Update 37 (15th of September 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
15th of September 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

- Almost 308,000 people were newly infected with the virus within 24 hours - more than ever before in one day. The biggest increases were in India, the USA and Brazil.
- **GPMB**: According to the report of the Global Preparedness Monitoring Board, the world is doing too little to prepare for the next pandemic after Corona. This will "definitely" come and be even more dangerous. If the correct conclusions are not drawn from the fight against the corona pandemic, "then the next pandemic will be even more devastating".
- **EU**: The applications of the European corona apps are to be made compatible. The EU Commission announced in Brussels that the test phase of a corresponding interface started on Monday. The official apps from Germany, the Czech Republic, Denmark, Ireland, Italy and Latvia can now communicate with each other using a server located in Luxembourg in order to warn users across borders.
- **WHO:** Across 17 districts in Banadir, Somalia over 3,000 health care workers conducted a 5-day campaign targeting the vaccination of 400.000 children under the age of five against measles and polio as well as offering vitamin A and deworming tablets. In addition, health care workers shared information with families on how to prevent the future spread of COVID-19.
- **WHO**: The first meeting of the International Health Regulations (IHR 2005) Review Committee on the functioning of the IHR during the COVID-19 pandemic was held this week. The committee will review the functioning of the IHR during the COVID-19 response.
- **WHO**: has published interim guidance for countries who are considering the integration of rapid immunoassays into COVID-19 outbreak management programs and has also revised guidance on diagnostic testing for SARS-CoV-2 which provides more background information on clinical diagnostic algorithms and new findings from the literature and best practices.

GLOBALLY
29 286 445 confirmed cases **19 894 800** recovered **929 123** deaths
EU/EEA and the UK
4 444 634 confirmed cases **2 426 750** recovered **220 636** deaths
USA → **(new cases/day 34 999)**
6 513 710 confirmed cases **2 472 123** recovered **193 944** deaths
Brazil ↗ **(new cases/day 27 562)**
4 345 610 confirmed cases **3 770 138** recovered **132 006** deaths
India → **(new cases/day 91 688)**
4 930 236 confirmed cases **3 859 399** recovered **80 776** deaths
Russia → **(new cases/day 5 301)**
1 069 873 confirmed cases **881 693** recovered **18 723** deaths
Spain ↗ **(new cases/day 9 740)**
593 730 confirmed cases **150 376** recovered **29 848** deaths

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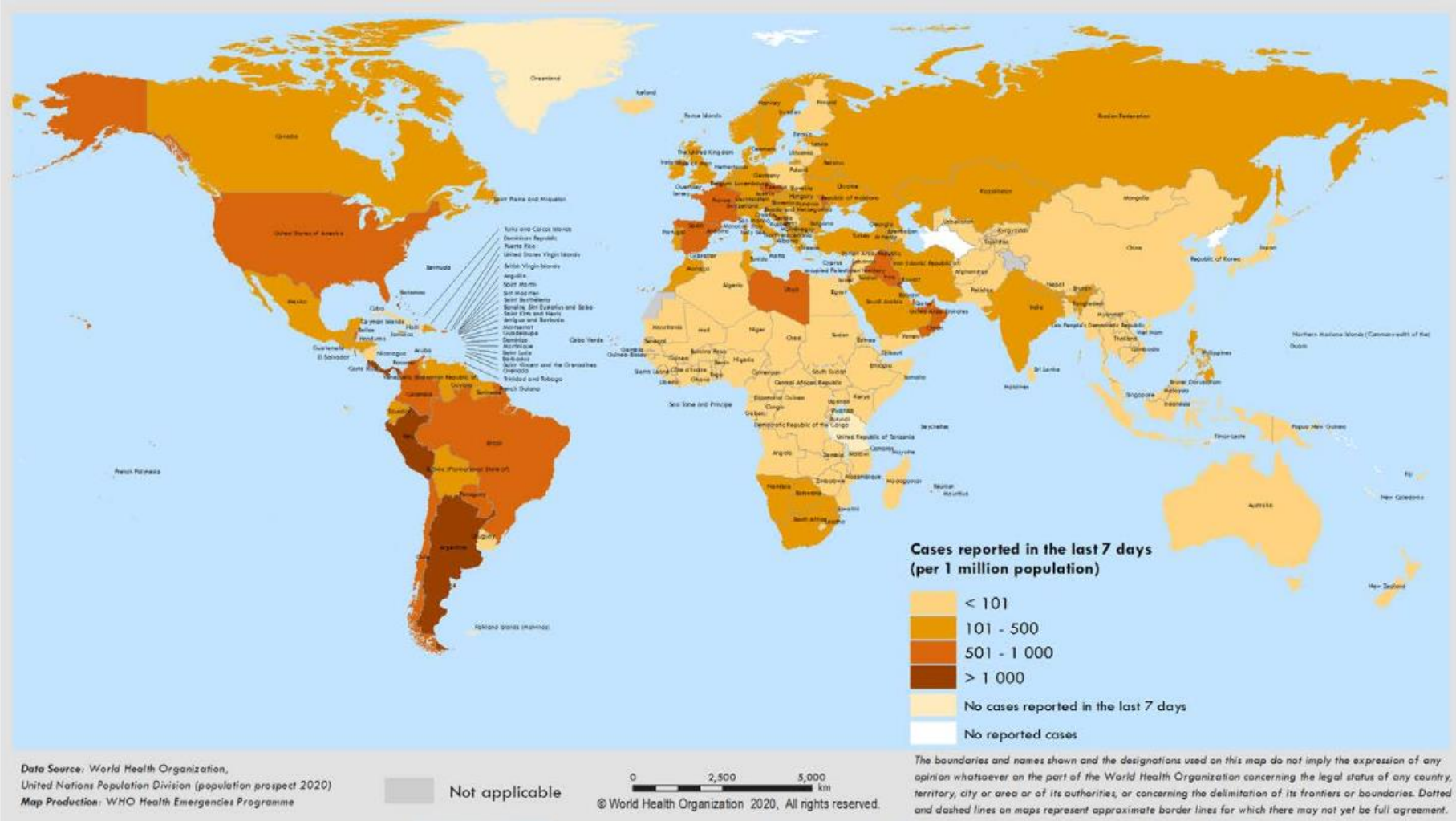
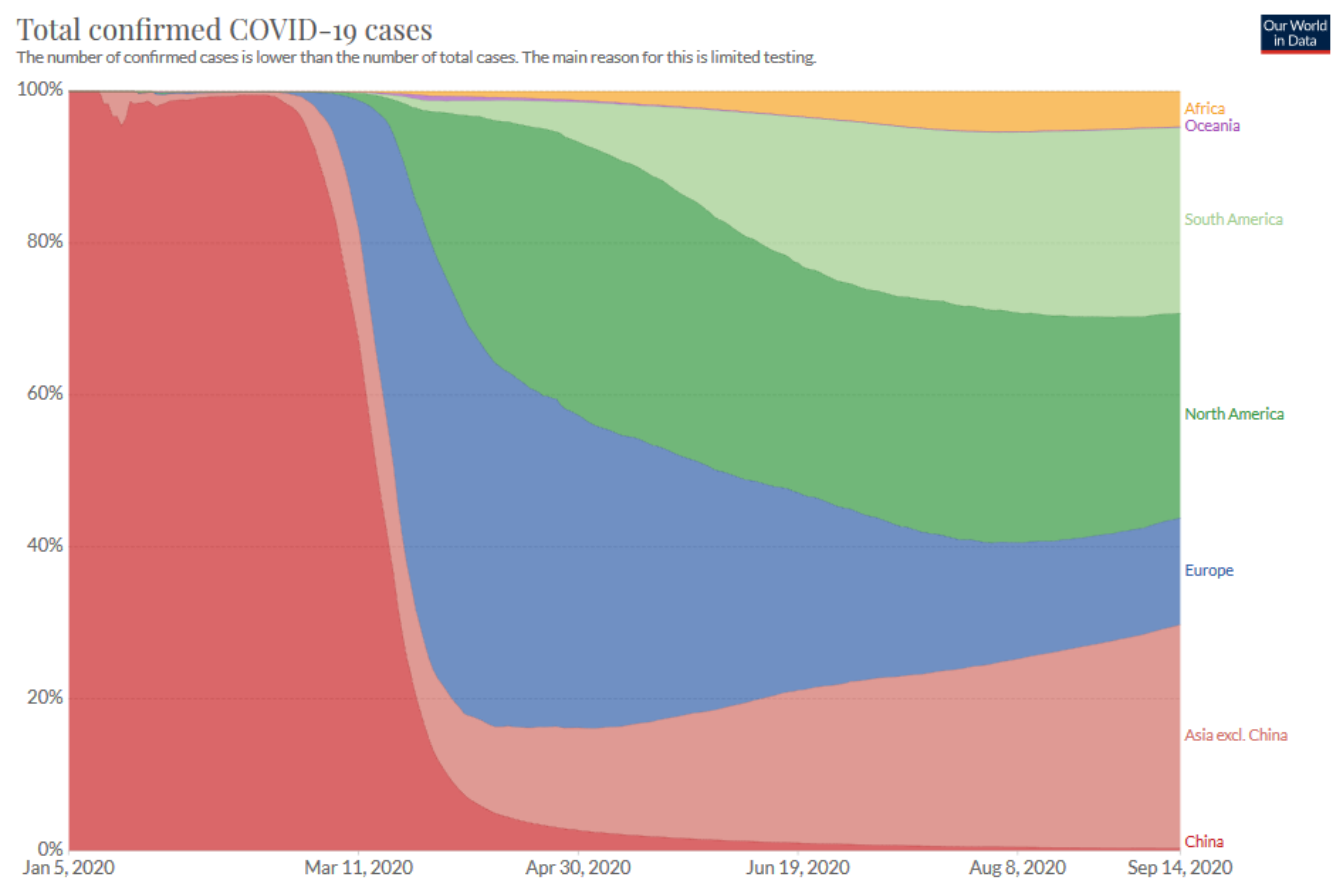
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation



COVID-19 and the younger ones

A recent publication from the USA describes the course of COVID-19 in 3222 young, adult patients (age 18-34 years old) in April, May and June of this year. 1030 US hospitals were included and a total of 8 million patient admissions were evaluated.

The study population ultimately comprised the named 3222 non-pregnant young adults from 419 US clinics. The average age was 28.3 years.

Patients:

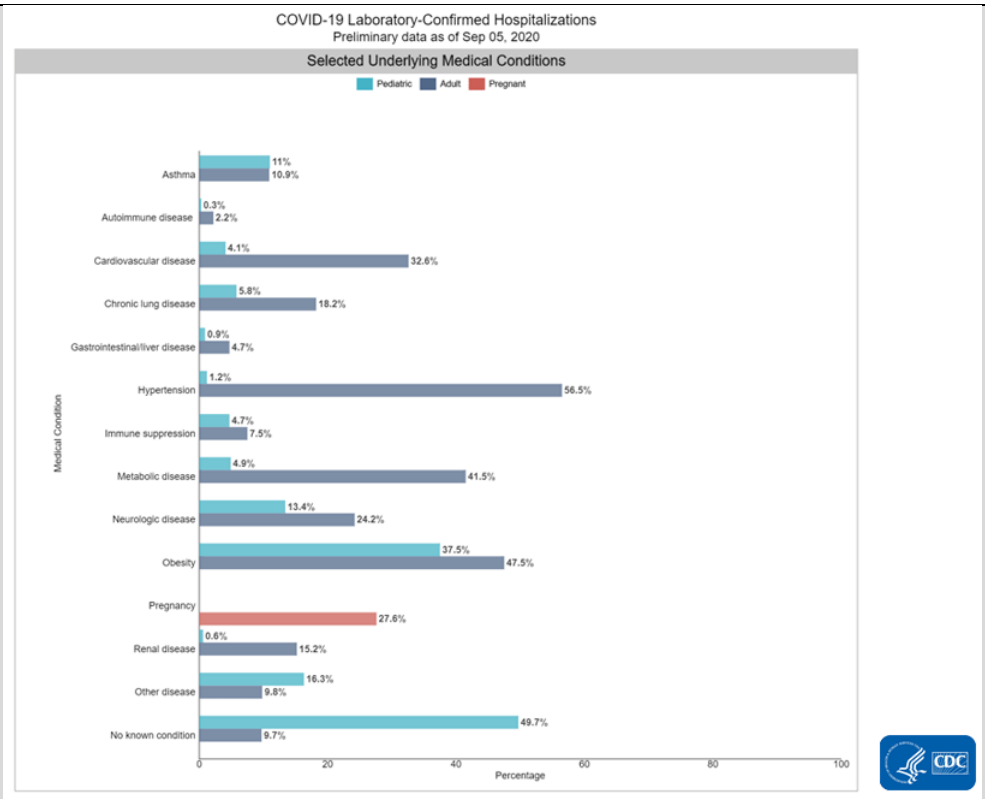
Approx. 58% were male, 57% were black or Hispanic. About 35% were obese, 25% pathologically obese, 18.2% had diabetes, and 16% had hypertension.

Results:

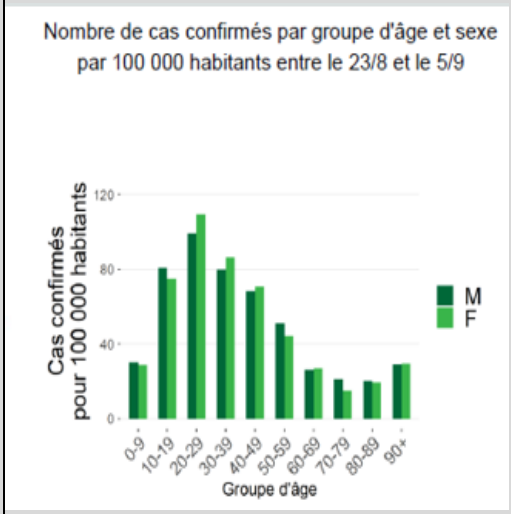
21% became intensive care, 10% had to be ventilated mechanically and ultimately 2.7% died (which corresponds to about twice as high a mortality as heart attacks in this age group). The average length of stay on the ITS was 4 days. Those who survived inpatient treatment were transferred to a post-acute treatment facility.

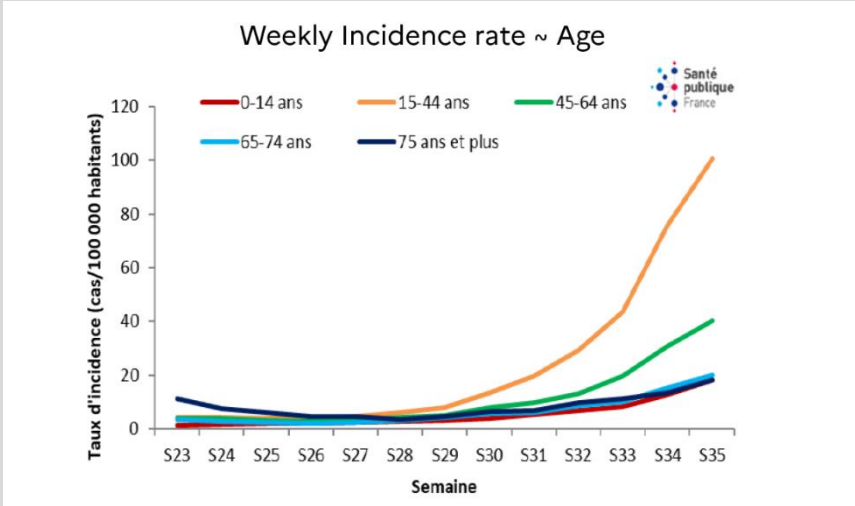
The statistical probability of having to be ventilated or even to die increased - as in the end also with older patients - due to pathological obesity and high blood pressure, especially in men - belonging to a certain origin was not of significant importance.

41% of the deceased or ventilated patients were pathologically obese. Diabetes was associated with the risks, but not statistically significant. Patients with multiple risk factors (morbid obesity, high blood pressure and diabetes) had similar risks for the serious course as the older age group (35-64 years).

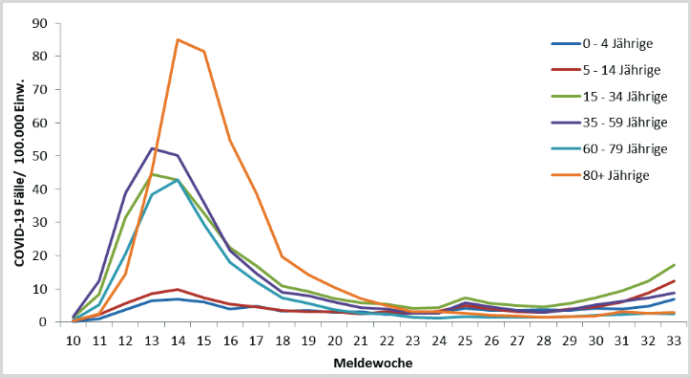


The shift from older adults to younger adults can be seen in almost all countries. For example see the current age distribution of COVID-19 cases in Belgium (left) and France (right) in the pictures below:





In Germany, according to the Robert Koch Institute, more than 90,300 people up to 34 years of age have contracted the corona virus. After all, they make up a third of the infections recorded. However, they die far less often from the consequences. So far, two deaths among under 20-year-olds have been reported nationwide, both of whom had previous illnesses. A further 34 deaths are known in the age range of 20 to 39 year olds.



It is estimated that a 25-year-old has a 250 times lower risk of dying from COVID-19 than an infected 85-year-old. But death does not mean risk. The recent study from the USA shows that younger people can also get seriously ill with COVID-19 - the US data also match the first surveys from Germany.

In a study by the AOK (one of the biggest German health insurance companys) with a total of more than 10,000 COVID-19 patients who had to be treated in hospital, only about 3% were between 18 and 29 years old. But at least 6.3% of them had to be artificially ventilated. The sample is small and therefore not representative. But it makes it clear that COVID-19 is not an easy cold for younger people either.

Overall, the rate of hospital admissions of 18 to 29 year olds per 100,000 in the US has tripled within a few months. According to an analysis in the "Journal of Adolescent Health" with more than 8,000 test subjects, a third of 18 to 25 year olds could be prone to a severe course, for example because they are overweight or have a cardiovascular disease. The greatest risk factor in this age group is nicotine consumption. The WHO also warned that smokers are more at risk of contracting COVID-19.

And even if an infection proceeds without symptoms, as is often the case with younger people, the possible consequences of the infection have still hardly been researched. For example, changes in the lungs that are typical of COVID-19 were found in people who at least initially had no symptoms. There are also individual cases of younger patients who have been diagnosed with diabetes in connection with COVID-19.

Nevertheless, since the beginning of the pandemic, the idea has haunted the world that if only younger people were infected, it would not be a big problem, but maybe even a good thing. The more young adults become infected, so the theory goes, the faster herd immunity could be achieved. The pandemic would subside by itself.

But as tempting as the plan might sound, it didn't work in practice. Neither the UK nor Sweden have managed to keep the virus out of high-risk groups. The number of deaths rose rapidly.

In almost all European countries, significantly more people have recently tested positive for the corona virus, and younger people are still particularly affected. How devastating the pandemic will continue in this countrys will depend on whether you pass the virus on to the elderly. In Germany for example already at the beginning of the outbreaks, young people who came home from a skiing holiday were mainly infected. In the weeks after their return, the number of infections among the elderly rose and with it the number of those who had to receive intensive care and the number of deaths.

Countries are now better prepared. Regular tests in hospitals and care facilities are intended to prevent chains of infection. Now it remains to be seen whether the precautionary measures are sufficient.

And not to forget saying it with the words of the well-known US immunologist Anthony Fauci:

"It is not true that there can be no harmful consequences for young people. We are seeing more and more complications in young people."

Sources:

Infektinfo 60g SARS-CoV19 Behörden; Bundeswehr HQ of Military Medicine

Briefing Belgium, COVID-19 VTC MilMedCOE, 10 September 2020

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WHO weekly operational update on COVID-19 as of 09 September 2020:

See information about partnership, logistics, health learning, medicines and health products, funding/donors and regional highlights in the document as well as links to Technical guidance and latest publications.
Find some selected topic out of the paper down below:

Operations Support and Logistics

The COVID-19 pandemic has prompted an unprecedented global demand for Personal Protective Equipment (PPE), diagnostics and clinical care products, leading to constrained market conditions for these critical supplies. To ensure market access for low- and middle-income countries, WHO and partners have created a COVID-19 Supply Chain System, which has delivered supplies to 150 countries across all WHO regions.
The table below reflects WHO-procured items that have been shipped to date.

Shipped items as of 8 September 2020	Laboratory supplies		Personal protective equipment					
Region	**Swabs**	**Tests (Manual PCR)**	**Face shields**	**Gloves**	**Goggles**	**Gowns**	**Medical Masks**	**Respirators**
Africa (AFR)	1,989,185	1,037,046	663,107	606,300	87,581	826,929	27,701,133	1,028,474
Americas (AMR)		13,478	4,350,901	88,000	328,580	3,996,470	57,807,110	7,984,656
Eastern Mediterranean (EMR)	526,920	1,020,970	789,285	2,366,750	113,660	386,122	17,153,650	1,207,995
Europe (EUR)	170,660	399,400	1,701,450	6,959,100	343,040	901,448	9,950,100	5,020,950
South East Asia (SEAR)	1,404,620	1,689,250	87,336	414,500	82,150	217,450	4,199,100	342,475
Western Pacific (WPR)	90,800	240,864	300,400	219,000	98,167	86,510	10,339,650	926,235

WHO weekly epidemiological report, 14 September 2020

Global epidemiological situation

In the week from 7 through 13 September, there were over 1.8 million new cases of COVID-19, comparable to the previous seven days (Table below); while deaths increased slightly as compared to the previous week, with over 40 600 deaths reported.

The Region of the **Americas** has consistently registered the greatest number of reported cases for many weeks. It continues to account for nearly half of the global total of cases even as cases have declined in the reporting week.

The **African Region** also showed a decline in reported cases this week and was the only region to report a decline in deaths.

The **European** region reported the third-highest number of new cases, amounting to 16% of the global total, and is the region with the second-highest cumulative number of cases per million population (5 172 cases per million population).

Figure 1: Number of COVID-19 cases reported weekly by WHO Region, and global deaths, 30 December 2019 through 13 September 2020[**]

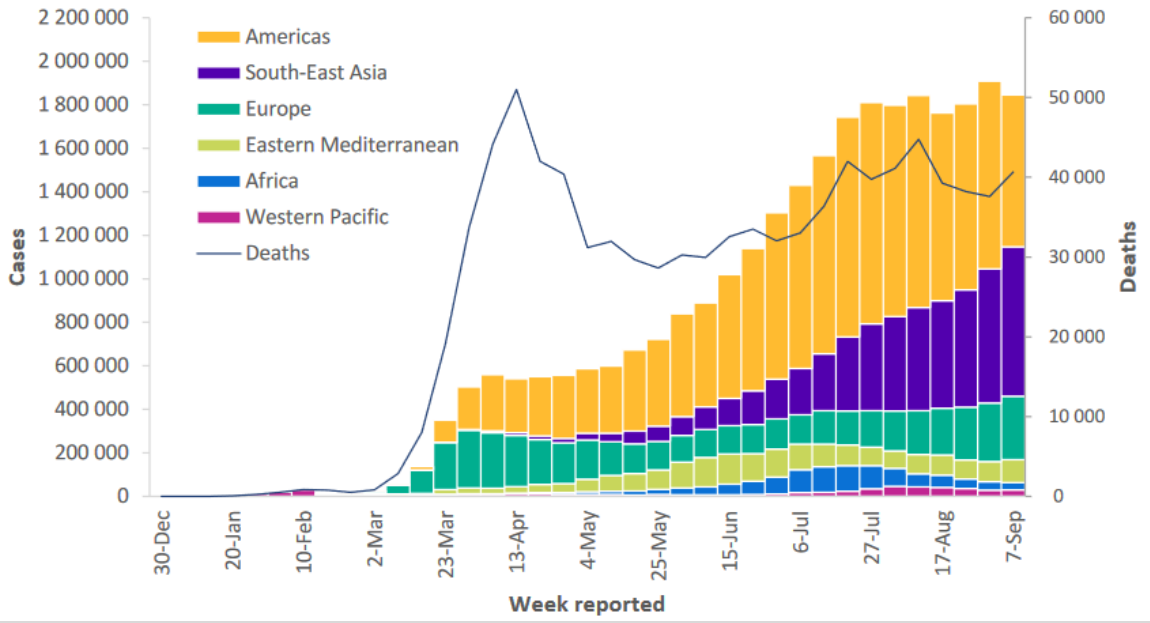


Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 13 September 2020[**]

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days*	Cumulative deaths (%)
Americas	697 780 (38%)	-19%	14 699 174 (51%)	24 626 (61%)	10%	508 705 (55%)
South-East Asia	687 119 (37%)	11%	5 377 062 (19%)	8 991 (22%)	11%	92 391 (10%)
Europe	291 387 (16%)	8%	4 796 426 (17%)	3 050 (8%)	<1%	225 494 (25%)
Eastern Mediterranean	105 430 (6%)	14%	2 101 676 (7%)	2 302 (6%)	3%	55 012 (6%)
Africa	33 169 (2%)	-14%	1 116 321 (4%)	1 007 (2%)	-15%	23 916 (3%)
Western Pacific	30 074 (2%)	4%	546 552 (2%)	680 (2%)	6%	11 886 (1%)
† Other	-	-	741 (<1%)	-	-	13 (<1%)
Global	**1 844 959 (100%)**	**-3%**	**28 637 952 (100%)**	**40 656 (100%)**	**8%**	**917 417 (100%)**

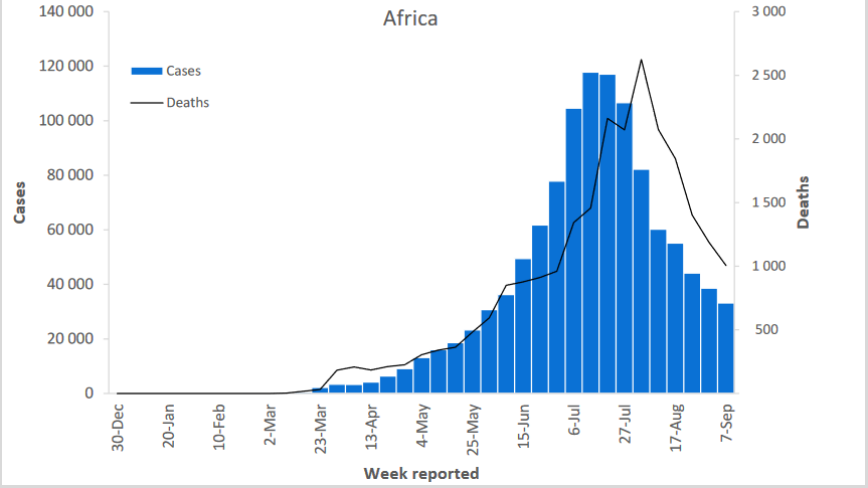
African Region

The African Region has witnessed declining trends in the number of new cases reported (a 14% decrease in cases and a 15% decrease in deaths in the past seven days), with 26 of the 47 affected countries reporting decreases in the past week. While this is encouraging, vigilance is still essential as many factors may be influencing these trends such as testing capacity and strategy, along with delays in reporting in some areas.

While **South Africa** continues to account for the greatest number of cumulative reported cases in the region, disease incidence by 1 million population is highest in **Mayotte** (12 367 per million).

Cumulative deaths per million population remains the highest in **South Africa** (260 per million population).

Figure 3: Number of COVID-19 cases and deaths reported weekly by the WHO African Region, as of 13 September 2020**



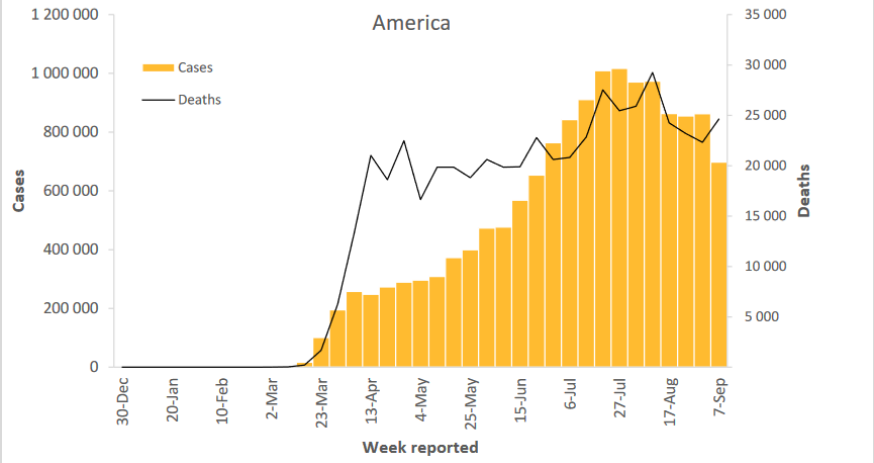
Region of the Americas

While the numbers are relatively low as compared to other countries in the region, **Guadeloupe** has reported its highest number of cases this week, rising from 428 new cases in the previous weekly update to 1717 new cases this week, and the transmission pattern has now moved from clusters of cases to community transmission. Cumulative cases and deaths have increased relative to the territory's population, over 100% in cases and a 20% increase in cumulative deaths in the past seven days.

In the past week, **Curaçao** has shown the highest weekly increase in the number of cases since the start of the outbreak in the country, a 250% increase in weekly new cases reported which translates to a 73% increase in cumulative cases.

While cases reported this week in **Costa Rica** are in line with the average for the country in the past few weeks, the number of deaths reported has increased by 84% and a 24% in the incidence of deaths relative to the country's population in the past week.

Figure 4: Number of COVID-19 cases and deaths reported weekly by the WHO Region of the Americas, as of 13 September 2020**



Eastern Mediterranean Region

Cases in the Region continue to rise, an increase of 14% in the past seven days, and currently account for 6% of global cases. Seasonal religious and cultural mass gatherings, wedding celebrations and other social events have contributed to the upsurge of cases in different countries in the region.

Upticks of cases reported in **Tunisia** and **Jordan** have been linked to ceremonies and celebrations.

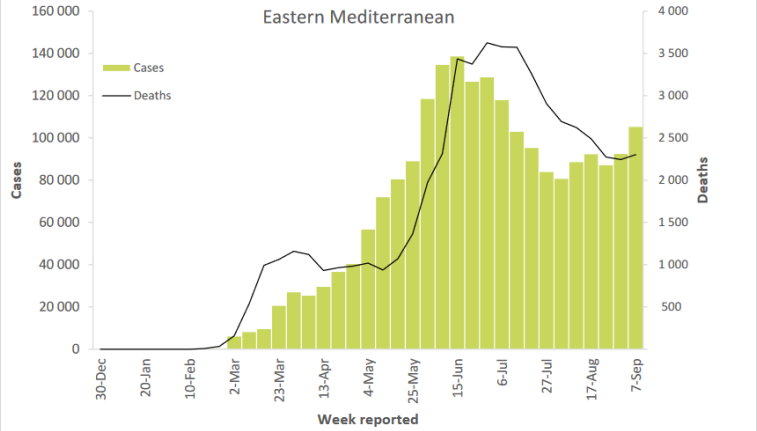
Cases in **Morocco** have reached a peak at approximately 2 000 per day, an increase of 41% in weekly new cases.

The majority of new cases (42%) are being reported in the **Casablanca-Settat** region, where public health and safety measures are being scaled up in response.

In **Jordan**, the number of weekly new cases has increased by 54%. Deaths have remained stable at 2 per million population. Additionally, the first two cases of COVID-19 were confirmed in a refugee camp hosting Syrian refugees.

In **Libya**, the number of new confirmed cases of COVID-19 has more than doubled over the past two weeks; both the cumulative cases and deaths per million population in Libya has increased by 30% in the past seven days. Given the acute shortages of tests and laboratory capacity, the real number of cases is likely to be much higher.

Figure 5: Number of COVID-19 cases and deaths reported weekly by the WHO Eastern Mediterranean Region, as of 13 September 2020**



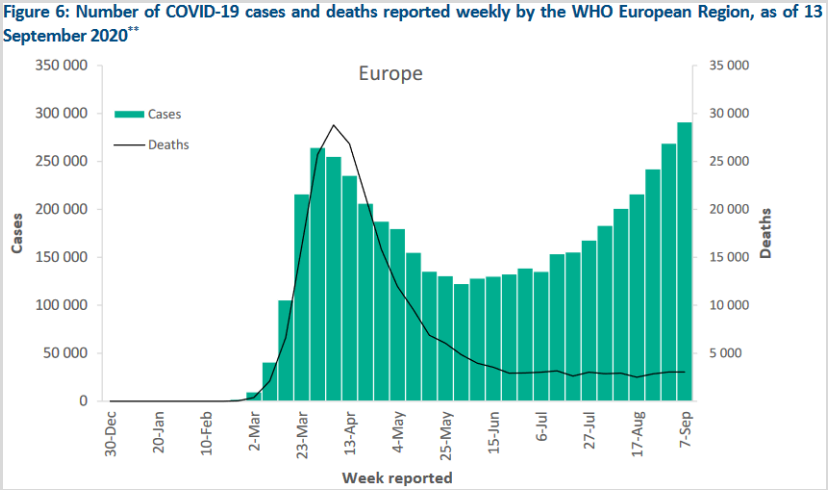
European Region

The European Region accounts for 16% of global COVID-19 cases and 25% of the deaths.

While **France** reported the highest number of new cases in the past seven days, the top three countries in the region reporting the highest cumulative cases per million population are **San Marino** (21 834 cases per million population), **Andorra** (17 395 per million population) and **Israel** (16 430 per million population).

The countries reporting the highest cumulative number of deaths relative to their population are **San Marino** (1 238 per million population), **Belgium** (856 per million population) and **Andorra** (686 per million population).

Figure 6: Number of COVID-19 cases and deaths reported weekly by the WHO European Region, as of 13 September 2020**

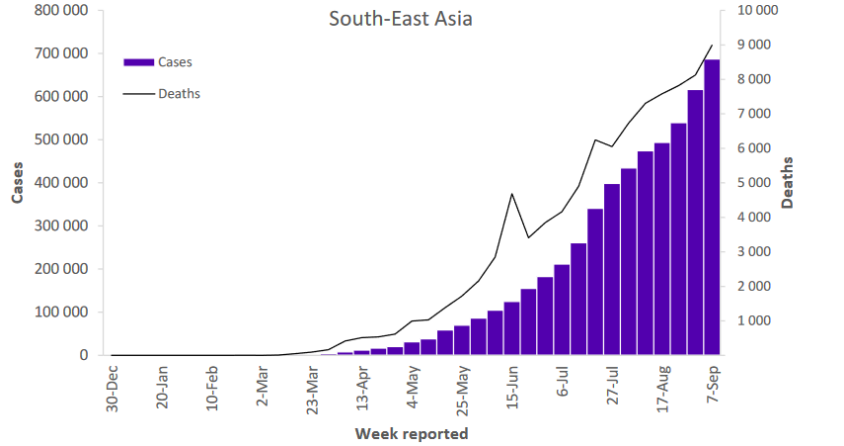


South-East Asia Region

In the South-East Asia Region, **India, Indonesia** and **Bangladesh** continue to report the highest number of cases, although the **Maldives** accounts for the highest number of cumulative cases relative to its population. The region recorded 22% of all new deaths in the last seven days but retains low overall cumulative deaths relative to the region's population.

Myanmar is continuing to show increasing case numbers, with a greater than 250% increase in weekly new cases, resulting in more than a doubling of cumulative incidence from 24 to 51 per million population. Deaths remain low, with an incidence of <1 per million population. An influx of local travelers from Rakhine State to Yangon Region occurring since the end of August has contributed to increasing trends; as incidence rises, there are concerns of spread of cases from Myanmar across its border with **Thailand**, where cases have remained low (50 per million population) since peaks in early April.

Figure 7: Number of COVID-19 cases and deaths reported weekly by the WHO South-East Asia Region, as of 13 September 2020**



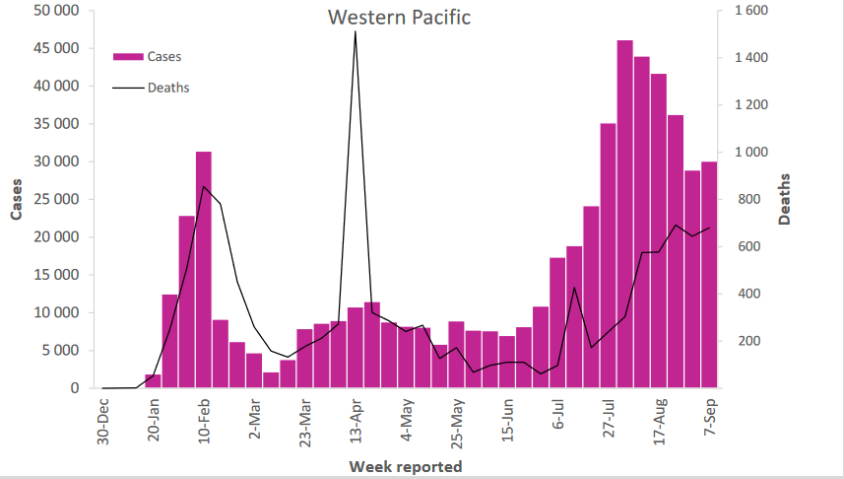
Western Pacific Region

Overall, the Western Pacific Region has the lowest cumulative cases (278) and deaths (6) per million population.

The **Philippines, Japan** and the **Republic of Korea** have the greatest number of new cases in the region; however, **Singapore** holds the largest number of cumulative cases per million population at 9 804.

Malaysia showed an increase in weekly new cases of nearly 650%, averaging about 68 cases per day. Prior to this, Malaysia had been reporting fewer than 20 cases per day since the end of July. In the last seven days the cumulative cases per million population rose by 5%.

Figure 8: Number of COVID-19 cases and deaths reported weekly by the WHO Western Pacific Region, data as of 13 September 2020**

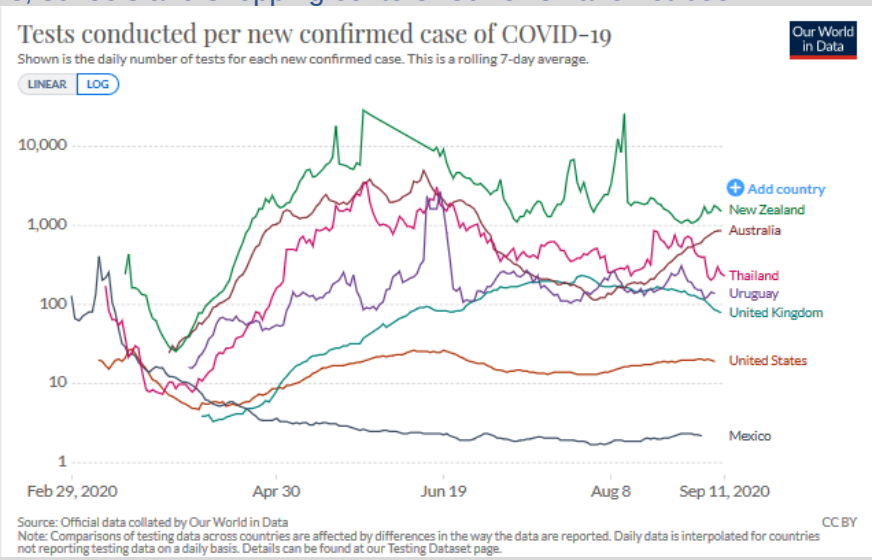


Updates from WHO regional offices:

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

Uruguay – A small state with a big pioneering role

Latin America, along with the USA, has been the center of the global coronavirus pandemic for several weeks. Ironically, the country with the oldest population on the continent has so far been largely unscathed by the crisis: Uruguay recently recorded 1,741 cumulative cases and only 45 deaths. When the first isolated cases were discovered in mid-March, President Luis Lacalle Pou declared a state of emergency and closed borders, schools and shopping centers. Curfews have not been imposed; rather, voluntary distance, wearing masks, meticulous tracking of infections and, above all, extensive testing have been and will continue to be set. 1,610 tests are carried out on average per newly confirmed case - this is the fourth highest value in the world after New Zealand, Australia and Thailand. For comparison: In the USA and Great Britain only 52 and 21 tests per new disease are carried out, respectively.



What makes the difference in Uruguay can already be seen when driving through the small agricultural country: There are only a few of the densely populated slums. Wherever you find them, running water comes from the tap - a decisive factor in overcoming the crisis and adhering to hygiene measures in the pandemic. In general, Uruguay is sparsely populated. And it has relatively few informal workers compared to most Latin American countries. That makes the difference to countries like Peru, Chile or Brazil, where many people simply could not afford a voluntary quarantine because they are dependent on their daily earnings.

This goes hand in hand with a high level of trust of the population in state institutions.

The well-developed welfare state provides comprehensive access to pensions, childcare, health care, education and income support. In addition, Uruguay's previous left-wing governments had invested in the welfare state for more than 15 years. When it comes to health expenditure per capita, Uruguay is by far the leader in South America.

Even though most of the shops have reopened and the children have returned to school, Uruguay remains vigilant - the situation all around seems too threatening. The country has an almost 1,000 kilometers long border with Brazil in the north and a nearly 600 kilometers long border with Argentina in the west. The city of Rivera is a neuralgic point - around 170,000 Uruguayans and Brazilians live there and cross the border every day to work, shop and visit the family on the other side.

Nevertheless, Uruguay's political stability is unparalleled in the region. The new president launched a corona relief fund, which was also financed by a substantial wage waiver by the president, his ministers and high-paid officials. This helped low-income citizens and brought the president a reputation among the population. Due to the relatively short closing times of shopping centers, parks and restaurants, experts anticipate that the country's economy will probably collapse far less in 2020 than elsewhere.

UAE: The United Arab Emirates approved a corona vaccine. However, it may only be available in an emergency “for those who have to do most with COVID-19 patients”.

AUS: The Australian police arrested more than one in three demonstrators during a demonstration against corona requirements. The police said there were 74 arrests at the rally with 200 to 250

	participants. 176 people were fined for violating health protection regulations. There were also scuffles between riot police and demonstrators. Melbourne is the focal point of the otherwise relatively moderate virus outbreak in Australia. On Monday, a strict lockdown that has been in place in the metropolis for weeks will be eased slightly: people will then be allowed to stay outside for two hours - instead of the previous one hour. --- **MEX**: Mexico passed the 70,000 corona death mark on Friday. On Monday alone, 534 people died within 24 hours of complications from coronavirus, bringing the total death toll to 70,183, according to the Ministry of Health. This exceeded even the most pessimistic forecasts: the authority had initially estimated the number of deaths caused by the pandemic at 8,000, before assuming up to 60,000 deaths in a “disaster” scenario. Corona restrictions have been in place in Mexico since the end of March. Some economic sectors have slowly reopened since June, but schools are still closed. --- **ISR:** In view of the rising number of new infections with the corona virus, the government has decided to impose a second nationwide lockdown. These should come into effect on Friday afternoon, before the start of the Jewish holidays, and initially apply for three weeks. Schools and kindergartens are said to be closed. Except in exceptional cases, people are only allowed up to 500 meters from their homes. Hotels, restaurants and shopping centers as well as leisure facilities should also remain closed according to media reports. Grocery shopping and visits to the doctor are still allowed. Authorities and private companies should work with restrictions. Contact restrictions also apply: up to 20 people can gather outdoors and up to ten people can gather indoors. Business people have already announced that they will not obey the blocking requirement.

Situation in Europe

ECDC COVID-19 surveillance report Week 36, as of 10 September 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 both 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 the epidemiological characteristics of COVID-19 cases reported to The European Surveillance System (TESSy) to date and assesses the quality of the data.

Trends in reported cases and testing

- As of 9 September 2020, the 14-day case notification rate for the EU/EEA and the UK was 66 (country range: 4–244) per 100 000 population. The rate has been increasing for 52 days.
- Increases in the 14-day COVID-19 case notification rates compared to the previous week have been observed in 14 countries (Austria, Czechia, Denmark, Estonia, France, Hungary, Ireland, Italy, Netherlands, Norway, Portugal, Slovakia, Slovenia and the United Kingdom). Rates in these countries have been increasing for between two and 50 days.
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 36, available for 27 countries, varied from 419 to 7 797 tests per 100 000 population. Luxembourg had the highest testing rate for week 36, followed by Denmark, Malta, Cyprus and Norway.
- Six countries (Croatia, Czechia, France, Hungary, Romania and Spain) had a weekly test positivity of 3% or higher and three countries (Czechia, France and Hungary) had a weekly test positivity that had increased compared to last week.

Primary care

- In the five countries that reported data up to week 36 from primary care sentinel surveillance for COVID-19, using the systems established for influenza, there were no detections of SARS-CoV-2 among the 52 patients tested.
- Among countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 36 using the systems established for influenza, almost all observed consultation rates that remain similar to or lower than those reported during the same period in the last two years. Ireland however has observed slightly higher ILI rates compared to previous years for the past four weeks.

Hospitalisation

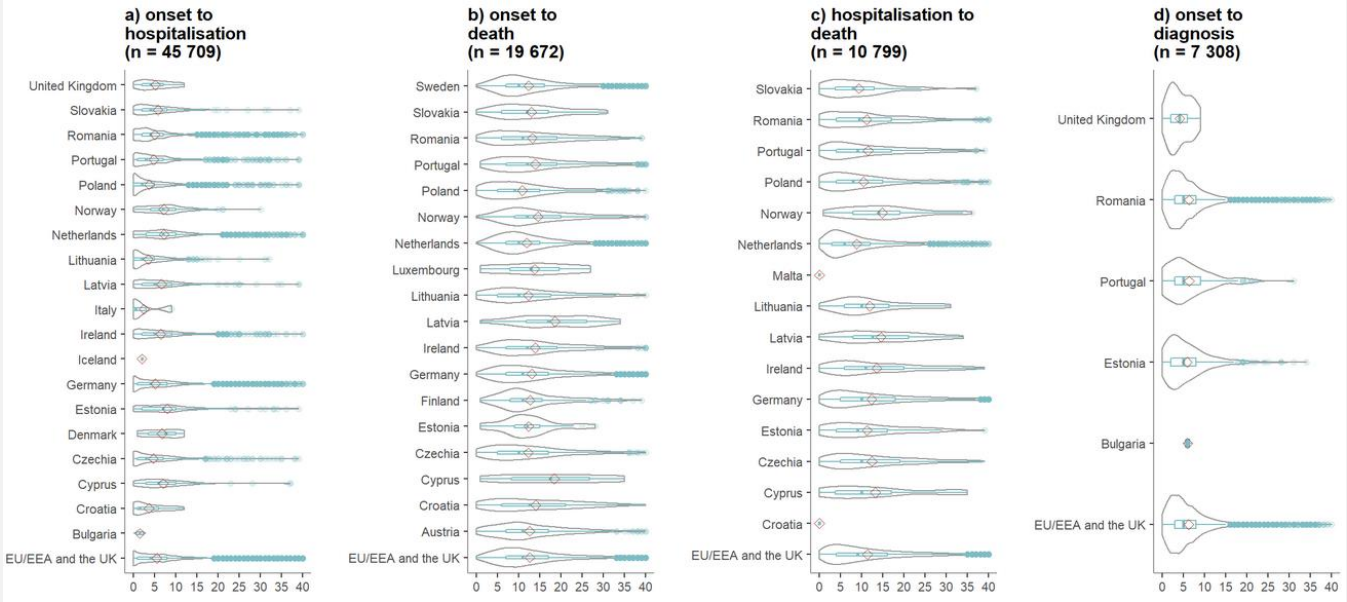
- Hospital and/or ICU occupancies and/or new admissions due to COVID-19 have recently increased in Bulgaria, Croatia, Czechia, France, Greece, Hungary, Slovakia and Slovenia. No other increases have been observed, although data availability varies.
- Based on data reported to date by 22 countries, we estimate that 24% (country range: 9–61%) of reported COVID-19 cases have been hospitalised. Data from 17 countries show that a total of 9% (country range: 0–62%) of hospitalised patients required ICU and/or respiratory support. These proportions vary considerably by age and sex.

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 68 days.
- Increases in the 14-day COVID-19 death notification rates compared to those reported seven days ago have been observed in three countries (Croatia, Malta and Spain). Rates in these countries have been increasing for between six and nine days.
- Overall pooled estimates of all-cause mortality reported by EuroMOMO show normal levels for the participating countries. In some countries, however, there seems to be a small excess mortality.

Country-specific distribution of duration of disease progression stages from onset to outcome, EU and UK

The figures below show the time in days between date variables in TESSy to give an indication of the distribution, by country and by age, of the times for different stages of disease progression or case management. Negative delays, which were likely introduced through errors in data entry, have been censored.



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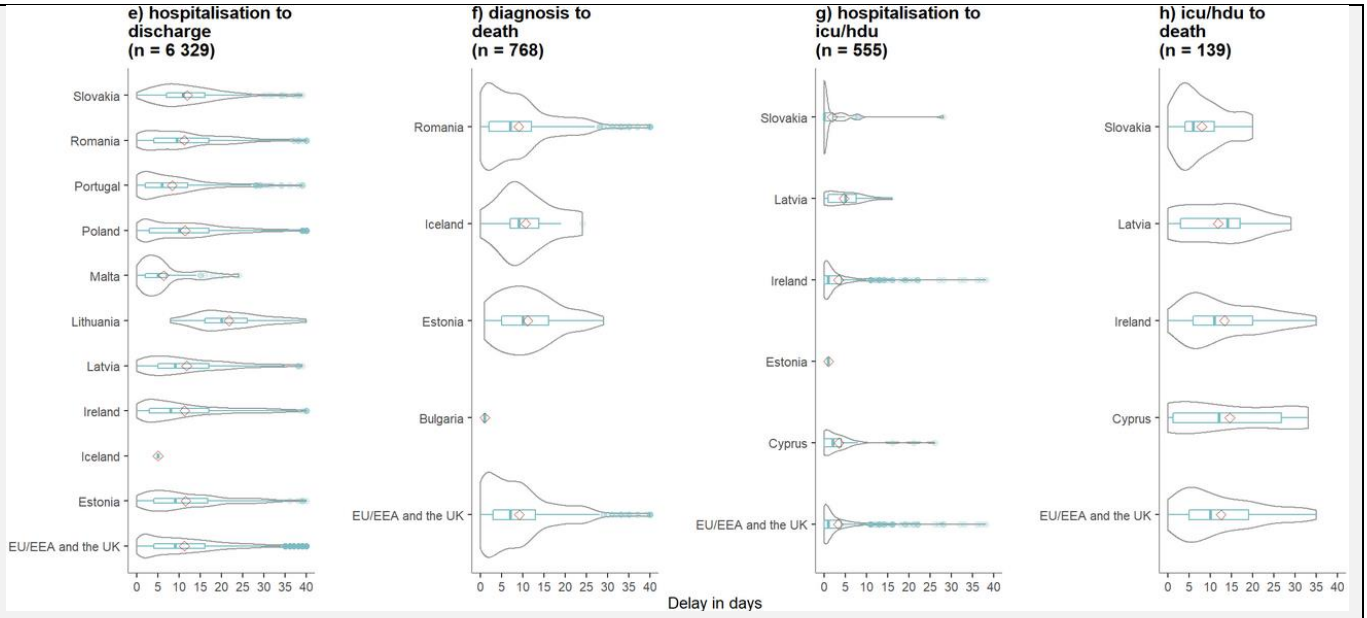
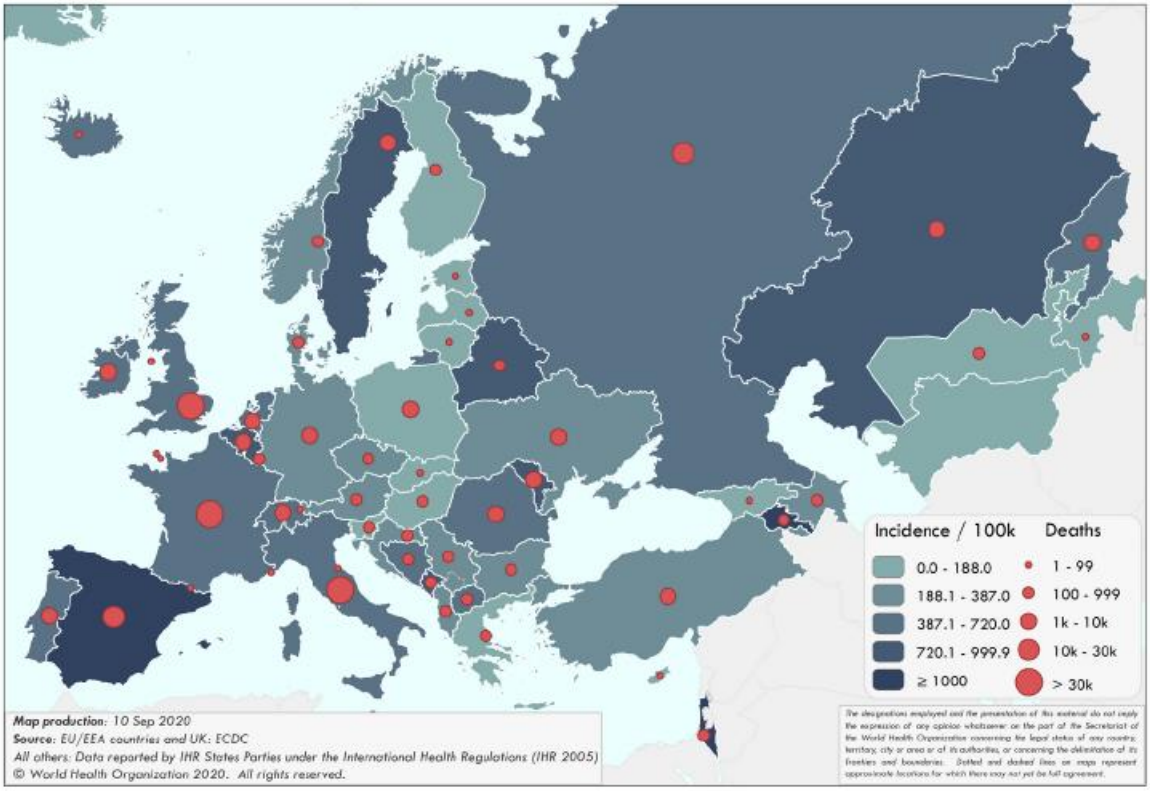


[COVID-19 situation update for the WHO European Region (31 August – 06 September 2020 Epi week 36)]

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



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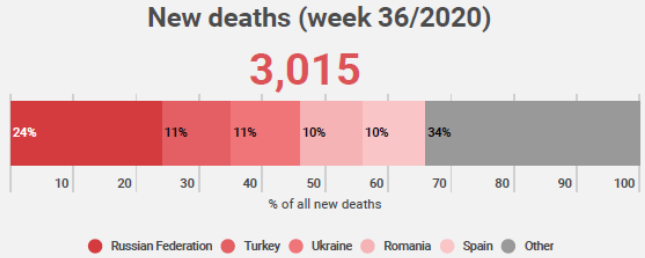
Key points

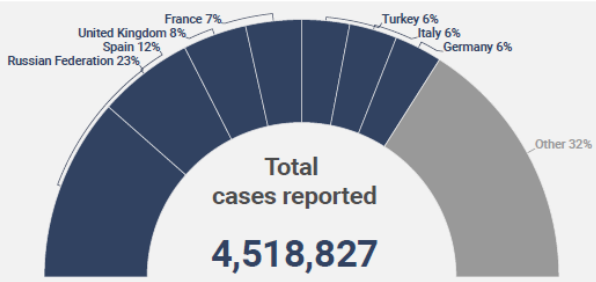
Week 36/2020 (31 Aug - 6 Sep 2020)

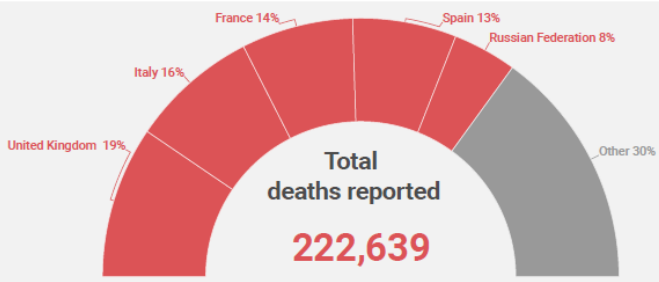
- The number of cases reported in the Region increased 10% to 268,160 in week 36/2020 compared to the previous week (243,613 cases in week 35/2020), and increased 118% compared with week 23/2020 (1-7 Jun; 123,099 cases) when the lowest number of cases per week were reported.
- The number of deaths in the Region in week 36/2020 increased 8% to 3,015 compared to the previous week (2,794 deaths in week 35/2020) (Figure 1)
- 63% (168,287) of the cases reported in week 36/2020 were reported from five countries: Spain (21%; 56,126), France (17%; 45,176), the Russian Federation (13%; 35,179), Ukraine (6%; 16,820) and Israel (6%; 14,986). The remaining cases (37%; 99,873) were reported by 52 countries and territories; each accounted for <5% of the total cases reported in week 36/2020
- Six countries had a crude incidence of ≥60 per 100,000 in week 36/2020: Andorra, France, Israel, Montenegro, Republic of Moldova and Spain.
- The crude incidence continues to vary across the region with a range from 2 per 100,000 population in Cyprus to 176 per 100,000 population in Israel (Figure 2A)
- The 14-day cumulative incidence increased by ≥10% in week 36/2020 in 30 countries and territories in the Region, however for some countries data was retro-adjusted by national authorities: Andorra, Austria, Azerbaijan, Belarus, Croatia, Czech Republic, Estonia, Finland, France, Georgia, Gibraltar, Hungary, Ireland, Israel, Italy, Jersey, Latvia, Lithuania, Monaco, Montenegro, Norway, Portugal, Republic of Moldova, Slovakia, Slovenia, Spain, Switzerland, Turkey, Ukraine, and the United Kingdom (see EURO COVID-19 Dashboard for recent trends)
- 66% (2,001) of the deaths reported in week 36/2020 were reported by the Russian Federation (24%; 727), Turkey (11%; 336), Ukraine (11%; 319), Romania (10%; 311) and Spain (10%; 308). The remaining deaths (34%; 1,014) were reported from 36 countries and territories; each accounted for <5% of the total deaths reported in week 36/2020
- The proportion of reported cases that died was 1.1% in week 36/2020
- Community-transmission was reported by 30 countries and territories, 23 countries and territories reported cluster transmission, while 5 countries and territories reported sporadic transmission in week 36/2020 (see EURO COVID-19 Dashboard)
- For a subnational view of the COVID-19 situation in the WHO-EURO Region see the WHO-EURO COVID19 Subnational Explorer

Summary overview

- The cumulative cases across the Region increased 6.3% to 4,518,827 cases in week 36/2020 (from 4,250,667 cases in week 35/2020) and cumulative deaths increased by 1.4% to 222,639 deaths (from 219,624 deaths in week 35/2020)
- As of 21 August 2020, ten countries in the Region had an effective reproductive number significantly over 1: Azerbaijan, Belarus, Czech Republic, France, Hungary, Italy, Israel, Monaco, Portugal and Slovakia (See EpiForecasts and the CMMID COVID working group COVID-19 Global Summary for latest estimates)
- Six countries in the Region each reported a cumulative incidence of ≥1000 cases per 100,000 population: (Figure 2B)
- As of week 36/2020, 68% (3,012,777) of cumulative cases were reported from the Russian Federation (23%; 1,025,505), Spain (12%, 520,851), the United Kingdom (8%;344,164), France (7%; 317,706), Turkey (6%; 278,228), Italy (6%; 276,338) and Germany (6%; 249,985). The remaining cases (32%; 1,506,050) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 36/2020
- As of week 36/2020, 70% of cumulative deaths (155,128) were reported from the United Kingdom (19%; 41,549), Italy (16%; 35,534), France (14%; 30,698), Spain (13%; 29,527) and the Russian Federation (8%; 17,820). The remaining deaths (30%; 67,511) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 36/2020
- 88% of all deaths with information available were in persons aged ≥65 years and 58% of all deaths were in men (Table 1)
- 96% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (75%) (Table 1)
- 14% of cases were in persons aged ≥65 years in week 36/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥65 years was 64% in week 36/2020 (compared to 91% in week 14/2020) (Figure 3)
- Pooled estimates of all-cause mortality for 22 countries in the EuroMOMO network show normal levels of excess mortality for the participating countries, however in some countries there seems to be a small excess mortality
- In week 36/2020, four countries reported a total of 321 tests, while only one country reported detections (n=13) of SARS-CoV-2 (North Macedonia) in persons with influenza-like illness (ILI) in primary care sentinel surveillance. The overall positivity was 4% in week 36/2020 (Figure 4)
- Overall, there were 129,133 (6.3%) COVID-19 cases among the total of 2,050,835 tests reported to have been performed in 21 countries in week 36/2020 (Figure 5)







Note: Reported cases and/or deaths from IHR States Parties may be subject to retrospective adjustments.

88% of deaths were in persons aged 65+

58% of deaths were in men

96% of deaths had at least 1 underlying condition

75% of deaths had cardiovascular disease

Figure 1: Number of COVID-19 cases (N=4,518,827) and deaths (N=222,639) by reporting week

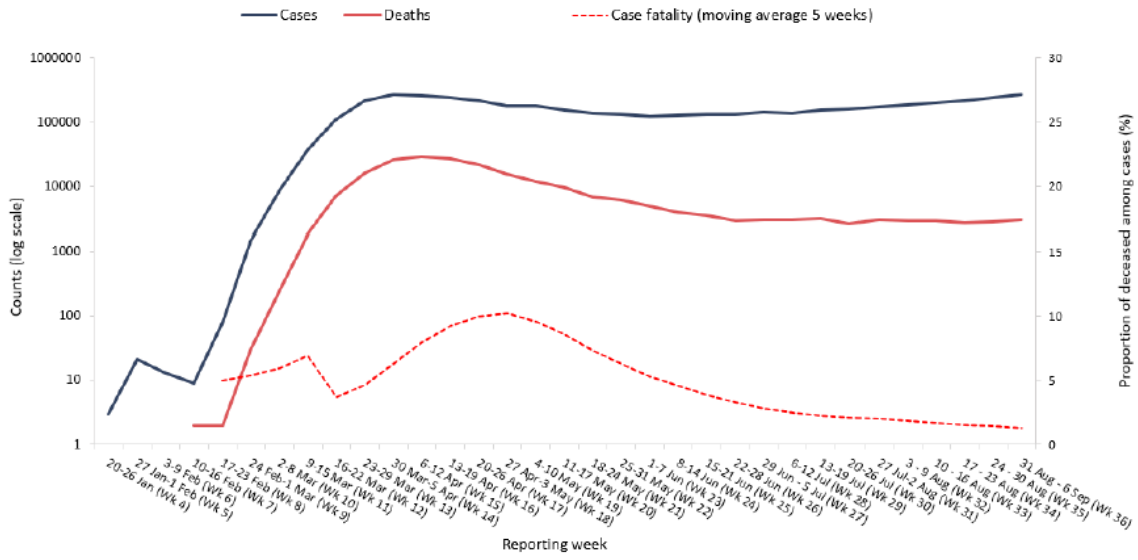
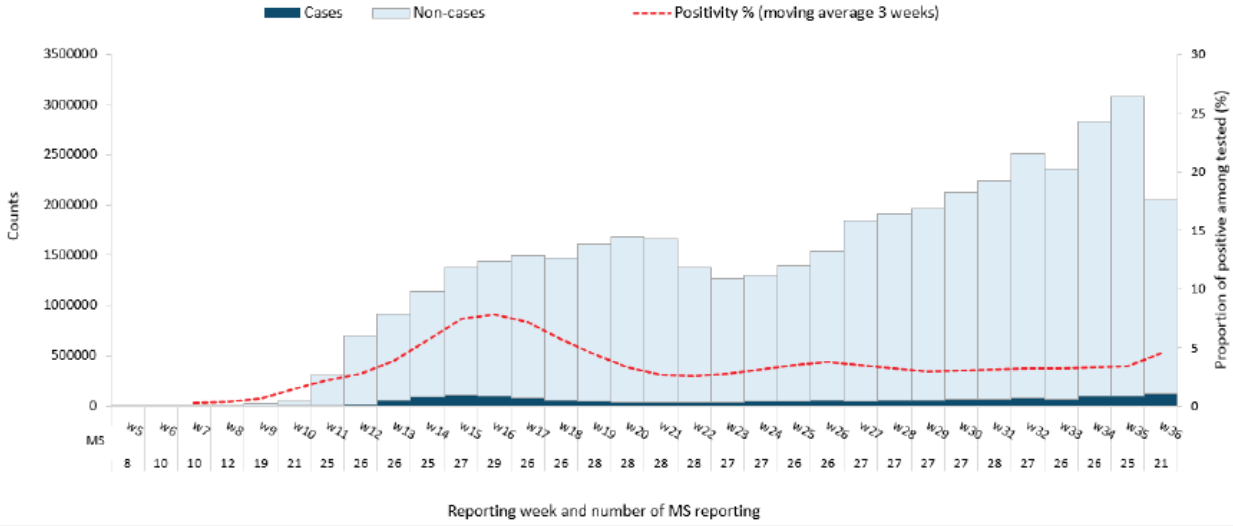


Figure 5. Percentage positive for COVID-19 among all tested by reporting week



Testing of returning travelers in Germany; first results

Lufthansa, Fraport and CENTOGENE are offering a COVID-19 test at Frankfurt Airport with a smear center in the immediate vicinity of the airport building. The test is the molecular test for SARS-CoV-2 based on RT-PCR.

The first results of the evaluation have now become known. The numbers refer to the period between July 15th and September 8th. At least 350 people were tested from all countries included in the evaluation. In total, 0.85 percent of 104 177 people tested were positive.
The so-called positivity rate was highest in the country of entry Kosovo at 6.38 percent. This is followed by Malta (4.71), Bosnia-Herzegovina (3.17), Hungary (2.57), Croatia (2.31) and Albania (2.14). At the bottom of the list are Spain with 0.30 percent, followed by the USA (0.28), Great Britain (0.21), Israel (0.16) and Portugal (0.09). Incoming travelers from Tunisia and the United Arab Emirates were all negative.

ITA: After six months at home, millions of children and young people in Italy can go back to school this Monday. However, even with the start of the new school year, the country is still a long way from normal classes: Among other things, there is a mask requirement - the authorities want to provide free 11 million masks for students and teachers nationwide every day.

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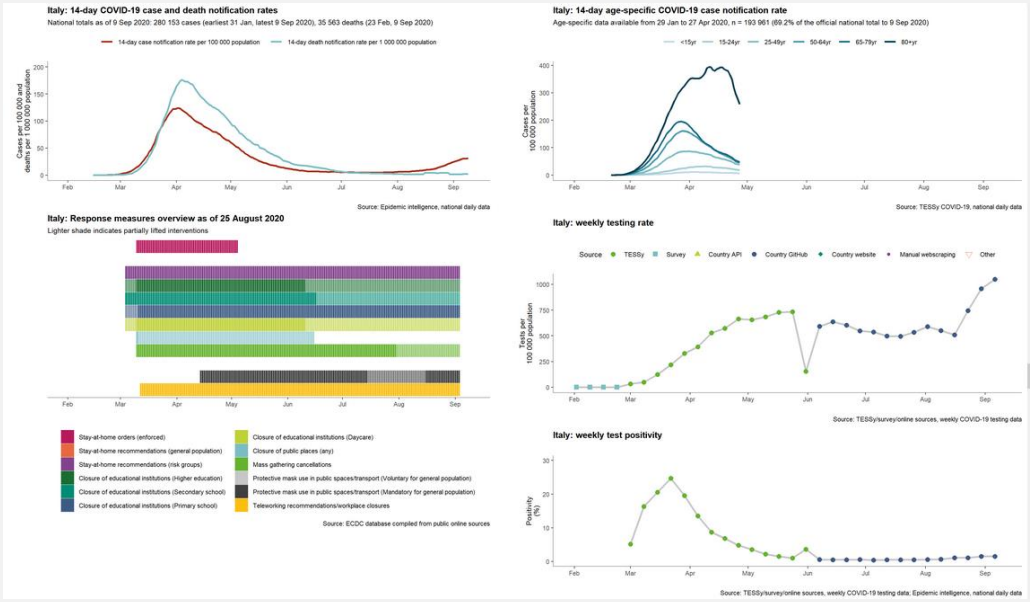
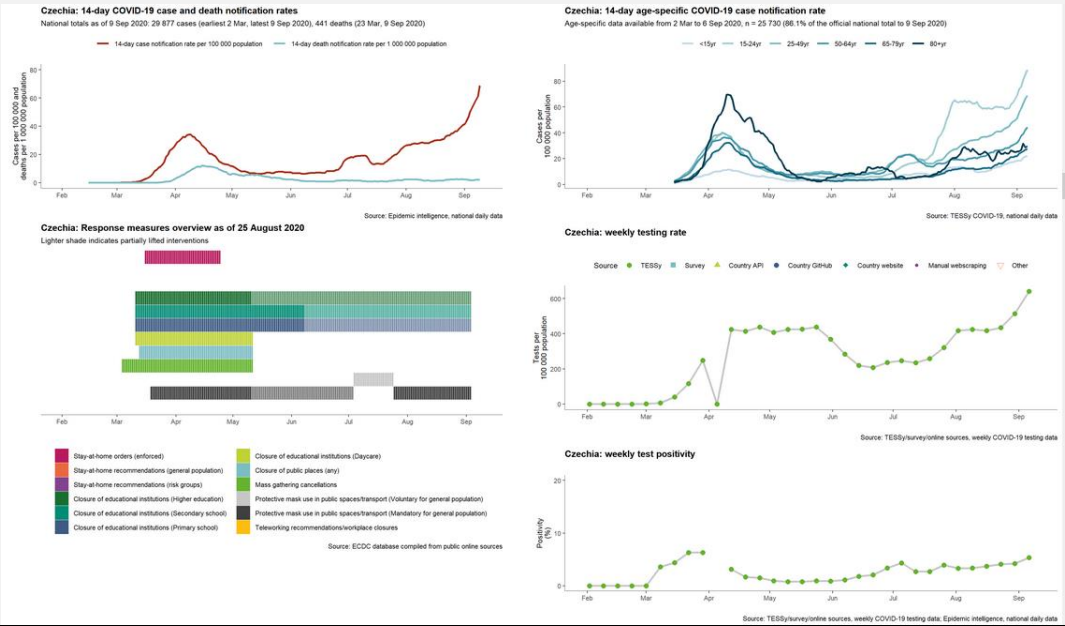
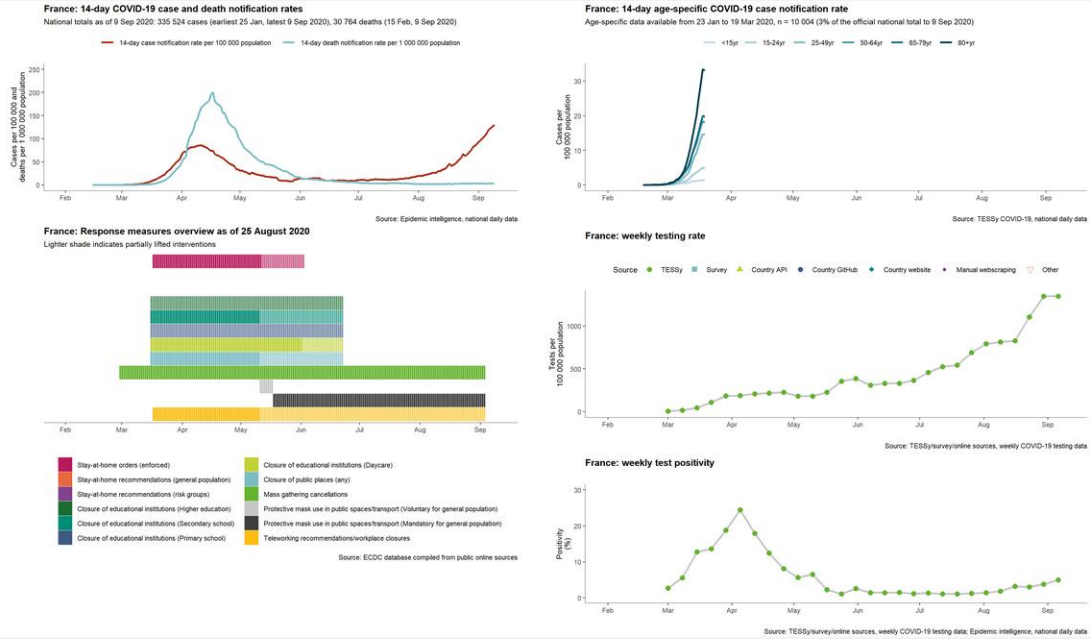
The Italian holiday island of Sardinia is tightening its entry requirements from this Monday due to the spread of the corona virus. Incoming passengers are "called upon" to show a negative corona test that is not older than 48 hours. Alternatively, travelers can also declare online that they have carried out a rapid corona test with a negative result themselves. Those who arrive without a negative test result can temporarily be tested on the island within 48 hours, but must remain in quarantine at home until the result. In addition, as of Monday, a mask is required outside if the distance of one meter cannot be maintained.



CZE: Despite the increasing number of corona cases, the Czech Republic is loosening its quarantine regulations. Anyone who has come into contact with an infected person and shows no symptoms no longer automatically needs to be isolated at home if both sides have worn a face mask. These contact persons would only have to monitor their health from Tuesday on. People who have had COVID in the last 90 days are exempt from the quarantine obligation for contact persons, as they are considered immune.



FRA: The government in France decided against a second lockdown. After an emergency meeting, France's Prime Minister Jean Castex announced that a second lockdown in France should be prevented by all means. For the time being, there will be no “general exit restriction”. Instead, he called on the authorities in particularly affected cities such as Marseille and Bordeaux as well as in the overseas territory of Gouadeloupe to propose localized measures by Monday.



DEU: Several people were arrested at the demonstration against the Corona measures in Munich with around 10,000 demonstrators. The number of arrests was in the lower double-digit range. In addition, more than 120 advertisements were added. In around 100 cases, it was about violations of the corona measures because people did not keep their distance or refused to cover their mouth and nose. More than 20 other people were charged for resisting law enforcement officers, libel, assault and violations of the assembly law.

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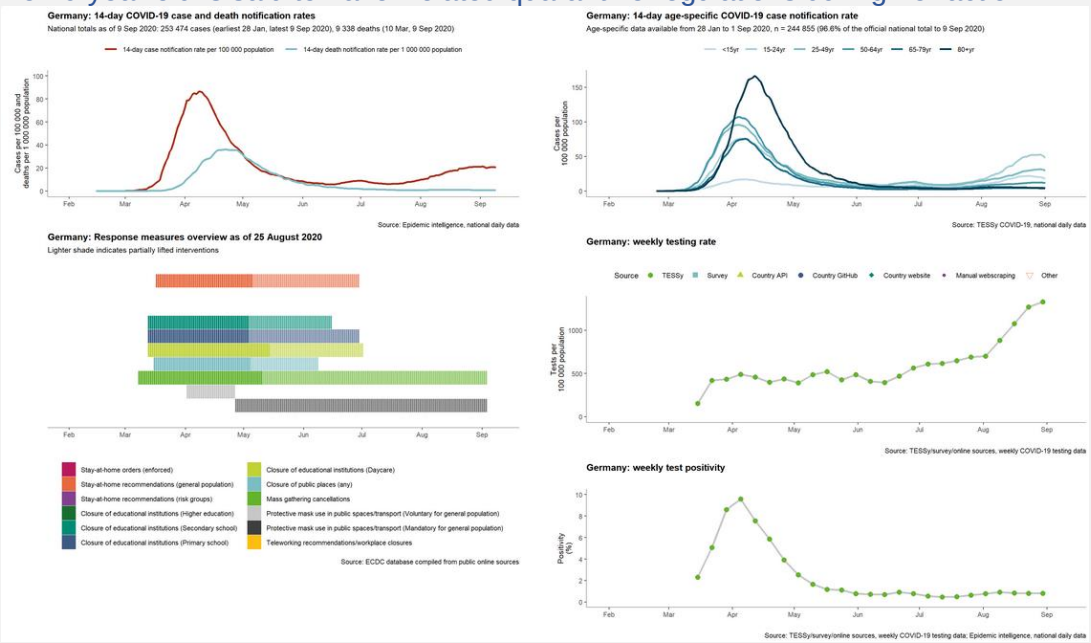
The Garmisch-Partenkirchen public prosecutor's office is investigating a US woman on suspicion of negligent bodily harm. The woman is said to have ignored the symptoms of her corona infection and to have wandered through various bars in the Bavarian community. In doing so, she probably infected numerous people and, as a super spreader, ensured that Garmisch-Partenkirchen is now a corona hotspot. The 26-year-old is said to have violated quarantine regulations during her action.



ESP: In Spain, the number of daily new corona infections climbed to the record level of 12,183 on Friday. It is the highest increase within a day since the beginning of the pandemic. The Ministry of Health in Madrid said there were 4708 positive test results in the past 24 hours and supplemental reported cases. In the past 14 days, a total of 112,364 new infections had been registered, an average of a good 8,000 per day.

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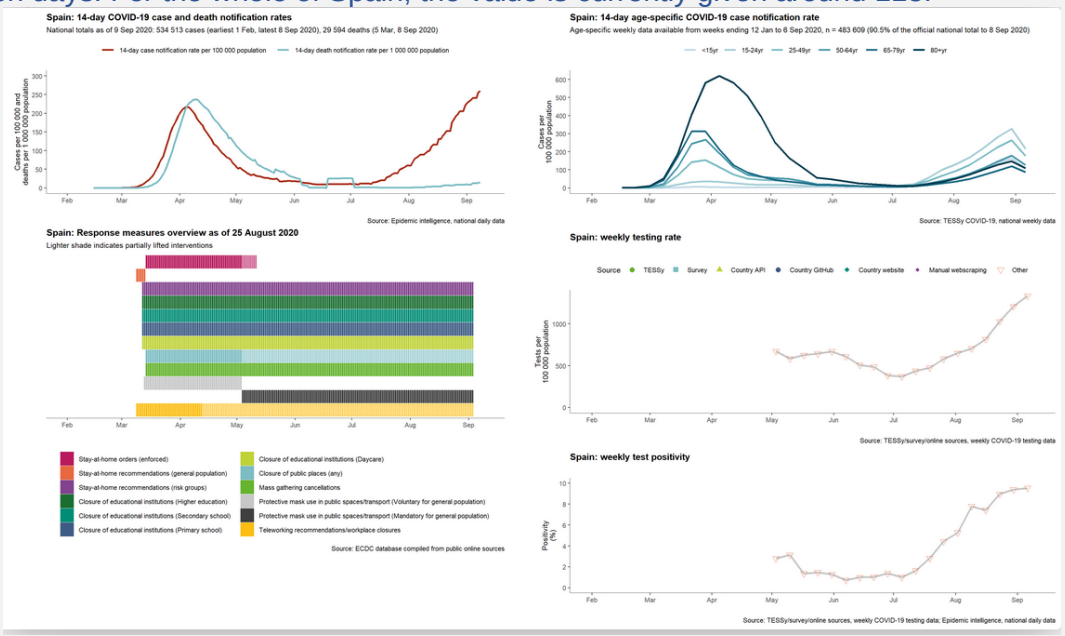
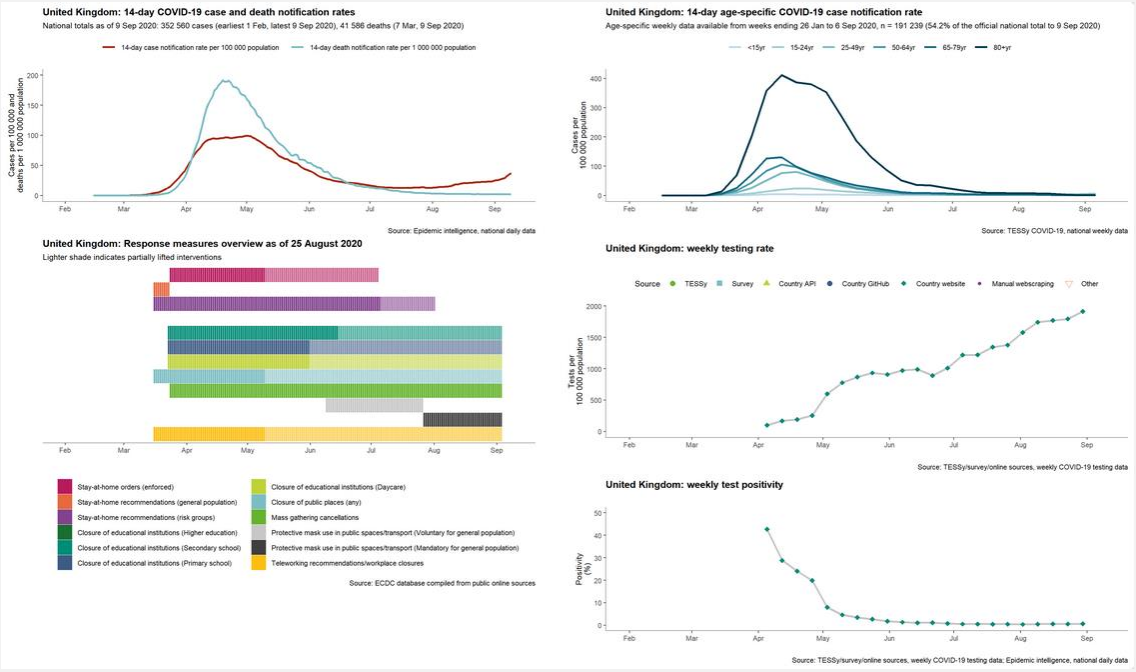
Due to an incorrect transmission of corona data from the Balearic Islands to the Spanish Ministry of Health in Madrid, the infection numbers have been reported too low for days, according to a press report. The number of new infections per 100,000 inhabitants for the past seven days was given as well below 50 due to the transmission errors, although it was actually much higher. According to the data from the local health authority, there is are around 120 to 170 new infections per 100,000 inhabitants within seven days. For the whole of Spain, the value is currently given around 113.



GBR: As of next week, residents of Birmingham, will no longer be allowed to visit other households. The rule in England's second largest city with 1.1 million inhabitants should apply from today. The city's authorities had already tightened the corona rules this week and banned gatherings of more than six people from different households.



Subject in Focus

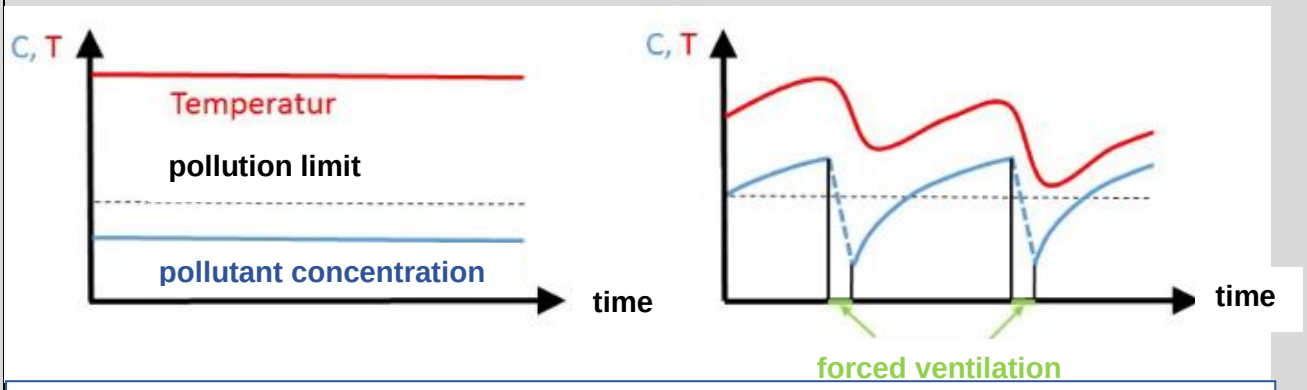
Risk of COVID-19 infections in rooms – Study on room air purifiers

Study on room air purifiers

The global development of the SARS-CoV-2 infection makes it clear that the pandemic is only just beginning and cannot be stopped. Even if an effective and well-tolerated vaccine were available, extensive vaccination of the world's population to combat the spread of the virus would not be feasible. It is therefore necessary to establish technical solutions to contain the pandemic. Therefore scientist of the Bundeswehr University in Munich raised one question:

Can mobile room air purifiers effectively reduce an indirect SARS-CoV-2 risk of infection from aerosols?

Mouth and nose covers are now generally recognized technical aids to reduce the direct risk of infection when speaking, singing, coughing and sneezing. The indirect infection via infectious aerosols, which accumulate in the room over time, cannot be prevented with mouth and nose covers. Particle-filtering respiratory protection masks are required for this, as has already been shown in another study. Alternatively, there is the option of separating the aerosol concentration in the room by filtering it or removing it through the window ventilation. Ventilation systems that reliably separate aerosols with a diameter of less than 1 µm (micrometer) are rare. Free ventilation through windows is often not efficient and no longer possible in winter at the latest without wasting energy and endangering people's health and well-being.



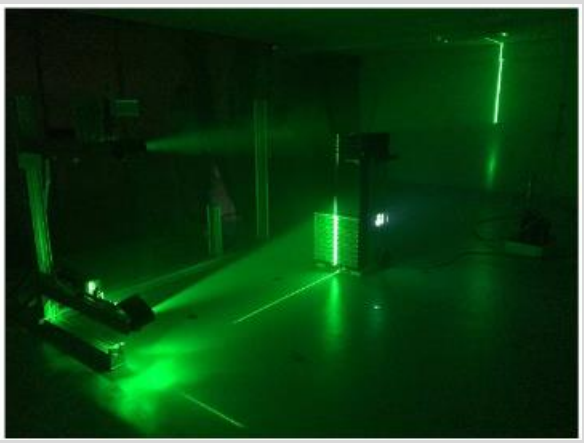
Schematic representation of the pollutant concentration and the temperature profile in a room with air conditioning system (left) and shock ventilation (right)

The main advantage of air conditioning systems compared to free ventilation is that they continuously ensure adequate indoor air quality and regular manual regulation using windows is no longer necessary. However, they must be maintained regularly and operated correctly. For energy reasons, they are often only operated with a small supply of fresh air and simple filters. To prevent indirect infections, however, a sufficient supply of fresh air or very good filtering of the room air is necessary. With burst ventilation, the existing pollutant concentration in the room can be greatly reduced within a short time under suitable wind conditions or temperature differences, but after closing the window the pollutant concentration increases again gradually, as shown in the diagram. In order to keep the concentration of pollutants at a low level, it is therefore often necessary to force ventilate the room or, better, keep it permanently ventilated. Cross ventilation is most effective in suitable weather conditions, but it can also quickly become uncomfortable. A tilted window, on the other hand, usually does not lead to any significant air exchange in the room. Under these conditions, it is advisable to open two windows and place a fan in front of one window, which allows fresh air into the room from outside.

It is difficult to determine which type of ventilation offers the best protection against indirect SARS-CoV-2 infection, since the number of viruses emitted or the virus concentration and thus the likelihood of infection in a room is not known. Since there is no correlation between virus concentration and other parameters such as the CO2 concentration exists, the viral load cannot be measured indirectly via the CO2 content. For this reason, the highest possible air exchange rates should be aimed for in order to minimize the likelihood of infection.

The question is, therefore, whether the viral load can also be effectively minimized in buildings without air conditioning systems with class H13 / H14 filters (like mobile air purifier) or 100% fresh air supply without reducing comfort or accepting acute damage to health.

Scientists of the University of the Bundeswehr in Munich tried to answer this question. Therefore a TROTEC TAC V + room air purifier with a volume flow of up to 1500 m3 / h was systematically analyzed using laser measurement technology.



The room air purifier has a filter combination that ensures that 99.995% of aerosol with a diameter of 0.1 to 0.3 µm is separated from the room air.

Outcome

The quantitative measurement results show that with the tested TROTEC TAC V + room air purifier, due to the large volume flow and the class F7 + H14 filter combination, the aerosol concentrations can be halved in 6-15 minutes, even in rooms with an area of 80 m^2, depending on the volume flow. In rooms with 20 m^2, halving is achieved in 3 - 5 minutes, depending on the volume flow. It is therefore possible with room air purifiers to keep the aerosol concentration at a low level in small and medium-sized rooms without any problems.
In large rooms, rooms with many objects or very unfavorable geometries, several room air purifiers should be used to filter all areas of the room quickly and to keep the virus load low everywhere so that there is no indirect risk of infection.

In order to filter the room air as effectively as possible, the room air cleaner should be positioned on the longest side of the room in the middle. Furthermore, the ceiling area should not be interrupted by objects in the direction of the outflows, as otherwise the spread of the filtered air is disturbed and unfavorable eddy currents can establish in the room. If the operating conditions are unfavorable, the volume flow can be increased to ensure adequate filter performance.

A major advantage of room air purifiers is that they permanently ensure a low virus load without having to worry about opening windows and without affecting the well-being in the room. Furthermore, in contrast to free ventilation with windows, they also ensure that there is a real reduction in the virus load, which can often not be guaranteed with open windows. They also offer the advantage over air conditioning systems permanently integrated in buildings that are operated with little or no fresh air in that the viruses are really separated and not distributed in the building through ventilation shafts.

So that the analyzed room air purifier does not turn into a "virus spinner", it can be set so that the H14 filter is heated to around 100 ° C for approx. 30 minutes a day in order to destroy the viruses in the filter and prevent the development of biofilms, bacteria and Counteracting fungi without harmful chemical additives or UV-C radiation.

Air purifiers could be a solution for schools and offices
As a result of the scientific investigations, it is clear that room air purifiers with a large volume flow and high-quality filters of class H14 are a very useful technical solution to reduce the indirect risk of infection in schools, offices, shops, waiting rooms, community and club houses, lounges and dining rooms, etc. greatly reduced by aerosols. However, they can also be used as a support in buildings

	with ventilation and air conditioning systems, in which people stand together (waiting area) and work together or in which a lot of aerosol is emitted due to the workload, such as fitness studios. **Mouth and nose protection is still necessary** Room air purifiers are therefore suitable tools for countering the indirect risk of infection from contamination in the room, but it should be noted that they cannot reduce the direct risk of infection that can result from coughing up directly or from long conversations over short distances. It is therefore important, even with room air filters, to ensure that there is sufficient distance from other people and to wear mouth and nose covers or particle-filtering respiratory protection masks so that, in addition to indirect infection from aerosols in the room, direct infection over short distances through coughing or longer conversations can be safely avoided. Source: Prof. Christian Kähler, Dr. Rainer Hain und Thomas Fuchs, Institut für Strömungsmechanik und Aerodynamik, Fakultät für Luft- und Raumfahrttechnik, UniBw München: https://www.unibw.de/home/news-rund-um-corona/corona-infektionsgefahr-in-raeumen https://www.unibw.de/lrt7/raumluftreiniger.pdf

Conflict and Health

COVID-19 Crisis in Afghanistan

Afghanistan

Area:	652.864 km^2
Population:	34.940.837
Capital:	Kabul
Age structure:	
0-14 years:	40.92%
15-24 years:	21.85%
25-54 years:	30.68%
55-64 years:	3.95%
65 years and over:	2.61%%

Source: Wikipedia; Indexmundi.com

CONFLICT:

Afghanistan is a geopolitically significant interface at the connection between Central and South Asia. The country, also known as the “graveyard of empires”, is shaped by different ethnic groups and cultural influences, with the Persian-born people of the Pashtuns from a historical point of view being considered to be state-supporting and thus setting the tone. The population lives predominantly within tribal associations that are patriarchally led by individual clan chiefs. Ethnic affiliation plays a major role in the strongly hierarchically organized AFG society, which also influences the political landscape. The country is deeply marked by an ongoing series of wars and occupations; up to now every great power has failed to pacify AFG. Since 2001, an international coalition led by the USA has been waging war against the radical Islamic Taliban, whose predecessors, the Mujahideen, had funded and trained them as allies against the Soviet Union during the Cold War. After the end of the Soviet occupation in 1989, a power vacuum developed that ultimately culminated in a bloody civil war between the rival tribal factions. The Islamic State of Afghanistan was proclaimed for the first time in 1992; with the help of the Pakistani government, the Taliban were able to capture the capital Kabul in 1996 and proclaim a de facto state of God based on Sharia law. The regime developed into a point of attraction for religious warriors, especially of Arab nationality, Bin Laden also sought refuge in AFG. After the attacks of September 11th, the patience of the international community was finally exhausted, the UN sanctioned an intervention through a mandate, the international Afghanistan protection force ISAF marched in and formed, which in 2002 authorized a transitional government. Since then the conflict has continued to smolder.
After no significant improvement in the security situation could be achieved in almost 20 years, the government, which has now largely been democratically legitimized, and the US, as the leader of the coalition, were forced to conclude a peace treaty with the Taliban at the beginning of 2020. The withdrawal of international troops has thus been decided, the situation in the country remains tense and is characterized by attacks and acts of war. The internal peace process is also making slow progress due to the tribal structures and rival political factions.

HEALTH:

The Afghan health system is one of the most underdeveloped on earth (see left). The war, which lasted four decades, razed every previously existing medical infrastructure to the ground. The system suffers from shortages of all kinds, be it manpower or material. Only about 1 in 4 Afghans have access to adequate health care, as both the security situation and the general regional distribution of

health facilities can at best be described as problematic. In addition to kinetic trauma of all kinds and psychiatric stress, poverty-related diseases represent the greatest risk for the population. Infectious diseases that are comparatively easy to treat are still widespread, and even before the pandemic broke out, more than 14 million people in the country were acutely affected by Malnutrition threatened. The World Bank estimates that one in 10 children dies before they reach the age of 5.

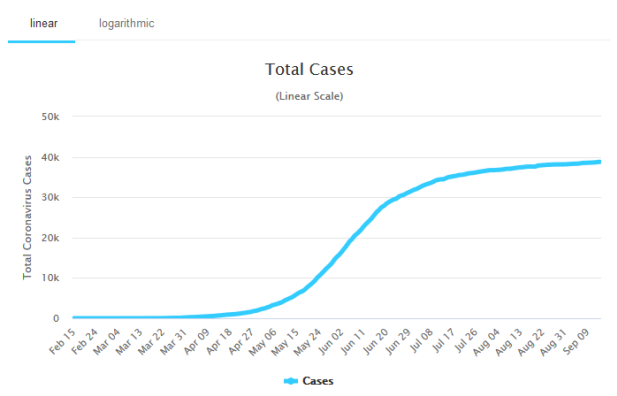
COVID-19 situation:

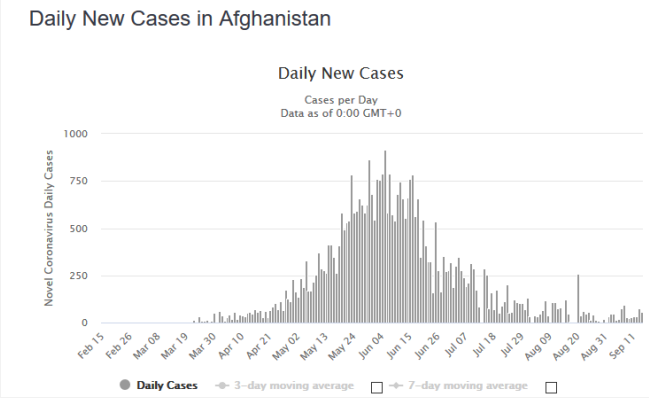
The first positive COVID-19 case in Afghanistan was confirmed in Herat on February 24, 2020. On March 22, 2020 there were already 34 cases tested positive and the first official death of an Afghan due to COVID-19 was confirmed. By March 29, 2020 there were a total of 120 COVID-19 tested positive Cases and four confirmed deaths in Afghanistan.

On May 2, 2020, General and former commander of the Afghan National Police Munir Mangal, the highest-ranking person in Afghanistan, died in Kabul.

Currently they have 38 802 cases, 32 081 recovered and 1 425 death with 278 daily reported new cases. According to the ministry, the infection rate would be particularly high in the capital and four-million-inhabitant metropolis of Kabul at an estimated 50 percent. For the extrapolation, one young and one old family member were randomly identified from 5760 families in the 34 provinces of Afghanistan and tested for antibodies. Then the results were extrapolated to the total population. The study method is internationally recognized. It can be assumed that 10 million people have already been infected with the novel coronavirus since February.

Test capacities: only 100 people can be tested per day. Kabul is the only City with the permanently functioning laboratory. In case of contamination they have also Laboratories in Kadahar and Nagahar.





The admission exams for universities took place last month in the country that was extremely hard hit by COVID-19. Around 210,000 prospective students took part in the written selection tests, which, due to the pandemic and the necessary social distancing measures, took place mostly outdoors. Many correspondents report that there is a noticeably high proportion of women among the participants who spent several hours outdoors wearing everyday masks at temperatures of up to 40 ° C in order to secure a place at the university and thus access to education and a life that was as self-determined as possible.

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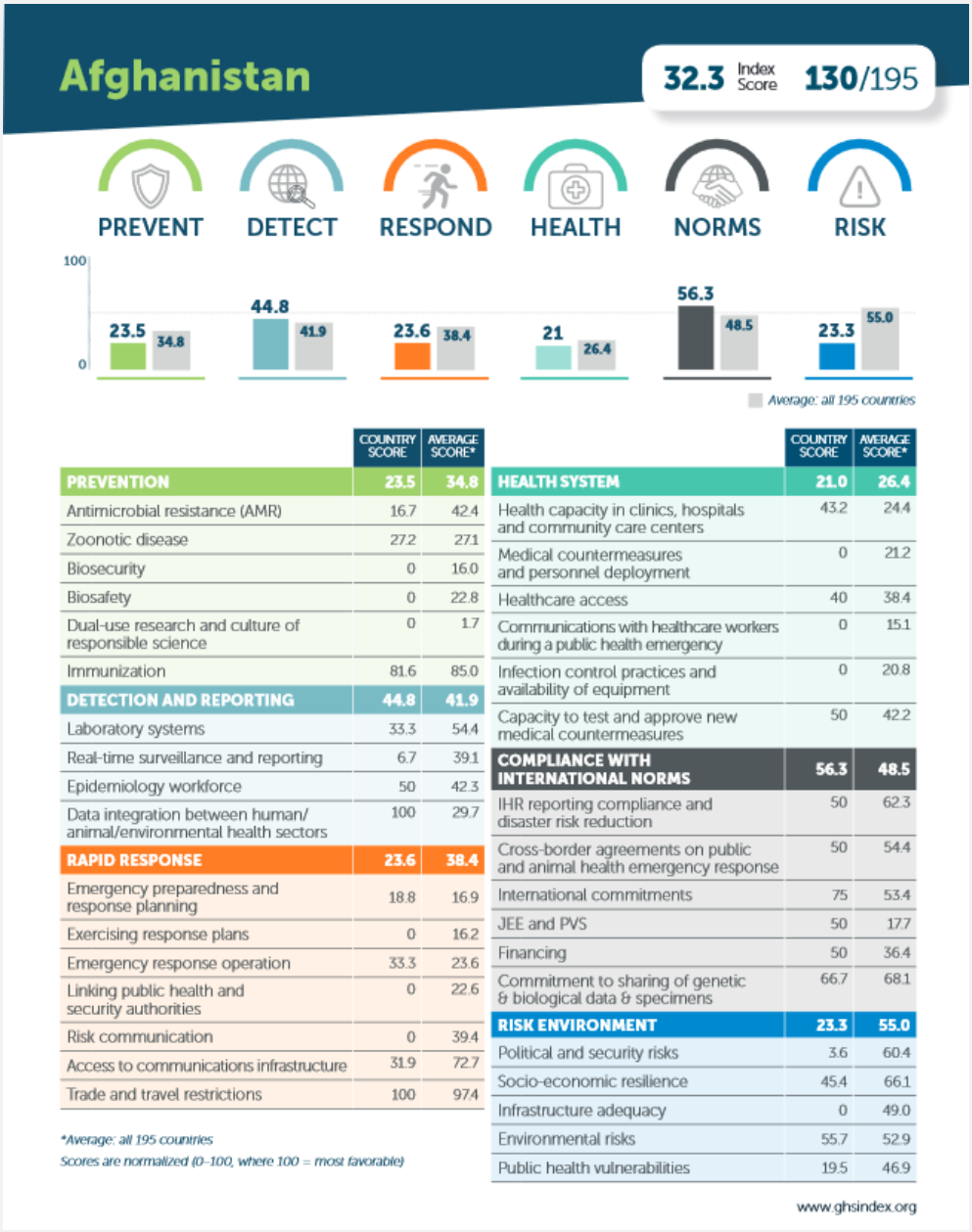
CONCLUSION:

The COVID-19 pandemic hits the country at an extremely critical time and will massively exacerbate any existing problems. Food prices have risen by almost a quarter, and many families are faced with the impossible decision to follow the lockdown and starve to death or risk contracting SARS-CoV-2. The Taliban pretend to have contained the disease in the areas they control. However, due to the ongoing fighting, coordinated measures to combat the outbreak are more than unlikely. In addition, high-ranking representatives of all conflicting parties affected by the disease, which leads to the advancement of a new, younger management team with still unclear motives and could endanger the peace process.



	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**23.5**	**34.8**
Antimicrobial resistance (AMR)	16.7	42.4
Zoonotic disease	27.2	27.1
Biosecurity	0	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	81.6	85.0
DETECTION AND REPORTING	**44.8**	**41.9**
Laboratory systems	33.3	54.4
Real-time surveillance and reporting	6.7	39.1
Epidemiology workforce	50	42.3
Data integration between human/animal/environmental health sectors	100	29.7
RAPID RESPONSE	**23.6**	**38.4**
Emergency preparedness and response planning	18.8	16.9
Exercising response plans	0	16.2
Emergency response operation	33.3	23.6
Linking public health and security authorities	0	22.6
Risk communication	0	39.4
Access to communications infrastructure	31.9	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**21.0**	**26.4**
Health capacity in clinics, hospitals and community care centers	43.2	24.4
Medical countermeasures and personnel deployment	0	21.2
Healthcare access	40	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	0	20.8
Capacity to test and approve new medical countermeasures	50	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**56.3**	**48.5**
IHR reporting compliance and disaster risk reduction	50	62.3
Cross-border agreements on public and animal health emergency response	50	54.4
International commitments	75	53.4
JEE and PVS	50	17.7
Financing	50	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	**23.3**	**55.0**
Political and security risks	3.6	60.4
Socio-economic resilience	45.4	66.1
Infrastructure adequacy	0	49.0
Environmental risks	55.7	52.9
Public health vulnerabilities	19.5	46.9

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

www.ghsindex.org

Source:
https://www.powellandbarnsmedia.com/post/hundreds-of-afghan-students-took-the-university-entrance-test-on-a-huge-beach
https://de.wikipedia.org/wiki/Afghanistan#/
https://www.crisisgroup.org/asia/south-asia/afghanistan/covid-19-afghanistan-compounding-crises
https://reliefweb.int/sites/reliefweb.int/files/resources/daily_brief_covid-19_7_june_2020.pdf
https://applications.emro.who.int/dsaf/EMROPUB_2016_EN_18925.pdf?ua=1&ua=1
https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930643-7
https://www.unhcr.org/dach/de/42159-covid-19-mehr-unterstuetzung-fuer-afghanistan-und-seine-nachbarlaender-benoetigt.html

MilMed CoE VTC COVID-19 response

Topic	The NATO Centre of Excellence for Military Medicine is putting its expertise and manpower to aid in any way possible during the pandemic. The VTC is for interested participants (experts) to exchange experiences, management regulations and restrictions due to COVID-19. We would like to propose just one of the most important topics in the next iteration. We will have some experts giving a short briefing and then afterward we will have time for questions and experiences as well as a fruitful discussion. **Topics former VTCs:** • Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities. • Testing strategies • Aeromedical evacuation • De-escalation strategy and measures • Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases • Immunity map, national strategies to measure and evaluate the immunity level” • Mental Health • Treatment of mild symptomatic cases of COVID-19 • Transition home office back to the office • COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation • Perspectives of the current COVID-19 vaccine development • National overview on current COVID-19 situation
National overview on current COVID-19 situation	COVID-19 VTC was remerged 10th September 2020 after the summer break. Starting with the topic “National overview on current COVID-19 situation". Briefers from UK, FRA, ITA, BEL and USA reported on the current situation in the countries. Summary: - In all countries case numbers arose over the last weeks - Age distribution shifted to younger people - ICU´s seems to be relieved in all countries - Mostly cluster outbreaks occure - Studies about long-term effects are implemented in some countries, up to 20% of infected service people showed after-effects Next VTC will be on Wednesday 23rd of September.

Recommendations

Recommendation for international business travellers

As of 15th September 2020

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.

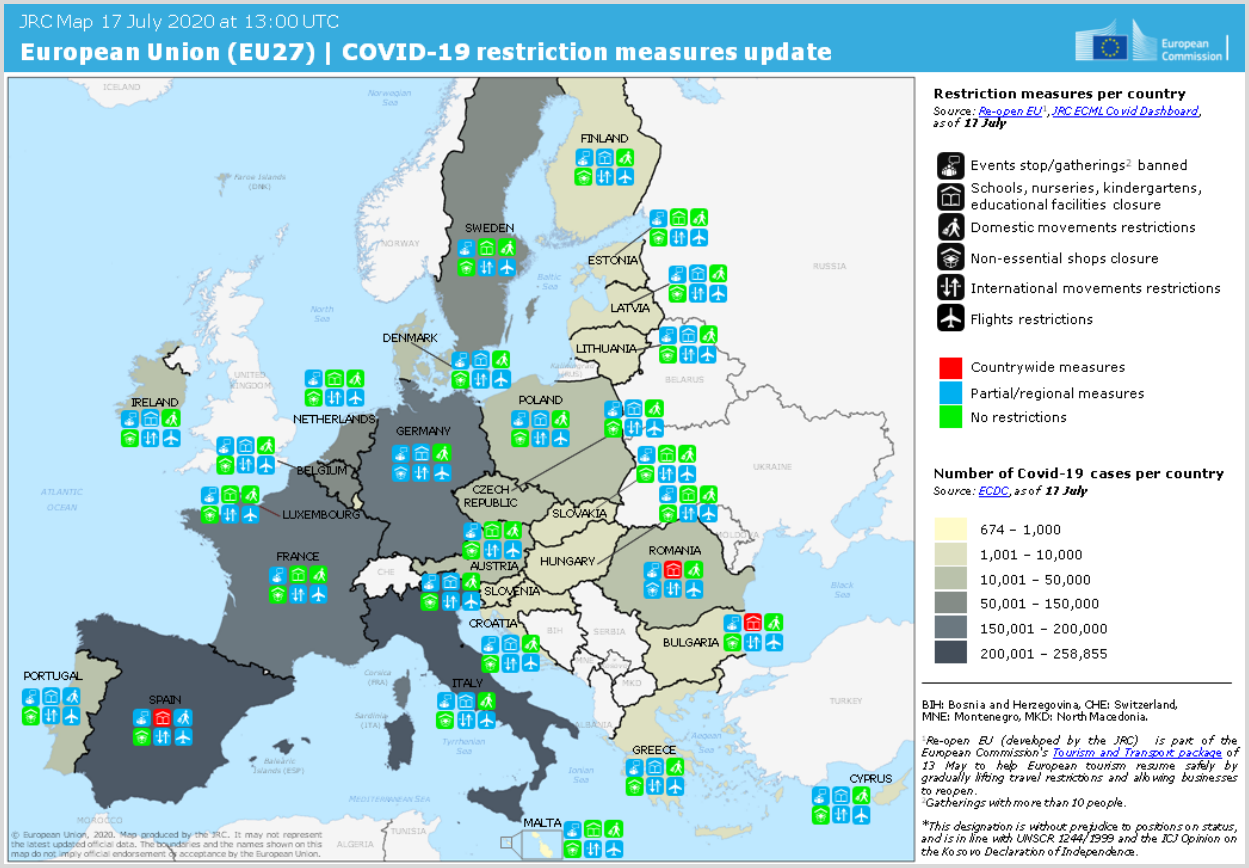
Travel advice and Border measures
Travel advice is a national competence and you should check if your national authority, e.g. the Ministry of Foreign Affairs, has issued an official travel warning concerning your planned destination. Travel advice is continuously updated as the situation evolves.

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 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. While the restrictions on non-essential travel and their lifting depend on the traveller's place of residence, the visa requirement continues to depend on nationality. If a traveller resides in a country where restrictions have been lifted, but is a national of a visa-required country, he or she must apply at the consulate of the Member State to which he wishes to travel to, in his or her country of residence. For all other third countries not on this list, Member States and Schengen Associated countries are temporarily suspending all non-essential travel from those third countries to the EU+ area, meaning that only certain categories of travellers could be authorised for entry. The "EU+ area" includes 30 countries: 26 out of the 27 EU Member States as well as the four Schengen Associated States: Iceland, Liechtenstein, Norway and Switzerland. Ireland does not currently apply the travel restriction. Travel restrictions aim to reduce the number of travellers entering the European Union. The aim is to restrict the spread of the coronavirus and protect public health within the EU, as well as to prevent the virus from spreading from the EU to other countries. As the epidemiological situation in and outside the EU evolves and travel restrictions at the EU's external borders gradually start to be lifted, visa operations will also resume gradually. On 11 June 2020, the Commission published a Guidance for a phased and coordinated resumption of visa operations. The rules for applying for a short-stay visa remain unchanged. Member States' consulates and external service providers will, however, have adapted practical aspects of access management, hygiene measures, payment methods etc. Appropriate information on the procedure to follow for lodging an application should be provided to applicants. Information on travel restrictions in place should be available on the websites of the relevant national authorities (e.g. Ministries of Interior and Foreign Affairs). A daily summary of flight and passenger restrictions is available on the Eurocontrol website and is entitled 'Covid Notam (notice to airmen) summary'. **Exemption from travel restriction** The following categories of persons are exempt from the temporary travel restriction to the EU+ area from the third countries which are not on the list agreed by the Member States: a) Union citizens within the meaning of Article 20(1) TFEU and third-country nationals who, under agreements between the Union and its Member States, on the one hand, and those third countries, on the other hand, enjoy rights of free movement equivalent to those of Union citizens, as well as their respective family members15; b) third-country nationals who are long-term residents under the Long-term Residence Directive or deriving their right to reside from other EU Directives or national law or who hold national long-term visas, as well as their respective family members. The temporary travel restrictions should also not apply to people with an essential function or need, including: • healthcare professionals, health researchers, and elderly care professionals • frontier workers • seasonal workers in agriculture • transport personnel • Diplomats, staff of international organisations and people invited by international organisations whose physical presence is required for the well-functioning of these organisations, military personnel and humanitarian aid workers and civil protection personnel in the exercise of their functions; • passengers in transit • passengers travelling for imperative family reasons • seafarers • persons in need of international protection or for other humanitarian reasons; • third-country nationals travelling for the purpose of study;

- highly qualified third-country workers if their employment is necessary from an economic perspective and the work cannot be postponed or performed abroad.



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

Risk Assessment	
Global	• Because of global spread and the human-to-human transmission the **moderate to high** risk of further transmission persists. • Travellers are at risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks. • Individual risk is dependent on exposure. • National regulation regarding travel restrictions, flight operation and screening for single countries you will find here. • Official IATA changed their travel documents with new travel restrictions. You will find the documents here. • Public health and healthcare systems are in high vulnerability as they already become overloaded in some areas with elevated rates of hospitalizations and deaths. Other critical infrastructure, such as law enforcement, emergency medical services, and transportation industry may also be affected. Health care providers and hospitals may be overwhelmed. • 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 As of 10th of August 2020	ECDC assessment for EU/EEA, UK as of 10 August 2020 (still valid): **Risk of COVID-19 across all EU/EEA countries and the UK:** • 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 of enforce multiple measures, including physical distancing, and have sufficient contact tracing and testing capacity. **Risk of COVID-19 in the countries that have reported a recent increase of cases:** • 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.europe.eu
- World Health Organization WHO; www.who.int
- Centres for Disease Control and Prevention CDC; www.cdc.gov
- European Commission; https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en
- Our World in Data; https://ourworldindata.org/coronavirus

- Morgenpost; https://interaktiv.morgenpost.de/corona-virus-karte-infektionen-deutschland-weltweit/

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