



Update 23 (9th of June 2020)

Information about Infection disease COVID-19 (novel coronavirus)



Force Health Protection Branch FHPB (former DHSC) NATO MILMED COE in Munich 9th 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

- After launching an independent third-party peer review on the Lancet article "Hydroxychloroquine or chloroquine without a macrolide for treatment of COVID-19" the author requested a retraction of the paper. [Lancet can no longer vouch for the veracity of the primary data sources](#). You find more information in our subject in focus.
- **WHO:** At the [media briefing](#) on COVID-19 on Friday, an updated guidance on the use of masks for the control of COVID-19 was announced. This guidance is based on evolving evidence and provides updated advice on who should wear a mask, when it should be worn and of what it should be made. More information in the global section of this document.
- **WHO:** released a new technical note, [Medical certification, ICD mortality coding, and reporting mortality associated with COVID-19](#), that describes medical certification and classification of deaths related to COVID-19. The primary goal is to identify all deaths due to this disease in all countries.
- **WHO Regional Office for Europe** has [joined forces](#) with the Central European Initiative (CEI) to improve and strengthen COVID-19 response and reduce the impact of the pandemic. With 17 CEI member states, the joint force is aimed to function as a strategic platform to share information with member states, as well as best practices and training.
- **WHO Office for the Americas** [pointed out](#) that markets selling live animals increase the risk of animal-to-human transmission of diseases, and that there should be regulations and inspections for sale of live animals to prevent the spread of diseases.
- **UN:** released a policy brief: ["COVID-19 and People on the Move"](#) in June offering four basic tenets to guide a collective response how to deal with displaced persons during a crisis.
- **FHP Branch** started to organize a weekly VTC on "COVID-19 response" next VTC will take place on Wednesday, 10th of June focusing on **"Transition from home office back to the office"**

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

7 088 430
confirmed cases
3 298 139 recovered
406 672 deaths

EU/EEA and the UK

2 234 980
confirmed cases
1 175 997 recovered
184 013 deaths

USA ↗

(new cases/day 22 111)

1 955 709
confirmed cases
518 278 recovered
110 849 deaths

Brazil ↗

(new cases/day 25 273)

707 412
confirmed cases
378 257 recovered
37 134 deaths

Russia →

(new cases/day 8 738)

476 043
confirmed cases
230 226 recovered
5 963 deaths

UK ↘

(new cases/day 1 581)

287 399
confirmed cases
not reported recovered
40 597 deaths

India →

(new cases/day 9 650)

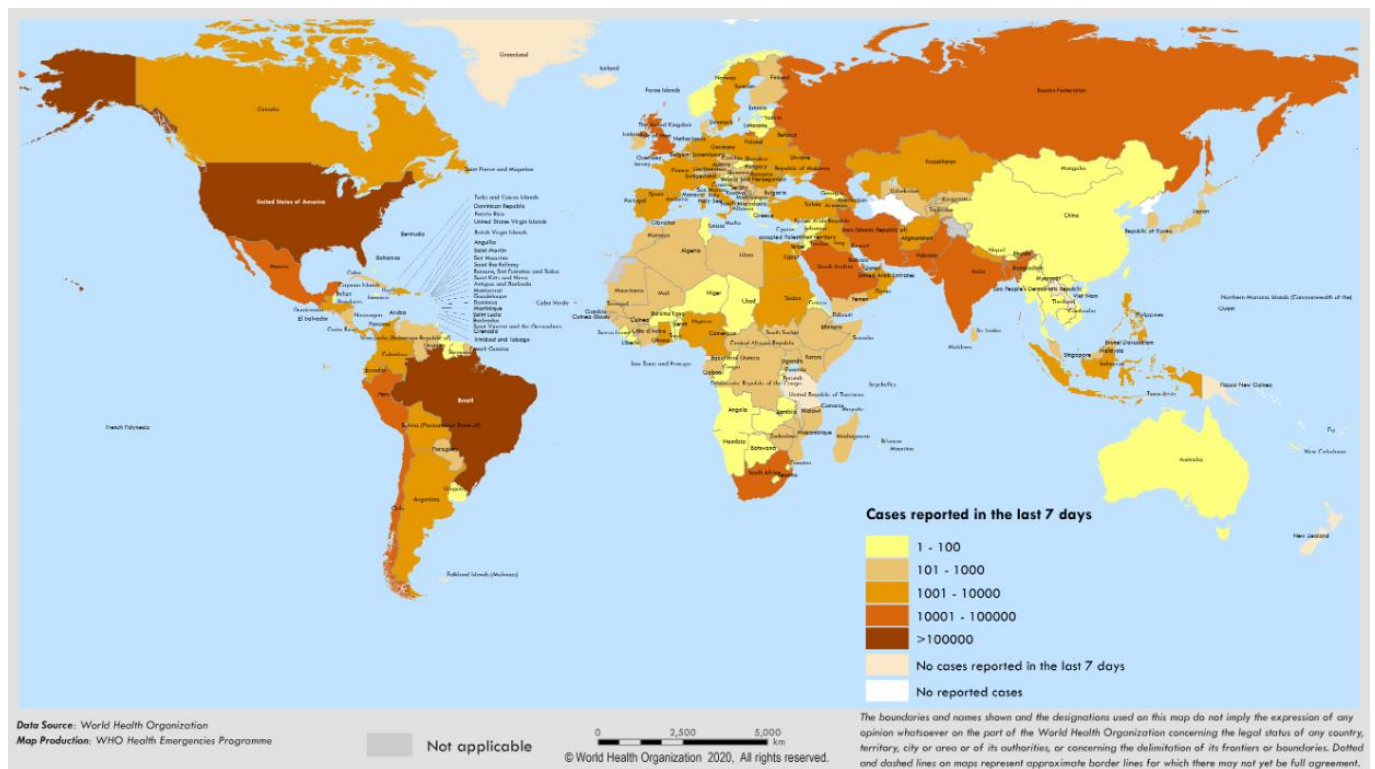
267 046 confirmed cases
129 215 recovered
7 473 deaths

Please click on the headlines to jump into the document

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



Worldwide Situation

Global Situation

In a [new guidance document](#), which replaces one from 6 April, the **World Health Organization (WHO)** said, "In light of evolving evidence, WHO advises that governments should encourage the general public to wear masks where there is widespread transmission and physical distancing is difficult, such as on public transport, in shops or in other confined or crowded environments." This is the first time WHO has recommended masks so broadly and is believed to be related to the now-established fact that people can spread COVID-19 before showing symptoms. The updated information also says that fabric masks should be made of at least three layers of different material.

The guidance also states that people who are older than 60 or have underlying health conditions should wear medical masks if they are unable to physically distance and there is community transmission in the area. Additionally, all healthcare workers in a facility should wear masks - even if they're not caring for COVID-19 patients - if COVID-19 is widespread in the geographic area of the facility. WHO stressed that masks are only part of a containment strategy and that fabric masks help protect others - not the wearer. **Physical distancing, hand hygiene and other public health measures remain crucial on an individual level.** The Director-General stated, "The cornerstone of the response in every country must be to find, isolate, test and care for every case, and to trace and quarantine every contact. That is what we know works. That is every country's best defence against COVID-19."

More information on the use of masks and COVID-19 you can find [here](#) and [here](#).

The **International Civil Aviation Organization (ICAO)**, a UN specialized agency, has published guidelines ([CART Take-off](#)) to facilitate air travel during the pandemic while minimising the health risk to passengers and all aviation workers. A risk based approach has been designed with five scenarios of air travel where stage 0 is one with travel restrictions and minimal travel and stage 4 is with residual travel restrictions and some pharmaceutical intervention available. It consists of "...a core set of measures to form a baseline aviation health safety protocol".

The public health risk mitigation measures have been divided in to:

- A) generally applicable measures meant for all phases of air passenger and cargo transport;
- B) specific modules targeting different aspects of air transport.

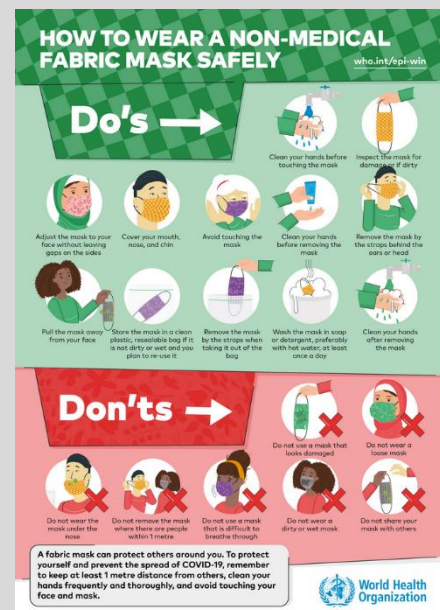
General measures comprise recommendations of public education, physical distancing, use of face covering and mask, routine sanitation, health screening, contact tracing, health declarations and testing. Specific module mitigation measures will address aspects of airport, aircraft, crew and cargo.

Countries in focus

SINGAPORE and **CHINA** have agreed on the rules to allow essential business travel to re-start between the two countries. In essence, travellers in both directions will be exempt from the 14-day quarantine periods applying to all international arrivals. This "fast-lane" travel will begin to six provinces in China from today.

ISRAEL: After the initial containment of the pandemic, ISR is hit by a second wave of infections. The starting point for these seems to be schools, since the opening of care facilities the number of new infections has skyrocketed - from 4 to over 100 per day. Almost all newly tested people were teachers or students. To avert a second lockdown, the government wants to rely on large-scale antibody tests and so-called Sentinel testing; parts of the population are randomly examined for the disease.

KENYA: Over the weekend, President of Kenya has extended the ban on public gatherings for a further 30 days, as well as prohibiting entry and exit from Nairobi, Mombasa and Mandera. There are plans for schools to reopen on 1 September.



India has reported nearly 10,000 new cases, the largest daily increase. More than 80% of the active cases are in five states - Maharashtra, Tamil Nadu, Delhi, Gujarat and Madhya Pradesh. More than 60% of the cases are in five cities, including Mumbai, Delhi and Ahmedabad. [News items](#) from Mumbai indicate that hospitals are overwhelmed. Mumbai has over 37,000 cases and 1,200 deaths making up one-fifth of India's total cases and a quarter of all deaths. Slums, with crowded conditions and communal showers, are being hard hit.

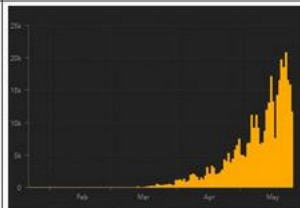
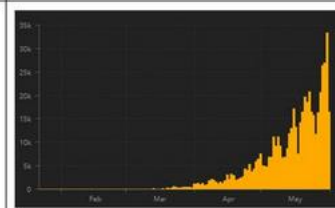
Despite not having passed the epidemic peak, India has announced plans to ease the lockdown. From 8 June, restaurants, hotels, shopping centres and places of worship will be allowed to re-open in many areas in the first stage of a three-phase plan. Hotspots will remain in tight lockdown. Schools and colleges may open again in July.

	LAST WEEK	THIS WEEK
CASES	158,000	199,000
DEATHS	4,337	5,608
DAILY NEW CASES	5,800	8,500
EPICURVE		

BRAZIL has stopped reporting the total number of COVID-19 cases and deaths, removing all data from official sites. It now only reports daily numbers as the President claims that total numbers did not reflect the true situation in Brazil.

Left table shows the increase in case numbers and death in Brazil from last week to this week. True numbers are assumed to be much higher because of lack of testing and imprecise reporting. A University of Washington study warns that the total death toll for Brazil could climb five-fold to 125,000 by early August.

Data and Graph: [Johns Hopkins University](#).

	LAST WEEK	THIS WEEK
CASES	375,000	526,000
DEATHS	24,000	30,000
DAILY NEW CASES	21,000	33,000
EPICURVE		

NEW ZEALAND: No active cases. The last new confirmed case was reported on 22 May and has been released from isolation. At 11:59pm New Zealand will move from Alert Level 2 to Alert Level 1. At Alert Level 1, everyone can return without restriction to work, school, sports and domestic travel, get together with as many people as they want. Controls at the borders remain for those entering New Zealand, including health screening and testing for all arrivals, and mandatory 14 day managed quarantine or isolation.

QATAR: The country in the northeast of the Arabian Peninsula has one of the highest per capita infection rates in the world with 24 cases per 1,000 inhabitants. According to press reports, the disease mainly affects migrant workers. They make up about 2 million of the country's 2.78 million inhabitants. The temporary workers mostly come from the Southeast Asian region or Nepal and are mainly employed in the domestic and construction sectors. Human rights organizations have repeatedly complained about the working and living conditions of migrants for many years, many of them are housed in confined spaces and have no access to sanitary facilities or health care.

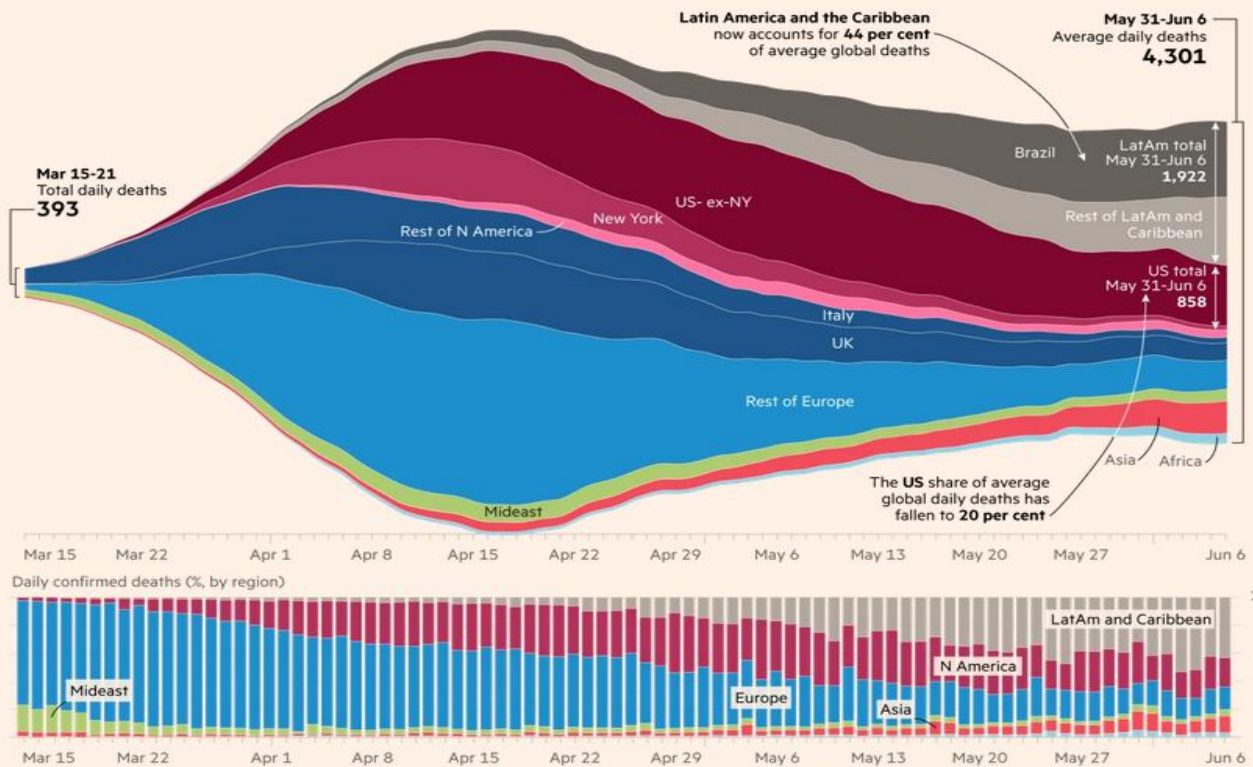
QAT has taken strict measures to contain the pandemic, there is an exit restriction, and centers of public life such as mosques and restaurants have been closed. The penalties for non-compliance with the mask requirement are considered the strictest worldwide; violators face 3 years imprisonment and high fines. In addition, the state Corona warning app EHTERAZ was introduced, the installation and use are required by law. Privacy advocates criticize the app for accessing all of the device's private data, such as all photos and videos. In addition, the application runs continuously in the background and constantly tracks the location of the users via GPS using a centrally assigned, so-called "national identification number".

In economic terms, the country is benefiting from developments in the crisis that were triggered by the conflict with neighboring countries Saudi Arabia and the United Arab Emirates in 2017. Since then, QAT

has radically trimmed its economy for autonomy and relocated entire branches of industry. Essential materials such as ventilators during the crisis are produced entirely independently within the country under the supervision of the state-owned company BARZAN. The International Monetary Fund is forecasting a clear economic plus for the country even after the crisis.

Global Covid-19 death toll: Latin America offsets decline in Europe and the US

Daily deaths of patients diagnosed with coronavirus (7-day rolling average)



FT graphic: Steven Bernard / @sdbernard
Source: FT analysis of ECDC and Covid Tracking Project data
© FT

Source: Financial Times

ECDC COVID-19 surveillance report Week 22, 2020

Summary of key messages

Overall reported cases

- Based on data available to ECDC on 4 June 2020, 30 out of 31 countries (EU/EEA countries and the UK) have observed COVID-19 notification rates lower than at peaks that were observed 10–64 days earlier (the average rate for the EU/EEA and the UK was 79% lower than at the peak on 9 April 2020).

Primary care

- All countries that reported data from primary care sentinel surveillance for COVID-19 using the systems established for influenza, observed stable or decreasing trends in SARS-CoV-2 positivity among individuals with respiratory symptoms.

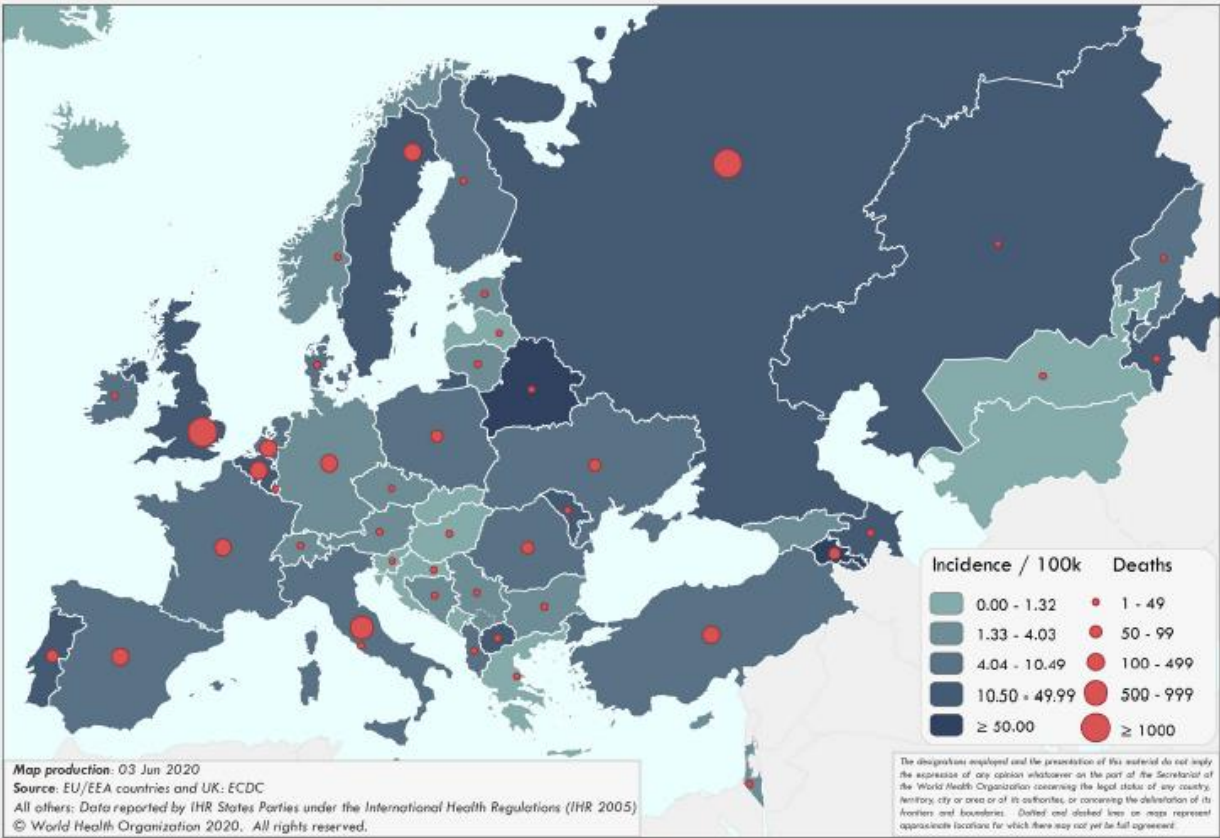
Hospitalisation

- Overall, 35% of reported COVID-19 cases to date in the EU/EEA and the UK were hospitalised; among hospitalised patients, 11% required ICU and/or respiratory support, although there is considerable variation between countries.

Mortality

- We estimate that 22% of hospitalised COVID-19 cases reported to date in the EU/EEA and the UK have died.
- Pooled estimates of all-cause mortality reported by EuroMOMO are now approaching normal expected levels following a period of substantially increased excess mortality that coincided with the COVID-19 pandemic peaks. A few countries are still seeing some excess mortality.

COVID-19 incidence per 100,000 population and number of deaths by country for week 22



COVID-19 situation update for the WHO European Region (25 May - 31 May 2020 Epi week 22)

Key points

Week 22/2020 (25 - 31 May 2020)

- The number of cases reported in week 22/2020 in the Region has declined by 48% since week 14/2020
- 57% of the cases reported in week 22/2020 were from the Russian Federation and the United Kingdom
- Two countries had a crude incidence of ≥ 50 per 100,000 in week 22/2020: Armenia and Belarus
- In 11 countries, the 14-day cumulative incidence increased by $\geq 10\%$ in week 22/2020 compared to the previous week. In order of percentage increase: Armenia, Kazakhstan, Tajikistan, Kyrgyzstan, Azerbaijan, North Macedonia, Estonia, Uzbekistan, Albania, Republic of Moldova and the Czech Republic. (see [EURO COVID-19 Dashboard](#) for recent trends)
- 56% of the deaths reported in week 22/2020 were from the United Kingdom, Russian Federation and Italy
- The proportion of reported cases that died decreased from 5.8% in week 21/2020 to 4.6% in week 22/2020, a change that is likely due to a range of factors

Summary overview

- Nine countries in the Region each reported a cumulative incidence of ≥ 400 cases per 100,000 population: San Marino, Andorra, Luxembourg, Iceland, Spain, Ireland, Belgium, Belarus and the United Kingdom
- 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
- 72% 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
- 95% 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 22, there were more than 172,400 excess deaths reported from 24 countries/regions. Primarily in the age group ≥ 65 years with over 157,400 excess deaths, but also in the 45-64 years age group with over 12,900 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 22/2020, five countries reported a total of 281 tests and 18 COVID-19 detections in persons with influenza-like illness in primary care sentinel surveillance. The updated positivity rate in week 21/2020 was 4.1% (8 countries) compared to 6.5% (8 countries) in week 20/2020. The highest positivity was 19.1%, seen in week 15/2020
- As of 21 May 2020, three countries in the European region had an effective reproductive number significantly over 1: France, Israel and Kazakhstan (See [EpiForecasts](#) and the CMMID COVID working group COVID-19 Global Summary for latest estimates)

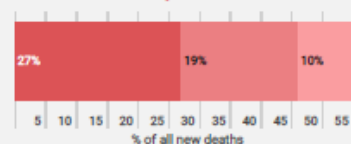
New cases Epi week 22

136,000

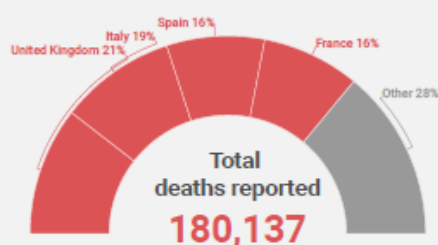


New deaths Epi week 22

6,200



Total cases reported
2,145,588



Total deaths reported
180,137

20%

of all people infected were health care workers

95%

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=780,196) and deaths (N=112,132) by age group

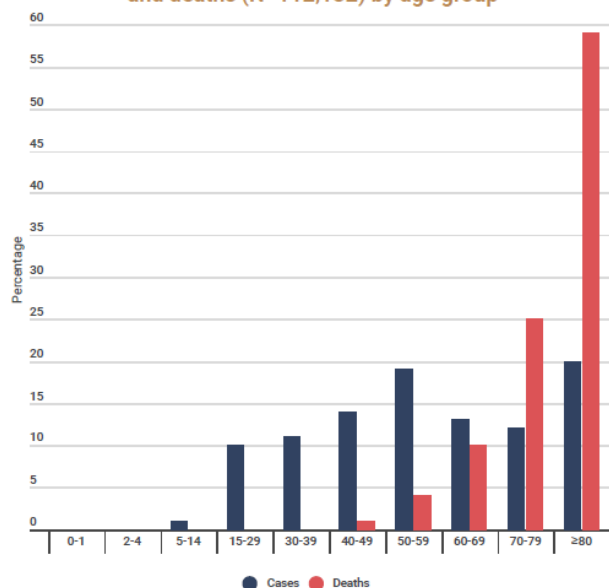


Table 1. Characteristics of COVID-19 cases and deaths

Characteristics		n	%	Total records with data available
Cases	Age in years, median (range)*	55 (1-105)		532,586
	Sex, male*	246,486	47	529,958
	Travelled*	17,399	12	145,226
	Recovered*	193,172	90	214,061
	Health care workers*	87,016	20	429,386
	Hospitalization*	127,754	25	513,620
	Intensive care unit admissions*	9,826	2	395,798
Deaths	Age in years, median (range)^	81 (0-108)		112,132
	Sex, male^	64,491	59	112,019
	At least one underlying condition^	54,284	95	57,259
	• cardiovascular disease	17,273	65	26,668
	• diabetes	8,575	33	25,733
	• lung disease	5,954	23	26,124
	• neurological disease / dementia	2,203	26	8,493
	• renal disease	1,539	20	7,729
	• malignancy	899	25	3,582
	• obesity	613	9	6,745
	• liver disease	368	5	7,712
	• immune disease	237	3	7,366
	• other	12,575	52	24,364

*Case report forms (n=524,429);

^Case report forms and aggregated data from Italy (28/29 May) and Spain (28 May 2020) (n=821,062); Health care workers refer to occupation and not to the place of exposure

^Case report forms, mortality survey, aggregated data from Italy (28 May 2020) and Spain (28 May 2020) (n=112,155)

Figure 4. Percentage of COVID-19 cases (N=775,920), hospitalizations (N=131,978), ICU admissions (N=12,226) and deaths (N=111,985) by age group and sex

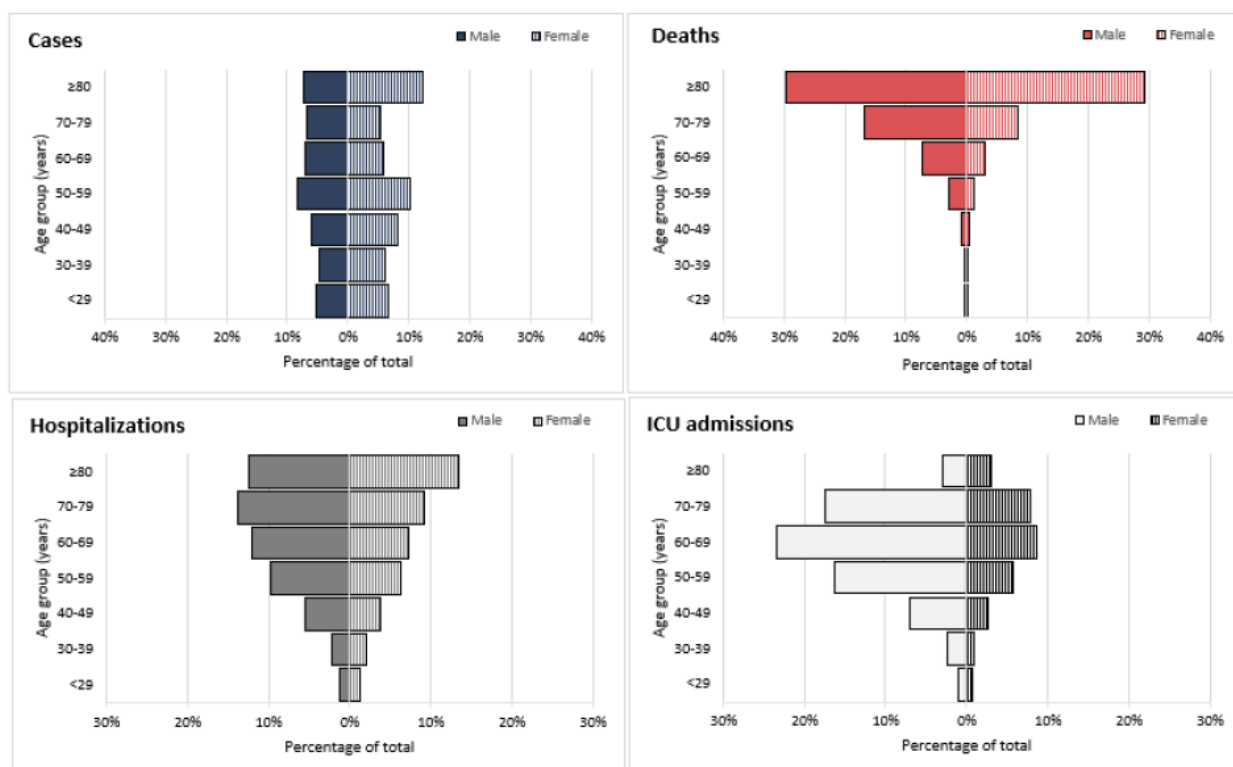


Figure 1: Number of COVID-19 cases (N=2,145,588) and deaths (N=180,137) by reporting week

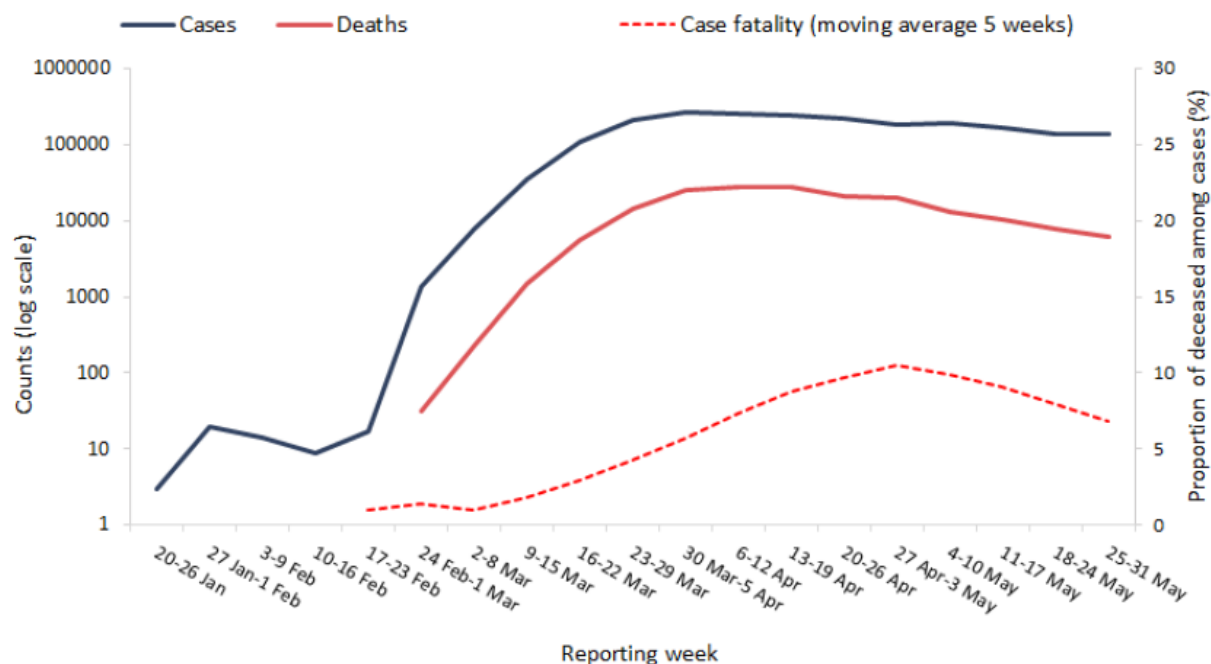
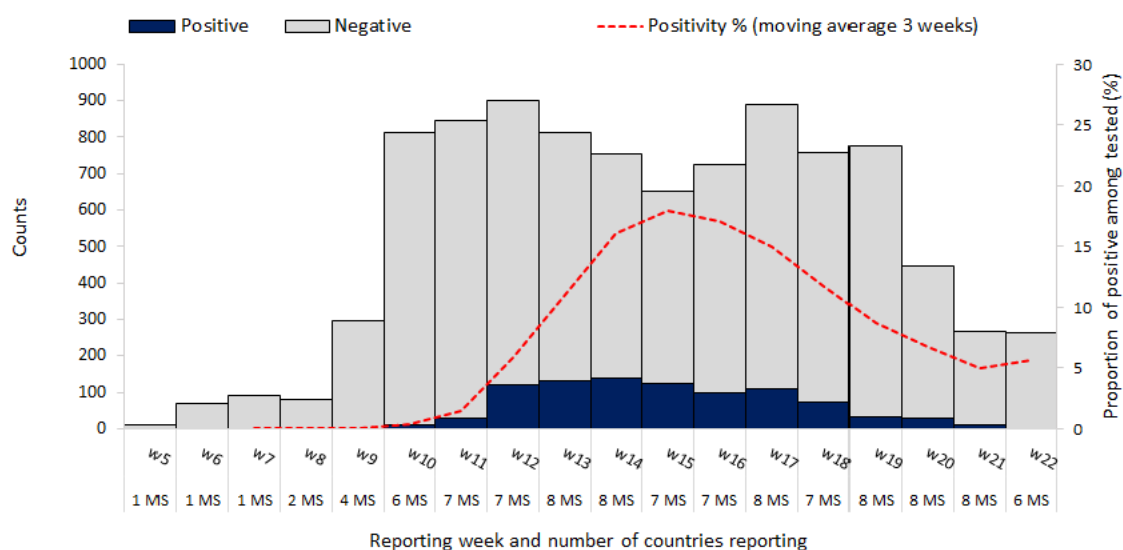
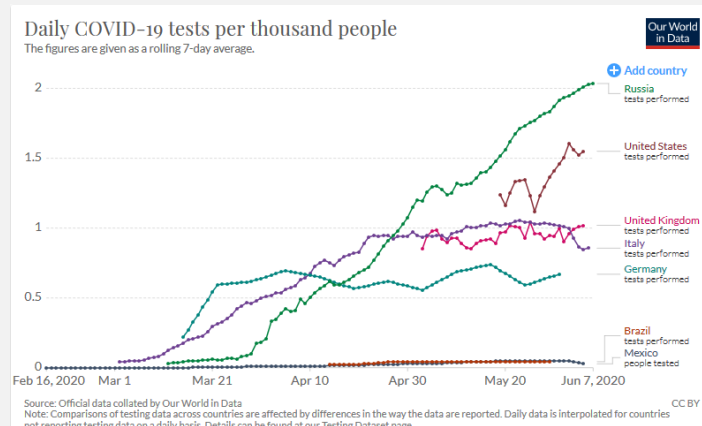


Figure 5. Percentage positive for COVID-19 in the ILI/ARI sentinel surveillance by reporting week



Country in focus:

RUS: The Eastern European country is now third in the world in terms of absolute cumulative numbers. At the same time, strikingly low death rates are reported (according to Johns-Hopkins currently 1.24%, compared to etc. DEU currently 4.67%). While the RUS government justifies this through good crisis management, there are international doubts. According to the RUS, far more people are tested than in other nations (see right chart), but the quality of the tests is criticized. In addition, the recording of the viral disease as the cause of death in the RUS reporting system differs, often only the primarily affected organ system is reported. In line with this, mortality from diseases such as pneumonia, heart attack and organ failure has increased dramatically since the pandemic began.



The RUS government, meanwhile, is talking about a return to normality and easing many restrictions. One reason for this could be the 01.07. upcoming referendum on a constitutional amendment. This would allow President Putin two more terms until 2036. In order to minimize the risk of a SARS-CoV-2 transmission, the voting process was completely reorganized; Election observers are already criticizing the changes, since independent monitoring of the referendum will hardly be possible.

ITA: In the northern Italian city of Bergamo, antibodies to the novel corona virus have been detected in 57 percent of almost 10,000 citizens tested.

GRC: Just before the holiday season began, the Greek government was concerned about a rise in corona infections again. Since Thursday, 97 new cases have been registered, the Ministry of Health in Athens announced on Monday 1 June. Almost a third of those affected are immigrants from abroad. The government plans to restart the release of corona virus numbers daily. This was stopped a week ago, after fewer than five new infections per day had been registered. Starting next Monday, the airports in Athens and Thessaloniki will reopen to travelers from 30 countries. Cafés and taverns have been open for two weeks after a six-week curfew.

POL: The number of new corona infections has skyrocketed. A total of 1151 new cases of infection were recorded at the weekend, as the Ministry of Health in Warsaw announced. Most of the new cases are related to the Zofiowka coal mine near the Czech border. According to the ministry, almost two thirds of the newly infected people work in the mine or are related to employees.

GBR: The United Kingdom announced that a 14-day quarantine will be enforced for all incoming travellers (residents and visitors) starting 080000Ajun20. This rule is scheduled to be reviewed after three weeks. Only some exceptions are made from this rule (e.g. it does not apply for incoming travel from Ireland, Isle of Man or the Channel Islands).

HRV: As of 08th June, Croatia has reported only one new case and one new fatality in June, with a total of 2,247 cases and 104 fatalities. The head of the Croatian institute of Public Health announced that fans will be allowed to return to outdoor-sport stadiums during the week, if hygiene measures are in place.

TUR: On 08th June it was reported that Turkey decided to refine the eligibility criteria for COVID-19 tests. Now also individuals showing symptoms like headache, muscle pain and the loss of smell/taste will be subjects to tests. Currently 171,121 cases (989 new) and 4,711 deaths (19 new) have been reported

FIN: While Finland saw 7,025 cases and 324 deaths until now, the Finnish Institute for Health and Welfare announced that it observed a notable decrease in the number of food and water-borne infections compared to the expected number of such infections between March and May. They made a link between better hygiene measures that were adapted by the public in the light of COVID-19 and this decrease in infections.

Subject in Focus

Hydroxychloroquine or chloroquine with or without a macrolide COVID-19 controversial treatment.

The complex choices facing medical teams caring for patients who are critically ill with coronavirus disease 2019 (COVID-19) are compounded by the absence of proven treatment strategies. Lacking robust trial evidence, clinicians are forced to consider all options based on preclinical and small observational studies, often in heart-wrenching settings of patients who are deteriorating in the throes of severe pneumonia, acute respiratory distress syndrome, cytokine storm, and in many cases, cardiovascular complications.

In the early days of the pandemic, when scientists were still learning about SARS-CoV-2, the coronavirus strain that causes COVID-19, researchers evaluated many drugs in hopes of finding leads on a possible treatment — including hydroxychloroquine. Hydroxychloroquine has been advocated and even politicized as a promising therapy because of its anti-inflammatory and potential antiviral properties. The drug, known for its immunosuppressive and antimalarial effects, has risen to the top of many treatment algorithms alone or in combination with azithromycin.

Hydroxychloroquine, along with its more toxic analogue chloroquine, was for several decades the most commonly prescribed antimalarial drug in the world. Hydroxychloroquine and chloroquine attack malaria by raising the pH level of parasite cells. The drug is also an immunosuppressant and today it is sometimes used to treat lupus, rheumatoid arthritis and other autoimmune diseases. Hydroxychloroquine is known to sometimes cause heart rhythm abnormalities, eye problems involving the retina, gastrointestinal distresses and skin rashes, as well as liver and kidney damage. What is known, hydroxychloroquine prolongs the QT interval because of blockade of inward cellular potassium current and has a known risk of proarrhythmic, especially in the setting of other drugs that also prolong the QT interval. The azithromycin has also been increasingly recognized for risks of QT interval prolongation and sudden death.

Following the SARS outbreak in 2002-03, in one study from 2005, researchers found that chloroquine slowed reproduction of the SARS coronavirus in cell cultures. An early onset of COVID-19 pandemic in China, same reports on chloroquine, showed good results in vitro. In February 2020, it was announced in China that chloroquine was found to be more effective than control treatment in clinical trials of patients with COVID-19. Officials announced that chloroquine treatment prevented worsening of pneumonia, improved findings on lung imaging, facilitated conversion to virus-negative status, and reduced disease duration, without significant side effects, leading to a panel recommendation in that country for its use in COVID-19. This soon led to the global study and emergency use of hydroxychloroquine for COVID-19. To date, there still isn't a lot of scientific evidence that indicates this anti-malaria medication could help prevent or treat coronavirus in people. In March 2020 the World Health Organization has started 'The Solidarity' trial to evaluate the safety and efficacy of four medicines (Remdesivir, Lopinavir/ritonavir, Interferon beta-1a and Hydroxychloroquine) by comparing them against standard care.

On 25 May 2020 Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO made a statement about temporarily stopping the hydroxychloroquine part of the Solidarity Trial. The rationale for pausing the hydroxychloroquine arm from the trial was based on a study published in medical journal The Lancet ([Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis](#) – on 22 May 2020) found that hospitalized Covid-19 patients treated with hydroxychloroquine had a higher risk of death than those who didn't take it. Dr. Mike Ryan, executive director of the WHO's emergencies program on May 27, said there was no evidence that the drug is actually effective against the coronavirus and the WHO is not advising the use of hydroxychloroquine or

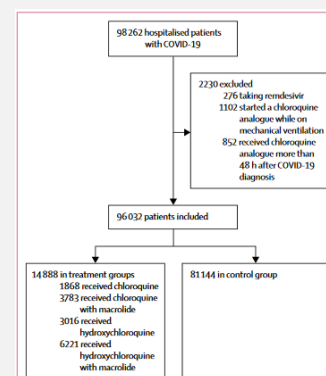


Figure 1: Study profile

chloroquine for the treatment of Covid-19 outside randomized control trials or under appropriate close clinical supervision subject to whatever national regulatory authorities have decided.

One week after The Lancet article, a group of more than 140 scientists, researchers, and statisticians have written an open letter to the magazine and the authors of a recently published observational study, call for the release of patient data and for the findings to be validated by the WHO, or at least one other independent institution. The letter raises several concerns about the observational analysis, among them inadequate adjustment for known and measured confounders and the absence of an ethics review for the study. The authors question some of the data from Australia, noting there were too many COVID-19 cases and too many deaths, numbers that are inconsistent with government reports. They also challenge some of the findings from Africa, question the dosing of hydroxychloroquine, and point to unusually small reported variances in baseline variables, interventions, and outcomes between the continents.

This prompted [The Lancet](#) to take note of these differences and update the notice as soon as they conducted an independent peer-review investigating the source of the data. When an independent third-party peer review of Surgisphere data was initiated with the consent of the co-authors of the study to evaluate the origination of the database, and to replicate the analyses presented in the paper, the peer reviewers said Surgisphere would not transfer the full dataset.

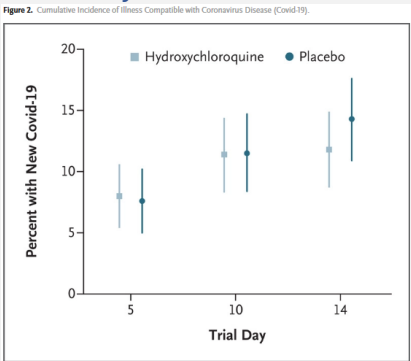
At a [press briefing on Wednesday June 3](#), Dr Tedros Adhanom Ghebreyesus, said the Data Safety Monitoring Board decided there was no reason to discontinue the international trial after reviewing available data on the drug. The WHO executive group received this recommendation and endorsed the continuation of all arms of solidarity trial including hydroxychloroquine, he said. What is more, the data used to generate the results have since been questioned, and the article from 22 May is now withdrawn. That study is now being re-examined. Finally, the WHO Director General stated the safety board will continue to closely monitor the safety of all therapeutics being tested in its trials, which involve more than 3,500 patients across 35 countries.

The same day (June 3) the first randomized, placebo-controlled trial into the drug was published in [The New England Journal of Medicine](#), found that hydroxychloroquine was no better than a placebo in preventing infection by the coronavirus. The study

Table 2. Outcomes of Hydroxychloroquine Therapy for Postexposure Prophylaxis against Covid-19.*

Outcome	Hydroxychloroquine (N=414)	Placebo (N=407)	P Value
	number (percent)	number (percent)	
Confirmed or probable Covid-19	49 (11.8)	58 (14.3)	0.35
Laboratory-confirmed diagnosis	11 (2.7)	9 (2.2)	0.82
Symptoms compatible with Covid-19	48 (11.6)	55 (13.5)	0.46
All new symptoms	57 (13.8)	59 (14.5)	0.84
Any hospitalization	1 (0.2)	1 (0.2)	0.99
Death	0	0	—

* Symptoms were adjudicated by four infectious disease physicians, who were unaware of the trial-group assignments, in accordance with U.S. Council of State and Territorial Epidemiologists case definition of probable Covid-19 after an epidemiologic link with a close contact.¹¹ (Descriptions of the symptom complex are provided in the Supplementary Appendix.) The median number of new symptoms reported in the hydroxychloroquine group was 4 (interquartile range, 2 to 6), as compared with 3 (interquartile range, 2 to 5) in the placebo group.



The cumulative incidence of illness compatible with Covid-19 was 11.8% in the hydroxychloroquine group (49 of 414 participants) and 14.3% in the placebo group (58 of 407) (P=0.35). The difference equates to a number needed to treat to prevent one infection of 42 persons (lower boundary of the 95% confidence interval for the number needed to treat to prevent one infection, 14 persons; upper boundary of the 95% confidence interval for the number needed to treat to harm 1 person, 50 persons). When we excluded participants who were lost to follow-up, who withdrew, or who were not fully adherent to the trial intervention, the results were similar. When we excluded 13 persons with possible Covid-19 cases who had only one symptom compatible with Covid-19 and no laboratory confirmation, the incidence of new Covid-19 still did not differ significantly between the two groups: 10.4% in the hydroxychloroquine group (43 of 414 participants) and 12.5% in the placebo group (51 of 407) (P=0.38). The vertical bars represent 95% confidence intervals. (Details on symptoms and the adjudication of cases are provided in the Supplementary Appendix.)

involved more than 800 patients in the U.S. and Canada and did not rely on data from the allegedly flawed dataset.

On June 5-th the preliminary outcomes come from a study called RECOVERY, funded by the U.K. government, that sought to randomly assign large numbers of patients to multiple potential treatments in the country's National Health Service. [The results from the RECOVERY trial](#) has showed that hydroxychloroquine does not reduce the risk of death among hospitalized patients with COVID-19.

In conclusion, the risk-benefit trade off hydroxychloroquine may also depend on whether other drugs with unclear benefit (such as remdesivir, tocilizumab, lopinavir-ritonavir, low-dose dexamethasone and azithromycin) are available as alternative therapies. We will continue to learn about hydroxychloroquine in the coming months, as many other studies and rigorous clinical trials are underway.

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

Summary of the Briefings (FRA, DEU, USA, KFOR, ESP, ITA)

FRA

The department were handling about 400 inpatients and 100 ICU patients. Of this, 12 were MIL inpatients. More than 2000 outpatients were also managed, 400 of which is confirmed COVID cases.

Management of COVID 19:

Standard:

- Enoxaparin
- Supportive care
- Antibiotics -if bacterial co-infection is present
- Isolation

No specific treatment was administered, only randomized.

COVID-19 and thromboembolic cases seem to correlate, so even for mild cases anticoagulants were prescribed for 7 days.

Discovery:

- SOC
- Lopinavir-ritonavir
- Lopinavir-ritonavir-interferon beta
- Hydroxychloroquine -army stopped the use after may 24
- Remdesivir

KFOR

In April, the registered upper respiratory cases rose. 114 cases were detected, most of them in one camp. 82 of them were STRATEVAC-ed. 51 are back in the mission.

The patients were categorised, isolated and regularly checked. Most of them had no symptoms. The majority of those who had symptoms were only mild ones, and no assistance was needed. Two of the symptomatic cases developed pneumonia.

Mental stress was a bigger issue of the personnel.

Overall, most cases were mild, easily treatable in theatre.

USA

Majority of the cases were mild.

No hydroxychloroquine or lopinavir was administered.

Treatment of mild COVID-19 cases

The biggest obstacle was the release from isolation. The criteria for being released was to produce two negative tests after isolation. However at least 3 individuals continued to test positive for approximately 40 days after recovery.

Supportive care was administered. Hydroxychloroquine was demanded but was ended up being unused due to late arrival.

For severe cases: ICU care, remdesivir and IV steroids (tocilizumab) were administered.

„How the military was able to get Remdesivir?": despite not being authorised by FDA, USAMMDA can give a special authorisation for the uses (this was granted) and remdesivir was administered.

Artesunate is not approved

DEU (Military hospital Koblenz)

Cohort: 43 patients in total. At no point the capacities were exhausted. 87% male patients. Male patients observed to have more severe courses. 12 patients were cared for at the ICU. All 12 developed ARDS, 3 received ECMO therapy, 4 passed away (they were patients transported from Bergamo). Almost all were offered experimental therapies.

Remdesivir:

In-vitro data is promising.

In-vivo patients seem to recover faster according to study. So far professionals at Koblenz hospital don't see proof of this.

As of right now almost no COVID cases left in the hospital. Patients were tested multiple times; 2 consecutive negative tests are required to be released.

Current protocol is remdesivir in favour over lopinavir/ritonavir. The use of hydroxychloroquine is abolished.

ESP

Due to the large numbers of patients admitted due to suspected COVID cases the hospital was adapted to deal with the issue. IM and Pulmonary units were tasked to help out and almost all the hospital was turned into a COVID-19 centre with approximately 400 beds. A 4 step scalability was implemented.

Dealing with mild cases:

At first, all patients were admitted, but it didn't work out, so the patients were discharged to be cared for at home.

The hospital's gym was transformed into an observation area.

Because many patients had comorbidities, lopinavir was not used. Remdesivir was not used due to national protocols.

Hydroxychloroquine (HCQ) was used. Results of an observation study are the following: in mild cases the HCQ was proven good/beneficial. After these results, the protocol was changed and HCQ was put in the focus of treatment even in ICU cases. Patient's cardiac status was monitored. Interferon were only used in the early stages of the disease. During the first weeks steroids were not used.

LMWH now offered to all patients.

ITA

Rome hospital was transformed into COVID-centre.

At the beginning patients had to be divided to be cared for at home or at the hospital.

ITA authorities had to approve medications and protocols. HCQ was approached and despite the controversy it was approved at some regions. HCQ is also used for other disease. 200 mg tablets were authorised and imported from china.

Azithromycin was added to the treatment with pantoprazole. The use of azithromycin showed negative effect on heart rhythm and Q-T prolongation was observed too. Due to these effects Azithromycin was taken off the treatment protocol.

So far the patients who were taken care of at home were not treated with anti-retroviral drugs.

HCQ was used with success and it is considered promising.

Topic next VTC:

- Transition from home office back to the office

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:

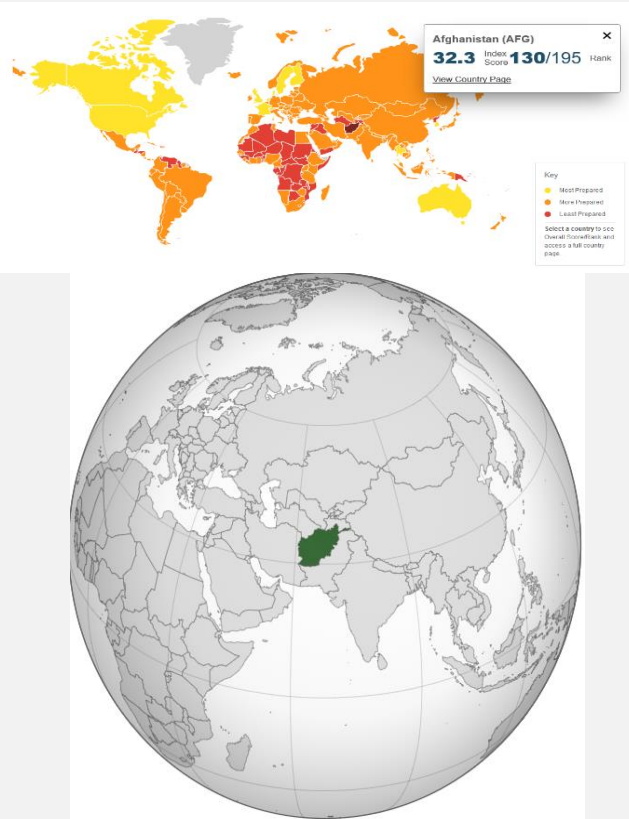
- Necessity and difficulty of maintaining **clear and transparent communication** (e.g. cultural/social barriers, distrust in existing governmental structures, disinformation campaigns orchestrated by conflict parties, the disease might be considered a less important problem compared to everyday risks 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

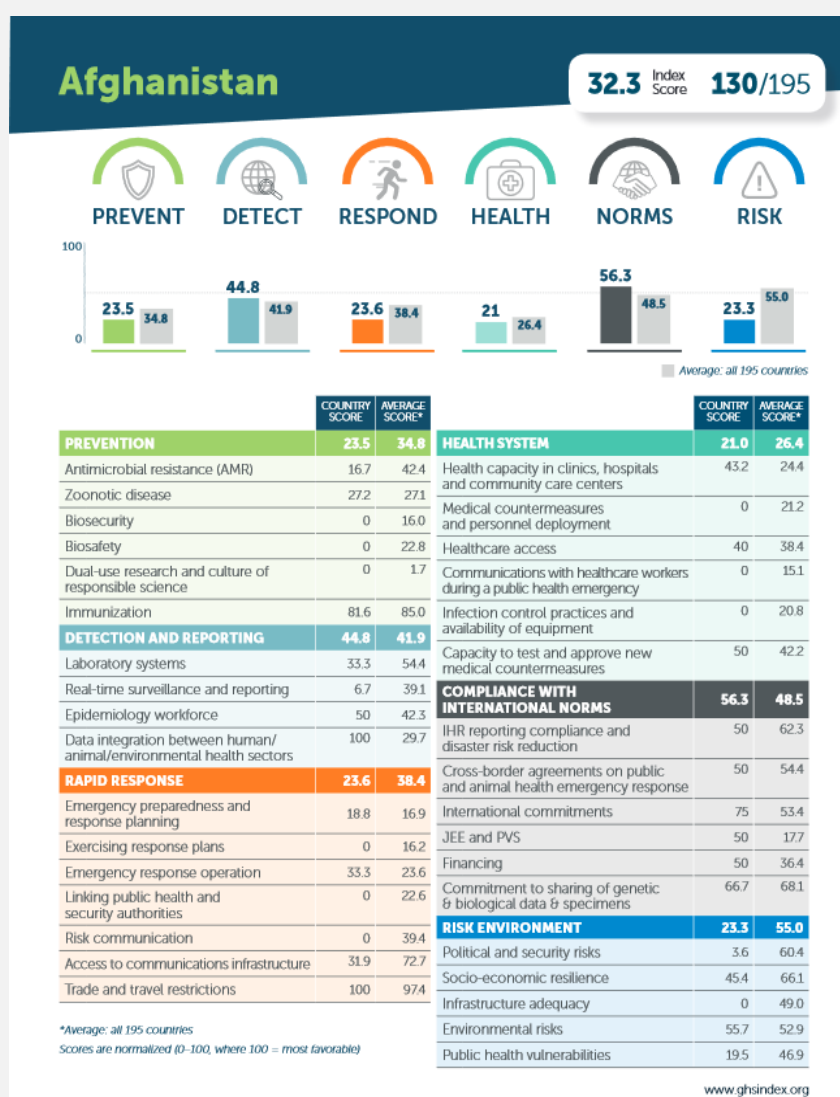
Owing to decades of conflict and under-development, the coverage of water and sanitation facilities,

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)



Recommendations

Recommendation for international business travellers

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

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

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

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

Most countries implemented strikt rules of contact reduction:

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

Risk of infection when travelling by plane:

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

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

- Perform hand hygiene frequently. Hand hygiene includes either cleaning hands with soap and water or with an alcohol-based hand rub. Alcohol-based hand rubs are preferred if hands are not visibly soiled; wash hands with soap and water when they are visibly soiled;
- Cover your nose and mouth with a flexed elbow or paper tissue when coughing or sneezing and disposing immediately of the tissue and performing hand hygiene;
- Refrain from touching mouth and nose; See also: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
- A medical mask is not required if exhibiting no symptoms, as there is no evidence that wearing a mask – of any type – protects non-sick persons. If masks are to be worn, it is critical to follow best practices on how to wear, remove and dispose of them and on hand hygiene after removal.
- WHO information for people who are in or have recently visited (past 14 days) areas where COVID-19 is spreading, you will find [here](#).

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

Source: WHO and ECDC

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 European Union Aviation Safety Agency ECDC European Centre for Disease Prevention and Control

INFO - COVID-19
Disease caused by the SARS-CoV-2 virus

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 European Union Aviation Safety Agency ECDC European Centre for Disease Prevention and Control

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 European Union Aviation Safety Agency ECDC European Centre for Disease Prevention and Control

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 European Union Aviation Safety Agency ECDC European Centre for Disease Prevention and Control

INFO - COVID-19
Disease caused by the SARS-CoV-2 virus

Arrival airport

- Practice **physical distancing**, **hand hygiene** and **cough etiquette** and wear a **medical face mask**
- Collect your bags** and leave the terminal building as soon as possible
- Reduce the risk of virus transmission** by minimising interaction with people in the arrival terminal

EASA European Union Aviation Safety Agency ECDC European Centre for Disease Prevention and Control

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
- Our World in Data; <https://ourworldindata.org/coronavirus>

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