Update 32 (11th of August 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

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

HIGHLIGHTS/NEWS

- **WHO** has published guidance on the public health surveillance of coronavirus disease 2019 (COVID-19) in humans caused by infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). This document combines and supersedes the Global surveillance guidance for COVID-19 caused by human infection with COVID-19 virus: Interim guidance, and Surveillance strategies for COVID-19 human infection: Interim Guidance 10 May 2020.
- **WHO:** A plane carrying 20 tonnes of trauma and surgical supplies from WHO has landed in Beirut, Lebanon to support the treatment of patients injured by the blast which occurred in the city on 4 August. This latest emergency has occurred at a time of recent civil unrest, economic crisis, the COVID-19 outbreak and heavy refugee burden. "We are in this together, and we are committed to supporting Lebanon in this very difficult time" said Dr Najat Rochdi, UN Resident Coordinator in Lebanon.
- **Europe WHO**: The North Macedonian Ministry of Health and Institute of Public Health are inaugurating the new Epidemics and Public Health Emergency Operations Centre in Skopje. The Centre will provide centralized, real-time information, monitoring and reporting, and advice on the response to public health events and emergencies.
- **ECDC** published **"**objectives for COVID-19 testing in school settings"

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GLOBALLY
20 098 042 confirmed cases 12 385 083 recovered 737 315 deaths
EU/EEA and the UK
3 279 969 confirmed cases **1 999 808** recovered **212 729** deaths
USA → **(new cases/day 53 089)**
5 070 578 confirmed cases **1 669 991** recovered **163 167** deaths
Brazil → **(new cases/day 43 106)**
3 057 470 confirmed cases **2 390 830** recovered **101 752** deaths
India ↗ **(new cases/day 58 768)**
2 268 675 confirmed cases **1 583 489** recovered **45 257** deaths
Russia → **(new cases/day 5 165)**
895 691 confirmed cases **701 796** recovered **15 103** deaths
UK ↘ **(new cases/day 860)**
311 641 confirmed cases **not reported** recovered 46 526 deaths

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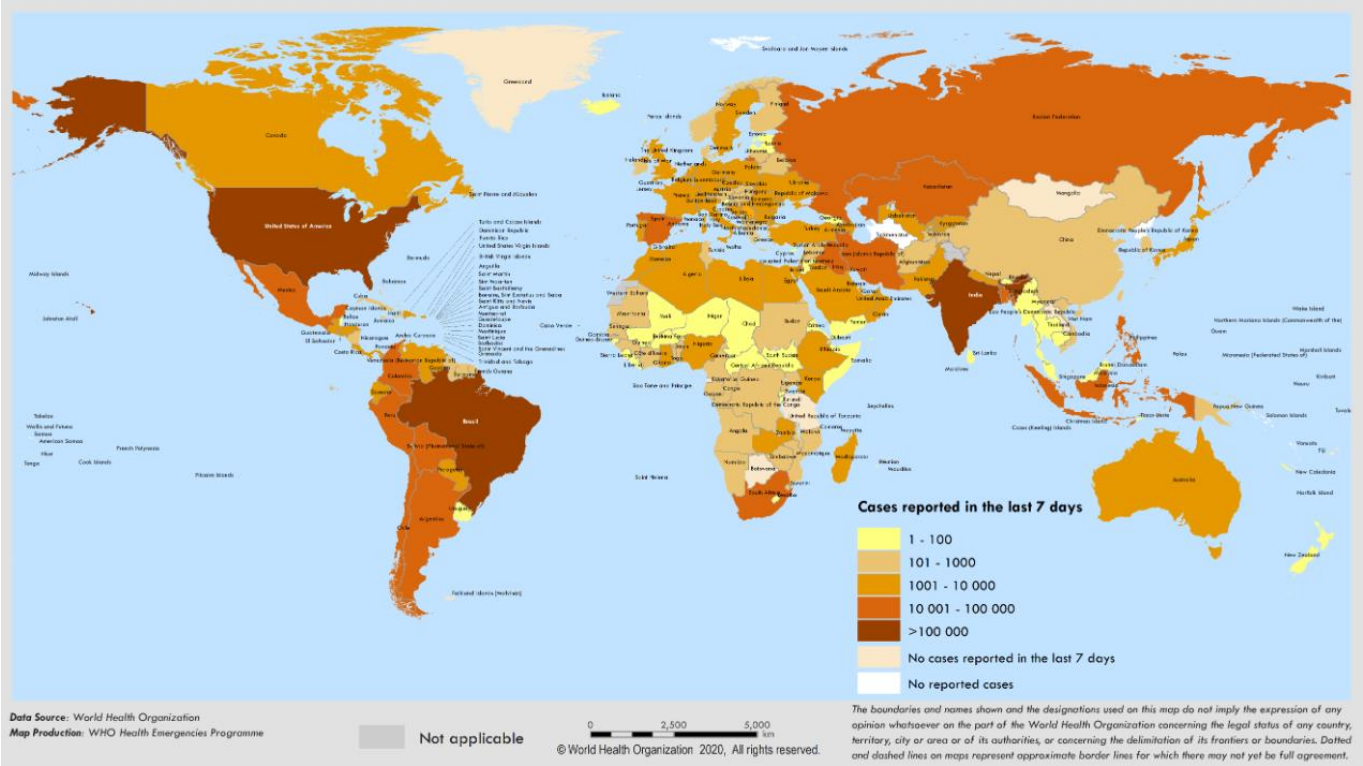
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

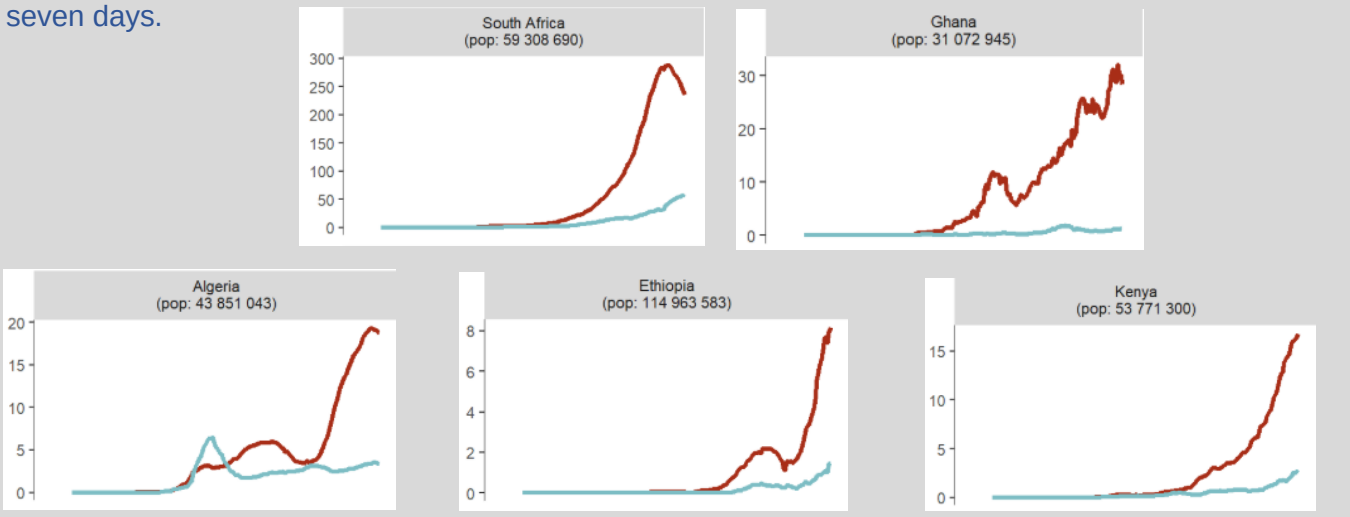
Global Situation

WHO:

Just a few days after the announcement, the 20 million infection mark was exceeded worldwide. This means that the number of cumulative infections has doubled in just 6 weeks. Half of the confirmed cases are in just 3 countries (USA, Brazil, India).

The corona cases will continue to rise until further notice. "You can call it a second wave, you can call it a second spike, you can call it a flare-up, you can call it what you want - if you take the pressure off this virus, the virus comes back," said WHO expert Michael Ryan in Geneva. It is extraordinarily difficult to stop the virus.

In the **African Region**, the number of newly confirmed cases decreased more than any other region, although deaths in the region still increased in the past seven days. This is primarily due to early declines in newly reported case numbers observed in South Africa. South Africa has contributed almost two thirds of the region's cases and deaths to date and reported over 49 000 new cases and 2 000 new deaths in the past week. Substantial increases were recorded in Ghana, Kenya, Ethiopia, and Algeria in the past seven days.



There have been multiple reports across the region of hospital systems being overwhelmed and under resourced medical staff, as the number of confirmed cases and individuals requiring hospitalization continues grow.

WHO Region	New cases in last seven days: no. (%)*	% change in new cases in last seven days**	Total cases: no. (%)	New deaths in last seven days: no. (%)*	% change in new deaths in last seven days**	Total cases: no. (%)
Americas	970 498 (54%)	-5%	10 590 929 (54%)	25 896 (63%)	2%	388 673 (53%)
South-East Asia	434 635 (24%)	9%	2 632 773 (13%)	6 732 (16%)	11%	53 677 (7%)
Europe	169 629 (10%)	1%	3 582 911 (18%)	2 772 (7%)	-18%	216 693 (30%)
Africa	82 198 (5%)	-23%	895 696 (5%)	2 624 (6%)	27%	16 713 (2%)
Eastern Mediterranean	80 875 (5%)	-4%	1 644 359 (8%)	2 694 (7%)	-7%	43 433 (6%)
Western Pacific	46 143 (3%)	31%	370 621 (2%)	303 (1%)	27%	8 811 (1%)
Global	**1 783 978 (100%)**	**-1%**	**19 718 030 (100%)**	**41 021 (100%)**	**2%**	**728 013 (100%)**

ZAF: Africa has surpassed the one million mark of coronavirus cases, but the true toll may be significantly higher. It took nearly five months to hit the 500,000 cases mark but only about a month to double that number. The government imposed lockdowns from early on, but quickly realized that people did not have enough money to bridge the financial gap caused by staying at home without salary and that - if they did

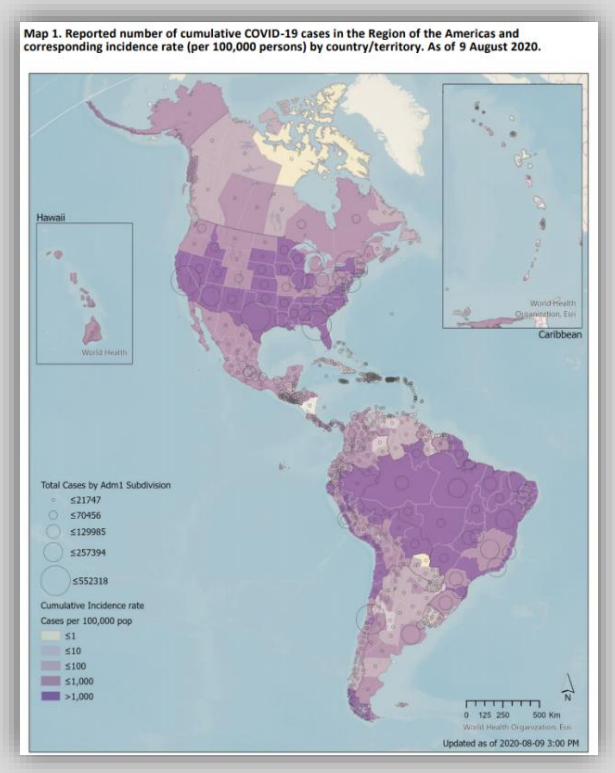
not ease restrictions - millions would suffer. The reported caseload of one million may has been reached unrecognized on the continent weeks or even months ago, due to extremely low testing rates. In addition, the fear of being stigmatized by being diagnosed with the virus and a plethora of conspiracy theories that caused many people to doubt the existence of the virus have probably kept a number of infected people from reporting their symptoms, experts said. More than half of the confirmed cases are in South Africa, the hardest hit African country by far, which has followed a comparatively extensive testing strategy. Dr. Caroline Tatua, a senior health coordinator at the International Rescue Committee, said the lack of testing – and therefore reliable data – was hampering countries' efforts to fight the virus. Africa is hitting a million reported cases, but that doesn't get close to the true picture. Indicators that the spread of the virus could be more extensive than official figures suggest, include increased mortality from respiratory diseases and the high percentage of infected health workers.

PAHO:

Over 10.5million cases and 388 000 deaths have been reported as of 9 August, with a little over 970 000 new cases in the past week, a 5% decrease compared to the previous seven days. The United States and Brazil remained the most affected countries, collectively accounting for 74% of cases and 67% of deaths in the region in the past seven days –or 41% of cases and 36% of deaths globally to date. Colombia, Mexico, Peru, and Argentina also reported substantial increases.

Total cases, deaths & CFR (%) among PAHO countries/territories with ≥ 10,000 cumulative cases.

Country/Territory	Cases	Deaths	CFR (%)
United States of America	4,951,851	160,989	3.3%
Brazil	3,012,412	100,477	3.3%
Mexico	475,902	52,006	10.9%
Peru	471,012	20,844	4.4%
Colombia	376,870	12,540	3.3%
Chile	373,056	10,077	2.7%
Argentina	241,811	4,556	1.9%
Canada	119,221	8,976	7.5%
Ecuador	94,459	5,922	6.3%
Bolivia	89,055	3,687	4.1%
Dominican Republic	79,732	1,309	1.6%
Panama	73,651	1,609	2.2%
Guatemala	56,605	2,211	3.9%
Honduras	46,973	1,476	3.1%
Venezuela	24,961	215	0.9%
Costa Rica	22,802	228	1.0%
Puerto Rico	22,121	279	1.3%
El Salvador	20,423	549	2.7%

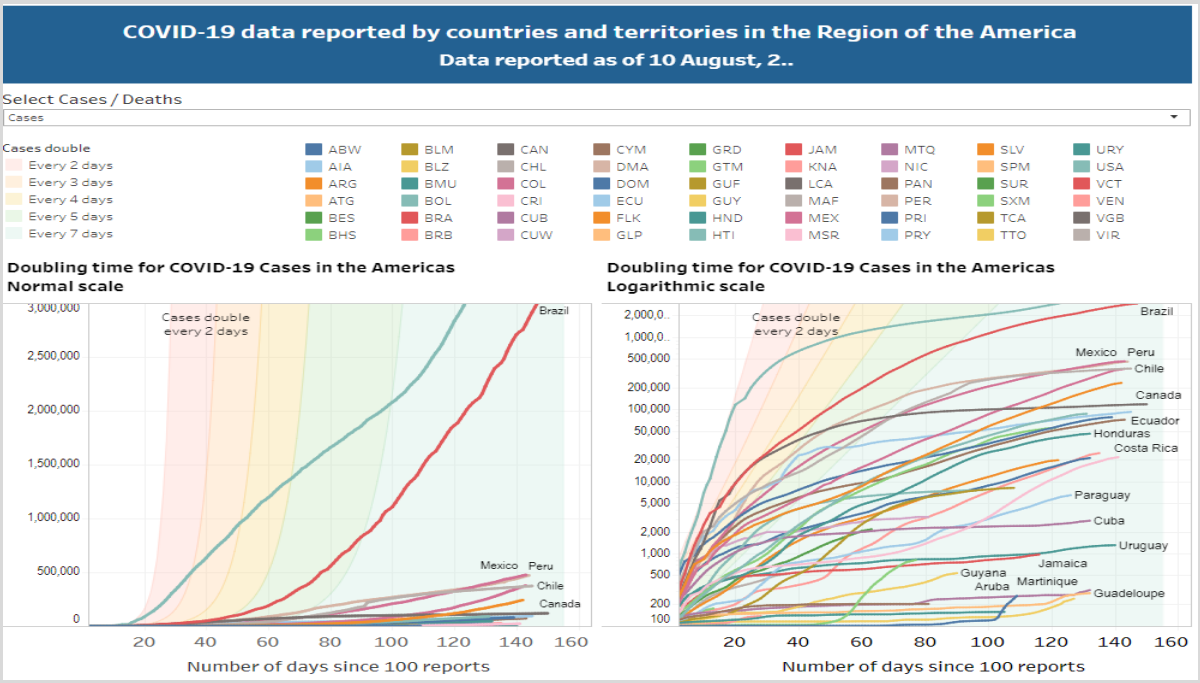


The French territories of Saint Martin and Saint-Barthélemy reported more than a 40% relative increase in cases compared to the previous week for a total of 29 additional cases – four in Saint-Barthélemy and 25 in Saint-Martin. •

Trinidad and Tobago reported 54 new cases overnight for a 24% relative increase compared to the previous day. This is the highest daily cases reported to date – the second highest was reported on 22 March when 41 new cases were reported in a single day

Bolivia continues to report an increasing trend in daily deaths with 163 additional deaths reported in the last 24 hours – a 5% relative increase compared the previous day. More than a total of 3 600 deaths have been reported in the country to date.

The United States and Brazil continue to report an average of approximately 1 000 deaths per day with the two countries accounting for 67% of all deaths reported to date.



https://www.paho.org/en/documents/covid-19-global-regional-update-9-aug-2020

BRA: became the second country in the world after the USA to exceed the 100,000 corona death mark. The number of those infected is more than three million. Red balloons rose in Rio in memory of the victims.

NZL: No new infections for 100 days: New Zealand is one of the few countries in the world which have the coronavirus pandemic under control. However, the authorities warn against carelessness - the infection process could flare up again quickly. The transmission of the coronavirus within the population has stopped. According to official information, there are currently 23 active cases in the country. The infected did not become infected in New Zealand but were tested positive on arrival and placed in quarantine facilities.
New Zealand quickly brought the spread of the coronavirus under control with rigorous measures. A strict curfew was imposed in mid-March and the country's borders were closed. In mid-June, the island nation in the South Pacific officially declared itself coronavirus-free. All restrictions were lifted again. However, the border is still closed to almost all foreigners, and all those who are allowed to enter the country have to stay in quarantine for 14 days. In total, around 1,200 cases of infection have been counted in the country with its five million inhabitants. The World Health Organization praised the crisis management of the New Zealand government as exemplary.

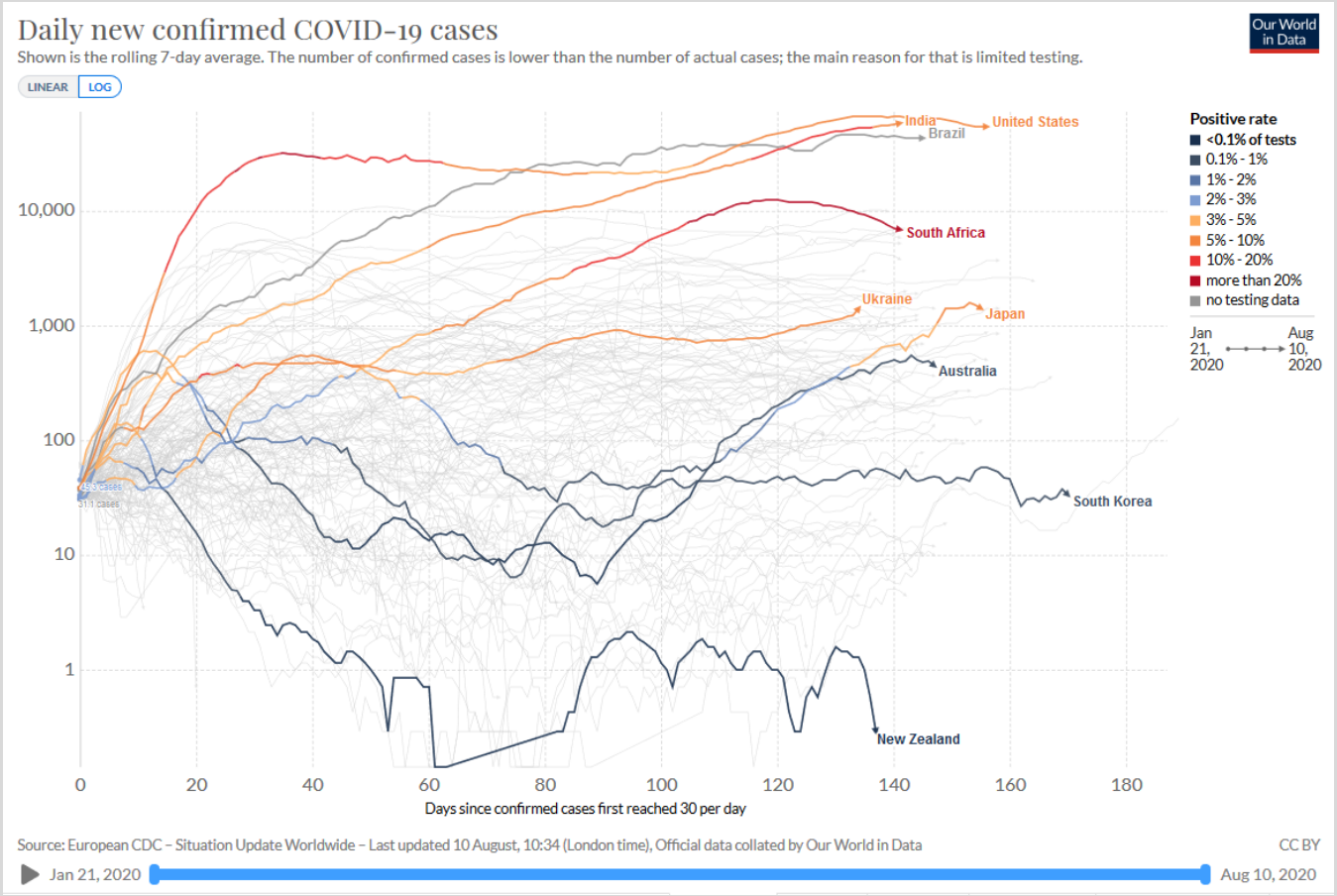
KOR: The Health Ministry said the country would lift a ban on travellers from the central Chinese province of Hubei.

IND: has recorded more than two million coronavirus infections. The country has the third-highest number of confirmed coronavirus cases following the United States and Brazil. Many prominent Indian politicians, including the powerful minister of Home Affairs, Amit Shah, and B.S. Yediyurappa, the chief minister of Kranataka, have recently been hospitalized after testing positive for the virus.

AUS: wants to keep its borders closed for the time being. It will take "a few more months" before foreigners are allowed to enter again, said Prime Minister Scott Morrison.

UKR: is temporarily sealing off its border with Crimea to prevent the further spread of the novel corona virus. All three crossings from the mainland to the peninsula will be closed from August 9th to August 30th, the government said. Russia annexed Crimea in 2014.

JPN: Last week, the country reported a new record since the beginning of the pandemic in terms of the number of infections reported every day. This makes it one of the nations that, after initially containing the first wave of infections well, are now struggling with a renewed flare-up of the outbreak. It is true that the number of cases in the capital Tokyo fell for the first time in two weeks; however, infection clusters continue to be detected in other prefectures. In Shimane, for example, the local high school is affected, and many of the infected students live together in a dormitory. Nationwide, more than 50% of the newly reported cases are attributable to people between the ages of 20 and 30.
At the same time, a new study by various JPN universities is investigating the spread of SARS-CoV-2 by so-called super spreaders. Analogous to observations in other countries, the researchers concluded that asymptomatic patients between 20 and 39 years of age seem to be responsible for clusters of infections on a larger scale. The young population has now been identified as an important factor in the spread of the pandemic, something similar has also been observed in the USA, ESP and DEU. The team classifies restaurants, concert halls, clubs, fitness studios and karaoke bars as particularly risky places.
The JPN government is taking a special approach to contain the pandemic, as it concentrates heavily on tracking chains of infection and is specifically looking for clusters.



Situation in Europe

ECDC COVID-19 surveillance report Week 31, as of 7 August 2020

Weekly surveillance summary

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

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

Trends in reported cases

- As of 5 August 2020, the 14-day case notification rate for the EU/EEA and the UK was 24 (country range: 2–194) per 100 000 population. The rate has been increasing for 17 days.
- Increases in the 14-day COVID-19 case notification rates compared to those reported seven days earlier have been observed in Belgium, Cyprus, Czechia, Denmark, France, Germany, Iceland, Malta, Netherlands, Poland, Romania, Spain and the United Kingdom. Rates in these countries have been increasing for between one and 52 days.
- Notification rates are highly dependent on a number of factors, one of which is the testing rate. Weekly testing rates for week 31 in the EU/EEA and the UK varied between 168 and 8 870 tests per 100 000 population. Luxembourg had the highest testing rate for week 31, followed by Denmark, Cyprus, the United Kingdom and Iceland. Two countries (Romania and Spain) had a weekly test positivity of 5% or higher.

Primary care

- Among five countries that reported data up to week 31 from primary care sentinel surveillance for COVID-19, using the systems established for influenza, there were no detections of SARS-CoV-2 from 44 patients tested.
- All countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 31, using the systems established for influenza, have observed consultation rates that remain similar to or lower than those reported during the same period in the last two years.

Hospitalisation

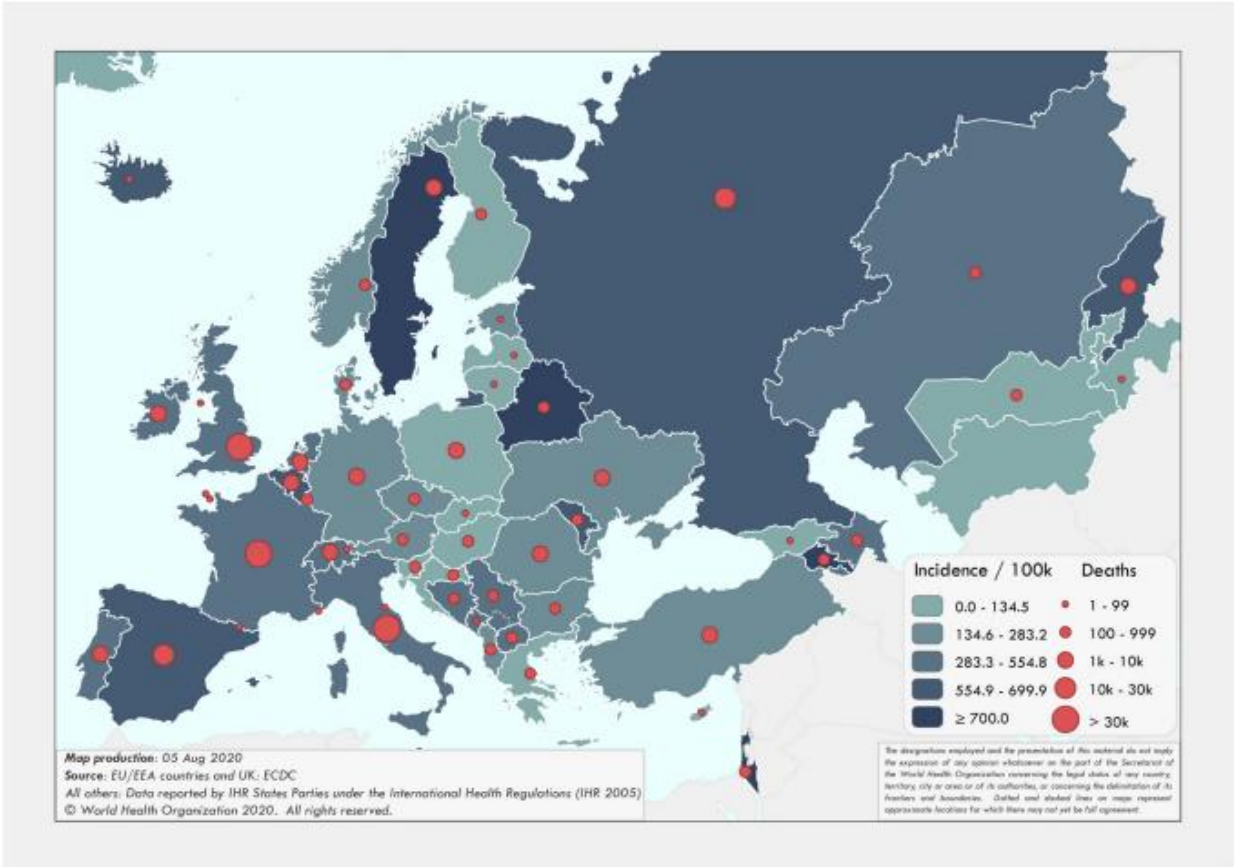
- Hospital and/or ICU occupancies due to COVID-19 are increasing in Bulgaria, Luxembourg, Romania and Slovenia. No other increases have been observed, although data availability varies.
- Overall, 28% of reported COVID-19 cases to date in the EU/EEA and the UK have been hospitalised; among hospitalised patients, 14% required ICU and/or respiratory support, although there is considerable variation among countries.

Mortality

- The 14-day COVID-19 death notification rate for the EU/EEA and the UK was 4 (country range: 0–21) per 100 000 population. The rate has been stable for 20 days.
- Increases in the 14-day COVID-19 death notification rates compared to those reported seven days earlier have been observed in Bulgaria, Croatia, Luxembourg and Romania. Rates in these countries have been increasing for between three and 12 days.
- We estimate that 24% (country range: 0–38%) of hospitalised COVID-19 cases reported in the EU/EEA and the UK have died.

COVID-19 situation update for the WHO European Region (27July – 2 August 2020 Epi week 31)

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



Key points

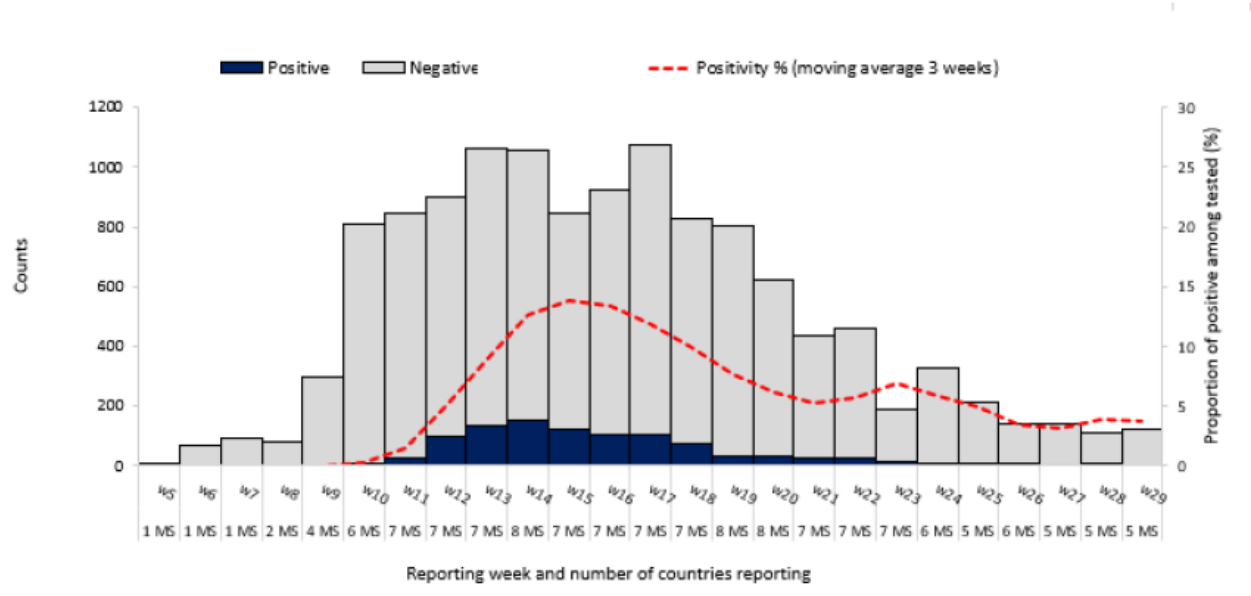
Week 31/2020 (27 Jul - 2 Aug 2020)

- The number of cases and deaths reported in the Region in the week 31/2020 remained stable compared to the previous week (Figure 1)
- 50% (76,708) of the cases reported in week 31/2020 were reported from five countries: the Russian Federation (25%; 38,385), Spain (8%; 11,665), Kazakhstan (6%; 9,873), Romania (5%; 8,433), and Israel (5%, 8,352). The remaining cases (50%; 76,858) were reported by 51 countries and territories; each accounted for <5% of the total cases reported in week 31/2020
- Five countries had a crude incidence of ≥60 per 100,000 in week 30/2020: Israel, Luxembourg, Montenegro, Bosnia and Herzegovina and Kyrgyzstan. The crude incidence continues to vary across the region with a range from 0.9 per 100,000 population in Hungary to 98 per 100,000 population in Israel (Figure 2A)
- The 14-day cumulative incidence increased by ≥10% in week 31/2020 in 34 countries and territories in the Region, however for some countries data was retro-adjusted by national authorities: Andorra, Albania, Austria, Belgium, Bosnia and Herzegovina, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Liechtenstein, Lithuania, Luxembourg, Malta, Montenegro, Netherlands, Norway, Poland, Republic of Moldova, Romania, Serbia, Slovakia, Spain, Switzerland, Ukraine, and Uzbekistan (see EURO COVID-19 Dashboard for recent trends)
- 58% (1,736) of the deaths reported in week 31/2020 were reported by the Russian Federation (29%; 859), the United Kingdom (15%; 455), Romania (7%, 214) and Kazakhstan (7%, 208). The remaining deaths (42%; 1,280) were reported from 38 countries and territories; each accounted for <5% of the total deaths reported in week 31/2020
- The proportion of reported cases that died was 2.0% in week 31/2020
- Community-transmission was reported by 26 countries and territories, 24 countries and territories reported cluster transmission, while 7 countries and territories reported sporadic transmission in week 31/2020(see EURO COVID-19 Dashboard)
- Since the emergence of COVID-19 virus in Europe at the end of February 2020, a wide range of public health and social measures (PHSM) have been implemented. See EURO COVID-19 Dashboard (NPI Explorer) for a snapshot of the temporal relationship between case and death numbers and the introduction and easing of these measures in some countries in the Region. In response to an increase in cases, some countries have recently started reintroducing PHSM.

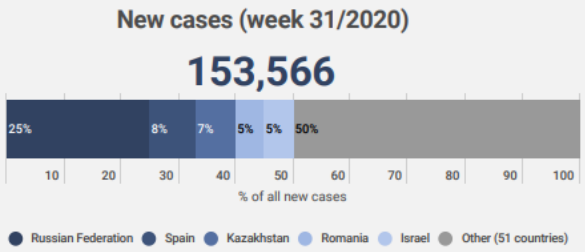
Summary overview

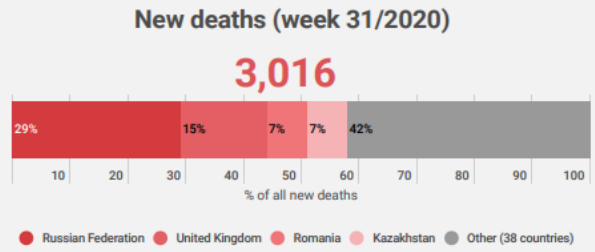
- The cumulative cases across the Region increased 4.7% to 3,338,172 cases in week 31/2020 (from 3,234,606 cases in week 30/2020) and cumulative deaths increased by 1.4% to 213,409 deaths (from 210,393 deaths in week 30/2020)
- As of 11 July 2020, nine countries in the European region had an effective reproductive number significantly over 1: Bosnia and Herzegovina, Czech Republic, France, Israel, Kazakhstan, Kyrgyzstan, Luxembourg, Serbia and Switzerland (See EpiForecasts and the CMMID COVID working group COVID-19 Global Summary for latest estimates)
- Seven countries in the Region each reported a cumulative incidence of ≥700 cases per 100,000 population: Andorra, Armenia, Belarus, Israel, Luxembourg, San Marino and Sweden (Figure 2B)
- As of week 31/2020, 68% (2,320,857) of cumulative cases were reported from the Russian Federation (25%; 850,870), United Kingdom (9%; 303,952), Spain (9%; 288,522), Italy (7%; 247,832), Turkey (7%; 231,869), Germany (6%; 209,893) and France (6%; 187,919). The remaining cases (32%;1,067,315) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 31/2020
- As of week 31/2020, 72% of cumulative deaths (154,177) were reported from the United Kingdom (22%; 46,193), Italy (16%; 35,146), France (14%; 30,265), Spain (14%; 28,445) and the Russian Federation (7%; 14,128). The remaining deaths (28%; 59,232) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 31/2020
- 89% of all deaths were in persons aged ≥65 years and 58% of all deaths were in men
- 94% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (75%)
- 14% of cases were in persons aged ≥65 years in week 31/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥65 years was 66% in week 31/2020 (compared to 91% in week 14/2020) (Figure 3)
- 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. In some countries there might be a tendency towards an increase in mortality, possibly due to heat waves
- In week 31/2020, three countries reported 73 tests and 3 COVID-19 detection in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in this surveillance system week 30/2020 was 1.0% (5 countries) compared to 1.9% (6 countries) in week 29/2020. The highest positivity in the sentinel surveillance was 14.6%, seen in week 15/2020 (Figure 4)
- Overall, there were 114,358 (6.9%) COVID-19 cases among the total of 1,652,457 tests performed in 20 countries for week 31/2020 (Figure 5).

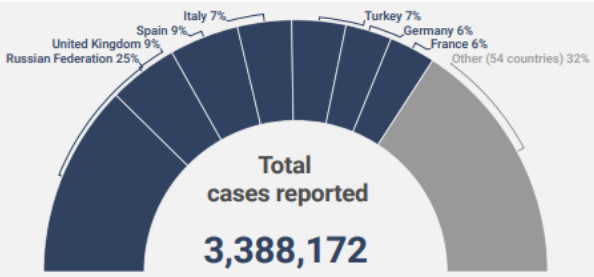
Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week

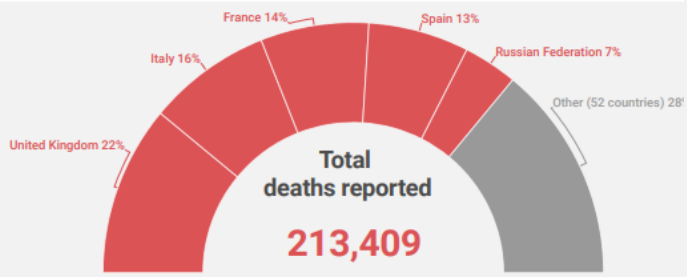


Source: Aggregate data from TESSy. MS: Member State









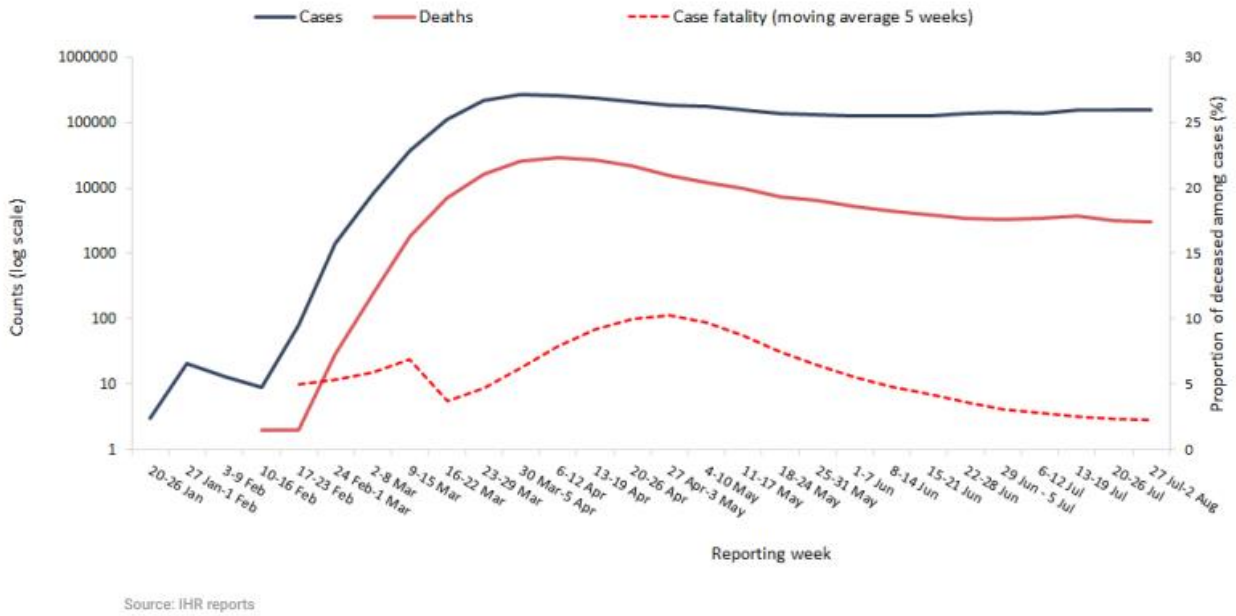
89%
of deaths
were in persons aged 65+

58%
of deaths
were in men

94%
of deaths
had at least 1 underlying condition

75%
of deaths
had cardiovascular disease

Figure 1: Number of COVID-19 cases (N=3,388,172) and deaths (N=213,409) by reporting week



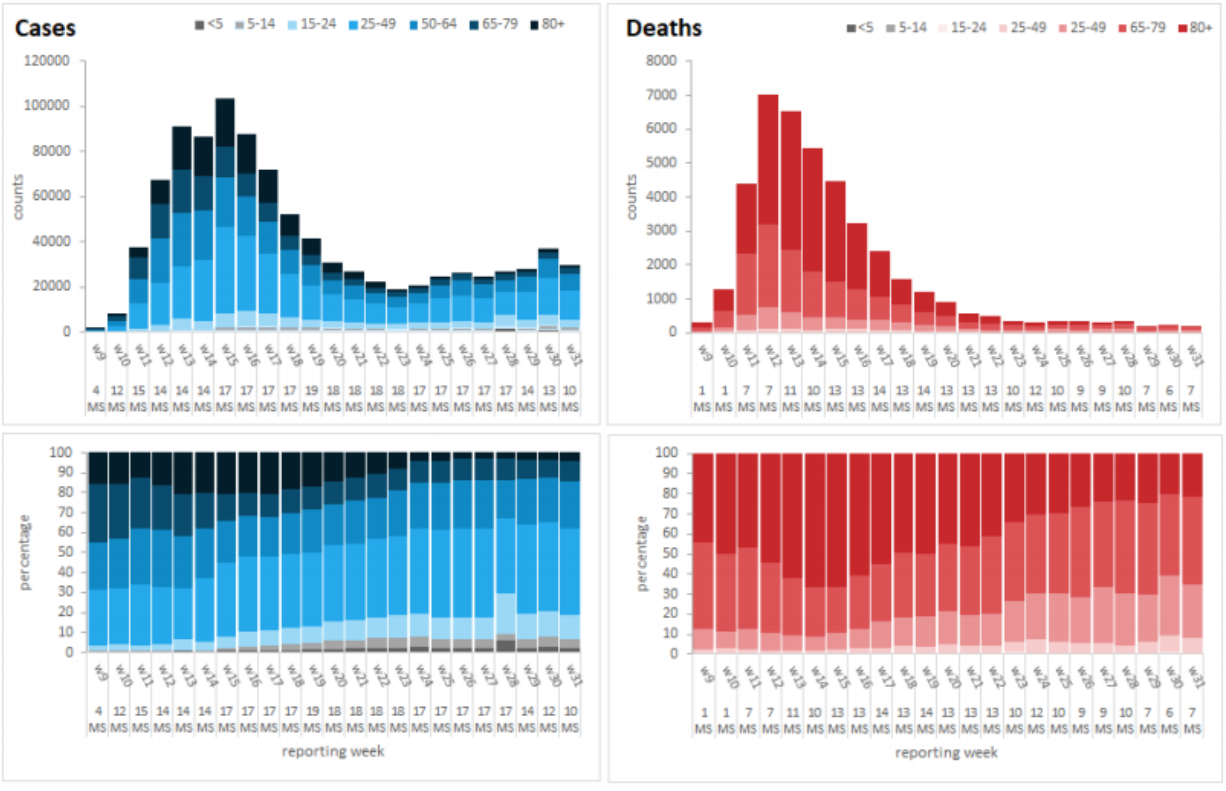
Source: IHR reports

Table 1. Characteristics of COVID-19 deaths

	Characteristics	n	%	Total records with data available
Deaths	Age in years, median (range)	81 (0-108)		96,169
	Sex, male	55,436	58	96,036
	At least one underlying condition	35,920	94	38,111
	• cardiovascular disease	7,345	75	9,746
	• diabetes	1,967	40	4,921
	• lung disease	1,692	29	5,764
	• neurological disease / dementia	2,046	26	7,951
	• renal disease	849	24	3,568
	• obesity	389	11	3,669
	• liver disease	410	6	7,190
	• immune disease	65	2	3,675
	• other	1,011	22	4,530

Source: Mortality database (n=96,179)

Figure 3. COVID-19 cases (N=966,781) and deaths (N=42,580) by age group and reporting week



Source: Aggregate data from TESSy. MS: Member State

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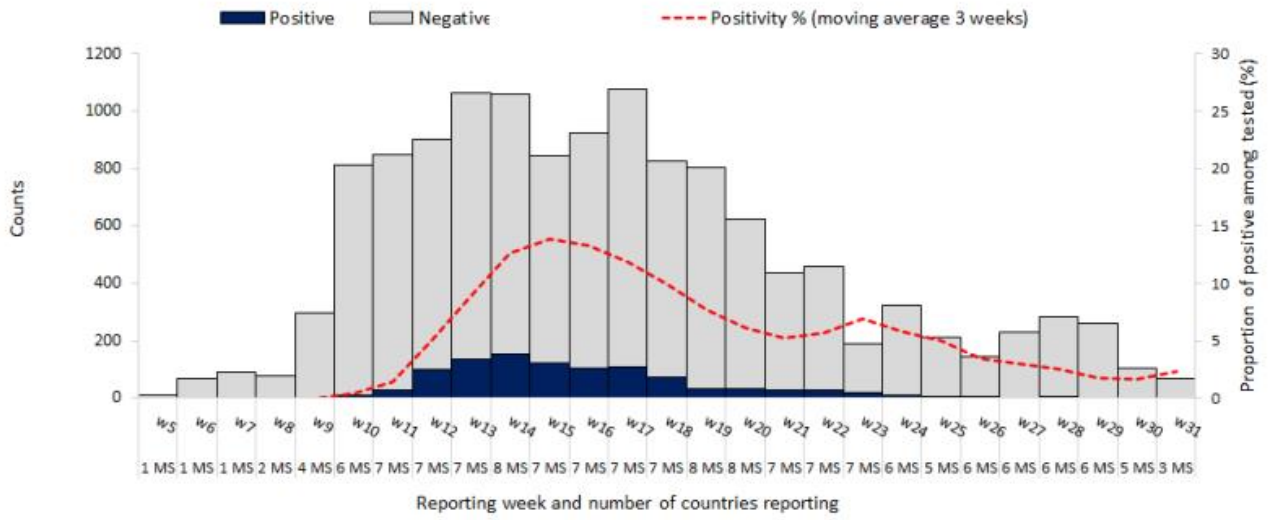
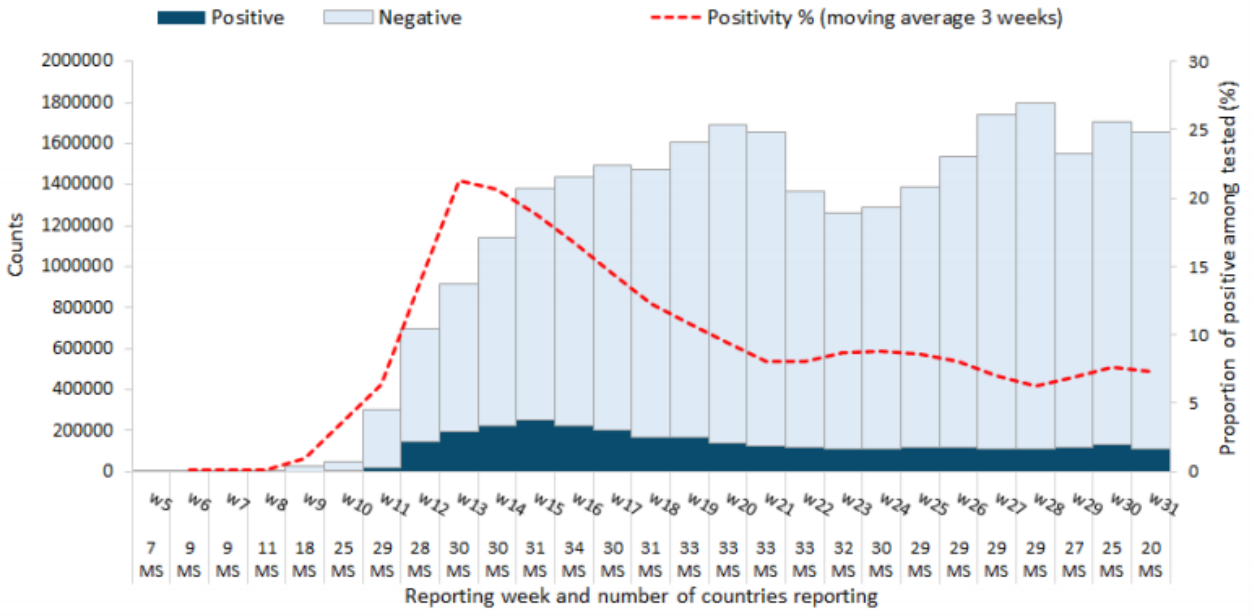
Figure 4. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



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

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



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

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EU Health Commissioner Stella Kyriakides is confident that a breakthrough in a corona vaccine will not be long in coming. "Even if predictions are still risky at this point in time, we have good indications that the first vaccine will be available towards the end of this or the beginning of next year," said the EU Health Commissioner in an interview with the "Handelsblatt".

The vaccine will not solve all problems right away, said the EU Commissioner. But it will "gradually allow a return to normality" when a "critical mass of citizens, especially in the risk groups" has been vaccinated.

It is unclear among scientists when a vaccine might be available. Theoretically, a development could take years or even fail completely.

DEU: In Germany, a COVID-19 test is now mandatory for travelers entering or returning from Corona risk areas. Anyone who comes to Germany from such regions is tested for the corona virus upon entry.

GRC: has reported the highest number of new infections per day since the epidemic broke out in February. A total of 5,623 confirmed cases were recorded in Greece.

GBR: Great Britain reports 1,062 new corona infections. For the first time since the end of June, the mark of 1,000 new daily cases was exceeded. 758 new cases were registered yesterday. Wearing masks are now mandatory in most indoor spaces. Among other things, mouth and nose protection is required during religious services, in museums, cinemas, banks and libraries, the authorities said. Previously, the measure primarily applied to shops and local public transport. By expanding the mask requirement, the government in London wants to get an upsurge in corona infections under control, which followed the relaxation of the restrictions.

FRA: In places with particularly high traffic in Paris, it is now mandatory to wear a mask outdoors. According to the Paris city administration, the banks of the Seine as well as other tourist attractions, markets and shopping streets are also affected by this new measure. Failure to comply with the mask requirement is fined with 135 euros.
Numerous other cities in France had previously made it mandatory to wear masks in busy locations, the list of cities includes Nice, Marseille and La Rochelle. A mask requirement applies nationwide in all publicly accessible rooms.

DNK: A slaughterhouse in Denmark has been temporarily closed because of a corona outbreak. As the meat processor Danish Crown announced, the premise in Ringsted will initially be closed for one week from Monday onwards. Almost 150 employees have so far tested positive for the corona virus.
The closure aims at breaking the chain of infection within the staff.

ITA: The Italian government has extended the country's anti-corona measures until September 7th. The respective decree still prescribes, among other things, the necessity of wearing a mask in closed, public spaces and distance rules. Larger gatherings of people are also (still) prohibited.

NOR: Norwegians should avoid travelling abroad, advises the country's health minister, Bent Hoie. This also applies if the corona infections are low at the destination.

ESP: should conduct an independent evaluation of what went wrong in its handling of the coronavirus pandemic, according to a group of 20 Spanish medical experts, who published their claim in a letter in the Lancet on Thursday.

IRL: The Northern Irish medical technology group Randox Laboratories has to recall up to 741,000 corona test kits by order of the British authorities. It is a precautionary measure, said the Ministry of Health. The government had previously expressed concerns as to whether the test kits meet all safety standards.

SWE: It takes two more weeks before school starts again in Sweden. Unlike many others, the country had not closed schools before the summer vacation. Chief epidemiologist Anders Tegnell considers the corona risk in schools to be low.

Subject in Focus

Lebanon Blast:

The current Situation and Impact of Health Sector

On 4th August large scale explosions took place in the capital of the Lebanon, Beirut. The event that is currently under investigation hit a health system that is already strained by an economic crisis and its fight against the coronavirus pandemic. The explosion led to numerous casualties and the destruction of much needed (health) goods. The World Health Organisation has issued some documents, two recent publications can be found here and here. In this update we decided to dedicate the Subject in Focus section that is usually reserved for important in-depth information on recent developments, technical specifications, research findings and other key information for fighting COVID-19, to highlighting WHO's assessment of the current situation in Beirut and how this tragic event might affects the fight against COVID-19. An example for NATO's role in alleviating the burden put on the Lebanon by this crisis can be found here.

WHO's DONOR ALERT: LebanonBlast6th August 2020

Current Situation and Impact on Health Sector

The recent explosion near the main port in Beirut on 4th August 2020 has caused widespread damage and resulted in over 135 dead and 5000+ people injured. These casualties have significantly overwhelmed the health system that was already reeling from a socio-economic crisis and the ongoing COVID pandemic. Although needs assessments and search and rescue operations are still ongoing, WHO is deeply concerned about the hospital and health workforce capacity, supplies of medicine, and chemical fumes which might have a harmful impact on the health of people with underlying conditions.

Furthermore, the MOPH central warehouse where WHO-supported essential medical supplies were stored has been severely damaged, necessitating immediate relocation to a different warehouse. Moreover, a recently delivered shipment of PPE, stored at the Beirut port warehouse pending transfer to MOPH warehouse was completely destroyed, leaving the nation in need of urgent trauma and PPE supplies.

135 deaths 5000 people suffering from injuries and burns - 100+ people reported missing

Severe damage to critical health infrastructure:

- 3 hospitals non-functional
- 2 hospitals with substantial damage
- 500 hospital bed equivalents lost
- 17 containers with essential medical supplies destroyed

Heavily damaged central drug warehouse, WHO Lebanon

While initial assessments indicate that three major hospitals are now non-functioning and two others are functioning well below capacity, a more thorough assessment of the impact on the health system is required. Early reports indicate that many health centers and primary care facilities are also damaged and/or out of action. WHO proposes to support the MOH in a detailed assessment of the damage to and functioning of health facilities.

International emergency medical teams (EMT) are already arriving in-country to support the government's response. WHO proposes to assist the MOH by establishing an EMT Coordination Cell and deploying an experienced EMT Coordinator. The Coordination Cell will be responsible for overseeing the reception and tasking of EMTs, promoting adherence to international EMT standards, and ensuring appropriate monitoring of and reporting by EMTs.

While the immediate response must address trauma and emergency medical needs, it is clear that a major humanitarian crisis is also evolving. Up to 300,000 people have been displaced from their

homes and need urgent support for shelter and food assistance. But the acute displacement of so many people also risks accelerating the spread of COVID-19 and the outbreak of other diseases, including other respiratory and water-borne diseases.
WHO will work with MOH to strengthen disease surveillance and ensure disease control measures are in place, especially among the displaced communities. We will work with other sectors to ensure that humanitarian needs are addressed.
Continuity of COVID-19 response activities is also vital. Prior to the explosion, the number of COVID cases in the country was increasing. WHO's aim is to avoid any reduction in the COVID response efforts, ensuring that all pillars of the response remain active and that there is a reliable supply of PPE and other supplies to replace the lost and damaged materials.
Finally, it is not too early to consider the needs to urgently rehabilitate and "build back better" hospitals and health facilities that were damaged. WHO will support the initial priority rehabilitation of health facilities, with a view to longer term reconstruction of health.

WHO Response

WHO is focusing its capacities on meeting immediate trauma, public health and humanitarian health needs, and will take initial first steps to support the health system to respond to the crisis, and then then rapidly transition to rehabilitation and strengthening the resilience of the health infrastructure, with an ultimate view to "building back better." In so doing, the most vulnerable Lebanese and refugee communities will be prioritized. Major activities include:

- **Meeting urgent trauma and emergency medical needs:** Within 24 hours, WHO has rapidly deployed 10 Trauma A & Trauma B kits, and 10 Surgical Supply kits to meet the needs of 1000 trauma cases and 1,000 surgical cases. These supplies, generously transported by the Government of the United Arab Emirates, were dispatched to Lebanon by late evening August 5th via WHO's Logistics Hub in Dubai. Further supplies and equipment are urgently required, including for hospital emergency departments (ED) and intensive care units (ICU).
- **Fully assessing the health impact of the explosion:** Undertaking a full assessment of the impact of the explosion and the resulting trauma and humanitarian health needs will be vital as well as identifying gaps and immediate lifesaving needs in collaboration with the Ministry of Health and local authorities, including conducting a health facility damage and needs assessment in the affected area and the access to health services of displaced persons.
- **Supporting the MOH to establish an EMT Coordination Cell and deploying an EMT Coordinator:** This will ensure that international teams are most effectively integrated into the national response and work according to international standards.
- **Ensuring the continuity of COVID-19 services,** including the deployment of PPE supplies to replace those lost through the explosion. WHO will assist the MOH in strengthening all pillars of the response and will rapidly deploy supplies of PPE to replace those that were lost as a result of the explosion.
- **Coordinating the humanitarian health response for those displaced by the explosion:** This will include ensuring access to essential health services, strengthening disease surveillance, and collaborating with other sectors to ensure disease control measures are in place.
- **Initiating an environmental impact assessment and guidance:** Together with the American University of Beirut, WHO will conduct this assessment and develop guidance for people on how to protect themselves from potentially harmful smoke and polluted air (e.g. wearing masks and staying away from blast area).

Current Situation:

- The death toll from the Beirut Port explosion rose to 158 people, as search teams continue their rescue efforts for the people still missing in and around the blast site.
- The Lebanese Red Cross announced that a policeman died and 238 protesters were injured in the clashes in central Beirut at Saturday during demonstrations demanding justice for victims of the Beirut blast. It added that 63 of those injured had been taken to hospital, while 175 were treated onsite.
- There is a critical need to continue COVID-19 response efforts while responding to the blast emergency needs, given the recent upward epidemiological trend. Lebanon confirmed 272

new cases of COVID-19 and 4 news deaths today. Of the new cases, 248 cases were detected locally and 24 found among incoming travellers. Total cases recorded is 6,225. Total 7,105 PCR tests were carried out in the last 24 hours.

- Major concerns regarding the resurgent spread of COVID-19are due to many factors: high risk of exposure for health workers due to crowding of emergency departments and shortages of PPEs; high risk of accelerated community transmission due to crowding; increased population vulnerability coupled with poor compliance to preventive measures and anxiety; and reduced number of beds and ICU capacity for COVID-19 care due to the blast casualties.

Health needs:

- Ongoing trauma care through provision of medical, surgical supplies and equipment to hospitals and primary healthcare centers, and deployment and coordination of emergency medical teams.
- Assessment and management of the environmental impact of the explosion associated with potential chemical or radiological contamination.
- Health facility functionality assessment is under preparation with WHO support to estimate the damage and needs of the most affected hospitals and PHCs.
- Addressing humanitarian needs and public health risks associated with the displacement of 300,000 left homeless by the blast.

WHO response:

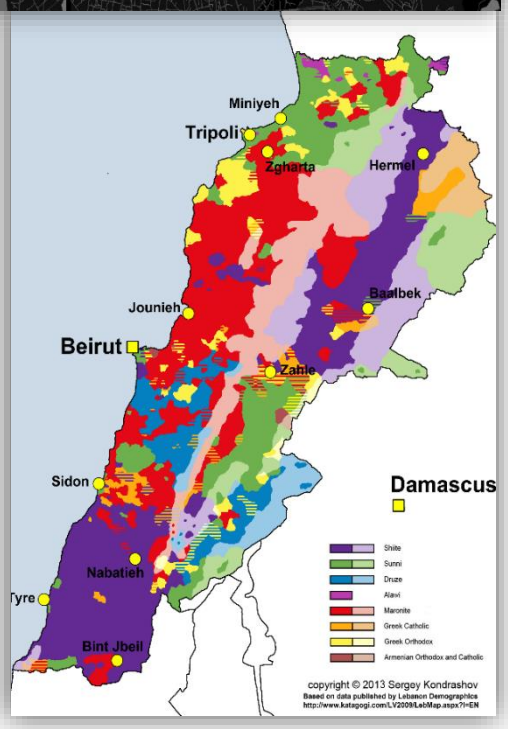
- Coordination with the national health authorities, UN agencies and INGOs is ongoing to mobilize resources and organize relief. Coordination mechanisms are kept as lean as possible as to allow partners to carry out implementation on the ground. A preliminary emergency response coordination structure has been created to rapidly proceed with a well-coordinated, inclusive and effective response to the blast.
- Preparations for the damage assessment of the 5 most affected hospitals by the blast have been initiated by WHO in close coordination with MOPH. The assessment is due to start on Saturday 8 August, and be completed by Wednesday 11 August.
- An EMT coordinator deployed by WHO to support MOPH arrived today to coordinate the EMT teams, compile information related to casualties and health services provided through EMTs.
- As the COVID-19 situation remains very concerning with an increase in cases among healthcare workers, extensive efforts are being undertaken to link the response of COVID-19 to the blast emergency response in order to promote awareness and preventive measures.
- Efforts are underway to reinforce and promote continuation of essential care including primary healthcare services which remains a key life-saving priority for WHO and the health sector partners. The health sector has prioritized three areas of support in response to Beirut blast: Primary Health Care, Mental Health and Mobile Medical Units (MMUs). Priority goes to the early rehabilitation at the primary health care centers and to provide mental health support to first responders and affected population. Two MMUs will be running in affected areas, they will be linked to fixed primary healthcare centers and acting as an outreach to target people with specific needs and older people mainly.
- A rapid health assessment of 55 primary healthcare centers in Beirut affected zone has been conducted on a voluntary basis by Connecting Research to Development (CRD) in consultation with WHO. Main findings reflected the following: 37.3% suffered moderate to serious damages, 12.7% had health workers injured during the blast, 47.3% only are presently capable of providing fully routine health services, and 54.6% expressed the need for equipment's.
- WHO and the National Mental Health Programme at the MOPH initiated coordination for the Mental Health and Psychosocial Support (MHPSS) response activities. A mapping of available specialized and non-specialized MHPSS services is ongoing. This mapping will serve to direct people in need of specialized services. A roster of specialized mental health professionals is being established and will be available to respond to the needs that arise, especially for bereaved persons, persons who have relatives missing, parents of/children

	who were exposed, as well as frontline responders. People are also directed towards the National Hotline for Emotional Support, or Embrace lifeline1564. • NGOs are being mobilized to provide MHPSS services, starting with Psychological First Aid (PFA). Deployment of PFA trained front liners will be done as needed to priority locations (e.g. tents in place in the affected area; in hospitals, etc.). • Information dissemination has been taking place on how to assist people in coping with the traumatic event, including specific considerations for children as well as tips for media professionals. A set of IEC material has been developed to this effect based on PFA, and disseminated through social media, TV channels, and to NGOs working on MHPSS. • A rapid assessment is taking place to assess functionality of the secondary mental health services. As mental health medications were damaged due to the destruction of the central drug warehouse, mobilizing funds for medications procurement is currently taking place. • The relocation of all medicines and supplies from the damaged MOPH warehouse in Qarantina near the blast site has completed. Stockpiling has been ensured in a safe and adapted location inside the Rafik Hariri University Hospital premises and rehabilitation work is underway. SourceS: http://www.emro.who.int/images/stories/media/donor-alert-lebanon-6-8-2020.pdf?ua=1&ua=1 http://www.emro.who.int/images/stories/lebanon/lebanon-blast-situation-report-8-8-20.pdf?ua=1

Conflict and Health

COVID 19 Crisis in Lebanon

In cooperation with Bundeswehr HQ of Military Medicine



The Lebanese Republic, formerly under the French League of Nations mandate, gained independence in 1943. It has an estimated population of 6.2 million who belongs to 18 different ethnic groups. 2/3 of the population live in an urban area. As diverse as its population is Lebanon's geography. The country, which is one of the smallest in the world, is also among the densest settled countries. It is divided into four landscape zones that are parallel to the coast. There are the 225 km long, narrow and steep coastline, the Lebanon Mountains with a height of up to 3,000m, the fertile Bekaa plain, which is considered to be the granary of Lebanon and which currently houses around 1.5 million Syrian refugees, finally the dry Anti-Lebanon mountain range and the Hermon form the border with Syria. The capital Beirut with 2.1 million inhabitants forms the multi-ethnic and multi-religious center of Lebanon.

The former partial autonomy known as "Reglement Organique" is considered to be the nucleus of Lebanese statehood. The principles anchored in it remain as guiding idea to this day: In general, religious communities (e.g. Christians, Sunnis, Shiites, etc.) are represented and allowed to participate in politics and administration according to a constantly disputed distribution key. Since official posts, jobs and social benefits as well as public investments are allocated proportionally to the various religious communities according to the principle of denominational proportional representation, economic and social struggles are always also religious-denominational disputes.

Lebanese domestic politics has always been closely linked to the regional balance of power, and substantial changes are only possible if the latter shifts significantly. Usually such changes are accompanied by violence. It was only with the reorganization of the balance of power in the region after 1990 that the Lebanese civil war, which had lasted for almost 25 years, could be resolved.

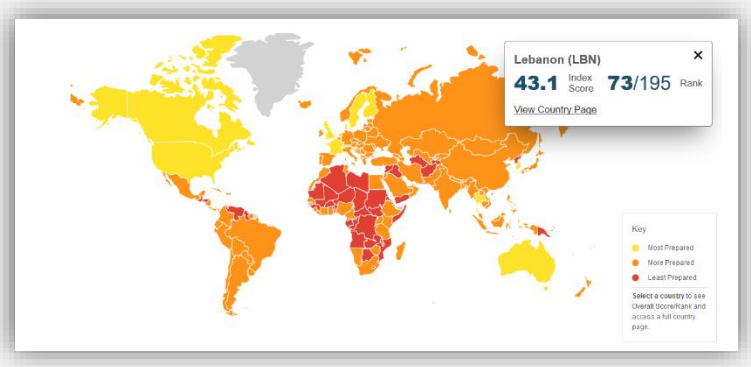
In mutual agreement between the USA and Saudi Arabia, the neighboring country Syria, which was deeply involved into the civil war, was tasked with the pacification of the country and was present in Lebanon with its own troops until 2005. The "Document of National Understanding" of 1989 declared a moderate shift in the denominational balance of power in favor of the Muslims. Since 2006, the country has been politically divided into two almost equally strong grops, which define themselves via their politically standpoints as well as denominationally. The Sunni-dominated "March 14 Alliance" is oriented towards Saudi Arabia and its regional and western allies, it supported the revolution in Syria, opposes alleged Iranian expansionist efforts and sees Hezbollah as the greatest threat to democracy in Lebanon. The "March 8 Alliance" led by the Shiite Hezbollah (both alliances are named after major rival demonstrations in spring 2005), conversely, takes sides with Iran and the allegedly "secular" regime of

Bashar al-Assad in Syria. It opposes an alleged US strategy of reorganizing the region with the help of the regional powers Turkey and Saudi Arabia according to US' and Israel's interests. The inner-Lebanese conflict over political power is thus directly linked to a hegemonic conflict of regional and global political importance and cannot be resolved autonomously by the Lebanese actors. This is still valid today and is particularly noticeable in the economic crisis that holds Lebanon gripped since October 2019.

In October the US dollar was decoupled from the Lebanese currency, this coupling used to be a guarantee of stability for decades. Since then, the Lebanese currency and economy found itself in free fall. There is hardly any foreign currency in the country, the financial assets are no longer accessible, and the prices keep rising making many goods unaffordable. The population has been demonstrating since October last year against the government and the small elite, which has enriched itself on the expense of the state and the population over decades. It is a new development that with this protests large parts of the population ignore the religious, political and ethnic barriers and demonstrate united nationwide against the government and the elite (the elite also has members from all religious, political and ethnic communities due to the distribution key explained above). A new, and for the first time common Lebanese identity has emerged in this multi-ethnic and religious state. The political elites try, to play the inhabitants off against each other and to bring them back into old patterns of segregation through political and religious propaganda.

The health system in Lebanon is considered to be one of the best in the region. Lebanon has 24 public and 138 private owned hospitals. In addition, NGOs and political parties operate about 760 local clinics. According to the Ministry of Health, there are 11,186 doctors, 4,200 dentists and 4,667 pharmacists in Lebanon.

Health services in Lebanon are generally of an average to good level. Lebanon has the best hospitals and doctors in the region. Nevertheless, the supply in rural areas is moderate. In addition, there are huge differences in quality between the publicly and private owned services. The high number of doctors (1 per 270 inhabitants) and the modern, highly developed technology of the country ensure fast and comprehensive, but very expensive medical care. Only a small proportion of the Lebanese are members of the National Social Insurance Fund. The Ministry of Health spends 80% of its budget on paying private hospitals to cover the cost of medical care for patients who are not socially or privately insured and cannot pay their hospital bills. This means that the proportion of the population with access to health services is very high. Maternal and infant mortality rates are lower in Lebanon than in most countries in the region. However, it hast to be mentioned that state benefits are only available for Lebanese citizens who have had Lebanese citizenship for at least ten years. This excludes the hundreds of thousands of Palestinian refugees who have lived in the country for decades. These and the millions of Syrian refugees are cared for by aid organizations. As a fourth type of health care the social and health system operated by the Shiite party and Hezbollah militia for its supporters has to be mentioned, this system also aims at securing the supporters loyalty (as long as it works and financial aid flows from Iran).



However, the current economic development and the conflict between the population and the government are negatively affecting the relatively good situation described above. The shortage of foreign currency has an immense impact on health care, as a large number of medical devices and medical infrastructure have to be paid for in foreign currency. At the same time, the state does no longer have the money to pay for health services. There is not only a shortage of food, but also a shortage of medicines. These were no good conditions for fighting the COVID-19 pandemic after the first cases were registered by Shiite pilgrims from Iran in March. To date, 5,417 COVID-19 cases and 68 deaths have been reported. The number of cases rose sharply after the easing of restrictions in July and led to another lockdown at the beginning of August and to the full-utilization of the intensive care capacities in the border area.

On August 4, 2020 at 6:08 p.m. local time, an explosion took place that had the equivalent explosive power of one tenth of the atomic bomb dropped over Hiroshima, according to experts' estimations. The

exact cause is still unclear. According to reports, at least 135 people died in the disaster and around 5,000 were injured. Local reports as well as reports from Lebanese Broadcasting Corporation International and statements by Lebanese Health Minister Hamad Hassan raised the fear of high casualties soon after the incident. The hospitals in Beirut were overwhelmed by the onslaught of injured people. The pressure wave of the explosion also caused immense material damage: In addition to cars being blown away and buildings being destroyed in the vicinity, even houses several kilometers away were severely damaged. The pressure wave also burst windows 20 kilometers away. Three hospitals were evacuated because they were severely damaged or destroyed; two other clinics also suffered damage. According to the Beirut office of the Konrad Adenauer Foundation, the power station in Beirut was also destroyed. According to reports from the Lebanese National News Agency, around 90% of the hotels in Beirut were also destroyed. Video recordings show devastated districts. Between 200,000 and 300,000 people are said to have become homeless.
According to initial estimates, the resulting property damage is up to five billion US dollars (just under 4.25 billion euros). Around 85% of all goods in Lebanon were imported in the past; the largely destroyed trading port of the Lebanese capital was one of the most important transshipment points in Lebanon. In the past few days, several states have started sending specially trained and equipped rescue teams to Beirut as well as aid and supplies. International sympathy and help came from all parts of the world, even from warring Israel.

Conclusion: Health care in Lebanon, which used to be among the best in the region, reached its limits shortly before the explosion due to the rising number of COVID-19 cases, the extreme economic crisis and the lack of international aid that was blocked by regional and global hegemonic conflicts and the lack of reforms. Due to the catastrophic destructions caused by the explosion, the health system is down on the ground and, after the first emergency response, also needs short, medium and long-term support in all areas of health care in order to cope with the physical and mental damages. This requires a comprehensive public health approach. A coordinated fight against the COVID-19 pandemic is currently unthinkable and an increase and an uncontrolled community spread has to be expected.
It is also still unclear whether this explosion will initiate a process of reformation that not only enables reconstruction, but also brings the population together on a path towards a common and united future. If the old system prevails in Lebanon, Lebanon will very likely sink back into sectarian chaos and corruption and the people will continue to suffer in this tragedy.

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Lebanon

43.1 Index Score **73**/195

	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**27.3**	**34.8**
Antimicrobial resistance (AMR)	41.7	42.4
Zoonotic disease	13.8	27.1
Biosecurity	0	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	93	85.0
DETECTION AND REPORTING	**62.0**	**41.9**
Laboratory systems	66.7	54.4
Real-time surveillance and reporting	61.7	39.1
Epidemiology workforce	25	42.3
Data integration between human/ animal/environmental health sectors	100	29.7
RAPID RESPONSE	**47.9**	**38.4**
Emergency preparedness and response planning	25	16.9
Exercising response plans	0	16.2
Emergency response operation	33.3	23.6
Linking public health and security authorities	100	22.6
Risk communication	25	39.4
Access to communications infrastructure	82.4	72.7
Trade and travel restrictions	100	97.4

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**23.8**	**26.4**
Health capacity in clinics, hospitals and community care centers	37.4	24.4
Medical countermeasures and personnel deployment	33.3	21.2
Healthcare access	30.4	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	0	20.8
Capacity to test and approve new medical countermeasures	50	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**49.3**	**48.5**
IHR reporting compliance and disaster risk reduction	100	62.3
Cross-border agreements on public and animal health emergency response	50	54.4
International commitments	37.5	53.4
JEE and PVS	25	17.7
Financing	16.7	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	**45.5**	**55.0**
Political and security risks	14.3	60.4
Socio-economic resilience	69.1	66.1
Infrastructure adequacy	33.3	49.0
Environmental risks	56.8	52.9
Public health vulnerabilities	59.5	46.9

*Average: all 195 countries

Scores are normalized (0–100, where 100 = most favorable)

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MilMed CoE VTC COVID-19 response

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.**

Recommendations

Recommendation for international business travellers	Many countries have halted some or all international travel since the onset of the COVID-19 pandemic but now have plans to re-open travel. This document outlines key considerations for national health authorities when considering or implementing the gradual return to international travel operations. 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

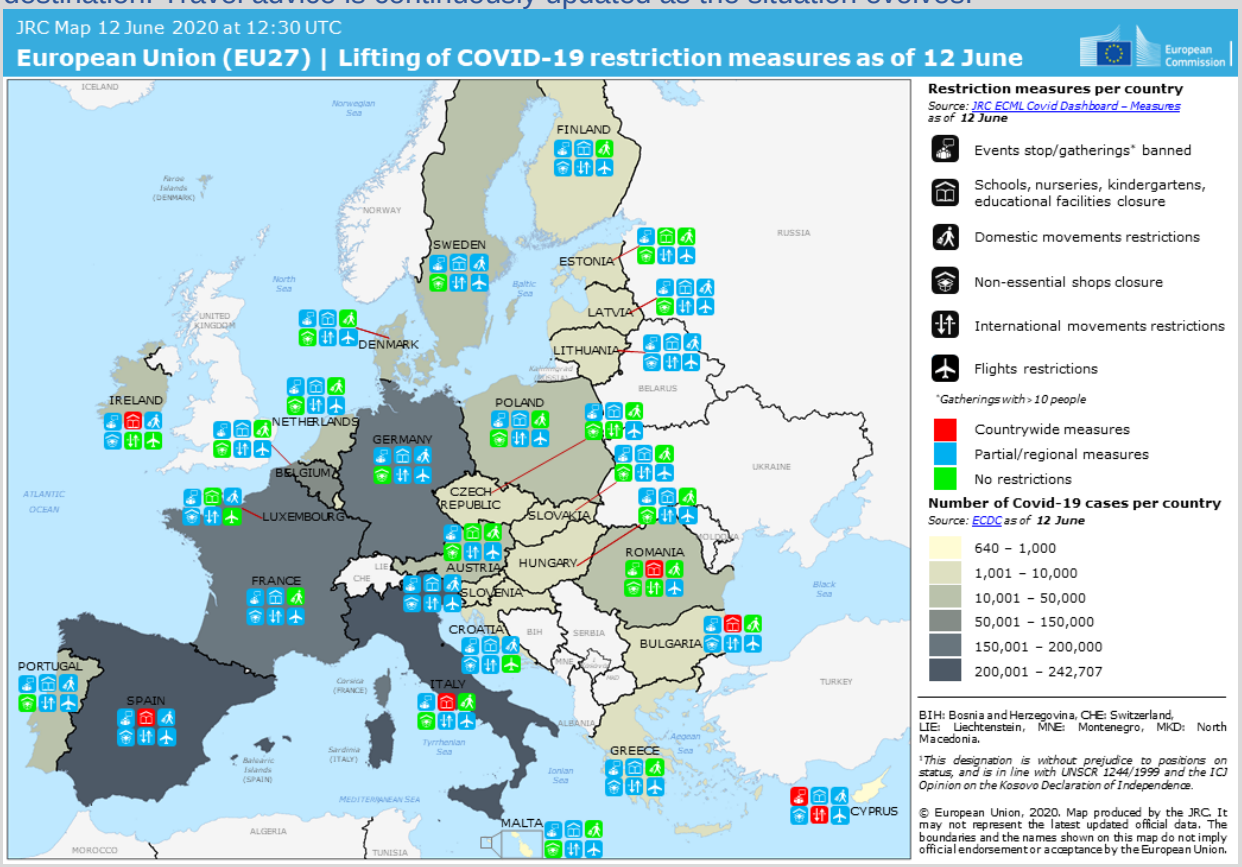
European Commission:
The coronavirus outbreak is a serious threat to public health. Lockdowns and other coordinated restrictive measures are necessary to save lives. However, these measures may also severely slow down our economies and can delay the deliveries of critical goods and services. The European 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.



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 10 August 2020: **Risk of COVID-19 across all EU/EEA countries and the UK:** • The risk of further escalation of COVID-19 is **moderate** for countries that continue to implement and enforce multiple measures, including physical distancing, and have sufficient contact tracing and testing capacity. • The risk of further escalation of COVID-19 is **very high** for countries that do not implement of enforce multiple measures, including physical distancing, and have sufficient contact tracing and testing capacity. **Risk of COVID-19 in the countries that have reported a recent increase of cases:** • The risk of further escalation of COVID-19 is **high** in countries that have also had an increase in hospitalisations, providing a strong indication that there is a genuine increase in transmission occurring. For these countries, the overall risk of escalation is **very high** if they do not implement or reinforce multiple measures, including physical distancing measures and contact tracing, and have sufficient testing capacity. • The risk of further escalation of COVID-19 is **high** for the countries reporting no increase in hospitalisations but having seen an increase in test positivity (if testing capacity is sufficient and intensity has remained stable), suggesting increasing levels of transmission. For these countries, the overall risk of escalation is **very high** if they do not implement or reinforce multiple measures, including physical distancing measures and contact tracing. The risk of further escalation of COVID-19 is **moderate to high** for those countries reporting no increase in hospitalisations or test positivity (if testing capacity is sufficient and intensity has remained stable), The countries that have multiple physical distancing measures in place should conduct local risk assessments to better understand the groups or settings driving the increase in cases and to determine which measures should be in place or strengthened.

References:

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

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