



Update 41 (13th of October 2020)

Information about Infection disease COVID-19 (novel coronavirus)



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

13th of October 2020

email: info.dhsc@coemed.org

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

HIGHLIGHTS/NEWS

- In the last 7 days over 2.2 million new cases and 39,000 deaths of COVID-19 have been reported across all six WHO regions. This is the highest number of reported cases so far in a single week.
- The **European Region** registered the highest weekly incidence of COVID-19 cases since the beginning of the pandemic with almost 700 000 new cases reported. The weekly incidence in cases and deaths increased by 34% and 16% respectively in comparison to the previous week. The Region is the second most active, contributing almost a third (31%) of new weekly cases reported globally.
- UN-WFP**: Is awarded this year's Nobel Peace Prize. The work of the WFP makes an important contribution to improving peace conditions in crisis areas. Due to the COVID-19 pandemic, more people than ever are currently threatened by malnutrition and hunger. Experts describe the situation as a "fire accelerator".
- PAHO**: [Ministries of health from selected countries in the Region of the Americas](#) begin preparations for the WHO Solidarity clinical trials for COVID 19 vaccines. The six countries participating in the trial are Argentina, Brazil, Chile, Colombia, El Salvador and Mexico. PAHO will coordinate the extensive technical, political, and operational issues.
- FAO**: reported on the last UN-CMT meeting on the approach for inter-sectoral work needed at the human/animal interface. The importance of One Health in the context of the environmental including climate change was also discussed.

Find articles and other materials at the MilMed CoE homepage: [click here](#)

Please use our online observation form to report your lessons learned observations as soon as possible.

[Click here to submit your lessons learned observations online](#)

GLOBALLY →

37 791 845
confirmed cases
26 296 250 recovered
1 080 909 deaths

EU/EEA and the UK ↗

6 468 595
confirmed cases
2 981 350 recovered
241 157 deaths

USA ↗ (new cases/day 39 216)

7 745 239
confirmed cases
3 078 733 recovered
214 265 deaths

Brazil ↗ (new cases/day 12 342)

5 103 408
confirmed cases
4 526 393 recovered
150 689 deaths

India ↘ (new cases/day 66 732)

7 175 880
confirmed cases
6 227 295 recovered
109 856 deaths

Russia ↗ (new cases/day 13 406)

1 305 093
confirmed cases
1 019 905 recovered
22 594 deaths

Spain ↗ (new cases/day 27 856)

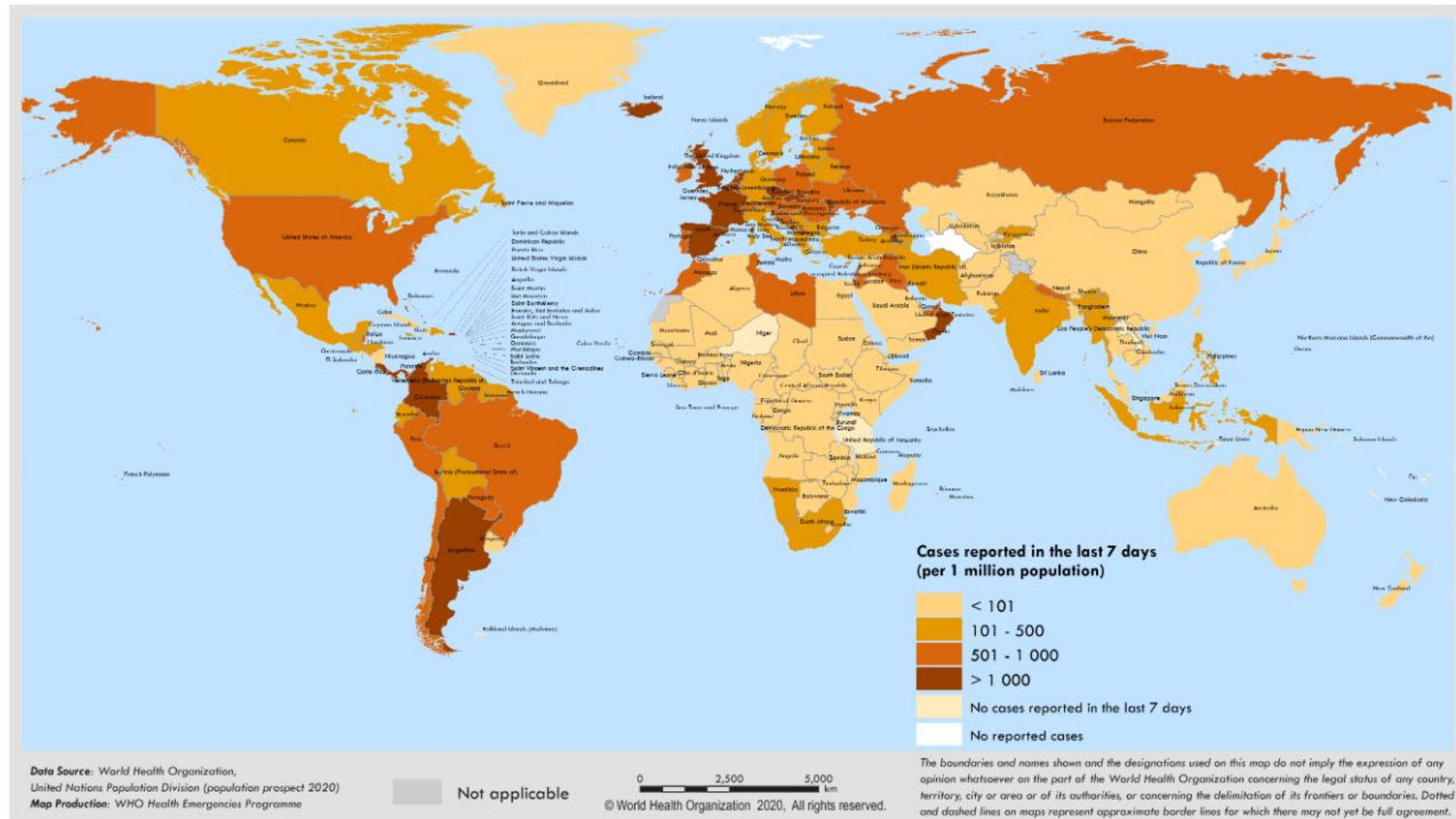
888 968
confirmed cases
150 376 recovered
33 124 deaths

Please click on the headlines to jump into the document

Table of Contents

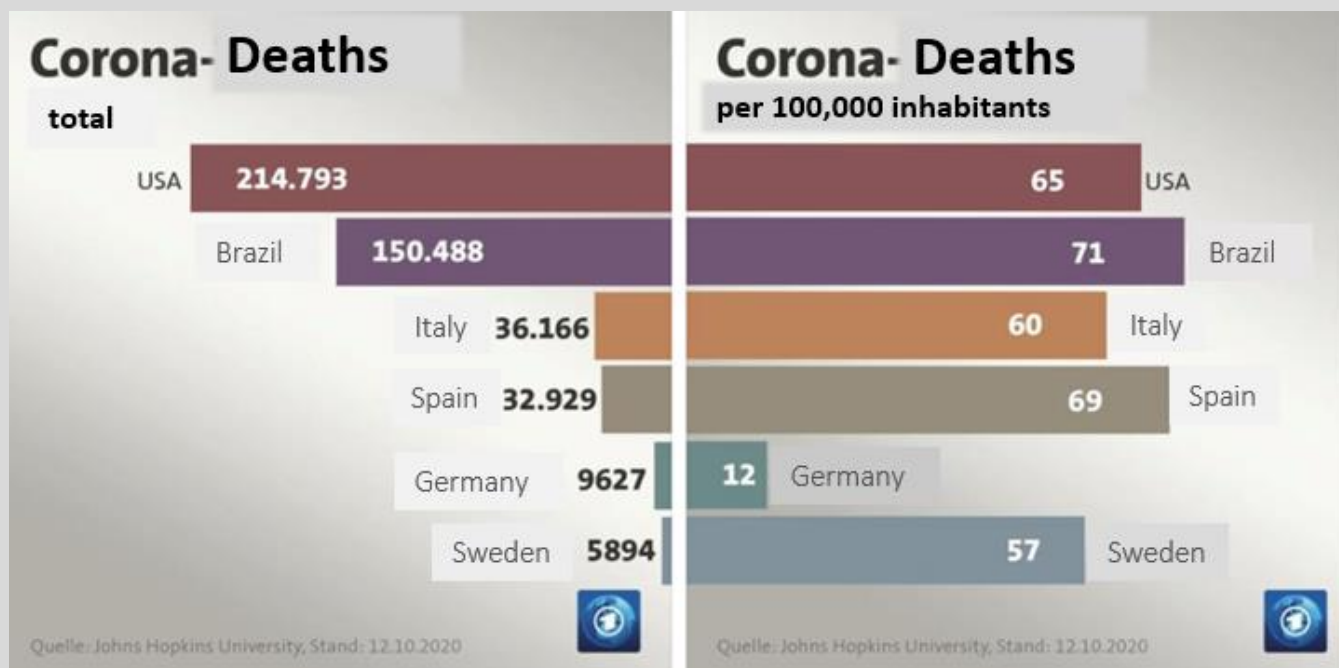
HIGHLIGHTS/NEWS	1
Map of countries with reported COVID-19 cases (last 7 days)	3
Worldwide Situation	4
<i>Global Situation</i>	<i>4</i>
<i>Situation in Europe.....</i>	<i>13</i>
Subject in Focus	22
<i>The Impact of a Six-Year Climate Anomaly on the “Spanish Flu” Pandemic and WWI.....</i>	<i>22</i>
MilMed CoE VTC COVID-19 response	26
<i>Topic.....</i>	<i>26</i>
<i>Overview on current COVID-19 situation in Missions</i>	<i>26</i>
Recommendations	27
<i>Recommendation for international business travellers</i>	<i>27</i>
Risk Assessment.....	31
<i>Global.....</i>	<i>31</i>
<i>Europe.....</i>	<i>31</i>
References:	31
Disclaimer:	31

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



Worldwide Situation

Global Situation



WHO weekly operational update on COVID-19 as of 9th October 2020:

See information about partnership, logistics, health learning, medicines and health products, funding/donors and regional highlights in the document as well as links to Technical guidance and latest publications.

Find some selected topic out of the paper down below:

Operations Support and Logistics

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

Shipped items as of 9 October 2020	Laboratory supplies		Personal protective equipment					
Region	Sample collection kits	Tests (Manual PCR)	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	2 458 135	1 041 046	1 034 364	754 300	151 639	1 028 048	45 128 789	1 655 314
Americas (AMR)	12 180	10 352 294	3 820 501	88 000	301 180	3 918 770	54 175 110	7 225 456
Eastern Mediterranean (EMR)	643 360	1 275 340	790 085	4 911 000	116 260	398 522	24 677 550	1 207 995
Europe (EUR)	294 560	542 086	1 704 850	7 190 100	374 720	985 048	37 292 100	5 126 950
South East Asia (SEAR)	1 301 800	1 585 800	87 336	442 500	82 150	217 450	5 406 300	353 075
Western Pacific (WPR)	90 800	248 864	300 400	670 000	98 167	86 510	10 339 650	926 235

COVID-19 Global Preparedness and response Summary Indicators

COVID-19 Global Preparedness and Response Summary Indicators^a

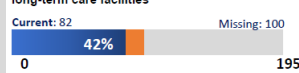
Countries have a COVID-19 preparedness and response plan



Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE)^b



Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



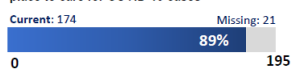
Countries with a national IPC programme & WASH standards within all health care facilities



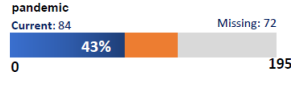
Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



Countries have a clinical referral system in place to care for COVID-19 cases



Countries that have defined essential health services to be maintained during the pandemic



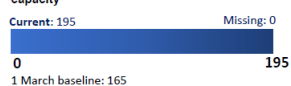
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



Countries have an occupational safety plan for health workers



Countries have COVID-19 laboratory testing capacity



Yes No Missing Data

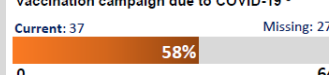
COVID-19 Global Preparedness and Response Summary Indicators

Selected indicators within the Monitoring and Evaluation Framework apply to designated priority countries. Priority Countries are mostly defined as countries affected by the COVID-19 pandemic as included in the [Global Humanitarian and Response Plan](#). A full list of priority countries can be found [here](#).

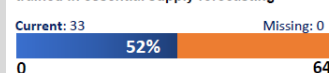
Priority countries with multisectoral mental health & psychosocial support working group



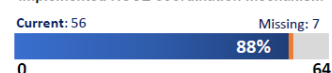
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19^c



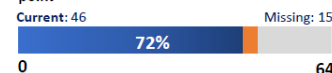
Priority countries where at least one Incident Management Support Team (IMST) member trained in essential supply forecasting



Priority countries with an active & implemented RCCE coordination mechanism



Priority countries with a contact tracing focal point



Priority countries with an IPC focal point for training



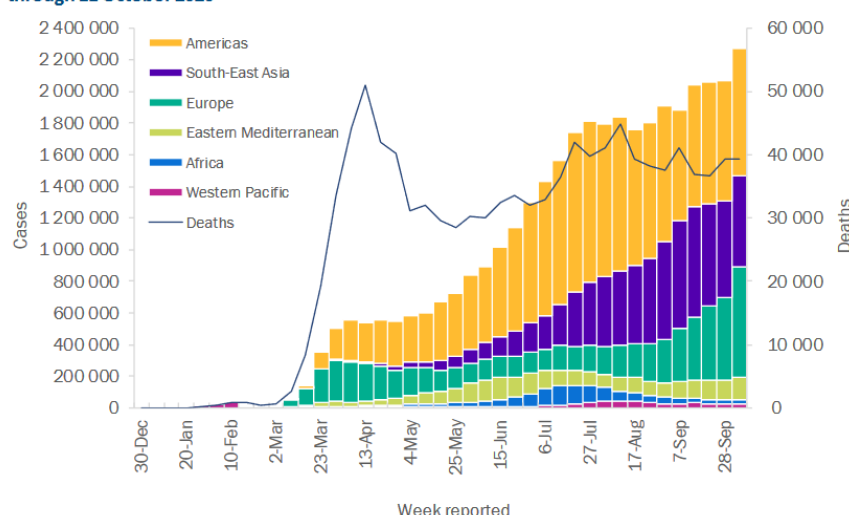
WHO weekly epidemiological report, 12 October 2020

Global epidemiological situation

Since the last Weekly Epidemiological Update over 2.2 million new cases and 39,000 deaths of COVID-19 have been reported across all six WHO regions. This is the highest number of reported cases so far in a single week. From 30 December through 11 October, over 37 million COVID-19 cases and 1 million deaths have been reported globally.

Nearly half of these cases (48%) and deaths (55%) continue to be reported in the **Region of the Americas** with the **United States of America, Brazil and Argentina** accounting for the greatest numbers of new cases and deaths in the region.

Figure 1: Number of COVID-19 cases reported weekly by WHO Region, and global deaths, 30 December 2019 through 11 October 2020**



By WHO region, the **European Region** reported the greatest increase (34%) in cases in the past week while the **African Region** reported a substantial rise in deaths, with a 27% increase compared to the previous week. Within the **African Region**, **South Africa** continues to register more than half (56%, 690 896) of all reported confirmed cases.

For the third week in a row, the **South-East Asia Region** reported a decline in new cases and deaths, 6% and 8% respectively, compared to the previous week. The decline is mainly due to decreases in reported cases in **India and Bangladesh**.

For the second week in a row, the **Regions of the Eastern Mediterranean** and the **Western Pacific** reported increases in cases and deaths.

Overall, during the reporting period, **all the Regions** showed an increase in cases except the **South-East Asia Region**.

Countries reporting the highest number of cases in the past seven days include; **India, the United States of America, Brazil, the United Kingdom and France**.

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 11 October 2020**

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days*	Cumulative deaths (%)
Americas	804 735 (35%)	6%	17 794 771 (48%)	20 509 (52%)	-5%	588 867 (55%)
South-East Asia	575 763 (25%)	-6%	7 911 036 (21%)	7 750 (20%)	-8%	126 917 (12%)
Europe	694 275 (31%)	34%	6 918 265 (19%)	6 172 (16%)	16%	246 709 (23%)
Eastern Mediterranean	138 751 (6%)	10%	2 605 478 (7%)	3 173 (8%)	13%	66 329 (6%)
Africa	29 169 (1%)	11%	1 227 719 (3%)	991 (3%)	27%	27 255 (3%)
Western Pacific	26 199 (1%)	6%	651 841 (2%)	633 (2%)	26%	14 265 (1%)
* Other	-	-	741 (<1%)	-	-	13 (<1%)
Global	2 268 892 (100%)	10%	37 109 851 (100%)	39 228 (100%)	<1%	1 070 355 (100%)

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

**See data, table and figure notes

African Region

Although the Region had seen a slow but continuous decline in newly-reported cases since mid-July, there were 11% more cases reported in the last 7 days compared to the prior week, reaching a total of over 1 200 000 cases. The current figures in the region represent 1% of confirmed COVID-19 cases and 3% of deaths reported worldwide in the past week. The increase in the number of newly-confirmed cases is partially attributed to the higher number of countries reporting an increase in cases, compared to the previous week.

Although there are a greater number of countries reporting increases, the pattern of increasing cases is driven by **South Africa** and **Ethiopia**, which continue to report the highest numbers of new cases in the last 7 days, followed by **Kenya, Uganda, and Algeria**.

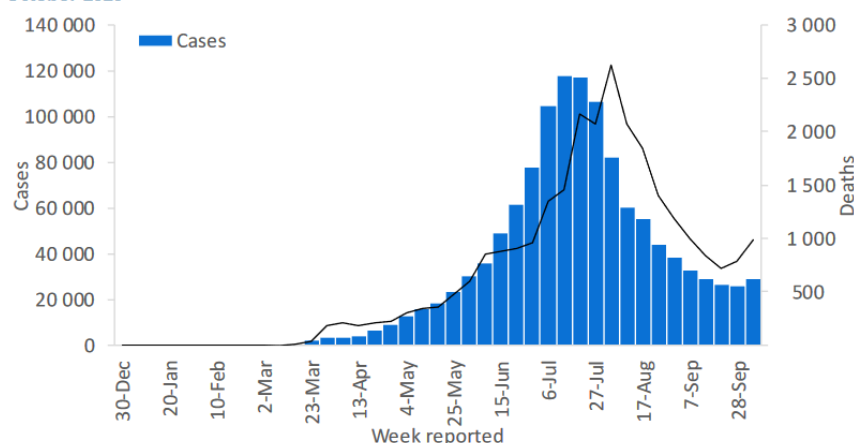
Continuing the trend from last week, the number of reported deaths increased this week with **South Africa** accounting for the majority of the new deaths in the Region (74%).

The current transmission pattern in the majority of the **47 Member States** in the **African Region** is reported as community transmission, with five reporting clusters of cases, and only **Seychelles, Mauritius and Eritrea** currently reporting sporadic cases.

South Sudan has reported a decrease in the number of newly -reported cases with an epidemiological link, with 29% in the past week, compared to 67% the week prior. This is attributed to a decrease in the proportion of cases that have been detected at a border crossing, where a history of travel can inform an epidemiological link.

This past week, **Mozambique** registered 795 new cases bringing the total figure to almost 10000 cases. Nevertheless, the country has registered a gradual decline over the last three weeks including a 39 and 40% decrease in new cases and deaths respectively in the past week, suggesting the epidemic may be slowing down in the country. While the number of tests per 1000 inhabitants has remained quite stable at 0.3 over the last 10 weeks, the test positivity rate has dropped this week to 9%. Schools have reopened with special measures to prevent further spread of the virus.

Figure 3: Number of COVID-19 cases and deaths reported weekly by the WHO African Region, as of 11 October 2020**



Region of the Americas

The **Region of the Americas** reported over 800 000 new cases in the last seven days, a 6% increase in the number of new cases in the past week which is a bigger increase than the increase reported in the previous week.

The **United States of America, Brazil, Argentina, Mexico, and Colombia** registered the highest number of newly-reported cases.

The Region also continues to account for a majority of all deaths reported globally in the past week (n=20 500, 52%). **Mexico, the United States of America, Brazil, Argentina and Colombia** registered the highest number of new deaths.

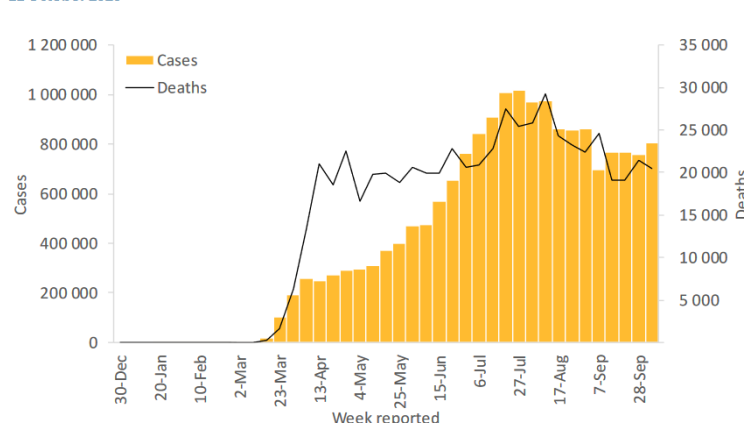
This past week, the **United States of America** reported the largest increase in newly -reported cases since early August, with over 327 000 cases reported.

Ten of the **50 states** reported the highest one-day increases in cases since their first reported case, including many in the **Midwest and the Southwest**, and three states reported their largest-ever one-day increase in new deaths.

The number of newly-reported cases has been increasing in **Canada** since mid-September, with an increase of 26.7% cases and 14.3% deaths in the past week. Most of the cases and deaths were reported in **Québec and Ontario**. Outbreaks in long-term care and retirement residences continue to account for most outbreaks in Canada to date. Since mid-July, incidence rates in those 20 to 39 years of age have remained consistently higher than all other age groups. Since mid-September, an increasing trend in the daily number of cases 20 to 39 years of age hospitalized has been observed.

Costa Rica, with the second-highest incidence of cases per million population in the Region, has now reached over 86 000 cases and over 1000 deaths. During the last 5 weeks, the country had reached a plateau with comparable figures of reported cases and deaths. The country has reported over 107 COVID-19 hospitalizations per million inhabitants of which over a third of them are in intensive care units.

Figure 4: Number of COVID-19 cases and deaths reported weekly by the WHO Region of the Americas, as of 11 October 2020**



Eastern Mediterranean Region

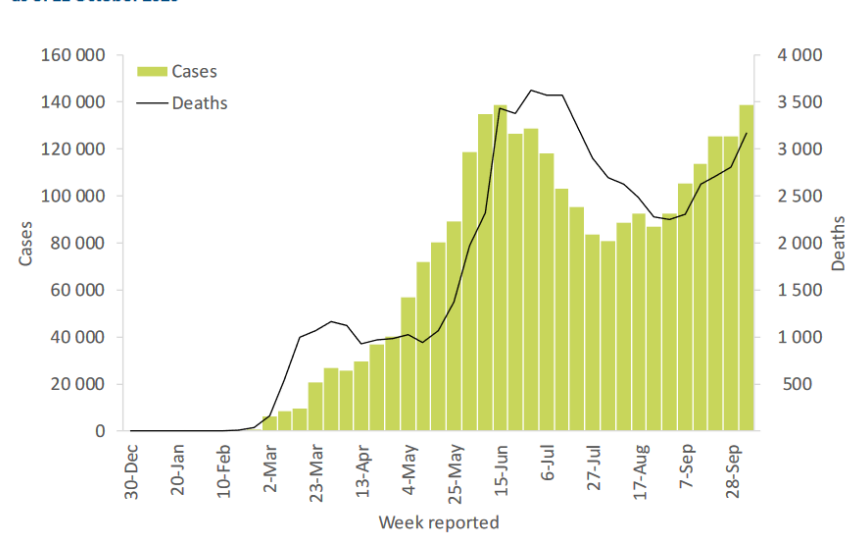
In the **Eastern Mediterranean Region** the weekly number of new cases and deaths have increased by 10% and 13% respectively in comparison to the previous week.

The **Islamic Republic of Iran** is the worst affected country in the region, accounting for 20% of all new cases reported this week.

The number of new cases in **Oman** have more than doubled in the last week amounting to an increase of more than 60%. This past week a 100 bed field hospital for COVID-19 patients along with an isolation center in the city of **Sohar**, the capital and largest city of the Al Batinah North Governorate and another isolation ward in Sur Hospital in the **South Sharqiya region** were opened to help mitigate the rising number of COVID-19 cases in the country.

In **Tunisia**, there have been peak new cases and deaths also reported this week and the country plans to impose increased public health and safety measures including bans on gatherings, cutting public sector work hours and imposing curfews in an effort to interrupt transmission.

Figure 5: Number of COVID-19 cases and deaths reported weekly by the WHO Eastern Mediterranean Region, as of 11 October 2020**



European Region

The Region registered the highest weekly incidence of COVID-19 cases since the beginning of the pandemic with almost 700 000 new cases reported. The weekly incidence in cases and deaths increased by 34% and 16% respectively in comparison to the previous week.

The Region is the second most active, contributing almost a third (31%) of new weekly cases reported globally.

The United Kingdom, France, the Russian Federation and Spain account for over half of all new cases reported in the region (51%).

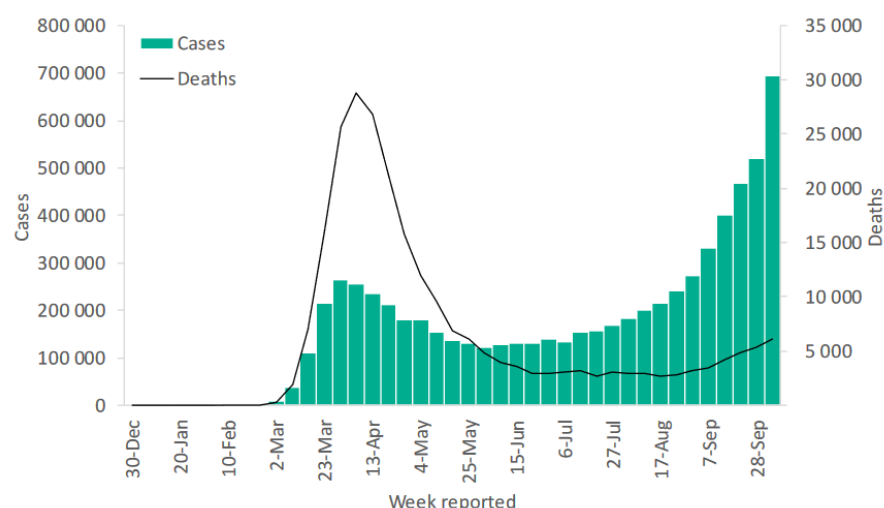
Latvia, Faroe Islands and Iceland have reported the greatest percentage increase in new cases in the past week while a marked decrease was reported in **Isle of Man, Malta and Spain**.

The majority of the countries in the region self-characterise their current transmission pattern as community transmission (56%) or clusters of cases (37%) with only **Liechtenstein, Monaco and the Holy See** reporting sporadic transmission.

Spain, with over 50 000 cases reported in the past week, is showing a noticeable decline in the weekly incidence of cases and deaths of 24% and 19% respectively. In the past week, over 740 000 PCR diagnostic tests were carried out (16 tests per 1000 inhabitants per week). As of 08 of October, the bed occupancy in intensive care unit ranged between 7% and 39% across all regions.

The incidence of cases and deaths in **Poland** increased this week by 93% and 104% respectively compared to the previous week, with almost 23 500 new cases and 370 deaths reported. **Poland** is tightening public health and social measures in response to these marked increases in an effort to avoid another lockdown. A coordination hospital will be created in each provide to manage the surge in COVID-19 patients.

Figure 6: Number of COVID-19 cases and deaths reported weekly by the WHO European Region, as of 11 October 2020**



South-East Asia Region

The gradual decline in incidence of cases and deaths in the **South East Asia Region** continued during the past week. The Region, nevertheless, remains among the most active, accounting for 25% of cases and 20% of deaths newly reported globally in the past seven days.

The countries reporting the highest number of new cases in the **South-East Asia Region** continue to be **India, Indonesia and Nepal**, while **Sri Lanka and Bhutan** are showing the highest increase in the proportion of new cases in the past week compared to the previous week. Across the ten countries in the region, only **Myanmar and Nepal** reported an increase in the number of new deaths in the past week compared to the previous week.

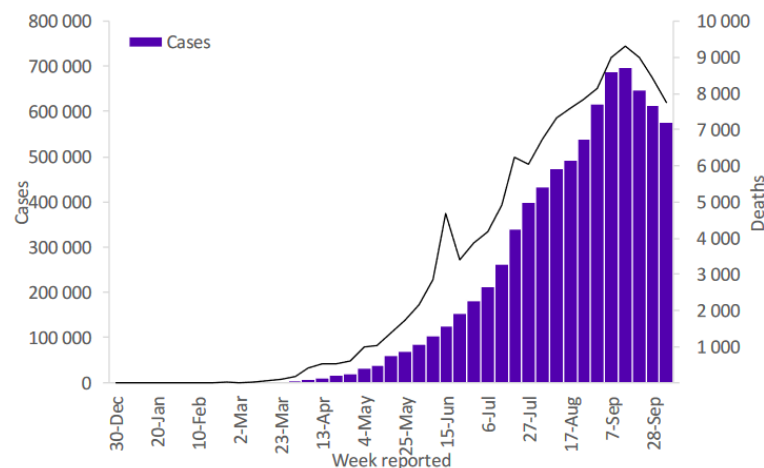
The countries reporting the highest number of new deaths per million population are **India and Myanmar**, with 5 and 4 new deaths per million population respectively.

In contrast to the other regions with currently high case incidence, most of the **10 Member States in the South-East Asian Region** self-report their current transmission pattern as either clusters of cases or sporadic cases, with only **Bangladesh and Indonesia** currently reporting community transmission.

Sri Lanka reported over 1200 new confirmed cases in the past epidemiological week, a substantial increase compared to the 46 cases confirmed the previous reporting week. In a recent development, a large cluster of cases was reported in an apparel manufacturing factory in **Gampaha** district about 50 km from Colombo. The exact epidemiological link is currently under investigation.

The reported number of cases increased rapidly in **Nepal** in the past week, with over 21 000 new cases and 86 new deaths reported. Although the test positivity rate has raised from 5 to 15% in just 8 weeks, there has also been an expansion in testing activity, which is currently around 3 samples tested / 1000 persons per week.

Figure 7: Number of COVID-19 cases and deaths reported weekly by the WHO South-East Asia Region, as of 11 October 2020**



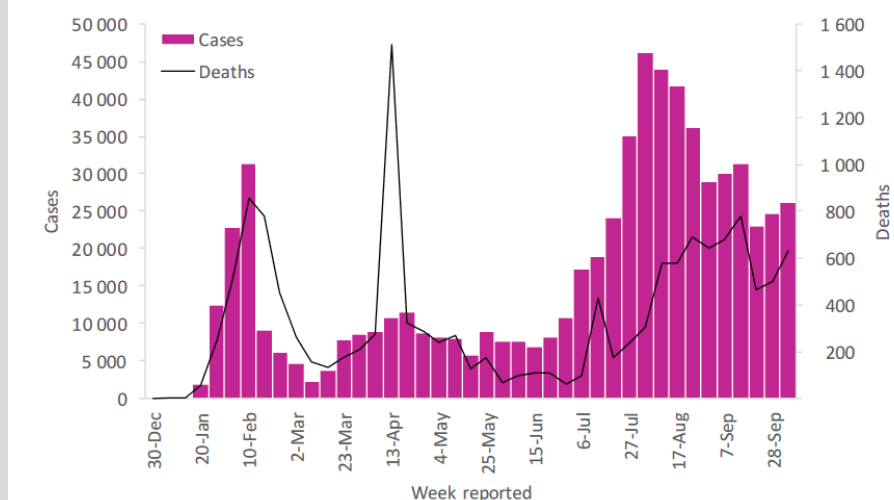
Western Pacific Region

The **Western Pacific region** accounts for the least number of reported cases globally this week, however the region has experienced an increase of 6% in newly-reported cases and a 26% increase in reported deaths in the past seven days.

New cases in the **Philippines** have stabilized over the past 3 weeks with around 18 000 cases reported weekly, lower than the peak of around 30 000 weekly new cases in early to mid-August however it does continue to account for the greatest number of new cases in the region. Reports suggest clustering of cases has occurred in several workplaces in **Davao Region** following the easing of lockdown restrictions under the modified general community quarantine and reopening of the economy measures, with most of the clusters reported in 12 establishments. As of October 12, the total number of cases in **Davao Region** is 3,743 with 686 cases reported in the past two weeks and **Davao City** (the capital) contributing 65% of the total cases in the region. There are also reports of near capacity utilization of ICU and Ward beds, in the major hospital in the region last week.

In **French Polynesia**, there were peak new cases this week, a 62% increase from last week, with reports suggesting most cases were detected from the **main island of Tahiti**, with cases spreading to adjacent **Islands of Moorea** and even reaching **several outer islands, including Raivavae, Arutua, and Nuku Hiva**. Deaths in French Polynesia remain low and have not increased in the past week. The positivity rate of COVID-19 tests is currently high, at 26.3%, however only symptomatic persons are being tested.

Figure 8: Number of COVID-19 cases and deaths reported weekly by the WHO Western Pacific Region, data as of 11 October 2020**



Updates from WHO regional offices:

WHO [AFRO](#)

WHO [EMRO](#)

WHO [EURO](#)

- WHO [PAHO](#)

- WHO [SEARO](#)

- WHO [WPRO](#)

New study: COVID-19 virus ‘survives for 28 days’ in lab conditions

New findings from Australia's national science agency suggest SARS-Cov-2 can survive for far longer than thought.

The fact that the main transmission of the virus takes place via the air is now part of the globally established scientific consensus. However, many respiratory viruses can also spread via a smear infection. Virus-containing particles are deposited on surfaces such as door handles and handrails and are picked up by the hands on the face. For this reason, researchers all over the world are investigating how long SARS-CoV-2 can survive on different materials and surfaces.

The Commonwealth Scientific and Industrial Research Organization (CSIRO, Australia's national scientific research institute) has now published new data on this matter. They report that the virus could potentially remain viable and infectious for up to 28 days, depending on environmental factors and circumstances. So far, however, this has only been proven in a laboratory environment. It was previously known that the virus could last for around 3 days on glass and banknotes and up to 6 days on plastic and steel. The researchers now describe a survival time of up to 4 weeks, especially for steel and glass surfaces such as smartphone touchscreens.

However, there are also experts who criticize the study. The data collection was carried out at a constant room temperature of 20°C and in complete darkness. Both factors have an extreme effect on the tenacity of the virus, so the UV light contained in daylight is an important inactivator of SARS-CoV-2. Higher temperatures also seem to prevent the virus from being transmitted. Various experts emphasize that environmental factors must be used more closely for the assessment of such studies, since otherwise panic would be unnecessarily fueled in the population. Some representatives even doubt that SARS-CoV-2 can even be transmitted by smear infections.

Nonetheless, the Australian study highlights an important factor that was previously observed - dark, damp and cold environments are ideal habitats for the virus.

In addition, the researchers note that hand hygiene and the regular cleaning of surfaces that frequently come into contact with hands (e.g. touch screens and keyboards) continue to be important measures for the containment of infectious diseases.

Sources: <https://virology.biomedcentral.com/articles/10.1186/s12985-020-01418-7>
<https://www.csiro.au/en/News/News-releases/2020/CSIRO-scientists-publish-new-research-on-SARS-COV-2-virus-survivability>
<https://www.bbc.com/news/health-54500673>

Vaccine development news:

The US pharmaceutical company Johnson & Johnson has temporarily suspended its study for a future corona vaccine due to an unexplained disease of a subject. The disease of the study participant will now be checked and assessed by an independent group of experts and internal doctors, according to the group.

“Adverse events” such as illnesses or accidents are, however, expected components of every clinical study.

Country reports:

KOR: reported a moderate increase in new corona infections from 97 cases. At the same time, loosening of the distance rules came into force. For example, higher-risk companies such as nightclubs and karaoke bars are allowed to reopen, as far as they adhere to precautions such as wearing masks and keep guest lists. Of the 97 new infections, 63 are of the densely populated greater Seoul area, where half of the country's 51 million residents live.

PER: International passenger flights take off and land at the airport in Panama City for the first time in around seven months. With the resumption of air traffic in 20 countries, 85 percent of the shops in the airport can now reopen. A negative corona test is required upon arrival, which must not be more than 48 hours old at the time of start. A quick test can be done at the airport for \$ 50.

USA: The last 7 days, USA reported the largest increase in newly -reported cases since early August, with over 327 000 cases reported.

Ten of the 50 states reported the highest one-day increases in cases since their first reported case, including many in the Midwest and the Southwest, and three states reported their largest-ever one-day increase in new deaths.

CRI: With the the second-highest incidence of cases per million population in the Americas Region, has now reached over 86 000 cases and over 1000 deaths. During the last 5 weeks, the country had reached a plateau with comparable figures of reported cases and deaths. The country has reported over 107 COVID-19 hospitalizations per million inhabitants of which over a third of them are in intensive care units.

CHN: The east Chinese coastal metropolis of Qingdao wants to test its entire population of more than nine million people for the corona virus. The local health commission announced this mass testing after a dozen new infections emerged over the weekend, most of which were hospital-related. Immediately after the first infections were discovered, more than 140,000 people had been tested, mainly in the health sector. "The entire city will be tested within five days," said the authority. Most recently, only imported infections from abroad were reported in China. The local outbreaks within the recent months, were quickly contained again.

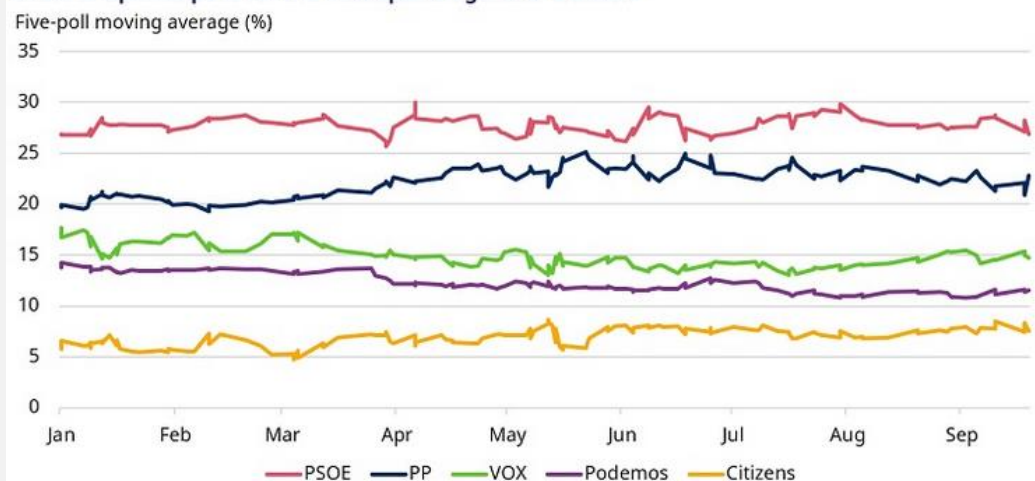
SPAIN - Loss of confidence in politics

Different articles were recently published in which the corona crisis in Spain is also described as an economic and state crisis. The pandemic-induced slump in the tourism sector would therefore lead to major economic upheavals. A drop in GDP of 6 to 12.8% (depending on the article) is expected for 2020. Among other things, the recent sharp rise in the number of infections with specific consequences for many people's everyday lives, as well as the already noticeable serious effects on the labor market, would lead to an increasing loss of confidence in politics and institutions. Spain has been experiencing a so-called "second wave" of the coronavirus pandemic since around August 2020. To date, there have been nearly 900,000 coronavirus cases and over 32,000 deaths related to COVID-19. Above all, the lack of constructive cooperation between the government and the opposition in fighting pandemics is a Spanish peculiarity. The increasing danger of a division in society and a strengthening of (right-wing) populist forces is described.

In any case, Spain has not necessarily been known as a guarantor of political stability in recent years. In the past decade, hardly any government survived the full legislative period. Parliamentary elections even had to take place twice in 2019.

The question of to what extent the corona crisis will affect the political spectrum in the future and lead to a possible strengthening of the political fringes may not yet be answered seriously at this point in time. On the part of the European nation states affected, as well as the European Union, a variety of

Chart 5: Opinion polls for the next Spanish general election



mechanisms have been activated that are intended to at least mitigate the already existing and still forecast economic slump. Government deficits rise (in some cases significantly) and thus the scope for future investments is also reduced. Short-time working regulations can also lead to a delayed rise in unemployment. It is possible that it will only become apparent in the medium to long term whether and to what extent there will be a strengthening of extreme and populist trends in Europe. So far, populist forces in Europe seem to have hardly benefited at least.

Source: <https://www.aa.com.tr/en/europe/spanish-economy-hit-hard-as-virus-continues-to-snowball/1975835>

<https://www.ft.com/content/53ab7751-56cb-4c19-8855-43065aea6448>

<https://www.sueddeutsche.de/politik/spanien-coronavirus-politik-1.5057257>

<https://www.qzeromedia.com/the-graphic-truth-eu-populist-parties-weather-covid-storm>

<https://www.schroders.com/de/bm/asset-management/insights/economic-views/has-covid-19-killed-off-populism-in-europe/>

ECDC COVID-19 surveillance report Week 40, as of 9 October 2020

Weekly surveillance summary

This summary presents highlights from two separate weekly ECDC surveillance outputs, using data up to the end of the current reporting week (week 40, ending Sunday 4 October 2020).

- The [COVID-19 country overview](#) provides a concise overview of the evolving epidemiological situation with the COVID-19 pandemic, both by country and for the European Union/European Economic Area (EU/EEA) and the United Kingdom (UK) as a whole, using daily and weekly data from a range of sources.
- The [COVID-19 surveillance report](#) presents the epidemiological characteristics of COVID-19 cases reported to The European Surveillance System (TESSy) to date and assesses the quality of the data.

New this week

- Two new tabs have been added to the countries' sections of the country overview, providing an expanded visualisation of the start and end dates of the public response measures and the testing strategies in place in each country.
- The visualisation of response measures previously shown on the first tab for each country has been removed from the country overview.
- An additional class break has been added to the maps in sections 2.5 and 3.4 to distinguish countries and regions with case notification rates of 240 per 100 000 population or higher.

Trends in reported cases and testing

- By the end of week 40 (4 October 2020), the 14-day case notification rate for the EU/EEA and the UK, based on data collected by ECDC from official national sources, was 130.6 (country range: 24.0–319.3) per 100 000 population. The rate has been increasing for 77 days.
- High levels (at least 60 per 100 000) or sustained increases (for at least seven days) in the 14-day COVID-19 case notification rates compared with the previous week have been observed in 28 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Hungary, Iceland, Ireland, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK).
- Based on data reported to TESSy, among people over 65 years of age, high levels or sustained increases in the 14-day COVID-19 case notification rates compared to last week have been observed in 19 countries (Austria, Belgium, Czechia, Estonia, Germany, Hungary, Iceland, Ireland, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovenia, Spain, Sweden and the UK).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 40, available for 27 countries, varied from 380 to 6 293 tests per 100 000 population. Luxembourg had the highest testing rate for week 40, followed by Denmark, Iceland, the UK and Cyprus.
- Weekly test positivity was high (at least 3%) or had increased compared to the previous week in 14 countries (Austria, Belgium, Bulgaria, Czechia, Estonia, Hungary, Ireland, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia and Sweden).

Primary care

- No countries reported data up to week 40 from primary care sentinel surveillance for COVID-19, using the systems established for influenza.
- Among those countries that reported influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data up to week 40, using the systems established for influenza, only Ireland had observed recent increases in consultation rates to levels higher than those reported during the same period for the last two years.

Hospitalisation

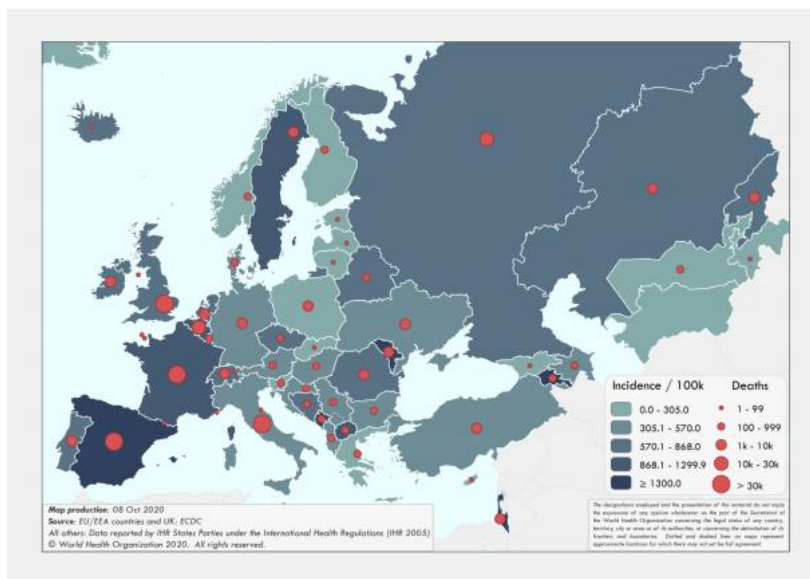
- Hospital and/or ICU occupancy and/or new admissions due to COVID-19 were high (at least 25% of the peak level during the pandemic) or had increased compared to the previous week in 19 countries (Austria, Belgium, Bulgaria, Croatia, Czechia, Denmark, Estonia, France, Greece, Hungary, Ireland, Luxembourg, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia and the UK). No other increases have been observed, although data availability varies.
- Based on surveillance data reported to TESSy by 22 countries to date, we estimate that 21% (country range: 4–67%) of reported COVID-19 cases have been hospitalised. Data from 15 countries show that a total of 8% (country range: 0–61%) of hospitalised patients required ICU and/or respiratory support. These proportions vary considerably by age and sex and may be influenced by national policies and practices.

Mortality

- The 14-day COVID-19 death rate for the EU/EEA and the UK, based on data collected by ECDC from official national sources, was 10.5 (country range: 0.0–40.5) per million population. The rate has been increasing for 23 days.
- High levels (at least 10 per million) or sustained increases (for at least seven days) in the 14-day COVID-19 death rates compared to those reported seven days ago are currently being observed in 14 countries (Belgium, Bulgaria, Croatia, Czechia, France, Hungary, Italy, Malta, the Netherlands, Poland, Romania, Slovenia, Spain and the UK).
- Overall pooled estimates of all-cause mortality reported by EuroMOMO for week 40 show normal levels for the participating countries. In some countries, however, there seems to be a small excess mortality.

COVID-19 situation update for the WHO European Region (28 September – 04 October 2020 Epi week 40)

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



Key points

Week 40/2020 (28 Sept - 4 Oct 2020)

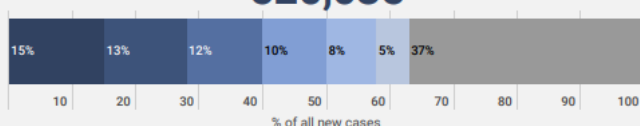
- The number of cases reported in the Region increased 11% to 520,035 in week 40/2020 compared to the previous week (470,062 cases in week 39/2020) and have now exceeded (96% increase) those reported when the pandemic first peaked in Europe in week 14/2020 (30 Mar - 5 Apr; 265,083)
- 63% (326,358) of the cases reported in week 40/2020 were reported from six countries: France (15%; 79,179), Spain (13%; 65,800), Russian Federation (12%; 63,563), United Kingdom (10%; 50,740), Israel (8%; 39,248) and Ukraine (5%; 27,828). The remaining cases (37%; 193,677) were reported by 52 countries and territories; each accounted for <5% of the total cases reported in week 40/2020
- The crude incidence continues to vary across the region with a range from 3.1 per 100,000 population in Tajikistan to 461 per 100,000 population in Israel in week 40/2020
- Ten countries had a crude incidence of ≥ 100 per 100,000 in week 40/2020: Israel (461), Andorra (355), Montenegro (267), Czech Republic (162), Belgium (150), Spain (141), Netherlands (136), Republic of Moldova (132), France (122) and Armenia (105) (Figure 2A)
- The 14-day cumulative incidence increased by $\geq 10\%$ in week 40/2020 in 41 countries and territories in the Region; an increase of $\geq 50\%$ was observed in 23 of these countries and territories: Andorra, Armenia, Belarus, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, Georgia, Gibraltar, Iceland, Ireland, Jersey, Kyrgyzstan, Latvia, Liechtenstein, Lithuania, Netherlands, Poland, Slovakia, Slovenia and the United Kingdom (see [EURO COVID-19 Dashboard](#) for recent trends)
- The number of deaths in the Region in week 40/2020 increased 11% to 5,325 compared to the previous week (4,813 deaths in week 39/2020) (Figure 1). The proportion of reported cases that died remains 1.0% in week 40/2020
- 65% (3,453) of the deaths reported in week 40/2020 were reported by the Russian Federation (19%; 1,034), Spain (13%; 682), France (9%; 498), Turkey (9%; 455), Ukraine (8%; 438) and the United Kingdom (6%; 346). The remaining deaths (35%; 1,872) were reported from 42 countries and territories; each accounted for <5% of the total deaths reported in week 40/2020
- Community-transmission was reported by 32 countries and territories, 22 countries and territories reported cluster transmission, while 4 countries and territories reported sporadic transmission in week 40/2020
- For an interactive subnational view of the recent COVID-19 situation in the WHO-EURO Region see the [WHO-EURO COVID19 Subnational Explorer](#)

Summary overview

- The cumulative cases across the Region increased 9.1% to 6,248,800 cases in week 40/2020 (from 5,728,765 cases in week 39/2020) and cumulative deaths increased by 2.3% to 240,736 deaths (from 235,411 deaths in week 39/2020)
- As of 21 September 2020, 19 countries in the Region had an effective reproductive number significantly over 1: Armenia, Belarus, Belgium, Denmark, Estonia, Georgia, Germany, Ireland, Italy, Kyrgyzstan, Latvia, Lithuania, Netherlands, Poland, Romania, Russian Federation, Slovakia, Sweden and the United Kingdom (See [EpiForecasts and the CMMID COVID working group COVID-19 Global Summary](#) for latest estimates)
- Nine countries in the Region each reported a cumulative incidence of ≥ 1300 cases per 100,000 population: Israel (3078), Andorra (2735), San Marino (2215), Montenegro (1950), Armenia (1775), Spain (1735), Holy See (1472), Luxembourg (1414) and Republic of Moldova (1382) (Figure 2B)
- As of week 40/2020, 65% (4,057,511) of cumulative cases were reported from the Russian Federation (19%; 1,215,001), Spain (13%; 810,866), France (10%; 606,625), United Kingdom (8%; 480,017), Turkey (5%; 323,014), Italy (5%; 322,751) and Germany (5%; 299,237). The remaining cases (35%; 2,191,289) were reported by 54 countries and territories; each accounted for <5% of the total cases reported until week 40/2020
- As of week 40/2020, 68% of cumulative deaths (164,220) were reported from the United Kingdom (18%; 42,317), Italy (15%; 35,968), Spain (13%; 32,379), France (13%; 32,198) and the Russian Federation (9%; 21,358). The remaining deaths (32%; 76,516) were reported by 52 countries and territories; each accounted for <5% of the total cases reported until week 40/2020
- 15.2% of cases were in persons aged ≥ 65 years in week 40/2020, a decrease from 38% in week 14/2020, while the percentage of fatal cases aged ≥ 65 years was 67% in week 40/2020 (compared to 91% in week 14/2020) (Figure 3)
- 88% of all deaths with information available were in persons aged ≥ 65 years and 56% of all deaths were in men (Table 1). 95% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (83%) (Table 1)
- Pooled estimates of all-cause mortality for 24 participating countries in the [EuroMOMO](#) network show normal levels. In some countries, however, there seems to be a small excess mortality.
- In week 40/2020, six countries reported a total of 118 tests and 4 detections of SARS-CoV-2 in persons with influenza-like illness (ILI) in primary care sentinel surveillance (Figure 4)
- Overall, there were 331,301 (8.7%) COVID-19 cases among the total of 3,825,688 tests reported to have been performed in 20 countries in week 40/2020 (Figure 5)

New cases (week 40/2020)

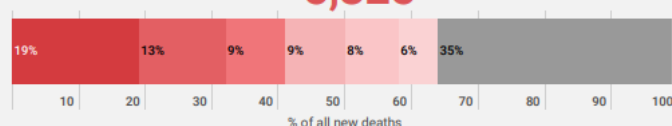
520,035



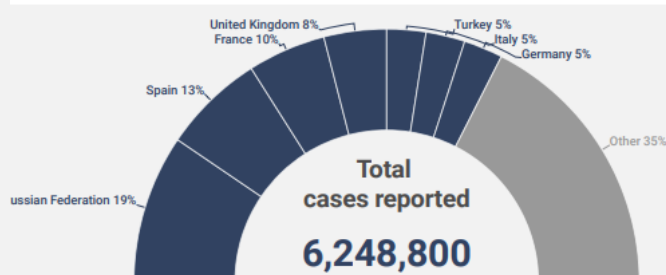
● France ● Spain ● Russian Federation ● United Kingdom ● Israel ● Ukraine ● Other

New deaths (week 40/2020)

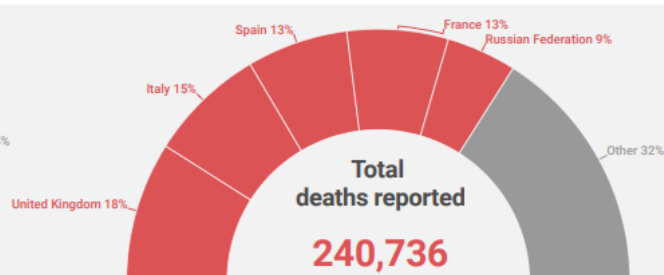
5,325



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



Total cases reported
6,248,800



Total deaths reported
240,736

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

88%
of all deaths
were in persons aged 65+

56%
of all deaths
were in men

95%
of all deaths
had at least 1 underlying
condition

83%
of all deaths
had cardiovascular disease

Figure 1: Number of COVID-19 cases (N=6,248,800) and deaths (N=240,736) by reporting week

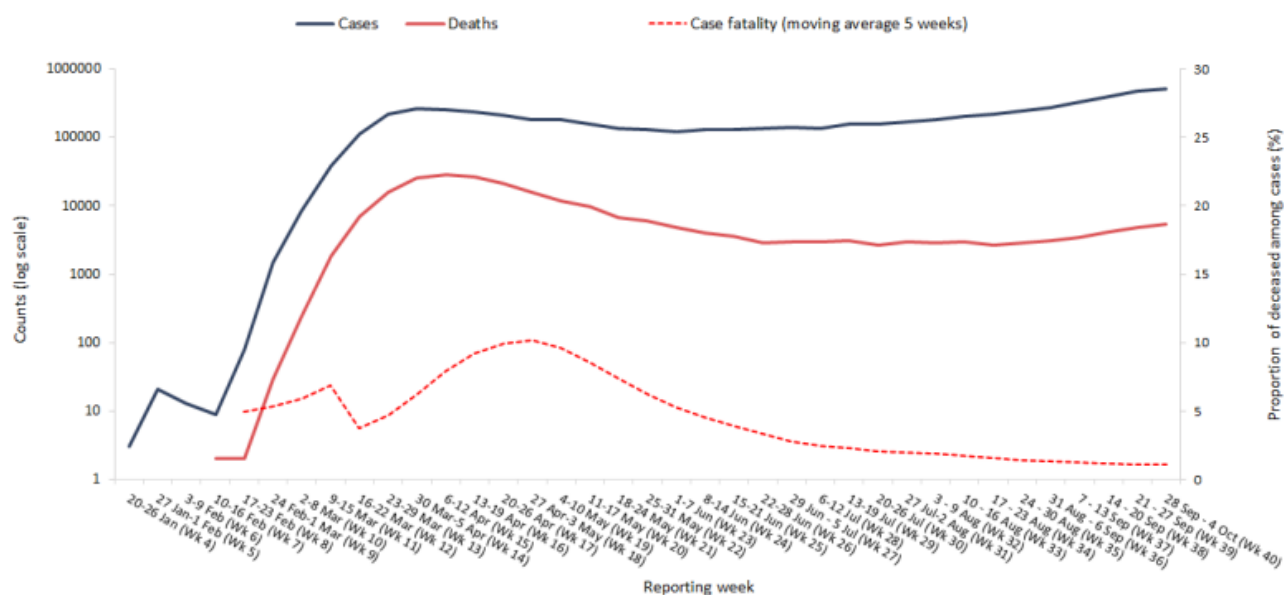
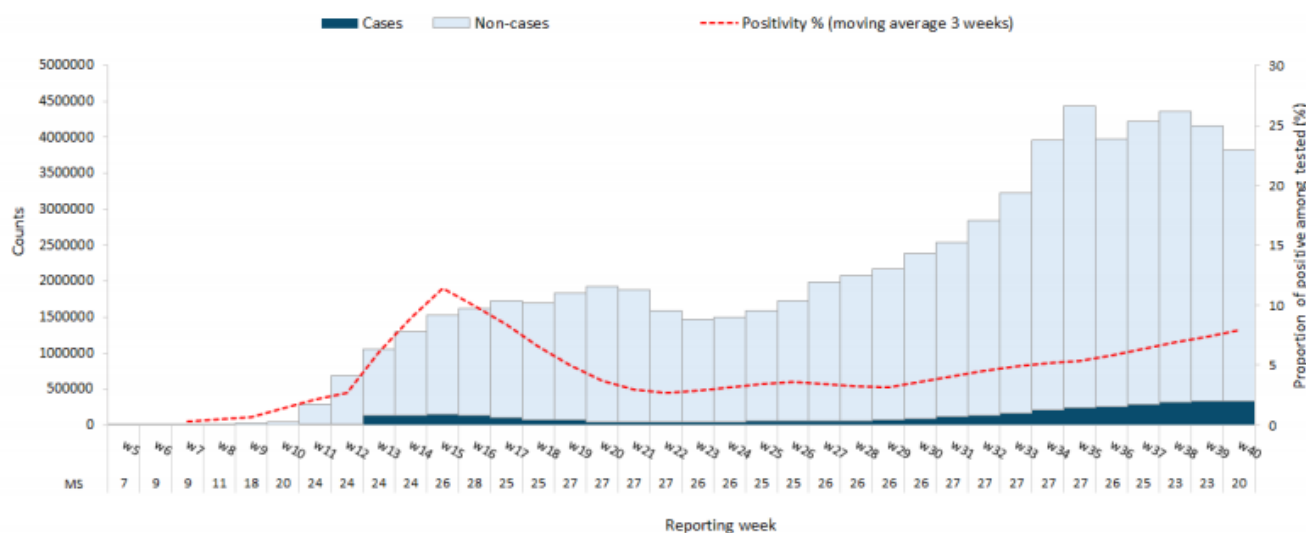


Figure 5. Percentage positive for COVID-19 among all tested by reporting week



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

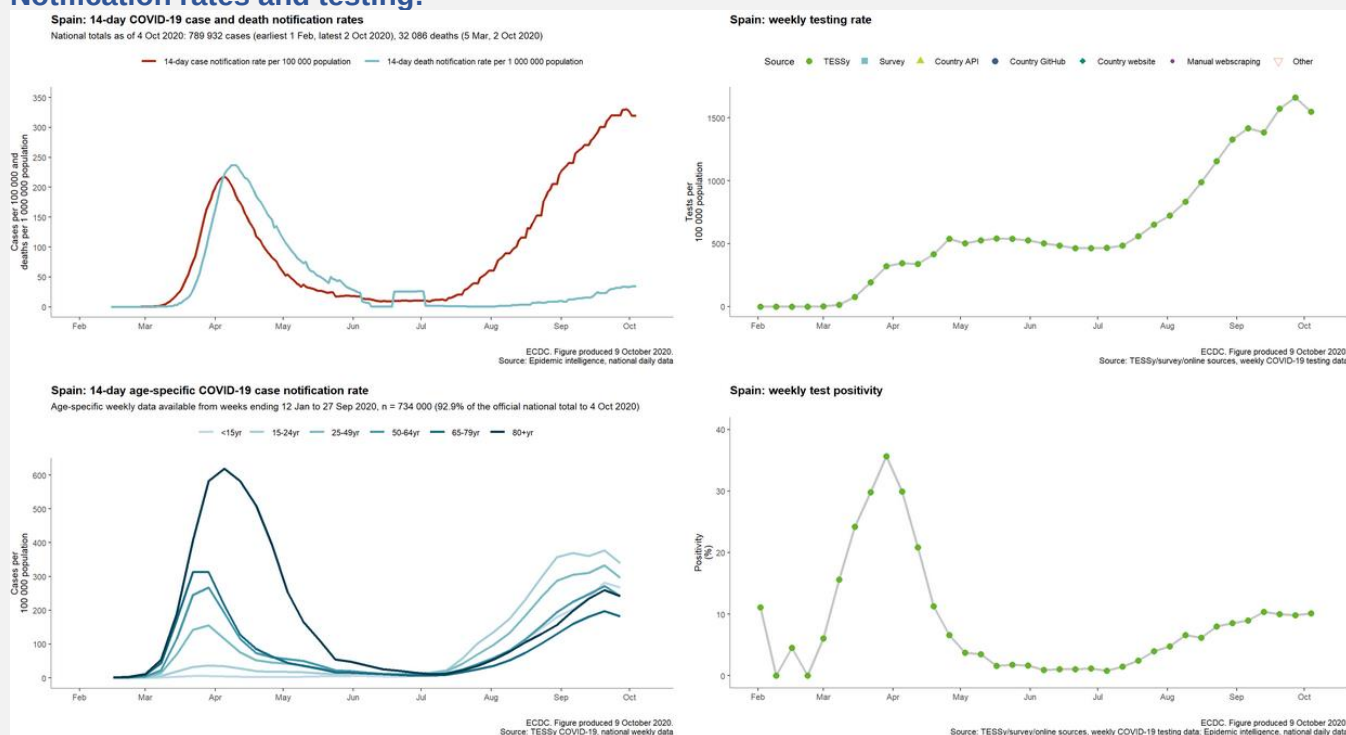
Weekly COVID-19 country overview, week 40

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

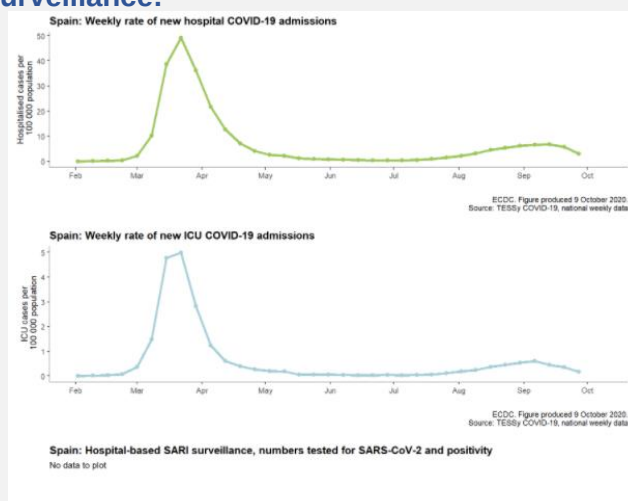
In contrast to this development, in most countries fewer people are admitted to the hospital for treatment or require intensive care compared to the first wave of COVID-19. This trend could be especially recognized in countries with the highest number of new cases.

Spain

Notification rates and testing:

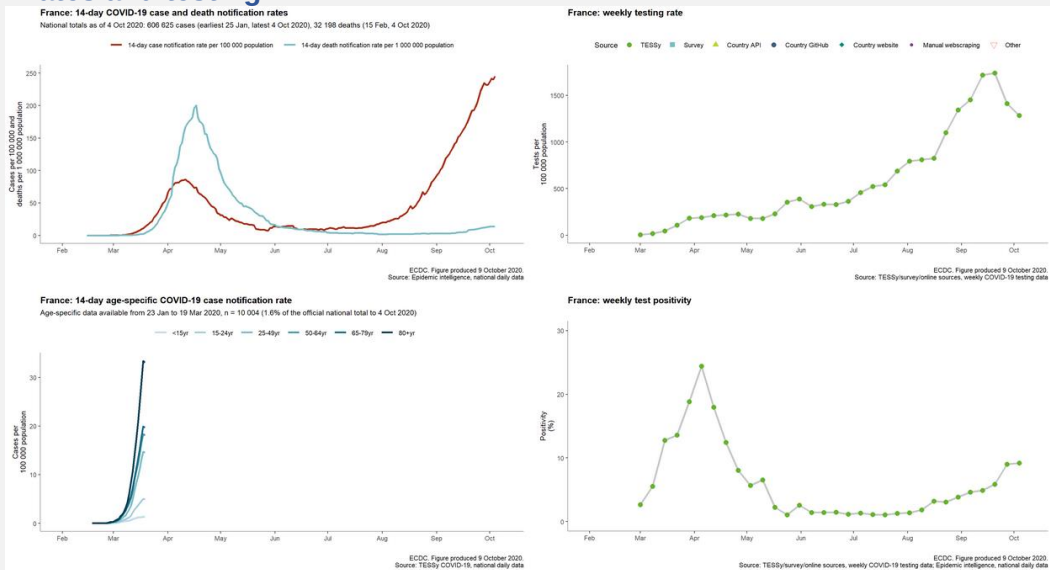


Hospital, ICU and SARI surveillance:

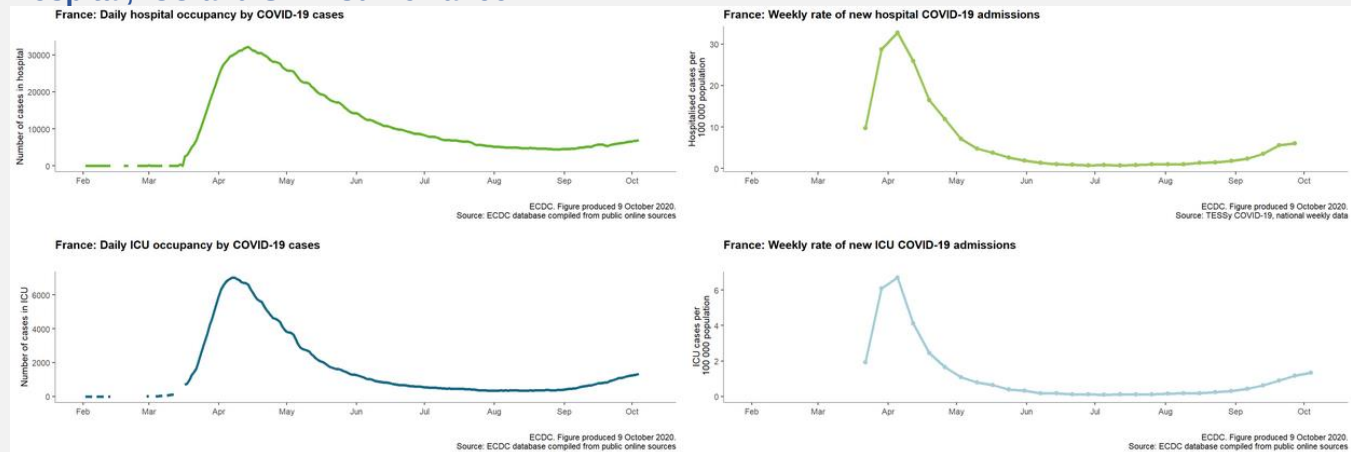


France

Notification rates and testing:

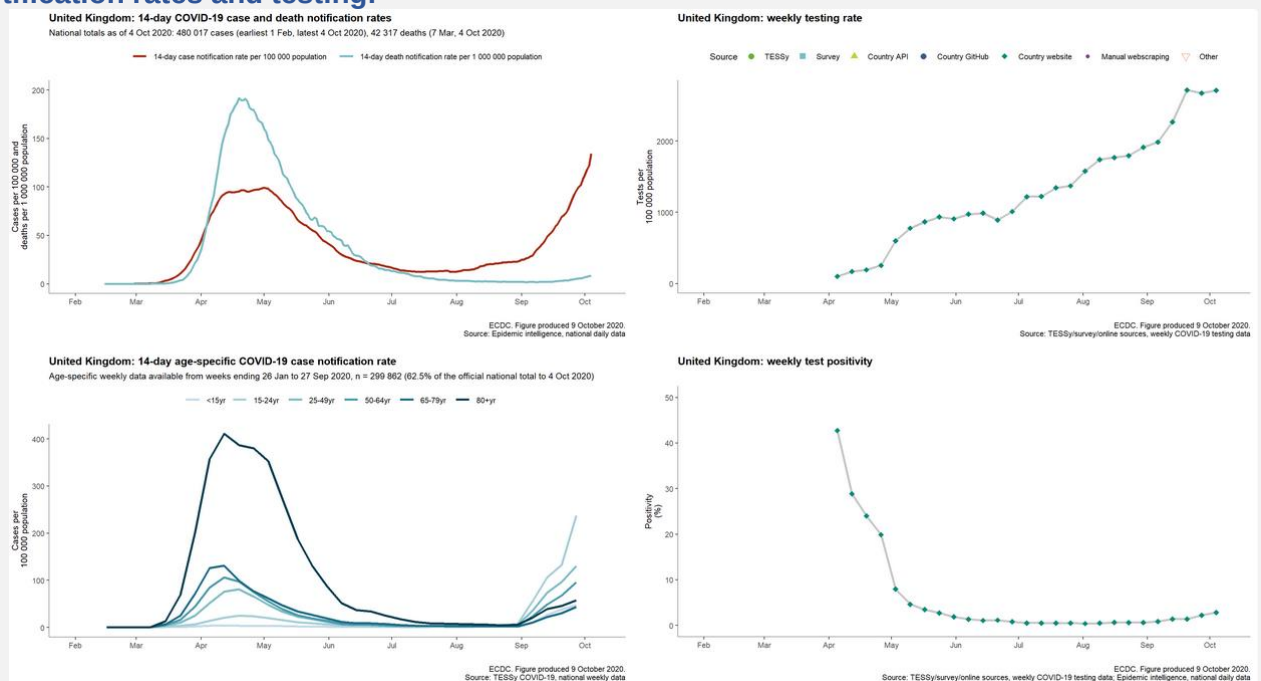


Hospital, ICU and SARI surveillance:



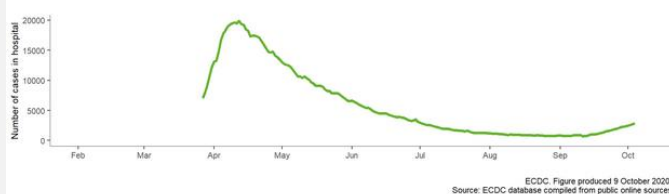
United Kingdom

Notification rates and testing:

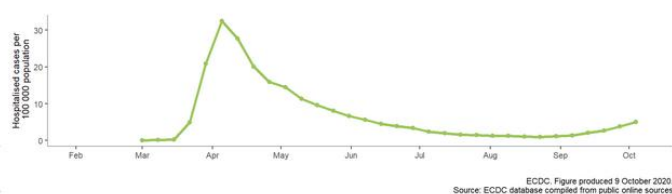


Hospital, ICU and SARI surveillance:

United Kingdom: Daily hospital occupancy by COVID-19 cases



United Kingdom: Weekly rate of new hospital COVID-19 admissions

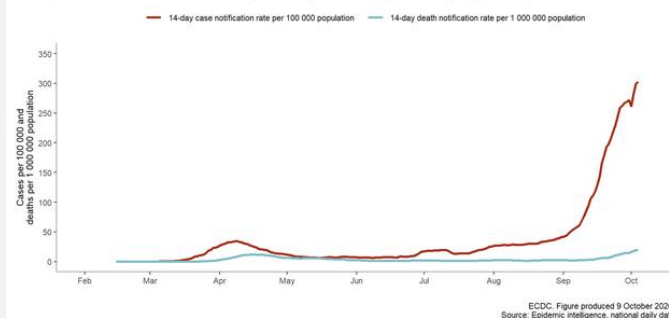


CZECH REPUBLIC

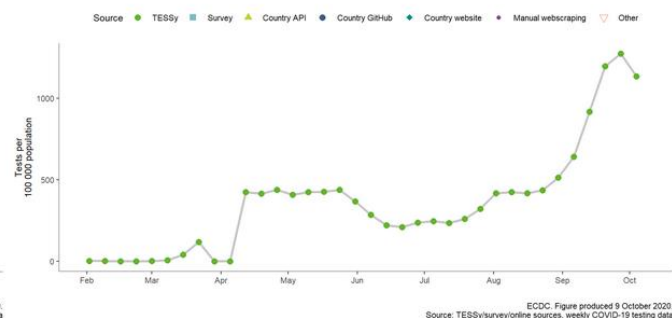
Notification rates and testing:

Czechia: 14-day COVID-19 case and death notification rates

National totals as of 4 Oct 2020: 80 605 cases (earliest 2 Mar, latest 4 Oct 2020), 711 deaths (23 Mar, 4 Oct 2020)

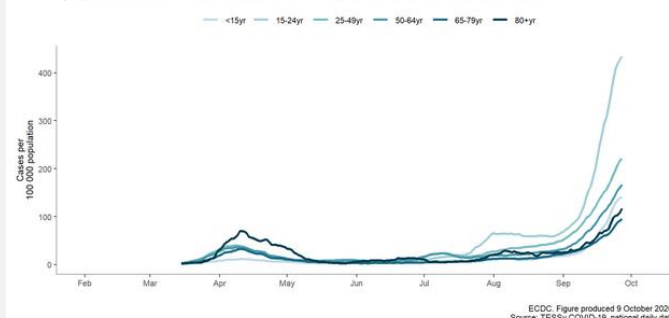


Czechia: weekly testing rate

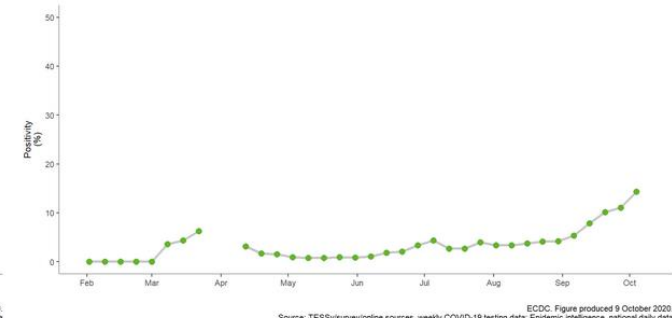


Czechia: 14-day age-specific COVID-19 case notification rate

Age-specific data available from 2 Mar to 27 Sep 2020, n = 51 786 (64.2% of the official national total to 4 Oct 2020)

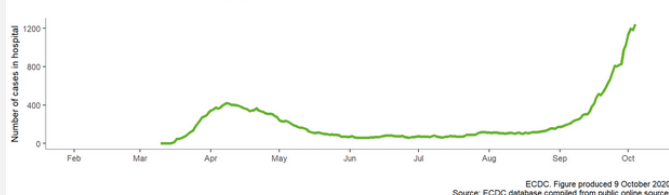


Czechia: weekly test positivity



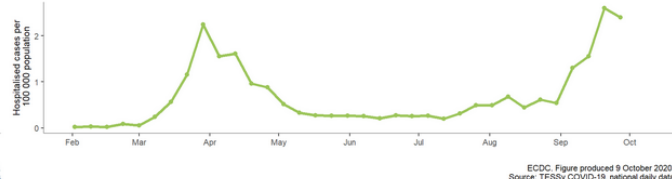
Hospital, ICU and SARI surveillance:

Czechia: Daily hospital occupancy by COVID-19 cases

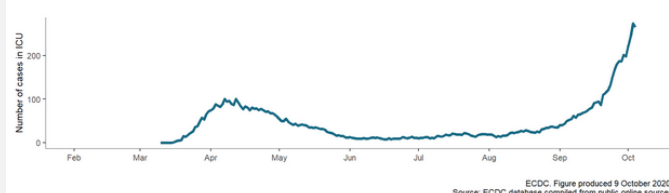


Czechia: Weekly rate of new hospital COVID-19 admissions

Date of hospitalisation for 100% (n = 2 559) of hospitalised cases. 51 786 cases in TESSy (64.2% of official national total to 4 Oct 2020)



Czechia: Daily ICU occupancy by COVID-19 cases



Czechia: Weekly rate of new ICU COVID-19 admissions

No data to plot

Country Reports:

EU: The majority of the European Ministers decided on Tuesday in Luxembourg a future traffic light map about the Corona situation in Europe. On the basis of common criteria, regions are marked either green, orange or red depending on the infection process. No entry bans should be imposed in future for green areas with low numbers of infections. However, this should not end with the patchwork of various rules. Because the concept does not provide common standards for travelers from more affected regions - i.e. regions marked orange or red. There are also no uniform criteria for quarantine and test obligations. The recommendations are also not binding.

ITA: The government has decided on further rules in the fight against Corona. The rules should initially apply for 30 days. The Italian government particularly restricts private parties indoors and outdoors. Parties are prohibited in bars and discos. Celebrations and ceremonies, such as weddings, would be limited to 30 participants. In addition, the government recommends around 60 million citizens to forego all dinners and other meetings with more than six non-household participants at home. Restaurants and bars will have to close at midnight in future. After 9 p.m. it is forbidden for guests to eat and drink while standing in front of restaurants. This is to avoid crowds of people in front of bars in the evening. The government also bans school trips. Contact sports for amateurs, such as football, will be restricted.

POL: On Saturday, the number of new infections every day exceeded the 5000 mark for the first time. 5300 new cases were added within 24 hours, most of them in the Masovian Voivodeship, which also includes the capital Warsaw.

CZE: From Wednesday on, gatherings with more than six people will be banned. Restaurants, bars and clubs will have to close until further notice. The consumption of alcohol in public is prohibited. All schools have to move to distance learning for just under three weeks by the beginning of November. The mask requirement now also applies at public transport stops. Shops stay open.

GBR: From today on the government is introducing local COVID alert levels. The alert level is three staged from medium to high and very high. Different measures and regulations will be imposed within every level. More information you can find [here](#).

In the region around the northern English city of Liverpool, which has already been declared the highest risk level, pubs and fitness studios will have to close until further notice. In addition, members of different households in these regions are no longer allowed to meet each other, either indoors or outdoors. In regions with the second highest warning level, this ban also applies to indoor areas, but so-called "support bubbles", i.e. small support groups, and meetings outside should still be allowed. In the lowest warning level, the same rules apply as before for the whole of England: pubs and restaurants must close at 10 p.m., and only meetings with a maximum of six people are allowed inside and outside. Wales, Northern Ireland and Scotland have their own, often stricter measures.

FRA: Reported around 27,000 new infections within 24 hours, that is the highest value since the beginning of the pandemic, which is why the government no longer wants to rule out renewed regional lockdowns.

DEU: With 4,122 new infections in 24 hours, the number of cases continues to rise continuously; 32 rural districts and urban districts (out of a total of 404) are now above the threshold specified by the German Health Institute RKI. Many regions are trying to stop the trend with tougher containment measures. In many places, schools remain closed, residents from risk areas are banned from staying and bigger cities imposed a general ban on serving alcohol between 10 p.m. and 6 a.m. from tomorrow. Many health authorities are reaching the limit of their capacities, which is why more than 1,000 requests for administrative assistance have been made to the German military since the beginning of the pandemic. So far, 67% of them have received a positive response, with the focus being on support for tracking contacts and chains of infection.

AUT: An expert commission sees serious errors in corona management in Ischgl. The operation of the ski buses and the cable cars was stopped a day later than necessary. The announcement of the

	quarantine over the Paznaun valley should have been better prepared and communicated, so that the tourists would have left “staggered and controlled” over the weekend. The outbreak has been one of the first hotspots and a super spreader event in Europe.
--	--

Subject in Focus

The Impact of a Six-Year Climate Anomaly on the "Spanish Flu" Pandemic and WWI

How rain and cold have influenced Spanish flu in 1918

In the current debate about the second wave of the COVID-19 pandemic, many experts and politicians are warning of autumn and winter. They believe the falling temperatures could worsen the spread of the virus. As more and more people will meet indoors.

When predicting the course of the current pandemic, it is an interesting exercise to compare it with last large-scale pandemic that hit mankind: the Spanish flu.

In the summer of 1918, the pandemic appeared to have disappeared for a short period of time, but it came back starting at the end of August in various places around the world - in the east of the USA, but also in France and West Africa. The second and more severe wave of the Spanish flu was observed from September to December 1918. In Europe, October and November were particularly bad.



THE UNUSUAL RELATIONSHIP BETWEEN CLIMATE & PANDEMICS

"I'm not saying that that this was 'the' cause of the pandemic, but it was certainly a potentiater, an added exacerbating factor to an already explosive situation."

-Alexander More

AGU THIRD POD FROM THE SUN

A team led by environmental researcher Alexander More from Harvard University has now investigated how climatic conditions during the First World War from 1914 to 1918 influenced mortality at the time of the Spanish flu. Using an ice core from the Alps, they reconstructed the weather from that time and compared the data obtained with historical records of deaths during the war.

The H1N1 "Spanish influenza" pandemic of 1918–1919 caused the highest known number of deaths recorded for a single pandemic in human history. From 1917 to 1919, between 50 and 100 million people died from the Spanish flu. In Europe, the number of deaths is estimated at 2.64 million. Several theories have been offered to explain the virulence and spread of the disease, but the environmental context remains underexamined.

Incessant torrential rain and declining temperatures increased casualties in the battlefields of World War I (WWI), setting the stage for the spread of the pandemic at the end of the conflict.



Impact of the weather

The environmental and especially climatic conditions in which the pandemic developed have received only little attention in the scientific literature, even though historical accounts universally describe abnormally high precipitation and cold temperatures in the years preceding the onset of the pandemic, in 1917, and during its deadliest wave in 1918. In contrast, detailed research has shown how extreme weather conditions impacted the outcome of major battles on the western front, most notably during the battles of Verdun (1916–1917), the Somme (1916), the Chemin-des-Dames (1917), and the Third Battle of Ypres-Passchendaele (1917). Extreme weather anomalies in these years disrupted governmental efforts in collecting meteorological records.

These records have been combined with detailed monthly records of overall mortality from 13 European countries and instrumental measures of precipitation and temperature for the same period.

European mortality data

Total European mortality peaked three times, concurrently or following cooling temperatures, increasing precipitation, and an extreme influx of cold marine air in winter 1915, 1916, and 1918 (see figure 2, below).

Marine air proxy's data

The first significant increases in all marine air proxies occurred in spring 1914 and winter 1914 -1915, with concurrent increases in precipitation and mortality in December 1914 and January - February 1915. With the highest increase in summer-autumn of 1915 and winter of 1915 and 1916.

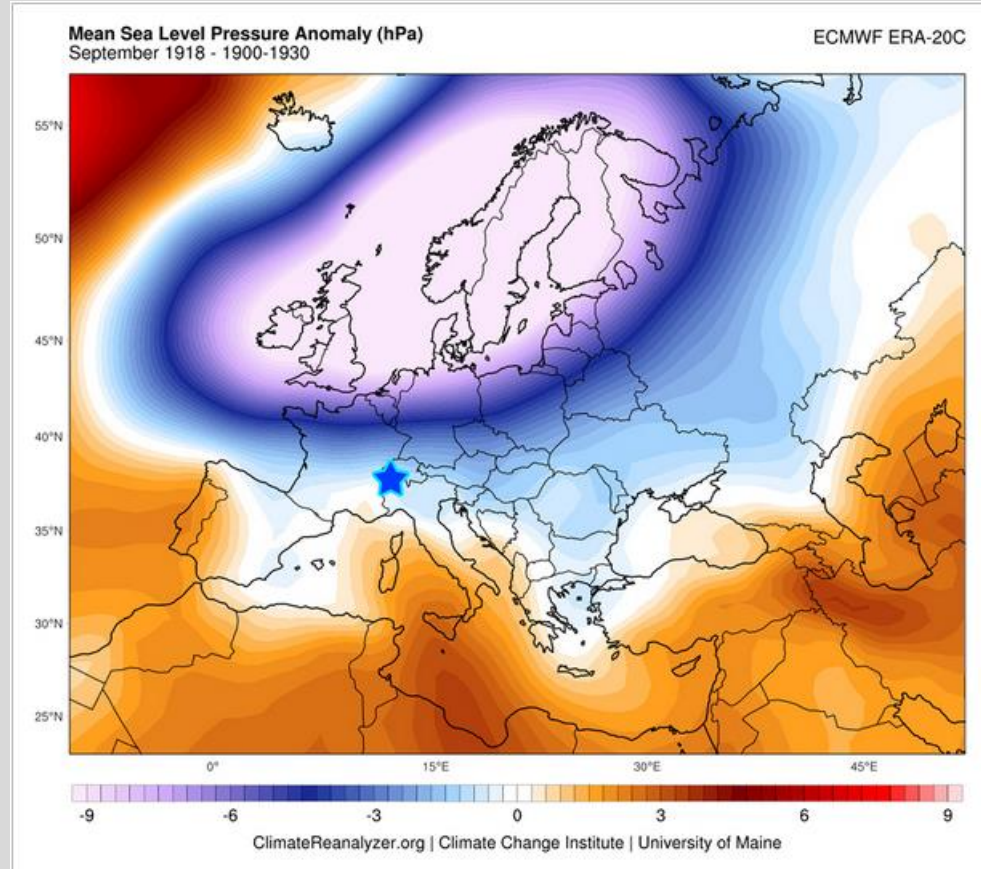


Figure 4

[Open in figure viewer](#) | [PowerPoint](#)

Atmospheric pressure anomaly over Europe. The CG ice core site (4,450 m.a.s.l.) is shown as a star. A mean sea level pressure difference map was calculated for September 1918 from an average for the 1900–1930 interval in the ECMWF ERA-20C reanalysis data set via the Climate Reanalyzer™. A strong Iceland low pressure system influenced unusually cold and wet climate conditions during the month of September 1918.

Historical data highlighting the impact of intensifying precipitation on British, French, and German military operations, where newly dug trenches and tunnels filled with rainwater, as bitter cold temperatures caused thousands to endure frostbite at night, while mud slowed down the movement of troops and artillery during the day. Extended winter conditions in 1917 caused

widespread harvest failures, resulting in the “turnip winter” of 1916-1917, whereby the German population resorted to root vegetables for their diet, due to failed potato and cereal harvests and the allied blockade.

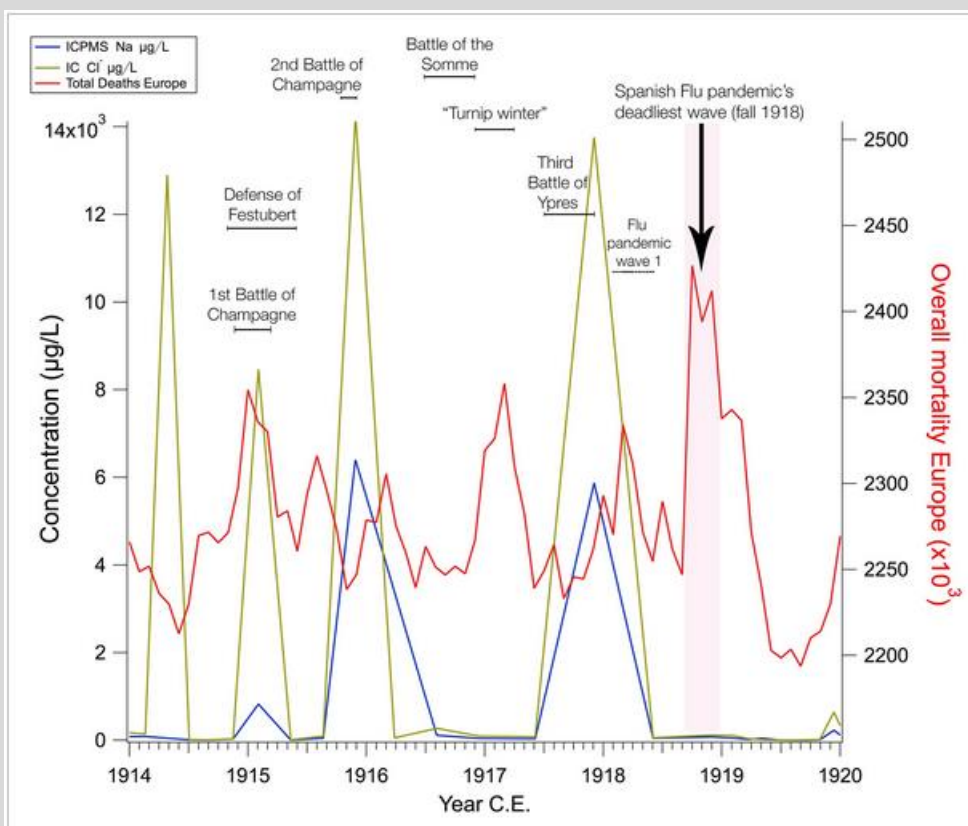


Figure 2

[Open in figure viewer](#) | [PowerPoint](#)

Marine air influx and total deaths in Europe 1914–2020. Concentrations of Na, Cl⁻, marine air proxies in the CG glacier and total mortality for 13 European countries 1914–2020 (Ansart et al., 2009; Bunle, 1954). In 1915, 1916, and 1918, overall mortality peaked during or immediately after periods of high marine air influx over Europe. Major battles of WWI where precipitation was a significant factor are labeled in black, along with the period of the three major waves of the Spanish Flu pandemic, the deadliest of which occurred in the autumn of 1918.

Impact of Spanish influenza

The first wave of H1N1 influenza in Europe emerged in the spring of 1918, most likely originating in the fall and winter of 1917. The combination of extremely high precipitation, the concentration of millions of troops on the battlefields, unsanitary conditions, and the use of chlorine gas as a chemical weapon have been cited as

contributing factors to the mutation and emergence of the most lethal wave of the Spanish influenza pandemic in the fall and winter of 1918 - 1919.

The deadliest wave of the flu in Europe began in the autumn of 1918, closely following a period of extremely high precipitation and cold temperatures.

Environmental induced factors that trigger the outbreak

The coincidence between increased precipitation and mortality in this pandemic wave in late 1918 (Figure 3) highlights the role of **environmental conditions** in a pandemic's morbidity and mortality, as already suggested in studies of recent H1N1 and other respiratory tract infections such as COVID-19 in human populations especially in regions with extensive, long-term air pollution such as Europe.

An additional exacerbating factor may have been the influence of the weather anomalies on established patterns of avian migration, specifically, the **migration of the mallard duck**—one of the primary reservoirs of H1N1 avian influenza virus—resulting in increased presence of this species throughout Europe in the autumn of 1917 and 1918, in close proximity to both military and civilian populations, as well as domesticated animals. Studies have shown that changes in the environment affect overall movement and direction and interrupting their normal migratory route.

Exposure of mammalian hosts to the same infected bodies of water where mallard ducks may have remained may explain connections to the current seasonal recurrence of H1N1 in human populations as shown in recent studies suggesting that severe weather anomalies in 1917 - 1919 may have contributed to both the diffusion and mutation of the Spanish flu virus, as previous studies have suggested.

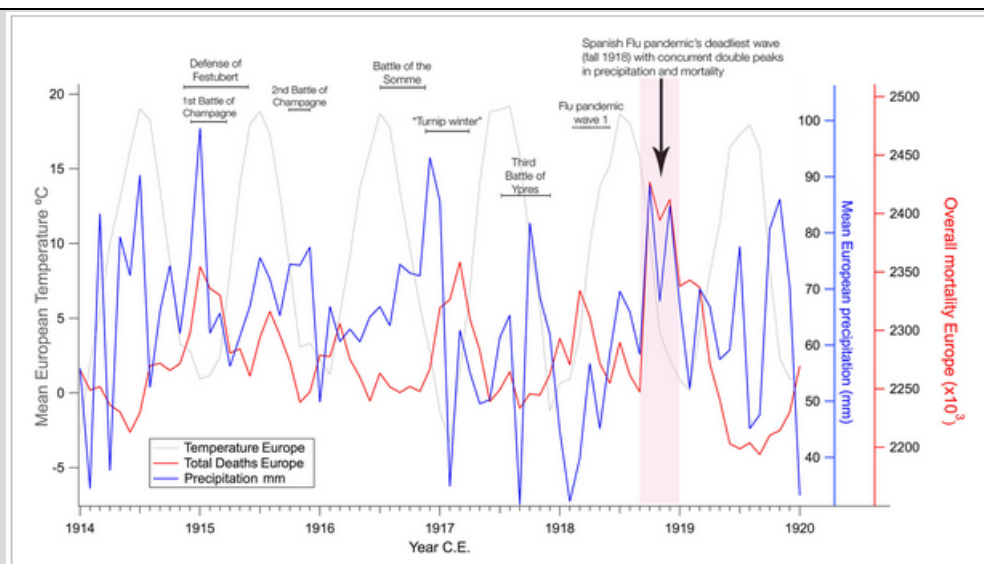


Figure 3

[Open in figure viewer](#) | [PowerPoint](#)

Mean temperature, precipitation, and total deaths in Europe, 1914–1920. Mean values of instrumental measurements of temperature and precipitation with overall deaths for 13 European countries (Ansart et al., 2009; Bunle, 1954; Schneider et al., 2014; Willmott & Matsuura, 2001). In the autumn and winter of 1918, mortality peaked together with high precipitation, with a peak in both records in the month of October, a slight decrease in November, and another peak in December of that year. The deadliest wave of the Spanish Influenza pandemic claimed most of its victims in the same months, where the arrow points to a double peak in both deaths and precipitation.

The influx of torrential rain accompanied by decreasing temperatures in the autumns of 1917 and 1918 provided ideal conditions for the survival and replication of the virus. Prolonged exposure to decreasing temperatures may also have been a factor in **increasing pneumococcal co-infections**, which recent studies have found to be more common in the WWI years than previously thought. Retrospective epidemiological studies have now shown that a significant contribution to high mortality during the Spanish Flu pandemic came from pneumococcal co-infections, amounting to as much as one fifth of influenza victims, with a 34% mortality.

Summary

A new, high-resolution climate record from Europe shows a once-in-a-century climate anomaly that occurred during the years of World War I and the Spanish flu pandemic. Overall mortality data (for all causes) show increases in times of worsening weather, precipitation, and temperatures, a factor in many of the major battles of WWI, as well as a possible exacerbating factor for the virulence of the pandemic.

Take home message

Our past and current crisis highlights a continuing and growing need for robust local and global public health and environmental agencies, such as the CDC, WHO and UNEP, dedicated to fighting the emergence of new pandemics, the on-going climate change and the combined risk new and old diseases pose to mankind in times of extreme weather that is more likely to occur as the climate change proceeds unhindered.

The role of climate anomalies such as the one described in this Subject in Focus (and in the underlying study) must be assessed in relation to more recent pandemics such as COVID-19.

Source:

- <https://agupubs.onlinelibrary.wiley.com/doi/10.1029/2020GH000277>
- <https://de.euronews.com/2020/09/28/wie-starker-regen-und-kalte-die-spanische-grippe-1918-beeinflusst-haben>

MilMed CoE VTC COVID-19 response

Topic	The NATO Centre of Excellence for Military Medicine is putting its expertise and manpower to aid in any way possible during the pandemic. The VTC is for interested participants (experts) to exchange experiences, management regulations and restrictions due to COVID-19. We would like to propose just one of the most important topics in the next iteration. We will have some experts giving a short briefing and then afterward we will have time for questions and experiences as well as a fruitful discussion. Topics former VTCs: • Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities. • Testing strategies • Aeromedical evacuation • De-escalation strategy and measures • Collateral damage of COVID-19 emphasizing Mental Health Aspects and other non COVID related diseases • Immunity map, national strategies to measure and evaluate the immunity level" • Mental Health • Treatment of mild symptomatic cases of COVID-19 • Transition home office back to the office • COVID-19 Second Wave prediction and preparedness based on facts/experiences, modelling and simulation • Perspectives of the current COVID-19 vaccine development • National overview on current COVID-19 situation • Long term effects of COVID-19 and the impact on force capability • Overview on current COVID-19 situation in Missions
Overview on current COVID-19 situation in Missions	Briefer from UK PJHQ, Belgium, ACT and European External Action Service (EEAS) reported. ACT Briefer gave us an outline to the work ACT is doing in response to the COVID Crisis. ACT Programme of Work is 1. Compare national responses to the Global COVID-19 pandemic THIS STUDY 2. Compare and contrast the experiences of the global COVID19 pandemic and large-scale warfighting interventions 3. Identify salient lessons and required capabilities for future conceptual and capability developmental activities for military medical services The Belgium briefer talked about small outbreaks during exercises on board off a frigate and of an outbreak in a contingent deployed in Maradi (Niger). They had some small limited outbreaks during exercises in Belgium as well. Since August they have a national military tracing center with direct access to the reference laboratories. This center look for all contacts within Defense. The Briefer from EEAS talked about the current status of the COVID-19 situation (case numbers and testing strategy) in EUTM Mali. Next VTC will be on Wednesday 21st of October with the topic "Civil – military cooperation in view of COVID-19"

Recommendations

Recommendation for international business travellers

As of 15th September 2020

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

The decision-making process should be multisectoral and ensure coordination of the measures implemented by national and international transport authorities and other relevant sectors and be aligned with the overall national strategies for adjusting public health and social measures. [WHO Public health considerations while resuming international travel.](#)

Travel has been shown to facilitate the spread of COVID-19 from affected to unaffected areas. Travel and trade restrictions during a public health event of international concern (PHEIC) are regulated under the International Health Regulations (IHR), part III.

The majority of measures taken by WHO Member States relate to the denial of entry of passengers from countries experiencing outbreaks, followed by flight suspensions, visa restrictions, border closures, and quarantine measures. Currently there are exceptions foreseen for travellers with an essential function or need.

In the case of non-deferrable trips, please note the following

- Many airlines have suspended inbound and outbound flights to affected countries. Contact the relevant airline for up-to-date information on flight schedules.
- Check your national foreign office advices for regulations of the countries you're traveling or regulations concerning your country.
- Information's about the latest travel regulations and De-escalation strategy measures you can find at [IATA](#) and [International SOS](#). For Europe you will find more information [here](#).

Most countries implemented strikt rules of contact reduction:

- Everyone is urged to reduce contacts with other people outside the members of their own household to an absolutely necessary minimum.
- In public, a minimum distance of 1.5 m must be maintained wherever possible.
- Staying in the public space is only permitted alone, with another person not living in the household or in the company of members of the own household (for most countries, please check bevor traveling).
- Follow the instructions of the local authorities.

Risk of infection when travelling by plane:

The risk of being infected on an airplane cannot be excluded, but is currently considered to be low for an individual traveller. The risk of being infected in an airport is similar to that of any other place where many people gather. If it is established that a COVID-19 case has been on an airplane, other passengers who were at risk (as defined by how near they were seated to the infected passenger) will be contacted by public health authorities. Should you have questions about a flight you have taken, please contact your local health authority for advice.

General recommendations for personal hygiene, cough etiquette and keeping a distance of at least one metre from persons showing symptoms remain particularly important for all travellers. These include:

- Perform hand hygiene frequently. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if hands are not visibly soiled; wash hands with soap and water when they are visibly soiled;
- Cover your nose and mouth with a flexed elbow or paper tissue when coughing or sneezing and disposing immediately of the tissue and performing hand hygiene;
- Refrain from touching mouth and nose; See also: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
- If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal.

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

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

Source: WHO and ECDC

European Commission:

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

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

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

On 15 June, the European Commission [launched](#) 'Re-open EU', a web platform that contains essential information allowing a safe relaunch of free movement and tourism across Europe. To help people confidently plan their travels and holidays during the summer and beyond, the platform will provide real-time information on borders, available means of transport, travel restrictions, public health and safety measures such as on physical distancing or wearing of facemasks, as well as other practical information for travellers.

Re-open EU will act as a key point of reference for anyone travelling in the EU as it centralises up-to-date information from the Commission and the Member States in one place. It will allow people to browse country-specific information for each EU Member State through an interactive map, offering updates on applicable national measures as well as practical advice for visitors in the country. Available in the 24 official EU languages.

Travel advice and Border measures

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

Lifting of travel restrictions: Council reviews the list of third countries

Following a review under the recommendation on the gradual lifting of the temporary restrictions on non-essential travel into the EU, the Council updated the list of countries for which travel restrictions should be lifted. As stipulated in the Council recommendation, this list will continue to be reviewed regularly and updated.

Based on the criteria and conditions set out in the recommendation, as from 8 August member states should **gradually lift the travel restrictions at the external borders for residents of the following third countries:**

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

Residents of Andorra, Monaco, San Marino and the Vatican should be considered as EU residents for the purpose of this recommendation.

While the restrictions on non-essential travel and their lifting depend on the traveller's place of residence, the visa requirement continues to depend on nationality. If a traveller resides in a country where restrictions have been lifted, but is a national of a visa-required country, he or she must apply at the consulate of the Member State to which he wishes to travel to, in his or her country of residence.

For all other third countries not on this list, Member States and Schengen Associated countries are temporarily suspending all non-essential travel from those third countries to the EU+ area, meaning that only certain categories of travellers could be authorised for entry. The "EU+ area" includes 30 countries: 26 out of the 27 EU Member States as well as the four Schengen Associated States: Iceland, Liechtenstein, Norway and Switzerland. Ireland does not currently apply the travel restriction.

Travel restrictions aim to reduce the number of travellers entering the European Union. The aim is to restrict the spread of the coronavirus and protect public health within the EU, as well as to prevent the virus from spreading from the EU to other countries.

As the epidemiological situation in and outside the EU evolves and travel restrictions at the EU's external borders gradually start to be lifted, visa operations will also resume gradually. On 11 June 2020, the Commission published a Guidance for a phased and coordinated resumption of visa operations.

The rules for applying for a short-stay visa remain unchanged. Member States' consulates and external service providers will, however, have adapted practical aspects of access management, hygiene measures, payment methods etc. Appropriate information on the procedure to follow for lodging an application should be provided to applicants.

Information on travel restrictions in place should be available on the websites of the relevant national authorities (e.g. Ministries of Interior and Foreign Affairs). A daily summary of flight and passenger restrictions is available on the [Eurocontrol website](#) and is entitled 'Covid Notam (notice to airmen) summary'.

Exemption from travel restriction

The following categories of persons are exempt from the temporary travel restriction to the EU+ area from the third countries which are not on the list agreed by the Member States:

- a) Union citizens within the meaning of Article 20(1) TFEU and third-country nationals who, under agreements between the Union and its Member States, on the one hand, and those third countries, on the other hand, enjoy rights of free movement equivalent to those of Union citizens, as well as their respective family members¹⁵;
- b) third-country nationals who are long-term residents under the Long-term Residence Directive or deriving their right to reside from other EU Directives or national law or who hold national long-term visas, as well as their respective family members.

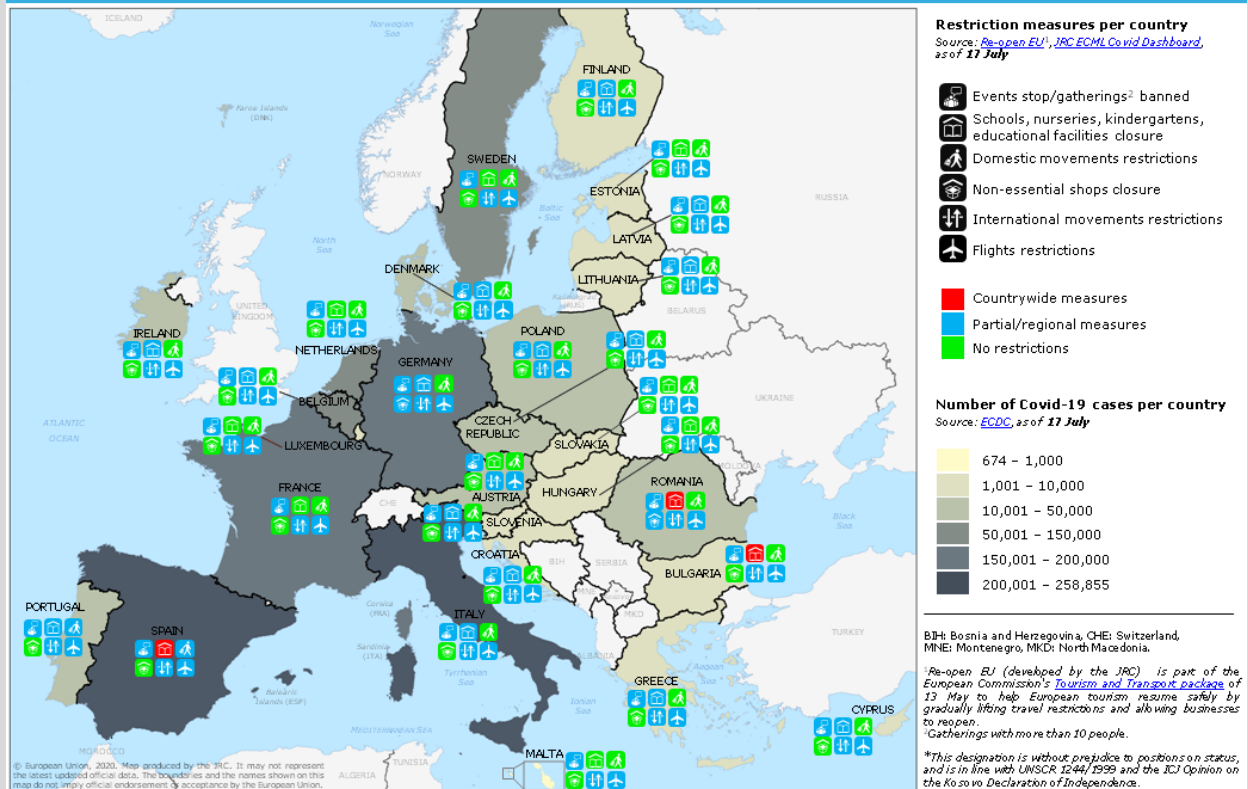
The temporary travel restrictions should also not apply to people with an essential function or need, including:

- healthcare professionals, health researchers, and elderly care professionals
- frontier workers
- seasonal workers in agriculture
- transport personnel
- Diplomats, staff of international organisations and people invited by international organisations whose physical presence is required for the well-functioning of these organisations, military personnel and humanitarian aid workers and civil protection personnel in the exercise of their functions;
- passengers in transit
- passengers travelling for imperative family reasons
- seafarers
- persons in need of international protection or for other humanitarian reasons;
- third-country nationals travelling for the purpose of study;

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

JRC Map 17 July 2020 at 13:00 UTC

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



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

Risk Assessment

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

References:

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

Disclaimer:

This update provided by the NATO Centre of Excellence (NATO MILMED COE) on its website is for general information purposes only and cannot be considered as official recommendation. All national and international laws, regulations, and guidelines as well as military orders supersede this information.

All information is provided in good faith, however, the NATO MILMed COE makes no representation or warranty of any kind, express or implied, regarding the accuracy, adequacy, validity, reliability, availability or completeness of any information.

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

The NATO MILMED COE disclaim any liability in connection with the use of this information.