Update 29 (21st of July 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
21st of July 2020
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

- **WHO**: reported 229,780 new infections worldwide in the last 24h.
- **WHO**: More than 150 countries engaged in COVID-19 vaccine global access facility. It is designed to guarantee rapid, fair and equitable access to COVID-19 vaccines for every country in the world, rich and poor, to make rapid progress towards slowing the pandemic.
- Encouraging results from phase 1/2 COVID-19 vaccine trials, one from investigators at the Jenner Institute at Oxford University (Oxford, UK), with support from AstraZeneca, and the second from investigators supported by CanSino Biologics in Wuhan, China.
- **WHO**: According to the chief scientist, a broad-based corona vaccination could take place in the middle of 2021. “There are currently more than 20 vaccine candidates in clinical trials. So, we are confident that a few of them will work”.
- **WHO**: more than 1.3 million doctors and nurses worldwide have contracted the new type of corona virus. Healthcare workers have previously accounted for approximately 10 percent of all COVID-19 cases worldwide.
- **EU parliament**: In the fight against the corona economic crisis, the EU countries have agreed on the largest budget and financial package in their history. The compromise was adopted by the 27 member states after more than four days of negotiations early Tuesday morning at a special summit in Brussels. Together, the package comprises EUR 1.8 trillion - thereof EUR 1074 billion for the next seven-year budget and EUR 750 billion for an economic and investment program to combat the consequences of the pandemic crisis.

GLOBALLY
14 672 630 confirmed cases 8 295 941 recovered 609 889 deaths
EU/EEA and the UK
2 865 136 confirmed cases **1 731 124** recovered **204 831** deaths
USA → **(new cases/day 65 615)**
3 816 646 confirmed cases **1 159 688** recovered **140 709** deaths
Brazil → **(new cases/day 33 387)**
2 118 646 confirmed cases **1 514 300** recovered **80 120** deaths
Russia → **(new cases/day 6 238)**
776 212 confirmed cases **552 644** recovered **12 408** deaths
India ↗ **(new cases/day 34 279)**
1 155 338 confirmed cases **724 578** recovered **28 082** deaths
UK → **(new cases/day 748)**
295 372 confirmed cases **not reported** recovered 45 312 deaths

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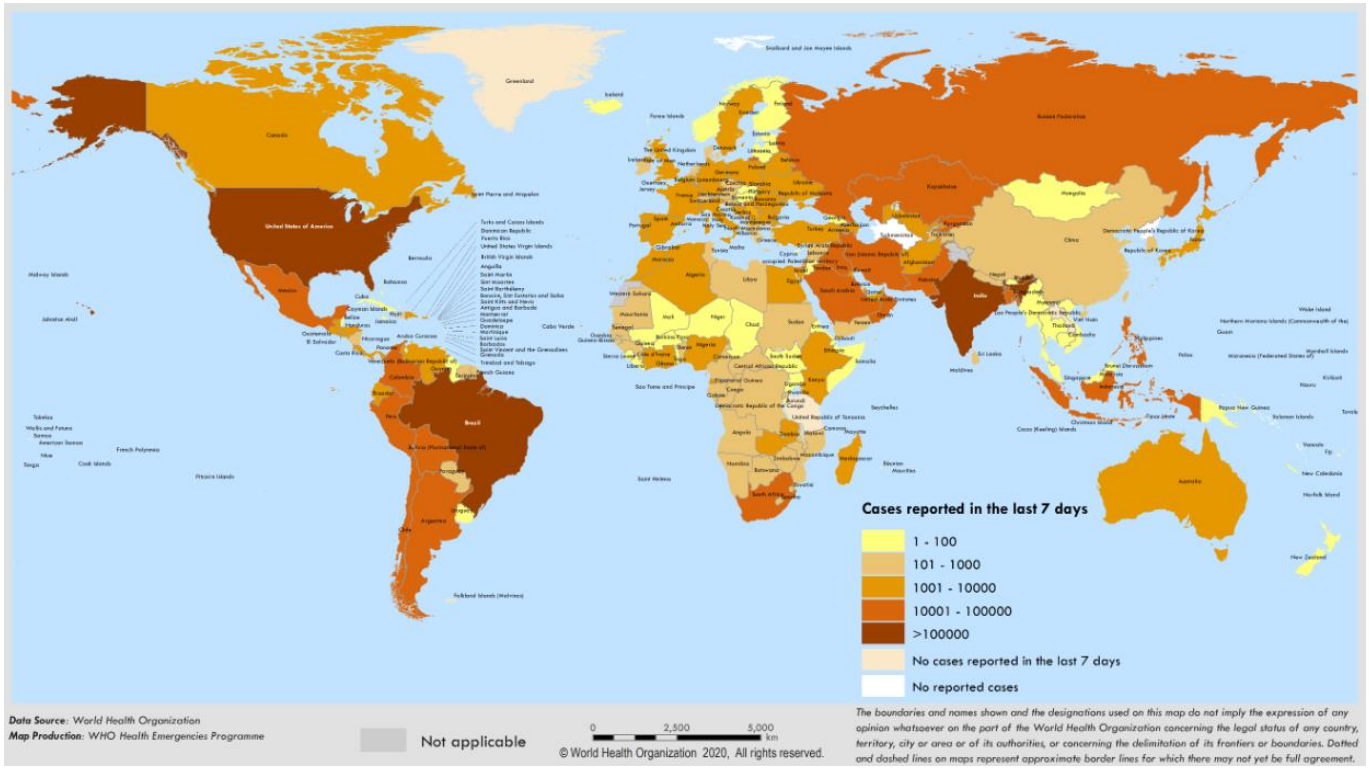
Map of countries with reported COVID-19 cases (last 7 days)



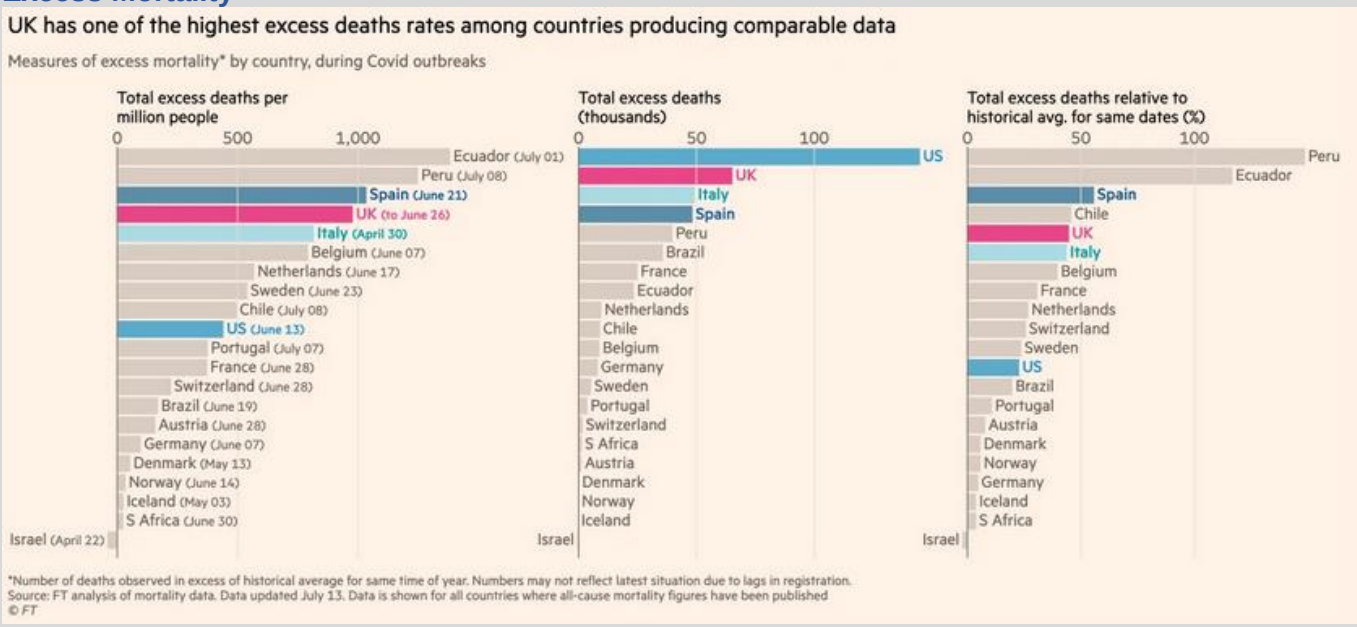
Worldwide Situation

Global Situation

Encouraging results from phase 1/2 COVID-19 vaccine trials

The Lancet reports the results of two early phase COVID-19 vaccine trials, one from investigators at the Jenner Institute at Oxford University (Oxford, UK), with support from AstraZeneca, and the second from investigators supported by CanSino Biologics in Wuhan, China. Both groups used an adenoviral vector, and both report the vaccine achieving humoral responses to the SARS-CoV-2 spike glycoprotein receptor binding domain by day 28 as well as T-cell responses. Both report local and systemic mild adverse events such as fever, fatigue, and injection site pain. In neither trial was a severe adverse event reported. In trials with more than a thousand subjects, the substance consistently caused “a strong immune response”.

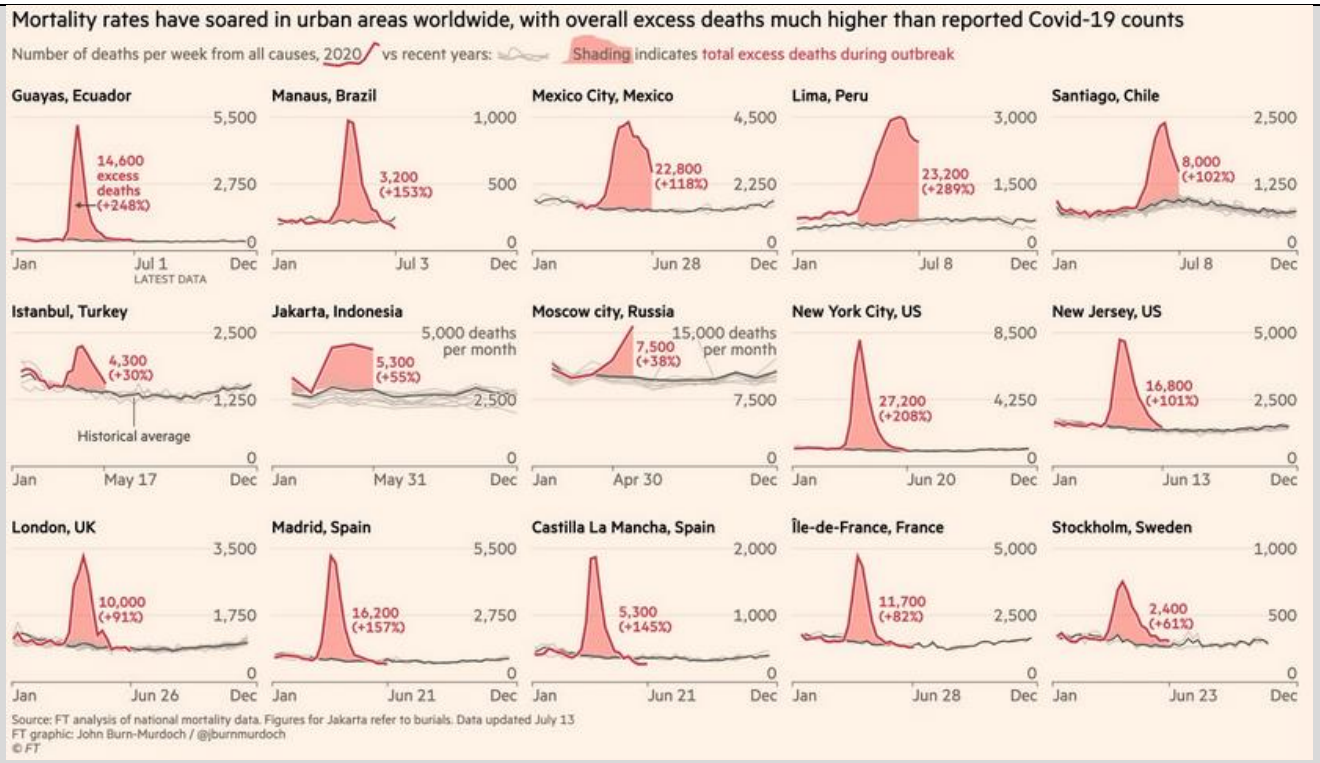
Excess Mortality



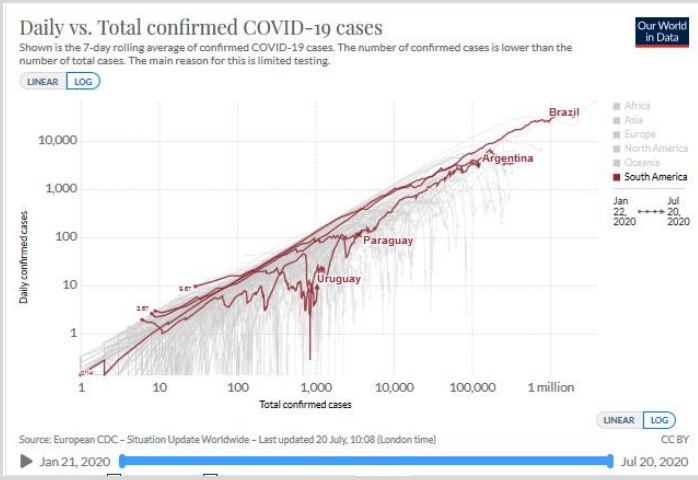
There are concerns, that reported COVID-19 deaths are not capturing the true impact of coronavirus on mortality around the world. A study done by the Financial Time has gathered and analysed data on excess mortality — the numbers of deaths over and above the historical average — across the globe and has found that death tolls in some countries are more than 50 per cent higher than usual. In many countries, these excess deaths exceed reported numbers of COVID-19 deaths by large margins.

The picture is even starker in the hardest-hit cities and regions. In Ecuador’s Guayas province, there have been 10,000 more deaths than normal since the start of March, an increase of more than 300 per cent. London has seen overall deaths more than double, and New York City’s total death numbers since mid March are more than four times the norm.

There are several different ways of comparing excess deaths figures between countries. In terms of absolute numbers, more have died in the US than in any other country, and the US excess death toll is 30 per cent higher than its reported COVID death toll at the same point.



South America Part 2

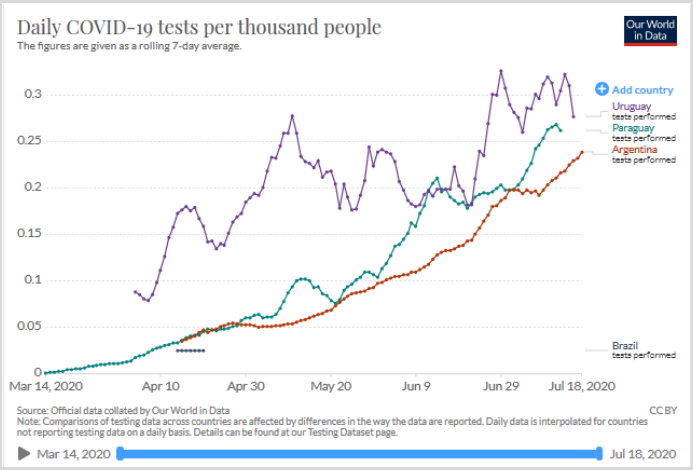


The new corona virus has now made South America the new epicenter of COVID-19 in the world. Although South America is the region with the most obvious social injustice worldwide, there are also conflicting realities. While the situation in Brazil, Peru, Ecuador and Chile remains alarming, there is also a group of countries that have managed to control the spread of COVID-19 and had a minimum number of illness-related deaths from this pathogen: Paraguay, Uruguay, Colombia, Bolivia and Argentina. Particularly successful in this were Paraguay and Uruguay. In the past few days and weeks, these countries have been able to afford their containment measures and the associated ones.

Now to loosen restrictions on the population and to find something like a “new normal”. Although both countries were equally successful in their containment measures, Paraguay and Uruguay have pursued completely opposite strategies.

Paraguay's Secret - By July 14, Paraguay had confirmed 2,980 cases, including 25 deaths. While mortality in this country was still 1.24% at the end of May, it has dropped to 0.84%, which is less than one fifth of the mortality rate in Germany. Paraguay quickly recognized its flank, which was vulnerable to the corona pandemic, and acted promptly by ordering drastic containment measures. Within South America, Paraguay was the first country to practically impose a total quarantine on March 11 in connection with a strict curfew. The capital Asunción was completely isolated: nobody came in, nobody came out. The Paraguayan government anticipated the country's precarious conditions regarding its housing situation and basic medical care. He was also aware of the weaknesses in his basic medical care with only 800 intensive care beds for a population of 7.2 million. Although the amount was increased by 200 intensive care beds, the increased number of beds would also not have been predictably enough to provide the avalanche of sick people expected for May even halfway. Although the country is particularly vulnerable to the social impact of the epidemic, it has the advantage of being well protected by its geographic location.

In contrast to its neighbouring countries Argentina and Brazil, Paraguay has few international flight connections. For this reason, Paraguay remained largely isolated as a landlocked country with the fewest connections abroad. The same conditions also exist in Bolivia: Little tourism with only few connections to the rest of the world.



Nevertheless, the small number of cases in Paraguay is astonishing again and again, as Simón Pachano, Professor of International Analysis at the Latin American Faculty of Social Sciences (Faculdade Latino-americana de Ciências Sociais - FLACSO) explained to the French broadcaster Radio France International (RFI) after he once again had analysed the infection numbers and course curves of Paraguay as well as of the rest of South America.

At the beginning of May, the Paraguayan government introduced the so-called "intelligent quarantine", which intends to gradually make the restrictions more flexible. In the fourth week of May, Paraguay opened 83% of its shops and even allowed the resumption of individual sports in public and the use of public transport. For June, the organization of football matches - albeit in front of empty grandstands - and the reopening of the churches were also considered. At this point in time, however, the dates for which the schools would reopen had not yet been set.

The country has shown itself to be extremely innovative in the area of risk communication. A Facebook page of the National Secretariat for the Human Rights of Persons with Disabilities (SENADIS) provides low-threshold and barrier-free information on rules of conduct, containment measures and the infection process - fully underlined with sign language, subtitles and a soundtrack for people with impaired vision.

Sources: https://noticias.uol.com.br/saude/ultimas-noticias/rfi/2020/05/28/paraguai-e-uruguai-os-dois-casos-de-sucesso-no-combate-ao-coronavirus-na-america-do-sul.htm
https://ourworldindata.org/coronavirus/country/paraguay?country=~PRY
https://bridgingthegap-project.eu/paraguay-launches-accessible-communication-service-inform-covid-19/

USA: On Friday evening 77,638 new infections were registered within 24 hours, these is the highest amount of new infections since beginning of the crisis.

With corona deaths soaring, several U.S. states have ordered refrigerated trucks for COVID-19 deaths bodys. In Texas and Arizona, authorities placed orders to prepare for the worst because of a lack of space in mortuaries and crematoriums. To date, more than 3,700 people have died from Covid-19 in Texas. In the state of Arizona, which has so far recorded 2,500 deaths, the authorities in the Maricopa district ordered 14 refrigerated vehicles with a capacity of around 300 victims.

On Friday evening (local time), 1,072 out of a total of 1,798 inmates at Seagoville Prison in northern Texas became infected. Ten members of the guards were also tested positive. A 65-year-old prisoner died of COVID-19 this week.

Hong Kong: After more than 500 of new infections with the novel corona virus in the past two weeks, the authorities in Hong Kong are raising the alarm. On Sunday, the authorities reported 108 new infections within a day - a new record for Hong Kong. "There are no signs that the situation is being brought under control" authorities announced. New stricter corona requirements, including a mask requirement in all public buildings and a home office for officials who don't necessarily have to work on site are considered. Given the limited capacity in the hospitals, an additional 2,000 quarantine beds will be set up near Disneyland Hong Kong.

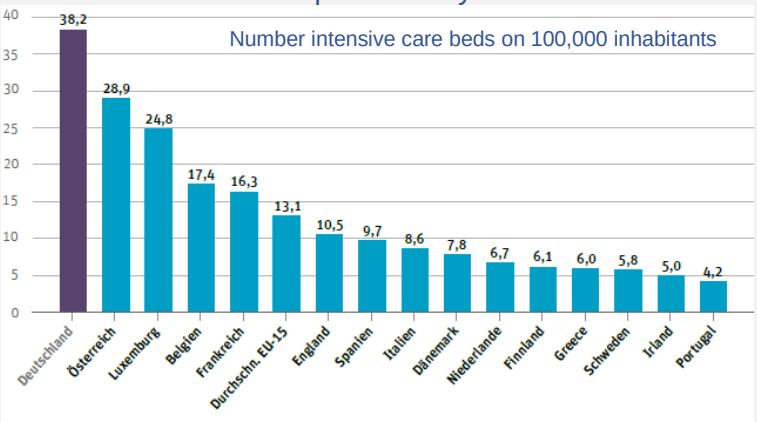
AUS: Despite a ten-day curfew, the number of new corona infections in Melbourne has continued to increase - now the Australian coastal metropolis has become the first city in the country to introduce an extensive mask requirement. People in Melbourne must wear face masks in public spaces from Thursday. Violations are punished with up to 200 Australian dollars.

Situation in Europe

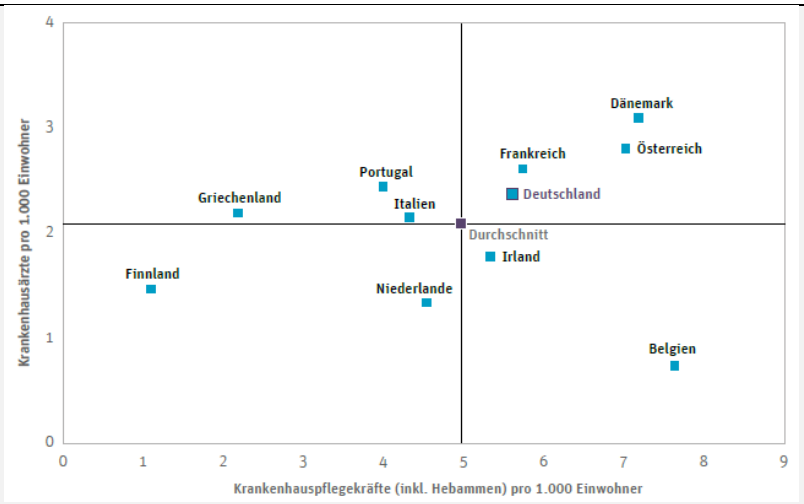
Comparison of European health systems in the Covid 19 pandemic

A comparative intermediate status between European countries outbreak preparation and response was drawn in a study done by the German Scientific Institute for Private Health Insurance (WIP). Question asked where: What was the position of the European countries (the analysis focuses here on the EU-15 states) before the pandemic in the healthcare system? To what extent have individual countries been affected by the pandemic and how have health systems reacted? Which explanations could be used for the different rate of spread and the associated burden on health systems?
The countries examined were: Belgium, Denmark, Germany, Finland, France, Greece, Great Britain, Ireland, Italy, Luxembourg, Netherlands, Austria, Portugal, Sweden, Spain.

1. **Health system capacities**
   a. *Hospital and intensive care beds*
   The countries considered show very different bed capacities in inpatient acute care. Germany has by far the most intensive care beds per 100,000 inhabitants of the EU-15, followed by Austria and Luxembourg. Portugal comes in last with only 4.2 intensive beds per 100,000 inhabitants. However, the authors point out that "the figures for the respective countries come from different points in time and from different sources, as there is as yet no uniform Europe-wide coverage".
   The numbers alone are not an indicator of adequate hospital care. However, more bed capacities offer a time advantage in the event of a pandemic because additional capacities do not have to be built up when they are needed.



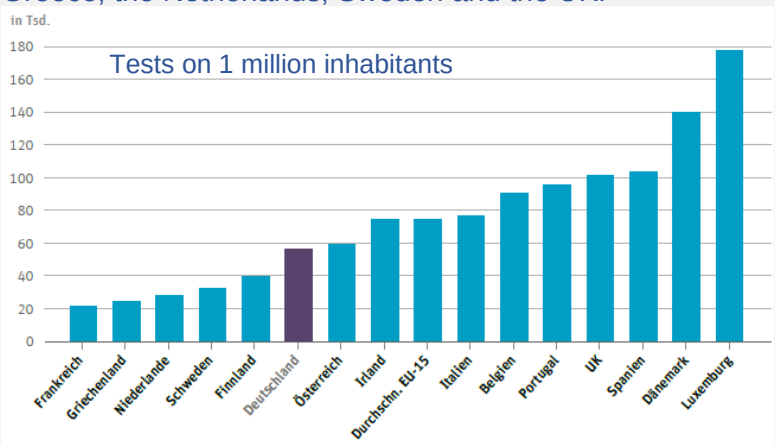
   Researchers at the University of Washington have used a forecast model for many countries to estimate how intensively the intensive capacities of the individual countries have been utilized by the Covid-19 pandemic or will be in the foreseeable future. According to these model calculations, the need for intensive care beds during the pandemic in Germany, Austria and Greece remained well below the respective capacity limits, and Luxembourg also had sufficient capacity despite the high number of infected people. Belgium, France, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and Great Britain, on the other hand, according to these estimates, sometimes had significantly more need for intensive care beds than were available in these countries.
   b. *Human resources*
   The staffing of hospitals with doctors and nurses was also very different before the pandemic began. France, Austria and Denmark and Germany had an above-average number of doctors and hospital nurses per 1,000 inhabitants. Belgium had the most nurses, but the fewest doctors per 1000 inhabitants. Portugal, Greece and Italy had a relatively large number of doctors, but below average fewer nurses.



c. *Tests and test capacities*

To get an overview of the spread of the virus, the appropriate test capacities are needed. However, the data currently available are subject to great uncertainty because of the different levels of testing in the various countries. When it comes to identifying deaths in connection with COVID-19, the test problem also arises, and there is also the difficulty that it is often difficult to understand whether the patients died of the consequences of the COVID-19 infection or only died with the infection.

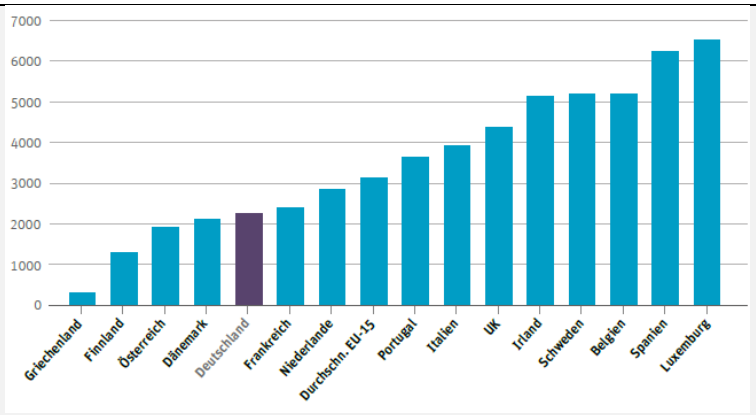
The countries under review operate different test regimes, some of which have also changed over time. Countries such as Belgium have started a very open testing (all people, including asymptomatic ones, can be tested, Regime 3) and have switched to a more restrictive approach after a few days (only people with symptoms and if other criteria are available, Regime 1). Ireland has also switched from a more open regime 2 (all people with COVID-19 symptoms can be tested) to more restrictive testing. Other countries have stayed with their chosen regime, such as Finland, France, Germany, Greece, the Netherlands, Sweden and the UK.



2. Affection of the countries in the pandemic

a. *Infected per inhabitant*

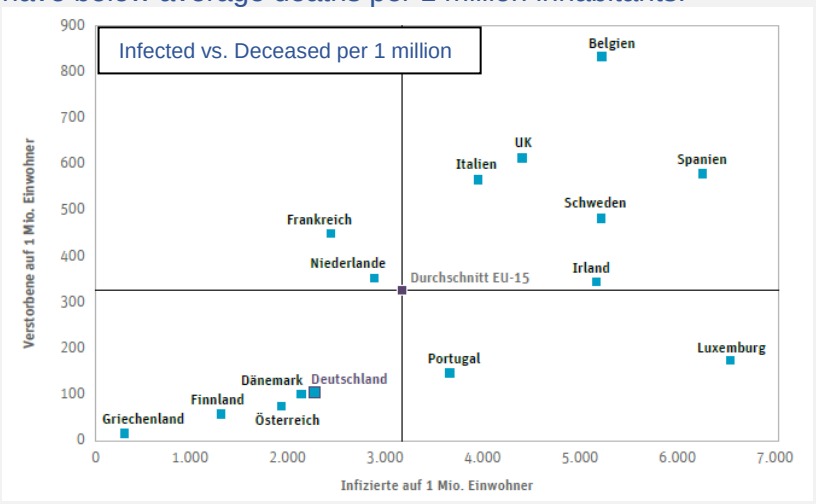
It should be noted that only the tested cases are registered. So, the number also depends on the test capacities. Most registered cases per 1 million inhabitants are currently in Luxembourg, followed by Spain, Belgium and Sweden. Ireland, Italy, Great Britain and Portugal also have above-average numbers of cases. Greece, Finland, Austria, Denmark and Germany have the lowest number of cases (data as of June 16, 2020).



In order to assess the reliability of these numbers, the number of infected people can be compared to the tests carried out. Luxembourg not only has the highest number of infected people per 1 million inhabitants, but also tests the most. In contrast, some countries that have a below-average number of infected people test relatively little compared to other countries. These countries include Greece, Finland, Austria, Germany, the Netherlands and France. It is therefore not clear for all countries whether the small number of cases is due to the below-average testing or whether the infection process is actually below-average.

b. Fatalities

Looking at the reported deaths per 1 million inhabitants, Belgium had the highest number of deaths, some distance ahead of Great Britain, Spain and Italy. There were also an above-average number of deaths in Sweden, France, the Netherlands and Ireland. In contrast, Luxembourg, which has the highest number of infected people with a population of 1 million, has fewer deaths than average. Since it is also the country with by far the highest number of tests per inhabitant, it can be assumed that these figures reflect the outbreak events relatively reliably. Portugal, Germany, Austria, Denmark, Finland and Greece also have below average deaths per 1 million inhabitants.



c. Excess Mortality

Due to the different test regimes and the recording of deaths, the mortality figures are not necessarily meaningful for the individual concern of the individual countries. A more reliable measure is the so-called over-mortality; H. the deviation from "normal" trends in mortality. Here, the number of tests or the recording of causes of death is irrelevant, but only whether the number of deaths has increased exceptionally compared to previous years or not. According to data from EuroMOMO (EuroMOMO, 2020), a deviation from normal mortality in the countries under consideration can be observed for Belgium, France, Ireland, Italy, the Netherlands, Spain, Sweden and the UK, albeit to a different extent. (Data see original document.)

3. Explanatory factors for the different affection of the countries in the pandemic

There are various reasons for the different levels of concern among the countries in the previous pandemic. On the one hand, time factors play a role, i.e. when infections were discovered and reacted or reacted accordingly at the political level. In addition, which

population groups were particularly badly affected and how high the treatment capacities were. Access to outpatient care also plays a role in the burden on the inpatient sector.
The following risk factors played a role in the first wave and could become significant in another wave:

- Cluster infections
- Demographic risks: Age of the population and household structures, Age of the infected,
  In the EU-15 countries, both age and household structures differ widely. In the southern countries of Italy, Spain, Portugal and Greece, the median age is well above the EU-15 average, while the share of single and couple households among the over 65-year-olds is relatively low. In countries where many of the over 65s either live alone or with their partner, they could be better protected against infections, since they do not live with younger people who are much less seriously ill, but the virus in the household, however, clearly could pass it on to more vulnerable older people. Austria and Germany, for example, also have a higher median age than the EU-15 average, but significantly more of the over 65-year-olds live there either in couples or single households and are therefore better protected against infection within a household. In Italy almost 70 percent of those infected were over 50 years old, in Finland and Luxembourg only 40 and 41 percent of those infected. Sweden, Belgium, UK and Spain also have relatively high proportions of people over the age of 50, which could explain the higher mortality rate. Putting the percentage of over 50-year-olds in all infected in relation to the deceased per 1 million inhabitants, it becomes clear that countries, in which the proportion of older people among the infected were higher, also had significantly higher death rates.
- Risk groups
- Infections in nursing homes
- Policy response time
  While some countries take relatively strong measures very early responded, even when there were still relatively few infected people, other countries took measures relatively late.

Abbildung 15: Stringency-Indicator für ausgewählte Länder

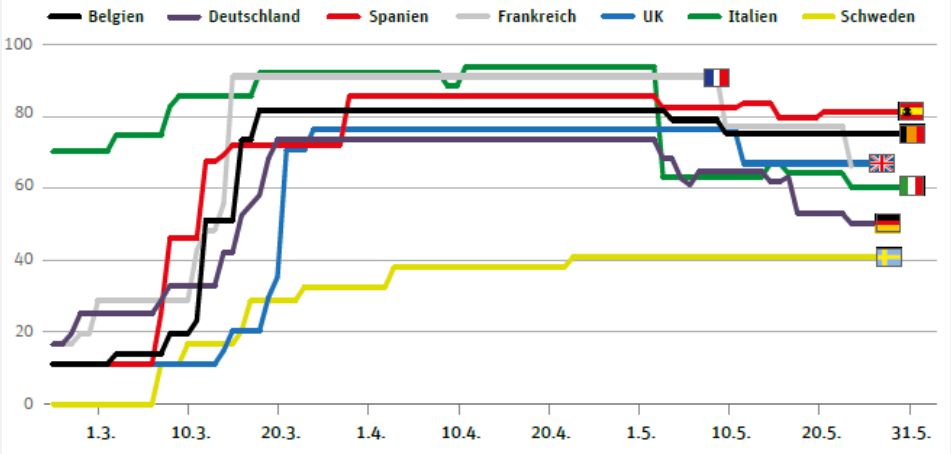


Figure 15 shows the development of the index from the end of February for selected countries. While the majority of the countries here still had a low index value, since information campaigns for the population and initial tracing of infections were primarily carried out, the value of Italy, which had been hit hardest by the pandemic, was already at 70 at this point in time here already exit restrictions, schools and workplaces closed, events banned, assembly bans introduced, public transport restricted and international travel prevented. The Swedish special route is easy to recognize from the curve, since the country has consistently lower values of the Stringency Index.

- Interaction between the outpatient and inpatient sector
  During the crisis, it was also found that outpatient testing and treatment for people infected with COVID-19 was an advantage. In many countries, tests were mainly carried out in hospitals, which increased the risk of infection for medical personnel and patients there.

Source: Wissenschaftliches Institut der PKV; Christine Arentz, Frank Wild, WIP-Analyse 3/2020

ESP: For the time being, almost 100,000 people in three other cities in Catalonia will no longer leave their homes. The authorities are thus extending the existing recommendation for four million Catalans, including the residents of the capital Barcelona. Apartments should only be left for necessary errands.

DEU: According to the German Weather Service (DWD), the lower car traffic in cities during the Corona crisis has had a major impact on exposure to nitrogen oxides, which are hazardous to health - even if this was not always evident from the measurement data. If one separates meteorological influences, there will be an improvement in air quality by around 30 percent for nitrogen oxides (NOx) in 48 cities with more than 100,000 inhabitants from March 23 to April 19.

GBR: The German pharmaceutical company Biontech and the US company Pfizer have signed a first delivery agreement with the UK for a possible corona vaccine that is currently under development. Subject to regulatory approval or approval, 30 million doses of the vaccine candidate “BNT 162” are expected to be delivered, probably in 2020 and 2021.
Phase I and II trials are currently ongoing in the United States and Germany for a total of four RNA vaccine candidates from Biontech and Pfizer. The US drug agency FDA recently approved an accelerated approval process for two of these candidates.

ECDC COVID-19 surveillance report Week 28, 2020

Weekly surveillance summary

This summary presents highlights from two weekly ECDC surveillance outputs, which have been streamlined to avoid overlaps.

- The COVID-19 country overview provides a concise overview of the evolving epidemiological situation for the COVID-19 pandemic by country, using weekly and daily data from a range of sources.
- The COVID-19 surveillance report presents epidemiological characteristics of COVID-19 cases reported to the European Surveillance System (TESSy) and assesses the quality of the data.

Trends in reported cases

- The average 14-day case notification rate for the EU/EEA and the UK as of 15 July 2020 was 11.6 (country range: 1–107) per 100 000 population.
- An increasing trend has been observed in the 14-day COVID-19 case notification rate in Austria, Belgium, Bulgaria, Croatia, Iceland, Luxembourg, Romania, Slovenia and Spain. These trends have been present for between five and 32 days.

Testing

- Notification rates are highly dependent on a number of other factors, one of which is the testing rate. Weekly testing in the EU/EEA and the UK vary between 96.5 and 11236.1 tests per 100 000 population. Luxembourg has the highest testing for week 28, followed by Denmark, Malta, Cyprus, and Ireland.

Primary care

- Among four countries that reported data up to week 28 from primary care sentinel surveillance for COVID-19 using the systems established for influenza, there are no detections of SARS-CoV-2.
- All countries that reported ILI and/or ARI syndromic surveillance data up to week 28 using the systems established for influenza, have observed consultation rates that remain similar to or are lower than those reported during the same period in the last two years.

Hospitalisation

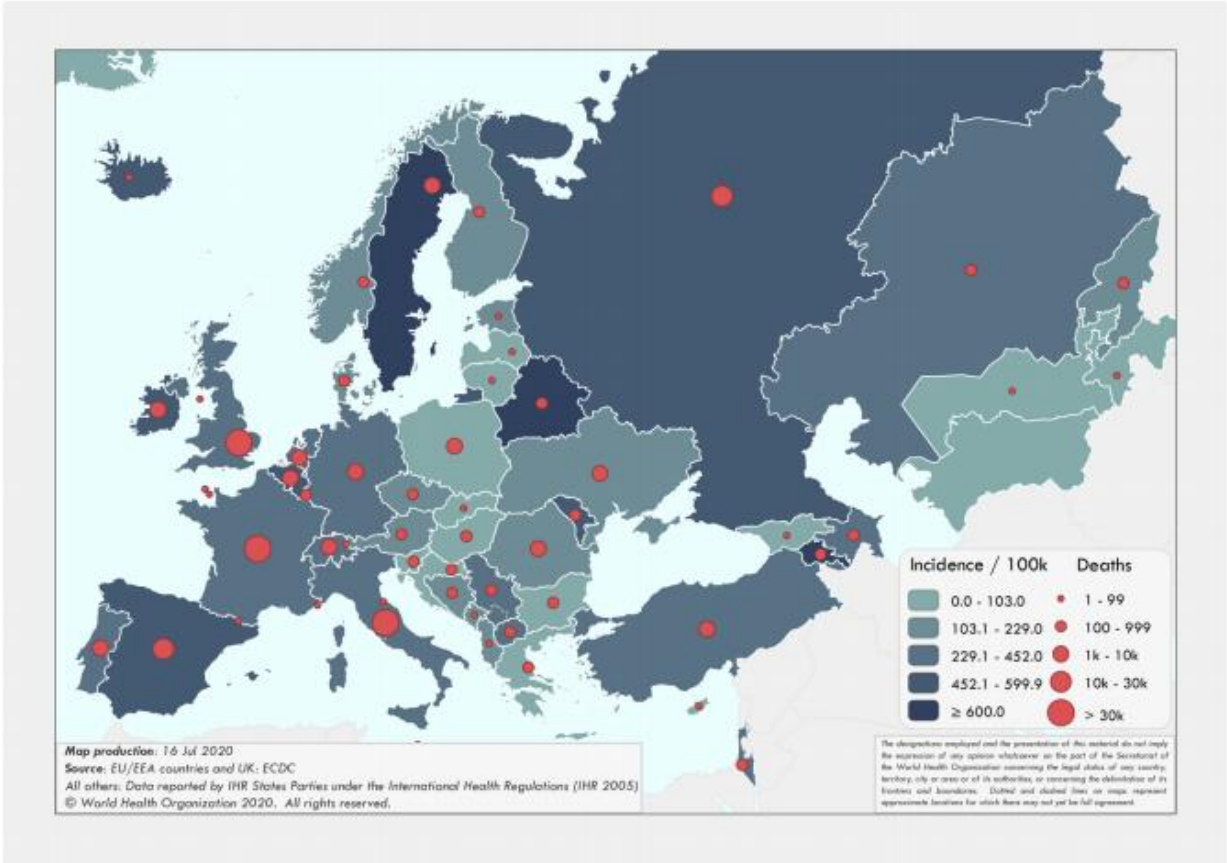
- Hospital and/or ICU occupancy due to COVID-19 are increasing in Bulgaria, Croatia, Czechia, Luxembourg and Romania. No other increases have been observed, although data availability varies.
- Overall, 30% of reported COVID-19 cases in the EU/EEA and the UK to date have been hospitalised; among hospitalised patients, 14% required ICU and/or respiratory support, although there is considerable variation among countries.

Mortality

- The 14-day COVID-19 death notification rate for the EU/EEA and the UK was 5.1 (country range: 0-20.7) per 1 000 000 population. The rate has been decreasing for 20 days.
- A decreasing trend in the 14-day COVID-19 death notification rate in Sweden and United Kingdom has been present for nine and 34 days, respectively.
- We estimate that 24% (country range: 0.5%–38.0%) of hospitalised COVID-19 cases reported in the EU/EEA and the UK have died.
- Pooled estimates of all-cause mortality reported by EuroMOMO have now returned to normal levels, following a period of substantially increased excess mortality that coincided with the COVID-19 pandemic peaks.

COVID-19 situation update for the WHO European Region (06 – 12 July 2020 Epi week 28)

Figure 2B. COVID-19 cumulative incidence per 100,000 population and number of deaths by country



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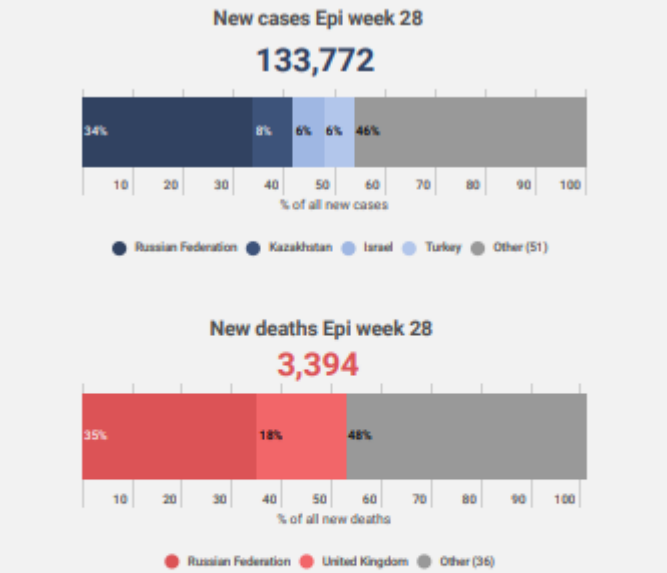
Key points

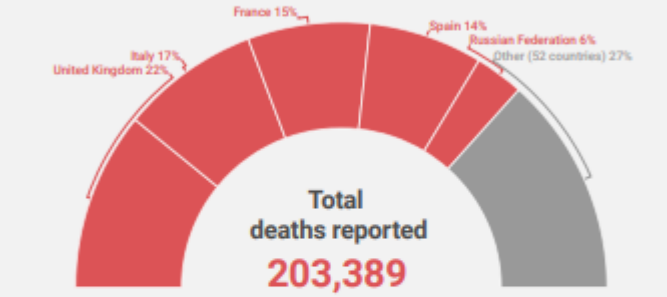
Week 28/2020 (6 - 12 Jul 2020)

- The overall number of cases reported in the Region has declined by 48% since week 14/2020; the overall number of deaths has declined by 87% in the same time period
- 54% (72,752) of the cases reported in week 28/2020 were reported from four countries: the Russian Federation (34%; 45,911), Kazakhstan (8%, 11,082), Israel (6%; 8,388) and Turkey (6%; 7,371). The remaining cases (46%; 61,020) were reported by 51 countries and territories; each accounted for <5% of the total cases reported in week 28/2020
- 12 countries had a crude incidence of ≥40 per 100,000 in week 28/2020 (in order of incidence): Armenia, Israel, Montenegro, Kazakhstan, Luxembourg, Kyrgyzstan, North Macedonia, Bosnia and Herzegovina and Serbia. The crude incidence continues to vary across the region with a range from 0.5 per 100,000 population in Malta to 144 per 100,000 population in Armenia
- The 14-day cumulative incidence increased by ≥10% in week 28/2020 in 28 countries in the Region, however for some countries data was retro-adjusted by national authorities: Albania, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, France, Greece, Hungary, Iceland, Ireland, Israel, Kazakhstan, Kyrgyzstan, Latvia, Luxembourg, Montenegro, Romania, Serbia, Slovakia, Slovenia, Spain, Switzerland and Uzbekistan (see EURO COVID-19 Dashboard for recent trends)
- 52% (1,774) of the deaths reported in week 28/2020 were reported by the Russian Federation (35%; 1174) and the United Kingdom (18%; 600). The remaining deaths (48%; 1620) were reported from 36 countries and territories; each accounted for <5% of the total deaths reported in week 28/2020
- The proportion of reported cases that died decreased from 2.9% in week 27/2020 to 2.5% in week 28/2020, a change that is likely due to a range of factors
- Community-transmission was reported by 26 countries and territories, 23 countries and territories reported cluster transmission, while 6 countries and territories reported sporadic transmission in week 28/2020 (see EURO COVID-19 Dashboard)
- Since the emergence of COVID-19 virus in Europe at the end of January 2020, a wide range of public health and social measures (PHSM) have been implemented. See EURO COVID-19 Dashboard (NPI Explorer) for an interactive snapshot of the temporal relationship between case and death numbers and the introduction and easing of these measures in some countries in the Region. A number of countries have recently started gradual easing of these measures. Continued vigilance is recommended as countries in the Region ease these measures

Summary overview

- As of 26 June 2020, nine countries in the European region had an effective reproductive number significantly over 1: Bosnia and Herzegovina, Czech Republic, France, Israel, Kazakhstan, Kyrgyzstan, Luxembourg, Serbia and Switzerland (See EpiForecasts and the CMMID COVID working group COVID-19 Global Summary for latest estimates)
- Six countries in the Region each reported a cumulative incidence of ≥600 cases per 100,000 population (in order of incidence): San Marino, Andorra, Armenia, Luxembourg, Sweden and Belarus
- As of week 28/2020, 72% of cumulative cases (2,094,387) were reported from the Russian Federation (25%; 727,162), United Kingdom (10%; 288,953), Spain (9%; 253,908), Italy (8%; 242,827), Turkey (7%; 211,981), Germany (7%; 198,804) and France (6%; 170,752). The remaining cases (28%; 823,647) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 28/2020
- 27% of all reported infections with information available were in a health care worker
- 76% of all ICU admissions were in persons aged 50-79 years of age, with 71% of all ICU admissions in men
- As of week 28/2020, 73% of cumulative deaths (149,485) were reported from the United Kingdom (22%;44,798), Italy (17%; 34,945), France (15%; 30,004), Spain (14%; 28,403) and the Russian Federation (6%, 11,335). The remaining deaths (27%; 53,904) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 28/2020
- 89% of all deaths were in persons aged ≥65 years and 58% of all deaths were in men
- 95% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (76%)
- Following a period of a very substantial excess mortality observed in some countries coinciding with the COVID-19 pandemic, pooled estimates of all-cause mortality for the countries in the EuroMOMO network have now returned to normal levels. A few countries are still seeing some excess mortality. Excess mortality was observed primarily in the age group of ≥65 years, followed by the age group of 45-64 years and 15-44 years
- In week 28/2020, five countries reported 108 tests and 6 COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The positivity rate in week 27/2020 was 2.2% (5 countries) compared to 4.2% (6 countries) in week 26/2020. The highest positivity was 14.6%, seen in week 15/2020





27% of all people infected were health care workers

95% of all deaths had at least 1 underlying condition

58% of all deaths were in men

76% of all ICU admissions were people aged 50-79 years

89% of all deaths were in persons aged 65+

76% of all deaths had cardiovascular disease

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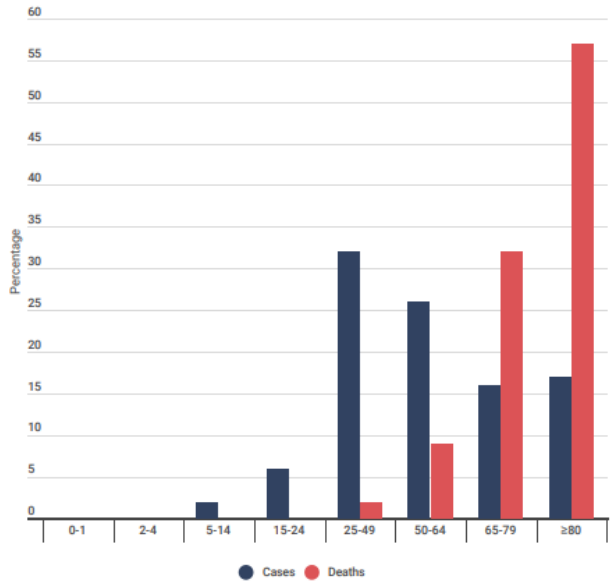
Figure 3. Percentage of COVID-19 cases (N=551,346) and deaths (N=93,954) by age group



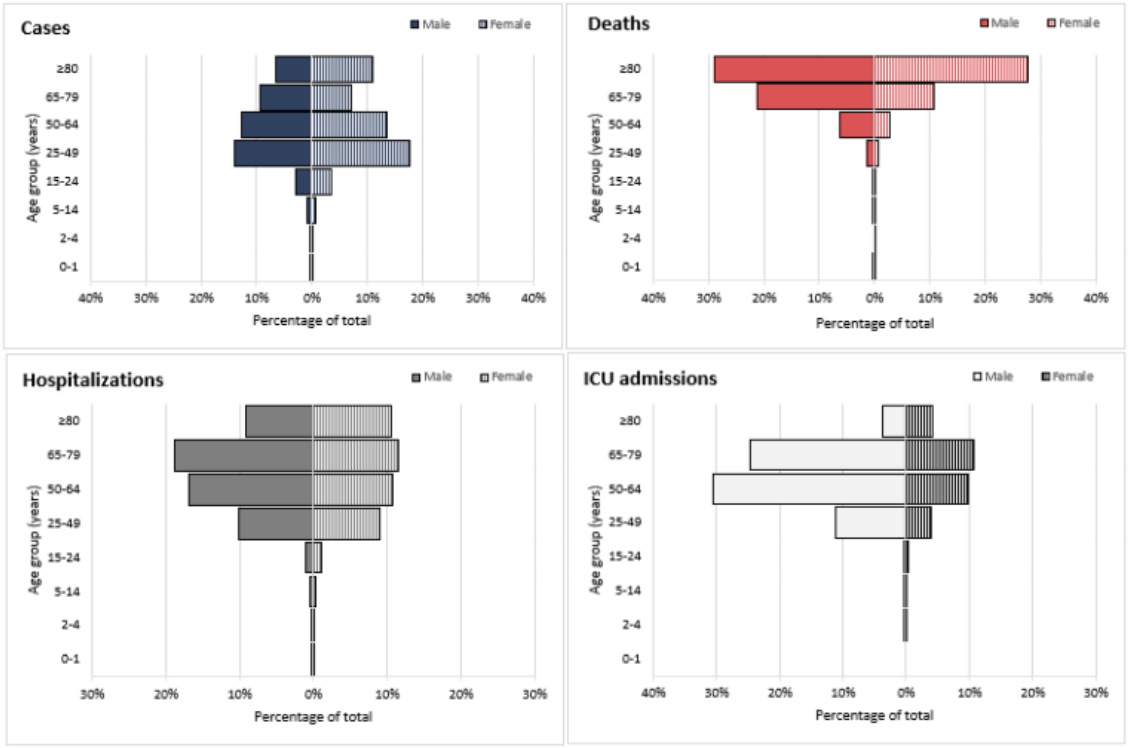
Source: Cases: Case-report forms; Deaths: Case report forms and mortality survey

Table 1. Characteristics of COVID-19 cases and deaths

	Characteristics	n	%	Total records with data available
Cases *	Age in years, median (range)	55 (1-105)		551,326
	Sex, male	255,185	46	549,295
	Recovered	205,687	91	226,657
	Health care workers	42,529	27	155,977
	Hospitalization	49,401	20	243,916
	Intensive care unit admissions	5,149	2	230,258
Deaths ^	Age in years, median (range)	82 (0-108)		93,954
	Sex, male	54,274	58	93,826
	At least one underlying condition	39,647	95	41,742
	• cardiovascular disease	6,768	76	8,891
	• diabetes	2,689	35	7,682
	• lung disease	1,635	33	5,020
	• neurological disease / dementia	1,981	28	7,085
	• renal disease	1,151	18	6,319
	• malignancy	448	100	448
	• obesity	297	10	2,913
	• liver disease	355	6	6,310
	• immune disease	68	2	2,922
	• other	883	23	3,796

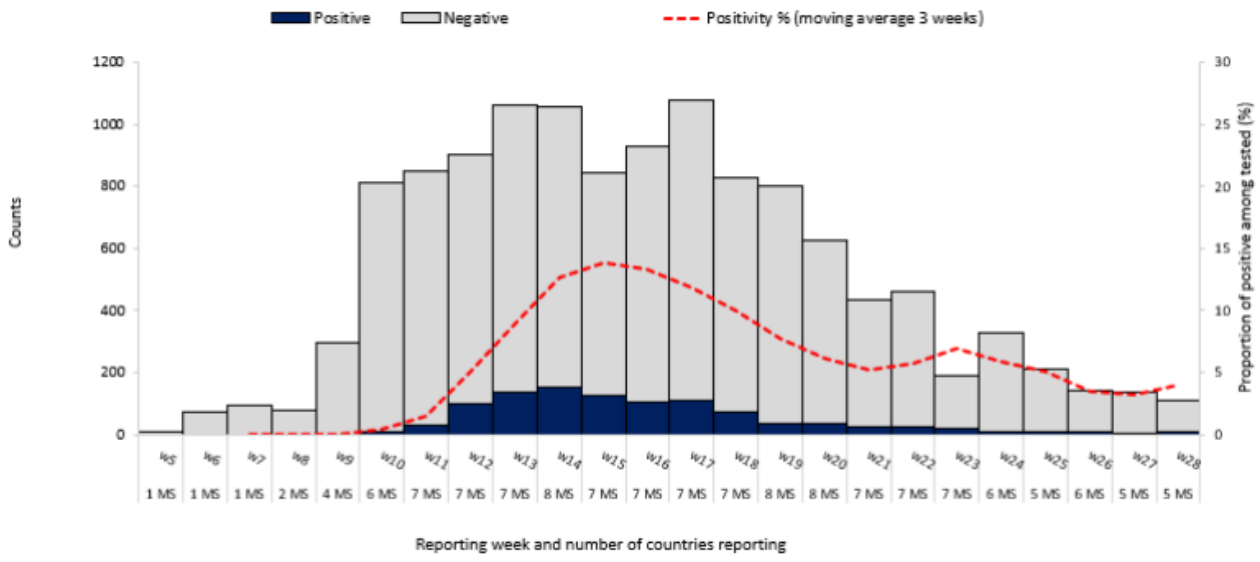
Source:
*Case report forms (n=553,810); Health care workers refer to occupation and not to the place of exposure
^Case report forms and mortality survey (n=93,960)

Figure 4. Percentage of COVID-19 cases (N=547,017), hospitalizations (N=48,956), ICU admissions (N=5,051) and deaths (N=93,816) by age group and sex



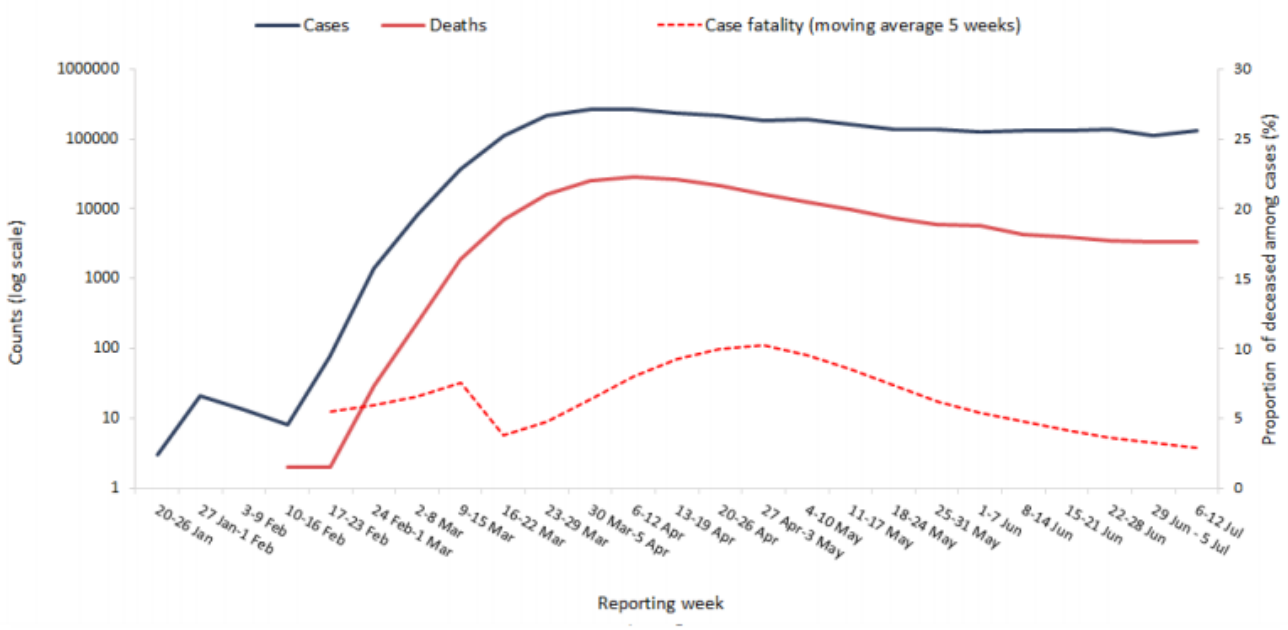
Source: Cases, hospitalizations and ICU data: case report forms; Deaths: Case report forms and mortality survey

Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



Source: Aggregate data from TESSy. MS: Member State

Figure 1: Number of COVID-19 cases (N=2,918,034) and deaths (N=203,389) by reporting week



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Subject in Focus

European armed forces and COVID-19

In times of a crisis the military is often seen as a last resort. However, as COVID-19 cases continued to grow many countries – especially in Europe – activated their armed forces to fight the pandemic.
A briefing published by the European Parliament shed a light on the various aspects of the use of armed forces in times of the pandemic. The briefing can be found, following this link. While the briefing was published at the end of April, most aspects are still valid.
The most important point is that the armed forces provided a huge additional value to the fight against the disease. The support and services added to the general response were not limited to logistics or providing "helping hands" but touched almost all aspects of the response. The picture on the right provides an overview of the variety of military assistance during the crisis.

Source: European Parliamentary Research Service (2020)

During the early stages of the pandemic, the military was mostly involved in transporting much needed equipment to hotspots of the outbreak (either donated equipment from partner nations or purchased equipment from countries with large production capacities). Thereby especially the multinational airlift commands (e.g. SALIS) proved to be very helpful. Another important aspect of international logistic cooperation was the use of various air forces to transport infected patients between severely and less affected countries to guarantee that they receive the best possible treatment; prior to that the air forces were tasked with the repatriation of European nationals stranded outside of the EU. All in all, these operations showed the necessity and effectiveness of multinational coordination between the armed forces. The ability of the armed forces to react to adverse scenarios like a pandemic on short notice and with a high degree of expertise and professionalism came in handy when field hospitals were needed to treat huge numbers of patients. The military's medical service was – and still is – a reliable partner that is capable of rapidly deploying physicians, nurses and auxiliary staff to the most affected areas.
But apart from the well-received help the armed forces provided during the pandemic, COVID-19 also poses some threats to the security ecosystem:

- Possible **reduction of military budgets**: Interestingly the pandemic is likely to bring some countries closer to NATO's 2%-goal of military budget in relation to a country's GDP. Due to the pandemic the GDP of most countries is believed to shrink dramatically. If military expenses stay constant this will – mathematically – increase the relative seize of the military budget. Unfortunately, many experts expect military budgets to be reduced in order to finance other governmental projects (e.g. the health system or restarting the economy), despite the armed force's praised reaction to the pandemic.
- **Vulnerability of the defence industry**: Many countries have reduced or cancelled their ordering of military equipment. This reduces the revenue of the affected companies and might makes it necessary for them to increase their debts. Thereby those companies become more vulnerable to foreign investors. Increased caution and more restrictive legislation are needed to protect key companies from being bought by foreign investors.
- **Geopolitical tensions**: It is highly unlikely that the crisis will make geopolitical tensions disappear. Keeping in mind the two points above, after the crisis the countries in general and the armed forces in particular might find themselves in more adverse and challenging surroundings than before.
- **Reduced speed of multinational integration**: With reduced budgets there is a risk that some key integration projects might be cancelled, postponed or at least slowed down, with negative consequences for the continent's ability to act as a global player in times of a challenging geopolitical situation.

But there is good news as well: The European countries' armed forces (re)action during the crisis demonstrated that many of the existing structures work quite well and more multinational coordination and integration is a good way to make best use of every countries' military potential.

MilMed CoE VTC COVID-19 response

Overview	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 **We transfer the VTC from July until end of August in an standby modus. If we will face a second wave we can resume the VTC immediately and come back to you. Otherwise we will inform you after the summer break how we proceed with the VTC's.**

Conflict and Health

COVID 19 Crisis in Gaza Strip

In cooperation with
Bundeswehr HO of Military Medicine

Quarantine and isolation in the Gaza Strip

The Gaza Strip is on the verge of collapse even without a corona. The UN warned five years ago that the Gaza Strip would no longer be really habitable by 2020: 14 years of economic blockade and isolation, three wars with Israel and internal Palestinian conflicts have brought the region into this humanitarian catastrophe. It is populated by approximately 1.9 million people, of whom 1.4 million are Palestinian refugees. They live on 365 square kilometers, which means about 6000 people per square kilometer, making it one of the most densely populated areas in the world. In particular, the Jabalia refugee camp with more than 120,000 refugees in 1.4 square kilometers has a population density of just under 80,000 people in one square kilometer.

95 percent of the population have no regulated access to drinking water and 50 percent depend on the food supply through humanitarian organizations or the United Nations.

Overpopulated, isolated, littered, without enough drinking water or electricity, the Gaza Strip has an even greater medical challenge with its barely existing health system.

After the first two COVID-19 cases were imported into the already isolated Gaza Strip in mid-March, the poor health system with COVID-19 was further exacerbated. To date, however, only a few corona cases are known, of which only one has died so far.

The 60-70 ventilators are spread across 70-100 intensive care beds. After the UN coordination office for the occupied Palestinian Territories calculated in early April that only 1,000 pharyngeal swabs and 500 corona tests are available in Gaza, more than 13,000 tests have been carried out in the meantime.

Several isolation centers have been set up, six of which are currently in operation.

Anyone entering the Gaza Strip must undergo a 21-day quarantine by the end of 2020. The strict closure measures (mosques, markets, playgrounds, evening curfew etc.) that were imposed in the spring have been relaxed again due to the positive development.

Even if the Gaza Strip was or was protected by its involuntary isolation, it may not prevent it from erupting in the future. The recommended preventive measures to prevent the spread do not come up against fertile soil in the Gaza Strip, since hardly any drinking water is available and there are hardly any hygiene and disinfectant products available.

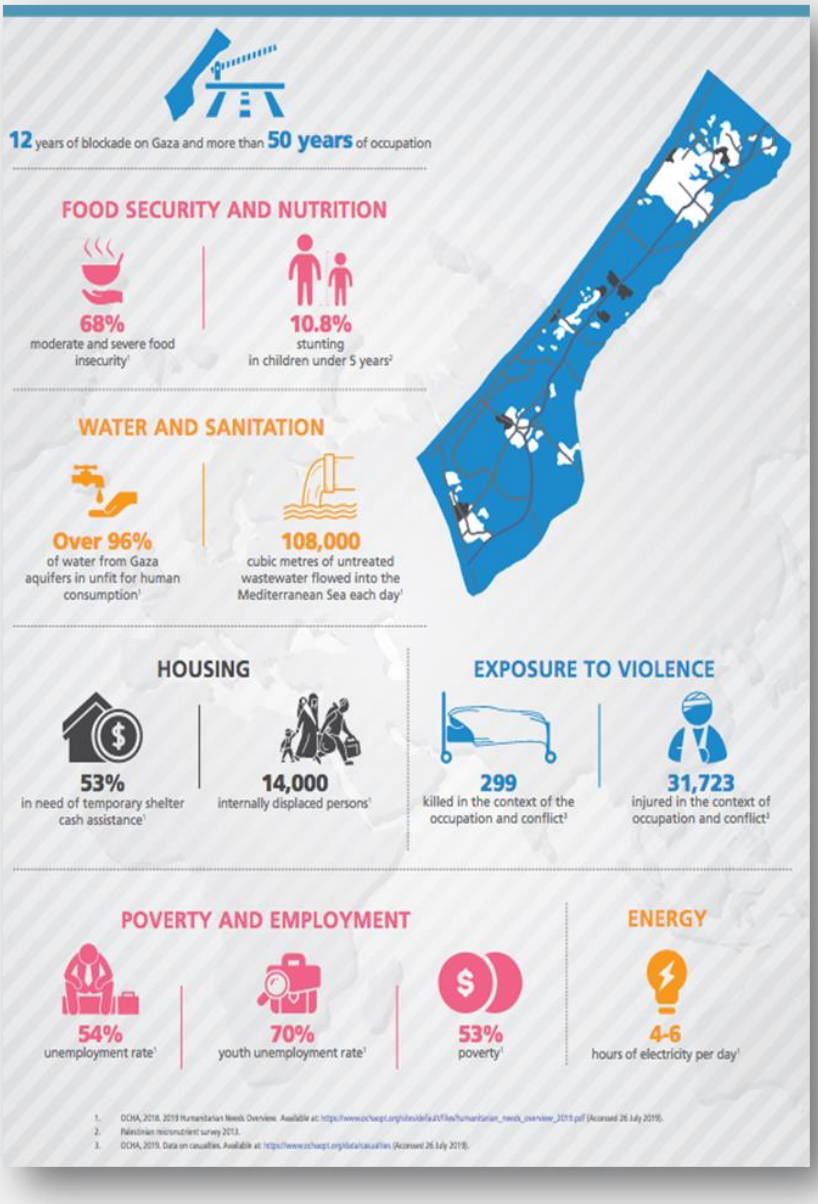
The population density and living conditions, especially in the 5 refugee camps (see in the picture), hardly allow any effective “social distancing” measures. A negative effect of the outbreak measures that are showing the effect is the very severely restricted medical treatment, especially outside the Gaza Strip.

Thousands of particularly chronically ill patients cannot be cared for at the moment, or only to a limited extent. According to the

Ministry of Health, unlike the only COVID-19 dead, 73 patients died from the consequences of the lack of resources reserved for the COVID-19 Response Plan or from the restrictions imposed by it.

Conclusion: So far, the Gaza Strip has managed to control COVID 19 with internal quarantine measures, involuntary external isolation, expanded testing options and other public health measures. So far, another humanitarian catastrophe, probably unheard of before, has been avoided. How long this "happy" state lasts in an "unhappy" overall situation is uncertain.

https://reliefweb.int/report/occupied-palestinian-territory/gaza-thousands-lives-chronic-disease-patients-risk-during



http://www.emro.who.int/in-press/commentaries/covid-19-in-gaza-a-pandemic-spreading-in-a-place-already-under-protracted-lockdown.html
http://www.crisisgroup.org/middle-east-north-africa/eastern-mediterranean/israelpalestine/b75-gaza-strip-and-covid-19-preparing-worst
https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_33-en.pdf
http://www.emro.who.int/images/stories/palestine/documents/who_right_to_health_2018_web-final.pdf?ua=1

Recommendations

Recommendation for international business travellers	**Travel has been shown to facilitate the spread of COVID-19 from affected to unaffected areas. Travel and trade restrictions during a public health event of international concern (PHEIC) are regulated under the International Health Regulations (IHR), part III.** The majority of measures taken by WHO Member States relate to the denial of entry of passengers from countries experiencing outbreaks, followed by flight suspensions, visa restrictions, border closures, and quarantine measures. Currently there are exceptions foreseen for travellers with an essential function or need. **In the case of non-deferrable trips, please note the following** • Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules. • Check your national foreign office advices for regulations of the countries you´re traveling or regulations concerning your country. • Information's about the latest travel regulations and De-escalation strategy measures you can find at IATA and International SOS. For Europe you will find more information here. **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 • A medical mask is not required if exhibiting no symptoms, as there is no evidence that wearing a mask – of any type – protects non-sick persons. 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

European Commission:
The coronavirus outbreak is a serious threat to public health. Lockdowns and other coordinated restrictive measures are necessary to save lives. However, these measures may also severely slow down our economies and can delay the deliveries of critical goods and services. The European Commission has taken measures to ensure continued and uninterrupted land, waterborne and air cargo services. These services are of crucial importance for the functioning of the EU's internal market and its effective response to the current public health crisis.

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. Measures intended to enable citizens to travel again after months of confinement include, but are not limited to:

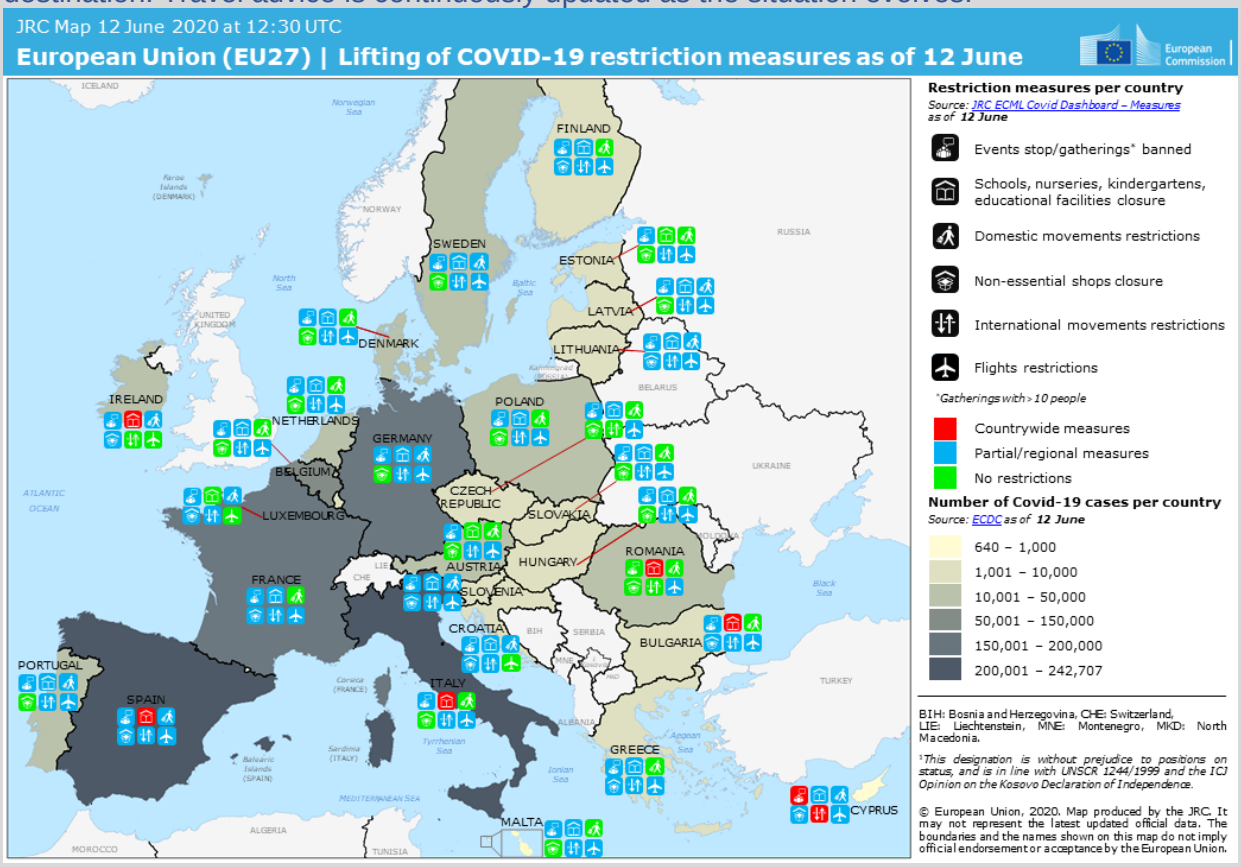
Re-open EU – new web platform to help travellers and tourists

On 15 June, the European Commission launched 'Re-open EU', a web platform that contains essential information allowing a safe relaunch of free movement and tourism across Europe. To help people confidently plan their travels and holidays during the summer and beyond, the platform will provide real-time information on borders, available means of transport, travel restrictions, public health and safety measures such as on physical distancing or wearing of facemasks, as well as other practical information for travellers.

Re-open EU will act as a key point of reference for anyone travelling in the EU as it centralises up-to-date information from the Commission and the Member States in one place. It will allow people to browse country-specific information for each EU Member State through an interactive map, offering updates on applicable national measures as well as practical advice for visitors in the country. Available in the 24 official EU languages.

Travel advice and Border measures

Travel advice is a national competence and you should check if your national authority, e.g. the Ministry of Foreign Affairs, has issued an official travel warning concerning your planned destination. Travel advice is continuously updated as the situation evolves.



Source: https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en

Risk Assessment	
Global	• Because of global spread and the human-to-human transmission the **moderate to high** risk of further transmission persists. • Travellers are at risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks. • Individual risk is dependent on exposure. • National regulation regarding travel restrictions, flight operation and screening for single countries you will find here. • 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. • Appropriate to the global trend of transmission of SARS-CoV-2 an extensive circulation of the virus is expectable. At this moment of time, 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	ECDC assessment for EU/EEA, UK as of 11 June 2020: • **Risk of COVID-19 to the general population currently assessed:** **Low** in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates. **Moderate** in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place. • **Risk of COVID-19 to the population with defined factors associated with severe disease outcome currently assessed:** **Moderate** in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates. **Very high** in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place. • **Risk of COVID-19 incidence rising to a level that may require the re-introduction of stricter control measures is currently assessed as:** **Moderate** if measures are phased out gradually, when only sporadic or cluster transmission is reported, and when appropriate monitoring systems and capacities for extensive testing and contact tracing are in place. **High** if measures are phased out when there is still ongoing community transmission, and no appropriate monitoring systems and capacities for extensive testing and contact tracing are in place.

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
- Our World in Data; https://ourworldindata.org/coronavirus
- Morgenpost; https://interaktiv.morgenpost.de/corona-virus-karte-infektionen-deutschland-weltweit/

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