



Update 39 (29<sup>th</sup> of September 2020)

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



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

**29th 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 30<sup>th</sup> January 2020 WHO declared a Public Health Emergency of International Concern. The disease was formally named COVID-19 on 11<sup>th</sup> of February. The virus itself has been named SARS-CoV-2. On 11<sup>th</sup> of March 2020 WHO characterized the disease as a pandemic.

## HIGHLIGHTS/NEWS

- COVID-19 accounts for nearly 33 million cases and one million deaths in 9 months.
- **WHO** wants to distribute 120 million test kits to low-income countries with insufficient health care capacities. The restricted infrastructure there often leads to an above-average time interval between testing and results, which leads to increased transmission within the population. The test method used should deliver a result after 15-30 minutes and is priced at around \$ 5 per kit.
- **WHO**: A total of 67 higher income economies have joined the COVAX Facility, with another 34 expected to sign, joining 92 low- and middle-income economies eligible for support for the procurement of vaccines.
- **WHO**: published the [Emergency Global Supply Chain System \(COVID-19\) catalogue](#), which lists all medical devices, including personal protective equipment, medical equipment, medical consumables, single use devices, laboratory and test-related devices that may be requested through the [COVID-19 Supply Portal](#).
- **WHO/UN**: launched a Video on "[The story of Italy's COVID-19 experience](#)". Both organizations praise the Italian way of dealing with the virus: The first western country to be hit hard by the pandemic has met it successfully and could become a role model for combating it.
- **ECDC**: published the twelfth update of [the Rapid risk assessment: Increased transmission of COVID-19 in the EU/EEA and the UK](#).

### GLOBALLY

33 339 352  
confirmed cases  
23 168 650 recovered  
1 001 824 deaths

### EU/EEA and the UK

5 220 565  
confirmed cases  
2 676 750 recovered  
229 171 deaths

### USA → (new cases/day 35 354)

7 096 797  
confirmed cases  
2 791 567 recovered  
204 360 deaths

### Brazil ↘ (new cases/day 14 318)

4 745 464  
confirmed cases  
4 197 372 recovered  
137 272 deaths

### India → (new cases/day 82 170)

6 145 291  
confirmed cases  
5 101 397 recovered  
96 318 deaths

### Russia ↗ (new cases/day 8 026)

1 154 299  
confirmed cases  
942 619 recovered  
20 299 deaths

### Spain ↗ (new cases/day 31 785)

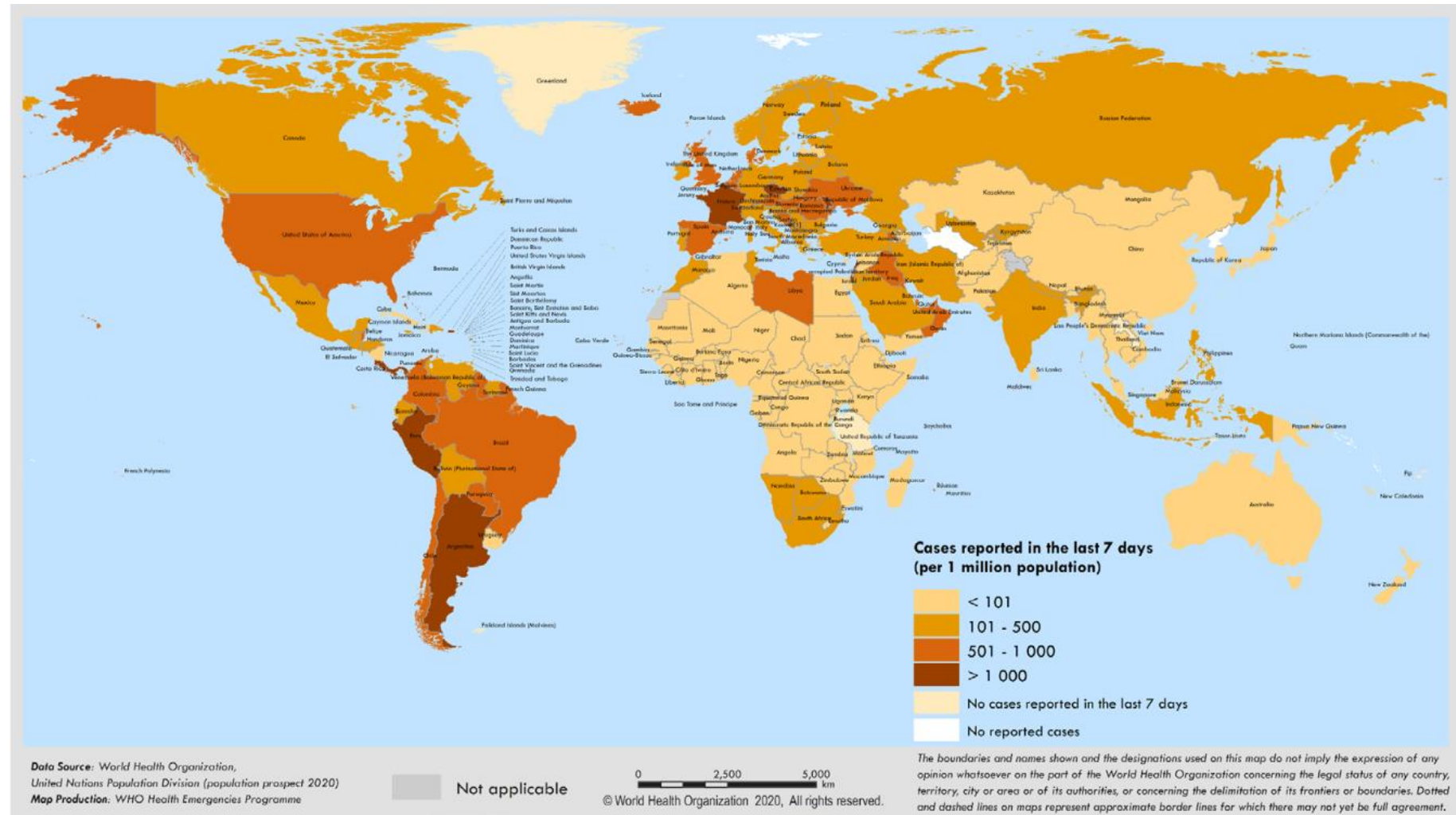
748 266  
confirmed cases  
150 376 recovered  
31 411 deaths

Please click on the headlines to jump into the document

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

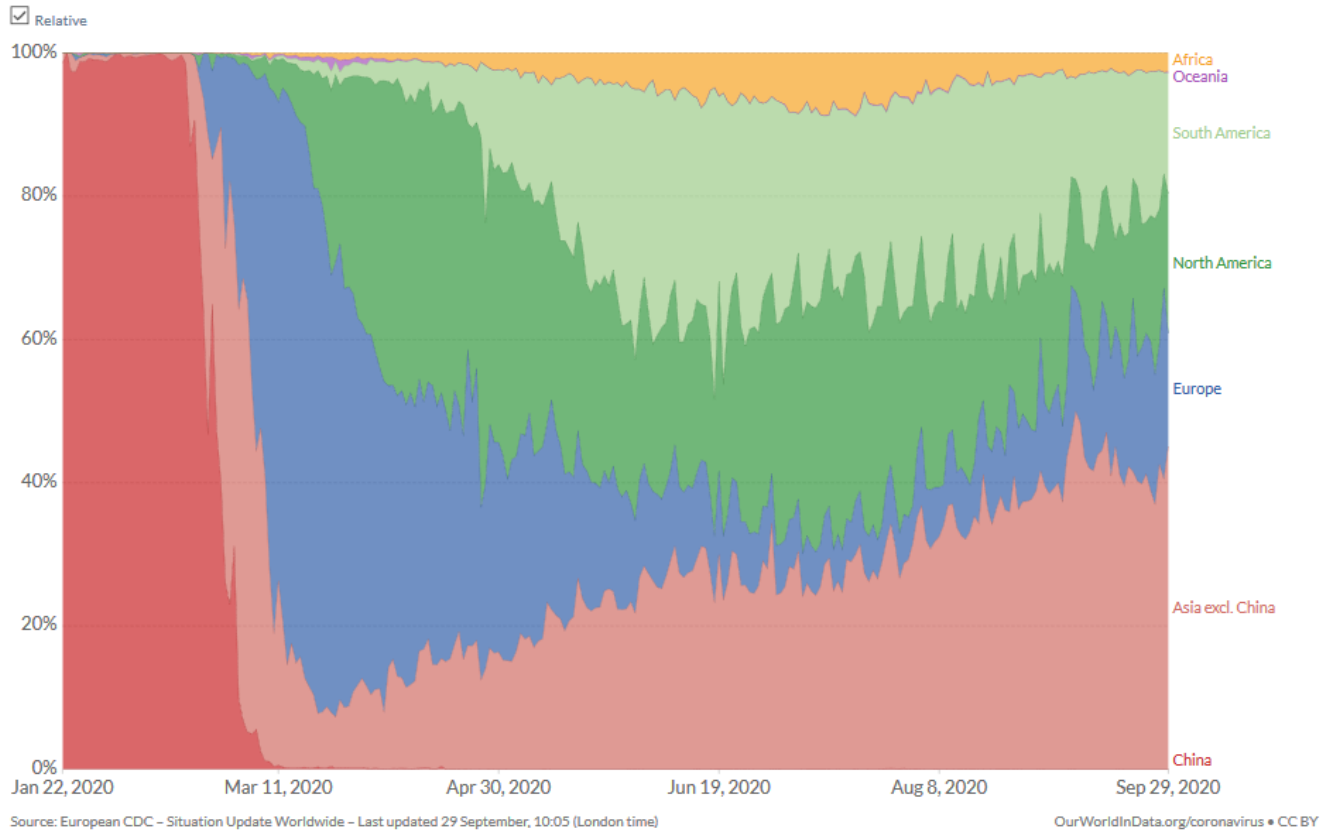


## Worldwide Situation

### Global Situation

#### Daily confirmed COVID-19 cases

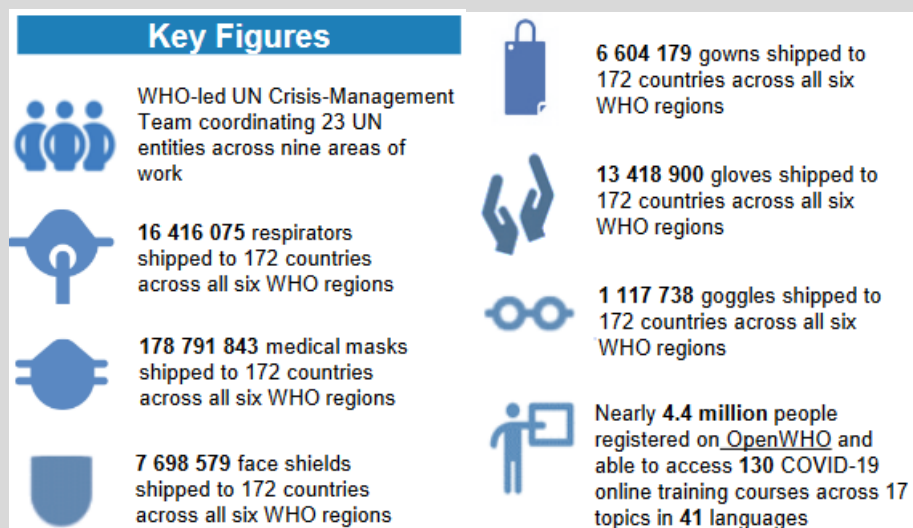
The number of confirmed cases is lower than the number of total cases. The main reason for this is limited testing.



#### WHO weekly operational update on COVID-19 as of 25 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:



## COVID-19 Preparedness

There will be a United Nations General Assembly (UNGA) Side Event on “[Sustainable preparedness for health security and resilience: Adopting a whole-of-society approach and breaking the “panic-then-forget” cycle](#)” on **1 October 2020 from 1300H – 1430H CET**.

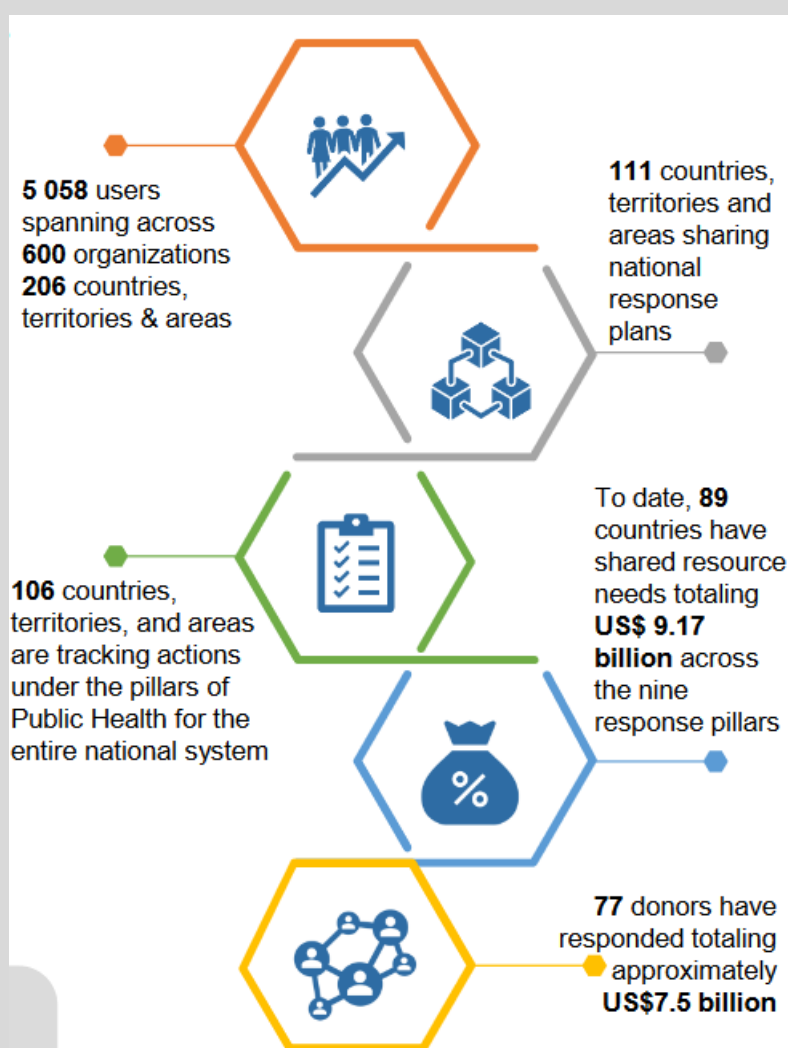
This meeting will bring together Ministers of Health and beyond, UN agencies, partners and donors interested and involved in public health emergency preparedness and response. It will capture good practices and lessons learnt in countries, explore innovative ways to address challenges, and seize opportunities and advances made during the COVID-19 pandemic to build better preparedness against future health threats.

Key objectives of the session are to:

- Highlight experiences and lessons learnt by countries in emergency preparedness before and during the COVID-19 pandemic;
- Advocate for long-term, sustainable emergency preparedness through diplomacy, investments, capacity building and health system strengthening;
- Advocate applying a whole-of-society approach in countries for sustainable emergency preparedness through effective multisectoral collaboration and community engagement.

## COVID-19 Partners Platform

The COVID-19 Partners Platform, developed collaboratively by WHO and the United Nations Development Coordination Office (UNDCO), is the first digital platform where governments, UN agencies, and partners can plan and coordinate together in one place, in real-time, for an acute event.



## Operations Support and Logistics

The table below reflects WHO-produced items that have been shipped to date. For further information on the COVID-19 supply chain system, see [here](#).

Shipped items as of 25 September 2020	Laboratory supplies		Personal protective equipment					
Region	Swabs	Tests (Manual PCR)	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	2,416,785	1,040,646	995,407	596,300	145,261	997,879	44,741,633	1,576,364
Americas (AMR)	6,960	13,478	3,820,501	88,000	301,180	3,918,770	54,175,110	7,225,456
Eastern Mediterranean (EMR)	607,460	1,020,970	790,085	4,911,000	116,260	398,522	24,677,550	1,207,995
Europe (EUR)	175,380	404,600	1,704,850	7,190,100	374,720	985,048	38,631,500	5,126,950
South East Asia (SEAR)	1,299,200	1,585,800	87,336	414,500	82,150	217,450	5,406,300	353,075
Western Pacific (WPR)	90,800	240,864	300,400	219,000	98,167	86,510	11,159,750	926,235

### WHO weekly epidemiological report, 27 September 2020

#### *Global epidemiological situation*

To date, over 32.7 million COVID-19 cases and 991,000 deaths have been reported to WHO. During the week of 21–27 September, there were more than 2 million new cases and 36,000 new deaths reported, which is comparable to the numbers reported in the previous week. Cumulative deaths are expected to exceed one million in the coming week.

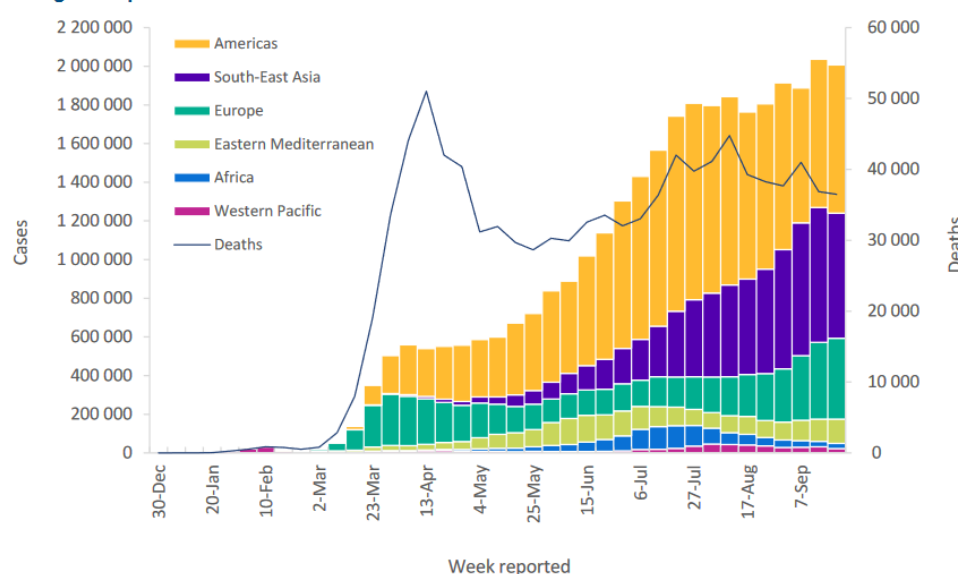
The **Region of the Americas** continues to carry the highest incidence of COVID-19 globally, reporting similar numbers of new cases and deaths as the previous week. The Region accounts for 38% of all new cases and 52% of all new deaths reported in the past seven days.

The **Eastern Mediterranean** Region showed the greatest increase (9%) in cases in the past week, while the **European Region** reported a substantial rise in deaths, with a 9% increase compared to the previous week.

The **WHO African, Western Pacific and South-East Asia Regions** reported decreases in the new case and deaths over the past week



**Figure 1: Number of COVID-19 cases reported weekly by WHO Region, and global deaths, 30 December 2019 through 27 September 2020\*\***



**Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 27 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	766 526 (38%)	<1%	16 233 110 (50%)	19 027 (52%)	-1%	546 864 (55%)
South-East Asia	647 309 (32%)	-7%	6 720 771 (21%)	9 011 (25%)	-3%	110 711 (11%)
Europe	418 719 (21%)	5%	5 662 875 (17%)	4 547 (12%)	9%	234 681 (24%)
Eastern Mediterranean	124 482 (6%)	9%	2 340 215 (7%)	2 704 (7%)	3%	60 345 (6%)
Africa	26 945 (1%)	-7%	1 172 342 (4%)	724 (2%)	-14%	25 481 (3%)
Western Pacific	22 986 (1%)	-27%	600 891 (2%)	462 (1%)	-41%	13 129 (1%)
† Other	-	-	741 (<1%)	-	-	13 (<1%)
<b>Global</b>	<b>2 006 967 (100%)</b>	<b>-1%</b>	<b>32 730 945 (100%)</b>	<b>36 475 (100%)</b>	<b>-1%</b>	<b>991 224 (100%)</b>

\*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number, global totals may not equal 100%.

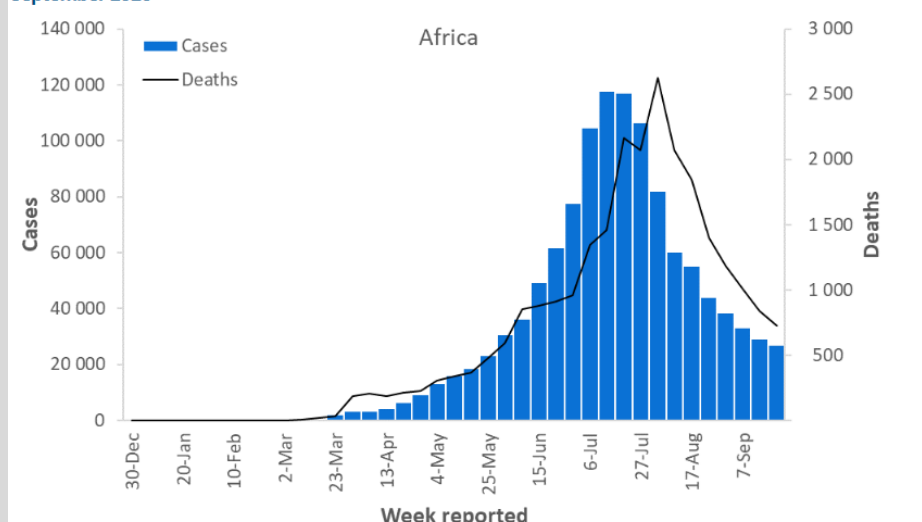
## **African Region**

The African Region continues its decreasing trend for the seventh week, reporting a 7% decrease in new cases and a 14% decrease in new deaths. During the past week, 33 of the 49 affected countries reported either a decrease in deaths or no deaths.

**South Africa** continues to report the highest number of new cases and new deaths followed by **Ethiopia**, **Uganda**, **Algeria** and **Mozambique**. South Africa also has the highest number of cumulative cases and deaths per one million population in the Region, followed by **Cabo Verde** which has reported increasing numbers of cases and deaths over the past month.

Cases in **Mozambique** have consistently increased over the last four weeks stretching the health system's capacity. More than half of the new cases (and total cases) are in the capital city, Maputo. Mozambique's overall case rate, however, remains relatively low: 248 cases per million population and two deaths per million population.

**Figure 3: Number of COVID-19 cases and deaths reported weekly by the WHO African Region, as of 27 September 2020\*\***



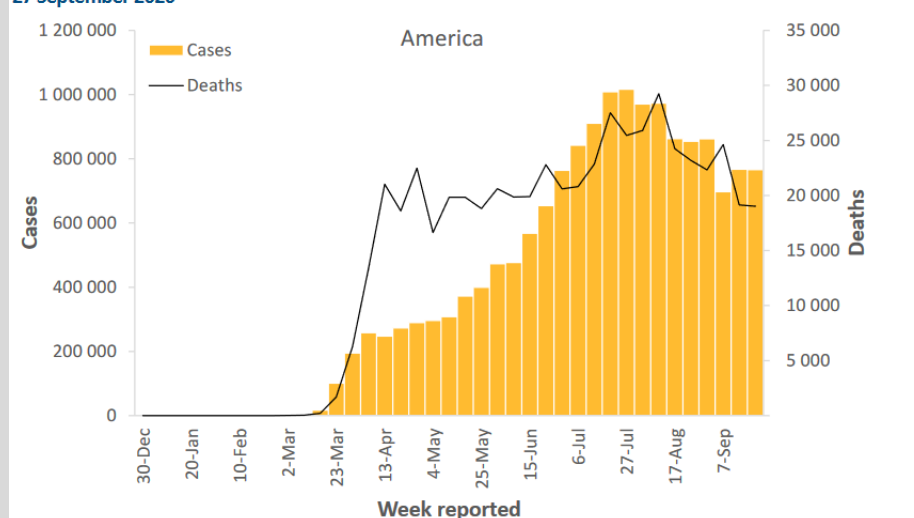
### Region of the Americas

The Region of the Americas remains the most affected WHO Region, accounting for 50% of all reported cases and 55% of deaths. The Region reported similar numbers of new cases and deaths this past week as compared to the previous week and accounts for 38% of new cases and 52% of new deaths.

The **United States of America, Brazil, Argentina** and **Colombia** continue to report the highest number of new cases in the past week.

**Mexico** reported the sixth highest number of new cases and third highest number of new deaths.

**Figure 4: Number of COVID-19 cases and deaths reported weekly by the WHO Region of the Americas, as of 27 September 2020\*\***



### Eastern Mediterranean Region

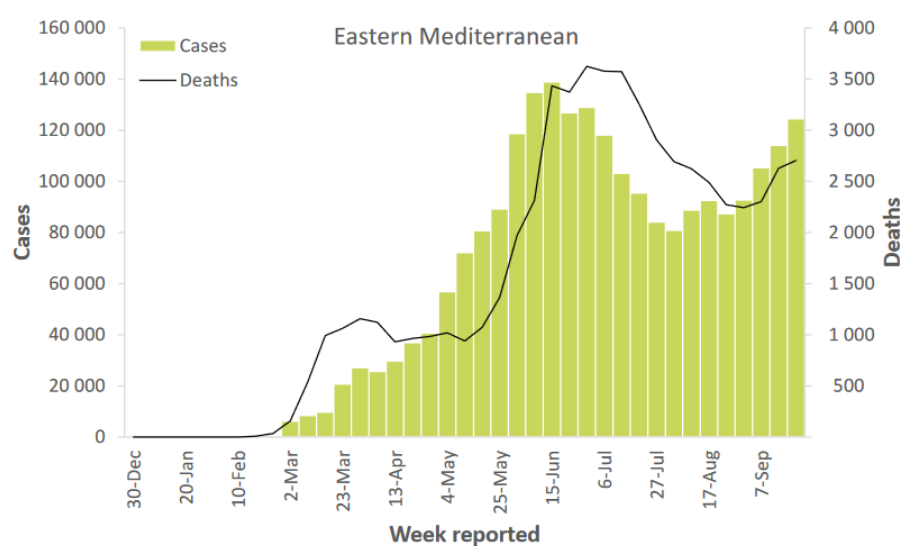
Over the past month, the number of new cases and deaths reported in the Eastern Mediterranean Region has consistently increased, with a 9% and 3% increase respectively.

The highest numbers of new cases were reported by **Iraq, Iran** and **Morocco**.

**Somalia, Jordan, United Arab Emirates** and **Tunisia** reported the greatest relative increase in cases compared to the previous week. While **Iraq** reported the highest number of new deaths, **Bahrain** and **Jordan** reported the greatest increase in deaths compared to the previous week.



Figure 5: Number of COVID-19 cases and deaths reported weekly by the WHO Eastern Mediterranean Region, as of 27 September 2020\*\*



### European Region

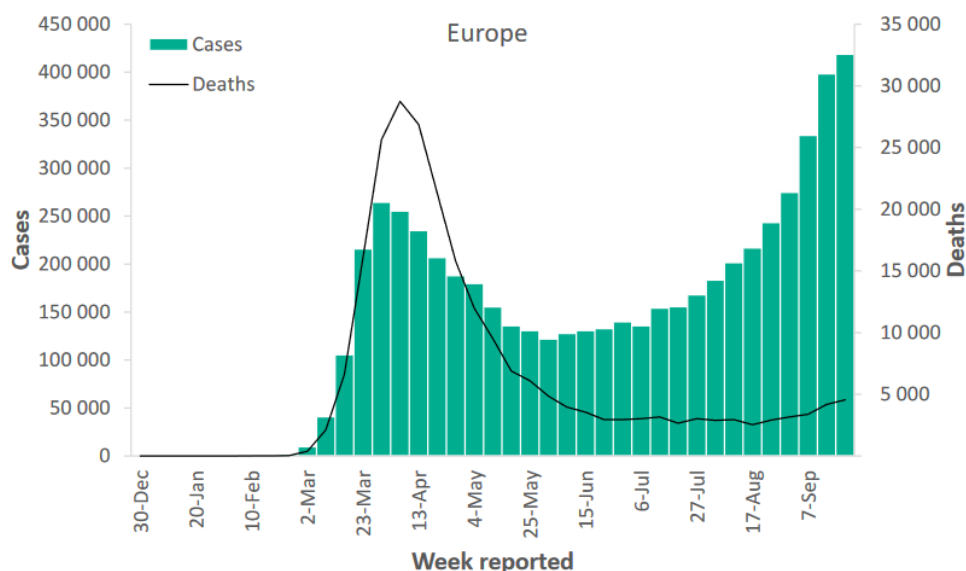
While the number of new cases and deaths reported in the European Region continued to increase in the past seven days, the rate slowed, with only a 5% increase in new cases and 9% increase in new deaths reported (compared to 11% and 27% increase, respectively, in the previous week).

**France, the Russian Federation, Spain** and the **United Kingdom** continue to report the highest numbers of new cases. **Turkey** reported the third highest number of deaths in last seven days after the **Russian Federation** and **Spain**.

In **France**, the highest 7-day incidence was observed in the regions of Île-de-France, Hauts-de-France and Provence-Alpes-Côte d'Azur – the latter including the city of Marseille, which has emerged as the epicenter of the country's second wave in recent weeks. While the number of hospitalized cases has doubled in the past 10 days, hospitalization numbers remain a magnitude smaller than observed earlier this year and hospital stays have tended to be shorter. Nonetheless, test positivity rates have continued to trend upwards (reaching 7.4% on 27 September), and 58/101 departments are now classified as a red zone indicating very high levels of infection.

In the **United Kingdom**, there has been an increase in the number of people testing positive for COVID-19 in all age groups, with the regions of Greater Glasgow and Clyde, the North West and the North East reporting the highest incidence in the past week. Wales has reported the highest rates of infection to date (727.7 per 100,000 population), followed by England (664), Northern Ireland (566.6) and Scotland (504.7).

Figure 6: Number of COVID-19 cases and deaths reported weekly by the WHO European Region, as of 27 September 2020\*\*

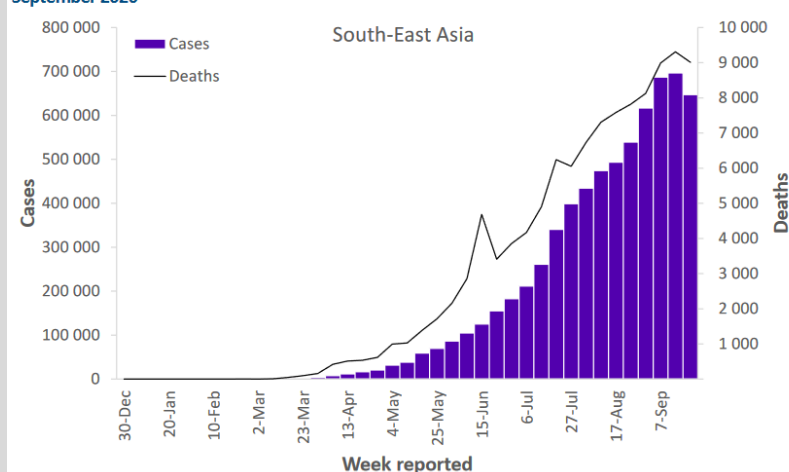


## South-East Asia Region

The South-East Asia Region is the second most affected Region, accounting for 21% and 11% of cumulative cases and deaths, respectively. While the Region had been reporting increasing cases and deaths since March, in the past week, a 7% decrease in new cases and a 3% decrease in new deaths were observed.

The countries reporting the highest number of new cases continue to be **India**, **Indonesia** and **Bangladesh**, while **Myanmar** reported the highest increase in cases (92% increase) and deaths (80% increase) compared to the previous week.

Figure 7: Number of COVID-19 cases and deaths reported weekly by the WHO South-East Asia Region, as of 27 September 2020\*\*



## Western Pacific Region

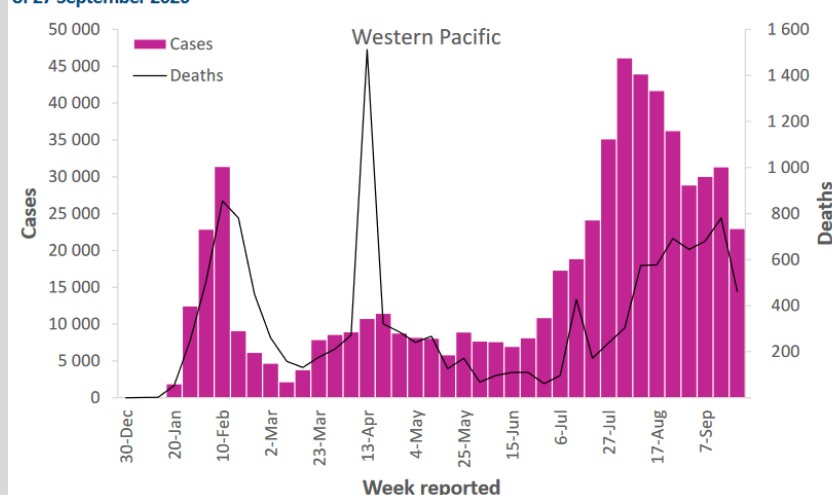
Overall, the Western Pacific Region continues to show the lowest cumulative cases, accounting for just 2% of global cases and 1% of all deaths.

The **Philippines** and **Japan** account for the highest number of new cases and new deaths in the Region.

All countries in the Region except **Malaysia**, **Papua New Guinea**, and **Guam** reported decreases in new cases, as compared to the previous week. Only **Malaysia** reported an increase in new deaths.

Incidence of COVID-19 in **Papua New Guinea** remains low. An 8-fold increase was reported in August (396 cases) compared to July (52 cases). The number of cases reported so far in September (73 cases) is lower but there may be other undetected cases since the testing and overall health care capacity in the country are limited.

Figure 8: Number of COVID-19 cases and deaths reported weekly by the WHO Western Pacific Region, data as of 27 September 2020\*\*



Updates from WHO regional offices:

WHO [AFRO](#)  
WHO [EMRO](#)  
WHO [EURO](#)

- WHO [PAHO](#)  
- WHO [SEARO](#)  
- WHO [WPRO](#)

## ISRAEL - NO RELAXATION IN SIGHT

The number of infections is rising rapidly in Israel. 119,026 cases have been reported in the last four weeks, which is more than 50 percent of the total 231,026 cases since the beginning of February. It's a sad record for the country that was touted for its pandemic management back in spring.

After the government was recently unable to lower the infection rate, it imposed a second lockdown. Stricter measures have been in effect since Friday: Only those people whose work is considered essential are still allowed to go to their workplace.

A tough test for a society that is exhausted and frustrated by months of restrictions in its social life, economic hardships and a governance that often seems erratic.

During the first curfew in the spring, nearly two-thirds of Israelis thought the measures were appropriate. This is shown by surveys by the Israel Democracy Institute (IDI), a liberal think tank.

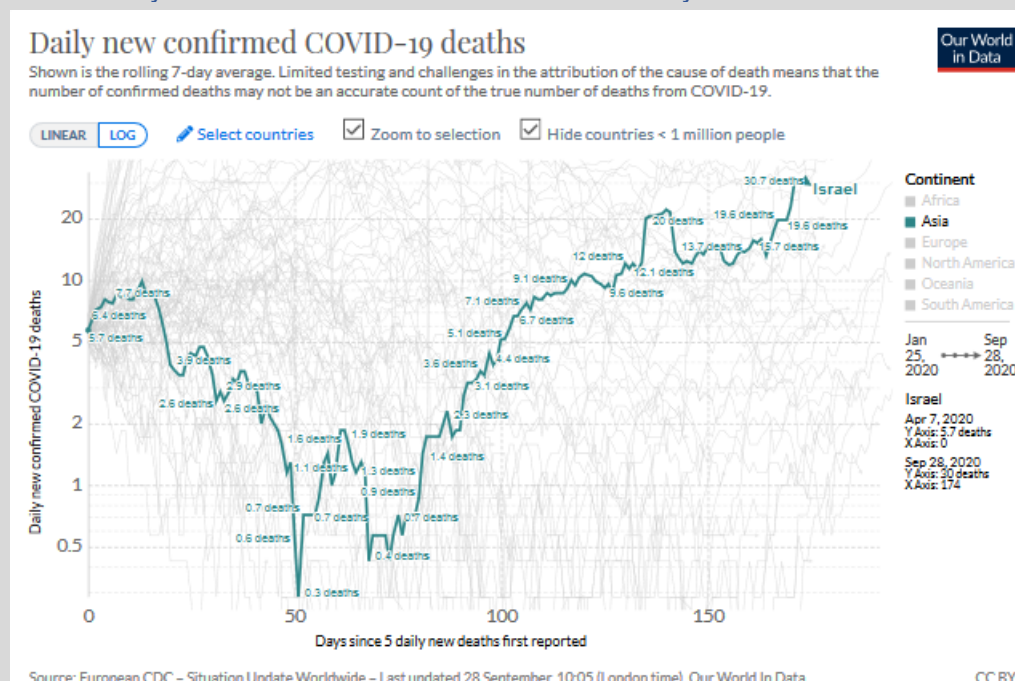
At that time, the government managed to push the number of infections into the marginal range. But the subsequent zigzag course with changing and often difficult to understand rules not only destroyed the first success, but also destroyed a lot of trust.

The economic crisis is also bothering many. According to the survey, 61 percent of Israelis are worried about their financial situation. The economic costs of the second lockdown are "huge", as even the state's Corona officer Ronni Gamzu has warned. He had unsuccessfully pleaded for less drastic measures.

Months ago, the government defined a red line: The health system could withstand 800 seriously ill with COVID-19. Not more. This red line will soon be crossed.

The virus is said to have been transmitted frequently in synagogues as well. So, the government decided to close them. But not on Yom Kippur, the holiest day of the year in Judaism.

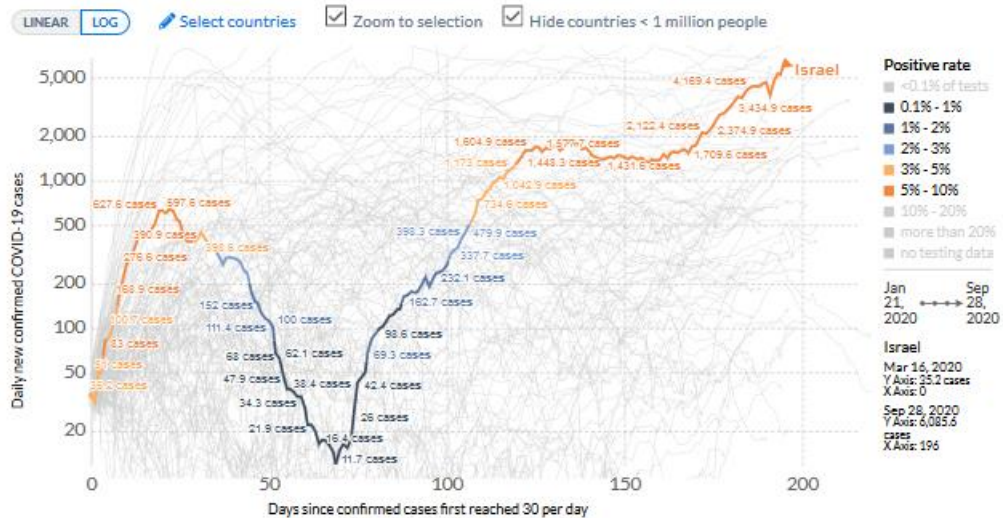
**Conclusion:** The population's compliance will be decisive for the further process. The population's trust which has been lost has to be regained and the religious groups, which up to now have not adhered to the prevention rules on principle have to be convinced. If this fails, the numbers will continue to rise and, as some epidemiologists predict, there will be further lockdowns. Israel may involuntarily take the Swedish route to herd immunity.



## Daily new confirmed COVID-19 cases

Shown is the rolling 7-day average. The number of confirmed cases is lower than the number of actual cases; the main reason for that is limited testing.

Our World in Data



Source: <https://www.bbc.com/news/world-middle-east-54278293>  
<https://www.ipost.com/health-science/coronavirus-lockdown-to-last-more-than-10-days-643808>  
<https://www.tagesschau.de/ausland/irael-iom-kippur-101.html>  
<https://www.tagesschau.de/ausland/israel-proteste-111.html>  
<https://ourworldindata.org/coronavirus/country/india?country=-ISR#what-is-the-cumulative-number-of-confirmed-cases>

**TUN:** For the first time since the beginning of the pandemic, Tunisia has registered more than 1,000 new corona infections within a single day. The Ministry of Health announced in Tunis on Saturday that 1,087 new corona infections were reported within 24 hours. Eleven people died. Wearing protective masks in public is now mandatory again. Health Minister Fausi Mehdi announced that everyone who tested positive would have to go to a hotel for quarantine. Mehdi said a return to stricter exit rules is also conceivable. In March, Tunisia imposed strict curfews, closed its borders and suspended international flights. Tunisia is suffering from a serious political and economic crisis. The corona pandemic has exacerbated the situation.

**USA: [Trump promises 'massive' expansion of coronavirus testing](#)**

Speaking from the White House, President Trump says he is announcing a "massive" and "ground-breaking" expansion of COVID-19 testing in the US. On testing, he says the US has conducted "far more than any other country". The president announced plans to distribute 150 million "rapid point of care" tests "in the coming weeks", which he claims are easy to use and take a maximum of 15 minutes to produce a result. 50 million of these will go to protect the most vulnerable communities, including 18 million kits that will be shipped to nursing homes, 15 million for assisted living facilities, 10 million for home health and hospice care and nearly one million for historically black colleges and universities, as well as tribal nation colleges.

He adds that states and territories will also get access to the tests, which would allow them to "on a very regular basis" test every teacher who needs it.



## Rapid risk assessment: Increased transmission of COVID-19 in the EU/EEA and the UK – twelfth update; as of 24 September 2020

### Executive summary

COVID-19 case notification rates have increased steadily across the EU/EEA and the UK since August 2020, but this is not having the same impact in all countries.

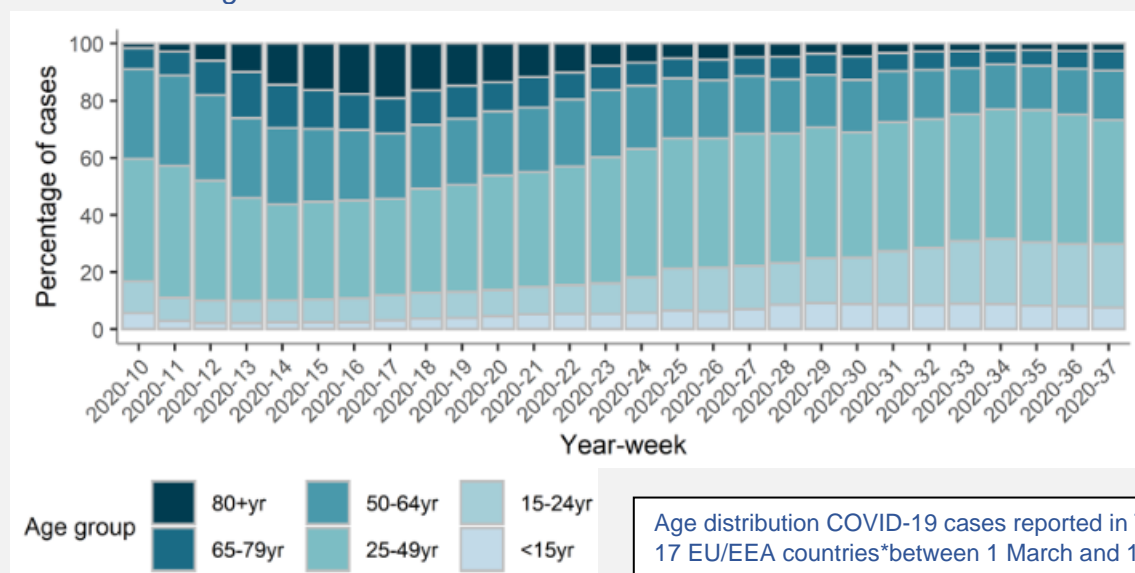
In several countries the observed upsurge correlates with increased testing rates and intense transmission among individuals between 15 and 49 years of age. In such countries most detections concern mild or asymptomatic cases.

However, in a number of other countries, the upsurge coincides with high or increasing notification rates in older individuals and, consequently, an increased proportion of hospitalised and severe cases. The observed increased transmission levels indicate that the non-pharmaceutical interventions in place have not achieved the intended effect, either because adherence to the measures is not optimal or because the measures are not sufficient to reduce or control exposure. In addition, the vulnerability of the population to infection remains high, as available data from seroprevalence studies suggest that the level of immunity in the population is <15% in most areas within the EU/EEA and the UK.

The current epidemiological situation in many countries is concerning as it poses an increasing risk of infection for vulnerable individuals (individuals with risk factors for severe COVID-19 disease, such as the elderly) and healthcare workers, particularly in primary care, and calls for targeted public health action.

### EU Options for Response

- *Preparing for a scenario of widespread transmission*
- *Find the key target populations*
- *Non-pharmaceutical interventions (NPI)*
- *Testing strategies*; now focus on more widespread testing in the community, prevention of nosocomial transmission, rapid identification and containment of outbreaks and identification of infectious cases to prevent further transmission.
- *Contact tracing*; Rapid identification, testing regardless of symptoms, and quarantine of high-risk contacts, testing of low-risk exposure contacts regardless of symptoms in high-risk settings.
- *Quarantine* - Fourteen-day quarantine is recommended for persons who have had contact with confirmed SARS-CoV-2 cases. This can be shortened to 10 days after exposure, if a PCR test at day 10 is negative.
- *Maintaining strong messaging to promote compliance with key protective behaviours*
- *Risk communication for younger people*
- *Protecting mental health*





## ECDC COVID-19 surveillance report Week 38, as of 24 September 2020

### Weekly surveillance summary

This summary presents highlights from two separate weekly ECDC surveillance outputs, using data up to the end of the current reporting week (week 38, ending Sunday 20 September 2020).

- The [COVID-19 country overview](#) provides a concise overview of the evolving epidemiological situation with the COVID-19 pandemic, both by country and for the European Union/European Economic Area (EU/EEA) and the United Kingdom (UK) as a whole, using daily and weekly 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

- By the end of week 38 (20 September 2020), the 14-day case notification rate for the EU/EEA and the UK, based on data collected by ECDC from official national sources, was 94.0 (country range: 4.7–300.5) per 100 000 population. The rate has been increasing for 63 days.
- High levels (at least 60 per 100 000) or sustained increases (for at least seven days) in the 14-day COVID-19 case notification rates against the previous week have been observed in 20 countries (Austria, Belgium, Croatia, Czechia, Denmark, Estonia, France, Hungary, Ireland, Luxembourg, Malta, Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK).
- Based on data reported to TESSy, among people over 65 years of age, high levels or sustained increases in the 14-day COVID-19 case notification rates compared to last week have been observed in 17 countries (Austria, Croatia, Czechia, Denmark, Estonia, Hungary, Ireland, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 38, available for 26 countries, varied from 357 to 6 612 tests per 100 000 population. Luxembourg had the highest testing rate for week 38, followed by Denmark, Iceland, the UK and Belgium.
- Weekly test positivity was high (at least 3%) or had increased compared to the previous week in 12 countries (Austria, Belgium, Bulgaria, Croatia, Czechia, Hungary, Netherlands, Poland, Portugal, Romania, Slovakia and Slovenia).

#### Primary care

- In the three countries that reported data from primary care sentinel surveillance for COVID-19 up to week 38, using the systems established for influenza, there were no detections of SARS-CoV-2 reported among the 14 patients tested.
- Among those countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 38, using the systems established for influenza, none had observed recent increases in consultation rates to levels higher than those reported during the same period for the last two years.

#### Hospitalisation

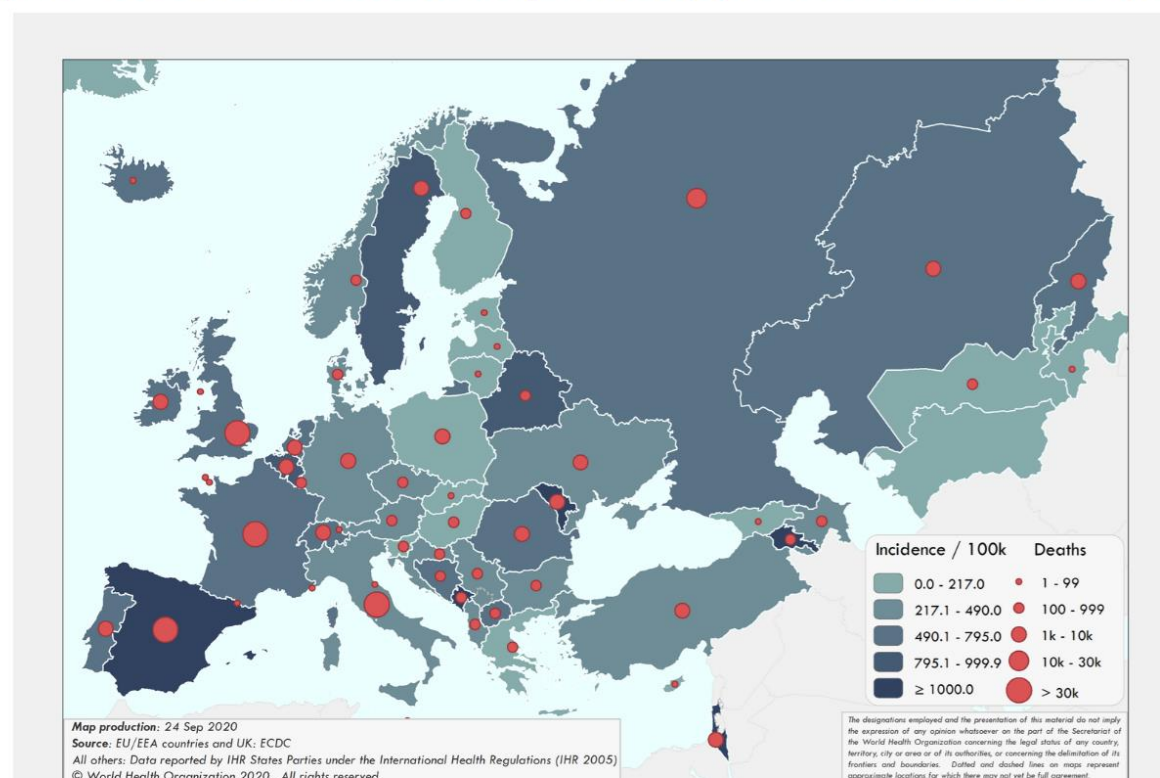
- Hospital and/or ICU occupancy and/or new admissions due to COVID-19 have recently increased in Austria, Czechia, Denmark, Estonia, France, Greece, Hungary, Latvia, Portugal, Slovakia and Slovenia. No other increases have been observed, although data availability varies.
- Based on surveillance data reported to TESSy by 22 countries to date, we estimate that 22% (country range: 3–63%) of reported COVID-19 cases have been hospitalised. Data from 16 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 and may be influenced by national policies and practices.

#### Mortality

- The 14-day COVID-19 death rate for the EU/EEA and the UK, based on data collected by ECDC from official national sources, was 6.4 (country range: 0.0–28.4) per million population. The rate has been increasing for six days.
- High levels (at least 10 per million) or sustained increases (for at least seven days) in the 14-day COVID-19 death rates compared to those reported seven days ago are currently being observed in four countries (Bulgaria, Croatia, Romania and Spain).
- Overall pooled estimates of all-cause mortality reported by EuroMOMO for week 38 show normal levels for the participating countries. However, in some countries there seems to be a small excess mortality.

## COVID-19 situation update for the WHO European Region (14 – 20 September 2020 Epi week 38)

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



## Key points

### Week 38/2020 (14 - 20 Sept 2020)

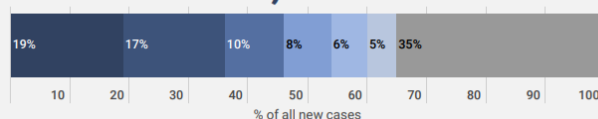
- The number of cases reported in the Region increased 19% to 400,071 in week 38/2020 compared to the previous week (337,059 cases in week 37/2020) and have now exceeded (51% increase) those reported when the pandemic first peaked in Europe in week 14/2020 (30 Mar - 5 Apr; 265,081)
- 65% (261,917) of the cases reported in week 38/2020 were reported from six countries: Spain (19%; 74,528), France (17%; 68,283), the Russian Federation (10%; 40,588), Israel (8%; 31,991), the United Kingdom (6%; 25,184) and Ukraine (5%; 21,343). The remaining cases (35%; 138,154) were reported by 53 countries and territories; each accounted for <5% of the total cases reported in week 38/2020
- The crude incidence continues to vary across the region with a range from 2.7 per 100,000 population in Latvia to 376 per 100,000 population in Israel in week 38/2020
- Ten countries had a crude incidence of  $\geq 80$  per 100,000 in week 38/2020: Israel (376), Andorra (285), Montenegro (265), Spain (160), Czech Republic (121), France (105), Luxembourg (91), Republic of Moldova (90), Belgium (85) and Malta (82) (Figure 2A)
- The 14-day cumulative incidence increased by  $\geq 10\%$  in week 38/2020 in 35 countries and territories in the Region; an increase of  $\geq 50\%$  was observed in 20 of these countries and territories: Andorra, Belgium, Czech Republic, Estonia, Finland, France, Georgia, Hungary, Iceland, Israel, Luxembourg, Montenegro, Netherlands, Norway, Portugal, Serbia, Slovakia, Slovenia, Switzerland, and the United Kingdom (see [EURO COVID-19 Dashboard](#) for recent trends)
- The number of deaths in the Region in week 38/2020 increased 23% to 4,156 compared to the previous week (3,375 deaths in week 37/2020) (Figure 1). The proportion of reported cases that died remains 1.0% in week 38/2020
- 70% (2,921) of the deaths reported in week 38/2020 were reported by the Russian Federation (20%; 840), Spain (15%; 617), Turkey (11%; 446), Ukraine (9%; 379), France (9%; 364) and Romania (7%; 275). The remaining deaths (30%; 1,235) were reported from 39 countries and territories; each accounted for <5% of the total deaths reported in week 38/2020
- 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 38/2020
- For an interactive subnational view of the recent COVID-19 situation in the WHO-EURO Region see the [WHO-EURO COVID19 Subnational Explorer](#)

## Summary overview

- The cumulative cases across the Region increased 8.2% to 5,266,504 cases in week 38/2020 (from 4,866,433 cases in week 37/2020) and cumulative deaths increased by 1.8% to 230,321 deaths (from 226,165 deaths in week 37/2020)
- As of 4 September 2020, 17 countries in the Region had an effective reproductive number significantly over 1: Austria, Belgium, Czech Republic, Estonia, Georgia, Hungary, Ireland, Israel, Malta, Montenegro, Netherlands, Portugal, Slovakia, Slovenia, Switzerland, United Kingdom and Uzbekistan (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  $\geq 1000$  cases per 100,000 population: Israel (2210), San Marino (2191), Andorra (2027), Armenia (1604), Holy See (1472), Spain (1437), Montenegro (1408), Luxembourg (1254) and Republic of Moldova (1146) (Figure 2B)
- As of week 38/2020, 66% (3,476,641) of cumulative cases were reported from the Russian Federation (21%; 1,103,399), Spain (13%; 671,358), France (8%; 442,194), the United Kingdom (7%; 390,358), Turkey (6%; 301,348), Italy (6%; 296,569) and Germany (5%; 271,415). The remaining cases (34%; 1,789,863) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 38/2020
- As of week 38/2020, 69% of cumulative deaths (158,836) were reported from the United Kingdom (18%; 41,759), Italy (15%; 35,692), France (14%; 31,274), Spain (13%; 30,693) and the Russian Federation (8%; 19,418). The remaining deaths (31%; 71,485) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 38/2020
- 15% of cases were in persons aged  $\geq 65$  years in week 38/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged  $\geq 65$  years was 67% in week 38/2020 (compared to 91% in week 14/2020) (Figure 3)
- 88% of all deaths with information available were in persons aged  $\geq 65$  years and 57% 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 (76%) (Table 1)
- Pooled estimates of all-cause mortality for 24 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 38/2020, four countries reported a total of 71 tests and 0 detections of SARS-CoV-2 in persons with influenza-like illness (ILI) in primary care sentinel surveillance (Figure 4)
- Overall, there were 164,863 (7.3%) COVID-19 cases among the total of 2,257,150 tests reported to have been performed in 17 countries in week 38/2020 (Figure 5)

### New cases (week 38/2020)

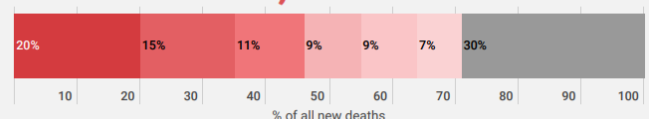
400,071



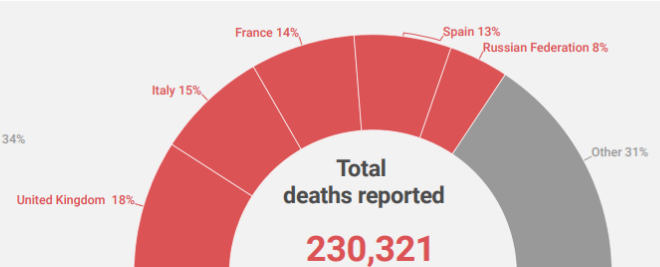
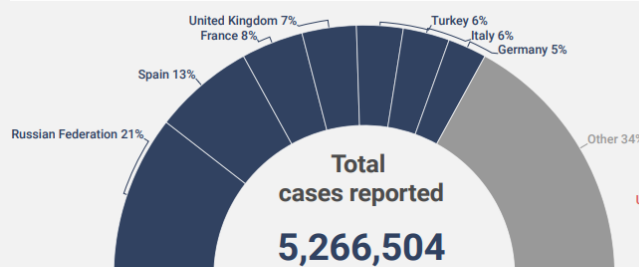
● Spain ● France ● Russian Federation ● Israel ● United Kingdom ● Ukraine ● Other

### New deaths (week 38/2020)

4,156



● Russian Federation ● Spain ● Turkey ● Ukraine ● France ● Romania ● Other



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

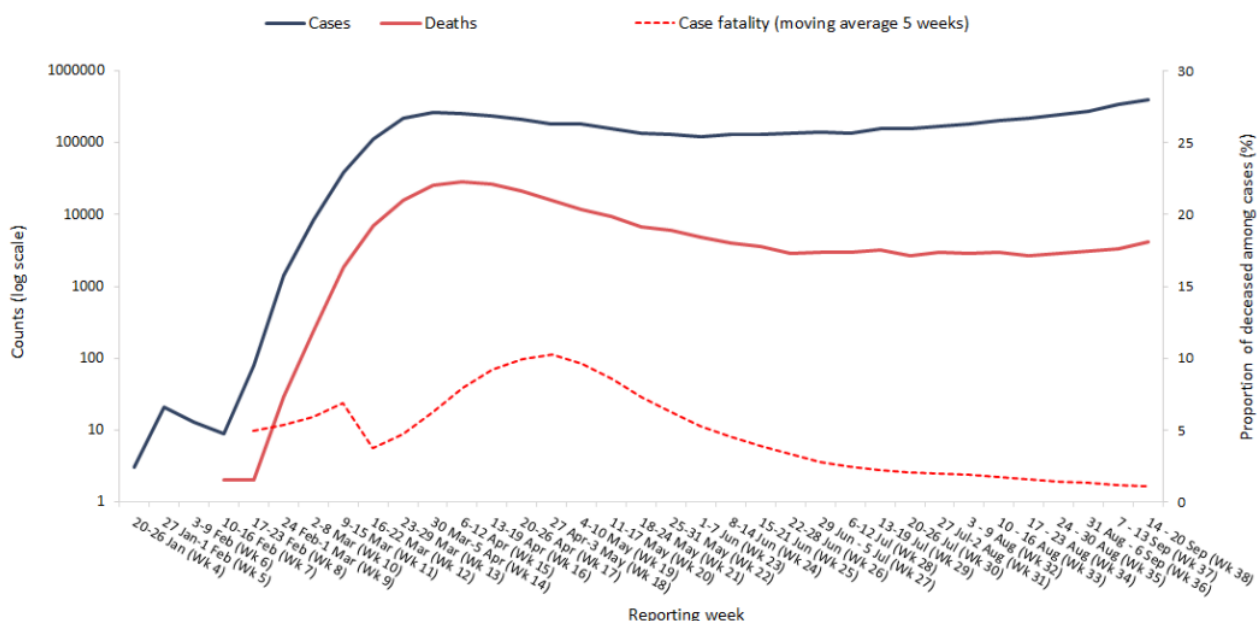
**88%**  
of all deaths  
were in persons aged 65+

**57%**  
of all deaths  
were in men

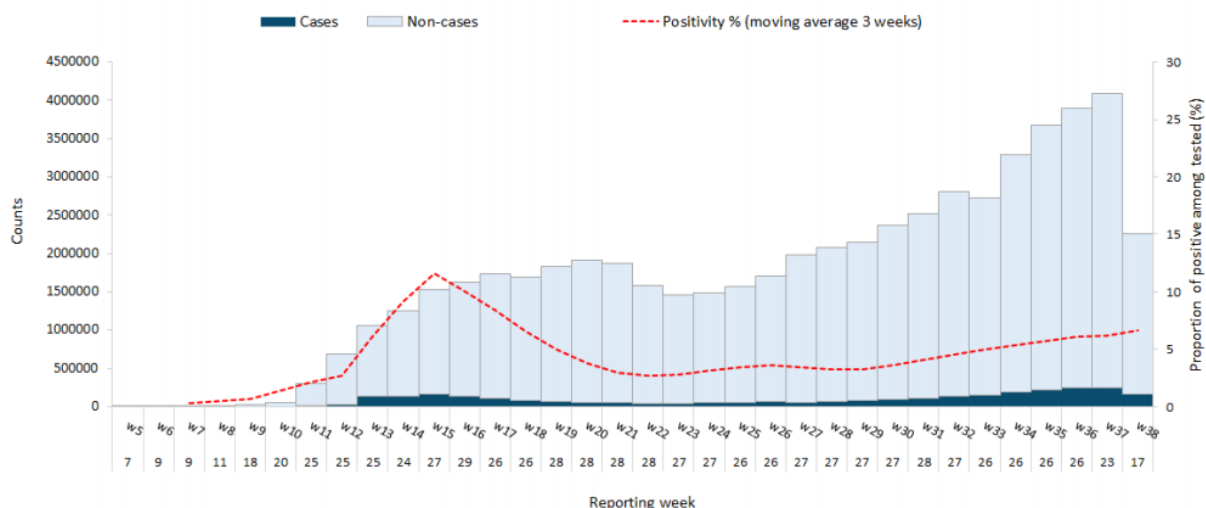
**95%**  
of all deaths  
had at least 1 underlying  
condition

**76%**  
of all deaths  
had cardiovascular disease

**Figure 1: Number of COVID-19 cases (N=5,266,504) and deaths (N=230,321) by reporting week**



**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

## SPAIN: INTENSIVE CARE UNITS IN MADRID ARE FULL

As of September 29th, Spain had 748,266 coronavirus infections and 31,411 deaths, making it the sad leader in Western Europe. The situation around the capital Madrid remains particularly tense. If you visit Madrid on these days, you should not only protect yourself from corona infection, but also not bring any other serious health disorder that has to be treated in an emergency ward or surgically in a clinic. The reason for this is that the intensive care units are already at their capacity, according to the



Spanish Professor of Epidemiology at Harvard University and Advisor to the Government, Miguel Hernán. A third of all second wave infections are currently reported from Madrid.

In order to curb the number of new infections, 45 health districts of Madrid, which are among the lower-income areas of the city, are currently being cordoned off. The inhabitants are only allowed to leave their districts to go to work, to the doctor or to school. Public parks are permanently closed, restaurants and shops have to close at 10 p.m. In areas where more

than a million people live, more than 1,000 new infections per 100,000 inhabitants have been registered in the past 14 days. In Germany for example, this number is currently 13 over seven days.

The Spanish central government, however, does not rule out taking "control of Madrid". In view of the continually increasing number of new infections, the Spanish Health Minister Salvador Illa has asked the conservative regional government to immediately quarantine most of the capital region with almost

### Covid now takes up almost all of Madrid's dedicated ICU beds

% of critical care beds currently occupied by Covid-19 patients, by grade



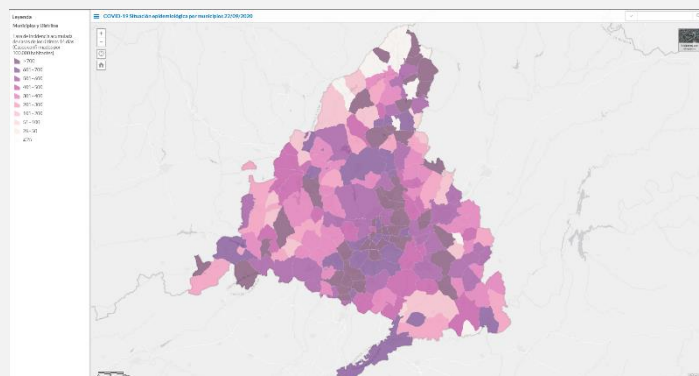
seven million inhabitants. Regional President Isabel Díaz Ayuso has so far rejected a lockdown for the entire capital area because of the feared devastating effects on the economy. The epidemiologist Miguel Hernán considers this to be hardly avoidable.

Should the regional government not give in, the central government could declare a state of emergency in Madrid, which parliament would have to approve. Also, with the help of the Public Health Act, the Ministry of Health could empower itself to take action and mobilize resources and officials, including security forces.

Hundreds of people demonstrated against the latest Corona regulations on Sunday. They gathered in front of the regional parliament in the southern district of Vallecas and demanded the resignation of the conservative regional president. "These are not restrictions - this is segregation," the demonstrators chanted. One of the banners read: "They do not impose restrictions on the rich."

### Affected zones:

**In the city of Madrid, the affected health areas are located in certain city districts** (Carabanchel (the health areas of Puerta Bonita, Vista Alegre and Guayaba), Usera (Almendrales, Las Calesas, Zofío, Orcasur and San Fermín), Villaverde (San Andrés, San Cristóbal, El Espinillo and Los Rosales), Villa de Vallecas, Puente de Vallecas (Entrevías, Martínez de la Riva, San Diego, Numancia, Peña Prieta, Pozo del Tío Raimundo, Ángela Uriarte, Alcalá de Guadaira and Federica Montseny), and Ciudad Lineal (Doctor Cirajas, Ghandi, Daroca and La Elipa).



**And also other affected municipalities besides the capital** (Fuenlabrada (the health areas of Alicante, Cuzco and Francia), Parla (San Blas and Isabel II), San Sebastián de los Reyes (Reyes Católicos), Getafe (Las Margaritas and Sánchez Morate), Alcobendas (Chopera and Miraflores) and the entire towns of Humanes and Moraleja de Enmedio).

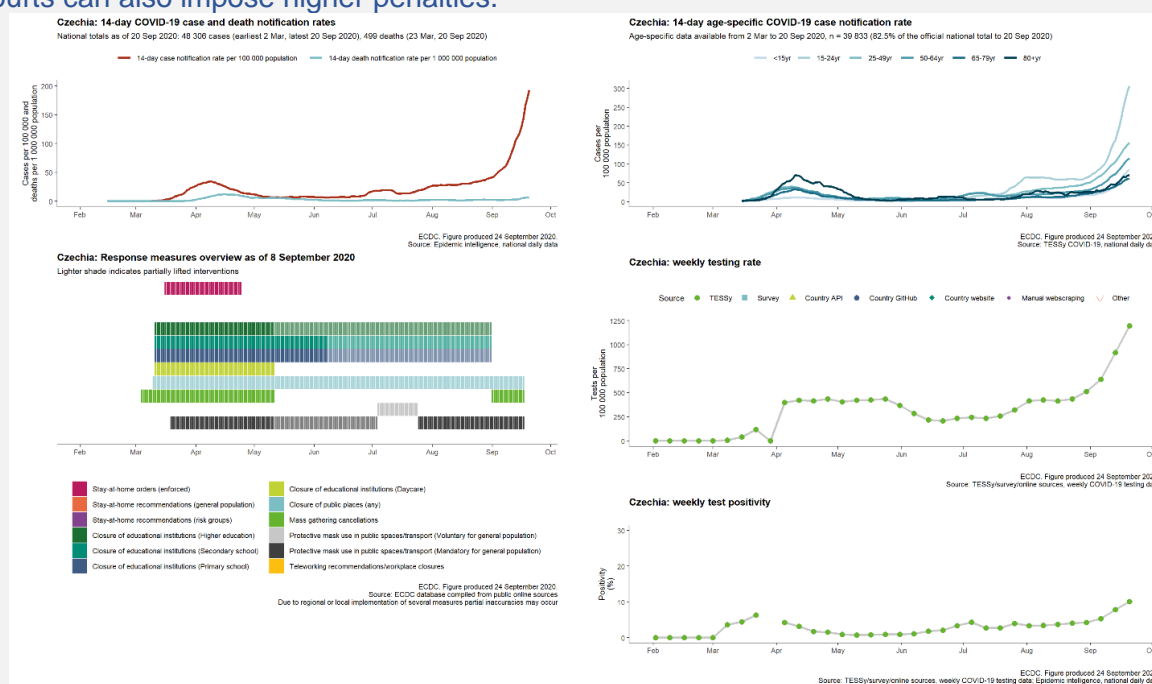
Source: <https://www.ft.com/content/b9653470-8779-4037-86ad-96edfcd6f3c3>

[https://www.esmadrid.com/en/informationcoronavirus?utm\\_referrer=https%3A%2F%2Fwww.google.com%2F](https://www.esmadrid.com/en/informationcoronavirus?utm_referrer=https%3A%2F%2Fwww.google.com%2F)

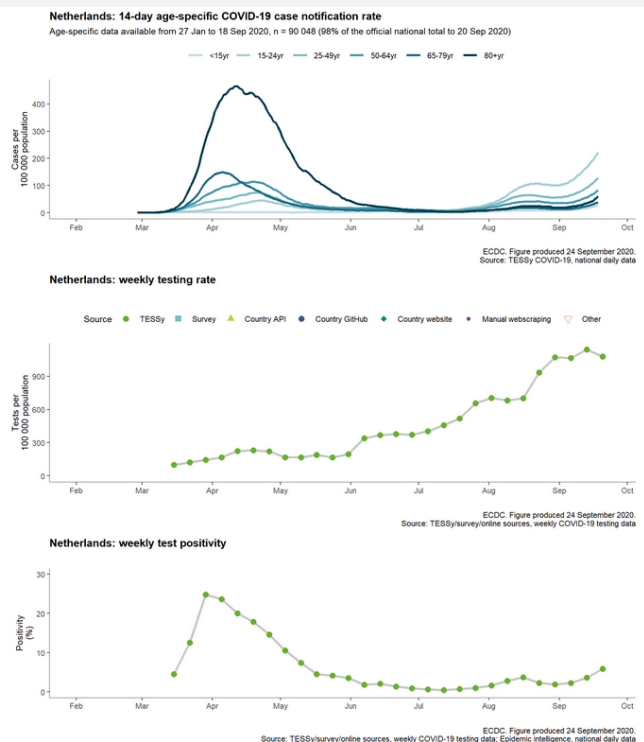
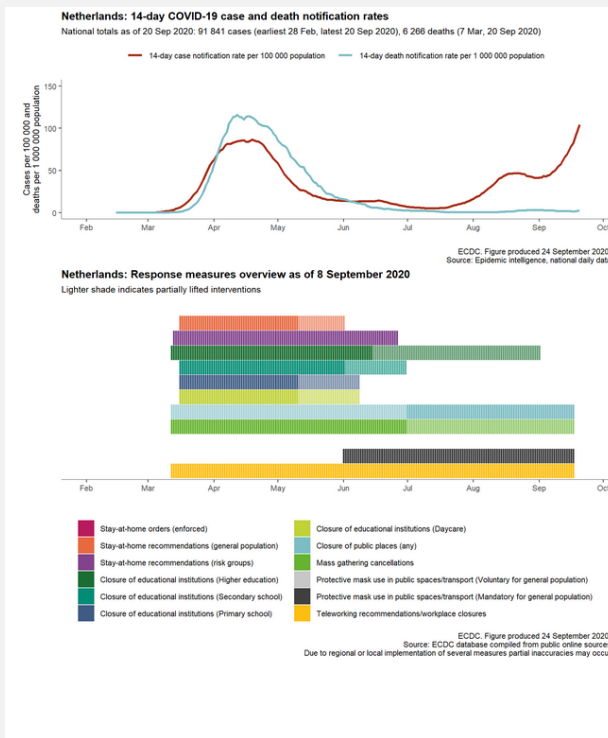
## Weekly COVID-19 country overview, week 38

### Eastern Europe:

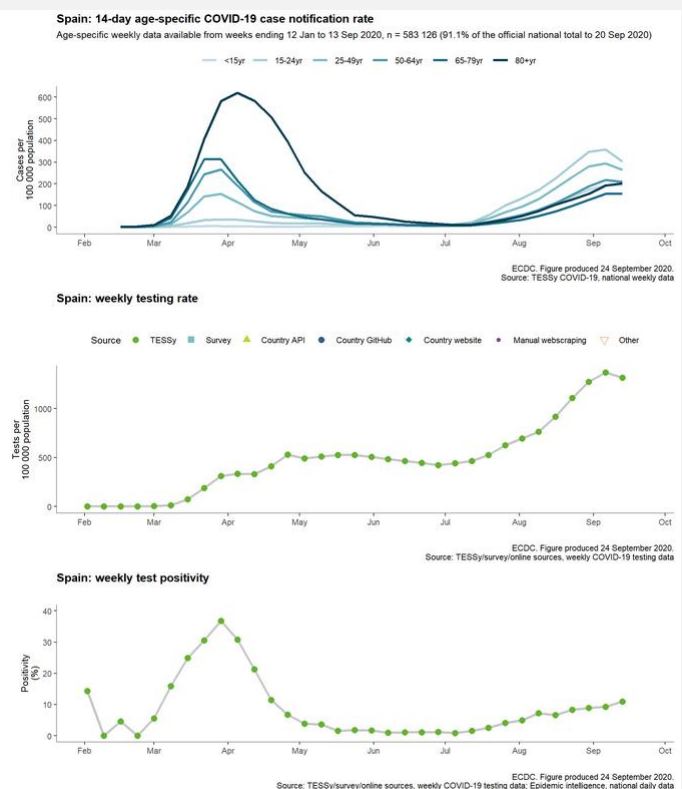
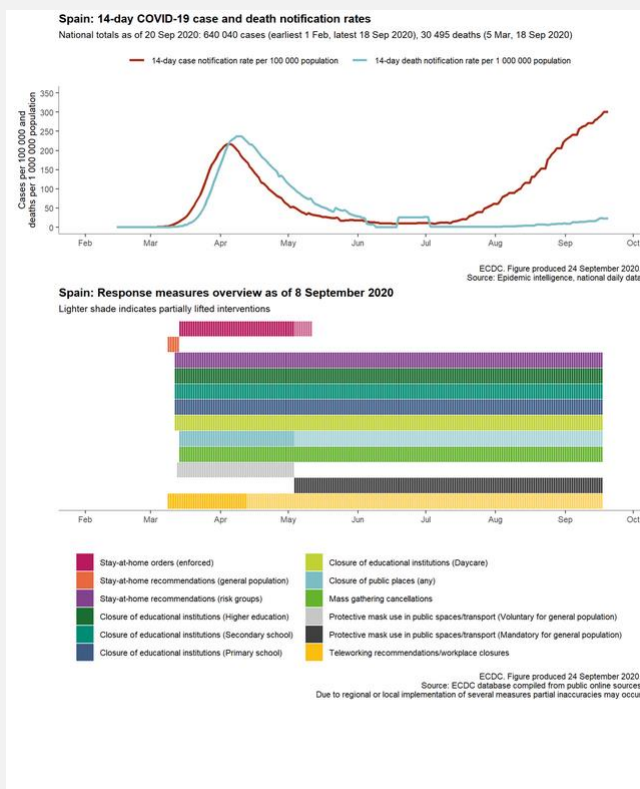
In view of increasing corona numbers, the **Czech Republic** wants to impose a state of emergency again. The cabinet is expected to hold a special session in Prague on Wednesday to approve this step. The state of emergency was in place for two months in the spring and expired at the end of May. Among other things, it enables the government to suspend civil rights such as freedom of assembly. The courts can also impose higher penalties.



**NDL:** The Netherlands have announced stricter corona rules. Bars and restaurants are expected to close at 10 p.m. in the future. In addition, no audience is allowed at sporting events for three weeks. In Amsterdam, Rotterdam and The Hague, shops could in future demand the wearing of masks.

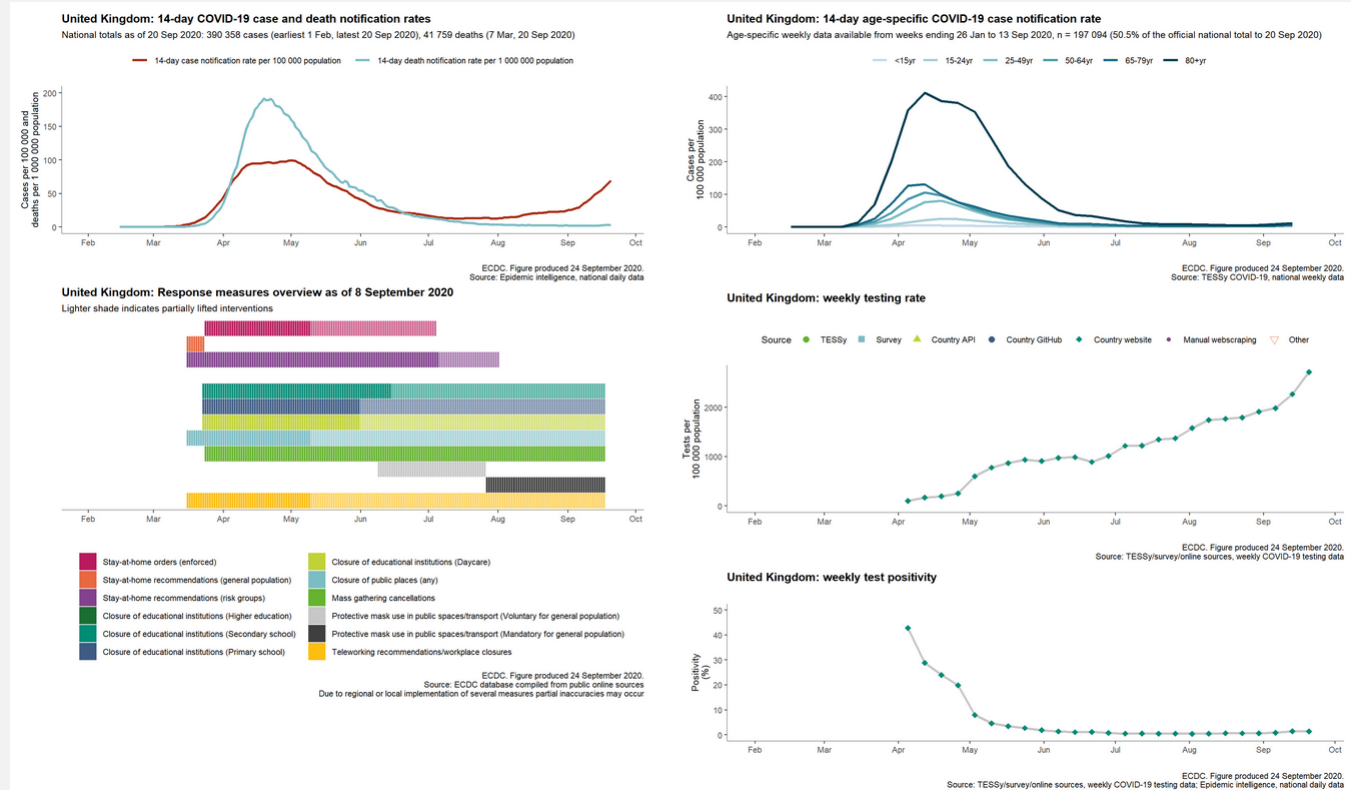


**ESP:** In Spain, the number of corona cases has been increasing worryingly for weeks, especially in Madrid the situation is getting increasingly out of control. Locking off the entire capital is now being discussed as well as a temporary forced administration of Madrid by the central government.

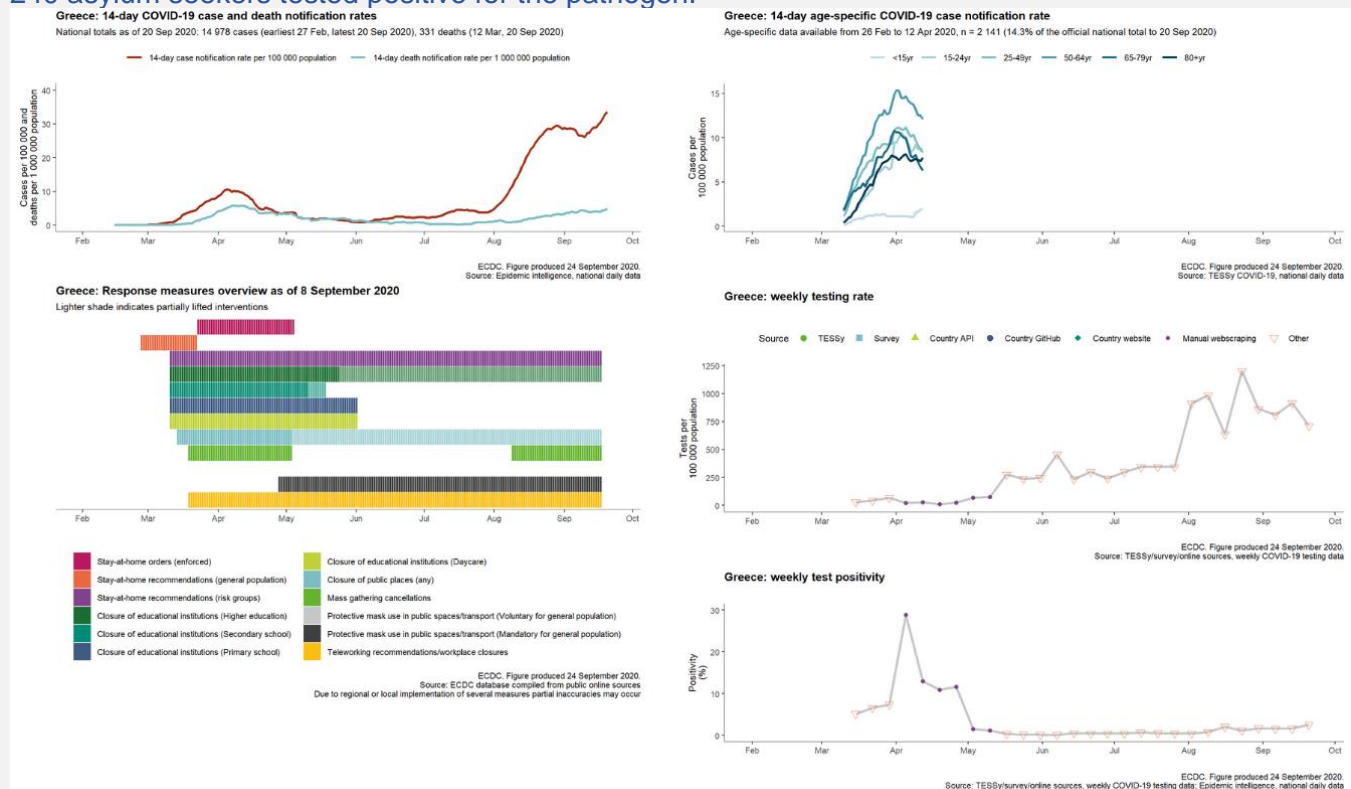




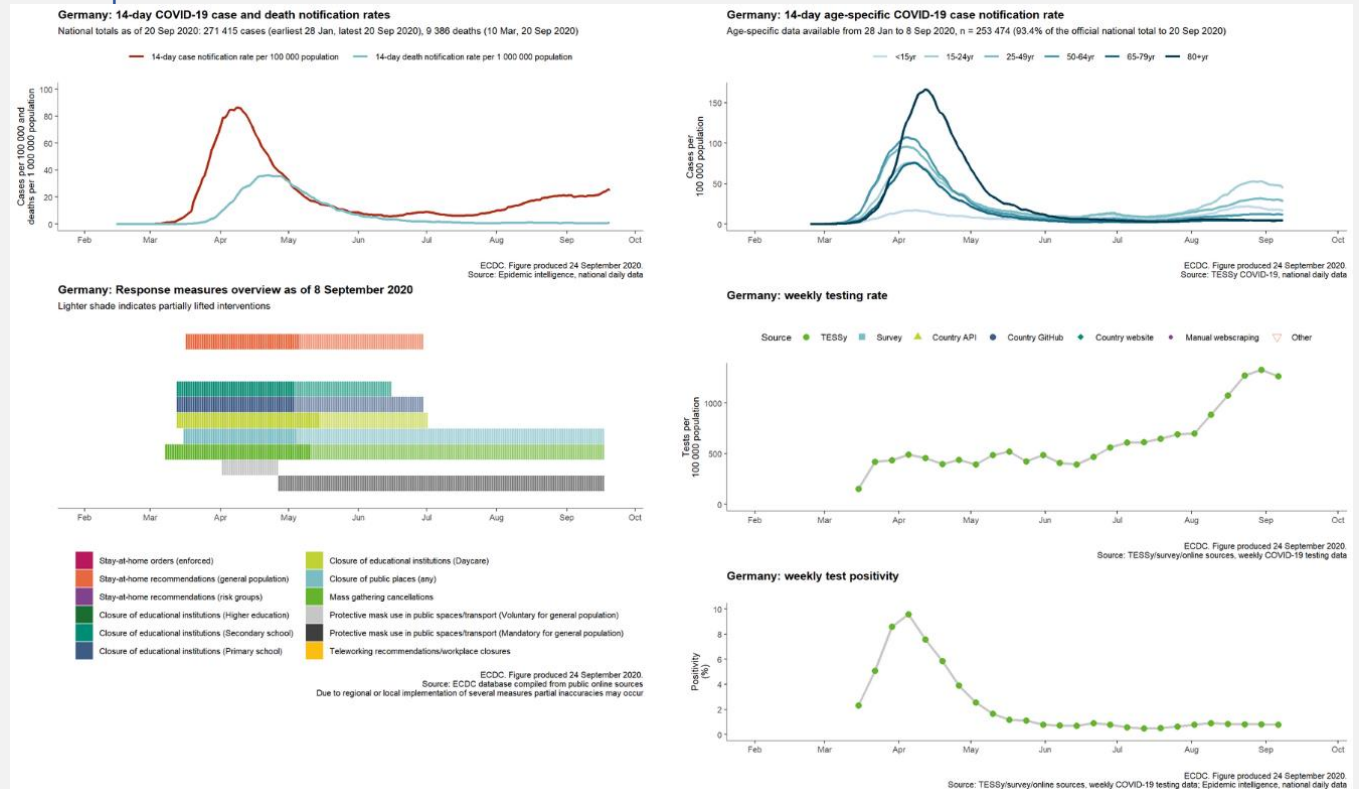
## GBR: The leaders of Liverpool, Leeds and Manchester warned that their hospitality sectors are at risk of collapse.



## GRC: According to the government, the first resident of a refugee camp died of a corona infection. A 61-year-old Afghan who was housed in the Malakassa camp near Athens died in a hospital in the Greek capital, the Ministry of Migration said on Sunday. The corona virus had recently spread strongly in the Greek refugee camps. In a controversial interim camp on the island of Lesbos alone, more than 240 asylum seekers tested positive for the pathogen.



**DEU:** Although more and more people are concerned about their own health in view of the increasing number of corona infections, the careless handling of preventive measures is also increasing. According to a survey by the [Hamburg Center for Health Economics \(HCHE\)](#) at the University of Hamburg, only 45 percent of people in Germany say that they observe distance rules. Even less, namely only 39 percent, adhere to the recommended hand hygiene. Hugs, kisses and handshakes in greeting are also on the rise again. Only 58 percent said they would avoid this. In April it was 77 percent.

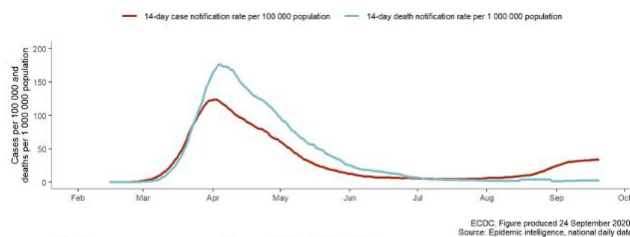


**ITA:** More and more regions in Italy are tightening their precautionary measures against corona infections. Sicily announced the start of rapid tests for all people arriving from abroad. In addition, from Wednesday onwards the Mediterranean island issued a mask requirement for all individuals over six years of age as soon as a stranger is nearby.



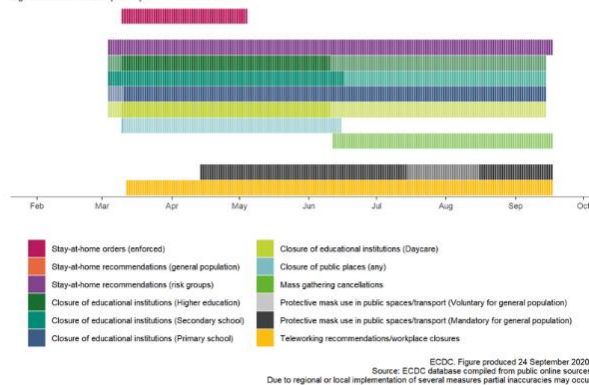
#### Italy: 14-day COVID-19 case and death notification rates

National totals as of 20 Sep 2020: 296 569 cases (earliest 31 Jan, latest 20 Sep 2020), 35 692 deaths (23 Feb, 20 Sep 2020)



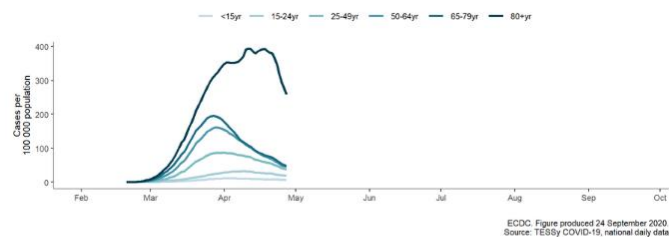
#### Italy: Response measures overview as of 8 September 2020

Lighter shade indicates partially lifted interventions

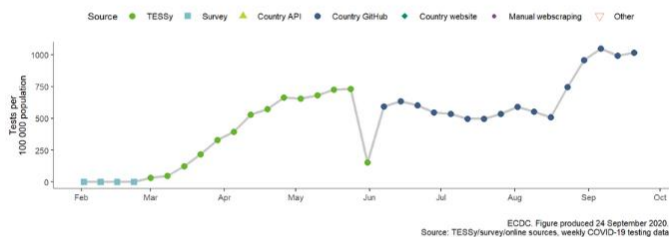


#### Italy: 14-day age-specific COVID-19 case notification rate

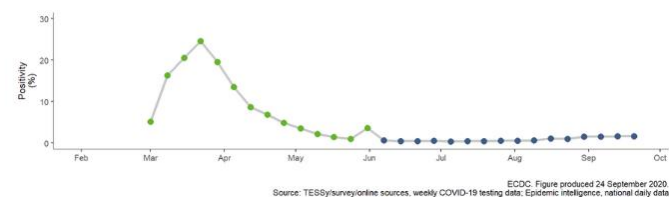
Age-specific data available from 29 Jan to 27 Apr 2020, n = 193 961 (65.4% of the official national total to 20 Sep 2020)



#### Italy: weekly testing rate



#### Italy: weekly test positivity



## Subject in Focus

### ECDC's Guidelines for the implementation of non-pharmaceutical interventions against COVID-19

Non-pharmaceutical interventions (NPI) against COVID-19 are public health measures that aim at preventing and/or controlling SARS-CoV-2 transmission in the community. As long as there is no effective and safe vaccine to protect those at risk of severe COVID-19 infections, NPIs are the most effective public health interventions against COVID-19.

The ECDC guidelines detail available options for NPI in various epidemiologic scenarios, assess the evidence for their effectiveness and address implementation issues, including potential barriers and facilitators.



### General considerations on NPI to control COVID-19

- NPI have played a critical role in reducing transmission rates and the impact of COVID-19 in the European Union, European Economic Area (EU/EEA) and United Kingdom (UK). Until a safe and effective vaccine is available to all those at risk of severe COVID-19 disease, NPI will continue to be the main public health tool against SARS-CoV-2.
- Most NPI can have a negative impact on the general well-being of people, the functioning of society, and the economy. Therefore, their use should be guided by data on the local epidemiological situation, with the overall goal of protecting the most vulnerable individuals in the society.
- Specific recommendations to protect the most vulnerable include enhanced surveillance, comprehensive testing, and intensified infection prevention and control practices in settings that host high-risk individuals, such as long-term care facilities.
- In countries/regions/municipalities/communities where sustained control of SARS-CoV-2 has been achieved, as documented by comprehensive surveillance, NPI can be relaxed, allowing society to function almost normally. Under the current exceptional circumstances, imposing travel restrictions on those coming from countries or areas that have not yet achieved transmission control will probably make a meaningful difference to the SARS-CoV-2 epidemiology within the population.
- In countries/regions/municipalities/communities that experience community transmission, the authorities should ensure that personal NPI are understood and correctly applied by the population. This includes maintaining physical distance in all settings, hand hygiene and respiratory etiquette, and the wearing of face masks when physical distancing cannot be guaranteed. The use of face masks is recommended both indoors (e.g. supermarkets, shops and public transport) and in crowded outdoor settings. In addition, use of face masks should be strongly recommended for groups at risk of developing severe complications if infected (e.g. individuals in older age groups or with underlying conditions) and for those whose occupations bring them into extensive face-to-face contact with the public when there is ongoing transmission.



**Table 1. Characteristics of SARS-CoV-2 transmission and relevance for NPI**

	Value/description (+ ref)	Relevance for NPI
Main transmission routes	Respiratory droplets (large and aerosols), fomites [3]	Mask wearing, hand and respiratory hygiene, avoid indoor and crowded places
Incubation period	Range: 1-14 days [8-11] Median: 5-6 days	Duration of quarantine Follow-up of contacts
Infectious period	1-2 days before symptom onset 10 days after symptom onset in mild cases, 14-20 days in severe cases [12,13]	Duration of isolation, duration of quarantine
Basic reproduction number	2-4 [14,15]	All NPI
Infectiousness by age	Unclear	School measures
Proportion of asymptomatic cases	30-40% [16,17]	Mask wearing, hand hygiene, avoid indoor and crowded places, testing strategy, quarantine
Transmission by asymptomatic cases	Yes	Quarantine, testing strategy
Risk factors for transmission (personal)	Activities, number of contacts	Physical distancing, hand and respiratory hygiene, contact tracing
Risk factors for transmission (setting)	Close contact, indoor settings, crowding, travel	Physical distancing, mass gatherings, travel restrictions
Risk factors for severity (personal)	Old age, underlying diseases	Protection of vulnerable groups

Decision-makers responsible for implementing population- and/or environmental-level NPI, either at local or national level, should consider the advice/evidence below when deciding on the combination of measures.

### Considerations in the event of community transmission

During the SARS-CoV-2 community transmission phase, the following interventions may be considered, irrespective of incidence level.

- Promoting and facilitating physical distancing in all settings is an effective NPI to reduce the levels of SARS-CoV-2 transmission in the community.
- Advising the population to voluntarily self-isolate if experiencing COVID-19 compatible symptoms is an essential measure for reducing the number of secondary infections. This should be linked to easy access to testing and rapid contact tracing, testing of high-risk contacts irrespective of symptoms, and the quarantining of contacts.
- Advising the population to consistently meet with the same people in 'social bubbles', whether friends or co-workers, can allow for a greater degree of contact between people, while still minimising the risk of SARS-CoV-2 transmission and associated outbreaks.
- Limiting the size of indoor and outdoor gatherings decreases the likelihood of SARS-CoV-2 spreading to large numbers of people. Such a measure is more effective if implemented consistently, even for relatively small gatherings (e.g. >10 individuals). Additional organisational measures such as event cancellation, postponement or re-arrangement should be considered, depending on the underlying epidemiological situation.
- Promoting teleworking where possible can reduce the risk of outbreaks in the workplace.
- Closing selected businesses, such as places where people have limited possibility for physical distancing, could be more effective than closing all businesses, and therefore is a possible option for reducing transmission while avoiding large-scale economic and social impact.
- Proactive school closure is not recommended as an effective COVID-19 containment strategy at this stage as there is currently little (and conflicting) evidence on the effect it has on SARS-CoV-2 transmission in the community. Firstly, children (18 years and younger) mostly experience a benign clinical course of COVID-19 and do not seem to have been the main vector of SARS-CoV-2 in the community. Secondly, because the impact of school closure on children's education, families' economies, and on society as a whole is significant and well-documented.
- Environmental measures, such as regular cleaning of frequently-touched surfaces and appropriate ventilation of indoor spaces, can lower the risk of disease transmission in the community. Such measures are particularly relevant in healthcare settings to reduce nosocomial transmission and infection of healthcare workers.

### Considerations in the event of widespread transmission

During widespread transmission of SARS-CoV-2, when hospitalisation rates, ICU admissions, and/or mortality is increasing, in addition to the NPI above, the following stricter measures can be considered.

- Stay-at-home measures are a last-resort option due to their significant impact on both society and individuals. Targeted implementation, both geographically and temporally, is preferred and can be considered to control outbreaks which are not responding to other measures. Available evidence does not prove that stay-at-home measures are more effective than other measures, such as the closing of (some) high-risk businesses.
- Population-wide testing strategies (testing all individuals, irrespective of symptoms) may be appropriate in local settings with high incidence. Such an approach would enable public health authorities to identify most of the infectious COVID-19 cases at a given point in time (e.g. including pre-symptomatic, pauci-symptomatic, and asymptomatic cases), allowing for their prompt isolation and the interruption of transmission chains. However, the effectiveness/cost-effectiveness of this approach remains unknown and should not compromise the accessibility or timeliness of testing for those who are symptomatic. Without timely analysis and notification to isolate cases, population-wide testing alone would not be effective in reducing transmission.
- Reactive closures of schools may be necessary as a consequence of widespread virus transmission in the community and educational settings. Reactive school and day-care closures will probably not reduce the impact of the epidemic but may be necessary due to high absenteeism and operational issues, especially if the spread of SARS-CoV-2 coincides with the ongoing influenza season in an EU/EEA country.

### Addressing NPI compliance

- Support for NPI has varied considerably across countries and in different population groups within the same country: what works to promote safe behaviour in one city, country, culture, or population may be ineffective or otherwise sub-optimal in another. Several EU/EEA countries have therefore been working to incorporate behavioural insights into their COVID-19 response work, using ongoing assessments of public attitudes, behaviour, and beliefs within their own populations. Innovative means have also been developed for collecting anonymised, aggregated data on people's movements, which can act as a proxy for compliance with measures (e.g. stay-at-home measures).
- While there is no 'one-size-fits-all' approach to promoting NPI compliance, there are nonetheless some key principles that can be applied in all settings, as defined in various theories of behaviour change. The COM-B model is one such theory, based on the common-sense idea that a given behaviour occurs when both the capability and opportunity are present, and when the individual concerned is more motivated to adopt that behaviour than any other. Systematically applying such models can optimise the effectiveness of strategies promoting NPI.

Countries should be prepared to adapt their strategies rapidly in response to indications of increased transmission. Introduction of further interventions could be considered at local or regional level, or for specific population groups, according to epidemiological data.

The table below presents an overview of control measures and indications for implementation based on the epidemiological situation.



**Table 2. Non-pharmaceutical interventions and indications for implementation during the COVID-19 pandemic based on the national/regional epidemiological situation**

Non-pharmaceutical intervention	Low prevalence	High prevalence	Geo-level	Disease impact	Negative societal impact	Comment
<b>Hygiene measures</b>						
Meticulous hand and respiratory hygiene	+	+	National	High	Low	
<b>Face masks</b>						
Recommendation to use face mask in public spaces	+/-	+	National	High	Low	
<b>Isolation and quarantine</b>						
Recommended isolation of confirmed, probable and possible COVID-19 cases	+	+	National	High	Low	
Quarantine for contacts of cases	+	+	National	High	Low	
Quarantine of specific groups (e.g. travellers from a region or a country with high incidence of COVID-19).	+/-	+/-	National	Low	Low	Can be implemented, but: - Challenging to harmonise classification across countries and regions; - Administrative borders may not match epidemiologically relevant areas; - Questionable effectiveness when community transmission is ongoing across EU/EEA and the UK.
<b>Physical distancing</b>						
Recommended >1-2 metres physical distance between individuals in public places	+	+	National	High	Low	
Closing of public spaces (e.g. non-essential shops, restaurants, entertainment venues)	-	+/-	Sub-national (preferably)	High	Medium	To consider at local/regional level first to minimise socio-economic disruption and political acceptability. To consider closing largest and most crowded spaces first.
Closing of public transport	-	+/-	Sub-national (preferably)	High	High	To consider at local/regional level first. To consider reducing capacity first.
Closing workplaces	-	+	Sub-national (preferably)	High	Medium	To consider at local/regional level first.
Recommending teleworking	+	+	National	High	Low	
Closing of schools (preschool, primary, secondary and tertiary)	-	+/-	Sub-national (preferably)	High	High	To consider, depending on pupils' age. Questionable effectiveness, especially in younger age-groups. To consider negative externalities.
Protecting high-risk groups and vulnerable populations	+/-	+	National	High	Medium	To also consider for hard-to-reach populations (e.g. testing in ethnic minorities or deprived populations).
Stay-at-home orders and recommendations	-	+/-	Sub-national (preferably)	High	High	To consider at local/regional level first to minimise socio-economic disruption and political acceptability.
<b>Mass gatherings</b>						
Interventions in place for public gatherings (small, medium and mass gatherings)	+/-	+	National	High	Medium	
<b>Movement restrictions</b>						
International travel restrictions	+/-	-	National	Low	High	May be considered in places with very low prevalence to limit introductions
National movement restrictions or recommendations	-	+	Sub-national	Medium	Medium	Prefer recommendation over restriction. To consider at local/regional level first, avoiding border closures.

*+: recommended, +/- can be considered, -: not recommended*

*Supporting evidence for each measure provided in the main text of the document.*

Source: <https://www.ecdc.europa.eu/en/publications-data/covid-19-guidelines-non-pharmaceutical-interventions>

# Conflict and Health

## COVID-19 Crisis in Republic of Kosovo

### Republic of Kosovo

Area:	10,887 km <sup>2</sup>
Population:	1,907,592
Capital:	Pristina
Age structure:	
0-14 years:	24,74%
15-24 years:	17,12%
25-54 years:	42,52%
55-64 years:	8,19%
65 years and over:	7,43%



Source: <https://www.indexmundi.com/kosovo/>

### CONFLICT:

The central Balkans were part of the Roman and Byzantine Empires before ethnic Serbs migrated to the territories of modern Kosovo in the 7<sup>th</sup> century. During the medieval period, Kosovo became the centre of a Serbian Empire and saw the construction of many important Serb religious sites, including many architecturally significant Serbian Orthodox monasteries. The defeat of Serbian forces at the Battle of Kosovo in 1389 led to five centuries of Ottoman rule during which large numbers of Turks and Albanians moved to Kosovo. By the end of the 19<sup>th</sup> century, Albanians replaced Serbs as the dominant ethnic group in Kosovo. Serbia reacquired control over the region from the Ottoman Empire during the First Balkan War of 1912. After World War II, Kosovo's present-day boundaries were established when Kosovo became an autonomous province of Serbia in the Socialist Federal Republic of Yugoslavia (S.F.R.Y.). Despite legislative concessions, Albanian nationalism increased in the 1980s, which led to riots and calls for Kosovo's independence. The Serbs - many of whom viewed Kosovo as their cultural heartland - instituted a new constitution in 1989 revoking Kosovo's autonomous status. Kosovo's Albanian leaders responded in 1991 by organizing a referendum declaring Kosovo independent. Serbia undertook repressive measures against the Kosovar Albanians in the 1990s, provoking a Kosovar Albanian insurgency.

Beginning in 1998, Serbia conducted a brutal counterinsurgency campaign that resulted in massacres and massive expulsions of ethnic Albanians (some 800,000 ethnic Albanians were forced from their homes in Kosovo). After international attempts to mediate the conflict failed, a three-month NATO military operation against Serbia beginning in March 1999 forced the Serbs to agree to withdraw their military and police forces from Kosovo. UN Security Council Resolution 1244 (1999) placed Kosovo under a transitional administration, the UN Interim Administration Mission in Kosovo (UNMIK), pending a determination of Kosovo's future status. An UN-led process began in late 2005 to determine Kosovo's final status. The 2006/07 negotiations ended without an agreement between Belgrade and Pristina, though the UN issued a comprehensive report on Kosovo's final status that endorsed independence. On 17 February 2008, the Kosovo Assembly declared Kosovo independent. Since then, over 100 countries have recognized Kosovo, and it has joined numerous international organizations. In October 2008, Serbia sought an advisory opinion from the International Court of Justice (ICJ) on the legality under international law of Kosovo's declaration of independence. The ICJ released the advisory opinion in July 2010 affirming that Kosovo's declaration of independence did not violate general principles of

international law, UN Security Council Resolution 1244, or the Constitutive Framework. The opinion was closely tailored to Kosovo's unique history and circumstances.

Demonstrating Kosovo's development into a sovereign, multi-ethnic, democratic country the international community ended the period of Supervised Independence in 2012. Kosovo held its most recent national and municipal elections in 2017. Serbia continues to reject Kosovo's independence, but the two countries agreed in April 2013 to normalize their relations through EU-facilitated talks, which produced several subsequent agreements the parties are engaged in implementing, though they have not yet reached a comprehensive normalization of relations. Kosovo seeks full integration into the international community and has pursued bilateral recognitions and memberships in international organizations. Kosovo signed a Stabilization and Association Agreement with the EU in 2015 and was named by a 2018 EU report as one of six Western Balkan countries that will be able to join the organization once it meets the criteria to accede. Kosovo also seeks memberships in the UN and in NATO.

## HEALTH:

The health system in Kosovo, as elsewhere in Eastern Europe, was largely based on the Semashko model of healthcare delivery. The Semashko system of health care was utilized throughout the Soviet Union and Eastern Europe. Its centralized decision-making and emphasized specialization of services. Polyclinics, located in major towns and municipalities, were the first point of contact for patients. General practitioners, dentists, paediatricians, and gynaecologists all practised at these clinics, and physiotherapy and basic diagnostic services were also available. The central government functioned as the purchaser as well as the provider of health care services.

Yugoslavia adapted the Semashko model to reflect its version of socialism--a system of self-management. While favouring the delivery of health care by specialists, decision-making for the system was decentralized to hospitals and health centres. The healthcare system succeeded in expanding the provision of healthcare, and Kosovo saw dramatic health improvements: the mortality rate declined from 46 per 1,000 in 1956 to 29 per 1,000 in 1990. Under the 1974 Yugoslav Constitution, Kosovo had been granted autonomous status within the Republic of Serbia. This status was revoked by Belgrade in March 1989, initiating a decade of tension and conflict. The health sector became a natural battleground for the conflict between Kosovo's majority Albanian population and the federal government in Belgrade. The Belgrade Ministry of Health assumed control of the Kosovo health system, and directors and boards of health institutions were forced to report directly to Belgrade. Pristina University's medical faculty was closed, and the medical training of many students was interrupted. Sixty-four percent of ethnic Albanian health workers (an estimated 2,400 people) left their jobs: some were fired, others were subject to smear campaigns, while others left of their own accord. Four hundred and forty of those dismissed were specialist physicians. The gynaecology and maternity clinics were particularly hard hit, with all Albanian doctors working in these units leaving their positions. Those healthcare workers that remained in the system were required to speak Serbian and to write in Cyrillic. Access to healthcare for Albanians suffered. Many Albanians lost their jobs after 1989, and as a result, lost their insurance coverage. During the 1990s, more than 50 percent of Albanians lacked a social insurance card needed to access the public health system. To respond to this need, Albanians organized a parallel primary healthcare system in conjunction with the parallel government that was established in the early 1990s. This system, known as the Mother Theresa Society, operated 96 clinics throughout Kosovo, many in remote areas. Healthcare workers volunteered their services, with financing for supplies and medicines provided by a parallel tax system. Many Albanian health professionals also established private healthcare facilities, including clinics and laboratories, during this period. Because Albanians were no longer able to receive medical training in their own language at Pristina University, they also created a parallel system of medical education. In the 1990s, 600 doctors and 1,200 nurses graduated from this parallel system. While this system provided students with a high degree of theoretical knowledge, clinical training was problematic given the lack of access of medical students to healthcare facilities. This left a generation of Albanian medical personnel with uncertain expertise and unrecognised qualifications. Despite these efforts, population health deteriorated in the 1990s. The incidence rate of



infectious diseases rose, immunisation rates declined, and vaccination coverage for children against polio, diphtheria, tetanus, pertussis, measles, mumps, and rubella fell below 60 percent, with some areas falling below 30 percent coverage. Polio re-emerged, with 52 cases reported between 1990 and 1997. Armed conflict broke out in 1998 between the Kosovo Liberation Army (KLA) and the Yugoslav Army and police. This conflict caused massive population displacements in rural areas of Kosovo. In the fall of 1998, UNHCR estimated that 200,000 Albanians were displaced. While many civilians fled to neighbouring Albania and Macedonia, others left their villages and took refuge in the hills of Kosovo. Health surveys showed that displacement, as well as the violence against Albanian civilians, took a devastating toll on population health.

Between February 1998 - roughly when the conflict between the KLA and Yugoslav authorities began - and June 1999, when NATO forces entered Kosovo, the crude mortality rate was 2.3 times higher than the pre-conflict baseline. War-related trauma was the major cause of death, with an estimated 12,000 deaths directly related to the war. The second leading cause of mortality was chronic disease.

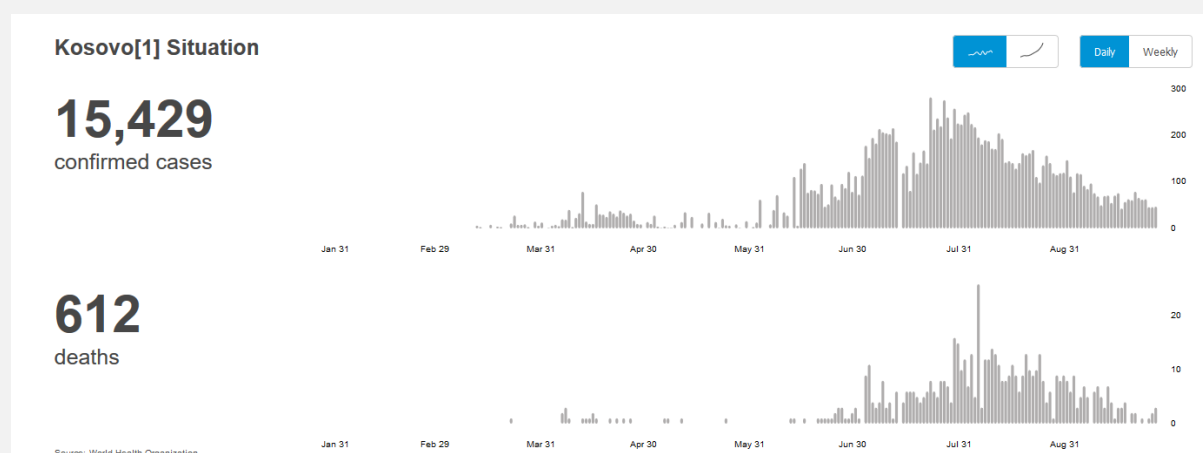
In 1999, NATO undertook a military intervention in Kosovo. After two and a half months of aerial bombardments, the Yugoslav government agreed to the deployment of NATO troops in Kosovo and to the United Nations administering the province.

On June 10, 1999, the United Nations Security Council passed Resolution 1244, which provided the legal foundation for United Nations control over the province. The United Nations Interim Administrative Mission in Kosovo (UNMIK) was formed, charged with building autonomous institutions of self-government. The mandate of UNMIK was to administer the province, while establishing and overseeing the development of provisional self-governing institutions.

The NATO-led KFOR (the Kosovo Force) provided security. The international community was given sweeping powers to build autonomous self-government and undertake political, social, and economic reform.

### Current situation COVID-19 and current measurements:

In the corona crisis, Kosovo is receiving help from Germany. Health experts from the Robert Koch Institute are on-site for two weeks to support the Balkan country in the fight against the virus. This involves analyzing data, risk management and case tracking.

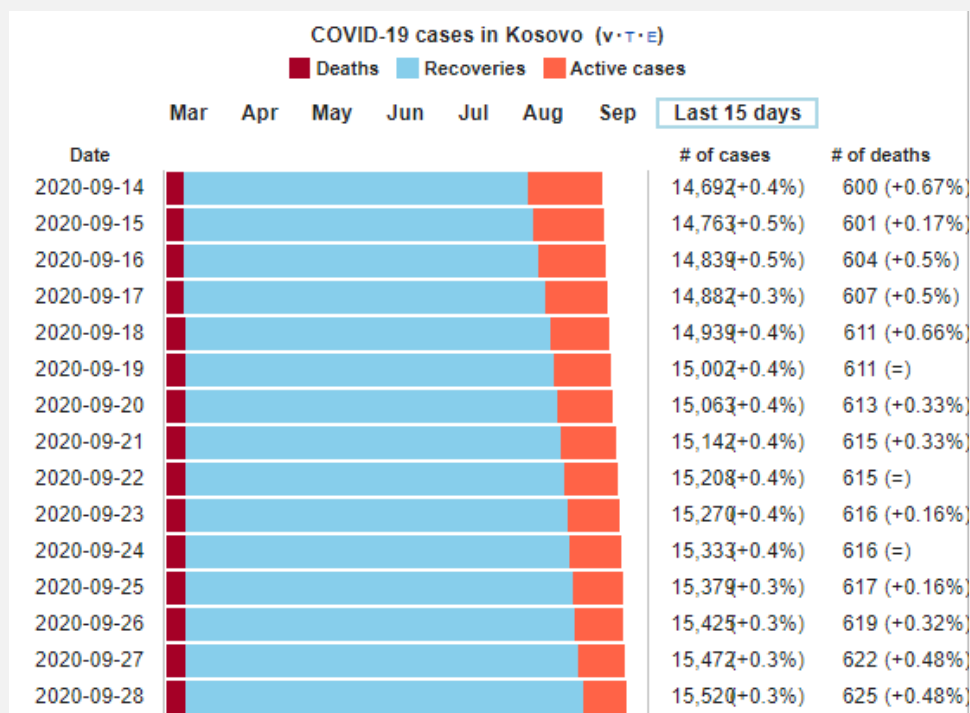


### Measurements COVID-19:

- In public, i.e. at any time outside of one's own home, there is an obligation to wear mouth and nose protection.
- Catering establishments are only allowed to open between 5:00 a.m. and 10:30 p.m. nationwide. With a few exceptions, food and drinks may only be served outside or offered to take away in compliance with the distance rules.
- Meetings of more than 5 people are not permitted in public places and parks. Public and private cultural and sporting events (including training), meetings or celebrations, especially private celebrations (e.g. weddings) are prohibited, as are religious meetings and church services. Funerals may only take place in close family circles.
- People over 65 years of age and the chronically ill are only allowed to leave their apartment in the morning between 5 a.m. and 10 a.m. and in the evening between 6 p.m. and 9 p.m.

- The following cities / municipalities also have a general curfew between 10:30 p.m. and 5:00 a.m.: Drenas, Ferizaj, Fushe Kosove, Gjakove, Gjilan, Leposavic, Lipjan, Mitrovica Nord, Mitrovica Süd, Peje, Podujeve, Pristina, Prizren, Strpce, Vushtrri, Zubin Potok and Zvecan.
- Local public transport (bus, train, taxi) is limited to max. 50% passenger capacity limited.

The Kosovar authorities currently allow most foreigners to enter Kosovo without any conditions as long as travelers do not show any symptoms of illness - there are increased controls and health examinations upon entry. Residents of Montenegro, Bosnia and Herzegovina and North Macedonia must present a negative Covid test (not older than 72 hours) upon entry. Direct transit from / to Pristina Airport is also permitted for this group of people without a test if the stay in Kosovo does not exceed 3 hours.



Source: [https://www.researchgate.net/publication/43181022\\_A\\_case\\_study\\_of\\_health\\_sector\\_reform\\_in\\_Kosovo/link/00b495245dafb7571b000000/download](https://www.researchgate.net/publication/43181022_A_case_study_of_health_sector_reform_in_Kosovo/link/00b495245dafb7571b000000/download)  
<https://covid19.who.int/region/euro/country/xk>  
<https://www.indexmundi.com/kosovo/#Militar>  
[https://de.wikipedia.org/wiki/COVID-19-Pandemie\\_im\\_Kosovo](https://de.wikipedia.org/wiki/COVID-19-Pandemie_im_Kosovo)  
<https://pristina.diplo.de/xk-de/service/coronavirus/2317006>



# 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 emphasizing Mental Health Aspects and other non COVID related diseases
- Immunity map, national strategies to measure and evaluate the immunity level"
- Mental Health
- Treatment of mild symptomatic cases of COVID-19
- Transition home office back to the office
- COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation
- Perspectives of the current COVID-19 vaccine development
- National overview on current COVID-19 situation
- Long term effects of COVID-19 and the impact on force capability

Briefers from UK give a short summary about the long term effects of COVID-19 and the impact on force capability.

Long term effects of COVID-19 and the impact on force capability

### COVID-19 disease severity and lingering symptoms

- Most people with COVID-19 experience **mild symptoms** or **moderate illness**.
- Approximately 10-15% of cases progress to severe disease, and about 5% become critically ill.
- Typically people recover from COVID-19 after 2 to 6 weeks. (See figure below)
- For some people, **some symptoms may linger** or recur for weeks or months following initial recovery. This can also happen in people with mild disease. People are not infectious to others during this time.
- Some patients develop medical complications that may have lasting health effects.



### What we know about people who feel they do not fully recover from COVID-19

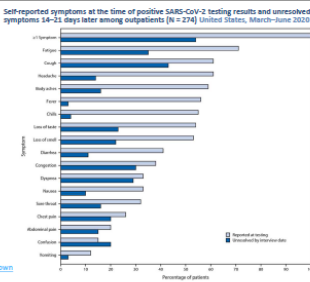
- COVID-19 can sometimes result in **prolonged illness**, even in young adults and children **without** underlying chronic medical conditions.
- There are many case reports from people who do not regain their previous health following COVID-19.
- Little is known about the clinical course of COVID-19 following milder illness.
- In a telephone survey of symptomatic adults who had a positive outpatient test result for SARS-CoV-2, 35% had not returned to their usual state of health when interviewed 2-3 weeks after testing.<sup>1</sup>
- Among those 18 to 34 years in good health, 20% (1 in 5) reported that some symptoms were prolonged.
- **Risk factors for persistence of symptoms:** high blood pressure, obesity, mental health conditions.

<sup>1</sup> <https://www.cdc.gov/mmwr/volumes/68/wr/mm6809a1.htm>

### Lingering symptoms reported by participants of a multi-state phone study in the USA

#### Symptoms which may persist:

- Fatigue
- Cough, congestion or shortness of breath
- Loss of taste or smell
- Headache, body aches
- Diarrhea, nausea
- Chest or abdominal pain
- Confusion



Source: [https://www.cdc.gov/mmwr/volumes/68/wr/mm6809a1.html#f1\\_down](https://www.cdc.gov/mmwr/volumes/68/wr/mm6809a1.html#f1_down)

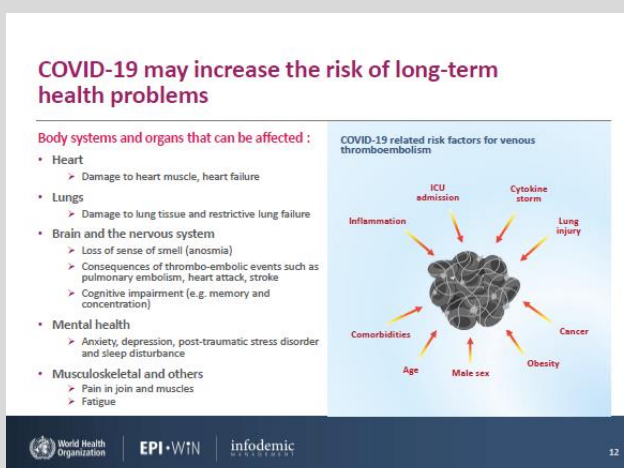
### Long-term health effects of other coronavirus infections

A study was performed on the long term effects of severe acute respiratory syndrome (SARS), the coronavirus that emerged in 2003

- This study showed there was **persistent and significant impairment of exercise capacity and health status** in survivors of SARS over 24 months. Health workers who had SARS experienced even more marked adverse impact<sup>1</sup>
- Another study, revealed that **40% of people recovering from SARS still had chronic fatigue symptoms 3.5 years after being diagnosed**<sup>2</sup>

<sup>1</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC182286/>  
<sup>2</sup> <https://www.frontiersin.org/journal/10.3389/fimm.2019.00014/full>





## COVID Rehabilitation – UK Elements and Experience

### Elements:

- VTC initial consultation (based on WHO data capture document) and initial advice from MDT – Consultant/Physio/OT/Exercise Rehab Instructor
- Patient Information booklet with self help guide to recovery and details of supporting charities and organisations
- Two week residential rehabilitation course
- Three month VTC review – determine need for further input
- Entry into conventional ‘viral fatigue’ programme if still have issues

### Patient information Booklet:

- Breathing – exercises and restoration of normal breathing patterns
- Nutrition – restoration of healthy intake
- Sleep – optimising restorative sleep
- Pain – management options for MSK related pain/discomfort
- Cognitive and emotional health – expected issues and techniques for supporting the patient
- Mental health and Well being – simple tips and signposting to services
- Pacing – guidance on return to normal activity in a structured way

### Residential Rehabilitation Course:

- Pulmonary rehab and breathing techniques – lots of dysfunctional patterns seen
- General mobility work, CV and strength exercise – slow, progressive approach to avoid boom and bust
- Improving sleep, relaxation work and mindfulness and mood stabilisation. Lots of health anxiety presenting in patients.
- Vocational support and optimising of activity in a paced approach
- Nutritional advice and restoration of a healthy weight
- Individualised goal setting for ongoing work and provision of a ‘toolkit’ of self help techniques and activities to maximise self management
- Referral on to local support services as required.

### Experience so far:

- Over 70 patients treated on residential course so far – approximately 75% conversion rate from referral to requiring residential input
- Still primarily a legacy effect – referrals for illness starting in Mar/Apr/May
- Majority community managed during acute stage, average age in 40s and higher BAME proportion than would be expected
- Health Anxiety rates high and reduced significantly with input

- Improved activity levels and decreased perceived exertion scores with structured exercise plan.
- Minimal conversion across to conventional rehab streams

Issues:

- Resource intensive – impact on normal services
- Structured plan improves delivery of course and allows a range of staff to be involved with no change to course content or consistency of delivery
- Variable primary care response – many referrals from certain regions
- Too early to see significant chronic (>6 months) disease patterns
- Importance of ‘what to expect’ information and external support elements. Acute services not generally providing much, which does have an impact on recovery.

Next VTC will be on Wednesday 7th of October with the topic “**Overview on current COVID-19 situation in Missions**”

## Recommendations

### Recommendation for international business travellers

As of 15<sup>th</sup> 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 members<sup>15</sup>;
- 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:

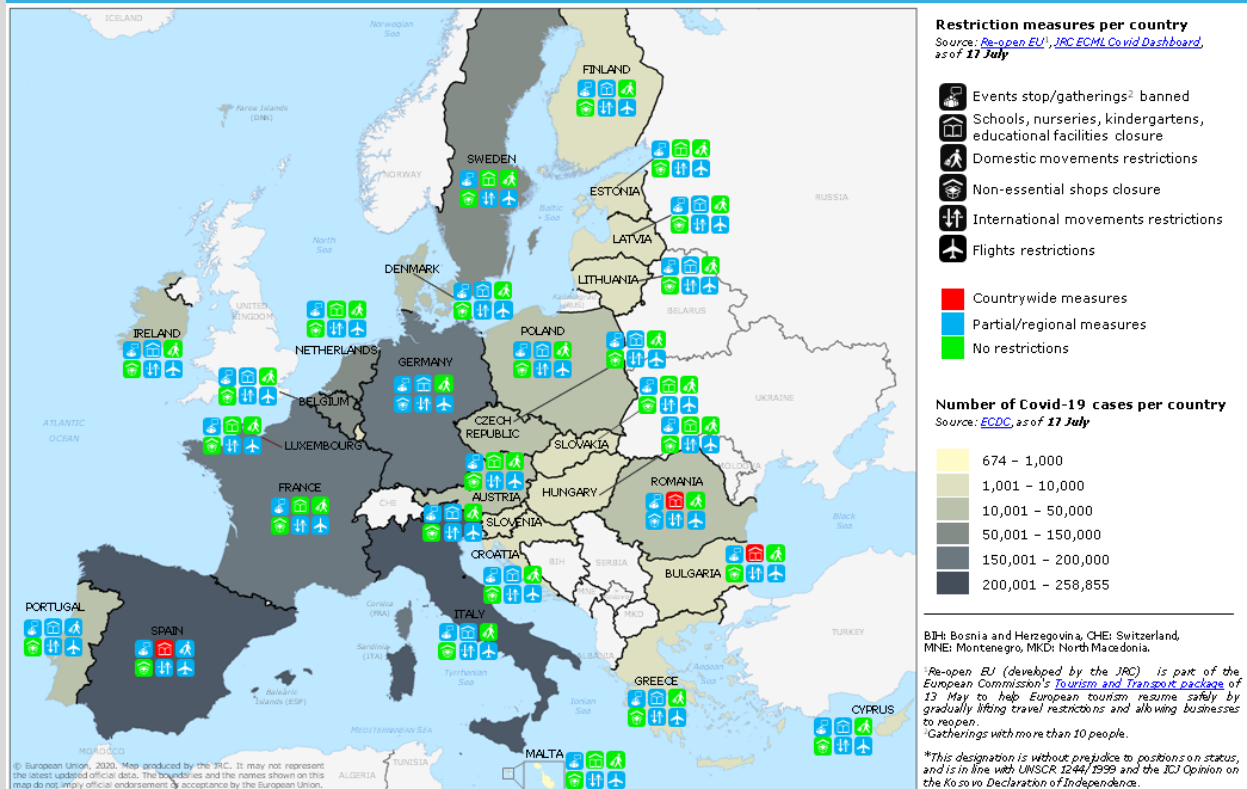
- healthcare professionals, health researchers, and elderly care professionals
- frontier workers
- seasonal workers in agriculture
- transport personnel
- Diplomats, staff of international organisations and people invited by international organisations whose physical presence is required for the well-functioning 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.

JRC Map 17 July 2020 at 13:00 UTC

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



Source: [https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic\\_en](https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en)

## Risk Assessment

Global	<ul style="list-style-type: none"> <li>Because of global spread and the human-to-human transmission the <b>moderate to high</b> risk of further transmission persists.</li> <li>Travellers are at risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks.</li> <li>Individual risk is dependent on exposure.</li> <li>National regulation regarding travel restrictions, flight operation and screening for single countries you will find <a href="#">here</a>.</li> <li>Official IATA changed their travel documents with new travel restrictions. You will find the documents <a href="#">here</a>.</li> <li>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.</li> <li>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.</li> </ul>
<b>Europe</b>  As of 25 <sup>th</sup> of September 2020	<p><a href="#">ECDC assessment</a> for EU/EEA, UK as of 25 September 2020:</p> <p><b>Risk in countries observing stable and low notification rates, and low test positivity:</b></p> <ul style="list-style-type: none"> <li>The risk of COVID-19 for the general population and for healthcare provision is <b>low</b>, based on a low probability of infection and low impact of the disease.</li> <li>The overall risk for vulnerable individuals is <b>moderate</b> based on a low probability of infection and very high impact of the disease.</li> </ul> <p><b>Risk in countries observing high or sustained increase in notification rates, or high test positivity, but with high testing rates and transmission occurring primarily in young individuals:</b></p> <ul style="list-style-type: none"> <li>The risk of COVID-19 is <b>moderate</b> for the general population and for healthcare provision, based on a very high probability of infection and low impact of the disease.</li> <li>The risk of COVID-19 for vulnerable individuals is <b>very high</b>, based on a very high probability of infection and very high impact of the disease.</li> </ul> <p><b>The risk in countries observing high or sustained increase in notification rates, or high test positivity, and an increasing proportion of older cases, and/or high or increasing COVID-19 mortality:</b></p> <ul style="list-style-type: none"> <li>The risk of COVID-19 is <b>high</b> for the general population, based on a very high probability of infection and moderate impact of the disease.</li> <li>The risk of COVID-19 for vulnerable individuals is <b>very high</b>, based on a very high probability of infection and very high impact of the disease.</li> </ul>

## References:

- European Centre for Disease Prevention and Control [www.ecdc.europe.eu](http://www.ecdc.europe.eu)
- World Health Organization WHO; [www.who.int](http://www.who.int)
- Centres for Disease Control and Prevention CDC; [www.cdc.gov](http://www.cdc.gov)
- European Commission; [https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic\\_en](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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