Update 40 (06th of October 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
06th of October 2020
email: info.dhsc@coemed.org

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

HIGHLIGHTS/NEWS

- More than 35 million corona infections have been registered worldwide, and more than a million people died of the lung disease COVID-19.
- **Spain** is the first European country to pass the 800,000 positive test threshold.
- **WHO**: estimates that every tenth person in the world has been infected with the novel corona virus. That would correspond to an unreported number of more than 700 million undetected infections in addition to the around 35 million cases that have been detected so far.
- The proportion of those already infected varies depending on the country, between urban and rural populations and also according to social groups. Even with such a high number of unreported cases, the overwhelming majority of people worldwide are still at risk of developing COVID-19.
- **ECDC**: Launched a new tool for the early detection of public health threats from Twitter data: "epitweetr". It allows users to automatically monitor trends of tweets by time, place and topic, with the aim of detecting public health threats early through signals, such as an unusual increase in the number of tweets.
- **European Commission:** Launched the Eurostat webpage with statistics on population and health related to COVID-19. On the page there is also a map with located health care services all over Europe.
- **Biontech:** The corona vaccine candidate developed by the Mainz-based company Biontech is entering the approval process. The European Medicines Agency EMA will examine the active ingredient BNT162b2 in a so-called rolling review process.

GLOBALLY ↗ 35 471 836 confirmed cases **24 776 350** recovered **1 044 254** deaths
EU/EEA and the UK ↗ **5 740 653** confirmed cases **2 823 250** recovered **234 660** deaths
USA → **(new cases/day 33 087)** **7 402 943** confirmed cases **2 931 953** recovered **209 421** deaths
Brazil ↘ **(new cases/day 8 456)** **4 927 235** confirmed cases **4 397 882** recovered **146 675** deaths
India ↘ **(new cases/day 74 442)** **6 685 082** confirmed cases **5 662 490** recovered **103 569** deaths
Russia ↗ **(new cases/day 10 757)** **1 219 796** confirmed cases **978 610** recovered **21 375** deaths
Spain ↘ **(new cases/day 23 480)** **813 412** confirmed cases **150 376** recovered **32 225** deaths

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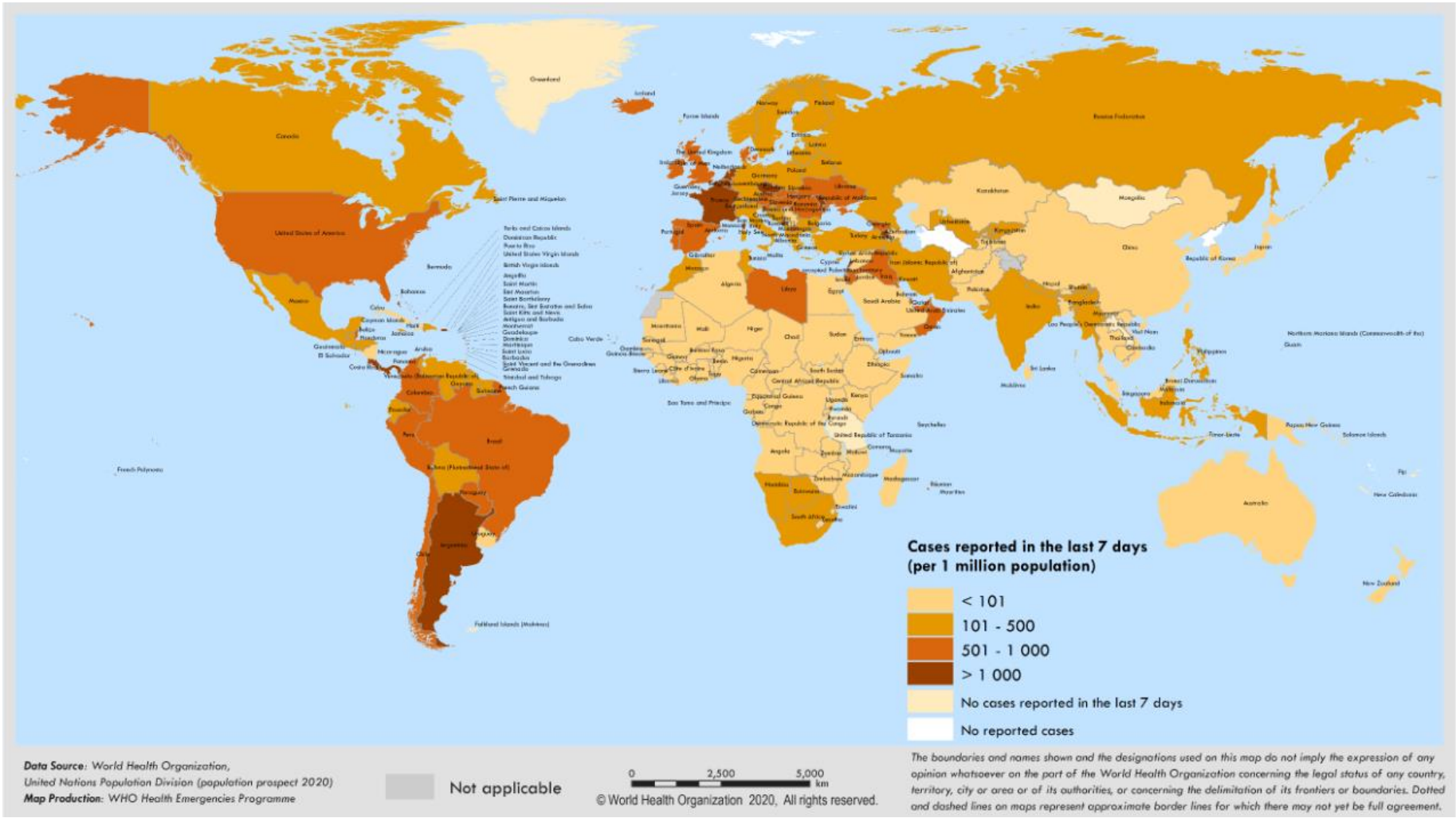
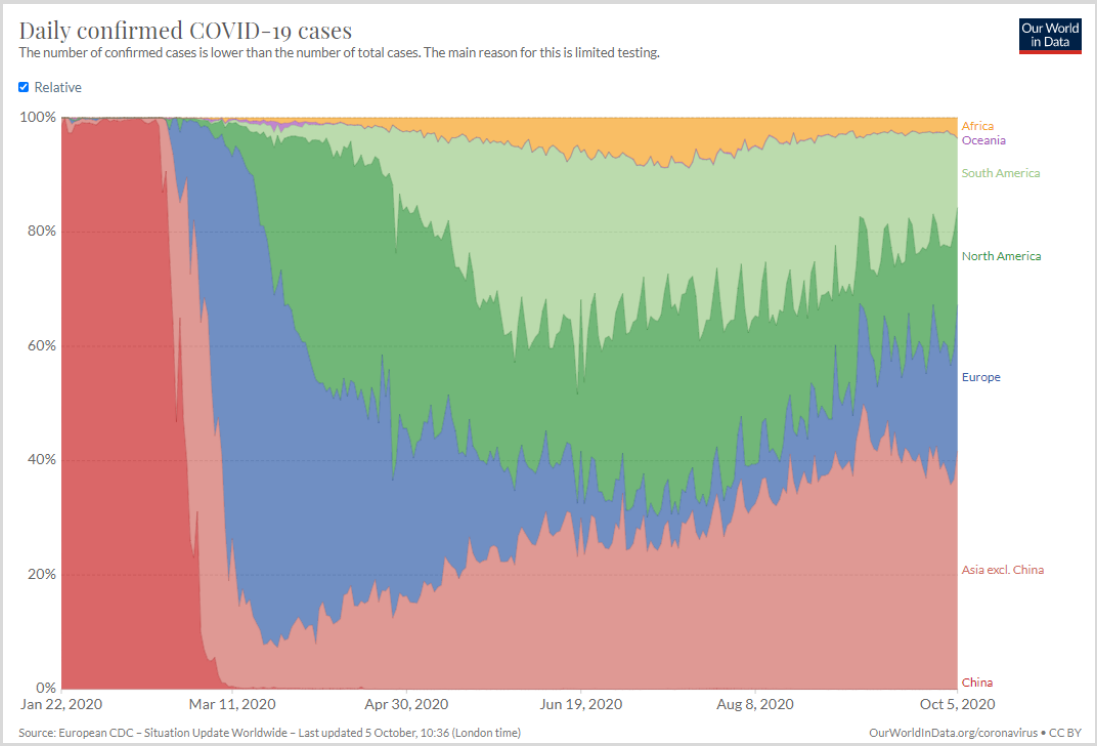
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation



[WHO weekly operational update on COVID-19 as of 2 October 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 National Rapid Response Teams Global Virtual Learning Series

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 2 October 2020	Laboratory supplies		Personal protective equipment					
Region	Swabs	Tests (Manual PCR)	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	2 423 985	1 040 646	996 407	596 300	149 781	994 079	43 498 733	1 535 974
Americas (AMR)	6 960	10 341 238	3 820 501	88 000	301 180	3 918 770	53 548 710	7 851 856
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)	189 900	416 700	1 704 850	7 190 100	374 720	985 048	37 292 100	5 126 950
South East Asia (SEAR)	1 301 800	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	544 000	98 167	86 510	10 339 650	926 235

WHO Funding Mechanisms

- **COVID-19 Solidarity Response Fund**

As of 2 October 2020, The Solidarity Response Fund has raised or committed more than US$ 237 million.

Among the latest allocations, the Solidarity Fund has supported a project to promote CSOs engagement in the COVID19 response, for a total of US$5 million. This is an innovative initiative on prevention and control of COVID-19 through direct partnership with civil society and community organizations at the country level.
The project will provide grants to selected CSOs as a pilot, review priorities in governance mechanisms for engagement with CSOs, and establish networks at global and regional levels to support CSO engagement in health emergencies.

- **The WHO Contingency Fund for Emergency (CFE)**

WHO's Contingency Fund for Emergencies (CFE) provided $8.9 million for COVID-19 preparedness and response worldwide at the very onset of the outbreak when no other funding was available.

WHO weekly epidemiological report, 5 October 2020

Global epidemiological situation

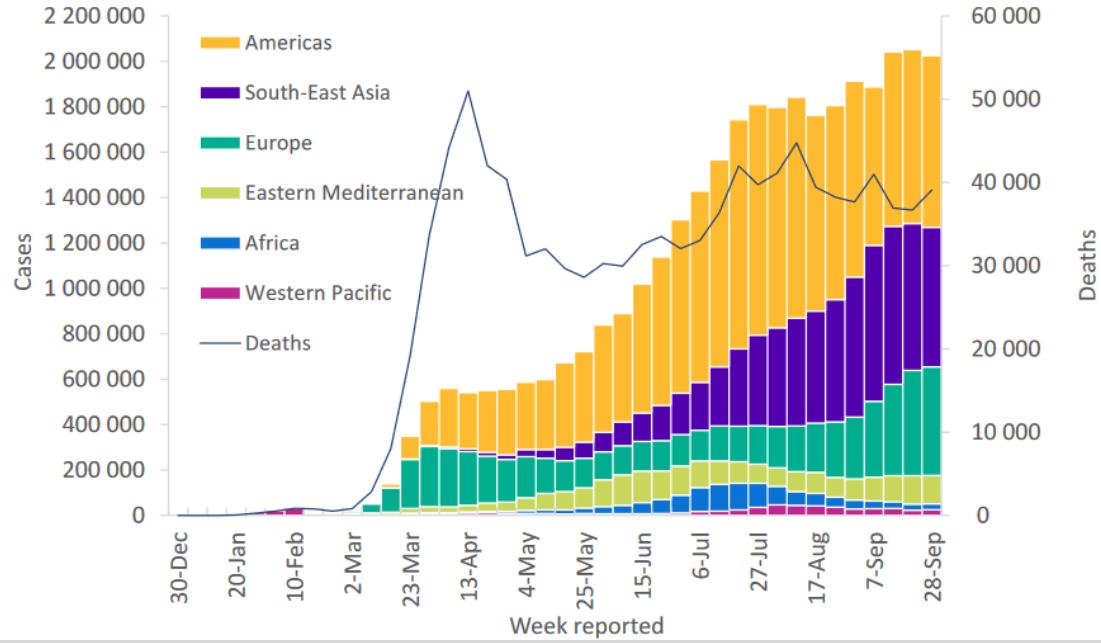
The number of new cases per week has remained stable at 2 million for the past three weeks, with the cumulative total of over 34.8 million cases.

Over 1 million deaths have now been reported globally, of which the majority were reported in the **Region of the Americas** (55%), followed by **Europe** (23%).

In the past week, the regions of the **Americas, South-East Asia, and Europe** account for 91% of new cases. Five countries (namely **India, the United States of America, Brazil, Argentina and France**) reported 60% of new global cases this past week, while **Israel** registered the highest incidence (3717 new cases per 1 million population).

Globally, the highest percentage of cases have been reported in the 25-39 age group, with approximately 50% of cases in the 25-64 age group. However, the percentage of deaths increases with age, and approximately 75% of deaths are in those aged 65 years and above.

Figure 1: Number of COVID-19 cases reported weekly by WHO Region, and global deaths, 30 December 2019 through 04 October 2020**



Although globally the number of new cases was like the number of cases in the previous week, there is considerable variation on a country-by-country basis. In several countries, the number of new cases is rising again, and in many (most notably within the European Region) the second wave is exceeding previous peaks; this can be partly attributed to enhancements in surveillance capacities over time.

In other countries we have seen a gradual decline in new cases from earlier peaks in August, for example in Brazil, Colombia and **Peru**.

In **India** and the **Philippines**, the number of new cases appear to have stabilized, but they are still reporting high numbers.

There are also examples of countries that have consistently shown an increasing incidence as their first wave continues; these include **Indonesia, Iraq**, and **Myanmar**, although Indonesia is reporting a slight drop this week.

South Africa and **Australia** are examples of countries that have successfully managed to reduce the number of new cases and have seen large reductions from earlier peaks.

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 04 October 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	756 926 (37%)	-1%	16 990 036 (49%)	21 494 (55%)	13%	568 358 (55%)
South-East Asia	614 502 (30%)	-5%	7 335 273 (21%)	8 456 (22%)	-6%	119 167 (12%)
Europe	478 119 (24%)	3%	6 187 384 (18%)	5 039 (13%)	6%	240 148 (23%)
Eastern Mediterranean	125 567 (6%)	<1%	2 466 722 (7%)	2 804 (7%)	3%	63 156 (6%)
Africa	26 208 (1%)	-3%	1 198 550 (3%)	783 (2%)	8%	26 264 (3%)
Western Pacific	24 751 (1%)	8%	625 642 (2%)	503 (1%)	9%	13 632 (1%)
[†] Other	-	-	741 (<1%)	-	-	13 (<1%)
Global	**2 026 073 (100%)**	**-1%**	**34 804 348 (100%)**	**39 079 (100%)**	**7%**	**1 030 738 (100%)**

*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%.
**See data, table and figure notes

African Region

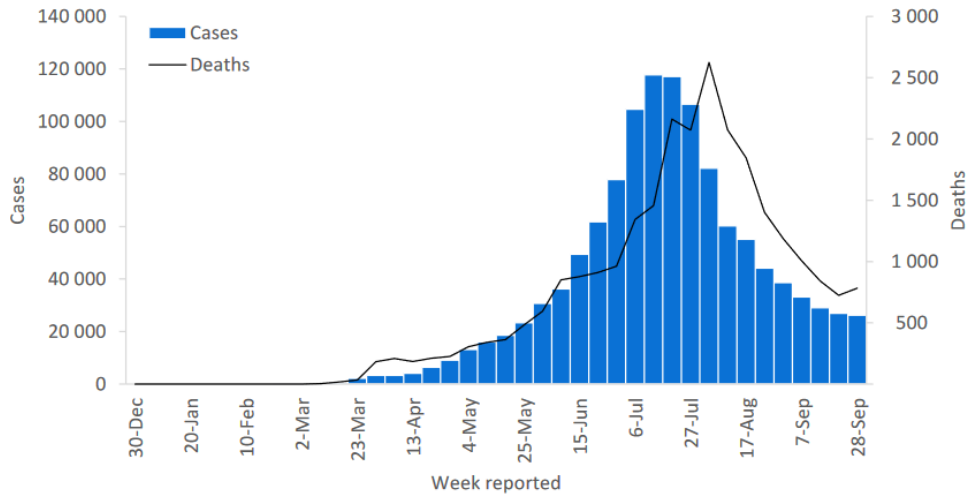
South Africa and **Ethiopia** continue to report the highest numbers of new cases in Africa, followed by **Mozambique, Uganda,** and **Nigeria**.

Africa has seen a continuous decline in case incidence since mid-July; however, this trend is now slowing.

For the first week since early August, the number of new deaths has risen –led by **South Africa** with a 29% increase in deaths in the past week. **South Africa** also has the second-highest mortality rate in the Region. The provinces of **Gauteng** and the **Western Cape** have reported the most cases and deaths to date; however, these regions, as well as the country itself, have maintained sustained declines in the daily incidence since the end of July. Despite this, weekly case numbers have continued to rise in less populated provinces. The country moved to Alert Level1 as of 21 September (the least stringent of the five alert levels applied by the South African Government), with all sectors of the economy now open with strict adherence to public health protocols.

New weekly cases have risen in **Angola** from 400 in the week of 7 September to 698 cases in the past week, a 74% increase, although the number of new cases has declined by 10% from the past week. Angola recently upgraded their self-reported transmission classification from 'clusters of cases' to 'community transmission'. **Luanda province** remains the epicentre with around 90% of all cases. A total of 16 out of the 18 provinces have reported confirmed cases.

Figure 3: Number of COVID-19 cases and deaths reported weekly by the WHO African Region, as of 4 October 2020[**]



Region of the Americas

A similar incidence of new cases was reported across the Region over the past week in comparison to previous week.

The **United States of America, Brazil, Argentina, Colombia, Mexico** and **Peru** registered the highest number of weekly new cases.

The **United States of America** continues to record approximately 300 000 new cases per week. Declines observed over July and August have stagnated in recent weeks, with several states reporting sharp rises in case numbers –most notably in **Midwest states**.

Canada is also showing a large increase in new cases and new deaths compared with last week, at 43% and 208% respectively.

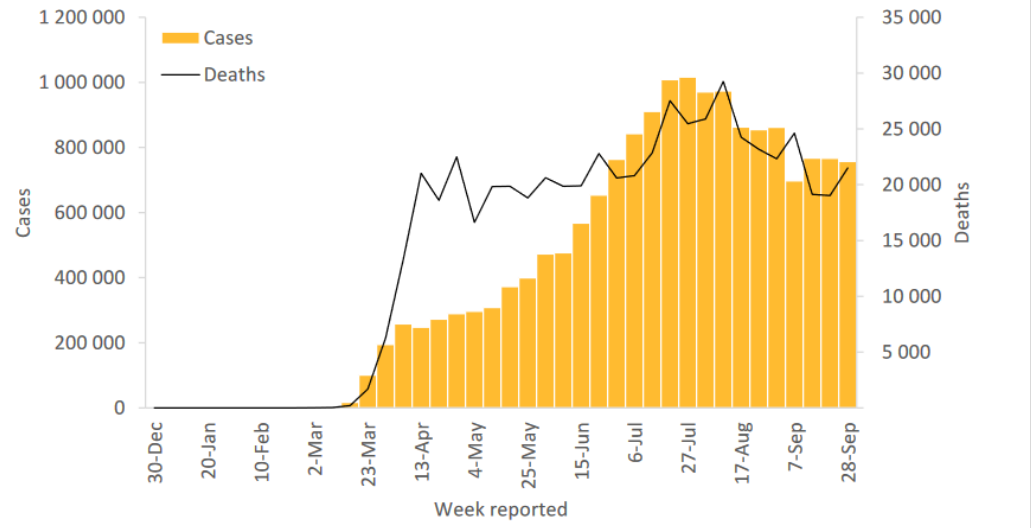
Likewise, **Argentina** continues to report an increase in cases and deaths, with cumulative deaths exceeding 20 000 last week after a backlog of over 3000 reported deaths from **Buenos Aires**.

Since peaking at just over 300 000 new weekly cases in the week of 27 July, new cases in **Brazil** have fallen to 190 000 new cases in the past week.

Weekly new cases have also fallen in Colombia and **Peru**.

Older persons are far more likely to experience severe disease following infection. **Brazil** reported that 76% of COVID-19 related deaths during February to September 2020 were in adults aged 60 years and older. In **Peru**, people over the age of 70 years had the highest COVID-19 mortality rates during March-May 2020 and estimates from **Canada** show that more than 80% of COVID-19 deaths have occurred in long-term-care facilities.

Figure 4: Number of COVID-19 cases and deaths reported weekly by the WHO Region of the Americas, as of 04 October 2020**



Eastern Mediterranean Region

A similar incidence of new cases was reported from the Eastern Mediterranean Region over the past week in comparison to previous week.

Iraq, Iran, Morocco, and **Lebanon** are reporting the highest numbers of new cases for the past week.

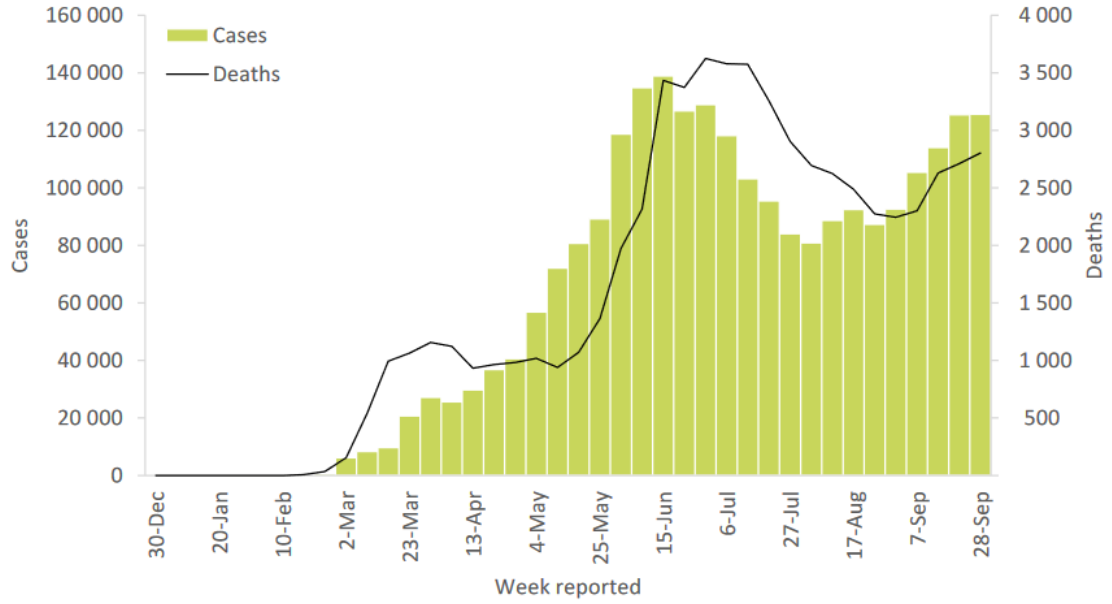
Iraq has reported over 20 000 cases per week since the beginning of August and this week just under 30 000 cases new cases were reported.

In **Jordan**, case incidence has almost doubled each week for the past five weeks, with over 6600 new cases (a 90% increase on the previous week) reported last week.

Since the start of September, the **Islamic Republic of Iran** has shown an upward trend in weekly new cases and is reporting their highest number of new cases – 25 000 new cases – since the beginning of the pandemic.

Lebanon reported a 19% increase in new cases compared with the previous week and has one of the highest rates of new cases in the Region.

Figure 5: Number of COVID-19 cases and deaths reported weekly by the WHO Eastern Mediterranean Region, as of 04 October 2020**



European Region

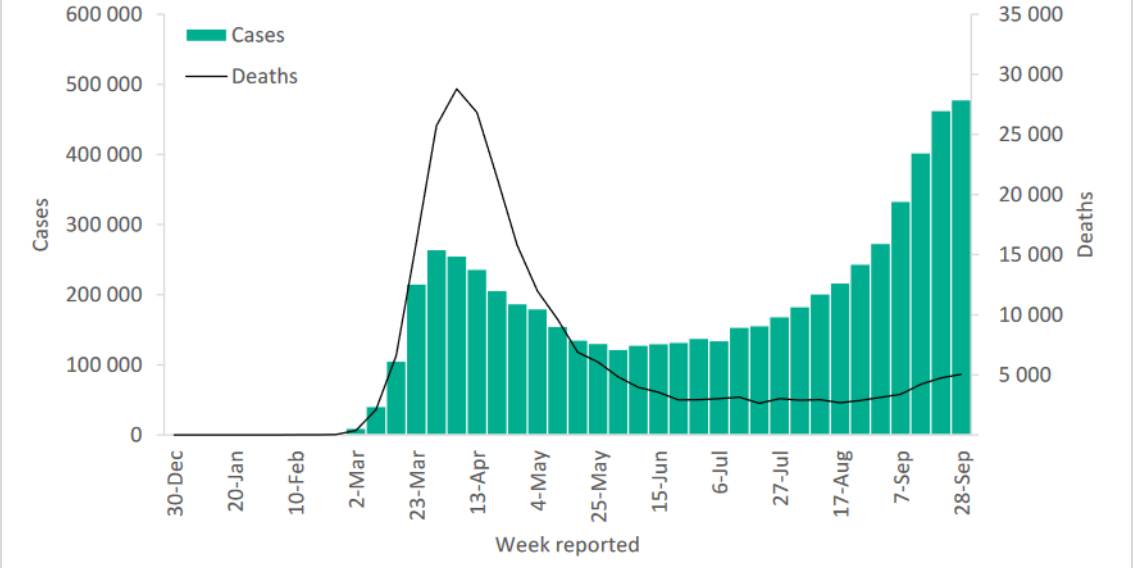
The incidence of new cases has continued to increase in the European Region overall.

France, the Russian Federation, the United Kingdom, Spain, and **Israel** reported the highest numbers of new cases in the past week. The numbers of new cases and new deaths in the **Russian Federation, the United Kingdom, Ukraine** and several other countries in Europe are showing considerable increases compared with last week. **The Netherlands, Czechia, Germany**, and **Italy** have also reported sizable increases.

With over 1.2 million COVID-19 cases, and over 63 000 new cases in the past week, the **Russia Federation** is reporting the second highest number of new cases in Europe and the sixth highest number globally. Russia's weekly new cases peaked at 75 000 cases in the week of 4 May, with a gradual decrease observed through late August, but rapid increases observed in the last three weeks.

In contrast to other European countries, **Ukraine** did not observe a large first peak, but has reported a continuous increase in new cases since mid-June. Over 27 000 new cases were reported in the past week, a 21% rise from the week before.

Figure 6: Number of COVID-19 cases and deaths reported weekly by the WHO European Region, as of 04 October 2020**



South-East Asia Region

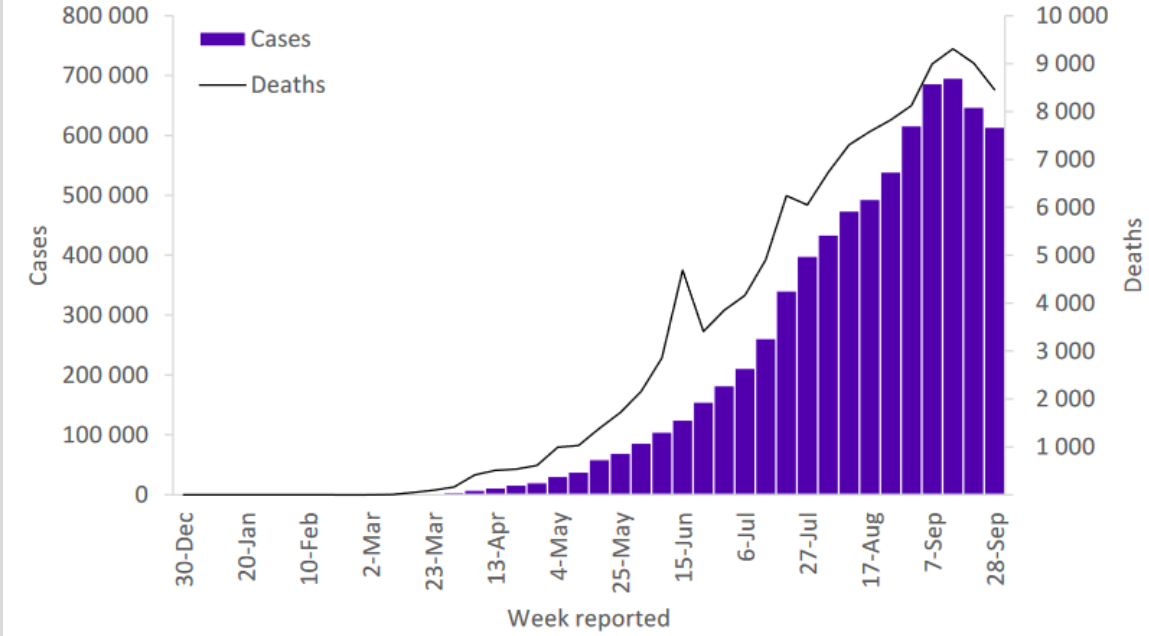
A gradual decline in case and deaths incidence in the South-East Asia Region continued during the past week. Nevertheless, the Region contributed almost a third of new cases reported global in the past week. At the same time, current weekly case incidence is markedly lower than that which is currently observed in the Americas and Europe.

India, reporting over 500 000 new cases per week since late-August, again contributed the majority of incident cases in the Region (91%) and globally (27%) last week, bringing cumulative counts in the country to an excess of 6.5 million cases and 100 000 deaths (10% of the global total). Over several months, case numbers in India rose rapidly, with Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, and **Uttar Pradesh** reporting the highest numbers of cases. This increase occurred with a concurrent expansion in testing activity, which has since stabilized at 7–8 million samples tested per week in the past five weeks. Weekly incidence of new cases is gradually easing, falling to 403 new cases per 1 million population this past week, after peaking three weeks ago, while test positivity rates fell marginally to 7.1%.

Indonesia is currently the second most affected country in the Region, nearing 300 000 cases to date, including over 28 000 new cases in the past week. Almost 60% of cases to date have been reported from the island of **Java**, which includes the capital Jakarta. Suspected case numbers have risen sharply in recent weeks; however, testing capacity has thus far been unable to meet demand, with approximately 23% (n=30 940 people) people tested among some 132 000 suspected cases reported on 30 September. Among four provinces that achieved a benchmark of 1 person tested/1000 population/week during September, weekly test positivity rates ranged markedly from less than 5% to over 40%, highlighting the heterogeneity in both surveillance capacity and COVID-19 activities across the island.

In **Myanmar**, COVID-19 incidence has risen sharply, with cumulative counts almost doubling each week since mid-August, and over 6500 new cases reported in the past week. **Rakhine State** and the country's largest city, Yangon has reported around 75% of cases, and has been hardest hit to date, with a possibility of community transmission in areas. On 20 September, Myanmar announced a stay-home order for its biggest city Yangon.

Figure 7: Number of COVID-19 cases and deaths reported weekly by the WHO South-East Asia Region, as of 04 October 2020[**]



Western Pacific Region

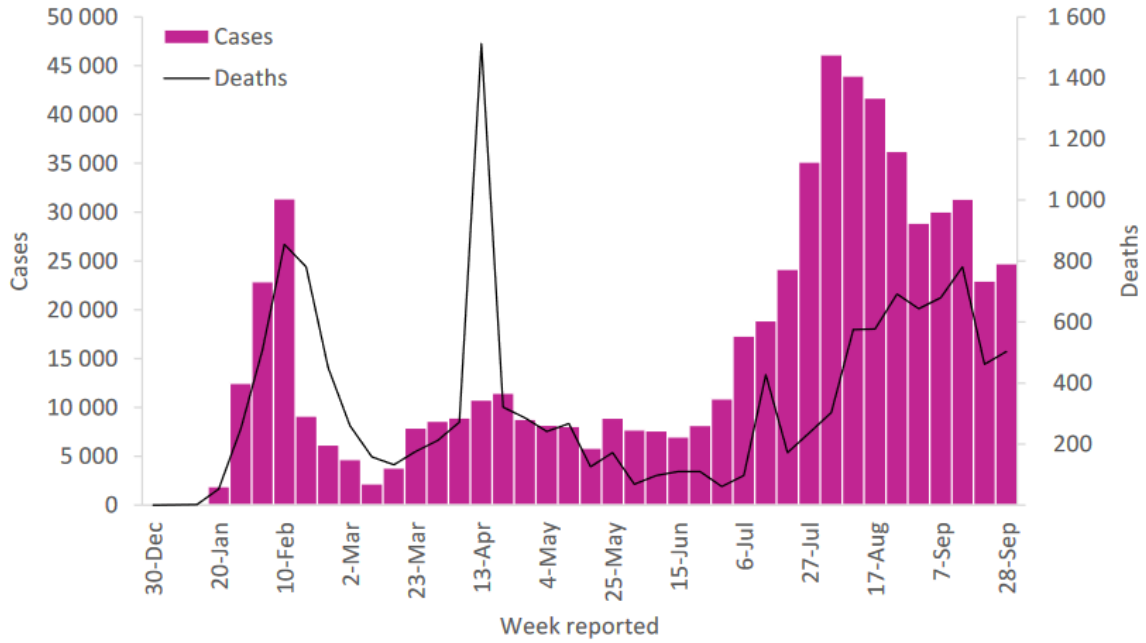
In the Western Pacific Region, the weekly number of new cases reported continues to fluctuate. The **Philippines, Japan**, and **Malaysia** are reporting the highest numbers of new cases, with **Malaysia** reporting an increase of 119% in new cases compared with last week.

Around three-quarters (73%) of new cases in the region were from the **Philippines**. Although weekly new cases in the Philippines peaked in the week of 10 August, the incidence of new cases remains relatively high compared to others in the Region, with over 18 000 new cases in the past week. Data as of 29 September shows that 50% of cases are in the age group 20-39 years, while 60% of deaths are in those aged 60 years and over. There is community transmission in all regions of the country, with three regions -**National Capital Region, Region 3**, and **Region 4A** –showing higher transmission intensity. The **National Capital Region** continues to report the most cases, with half of national cases, where Metro Manila mayors have recommended the extension of the general community quarantine status for the month of October.

In **Malaysia**, the weekly number of new cases has been increasing for the past 3 weeks, with 1319 cases reported in the past week. The state of **Sabah** has been the worst affected in recent weeks, accounting for 77% of cases reported in September. A number of clusters in other states have also been linked to travellers from Sabah. Malaysia has a nationwide recovery movement control order (RMCO) in place and most communities and services are operating under these limited restrictions. However, targeted enhanced movement control orders (TEMCO), the most stringent form of community and business restrictions, have been implemented in a number of areas with high levels of community transmission.

The **Solomon Islands** recorded their first COVID-19 case: a student returning from the Philippines on a repatriation flight. The Solomon Islands have planned to use repatriation flights to return students studying in the Philippines and Indonesia.

Figure 8: Number of COVID-19 cases and deaths reported weekly by the WHO Western Pacific Region, data as of 04 October 2020**



Updates from WHO regional offices:

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

	RUS: Health authorities reported 10,888 new infections in one day - the highest figure since May 12. 3537 cases were registered in Moscow alone. In view of the rising numbers, the capital Moscow is tightening the rules to contain the pandemic. From this Monday on, companies must have at least a third of their employees work from home. This measure also applies to all employees who are older than 65 years or who are chronically ill. In addition, the students in Moscow were sent on extended autumn vacation. After the holidays, students in Moscow and some other regions should study at home again. ---------- **NZE**: New Zealand Prime Minister Jacinda Ardern announced the lifting of all coronavirus restrictions in the city of Auckland from midnight on Wednesday. This means that New Zealand's largest city is also formally returning to the lowest alert level 1, which is already in place in the rest of the country. After ten days without infection within the country, the end of the restrictions is justified. ---------- **USA**: The number of new infections in the US remains high. The US Disease Centers CDC announced 49,327 new cases, up from 50,160 on Saturday. …… Doctors and scientists reacted with sheer horror to the decision of US President Donald Trump to briefly leave the hospital despite his infection with the coronavirus. After the 74-year-old head of state was cheered by supporters on Sunday (local time) on a jaunt in an armored car in front of the Walter Reed Military Hospital in Bethesda, Maryland, he was accused of dangerous behavior. After Trump was brought to the hospital by helicopter on Friday evening, there were conflicting reports about his health. On Sunday the doctors finally admitted that the course of the disease was more severe than initially presented. US President Donald Trump has returned to the White House this morning, after three days of hospital treatment for his COVID-19 illness. …… In several neighborhoods of New York, schools are to be closed again due to the massive increase in the number of corona cases and the operation of businesses that are not absolutely necessary is to be restricted. ---------- **MEX**: has changed the way it counts its corona cases and registered 28,115 new infections and 2,789 new deaths within one day. The death toll related to the Covid-19 disease - the fourth highest in the world - rose to 81,877 on Monday (local time). On the previous day, 3712 infections and 208 deaths had been added.

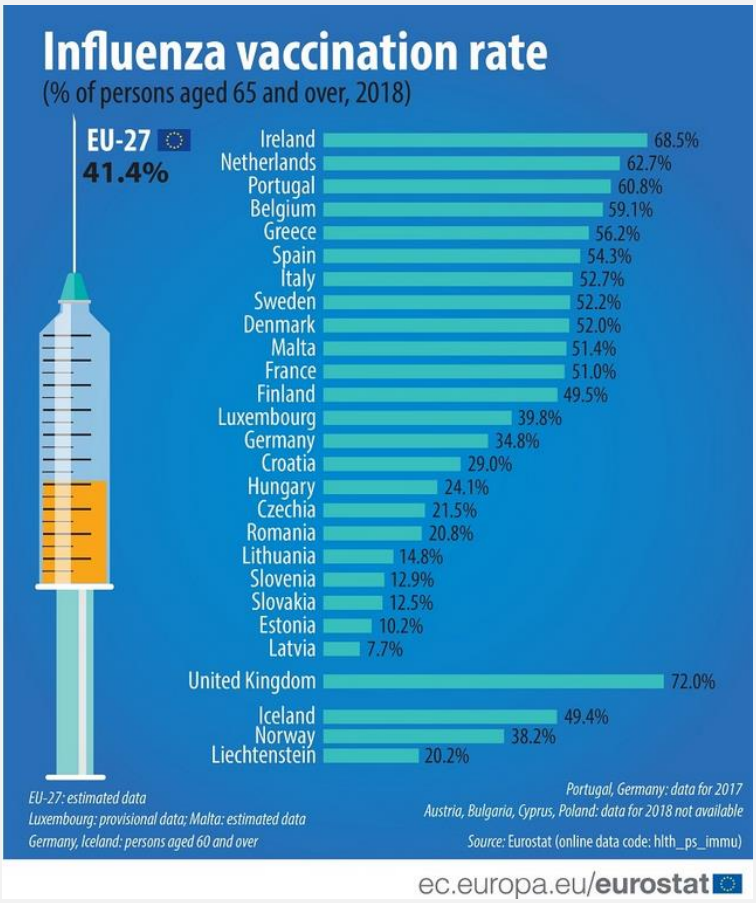
Situation in Europe

Vaccination against influenza, Eurostat as of 15 September 2020

For 2020 WHO and most national health ministry's recommend the vaccination against influenza not only for older people and people at risk, but for the whole population including children.

Eurostat, the statistical webpage of the European Commission had summarized former years vaccination rates as followed:

Among the EU Member States, there is a range of different policies with respect to making influenza vaccines available to the general public — often they are specifically targeted at older groups of people or other at-risk groups. In the EU in 2018, about 41% of those aged 65 and over were vaccinated against influenza.
Among the 23 Member States for which recent data is available, there were considerable differences in the shares of people being vaccinated against influenza: close to 7 out of 10 persons aged 65 and over (69%) were vaccinated in **Ireland**, with slightly lower shares in the **Netherlands** (63%), **Portugal** (61%, 2017 data) and **Belgium** (59%), while less than 10% of the elderly population were vaccinated in **Latvia** (8%).



Source: European Commission

Epitweetr; a new tool for the early detection of public health threats from Twitter data

ECDC has launched a free, open source interactive tool to help with the automatized early detection of public health threats using Twitter data.

The R-based tool epitweetr allows users to automatically monitor trends of tweets by time, place and topic, with the aim of detecting public health threats early through signals, such as an unusual increase in the number of tweets. It was designed to support public health experts with the early detection of threats from infectious diseases but can be extended to all hazards and other fields of study by modifying the topics and keywords.

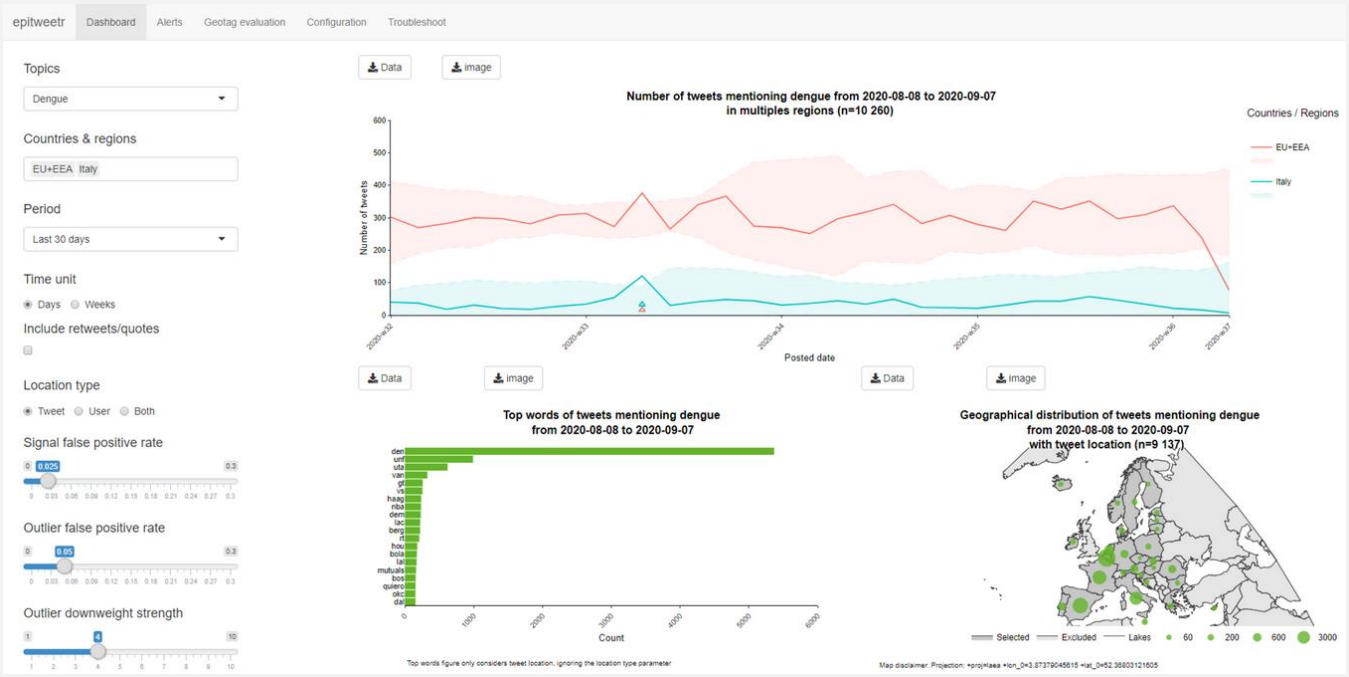
The epitweetr package includes an interactive web application (based on the R package Shiny) with five pages:

1. Dashboard, where a user can visualise and explore tweets, and download the associated outputs and data;
2. Alerts page, where you can view the current alerts and associated information;
3. Geotag evaluation page, where you can evaluate the geolocation algorithm in different tweet fields to manually choose the geolocation threshold;
4. Configuration page, where you can change settings and check the status of the underlying processes;
5. Troubleshooting page, with automatic checks and hints for using epitweetr with all its functionalities.

To make epitweetr as widely available as possible, R was chosen as the computing platform. R is free, open source, and runs on any modern operating system.

epitweetr can be downloaded free of charge from the ECDC website, the CRAN website (for CRAN users) or GitHub (for GitHub users).

Source: ECDC



ECDC COVID-19 surveillance report Week 39, as of 1 October 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 39, ending Sunday 27 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 39 (27 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 113.6 (country range: 9.9–319.9) per 100 000 population. The rate has been increasing for 70 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 27 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Poland, 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 18 countries (Austria, Belgium, Croatia, Czechia, Denmark, Estonia, Germany, Hungary, Ireland, Luxembourg, Malta, Netherlands, Norway, Portugal, Romania, Slovenia, Spain and Sweden).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 39, available for 28 countries, varied from 335 to 6 003 tests per 100 000 population. Denmark had the highest testing rate for week 39, followed by Luxembourg, Iceland, Malta and Cyprus.
- Weekly test positivity was high (at least 3%) or had increased compared to the previous week in 15 countries (Austria, Belgium, Bulgaria, Croatia, Czechia, France, Hungary, Lithuania, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia and Spain).

Primary care

- In the six countries that reported data from primary care sentinel surveillance for COVID-19 up to week 39, using the systems established for influenza, two detections of SARS-CoV-2 were reported among the 63 patients tested.
- Among those countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 39, using the systems established for influenza, Belgium and Ireland had observed recent increases in consultation rates to levels higher than those reported during the same period for the last two years.

Hospitalisation

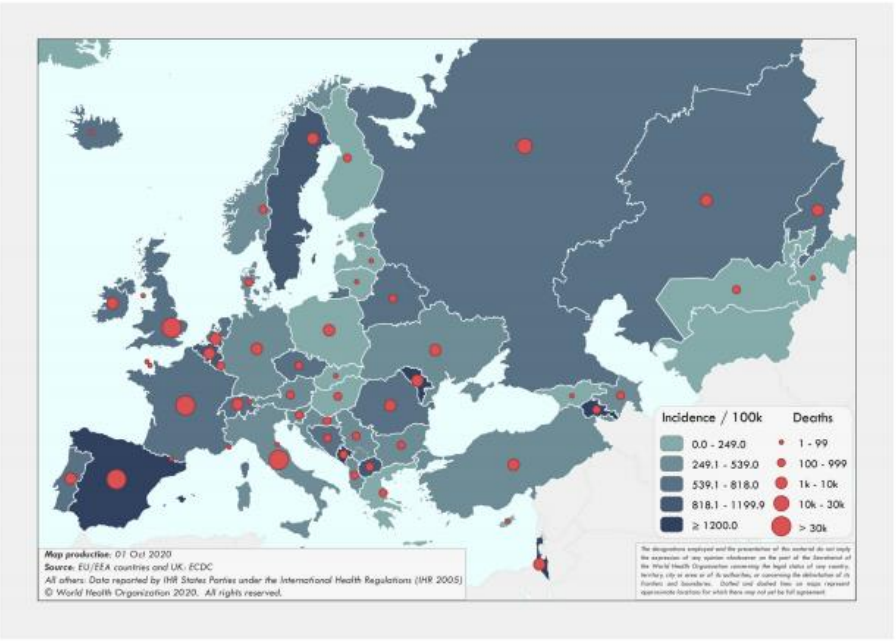
- Hospital and/or ICU occupancy and/or new admissions due to COVID-19 were high (at least 25% of the peak level during the pandemic) or had increased compared to the previous week in 14 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, France, Greece, Hungary, Ireland, Netherlands, Portugal 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 21% (country range: 4–65%) 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 8.8 (country range: 0.0–31.6) per million population. The rate has been increasing for 16 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 14 countries (Belgium, Bulgaria, Croatia, Czechia, France, Greece, Hungary, Italy, Malta, Netherlands, Portugal, Romania, Spain and the UK).
- Overall pooled estimates of all-cause mortality reported by EuroMOMO for week 39 show normal levels for the participating countries. However, excess mortality is observable in the age group 75 to 84 years and overall in a few countries.

COVID-19 situation update for the WHO European Region (21 – 27 September 2020 Epi week 39)

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



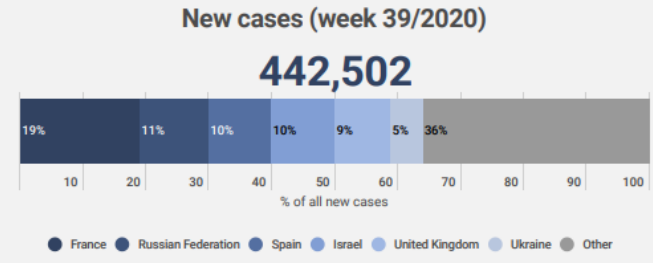
Key points

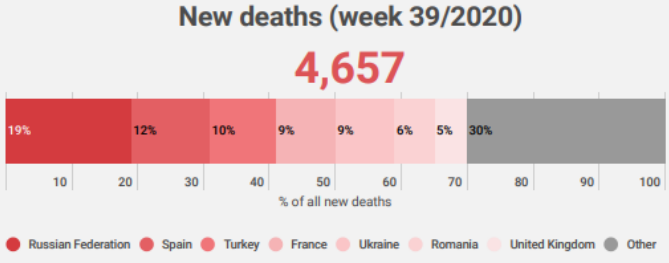
Week 39/2020 (21 - 27 Sept 2020)

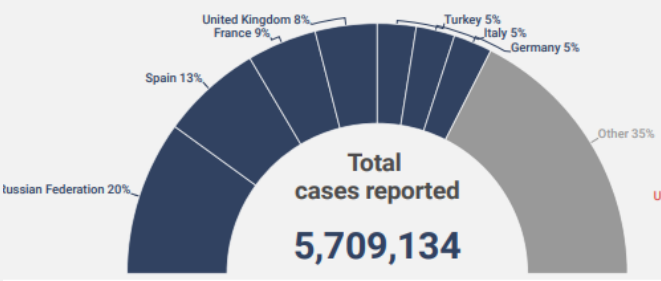
- The number of cases reported in the Region increased 11% to 442,502 in week 39/2020 compared to the previous week (400,201 cases in week 38/2020) and have now exceeded (by 67%) those reported when the pandemic first peaked in Europe in week 14/2020 (30 Mar - 5 Apr; 265,081)
- 64% (284,339) of the cases reported in week 39/2020 were reported from six countries: France (19%; 85,252), Russian Federation (11%; 48,039), Spain (10%; 45,123), Israel (10%; 44,050), United Kingdom (9%; 38,919) and Ukraine (5%; 22,956). The remaining cases (36%; 158,163) were reported by 53 countries and territories; each accounted for <5% of the total cases reported in week 39/2020
- The crude incidence continues to vary across the region with a range from 3.2 per 100,000 population in Tajikistan to 517 per 100,000 population in Israel in week 39/2020
- Six countries had a crude incidence of ≥100 per 100,000 in week 39/2020: Israel (517), Andorra (353), Montenegro (237), Czech Republic (140), France (131) and Republic of Moldova (104) (Figure 2A)
- The 14-day cumulative incidence increased by ≥10% in week 39/2020 in 46 countries and territories in the Region; an increase of ≥50% was observed in 30 of these countries and territories: Andorra, Armenia, Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Georgia, Guernsey, Hungary, Iceland, Ireland, Isle of Man, Jersey, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovakia, Slovenia, Sweden, and the United Kingdom (see EURO COVID-19 Dashboard for recent trends)
- The number of deaths in the Region in week 39/2020 increased 11% to 4,657 compared to the previous week (4,187 deaths in week 38/2020) (Figure 1). The proportion of reported cases that died was 1.0% in week 39/2020
- 70% (3,254) of the deaths reported in week 39/2020 were reported by the Russian Federation (19%; 906), Spain (12%; 539), Turkey (10%; 484), France (9%; 426), Ukraine (9%; 402), Romania (6%; 285) and the United Kingdom (5%; 212). The remaining deaths (30%; 1,403) were reported from 37 countries and territories; each accounted for <5% of the total deaths reported in week 39/2020
- Community-transmission was reported by 31 countries and territories, 23 countries and territories reported cluster transmission, while 4 countries and territories reported sporadic transmission in week 39/2020
- For an interactive subnational view of the recent COVID-19 situation in the WHO-EURO Region see the WHO-EURO COVID19 Subnational Explorer

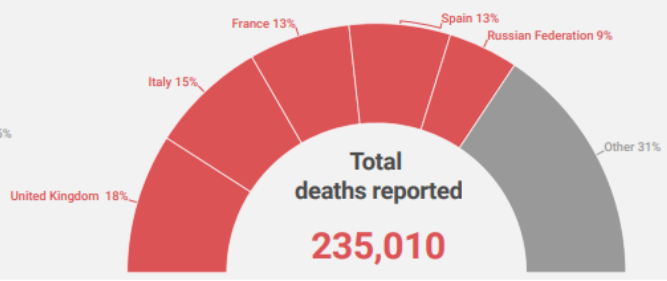
Summary overview

- The cumulative cases across the Region increased 8.4% to 5,709,134 cases in week 39/2020 (from 5,266,632 cases in week 38/2020) and cumulative deaths increased by 2.0% to 235,010 deaths (from 230,353 deaths in week 38/2020)
- As of 14 September 2020, 18 countries in the Region had an effective reproductive number significantly over 1: Belgium, Czech Republic, Cyprus, Estonia, Finland, Georgia, Greece, Iceland, Ireland, Israel, Lithuania, Montenegro, Netherlands, Poland, Slovakia, Slovenia, Sweden and United Kingdom (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 ≥1200 cases per 100,000 population: Israel (2727), Andorra (2380), San Marino (2203), Armenia (1670), Montenegro (1645), Spain (1533), Holy See (1472), Luxembourg (1350) and Republic of Moldova (1250) (Figure 2B)
- As of week 39/2020, 65% (3,729,852) of cumulative cases were reported from the Russian Federation (20%; 1,151,438), Spain (13%, 716,481), France (9%; 527,446), the United Kingdom (8%; 429,277), Turkey (5%; 312,966), Italy (5%; 308,104) and Germany (5%; 284,140). The remaining cases (35%; 1,979,282) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 39/2020
- As of week 39/2020, 69% of cumulative deaths (161,045) were reported from the United Kingdom (18%; 41,971), Italy (15%; 35,818), France (13%; 31,700), Spain (13%; 31,232) and the Russian Federation (9%; 20,324). The remaining deaths (31%; 73,965) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 39/2020
- 14.4% of cases were in persons aged ≥65 years in week 39/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥65 years was 68% in week 39/2020 (compared to 91% in week 14/2020) (Figure 3)
- 88% of all deaths with information available were in persons aged ≥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 for the participating countries. However, excess mortality is observable in the age group 75 to 84 years and overall in a few countries.
- In week 39/2020, six countries reported a total of 235 tests and 2 detections of SARS-CoV-2 in persons with influenza-like illness (ILI) in primary care sentinel surveillance (Figure 4)
- Overall, there were 176,199 (8.3%) COVID-19 cases among the total of 2,120,249 tests reported to have been performed in 18 countries in week 39/2020 (Figure 5)









Note: Reported cases and/or deaths from IHR States Parties may be subject to retrospective adjustments. Data as of 30 September 2020

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=5,709,134) and deaths (N=235,010) by reporting week

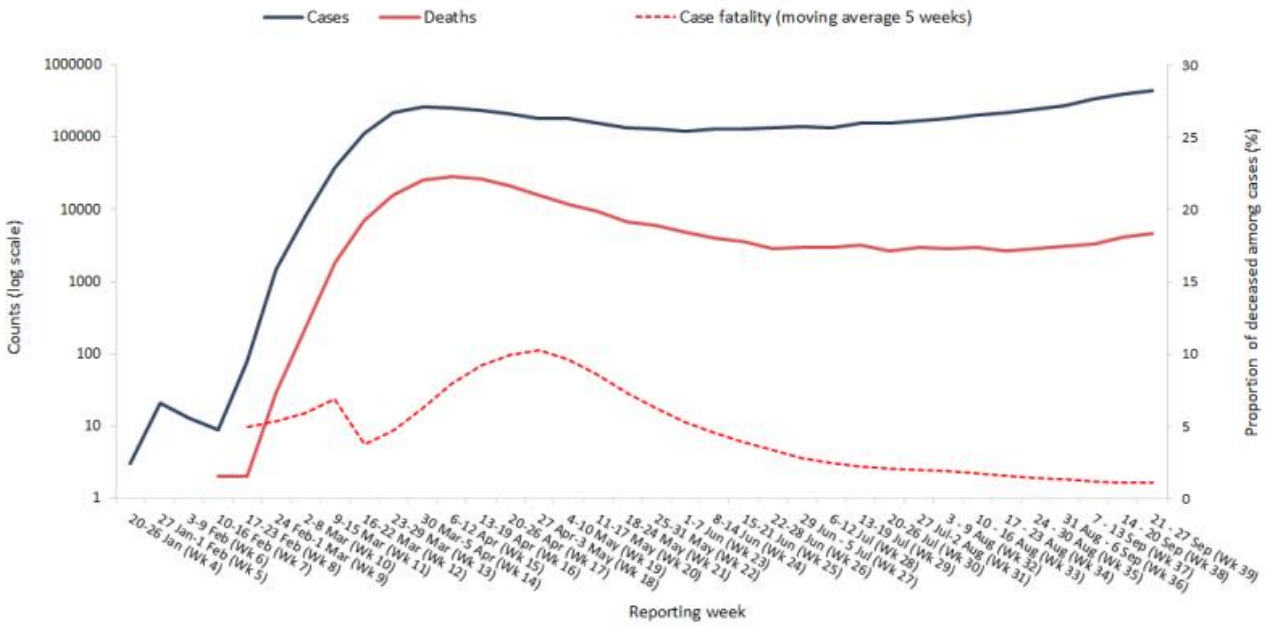
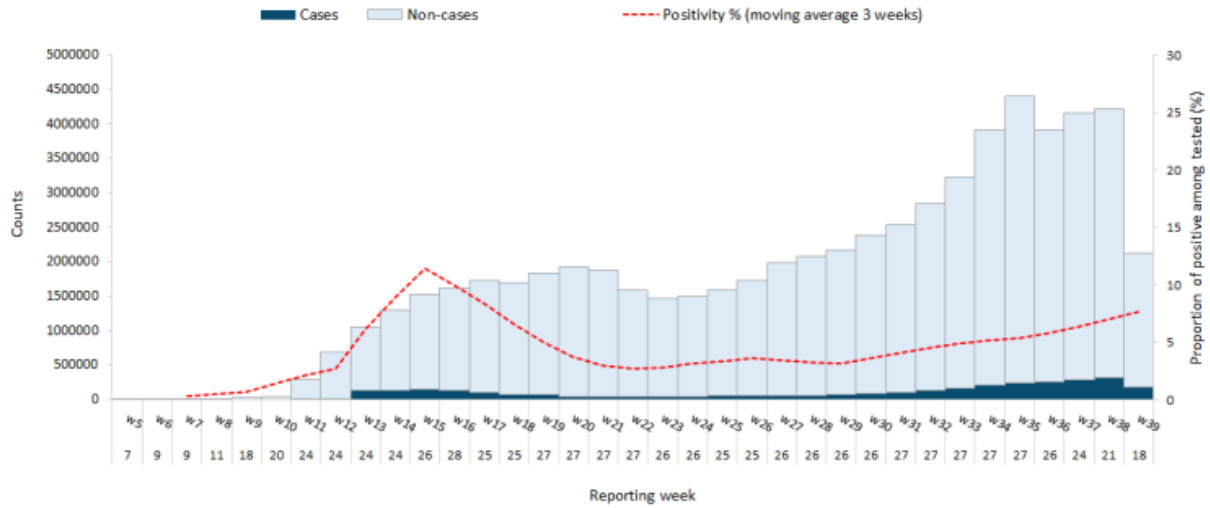


Figure 5. Percentage positive for COVID-19 among all tested by reporting week

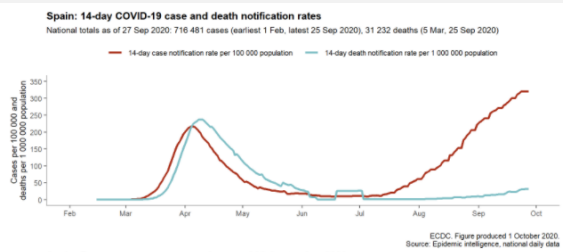


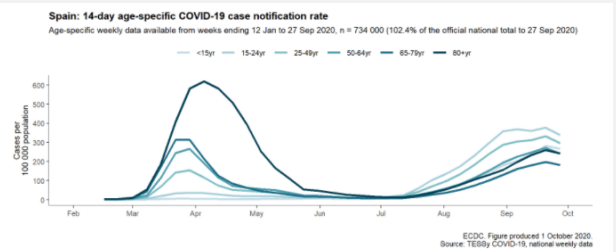
Source: Aggregate data from WHO Xmart and TESSy. Note: Member States that report cases only (no testing data) are not included. MS: Member State

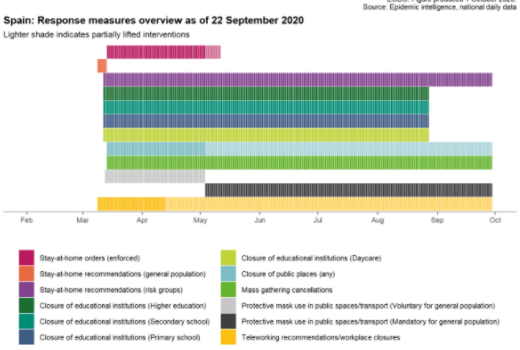
Weekly COVID-19 country overview, week 39

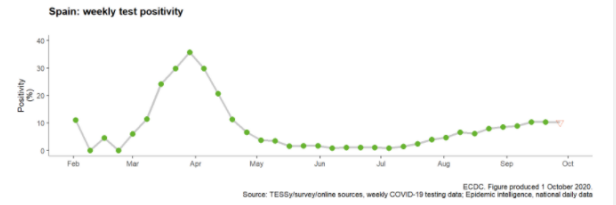
All over Europe an increase in case numbers is detectable. When you check the 14-day COVID-19 case and death notification rates in a large number of European countries a high rise in the curve is recognisable. The high of the curves are somehow higher than during the first wave of the Coronavirus outbreak in spring 2020.

Spain:

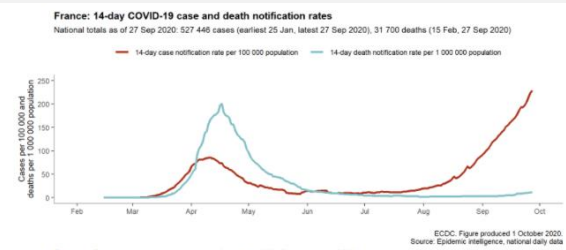


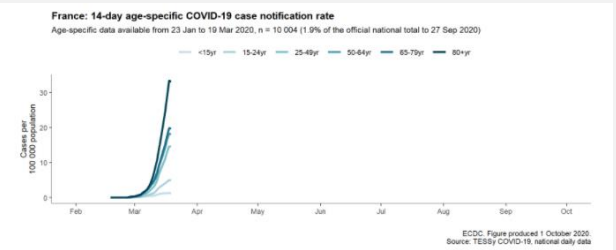


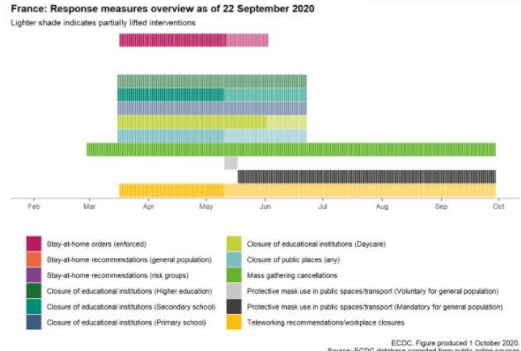


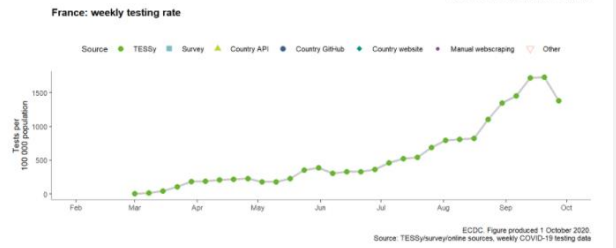


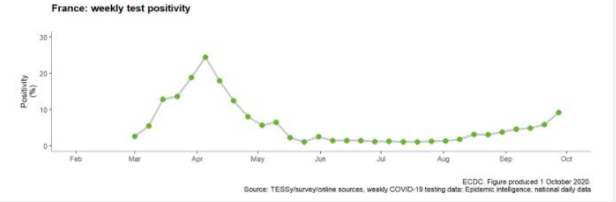
FRANCE:



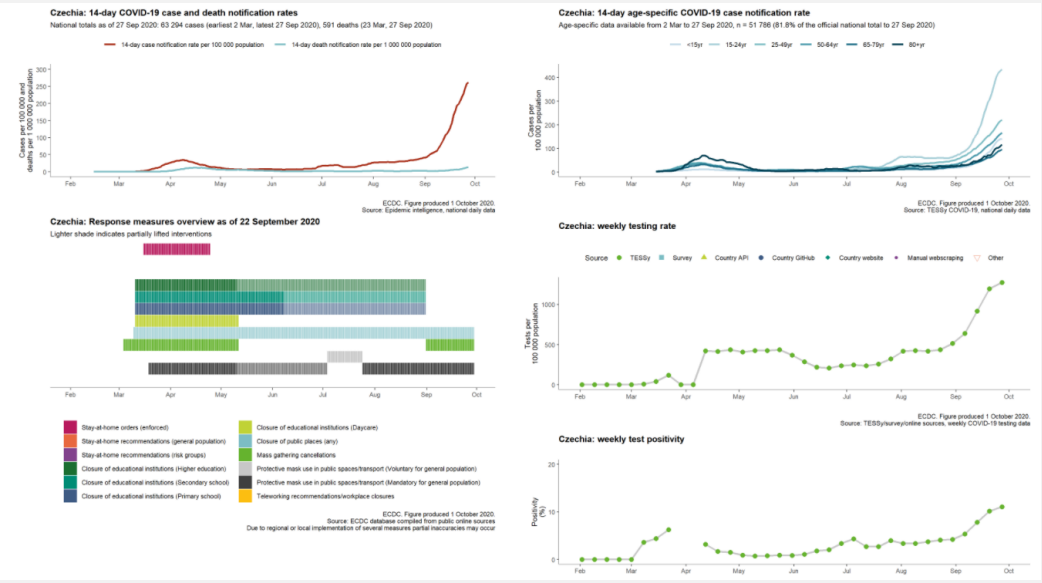




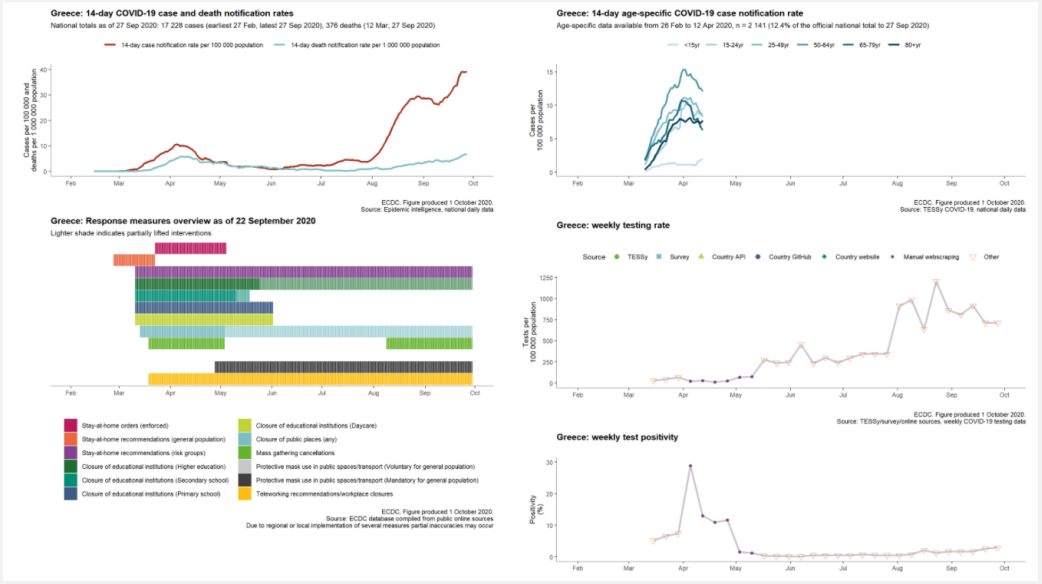




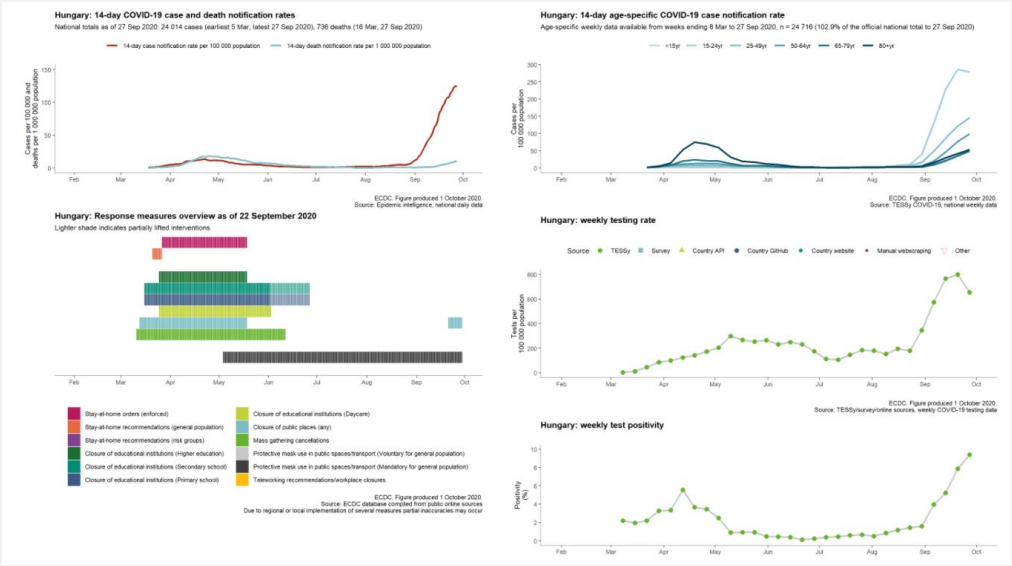
CZECH REPUBLIC:



GREECE:



HUNGARY:



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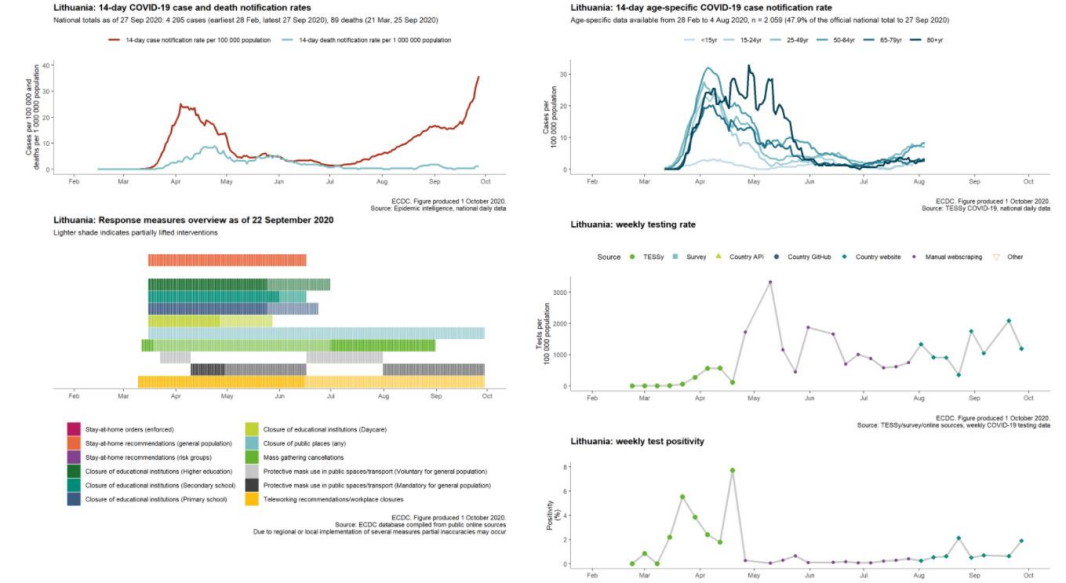
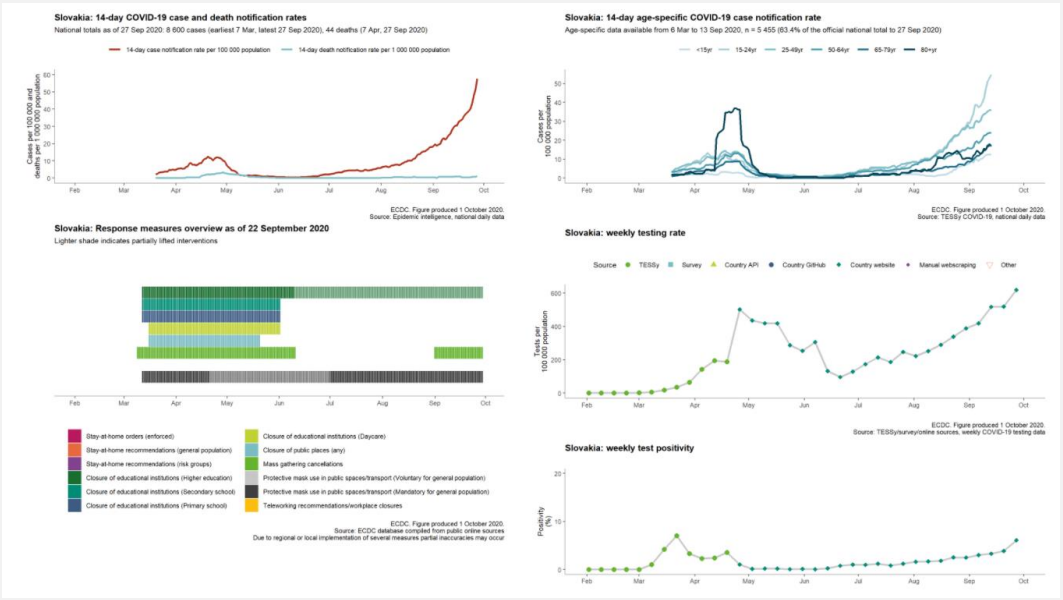
LITHUANIA:



SLOVAKIA:



CZE: Despite the rapidly increasing number of cases, the CZE government had until now hesitated to implement stricter measures. With around 3,800 new infections within 24 hours, however, the pain limit was reached, since yesterday the national emergency has been in effect again. This is justified with the figures in international comparison, only ESP currently has a worse 14-day average in Europe. During the 14-day period, the economy should be spared, schools should stay open as long as possible, only the higher grades should switch to online lessons. Football and ice hockey games will take place without spectators until further notice, events in closed rooms are limited to ten people, outdoors to 20 participants.
The development is exacerbated by the situation in the health system, in Prague the capacities of the intensive care beds are already exhausted. In addition, around 1,700 health care workers were infected.

FRA: In Paris, the "maximum alert level" now applies. Due to the very tense Corona situation in Paris, bars in the French capital will be closed for at least two weeks from Tuesday. Restaurants can stay open if they adhere to stricter hygiene rules. Clubs and dance halls would be closed, student parties and any kind of celebration would not be allowed. More than 260 out of 100,000 people in Paris have become infected with the corona virus in the past seven days. The number is worryingly high among those over 65. With around 500 this number is even higher among younger people, according to the health authorities. More than a third of the intensive care beds are occupied by COVID-19 patients. The

	“maximum alert” has so far only applied in Marseille and the French overseas territory of Guadeloupe. The next level of escalation would be the declaration of a health emergency. --- **IRL:** In the face of a second wave of corona infections, the Irish government has tightened measures to contain the virus. With immediate effect, restaurants and pubs across the country are no longer allowed to serve guests indoors. Events that have already been planned must be canceled. In addition, citizens are called on not to take any domestic trips. Employees should only not work from home if they are urgently needed at work. Services should take place online again. --- **ESP:** Spain is the first European country to pass the 800,000 positive test threshold. 23,480 new cases were added over the weekend. Almost 150 people have died from the virus since Friday. The number is as high as it was last in early May. --- **GBR:** has passed the threshold of half a million detected corona infections. Health officials reported an increase in infections of nearly 23,000 cases on Sunday - more than 10,000 more than the previous day. According to the authorities, the reason for this is the correction of a technical error that prevented several thousand corona cases from being published at the end of September. The British government has initiated an investigation on the technical breakdown. 51 percent of the unregistered cases have since been contacted. At the weekend it became known that 15,841 virus cases were not recorded in tables from September 25 to October 2. --- **POL:** The number of new infections with the corona virus reached a record level in Poland for the third day in a row on Saturday. The authorities recorded 2,367 new infections within 24 hours. --- **FRA:** On Monday, the number of intensive cases rose above the 1400 mark for the first time since the end of May. --- **DEU:** Travelers returning to Germany from risk areas will have to be prepared for stricter quarantine rules from October 15. According to this, travelers from risk areas should have to go into quarantine for ten days after returning. The quarantine can be shortened with a negative test early on the fifth day at the latest. --- **ISL**: After an increase in the number of cases of coronavirus infection, Iceland has imposed strict requirements. Most sports facilities, bars and restaurants are to be closed from Monday. No more than a hundred customers are allowed in the supermarkets at the same time, and swimming pools are only allowed to take half as many visitors as usual. Now only groups of a maximum of 20 people are allowed to meet. According to the ministry, the restrictions should apply for two to three weeks. Recent steps to tighten regulations came after coronavirus outbreaks in two nursing homes in Reykjavik and a surge in hospital admissions. In the past 19 days, Iceland has reported 663 new cases, mostly in the capital Reykjavik and the surrounding area.

Subject in Focus

Phylogenetic network analysis of SARS-CoV-2 genomes

When and where has COVID-19/SARS-CoV-2 entered the human population?

In the past months the ongoing COVID-19 pandemic received attention all over the world and led to numerous scientific publications, trying to describe almost all aspects of the underlying pathogen, the course and potential cure of the disease, epidemiological observations as well as projections of its social and economic impact. In the early days it was taken as a given that the pandemic originated from Wuhan, Hubei Province, China and began its devastating journey around the globe at the Huanan Seafood Wholesale Market.

Only a few publications were issued raising doubts on this perception. One of those studies (dating back to April) conducted by an international team is presented in parts in the following. The study was conducted by Peter Forster et al. with researchers from (among others) the universities of Münster (DEU), Cambridge (GBR) and Kiel (DEU). The study has undergone peer-review but there are some – not yet peer-reviewed – studies pointing out that the methodology of this study might be insufficient to draw firm conclusions. For the reader's further information these critical papers can be found here and here. We decided to present this study to highlight the necessity of in-depth analysis of the origin and geographical course of the virus to improve the understanding of the on-going and potential future pandemics in order to improve global preparedness and health surveillance. For a better readability we decided to include headlines that are not part of the underlying paper and to leave out some very technical parts. The original full study can be found here.

Has COVID-19 started earlier? Did it start in Wuhan?

In a combined DEU and GBR study a phylogenetic network analysis of 160 complete human severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) genomes have been conducted. The scientists found three central variants distinguished by amino acid changes, which they have named A, B, and C, with:

- **The A type** being the ancestral type according to the bat outgroup coronavirus. He has been found in significant proportions outside East Asia, that is, in Europeans and Americans.
- **The B type** is the most common type in East Asia, and its ancestral genome appears not to have spread outside East Asia without first mutating into derived B types, pointing to founder effects or immunological or environmental resistance against this type outside Asia.
- **The C type has been** found in significant proportions outside East Asia, the same as the A type.

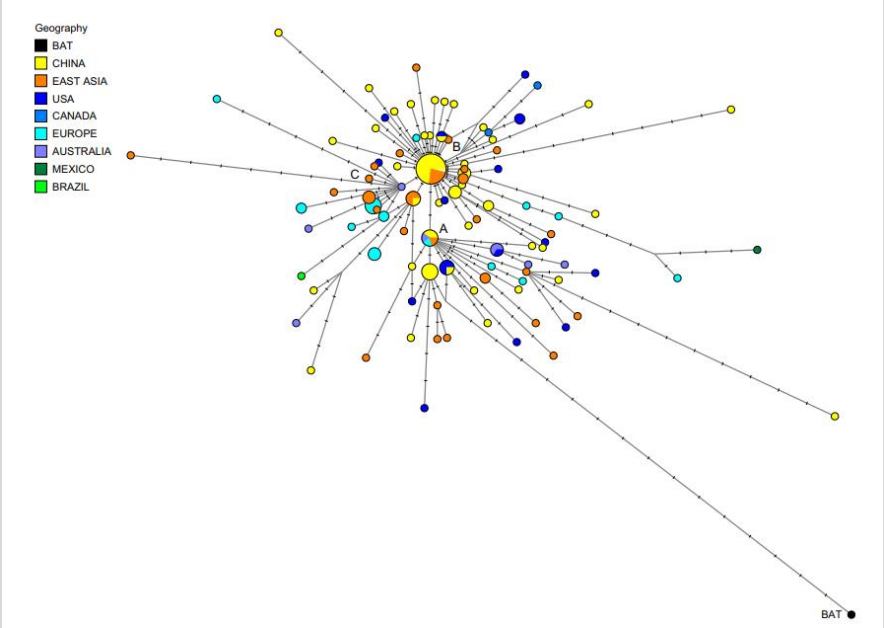
The network faithfully traces routes of infections for documented coronavirus disease 2019 (COVID-19) cases, indicating that phylogenetic networks can likewise be successfully used to help trace undocumented COVID-19 infection sources, which can then be quarantined to prevent recurrent spread of the disease worldwide.

Genetic analysis of virus genomes indicates the place of origin

In early March 2020, the GISAID database (https://www. gisaid.org/) contained a compilation of 253 severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) complete and partial genomes contributed by clinicians and researchers from across the world since December 2019.

To understand the evolution of this virus within humans, and to assist in tracing infection pathways and designing preventive strategies, the scientist present a phylogenetic network of 160 largely complete SARS-Cov-2 genomes. Another study recently reported a closely related bat coronavirus, with 96.2% sequence similarity to the human virus. They use this bat virus as an outgroup, resulting in the root of the network being placed in a cluster of lineages which we have labeled "A."

There are two **subclusters of A** which are distinguished by the synonymous mutation T29095C. In the T-allele subcluster, four Chinese individuals (from the southern coastal Chinese province of Guangdong) carry the ancestral genome, while three Japanese and two American patients differ from it by several mutations. These American patients are reported to have had a history of residence in the presumed source of the outbreak in Wuhan.



The **C-allele subcluster** sports relatively long mutational branches and includes five individuals from Wuhan, two of which are represented in the ancestral node, and eight other East Asians from China and adjacent countries. It is noteworthy that nearly half (15/33) of the types in this subcluster, however, are found outside East Asia, mainly in the United States and Australia. Two derived network nodes are striking in terms of the number of individuals included in the nodal type and in mutational branches radiating from these nodes. They have labelled these phylogenetic clusters B and C.

For **type B**, all but 19 of the 93 type B genomes were sampled in Wuhan, in other parts of eastern China, and, sporadically, in adjacent Asian countries. Outside of East Asia, 10 B-types were found in viral genomes from the United States and Canada, one in Mexico, four in France, two in Germany, and one each in Italy and Australia. Node B is derived from A by two mutations: the synonymous mutation T8782C and the nonsynonymous mutation C28144T changing a leucine to a serine. Cluster B is striking with regard to mutational branch lengths: While the ancestral B type is monopolized (26/26 genomes) by East Asians, every single (19/19) B-type genome outside of Asia has evolved mutations. This phenomenon does not appear to be due to the month-long time lag and concomitant mutation rate acting on the viral genome before it spread outside of China. A complex founder scenario is one possibility, and a different explanation worth considering is that the ancestral Wuhan B-type virus is immunologically or environmentally adapted to a large section of the East Asian population and may need to mutate to overcome resistance outside East Asia.

Type C differs from its parent type B by the nonsynonymous mutation G26144T which changes a glycine to a valine. In the dataset, this is the major European type, with representatives in France, Italy, Sweden, and England, and in California and Brazil. It is absent in the mainland Chinese sample, but evident in Singapore and also found in Hong Kong, Taiwan, and South Korea. One practical application of the phylogenetic network is to reconstruct infection paths where they are unknown and pose a public health risk. The following cases where the infection history is well documented may serve as illustrations.

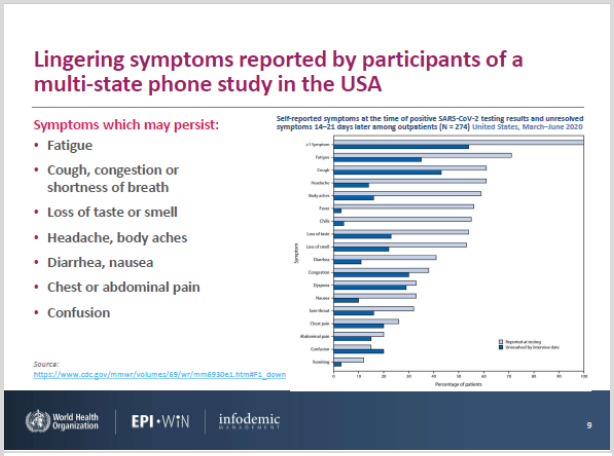
The first case in Italy is not due to a Wuhan contact either
On 25 February 2020, the first Brazilian was reported to have been infected following a visit to Italy, and the network algorithm reflects this with a mutational link between an Italian and his Brazilian viral genome in cluster C.

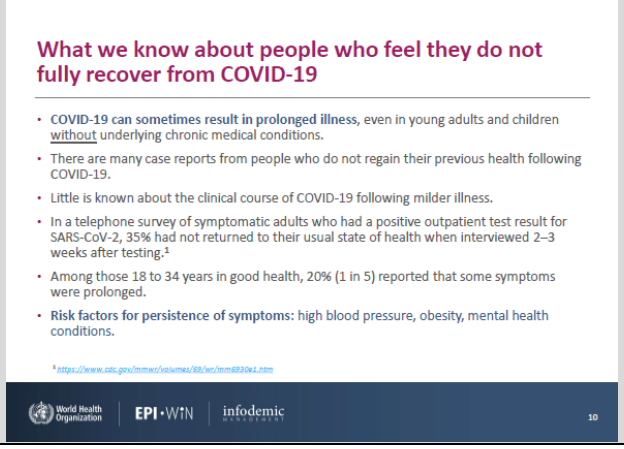
Virus spread in Mexico and Brazil can be traced back to Italy
In another case, a man from Ontario had travelled from Wuhan in central China to Guangdong in southern China and then returned to Canada, where he fell ill and was conclusively diagnosed with coronavirus disease 2019 (COVID-19) on 27 January 2020. In the phylogenetic network, his virus genome branches from a reconstructed ancestral node, with derived virus variants in Foshan and Shenzhen (both in Guangdong province), in agreement with his travel history. His virus genome now coexists with those of other infected North Americans (one Canadian and two Californians)

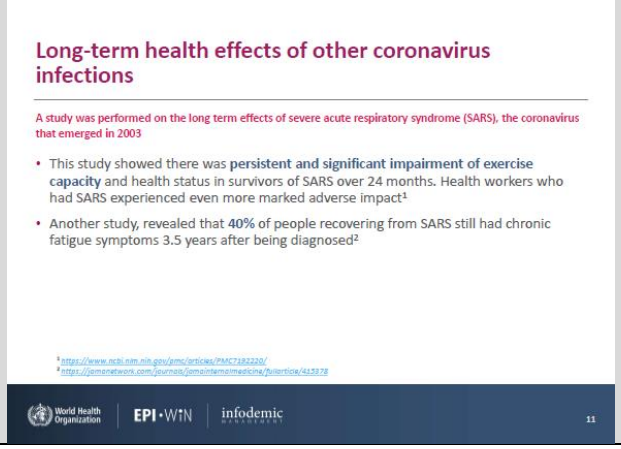
	who evidently share a common viral genealogy. The case of the single Mexican viral genome in the network is a documented infection diagnosed on 28 February 2020 in a Mexican traveler to Italy. Not only does the network confirm the Italian origin of the Mexican virus, but it also implies that this Italian virus derives from the first documented German infection on 27 January 2020 in an employee working for the Webasto company in Munich, who, in turn, had contracted the infection from a Chinese colleague in Shanghai who had received a visit by her parents from Wuhan. This viral journey from Wuhan to Mexico, lasting a month, is documented by 10 mutations in the phylogenetic network. This viral network is a snapshot of the early stages of an epidemic before the phylogeny becomes obscured by subsequent migration and mutation. The question may be asked whether the rooting of the viral evolution can be achieved at this early stage by using the oldest available sampled genome as a root. However, the first virus genome that was sampled on 24 December 2019 already is distant from the root type according to the bat coronavirus outgroup rooting. The described core mutations have been confirmed by a variety of contributing laboratories and sequencing platforms and can be considered reliable. The phylogeographic patterns in the network are potentially affected by distinctive migratory histories, founder events, and sample size. Nevertheless, it would be prudent to consider the possibility that mutational variants might modulate the clinical presentation and spread of the disease. The phylogenetic classification provided here may be used to rule out or confirm such effects when evaluating clinical and epidemiological outcomes of SARS-CoV-2 infection, and when designing treatment and, eventually, vaccines. Sources: • Phylogenetic network analysis of SARS-CoV-2 genomes Peter Forster, Lucy Forster, Colin Renfrew, Michael Forster Proceedings of the National Academy of Sciences Apr 2020, 117 (17) 9241-9243 DOI: 10.1073/pnas.2004999117 • No evidence for distinct types in the evolution of SARS-CoV-2 Oscar A MacLean, Richard J Orton, Joshua B Singer, David L Robertson Virus Evolution, Volume 6, Issue 1, January 2020, veaa034 https://doi.org/10.1093/ve/veaa034 • Phylogenetic analysis of SARS-CoV-2 data is difficult Benoit Morel, Pierre Barbera, Lucas Czech, Ben Bettisworth, Lukas Hübner, Sarah Lutteropp, Dora Serdari, Evangelia-Georgia Kostaki, Ioannis Mamais, Alexey M Kozlov, Pavlos Pavlidis, Dimitrios Paraskevis, Alexandros Stamatakis bioRxiv 2020.08.05.239046 doi: https://doi.org/10.1101/2020.08.05.239046

MilMed CoE VTC COVID-19 response

Topic	The NATO Centre of Excellence for Military Medicine is putting its expertise and manpower to aid in any way possible during the pandemic. The VTC is for interested participants (experts) to exchange experiences, management regulations and restrictions due to COVID-19. We would like to propose just one of the most important topics in the next iteration. We will have some experts giving a short briefing and then afterward we will have time for questions and experiences as well as a fruitful discussion. **Topics former VTCs:** • Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities. • Testing strategies • Aeromedical evacuation • De-escalation strategy and measures • Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases • Immunity map, national strategies to measure and evaluate the immunity level" • Mental Health • Treatment of mild symptomatic cases of COVID-19 • Transition home office back to the office • COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation • Perspectives of the current COVID-19 vaccine development • National overview on current COVID-19 situation • Long term effects of COVID-19 and the impact on force capability
National overview on current COVID-19 situation	Briefers from UK give a short summary about the long term effects of COVID-19 and the impact on force capability.







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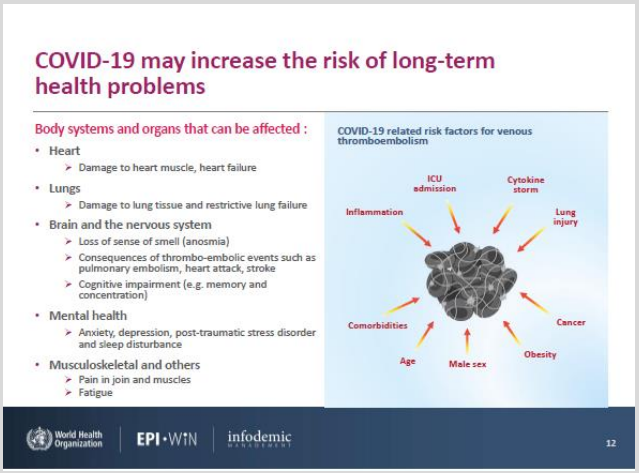


COVID Rehabilitation – UK Elements and Experience

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 15th September 2020	Many countries have halted some or all international travel since the onset of the COVID-19 pandemic but now have plans to re-open travel. This document outlines key considerations for national health authorities when considering or implementing the gradual return to international travel operations. The decision-making process should be multisectoral and ensure coordination of the measures implemented by national and international transport authorities and other relevant sectors and be aligned with the overall national strategies for adjusting public health and social measures. WHO Public health considerations while resuming international travel. **Travel has been shown to facilitate the spread of COVID-19 from affected to unaffected areas. Travel and trade restrictions during a public health event of international concern (PHEIC) are regulated under the International Health Regulations (IHR), part III.** The majority of measures taken by WHO Member States relate to the denial of entry of passengers from countries experiencing outbreaks, followed by flight suspensions, visa restrictions, border closures, and quarantine measures. Currently there are exceptions foreseen for travellers with an essential function or need. **In the case of non-deferrable trips, please note the following** • Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules. • Check your national foreign office advices for regulations of the countries you´re traveling or regulations concerning your country. • Information's about the latest travel regulations and De-escalation strategy measures you can find at IATA and International SOS. For Europe you will find more information here. **Most countries implemented strikt rules of contact reduction:** • Everyone is urged to reduce contacts with other people outside the members of their own household to an absolutely necessary minimum. • In public, a minimum distance of 1.5 m must be maintained wherever possible. • Staying in the public space is only permitted alone, with another person not living in the household or in the company of members of the own household (for most countries, please check bevor traveling). • Follow the instructions of the local authorities. **Risk of infection when travelling by plane:** The risk of being infected on an airplane cannot be excluded, but is currently considered to be low for an individual traveller. The risk of being infected in an airport is similar to that of any other place where many people gather. If it is established that a COVID-19 case has been on an airplane, other passengers who were at risk (as defined by how near they were seated to the infected passenger) will be contacted by public health authorities. Should you have questions about a flight you have taken, please contact your local health authority for advice. **General recommendations for personal hygiene**, cough etiquette and keeping a distance of at least one metre from persons showing symptoms remain particularly important for all travellers. These include: • Perform hand hygiene frequently. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if hands are not visibly soiled; wash hands with soap and water when they are visibly soiled; • Cover your nose and mouth with a flexed elbow or paper tissue when coughing or sneezing and disposing immediately of the tissue and performing hand hygiene; • Refrain from touching mouth and nose; See also: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public • If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal.

- WHO information for people who are in or have recently visited (past 14 days) areas where COVID-19 is spreading, you will find here.

Travellers who develop any symptoms during or after travel should self-isolate; those developing acute respiratory symptoms within 14 days upon return should be advised to seek immediate medical advice, ideally by phone first to their national healthcare provider.
Source: WHO and ECDC

European Commission:
The coronavirus outbreak is a serious threat to public health. Lockdowns and other coordinated restrictive measures are necessary to save lives. However, these measures may also severely slow down our economies and can delay the deliveries of critical goods and services. The European Commission has taken measures to ensure continued and uninterrupted land, waterborne and air cargo services. These services are of crucial importance for the functioning of the EU's internal market and its effective response to the current public health crisis.

On 13 May, the European Commission presented guidelines and recommendations to help Member States gradually lift travel restrictions, with all the necessary safety and precautionary means in place. Measures intended to enable citizens to travel again after months of confinement include, but are not limited to:

Re-open EU – new web platform to help travellers and tourists
On 15 June, the European Commission launched 'Re-open EU', a web platform that contains essential information allowing a safe relaunch of free movement and tourism across Europe. To help people confidently plan their travels and holidays during the summer and beyond, the platform will provide real-time information on borders, available means of transport, travel restrictions, public health and safety measures such as on physical distancing or wearing of facemasks, as well as other practical information for travellers.
Re-open EU will act as a key point of reference for anyone travelling in the EU as it centralises up-to-date information from the Commission and the Member States in one place. It will allow people to browse country-specific information for each EU Member State through an interactive map, offering updates on applicable national measures as well as practical advice for visitors in the country. Available in the 24 official EU languages.

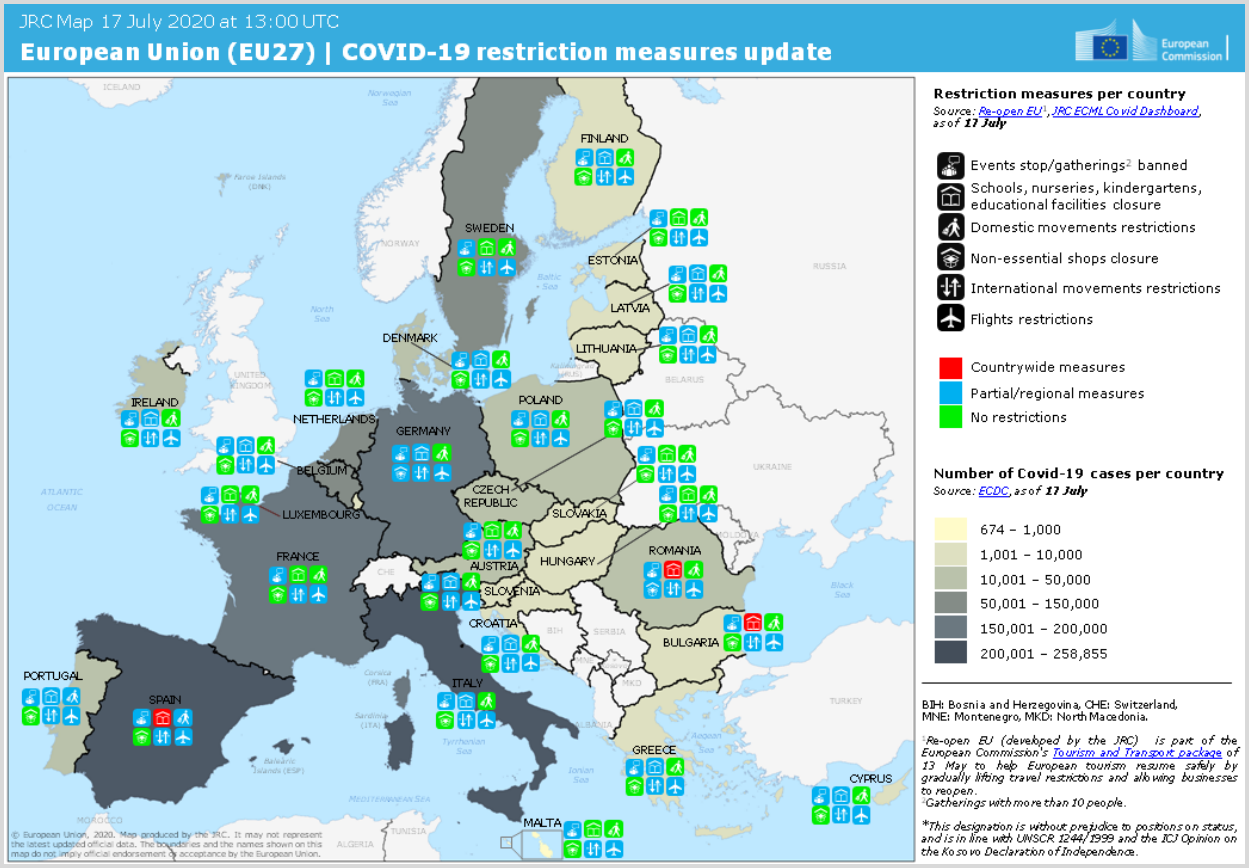
Travel advice and Border measures
Travel advice is a national competence and you should check if your national authority, e.g. the Ministry of Foreign Affairs, has issued an official travel warning concerning your planned destination. Travel advice is continuously updated as the situation evolves.

Lifting of travel restrictions: Council reviews the list of third countries
Following a review under the recommendation on the gradual lifting of the temporary restrictions on non-essential travel into the EU, the Council updated the list of countries for which travel restrictions should be lifted. As stipulated in the Council recommendation, this list will continue to be reviewed regularly and updated.
Based on the criteria and conditions set out in the recommendation, as from 8 August member states should **gradually lift the travel restrictions at the external borders for residents of the following third countries**:

- Australia
- Canada
- Georgia
- Japan
- New Zealand
- Rwanda
- South Korea
- Thailand
- Tunisia
- Uruguay
- China, subject to confirmation of reciprocity

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

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



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

Risk Assessment	
Global	• Because of global spread and the human-to-human transmission the **moderate to high** risk of further transmission persists. • Travellers are at risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks. • Individual risk is dependent on exposure. • National regulation regarding travel restrictions, flight operation and screening for single countries you will find here. • Official IATA changed their travel documents with new travel restrictions. You will find the documents here. • Public health and healthcare systems are in high vulnerability as they already become overloaded in some areas with elevated rates of hospitalizations and deaths. Other critical infrastructure, such as law enforcement, emergency medical services, and transportation industry may also be affected. Health care providers and hospitals may be overwhelmed. • Asymptomatic persons as well as infected but not sickened persons could be a source of spreading the virus. Therefore, no certain disease-free area could be named globally.
Europe As of 25th of September 2020	ECDC assessment for EU/EEA, UK as of 25 September 2020: **Risk in countries observing stable and low notification rates, and low test positivity**: • The risk of COVID-19 for the general population and for healthcare provision is **low**, based on a low probability of infection and low impact of the disease. • The overall risk for vulnerable individuals is **moderate** based on a low probability of infection and very high impact of the disease. **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:** • The risk of COVID-19 is **moderate** for the general population and for healthcare provision, based on a very high probability of infection and low impact of the disease. • The risk of COVID-19 for vulnerable individuals is **very high**, based on a very high probability of infection and very high impact of the disease. **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:** • The risk of COVID-19 is **high** for the general population, based on a very high probability of infection and moderate impact of the disease. • The risk of COVID-19 for vulnerable individuals is **very high**, based on a very high probability of infection and very high impact of the disease.

References:

- European Centre for Disease Prevention and Control www.ecdc.europe.eu
- World Health Organization WHO; www.who.int
- Centres for Disease Control and Prevention CDC; www.cdc.gov
- European Commission; https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en
- Our World in Data; https://ourworldindata.org/coronavirus
- Morgenpost; https://interaktiv.morgenpost.de/corona-virus-karte-infektionen-deutschland-weltweit/

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