Update 31 (4th of August 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
4th of August 2020
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In December 2019, a novel coronavirus emerged in Wuhan City, China. Since then the virus spread to 65 countries including Europe and America. Since then the virus showed evidence for human-to-human transmission as well as evidence of asymptomatic transmission. At 30th January 2020 WHO declared a Public Health Emergency of International Concern. The disease was formally named COVID-19 on 11th of February. The virus itself has been named SARS-CoV-2. On 11th of March 2020 WHO characterized the disease as a pandemic.

HIGHLIGHTS/NEWS

- **WHO** has updated the interim guidance on Water, sanitation, hygiene(WASH), and waste management for SARS-CoV-2.The document provides additional details on risks associated with excreta and untreated sewage, on hand hygiene, on protecting WASH workers and on supporting the continuation and strengthening of WASH services, especially in underserved areas.
- **WHO** has published a draft for Target Product Profiles (TPP) for COVID-19 therapeutics. The three sets of TPPs describe the preferred and minimally acceptable profiles for therapeutic agents for the treatment of those withCOVID-19, ranging from mild through critically ill patients.
- **WHO** has published a COVID-19 Preparedness and Response Progress Report. The report highlights the progress made from 1 February to 30 June 2020 under the three objectives outlined in the Strategic Response and Preparedness Plan: scaling up international coordination and support, scaling up country preparedness and response by pillar and accelerating research and innovation. The report also discusses some of the key challenges faced, and provides an update on the resource requirements for the next phase of WHO's response.
- **Europe WHO:** A team of Russian laboratory experts is providing support to Tajikistan's COVID-19 response. The team from Rospotrebnadzor, Russian Federation, an active member of the Global Outbreak Alert and Response Network, will assess Tajikistan's existing laboratory system, including the flow of information, and suggest steps to strengthen the COVID-19 laboratory data management system
- **ECDC** has published an EU guidance for cruise ship operations

GLOBALLY
18 199 288 confirmed cases 10 875 790 recovered 692 795 deaths
EU/EEA and the UK
3 116 518 confirmed cases **1 907 083** recovered **209 908** deaths
USA → **(new cases/day 59 704)**
4693 697 confirmed cases **1 512 758** recovered **155 154** deaths
Brazil → **(new cases/day 44 941)**
2 750 318 confirmed cases **2 098 976** recovered **94 665** deaths
India → **(new cases/day 52 606)**
1 803 695 confirmed cases **1 186 203** recovered **38 135** deaths
Russia → **(new cases/day 5 423)**
854 641 confirmed cases **652 372** recovered **14 183** deaths
UK ↗ **(new cases/day 787)**
305 623 confirmed cases **not reported** recovered 46 210 deaths

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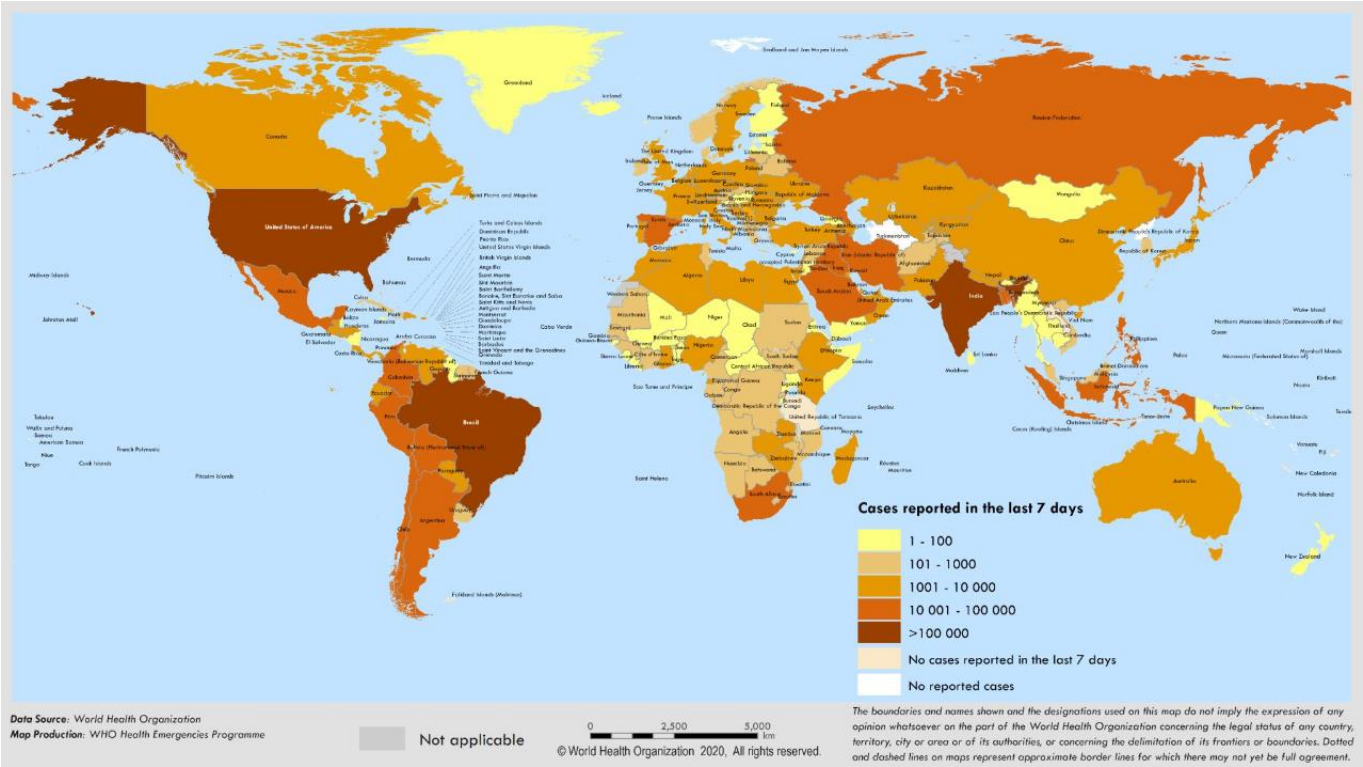
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation

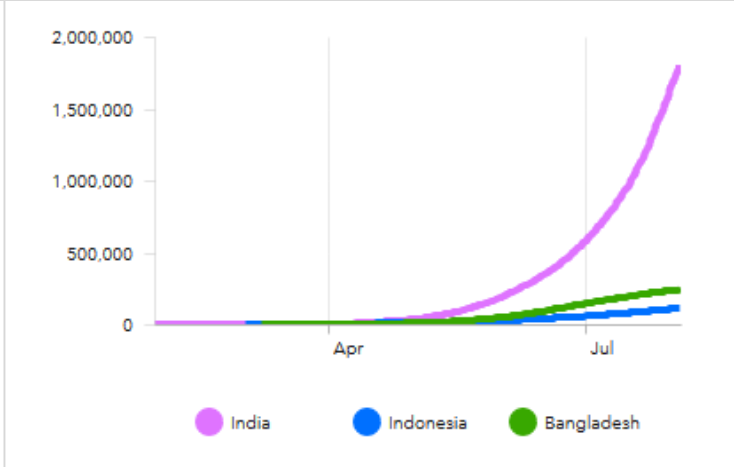
WHO

Worldwide, people are waiting for the Corona vaccine, which could enable them to return to normal life - at least partly. The progress of pharmaceutical companies like Biontech or Curevac is closely monitored. But the World Health Organization (WHO) has now warned against being overly optimistic about finding a vaccine. "There is no panacea at the moment, and maybe there will never be" said WHO director general Tedros Adhanom Ghebreyesus on Monday.
Therefore, the best protection is still to follow all standard rules such as wearing masks, washing your hands frequently and keeping your distance. The WHO Emergency Committee believes that the pandemic will “last very long”.

WHO

Over the past seven days, the pandemic has continued to accelerate with almost 1.8 million new cases and 40,000 new deaths reported –a daily average of 256,294 new cases and 5,675 new deaths per day. It took only four days for the number of cases to increase from 16 million to 17 million. The WHO Region of the Americas remains the hardest-hit, contributing over half (54%) of all newly confirmed cases reported and deaths during the past week. The Southeast Asian and Western Pacific regions also continued to see substantial increases in confirmed cases and deaths. Among all the countries, territories, and areas reporting confirmed cases, the United States of America, Brazil, and India remain the top three most affected countries in the past seven days.

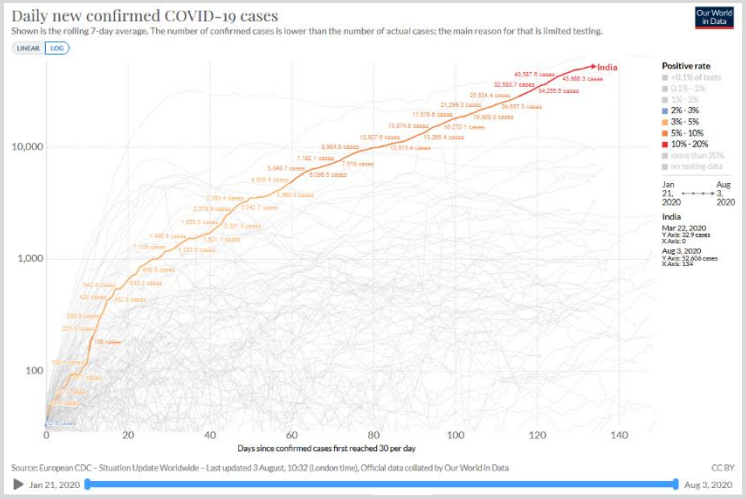
INDIA:



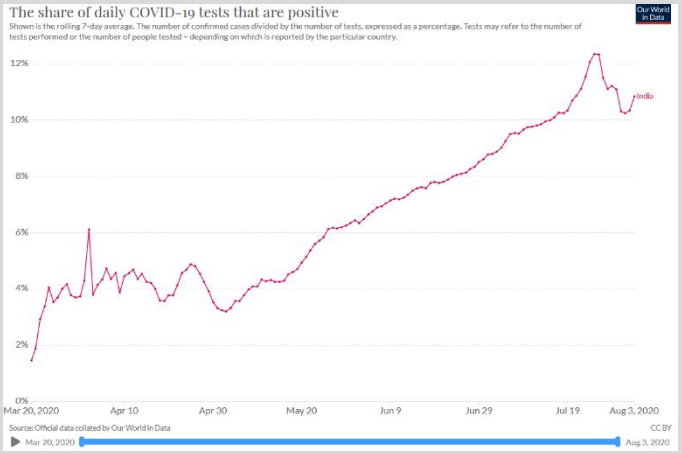
Following the initial detection of SARS-CoV-2 in Kerala on January 30th 2020, there was no significant increase in infection numbers throughout February until 22 new cases were reported on March 4th, including 14 infected tourists from an Italian tourist group. A Sikh cleric participated in the Sikh festival "Hola Mohalla" in Anandpur Sahib in the state of Punjab from March 10th to 12th after returning from a trip to Italy and Germany. According to reports, the priest had become infected during his trip to Europe and, without showing any obvious signs of illness, had acted as a "super spreader" for the corona virus during the festival. Following the festival, 27 cases of COVID-19 were identified who had also participated in the festival and had contact with the priest. As a result, on March 27th, more than 40,000 people were quarantined in 20 villages in the state of Punjab to counter the spread of the virus. Another “super spreader” event was announced on March 31st, just a few days after the event in Punjab: Although India was already in lockdown, a meeting of the Muslim faith community was held in the Markaz Nizzamuddin Mosque in the south of the capital Delhi the Tablighi Jamaat. Thousands of members of this group stayed together for days in a confined space in the mosque without any complying with the rules of social distancing. The 1,023 infections that could be attributed to this event by April 4th represent more than a third of the 2,902 cases registered in India at that time. Infections from 21 of the Indian states were directly related to Tablighi Jamaat. 22,000 people in contact with members of the Tablighi Jamaat group were quarantined. The event at the Markaz Nizamuddin Mosque was considered the country's most important hotspot among the 14 hotspots observed in India at the time.
Six months after the initial case (January 30th), India took third place among the countries most affected by SARS-CoV-2 worldwide. With the second largest population in the world and its extremely high population density, especially in urban areas, India has become a new corona hotspot. The unusual low death rate in India of just 2.34% makes scientists question the reliability of the data. Five facts are known about the spread of SARS-CoV-2 in India.

1. India's case numbers are increasing rapidly.

With the daily detection of tens of thousands of new infections, India has continued to break new records with its growth in infections in the past few weeks. However, the greatest increase in infection numbers only occurred in June after the strict lockdown was eased as stores reopened and the economy slowly restarted.



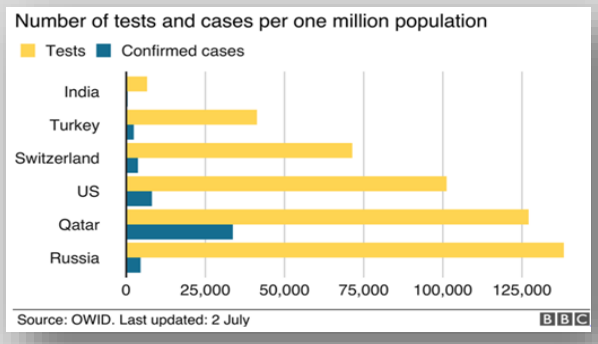
However, the actual extent of infection rates among the population remains largely unclear. In May, the Indian government carried out a PCR-based study among 26,000 people, with the result that 0.73% of those tested were infected. Some experts had concerns about the size of the sample, while others stated that this is – in their opinion - the only indicator for the COVID-19 situation that can be used in India at all. It is well known that if the number of tests is increased the detection of new cases increases as well. More testing has been done in India in the past few weeks. India has performed more than 10 million PCR tests since March 13th, but half of these tests were performed after June 1st, 2020.



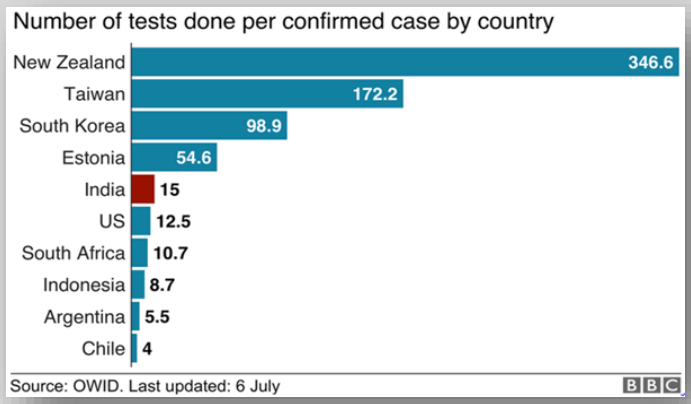
An antibody-based study in New Delhi, which was commissioned by the government, seems to have led to similar results. According to this, antibodies against SARS-CoV-2 as a correlate of a past infection were detected in 23.48% of the 21,387 tested inhabitants of the capital. Previous PCR testing only showed an infection in less than 1% of Dehli's 19.8 million inhabitants. Extrapolating the findings of the anti-body study the 23.48% of people showing anti-bodies would translate into 4.65 million inhabitants of the capital being infected. In a press release, the government explains this discrepancy with the high rate of asymptomatic infections. The government even goes so far as to say that the share of 23.48% antibody-positive people may even be underestimated due to the existence of numerous extremely densely populated neighborhoods in Delhi, which were underrepresented in the study. Delhi is one of the major cities affected by COVID-19

2. India is far from testing extensively

India's official case numbers appear to be high in absolute terms, but seem relatively low in relation to the population. The Indian government recently noted that population-borne infections in other parts of the world are – on average - three times higher than in India. Dr. Jameel countered that India's population-based number of cases was so small precisely because the country was testing too little. If you compare India with countries that have a high number of infected people, based on their population, it shows that in these countries much more testing is conducted. India has carried out only 6,500 tests per 1 million inhabitants. However, it is not just a question of how much is tested, but above all who is being tested. India has limited its testing, including contact tracing, to high-risk individuals for far too long without extending its testing strategy to the



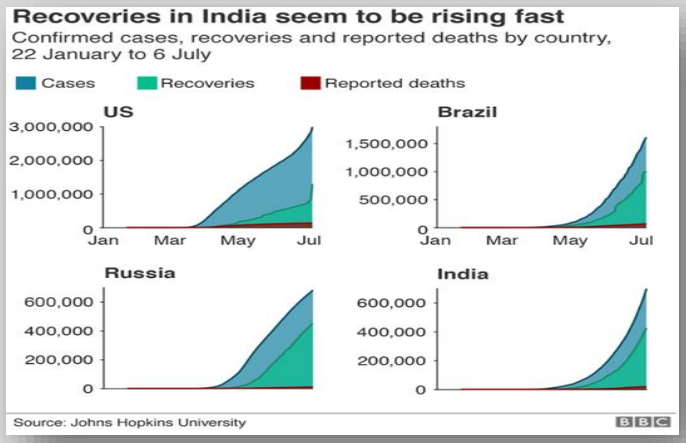
general population. As the infection spread quickly to the general population, the containment measures taken, became increasingly inadequate, according to Himanshu Tyagi (Indian Institute of Science) and Aditya Gopalan (Institute of Technology, Haifa, Israel), both mathematicians who have worked in the field of Corona test strategies. The previous procedure was helpful regarding containment measures, but so far has hardly revealed community-based transmissions. For this purpose, the population would have to be tested to a completely different extent. But how do we know who is being tested in India according to which principle? A comparison of the number of tests carried out in different countries is often not possible without restrictions. For example, some countries count the number of people tested, while other countries, including India, count how many tests have been performed. Because most people undergo multiple tests, India's number of tests performed is higher than in countries which number of tests relates to the number of people tested. For this reason, researchers prefer to count the number of tests necessary to detect a confirmed case. Looking at this indicator, India performs poorly compared to most countries that have managed to slow the spread of the virus. The more widespread testing is conducted, the lower the proportion of positive test results- this is one reason why the rate of positive tests in New Zealand and Taiwan is below 1%. In India it was at 3.8% in April and rose to 15% in July. If the rate of positive tests continues to increase, it is because the number of tests conducted is still too limited and the testing strategy is focusing on high-risk people and their contacts.



3. India's recovery rates are promising.

The data gives the impression that COVID-19 patients in India recover from the disease faster patients die from it. "This is vital for survival," says Dr. Jameel, “because this dynamic determines whether and to what extent the health system is overloaded.

At the moment, the number of deaths is increasing slower than the infections and recoveries after illness. However, as soon as the rise in the number of deaths accelerates compared to the other two parameters, this would signal an even higher pressure in the hospitals and would therefore probably provoke further deaths."

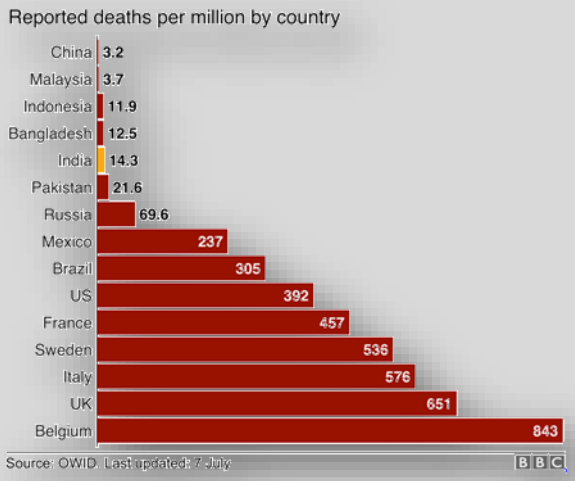


In a global comparison, India's curve of those recovering from COVID-19 appears to be rising more steeply than in other countries that have been hit hard. A steeper curve climb would have a positive implication: It would mean that Indian COVID-19 patients recover faster than patients in the United States or Brazil. India's share of recovered, i.e. the percentage of patients who have fully recovered from confirmed illness would be higher. With 60%, India appears to be clearly ahead of the USA, where the number of people who have fully recovered is only at 27%. Looking at the term “recovery” as it is understood in India, the data is extremely sketchy and the definition of what “recovery” actually means varies considerably. India classifies everyone as "recovered" who has tested positive for the virus and whose test became negative after a few weeks. However, some other countries only count hospitalized cases presenting a negative test result afer hospitalization as “recovered”.

4. India's death rate is extremely low

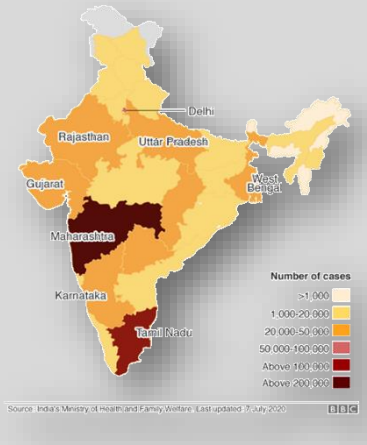
India has so far registered 32,771 confirmed deaths from SARS-CoV-2. In absolute numbers, this is the sixth highest number of deaths worldwide. In relation to the population of 1.353 billion people, however,

this value is very low and results in only 24 deaths per 1 million inhabitants. In contrast, Brazil has a death rate of 415 per 1 million with 209.5 million inhabitants. "The Indian death rate from COVID-19 is only a fraction of what has been observed in Western Europe to date, said economist Dr. Shamika Ravi of the Brookings Institution in Washington. There have been numerous doubts about the death rates reported by the Indian side, and most experts agree that this is probably also due to massive underreporting. "Nevertheless, this does not explain the extreme difference between the Indian and e.g. Western European numbers. If the death toll in India was actually comparable to that in the western world, no data in the world could hide the 20 to 40 times higher mortality rate from COVID-19, ”said Dr. Ravi. India's low death rates are similar to those reported in other countries such as Pakistan and Indonesia. The attempted explanatory models range from a higher prevalence of infections in the region with a less virulent virus strain circulating in these countries to an on average significantly younger population with less severe courses compared to the sometimes very badly affected western countries with their on average older population. Not every country is able to style its numbers like this, Dr. Jameel. An unknown innate immunity may exist within Southeast Asian populations. The fact is, we don't know why India's death rates are so low.



5. Every Indian state tells a different story

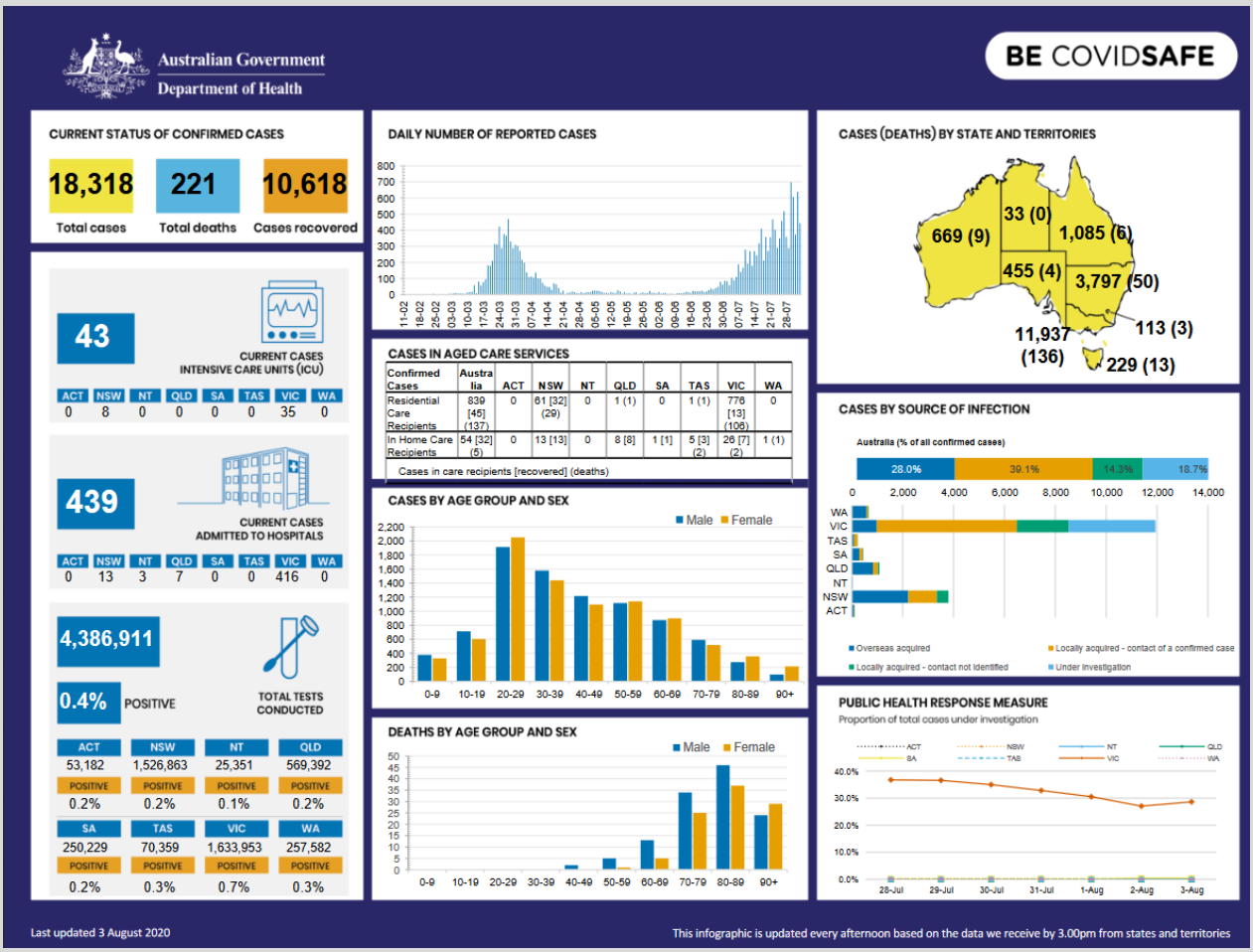
Similar to the USA or the European Union, the corona statistics also vary considerably in the different Indian states or Indian Union territories. Delhi, Maharashthra and Tamil Nadu together account for about 60% of all cases registered nationwide. While new cases in some states continue to decline, in return they have increased in other states. The last massive increase in cases occurred in Karnataka and Telangana. In the southern state of Andra Pradesh, we see constant transmission rates.



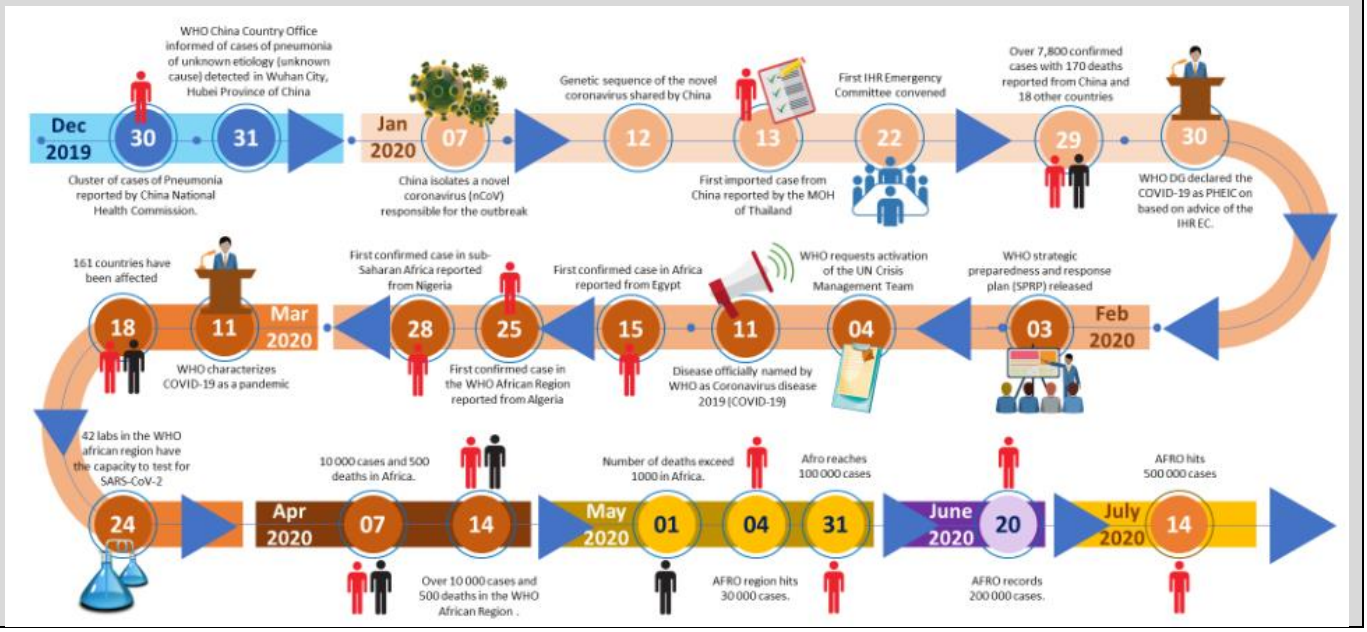
Source: https://www.bbc.com/news/world-asia-india-53284144
https://www.ndtv.com/india-news/coronavirus-tablighi-jamaat-30-per-cent-of-coronavirus-cases-linked-to-delhi-mosque-event-government-2206163

USA: in the United States, the number of new coronavirus infections has decreased for the second day in a row.

AUS: Victoria has reported increasing numbers of people who have acquired COVID-19 locally. This increase is linked with multiple outbreaks across a range of settings in metropolitan Melbourne.
In Victoria, over the week from 23rd to 29th July 2020 there have been over 2,500 cases reported, an increase from over 2,200 cases reported a the week before; while cases have spanned all age groups, the majority of people recently diagnosed with COVID-19 in Victoria is in the age groups of 10 to 49 years; approximately 6% of the cases recently diagnosed have been admitted to hospital.



ZAF: The COVID-19 outbreak continues to accelerate across the African Region and South Africa remains the epicentre of the outbreak in the African continent, and is now ranked fifth globally, although with a comparatively low number of reported deaths.



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Situation in Europe

ECDC COVID-19 surveillance report Week 30, as of 1 August 2020

Weekly surveillance summary

This summary presents highlights from two separate 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

- As of 29 July 2020, the 14-day case notification rate for the EU/EEA and the UK was 18.8 (country range: 2–215) per 100 000 population. The rate has been increasing for 12 days.
- An increasing trend has been observed in the 14-day COVID-19 case notification rate in Austria, Belgium, Czechia, France, Luxembourg, Netherlands, Poland, Romania and Spain. These trends have been present for between five and 45 days.
- Notification rates are highly dependent on a number of factors, one of which is the testing rate. Weekly testing rates in the EU/EEA and the UK vary between 95.5 and 10 657 tests per 100 000 population. Luxembourg has the highest testing rate for week 30, followed by Denmark, Cyprus, Austria, Ireland and Portugal.

Primary care

- Among the countries that reported data up to week 30 from primary care sentinel surveillance for COVID-19 using the systems established for influenza. There was only a single detection of SARS-CoV-2.
- All countries that reported ILI and/or ARI syndromic surveillance data up to week 30 using the systems established for influenza, have observed consultation rates that remain similar to or lower than those reported during the same period in the last two years.

Hospitalisation

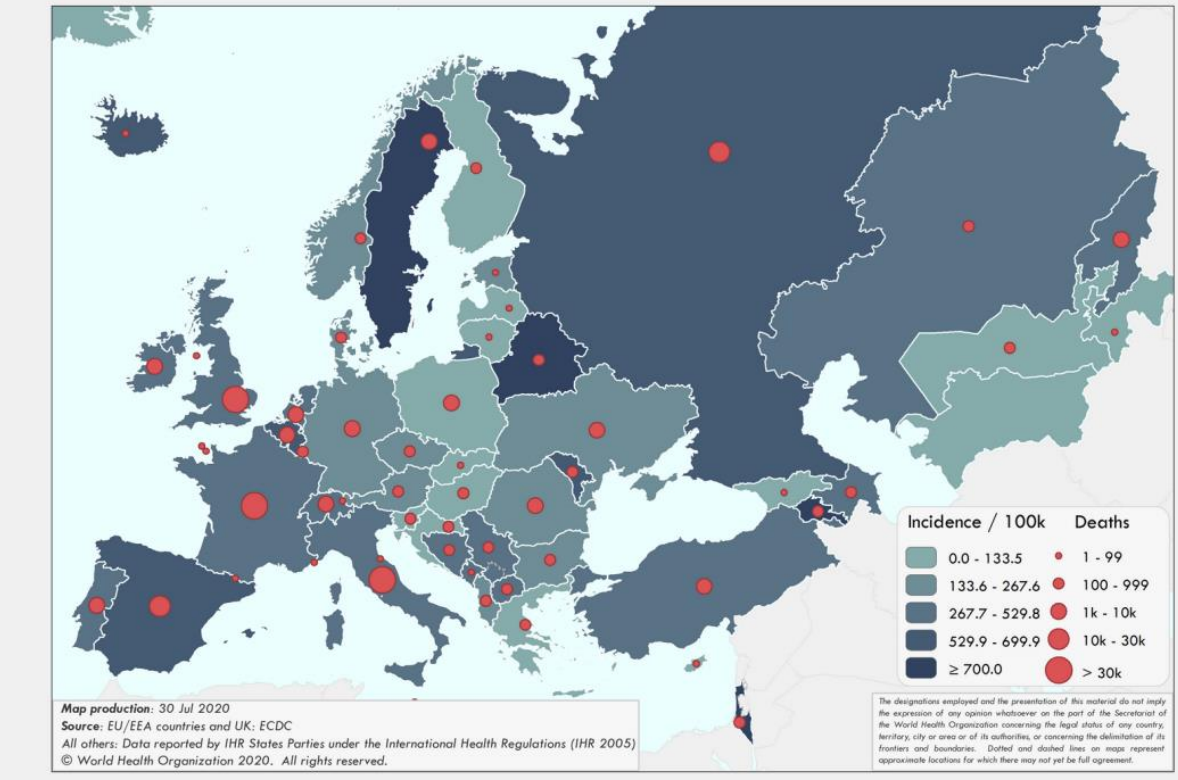
- Hospital and/or ICU occupancies due to COVID-19 are increasing in Bulgaria, Czechia, Luxembourg, Romania and Slovenia. No other increases have been observed, although data availability varies.
- Overall, 29% of reported COVID-19 cases to date in the EU/EEA and the UK have been hospitalised; among hospitalised 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 4.1 (country range: 0-15.9) per 1 000 000 population. The rate has been stable for 13 days.
- A decreasing trend in the 14-day COVID-19 death notification rate in Portugal, Sweden and United Kingdom has been evident for between four and 11 days.
- 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. However, in some countries there might be a tendency towards an increase in mortality which could be linked to heat waves. However this needs to be kept under close observation and further assessment is needed.

COVID-19 situation update for the WHO European Region (20 – 26 July 2020 Epi week 30)

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



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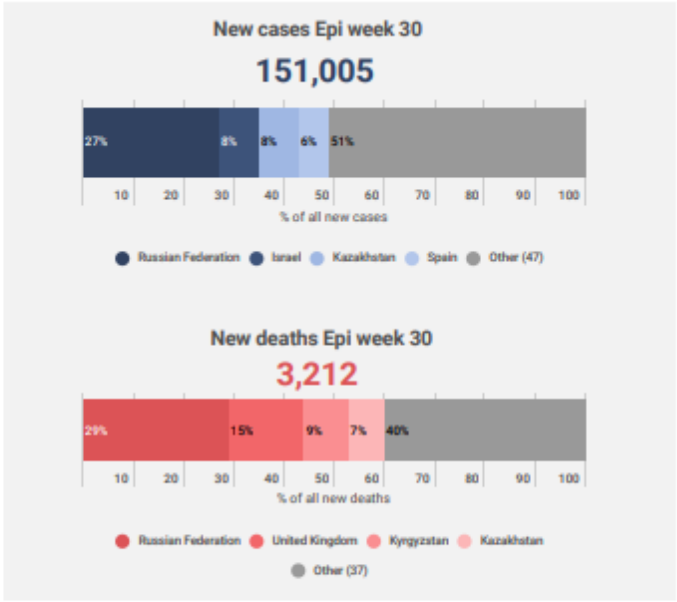
Key points

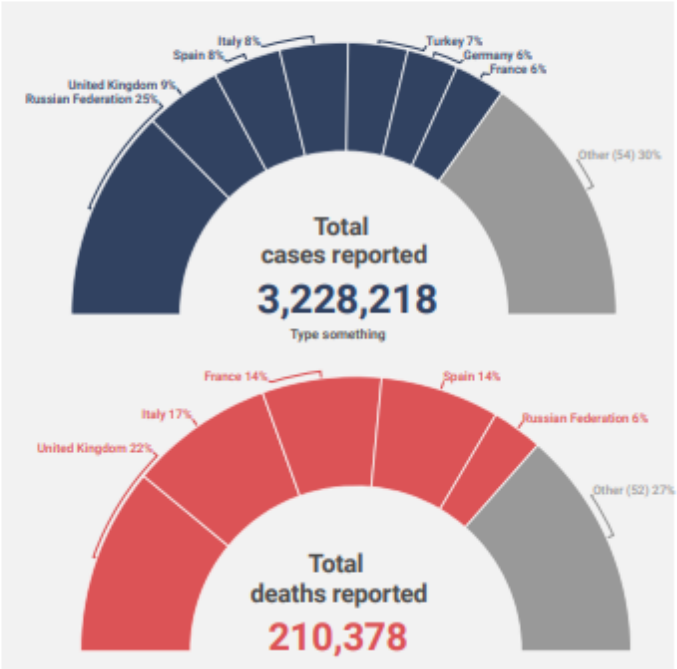
Week 30/2020 (20 - 26 Jul 2020)

- The number of cases reported in the Region has decreased by 4% since week 29/2020; the number of reported deaths has decreased by 11% since week 29/2020
- 48% (72,820) of the cases reported in week 30/2020 were reported from four countries: the Russian Federation (27%; 40,939), Israel (8%, 12,099), Kazakhstan (8%; 11,381) and Spain (6%; 8,401). The remaining cases (51%; 78,185) were reported by 47 countries and territories; each accounted for <5% of the total cases reported in week 30/2020
- Six countries had a crude incidence of ≥60 per 100,000 in week 30/2020: Israel, Luxembourg, Kyrgyzstan, Montenegro, Armenia, Kazakhstan. The crude incidence continues to vary across the region with a range from 0.9 per 100,000 population in Estonia and Latvia to 142 per 100,000 population in Israel
- The 14-day cumulative incidence increased by ≥10% in week 30/2020 in 29 countries and territories in the Region, however for some countries data was retro-adjusted by national authorities: Albania, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Cyprus, Czech Republic, Denmark, France, Georgia, Germany, Hungary, Ireland, Israel, Italy, Kyrgyzstan, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Poland, Republic of Moldova, Romania, Serbia, Spain, Switzerland, the United Kingdom, and Uzbekistan (see EURO COVID-19 Dashboard for recent trends)
- 58% (1,876) of the deaths reported in week 30/2020 were reported by the Russian Federation (29%; 927), the United Kingdom (15%; 465), Kyrgyzstan (9%, 274) and Kazakhstan (7%, 210). The remaining deaths (40%; 1336) were reported from 37 countries and territories; each accounted for <5% of the total deaths reported in week 30/2020
- The proportion of reported cases that died decreased from 2.4% in week 29/2020 to 2.1% in week 30/2020, a change that is likely due to a range of factors
- Community-transmission was reported by 26 countries and territories, 26 countries and territories reported cluster transmission, while 6 countries and territories reported sporadic transmission in week 30/2020 (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. In response to an increase in cases, some countries have recently started reintroducing measures

Summary overview

- The cumulative cases across the Region increased 4.9% to 3,228,218 cases in week 30/2020 (from 3,077,213 cases in week 29/2020) and cumulative deaths increased by 1.6% to 210,378 deaths (from 207,166 deaths in week 29/2020)
- As of 11 July 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)
- Seven countries in the Region each reported a cumulative incidence of ≥700 cases per 100,000 population: Andorra, Armenia, Belarus, Israel, Luxembourg, San Marino and Sweden
- As of week 30/2020, 70% (2,240,421) of cumulative cases were reported from the Russian Federation (25%; 812,485), United Kingdom (9%; 298,681), Spain (8%; 272,421), Italy (8%; 245,864), Turkey (7%; 225,173), Germany (6%; 205,269) and France (6%; 180,528). The remaining cases (30%; 987,797) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 30/2020
- 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 (data as of 20 July 2020)
- As of week 30/2020, 73% of cumulative deaths (152,733) were reported from the United Kingdom (22%; 45,738), Italy (17%; 35,102), France (14%; 30,192), Spain (14%; 28,432) and the Russian Federation (6%; 13,269). The remaining deaths (27%; 57,645) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 30/2020
- 13% of cases were in persons aged ≥65 years in week 30/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥65 years was 58% in week 30/2020 (compared to 91% in week 14/2020) (Figure 3)
- 95% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (81%)
- 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.
- In week 30/2020, five countries reported 87 tests and 1 COVID-19 detection in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 29/2020 was 1.9% (5 countries) compared to 2.1% (5 countries) in week 28/2020. The highest positivity in the sentinel surveillance was 14.6%, seen in week 15/2020
- Overall, there were 80,086 (7.1%) COVID-19 cases among the total of 1,132,652 tests performed in 22 countries for week 30/2020





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

90% of all deaths were in persons aged 65+

81% of all deaths had cardiovascular disease

For more detailed information see: WHO Global situation reports WHO Global situation dashboard

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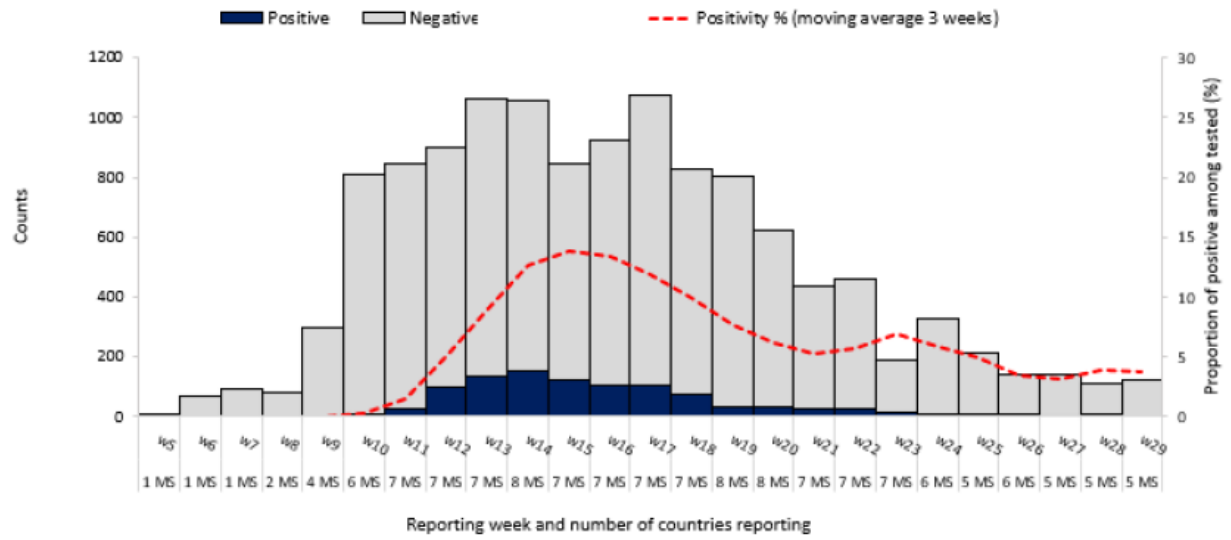
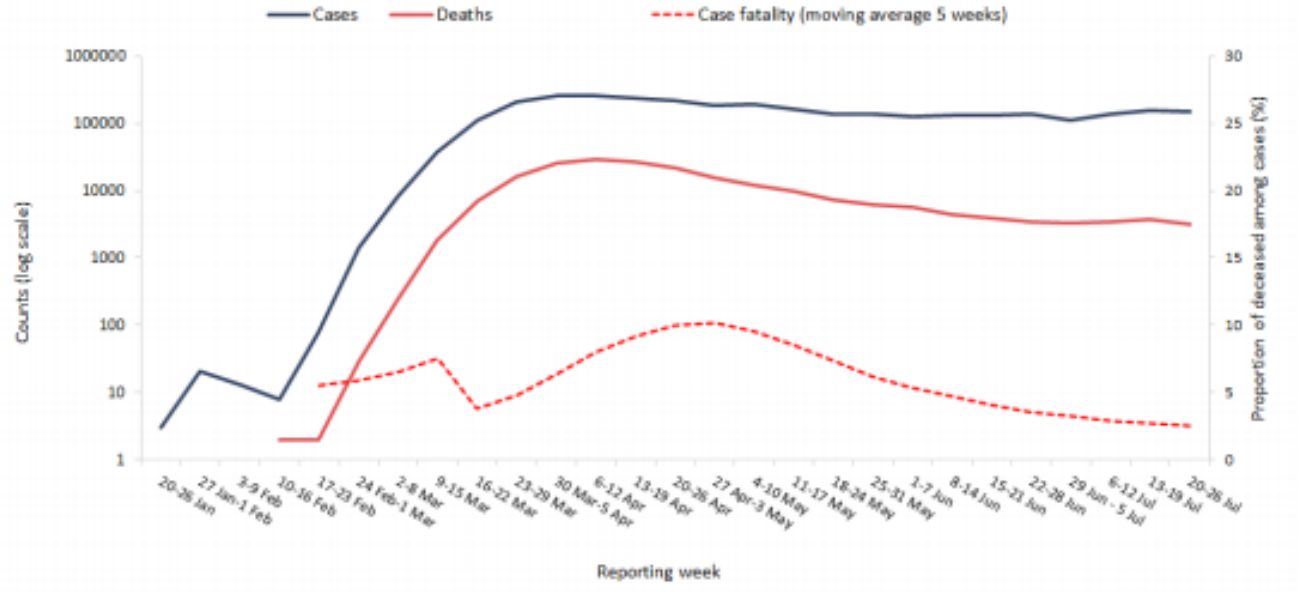
Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



Source: Aggregate data from TESSy. MS: Member State

Figure 1: Number of COVID-19 cases (N=3,228,218) and deaths (N=210,378) by reporting week



Source: IHR reports

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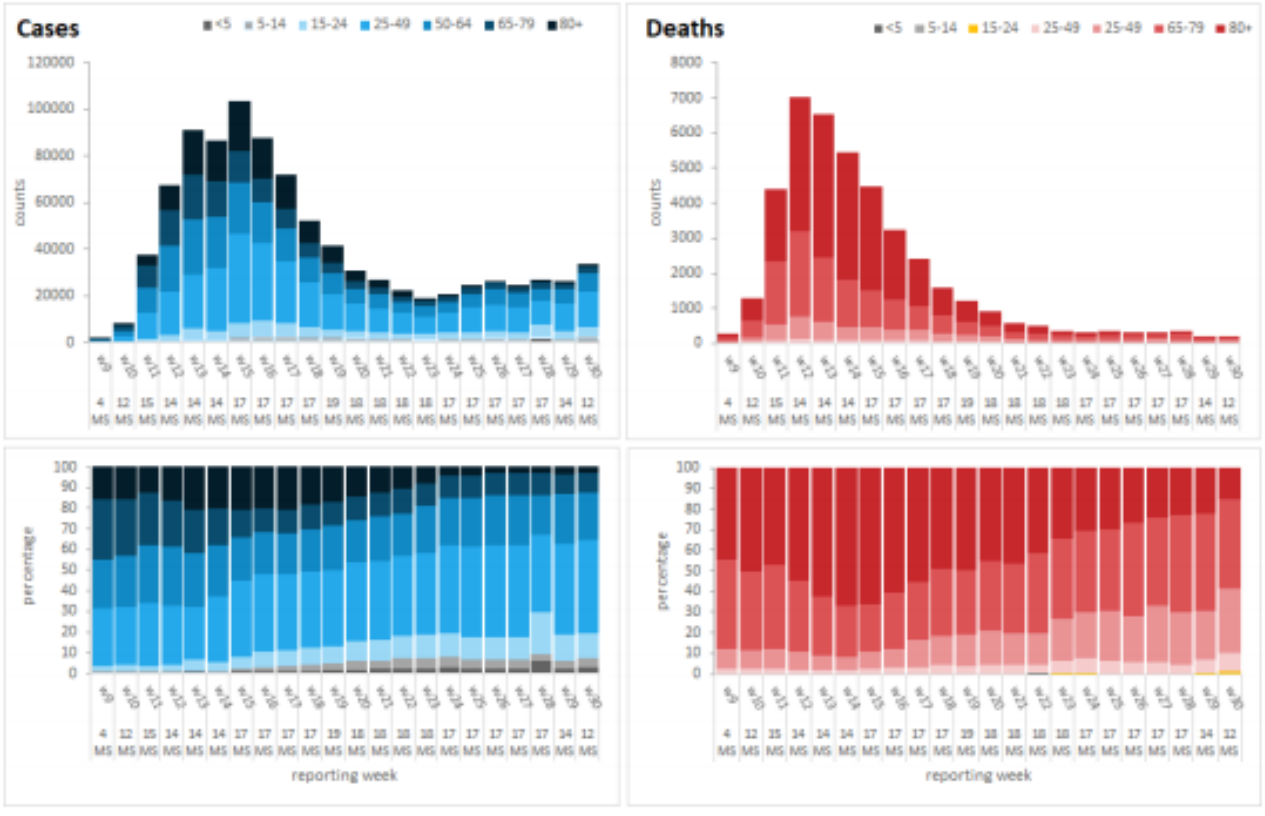
Table 1. Characteristics of COVID-19 cases and deaths

	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	42,549	27	155,077
	Hospitalization	49,401	20	248,916
	Intensive care unit admissions	5,149	2	280,258
Deaths†	Age in years, median (range)	82 (0-108)		137,735
	Sex, male	79,508	58	136,398
	At least one underlying condition	39,518	95	41,594
	• cardiovascular disease	8,585	81	10,622
	• diabetes	2,827	50	5,692
	• lung disease	2,927	51	5,791
	• neurological disease / dementia	3,009	38	7,886
	• renal disease	821	24	3,446
	• obesity	256	10	2,650
	• liver disease	411	7	6,116
	• immune disease	91	3	2,684
	• other	1,423	35	4,121

Source:
*Case report forms, as at 20 July 2020 (n=553,818); Health care workers refer to occupation and not to the place of exposure
†Case report forms as at 20 July 2020 and mortality survey (n=137,751)

Figure 3. COVID-19 cases (N=931,957) and deaths (N=42,358) by age group and reporting week



Source: TESSy aggregated dataset

GBR: plans to use two new rapid test systems to contain the corona virus. Minister of Health Matt Hancock said, according to a statement from his ministry early Monday morning, "Millions of new rapid coronavirus tests will deliver results in less than 90 minutes on site and help us quickly break transmission chains." Hospitals, nursing homes, and laboratories would follow next week and after the new test systems were made available, it was said. This means that more than six million additional tests will be possible in the coming months.
How reliable the tests are has yet to be proven in practice. According to Professor Chris Toumazou from Imperial College in London, the DnaNudge test he co-developed provides next to no false positive or false negative results. There was initially no information on the other test. In addition to Sars-CoV-2, both tests can also detect other viruses, such as influenza viruses, which circulate in the population particularly during the winter. No trained medical professionals are required for implementation, which means that they can also be carried out comparably easily in non-clinical environments.
Great Britain had great difficulties in performing a sufficient number of tests at the beginning of the pandemic, but then expanded its capacity significantly. "The fact that these tests can detect both flu and Covid-19 will help us immensely on our way into the winter so that patients can follow the right advice to protect themselves and others," said Hanco.

In the UK, the coronavirus situation has continued to deteriorate. The increases in Manchester, Tameside and Oldham are striking, the "Manchester Evening News" reported.
Prime Minister Boris Johnson had previously stopped further easing measures across England for at least 14 days. The measures were even tightened in the north: there, members of different households are no longer allowed to meet indoors and in private gardens. Visiting pubs and restaurants together is also prohibited.

NOR: After the Corona outbreak on their cruise ship "Roald Amundsen", the Norwegian cruise ship provider Hurtigruten is no longer offering trips with its three expedition ships.
Previously, 36 crew members and now several passengers on the ship had tested positive for the corona virus.
The Hurtigruten ships on the so-called “mail line” between Bergen and Kirkenes, on the other hand, continue to operate.

FRA: In some French communities, an outdoor mask requirement is now mandatory. In 69 additional municipalities in the Mayenne department, protective masks have also to been worn on the street since Monday.
According to media reports, in the coastal metropolis of Nice, a mask has to be worn outdoors in places popular with tourists. Failure to comply could result in a fine of 35 euros.
The prefecture of Lille had previously announced a mask requirement for the city, for example in the pedestrian zone. The mask is also mandatory in parking lots at shopping centers or in parks.

ITA: Pets such as dogs and cats can be infected by the corona virus. A study by Italian researchers has now confirmed this assumption. They examined 540 dogs and 277 cats in northern Italy, especially in Lombardy. The animals lived in households with corona patients or in areas particularly affected by corona. 3.4 percent of the dogs and 3.9 percent of the cats had raised antibodies to the virus. The study confirms the Friedrich Loeffler Institute’s (located in Greifswald, Germany) assessment that dogs or cats have so far played no role in the spread of the SARS CoV-2 virus. The decisive factor is the transmission from person to person.

Subject in Focus

Water, sanitation, hygiene, and waste management for SARS-CoV-2, the virus that causes COVID-19

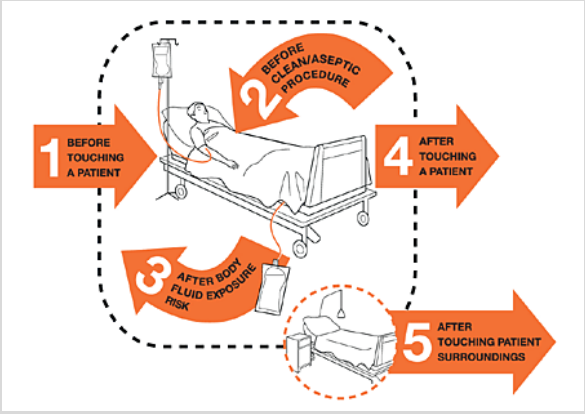
On 29th July 2020 WHO published an updated version of its interim guidance on "Water, sanitation, hygiene, and waste management for SARS-CoV-2, the virus that causes COVID-19" updating its previous guidance from 23rd March. This guidance provides an overview on recommended WASH measures as well as recommendations that should be considered for example when handling waste, sewage water, excreta or when caring for an infected person in the light of COVID-19.
First and foremost, this guidance emphasises the necessity of frequent and correct hand hygiene (i.e. regularly washing hands with either alcohol-based hand rub or soap and water). While hand hygiene is a key component of the fight against COVID-19 it also helps preventing numerous other diseases. In the following some key statements that can be found within the guidance are highlighted, thereby the general structure of the guidance is replicated. For receiving more detailed information, reading the original document as well as documents referenced in the guidance is necessary.

Background:
COVID-19 is – according to current scientific knowledge - mainly transmitted via respiratory droplets and direct contact. Droplets landing on surfaces can contain active viruses and therefore the environment of an infected individual can also be a source of transmission. The fecal-oral path of transmission is considered to be of low risk, even though some studies found RNA material in the excreta of infected or recovered patients.
The existence of SARS-CoV-2 in untreated drinking water is generally possible but infectious SARS-CoV-2 hasn't been detected drinking-water supplies yet. As for other Coronaviruses the risk posed to water supplies by SARS-CoV-2 is considered to be low.
No infectious SARS-CoV-2 has been detected in treated or untreated sewage. There are studies on-going that aim at analysing old sewage samples in order to see if the virus had been around prior to the first reported cases. Generally an increase in RNA fragments in untreated sewage samples was observed when the case-load of the respective region increased (and a reduction was reported when the number of cases decreased).
Because of (unlikely but potentially possible) infections via faeces wastewater should be contained and/or treated in specialized facilities. As SARS-CoV-2 is and enveloped virus, standard treatment processes are effective. Sanitation-workers' health is an essential good, especially during the pandemic, therefore staff handling wastewater or sludge should wear personal protective equipment (protective outerwear, heavy-duty gloves, boots, medical mask, goggles and/or a face shield), follow standard operation procedures (SOP) and perform good hygiene.
Keeping water supplies safe is key during the pandemic. In case centralized treatment of water supplies and/or safe-piped water is not available water treatment should be administered on household-level (e.g. boiling water). Buildings that were not used for a longer time (e.g. due to the closure of public buildings) may see a notable reduction in water quality due to water stagnation in the pipes (followed for example by the regrowth of microbial pathogens). This can pose a public health risk and should be resolved by adequately exchanging stagnant water (e.g. by flushing pipes) and making sure only disinfected and clean water is in the pipes prior to reopening the building.

WASH in health care settings
No new/additional WASH (water, sanitation and hygiene) measures are necessary in health care settings but some of the existing recommendations are of particular importance (e.g. frequent hand hygiene, regular environmental cleaning and disinfection practices, managing excreta safely and safely managing dead bodies). In addition it is important to put special attention on handling COVID-19 cases (including the provision of separate toilets). Providing sufficient drinking water and making sure that personal hygiene (including hand hygiene) can be maintained is highly important. Providing sufficient materials for adequate (hand) hygiene should be accompanied by refreshing or introducing hygiene programs and communication campaigns.

Hand hygiene should be performed according to the “My 5 moments for hand hygiene” instructions (1. before touching a patient, 2. before clean/aseptic procedures, 3. after body fluid exposure/risk, 4. after touching a patient, and 5. after touching patient surroundings) as well as in the following situations:

- before putting on PPE and after removing it
- when changing gloves
- after any contact with a patient with suspected or confirmed SARS-CoV-2 infection, their waste or the environment in that patient’s immediate surroundings;
- after contact with respiratory secretions
- before food preparation and consumption
- after using the toilet.



Hands hand hygiene should be preferably performed by either using alcohol-based hand rub for 20-30 seconds (if hands are not visibly dirty) or by using soap and clean water for 40-60 seconds (if hands are visibly dirty). An effective alcohol-based hand rub should contain 60-80% of alcohol and its efficacy should be proven (either according to European Norm 1500 or the respective standards of ASTM international (ASTM E-1174)). If no such effective alcohol-based had rub is available, pharmacies can produce a substitute locally, following official WHO guidance that can be found here.

As mentioned above COVID-19 cases and suspected cases should be provided with a sperate toilet whenever possible. It is recommended to flush toilets with the lid down to prevent droplet splatter and aerosol clouds. If no separate toilets are available, toilets should be cleaned and disinfected by trained staff wearing adequate PPE (PPE-impermeable gown, or if not available, an apron, heavy-duty gloves, boots, mask and googles or a face shield) regularly (e.g. twice a day). Health care personnel should have access to sperate toilets that are not used by any patients. Well maintained plumbing and a functioning ventilation system are key to prevent aerosolized faecal matter from entering the plumbing or ventilation system which could cause the spread of the virus. A risk assessment should be conducted whenever deemed

necessary (e.g. if healthcare facilities are connected to sewers). There is no reason to empty latrine pits and holding tanks of excreta from suspected or confirmed COVID-19 cases unless they are at capacity. All sanitary facilities (including latrine pits and holding tanks) should be provided to an extent that fits the number of patients (the planning should account for a sudden uptick in the number of patients). All workers that are tasked with handling excreta or untreated sewage (e.g. operators of pumper trucks) should be properly trained in safely putting on, wearing and taking off PPE. Untreated faecal sludge and wastewater from health facilities should never be released on land used for food production, aquaculture or disposed of in recreational waters. In all health-care settings, including those with suspected or confirmed COVID-19 cases, faeces must be treated as a biohazard.
It is recommended to follow best practices for managing health-care waste. Thereby no differentiation between healthcare waste generated from facilities that treat COVID-19 cases and facilities not treating COVID-19 cases is necessary. Additional treatment or disinfection beyond existing safe waste management recommendations are not needed. The increased number of medical waste (sometimes up to five times higher compared to pre-pandemic times) created in healthcare facilities (mostly due to increased use of PPE) makes it important to increase the capacities for handling such waste. The guidance also includes advice on environmental cleaning and laundry as well as on the disposal of greywater that are not part of this summary.

The treatment of dead bodies is described as follows:

> *While the risk of transmission of COVID-19 from handling the body of a deceased person is low, health care workers and others handling dead bodies should apply standard precautions at all times. Health care workers or mortuary staff preparing the body should wear: scrub suit, impermeable disposable gown (or disposable gown with impermeable apron), gloves, mask, face shield (preferably) or goggles, and boots. After use, PPE should be carefully removed and decontaminated or disposed of as infectious waste as soon as possible and hand hygiene should be performed. The body of a deceased person confirmed or suspected to have SARS-CoV-2 infection should be wrapped in cloth or fabric and transferred without delay to the mortuary area. Body bags are not necessary for SARS-CoV-2 although they may be used for other reasons (e.g. excessive body fluid leakage).*

Considerations for WASH practices in homes and communities

The access to clean drinking water is extremely important in the fight against COVID-19 and also helps in the fight against other infectious diseases by enabling people to comply with basic WASH recommendations. Therefore, people that are not able to afford access to clean water must not be cut off from existing water services and people who don't yet have access should be supplied with clean water via alternative routes (e.g. tanker trucks). Providers of water, sanitation and hygiene services should be classified as essential good providers. This would allow them to move freely (irrespective of movement restrictions) in order to provide their services and would grant them access to PPE.
As with in a healthcare setting the proper practice of hand hygiene is of utmost importance at home and in communities. Hand hygiene should be performed in the following situations:

- after coughing and sneezing and/or disposing of a tissue
- on entering the home having come from public places
- before preparing food
- before and after eating and feeding/breastfeeding
- after using the toilet or changing a child's diaper
- after touching animals

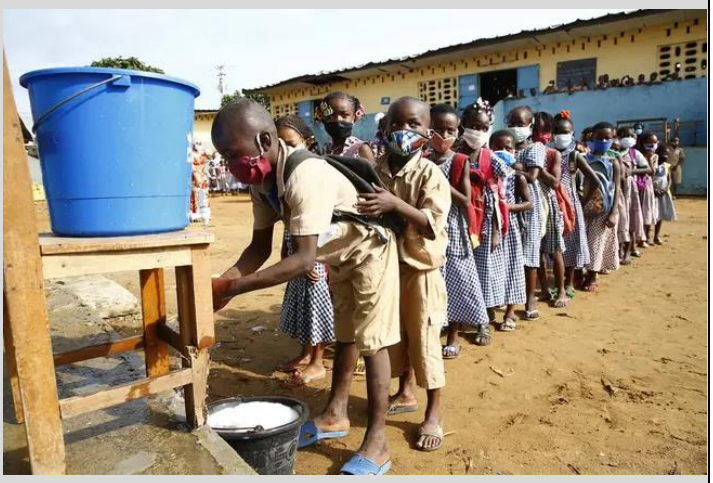
In case of limited hand WASH resources, individuals prioritize the key situations for hand hygiene. WHO recommends the provision of universal access to hand hygiene facilities in front of public buildings and transportation hubs (e.g. markets, schools and trains). Furthermore handwashing facilities should be available within 5 meters to a toilet (public and private). Local public health authorities should takt the overall leadership in installation, regular refilling and maintenance of such facilities. It is also recommended that these facilities are accessible for children, as well as for people with limited mobility.

Four possible ways of handwashing are mentioned in the guidance (descending order of effectiveness):

- Water and soap **or** alcohol-based hand rub
- Ash
- Water alone

In case of the use of alcohol-based hand rub it is important to not let children use the hand rub unsupervised. Highly concentrated alcohol is toxic if ingested and hence needs to be handled with care. There is no evidence that a special soap (e.g. antibacterial soap) is needed, regular soap is sufficient to inactivate SARS-CoV-2. In any case the ability to dry hands after washing is important for the effectiveness of hand hygiene as wet hands are far more likely to transmit pathogens to surfaces and vice versa. Clean single-use towels are recommended but can be substituted by air-drying systems or shaking the hands in the air. If no soap or alcohol-based hand rub is available, the use of ash can be seen as an alternative (ash inactivates pathogens by raising the pH value). If none of the above is available, the use of water is considered to be better than not applying any hand hygiene.

Water that is used for hand washing does not have to met drinking-water standards. Evidence suggests that even water with moderate faecal contamination can be effective in removing pathogens from hands (when used with soap and correct technique). However, it is desirable to provide high-quality water for hand hygiene purposes. Field experience suggests that an amount of only 0.2 litres of water per person per hand-washing session is sufficient. But other reports usually recommend 0.5 to 2 litres per person and session to reduce of faecal contamination. The quantity of water used is (positively) correlated with the reduction of viral contamination of hands. If water is not available in huge quantities wetting the hands, then turning off the water, applying soap and scrubbing for at least 20 seconds before washing off the soap is a viable option. For more details on the design of handwashing facilities please refer to the original guidance.



In case of caring for an actual or suspected COVID-19 case at home some safety measures should be adhered to immediately. Caregivers should receive clear instructions on the safe and correct use and storage of cleaners and disinfectants (which also includes an instruction to keeping them out of the reach of children). Objects and surfaces within the patient's area (e.g. bedroom furniture) should be cleaned regularly. Cutlery and crockery should be washed and dried after each use and not shared with others. Bathrooms shared by COVID-19 patients and other household members should be cleaned and disinfected at least once a day. Regular household soap or detergent should be used for cleaning first and then, after rinsing, regular household disinfectant should be applied. People cleaning rooms that were used by a (suspected or confirmed) COVID-19 case should wear PPE. Waste generated at home during quarantine, while caring for a sick family member or during the recovery period should be packed in strong bags and closed completely before disposal and eventual collection by municipal waste services. Disposing masks and other PPE into the toilet can lead to clogging the sewers and waterways resulting in human and broader ecological impacts and should therefore be refrained from. Those tasked with collecting waste should wear PPE (heavy duty gloves, boots, coveralls, and masks when working in confined spaces) and have facilities for regularly conducting hand hygiene.

Sources:

WHO, "*Water, sanitation, hygiene, and waste management for SARS-CoV-2, the virus that causes COVID-19*", 29.07.2020, https://www.who.int/publications/i/item/water-sanitation-hygiene-and-waste-management-for-the-covid-19-virus-interim-guidance

WHO, "*Guide to local production: WHO-recommended handrub formulations*", 29.07.2020, https://www.who.int/publications/i/item/guide-to-local-production-who-recommended-handrub-formulations

MilMed CoE VTC COVID-19 response

Topic	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.**

COVID 19 Crisis in Russia

Area: 17,098,246 km2 (without Crimea)

Population: 144,386,830 (excluding Crimea)

Capital: Moscow

Ethnic groups:

80.9% Russian
3.9% Tatar
1.4% Ukrainian
1.1% Bashkir
1.0% Chuvash
1.0% Chechen
10.7% others

Age structure:

0-14 years: 17.21%
15-24 years: 9.41%
25-54 years: 44.21%
55-64 years: 14.51%
65 years and over: 14.66%

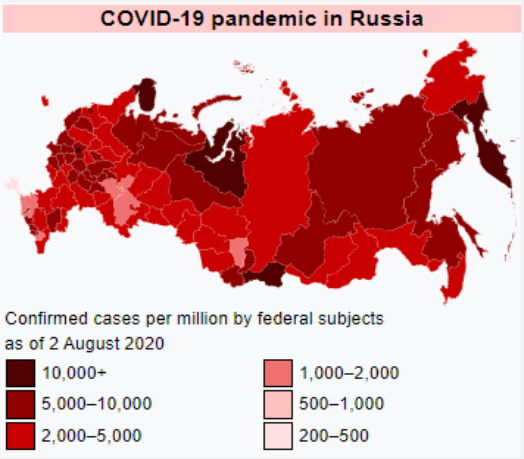
Confirmed COVID 19 Cases:

856.264

Confirmed deaths:

14.207

(Source: Indexmundi.com)



(Source: Wikipedia)

DISINFORMATION, CONCEALMENT OF THE TRUTH

Official statements:
For most of the spring, the official line from state media was that Russia had nothing to worry about. The coronavirus was happening somewhere else, in Europe and Asia and the United States, but not in Russia. The country had reacted promptly to potential danger, closing the border with China on January 30, then screening incoming passengers and finally halting all incoming air traffic to keep the invading viral army out. Hospitals were refitted, doctors retrained, and protective gear and equipment sent to every hospital in the country. According to the Kremlin: No problem.

The facts:
That's no longer believable. As of Monday, May 18, Russia was in second place after the United States (today 4th) in number of infections — 290.678 (Today 856.264). And those are just the official statistics. Moscow Mayor Sergei Sobyanin has said he believes about 2 percent of the population of Moscow is infected — that was, about 250.000 people. The death rate remained low, with only 2,722 deaths (Today 14.207), although there are doubts about that number too: Recent media reports have shown how Russian methodology for assigning cause of death has lowered the COVID morbidity numbers, perhaps by more than 50 percent. Who thinks the statistics are accurate just because people in Russia died of COVID if they weren't tested?

RUSSIAN SPIES TARGET COVID-19 VACCINE RESEARCH

National Cyber Security Centre (NCSC) said the hackers "almost certainly" operated as "part of Russian intelligence services". But it said vaccine research had not been hindered by the hackers.

Russia has denied responsibility. "We do not have information about who may have hacked into pharmaceutical companies and research centres in Great Britain. We can say one thing - Russia has nothing at all to do with these attempts," said Dmitry Peskov, a spokesman for President Putin, according to the TASS news agency.

The warning was published by an international group of security services:

the United Kingdom's NCSC, the Canadian Communication Security Establishment (CSE), the United States Department for Homeland Security (DHS) the Cyber-security Infrastructure Security Agency (CISA), as well as the US National Security Agency (NSA).

According to a security expert, "Cozy Bear (the named group) has been implicated in past cyber-attacks and has left quite a trail, and there are fairly good links to the Russian state itself." This group were also blamed with hacking the vaccine developer pharmaceutical companies and research centres' websites.

CORONAVIRUS: RUSSIA PLANS MASS VACCINATION CAMPAIGN IN OCTOBER

Vladimir Putin has announced that it will have the coronavirus vaccine in two weeks. Russian health authorities are preparing to start a mass vaccination campaign against coronavirus in October. The health minister has said that doctors and teachers would be the first to receive the vaccine. According to news agencies Russia's first potential vaccine would be approved by regulators this month. However, some experts are concerned at Russia's fast-track approach. On Friday, the leading infectious disease expert in the US, **Dr Anthony Fauci, said he hoped that Russia - and China - were "actually testing the vaccine" before administering them to anyone.** Dr Fauci has said that the US should have a "safe and effective" vaccine by the end of this year.

(*Source: BBC*)

COVID 19 IN RUSSIA

The virus was confirmed to have spread to Russia on 31 January 2020, when two Chinese citizens tested positive for the virus, with both cases being contained. Early prevention measures included restricting the border with China and extensive testing. The infection spread from Italy on 2 March, leading to additional measures such as cancelling events, closing schools, theatres, and museums, as well as shutting the border and declaring a non-working period which lasted until 11 May 2020. By the end of March 2020, the vast majority of federal subjects, including Moscow, had imposed lockdowns.

Russia currently has the largest number of confirmed cases in Europe, and the fourth-highest number of confirmed cases in the world, after the United States, Brazil, and India. According to figures from the national coronavirus crisis centre, as of 3 August 2020, Russia has 856,264 confirmed cases, 653,593 recoveries, 14,207 deaths, and over 29.0 million tests performed.

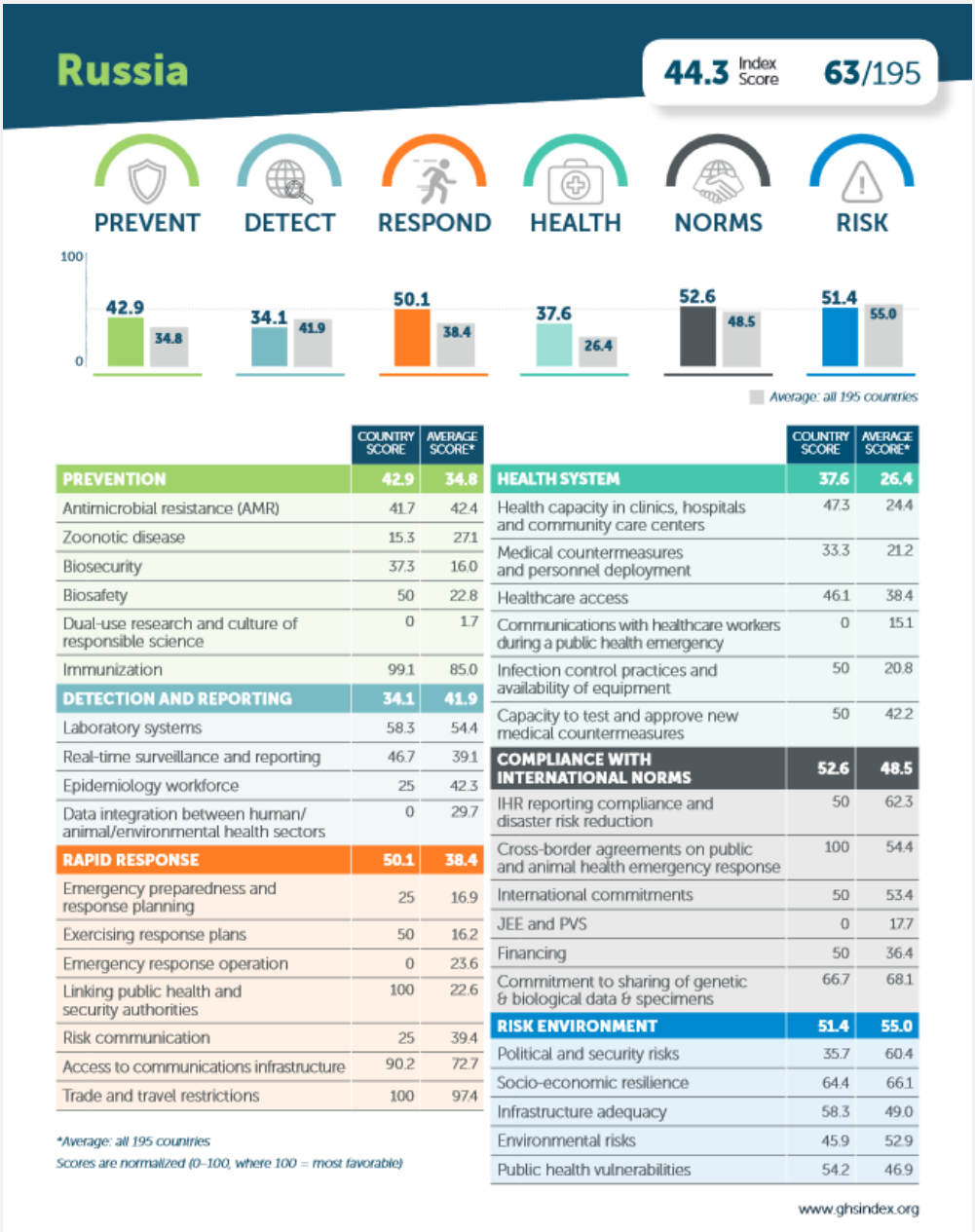
RESTRICTIONS TAKEN

On 25 March, President Putin announced that the 2020 Russian constitutional referendum would be postponed due to the epidemic. He said that the next week starting with 30 March, would be non-working nationwide and urged Russians to stay at home. International flights were grounded after the government ordered the civil aviation authority to suspend all regular and charter flights to and from the country. Later, Mayor of Moscow Sergey Sobyanin issued a stay-at-home order starting the next day. Also, on 30 March, similar orders or recommendations were announced in numerous other federal subjects, with many more announcing such restrictions over the next few days. The same day, the border was shut, with all border crossings closed.

On 10 May, the World Health Organisation's representative to Russia, Melita Vujnovic, said that day that Russia may have reached the plateau for the virus. On 11 May, President Putin announced the end of the national non-working period on 12 May and he also announced additional support measures including bonuses for doctors, subsidies for companies and payments to families with children. He also said that regional leaders can choose to keep restrictions. On 27 May, Moscow's mayor announced that some restrictions in Moscow would be eased on 1 June, with all non-food stores and some service sector businesses re-opening and residents would be able to go outside for walks and sport according to a schedule. Later he said that the city would lift coronavirus restrictions. Self-isolation rules and travel permits would be waived on 9 June, with no more walking schedules. Residents would be able to freely travel around the city and visit public places. Places like beauty salons, hairdressers and

veterinarian clinics would re-open, with other places like restaurants re-opening over the course of June. But residents were still required to wear face masks and gloves and are advised to maintain their distance from others. That day, Prime Minister also announced the partial re-opening of the border for some travellers, saying that it would allow citizens to leave the country for work, studying, medical treatment or to take care of relatives. It would also allow foreign citizens to enter for medical treatment or those needing to care for relatives and family.
On 22 June, Moscow's mayor announced further easing of restrictions on 23 June with cafes and restaurants reopening as well as fitness centres and swimming pools. Restrictions on libraries, kindergartens would be lifted. On 24 June, the Victory Day parade in Red Square took place while it was reported that 30 major cities in Russia had cancelled their parade.
(Source: Wikipedia)

Since the above-mentioned lifts of restriction, the daily number of new confirmed cases are between 5.000 and 6.000, and the confirmed deaths are between 70 and 160 in the past weeks, perhaps the total reopening of economics and society has been too early.



	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**42.9**	**34.8**
Antimicrobial resistance (AMR)	41.7	42.4
Zoonotic disease	15.3	27.1
Biosecurity	37.3	16.0
Biosafety	50	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	99.1	85.0
DETECTION AND REPORTING	**34.1**	**41.9**
Laboratory systems	58.3	54.4
Real-time surveillance and reporting	46.7	39.1
Epidemiology workforce	25	42.3
Data integration between human/ animal/environmental health sectors	0	29.7
RAPID RESPONSE	**50.1**	**38.4**
Emergency preparedness and response planning	25	16.9
Exercising response plans	50	16.2
Emergency response operation	0	23.6
Linking public health and security authorities	100	22.6
Risk communication	25	39.4
Access to communications infrastructure	90.2	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**37.6**	**26.4**
Health capacity in clinics, hospitals and community care centers	47.3	24.4
Medical countermeasures and personnel deployment	33.3	21.2
Healthcare access	46.1	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	50	20.8
Capacity to test and approve new medical countermeasures	50	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**52.6**	**48.5**
IHR reporting compliance and disaster risk reduction	50	62.3
Cross-border agreements on public and animal health emergency response	100	54.4
International commitments	50	53.4
JEE and PVS	0	17.7
Financing	50	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	**51.4**	**55.0**
Political and security risks	35.7	60.4
Socio-economic resilience	64.4	66.1
Infrastructure adequacy	58.3	49.0
Environmental risks	45.9	52.9
Public health vulnerabilities	54.2	46.9

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

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Recommendations

Recommendation for international business travellers	Many countries have halted some or all international travel since the onset of the COVID-19 pandemic but now have plans to re-open travel. This document outlines key considerations for national health authorities when considering or implementing the gradual return to international travel operations. The decision-making process should be multisectoral and ensure coordination of the measures implemented by national and international transport authorities and other relevant sectors and be aligned with the overall national strategies for adjusting public health and social measures. WHO Public health considerations while resuming international travel **Travel has been shown to facilitate the spread of COVID-19 from affected to unaffected areas. Travel and trade restrictions during a public health event of international concern (PHEIC) are regulated under the International Health Regulations (IHR), part III.** The majority of measures taken by WHO Member States relate to the denial of entry of passengers from countries experiencing outbreaks, followed by flight suspensions, visa restrictions, border closures, and quarantine measures. Currently there are exceptions foreseen for travellers with an essential function or need. **In the case of non-deferrable trips, please note the following** • Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules. • Check your national foreign office advices for regulations of the countries you´re traveling or regulations concerning your country. • Information's about the latest travel regulations and De-escalation strategy measures you can find at IATA and International SOS. For Europe you will find more information here. **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

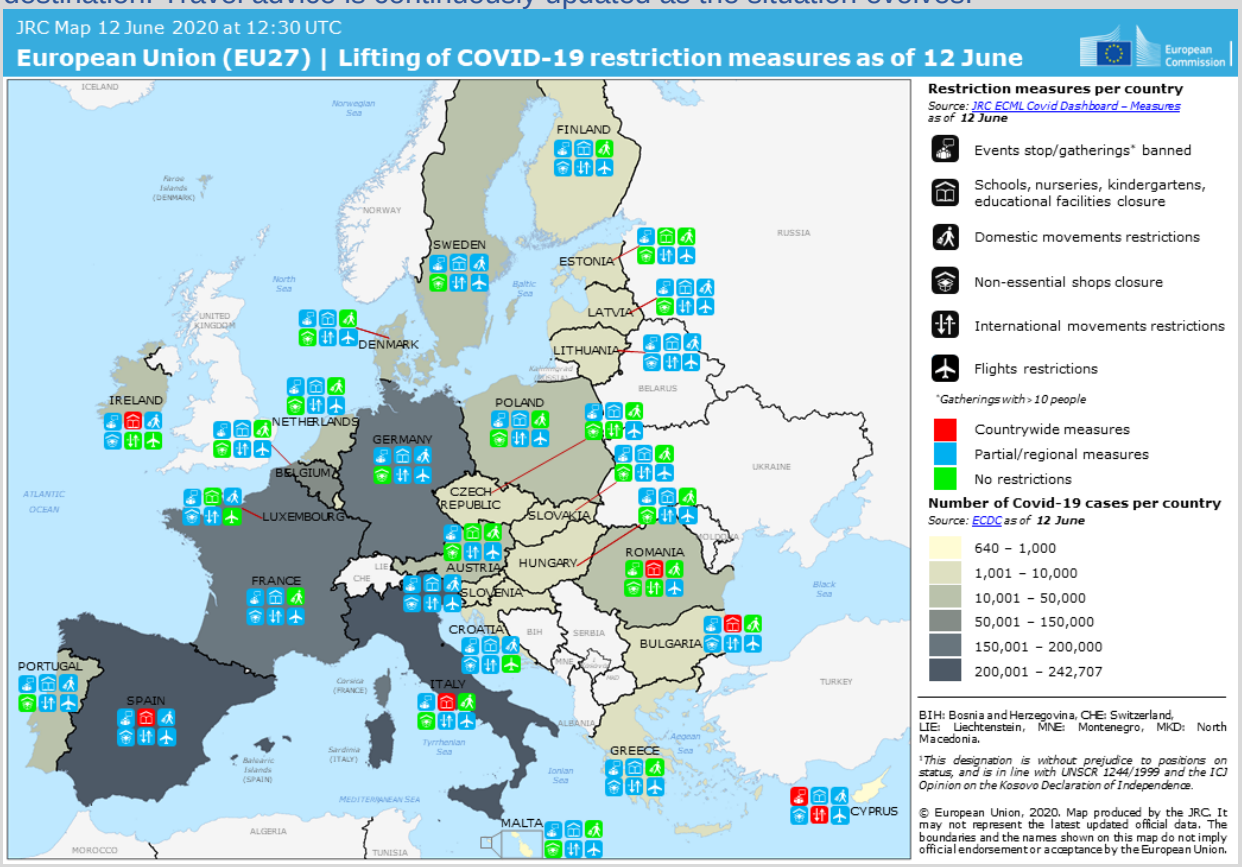
On 15 June, the European Commission launched 'Re-open EU', a web platform that contains essential information allowing a safe relaunch of free movement and tourism across Europe. To help people confidently plan their travels and holidays during the summer and beyond, the platform will provide real-time 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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