



Update 79 COVID-19 Coronavirus Disease 21st of July 2021



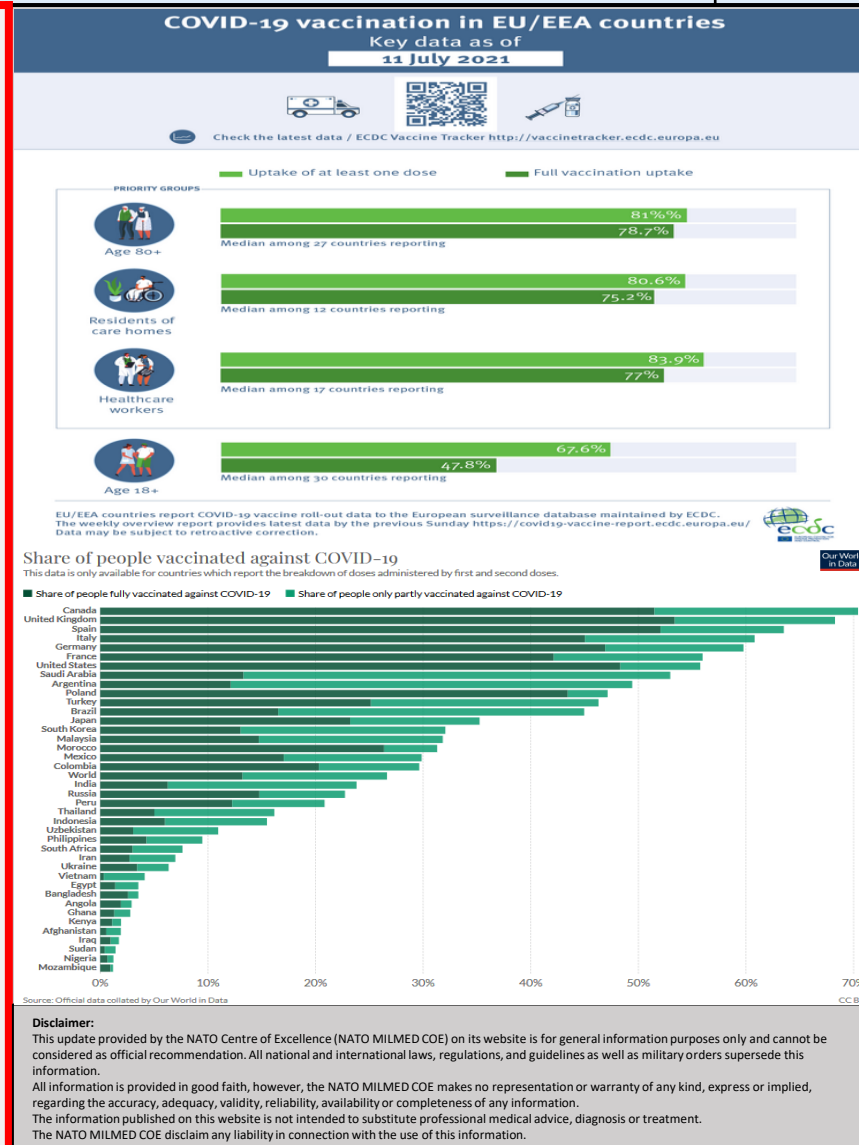
GLOBAL
↗
191 553 562
Confirmed cases
179 700 000 recovered
4 119 798 deaths

USA
(7-days incidence 75,4)
↗
34 019 525
confirmed cases
32 970 000 recovered
606 783 deaths

India
(7-days incidence 19,6)
↘
31 216 337
confirmed cases
30 120 000 recovered
418 480 deaths

Brazil
(7-days incidence 134,8)
↘
19 419 437
confirmed cases
18 150 000 recovered
544 180 deaths

- News:**
- WHO:** [Published the statement on the eighth meeting of the International Health Regulations](#) (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic.
 - WHO/UNICEF:** New data show that [23 million children missed out on basic childhood vaccines](#) through routine health services in 2020, the highest number since 2009 and 3.7 million more than in 2019.
 - WHO:** A [new report confirms that HIV infection is a significant independent risk factor](#) for both severe/critical COVID-19 presentation at hospital admission and in-hospital mortality. Overall, nearly a quarter (23.1%) of all people living with HIV who were hospitalized with COVID-19, died.
 - WHO/WFP:** Launching [INITIATE2](#), a joint project to bring together emergency actors, research and academic institutions, and international and national partners to promote knowledge sharing and skills transfer for improved emergency response to health crises.
 - ECDC:** Is [reporting that the SARS-CoV-2 resurgence](#) in EU and EEA is related to relaxation of non-pharmaceutical interventions and increasing spread of Delta variant.
 - CDC:** Published a [modelling study](#) revealing that in the first 14 months of the COVID-19 pandemic, at least 1.5 million children lost a parent, custodial grandparent, or other caregiver due to COVID-19.
 - WHO:** As an answer to the CDC study on parental lost [WHO stressed](#) that the magnitude of caregiver loss during the COVID-19 pandemic shows an urgent need for ensuring equitable global access to vaccines, supporting family-based care for children, and using evidence-based interventions such as those highlighted in [INSPIRE: seven strategies for ending violence against children](#) to reduce the increased risk of vulnerability to abuse, neglect and other forms of violence in children who have lost parents or caregivers.
 - EMA/ECDC:** Published an [update on COVID-19](#).
- Topics:**
- Global situation
 - European situation
 - Vaccination news
 - SARS-CoV-2 VOIs and VOCs
 - Other Infectious Disease Outbreaks
 - NATO Member State: Summary of information on the individual national Corona restrictions
 - Travel Recommendations and other Useful Links



EUROPE
↗
55 838 430
confirmed cases
52 790 000 recovered
1 174 492 deaths

Russia
(7-days incidence 115,7)
→
5 931 925
confirmed cases
5 405 000 recovered
147 457 deaths

France
(7-days incidence 103,2)
↗
5 890 062
confirmed cases
5 677 000 recovered
111 525 deaths

TUR
(7-days incidence 53,1)
→
5 546 166
confirmed cases
5 391 000 recovered
50 650 deaths

Situation by WHO Region, as of 18th July

Global epidemiological situation overview; WHO as of 11 July 2021

The global number of new cases reported last week (12-18 July 2021) was over 3.4 million, a 12% increase as compared to the previous week (Figure 1). Globally, COVID-19 weekly case incidence increased with an average of around 490 000 cases reported each day over the past week as compared to 400 000 cases reported daily in the previous week. Following a steady decline for over two months, the number of weekly deaths reported was similar to the previous week, with almost 57 000 deaths reported. The cumulative number of cases reported globally is now over 190 million and the number of deaths exceeds 4 million. At this rate, it is expected that the cumulative number of cases reported globally could exceed 200 million in the next three weeks. Last week, four Regions (all except the **Regions of the Americas and Africa**) reported an increase in case incidence. **The Western Pacific Region** recorded the largest increase in case incidence as compared to the previous week, followed by the **European Region** (30% and 21%, respectively). **The South-East Asia and Eastern Mediterranean Regions** also recorded increases in case incidence, 16% and 15%, respectively, as compared to the previous week. The number of deaths increased in the **South-East Asia and the Western Pacific Regions** by 12% and 10%, respectively, as compared to the previous week. **The African, Eastern Mediterranean and European Regions** reported similar numbers of deaths as compared to the previous week, whereas the **Region of the Americas** reported a 6% decrease.

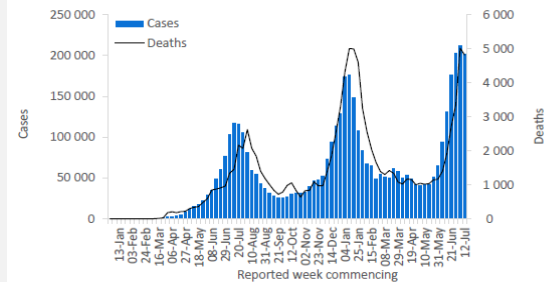
In the past week, the five countries reporting the highest number of new cases were:

- **Indonesia**; reporting 350 273 new cases; 44% increase,
- **United Kingdom**; reporting 296 447 new cases; 41% increase,
- **Brazil**; reporting 287 610 new cases; 14% decrease,
- **India**; reporting 268 843 new cases; 8% decrease,
- **United States of America**; reporting 216 433 new cases; 68% increase

African Region

Following an increasing trend in the weekly number of new COVID-19 cases and deaths since early May 2021, the Region reported a slight decrease in case incidence (with over 202 000 new cases) and mortality (over 4800 new deaths) in the past week, as compared to the previous week. These trends were largely driven by decreases reported in South Africa, which reported the highest numbers of new cases (104 583 cases) and more than 50% of the cases reported in the region in the past week. Other countries reporting high numbers of new cases include: Zimbabwe (15 760 cases; 106.0 cases/100 000; +20%), and Botswana (10 745 cases; 456.9 cases/100 000; +172%), while the highest numbers of new cases per population were reported in Seychelles (545 cases/100 000; -28%), Botswana (see above) and Namibia (317 cases/100 000; -19%).

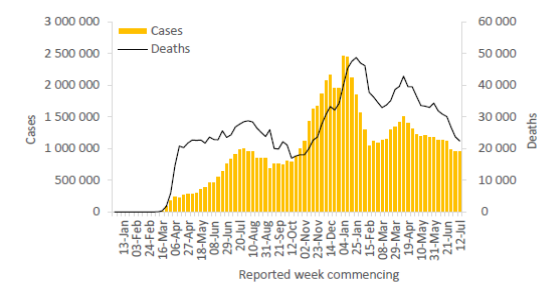
The highest numbers of new deaths were reported from South Africa (2538 deaths; 4.3 deaths/100 000; -4%), Namibia (595 deaths; 23.4/100 000; -109%), and Zimbabwe (462 deaths; 3.1 deaths/100 000; +73%).



Region of the Americas

The Region reported over 967 000 new cases, a similar number as compared to the previous week, and over 22 000 new deaths, a 6% decrease as compared to the previous week. A decline in weekly case incidence has been reported since the last peak in mid-April 2021, however, very high transmission levels and high mortality rates are still observed across many countries in the Region. The highest numbers of new cases were reported from Brazil (287 610 cases; 135.3 cases/100 000; -14%), the United States of America (216 433 cases; 65.4 cases/100 000; +68%), and Colombia (129 713 cases; 254.9 cases/100 000; -26%), while the highest numbers of new cases per population were reported in the British Virgin Islands (2900 cases/100 000; +16%), Martinique (574.8 cases/100 000; +425%) and Cuba (388.8 cases/100 000; +43%).

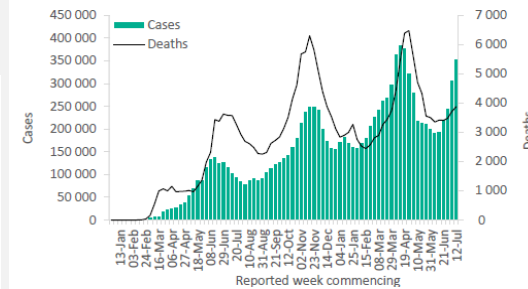
The highest numbers of new deaths were reported from Brazil (8710 deaths; 4.1 deaths/100 000; -11%), Colombia (3602 deaths; 7.1/100 000; -10%), and Argentina (2927 deaths; 6.5 deaths/100 000; similar to the previous week).



Eastern Mediterranean Region

The Region has reported a marked increase in weekly case incidence for more than one month with over 354 000 new cases reported, a 15% increase as compared to the previous week. This increase has been driven mainly by surges in several countries in the Region including Iran, Iraq, Libya, Pakistan and Morocco. The Region reported over 3800 new deaths, a similar number as compared to the previous week.

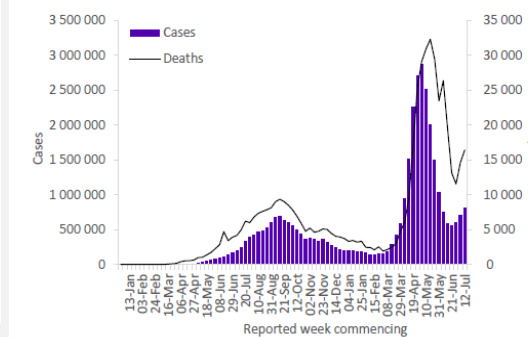
The highest numbers of new cases were reported from the Islamic Republic of Iran (145 293 cases; 173.0 cases/100 000; +27%), Iraq (61 268 cases; 152.3 cases/100 000; +8%), and Tunisia (49 777 cases; 421.2 cases/100 000; similar to the previous week), while the highest weekly case incidence per population was registered in Tunisia (see above), Kuwait (245.1 cases/100 000) and Libya (235.7 cases/100 000). The highest numbers of new deaths were reported from the Islamic Republic of Iran (1272 deaths; 1.5 deaths/100 000; +9%), Tunisia (1110 deaths; 9.4 deaths/100 000; +13%), and Afghanistan (423 deaths; 1.1 deaths/100 000; -19%).



South-East Asia Region

The Region reported over 829 000 new cases and over 16 000 new deaths, increases of 16% and 12%, respectively as compared to the previous week. Weekly case incidence and mortality in India and Sri Lanka continue to decline, with the regional trends being driven mainly by marked increases in Indonesia, Thailand and Myanmar. The highest numbers of new cases were reported from Indonesia (350 273 cases; 128.1 cases/100 000; +44%), India (268 843 cases; 19.5 cases/100 000; -8%) and Bangladesh (82 800 cases; 50.3 cases/100 000; +9%), while the highest weekly case incidence per population was registered in Maldives (150 cases/100 000), Indonesia (see above) and Thailand (96 cases/100 000).

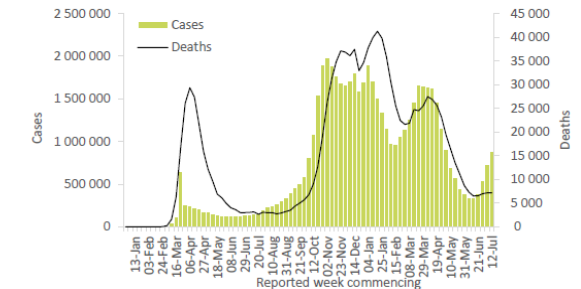
The highest numbers of new deaths were reported from Indonesia (7118 deaths; 2.6 deaths/100 000; +21%), India (5569 deaths; 0.4 deaths/100 000; -8%), and Bangladesh (1475 deaths; 0.9 deaths/100 000; +9%).



European Region

In the European Region, weekly case incidence has increased significantly across the past month, with over 885 000 new cases reported in the past week, a 21% increase as compared to the previous week. Over 7100 new deaths were reported in the past week, similar to the number reported during the previous week. The increase in reported COVID-19 cases in the Region since mid-June 2021 has been observed across all age groups, but has been most pronounced in those aged 15-24 years. The highest numbers of new cases were reported from the United Kingdom (296 447 cases; 436.7 cases/100 000; +41%), the Russian Federation (174 800 cases; 119.8 cases/100 000; similar to the previous week), and Spain (85 802 cases; 181.3 cases/100 000; -29%), while the highest weekly case incidence per population was registered in Jersey (1274 cases/100 000), Cyprus (779 cases/100 000) and Gibraltar (451 cases/100 000).

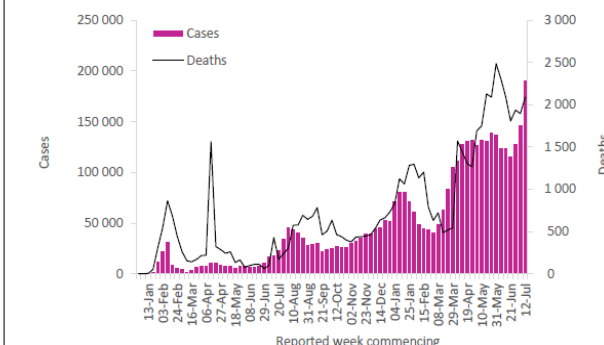
The highest numbers of new deaths were reported from the Russian Federation (5417 deaths; 3.7 deaths/100 000; +7%), Turkey (296 deaths; 0.4 deaths/100 000; -7%), and the United Kingdom (284 deaths; 0.4 deaths/100 000; +48%).



Western Pacific Region

Over the past week, weekly case incidence increased sharply in the Region with over 191 000 new cases reported, representing a 30% increase as compared to the previous week. This trend was driven mainly by increases in Fiji, Japan, Malaysia and Viet Nam. The Region reported over 2000 new deaths this week, a 10% increase as compared to the previous week. The highest numbers of new cases were reported from Malaysia (78 660 cases; 243.0 cases/100 000; +44%), the Philippines (35 235 cases; 32.2 cases/100 000; similar to the previous week), and Viet Nam (22 532 cases; 23.1 cases per 100 000; +146%), while the highest weekly case incidence per population was registered in Fiji (719 cases/100 000), Mongolia (297 cases/100 000) and Malaysia (see above).

The highest numbers of new deaths were reported from Malaysia (799 deaths; 2.5 deaths/100 000; +26%), the Philippines (782 deaths; 0.7 deaths/100 000; similar to the previous week), and Cambodia (195 deaths; 1.2 deaths/100 000; +5%).



Global Situation

ISR: In view of the rising number of corona infections in Israel, new restrictions have come into force in the country. These apply above all to festival halls and to gatherings of more than 100 people in closed rooms. From now on, only vaccinated, convalescent or people with a negative test result may participate in such events. The mask requirement in closed rooms, which was lifted at short notice in June, also applies again in the meantime.

POR: As of July 18, Portugal reported the **highest seven-day rolling average number of daily new cases since February**. According to officials, **over 90% of all incident cases in the Lisbon area and more than 80% of daily incident cases** in the country have been **attributable to the Delta variant**. The rise in infections began after Portugal reopened tourism to the European Union and the U.K. in mid-May with most businesses reopened. The number of people in need of hospital care has also increased by 30% in July compared to that in June but it is still far below the level observed when the country was under lockdown earlier this year and prior to vaccination roll-out.

Strict rules have been reimposed in July to limit the latest rise in cases, including requiring international visitors to show a negative test, vaccination certificate, or proof of recovery from COVID-19 to stay in hotels. A curfew from 11 p.m. to 5 a.m. is currently in place in 50 municipalities. The government ordered bars and restaurants to reduce the opening hours in the most affected cities, including the capital city of Lisbon, the city of Porto, and the city of Albufeira. In addition, travel between the region of Lisbon and the rest of the country during weekends has been banned.

ROU: Disease activity has been steadily decreasing since **reaching its second-highest peak in late March**. The current 14-day test positivity rate has been <1% since June 13, while the 14-day testing rate per 100,000 individuals has also been gradually decreasing in the past month. The seven-day rolling average number of daily new cases has decreased from 5,665 on March 31 to 56 as of July 18.

As of July 12, authorities have **extended the state of alert** and restrictions until August 10. Businesses and services remain operational with capacity restrictions. International travel to Romania remains open with restrictions; authorities designate countries as Green, Yellow, or Red depending on local infection rates and variant presence. Travellers from Green countries may enter Romania without restriction. Travellers from Yellow or Red countries must follow self-quarantine and PCR testing protocols upon arrival, with exceptions for those who are fully vaccinated and/or have recovered from COVID-19 within 14-180 days before arriving.

TUN: Between May 17 and July 13, disease activity has been increasing with **the seven-day rolling average number of daily new cases reaching a record high** of 7,901 on July 13. As of July 18, this value is now 6,169. Between May 17 and July 18, the **seven-day rolling average number of daily new deaths has more than doubled** from 62 to 138. On July 17, 205 deaths were recorded, the **highest single-day tally since the start of the pandemic**. On July 14, the WHO stated that Tunisia has reported the **highest COVID-19 mortality rate per capita in the Middle East region and in Africa**. As of July 16, the 14-day testing rate per 100,000 individuals is 1,309 and the 14-day **test positivity rate is 37%**, which suggests that there is a substantial degree of community transmission where mild or asymptomatic cases are not being detected. Along with this rise in cases, media articles have reported that hospitals in the country are struggling with an influx of patients and a lack of sufficient oxygen supplies. On July 15, authorities **extended coronavirus restrictions** in Kairouan Governorate through July 22 and Grand Tunis through July 31. A nightly 8 p.m. to 5 a.m. curfew remains in effect in Grand Tunis until further notice. The use of vehicles is banned in Grand Tunis on weekends and all travel to and from the governorate is banned. Places of worship are closed and public gatherings are prohibited. Further restrictions may be introduced depending on the local epidemiological situation. All land, sea, and air borders are open with testing and quarantine requirements in place.

JAP: The number of daily new infections in Tokyo has reached its highest level in six months. Infections were registered in 1832 people within 24 hours - two days before the official start of the Olympic Games on Friday and despite the fourth state of emergency, which is intended to contain the wave of infections by 22 August.

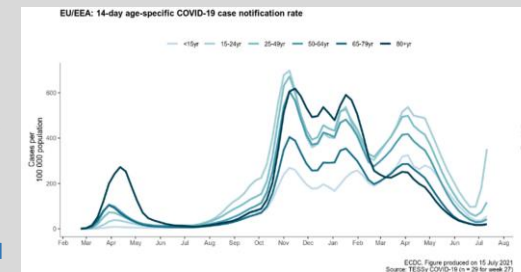
PAK: In the Pakistani port metropolis of Karachi, hospitals have to turn away patients due to rapidly increasing numbers. On Tuesday, nearly a quarter of corona tests in the city of an estimated 20 million people were positive. According to authorities, the increase in the number of daily new infections is driven by the Delta variant. It currently accounts for almost 90 percent of newly tested positive cases. A further aggravation of the situation because of the beginning of the Muslim Eid holidays on Wednesday, is assumed as people traditionally come together in large numbers.

SARS-CoV-2 resurgence in EU and EEA related to relaxation of non-pharmaceutical interventions and increasing spread of Delta variant, by ECDC as of 16 July 2021

According to ECDC's epidemic intelligence and TESSy data reported by EU and EEA countries, as of 15 July 2021, there has been an 64.3% increase of weekly COVID-19 cases compared to last week.

An increasing trend is observed in 20 countries. In the most affected countries, the steepest increases and highest notification rates were reported among 15 to 24-year-olds, with limited increases in persons aged over 65 years.

At this stage, the reported hospital occupancy rate (the daily occupancy in the last week per 100 000 population) for the EU/EEA overall remains stable. Based on data reported by 24 countries, the rate was 4.2 per 100 000, compared to 5.0 in week 26. This pooled rate has been stable for one week. However, increasing trends are reported in 3 countries. The ICU occupancy rate for the EU/EEA has been decreasing for nine weeks. Based on data reported by 18 countries, the rate was 0.7 per 100 000 population, compared to 0.9 in week 26. However, increasing trends have been reported in 2 countries.



UEFA European Football Championship 2021 Surveillance by ECDC (week 04 to 10 July 2021)

From 9 July to 15 July 2021, no significant events nor additional SARS-CoV-2 positive cases linked to attendance at UEFA EURO 2020 games have been detected.

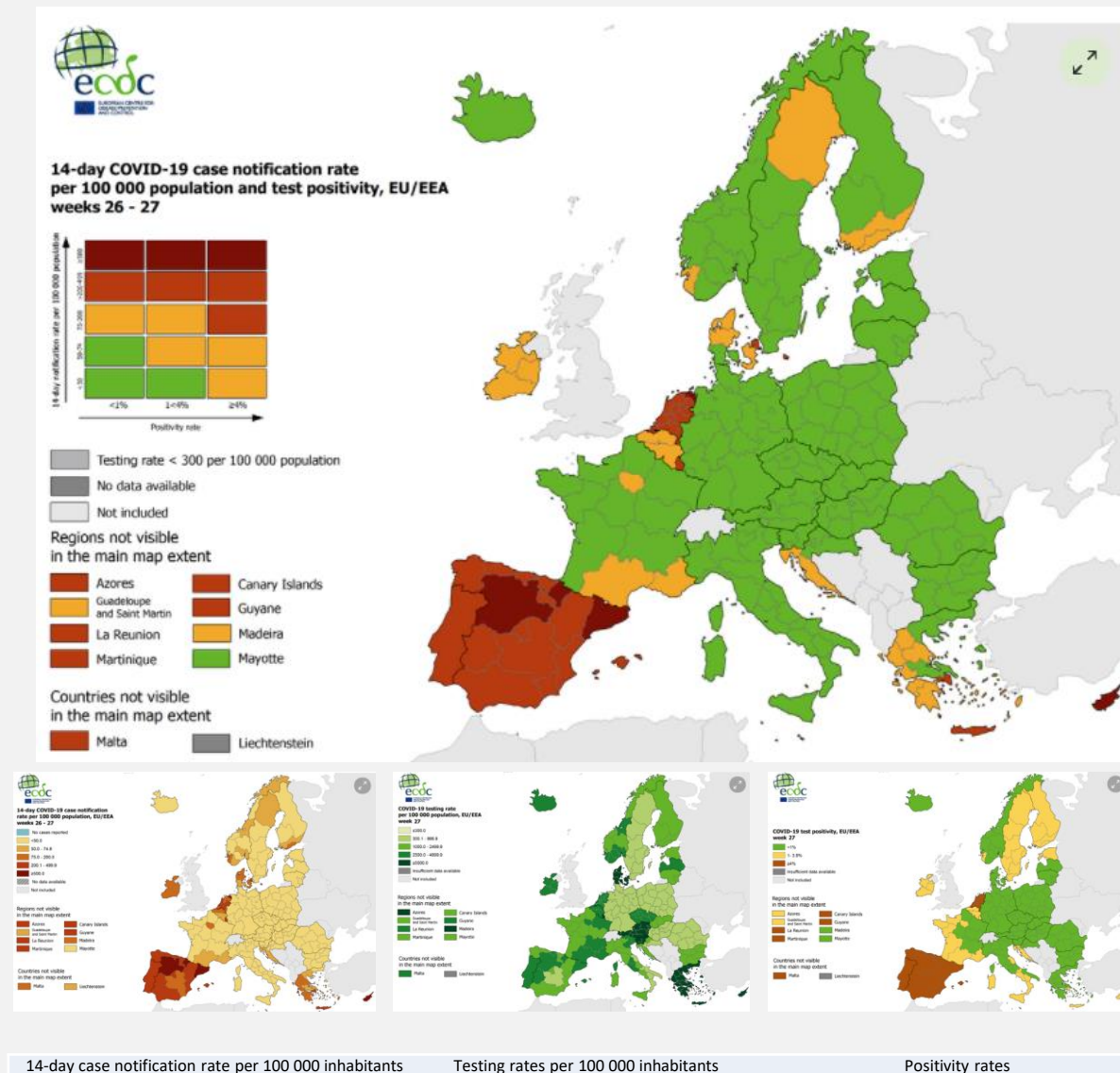
Summary:

According to multiple sources, from the beginning of the UEFA EURO 2020 and as of 8 July 2021, eight countries have reported 2512 SARS-CoV-2 positive cases linked to attendance at UEFA EURO 2020 games: **Croatia** (2), **Denmark** (source 1, source 2) (35; of these, five with the Delta variant), **Finland** (481), **France** (3), the **Netherlands** (3), **Sweden** (2), **Scotland** (1991) and **Germany** (18). In addition, **Finland** reported that in week 25 (ending on 27 June 2021), more than 40% of the positive SARS-CoV-2 infections detected were directly related to the UEFA EURO 2020, and in week 26 (ending on 4 July 2021) the corresponding proportion was 15%. **Danish Agency for Patient Safety** started a testing campaign in Aarhus, **Denmark**, due to the recent increase of SARS-CoV-2 cases in the municipality. Many of Aarhus' citizens who tested positive in recent days indicated football events or other festivities as a possible source of infection.

According to media and **WHO EURO 2020 explorer**, among the UEFA host cities, an increase of SARS-CoV-2 cases during the monitoring period from 4 June to 15 July 2021, was reported in **St. Petersburg (Russia)**, **Rome (Italy)**, **Baku (Azerbaijan)**, **Amsterdam (Netherlands)**, **Copenhagen (Denmark)**, **Munich (Germany)**, and **London (UK)**.

European Situation

Maps in support of the Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic in the EU, as of 15 July 2021



ECDC COVID-19 surveillance report Week 27, as of 15 July 2021

Overall situation:

- At the end of week 27 (week ending Sunday 11 July 2021), the overall COVID-19 case notification rate for the European Union and European Economic Area (EU/EEA) was 89.6 per 100 000 population (51.6 the previous week). This rate has been increasing for two weeks. Overall hospital admissions due to COVID-19 have been stable for six weeks and the 14-day COVID-19 death rate (6.8 per million population, 9.5 the previous week) has been stable for two weeks.
- ECDC's assessment of each country's epidemiological situation derives from a composite score based on the absolute value and trend of five weekly COVID-19 epidemiological indicators. As shown below, for week 27, the EU/EEA was categorised overall as of low concern (the same as the previous week). Two countries were categorised as of high concern, four as of moderate concern, eight as of low concern and 16 as of very low concern. Compared to the previous week, eight countries (Croatia, Finland, France, Luxembourg, Malta, the Netherlands, Portugal and Spain) moved to a higher category, 21 countries (Austria, Belgium, Bulgaria, Czechia, Denmark, Estonia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Norway, Poland, Romania, Slovakia, Slovenia and Sweden) stayed in the same category and one country (Cyprus) moved to a lower category.
- Ensemble model forecasts produced for each EU/EEA country on 12 July 2021 by the [European COVID-19 Forecast Hub](#) provide 4-week predictions for weeks 28 to 31. During this period, increasing trends in cases are forecast and increasing trends in deaths are forecast, reaching 622.9 per 100 000 population and 10.5 per million population, respectively, by the end of week 31. At the country level, increasing trends in cases are forecast for 20 countries (Austria, Belgium, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Portugal, Slovenia and Spain) and increasing trends in deaths are forecast for nine countries (Cyprus, Greece, Lithuania, Luxembourg, Malta, the Netherlands, Portugal, Slovenia and Spain). Note that the uncertainty present in these forecasts, not shown here, increases the further ahead predictions are made.
- By the end of week 27, 63.4% of people aged 18 years and older in the EU/EEA (country median, range: 67.6%, 17.4–90.0%) had received at least one dose of vaccine against COVID-19 and 48.1% (country median, range: 47.8%, 15.6–82.6%) had been fully vaccinated.
- The estimated distribution (median and range of values from 16 countries) of variants of concern was 42.5% (2.1–95.8%) for B.1.1.7 (Alpha), 39.1% (0.7–87.3%) for B.1.617.2 (Delta), 0.4% (0.0–11.1%) for B.1.351 (Beta), 0.3% (0.0–65.0%) for P.1 (Gamma) and 0.0% (0.0–3.2%) for B.1.1.7+E484K.
- The current continuing deterioration of the epidemiological situation in many countries is expected to continue given the rapid increase in the Delta variant. To date, most recent increases in cases have been reported among younger age groups, with limited observed changes so far in indicators of COVID-19 severity.

Severity of COVID-19 in the EU/EEA as of week 27

Case notification rates in people 65 years and older

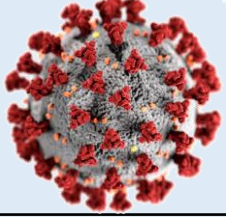
- The 14-day case notification rate in people aged 65 years or older for the EU/EEA, based on data reported by 26 countries, was 21.1 per 100 000 population (country range: 3.1–93.9), compared to 17.0 (country range: 1.1–98.3) in week 26. This pooled rate has been increasing for one week. The rate per 100 000 population was <20 in 19 countries, 20–<50 in three countries (Latvia, Luxembourg and Poland) and 50 or higher in four countries (Croatia, Cyprus, Portugal and Spain). Increasing trends were reported in seven countries.

Rates of hospitalisation and ICU admission and occupancy

- The hospital admission rate for the EU/EEA, based on data reported by 16 countries, was 0.8 per 100 000 population (country range: 0.2–9.5), compared to 1.0 (country range: 0.2–8.2) in week 26. This pooled rate has been stable for six weeks. As a percentage of each country's pandemic peak, this rate was <10% in 14 countries, 10–<25% in one country (Portugal) and 25% or higher in one country (Cyprus). An increasing trend (of duration in weeks) was reported in one country (Cyprus (two)).
- The hospital occupancy rate (mean daily occupancy in the last week per 100 000 population) for the EU/EEA, based on data reported by 24 countries, was 4.2 per 100 000 population (country range: 0.0–14.1), compared to 5.0 (country range: 0.3–20.8) in week 26. This pooled rate has been stable for one week. As a percentage of each country's pandemic peak, this rate was <25% in 23 countries and 25% or higher in one country (Cyprus). Increasing trends (of duration in weeks) were reported in two countries (Cyprus (three) and Finland (one)).
- The ICU admission rate for the EU/EEA, based on data reported by 14 countries, was 0.1 per 100 000 population (country range: 0.0–1.3), compared to 0.2 (country range: 0.0–2.5) in week 26. This pooled rate has been stable for four weeks. As a percentage of each country's pandemic peak, this rate was <10% in 12 countries, 10–<25% in one country (Latvia) and 25% or higher in one country (Cyprus).
- The ICU occupancy rate for the EU/EEA, based on data reported by 18 countries, was 0.7 per 100 000 population (country range: 0.0–1.7), compared to 0.9 (country range: 0.1–2.5) in week 26. This pooled rate has been decreasing for nine weeks. As a percentage of each country's pandemic peak, this rate was <25% in 17 countries and 25% or higher in one country (Cyprus). Increasing trends (of duration in weeks) were reported in two countries (Cyprus (one) and Portugal (four)).

VOCs and VOIs:

- Sequencing capacity varies greatly across the EU/EEA. ECDC uses data reported to the [GISAID EpiCoV database](#) or TESSy to estimate the distribution of variants in countries reporting an adequate average weekly volume of SARS-CoV-2-positive cases sequenced (to estimate the proportion with sufficient precision for a variant prevalence of 5% or lower). Due to reporting delays in many countries a two-week window excluding the most recent week (weeks 25 to 26, 21 June to 4 July 2021) was used.
- In this period, 17 countries (Belgium, Bulgaria, Denmark, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Norway, Poland, Portugal and Sweden) reported an adequate average weekly sequencing volume (eight at 1% precision or lower, four at >1-2.5% precision and five at >2.5-5% precision), eight countries reported an inadequate sequencing volume at >5% precision and five did not report any data.
- Among the 17 countries with an adequate sequencing volume in this period, 16 had a valid denominator. The median (range) of the VOC reported in all samples sequenced in these 16 countries was 42.5% (2.1–95.8%) for B.1.1.7 (Alpha), 39.1% (0.7–87.3%) for B.1.617.2 (Delta), 0.4% (0.0–11.1%) for B.1.351 (Beta), 0.3% (0.0–65.0%) for P.1 (Gamma) and 0.0% (0.0–3.2%) for B.1.1.7+E484K.
- The median (range) of the VOI reported in all samples sequenced in the period for these 16 countries was 0.0% (0.0–1.5%) for B.1.617.1 (Kappa), 0.0% (0.0–0.9%) for B.1.525 (Eta), 0.0% (0.0–0.2%) for B.1.620, 0.0% (0.0–0.2%) for B.1.621 and 0.0% (0.0–0.0%) for B.1.617.3.



Vaccination news



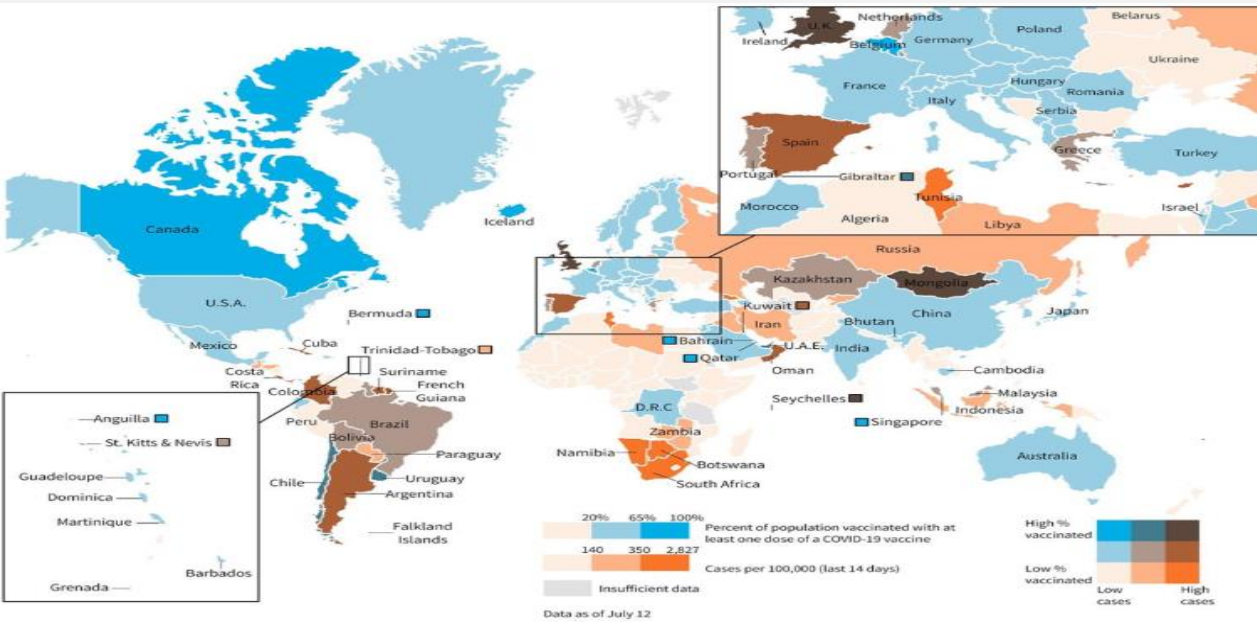
According to data collected by Our World in Data, more than 3.54 billion COVID-19 vaccine doses have been administered in 180 countries. As of July 15, the WHO's COVAX program has shipped 119 million doses to 136 eligible countries. As of July 20, 106 countries have reported the Delta (B.1.617.2) variant. A number of countries are facing a rise in disease activity with the increased dominance of the Delta variant, including countries with high vaccination coverage.

Surges in disease activity related to Delta VoC have been occurring despite high vaccination coverage. For example, as of July 8, in Israel, the seven-day rolling average number of daily new cases have increased to a level which was last seen in April. The resurgence began after Israel officials lifted the indoor mask requirement in the country on June 18. As of June 25, daily infections had increased more than four-fold compared to the week prior. On June 25, officials reimposed indoor mask restrictions in public settings again as they continue to urge parents to vaccinate children aged above 12. According to the latest Health Ministry figures, as of June 28, 51% of active infections are among Israelis who are 19 or younger and 77.3% of those hospitalized in serious condition are unvaccinated.

According to a study published in Lancet based on data from Public Health Scotland and a preprint study based on ICES data from February to June in Ontario, the Delta variant increased the risk of hospitalization and death by roughly 85% and 61%, respectively, compared to the Alpha variant. However, there is evidence to support ongoing high protection among those vaccinated against severe outcomes of infection (leading to hospitalization) with the Delta variant.

Other countries where the Delta variant became dominant are experiencing surging incident cases, including Kuwait, Portugal, and Russia, appear to have relaxed many restrictions quickly while population immunity and vaccination coverage was below the accomplished threshold.

Source: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01358-1/fulltext#articleInformation](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01358-1/fulltext#articleInformation)
<https://www.medrxiv.org/content/10.1101/2021.07.05.21260050v2.full.pdf>
<https://www.medrxiv.org/content/10.1101/2021.05.22.21257658v1.full.pdf>



Vaccine Research Update

What are the updates for vaccine candidates in Phase 3 or Phase 2/3 trials?

Company	Vaccine Candidate	Updates
Pfizer/BioNTech 	BNT162	<ul style="list-style-type: none"> Pfizer officials announced that the company expects to seek emergency authorization for a third booster dose of its vaccine in August 2021, following positive preliminary results from its booster dose study.
AstraZeneca/University of Oxford 	AZD1222	<ul style="list-style-type: none"> AstraZeneca researchers reported that a third dose of its vaccine produces strong immune response, although there was not yet evidence that a third dose is needed. The study looked at 30 participants who received a late second dose and 90 participants who received a third dose. Results were released in a preprint study.
Zydus 	ZyCoV-D	<ul style="list-style-type: none"> On July 1, the company announced that its vaccine reported 66.6% effectiveness against symptomatic disease and none of the vaccinated volunteers in the trial developed severe disease or died, making its vaccine the world's first DNA-based COVID-19 vaccine. The company is currently applying for emergency use authorization in India.
Johnson & Johnson 	JNJ-78436725	<ul style="list-style-type: none"> On July 1, Johnson & Johnson released results that its vaccine induces a 40% reduced level of antibodies against the Delta variant. However, the level of antibodies generated is still expected to offer protection against symptomatic COVID-19 disease. On July 12, the United States Centers for Disease Control and Prevention (CDC) and the US Food and Drug Administration (FDA), updated in a statement that Johnson & Johnson's COVID-19 vaccine may pose a small risk of a rare but potentially dangerous neurological autoimmune-mediated syndrome i.e. Guillain-Barre (GBS) also known as acute inflammatory demyelinating polyradiculoneuropathy (AIDP).
GlaxoSmithKline/Clover Biopharmaceuticals/Dynavax 	No name announced	<ul style="list-style-type: none"> On June 30, the company announced its agreement to provide 400 million to WHO's COVAX initiative to deliver its vaccines to low- and middle-income countries. The company expected results from its Phase 2/3 trial in the third quarter of 2021. In July, the company registered a Phase 2 trial tailored for the Beta variant (B.1.351).
Finlay Vaccine Institute 	Soberana 2	<ul style="list-style-type: none"> On July 8, Cuban officials announced that its vaccine candidate Soberana 2 delivered with a booster called Soberana Plus, showed 91.2% effective in Phase 3 clinical trial against symptomatic COVID-19.
Center for Genetic Engineering and Biotechnology of Cuba 	Abdala	<ul style="list-style-type: none"> On July 9, the Cuban government granted emergency use authorization to Abdala, citing that the vaccine Abdala was 92.28% effective in Phase 3 trial, using a three-dose vaccination schedule.
Bharat BioTech/Indian Council of Medical Research/National Institute of Virology 	Covaxin	<ul style="list-style-type: none"> On July 2, the company released the final results of its Phase 3 trial, stating that its vaccine showed 77.8% effectiveness against symptomatic COVID-19, also showing 93.4% effectiveness against severe outcomes including hospitalization and death. The researchers also studied the effectiveness of the vaccine against the Delta variant, indicating that its effectiveness against Delta was 65.2%

European Situation on Vaccination

Source: <https://gap.ecdc.europa.eu/public/extensions/COVID-19/vaccine-tracker.html#uptake-tab>

Total doses distributed to EU/EEA countries

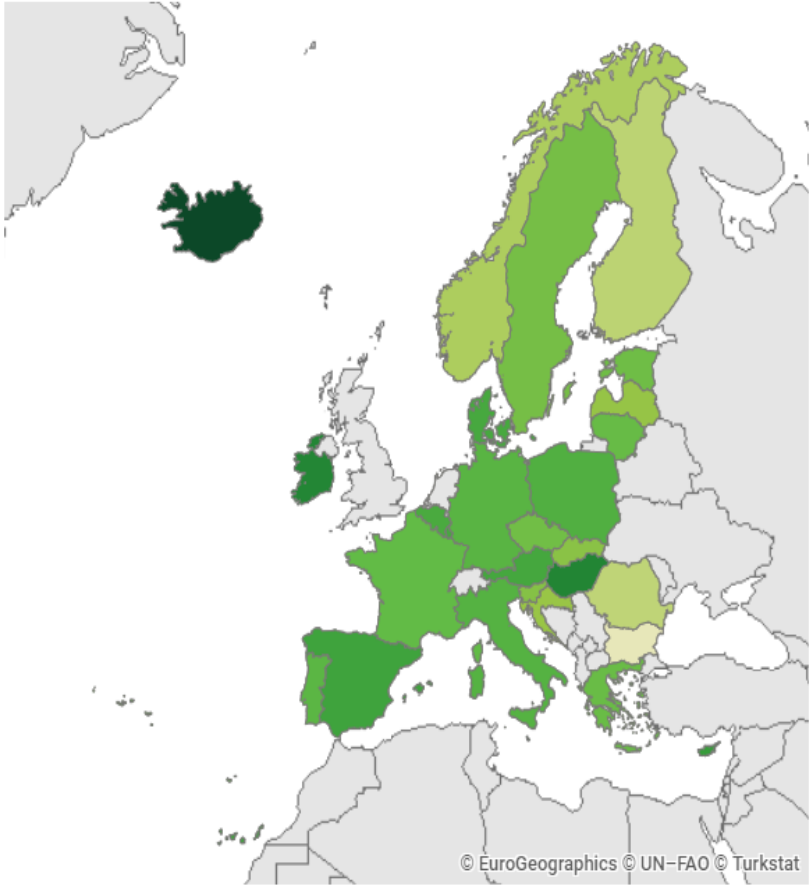
498,296,553

421,484,658

Select View : Uptake full vaccination

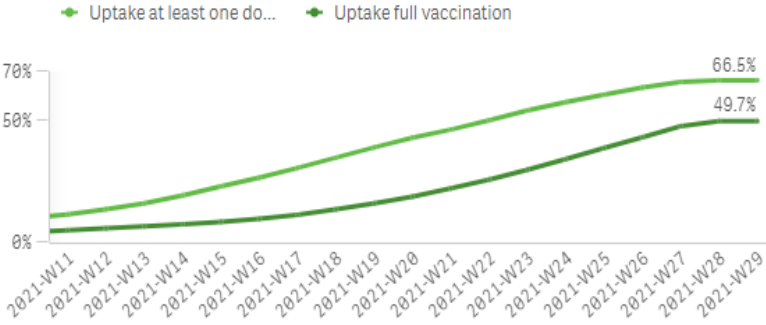
Select Country : All EU/EEA countries

Cumulative uptake (%) of full vaccination among adults (18+) in EU/EEA countries as of 2021-07-20



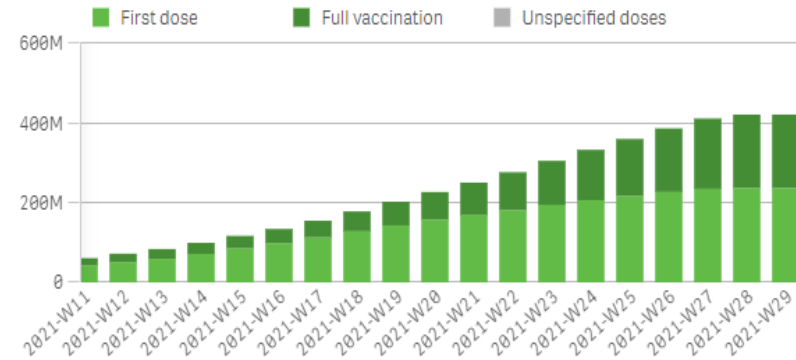
Cumulative uptake (%) of at least one vaccine dose and full vaccination among adults (18+) in EU/EEA countries as of 2021-07-20

by reporting week (data for the current week are preliminary)



Cumulative number of doses administered to adults (18+) in EU/EEA countries as of 2021-07-20

by reporting week (data for current week are preliminary)



Weekly doses Cumulative doses

Cumulative uptake (%) of at least one vaccine dose among people aged 80 years and above in EU/EEA countries as of 2021-07-20

Country	Uptake at least one dose (%) - 80 years old and above
Austria	98.6%
Belgium	89.8%
Bulgaria	17.7%
Croatia	54.7%
Cyprus	91.5%
Czechia	81.1%
Denmark	100.0%
Estonia	62.8%
Finland	94.2%
France	80.6%
Germany	-
Greece	70.3%
Hungary	73.9%
Iceland	100.0%
Ireland	100.0%
Italy	93.4%
Latvia	38.0%
Liechtenstein	-
Lithuania	53.3%
Luxembourg	80.6%
Malta	100.0%
Netherlands	-
Norway	100.0%
Poland	62.2%
Portugal	99.6%
Romania	19.2%
Slovakia	51.1%
Slovenia	68.9%
Spain	100.0%
Sweden	94.6%
The Netherlands	-

Update on SARS-CoV-2 Variants Of Concern (VOC)

Source: <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---20-july-2021>

WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 result in changes in transmissibility, clinical presentation and severity, or if they result in changes in public health and social measures (PHSM) implementation by national health authorities. Globally, systems have been established and are being strengthened to detect “signals” of potential Variants of Interest (VOIs) or Variants of Concern (VOCs) and assess these based on the risk posed to global public health.

As surveillance activities to detect SARS-CoV-2 variant cases are strengthened at local and national levels, including systematic genomic sequencing, the number of countries reporting VOCs has continued to increase. This information should be interpreted with due consideration of surveillance limitations, including but not limited to differences between countries in sequencing capacity and prioritization of samples for sequencing.

Summary of phenotypic impacts of Variants of Concern (VOCs)

WHO label	Alpha	Beta	Gamma	Delta
Transmissibility	Increased transmissibility and secondary attack rate ⁶	Increased transmissibility ⁷	Increased transmissibility ⁸	Increased transmissibility and secondary attack rate ^{1,9,10}
Disease severity	Increased risk of hospitalization ¹¹ , possible increased risk of severity and mortality ¹²	Not confirmed, possible increased risk of in-hospital mortality ^{13,14}	Not confirmed, possible increased risk of hospitalization ¹⁵	Increased risk of hospitalization ^{3,16}
Risk of reinfection	Neutralizing activity retained, ¹⁷ risk of reinfection remains similar ^{18,19}	Reduction in neutralizing activity reported; T cell response elicited by D614G virus remains effective ^{20–23}	Moderate reduction in neutralizing activity reported ^{24,25}	Reduction in neutralizing activity reported ²⁶
Impacts on diagnostics	Limited impact – S gene target failure (SGTF); no impact on overall result from multiple target RT-PCR, No impact on Ag RDTs observed ²⁷	No impact on RT-PCR or Ag RDTs observed ¹⁶	None reported to date	None reported to date

As of 20 July 2021, a total of 2 418 133 SARS-CoV-2 sequences have been submitted to GISAID, a global science initiative and primary source that provides open access to genomic data. Over 220 000 (9%) of SARS-CoV-2 sequences submitted to GISAID are confirmed as the Delta Variant. As mentioned in our last update, based on the estimated transmission advantage of the Delta variant, it is expected that it will rapidly outcompete other variants and become the dominant circulating lineage over the coming months. The prevalence of Delta among the specimens sequenced over the past 4 weeks exceeded 75% in many countries worldwide including Australia, Bangladesh, Botswana, China, Denmark, India, Indonesia, Israel, Portugal, Russian Federation, Singapore, South Africa and the United Kingdom.

Growing evidence supports the increased transmissibility of the Delta variant as compared to non-VOCs. However, the exact mechanism for the increase in transmissibility remains unclear.

A recent study from China during an outbreak of the Delta variant examined the time interval from the exposure of a quarantined population to the first positive PCR result and found that the interval may be shorter for the Delta variant when compared to non-VOCs [4 (IQR 3.00-5.00) days compared to 6 (IQR 5.00 to 8.00) days, respectively]. Moreover, the viral load of the first positive test of Delta infection was over 1200 times higher than non-VOCs, suggesting that this VOC may be able to replicate faster and be more infectious during the early stages of infection.

A study from Canada analysing data from over 200 000 COVID-19 cases showed an increase in virulence of the Delta variant when compared to non-VOCs.

Among the COVID-19 cases, the risk of hospitalization, ICU admission and death associated with the Delta variant compared to non-VOCs increased by 120% (93-153%), 287% (198-399%) and 137% (50-230%), respectively. Increased disease severity was also identified for Alpha, Beta and Gamma variants combined when compared to non-VOCs: 59% (49-69%) for hospitalization, 105% (82-134%) for ICU admission and 61% (40-87%) for death.

Preliminary findings from a study in the United Kingdom, which measured antibodies in a cohort of 112 SARS-CoV-2-infected individuals, indicated significantly reduced neutralization titres (2.5 to 5-fold reduction) in sera from individuals infected with Delta, Beta or Alpha variants with a S:484K mutation (but not Alpha without any additional mutations) when compared to the non-VOCs.

A recent modelling study simulated the effects of non-pharmaceutical interventions (NPIs) in the context of expanding vaccination coverage and the predominance of the Delta variant in Germany, while accounting for age-associated factors and commuting activities. The authors indicated that timely implementation of NPIs in combination with masks and testing would considerably reduce the chance of a further surge in infections.

VOC impacts on vaccines

Table 3 presents the impact of variants on vaccine efficacy/effectiveness (VE) and quantifies the reduction in VE due to variants compared to VE in non-VOC settings. Of note, reductions in VE do not necessarily mean loss of protection, as indicated by the absolute VE estimate. For example, a 10-percentage point reduction in VE against symptomatic disease for mRNA vaccines would still mean high vaccine effectiveness of ~85%. In addition, vaccines have shown higher VE against severe disease; thus, small reductions in VE against severe disease due to VOCs may still mean good protection, as is the case for AstraZeneca-Vaxzevria.

Since 6 July update, two notable studies have provided further evidence of the performance of mRNA vaccines against Alpha and Beta variants. The first, a test-negative case-control study in the United States of America, found that vaccination with two doses of Moderna-mRNA-1273 or Pfizer BioNTech-Comirnaty vaccines was 92.8% (95% CI: 83.0-96.9%) effective at preventing hospitalization due to the Alpha variant 14 or more days after receipt of the second dose; VE against all variants was 86.9% (95% CI: 80.4-91.2%). It should be noted that approximately 21% of the 1210 adults participating in the study were immunosuppressed.

A second study, from Qatar, evaluated VE of Moderna-mRNA-1273 against SARS-CoV-2 infection and severe disease due to Alpha and Beta variants among a large cohort of adults using a matched test negative case-control design. Adjusted VE against infection due to the Alpha and Beta variants 14 or more days after receipt of the second dose was 100% and 96% (95% CI: 90.9-98.2%), respectively. Single dose VE against infection due to Alpha and Beta was reduced: 88.2% (95% CI: 83.8-91.4%) and 68.2% (95% CI: 64.3-71.7%), respectively. The study also evaluated VE of Moderna-mRNA-1273 against asymptomatic, symptomatic, and severe, critical, or fatal disease due to all variants (predominantly Alpha and Beta). VE of two doses of the vaccine ranged from 90-99% for these outcomes. VE of a single dose remained high for severe, critical or fatal disease (84%) but was markedly lower for asymptomatic and symptomatic disease at 47.3% (95% CI: 37.6-55.5%) and 66.0% (60.6-70.7%), respectively, thus, highlighting the importance of two doses.²⁹

Update on SARS-CoV-2 Variants Of Concern (VOC)

Source: <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---20-july-2021>

Summary of vaccine performance against Variants of Concern

Alpha	Beta	Gamma	Delta
Efficacy/effectiveness against disease or infection (full vaccination), see key below table			
Protection retained against all outcomes	Protection retained against severe disease; possible reduced protection against symptomatic disease and infection	Unclear impact; very limited evidence	Protection retained against severe disease; possible reduced protection against symptomatic disease and infection
Severe disease			
<ul style="list-style-type: none"> ↔: Moderna-mRNA-1273 (1), Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty (1), Pfizer BioNTech-Comirnaty (2)^{28,30-32} ↓: AstraZeneca- Vaxzevria (1)³¹ 	<ul style="list-style-type: none"> ↔: Janssen Ad26.COV 2.5 (1), PfizerBioNTech-Comirnaty (1)^{30,33} 	<ul style="list-style-type: none"> No evidence 	<ul style="list-style-type: none"> ↔: AstraZeneca- Vaxzevria (1), Pfizer BioNTech-Comirnaty (1)³¹
Symptomatic disease			
<ul style="list-style-type: none"> ↔: Moderna-mRNA-1273 (1), Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty (1), Pfizer BioNTech-Comirnaty (3)³⁴⁻³⁷ ↔ to ↓: AstraZeneca-Vaxzevria (3)^{35,36,38} ↓: Novavax-Covavax (1)³⁹ 	<ul style="list-style-type: none"> ↔: Janssen-Ad26. COV 2.5 (1)³³ ↓↓↓: AstraZeneca-Vaxzevria (1), Novavax-Covavax (1)^{40,41} 	<ul style="list-style-type: none"> ↔ to ↓: Sinovac-CoronaVac (1)^{42,43} 	<ul style="list-style-type: none"> ↔ to ↓: PfizerBioNTech-Comirnaty (3)³⁵⁻³⁷ ↓: Bharat-Covaxin (1)⁴⁴ ↓↓: AstraZeneca- Vaxzevria (2)^{35,36}
Infection			
<ul style="list-style-type: none"> ↔: PfizerBioNTech-Comirnaty (1)³⁶ ↔ to ↓: AstraZeneca-Vaxzevria (2)^{36,38} 	<ul style="list-style-type: none"> ↔: Moderna-mRNA-1273 (1)²⁹ ↓: PfizerBioNTech-Comirnaty (1)³⁰ 	<ul style="list-style-type: none"> No evidence 	<ul style="list-style-type: none"> ↓: AstraZeneca-Vaxzevria (1), Pfizer BioNTech-Comirnaty (1)³⁶
Neutralization (full vaccination), see key below table			
<ul style="list-style-type: none"> ↔: Anhui ZL-Recombinant (1), Beijing CNBG-BBIBP-CorV (1), Bharat-Covaxin (1), Gamaleya-Sputnik V (1), Novavax-Covavax (1)⁴⁵⁻⁴⁹ ↔ to ↓: Janssen-Ad26.COV 2.5 (3), Moderna-mRNA-1273 (9), Pfizer BioNTech-Comirnaty (27) Sinovac-CoronaVac (5)^{23,45,48-84} ↓ to ↓↓: AstraZeneca-Vaxzevria (2)^{38,55} 	<ul style="list-style-type: none"> ↔ to ↓: Anhui ZL-Recombinant (2), Beijing CNBG-BBIBP-CorV (2)^{45,85,86} ↓: Bharat-Covaxin (1)⁸⁷ ↓ to ↓↓: Moderna-mRNA-1273 (11), Pfizer BioNTech-Comirnaty (27), Sinovac-CoronaVac (4)^{23,45,50-52,55,57-61,63,64,66-69,71,73-78,81,84,85,88-96} ↓ to ↓↓↓: Janssen-Ad26.COV 2.5 (3)^{79,80,97} ↓↓: AstraZeneca-Vaxzevria (4), Gamaleya-Sputnik V (1)^{40,47,55,68,93} ↓↓↓: Novavax-Covavax (1)⁵⁹ 	<ul style="list-style-type: none"> ↔ to ↓: Pfizer BioNTech-Comirnaty, (12), Sinovac-CoronaVac (3)^{51,55,57,59,61,64,74,82-84,88,99-101} ↓: AstraZeneca-Vaxzevria (1), Janssen-Ad26.COV 2.5 (2), Moderna-mRNA-1273 (4)^{55,57,73,76-80,100} 	<ul style="list-style-type: none"> ↔: Janssen-Ad.COV 2.5 (1)⁷⁹ ↓: Anhui ZL-Recombinant (1), AstraZeneca-Vaxzevria (2), Bharat-Covaxin (1), Moderna-mRNA-1273 (2), SII – Covishield (1)^{49,78,87,93,102-104} ↓ to ↓↓: Pfizer BioNTech-Comirnaty (6)^{71,84,93,99,102,103} ↓ to ↓↓↓: Sinovac-CoronaVac (2)^{49,81}

Additional notes on VOC impacts on vaccines

Studies presenting VOC specific VE estimates for full vaccination (≥ 7 days post final dose) are assessed against a comparator VE estimate to determine level of reduction in VE. For symptomatic disease, VOC VE is compared against phase 3 randomised RCT results from non-VOC settings. For severe disease and infection, VOC VE is compared to non-VOC VE estimates from the same study when available (or to Alpha VE from same study when assessing Beta, Gamma, or Delta); with an exception for AstraZeneca Vaxzevria for severe disease (phase 3 RCT efficacy estimates against severe disease are used as comparator since within study comparator is unavailable) and for infection (when phase 3 estimate of VE against infection due to non-VOC is available and used as comparator). In some instances, a study may be included for severe disease or infection even without a comparator if very high VE estimate against a VOC is reported (i.e., >90%).

It is also important to note that studies vary in population, outcome definitions, study design and other methodological considerations, which may in part explain differences when comparing VE estimates between different studies. In addition, the reductions presented consider VE point estimates only and do not take into account the uncertainty around these estimates. The reductions in VE noted should be interpreted with these limitations in mind.

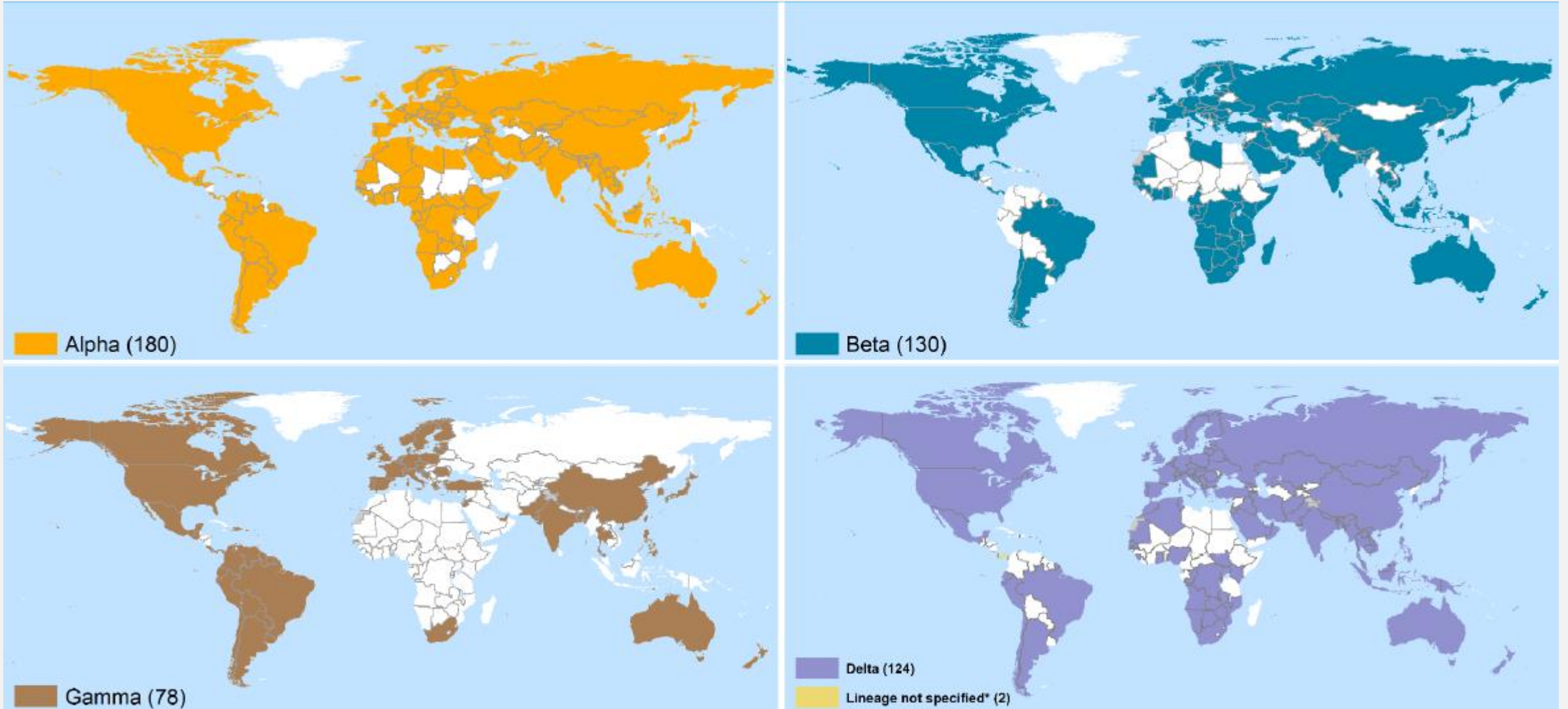
Arrows generalize the magnitude of reduction in VE or neutralization: “↔” <10% reduction in VE, or VE >90% with no comparator, or that there was a <2-fold reduction in neutralization; “↓” 10 to <20% reduction in VE, or 2 to <5-fold reduction in neutralization; “↓↓” 20 to <30% reduction in VE, or 5 to <10-fold reduction in neutralization; “↓↓↓” ≥30% reduction in VE, or ≥10-fold reduction in neutralization. When more than one neutralization study is available, the interquartile range (25th and 75th percentiles) of fold-reductions across all studies for specific vaccine/variant was used.

The number of studies is shown in parentheses.

“Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty” indicates that both vaccines were evaluated together in study.

Update on SARS-CoV-2 Variants Of Concern (VOC)

Countries, territories and areas reporting variants Alpha (B.1.1.7), Beta (B.1.351), Gamma (P.1) and Delta (B.1.617.2), as of 20 July 2021



Other Infectious Disease Outbreaks

First Historical B Virus Human Infection in China

- Health authorities in China have confirmed the **first historical human infection and related death due to B virus** (*Herpesvirus simiae*, or *Herpes virus B* infecting macaque monkeys).
- According to the Chinese Centre for Disease Control and Prevention (CCDC), the deceased is a 53-year-old veterinarian in Beijing, China's capital who died in May. The individual had dissected two dead primates, believed to be macaques, in early March as part of experimental research.
- **B virus infections are mostly a zoonotic threat to occupational workers**, including primate veterinarians, animal care personnel, and laboratory researchers. Individuals are typically infected with B virus if they are bitten or scratched by an infected macaque monkey, or have contact with the monkey's eyes, nose, or mouth. However, there has been one case of human-to-human transmission documented.
- This event is noteworthy as no fatal or even clinically evident B virus infections have been reported in China before 2021, and **highlights once more the occurrences of animal-to-humans spillovers**.

Source: <https://www.aninews.in/news/world/asia/china-reports-first-death-due-to-monkey-b-virus20210718180817/>

Multi-country outbreak of Salmonella Braenderup ST22

Europe - Between 15 March and 6 July 2021, 348 confirmed *S. Braenderup* sequence type 22 (ST22) cases were reported in 12 EU/EEA countries and the UK. The cases were spread throughout the countries and only two reported travel. A total of 68 cases were hospitalised. No deaths were reported.

The case interviews and an analytical epidemiological study suggested small melons (in particular Galia melons) as the possible vehicle of infection. *S. Braenderup* ST22 matching the outbreak strain was isolated in the UK in two imported Galia melons from one batch from Honduras, and in Austria from a pooled sample of melons (unknown origin) including Galia melons.

Based on epidemiological, microbiological and traceability investigations, the vehicles of infection are presumed to be melons imported from outside the EU/EEA and the UK. Galia melons from the batch imported from a Honduran producer are probable vehicles of infection, at least in those cases reporting having consumed Galia melons. Further investigation is needed to identify the point of contamination along the production chain.

The first cases in the EU/EEA and the UK were detected in March 2021, before the batch found to be contaminated had been harvested. This indicates that contaminated food vehicles had been circulating in these countries earlier. This is confirmed by the detection of the outbreak strain in melons in Austria in April 2021.

Control measures have been implemented for imported melons distributed on the EU market. The Honduran producer finished harvesting melons in April 2021. These melons are no longer on the market. No additional exports from Honduras are foreseen until the new season starts in December. These measures reduce the risk of new infections. Given delays in reporting and the possibility of secondary cases, further cases may still be reported, but with decreasing frequency.

Source: <https://www.ecdc.europa.eu/en/publications-data/rapid-outbreak-assessment-multi-country-outbreak-salmonella-braenderup-st22>



Risk of infectious diseases in flood-affected areas from the European Union

The recent heavy rainfall and subsequent flooding in Belgium, Germany, Luxembourg and the Netherlands has caused substantial damage and has taken a high number of human lives.

- While recovery activities are ongoing, outbreaks of **waterborne infections** are possible, and people in areas affected by disruptions of sewage water systems are at risk of increased direct or indirect transmission of several gastrointestinal pathogens, particularly infections caused by *E. coli*, norovirus, rotavirus, Cryptosporidium, Giardia, Campylobacter, different *Salmonella enterica* serotypes, Shigella, and hepatitis A. Other diseases such as leptospirosis and tetanus may also occur more frequently.
- The **risk of vector-borne diseases** is considered **very low** as none of the flood-affected areas in Belgium, Germany, Luxembourg, or the Netherlands have any history of West Nile virus circulation, nor established populations of the invasive mosquito *Aedes albopictus*, which is responsible for the transmission of diseases such as dengue and chikungunya.
- The **population displacement** that occurs after flooding may lead to **sub-optimal sheltering conditions and crowding** which can also contribute to the **increased risk of gastrointestinal and respiratory infections**, as well as COVID-19. While volunteering, assisting or staying in shelters, face masks should be worn at all times, hand hygiene and respiratory hygiene measures should be practised.
- Risks of **vaccine-preventable diseases** such as tetanus or hepatitis A should be assessed and all those without updated vaccinations should receive a booster dose. Vaccination programmes should continue to operate as much as possible, prioritising COVID-19 vaccination of the elderly and other risk groups, and MMR vaccination.
- **Wounds** may be contaminated with sewage water or soil and wound infections are common if not managed appropriately.
- For **addressing the risks of infectious diseases**, public health authorities may consider creating or scaling up real-time syndromic surveillance to detect outbreaks of gastrointestinal, respiratory, and other syndromes as early as possible.

Source: <https://www.ecdc.europa.eu/en/news-events/risk-infectious-diseases-flood-affected-areas-european-union>

Other Infectious Disease Outbreaks

Distribution of West Nile virus infections among humans and outbreaks among equids and/or birds in the EU as of 15 July



Monitoring West Nile virus – Season 2021

Europe - Between 9 and 15 July 2021, EU and EEA countries reported no human cases of West Nile virus (WNV) infection and no deaths related to WNV infections. EU-neighbouring countries reported no human cases of WNV infection.

Since the beginning of the **2021 transmission season** and as of 15 July 2021, EU/EEA countries have reported **one human case** of WNV infection in **Italy** and **no deaths**. The case was reported by La Spezia in Italy, and it was the first time that this province reported a human case.

EU-neighbouring countries have reported **no human cases** of WNV infection.

Since the beginning of the 2021 transmission season, **one outbreak**

among **equids** and **no outbreaks** among **birds** have been reported by EU/EEA countries. The outbreak among equids was reported by **Spain**.

Source: https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-16-Jul-2021_public.pdf

Crimean-Congo Hemorrhagic Fever

Iraq; Baghdad – Fatal cases of Crimean-Congo Hemorrhagic Fever (CCHF) are under investigation in Iraq. According to a local media report, health officials confirmed that at least three CCHF deaths were recorded during the past 2 weeks in Baghdad, located in the southern governorate of Dhi Qar. In addition, there are an unspecified number of cases under investigation in Al-Anbar governorate, in the western Iraq. CCHF is endemic in the Middle East, including Iraq, with sporadic human cases and outbreaks being reported. Despite the rapidly growing incidence of the disease, there are currently no accurate data on the burden of the disease in the region. Officials have indicated that health, veterinary, and vector control sectors need to work together on formulating awareness messages about how to minimize exposures, especially for high-risk populations.

Source: <https://promedmail.org/promed-post/?id=8526056>

Crimean-Congo Hemorrhagic Fever (CCHF) in Iraq

Last checked on July 18, 2021



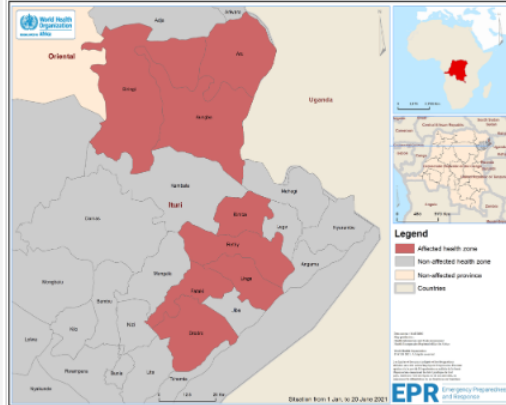
Invasive Mosquito

USA; Florida - The Collier Mosquito Control District found 2 mosquito species in their traps that are new to Collier County. Scientists collected the invasive *Aedes scapularis* and *Aedes tortilis*. This increases the number of known mosquito species in Collier County to 48. The *Aedes scapularis* is a potential threat because it is capable of transmitting yellow fever and Venezuelan equine encephalitis [viruses]. The district will continue to closely monitor their collection of mosquitos each week and will be keeping an eye out for this species.

Canada, Ontario - Mosquito surveillance efforts in Windsor-Essex have detected a tropical invasive *Aedes albopictus* mosquito that can potentially spread the Zika virus. The mosquito found tested negative for Zika virus and West Nile virus. The mosquito was first detected in Windsor-Essex in 2016 and has also been found in Ottawa, Toronto, and Peel region, as well as in the USA.

Source: <https://entomologytoday.org/2020/12/18/another-invasive-mosquito-species-florida-aedes-scapularis/>
<https://ca.news.yahoo.com/zika-transmitting-mosquito-known-aggressive-172539369.html?guccounter=1>

Geographical location of Plague Cases in the Democratic Republic of the Congo, 1 January 2021 – 20 June 2021.



Plague

Democratic Republic of the Congo (DRC), Ituri Province – An outbreak of plague in seven health zones in Ituri province, in the north-east of the DRC, has been reported in the period between 1 January to 20 June 2021.

During this period, 117 suspected cases, including 13 deaths (CFR: 11.1%) have been reported. Of these cases, between 22 April to 28 May 2021, 28 suspected cases had the pulmonary form of plague (12 deaths; CFR 44%) from the Fataki (27) and Drodro (1) health zones.

Plague is **endemic in Ituri province**; however, cases of plague had **not been reported** in Fataki, a health zone in the Ituri province, **since over a decade ago**. In the first half of 2020, Ituri province reported a total of 70 cases and 16 deaths, and between 2013 and 2020 an average of 114 cases were reported per year.

The course of plague in Ituri province is markedly influenced by the rainy season, harvesting, and presence of rodents. Although the presence of

plague cases is not unexpected, the potential increase in pulmonary and septicaemic forms need to be monitored closely.

Source: <https://apps.who.int/iris/bitstream/handle/10665/342715/OEW28-0511072021.pdf>

Monitoring of environmental suitability of Vibrio growth in the Baltic Sea - Summer 2021

The Elevated sea surface temperature (SST) in marine environments with low salt content offer ideal growth conditions for certain *Vibrio* species. These conditions occur during the summer months in estuaries and enclosed water bodies with moderate salinity. ECDC has developed a model to map the environmental suitability for *Vibrio* growth in the Baltic Sea (ECDC [Vibrio Map Viewer](#)). The model has been calibrated to the Baltic Region in Northern Europe and might not apply to other worldwide settings prior to validation.

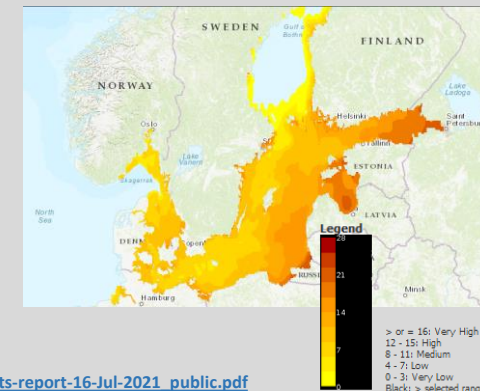
As of 15 July 2021, the environmental **suitability for Vibrio growth** in the Baltic Sea was identified as generally **medium to high** in EU/EEA countries, except in the *Gulf of Bothnia (Sweden), Skåne county and Blekinge county (Sweden), Zealand and Bornholm (Denmark) and Vorpommern-Rügen (Germany), where it was very low to low. In addition, in Elblaski (Poland); Klaipeda (Lithuania); the Gulf of Riga (Estonia, Latvia); Lääne-Viru county and Ida-Viru county (Estonia); Southwest Finland, Uusimaa and Kymenlaakso (Finland); and Stockholm county (Sweden), the suitability was very high.*

For the next five days overall, the **environmental suitability for Vibrio growth** in the Baltic Sea is considered to be generally **medium to high**, except in *Öresund (Denmark, Sweden); Vorpommern-Rügen (Germany); West Pomerania Province (Poland); the Gulf of Gdansk (Poland); Klaipeda (Lithuania); the Gulf of Riga (Latvia, Estonia); Southwest Finland, Uusimaa and Kymenlaakso (Finland); and Kalmar Strait and Gotland (Sweden), where the risk is considered to be very high.*

Outside EU/EEA countries, the environmental suitability for Vibrio growth in the Baltic Sea was identified as very high in Kaliningrad and Saint Petersburg (Russia), and it continues to be so in the next five days.








































































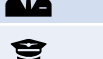








































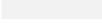
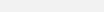
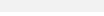
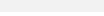
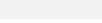
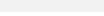
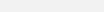
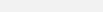
In 2021 and as of 16 July, **Sweden** has reported **10 cases of vibriosis**.

Source: https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-16-Jul-2021_public.pdf



Summary of information on the individual national Corona restrictions

The icons are linked to the respective information. Please click on the icons for information.

NATO Member State		Health information	Vaccination news	Governmental information	NATO Member State		Health information	Vaccination news	Governmental information
	Albania					Latvia			
	Belgium					Lithuania			
	Bulgaria					Luxembourg			
	Canada					Montenegro			
	Croatia					Netherland			
	Czech Republic					North Macedonia			
	Denmark					Norway			
	Estonia					Poland			
	France					Portugal			
	Germany					Rumania			
	Great Britain					Slovakia			
	Greece					Slovenia			
	Hungary					Spain			
	Italy					Turkey			
	Iceland					USA			

Travel Recommendations and other Useful Links

Travel Recommendations

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

The decision-making process should be multisectoral and ensure coordination of the measures implemented by national and international transport authorities and other relevant sectors and be aligned with the overall national strategies for adjusting public health and social measures.

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.

Information on COVID-19 testing and quarantine of air travellers in the EU and the US you can find following the link:

- <https://www.ecdc.europa.eu/en/publications-data/guidelines-covid-19-testing-and-quarantine-air-travellers>
- <https://www.cdc.gov/coronavirus/2019-ncov/travelers/testing-air-travel.html>

More information about traveling worldwide:

- National regulation regarding travel restrictions, flight operation and screening for single countries you will find [here](#) (US) and [here](#) (EU).
- Official IATA travel restrictions. You will find [here](#).

More information about traveling in the EU

- by the **European Commission** you will find here:

<https://www.consilium.europa.eu/en/policies/coronavirus/covid-19-travel-and-transport/>

- The **ECDC** publishes a map of EU Member States, broken down by regions, which show the risk levels across the regions in Europe using a traffic light system. Find it [here](#).

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

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

Useful links

ECDC:

- [All info about the COVID-19 pandemic](#); (situation updates, latest news and reports, risk assessments etc.)
- [COVID-19 Vaccine tracker](#)
- [SARS-CoV-2 variants dashboard](#) for EU
- [Latest Risk assessment on COVID-19](#), 15 Feb 2021
- All “guidance’s and technical reports” can be found under “All COVID-19 outputs” on this page [here](#)

WHO:

- Epi-WIN [webinars and updates](#)
- Status of “[COVID-19 Vaccines within WHO](#) EUL/PQ evaluation process” and the “Draft landscape and tracker of [COVID-19 candidate vaccines](#)”
- Weekly [Epidemiological and operational updates](#)
- COVID-19 new variants: [Knowledge gaps and research](#)
- COVID-19 [Dashboard](#)
- [Vaccines explained](#)
- Tracking [SARS-CoV-2 variants](#)
- Science in 5: [WHO’s series on science and COVID-19](#)
- [Quick links](#)

CDC:

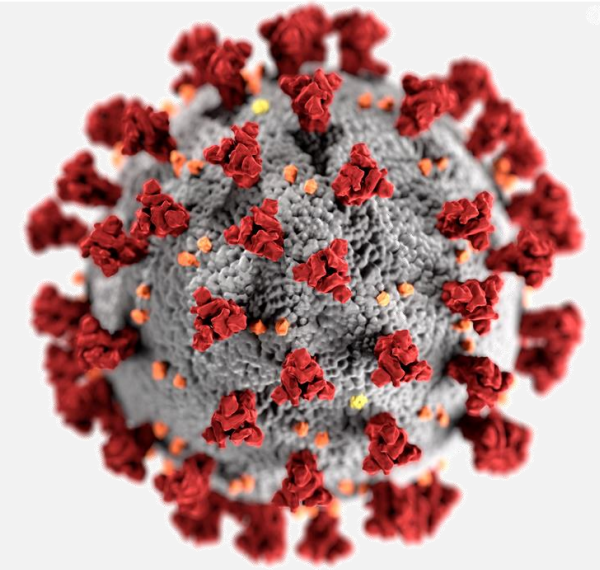
- COVID [Data Tracker](#) and [weekly review](#)
- [What’s new and Updated](#)
- [Guidance for COVID-19](#)

References:

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

Upcoming Events FHPB

We are happy to announce the;
Force Health Protection Event:
COVID-19; A retrospective look at a turbulent time



When: 3rd to 4th November 2021
Location: virtual event via Microsoft Office
Teams platform
Registration: open 3rd May 2021
Call for papers: 3rd May to 25th June 2021
Link: [Registration/Submission page](#)

