



Update 64 (07th of April 2021)

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



**Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE
in Munich
07th of April 2021
email: info.dhsc@coemed.org**

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

HIGHLIGHTS/NEWS

- The **WHO** has criticised the speed of the vaccination campaign in Europe as too slow. The production of vaccines must be boosted, while bureaucracy must be reduced.
- **WHO:** The [report of the international team](#) on their Wuhan field visit, from 14 January -10 February 2021, was published on the 30 March.
- **WHO:** Calls for [further studies, data on origin of SARS-CoV-2 virus](#), reiterates that all hypotheses remain open.
- **EU/AUS:** The EU is blocking the export of 3.1 million doses of the AstraZeneca vaccine, according to the Australian government. So far, only 250,000 doses of the vaccine have been delivered to Australia from the EU. Australia is 83 per cent behind original plans for vaccination. The EU has denied the allegations. There would be no new delivery freeze. The Commission has so far rejected one of 491 vaccine export applications. This was 250,000 doses for Australia. Seven applications are still under review.
- **GBR:** The UK Medicines and Healthcare Regulatory Agency (MHRA) reported 30 cases of blood clots associated with the AZ vaccine. However, it reported that the risks of the vaccine are still outweighed by the risk of COVID-19.
- **EMA:** Following comments by an EMA official about a link between the Corona vaccination with the AstraZeneca vaccine and the occurrence of rare blood clots, the EU Medicines Agency has made it clear that it has not yet taken a decision on the matter. The EMA's Committee on Drug Safety "has not yet reached a conclusion and the investigation is ongoing," the EU authority told the AFP news agency. A decision is expected to be announced on Wednesday or Thursday.
- **COVAX:** Over 33 million doses of COVID vaccines have been distributed to 74 participants with Vietnam and Belize being the most recent recipients.
- **CDC:** Updated guidance on travel options for fully immunized people has been [released](#). Testing and quarantine restrictions have been lifted for fully vaccinated people when they travel within the US however NPIs should be followed. Quarantine and testing requirements remain for international travel.
- **WHO:** The evaluation process and status for COVID vaccines have been [published](#). Decisions on Sinopharm, Sinovac and Moderna are expected in mid-April.

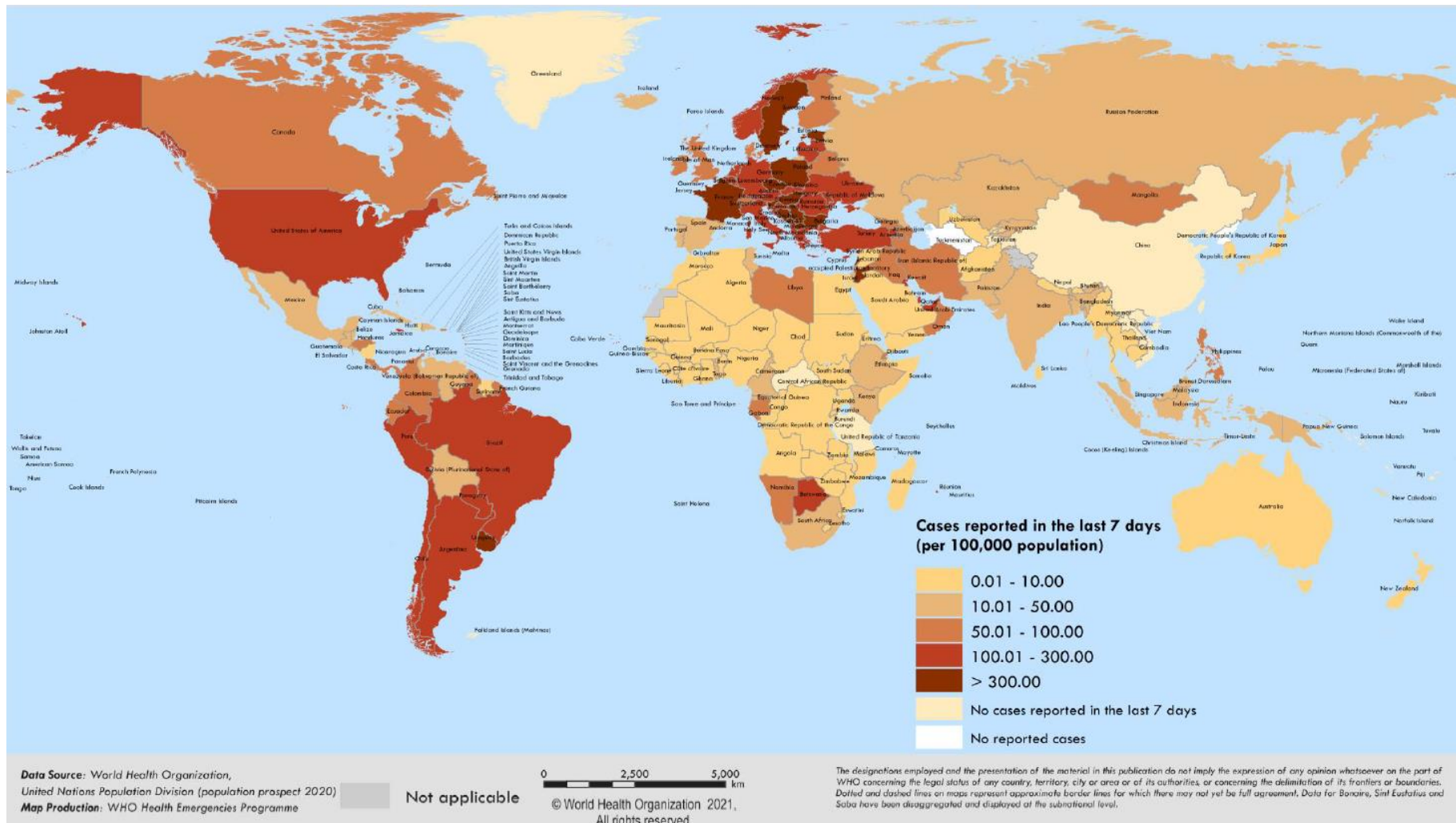
GLOBALLY ↗ 127 613 570 confirmed cases 72 385 200 recovered 2 791 641 deaths
EU/EEA and the UK ↗ 42 538 275 confirmed cases 23 076 750 recovered 938 002 deaths
USA ↘ (new cases/day 36 774) 30 212 731 confirmed cases xx recovered 547 726 deaths
Brazil → (new cases/day 44 326) 12 573 615 confirmed cases 11 022 192 recovered 313 866 deaths
India ↗ (new cases/day 68 020) 12 039 644 confirmed cases 11 355 993 recovered 161 843 deaths
France ↘ (new cases/day 9 094) 4 554 683 confirmed cases 290 810 recovered 94 956 deaths
Russia → (new cases/day 8 589) 4 477 916 confirmed cases 4 099 263 recovered 96 413 deaths

Please click on the headlines to jump into the document

Table of Contents

HIGHLIGHTS/NEWS	1
Map of countries with reported COVID-19 cases (last 7 days), as of 22 to 28 March 2021	3
Worldwide Situation	4
<i>Global Situation</i>	4
<i>Situation in Europe</i>	10
Subject in Focus	13
<i>COVID in Africa</i>	13
Conflict and Health	15
<i>NIGERIA</i>	15
MilMed CoE VTC COVID-19 response	18
<i>Topics former VTCs</i>	18
Recommendations	19
<i>Recommendations for international business travellers</i>	19
Risk Assessment	23
<i>Global</i>	23
<i>Europe</i>	23
References:	24
Disclaimer:	24

Map of countries with reported COVID-19 cases (last 7 days), as of 22 to 28 March 2021



Shading/gradient fill of areas does not reflect a regional risk assessment but illustrates the country-wide assessment, e.g., areas shaded green to orange do not have low risk in the green areas and moderate risk in the orange areas but "low to moderate" risk country-wide.

Worldwide Situation

Global Situation

Global overview, as of 28 March 2021; WHO

Globally, new COVID-19 cases rose for a fifth consecutive week, with just over 3.8 million new cases reported in the last week. The number of new deaths increased for the second consecutive week, increasing by 5% compared to last week, with over 64 000 new deaths reported.

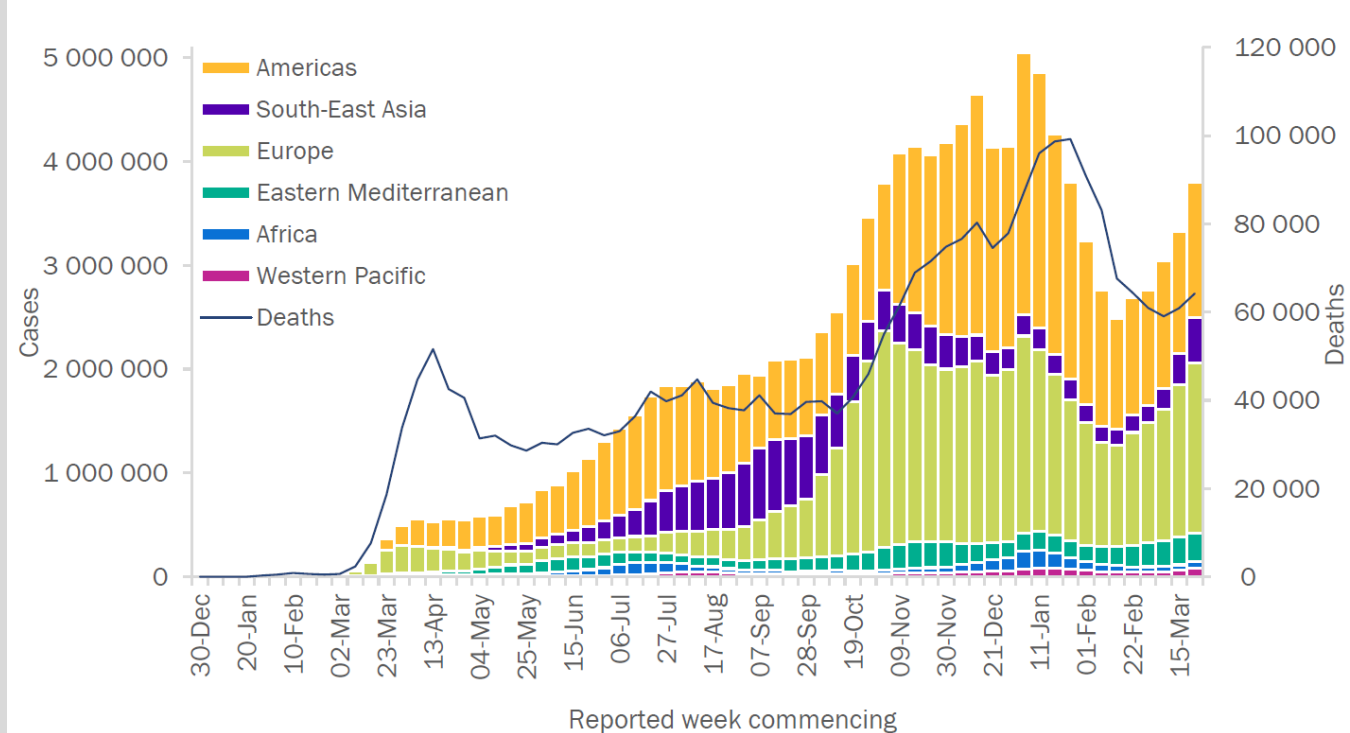
All regions reported an increase in the number of cases this week, with the largest increases in the South-East Asia, Western Pacific, and African Regions, all of which have been on an upward trajectory in recent weeks.

All regions, except for the African Region, reported an increase in the number of deaths, with the largest increase of 21% from the South-East Asia Region, which is on its third week of an increasing trend.

The European Region and the Region of the Americas continue to account for approximately 80% of all new and cumulative cases and deaths.

The highest numbers of new cases were reported from **Brazil** (533 024 new cases; 5% increase), the **United States of America** (421 936 new cases; 13% increase), **India** (372 494 new cases; 55% increase), **France** (254 228 new cases; 24% increase), and **Poland** (192 441 new cases; 27% increase).

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 28 March 2021**

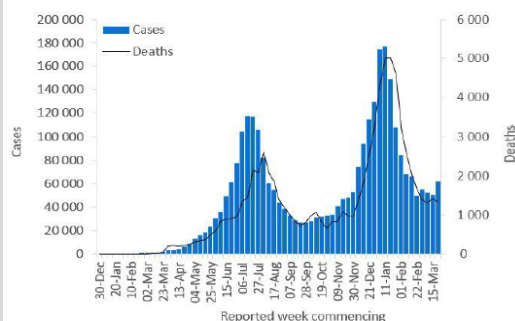


WHO regional overviews

African Region

After reporting a decline in new cases for two consecutive weeks, the African Region reported a 22% increase in new cases (>62 000 cases) compared to the previous week, and over 1300 new deaths, a 6% decrease. The highest numbers of new cases were reported from Ethiopia (13 153 new cases; 11.4 new cases per 100 000 population; a 14% increase) and Kenya (9167 new cases; 17 new cases per 100 000; a 25% increase).

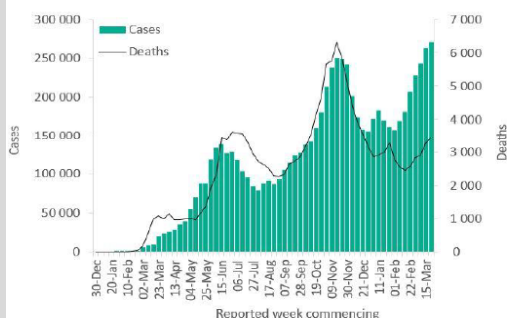
The highest numbers of new deaths were reported from South Africa (566 new deaths; one new death per 100 000 population; a 31% decrease) and Ethiopia (137 new deaths; <0.1 new deaths per 100 000; a 28% increase).



Eastern Mediterranean Region

The Eastern Mediterranean Region reported just under 271 000 new cases and over 3400 new deaths, a 3% and a 5% increase respectively compared to the previous week. Both cases and deaths are on an upward trajectory with new cases increasing for the past seven weeks and deaths for the past five weeks. The highest numbers of new cases were reported from Jordan (55 467 new cases; 543.6 new cases per 100 000; a 4% decrease), the Islamic Republic of Iran (53 118 new cases; 63.2 new cases per 100 000; a 2% decrease), and Iraq (37 767 new cases; 93.9 new cases per 100 000; an 8% increase).

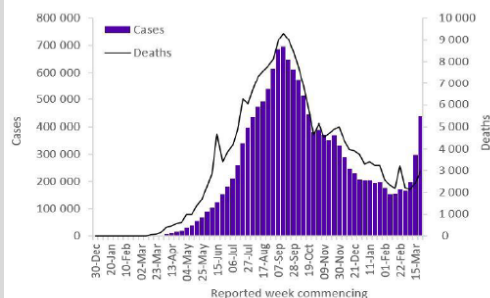
The highest numbers of new deaths were reported from Jordan (684 new deaths; 6.7 new deaths per 100 000; a 36% increase), the Islamic Republic of Iran (584 new deaths; 0.7 new deaths per 100 000; similar to last week), and Pakistan (359 new deaths; 0.2 new deaths per 100 000; an 11% increase).



South-East Asia Region

The South-East Asia Region reported over 437 000 new cases and just under 3000 new deaths, a 46% and a 21% increase respectively compared to the previous week. Cases in the Region have been steadily increasing over the past three weeks, with a sharp increase in the past two weeks. Almost 85% of cases in the Region over the past week were from India which reported 372 494 new cases (27 new cases per 100 000; a 55% increase). The other countries reporting the highest numbers of new cases in the Region were Indonesia (36 214 new cases; 13.2 new cases per 100 000; a 12% decrease) and Bangladesh (23 100 new cases; 14.0 new cases per 100 000; an 85% increase).

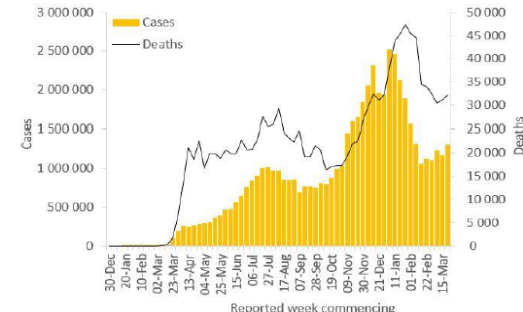
The highest numbers of new deaths were reported from India (1797 new deaths; <0.1 new deaths per 100 000; a 57% increase), Indonesia (917 new deaths; 0.3 new deaths per 100 000; an 18% increase), and Bangladesh (201 new deaths; <0.1 new deaths per 100 000; a 43% increase).



Region of the Americas

The Region of the Americas reported over 1.3 million new cases and over 32 000 new deaths, an 11% and 4% increase respectively compared to the previous week. Overall, there has been an increasing trend in weekly reported cases in the last five weeks. A slight increase in new deaths has been reported in the last two weeks after a decline in deaths for the six prior weeks. The highest numbers of new cases were reported from Brazil (533 024 new cases; 250.8 new cases per 100 000; a 5% increase), the United States of America (421 936 new cases; 127.5 new cases per 100 000; a 13% increase), and Peru (60 739 new cases; 184.2 new cases per 100 000; a 24% increase).

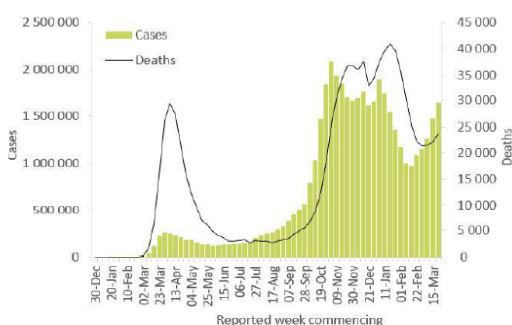
The highest numbers of new deaths were reported from Brazil (16 798 new deaths; 7.9 new deaths per 100 000; a 10% increase), the United States of America (6995 new deaths; 2.1 new deaths per 100 000; a 7% decrease), and Mexico (3643 new deaths; 2.8 new deaths per 100 000; an 8% increase).



European Region

The European Region reported over 1.6 million new cases and just under 24 000 new deaths in the past week, an 11% and a 7% increase respectively compared to the previous week. The number of new cases in the Region has been steadily increasing over the past five weeks while the number of new deaths has increased for the past three weeks. The highest numbers of new cases were reported from France (254 228 new cases; 389.5 new cases per 100 000; a 24% increase), Poland (192 441 new cases; 508.5 new cases per 100 000; a 27% increase), and Turkey (186 421 new cases; 221.0 new cases per 100 000; a 47% increase).

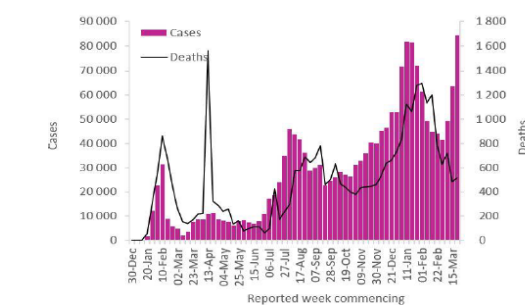
The highest numbers of new deaths were reported from Italy (2994 new deaths; 5.0 new deaths per 100 000; an 8% increase), the Russian Federation (2710 new deaths; 1.9 new deaths per 100 000; an 8% decrease), and Poland (2584 new deaths; 6.8 new deaths per 100 000; a 22% increase).



Western Pacific Region

The Western Pacific Region reported over 84 000 new cases and just over 500 new deaths, a 32% and a 7% increase respectively compared to the previous week. The Region has reported a steep increase in the number of new cases over the past three weeks. The highest numbers of new cases were reported from the Philippines (56 380 new cases; 51.5 new cases per 100 000; a 43% increase), Japan (11 211 new cases; 8.9 new cases per 100 000; a 28% increase), and Malaysia (8929 new cases; 27.6 new cases per 100 000; a 4% decrease).

The highest numbers of new deaths were reported from the Philippines (229 new deaths; 0.2 new deaths per 100 000; a 40% increase), Japan (219 new deaths; 0.2 new deaths per 100 000; a 13% decrease), and the Republic of Korea (26 new deaths; <0.1 new deaths per 100 000; a 4% decrease).



Update on SARS-CoV-2 Variants

Table 3: Overview of emerging information on variants of concern, as of 30 March 2021*

Nextstrain clade	20I/501Y.V1	20H/501Y.V2 [†]	20J/501Y.V3
PANGO lineage	B.1.1.7	B.1.351	B.1.1.28.1, alias P.1 [†]
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01 [†]	VOC 202012/02	-
First detected by	United Kingdom	South Africa	Brazil / Japan
Earliest sample date	20 September 2020	Early August 2020	December 2020
Key spike mutations	H69/V70 deletion; Y144 deletion; N501Y; A570D; and P681H	L242/A243/L244 deletion; K417N E484K, N501Y	K417T, E484K; N501Y
Key mutation in common	S106/G107/F108 deletion in Non-Structural Protein 6 (NSP6)		
Countries reporting cases (newly reported in last week)**	130 (5)	80 (5)	45(4)

Overview of variants of interest (VOIs), as of 30 March 2021*

Nextstrain clade	20C	20C/S.452R	20B/S.484K	Not yet assigned	20C	20C
PANGO lineage	B.1.525	B.1.427/B.1.429	B.1.1.28.2, alias P.2	B.1.1.28.3 alias P.3	B.1.526 (with E484K or S477N)	B.1 descendant with 9 mutations
GISAID clade	G/484K.V3	GH/452R.V1	GR	Not yet assigned	GH	GH
Alternate names		CAL.20C/L452R		PHL-B.1.1.28		
First detected by	United Kingdom and Nigeria	United States of America	Brazil	Philippines and Japan	United States of America	France
First appearance	December 2020	June 2020	April 2020	February 2021	November 2020	January 2021
Key spike mutations	H69-V70 deletion; Y144 deletion; Q52R; E484K; Q677H; D614G; and F888L	L452R; W152C; S13I; and D614G	L18F; T20N; P26S; F157L; E484K; D614G; S929I; and V1176F	141-143 deletion; E484K; N501Y; and P681H	L5F; T95I; D253G; D614G; A701V; and E484K or S477N	G142 deletion; D66H; Y144V; D215G; V483A; D614G; H655Y; G669S; Q949R; and N1187D

Source: <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---31-march-2021>

WHO global study of origins of SARS-CoV-2

In May 2020, WHO was requested to identify the zoonotic source of the virus and the route of introduction to the human population, including the possible role of intermediate hosts. The aim is to prevent both reinfection with the virus in animals and humans and the establishment of new zoonotic reservoirs, thereby reducing further risks of the emergence and transmission of zoonotic diseases.

In July 2020, WHO and China began the groundwork for studies to better understand the origins of the virus. A joint international team comprised 17 Chinese and 17 international experts was set up. Following initial online meetings, a joint study was conducted over a 28-day period from 14 January to 10 February 2021 in the city of Wuhan, People's Republic of China.

The epidemiology working group closely examined the possibilities of identifying earlier cases of COVID-19 through studies from surveillance of morbidity due to respiratory diseases in and around Wuhan in late 2019. It also drew on national sentinel surveillance data; laboratory confirmations of disease; reports of retail pharmacy purchases for antipyretics, cold and cough medications; a convenience subset of stored samples of more than 4500 research project samples from the second half of 2019 stored at various hospitals in Wuhan, the rest of Hubei Province and other provinces. In none of these studies was there evidence of an impact of the causative agent of COVID-19 on morbidity in the months before the outbreak of COVID-19.

Furthermore, surveillance data on all-cause mortality and pneumonia-specific mortality from Wuhan city and the rest of Hubei Province were reviewed. The documented rapid increase in all-cause mortality and pneumonia-specific deaths in the third week of 2020 indicated that virus transmission was widespread among the population of Wuhan by the first week of 2020. The steep increase in mortality that occurred one to two weeks later among the population in the Hubei Province outside Wuhan suggested that the epidemic in Wuhan preceded the spread in the rest of Hubei Province.

Many of the early cases were associated with the Huanan market, but a similar number of cases were associated with other markets and some were not associated with any markets. Transmission within the wider community in December could account for cases not associated with the Huanan market which, together with the presence of early cases not associated with that market, could suggest that

the Huanan market was not the original source of the outbreak. Other milder cases that were not identified, however, could provide the link between the Huanan market and early cases without an apparent link to the market. No firm conclusion therefore about the role of the Huanan market in the origin of the outbreak, or how the infection was introduced into the market, can currently be drawn.

The molecular epidemiology and bioinformatics working group examined the genomic data of viruses collected from animals. Evidence from surveys and targeted studies so far have shown that the coronaviruses most highly related to SARS-CoV-2 are found in bats and pangolins, suggesting that these mammals may be the reservoir of the virus that causes COVID-19. However, neither of the viruses identified so far from these mammalian species is sufficiently similar to SARS-CoV-2 to serve as its direct progenitor. In addition to these findings, the high susceptibility of mink and cats to SARS-CoV-2 suggests that additional species of animals may act as a potential reservoir. All sequence data from samples collected in December 2019 and January 2020 were subjected to deeper analysis to see the diversity of viruses in the first phases of the outbreak. For the cases detected in Wuhan, data on samples from cases with illness onset before 31 December 2019 were linked with epidemiological background data. Several samples from patients with exposure to the Huanan market had identical virus genomes, suggesting that they may have been part of a cluster. However, the sequence data also showed that some diversity of viruses already existed in the early phase of the outbreak in Wuhan, suggesting unsampled chains of transmission beyond the Huanan market cluster. There was no obvious clustering by the epidemiological parameters of exposure to raw meat or furry animals.

In addition, the time to the most recent common ancestor of the SARS-CoV-2 sequences in the final dataset was estimated and compared with results from previous studies. Such analyses can be considered estimates but do not provide definitive proof of time of origins. Based on molecular sequence data, the results suggested that the outbreak may have started sometime in the months before the middle of December 2019. The point estimates for the time to the most recent ancestor ranged from late September to early December, but most estimates were between mid-November and early December.

The animal and environment working group reviewed existing knowledge on coronaviruses that are phylogenetically related to SARS-CoV-2 identified in different animals, including horseshoe bats (*Rhinolophus* spp) and pangolins. However, the presence of SARS-CoV-2 has not been detected through sampling and testing of bats or of wildlife across China. More than 80 000 wildlife, livestock and poultry samples were collected from 31 provinces in China and no positive result was identified for SARS-CoV-2 antibody or nucleic acid before and after the SARS-CoV-2 outbreak in China. Through extensive testing of animal products in the Huanan market, no evidence of animal infections was found.

Environmental sampling in Huanan market from right at the point of its closing showed out of 923 environmental samples in Huanan market, 73 samples were positive. This revealed widespread contamination of surfaces with SARS-CoV-2, compatible with introduction of the virus through infected people, infected animals or contaminated products. There is evidence that some domesticated wildlife the products of which were sold in the market are susceptible to SARS-CoV, but none of the animal products sampled in the market tested positive in this study.

SARS-CoV-2 has been found to persist in conditions found in frozen food, packaging and cold-chain products. Index cases in recent outbreaks in China have been linked to the cold chain; the virus has been found on packages and products from other countries that supply China with cold-chain products, indicating that it can be carried long distances on cold-chain products.

Outcome:

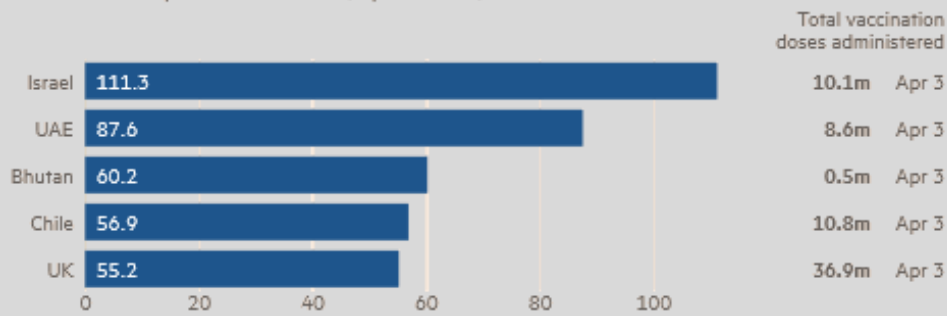
The joint international team examined four scenarios for introduction and done an assessment of likelihood of each possible pathway:

- direct zoonotic transmission to humans (spillover); considered to be a possible-to-likely pathway;
- introduction through an intermediate host followed by spillover; considered to be a likely to very likely pathway;
- introduction through the (cold) food chain; considered a possible pathway;
- introduction through a laboratory incident; considered to be an extremely unlikely pathway.

Source: <https://www.who.int/publications/item/who-convened-global-study-of-origins-of-sars-cov-2-china-part>

The global race to vaccinate

Doses administered per 100 residents (top locations)*



*Chart excludes territories with populations of less than 200,000

Figures have been compiled from a variety of sources and are subject to revision

Source: Our World in Data, national sources. Data updated April 5 2021 9:19AM GMT

© FT

Vaccination report

Country reports on vaccination

Moderna: According to researchers, the Moderna vaccine provides protection against coronavirus vaccinated people for at least six months. This is the conclusion of a study in the USA published in the New England Journal of Medicine.

USA: In New York, all adults over the age of 16 are now eligible to receive corona vaccination. To date, three vaccines have been approved in the US. Overall, more than a third of New Yorkers, nearly 20, have already received at least one dose of vaccination. An average of 200,000 doses are vaccinated every day. The U.S. government in Washington wants to achieve vaccination eligibility for all adults nationwide from April 19.

FRA: A mass vaccination campaign has begun at France's largest football stadium. People have been vaccinated against the coronavirus at the Stade de France in the northern Paris suburb of Saint-Denis since Tuesday. The aim is to administer 10,000 doses of vaccination a week in the stadium. Half of the vaccines will be given to residents of the Saint-Denis district, which is currently the most affected by the pandemic in France. The so-called seven-day incidence in the densely populated area had risen to more than 800 new infections per 100,000 inhabitants at the beginning of March. Most recently, it declined slightly.

ESP: By the end of July, 53 percent of the population of 47 million people is expected to be fully vaccinated. By the end of August, it should be 70 percent. The vaccination rate will pick up speed in April and then increase from month to month. According to data from Monday, 5.7 million Spaniards have received the first vaccination so far, and 2.8 million have already received the second.

POL: By the end of April, all citizens over the age of 60 should be allowed to have corona vaccination. Over the next two weeks, the country expects to deliver two million doses of vaccine

ISR: ha

Country Reports:

BRA: Amid the worsening pandemic, Brazil has registered for the first time more than 4,000 victims infected with the coronavirus in one day. Within 24 hours, 4,195 deaths were reported related to COVID-19. This may be due to the subsequent reporting of numerous deaths from the Easter holidays. So far, only the US has reported more than 4,000 deaths per day.

USA: Many vaccinations, but increasing numbers of cases of new infections: this is the corona situation in the USA. Authorities reported 78,279 new cases on Monday, according to data from Johns Hopkins University (JHU). That's about 8,800 more than a week ago.

IND: Infection rates remain high following recent highs for corona new infections. Nearly 97,000 cases have been recorded recently, according to figures from India's Ministry of Health on Tuesday. On Monday, more than 103,000 new cases were reported within 24 hours. It is feared that the number of infections will continue to rise significantly. The reasons for this are increasing carelessness among the population. More contagious viral mutants could also play a role. There are currently parliamentary elections in several states with large election events. In addition, hundreds of thousands of Indians flock to the holy river Ganges for the great pilgrimage festival Kumbh Mela - often without masks, as footage on the ground shows.

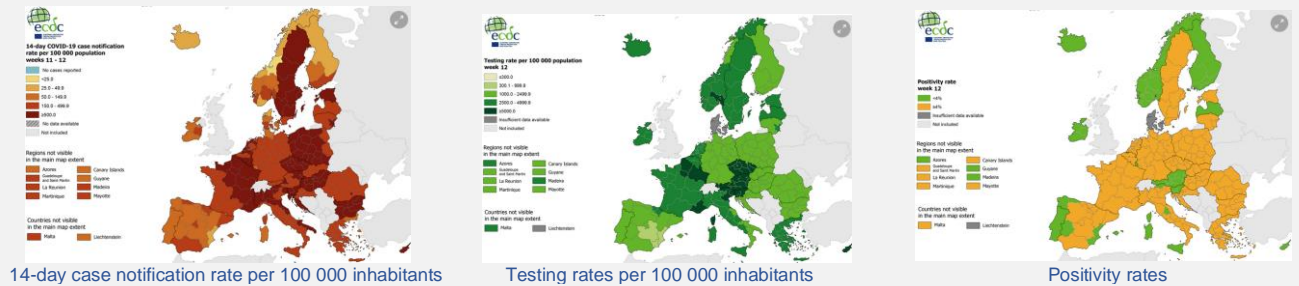
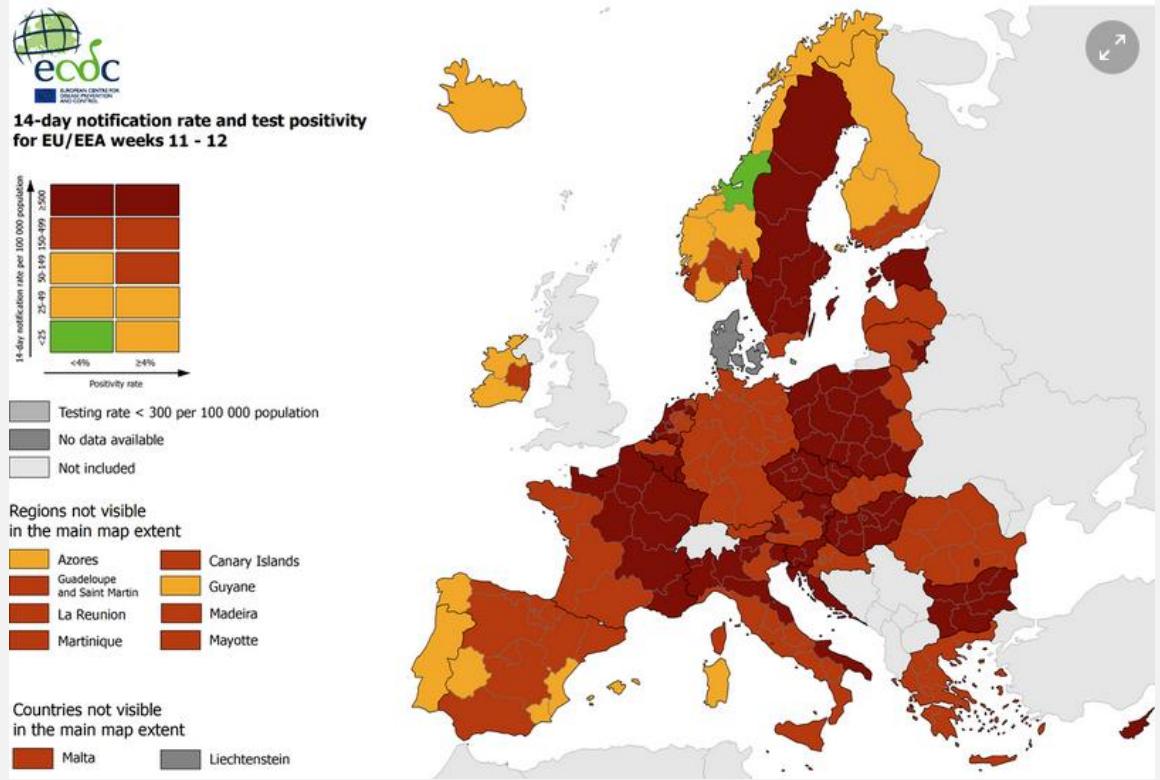
AUS/NZL: From 19 April, there will again be a quarantine-free travel service between Australia and New Zealand. The aim is to facilitate contact between spatially separated families. There are few corona cases in both countries.

JPN: Due to rising Corona numbers, the Olympic torchrelay is not expected to pass through Osaka as planned. The government of Osaka Prefecture has formally requested that the torchlight race scheduled for next week in the city of millions be cancelled for the Summer Olympics in Tokyo, the Olympic Organizing Committee announced. The government declared a state of emergency in Osaka and two other prefectures on Monday amid fears of a new wave of corona.

CHN: Within 24 hours, the largest increase in new Corona infections in more than two months was reported on Monday. Thirty-two other confirmed cases have occurred, including 15 in Yunnan province, due to a cluster in the town of Ruili on the border with Myanmar, the National Health Commission said. The number of new asymptomatic cases that China does not classify as confirmed cases is given as 18.

PRK: North Korea continues to present itself as a coronavirus-free country in its latest report to the WHO. Pyongyang reported that 23,121 people had been tested by April 1 and that all tests had been negative. Observers doubt, however, that the pandemic may have passed North Korea, with its poor health infrastructure and porous border with China. The country has severely restricted border traffic, banned tourists, flown out diplomats and quarantined tens of thousands of people with symptoms of infection. North Korea became the first country in the world to cancel its participation in the Tokyo Olympics on Tuesday, according to official figures concerned about the Corona pandemic.

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 01 April 2021



ECDC COVID-19 surveillance report Week 11, as of 25 March 2021

Overall situation

By the end of week 12 (week ending Sunday 28 March 2021), 18 countries in the European Union/European Economic Area (EU/EEA) had reported increasing case notification rates and/or test positivity. Case rates in older age groups had increased in six countries, 13 countries reported increasing hospital or ICU admissions and/or occupancy due to COVID-19 and 12 countries reported increasing death rates. The absolute values of the indicators remain high, suggesting that transmission is still widespread. It is possible that further 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

Figures showing national level weekly long-term care facility (LTCF) surveillance data for LTCFs with confirmed COVID-19 cases and clusters, COVID-19 cases and death notification rates amongst LTCF resident COVID-19 cases.

Maps showing trends in 14-day notification rates at the subnational level for all (EU/EEA) countries (section 3.6).

Figures and a table showing weekly sequencing volumes and estimated variant proportions by country, based on data reported to TESSy and the GISAID EpicCoV database (section 3.7).

Trends in reported cases and testing

- By the end of week 12, the 14-day case notification rate for the EU/EEA, based on data collected by ECDC from official national sources in 30 countries, was 489 (country range: 27-1 364) per 100 000 population. The rate has been increasing for five weeks.
- Among the 29 countries with high case notification rates (at least 60 per 100 000 population), increases were observed in 17 countries (Austria, Belgium, Bulgaria, Croatia, France, Germany, Hungary, Liechtenstein, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Romania, Slovenia, Spain and Sweden). Stable or decreasing trends in case rates of 1-8 weeks' duration were observed in 12 countries (Cyprus, Czechia, Denmark, Estonia, Finland, Greece, Ireland, Italy, Latvia, Malta, Portugal and Slovakia).
- Based on data reported to The European Surveillance System (TESSy) from 23 countries for people over 65 years of age, high levels (at least 60 per 100 000 population) or increases in the 14-day COVID-19 case notification rates compared with last week were observed in 18 countries (Austria, Belgium, Cyprus, Czechia, Estonia, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Slovenia, Spain and Sweden).
- Notification rates are dependent on several factors, one of which is the testing rate. Weekly testing rates for week 12, available for 28 countries, varied from 1 151 to 34 284 tests per 100 000 population. Cyprus had the highest testing rate for week 12, followed by Austria, Luxembourg, Slovenia and Czechia.
- Among 22 countries in which weekly test positivity was high (at least 3%), four countries (Croatia, Germany, Lithuania and Sweden) had observed an increase in test positivity compared with the previous week. Test positivity remained stable or had decreased in 18 countries (Belgium, Bulgaria, Czechia, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Latvia, Malta, the Netherlands, Poland, Romania, Slovakia, Slovenia and Spain).

Hospitalisation and ICU

- Pooled data from 24 countries for week 12 show that there were 11.6 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 12.7 per 100 000 population.
- Pooled data from 19 countries for week 12 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 13 countries show that there were four new admissions per 100 000 population.
- 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, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, 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 for 30 countries, was 72.8 (country range: 0.0-315.1) per million population. The rate has been stable for four weeks.
- Among 25 countries with high 14-day COVID-19 death rates (at least 10 per million), increases were observed in 11 countries (Austria, Croatia, Cyprus, Estonia, France, Greece, Hungary, Italy, Poland, Romania and Spain). Stable or decreasing trends in death rates of 1-9 weeks' duration were observed in 14 countries (Belgium, Bulgaria, Czechia, Germany, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Portugal, Slovakia, Slovenia and Sweden).

Variants of concern

- Sequencing capacity varies greatly across the EU/EEA; nine EU/EEA countries (Belgium, France, Germany, Iceland, Italy, Lithuania, Luxembourg, Norway and Poland) met the recommended level of 10% or 500 sequences of SARS-CoV-2-positive cases sequenced and reported to the GISAID EpicCoV database and TESSy by 30 March 2021 (data referring to the period 8 March to 21 March 2021). During the same period, 12 countries sequenced and reported between 60 and 499 samples, while nine countries sequenced and reported <60 samples or did not report data.
- Among nine countries with the recommended level of 10% or 500 sequences reported per week in the period 8 March to 21 March 2021, the median (range) of the variant in all samples sequenced in the period was 70.9% (3.2-79.4%) for B.1.1.7, 1.5% (0.0-19.6%) for B.1.351 and 0.0% (0.0-22.2%) for P.1.

COVID-19 Vaccine roll-out overview EU, as of 28 March 2021

Key figures on the vaccine rollout in the EU/EEA as of week 12, 2021 (28 March 2021)

Total doses distributed and administered

Total number of vaccine doses distributed by manufacturers to EU/EEA countries: 85 137 028 (29 countries reporting)

Median number of vaccine doses distributed by manufacturers to EU/EEA countries: 23.7 per hundred inhabitants (range: 10.7–36.9) (29 countries reporting)

Total number of vaccine doses administered: 70 895 546 (30 countries reporting)

Cumulative vaccine uptake in adults

Cumulative uptake of first vaccine dose among adults aged 18 years and above: median of 13.6% (range: 6–25.5%) (30 countries reporting)

Cumulative uptake of full vaccination among adults aged 18 years and above: median of 5.8% (range: 1.4–10.9%) (30 countries reporting)

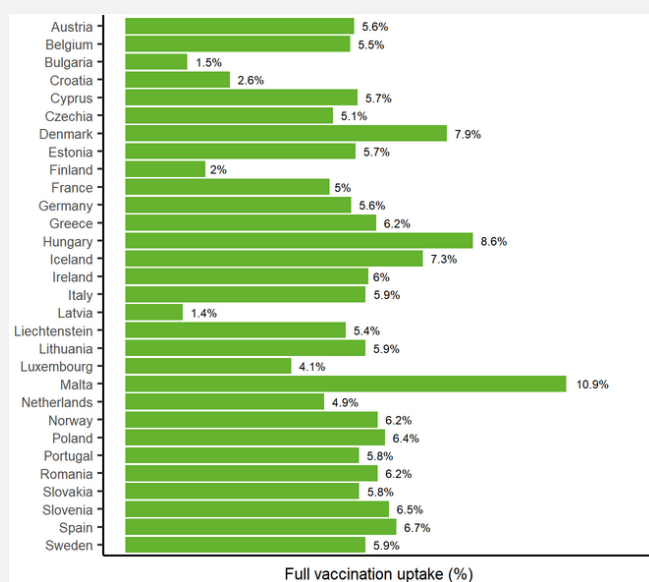
Cumulative vaccine uptake in target groups

Cumulative uptake of the first vaccine dose among persons aged 80 years and above: median of 59.8% (range: 5.1–97.9%) (25 countries reporting)

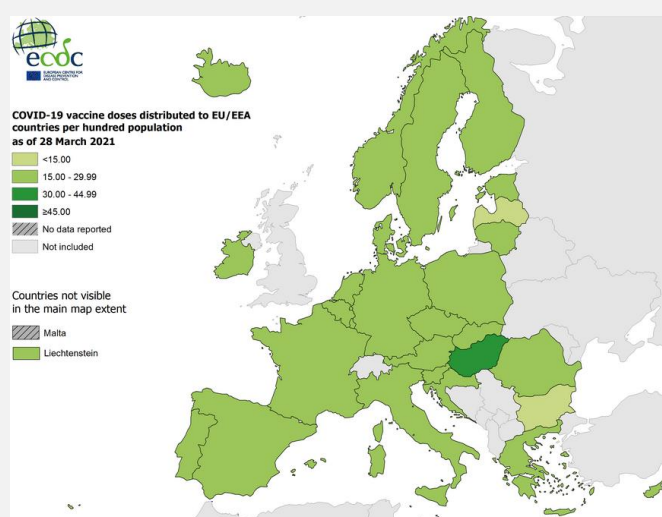
Cumulative uptake of full vaccination among persons aged 80 years and above: median of 33.1% (range: 0.6–88.5%) (25 countries reporting)

Cumulative uptake of the first vaccine dose among healthcare workers: median of 61.1% (range: 17.6–100%) (13 countries reporting)

Cumulative uptake of full vaccination among healthcare workers: median of 47% (range: 13.4–99.6%) (13 countries reporting)



Full vaccination uptake among adults in



Vaccine doses distributed per hundred inhabitants

Other sources: <https://vaccinetracker.ecdc.europa.eu/public/extensions/COVID-19/vaccine-tracker.html#uptake-tab>

Country Reports:

FRA: The number of Corona patients in French intensive care units has risen to 5626 at the highest level this year. In the past 24 hours, 193 cases have been added, the Ministry of Health says.

POR: Museums, secondary schools and outdoor cafes have reopened for the first time in more than two months. However, according to the authorities, there are still restrictions. For each table, cafés are only allowed to welcome four guests on their terraces. Primary schools have already resumed teaching in the classroom. Group sports in gyms and gyms remain prohibited, and museums must limit their opening hours.

GRE: Despite persistently high Corona cases, Greece has eased its restrictions on the pandemic. Most retail stores were allowed to reopen today, according to authorities. Customers must book an appointment in advance and a maximum of 20 people may be in a shop at a time. Department stores and shopping centres are initially exempt from the easing. Restrictions remain in place in the region around the particularly hard-hit cities of Thessaloniki and Patras. The government hopes the easing will limit the economic damage caused by the slumps in the tourism industry.

GBR: British Prime Minister Boris Johnson has officially confirmed the Corona easing planned for England from 12 April. From next week, pubs in England will be allowed to reopen their beer gardens and restaurants. Zoos, gyms, hairdressers and shops are also allowed to open. The other parts of the UK set their own Corona rules. Infection rates in the UK have eased significantly in recent weeks - the seven-day incidence was last at 44 cases per 100,000 inhabitants.

.....
The British government wants all adults and children to test for the coronavirus twice a week. For this purpose, so-called lateral flow tests will be distributed free of charge via pharmacies, workplaces and by post from Friday.

.....
In Scotland, after months of lockdown, hairdressers welcomed their first customers on Easter Monday. Garden centres and several other shops were also allowed to reopen this morning.

DNK: Since Tuesday, hairdressers, tattooists, masseurs and beauticians in Denmark have been able to serve customers again. Customers must be able to demonstrate a 72-hour-old negative corona test, a COVID-19 vaccination or a surviving infection on their smartphone. The higher grades have also been taught in the classroom since Monday. Excluded from the relaxations are a few municipalities where the number of new infections is currently too high.

HUN: The President announces a relaxation of the restrictions. More than a quarter of the population have now received at least one dose of vaccination. As of Thursday, shops and services may be reopened. Other restrictions are to remain, with schools due to open on April 17.

CZE: The government expects the first easing for catering and retail by the end of the month. Also, the Corona emergency is not to be extended. The state of emergency expires on the night of 11 to 12 April. This ends the nightly curfew and the ban on leaving one's own residential district.

TUR: With around 49,000 new Corona infections in one day, the number on Tuesday was above the 40,000 mark for the fifth day in a row. The seven-day incidence is particularly high in the metropolis of millions of people in Istanbul. It was last around 590 cases per 100,000 inhabitants. The country had partially lifted the Corona restrictions at the beginning of March - since then the number of cases has risen rapidly. Meanwhile, stricter measures are again in place in certain regions, such as weekend curfews.

Subject in Focus

COVID in Africa

The purpose of the deep dive into COVID in the African continent is to better understand how the COVID pandemic is affecting the countries within the region and the potential impact on NATO missions in Mali and Somalia.

Epidemiology

The African Union (AU) and Africa CDC produce a weekly brief that on 23 Mar 21 estimated that there had been 4.1 million cases across 55 AU member states with 110,000 deaths. The largest number of cases had been reported from South Africa (1.5 million) followed by Morocco and Tunisia. The WHO Africa Regional Office¹ maintains a [dashboard](#) which describes the epidemiology of COVID by country across the region. As of 28 Mar 21 a trend of increasing numbers of cases was noted.

The high proportion of cases reported from South Africa is likely to reflect under reporting from other countries on the continent. This is probably due to weak surveillance systems and ascertainment bias where cases are not reported. For example; Nigeria (population approximately 200 million people) has only reported 160,000 cases. The scale of this problem is illustrated by a cross-sectional survey in Zambia² which suggested that approximately 450,000 COVID infections had occurred in six districts under investigation compared to the 4900 positive test results.

The implication of weak surveillance is that caution must be applied to data emerging from countries in Africa as the data might not reflect the risk of COVID in the country. Somalia has reported 11,000 cases and nearly 500 deaths (population 15 million) and Mali has reported 10,000 cases and 400 deaths (population 20 million). It is likely that the majority of cases that have been identified in both countries are located in the major cities and grossly underestimate the true prevalence.

Variants

Detection of variants is dependent both on robust surveillance systems and the ability to process and type samples in the laboratory. This capability is extremely limited across the African continent and caution must be applied to any data.

Sixteen member states (Algeria, Angola, DR Congo, Gabon, Gambia, Ghana, Kenya, Libya, Mauritius, Morocco, Nigeria, Rwanda, Senegal, South Africa, Togo and Tunisia) have identified the 501Y.V1 variant (lineage B.1.1.7). Seventeen states (Angola, Botswana, Cameroon, Comoros, DR Congo, Eswatini, Gambia, Ghana, Kenya, Malawi, Mauritius, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe) have reported the 501Y.V2 variant (B.1.351).

The increase in numbers of cases being detected might reflect further circulation of VOC however there is limited information available. One of the priorities for the WHO is to improve detection of variants in African countries so more data should emerge to better understand the situation.

Response

Vaccination Status

Africa CDC has produced an indicative summary of the status of vaccination in Africa (see [here](#)). This identifies a range of vaccines; AZ, BioNTech, Sinopharm, J&J and Sputnik V that are available and the quantity supplied. Both AZ and BioNTech are part of the COVAX campaign (see [here](#)) which aims to supply COVID vaccines to low income countries.

It should be noted that, as part of COVAX, Mali has been allocated 1.3 million doses of SII³ AZ vaccine and received 400,000 doses on 05 Mar 21. Somalia has been allocated 1 million doses of SII AZ vaccine and received the first batch of 300,000 doses on 15 Mar 21.⁴ Both countries report starting their vaccine campaigns.

Non-Pharmaceutical Interventions

A wide range of social interventions to minimise spread of COVID have been implemented across most African countries. These include school closures, banning large gatherings and restrictions on travel. There has been widespread introduction of face coverings which are mandatory in most places. Details of requirements should be sought in advance of travel as they vary between countries.

Health Systems

The management of COVID in many African countries is compounded by weak healthcare systems with limited resources. Reports from Somalia suggested that the single hospital in Mogadishu that manages COVID cases may have run out of oxygen amidst a rapid increase in numbers of cases. This has been mirrored in many countries in Africa and there is concern about whether health systems can be maintained through the pandemic. This, obviously, has implications for the management of other significant diseases such as malaria, TB and HIV if healthcare systems cannot deliver treatment because they are overwhelmed by COVID cases.

Force Health Protection Recommendations for travel to African countries

1. Regardless of reported data maintain high level of caution.
 - a. Maintain social distancing (1.5m minimum) at all times.
 - b. Avoid gatherings of people wherever possible.
 - c. Wear a face mask at all times
 - d. Maintain scrupulous hand hygiene through either hand washing (preferred) or hand sanitiser.
2. Comply with National and International requirements. These may include:
 - a. Negative COVID test pre-arrival
 - b. Quarantine on arrival

References:

¹ It should be noted that this excludes those African countries that are considered part of the WHO Eastern Mediterranean Region.

² [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(21\)00053-X/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00053-X/fulltext)

³ Serum Institute of India

⁴ https://cdn.who.int/media/docs/default-source/3rd-edl-submissions/covax-first-round-allocation-of-az-and-sii-az---overview-tablev2.pdf?sfvrsn=85879c81_1&download=true

Conflict and Health

NIGERIA



In cooperation with Bundeswehr HQ of Military Medicine

CONFLICT:

Nigeria is Africa's most populous country with more than 190 million inhabitants. As the continent's largest oil and gas producer, economic output is still far behind South Africa's. The population is extremely young and has more than doubled in the last 30 years, without any corresponding expansion of infrastructure or economic development, resulting in a massive youth unemployment and generational problem. The domestic political situation is largely influenced by the dominance of the three majority peoples Hausa-Fulani, Igbo and Yoruba. The predominant differences between the Islamic, underdeveloped North and the Christian, prosperous South go back to colonialism. Since its independence in 1960, Nigeria has not yet overcome the stage of "unfinished state" and, even under the democratic auspices of the Fourth Republic (since 1999), has only in its beginnings a functioning statehood. In particular, the lack of modernization efforts in the north created space for radical political-religious groups such as Boko Haram, which use institutionalized violence and crime to exploit state arbitrariness. The conflict is particularly simmering in the north-east, where various groups have created totalitarian local governance structures and are carrying violence and terror to the neighbouring states on Lake Chad. The Nigerian side is using this as a pretext to evade responsibility and declare the conflict an international challenge. At the same time, their willingness to cooperate with the affected states of Chad, Cameroon and Niger has decreased markedly. The rest of the north and central Nigeria also lack any monopoly on state violence. Especially in the Niger Delta, the various amnesty, reintegration and training programmes have little effect. A considerable proportion of the former militiamen have organized themselves into criminal syndicates that terrorize the highways, carry out robberies and carry out kidnappings. Student groups have turned into serious criminal organisations and do not shy away from extortion, robbery and murder, and the Gulf of Biafra is now one of the world's most vulnerable maritime zones.

The country remains in crisis mode. After the controversial re-election of Muhammadu Buhari in 2019, in which several hundred people were killed by the martial practices of the military and police, but whose legality the Supreme Court unabatedly acknowledged, the government has not succeeded in significantly improving the security situation, restructuring the economy or curbing corruption. The multiple conflicts are above all an expression of distrust of the political elites and the weakness of state institutions. Social groups increasingly see violence and crime as an adequate way to assert political and profit interests and thus gain a share of social wealth. In Buhari's tenure alone, at least USD 17 billion has gone into security without improving the security situation. At the same time, civil rights are falling by the wayside.

HEALTH:

Nigeria's health system is considered weak and underserved. In 2001, African Union member states committed to spending at least 15 percent of the public budget on health each year. Nigeria's spending, however, averages less than 5 percent per year. In addition to the limited public resources, there is a high burden of communicable (Covid-19, HIV/AIDS) and non-communicable diseases (cardiovascular diseases, cancer, diabetes) as well as increased maternal and infant mortality. In addition to insufficiently modern facilities, there is a lack of qualified medical staff. The WHO estimates that there are only 35,000 doctors in Nigeria instead of the 240,000 needed. As a result, the country loses at least USD 1.5 billion in medical revenues annually. Rich Nigerians can be treated expensively abroad, especially in India, the US, and Europe. The growing population and the growing middle income class are expected to increase

demand for health care. To reverse this negative trend, the government has adopted a National Strategic Health Development Plan and established a fund for primary health care. These are to be used to receive state funds, but also those from private actors such as the Bill and Melinda Gates Foundation. Private sector involvement is also seen as essential, which will translate into more public-private partnerships. In cooperation with the Federal Ministry of Health, a number of agreements have already been concluded with private actors for the expansion of hospital capacities and diagnostic centres. Private sector representatives have also launched the Adopt-a-Healthcare-Facility Programme initiative, which aims to provide universal access to healthcare for low-income people. Conceived as early as 2019, the urgency of such an initiative is made all the more clear by the Corona Crisis. The government has also begun to adopt telemedicine as part of its public health intervention programs, as many people have increasingly introduced themselves through these platforms for fear of stigma or corona infection. Overall, however, many African countries are significantly less affected by the pandemic than Western industrialized nations. In studies, a seroprevalence of approximately 10% to 25% was demonstrated in the subjects, depending on the state. This is in marked contrast to the officially reported case numbers, which showed a COVID-19 infection in about 0.03% of the population at the time of sampling (autumn 2020). This discrepancy is reflected in the daily lives of many people who hear of increasing numbers of cases but do not feel it. Based on this seroprevalence study, about 3 million infected people would have to live in Lagos, but until now relatively few cases have been detected. This may be due to the fact that the clinical symptoms are very similar to those of malaria and only a few are performed on the basis of very high costs for a test, which confirms the persistently low test scope. Since the population as a whole is very young, even a small proportion of those have an increased risk of serious COVID-19 disease, so the comparatively small number of official deaths is likely to be much closer to the real occurrence than that of reported cases of infection.

CONCLUSION:

Nigeria is once again experiencing a severe political and economic crisis, exacerbated by the collapse in world oil and gas prices and the consequences of the COVID-19 pandemic. The northeast is still suffering from the organized raids of the Islamist militia Boko Haram, ethnic clashes and sectarian distribution altogether in central Nigeria, and in the resource-rich Niger Delta, well-organized piracy is holding security forces and commercial shipping in suspense. In addition, organised crime remains at a consistently high level across the country. The health care system, which is also rather weak, is likely to be pushed to its limits by the ongoing Corona crisis. However, different individual perceptions regarding the extent and relevance of a COVID-19 event do not necessarily have to be contradictions but must always be evaluated in the concrete context.

Nigeria

37.8 Index Score

96/195



PREVENT



DETECT



RESPOND



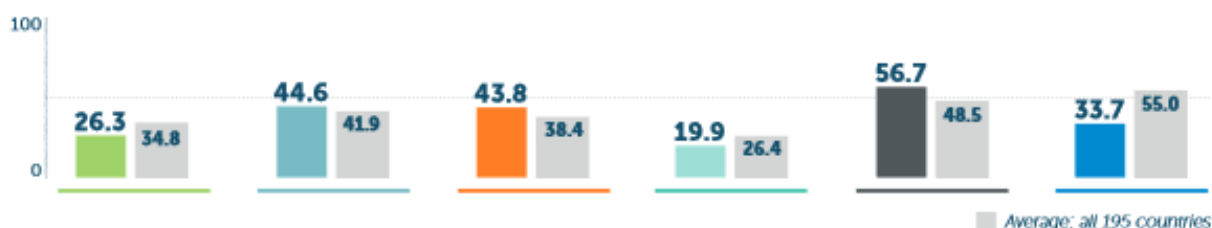
HEALTH



NORMS



RISK



Average: all 195 countries

	COUNTRY SCORE	AVERAGE SCORE*		COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	26.3	34.8	HEALTH SYSTEM	19.9	26.4
Antimicrobial resistance (AMR)	41.7	42.4	Health capacity in clinics, hospitals and community care centers	2.8	24.4
Zoonotic disease	33.5	27.1	Medical countermeasures and personnel deployment	0	21.2
Biosecurity	24	16.0	Healthcare access	71.7	38.4
Biosafety	0	22.8	Communications with healthcare workers during a public health emergency	0	15.1
Dual-use research and culture of responsible science	0	1.7	Infection control practices and availability of equipment	0	20.8
Immunization	50	85.0	Capacity to test and approve new medical countermeasures	50	42.2
DETECTION AND REPORTING	44.6	41.9	COMPLIANCE WITH INTERNATIONAL NORMS	56.7	48.5
Laboratory systems	50	54.4	IHR reporting compliance and disaster risk reduction	50	62.3
Real-time surveillance and reporting	70	39.1	Cross-border agreements on public and animal health emergency response	50	54.4
Epidemiology workforce	50	42.3	International commitments	78.1	53.4
Data integration between human/animal/environmental health sectors	0	29.7	JEE and PVS	50	17.7
RAPID RESPONSE	43.8	38.4	Financing	50	36.4
Emergency preparedness and response planning	12.5	16.9	Commitment to sharing of genetic & biological data & specimens	66.7	68.1
Exercising response plans	100	16.2	RISK ENVIRONMENT	33.7	55.0
Emergency response operation	33.3	23.6	Political and security risks	39.3	60.4
Linking public health and security authorities	0	22.6	Socio-economic resilience	42.1	66.1
Risk communication	25	39.4	Infrastructure adequacy	16.7	49.0
Access to communications infrastructure	56.7	72.7	Environmental risks	55.2	52.9
Trade and travel restrictions	100	97.4	Public health vulnerabilities	18.4	46.9

*Average: all 195 countries

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

www.ghsindex.org

Source:

<https://www.ghsindex.org/country/nigeria/>
<https://reliefweb.int/country/nga#digital-sitrep>

MilMed CoE VTC COVID-19 response

Topics former VTCs

The NATO Centre of Excellence for Military Medicine is providing expertise and resources to support the response to the pandemic. This includes a regular VTC focusing on different COVID-related topics. The purpose of the VTC is to act as a forum for exchanging experiences, sharing learning and understanding the different responses to the pandemic from partner nations. We are always looking for topics that would be of interest and experts that are able to speak to each topic. Each VTC provides an opportunity for short briefings following by facilitated questions and discussion.

Topics of 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
- Vaccinated Personnel – National Regulations for Deployments

Vaccinated Personnel – Logistic Challenges of the COVID-19 Vaccine Distribution

We had very comprehensive national briefings from the USA, GBR and Italy letting us know about the logistic challenges they are facing in their countries, the strategies of their government and also how military is involved in the national logistic chains for vaccine distribution and how military vaccination campaigns are being handled.

Militaries use different ways to move vaccines and to deliver doses to soldiers overseas.

All the informative national presentations were topped off with a short briefing from Zipline a private US company founded in 2014 and building up the world's largest autonomous logistics network. Enabled by the fastest and most experienced drone medical delivery service, Zipline delivers critical and lifesaving products precisely where and when they are needed, safely and reliably.

To summarize this week's VTC on Logistic challenges of the COVID-19 Distribution: There are significant challenges posed by the different vaccines and maintaining a cold chain to ensure that they reach the end user intact. Each of the countries described methods to achieve this goal using innovation and close communication with the medical community. The innovation theme was continued with the Zipline presentation on autonomous drone technology to deliver medication and vaccines in resource poor environments.

The next VTC will be held on 21 April, with the topic **“How has COVID-19 driven medical innovation?”**

Logistic Challenges of the COVID-19 Vaccine Distribution”

Recommendations

Recommendations 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

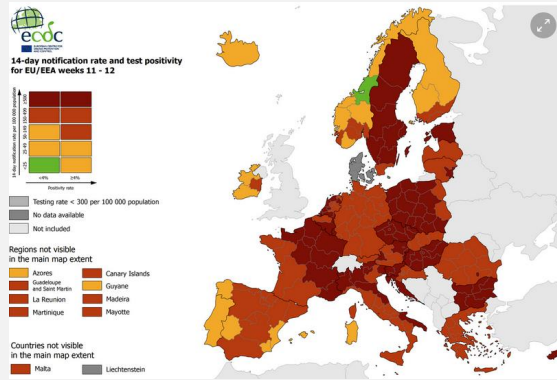
- **the notification rate** (the total number of newly notified COVID-19 cases per 100 000 population in *the last 14 days* at regional level)
- **the test positivity rate** (the percentage of positive tests among all tests for COVID-19 infection carried out during the last week)
- **the testing rate**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

2. A common map

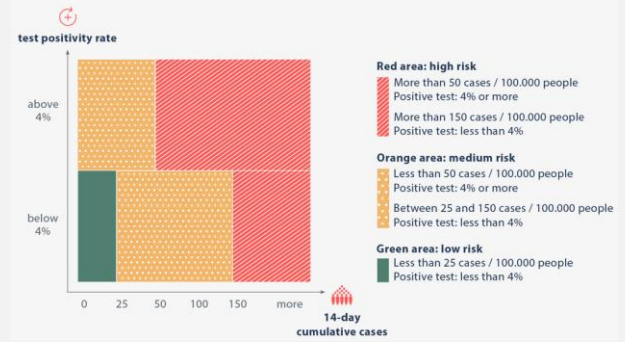
The ECDC will publish a map of EU Member States, broken down by regions, which will show the risk levels across the regions in Europe using a traffic light system. See also [“Situation in Europe”](#).

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. Unnecessary travel should currently be avoided. • Individual risk is dependent on exposure. • National regulations regarding travel restrictions, flight operations and screening for specific countries are here and here. • IATA has updated their travel documents with new travel restrictions. You will find the documents here. • Public health and healthcare systems are highly vulnerability as they already overloaded in some places 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 those who are infected but not unwell are a source of the virus. Therefore, no disease-free areas exist 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 ‘<i>of concern</i>’.</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 published on 15th 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. recent 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 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>

•

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/>

Disclaimer:

This update provided by the NATO Centre of Excellence (NATO MILMED COE) on its website is for general information purposes only and cannot be considered as official recommendation. All national and international laws, regulations, and guidelines as well as military orders supersede this information. All information is provided in good faith, however, the NATO MilMed COE makes no representation or warranty of any kind, express or implied, regarding the accuracy, adequacy, validity, reliability, availability or completeness of any information.

The information published on this website is not intended to substitute professional medical advice, diagnosis or treatment.

The NATO MILMED COE disclaim any liability in connection with the use of this information.