



# Update 80 COVID-19 Coronavirus Disease 28<sup>th</sup> of July 2021



News:

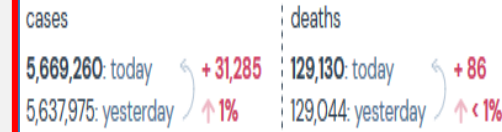
- On 23 July 2021 [WHO/Europe and the ECDC warned](#) that the SARS-CoV-2 Delta variant has now become the dominant strain in much of the European Region and that efforts must be reinforced to prevent transmission.
- WHO:** Published the [Statement of the WHO Global Advisory Committee on Vaccine Safety \(GACVS\)](#) COVID-19 subcommittee on reports of Guillain-Barré Syndrome (GBS) following adenovirus vector COVID-19 vaccines.
- CDC:** Because of the highly contagious delta variant of the coronavirus, the CDC recommends mask wearing indoors again in the future. Even fully vaccinated people are to cover their mouths and noses in public spaces in some parts of the country where the virus is currently spreading particularly strongly.
- UNDP:** The [new Global Dashboard on COVID-19 Vaccine Equity](#) finds low-income countries would add \$38 billion to their GDP forecast for 2021 if they had the same vaccination rate as high-income countries. The global economic recovery is at risk if vaccines are not equitably manufactured, scaled up and distributed.
- WHO:** Regular physical activity is key to maintaining a healthy body and mind. Therefore WHO in cooperation with private partners launched an in-game, week-long tournament called [Stay Active](#). The tournament features 24 brand-new video game levels related to sports and healthy living, as well as numerous WHO recommendations and tips on how to stay physically active.
- ECDC:** Published a summary of evidence on ["Partial COVID-19 vaccination, vaccination following SARS-CoV-2 infection and heterologous vaccination schedule"](#).
- ECDC:** Published a new [Rapid Risk Assessment](#): On COVID-19 outbreaks in long-term care facilities in the EU/EEA in the context of current vaccination coverage.
- CDC:** Published a [communication toolkit](#) to help public health professionals, health departments, community organizations, and healthcare systems and providers reach populations who may need COVID-19 prevention messaging in their native languages.
- CDC:** Published a [Guidance for Implementing COVID-19 Prevention Strategies in the Context of Varying Community Transmission Levels and Vaccination Coverage](#).
- According to expert estimates, the global consumption of natural resources has returned to about the level before the beginning of the corona pandemic. In 2021, the so-called Earth Overload Day is this Thursday (29.7.), according to calculations by the Global Footprint Network based in the USA and Switzerland. On this date, all renewable resources for the current year are used up. The most important indicator of this is CO2 emissions. A year ago, due to the pandemic, the cut-off date only fell on August 22, in 2019 it was already reached on July 26.

Topics:

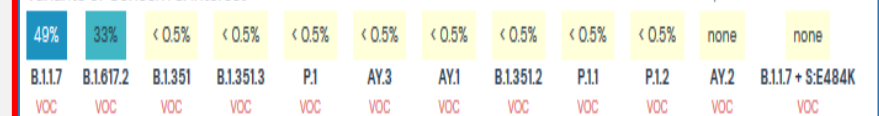
- Global situation
- European situation
- Vaccination news
- SARS-CoV-2 VOIs and VOCs
- Subject in Focus: Are face masks effective?
- Other Infectious Disease Outbreaks
- NATO Member State: Summary of information on the individual national Corona restrictions
- Travel Recommendations and other useful Links

United Kingdom

24 July 2021

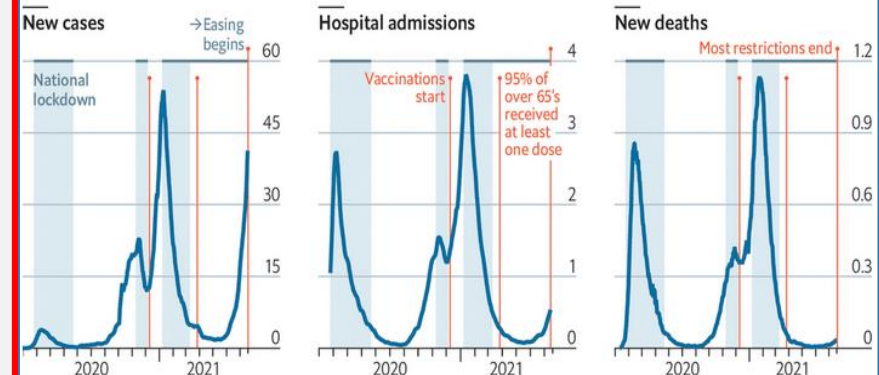


Variants of Concern & Interest



The needle of life

England, covid-19, seven-day moving average, '000



Source: Public Health England

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**EUROPE**

56 829 077 confirmed cases  
53 510 000 recovered  
1 182 011 deaths

**Russia**

6 094 379 confirmed cases  
5 566 000 recovered  
152 836 deaths

**France**

6 026 115 confirmed cases  
5 566 000 recovered  
152 836 deaths

**GBR**

5 745 530 confirmed cases  
5 017 000 recovered  
129 303 deaths

**GLOBAL**

195 424 694 confirmed cases  
182 800 000 recovered  
4 178 648 deaths

**USA**

34 446 207 confirmed cases  
33 120 000 recovered  
608 530 deaths

**India**

31 484 605 confirmed cases  
30 410 000 recovered  
422 022 deaths

**Brazil**

19 749 073 confirmed cases  
18 470 000 recovered  
551 835 deaths

# Situation by WHO Region, as of 25<sup>th</sup> July

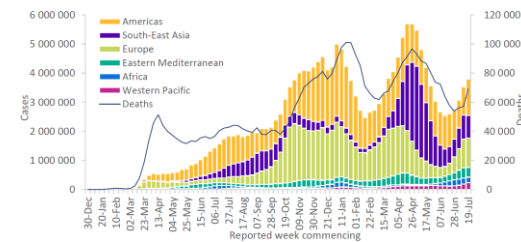
## Global epidemiological situation overview; WHO as of 25 July 2021

The global number of new cases reported last week (19-25 July 2021) was over 3.8 million, an 8% increase as compared to the previous week (Figure 1); an average of around 540 000 cases were reported each day over the past week as compared to 490 000 cases reported daily the week before. This trend is largely attributed to substantial increases in the Americas and Western Pacific Regions. The number of deaths reported this week increased sharply with over 69 000 deaths, a 21% increase when compared to the previous week; the greatest number of new deaths were reported from the **Americas and South-East Asia Regions**. The cumulative number of cases reported globally is now nearly 194 million and the number of cumulative deaths exceeds 4 million. If these trends continue, the cumulative number of cases reported globally could exceed 200 million in the next two weeks. Last week, three WHO Regions - **the Americas, Europe and South-East Asia** reported an increase in case incidence. The **Region of the Americas** reported the largest increase in case incidence as compared to the previous week, followed by the **Western Pacific Region** (30% and 25%, respectively). **The South-East Asia Region** also reported an increase in new cases, albeit at a much lower rate of 3%, when compared to the previous week. The number of new deaths increased in all regions apart from the **European Region** where it remained similar to the previous week.

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

- **United States of America**; reporting 500 332 new cases; 131% increase,
- **Brazil**; reporting 324 334 new cases; 13% increase,
- **Indonesia**; reporting 289 029 new cases; 17% decrease,
- **United Kingdom**; reporting 282 920 new cases; 5% decrease,
- **India**; reporting 265 836 new cases; similar to the previous week.

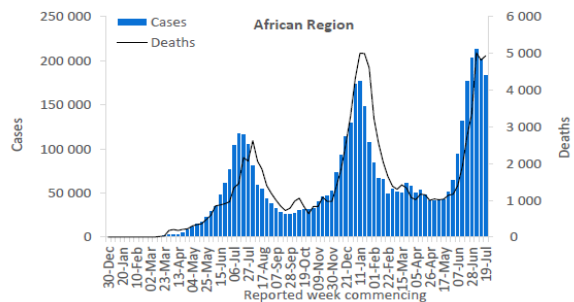
Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 25 July 2021\*\*



## African Region

The African Region reported over 184 000 new cases, a 9% decrease, and over 4900 new deaths, similar numbers as compared to the previous week. Over the past two weeks, weekly cases in the Region have begun to decrease after increasing sharply over the previous three weeks. This is largely driven by declines observed in South Africa as many other countries in the Region are still reporting increasing case incidences. The highest numbers of new cases were reported from South Africa (84 225 new cases; 142.0 new cases per 100 000 population; -19%), Zimbabwe (14 664 new cases; 98.7 new cases per 100 000; -7%), and Botswana (11 524 new cases; 490.0 new cases per 100 000; +7%).

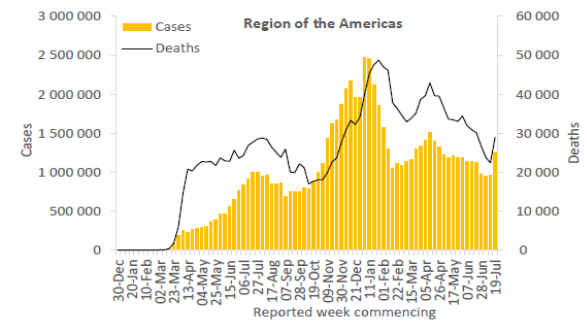
The highest numbers of new deaths were reported from South Africa (2812 new deaths; 4.7 new deaths per 100 000 population; +11%), Zimbabwe (462 new deaths; 3.1 new deaths per 100 000; similar to the previous week), and Namibia (254 new deaths; 10.0 new deaths per 100 000; -57%).



## Region of the Americas

After more than three months of overall declining trends in case and death incidence, in the past week the Region reported sharp increases in both. The Region of the Americas reported over 1.2 million new cases and just under 29 000 new deaths, a 30% and a 29% increase respectively as compared to the previous week. The highest numbers of new cases were reported from the United States of America (500 332 new cases; 151.2 new cases per 100 000; +131%), Brazil (324 334 new cases; 152.6 new cases per 100 000; +13%), and Colombia (104 399 new cases; 205.2 new cases per 100 000; -20%).

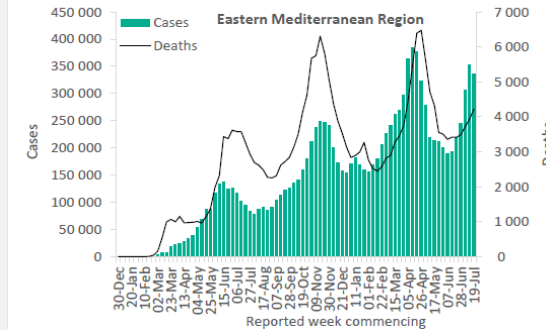
The highest numbers of new deaths were reported from Ecuador (8864 new deaths; 50.2 new deaths per 100 000; +7349%), Brazil (7942 new deaths; 3.7 new deaths per 100 000; -9%), and Colombia (2855 new deaths; 5.6 new deaths per 100 000; -21%).



## Eastern Mediterranean Region

The number of weekly cases reported in the Eastern Mediterranean Region declined in the past week after increasing sharply from mid-June through to mid-July. The Region recorded over 338 000 new cases in the past week, similar to the previous week. Deaths, however, continued to increase this week by 8% as compared to the previous week with over 4200 new deaths reported. The highest numbers of new cases were reported from the Islamic Republic of Iran (163 207 new cases; 194.3 new cases per 100 000; +2%), Iraq (60 487 new cases; 150.4 new cases per 100 000; -1%), and Tunisia (28 491 new cases; 241.1 new cases per 100 000; -43%).

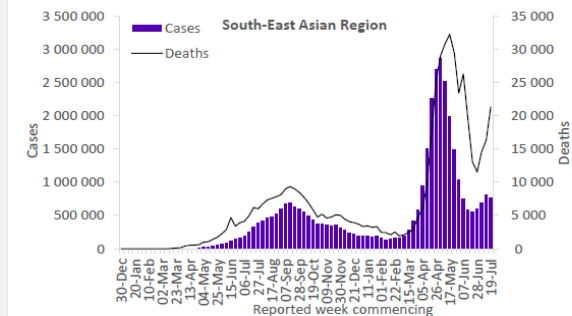
The highest numbers of new deaths were reported from the Islamic Republic of Iran (1566 new deaths; 1.9 new deaths per 100 000; +23%), Tunisia (1194 new deaths; 10.1 new deaths per 100 000; +3%), and Iraq (443 new deaths; 1.1 new deaths per 100 000; +62%).



## South-East Asia Region

After reporting an increase in weekly cases for three consecutive weeks, the Region reported a slight decrease (-7%) in cases this week, with over 775 000 new cases reported. However, new weekly deaths have continued to increase for the past three weeks, with over 21 000 new deaths reported in the past week, a 30% increase as compared to the previous week. The highest numbers of new cases were reported from Indonesia (289 029 new cases; 105.7 new cases per 100 000; a 17% decrease), India (265 836 new cases; 19.3 new cases per 100 000; similar to the previous week), and Thailand (93 916 new cases; 134.6 new cases per 100 000; a 40% increase).

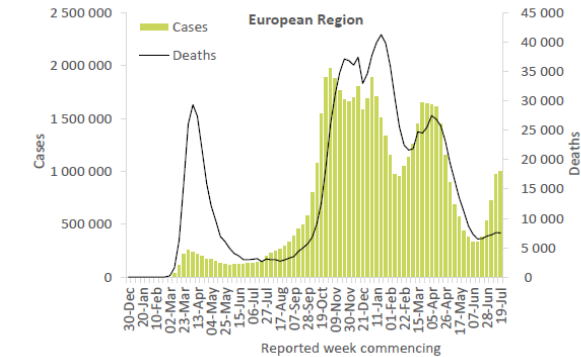
The highest numbers of new deaths were reported from Indonesia (9697 new deaths; 3.5 new deaths per 100 000; a 36% increase), India (6942 new deaths; 0.5 new deaths per 100 000; a 25% increase), and Myanmar (2111 new deaths; 3.9 new deaths per 100 000; an 82% increase).



## European Region

After reporting increases in weekly case and death incidence for the past month, the European Region this week reported numbers of cases and deaths similar to that of the past week (over 1.0 million cases and 7500 deaths reported). The highest numbers of new cases were reported from the United Kingdom (282 920 new cases; 416.8 new cases per 100 000; a 5% decrease), the Russian Federation (168 408 new cases; 115.4 new cases per 100 000; similar to the previous week), and France (117 832 new cases; 181.2 new cases per 100 000; a 178% increase).

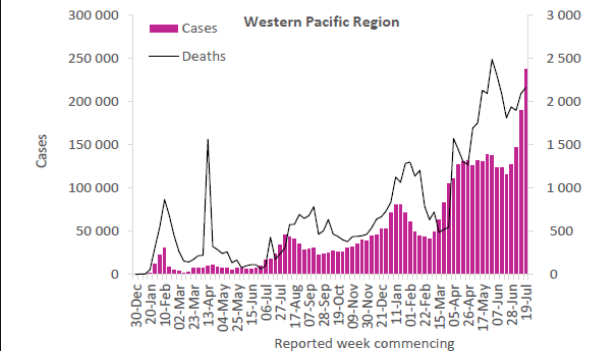
The highest numbers of new deaths were reported from the Russian Federation (5455 new deaths; 3.7 new deaths per 100 000; a 1% increase), the United Kingdom (447 new deaths; 0.7 new deaths per 100 000; a 57% increase), and Turkey (391 new deaths; 0.5 new deaths per 100 000; a 32% increase).



## Western Pacific Region

In the Western Pacific Region, cases have continued to increase for a month, with over 238 000 new cases reported in the past week, a 25% increase compared to the previous week. Deaths have also shown an increasing trend for the past several weeks, with over 2100 new deaths reported in the past week, this remains similar to the previous week's trend. The highest numbers of new cases were reported from Malaysia (90 542 new cases; 279.7 new cases per 100 000; a 15% increase), Viet Nam (43 911 new cases; 45.1 new cases per 100 000; a 95% increase), and the Philippines (40 932 new cases; 37.4 new cases per 100 000; a 16% increase).

The highest numbers of new deaths were reported from Malaysia (1036 new deaths; 3.2 new deaths per 100 000; a 30% increase), the Philippines (533 new deaths; 0.5 new deaths per 100 000; a 32% decrease), and Cambodia (178 new deaths; 1.1 new deaths per 100 000; a 9% decrease).





# Global Situation

**MMR: Skyrocketing deaths, a shattered healthcare system**, and a deep distrust of junta authorities amid a coup crisis – Myanmar’s spiralling coronavirus disaster is spurring calls for emergency intervention amid warnings the Southeast Asian nation will become a “**super spreader**”. There are **oxygen shortages**, queues outside crematoriums, and hospitals and clinics are turning people away. Officially reported daily deaths have jumped exponentially – from 13 at the start of the month to more than 300 on 22 July – but the true scale of the crisis is obscured by **minimal testing and a collapsed health system**. The EU’s humanitarian aid arm, ECHO, says Myanmar’s COVID-19 outbreak is “likely the **worst in Southeast Asia**”. Rights groups say the military junta has weaponised the virus as it targets healthcare staff aligned with the anti-coup movement. Last week, Myanmar’s government in exile, the National Unity Government, said it has a vaccination plan and a COVID-19 task force, but it **needs international support**. Former senior UN rights monitors are calling for a “massive” intervention: “An international presence of health and medical personnel has become critical,” they said in a statement. Between July 17 and 25, a nationwide stay-home order has been put in place; this is in tandem with the government declaring the same date range as public holidays. Medical facilities and shops selling essential items are allowed to remain open, however food establishments can only serve takeaway and delivery orders. A curfew from 8 p.m. to 4 a.m. remains in place, and some areas with high coronavirus activity may require people to have permission from the local administration to leave the area. International passenger flights, visa-on-arrival and e-visa services remain suspended until July 31, although cargo and relief flights are exempt from this ruling.

**CUB:** Cuba currently has the **highest number of cases per capita reported in the past week in Latin America**. Diseases activity has **rapidly increased in the past month**, with the seven-day rolling average number of daily new cases climbing from 1,432 on June 18 to 6,274 as of July 20. As of July 20, there have been 126,645 cases (**43% of cumulative cases**) reported in the past 30 days. It is believed that the **Delta variant (B.1.617.2)** is causing this upsurge, with an unspecified proportion of cases attributed to this variant of concern. The provinces with the highest incidence of the Delta variant are Ciego de Avila and Matanzas, the new coronavirus epicentres in Cuba. The strain of SARS-CoV-2 cases on the healthcare sector has fuelled nationwide protests over the economic situation, food and medicine shortages, price hikes and criticism over the government's handling of the pandemic.

As of July 5, authorities expect to maintain most restrictions through August. International travel to the island nation is limited; travellers must present negative PCR tests with 72 hours, declare current health status, complete a mandatory seven-day quarantine upon arrival, and pay a sanitary/health tax as part of their flight ticket price to cover sanitation and COVID-19 testing costs. Domestic restrictions include limiting nonessential commercial activity and interprovincial travel, with transportation traffic prohibited in Havana between 9 p.m. to 5 a.m. On June 29, officials have declared Cuba is under a **Community Transmission Phase** due to increasing cases and the presence of highly contagious variants.

**GHA: Disease activity is gradually increasing again** due to the **rising prevalence of the Delta variant** in the country, signalling the start of a third wave. The second wave peaked at a seven-day rolling average number of new cases of 827 on February 13. In the past month, the seven-day rolling average number of new cases has increased from 83 on June 25 to 171 on July 25. The 14-day test positivity rate has increased from **2.4%** on June 25 to **4.5%** on July 25, however, underreporting is expected due to low testing.

As of June 29, authorities in Ghana are expecting to maintain domestic and international restrictions to curb the spread of COVID-19 at least until July 29. Land and sea borders remain closed to international travel. Kotoka International Airport (ACC) in Accra has re-opened for international passenger travel, with travel restrictions in place. Officials have limited private events, such as funerals, to 25 people. Other social gatherings, such as political rallies, sports, and religious events, remain banned. All educational centres, hotels, malls, and restaurants are open with capacity limitations.

**IDN: Disease activity across the country continues to rise.** Over the past month, the seven-day rolling average number of new cases has **increased from 15,657 cases on June 25 to 41,290 cases on July 25**. Officials have stated that **more intensive care units would be added** following a record-high of 1,566 deaths on July 23. Hospitals on the islands of Java and Bali have been inundated with COVID-19 cases and face **low oxygen supplies**. The 14-day test positivity rate as of July 25 was **28.6%**, which is approximately a **10%** increase since the end of June 2021.

**Ongoing public activity restrictions have been extended until August 2.** This includes the closure of shopping malls, places of worship, and tourism areas. For domestic long-distance travel, individuals must provide a vaccination card indicating they have received at least one dose of a COVID-19 vaccine. If travelling via air, a negative PCR test result completed within 48 hours of departure is required. If travelling via land and/or sea, travellers must provide a negative rapid antigen test result completed within the past 48 hours. International travel bans remain in place, exemptions are in place for high-level state visits and Limited Stay Permit Cardholders. These travellers must provide a negative RT-PCR test result within 72 hours of departure and register on the Health Alert Card mobile application. Depending on the country of origin, travellers are required to quarantine at designated facilities for eight or 14 days. Officials strongly advise all domestic and international travellers to download the Pedulilindungi contact tracing mobile application.

**KWT:** The seven-day rolling average number of daily new cases began **decreasing significantly in July**, after reaching an **all-time high of 1,827 cases as of July 6**. On June 14, Kuwait confirmed the first cases of the **Delta variant**, which has been spreading rapidly across the country. As of July 20, the 14-day test positivity rate is **11%**, which decreased slightly from **13% in late June**, while the 14-day testing rate per 100,000 individuals remains about the same during the time period.

On July 18, the government imposed new restrictions to only allow vaccinated individuals to visit shopping malls, salons, gyms, and restaurants in the country. Starting July 25, Kuwait officials ordered all activities for children including summer clubs to close until further notice to limit the spread of the virus among the unvaccinated. Commercial flights to and from India remain suspended indefinitely. A ban on entry for non-Kuwaiti citizens regardless of vaccination status is in place until further notice.

## **Olympic Games 2021 Surveillance by ECDC (16 to 22 July 2021)**

Japan, Tokyo - As of 22 July 2021, 91 SARS-CoV-2 positive cases have been detected among the Tokyo Olympic 2020 (2021) participants according to the [Tokyo 2020 Organising Committee](#). These cases were reported among Tokyo 2020 **contractors (48)**, **Games-related personnel (22)**, **athletes (8)**, **media staff (5)**, **Tokyo 2020 employees (3)** and **volunteers (1)**. Other municipal governments and the national government have also reported: **athletes (2)**, **Games-related personnel (2)**.

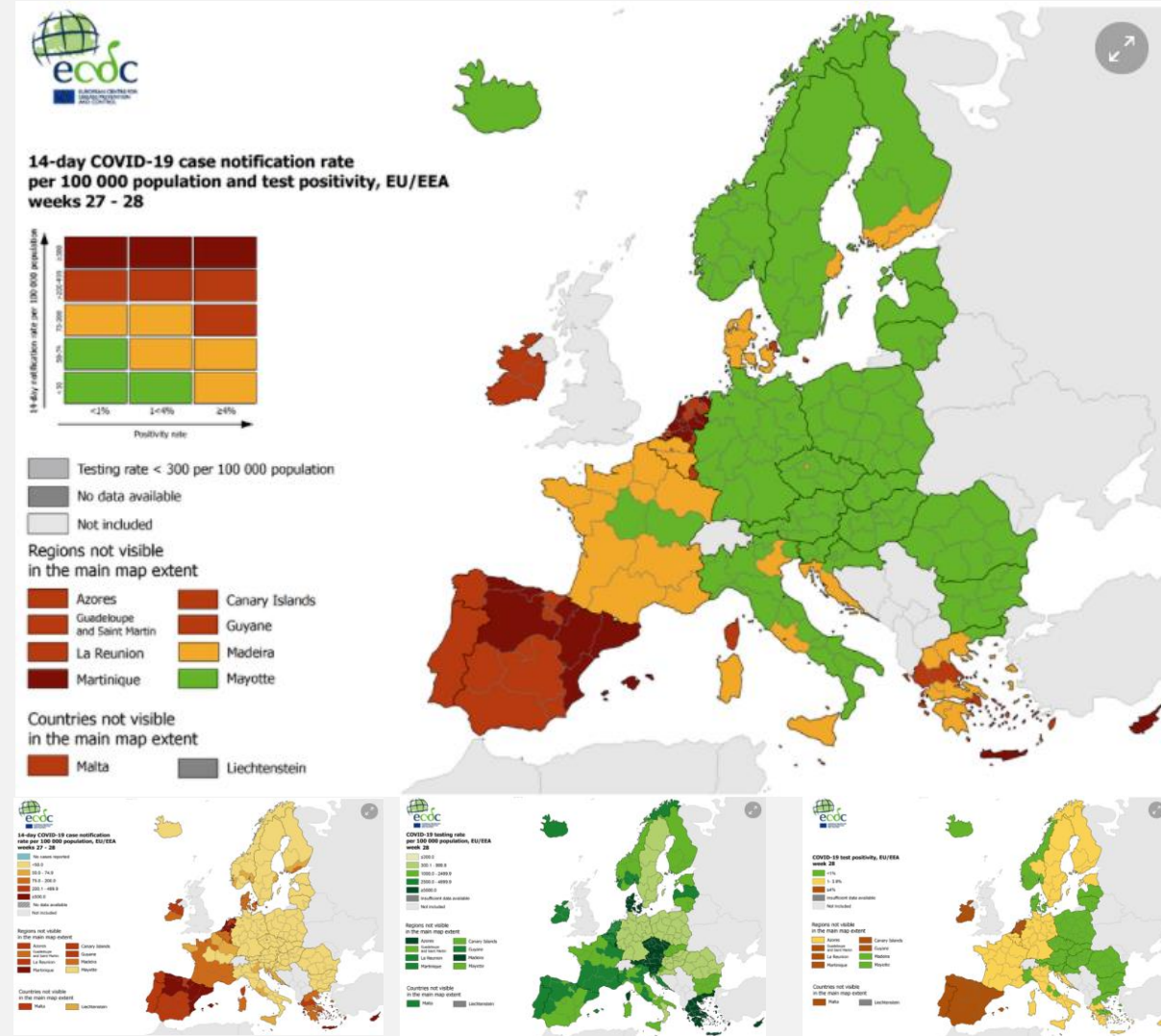
According to [multiple media sources](#), some of the positive cases reported among athletes were in citizens of the **Netherlands (2)**, **Czech Republic (3)**, **South Africa (2)**, **United States of America (1)** and **Chile (1)**.

A State of Emergency has been declared in Tokyo for the period 12 July to 22 August 2021, following on from the previously declared State of Emergency for Okinawa Prefecture running until the same date. Local and foreign spectators are not expected to attend the events at Tokyo Olympic venues, or the surrounding areas. Other Japanese prefectures such as Saitama, Chiba, Kanagawa and Osaka are under [priority measures](#) which include limited opening hours for restaurants (8 pm), prohibition on group drinking, teleworking etc. These measures can be modified, based on the local COVID situation.



# European Situation

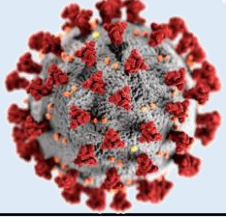
Maps in support of the Council Recommendation on a coordinated approach to the restriction of free movement in response to the COVID-19 pandemic in the EU, as of 22 July 2021



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

## Overall situation:

- At the end of week 28 (week ending Sunday 18 July 2021), the overall COVID-19 case notification rate for the European Union and European Economic Area (EU/EEA) was 151.0 per 100 000 population (89.6 the previous week). This rate has been increasing for three weeks. Overall, hospital admissions due to COVID-19 have been stable for seven weeks and the 14-day COVID-19 death rate (4.3 deaths per million population, 6.7 deaths per million population in the previous week) has decreased comparing to the previous week.
- 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 28, the epidemiological situation in the EU/EEA overall was categorised as of moderate concern (as of low concern in the previous week). Four countries were categorised as of high concern, four as of moderate concern, 10 as of low concern and 12 as of very low concern. Compared to the previous week, eight countries (Estonia, France, Germany, Greece, Iceland, Ireland, Italy and Malta) moved to a higher category, 20 countries (Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Finland, Hungary, Latvia, Liechtenstein, Lithuania, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden) stayed in the same category and two countries (Belgium and Luxembourg) moved to a lower category.
- Ensemble model forecasts produced for each EU/EEA country on 19 July 2021 by the [European COVID-19 Forecast Hub](#) provide 4-week predictions for weeks 29 to 32. During this period, increasing trends in cases are forecasted and stable trends in deaths are forecasted, reaching 373.2 per 100 000 population and 9.3 per million population, respectively, by the end of week 32. At the country level, increasing trends in cases are forecasted for 19 countries (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Lithuania, Malta, the Netherlands, Portugal and Spain) and increasing trends in deaths are forecasted for seven countries (Cyprus, France, Greece, Ireland, Italy, Portugal 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 28, 64.7% of people aged 18 years and older in the EU/EEA (country median, range: 68.3%, 18.0–84.0%) had received at least one dose of vaccine against COVID-19 and 52.2% (country median, range: 52.7%, 16.2–82.7%) had been fully vaccinated.
- The estimated distribution (median and range of values from 17 countries) of variants of concern was 69.7% (0.0–92.1%) for B.1.617.2 (Delta), 22.5% (2.3–99.4%) for B.1.1.7 (Alpha), 0.4% (0.0–66.5%) for P.1 (Gamma), 0.1% (0.0–11.8%) for B.1.351 (Beta) and 0.0% (0.0–1.9%) for B.1.1.7+E484K.
- The current deterioration of the epidemiological situation in many countries is expected to continue due to the in the Delta variant which is now dominant in the EU/EEA. To date, most recent increases in cases have been rapid increase reported among younger age groups, with some increases observed also in older age groups and in COVID-19 hospitalisation indicators.



# Vaccination news

As of July 22, a total of 10 countries accounted for 75% of all vaccinations administered globally. The top five countries/territories with the highest number of cumulative people vaccinated with at least one dose per 100,000 population are Gibraltar (116,680), Malta (88,110), Palau (80,960), Iceland (78,290), and the United Arab Emirates (77,700).

**BioNTech:** The company has announced plans to manufacture their COVID-19 vaccine at South Africa's Biovac Institute. The first doses will be produced in 2022 and will be available exclusively to African countries. However, Médecins Sans Frontières described the deal as "restrictive", and said it wouldn't be enough "to achieve vaccine independence on the African continent".

**AstraZeneca:** A second dose of the AstraZeneca vaccine Vaxzevria does not lead to an increased risk of rare blood clots, according to a study. According to the [data published in the journal "Lancet"](#), 2.3 cases of so-called TTS thrombosis occurred for every one million vaccinated people. This is comparable to the number of cases in unvaccinated persons. After the first dose, a rate of 8.1 cases per million vaccinated was detected.

**CUB:** As of July 20, of the country's more than 11.3 million population, 3,367,337 (29.7%) individuals have received at least one dose of a COVID-19 vaccine and 2,109,050 (18.6%) are fully vaccinated. Cuba is domestically developing five COVID-19 vaccines and currently vaccinating their population with two of these vaccines, called Abdala and Soberana, in their final Phase 3 trials. The local vaccines are expected to receive emergency approval from regulators to continue mass vaccination.

**KWT:** On July 18, Kuwait started vaccinating teenagers aged 12-15 in preparation for the new school year that starts in September. As of July 20, 34% of Kuwait's four million population has received at least one dose of a COVID-19 vaccine, and 21% have been fully vaccinated with either Pfizer, AstraZeneca, Moderna, or one dose of the Johnson & Johnson vaccine.

**MMR:** As of July 20, 3.8% of the 54.7 million population has received at least one dose of the COVID-19 vaccine. The COVAX facility is expected to provide enough COVID-19 vaccines during 2021 to cover 20% of the country's population. Urgent scaling up of critical health services and COVID-19 vaccination campaigns remains a pressing priority.

**IDN:** 45 million doses of COVID-19 vaccines are expected to be delivered in August. This delivery will include Sinovac, Moderna and Pfizer vaccines. As of July 26, 16.9% of Indonesia's population of 276 million have received at least one dose of a vaccine.

**GHA:** On July 25, officials announced they expect to receive over 18 million doses of COVID-19 vaccines before October, consisting of vaccines from Johnson & Johnson, Pfizer/BioNTech, and AstraZeneca. While Ghana is doing relatively well compared to its West African counterparts in vaccine administration, it has fallen short of acquiring vaccine doses through COVAX from India, which is experiencing a coronavirus surge associated with the Delta variant. As of July 25, of the country's more than 30.4 million population, 865,422 (2.8%) individuals have received at least one dose of a COVID-19 vaccine and 405,971 (1.3%) are fully vaccinated.

**GBR:** Fully vaccinated EU citizens will reportedly no longer have to go into quarantine in England soon after entering the country. So far, foreign travelers from countries from the "orange list" are subject to a strict quarantine obligation. Arrivals must isolate themselves for at least five days, even if they are fully vaccinated.

**USA:** The New York Metropolitan Opera will only admit vaccinated spectators in the coming season. Both the audience and the performing artists must have complete vaccination protection. Children under the age of twelve — who are currently not eligible for vaccination — will be allowed to attend the opera if the adults accompanying them are vaccinated.

## Statement of the WHO GACVS COVID-19 subcommittee on reports of Guillain-Barré Syndrome (GBS) following adenovirus vector COVID-19 vaccines (Janssen and AstraZeneca)

GBS is a rare immune system disorder that results in muscle weakness, pain or numbness, and, in more severe cases, paralysis. GBS could result from different causes, including infections, and occurs more frequently in males and persons over 50 years old. Cases may occur coincidentally following vaccination. For example, rare cases of GBS have been observed following seasonal influenza vaccines and vaccines to protect against shingles, but it is not known if the vaccines cause GBS.

For **Vaxzevria** (the AstraZeneca COVID-19 vaccine manufactured in Europe), the EMA Pharmacovigilance Risk Assessment Committee (PRAC) issued a statement on 9 July recommending the addition of a warning to raise awareness of GBS following vaccination, although they could not confirm nor rule out an association with the vaccine. A total of **227 cases of GBS** had been reported from the EU/EEA to EMA with Vaxzevria by 27 June 2021, while around **51.4 million doses** of Vaxzevria had been given to people in the EU/EEA by 20 June 2021.

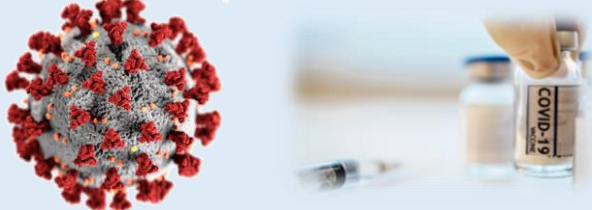
For **Johnson & Johnson** (Janssen) COVID-19 vaccine, the US FDA announced on 13 July a revision to the vaccine recipient and vaccination provider fact sheets to include information pertaining to an observed increased risk of GBS following vaccination (. The US Advisory Committee on Immunization Practices (ACIP) reviewed the information at its meeting on 22 July and noted that as of 30 June, **100 cases of GBS** had been reported in the Vaccine Adverse Events Reporting System, the US nationwide passive surveillance system, with approximately **12.2 million of doses** of the Janssen vaccine. Similarly, on 22 July the EMA issued a statement that GBS will be listed as a very rare side effect of COVID-19 Vaccine Janssen and that a warning will be included in the product information to raise awareness among healthcare professionals and people taking the vaccine.

### **Based on a careful scientific review of the available information, the GACVS subcommittee came to the following conclusions and recommendations:**

- Rare cases of GBS have been reported following vaccinations with adenovirus vector COVID-19 vaccines.
- Increased reports of GBS have not been observed following mRNA COVID-19 vaccines.
- More rigorous studies using alternative data sources and robust study designs, and comparison of vaccinated and unvaccinated populations would be needed, to fully assess the significance of these events. The GACVS subcommittee will continue to monitor GBS and any other safety concerns and review further as more data become available.
- Healthcare professionals should monitor for and report all adverse events including GBS. Countries should continue to collate detailed data on cases. Ideally, data should be gathered through active surveillance within hospitals to provide a more thorough understanding of this safety issue. The WHO COVID-19 vaccine safety surveillance manual provides guidance to countries on the safety monitoring and adverse events data sharing for COVID-19 vaccines(8).
- Individuals receiving Janssen or AstraZeneca COVID-19 vaccines should be alert to signs and symptoms of GBS and should seek immediate medical attention if they develop weakness/tingling and paralysis in the extremities that may progress to other parts of the body including the chest and face. Symptoms may include difficulty in walking; difficulty with facial movements; double vision or inability to move eyes; or difficulty controlling bladder or bowel functions. Healthcare professionals should be aware of these signs and symptoms to allow for early diagnosis and treatment. Most people fully recover from GBS.
- Though countries should always consider their individual pandemic circumstances and benefit-risk profiles, overall the subcommittee concludes that the potential benefits of both the Janssen and AstraZeneca COVID-19 vaccines continue to outweigh any potential risk of GBS, particularly given the increase in the more transmissible Delta (B.1.617.2) variant.

Source: <https://www.who.int/news/item/26-07-2021-statement-of-the-who-gacvs-covid-19-subcommittee-on-gbs>





# Vaccination news



## Partial COVID-19 vaccination, vaccination following SARS-CoV-2 infection and heterologous vaccination schedule, a summary of evidence by ECDC, 22 July 2021

### Partial vaccination

- Available data, across different population groups and SARS-CoV-2 variants of concern (VOCs), confirm that the protection against asymptomatic and symptomatic infection and severe disease conferred by **two vaccine doses** (Comirnaty, Spikevax and Vaxzevria) is **significantly higher** than with partial vaccination (i.e. one dose of a two-dose regimen). Evidence is limited on the long-term effectiveness of partial vaccination.
- Preliminary evidence from some studies indicates that individuals who are partially vaccinated are **less protected** against symptomatic infection with the B.1.617.2 (Delta) VOC than against the B.1.1.7 (Alpha) VOC, regardless of the vaccine type. However, full vaccination provides nearly equivalent protection against the Delta to that for the Alpha VOC.
- This supports ECDC's previous recommendation that, in the context of increasing circulation of the Delta VOC, **full vaccination should be achieved as early as possible and the second vaccine dose be administered after the shortest possible interval**, with priority given to population groups at highest risk of severe outcomes following SARS-CoV-2 infection.

### Previously infected individuals

- Studies of single-dose regimens of Comirnaty, Spikevax and Vaxzevria in previously infected individuals **indicate antibody and cellular immune responses are comparable to naive individuals who complete the two-dose regimen**. However, data on the long-term duration of protective immunity are sparse.
- Caution must be exercised in translating immunogenicity data into protection from COVID-19 clinical outcomes. No evidence is currently available on clinical endpoints, such as risk of laboratory-confirmed infection and symptomatic disease, for previously infected individuals receiving just one dose of a vaccine intended as a two-dose regimen.
- Given the current evidence gaps, as a precaution, consideration should be given to the **continued administration of a two-dose regimen**, as per EMA authorisation, particularly for those **individuals at greatest risk of severe outcomes** following SARS-CoV-2 infection.

### Heterologous vaccination

- Evidence from studies on heterologous ('mix and match') vaccination suggests that the combination of Vaxzevria and mRNA vaccines induces a robust humoral response against SARS-CoV-2 and elicits a **higher T-cell response than homologous combinations**. Although increased mild-to-moderate systemic reactivity was observed after administration of the second dose, heterologous regimens were generally well tolerated.
- Several EU/EEA countries are currently using 'mix and match' schedules, mainly with an mRNA vaccine (Comirnaty or Spikevax) following a first dose of Vaxzevria, especially to complete the vaccination course in the event of severe reactions after the first dose or for other precautionary reasons based on national protocols. Current evidence provides scientific grounds to expect these 'off-label' approaches to **be safe and elicit** a satisfactory immune response.
- While research is ongoing to provide more evidence on long-term safety, duration of immunity and effectiveness, the use of heterologous schedules may offer flexibility in terms of vaccination options, particularly to mitigate the impact on the vaccine rollout should a vaccine product not be available, or if it is discontinued or paused.

Source: <https://www.ecdc.europa.eu/sites/default/files/documents/Partial%20COVID%20vaccination%20and%20heterologous%20vacc%20schedule%20-%202022%20July%202021.pdf>

Table 1. Adjusted vaccine effectiveness [% (95% CI); time after injection] of one and two doses against SARS-CoV-2 infection (any, symptomatic, asymptomatic) in the general population as reported in preprint/peer-reviewed studies (as of 14 July 2021)

	Comirnaty		Pooled analysis for several products		Ref
	Dose 1	Dose 2	Dose 1	Dose 2	
Any infection	46% (40-51) 14-20 days 81% (49-71) ≥2 weeks	82% (80-85) ≥7 days 89% (82-94) Unknown	C/S 66% (59-63) ≥7 days C/S/V 35% (25-44) ≥14 days	C/S 78% (73-84) ≥7 days 66% (57-74) ≥14 days	[14] [17]* [20]* [21]
	42% (14-63) ≥14 days 57% (50-63) 14-20 days 62.5% (59.3-65.4) 14-21 days 20.6% (19.7-21.4) up to two weeks after the first dose	86% (72-94) ≥7 days 94% (87-98) ≥7 days 97.7% (97.5-97.9) ≥7 days			[22]* [14] [16]
	57.7% (57.1-58.4) from two weeks after the first dose to six days after the second dose	92.8% (92.6-93.0) ≥7 days			[18]*
Symptomatic	52% (49.9-55.0) 14-21 days	93.8% (93.3-94.2) ≥7 days	C/S/V 42% (31-52) ≥14 days	C/S/V 82% (74-88) ≥14 days	[16] [21]
			C/S 79% (63-88) ≥10 days		[19]*

C (Comirnaty), S (Spikevax), V (Vaxzevria). \*Preprint.

Table 2. Adjusted vaccine effectiveness [% (95% CI); time after injection] of one and two doses against COVID-19 vaccine effectiveness against severe diseases and hospitalisation in the general population as reported in preprint/peer-reviewed studies (as of 14 July 2021)

	Comirnaty		Pooled analysis for several products		Reference
	Dose 1	Dose 2	Dose 1	Dose 2	
Severe disease	62% (39-80) 14-20 days 49.3% (45.7-52.7) up to two weeks after the first dose	92% (75-100) ≥7 days 94.4% (93.6-95.0) ≥7 days	Dose 1 Dose 2		[14] [18]*
	62% (39-80) 14-20 days 49.3% (45.7-52.7) up to two weeks after the first dose	92% (75-100) ≥7 days 94.4% (93.6-95.0) ≥7 days			[18]*
Hospitalisation	74% (55-86) 14-20 days 75.7% (72.0-79.0) 14-21 days	87% (55-100) ≥7 days Any hospitalisation 96.0% (97.7-98.3) at least 28 days after dose 1	Dose 1 Dose 2		[14] [16]
	74% (55-86) 14-20 days 75.7% (72.0-79.0) 14-21 days	87% (55-100) ≥7 days Any hospitalisation 96.0% (97.7-98.3) at least 28 days after dose 1			[16]
Symptomatic	For severe illness 75.6% (71.9-78.9) 14-21 days 45.7% (43.1-48.2) up to two weeks after the first dose	For severe illness 98.4% (98.1-98.6) ≥7 days 94.2% (93.6-94.7) ≥7 days			[18]*
	75.6% (71.9-78.9) 14-21 days 45.7% (43.1-48.2) up to two weeks after the first dose	98.4% (98.1-98.6) ≥7 days 94.2% (93.6-94.7) ≥7 days			[18]*
Asymptomatic	52% (49.9-55.0) 14-21 days	93.8% (93.3-94.2) ≥7 days	C/S 77% (71-82) ≥7 days	C/S 96% (95-99) ≥7 days	[20]* [21]
			C/S 72% (47-85) ≥14 days	C/S 95% (82-99) ≥14 days	[21]

Table 3. Adjusted vaccine effectiveness [% (95% CI); time after injection] of one and two doses against COVID-19 infection (any or symptomatic) caused by any of the Alpha, Beta, Gamma and Delta VOCs as reported in preprint/peer-reviewed studies (as of 14 July 2021)

VOC	Spikevax		Comirnaty		Vaxzevria		Pooled analysis for several products		Ref
	Dose 1	Dose 2	Dose 1	Dose 2	Dose 1	Dose 2	Dose 1	Dose 2	
Non-VOCs	54% (28-72) ≥14 days	89% (85-96) ≥7 days	61% (54-68) ≥14 days	93% (89-96) ≥7 days	61% (58-62) ≥14 days				[42]*
Alpha	SI 82% (80-88) ≥14 days	SI 92% (89-96) ≥7 days	SI 68% (64-68) ≥14 days	SI 89% (86-91) ≥7 days	SI 64% (60-68) ≥14 days	SI 85.1% at least 28 days after dose 2	SI 88.8% (83.1-89.6) ≥14 days	SI 80.8% (77.3-81.7) ≥14 days	[42]* [43]*
	SI 82% (80-88) ≥14 days	SI 92% (89-96) ≥7 days	SI 68% (64-68) ≥14 days	SI 89% (86-91) ≥7 days	SI 64% (60-68) ≥14 days	SI 85.1% at least 28 days after dose 2	SI 88.8% (83.1-89.6) ≥14 days	SI 80.8% (77.3-81.7) ≥14 days	[42]* [43]*
Beta	SI 72% (57-82) ≥14 days	SI 58% (45-64) ≥7 days	SI 67% (54-65) ≥7 days	SI 67% (44-80) ≥14 days	SI 82% (90-93) at least 28 days after dose 2	SI 92% (90-93) at least 28 days after dose 2	SI 82% (90-93) at least 28 days after dose 2	SI 82% (90-93) at least 28 days after dose 2	[44]* [45]
	SI 72% (57-82) ≥14 days	SI 58% (45-64) ≥7 days	SI 67% (54-65) ≥7 days	SI 67% (44-80) ≥14 days	SI 82% (90-93) at least 28 days after dose 2	SI 92% (90-93) at least 28 days after dose 2	SI 82% (90-93) at least 28 days after dose 2	SI 82% (90-93) at least 28 days after dose 2	[44]* [45]
Gamma	SI 33% (9-54) at least 28 days after dose 1	SI 79% (75-82) at least 28 days after dose 1	SI 33% (23-41) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	[46]* [47]
	SI 33% (9-54) at least 28 days after dose 1	SI 79% (75-82) at least 28 days after dose 1	SI 33% (23-41) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	SI 61% (51-71) at least 28 days after dose 1	[46]* [47]
Delta	SI 77% (53-85) ≥14 days	SI 92% (82-97) ≥14 days	SI 84% (69-92) ≥14 days	SI 91% (89-92) ≥14 days	SI 48% (28-63) ≥14 days	SI 48% (28-63) ≥14 days	SI 48% (28-63) ≥14 days	SI 48% (28-63) ≥14 days	[42]*
	SI 77% (53-85) ≥14 days	SI 92% (82-97) ≥14 days	SI 84% (69-92) ≥14 days	SI 91% (89-92) ≥14 days	SI 48% (28-63) ≥14 days	SI 48% (28-63) ≥14 days	SI 48% (28-63) ≥14 days	SI 48% (28-63) ≥14 days	[42]*

S (Spikevax), C (Comirnaty), V (Vaxzevria), NE (No estimate), SI (Symptomatic infection), AI (Any infection). \*Preprint  
# Non-VOC specimens with no lineage information and NS01Y/E494K: specimens collected prior to 1 April 2021.  
& Non-VOC: Whole Genom Sequencing=non-VOC or Serology RT-PCR=Negative for NS01Y (presumptive) (In >70 years old).

Table 4. Adjusted vaccine effectiveness [% (95% CI); time after injection] of one and two doses against severe COVID-19 infection caused by any of the Alpha, Beta, Gamma and Delta VOCs as reported in preprint/peer-reviewed studies (as of 14 July 2021)

Variant	Spikevax		Comirnaty		Vaxzevria		Pooled analysis for several products		Ref
	Dose 1	Dose 2	Dose 1	Dose 2	Dose 1	Dose 2	Dose 1	Dose 2	
Non-VOC	HD 57% (28-76) ≥14 days	HD 90% (75-99) ≥7 days	HD 50% (44-56) ≥14 days	HD 90% (82-96) ≥7 days	HD 50% (44-56) ≥14 days	HD 90% (82-96) ≥7 days	HD 50% (44-56) ≥14 days	HD 90% (82-96) ≥7 days	[42]*
	HD 57% (28-76) ≥14 days	HD 90% (75-99) ≥7 days	HD 50% (44-56) ≥14 days	HD 90% (82-96) ≥7 days	HD 50% (44-56) ≥14 days	HD 90% (82-96) ≥7 days	HD 50% (44-56) ≥14 days	HD 90% (82-96) ≥7 days	[42]*
Alpha	SI 79% (74-83) ≥14 days	SI 94% (89-97) ≥7 days	SI 80% (78-81) ≥14 days	SI 96% (92-97) ≥7 days	SI 80% (78-81) ≥14 days	SI 96% (92-97) ≥7 days	SI 80% (78-81) ≥14 days	SI 96% (92-97) ≥7 days	[45]
	SI 79% (74-83) ≥14 days	SI 94% (89-97) ≥7 days	SI 80% (78-81) ≥14 days	SI 96% (92-97) ≥7 days	SI 80% (78-81) ≥14 days	SI 96% (92-97) ≥7 days	SI 80% (78-81) ≥14 days	SI 96% (92-97) ≥7 days	[45]
Beta	SI 0.0% (0-0) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	[47]*
	SI 0.0% (0-0) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	SI 100% (72.7-100) ≥14 days	[47]*
Gamma	HD 89% (73-95) ≥14 days	HD 77% (60-90) ≥14 days	HD 95% (88-99) ≥14 days	HD 95% (88-99) ≥14 days	HD 89% (73-95) ≥14 days	HD 77% (60-90) ≥14 days	HD 95% (88-99) ≥14 days	HD 95% (88-99) ≥14 days	[42]*
	HD 89% (73-95) ≥14 days	HD 77% (60-90) ≥14 days	HD 95% (88-99) ≥14 days	HD 95% (88-99) ≥14 days	HD 89% (73-95) ≥14 days	HD 77% (60-90) ≥14 days	HD 95% (88-99) ≥14 days	HD 95% (88-99) ≥14 days	[42]*
Delta	SI 94% (46-99) ≥14 days	SI 96% (96-99) ≥14 days	SI 71% (51-83) ≥14 days	SI 92% (75-97) ≥14 days	SI 94% (46-99) ≥14 days	SI 96% (96-99) ≥14 days	SI 71% (51-83) ≥14 days	SI 92% (75-97) ≥14 days	[46]*
	SI 94% (46-99) ≥14 days	SI 96% (96-99) ≥14 days	SI 71% (51-83) ≥14 days	SI 92% (75-97) ≥14 days	SI 94% (46-99) ≥14 days	SI 96% (96-99) ≥14 days	SI 71% (51-83) ≥14 days	SI 92% (75-97) ≥14 days	[46]*

S (Spikevax), C (Comirnaty), V (Vaxzevria), H (Hospitalisation) D (Death). \*Preprint.  
# Severe, critical, or fatal disease  
\* Non-VOC specimens with no lineage information and NS01Y/E494K: specimens collected prior to 1 April 2021.

# 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

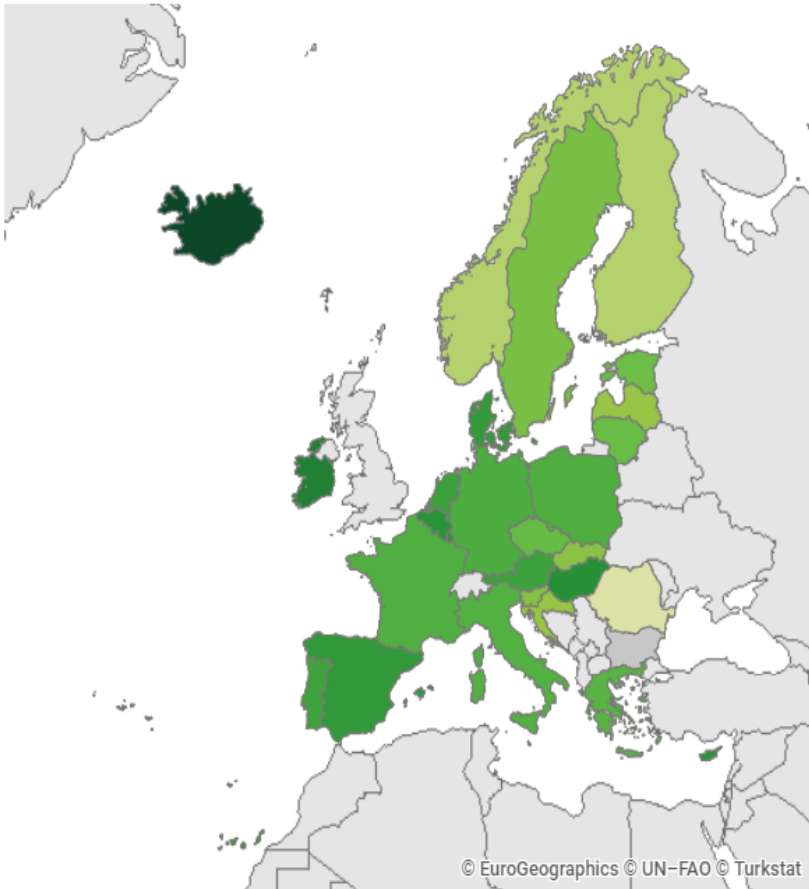
519,492,423

442,802,569

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 2021-07-27

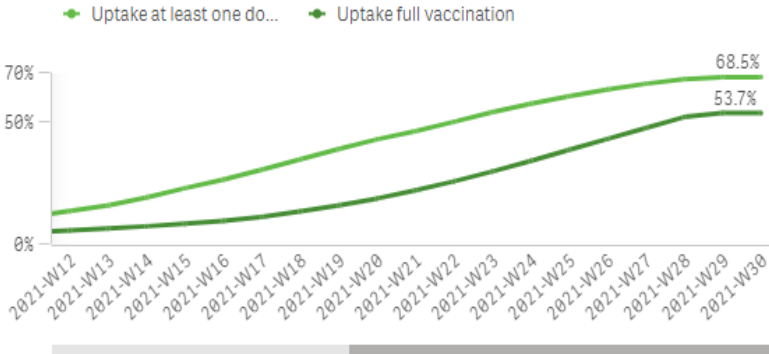


Uptake full vaccination (%)



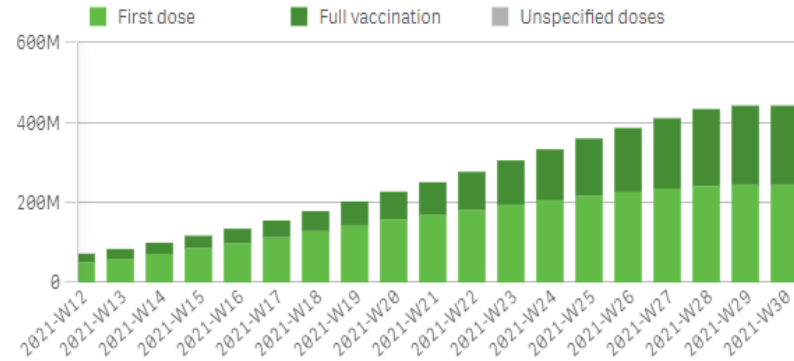
Cumulative uptake (%) of at least one vaccine dose and full vaccination among adults (18+) in EU/EEA countries as of 2021-07-27

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



Cumulative number of doses administered to adults (18+) in EU/EEA countries as of 2021-07-27

by reporting week (data for current week are preliminary)



Cumulative uptake (%) of full vaccination by age group in EU/EEA countries as of 2021-07-28

Country	80+ years	70-79 years	60-69 years	50-59 years	25-49 years
Austria	94.2%	76.9%	76.6%	63.9%	46.1%
Belgium	87.8%	93.3%	87.5%	77.8%	56.1%
Bulgaria	16.5%	25.7%	23.8%	18.8%	12.3%
Croatia	52.6%	67.9%	60.6%	46.3%	31.2%
Cyprus	90.4%	90.0%	80.8%	71.0%	56.1%
Czechia	78.9%	82.5%	68.5%	62.3%	39.6%
Denmark	100.0%	99.1%	95.3%	88.1%	31.6%
Estonia	61.8%	70.3%	61.1%	55.0%	41.0%
Finland	89.8%	92.7%	63.7%	35.2%	12.8%
France	73.9%	83.3%	69.4%	59.6%	42.7%
Germany	-	-	-	-	-
Greece	68.9%	78.1%	72.9%	63.3%	43.3%
Hungary	72.1%	84.5%	75.3%	67.7%	56.3%
Iceland	99.6%	100.0%	94.4%	86.9%	80.7%
Ireland	100.0%	100.0%	95.7%	93.6%	53.8%
Italy	91.2%	81.6%	71.3%	64.8%	39.5%
Latvia	37.1%	45.7%	43.7%	39.3%	37.9%
Liechtenstein	-	-	-	-	-
Lithuania	48.3%	66.0%	62.7%	50.3%	44.5%
Luxembourg	84.1%	84.1%	81.4%	77.8%	56.9%
Malta	96.2%	100.0%	99.4%	87.5%	70.8%
Netherlands	-	-	-	-	-
Norway	90.3%	96.2%	71.4%	33.6%	14.6%
Poland	61.3%	80.6%	67.0%	56.7%	44.4%
Portugal	96.5%	97.6%	89.5%	80.9%	39.9%
Romania	18.8%	35.3%	37.0%	34.9%	27.8%
Slovakia	49.2%	66.8%	58.4%	47.0%	35.9%
Slovenia	63.6%	72.2%	60.6%	48.8%	31.9%

# Variants Of Concern (VOC) Notable Update – Delta Variants -



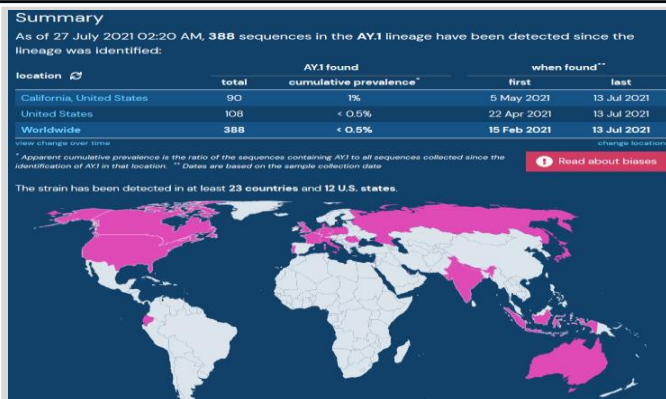
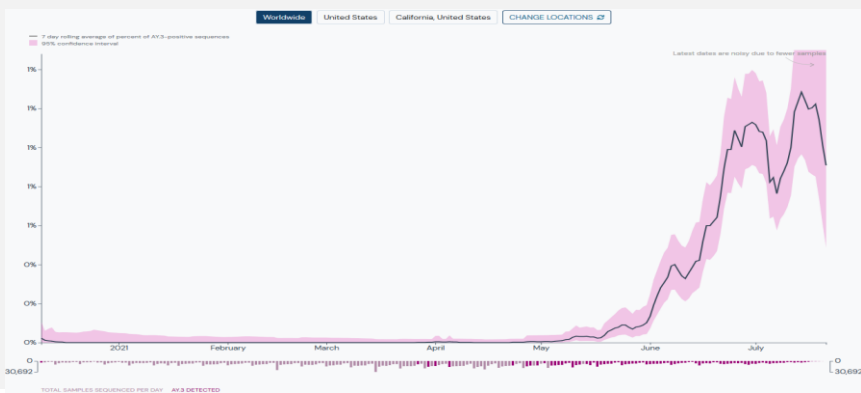
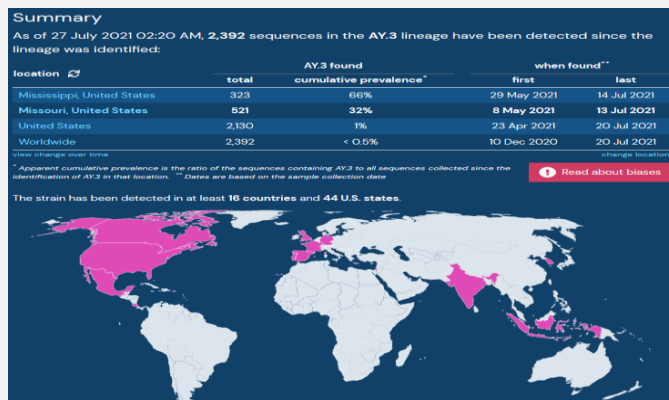
## Delta Variant (AY.3)

Global monitoring of a new Delta plus variant sub-lineage identified as AY.3 (B.1.617.2.3) has increased due to escalating prevalence across the United States. AY.3 is defined by the presence of mutations including ORF1a: **I3731V** common to AY.1 except for S: K417. There is **no data available** about the potential effects of this variant related to transmissibility, clinical impact, and whether it could lead to a reduction in neutralization by some approved monoclonal antibody treatments, or reduction in neutralization after vaccination.

While distinct clinical properties of AY.3 compared to its AY.1 and AY.2 counterparts are not known, the Indian SARS-CoV-2 Genomics Consortium considers it a distinct Delta variant of concern (VOC) sub-lineage. However, the U.S. CDC aggregates the sub-lineages data of AY.1, AY.2, and AY.3 with Delta Plus (B.1.617.2) VOC. The U.S. CDC will conduct further evaluations to determine whether there is a need for independent classifications as more data becomes available.

According to [outbreak.info](https://outbreak.info/), the AY.3 sub-lineage was first identified in April 2021 in the U.S. and has now been detected in at least 16 countries and 44 U.S. states as of July 27. More recently, the proportion of variants identified as AY.3 increased to 60% in Mississippi in less than 60 days. As of July 19, available data from Missouri indicates that the proportion of variants identified as AY.3 has reached 40% over the last 60 days.

According to data available via [outbreak.info](https://outbreak.info/), as of July 27, 2,392 sequences in the AY.3 sub-lineage have been detected globally. Most cases have been reported in the United States (2,130), with the remaining cases reported in the United Kingdom (206), Mexico (20), Puerto Rico (9), Canada (6), India (6), Indonesia (5), Barbados (2), France (1), Portugal (1), South Korea (1), Germany (1) Israel (1), Aruba (1), Costa Rica (1) and Spain (1).

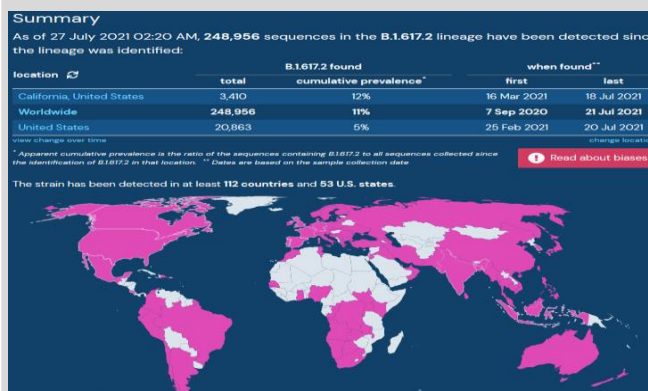
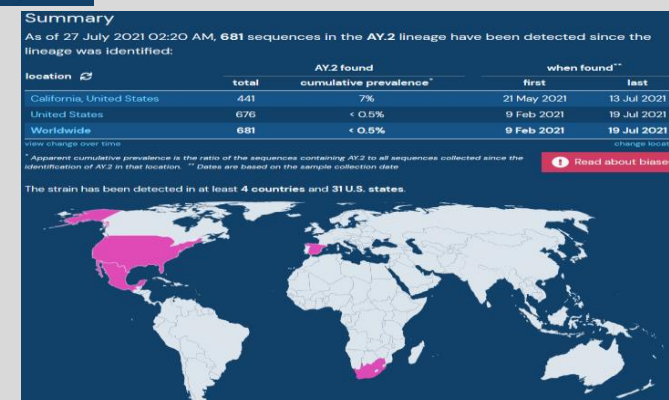


## Delta Variant (AY.1)

According to data available via [outbreak.info](https://outbreak.info/), as of July 27, 388 sequences of the AY.1 variant sub-lineage have been detected globally in at least 23 countries. The highest case numbers have been reported in the United States (108), Portugal (55), Japan (49), the United Kingdom (43), Switzerland (43), Poland (35), India (13), France (12) and Nepal.

## Delta Variant (AY.2)

Similarly, as of July 27, 681 sequences of the AY.2 variant sub-lineage has been detected globally in at least 4 countries. The majority of AY.2 cases have been reported in the United States (676), with other cases reported in Mexico (2), Spain (1) and South Africa (1).



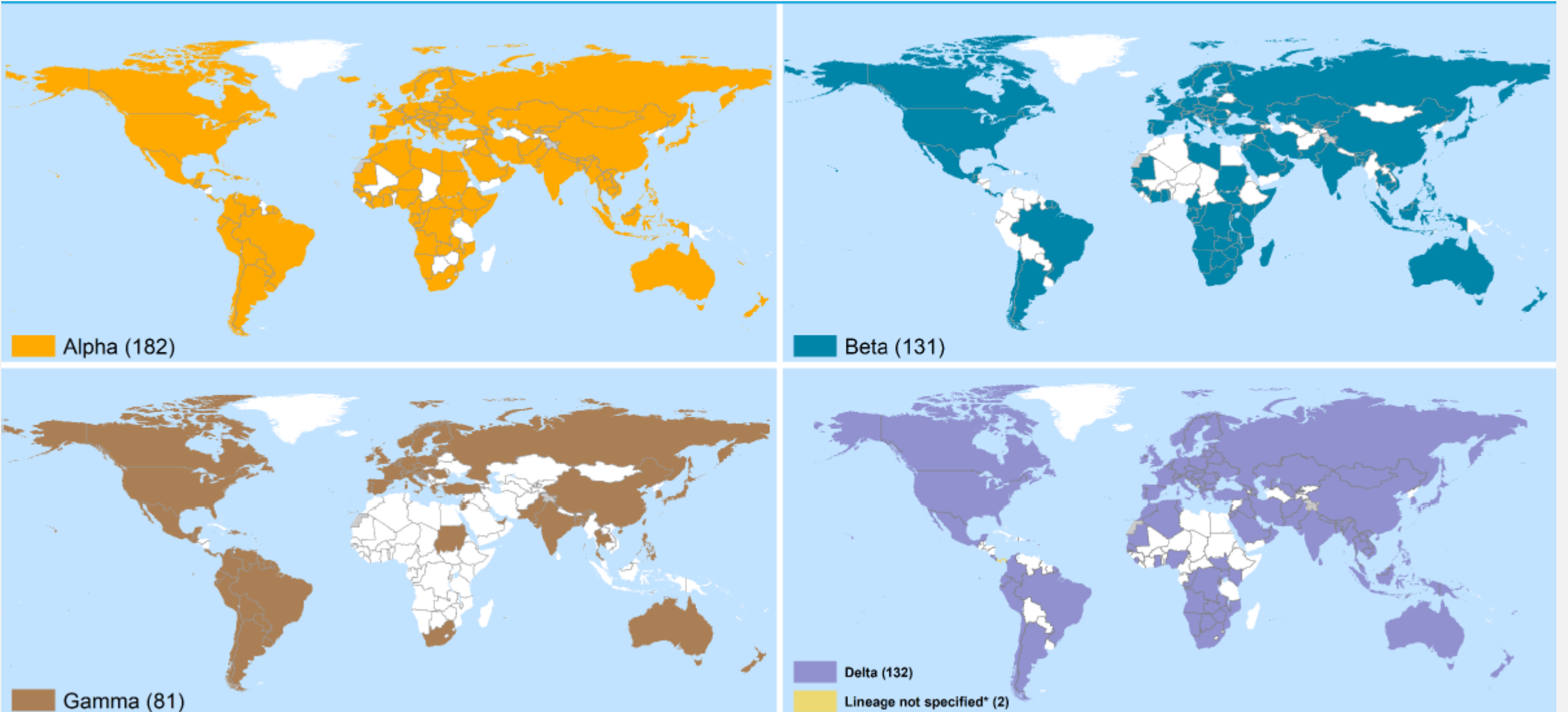
## Delta Variant (B.1.617.2)

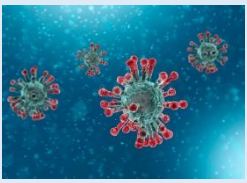
As of July 27, 112 countries have reported the Delta (B.1.617.2) variant. 248,956 sequences in the B.1.617.2 lineage have been detected since the lineage was identified. The highest case numbers have been reported in the United Kingdom (156,477), the United States (20,863), India (14,911), Denmark (9,152), Germany (4,626), Spain (3,428), Italy (3,420) and Portugal (3,119).



# 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 27 July 2021





# Subject in Focus

## Are face masks effective?

### Introduction

There has been discussion about whether the US needs to revise its mask wearing guidance in view of the spread of the SARS-CoV-2 Delta variant. The current CDC recommendation is that 'If you are fully vaccinated, you can resume activities that you did before the pandemic without wearing a mask or physically distancing, except where required by laws, rules, regulations, or local guidance.' Anthony Fauci announced that mask recommendations remain unchanged despite the increased prevalence of the delta variant.

The ECDC have revised their original guidance from April 21 which stated that full vaccination would relax the requirement for face masks. With the increasing proportion of the more transmissible delta variant a press release stated "We need to remain vigilant and continue to use common sense to prevent the spread of the virus. This means getting a full course of vaccination as soon as the opportunity arises and maintaining physical distancing, washing hands, avoiding crowded spaces, and wearing a mask when necessary. These are measures that we know work to protect ourselves and others. We should think of these as 'anti-lock down measures' because they can help prevent the spread of disease without having to shut down large parts of society."

There is consensus that face masks have a role in preventing spread of COVID-19 however there appears to be variance in the views of decision makers about their role in vaccinated individuals. This SIF explores the evidence of effectiveness of face masks in mitigating the spread of infectious diseases.

### Evidence of Effectiveness

A well written overview of the evidence of effectiveness of face masks was published in Jan 21. The paper reviewed published evidence of effectiveness of mask use in several different diseases. It reported one study from China that retrospectively reviewed evidence of effectiveness of face masks in a community setting. Family members with at least one confirmed case of COVID-19 in the household were questioned on behaviours before and after the index case developed symptoms. The study reported that:

"Face mask use by the primary case and family contacts before the primary case developed symptoms was 79% effective in reducing transmission (OR=0.21, 95% CI 0.06 to 0.79). Daily use of chlorine or ethanol based disinfectant in households was 77% effective (OR=0.23, 95% CI 0.07 to 0.84). Wearing a mask after illness onset of the primary case was not significantly protective. The risk of household transmission was 18 times higher with frequent daily close contact with the primary case (OR=18.26, 95% CI 3.93 to 84.79), and four times higher if the primary case had diarrhoea (OR=4.10, 95% CI 1.08 to 15.60). Household crowding was not significant."

In summary, face masks were as effective as daily cleaning with disinfectant in reducing transmission although they did not appear to prevent spread after the case developed symptoms.

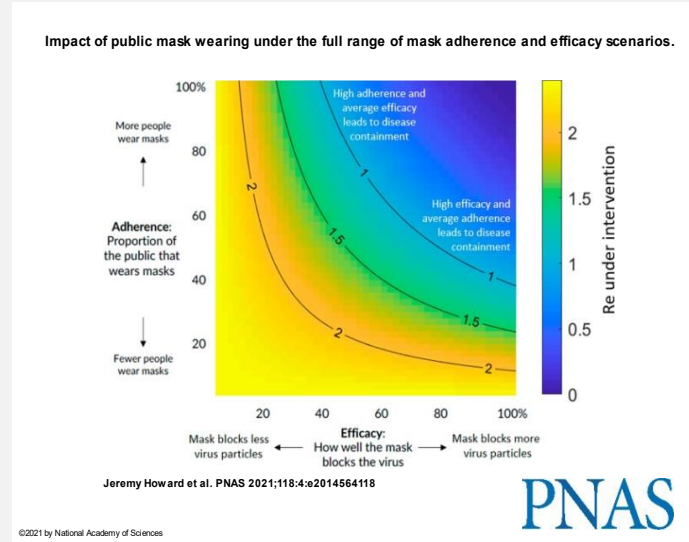
Obviously, there are significant limitations, including numerous potential confounders, in a retrospective cohort-type study which may have affected the outcome however it provided interesting information about the utility of face masks.

The PNAS paper also explored models of transmission (and reproduction rates) with different parameters and criteria (see Fig 1). It proposed that there would be a significant reduction in the R value with high compliance of mask wearing and an effective mask.

<https://www.usnews.com/news/national-news/articles/2021-07-01/fauci-cdc-masking-guidance-unchanged-in-face-of-delta-coronavirus-variant>  
<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html>  
<https://www.ecdc.europa.eu/en/news-events/ecdc-guidance-adjusting-non-pharmaceutical-interventions-based-vaccination-status>  
<https://www.ecdc.europa.eu/en/news-events/sars-cov-2-delta-variant-now-dominant-european-region>  
<https://www.pnas.org/content/118/4/e2014564118>

[https://gh.bmj.com/content/5/5/e002794?ikey=43faa3891f932d436dd66388b28de2c1b016ca37&keytype=if\\_ipsecsha](https://gh.bmj.com/content/5/5/e002794?ikey=43faa3891f932d436dd66388b28de2c1b016ca37&keytype=if_ipsecsha)  
<https://www.nature.com/articles/d41586-020-02801-8>  
<https://www.medrxiv.org/content/10.1101/2020.05.22.20109231v5>  
<https://www.acpjournals.org/doi/10.7326/m20-6817>  
<https://www.clinicaltrials.gov/ct2/show/NCT04471766>

Fig 1



An opinion piece published in Nature in Oct 20 reviewed a range of different studies that explored the effectiveness of masks including lab-based studies. It reported the results from an ecological study that assessed the impact of different interventions at population level on mortality from COVID-19. The authors found that duration of mask wearing was negatively associated with mortality. Interestingly the lab-based science all demonstrated a good effect of masks reducing droplet transmission (although, obviously, this does not necessarily equate to reduction in incidence of disease).

Part of the issue with understanding the evidence of effectiveness of face masks is the lack of RCTs which is, in part, due to the difficulty in designing a RCT that meets the requirements. A Danish study randomised 6000 adults to wearing or not wearing masks (Denmark did not mandate masks at the time of the study) outside the home. They found that there was no statistical difference in incidence of disease between the mask and the non-mask group. A large RCT exploring the effectiveness of face masks is underway in Guinea-Bissau where 40,000 people will be followed up to determine whether face masks reduce spread. Results are awaited.

### Summary

There is limited robust evidence of effectiveness of face masks in reducing transmission of COVID-19 however there is a large body of evidence that suggests that they have some role in reduction of transmission. Evidence suggests that they are probably best used alongside other non-pharmaceutical interventions and not as the sole preventive measure.

It is likely that the efficacy of face masks increases as larger numbers of people wear them – and they are more likely to be effective if they are made from materials that are less porous. However, there is limited real world data on their acceptability and there must be a balance between compliance and acceptability to ensure that their use is maximised by the largest number of people.

It is unclear whether those who are fully vaccinated should be exempt from mask wearing. If there is robust evidence that fully vaccinated individuals do not transmit infection and are unable to be infected then it would be reasonable to remove the requirement for non-pharmaceutical interventions like face masks – however, current experience with the delta variant suggests that this is not the case.



# Other Infectious Disease Outbreaks

## Environmental Suitability of Vibrio growth

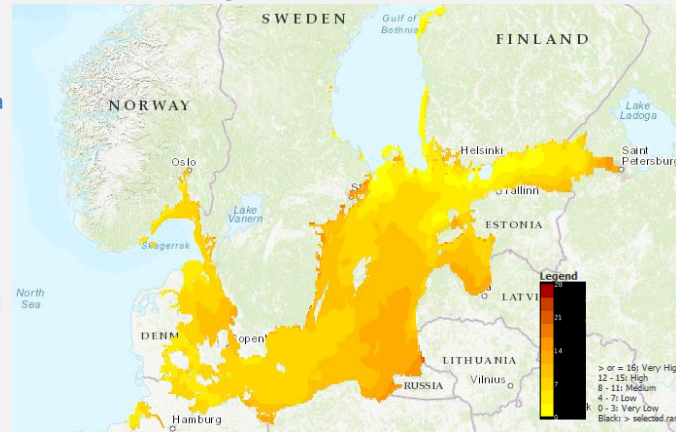
**Sweden** - As of 22 July, there have been 13 documented cases of vibriosis in Sweden, all recorded in July with serious clinical presentation sometimes referred to as 'bath ulcer fever'. This is a significant increase from 2020 and 2019 which saw less than 5 cases in July each year. The last large outbreak was in 2018 when 68 cases were reported in July and August. The cases were reported in Gotland and Svealand, which are along the Swedish coast and most cases were males over the age of 65. In Finland, three *Vibrio cholerae* infections and one *Vibrio vulnificus* infection have been detected so far in 2021. The most common symptoms of vibriosis infections are gastroenteritis with nausea, vomiting and diarrhoea; infected wounds or abrasions from contaminated seawater; primary septicæmia; and otitis externa.

Epidemiological summary by ECDC: As of 22 July 2021, the environmental suitability for *Vibrio* growth in the Baltic Sea was identified as generally medium-to-high in the EU/EEA countries, except in the Gulf of Bothnia (Sweden, Finland), Zealand and Bornholm (Denmark) and Mecklenburg-Western Pomerania and Schleswig-Holstein (Germany), where it was very-low-to-low. In addition, in Stockholm and Södermännland counties (Sweden), Helsinki (Finland), Saare and Pärnu counties (Estonia), Szczecinski and Elblaski (Poland) the suitability was very high.

Outside the 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 will continue to be considered very high for the next five days.

According to [Finnish authorities](#), three *Vibrio cholerae* infections and one *Vibrio vulnificus* infection have been detected in Finland in 2021.

Source: <http://outbreaknewstoday.com/sweden-reports-13-vibrio-infections-this-july-60864/>  
[https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-23-Jul-2021\\_0.pdf](https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-23-Jul-2021_0.pdf)  
<https://geoportal.ecdc.europa.eu/vibriomapviewer/>



## OXA-244-producing Escherichia coli ST38

**EU/UK** - Following the report of an outbreak of OXA-244-producing *E. coli* ST38 in three hospitals in Vestland, Norway in 2020, ECDC constructed a phylogenetic tree including data on 458 isolates of *E. coli* ST38, of which 370 carried blaOXA-244. Several clusters were identified, including one large cluster with 210 closely-related OXA-244-producing *E. coli* ST38 isolates from 11 EU/EEA countries and the UK (cluster A). This cluster had 20 cgMLST allelic differences from root to tip of the cluster subtree and isolates in this cluster generally carried both the blaOXA-244 and blaCTX-M-27 genes. Cluster A was first detected in 2016 and the number of corresponding cases continued to increase over time. Cases related to cluster A had a median age of 51 years, a high proportion of women (75%), and the isolates were frequently isolated from urine samples (51%).

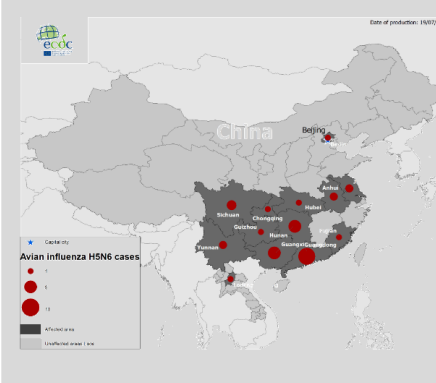
**Assessment by ECDC:** The observed increase in the number of cases of *E. coli*, a species that frequently causes community-acquired infections, producing a difficult-to-detect carbapenemase (OXA-244), is of concern. The risk of further spread of OXA-244-producing *E. coli* in the EU/EEA is high, given the rapid and simultaneous increase in various countries. In addition, difficulties with laboratory detection and lack of identification of the route of introduction into the EU/EEA are hampering the initiation of targeted control measures.

Source: <https://www.ecdc.europa.eu/en/all-topics-z/threats-and-outbreaks/risk-assessments>

## Influenza A(H5N6) – Multi country-

On 14 July 2021, the Chinese authorities reported a new case of human infection with avian influenza A(H5N6) in Bazhong City in Sichuan Province, China. The case is a 55-year-old man. He developed symptoms on 30 June 2021 and was admitted to hospital on 4 July 2021. The patient is in a critical condition. He was exposed to domestic poultry. No further cases have been detected among contacts of the case.

Geographical distribution of confirmed human cases with avian influenza A(H5N6) virus infection, 2014–2021



Source: ECDC

Since 2014 and as of 14 July 2021, overall 34 cases, including 17 deaths, of human influenza A(H5N6) virus infection have been reported from China (33) and Laos (1). One additional case in China with year of onset 2015 has been reported in the literature.

Assessment by ECDC: Sporadic human cases of influenza A(H5N6) virus infection have been observed previously. **No human-to-human transmission** has been reported and further investigations on exposure as well as on the virus characteristics are needed to understand the circumstances of the transmission to humans. As **sporadic zoonotic transmission cannot be excluded**, the use of personal protective measures for people directly exposed to poultry and birds with avian influenza viruses will minimise the remaining risk. The **risk of zoonotic influenza transmission to the general public** in EU/EEA countries is considered to be **very low**.

Source: [https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-23-Jul-2021\\_0.pdf](https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-23-Jul-2021_0.pdf)

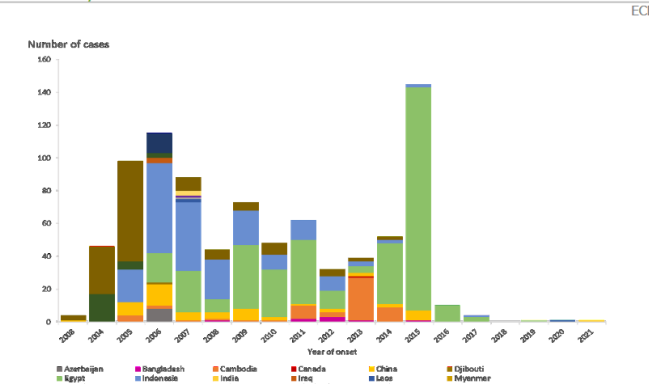
## Influenza A(H5N1) – Multi country -

From January 2003 and as of 21 July 2021, there have been 863 laboratory-confirmed human cases of avian influenza A(H5N1) virus infection world-wide, including 456 deaths (Case Fatality Rate: 52.8%), from 18 countries. Most of the cases have been reported from Egypt, Indonesia and Vietnam. The latest case was reported in November 2020 in Laos.

**Assessment by ECDC:** Human cases related to the avian influenza A(H5N1) virus could occur in regions where A(H5N1) is endemic in the poultry population (Asia, Africa and the Middle East). Current epidemiological and virological evidence suggests that A(H5N1) viruses have **not** acquired the ability to **transmit from human to human**, so the likelihood of sustained human-to-human transmission is low. No human cases due to A(H5N1) have been reported in Europe. The **risk of zoonotic influenza transmission** to the general public in EU/EEA countries is considered to be **very low**. Direct contact with infected birds or a contaminated environment is the most likely source of infection and the use of personal protective measures for people exposed to dead birds or their droppings will minimise the remaining risk.

Source: [https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-23-Jul-2021\\_0.pdf](https://www.ecdc.europa.eu/sites/default/files/documents/Communicable-disease-threats-report-23-Jul-2021_0.pdf)

Distribution of confirmed human cases of A(H5N1) by year and reporting country from 2003 to 21 July 2021

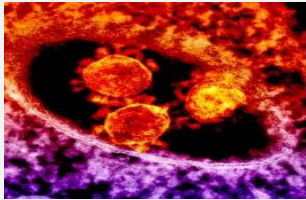


# Other Infectious Disease Outbreaks

## Malaria

**Romania** - A case of malaria has been reported in Romania in 2021. The affected individual is a 59-year-old from Iași (eastern Romania) who travels frequently to Africa and other tropical countries for work. The individual returned to Iași from Douala, Cameroon via Istanbul and Bucharest on June 13, 2021, and reported symptoms of the illness two weeks later. The individual is currently hospitalized and is receiving malaria-specific treatment.

Source: <https://www.ziarulevenimentul.ro/stiri/moldova/caz-de-malarie-la-ia-i-un-barbat-care-calatore-te-frecvent-in-africa-s-a-intors-bolnav-217511577.html>



## Middle East respiratory syndrome coronavirus

**Saudi Arabia; Riyadh** – Saudi Arabia health officials reported a new case of Middle East respiratory syndrome coronavirus (MERS-CoV) in a 67-year-old man from Riyadh City. It is reported the man had contact with camels. This is the tenth MERS case of 2021 in the Kingdom and the 11th overall (one in the United Arab Emirates).

Source: <http://outbreaknewstoday.com/riyadh-man-is-saudi-arabia-10th-mers-case-of-2021/>

## Monkeypox; Nigeria, USA, GBR –

- In September 2017, Nigeria experienced its first monkeypox outbreak in 40 years, signalling re-emergence of the disease. Since then, sporadic activity across 30 states and some large outbreaks have been reported.
- As of July 19, 2021, the Nigeria Centre for Disease Control has registered 59 suspected cases, of which 15 have been confirmed, across five states: Delta (3), Bayelsa (2), Lagos (4), Edo (1), and Rivers (1). No deaths have been reported.
- Since May 2021, two unrelated monkeypox cases have been exported from Africa. The first was an individual travelling from Delta State to Liverpool, England, U.K. (reported in May 2021). The second was an individual travelling from Lagos State to Dallas, Texas, U.S. (reported July 2021).



## Reasons for concern

- While the primary route of transmission is considered to be through direct contact with an infected animal, human, or materials contaminated with the virus, human-to-human transmission can occur through respiratory droplets.
- The importation of cases highlights that the true extent of the ongoing outbreak in Nigeria is likely greater than what is officially reported.
- Potential underreporting of monkeypox in Nigeria may be due to challenges in surveillance amid stretched healthcare and laboratory resources during the COVID-19 pandemic, and setbacks to public health awareness campaigns.
- There are concerns that previous wins from the improvements made in awareness and knowledge of monkeypox among healthcare workers and the public since 2017 have been negatively impacted by the COVID-19 pandemic.

## Outlook

- Using data on exported cases, air travel, and Lagos' estimated population size, we estimate that 2,938 (95% CI: 75 - 16,366) new monkey-pox cases may have emerged between May and end of July 2021 in Lagos State, Nigeria.
- The five countries that receive the most air travel from Nigeria and could see imported cases of monkeypox are: the U.K., the U.S, United Arab Emirates, South Africa, and Turkey.
- While border restrictions prohibit nonessential land travel into Nigeria, neighbouring countries (such as Benin, Niger, Chad, Cameroon) may be at risk of importation.

## Global Influenza Surveillance during the COVID-19 Pandemic

- Record low numbers of laboratory confirmed cases of influenza have been reported globally since March 2020. These trends cannot be explained by a lack of testing as testing rates have remained roughly equivalent to previous years. The disruption to seasonal influenza activity was swift, widespread and has not yet returned to pre-pandemic rates.
- The drivers governing the record low transmission rates of influenza are highly complex and interconnected. Of particular note, government restrictions and reopening associated with COVID-19 vaccination rates and the emergence of novel COVID-19 variants are likely the more influential drivers of instability associated with influenza patterns.
- Disruptions to seasonal influenza activity should be expected to remain for as long as public health restrictions are in place to contain COVID-19; however, we may experience unstable transmission among groups of countries that have agreed to open for trade and travel.

## Factors affecting the dynamic of future influenza seasons

Several drivers will influence how and when increasing influenza activity may return in upcoming seasons.

### 1) transmission and movement

Individual Behaviours and Policy Shifts; How individuals, workplaces, and cultures have adjusted to control COVID-19 has played a significant role in disrupting the diseases' transmission dynamics. While this could also impact the approach to future influenza seasons, the long-term adoption of these practices versus reverting to pre-existing behaviours remain uncertain.

Domestic Re-opening; As a result of most indoor business, institutions, services, and venues as well as schools experiencing partial and/or complete closures during the heights of the pandemic, seasonal influenza has had limited opportunity to spread in community settings. Influenza is generally less effective than SARS-CoV-2 at spreading from person-to-person which helps explain why public health measures intended to limit COVID-19 transmission all but eliminated the occurrence of seasonal influenza.

International Travel; Population mobility, whether local or international, drives disease transmission by introducing or re-introducing infectious individuals into communities around the world. There have been documented accounts for how disruptions to air travel can delay or dampen the onset of an influenza season. It may be reasonable to expect influenza spread and transmission to follow air transportation patterns as countries reopen.

### 2) SARS-CoV-2 and influenza immunity

Vaccine-induced Immunity; An effective COVID-19 vaccination drive will accelerate progress toward opening restrictions, and may promote influenza activity as barriers to transmission are removed. Seasonal influenza vaccines will once again serve as a first line of prevention. During a regular season, it is estimated that a seasonal influenza vaccine is between 40-60% effective because of the limited visibility into the diversity of circulating strains. Therefore confidence in the upcoming vaccine candidates can not be known with a high degree of certainty.

Natural Influenza Immunity; The duration of the COVID-19 pandemic may influence how the body's natural immune system will react to the influenza virus. It is estimated between 4-50 million people have symptomatic influenza infections in Europe annually, and receive a boost to their immune system as a result of exposure. If seasonal influenza is depressed for several years in the shadow of COVID-19, the opportunity among key cohorts of the population to build natural immunity against influenza will be limited or absent.








































































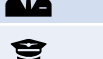








































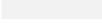
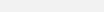
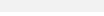
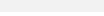
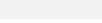
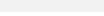
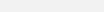
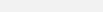
SARS-CoV-2 Variants; The introduction of further SARS-CoV-2 variants of concern has the potential to directly impact reopening timelines and the return of seasonal influenza.

**Outcome**: The longevity of policy and cultural shifts of disruptions to mobility, vaccine efficacy, and circulating SARS-CoV-2 variants are unknown and will all play a role in shaping the near and long-term future of influenza activity. There is uncertainty about the severity of an influenza season upon its return. Longer term shifts in population behaviour may be an important determinant of severity.



# 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](#)

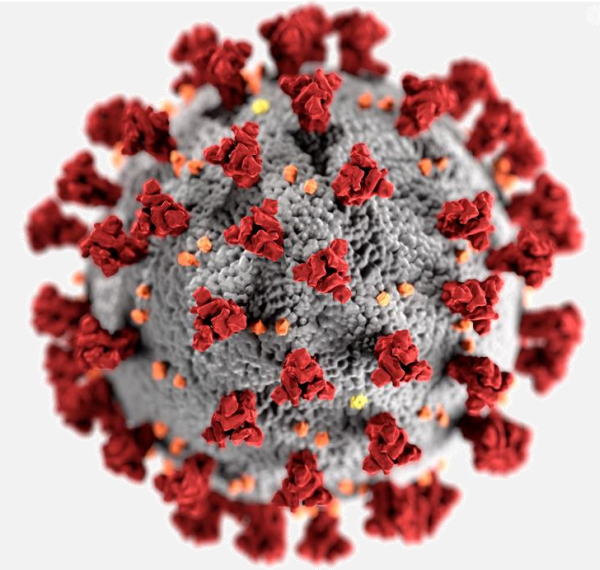
**References:**

- European Centre for Disease Prevention and Control [www.ecdc.europa.eu](http://www.ecdc.europa.eu)
- World Health Organization WHO; [www.who.int](http://www.who.int)
- Centres for Disease Control and Prevention CDC; [www.cdc.gov](http://www.cdc.gov)
- European Commission; [https://ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/travel-and-transportation-during-coronavirus-pandemic\\_en](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:** 3<sup>rd</sup> to 4<sup>th</sup> November 2021  
**Location:** virtual event via Microsoft Office Teams platform  
**Registration:** open 3<sup>rd</sup> May 2021  
**Call for papers:** 3<sup>rd</sup> May to 25<sup>th</sup> June 2021  
**Link:** [Registration/Submission page](#)

