Update 28 (14th of July 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
14th of July 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

- The WHO sees “no return to normal” in the foreseeable future. Too many countries are on the wrong track in dealing with the coronavirus pandemic. The pandemic would worsen if people did not follow basic precautions: observe distance rules, wash hands and wear masks. The WHO warns that in many countries that loosen restrictions and “disregard effective measures that reduce the risk of infection”, the number of cases increases again. A new daily record of 230,000 new infections was reported on Sunday. "The virus remains the number one enemy of the state, but the behaviour of many governments and people does not reflect that."
- **WHO**: reports record number of new infections with 230,000 in one day. The number of deaths is constant at around 5,000 a day. The epicentres are in the USA, Brazil, India and South Africa.
- **WHO**: On 9 July 2020, WHO updated the scientific brief on transmission of SARS-CoV-2, the virus that causes COVID-19. This replaces a previous version of the scientific brief, published on 29 March 2020.
- **WHO**: WHO has published guidance on maintaining a safe and adequate blood supply during the coronavirus disease pandemic.
- **WHO**: has published an Emergency Global Supply Chain System (COVID-19) catalogue listing all medical devices, including personal protective equipment, medical equipment, medical consumables, single use devices, and laboratory and test-related devices, which may be requested through the COVID-19 Supply Portal. The catalogue represents an initial prioritized selection of items and are subject to constant review.
- **WHO**: surveyed networks of laboratories to map out global animal laboratory capacity around the world to potentially help with accelerating vaccine and therapeutic evaluation.
- **WHO**: updated the risk assessment tools for mass gatherings, religious gatherings, and mass gatherings during sports events to guide authorities and planning and event organizers during the current COVID-19 pandemic.

GLOBALLY
13 043 396 confirmed cases 7 235 077 recovered 572 526 deaths
EU/EEA and the UK
2 758 474 confirmed cases **1 660 189** recovered **202 195** deaths
USA ↗ (new cases/day 61 737)
3 352 343 confirmed cases **1 031 539** recovered **135 422** deaths
Brazil → (new cases/day 37 375)
1 884 967 confirmed cases **1 291 251** recovered **72 833** deaths
Russia → (new cases/day 6 539)
732 547 confirmed cases **503 168** recovered **11 422** deaths
India ↗ (new cases/day 25 834)
878 254 confirmed cases **553 471** recovered **23 174** deaths
UK ↗ (new cases/day 624)
290 133 confirmed cases **not reported** recovered 44 830 deaths

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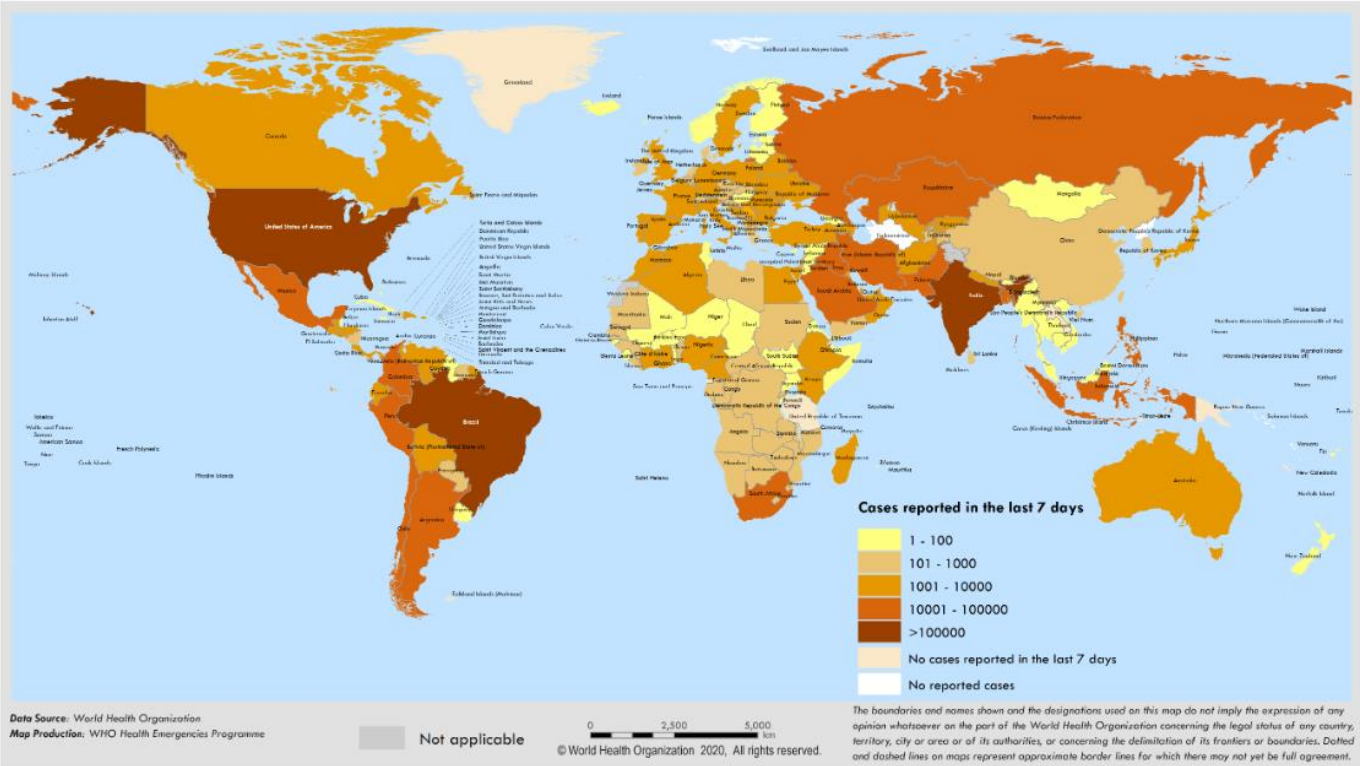
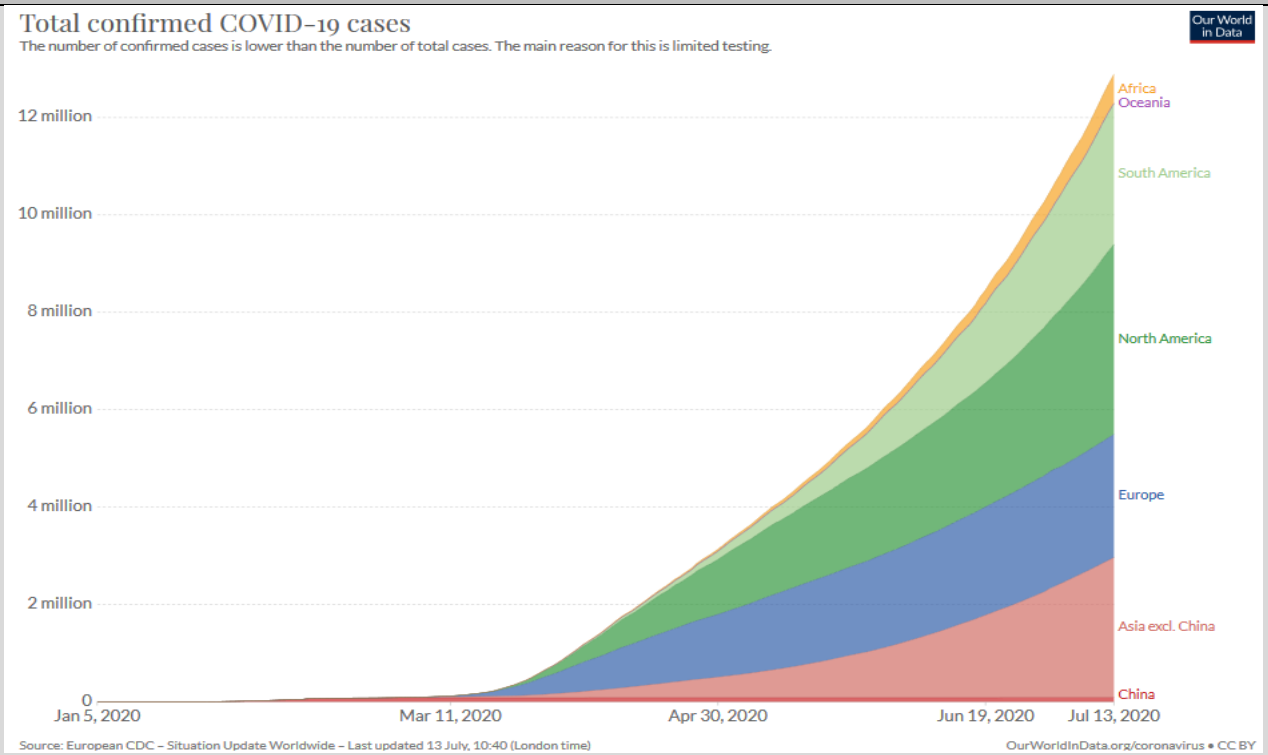
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation



Key points of the Scientific briefing on transmission of SARS-CoV-2; WHO

Main findings

- Understanding how, when and in what types of settings SARS-CoV-2 spreads between people is critical to develop effective public health and infection prevention measures to break chains of transmission.
- Current evidence suggests that transmission of SARS-CoV-2 occurs primarily between people through direct, indirect, or close contact with infected people through infected secretions such as saliva and respiratory secretions, or through their respiratory droplets, which are expelled when an infected person coughs, sneezes, talks or sings.
- Airborne transmission of the virus can occur in health care settings where specific medical procedures, called aerosol generating procedures, generate very small droplets called aerosols. Some outbreak reports related to indoor crowded spaces have suggested the possibility of aerosol transmission, combined with droplet transmission, for example, during choir practice, in restaurants or in fitness classes.
- Respiratory droplets from infected individuals can also land on objects, creating fomites (contaminated surfaces). As environmental contamination has been documented by many reports, it is likely that people can also be infected by touching these surfaces and touching their eyes, nose or mouth before cleaning their hands.
- Based on what we currently know, transmission of COVID-19 is primarily occurring from people when they have symptoms, and can also occur just before they develop symptoms, when they are in close proximity to others for prolonged periods of time. While someone who never develops symptoms can also pass the virus to others, it is still not clear to what extent this occurs and more research is needed in this area.
- Urgent high-quality research is needed to elucidate: the relative importance of different transmission routes; the role of airborne transmission in the absence of aerosol generating procedures; the dose of virus required for transmission to occur; the settings and risk factors for superspreading events; and the extent of asymptomatic and pre-symptomatic transmission

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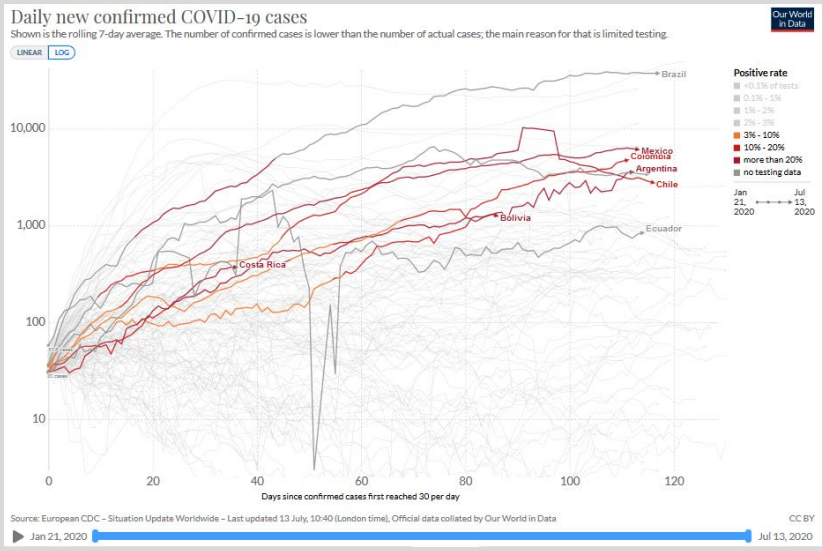
Accelerated approval process for two vaccine candidates by FDA

Pharmaceutical companies Pfizer and Biontech have received fast-track status, an accelerated approval process, from the US Food and Drug Administration for two vaccine candidates against coronavirus. The funds are the mRNA-based substances BNT162b1 and BNT162b2. They are the two most advanced agents in the BNT162 vaccine program.
The substances are currently being investigated in studies in the USA and Germany. Fast track status was given based on preliminary results from these studies and animal immunogenicity studies. The companies plan to begin the next phase of the study with 30,000 subjects later this month. If implemented successfully and after approval by the authorities, Pfizer and Biontech could produce up to 100 million doses of vaccine by the end of 2020.

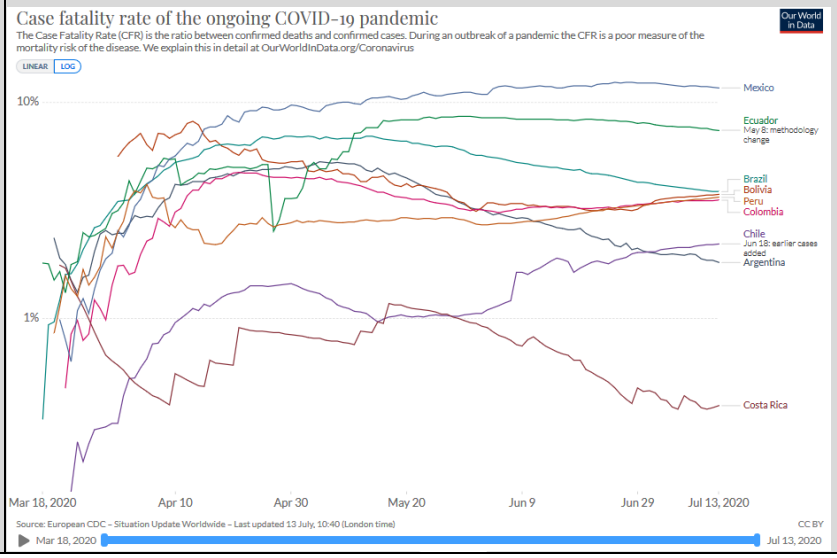
South America

The number of cases of COVID-19 is rising rapidly in Latin American countries, contributing to the global record of new infections.
Brazil now has more than 1,885,000 infections from SARS-CoV-2 - the second highest number in the world behind the United States. Other countries on the subcontinent including **Mexico, Chile** and **Peru** are also struggling with the enormous number of new infections every day.

So, what are the main trends in Latin America right now?



The first case in South America was confirmed in Brazil on February 26, although according to FIOCRUZ (Fundação Oswaldo Cruz, Research Institute for Biological Sciences, Rio de Janeiro) it is likely to be the first case of COVID-19 disease in Brazil came in January 2020. This is suggested by molecular biological studies of the pathogen, which came from a patient who died of a respiratory infection between 19 and 25 January in Rio de Janeiro. Since then, SARS-CoV-2 has spread to every country in the region. Since then, approximately 3.3 million cases have been identified in Latin America and, according to the ECDC figures, approximately 140,000 people have died there. The two most populous Latin American countries, **Brazil** and *Mexico*, have almost 72,000 and 35,000 deaths, respectively. Peru currently ranks fifth in the world with almost 323,000 infections and passed the 12,000 deaths mark a few hours ago. **Chile** also reports thousands of new corona cases every day and is currently complaining about 7,000 deaths.



The outbreak in **Ecuador** was the earliest and initially the most violent in South America. Guayaquil was overrun by the dead in such a way that corpses could no longer be recovered in the city streets. Between January and mid-May alone, the COVD-19 mortality attributed to Guayaquil alone was 12,000 cases. Nevertheless, there has been some relaxation in the country since mid-May. However, this trend is not evident for many other countries in the region.

The summit has not yet been reached

The reported death toll in many Latin American countries remains high,

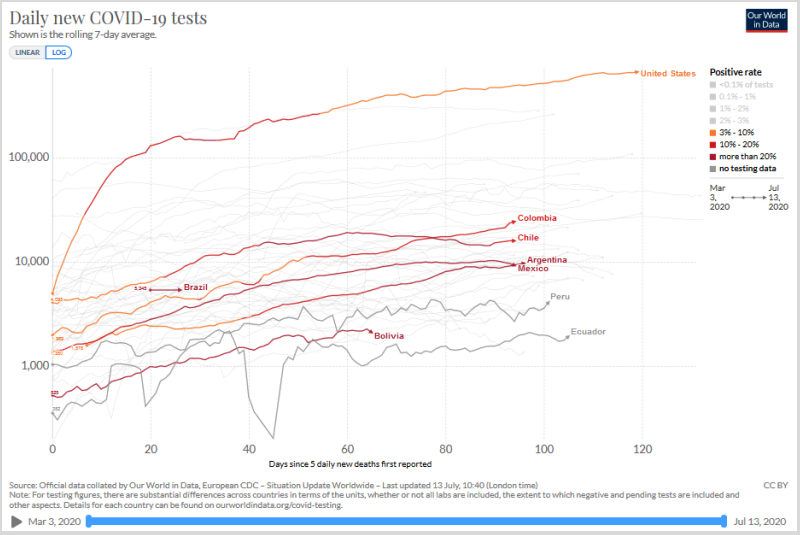
while it is falling dramatically in most European countries. Compared to the most severely affected countries in Europe, such as the UK, Spain, Italy or France, the trends in Brazil, Mexico and Peru are completely different. The head of the Pan American Health Organization (PAHO), Dr. Carissa Etienne warned that the coronavirus is "exponentially" spreading in many areas of Latin America. In Brazil, Mexico and Peru, the number of deaths is currently doubling every 3-4 weeks.

Nevertheless, researchers believe that the number of cases of infection as well as that of deaths is likely to be significantly underestimated. For example, the medical school at the University of São Paulo (USP) believes that the actual number of infections in Brazil could be 6 times higher than the official figures. Dr. Etienne said there can be no doubt that Latin America has become the new epicenter of the pandemic. And the peak of the epidemic would even be reached in a few weeks in some of the countries. As the number of infected people grows daily, fears grow that national health systems may be overrun in a way that has already been the case in Ecuador.

What is currently being done to limit further spread?

Mexico and Brazil continue their reluctantly installed "lockdown" measures as halfheartedly as before. Both countries have issued guidelines on how to deal with the pandemic, but no national restrictions have been imposed on the countries. Now Brazil's President Jair Bolsonaro, who regularly downplayed the danger of the risk posed by the virus at every opportunity, has contracted the disease himself. Professor Marcia Castro, who teaches global health at Harvard University, said the Brazilian response to the pandemic is far from ideal. There is currently a lack of common direction in the country's various management levels in coping with the crisis. Other countries, such as **Argentina**, have been forced to lockdown their populations. Like Argentina, **Uruguay** is now able to control the spread of the virus. Peru had one of the first and hottest lockdowns in the region, which was maintained until late June.

Nevertheless, the increase in infections and deaths - of which relatively unimpressed - continued. As the epidemic spread through **Chile**, the Chilean government tightened its lockdown measures in all parts of the country. Chile has one of the highest test rates in Latin America and has now reached 63 tests per 1,000 inhabitants. However, the test rates in other parts of Latin America are significantly below this value, according to "Our World in Data". While Brazil does fewer than 7 tests per 1,000 residents, Mexico only does a little over 4 tests / 1,000. In contrast, it is 109 / 1,000 in the USA.



Sources: https://www.bbc.com/news/world-latin-america-52711458
https://www.bbc.com/news/world-latin-america-52638352
https://ciis.fmrp.usp.br/covid19-subnotificacao/

ZAF: due to the increasing number of infections, a further tightening of the restrictions has been announced - in addition to curfews, there is a requirement to wear a mask and a ban of alcoholic drinks has been introducd. The national state of emergency is extended until 12th August.

AUS: On Monday authorities have expressed concerns about surging cases of community transmission — which accounted for eight of the 14 new cases in New South Wales in the last 24 hours, while the rest were people who have returned from overseas or have returned from the neighboring state of Victoria. The majority of these community cases were people who recently visited the Crossroads Hotel pub, taking the cluster to 13 in all. The pub and hotel is used by freight drivers who are transporting essential supplies across the country. They are not being tested. Meanwhile, Victoria reported 177 new infections in 24 hours. The state which holds Australia's second most populated city, Melbourne, last week forced some five million people back into lockdown after a jump in new COVID-19 cases.

ISR: On Friday, the Ministry of Health reported a record number of 1,464 cases. After a first outbreak, hardly any new cases were reported in Israel in May. Since the end of May, however, the number of new daily infections has risen again significantly. Some government officials are now demanding a lockdown.

USA: In the US state of California, all restaurants have to close their indoor areas again. Bars and cinemas across the state will also have to close again, Governor Gavin Newsom said on Monday. Churches, shopping centres, fitness studios and hairdressers are also closed in 30 of the most affected counties in the West Coast state. California's two largest school districts, Los Angeles and San Diego, announced that they would not be resuming in-person classes when schools reopen during the fall. More than 8,300 new infections were reported in California on Sunday alone. In total, more than 325,000 infections and more than 7,000 deaths have been confirmed.

The Corona entry ban for people from Europe persists until further notice.

In Texas, a 30-year-old died of coronavirus infection after attending a “COVID-19 party”. The host of the party was infected with the virus as well. At the party, the participants wanted to find out whether the virus really existed and whether it could be defeated, the treating doctor said.

HKG: Disneyland Hong Kong has closed once again after reopening less than a month ago. The city will impose strict new social distancing measures beginning at midnight tonight, making it impossible for large groups to be together. These measures are the strictest since Hong Kong reported its first cases of COVID-19.

MAR: reimposed lockdown measures in Tangiers on Monday. The northern port city suspended public transport, closed cafes and public spaces, and restricted movement following the appearance of "new infection clusters." The measures were imposed by authorities to "prevent the spread of the virus" and include requiring locals to stay at home. Residents are only allowed to leave their homes "in cases of extreme necessity".

PAK: Pakistan has banned open-air livestock markets in cities ahead of the upcoming Eid al-Adha holiday. Instead, people will be allowed to buy and sell sacrificial animals at 700 designated markets, which will be set up outside cities across the country. Eid al-Adha is a three-day holiday in which Muslims slaughter livestock and distribute part of the meet to the poor. The holiday is scheduled to begin on 31stJuly in Pakistan. The country reported 69 new coronavirus deaths on Monday, bringing its total to 5,266 since the pandemic began. Pakistan has also recorded 251,625 cases, the 12th highest total in the world.

LKA: ordered schools across the country to close again a week after they’ve reopened. Nearly half of the 110,000 residents at a drug rehab facility near the island nation's capital of Colombo tested positive in the past week, and some visitors may have also been infected.

RUS: Despite Russia recording more than 6,000 new cases per day, Moscow has relaxed its mandatory face mask rules. The city said the covering of noses and mouths is now voluntary. People are, however, still obligated to wear masks on public transport and when shopping.

IND: has reported another single-day record of new coronavirus cases, recording 28,701 new cases and 500 new death in 24 hours on Monday. New Dehli, Mumbai, Chennai, Bangalore and Pune are among the key cities where the outbreak has been most prominent. States have reinstituted lockdown measures after relaxing them in an attempt to bolster an ailing economy. India has reported record surges on each of the past four days. It has the third most cases worldwide behind the United States and Brazil.

CUB: has sent a team of 115 doctors and nurses to Azerbaijan to help the country fight the health crisis, marking it the first time Cuban health professionals are serving the Central Asian country.

Situation in Europe	**HUN**: The requirements to enter Hungary will be regulated according to three categories on the epidemiological situation of the countries of origin, in a so-called “traffic light system. Red indicates an entry ban for inbound travel from e.g. Africa, South America & almost all Asian countries (except China & Japan) and some European countries (Albania, Bosnia-Herzegovina, North Macedonia, Kosovo, Belarus, Montenegro, Ukraine); Great Britain, Norway, Russia, Serbia, China, Japan and the USA are flagged yellow. The yellow categorization means a 2-week quarantine (exception: negative test result provided). --- **ESP**: the number of cases of corona increases again in many regions. After Catalonia, the Balearic Islands also introduced more stringent mask requirements. After holidaymakers celebrated in Mallorca on the weekend without complying with the restrictions, a stricter mask requirement now applies in Mallorca. Mouth and nose protection must be worn on regional government’s order in all enclosed public spaces, as well as on the street and outdoors, as soon as it is possible to meet other people. On the beach, at the pool and during sports, however, still nobody has to wear a mask.  Catalan authorities on Sunday reimpose lockdown measures on nearly 160,000 people in the region, which reported 800 new cases on Sunday. The new resolution obliged people to only leave their homes for work or other essential activities. The area was isolated from the rest of the country a week ago. The hospitals in the Lleida area are on the brink of overload. The area's curfew is the first such measure since the Corona pandemic emergency state in Spain ended on 21st June. Those affected may only leave their homes to go to work or to the doctor or to buy groceries. Gatherings of more than ten people are been prohibited. --- **GBR:** After much hesitation, England is now introducing a mask requirement in shops during the corona pandemic. The measure is expected to enter into force on 24th July. The new requirement only applies in England. Scotland has already made masks compulsory in shops. Failure to comply will result in a fine of up to £ 100. --- **DEU**: German vaccine study draws thousands of volunteers. Researchers say they are surprised at the number of people who have offered to participate, as they usually struggle to find enough guinea pigs. The study will test the success of a COVID-19 vaccine developed by CureVac. --- **MKD**: With nearly 8,200 confirmed infections and 385 deaths, the Balkan country of some 2.1 million people is one of the hardest hit European nations (per capita). People under quarantine in North Macedonia — who could not leave their homes to vote in the country's general election — were visited on Monday by election officials carrying ballot boxes. The officials visited 700 quarantined voters who were unable to travel to polling stations. ECDC COVID-19 surveillance report Week 27, 2020

Weekly surveillance summary

This summary presents highlights from two weekly ECDC surveillance outputs, which have been streamlined to avoid overlaps.

- COVID-19 country overview provides a concise overview of the evolving epidemiological situation for the COVID-19 pandemic by country, using weekly and daily data from a range of sources.
- COVID-19 surveillance report presents epidemiological characteristics of the total number of COVID-19 cases reported to the European Surveillance System (TESSy) and assesses the quality of the data.

Trends in reported cases

- The average 14-day case notification rate for the EU/EEA and the UK as of 10 July 2020 was 12 (country range: 1–102) per 100 000 population. The rate has been stable for the last one day.
- An increasing trend has been observed in the 14-day COVID-19 case notification rate in Austria, Bulgaria, Croatia, Iceland, Luxembourg and Romania. These trends have been present for between seven and 27 days.

Primary care

- Among four countries that reported data up to week 27 from primary care sentinel surveillance for COVID-19 using the systems established for influenza, there are no detections of SARS-CoV-2.
- All countries that reported ILI and/or ARI syndromic surveillance data up to week 27 using the systems established for influenza have observed consultation rates that remain similar to or lower than those reported during the same period in the last two years.

Hospitalisation

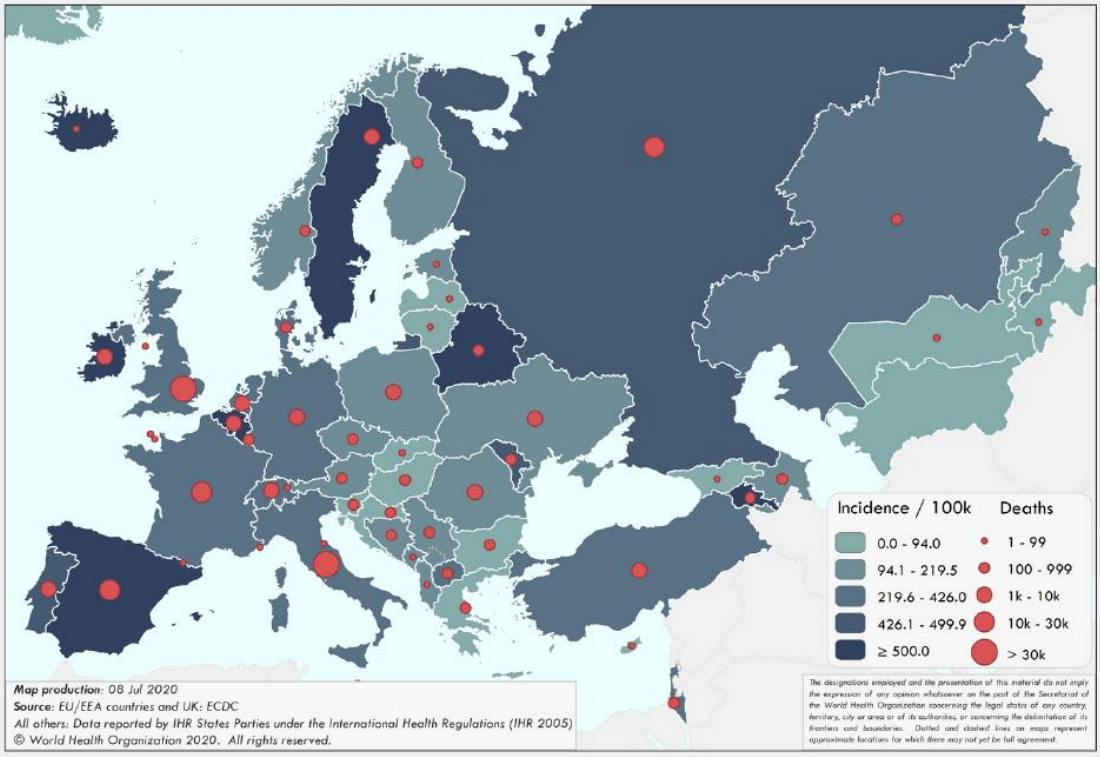
- Only Sweden reported data from in-hospital SARI surveillance for week 27 and has observed a decreasing trend in the numbers positive for SARS-CoV-2 and/or SARS-CoV-2 positivity among individuals with SARI.
- Hospital and ICU occupancy due to COVID-19 patients is increasing in Bulgaria, Portugal and Romania. No other increases have been observed in either new admissions or occupancy in other countries, although data availability varies.
- Overall, 30% of reported COVID-19 cases in the EU/EEA and the UK to date have been hospitalised; among hospitalised patients, 14% required ICU and/or respiratory support, although there is considerable variation among countries.

Mortality

- An increasing trend in the 14-day COVID-19 death notification rate in Portugal and Romania has been present for ten and seven days, respectively.
- We estimate that 24% of hospitalised COVID-19 cases reported to date in the EU/EEA and the UK have died.
- Pooled estimates of all-cause mortality reported by EuroMOMO have now returned to normal levels following a period of substantially increased excess mortality that coincided with the COVID-19 pandemic peaks. A few countries are still seeing low levels of excess mortality.

[COVID-19 situation update for the WHO European Region (29 – 05 July 2020 Epi week 27)]

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



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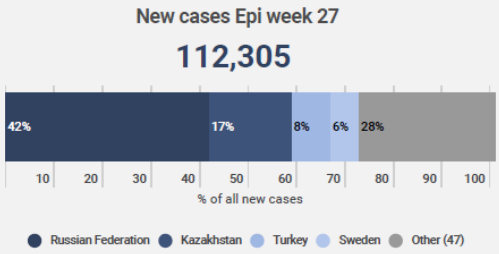
Key points

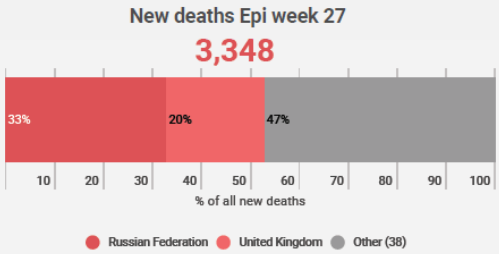
Week 27/2020 (29 Jun - 5 Jul 2020)

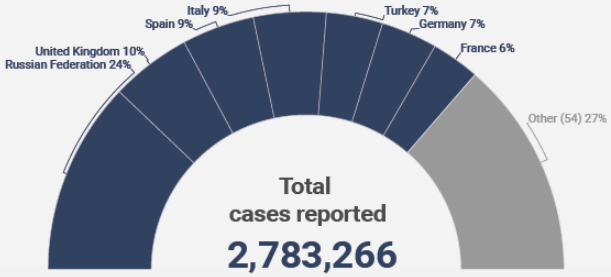
- The overall number of cases reported in the Region has declined by 57% since week 14/2020; the overall number of deaths has declined by 87% in the same time period
- 72% (80,931) of the cases in week 27/2020 were reported from four countries: the Russian Federation (42%; 46,814), Kazakhstan (17%, 19,108), Turkey (8%; 8728) and Sweden (6%; 6282). The remaining cases (28%; 31,374) were reported by 47 countries and territories; each accounted for <5% of the total cases reported in week 27/2020
- 11 countries had a crude incidence of ≥35 per 100,000 in week 27/2020: Armenia, Azerbaijan, Bosnia and Herzegovina, Israel, Kazakhstan, Kyrgyzstan, Luxembourg, Montenegro, North Macedonia, Republic of Moldova and Sweden. The crude incidence continues to vary across the region with a range from 0.4 per 100,000 population in Latvia to 134 per 100,000 population in Armenia
- In 23 countries, the 14-day cumulative incidence increased by ≥10% in week 27/2020, however for some countries data was retro-adjusted by national authorities: Albania, Armenia, Austria, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Germany, Iceland, Israel, Kazakhstan, Kyrgyzstan, Luxembourg, Montenegro, Romania, Serbia, Slovakia, Slovenia, Sweden, Switzerland, Ukraine and Uzbekistan (see EURO COVID-19 Dashboard for recent trends)
- 53% of the deaths reported in week 27/2020 (3348) were from the Russian Federation (33%; 1088) and the United Kingdom (20%; 684). The remaining deaths (47%; 1576) were reported from 38 countries and territories; each accounted for <5% of the total deaths reported in week 27/2020
- The proportion of reported cases that died increased from 2.5% in week 26/2020 to 3% in week 27/2020, a change that is likely due to a range of factors
- The number of countries and territories (27) reporting community-transmission remains the same as week 26/2020 (see EURO COVID-19 Dashboard)
- Since the emergence of COVID-19 virus in Europe at the end of February 2020, a wide range of public health and social measures (PHSM) have been implemented. See EURO COVID-19 Dashboard (NPI Explorer) for a snapshot of the temporal relationship between case and death numbers and the introduction and easing of these measures in some countries in the Region. A number of countries have recently started gradual easing of these measures. Continued vigilance is recommended as countries in the Region ease these measures.

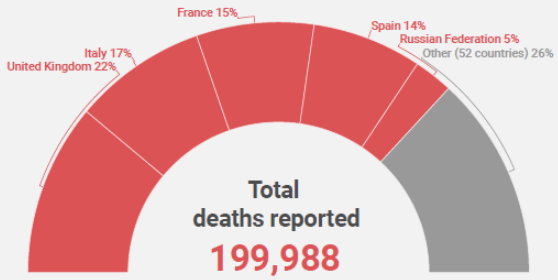
Summary overview

- As of 22 June 2020, nine countries in the European region had an effective reproductive number significantly over 1: Bosnia and Herzegovina*, Czech Republic, France*, Israel, Kazakhstan, Kyrgyzstan, Luxembourg*, Serbia and Switzerland* (* increase since last update on 11 June 2020) (See EpiForecasts and the CMMID COVID working group COVID-19 Global Summary for latest estimates)
- 11 countries in the Region each reported a cumulative incidence of ≥500 cases per 100,000 population: Andorra, Armenia, Belarus, Belgium, Iceland, Ireland, Luxembourg, San Marino, Spain, Sweden and the United Kingdom
- As of week 27/2020, 73% of cumulative cases (2,026,020) were reported from the Russian Federation (24%; 681,251), United Kingdom (10%; 284,900), Spain (9%; 250,545), Italy (9%; 241,419), Turkey (7%; 204,610), Germany (7%; 196,335) and France (6%; 166,960). The remaining cases (27%; 757,246) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 27/2020
- 21% of all reported infections with information available were in a health care worker
- 76% of all ICU admissions were in persons aged 50-79 years of age, with 70% of all ICU admissions in men
- As of week 27/2020, 74% of cumulative deaths (147,491) were reported from the United Kingdom (22%; 44,198), Italy (17%; 34,854), France (15%; 29,893), Spain (14%; 28,385) and the Russian Federation (5%, 10,161). The remaining deaths (26%; 52,497) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 27/2020
- 90% of all deaths were in persons aged ≥65 years and 57% of all deaths were in men
- 95% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (66%)
- Following a period of a very substantial excess mortality observed in some countries coinciding with the COVID-19 pandemic, pooled estimates of all-cause mortality for the countries in the EuroMOMO network have now returned to normal levels. A few countries are still seeing some excess mortality. Excess mortality was observed primarily in the age group of ≥65 years, followed by the age group of 45-64 years and 15-44 years
- In week 27/2020, five countries reported 110 tests and 3 COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The positivity rate in week 26/2020 was 3.7% (6 countries) compared to 2.8% (5 countries) in week 25/2020. The highest positivity was 14.6%, seen in week 15/2020









21%
of all people infected were health care workers

95%
of all deaths had at least 1 underlying condition

57%
of all deaths were in men

76%
of all ICU admissions were people aged 50-79 years

90%
of all deaths were in persons aged 65+

66%
of all deaths had cardiovascular disease

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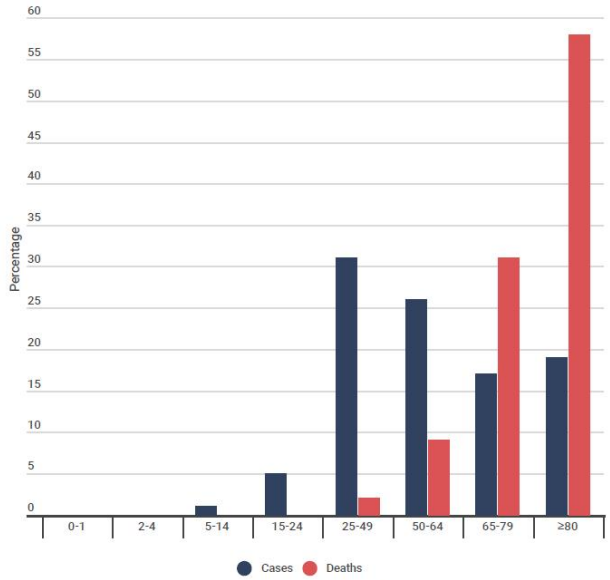
Figure 3. Percentage of COVID-19 cases (N=806,781) and deaths (N=120, 013) by age group



Source: Cases: Case-report forms and aggregate data from TESSy (Spain; until week 25/2020); Deaths: Case report forms, mortality survey, aggregated data from TESSy (Spain; until week 25/2020)

Table 1. Characteristics of COVID-19 cases and deaths

	Characteristics	n	%	Total records with data available
Cases	Age in years, median (range)*	55 (1-105)		551,326
	Sex, male*	255,185	46	549,295
	Recovered*	205,687	91	226,657
	Health care workers#	92,563	21	445,533
	Hospitalization#	126,767	32	392,083
	Intensive care unit admissions#	10,089	3	315,068
Deaths	Age in years, median (range)^	82 (0-108)		122,797
	Sex, male^	69,690	57	122,669
	At least one underlying condition^	59,509	95	62,783
	• cardiovascular disease	19,104	66	29,086
	• diabetes	9,217	33	27,745
	• lung disease	5,773	23	25,317
	• neurological disease / dementia	2,552	25	10,392
	• renal disease	1,809	20	9,036
	• malignancy	1,026	25	4,061
	• obesity	650	10	6,241
	• liver disease	489	5	9,583
	• immune disease	205	3	6,245
	• other	12,565	52	24,084

Source:
*Case report forms (n=553,810) until week 26/2020;
#Case report forms and aggregated data from Italy (30 June) and Spain (29 May 2020, TESSy) (n=856,741); Health care workers refer to occupation and not to the place of exposure
^Case report forms, mortality survey, aggregated data from Italy (25 June 2020) and Spain (29 May 2020) (n=122,797)

Figure 4. Percentage of COVID-19 cases (N=794,619), hospitalizations (N=140,756), ICU admissions (N=12,732) and deaths (N=122,656) by age group and sex

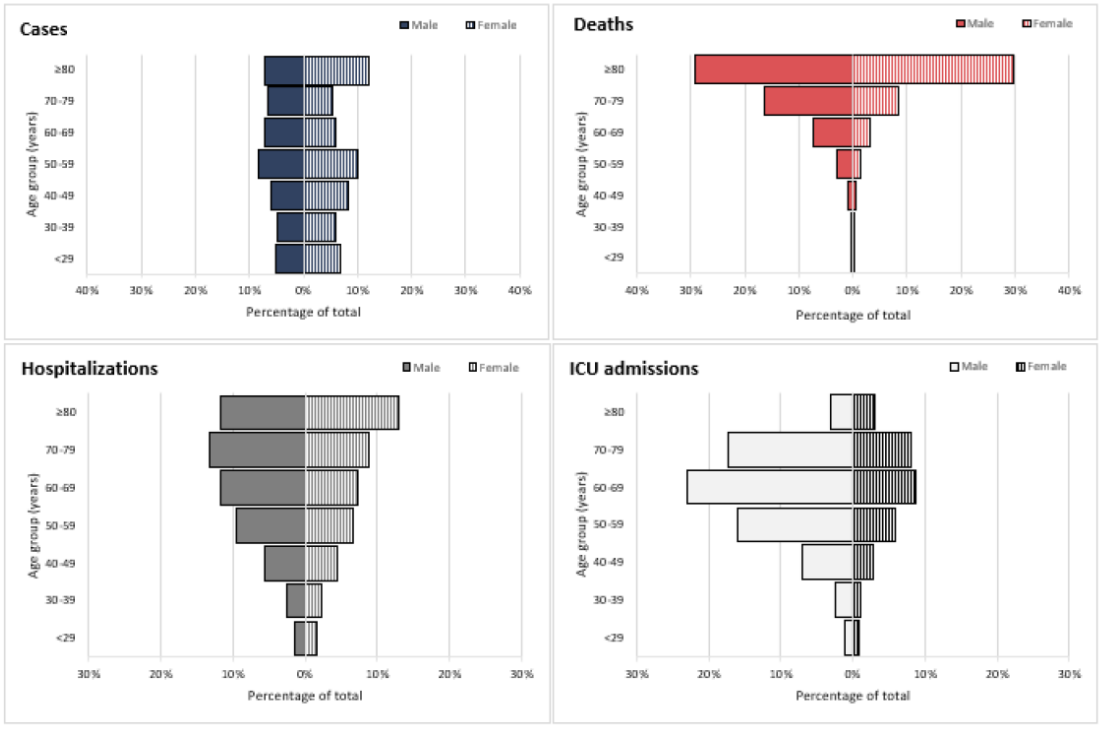


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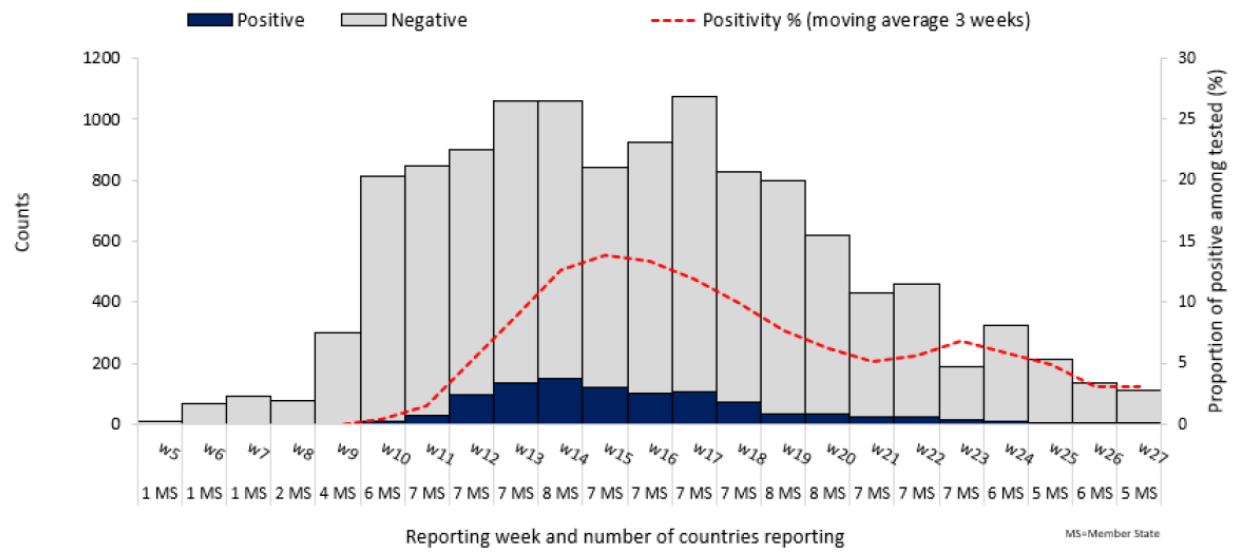
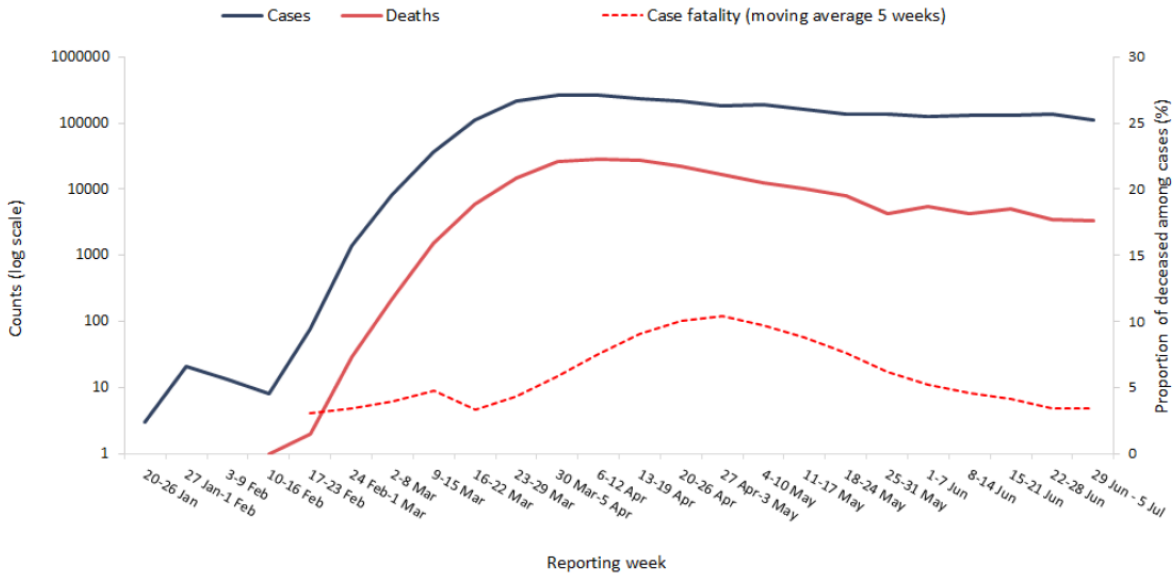
Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



Source: Aggregate data from TESSy. MS: Member State

Figure 1: Number of COVID-19 cases (N=2,783,266) and deaths (N=199,988) by reporting week



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Subject in Focus

Coronavirus Antibody Testing Basics

There are two different types of tests – diagnostic tests and antibody tests.

A diagnostic test can show if you have an active coronavirus infection and should take steps to quarantine or isolate yourself from others. Currently there are two types of diagnostic tests – molecular (RT-PCR) tests that detect the virus's genetic material, and antigen tests that detect specific proteins on the surface of the virus.

An antibody test looks for antibodies that are made by the immune system in response to a threat, such as a specific virus. Antibodies can help fight infections. Antibodies most commonly become detectable 1-3 weeks after symptom onset and may stay in your blood for several weeks after recovery. Because of this, antibody tests should not be used to diagnose an active coronavirus infection.

	MOLECULAR TEST	ANTIGEN TEST	ANTIBODY TEST
Also known as...	Diagnostic test, viral test, molecular test, nucleic acid amplification tests (NAAT), RT-PCR tests	Rapid diagnostic test*	Serological test, serology, blood test, serology test
How the sample is taken...	Nasal or throat swab (most tests) Saliva (a few tests)	Nasal or throat swab	Finger stick or blood draw
How long it takes to get results...	Same day (some locations) or up to a week	One hour or less	Same day (many locations) or 1-3 days
Is another test needed...	This test is typically highly accurate and usually does not need to be repeated.	Positive results are usually highly accurate but negative results may need to be confirmed with a molecular test.	Sometimes a second antibody test is needed for accurate results.
What it shows...	Diagnoses active coronavirus infection	Diagnoses active coronavirus infection	Shows if you've been infected by coronavirus in the past
What it can't do...	Show if you ever had COVID-19 or were infected with the coronavirus in the past	Definitively rule out active coronavirus infection. Antigen tests are more likely to miss an active coronavirus infection compared to molecular tests. Your health care provider may order a molecular test if your antigen test shows a negative result but you have symptoms of COVID-19.	Diagnose active coronavirus infection at the time of the test or show that you do not have COVID-19

Some molecular tests are also rapid tests.

The usability of tests on Antibodies against SARS-COV-2?

Serologic assays for SARS-CoV-2, now broadly available, can play an important role in understanding the virus's epidemiology in the general population and identifying groups at higher risk for infection. Unlike viral direct detection methods such as nucleic acid amplification or antigen detection tests that can detect acutely infected persons, antibody tests help determine whether the individual being tested was ever infected—even if that person never showed symptoms. Serologic tests detect waning or past SARS-CoV-2 virus infection indirectly, by measuring the host humoral immune response to the virus. Therefore, serology assays do not typically replace direct detection methods as the primary tool for diagnosing an active SARS-CoV-2 infection, but they do have several important applications in monitoring and responding to the COVID-19 pandemic.

The market for antibody testing against the new SARS-CoV-2 coronavirus is booming. To date, 28 antibody tests have been authorized under an individual EUA by the FDA, and over 200 antibody tests are currently the subject of a pre-EUA or EUA review. In advertising, the tests promise certainty whether the corona infection has already gone through, possibly even completely unnoticed.

Antibody tests are also said to provide information on the prevalence of the pandemic in the population as part of studies. They are also used for testing donors of the convalescent plasma,

which is now also used therapeutically, and for checking the effectiveness of vaccine development. The expectations for these tests are accordingly high.
Types of Antibody testing:

- **Binding antibody detection**: These tests use purified proteins of SARS-CoV-2, not live virus, and can be performed in lower biosafety level laboratories (e.g., BSL-2). With specific reagents, individual antibody types, like IgG, IgM, and IgA, can be determined. In general, IgM is one of the first types of antibodies produced after infection and is most useful for determining recent infection, while IgG generally develops after IgM and may remain detectable for months or years. IgA is important for mucosal immunity and can be detected in mucous secretions like saliva in addition to blood, though its significance in this disease is still to be determined. Depending on the complexity of assays, these tests can be performed rapidly (less than 30 minutes) in a field setting or in a few hours in a laboratory.

Tests that detect binding antibodies fall into two broad categories.

  - *Rapid or point-of-care tests*: POC tests generally are lateral flow devices that detect IgG or IgG and IgM, or total antibody in serum, plasma, whole blood, and/or saliva. An advantage of some point-of-care tests using whole blood is that they can be performed on blood samples obtained by fingerstick rather than venipuncture.
  - *Enzyme-linked immunosorbent assays (ELISA) and chemiluminescence immunoassays (CLIA):* Commercially available, now also available for the high sample throughput in the laboratory. May require trained laboratorians and specialized instruments. Based on the reagents, IgG, IgM, and IgA can be detected separately or combined as total antibody.

- **Detection of neutralizing antibodies**: the gold standard. The test involves incubating serum or plasma with live virus followed by infection and incubation of cells. Testing will require either BSL-3 or BSL-2 laboratories, depending on what form of the SARS-CoV-2 virus is used. Neutralizing antibodies inhibit viral replication in vitro, and as with many infectious diseases, their presence correlates with immunity to future infection, at least temporarily.

Tests that detect binding antibodies fall into two broad categories:

  - *Virus neutralization tests (VNT):* such as the plaque-reduction neutralization test (PRNT) and microneutralization, use a SARS-CoV-2 virus from a clinical isolate or recombinant SARS-CoV-2 expressing reporter proteins. This testing requires BSL-3 laboratories and may take up to 5 days to complete.
  - *Pseudovirus neutralization tests (pVNT):* use recombinant pseudoviruses (like vesicular stomatitis virus, VSV) that incorporate the S protein of SARS-CoV-2. This testing can be performed in BSL-2 laboratories depending on the VSV strain used.

Challenges of Antibody tests:
As medical devices, in vitro diagnostics (IVD), like COVID-19 tests, have lower marketing hurdles than medicines products. For example in the EU; COVID-19 tests performed by health professionals are classified as “IVD low risk” that means manufacturers can therefore certificate the tests by themselves.

The question of test reliability relates to the rapid tests offered independently of laboratories. Their sensitivity (rate of correctly recognized sick people) and specificity (rate of correctly recognized healthy people) are usually only examined by the manufacturers on very small samples. Due to the commonly used test design, the case control study, the test properties should also be systematically overestimated.
The few published independent validation studies examine only a small selection of rapid tests with very heterogeneous results.
The authorities have apparently recognized the problem of many poorly validated antibody tests in retail. The European Commission for example, strongly recommends in a guideline to "additionally validate the clinical performance of COVID-19 tests by comparing them with a reference method in a sufficiently large target population before the products are included in the clinical routine".
Public health institutes warn of tests that are offered on the Internet or in the pharmacy. Their validation is not guaranteed. There is evidence that there are also counterfeits. In Germany, pharmacies are only allowed to give rapid tests for COVID-19 antibodies to medical professionals, not to laypeople. Violation of this tax ban can result in fines of up to € 30,000.

Utility of Antibody tests

The utility of tests depends on the sensitivity and specificity of the assays; these performance characteristics are determined by using a defined set of negative and positive samples. In addition, the predictive values of a test should be considered because these values affect the overall outcome of testing. Positive predictive value is the probability that individuals with positive test results are truly antibody positive. Negative predictive value is the probability that individuals with negative test results are truly antibody negative. Positive and negative predictive values are determined by the percentage of truly antibody positive individuals in the tested population (prevalence, pre-test probability) and the sensitivity and specificity of the test. For example:

- In a high-prevalence setting, the positive predictive value increases — meaning it is more likely that persons who test positive are truly antibody positive – than if the test is performed in a population with low-prevalence. When a test is used in a population where prevalence is low, the positive predictive value drops because there are more false-positive results, since the pre-test probability is low.
- Likewise, negative predictive value is also affected by prevalence. In a high-prevalence setting, the negative predictive value declines whereas in a low-prevalence setting, it increases.

In most countries, including areas that have been heavily impacted, the prevalence of SARS-CoV-2 antibody is expected to be low, ranging from <5% to 25%, so that testing at this point might result in relatively more false positive results and fewer false-negative results.

Testing strategies

In the current pandemic, maximizing specificity and thus positive predictive value in a serologic algorithm is preferred in most instances, since the overall prevalence of antibodies in most populations is likely low. For example, in a population where the prevalence is 5%, a test with 90% sensitivity and 95% specificity will yield a positive predictive value of 49%. In other words, less than half of those testing positive will truly have antibodies. Alternatively, the same test in a population with an antibody prevalence exceeding 52% will yield a positive predictive greater than 95%, meaning that less than one in 20 people testing positive will have a false positive test result.
Three strategies can be used to improve positive predictive value:

- Choosing a test with a very high specificity, perhaps 99.5% or greater, will yield a high positive predictive value in populations tested with prevalence >5%.
- Another strategy is to focus testing on persons with a high pre-test probability of having SARS-CoV-2 antibodies, such as persons with a history of COVID-19-like illness.
- A third approach is to employ an orthogonal testing algorithm in which persons who initially test positive are tested with a second test. Effective orthogonal algorithms are generally based on testing a patient sample with two tests, each with unique design characteristics (e.g., antigens or formats).

Algorithms can be designed to maximize overall specificity while retaining maximum sensitivity. For example, in the example above with a population prevalence of 5%, a positive predictive value of 95% can be achieved if samples initially positive are tested with a second different orthogonal assay that also has 90% sensitivity and 95% specificity. The performance of orthogonal testing algorithms has not been systematically evaluated but can be estimated using an on-line calculator icon from the FDA.

Table 1: Predictive value positive using one test or two orthogonal tests, by the background prevalence in the population tested.

Prevalence	PPV for one test (SE=90%, SP=95%)	PPV for two orthogonal tests (SE=90%, SP=95%)
2%	26.9%	86.9%
5%	48.6%	94.5%
10%	66.7%	97.3%
30%	88.5%	99.3%

PPV = positive predictive value

SE = sensitivity

SP = specificity

How to use and interpret Antibody tests:

What antibody tests can do in the diagnosis of COVID-19 depends not only on the method used, but also on the situation in which testing is carried out.

In the early phase of the disease, the tests often are false negative.

The median time to seroconversion, i.e. until the first detection of specific antibodies, is given in observational studies for SARS-CoV-2 for IgM antibodies with 5 to 13 days and for IgG antibodies with 12 to 14 days after the onset of symptoms.

In a study, for example, antibodies were not detectable until 7 days after the onset of symptoms in 50% of the patients and 14 days in all patients. Therefore, the direct detection of the virus by PCR remains the gold standard for acute diagnosis of SARS-CoV-2 infection.

Incorrect positive findings with low prevalence:

Results of tests for SARS-CoV-2 antibodies can also not be interpreted adequately without considering the (estimated) prevalence, i.e. the pre-test probability of the disease in the tested persons. According to the current state of knowledge, the prevalence of a SARS-CoV-2 infection has been low in the previously published studies.

Against the background of the very low pre-test probability, an antibody test should clarify the question of whether the infection may have already passed through (unnoticed) in persons without typical COVID-19 symptoms or a positive PCR test in the past and without known contacts to infected persons this group the rate of false positive results is high even in laboratory tests, which the manufacturers attest to very good test properties, such as that of Roche or Siemens. Both companies state a sensitivity of 100% and a specificity of 99.8% for their tests. Roche's test also shows no cross-reactivity on a small number of sera taken after infection with endemic human coronavirus to have gone through, only 83%, the probability of a false positive result is therefore almost 20%. In a validation study of the Roche test by the British public health institute England, the sensitivity was 86.1% from the 14th day after the onset of symptoms and 86.7% from the 21st day after the onset of symptoms.

However, if the same question is to be answered with a quick test that is even more less precise, but which the manufacturer still certifies comparatively good test properties (for example CLEARTEST CORONA IGG / IGM test, sensitivity and specificity for IgG 100% and 98%, for IgM 85 % or 96%), a positive result would remain, given the high rate of false positive results, without any meaningfulness.

Of the 1,000 people tested in this way, 30 would have had a positive result in the best case (detection only of IgG; specificity 98%), but only 10, i.e. a third, of them would have gone through the disease.

On the other hand, 67% of those tested with a positive result would consider themselves to be under false security.

Even less meaningful are test kits for taking and sending samples, such as the Corascavirus Antibody Test" from Cerascreen, which is evaluated in laboratories using the ELISA method. The

	sensitivity and specificity are given as 97.4% to 100% and 98.9% to 99.2%. With these test characteristics and a pre-test probability of 1%, positive results do not provide more information than tossing a coin. In the best-case scenario, the subsequent test probability is 55%. **Antibody tests in patients with typical symptoms:** Antibody tests as an add-on to PCR can support the diagnosis of those with typical symptoms (cough, fever, shortness of breath or taste or smell disorder), for example if this occurs very late, so that the sensitivity of the virus detection in the throat swab is already diminishing. Here, the pre-test probability is significantly higher and thus the meaningfulness of a positive serological finding. For this purpose, the patients should be tested twice in an interval of 7 to 14 days using the same procedure in the same laboratory (the second sample should not be taken before the third week after the onset of symptoms). Seroconversion or a significant increase in titer, particularly in connection with the corresponding symptoms, is an indication of an acute infection and is subject to notification. **Immunity:** Recurrence of COVID-19 illness appears to be very uncommon, suggesting that the presence of antibodies could confer at least short-term immunity to infection with SARS-CoV-2. Consistent with this observation, experimental primary infection in primates and subsequent development of antibodies resulted in protection from reinfection after the primates were rechallenged. Additionally, antibody development in humans correlates with a marked decrease in viral load in the respiratory tract. Taken together, these observations suggest that the presence of antibodies may decrease a person's infectiousness and offer some level of protection from reinfection. However, definitive data are lacking, and it remains uncertain whether individuals with antibodies (neutralizing or total) are protected against reinfection with SARS-CoV-2, and if so, what concentration of antibodies is needed to confer protection. New examinations of recovered COVID-19 patients dampen the hope of long-lasting immunity and thus the long-term effectiveness of a possible vaccination. Blood tests of the first corona patients in Germany who were treated at Munich Clinic Schwabing at the end of January showed a significant decrease in the number of so-called neutralizing antibodies in the blood. In addition to the so-called B-cell-associated immunity measured via antibodies, the so-called T-cell immunity is also relevant for long-term immunity. Whether T lymphocytes lead to long-term immunity in COVID-19 is currently still being investigated.

CDC Guidance on Interpreting COVID-19 Test Results:

GUIDANCE ON

INTERPRETING COVID-19 TEST RESULTS

	RESULT	INTERPRETATION	RECOMMENDED ACTION
VIRAL TESTING† (testing for current infection)	**Positive**	*Most likely** you DO currently have an active COVID-19 infection and can give the virus to others.	Stay home* and follow CDC guidance on steps to take if you are sick. *If you are a healthcare or critical infrastructure worker, notify your work of your test result.
	Negative	*Most likely** you DO NOT currently have an active COVID-19 infection.	If you have symptoms, you should keep monitoring symptoms and seek medical advice about staying home and if you need to get tested again. If you don't have symptoms, you should get tested again only if your medical provider and/or workplace tells you to. Take steps to protect yourself and others.
ANTIBODY TESTING‡ (testing for past infection with the virus)	**Positive**‡	You *likely** have HAD a COVID-19 infection.	You may be protected from re-infection (have immunity), but this cannot be said with certainty. Scientists are conducting studies now to provide more information. Take steps to protect yourself and others.
	Negative	You *likely** NEVER HAD (or have not yet developed antibodies to) COVID-19 infection.	You could still get COVID-19. Take steps to protect yourself and others.
BOTH (antibody and viral testing)	Viral **Positive**, Antibody **Positive**‡	*Most likely** you DO currently have an active COVID-19 infection and can give the virus to others.	Stay home* and follow CDC guidance on steps to take if you are sick. *If you are a healthcare or critical infrastructure worker, notify your work of your test result.
	Viral **Positive**, Antibody **Negative**	*Most likely** you DO currently have an active COVID-19 infection and can give the virus to others.	Stay home* and follow CDC guidance on steps to take if you are sick. *If you are a healthcare or critical infrastructure worker, notify your work of your test result.
	Viral **Negative**, Antibody **Positive**	You *likely** have HAD and RECOVERED FROM a COVID-19 infection.	You may be protected from re-infection (have immunity), but this cannot be said with certainty. Scientists are conducting studies now to provide more information. You should get tested again only if your medical provider and/or workplace tells you to. Take steps to protect yourself and others.
	Viral **Negative**, Antibody **Negative**	You *likely** have NEVER HAD a COVID-19 infection.	You could still get COVID-19. You should get tested again only if your medical provider and/or workplace tells you to. Take steps to protect yourself and others.

*No test is ever perfect. All tests occasionally result in false positive results (the test result should be negative because you DO NOT have COVID-19 but comes back positive) or false negative results (the test result should be positive because you DO have COVID-19, but comes back negative). Sometimes the results are not definitive (the result is unclear, and you don't know if it is positive or negative). For this and other reasons, results should always be reviewed by a healthcare professional.

† Viral tests are typically performed on respiratory specimens such as nasal swabs or throat swabs. They test for the presence of the virus, usually by testing for the virus's RNA or sometimes by testing for the virus's proteins ("antigen testing"). Antigen testing may be less sensitive than tests for the virus's RNA. If your antigen test is negative, please ask your healthcare provider if additional testing with an RNA test is needed and how long you should stay home.

‡ Antibody testing, also called "serologic testing" or "serology", is typically performed on a blood sample. Ideally, the results show whether you have ever been infected with the virus in the past or may be currently infected. Antibody tests check for antibodies that appear in the blood between about one and three weeks after symptom onset and may remain as long as a lifetime. Antibody tests may be positive while a person is infected. It is not yet known whether these antibodies protect against reinfection with the COVID-19 virus. For many other similar viruses, antibodies are protective for years or longer, but we do not yet have adequate data to know for COVID-19.

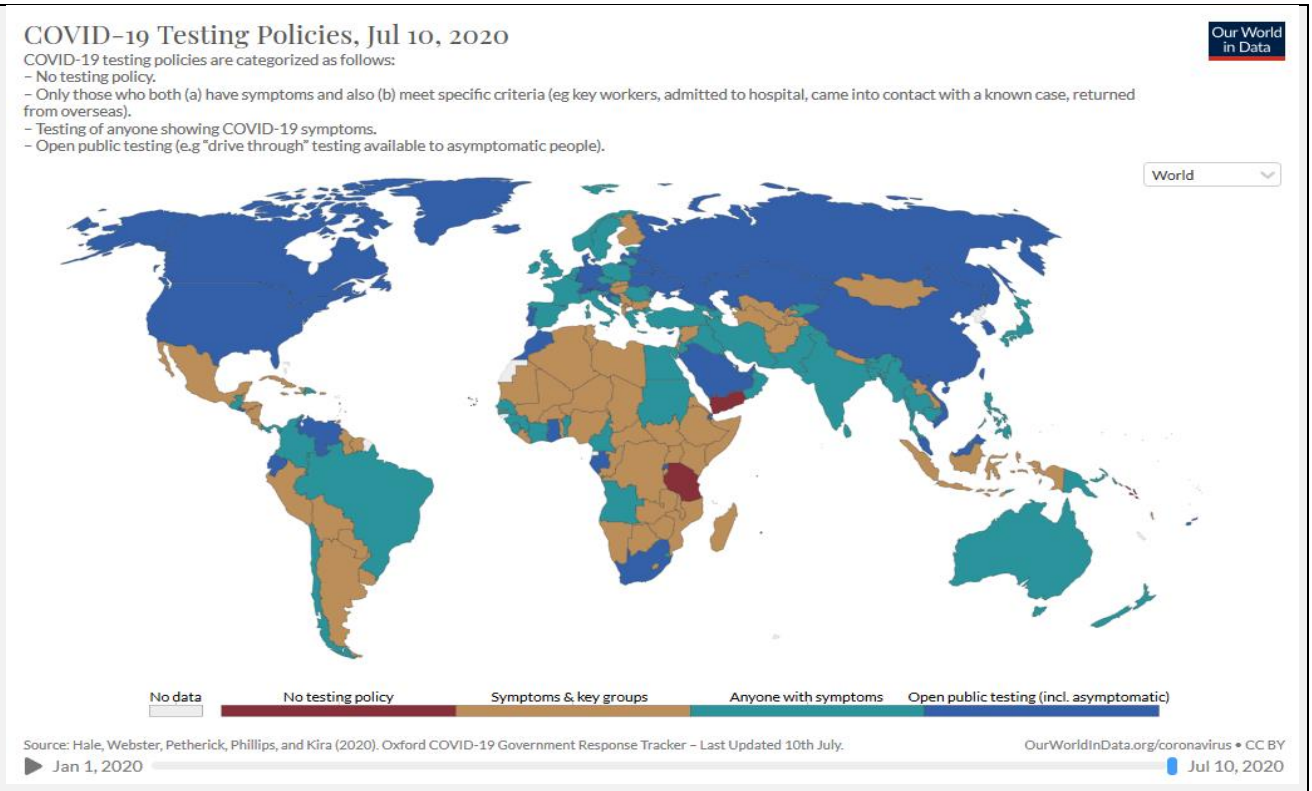
Take Home message:

Outside of research, tests for antibodies against SARS-CoV-2 currently have only a very limited indication. In certain situations, they can support the diagnosis of typical COVID-19 symptoms. The gold standard here is PCR, which is less sensitive in the later course of the disease.

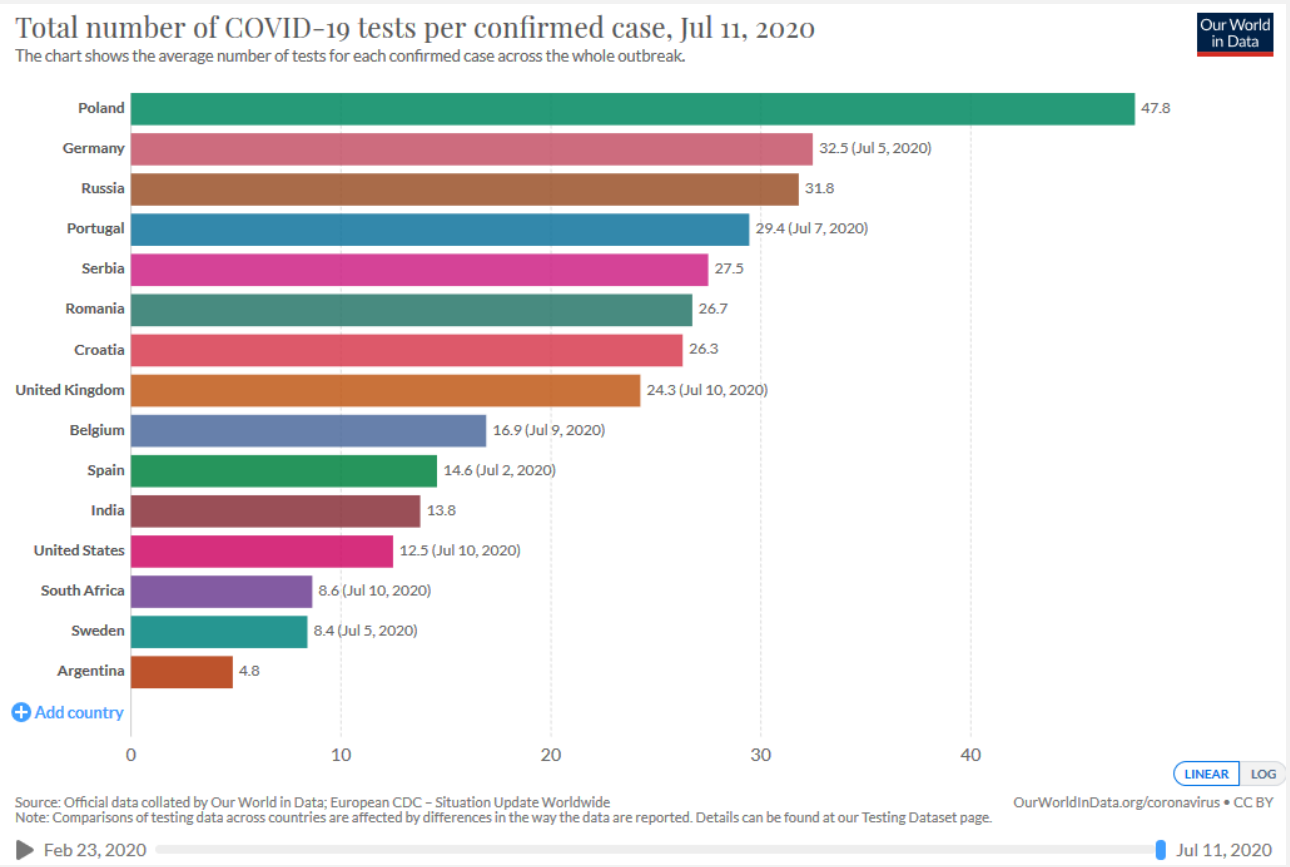
Individual testing without direct reference to specific clinical symptoms is not recommended. Because of the high rate of false positive results given the low prevalence of the disease in most countries, the tests cannot currently reliably answer whether the infection has already passed (unnoticed).

Rapid tests should not be used at all.

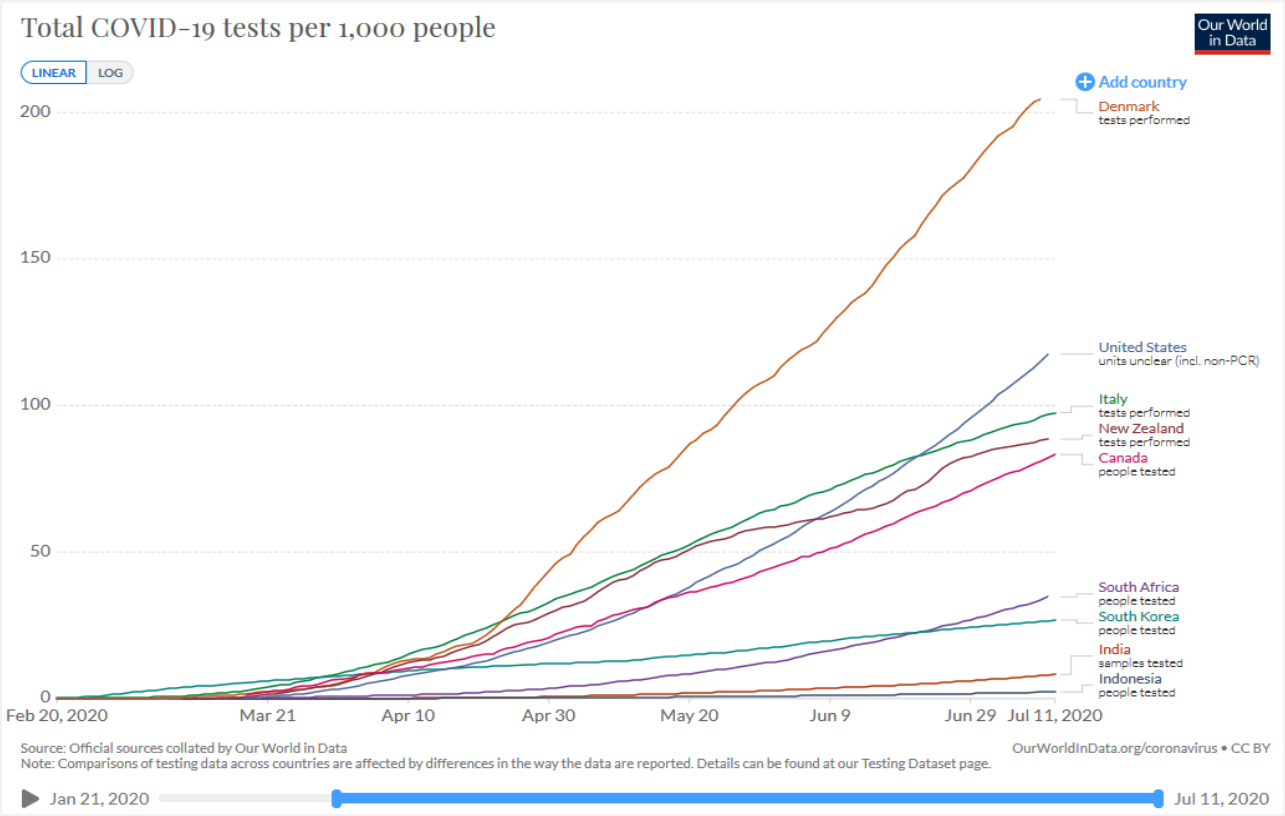
Source: https://www.arznei-telegramm.de/html/2020_06/2006041_01.html
https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html



This picture shows the 15 countries with the increasing trend of new cases in relation to the number of COVID-19 Tests per confirmed case.



Total COVID-19 tests per 1,000 people



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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 **We transfer the VTC from July until end of August in an standby modus. If we will face a second wave we can resume the VTC immediately and come back to you. Otherwise we will inform you after the summer break how we proceed with the VTC's.**

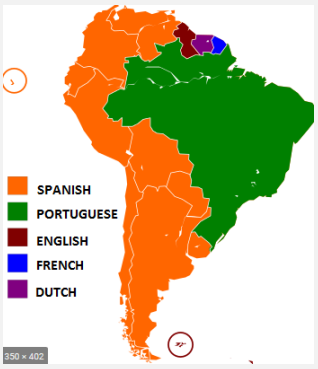
Conflict and Health

COVID 19 Crisis in Latin America

In cooperation with Bundeswehr HQ of Military Medicine

Children are the hidden victims of Latin America's Corona crisis

Latin America has been declared the new epicentre of the global COVID-19 pandemic. With weak healthcare systems, informal economies and high levels of inequality, the crisis presents an unprecedented challenge for struggling families. Children are especially vulnerable and their families risk collapsing.



Nine out of 10 children in Latin America and the Caribbean between three and four years old are exposed to at least one of the major risk factors of emotional abuse, domestic violence and punishment, failure to receive early education, lack of support and inadequate care. Due to COVID-19, the situation is likely to worsen as isolation measures and a lack of income heighten the risk of child abuse and violence in the home.

"New stress factors on parents and caregivers who may be out of work can increase the risk of children losing parental care," says Fabiola Flores, International Director for SOS Children's Villages in Latin America. "In a region where domestic violence rates are alarming, emotional stress can lead to violence."

With more than 95% of children out of school due to the crisis - and only a small percentage with access to online education -- there is a higher risk of children and young people falling behind and even dropping out of school. Not attending school also means that some 80 million children in Latin America are missing out on school meals. For some families, the pressure of putting food on the table in times of crisis may also be difficult to surmount.

"Children are becoming the hidden victims of this pandemic, and it will have short- and long-term repercussions that will affect their health, well-being, development and prospects," Ms Flores says.

Weak health systems and informal economies

Health-system coverage in Latin America and the Caribbean is highly segregated according to household income levels. Thirty percent of the population does not have access to health services due to financial and geographical constraints, according to the World Health Organization. Compared to developed countries, governments across Latin America have invested three times less in public health systems.

Compounding the health crisis, a striking 140 million Latin Americans have informal jobs. Due to the pandemic, the contracting economy will jeopardize the well-being of millions of people. This, combined with weak health systems, leaves many vulnerable and at risk, says Ms Flores.

"Without any other source of income nor safety net that can compensate for the sudden lack of income, this crisis forces millions to decide every day to provide food or risk exposure to the virus," she says.

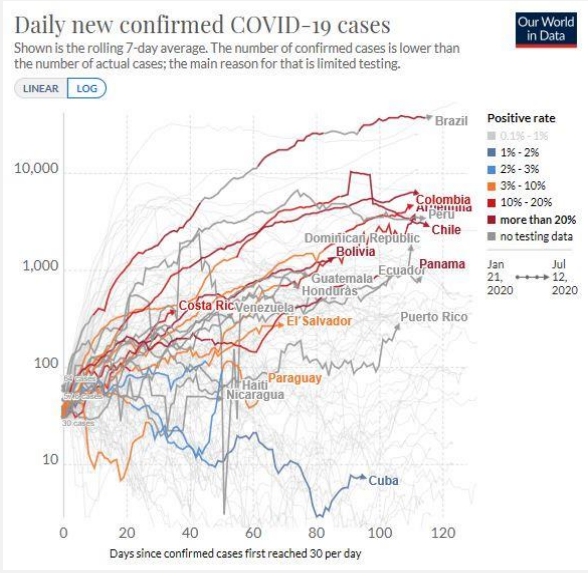
Governments and organisations, she adds, must support families in this time of crisis.

For its part, SOS Children's Villages provides medical, hygiene, livelihood and psychosocial support -- and is committed to providing alternative care of children in case of family breakdown.

"It is critical that we support families to avoid child's rights violations, as well as to provide quality alternative care when there is no possibility that children stay with their families," Ms Flores says.

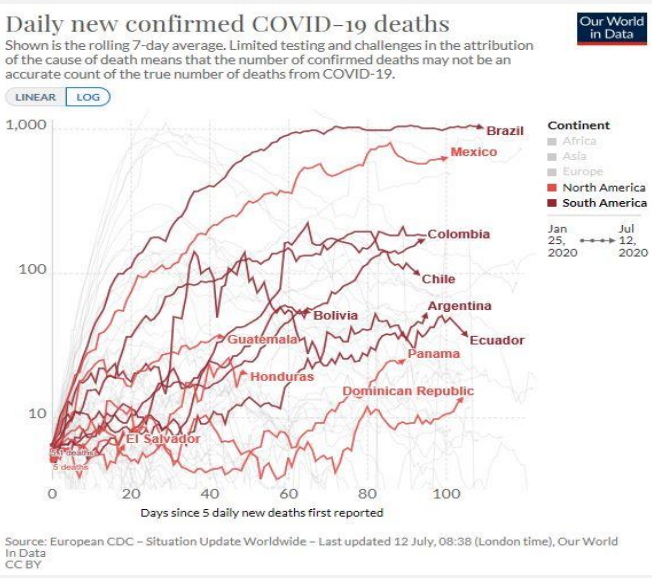
Brazil is among the countries worst affected by the pandemic across the globe -- second only to the USA. With the first case identified in late February, the country now faces alarming rates of infections and deaths, while the government has yet to declare an emergency and impose social distancing measures. SOS Children's Villages Brazil offers emotional support and assistance with immediate needs, says Alberto Guimaraes, National Director at SOS Children's Villages Brazil.

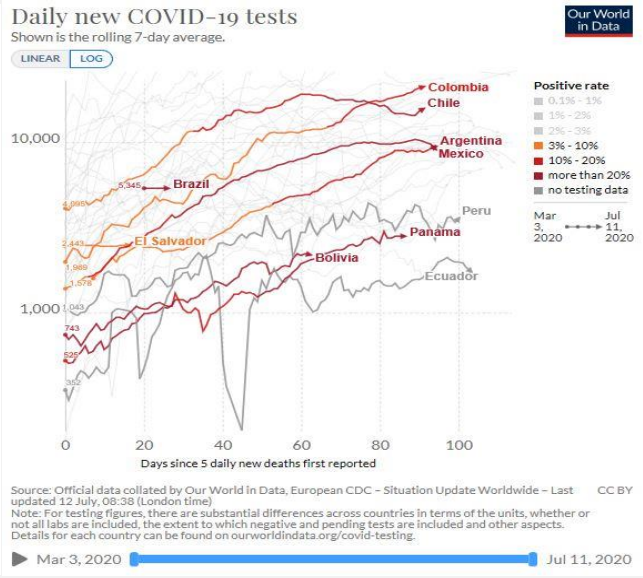
"As the crisis grows, our concerns are on rising unemployment and the immediate consequences on families to cover children's basic needs, plus the delay in children's education because of the lack of access and appropriate tools," says Mr Guimaraes.
He adds: "In the future, we must work to help parents and caregivers reintegrate into the labour market, as well as improve children's access to education and assist Brazilian youth with job training and employment."
According to SOS regional programme director, Patricia Sainz, the main short-term challenge is to reach families and children during the lockdown.
With a mixed approach between phone calls and occasional visits depending on the country's restrictions, SOS Children's Villages seeks to provide emotional support while responding to vulnerable families' immediate needs.



"We must support families with hygiene items and food supplies, but we must also keep in mind the long-term development of children," says Ms Sainz. "We are rethinking and changing the way we support families while adhering to our quality standards of protection and care for children."

https://reliefweb.int/report/world/children-are-hidden-victims-latin-america-s-corona-crisis





Recommendations

Recommendation for international business travellers	**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 • A medical mask is not required if exhibiting no symptoms, as there is no evidence that wearing a mask – of any type – protects non-sick persons. 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:

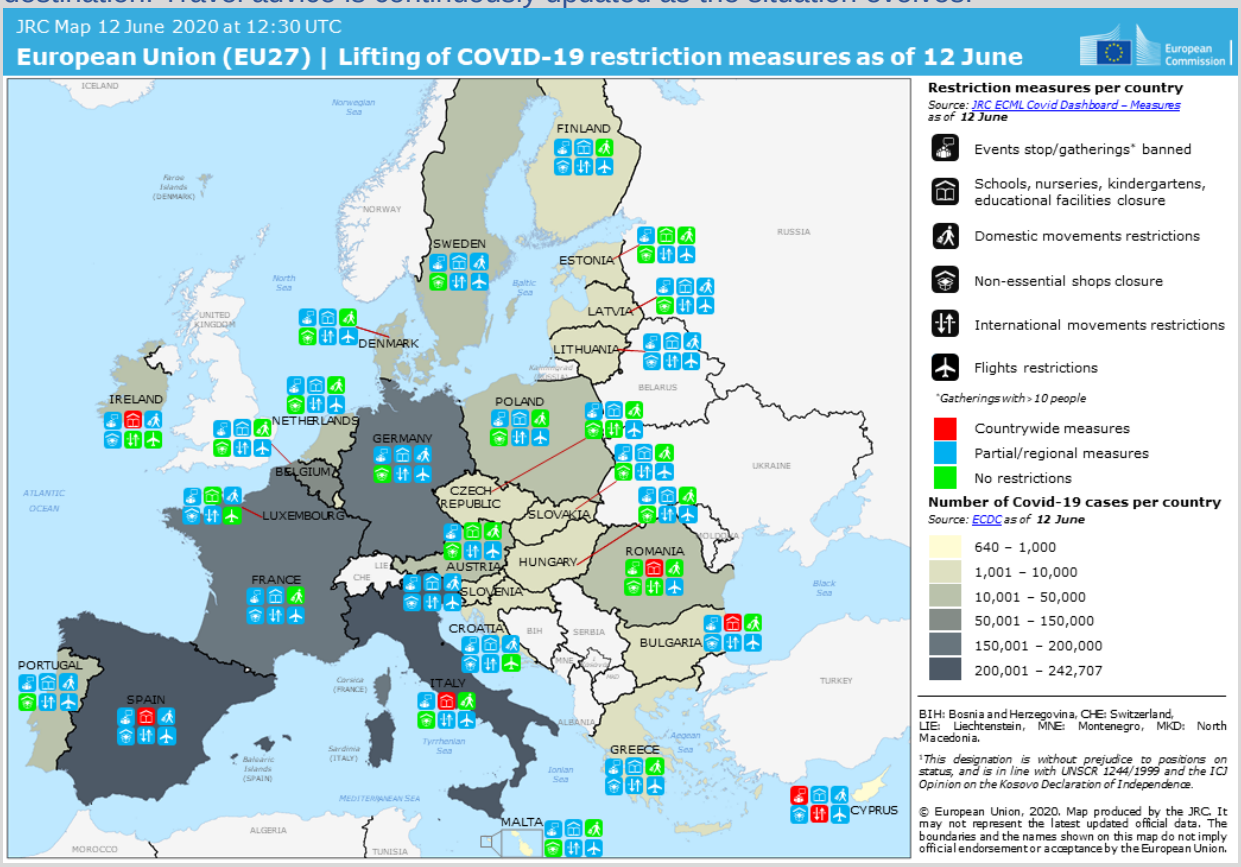
Re-open EU – new web platform to help travellers and tourists

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.



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. • Appropriate to the global trend of transmission of SARS-CoV-2 an extensive circulation of the virus is expectable. At this moment of time, asymptomatic persons as well as infected but not sickened persons could be a source of spreading the virus. Therefore, no certain disease-free area could be named globally.
Europe	ECDC assessment for EU/EEA, UK as of 11 June 2020: • **Risk of COVID-19 to the general population currently assessed:** **Low** in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates. **Moderate** in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place. • **Risk of COVID-19 to the population with defined factors associated with severe disease outcome currently assessed:** **Moderate** in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates. **Very high** in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place. • **Risk of COVID-19 incidence rising to a level that may require the re-introduction of stricter control measures is currently assessed as:** **Moderate** if measures are phased out gradually, when only sporadic or cluster transmission is reported, and when appropriate monitoring systems and capacities for extensive testing and contact tracing are in place. **High** if measures are phased out when there is still ongoing community transmission, and no appropriate monitoring systems and capacities for extensive testing and contact tracing are in place.

References:

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

Disclaimer:

The information published on this website is not intended to substitute professional medical advice, diagnosis or treatment.

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