Update 22 (2nd of June 2020)

Information about Infection disease
COVID-19 (novel coronavirus)

Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich
2nd of June 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

- 40 million health professionals sent a letter to the leaders of the G20 nations on 26 May, calling for a healthy and green recovery from COVID-19. The pandemic has given us a glimpse of what our world could look like if we took the bold steps that are needed to curb climate change and air pollution, the WHO said.
- **WHO:** Community pharmacists are key players in the COVID-19 response and should be aware of what steps to take if they suspect or see signs of COVID-19.The WHO Regional Office for Europe has published technical guidelines on practical ways in which health systems can better respond to COVID-19.
- **WHO** has published key planning recommendations for mass gatherings in the context of the current COVID-19 outbreak. The document provides guidance on containing risks of COVID-19 transmission associated with mass gathering events.
- **UN and WHO** have urged governments around the world to take the mental health consequences of the pandemic seriously and ensure widespread availability of mental health support.
- **WHO**: has warned of an increase in the number of deaths in the corona crisis due to the excessive use of antibiotics. The greatly increased administration of antibiotics would lead to increasing resistance of bacteria to these agents.
- **FHP Branch** started to organize a weekly VTC on “COVID-19 response” next VTC will take place on Wednesday,3rd of June focusing on **"Treatment of the mild symptomatic cases of COVID-19”**

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
6 237 716 confirmed cases 2 699 648 recovered 375 710 deaths
EU/EEA and the UK
2 115 774 confirmed cases **1 076 239** recovered **179 132** deaths
USA ↘ (new cases/day 20 240)
1 806 985 confirmed cases **458 008** recovered **104 995** deaths
Brazil → (new cases/day 21 663)
526 447 confirmed cases **211 080** recovered **29 937** deaths
Russia → (new cases/day 8 779)
414 328 confirmed cases **175 514** recovered **4 849** deaths
UK → (new cases/day 2 164)
276 332 confirmed cases **not reproted** recovered **39 045** deaths
Spain ↗ (new cases/day 605)
239 638 confirmed cases **150 376** recovered **27 127** deaths

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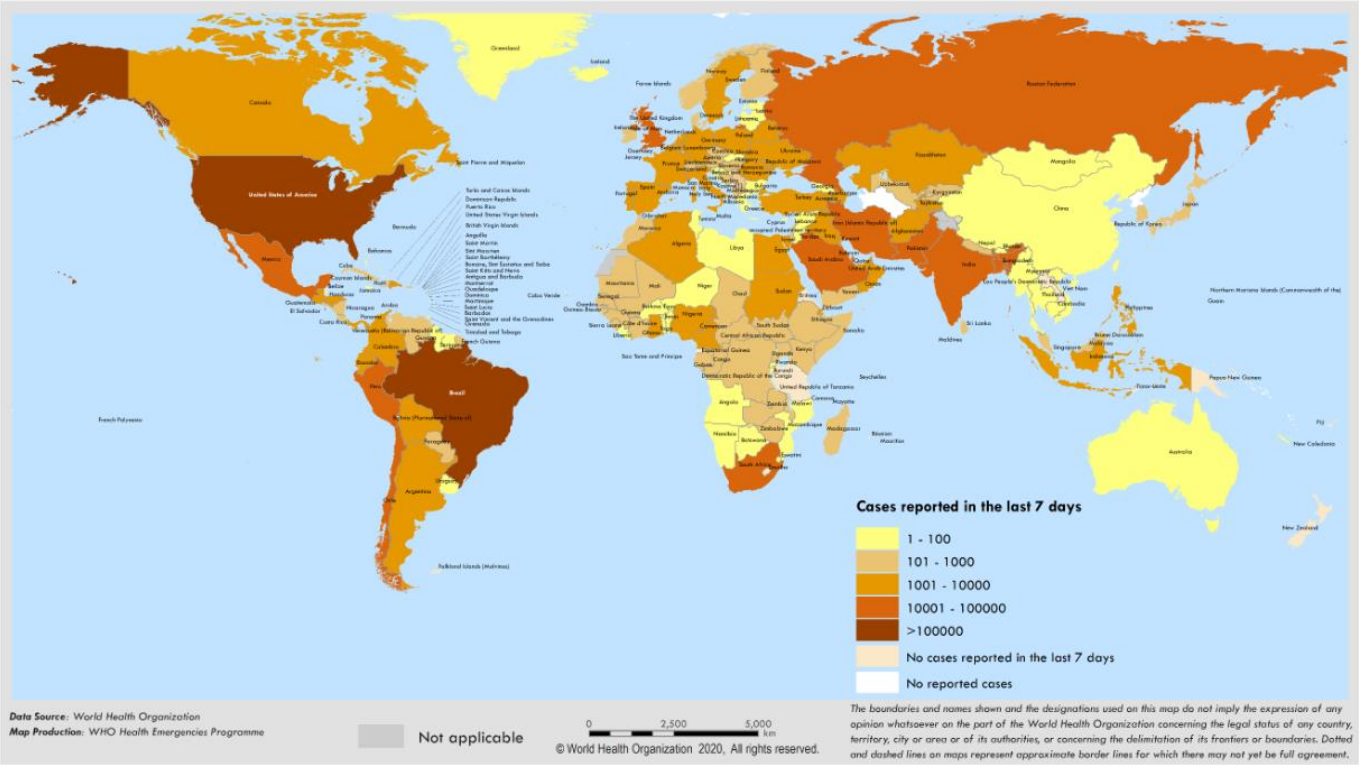
Map of countries with reported COVID-19 cases (last 7 days)



Worldwide Situation

Global Situation

WHO: Accelerating Research for the development of a Vaccine against COVID-19

Since the start of the pandemic, there has been an urgent need to accelerate the research and development of COVID-19 candidate vaccines. WHO has been supporting this effort under the umbrella of the Global Research Roadmap, the WHO Working Group for Vaccine Prioritization and R&D Blueprint team. Currently over 120 candidate vaccines have been mapped and sites in 40 countries have expressed an interest to join the Vaccine Solidarity Trial.

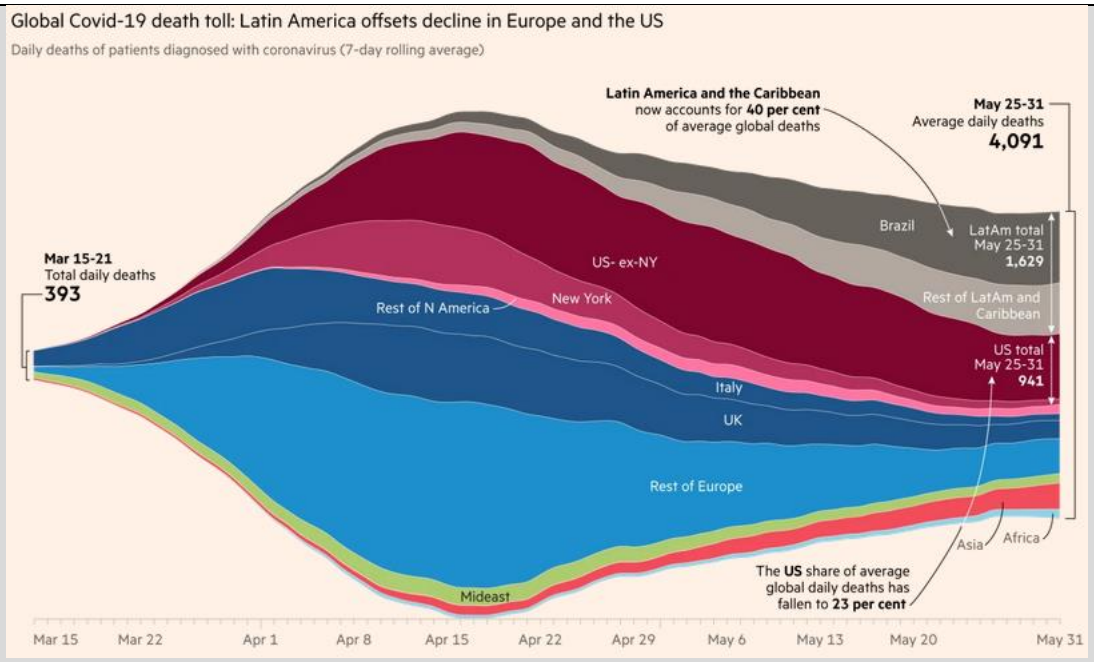
In the past three months, since the creation of the WG important progress has been achieved including:

- Continuously landscaping and mapping candidate vaccines and their progress across the world.
- Developing specific criteria that vaccine scientists, product developers, manufacturers, regulators and funding agencies can use for prioritization.
- Outlining the desired characteristics for safe and effective vaccines, published in the WHO Target Product Profiles (TPP) for COVID-19 vaccines.
- Developing a core protocol for a globally coordinated randomized controlled clinical trial for vaccines.
- Launching a call for expressions of interest from vaccine trial sites around the world using the core protocol, which will include several candidate COVID-19 vaccines that meet WHO prioritization criteria.
- Launching a call for interest in engaging on animal studies for vaccine evaluations with 17 laboratories in 8 countries with animal laboratory facilities.
- Establishing an Expert Group focusing on COVID-19 viruses, reagents and immune assays.
- Establishing an Expert Group focusing on COVID-19 disease modelling and animal models that would replicate human COVID-19 with the goal of accelerating testing of vaccines and therapeutics.
- Coordinating the Human Challenge Studies Working Group, tasked with consider the feasibility, utility, realistic timelines and approximate costs for establishing a closely monitored experimental challenge model of infection with SARS-CoV-2 in healthy adult volunteers.

Further information on WHO's work relating to vaccine research can be found on this webpage.

Countries in focus

The epicenter of the pandemic is shifting to **Latin America**. **Peru** reported a sharp increase in infections: despite initial restrictions that had been going on for weeks, the authorities registered 8,800 new cases within a day.
The number of infections already exceeded the one million mark. Half of Latin America's infections are in **Brazil**, which also has the fourth highest COVID-19 death rate in the world, with around 30,000 deaths. After the United States, Brazil is the country with the most corona infections worldwide. Since relatively little is tested in the largest country in Latin America, the actual number of infected people is likely to be much higher.
Meanwhile, the country is paralyzed by a dispute between right-wing populist President Jair Bolsonaro, several governors, and Congress. The head of state considers the lung disease COVID-19 to be "light flu" and rejects protective measures. He fears that a lockdown could harm the country's economy. However, several states have imposed exit restrictions and shutdowns to slow the spread of the virus. On Sunday, clashes between supporters of Bolsonaro, opponents of the government and the police occurred in several cities in Brazil.



Source: Financial Times

IRAN: With almost 3000 new corona infections, Iran has registered the highest increase in two months. The number of infections has been rising almost continuously since May 2. Some Iranian officials and foreign experts believe the official government figures with a high estimated number of unreported cases.

CHN: As Chinese officials announced today the city of Wuhan has completed a sweeping push to test almost all its 11 million residents in the span of a few weeks. Officials said nearly 9.9 million people were tested during the drive, which began in mid-May. Children and those who had recently been tested were exempt. It revealed no new symptomatic infections and about 300 asymptomatic infections.

Hong Kong: The government extended restrictions on public gatherings and travelers' movements as the city recorded new local infections after more than two weeks with no such cases. A 14-day quarantine will remain in effect for arrivals from mainland China, Macau and Taiwan until July 7, and for travelers from the rest of the world until September 18.

AFG: The supreme leader of the Afghan Taliban has contracted COVID-19 and has possibly died while receiving treatment, according to Taliban officials. The death is not officially verified until now. A senior official in the Afghan government said other Taliban leaders, including many in the movement's office in Doha, Qatar, were also ill with COVID-19. If COVID-19 sweeps through the Taliban leadership, infecting negotiators and commanders, the peace process will be hit by the uncertainty of how the pandemic will impact the uppermost echelons of the group. Source: https://foreignpolicy.com/2020/06/01/afghan-taliban-coronavirus-pandemic-akhunzada/

Situation in Europe	WHO Europe - Statement – Recovery must lead to a different economy, an economy of well-being

A brief overview of the current situation regarding COVID-19 across the 53 countries, and 900 million people living in the WHO European Region: As of last week, there have been over 2 million confirmed cases of COVID-19 across the Region, and tragically, over 175,000 people have died.
A less reported, but equally alarming figure is that since early March, more than 159,000 excess deaths, coinciding with the pandemic, have been reported from 24 European countries. These are deaths above and beyond what we would have expected normally at this time of the year.
Based on case information reported to WHO, 94% of all COVID-19 deaths were in persons aged 60 years and above, and 59% of all those who died were men. 97% of all deaths were among those with at least one underlying condition, according to information available, with cardiovascular disease the leading comorbidity.
Over the past 14 days cumulative cases in the European Region have increased 15% and the Region still accounts for 38% of cases and 50% of deaths globally.
The five European countries reporting the highest cumulative numbers of confirmed COVID-19 cases over the past 14 days are the Russian Federation, the United Kingdom, Turkey, Belarus, and Italy. Spain, Italy, the UK and France continue to account for 72% of all COVID-19 deaths in the Region.

48 countries across the WHO European Region are adjusting their public health and social measures. The most common measures that are eased first are the opening of non-essential businesses and relaxation of domestic movement restrictions.

Learning from the past, looking to the future, WHO-Europe has 3 messages:

- **Controlling the virus and economic recovery go hand-in-hand.**
  Europe is entering an economic recession. According to the EU's Spring Economic Forecast, "GDP is forecast to contract by about 7½ % this year, far deeper than during the global financial crisis in 2009, and to rebound by only 6% in 2021. This rebound, however, would leave the European economy, at the end of this forecast horizon, about 3% lower than the output level implied by the autumn forecast."
  The worst scenario is that countries responded to that crisis by cutting public spending on health. Those cuts prevented many people from accessing the health care they needed. Remember from former economic crisis, countries that took the path of cuts to health spending struggled to recover from the economic shock. Today, the priority must be to invest in health, invest in social protection and, above all, avoid austerity, which has devastated the lives of so many in Europe.
- **COVID-19 impacts all, but some more than others – we cannot afford to leave anyone behind.**
  The vulnerable people in society have become even more vulnerable as a result of COVID-19. Yet in recent weeks, many examples of actions by countries and communities to alleviate insecurity, reinforce the social fabric, and support health have been seen. COVID-19 has highlighted a fundamental truth: when one of us lacks health and care, we are all at risk. No one is safe until everyone is safe. We cannot afford to leave anyone behind.
- **We can build back better – a different economy that is more equal and inclusive.**
  May call it an economy of well-being and that means:
  - An economy that puts people in the centre.
  - An economy that provides a safety net for everyone and protects front line workers.
  - An economy that contributes to a green climate and environmental sustainability.
  - An economy where public health is seen as a driver of jobs in the health sector, particularly for young people and as a safeguard of economy, security and peace.

Beyond defeating the disease, the great test all countries will soon face is whether current feelings of common purpose will shape society after the crisis. As leaders learnt in the Great Depression, to demand collective sacrifice you must offer a social contract that benefits everyone. The leaders at that time did not wait for victory to plan for what would follow. We must mobilize the will from politicians and people alike to create a better society which is fair and safe for everyone. An economy where we leave no one behind.

Statement to the press by Dr Hans Henri P. Kluge, WHO Regional Director for Europe, 28 May 2020, Copenhagen, Denmark

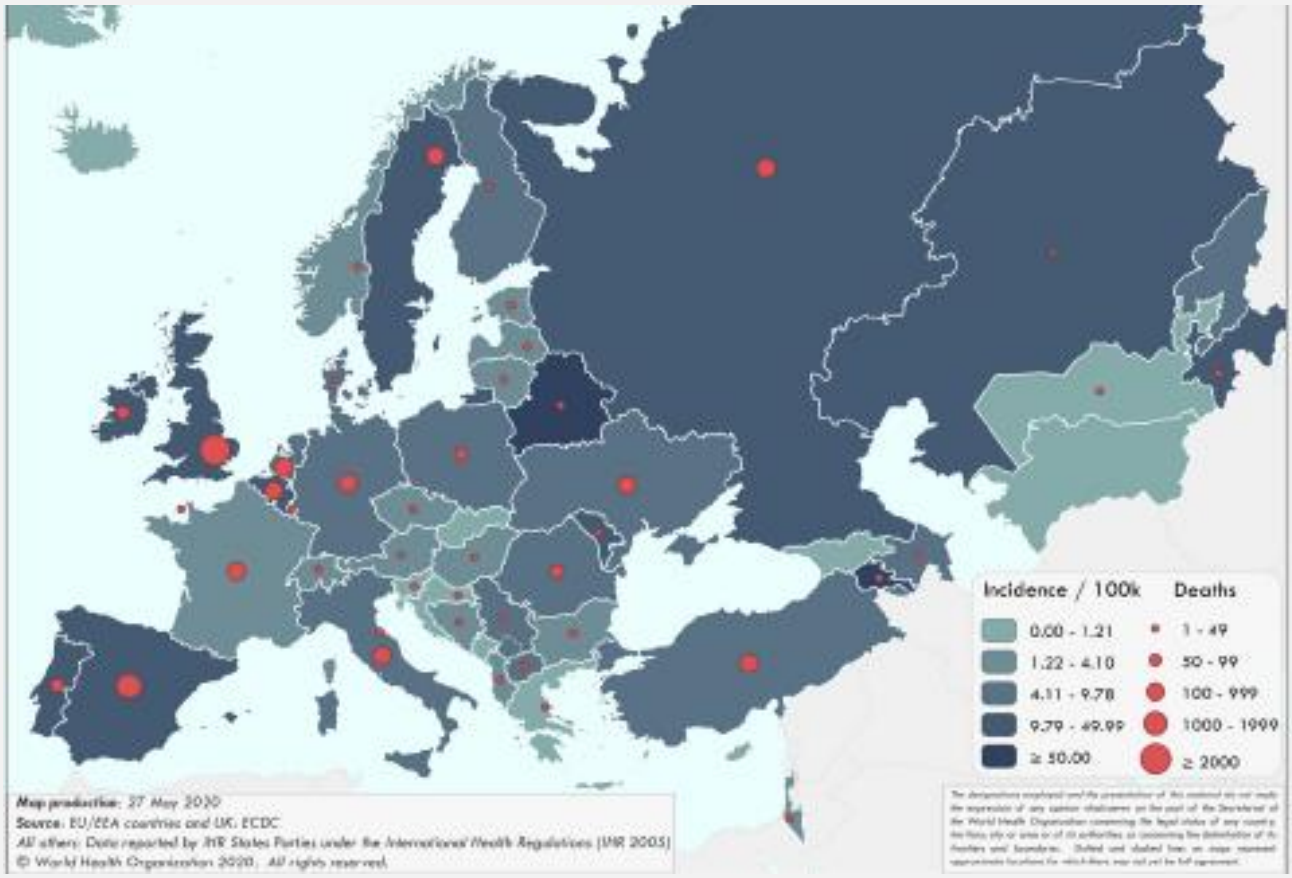
Countries in focus:

TUR: Istanbul and 14 other Turkish cities and provinces have been under a 48-hour curfew beginning last Friday. Since Sunday at midnight people are allowed to leave their homes again.
In addition, travel restrictions for the metropolis of Istanbul and 14 other provinces were lifted Sunday at midnight as well. The residents are now allowed to leave their region for the first time since the beginning of April. Previously, this was only possible with an exceptional permit. Since the first of June, numerous other corona restrictions are lifted: domestic flights are resumed, restaurants, cafes and sports facilities may reopen subject to conditions. The famous Grand Bazaar in Istanbul opens again for visitors. The start of international air traffic was last scheduled for June 10.

RUS: Since first of June RUS allows greater loosening of restrictions, despite increasing numbers of infections. After more than two months of strict curfews, people in Moscow are allowed to take walks on the streets for the first time on individual days. Sports are also allowed between 5 a.m. and 9 a.m. However, there is a tightened mask requirement: for the first time, mouth and nose protection must also be worn outdoors - so far only in public spaces and means of transport. For the first time, shopping centers and service providers such as dry cleaners and repair shops are opening in Moscow again. This will enable more than 300,000 people to return to work in the capital for the first time in months. Among others, hairdressers, restaurants, schools and cultural institutions remain closed.

ESP: Wants to lift the forced quarantine ordered by the Corona crisis for those arriving from abroad as of June 21. The borders will only be opened to tourists as announced on July 1st. This Monday the health ministry reported no COVID-19 deaths, this is the first time without recording overnight fatalities since March.

COVID-19 incidence per 100,000 population and number of deaths by country for week 21



COVID-19 situation update for the WHO European Region (18 May - 24 May 2020 Epi week 21)

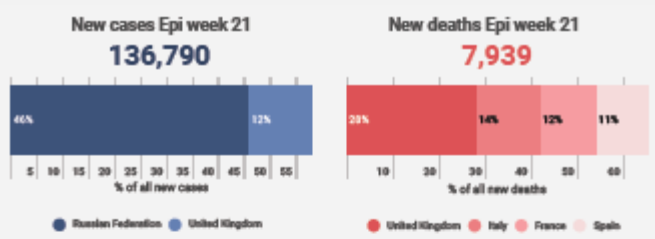
Key points

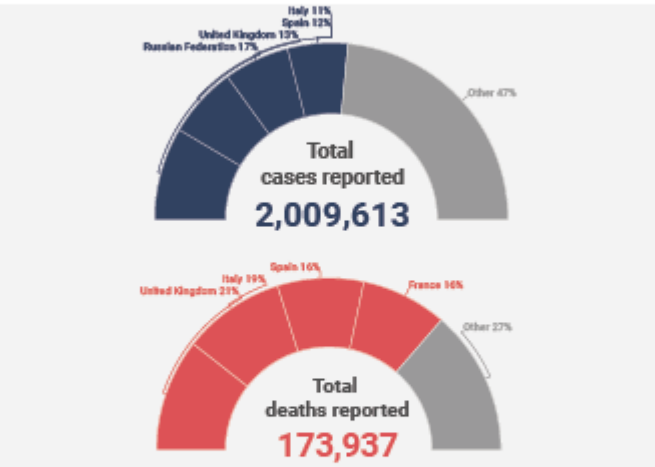
Week 21/2020 (18 - 24 May 2020)

- The number of cases reported in week 21/2020 in the Region has declined by 46% since week 14/2020
- 58% of the cases reported in week 21/2020 were from the Russian Federation and the United Kingdom
- Three countries had a crude incidence of ≥50 per 100,000 in week 21/2020: Armenia, Belarus and San Marino (Fig 2A)
- In 12 countries and territories, the 14-day cumulative incidence increased by ≥10% in week 21/2020 compared to the previous week. In order of percentage increase: Lithuania, Tajikistan, Malta, Armenia, Azerbaijan, Uzbekistan, the Republic of Moldova, Kazakhstan, Kyrgyzstan, North Macedonia, Ukraine and Kosovo. (see EURO-COVID-19 Dashboard for recent trends)
- 66% of the deaths reported in week 21/2020 were from the United Kingdom, Italy, France and Spain
- The proportion of reported cases that died decreased from 6.4% in week 20/2020 to 5.8% in week 21/2020, a change that is likely due to a range of factors

Summary overview

- Seven countries in the Region each reported a cumulative incidence of ≥400 cases per 100,000 population: San Marino, Andorra, Luxembourg, Iceland, Ireland, Spain and Belgium
- 20% of all reported infections with information available were in a health care worker
- 79% of all ICU admissions were in persons aged 50-79 years of age, with 70% of all ICU admissions in men
- 73% of cumulative deaths were reported from the United Kingdom, Italy, Spain and France
- 94% of all deaths were in persons aged ≥60 years and 58% of all deaths were in men
- 97% of all deaths with information available had at least one underlying condition, with cardiovascular disease the leading comorbidity (65%)
- From week 10/2020 and as of week 21/2020, there were more than 168,000 excess deaths reported from 24 countries/regions. Primarily in the age group ≥65 years with over 153,000 excess deaths, but also in the 15-64 years age group with over 14,000 excess deaths. This time period includes part of the influenza season as well as the start of the COVID-19 pandemic. See European Mortality Bulletin
- In week 21/2020, three countries reported a total of 68 tests and one COVID-19 detection in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 20/2020 was 6.2% (8 countries) compared to 4.3% (8 countries) in week 19/2020. The highest positivity was 18.6%, seen in week 15/2020 (Fig 5)
- As of 13 May 2020, two countries in the European region have an Effective Reproductive Number significantly over 1: Kazakhstan and Armenia. (See EpiForecasts and the CMMID COVID working group COVID-19 Global Summary for latest estimates)
- Since the emergence of COVID-19 virus in Europe at the end of February 2020, a wide range of public health and social measures (PHSM) have been implemented. See Figure 6 for a snapshot of the temporal relationship between case and death numbers and the introduction and easing of these measures in some countries in the Region. A levelling off and then decrease in the number of daily COVID-19 cases (A) has been observed approximately two weeks after implementing the measures. Daily deaths (B) appeared to begin to level off and then decrease three to four weeks after implementation of PHSM. A number of countries have recently started gradual easing of these measures. Continued vigilance is recommended as countries in the Region continue to ease these measures.





20% of all people infected were health care workers

97% of all deaths had at least 1 underlying condition

58% of all deaths were in men

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

94% of all deaths were in persons aged 60+

65% of all deaths had cardiovascular disease

Figure 3. Percentage of COVID-19 cases (N=775,004) and deaths (N=102,541) by age group

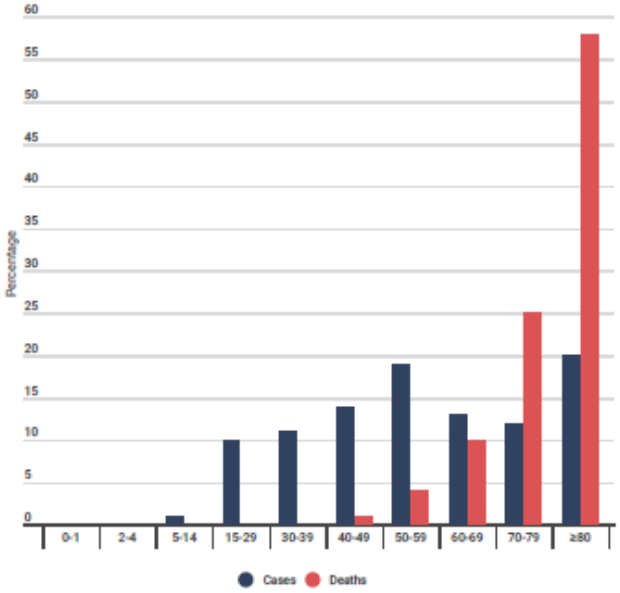


Table 1. Characteristics of COVID-19 cases and deaths

	Characteristics	n	%	Total records with data available
Cases	Age in years, median (range)*	55 (1-105)		528,509
	Sex, male*	244,434	46	525,849
	Travelled*	17,149	12	143,087
	Recovered*	187,575	90	208,876
	Health care workers‡	86,231	20	425,883
	Hospitalization*	129,524	26	504,633
	Intensive care unit admissions*	10,013	3	387,350
Deaths	Age in years, median (range)^	81 (0-108)		102,541
	Sex, male^	59,507	59	102,430
	At least one underlying condition^	28,590	97	29,529
	• cardiovascular disease	16,958	65	26,195
	• diabetes	8,458	33	25,293
	• lung disease	5,868	23	25,624
	• neurological disease / dementia	2,141	27	8,069
	• renal disease	1,446	20	7,279
	• malignancy	873	25	3,431
	• obesity	574	9	6,308
	• liver disease	347	5	7,215
	• immune disease	225	3	6,943
	• other	12,449	52	24,040

*Case report forms (n=630,353);
‡Case report forms and aggregated data from Italy (21/22 May) and Spain (21 May 2020) (n=813,173); Health care workers refer to occupation and not to the place of exposure
^Case report forms, mortality survey, aggregated data from Italy (21 May 2020) and Spain (21 May 2020) (n=102,556)

Percentage of COVID-19 cases (N=763,258), hospitalizations (N=126,177), ICU admissions (N=11,696) and deaths (N=93,401) by age group and sex

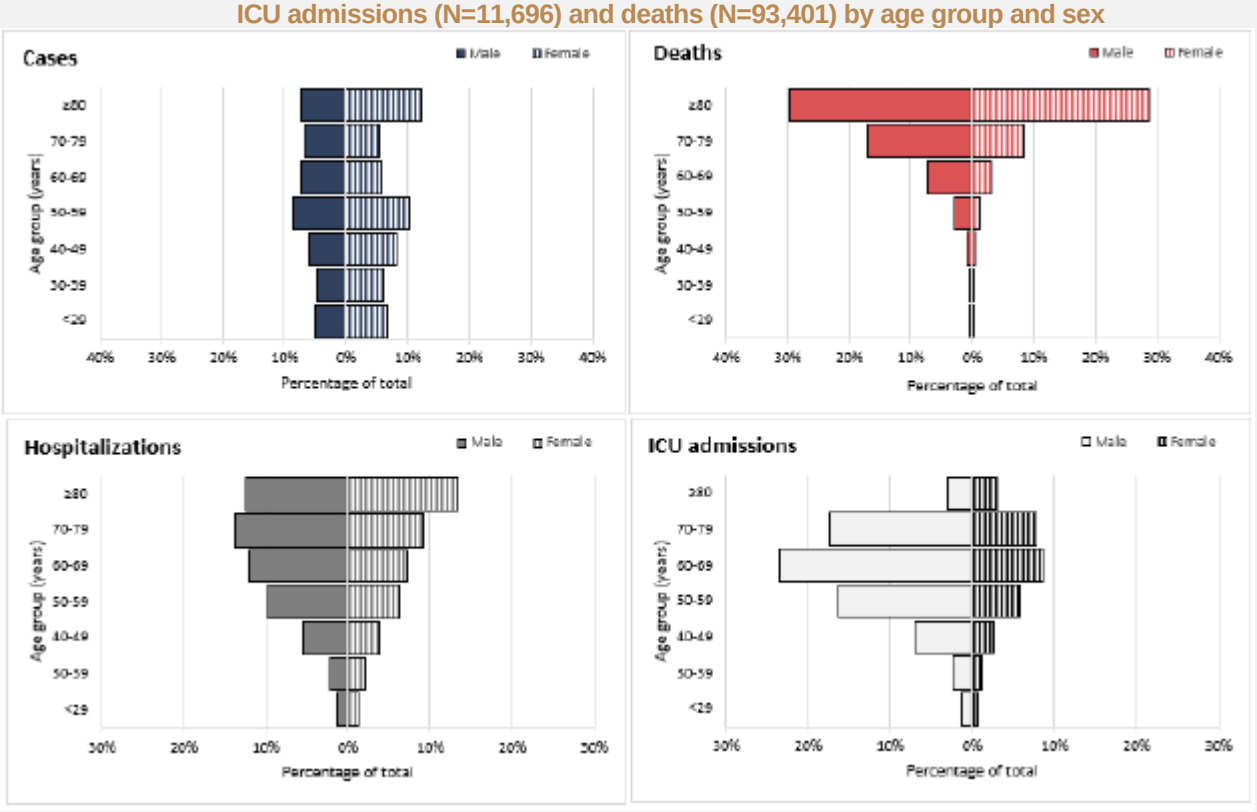


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Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week

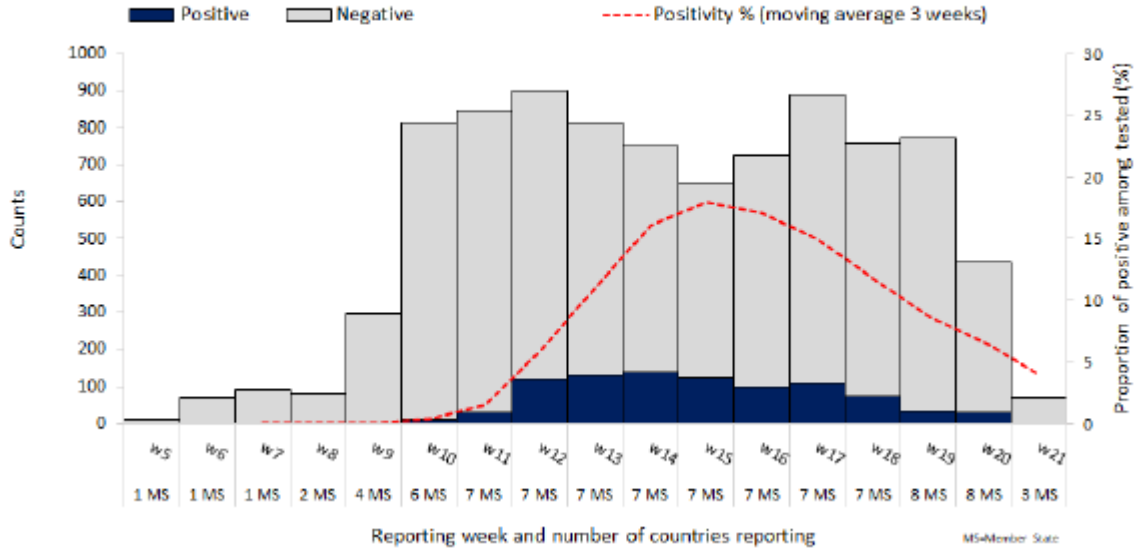


Figure 6A. Daily reported COVID-19 cases aligned by date of first Public Health and Social Measures (PHSM)

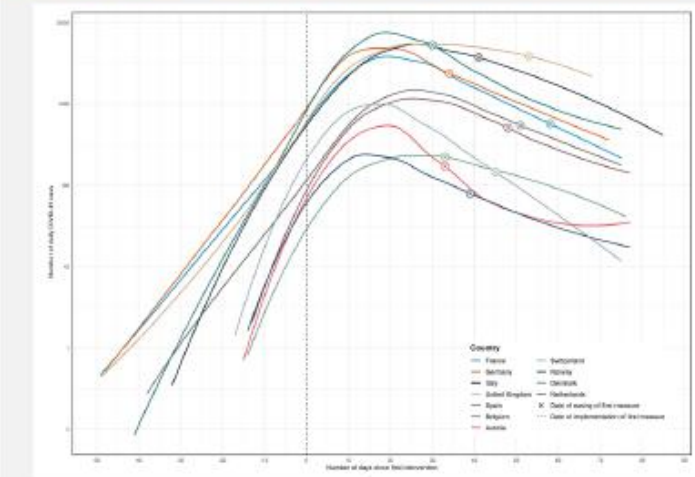
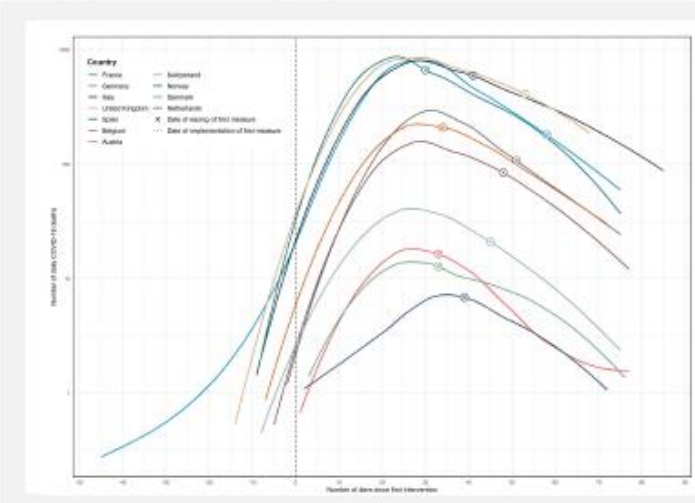


Figure 6B. Daily reported COVID-19 deaths aligned by date of first Public Health and Social Measures (PHSM)



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Subject in Focus

Smoking and COVID-19

Background:
The harms of tobacco use are well-established. Tobacco causes 8 million deaths every year from cardiovascular diseases, lung disorders, cancers, diabetes, and hypertension.Smoking tobacco is also a known risk factor for severe disease and death from many respiratory infections. In the COVID-19 pandemic, questions have been asked about clinical outcomes for smokers, and whether they are equally susceptible to infection, and if nicotine has any biological effect on the SAR-CoV-2 virus (the virus that causes COVID-19). At the time of writing, one clinical trial to test the effects of nicotine has been announced, but no trial registration record was found as of 12 May 2020.
This review therefore assesses the available peer-reviewed literature on the association between smoking and COVID-19, risk of infection by SARS-CoV-2; hospitalization with COVID-19; severity of COVID-19 outcomes amongst hospitalized patients such as admission into intensive care units (ICU), use of ventilators and death.

Methods:
A review was conducted on 12 May 2020 on smoking and COVID-19, using MEDLINE, EMBASE, Cochrane Library, and WHO Global Database. Quantitative primary research on adults or secondary analyses of such studies were included. Individual studies included in meta-analyses that were not otherwise identified in the search were sought. Due to the preliminary nature of the many non-peer-reviewed reports issued during the COVID-19 pandemic, preprint repositories were deliberately excluded from this review.

Review of the evidence:
Thirty-five peer-reviewed studies met the inclusion criteria. All included studies were in English. None examined tobacco use and the risk of infection or the risk of hospitalization.
A total of 27 observational studies and eight meta-analyses were identified. All observational studies reported the prevalence of smoking amongst hospitalized COVID-19 patients. Two meta-analyses reported pooled prevalence of smoking in hospitalized patients using a subset of these studies (between 6 and 13 studies).
Nineteen of the 27 observational studies containing data on smoking status by severity of COVID-19 outcomes.
Six meta-analyses were identified that examined the association between smoking and severity of COVID-19. Nine of the 19 studies were included in the six meta-analyses of smoking and severity (five to seven studies in each analysis), resulting in 1,604 sets of patient data being reported more than once. All data in the six meta-analyses come from patients in China.

What is the risk of smokers being infected by SARS-CoV-2?
There are currently no peer-reviewed studies that directly estimate the risk of hospitalization with COVID-19 among smokers. However, 27 observational studies found that smokers constituted 18.5% of hospitalized adults. Two meta-analyses have been published which pooled the prevalence of smokers in hospitalized patients across studies based in China. The meta-analysis by Emami et al. analysed data for 2986 patients and found a pooled prevalence of smoking of 7.6% (3.8% -12.4%) while Farsalinos et al. analysed data for 5960 hospitalized patients and found a pooled prevalence of 6.5% (1.4% - 12.6%).

What is the risk of severe COVID-19 disease and death amongst smokers?
Meta-analyses: Zhao et al. analysed data from 7 studies (1726 patients) and found a statistically significant association between smoking and severity of COVID-19 outcomes amongst patients (Odds Ratio (OR) 2.0 (95% CI 1.3 – 3.1). The statistical significance disappeared when the largest study by Guan et al. was removed from the analysis (a sensitivity test to see the impact of a single study on the Smoking and COVID-19:
Scientific brief -2- findings of the meta-analysis). An updated version of this meta-analysis which included an additional study remained significant when this same sensitivity test was applied however. Zheng et al. analysed data from 5 studies totalling 1980 patients and found a statistically significant association between smoking and COVID-19 severity when using a fixed effects model:

	OR: 2.0 (95% CI 1.3 – 3.2). Lippi et al. analysed data from 5 studies totalling 1399 patients and found a non-significant association between smoking and severity. Guo et al., however, later identified errors in the calculation and concluded that this association was indeed statistically significant (OR 2.2 (95% CI 1.3 – 3.7). Vardavas et al. analysed data from 5 studies totalling 1549 patients and calculated a relative risk that indicated a non-significant relationship between smoking and severity of COVID-19. However, the same authors found a statistically significant association between smoking status and primary endpoints of admission to Intensive Care Unit (ICU), ventilator use or death. **Individual studies not included in meta-analyses:** Ten studies were not included in any of the meta-analyses identified. One of these studies reported observational data for 7162 people in hospital and outpatient settings in the United States of America but did not include any statistical analysis of association. Another study of 323 hospitalized patients in Wuhan, China, reported a statistically significant association between smoking and severity of disease (OR 3.5 (95% CI 1.2 – 10.2). A third study reported on 8910 patients across 11 countries in Asia, Europe and North America and found a statistically significant association with death (OR of 1.8 (95% CI 1.3 – 2.5). Kozak et al. found a statistically significant association between smoking and ICU admission and mortality amongst 226 patients in Toronto, Canada. The remaining six studies were small case series (ranging from 11 to 145 people) that reported no statistically significant associations between smoking status and severity of COVID-1,8, apart from Yu et al. who reported on a study of 70 patients a statistically significant OR of 16.1 (95% CI 1.3 – 204.2) in a multivariate analysis examining the association between smoking and the exacerbation of pneumonia after treatment. **Limitations** Hospital based studies that report patient characteristics can suffer from several limitations, including poor data quality. Collecting smoking history is challenging in emergency contexts and severity of disease is often not clearly defined and is inconsistent across studies. Such studies are also prone to significant sampling bias. Characteristics of those who are hospitalized will differ by country and context depending on available resources, access to hospitals, clinical protocols and possibly other factors not considered in the studies. Further, most studies did not make statistical adjustments to account for age and other confounding factors. Well-designed population-based studies are needed to address questions about the risk of infection by SARS-CoV-2 and the risk of hospitalization with COVID-19. **Conclusions** At the time of this review, the available evidence suggests that smoking is associated with increased severity of disease and death in hospitalized COVID-19 patients. Although likely related to severity, there is no evidence to quantify the risk to smokers of hospitalization with COVID-19 or of infection by SARS-CoV-2 was found in the peer-reviewed literature. Population-based studies are needed to address these questions. https://www.who.int/publications-detail/smoking-and-covid-19

MilMed CoE VTC COVID-19 response

Topic	The NATO Centre of Excellence for Military Medicine is putting its expertise and manpower to aid in any way possible during the pandemic. The VTC is for interested participants (experts) to exchange experiences, management regulations and restrictions due to COVID-19. We would like to propose just one of the most important topics in the next iteration. We will have some experts giving a short briefing and then afterward we will have time for questions and experiences as well as a fruitful discussion. **Topics former VTCs:** • Regulations on the public, military and missions abroad. Medical Treatment Facilities: how equipped they are, is there pooling / isolation of COVID-19 patients in separate facilities. • Testing strategies • Aeromedical evacuation • De-escalation strategy and measures • Collateral damage of COVID-19 emphasing Mental Health Aspects and other non COVID related diseases • Immunity map, national strategies to measure and evaluate the immunity level" • Mental Health
Mental Health response	**Summary of the Briefings (USA, HUN, ITA)** Pandemic Picture: New stressors such as restrictions, relational strains, Limited amounts of options normally available to deflate. Some new trends are emerging(such as virtual funeral/graduations etc) to help people cope with the situation. Increased substance use is observed. A letter was written to President Trump to warn of a possible major MASCAL situation created by the current pandemic. As clinics and health care facilities are shut down or operate on reduces/limited capacity there are limited access to diagnostic and treatment possibilities for large groups of people. The clusters of these cases will act as extra stressors for the healthcare system later. **The emotional stressor of the essential/non-essential worker status:** There is a conflict as essential workers often overworked, and isolated, yet non-essential workers may experience self-worth-doubt and uncertain situation. Traumatization and re-traumatization of front-line workers is a major problem, as well as fatigue, anxiety, depression etc all stemming from the situation. The conflicting messages in the media and social media creates a sense of confusion, uncertainty around the pandemic. **PTSD:** 2019- 1,45 billion individuals experienced war in the past 25 years. 354 million of them suffers from PTSD. From the symptoms shame is one very debilitating. It can make a person shut down. Depression downward spiral towards feeling worthless. These factors can create a vicious cycle: inaccurate interpretation of the event, making it worse. Possible ways to cope go to the gym, meet some friend (if you can) seek help if available. Risk factors: mental issues can create a downward spiral, and it may end in suicide. Even if the bottom of this spiral is not self-harm it may cause a person to shut down and to quit functioning as they should. Protective factors: • Maintain physical fitness • Maintain normal sleep schedule • Take your time to maintain a healthy nutrition • Maintain social health- preserve the sense of belonging thru meaningful relationships • Maintain spiritual health- mindfulness, purpose, gratitude

SMART picture in the presentation:
Based on the SMART goal idea: a goal that is specific (strategic), measurable (motivating), achievable (attainable), realistic (relevant, reasonable), and time-bound (time-limited, time-sensitive).

Resources:
Make a list of available hotlines/helplines, doctors, counsellors, trusted friends/family, local groups, activities that bring you joy, music playlists that motivate and help you feel better, etc. What talents, skills, or abilities do you have that could help contribute to your success?
Current reality:
Use descriptive words. Define your internal experience. If you EXPERIENCE distress and anxiety when completing this, do not hesitate to contact a mental health provider.
Obstacles:
What prevents you from reaching your desired reality? One of the biggest hurdles is getting past your own self-defeating thoughts and limitations.
Desired Reality:
Where do you see yourself when you are at the top of your game? When you are at your optimal self? Who are you? What values, traits, talents do you have? What will you be able to accomplish?
Steps to Take:
What do you need to do to reach where you want to be?
Projected Date of Completion: When could this be achieved? When should it be achieved? Is there a difference?

HUN Military activities have changed during the pandemic.

- Taking part in law-enforcement
- Taking part in emergency construction efforts
- Helping out in the CIV area

There are a lot of conflicting and confusing information about the current structuration.
The lockdown can create new reasons to be frustrated. Also, if the soldier is away from the family the frustration can be more severe as the stay-at home family member or spouse can push their frustration on them.

Mental problems:
A major part of the normal healing process after a trauma is to know when the trauma ends, to have a sense of closure. In this current pandemic, one of the main factors is the uncertainty around the timeline.
Usual (health) services are harder to access. Wearing PPE can also cause mental distress: difficulty to recognise fellow co-workers and friends and feeling guilt over.
Challenges for mental health care providers: going online can be challenging, however, some patient groups (younger demographic mostly) liked it more.

Main problems they share:

- Isolation
- Changed workplace
- If infected and symptomatic: hypoxia (studies have shown that experiencing hypoxia can cause PTSD like symptoms)
- Case: COVID-19 related suicide: chronic back pain was severe. Surgery was scheduled but postponed due to COVID-19. The pain was unbearable and there was an uncertainty about when the situation will normalize enough to have the surgery. This led the man to take his own life instead of coping with the pain.

	In **ITA** the COVID fight is on since February. Currently psycho education is conducted. A research is conducted currently together with the University of Rome. The Aim is to investigate the Psychosocial resilience of MIL healthcare personnel. They are involved in many duties, even outside of their normal work. Medical personnel is the most affected. High level of resilience is needed from them. Psychological support is needed for the personnel. **Topic next VTC:** • Treatment of mild symptomatic patients of COVID-19

Conflict and Health

Conflict and Health

(Public) Health is a topic that is often neglected during times of conflicts and civil unrest. While military personnel regularly have access to medical supplies and a dedicated military health service, the public often suffers from a lack of supply with medical equipment and basic goods (e.g. clean water), low number of health-care professionals and an increased burden on the individuals' mental and physical wellbeing.

During conflicts an increased probability of the emergence of infectious diseases can be observed (e.g. in refugee-camps or in war zones with numerous unburied corpses). Given those circumstances public authorities are seldom capable of maintaining surveillance networks and enforcing mitigation and containment measures (e.g. contact tracing) which are key for preventing large-scale outbreaks within an already highly vulnerable and challenged population. If a disease like COVID-19 is introduced into such a population an uncontrolled spread and devastating consequences for the society are highly likely. In addition, in some conflict areas external/international help is either unwanted by the public (due to previous bad subjective experience or disinformation campaigns) or prohibited by local authorities/conflict parties. In certain conflicts the emergence of an infectious disease might also be used as a "natural" bioweapon by only protecting selected (ethnic/political) groups or not protecting the population of opponent's areas.
If countries want to help areas with on-going conflicts, they should keep in mind aspects like:

- Necessity and difficulty of maintaining **clear and transparent communication** (e.g. cultural/social barriers, distrust in existing governmental structures, disinformation campaigns orchestrated by conflict parties, the disease might be considered a less important problem compared to everyday risks within a warzone)
- Necessity of a **minimum stability** within the area to send civil personnel. A robust mission with mostly military personnel comes with additional difficulties and is usually not possible without major political consequences and planning. In addition, a military operation can negatively affect the publics willingness to accept foreign help.
- Allowing a virus to spread within war zones can on the one hand put an unbearable burden on already heavily challenged populations, on the other hand it can foil the plan of global containment of the pandemic if the virus is allowed to become **endemic** in the affected population due to possible **global re-infections**.

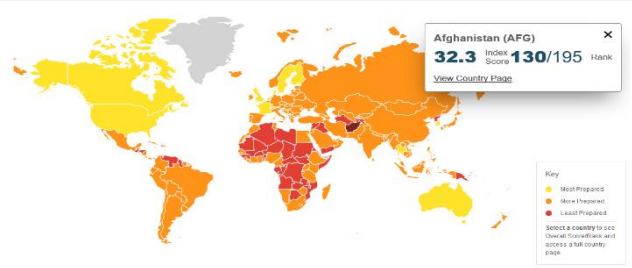
Country in Focus Afghanistan

AFGHANISTAN

DEMOGRAPHIC

AREA:	652.230 km^2
POPULATION:	33.225.560 (2019 est.)
CAPITAL:	Kabul (4.273.000)
RELIGION:	Islam (99.7%)
AGE STRUCTURE:	
	0-14 years: 40.92%
	15-24 years: 21.85%
	25-54 years: 30.68%
	55-64 years: 3.95%
	65 years and over: 2.61%

AS of today 15.750 COVID 19 conformen cases and 265 deaths were reported.



HISTORY

Afghanistan's history has been marked by centuries of strife, civil struggles, riots and tribal wars. In 1838, the British marched into Afghanistan and arrested the king currently in power. This led to the first Anglo-Afghan war. In 1878, the Second Anglo-Afghan War was fought over perceived Russian influence and Britain gained control of Afghanistan's foreign relations. After the Third Anglo-Afghan War and the signing of the Treaty of Rawalpindi on 19 August 1919, King Amanullah Khan declared Afghanistan a sovereign and fully independent state. He moved to end his country's traditional isolation by establishing diplomatic relations with the international community and, following a 1927–28 tour of Europe and Turkey, introduced several reforms intended to modernize his nation. Some of the reforms that were put in place, such as the abolition of the traditional burqa for women and the opening of several co-educational schools, quickly alienated many tribal and religious leaders, and this led to the Afghan Civil War (1928–1929). Prince Mohammed Nadir Shah, Amanullah in turn defeated and killed the insurgent's leader in October 1929 and was declared King. He abandoned the reforms of Amanullah Khan in favour of a more gradual approach to modernization but was assassinated in 1933. King Zahir Shah, the son of Nadir Shah, had a policy of maintaining national independence while pursuing gradual modernization, creating nationalist feeling, and improving relations with the United Kingdom. Close relations with the Muslim states Turkey, the Kingdom of Iraq and Iran were also pursued in 1934.

In April 1978, the People's Democratic Party of Afghanistan (PDPA) seized power in the Saur Revolution, a coup d'état against the President, and finally declared the establishment of the Democratic Republic of Afghanistan. The land redistribution policy and modernization of civil and marriage laws led to unrest which became an open revolt by October 1978. That uprising quickly expanded into a civil war waged by guerrilla mujahideen against regime forces countrywide. The Soviet Union sent thousands of military advisers to support the PDPA regime. The United States supported Afghan mujahideen fighters. The Soviet Union was displeased with Amin's government and decided to intervene and invade the country on 24 December 1979, killing Amin just 3 days later, when the Soviet Army entered Kabul. Faced with mounting international pressure and numerous casualties, the Soviets withdrew from Afghanistan in 1989, but continued to support Afghan President Mohammad Najibullah until 1992, when Najibullah agreed to step aside and make way for a mujahideen coalition government. At this time there were seven main mujahideen groups. This kicked off a civil war, starting 25 April 1992, between initially three, but within weeks five or six mujahideen groups. Kabul was heavily bombarded and partially destroyed by the fighting. The war continued in 1993–95, the mujahideen committed widespread rape, murder and extortion. In late September 1996, the Taliban, in control of Kabul and most of Afghanistan, proclaimed the Islamic Emirate of Afghanistan. The Taliban were condemned internationally for the harsh enforcement of their interpretation of Islamic sharia law, which resulted in the brutal treatment of many Afghans, especially women. From 1996 to 2001, the al-Qaeda network of Osama bin Laden and Ayman al-Zawahiri was also operating inside Afghanistan. Around 400,000 Afghans died in internal conflicts between 1990 and 2001. On 9 September 2001, the opposition leader was assassinated by two Arab suicide attackers in Panjshir province. Two days later, the 11 September attacks were carried out in the United States. The US government suspected Osama bin Laden as the perpetrator of the attacks. The US launched the October 2001 Operation Enduring Freedom. Most Afghans supported the American invasion of their country. During the initial invasion, US and UK forces bombed al-Qaeda training camps. Working with the Northern Alliance, the US removed the Taliban from power. In December 2001, after the Taliban government was overthrown, the Afghan Interim Administration under Hamid Karzai was formed. The International Security Assistance Force (ISAF) was established by the UN Security Council to help assist the Karzai administration and provide basic security. Shortly after their fall from power, the Taliban began an insurgency to regain control of Afghanistan. Over the next decade, ISAF and Afghan troops led many offensives against the Taliban but failed to fully defeat them. Afghanistan remains one of the poorest countries in the world due to a lack of foreign investment, government corruption, and the Taliban insurgency. In September 2014 Ashraf Ghani became president after the 2014 presidential election where for the first time in Afghanistan's history power was democratically transferred. On 28 December 2014, NATO formally ended ISAF combat operations in Afghanistan and transferred full security responsibility to the Afghan government. The NATO-led Operation Resolute Support was formed the same day as a successor to ISAF.

(Source. WIKIPEDIA)

COVID-19 IMPACT AND RESPONSES

The return of nearly 300,000 Afghan migrant workers since February from Pakistan and Iran, one of the virus' global epicentres, appears to have overwhelmed the government's attempt to prevent the spread of the epidemic. The Afghan government has announced a wide range of measures to control the virus, mirroring global practices of physical distancing, but Iran's border with Afghanistan remained open. Afghanistan's minister of public health publicly shared estimates that up to 25 million Afghans (out of the 33 million population) could eventually be infected with the novel coronavirus. The weaknesses of health care infrastructure in a country weighed down by poverty and four decades of bloody conflict render Afghanistan especially challenged to manage any major epidemic. Adds to that trouble, that hospitals are straining and are beginning to lose staff: staff are not only falling ill, with some even dying of the disease, but many are simply refusing to work under the hazardous conditions. As yet the toll on Afghans from COVID-19 remains unclear; the World Health Organisation admits there "is no model" for how the virus may impact a country with Afghanistan's vulnerabilities. *(Source: Crisisgroup.org)*

ONGOING CONFLICT AND POLITICAL TENSIONS

The COVID-19 epidemic comes at a time of political uncertainty following the results of the 2019 Presidential election and developments towards a reduction in hostilities. Despite a joint agreement between the US and the Taliban to reduce fighting, this has not yet translated into sustained reduction in violence on the ground. Considering the COVID-19 outbreak, continued violence is now seen as a threat to not only the immediate safety and well-being of citizens of Afghanistan but also to overall public health as it may hinder detection and the delivery of life-saving medical care. Conflict-related movement among armed groups, as well as displacement of civilians, creates further risk of intensifying the scale and spread of the virus.

FLOODS

The COVID-19 outbreak comes against the backdrop of the Spring flood season. Each year, floods affect large swathes of the country as heavy snow melts and rivers swell, inundating communities. Heavy rainfall also contributes to flash flooding. The typical flood season runs from March to June each year. In 2020, some 200,000 people are expected to be affected by floods. While flood-related displacement is usually temporary, it creates conditions that are ripe for the spread of various diseases, in turn weakening people's immune systems, and creating risks of higher transmission of COVID-19 due to higher population concentrations.

LOCUSTS

Due to the current favourable breeding season in the region there could be three times higher than normal breeding rates of desert locust swarms in Iran. Another potential source of desert locust could be from the Horn of Africa that could spread as far as India. Technically the chances of desert locusts invading Afghanistan are low, however this situation can easily change. The most likely timeframe for any such invasion in Afghanistan would be between April-July. This would occur at the same time as the primary harvest season which will be vital at a time of potential food and financial insecurity caused by COVID-19. Locust attacks affect the region's standing crops - mostly wheat, vegetable and fodder crops.

WEAK HEALTH SYSTEM

Afghanistan's under-developed health system is thinly spread across the country, due to ongoing conflict and insecurity, as well as infrastructure challenges. Before the COVID-19 epidemic only 0.3 doctors can count on a population of 1,000 people, but since the crisis, that number has continued to decline. Around 30 % of the population has limited access to basic health services within a two-hour travel radius and maternal mortality is among the highest in the world. Only 50 % of children under five have received the full suite of recommended vaccinations to keep them safe and healthy. The fragile health system is further overburdened by mass casualty incidents and recurrent outbreaks of communicable diseases, especially among internally displaced people.

INADEQUATE WATER AND SANITATION INFRASTRUCTURE

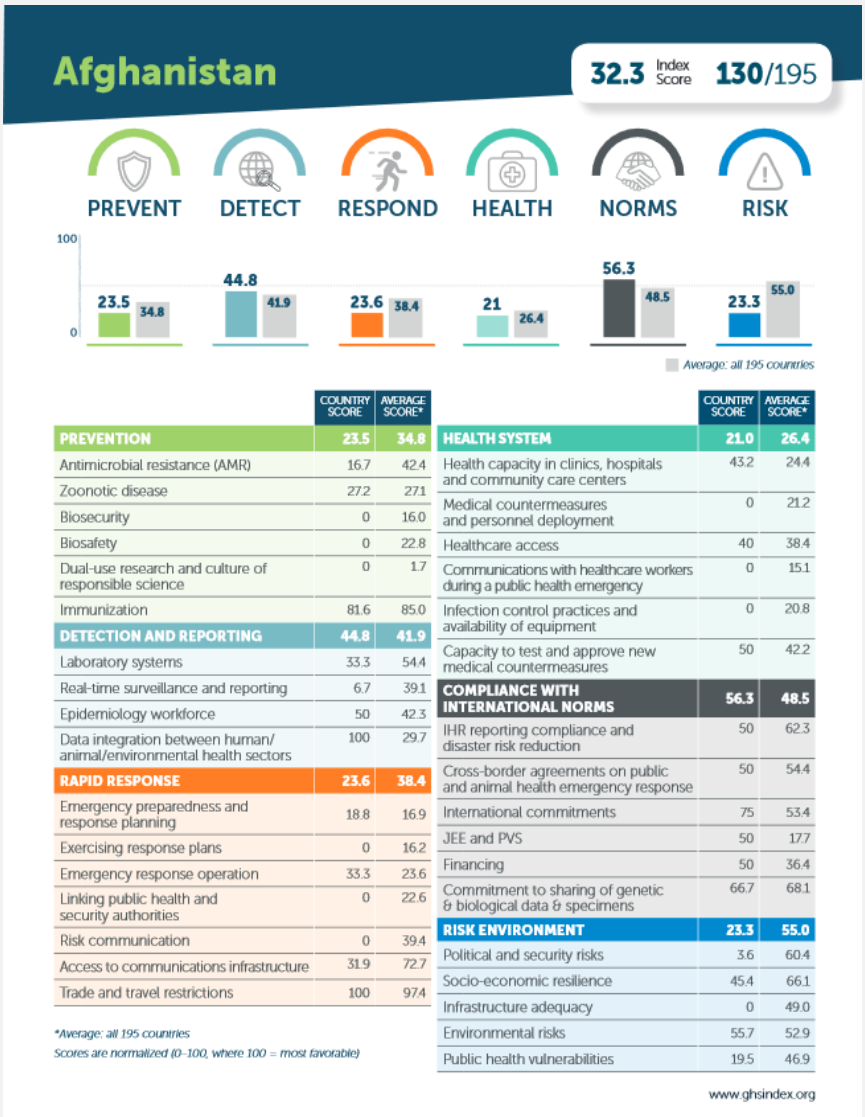
Owing to decades of conflict and under-development, the coverage of water and sanitation facilities,

as well as hygiene access, remains low in Afghanistan. This is particularly the case for displaced households – 57 % of whom have insufficient or barely enough water. More than 65 % of returnees (majority of whom coming from Iran) live in settlements that do not have access to Water, Sanitation and Hygiene (any WASH services), whilst others stay with host communities where services are already over-stretched. Poor WASH conditions contribute to disease outbreaks, especially diarrhoea, that spread at a rapid pace. In a 'normal' year, 13 % of all deaths among children under five in Afghanistan are associated with diarrhoeal diseases. Furthermore, the immune response of children affected by acute watery diarrhoea is highly compromised, increasing their risk of mortality when exposed to other diseases – such as COVID-19. Some 33 % of schools (nearly 6,000 schools serving 2.3m students) lack water and WASH facilities.

MALNUTRITION

The lasting impact of the drought in rural communities, combined with consecutive years of conflict, widespread displacement, annual exposure to flooding and the subsequent interruption to agriculture, have resulted in high levels of hunger and malnutrition. As a result of these combined factors, 14.28 million people are estimated to be in either crisis or emergency food insecurity. The most recent nutrition surveys across Afghanistan showed that 25 out of 34 provinces are currently above the emergency level threshold of acute malnutrition. Annually, an estimated 2 million children under the age of five and 485,000 pregnant and lactating women are affected by acute malnutrition. This compromises people's overall health and well-being and is likely to worsen the symptoms of people who contract COVID-19.

(Source: reliefweb.int)



	COUNTRY SCORE	AVERAGE SCORE*
PREVENTION	**23.5**	**34.8**
Antimicrobial resistance (AMR)	16.7	42.4
Zoonotic disease	27.2	27.1
Biosecurity	0	16.0
Biosafety	0	22.8
Dual-use research and culture of responsible science	0	1.7
Immunization	81.6	85.0
DETECTION AND REPORTING	**44.8**	**41.9**
Laboratory systems	33.3	54.4
Real-time surveillance and reporting	6.7	39.1
Epidemiology workforce	50	42.3
Data integration between human/ animal/environmental health sectors	100	29.7
RAPID RESPONSE	**23.6**	**38.4**
Emergency preparedness and response planning	18.8	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	31.9	72.7
Trade and travel restrictions	100	97.4

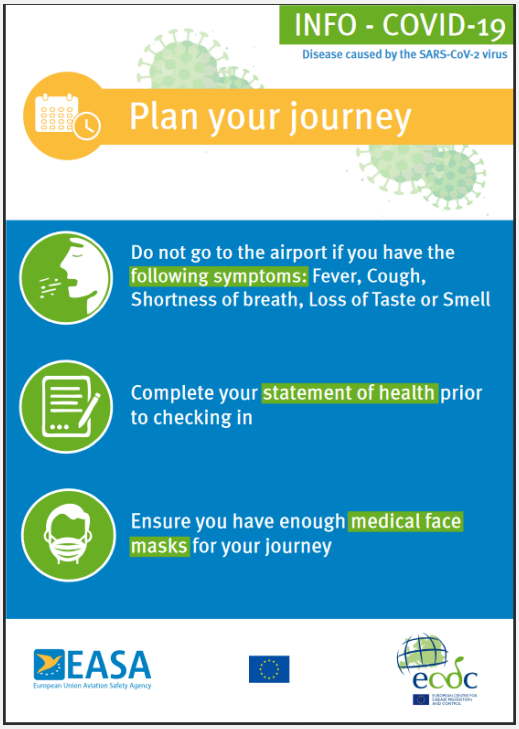
	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	**21.0**	**26.4**
Health capacity in clinics, hospitals and community care centers	43.2	24.4
Medical countermeasures and personnel deployment	0	21.2
Healthcare access	40	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	0	20.8
Capacity to test and approve new medical countermeasures	50	42.2
COMPLIANCE WITH INTERNATIONAL NORMS	**56.3**	**48.5**
IHR reporting compliance and disaster risk reduction	50	62.3
Cross-border agreements on public and animal health emergency response	50	54.4
International commitments	75	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	**23.3**	**55.0**
Political and security risks	3.6	60.4
Socio-economic resilience	45.4	66.1
Infrastructure adequacy	0	49.0
Environmental risks	55.7	52.9
Public health vulnerabilities	19.5	46.9

*Average: all 195 countries
Scores are normalized (0–100, where 100 = most favorable)

www.ghsindex.org

Recommendations

Recommendation for international business travellers	**As of 11 April 2020, 167 countries, territories and areas have implemented additional health measures that significantly interfere with international traffic.** 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. **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. **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. General recommendations for personal hygiene, cough etiquette and keeping a distance of at least one metre from persons showing symptoms remain particularly important for all travellers. These include: • Perform hand hygiene frequently. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if hands are not visibly soiled; wash hands with soap and water when they are visibly soiled; • Cover your nose and mouth with a flexed elbow or paper tissue when coughing or sneezing and disposing immediately of the tissue and performing hand hygiene; • Refrain from touching mouth and nose; See also: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public • A medical mask is not required if exhibiting no symptoms, as there is no evidence that wearing a mask – of any type – protects non-sick persons. If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal. • WHO information for people who are in or have recently visited (past 14 days) areas where COVID-19 is spreading, you will find here. **People returning from affected areas** (= countries, provinces, territories or cities experiencing ongoing transmission of COVID-19, in contrast to areas reporting only imported cases) **should self-monitor for symptoms for 14 days and follow national protocols of receiving countries. Some countries may require returning travellers to enter quarantine. If symptoms occur, such as fever, or cough or difficulty breathing, persons are advised to contact local health care providers, preferably by phone, and inform them of their symptoms and their travel history.** Source: WHO
Plan your journey	These posters summarise the air travel experience for passengers following the outbreak of COVID-19, as defined in the EASA/ECDC operational guidelines. Source: ECDC


INFO - COVID-19
Disease caused by the SARS-CoV-2 virus
Plan your journey
Do not go to the airport if you have the following symptoms: Fever, Cough, Shortness of breath, Loss of Taste or Smell
Complete your statement of health prior to checking in
Ensure you have enough medical face masks for your journey
EASA
ecdc


INFO - COVID-19
Disease caused by the SARS-CoV-2 virus
TAXI
To the airport
Be aware that only travellers may enter the airport terminal buildings
Leave enough time to allow for checks and new procedures
Follow cough etiquette and wear a medical face mask to protect yourself and your fellow passengers
EASA
ecdc


INFO - COVID-19
Disease caused by the SARS-CoV-2 virus
Departure airport
Ask airport or airline staff if you have any questions or concerns
Check in online if possible, bring everything you need for your journey and have all documents ready
Make sure to practice physical distancing, wear a medical face mask and expect to be refused boarding if you don't
Comply with thermal screening, if requested
EASA
ecdc


INFO - COVID-19
Disease caused by the SARS-CoV-2 virus
On the plane
Practice hand hygiene, follow cough etiquette and wear a medical face mask
Watch the cabin safety demonstration to be aware of specific instructions for your flight
If you feel ill while travelling, inform crew and seek medical care as soon as possible
Limit your movement in the cabin to that essential for well-being
EASA
ecdc

Risk Assessment

Global	• Because of global spread and the human-to-human transmission the **high** risk of further transmission persists. • Travellers are at high risk of getting infected worldwide. It is highly recommended to avoid all unnecessary travel for the next weeks. • Individual risk is dependent on exposure. • National regulation regarding travel restrictions, flight operation and screening for single countries you will find here. • Official IATA changed their travel documents with new travel restrictions. You will find the documents here. • Public health and healthcare systems are in high vulnerability as they already become overloaded in some areas with elevated rates of hospitalizations and deaths. Other critical infrastructure, such as law enforcement, emergency medical services, and transportation industry may also be affected. Health care providers and hospitals may be overwhelmed. • Appropriate to the global trend of transmission of SARS-CoV-2 an extensive circulation of the virus is expectable. At this moment of time, asymptomatic persons as well as infected but not sickened persons could be a source of spreading the virus. Therefore, no certain disease-free area could be named globally.
Europe	ECDC assessment for EU/EEA, UK: • **Risk of sever disease associated with SARS-CoV-2 infection for general population:** currently considered **low** in areas where appropriate physical distancing measures are in place and/or where community transmission has been reduced and/or maintained at low levels and **moderate** in areas where appropriate physical distancing measures are not in place and/or where community transmission is still high and ongoing. and **very high** for older adults and individuals with chronic underlying conditions. • **Risk of sever disease associated with SARS-CoV-2 infection in populations with defined factors associated with elevated risk for COVID-19:** currently considered **moderate** in areas where appropriate physical distancing measures are in place and/or where community transmission has been reduced or maintained at low levels and **very high** in areas where appropriate physical distancing measures are not in place and/or where community transmission is still high and ongoing. • **Risk of resurgence of sustained community transmission:** currently considered **moderate** if measures are phased out gradually and accompanied by appropriate monitoring systems and capacities, with the option to reintroduce measures if needed, and remains **very high** if measures are phased out without appropriate systems and capacities in place, with a likely rapid increase in population morbidity and mortality.

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

Disclaimer: