World Health Organization

COVID-19 Weekly Epidemiological Update

25 February 2021

Special edition: Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern

This special edition is supplementary to the 23 February Weekly Epidemiological Update, which included a global and regional overview of COVID-19 case and death trends, and special focus updates on SARS-CoV-2 variants of concern, and WHO COVID-19 vaccine policy recommendations.

In the following, we provide working definitions for SARS-CoV-2 variants of interest and variants of concern and the associated actions WHO will take to support Member States, their national public health institutes and reference laboratories, along with the recommended actions Member States should take. It includes general and non-exhaustive guidance on the prioritization of variants of greatest public health relevance in the context of wider SARS-CoV-2 transmission, and established response mechanisms and public health and social measures (PHSM).

- The threshold for determination of a variant of interest is relatively low in order to maintain sensitive surveillance for potentially important variants.
- The threshold for determination of a variant of concern is high in order to focus attention and resources on the variants with the highest public health implications, while reducing noise and unwarranted diversion of limited resources.

These definitions will be reviewed regularly and updated as necessary.

Working Definition of "SARS-CoV-2 Variant of Interest"

A SARS-CoV-2 isolate is a variant of interest (VOI) if it is phenotypically changed compared to a reference isolate or has a genome with mutations that lead to amino acid changes associated with established or suspected phenotypic implications[1];

AND

has been identified to cause community transmission[2]/multiple COVID-19 cases/clusters, or has been detected in multiple countries;

OR

is otherwise assessed to be a VOI by WHO in consultation with the WHO SARS-CoV-2 Virus Evolution Working Group.

[1] Phenotypic changes include changes in the epidemiology, antigenicity, or virulence or changes that have or potentially have a negative impact on available diagnostics, vaccines, therapeutics or public health and social measures. WHO will provide guidance on amino acid changes with established or suspected phenotypic implications, and may be informed by a database on key amino acid changes, or as reported in the scientific literature.

[2] See WHO public health surveillance for COVID-19: interim guidance for definitions

Main actions by a Member State, if a potential VOI is identified:

- Inform WHO through established WHO Country or Regional Office reporting channels with supporting information about VOI-associated cases (person, place, time, clinical and other relevant characteristics).
- Submit complete genome sequences and associated metadata to a publicly available database, such as GISAID.
- Perform field investigations to improve understanding of the potential impacts of the VOI on COVID-19 epidemiology, severity, effectiveness of public health and social measures, or other relevant characteristics.
- Perform laboratory assessments or contact WHO for support to conduct laboratory assessments on the impact of the VOI on diagnostic methods, immune responses, antibody neutralization or other relevant characteristics.

Main actions by WHO for a potential VOI:

- Assessment by WHO in consultation with the SARS-CoV-2 Virus Evolution Working Group, and if meets criteria, designation as VOI.
- If determined necessary, coordinated laboratory investigations with Member States and partners[3].
- Review global epidemiology of VOI.
- Monitor and track global spread of VOI.

Working Definition of "SARS-CoV-2 Variant of Concern"

A VOI (as defined above) is a variant of concern (VOC) if, through a comparative assessment, it has been demonstrated to be associated with

- Increase in transmissibility or detrimental change in COVID-19 epidemiology;
- Increase in virulence or change in clinical disease presentation; or
- Decrease in effectiveness of public health and social measures or available diagnostics, vaccines, therapeutics.

OR

assessed to be a VOC by WHO in consultation with the WHO SARS-CoV-2 Virus Evolution Working Group.

Main actions by WHO for a potential VOC:

- Assessment, and if meets criteria, designation as VOC.
- Assessment by Virus Evolution Working Group and, if determined necessary, coordinate additional laboratory investigations with Member States and partners[3].
- Rapid risk assessment, as warranted.
- Communicate new designations and findings with Member States and public through established mechanisms.
- Evaluate WHO guidance through established WHO mechanisms and update, if necessary.

[3] The WHO SARS-CoV-2 Reference laboratory system will be made available to support Member States that cannot perform laboratory investigations in their country, when needed.

Main actions by a Member State, if a VOC is identified:

- Report initial cases/clusters associated with VOC infection to WHO through the IHR mechanism.
- Submit complete genome sequences and associated metadata to a publicly available database, such as GISAID.
- Where capacity exists and in coordination with the international community, perform field investigations to improve understanding of the potential impacts of the VOC on COVID-19 epidemiology, severity, effectiveness of public health and social measures, or other relevant characteristics.
- Perform laboratory assessments or contact WHO for support to conduct laboratory assessments on the impact of the VOC on diagnostic methods, immune responses, antibody neutralization or other relevant characteristics.

WHO Recommendations

WHO, in collaboration with national authorities, institutions and researchers, continues to monitor the public health events associated with SARS-CoV-2 variants and provides updates as new information becomes available. Further information on the background of the variants of concern is available from previously published Disease Outbreak News and recent publications of the Weekly Epidemiological Update.

National and local authorities are encouraged to continue strengthening existing disease control activities, including epidemiological surveillance, strategic testing, and increased routine systematic sequencing of a representative sample of SARS-CoV-2 isolates from across each country, wherever feasible. WHO is working to increase sequencing capacities globally and has published a comprehensive implementation guide and risk-monitoring framework to support countries set up high-impact sequencing programmes for SARS-CoV-2 variants and maximize public health impact. Where sequencing capacity is limited, WHO encourages countries to reach out through existing regional systems and laboratory networks to support and build capacity.WHO has been tracking mutations since the beginning of the pandemic. In June 2020, WHO established the SARS-CoV-2 Virus Evolution Working Group to specifically assess new variants. Together with Member States and partners, a global risk monitoring framework has been established to:

- Coordinate and harmonize a global system for monitoring and assessing SARS-CoV-2 variants and their impact;
- Identify critical priorities, thresholds, and triggers for decision-making;
- Define a multi-disciplinary coordination mechanism to collect, analyze, and share data to inform decision-making, including on vaccination programs; and,
- Leverage and enhance existing technical networks and expert groups.

A holistic response should continue to be taken against all SARS-CoV-2 transmission. PHSM and current infection prevention and control (IPC) measures in health facilities and outside of health facilities have proven to remain effective against VOCs to date. WHO continues to advise that the application and adjustment of PHSM and IPC measures should be driven by detailed data analyses of epidemiological indicators at the most local level possible and by research studies and outbreak investigations carried out by Member States (for more information, please see our technical guidance).

Technical guidance and other resources

- COVAX Statement on New Variants of SARS-CoV-2
- SARS-CoV-2 genomic sequencing for public health goals: Interim guidance, 8 January 2021
- Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health
- Q&A on Coronavirus disease (COVID-19): Virus Evolution
- Disease Outbreak News - SARS-CoV-2 Variants- 31 December 2020
- Weekly Epidemiological Updates – From 12 January to date

COVID-19 Weekly Epidemiological Update

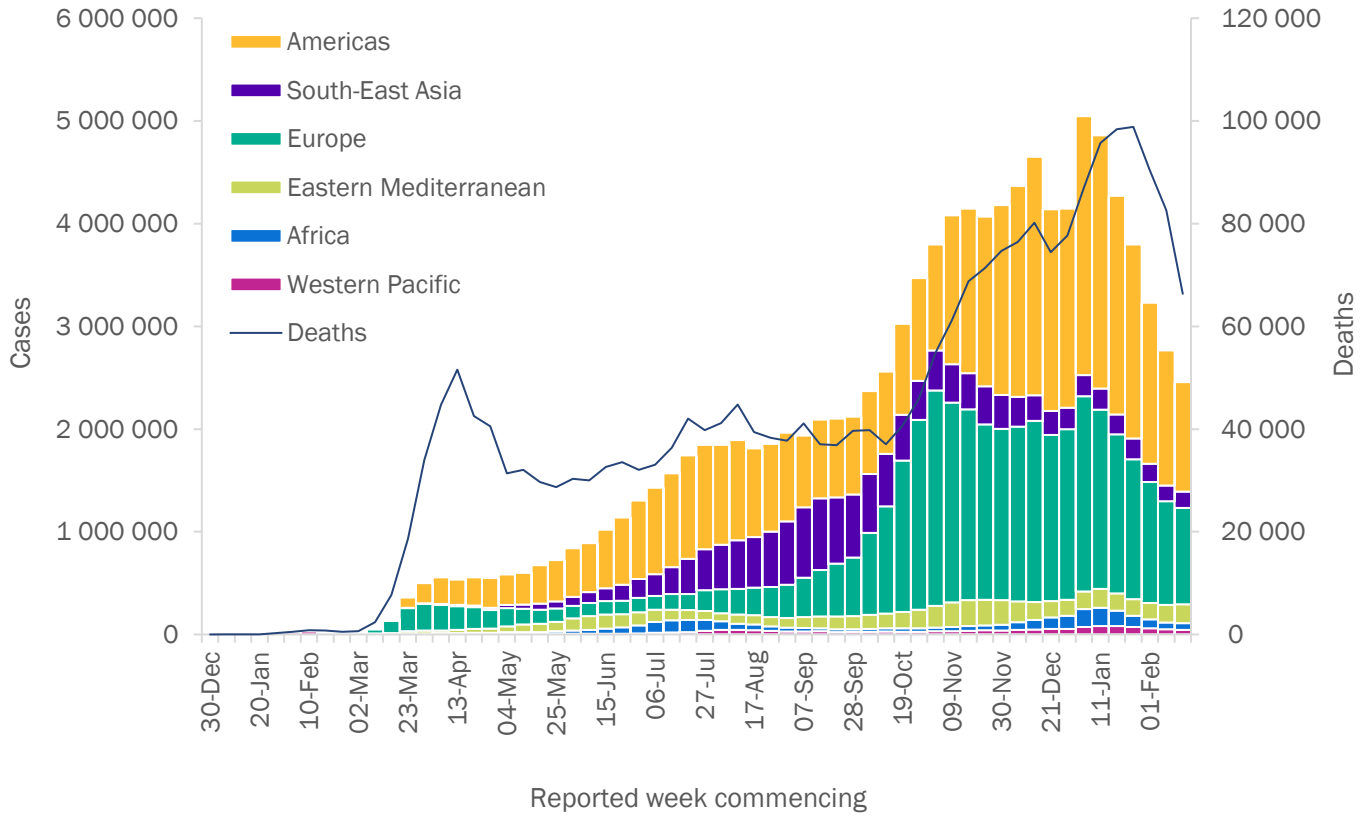
Data as received by WHO from national authorities, as of 21 February 2021, 10 am CET

In this edition:

Global overview

The number of global new cases reported continues to fall for the sixth consecutive week, with 2.4 million new cases last week, a 11% decline compared to the previous week (Figure 1). The number of new deaths also continued to fall for the past three weeks, with nearly 66 000 new deaths reported last week, a 20% decline as compared to the previous week. A total of four out of six WHO regions reported declines in new cases (Table 1), with only South-East Asia and the Eastern Mediterranean regions showing a small 2% and 7% increase, respectively. The Americas continue to see the greatest drops in absolute numbers of cases. Meanwhile, the number of new deaths declined in all regions apart from the Western Pacific (6% increase).

Figure 1: COVID-19 cases reported weekly by WHO Region, and global deaths, as of 21 February 2021**



**See *Annex: Data, table and figure notes*

In the past week, the five countries reporting the highest number of new cases continue to be the United States of America (480 467 new cases, a 29% decrease), Brazil (316 221 new cases, a 1% decrease), France (131 179 new cases, a 3% increase), the Russian Federation (92 843 new cases, an 11% decrease), and India (86 711 new cases, a 10% increase).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 21 February 2021**

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	1 066 990 (43%)	-19%	49 296 115 (45%)	34 386 (52%)	-23%	1 171 294 (48%)
Europe	939 271 (38%)	-7%	37 574 211 (34%)	24 102 (36%)	-19%	838 761 (34%)
South-East Asia	157 379 (6%)	2%	13 345 590 (12%)	2 189 (3%)	-6%	204 796 (8%)
Eastern Mediterranean	181 969 (7%)	7%	6 181 023 (6%)	2 443 (4%)	-3%	141 915 (6%)
Africa	66 453 (3%)	-2%	2 789 884 (3%)	2 038 (3%)	-20%	70 332 (3%)
Western Pacific	44 964 (2%)	-9%	1 576 330 (1%)	1 201 (2%)	6%	28 220 (1%)
Global	**2 457 026 (100%)**	**-11%**	**110 763 898 (100%)**	**66 359 (100%)**	**-20%**	**2 455 331 (100%)**

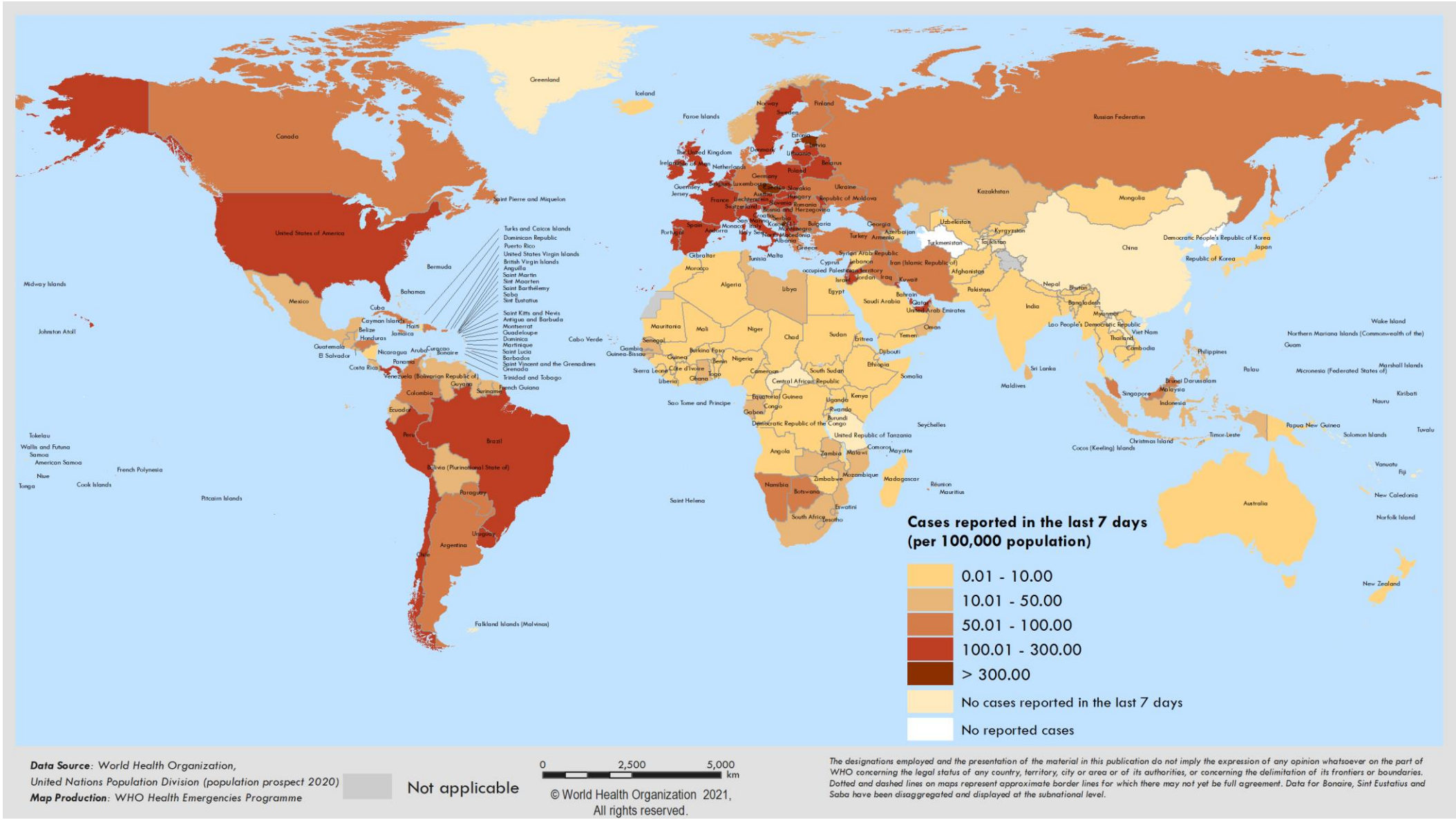
**Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number; global totals may not equal 100%.*

**See *Annex: Data, table and figure notes*

For the latest data and other updates on COVID-19, please see:

- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update

Figure 2. COVID-19 cases per 100 000 population reported in the last seven days by countries, territories and areas, 15 February through 21 February 2021**



**See *Annex: Data, table and figure notes*

Special Focus: WHO COVID-19 vaccine policy recommendations

WHO relies on the Strategic Advisory Group of Experts on Immunization (SAGE) to issue policy recommendations on COVID-19 vaccination to Members States. Through an established methodological process rooted in evidence-based medicine, and with the support of a dedicated COVID-19 vaccine working group, SAGE has issued three sets of interim recommendations to date, covering: the Pfizer- BioNTech BNT162b2 vaccine , the Moderna mRNA-1273 vaccine , and the AstraZeneca – Oxford University AZD1222 vaccine.

The last of these reviews examined AstraZeneca core clinical data from the Phase 1-3 clinical trials. The WHO interim recommendations that ensued apply to AZD1222 (named generically as ChAdOx1-S [recombinant]) vaccine against COVID-19, developed by Oxford University (United Kingdom) and AstraZeneca, as well as to ChAdOx1-S [recombinant]) vaccines against COVID-19 produced by other manufacturers. These include the Serum Institute of India and SK Bioscience (South Korea), both of which rely on the AstraZeneca core clinical data and have demonstrated equivalence in their regulatory review. It will be the responsibility of regulatory bodies and WHO's Emergency Use Listing (EUL) process to ensure that products emerging from different manufacturing facilities are equivalent.

For each of these three vaccines, SAGE was able to issue policy recommendations because of the publication of appropriate data by the vaccine developers and on the basis that the vaccine was in the process of acquiring EUL from WHO or a marketing authorization from a stringent regulatory authority, such as the European Medicines Agency. WHO assesses vaccines with a pathway to prequalification or EUL as they become available. In that context and under exceptional circumstances, WHO will review products with authorization from a regulatory authority considered by WHO as maintaining the highest of standards, even if EUL has yet to be confirmed, such as was the case for the Moderna and AstraZeneca vaccines. It should further be noted that EUL is a WHO time-limited regulatory recommendation based on a risk-benefit assessment of limited amount of quality, safety and efficacy data for use during a public health emergency. SAGE recommendations, on the other hand, are policy recommendations to guide ministries of health and their recommending bodies and disease programmes on the use of regulated products to optimize the individual and public health benefit of vaccines. The two sets of recommendations are complementary. WHO cannot comment or make recommendations on vaccines until the manufacturer in question has chosen to share the relevant data and allows SAGE, on behalf of WHO, to conduct a formal assessment. WHO urges all manufactures to share evidence to allow prompt review and guidance by designated WHO experts and advisory groups.

SAGE does not usually make vaccine- or product-specific recommendations, issuing instead one recommendation that covers all vaccines for a given disease, unless the evidence suggests product-specific recommendations are needed. The current situation with respect to COVID-19 differs as a large variety of vaccines based on very different platform technologies is being developed, and data on the performance of each vaccine are still emerging. Products also have varying characteristics, including storage and handling requirements, such that some may be considered more suitable for certain settings than others. Consequently, SAGE is issuing product-specific recommendations for COVID-19 and will likely continue doing so for additional candidate vaccines. In the longer run, these recommendations may be regrouped into overall recommendations for COVID-19 vaccination.

SAGE began to mobilize its evidence review and recommendation process for COVID-19 vaccination policy as early as the summer of 2020. An essential starting point to this process was the preparation and release of two critical documents forming the foundation for future vaccine-specific interim recommendations. These consist of the WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination and the WHO SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply, which jointly guide countries in their prioritization of target groups. The Roadmap highlights the importance of vaccinating

frontline health workers and older people with and without comorbidities first, and outlines how additional groups can then be vaccinated as more vaccine becomes available, in keeping with the local epidemiological context. The Roadmap also encourages national programmes to consider groups that are disproportionately affected by the pandemic and to continuously base vaccination decisions on a thorough risk benefit assessment.

For all three vaccines reviewed to date, SAGE concluded that the known and potential benefits outweigh the known and potential risks. The high efficacy of each of the products was acknowledged, despite insufficient data on if and how these vaccines impact virus transmission, although it is likely there will be some level of protection against transmission. These vaccines will have a beneficial effect on the high rate of severe disease and mortality caused by SARS-CoV-2 infection, a key objective of vaccination. More work is needed to understand if this is the case for all circulating variants of concern.

Based on current data for each of these three vaccines, a regimen of 2 full doses of the same vaccine is recommended, injected intramuscularly in the upper arm. This means the dosage cannot be reduced, or interchanged (i.e., if the first dose is Pfizer-BioNTech vaccine, the second should not be Moderna or AstraZeneca vaccines). There are multiple reasons for this, including a lack of research so far on interchangeability. Furthermore, each vaccine has a different minimum interval time between doses: a second dose of the Pfizer-BioNTech vaccine can be administered after three weeks; the Moderna vaccine requires a minimum interval of four weeks, which can be extended to six weeks; and the AstraZeneca vaccine requires an interval of no less than eight weeks which can be extended to twelve. This latter WHO recommendation deviates slightly from the vaccine developers, who have determined the product is sufficiently efficacious when a second dose is administered after four weeks. SAGE preferred to recommend a longer interval for the AstraZeneca vaccines based on the evidence that supported an improved vaccine performance (for efficacy and immunogenicity) when delaying the second dose by a few weeks.

With all three vaccines, it is recommended that the administration of any other vaccines against other conditions be held off for at least two weeks after vaccination against COVID-19, until data on co-administration become available.

The minimum recommended ages for COVID-19 vaccination vary only slightly between the three vaccines and SAGE confirmed there is no upper limits for any of the three vaccines. These conclusions were based on available data and will evolve when more efficacy and safety data become available. The same evidence scenario applies for specific populations such as pregnant or lactating women, as well as persons with compromised immune systems or living with HIV. For each of these groups, there is no reason to believe the vaccine would be harmful – especially since these are not vaccines containing live viruses which can replicate; however, more evidence is being sought in order to further inform WHO policy recommendations. Whenever possible, potential vaccine recipients should be informed and counselled in relation to the available data and a risk-benefit assessment of their individual case. It should be clarified that, while recommendations exist for these profiles, there are no current COVID-19 vaccination recommendations for children and adolescents.

WHO recommendations on who may be vaccinated with each of the three vaccines are summarized in Table 2, with the assumption that people falling into high-risk groups (e.g., health workers or people with co-morbidities) are being prioritized as per the WHO SAGE Roadmap on COVID-19 vaccines.

Table 2. Who can be vaccinated with which vaccine against COVID-19?

SAGE INTERIM RECOMMENDATION	Pfizer-BioNTech BNT162b2 vaccine	Moderna mRNA-1273 vaccine	Oxford University – Astra Zeneca AZD1222 vaccine
Minimum age requirement	**16** years 	**18** years 	**18** years 
Maximum age requirement	**none** 	**none** 	**none** 
Ok for pregnant women?	**Yes**, if in high priority group and ok'd by health care provider. 	**Yes**, if in high priority group and ok'd by health care provider. 	**Yes**, if in high priority group and ok'd by health care provider. 
Ok for breastfeeding mothers?	**Yes**, if in high priority group. 	**Yes**, if in high priority group. 	**Yes**, if in high priority group. 
Ok for people with compromised immune systems?	**yes** 	**yes** 	**yes** 
Ok for people living with HIV?	**yes** 	**yes** 	**yes** 
Ok for people previously infected with SARS-CoV-2 (confirmed by PCR test)?	**Yes**, though that person may elect to delay vaccination up to 6 months from the time of infection. 	**Yes**, though that person may elect to delay vaccination up to 6 months from the time of infection. 	**Yes**, though that person may elect to delay vaccination up to 6 months from the time of infection. 
Ok for people with a history of severe allergic reaction (anaphylaxis)?	**no** 	**no** 	**No**, if anaphylactic reaction was linked to any component of the vaccine. 

No studies have yet been conducted to compare these three vaccines and despite the above listed similarities, there are also notable differences such as the dose size, the number of doses per container, and the required storage conditions. These differences affect the practices around vaccination, including the handling of vaccine vials and the timeframe within which a vial must be used once thawed or brought to ambient temperatures. In some cases, the less constraining temperature requirements can make storage and distribution much easier, especially when freezing is neither needed nor recommended. However, in no way do these differences diminish the respective performance of the vaccines, which in all three cases are recognized as highly efficacious and with excellent safety profiles.

While these vaccines, and others coming through the pipeline, offer us reason to be optimistic, the current lack of evidence of their effect on transmission, circulating variants of concern, coupled with a continuing limited supply of the vaccines, mean that more data collection is required, and public health and social measures (PHSM) must continue, and should be practised by all individuals regardless of vaccination status, including use of face masks, physical distancing, hand-washing and other measures.

Special Focus: Update on SARS-CoV-2 Variants of Concern

WHO, in collaboration with national authorities, institutions and researchers, continues to monitor the public health events associated with SARS-CoV-2 variants and provides updates as new information becomes available.

Further information on the background of the variants of concern (VOCs) is available from previously published Disease Outbreak News and recent publications of the Weekly Epidemiological Update. Here we provide an update on ongoing studies and the geographical distribution of select VOCs as reported by countries, territories and areas (hereafter countries) as of 23 February 2021. New variants of potential interest or concern are continuously emerging; we provide here an update on two such variants currently under review.

Results of ongoing studies of VOCs are summarized in Table 3 below. While many countries worldwide are currently experiencing a decline in overall SARS-CoV-2 infections likely as a result of the public health and social measures (PHSM) implemented, there has been an increased number of reports of variants which are of concern. As surveillance activities at local and national levels are strengthened, including strategic genomic sequencing to detect cases infected with SARS-CoV-2 variants, the number of countries reporting VOCs has continued to increase in the past two weeks (Table 3, Figures 3, 4 and 5, Annex 2). In addition, the number of countries reporting local transmission of VOCs has increased in the same period.

Increased transmissibility has been reported for some VOCs resulting in increased incidence in settings experiencing community transmission. PHSM remain critically important to curb the spread of SARS-CoV-2, including newly reported variants. Evidence from multiple countries with extensive transmission of VOCs has indicated that the implementation of physical distancing and other PHSM has been effective in reducing COVID-19 case incidence, which has led to a reduction in hospitalizations among COVID-19 patients. Findings from new studies evaluating transmission, severity and impact on medical countermeasures will continue to help inform PHSM employed by Member States.

Table 3: Overview of emerging information on key variants of concern, as of 23 February 2021*

Nextstrain clade	20I/501Y.V1	20H/501Y.V2†	20J/501Y.V3
Pango lineage	B.1.1.7	B.1.351	B.1.1.28.1
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01†	VOC 202012/02	P.1†
First detected by	United Kingdom	South Africa	Brazil / Japan
First appearance	20 September 2020	Early August 2020	December 2020
Key spike mutations	H69/V70 deletion; Y144 deletion; N501Y; A570D; D614G; and P681H	L242/A243/L244 deletion; N501Y; D614G; E484K; and K417N	N501Y; D614G; E484K; and K417N
Key mutation in common	S106/G107/F108 deletion in Non-Structural Protein 6 (NSP6)		
Transmissibility*	Increased[1] (36%-75%)[2], increased secondary attack rate[3] (10% to 13%)	Increased [1.50 (95% CI: 1.20-2.13) times more transmissible than previously circulating variants][4,5]	Suggested to be increased
Severity*	Possible increased severity and mortality[6]	No impact reported to date[4,5], no significant change in-hospital mortality[7]	Under investigation, no impact reported to date
Neutralization capacity*	Slight reduction but overall neutralizing titers still remained above the levels expected to confer protection[8]	Decreased, suggesting potential increased risk of reinfection[4,9,10]	Potential decrease, small number of reinfections reported[11,12]
Potential impacts on vaccines*	No significant impact on Moderna, Pfizer-BioNTech, and Oxford-AstraZeneca vaccines[13-16]	Moderna and Pfizer-BioNTech: Reduction in the neutralizing activity, but impact on protection against disease not known.[13-16] Novavax and Johnson & Johnson: Lower vaccine efficacy in South Africa compared to settings without the variant (press release data only). Moderate-severe disease were assessed. Serologic neutralization results pending.[17,18] Oxford/AstraZeneca: Limited vaccine efficacy against mild-moderate COVID-19 disease, with wide confidence intervals, impact on severe disease undetermined. Serologic neutralization substantially reduced compared with original strains, based on small number of samples analyzed[19,20]	Under investigation
Potential impacts on diagnostics*	S gene target failure (SGTF).[19] No impact on Ag RDTs observed[21]	None reported to date	None reported to date
Countries reporting cases (newly reported in last week)**	101 (7)	51 (5)	29 (8)

†*While work is ongoing to establish standardized nomenclature for key variants, these are the names by which WHO will refer to them in this publication.*

**Generalized findings as compared to non-VOC viruses. Based on emerging evidence from multiple countries, including non-peer-reviewed preprint articles and reports from public health authorities and researchers – all subject to ongoing investigation and continuous revision.*

***Includes official and unofficial reports of VOCs detections in countries among either travellers (imported cases only) or community samples (local transmission).*

Variant VOC 202012/01

Since our last update on 16 February, VOC 202012/01 has been detected in seven additional countries. As of 23 February, a total of 101 countries across all six WHO regions have reported cases of this variant (Figure 3). Community transmission has been reported in at least 45 countries across five WHO regions, noting that transmission classification is currently incomplete for 23 (23%) countries reporting this variant.

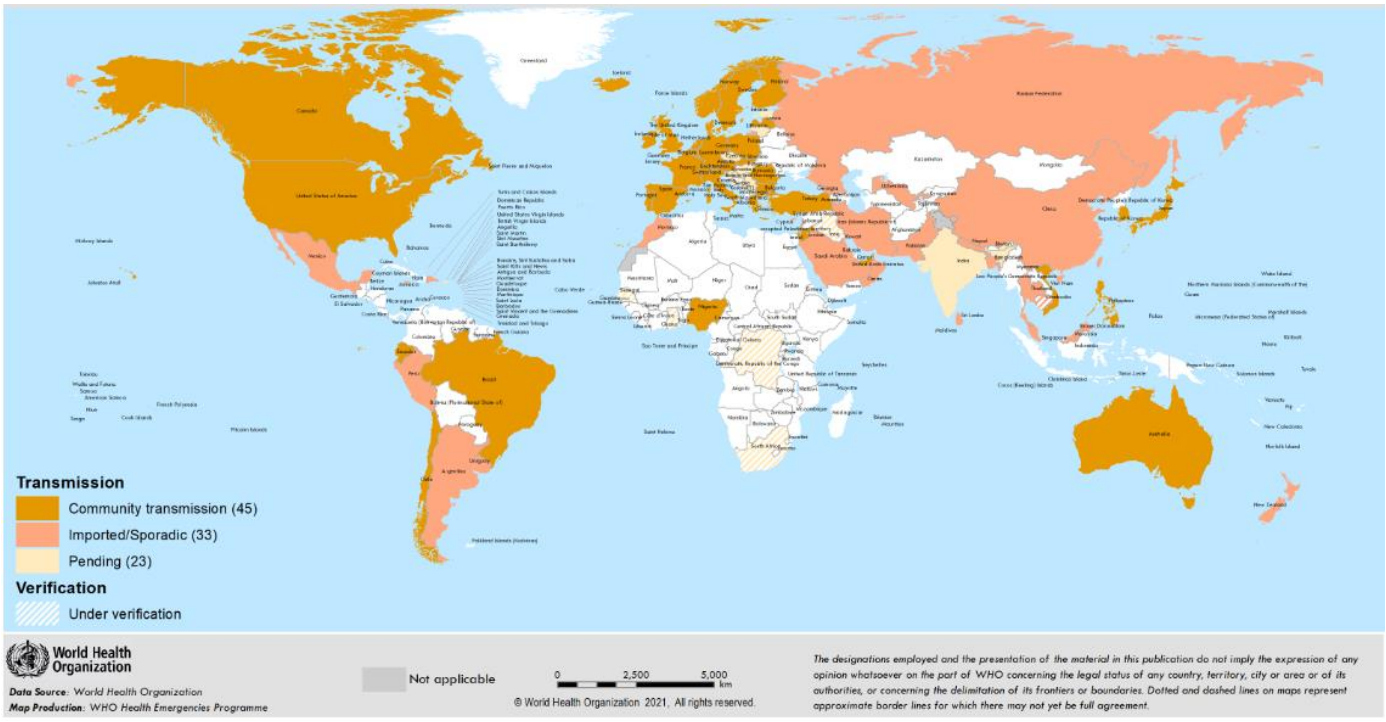
Since January 2021, several countries and in the European Region in particular, have observed a marked increase in the number and proportion of cases infected with VOC 202012/01 among samples tested by PCR-based screening and whole genome sequencing.[22] As of 8 February, the proportion of sequenced samples in which VOC 202012/01 was detected in Spain varied across the different regions from 0.4% to 53.3%.[23] During the epidemiological week 6 (from 7 to 14 February 2021), Germany detected VOC 202012/01 in 22% of the specimens analysed (23 000 samples tested),[24] 36% in France,[25] and 47% in Denmark.[26,27] In the United States of America (USA), genomic sequencing by one commercial laboratory suggested prevalence of VOC 202012/01 to be approximately 1% nationwide, and over 2% in some States as of 3 February 2021.[28] Another study estimated a 3.6% prevalence of VOC 202012/01 by the end of January 2021 using the S-gene target failure (SGTF; a proxy used to identify cases infected with VOC 202012/01).[29] As of 21 February, the USA has reported a total of 1661 cases from 44 States in the United States of America.[30] Additionally, the VOC 202012/01 has increasingly been associated with outbreaks in several different settings.[31,32]

On 21 January 2021, the United Kingdom's New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) released analyses suggesting increased disease severity and risk of death in cases with SGTF compared to cases without SGTF.[3] When comparing cases with SGTF to cases without SGTF: (i) one study reported the relative hazard of death within 28 days of testing to be 1.35 (95% CI: 1.08-1.68); (ii) one study reported the mean case fatality ratio to be 1.36 (95% CI 1.18-1.56) by a case-control weighing method; (iii) one study reported a mortality hazard ratio of 1.91 (95% CI 1.35-2.71) (studies unpublished to date). In addition, a matched cohort analysis reported a death risk ratio of 1.65 (95% CI: 1.21-2.25) for cases infected with VOC 202012/01 compared with non-VOC 202012/01 cases. Although there are limitations to these studies including representativeness of the dataset used, these findings follow an initial assessment that there was no significant difference in the risk of hospitalization or death as compared to other variants, conducted in December 2020. The absolute risk of death of SARS-CoV-2 remains low, and additional studies are required to investigate these findings.

Based on available information, VOC 202012/01 has not been associated with decreased neutralization activity of polyclonal antibodies such as vaccine-derived or convalescent sera. However, the genomic changes of the epitope which binds to the host cell receptor, such as deletions in the N terminal domain, may affect binding of this variant to monoclonal antibodies, indicating possible effects on the efficacy of monoclonal antibodies used as therapeutics.[33]

A pre-print study with a small sample size (n=65, including 7 infected individuals with VOC 202012/01), suggested that individuals infected with VOC 202012/01 had longer duration of acute infection and similar peak viral load when compared to non-VOC 202012/01 variants.[34] However, these are preliminary findings and require further investigations with larger cohorts.

Figure 3. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 23 February 2021



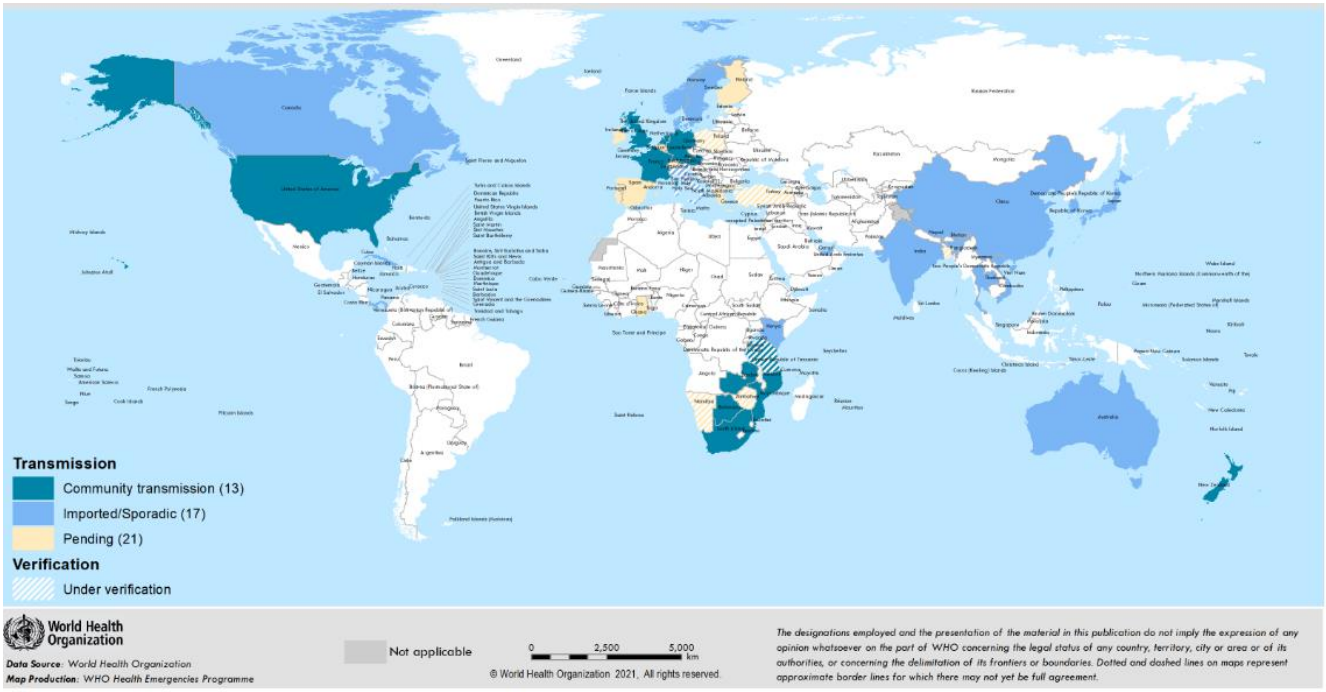
Variant 501Y.V2

Since the last update on 16 February, 501Y.V2 has been reported from five additional countries – now totalling 51 countries across all six WHO regions (Figure 4). Community transmission of 501Y.V2 has been reported in 13 countries across four WHO regions, noting the transmission classification is currently incomplete for 21 (41%) countries reporting this variant. In several areas within the African Region, variant 501Y.V2 has been reported to comprise a high proportion of sequenced samples.[35]

Studies highlighting reductions in neutralizing antibody activity against 501Y.V2 following either natural infection or vaccination, with potential to impact re-infection risk or vaccine effectiveness have been discussed previously (see Table 3, and past editions of the Weekly Epidemiological Update). A preliminary report with a small sample size (n=20) indicated that the serum neutralization capacity of serum elicited by BNT162b2 vaccine, produced by Pfizer-BioNTech, was weaker against variant 501Y.V2 by approximately two thirds as compared to that of another variant.[36] Further studies are needed to fully understand efficacy of existing vaccines.

Recent preliminary evidence suggests that variant 501Y.V2 may compromise immunity indicating potential increased risk of reinfection. There is now growing evidence that the mutations present in this variant may help the virus evade immune system responses triggered by previous infections of SARS-CoV-2 or by vaccines. There has been a report of a SARS-CoV-2 reinfection with the 501Y.V2 variant months after recovering from a first episode of COVID-19 with a more severe clinical presentation.[37]

Figure 4. Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 23 February 2021

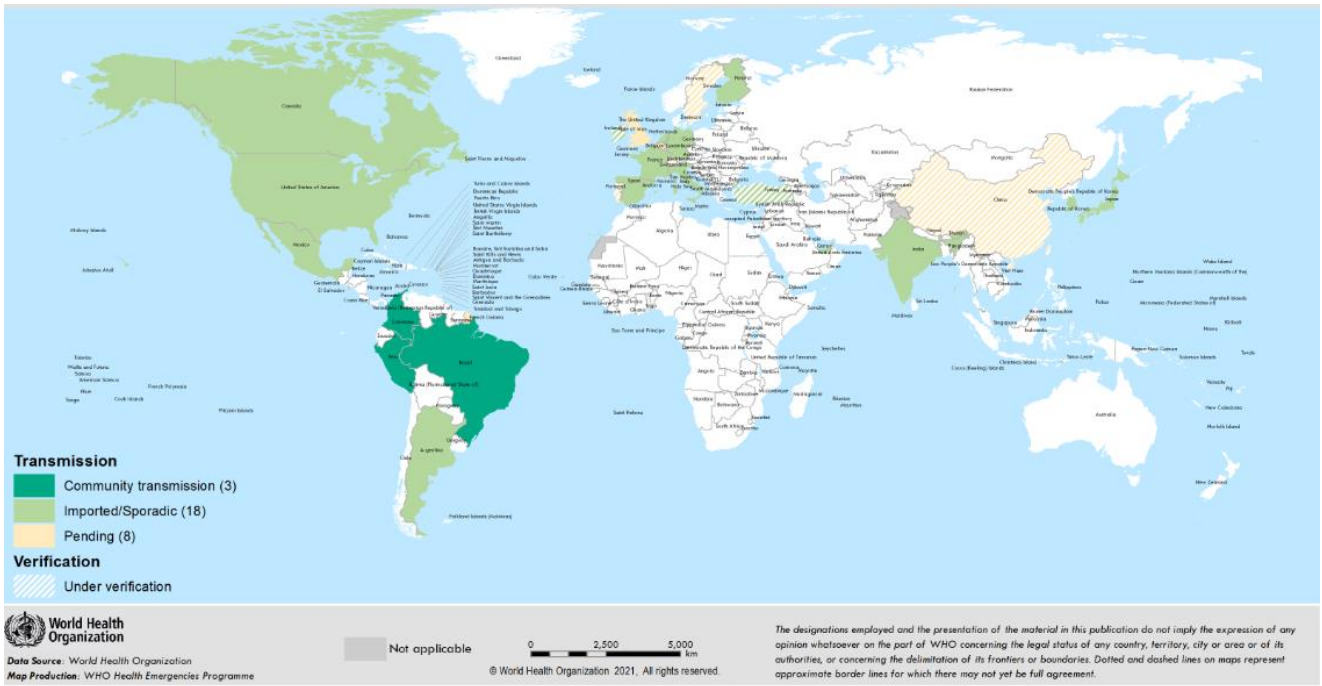


Variant P.1

Since our last update, variant P.1 has been reported in eight additional countries. To date, this variant is reported in 28 countries across all six WHO regions (Figure 5). Community transmission of P.1 has been reported in at least three countries in one WHO region, noting the transmission classification is currently incomplete for 8 (28%) countries reporting this variant.

In a genomic survey conducted from April to November 2020 in Amazonas State, Brazil, variant P.1 was found to be the most prevalent variant among 148 whole-genomes sequenced, comprising 47% (69/148) of specimens collected from 12 municipalities.[38] During the period of 1 November 2020 to 13 January 2021, sequencing of samples from different municipalities in Amazonas found rapid increase in the proportion of variant P.1 in the state. In the state capital Manaus, cases associated to the P.1 variant were initially detected on the 4 December 2020 and as of January 2021, 91% of cases were infected with the P1 variant. Furthermore, the variant was found in a widespread geographic distribution in the state.[39]

Figure 5. Countries, territories and areas reporting SARS-CoV-2 P.1 variant as of 23 February 2021



Emerging variants of interest or concern

To inform local, national and regional risk assessments, surveillance of SARS-CoV-2 variants continues globally with timely sharing of sequence data. As of 23 February 2021, over 590 000 sequences of SARS-CoV-2 globally have been uploaded into publicly available databases. New variants of potential interest or concern are continuously emerging and undergo assessment. We provide here an update on two such variants currently under review.

Variant B.1.525 (also referred to as VUI-202102/03, and previously UK1188), was first detected in the United Kingdom and Nigeria in December 2020.[40] Since then, it has been detected in at least another 13 countries.[41] This variant is partially similar to the 501Y.V2 variant and contains mutations which may be associated with some degree of biological significance, including the E484K, Q677H and F888L mutations, as well as a similar number of deletions that are contained in B.1.1.7.

A variant of B.1.1.7 with an E484K mutation (labelled VOC 202102/02 by the United Kingdom health authorities) has been detected in South West England. As of 17 February 2021, 26 cases of this variant have been detected in the United Kingdom.[33] Local authorities are responding with enhanced PHSM with the aim to prevent further spread. The E484K mutation is a mutation in the spike protein and has been associated with antigenic change, as well as increased binding affinity to the human host receptor, Angiotensin Converting Enzyme 2 (ACE2), in conjunction with the N501Y mutation.[42] E484K has been labelled as an escape mutation, so called because it may help the SARS-CoV-2 virus to evade host immune defences. It has been identified as an adaptation of SARS-CoV-2 in at least one immunocompromised patient with long lasting infection.[43] The E484K mutation has been identified independently in several variants (including 501Y.V2 and P.1.), indicating convergent mutations, where distinct lineages independently acquire similar genetic mutations.[42,44] Although there is no evidence that this mutation alone is associated with increased disease severity or higher transmissibility, E484K is of significance due to its possible impact on immune response, vaccine efficacy and transmissibility.[40]

Further investigations are required to better understand the importance of specific mutations (and/or clusters of mutations), whether they are identified in emerging variants of interest or concern, as well as ongoing adaptations and evolution of SARS-CoV-2.

WHO Recommendations

National and local authorities are encouraged to continue strengthening existing disease control activities, including epidemiological surveillance, strategic testing, and increased routine systematic sequencing of SARS-CoV-2 where feasible (for more information, please see WHO advice in the previously published Disease Outbreak News).

WHO has been tracking mutations since the beginning of the pandemic. In June 2020, WHO established the SARS-CoV-2 Virus Evolution Working Group (VEWG) to specifically assess new variants. Together with Member States and partners, a global risk monitoring framework has been established to:

- Coordinate and harmonize a global system for monitoring and assessing SARS-CoV-2 variants and their impact;
- Identify critical priorities, thresholds, and triggers for decision-making;
- Define a multi-disciplinary coordination mechanism to collect, analyze, and share data to inform decision-making, including on vaccination programs; and
- Leverage and enhance existing technical networks and expert groups.

Working definitions of SARS-CoV-2 variants of interest and variants of concern have been developed and are currently under review, with an aim to publish later this week.

WHO is working to increase sequencing capacities globally and has published a comprehensive implementation guide and risk-monitoring framework to support countries set up high-impact sequencing programmes for SARS-CoV-2 variants and maximize public health impact.

PHSM have proven to remain effective against VOCs to date. WHO continues to advise that the application and adjustment of PHSM should be driven by detailed data analyses of epidemiology at the most local level possible (for more information, please see our technical guidance).

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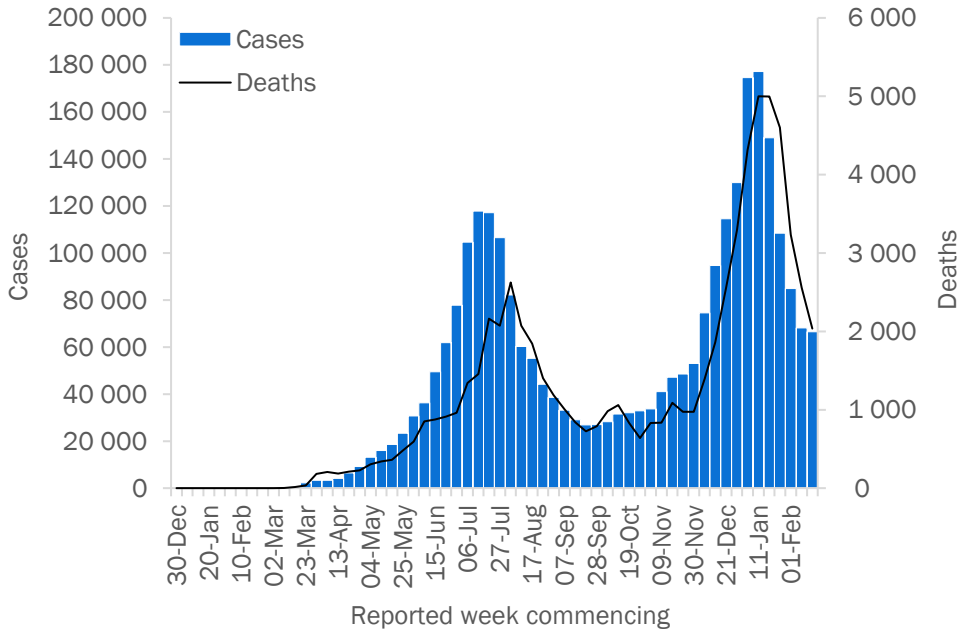
WHO regional overviews

African Region

In the past week, the African Region reported over 66 400 cases and 2000 deaths, a 2% and 20% decrease respectively compared to the previous week. This is the fifth consecutive week the Region reported decreases in both new cases and deaths. The highest numbers of new cases were reported in South Africa (12 304 new cases; 20.7 new cases per 100 000 population; a 25% decrease), Mozambique (6380 new cases; 20.4 new cases per 100 000; a 42% increase) and Ethiopia (6153 new cases; 5.4 new cases per 100 000; a 45% increase).

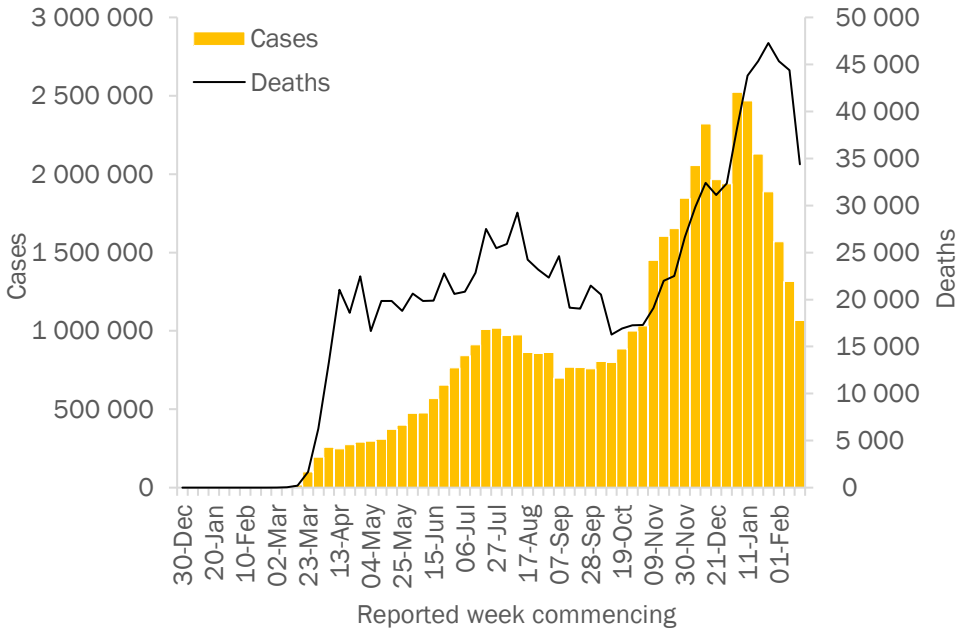
The countries reporting the highest number of new deaths in the past week were South Africa (1119 new deaths; 1.9 new deaths per 100 000; a 32% decrease), Ethiopia (90 new deaths; 0.1 new deaths per 100 000; a 150% increase), and Nigeria (84 new deaths; <0.1 new deaths per 100 000; a 16% decrease).



Region of the Americas

Over 1 million new cases and over 34 300 new deaths were reported in the Region of the Americas this week, a 19% and 23% decrease respectively compared to the previous week. The highest numbers of new cases were reported from the United States of America (480 467 new cases; 145.2 new cases per 100 000 population; a 29% decrease), Brazil (316 221 new cases; 148.8 new cases per 100 000; a 1% decrease) and Mexico (51 537 new cases; 40 new cases per 100 000; a 22% decrease).

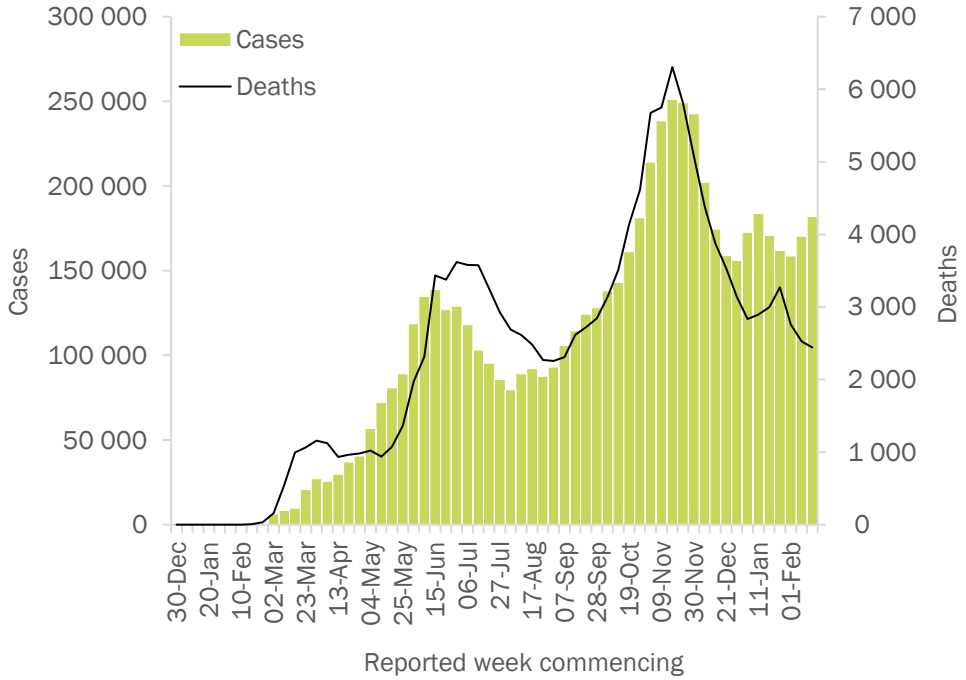
The highest numbers of new deaths were reported from the same countries, the United States of America (14 747 new deaths; 4.5 new deaths per 100 000; a 31% decrease), Brazil (7276 new deaths; 3.4 new deaths per 100 000; a 2% decrease) and Mexico (6408 new deaths; 5.0 new deaths per 100 000; a 22% decrease).



Eastern Mediterranean Region

In the past week, the Eastern Mediterranean Region reported over 181 000 new cases, a 7% increase compared to last week. The region reported just over 2400 new deaths, a 3% decrease. The three countries reporting the highest numbers of new cases this week were the Islamic Republic of Iran (55 208 new cases; 65.7 new cases per 100 000 population; a 7% increase), Iraq (23 122 new cases; 57.5 new cases per 100 000; a 63% increase) and the United Arab Emirates (22 570 new cases; 228.2 new cases per 100 000; a 2% increase).

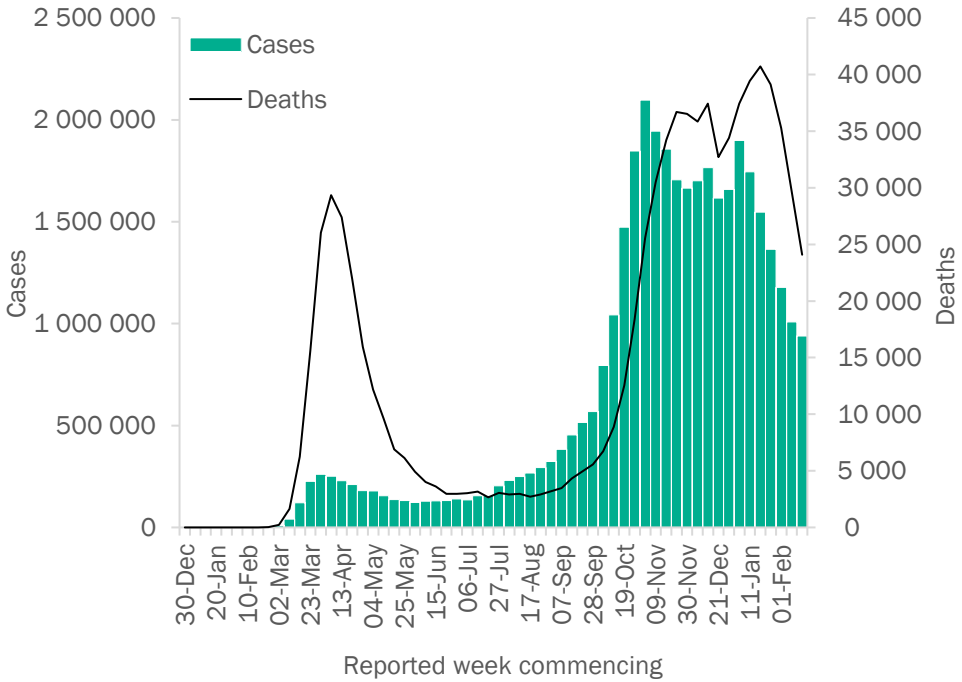
The highest numbers of new deaths this week have been reported in the Islamic Republic of Iran (526 new deaths; 0.6 new deaths per 100 000 population; a 12% increase), Egypt (363 new deaths; 0.4 new deaths per 100 000; a 10% increase) and Lebanon (336 new deaths; 4.9 new deaths per 100 000; a 16% decrease).



European Region

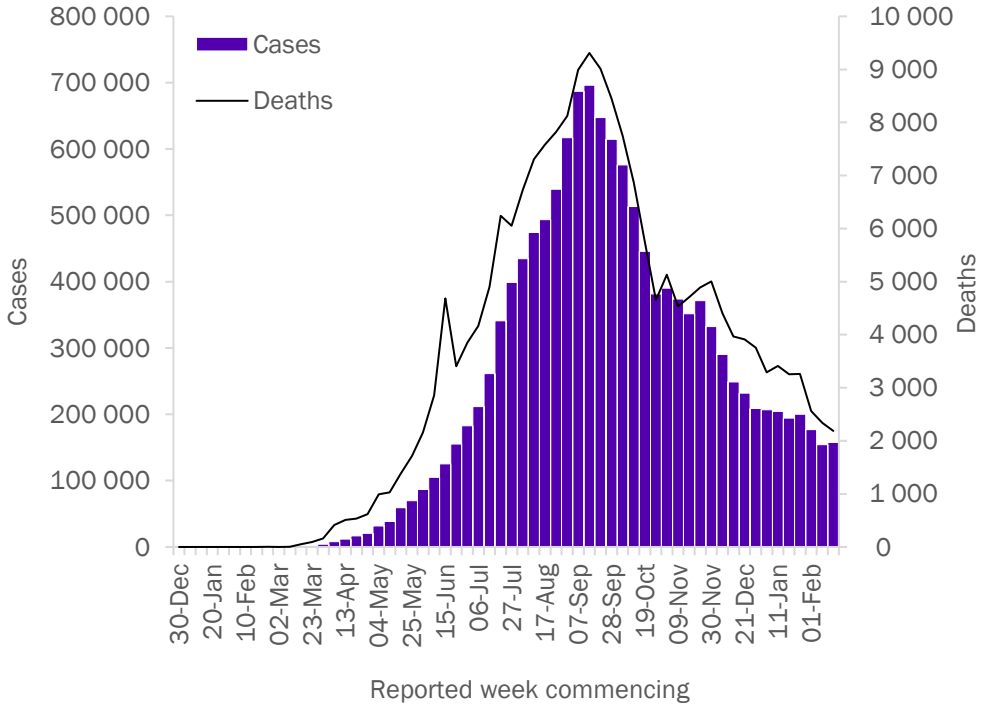
The European Region reported over 939 000 new cases and over 24 000 new deaths, a decrease of 7% and 19% respectively when compared to the previous week. The three countries reporting the highest numbers of new cases were France (131 179 new cases; 201 new cases per 100 000; a 3% increase), the Russian Federation (92 843 new cases; 63.6 new cases per 100 000; an 11% decrease), and Italy (84 977 new cases; 140.5 new cases per 100 000; an 1% decrease).

The highest numbers of deaths were reported from the United Kingdom (3457 new deaths; 5.1 new deaths per 100 000; a 28% decrease), the Russian Federation (3167 new deaths; 2.2 new deaths per 100 000; a 9% decrease) and Germany (2881 new deaths; 3.4 new deaths per 100 000; a 16% decrease).



South-East Asia Region

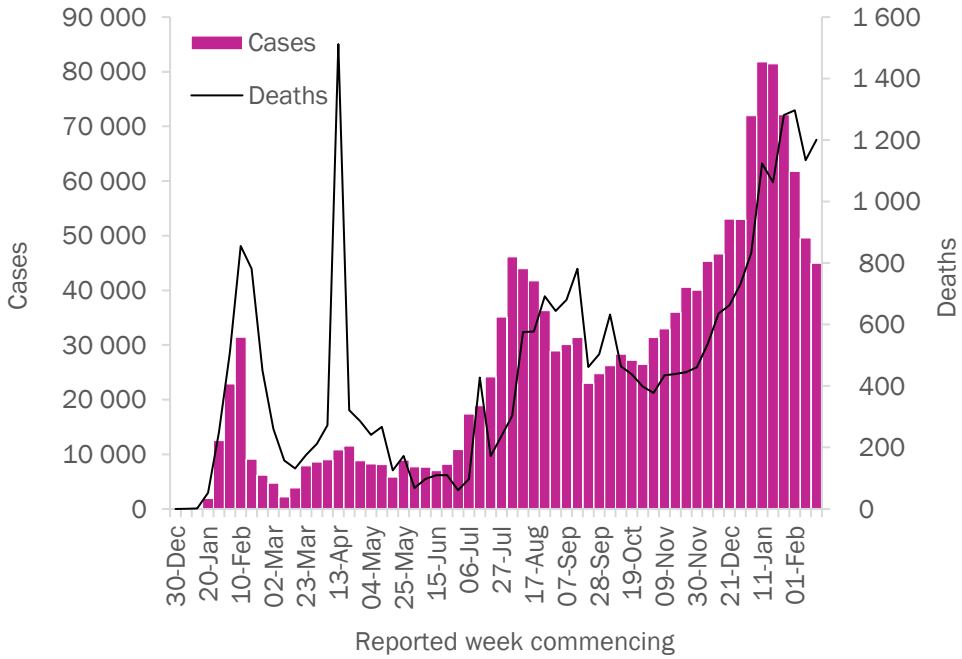
In the past week, the South-East Asia Region reported over 157 000 new cases, an increase of 2% compared to last week. The region reported over 2100 new deaths, a 6% decrease. The three countries reporting the highest numbers of new cases were India (86 711 new cases; 6.3 new cases per 100 000; a 10% increase), Indonesia (60 650 new cases; 22.2 new cases per 100 000; a 5% decrease), and Sri Lanka (4628 new cases; 21.6 new cases per 100 000; a 26% decrease).
The three countries reporting the highest numbers of new deaths this week were Indonesia (1380 new deaths; 0.5 new deaths per 100 000; an 11% decrease), India (660 new deaths; <0.1 new deaths per 100 000; a 2% increase) and Bangladesh (76 new deaths; <0.1 new deaths per 100 000, no change in new deaths reported this week as compared to last week).



Western Pacific Region

The Western Pacific Region reported just under 45 000 new cases the past week, a 9% decrease compared to the previous week. The region reported 1200 new deaths, a 6% increase. The three countries reporting the highest numbers of new cases in the region this week were Malaysia (18 467 new cases; 57.1 new cases per 100 000; a 20% decrease), the Philippines (12 033 new cases; 11.0 new cases per 100 000; a 2% increase), and Japan (10 035 new cases; 7.9 new cases per 100 000; a 9% decrease).

The three countries reporting the highest numbers of new deaths this week were the Philippines (561 new deaths; 0.5 new deaths per 100 000; a 41% increase), Japan (505 new deaths; 0.4 new deaths per 100 000; a 12% decrease), and Malaysia (93 new deaths; 0.3 new deaths per 100 000; an 8% decrease).



Key weekly updates

- **WHO Director-General Dr Tedros issued a statement on Tanzania on 20 February** "A number of Tanzanians travelling to neighbouring countries and beyond have tested positive for COVID-19." The situation in Tanzania remains concerning. WHO urges Tanzania:
    - to start reporting COVID-19 cases and share data;
    - to implement the public health measures that we know work in breaking the chains of transmission;
    - and to prepare for vaccination.

GISRS Surveillance of SARS-CoV-2

- Operational considerations to expedite genomic sequencing component of GISRS surveillance of SARS-CoV-2, 16 February 2021

Management of the blood supply in response to the pandemic outbreak of coronavirus disease (COVID-19)

- Maintaining a safe and adequate blood supply and collecting convalescent plasma in the context of the COVID-19 pandemic**:** Interim guidance, 17 February 2021

COVID-19 vaccines

- Country readiness for COVID-19 vaccines
- Draft landscape and tracker of COVID-19 candidate vaccines
- World Waking Up to Vaccine Equity
- G7 leaders commit US$ 4.3 billion to finance global equitable access to tests, treatments and vaccines in 2021
- COVAX Statement on WHO Emergency Use Listing for AstraZeneca/Oxford COVID-19 Vaccine
- Coronavirus disease (COVID-19) Q&A update: Vaccines safety

Technical guidance and other resources

- Technical guidance
- WHO Coronavirus Disease (COVID-19) Dashboard
- Weekly COVID-19 Operational Updates
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- Online courses on COVID-19 in official UN languages and in additional national languages
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Updates from WHO regions:
  - African Region
  - Region of the Americas
  - Eastern Mediterranean Region
  - South-East Asia Region
  - European Region
  - Western Pacific Region
- Recommendations and advice for the public:
  - Protect yourself
  - Questions and answers
  - Travel advice
  - EPI-WIN: tailored information for individuals, organizations and communities

Annex

Annex 1. COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region, as of 21 February 2021**

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Africa	**66 453**	**2 789 884**	**248.7**	**2 038**	**70 332**	**6.3**	
South Africa	12 304	1 502 367	2 533.1	1 119	48 940	82.5	Community transmission
Mozambique	6 380	54 968	175.9	73	587	1.9	Community transmission
Ethiopia	6 153	151 857	132.1	90	2 271	2.0	Community transmission
Nigeria	5 889	151 553	73.5	84	1 831	0.9	Community transmission
Zambia	5 440	73 894	401.9	76	1 016	5.5	Community transmission
Ghana	4 538	79 656	256.4	54	572	1.8	Community transmission
Cameroon	2 355	33 749	127.1	49	523	2.0	Community transmission
Senegal	1 989	32 630	194.9	54	795	4.7	Community transmission
Malawi	1 652	30 528	159.6	67	1 004	5.2	Community transmission
Botswana	1 598	26 524	1 127.9	52	254	10.8	Community transmission
Namibia	1 498	37 295	1 467.8	16	402	15.8	Community transmission
Algeria	1 251	111 764	254.9	23	2 958	6.7	Community transmission
Kenya	1 201	103 993	193.4	22	1 817	3.4	Community transmission
South Sudan	1 107	6 417	57.3	11	85	0.8	Community transmission
Côte d'Ivoire	1 030	31 914	121.0	12	185	0.7	Community transmission
Gabon	976	13 553	608.9	2	75	3.4	Community transmission
Democratic Republic of the Congo	840	25 079	28.0	8	700	0.8	Community transmission
Rwanda	721	17 988	138.9	11	247	1.9	Community transmission
Zimbabwe	664	35 768	240.7	34	1 432	9.6	Community transmission
Lesotho	609	10 461	488.3	60	285	13.3	Community transmission
Benin	583	5 143	42.4	9	65	0.5	Community transmission
Togo	445	6 268	75.7	1	81	1.0	Community transmission
Seychelles	436	2 328	2 367.1	2	10	10.2	Community transmission
Guinea	408	15 303	116.5	2	86	0.7	Community transmission
Mauritania	306	17 083	367.4	9	434	9.3	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Cabo Verde	299	14 999	2 697.7	4	143	25.7	Community transmission
Eswatini	276	16 764	1 445.0	15	645	55.6	Community transmission
Eritrea	256	2 685	75.7	0	7	0.2	Community transmission
Gambia	241	4 543	188.0	8	143	5.9	Community transmission
Madagascar	238	19 598	70.8	7	292	1.1	Community transmission
Burundi	207	2 031	17.1	0	3	0.0	Community transmission
Congo	206	8 625	156.3	4	127	2.3	Community transmission
Guinea-Bissau	206	3 091	157.1	0	46	2.3	Community transmission
Burkina Faso	195	11 783	56.4	1	139	0.7	Community transmission
Uganda	180	40 199	87.9	5	333	0.7	Community transmission
Chad	172	3 794	23.1	6	133	0.8	Community transmission
Angola	170	20 499	62.4	7	498	1.5	Community transmission
Comoros	158	3 490	401.3	15	143	16.4	Community transmission
Equatorial Guinea	104	5 798	413.3	2	89	6.3	Community transmission
Sao Tome and Principe	96	1 578	720.0	2	21	9.6	Community transmission
Mali	66	8 292	40.9	5	347	1.7	Community transmission
Niger	43	4 733	19.6	1	170	0.7	Community transmission
Sierra Leone	28	3 849	48.3	0	79	1.0	Community transmission
Liberia	19	1 988	39.3	1	85	1.7	Community transmission
Mauritius	8	603	47.4	0	10	0.8	Sporadic cases
Central African Republic	0	4 996	103.4	0	63	1.3	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territories[iii]							
Mayotte	2 257	15 792	5 788.5	14	92	33.7	Community transmission
Réunion	655	11 562	1 291.4	1	48	5.4	Community transmission
Americas	**1 066 990**	**49 296 115**	**4 819.8**	**34 386**	**1 171 294**	**114.5**	
United States of America	480 467	27 702 074	8 369.1	14 747	491 894	148.6	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Brazil	316 221	10 081 676	4 743.0	7 276	244 765	115.2	Community transmission
Mexico	51 537	2 030 491	1 574.8	6 408	178 965	138.8	Community transmission
Peru	48 775	1 269 523	3 850.3	1 435	44 690	135.5	Community transmission
Argentina	33 128	2 054 681	4 546.2	812	51 000	112.8	Community transmission
Colombia	31 832	2 217 001	4 357.1	1 315	58 511	115.0	Community transmission
Chile	23 450	795 845	4 163.2	531	19 974	104.5	Community transmission
Canada	20 280	840 586	2 227.2	414	21 576	57.2	Community transmission
Ecuador	7 570	273 097	1 547.9	244	15 513	87.9	Community transmission
Paraguay	7 086	149 684	2 098.6	122	3 026	42.4	Community transmission
Cuba	6 001	43 484	383.9	30	291	2.6	Community transmission
Dominican Republic	5 607	234 502	2 161.7	96	3 028	27.9	Community transmission
Bolivia (Plurinational State of)	5 578	240 676	2 061.8	283	11 390	97.6	Community transmission
Honduras	5 053	164 077	1 656.6	127	3 975	40.1	Community transmission
Panama	4 354	335 339	7 771.9	116	5 711	132.4	Community transmission
Guatemala	3 860	170 931	954.1	155	6 249	34.9	Community transmission
Uruguay	3 549	51 377	1 479.0	36	563	16.2	Community transmission
Venezuela (Bolivarian Republic of)	2 855	135 114	475.2	41	1 308	4.6	Community transmission
Costa Rica	2 491	201 678	3 959.0	49	2 763	54.2	Community transmission
Jamaica	2 094	20 924	706.6	19	391	13.2	Community transmission
El Salvador	1 118	58 546	902.6	58	1 792	27.6	Community transmission
Barbados	730	2 677	931.5	7	30	10.4	Community transmission
Saint Lucia	373	2 860	1 557.5	5	28	15.2	Community transmission
Guyana	176	8 357	1 062.5	3	189	24.0	Clusters of cases
Antigua and Barbuda	171	598	610.6	2	11	11.2	Sporadic cases
Haiti	131	12 274	107.6	0	247	2.2	Community transmission
Belize	93	12 227	3 075.0	1	314	79.0	Community transmission
Saint Vincent and the Grenadines	80	1 498	1 350.3	0	6	5.4	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Suriname	76	8 854	1 509.3	2	168	28.6	Community transmission
Nicaragua	42	5 106	77.1	1	172	2.6	Community transmission
Bahamas	33	8 403	2 136.8	0	179	45.5	Clusters of cases
Trinidad and Tobago	29	7 666	547.8	2	139	9.9	Community transmission
Dominica	13	134	186.1	0	0	0.0	Clusters of cases
Saint Kitts and Nevis	1	41	77.1	0	0	0.0	Sporadic cases
Grenada	0	148	131.5	0	1	0.9	Sporadic cases
Territories[iii]							
Puerto Rico	1 522	98 835	3 454.7	42	1 957	68.4	Community transmission
Aruba	215	7 553	7 074.3	2	70	65.6	Community transmission
Turks and Caicos Islands	165	1 998	5 160.4	2	14	36.2	Clusters of cases
French Guiana	73	16 529	5 534.0	3	83	27.8	Community transmission
United States Virgin Islands	51	2 575	2 465.9	0	25	23.9	Community transmission
Sint Maarten	42	2 027	4 726.9	0	27	63.0	Community transmission
Curaçao	33	4 666	2 843.5	0	22	13.4	Community transmission
Bonaire	15	387	1 850.3	0	4	19.1	Community transmission
Cayman Islands	12	428	651.2	0	2	3.0	Sporadic cases
Bermuda	5	699	1 122.5	0	12	19.3	Sporadic cases
British Virgin Islands	2	153	506.0	0	1	3.3	Clusters of cases
Montserrat	1	20	400.1	0	1	20.0	Sporadic cases
Anguilla	0	18	120.0	0	0	0.0	Sporadic cases
Falkland Islands (Malvinas)	0	49	1 406.8	0	0	0.0	No cases
Guadeloupe	0	9 455	2 363.0	0	160	40.0	Community transmission
Martinique	0	6 593	1 756.9	0	45	12.0	Community transmission
Saba	0	6	310.4	0	0	0.0	No cases
Saint Barthélemy	0	475	4 805.3	0	0	0.0	Clusters of cases
Saint Martin	0	1 456	3 766.3	0	12	31.0	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	Sporadic cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	**181 969**	**6 181 023**	**845.8**	**2 443**	**141 915**	**19.4**	
Iran (Islamic Republic of)	55 208	1 566 081	1 864.5	526	59 409	70.7	Community transmission
Iraq	23 122	664 750	1 652.7	81	13 245	32.9	Community transmission
United Arab Emirates	22 570	368 175	3 722.5	107	1 108	11.2	Community transmission
Lebanon	16 379	353 371	5 177.3	336	4 297	63.0	Community transmission
Jordan	15 008	359 811	3 526.5	99	4 543	44.5	Community transmission
Pakistan	8 221	569 846	258.0	287	12 563	5.7	Community transmission
Kuwait	6 419	183 322	4 292.7	41	1 039	24.3	Community transmission
Tunisia	5 139	227 643	1 926.1	247	7 755	65.6	Community transmission
Bahrain	5 132	117 234	6 889.7	22	420	24.7	Clusters of cases
Egypt	4 341	177 543	173.5	363	10 298	10.1	Clusters of cases
Qatar	3 163	159 967	5 552.4	1	256	8.9	Community transmission
Morocco	2 813	480 948	1 303.0	88	8 548	23.2	Clusters of cases
Libya	2 444	129 325	1 882.1	74	2 088	30.4	Community transmission
Saudi Arabia	2 281	374 691	1 076.3	29	6 457	18.5	Sporadic cases
Oman	1 872	138 494	2 712.0	10	1 549	30.3	Community transmission
Somalia	797	5 889	37.1	46	194	1.2	Community transmission
Syrian Arab Republic	323	15 143	86.5	21	996	5.7	Community transmission
Sudan	139	30 128	68.7	11	1 864	4.3	Community transmission
Afghanistan	112	55 604	142.8	5	2 432	6.2	Clusters of cases
Djibouti	54	6 022	609.5	0	63	6.4	Sporadic cases
Yemen	21	2 161	7.2	2	619	2.1	Community transmission
Territories[iii]							
occupied Palestinian territory	6 411	194 875	3 820.0	47	2 172	42.6	Community transmission
Europe	**939 271**	**37 574 211**	**4 025.5**	**24 102**	**838 761**	**89.9**	
France	131 179	3 521 249	5 394.6	2 481	83 707	128.2	Community transmission
Russian Federation	92 843	4 164 726	2 853.8	3 167	83 293	57.1	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Italy	84 977	2 795 796	4 624.1	2 130	95 486	157.9	Clusters of cases
The United Kingdom	78 569	4 105 679	6 047.9	3 457	120 365	177.3	Community transmission
Czechia	65 150	1 153 159	10 768.1	1 071	19 214	179.4	Community transmission
Germany	51 998	2 386 559	2 848.5	2 881	67 841	81.0	Community transmission
Turkey	51 980	2 631 876	3 120.6	606	27 983	33.2	Community transmission
Poland	49 812	1 638 767	4 330.0	1 364	42 171	111.4	Community transmission
Ukraine	33 313	1 304 456	2 982.7	773	25 103	57.4	Community transmission
Spain	29 764	3 121 687	6 676.7	680	66 704	142.7	Community transmission
Netherlands	26 268	1 051 919	6 139.1	413	15 200	88.7	Community transmission
Israel	22 209	742 752	8 581.2	177	5 522	63.8	Community transmission
Sweden	19 212	631 166	6 249.6	39	12 649	125.2	Community transmission
Romania	17 185	777 276	4 040.4	470	19 795	102.9	Community transmission
Slovakia	15 909	292 143	5 351.0	693	6 505	119.1	Clusters of cases
Hungary	15 561	403 023	4 171.9	593	14 299	148.0	Community transmission
Serbia	14 629	434 122	6 234.0	107	4 321	62.0	Community transmission
Belgium	14 285	754 473	6 509.9	226	21 903	189.0	Community transmission
Portugal	12 260	796 339	7 809.8	714	15 897	155.9	Clusters of cases
Austria	11 187	439 879	4 884.1	159	8 247	91.6	Community transmission
Belarus	9 961	276 990	2 931.3	63	1 903	20.1	Community transmission
Greece	7 452	178 918	1 716.6	169	6 272	60.2	Community transmission
Albania	7 075	99 062	3 442.3	110	1 653	57.4	Clusters of cases
Bulgaria	6 923	236 439	3 402.8	231	9 839	141.6	Clusters of cases
Republic of Moldova	6 440	176 245	4 369.0	120	3 760	93.2	Community transmission
Kazakhstan	5 833	257 100	1 369.2	65	3 311	17.6	Clusters of cases
Ireland	5 582	214 378	4 341.6	204	4 135	83.7	Community transmission
Slovenia	5 207	184 351	8 867.6	26	4 056	195.1	Clusters of cases
Estonia	5 200	57 616	4 343.3	40	535	40.3	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Latvia	4 827	81 109	4 300.1	95	1 538	81.5	Community transmission
Switzerland	4 811	545 158	6 299.0	50	9 148	105.7	Community transmission
Lithuania	3 327	194 051	7 128.2	101	3 171	116.5	Community transmission
Denmark	3 014	207 081	3 575.2	49	2 333	40.3	Community transmission
Georgia	2 798	268 355	6 727.1	83	3 435	86.1	Community transmission
Montenegro	2 696	71 995	11 463.0	49	939	149.5	Clusters of cases
Finland	2 646	52 653	950.3	16	726	13.1	Community transmission
Bosnia and Herzegovina	2 407	128 049	3 903.0	103	4 995	152.2	Community transmission
Croatia	2 288	239 945	5 844.8	111	5 429	132.2	Community transmission
North Macedonia	2 159	99 031	4 753.4	71	3 047	146.3	Community transmission
Norway	1 871	68 107	1 256.3	15	607	11.2	Clusters of cases
Luxembourg	1 269	53 968	8 621.4	17	623	99.5	Community transmission
Armenia	1 235	170 402	5 750.5	23	3 164	106.8	Community transmission
Malta	1 111	20 762	4 702.1	13	303	68.6	Clusters of cases
Azerbaijan	978	232 973	2 297.8	17	3 195	31.5	Clusters of cases
Cyprus	763	33 153	2 745.9	9	229	19.0	Clusters of cases
Kyrgyzstan	410	85 885	1 316.4	17	1 458	22.3	Clusters of cases
Uzbekistan	238	79 654	238.0	0	622	1.9	Clusters of cases
Andorra	209	10 672	13 812.2	0	107	138.5	Community transmission
San Marino	168	3 472	10 230.4	0	72	212.2	Community transmission
Monaco	107	1 862	4 744.7	1	22	56.1	Sporadic cases
Iceland	12	6 045	1 771.5	0	29	8.5	Community transmission
Liechtenstein	4	2 617	6 862.1	0	52	136.4	Sporadic cases
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories[iii]							
Kosovo	1 887	65 939	3 544.4	27	1 561	83.9	Community transmission
Guernsey	28	810	1 281.7	1	14	22.2	Community transmission
Gibraltar	16	4 228	12 549.3	4	88	261.2	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Jersey	15	3 213	2 953.1	1	68	62.5	Community transmission
Isle of Man	13	449	528.0	0	25	29.4	No cases
Faroe Islands	1	658	1 346.6	0	1	2.0	Sporadic cases
Greenland	0	30	52.8	0	0	0.0	No cases
South-East Asia	**157 379**	**13 345 590**	**660.2**	**2 189**	**204 796**	**10.1**	
India	86 711	10 991 651	796.5	660	156 302	11.3	Clusters of cases
Indonesia	60 650	1 271 353	464.8	1 380	34 316	12.5	Community transmission
Sri Lanka	4 628	79 480	371.2	51	435	2.0	Clusters of cases
Bangladesh	2 758	543 024	329.7	76	8 342	5.1	Community transmission
Maldives	896	18 612	3 443.2	4	60	11.1	Clusters of cases
Thailand	844	25 415	36.4	3	83	0.1	Clusters of cases
Nepal	737	273 351	938.2	7	2 061	7.1	Clusters of cases
Myanmar	150	141 735	260.5	8	3 196	5.9	Clusters of cases
Bhutan	3	866	112.2	0	1	0.1	Clusters of cases
Timor-Leste	2	103	7.8	0	0	0.0	Sporadic cases
Western Pacific	**44 964**	**1 576 330**	**80.2**	**1 201**	**28 220**	**1.4**	
Malaysia	18 467	280 272	865.9	93	1 051	3.2	Clusters of cases
Philippines	12 033	559 288	510.4	561	12 068	11.0	Community transmission
Japan	10 035	424 507	335.6	505	7 417	5.9	Clusters of cases
Republic of Korea	3 467	86 992	169.7	35	1 557	3.0	Clusters of cases
Mongolia	293	2 586	78.9	0	2	0.1	Clusters of cases
Viet Nam	173	2 368	2.4	0	35	0.0	Clusters of cases
China	154	101 669	6.9	4	4 842	0.3	Clusters of cases
Singapore	72	59 858	1 023.2	0	29	0.5	Sporadic cases
Cambodia	54	533	3.2	0	0	0.0	Sporadic cases
Papua New Guinea	48	970	10.8	0	10	0.1	Community transmission
Australia	28	28 920	113.4	0	909	3.6	Sporadic cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
New Zealand	20	1 994	41.4	1	26	0.5	Clusters of cases
Brunei Darussalam	1	185	42.3	0	3	0.7	Sporadic cases
Fiji	0	56	6.2	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	0	45	0.6	0	0	0.0	Sporadic cases
Solomon Islands	0	18	2.6	0	0	0.0	No cases
Territories[iii]							
French Polynesia	83	18 346	6 531.0	2	137	48.8	Sporadic cases
Guam	23	7 507	4 447.9	0	130	77.0	Clusters of cases
Northern Mariana Islands (Commonwealth of the)	9	143	248.4	0	2	3.5	Pending
New Caledonia	3	55	19.3	0	0	0.0	Sporadic cases
Samoa	1	4	2.0	0	0	0.0	No cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Vanuatu	0	1	0.3	0	0	0.0	No cases
Wallis and Futuna	0	9	80.0	0	0	0.0	Sporadic cases
Global	**2 457 026**	**110 763 898**	**1 421.0**	**66 359**	**2 455 331**	**31.5**	

*See *Annex: Data, table and figure notes*

Annex 2. List of countries/territories/areas reporting variants of concern as of 23 February 2021**

Country/Area/Territory[i]	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Argentina		Verified	Verified
Aruba			Verified
Australia	Verified		Verified
Austria	Verified		Verified
Bahrain			Verified
Bangladesh	Unverified		Verified
Barbados			Verified
Belgium	Verified	Verified	Verified
Bosnia and Herzegovina			Unverified
Botswana	Verified		
Brazil		Verified	Verified
Brunei Darussalam	Verified		
Bulgaria			Verified
Cambodia			Unverified
Canada	Verified	Verified	Verified
Cayman Islands			Unverified
Chile			Verified
China	Verified	Unverified	Verified
Colombia		Verified	
Comoros	Unverified		
Croatia		Unverified	Verified
Cuba	Verified		
Curaçao			Verified
Cyprus			Verified
Czechia			Verified
Democratic Republic of the Congo			Unverified
Denmark	Verified		Verified
Dominican Republic			Verified

Country/Area/Territory[i]	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Ecuador			Verified
Estonia	Unverified		Verified
Faroe Islands		Verified	
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana		Verified	
French Polynesia			Verified
Gambia	Verified		Verified
Georgia			Verified
Germany	Verified	Verified	Verified
Ghana	Verified		Unverified
Gibraltar			Unverified
Greece	Verified		Verified
Guadeloupe			Verified
Hungary			Verified
Iceland			Verified
India	Verified	Verified	Verified
Iran (Islamic Republic of)			Verified
Iraq			Unverified
Ireland	Verified	Unverified	Verified
Israel	Verified		Verified
Italy	Unverified	Verified	Verified
Jamaica			Verified
Japan	Verified	Verified	Verified
Jordan			Verified
Kenya	Verified		
Kosovo[1]			Verified
Kuwait			Verified
Latvia			Verified
Lebanon			Verified
Liechtenstein			Verified

Country/Area/Territory[i]	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Lithuania			Verified
Luxembourg	Verified		Verified
Malawi	Unverified		
Malaysia			Verified
Malta	Unverified		Verified
Martinique			Verified
Mayotte	Verified		Verified
Mexico		Verified	Verified
Montenegro			Verified
Morocco			Verified
Mozambique	Verified		
Namibia	Unverified		
Nepal			Verified
Netherlands	Verified	Verified	Verified
New Zealand	Verified		Verified
Nigeria			Verified
North Macedonia			Verified
Norway	Verified		Verified
occupied Palestinian territory			Verified
Oman			Verified
Pakistan			Verified
Panama	Verified		
Peru		Verified	Verified
Philippines			Verified
Poland	Unverified		Verified
Portugal	Verified	Unverified	Verified
Puerto Rico			Verified
Republic of Korea	Verified	Verified	Verified
Réunion	Verified	Verified	Verified

Country/Area/Territory[i]	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Romania			Verified
Russian Federation			Verified
Saint Barthélemy			Verified
Saint Lucia			Verified
Saint Martin			Verified
Saudi Arabia			Verified
Senegal			Unverified
Serbia			Verified
Singapore			Verified
Slovakia			Verified
Slovenia			Verified
South Africa	Verified		Unverified
Spain	Verified	Verified	Verified
Sri Lanka			Verified
Sweden	Verified	Unverified	Verified
Switzerland	Verified	Unverified	Verified
Thailand	Verified		Verified
The United Kingdom	Verified	Verified	Verified
Trinidad and Tobago			Verified
Turkey	Unverified	Unverified	Verified
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania	Unverified		
United States of America	Verified	Verified	Verified
Uruguay			Verified
Uzbekistan			Verified
Viet Nam	Verified		Verified
Zambia	Verified		
Zimbabwe	Unverified		

[**]See *Annex : Data, table and figure notes*

Annex 3. Data, table and figure notes

Data presented are based on official laboratory-confirmed COVID-19 case and deaths reported to WHO by country/territories/areas, largely based upon WHO case definitions and surveillance guidance. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change, and caution must be taken when interpreting these data as several factors influence the counts presented, with variable underestimation of true case and death incidence, and variable delays to reflecting these data at global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/areas. A small number of countries/territories/areas report combined probable and laboratory-confirmed cases. Differences are to be expected between information products published by WHO, national public health authorities, and other sources. Due to public health authorities conducting data reconciliation exercises which remove large numbers of cases or deaths from their total counts, negative numbers may be displayed in the new cases/deaths columns as appropriate. When additional details become available that allow the subtractions to be suitably apportioned to previous days, graphics will be updated accordingly. A record of historic data adjustment made is available upon request by emailing epi-data-support@who.int. Please specify the country(ies) of interest, time period(s), and purpose of the request/intended usage. Prior situation reports will not be edited; see covid19.who.int for the most up-to-date data. Global totals include 745 cases and 13 deaths reported from international conveyances.

The designations employed, and the presentation of these materials do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Countries, territories and areas are arranged under the administering WHO region. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). In the map, number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes.

[i] Excludes countries, territories, and areas that have never reported a confirmed COVID-19 case (Annex 1), or the detection of a variant of concern (Annex 2).

[ii] Transmission classification is based on a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be revised as new information becomes available. Differing degrees of transmission may be present within countries/territories/areas. For further information, please see: Considerations for implementing and adjusting public health and social measures in the context of COVID-19:

- No (active) cases: No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust surveillance system. This implies a near-zero risk of infection for the general population.
- Imported / Sporadic cases: Cases detected in the past 14 days are all imported, sporadic (e.g., laboratory acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.
- Clusters of cases: Cases detected in the past 14 days are predominantly limited to well-defined clusters that

are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.

- Community transmission: Which encompasses a range of levels from low to very high incidence, as described below and informed by a series of indicators described in the aforementioned guidance. As these subcategorization are not currently collated at the global level, but rather intended for use by national and sub-national public health authorities for local decision-making, community transmission has not been disaggregated in this information product.
    - CT1: Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
    - CT2: Moderate incidence of locally acquired, widely dispersed cases detected in the past 14 days; transmission less focused in certain population sub-groups. Moderate risk of infection for the general population.
    - CT3: High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population sub-groups. High risk of infection for the general population.
    - CT4: Very high incidence of locally acquired, widely dispersed cases in the past 14 days. Very high risk of infection for the general population.
- Pending: transmission classification has not been reported to WHO.

[iii] "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status.

Weekly Operational Update on COVID-19

22 February 2021

Confirmed cases[a]
110 974 862

Confirmed deaths
2 460 792

Cox's Bazar COVID-19 Intra Action Review: A Year without precedent in review

WHO Health Sector Coordinator Dr Egmond Evers (left), and WHO Head of Sub-Office, Dr Kai von Harbou (right), facilitating the Intra Action Review meeting held in Cox's Bazar. WHO Bangladesh/Tatiana Almeida

WHO supported the Government of Bangladesh in conducting a COVID-19 Intra Action Review (IAR) at their request last week to share lessons learnt and further improve the response to the pandemic in Cox's Bazar district including the Rohingya refugee camps.

This "was an opportunity to review the functional capacities of public health and the emergency response in Cox's Bazar… The meaningful discussions we had during the IAR will help shape the response in 2021 and strengthen the health sector" says Health Sector Coordinator, Dr Egmond Evers.

The early technical response was an extraordinary collaboration. "We were ready to prevent, respond to and mitigate the impact of the pandemic before local transmission started," noted UNICEF Bangladesh Health Specialist Dr. Yulia Widiati.

WHO Cox's Bazar will disseminate findings and recommendations at the upcoming Strategic Advisory Group (SAG) meeting in Cox's Bazar and with national, regional and global stakeholders to support immediate improvements of the response.

For further information, click here

Key Figures

WHO-led UN Crisis-Management Team coordinating 23 UN entities across nine areas of work

150 GOARN deployments conducted to support COVID-19 pandemic response

20 002 365 respirators shipped globally

198 709 426 medical masks shipped globally

8 602 831 face shields shipped globally

6 946 179 gowns shipped globally

36 600 900 gloves shipped globally

More than **4.9 million** people registered on OpenWHO and accessing online training courses across **25** topics in **44** languages

[a] For the latest data and information, see the WHO COVID-19 Dashboard and Situation Reports

From the field:

Joint actions to strengthen access to essential services for refugees in Timișoara by WHO Romania Country Office and UNHCR

Since late 2020, WHO has been involved in providing guidance to public authorities in Romania's Timiș county and Timișoara Mayoralty, in response to increased cross-border population movement and an associated surge in local COVID-19 transmission.

Situated on the western border, Timișoara city receives a significant number of refugees and asylum seekers in addition to hosting people coming from other refugee centres throughout the country.

WHO Representative Dr Miljana Grbic in Timisoara Romania
Credit: WHO Romania Country Office

Building on joint WHO-UNHCR activities undertaken in previous months, on 15 February, WHO met with the leading authorities on COVID-19 response in Timisoara. The focus of this visit was to support and strengthen refugee access to essential services, included to COVID-19 testing and vaccination.

WHO, UNHCR and Romanian experts from the Ministry of Health met to develop short and medium-term solutions for these vulnerable populations with Timișoara's Mayor and representatives from the Public Health Authority, Local Police Department, Centre for Refugees and of the Border Police. WHO underscored the importance of support to refugees and asylum seekers as part of the COVID-19 response as they live in conditions that disproportionately increase their risk associated with the disease. WHO also highlighted that refugees and asylum seekers need to be included at all levels as part of the national response to COVID-19 pandemic.

With the WHO Romania Country Office and UNHCR's early engagement in this area, the Romanian national strategy for COVID-19 vaccination will include refugees as part of the high priority group in phase 1 of vaccine deployment. WHO and other UN agencies will continue to support local and national authorities in their mission to deliver high quality healthcare and social services to all vulnerable persons according to the core principle of leaving no one behind.

From the field:

WHO supports COVID-19 response in Kurdistan with allocation of US$ 1 million for medical supplies and materials

Currently, there is a new spike in COVID-19 cases in the Kurdistan region of Iraq amidst the confirmation of a new COVID-19 variant in the country. As of 15 February, Kurdistan health authorities reported 106 976 confirmed cases of COVID-19 with 3499 associated deaths and 102 335 recoveries.

"WHO continues to provide technical and operational support to health authorities at [the] central level and in the Kurdistan region with the aim of scaling up preparedness and response to the pandemic" reported Dr Ahmed Zouiten, WHO Representative in Iraq. "Challenging times still lie ahead, that is why we need to unite our efforts, mobilize all possible resources and invest in strengthening both prevention and response measures to win this battle" he added.

As a part of mobilizing resources, on 16 February, WHO distributed 13 tons of medical supplies and equipment worth US$1 million to the Ministry of Health in the Kurdistan region. This donation will scale up intensive care capacity to respond to efforts aimed at controlling the recent increase in the number of COVID-19 cases in Iraq.

Since February 2020, there have been three medical consignments. This most recent distribution will support health facilities with personal protective equipment (PPE), COVID-19 diagnostic kits, oxygen concentrators, oximeters, intensive care beds and devices, hospital bedding and related medical furniture, patient monitors, and more.

Dr Saman H. Barzangy, Minister of Health of the Kurdistan region noted the supplies come "at an opportune time to support our efforts while we are battling to reverse the upward trend in the number of COVID-19 reported in the last few weeks", as well as an increase in hospitalized cases. The medical supplies provided by WHO will serve both for the diagnosis and the management of COVID-19 patients.

For further information, click here

Public health response and coordination highlights

At the UN Crisis Management Team meeting (CMT) meeting on 10 February 2021, **WHO** reported continued decrease of new cases and death globally and noted that the encouraging epidemiological situation is the result of stepped-up measures, including stringent lockdowns and stay-at-home orders. WHO reported that it is monitoring the new virus variants and urges authorities, researchers, media and the general public to use non-stigmatizing nomenclature and language for describing variants.

WHO also provided a brief update on the Global Study of the Origins of SARS-CoV-2, noting that the mission has furthered understanding of the specific epidemiological, human-animal interface and molecular epidemiological work but will require more study and targeted research to determine the origin and transmission pathways.

WHO and UNICEF updated the CMT on the latest progress of COVID-19 Vaccination Access, Readiness and Delivery, and suggested that response is transitioning from introduction of vaccine towards scaling-up vaccines, with a shift in focus from inputs and plans towards optimization, monitoring progress and accountability.

WHO noted that it has published a position paper on the scientific, ethical, legal and technological considerations on the introduction of requirements for proof of COVID-19 vaccination for outgoing or incoming international travelers.

Regarding humanitarian settings, **WHO** advised that an IASC Working Group is working with Gavi and the COVAX Facility on establishing a humanitarian buffer and noted that it is essential that all population groups are included in National Deployment and Vaccination Plans (NDVP), independent of their legal and residency status.

Health Learning

WHO is expanding access to online learning for COVID-19 through its open learning platform for health emergencies, OpenWHO.org.

The OpenWHO platform was launched in June 2017 and published its first COVID-19 course on 26 January 2020.

4 906 827
Course enrollments

44 languages

25 topical courses

Over 2.6 million certificates

Partnerships

The Global Health Cluster - GHC

The Global Health Cluster and the WHO Department of Mental Health and Substance Use, Co-Chair of the IASC Reference Group on Mental Health and Psychosocial Support (MHPSS), are launching a series of Global Health Cluster MHPSS Clinics to support Global Health Cluster partners to provide programmatic support, share best practices and link technical support to health practitioners in countries in humanitarian settings. The first clinic of its kind will launch on 26 February 2021.

Subsequent clinics will be held on the last Friday of every month at the same time (16h00-17h30 CET) for the next six months based on demand of Health Cluster partners.

To learn more, access the MHPSS Clinic Flyer and click here to register.

Medicines and Health Products

- The WHO-led COVID-19 Technology Access Pool (C-TAP) aims to facilitate sharing of COVID-19 health technology related knowledge, intellectual property and data.

C-TAP operates as a hub involving the WHO Secretariat and other partners such as the Medicines Patent Pool and the Technology Access Partnership.

The initiative is intended to accelerate the development of products needed to fight COVID-19, to accelerate the scale-up of manufacturing as well as to remove barriers to access in order to make products available globally.

At a consultation with the private sector on 14 January 2021, the engagement of research institutions and producers of novel technologies met to discuss the aforementioned three objectives, as well as the C-TAP concept, rationale and objectives. The goal is to ensure that individuals globally have equitable access to COVID-19 vaccines, therapeutics, in-vitro diagnostics and medical devices.

- The WHO Prequalification teams assessed the potential impact of the SARS-CoV-2 VOC 202012/01 (B1.1.7.) variant on the performance of the molecular tests listed for WHO emergency use. The assessment included impact of S gene mutations and deletions and found the risk of false negative results to be low. More information about the virus variants is available here.

- The quality of products procured and/or supplied under the COVAX Facility must be assured at all times to ensure a positive impact on the recipient population and to preserve the trust that has been placed in the Facility. WHO has advised that the COVAX Facility should only consider products listed with WHO Emergency Use Listing (EUL) or Prequalification. Under exceptional circumstances, products approved by specified Stringent Regulatory Authority can be accepted.

- The Pfizer/BioNTech Comirnaty COVID-19 mRNA vaccine has received emergency validation from WHO and was placed on the EUL. On 15 Feb, WHO listed two versions of the AstraZeneca/Oxford COVID-19 vaccine for emergency use as well. Countries can now expedite their national regulatory approval processes to import and administer the vaccine. Other UN organisations are now enabled to procure the vaccine for distribution to countries in need.

- The WHO COVID-19 vaccine safety surveillance manual has been published. WHO Regional Offices are supporting countries to implement safety surveillance as recommended in the manual.

Infodemic management

10 steps to community readiness: What countries should do to prepare communities for a COVID-19 vaccine, treatment or new test

The Infodemic Management workstream released the 10 steps to community readiness for COVID-19 vaccine, treatment and testing this week. These steps highlight 10 well-established Risk Communication and Community Engagement (RCCE) principles that have proven their power. Together they put communities at the heart of the roll out of new vaccines, treatments and tests and promote trust, the critical ingredient for all community action.

Informed, engaged and empowered communities are the bedrock for the arrival of new vaccines, treatments and tests that will be introduced to reduce the spread of COVID-19 and save lives. With communities fully engaged and actively participating through the full cycle of planning, delivery and assessment for biomedical tools, demand for these tools can be increased, leading to widespread and effective uptake and use.

For further information on EPI-WIN: WHO Information Network for Epidemics and for the full document, click here

COVID-19 Preparedness

COVID-19 vaccine deployment readiness drill in Republic of Moldova

On 3 February 2021, the Republic of Moldova conducted a COVID-19 vaccine deployment drill following the announcement by the COVAX facility that the estimated delivery date for the country's first consignment of vaccines in-country would be mid-February 2021. WHO's **COVID-19 simulation exercise package** was adapted to align with the country's need to practice systems and procedures in readiness for deployment.

The drill was led by the National COVID-19 Immunization Focal Point team, the Ministry of Health, Labour and Social Protection and the National Agency for Public Health with support from WHO. It aimed to assess the readiness of the country's COVID-19 vaccine deployment plan and identify the strengths and potential challenges which might affect vaccine delivery.

Photo credit: WHO

The exercise started at the Chisinau International Airport, mobilizing a special transportation freezer and used a scenario for COVID-19 vaccine reception, distribution and administration. The customs service checked all documentation and completed the steps required for regulatory clearance for emergency imports customs declaration and release of goods.

The vaccines were then delivered to the National Vaccines Warehouse, an institution responsible for vaccines reception and distribution nationally. Specialists unloaded and verified the temperature devices located in every box of vaccines before storing them in the designated ultra-cold storage freezer.

Vaccines were then distributed, including to Buiucani Territorial Medical Association (AMT). "We received labeled boxes with vaccines. The team checked the transportation information, and placed COVID-19 vaccines in the [necessary] cold chain conditions" while "the nurses verified the quantity of syringes for vaccination and boxes for syringe disposal."

"The simulation exercises are important to ensure we avoid any errors, including transportation, storage or cold chain problems", said Dr. Alexei Ceban from the Surveillance of Vaccine-Preventable Diseases Department of the National Agency for Public Health during the drill.

WHO's COVID-19 vaccine simulation exercise package is **available online.** WHO at all levels of the organization are providing support to Member States for planning, implementation and follow-up to enhance national and sub-national preparedness capacities required for COVID-19 and other health emergency threats.

COVID-19 Preparedness

Safe hospitals: Managing risks during COVID-19 pandemic

Hope Field Hospital for Women, Ukhiya, Cox's Bazar. Photo credit: Hope Foundation

Following the temporary recommendations of the IHR Emergency Committee to promote Member States to share innovations and lessons learned, WHO in collaboration with the International Hospital Federation and the UN Office for Disaster Risk Reduction hosted its first webinar in this year's COVID-19 Safe Hospital Webinar Series on 28 January 2021.

Attended by 364 participants from 64 countries, the webinar focused on country experience and application of WHO technical guidance in managing risks within health facilities. Dr Stella Chungong, Director of the Health Security Preparedness (HSP) department, opened the meeting, highlighting the value of collective experiences and learning from good practices to advance whole-of-society action toward stronger hospital preparedness to manage COVID-19 risks.

Presenters shared best-practices from different contexts for maintaining safe hospital services during the pandemic. Dr Wang-Jun Lee from Myongji Hospital in the Republic of Korea shared the experience of a 'dual-track' healthcare system where medical resources were appropriately allocated for COVID-19 and non-COVID-19 patients, thus maintaining core hospital functions.

Dr Helen Kiarie from Ministry of Health, Kenya presented findings from a survey of 132 health facilities. She highlighted the need for health systems to maintain real-time data to monitor the continuity of essential health services, inclusive of the inventory of supplies, and supporting operational adaptations including telemedicine and prioritization of high-risk patients.

Dr Iftikher Mahmood from Hope Foundation highlighted how Hope hospital repurposed existing resources in a complex emergency situation to manage COVID-19 cases in Cox's Bazar, Bangladesh. This included the usage of WHO's Rapid Readiness Checklist for Hospitals to scale-up COVID-19 readiness and maintain safe essential health services.

The COVID-19 hospital webinar series will continue to convene hospital managers together to share best practices from across regions. The next meeting in this webinar series will be on "Hospitals and national strategic plans for emergencies and disasters from all hazards" and will take place on 25 February 2021.

COVID-19 Partners Platform

Countries progress towards vaccine allocation with completion of Standard Reporting Forms (SRFs)

Last week countries completed the first round of uploading National Deployment and Vaccination Plans (NDVPs) to the Partners Platform. Of the 87 Advanced Market Commitment (AMC) countries opting-in for February allocation through the COVAX facility, 86 countries have uploaded an NDVP to the Partners Platform. One additional country is set to submit the NDVP by end of February. Fifteen self-financing countries have also submitted an NDVP to the Partners Platform.

All downloaded plans have now been validated by a Vaccine Country Administrator for the Government reviewed by the Regional Review Committee (RRC). The plan assessments, called the Standard Review Form (SRF) have now been completed by the Vaccine Regional Administrators (VRAs) for all 86 uploaded NDVPs and uploaded to the Platform.

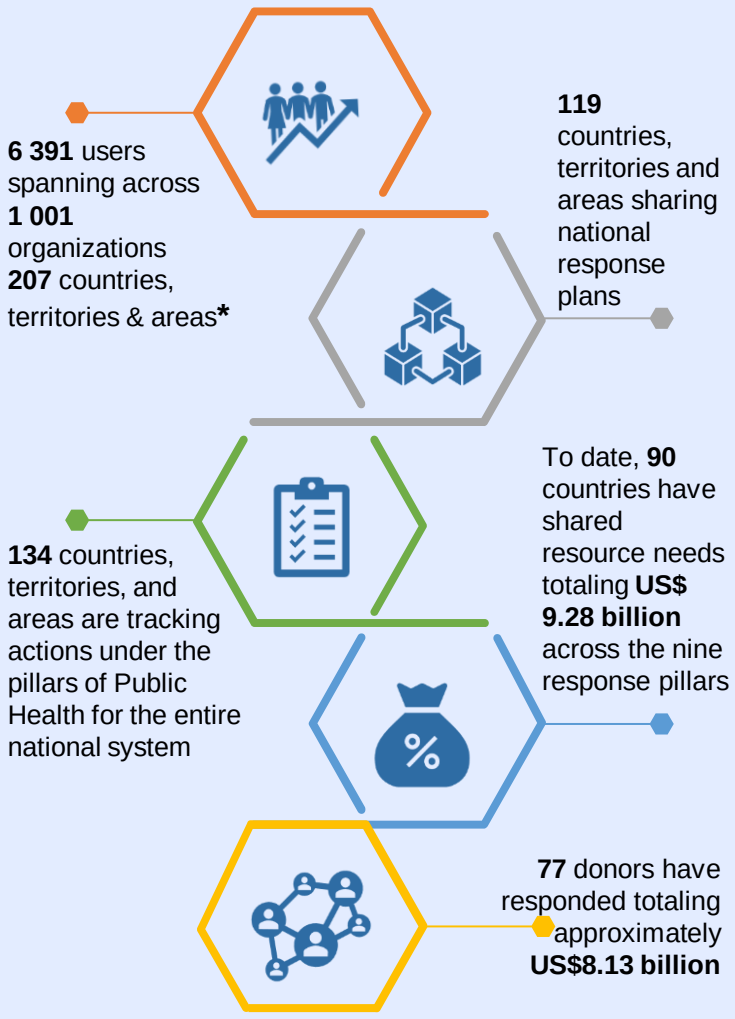
Once a country's SRF is uploaded and the NDVP does not require any further modification, the country moves forward to the vaccine allocation process.

During the allocation process vaccine partners confirm regulatory approval and import procedures (UNICEF/AMRO), handle indemnification and liability agreements (COVAX Facility), and verify revisions (Country Readiness and Delivery). Once allocation procedures have concluded, allocated doses may be shipped to country.

The Partners Platform serves as a global repository for NDVPs and is a secure digital space to facilitate and expedite review of these plans in record time. Through the combination of science, solidarity and ceaseless collaboration, countries in the first wave can anticipate shipments beginning end of March, advancing equitable distribution and access.

While AMC countries are obligated to complete an NDVP for vaccine allocation, vaccine self-financing countries are also encouraged to upload an NDVP to the Partners Platform. All countries, including self-financed, will receive WHO guidance for completion of the plan, as needed.

2020 Strategic Preparedness and Response Plan (SPRP)



**Note: viewing of vaccine information may be restricted to key vaccines stakeholders according to countries' preferences.*

Operations Support and Logistics

The COVID-19 pandemic has prompted an unprecedented global demand for Personal Protective Equipment (PPE), diagnostics and clinical care products.

To ensure market access for low- and middle-income countries, WHO and partners have created a COVID-19 Supply Chain System, which has delivered supplies globally.

The table below reflects WHO/PAHO-procured items that have been shipped as of 19 February 2021.

Shipped items as of 19 February 2021	Laboratory supplies*			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	700 800	3 548 265	1 825 642	1 423 210	10 154 300	208 050	1 717 279	53 429 400	2 700 630
Americas (AMR)	6 520 050	1 020 412	10 518 478	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	934 050	1 249 320	1 439 590	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	248 000	409 300	540 770	1 750 900	8 935 100	409 900	1 757 548	40 911 500	5 423 350
South East Asia (SEAR)	320 000	2 352 150	2 240 200	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		175 800	346 834	768 700	3 021 000	311 927	463 710	14 974 146	2 102 035
TOTAL	**8 722 900**	**8 755 247**	**16 911 514**	**8 602 831**	**36 600 900**	**1 545 807**	**6 946 179**	**198 709 426**	**20 002 365**

*Note: The laboratory supplies data is as of 13 February 2021

For further information on the **COVID-19 supply chain system**, see here.

Appeals

On Thursday, 18 Feb 2021 WHO launched the Strategic Preparedness and Response Plan (SPRP) 2021 and seeks to raise $1.96 billion in funding for it. “Fully funding the SPRP is not just an investment in responding to COVID-19, it’s an investment in the global recovery and in building the architecture to prepare for, prevent and mitigate future health emergencies”, noted WHO Director-General, Dr Tedros Adhanom Ghebreyesus.

WHO’s SPRP 2021 is critical to end the acute phase of the pandemic, and as such the SPRP is an integrated plan bringing together efforts and capacities for preparedness, response, health systems strengthening for the roll out of COVID-19 tools (ACT-A). Of the $1.96 billion appealed for, $1.2 billion is directly attributable towards ACT-A, and as such also part of the ACT-A workplan. In 2021 COVID-19 actions are being integrated into broader humanitarian operations to ensure a holistic approach at country level. $ 643 million of the total appeal is intended to support the COVID-19 response specifically in countries included in the Global Humanitarian Overview.

WHO appreciates and thanks donors for the support already provided or pledged and encourages donors to give fully flexible funding for SPRP 2021 and avoid even high-level/soft geographic earmarking at e.g. regional or country level. This will allow WHO to direct resources to where they are most needed, which in some cases may be towards global procurement of supplies, intended for countries. See below and the following page for the distribution of requirements

SPRP 2021 – WHO RESOURCE REQUIREMENTS

Total requirement: US$ 1.96 billion **As of 19 February 2021**

Total WHO requirement under SPRP 2021

Proportion of requirement attributed to ACT Accelerator*

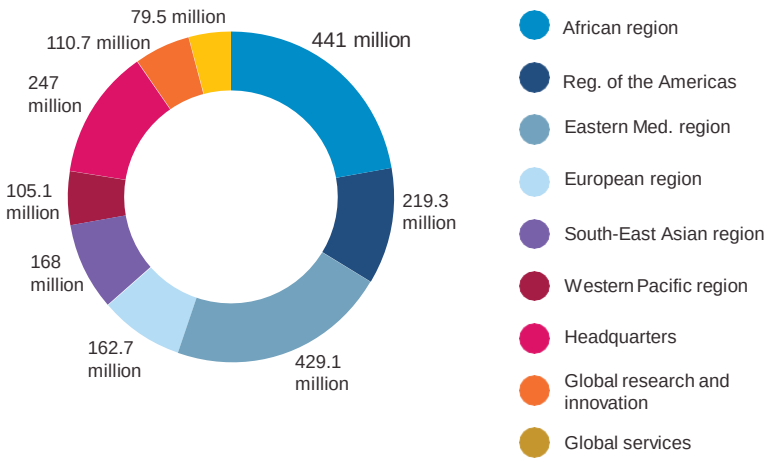
Of the total US$1.96 billion WHO requirement, US$1.22 billion (62%) counts towards WHO’s requirement for the Access to COVID-19 tools accelerator

The status of funding raised for WHO against the SPRP can be found here

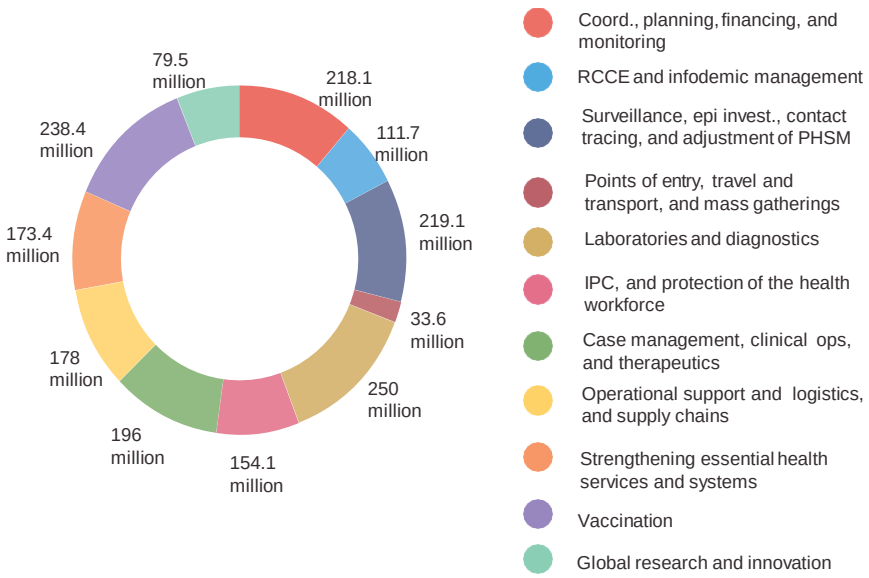
Appeals

SPRP 2021 – WHO RESOURCE REQUIREMENTS

Total requirement by major WHO office (US$)



Total requirement by pillar (US$)



The status of funding raised for WHO against the SPRP can be found here

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

To date, the COVID-19 Solidarity Response Fund has more than $242 million raised or committed from more than 660,000 individual donors, corporations, and foundations.

More than US$ 242 Million

660 000 donors

[individuals – companies – philanthropies]

Last week, COVID-19 Solidarity Response Fund resources were allocated to provide support in *Engaging Government Lawyers and Judicial Officers on Fundamental Rights in the context of COVID-19.*

Public health interventions to control COVID-19 have had profound implications for vulnerable groups and as the pandemic continues, several interventions are increasingly being challenged before the courts on grounds that they violate fundamental rights. Litigation has addressed a wide range of important issues from the right to education in the context of school closures to human rights associated with vaccination campaigns.

The global project, supported by the COVID-19 Solidarity Response Fund will engage government lawyers, judges and more to better protect and balance health with fundamental rights in the context of COVID-19. The project, scheduled to initiate in March, will provide a platform for the sharing of country experiences from all WHO Regions, the dissemination of existing WHO guidance through online training workshops accessible to all Member States and the publication of a database of relevant litigation.

The project is premised on the idea that successful collective action is dependent on the effective balancing of a government's right to protect health through public health interventions against the rights of those affected by such interventions.

The WHO Contingency Fund for Emergency (CFE)

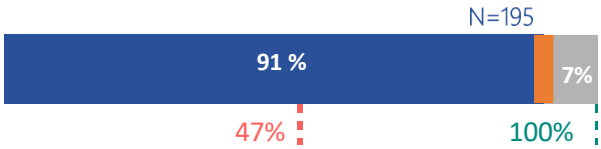
WHO's Contingency Fund for Emergencies (CFE) provided $8.9 million for COVID-19 preparedness and response worldwide at the very onset of the outbreak when no other funding was available.

US$ 8.9 Million released

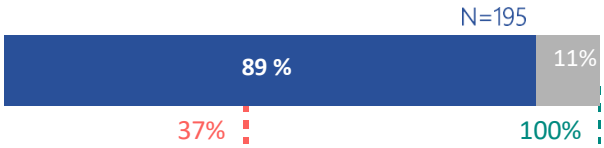
The WHO Contingency Fund for Emergencies 2019 Annual Report was published on 7 August. WHO is grateful to all donors who contributed to the fund allowing us to respond swiftly and effectively to emerging crises including COVID-19. Full report is available here.

COVID-19 Global Preparedness and Response Summary Indicators [a]

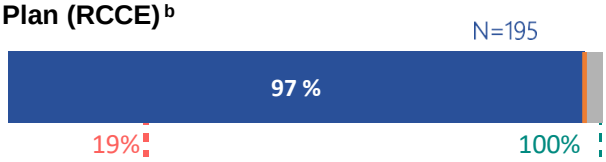
Countries have a COVID-19 preparedness and response plan



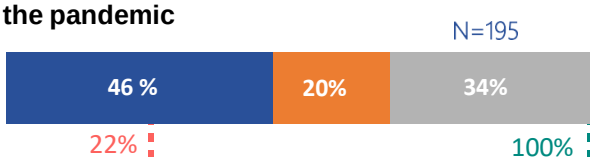
Countries have a clinical referral system in place to care for COVID-19 cases



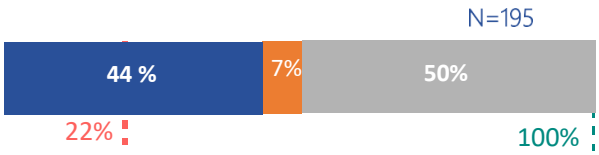
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE) [b]



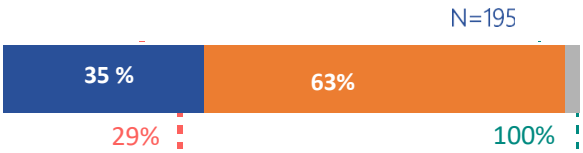
Countries that have defined essential health services to be maintained during the pandemic



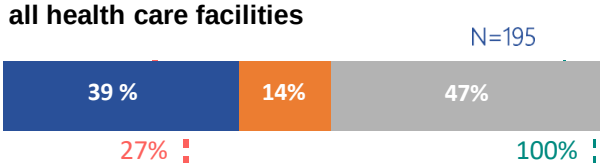
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



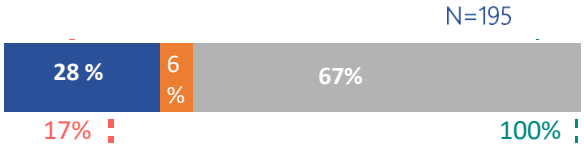
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



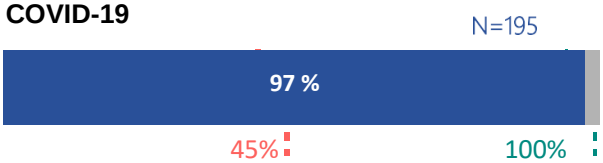
Countries with a national IPC programme & WASH standards within all health care facilities



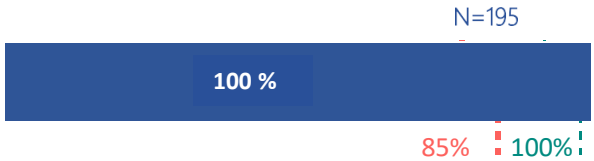
Countries have a health occupational safety plan for health care workers



Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



Countries have COVID-19 laboratory testing capacity



Legend

Yes | No | No information | Baseline value | Target value

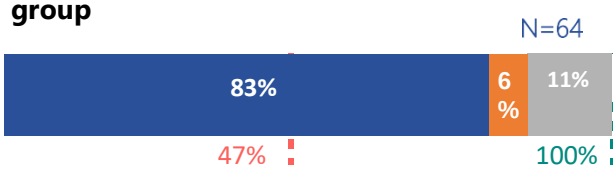
Notes:

a Data collected from Member States and territories. The term "countries" should be understood as referring to "countries and territories." b Source: UNICEF and WHO

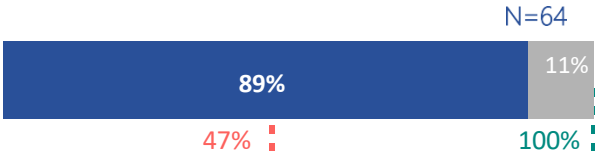
COVID-19 Global Preparedness and Response Summary Indicators

Selected indicators within the Monitoring and Evaluation Framework apply to designated priority countries. Priority Countries are mostly defined as countries affected by the COVID-19 pandemic as included in the Global Humanitarian and Response Plan. A full list of priority countries can be found here.

Priority countries with multisectoral mental health & psychosocial support working group

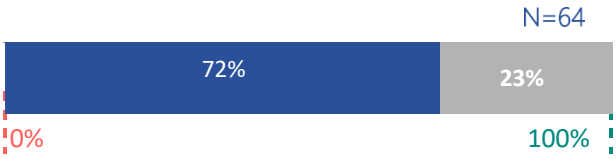


Priority countries with an active & implemented RCCE coordination mechanism

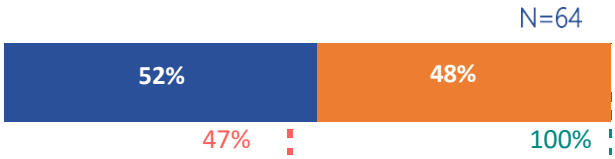


Priority countries that have postponed at least 1 vaccination campaign due to COVID-19 [c]

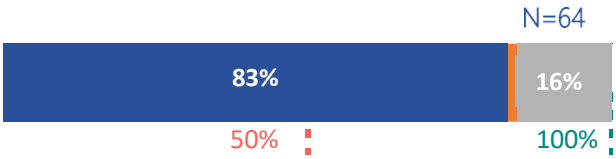
Priority countries with a contact tracing focal point

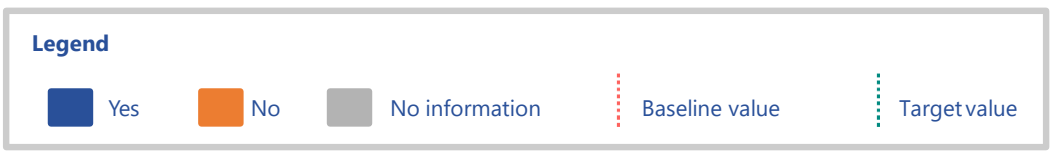


Priority countries where at least one Incident Management Support Team (IMST) member trained in essential supply forecasting



Priority countries with an IPC focal point for training





Notes:

c Source: WHO Immunization Repository

The Unity Studies: WHO Early Investigations Protocols

Unity studies is a global sero-epidemiological standardization initiative, which aims at increasing the evidence-based knowledge for action.

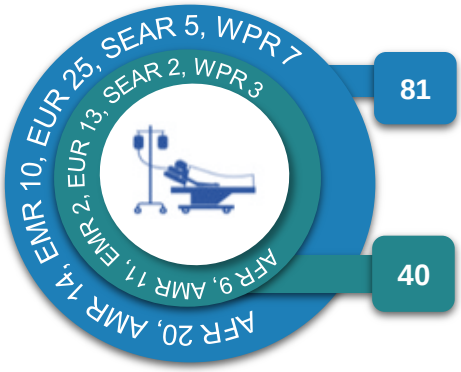
It enables any countries, in any resource setting, to gather rapidly robust data on key epidemiological parameters to understand, respond and control the COVID-19 pandemic.

The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays

Global COVID-19 Clinical Data Platform

Global understanding of the severity, clinical features and prognostic factors of COVID-19 in different settings and populations remains incomplete.

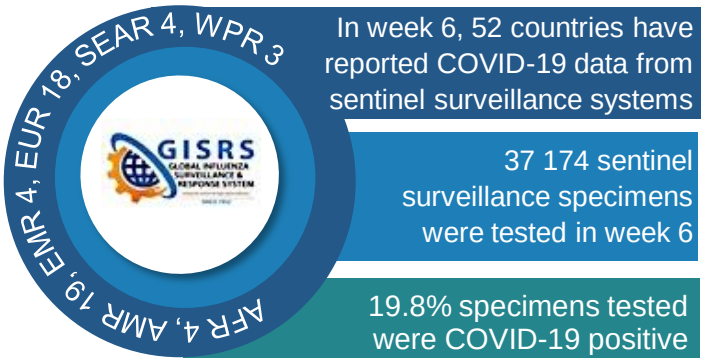
WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



Leveraging the Global Influenza Surveillance and Response System

WHO recommends that countries use existing syndromic respiratory disease surveillance systems such as those for influenza like illness (ILI) or severe acute respiratory infection (SARI) for COVID-19 surveillance.

Leveraging existing systems is an efficient and cost-effective approach to enhancing COVID-19 surveillance. The Global Influenza Surveillance and Response System (GISRS) is playing an important role in monitoring the spread and trends of COVID-19



Key links and useful resources

- ❑ For EPI-WIN: WHO Information Network for Epidemics, click **here**
- ❑ For more information on COVID-19 regional response:
  - **African Regional Office**
  - **European Regional Office**
  - **Southeast Asia Regional Office**
  - **Regional Office of the Americas**
  - **Eastern Mediterranean Regional Office**
  - **Western Pacific Regional Office**
- ❑ For the latest **Weekly Epidemiological Update**, click **here.** Highlights this week include:
  - Overviews of global and regional epidemiological situation
  - Special focus sections on:
    - The Global Influenza Surveillance and Response System (GISRS)
    - SARS-CoV-2 variants of concern
  - Updates on publications and other news
- ❑ For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection published on 16 December 2020, click **here**
- ❑ For updated WHO Publications and Technical Guidance on COVID-19, click **here**
- ❑ For updated GOARN network activities, click **here**
- ❑ Updated COVID-19 Table top Exercise packages are now available online. All COVID-19 simulation exercises can be found **here**

COVID-19 Weekly Epidemiological Update

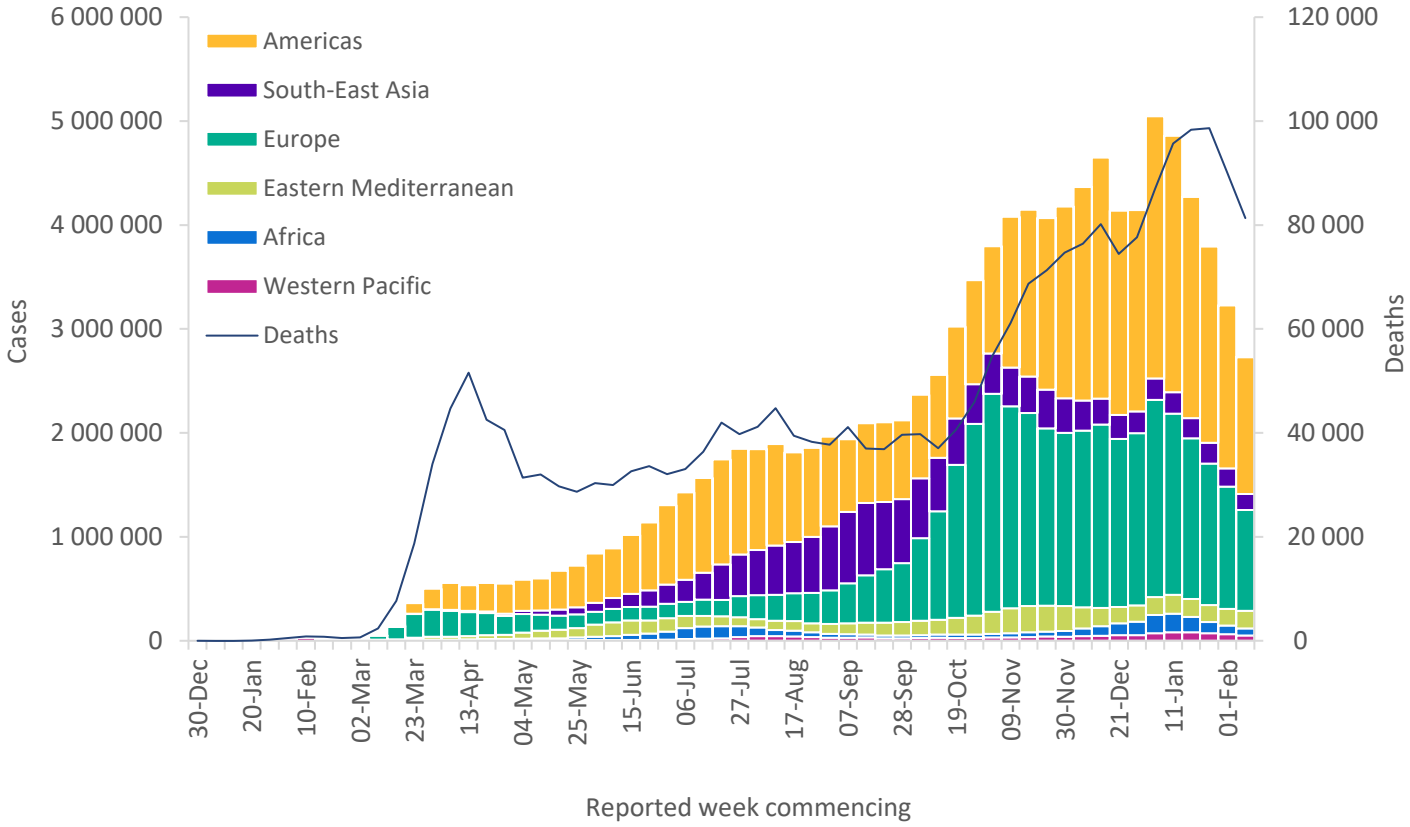
Data as received by WHO from national authorities, as of 14 February 2021, 10 am CET

In this edition:

Global overview

The number of global new cases reported has continued to fall, with 2.7 million new cases last week, a 16% decline over 500 000 fewer new cases compared to the previous week (Figure 1). The number of new deaths reported also fell, with 81 000 new deaths reported last week, a 10% decline as compared to the previous week. A total of five out of six WHO regions reported a double-digit percentage decline in new cases (Table 1), with only the Eastern Mediterranean Region showing a 7% rise. Europe and the Americas continue to see the greatest drops in absolute numbers of cases. Meanwhile, the number of new deaths declined in all regions.

Figure 1: COVID-19 cases reported weekly by WHO Region, and global deaths, as of 14 February 2021**



**See *Annex: Data, table and figure notes*

In the past week, the five countries reporting the highest number of new cases continue to be the United States of America (673 630 cases, a 23% decrease), Brazil (318 290 cases, a 3% decrease), France (127 565 cases, a 6% decrease), the Russian Federation (104 602 cases, an 11% decrease), and the United Kingdom of Great Britain and Northern Ireland (97 271 cases, a 27% decrease).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 14 February 2021**

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	1 315 480 (48%)	-16%	48 228 712 (45%)	44 385 (55%)	-2%	1 136 906 (48%)
Europe	968 943 (36%)	-18%	36 575 529 (34%)	28 404 (35%)	-19%	812 410 (34%)
South-East Asia	154 414 (6%)	-13%	13 188 211 (12%)	2 340 (3%)	-9%	202 607 (8%)
Eastern Mediterranean	170 445 (6%)	7%	5 998 998 (6%)	2 519 (3%)	-9%	139 468 (6%)
Africa	68 115 (2%)	-20%	2 723 431 (3%)	2 558 (3%)	-21%	68 294 (3%)
Western Pacific	49 577 (2%)	-20%	1 531 366 (1%)	1 134 (1%)	-13%	27 019 (1%)
Global	**2 726 974 (100%)**	**-16%**	**108 246 992 (100%)**	**81 340 (100%)**	**-10%**	**2 386 717 (100%)**

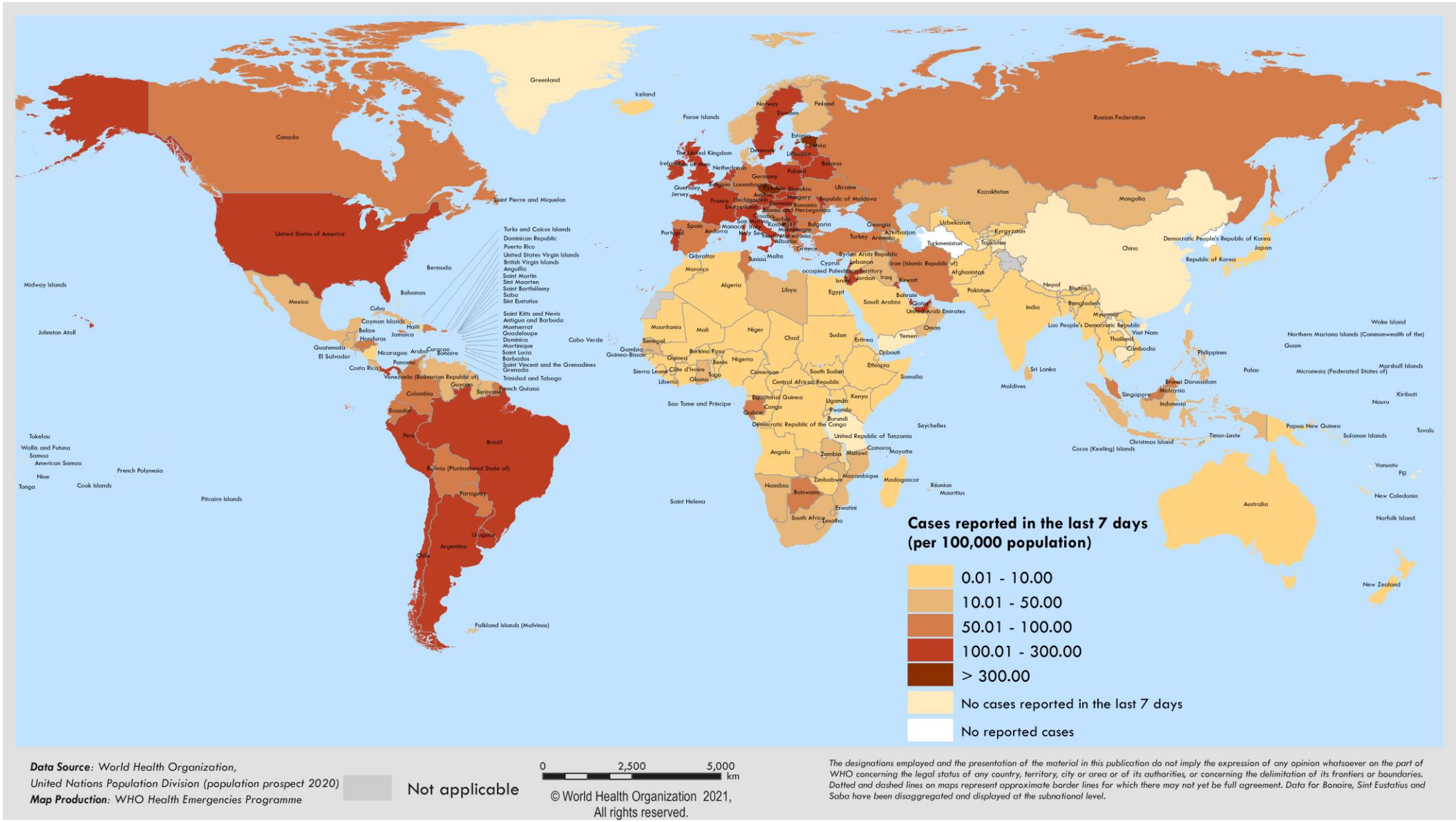
**Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number, global totals may not equal 100%.*

**See *Annex: Data, table and figure notes*

For the latest data and other updates on COVID-19, please see:

- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update

Figure 2. COVID-19 cases per 100 000 population reported in the last seven days by countries, territories and areas, 8 February through 14 February 2021**



**See *Annex: Data, table and figure notes*

Special Focus: Global Influenza Surveillance and Response System – leveraging influenza sentinel surveillance systems to respond to COVID-19

Overview

The Global Influenza Surveillance and Response System (GISRS) is a network of 158 institutions monitoring the spread and evolution of influenza all year-round. It includes six WHO Collaborating Centres and National Influenza centres (NICs) from 126 countries, areas and territories. It functions as a global mechanism for surveillance, preparedness and response for seasonal, pandemic and zoonotic influenza, and a global alert for novel influenza viruses and other respiratory pathogens. More than 3.5 million respiratory specimens are tested for influenza each year with assured quality and standards. These specimens are collected from patients presenting at sentinel hospitals and primary care settings with influenza-like illness (ILI) and severe acute respiratory infection (SARI). More than 10 000 representative influenza viruses are sequenced each year and the genetic sequence data shared via the Global Initiative on Sharing Avian Influenza Data (GISAID). Countries also typically share about 40 000 influenza specimens throughout the year with WHO Collaborating Centres, of which around a quarter undergo a detailed virus characterization that informs the biannual recommendations for the seasonal influenza vaccine composition for the northern and southern hemispheres.

GISRS and COVID-19

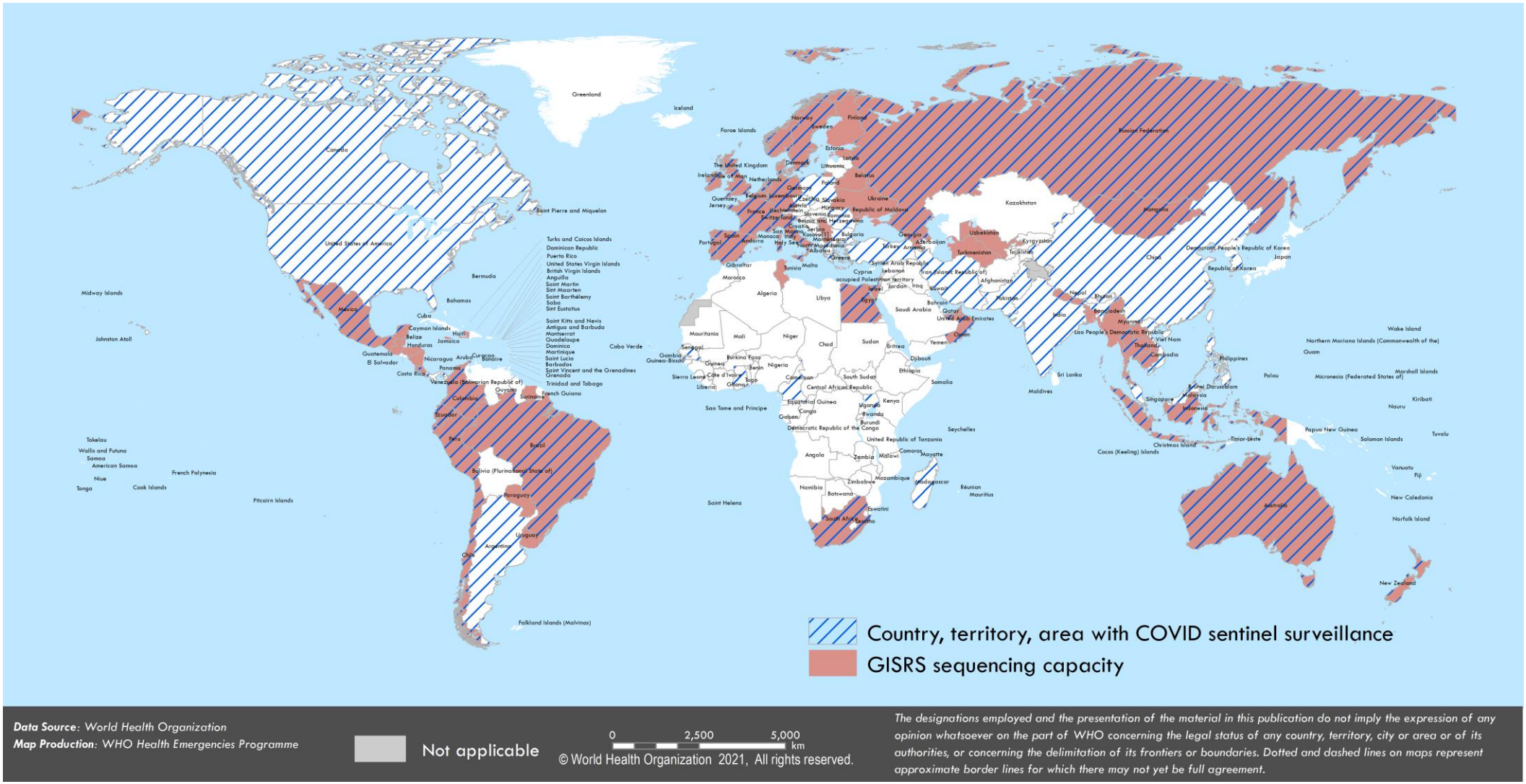
Throughout the COVID-19 response, GISRS laboratories have contributed significantly to country diagnostic and sequencing capacities. Since the onset of the pandemic, 87% of GISRS laboratories have been serving as national reference laboratories for SARS-CoV-2 detection. GISRS has leveraged its External Quality Assessment Program (EQAP) for influenza molecular diagnostics to develop and implement the SARS-CoV-2 EQAP to more than 233 national public health laboratories (including 130 NICs) from 164 countries, areas and territories, with 94% of the laboratories demonstrating 100% correct results.

Early in the COVID-19 pandemic, influenza surveillance systems were leveraged to address the critical need to monitor trends in community circulation of SARS-CoV-2 and influenza. To date, approximately 60 countries have reported integrated SARS-CoV-2 and influenza data that complement SARS-CoV-2 cases detected through non-sentinel sources. The transmission trends based on sentinel surveillance serve to complement and corroborate the transmission trends seen from non-sentinel data sources.

The emergence of SARS-CoV-2 Variants of Concern highlights the importance of quality, representativeness and geographical coverage of genetic sequencing, and the timeliness of sharing of genetic sequence data on publicly accessible databases. As of 10 February 2021, more than 450 000 whole genome sequences of SARS-CoV-2 from 131 countries had been shared with GISAID. However, the majority (approximately 70%) are from three countries (Denmark, the United Kingdom and the United States of America). At least 60% of GISRS laboratories have shared whole genome sequences with GISAID (Figure 3).

The IHR Emergency Committee for COVID-19 recommended further increases in global sequencing capacities and encouraged the further rapid sharing of data. It recognizes the role of GISRS to strengthen sequencing capacities for SARS-CoV-2 and increase the global genetic database that improves the geographic and demographic representativeness, timeliness and quality of meta-data around the world. WHO is working with GISRS to expedite the sequencing component of sentinel surveillance for SARS-CoV-2 along with influenza and has issued guidance to support in this effort.

Figure 3: SARS-CoV-2 detection and sequencing capacities and capabilities



Special Focus: Update on SARS-CoV-2 Variants of Concern

WHO, in collaboration with national authorities, institutions and researchers, continues to monitor the public health events associated with SARS-CoV-2 variants and provides updates as new information becomes available. Further information on the background of the variants of concern (VOC) is available from previously published Disease Outbreak News and recent publications of the Weekly Epidemiological Update. Here we provide an update on the geographical distribution of three variants of concern as reported by countries, territories and areas (hereafter countries) as of 15 February 2021. New variants of potential interest or concern are currently under review and may be incorporated into future updates.

Table 2: Condensed overview of emerging information on key variants of concern, as of 15 February 2021*

Nextstrain clade	**20I/501Y.V1**	**20H/501Y.V2†**	**20J/501Y.V3**
Pango lineage	B.1.1.7	B.1.351	B.1.1.28.1
GISAID clade	GR	GH	GR
Alternate names	**VOC202012/01†**	VOC202012/02	**P.1†**
First detected by	United Kingdom	South Africa	Brazil / Japan
First appearance	20 September 2020	Early August 2020	December 2020
Key spike mutations	• H69/V70 deletion • Y144 deletion • N501Y • A570D • D614G • P681H	• L242/A243/L244 deletion • N501Y • D614G • E484K • K417N	• N501Y • D614G • E484K • K417N
Key mutation common to all 3 variants	S106/G107/F108 deletion in Non-Structural Protein 6 (NSP6)		
Countries reporting cases (newly reported in last week)**	94 (8)	46 (2)	21 (6)

** A more detailed version of this table is available in the previous Weekly Epidemiological Update, and an update version will be available in the next issue.*

†While work is ongoing to establish standardized nomenclature for key variants, these are the names by which WHO will refer to them in this publication.

***Includes official and unofficial reports of VOCs detections in countries among either travellers (imported cases only) or community samples (local transmission).*

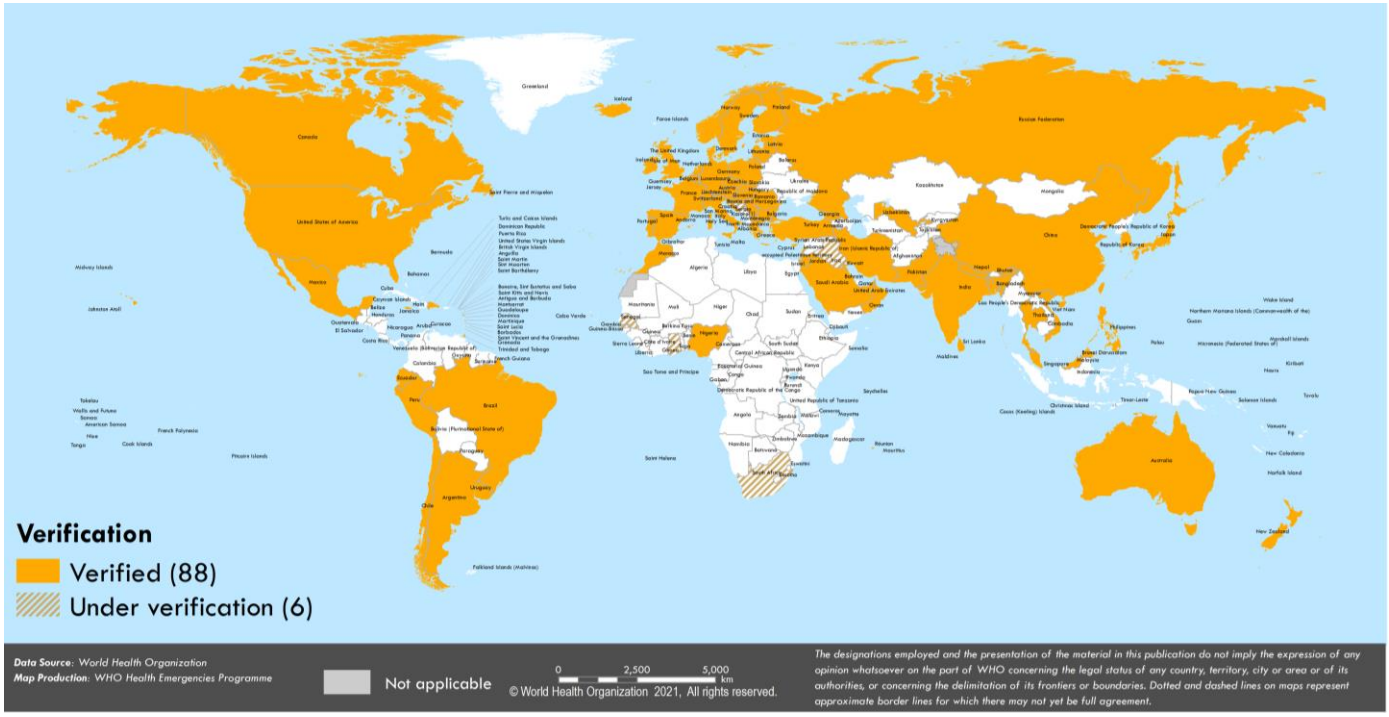
Variant VOC 202012/01

Since our last update on 9 February, variant VOC 202012/01 has been detected in eight additional countries. As of 16 February, a total of 94 countries across all six WHO regions have reported either imported cases or community transmission of this variant (Figure 4). Local transmission has been reported in at least 47 countries across all six WHO regions.

In an updated report on SARS-CoV-2 and increased circulation of variants of concern in the EU/EEA and vaccine rollout, the European Centre for Disease Control and Prevention (ECDC) highlights that while a number of European countries have been reporting an overall decrease in the incidence of COVID-19, likely due to a strong combination of public health and social measures, the majority of countries in Europe continues to experience high or increasing notification rates among older age groups and/or high death rates.[1] Moreover, among samples tested in Europe by PCR-based screening and whole genome sequencing, the proportion of cases infected with VOC 202012/01 has increased in the past weeks, indicating community transmission in a number of countries.[1]

[1] European Centre for Disease Prevention and Control, Risk assessment on COVID-19, 15 February 2021. Available at : https://www.ecdc.europa.eu/en/current-risk-assessment-novel-coronavirus-situation

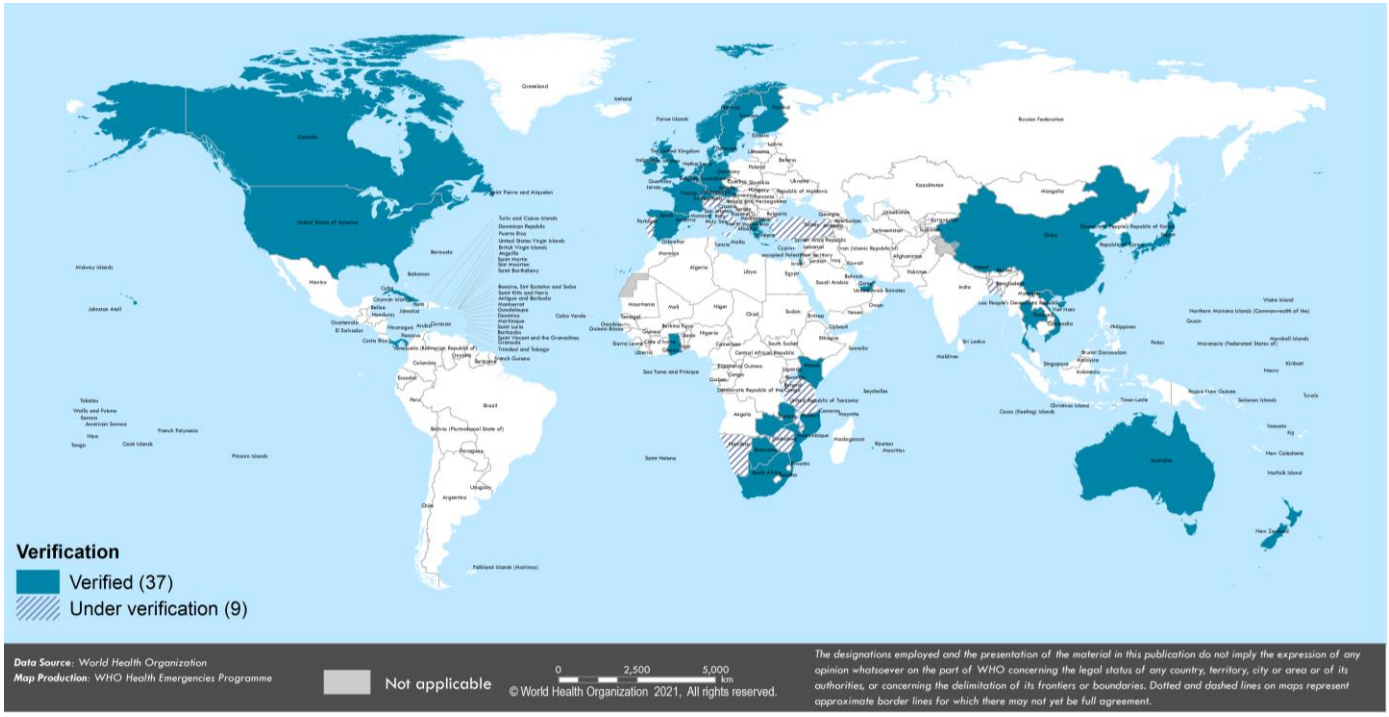
Figure 5. Countries, territories and areas reporting SARS-CoV-2 variant VOC 202012/01 as of 16 February 2021



Variant 501Y.V2

Since the last update on 9 February, 501Y.V2 has been reported from two additional countries– now totaling 46 countries across all six WHO regions (Figure 5). Local transmission has been reported in at least 12 countries across four WHO regions.

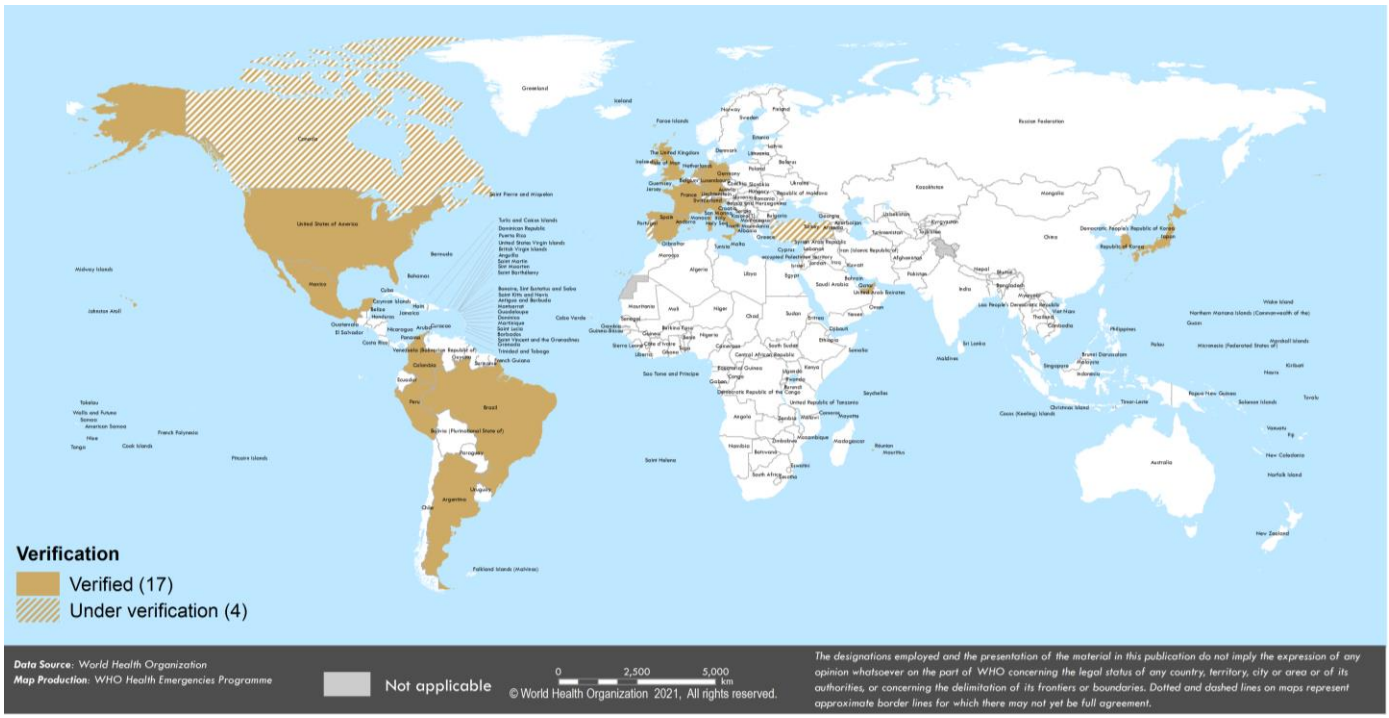
Figure 6. Countries, territories and areas reporting SARS-CoV-2 variant 501Y.V2 as of 16 February 2021



Variant P.1

Since our last update, variant P.1 has been reported in six additional countries. To date, this variant is reported in 21 countries across five of the six WHO regions (Figure 6). So far, local transmission has been reported in at least two countries in one WHO region.

Figure 7. Countries, territories and areas reporting SARS-CoV-2 variant P.1 as of 16 February 2021



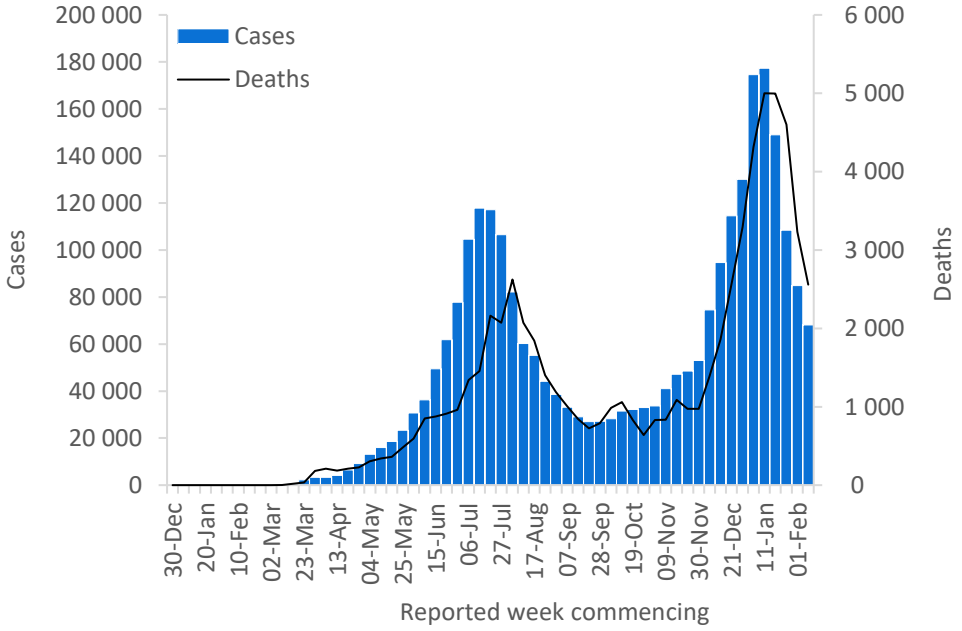
A list of countries/territories/areas reporting variants of concern can be found in Annex 2.

WHO regional overviews

African Region

In the past week, the African Region reported over 68 000 cases and 2500 deaths, a 20% and 21% decrease respectively compared to the previous week. This is the fourth consecutive week the Region reported decreases in both new cases and deaths. The highest numbers of new cases were reported in South Africa (16 363 new cases; 27.6 new cases per 100 000 population; a 33% decrease), Zambia (7027 new cases; 38.2 new cases per 100 000; a 13% decrease) and Nigeria (6422 new cases; 3.1 new cases per 100 000; a 26% decrease),

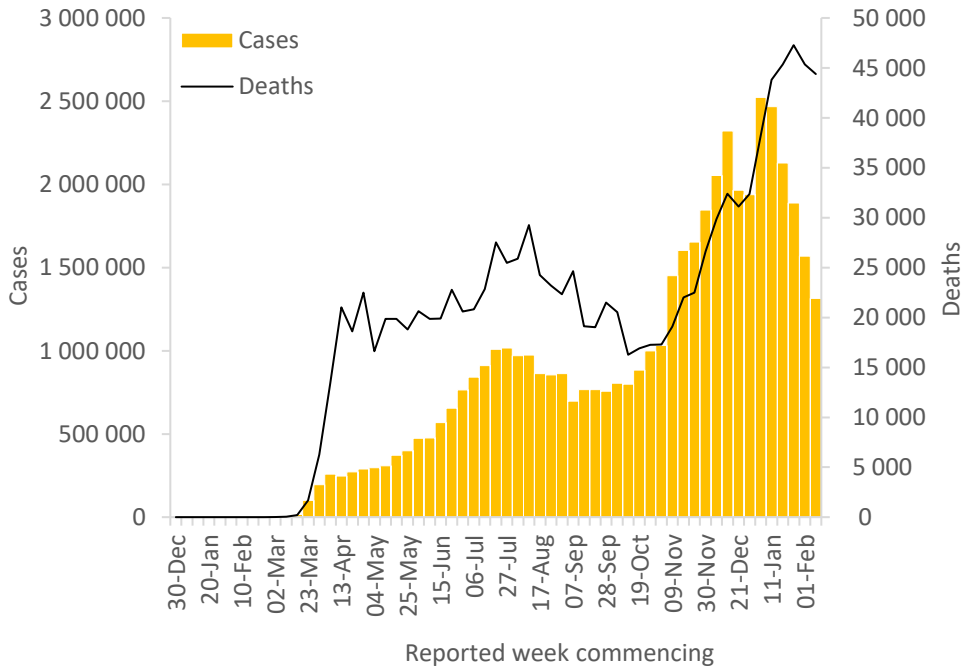
The countries reporting the highest number of new deaths in the past week were South Africa (1641 new deaths; 2.8 new deaths per 100 000; a 26% decrease), Zambia (101 new deaths; 0.5 new deaths per 100 000; a 7% increase), Nigeria (100 new deaths; <0.1 new deaths per 100 000; a 45% increase) and Malawi (100 new deaths; 0.5 new deaths per 100 000; a 33% decrease).



Region of the Americas

Over 1.3 million new cases and over 44 000 new deaths were reported in the Region of the Americas this week, a 16% and 2% decrease respectively compared to the previous week. The highest numbers of new cases were reported from the United States of America (673 630 new cases; 203.5 new cases per 100 000 population; a 23% decrease), Brazil (318 290 new cases; 149.7 new cases per 100 000; a 3% decrease) and Mexico (66 083 new cases; 51.3 new cases per 100 000; a 7% decrease).

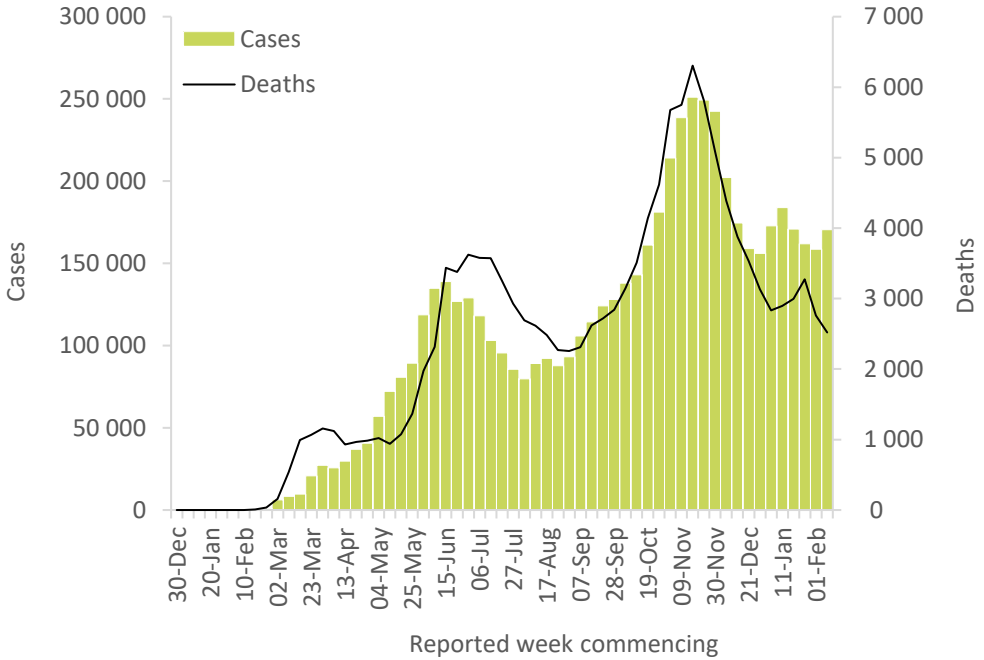
The highest numbers of deaths were reported from the same countries, the United States of America (21 412 new deaths; 6.5 new deaths per 100 000; a 5% decrease), Mexico (8267 new deaths; 6.4 new deaths per 100 000; a 7% increase) and Brazil (7455 new deaths; 3.5 new deaths per 100 000; a 1% increase).



Eastern Mediterranean Region

In the past week, the Eastern Mediterranean Region reported over 170 000 new cases, a 7% increase compared to last week. The region reported just over 2500 new deaths, a 9% decrease. The three countries reporting the highest numbers of new cases continue to be the Islamic Republic of Iran (51 503 new cases; 61.3 new cases per 100 000 population; an 8% increase), United Arab Emirates (22 203 new cases; 224.5 new cases per 100 000; a 2% decrease) and Lebanon (19 156 new cases; 280.7 new cases per 100 000; a 1% increase).

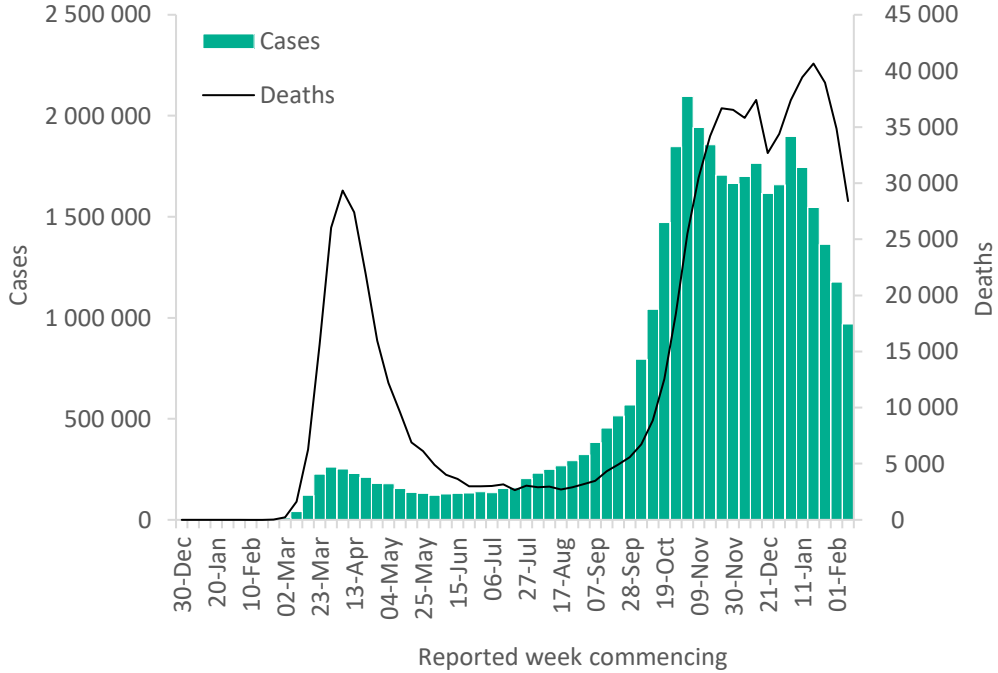
The highest numbers of new deaths continue to be reported in the Islamic Republic of Iran (471 new deaths; 0.6 new death per 100 000 population; a 10% decrease), Lebanon (399 new deaths; 5.8 new death per 100 000; a 25% decrease) and Pakistan (362 new deaths; 0.2 new death per 100 000; a 24% increase).



European Region

The European Region reported over 960 000 new cases and over 28 000 new deaths, a decrease of 18% and 19% respectively when compared to the previous week. The three countries reporting the highest numbers of new cases were France (127 565 new cases; 195.4 new cases per 100 000; a 6% decrease), the Russian Federation (104 602 new cases; 71.7 new cases per 100 000; a 11% decrease), and the United Kingdom (97 271 new cases; 143.3 new cases per 100 000; an 27% decrease).

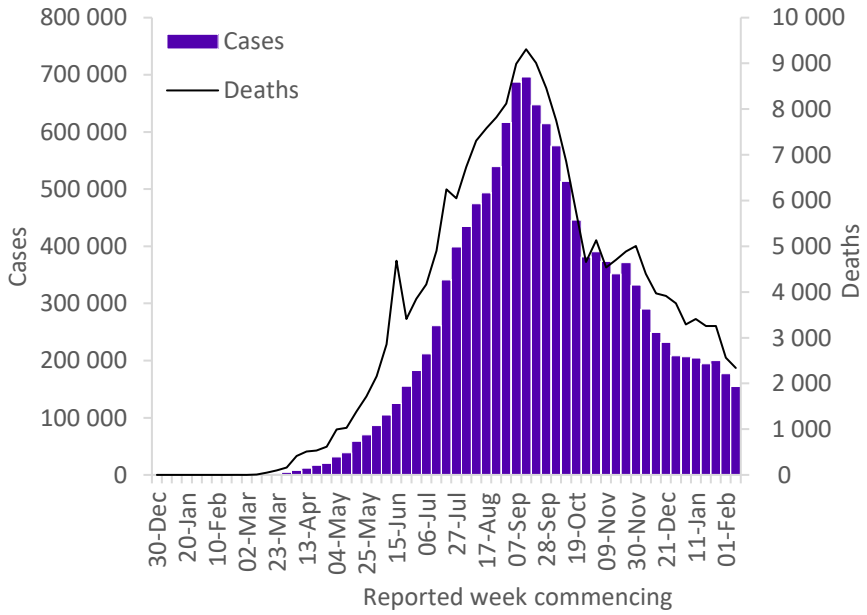
The highest numbers of deaths were reported from the United Kingdom (4816 new deaths; 7.1 new deaths per 100 000; a 26% decrease), the Russian Federation (3465 new deaths; 2.4 new deaths per 100 000, similar to previous week) and Germany (3443 new deaths; 4.1 new deaths per 100 000; a 25% decrease).



South-East Asia Region

In the past week, the South-East Asia Region reported over 150 000 new cases, a decrease of 13% compared to last week. The region reported over 2300 new deaths, a 9% decrease. The three countries reporting the highest numbers of new cases were India (78 577 new cases; 5.7 new cases per 100 000; a 2% decrease), Indonesia (63 693 new cases; 23.3 new cases per 100 000; a 21% decrease), and Sri Lanka (6276 new cases; 29.3 new cases per 100 000; a 19% increase).

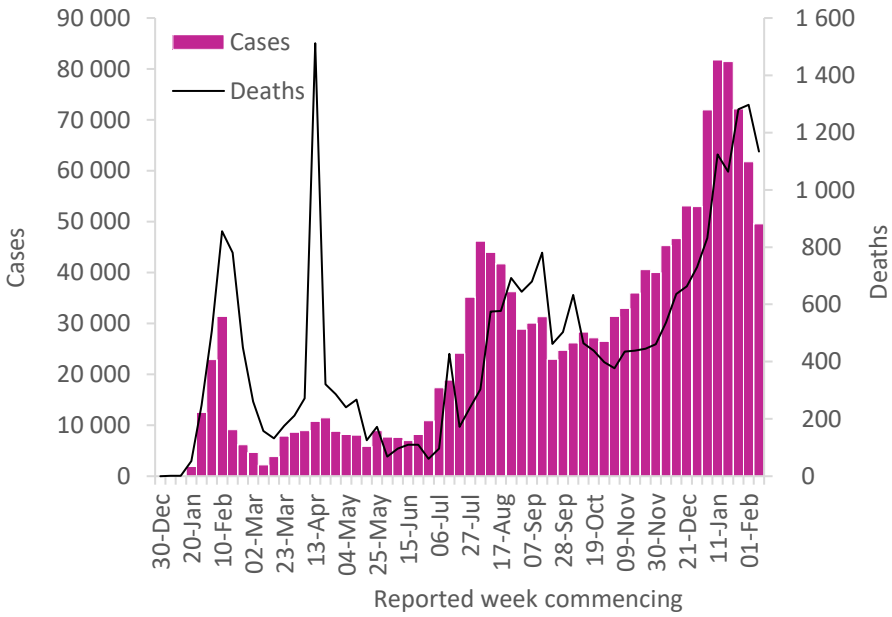
The three countries reporting the highest numbers of new deaths this week were Indonesia (1543 new deaths; 0.6 new deaths per 100 000; a 7% decrease), India (646 new deaths; <0.1 new deaths per 100 000; a 11% decrease) and Bangladesh (76 new deaths; <0.1 new deaths per 100 000; a 4% decrease).



Western Pacific Region

The Western Pacific Region reported over 49 000 new cases the past week, a 20% decrease compared to the previous week. The region reported 1100 new deaths, a 13% decrease. The three countries reporting the highest numbers of new cases in the region this week were Malaysia (23 084 new cases; 71.3 new cases per 100 000; a 21% decrease), the Philippines (11 734 new cases; 10.7 new cases per 100 000; a 2% decrease), and Japan (11 037 new cases; 8.7 new cases per 100 000; a 34% decrease).

The three countries reporting the highest numbers of new deaths this week were Japan (574 new deaths; 0.5 new deaths per 100 000; a 16% decrease), the Philippines (397 new deaths; 0.4 new deaths per 100 000; a 10% decrease) and Malaysia (101 new deaths; 0.3 new deaths per 100 000; a 9% decrease).



Key weekly updates

WHO Director-General Dr Tedros messages

- Member States information session on COVID-19 – 11 February 2021 : "We have to be ready to adapt vaccines so they remain effective, as we do with flu vaccines, which are updated twice a year. Manufacturers will have to adjust to the evolution of the virus, taking into account the latest variants for future shots, including boosters."

Clinical data collection

- Global COVID-19 Clinical Platform Case Report Form (CRF) for Post COVID condition (Post COVID-19 CRF)

COVID-19 vaccines

- 10 steps to community readiness: What countries should do to prepare communities for a COVID-19 vaccine, treatment or new test
- Data for action: achieving high uptake of COVID-19 vaccines: Interim Guidance
- Community needs, perceptions and demand: community assessment tool
- Conducting community engagement for COVID-19 vaccines: Interim guidance, 31 January 2021
- Acceptance and demand for COVID-19 vaccines: Interim guidance, 31 January 2021 and communications plan template
- COVAX Statement on New Variants of SARS-CoV-2
- In the COVID-19 vaccine race, we either win together or lose together
- The Oxford/AstraZeneca COVID-19 vaccine: what you need to know
- AZD1222 vaccine against COVID-19 developed by Oxford University and AstraZeneca: Background paper
- Interim recommendations for use of the AZD1222 (ChAdOx1-S (recombinant)) vaccine against COVID-19 developed by Oxford University and AstraZeneca

Mother-to-child SARS-CoV-2 transmission

- Definition and categorization of the timing of mother-to-child transmission of SARS-CoV-2

Mental health

- WHO Executive Board stresses need for improved response to mental health impact of public health emergencies

Partnerships

- ILO joins the Global Action Plan for Healthy Lives and Well-being for All

Technical guidance and other resources

- Technical guidance
- WHO Coronavirus Disease (COVID-19) Dashboard
- Weekly COVID-19 Operational Updates
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- Online courses on COVID-19 in official UN languages and in additional national languages
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Updates from WHO regions:
  - African Region
  - Region of the Americas
  - Eastern Mediterranean Region
  - South-East Asia Region
  - European Region
  - Western Pacific Region
- Recommendations and advice for the public:
  - Protect yourself
  - Questions and answers
  - Travel advice
  - EPI-WIN: tailored information for individuals, organizations and communities

Annex

Annex 1. COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region, as of 14 February 2021**

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Africa	**68 115**	**2 723 431**	**242.7**	**2 558**	**68 294**	**6.1**	
South Africa	16 363	1 490 063	2 512.4	1 641	47 821	80.6	Community transmission
Zambia	7 027	68 454	372.4	101	940	5.1	Community transmission
Nigeria	6 422	145 664	70.7	100	1 747	0.8	Community transmission
Ghana	5 072	75 118	241.7	69	518	1.7	Community transmission
Mozambique	4 476	48 588	155.5	63	514	1.6	Community transmission
Ethiopia	4 251	145 704	126.7	36	2 181	1.9	Community transmission
Senegal	2 152	30 641	183.0	66	741	4.4	Community transmission
Malawi	2 001	28 876	150.9	100	937	4.9	Community transmission
Algeria	1 661	110 513	252.0	24	2 935	6.7	Community transmission
Botswana	1 423	24 926	1 059.9	39	202	8.6	Community transmission
Côte d'Ivoire	1 317	30 884	117.1	11	173	0.7	Community transmission
Gabon	1 120	12 577	565.1	2	73	3.3	Community transmission
Kenya	1 102	102 792	191.2	19	1 795	3.3	Community transmission
Cameroon	1 081	31 394	118.3	0	474	1.8	Community transmission
South Sudan	955	5 310	47.4	9	74	0.7	Community transmission
Namibia	952	35 797	1 408.8	15	386	15.2	Community transmission
Rwanda	930	17 267	133.3	19	236	1.8	Community transmission
Democratic Republic of the Congo	755	24 239	27.1	13	692	0.8	Community transmission
Zimbabwe	617	35 104	236.2	82	1 398	9.4	Community transmission
Lesotho	472	9 852	459.9	42	225	10.5	Community transmission
Seychelles	388	1 892	1 923.8	2	8	8.1	Community transmission
Togo	387	5 823	70.3	1	80	1.0	Community transmission
Benin	367	4 560	37.6	1	56	0.5	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Burkina Faso	361	11 588	55.4	4	138	0.7	Community transmission
Congo	359	8 419	152.6	1	123	2.2	Community transmission
Cabo Verde	320	14 700	2 643.9	4	139	25.0	Community transmission
Eswatini	307	16 488	1 421.2	26	630	54.3	Community transmission
Madagascar	295	19 360	69.9	4	285	1.0	Community transmission
Angola	267	20 329	61.9	16	491	1.5	Community transmission
Comoros	246	3 332	383.2	20	128	14.7	Community transmission
Guinea	230	14 895	113.4	0	84	0.6	Community transmission
Uganda	198	40 019	87.5	1	328	0.7	Community transmission
Chad	149	3 622	22.1	2	127	0.8	Community transmission
Sao Tome and Principe	143	1 482	676.2	1	19	8.7	Community transmission
Equatorial Guinea	116	5 694	405.8	1	87	6.2	Community transmission
Guinea-Bissau	113	2 885	146.6	0	46	2.3	Community transmission
Eritrea	103	2 429	68.5	0	7	0.2	Community transmission
Burundi	101	1 824	15.3	0	3	0.0	Community transmission
Niger	92	4 690	19.4	4	169	0.7	Community transmission
Mali	66	8 226	40.6	4	342	1.7	Community transmission
Gambia	65	4 302	178.0	1	135	5.6	Community transmission
Sierra Leone	62	3 821	47.9	0	79	1.0	Community transmission
Liberia	13	1 969	38.9	0	84	1.7	Community transmission
Mauritius	11	595	46.8	0	10	0.8	Clusters of cases
Central African Republic	7	4 996	103.4	0	63	1.3	Community transmission
Mauritania	0	16 777	360.8	0	425	9.1	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territories[iii]							
Mayotte	2 780	13 535	4 961.2	14	78	28.6	Clusters of cases
Réunion	420	10 907	1 218.2	0	47	5.2	Clusters of cases
Americas	**1 315 480**	**48 228 712**	**4 715.5**	**44 385**	**1 136 906**	**111.2**	
United States of America	673 630	27 221 607	8 224.0	21 412	477 147	144.2	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Brazil	318 290	9 765 455	4 594.2	7 455	237 489	111.7	Community transmission
Mexico	66 083	1 978 954	1 534.9	8 267	172 557	133.8	Community transmission
Argentina	51 544	2 021 553	4 472.9	1 203	50 188	111.0	Community transmission
Peru	47 703	1 220 748	3 702.4	1 322	43 255	131.2	Community transmission
Colombia	42 509	2 185 169	4 294.5	1 793	57 196	112.4	Community transmission
Chile	24 313	772 395	4 040.5	548	19 443	101.7	Community transmission
Canada	22 550	820 306	2 173.4	553	21 162	56.1	Community transmission
Bolivia (Plurinational State of)	9 188	235 098	2 014.0	420	11 107	95.2	Community transmission
Ecuador	8 412	265 527	1 505.0	265	15 269	86.5	Community transmission
Dominican Republic	6 747	228 895	2 110.0	131	2 932	27.0	Community transmission
Honduras	5 771	159 024	1 605.6	154	3 848	38.9	Community transmission
Paraguay	5 708	142 598	1 999.3	113	2 904	40.7	Community transmission
Panama	5 498	330 985	7 671.0	169	5 595	129.7	Community transmission
Cuba	5 472	37 483	330.9	28	261	2.3	Community transmission
Guatemala	4 134	167 071	932.5	240	6 094	34.0	Community transmission
Uruguay	3 525	47 828	1 376.8	49	527	15.2	Community transmission
Venezuela (Bolivarian Republic of)	3 028	132 259	465.1	44	1 267	4.5	Community transmission
Costa Rica	2 749	199 187	3 910.1	42	2 714	53.3	Community transmission
Jamaica	1 989	18 830	635.9	15	372	12.6	Community transmission
El Salvador	1 191	57 428	885.4	61	1 734	26.7	Community transmission
Saint Lucia	674	2 487	1 354.4	5	23	12.5	Community transmission
Haiti	337	12 143	106.5	1	247	2.2	Community transmission
Guyana	294	8 181	1 040.1	7	186	23.6	Clusters of cases
Barbados	271	1 947	677.5	5	23	8.0	Community transmission
Saint Vincent and the Grenadines	248	1 418	1 278.2	3	6	5.4	Community transmission
Suriname	159	8 778	1 496.3	8	166	28.3	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Antigua and Barbuda	150	427	436.0	2	9	9.2	Sporadic cases
Belize	121	12 134	3 051.6	7	313	78.7	Community transmission
Bahamas	41	8 311	2 113.4	2	178	45.3	Clusters of cases
Nicaragua	37	5 064	76.4	1	171	2.6	Community transmission
Trinidad and Tobago	30	7 637	545.7	2	137	9.8	Community transmission
Dominica	0	121	168.1	0	0	0.0	Clusters of cases
Grenada	0	148	131.5	0	1	0.9	Sporadic cases
Saint Kitts and Nevis	0	40	75.2	0	0	0.0	Sporadic cases
Territories[iii]							
Puerto Rico	1 958	97 313	3 401.5	43	1 915	66.9	Community transmission
Aruba	204	7 338	6 873.0	7	68	63.7	Community transmission
Turks and Caicos Islands	179	1 833	4 734.2	3	12	31.0	Clusters of cases
French Guiana	160	16 456	5 509.5	1	80	26.8	Community transmission
Guadeloupe	146	9 302	2 324.8	1	159	39.7	Community transmission
Saint Martin	88	1 377	3 561.9	0	12	31.0	Community transmission
Martinique	79	6 521	1 737.7	0	45	12.0	Community transmission
United States Virgin Islands	75	2 524	2 417.0	1	25	23.9	Community transmission
Sint Maarten	74	1 985	4 629.0	0	27	63.0	Community transmission
Saint Barthélemy	46	425	4 299.4	0	0	0.0	Sporadic cases
Curaçao	36	4 633	2 823.4	1	22	13.4	Community transmission
Cayman Islands	11	416	633.0	0	2	3.0	Sporadic cases
British Virgin Islands	10	151	499.4	0	1	3.3	Clusters of cases
Bonaire	6	372	1 778.6	1	4	19.1	Community transmission
Falkland Islands (Malvinas)	5	49	1 406.8	0	0	0.0	No cases
Montserrat	4	19	380.1	0	1	20.0	Sporadic cases
Bermuda	2	694	1 114.4	0	12	19.3	Sporadic cases
Anguilla	1	18	120.0	0	0	0.0	Sporadic cases
Saba	0	6	310.4	0	0	0.0	Sporadic cases
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Sint Eustatius	0	20	637.1	0	0	0.0	Sporadic cases
Eastern Mediterranean	**170 445**	**5 998 998**	**820.9**	**2 519**	**139 468**	**19.1**	
Iran (Islamic Republic of)	51 503	1 510 873	1 798.8	471	58 883	70.1	Community transmission
United Arab Emirates	22 203	345 605	3 494.3	87	1 001	10.1	Community transmission
Lebanon	19 156	336 992	4 937.3	399	3 961	58.0	Community transmission
Iraq	14 212	641 628	1 595.2	53	13 164	32.7	Community transmission
Jordan	10 948	344 803	3 379.4	75	4 444	43.6	Community transmission
Pakistan	8 497	561 625	254.3	362	12 276	5.6	Community transmission
Kuwait	6 867	176 903	4 142.4	34	998	23.4	Community transmission
Tunisia	6 328	222 504	1 882.7	346	7 508	63.5	Community transmission
Bahrain	5 389	112 102	6 588.1	19	398	23.4	Clusters of cases
Egypt	4 096	173 202	169.3	331	9 935	9.7	Clusters of cases
Libya	3 987	126 881	1 846.5	78	2 014	29.3	Community transmission
Morocco	3 169	478 135	1 295.4	79	8 460	22.9	Clusters of cases
Qatar	3 114	156 804	5 442.6	5	255	8.9	Community transmission
Saudi Arabia	2 449	372 410	1 069.7	31	6 428	18.5	Sporadic cases
Oman	1 581	136 622	2 675.4	7	1 539	30.1	Community transmission
Syrian Arab Republic	412	14 820	84.7	28	975	5.6	Community transmission
Somalia	238	5 092	32.0	14	148	0.9	Community transmission
Sudan	180	29 933	68.3	15	1 849	4.2	Community transmission
Afghanistan	157	55 492	142.5	17	2 427	6.2	Clusters of cases
Djibouti	27	5 968	604.0	0	63	6.4	Clusters of cases
Yemen	9	2 140	7.2	1	617	2.1	Community transmission
Territories[iii]							
occupied Palestinian territory	5 923	188 464	3 694.3	67	2 125	41.7	Community transmission
Europe	**968 943**	**36 575 529**	**3 918.5**	**28 404**	**812 410**	**87.0**	
France	127 565	3 390 070	5 193.6	2 837	81 226	124.4	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Russian Federation	104 602	4 071 883	2 790.2	3 465	80 126	54.9	Clusters of cases
The United Kingdom	97 271	4 027 110	5 932.2	4 816	116 908	172.2	Community transmission
Italy	85 721	2 710 819	4 483.5	2 353	93 356	154.4	Clusters of cases
Turkey	55 110	2 579 896	3 059.0	692	27 377	32.5	Community transmission
Czechia	53 034	1 088 009	10 159.8	908	18 143	169.4	Community transmission
Germany	50 551	2 334 561	2 786.4	3 443	64 960	77.5	Community transmission
Spain	49 840	3 041 454	6 505.1	1 053	64 217	137.3	Community transmission
Poland	38 700	1 588 955	4 198.4	1 720	40 807	107.8	Community transmission
Israel	36 500	720 393	8 322.9	268	5 335	61.6	Community transmission
Ukraine	26 294	1 271 143	2 906.5	733	24 330	55.6	Community transmission
Netherlands	24 162	1 025 787	5 986.5	443	14 793	86.3	Community transmission
Portugal	22 173	784 079	7 689.5	1 229	15 183	148.9	Clusters of cases
Sweden	17 115	608 411	6 024.3	51	12 428	123.1	Community transmission
Romania	16 748	760 091	3 951.1	516	19 325	100.5	Community transmission
Slovakia	14 460	276 234	5 059.6	677	5 812	106.5	Clusters of cases
Serbia	13 141	419 493	6 023.9	102	4 214	60.5	Community transmission
Belgium	11 879	738 631	6 373.2	252	21 662	186.9	Community transmission
Hungary	10 967	387 462	4 010.8	616	13 706	141.9	Community transmission
Belarus	10 070	267 029	2 825.9	67	1 840	19.5	Community transmission
Austria	9 385	428 692	4 759.9	204	8 088	89.8	Community transmission
Greece	8 253	171 466	1 645.1	152	6 103	58.6	Community transmission
Albania	7 775	91 987	3 196.4	97	1 543	53.6	Clusters of cases
Ireland	6 248	208 796	4 228.5	257	3 931	79.6	Community transmission
Kazakhstan	6 048	250 476	1 334.0	0	3 185	17.0	Clusters of cases
Slovenia	5 970	179 153	8 617.5	46	3 977	191.3	Clusters of cases
Bulgaria	5 964	229 516	3 303.1	297	9 608	138.3	Clusters of cases
Switzerland	5 814	538 116	6 217.7	70	8 982	103.8	Community transmission
Republic of Moldova	5 562	169 805	4 209.4	110	3 640	90.2	Community transmission
Latvia	4 962	76 282	4 044.2	116	1 443	76.5	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Estonia	4 488	52 416	3 951.3	34	495	37.3	Clusters of cases
Lithuania	3 954	190 724	7 006.0	133	3 070	112.8	Community transmission
Georgia	3 533	265 557	6 657.0	69	3 352	84.0	Community transmission
Montenegro	3 256	68 921	10 973.5	44	882	140.4	Clusters of cases
Denmark	2 881	204 067	3 523.1	69	2 284	39.4	Community transmission
Finland	2 310	49 572	894.7	15	710	12.8	Community transmission
North Macedonia	2 273	96 872	4 649.8	60	2 976	142.8	Community transmission
Croatia	2 255	237 657	5 789.1	149	5 318	129.5	Community transmission
Bosnia and Herzegovina	1 938	125 642	3 829.6	101	4 892	149.1	Community transmission
Norway	1 753	66 236	1 221.8	10	592	10.9	Clusters of cases
Armenia	1 079	169 167	5 708.8	24	3 141	106.0	Community transmission
Malta	1 075	19 651	4 450.5	11	290	65.7	Clusters of cases
Luxembourg	1 010	52 699	8 418.7	14	606	96.8	Community transmission
Azerbaijan	973	231 995	2 288.1	22	3 178	31.3	Clusters of cases
Cyprus	746	32 390	2 682.7	9	220	18.2	Clusters of cases
Kyrgyzstan	404	85 475	1 310.1	15	1 441	22.1	Clusters of cases
Uzbekistan	318	79 416	237.3	1	622	1.9	Clusters of cases
Andorra	257	10 463	13 541.7	2	107	138.5	Community transmission
San Marino	168	3 304	9 735.4	3	72	212.2	Community transmission
Monaco	108	1 755	4 472.0	1	21	53.5	Sporadic cases
Liechtenstein	17	2 611	6 846.4	0	49	128.5	Sporadic cases
Iceland	13	6 033	1 767.9	0	29	8.5	Community transmission
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories[iii]							
Kosovo	2 086	64 052	3 443.0	24	1 534	82.5	Community transmission
Guernsey	93	782	1 237.4	0	13	20.6	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Gibraltar	42	4 212	12 501.9	4	84	249.3	Clusters of cases
Jersey	25	3 198	2 939.3	0	67	61.6	Community transmission
Faroe Islands	2	657	1 344.5	0	1	2.0	Sporadic cases
Isle of Man	2	436	512.7	0	25	29.4	No cases
Greenland	0	30	52.8	0	0	0.0	No cases
South-East Asia	**154 414**	**13 188 211**	**652.4**	**2 340**	**202 607**	**10.0**	
India	78 577	10 904 940	790.2	646	155 642	11.3	Clusters of cases
Indonesia	63 693	1 210 703	442.6	1 543	32 936	12.0	Community transmission
Sri Lanka	6 276	74 852	349.6	33	384	1.8	Clusters of cases
Bangladesh	2 496	540 266	328.1	76	8 266	5.0	Community transmission
Thailand	1 200	24 571	35.2	1	80	0.1	Clusters of cases
Maldives	1 060	17 716	3 277.4	2	56	10.4	Clusters of cases
Nepal	808	272 614	935.6	19	2 054	7.0	Clusters of cases
Myanmar	281	141 585	260.2	20	3 188	5.9	Clusters of cases
Timor-Leste	21	101	7.7	0	0	0.0	Sporadic cases
Bhutan	2	863	111.8	0	1	0.1	Clusters of cases
Western Pacific	**49 577**	**1 531 366**	**77.9**	**1 134**	**27 019**	**1.4**	
Malaysia	23 084	261 805	808.9	101	958	3.0	Clusters of cases
Philippines	11 734	547 255	499.4	397	11 507	10.5	Community transmission
Japan	11 037	414 472	327.7	574	6 912	5.5	Clusters of cases
Republic of Korea	2 629	83 525	162.9	51	1 522	3.0	Clusters of cases
Mongolia	304	2 293	69.9	0	2	0.1	Clusters of cases
China	243	101 515	6.9	7	4 838	0.3	Clusters of cases
Viet Nam	210	2 195	2.3	0	35	0.0	Clusters of cases
Singapore	111	59 786	1 021.9	0	29	0.5	Sporadic cases
Australia	44	28 892	113.3	0	909	3.6	Sporadic cases
Papua New Guinea	28	922	10.3	1	10	0.1	Community transmission
New Zealand	10	1 974	40.9	0	25	0.5	Clusters of cases
Cambodia	5	479	2.9	0	0	0.0	Sporadic cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Brunei Darussalam	3	184	42.1	0	3	0.7	Sporadic cases
Solomon Islands	1	18	2.6	0	0	0.0	No cases
Fiji	0	56	6.2	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	0	45	0.6	0	0	0.0	Sporadic cases
Territories[iii]							
French Polynesia	78	18 263	6 501.4	2	135	48.1	Sporadic cases
Guam	48	7 484	4 434.3	1	130	77.0	Clusters of cases
Wallis and Futuna	4	9	80.0	0	0	0.0	Sporadic cases
New Caledonia	3	52	18.2	0	0	0.0	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	1	134	232.8	0	2	3.5	Pending
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Samoa	0	3	1.5	0	0	0.0	No cases
Vanuatu	0	1	0.3	0	0	0.0	No cases
Global	**2 726 974**	**108 246 992**	**1 388.7**	**81 340**	**2 386 717**	**30.6**	

**See *Annex: Data, table and figure notes*

Annex 2. List of countries/territories/areas reporting variants of concern as of 16 February 2021**

Reporting Country/Territory/Area[i]	Variants of concern		
	501Y.V2	P.1	VOC 202012/01
Argentina		Verified	Verified
Aruba			Verified
Australia	Verified		Verified
Austria	Verified		Verified
Bangladesh	Unverified		Verified
Barbados			Verified
Belgium	Verified		Verified
Bosnia and Herzegovina			Unverified
Botswana	Verified		
Brazil		Verified	Verified
Bulgaria			Verified
Canada	Verified	Unverified	Verified
Chile			Verified
China	Verified		Verified
Colombia		Verified	
Comoros			
Croatia			Verified
Cuba	Verified		
Curaçao			Verified
Cyprus			Verified
Czechia			Verified
Denmark	Verified		Verified
Dominican Republic			Verified
Ecuador			Verified
Estonia			Verified
Faroe Islands		Verified	
Finland	Verified		Verified
France	Verified	Verified	Verified
Gambia	Verified		Verified

Reporting Country/Territory/Area[i]	Variants of concern		
	501Y.V2	P.1	VOC 202012/01
Georgia			Verified
Germany	Verified	Verified	Verified
Ghana	Verified		Unverified
Gibraltar			Unverified
Greece	Verified		Verified
Guadeloupe			Verified
Hungary			Verified
Iceland			Verified
India			Verified
Iran (Islamic Republic of)			Verified
Iraq			Unverified
Ireland	Verified		Verified
Israel	Verified		Verified
Italy	Unverified	Verified	Verified
Jamaica			Verified
Japan	Verified	Verified	Verified
Jordan			Verified
Kenya	Verified		
Kosovo[1]			Verified
Kuwait			Verified
Latvia			Verified
Lebanon			Verified
Liechtenstein			Verified
Lithuania			Verified
Luxembourg	Verified		Verified
Malawi	Unverified		
Malaysia			Verified
Malta			Verified
Martinique			Verified

Reporting Country/Territory/Area[i]	Variants of concern		
	501Y.V2	P.1	VOC 202012/01
Mayotte	Verified		Verified
Mexico		Verified	Verified
Morocco			Verified
Mozambique	Verified		
Namibia	Unverified		
Nepal			Verified
Netherlands	Verified	Verified	Verified
New Zealand	Verified		Verified
Nigeria			Verified
North Macedonia			Verified
Norway	Verified		Verified
occupied Palestinian territory			Verified
Oman			Verified
Pakistan			Verified
Panama	Verified		
Peru		Verified	Verified
Philippines			Verified
Poland			Verified
Portugal	Unverified	Unverified	Verified
Republic of Korea	Verified	Verified	Verified
Réunion	Verified	Verified	Verified
Romania			Verified
Russian Federation			Verified
Saint Barthélemy			Verified
Saint Lucia			Verified

Reporting Country/Territory/Area[i]	Variants of concern		
	501Y.V2	P.1	VOC 202012/01
Saint Martin			Verified
Saudi Arabia			Verified
Senegal			Unverified
Serbia			Verified
Singapore			Verified
Slovakia			Verified
Slovenia			Verified
South Africa	Verified		Unverified
Spain	Verified	Verified	Verified
Sri Lanka			Verified
Sweden	Verified		Verified
Switzerland	Verified	Unverified	Verified
Thailand	Verified		Verified
The United Kingdom	Verified	Verified	Verified
Trinidad and Tobago			Verified
Turkey	Unverified	Unverified	Verified
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania	Unverified		
United States of America	Verified	Verified	Verified
Uruguay			Verified
Uzbekistan			Verified
Viet Nam	Verified		Verified
Zambia	Verified		
Zimbabwe	Unverified		

**See *Annex : Data, table and figure notes*

Annex 3. Data, table and figure notes

Data presented are based on official laboratory-confirmed COVID-19 case and deaths reported to WHO by country/territories/areas, largely based upon WHO case definitions and surveillance guidance. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change, and caution must be taken when interpreting these data as several factors influence the counts presented, with variable underestimation of true case and death incidence, and variable delays to reflecting these data at global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/areas. A small number of countries/territories/areas report combined probable and laboratory-confirmed cases. Differences are to be expected between information products published by WHO, national public health authorities, and other sources. Due to public health authorities conducting data reconciliation exercises which remove large numbers of cases or deaths from their total counts, negative numbers may be displayed in the new cases/deaths columns as appropriate. When additional details become available that allow the subtractions to be suitably apportioned to previous days, graphics will be updated accordingly. A record of historic data adjustment made is available upon request by emailing epi-data-support@who.int. Please specify the country(ies) of interest, time period(s), and purpose of the request/intended usage. Prior situation reports will not be edited; see covid19.who.int for the most up-to-date data. Global totals include 745 cases and 13 deaths reported from international conveyances.

The designations employed, and the presentation of these materials do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Countries, territories and areas are arranged under the administering WHO region. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). In the map, number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes.

[i] Excludes countries, territories, and areas that have never reported a confirmed COVID-19 case (Annex 1), or the detection of a variant of concern (Annex 2).

[ii] Transmission classification is based on a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be revised as new information becomes available. Differing degrees of transmission may be present within countries/territories/areas. For further information, please see: Considerations for implementing and adjusting public health and social measures in the context of COVID-19:

- No (active) cases: No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust surveillance system. This implies a near-zero risk of infection for the general population.
- Imported / Sporadic cases: Cases detected in the past 14 days are all imported, sporadic (e.g., laboratory acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.
- Clusters of cases: Cases detected in the past 14 days are predominantly limited to well-defined clusters that

are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.

- Community transmission: Which encompasses a range of levels from low to very high incidence, as described below and informed by a series of indicators described in the aforementioned guidance. As these subcategorization are not currently collated at the global level, but rather intended for use by national and sub-national public health authorities for local decision-making, community transmission has not been disaggregated in this information product.
    - CT1: Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
    - CT2: Moderate incidence of locally acquired, widely dispersed cases detected in the past 14 days; transmission less focused in certain population sub-groups. Moderate risk of infection for the general population.
    - CT3: High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population sub-groups. High risk of infection for the general population.
    - CT4: Very high incidence of locally acquired, widely dispersed cases in the past 14 days. Very high risk of infection for the general population.
- Pending: transmission classification has not been reported to WHO.

[iii] "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status.

Weekly Operational Update on COVID-19

13 February 2021

Confirmed cases[a]
107 838 255

Confirmed deaths
2 373 398

Nepali Audio Journalists Engaged in Webinar on "Science behind COVID-19"

Recently, around a hundred audio journalists from across Nepal participated in a webinar on the *"Science Behind COVID-19"* organized by the Ministry of Health and Population (MoHP). The objective was to brief them on scientific evidence concerning COVID-19 including vaccination against the disease, to increase their understanding of the pandemic and thereby improve the accuracy of their reporting.

Participants also heard about community engagement and how to create content during a pandemic. They were then able to put forward their questions and concerns with the respective speakers related to COVID-19, vaccines, and communicating during a pandemic, with most queries related to vaccines, their side effects and availability.

A spokesperson for the MoHP emphasized the importance of communicating information based on science during the COVID-19 pandemic, while the WHO Representative to Nepal, Dr Rajesh Sambhajirao Padav, highlighted the role of audio producers in countering rumors and misinformation during the pandemic.

For further information, click here.

Key Figures

WHO-led UN Crisis-Management Team coordinating 23 UN entities across nine areas of work

150 GOARN deployments conducted to support COVID-19 pandemic response

19 951 965 respirators shipped globally

198 343 426 medical masks shipped globally

8 582 631 face shields shipped globally

6 835 879 gowns shipped globally

36 600 900 gloves shipped globally

More than **4.9 million** people registered on OpenWHO and accessing online training courses across **25** topics in **44** languages

[a] For the latest data and information, see the WHO COVID-19 Dashboard and Situation Reports

From the field:

EU and WHO provide additional support to prevent COVID-19 spread and strengthen health systems in Somalia

On 3 February, the European Union (EU) launched a €5 million multi-year project to support the WHO and the Federal Government of Somalia to prevent further community spread of COVID-19 and to strengthen health service delivery across the country as Somalia's health systems start recovering from the aftershock of the pandemic.

This new and vital multi-year partnership stems from a Bilateral Technical Coordination Mechanism previously established between WHO Somalia and the EU Delegation to Somalia which sought to strengthen operational response capacities for COVID-19 and other health emergencies.

The project, to be implemented by WHO and the Federal Ministry of Health, will contribute to preventing large-scale community transmission of COVID-19 and further spread or resurgence of the virus and other epidemic-prone diseases, while helping health systems recover better and stronger. Dr Mamunur Rahman Malik, WHO Representative in Somalia noted "We are leaving no stone unturned. Together with the EU, and the Federal Government of Somalia, we are redoubling our efforts to ensure everyone, everywhere in this country is safe and protected from COVID-19 and other health threats."

Over a 3-year period, the project will support institution and capacity-building of the health workforce in the country, such as establishing integrated data management and surveillance system and launching a new services availability and readiness assessment (SARA) survey, which will consolidate information on all health facilities and services available across the country. This information will be useful to better understand how the project is having an impact on its beneficiaries by improving health and keeping them safe and protected.

"In addition to saving lives and preventing the spread of COVID-19, this project will help us build a legacy for Somalia's health systems" said HE Dr Fawziya Abikar Nur, Minister of Health and Human Services, Federal Government of Somalia.

For further information, click here.

From the field:

WHO Regional Office for Europe's Southern Caucasus Hub points of entry assessment in Azerbaijan

Points of Entry assessment at the sea port in Baku, Azerbaijan Credit: WHO Azerbaijan Country Office

Points of Entry (PoE) play a critical role in safeguarding a country's public health and well-being, which is recognized by the International Health Regulations (2005).

Large international airports and sea ports often represent a challenge due to the complex issues they deal with daily (such as high volume and frequency of traffic, population density around PoE, etc.) and the presence of many stakeholders including international travelers, government authorities, private air and sea companies and more.

Upon request from the Sanitary and Quarantine Service of the State Customs Committee of Azerbaijan and in coordination with the Ministry of Health, the WHO Health Emergencies Hub for the Southern Caucasus organized an informal assessment on the preparedness and response capacities for COVID-19 at key national PoE including the international airport, the sea port of Baku and ground-crossings with Georgia, Iran and the Russian Federation.

During the assessment, key aspects related to coordination and communication mechanisms, health and non-pharmaceutical measures in place, cleaning, disinfection and training of the responsible staff were addressed. Discussions were held with key persons in charge and representatives of the responsible agencies.

Critical functions addressed included on-site observations of physical spaces and equipment with an emphasis on practical recommendations. While Azerbaijan has taken the threat of COVID-19 seriously and significantly increased public health capacities to prevent, detect and respond to COVID-19 at PoE, opportunities exist to further strengthen and align actions with WHO guidance.

WHO is maintaining direct communication with the responsible authorities and the results of the assessment and technical recommendations will be provided and used to further enhance the measures in place, which health authorities at PoE are keen to operationalize to further prevent cross-border spread of COVID-19.

Infodemic management

Responding to and combatting an infodemic with science-based interventions

In the early days of the COVID-19 pandemic, people around the world were suffering from information overload, while lacking credible, accurate information and falling prey to mis- and disinformation.

Recognizing this COVID-19 "infodemic" was perpetuating online and causing harm to people's health offline, WHO's Director-General, Tedros Adhanom Ghebreyesus sounded the alarm that "we're not just fighting an epidemic; we're fighting an infodemic."

After an initial consultation in April 2020, WHO organized a major global infodemic conference in June and July where over 100 experts convened virtually to define the nascent science of infodemic management and build a public health research agenda that serves as a playbook for conducting relevant public health research.

This research agenda provides guidance to invest in research and innovation so that we have better interventions and tools to understand, measure and respond to infodemics, and ultimately to steer people towards timely, accessible, understandable health information that can help them make good health choices.

Within the research agenda, five streams of thinking and 65 research questions were developed and prioritized so that the practice of infodemic management has a structure, a methodology that is rooted in evidence and has room to further evolve as a discipline.

This exciting progress will challenge country authorities to explore:

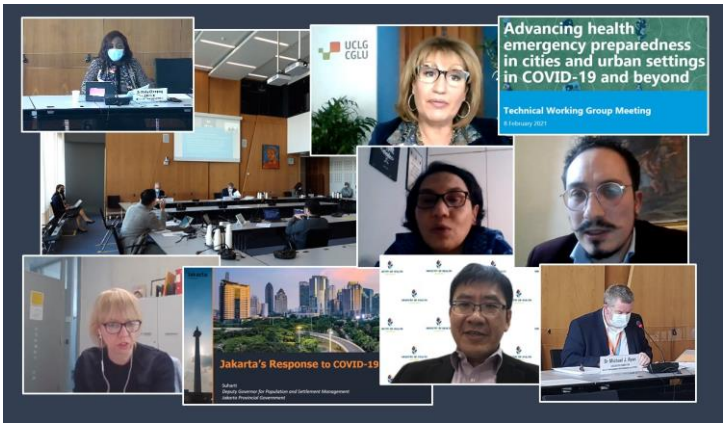
- How do overwhelming amounts of information affect behaviour in emergencies and what interventions are effective in addressing it?
- How does online behaviour affect offline action?
- How does the infodemic affect cognition and influence uptake of health services?
- How do policy interventions successfully address and mitigate health misinformation?

The next steps will be to track implementation of the agenda and review evidence of its effectiveness.

Click here for more information and to download the research agenda, and please commit to practicing infodemic management in the world around you.

COVID-19 Preparedness

First Meeting of the Technical Working Group on "Advancing health emergency preparedness in cities and urban settings in COVID-19 and beyond"



COVID-19 has disproportionately impacted cities and urban settings and will unfortunately not be the last health threat or emergency. The inaugural meeting of a technical working group on urban preparedness held its first meeting on 8 February 2021.

Members included representatives from countries across all WHO regions (from Ministries of health and interior and local governments), partners (academia, national public health institutes and the private sector), city networks, international organizations and all levels of WHO.

The working group's objectives are to discuss unique considerations that influence emergency planning and implementation, share experiences and best practices in cities and urban settings, discuss how the approach to preparedness will change given the pandemic including seven key areas of focus (such as population density and mobility, including ways to manage congestion and ensure safe public transportation) and to develop clear roles and actions moving forward.

The meeting was opened by Executive Director for the WHO Health Emergencies Programme, Dr Mike Ryan, and Deputy Secretary for Health of the Republic of Singapore, Dr Benjamin Koh. They highlighted the need to learn from the impact of the current crisis in urban areas and build back cities that are safer, healthier and better prepared for future emergencies.

Members shared their experiences and perspectives including the Secretary-General of the NGO, United Cities and Local Governments; the Deputy Governor from Jakarta Provincial Government in Indonesia; an urban planner from a university in Bochum in Germany; Ministry of Health officials from the United Arab Emirates and Singapore; the 'ASL Roma 1' Regional Health System from Italy; and the International Organization for Migration.

Topics for deliberation in future meetings were discussed. The working group will complete its work in mid-April and contribute to the development of a technical guidance for national and local authorities including the experiences and lessons learnt during the COVID-19 pandemic to be published mid-2021.

Health Learning

WHO is expanding access to online learning for COVID-19 through its open learning platform for health emergencies, OpenWHO.org.

The OpenWHO platform was launched in June 2017 and published its first COVID-19 course on 26 January 2020.

WHO launches free online course on rehabilitation from COVID-19

A new training devoted to the rehabilitation of COVID-19 patients is available for free on OpenWHO.org as part of the *Clinical Management of Patients with COVID-19* course series.

The series is designed to equip healthcare workers with crucial knowledge to provide safe, effective quality patient care during the COVID-19 pandemic. The rehabilitation course is the second to launch; the first course on general considerations was published in October 2020. In total, seven courses are planned.

The seven modules of the rehabilitation training address the varied rehabilitation needs of patients recovering from COVID-19, including patients with cognitive impairment, physical deconditioning and weakness, respiratory impairment, swallow impairment, communication impairment, and challenges in completing Activities of Daily Living (ADLs). Techniques for rehabilitation also are addressed.

In total, the course will take approximately three hours to complete. Certificates are available for participants who score at least 80% across all quizzes or complete at least 80% of the course material.

As per 9 February 2021

4 882 837
Course enrollments

44 languages

25 topical courses

Over 2.6 million certificates

COVID-19 Partners platform

Over the past three weeks WHO has been working diligently to support countries intending to participate in the February round of vaccine allocation through the COVAX facility. In that time span, the Partners Platform team has provided 50 countries, territories, or areas with 1:1 mentoring for their completion of the National Deployment and Vaccination Plan (NDVP) and support for uploading the plan onto the Partners Platform.

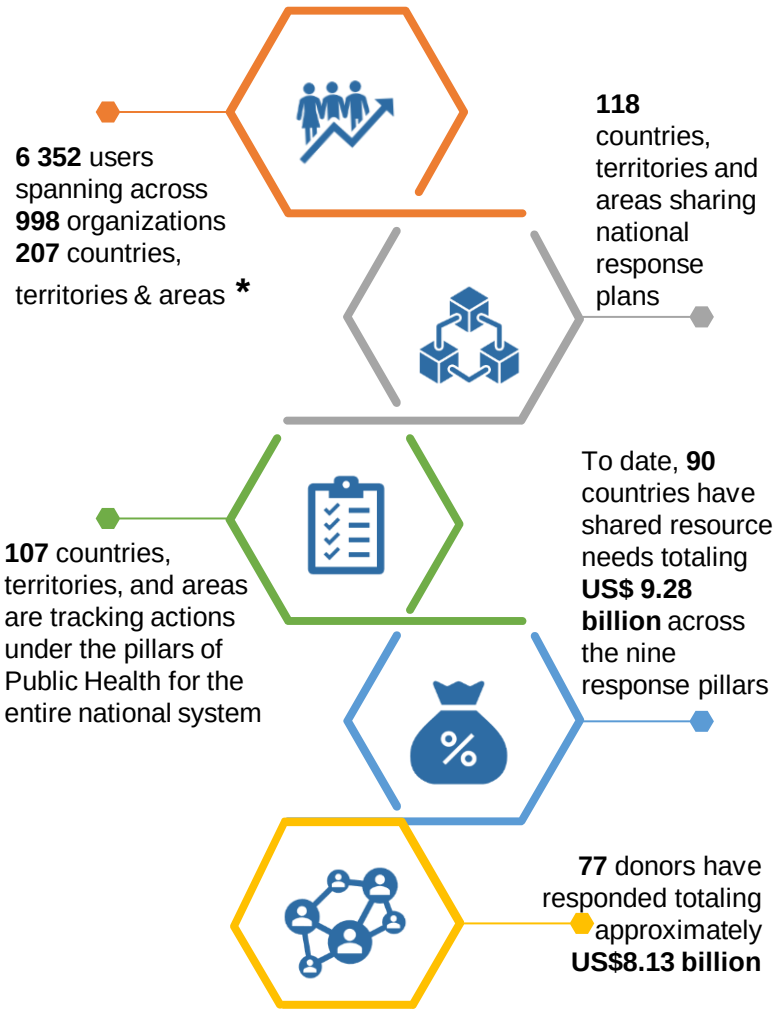
The Platform is the global repository for all NDVPs, in an effort to ensure uncomplicated and efficient access to the plans for the Regional Review Committees involved in assessing them and for other key vaccine stakeholders, such as global and regional donors providing essential funds and logistical contributions towards COVAX's equitable vaccine distribution initiative.

Tuesday, 9 February marked the deadline for the first round of NDVPs to be uploaded to the Platform. By the deadline 81 out of 87 countries that opted in for February allocation had uploaded their national plan to the Platform. A second round of vaccine allocation will occur in March.

Since its launch in March 2020, and especially in the execution of its central coordinating role in the global roll-out of vaccine readiness assessment, the Partners Platform has demonstrated its value as a digital repository.

In addition to the thorough guidance that WHO technical leads provided for vaccine introduction, the Platform's technical leads have been providing country and regional offices extensive mentorship for the development of national COVID-19 response plans across the Strategic Preparedness and Response Plan's (SPRP) nine recognized areas of response.

With the pending 2021 updates to the SPRP and its Operational Planning Guidance, the Partners Platform will continue to expand its functionality and provide crucial support as countries have the opportunity to adjust their national response plans in line with the changing nature of the pandemic.



For further information on Partners platform click here

**Note: viewing of vaccine information may be restricted to key vaccines stakeholders according to countries' preferences.*

Operations Support and Logistics

The COVID-19 pandemic has prompted an unprecedented global demand for Personal Protective Equipment (PPE), diagnostics and clinical care products.

To ensure market access for low- and middle-income countries, WHO and partners have created a COVID-19 Supply Chain System, which has delivered supplies globally

The table below reflects WHO/PAHO-procured items that have been shipped as of 12 February 2021

Shipped items as of 12 Feb 2021	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	700 800	3 548 265	1 825 642	1 423 210	10 154 300	208 050	1 717 279	53 429 400	2 700 630
Americas (AMR)	6 520 050	1 020 412	10 518 478	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	934 050	1 249 320	1 439 590	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	248 000	409 300	540 770	1 730 700	8 935 100	399 820	1 647 248	40 545 500	5 372 950
South East Asia (SEAR)	320 000	2 352 150	2 240 200	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		175 800	346 834	768 700	3 021 000	311 927	463 710	14 974 146	2 102 035
TOTAL	**8 722 900**	**8 755 247**	**16 911 514**	**8 582 631**	**36 600 900**	**1 535 727**	**6 835 879**	**198 343 426**	**19 951 965**

For further information on the **COVID-19 supply chain system**, see here.

Appeals

WHO appreciates and thanks donors for the support already provided or pledged and encourages donors to **give fully flexible funding for the SPRP** and avoid even high-level/soft geographic earmarking at e.g. regional or country level. This will allow WHO to direct resources to where they are most needed, which in some cases may be towards global procurement of supplies, intended for countries.

As of 20 January 2021

Global Strategic Preparedness & Response Plan (SPRP)

US$ 1.5 billion raised

US$ 1.7 billion requested

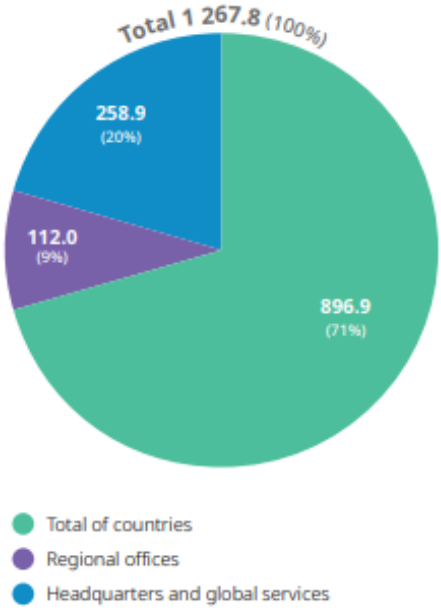
US$ 1.5 billion raised by WHO during 2020
US$ 1.3 billion projected utilization for 2020 SPRP

US$ 240 million raised by the COVID-19 Solidarity Response Fund

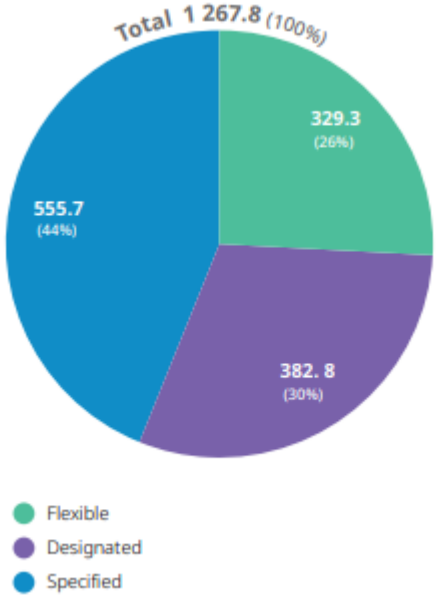
US$1 billion on country support and regional coordination

The status of funding raised for WHO against the SPRP can be found here

Utilization* by type of funds by level of organization (US$ million)



Utilization* by type of funding by level of earmarking (US$ million)



*Based on interim 2020 year-end figures and estimated 2021 Q1 transition period implementation

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

The COVID-19 Solidarity Response Fund remains the foremost way for companies, organisations and individuals to contribute to the essential work of WHO and its partners to help countries prevent, detect and respond to the global pandemic.

By 5 February 2021, more than 660,000 leading companies, foundations and individuals from more than 190 countries had committed more than US$ 242 million in fully flexible funding to the COVID-19 Solidarity Response Fund to support the lifesaving work of WHO and its partners.

More than US$ 242 Million

660 000 donors

[individuals – companies – philanthropies]

The WHO Contingency Fund for Emergency (CFE)

WHO's Contingency Fund for Emergencies (CFE) provided $8.9 million for COVID-19 preparedness and response worldwide at the very onset of the outbreak when no other funding was available.

US$ 8.9 Million released

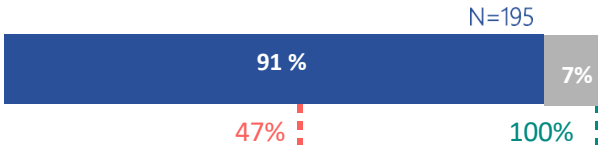
The WHO Contingency Fund for Emergencies 2019 Annual Report was published on 7 August. WHO is grateful to all donors who contributed to the fund allowing us to respond swiftly and effectively to emerging crises including COVID-19. Full report is available here.

World Health Organization

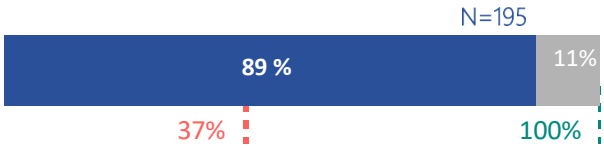
HEALTH
EMERGENCIES
programme

COVID-19 Global Preparedness and Response Summary Indicators [a]

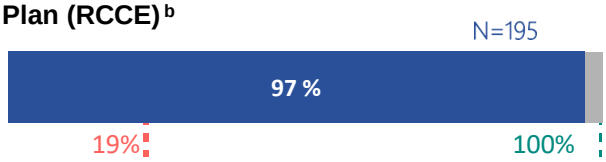
Countries have a COVID-19 preparedness and response plan



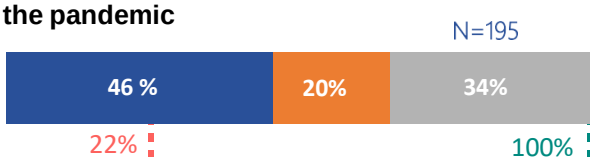
Countries have a clinical referral system in place to care for COVID-19 cases



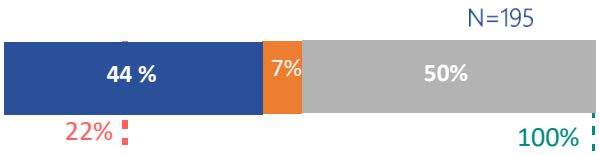
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE) [b]



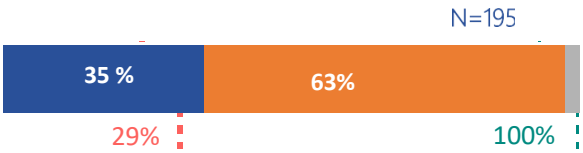
Countries that have defined essential health services to be maintained during the pandemic



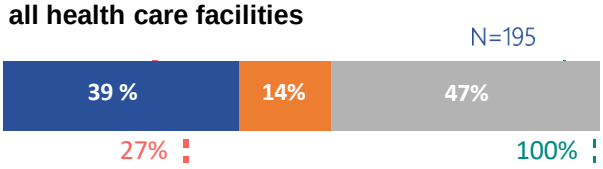
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



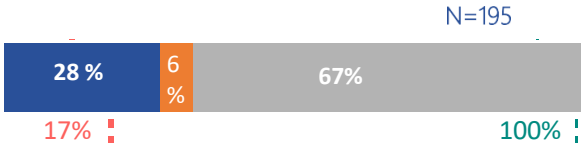
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



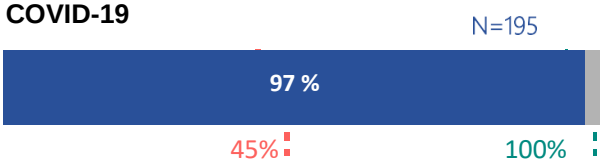
Countries with a national IPC programme & WASH standards within all health care facilities



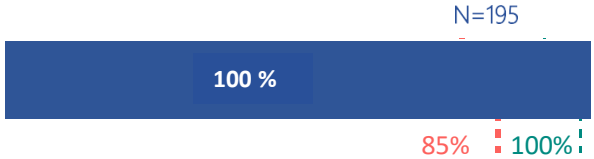
Countries have a health occupational safety plan for health care workers



Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



Countries have COVID-19 laboratory testing capacity



Legend

Yes | No | No information | Baseline value | Target value

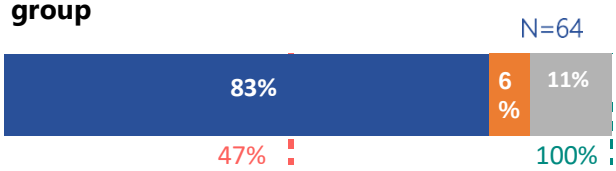
Notes:

a Data collected from Member States and territories. The term "countries" should be understood as referring to "countries and territories." b Source: UNICEF and WHO

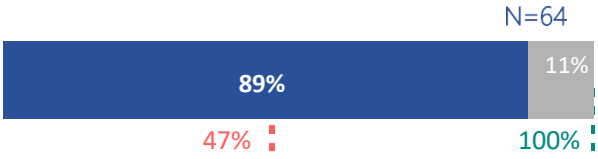
COVID-19 Global Preparedness and Response Summary Indicators

Selected indicators within the Monitoring and Evaluation Framework apply to designated priority countries. Priority Countries are mostly defined as countries affected by the COVID-19 pandemic as included in the Global Humanitarian and Response Plan. A full list of priority countries can be found here.

Priority countries with multisectoral mental health & psychosocial support working group



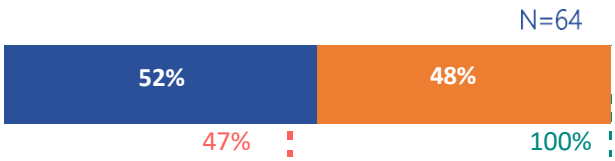
Priority countries with an active & implemented RCCE coordination mechanism



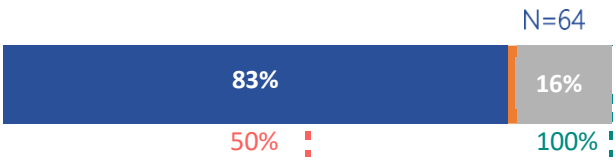
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19 [c]

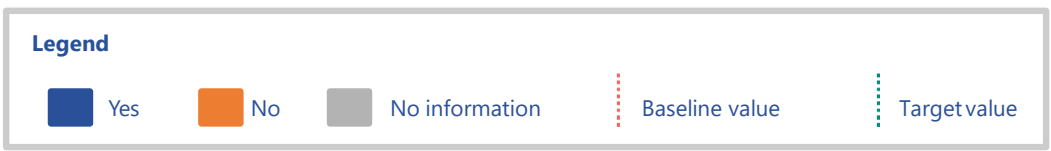
Priority countries with a contact tracing focal point

Priority countries where at least one Incident Management Support Team (IMST) member trained in essential supply forecasting



Priority countries with an IPC focal point for training





Notes:

c Source: WHO Immunization Repository

The Unity Studies: WHO Early Investigations Protocols

Unity studies is a global sero-epidemiological standardization initiative, which aims at increasing the evidence-based knowledge for action.

It enables any country, in any resource setting, to gather rapidly robust data on key epidemiological parameters to understand, respond and control the COVID-19 pandemic.

The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays.

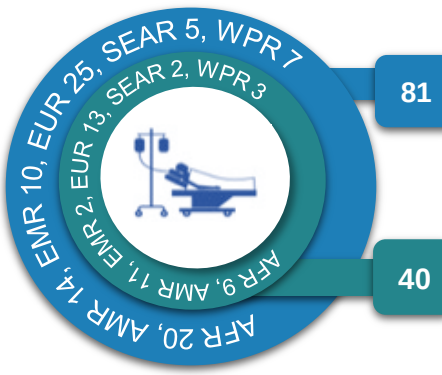
121 countries intend to implement at least one Unity Study protocol

77 countries have started implementation

Global COVID-19 Clinical Data Platform

Global understanding of the severity, clinical features and prognostic factors of COVID-19 in different settings and populations remains incomplete.

WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



81 countries intend to contribute data to the clinical platform

40 countries have started sharing data

Leveraging the Global Influenza Surveillance and Response System

WHO recommends that countries use existing syndromic respiratory disease surveillance systems such as those for influenza like illness (ILI) or severe acute respiratory infection (SARI) for COVID-19 surveillance. Leveraging existing systems is an efficient and cost-effective approach to enhancing COVID-19 surveillance. The Global Influenza Surveillance and Response System (GISRS) is playing an important role in monitoring the spread and trends of COVID-19.

In week 5, 49 countries have reported COVID-19 data from sentinel surveillance systems

41,970 sentinel surveillance specimens were tested in week 5

18.5% specimens tested were COVID-19 positive

Key links and useful resources

- For EPI-WIN: WHO Information Network for Epidemics, click **here**
- For more information on COVID-19 regional response:
  - **African Regional Office**
  - **Regional Office of the Americas**
  - **European Regional Office**
  - **Eastern Mediterranean Regional Office**
  - **Southeast Asia Regional Office**
  - **Western Pacific Regional Office**
- For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection published on 16 December 2020, click **here**
- For updated WHO Publications and Technical Guidance on COVID-19, click **here**
- For updated GOARN network activities, click here
- Updated COVID-19 Table top Exercise packages are now available online to better reflect the current situation as well as align it to the latest WHO guidance. The updated exercises include:
  - Generic table top exercise
  - Health Facility & IPC table top exercise
  - A Point of Entry (POE) table top exercise
  - Target population, supply chain and community engagement & communications table top exercise
  - The regulatory and safety issues table top exercise

  All COVID-19 simulation exercises can be found here

COVID-19 Weekly Epidemiological Update

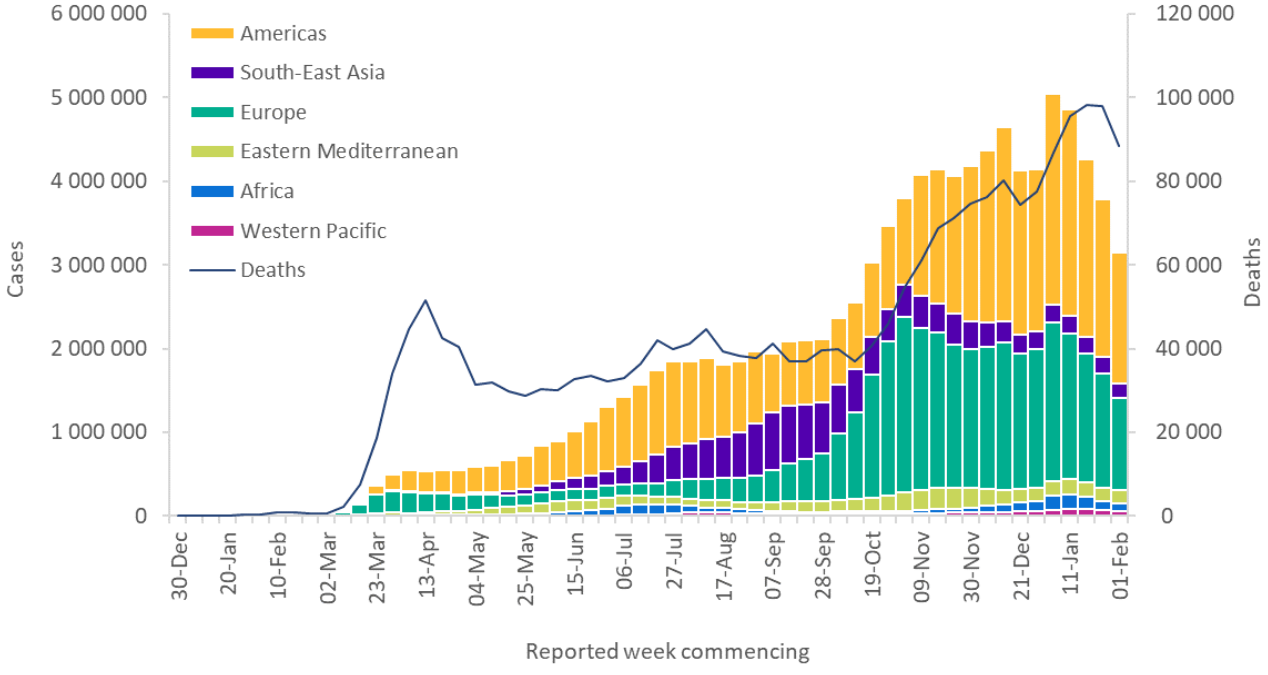
Data as received by WHO from national authorities, as of 7 February 2021, 10 am CET

In this edition:

Global overview

For the fourth week in a row, the number of global new cases reported fell, with 3.1 million new cases last week, a 17% decline compared to the previous week (Figure 1). This is the lowest figure since the week of 26 October (15 weeks ago). Although there are still many countries with increasing numbers of cases, at the global level, this is encouraging. The number of new deaths reported also fell for a second week in a row, with 88 000 new deaths reported last week, a 10% decline as compared to the previous week. All WHO regions reported a decline in new cases, with five out of six regions reporting more than 10% decreases (Table 1). Europe and the Region of the Americas saw the greatest drops in absolute numbers, with together nearly 0.5 million fewer new cases reported last week (153 000 and 320 000 fewer new cases reported, respectively). New deaths also declined in all regions except the Western Pacific, where mortality rates remained similar to the previous week.

Figure 1: COVID-19 cases reported weekly by WHO Region, and global deaths, as of 7 February 2021**



**See *data, table and figure notes*

In the past week, the five countries reporting the highest number of new cases continue to be the United States of America (871 365 cases, a 19% decrease), Brazil (328 652 cases, a 10% decrease), France (136 154 cases, a 4% decrease), the United Kingdom of Great Britain and Northern Ireland (133 747 cases, a 25% decrease), and the Russian Federation (116 842 cases, a 11% decrease).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 7 February 2021**

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	1 568 167 (50%)	-17%	46 913 218 (44%)	45 350 (51%)	-4%	1 092 521 (47%)
Europe	1 102 953 (35%)	-19%	35 515 952 (34%)	33 169 (38%)	-13%	781 242 (34%)
South-East Asia	177 074 (6%)	-12%	13 033 797 (12%)	2 560 (3%)	-21%	200 267 (9%)
Eastern Mediterranean	158 625 (5%)	-2%	5 828 565 (6%)	2 761 (3%)	-16%	136 950 (6%)
Africa	84 842 (3%)	-22%	2 655 316 (3%)	3 232 (4%)	-30%	65 736 (3%)
Western Pacific	61 765 (2%)	-14%	1 481 789 (1%)	1 297 (1%)	1%	25 885 (1%)
Global	**3 153 426 (100%)**	**-17%**	**105 429 382 (100%)**	**88 369 (100%)**	**-10%**	**2 302 614 (100%)**

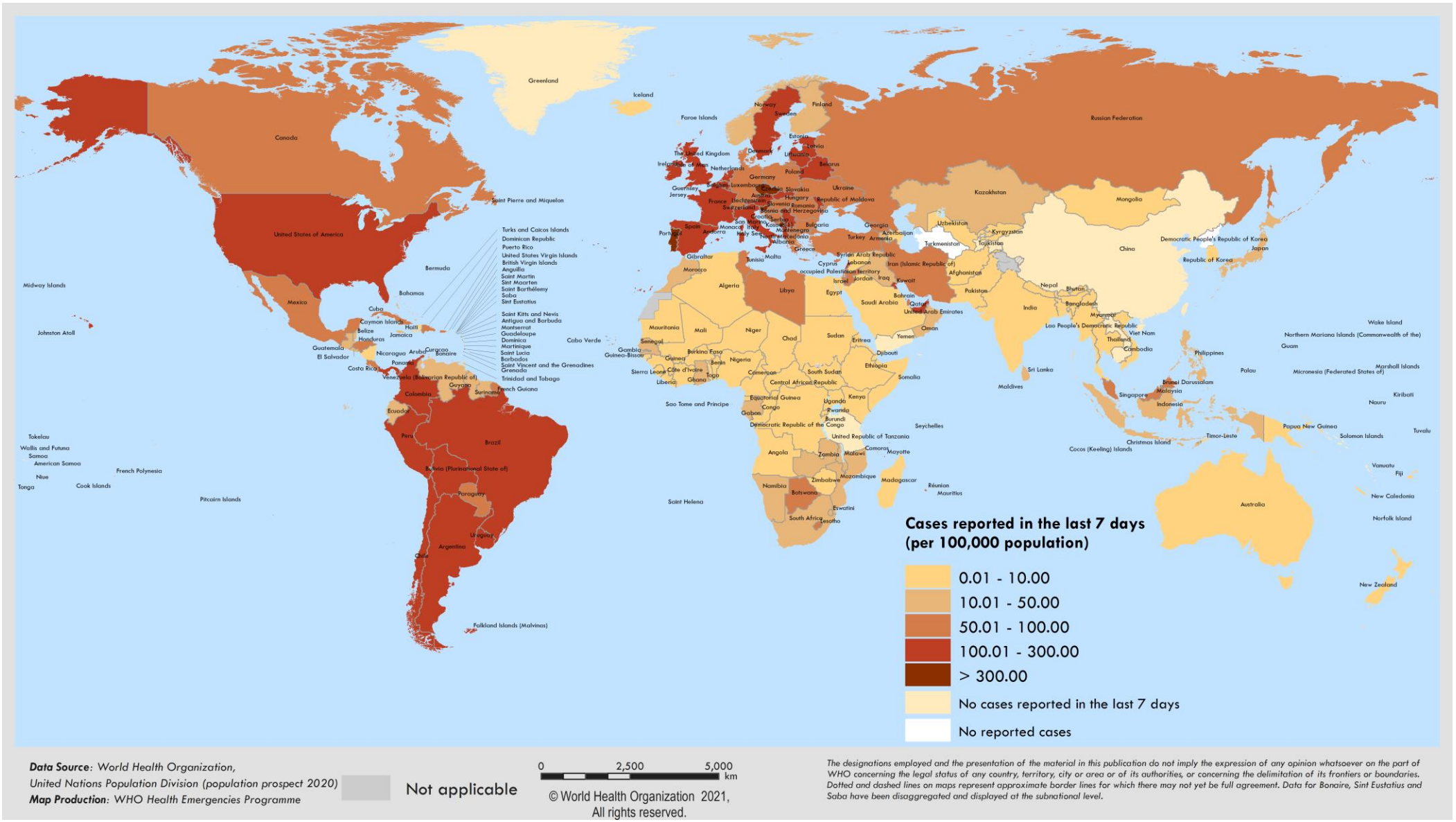
**Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number, global totals may not equal 100%.*

***See data, table and figure notes.*

For the latest data and other updates on COVID-19, please see:

- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update

Figure 2. COVID-19 cases per 100 000 population reported in the last seven days by countries, territories and areas, 1 February through 7 February 2021**



**See *data, table and figure notes*

Special Focus: How COVAX is distributing the first COVID-19 vaccines to prioritized countries in all six WHO regions

The Access to COVID-19 Tools Accelerator (ACT-Accelerator) was formed ten months ago with two aims: first to develop COVID-19 vaccines, diagnostics and therapeutics fast, and second, to distribute them fairly. The first aim has been achieved. As WHO Director-General Dr Tedros said in his opening remarks at the High-Level Finance Ministries' Meeting for the ACT Accelerator on 29 January: "The development and approval of safe and effective vaccines less than a year after the emergence of a new virus is a stunning scientific achievement, and a much-needed source of hope."

However, in opening remarks at a media briefing on COVID-19 on 5 February, he highlighted that around 130 countries, with 2.5 billion people, were yet to administer a single dose. More than 90% of the countries now rolling out vaccines are high- or upper-middle income countries. Seventy-five percent of doses have been deployed in only 10 countries. At the 148th session of the Executive Board, Dr Tedros stressed that "Vaccine equity is not just a moral imperative, it is a strategic and economic imperative." The International Chamber of Commerce Research Foundation found in a study that "the global economy stands to lose as much as $9.2 trillion if governments fail to ensure developing economy access to COVID-19 vaccines, as much as half of which would fall on advanced economies."[1] Once countries with vaccines have vaccinated their own health workers and older people, the best way to protect the rest of their own population is to share vaccines so other countries can do the same. The longer it takes to vaccinate those most at risk everywhere, the more opportunity the virus has to mutate and evade vaccines.

COVAX, the vaccines pillar of the ACT-Accelerator with 190 participating economies, is supporting the fair distribution of vaccines, and has secured 2 billion doses from five producers, with options on more than 1 billion more doses. A total of 44 bilateral deals were signed last year, and a further 12 signed this year. In this Special Focus, we present how COVAX is receiving and distributing an exceptional first round allocation of 1.2 million doses of the Pfizer-BioNTech vaccine in the first quarter of 2021 to prioritised participants, and 336 million doses of the AstraZeneca/Oxford vaccine.

Following a letter sent to the 190 COVAX participants, as of the deadline of 18 January, 72 expressions of interest were received for the exceptional first round allocation of the ultra-cold chain vaccine from Pfizer-BioNTech. Six regional review committees (composed of staff from WHO, UNICEF, Gavi and members of Gavi's Independent Review Committee) undertook a technical assessment of the applications. Due to the limited quantities of the first wave of vaccines, the list of participants was then narrowed down based on the following considerations; priority was given to COVAX participants that had not started COVID-19 vaccination (as of 29 January 2021), met all of the readiness criteria (including being able to manage the ultra-cold chain vaccine storage at -70°C) and, for self-financing participants, were within the Pfizer price point; this left a total of 51 participants. Participants were then grouped by WHO Region and advance market commitment/self-financing status to ensure all Regions/groups would be represented. Participants in each group were ranked by their 28-day mortality rate as a proxy for the risk of health care worker exposure (i.e. high COVID-19 mortality = high exposure). Eligible COVAX participants were selected from each group up to the 18 maximum that could be covered and supported by the 1.2 million doses. The doses will be delivered in the first quarter of 2021. For more details on the selection factors and countries chosen for the initial COVAX vaccine distribution see the interim distribution forecast. This document complements the recently published COVAX global supply forecast.

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[1] International Chamber of Commerce Research Foundation (2021) '*Study shows vaccine nationalism could cost rich countries US$4.5 trillion*' Retrieved from: https://iccwbo.org/media-wall/news-speeches/study-shows-vaccine-nationalism-could-cost-rich-countries-us4-5-trillion/

A further 336 million AstraZeneca/Oxford vaccine doses (240 million doses produced by the Serum Institute of India and 96 million doses produced by AstraZeneca) will be delivered in the first and second quarters of 2021. The combined population coverage of these initial doses will cover, on average, 3.3% of the total population of the 145 participants receiving doses. This is in line with the COVAX target to reach at least 3% population coverage in all countries, territories and areas in the first half of the year, enough to protect the most vulnerable groups such as health care workers.

COVAX is aiming to have 2 billion doses distributed, including at least 1.3 billion doses to 92 lower income economies, by the end of 2021, protecting at least 20% of each participating population (unless a participant has requested a lower percentage of doses). However, to achieve this, there needs to be prompt and equitable dose sharing, and support to close the funding gap of US$26 billion for the ACT-Accelerator this year, including US$7.8 billion for COVAX. This year the theme for World Health Day is 'health inequality.' The WHO Director-General has challenged Member States to ensure that by the time World Health Day arrives on 7 April, COVID-19 vaccines are being administered in every country. To support Member States in this endeavor, WHO has a COVID-19 vaccine country readiness and delivery portal, which includes guidance and tools, training (including two free online courses on OpenWHO.org), and answers to frequently asked questions.

Other resources

- List of participating economies
- Preparing countries for COVID-19 vaccine introduction
- WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination
- Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines
- COVID-19 vaccine introduction and deployment costing tool
- Diagnostics, therapeutics, vaccine readiness, and other health products for COVID-19
- Behavioural considerations for acceptance and uptake of COVID-19 vaccines
- COVAX announces additional deals to access promising COVID-19 vaccine candidates; plans global rollout starting Q1 2021
- COVAX publishes first interim distribution forecast
- International Labour Organization (2021) '*ILO Monitor: COVID-19 and the world of work. Seventh edition Updated estimates and analysis*' Retrieved from: https://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/documents/briefingnote/wcms_767028.pdf
- Gavi the Vaccine Alliance (2021) '*COVAX announces new agreement, plans for first deliveries*' Retrieved from: https://www.gavi.org/news/media-room/covax-announces-new-agreement-plans-first-deliveries

Special Focus: Update on SARS-CoV-2 variants of concern

WHO is closely monitoring the public health events associated with SARS-CoV-2 variants and continues to provide updates as new information becomes available (see: Disease Outbreak News and Weekly Epidemiological Updates). WHO is working with member states, external partners and experts to evaluate the available evidence around transmissibility, severity, and to assess the potential impacts on countermeasures including vaccines, diagnostics, therapeutics, and public health and social measures (PHSM). Here we provide an update on ongoing studies and the geographical distribution of three variants of concern (VOCs) as reported by countries, territories and areas (hereafter countries) as of 8 February 2021. Emerging evidence is summarized in Table 3 below.

The reported geographical extent of VOC detections has continued to increase as local and national surveillance activities are adapted and strengthened to include strategic sequencing to detect cases with SARS-CoV-2 variants. Since our last update, an additional 6 countries have reported cases of variants VOC202012/01, 3 additional countries reported variant 501Y.V2, and 5 additional countries reported variant P.1 (Table 3, Figures 3,5,7). In many countries, detections remain limited to imported cases only; however, VOCs are increasingly being identified among a subset of community-based samples with no direct links to travellers. Local transmission of VOC202012/01 has been reported in a growing number of countries in the European Region and in some areas of North America. Similarly, there is evidence to suggest that 501Y.V2 transmission is occurring in several countries in the African Region, with clusters of cases or ongoing local transmission suggested in countries in other regions.

On 2 February, the WHO Virus Evolution Working Group convened a meeting with GISAID, Nextstrain and Pango (three prominent systems for tracking the genomic evolution of SARS-CoV-2) and other experts to discuss mechanism for designating variants of concern and labeling these with unbiased, easy to pronounce names. While work is ongoing to establish standardized nomenclature for VOCs, WHO urges authorities, researchers, media and the general public to use non-stigmatizing nomenclature and language for describing VOCs. The group met again today to further discussions and propose a nomenclature.

The emergence of new variants has highlighted the importance of countries continuing to strengthen the PHSM (for more information, please see our technical guidance). As countries work to prepare for and rollout COVID-19 vaccines while continuously adapting other PHSM, it is essential to incorporate studies to investigate potential impacts of emerging VOCs on transmission, disease, and the effectiveness of countermeasures, and to continuously share findings with the global community.

Table 3: Summary of emerging information on key variants of concern, as of 8 February 2021

Nextstrain clade	**20I/501Y.V1**	**20H/501Y.V2†**	**20J/501Y.V3**
Pango lineage	B.1.1.7	B.1.351	B.1.1.28
GISAID clade	GR	GH	GR
Alternate names	VOC202012/01†	VOC202012/02	P.1†
First detected by	United Kingdom	South Africa	Brazil / Japan
First appearance	20 September 2020	Early August 2020	December 2020
Key mutations	• N501Y • D614G • 69/70 deletion • 144Y deletion • A570D • *E484K (detected only in 11 sequences)*[1]	• N501Y • D614G • E484K • K417N	• N501Y • D614G • E484K • K417N
Transmissibility*	Increased[(1)] (36%-75%)[(2)], increased secondary attack rate[(3)] (10% to 13%)	Increased [1.50 (95% CI: 1.20-2.13) times more transmissible than previously circulating variants][(4,6)]	Suggested to be increased
Severity*	Mixed evidence, potential increased mortality based on epidemiological observations[(1,5)]	No impact reported to date[(4,6)], no significant change in-hospital mortality[(17)]	Under investigation, no impact reported to date
Neutralization capacity*	Slight reduction but overall neutralizing titers still remained above the levels expected to confer protection[(7)]	Decreased, suggesting potential increased risk of reinfection[(4,8)]	Potential decrease, small number of reinfections reported[(18,19)]
Potential impacts on vaccines*	No significant impact on Moderna, Pfizer-BioNTech, and Oxford-AstraZeneca vaccines [(9-12)]	Moderna and Pfizer-BioNTech: Reduction in the neutralizing activity, but impact on protection against disease not known.[(9-12)] Novavax and Johnson & Johnson: Lower vaccine efficacy in South Africa compared to settings without the variant (press release data only). Moderate-severe disease were assessed. Serologic neutralization results pending.[(13,14)] Oxford/AstraZeneca: Minimal vaccine efficacy against mild-moderate COVID-19 disease, with wide confidence intervals (press release data only), impact on severe disease undetermined. Serologic neutralization substantially reduced compared with original strains, based on small number of samples analyzed.[(15,16)]	Potential reduction, under investigation
Potential impacts on diagnostics*	S gene target failure.[(15)] No impact on Ag RDTs observed[(20)]	None reported to date.	None reported to date.
Countries reporting cases (newly reported in last week)**	86 (6)	44 (3)	15 (5)

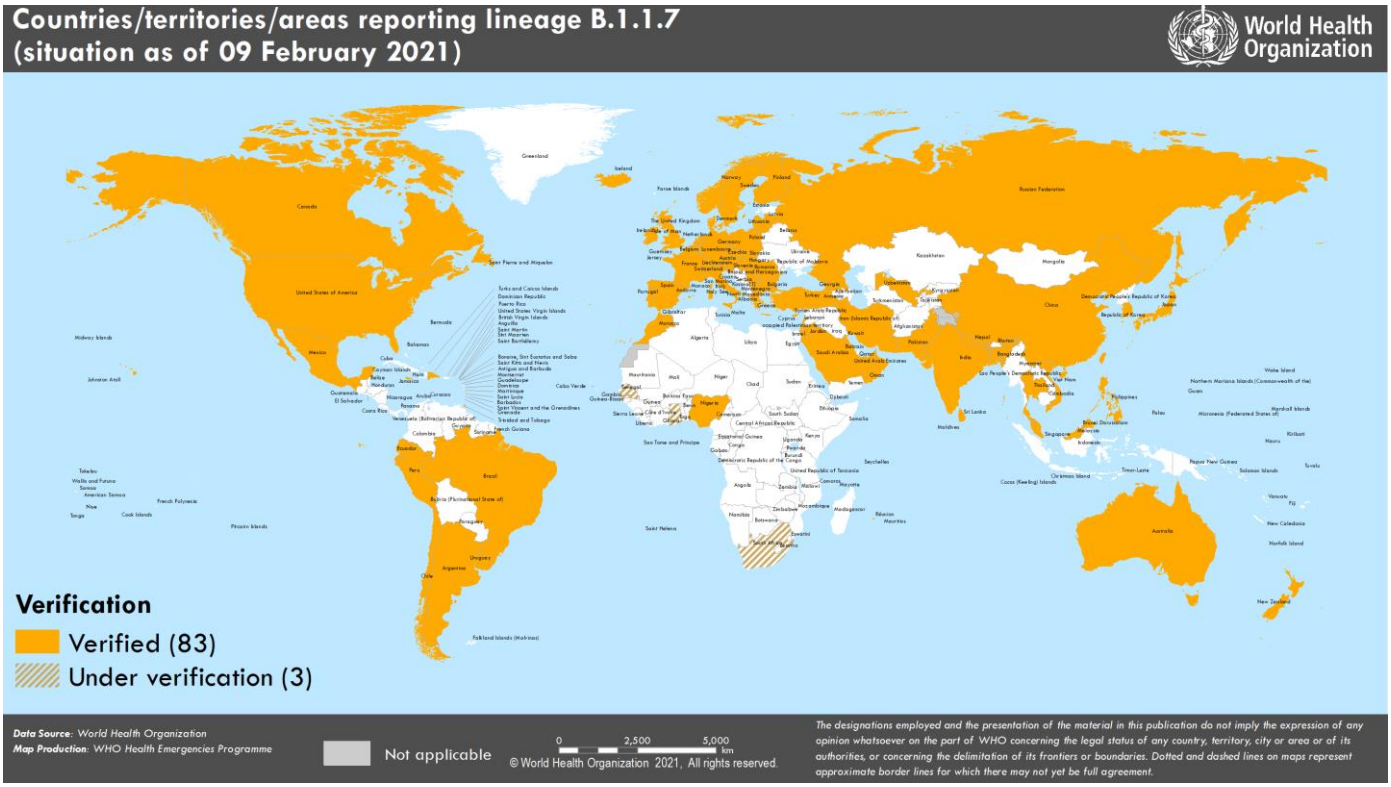
**Generalized findings as compared to non-VOC viruses. Based on emerging evidence from multiple countries, including non-peer-reviewed preprint articles and reports from public health authorities and researchers – all subject to ongoing investigation and continuous revision.*

***Includes official and unofficial reports of VOCs detections in countries among either travellers (imported cases only) or community samples (local transmission).*

†While work is ongoing to establish standardized nomenclature for key variants, these are the names by which WHO will refer to them in this publication.

Variant VOC 202012/01

Figure 3. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 9 February 2021



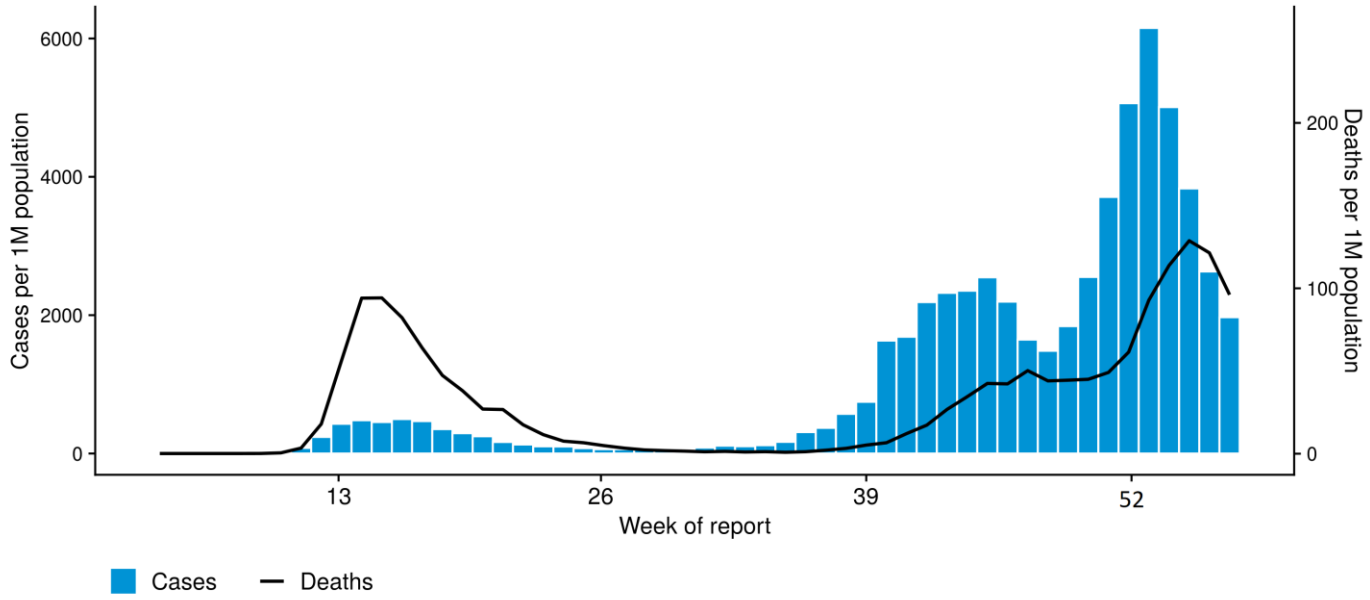
As mentioned in previous publications, the VOC 202012/01 variant has shown increased transmissibility, including increased secondary attack rates, and some evidence of increase in disease severity based on preliminary findings (1,3). More recently, results from a Phase 3 trial conducted by Novavax demonstrated an efficacy of 85.6% against this variant in the United Kingdom (14).

While previously mentioned preliminary studies showed post-vaccination sera with Pfizer-BioNTech and Moderna vaccines had limited to no significant change against the VOC202012/01 variant, recently, the E484K mutation in the spike protein has been detected in 11 sequences within the B.1.1.7 lineage in the United Kingdom (7,9-12,20,21). This mutation is also found in 501Y.V2 and P.1 variant, but the three variants have arisen separately and are not linked to each other (3). Mutation E484K has been identified as an "escape mutation," which has shown the ability to reduce the neutralising activity by monoclonal antibodies or convalescent sera. A preliminary study has shown further reduction in neutralization activity by vaccine elicited antibodies if E484K mutation is present alongside the VOC202012/01 variant (22). The detected E484K mutation within this lineage is currently limited to a small number of cases, and these are all preliminary findings which require further investigation involving larger sample sizes.

In the United Kingdom where this variant was initially identified, the proportion of cases with VOC202012/01 among tested samples has increased from 63% in week commencing 14 December, to 90% in week beginning 18 January 2021 (1).This high rate of detection of VOC202012/01 has persisted in recent weeks while the case and death counts are showing a declining trend (1). From 11 January through 7 February, a decreasing trend has been observed, following the implementation of stringent public health and social measures (Figure 4).

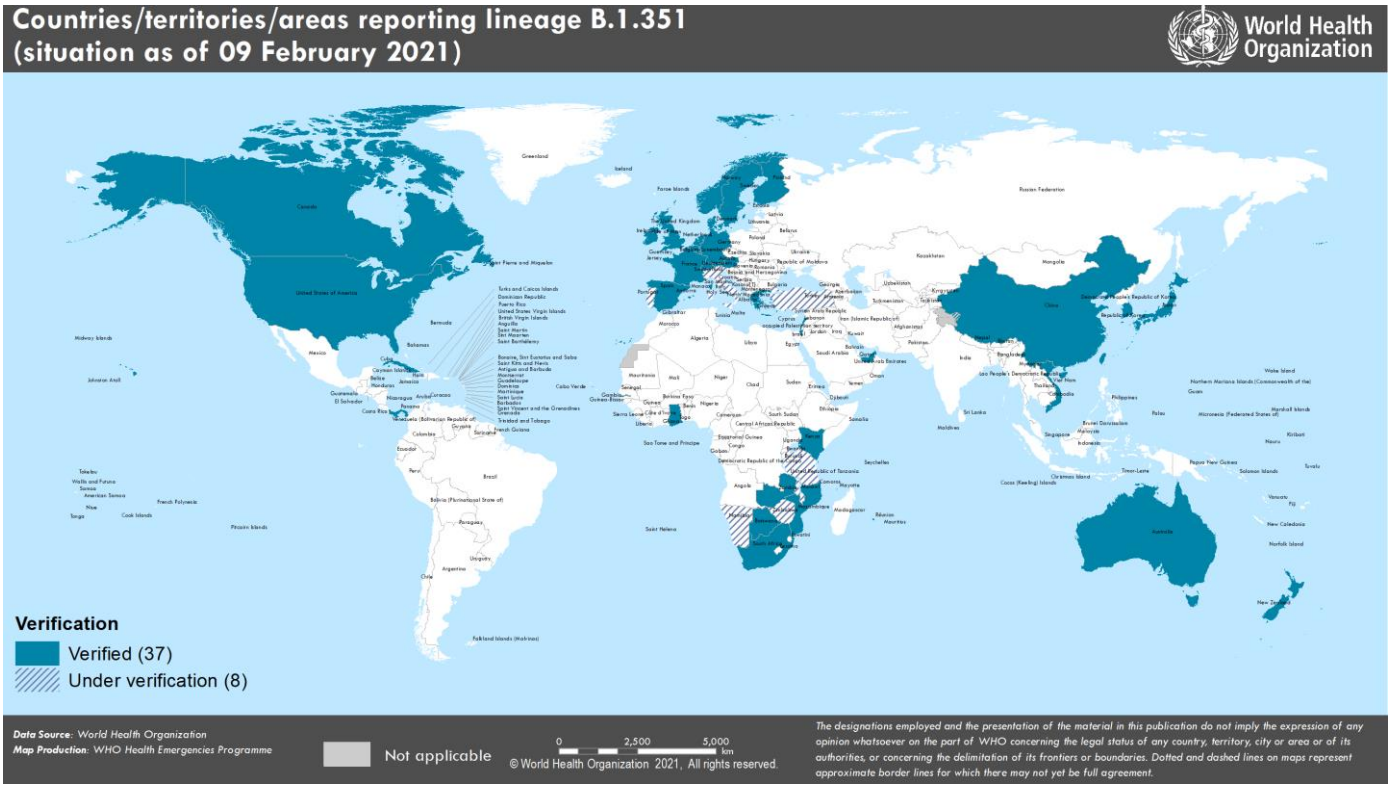
Similarly, in other European countries such as Ireland and Denmark, a marked increasing trend in the number of new COVID-19 cases was detected in late December 2020 as the countries were reporting local transmission of VOC202012/01. In Ireland, local authorities have reported the proportion of cases with VOC202012/01 among tested samples reached over 63% in the week starting on the 25 January and over 7% in Denmark the week starting the 11 January 2021. Implementation of more intensive public health and social measures at the end of December and beginning of January led to marked declines in COVID-19 case and death incidence in both countries.

Figure 4: Weekly COVID-19 cases per 1 million population in the United Kingdom, as of 7 February 2021



Variant 501Y.V2

Figure 5: Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 9 February 2021



As mentioned in previous publications, the 501Y.V2 variant has shown increased transmissibility (4,6), and laboratory-based studies noted a small reduction in the neutralizing activity against SARS-CoV-2 501Y.V2 variants in individuals vaccinated with the Moderna or Pfizer-BioNTech vaccines, although the neutralizing titers still remained above the levels expected to confer protection (4,8-12).

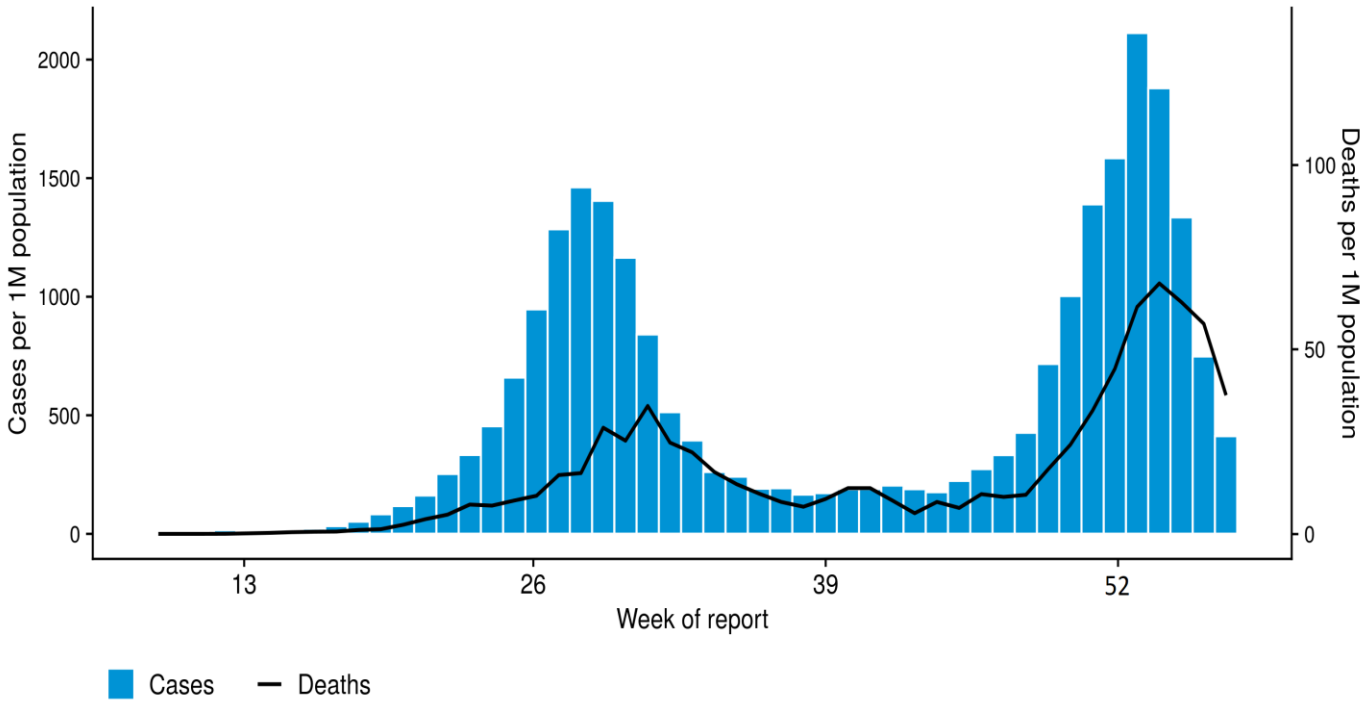
New preliminary results of Novavax, Johnson & Johnson, and Oxford/AstraZeneca vaccines have shown potential reduced effectiveness against 501Y.V2. Phase 3 trials of the Johnson& Johnson vaccine found 66% effectiveness in preventing moderate to severe infections, 28 days after vaccination; however, the efficacy varied across the three trial locations: the South Africa efficacy (57%) was lowest, and reflects 95% of the disease causing strains were the variant (13). Similar preliminary results from Novavax have shown 60%

efficacy against 501Y.V2 (14). In a small trial of approximately 2200 subjects in South Africa, a two-dose regimen of the Oxford/AstraZeneca vaccine resulted in a non-significant efficacy of 21.9% against mild-moderate COVID-19 which included a period when the majority of cases were caused by 501Y.V2; however, efficacy against severe COVID-19, hospitalizations and deaths was not studied (15,16). Serologic neutralization was substantially reduced compared with original strains, based on small number of samples analysed. Notably, primary analysis of data from Phase III trials in the context of viral settings without this variant have shown that the AstraZeneca/Oxford vaccine offers protection against severe disease, hospitalisation and death; therefore, it remains vitaldly important to determine the vaccine's effectiveness for preventing more severe illness caused by the 501Y.V2 variant (22).

It is important to note that these are preliminary findings which require further investigation including the need for assessment of vaccine performance against severe disease, assessment of neutralizing activity in a larger number of samples and for other vaccines against this strain, an evaluation of changes in neutralization on clinical efficacy and eventually, an estimate of the effectiveness of these vaccines on the current emerging variants. Manufacturers are concurrently exploring potential ways to improve protection against emerging VOCs, such as augmenting dosages and dosage intervals, introducing booster doses or booster vaccines, and beginning work to adapt vaccines and optimize production pipelines to allow for rapid strain changes, should this become necessary.

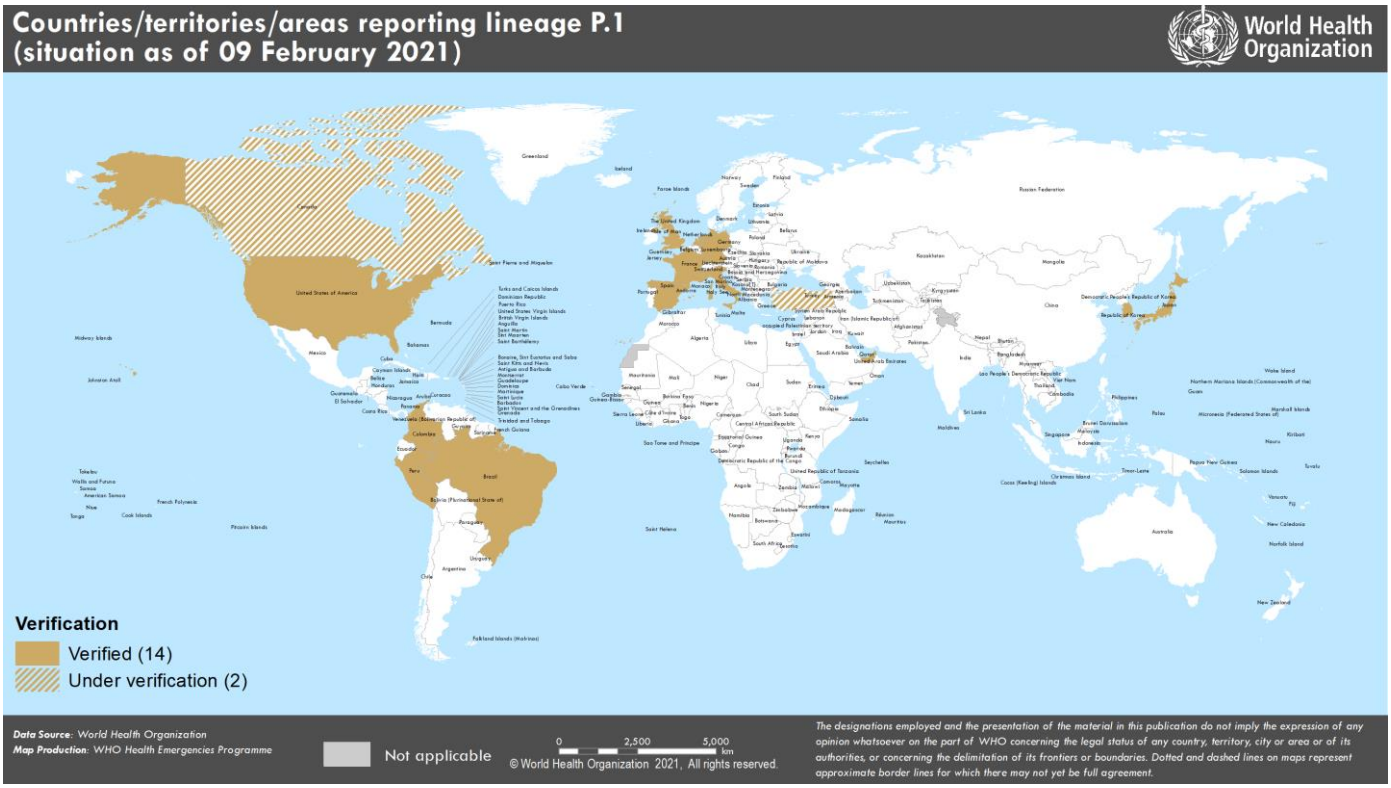
In South Africa, where this variant was initially identified, a progressive decreasing trend in case and death incidence (Figure 6), has been observed following the implementation of stringent PHSM. Here, studies have shown that the second wave (predominated by 501Y.V2 circulation) was associated with a higher incidence, faster increases in cases and hospitalizations, and increased mortality risk in weeks with high rates of hospital admission reflecting increased pressure on the health system. However, it was not associated with increased in-hospital mortality (17) – suggesting disease severity may be similar to previously circulating variants.

Figure 6. Weekly COVID-19 cases per 1 million population in South Africa, as of 7 February 2021



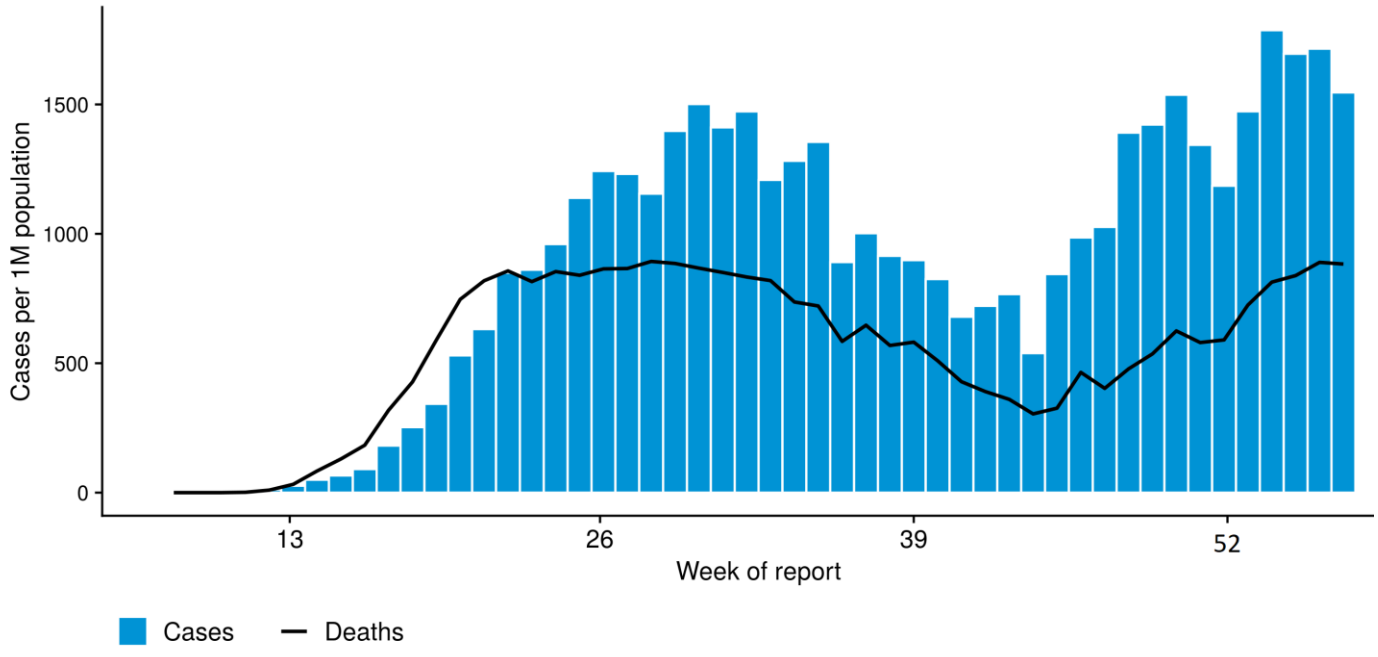
Variant P.1

Figure 7. Countries, territories and areas reporting SARS-CoV-2 P.1 variant as of 9 February 2021



In Brazil, where the P.1 variant was initially identified in addition to detection in a group of travellers from Brazil to Japan, a second wave of cases and corresponding deaths was observed with increasing trends beginning late November 2020, but has shown early signs of waning this week (Figure 8). In Manaus, Brazil, the proportion of cases with P.1 among tested samples have increased from 52% in December 2020 to 85% in January 2021 (23). Based on preliminary investigations, the mutations detected in P.1 variant could potentially reduce antibody neutralization (18); however, additional studies are required to assess if there are changes in transmissibility, severity or antibody neutralizing activity as a result of this new variants.

Figure 8. Weekly COVID-19 cases per 1 million population in Brazil, as of 7 February 2021



Resources

- COVAX Statement on New Variants of SARS-CoV-2
- SARS-CoV-2 genomic sequencing for public health goals: Interim guidance, 8 January 2021
- Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public healthQ&A on virus evolution

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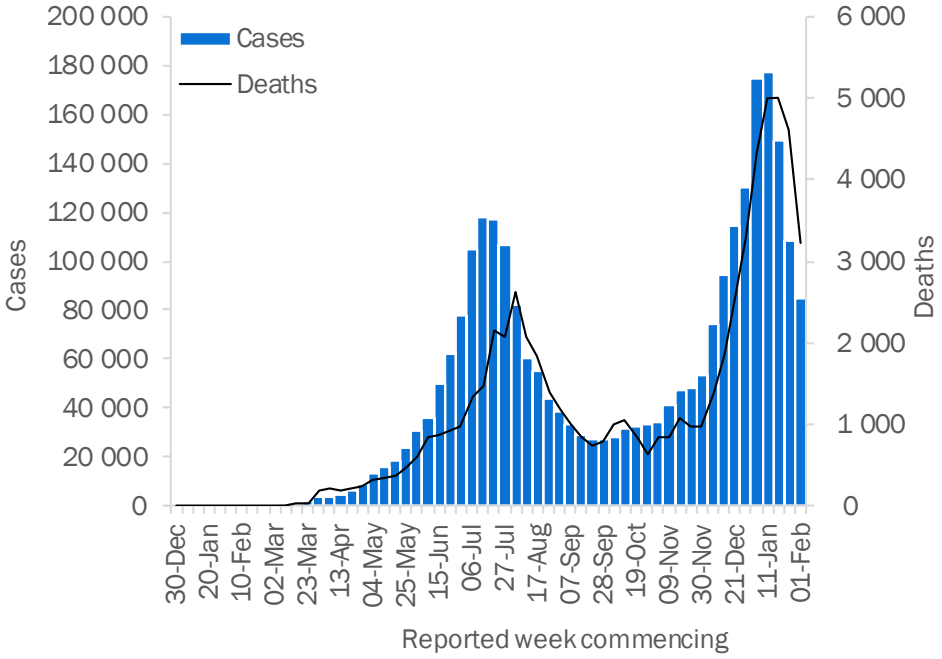
Situation by WHO Region

African Region

In the past week, the African Region reported over 84 800 cases and just over 3200 deaths, a 22% decrease in cases and a 30% decrease in deaths respectively compared to the previous week. This is the third consecutive week the region reported decreases in both new cases and deaths. The highest numbers of new cases were reported in South Africa (24 464 new cases; 41.2 new cases per 100 000 population; a 45% decrease), Nigeria (8685 new cases; 4.2 new cases per 100 000; a 13% decrease) and Zambia (8075 new cases; 43.9 new cases per 100 000; an 8% decrease).

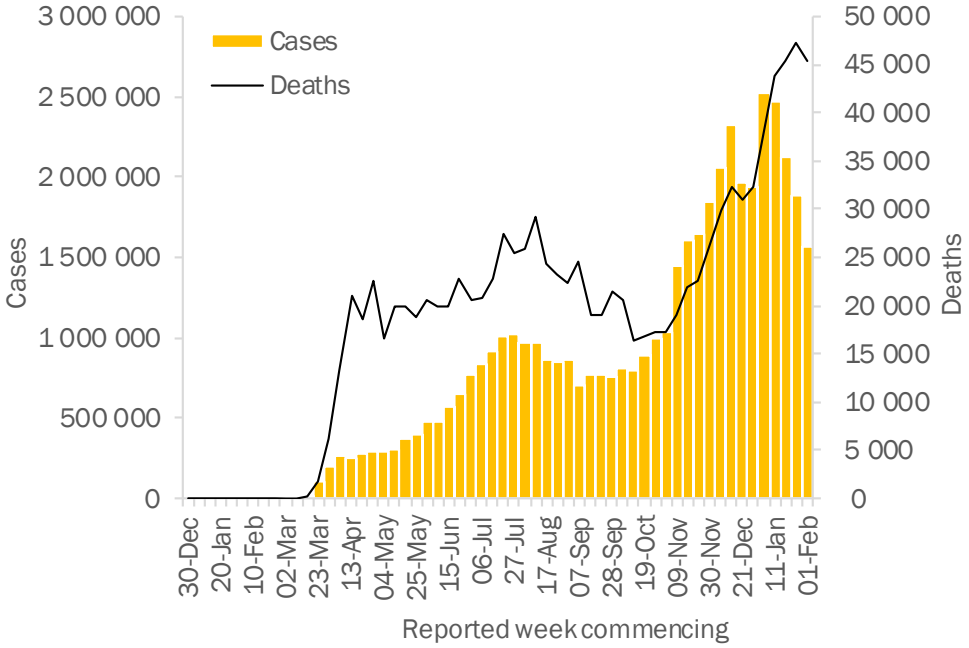
The countries reporting the highest number of new deaths in the past week were South Africa (2229 new deaths; 3.8 new deaths per 100 000; a 34% decrease), Malawi (150 new deaths; 0.8 new deaths per 100 000; a 31% decrease) and Zimbabwe (123 new deaths; 0.8 new deaths per 100 000; a 44% decrease).



Region of the Americas

Over 1.5 million new cases and over 45 000 new deaths were reported in the Region of the Americas this week, a decrease of 17% in cases and a decrease of 4% in deaths compared to the previous week. The highest numbers of new cases were reported from the United States of America (871 365 new cases; 263.3 new cases per 100 000 population; a 19% decrease), Brazil (328 652 new cases; 154.6 new cases per 100 000; a 10% decrease) and Mexico (70 978 new cases; 55.1 new cases per 100 000; a 35% decrease).

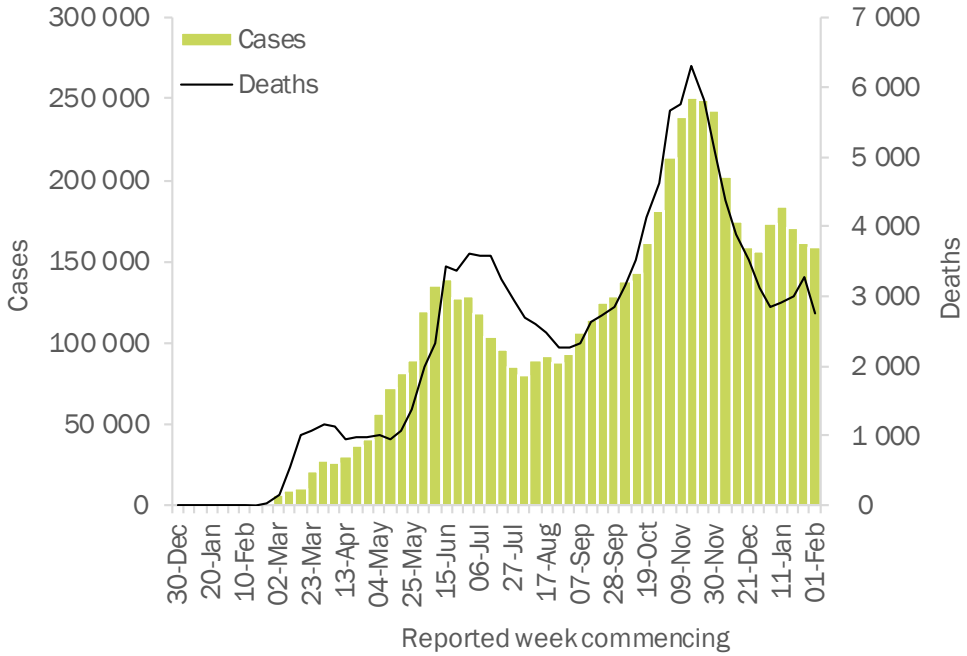
The highest numbers of deaths were reported from the same countries, the United States of America (22 562 new deaths; 6.8 new deaths per 100 000; a 0.2% increase), Mexico (7711 new deaths; 6.0 new deaths per 100 000; a 14% decrease) and Brazil (7368 new deaths; 3.5 new deaths per 100 000; a 1% decrease).



Eastern Mediterranean Region

In the past week, the Eastern Mediterranean Region reported over 158 600 new cases, a decrease of 2% compared to last week. The region reported 2761 new deaths, a 16% decrease. The three countries reporting the highest numbers of new cases continue to be the Islamic Republic of Iran (47 639 new cases, 56.7 new cases per 100 000 population, a 7% increase), United Arab Emirates (22 741 new cases, 229.9 new cases per 100 000, 13% decrease) and Lebanon (18 923 new cases, 277.2 new cases per 100 000, a 15% decrease).

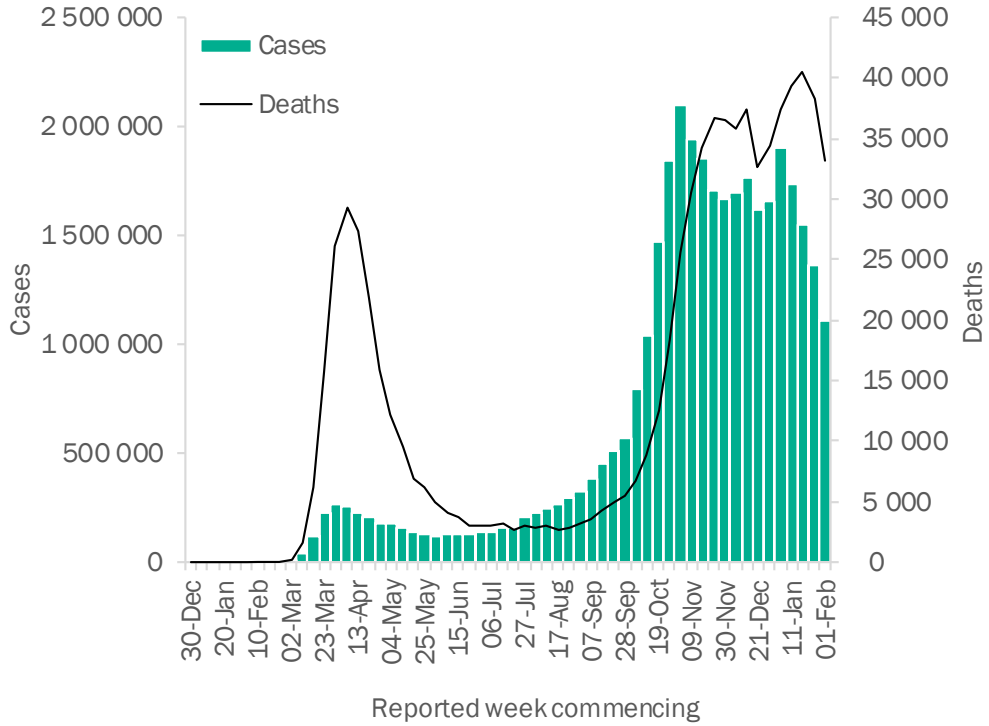
The highest numbers of new deaths continue to be reported in Lebanon (531 new deaths, 7.8 new death per 100 000, an 29% decrease), Islamic Republic of Iran (523 new deaths, 0.6 new death per 100 000 population, a 12% decrease), and Tunisia (482 new deaths, 4.1 new death per 100 000, a 8% decrease).



European Region

The European Region reported over 1.1 million new cases and over 33 000 new deaths, a decrease of 19% and 13% respectively when compared to the previous week. The three countries reporting the highest numbers of new cases were France (136 154 new cases; 208.6 new cases per 100 000, a 3% decrease), the United Kingdom (133 747 new cases, 197 new cases per 100 000, a 25% decrease), and the Russian Federation (116 842 new cases, 80.1 new cases per 100 000, an 11% decrease).

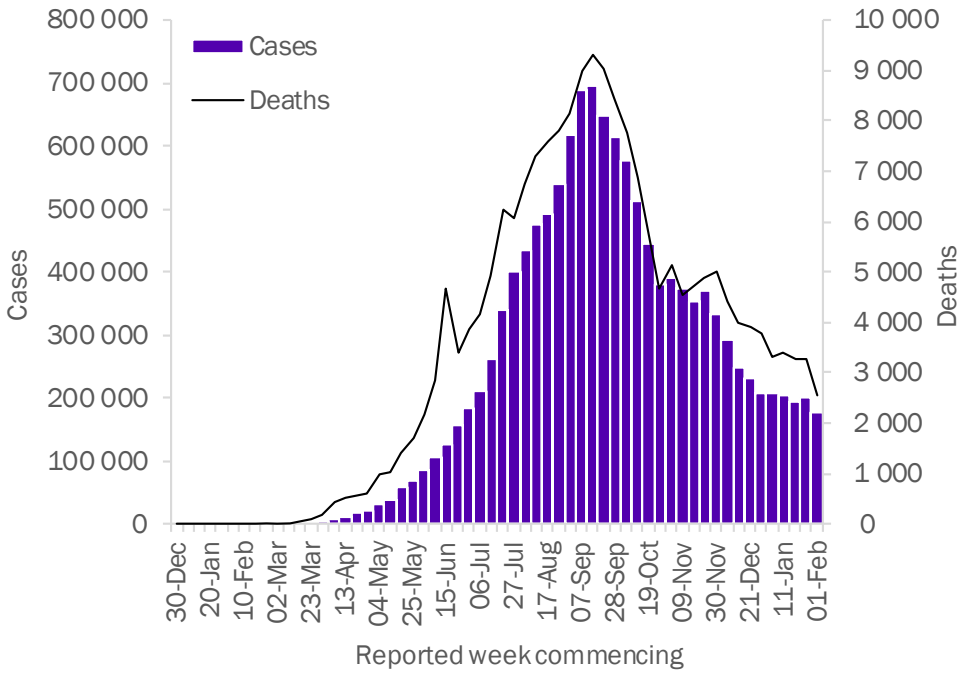
The highest numbers of deaths were reported from the United Kingdom (6521 new deaths; 9.6 new deaths per 100 000, a 21% decrease), Germany (4572 new deaths; 5.5 new deaths per 100 000, a 10% decrease) and the Russian Federation (3479 new deaths; 2.4 new deaths per 100 000, a 6% decrease).



South-East Asia Region

In the past week, the South-East Asia region reported over 177 000 new cases, a decrease of 12% compared to last week. The region reported 2560 new deaths, a 21% decrease. The three countries reporting the highest numbers of new cases and new deaths were Indonesia (80 697 new cases; 29.5 new cases per 100 000; a 9% decrease), India (80 180 new cases; 5.8 new cases per 100 000, a 12% decrease), and Sri Lanka (5283 new cases; 24.7 new cases per 100 000; a 7% decrease).

The three countries reporting the highest numbers of new deaths this week remain Indonesia (1665 new deaths; 0.6 new deaths per 100 000, a 19% decrease), India (722 new deaths; 0.1 new deaths per 100 000, a 23% decrease)

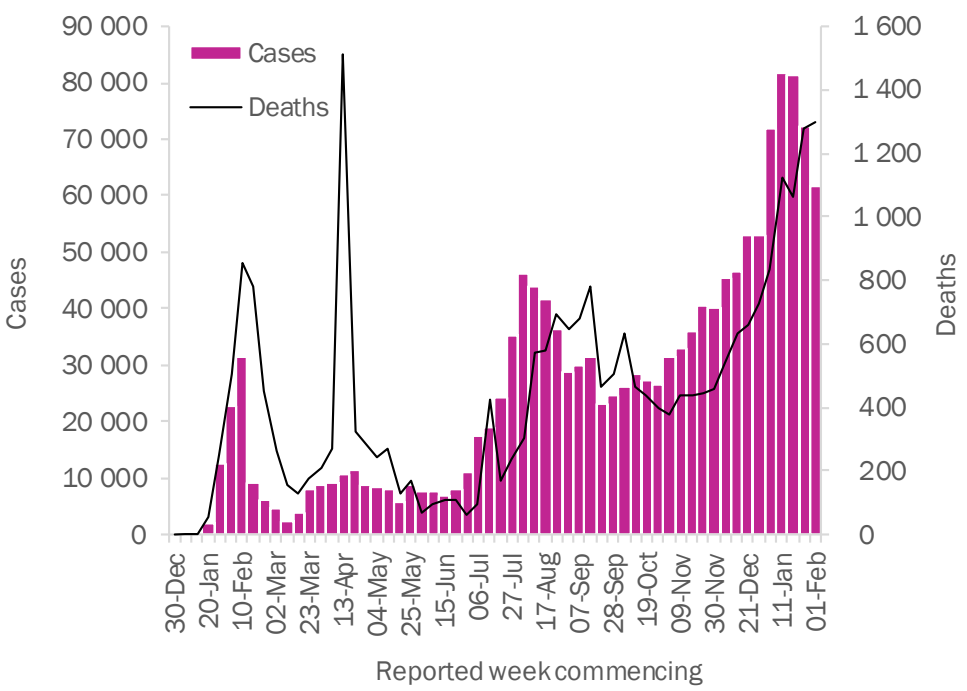


and Bangladesh (79 new deaths; <0.1 new deaths per 100 000; a 27% decrease).

Western Pacific Region

The Western Pacific Region reported over 61 700 new cases the past week, a 14% decrease compared to the previous week. The region reported 1297 new deaths, a 1% increase. The three countries reporting the highest numbers of new cases in the region this week were Malaysia (29 060 new cases; 89.8 new cases per 100 000, a 0.5% decrease), Japan (16 693 new cases; 13.2 new cases per 100 000, a 36% decrease), and the Philippines (12 005 new cases; 11 new cases per 100 000, a 1.4% increase).

The three countries reporting the highest numbers of new deaths this week were Japan (684 new deaths; 0.5 new deaths per 100 000, an 8% increase), the Philippines (441 new deaths; 0.4 new deaths per 100 000, an 8% decrease) and Malaysia (111 new deaths; 0.3 new deaths per 100 000, a 40%



increase).

Table 4. COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region, as of 7 February 2021**

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Africa	**84 842**	**2 655 316**	**236.7**	**3 232**	**65 736**	**5.9**	
South Africa	24 464	1 473 700	2 484.8	2 229	46 180	77.9	Community transmission
Nigeria	8 685	139 242	67.5	69	1 647	0.8	Community transmission
Zambia	8 075	61 427	334.1	94	839	4.6	Community transmission
Mozambique	6 407	44 112	141.1	88	451	1.4	Community transmission
Ghana	4 619	70 046	225.4	44	449	1.4	Community transmission
Ethiopia	4 432	141 453	123.0	54	2 145	1.9	Community transmission
Malawi	3 378	26 875	140.5	150	837	4.4	Community transmission
Senegal	2 276	28 489	170.1	54	675	4.0	Community transmission
Botswana	2 210	23 503	999.4	29	163	6.9	Community transmission
Algeria	1 730	108 852	248.2	23	2 911	6.6	Community transmission
Côte d'Ivoire	1 389	29 567	112.1	10	162	0.6	Community transmission
Rwanda	1 219	16 337	126.1	24	217	1.7	Community transmission
Zimbabwe	1 216	34 487	232.0	123	1 316	8.9	Community transmission
Lesotho	1 102	9 380	437.9	23	183	8.5	Community transmission
Namibia	1 017	34 845	1 371.4	21	371	14.6	Community transmission
Kenya	1 015	101 690	189.1	21	1 776	3.3	Community transmission
Democratic Republic of the Congo	881	23 484	26.2	8	679	0.8	Community transmission
Gabon	709	11 457	514.8	3	71	3.2	Community transmission
Cameroon	696	30 313	114.2	12	474	1.8	Community transmission
Burkina Faso	647	11 227	53.7	14	134	0.6	Community transmission
Eswatini	515	16 181	1 394.7	42	604	52.1	Community transmission
Benin	407	4 193	34.6	7	55	0.5	Community transmission
Cabo Verde	399	14 380	2 586.4	2	135	24.3	Community transmission
Togo	395	5 436	65.7	2	79	1.0	Community transmission
South Sudan	394	4 355	38.9	1	65	0.6	Community transmission
Comoros	368	3 086	354.9	18	108	12.4	Community transmission
Madagascar	322	19 065	68.8	2	281	1.0	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Seychelles	318	1 504	1 529.3	3	6	6.1	Clusters of cases
Mauritania	317	16 777	360.8	7	425	9.1	Community transmission
Uganda	288	39 821	87.1	3	327	0.7	Community transmission
Angola	280	20 062	61.0	11	475	1.4	Community transmission
Sierra Leone	231	3 759	47.1	0	79	1.0	Community transmission
Eritrea	191	2 326	65.6	0	7	0.2	Community transmission
Guinea	190	14 665	111.7	2	84	0.6	Community transmission
Congo	173	8 060	146.1	5	122	2.2	Community transmission
Guinea-Bissau	149	2 772	140.9	1	46	2.3	Community transmission
Gambia	147	4 237	175.3	6	134	5.5	Community transmission
Chad	126	3 473	21.1	7	125	0.8	Community transmission
Burundi	91	1 723	14.5	1	3	0.0	Community transmission
Mali	91	8 160	40.3	8	338	1.7	Community transmission
Sao Tome and Principe	83	1 339	611.0	1	18	8.2	Community transmission
Niger	82	4 598	19.0	6	165	0.7	Community transmission
Equatorial Guinea	62	5 578	397.6	0	86	6.1	Community transmission
Liberia	17	1 956	38.7	0	84	1.7	Community transmission
Mauritius	16	584	45.9	0	10	0.8	Sporadic cases
Central African Republic	8	4 989	103.3	0	63	1.3	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territories[iii]							
Mayotte	2 524	10 755	3 942.2	3	64	23.5	Clusters of cases
Réunion	491	10 487	1 171.3	1	47	5.2	Clusters of cases
Americas	**1 568 167**	**46 913 218**	**4 586.9**	**45 350**	**1 092 521**	**106.8**	
United States of America	871 365	26 547 977	8 020.5	22 562	455 735	137.7	Community transmission
Brazil	328 652	9 447 165	4 444.5	7 368	230 034	108.2	Community transmission
Mexico	70 978	1 912 871	1 483.6	7 711	164 290	127.4	Community transmission
Colombia	65 027	2 142 660	4 211.0	2 119	55 403	108.9	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Argentina	54 647	1 970 009	4 358.8	1 210	48 985	108.4	Community transmission
Peru	47 170	1 173 045	3 557.7	1 247	41 933	127.2	Community transmission
Canada	26 963	797 756	2 113.7	808	20 609	54.6	Community transmission
Chile	25 182	748 082	3 913.3	556	18 895	98.8	Community transmission
Bolivia (Plurinational State of)	12 518	225 910	1 935.3	461	10 687	91.6	Community transmission
Dominican Republic	9 595	222 148	2 047.8	155	2 801	25.8	Community transmission
Ecuador	7 336	257 115	1 457.3	153	15 004	85.0	Community transmission
Panama	7 234	325 487	7 543.6	205	5 426	125.8	Community transmission
Honduras	7 143	153 253	1 547.3	119	3 694	37.3	Community transmission
Cuba	6 337	32 011	282.6	20	233	2.1	Community transmission
Paraguay	5 004	136 890	1 919.2	98	2 791	39.1	Community transmission
Guatemala	3 819	162 937	909.5	236	5 854	32.7	Community transmission
Uruguay	3 774	44 303	1 275.4	53	478	13.8	Community transmission
Venezuela (Bolivarian Republic of)	3 455	129 231	454.5	46	1 223	4.3	Community transmission
Costa Rica	3 162	196 438	3 856.2	68	2 672	52.5	Community transmission
El Salvador	2 248	56 237	867.0	59	1 673	25.8	Community transmission
Jamaica	1 314	16 841	568.7	9	357	12.1	Community transmission
Saint Lucia	618	1 813	987.3	5	18	9.8	Sporadic cases
Guyana	359	7 887	1 002.7	4	179	22.8	Clusters of cases
Saint Vincent and the Grenadines	274	1 170	1 054.6	1	3	2.7	Clusters of cases
Haiti	273	11 806	103.5	1	246	2.2	Community transmission
Suriname	255	8 619	1 469.2	4	158	26.9	Community transmission
Barbados	178	1 676	583.2	6	18	6.3	Community transmission
Belize	136	12 013	3 021.2	5	306	77.0	Community transmission
Bahamas	82	8 256	2 099.5	0	176	44.8	Clusters of cases
Trinidad and Tobago	74	7 607	543.6	1	135	9.6	Community transmission
Antigua and Barbuda	59	277	282.9	0	7	7.1	Sporadic cases
Nicaragua	35	5 027	75.9	1	170	2.6	Community transmission
Dominica	4	121	168.1	0	0	0.0	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Saint Kitts and Nevis	3	40	75.2	0	0	0.0	Sporadic cases
Grenada	0	148	131.5	0	1	0.9	Sporadic cases
Territories[iii]							
Puerto Rico	1 949	95 355	3 333.1	49	1 872	65.4	Community transmission
Aruba	276	7 134	6 681.9	3	61	57.1	Community transmission
French Guiana	213	16 296	5 456.0	3	79	26.4	Community transmission
Turks and Caicos Islands	195	1 654	4 271.9	1	9	23.2	Clusters of cases
Sint Maarten	89	1 911	4 456.4	0	27	63.0	Community transmission
Martinique	72	6 442	1 716.7	1	45	12.0	Community transmission
United States Virgin Islands	51	2 449	2 345.2	0	24	23.0	Community transmission
Curaçao	23	4 597	2 801.5	1	21	12.8	Community transmission
Cayman Islands	15	405	616.3	0	2	3.0	Sporadic cases
Bonaire	4	366	1 749.9	0	3	14.3	Community transmission
Falkland Islands (Malvinas)	4	44	1 263.3	0	0	0.0	No cases
Montserrat	2	15	300.1	0	1	20.0	No cases
Bermuda	1	692	1 111.2	0	12	19.3	Sporadic cases
Anguilla	0	17	113.3	0	0	0.0	Sporadic cases
British Virgin Islands	0	141	466.3	0	1	3.3	Clusters of cases
Guadeloupe	0	9 156	2 288.3	1	158	39.5	Community transmission
Saba	0	6	310.4	0	0	0.0	Sporadic cases
Saint Barthélemy	0	379	3 834.1	0	0	0.0	Sporadic cases
Saint Martin	0	1 289	3 334.3	0	12	31.0	Community transmission
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	Clusters of cases
Sint Eustatius	0	20	637.1	0	0	0.0	Sporadic cases
Eastern Mediterranean	**158 625**	**5 828 565**	**797.5**	**2 761**	**136 950**	**18.7**	
Iran (Islamic Republic of)	47 639	1 459 370	1 737.5	523	58 412	69.5	Community transmission
United Arab Emirates	22 741	323 402	3 269.9	76	914	9.2	Community transmission
Lebanon	18 923	317 836	4 656.6	531	3 562	52.2	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Pakistan	9 914	553 128	250.4	291	11 914	5.4	Community transmission
Tunisia	8 708	216 176	1 829.1	482	7 162	60.6	Community transmission
Iraq	8 494	627 416	1 559.9	70	13 111	32.6	Community transmission
Jordan	8 181	333 855	3 272.1	65	4 369	42.8	Community transmission
Kuwait	5 414	170 036	3 981.6	5	964	22.6	Community transmission
Libya	5 244	122 894	1 788.5	94	1 936	28.2	Community transmission
Morocco	4 275	474 966	1 286.8	122	8 381	22.7	Clusters of cases
Bahrain	4 087	106 713	6 271.4	7	379	22.3	Clusters of cases
Egypt	3 688	169 106	165.2	341	9 604	9.4	Clusters of cases
Qatar	2 706	153 690	5 334.5	2	250	8.7	Community transmission
Saudi Arabia	2 148	369 961	1 062.7	25	6 397	18.4	Sporadic cases
Oman	1 313	135 041	2 644.4	5	1 532	30.0	Community transmission
Syrian Arab Republic	410	14 408	82.3	31	947	5.4	Community transmission
Sudan	316	29 765	67.9	28	1 835	4.2	Community transmission
Afghanistan	312	55 335	142.1	10	2 410	6.2	Clusters of cases
Somalia	70	4 854	30.5	4	134	0.8	Community transmission
Djibouti	10	5 941	601.3	1	63	6.4	Clusters of cases
Yemen	7	2 131	7.1	0	616	2.1	Community transmission
Territories[iii]							
occupied Palestinian territory	4 025	182 541	3 578.2	48	2 058	40.3	Community transmission
Europe	**1 102 953**	**35 515 952**	**3 805.0**	**33 169**	**781 242**	**83.7**	
France	136 154	3 262 505	4 998.2	2 923	78 389	120.1	Community transmission
The United Kingdom	133 747	3 929 839	5 788.9	6 521	112 092	165.1	Community transmission
Russian Federation	116 842	3 967 281	2 718.5	3 479	76 661	52.5	Clusters of cases
Italy	83 315	2 625 098	4 341.7	2 724	91 003	150.5	Clusters of cases
Spain	82 192	2 913 425	6 231.3	1 202	60 802	130.0	Community transmission
Germany	67 647	2 284 010	2 726.1	4 572	61 517	73.4	Community transmission
Turkey	53 885	2 524 786	2 993.6	820	26 685	31.6	Community transmission
Portugal	50 888	761 906	7 472.1	1 775	13 954	136.8	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Czechia	50 201	1 034 975	9 664.6	927	17 235	160.9	Community transmission
Israel	39 414	677 315	7 825.2	285	5 014	57.9	Community transmission
Poland	36 870	1 550 255	4 096.2	1 907	39 087	103.3	Community transmission
Netherlands	27 226	1 001 797	5 846.5	400	14 355	83.8	Community transmission
Ukraine	25 394	1 244 849	2 846.4	890	23 597	54.0	Community transmission
Sweden	16 892	588 062	5 822.8	69	12 115	120.0	Community transmission
Romania	16 425	743 343	3 864.0	545	18 809	97.8	Community transmission
Belgium	14 384	725 610	6 260.9	274	21 389	184.6	Community transmission
Slovakia	13 413	263 326	4 823.1	557	5 199	95.2	Clusters of cases
Serbia	12 455	406 352	5 835.2	112	4 112	59.0	Community transmission
Belarus	10 389	256 959	2 719.3	65	1 773	18.8	Community transmission
Austria	9 415	419 307	4 655.7	248	7 884	87.5	Community transmission
Hungary	8 909	376 495	3 897.3	566	13 090	135.5	Community transmission
Kazakhstan	8 584	244 428	1 301.8	59	3 185	17.0	Clusters of cases
Ireland	7 245	202 548	4 102.0	382	3 674	74.4	Community transmission
Slovenia	7 169	173 696	8 355.0	62	3 891	187.2	Clusters of cases
Switzerland	7 134	529 285	6 115.6	91	8 822	101.9	Community transmission
Albania	6 961	84 212	2 926.3	77	1 446	50.2	Clusters of cases
Greece	6 740	163 213	1 565.9	172	5 951	57.1	Community transmission
Latvia	5 612	71 320	3 781.2	147	1 327	70.4	Community transmission
Bulgaria	4 934	223 552	3 217.3	283	9 311	134.0	Clusters of cases
Republic of Moldova	4 730	164 243	4 071.5	96	3 530	87.5	Community transmission
Lithuania	4 231	186 770	6 860.8	134	2 937	107.9	Community transmission
Georgia	3 913	262 024	6 568.4	105	3 283	82.3	Community transmission
Estonia	3 720	47 928	3 613.0	42	461	34.8	Clusters of cases
Montenegro	3 229	65 227	10 385.4	31	836	133.1	Clusters of cases
Denmark	3 091	201 186	3 473.4	109	2 215	38.2	Community transmission
Croatia	2 976	235 402	5 734.1	142	5 169	125.9	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
North Macedonia	2 081	94 599	4 540.7	68	2 916	140.0	Community transmission
Finland	2 023	46 894	846.4	21	692	12.5	Community transmission
Norway	1 908	64 483	1 189.5	19	582	10.7	Clusters of cases
Bosnia and Herzegovina	1 813	123 704	3 770.5	95	4 791	146.0	Community transmission
Luxembourg	1 142	51 689	8 257.3	13	592	94.6	Community transmission
Armenia	1 062	168 088	5 672.4	37	3 117	105.2	Community transmission
Azerbaijan	956	231 022	2 278.5	30	3 156	31.1	Clusters of cases
Cyprus	874	31 644	2 620.9	14	211	17.5	Clusters of cases
Malta	773	18 676	4 229.7	15	282	63.9	Clusters of cases
Kyrgyzstan	542	85 071	1 303.9	14	1 426	21.9	Clusters of cases
Uzbekistan	387	79 098	236.3	0	621	1.9	Clusters of cases
Andorra	321	10 206	13 209.1	4	105	135.9	Community transmission
Monaco	172	1 647	4 196.8	8	20	51.0	Sporadic cases
San Marino	111	3 136	9 240.4	2	69	203.3	Community transmission
Liechtenstein	23	2 588	6 786.1	0	46	120.6	Sporadic cases
Iceland	19	6 021	1 764.4	0	29	8.5	Community transmission
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories[iii]							
Kosovo	2 075	61 966	3 330.8	28	1 510	81.2	Community transmission
Guernsey	240	689	1 090.3	0	13	20.6	Community transmission
Gibraltar	74	4 170	12 377.2	7	80	237.5	Clusters of cases
Jersey	30	3 173	2 916.4	1	67	61.6	Community transmission
Faroe Islands	1	655	1 340.4	0	1	2.0	Sporadic cases
Greenland	0	30	52.8	0	0	0.0	No cases
Isle of Man	0	434	510.4	0	25	29.4	No cases
South-East Asia	**177 074**	**13 033 797**	**644.8**	**2 560**	**200 267**	**9.9**	
Indonesia	80 697	1 147 010	419.3	1 665	31 393	11.5	Community transmission
India	80 180	10 826 363	784.5	722	154 996	11.2	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Sri Lanka	5 283	68 576	320.3	38	351	1.6	Clusters of cases
Thailand	4 589	23 371	33.5	2	79	0.1	Clusters of cases
Bangladesh	3 000	537 770	326.5	79	8 190	5.0	Community transmission
Myanmar	1 440	141 304	259.7	43	3 168	5.8	Clusters of cases
Nepal	952	271 806	932.9	8	2 035	7.0	Clusters of cases
Maldives	920	16 656	3 081.3	3	54	10.0	Clusters of cases
Timor-Leste	10	80	6.1	0	0	0.0	Sporadic cases
Bhutan	3	861	111.6	0	1	0.1	Clusters of cases
Western Pacific	**61 765**	**1 481 789**	**75.4**	**1 297**	**25 885**	**1.3**	
Malaysia	29 060	238 721	737.6	111	857	2.6	Clusters of cases
Japan	16 693	403 435	319.0	684	6 338	5.0	Clusters of cases
Philippines	12 005	535 521	488.7	441	11 110	10.1	Community transmission
Republic of Korea	2 694	80 896	157.8	51	1 471	2.9	Clusters of cases
China	395	101 272	6.9	8	4 831	0.3	Clusters of cases
Mongolia	247	1 989	60.7	0	2	0.1	Clusters of cases
Viet Nam	204	1 985	2.0	0	35	0.0	Clusters of cases
Singapore	168	59 675	1 020.0	0	29	0.5	Sporadic cases
Papua New Guinea	43	894	10.0	0	9	0.1	Community transmission
Australia	42	28 848	113.1	0	909	3.6	Sporadic cases
New Zealand	17	1 964	40.7	0	25	0.5	Clusters of cases
Cambodia	9	474	2.8	0	0	0.0	Sporadic cases
Brunei Darussalam	1	181	41.4	0	3	0.7	Sporadic cases
Fiji	1	56	6.2	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	1	45	0.6	0	0	0.0	Sporadic cases
Solomon Islands	0	17	2.5	0	0	0.0	No cases
Territories[iii]							
French Polynesia	125	18 185	6 473.6	2	133	47.3	Sporadic cases
Guam	57	7 436	4 405.9	0	129	76.4	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
New Caledonia	2	49	17.2	0	0	0.0	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	1	133	231.1	0	2	3.5	Pending
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Samoa	0	3	1.5	0	0	0.0	No cases
Vanuatu	0	1	0.3	0	0	0.0	No cases
Wallis and Futuna	0	5	44.5	0	0	0.0	Sporadic cases
Global	**3 153 426**	**105 429 382**	**1 352.5**	**88 369**	**2 302 614**	**29.5**	

Key Weekly Updates

WHO Director-General Dr Tedros' remarks

- *Do not rush to reopen*

Now as we begin to roll out vaccines, we must remember that vaccines alone will not control this pandemic. It is vital that governments do not rush to re-open, and that they continue public health measures to prevent the spread of the virus.
Opening remarks at the Member States briefing on COVID-19 - 4 February 2021

- *Sharing vaccines to protect the population*

Once countries with vaccines have vaccinated their own health workers and older people, the best way to protect the rest of their own population is to share vaccines so other countries can do the same. That's because the longer it takes to vaccinate those most at risk everywhere, the more opportunity we give the virus to mutate and evade vaccines.

- *Scaling-up the manufacturing process*

We need a massive scale-up in production. Manufacturers can do more: having received substantial public funding, we encourage all manufacturers to share their data and technology to ensure global equitable access to vaccines.

- *Sharing dossiers with WHO for emergency listing*

We call on companies to share their dossiers with WHO faster and more fully than they have been doing, so we can review them for emergency use listing.
Opening remarks at the media briefing on COVID-19 – 5 February 2021

Health for All film festival
WHO receives nearly 1200 entries for the second edition of Health for All Film Festival

WHO and FIFA partnership
FIFA and WHO #ACTogether to tackle COVID-19

WHO SCORE Global Report
WHO SCORE Global Report highlights urgent need for better data to strengthen pandemic response and improve health outcomes
Score dashboard

COVID-19 and Non-Communicable Diseases
Michael R. Bloomberg and Dr Tedros Adhanom Ghebreyesus call for global focus on noncommunicable diseases to save lives from COVID-19

Publications
Background document on the mRNA-1273 vaccine (Moderna) against COVID-19
COVID-19: Occupational health and safety for health workers
Contact tracing in the context of COVID-19
Interim position paper: Considerations regarding proof of COVID-19 vaccination for international travellers
WHO publishes public health research agenda for managing infodemics
Course 6: Clinical management of patients with COVID-19 - Rehabilitation of patients with COVID-19

Technical guidance and other resources

- Technical guidance
- WHO Coronavirus Disease (COVID-19) Dashboard
- Weekly COVID-19 Operational Updates
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- Online courses on COVID-19 in official UN languages and in additional national languages
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Updates from WHO regions

- African Region
- Eastern Mediterranean Region
- European Region
- Region of the Americas
- South-East Asia Region
- Western Pacific Region

Recommendations and advice for the public

- Protect yourself
- Questions and answers
- Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities

Data, table and figure notes

Data presented are based on official laboratory-confirmed COVID-19 case and deaths reported to WHO by country/territories/areas, largely based upon WHO case definitions and surveillance guidance. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change, and caution must be taken when interpreting these data as several factors influence the counts presented, with variable underestimation of true case and death incidence, and variable delays to reflecting these data at global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/areas. A small number of countries/territories/areas report combined probable and laboratory-confirmed cases. Differences are to be expected between information products published by WHO, national public health authorities, and other sources. Due to public health authorities conducting data reconciliation exercises which remove large numbers of cases or deaths from their total counts, negative numbers may be displayed in the new cases/deaths columns as appropriate. When additional details become available that allow the subtractions to be suitably apportioned to previous days, graphics will be updated accordingly. A record of historic data adjustment made is available upon request by emailing epi-data-support@who.int. Please specify the country(ies) of interest, time period(s), and purpose of the request/intended usage. Prior situation reports will not be edited; see covid19.who.int for the most up-to-date data. Global totals include 745 cases and 13 deaths reported from international conveyances.

The designations employed, and the presentation of these materials do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory or area or of its

authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Countries, territories and areas are arranged under the administering WHO region. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). In the map, number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes.

[i] Excludes countries, territories, and areas that have never reported a confirmed COVID-19 case.

[ii] Transmission classification is based on a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be revised as new information becomes available. Differing degrees of transmission may be present within countries/territories/areas. For further information, please see: Considerations for implementing and adjusting public health and social measures in the context of COVID-19:

- No (active) cases: No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust surveillance system. This implies a near-zero risk of infection for the general population.
- Imported / Sporadic cases: Cases detected in the past 14 days are all imported, sporadic (e.g., laboratory acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.
- Clusters of cases: Cases detected in the past 14 days are predominantly limited to well-defined clusters that are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.
- Community transmission: Which encompasses a range of levels from low to very high incidence, as described below and informed by a series of indicators described in the aforementioned guidance. As these subcategorization are not currently collated at the global level, but rather intended for use by national and sub-national public health authorities for local decision-making, community transmission has not been disaggregated in this information product.
    - CT1: Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
    - CT2: Moderate incidence of locally acquired, widely dispersed cases detected in the past 14 days; transmission less focused in certain population sub-groups. Moderate risk of infection for the general population.
    - CT3: High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population sub-groups. High risk of infection for the general population.
    - CT4: Very high incidence of locally acquired, widely dispersed cases in the past 14 days. Very high risk of infection for the general population.
- Pending: transmission classification has not been reported to WHO.

[iii] "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status.

Weekly Operational Update on COVID-19

8 February 2021

Confirmed cases[a]
105 394 301

Confirmed deaths
2 302 302

Indonesia: WHO helps assess and improve COVID-19 pandemic preparedness and response capacity

WHO, in collaboration with University of Hasanuddin and National Board for Disaster Management (BNPB), supported the Ministry of Health to conduct field assessments in 211 locations across Indonesia from 4 September to 9 October 2020. The project aimed to assess COVID-19 preparedness in fifteen provinces based on the status of their pandemic risk.

The assessment covered provincial command centres, provincial health offices, port health offices, hospitals, laboratories, district health offices, public health centres, and community health centres. All assessed provinces had a functioning command and control structure for pandemic management.

Key areas identified of improvement included: icase reporting and analysis for pandemic severity, budget allocation for response in points of entry, personal protective equipment stockpiling, and exit screening of passengers. The assessment also identified potential gaps in ICU and other health systems capacities in the event of rising COVID-19 cases.

The results of the field assessment will be used to inform key stakeholders of the strengths and gaps in each province in responding to the ongoing COVID-19 pandemic as well as supporting the country to prepare for future outbreaks.

For further information on this assessment and next steps, click here.

Key Figures

WHO-led UN Crisis-Management Team coordinating **23** UN entities across nine areas of work

148 GOARN deployments conducted to support COVID-19 pandemic response

19 948 965 respirators shipped globally

198 343 426 medical masks shipped globally

8 540 231 face shields shipped globally

6 713 379 gowns shipped globally

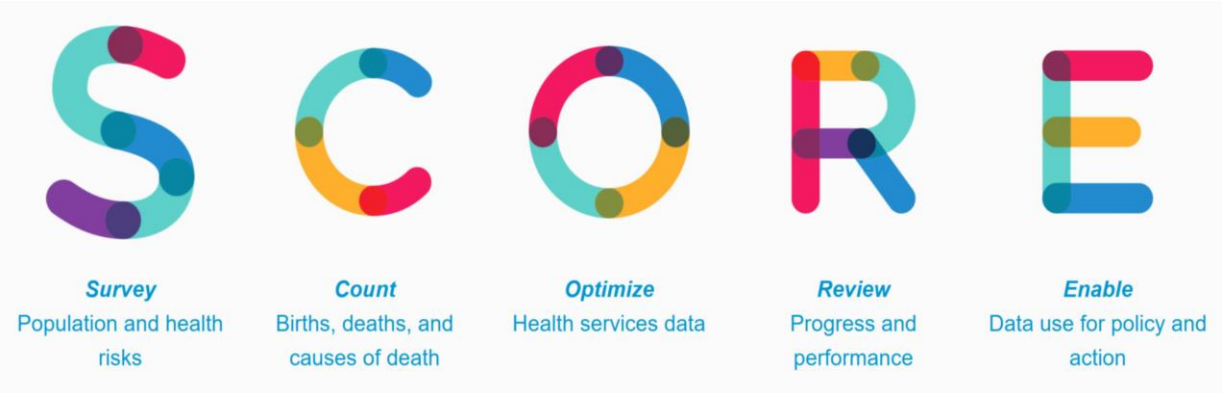
36 587 900 gloves shipped globally

More than **4.8 million** people registered on OpenWHO and able to access online training courses across **24** topics in **44** languages

[a] For the latest data and information, see the WHO COVID-19 Dashboard and Situation Reports

From the field:

The WHO "SCORE Report" highlights urgent need for better data to strengthen pandemic response



According to the first ever global assessment of country health information systems, 40% of the world's deaths are unregistered and this figure increases to 90% for the African region. The SCORE report, recently published by WHO in partnership with Bloomberg Philanthropies, highlights the urgent need to strengthen standardized systems for reporting causes of death, particularly in low-income countries.

The COVID-19 pandemic has highlighted that even the most advanced health and data systems still struggle to provide data in near real-time in order to act swiftly. The lack of data worldwide limits global understanding of absolute mortality, including of the true mortality impact of the COVID-19 pandemic, undermining response planning.

Dr Tedros Adhanom Ghebreyesus, WHO Director-General remarked that *"The pandemic has stretched the capacity of health information systems around the world, so the SCORE report is an important step towards better data for better decisions in health."*

Although there is good availability of date on immunization, tuberculosis, and HIV incidence, the ability of countries to plan and implement effective health programmes is severely limited by the lack of data on other critical health issues, such as mental health and cancer. "*The report urges countries to improve their death data registration systems and to collect better data to address inequalities,"* said Michael Bloomberg, WHO Global Ambassador for Noncommunicable Diseases and Injuries.

For further information on the SCORE report, click here.

From the field:

WHO laboratory mission to the Republic of Moldova

The WHO Regional Office for Europe is supporting the Ministry of Health of the Republic of Moldova to expand the public health laboratory capacities and improve the overall response to the COVID-19 pandemic.

SARS-CoV-2 Antigen RDT Training Workshop in the Republic of Moldova.Credit: Maria Valerie Amante

The main objectives of the mission include:

- Finalizing the national strategy for scaling-up laboratory testing with SARS-CoV-2 Antigen Rapid Diagnostic Test (Ag-RDT) integration;
- Carrying out a training of trainers of Ag-RDT for SARS-CoV-2 Ag-RDT testing and use;
- Discussing and finalizing the laboratory information system platform technical specification;
- Implementing the laboratory costing & needs assessment tools to facilitate the management of the public health laboratory network.

Since the start of the mission on 1 February 2021, a SARS-CoV-2 Ag-RDT User Training Workshop was held for health care and laboratory workers who will be using SARS-CoV-2 Ag-RDTs to collect samples and perform testing at clinical facilities.

The objective of this workshop was to convey the theoretical and practical knowledge required to safely and accurately collect samples, conduct SARS-CoV-2 Ag-RDT testing, interpret and record results, and understand their implications for patient management.

In addition, national laboratory experts will be trained on cost evaluation using WHO EURO costing tools. These tools will help to analyze the costs of PCR tests and Ag-RDTs in the context of COVID-19 and will provide support to the Republic of Moldova in costing and establishing a monitoring framework for the implementation of Ag-RDTs.

Infodemic management

WHO launches EARS, an AI-powered public-access social listening tool

In an effort to provide health authorities with concrete tools to support their response to the harm caused by the COVID-19 infodemic, WHO has developed the Early AI-supported Response with Social Listening tool (EARS)

The EARS platform is open to the public and allows anyone to keep a finger on the pulse of online conversations that are happening in real time, so that they can better assess what topics are trending, what's of interest and where there are gaps of credible information that need to be filled. When health authorities understand what topics are catching people's attention—and where there are information voids—they can respond in real time with high-quality, evidence-based information and intervention recommendations to health systems and emergency response administrators.

EARS combs the internet, reading publicly available conversations on social media such as Twitter, online forums, commentaries on blogs and news articles, and then analyses what people are discussing. By using natural language processing, EARS can interpret context cues, such as if people are asking questions, if people are complaining, and when there are gender differences. Supported by the WHO Solidarity Fund, EARS is currently in pilot phase, mining in 20 countries across all 6 WHO Regions in French, English, Spanish and Portuguese. Since 15 December 2020, EARS has analysed nearly 9.9 M posts within the 20 pilot countries.

The tool analyzes 41 narratives based on keywords and hashtags and can be scaled to study any local context, language or future epidemic. Narratives analysed by the tool include such topics as the COVID-19 vaccine, the cause of the virus, modes of transmission, COVID-19 treatment, impact of COVID-19 on mental health, and research and development.

For more information on EARS and to explore the listening tool, click here

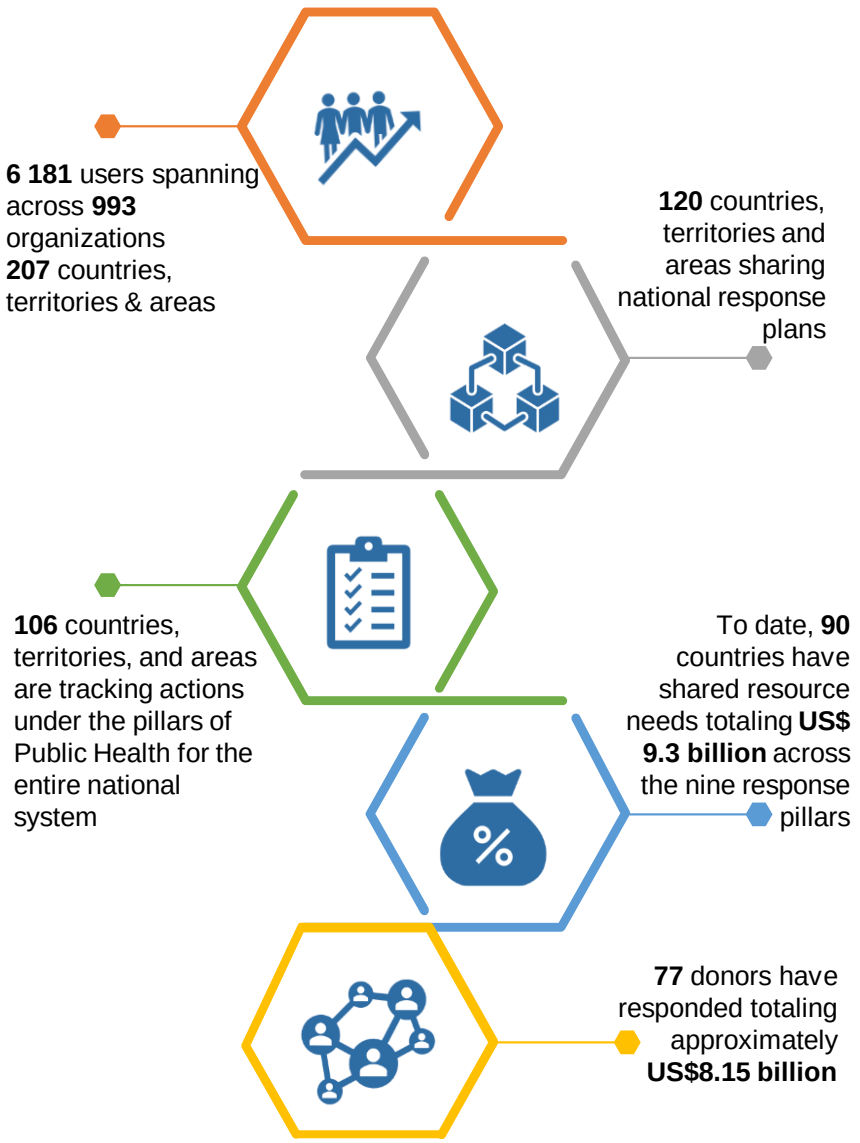
COVID-19 Partners platform

Countries submit vaccination plans for consideration of the next round of allocation

As of 4 February, 18 National Deployment and Vaccination Plans (NDVPs) have been uploaded to the Partners Platform. Countries will submit their NDVPs on the Platform for consideration for the next allocation round of COVID-19 by **9 February 2021.**

Once a country's NDVP has been uploaded to the Partners Platform and validated by a government vaccine official, the Regional Review Committee (RRC) will review and assess the plan using the Standard Review Form (SRF). The deadline to upload the SRF is set for **12 February**. Country support for development and pre-assessment of NDVPs has been made available through the regional office or through the Partners Platform at covid19-platform-support@who.int.*

The Platform enhances transparency between donors and countries who can each respectively view resources gaps and contributions.



* viewing of vaccine information may be restricted to key vaccines stakeholders per countries' preferences.

Operations Support and Logistics

The COVID-19 pandemic has prompted an unprecedented global demand for Personal Protective Equipment (PPE), diagnostics and clinical care products.

To ensure market access for low- and middle-income countries, WHO and partners have created a COVID-19 Supply Chain System, which has delivered supplies globally

The table below reflects WHO/PAHO-procured items that have been shipped as of 4 February. 2021

Shipped items as of 4 Feb 2021*	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	700 800	3 646 015	1 805 750	1 423 210	10 154 300	208 050	1 717 279	53 429 400	2 700 630
Americas (AMR)	6 030 050	1 019 862	10 518 478	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	840 300	1 244 910	1 424 362	914 985	7 600 000	174 480	799 322	27 317 550	1 502 095
Europe (EUR)	248 000	404 050	539 198	1 728 300	8 935 100	399 820	1 564 748	40 545 500	5 369 950
South East Asia (SEAR)	200 000	2 352 1500	2 240 200	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		174 800	314 384	768 700	3 021 000	311 927	463 710	14 974 146	2 102 035
TOTAL	**8 019 150**	**8 842 787**	**16 842 372**	**8 540 231**	**36 587 900**	**1 503 727**	**6 713 379**	**198 343 426**	**19 948 965**

For further information on the **COVID-19 supply chain system**, see here.

**Periodic fluctuations in supply figures will occur as data is compiled*

Appeals

WHO appreciates and thanks donors for the support already provided or pledged and encourages donors to **give fully flexible funding for the SPRP** and avoid even high-level/soft geographic earmarking at e.g. regional or country level. This will allow WHO to direct resources to where they are most needed, which in some cases may be towards global procurement of supplies, intended for countries.

As of 20 January 2021

Global Strategic Preparedness & Response Plan (SPRP)

US$ 1.5 billion raised

US$ 1.7 billion requested

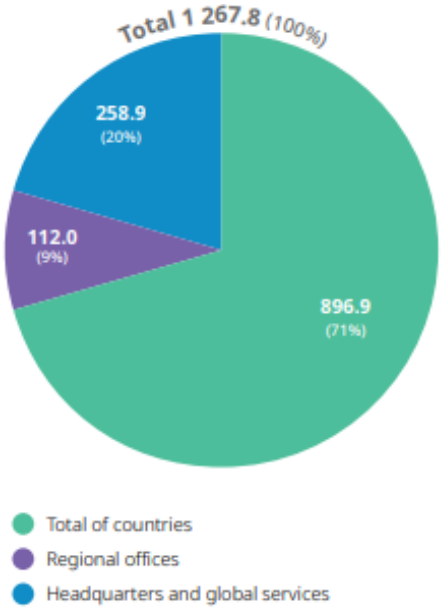
US$ 1.5 billion raised by WHO during 2020
US$ 1.3 billion projected utilization for 2020 SPRP

US$ 240 million raised by the COVID-19 Solidarity Response Fund

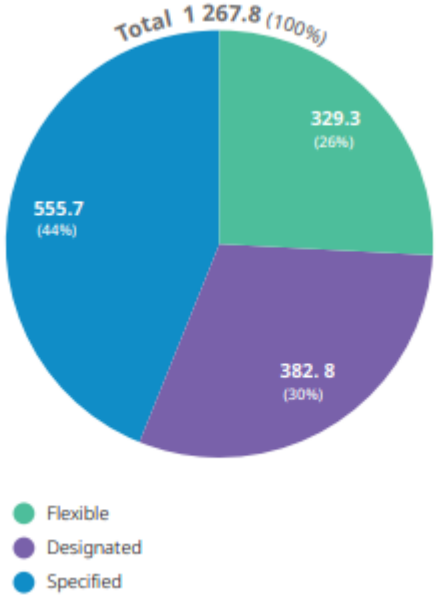
US$1 billion on country support and regional coordination

The status of funding raised for WHO against the SPRP can be found here

Utilization* by type of funds by level of organization (US$ million)



Utilization* by type of funding by level of earmarking (US$ million)



*Based on interim 2020 year-end figures and estimated 2021 Q1 transition period implementation

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

The COVID-19 Solidarity Response Fund remains the foremost way for companies, organisations and individuals to contribute to the essential work of WHO and its partners to help countries prevent, detect and respond to the global pandemic.

By 5 February 2021, more than 659,000 leading companies, foundations and individuals from more than 190 countries had committed more than US$ 241 million in fully flexible funding to the COVID-19 Solidarity Response Fund to support the lifesaving work of WHO and its partners.

More than US$ 241 Million

659 000 donors

[individuals – companies – philanthropies]

Health Learning

WHO is expanding access to online learning for COVID-19 through its open learning platform for health emergencies, OpenWHO.org.

The OpenWHO platform was launched in June 2017 and published its first COVID-19 course on 26 January 2020.

4 858 586
Course enrollments

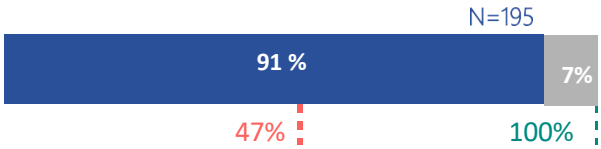
44 languages

25 topical courses

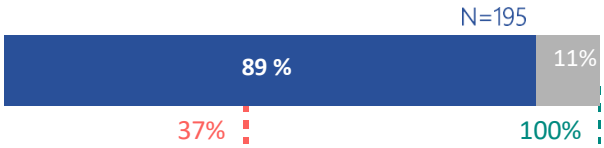
Over 2.6 million certificates

COVID-19 Global Preparedness and Response Summary Indicators [a]

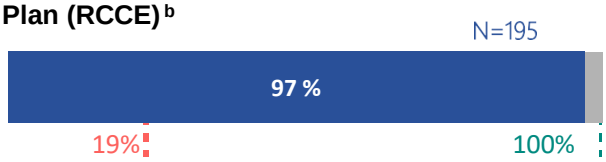
Countries have a COVID-19 preparedness and response plan



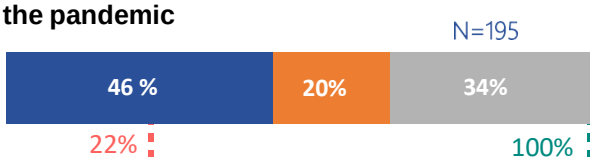
Countries have a clinical referral system in place to care for COVID-19 cases



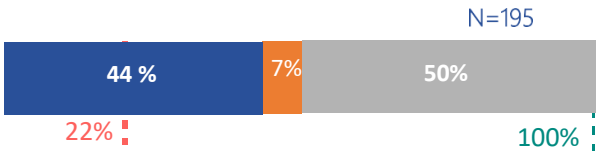
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE) [b]



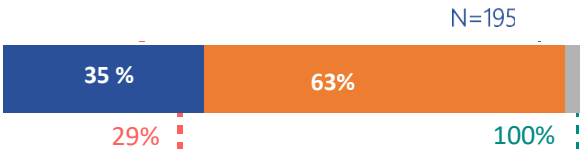
Countries that have defined essential health services to be maintained during the pandemic



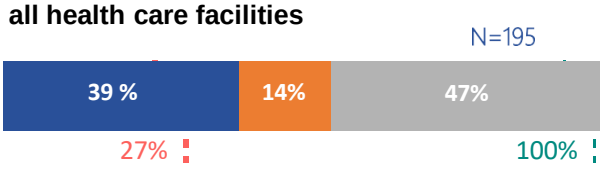
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



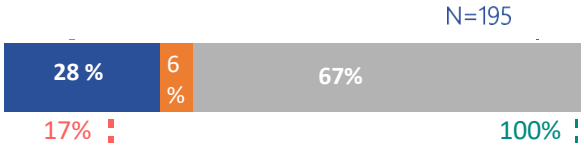
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



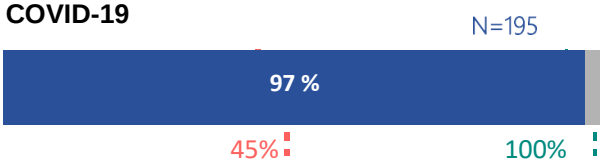
Countries with a national IPC programme & WASH standards within all health care facilities



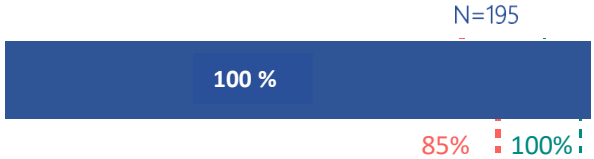
Countries have a health occupational safety plan for health care workers



Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



Countries have COVID-19 laboratory testing capacity



Legend

Yes | No | No information | Baseline value | Target value

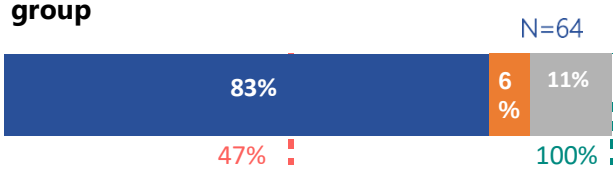
Notes:

a Data collected from Member States and territories. The term "countries" should be understood as referring to "countries and territories." b Source: UNICEF and WHO

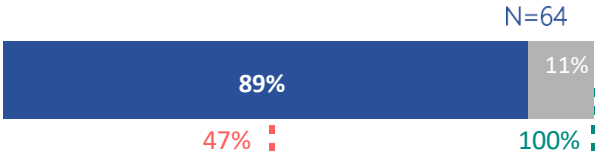
COVID-19 Global Preparedness and Response Summary Indicators

Selected indicators within the Monitoring and Evaluation Framework apply to designated priority countries. Priority Countries are mostly defined as countries affected by the COVID-19 pandemic as included in the Global Humanitarian and Response Plan. A full list of priority countries can be found here.

Priority countries with multisectoral mental health & psychosocial support working group

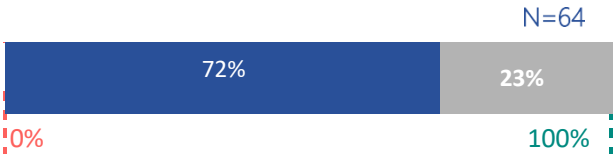


Priority countries with an active & implemented RCCE coordination mechanism

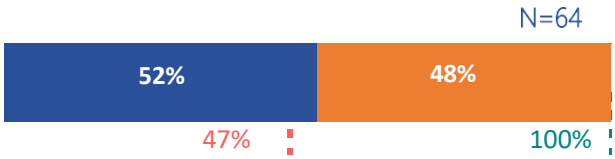


Priority countries that have postponed at least 1 vaccination campaign due to COVID-19 [c]

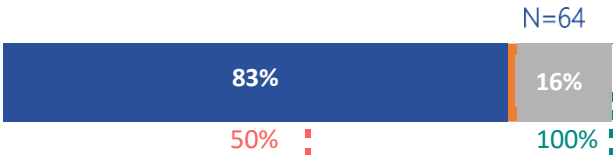
Priority countries with a contact tracing focal point

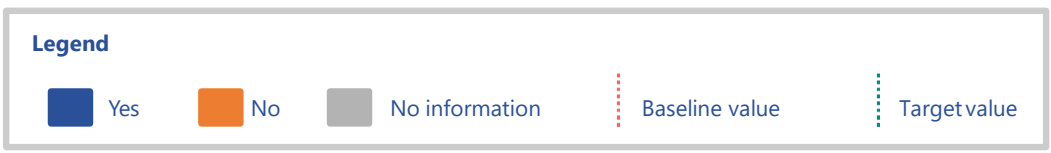


Priority countries where at least one Incident Management Support Team (IMST) member trained in essential supply forecasting



Priority countries with an IPC focal point for training





Notes:

c Source: WHO Immunization Repository

The Unity Studies: WHO Early Investigations Protocols

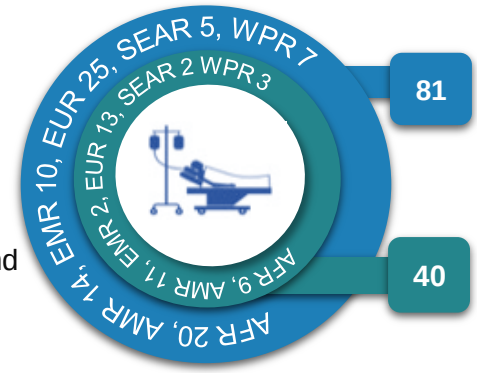
Unity studies is a global sero-epidemiological standardization initiative, which aims at increasing the evidence-based knowledge for action.
It enables any countries, in any resource setting, to gather rapidly robust data on key epidemiological parameters to understand, respond and control the COVID-19 pandemic.

The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays

Global COVID-19 Clinical Data Platform

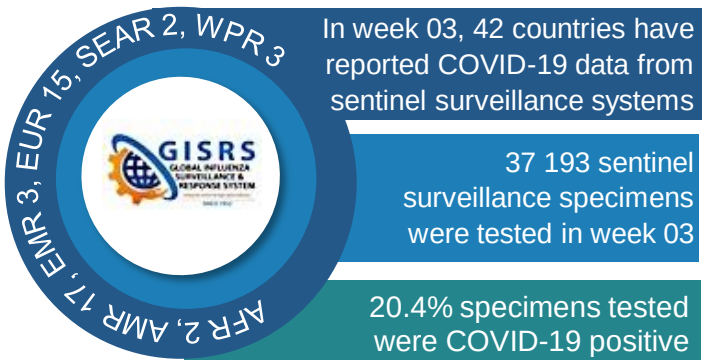
Global understanding of the severity, clinical features and prognostic factors of COVID-19 in different settings and populations remains incomplete.

WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



Leveraging the Global Influenza Surveillance and Response System

WHO recommends that countries use existing syndromic respiratory disease surveillance systems such as those for influenza like illness (ILI) or severe acute respiratory infection (SARI) for COVID-19 surveillance. Leveraging existing systems is an efficient and cost-effective approach to enhancing COVID-19 surveillance. The Global Influenza Surveillance and Response System (GISRS) is playing an important role in monitoring the spread and trends of COVID-19



Key links and useful resources

- For EPI-WIN: WHO Information Network for Epidemics, click **here**
- For more information on COVID-19 regional response:
  - **African Regional Office**
  - **Regional Office of the Americas**
  - **European Regional Office**
  - **Eastern Mediterranean Regional Office**
  - **Southeast Asia Regional Office**
  - **Western Pacific Regional Office**
- For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection published on 16 December 2020, click **here**
- For updated WHO Publications and Technical Guidance on COVID-19, click **here**
- For updated GOARN network activities, click here
- Updated COVID-19 Table top Exercise packages are now available online to better reflect the current situation as well as align it to the latest WHO guidance. The updated exercises include:
  - Generic table top exercise
  - Health Facility & IPC table top exercise
  - A Point of Entry (POE) table top exercise
  - Target population, supply chain and community engagement & communications table top exercise
  - The regulatory and safety issues table top exercise

  All COVID-19 simulation exercises can be found here

COVID-19 Weekly Epidemiological Update

Data as received by WHO from national authorities, as of 31 January 2021, 10 am CET

For the latest data and other updates on COVID-19, please see:

- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update

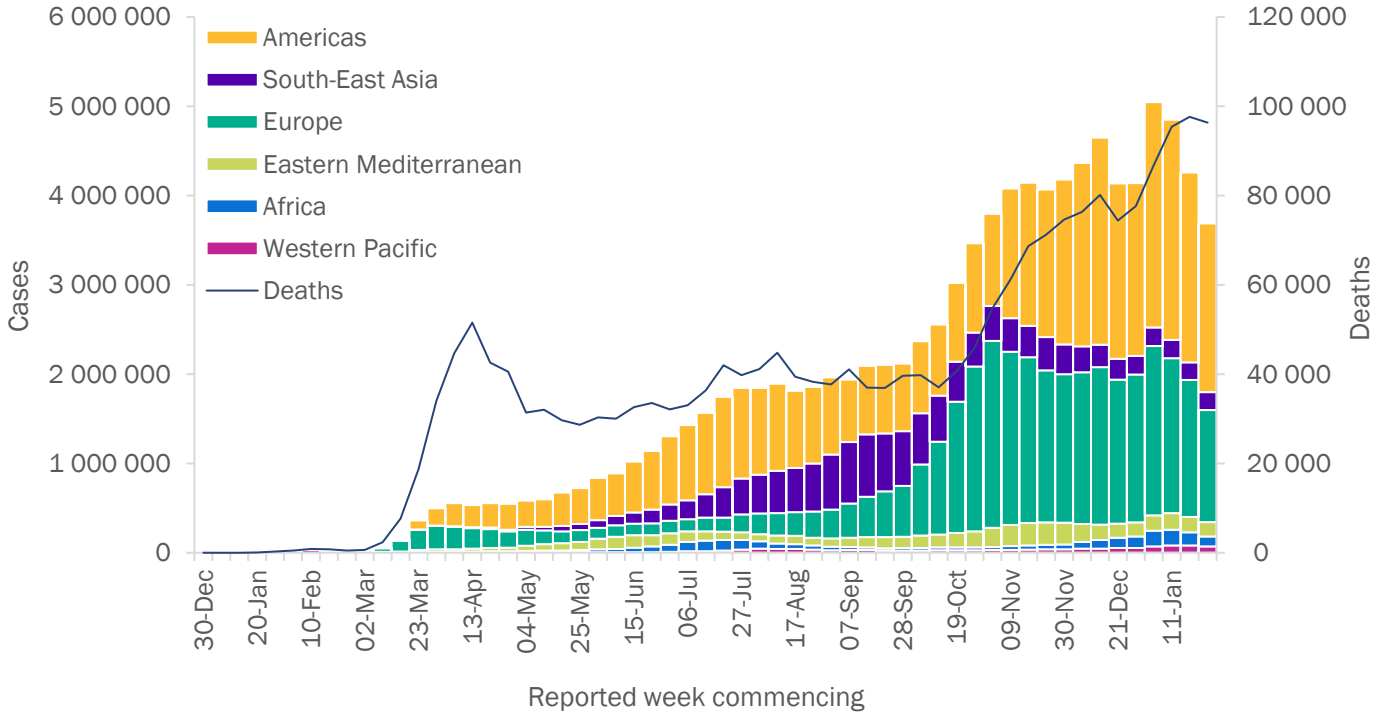
Global epidemiological situation

Globally, 3.7 million new cases were reported last week, a 13% decline as compared to the previous week, and the third consecutive week showing a decline in cases. There were 96 000 new deaths, and a 1% decline as compared to the previous week, (Figure 1). This brings the total number of cases to over 102 million and the total number of deaths to 2.2 million from 222 countries and territories. Last week, all WHO regions, except South-East Asia reported a decline in new cases (Table 1). Although new deaths declined globally by 1%, they rose in the Western Pacific (21%), Eastern Mediterranean (9%), and the Americas (4%).

Saturday 30 January 2021 marked one year since WHO declared COVID-19 a Public Health Emergency of International Concern. At that time, there were 9826 cases in 20 countries, and 213 deaths in one country (all of which were in China).

In the past week, the five countries reporting the highest number of new cases continue to be the United States of America (1 072 287 cases, a 15% decrease), Brazil (364 593 cases, a 1% increase), the United Kingdom of Great Britain and Northern Ireland (178 629 cases, a 31% decrease), France (141 092 cases, a 2% increase) and the Russian Federation (131 039 cases, a 13% decrease).

Figure 1: COVID-19 cases reported weekly by WHO Region, and global deaths, as of 31 January 2021**



**See *data, table and figure notes*

In this edition of the COVID-19 Weekly Epidemiological Update, special focus updates are provided on:

- COVID-19 and Health Workers
- SARS-CoV-2 variants of concern
- Additional Region-specific information: African Region, Region of the Americas, Eastern Mediterranean Region, European Region, South-East Asia Region, and Western Pacific Region
- Key Weekly Updates

Note: From 3 February 2021, a daily log of major changes and errata in WHO daily aggregate case and death count data will no longer be published online. A record of historic data adjustment made will continue to be available upon request by emailing epi-data-support@who.int. Please specify the country(ies) of interest, time period(s), and purpose of the request/intended usage.

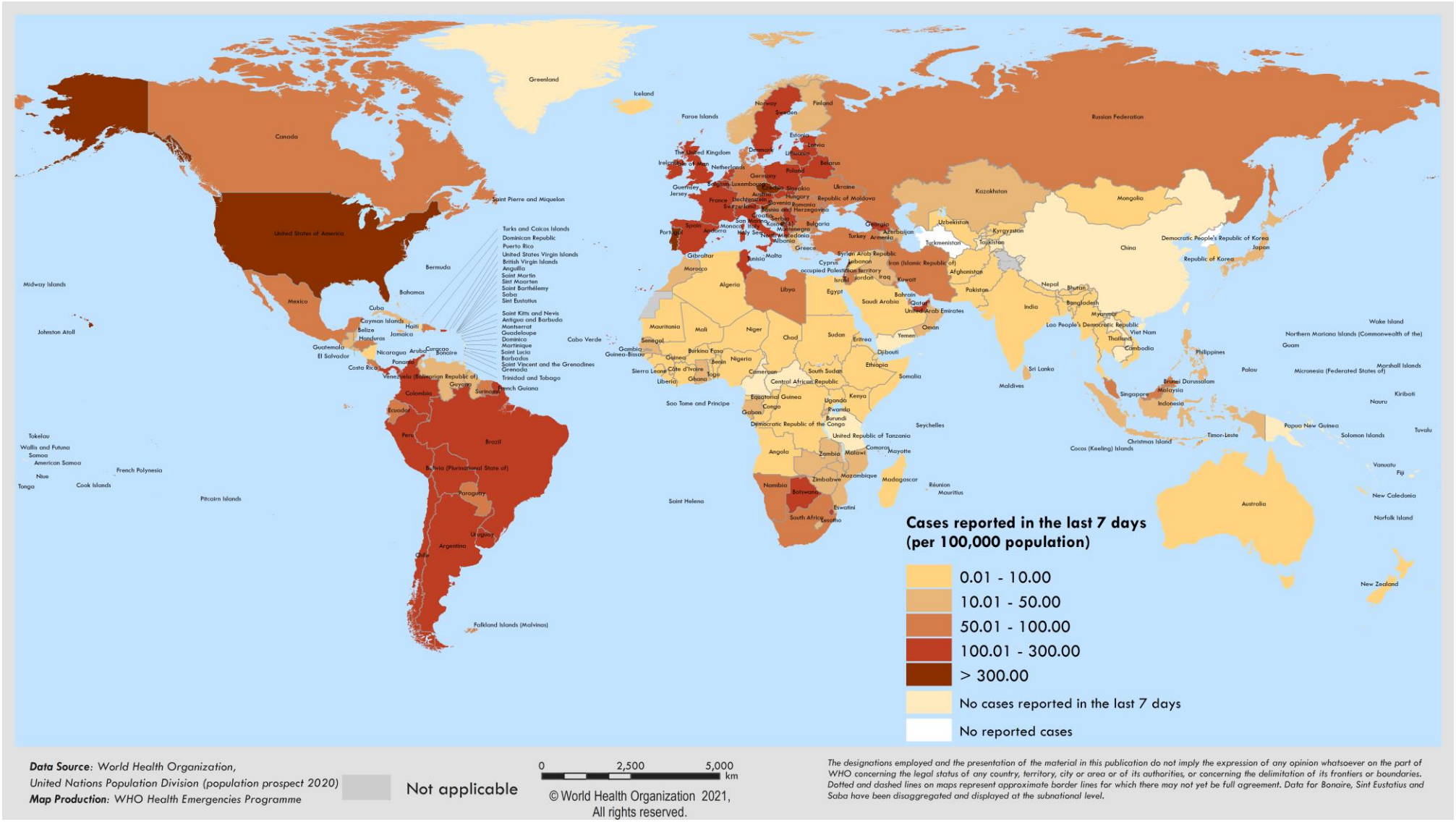
Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 31 January 2021**

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	1 888 070 (51%)	-11%	45 345 051 (44%)	47 277 (49%)	4%	1 047 171 (47%)
Europe	1 255 352 (34%)	-18%	34 276 814 (34%)	36 674 (38%)	-8%	745 590 (34%)
South-East Asia	200 219 (5%)	3%	12 856 723 (13%)	3 258 (3%)	0%	197 707 (9%)
Eastern Mediterranean	161 943 (4%)	-5%	5 669 940 (6%)	3 272 (3%)	9%	134 189 (6%)
Africa	108 391 (3%)	-27%	2 570 474 (3%)	4 602 (5%)	-8%	62 504 (3%)
Western Pacific	72 135 (2%)	-11%	1 420 024 (1%)	1 281 (1%)	21%	24 588 (1%)
Global	**3 686 110 (100%)**	**-13%**	**102 139 771 (100%)**	**96 364 (100%)**	**-1%**	**2 211 762 (100%)**

**Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number, global totals may not equal 100%.*

***See data, table and figure notes.*

Figure 2. COVID-19 cases per 100 000 population reported in the last seven days by countries, territories and areas, 25 January through 31 January 2021**



**See *data, table and figure notes*

Special Focus: COVID-19 and Health Workers

Overview

In his press briefing of 29 January 2021, WHO Director-General Dr Tedros again emphasized that healthcare workers have been at the forefront of the response to the pandemic but are often under-protected and over-exposed. He reiterated his 18 January 2021 call to action: for governments and industry leaders to work together to ensure that in the first 100 days of 2021, vaccination of health workers and older people is underway in all countries.

In this Special Focus – recognizing that 2021 has been designated as the International Year of Health and Care Workers – we present an overview of health worker SARS-CoV-2 infections using data collected via the WHO Global Surveillance systems, and analyse risk factors from available scientific literature.

To date, a total of 183 countries have reported data via WHO Case Report Forms (CRFs) to date, covering 37 million cases (36% of current global COVID-19 cases). The CRFs were mainly received from Member States in the Region of the Americas and European Region. Over 16 million CRFs (43% of CRFs received, representing 16% of global COVID-19 cases) included information on occupation status, including health workers[1]. Within this subset, health workers accounted for close to 1.29 million COVID-19 cases, or 8% of cases. The median age of health worker cases was 42 years (interquartile range 27 to 60 years), and 68% were women. This is in line with the proportion of women working in the health and social sectors globally.

At the outset, it is important to mention that the analyses based on CRF data provided to WHO has limitations, mainly due to variations in reporting coverage and completeness, reporting methods, some irregularity of weekly reports, health worker definitions, and lack of information about the setting of exposure. WHO advises Member States to use the definition of health workers as stated in the Surveillance Protocol for SARS-CoV-2 infection.[2]

Percentage of health worker infections and relative risk over time

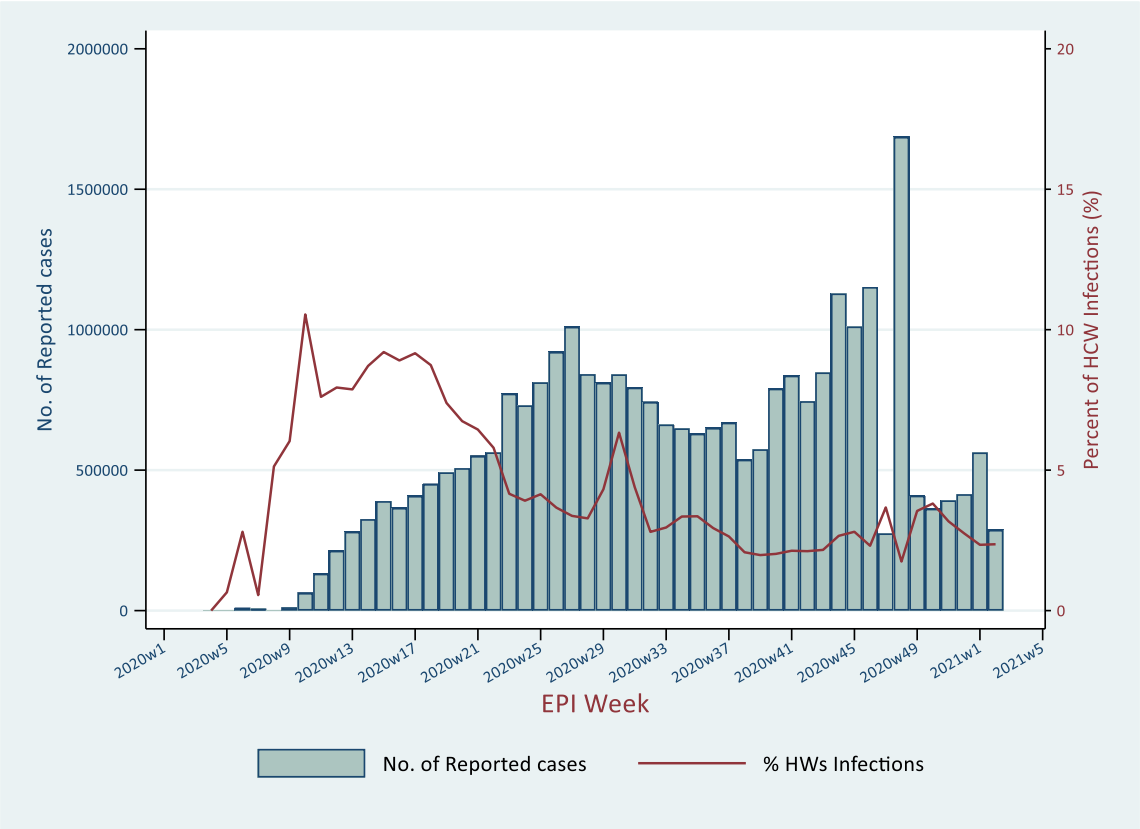
It is important to acknowledge that country-specific trends remain highly variable, and the data are based on reported cases (those testing positive for SARS-CoV-2) often without providing information on the overall number tested. Therefore, it is difficult to reliably compare incidence of health worker infections over time and trends should be interpreted with caution due to variations in reporting coverage and completeness, adaptations to testing strategies, differences in the implementation of public health measures and interventions, as well as differences in the circulation of SARS-CoV-2 in the community over time. Additionally, it is not possible to determine the place of exposure (e.g., health care facility or community) among health workers from WHO CFR data.

Based on WHO CRF data, in the first three months of the pandemic, health worker infections slightly exceeded 10% of reported cases (Figure 3), declining to less than 5% by early-June 2020 (Epi week 2) and to approximately 2.5% by September 2020 (Epi week 37).

[1] For the purposes of the case-based surveillance, 'health workers' were defined as those working "any job in a health care setting".

[2] The term "health worker" includes allied health workers and auxiliary health workers such as cleaning and laundry personnel, x-ray physicians and technicians, clerks, phlebotomists, respiratory therapists, nutritionists, social workers, physical therapists, laboratory personnel, cleaners, admission/reception clerks, patient transporters, catering staff and so on).

Figure 3: Weekly total number of cases, and percentage of health worker cases among infected individuals reported, data from WHO Case Report Forms where occupation was indicated, 20 January 2020 to 31 January 2021.



A relative risk measure (dividing the rate of health worker infections by that of the non-health workers) was calculated for each week by estimating the total number of health workers and non-health workers. The rate of health worker infections was calculated by dividing their number by all workers employed in the health and social sector. A similar rate of infection was calculated for non-health workers relative to the general population size. It must be noted that there has likely been surveillance bias and differences in testing of health workers compared to general population, particularly early on. Based on the data we have available, it is observed that health workers experienced more than triple the risk of infection as that of the general population in the period between mid-March to mid-May 2020. A similar level of relative risk[3] was also reported by an observational cohort study of about 2 million community individuals and 100 000 front-line health-care workers in the United Kingdom of Great Britain and Northern Ireland, and the United States of America. Our data suggests this period of elevated risk was followed by a steep decline to that found in the general population by end of May 2020.

Analysis of health worker risk factors

WHO first commissioned a rapid systematic review of published literature on the risk factors in health workers for SARS-CoV-2 infections in April 2020 and this has been updated regularly since. The latest update on 24 December 2020 identified a total of 37 studies evaluating risk factors associated with SARS-CoV-2 infection in health workers. Highlights include:

- SARS-CoV-2 infections occurred among health workers in various roles (clinical or non-clinical) and departments/settings (including outpatient and non-COVID-19 care settings).
- There was no consistent difference in risk of infection between job titles, including between nurses compared with physicians, which represented the most commonly reported health worker roles.

[3] Adjusted HR 3·40, 95% CI 3·37–3·43

- There was no association found between sex or age and risk of SARS-CoV-2 infection or seropositivity in health workers.
- African-Americans and Hispanic health workers had an increased risk of SARS CoV-2 infection.
- Education and training in infection prevention and control were associated with decreased risk of SARS-CoV-2 infection in health workers.
- Certain exposures such as those involving intubations, other aerosol-generating procedures, direct patient contact, or contact with bodily secretions were found to be associated with increased infection risk compared with less intensive or direct exposure; though evidence was inconsistent, likely related to confounding factors such as those related to the availability, distribution, and use of PPE.
- Evidence on the association between health worker infection and use of individual PPE measures (masks, gloves, gown, eye protection) and hand hygiene was limited. However, most studies found that availability and appropriate use of PPE as recommended by local authorities was associated with decreased risk of SARS-CoV-2 infection. Evidence on the use of N95 or FFP2 respirators versus medical/surgical masks was inconclusive and limited to two inconsistent observational studies. Further information on the use of masks in health facilities can be found in the interim guidance on mask use in the context of COVID-19.
- Three studies found that universal masking in health facilities was associated with decreased risk of SARS-CoV-2 infection in health workers.

A number of possible hypotheses may help to explain the observed trends in health worker infections. The higher proportion of health worker infections at the beginning of the pandemic in some countries may be due to the lack of preparedness to infectious disease outbreaks, of standard IPC precautions during care delivery, and reduced access to PPE, and overburdened health systems due to increased hospitalizations and limited health care capacities. Trends could also reflect different testing strategies prioritizing health workers over the general public. The subsequent decline in health worker infections could be a result of multiple interventions, including: i) training of health workers on IPC measures; ii) increased availability and appropriate use of personal protective equipment (PPE); iii) monitoring of IPC practices by occupational health and safety personnel; iv) improved clinical management based on improved knowledge about COVID-19, v) reduced bed capacity of COVID-19 patients in hospitals; vi) general reduction in community transmission with implementation of public health and social measures resulting in less pressure on hospital systems and hospitalizations; vi) increased SARS-CoV-2 testing capabilities; and, vii) increased knowledge of methods of transmission. Hence, it is impossible to determine from the available data how these interventions (individually or as a mix) contributed to the observed trends.

The WHO review of available studies found that observational studies provided important insights but had some methodological limitations. These limitations include potential recall bias, low or unclear participation rates, small sample sizes, and challenges in disentangling the effect of different measures, which were often implemented at the same time.

To bridge these gaps and improve the understanding of SARS-CoV-2 infection among health workers, WHO has developed a standardized protocol for COVID-19 surveillance among health workers that countries can use, and is leading an international multi-centre case-control study primarily aimed at identifying risk factors and settings of exposure. More than 140 sites in 28 countries have enrolled so far and recruitment is ongoing (for more information please contact: earlyinvestigations-2019-nCoV@who.int).

Additionally, to mitigate health workers' infections WHO has developed a health workers' risk assessment and management of exposure to COVID-19 cases and guidance on Prevention, identification and management of health worker infection in the context of COVID-19.

WHO continues to support health workforce managers and policy makers with the December 2020 release of Health workforce policy and management in the context of the COVID-19 pandemic response interim guidance, consolidating the evolving evidence on the design, management and preservation of the workforce necessary to respond to the COVID-19 pandemic and maintain essential health services.

References

International Labour Organization, 2020, *ILOSTAT*, 2/2/2021, https://ilostat.ilo.org/data/

Nguyen LH et al., Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. Lancet Public Health. 2020;5(9):E475–E483

Chou et al., Epidemiology of and Risk Factors for Coronavirus Infection in Health Care Workers: A Living Rapid Review, Annals of Internal Medicine. 2020 Jul 21;173(2):120-136. doi: 10.7326/M20-1632. Epub 2020 May 5

Chou et al., Update Alert 6: Epidemiology of and Risk Factors for Coronavirus Infection in Health Care Workers, Annals of Internal Medicine. 2020 Nov 24 : L20-1323. Epub Nov 24. doi: 10.7326/L20-1323

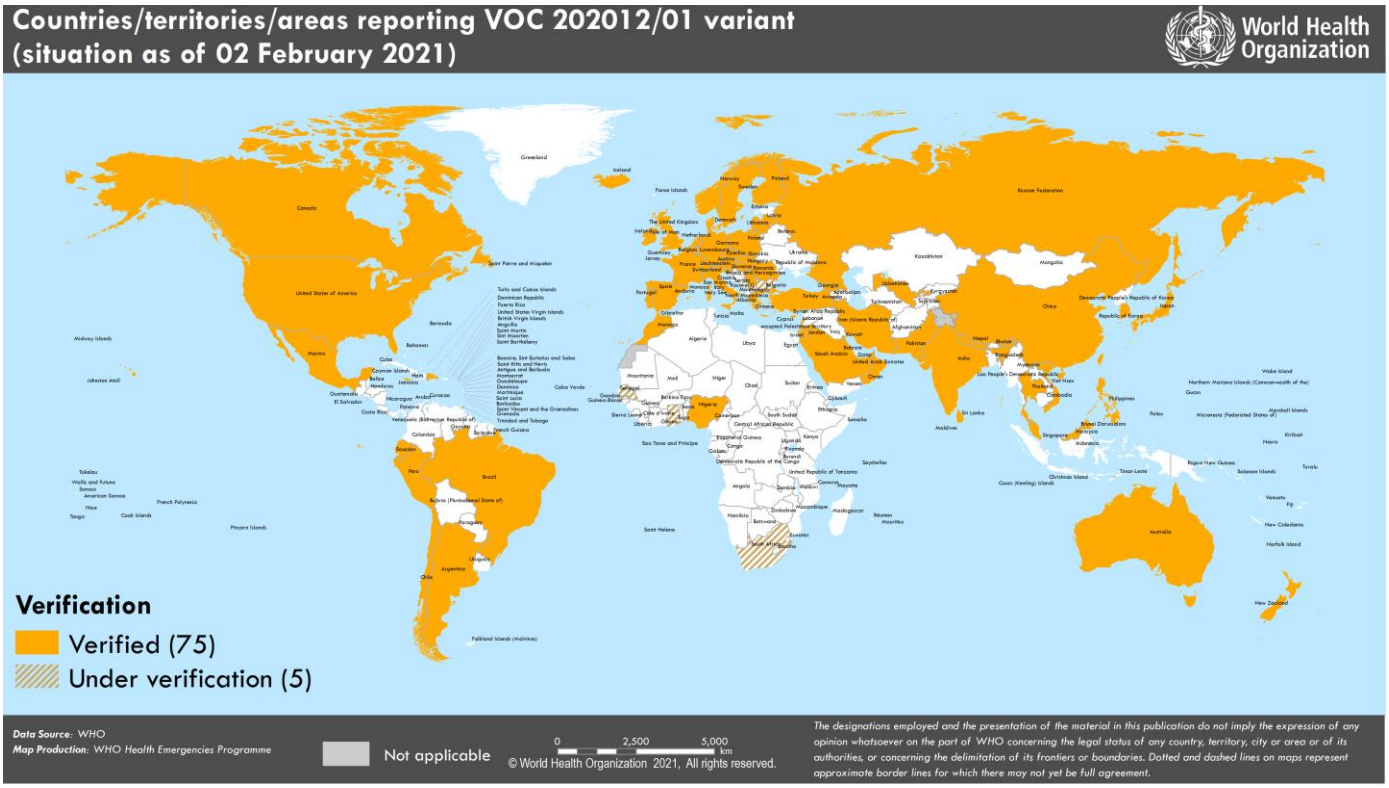
Special Focus: Update on SARS-CoV-2 variants of concern

WHO, in collaboration with national authorities, institutions and researchers, continues to monitor the public health events associated with SARS-CoV-2 variants and provides updates as new information becomes available. Further information on the background of the variants of concern (VOC) is available from previously published Disease Outbreak News and in the last four publications of the Weekly Epidemiological Updates.

WHO continues to work with partners to evaluate available evidence around transmissibility, severity, antibody neutralization capabilities and potential impacts on vaccines of specific mutations, variants of interest and variants of concern. Here we provide an update on the geographical distribution of three variants of concern as reported by countries, territories and areas (hereafter countries) as of 2 February 2021:

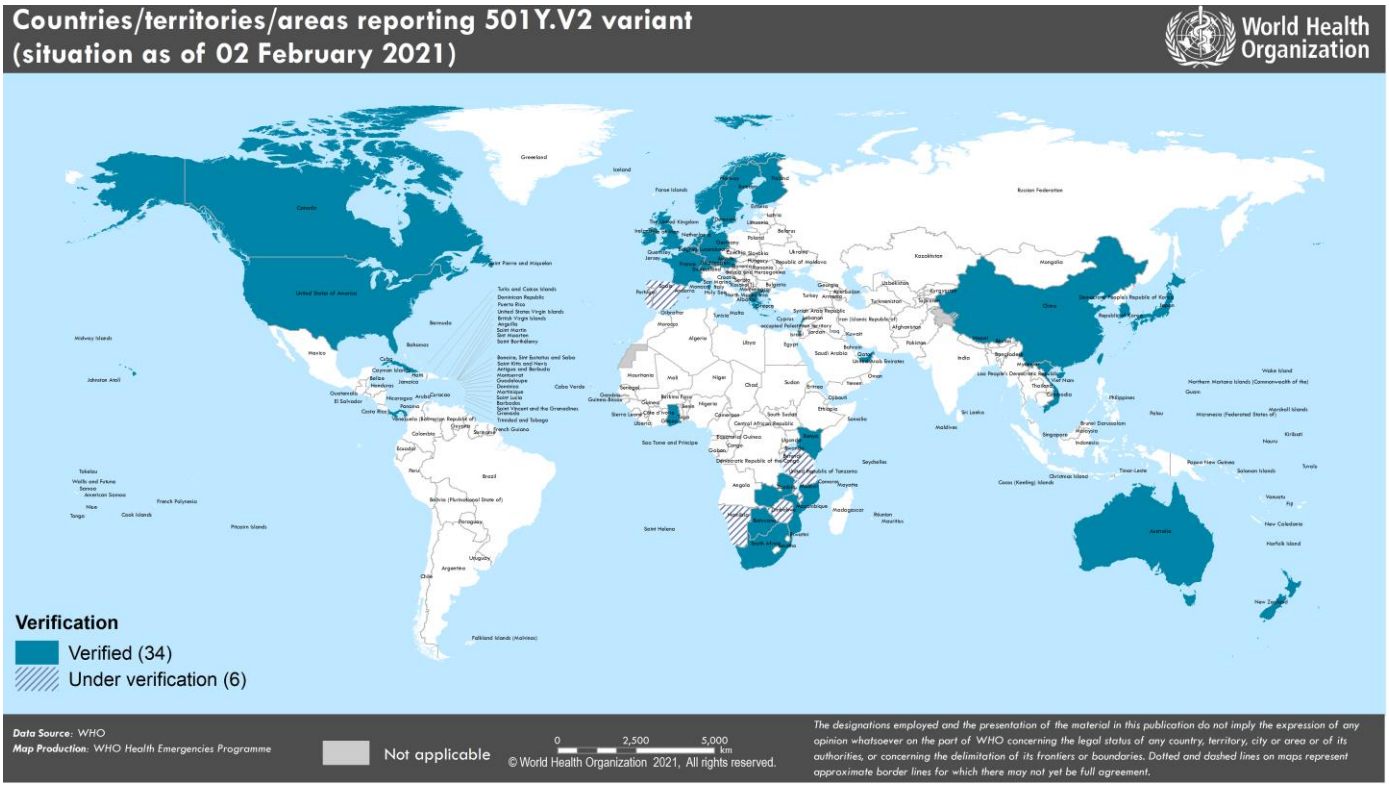
1. Variant VOC 202012/01, lineage B.1.1.7: Since our last update on 27 January, variant VOC 202012/01 has been detected in ten additional countries. As of 2 February, a total of 80 countries across all six WHO regions have reported either imported cases or community transmission of this variant (Figure 5).

Figure 5. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 2 February 2021



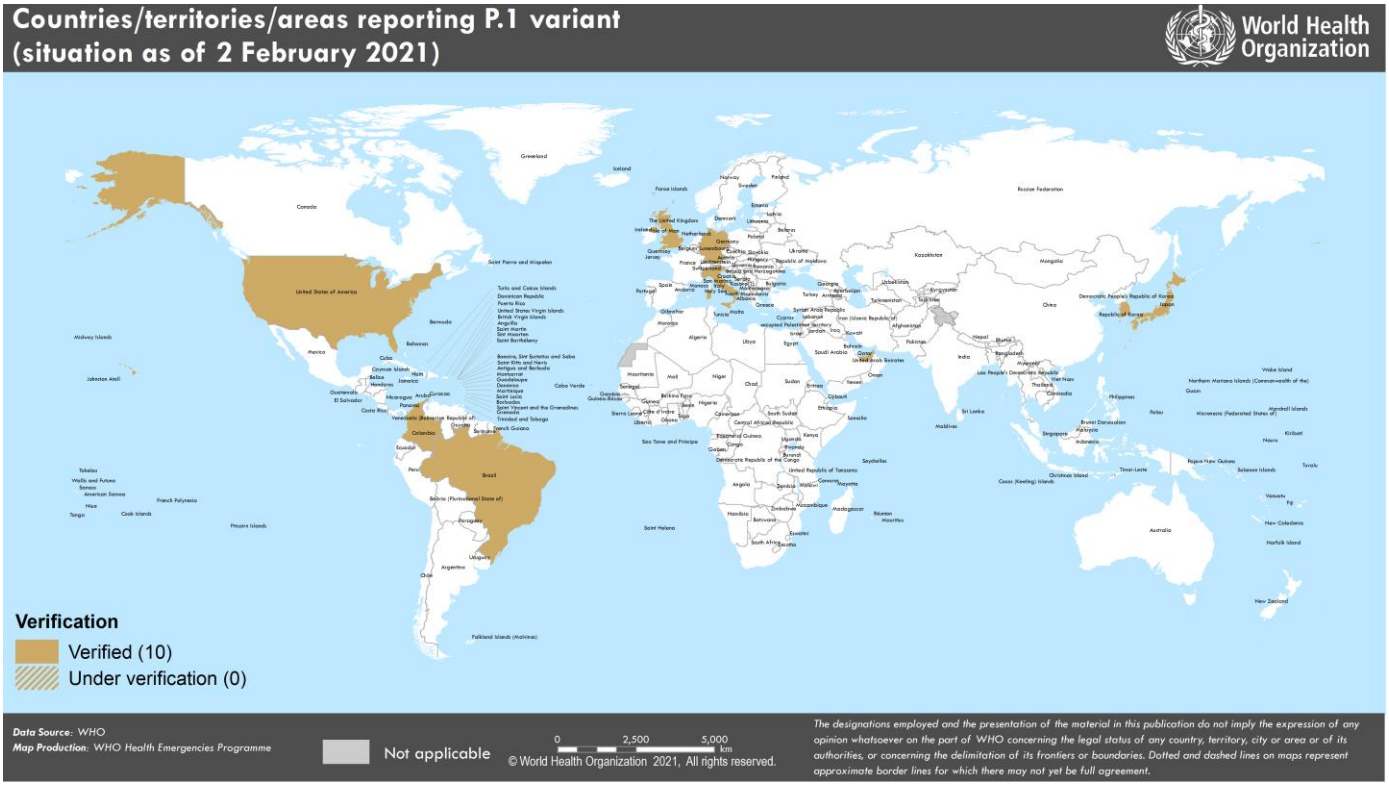
2. Variant 501Y.V2, lineage B.1.351: Since the last update on 27 January, 501Y.V2 has been reported from ten additional countries– now totaling 41 countries across four of the six WHO regions (Figure 6).

Figure 6. Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 2 February 2021



3. Variant P.1, lineage B.1.1.28: Since our last update, variant P.1 has been reported in two additional countries. To date, this variant is reported in ten countries across four of the six WHO regions (Figure 7).

Figure 7. Countries, territories and areas reporting SARS-CoV-2 P.1 variant as of 2 February 2021



Last week, WHO held a multidisciplinary Global Transmission Discussion Seminar on SARS-CoV-2 variants and transmission. Participants from Brazil, Denmark, South Africa and the United Kingdom presented ongoing work aiming to understand transmission aspects of the variants of concern emerging in their countries, namely variants: P.1/P.2, cluster 5, 501Y.V2 and VOC202012/01, respectively. Initial analyses suggest that some variants may be more transmissible, possibly due to mutations that improve the virus's ability to bind to human cells, but available studies have found that the modes of transmission have not changed.

SARS-CoV-2 incidence and hospitalizations in a number of countries where VOC202012/01 and 501Y.V2 are circulating has started to decline in recent weeks, demonstrating the effectiveness of public health and social measures for controlling transmission of these variants.

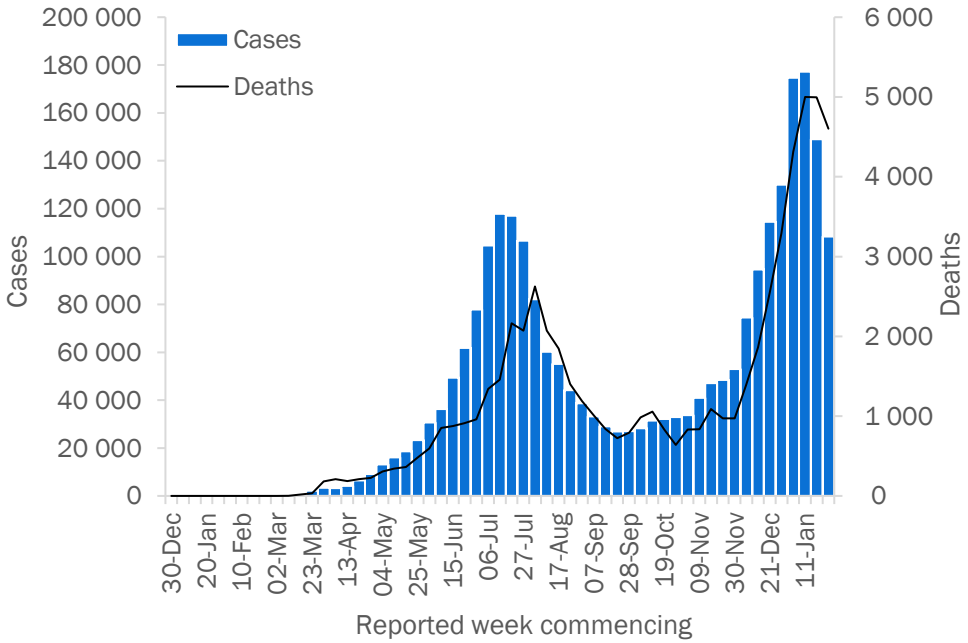
The emergence of new variants has highlighted the importance for everyone to continue to comply with local and national public health and social measures, and to take simple precautions, such as physical distancing, wearing a mask, keeping rooms well ventilated, avoiding crowds, cleaning your hands, and coughing into a bent elbow or tissue (see also Protect yourself and others from COVID-19). It remains critical to increase diagnostic capacity and strategic genetic sequencing of SARS-CoV-2 where capacity allows, and continue to share sequence data internationally in a timely manner. Genetic sequencing should be considered for a subset of SARS-CoV-2 cases in each country, especially among outbreaks or clusters where transmission and/or severity may appear unusual. WHO has recently issued guidance for SARS-CoV-2 suggesting how to apply the use sequencing to monitor virus evolution in addition to epidemiological and virologic surveillance sequencing (SARS-CoV-2 genomic sequencing for public health goals: Interim guidance; Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health).

Situation by WHO Region

African Region

In the past week, the African Region reported over 108 000 cases and just over 4600 deaths, a 27% decrease in cases and an 8% decrease in deaths respectively compared to the previous week. Cases have decreased for two consecutive weeks. The highest numbers of new cases were reported in South Africa (44 397 new cases; 74.9 new cases per 100 000 population; a 44% decrease), Nigeria (9955 new cases; 4.8 new cases per 100 000; a 15% decrease) and Zambia (8760 new cases; 47.7 new cases per 100 000; a 3% increase).

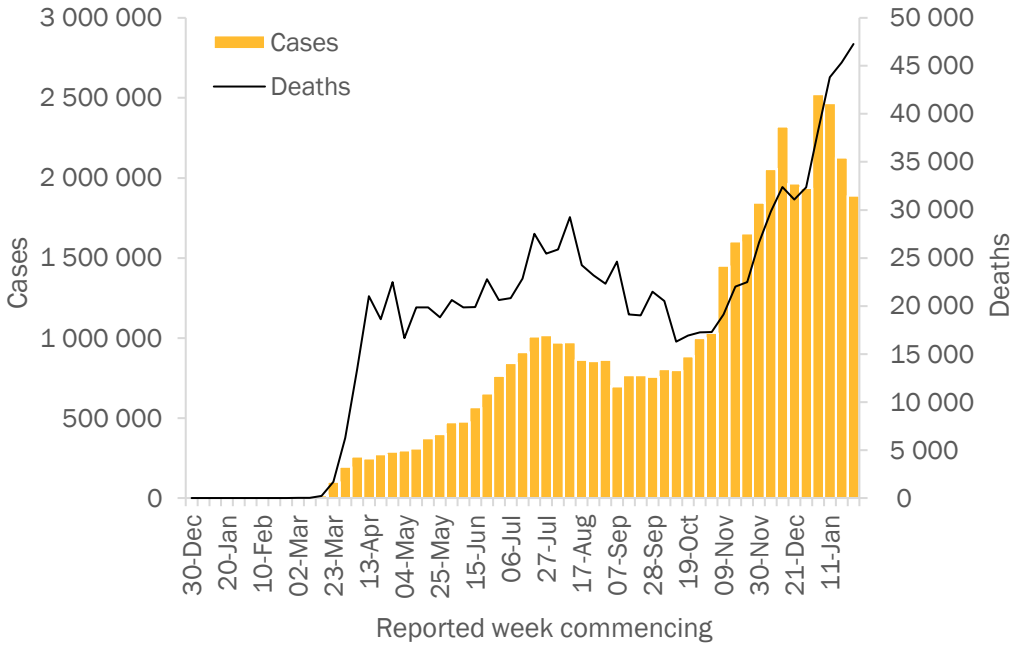
The countries reporting the highest number of new deaths in the past week were South Africa (3377 new deaths; 5.7 new deaths per 100 000; a 9% decrease), Zimbabwe (219 new deaths; 1.5 new deaths per 100 000; a 25% decrease) and Malawi (217 new deaths; 1.1 new deaths per 100 000; a 28% increase).



Region of the Americas

Over 1.8 million new cases and over 47 000 new deaths were reported in the Region of the Americas this week, a decrease of 11% and an increase of 4% respectively compared to the previous week. The highest numbers of new cases were reported from the United States of America (1 072 287 new cases; 324.0 new cases per 100 000 population; a 15% decrease), Brazil (364 593 new cases; 171.5 new cases per 100 000; a 1% increase) and Mexico (109 603 new cases; 85.0 new cases per 100 000; an 11% decrease).

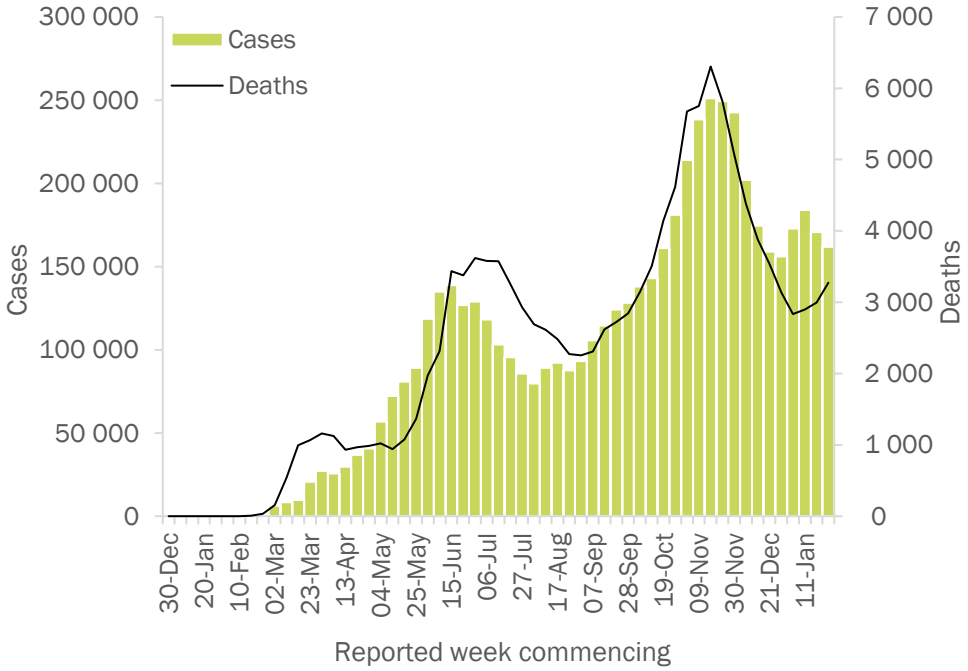
The highest numbers of deaths were reported from the same countries, the United States of America (22 506 new deaths; 6.8 new deaths per 100 000; a 4% increase), Mexico (8965 new deaths; 7.0 new deaths per 100 000; a 4% increase) and Brazil (7423 new deaths; 3.5 new deaths per 100 000; a 6% increase).



Eastern Mediterranean Region

In the past week, the Eastern Mediterranean Region reported over 161 000 new cases, a decrease of 5% compared to last week. The region reported 3200 new deaths, a 9% increase. The three countries reporting the highest numbers of new cases continue to be the Islamic Republic of Iran (44 699 new cases, 53.2 new cases per 100 000 population, a 5% increase), Lebanon (22 326 new cases, 327.1 new cases per 100 000, a 19% decrease) and United Arab Emirates (26 285 new cases, 265.8 new cases per 100 000, 7% increase).

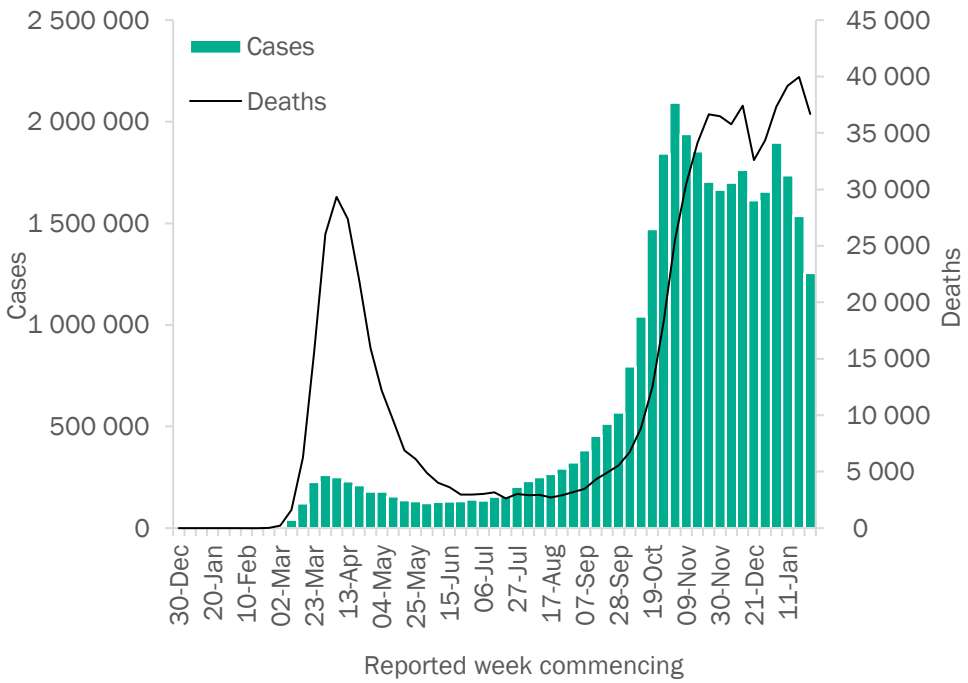
The highest numbers of new deaths were reported in Lebanon (751 new deaths, 11.0 new death per 100 000, an 81% increase), Iran (595 new deaths, 0.7 new death per 100 000 population, a 3% increase), and Tunisia (526 new deaths, 4.5 new death per 100 000, a 2% decrease).



European Region

The European Region reported over 1.2 million new cases and over 36 000 new deaths, a decrease of 18% and 8% respectively when compared to the previous week. The three countries reporting the highest numbers of new cases were the United Kingdom (178 629 new cases, 263.1 new cases per 100 000, a 31% decrease), France (141 092 new cases; 216.2 new cases per 100 000, a 2% increase) and the Russian Federation (131 039 new cases, 89.8 new cases per 100 000, a 13% decrease).

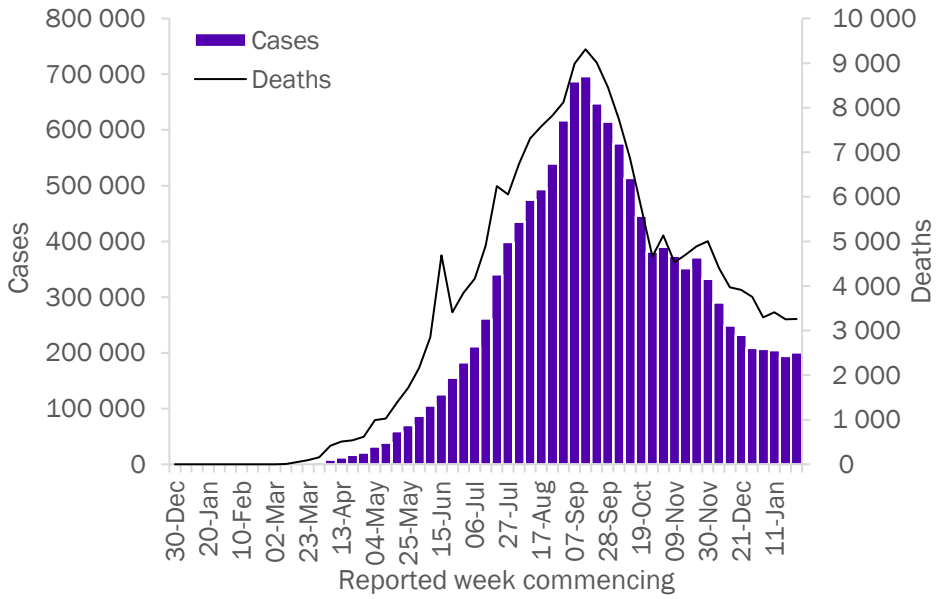
The highest numbers of deaths were reported from the United Kingdom (8242 new deaths; 12.1 new deaths per 100 000, a 6% decrease), Germany (5075 new deaths; 6.1 new deaths per 100 000, a 7% decrease) and the Russian Federation (3720 new deaths; 2.5 new deaths per 100 000, a 5% decrease).



South-East Asia Region

Following slow declines in the number of new cases in the South-East Asia Region in recent weeks, there was a plateau in newly reported cases (200 000 new cases, 3% increase from last week), and deaths (3000 new deaths, 0% change) this week. The three countries reporting the highest numbers of new cases and new deaths were India (91 650 new cases; 6.6 new cases per 100 000, a 5% decrease), Indonesia (88 839 new cases; 32.5 new cases per 100 000; a 10% increase) and Sri Lanka (5706 new cases; 26.6 new cases per 100 000; an 8% increase).

The three countries reporting the highest numbers of new deaths this week were Indonesia (2064 new deaths; 0.8 new deaths per 100 000, a 9% increase), India (935 new deaths; <0.1 new deaths per 100 000, a 12% decrease) and Bangladesh (108 new deaths; <0.1 new deaths per 100 000; a 10% decrease).



Western Pacific Region

The Western Pacific Region reported 72 000 new cases the past week, an 11% decrease compared the previous week, while a marked (21%) increase was seen in the number of new deaths, with over 1200 deaths reported this week. The three countries reporting the highest numbers of new cases in the region this week were Malaysia (29 206 new cases; 90.2 new cases per 100 000, a 15% decrease), Japan (26 081 new cases; 20.6 new cases per 100 000, a 32% decrease), and the Philippines (11 837 new cases; 10.8 new cases per 100 000, a 9% decrease).

The three countries reporting the highest numbers of new deaths this week were Japan (635 new deaths; 0.5 new deaths per 100 000, an 8% increase), the Philippines (479 new deaths; 0.4 new deaths per 100 000, an 11% increase) and Malaysia (79 new deaths; 0.2 new deaths per 100 000, a 56% increase).

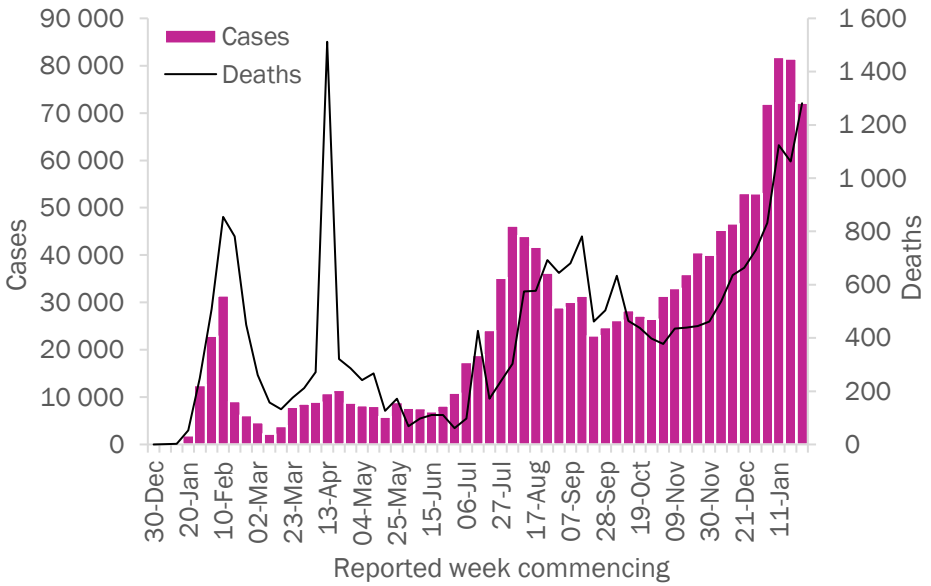


Table 2. COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region, as of 31 January 2021**

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Africa	**108 391**	**2 570 474**	**229.1**	**4 602**	**62 504**	**5.6**	
South Africa	44 397	1 449 236	2 443.5	3 377	43 951	74.1	Community transmission
Nigeria	9 955	130 557	63.3	83	1 578	0.8	Community transmission
Zambia	8 760	53 352	290.2	118	745	4.1	Community transmission
Mozambique	6 077	37 705	120.6	66	363	1.2	Community transmission
Ghana	5 312	65 427	210.6	44	405	1.3	Community transmission
Malawi	5 058	23 497	122.8	217	687	3.6	Community transmission
Ethiopia	3 723	137 021	119.2	28	2 091	1.8	Community transmission
Botswana	2 663	21 293	905.5	46	134	5.7	Community transmission
Rwanda	2 471	15 118	116.7	21	193	1.5	Community transmission
Zimbabwe	2 264	33 271	223.9	219	1 193	8.0	Community transmission
Algeria	1 753	107 122	244.3	27	2 888	6.6	Community transmission
Senegal	1 753	26 213	156.6	52	621	3.7	Community transmission
Namibia	1 615	33 828	1 331.3	33	350	13.8	Community transmission
Côte d'Ivoire	1 566	28 178	106.8	7	152	0.6	Community transmission
Eswatini	1 336	15 666	1 350.3	104	562	48.4	Community transmission
Kenya	777	100 675	187.2	15	1 755	3.3	Community transmission
Democratic Republic of the Congo	735	22 603	25.2	11	671	0.7	Community transmission
Lesotho	622	8 278	386.4	37	160	7.5	Community transmission
Burkina Faso	613	10 580	50.6	11	120	0.6	Community transmission
Cabo Verde	567	13 981	2 514.6	9	133	23.9	Community transmission
Uganda	489	39 533	86.4	7	324	0.7	Community transmission
Gabon	470	10 748	482.9	1	68	3.1	Community transmission
Comoros	458	2 718	312.6	20	90	10.3	Community transmission
Madagascar	442	18 743	67.7	6	279	1.0	Community transmission
Angola	415	19 782	60.2	7	464	1.4	Community transmission
Sierra Leone	408	3 528	44.2	2	79	1.0	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Togo	405	5 041	60.9	3	77	0.9	Community transmission
Mauritania	238	16 460	354.0	8	418	9.0	Community transmission
Chad	210	3 347	20.4	3	118	0.7	Community transmission
Eritrea	195	2 135	60.2	1	7	0.2	Sporadic cases
Niger	195	4 516	18.7	8	159	0.7	Community transmission
South Sudan	188	3 961	35.4	0	64	0.6	Community transmission
Guinea	175	14 475	110.2	1	82	0.6	Community transmission
Burundi	160	1 632	13.7	0	2	0.0	Community transmission
Seychelles	153	1 186	1 205.9	0	3	3.1	Clusters of cases
Benin	143	3 786	31.2	0	48	0.4	Community transmission
Gambia	132	4 090	169.2	0	128	5.3	Community transmission
Equatorial Guinea	115	5 516	393.2	0	86	6.1	Community transmission
Mali	104	8 069	39.8	7	330	1.6	Community transmission
Congo	93	7 887	142.9	0	117	2.1	Community transmission
Guinea-Bissau	92	2 623	133.3	0	45	2.3	Community transmission
Sao Tome and Principe	74	1 256	573.1	0	17	7.8	Community transmission
Liberia	25	1 939	38.3	0	84	1.7	Community transmission
Mauritius	12	568	44.7	0	10	0.8	Sporadic cases
Central African Republic	1	4 981	103.1	0	63	1.3	Community transmission
Cameroon	0	29 617	111.6	0	462	1.7	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territories[iii]							
Mayotte	687	8 231	3 017.1	2	61	22.4	Clusters of cases
Réunion	295	9 996	1 116.5	1	46	5.1	Clusters of cases
Americas	**1 888 070**	**45 345 051**	**4 433.5**	**47 277**	**1 047 171**	**102.4**	
United States of America	1 072 287	25 676 612	7 757.2	22 506	433 173	130.9	Community transmission
Brazil	364 593	9 118 513	4 289.9	7 423	222 666	104.8	Community transmission
Mexico	109 603	1 841 893	1 428.6	8 965	156 579	121.4	Community transmission
Colombia	90 215	2 077 633	4 083.2	2 698	53 284	104.7	Community transmission
Argentina	61 532	1 915 362	4 237.9	1 200	47 775	105.7	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Peru	37 779	1 125 875	3 414.7	1 259	40 686	123.4	Community transmission
Canada	33 386	770 793	2 042.3	973	19 801	52.5	Community transmission
Chile	28 253	722 900	3 781.6	485	18 339	95.9	Community transmission
Bolivia (Plurinational State of)	15 135	213 392	1 828.1	355	10 226	87.6	Community transmission
Ecuador	11 547	249 779	1 415.7	255	14 851	84.2	Community transmission
Panama	10 460	318 253	7 375.9	241	5 221	121.0	Community transmission
Dominican Republic	10 046	212 553	1 959.4	133	2 646	24.4	Community transmission
Honduras	6 928	146 110	1 475.2	136	3 575	36.1	Community transmission
Paraguay	5 516	131 886	1 849.1	108	2 693	37.8	Community transmission
Guatemala	5 228	159 118	888.2	162	5 618	31.4	Community transmission
Cuba	5 047	25 674	226.7	22	213	1.9	Clusters of cases
Uruguay	4 359	40 529	1 166.7	61	425	12.2	Community transmission
Costa Rica	3 968	193 276	3 794.1	86	2 604	51.1	Community transmission
Venezuela (Bolivarian Republic of)	2 981	125 776	442.3	41	1 177	4.1	Community transmission
El Salvador	1 317	53 989	832.4	63	1 614	24.9	Community transmission
Jamaica	755	15 527	524.4	12	348	11.8	Community transmission
Haiti	434	11 533	101.1	2	245	2.1	Community transmission
Saint Lucia	425	1 195	650.8	3	13	7.1	Sporadic cases
Suriname	419	8 364	1 425.8	6	154	26.3	Clusters of cases
Guyana	385	7 528	957.1	5	175	22.2	Clusters of cases
Barbados	255	1 498	521.3	3	12	4.2	Community transmission
Belize	177	11 877	2 987.0	11	301	75.7	Community transmission
Saint Vincent and the Grenadines	176	896	807.6	0	2	1.8	Clusters of cases
Trinidad and Tobago	77	7 533	538.3	1	134	9.6	Community transmission
Bahamas	64	8 174	2 078.6	1	176	44.8	Clusters of cases
Nicaragua	39	4 992	75.4	1	169	2.6	Community transmission
Antigua and Barbuda	23	218	222.6	1	7	7.1	Sporadic cases
Dominica	4	117	162.5	0	0	0.0	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Saint Kitts and Nevis	2	37	69.6	0	0	0.0	Sporadic cases
Grenada	1	148	131.5	0	1	0.9	Sporadic cases
Territories[iii]							
Puerto Rico	3 333	93 406	3 265.0	52	1 823	63.7	Community transmission
French Guiana	419	16 083	5 384.7	0	76	25.4	Community transmission
Aruba	235	6 858	6 423.4	6	58	54.3	Community transmission
Turks and Caicos Islands	215	1 459	3 768.3	1	8	20.7	Clusters of cases
Sint Maarten	114	1 822	4 248.9	0	27	63.0	Community transmission
Guadeloupe	100	9 156	2 288.3	0	157	39.2	Community transmission
Saint Martin	98	1 289	3 334.3	0	12	31.0	Community transmission
United States Virgin Islands	63	2 398	2 296.4	0	24	23.0	Community transmission
Curaçao	37	4 574	2 787.4	0	20	12.2	Community transmission
Bonaire	12	362	1 730.8	0	3	14.3	Community transmission
Cayman Islands	7	390	593.4	0	2	3.0	Sporadic cases
Bermuda	5	691	1 109.6	0	12	19.3	Sporadic cases
British Virgin Islands	4	141	466.3	0	1	3.3	Clusters of cases
Saint Pierre and Miquelon	4	24	414.2	0	0	0.0	Clusters of cases
Falkland Islands (Malvinas)	3	40	1 148.4	0	0	0.0	No cases
Saint Barthélemy	3	379	3 834.1	0	0	0.0	Sporadic cases
Anguilla	2	17	113.3	0	0	0.0	Sporadic cases
Martinique	0	6 370	1 697.5	0	44	11.7	Community transmission
Montserrat	0	13	260.1	0	1	20.0	No cases
Saba	0	6	310.4	0	0	0.0	Sporadic cases
Sint Eustatius	0	20	637.1	0	0	0.0	Sporadic cases
Eastern Mediterranean	**161 943**	**5 669 940**	**775.8**	**3 272**	**134 189**	**18.4**	
Iran (Islamic Republic of)	44 699	1 411 731	1 680.8	595	57 889	68.9	Community transmission
United Arab Emirates	26 285	300 661	3 039.9	55	838	8.5	Community transmission
Lebanon	22 326	298 913	4 379.4	751	3 031	44.4	Community transmission
Pakistan	12 396	543 214	245.9	376	11 623	5.3	Community transmission
Tunisia	12 154	207 468	1 755.4	526	6 680	56.5	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Jordan	6 155	325 674	3 191.9	87	4 304	42.2	Community transmission
Iraq	6 052	618 922	1 538.7	53	13 041	32.4	Community transmission
Libya	5 110	117 650	1 712.2	105	1 842	26.8	Community transmission
Morocco	4 922	470 691	1 275.2	131	8 259	22.4	Clusters of cases
Egypt	4 275	165 418	161.6	361	9 263	9.1	Clusters of cases
Kuwait	3 721	164 622	3 854.8	7	959	22.5	Community transmission
Bahrain	3 170	102 626	6 031.2	5	372	21.9	Clusters of cases
Qatar	2 212	150 984	5 240.6	0	248	8.6	Community transmission
Saudi Arabia	1 628	367 813	1 056.5	22	6 372	18.3	Sporadic cases
Oman	1 242	133 728	2 618.7	10	1 527	29.9	Community transmission
Sudan	579	29 449	67.2	69	1 807	4.1	Community transmission
Syrian Arab Republic	441	13 998	80.0	37	916	5.2	Community transmission
Afghanistan	428	55 023	141.3	22	2 400	6.2	Clusters of cases
Somalia	30	4 784	30.1	0	130	0.8	Community transmission
Djibouti	13	5 931	600.3	1	62	6.3	Clusters of cases
Yemen	2	2 124	7.1	0	616	2.1	Community transmission
Territories[iii]							
occupied Palestinian territory	4 103	178 516	3 499.3	59	2 010	39.4	Community transmission
Europe	**1 255 352**	**34 276 814**	**3 672.2**	**36 674**	**745 590**	**79.9**	
The United Kingdom	178 629	3 796 092	5 591.9	8 242	105 571	155.5	Community transmission
France	141 092	3 126 351	4 789.6	2 982	75 466	115.6	Community transmission
Russian Federation	131 039	3 850 439	2 638.5	3 720	73 182	50.1	Clusters of cases
Spain	109 866	2 705 001	5 785.5	1 153	57 806	123.6	Community transmission
Italy	86 598	2 541 783	4 203.9	3 117	88 279	146.0	Clusters of cases
Portugal	86 549	711 018	6 973.0	1 985	12 179	119.4	Clusters of cases
Germany	81 427	2 216 363	2 645.3	5 075	56 945	68.0	Community transmission
Czechia	47 157	984 774	9 195.8	939	16 308	152.3	Community transmission
Turkey	46 573	2 470 901	2 929.7	932	25 865	30.7	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Israel	45 194	637 242	7 362.2	406	4 722	54.6	Community transmission
Poland	37 940	1 513 385	3 998.7	1 817	37 180	98.2	Community transmission
Netherlands	31 069	974 761	5 688.8	455	13 958	81.5	Community transmission
Ukraine	27 643	1 219 455	2 788.4	846	22 707	51.9	Community transmission
Romania	17 724	726 918	3 778.6	542	18 264	94.9	Community transmission
Sweden	16 073	566 957	5 613.8	76	11 591	114.8	Community transmission
Belgium	15 503	710 153	6 127.5	283	21 092	182.0	Community transmission
Slovakia	13 437	249 913	4 577.5	574	4 642	85.0	Clusters of cases
Serbia	11 612	393 897	5 656.4	132	4 000	57.4	Community transmission
Belarus	10 711	246 570	2 609.4	69	1 708	18.1	Community transmission
Kazakhstan	9 953	235 844	1 256.0	91	3 126	16.6	Clusters of cases
Austria	9 705	409 892	4 551.1	318	7 636	84.8	Community transmission
Ireland	9 119	195 303	3 955.3	345	3 292	66.7	Community transmission
Slovenia	8 593	166 473	8 007.6	124	3 752	180.5	Clusters of cases
Switzerland	8 120	518 759	5 994.0	138	8 601	99.4	Community transmission
Hungary	8 012	367 586	3 805.1	556	12 524	129.6	Community transmission
Lithuania	5 915	182 539	6 705.3	154	2 803	103.0	Community transmission
Albania	5 810	77 251	2 684.4	59	1 369	47.6	Clusters of cases
Latvia	5 212	65 708	3 483.6	83	1 180	62.6	Community transmission
Greece	4 827	156 473	1 501.2	157	5 779	55.4	Community transmission
Georgia	4 593	258 111	6 470.3	123	3 178	79.7	Community transmission
Denmark	4 178	198 095	3 420.0	137	2 106	36.4	Community transmission
Bulgaria	3 922	218 618	3 146.3	217	9 028	129.9	Clusters of cases
Republic of Moldova	3 576	159 513	3 954.3	87	3 434	85.1	Community transmission
Croatia	3 506	232 426	5 661.7	200	5 027	122.5	Community transmission
Estonia	3 492	44 208	3 332.6	43	419	31.6	Clusters of cases
Montenegro	3 034	61 719	9 826.8	37	805	128.2	Clusters of cases
Finland	2 068	44 402	801.4	23	671	12.1	Community transmission
Bosnia and Herzegovina	2 051	121 891	3 715.3	127	4 696	143.1	Community transmission
North Macedonia	2 047	92 518	4 440.8	69	2 848	136.7	Community transmission

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Norway	2 010	62 575	1 154.3	19	563	10.4	Community transmission
Azerbaijan	1 378	230 066	2 269.1	54	3 126	30.8	Clusters of cases
Malta	1 245	17 903	4 054.6	16	267	60.5	Clusters of cases
Armenia	990	167 026	5 636.6	41	3 080	103.9	Community transmission
Luxembourg	966	50 547	8 074.9	15	579	92.5	Community transmission
Cyprus	883	30 770	2 548.5	14	197	16.3	Clusters of cases
Kyrgyzstan	629	84 529	1 295.6	12	1 412	21.6	Clusters of cases
Andorra	386	9 885	12 793.6	5	101	130.7	Community transmission
Uzbekistan	336	78 711	235.2	0	621	1.9	Clusters of cases
San Marino	151	3 025	8 913.3	2	67	197.4	Community transmission
Monaco	130	1 475	3 758.5	4	12	30.6	Sporadic cases
Liechtenstein	50	2 561	6 715.3	0	46	120.6	Sporadic cases
Iceland	21	6 002	1 758.9	0	29	8.5	Community transmission
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories[iii]							
Kosovo	2 235	59 891	3 219.3	42	1 482	79.7	Community transmission
Gibraltar	191	4 096	12 157.5	14	73	216.7	Clusters of cases
Guernsey	139	449	710.5	0	13	20.6	Community transmission
Jersey	39	3 143	2 888.8	3	66	60.7	Community transmission
Faroe Islands	2	654	1 338.4	0	1	2.0	Sporadic cases
Isle of Man	2	434	510.4	0	25	29.4	No cases
Greenland	0	30	52.8	0	0	0.0	No cases
South-East Asia	**200 219**	**12 856 723**	**636.0**	**3 258**	**197 707**	**9.8**	
India	91 650	10 746 183	778.7	935	154 274	11.2	Clusters of cases
Indonesia	88 839	1 066 313	389.8	2 064	29 728	10.9	Community transmission
Sri Lanka	5 706	63 293	295.6	33	313	1.5	Clusters of cases
Thailand	5 282	18 782	26.9	4	77	0.1	Clusters of cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Bangladesh	3 444	534 770	324.7	108	8 111	4.9	Community transmission
Myanmar	2 766	139 864	257.1	80	3 125	5.7	Clusters of cases
Nepal	1 674	270 854	929.6	33	2 027	7.0	Clusters of cases
Maldives	851	15 736	2 911.1	1	51	9.4	Clusters of cases
Bhutan	4	858	111.2	0	1	0.1	Clusters of cases
Timor-Leste	3	70	5.3	0	0	0.0	Sporadic cases
Western Pacific	**72 135**	**1 420 024**	**72.3**	**1 281**	**24 588**	**1.3**	
Malaysia	29 206	209 661	647.8	79	746	2.3	Clusters of cases
Japan	26 081	386 742	305.8	635	5 654	4.5	Clusters of cases
Philippines	11 837	523 516	477.7	479	10 669	9.7	Community transmission
Republic of Korea	3 122	78 203	152.5	71	1 420	2.8	Clusters of cases
China	946	100 877	6.9	13	4 823	0.3	Clusters of cases
Singapore	247	59 507	1 017.2	0	29	0.5	Sporadic cases
Viet Nam	233	1 781	1.8	0	35	0.0	Clusters of cases
Mongolia	131	1 742	53.1	0	2	0.1	Clusters of cases
Australia	45	28 806	113.0	0	909	3.6	Clusters of cases
New Zealand	21	1 947	40.4	0	25	0.5	Clusters of cases
Cambodia	7	465	2.8	0	0	0.0	Sporadic cases
Brunei Darussalam	5	180	41.1	0	3	0.7	Sporadic cases
Papua New Guinea	2	851	9.5	0	9	0.1	Community transmission
Lao People's Democratic Republic	1	44	0.6	0	0	0.0	Sporadic cases
Fiji	0	55	6.1	0	2	0.2	Sporadic cases
Solomon Islands	0	17	2.5	0	0	0.0	No cases
Territories[iii]							
French Polynesia	208	18 060	6 429.2	3	131	46.6	Sporadic cases
Guam	39	7 379	4 372.1	1	129	76.4	Clusters of cases
New Caledonia	3	47	16.5	0	0	0.0	Sporadic cases
Wallis and Futuna	1	5	44.5	0	0	0.0	Sporadic cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases

Reporting Country/Territory/Area[i]	New cases in last 7 days	Cumulative cases	Cumulative cases per 100 thousand population	New deaths in last 7 days	Cumulative deaths	Cumulative deaths per 100 thousand population	Transmission classification[ii]
Northern Mariana Islands (Commonwealth of the)	0	132	229.3	0	2	3.5	Pending
Samoa	0	2	1.0	0	0	0.0	No cases
Vanuatu	0	1	0.3	0	0	0.0	No cases
Global	**3 686 110**	**102 139 771**	**1 310.3**	**96 364**	**2 211 762**	**28.4**	

See *data, table and figure notes*

Key Weekly Updates

WHO Director-General Dr Tedros remarks

On health workers and older people
"I leave you with the challenge I set at the beginning of the week: together, we must ensure that vaccination of health workers and older people is underway in all countries within the first 100 days of this year." Closing remarks at 148th session of the Executive Board

On vaccine equity
"Vaccine nationalism is self-defeating and inefficient, leaving the world's poorest and most vulnerable people at risk." The Director-General recommended three urgent actions: "First, prompt and equitable dose sharing is critical if we are to overcome this pandemic. Second, we need support to close the funding gap of 26 billion US dollars for the ACT Accelerator this year, including 7.8 billion dollars for COVAX. If fully funded, the ACT Accelerator would return up to 166 US dollars for every dollar invested. And third, even as we work to end the pandemic, we must learn the lessons it is teaching us." NORAD Conference 2021, panel: Vaccine nationalism and global distribution and Closing remarks at 148th session of the Executive Board

Therapeutics and vaccines
"We have identified dexamethasone to treat severe disease, which is being stockpiled for use in low and lower-middle income countries.

And the development and approval of safe and effective vaccines less than a year after the emergence of this new virus is a stunning scientific achievement. It gives us all a much-needed source of hope." Debate on the report "COVID-19 vaccines: ethical, legal and practical considerations

Moderna vaccine

The Moderna COVID-19 (mRNA-1273) vaccine: what you need to know

Interim recommendations for use of the Moderna mRNA-1273 vaccine against COVID-19

Testing

WHO publishes new Essential Diagnostics List and urges countries to prioritize investments in testing

The selection and use of essential in vitro diagnostics - TRS 1031

COVID-19 and oral health-care

New videos explain how to prevent COVID-19 infection in oral health-care services

Publications

COVID-19 Clinical management: living guidance

Laboratory biosafety guidance related to coronavirus disease (COVID-19): Interim guidance

Technical guidance and other resources

- Technical guidance
- WHO Coronavirus Disease (COVID-19) Dashboard
- Weekly COVID-19 Operational Updates
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- Online courses on COVID-19 in official UN languages and in additional national languages
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Updates from WHO regions
  - African Region
  - Eastern Mediterranean Region
  - European Region
  - Region of the Americas
  - South-East Asia Region
  - Western Pacific Region

Recommendations and advice for the public

- Protect yourself
- Questions and answers
- Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities

Data, table and figure notes

Data presented are based on official laboratory-confirmed COVID-19 case and deaths reported to WHO by country/territories/areas, largely based upon WHO case definitions and surveillance guidance. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change, and caution must be taken when interpreting these data as several factors influence the counts presented, with variable underestimation of true case and death incidence, and variable delays to reflecting these data at global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/areas. A small number of countries/territories/areas report combined probable and laboratory-confirmed cases. Differences are to be expected between information products published by WHO, national public health authorities, and other sources. Due to public health authorities conducting data reconciliation exercises which remove large numbers of cases or deaths from their total counts, negative numbers may be displayed in the new cases/deaths columns as appropriate. When additional details become available that allow the subtractions to be suitably apportioned to previous days, graphics will be updated accordingly. See the log of major changes and errata for details. Prior situation reports will not be edited; see covid19.who.int for the most up-to-date data.
Global totals include 745 cases and 13 deaths reported from international conveyances.

The designations employed, and the presentation of these materials do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Countries, territories and areas are arranged under the administering WHO region. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). In the map, number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes.

[i] Excludes countries, territories, and areas that have never reported a confirmed COVID-19 case.

[ii] Transmission classification is based on a process of country/territory/area self-reporting. Classifications are reviewed on a weekly basis and may be revised as new information becomes available. Differing degrees of transmission may be present within countries/territories/areas. For further information, please see: Considerations for implementing and adjusting public health and social measures in the context of COVID-19:

- No (active) cases: No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust surveillance system. This implies a near-zero risk of infection for the general population.
- Imported / Sporadic cases: Cases detected in the past 14 days are all imported, sporadic (e.g., laboratory acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.
- Clusters of cases: Cases detected in the past 14 days are predominantly limited to well-defined clusters that are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.
- Community transmission: Which encompasses a range of levels from low to very high incidence, as described below and informed by a series of indicators described in the aforementioned guidance. As these subcategorization are not currently collated at the global level, but rather intended for use by national and sub-national public health authorities for local decision-making, community transmission has not been disaggregated in this information product.
    - CT1: Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
    - CT2: Moderate incidence of locally acquired, widely dispersed cases detected in the past 14 days; transmission less focused in certain population sub-groups. Moderate risk of infection for the general population.
    - CT3: High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population sub-groups. High risk of infection for the general population.
    - CT4: Very high incidence of locally acquired, widely dispersed cases in the past 14 days. Very high risk of infection for the general population.
- Pending: transmission classification has not been reported to WHO.

[iii] "Territories" include territories, areas, overseas dependencies and other jurisdictions of similar status.

Weekly Operational Update on COVID-19

1 February 2021

Confirmed cases[a]
102 399 513

Confirmed deaths
2 217 005

PAHO launches app that helps health workers use PPE more effectively

The Pan American Health Organization (PAHO) launched a mobile application, MedPPE, this week that provides detailed information on the personal protective equipment that health personnel should use to guard against COVID-19, depending on their role and workplace.

MedPPE emphasizes the role and timing of health workers jobs and offers specific information to prevent the spread of COVID-19 and is available in Spanish, English, Portuguese, and French. The guidelines are aimed at all personnel working in health facilities, including security guards, administrative and cleaning personnel, transfer assistants, nurses, biomedical and imaging technicians, surgeons, and physicians, among others.

The correct use of PPE remains key to preventing infection and spread of the virus in hospital settings and to protecting essential workers in the response to the pandemic.

MedPPE provides guidance for the use of PPE according to workers' function, the level of care they provide, and the multiple environments of primary health care and hospitals.

For more information on MedPPE, click here.

Key Figures

WHO-led UN Crisis-Management Team coordinating 23 UN entities across nine areas of work

145 GOARN deployments conducted to support COVID-19 pandemic response

19 948 965 respirators shipped globally

197 343 426 medical masks shipped globally

8 540 231 face shields shipped globally

6 713 379 gowns shipped globally

35 821 900 gloves shipped globally

More than **2.5 million** people registered on OpenWHO and able to access **25 topical** courses in **44** languages

[a] For the latest data and information, see the WHO COVID-19 Dashboard and Situation Reports

From the field:

Ukraine conducts Intra-Action Review to adjust COVID-19 response

Intra-Action Review in Ukraine. Credit: WHO CO Ukraine

On 27-28 January 2021, WHO Regional Office for Europe and the Ukraine WHO Country Office supported the Ministry of Health and the Ukrainian Public Health Centre to conduct a Country Intra-Action Review (IAR) for the COVID-19 response in Ukraine. The IAR allowed to review the national functional capacity of the public health and emergency response systems and to identify practical areas for immediate remediation or continuous improvement of the current response to the COVID-19 outbreak.

During the review, over 130 participants from multisectoral teams took part in 7 groups centered around the pillars of the response, including country-level coordination, risk communication and community engagement, points of entry, national laboratories, infection prevention and control, and operation support and logistics. The format of the IAR was a mix of in person and virtual collaboration to adjust to COVID-19 prevention measures in place.

The main goal of the IAR was to support the country in reviewing the actions implemented in all the critical response areas over the past year at the national and regional levels. WHO Regional Office for Europe provided guidance on the organization of an IAR according to WHO recommendations, and helped to run and facilitate the review sessions.

The IAR will provide practical recommendations and action points identified by the participants for sustained improvement of the ongoing COVID-19 response and updating the Ukrainian Country Preparedness and Response Plan (CPRP) accordingly.

Public health response and coordination highlights

During the United Nations (UN) Crisis Management Team (CMT) meeting on 27 January 2021, **WHO** provided an update on the SARS-COV-2 variants identified in the UK, South Africa and Brazil and noted that current vaccines appear to be effective to the variants. WHO advised the continued development of a common risk monitoring framework, building on existing detection systems, linking human/animal transmission with broader surveillance efforts.

The Yellow House, an independent consultant briefed on their COVID-19 Supply Chain System (CSCS) assessment, citing immense achievements made by UN partners, including **WFP, UNICEF and WHO** among others, in the procurement and delivery of large quantities of critical COVID-19 supplies to countries worldwide.

On external communications, **WHO** informed that it is working with UNICEF on vaccine equity campaigns and asked the rest of the UN system to draw attention to the success in procuring and delivering large quantities of essential goods during a critical phase of the pandemic.

COVID-19 Preparedness

Mauritius conducts a COVID-19 vaccine simulation exercise prior to the national vaccine roll-out.

In collaboration with the Ministry of Health, the WHO Country Office in Mauritius conducted a discussion-based table top exercise on 25 January 2021. The exercise focused on the national deployment and vaccination plan (NDVP) and tested the planning assumptions before national vaccination roll-out. The exercise was carried out using the COVID-19 vaccine tabletop exercise packages that were developed and published by WHO.

Start of the COVID-19 national vaccination roll-out in Mauritius. Photo Credit: WHO/Mauritius

The exercise focused on potential regulatory and safety issues, as well as the overall strategy, supply chain and communications aspects of vaccine roll-out. It helped test the regulatory frameworks and systems, as well as procedures and oversight for monitoring vaccine safety after it is deployed, while the strategy, supply chain and communications aspects helped identify the target populations and test vaccination strategies, manage supply chains, and prepare communication plans to promote vaccine acceptance and uptake.

Around 25 participants joined in the exercise including from National Regulatory Agency, decision-makers, logisticians, warehouse & logistic managers and communication specialists. The exercise helped to test and make final adjustments to the national vaccination strategy and plan before the national roll-out started on 26 January 2021.

Prior to the exercise, together with AFRO a brief training was provided to the MoH and Country Office staff to update them on the vaccine exercise package content and ensure smooth implementation and support. The vaccine exercise packages have been developed by the Health Security Preparedness (HSP) Department and through the collaboration with the Access to COVID-19 Tools (ACT) Accelerator's Country Readiness and Delivery (CRD) workstream.

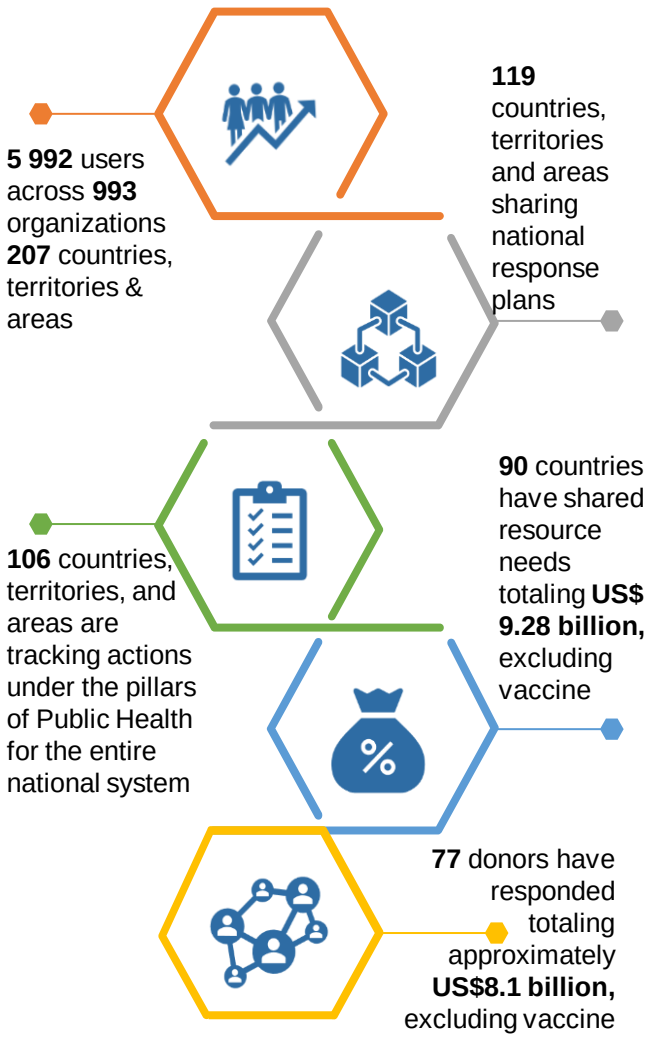
COVID-19 Partners platform

Trainings for roll-out of vaccine introduction

WHO, UNICEF and partners are supporting countries in preparing for COVID-19 vaccine introduction through the Access to COVID-19 Tools (ACT) Accelerator.

The Country Readiness and Delivery (CRD) workstream – which is part of the ACT Accelerator and is included in the SPRP – has developed a toolbox with guidance, tools, and trainings.

The trainings for national/subnational focal points and health workers to prepare for COVID-19 vaccine roll-out have been taken by more than 35,000 learners globally and are being translated into 12 languages. Additional trainings and resources, including for acceptance and uptake of COVID-19 vaccines and preparing for COVID-19 vaccine supply and logistics, will be added to the toolbox shortly.



With the launch of the CRD COVID-19 vaccine introduction on the Partners Platform online tool, WHO is providing technical training sessions to ensure all the new Vaccine Regional Administrators (VRA) and Vaccine Country Administrators (VCA) are able to quickly and efficiently perform essential tasks in the National Deployment and Vaccination Plan (NDVP) process. VRAs and VCAs are appointed by the Regional Advisors for Immunization.

In these digital training sessions, provided in English, Spanish, French and Arabic, WHO technical experts from the Partners Platform team will guide participants through the completion and uploading of the NDVP and provide an overview of the next stages of the process, including validation by a government official, Costing Technical Assistance and funding resource needs, assessment by the Regional Review Committee (RRC), and progression to allocation by the Joint Allocation Task Force.

These trainings take place from Monday, 25 January to Tuesday, 5 February. Regional Advisors for Immunization can provide the VCAs and RCAs with the training schedule. Archived recordings of these sessions will be available here.

Operations Support and Logistics

The COVID-19 pandemic has prompted an unprecedented global demand for Personal Protective Equipment (PPE), diagnostics and clinical care products.

To ensure market access for low- and middle-income countries, WHO and partners have created a COVID-19 Supply Chain System, which has delivered supplies globally

The table below reflects WHO/PAHO-procured items that have been shipped as of 29 January. 2021

Shipped items as of 29 Jan 2021	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	700 800	3 649 890	2 079 446	1 423 210	10 139 300	208 050	1 717 279	53 429 400	2 700 630
Americas (AMR)	6 030 050	1 019 862	10 518 766	3 333 200	4 696 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	840 300	1 245 910	1 843 210	914 985	6 905 000	174 480	799 322	26 317 550	1 502 095
Europe (EUR)	248 000	404 050	580 190	1 728 300	8 935 100	399 820	1 564 748	40 545 400	5 369 950
South East Asia (SEAR)	200 000	2 352 150	2 482 024	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		175 800	348 848	768 700	3 021 000	311 927	463 710	14 974 146	2 102 035
TOTAL	**8 019 150**	**8 847 662**	**17 852 484**	**8 540 231**	**35 821 900**	**1 503 727**	**6 713 379**	**197 343 426**	**19 948 965**

For further information on the **COVID-19 supply chain system**, see here.

Appeals

WHO *appreciates and thanks donors for the support already provided or pledged and encourages donors to* ***give fully flexible funding for the SPRP*** *and avoid even high-level/soft geographic earmarking at e.g. regional or country level. This will allow WHO to direct resources to where they are most needed, which in some cases may be towards global procurement of supplies, intended for countries.*

As of 20 January 2021

Global Strategic Preparedness & Response Plan (SPRP)

US$ 1.5 billion raised

US$ 1.7 billion requested

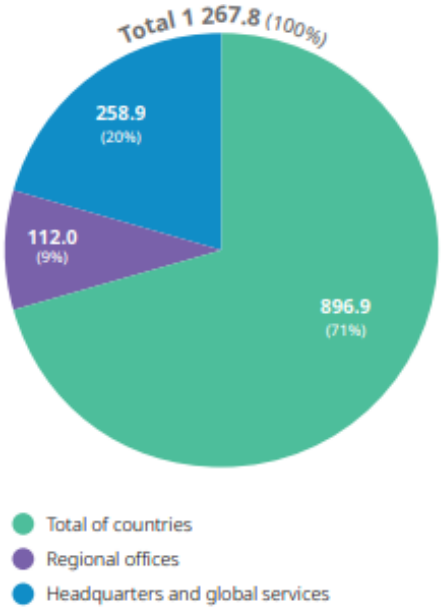
US$ 1.5 billion raised by WHO during 2020
US$ 1.3 billion projected utilization for 2020 SPRP

US$ 240 million raised by the COVID-19 Solidarity Response Fund

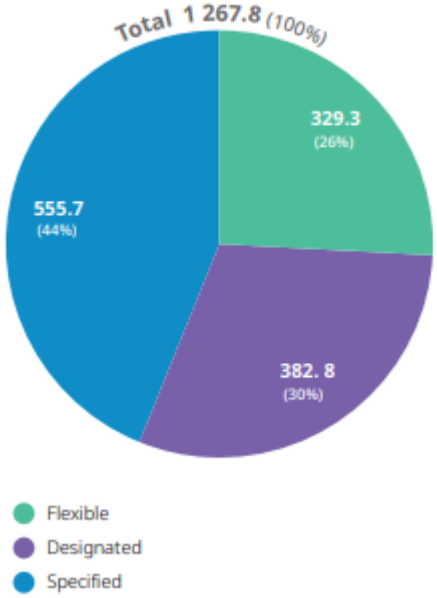
US$1 billion on country support and regional coordination

The status of funding raised for WHO against the SPRP can be found here

Utilization* by type of funds by level of organization (US$ million)



Utilization* by type of funding by level of earmarking (US$ million)



*Based on interim 2020 year-end figures and estimated 2021 Q1 transition period implementation

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

The COVID-19 Solidarity Response Fund remains the foremost way for companies, organisations and individuals to contribute to the essential work of WHO and its partners to help countries prevent, detect and respond to the global pandemic.

By 29 January 2021, more than 659,000 leading companies, foundations and individuals from more than 190 countries had committed more than US$ 241 million in fully flexible funding to the COVID-19 Solidarity Response Fund to support the lifesaving work of WHO and its partners.

More than US$ 241 Million

659 000 donors

[individuals – companies – philanthropies]

Health Learning

WHO is expanding access to online learning for COVID-19 through its open learning platform for health emergencies, OpenWHO.org.

The OpenWHO platform was launched in June 2017 and published its first COVID-19 course on 26 January 2020.

4 830 789
Course enrollments

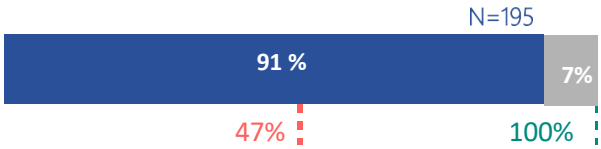
44 languages

25 topical courses

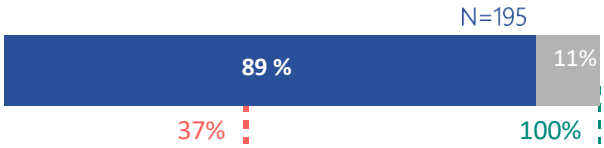
Over 2.5 million certificates

COVID-19 Global Preparedness and Response Summary Indicators [a]

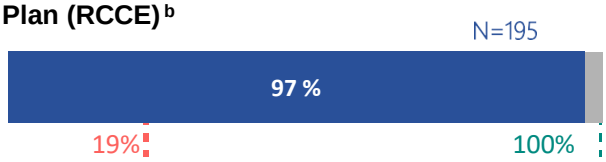
Countries have a COVID-19 preparedness and response plan



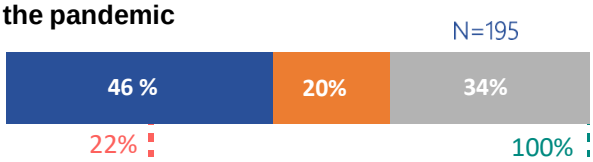
Countries have a clinical referral system in place to care for COVID-19 cases



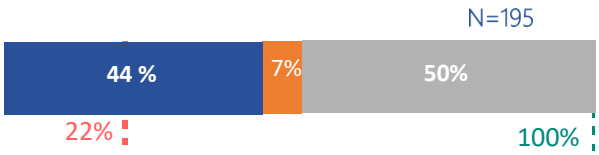
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE) [b]



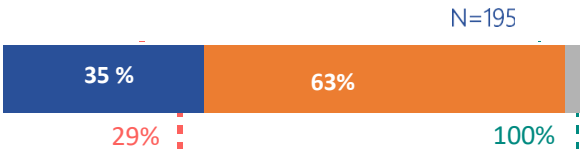
Countries that have defined essential health services to be maintained during the pandemic



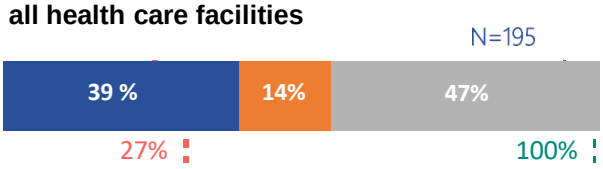
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



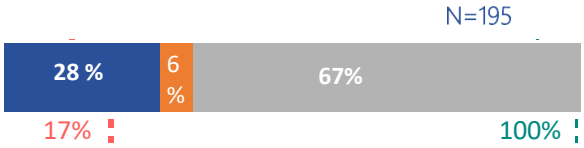
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



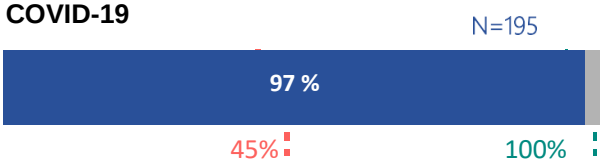
Countries with a national IPC programme & WASH standards within all health care facilities



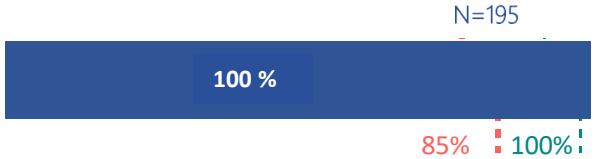
Countries have a health occupational safety plan for health care workers



Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



Countries have COVID-19 laboratory testing capacity



Legend

Yes | No | No information | Baseline value | Target value

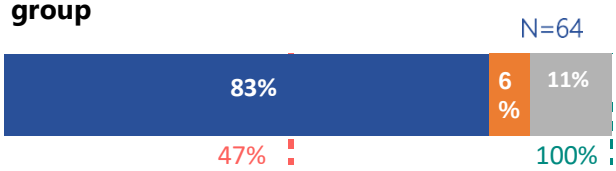
Notes:

a Data collected from Member States and territories. The term "countries" should be understood as referring to "countries and territories." b Source: UNICEF and WHO

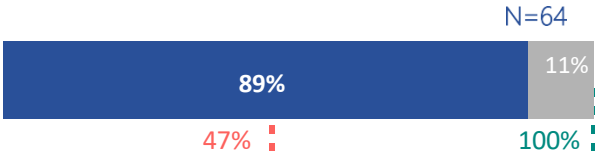
COVID-19 Global Preparedness and Response Summary Indicators

Selected indicators within the Monitoring and Evaluation Framework apply to designated priority countries. Priority Countries are mostly defined as countries affected by the COVID-19 pandemic as included in the Global Humanitarian and Response Plan. A full list of priority countries can be found here.

Priority countries with multisectoral mental health & psychosocial support working group

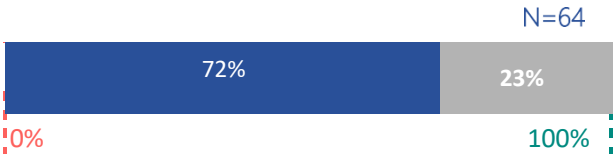


Priority countries with an active & implemented RCCE coordination mechanism

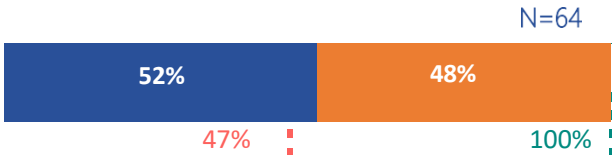


Priority countries that have postponed at least 1 vaccination campaign due to COVID-19 [c]

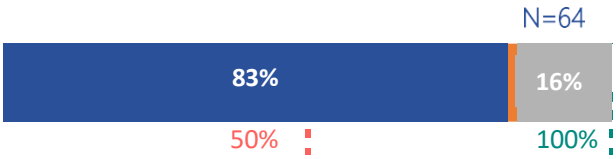
Priority countries with a contact tracing focal point

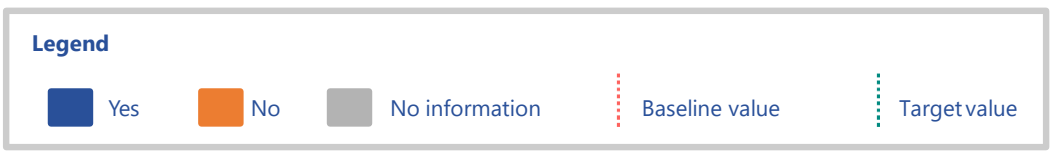


Priority countries where at least one Incident Management Support Team (IMST) member trained in essential supply forecasting



Priority countries with an IPC focal point for training





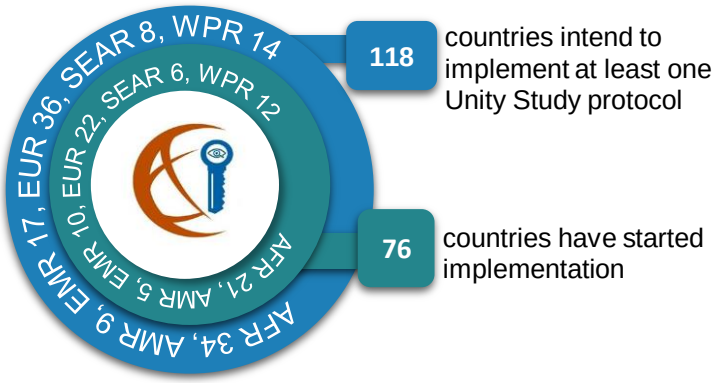
Notes:

c Source: WHO Immunization Repository

The Unity Studies: WHO Early Investigations Protocols

Unity studies is a global sero-epidemiological standardization initiative, which aims at increasing the evidence-based knowledge for action.
It enables any countries, in any resource setting, to gather rapidly robust data on key epidemiological parameters to understand, respond and control the COVID-19 pandemic.

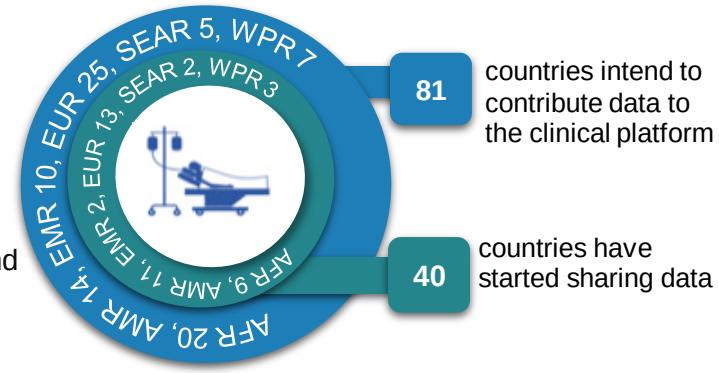
The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays



Global COVID-19 Clinical Data Platform

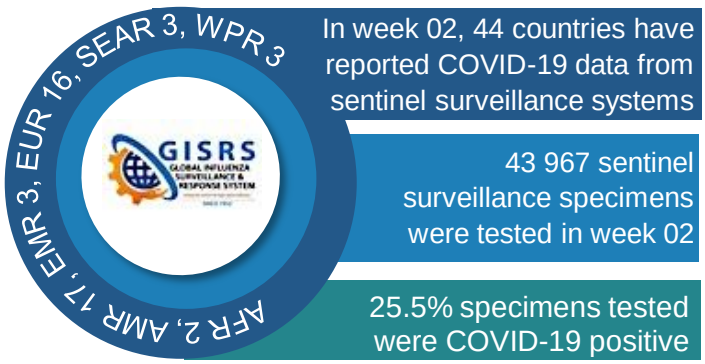
Global understanding of the severity, clinical features and prognostic factors of COVID-19 in different settings and populations remains incomplete.

WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



Leveraging the Global Influenza Surveillance and Response System

WHO recommends that countries use existing syndromic respiratory disease surveillance systems such as those for influenza like illness (ILI) or severe acute respiratory infection (SARI) for COVID-19 surveillance. Leveraging existing systems is an efficient and cost-effective approach to enhancing COVID-19 surveillance. The Global Influenza Surveillance and Response System (GISRS) is playing an important role in monitoring the spread and trends of COVID-19



Key links and useful resources

- For EPI-WIN: WHO Information Network for Epidemics, click **here**
- For more information on COVID-19 regional response:
  - **African Regional Office**
  - **Regional Office of the Americas**
  - **European Regional Office**
  - **Eastern Mediterranean Regional Office**
  - **Southeast Asia Regional Office**
  - **Western Pacific Regional Office**
- For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection published on 16 December 2020, click **here**
- For updated WHO Publications and Technical Guidance on COVID-19, click **here**
- For updated GOARN network activities, click here
- Updated COVID-19 Table top Exercise packages are now available online to better reflect the current situation as well as align it to the latest WHO guidance. The updated exercises include:
  - Generic table top exercise
  - Health Facility & IPC table top exercise
  - A Point of Entry (POE) table top exercise
  - Target population, supply chain and community engagement & communications table top exercise
  - The regulatory and safety issues table top exercise

  All COVID-19 simulation exercises can be found here