



Update 33 (18th of August 2020)

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



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

18th 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 published revised interim guidance on public health surveillance for COVID-19 cases ([WHO-Revised COVID-19 case definitions](#)). This document includes revision of suspected and probable case definitions to integrate increased knowledge on the clinical spectrum of COVID-19 signs and symptoms. WHO has published revised interim guidance on public health surveillance for COVID-19 cases. This document provides guidance to Member States on the implementation of surveillance for COVID-19 and the reporting requirements for WHO. What is new in this revised version:
- revision of suspected and probable case definitions to integrate increased knowledge on the clinical spectrum of COVID19 signs and symptoms;
- updated approaches to surveillance, including environmental and serological surveillance for SARS-CoV-2;
- revision of variables included in weekly surveillance to fit with new case definitions and surveillance objectives (that is, inclusion of probable cases, health-care worker cases and updated age groups for reporting cases and deaths);
- information on the importance of the collection of metadata for analysis and interpretation of surveillance data;
- recommendations for ending case-based reporting for global surveillance and replacing it with aggregate reporting.

Find articles and other materials at the MilMed CoE homepage: [click here](#)

Please use our online observation form to report your lessons learned observations as soon as possible.
[Click here to submit your lessons learned observations online](#)

GLOBALLY

21 858 237
confirmed cases
13 900 294 recovered
774 161 deaths

EU/EEA and the UK

3 442 899
confirmed cases
2 070 223 recovered
209 656 deaths

USA ↘

(new cases/day 49 181)

5 410 022
confirmed cases
1 864 674 recovered
170 143 deaths

Brazil →

(new cases/day 43 539)

3 359 570
confirmed cases
2 699 080 recovered
108 536 deaths

India ↗

(new cases/day 61 798)

2 702 681
confirmed cases
1 977 671 recovered
51 797 deaths

Russia →

(new cases/day 4 966)

925 558
confirmed cases
477 671 recovered
15 707 deaths

Spain ↗

(new cases/day 5 157)

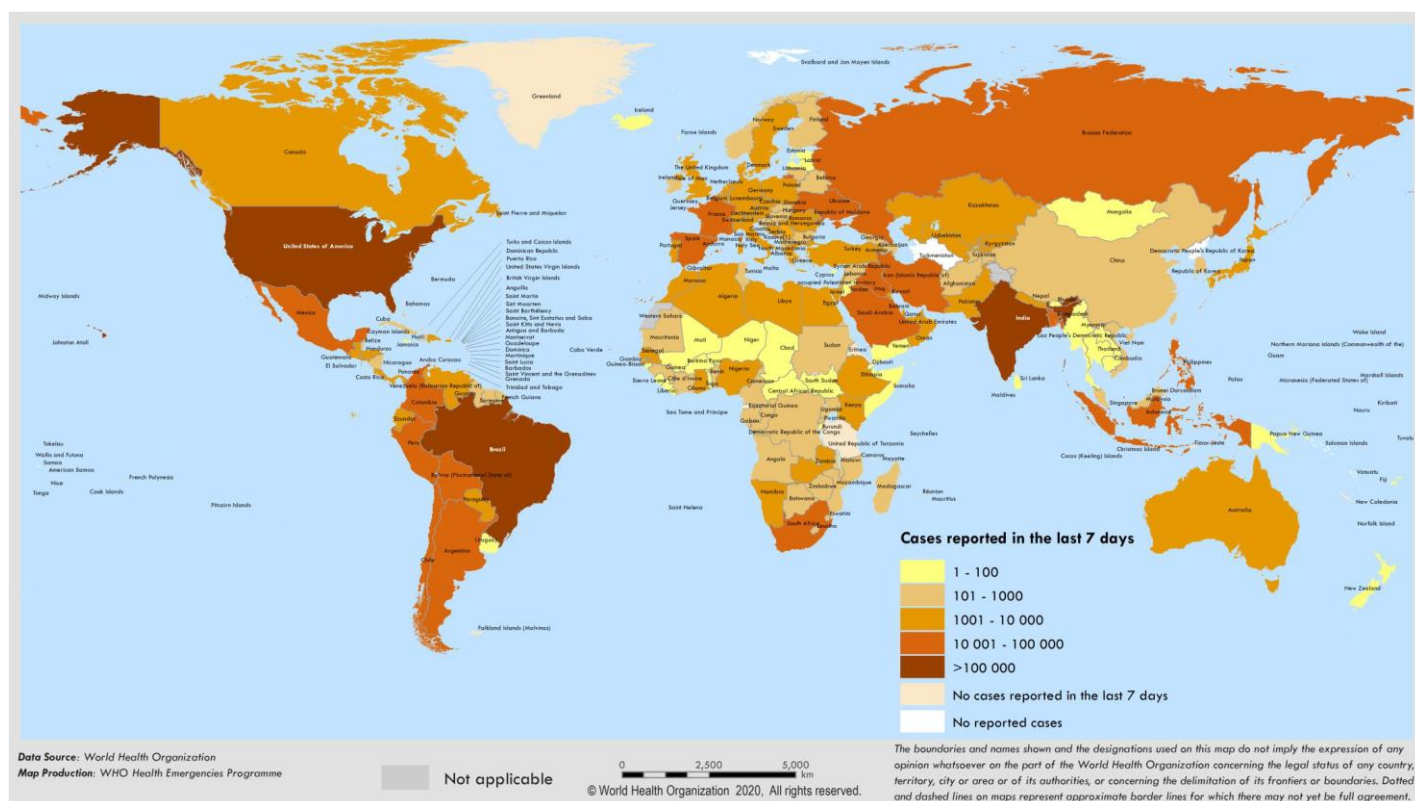
359 082
confirmed cases
150 376 recovered
28 646 deaths

Please click on the headlines to jump into the document

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



Worldwide Situation

Global Situation

WHO:

According to the [WHO dashboard](#) global cases exceeded the 21 million infection. This means that the number of cumulative infections has doubled in just 6 weeks. Half of the confirmed cases are in just 3 countries (USA, Brazil, India).

The corona cases will continue to rise: "You can call it a second wave, you can call it a second spike, you can call it a flare-up, you can call it what you want - if you take the pressure off this virus, the virus comes back," said WHO expert Michael Ryan in Geneva. It is extraordinarily difficult to stop the virus.

The spread of the coronavirus is increasingly favored by infected people aged between 20 and 40. This was announced by the WHO Regional Director for the Western Pacific, Takeshi Kasai. Many of those infected would not know that they were infected, Kasai said. This puts other population groups at risk worldwide, including the elderly and the sick in densely populated areas with poor health care.

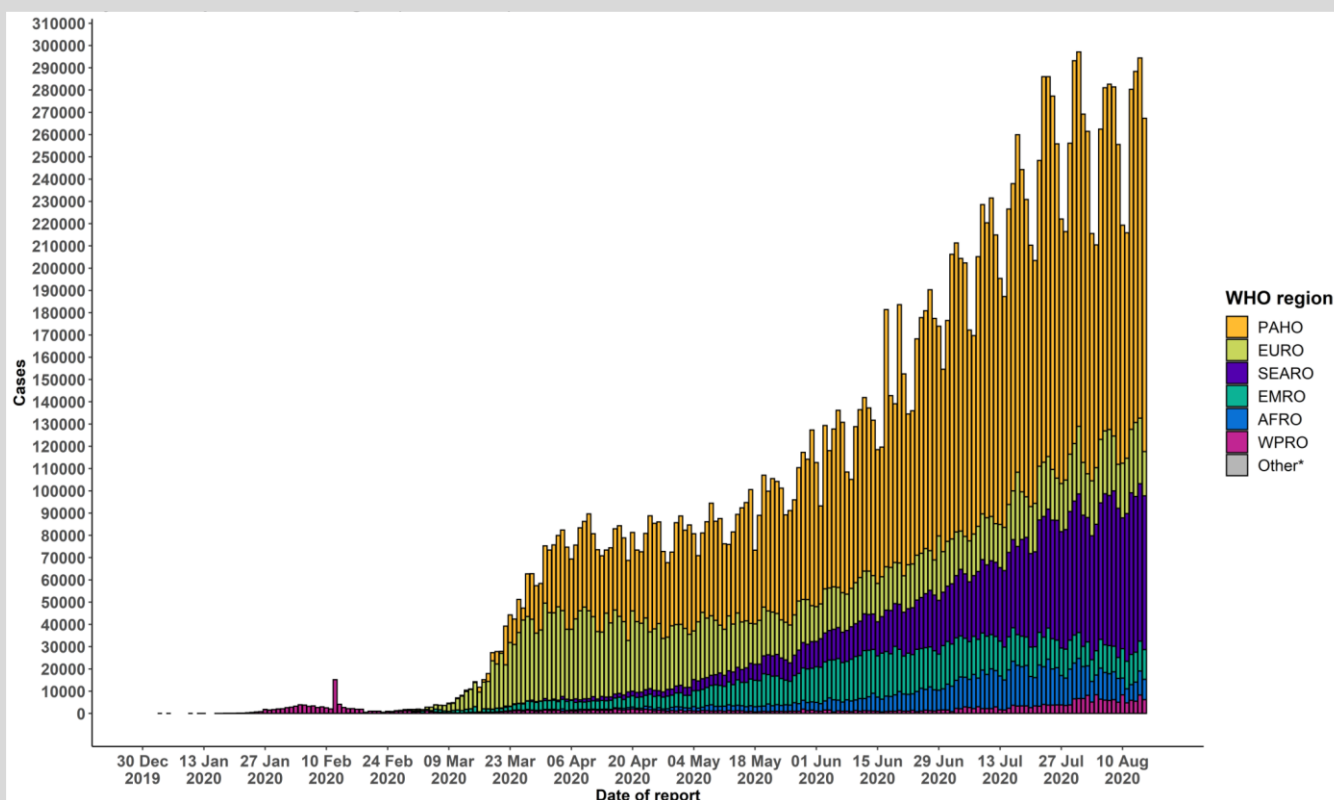


Figure. Number of confirmed* COVID-19 cases, by date of report and WHO region, 30 December through 16 August – WHO Situational Report - 209

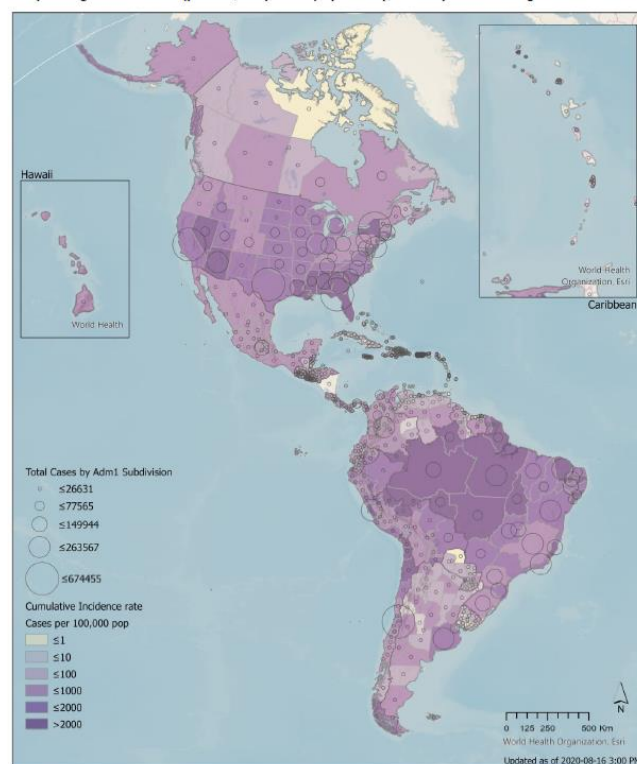
PAHO:

As of 17th August, an additional 105,642 cases and 2,296 deaths were reported in the past 24 hours, representing a 0.91% relative increase in cases and a 0.55% relative increase in deaths, compared to the previous day. According to [PAHO's website](#) as of 18th August a total of 11.7m cases (420,000 deaths) have been reported in the Americas. Thereof approx. 250,000 cases (6,774) occurred in the Central American Region. 5.3m (176,100) in the South American Region and 144,000 (2,358) in the Caribbean.

Total cases, deaths & CFR (%) among PAHO countries/territories with ≥ 10,000 cumulative cases.

Country/Territory	Cases	Deaths	CFR (%)
United States of America	5,312,940	168,345	3.2%
Brazil	3,317,096	107,232	3.2%
Peru	525,803	26,075	5.0%
Mexico	517,714	56,543	10.9%
Colombia	456,689	14,810	3.2%
Chile	385,946	10,452	2.7%
Argentina	289,100	5,657	2.0%
Canada	121,889	9,024	7.4%
Ecuador	101,542	6,070	6.0%
Bolivia	99,146	4,003	4.0%
Dominican Republic	86,309	1,453	1.7%
Panama	80,665	1,746	2.2%
Guatemala	62,562	2,379	3.8%
Honduras	49,979	1,567	3.1%
Venezuela	32,607	276	0.8%
Costa Rica	27,737	291	1.0%
Puerto Rico	26,006	335	1.3%
El Salvador	22,912	612	2.7%

Map 1. Reported number of cumulative COVID-19 cases in the Region of the Americas and corresponding incidence rate (per 100,000 persons) by country/territory. As of 16 August 2020.



PAHO COVID-19 Daily Update: 16 August: [direct link](https://www.paho.org/en/documents/paho-covid-19-daily-update-16-august-2020)

<https://www.paho.org/en/documents/paho-covid-19-daily-update-16-august-2020>

With more than 15,000 deaths in **Colombia** and record levels of infection in **Peru**, the corona pandemic in **South America** continues to cause great concern. The Ministry of Health in Bogotá announced on Sunday (local time) that the number of corona victims in Colombia had increased by 287 to 15,097 deaths in the past 24 hours. So far, 468,332 infections with the new type of corona virus have been detected in the country with 50 million inhabitants.

The Peruvian Ministry of Health reported more than 10,000 new infections within 24 hours. With 10,143 cases, the Andean country exceeded the record of daily new cases, which had only been recorded the day before with 9501 new infections. The number of corona deaths in Peru increased according to the information by 206 to 26,281.

In the neighboring country of **Bolivia**, the number of registered corona infections exceeded the threshold of 100,000 cases on Sunday. More than 4,000 infected people have died in the country so far, as the advisor to the Bolivian Ministry of Health, René Sahonero, told journalists. He expects the number of infections to rise to 150,000 cases by mid-September.

With more than six million detected infections, **Latin America and the Caribbean** are the regions in the world most severely affected by the corona pandemic, with a high number of unreported cases being suspected. Brazil leads the ranking in the region with officially more than 3.3 million infections and more than 107,000 deaths.

ARG: Despite strict exit restrictions, thousands of people gathered in the streets in Argentina to protest against the government of President Alberto Fernández. In the capital, Buenos Aires, numerous demonstrators protested on Monday against the 150-day quarantine to contain the spread of the corona virus, a planned judicial reform, corruption, the release of prisoners and the tense security situation. In numerous other cities in the South American country, people took to the streets in the largest protests to date since the beginning of the Corona crisis.

In the greater Buenos Aires area, very strict exit restrictions have been in place since mid-March in order to slow the spread of the corona virus. With the strict measure, the government initially succeeded in keeping the number of infected and victims low compared to surrounding areas. However, due to the long duration of the quarantine, the population's compliance to the curfew has recently decreased.

TUN: According to the Tunisian Ministry of Health, the corona situation in Tunisia is "serious" and "dangerous" due to the increasing number of infections. In contrast, there is a general feeling among citizens that the pandemic is over. At the beginning of the pandemic, the government had implemented strict measures to prevent the virus from spreading, but relaxed them again after containing the spread. Mouth-and-nose protection is currently only occasionally worn on the beaches and in local public transport in the capital Tunis.

Due to the latest developments, regional measures have now been tightened again. So far, Tunisia has reported 2,107 corona cases and 54 deaths. Although the numbers are smaller than in other countries in the region, the number of new infections every day has risen recently.

BRA: The corona virus is spreading uncontrolled in the communities of the Brazilian indigenous people. A total of 652 indigenous people have already died after being infected with the corona virus, as announced by the Catholic Indian Mission Council. 85 percent of the deceased lived in the Amazonas region.

According to a study by the Environmental Research Institute for the Amazon (IPAM), the death rate among the indigenous people is 2.5 times higher than in the general population. The reasons for this are the lack of health care, but also malnutrition and the invasion of illegal loggers and gold miners who brought the virus into the indigenous communities.

KOR: After several infections in connection with religious groups in South Korea, thousands of members of a Protestant community have been quarantined in the capital Seoul. By Monday, 315 corona cases have been detected among the members of the controversial Sarang Jeil Church. Around 3,400 of the believers would therefore have to isolate themselves. The follow-up of suspected cases is made more difficult by an "incorrect" list of members provided by the church. So far, every sixth corona test carried out in the community has been positive.

NZL: is postponing the general election by four weeks to October 17th due to the corona pandemic. In addition, a twelve-day extension of the corona lockdown in the metropolis of Auckland was announced.

AUS: Australia's coronavirus hotspot recorded the lowest number of new infections in a month. There were 222 new infections with the virus in Victoria. The number of new infections has been falling since strict measures were imposed in Victoria's capital, Melbourne, in early August. This includes a curfew during the night and the mandatory wearing of mouth and nose covers.

NGA: will reopen its airports for international flights from August 29th. Domestic connections were resumed at the beginning of July and there were no confirmed coronavirus cases connected to this. The airports of Africa's most populous country have been closed since March 23rd to contain the spread of the coronavirus.

LBY: the corona pandemic threatens to get out of control, according to local authorities. The number of cases in Libya initially remained low because travel is hardly possible due to the on-going conflict. According to medical experts, however, the disease is now spreading faster and faster in the civil war country, also because people keep attending events such as weddings. The number of known infections has jumped to almost 8,200 in a comparatively short time, more than 150 deaths were reported.

IDN: There were 1,821 new corona cases reported. This increased the total number of corona infections in the country to 141,370. The number of reported deaths rose by 57 to 6,207. This is the highest number of deaths in Southeast Asia.

LBN: The government is considering a two-week lockdown. Most recently, 439 people tested positive for the corona virus in Lebanon within 24 hours. A record in the crisis-ridden country.

ECDC COVID-19 surveillance report Week 32 as of 14 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 and for the EU/EEA and the UK as a whole, using weekly and daily data from a range of sources.
- The [COVID-19 surveillance report](#) presents epidemiological characteristics of COVID-19 cases reported to date to the European Surveillance System (TESSy) and assesses the quality of the data.

Trends in reported cases and testing

- As of 12 August 2020, the 14-day case notification rate for the EU/EEA and the UK was 30 (country range: 3–141) per 100 000 population. The rate has been increasing for 24 days.
- Increases in the 14-day COVID-19 case notification rates compared to those reported seven days earlier have been observed in 14 countries (Cyprus, Denmark, France, Germany, Greece, Iceland, Ireland, Malta, Netherlands, Norway, Poland, Spain, Sweden and the United Kingdom). Rates in these countries have been increasing for between one and 35 days.
- Notification rates are highly dependent on a number of factors, one of which is the testing rate. Weekly testing rates for week 32 in the EU/EEA and the UK varied between 166 and 7 012 tests per 100 000 population. Luxembourg had the highest testing rate for week 32, followed by Denmark, Cyprus, the United Kingdom and Iceland. Seven countries (Belgium, Bulgaria, Croatia, Czechia, Poland, Romania and Spain) had a weekly test positivity of 3% or higher.

Primary care

- Among four countries that reported data up to week 32 from primary care sentinel surveillance for COVID-19, using the systems established for influenza, there were no detections of SARS-CoV-2 from 28 patients tested.
- All countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 32, 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

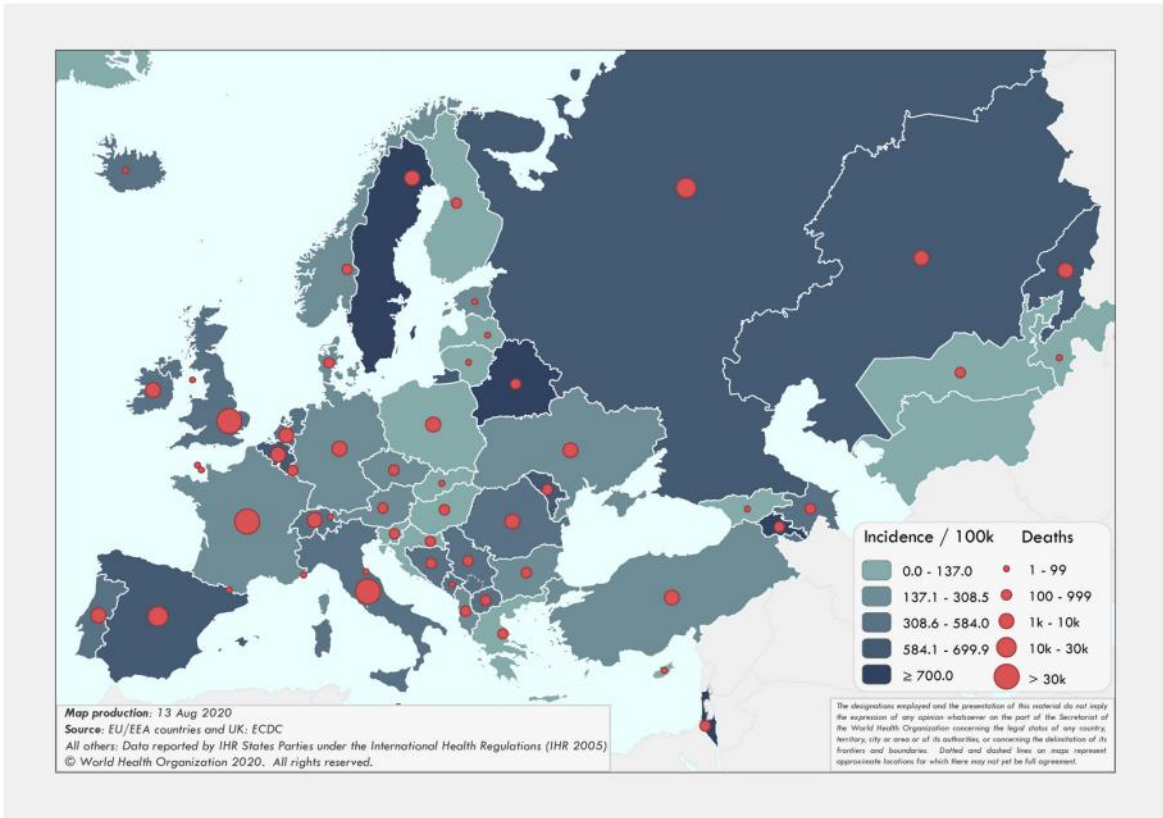
- Hospital and/or ICU occupancies due to COVID-19 are increasing in Bulgaria, Poland, Romania, Slovakia and Slovenia. No other increases have been observed, although data availability varies.
- Overall, 26% of reported COVID-19 cases to date in the EU/EEA and the UK have been hospitalised; among hospitalised 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 (country range: 0–27) per million population. The rate has been stable for 27 days.
- Increases in the 14-day COVID-19 death notification rates compared to those reported seven days earlier have been observed in three countries (Bulgaria, Luxembourg and Romania). Rates in these countries have been increasing for between 10 and 19 days.
- We estimate that 24% (country range: 0–38%) of hospitalised COVID-19 cases reported in the EU/EEA and the UK have died.
- Pooled estimates of all-cause mortality reported by EuroMOMO remain at normal levels, following a period of substantially increased excess mortality that coincided with the COVID-19 pandemic peaks. However, in some countries there seems to be a small increase in mortality which could be related to heat waves.

COVID-19 situation update for the WHO European Region (3 – 9 August 2020 Epi week 32)

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



The designations employed and the presentation of the information in this Web site do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers and boundaries.

Key points

Week 32/2020 (3 - 9 Aug 2020)

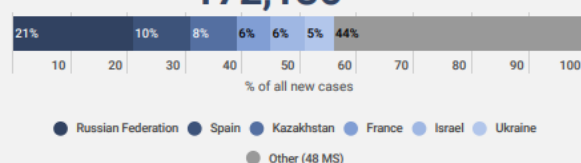
- The number of cases and deaths reported in the Region in the week 32/2020 remained stable compared to the previous week (Figure 1)
- 50% (95,851) of the cases reported in week 32/2020 were reported from six countries: the Russian Federation (21%; 36,666), Spain (10%; 17,241), Kazakhstan (8%; 13,181), France (6%; 10,002), Israel (6%; 9,980) and Ukraine (5%; 8,781). The remaining cases (44%; 76,285) were reported by 51 countries and territories; each accounted for <5% of the total cases reported in week 32/2020
- Five countries had a crude incidence of ≥ 60 per 100,000 in week 32/2020: Israel, Kazakhstan, Luxembourg, Montenegro and Bosnia and Herzegovina. The crude incidence continues to vary across the region with a range from 1.2 per 100,000 population in Georgia to 117.1 per 100,000 population in Israel (Figure 2A)
- The 14-day cumulative incidence increased by $\geq 10\%$ in week 32/2020 in 35 countries and territories in the Region, however for some countries data was retro-adjusted by national authorities: Albania, Belgium, Bosnia and Herzegovina, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Kazakhstan, Latvia, Lithuania, Malta, Netherlands, Norway, Poland, Republic of Moldova, Romania, Slovakia, Spain, Switzerland, Turkey, Ukraine, the United Kingdom and Uzbekistan (see [EURO COVID-19 Dashboard](#) for recent trends)
- 59% (1,628) of the deaths reported in week 32/2020 were reported by the Russian Federation (29%; 803), the United Kingdom (13%; 373), Romania (10%; 280) and Ukraine (6%; 172). The remaining deaths (41%; 1,154) were reported from 38 countries and territories; each accounted for <5% of the total deaths reported in week 32/2020
- The proportion of reported cases that died was 1.6% in week 32/2020
- Community-transmission was reported by 26 countries and territories, 27 countries and territories reported cluster transmission, while 5 countries and territories reported sporadic transmission in week 32/2020 (see [EURO COVID-19 Dashboard](#))
- Since the emergence of COVID-19 virus in Europe at the end of February 2020, a wide range of public health and social measures (PHSM) have been implemented. See [EURO COVID-19 Dashboard \(NPI Explorer\)](#) for a 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 PHSM.

Summary overview

- The cumulative cases across the Region increased 5.1% to 3,579,786 cases in week 32/2020 (from 3,407,650 cases in week 31/2020) and cumulative deaths increased by 1.3% to 216,563 deaths (from 213,781 deaths in week 31/2020)
- 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 (Figure 2B)
- As of week 32/2020, 67% (2,415,198) of cumulative cases were reported from the Russian Federation (25%; 887,536), Spain (9%; 314,362), the United Kingdom (9%; 309,763), Italy (7%; 250,103), Turkey (7%; 239,622), Germany (6%; 215,891) and France (6%; 197,921). The remaining cases (33%; 1,164,588) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 32/2020
- As of week 32/2020, 72% of cumulative deaths (155,527) were reported from the United Kingdom (22%; 46,566), Italy (16%; 35,203), France (14%; 30,324), Spain (13%; 28,503) and the Russian Federation (7%; 14,931). The remaining deaths (28%; 61,036) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 32/2020
- 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 (75%)
- 14% of cases were in persons aged ≥ 65 years in week 32/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥ 65 years was 66% in week 32/2020 (compared to 91% in week 14/2020) (Figure 3)
- 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. In some countries there might be a tendency towards an increase in mortality, possibly due to heat waves
- In week 32/2020, four countries reported 87 tests and 2 SARS-CoV2 detection in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in this surveillance system week 31/2020 was 2.2% (7 countries) compared to 1.3% (7 countries) in week 30/2020. The highest positivity in the sentinel surveillance was 14.6%, seen in week 15/2020 (Figure 4)
- Overall, there were 62,612 (5%) COVID-19 cases among the total of 1,250,682 tests performed in 19 countries for week 32/2020 (Figure 5)

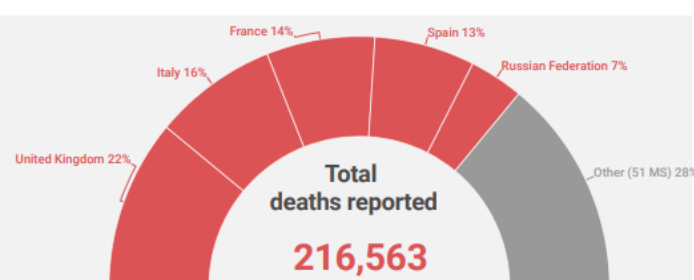
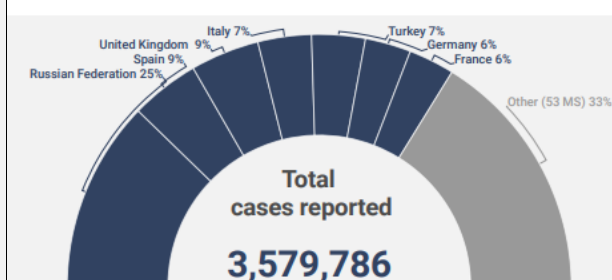
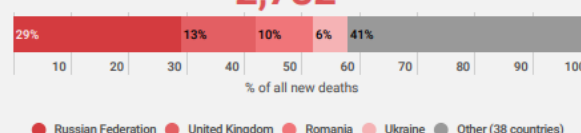
New cases (week 32/2020)

172,136



New deaths (week 32/2020)

2,782



MS: Member State

89%
of deaths
were in persons aged 65+

58%
of deaths
were in men

95%
of deaths
had at least 1 underlying
condition

75%
of deaths
had cardiovascular disease

Figure 1: Number of COVID-19 cases (N=3,579,786) and deaths (N=216,563) by reporting week

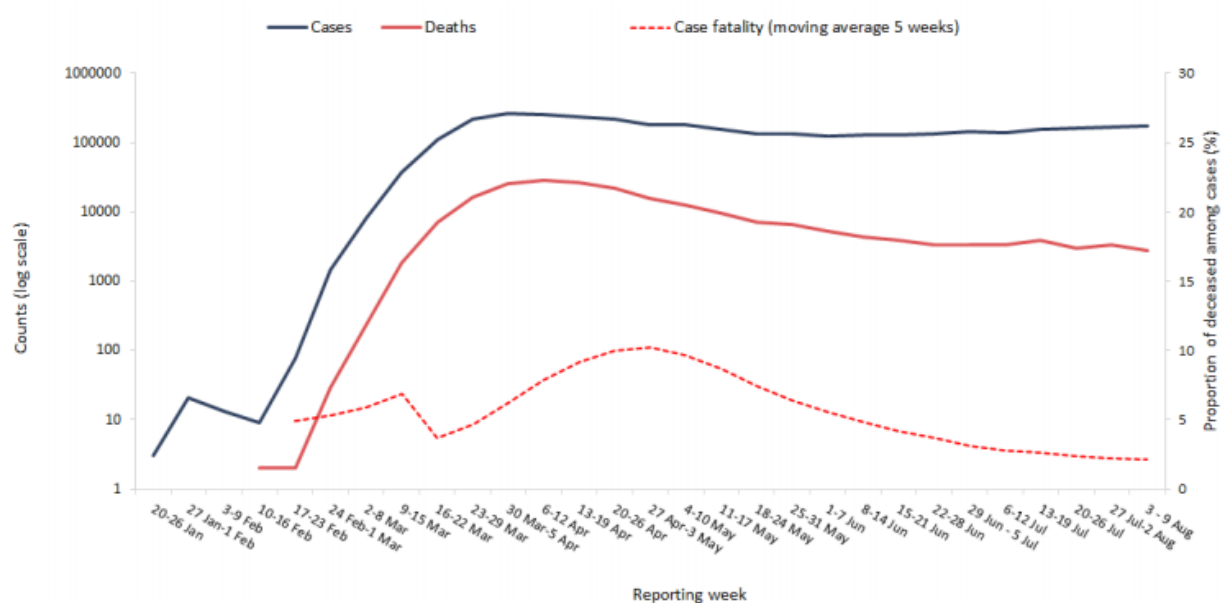
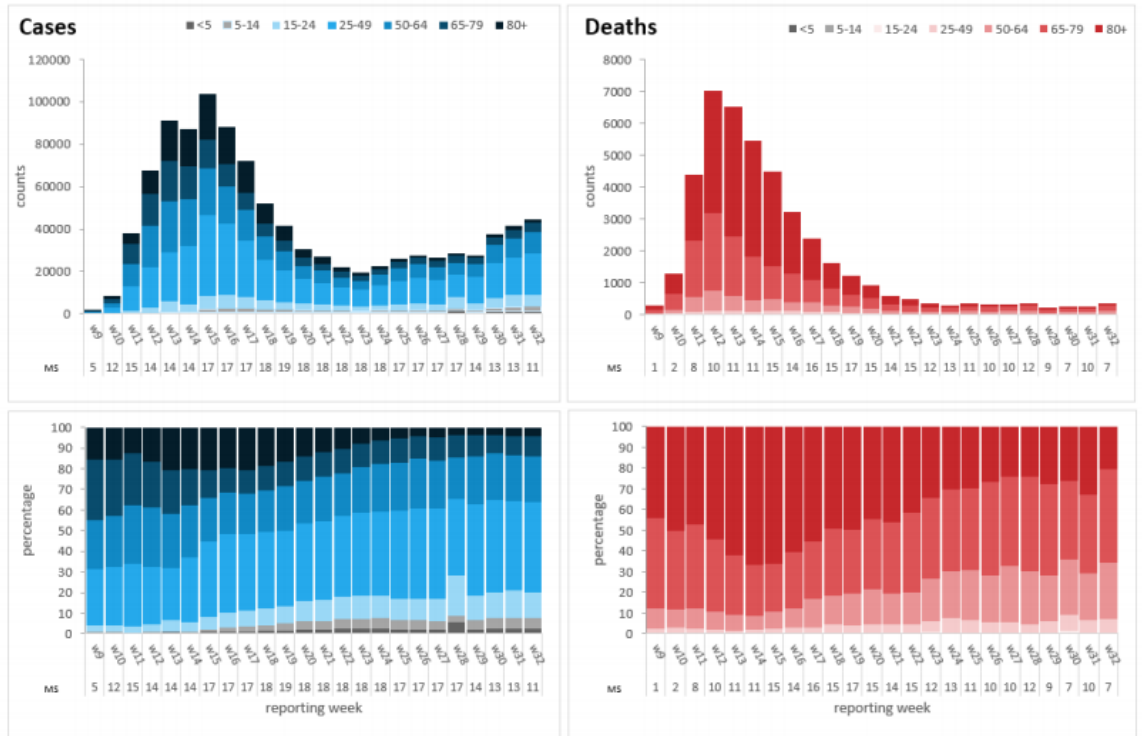


Table 1. Characteristics of COVID-19 deaths

Characteristics	n %		Total records with data available
	n	%	
Age in years, median (range)	76 (0-104)		96,843
Sex, male	55,768	58	96,673
At least one underlying condition	40,755	95	42,939
• cardiovascular disease	7,508	75	9,959
• diabetes	1,967	40	4,921
• lung disease	1,708	29	5,976
• neurological disease / dementia	2,072	25	8,163
• renal disease	849	24	3,568
• obesity	418	11	3,881
• liver disease	425	6	7,404
• immune disease	68	2	3,887
• other	1,049	22	4,733

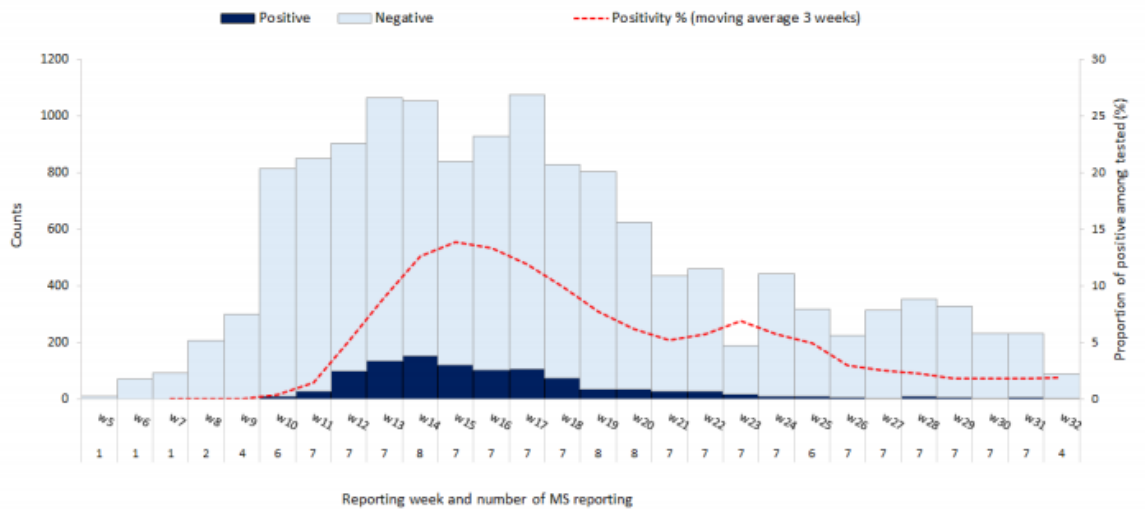
Source: Mortality database (n=96,854)

Figure 3. COVID-19 cases (N=1,031,584) and deaths (N=43,043) by age group and reporting week



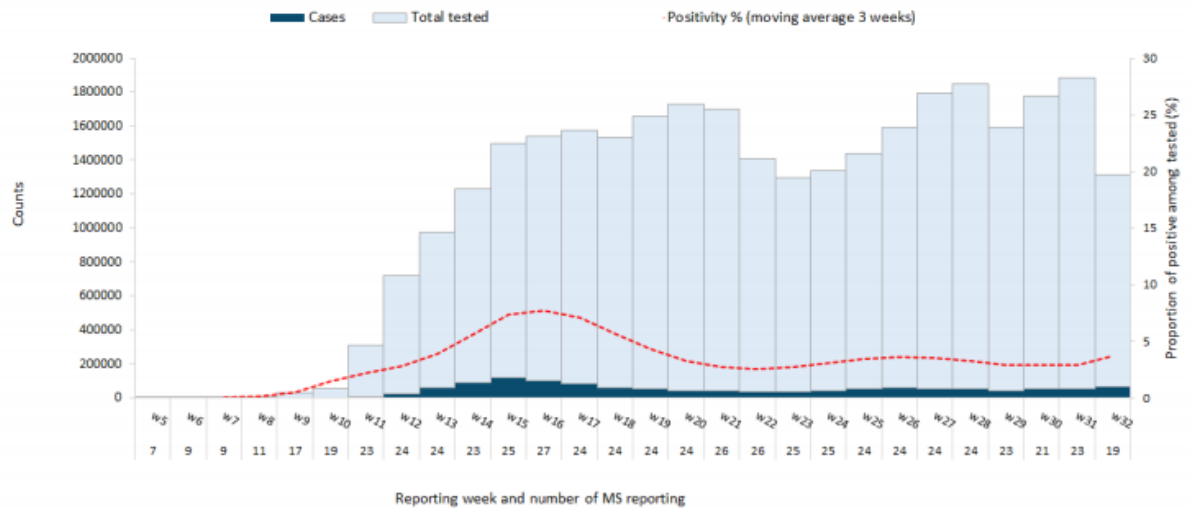
Source: Aggregate data from TESSy. MS: Member State

Figure 4. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



Source: Aggregate data from WHO XMart and TESSy. MS: Member State

Figure 5. Percentage positive for COVID-19 among all tested by reporting week



Source: Aggregate data from WHO Xmart and TESSy. Note: Member States that report cases only (no testing data) are not included. MS: Member State

GBR: More than 70 employees at a British food factory are infected with the coronavirus. The Bakkavor company in Newark-on-Trent in the east of England specializes in fresh food. During testing 701 employees, the pathogen was detected in around one in ten. Now all of the other approx. 1,600 employees are to be tested. The report states that it is currently unclear how the outbreak started.

LTU: Lithuania has changed the entry regulations in view of the rising COVID-19 numbers across Europe. Entering the country is generally prohibited except for citizens of the countries of the European Economic Area, the Swiss Confederation and of the United Kingdom of Great Britain and Northern Ireland, and persons lawfully residing in these countries. Some other exceptions also exist (e.g. for military personnel serving in NATO units). However, anyone entering from countries with an infection rate of more than 25 cases per 100,000 inhabitants must show a valid negative corona test upon arrival. Furthermore, there is an obligation to go into quarantine for people entering from countries with a rate of more than 16 cases per 100,000 inhabitants - they must remain in domestic isolation for two weeks after entering Lithuania. Lithuania has so far recorded 2,436 confirmed infections and 81 deaths related to the coronavirus.

FRA: France recorded the highest number of new infections in three months with 3,310 new cases on Saturday. The city of Paris is classified as particularly at risk.

ESP: After Germany issued a travel warning for almost the whole country, including Mallorca, the fear of an economic crash in the Balearic Islands is growing.

NDL: The Netherlands have tightened their travel warnings for Spain, France and Belgium.

CZE: The Czech Republic will make wearing face masks mandatory again in public transport and many closed rooms from September 1st. This is due to a renewed increase in new infections and an expected difficult time during autumn. The mask requirement is a precautionary measure, because the school openings will lead to more frequent social interactions. According to the new rules, people must wear face masks in shops, public areas used by many people, in schools and in public buildings, but not in the workplace or in restaurants and bars.

MLT: Due to the increasing number of corona infections, the government of Malta will close all bars and nightclubs from Wednesday onwards. The only exceptions are pubs that also serve as a restaurant. In addition, the Minister of Health Chris Fearne ordered to ban boat parties. Overall, there should be no gatherings of groups that include more than 15 people.

In Malta wearing a mask is required in public places - except for restaurants, for which there are special regulations. In the small island state, the authorities had recently registered around 70 new infections every day.

Subject in Focus

How a vaccine is developed and tested - from exploratory stage to quality control

During the on-going COVID-19 pandemic many people recognized the variety and complexity of the systems that are constantly there for improving, protecting and re-establishing their health without the public really knowing about their existence or mechanisms. In the early stages of the pandemic the public got to know the public health authorities, publishing daily reports on the course of the disease. Numerous studies were released about (preliminary) findings regarding potential transmission modes and the threat the SARS-CoV-2 poses to mankind. Overtime everybody got used to checking the latest case-count and the currently estimated (effective) reproduction number. Social distancing quickly became a part of daily routine and working from home became a common thing as well. Experts and politicians argued about the pros and cons of a lockdown or other measures and the economy faced one of its most devastating downturns ever. But irrespective of their individual opinions on the right way forward, almost everyone agreed that only a vaccine will allow us to getting back into a “new normal” that doesn’t look much different to the “old normal” prior to the spread of COVID-19. It soon became clear that the necessary research and development won’t be conducted within weeks and that it is unlikely that a vaccine will be ready for large-scale use by the end of the year. After the public has received a crash course in epidemiology and microbiology, the race for being the first to develop an efficient and secure vaccine against COVID-19 left many people wondering how a vaccine is developed and what steps are necessary to make sure that a vaccine does more good than harm. Usually the following steps must be taken to receive approval for producing and administering a vaccine to the public:

- Exploratory stage
- Pre-clinical stage
- Clinical development
- Regulatory review and approval
- Manufacturing
- Quality control

At first, researchers are spending up to four years with identifying potential antigens during the **exploratory stage** of vaccine development. These antigens are usually assessed in laboratories and no vaccine is created or administered. The only objective is to find antigens (e.g. virus-like particles) that might be capable of helping with prevention or treatment of a disease.

In a next step, the **pre-clinical stage** the safety and immunogenicity (the ability of a substance to provoke an immune response) of the previously identified antigens are assessed. Therefore, cell- or tissue-cultures are used, as well as animal testing (e.g. testing the antigen’s effect Monkeys). It is not uncommon to change the exact receipt of the so called (vaccine) candidate to determine a safe dose for further research (e.g. in humans). This stage helps researches to identify promising candidates that are worth further investigation. At the same time this stage is the final destination for many candidates as they fail to produce the desired immune response. Following a huge amount of paperwork, the clinical development can start. The clinical development consists of at least three phases (I-III). Sometimes an additional fourth phase (IV) is also part of the vaccine development. The three phases usually can’t be taken in parallel, but the candidate has to pass through all of them from I to III (even though a combination on I/II or II/III is sometimes possible).

- **Phase I:** In the first phase the vaccine candidate is given to (approx. 20-80) healthy adults in order to see how the immune response looks like. These studies are often not-blinded/open-label (i.e. the researchers and the subjects know if they are part of the intervention or the control group), are not randomized and may or may not contain a placebo group. The main objective is to determine if the vaccine is safe for use in healthy adults. If no massive side effects/adverse events occur, the candidate may proceed to phase II.
- **Phase 2:** In phase two a larger group of (several hundred) people is given the candidate vaccine. Usually individuals that are at risk for acquiring the disease against which the vaccine should protect are part of the phase II trial. Phase II trials always contain a placebo group and are usually double-blinded follow the approach of a randomized-controlled trial (RCT). During this phase parameters as the candidate vaccine’s safety, immunogenicity, proposed doses, schedule of immunizations, and method of delivery are assessed. After successful completion of phase 2, the candidate enters phase III.

- **Phase III:** In phase III a large group of people (several thousand to tens of thousands) is given the vaccine candidate. Again, the study follows a double-blinded RCT design. The overall objective is to make sure that the vaccine is safe and effective (an adequate immune response (e.g. production of antibodies) is triggered and/or an infection is prevented). In addition, the large size of the treatment group allows to detect rare adverse events. Finally, with the completion of phase III the necessary paperwork to complete the approval process can be handed in.

After **regulatory review and approval**, the **manufacturing** and “regular”/public use of the vaccine can begin. As soon as the widespread use of the vaccines starts various surveillance systems (e.g. US-administrated VAERS) and an optional **phase IV** (if the producer of the vaccine decides to implement one) begin to **control quality**. Phase IV aims at studying long-term effects, efficacy, safety and other uses of the vaccine.

Usually the long and complex process of developing a vaccine and getting it approved takes 10 to 15 years.

Excursus I:

Human challenge studies/trials:

Sometimes so called “challenge trials” are conducted in the pre-clinical phase (animal testing) and or the clinical phase. In this special set-up, subjects intentionally get infected/confronted with the pathogen from which the vaccine candidate should protect them. This usually happens in a controlled clinical setting and aims at speeding-up the respective stage/phase. During the early stages of the COVID-19 pandemic it was already discussed to use this approach to hasten the development of a vaccine. Usually this approach is used when a new vaccine against a well-known disease for which effective and approved treatment is already available and the failure to protect of the candidate vaccine can easily be compensated by an existing drug or vaccine to minimize the potential harm done to the volunteers participating in this challenge trial.

Excursus II:

The Russian anti-COVID-19 vaccine Sputnik V (GamCovidVac):

About a week ago, on Tuesday 11th August, the Russian government announced that it has granted approval to the first anti-COVID-19 vaccine worldwide (developed by Russian state-run Gamaleya Institute and Russian Defence Ministry).

This raised international concerns regarding the safety and efficacy of this vaccine. These concerns are especially fuelled by the extraordinary short time it took the vaccine to receive approval and the fact that neither phase I/II results were published nor were they peer reviewed. In addition, the normally mandatory phase III trial hasn't yet started at the time the vaccine was approved by the Russian ministry of health under a newly introduced emergency law.

The vaccine is nicknamed “Sputnik V” and has – according to a dedicated website run by the Russian Direct Investment Fund – passed two clinical phase I/II trials without any complications. This couldn't be checked by independent experts as still no results (reviewed or preliminary) are available, not even the animal testing results have been published. So far only 76 individuals have participated in the phase I/II trial. It was announced that a multi-country (Russia, UAE, Saudi Arabia, Brazil and Mexico) phase III study including 2,000 participants was about to start on 12th of August, but no scientific documentation thereof has been published yet.

Irrespective of the lack of peer reviewed result and the missing phase III trial, widespread public use has already been announced (with medical personnel and high-risk groups being the first to receive the vaccine) The broad public will be able to get vaccinated at the end of 2020/beginning of 2021 the Russian Ministry of health has announced.

According to official Russian statements up to 20 countries already stated that they are interested in buying the novel vaccine, production is planned to take place in the respective countries. Questions on the extremely speedy development of Sputnik V are answered by pointing out that the researchers' previous work on an anti-MERS vaccine allowed them to simply adjust an almost ready-to-use vaccine against a pathogen that is only slightly different from SARS-CoV-2. However, international researchers doubt this argument, as other vaccine candidates (e.g. Oxford-Astrazeneca) are also based on existing anti-MERS vaccine projects. All in all, the international concerns will continue to persist unless reliable research data is disclosed and reviewed by

independent experts, as well as a transparent and well-documented phase III trial is conducted and reviewed, proofing the current claims.

Currently some other vaccine candidates are already in multicenter phase III trials with up to 30,000 participants but no comparably ambitious planning became public. The developers of the other candidates are – on average – planning to finalize their phase III trials in the fourth quarter of 2020 at the earliest.

Researchers from Russia and other countries also stated that they are afraid that during the development process of Sputnik V corners were cut just to enable Russia to claim that it was the first country to develop an approved anti-COVID-19 vaccine, putting political vanity over the safety of human beings. They stressed that phase III trials are among the most important parts of a vaccine to receive approval and must not be skipped to speed up the development process.

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Conflict and Health

COVID - 19 in Mali

Mali, officially the Republic of Mali, is a landlocked, vast Sahelian country in West Africa. Mali is the eighth-largest country in Africa. The population of Mali is 19.1 million. 67% of its population was estimated to be under the age of 25 in 2017. Its capital is Bamako. The sovereign state of Mali consists of eight regions and its borders on the north reach deep into the middle of the Sahara Desert, while the country's southern part, where the majority of inhabitants live, features the Niger and Senegal rivers. The country's economy centres on agriculture and mining. Some of Mali's prominent natural resources include gold, being the third largest producer of gold in the African continent, and salt.

Mali has a low-income economy that is undiversified and vulnerable to commodity price fluctuations. High population growth rates (a fertility rate of six children per woman in 2017) and climate change pose major risks for the country's agricultural sector and food security.

After rising to 47.2% between 2011 and 2015 owing to the security crisis, the extreme poverty rate fell slightly to 42.7% in 2019 as a result of exceptionally high agricultural production in the past four years. Poverty is concentrated in the rural areas of southern Mali (90%), where the population density is the highest.

QUICK HISTORY OVERVIEW

Present-day Mali was once part of three West African empires that controlled trans-Saharan trade: the Ghana Empire (after which Ghana is named), the Mali Empire (after which Mali is named), and the Songhai Empire. During its golden age, there was a flourishing of mathematics, astronomy, literature, and art. At its peak in 1300, the Mali Empire covered an area about twice the size of modern-day France and stretched to the west coast of Africa. In the late 19th century, during the Scramble for Africa, France seized control of Mali, making it a part of French Sudan. French Sudan (then known as the Sudanese Republic) joined with Senegal in 1959, achieving independence in 1960 as the Mali Federation. Shortly thereafter, following Senegal's withdrawal from the federation, the Sudanese Republic declared itself the independent Republic of Mali. After a long period of one-party rule, a coup in 1991 led to the creation of a new constitution and the establishment of Mali as a democratic, multi-party state.

POLITICAL CONTEXT

Mali has been experiencing instability and conflict since the military coup in 2012 and the occupation of the northern regions by armed groups. The operations of the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA) date back to July 2014.

President Ibrahim Boubacar Keïta, first elected in 2013, was re-elected for a second term in August 2018. Parliamentary elections scheduled for fall 2018 were postponed several times. The first round took place on March 29, 2020, following an electoral campaign marked by the kidnapping of Soumaïla Cissé, head of the Union for the Republic and Democracy (URD) opposition party, in Saraféré on March 25, 2020. In the first round, 12 of 147 representatives were re-elected.

Peace negotiations between the government and two rebel coalitions, the "Platform" and the "Coordination," concluded with the signing of an agreement in June 2015. This agreement provides for greater decentralization, creating a special development zone for Mali's northern regions. It includes several projects, among them the program of accelerated development in the north (Programme de développement accéléré du Nord) and the emergency program for the revival of development in the northern regions (Programme d'urgence pour la relance du développement des régions du Nord). However, the country is encountering difficulties with the implementation of this agreement.

Security, which is critical for economic recovery, health system stability and poverty reduction, remains fragile in the face of continued attacks by armed groups against UN peacekeepers, the Malian army, and civilians, mainly in the north and central regions.

MAIN COUNTRY INFORMATION

- Area of the country: 1,240,000 km² (471,118 sq. miles)
 - Estimated population: 20 million
 - The population density in Mali is 17 per km² (43 people per mi²).
 - 44.0 % of the population is urban (8,906,636 people in 2020)
 - The median age in Mali is 16.3 years.
- <https://www.worldometers.info/world-population/mali-population/>



Map:

<https://www.cdc.gov/globalhealth/countries/mali/default.htm>

NUMBERS AT A GLANCE

Population: 20,320,503

Per capita income: \$2,160

Life expectancy at birth: F 62 /M 58 years

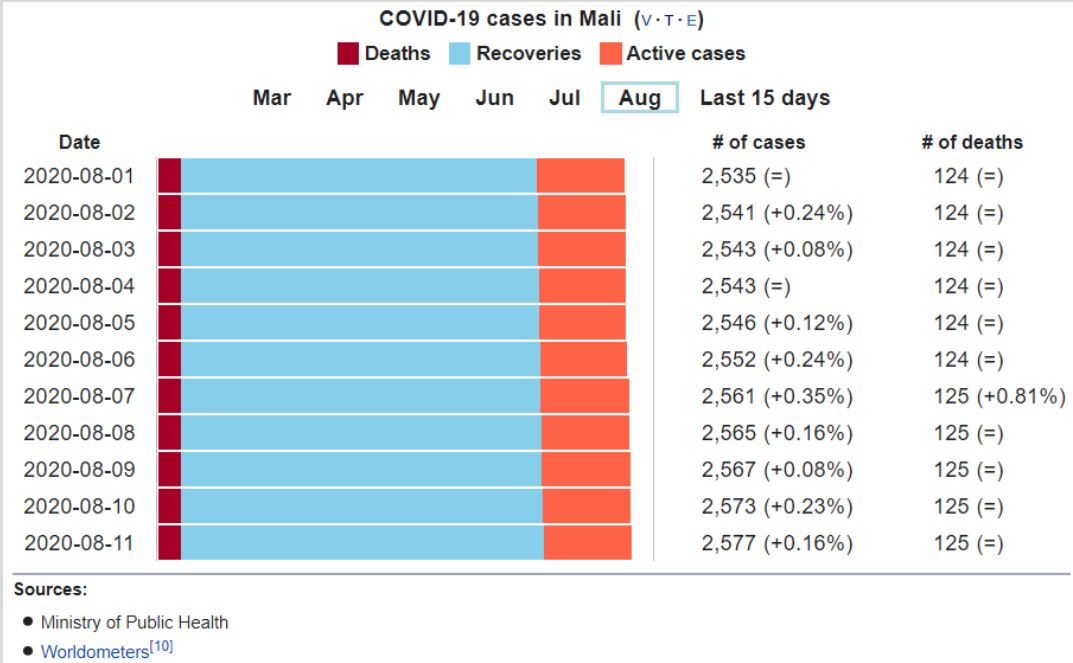
Infant mortality rate: 56/1,000 live births

Besides the just recently started COVID-19 crisis, other endemic infectious diseases have the potential to cause epidemics, and death such as:

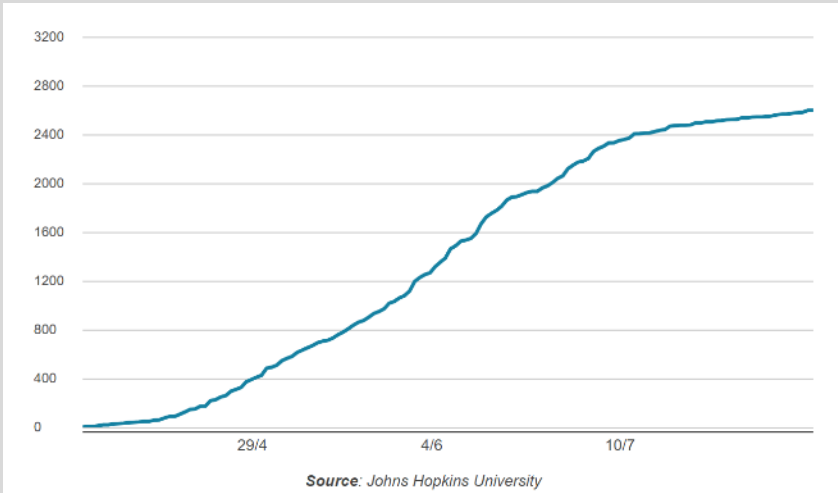
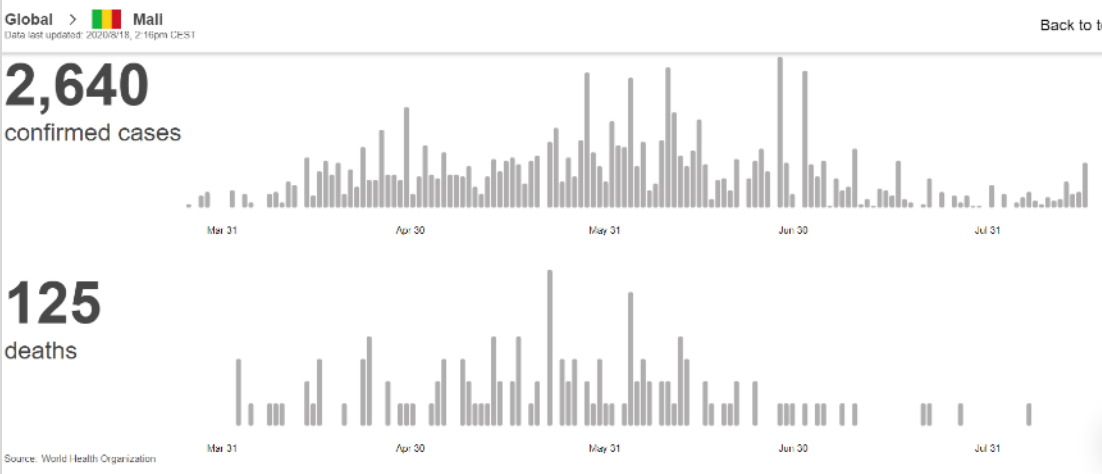
- Neonatal disorders
- Malaria
- Diarrheal diseases
- Lower respiratory infections
- Stroke
- Ischemic heart disease
- Congenital defects
- Malnutrition
- HIV/AIDS
- Meningitis

KEY SITUATION and COVID-19 CASES DEVELOPMENT.

On 25 March, Mali confirmed its first two COVID-19 cases. On 26 March, two new cases were registered by the Ministry of Health and Social Affairs. To address the epidemic which had so far spared the country, in an address to the nation, Ibrahim Boubacar Kéïta, the President of the Republic of Mali declared a state of emergency and instituted a curfew from 9.00 p.m. to 5:00 a.m. On 27 March, 7 new positive tests for Coronavirus: the case count for Mali rose to 11 cases. On 28 March, 7 new cases were confirmed, the total rose to 18. The first COVID-19 death occurred. On 31 March, 25 persons had tested positive and there had been 2 deaths according to health authorities. By the end of April there had been 490 confirmed cases of which 329 were still active, and 26 deaths. By the end of May there had been 1,265 confirmed cases of which 472 were still active, and 77 deaths. By the end of June there had been 2,181 confirmed cases of which 591 were still active, and 116 deaths. There were 354 confirmed cases in July, bringing the total number to 2,535 of which 474 were still active at the end of the month. The death toll rose by eight to 124. In the current month new cases were reported but frequency of occurrence is decreasing in comparison with previous two months. The infection curve is flattening but no significant descent is visible.



Total number of COVID-19 cases in Mali:



In accordance with available information from July nine regions and 36 health districts are affected by the COVID-19 epidemic in Mali. As of 18 August, the cumulative number of confirmed cases is 2,640 and 125 deaths were recorded, representing an overall mortality of 4.7 per cent. The epidemic remains concentrated in Bamako, Timbuktu and Mopti.

The Government of Mali decided to reopen schools only for the final year of primary and secondary (general and technical) school, technical and vocational education as well as Teacher Training Institutes classes since 2 June. A state of emergency is still in effect in the country and the air borders remain closed. Concluding, Mali is still experiencing a continuity of SARS-CoV-2 transmissions and international assistance is required to deal with the pandemic.

HEALTH SYSTEM

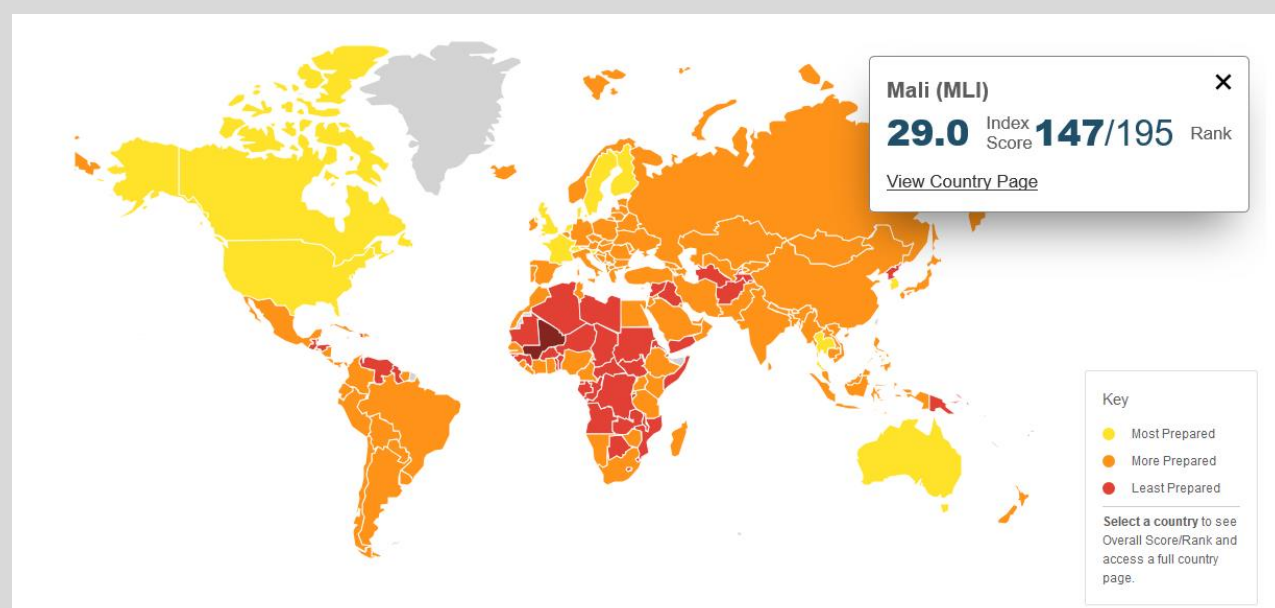
Although there have been significant improvements in the Health sector in Mali, the country continues to face serious challenges in the health sector, with some of the world's worst health indicators. Under terrorist occupation, nearly all health facilities in northern Mali were ransacked in 2012, and internally displaced people overburdened the health system in the south. Mali's health system is heavily dependent upon international development organizations and foreign missionary groups for much of the health care services it provides. In 2015, the health expenditure by the government was only 5.8% of GDP. Medical facilities in Mali are very limited, especially outside of Bamako, and medicines are in short supply.

There are three major public hospitals in the greater Bamako region. However, Mali still lacks a great number of physicians, as there are only .08 physicians per 10,000 citizens. In 2009, there were only 729 physicians in the entire country of nearly 15 million people.

In Northern Mali, there are only a few areas in which civilians can ask for medical assistance. Health authorities have proven to be unable to manage epidemics within the population in northern Mali, and this gap has been filled by the Doctors Without Borders association, also known as Médecins Sans Frontières (MSF). Since the arrival of MSF, more than 40,000 children have been protected from malaria and improved regional hospitals were created. The struggling with the health care situation still remains as over 40% of the inhabitants of some regions must walk 9 miles or more to the nearest health clinic. Much of northern Mali has been hit with (armed) conflict, resulting in many refugees and internally displaced people. In southern Mali, which is more peaceful, MSF has worked to improve hospital bed numbers and malaria vaccinations.

Sources:

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- <https://www.who.int/hac/crises/mli/sitreps/en/>
- <https://covid19.who.int/region/afro/country/ml>
- https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Mali
- <https://www.worldometers.info/coronavirus/country/mali/>
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Mali

29.0 Index Score **147/195**



	COUNTRY SCORE	AVERAGE SCORE*		COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	23.4	34.8	HEALTH SYSTEM	13.0	26.4
Antimicrobial resistance (AMR)	8.3	42.4	Health capacity in clinics, hospitals and community care centers	0.5	24.4
Zoonotic disease	34.4	27.1	Medical countermeasures and personnel deployment	33.3	21.2
Biosecurity	4	16.0	Healthcare access	22.8	38.4
Biosafety	0	22.8	Communications with healthcare workers during a public health emergency	0	15.1
Dual-use research and culture of responsible science	0	1.7	Infection control practices and availability of equipment	0	20.8
Immunization	78.1	85.0	Capacity to test and approve new medical countermeasures	25	42.2
DETECTION AND REPORTING	25.5	41.9	COMPLIANCE WITH INTERNATIONAL NORMS	53.2	48.5
Laboratory systems	25	54.4	IHR reporting compliance and disaster risk reduction	100	62.3
Real-time surveillance and reporting	23.3	39.1	Cross-border agreements on public and animal health emergency response	0	54.4
Epidemiology workforce	50	42.3	International commitments	15.6	53.4
Data integration between human/animal/environmental health sectors	0	29.7	JEE and PVS	75	17.7
RAPID RESPONSE	29.5	38.4	Financing	50	36.4
Emergency preparedness and response planning	12.5	16.9	Commitment to sharing of genetic & biological data & specimens	66.7	68.1
Exercising response plans	0	16.2	RISK ENVIRONMENT	32.1	55.0
Emergency response operation	33.3	23.6	Political and security risks	25	60.4
Linking public health and security authorities	0	22.6	Socio-economic resilience	38.8	66.1
Risk communication	25	39.4	Infrastructure adequacy	16.7	49.0
Access to communications infrastructure	51.7	72.7	Environmental risks	65	52.9
Trade and travel restrictions	100	97.4	Public health vulnerabilities	20.5	46.9

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

www.ghsindex.org

MilMed CoE VTC COVID-19 response

Topic	<p>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.</p> <p>Topics former VTCs:</p> <ul style="list-style-type: none">• Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities.• Testing strategies• Aeromedical evacuation• De-escalation strategy and measures• Collateral damage of COVID-19 emphasizing Mental Health Aspects and other non COVID related diseases• Immunity map, national strategies to measure and evaluate the immunity level"• Mental Health• Treatment of mild symptomatic cases of COVID-19• Transition home office back to the office• COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation• Perspectives of the current COVID-19 vaccine development <p>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.</p>
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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>

- 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.

Lifting of travel restrictions: Council reviews the list of third countries

Following a review under the recommendation on the gradual lifting of the temporary restrictions on non-essential travel into the EU, the Council updated the list of countries for which travel restrictions should be lifted. As stipulated in the Council recommendation, this list will continue to be reviewed regularly and, as the case may be, updated.

Based on the criteria and conditions set out in the recommendation, as from 8 August member states should **gradually lift the travel restrictions at the external borders for residents of the following third countries:**

- Australia
- Canada
- Georgia
- Japan
- New Zealand
- Rwanda
- South Korea
- Thailand
- Tunisia
- Uruguay

- China, subject to confirmation of reciprocity

Residents of Andorra, Monaco, San Marino and the Vatican should be considered as EU residents for the purpose of this recommendation.

The **criteria** to determine the third countries for which the current travel restriction should be lifted cover in particular the epidemiological situation and containment measures, including physical distancing, as well as economic and social considerations. They are applied cumulatively.

Regarding the **epidemiological situation**, third countries listed should meet the following criteria, in particular:

- number of new COVID-19 cases over the last 14 days and per 100 000 inhabitants close to or below the EU average (as it stood on 15 June 2020)
- stable or decreasing trend of new cases over this period in comparison to the previous 14 days
- overall response to COVID-19 taking into account available information, including on aspects such as testing, surveillance, contact tracing, containment, treatment and reporting, as well as the reliability of the information and, if needed, the total average score for International Health Regulations (IHR). Information provided by EU delegations on these aspects should also be taken into account.

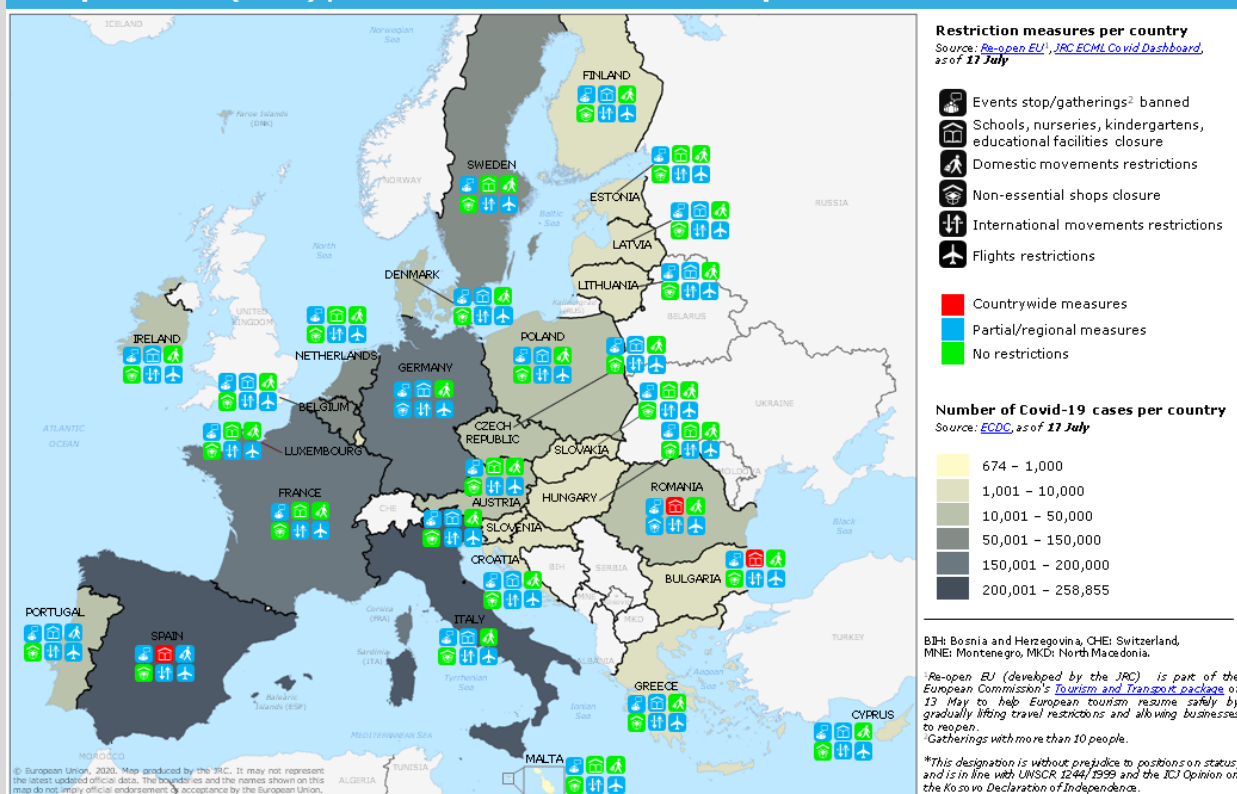
Reciprocity should also be taken into account regularly and on a case-by-case basis.

For countries **where travel restrictions continue to apply**, the following **categories of people should be exempted** from the restrictions:

- EU citizens and their family members
- long-term EU residents and their family members
- travellers with an essential function or need, as listed in the Recommendation.
- Schengen associated countries (Iceland, Lichtenstein, Norway, Switzerland) also take part in this recommendation.

JRC Map 17 July 2020 at 13:00 UTC

European Union (EU27) | COVID-19 restriction measures update



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

Risk Assessment

Global	<ul style="list-style-type: none"> 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	<p>ECDC assessment for EU/EEA, UK as of 10 August 2020 (still valid):</p> <p>Risk of COVID-19 across all EU/EEA countries and the UK:</p> <ul style="list-style-type: none"> The risk of further escalation of COVID-19 is moderate for countries that continue to implement and enforce multiple measures, including physical distancing, and have sufficient contact tracing and testing capacity. The risk of further escalation of COVID-19 is very high for countries that do not implement or enforce multiple measures, including physical distancing, and have sufficient contact tracing and testing capacity. <p>Risk of COVID-19 in the countries that have reported a recent increase of cases:</p> <ul style="list-style-type: none"> The risk of further escalation of COVID-19 is high in countries that have also had an increase in hospitalisations, providing a strong indication that there is a genuine increase in transmission occurring. For these countries, the overall risk of escalation is very high if they do not implement or reinforce multiple measures, including physical distancing measures and contact tracing, and have sufficient testing capacity. The risk of further escalation of COVID-19 is high for the countries reporting no increase in hospitalisations but having seen an increase in test positivity (if testing capacity is sufficient and intensity has remained stable), suggesting increasing levels of transmission. For these countries, the overall risk of escalation is very high if they do not implement or reinforce multiple measures, including physical distancing measures and contact tracing. The risk of further escalation of COVID-19 is moderate to high for those countries reporting no increase in hospitalisations or test positivity (if testing capacity is sufficient and intensity has remained stable), The countries that have multiple physical distancing measures in place should conduct local risk assessments to better understand the groups or settings driving the increase in cases and to determine which measures should be in place or strengthened.

References:

- European Centre for Disease Prevention and Control www.ecdc.europa.eu
- World Health Organization WHO; www.who.int
- Centres for Disease Control and Prevention CDC; www.cdc.gov
- Our World in Data; <https://ourworldindata.org/coronavirus>
- Morgenpost; <https://interaktiv.morgenpost.de/corona-virus-karte-infektionen-deutschland-weltweit/>

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