



Update 44 (3rd of November 2020)

Information about Infection disease COVID-19 (novel coronavirus)



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

3rd of November 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

- The Director General of the WHO went into quarantine at home after contact with a person who tested positive for SARS-CoV-2. Through a public announcement, he drew attention to the fact that adherence to the guidelines was essential for all people.
- **WHO:** published an interim guidance to harmonized [health service capacity assessments in the context of the COVID-19 pandemic](#)
- **WHO:** published an interim guidance on the [prevention, identification and management of health worker infection in the context of COVID-19](#). It is intended for occupational health departments, infection prevention and control departments or focal points, health facility administrators and public health authorities at both the national and facility level.
- **UNESCO:** The SADC Secretariat and UNESCO are committed to supporting the learning continuity strategies of Member States through a #LearningNeverStops campaign. [They will convene a member State Consultation Webinar on Open and Distance Learning in Southern Africa](#)

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 ↗

46 917 180
confirmed cases
31 366 700 recovered
1 206 474 deaths

EU/EEA and the UK ↗

10 797 585
confirmed cases
3 912 350 recovered
281 167 deaths

USA ↗ (new cases/day 79 485)

9 216 288
confirmed cases
3 641 614 recovered
230 607 deaths

India → (new cases/day 45 231)

8 267 623
confirmed cases
7 603 121 recovered
123 097 deaths

Brazil ↘

(new cases/day 10 100)

5 554 206
confirmed cases
5 039 438 recovered
160 253 deaths

Russia → (new cases/day 18 017)

1 642 665
confirmed cases
1 228 921 recovered
28 264 deaths

France ↗ (new cases/day 52 518)

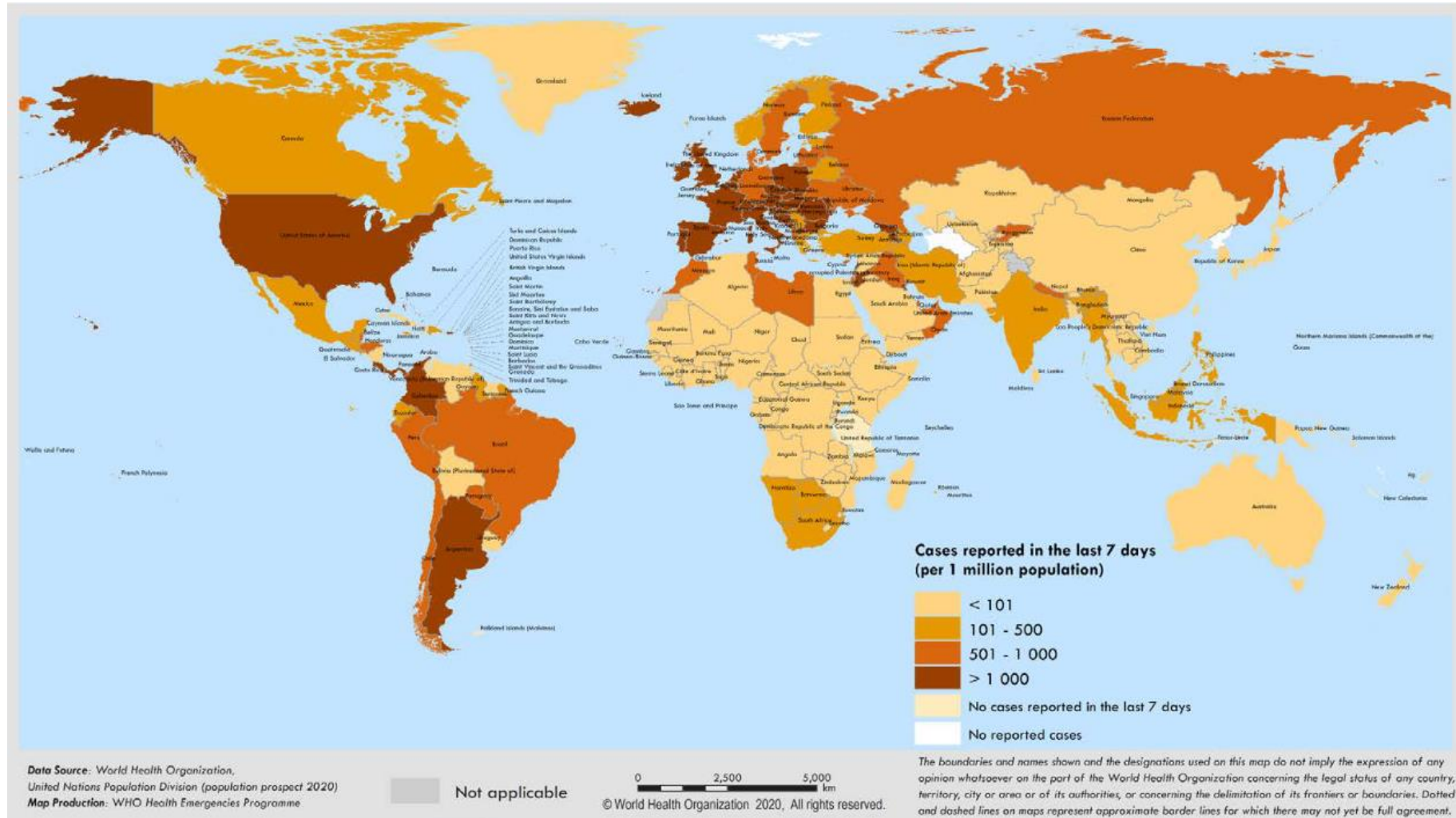
1 466 433
confirmed cases
119 104 recovered
37 435 deaths

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>7</i>
Subject in Focus	12
<i>The power of the small number showed by the example of Germany.....</i>	<i>12</i>
Conflict and Health	17
<i>COVID-19 Crisis in Sri Lanka</i>	<i>17</i>
MilMed CoE VTC COVID-19 response	20
<i>Topic.....</i>	<i>20</i>
<i>Civil – military cooperation in view of COVID-19</i>	<i>20</i>
Recommendations	21
<i>Recommendation for international business travellers</i>	<i>21</i>
Risk Assessment.....	24
<i>Global.....</i>	<i>24</i>
<i>Europe.....</i>	<i>24</i>
References:	25
Disclaimer:	25

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



Worldwide Situation

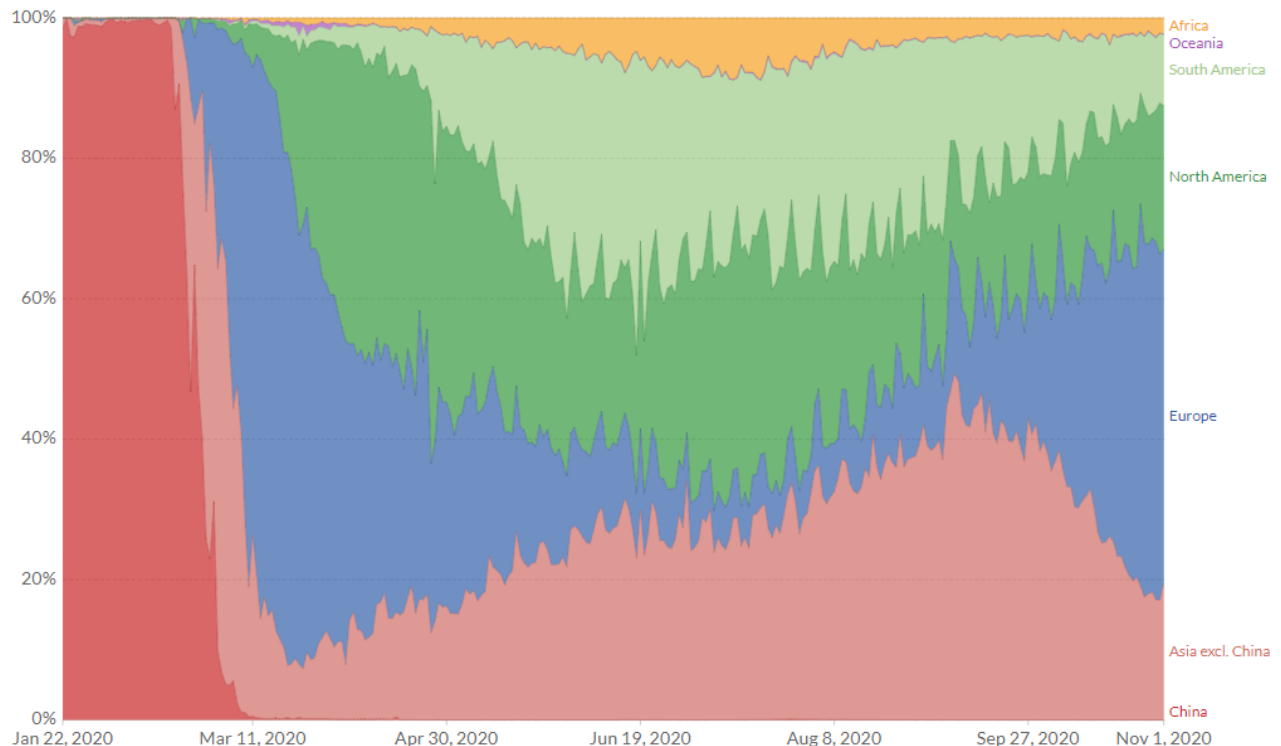
Global Situation

Daily confirmed COVID-19 cases

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



☒ Relative



Source: European CDC – Situation Update Worldwide – Last updated 2 November, 10:06 (London time)

OurWorldInData.org/coronavirus • CC BY

WHO weekly operational update on COVID-19 as of 30th 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. To assess household transmission, a case-ascertained study was conducted by the CDC in Nashville, Tennessee, and Marshfield, Wisconsin, commencing in April – September 2020.

Transmission of SARS-CoV-2 Infections in Households

Only a few studies have systematically characterized the transmission of SARS-CoV-2 in households. Previously reported transmission rates vary widely, and data on transmission rates from children are limited.

After enrollment, index patients and household members were trained remotely by study staff members to complete symptom diaries and obtain self-collected specimens, nasal swabs only or nasal swabs and saliva samples, daily for 14 days.

Results

- A total of 191 enrolled household contacts of 101 index patients reported having no symptoms on the day of the associated index patient's illness onset, and among these 191 contacts, 102 had SARS-CoV-2 detected in either nasal or saliva specimens during follow-up, for a secondary infection rate of 53%.
- Among fourteen households in which the index patient was aged <18 years, the secondary infection rate from index patients aged <12 years was 53% and from index patients aged 12–17 years was 38%.
- Approximately 75% of secondary infections were identified within 5 days of the index patient's illness onset, and substantial transmission occurred whether the index patient was an adult or a child.

Conclusion

In this ongoing prospective study that includes systematic and daily follow-up, transmission of SARS-CoV-2 among household members was common, and secondary infection rates were higher than have been previously reported. Secondary infections occurred rapidly, with approximately 75% of infections identified within 5 days of the index patient's illness onset. Secondary infection rates were high across all racial/ethnic groups. Substantial transmission occurred whether the index patient was an adult or a child.

Because household transmission of SARS-CoV-2 is common and can occur rapidly after the index patient's illness onset, persons should self-isolate immediately at the onset of COVID-like symptoms, at the time of testing as a result of a high risk exposure, or at the time of a positive test result, whichever comes first. Concurrent to isolation, all members of the household should wear a mask when in shared spaces in the household.

TABLE 2. Rates of secondary laboratory-confirmed SARS-CoV-2 infections among household members enrolled in a prospective study of SARS-CoV-2 household transmission — Tennessee and Wisconsin, April–September 2020



Characteristic	Laboratory-confirmed SARS-CoV-2 infections/Household members at risk	Secondary infection rate % (95% CI)*
All household members	102/191	53 (46–60)
Nasal swab–positive tests only	89/191	47 (40–54)
RT-PCR–negative at enrollment	48/137	35 (28–43)
Index patient age group, yrs		
<12	9/17	53 (31–74)
12–17	11/29	38 (23–56)
18–49	64/116	55 (46–64)
≥50	18/29	62 (44–77)
Index patient sex		
Female	66/108	61 (52–70)
Male	36/83	43 (33–54)

Sources:

<https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e1.htm>

Country reports:

NZL: For the first time in ten days, a new local infection with the coronavirus was recorded. It is a health worker from a state quarantine facility in Christchurch. The facility is used exclusively by seafarers from Russia and Ukraine who are flown in on charter flights by fishing companies. They now have to stay in quarantine 24 hours longer than originally planned. At the same time, New Zealand reported four new imported cases. The country had brought the virus under control relatively quickly with very strict measures. The people there have returned to a relative normalcy - even large events without a mask are allowed again.

USA: Shortly before the end of the presidential election, the conflict between health experts and the president intensifies. After the highest-ranking specialist in infectious diseases, Fauci, criticized the government's actions in view of the continued rise in the number of cases and inadequate measures, the incumbent president publicly threatened his dismissal.

Trump adviser and doctor Deborah Birx called on the US government to take more drastic measures to deal with the corona pandemic in the US shortly before the election. In view of the current situation, "much more aggressive measures" are necessary. Birx, who also coordinates the Coronavirus Task Force of the White House, contradicts the policy of the US President in the report on many points. For example, she expressly warns of major events like the one Trump carried out in the election campaign with hundreds of participants. Contrary to what Trump claims, the increasing numbers of infections are not due to more tests she said.

ARE: The Emir of Dubai and Prime Minister of the United Arab Emirates, Sheikh Mohammed bin Raschid al-Maktum, has been vaccinated with an experimental coronavirus vaccine. A photo published on Twitter on Tuesday shows the 71-year-old having the active ingredient injected into his upper arm. Sheikh Mohammed left open what type of vaccine it was. Previously, the Vice Prime Minister of the Emirates and Foreign Minister had already had a test vaccination.

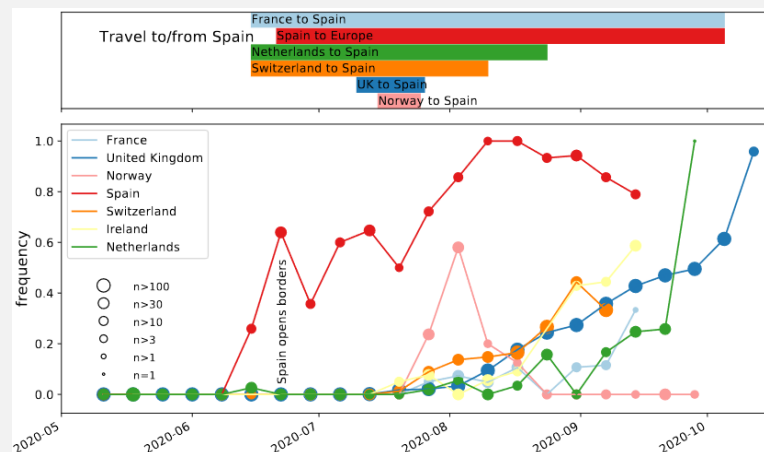
Situation in Europe

Emergence and spread of a SARS-CoV-2 variant through Europe in the summer of 2020

Not only vacationers use the summer to travel - a new SARS-CoV-2 variant has spread in Europe. A variant of SARS-CoV-2 emerged in early summer 2020, presumably in Spain, and has since spread to multiple European countries.

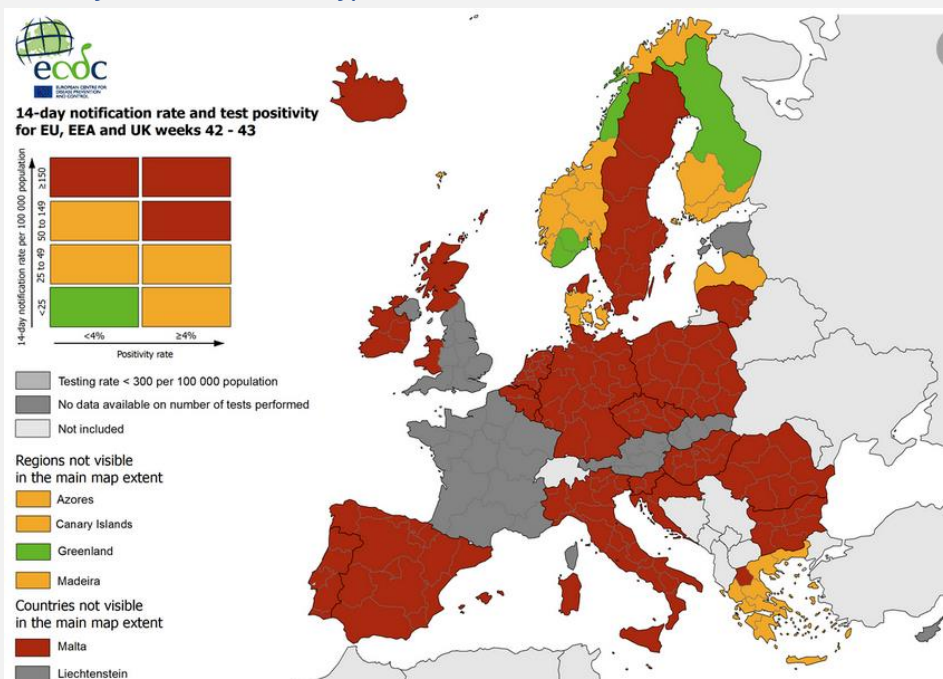
The variant was first observed in Spain in June and has been at frequencies above 40% since July. Until then, this mutation almost never occurred outside of Spain. Since mid-July, however, the new form 20A.EU1 (S: A222V) has spread over large parts of Europe and now accounts for more than 70% of the new certificates in some countries. After cases in England and Switzerland first occurred, corresponding samples were also found in Northern Ireland, Belgium and Norway. By the end of August, France, Scotland, Wales, Germany, Lithuania, Sweden and Italy were also affected. Sequence findings in Hong Kong and New Zealand are very likely due to an import from Europe. The evaluations of the temporal dynamics were also interesting, as they indicate several different entries of the new variant, i.e. not a single event was responsible for the spread in a country. After the spread in Spain was a good 60%, it increased e.g. in Wales and Scotland to around 80% by mid-September. In the rest of England and Switzerland, however, it was only 50% at the time.

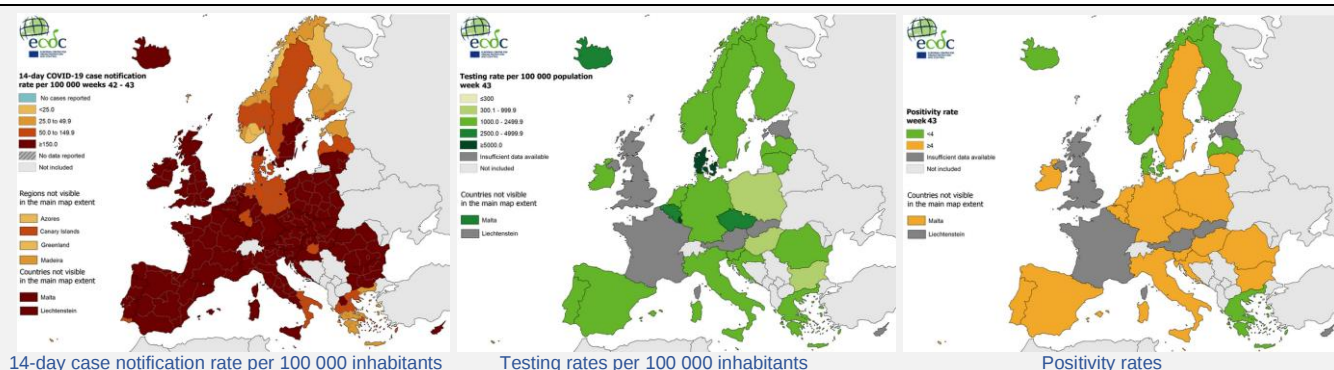
So far there is no reliable evidence that this new sequence variant has special properties that could explain this spread. The mutation occurs in a region of the spike protein that has not previously played a role in receptor binding or membrane fusion. The authors therefore suspect epidemiological reasons rather than the cause. Here partly dependence on the resumed travel activity within Europe in general, but also specifically in Spain, which has been particularly hard hit by the COVID-19 pandemic (see picture).



Source: <https://www.medrxiv.org/content/10.1101/2020.10.25.20219063v1.full.pdf>

Maps in support of the Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic in the EU, as of 29 October 2020 (maps are updated every week by 23:59 on Tuesday)





ECDC COVID-19 surveillance report Week 41, as of 29 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 43, ending Sunday 25 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.

Additional weekly surveillance bulletins relevant to the COVID-19 pandemic in Europe include [EuroMOMO](#) (estimates of all-cause mortality) and [Flu News Europe](#) (including primary care sentinel and hospital-based surveillance for respiratory disease), which are published every Thursday and Friday, respectively.

The data behind most of the figures in this report are available to download in multiple formats from [ECDC's website](#).

New this week

- These reports no longer include information on all-cause mortality or figures based on influenza-like illness (ILI) and/or acute respiratory infection (ARI) syndromic surveillance data using the systems established for influenza. Please refer to [EuroMOMO](#) and [Flu News Europe](#) where these data are published and analysed in detail.

Trends in reported cases and testing

- By the end of week 43 (25 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 from 31 countries, was 360.2 (country range: 37.7–1453.2) per 100 000 population. The rate has been increasing for 98 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, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK).
- Based on data reported to TESSy from 25 countries, among people over 65 years of age, high levels (at least 60 per 100 000) or sustained increases in the 14-day COVID-19 case notification rates compared to last week have been observed in 22 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden).
- Notification rates are highly dependent on several factors, one of which is the testing rate. Weekly testing rates for week 43, available for 25 countries, varied from 746 to 9 871 tests per 100 000 population. Luxembourg had the highest testing rate for week 43, followed by Denmark, Malta, Belgium and the UK.
- Weekly test positivity was high (at least 3%) or had increased against the previous week in 22 countries (Belgium, Bulgaria, Croatia, Czechia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK).

Primary care

- In the seven countries that reported data from primary care sentinel surveillance for COVID-19 up to week 43, using the systems established for influenza, three detections of SARS-CoV-2 were reported among the 83 patients tested.

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 24 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Italy, Latvia, 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 24 countries to date, we estimate that 17% (country range: 2–76%) of reported COVID-19 cases have been hospitalised. Data from 17 countries show that in total 8% (country range: 0–60%) of hospitalised patients required ICU and/or respiratory support. However, 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 from 31 countries, was 25.7 (country range: 0.0–101.6) per million population. The rate has been increasing for 44 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 22 countries (Austria, Belgium, Bulgaria, Croatia, Czechia, France, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and the UK).

New cases (week 43/2020)

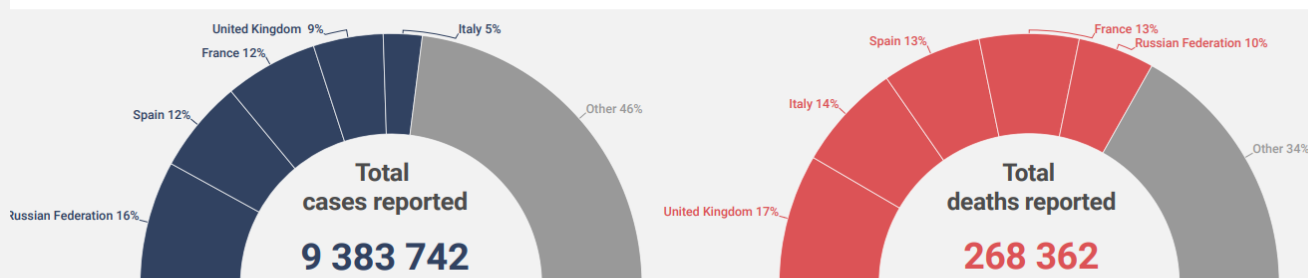
1 394 946

Country	Percentage
France	16%
United Kingdom	11%
Spain	8%
Russian Federation	8%
Italy	7%
Belgium	7%
Czech Republic	6%
Poland	5%
Other	31%

New deaths (week 43/2020)

12 026

Country	Percentage
Russian Federation	15%
France	10%
United Kingdom	10%
Spain	7%
Poland	7%
Czech Republic	7%
Ukraine	6%
Italy	6%
Other	32%



Note: Reported cases and/or deaths from IHR States Parties may be subject to retrospective adjustments. * All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999)

88%
of all deaths
were in persons aged 65+

56%
of all deaths
were in men

96%
of all deaths
had at least 1 underlying
condition

83%
of all deaths
had cardiovascular disease

Cases

Counts

MS

7 14 17 16 16 16 19 19 19 21 20 20 20 20 19 19 19 19 20 20 20 20 20 20 20 20 20 20 18 19 20 21 14

■ <5 ■ 5-14 ■ 15-24 ■ 25-49 ■ 50-64 ■ 65-79 ■ 80+

Deaths

Counts

MS

1 3 10 13 13 14 16 17 18 17 16 17 15 16 14 13 13 13 15 12 16 14 15 17 16 17 15 17 17 13

■ <5 ■ 5-14 ■ 15-24 ■ 25-49 ■ 50-64 ■ 65-79 ■ 80+

Cases (Percentage)

Percentage

MS

7 14 17 16 16 16 19 19 19 21 20 20 20 20 19 19 19 19 20 20 20 20 20 20 20 20 20 20 18 19 20 21 14

Deaths (Percentage)

Percentage

MS

1 3 10 13 13 14 16 17 18 17 16 17 15 16 14 13 13 13 15 12 16 14 15 17 16 17 15 17 17 13

Source: Aggregate data from TESSy. MS: Member State

Country Reports:

EU: Russia, Ukraine, Czech Republic and Spain reported a new high in new infection the last 24h.

SVK: tested two thirds of its 5.5 million inhabitants for the coronavirus in just two days. More than 38,000 people tested positive and now have to go into quarantine.

According to the balance sheet presented by the government in Bratislava, more than 3.6 million people took part in the action on Saturday and Sunday. All residents over ten years old who did not have a valid test from another location were called upon to do so. Participation was formally voluntary. But anyone who cannot possess a negative test is now subject to a strict curfew and is not allowed to go to work.

There is now growing resistance among experts and local administrations to a second test round planned for next weekend. Even before the start of the test, the Medical Association had criticized the action, led by the Ministry of Defense, as a waste of already scarce resources. Municipalities complained that they had been pushed into "the largest logistical operation in the history of Slovakia" without sufficient information and preparation time.

DEU: A four-week partial lockdown has begun across Germany in order to slow down the spread of the corona virus. From this Monday on, the corresponding ordinances are in force in all federal states. Nationwide, restaurants, culture and leisure facilities have to close as far as possible.

The corona slump in the economy is expected to reduce energy consumption in Germany by almost seven percent this year. This is the [result of an estimate by the Working Group on Energy Balances](#). Because the use of renewable energies has continued to increase at the same time, energy-related carbon dioxide emissions could even fall by ten percent in 2020. Should the course of the corona pandemic force further measures, a greater decline in energy consumption and CO2 emissions can be expected.

The director of intensive care medicine at the Hamburg University Hospital Eppendorf (UKE) reports that more and more young corona patients are in the intensive care unit. Unlike the first wave of the virus spread in spring, this time many young people are affected. The patients are well under 50 years of age and some of them have no previous illnesses.

CHE: reported 21,926 new positive tests for the weekend. With an average of 7309 per day, the number is less than in the days before. For fear of overloading the intensive care units, the government in Bern recently issued new restrictions on public life. With regard to the new positive tests, Switzerland is one of the worst affected countries in Europe.

AUT: Without a trend reversal in new corona infections, Austria is heading towards an early overload of the health system. A critical situation would then be expected in the second half of November. Within a week, the number of intensive care beds occupied by COVID-19 patients rose by 78 percent. It is therefore necessary that the population strictly adhere to the new measures in the partial lockdown.

FRA: The alleged knife attacker from Nice has tested positive for the novel corona virus. As a result, the questioning of the 21-year-old Tunisian could be delayed by several days, according to the French investigators.

GBR: In Liverpool in the north of England, the region of the country hardest hit by corona, masses of citizens are to be tested for the corona virus with voluntary rapid tests from next Friday. The aim is to discover more infected people and break the chains of infection.

HUN: Hungary reports a new record with 3989 new corona infections within one day. The daily death toll has also risen to a record high of 84, the government said.

ESP: The number of international tourists fell by 87 percent in September compared to the previous year, according to official data from the national statistics institute INE. In the first nine months of the year, around 16.8 million foreign tourists visited Spain, around 75 percent fewer than in the same period in 2019, the INE said.

BEL: The French government wants to impose another curfew on Paris and possibly also the greater Paris Île-de-France area in order to combat the country's rapidly increasing numbers of infections.

POR: The Portuguese government wants to impose a nationwide health emergency in order to be able to order further restrictions in the corona crisis. Only the President can declare a state of emergency after consulting Parliament. From Wednesday, over 120 of the more than 300 municipalities in Portugal will have a partial lockdown.

SWE: After a rapid increase in corona infections, the government announced stricter measures in three other regions of the country. For example, private parties in restaurants are limited to eight people. Sweden registers 10,177 new corona cases and 31 new deaths. Overall, the number of deaths related to Corona rises to 5,969. The Swedish mortality rate per capita is thus many times higher than that of its Nordic neighbors.

Subject in Focus

The power of the small number showed by the example of Germany

Germany is going into partial lockdown, nevertheless the intensive care units will continue to fill, and more people will die of the corona virus. However, the tough measures could just prevent a collapse of the health system.

As many other European countries Germany has pulled the emergency brake. The federal government saw no other way out than to restrict public life as far as possible, e.g. private contacts are reduced to a minimum. These measures were used to master the recently uncontrolled increase in the number of reported new corona infections.

The declared goal is to reduce the number of new infections every day to a level at which the health authorities, which are currently hopelessly overwhelmed in many places, can make their contribution to fighting the pandemic again, as during the summer.

In all countries that have chosen this path, the temporary lockdown is intended to break the wave before it rolls over their heads.

In Germany, this may seem exaggerated given the few COVID-19 deaths and the intensive care units that are not yet overloaded in most regions. But when you look abroad, it becomes clear what impact even small numbers can have in a phase of exponential growth.

France

The situation is already more dramatic than in spring: Despite the strict lockdown regulations, the health authorities are overloaded with the number of new infections. Three quarters of the contact follow-ups by the French authorities end up nowhere, and the evaluation of tests sometimes takes weeks.

Belgium

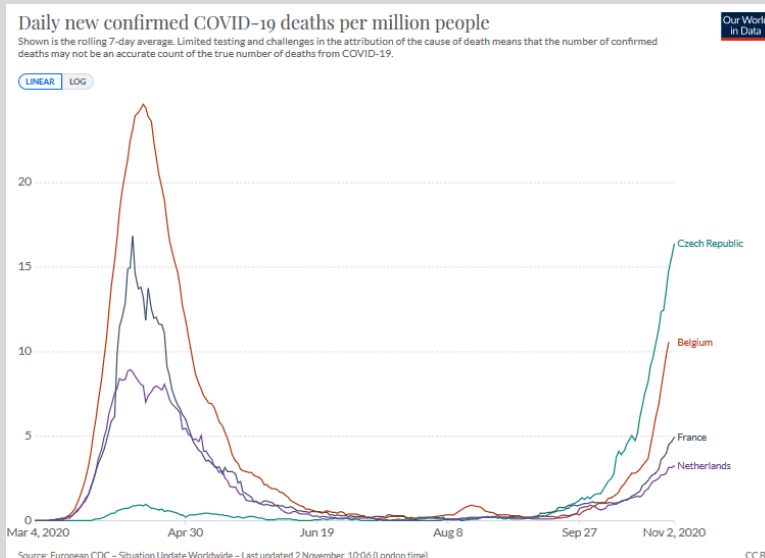
Experts estimate that hospitals in nine out of ten provinces will be completely overloaded by mid-November. In Liège, despite positive COVID-19 findings, according to labour unions, more than 100 infected nurses are on duty and take care of infected patients. Sufficiently healthy nursing staff is no longer available here.

Czech Republic

Many hospitals only admit patients who need intensive care, as thousands of nurses are infected and are therefore unable to work. At the same time, the country is wooing doctors willing to return. It can be assumed that the development will intensify further. The positive rate of the corona tests is 33 percent on a few days.

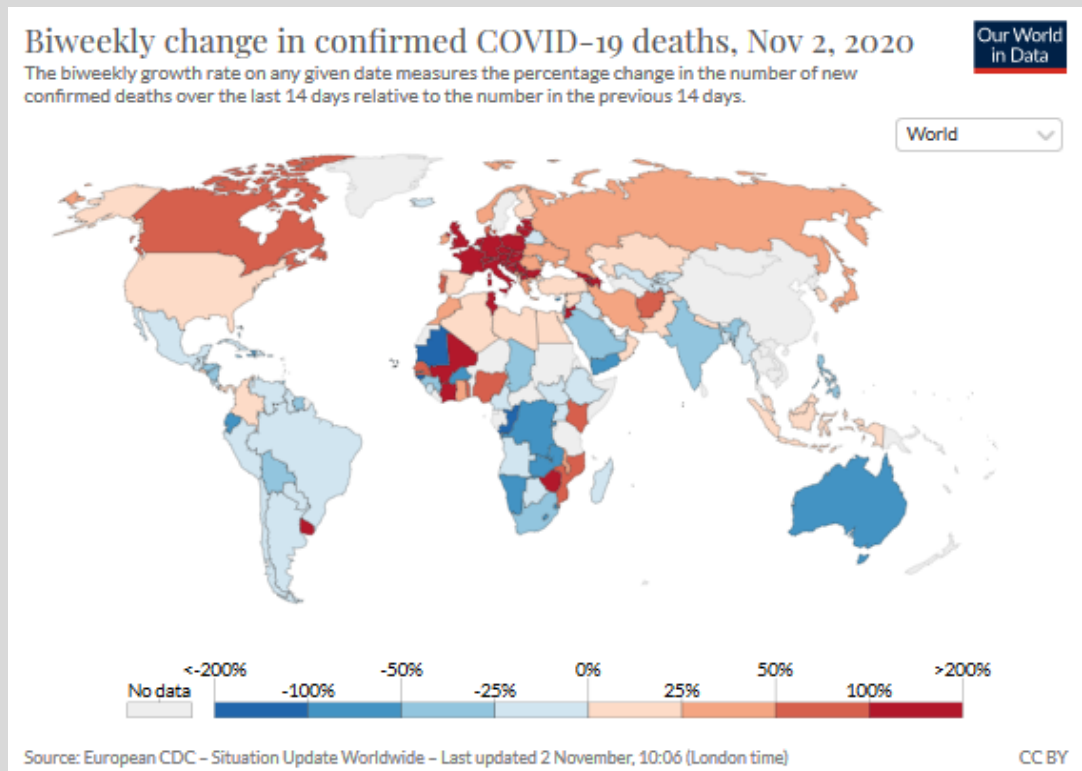
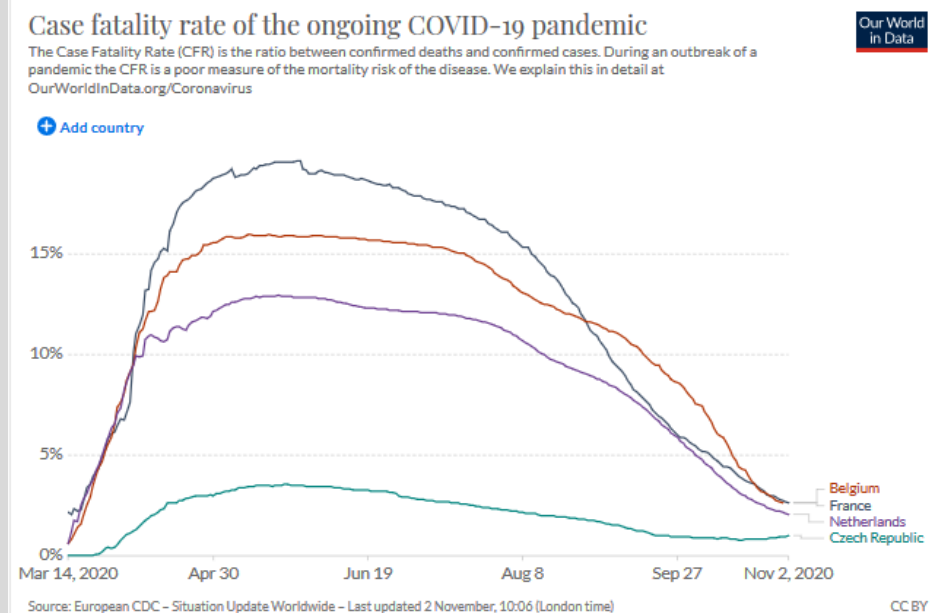
The Netherlands

Every second bed in intensive care units with corona patients is currently occupied. Some hospitals are so overloaded that the first patients have already been transferred to Germany. It is currently still possible for German hospitals to help neighbouring countries - for a while.



On positive fact is, that in most countries (beside of the Czech Republic), the death rate of COVID-19 patients is significantly lower now than in spring. A fact that needs to be preserved. Keeping ICU's capacities available, at least for the time being.

Case fatality rate is also still lower as in the beginning of the outbreak in most countries.



The map above is looking at the biweekly death change, which is less affected by the daily variation in reporting and is thereby providing a clearer picture of where the pandemic is accelerating, staying the same, or reducing.

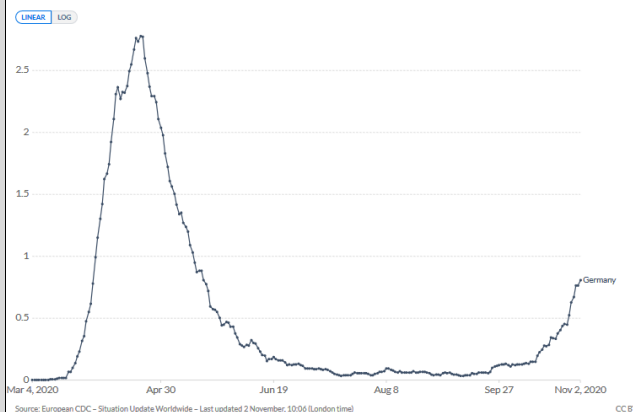
It shows the growth rate over this period: **blue** marks those countries in which the death count in the last two weeks was lower than in the two weeks before, whereas **red** identifies countries where the death count has increased.

Taking that in account we can see that death rates are increasing over the last days all over Europe and measures to stop this dynamic are clearly needed.

That means even though we are recording significantly fewer deaths than in spring currently, the forecasts show that if the dynamic remains the same, the numbers could well exceed those of the first wave.

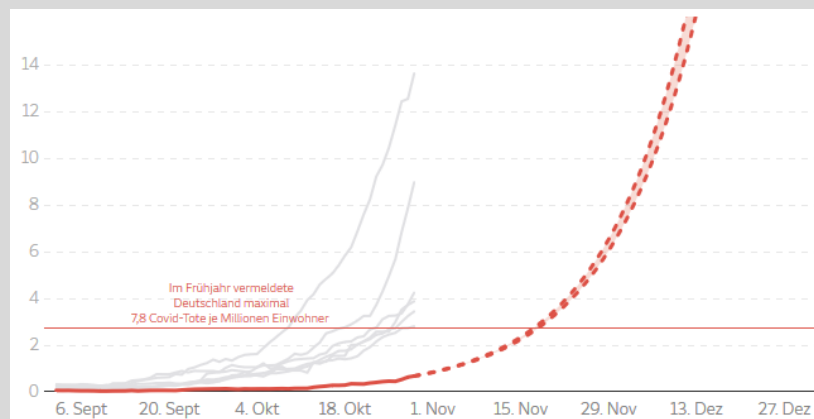
Daily new confirmed COVID-19 deaths per million people

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.



In Germany, the same development as in the other European countries can be observed - only delayed by a few weeks. Most recently, the Robert Koch Institute (RKI), the German agency for disease control and prevention reported an average of significantly more than 50 deceased infected with the coronavirus per day. In terms of population, the current situation is roughly comparable to the situation in France and the Czech Republic about six weeks ago and Belgium and the Netherlands a good four weeks ago. Without countermeasures, the loss of control would soon have been programmed in Germany as well.

Even with the recent measures, however, it must be expected that the number of deaths will continue to rise. Compared to a few weeks ago, the number of deaths has now increased sevenfold. Should deaths continue to increase in the same pace as before and double about every 11 and a half days (which is an optimistic assumption), the number of daily deaths can be expected to rise to a similar level as in spring by the end of November. At that time, more than 200 COVID patients died every day. Should the health authorities have increasing difficulties in containing the spread, and should more vulnerable population groups become infected, the number of deaths could rise even faster and higher. The new infections are already growing at a faster pace, currently about every nine days there is a doubling.

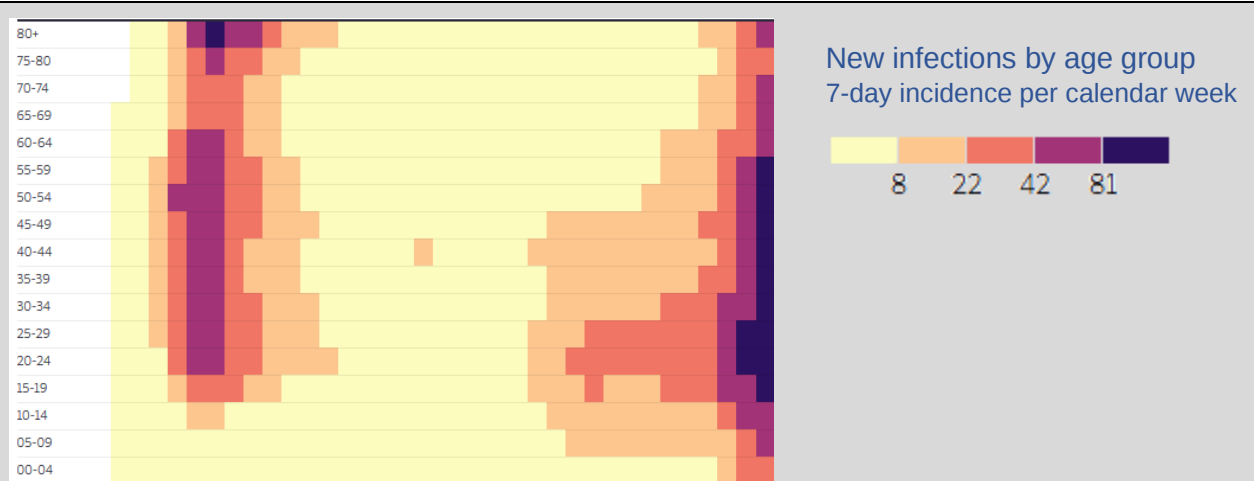


The chart on the left shows the prognosis of deaths in Germany per 1 million inhabitants for two scenarios:
upper line: infections grow as the latest numbers suggest (doubling every nine days)
lower line: infections double every eleven and a half days, as before.

A new model from the [Max Planck Institute for Dynamics and Self-Organization](#) shows that if the number of new infections exceeds the limits of the health

authorities, the pandemic will accelerate on its own. That would lead to an implementation of more radical measures and massive contact reduction - or the number of new infections will rise rapidly. This can already be observed in numerous regions in Germany and Europe. This is a clear sign that the health authorities have already lost control in many places. From this it would inevitably follow that the virus is unwittingly carried to the elderly and persons at risk, as infected people do not know that they are infected due to the no longer traceable chains of infection.

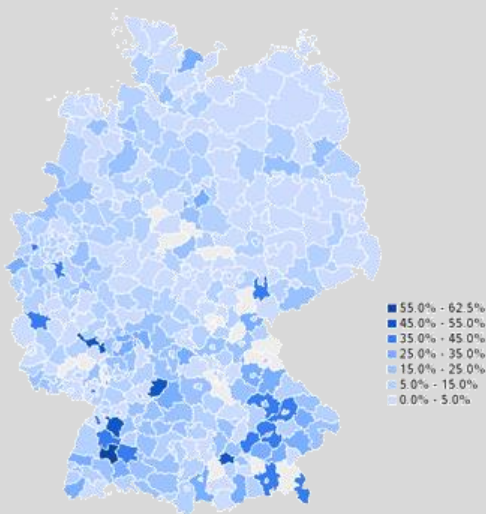
In fact, this increase in incidence has been observed in the upper age groups for a few weeks. This development suggests that the number of deaths will continue to rise significantly over the next few weeks. A rule of thumb says: Every 20 years of life, the risk of dying from COVID-19 increases tenfold. As an anchor point: Current numbers indicate that one in ten patients aged 82 and older dies.



The first such tipping point was already exceeded at the beginning of October. This can be seen well from the development of new infections. In September the number of cases rose within a week, usually by less than 20 percent, now it is significantly more than 70 percent.

There have been two developments that came together this early in October. On the one hand, the number of corona hotspots increased, and in several counties the health authorities were overwhelmed with contact tracing. In addition, there was a cold snap at the end of September, which, taking into account the time delay between infection and reporting to the Robert Koch Institute, corresponds exactly with the accelerated infection process. The cooler temperatures are likely to have resulted in people staying indoors more often. Since the risk of infection is much higher there than outside, the number of contacts doesn't even have to have changed to explain the sudden increase.

In some regions, intensive care units could soon be full



The rapidly increasing number of new infections will also affect the utilization of the intensive care units. Even if the situation there is not yet as critical as it is in many other European countries, experts are already advising German hospitals to switch to corona emergency operation mode, in the view of increasing corona numbers.

The treatment capacity however is monitored on a daily basis; according to the [Divi intensive care register](#), more than 7,500 beds are still available. The map on the left shows the occupancy of the districts with intensive care patients. The darker the color, the higher the occupancy.

The central problem in intensive care units at the moment, however, is not the overload or the availability of beds or ventilators - but the availability of nursing staff. Even before the pandemic began, there was a lack of specialized staff for up to 30 percent of the intensive care beds. Hospitals

are postponing interventions that are already planned but are not urgently required in order to have capacities ready for the care of corona patients.

According to Divi, the intensive care register only includes "beds that are ready for operation" - that is, those that are "available with doctors, nurses, protective clothing and medication". Whether or not a bed is reported as "care-able" depends on the definition of the senior physicians on duty - and thus of the individual hospitals. Just today Divi announced, that the information provided by the clinics on the number of usable intensive care beds is apparently not always correct. Indications and random tests showed that beds for which no nursing staff is available were sometimes reported as ready to use.

In winter, due to the flu wave, there are staff shortages in German hospitals every year. Corona patients not only require intensive care due to the special hygiene measures; they also need specially qualified nursing staff. Although staff from other stations has received additional training

on how to use ventilators since spring, these nurses can still only take on 30 to 40 percent of the tasks in intensive care, the rest of the activities are too specialized.

The situation in the hospitals can only be controlled if new infections do not continue to grow exponentially. How critical a continued growth in new infections would be for hospitals is particularly evident at the local level. The available intensive care beds could be occupied in a few weeks - in Berlin and Frankfurt for example that can be the case in ten days.

In some regions of Germany, it is about time to change the look at the on-going pandemic and to stop the spread of the virus by implementing stricter regulations. The earlier restrictions come, the shorter the time they have to remain in place to be effective. The lockdown might be the right measure at the right time.

Conclusion

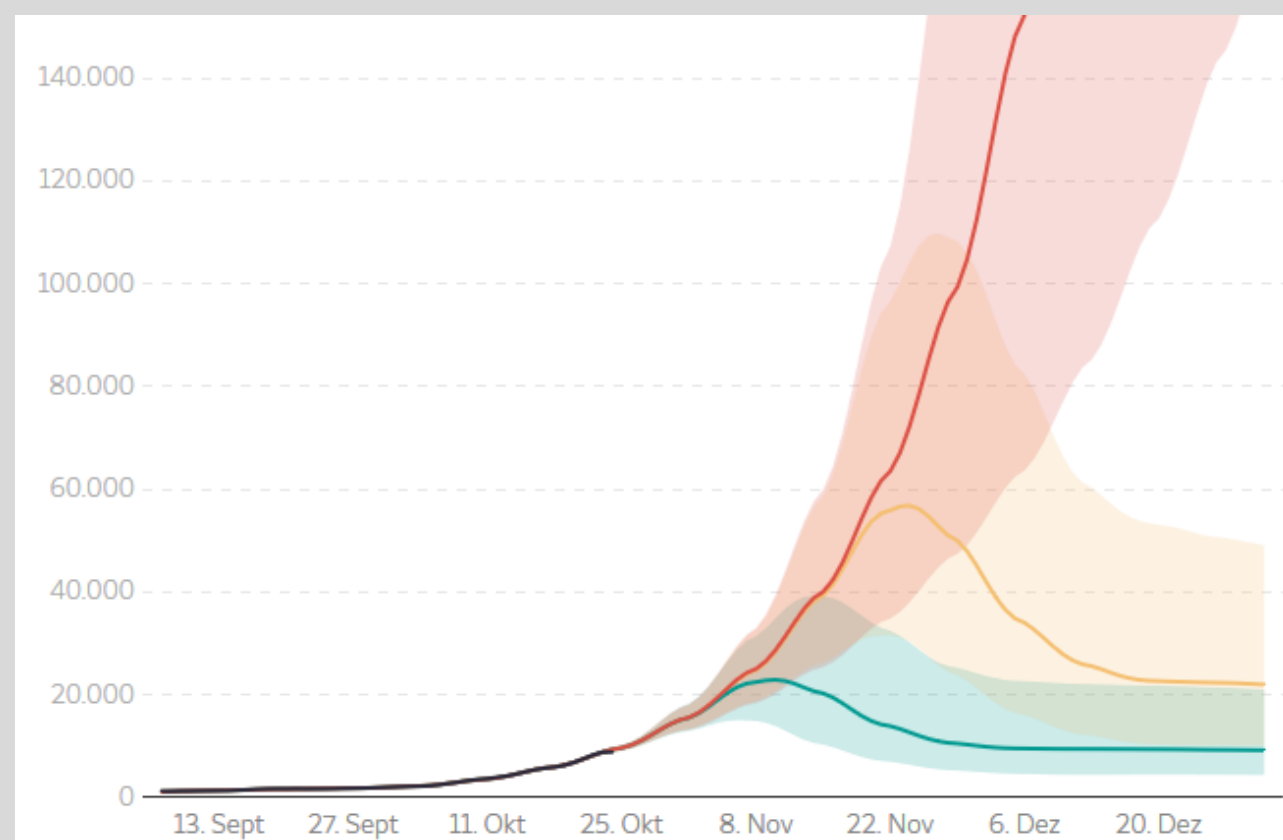
The aim of the tough contact restrictions is to stop and reverse the growth of new infections, i.e. to reduce the number of daily infections. The conditions must remain in force until the numbers have fallen below the threshold that allows health authorities to track and trace contacts. Otherwise the trend would reverse immediately after an easing and the next lockdown would be imminent. The longer infection curves are allowed to rise, the longer lock-down has to remain in place to reduce infections. And the more extensive the restrictions, the faster the numbers are likely to fall. At the same time all restrictions should be balanced with the harm they might cause to mental health and economic welfare for the society and the individuals.

Predicted new infections with and without lockdown

Epidemiologists have calculated how the current **curve of daily new infections** would continue in different scenarios:

without lockdown, with a **three-week lockdown** from November 15th and, as now decided, with a **lockdown from November 1st**.

The areas of uncertainty are highlighted in color, data are smoothed using a 7-day mean



Sources:

- <https://www.sueddeutsche.de/wissen/covid-19-sars-cov-2-intensivbetten-todesfaelle-lockdown-welle-wellenbrecher-1.5100285>
- <https://coronavirus.jhu.edu/map.html>
- <https://ourworldindata.org/coronavirus/country/india?country=~FRA#confirmed-deaths>
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- <https://www.divi.de/register/tagesreport>

Conflict and Health

COVID-19 Crisis in Sri Lanka



In cooperation with Bundeswehr HQ of Military Medicine

SRI LANKA

Area: 65 610 km²

Population: 21,670,000

Capital: Sri Jayawardenepura Kotte

Age structure:

0-14 years: 23,75%

15-24 years: 14,6%

25-54 years: 41,46%

55-64 years: 10,22%

65 years and over: 9,98%



Source: [Indexmundi.com](https://www.indexmundi.com)

CONFLICT:

Sri Lanka is an island state in the Indian Ocean and is located east of the southern tip of the Indian subcontinent. Sri Lanka (LKA) is a strategically important hub for seafaring between East Africa, the Middle East and Southeast Asia. The country is known for its culturally rich history and is still extremely multi-ethnic and multi-religious. The dominant population group are the Buddhist Sinhalese, the northern and eastern part of the country is inhabited by a Tamil minority, the majority of whom are Hindus. There is also the Muslim minority of the Moors and, among all population groups, minorities of the Christian faith. Due to the favorable location, a high culture emerged on Sri Lanka, which maintained trade relations with China via the Silk Road and with the Roman Empire. The country lost its independence as late as 1796 when the island, then called Ceylon, was incorporated into the British colonial empire. It was only during this period that the potential for ethnic conflict between Tamils and Sinhalese developed, which later led to a bloody civil war.

In 1948 Sri Lanka became an independent state again and has developed a stable, democratic system. However, the tensions between the Sinhala majority and the Tamil minority became more and more apparent, which was intensified by minority discrimination, youth unemployment and Marxist-motivated revolutionary efforts from parts of the Tamils. After several Tamil parties were declared enemies of the state because of their efforts to separate, open civil war broke out in 1983 between the United National Party (UNP)-led government and the Liberation Tigers of Tamil Eelam (LTTE) militia. The conflict was marked on all sides by human rights violations of the worst kind and asymmetrical warfare against civilians. Attempts by the international community to mediate between the two parties failed several times. The war was ended after more than 25 years, when government troops took the last areas controlled by the LTTE as part of a major offensive in 2009; this last battle again claimed the lives of tens of thousands of civilians. Since then, there has been a fragile peace in the country, which is, however, due more to the collective repression than to real reappraisal of the conflict. Since the election of a former lieutenant colonel as president, the government is increasingly shaped by the military.

HEALTH:

Compared to other developing countries, Sri Lanka has an above-average health system. Life expectancy, maternal and child mortality have steadily improved in the last few decades; at least in theory, all citizens have access to partly free health care. On the one hand, infectious and tropical diseases are still widespread, on the other hand, resources have to be better distributed, since malnutrition is still a problem for children in rural regions. In the cities and better-off sections of the population, however, an increase in lifestyle-based diseases such as diabetes, cardiovascular diseases and cancer can already be observed. As a result of the long and never resolved civil war, a disproportionately high proportion of the population suffers from psychiatric, psychosomatic and post-traumatic health disorders. Medical care by doctors and hospitals in Sri Lanka is above average but does not reach the average level that is achieved, for example, within the EU. There are 3.6 hospital beds available for every 1,000 inhabitants in the country. The global mean here is 2.7 beds. Within the EU there are 5.6 beds for every 1,000 inhabitants. With around 20,900 trained doctors in Sri Lanka, around 0.96 doctors are available for every 1,000 inhabitants. In comparison: worldwide this standard is 1.50 doctors per 1,000 inhabitants and in the EU it reaches 3.57.

Because of this, the mortality due to major known diseases can only be reduced in comparatively few cases. Currently, around 17 percent of all people who suffer from cancer, diabetes, cardiovascular disease or chylomicron retention disease (CRD) die.

Current SARS-CoV-2 / COVID-19 outbreak:

- 11,335 confirmed infections, 21 deaths
- Implementation of a strict lockdown on March 22nd; extensive school closings, hesitant easing only under strict hygiene and social distancing requirements; state price regulation for protective equipment and face masks
- Temperature screenings of air travelers with subsequent quarantine as early as January

After Sri Lanka had managed keeping the number of infections low, the number of new cases grew exponentially since early October. Approximately three quarters of all positive cases were reported within the last four weeks. Two large clusters with several thousand cases each led to a massive growth in newly reported cases. Due to high usage the central PCR-testing machine broke and numerous tests had to be held back until repair.

CONCLUSION:

Sri Lanka managed to contain the spread of COVID-19 within the country with exceptional speed. Unfortunately, this success was paid for by weakening the democracy and constitution. The elections for parliament initially planned for April were postponed and only held on 05th August after sound protests by the opposition. Many of the measures against COVID-19 were enforced by the military. The election resulted in a massive change in the political landscape in Sri Lanka. The former two-party system consisting of UNP and SLFP was replaced by a new two-party system with their SJB and SLPP as successors of the respective parties. The SLPP (the party of president Gotabaya Rajapaksa) won 145 of 225 seats in the parliament (64.4%) and missed the two-third minority (150 seats) which is necessary to change the constitution. Nevertheless at least four minor parties announced that they are planning to work closely with SLPP, which would likely allow the newly elected government to change the constitution. Observers of the election expected the SLPP to win but were surprised by the huge majority SLPP won. Critics raised concerns that the concentration of power in the hands of a single family will likely lead to the erosion of the independence of governmental institutions in Sri Lanka.

Especially the competences and rights of the provincial councils as parts of the regional self-administrations can be cut, which would hit the Tamil minority in particular.

The result of the election and the massive changes initiated thereby bear the risk of further cuts to democracy and constitution. COVID-19 and the exponential increase of cases within the last four weeks allow the government to consolidate and rectify its power.

Sri Lanka

33.9 Index Score

120/195



PREVENT



DETECT



RESPOND



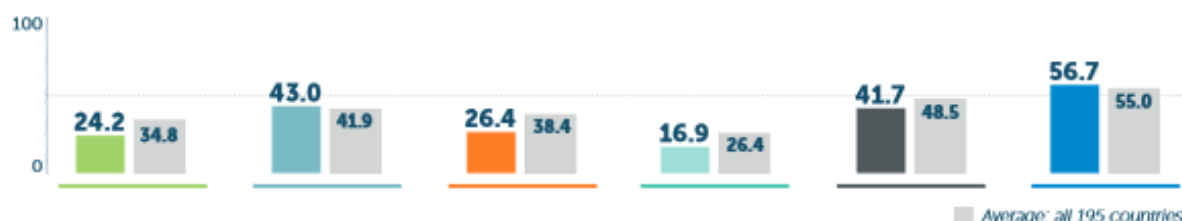
HEALTH



NORMS



RISK



	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	24.2	34.8
Antimicrobial resistance (AMR)	25	42.4
Zoonotic disease	0	27.1
Biosecurity	4	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	100	85.0
DETECTION AND REPORTING	43.0	41.9
Laboratory systems	83.3	54.4
Real-time surveillance and reporting	31.7	39.1
Epidemiology workforce	50	42.3
Data integration between human/animal/environmental health sectors	0	29.7
RAPID RESPONSE	26.4	38.4
Emergency preparedness and response planning	12.5	16.9
Exercising response plans	0	16.2
Emergency response operation	33.3	23.6
Linking public health and security authorities	0	22.6
Risk communication	0	39.4
Access to communications infrastructure	62.8	72.7
Trade and travel restrictions	100	97.4

*Average: all 195 countries

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

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	16.9	26.4
Health capacity in clinics, hospitals and community care centers	10.5	24.4
Medical countermeasures and personnel deployment	0	21.2
Healthcare access	48	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	41.7	48.5
IHR reporting compliance and disaster risk reduction	50	62.3
Cross-border agreements on public and animal health emergency response	0	54.4
International commitments	25	53.4
JEE and PVS	50	17.7
Financing	50	36.4
Commitment to sharing of genetic & biological data & specimens	66.7	68.1
RISK ENVIRONMENT	56.7	55.0
Political and security risks	57.1	60.4
Socio-economic resilience	60	66.1
Infrastructure adequacy	50	49.0
Environmental risks	65.3	52.9
Public health vulnerabilities	52.6	46.9

www.ghsindex.org

Source:

https://de.wikipedia.org/wiki/Sri_Lanka

<https://www.crisisgroup.org/asia/south-asia/sri-lanka/sri-lankas-other-covid-19-crisis-parliamentary-democracy-risk>

<https://www.economist.com/asia/2020/05/14/sri-lankas-new-president-is-putting-soldiers-in-charge-of-everything>

<https://reader.chathamhouse.org/chinese-investment-and-bri-sri-lanka?preview=1#>

<https://roar.media/english/life/in-the-know/sri-lankas-healthcare-system-everyone-everywhere/>

<https://reliefweb.int/report/sri-lanka/sri-lankan-officials-stoke-covid-19-communal-hate>

https://de.wikipedia.org/wiki/COVID-19-Pandemie_in_Sri_Lanka

<https://www.republicworld.com/world-news/rest-of-the-world-news/sri-lanka-key-pcr-machine-breaks-down-amid-a-surge-in-covid-19-cases.html>

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 • Civil – military cooperation in view of COVID-19
Civil – military cooperation in view of COVID-19	Briefer from DEU, BEL, ESP and CZE reported. The German Briefer give an overview about the evaluation of outbreak management as well as introduced the for the Model Munich as an way of civil-military cooperation in knowledge management & control. They designed a matrix based on the WHO framework for the Strategic preparedness and response plan. The Dashboard Munich-Knowledge management & control tool includes data for Epidemiology, Patient care, Laboratory/Testing, Risk communication, Execution and current Studies. The Briefer from Czech Republic talked about the COVID-19 Epidemic Countermeasures, the military medicine capabilities and capacities in CZE, the CZE MoD Support to civilian organisations and the potential to expand. ESP introduce the Balmis Operation, talked about the Armed Forces activities and about the Military medical role during Op. Balmis. The BEL Briefer talked about the development of courses of action, Procedures and protocols. Next VTC will be on Wednesday 4th of November with the topic "Immunity development versus reinfections of COVID-19".

Recommendations

Recommendation for international business travellers

As of 19th October 2020

Many countries have halted some or all international travel since the onset of the COVID-19 pandemic but now have re-open travel some already closed public-travel again. 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:

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.

On 13 October, EU Member States adopted a [Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic](#).

1. Common criteria

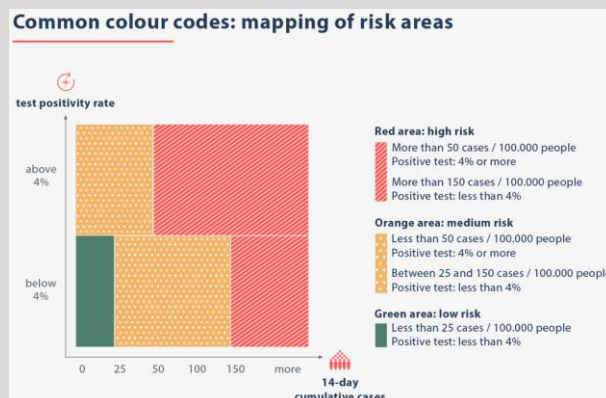
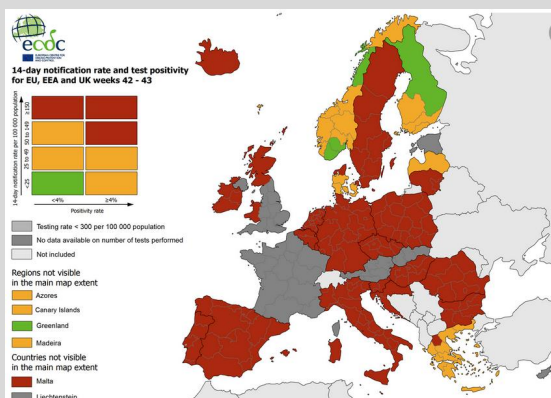
- **the notification rate** (the total number of newly notified COVID-19 cases per 100 000 population in *the last 14 days* at regional level)
- **the test positivity rate** (the percentage of positive tests among all tests for COVID-19 infection carried out during the last week)
- **the testing rate** (the number of tests for COVID-19 infection per 100 000 population carried out during the *last week*)

2. A common map

The ECDC will publish a map of EU Member States, broken down by regions, which will show the risk levels across the regions in Europe using a traffic light system. See also [“Situation in Europe”](#).

Areas are marked in the following colours:

- **green** if the 14-day notification rate is lower than 25 cases per 100 000 and the test positivity rate below 4%;
- **orange** if the 14-day notification rate is lower than 50 cases per 100 000 but the test positivity rate is 4% or higher or, if the 14-day notification rate is between 25 and 150 cases per 100 000 and the test positivity rate is below 4%;
- **red** if the 14-day notification rate is 50 cases per 100 000 or higher and the test positivity rate is 4% or higher or if the 14-day notification rate is higher than 150 cases per 100 000;
- **grey** if there is insufficient information or if the testing rate is lower than 300 cases per 100 000.



3. A common approach for travellers

Common framework for COVID-19 travel measures

Green areas



No restriction of free movement of persons should be applied

Orange and red areas



Measures should be proportionate and respect differences in the epidemiological situation of orange and red areas



In principle, entry should not be refused to travellers from orange/red areas but requirements could be applied



Possible requirements for travellers coming from orange/red areas: quarantine/ self-isolation, COVID-19 testing prior to/ after arrival



Measures should take into account the epidemiological situation in their own territory



Inform other affected EU countries 48 hours before applying measures



Travellers could be asked to submit passenger locator forms



Exceptions: no quarantine requirement for travellers with essential function or need while performing that function

4. Clear and timely information to the public about any restriction

As a general rule, information on new measures will be published 24 hours before they come into effect.

All information should also be made available on [Re-open EU](#), which should contain a cross-reference to the map published regularly by the European Centre for Disease Prevention and Control.

More information about traveling in the EU by the European Commission you will find here: https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic_en
<https://www.consilium.europa.eu/en/policies/coronavirus/covid-19-travel-and-transport/>

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 23rd of October 2020	ECDC assessment for EU/EEA, UK as of 23 October 2020: Under the current classification system, based on epidemiological indicators, the epidemiological situation in countries is classified as <i>stable</i>, <i>of concern</i> or of <i>serious concern</i>. The majority of countries in the European region are currently classified as experiencing an epidemiological situation of serious concern due to the increasing case notification rates and/or test positivity $\geq 3\%$ as well as the high notification rates in the older age groups and/or high mortality rates. Countries have implemented various non-pharmaceutical interventions, but these have not been sufficiently effective in controlling transmission due to several factors: - adherence to the measures was sub-optimal; - the measures were not implemented quickly enough; - or the measures were insufficient to reduce exposure. As a result, the epidemiological situation is now rapidly deteriorating in most countries. There are currently only six countries in the region that are classified as experiencing a <i>stable epidemiological situation</i>. - In countries where the epidemiological situation is stable: - the probability of infection for the population is generally low but the impact of infection still varies depending on the individuals affected; - the risk for the general population in these countries is low; - for vulnerable individuals, including the elderly and people with underlying medical conditions, the risk is moderate. Nevertheless, in these six countries, there is still ongoing transmission and the situation must be closely monitored. Based on the latest available data to ECDC, there are currently no countries categorised as having an epidemiological situation ‘<i>of concern</i>’. In countries where the epidemiological situation is of serious concern: - there is a high risk to the general population, - and for vulnerable individuals the COVID-19 epidemiological situation represents a very high risk. In these countries the continuously increasing trend in notification rates calls for strong public health action in order to prevent the imminent risk that health care systems will be overwhelmed, rendering them unable to provide safe, adequate care.

References:

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

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