**Update 34 (25th of August 2020)**

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

**Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich**
**25th of August 2020**
email: info.dhsc@coemed.org

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

## HIGHLIGHTS/NEWS

- **WHO** has published a timeline of: WHO´s COVID-19 response to the pandemic from 31 December 2019, that will present you with all actions done by WHO on information, science, leadership, advice, response and resourcing.
- **WHO**: published a paper on Public Health considerations while resuming international travel. The document should provide governments, health authorities with elements to consider in adjusting international travel measures to the changing epidemiological situation of the COVID-19 pandemic, national public health and health service capacity available in countries and evolving understanding of the virus.
- **WHO** stopped their daily COVID-19 Situation Reports. Beginning of 17 August 2020 COVID-19 only weekly Epidemiological Update will be publishing the which will focus on analysis and interpretation of the evolving epidemiological situation.
- **ECDC** published the "Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK –eleventh update".
- **UNO**: The Syria negotiations on a new constitution are provisionally on hold after one day due to positive corona tests with several participants. On Monday afternoon, participants were informed of the interruption of the sessions after three positive corona tests. The participants were put in quarantine "between two and ten days" in their hotels.
  15 representatives each from government, opposition and civil society should work on a new constitution this week in Geneva. They had come to the European headquarters of the United Nations with mouth and nose protection and sat in a large hall at a distance from each other. They had been tested for the coronavirus before leaving and after arriving in Geneva.

**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** |
|---|
| **23 635 500** confirmed cases<br>15 354 733 recovered<br>813 397 deaths |
| **EU/EEA and the UK** |
| **3 644 909** confirmed cases<br>2 152 578 recovered<br>212 105 deaths |
| **USA → (new cases/day 43 860)** |
| **5 708 194** confirmed cases<br>2 019 605 recovered<br>**176 866** deaths |
| **Brazil → (new cases/day 43 860)** |
| **3 622 861** confirmed cases<br>**2 976 256** recovered<br>**115 309** deaths |
| **India ↗ (new cases/day 65 526)** |
| **3 167 323** confirmed cases<br>2 404 585 recovered<br>**58 390** deaths |
| **Russia → (new cases/day 4 780)** |
| **959 016** confirmed cases<br>**771 357** recovered<br>**16 406** deaths |
| **Spain ↘ (new cases/day 6 622)** |
| **405 436** confirmed cases<br>**150 376** recovered<br>28 872 deaths |

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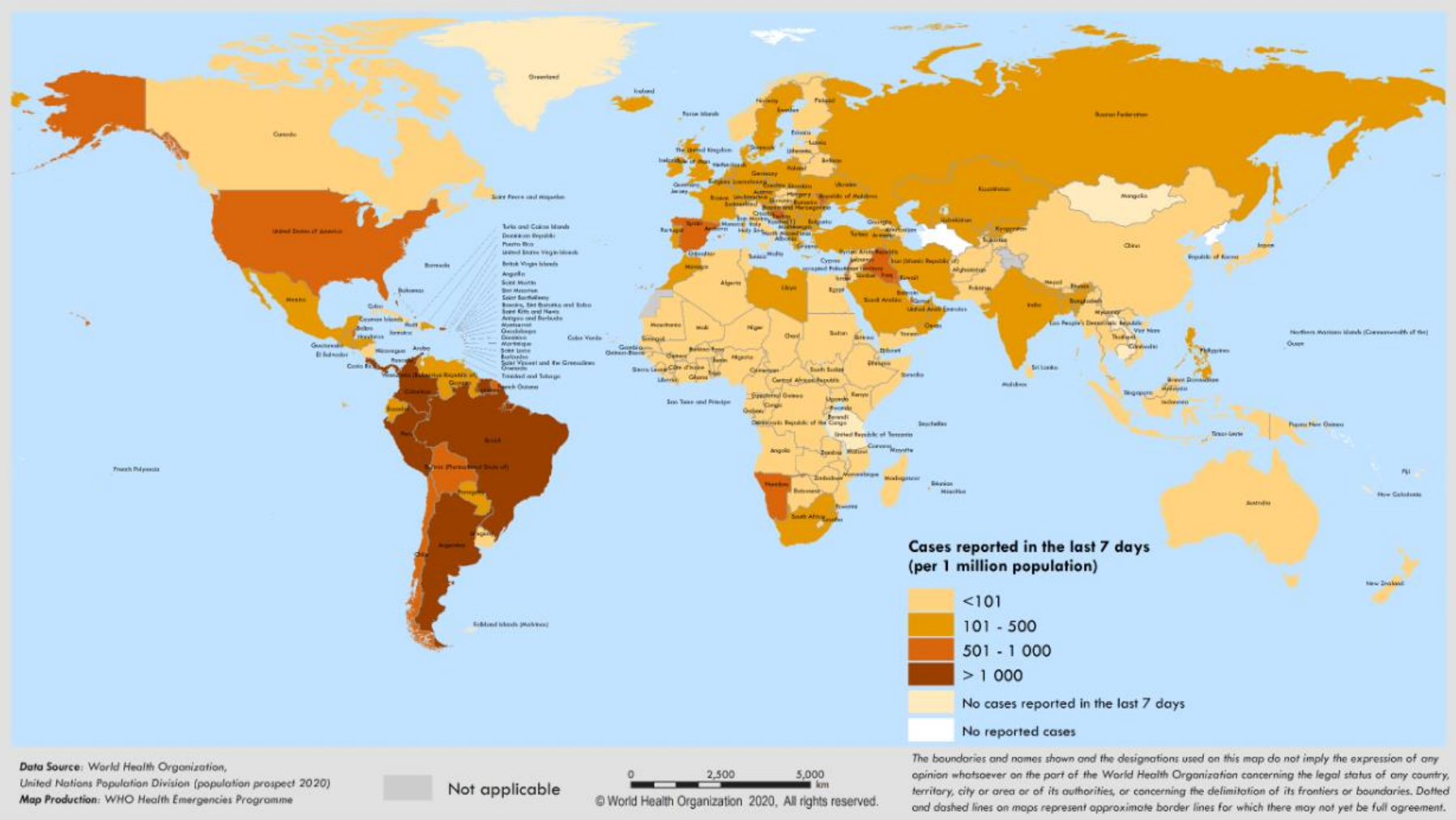
## Map of countries with reported COVID-19 cases (last 7 days)

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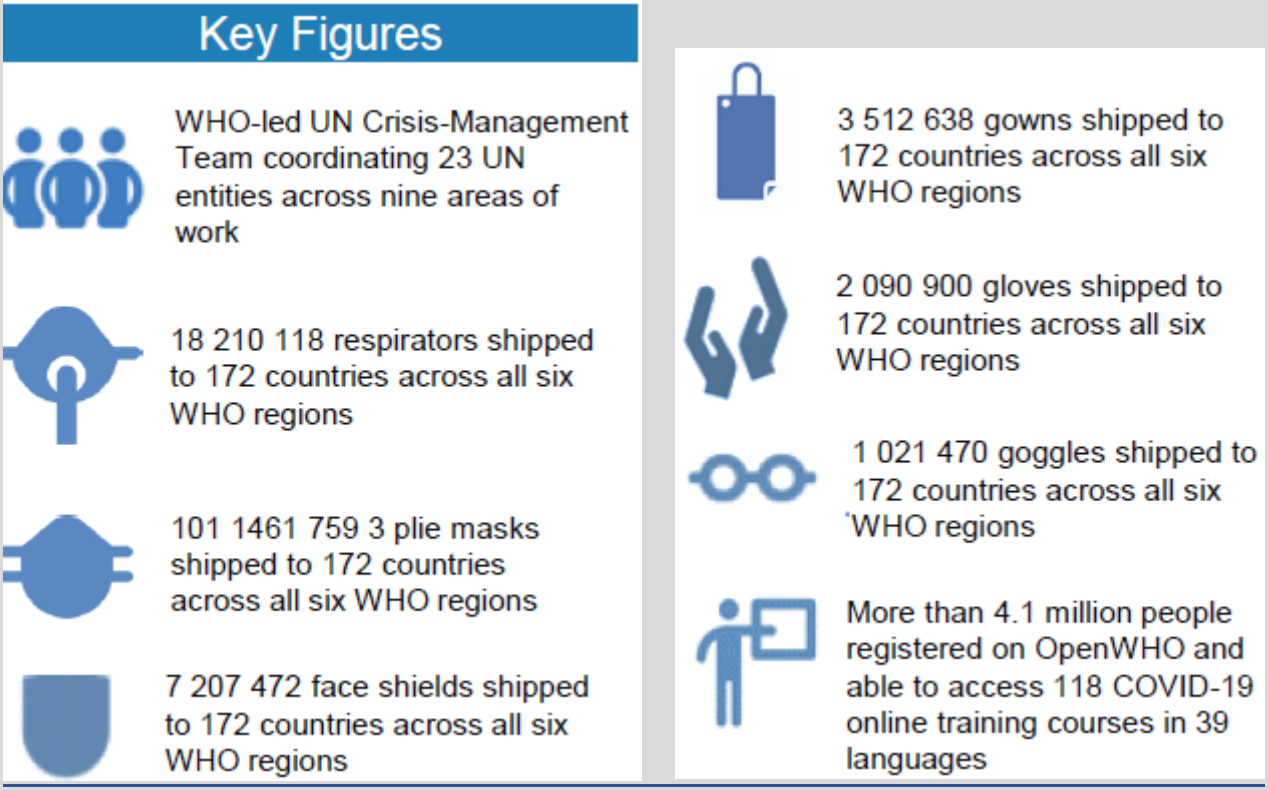
## Worldwide Situation

Global Situation

**WHO weekly operational update on COVID-19 as of 21 August 2020:**

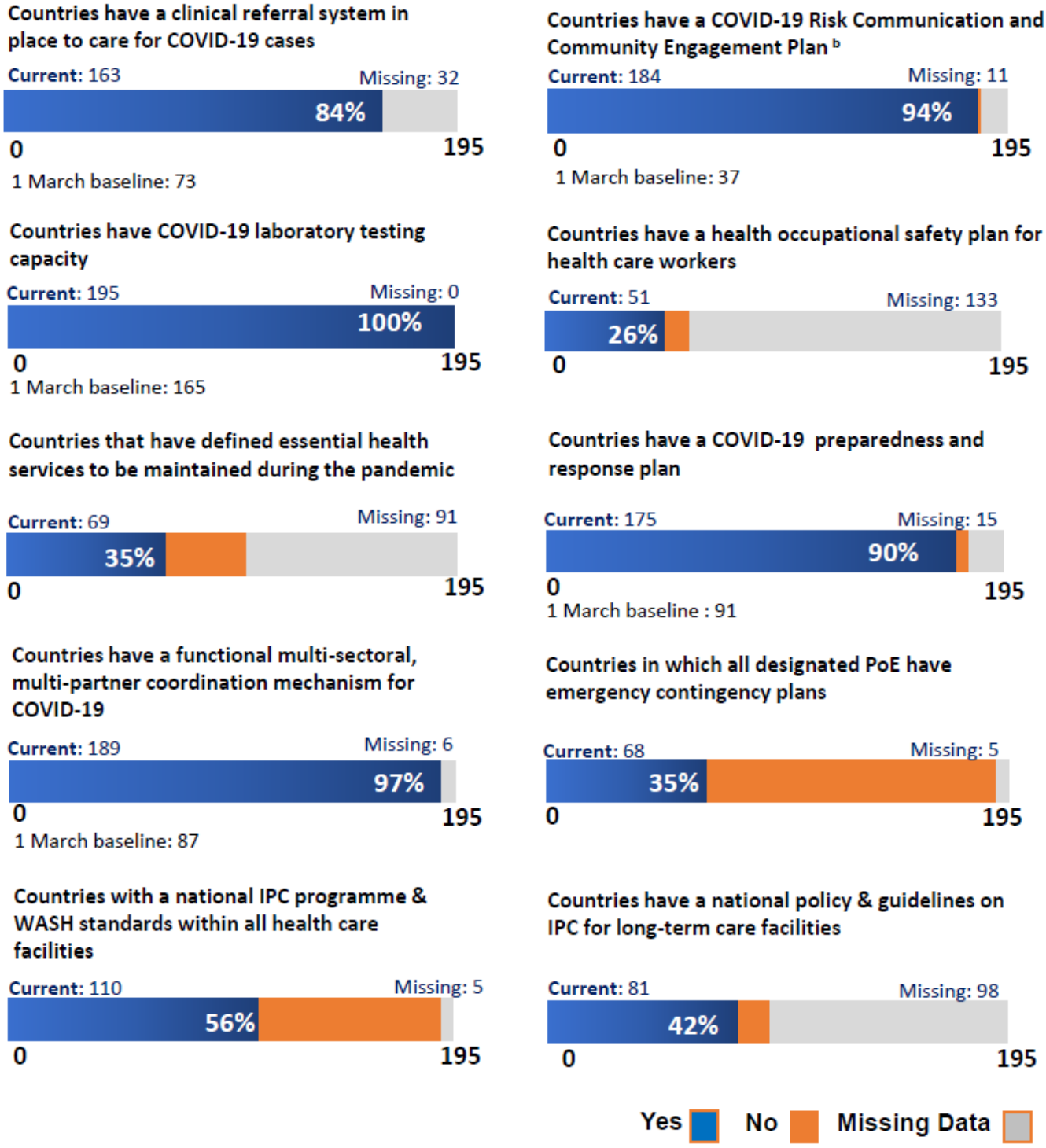



See information about partnership, logistics, health learning, medicines and health products, funding/donors and regional highlights in the document.
Find some selected topic out of the paper down below:

You will find a technical guidance on "Considerations for quarantine of contacts of COVID-19 cases".
**Who should be quarantined?**
WHO recommends the rapid identification of COVID-19 cases and their isolation and management either in a medical facility or an alternative setting, such as the home. All contacts of individuals with a confirmed or probable COVID-19 be quarantined in a designated facility or at home for 14 days from their last exposure.
A contact is a person in any of the following situations from 2 days before and up to 14 days after the onset of symptoms in the confirmed or probable case of COVID-19:

- face-to-face contact with a probable or confirmed case of COVID-19 within 1 meter and for more than 15 minutes;
- direct physical contact with a probable or confirmed case of COVID-19
- direct care for an individual with probable or confirmed COVID-19 without using proper personal protective equipment; or
- other situations, as indicated by local risk assessments.

**COVID-19 Global Preparedness and Response Summary Indicators[a]**




Notes

a) Data collected from Member States and territories. The term "countries" should be understood as referring to "countries and territories."

b) Source: UNICEF and WHO reporting

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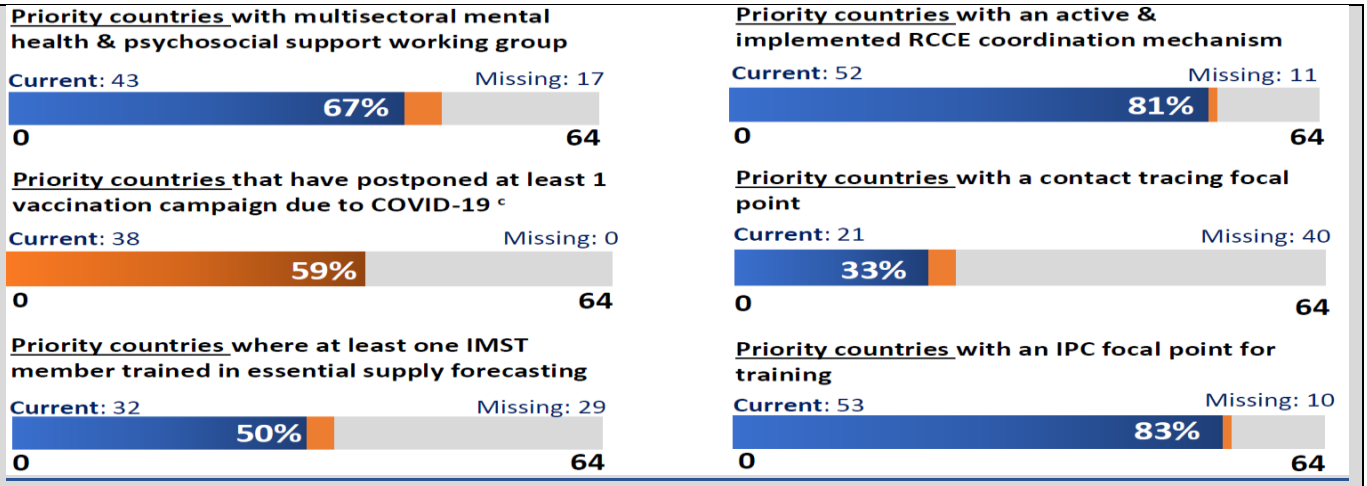


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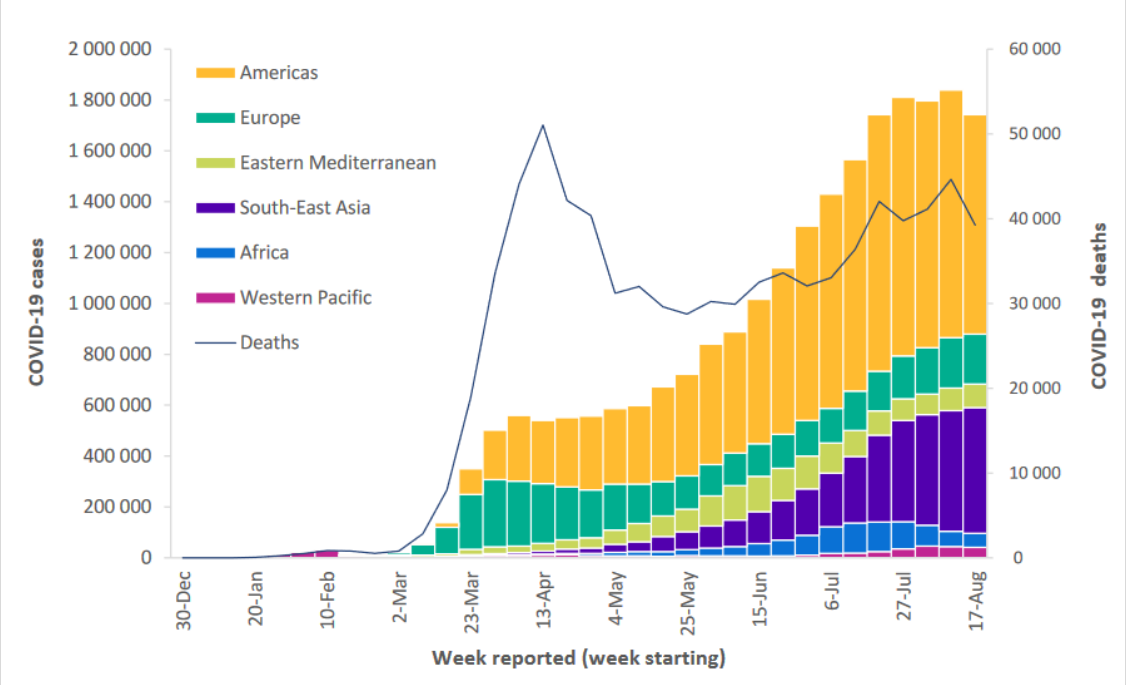
## WHO weekly epidemiological report

### *Global epidemiological situation*

Over 1.7 million new COVID-19 cases and 39 000 new deaths were reported to WHO for the week ending 23 August, a 5% decrease in the number of cases and 12% decrease in the number of deaths compared to the previous week (10 to 16 August) (Figure below). A cumulative total of over 23 million cases and 800000 deaths have been reported so far.




With the exception of the South-East Asia and Eastern Mediterranean regions, a decrease in the weekly case incidence was reported across WHO regions in the last seven days (Table 1, Figure 2).

Although the WHO Region of **the Americas** remains the most affected, accounting for 50% of newly reported cases and 62% of deaths, the region had the largest decrease compared to the previous week.

The **South-East Asia Region**, which is the second most active region, continues to report an increase accounting for 28% and 19% of newly reported cases and deaths respectively.

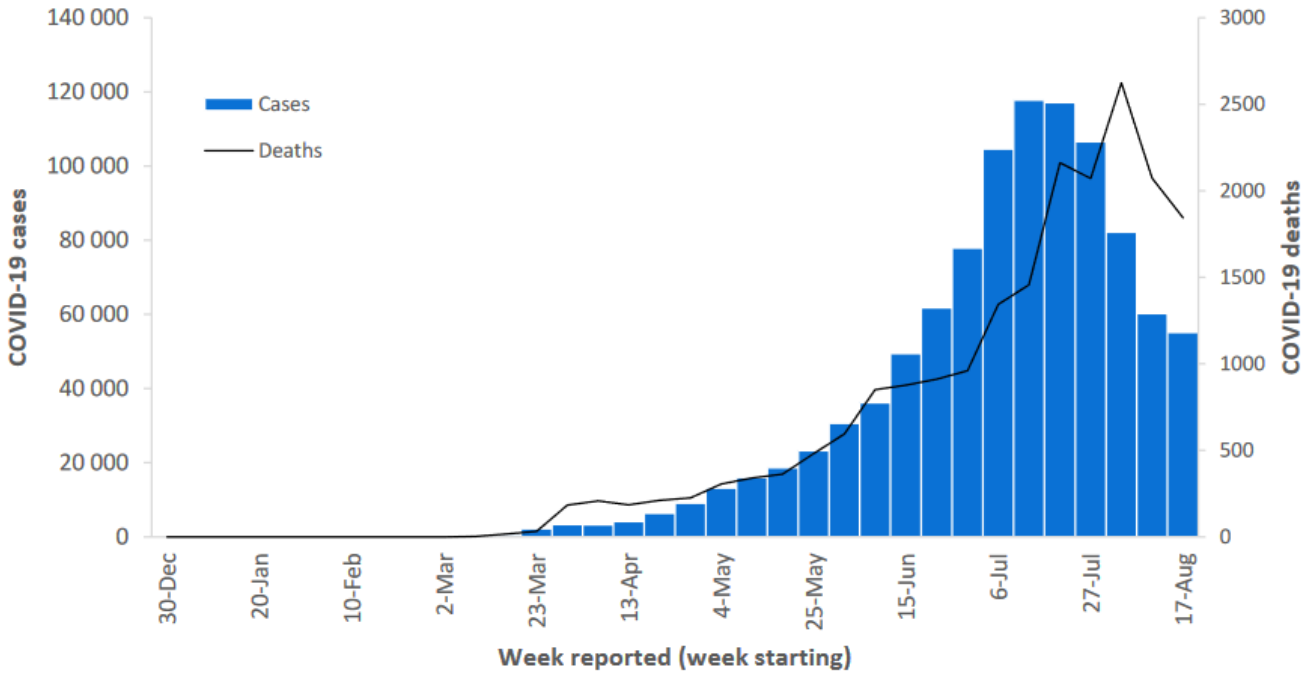
In the **European Region**, the number of cases reported has consistently increased over the last three weeks, however, a slight decrease (1%) was reported in the most recent week, and the number of deaths has continued to decrease across the region.

In the **Eastern Mediterranean Region**, the number of reported cases increased by 4% compared to the previous week, however, the number of reported deaths have consistently decreased over the last six weeks. Likewise, the **African** and **Western Pacific** regions reported overall decreases in case activity over the past week.

### *African Region*

The number of cases and deaths reported in the African Region decreased by 8% and11% respectively in the past seven days, primarily due to a decrease in cases reported in Algeria, Ghana,Kenya, Senegal and South Africa. Despite the overall decrease in the number of cases across the region, Uganda reported an increase of over 300%. Here, intensive community transmission has been reported in capital Kampala, particularly the divisions of Makindye, Nakawa and Kawempe. Ethiopia has continued to report an increase in cases and deaths; and similarly, Namibia and Nigeria reported a 55% and 19% increase in the number of cases respectively. After 22 days of no cases, Mauritius reported two new cases in returnees who were repatriated from a neighbouring country.

**Figure 3: Number of COVID-19 cases and deaths reported weekly by African Region, data as of 23 August 2020****



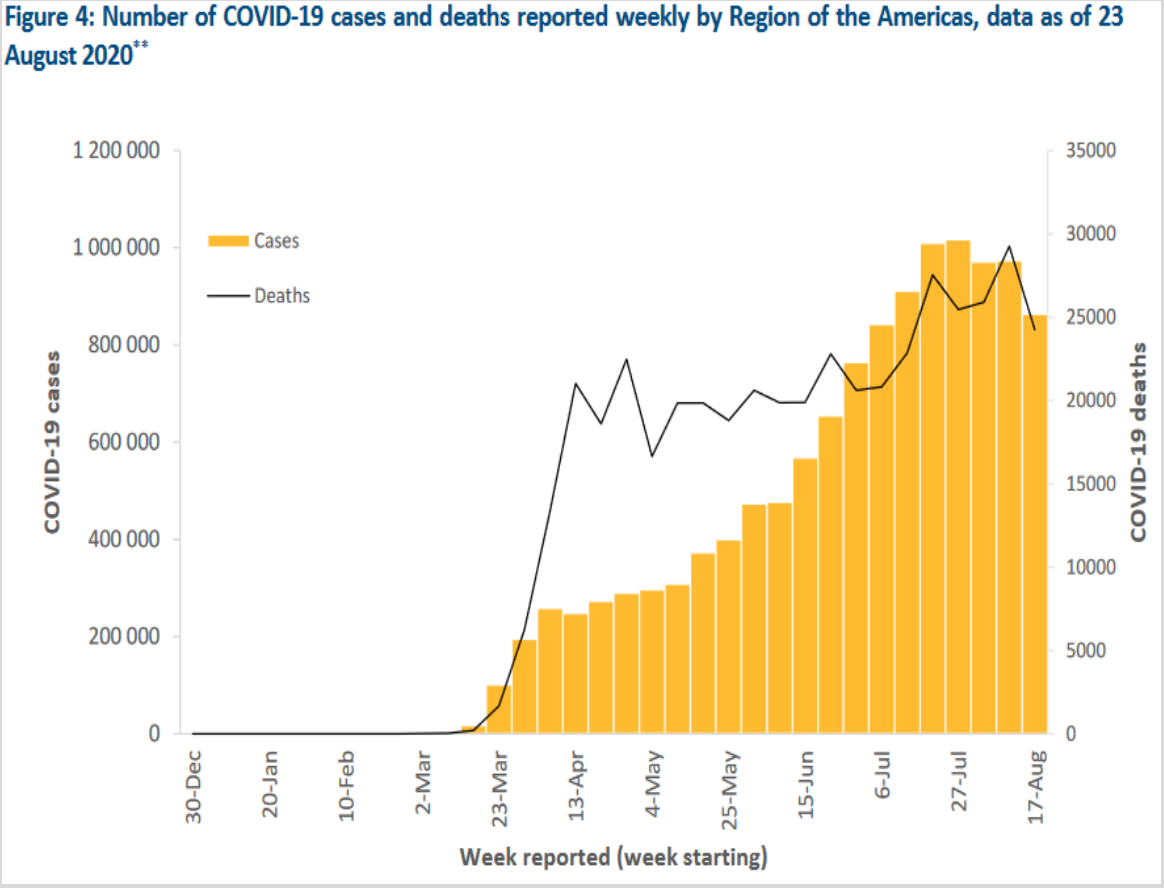

### *Region of the Americas*

The number of new cases and deaths decreased by 11% and 17% respectively compared to the previous week–primarily driven by reduced transmission rates reported from Brazil, Dominican Republic, Panama and the United States of America.

Several countries and territories in the Carribean islands have, however, reported a large increase in cases and deaths in the last seven days including Bahamas, Guadeloupe, Guyana, Jamaica and Trinidad and Tobago. The increase in cases observed in the Carribean islands may in part be due to an increase in tourism.

The number of deaths reported in Peru decreased by 73% compared to the previous week, however, the incidence death rate in the last seven days (42 deaths per 1 million population) and the cumulative death rate in the country (826 deaths per 1 million population) remains the highest in the region.

**Figure 4: Number of COVID-19 cases and deaths reported weekly by Region of the Americas, data as of 23 August 2020[**]**

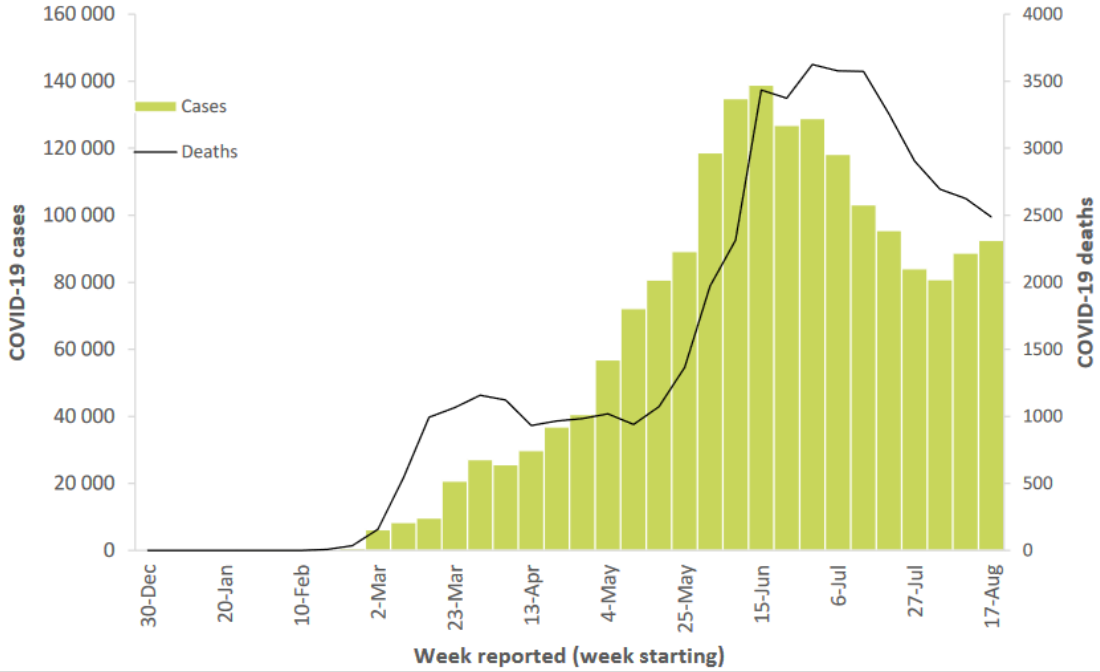



### *Eastern Mediterranean Region*

The number of cases reported in the Eastern Mediterranean Region increased by 4% in the last seven days, however, the number of deaths decreased by 5% and has consistently decreased over the last six weeks. Jordan, Lebanon and Tunisia reported the highest increase in cases compared to the previous week.

Following the explosion in Beirut, Lebanon on 4 August, health care capacity in the area has diminished while COVID-19 cases continue to rise. As a result of the increase in cases, the Ministry of Public Health has established testing sites for residents and volunteers in the areas most affected by the blast. In addition, several health facilities are being restored and health supplies, including personal protective equipment, have been received.

**Figure 5: Number of COVID-19 cases and deaths reported weekly by Eastern Mediterranean Region, data as of 23 August 2020****




### *European Region*

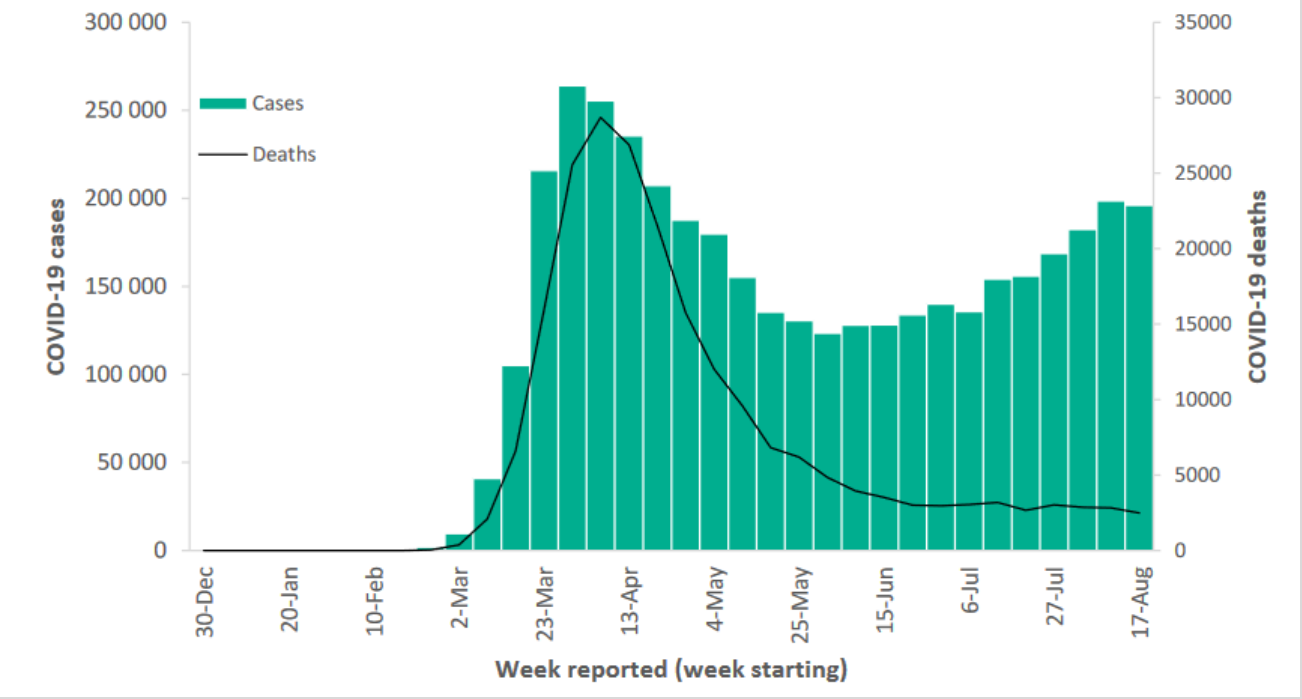
Following a steady increase in the number of cases reported in the European Region over the last few weeks, the number of cases decreased slightly by 1% in the last seven days. The number of deaths reported in the last seven days decreased by 12%, continuing the downward trend. Not all countries are reporting a decline:

Spain reported a 200% increase in the number of deaths in the last week compared to the previous week.

As countries across the region continue to report a resurgence in cases, several countries reported record high numbers in the last seven days including Croatia, Czechia, Poland, Republic of Moldova and Ukraine.

In response to the increase in cases across the region, many countries have recently re-introduced public health and social measures including travel restrictions.

**Figure 6: Number of COVID-19 cases and deaths reported weekly by European Region, data as of 23 August 2020**[**]



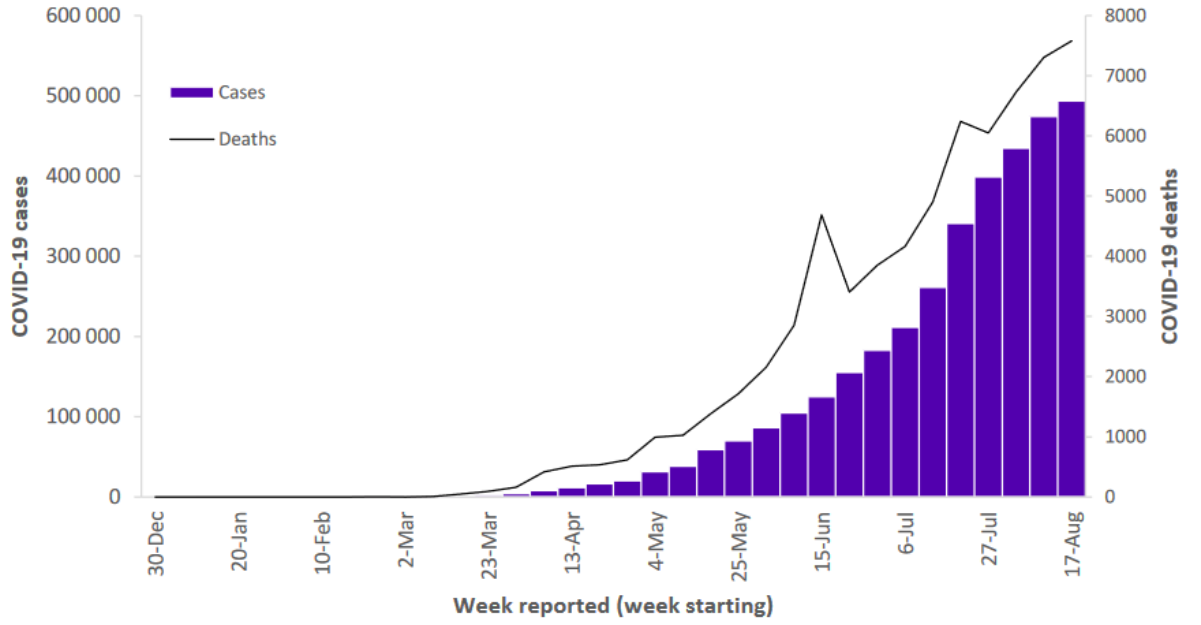

### *South-East Asia Region*

South-East Asia is the second most affected region and currently accounts for 28% and 19% of newly reported cases and deaths respectively, globally in the past seven days. The region has seen a steady increase in reported cases and deaths, with a 4% increase in the past seven days.

India continues to report the majority of cases and has reported a cumulative total of over three million cases, which accounts for 86% of all regional confirmed cases.

The number of cases and deaths in Nepal has rapidly increased in the last seven days with a 49% and 52% increase respectively compared to the previous weeks. In addition, the testing capacity in Nepal has significantly increased resulting in a 38% increase in the testing rate.

**Figure 7: Number of COVID-19 cases and deaths reported weekly by South-East Asia Region, data as of 23 August 2020[**]**



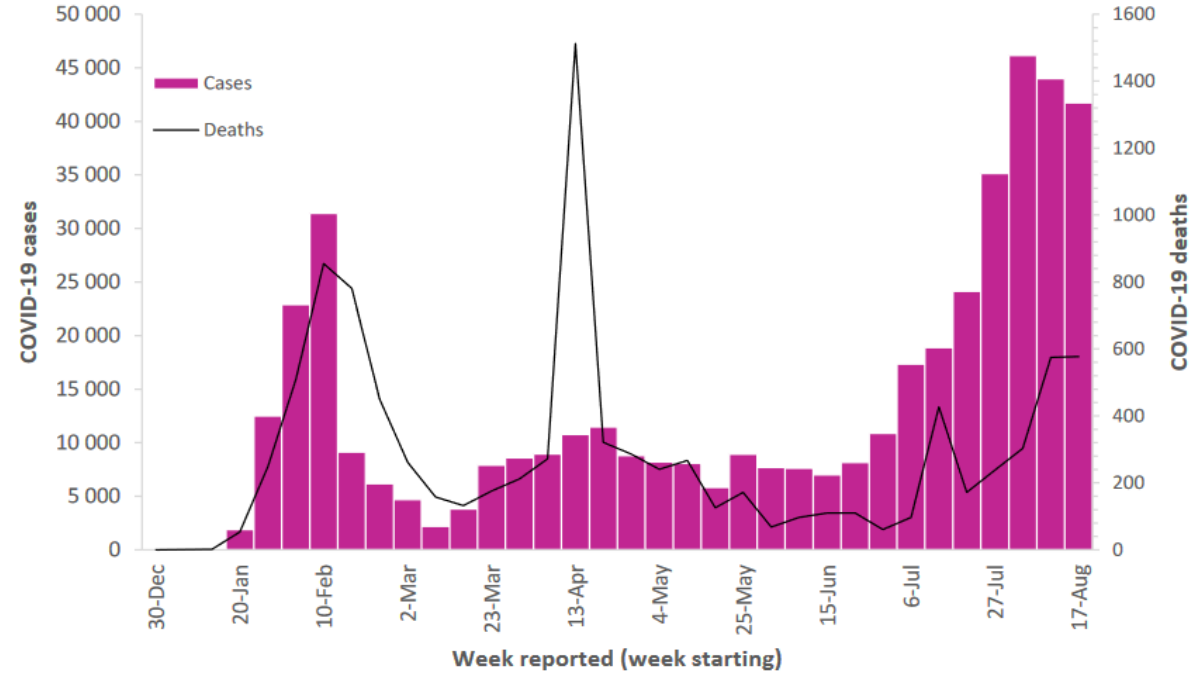

### *Western Pacific Region*

The number of cases reported in the Western Pacific Region decreased by 5% following a decrease in the number of new cases reported by Australia, China, Japan, Singapore and Viet Nam.

The Republic of Korea reported a 180% increase in cases, mainly due to an increase in cases associated with religious gatherings.

Due to the increase in cases reported in the region, some Pacific Island countries are tightening border measures. There is also an increase in active testing and case finding systems across the region, which are facilitating the detection and control of clusters.

**Figure 8: Number of COVID-19 cases and deaths reported weekly by Western Pacific Region, data as of 23 August 2020[**]**



Updates from WHO regional offices

- WHO AFRO
- WHO EMRO
- WHO EURO
- WHO PAHO
- WHO SEARO
- WHO WPRO

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**IS in the context of COVID-19**

The global corona protective measures have apparently reduced the threats from the Islamic State (IS) jihadist militia. The restrictions on public life and travel restrictions have apparently reduced the “risk of terrorist attacks” by IS in many countries, said the head of the UN's anti-terrorist office in New York on Monday. However, there are indications that the militia are currently regrouping in conflict areas in Iraq and Syria. The IS has had a new leader for several months. Former Iraqi army officer Amir Mohammed Abdul Rahman al-Mawli rose to head the extremist organization after its predecessor, Abu Bakr al-Baghdadi, was killed in a US military operation in October.

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**USA:** President Trump recently approved the little-researched blood plasma treatment. In the so-called immune plasma therapy, patients receive plasma from people who have formed antibodies after a natural infection. It is still unclear how effective plasma actually is in reducing the COVID mortality rate.

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**MAR:** The country recently recorded more than 1,500 new infections daily; it is feared that the weak medical infrastructure will not be able to cope with the pandemic. In Tangier and Rabat, badly affected areas have been completely cordoned off, while Casablanca and Marrakech have serious curfews.

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**IDN:** As it became known on Monday, unlike previously planned, the Balinese government does not want foreign holidaymakers to return from September 11th, but rather next year at the earliest. The background to this is the increasing number of infections in Indonesia and numerous travel restrictions imposed in the tourists' countries of origin.

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**HKG**: Doctors have published a case report according to which a 33-year-old man was infected with SARS-CoV-2 for the second time within 5 months. The two infections are each due to different subtypes of the virus.

Situation in Europe

## ECDC COVID-19 surveillance report Week 33, as of 21 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 19 August 2020, the 14-day case notification rate for the EU/EEA and the UK was 37 (country range: 4–124) per 100 000 population. The rate has been increasing for 31 days.
- Increases in the 14-day COVID-19 case notification rates compared to those reported seven days earlier have been observed in 18 countries (Austria, Croatia, Denmark, France, Germany, Greece, Ireland, Italy, Liechtenstein, Lithuania, Malta, Netherlands, Norway, Slovakia, Slovenia, Spain, Sweden and the United Kingdom). Rates in these countries have been increasing for between one and 42 days.
- Notification rates are highly dependent on a number of factors, one of which is the testing rate. Weekly testing rates for week 33 in the EU/EEA and the UK varied from 193 to 5 340 tests per 100 000 population. Luxembourg had the highest testing rate for week 33, followed by Denmark, Malta, Cyprus and the United Kingdom.
- Seven countries (Bulgaria, Czechia, France, Netherlands, Poland, Romania and Sweden) had a weekly test positivity of 3% or higher and four countries (France, Greece, Netherlands and Slovenia) had a weekly test positivity that had increased compared to last week.

**Primary care**

- Among six countries that reported data up to week 33 from primary care sentinel surveillance for COVID-19, using the systems established for influenza, there were no detections of SARS-CoV-2 from 68 patients tested.
- All countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 33, 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 and/or new admissions due to COVID-19 have recently increased in Bulgaria, Czechia, Greece, Poland, Romania and Slovakia. No other increases have been observed, although data availability varies.
- Based on data reported to date by 22 countries, we estimate that 25% (country range: 6–60%) of reported COVID-19 cases have been hospitalised. Data from 16 countries show that a total of 14% (country range: 0–62%) of hospitalised patients required ICU and/or respiratory support.

**Mortality**

- The 14-day COVID-19 death notification rate for the EU/EEA and the UK was four (country range: 0–31) per million population. The rate has been stable for 46 days.
- Increases in the 14-day COVID-19 death notification rates compared to those reported seven days ago have been observed in two countries (Belgium and Romania). Rates in these countries have been increasing for between eight and 23 days.
- Pooled estimates of all-cause mortality reported by EuroMOMO remain at normal levels. However, in some countries there seems to be a small increase in mortality which could be related to local heat waves.

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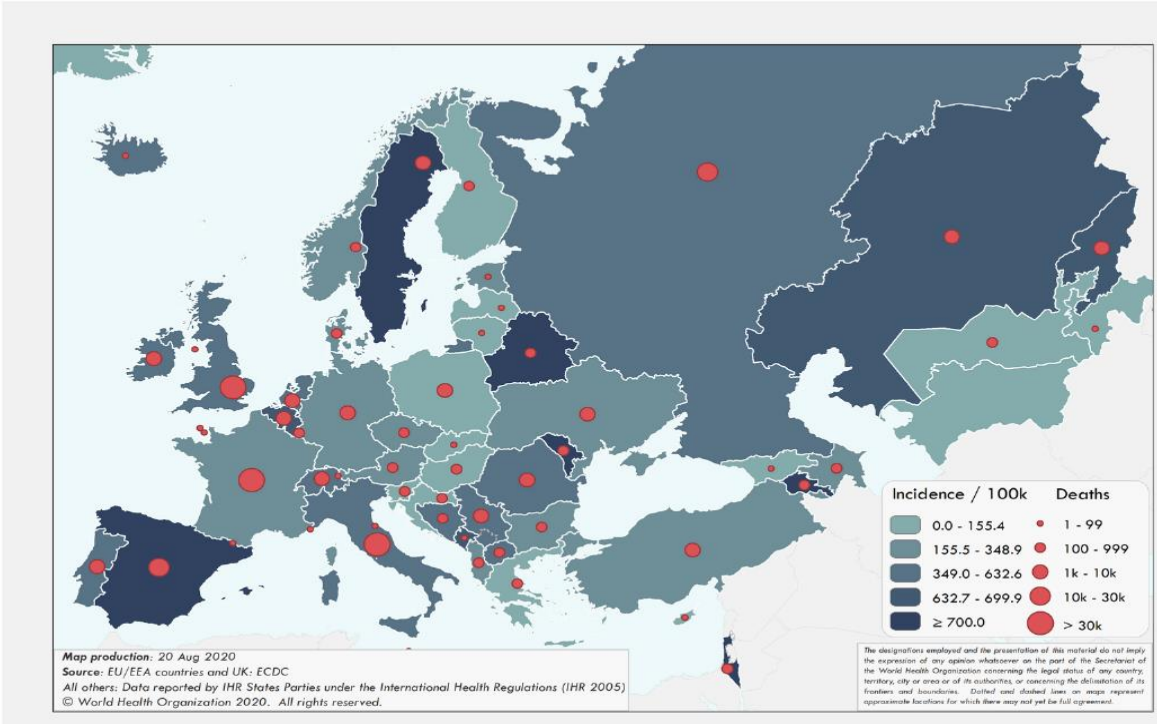
## COVID-19 situation update for the WHO European Region (10 – 16 August 2020 Epi week 33)

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



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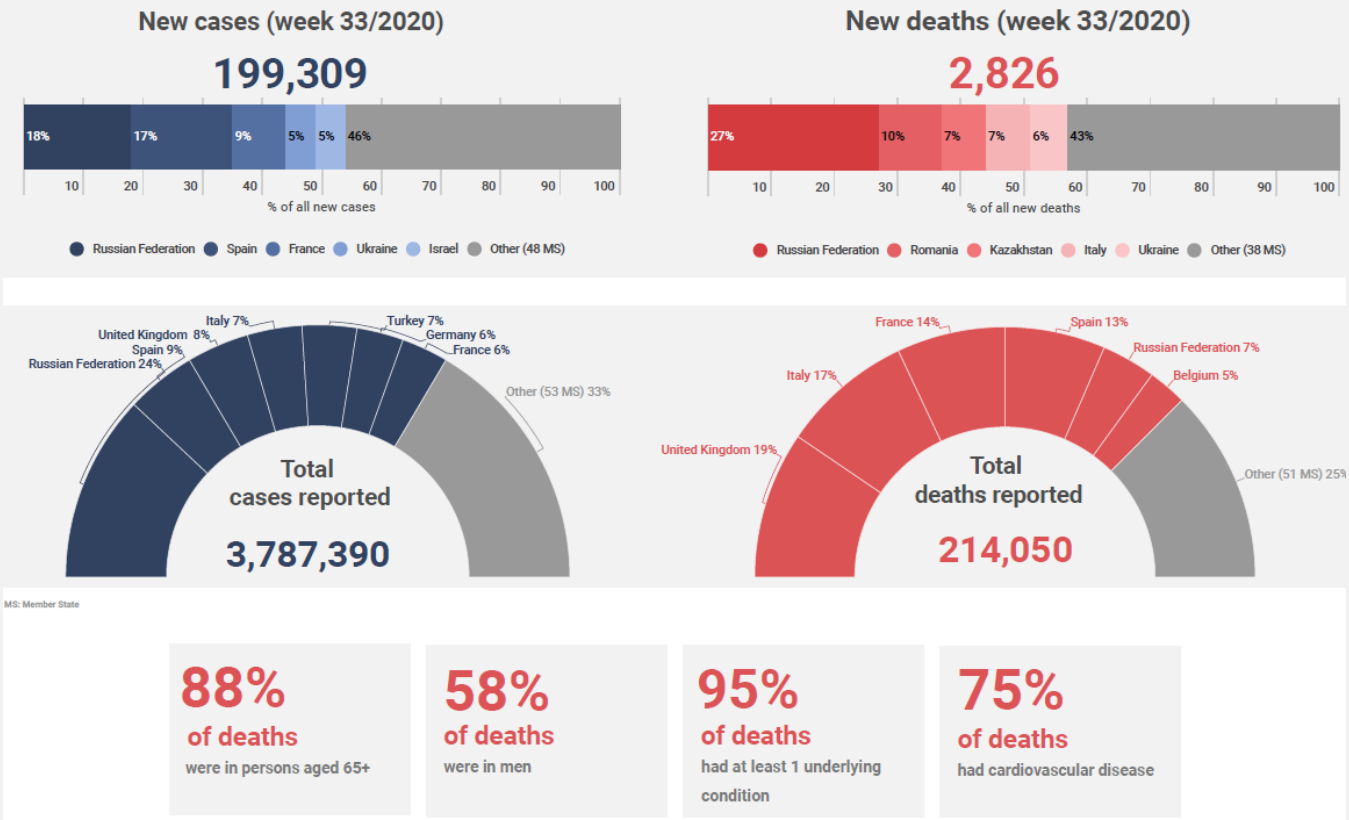
## Key points

### Week 33/2020 (10 - 16 Aug 2020)

- The number of cases reported in the Region in week 33/2020 increased 9% compared to the previous week, and increased 63% compared with week 23/2020 when the lowest number of cases / week were reported. The number of deaths in the Region in week 33/2020 remained stable compared to the previous week (Figure 1)
- 54% (107,629) of the cases reported in week 33/2020 were reported from five countries: the Russian Federation (18%; 35,317), Spain (17%; 34,421), France (9%; 17,600), Ukraine (5%, 10,407) and Israel (5%, 9,884). The remaining cases (46%; 91,680) were reported by 51 countries and territories; each accounted for <5% of the total cases reported in week 33/2020
- Five countries had a crude incidence of ≥60 per 100,000 in week 33/2020: Israel, Spain, Malta, Montenegro and Republic of Moldova. The crude incidence continues to vary across the region with a range from 1.4 per 100,000 population in Latvia to 116 per 100,000 population in Israel (Figure 2A)
- The 14-day cumulative incidence increased by ≥10% in week 33/2020 in 36 countries and territories in the Region, however for some countries data was retro-adjusted by national authorities: Albania, Andorra, Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lichtenstein, Lithuania, Malta, Monaco, Netherlands, Norway, Poland, Republic of Moldova, Romania, Slovakia, Spain, Sweden, Switzerland, Turkey, Ukraine, the United Kingdom and Uzbekistan (see EURO COVID-19 Dashboard for recent trends)
- 57% (1,611) of the deaths reported in week 33/2020 were reported by the Russian Federation (27%; 754), Romania (10%, 295), Kazakhstan (7%; 200), Italy (7%, 189) and Ukraine (6%, 173). The remaining deaths (43%; 1,215) were reported from 38 countries and territories; each accounted for <5% of the total deaths reported in week 33/2020
- The proportion of reported cases that died was 1.4% in week 33/2020
- 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 5.6% to 3,787,390 cases in week 33/2020 (from 3,588,081 cases in week 32/2020) and cumulative deaths increased by 1.3% to 214,050 deaths (from 211,224 deaths in week 32/2020). Note the decrease in the total number of deaths due to retrospectiv reclasification of the COVID-19 deaths in two countries.
- 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)
- Nine countries in the Region each reported a cumulative incidence of ≥700 cases per 100,000 population: Andorra, Armenia, Belarus, Israel, Luxembourg, Republic of Moldova, San Marino, Spain and Sweden (Figure 2B)
- As of week 33/2020, 67% (2,536,162) of cumulative cases were reported from the Russian Federation (24%; 922,853), Spain (9%, 355,336), the United Kingdom (8%; 317,444), Italy (7%; 253,438), Turkey (7%; 249,117), Germany (6%; 223,453) and France (6%; 215,521). The remaining cases (33%; 1,251,228) were reported by 53 countries and territories; each accounted for <5% of the total cases reported until week 33/2020
- As of week 33/2020, 75% of cumulative deaths (161,437) were reported from the United Kingdom (19%; 41,361), Italy (17%; 35,392), France (14%; 30,409), Spain (13%; 28,647), the Russian Federation (7%; 15,685) and Belgium (5%; 9943). The remaining deaths (25%; 52,613) were reported by 50 countries and territories; each accounted for <5% of the total cases reported until week 33/2020
- 88% of all deaths with information available were in persons aged ≥65 years and 58% of all deaths were in men (Table 1)
- 95% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (75%) (Table 1)
- 13.5% of cases were in persons aged ≥65 years in week 33/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥65 years was 67% in week 33/2020 (compared to 91% in week 14/2020) (Figure 3)
- Pooled estimates of all-cause mortality for 24 countries in the EuroMOMO network show normal levels in week 33/2020. In some countries in Southern Europe, a small excess mortality might be related to local heat waves
- In week 33/2020, five countries reported 107 tests and no SARS-CoV-2 detections in persons with influenza-like illness (ILI) in primary care sentinel surveillance. The updated positivity percentage in this surveillance system in week 32/2020 was 2.1% (6 countries) and 2.2% (7 countries) in week 31/2020. The highest positivity in the ILI sentinel surveillance was 14.6%, seen in week 15/2020 (Figure 4)
- Overall, there were 43,868 (3.3%) COVID-19 cases among the total of 1,281,146 tests performed in 20 countries for week 33/2020 (Figure 5).

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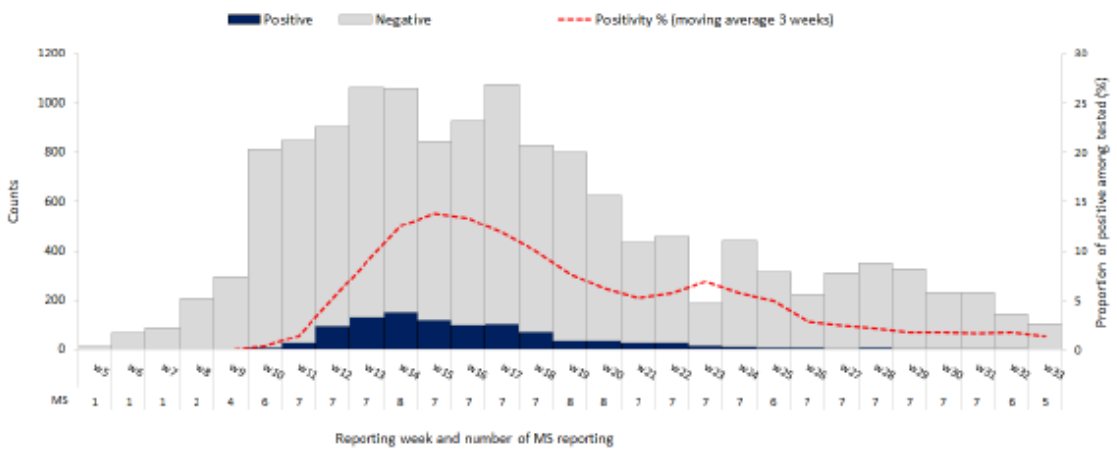
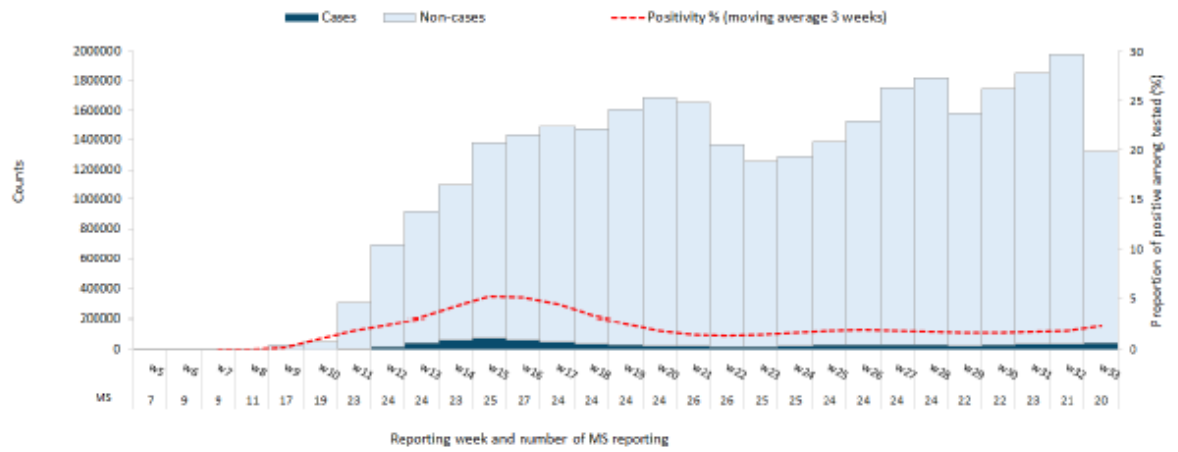
## Figure 4. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



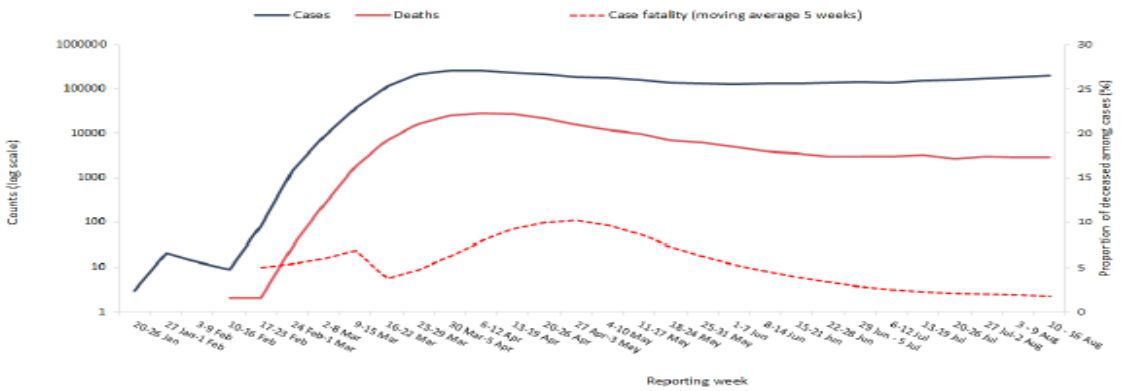

Source: Aggregate data from WHO XMart and TESSy. MS: Member State

## 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

## Figure 1: Number of COVID-19 cases (N=3,787,390) and deaths (N=214,050) by reporting week



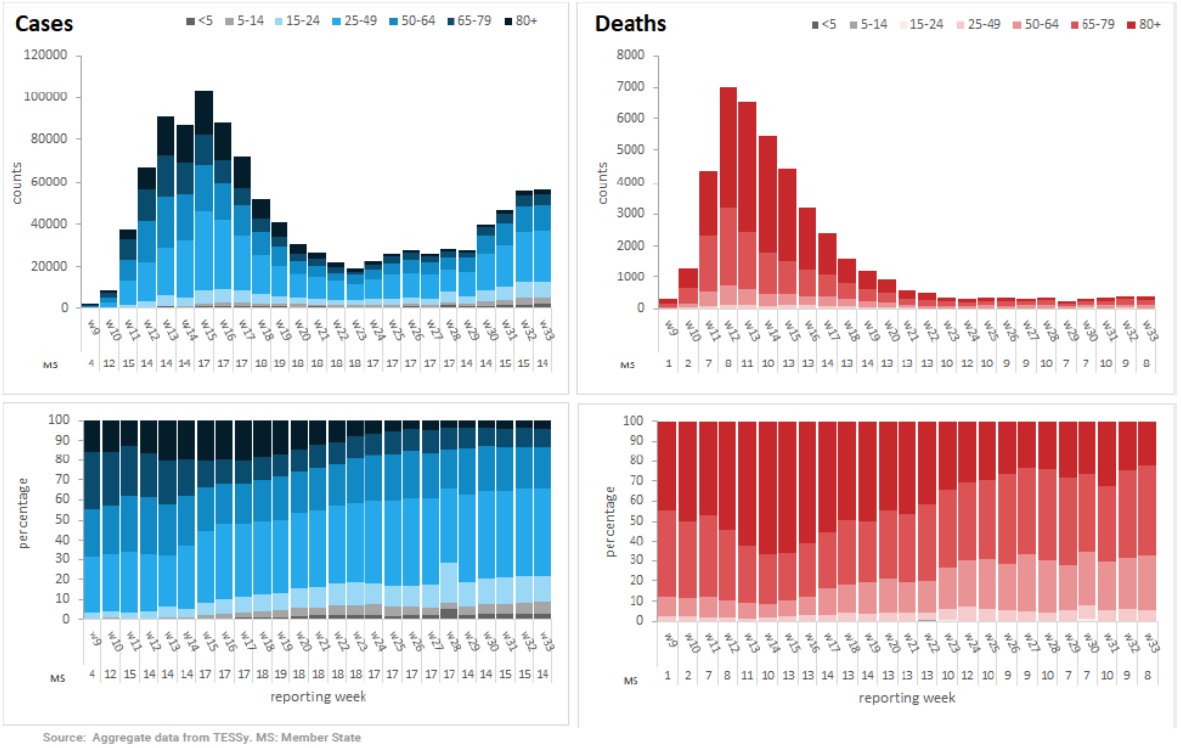

Source: IHR reports

## Table 1. Characteristics of COVID-19 deaths

| | Characteristics | n | % | Total records with data available |
|---|---|---|---|---|
| Deaths | Age in years, median (range) | 81 (0-108) | | 97,170 |
| | Sex, male | 55,986 | 58 | 97,039 |
| | At least one underlying condition | 41,037 | 95 | 43,246 |
| | • cardiovascular disease | 7,750 | 75 | 10,266 |
| | • diabetes | 1,967 | 40 | 4,921 |
| | • lung disease | 1,729 | 28 | 6,274 |
| | • neurological disease / dementia | 2,096 | 25 | 8,465 |
| | • renal disease | 849 | 24 | 3,568 |
| | • obesity | 446 | 11 | 4,182 |
| | • liver disease | 436 | 6 | 7,706 |
| | • immune disease | 70 | 2 | 4,189 |
| | • other | 1,085 | 22 | 5,030 |

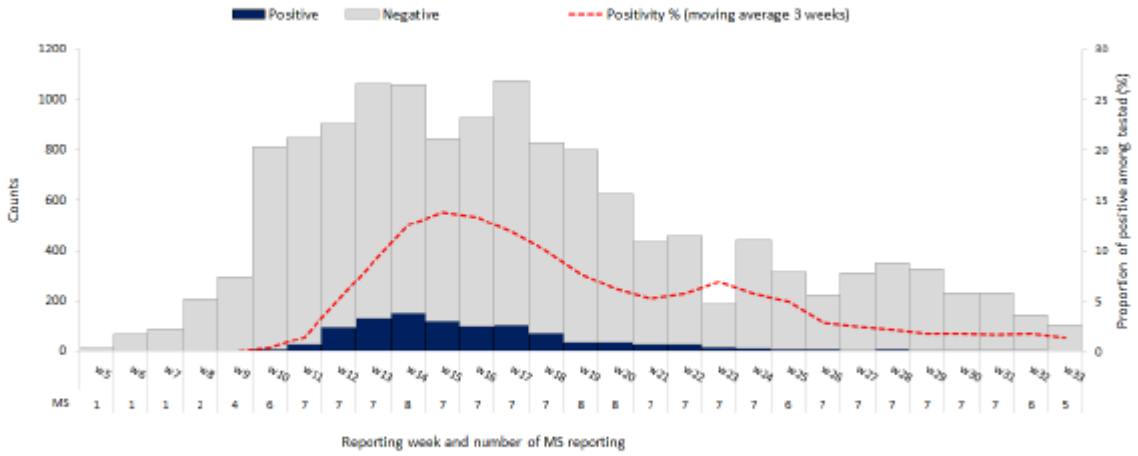
Source: Mortality database (n=97,181)

## Figure 3. COVID-19 cases (N=1,108,064) and deaths (N=43,601) by age group and reporting week



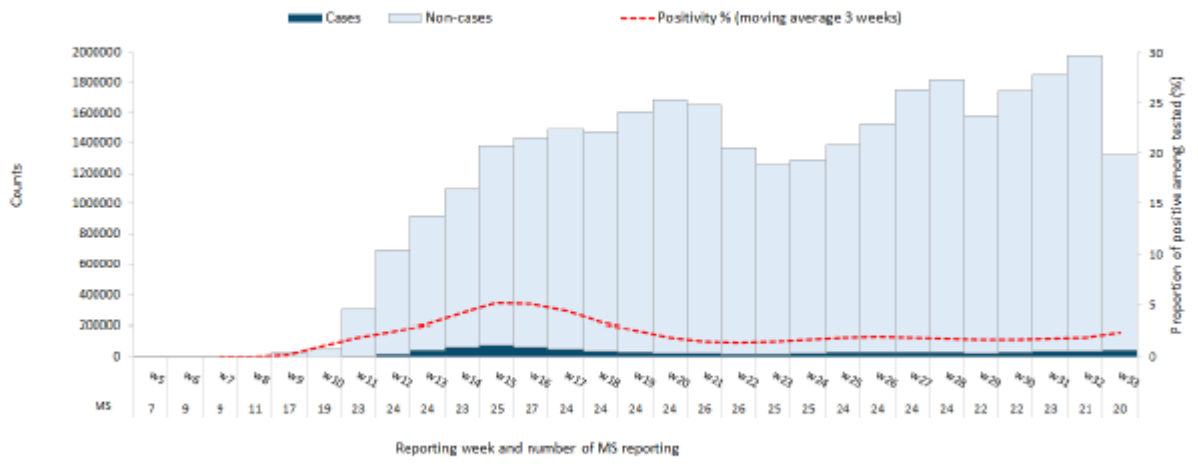

Source: Aggregate data from TESSy. MS: Member State

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

**The EU** has concluded preliminary talks with pharmaceutical companies about the purchase of a possible vaccine to protect against COVID-19. More than 1.5 billion doses of different vaccines have been ordered from various pharmaceutical manufacturers. As the responsible EU Commission announced on Monday, the specific aim is to take 80 million doses from the US biotechnology company Moderna in the event of a successful vaccine development. A pre-emption is planned for a further 80 million doses. The Commission had previously concluded similar talks with a joint venture from Sanofi (pre-emption for 300 million doses) and GSK as well as with Johnson & Johnson (purchase of 200 million doses) and CureVac (pre-emption for 225 million doses plus 180 extra). A purchase agreement has already been signed with AstraZeneca (300 million doses plus 100 extra).

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**Population-wide testing of SARS-CoV-2: country experiences and potential approaches in the EU/EEA and the United Kingdom;** Technical report by ECDC as of 19 August 2020

The document summarizes country experiences and perspectives relating to testing and application of different population-wide testing approaches and discusses the options in the context of the EU/EEA and the UK.

**Executive summary**

- Different population-wide testing approaches have already been used in various countries, including household testing, individual testing and the testing of incoming travellers, irrespective of whether or not they are displaying symptoms.
- Factors that need to be considered prior to implementation of any population-wide testing strategy which is to include all individuals are the epidemiological situation, costs, logistics, technical feasibility, resource availability, contract tracing capabilities, barriers to testing, potential false positivity and timely notification.
- Population-wide testing strategies can complement other public health measures and are more effective when paired with case isolation and contact tracing.


**Source: ECDC**

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**ESP:** Because of rising corona numbers, several regions in Spain have ordered new measures to combat the virus pandemic. In Catalonia, with the tourist metropolis of Barcelona, private meetings of more than ten people are prohibited. In the Murcia region in the south-east of the country, all meetings of more than six people who do not live in the same household have been banned. And in the hardest-hit capital, Madrid, authorities urged people to avoid all unnecessary social contacts.

In the Balearic Islands the local government admitted that there was a second corona wave. The virus is spreading again so quickly that it is difficult to trace contacts

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**DEU:** The Ministry of the Interior of Bavaria is currently working with the Ministry of Health on a new catalog of fines in the context of violations of corona regulations, it should be made known later this week. In the future, police officers will also be able to issue warnings directly, previously the health and regulatory authorities were responsible for this.
There will be higher fines for mask refusers. The catalog of fines will be increased to 250 euros for one-time violations and up to 500 euros for repeated violations. For violations of quarantine requirements, 2000 euros are due.

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**FRA:** The number of corona infections in France continues to rise significantly: the country's health authorities reported a total of 4897 new infections within 24 hours on Sunday. This was the highest number since the lockdown ended in May.

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**AUT**: Due to stricter corona border controls in Austria, travelers are stuck in Slovenia for more than 12 hours. In front of the Karawanken tunnel, according to the Slovenian media, there was a traffic jam of up to twelve kilometers in length on Sunday night. Many vacationers on their return journey from Croatia were also affected.

## Subject in Focus

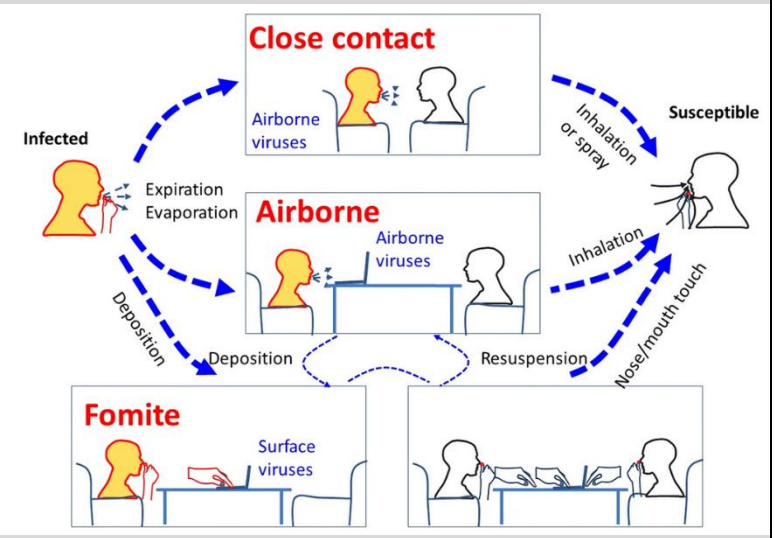
Droplet and aerosol transmission in the context of COVID-19

The practice of social distancing and wearing masks has been popular worldwide in combating the contraction of COVID-19. Undeniably, although such practices help control the COVID-19 pandemic to a greater extent, the complete control of virus-laden droplet and aerosol transmission by such practices is poorly understood.

### What is an aerosol?

Aerosols are mixtures of solid or liquid particles ("suspended particles") in a gas or mix of gases, such as air. Environmental aerosol particles may differ enormously in size, having diameters ranging from about 1 nanometer (nm) up to several 100 micrometres (µm). Larger particles usually sink to the ground quickly. Particles of less than 10 µm in diameter can remain suspended in the air for hours or even days.

Aerosols are generally unstable and usually change over time depending on humidity, temperature and other physical and chemical processes. Aerosols can also contain bacteria and viruses.




In medical research, a distinction is often made between "droplet infection" and infection "via aerosols". In this context, the larger liquid aerosol particles between 5 µm and about 500 µm (the bigger ones being barely visible) are often referred to as "droplets", while those smaller than 5 µm are described as "aerosols". In physical terms, however, both are aerosols. With respect of their properties, there is no clear boundary between droplets and other aerosol particles, their transition being smooth.

### How are SARS-CoV-2 containing aerosols formed?

When exhaling, every individual spreads a bulk of gases and also aerosol particles into his or her immediate environment. Speaking, shouting or singing, but especially coughing, sneezing or physical exertion give rise to the emission of larger numbers of particles. When pathogens such as SARS-CoV-2 viruses are present in the airways, aerosols emitted may contain these pathogens. In the case of SARS-CoV-2, the formation of such aerosols is particularly problematic because even infected individuals without symptoms can emit virus-containing particles.

The spectrum of exhaled particles differs depending on whether the individual is breathing normally, singing, coughing or sneezing. Normal breathing mainly produces small particles (less than 5 µm). When speaking and singing, greater numbers of such particles are exhaled in comparison to breathing, while coughing and sneezing also generate larger particles of up to 100 µm or more in diameter. Moisture-laden speaking produces even larger saliva drops that may be visible to the naked eye.

Coronaviruses have a diameter of 0.12-0.16 µm but are usually emitted as part of larger particles which remain airborne for different lengths of time, depending on their size, and can be transported over varying distances with the air flow.

Exhaled aerosol particles change in size and composition according to the environmental conditions. Particles usually shrink during the transition from the respiratory tract into the ambient air due to the evaporation of their water content. The exact processes that lead to the formation and modification of such aerosol particles depend on a variety of different factors and are difficult to predict in individual cases.

**When can individuals catch COVID-19 via aerosols?**

COVID-19 can be transmitted via aerosol particles under the following conditions:

- The amount of infectious SARS-CoV-2 in the aerosol is large enough to convey a critical dose to the receiving susceptible person. The exact amount of viruses necessary for infection is not yet known and probably depends on several individual factors.
- The virus-containing aerosol must come into contact with sensitive cells such as respiratory tract cells, or the connective membranes of the eyes of an uninfected person.
- The virus must be able to replicate in these cells.

As far as exposure to virus-containing particles is concerned, there are two opposing effects:

Larger particles can contain more viruses in absolute terms and may thus be more infectious. At the same time, larger droplets will sink to the ground more rapidly and are thus available for airborne infection for a shorter period. Reducing the risk of infection by such larger particles was a rationale to recommend the minimum social distance of 1.5 metres.

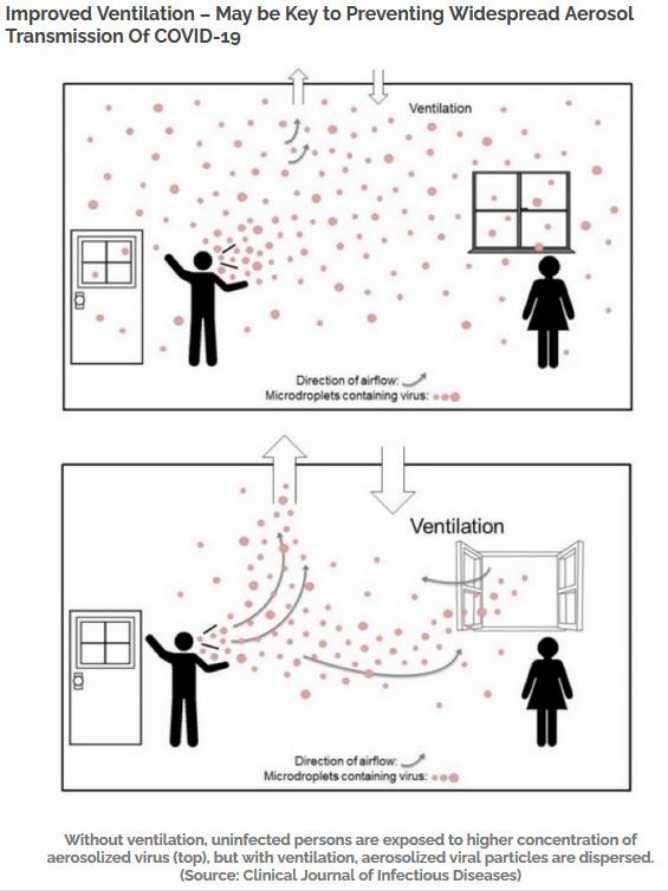
Smaller aerosol particles tend to contain fewer viruses but can remain airborne for longer. This means that they pose a risk of infection over distances greater than 1-2 metres and for longer periods. A report of infections during a choir rehearsal lasting several hours, in which social distance rules were being observed, suggests that the increased infections observed in that context were caused by the transmission of smaller particles which remained suspended for longer in the ambient air.

**How can the risk of infection via aerosol particles be reduced?**

On the one hand, measures can be taken to reduce the exhalation of aerosol particles. These include hygienic sneezing practices (sneezing into the crook of the arm or a tissue) and wearing a mask that covers the nose and mouth. Wearing such a face cover significantly reduces the amount of aerosol particles released. The protective effect increases with the size of the particles involved. Smaller particles are less likely to be retained by a face cover than larger ones.

On the other hand, the now-familiar social distancing measures can be adopted to prevent exhaled aerosol particles from passing undiluted from one person to another. However, in situations where smaller particles may accumulate in the air, this measure may be not sufficient.

Indoors, due to limited air volume, the probability of accumulation of infectious particles is generally higher than outdoors. It follows that there is an increased risk of infection when two or more people gather in indoor spaces. Many factors play a role in the probability of infection in indoor spaces, and these can vary greatly from case to case: the number of persons present, their type of activity, the volume of the indoor space, the rate of air exchange, the kind of air flow, the type of ventilation available (window ventilation, ventilation technology) and any filters that may be in use.




Small rooms such as toilets, shared kitchens, changing rooms and lifts or small offices are problematic when used simultaneously by several people. Plans for the shared use of such spaces, must be drawn up to ensure that users can either be kept physically separate or use the spaces during different time slabs. In meeting rooms, care must be taken to ensure that they are

not used by too many people at the same time and that the number of persons allowed in the space or the length of their stay takes into account the characteristics of the space (e.g. room size, air exchange). Furthermore, adapted ventilation concepts can contribute to the reduction of particle concentrations (see question below).

During indoor gatherings, any activities should be avoided that increase the exhalation of aerosol particles and, subsequently, the concentration of potentially infectious particles in the corresponding indoor spaces. Such actions include occasional sneezes and coughs (not necessarily associated with an infectious disease); anyone who coughs or sneezes should do so into the crook of the arm. Singing, shouting and screaming also lead to an increase in particles which accumulate in indoor spaces. Aerosol particles can also be produced while playing wind instruments. It should be borne in mind that sports activities associated with an elevated respiratory rate also lead to an increased exhalation of aerosol particles. If activities releasing increased aerosol concentrations cannot be avoided, the recommendation is to ventilate more intensively (see below) or, where possible, to hold such activities outside.

Models to mathematically simulate the dispersion of virus-containing particles and infection are currently under development to predict the infection probability from indoor aerosol particles; these models take into account various factors regarding the number of people in the group, their activities (speaking, singing, etc.), their duration of stay, the room characteristics (room volume) and ventilation (ventilation rate). Such models, which are currently still being tested by UBA for their practical suitability, may provide assistance in the future when it becomes necessary to estimate the maximum duration of meetings in an indoor space for the case an infected person is in the room. Since many other factors, such as correct compliance with social distancing and hygiene measures, the dose of infection and individual sensitivities, can influence the likelihood of infection, it is not yet clear whether a reliable assessment of the risk of infection based on such models will be possible in the near future.

**Which indoor hygiene measures can minimise the concentration of infectious aerosol particles?**

Effective ventilation (exchange of indoor air with outdoor air) can reduce the concentration of infectious particles in the indoor air.

In the case of window ventilation, cross-ventilation which quickly exchanges indoor air with fresh ambient air by means of a draught is optimal but, unfortunately, not always practical. Brief but intense ventilation for a few minutes with a wide-open window (ideally several open windows at a time) is considered most effective. Keeping windows partially open, even permanently, is not effective.

For effective infection protection, rooms where many people gather should be ventilated as well and as often as possible. Classrooms in schools should be ventilated frequently to reduce increased concentrations of carbon dioxide during lessons [10]. In the case of new buildings and complex renovations, the best long-term solution is to ensure that a mechanical ventilation system is implemented for densely-populated rooms from the outset. For schools, this is regarded as the desirable regulatory standard for the future. Mechanical ventilation may also become increasingly necessary for residential buildings as building envelopes become increasingly airtight.

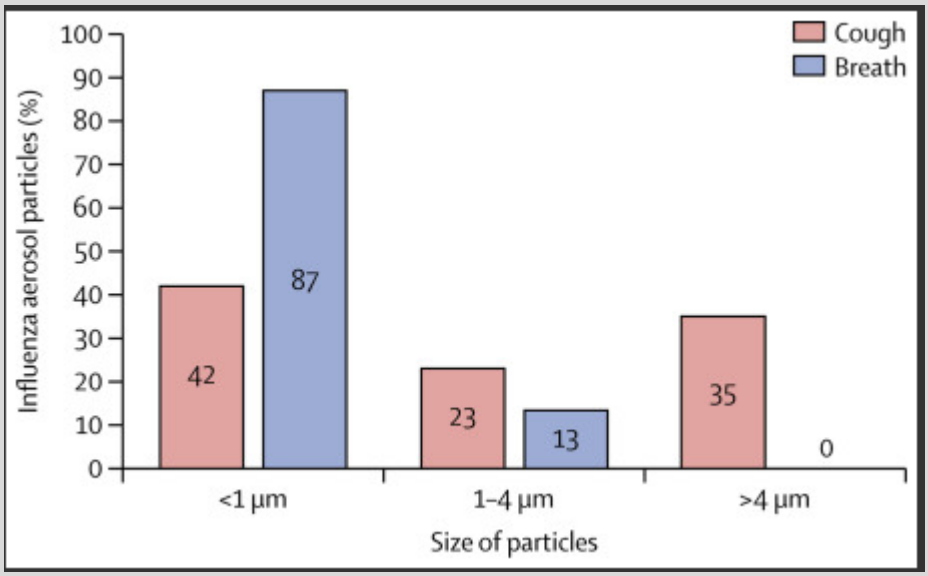
It is worth to note that efficient ventilation alone cannot in general prevent the transmission of SARS-CoV-2 viruses from an infected person to another. This would require very high air exchange rates that cannot be implemented in practice. In indoor spaces used by two or more people, additional measures such as the wearing of face coverings, maintaining social distancing and an adapted usage plan remain essential.

***Scientific studies***

The case studies that have come out in different countries have, with prima facie evidence, manifested that the airborne transmission plays a profound role in contracting susceptible hosts. Studies of cough aerosols and of exhaled breath from patients with various respiratory infections have shown striking similarities in aerosol size distributions, with a predominance of pathogens in small particles (<5 µm). These are immediately respirable, suggesting the need for personal respiratory protection (respirators) for individuals in close proximity to patients with potentially

virulent pathogens. There is no evidence that some pathogens are carried only in large droplets. Surgical masks might offer some respiratory protection from inhalation of infectious aerosols, but not as much as respirators. However, surgical masks worn by patients reduce exposures to infectious aerosols to health-care workers and other individuals. The variability of infectious aerosol production, with some so-called super-emitters producing much higher amounts of infectious aerosol than most, might help to explain the epidemiology of super-spreading. Airborne infection control measures are indicated for potentially lethal respiratory pathogens such as severe acute respiratory syndrome coronavirus 2.

Current infection control policies are based on the premise that most respiratory infections are transmitted by large respiratory droplets—ie, larger than 5 μm—produced by coughing and sneezing, then deposited onto exposed fomite or mucosal surfaces. Airborne transmission has often been attributed to infectious droplet nuclei produced by the desiccation of suspended droplets and defined as 5 μm or smaller in size. This has been thought to occur only for tuberculosis and a few other pathogens. Thus, surgical masks have been recommended for use against most respiratory infections.




**Proportions of influenza aerosol particles sizes in cough and exhaled breath sample collections**

### Infectious aerosols of SARS CoV-2

Since the outbreak of COVID-19, there has been a question over airborne transmission of SARS-CoV-2. Similar to that seen with SARS-CoV, there was only a mild reduction in viability over a 3-h period in an experimental aerosol generated in a laboratory, consistent with a potential for airborne spread.

To date, there are no published reports of cough aerosol or exhaled breath sampling from patients with COVID-19, but SARS-CoV-2 has been detected in the air of hospitals in China and the USA. The virus was detected in both surface and air samples in another hospital in Wuhan, China, with positive PCR tests on 14 (35%) of 40 air samples from the intensive care unit and two (12·5%) of 16 air samples from the general ward.

It appears that SARS-CoV-2 has the potential to be spread by all modes of transmission: direct contact (ie, person-to-person) and indirect contact (eg, via contaminated objects and aerosol).

It is not yet clear which mode occurs most frequently. Air sampling for SARS-CoV-2 was negative in three studies, but two included small numbers of patients in rooms with high rates of dilution ventilation, and one study included a small number of air samples using inefficient impinger devices (see Lancet article for more information).

The outbreaks of COVID-19 in nursing homes, choirs, and correctional facilities are reminiscent of tuberculosis outbreaks and suggestive of both traditional airborne transmission and so-called super-spreading epidemiology.

Experiments using the golden hamster model have shown 100% efficient aerosol transmission among animals caged separately as well as by direct contact.

### Masks versus respirators

Modelling studies and simulated workplace protection studies in the USA have shown benefits of various types of respirators and little to no protection from surgical masks. A study in the UK found that surgical masks could reduce inert aerosol exposure by two times, but filtering facepiece respirators reduced the exposure by a factor of 100 or higher.

In a study of influenza aerosols, surgical masks reduced exposure by an average of six times, but there was a wide range of reduction from 1·1 to 55 times, depending on the design of the mask. Two randomised trials did not show any benefit of N95 respirators over surgical masks in reducing respiratory illnesses, and two showed that the respirators were protective. However, none of the trials used quantitative fit testing, and two had surprisingly low failure rates (1·1–2·6%) compared with 60% found in a panel study for the same N95 respirators. The low failure rates suggest a problem with fit testing.

Filtering facepiece respirators are only as effective as their fit, as the weak point of these respirators is the face-mask leak. Unfortunately, there has been little operational research on the process of fit-testing respirators for health-care workers. There is wide variability among filtering facepiece respirators, and “it may be of more benefit…to wear a respirator model with good-fitting characteristics without fit testing than to wear a respirator model with poor-fitting characteristics after passing a fit-test.”

Similarly, there are some surgical masks that offer good protection, but as they are not certified or regulated as devices for respiratory protection, it is difficult to know which is the best to use. There is a pressing need for research in this area. Face shields can decrease inhalation exposures to wearers and surface contamination of filtering facepiece respirators by aerosol particles of a median diameter of 8·5 μm by 96% and 97%, respectively, but they only reduce inhalation exposures to smaller particle aerosols of 3·4 μm by 23%.

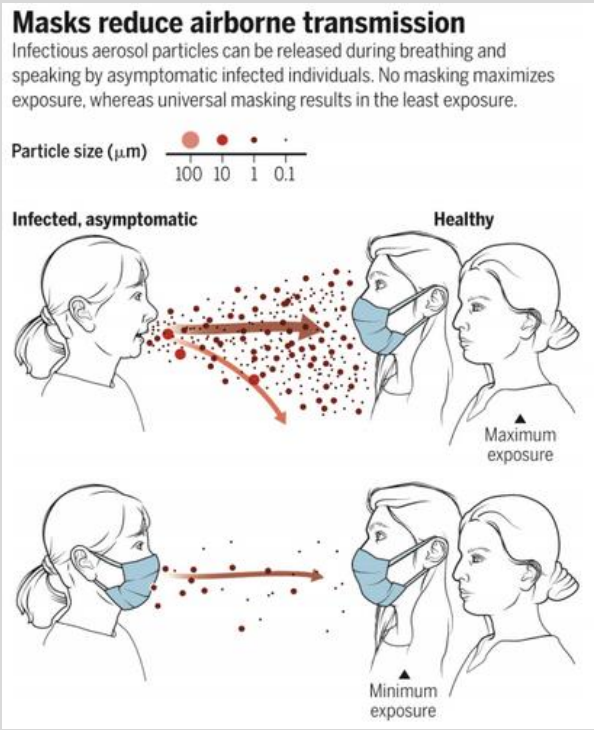
### Masks to prevent transmission from the wearer

Although surgical masks offer little protection from inhaled agents, they have a role in protecting health-care workers when worn by patients. Placing surgical masks on patients with multidrug-resistant tuberculosis decreased transmission to guinea pigs by 56%, and masking of patients with cystic fibrosis reduced P aeruginosa air contamination by 8%. Surgical masks reduced the quantity of influenza viral RNA by 2·8 times in small particles and by 25 times in large ones.

More recently, surgical masks effectively reduced large droplets (>5 μm) of seasonal coronaviruses from three of ten patients to 0 of 11 and small aerosols (<5 μm) from four of ten patients to 0 of 11.

Similarly, surgical masks reduced droplets of influenza from six of 23 to one of 27. However, the reduction in influenza small aerosols (<5 μm) was not significant. There is mounting evidence suggesting that the wearing of masks can reduce transmission of SARS-CoV-2 in community and health-care settings.

A major limitation to much of the data on infectious aerosols of viruses is the reliance on PCR findings; few studies have evaluated viability using cell cultures or other methods. Viability itself can be difficult to assess. Aerosolisation from the respiratory tract produces multiple stresses on microbes that can decrease their viability, usually defined by the ability to be cultured. Indoors, desiccation predominates, but temperature, radiation, oxygen, ozone and its reaction products, and other exposures can also damage viral lipids, proteins, and nucleic acids.



| | |
|---|---|
| | Aerosol sampling itself can produce additional stresses, including mechanical trauma, additional desiccation, and injury in post-sampling processes and extraction. PCR assays are usually easier to do logistically than using cell cultures for viral sampling. For example, our group was able to directly sample influenza virus onto monolayers of cell cultures in the laboratory, but this proved impractical for transport to and from clinical sites because of the sensitivity of the cells to spillage and pH stresses. These multiple factors, as well as inherent physical inefficiencies of air samplers, suggest that most infectious aerosol data are probably underestimates of the exposures to health-care workers.<br>Obviously, infectious individuals breathe continuously 24 h per day, but there are no data on possible circadian rhythms or variability in output. By contrast, coughing can be very paroxysmal and sporadic. Although 24-h cough frequency can be measured, it has not been linked to aerosol production. There is only one study of the association between cough aerosol production by tuberculosis index cases and new infections in exposed contacts; however, no studies have documented transmission of any respiratory infections exclusively via large respiratory droplets or fomites. Although the data reviewed here indicate that there are small proportions of patients who are highly infectious and probably super-spreaders, until a diagnostic test or other method is available to identify them, we must consider all patients with respiratory pathogens as potentially infectious.<br><br>Sources:<br>https://www.umweltbundesamt.de/en/infectious-aerosols-in-indoor-spaces#which-indoor-hygiene-measures-can-minimise-the-concentration-of-infectious-aerosol-particles<br>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7293495/<br>https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30323-4/fulltext |

## Conflict and Health

COVID 19 Crisis in Mexico

Mexico

| | |
|---|---|
| Area: | 1.972.550 km$^2$ |
| Population: | 128.649.565 |
| Capital: | Mexico City |
| Age structure: | |
| 0-14 years: | 26.61% |
| 15-24 years: | 17.35% |
| 25-54 years: | 40.91% |
| 55-64 years: | 7.87% |
| 65 years - : | 7.26% |
| COVID 19 crisis, as of today, | |
| all cases : | 560.164 |
| all deaths: | 60.480 |

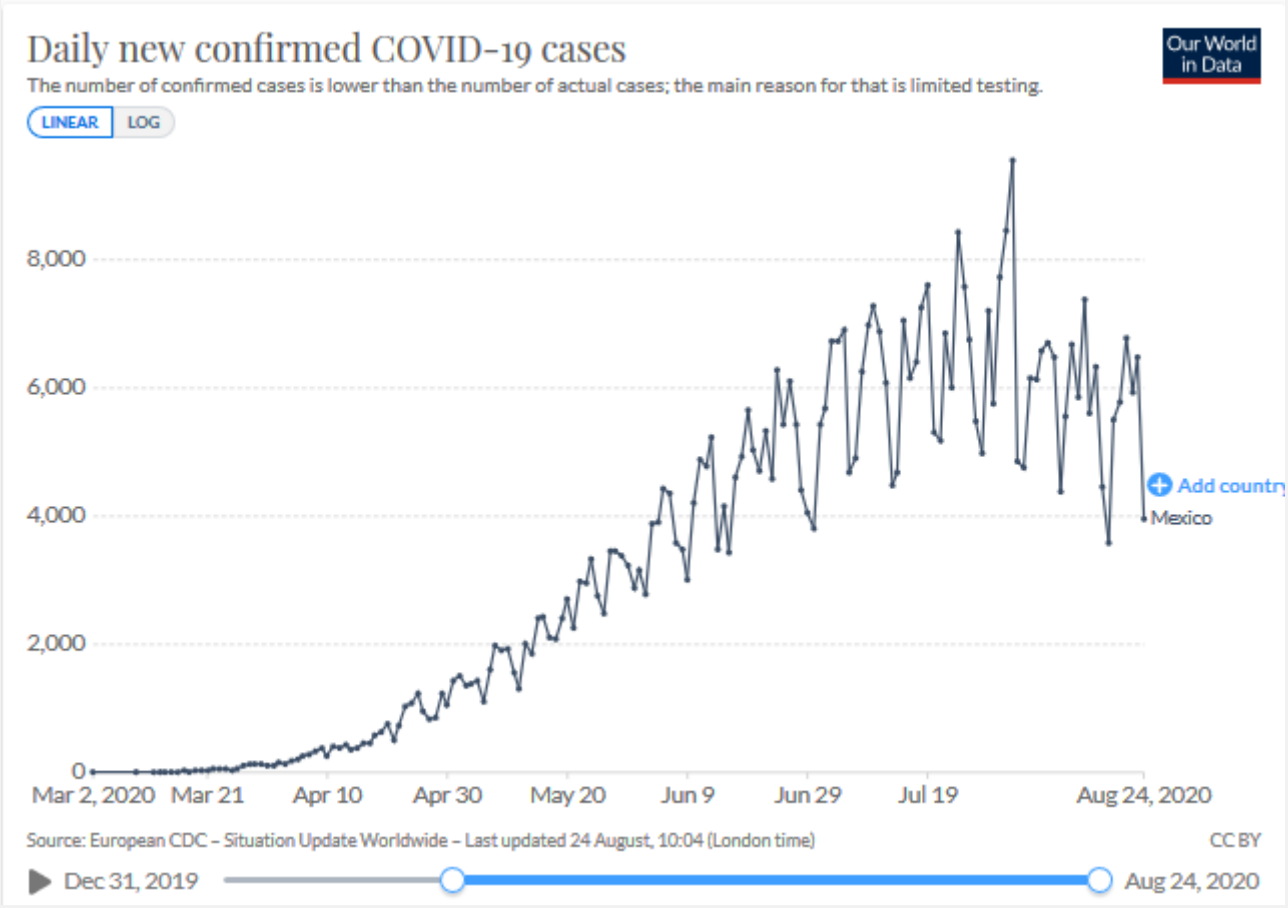
Source: Wikipedia; Indexmundi.org

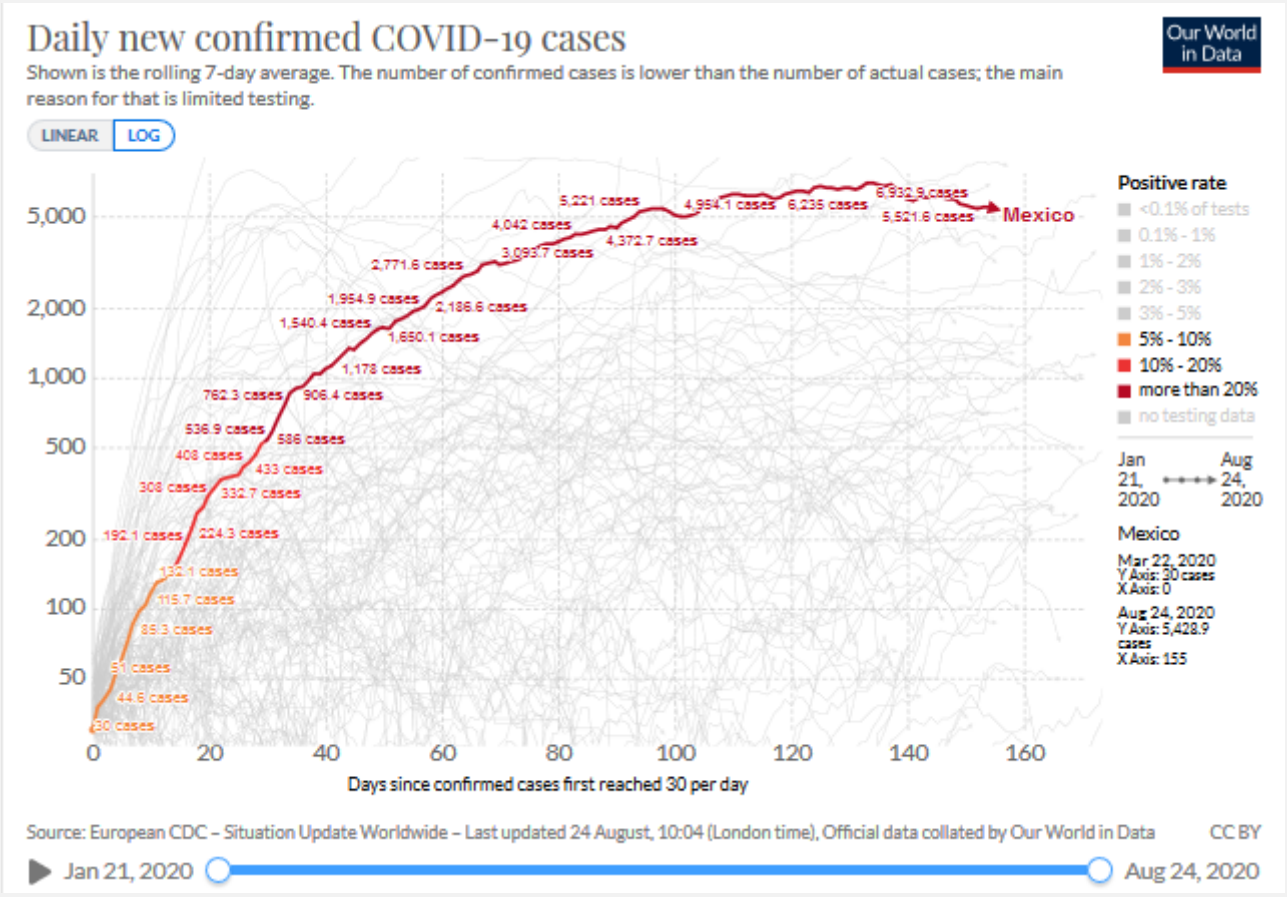
### The background

In January the Secretariat of Health issued a statement saying that the novel coronavirus COVID-19 did not present a danger to Mexico. But, before the declaration of a pandemic by the World Health Organization the Government of Mexico designed a Preparation and Response Plan that was made by the National Committee for Health Safety, a working group led by Secretariat of Health aiming to act upon the imminent arrival of the pandemic. This group carried out a series of alert measures, rehabilitation and updating of epidemiological regulations based on the International Health Regulations, being the first country in Latin America, that deployed a mathematical modelling of infectious disease. At the end of February, Mexico confirmed its first three cases, all of them travelled back from Italy. Over time, the number of new infections and deaths has steadily increased. On May 1, Mexico surpassed 20,000 infections of COVID-19. On the next day, Mexico surpassed 2,000 deaths due to the COVID-19 pandemic. By that time more than 100 health workers (doctors, nurses etc.) were among the dead from the virus.

An article published on The New York Times on May 8 assured that both the federal government and the state government of Mexico City ignored the wave of coronavirus deaths in the capital city. The article criticized the way that President Andrés Manuel López Obrador has been handling the pandemic citing the lack of testing done and the fact that the government has been hiding the real number of COVID-19 cases and deaths. It was also mentioned that despite the fact that the Undersecretary has been saying that "Mexico has flattened the curve" and that only 5% of those infected will show symptoms, and only 5% of those patients with symptoms will go to the hospital, experts say that "their model is wrong".

The graph below shows that the average number of new cases per day in Mexico is about 5000 since the end of June with a peak of 9556 cases. These data prove that the curve hasn't been flattening at all in the past two months. And even number of testing is decreasing over time as seen on the graph. The situation has been the worst in Mexico City (capital) and Mexico state. As of today, 560.164 cases and 60.480 deaths were reported in Mexico.

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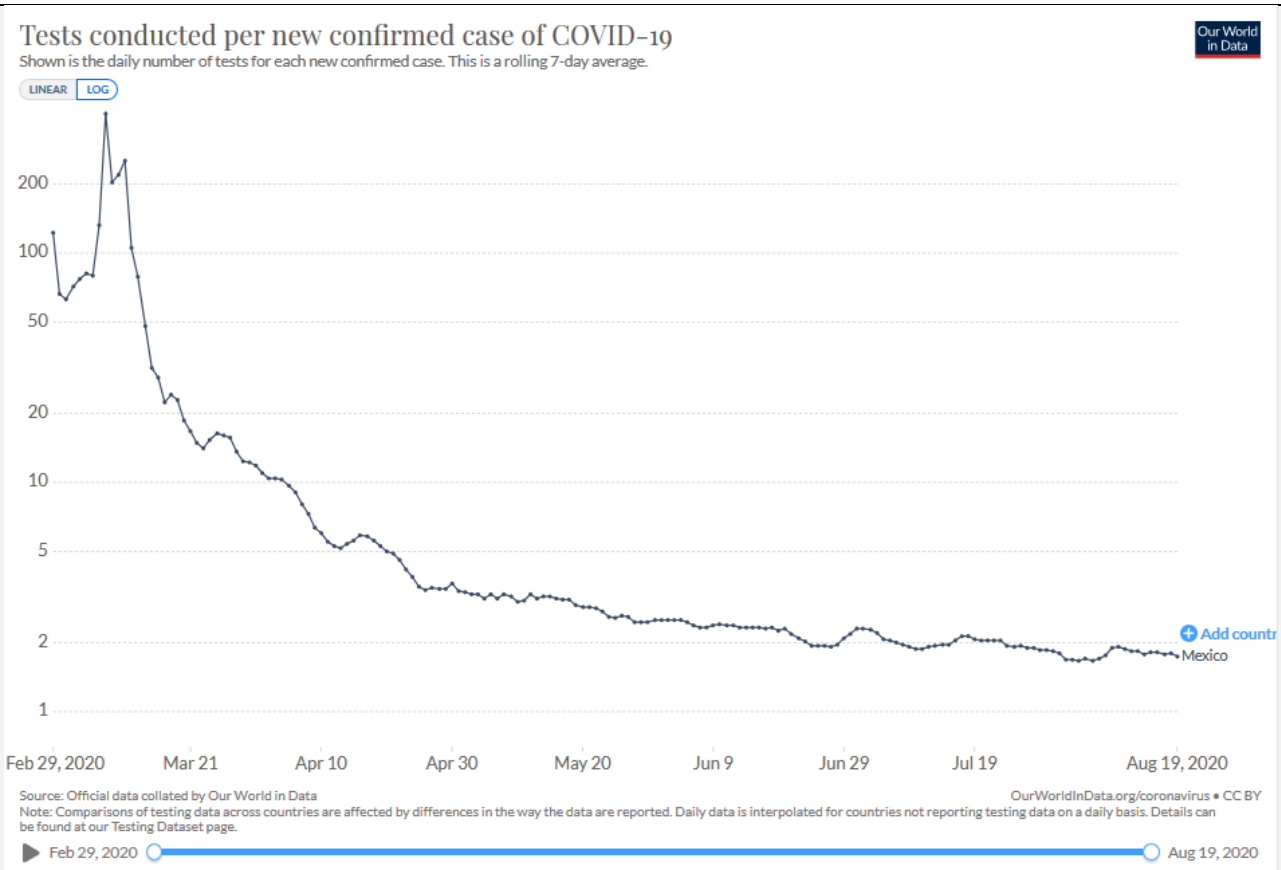



*Source: Our world in data*

### How politicians react?

Andres Manuel Lopez Obrador, the president of Mexico, has defended his government's record fighting the coronavirus and ruled out a change in strategy after the official death toll surged past 50.000. The Latin American nation of 128 million recently overtook the United Kingdom to become the third hardest-hit country in terms of total virus deaths, after Brazil and the United States. But Lopez Obrador said in terms of deaths relative to population size, "we have not been so hard hit", and on that basis, Mexico ranks fifth in the Americas, behind the US, Brazil, Chile and Peru. "And if we compare ourselves with Europe, there are more deaths in Spain, France and England than in Mexico," he said.

### Health workers face violent attacks in Mexico

**While in many countries doctors and nurses are being praised for their work on the coronavirus front line, in Mexico dozens have been attacked. Some people are behaving psychotically in response to this virus. As of 28 April, there have been at least 47 attacks against health workers, particularly nurses, in the country. The authorities recognise the true figure may be higher - reports on social media of discrimination range from nurses stopped from getting on buses to doctors assaulted by relatives of Covid-19 patients.**

Mexican nurse says that in 40 years of work, she has never witnessed such a poisonous reaction to health workers. She was attacked after leaving work in her hometown of Merida, Yucatan. Someone droves past her and threw hot coffee down her back. "Infected!" they yelled through the car window before speeding away.

An ear, nose and throat specialist, had diluted bleach thrown over her on 13 April while walking her dogs in the city of Guadalajara. She does not see COVID-19 patients in her clinic but is convinced her uniform made her a target.

A hospital cleaner was getting off a bus a few blocks from the Guadalajara hospital where he works as a cleaner when he was brutally attacked by a group of other passengers.

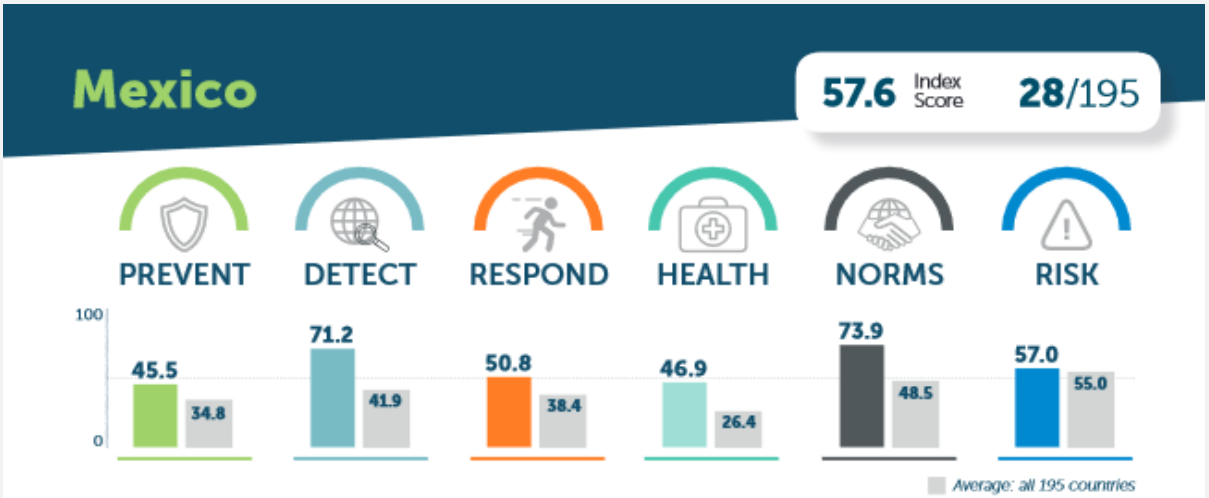
A nurse was warned by residents, if she entered the village she wouldn't be allowed to leave again. And they said that it would be better if she didn't enter at all because she came from a source of infection. The government has subsequently deployed members of the National Guard in hospitals and some

states have offered medical workers private transport and even hotel rooms so they can avoid long commutes home.

The World Health Organization says up to 38% of health workers experience physical violence at some point in their careers, but the coronavirus pandemic seems to have exacerbated this threat in Mexico.

Experts think the attacks reflect the public's conflicted feelings about what the medical workers represent in a country. The health workers symbolically represent the disease itself and the cure according to a psychologist from the Faculty of Psychology at the Universidad Nacional Autónoma de México.

But most of the attacked health care workers are determined to keep working, returning to their clinic. Mexico's health workers say they are not expecting applause, just respect.
*Source: BBC*




| | COUNTRY SCORE | AVERAGE SCORE* |
|---|---|---|
| **PREVENTION** | **45.5** | **34.8** |
| Antimicrobial resistance (AMR) | 50 | 42.4 |
| Zoonotic disease | 34.7 | 27.1 |
| Biosecurity | 44 | 16.0 |
| Biosafety | 50 | 22.8 |
| Dual-use research and culture of responsible science | 0 | 1.7 |
| Immunization | 82.5 | 85.0 |
| **DETECTION AND REPORTING** | **71.2** | **41.9** |
| Laboratory systems | 83.3 | 54.4 |
| Real-time surveillance and reporting | 80 | 39.1 |
| Epidemiology workforce | 25 | 42.3 |
| Data integration between human/ animal/environmental health sectors | 100 | 29.7 |
| **RAPID RESPONSE** | **50.8** | **38.4** |
| Emergency preparedness and response planning | 25 | 16.9 |
| Exercising response plans | 0 | 16.2 |
| Emergency response operation | 33.3 | 23.6 |
| Linking public health and security authorities | 100 | 22.6 |
| Risk communication | 50 | 39.4 |
| Access to communications infrastructure | 70.3 | 72.7 |
| Trade and travel restrictions | 100 | 97.4 |

| | COUNTRY SCORE | AVERAGE SCORE* |
|---|---|---|
| **HEALTH SYSTEM** | **46.9** | **26.4** |
| Health capacity in clinics, hospitals and community care centers | 51.2 | 24.4 |
| Medical countermeasures and personnel deployment | 33.3 | 21.2 |
| Healthcare access | 30.1 | 38.4 |
| Communications with healthcare workers during a public health emergency | 50 | 15.1 |
| Infection control practices and availability of equipment | 50 | 20.8 |
| Capacity to test and approve new medical countermeasures | 75 | 42.2 |
| **COMPLIANCE WITH INTERNATIONAL NORMS** | **73.9** | **48.5** |
| IHR reporting compliance and disaster risk reduction | 100 | 62.3 |
| Cross-border agreements on public and animal health emergency response | 100 | 54.4 |
| International commitments | 100 | 53.4 |
| JEE and PVS | 0 | 17.7 |
| Financing | 50 | 36.4 |
| Commitment to sharing of genetic & biological data & specimens | 100 | 68.1 |
| **RISK ENVIRONMENT** | **57.0** | **55.0** |
| Political and security risks | 53.6 | 60.4 |
| Socio-economic resilience | 60.7 | 66.1 |
| Infrastructure adequacy | 58.3 | 49.0 |
| Environmental risks | 59 | 52.9 |
| Public health vulnerabilities | 54.4 | 46.9 |

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

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## MilMed CoE VTC COVID-19 response

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| 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.<br><br>**Topics former VTCs:**<br>• 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.<br>• Testing strategies<br>• Aeromedical evacuation<br>• De-escalation strategy and measures<br>• Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases<br>• Immunity map, national strategies to measure and evaluate the immunity level”<br>• Mental Health<br>• Treatment of mild symptomatic cases of COVID-19<br>• Transition home office back to the office<br>• COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation<br>• Perspectives of the current COVID-19 vaccine development<br><br>**We are planning to run the next VTC on 10th of September about the current national status on the outbreak.** |

## Recommendations

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| 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.<br>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.<br><br>**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.**<br>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.<br><br>**In the case of non-deferrable trips, please note the following**<br>• Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules.<br>• Check your national foreign office advices for regulations of the countries you´re traveling or regulations concerning your country.<br>• 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.<br><br>**Most countries implemented strikt rules of contact reduction:**<br>• Everyone is urged to reduce contacts with other people outside the members of their own household to an absolutely necessary minimum.<br>• In public, a minimum distance of 1.5 m must be maintained wherever possible.<br>• 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).<br>• Follow the instructions of the local authorities.<br><br>**Risk of infection when travelling by plane:**<br>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.<br><br>**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:<br>• 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;<br>• 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;<br>• Refrain from touching mouth and nose; See also: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public<br>• 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 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

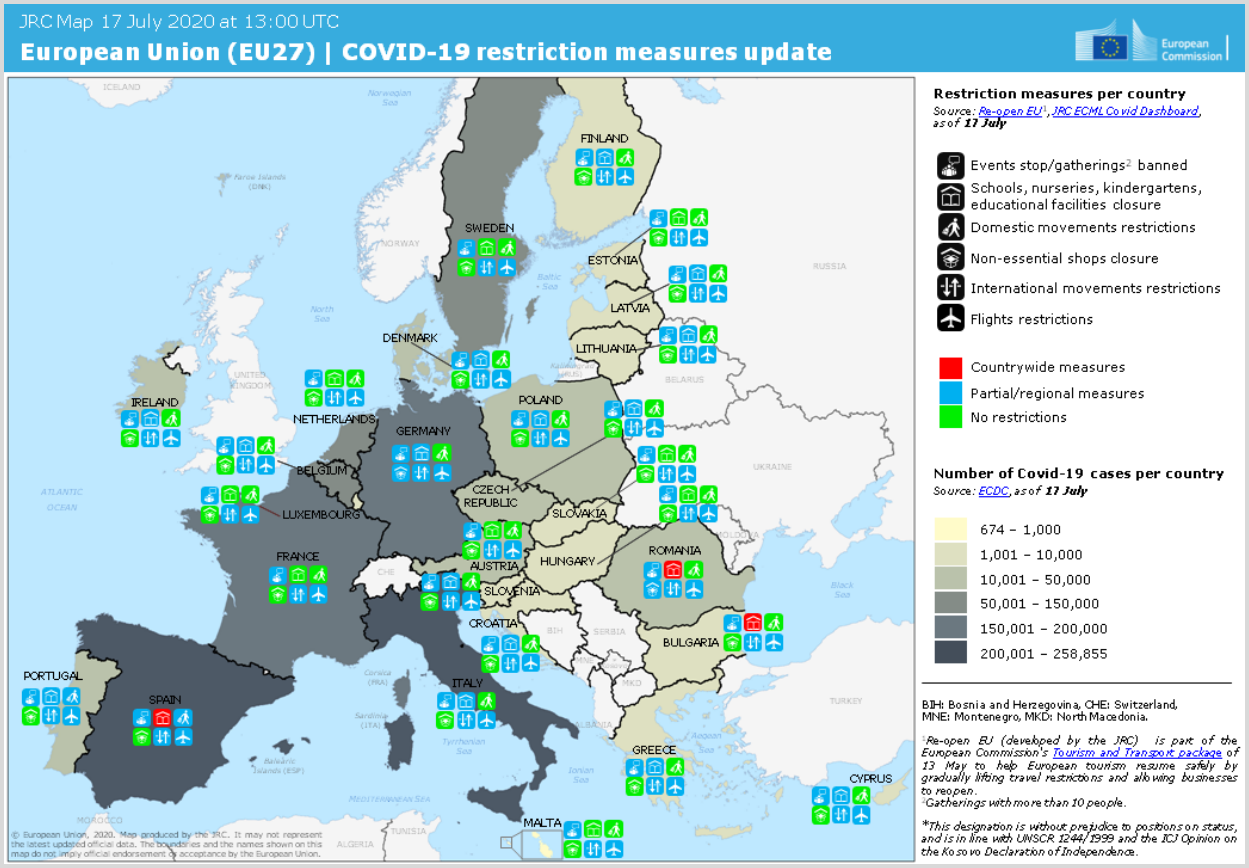
Residents of Andorra, Monaco, San Marino and the Vatican should be considered as EU residents for the purpose of this recommendation.
The **criteria** to determine the third countries for which the current travel restriction should be lifted cover in particular the epidemiological situation and containment 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.




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

| Risk Assessment | |
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| Global | • Because of global spread and the human-to-human transmission the **moderate to high** risk of further transmission persists.<br>• Travellers are at risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks.<br>• Individual risk is dependent on exposure.<br>• National regulation regarding travel restrictions, flight operation and screening for single countries you will find here.<br>• Official IATA changed their travel documents with new travel restrictions. You will find the documents here.<br>• 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.<br>• 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 10 August 2020 (still valid):<br>**Risk of COVID-19 across all EU/EEA countries and the UK:**<br>• 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.<br>• The risk of further escalation of COVID-19 is **very high** for countries that do not implement of enforce multiple measures, including physical distancing, and have sufficient contact tracing and testing capacity.<br>**Risk of COVID-19 in the countries that have reported a recent increase of cases:**<br>• 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.<br>• 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.<br>• 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.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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