Update 56 (09th of February 2021)

Information about infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
09th of February 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

- Globally, just under 3.7 million new cases were reported in the past week, a decline of 13% from last week, and the number of new deaths reported was over 96 000, comparable to the previous week. This brings the cumulative numbers to over 102.1 million reported cases and over 2.2 million deaths globally since the start of the pandemic.
- **WHO**: The WHO expert mission sent to China was unable to clarify how the novel coronavirus spread to humans during its several weeks' stay in China. Evidence that there were infections with Sars-CoV-2 in humans before December 2019 were also not found. See full press conference here.
- According to Russia, a combination of the Russian vaccine **Sputnik V** with the vaccine from **AstraZeneca** will be tested this week in Azerbaijan and some other countries in the region. The first results are therefore expected for March.
- **AstraZeneca:** According to a new study the vaccine does not appear to offer protection against mild and moderate disease caused by the viral variant first identified in South Africa.
- **WHO/COVAX:** Warning against writing off the AstraZeneca corona vaccine prematurely. It is too early to dismiss the vaccine as not being effective enough. In the fight against the coronavirus, it is "absolutely crucial" to use all available means "as effectively as possible".
- **Facebook** wants to act against misinformation about the pandemic and vaccinations. Among other things, groups or accounts that regularly share false information should be deleted. In addition, it should be made easier for users to find out about vaccination options.
- **EU Commission**: After ratification by the EU countries, the commission wants to pay out the first aid from the Corona development fund in the summer.
- **WHO:** Launches free OpenWHO.org training on rehabilitation for COVID-19.
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GLOBALLY ↘ 106 528 921 confirmed cases 70 707 500 recovered 2 327 094 deaths
EU/EEA and the UK ↘ 34 084 103 confirmed cases 18 419 250 recovered 769 551 deaths
USA ↘ **(new cases/day 83 447)** 26 990 520 confirmed cases **11 132 598** recovered 463 025 deaths
India → **(new cases/day 11 831)** **10 847 304** confirmed cases **10 548 521** recovered **155 158** deaths
Brazil ↗ **(new cases/day 77 475)** **9 524 640** confirmed cases **8 478 818** recovered **231 534** deaths
UK ↘ **(new cases/day 14 104)** **3 959 784** confirmed cases -not reported- recovered **112 798** deaths
Russia ↘ **(new cases/day 15 701)** **3 953 970** confirmed cases **3 455 582** recovered **76 347** deaths

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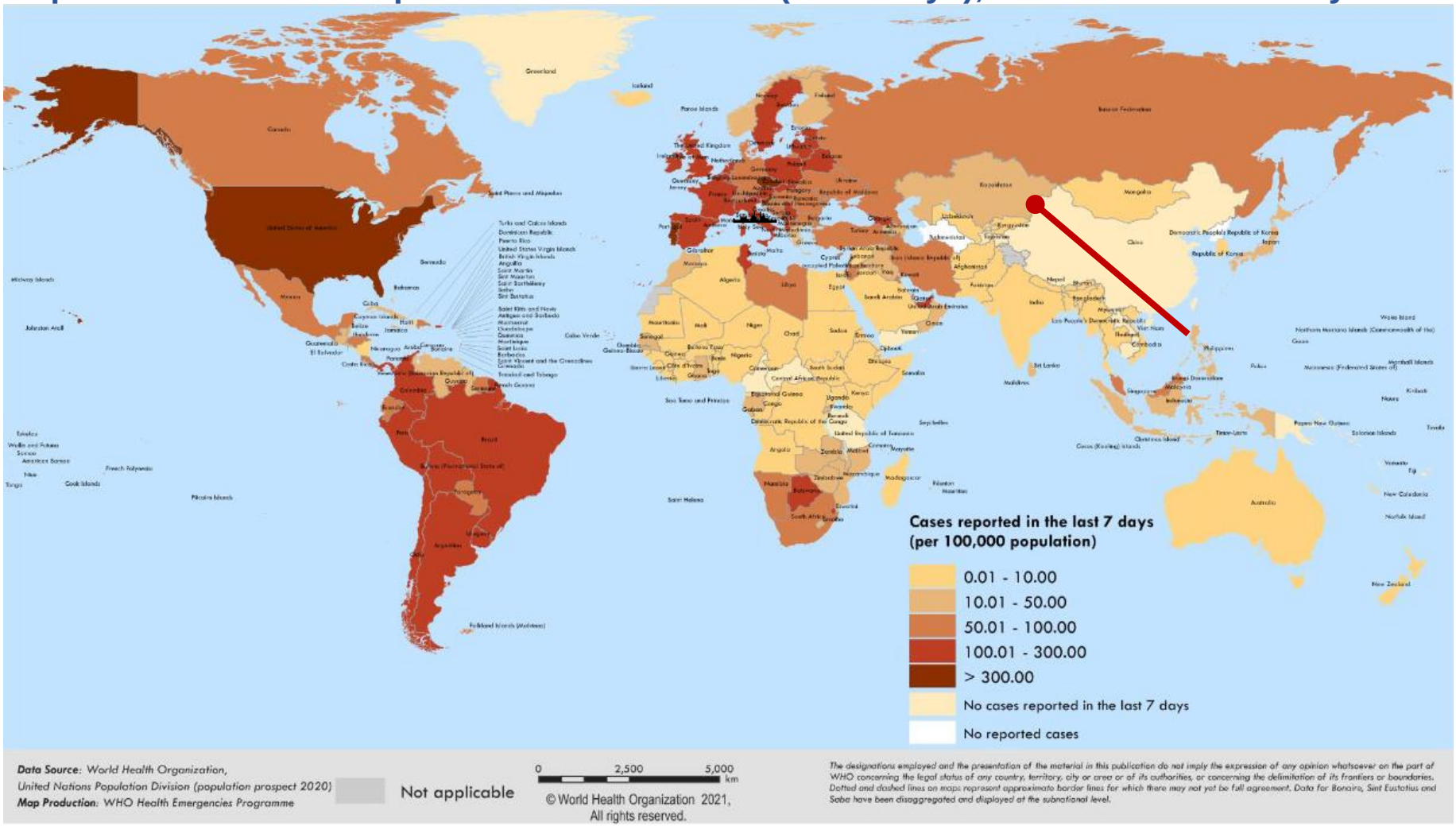
Map of countries with reported COVID-19 cases (last 7 days), as of 25 to 31 January



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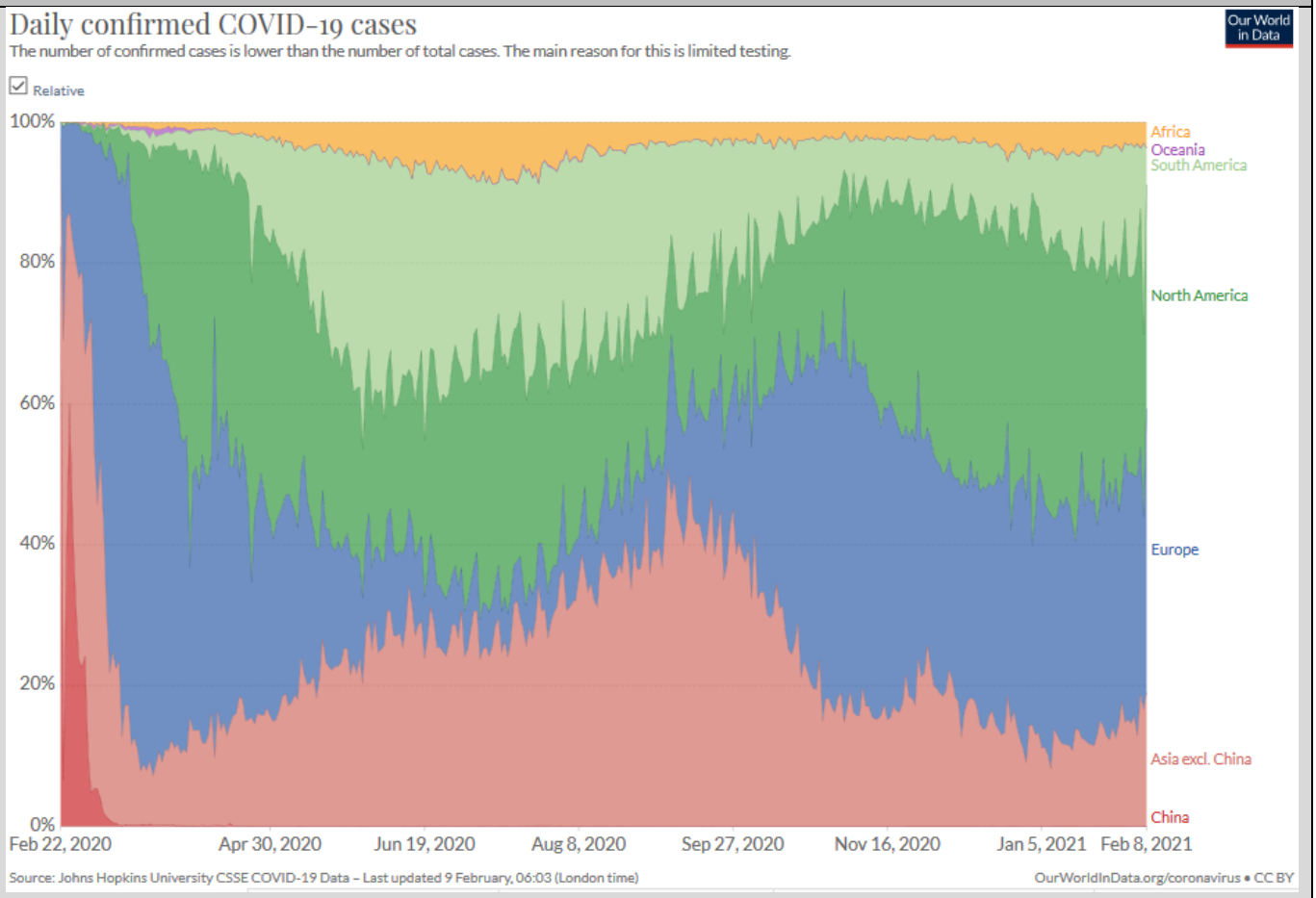
Worldwide Situation

Global Situation



Most vaccine appears to be of limited effectiveness to the South African variant

The **Oxford/AstraZeneca** COVID-19 vaccine does not appear to offer protection against mild and moderate disease caused by the viral variant first identified in South Africa, according to a new study. The study had not yet been reviewed but first findings show in the 2,000 mainly healthy and young patients significantly reduced efficacy against the 501Y.V2 viral variant, which is dominant in South Africa, according to the randomised, double-blind study. It was tested in human trials and tests on the blood of those vaccinated.

There are caveats to the study, as the sample sizes were relatively small. The study, led by South Africa's University of the Witwatersrand and Oxford University, enrolled 2,026 HIV negative individuals, with a median age of 31. Half the group was given at least one dose of placebo, with the other half receiving at least one dose of vaccine.

AstraZeneca said it had not been able to properly ascertain the effect of the vaccine on severe disease and hospitalisation caused by the South African variant in the study given most of the participants were young, healthy adults. It noted that it had begun to adapt the vaccine against this variant with Oxford, advancing rapidly through clinical development "so that it is ready for autumn delivery [if] needed".

While all COVID-19 vaccines so far have largely held up against the B.1.1.7 variant that emerged in the UK, the strain that originated in South Africa has been more worrying. Both **Johnson & Johnson** and **Novavax** have said their vaccines were less effective against the strain in clinical trials conducted in South Africa.

Moderna has said it will test a booster shot and a reformulated vaccine to target the South African variant, after studies showed its vaccine was significantly less effective.

BioNTech/Pfizers coronavirus vaccine should grant protection against both the South African and British variants, according to an article published in Nature Medicine on Monday. The journal article

noted that the neutralization of the virus containing mutations found in South African variant was "slightly lower" when compared to the one that imitated the U.K. variant. But the differences were small.

It has been shown in the laboratory that the blood of 20 people vaccinated with the vaccine neutralized the key mutations of the coronavirus variants from Great Britain and South Africa, meaning that there were sufficient neutralizing antibodies in the blood. However, one limitation of the peer-reviewed study is "that the engineered viruses do not include the full set of spike mutations found in the [U.K.] or [South African] variants," the researchers said.

The publication states, among other things, that clinical data are now needed to learn even more about the effect of the vaccine against virus variants. The ongoing development of Sars-CoV-2 makes continuous monitoring of the variations and possible consequences for the effectiveness of vaccines necessary.

Source: https://www.ft.com/content/e9bbd4fe-e6bf-4383-bfd3-be64140a3f36
https://www.nature.com/articles/s41591-021-01270-4

ECDC: Stress test on logistical aspects of COVID-19 vaccination deployment plans

ECDC, together with the European Commission's Directorate-General for Health and Food Safety, organised a stress test of the logistical aspects of COVID-19 vaccination deployment plans. Twelve EU/EEA Member States participated in this stress test, a focused simulation exercise conducted in two rounds, one in mid-December 2020 and the second in early January 2021.

Summary:

Member States were asked to describe the deployment plans in place for delivering a vaccine with strict cold chain requirements to their target priority groups. All participating Member States were able to describe the process, albeit in varying levels of detail, reflecting that they were at different points in their planning. Most described bespoke cross-government governance arrangements where a task force had been convened to oversee the deployment. Electronic systems for logistics management and vaccination registries were described, some newly developed and others that had been used in previous vaccination programmes. Plans were also in place, or in development, to promote the vaccination campaign including using and monitoring social media to support the roll-out.

One of the most important aspects of the stress test, however, was to provide an opportunity for those involved in developing their vaccine deployment plan to test it against a realistic scenario, to work through all the elements of deployment and provide reassurance that the plan was robust and that any issues identified could be addressed. Feedback from those who took part in the stress test indicated that this was achieved. The stress test was completed when participants came together in a webinar to hear an overview of the results and share their experiences of vaccine roll-out to date.

Source: https://www.ecdc.europa.eu/en/publications-data/covid-19-stress-test-logistical-aspects-vaccination-deployment-plans

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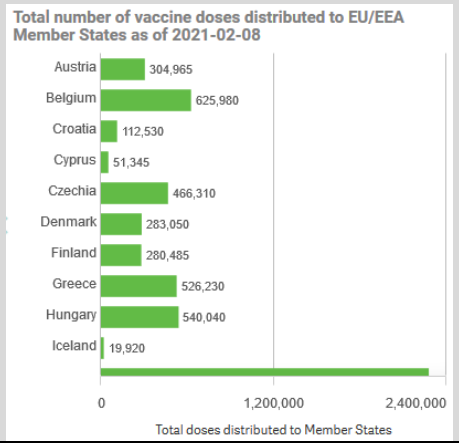
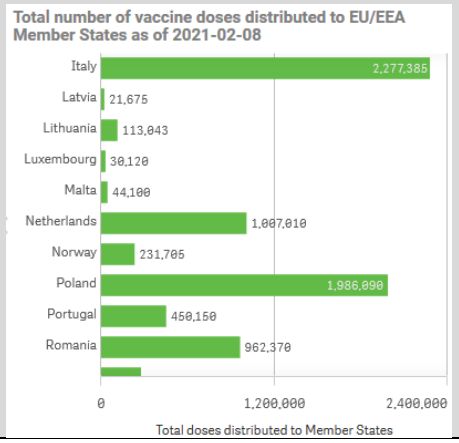
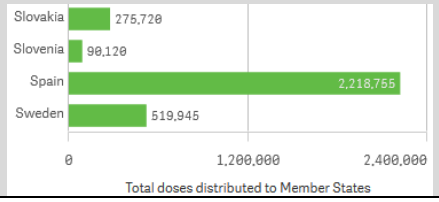
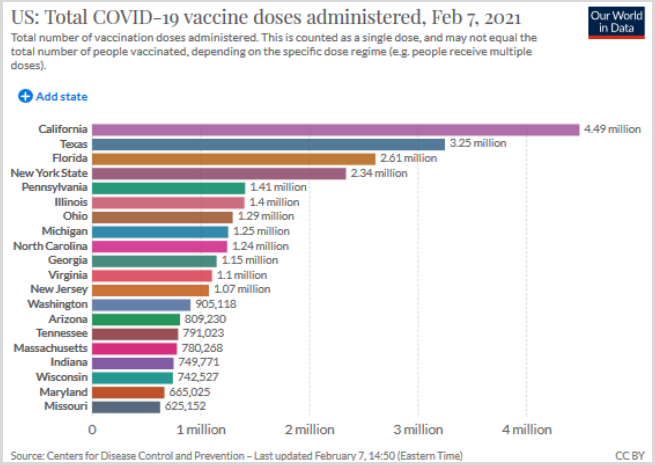
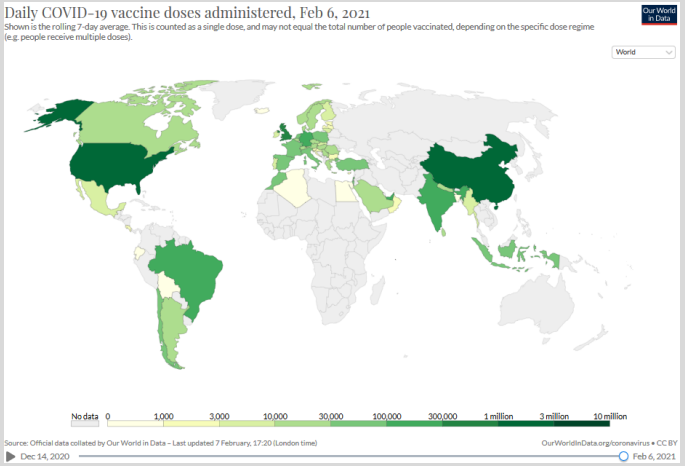
Vaccination report











Source: ECDC and Our world in Data

WHO experts advise on AstraZeneca

WHO experts have discussed the further handling of the AstraZeneca vaccine. South Africa had temporarily stopped planned vaccinations with the vaccine due to doubts about its effectiveness against the coronavirus variant prevalent there. "This is definitely worrying news," said WHO chief Tedros Adhanom Ghebreyesus in Geneva. The development shows that vaccines must be produced quickly and brought to people. "We know that viruses mutate, and we know that we have to be ready to adapt vaccinations so that they remain effective," said the WHO chief.

Tedros plans to meet with the experts from the WHO strategy group (SAGE) on Tuesday to discuss recommendations for dealing with the vaccine that AstraZeneca has developed together with Oxford University. He appealed to the international community to report every newly discovered virus mutation to the WHO. This is the only way for the organization to observe developments and react accordingly.

Vaccination of children: Some manufacturers have started testing their COVID-19 vaccines on minors. Experts do not expect their deployment until the end of this year or the beginning of next year at the earliest.
BioNTech plans to test the vaccines on children between 0 and 15 years of age.
AstraZeneca plans to include 6 to 18-year olds in its studies "in the coming months".
Moderna started a study with 3000 minors in the US in December.

The **EU Commission** has signed a purchase agreement with BioNTech for a further 300 million vaccine doses. The EU ordered the first 300 million doses in November and announced at the beginning of January that it was negotiating the delivery of 300 million more doses. This sales contract has now been concluded. 200 million have therefore been firmly ordered, while Brussels has an option for a further 100 million. According to the EU Commission from January, the first 75 million doses of the second order are to be delivered in the second quarter of 2021, and the rest of the vaccine by the end of the year.

GBR: More than twelve million people have already received a first vaccination against the coronavirus. By mid-February, the British government wants to have offered vaccinations to the most vulnerable groups - including those over 70, people with pre-existing conditions, and medical and nursing staff - and thus 15 million people. All over-50s should then receive a vaccination by May.

Due to the early and extensive purchase from various manufacturers, Great Britain is less affected by delivery bottlenecks for vaccines than, for example, the EU countries. The WHO has already called on the country to dispense vaccination doses as soon as the most vulnerable groups of the UK population are vaccinated. If all vaccine manufacturers with whom the UK has signed contracts were to get approvals for their drugs, the country would have ordered enough doses to vaccinate its population three times.

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UK authorities are looking into the possibility of booster vaccinations against variants of the coronavirus this fall.

HUN: As expected, the Center for National Public Health approved the Russian corona vaccine Sputnik V after the necessary test. For the first time, Hungary is using a vaccine against the coronavirus that has not yet been approved across the EU. The anti-corona vaccine produced by the Chinese company Sinopharm is also in the approval process in Hungary. The country also inoculates the vaccines from BioNTech, Moderna and AstraZeneca.

IRN: Has presented the second corona vaccine developed in the country and, according to the country's own statements, has started tests on people. Accordingly, the new vaccine will initially be tested on 13 people. If there are no serious counter-reactions, the tests should initially be extended to 20 to 120 people. According to the information, tests on animals have already been completed. Iran is also working on a joint vaccine with Cuba.

ZAF: Unlike previously planned, health care workers are not to be vaccinated with the AstraZeneca vaccine. The reason is that, according to Oxford, the first results of a small-scale study recently indicated that the AstraZeneca vaccine only offers "minimal protection" against mild courses of the disease COVID-19 in the case of infections with the South African Corona variant. The new variant of the coronavirus, which was first discovered in South Africa, is now responsible for more than 90 percent of corona infections in the country, according to the Ministry of Health.

CHL: Within three days, more than 550,000 citizens have been vaccinated against the novel coronavirus. According to the Ministry of Health, around 112,000 vaccine doses were administered to seniors over the age of 85 on Friday alone. The vaccination centers opened on Wednesday. The government set a goal of vaccinating five million people by the end of March. By July 15 million of the total of 18 million residents should have received a vaccination. The first vaccine doses were given to health workers in Chile in December. In addition to the vaccine from BioNTech, the country also uses the vaccine from the Chinese company Sinovac. In addition, supply contracts were signed with the pharmaceutical groups Johnson & Johnson and AstraZeneca.

PER: has received an initial shipment of 300,000 doses of the Chinese corona vaccine Vero. Another 700,000 doses should arrive on February 14, according to the government. At first medical personnel will be vaccinated. Sinopharm had already worked with Peru in the practical test phase of the vaccine.

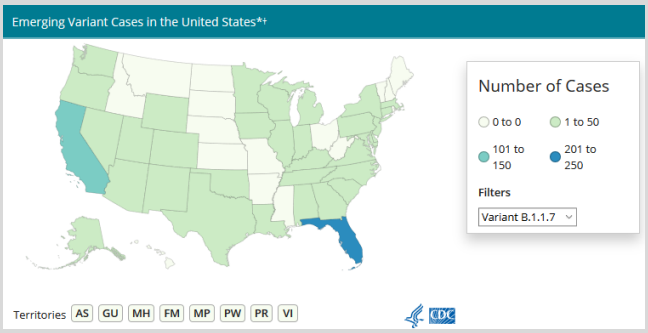
Country reports:

USA:

US COVID-19 Cases Caused by Variants

Updated Feb. 7, 2021 Languages Print

Variant	Reported Cases in US	Number of States Reporting
B.1.1.7	690	33
B.1.351	6	3
P.1	3	2



The infection process is slowing down significantly. 825,000 patients were infected in the past week - 25 percent less than in the previous week. The US health authorities are concerned about the virus mutations. Experts warn that the British variant could be the dominant one by the end of March.

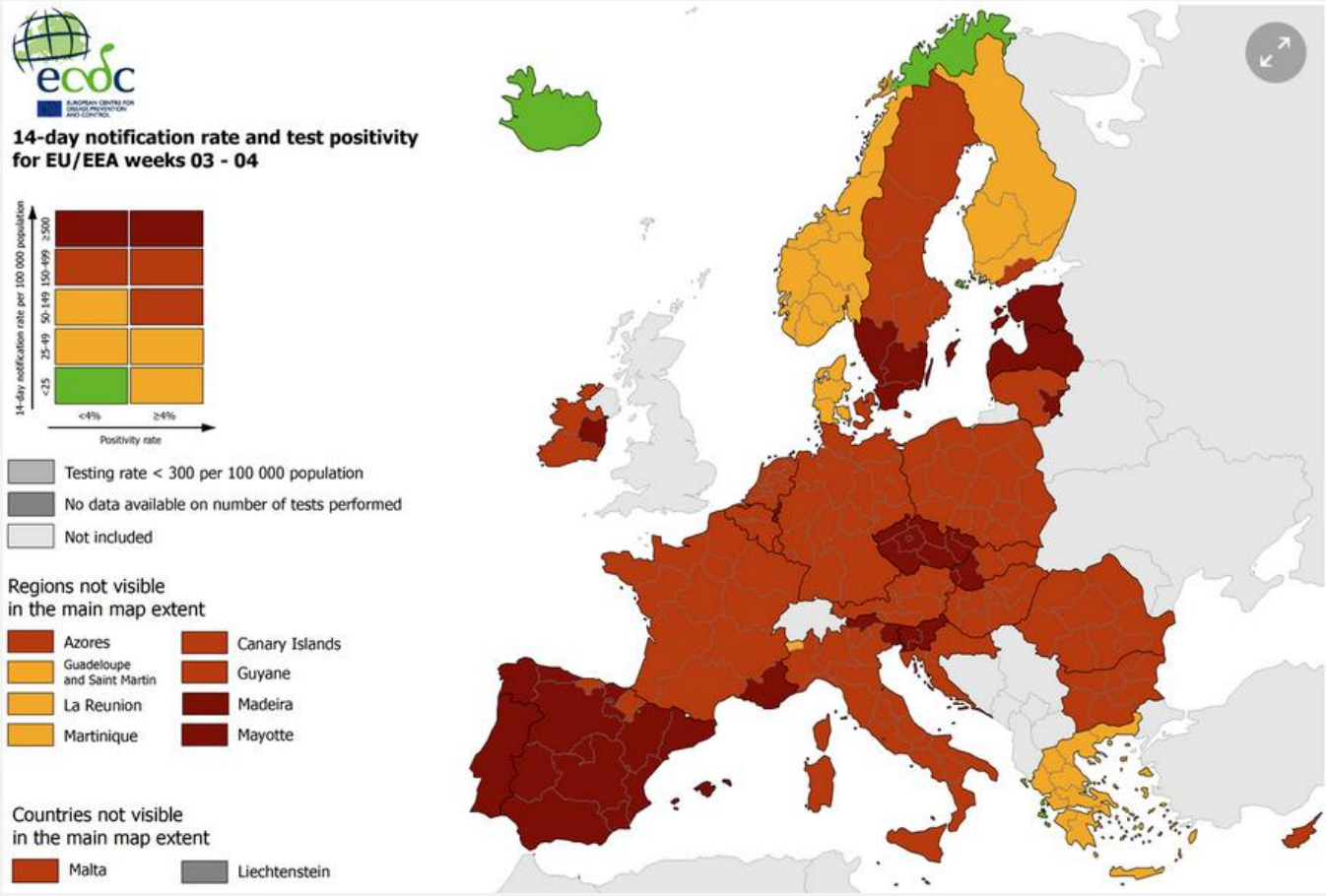
ISR: The government has started to loosen the third corona lockdown. Employees who have no contact with customers are allowed to return to their jobs. Visits in private circles are again allowed, as are excursions into nature and overnight stays by core families in holiday apartments. Kindergartens and schools are to be reopened to a limited extent from today. The international airport Ben Gurion near Tel Aviv remains closed in principle. Israel imposed a partial lockdown at the end of December and tightened it a month ago. Despite a massive vaccination campaign, the number of infections there remains at a high level. The government blames the mutations above all for this.

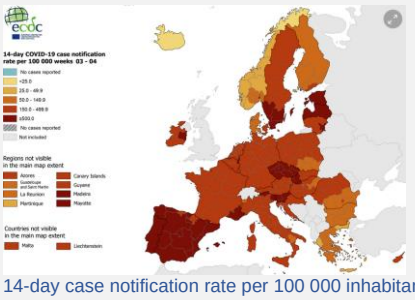
IND: According to the third nationwide corona study published by the Ministry of Health, the number of corona infections in India is apparently many times higher than the official information. At the beginning of the vaccination program in January, 21.4 percent of adults were already infected. In the slums of large cities, the proportion was even close to a third. In the other urban areas, antibodies against the coronavirus were found in 26.2 percent of people. In addition, the study shows that more than a quarter of children and adolescents between the ages of ten and 17 were already infected with the virus. The proportion of those infected was about the same among doctors and nurses.

KOR: In Seoul, corona tests are to be provided for dogs and cats under certain circumstances. This is planned if the animals were in contact with infected people and then show symptoms. Infected animals must be isolated for 14 days privately or in municipal facilities. After the detection of a corona infection in a cat in the city of Jinjuln, the South Korean government published guidelines for tests on animals last week.

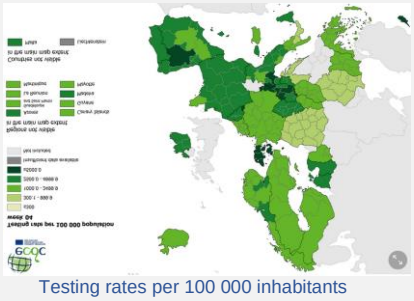
Situation in Europe

[Maps in support of the Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic in the EU](), as of 04 February 2021

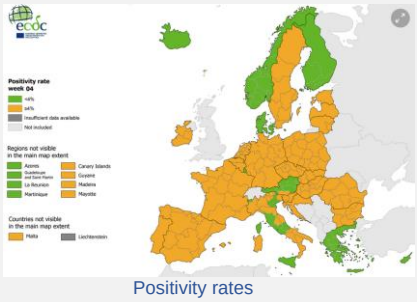




14-day case notification rate per 100 000 inhabitants



Testing rates per 100 000 inhabitants



Positivity rates

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ECDC COVID-19 surveillance report Week 04, as of 04 February 2021

Weekly surveillance summary

Overall situation

By the end of week 4 (ending Sunday 31 January 2021), seven countries observed increasing case rates (compared to four countries in previous week) and four reported increasing hospital or ICU admissions and/or occupancy due to COVID-19 (compared to five in the previous week). Case rates among older age groups increased in two countries and five 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. Although in most countries indicators show an improving epidemiological situation, in a number of countries reporting increasing case trends it is likely that hospitalisations and ICU admissions, and potentially deaths, will increase in the coming weeks.

New this week

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 2 (Section 3.8).

Trends in reported cases and testing

- By the end of week 4, the 14-day case notification rate for the EU/EEA, based on data collected by ECDC from official national sources from 30 countries, was 402 (country range: 11–1 652) per 100 000 population. The rate has been decreasing for two weeks.
- Among 29 countries with high case notification rates (at least 60 per 100 000), increases were observed in seven countries (Belgium, Finland, France, Greece, Luxembourg, Portugal and Spain). Stable or decreasing trends in case rates of 1–7 weeks' duration were observed in 22 countries (Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Germany, Hungary, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Malta, 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 23 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Germany, Greece, Hungary, 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 4, available for 29 countries, varied from 742 to 13 409 tests per 100 000 population. Denmark had the highest testing rate for week 4, followed by Cyprus, Luxembourg, Austria and Slovenia.
- Among 21 countries in which weekly test positivity was high (at least 3%), three countries (France, Portugal and Slovakia) observed an increase in test positivity compared with the previous week. Test positivity remained stable or had decreased in 18 countries (Belgium, Bulgaria, Croatia, Czechia, Estonia, Germany, Hungary, Ireland, Italy, Latvia, Lithuania, Malta, the Netherlands, Poland, Romania, Slovenia, Spain and Sweden).

Hospitalisation and ICU

- Pooled data from 19 countries for week 4 show that there were 1.6 patients per 100 000 population in ICU due to COVID-19. Pooled weekly ICU admissions based on data from 13 countries were 2.5 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 27 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Hungary, 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.

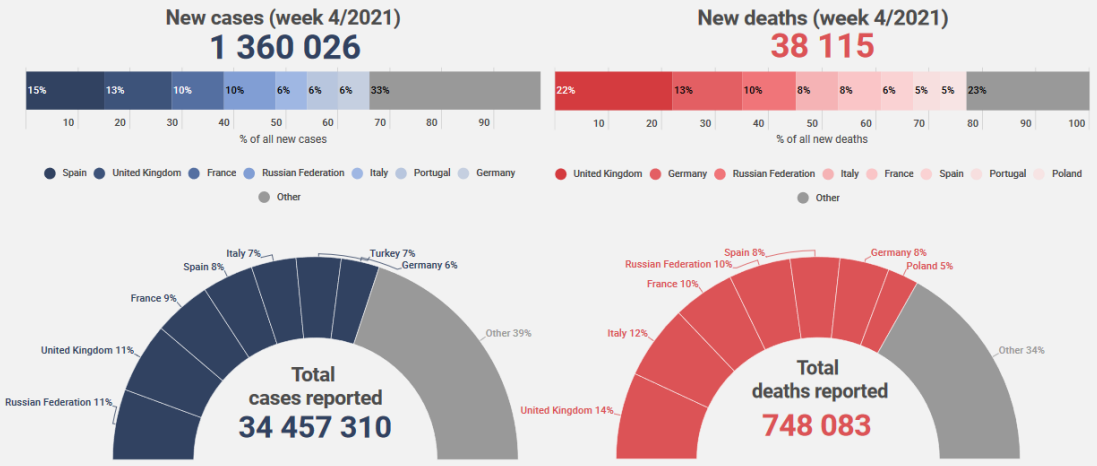
Mortality

- 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 103.9 (country range: 0.0–362.9) per million population. The rate has been stable for 10 weeks.
- Among 28 countries with high 14-day COVID-19 death rates (at least 10 per million), increases were observed in five countries (Ireland, Malta, Portugal, Slovakia and Spain). Stable or decreasing trends in death rates of 1–7 weeks' duration were observed in 23 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, the Netherlands, Poland, Romania, Slovenia and Sweden).

Notes

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

COVID-19 situation update for the WHO European Region (25 Jan – 31 Jan 2021 Epi week 03)



Country Reports:

DEU: The lock down is showing the first effects. For the first time in three months, the seven-day incidence fell below 75. 72.8 people per 100,000 inhabitants were infected within a week. The seven-day incidence peaked on December 22 at 197.6 cases per 100,000 population. Then twelve days ago it fell below the value of 100.
Experts are now warning against loosening the restrictions too quickly. The first success should not be gambled away lightly.

NLD: Despite massive protests, the government will extend the night curfew until March 3rd.

ITA: For fear of the spread of two corona mutations in the Italian province of Perugia (Umbria region), the responsible regional government has imposed a lockdown after several cases of both the British and the Brazilian variant have occurred. In the province and some municipalities of the neighboring province of Terni, the rules of the red zone will therefore apply for a little more than two weeks from next Monday. Public life is thus severely restricted. Bars, restaurants, and most shops are closed. People are no longer allowed to eat or drink in public places and should only leave their homes for necessary things, such as shopping or visiting the doctor. Almost all students must attend classes from home again via the Internet. Kindergartens remain closed.

GBR: The number of new infections, which after the spread of variant B.1.1.7 in December was at times more than 70,000 cases per day, has fallen sharply in recent weeks thanks to a hard lockdown. In the past seven days, the country counted 218 new corona cases per 100,000 inhabitants.
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Employees who cannot work from home should be provided with regular rapid tests by the government. This affects companies with more than 50 employees. It is also planned to vaccinate employees against the corona virus at their workplaces in the spring.
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GBR stricter its entry regulations. In the future, people traveling to Great Britain will have to present a negative corona test upon arrival, two further tests during a ten-day quarantine. The tests should therefore be carried out on day two and day eight of the quarantine. Travelers have to pay for the costs themselves. Even now, everyone who enters the country must present a negative test result on arrival that is not older than 72 hours.

FRA: Currently 3363 patients are being treated in intensive care units. That is the highest level in two months. Meanwhile, the vaccination campaign is making progress. Almost 2 million French people are vaccinated.

NOR: The Foreign Ministry has extended its recommendation to refrain from all unnecessary trips abroad until April 15th. The decision is based on several factors, for example the global infection situation, the spread of virus mutations and the capacities of the respective health systems in other countries. Only countries and regions in the Schengen and European Economic Area with low infection rates are excluded from the recommendation. That means Iceland, the Faroe Islands, Greenland and a few areas in Finland.

RUS: According to new statistics, significantly more people died with a corona infection in the past year than previously reported. The statistics agency Rosstat put the number at 162,429. The government's corona working group had so far reported 77,068 deaths. Officials attributed the differences to different methods. The working group only counts deaths for which COVID-19 is considered the main cause of death. In addition, the task force's figures were based on data from medical institutions, whereas Rosstat used death reports from civil registration offices.
In total, 323,802 more people died in 2020 than in 2019. This corresponds to an increase of 17.9 percent. In December alone, 44,435 people died after a COVID-19 infection.

Subject in Focus

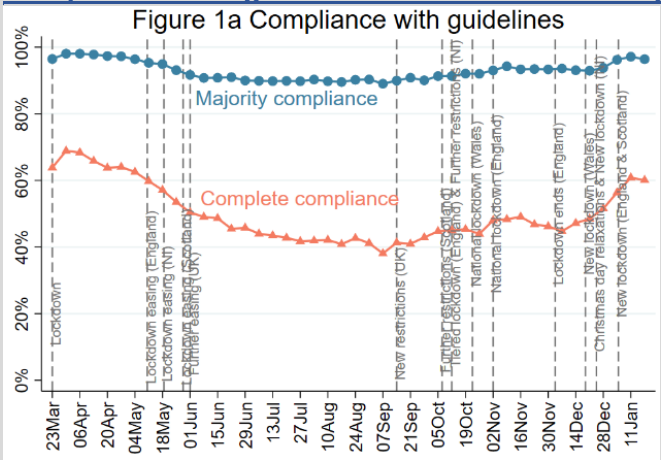
British COVID-19 Social Study Phsychological response and behaviour during lockdown

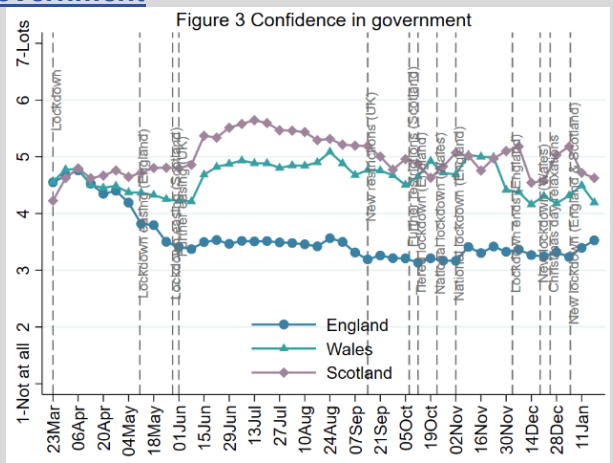
The study, conducted by University College London, and funded by the Nuffield Foundation think tank, has followed 70,000 people for more than 40 weeks focusing on the psychological and social experiences of adults living in the UK during the COVID-19 pandemic. Participants in the ongoing study were recruited through adverts and social media posts, as well as from organisations representing a range of communities.

1. Compliance and confidence

Respondents were asked to what extent they are following the recommendations from government such as social distancing and staying at home, as well as how much confidence they had in the government to handle the COVID-19 epidemic, ranging from 1 (not at all) to 7 (very much so).

Compliance with guidelines and confidence in government





Results:

Compliance has continued increasing since Christmas and is now as high as it was in May 2020 just before the first lockdown began to be eased.

Majority compliance is being reported by 97% of people, a continued improvement across all demographic groups. Complete compliance with the rules (i.e. following them with no bending or even minor infringements) is being reported by the majority of people (60% for the week ending 24thJanuary).

The patterns of compliance remain as they were for the last few months though, with compliance lower in higher income households, in urban areas, amongst men, and amongst people in good physical health. But the improvements have been seen across all groups.

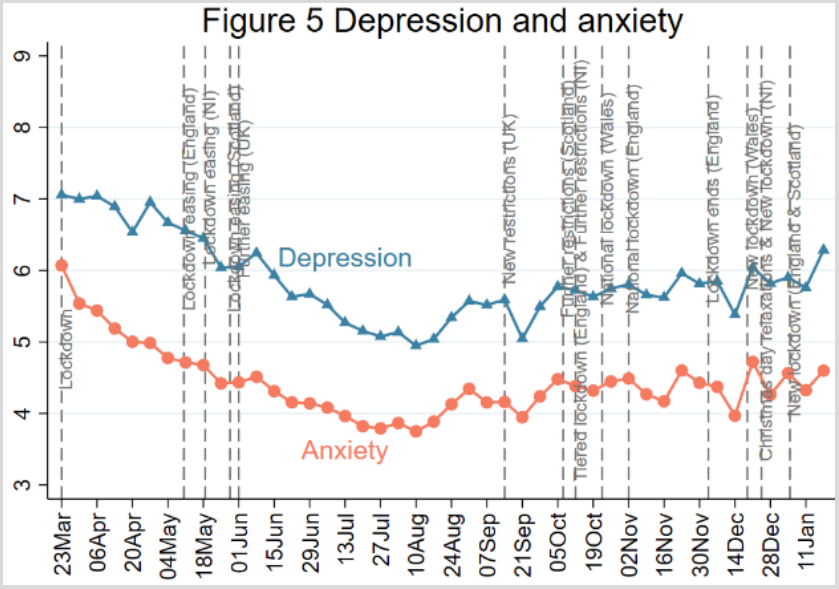
Levels of **confidence in central government** to handle the COID-19 epidemic are slightly higher than in the autumn, with levels similar to in August 2020. But levels in Wales and Scotland are lower than they were in the summer, narrowing the gap between the nations in terms of trust. Nonetheless, levels remain lower in England than for devolved nations.

In England, confidence in government is still lowest in those under the age of 30. Confidence is also lower in urban areas, amongst people from ethnic minority backgrounds, amongst people with higher educational qualifications, and in people with a mental health diagnosis. Confidence is also slightly lower in people of higher household income.

2. Mental Health

2.1 Depression and anxiety

Respondents were asked about depression levels during the past week using the Patient Health Questionnaire (PHQ-9) and anxiety using the Generalised Anxiety Disorder assessment (GAD-7); standard instruments for diagnosing depression and anxiety in primary care. These are 9 and 7 items respectively with 4-point responses ranging from “not at all” to “nearly every day”, with higher overall scores indicating more symptoms. Scores of higher than 10 can indicate major depression or moderate anxiety.



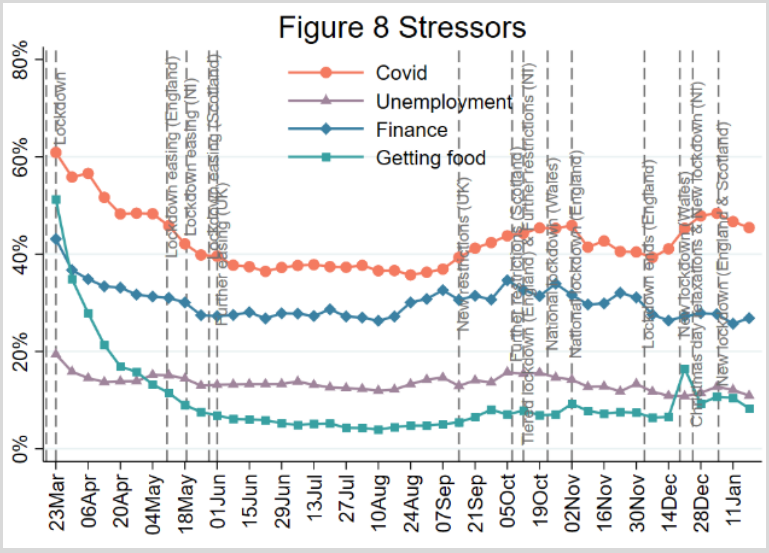
Results

Depression and anxiety levels are the worst they've been since June 2020, with clear worsening since the summer. Although this study focuses on trajectories rather than prevalence, the levels overall are higher than usual reported averages using the same scales

Depression and anxiety are still highest in young adults, women, people living alone, people with lower household income, people with a long-term physical health condition, people with lower educational qualifications, people from ethnic minority backgrounds, people living with children, and people living in urban areas. People with a diagnosed mental illness have still been reporting higher levels of symptoms (as might be expected), but there appears to have been a particular increase in depression and anxiety symptoms amongst this group in recent weeks.

2.2 Stress

Participants were asked to report which factors were causing them stress in the last week, either minor stress or major stress (which was defined as stress that was constantly on their mind or kept them awake at night).



Results

Stress about catching COVID-19 or becoming seriously ill from itis substantially higher than in the autumn, especially since news of the new more contagious variant was released. Around 45% of people are now worried; the highest level since the middle of the first lockdown back in April.

Worries about finance have remained stable since the latest lockdown started, comparable to their lowest levels of 1 in 4 people over the summer. Similarly, worries about unemployment remain relatively low, concerning just 1 in 8 people. However, worries about accessing food remain higher than in the summer, affecting 1 in 10 people; the highest level since lockdown easing began in May.

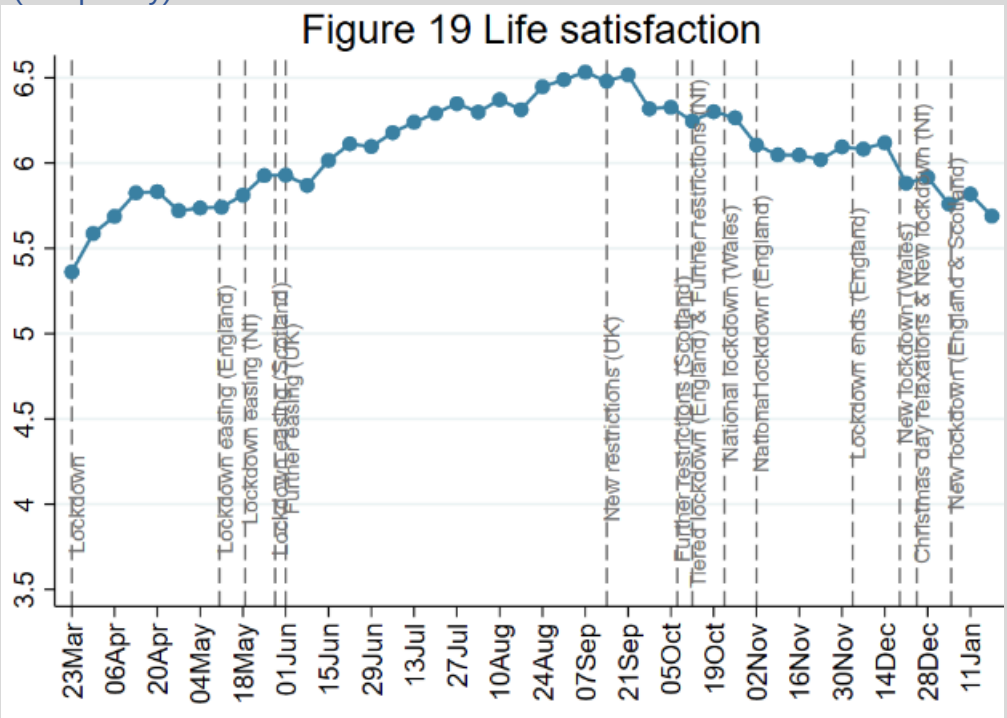
People with diagnosed mental illness have been more worried about all factors. But other predictors of stressors have varied. Specifically, in relation to worries about COVID-19, these levels are highest in adults over the age of 30, women, and people with diagnosed physical health conditions, but they have been rising across other groups too. They are similar across most other demographic factors.

Concerns about unemployment and finances are highest in lower income households, amongst those under the age of 60, those living with children, those from ethnic minority groups, and those living in urban areas. All groups are showing similar concern about accessing food, although these concerns are highest in people with a diagnosed physical health condition, where going to supermarkets may be more of a concern.

3. General well-being

3.1 Life satisfaction

Respondents were asked to rate their life satisfaction during the past week using the ONS wellbeing scale, which asks respondents about how satisfied they are with their life, using a scale from 0 (not at all) to 10 (completely).



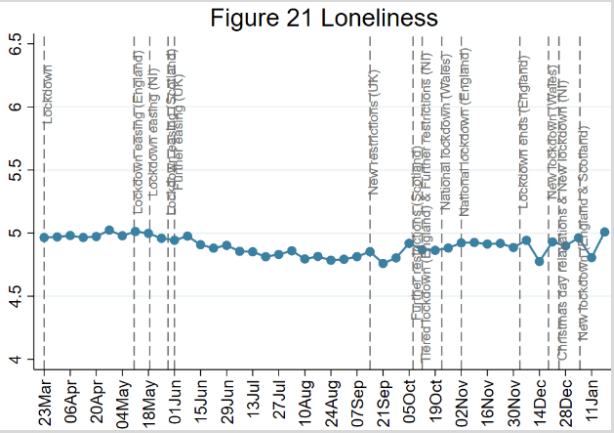
Results

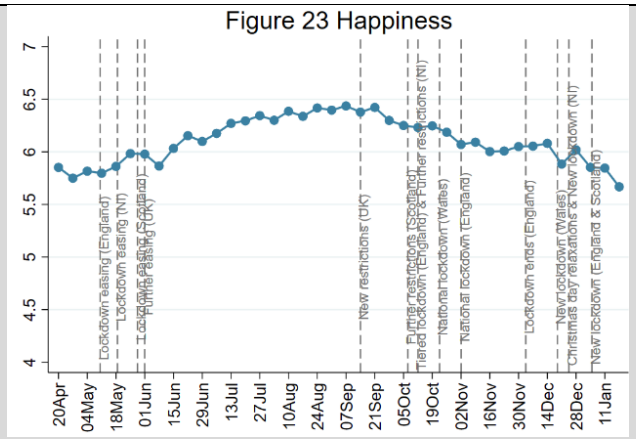
Life satisfaction has continued to deteriorate in lockdown, with levels now comparable to those near the start of lockdown in spring 2020. This decrease since August appears to have occurred across all age groups, although adults under the age of 60 have lowest levels of life satisfaction. It is also lower in people living alone, people with lower household income, people with diagnosed mental health condition, and people living in urban areas. It is similar across UK nations and amongst key workers. Women have lower levels of life satisfaction, as do people with a long-term physical health condition and people from ethnic minority backgrounds (although smaller sample sizes compared to people with white ethnicity mean there has been greater volatility in these data).

Life satisfaction is still noticeably lower than for the past 12 months (where usual averages are around 7.7), and wellbeing more generally appears to have decreased substantially in the weeks preceding lockdown.

3.2 Loneliness and Happiness

Respondents were asked about levels of loneliness using the 3-item UCLA-3 loneliness, a short form of the Revised UCLA Loneliness Scale (UCLA-R). Each item is rated with a 3-point rating scale, ranging from “never” to “always”, with higher scores indicating greater loneliness. And to rate to what extent they felt happy during the past week using the Office for National Statistics wellbeing scale on a scale from 0 (not at all) to 10 (completely).





Results

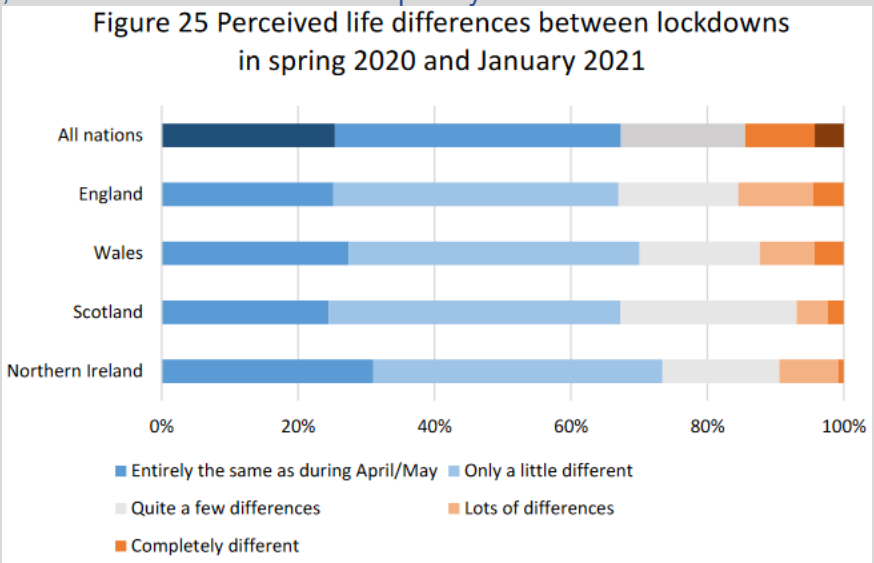
Loneliness levels have been relatively stable in the past month but are very slightly higher than they were over the summer before new restrictions were brought in. The greatest increase in recent weeks has occurred in people living alone. Levels are still highest in younger adults, women, people from ethnic minority backgrounds, people with lower household income, people living with children, people living in urban areas, and people with a diagnosed mental or physical health condition.

Happiness levels have further decreased in the past few month during lockdown, reaching levels that are lower than during lockdown in April 2020. The decrease in recent weeks has been particularly evident amongst older adults (although they remain higher in this age group compared to younger adults). Happiness levels are also lower amongst those living alone, those with lower household income, people with a diagnosed mental or physical health condition, people living in urban areas, women, and people from ethnic minority backgrounds.

4. Experiences of the first and second lockdowns

4.1 Perceived life differences

Participants where asked how different they feel their life is in the current January 2021 lockdown compared to during the first lockdown in the spring of 2020. Participants were asked to give their response on a 5-point scale: “entirely the same as during April/May”, “only a little different”, “quite a few differences”, “lots of differences” and “completely different”.



Result

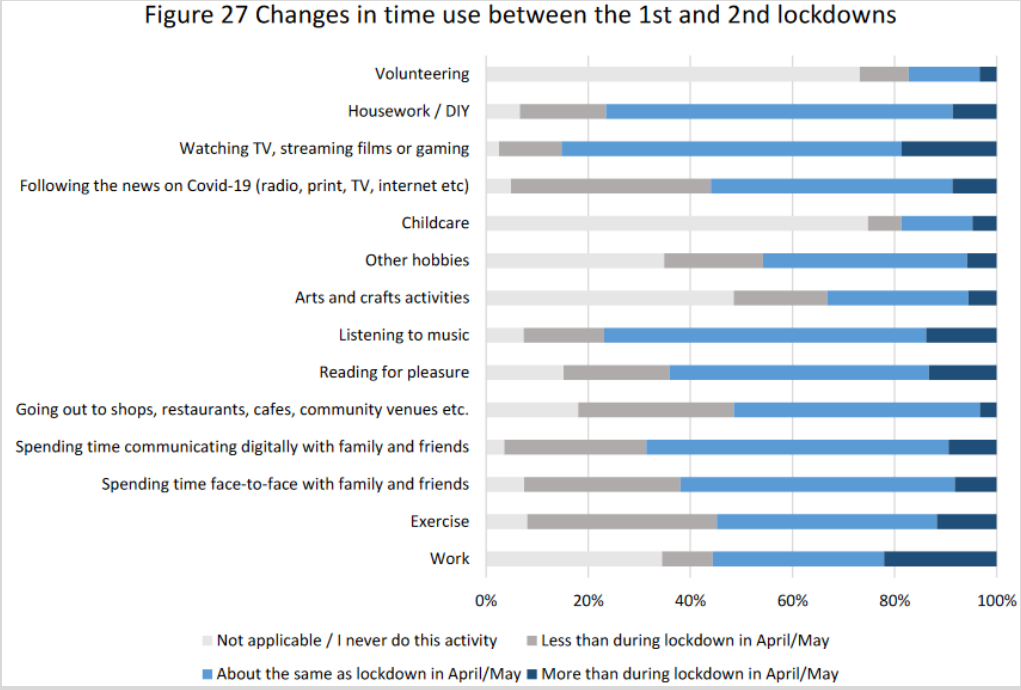
Just 25% of people are finding this current lockdown alike to the first lockdown in terms of changes to their lives. The remainder are finding it different, ranging from 42% finding it a little different to 15% finding it very or completely different. This suggests that this lockdown is not causing the same changes to people’s lives or behaviours as the first lockdown did.

There has been no meaningful difference amongst keyworkers and non-keyworkers (perhaps as their work has continued through both lockdowns), nor amongst people living with vs without children, amongst people living in urban vs rural areas, or amongst men vs women.

4.2 Changes in time use

Participants where asked about how they had been spending their time in the past week, focusing specifically on how that time use compared to time use during the first lockdown in 2020.

Figure 27 Changes in time use between the 1st and 2nd lockdowns



Results

Overall, the most ubiquitous activity during the January 2021 lockdown has been watching TV, streaming films or gaming (97% of participants), followed closely by 96% spending time communicating digitally with family and friends, 95% following the news on COVID-19, and 93% listening to music and spending time face-to-face with friends and family (which includes those people live with).

However, within these behaviours there are some changes since the first lockdown in 2020. Of those engaging in activities (discounting those who reported not doing the activity), 41% reported following the news on COVID-19 less than during the first lockdown, with only 9% reporting watching the news more. Younger adults in particular have been following the news less (64% aged 18-29 report decreasing this activity compared to just 21% of adults aged 60+), as have women (46% decreasing this activity compared to 36% of men).

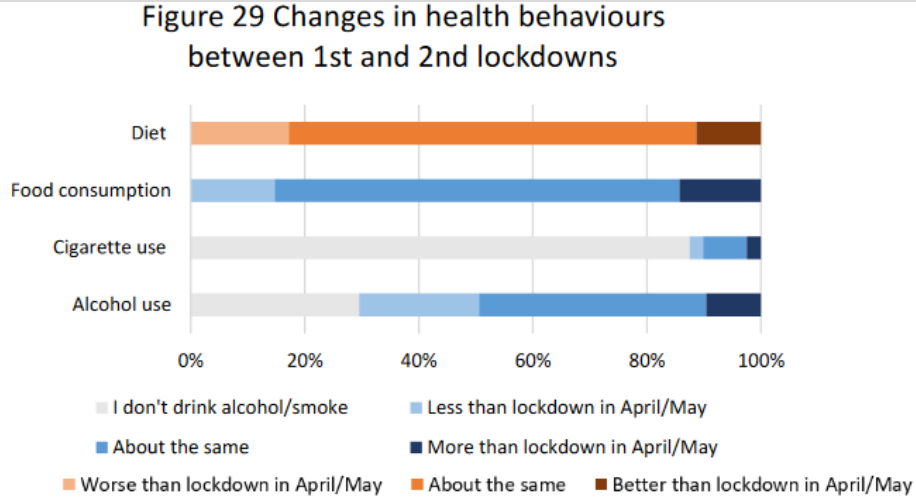
36% are reporting engaging less with arts and crafts and 30% less with other hobbies compared with just 11% and 9% reporting doing these activities more. Younger adults have reported decreasing these activities most although the numbers increasing have been stable across all age groups. However, women have been more likely than men to increase their engagement (14% of women report increasing arts engagement in this latest lockdown vs just 6% of men).Volunteering has also decreased, with 36% spending less time volunteering and just 13% increasing their volunteering.40% are reporting exercising less than during first lockdown, compared to just 13% reporting exercising more. Women have decreased exercise more than men (43% decreasing vs 38%).

Conversely, activities that have particularly increased include working (34% working more vs just 15% working less), and watching television, streaming films and gaming (19% doing these activities more and just 13% doing them less).Younger adults in particular have increased their working (45% vs 21% of adults over 60) and are compensating with less time watching television (28% of younger adults reporting a decrease vs 6% of older adults). By contrast, 20% of older adults have increased their time spent watching television.

4.3 Changes in health behaviours

Participants have been asked about their health behaviours in the past week, focusing on how these behaviours compared to those during the first lockdown in 2020. The responses where then categorised based on the response participants had given during first lockdown on each behaviour.

Figure 29 Changes in health behaviours between 1st and 2nd lockdowns



Results

In terms of diet, 71% of participants reported that their food consumption had been about the same as in the first lockdown, with equal numbers (15% and 14%) respectively reporting that they had eaten less or more. When splitting participants by the response they had given in first lockdown about their diet, of those who reported eating more than normal during the spring 2020 lockdown, 59% reported maintaining the eating patterns from first lockdown, and 20% reported eating even more now, suggesting a prolonged increase in food consumption, while the other 21% reported that they had decreased their eating again.

Of those who had reported eating less during the spring 2020 lockdown, 21% reported even less now, and 64% reported maintaining the patterns of the first lockdown, suggesting a prolonged decrease in food consumption, while the other 16% reported that they had decreased their eating again. The quality of the diet had also largely stayed the same (for 72% of participants), with 11% reporting that they were eating a healthier diet than during the first lockdown and 17% reporting a worse diet. When splitting participants by the response they had given in first lockdown about their diet, of those who reported eating more healthily than normal during the spring 2020 lockdown, 11% reported eating even more healthily now, and 66% reported maintaining the healthiness from the first lockdown, suggesting a prolonged improvement in diet, while 23% reported that they were not maintaining the same level of healthiness now. Of those who had reported eating less healthily during the spring 2020 lockdown, 24% reported that their diet now was even worse, and 58% reported it was about the same, whilst 18% said it had improved again.

Of our sample, 13% reported smoking. Of these, 61% reported smoking the same amount that they did during first lockdown, whilst an even number reported increasing and decreasing their smoking (20% vs 19%).When splitting participants by the response they had given in first lockdown about their smoking, of those who reported smoking more than normal during the spring 2020 lockdown, 47% reported maintaining that behaviour since and 30% reported further increasing it, whilst 23% reported decreasing it again. Of those who had reported smoking less during the spring 2020 lockdown, 49% reported maintaining that behaviour since and 34% reported decreasing it further, whilst 17% reported increasing it again. Of those who reported not smoking during first lockdown, only 0.5% reported now smoking during the current lockdown.

Of our sample, 70% reported drinking alcohol. Of these, 57% reported drinking the same amount as in first lockdown, with 30% drinking less and 14% drinking more. When splitting participants by the response they had given in first lockdown about their drinking, of those who reported drinking more than normal during the spring 2020 lockdown, 48% reported maintaining that behaviour since and 15% reported further increasing it, whilst 37% reported decreasing it again. Of those who had reported smoking less during the spring 2020 lockdown, 48% reported maintaining that behaviour since and 37% reported decreasing it further, whilst 15% reported increasing it again. Of those who reported not drinking during first lockdown, 6% reported now drinking during the current lockdown.

Summary of Findings

- Compliance has continued increasing since Christmas across the latest lockdown and is now as high as it was at the end of the strict lockdown in the UK in May 2020. Majority compliance is being reported by 97%of people -a continued improvement across all demographic groups –while complete compliance (no bending of the rules) by 60% of people.
- However, the lockdown itself is being perceived as very different by people to the lockdown in spring 2020. Just 25% of people are finding this current lockdown alike to the first lockdown in terms of changes to their lives. The remainder are finding it different, ranging from 42% finding it a little different to 15% finding it very or completely different. This suggests that this lockdown is not causing the same changes to people's lives or behaviours as the first lockdown did.
- Younger adults have been finding this lockdown most different to the first, with only 16% of those aged 18-29 finding it comparable to the first lockdown (compared to 30% of over 60s), and 27% finding it very or completely different (compared to 11% of over 60s).
- Fewer people with higher educational qualifications have reported finding things the same as during the first lockdown (20% vs 30% of people with lower levels of qualifications), perhaps as more have returned to working in offices. But more people with diagnosed physical health conditions have reported finding the lockdowns the same (28% vs 23% without diagnosed conditions), perhaps as these individuals have been more likely to take equally careful precautions to avoid the virus. There has been no meaningful difference amongst keyworkers and non-keyworkers (perhaps as their work has continued through both lockdowns).
- Overall, the most ubiquitous activity during the January 2021 lockdown has been watching TV, streaming films or gaming (97% of participants), followed closely by 96% spending time communicating digitally with family and friends, 95% following the news on COVID-19, and 93% listening to music.
- However, within these behaviours there are some changes since the first lockdown in 2020. Of those engaging in activities (discounting those who reported not doing the activity), 41% reported following the news on COVID-19 less than during the first lockdown, with only 9% reporting watching the news more. Younger adults have been following the news less (64% aged 18-29 report decreasing this activity compared to just 21% of adults aged 60+), as have women (46% decreasing this activity compared to 36% of men).
- 36% are reporting engaging less with arts and crafts and 30% less with other hobbies compared with just 11% and 9% reporting doing these activities more. Volunteering has also decreased, with 36% spending less time volunteering and just 13% increasing their volunteering. 40% are reporting exercising less than during first lockdown, compared to just 13% reporting exercising more. Women have decreased exercise more than men (43% decreasing vs 38%).
- Conversely, activities that have particularly increased include working (34% working more vs just 15% working less), and watching television, streaming films, and gaming (19% doing these activities more and just 13% doing them less). Younger adults have increased their working (45% vs 21% of adults over 60) and are compensating with less time watching television (28% of younger adults reporting a decrease vs 6% of older adults). By contrast, 20% of older adults have increased their time spent watching television.
- In terms of diet, 71% of participants reported that their food consumption had been about the same as in the first lockdown, with equal numbers (15% and 14%) respectively reporting that they had eaten less or more. The quality of the diet had also largely stayed the same (for 72% of participants), with 11% reporting that they were eating a healthier diet than during the first lockdown and 17% reporting a worse diet.
- Of our sample, 13% reported smoking. Of these, 61% reported smoking the same amount that they did during first lockdown, whilst an even number reported increasing and decreasing their smoking (20% vs 19%). Of our sample 70% reported drinking alcohol. Of these, 57% reported drinking the same amount as in first lockdown, with 30% drinking less and 14% drinking more.
- The pandemic continues to affect mental health. Depression and anxiety levels are the worst they've been since June 2020, with clear worsening since the summer. Stress about catching Covid-19 or becoming seriously ill from it is substantially higher than in the autumn, especially since news of the new more contagious variant was released. Around 45% of people are now worried; the highest level since the middle of the first lockdown back in April. Life satisfaction has continued to deteriorate in lockdown, with levels now comparable to those near the start of lockdown in spring 2020. Happiness levels have further decreased in the past few month during lockdown, reaching levels that are lower than during lockdown in April 2020.

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COVID-19 Crisis in Central African Republic

In cooperation with Bundeswehr HQ of Military Medicine

Central African Republic

Area:	622,984 km^2
Population:	4,666,368
Capital:	Bangui
Age structure:	
0-14 years:	39,49%
15-24 years:	19,89%
25-54 years:	32,95%
55-64 years:	4,32%
65 years and over:	3,35%

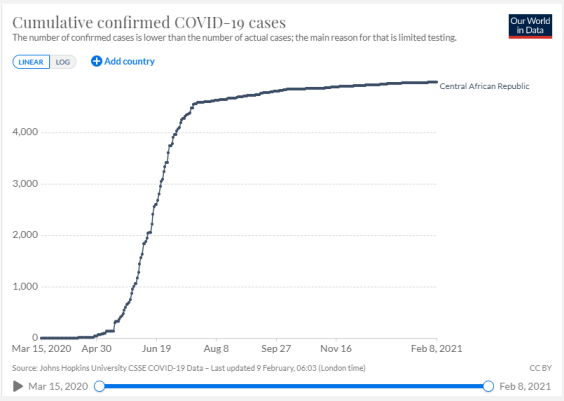
CONFLICT:
The humanitarian disaster in the middle of Africa

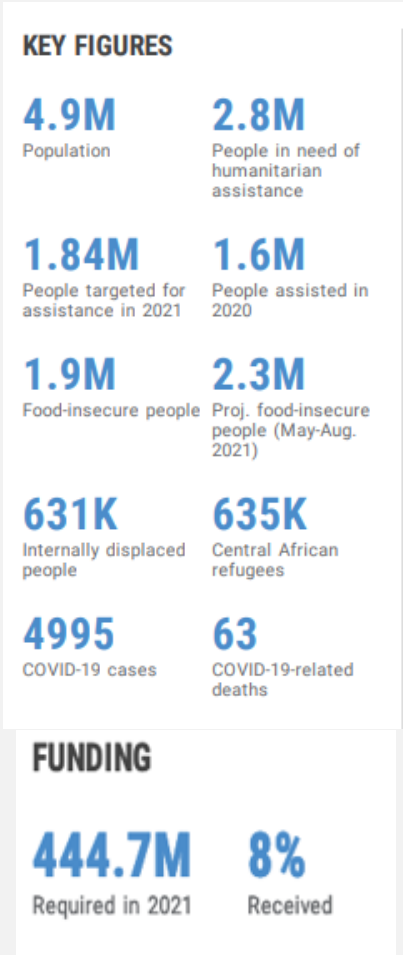
The Central African Republic, as one of the states that always ranks at the bottom on all humanitarian and conflict rankings, has been subject to military revolts, coups and attempts at overthrowing, in part, since it was released from French colonial rule in 1960 was involved. These have paved the way to the end of the scale for decades. Since 2012, the increasing religious conflict between Islamic and Christian residents in the sub-Saharan region has made matters worse. Islamic militias from the north of the country (Seleka) conquered the capital Bangui in 2013 and their leader appointed himself the new president. The 4.6 million inhabitants, who lived together peacefully for decades before the religious conflicts that arose, elected Faustin Archange Touadéra as the new president in 2016 following the resignation of the militia leader and an interim president. A new constitution also came into force. In addition to this development, external players such as Russia and France in particular are trying to expand their influence in this resource-rich (gold, coltan, manganese, oil, uranium or diamonds) country and are influencing the various conflicting parties in the background to assert their interests. In 2013, the United Nations mandated the UN mission MINUSCA, which has since been accused of rape and abuse by contingent members. The elections held at the end of last year and the renewed success of Touadéra are not recognized by the defeated opposition. The situation has escalated in recent weeks and the fighting and violent clashes between the conflicting parties continue to this day. The violent conflict is currently spreading across the country. The Secretary General of the United Nations yesterday called on the conflicting parties to a ceasefire and repeated the call for a "Global Ceasefire in the context of COVID-19". He also deplored the new casualties and displaced persons among the civilian population and among United Nations officials. On February 1st, OCHA reported on the resulting humanitarian situation, approx. 226,000 IDPs in the last 6 weeks of which 129,000 have returned to their hometowns. 92,000 refugees fled to the Democratic Republic of the Congo and 13,200 to Cameroon. The security situation prevents essential transports via the main supply route from Cameroon and hundreds of trucks were stopped at the border. Aid organizations report critical stocks, especially of food and trauma kits. At the same time, the closure of the supply route will drive up the prices of basic foods by between 75 and 220 percent. Many markets across the country are closing because no new goods are being delivered. These ongoing conflicts, approx. 630,000 IDPs, approx. 630,000 refugees in the neighboring states and a non-existent health system form the breeding ground for a lasting one humanitarian catastrophe that occurs repeatedly or constantly in the Central African Republic. The country with the lowest life

expectancy in the world has been hit by various epidemics such as cholera, rabies and measles in recent years. The WHO is currently fighting a renewed measles outbreak, which has persisted and increased since the beginning of 2019. The WHO classifies the risk of this as high for the Central African Republic in the meantime. The factors assessed for this also offer the reason for the SARS-CoV-2 virus, which is now spreading in the Central African Republic, to classify its risk of infection as high. These factors include the poor security situation, which prevents access to possible outbreak regions, a lack of infrastructure (including laboratory capacity) and the provision of free health care, large movements within the population and the lack of personnel for clinical management of an outbreak. At the same time, seven ventilators are now available from a total of 25 approved throughout the country. As assessed by the Global Health Security Index, there are hardly any health facilities at all levels of care, qualification of staff and treatment measures, laboratory capacities and SOPs such as equipment for infection protection in the health sector virtually non-existent.

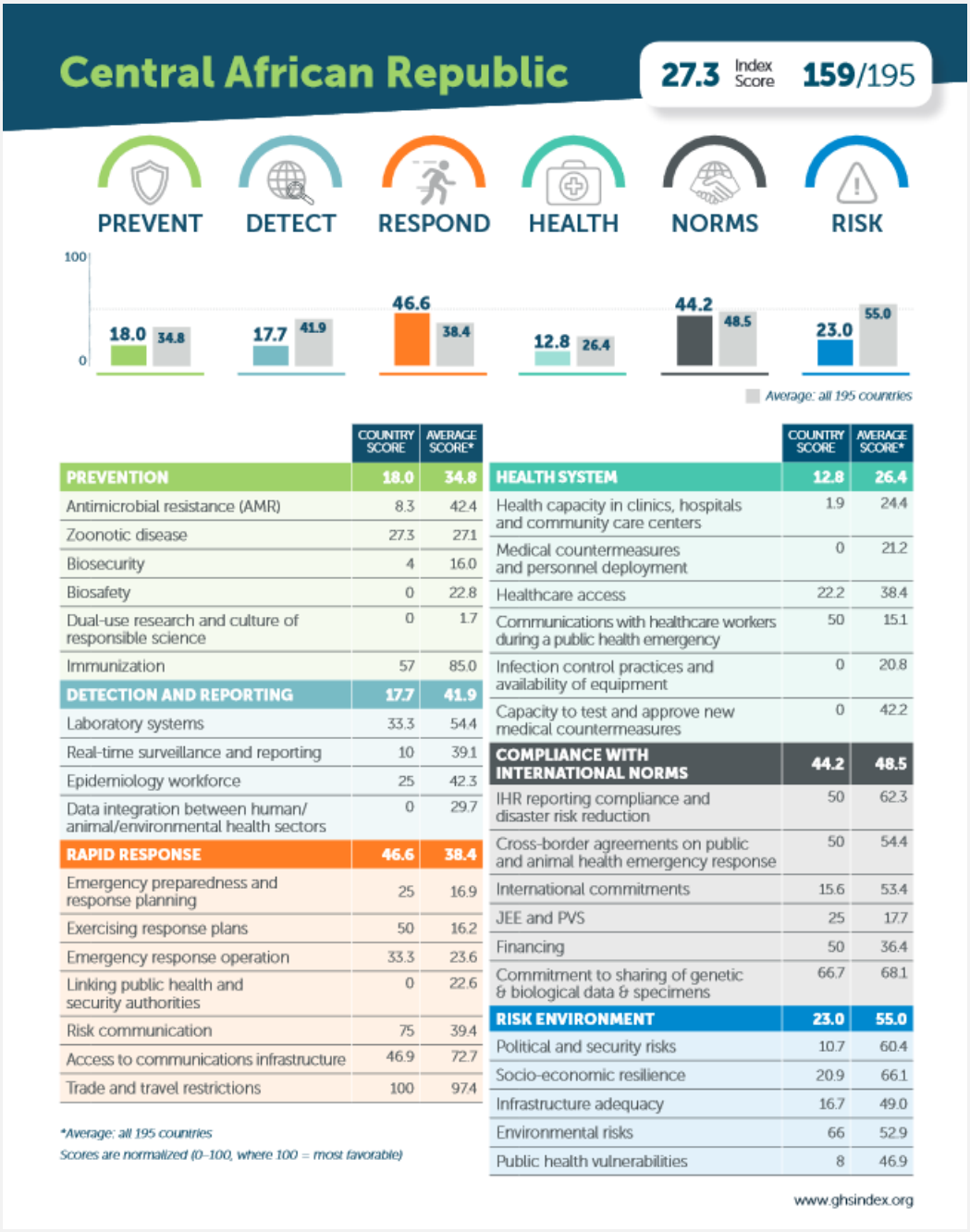
HEALTH:

So far, **4995 cases of SARS-CoV-2 / COVID-19 and 63 deaths** have been confirmed (possibly a very high number of unreported cases - with hardly any laboratory capacity for detection). That is less than 150 cases more than 3 months ago in the last post about the Central African Republic. All seven regions of the country are affected, with a focus on Bangui, the capital with around 17% of the total population. The United Nations warned that the decrease in the number of cases since July (see graphic above left) must be assessed with caution, especially since from this point in time relaxation and school openings came into force again. After the first case was imported on March 14th by a 74-year-old Italian missionary. However, this import from Europe has led to great distrust, resentment and violence against foreigners in the Central African population. After various theories initially circulated in the newspapers and on social media that France and Italy would wipe out the population, destabilize the country or promote impoverishment by importing the virus, support for fighting pandemics is now being provided by NGOs and the WHO sought and used. The WHO rates the Central African Republic as one of the least prepared countries for COVID 19. Isolation facilities, medical aid and support in risk communication were provided by the UN and aid organizations. At the same time, health committees at the local level were supported in implementing the national pandemic plan. The measures introduced, such as closing the border with neighboring countries, had increased the price of imported goods by over 30 percent. At the same time, domestic transport costs have increased by over 60 percent as a result of the “social distancing” measures introduced. The United Nations had imposed exit restrictions on its employees and soldiers in order to prevent possible attacks and hostility. In spite of all this, attacks on the staff took place regularly. The personnel of the humanitarian aid organizations, however, provide 70 percent of the rudimentary health care and the population is directly dependent on it. The group most affected are believed to be the 631,000 Internally Displaced People. The United Nations also reports that around 1.9 million people suffer from extreme "food insecurity" despite the aid provided. They also report that only 8 percent of the required financial aid of 444.7 million US dollars is financed and that





essential financial resources for crisis management are lacking. Conclusion: The disastrous humanitarian situation in the Central African Republic has worsened considerably as a result of the pandemic and its health and socio-economic consequences. Adding to this deterioration is the escalation of violence across the country, which continues to negatively affect the situation. Significant (especially financial) resources are required to successfully combat COVID-19. The prospect of adequate humanitarian support in general or in particular in the shadow of the COVID-19 outbreak cannot be foreseen under the current circumstances.



	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**18.0**	**34.8**
Antimicrobial resistance (AMR)	8.3	42.4
Zoonotic disease	27.3	27.1
Biosecurity	4	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	57	85.0
DETECTION AND REPORTING	**17.7**	**41.9**
Laboratory systems	33.3	54.4
Real-time surveillance and reporting	10	39.1
Epidemiology workforce	25	42.3
Data integration between human/ animal/environmental health sectors	0	29.7
RAPID RESPONSE	**46.6**	**38.4**
Emergency preparedness and response planning	25	16.9
Exercising response plans	50	16.2
Emergency response operation	33.3	23.6
Linking public health and security authorities	0	22.6
Risk communication	75	39.4
Access to communications infrastructure	46.9	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**12.8**	**26.4**
Health capacity in clinics, hospitals and community care centers	1.9	24.4
Medical countermeasures and personnel deployment	0	21.2
Healthcare access	22.2	38.4
Communications with healthcare workers during a public health emergency	50	15.1
Infection control practices and availability of equipment	0	20.8
Capacity to test and approve new medical countermeasures	0	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**44.2**	**48.5**
IHR reporting compliance and disaster risk reduction	50	62.3
Cross-border agreements on public and animal health emergency response	50	54.4
International commitments	15.6	53.4
JEE and PVS	25	17.7
Financing	50	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	**23.0**	**55.0**
Political and security risks	10.7	60.4
Socio-economic resilience	20.9	66.1
Infrastructure adequacy	16.7	49.0
Environmental risks	66	52.9
Public health vulnerabilities	8	46.9

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

www.ghsindex.org

Source:
https://www.unocha.org/story/daily-noon-briefing-highlights-central-african-republic-ethiopia-myanmar
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https://www.bpb.de/internationales/weltweit/innerstaatliche-konflikte/185581/zentralafrikanische-republik

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 • Resilience strategies from the private sector At the last VTC, the private companies International SOS, GIDEON, MIGITA solution and MI2 introduce themselves and presented how their companies can support public institutions in order to support the fight against the current pandemic.
International SOS	---------- They are in the business of saving and protecting lives, when involved in health or security situations. More than 10,000 multi-cultural health, security and logistics experts stand by to provide support and assistance from over 1,000 locations in 85 countries. International SOS has 26 Assistance Centres with local experts worldwide for 24/7 and they provide clients with immediate access to experts with extensive experience in all fields of medicine coupled with a thorough knowledge of the local environment and healthcare system. They have an 24/7 access to travel security reporting, analysis and expert advice from there security consultants, analysts and tracking experts around the world and an accredited, integrated network of 62 clinics and 900 remote site projects around the world. Practicing a supervised international standard of medicine - in developed and emerging countries, offshore and remote locations. They also have access to a network of accredited healthcare, aviation and security providers ensuring to provide clients with the best logistics in the air, on the ground and at sea. https://www.internationalsos.com/

GIDEON	GIDEON is a medical decision support web application and ebooks series covering infectious diseases and microbiology. GIDEON Informatics, founded in 1992, produces the GIDEON web application and GIDEON ebook series, targeted towards health professionals and educators. Hundreds of customers from around the world, including educational institutions, hospitals, public health departments and military organizations, have chosen GIDEON as their diagnosis and reference tool for Infectious Diseases and Microbiology. GIDEON Informatics is managed by an experienced executive team and maintains a distinguished medical advisory board. **GIDEON is helping to tackle COVID-19 to provide:** • Comprehensive distribution data and maps with rates per 100,000 persons • Detailed descriptions of clinical & laboratory findings, therapy notes, risk groups, and imaging studies • Daily updates to ensure the most current and relevant information is available without delay https://www.gideononline.com/
MITIGA solution	--- MITIGA Solutions is a spin-off of the Barcelona Supercomputing Center, a world-renowned institution with over two decades of experience in developing and implementing models in the fields of geophysics, volcanology and atmospheric science under one roof. The Center houses Mare Nostrum, one of the most powerful supercomputers in Europe. Due to this they bring this expertise together with computational resources to help make the world safer and more resilient against natural hazards. Migita bridge the gap between scientific research and operational impact, helping clients manage their risks and make their decision-making more accurate, reliable and timely. • Data, algorithms, and machine learning to uncover novel insights from historical records. • Tailored spatial and temporal high-resolution forecasting with 24/7 alerts. • Deterministic and stochastic models to quantify risks and create high-performance indices. • High-end interactive data viz to help clients make quicker, more informed decisions. • Access to leading experts and to one of the most powerful supercomputers in Europe. https://www.mitigasolutions.com/
M2 Medical Intelligence	--- M2 Medical Intelligence manage complex data to produce easy to understand outputs, resulting in cost-effective improvements in hospital emergency preparedness and response. They marry world-leading health security intelligence with emergency management to produce a world class solution for today's difficult-to-predict emergencies. • On December 30, 2019, the M2 health security intelligence team detected report of unusual respiratory disease reported in Wuhan, China. The following day, M2 issued public notice of the Wuhan situation representing the lead crisis they were monitoring globally, and the crisis was heavily linked to San Francisco by direct, non-stop air traffic. • On Jan 1st, M2 notified the World Health Organization we were monitoring, and the communication signal pattern did not match SARS 2002-2003- an assessment validated nearly a week later with the discovery of a novel coronavirus. • On January 5th, M2 issues the first of multiple health security risk reports to its clients, emphasizing awareness as the first step to preparedness, with emphasis to check a travel history to protect the integrity of the core critical care elements of hospitals. • On February 4th, M2 escalated its warning to clients. On March 22nd, this warning was escalated further based on medical infrastructure collapse reported by Lombardia, Italy. Four days later, M2, based on health security intelligence gathered from multiple countries experiencing first contact with COVID, designed and implemented a comprehensive hospital surveillance system in 10 days that is the first of its kind in the United States. This system is currently used to support the state of Nevada's emergency response to COVID.

	• In August, researchers reported a significant mutation in the virus that may have contributed to enhanced transmission- this mutation first appeared in Italy in late February, with dramatic impact on Lombardia's medical infrastructure reported during this period. M2 was unaware of the mutation, however leveraged its expert analysis to recognize a substantive change in the threat pattern of the virus and escalated warning to M2's clients accordingly. https://www.m2medintel.com/ **Next VTC will take place on 10th of February 2021 on the subject of "Vaccination: News and Facts"**

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:

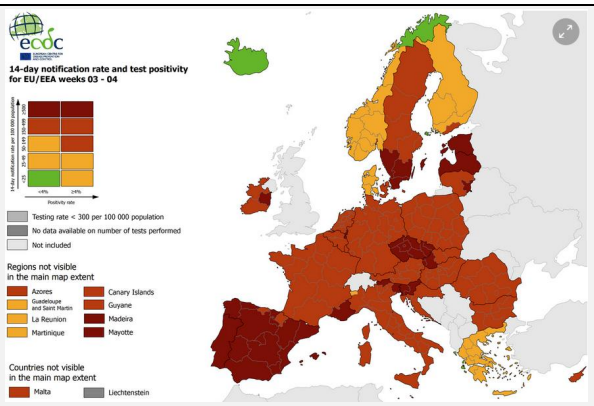
On 13 May, the European Commission presented guidelines and recommendations to help Member States gradually lift travel restrictions, with all the necessary safety and precautionary means in place.

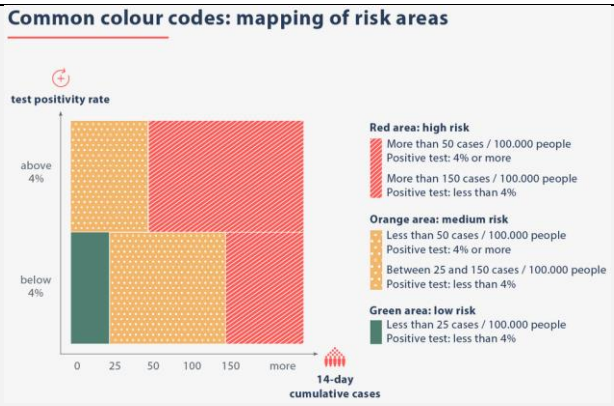
On 13 October, EU Member States adopted a Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic.

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*)

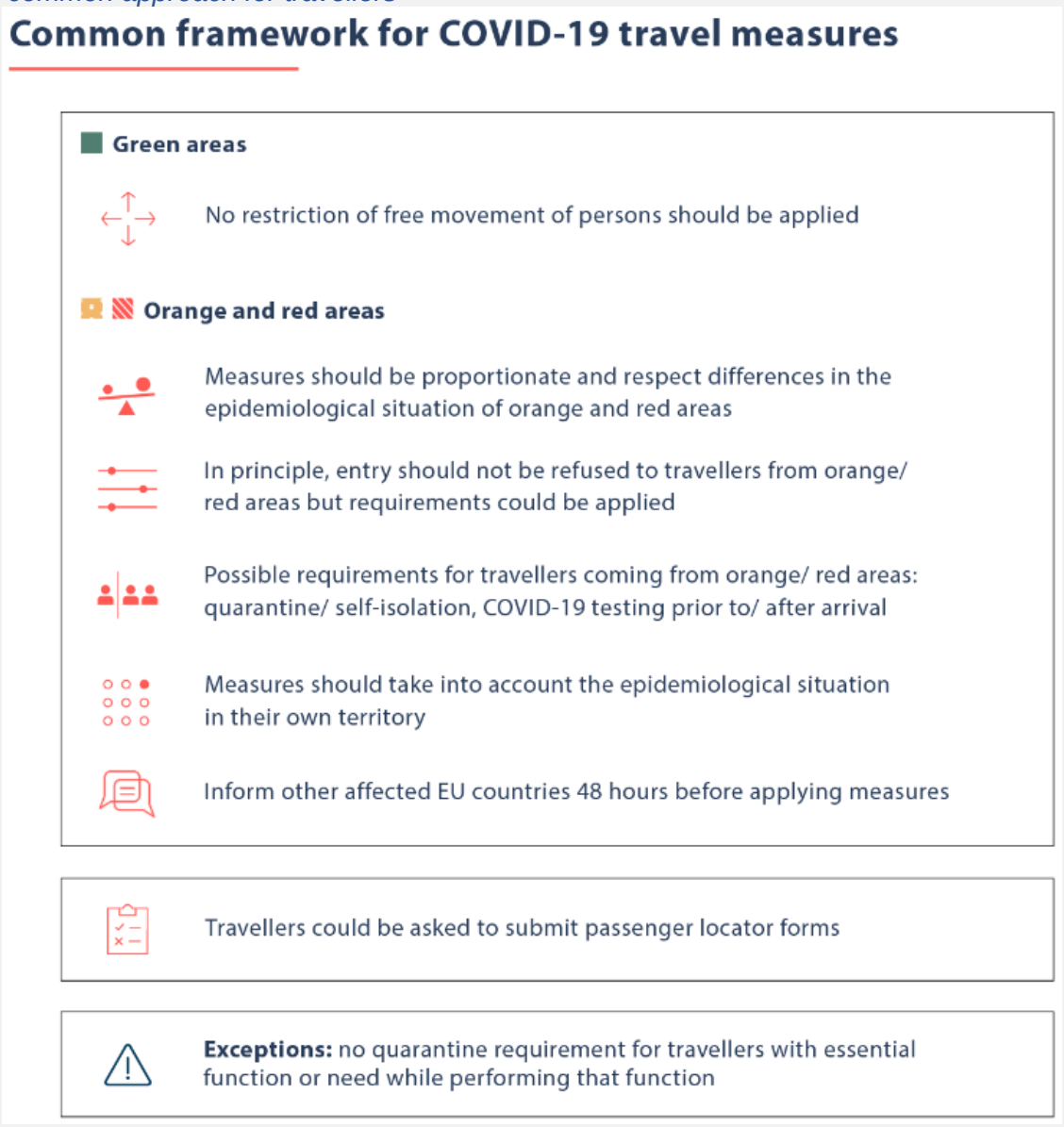
2. A common map
The ECDC will publish a map of EU Member States, broken down by regions, which will show the risk levels across the regions in Europe using a traffic light system. See also "Situation in Europe".

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.





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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