



Update 59 (2nd of March 2021)

**Information about infection disease
COVID-19 (novel coronavirus)**



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

2nd of March 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

- **Israel** is considering buying 36 million COVID-19 booster vaccinations. That would be three times as many doses as the country has already purchased. These would be stored in the event that booster vaccinations were needed later in the year. Scientists had suggested the possibility of regular booster vaccinations to deal with the coronavirus mutations.
- According to a [not peer review article](#) the coronavirus variant on the rise in **New York City** contains the same E484K mutation seen in variants in Brazil and South Africa believed to make COVID-19 vaccines and antibody therapies less effective, as well as a mutation called S477N that helps it bind more tightly to cells when it breaks into them.
- Just 4% of scientific research published on COVID-19 is relevant to Africa despite the continent containing close to a fifth of humanity, according to an analysis [published in the online journal BMJ Global Health](#).
- **WHO:** The WHO chief urged the international community not to rely on vaccinations alone. The number of new infections worldwide is rising for the first time in seven weeks. Apart from Africa and the region in the western Pacific, an upward trend can be observed everywhere. According to the WHO, the increase is "disappointing but not surprising". The causes could be the corona easing and the more contagious variants of the virus - "and that people are becoming less careful".
- **WHO:** [COVID-19 oxygen emergency impacting more than half a million people in low- and middle-income countries every day](#). New assessments show US\$90 million immediate funding required to meet urgent need in up to 20 LMICs.
- **WHO:** Consider an end to the coronavirus pandemic this year unrealistic. However, vaccines can help drastically reduce deaths and hospital treatment for the virus. Data show that many of the vaccines that have been approved to date help to slow down the explosive spread of the virus.
- **EU:** Reminded Member States that vaccination campaigns have to keep pace with growing amounts of vaccines. It is crucial that there is no gap between the doses delivered and the doses administered and that no vaccines go unused.
- **EU:** The EU Commission wants to present a draft law for the introduction of a digital vaccination pass already in March.
- **ECDC:** Even with seven human cases due to A(H5N8) HPAI virus reported from Russia and five human cases due to A(H5N6) HPAI and 10 cases due to A(H9N2) LPAI viruses reported from China (all poultry workers with mild or no symptoms). [ECDC assesses the risk](#) for the general population as well as travel-related imported human cases as **very low** and the risk for people occupationally exposed as **low**.
- **WHO:** El Salvador became the first country in Central America to be awarded a [certification of malaria elimination](#) by the WHO as of 25 February 2021.

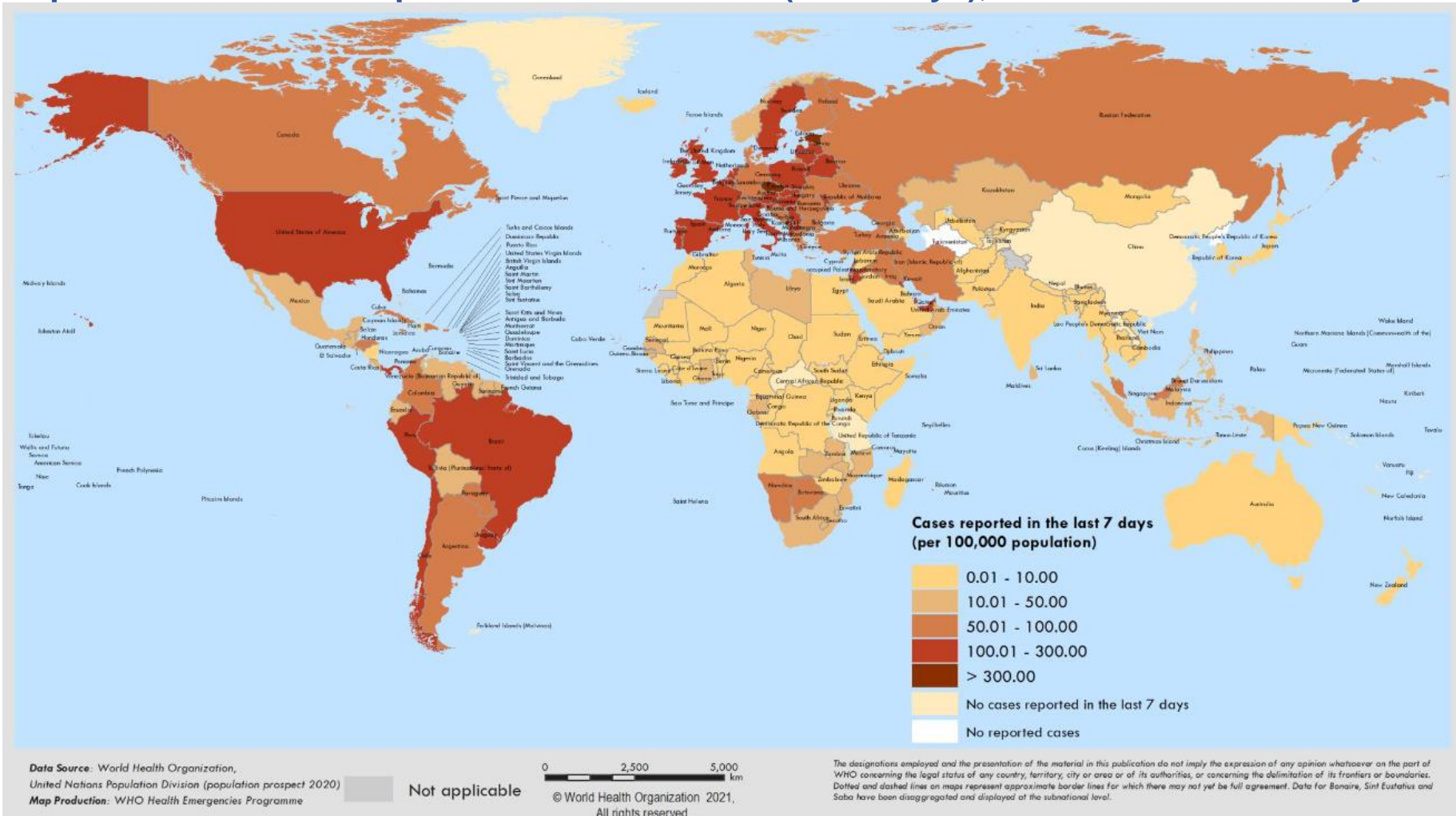
<p>GLOBALLY ↗</p> <p>114 441 349 confirmed cases 75 384 600 recovered 2 538 268 deaths</p>
<p>EU/EEA and the UK ↗</p> <p>37 061 664 confirmed cases 20 219 150 recovered 845 750 deaths</p>
<p>USA → (new cases/day 55 057)</p> <p>28 548 525 confirmed cases 11 977 707 recovered 512 136 deaths</p>
<p>India ↗ (new cases/day 15 510)</p> <p>11 112 241 confirmed cases 10 786 452 recovered 157 157 deaths</p>
<p>Brazil ↗ (new cases/day 69 769)</p> <p>10 587 001 confirmed cases 9 436 957 recovered 255 720 deaths</p>
<p>Russia ↘ (new cases/day 11 450)</p> <p>4 209 850 confirmed cases 3 780 195 recovered 85 025 deaths</p>
<p>UK ↘ (new cases/day 5 455)</p> <p>4 182 013 confirmed cases -not reported- recovered 122 953 deaths</p>

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Map of countries with reported COVID-19 cases (last 7 days), as of 15 to 21 February 2021

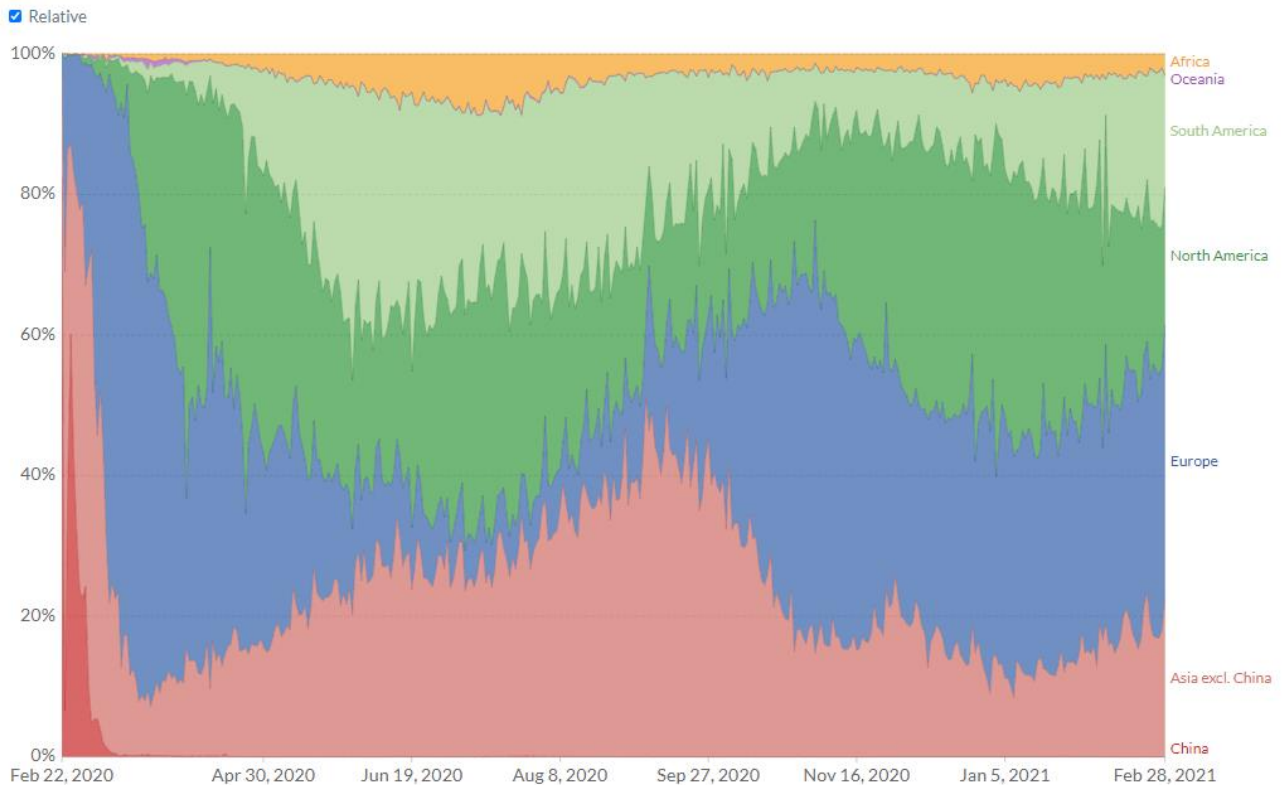


Worldwide Situation

Global Situation

Daily confirmed COVID-19 cases

The number of confirmed cases is lower than the number of total cases. The main reason for this is limited testing.



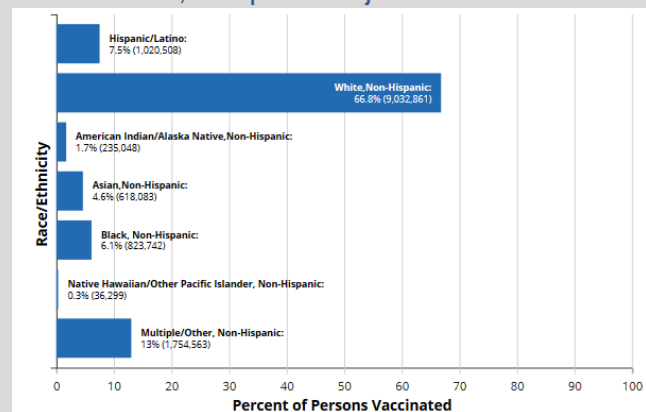
USA: New Vaccine – Old Problems

The vector-based vaccine from Johnson & Johnson has now been approved in the USA and is currently undergoing an EMA approval process in the EU. The advantage of this vaccine is that only one vaccine dose is necessary to achieve adequate immunity (85% effectiveness against a serious illness), and the vaccine is stable even at refrigerator temperature.

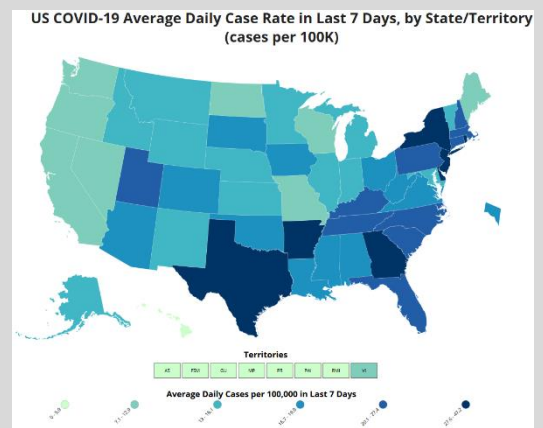
A comparison of the effectiveness compared to the already approved mRNA-based vaccines from Moderna or BioNTech may at first glance show a somewhat lower effectiveness of the Johnson & Johnson vaccine. However, the phase three study of the Johnson & Johnson vaccines in South Africa and Brazil took place at a time when the VOC (variants of concern) B.1.351 and P.1 were already widespread. In this respect, it can presumably be assumed that the vaccine is effective.

Since the manufacturer has announced that it will deliver 100 million vaccine doses to the USA by the end of June 2021, the vaccination campaign in the USA, which can already be described as comparatively fast, is likely to gain momentum. As of February 27, 2021, 14.5% of the population in the USA had already received at least one dose of a COVID-19 vaccine, compared to just 4.6% of the population in Germany.

In the USA, however, it became apparent as early as the end of January 2021 that certain population groups had less access to COVID-19 vaccines compared to their share of the total population. This appeared to affect black people in particular, a group of people who were also more likely to have had severe disease or death in the United States in the past. Whereby, of course, “poverty”, with all the consequences that can be derived, comes into play as a risk factor.



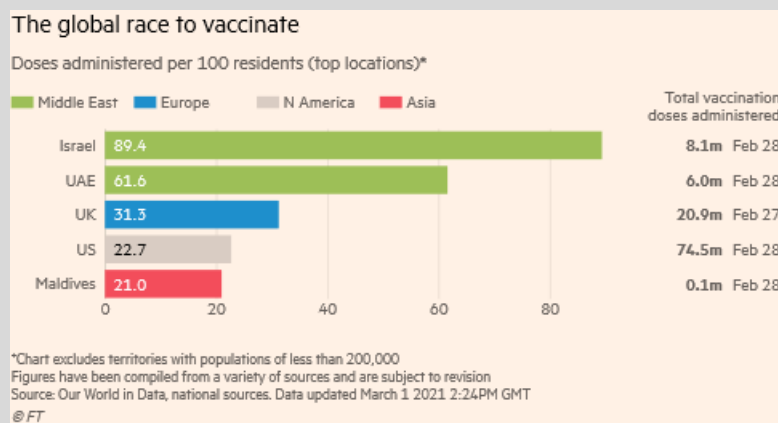
The incidence of infections in the USA has been falling for a few weeks, but the 7-day incidence was recently still 142.5 / 100,000 inhabitants (as of March 1, 2021) and thus more than twice as high as, for example, in Germany. The focus of the infection process can currently be located primarily on the (populous) east coast and in Texas. Bear in mind that the USA also has a strong federalism. The daily number of cases on the west coast is lower than on the east coast, but California in particular still has a fairly high rate of daily COVID-19 deaths, as many cases of the previous strong coronavirus wave of Dec 2020 and Jan 2021 are probably still counting here.



There are also concerns about new VOCs. Most recently, variants B.1.427 and B.1.429 were discovered in California, which, according to initial data, assume that infectiousness and disease severity could be increased in these variants. The probability of a stay in ICU was therefore 5 times higher than in the case of infection with the SARS-CoV-2 wild type, the probability of death even 11 times higher. However, due to the still small amount of data, caution is called for in the interpretation. Another VOC with the designation B.1.526 has been rampant in New York since November 2020 and currently accounts for more than 25% of all sequenced samples in New York.

In this respect, there seems to be a certain race between the vaccination campaign and the spread of new VOCs, whereby the vaccine from Johnson & Johnson offers good potential for a sufficient vaccination campaign due to the one-dose scheme. Despite the relatively rapid progress of the vaccination campaign, large parts of the particularly vulnerable older population have not yet been vaccinated. As of February 28, 2021, 72% of those over 75 years old were still without a first vaccination. The increasingly widespread availability of vaccines promises to be a remedy soon.

Sources: Infekt Info Nr. 68a, KdoSanDstBw VI.2, German Bundeswehr
<https://www.bbc.com/news/election-us-2020-54423928>
<https://www.worldometers.info/coronavirus/country/us/>
<https://covid.cdc.gov/covid-data-tracker/#datatracker-home>



Vaccination report

First COVID-19 COVAX vaccine doses administered in Africa

As of the 1 March the governments of **Côte d'Ivoire** and **Ghana** began COVID-19 vaccination campaigns aimed at protecting healthcare workers. The campaigns in Ghana and Côte d'Ivoire follow deliveries to both countries last week with Ghana taking delivery of 600,000 doses on February 24 and Côte d'Ivoire 504,000 doses two days later. Both countries received the AstraZeneca/Oxford vaccine licensed and manufactured by the Serum Institute of India (SII).

The deliveries mark the start of what will be the largest, most rapid and complex global rollout of vaccines in history. In total, COVAX aims to deliver at least 2 billion doses of COVID-19 vaccines by the end of 2021, including at least 1.3 billion to the 92 economies eligible for support through the COVAX AMC.

COVAX doses to date have been delivered by SII to India, Ghana, Cote d'Ivoire, while Pfizer-BioNTech has delivered doses to the Republic of Korea. More deliveries by these two manufacturers are planned in the coming days, with 11 million doses in total planned to be delivered over the next seven days. In addition, AstraZeneca is set to commence shipments this week.

The start of Africa's biggest immunization drive in history through the COVAX Facility marks a step forward in the continent's fight against COVID-19. It is a welcome shift towards bringing African countries off the sidelines and back into the vaccination race, correcting the glaring inequity which has been an unfortunate hallmark of the global vaccine rollout to date. For months WHO teams in the region and partners have been supporting countries to plan and prepare for the complex challenges of such a massive vaccination campaign.

<https://www.who.int/news/item/01-03-2021-first-covid-19-covax-vaccine-doses-administered-in-africa>

Effectiveness of the first dose of COVID-19 vaccines against hospital admissions in Scotland

There is an urgent need to study the 'real-world' effects of the approved COVID-19 vaccines. The aim of this study was to estimate the effectiveness of the first dose of these COVID-19 vaccines in preventing hospital admissions. This is a preprint and has not yet been peer reviewed.

The scientists conducted a prospective cohort study using the Early Pandemic Evaluation and Enhanced Surveillance of COVID-19 (EAVE II) database comprising of linked vaccination, primary care, Real-Time Polymerase Chain Reaction (RT-PCR) testing, hospitalisation and mortality records for 5.4 million people in Scotland (covering ~99% of population). A time-dependent Cox model and Poisson regression models were fitted to estimate effectiveness against COVID-19 related hospitalisation (defined as 1- Adjusted Hazard Ratio) following the first dose of vaccine.

Clinical trials of all three currently UK authorised vaccines (i.e., Pfizer-BioNTech, Oxford-AstraZeneca and Moderna) have reported high vaccine efficacy. For the **Pfizer-BioNTech** vaccine (BNT162b2 mRNA COVID-19 Vaccine), **95% efficacy** was reported against laboratory confirmed COVID-19. The **Oxford-AstraZeneca** vaccine was found to have **70%** efficacy against symptomatic COVID-19 amongst seronegative participants. The **Moderna** vaccine (mRNA-1273) was reported to have **95%** efficacy against confirmed COVID.

To the knowledge of the scientists, this is the first study of COVID-19 vaccine effect against hospitalisation for an entire nation after a single dose of vaccine.

Findings:

This national prospective cohort study comprising almost the entire Scottish population demonstrated that a single dose of either the BNT162b2 mRNA or ChAdOx1 vaccines was associated with substantial protection against COVID-19 hospitalisation. Peak VEs of **85%** for the **BNT162b2** vaccine and **94%** for the **ChAdOx1** vaccine were found against COVID-19 related hospitalisations.

In the **oldest age group** (=80 years), based on a pooled analysis for both vaccines, we observed peak VE of **81%** against COVID-19 related hospitalisations.

VE tended to increase over time after the first dose for this age group, with the optimal time being >28 days.

Interpretation

A single dose of the BNT162b2 mRNA and ChAdOx1 vaccines resulted in substantial reductions in the risk of COVID-19 related hospitalisation in Scotland.

https://www.ed.ac.uk/files/atoms/files/scotland_firstvaccinatedata_preprint.pdf

<https://www.bmj.com/content/372/bmj.n523>

DEU: Starts a model project with corona vaccinations in initially 4 medical practices. The offer should be expanded to 50 practices in March. For regular vaccinations in medical practices, however, the federal corona vaccination ordinance would have to be changed. According to experts, around 3,000 medical practices are suitable for corona vaccinations. A pilot phase with around 120 practices is currently being prepared. The program will start as soon as sufficient vaccine is available, currently the end of March or April is assumed.

The Bundeswehr's first vaccination center was also opened this week. It is the first to be operated on a Bundeswehr property. With sufficient vaccine availability, around 300 vaccinations per day are possible.

FRA: In the fight against the coronavirus pandemic, the French government is expanding the use of AstraZeneca's vaccine. People in the age group from **65 to 75** years can now receive the vaccine from this manufacturer, for example if they suffer from diabetes or high blood pressure.

RUS: According to a survey, 62 percent of Russians do not want to be vaccinated with the domestic vaccine Sputnik V. The group of 18 to 24-year-olds shows the greatest resistance, as the survey by the opinion research institute Levada Center showed. The main reason given is therefore possible side effects. Furthermore, 64 percent of those questioned expressed the assessment that the coronavirus had been artificially produced as a biological weapon.

USA: US disease expert Anthony Fauci has spoken out against the postponement of the second corona vaccination with the vaccination from BioNTech and Moderna. With such a delay to vaccinate more people, there is a risk that people will be less protected and virus variants will spread. In addition, if the plans suddenly change, people's confidence in the government's vaccination strategy can dwindle.

According to official figures, 1.7 million vaccine doses a day were last administered in the USA - more than 50 million people have now received their first vaccination. In total, more than 76 million vaccine doses were administered, according to figures from the US health authority CDC. More than 25 million people have already received two doses of vaccine.

NPL: Without political help from other countries, the country will probably not get enough corona vaccine. India gave its neighbor a million doses of the AstraZeneca vaccine in January, which the Serum Institute of India had produced under license. With the support of the Indian government, Nepal also bought two million doses at a subsidized price. However, the government is very concerned about the continued supply of vaccines. Nepal is now also receiving 500,000 doses of a Chinese vaccine. Whether the country will buy more of it has not yet been decided, said the health minister: "The AstraZeneca vaccine is the one that is preferred by the world and has also been approved and recommended by the WHO." Russia has offered to deliver 25 million doses of its Sputnik V vaccine, but Nepal has asked for additional documents for a review. In addition, 2.25 million doses have been promised to Nepal under the United Nations COVAX program.

IND: Because of an error in the online booking system for vaccination appointments, thousands of people in India have been turned away from vaccination centers even though they actually had an appointment. In theory, anyone over 60 and anyone over 45 with serious illnesses can now be vaccinated in the country. The Indian government had set a goal of vaccinating 300 million people by the end of June. However, since the vaccination campaign began in January, only 14 million people have had an injection, mainly health and security workers.

CIV: The vaccination campaign started on Monday. The corona vaccine was funded from the COVAX initiative. Healthcare workers, the military and educators come first.

CHN: 40 percent of the Chinese population should be vaccinated against the coronavirus by June. By February 28, more than 52 million doses of corona vaccines had been administered in the country.

Country Reports:

BRA: Brazil's capital Brasilia has entered a corona lockdown. Governor Ibaneis Rocha ordered bars, restaurants, shopping centers and schools to be closed by March 15. The sale of alcoholic beverages after 8 p.m. was banned. About a dozen other states in the country, which has been hard hit by the pandemic, are taking new measures to curb the spread of Covid-19, which is leading to an increasing occupancy of intensive care beds in some important cities in the country.

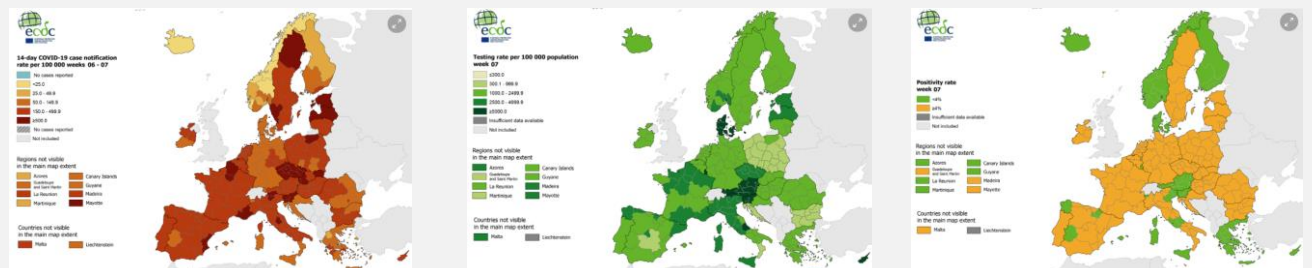
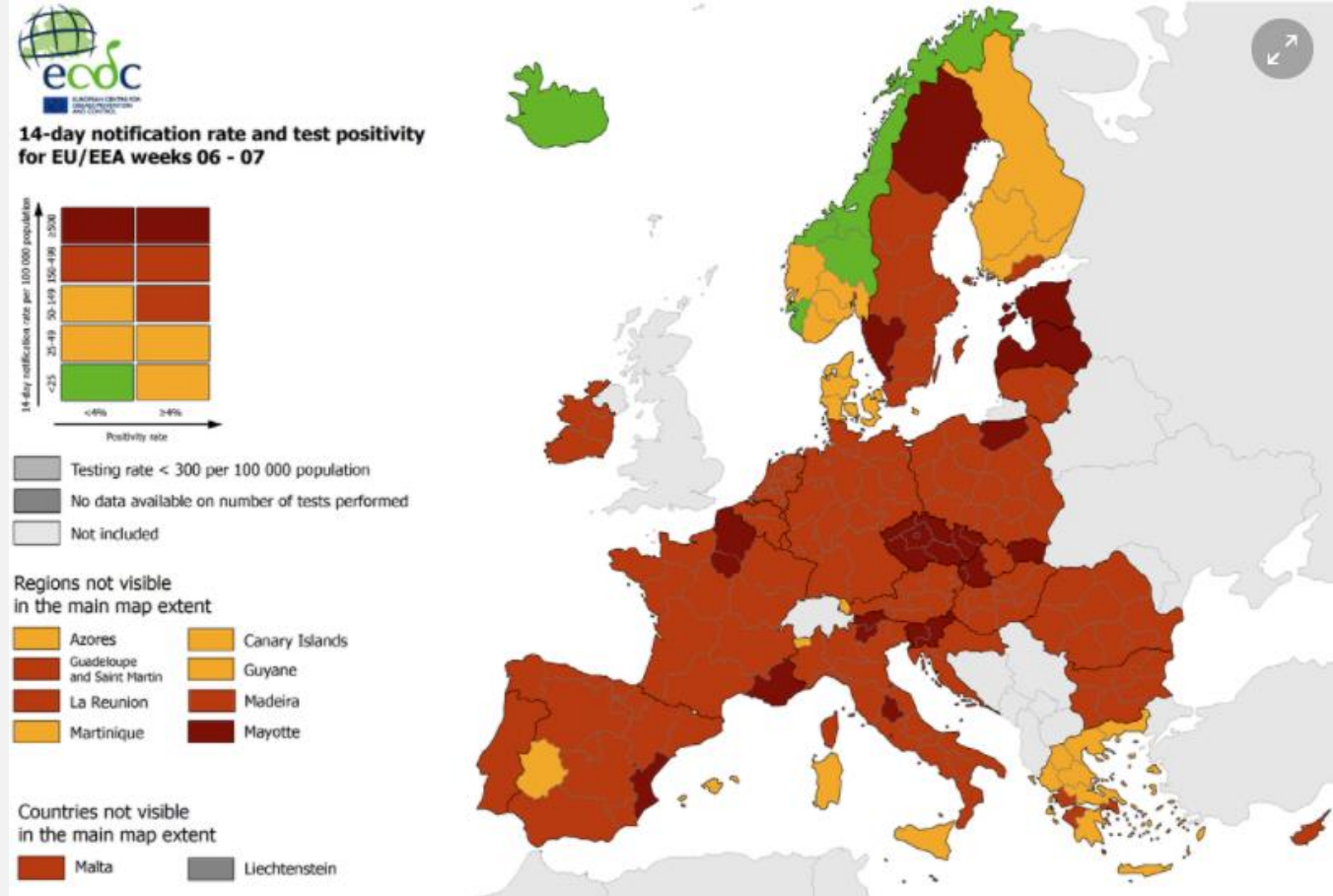
ISR: The Supreme Court has banned the government from using cell phone tracking for people infected with coronavirus. The measure is a serious violation of civil liberties. It is to be feared that cell phone tracking, introduced as a temporary emergency measure, will gradually become a permanent feature. The government has until March 14 to end the indiscriminate use of surveillance and restrict it to confirmed coronavirus infections who have refused to receive epidemiological questioning. The secret service Shin Bet has been using the surveillance technology since March 2020 to contain the pandemic. In order to establish contact, the locations of infected people were compared with the cell phone data of other people in the vicinity. Civil rights groups, on the other hand, went to court.

NIC: Will begin its COVID-19 vaccination campaign on Tuesday. People with pre-existing conditions such as heart disease, kidney failure and cancer, will be given priority. Last week, the country received its first batch of vaccine doses from an initial donation of Russia's Sputnik V.

CHL: Plans to ramp up its purchase of vaccines from China's Sinovac and hopes to sign a deal shortly with Johnson & Johnson, as the nation moves to strengthen its widely lauded coronavirus vaccination campaign. The country already jumped ahead of the rest of Latin America and many countries globally with its inoculation programme. The country has already inoculated 3.35 million of its 19 million citizens against Covid-19, officials said on Monday.

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 25 February 2021

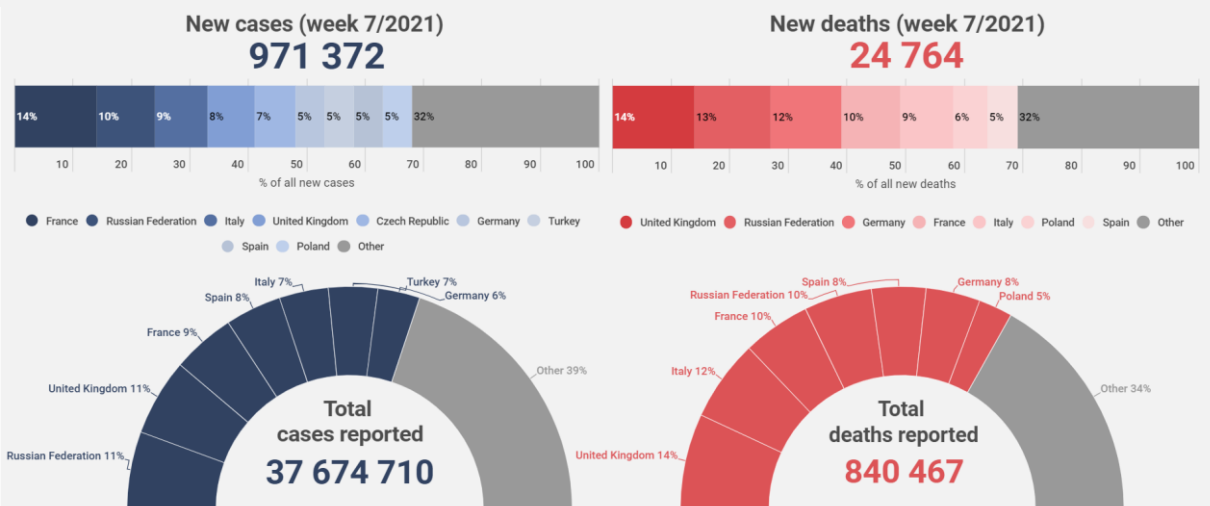


14-day case notification rate per 100 000 inhabitants

Testing rates per 100 000 inhabitants

Positivity rates

COVID-19 situation update for the WHO European Region (15 Feb – 21 Feb 2021 Epi week 07)



ECDC COVID-19 surveillance report Week 07, as of 25 February 2021

Weekly surveillance summary

Overall situation

By the end of week 7 (week ending Sunday 21 February 2021), 13 countries in the EU/EEA had reported increasing case notification rates and/or test positivity. Case rates in older age groups had increased in four countries, three countries reported increasing hospital or ICU admissions and/or occupancy due to COVID-19 and three countries reported increasing death rates. Although the overall epidemiological situation is improving in most countries, absolute values of these indicators remain high, suggesting that transmission is still widespread. It is possible that increases in admissions to hospital, ICU and mortality will follow in the coming weeks in those countries that are currently observing increasing case notification rates.

New

A map presenting data submitted by EU/EEA countries to the [GISAID EpiCoV database](#) shows the distribution of variants among sequenced samples and the average weekly number of samples with a published sequence for the five weeks to week 5 (Section 3.8). A bullet point under 'Variants of concern' summarises the sequencing volumes in the EU/EEA based on these data.

Trends in reported cases and testing

- By the end of week 7, the 14-day case notification rate for the EU/EEA, based on data collected by ECDC from official national sources in 30 countries, was 283 (country range: 8–1 120) per 100 000 population. The rate has been decreasing for five weeks.
- Among the 29 countries with high case notification rates (at least 60 per 100 000), increases were observed in 11 countries (Austria, Bulgaria, Czechia, Estonia, Finland, Hungary, Luxembourg, Malta, the Netherlands, Poland and Sweden). Stable or decreasing trends in case rates of 1–10 weeks' duration were observed in 18 countries (Belgium, Croatia, Cyprus, Denmark, France, Germany, Greece, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Norway, Portugal, Romania, Slovakia, Slovenia and Spain).
- Based on data reported to The European Surveillance System (TESSy) from 24 countries for 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 were observed in 21 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Estonia, Finland, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia and Spain).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 7, available for 29 countries, varied from 836 to 24 195 tests per 100 000 population. Cyprus had the highest testing rate for week 7, followed by Austria, Denmark, Luxembourg and Slovenia.
- Among 23 countries in which weekly test positivity was high (at least 3%), five countries (Belgium, Bulgaria, Finland, Hungary and Poland) had observed an increase in test positivity compared with the previous week. Test positivity remained stable or had decreased in 18 countries (Croatia, Czechia, Estonia, France, Germany, Greece, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden).

Hospitalisation and ICU

- Pooled data from 23 countries for week 7 show that there were nine patients per 100 000 population in hospital due to COVID-19. According to pooled weekly hospital admissions based on data from 20 countries, new admissions were 9.1 per 100 000.
- Pooled data from 17 countries for week 7 show that there were 1.8 patients per 100 000 population in ICU due to COVID-19. Pooled weekly ICU admissions based on data from 14 countries were 2.6 new admissions per 100 000.
- 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 26 countries (Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia 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 for 30 countries, was 78.7 (country range: 0.0–239.3) per million population. The rate has been decreasing for one week.
- Among 27 countries with high 14-day COVID-19 death rates (at least 10 per million), increases were observed in three countries (Czechia, Liechtenstein and Luxembourg). Stable or decreasing trends in death rates of 1–8 weeks' duration were observed in 24 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Denmark, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden).

Variants of concern

- Sequencing capacity varies greatly across the EU/EEA; the rate of SARS-CoV-2-positive cases sequenced and reported to the [GISAID EpiCoV database](#) by 23 February 2021 for the period from 4 January 2021 to 7 February 2021 was lower than the recommended level of 10% or 500 sequences in all but three EU/EEA countries (Denmark, Iceland and Netherlands). During the same period, 12 countries sequenced and reported between 60 and 499 samples to GISAID EpiCoV, while 15 countries sequenced and reported <60 samples or did not report data.

Notes

- ECDC produces two 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 Vaccine roll-out overview EU, as of 24 February 2021

Vaccine rollout summary

Key figures as of 21 February 2021

Total number of vaccine doses distributed by manufacturers to EU/EEA Member States: **35 848 636** (28 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden*

Number of vaccine doses distributed by manufacturers to EU/EEA Member States per hundred inhabitants: **median of 10.3 per hundred inhabitants (range: 4.5-18.3 per hundred inhabitants)** (28 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden*

Total number of vaccine doses administered in EU/EEA Member States: **27 425 844** (29 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden*

Uptake of first vaccine dose among adults aged 18 years and above in EU/EEA Member States: **median of 5.2% (range: 1.6%-10.6%)** (29 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden*

Uptake of first vaccine dose among persons aged 80 years and above: **median of 25.1% (range: 0.4%-77.2%)** (21 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Hungary, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Sweden*

Full vaccination uptake in adults aged 18 years and above among EU/EEA Member States: **median of 2.5% (range: 0.5%-4.5%)** (29 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden*

Full vaccination uptake in persons aged 80 years and above among EU/EEA Member States: **median of 10.5% (range: <0.1%-32.8%)** (21 countries reporting)

Reporting countries: *Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Hungary, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Sweden*

Country Reports:

GBR: Six cases of a highly contagious coronavirus variant first recognized in Brazil have been found in the UK. According to scientists, the variant is more contagious than the original virus, and the vaccines currently in use may be less effective against it. The variant could also infect people who have already contracted COVID-19. Direct flights between Brazil and the UK are suspended. The newly discovered cases were traced back to people who came to Great Britain from Brazil via other European countries in early February. A few days after their arrival, the kingdom imposed a ten-day hotel quarantine for travelers from high-risk areas, including Brazil. Three of the cases with the Brazilian variant occurred in Scotland and two in south-west England. The sixth person could not be identified at first because they had not correctly filled in a form with their contact details. The health authorities say they are trying to find the person. In addition, mass tests should be used to find out whether the variant has already spread.

CZE: Tens of thousands of members of the police and military in the Czech Republic are supposed to check whether people are complying with the restrictions on freedom of movement imposed due to the pandemic. A total of around 30,000 emergency services set up 500 checkpoints across the country where the controls are to take place. The measure is part of an action plan with which the country aims to curb the spread of a more infectious variant of the coronavirus, which was first discovered in the UK. The government justified the restrictions with the fact that a collapse in the supply of COVID-19 patients should be avoided.

.....
The Czech Republic orders mandatory corona mass tests in all medium-sized and large companies. Around 2.1 million workers and employees are to be tested at least once within the next two weeks. After that, weekly intervals apply. Small businesses with fewer than 50 employees are excluded.

BGR: Despite increasing numbers, cafes and restaurants can reopen under certain conditions after a three-month corona lockdown. A maximum of six customers can sit at one table. Personnel must wear mouth and nose protection. Schools and kindergartens as well as shopping centers, fitness studios and dance clubs have already been reopened beforehand.

AUT: In Austria, free corona rapid tests have been distributed since Monday. Every Austrian over 15 years of age can pick up five tests per month in the country's pharmacies. The campaign applies to people over 15 years of age because younger people in Austria have been able to take part in regular free rapid tests in schools for some time.

.....
Despite the recently significantly increased corona numbers, the measures are to be relaxed on March 15 in the westernmost state of Vorarlberg. For the rest of the country, the goal is that from March 27, at least outdoor dining should be possible. Access tests should continue to play a central role in the easing. Austria had already reopened trade, body-hugging service providers such as hairdressers and schools three weeks ago.

DNK: In Denmark, the majority of retailers are once again able to welcome customers into their shops. After more than two months of corona-related closure, shops with an area of less than 5000 square meters are allowed to reopen, provided they are not in a shopping center - they will remain closed for the time being. Larger shops such as furniture stores are also allowed to reopen their doors, albeit strictly limited: customers must have booked a time in advance in order to be able to shop in these shops. Open-air facilities - e.g. zoos, amusement parks and open-air museums - can now receive visitors again if the guests can show a corona test that is no more than 72 hours old. For the easing, Denmark is increasing its already good test capacities in order to be able to carry out a maximum of 400,000 rapid PCR or corona tests per day. The number of new infections in Denmark has fallen sharply since mid-December.

FIN: The government declares a state of emergency as a result of the sharp increase in infections with mutants of the coronavirus. This gives the government the right to close restaurants and take other measures to prevent the pathogen from spreading. Of all European countries, Finland has so far been the least affected by the pandemic.

TUR: The coronavirus restrictions in regions with low levels of new infections will be relaxed. Exit restrictions will be lifted in some provinces over the weekend. In addition, restaurants and cafés could reopen to a limited extent, except in regions with a high risk of infection. Schools would also be partially reopened. Exit restrictions in the evening therefore remain nationwide.

Subject in Focus

WHO: Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern

Supplementary to the 23 February Weekly Epidemiological Update, WHO released a special edition with proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern.

The paper should provide:

- A working definition for SARS-CoV-2 variants of interest and variants of concern.
- The associated actions WHO will take to support Member States, their national public health institutes and reference laboratories.
- The recommended actions Member States should take.
- A general and non-exhaustive guidance on the prioritization of variants of greatest public health relevance in the context of wider SARS-CoV-2 transmission.
- The established response mechanisms and public health and social measures (PHSM).

These definitions will be reviewed regularly and updated as necessary, as of this edition:

- The threshold for determination of a variant of interest is relatively low in order to maintain sensitive surveillance for potentially important variants.
- The threshold for determination of a variant of concern is high in order to focus attention and resources on the variants with the highest public health implications, while reducing noise and unwarranted diversion of limited resources.

1. Working Definition of “SARS-CoV-2 Variant of Interest”

A SARS-CoV-2 isolate is a variant of interest (VOI) if it is phenotypically changed compared to a reference isolate or has a genome with mutations that lead to amino acid changes associated with established or suspected phenotypic implications;

AND

has been identified to cause community transmission/multiple COVID-19 cases/clusters, or has been detected in multiple countries;

OR

is otherwise assessed to be a VOI by WHO in consultation with the WHO SARS-CoV-2 Virus Evolution Working Group.

1.1) Main actions by a Member State, if a potential VOI is identified:

- Inform WHO through established WHO Country or Regional Office reporting channels with supporting information about VOI-associated cases (person, place, time, clinical and other relevant characteristics).
- Submit complete genome sequences and associated metadata to a publicly available database, such as GISAID.
- Perform field investigations to improve understanding of the potential impacts of the VOI on COVID-19 epidemiology, severity, effectiveness of public health and social measures, or other relevant characteristics.
- Perform laboratory assessments or contact WHO for support to conduct laboratory assessments on the impact of the VOI on diagnostic methods, immune responses, antibody neutralization or other relevant characteristics.

1.2) Main actions by WHO for a potential VOI:

- Assessment by WHO in consultation with the SARS-CoV-2 Virus Evolution Working Group, and if meets criteria, designation as VOI.
- If determined necessary, coordinated laboratory investigations with Member States and partners.
- Review global epidemiology of VOI.
- Monitor and track global spread of VOI.

2. Working Definition of “SARS-CoV-2 Variant of Concern”

A VOI is a variant of concern (VOC) if, through a comparative assessment, it has been demonstrated to be associated with

- Increase in transmissibility or detrimental change in COVID-19 epidemiology;
- Increase in virulence or change in clinical disease presentation; or
- Decrease in effectiveness of public health and social measures or available diagnostics, vaccines, therapeutics.

OR

assessed to be a VOC by WHO in consultation with the WHO SARS-CoV-2 Virus Evolution Working Group.

2.1) Main actions by a Member State, if a VOC is identified:

- Report initial cases/clusters associated with VOC infection to WHO through the IHR mechanism.
- Submit complete genome sequences and associated metadata to a publicly available database, such as GISAID.
- Where capacity exists and in coordination with the international community, perform field investigations to improve understanding of the potential impacts of the VOC on COVID-19 epidemiology, severity, effectiveness of public health and social measures, or other relevant characteristics.
- Perform laboratory assessments or contact WHO for support to conduct laboratory assessments on the impact of the VOC on diagnostic methods, immune responses, antibody neutralization or other relevant characteristics.

2.2) Main actions by WHO for a potential VOC:

- Assessment, and if meets criteria, designation as VOC.
- Assessment by Virus Evolution Working Group and, if determined necessary, coordinate additional laboratory investigations with Member States and partners.
- Rapid risk assessment, as warranted.
- Communicate new designations and findings with Member States and public through established mechanisms.
- Evaluate WHO guidance through established WHO mechanisms and update, if necessary.

WHO Recommendations

WHO, in collaboration with national authorities, institutions and researchers, continues to monitor the public health events associated with SARS-CoV-2 variants and provides updates as new information becomes available. Further information on the background of the variants of concern is available from previously published [Disease Outbreak News](#) and recent publications of the Weekly Epidemiological Update.

National and local authorities are encouraged to continue strengthening existing disease control activities, including epidemiological surveillance, strategic testing, and increased routine systematic sequencing of a representative sample of SARS-CoV-2 isolates from across each country, wherever feasible. WHO is working to increase sequencing capacities globally and has published a [comprehensive implementation guide and risk-monitoring framework](#) to support countries set up high-impact sequencing programmes for SARS-CoV-2 variants and maximize public health impact. Where sequencing capacity is limited, WHO encourages countries to reach out through existing regional systems and laboratory networks to support and build capacity. WHO has been tracking mutations since the beginning of the pandemic. In June 2020, WHO established the SARS-CoV-2 Virus Evolution Working Group to specifically assess new variants. Together with Member States and partners, a global risk monitoring framework has been established to:

- Coordinate and harmonize a global system for monitoring and assessing SARS-CoV-2 variants and their impact;
- Identify critical priorities, thresholds, and triggers for decision-making;
- Define a multi-disciplinary coordination mechanism to collect, analyze, and share data to inform decision-making, including on vaccination programs; and,
- Leverage and enhance existing technical networks and expert groups.

A holistic response should continue to be taken against all SARS-CoV-2 transmission. PHSM and current infection prevention and control (IPC) measures in health facilities and outside of health facilities have proven to remain effective against VOCs to date. WHO continues to advise that the application and adjustment of PHSM and IPC measures should be driven by detailed data analyses of epidemiological indicators at the most local level possible and by research studies and outbreak investigations carried out by Member States.

References:

- <https://www.who.int/publications/m/item/covid-19-weekly-epidemiological-update>
- <https://www.who.int/publications/i/item/9789240018440>
- <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>
- <https://www.who.int/csr/don/31-december-2020-sars-cov2-variants/en/>
- <https://www.who.int/publications/i/item/considerations-in-adjusting-public-health-and-social-measures-in-the-context-of-covid-19-interim-guidance>

Conflict and Health

COVID-19 Crisis in AFG



In cooperation with Bundeswehr HQ of Military Medicine

AFGHANISTAN

Area:	652,864 km ²
Population:	39,296,240
Capital:	Kabul
Age structure:	
0-14 years:	40,62%
15-24 years:	21,26%
25-54 years:	31,44%
55-64 years:	4,01%
65 years and over:	2,68%



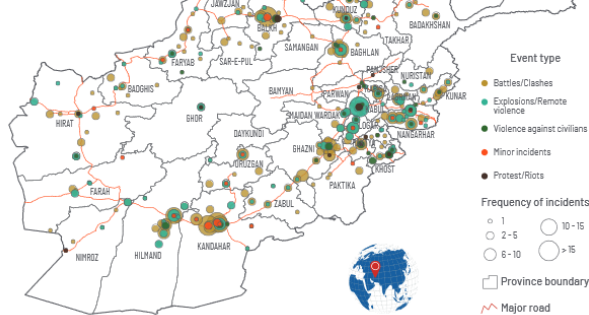
CONFLICT:

AFGHANISTAN is a geopolitically significant interface at the connection between Central and South Asia. The country, also known as the “graveyard of empires”, is shaped by various ethnic groups and cultural influences, with the Persian-born Pashtun people from a historical point of view being considered to be the mainstay of the state and thus setting the tone. The population lives predominantly within tribal associations that are patriarchally led by individual clan chiefs. Ethnic affiliation plays a major role in the strongly hierarchically organized AFG society, which also influences the political landscape. The country is deeply marked by an ongoing series of wars and occupations; so far every major power has failed to pacify AFG. Since 2001, an international coalition led by the USA has been waging war against the radical Islamic Taliban, whose predecessors, the mujahideen, had funded and trained them as allies against the Soviet Union during the Cold War. After the end of the Soviet occupation in 1989, a power vacuum developed that ultimately culminated in a bloody civil war between the rival tribal factions. The Islamic State of Afghanistan was proclaimed for the first time in 1992; with the help of the Pakistani government, the Taliban were able to capture the capital Kabul in 1996 and proclaim a de facto state of God based on Sharia law. The regime developed into a point of attraction for religious warriors, especially of Arab nationality, so Bin Laden also sought refuge in AFG. After the attacks of September 11, the patience of the international community was finally exhausted, the UN sanctioned an intervention through a mandate, the invasion and formation of the international Afghanistan protection force ISAF, which authorized a transitional government in 2002. Since then, the conflict has continued to smolder. In the almost 20-year conflict, no significant improvement in the security situation has been achieved until recently. About a year ago, the conflicting parties had actually agreed in a peace agreement on the withdrawal of international troops, but the Taliban accepted the formation of a transitional government together with the current government. But this refuses to cooperate with the rival faction; the Taliban then launched another military offensive in winter 2020. Terrorist groups like al-Qaeda are also still active; Currently, hardly a day goes by in the capital Kabul without attacks and, above all, civilian victims. The German government of DEU is planning to extend the mandate to station DEU soldiers at least until January 2022.

AFGHANISTAN - Overview of Reported Security-Related Incidents (ACLED Data - January 2021)

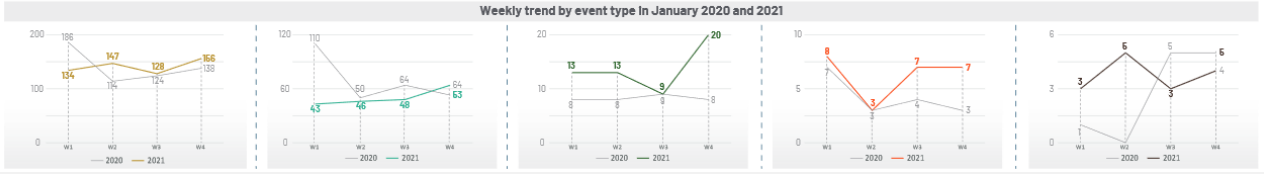
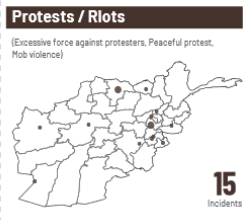
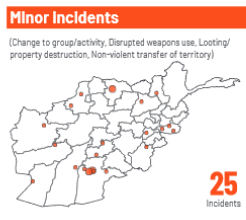
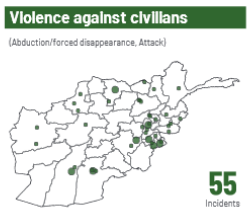
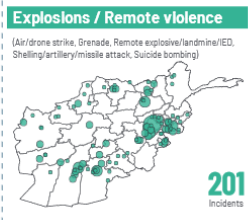
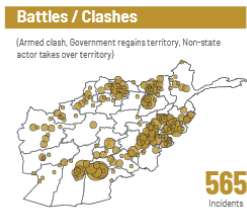


861
Incidents



Based on security-related data compiled by the Armed Conflict Location & Event Data (ACLED) Project, there were over 860 incidents recorded in January 2021, with a slim (4%) decrease in the number of incidents compared to January last year (900 incidents in 2020). Around 66% of these incidents featured **Battles or Armed clashes** over territorial control between government and non-state actors with the majority occurring in the Southern Region of Afghanistan. 205 out of the 401 districts of the country's 34 provinces experienced different security-related events in January 2021, with the provinces of Helmand, Nangarhar, and Kandahar the most affected by events of various types in both 2020 and 2021. Despite the incidents' declining trend from the last two years, the security situation in the country remains volatile and continues to impact on the civilian population in terms of insecurity, uncertainty and socio-economic growth.

HIGHLIGHTS BY REGION	January Recorded Incidents		NO. OF DISTRICTS BY REGION	January Affected Districts	
	Year 2021	Year 2020		Year 2021	Year 2020
Capital	126	70	55	25	19
Central Highland	3	2	16	2	1
Eastern	118	92	50	30	21
North Eastern	105	104	67	28	22
Northern	105	180	55	33	36
South Eastern	113	82	62	32	28
Southern	229	268	62	31	30
Western	62	102	44	24	25
TOTAL	861	900	401	205	182

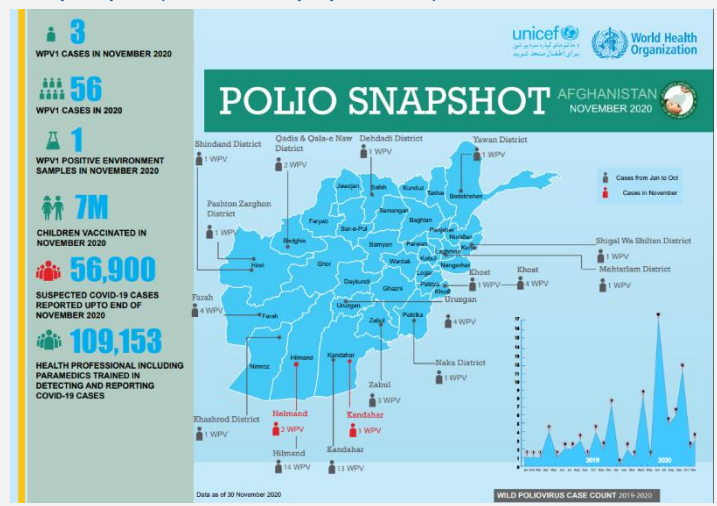


HEALTH:

The Afghan health system is considered to be one of the most underdeveloped on earth. The war, which lasted four decades, razed every previously existing medical infrastructure to the ground. The system suffers from shortages of all kinds, be it personnel or material. Only about 1 in 4 Afghans have access to adequate health care, as both the security situation and the general regional distribution of health facilities can at best be described as problematic. In addition to kinetic trauma of all kinds and psychiatric stress, poverty-related diseases represent the greatest risk for the population. Infectious diseases that are comparatively easy to treat are still widespread, and even before the outbreak of the pandemic, more than 14 million people in the country were acutely malnourished threatened. The World Bank estimates that one in 10 children dies before the age of five.

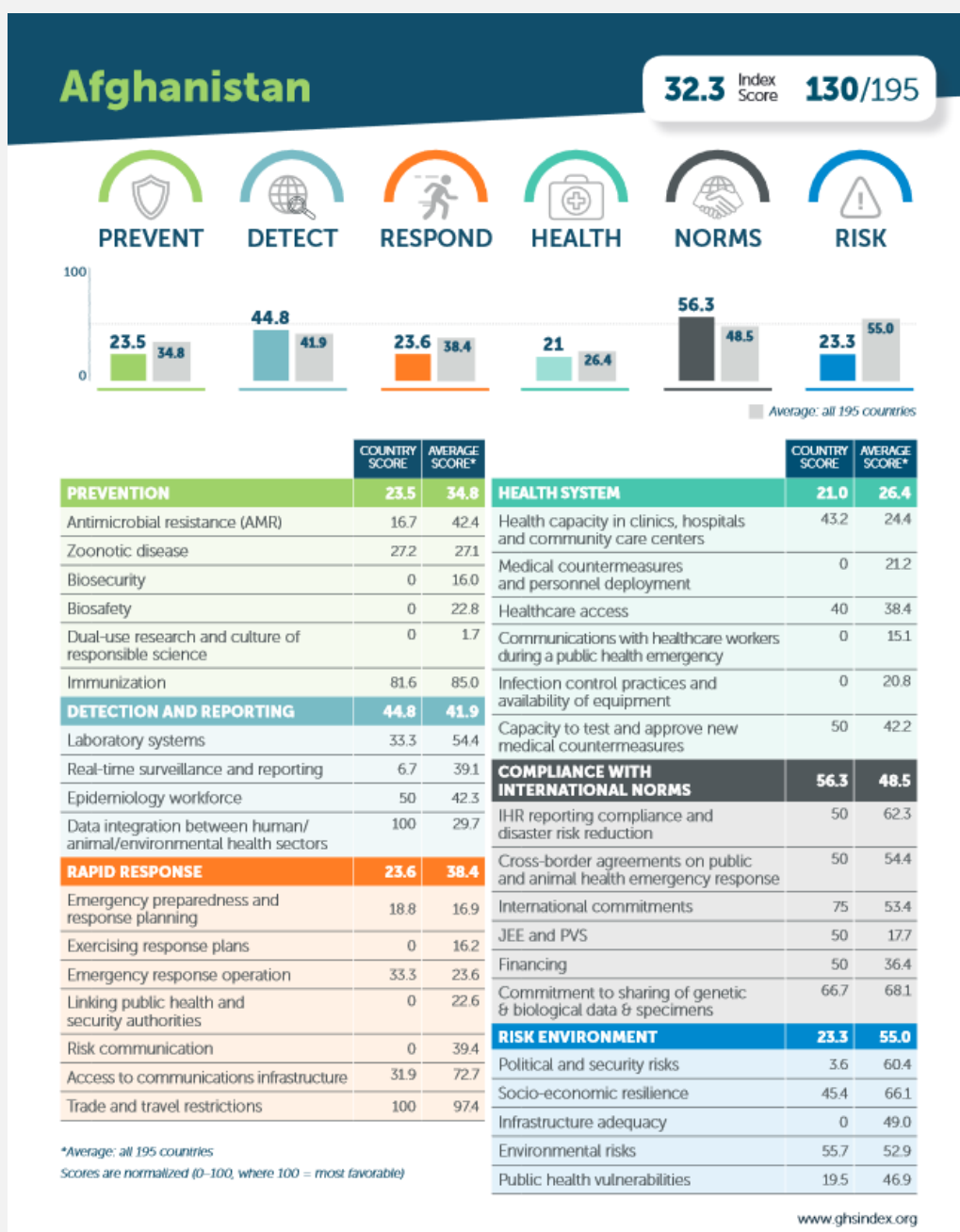
Current SARS-CoV-2 / COVID-19 outbreak:

Since the beginning of the pandemic with the first proven case in Herat in February 2020, only just under 100,000 tests for SARS-CoV-2 have been carried out in the country. Due to the massive infrastructural restrictions, it must be assumed that the majority of infections in the country will not be recorded. Government estimates assume that around 10 million people (1/3 of the population) could have been infected so far. In order to slow down the spread at least rudimentary and to protect systemically important personnel, the country has started a vaccination campaign in the last few days, INDIA has donated 500,000 doses of the active ingredient from AstraZeneca. Above all, security forces, politicians, health workers and journalists should be immunized as soon as possible. An expansion of the vaccination campaign to include the rest of the population is viewed with great skepticism, since the catastrophic security situation has already brought other immunization efforts, such as against polio, to a complete standstill in rural regions.



CONCLUSION:

In view of the precarious security situation, the COVID-19 pandemic is more of a challenge for many that the country has to face. As predicted, the already ailing health system was hardly able to cope with the additional burden, which is why it must be assumed that no reliable data is available on the real extent of the pandemic in the country and that many (death) cases have not been included in the statistics, especially in the rural areas. Existing problems in the areas of health care, nutrition and safety have been massively exacerbated. The focus in the coming months will be more on the peace process in the crisis-ridden country.



Source:

- https://de.wikipedia.org/wiki/Afghanistan#/media/Datei:Afghanistan_Ethnien.svg
- <https://fragilestatesindex.org/>
- <https://www.crisisgroup.org/asia/south-asia/afghanistan/covid-19-afghanistan-compounding-crises>
- <https://www.lowyinstitute.org/the-interpreter/afghanistan-s-unseen-covid-crisis>
- <https://www.nytimes.com/2020/12/20/world/asia/covid-afghanistan-coronavirus.html>
- <https://www.arabnews.com/node/1814261/world>
- <https://reliefweb.int/report/afghanistan/afghanistan-strategic-situation-report-covid-19-no-91-25-february-2021>
- <https://reliefweb.int/report/afghanistan/afghanistan-covid-19-multi-sectoral-response-operational-situation-report-18>
- <https://www.oe24.at/newsfeed/impfung-afghanistan-beginnt-corona-immunisierungskampagne/466415302>

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 emphasizing 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
- Resilience strategies from the private sector
- Vaccination: News and Facts
- Vaccination and Variants in Concern: News and Facts

Vaccination and Variants of Concern: New's and Facts

Vaccination and Variants in Concern: New's and Facts

We had very comprehensive national briefings of Poland, the Netherlands and France letting us know about the current status of vaccination in their countries, the strategies of their government and also how military is involved in the national campaigns as well in what prioritisation the soldiers will be vaccinated.

These very useful briefing were followed by briefings by GBR and Italy taking about the way of sequencing and the quantity and distribution of the different variants of SARS-CoV-2 and the Variants of concern.

All these very scientific and informative presentations were topped off with a short briefing about the perceptive of a Privat Health Security Intelligence Unit on Variants of Concern of COVID-19. This presentation gave a far beyond outlook at the current pandemic situation and also approaches health topics with a potential impact on the global community beside of COVID.

All briefings lead to a very good discussion between the briefer and the audience. Like last time the audience was very interested in the strategy of the countries for getting their soldiers vaccinated and how the countries handle vaccination for soldiers abroad. The EU was keen on knowing how countries will get their embassy personal vaccinated. During the discussions we found out, that most countries will rely on Host Nation support to vaccinate their soldiers stationed in a foreign country only one nation will repatriate their soldiers to get vaccinated in their own country.

All nations will vaccinate their soldiers only with EMA or FDA approved vaccines. In all countries briefing and as well in those leading the discussions, soldiers going to a mission are in first line for receiving a vaccination and for all soldiers it will be mandatory if they would like to be stationed aboard. Unlike last week when only one country already started to vaccinate their soldiers this week

several other countries also reported on the start of the vaccination campaigns for soldiers. Most of the countries are relying on the vaccination the government are distributing and do not have their own stock of vaccine designated for soldiers.

Talking about sequencing and the variants of concern it was clearly seen that in most country the new British variant was the most recognized and sequenced variant followed by the south African one. There were different other variants in a very small amount mentioned. GBR clearly showed their very early implementation of a very innovative way to start sequencing in a very early state of the pandemic so that it was very understandable why the British variant was first recognized in GBR and not in another state. GBR is one of the only countries worldwide which already achieved to sequence 10% of the positive cases in England. Most of the other countries just started their sequencing programs and are far away from the 5-10% range the WHO and EU would like countries to achieve. It was made clear in the last briefing that this lack of adequate genomic sequencing to support the surveillance lead to a loss of a lot of COVID-19 clarity around the planet. So, there is a lot of information we just do not know. Of course we seem to do a lot of testing and reporting and that is very important but these efforts only touch the edge of the iceberg and with this very new disease there is a lot of information lost as we are just not able to find it until now.

But as expert assume the next big wave around May 2021, we will find out by the hight of that wave if all our surveillance and regulation and of course vaccination strategies had been well implemented and should be followed. With this disease it is still a long way to go and a lot to learn.

The next VTC will be held on 24 March, the topic is not decided yet.

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](#). 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

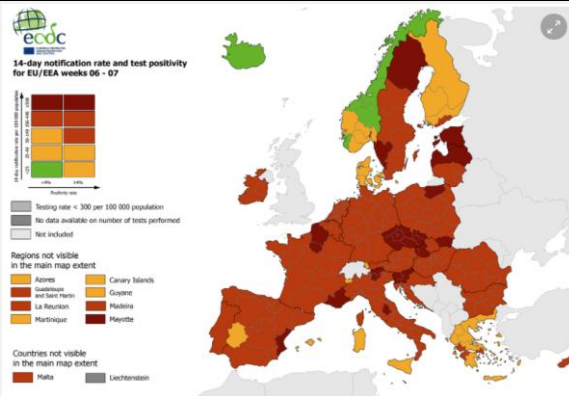
- **the notification rate** (the total number of newly notified COVID-19 cases per 100 000 population in *the last 14 days* at regional level)
- **the test positivity rate** (the percentage of positive tests among all tests for COVID-19 infection carried out during the last week)
- **the testing rate**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

2. A common map

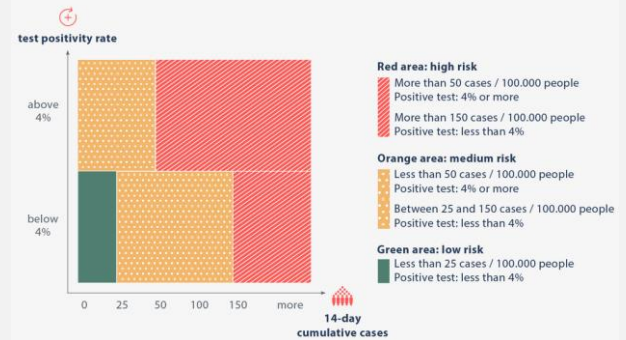
The ECDC will publish a map of EU Member States, broken down by regions, which will show the risk levels across the regions in Europe using a traffic light system. See also [“Situation in Europe”](#).

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.



Common colour codes: mapping of risk areas



3. A common approach for travellers

Common framework for COVID-19 travel measures

Green areas

No restriction of free movement of persons should be applied

Orange and red areas

Measures should be proportionate and respect differences in the epidemiological situation of orange and red areas

In principle, entry should not be refused to travellers from orange/red areas but requirements could be applied

Possible requirements for travellers coming from orange/red areas: quarantine/ self-isolation, COVID-19 testing prior to/ after arrival

Measures should take into account the epidemiological situation in their own territory

Inform other affected EU countries 48 hours before applying measures

Travellers could be asked to submit passenger locator forms

Exceptions: no quarantine requirement for travellers with essential function or need while performing that function

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

<p>Global</p>	<ul style="list-style-type: none"> • 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.
<p>Europe</p> <p>As of 23rd of October 2020</p>	<p>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 <i>stable</i>, <i>of concern</i> or of <i>serious concern</i>. 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 $\geq 3\%$ as well as the high notification rates in the older age groups and/or high mortality rates.</p> <p>Countries have implemented various non-pharmaceutical interventions, but these have not been sufficiently effective in controlling transmission due to several factors:</p> <ul style="list-style-type: none"> • adherence to the measures was sub-optimal; • the measures were not implemented quickly enough; • or the measures were insufficient to reduce exposure. <p>As a result, the epidemiological situation is now rapidly deteriorating in most countries.</p> <p>There are currently only six countries in the region that are classified as experiencing a <i>stable epidemiological situation</i>.</p> <ul style="list-style-type: none"> • 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. <p>Nevertheless, in these six countries, there is still ongoing transmission and the situation must be closely monitored.</p> <p>Based on the latest available data to ECDC, there are currently no countries categorised as having an epidemiological situation ‘of concern’.</p> <p>In countries where the epidemiological situation is of serious concern:</p> <ul style="list-style-type: none"> • there is a high risk to the general population, • and for vulnerable individuals the COVID-19 epidemiological situation represents a very high risk. <p>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.</p>
<p>As of 15th of February 2021</p>	<p>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 15th of February 2021</p>

Risks associated with new variants of current concern:

The risk associated with further spread of the SARS-CoV-2 VOCs in the EU is currently assessed as **high** to **very high** for the overall population and **very high** for vulnerable individuals. This assessment is based on several findings and concerns:

1. the increased transmissibility,
2. recently found evidence of increased severity and
3. the potential for the existing licensed COVID-19 vaccines to be partially or significantly less effective against a VOC,
4. combined with the high probability that the proportion of SARS-CoV-2 cases due to B.1.1.7 (and possibly also B.1.351 and P.1) will increase.

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/sites/default/files/documents/RRA-covid-19-14th-update-15-feb-2021.pdf>

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References:

- European Centre for Disease Prevention and Control www.ecdc.europa.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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