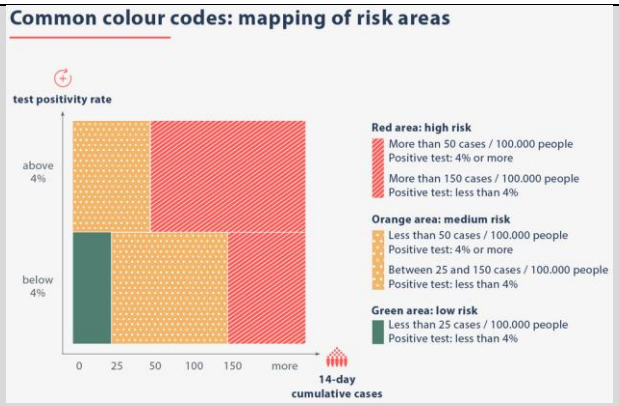
On 13 October, EU Member States adopted a Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic.

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*)

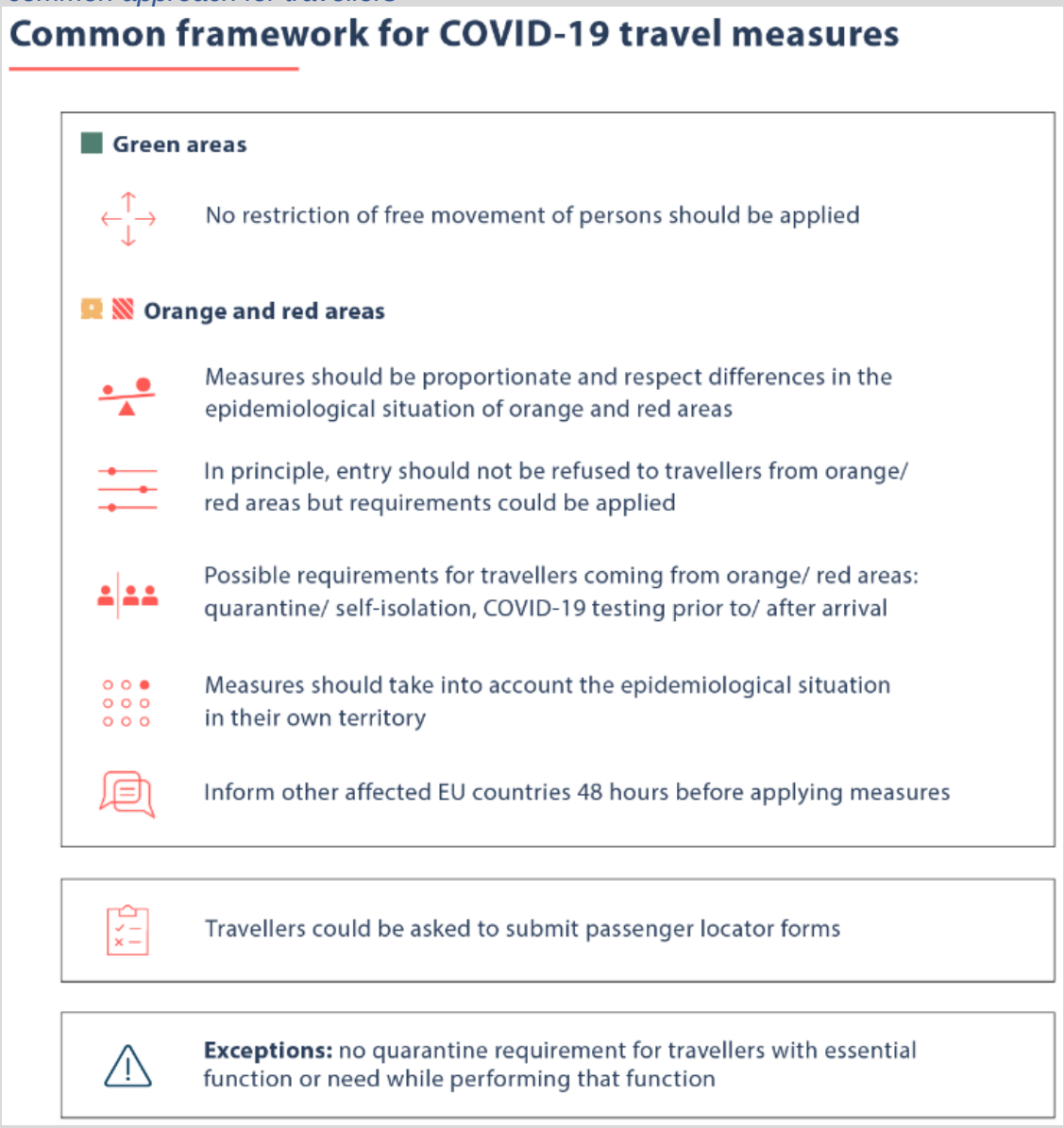
2. A common map
The ECDC will publish a map of EU Member States, broken down by regions, which will show the risk levels across the regions in Europe using a traffic light system. See also "Situation in Europe".

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 **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 21st of January 2021	**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 and 21st of January 2021 **Risks associated with new variants of current concern:** • The probability of introduction and further spread in the EU is currently assessed as **very 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/very 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/current-risk-assessment-novel-coronavirus-situation https://www.ecdc.europa.eu/en/publications-data/covid-19-risk-assessment-increased-transmission-thirteenth-update

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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