

COVID-19 Weekly Epidemiological Update

Data as received by WHO from national authorities, as of 28 March 2021, 10 am CET

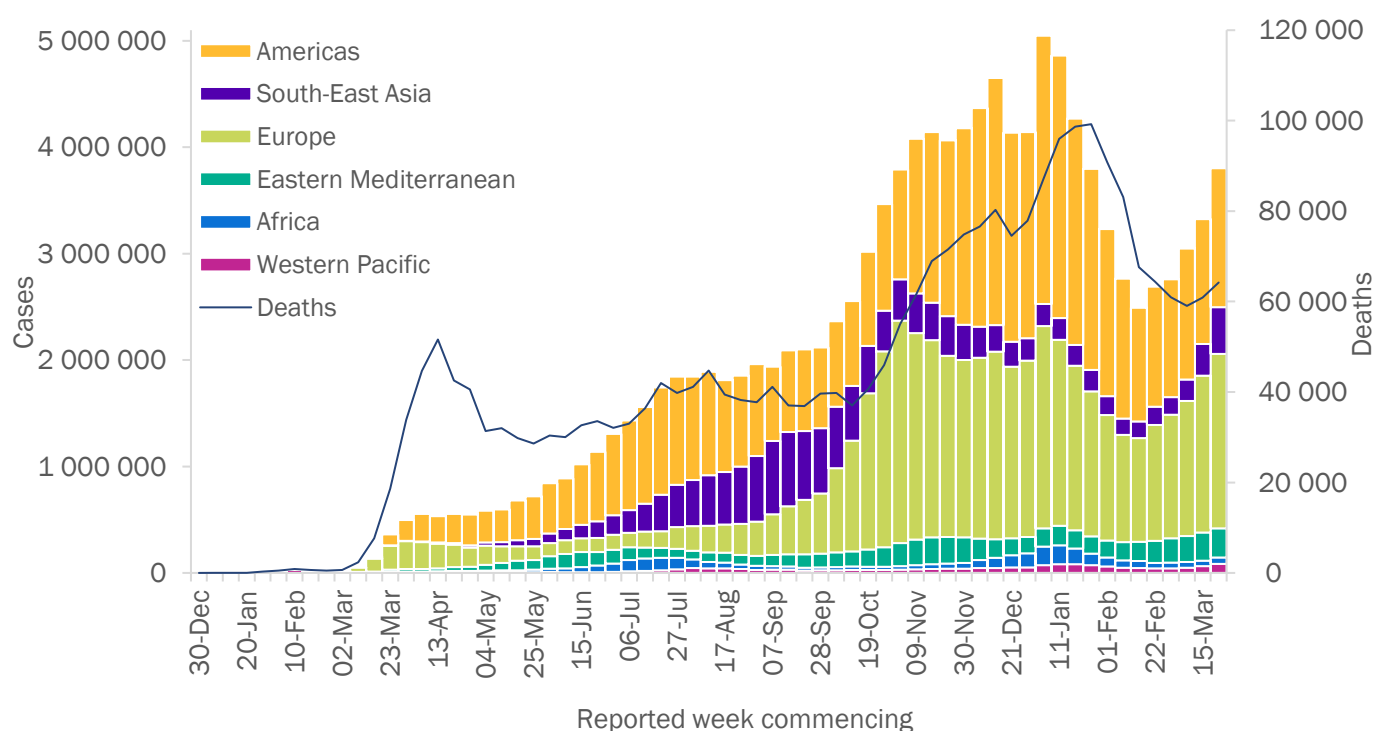
In this edition:

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Global overview

Globally, new COVID-19 cases rose for a fifth consecutive week, with just over 3.8 million new cases reported in the last week (Figure 1). The number of new deaths increased for the second consecutive week, increasing by 5% compared to last week, with over 64 000 new deaths reported. All regions reported an increase in the number of cases this week, with the largest increases in the South-East Asia, Western Pacific, and African Regions, all of which have been on an upward trajectory in recent weeks. All regions, except for the African Region, reported an increase in the number of deaths, with the largest increase of 21% from the South-East Asia Region, which is on its third week of an increasing trend. The European Region and the Region of the Americas continue to account for approximately 80% of all new and cumulative cases and deaths.

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 28 March 2021**



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

The highest numbers of new cases were reported from Brazil (533 024 new cases; 5% increase), the United States of America (421 936 new cases; 13% increase), India (372 494 new cases; 55% increase), France (254 228 new cases; 24% increase), and Poland (192 441 new cases; 27% increase).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 28 March 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	1 306 017 (34%)	11%	55 243 776 (44%)	32 176 (50%)	4%	1 331 419 (48%)
Europe	1 641 672 (43%)	11%	44 191 579 (35%)	23 778 (37%)	7%	954 829 (34%)
South-East Asia	437 060 (11%)	46%	14 619 886 (12%)	2 947 (5%)	21%	217 737 (8%)
Eastern Mediterranean	270 884 (7%)	3%	7 395 085 (6%)	3 428 (5%)	5%	156 891 (6%)
Africa	62 286 (2%)	22%	3 061 438 (2%)	1 340 (2%)	-6%	77 446 (3%)
Western Pacific	84 395 (2%)	32%	1 859 933 (1%)	518 (1%)	7%	31 361 (1%)
Global	3 802 314 (100%)	14%	126 372 442 (100%)	64 187 (100%)	5%	2 769 696 (100%)

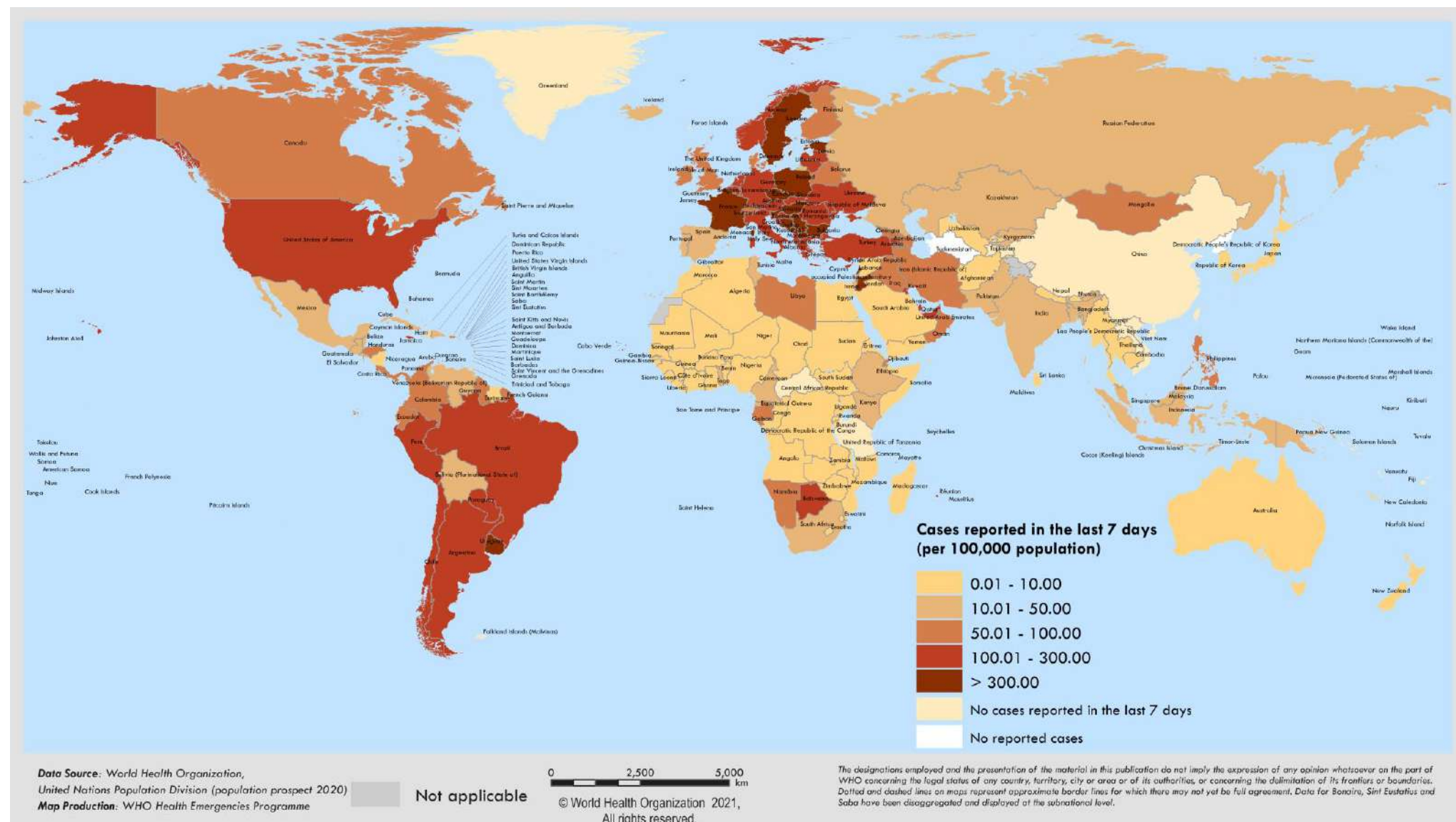
*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number; global totals may not equal 100%.

**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 by countries, territories and areas, 22-28 March 2021**

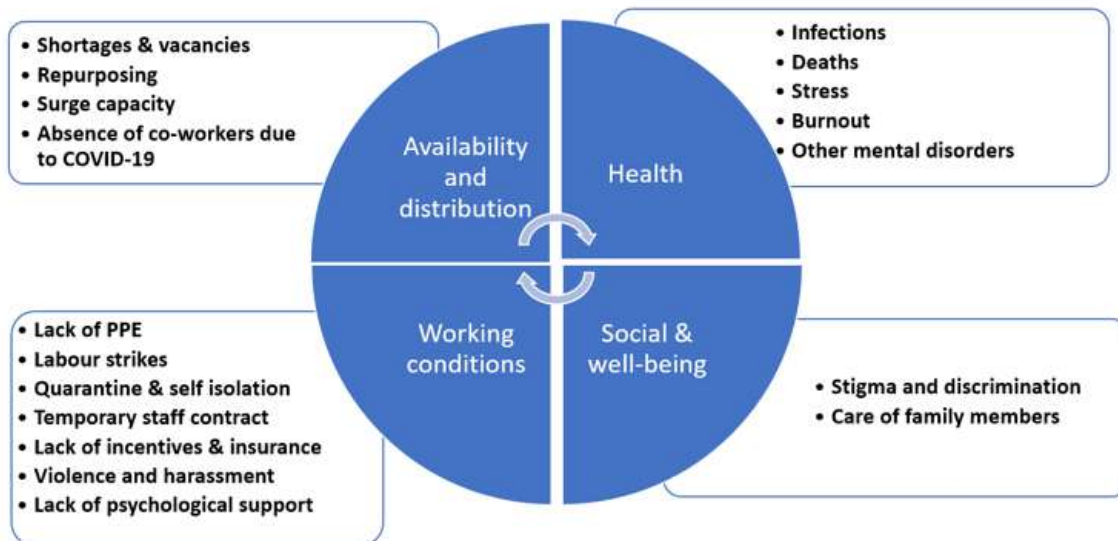


**See [Annex: Data, table and figure notes](#)

Special Focus: COVID-19 and Health and Care Workers (HCWs)

HCWs have been central to the COVID-19 response since the beginning of the pandemic. Many of their functions and roles put them at risk of exposure to hazards that can impact their working conditions as well as have impact their physical and social well-being. It is therefore critical to monitor the multidimensional factors affecting HCWs as the pandemic continues (Figure 3).

Figure 3. Multidimensional factors related to COVID-19 that impact HCWs



HCWs continue to face a range of interconnected factors that affect their mental health and stress levels which increase with irregular working hours, higher levels of exposure to illness, fear of infection with COVID-19 related to exposure, and/or lack of adequate PPE amongst others. Published studies show that the prevalence of mental health conditions among HCWs was significantly higher than other professional groups. HCWs reported a higher level of anxiety (13.0% vs. 8.5%) and depression (12.2% vs. 9.5%)¹ as compared to other groups, with insomnia as a risk factor for both. A recent study with data from six countries found that insomnia, sleeping disorders and burnout were significant risk factors for COVID-19 infection among HCWs².

As the pandemic continues, more evidence has been collected to describe the challenging working and psychosocial conditions HCWs face daily (Table 2).

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7409979/>

² <https://nutrition.bmj.com/content/early/2021/03/03/bmjnph-2021-000228>

Table 2. A selective summary of the COVID-19 impact dimension on HCWs

Dimension	Evidence
Stigma and discrimination	HCWs were at increased risk to experience stigma and bullying, adjusted odds ratio: 1.5 (95% CI 1.2 to 2.0). ³
Violence	Since the beginning of the outbreak, attacks on health care have continuously been reported and now also include incidents linked to the COVID-19 pandemic across the world. ⁴
Lack of PPE	Lack of PPE for HCWs has been observed in several countries. ^{5 6}
Strike actions	An independent analysis has identified industrial dispute and strike action in 84 Member States since February 2020; of which 38% and 29% of strikes are due to poor working conditions and lack of PPE, respectively. ⁷
Quarantine and self-isolation	In a survey of health professionals and allied employees, 24% of HCWs declared that they had to return to work while still having symptoms of COVID-19. ⁸
Other working conditions	Role of privatization in delivery of services, managerial practices in nursing homes exacerbated impact of COVID-19. ⁹

HCWs continue to play an integral role in the pandemic response. It is crucial that HCWs be adequately supported in order to ensure their physical and mental well-being.

³ Dye TD, Alcantara L, Siddiqi S, et al. Risk of COVID-19-related bullying, harassment and stigma among healthcare workers: an analytical cross-sectional global study. *BMJ Open* 2020;10:e046620. doi: 10.1136/bmjopen-2020-046620

⁴ <https://www.who.int/news-room/feature-stories/detail/attacks-on-health-care-in-the-context-of-covid-19>

⁵ J Cohena, YM Rodgersc. Contributing factors to personal protective equipment shortages during the COVID-19 pandemic. *Prev Med.* 2020 Dec; 141: 106263.

⁶ <https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide>

⁷ <https://www.who.int/campaigns/annual-theme/year-of-health-and-care-workers-2021/facts>

⁸ Health professionals and allied employees. Exposed and at risk. HPAE white paper July 2020.

⁹ Pat Armstrong, Hugh Armstrong, Ivy Lynn Bourgeault, Pat Armstrong. Privatization and COVID-19: A Deadly Combination for Nursing Homes July 2020 In book: *Vulnerable: The Policy, Law and Ethics of COVID-19*. Publisher: University of Ottawa Press

Special Focus: Update on SARS-CoV-2 Variants

All viruses, including SARS-CoV-2, change over time resulting in the emergence of new variants, most without a direct benefit to the virus or other public health impacts. WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 result in changes in transmissibility, clinical presentation and severity, or if they impact public health and social measures (PHSM). Systems have been established to detect “signals” of potential variants of concern (VOCs) or variants of interest (VOIs), as well as unusual events potentially associated with a variant, and assess these based on the risk posed to global public health (see also [working definitions](#)). A number of such signals are currently under assessment, and as new VOCs and VOIs are determined, WHO is committed to highlighting these to support prioritization for further monitoring and assessment. National authorities may choose to designate other variants of local interest/concern as every local situation is unique, with different variants circulating, requiring surveillance and response systems to adapt to their local epidemiological situation.

Further information on the background of the variants of concern (VOCs) and variants of interest (VOIs) is available in previously published editions of the [Weekly Epidemiological Update](#). Here we provide a brief update on the geographical distribution of the three variants classified as VOCs by WHO as of 30 March 2021 as well as an update on emerging VOIs.

As surveillance activities to detect SARS-CoV-2 variant cases are strengthened at local and national levels, including systematic genomic sequencing, the number of countries reporting VOCs has continued to increase (Table 3, Figures 4-6, Annex 2). This information should be interpreted with due consideration of surveillance limitations, including but not limited to differences between countries in sequencing capacity and prioritization of samples for sequencing. WHO continues to advocate for strengthening surveillance and sequencing capacity, and a systematic approach to provide a representative indication of the extent of transmission of SARS-CoV-2 variants based on the local epidemiological situation and capacity, and the detection of unusual events.

Table 3: Overview of emerging information on variants of concern, as of 30 March 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, alias P.1 [†]
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01 [†]	VOC 202012/02	-
First detected by	United Kingdom	South Africa	Brazil / Japan
Earliest sample date	20 September 2020	Early August 2020	December 2020
Key spike mutations	H69/V70 deletion; Y144 deletion; N501Y; A570D; and P681H	L242/A243/L244 deletion; K417N E484K, N501Y	K417T, E484K; N501Y
Key mutation in common	S106/G107/F108 deletion in Non-Structural Protein 6 (NSP6)		
Countries reporting cases (newly reported in last week)**	130 (5)	80 (5)	45(4)

[†]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).

Figure 4. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 30 March 2021



Figure 5. Countries, territories and areas reporting SARS-CoV-2 variant 501Y.V2 as of 30 March 2021

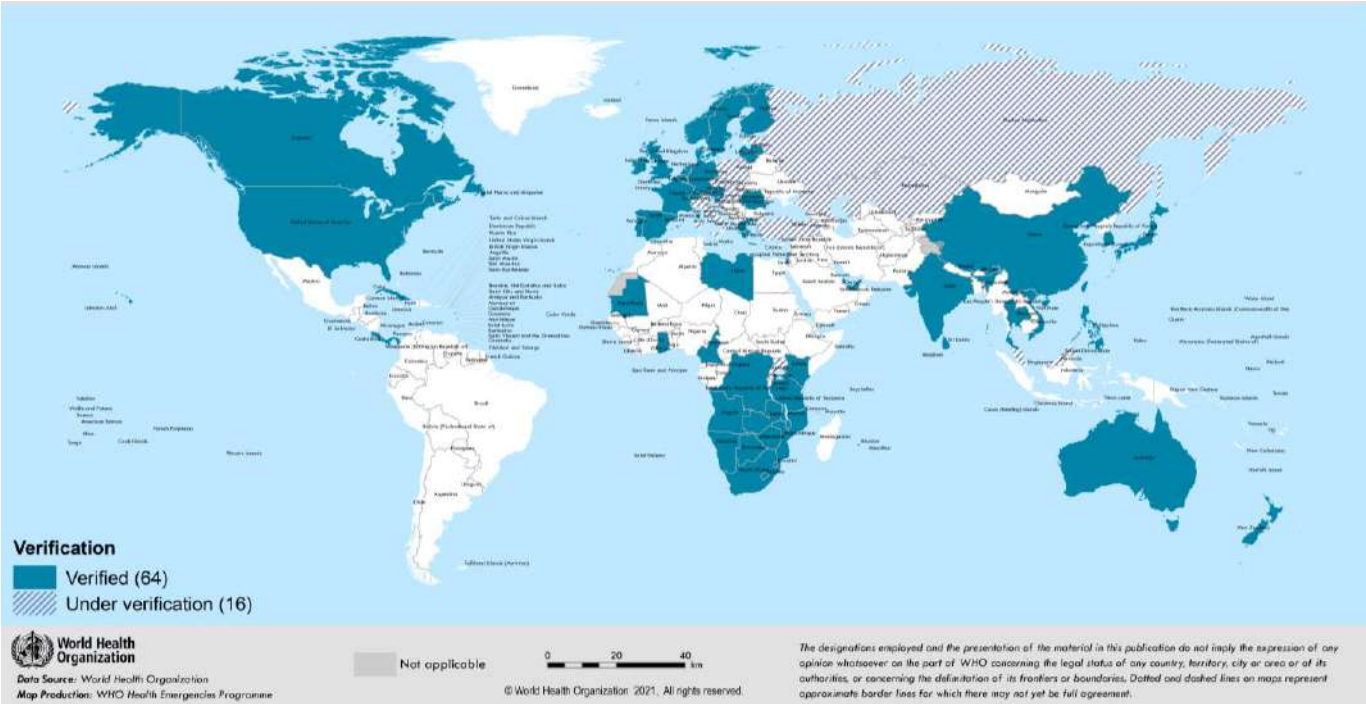


Figure 6. Countries, territories and areas reporting SARS-CoV-2 variant P.1 as of 30 March 2021



Emerging variants of interest (VOIs)

Table 4: Overview of variants of interest (VOIs), as of 30 March 2021*

Nextstrain clade	20C	20C/S.452R	20B/S.484K	Not yet assigned	20C	20C
PANGO lineage	B.1.525	B.1.427/B.1.429	B.1.1.28.2, alias P.2	B.1.1.28.3 alias P.3	B.1.526 (with E484K or S477N)	B.1 descendant with 9 mutations
GISAID clade	G/484K.V3	GH/452R.V1	GR	Not yet assigned	GH	GH
Alternate names		CAL.20C/L452R		PHL-B.1.1.28		
First detected by	United Kingdom and Nigeria	United States of America	Brazil	Philippines and Japan	United States of America	France
First appearance	December 2020	June 2020	April 2020	February 2021	November 2020	January 2021
Key spike mutations	H69-V70 deletion; Y144 deletion; Q52R; E484K; Q677H; D614G; and F888L	L452R; W152C; S13I; and D614G	L18F; T20N; P26S; F157L; E484K; D614G; S929I; and V1176F	141-143 deletion; E484K; N501Y; and P681H	L5F; T95I; D253G; D614G; A701V; and E484K or S477N	G142 deletion; D66H; Y144V; D215G; V483A; D614G; H655Y; G669S; Q949R; and N1187D

WHO recommendations and working definitions of VOI and VOC

The potential for virus mutation increases with the frequency of human and animal infections. Therefore, reducing transmission of SARS-CoV-2 through established disease control methods as well as avoiding introductions to animal populations are crucial aspects of the global strategy to reduce the occurrence of mutations that have negative public health implications. PHSM remain critical to curb the spread of SARS-CoV-2, including new variants. Evidence from multiple countries with extensive transmission of VOCs has indicated that the implementation of PHSM and infection prevention and control (IPC) measures in health facilities has been effective in reducing COVID-19 case incidence, which has led to a reduction in hospitalizations and deaths among COVID-19 patients. Findings from new studies evaluating transmission, severity and impact on medical countermeasures will continue to help inform PHSM and IPC measures employed by Member States. National and local authorities are encouraged to continue strengthening existing PHSM, IPC and disease control activities, including epidemiological surveillance, strategic testing, and systematic sequencing of SARS-CoV-2 where feasible.

Additional resources

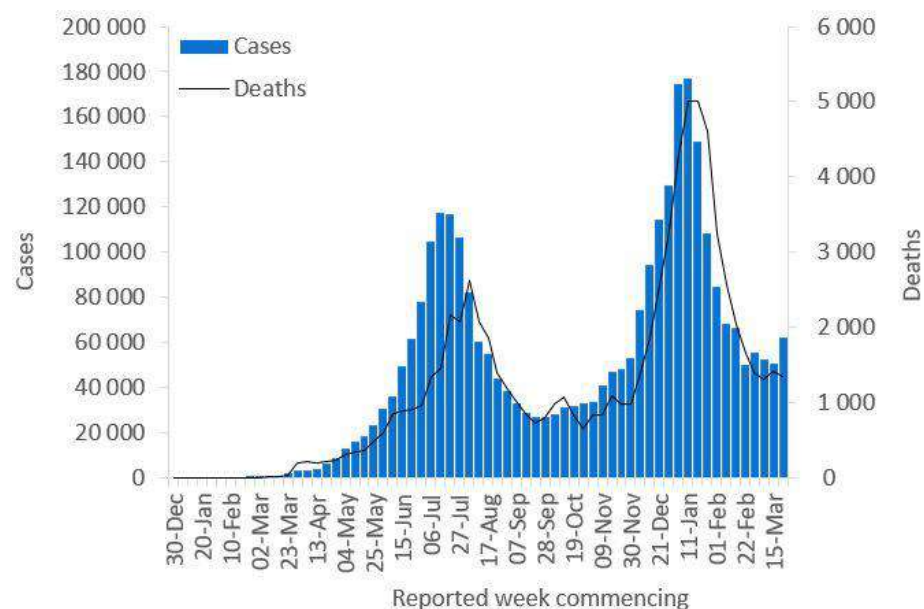
- [Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern](#)
- [COVID-19 new variants: Knowledge gaps and research](#)
- [PAHO Epidemiological Update: Variants of SARS-CoV-2 in the Americas - 24 March 2021](#)
- [Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health](#)
- [Considerations for implementing and adjusting PHSM in the context of COVID-19](#)
- [Disease Outbreak News on SARS-CoV-2 Variants, 31 December 2020](#)

WHO regional overviews

African Region

After reporting a decline in new cases for two consecutive weeks, the African Region reported a 22% increase in new cases (>62 000 cases) compared to the previous week, and over 1300 new deaths, a 6% decrease. The highest numbers of new cases were reported from Ethiopia (13 153 new cases; 11.4 new cases per 100 000 population; a 14% increase) and Kenya (9167 new cases; 17 new cases per 100 000; a 25% increase).

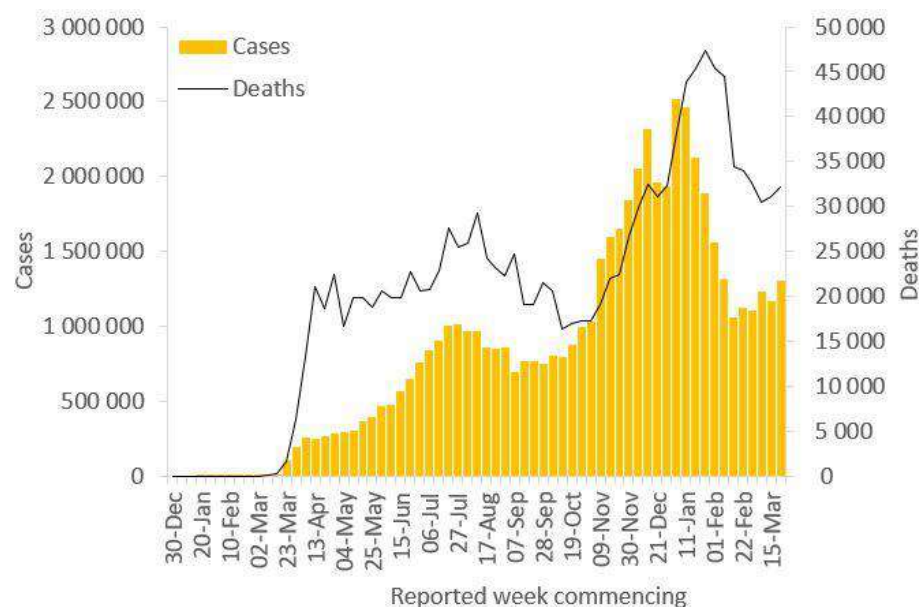
The highest numbers of new deaths were reported from South Africa (566 new deaths; one new death per 100 000 population; a 31% decrease) and Ethiopia (137 new deaths; <0.1 new deaths per 100 000; a 28% increase).



Region of the Americas

The Region of the Americas reported over 1.3 million new cases and over 32 000 new deaths, an 11% and 4% increase respectively compared to the previous week. Overall, there has been an increasing trend in weekly reported cases in the last five weeks. A slight increase in new deaths has been reported in the last two weeks after a decline in deaths for the six prior weeks. The highest numbers of new cases were reported from Brazil (533 024 new cases; 250.8 new cases per 100 000; a 5% increase), the United States of America (421 936 new cases; 127.5 new cases per 100 000; a 13% increase), and Peru (60 739 new cases; 184.2 new cases per 100 000; a 24% increase).

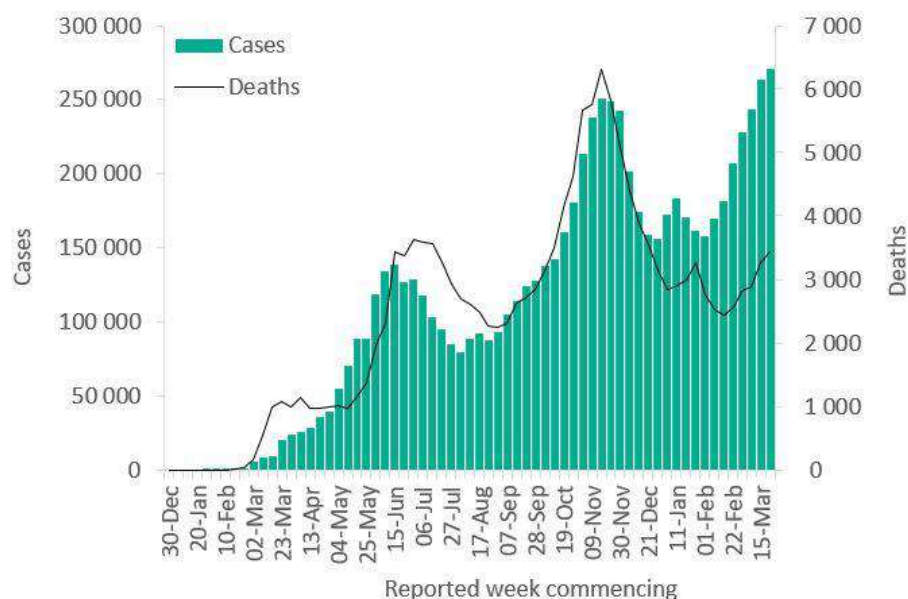
The highest numbers of new deaths were reported from Brazil (16 798 new deaths; 7.9 new deaths per 100 000; a 10% increase), the United States of America (6995 new deaths; 2.1 new deaths per 100 000; a 7% decrease), and Mexico (3643 new deaths; 2.8 new deaths per 100 000; an 8% increase).



Eastern Mediterranean Region

The Eastern Mediterranean Region reported just under 271 000 new cases and over 3400 new deaths, a 3% and a 5% increase respectively compared to the previous week. Both cases and deaths are on an upward trajectory with new cases increasing for the past seven weeks and deaths for the past five weeks. The highest numbers of new cases were reported from Jordan (55 467 new cases; 543.6 new cases per 100 000; a 4% decrease), the Islamic Republic of Iran (53 118 new cases; 63.2 new cases per 100 000; a 2% decrease), and Iraq (37 767 new cases; 93.9 new cases per 100 000; an 8% increase).

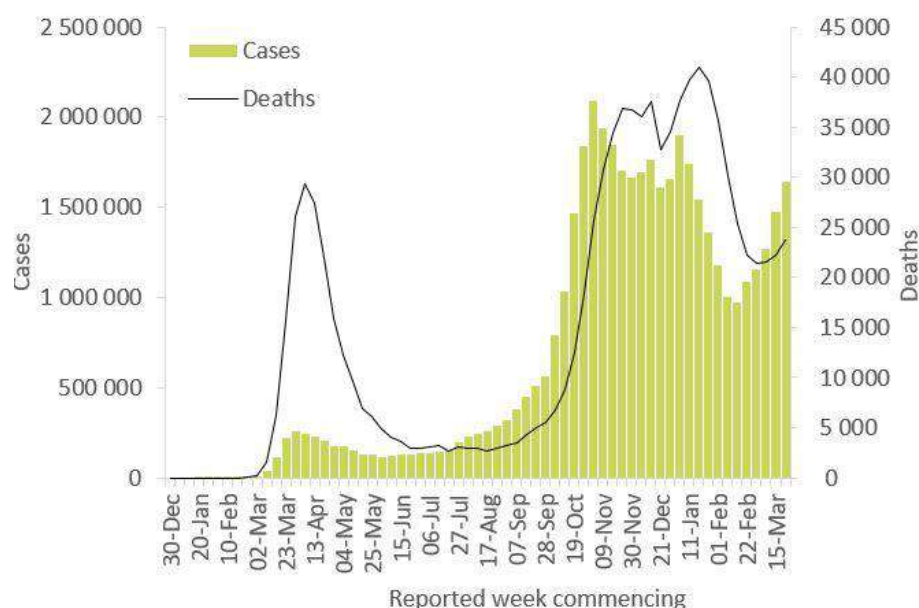
The highest numbers of new deaths were reported from Jordan (684 new deaths; 6.7 new deaths per 100 000; a 36% increase), the Islamic Republic of Iran (584 new deaths; 0.7 new deaths per 100 000; similar to last week), and Pakistan (359 new deaths; 0.2 new deaths per 100 000; an 11% increase).



European Region

The European Region reported over 1.6 million new cases and just under 24 000 new deaths in the past week, an 11% and a 7% increase respectively compared to the previous week. The number of new cases in the Region has been steadily increasing over the past five weeks while the number of new deaths has increased for the past three weeks. The highest numbers of new cases were reported from France (254 228 new cases; 389.5 new cases per 100 000; a 24% increase), Poland (192 441 new cases; 508.5 new cases per 100 000; a 27% increase), and Turkey (186 421 new cases; 221.0 new cases per 100 000; a 47% increase).

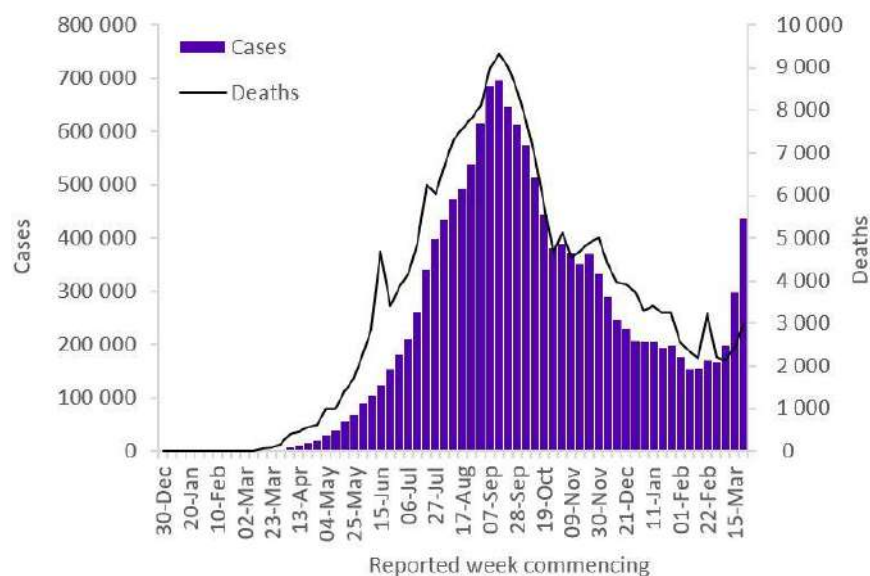
The highest numbers of new deaths were reported from Italy (2994 new deaths; 5.0 new deaths per 100 000; an 8% increase), the Russian Federation (2710 new deaths; 1.9 new deaths per 100 000; an 8% decrease), and Poland (2584 new deaths; 6.8 new deaths per 100 000; a 22% increase).



South-East Asia Region

The South-East Asia Region reported over 437 000 new cases and just under 3000 new deaths, a 46% and a 21% increase respectively compared to the previous week. Cases in the Region have been steadily increasing over the past three weeks, with a sharp increase in the past two weeks. Almost 85% of cases in the Region over the past week were from India which reported 372 494 new cases (27 new cases per 100 000; a 55% increase). The other countries reporting the highest numbers of new cases in the Region were Indonesia (36 214 new cases; 13.2 new cases per 100 000; a 12% decrease) and Bangladesh (23 100 new cases; 14.0 new cases per 100 000; an 85% increase).

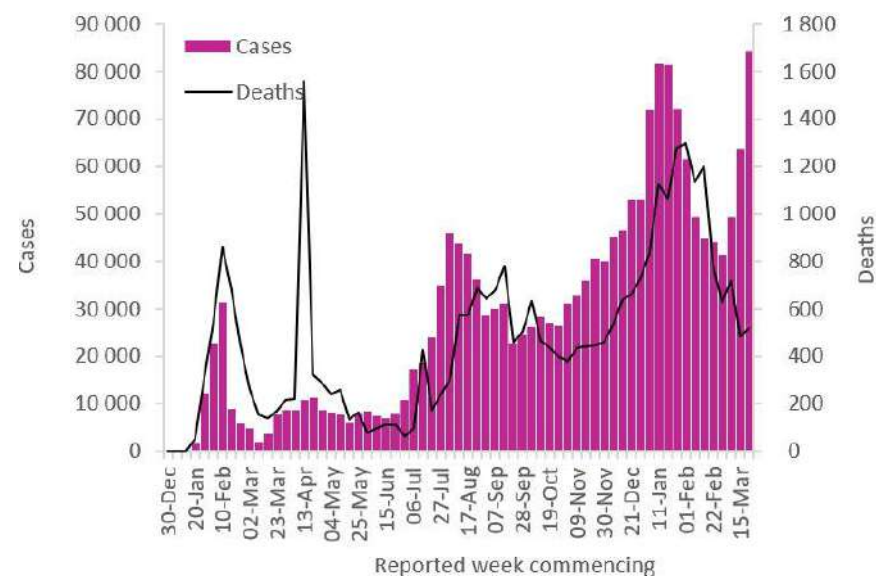
The highest numbers of new deaths were reported from India (1797 new deaths; < 0.1 new deaths per 100 000; a 57% increase), Indonesia (917 new deaths; 0.3 new deaths per 100 000; an 18% decrease), and Bangladesh (201 new deaths; <0.1 new deaths. per 100 000; a 43% increase).



Western Pacific Region

The Western Pacific Region reported over 84 000 new cases and just over 500 new deaths, a 32% and a 7% increase respectively compared to the previous week. The Region has reported a steep increase in the number of new cases over the past three weeks. The highest numbers of new cases were reported from the Philippines (56 380 new cases; 51.5 new cases per 100 000; a 43% increase), Japan (11 211 new cases; 8.9 new cases per 100 000; a 28% increase), and Malaysia (8929 new cases; 27.6 new cases per 100 000; a 4% decrease).

The highest numbers of new deaths were reported from the Philippines (229 new deaths; 0.2 new deaths per 100 000; a 40% increase), Japan (219 new deaths; 0.2 new deaths per 100 000; a 13% decrease), and the Republic of Korea (26 new deaths; <0.1 new deaths per 100 000; a 4% decrease).



Key weekly updates

WHO Director-General's key message

[Opening remarks at the media briefing on COVID-19](#) – 26 March 2021:

- A total of 177 countries and economies have started vaccination. In just one month, COVAX has distributed more than 32 million vaccines to 61 countries.
- Four more vaccines are currently at different stages in the process of being assessed for WHO Emergency Use Listing, with the hope to approve at least one of them by the end of April.

Vaccine publications

- [Evaluation of COVID-19 vaccine effectiveness, Interim guidance](#)
- [Sample size calculator for evaluation of COVID-19 vaccine effectiveness \(Excel\)](#)
- [COVAX updates participants on delivery delays for vaccines from Serum Institute of India \(SII\) and AstraZeneca](#)
- [Joint Statement on prioritization of COVID-19 vaccination for seafarers and aircrew](#)

Surveillance of SARS-CoV-2

- [Operational considerations to expedite genomic sequencing component of GISRS surveillance of SARS-CoV-2](#)
- [COVID-19 new variants: Knowledge gaps and research](#)

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](#)
- [WHO Academy COVID-19 mobile learning app](#)

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 30 March 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	62 286	3 061 438	272.9	1 340	77 446	6.9	
Ethiopia	13 153	198 794	172.9	137	2 784	2.4	Community transmission
Kenya	9 167	129 330	240.5	117	2 104	3.9	Community transmission
Cameroon	8 681	47 669	179.6	133	721	2.7	Community transmission
South Africa	7 665	1 544 466	2 604.1	566	52 648	88.8	Community transmission
Botswana	2 973	38 466	1 635.7	48	506	21.5	Community transmission
Côte d'Ivoire	2 555	42 468	161.0	12	229	0.9	Community transmission
Zambia	1 454	87 727	477.2	20	1 198	6.5	Community transmission
Madagascar	1 311	23 424	84.6	41	381	1.4	Community transmission
Namibia	1 296	43 499	1 711.9	16	508	20.0	Community transmission
Mozambique	1 212	67 011	214.4	22	762	2.4	Community transmission
Gabon	1 129	18 426	827.9	4	109	4.9	Community transmission
Ghana	1 011	90 287	290.6	24	740	2.4	Community transmission
Guinea	939	19 501	148.5	8	116	0.9	Community transmission
Nigeria	838	162 489	78.8	11	2 041	1.0	Community transmission
Togo	837	9 676	116.9	5	107	1.3	Community transmission
Senegal	763	38 456	229.7	27	1 034	6.2	Community transmission
Algeria	684	116 750	266.2	22	3 077	7.0	Community transmission
Cabo Verde	578	17 018	3 060.9	6	165	29.7	Community transmission
Rwanda	548	21 309	164.5	13	300	2.3	Community transmission
Mali	503	9 773	48.3	16	376	1.9	Community transmission
Seychelles	438	4 054	4 122.1	2	18	18.3	Community transmission
Democratic Republic of the Congo	419	27 886	31.1	8	734	0.8	Community transmission
Angola	335	22 031	67.0	7	533	1.6	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
Benin	282	7 100	58.6	0	90	0.7	Community transmission
Malawi	242	33 458	174.9	20	1 113	5.8	Community transmission
South Sudan	199	10 048	89.8	2	108	1.0	Community transmission
Equatorial Guinea	166	6 902	492.0	2	102	7.3	Community transmission
Mauritania	158	17 745	381.6	2	448	9.6	Community transmission
Burkina Faso	157	12 673	60.6	0	145	0.7	Community transmission
Zimbabwe	156	36 818	247.7	9	1 519	10.2	Community transmission
Lesotho	151	10 686	498.8	6	315	14.7	Community transmission
Gambia	146	5 401	223.5	2	163	6.7	Community transmission
Burundi	144	2 757	23.2	0	6	0.1	Community transmission
Congo	117	9 681	175.4	1	135	2.4	Community transmission
Uganda	116	40 767	89.1	1	335	0.7	Community transmission
Chad	91	4 501	27.4	3	160	1.0	Community transmission
Eritrea	90	3 208	90.5	2	9	0.3	Community transmission
Guinea-Bissau	72	3 630	184.5	6	61	3.1	Community transmission
Niger	69	4 987	20.6	0	185	0.8	Community transmission
Sao Tome and Principe	68	2 210	1 008.4	0	34	15.5	Community transmission
Mauritius	58	870	68.4	0	10	0.8	Clusters of cases
Eswatini	35	17 318	1 492.7	1	666	57.4	Community transmission
Comoros	25	3 690	424.3	0	146	16.8	Community transmission
Sierra Leone	14	3 962	49.7	0	79	1.0	Community transmission
Liberia	11	2 053	40.6	0	85	1.7	Community transmission
Central African Republic	0	5 087	105.3	0	64	1.3	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesⁱⁱⁱ							
Réunion	930	15 561	1 738.1	15	102	11.4	Community transmission
Mayotte	300	19 306	7 076.6	3	154	56.4	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
Americas	1 306 017	55 243 776	5 401.4	32 176	1 331 419	130.2	
Brazil	533 024	12 404 414	5 835.7	16 798	307 112	144.5	Community transmission
United States of America	421 936	29 859 706	9 021.0	6 995	543 003	164.0	Community transmission
Peru	60 739	1 512 384	4 586.9	1 135	51 032	154.8	Community transmission
Argentina	56 138	2 291 051	5 069.2	759	55 235	122.2	Community transmission
Chile	44 824	969 913	5 073.8	473	22 653	118.5	Community transmission
Colombia	42 911	2 367 337	4 652.5	874	62 645	123.1	Community transmission
Mexico	31 935	2 219 845	1 721.7	3 643	200 862	155.8	Community transmission
Canada	29 586	956 655	2 534.7	209	22 826	60.5	Community transmission
Paraguay	14 205	204 704	2 870.0	296	3 958	55.5	Community transmission
Uruguay	13 942	92 343	2 658.3	115	875	25.2	Community transmission
Ecuador	11 831	322 699	1 829.0	244	16 679	94.5	Community transmission
Venezuela (Bolivarian Republic of)	5 760	154 905	544.8	68	1 543	5.4	Community transmission
Cuba	5 622	71 584	632.0	22	414	3.7	Community transmission
Honduras	4 980	186 337	1 881.3	114	4 536	45.8	Community transmission
Bolivia (Plurinational State of)	4 903	268 711	2 302.0	102	12 143	104.0	Community transmission
Guatemala	4 474	192 133	1 072.4	90	6 775	37.8	Community transmission
Costa Rica	3 275	215 178	4 224.0	35	2 931	57.5	Community transmission
Jamaica	3 082	37 747	1 274.7	32	556	18.8	Community transmission
Panama	2 797	353 017	8 181.6	52	6 087	141.1	Community transmission
Dominican Republic	2 593	251 582	2 319.2	33	3 302	30.4	Community transmission
El Salvador	1 235	63 766	983.1	23	1 998	30.8	Community transmission
Guyana	521	10 007	1 272.3	13	225	28.6	Clusters of cases
Trinidad and Tobago	118	7 939	567.3	1	141	10.1	Community transmission
Bahamas	116	9 000	2 288.7	2	188	47.8	Clusters of cases
Barbados	91	3 603	1 253.8	2	41	14.3	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	89	1 122	1 145.7	0	28	28.6	Clusters of cases
Saint Lucia	78	4 191	2 282.3	3	58	31.6	Community transmission
Belize	40	12 440	3 128.6	1	317	79.7	Community transmission
Nicaragua	37	5 288	79.8	1	177	2.7	Community transmission
Suriname	33	9 088	1 549.2	1	177	30.2	Clusters of cases
Saint Vincent and the Grenadines	27	1 721	1 551.3	1	10	9.0	Community transmission
Haiti	22	12 736	111.7	1	252	2.2	Community transmission
Dominica	4	161	223.6	0	0	0.0	Clusters of cases
Grenada	1	155	137.7	0	1	0.9	Sporadic cases
Saint Kitts and Nevis	0	44	82.7	0	0	0.0	Sporadic cases
Territoriesⁱⁱⁱ							
Puerto Rico	1 734	105 625	3 692.1	17	2 109	73.7	Community transmission
Curaçao	1 128	6 648	4 051.4	4	27	16.5	Community transmission
Aruba	449	9 073	8 498.0	1	82	76.8	Community transmission
Guadeloupe	417	11 512	2 877.1	4	173	43.2	Community transmission
Martinique	415	7 679	2 046.3	3	50	13.3	Community transmission
Bonaire	302	1 221	5 837.9	4	10	47.8	Community transmission
Bermuda	180	947	1 520.7	0	12	19.3	Sporadic cases
French Guiana	158	16 922	5 665.6	2	89	29.8	Community transmission
United States Virgin Islands	87	2 901	2 778.1	1	26	24.9	Community transmission
Saint Barthélemy	81	857	8 669.7	0	1	10.1	Clusters of cases
Turks and Caicos Islands	35	2 325	6 005.0	2	17	43.9	Clusters of cases
Sint Maarten	25	2 118	4 939.1	0	27	63.0	Community transmission
Saint Martin	24	1 657	4 286.2	0	12	31.0	Community transmission
Cayman Islands	12	487	741.0	0	2	3.0	Sporadic cases
Anguilla	1	23	153.3	0	0	0.0	Sporadic cases
British Virgin Islands	0	154	509.3	0	1	3.3	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
Falkland Islands (Malvinas)	0	51	1 464.3	0	0	0.0	No cases
Montserrat	0	20	400.1	0	1	20.0	Sporadic cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	No cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	270 884	7 395 085	1 011.9	3 428	156 891	21.5	
Jordan	55 467	582 133	5 705.4	684	6 472	63.4	Community transmission
Iran (Islamic Republic of)	53 118	1 846 923	2 198.9	584	62 308	74.2	Community transmission
Iraq	37 767	827 157	2 056.5	208	14 177	35.2	Community transmission
Pakistan	26 689	649 824	294.2	359	14 158	6.4	Community transmission
Lebanon	21 763	458 338	6 715.1	343	6 058	88.8	Community transmission
United Arab Emirates	14 431	453 069	4 580.9	44	1 477	14.9	Community transmission
Kuwait	9 245	227 178	5 319.6	64	1 279	29.9	Community transmission
Libya	5 775	156 116	2 272.0	115	2 602	37.9	Community transmission
Bahrain	5 492	140 818	8 275.7	15	513	30.1	Clusters of cases
Oman	4 703	153 838	3 012.5	30	1 650	32.3	Community transmission
Egypt	4 593	199 364	194.8	288	11 845	11.6	Clusters of cases
Tunisia	4 298	249 703	2 112.8	179	8 705	73.7	Community transmission
Qatar	3 929	177 135	6 148.3	12	284	9.9	Community transmission
Saudi Arabia	3 141	387 794	1 113.9	41	6 643	19.1	Sporadic cases
Morocco	2 895	494 358	1 339.3	35	8 798	23.8	Clusters of cases
Syrian Arab Republic	1 116	18 356	104.9	74	1 227	7.0	Community transmission
Somalia	870	10 838	68.2	69	488	3.1	Community transmission
Djibouti	731	7 249	733.7	3	66	6.7	Community transmission
Yemen	691	3 973	13.3	95	833	2.8	Community transmission
Afghanistan	191	56 294	144.6	7	2 470	6.3	Sporadic cases
Sudan	180	31 407	71.6	25	2 028	4.6	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
Territoriesⁱⁱⁱ							
occupied Palestinian territory	13 799	263 220	5 159.7	154	2 810	55.1	Community transmission
Europe	1 641 672	44 191 579	4 734.4	23 778	954 829	102.3	
France	254 228	4 435 057	6 794.6	2 271	93 884	143.8	Community transmission
Poland	192 441	2 250 991	5 947.7	2 584	51 884	137.1	Community transmission
Turkey	186 421	3 179 115	3 769.4	964	30 923	36.7	Community transmission
Italy	156 122	3 512 453	5 809.4	2 994	107 636	178.0	Clusters of cases
Germany	112 885	2 772 401	3 309.0	1 206	75 870	90.6	Community transmission
Ukraine	97 700	1 644 063	3 759.3	2 013	31 954	73.1	Community transmission
Russian Federation	62 963	4 519 832	3 097.2	2 710	97 740	67.0	Clusters of cases
Hungary	62 265	633 861	6 561.5	1 710	19 972	206.7	Community transmission
Netherlands	50 622	1 244 924	7 265.4	189	16 450	96.0	Community transmission
Czechia	45 482	1 515 029	14 147.3	1 207	25 874	241.6	Community transmission
Romania	39 331	932 179	4 845.6	865	22 997	119.5	Community transmission
The United Kingdom	37 909	4 329 184	6 377.1	451	126 573	186.4	Community transmission
Serbia	34 721	581 617	8 352.0	251	5 151	74.0	Community transmission
Belgium	31 828	870 757	7 513.2	185	22 897	197.6	Community transmission
Sweden	30 393	780 018	7 723.5	34	13 402	132.7	Community transmission
Bulgaria	25 290	327 770	4 717.2	684	12 650	182.1	Clusters of cases
Austria	22 100	530 844	5 894.1	178	8 995	99.9	Community transmission
Spain	20 139	3 247 738	6 946.3	178	74 420	159.2	Community transmission
Greece	16 979	252 590	2 423.4	405	7 826	75.1	Community transmission
Republic of Moldova	11 457	225 660	5 594.0	254	4 785	118.6	Community transmission
Bosnia and Herzegovina	11 121	163 875	4 994.9	461	6 278	191.4	Community transmission
Croatia	9 583	267 222	6 509.2	120	5 893	143.5	Community transmission
Kazakhstan	9 279	292 306	1 556.7	110	3 696	19.7	Clusters of cases
Slovakia	9 041	357 910	6 555.6	452	9 496	173.9	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
Azerbaijan	8 880	254 370	2 508.8	125	3 464	34.2	Clusters of cases
Switzerland	8 395	589 486	6 811.2	31	9 577	110.7	Community transmission
Belarus	8 338	317 631	3 361.4	63	2 211	23.4	Community transmission
Estonia	8 229	103 630	7 812.1	60	847	63.9	Clusters of cases
North Macedonia	7 494	126 230	6 058.9	194	3 642	174.8	Community transmission
Armenia	6 604	190 317	6 422.6	116	3 464	116.9	Community transmission
Slovenia	6 526	212 039	10 199.4	33	4 309	207.3	Clusters of cases
Norway	6 381	90 934	1 677.4	8	656	12.1	Community transmission
Denmark	5 017	227 049	3 919.9	14	2 413	41.7	Community transmission
Lithuania	4 930	213 941	7 858.9	75	3 551	130.4	Community transmission
Finland	4 422	75 545	1 363.5	12	817	14.7	Community transmission
Ireland	4 106	233 937	4 737.7	68	4 653	94.2	Community transmission
Israel	4 008	831 084	9 601.8	81	6 165	71.2	Community transmission
Latvia	3 567	100 716	5 339.6	51	1 872	99.2	Community transmission
Albania	3 100	123 641	4 296.4	71	2 204	76.6	Clusters of cases
Portugal	2 962	820 042	8 042.2	65	16 827	165.0	Clusters of cases
Georgia	2 821	280 301	7 026.6	51	3 751	94.0	Community transmission
Montenegro	2 454	90 081	14 342.6	42	1 241	197.6	Clusters of cases
Cyprus	2 423	44 305	3 669.6	8	250	20.7	Clusters of cases
Luxembourg	1 545	60 755	9 705.6	23	738	117.9	Community transmission
Uzbekistan	1 001	82 340	246.0	4	626	1.9	Clusters of cases
Malta	904	28 808	6 524.4	16	385	87.2	Clusters of cases
Kyrgyzstan	703	88 092	1 350.2	5	1 495	22.9	Clusters of cases
Andorra	328	11 809	15 283.8	2	115	148.8	Community transmission
San Marino	270	4 626	13 630.7	5	84	247.5	Community transmission
Monaco	81	2 254	5 743.6	1	28	71.3	Sporadic cases
Iceland	66	6 163	1 806.0	0	29	8.5	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
Liechtenstein	19	2 731	7 161.0	0	54	141.6	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
Territoriesⁱⁱⁱ							
Kosovo ^[1]	5 675	87 024	4 677.8	78	1 820	97.8	Community transmission
Isle of Man	119	1 551	1 824.0	0	26	30.6	No cases
Gibraltar	3	4 273	12 682.9	0	94	279.0	Clusters of cases
Jersey	1	3 225	2 964.2	0	69	63.4	Community transmission
Faroe Islands	0	661	1 352.7	0	1	2.0	Sporadic cases
Greenland	0	31	54.6	0	0	0.0	No cases
Guernsey	0	821	1 299.1	0	14	22.2	Community transmission
South-East Asia	437 060	14 619 886	723.3	2 947	217 737	10.8	
India	372 494	11 971 624	867.5	1 797	161 552	11.7	Clusters of cases
Indonesia	36 214	1 492 002	545.5	917	40 364	14.8	Community transmission
Bangladesh	23 100	591 806	359.3	201	8 869	5.4	Community transmission
Sri Lanka	1 993	91 839	428.9	14	558	2.6	Clusters of cases
Maldives	1 030	23 403	4 329.5	1	66	12.2	Clusters of cases
Thailand	931	28 734	41.2	4	94	0.1	Clusters of cases
Nepal	921	276 750	949.8	11	3 027	10.4	Clusters of cases
Timor-Leste	209	480	36.4	0	0	0.0	Clusters of cases
Myanmar	165	142 377	261.7	2	3 206	5.9	Clusters of cases
Bhutan	3	871	112.9	0	1	0.1	Sporadic cases
Western Pacific	84 395	1 859 933	94.7	518	31 361	1.6	
Philippines	56 380	712 417	650.1	229	13 159	12.0	Community transmission
Japan	11 211	466 849	369.1	219	9 031	7.1	Clusters of cases
Malaysia	8 929	340 642	1 052.5	22	1 251	3.9	Clusters of cases
Republic of Korea	3 100	101 757	198.5	26	1 722	3.4	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
Mongolia	1 887	6 693	204.2	1	6	0.2	Clusters of cases
Papua New Guinea	1 846	5 205	58.2	9	45	0.5	Community transmission
Cambodia	553	2 233	13.4	7	10	0.1	Sporadic cases
China	157	102 680	7.0	2	4 851	0.3	Clusters of cases
Singapore	104	60 288	1 030.5	0	30	0.5	Sporadic cases
Australia	60	29 252	114.7	0	909	3.6	Clusters of cases
New Zealand	29	2 126	44.1	0	26	0.5	Clusters of cases
Viet Nam	18	2 590	2.7	0	35	0.0	Clusters of cases
Brunei Darussalam	1	206	47.1	0	3	0.7	Clusters of cases
Fiji	0	67	7.5	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	0	49	0.7	0	0	0.0	Sporadic cases
Solomon Islands	0	18	2.6	0	0	0.0	No cases
Territoriesⁱⁱⁱ							
Wallis and Futuna	65	376	3 343.4	3	4	35.6	Sporadic cases
French Polynesia	31	18 607	6 623.9	0	141	50.2	Sporadic cases
Guam	17	7 587	4 495.3	0	134	79.4	Clusters of cases
New Caledonia	5	121	42.4	0	0	0.0	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	2	159	276.2	0	2	3.5	Pending
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Samoa	0	4	2.0	0	0	0.0	No cases
Vanuatu	0	3	1.0	0	0	0.0	No cases
Global	3 802 314	126 372 442	1 621.2	64 187	2 769 696	35.5	

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

Annex 2. List of countries/territories/areas reporting variants of concern as of 30 March 2021**

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Albania	Not Verified		
Algeria	Verified		
Angola	Verified	Verified	
Argentina	Verified		Verified
Aruba	Verified	Verified	Verified
Australia	Verified	Verified	Not Verified
Austria	Verified	Verified	Verified
Azerbaijan	Verified		
Bahrain	Verified		
Bangladesh	Verified		
Barbados	Verified		
Belarus	Verified		
Belgium	Verified	Verified	Verified
Belize	Verified		
Bonaire	Verified		
Bosnia and Herzegovina	Not Verified		
Botswana		Verified	
Brazil	Verified		Verified
Brunei Darussalam	Verified	Verified	
Bulgaria	Verified		
Cabo Verde	Verified		
Cambodia	Verified		
Cameroon		Verified	
Canada	Verified	Verified	Verified
Cayman Islands	Verified		
Chile	Verified		Verified

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
China	Verified	Verified	Not Verified
Colombia			Verified
Comoros		Verified	
Costa Rica	Verified	Verified	
Croatia	Verified	Not Verified	
Cuba		Verified	
Curaçao	Verified		
Cyprus	Verified		
Czechia	Verified	Not Verified	
Democratic Republic of the Congo	Verified	Verified	
Denmark	Verified	Verified	Verified
Dominican Republic	Verified		
Ecuador	Verified		
Estonia	Verified	Not Verified	
Eswatini		Verified	
Faroe Islands			Verified
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana	Verified		Verified
French Polynesia	Verified		
Gambia	Verified		
Georgia	Verified		
Germany	Verified	Verified	Verified
Ghana	Verified	Verified	
Gibraltar	Not Verified		

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Greece	Verified	Verified	
Guadeloupe	Verified	Verified	Verified
Hungary	Verified	Not Verified	
Iceland	Verified		
India	Verified	Verified	Verified
Indonesia	Verified		
Iran (Islamic Republic of)	Verified		
Iraq	Verified		
			Not
Ireland	Verified	Verified	Verified
Israel	Verified	Verified	
Italy	Verified	Not Verified	Verified
Jamaica	Verified		
Japan	Verified	Verified	Verified
Jordan	Verified		
Kazakhstan	Not Verified	Not Verified	
Kenya	Not Verified	Verified	
Kosovo[1]	Verified		
Kuwait	Verified		
Latvia	Verified	Verified	
Lebanon	Verified		
Lesotho		Verified	
Libya	Verified	Verified	
Liechtenstein	Verified		
Lithuania	Verified	Verified	
Luxembourg	Verified	Verified	
Malawi	Verified	Verified	
Malaysia	Verified	Not Verified	

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Malta	Verified	Not Verified	
Martinique	Verified	Verified	Verified
Mauritania	Verified	Verified	
Mauritius	Not Verified		
Mayotte	Verified	Verified	
Mexico	Verified		Verified
Monaco	Verified	Not Verified	
Montenegro	Verified		
Morocco	Verified		
Mozambique		Verified	
Namibia		Verified	
Nepal	Verified		
Netherlands	Verified	Verified	Verified
New Caledonia	Verified		
			Not
New Zealand	Verified	Verified	Verified
Nigeria	Verified		
North Macedonia	Verified		
Norway	Verified	Verified	Verified
occupied Palestinian territory	Verified	Verified	
Oman	Verified		
Pakistan	Verified		
Panama		Verified	Verified
Paraguay			Verified
Peru	Verified		Verified
Philippines	Verified	Verified	Verified
Poland	Verified	Not Verified	

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Portugal	Verified	Verified	Not Verified
Puerto Rico	Verified		
Qatar	Verified	Verified	
Republic of Korea	Verified	Verified	Verified
Republic of Moldova	Not Verified		
Réunion	Verified	Verified	Verified
Romania	Verified	Verified	Verified
Russian Federation	Verified	Not Verified	
Rwanda	Not Verified	Not Verified	
Saint Barthélemy	Verified		
Saint Lucia	Verified		
Saint Martin	Verified	Verified	Verified
Saudi Arabia	Verified		
Senegal	Verified		
Serbia	Verified		
Singapore	Verified	Not Verified	
Sint Maarten	Verified		
Slovakia	Verified	Not Verified	
Slovenia	Verified	Verified	Not Verified
South Africa	Verified	Verified	
Spain	Verified	Verified	Verified
Sri Lanka	Verified	Verified	

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Sweden	Verified	Verified	Verified
Switzerland	Verified	Verified	Not Verified
Thailand	Verified	Verified	
The United Kingdom	Verified	Verified	Verified
Togo	Verified		
Trinidad and Tobago	Verified		
Tunisia	Verified		
Turkey	Verified	Not Verified	Not Verified
Turks and Caicos Islands	Verified		
Uganda		Not Verified	
Ukraine	Not Verified		
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania		Verified	
United States of America	Verified	Verified	Verified
Uruguay	Verified		Verified
Uzbekistan	Verified		
Venezuela (Bolivarian Republic of)			Verified
Viet Nam	Verified	Verified	
Wallis and Futuna	Not Verified		
Zambia		Verified	
Zimbabwe		Verified	

**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

29 March 2021

Issue No. 48

Confirmed cases^{*}
126 697 603

Confirmed deaths
2 776 175

Celebrating Responsible Coverage of Mental Health and Psychosocial Support During COVID-19

The objective of a training series titled 'Reporting during the COVID-19 pandemic', hosted by PAHO and the Caribbean Development Bank, was to provide tools to help communicators practice responsible coverage of the pandemic, using evidence-based information. It also aimed to encourage journalists to provide advice and solutions that help reduce health risks and save lives in the pandemic with a focus on mental



mental health, psychosocial wellbeing and domestic violence.

More than 300 journalists and health communicators participated and were subsequently invited to submit television, radio and print entries covering topics explored in the webinars for a competition.

Journalist Daphne Ewing-Chow of the Cayman Islands won the print category for her article examining the impact of the COVID-19 pandemic on the mental health of teenagers, titled 'Mental health professionals voice looming concerns for Cayman teens', featuring the personal experiences of Cayman Islands teenagers who were feeling the psychological impact of lockdown measures and offered tips for supporting teenagers struggling with mental health challenges.

For further information and access to the webinars, click [here](#).

Key Figures



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



More than **5 million** people registered on [OpenWHO](#) and accessing online training courses across **29** topics in **47** languages



17 559 888 PCR tests shipped globally



198 747 426 medical masks shipped globally



8 659 511 face shields shipped globally



37 135 700 gloves shipped globally



165 GOARN deployments conducted to support COVID-19 pandemic response



462 824 374 COVID-19 vaccine doses administered globally as of 25 March

^a COVAX has shipped over **32 million** vaccines to **60** participants as of 25 March

^a See Gavi's [COVAX updates](#) for the latest COVAX vaccine roll-out data

For all other latest data and information, see the [WHO COVID-19 Dashboard](#) and [Situation Reports](#)

From the field:

Belgian and Danish Emergency Medical Team support to Slovakia

In January 2021, Slovakia reported high hospitalization rates for COVID-19 patients; the hospitalization rates briefly reduced, followed by sustained high rates from late February to early March. Subsequent to high levels of transmission, the Government requested for foreign assistance to the European Union and WHO.

In response, clinicians from the WHO-classified Emergency Medical Team (EMT) from Belgian

First Aid and Support (B-FAST) and the Danish Emergency Management Agency (DEMA) deployed together to Slovakia.



Belgian (B-FAST) and Danish (DEMA) Emergency Medical Teams working in the ICU at the F.D Roosevelt University hospital. Credit: WCO Slovakia

The missions are being facilitated by the Emergency Response Coordination Centre (ERCC) at the European Commission's European Civil Protection and Humanitarian Aid Operations (DG ECHO) and are run in close coordination with WHO. The joint EMTs, comprised of 4 medical doctors, 7 nurses and a team leader, arrived in Slovakia on 12 March as surge capacity to help support hands-on clinical care in hospitals and Intensive Care Units (ICU).

Upon arrival, the teams were temporarily deployed in the F.D. Roosevelt University hospital in Banksá Bystrica to support patients requiring intensive care with the clinicians in teams covering 12-hour shifts. On 14 March, the teams started by shadowing Slovakian staff to familiarize themselves with equipment, rooms, systems, and the following day, started working independently.

On 18 March, the WHO Country Office Representative (WR) visited the University hospital to recognize the work of the team and their collaboration with Slovak colleagues. While the EMTs are still deployed, as the situation in the hospital begins to stabilize possible exit strategies and handover from the Belgian and Danish team are now being prepared together with the Ministry of Health and WHO.

From the field:

WHO provides one million antigen-detecting rapid diagnostic test kits to accelerate testing in Indonesia

To support ongoing efforts in expanding testing strategies and capacity in Indonesia, WHO provided one million antigen-detecting rapid diagnostic tests (Ag-RDTs) to the Ministry of Health on Saturday, 13 March 2021 to be further distributed to community health centres (puskesmas) and other points of care across the country. The procurement, at an estimated cost of US\$ 5 million, was made possible among others by the Government of Japan.

Timely and reliable testing is crucial to control and manage the COVID-19 pandemic. Compared to polymerase chain reaction (PCR) tests, ag-RDTs perform faster and are simpler to use. Ag-RDTs provide a result in less than 30 minutes, by detecting SARS-CoV-2 viral proteins in respiratory excretion using a test format that is commonly used for HIV and malaria testing.

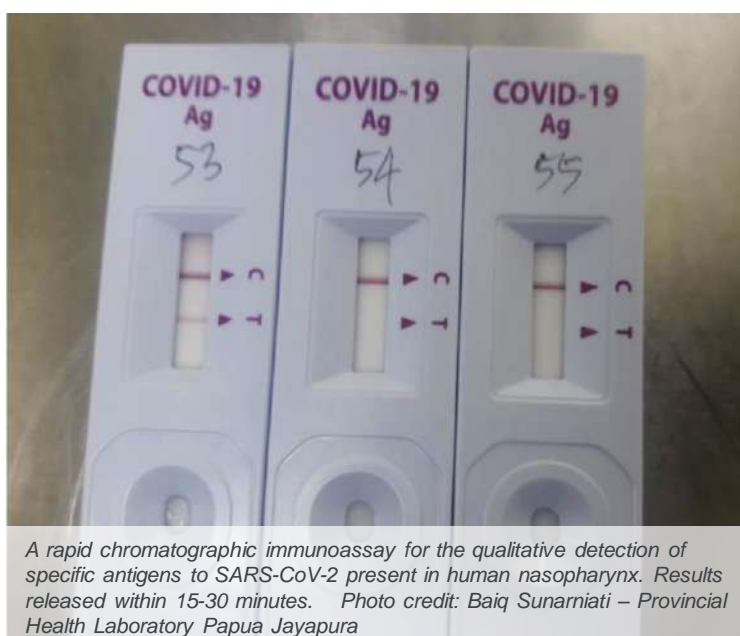
Ag-RDTs could significantly contribute to enabling quick isolation of cases and timely start of contact tracing to curb transmission in communities. The simplicity of use provides a major advantage to conduct tests in areas with limited

access to laboratories with PCR testing, or when there is a long turnaround time for PCR test results.

WHO still recommends the PCR as the gold standard test for the SARS-CoV-2 virus. Ag-RDTs do not replace PCR testing but instead complement and accelerate the country's overall testing capacity. The use of ag-RDTs is recommended for testing persons with symptoms of COVID-19 and contacts of confirmed cases.

WHO provided technical assistance to the Ministry of Health to develop a Ministerial Decree on the 'Use of Antigen Rapid Diagnostic Test in Testing of Coronavirus Disease 2019 (COVID-19)', released on 8 February. This provides guidance on how antigen-detecting rapid diagnostic tests can be used for SARS-CoV-2 diagnosis as well as the criteria for products that can be used in Indonesia, including those that are listed in WHO Emergency Use Listing.

For further information, click [here](#).



A rapid chromatographic immunoassay for the qualitative detection of specific antigens to SARS-CoV-2 present in human nasopharynx. Results released within 15-30 minutes. Photo credit: Baiq Sunarniati – Provincial Health Laboratory Papua Jayapura

From the field:

COVID-19 vaccines shipped by COVAX Facility arrive in Lao People's Democratic Republic

On 20 March 2021, Lao People's Democratic Republic received its first shipment of COVID-19 vaccine doses through the COVAX Facility, a partnership between the Coalition for Epidemic Preparedness Innovations, Gavi, the Vaccine Alliance, UNICEF and WHO.

The shipment, consisting of 132 000 doses of the AstraZeneca/Oxford vaccine, manufactured by the Serum Institute of India, was shipped by air to the Wattay International Airport in Vientiane from Pune, India according to the Regional Office for the Western Pacific.



UNICEF Representative Dr Pia Rebello Britto and WHO Representative Dr Mark Jacobs gathered with members of the international community in Vientiane to welcome the arrival of vaccines. Photo credit: WHO/Vannaseng Insaal

This batch of AstraZeneca/Oxford vaccines is the first of the total of 480 000 doses being planned for delivery to Lao People's Democratic Republic via the COVAX initiative this year to help cover about 20% of the total population.

According to the country's National Deployment and Vaccination Plan (NDVP), this initial batch will be used by the Government of Lao People's Democratic Republic to first immunize priority groups including frontline healthcare workers, older adults above the age of 60, people with underlying health conditions and some essential workers at high risk of exposure to COVID-19, such as workers at points of entry and in quarantine centres.

"The arrival of the vaccines provided by the COVAX Facility is a game changer for Lao People's Democratic Republic's ongoing fight against the COVID-19 pandemic and shows what is possible when there is a spirit of solidarity among the international community to collectively address this common threat. These COVID-19 vaccines have been carefully reviewed by WHO and assessed for quality, safety and efficacy; we are so pleased that Lao People's Democratic Republic has access to these vaccines just one month following their Emergency Use Listing by WHO in February," said Dr Mark Jacobs, WHO Representative to Lao People's Democratic Republic. "No country will be safe from the pandemic until all countries are protected. The arrival of the vaccines from COVAX in Lao People's Democratic Republic today is a step in the right direction towards this ultimate goal."

For further information, click [here](#).

From the field:

COVID-19 vaccines rolled out in the Eastern Mediterranean Region amid continued upsurge in cases



Photo credit: WHO Afghanistan Country office

As COVID-19 continues to take a toll on people's lives in the Eastern Mediterranean Region, COVID-19 vaccines delivered through the COVAX Facility have now arrived in Afghanistan, Djibouti, Jordan, Tunisia, Somalia, Sudan and the occupied Palestinian territory including east Jerusalem with a total of more than 1.9 million doses delivered as of 21 March. The coming days will mark the arrival of more batches to others as well.

"After a year since declaring COVID-19 a global pandemic, we are pleased that vaccines are now a real and present tool in our fight against COVID-19, supporting our historic efforts towards ending this pandemic," said Ahmed Dr Al-Mandhari, WHO Regional Director for the Eastern Mediterranean. "As an effective tool in the fight against this pandemic, we call on countries to unite under the banner of vaccine equity. However, everyone should know that vaccines alone can't end the pandemic," Dr Al-Mandhari continued, stressing that "countries need to continue imposing and adhering to the proven public health measures such as physical distancing, wearing a mask, ensur[ing] sufficient ventilation,".

To date, 19 countries and areas in the Eastern Mediterranean Region have commenced vaccination against COVID-19, administering over 16 million doses by targeting high-risk groups aiming to cover 20% of their population. Of these 19 countries and areas, Djibouti, Somalia, and Sudan relied on the delivery via the COVAX Facility as their only source of COVID-19 vaccines. More than 15 of these countries and areas vaccinating their populations have already procured vaccines through bilateral agreements with vaccine manufacturers.

For further information, click [here](#).

From the field:

PAHO/WHO seeks to gauge acceptance of COVID-19 vaccines among Caribbean health care workers

To better understand the concerns, attitudes and intended practices of Caribbean health care workers regarding COVID-19 vaccines, the PAHO sub-regional Caribbean office has launched a survey which will inform a communication campaign for this priority group.

Healthcare providers have been shown to be the most trusted source of information on vaccination in various studies. It is hoped that the results of the PAHO survey will guide the development of public policy, with the goal of increasing vaccine acceptance, improving confidence and enabling effective championing of the COVID-19 vaccine to the population.



Credit: PAHO/WHO

WHO has recommended that health care providers be the first group to be vaccinated against COVID-19, and health care workers are recognized as significant influencers of health-related attitudes and behaviors related to vaccination in their communities. As a result, health care workers are being prioritized for communications to support the group in accepting COVID-19 vaccines, as well as to ensure they are equipped to share the correct knowledge with their patients and members of the public.

The survey will target health care workers in 14 countries: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname and Trinidad and Tobago. The study will seek to ascertain attitudes to vaccines in general, and intentions to take and recommend COVID-19 vaccines and factors influencing these intentions.

Targeting health care workers with accurate communication and information regarding COVID-19 vaccines is critical to the success of the rollout of vaccines, which have been the topic of significant mis and dis-information. Through this survey, PAHO is assessing the perceptions on the COVID-19 vaccines across the Caribbean with future activities geared toward the general public to promote high uptake of the vaccines, which is key to ending the acute phase of the pandemic.

For further information on the survey, click [here](#). If you are a healthcare worker in one of the aforementioned countries and would like to participate in the survey, click [here](#).

Public health response and coordination highlights

At the UN Crisis Management Team (CMT) meeting on 24 March 2021, **WHO** briefed on the epidemiological situation and indicated that confirmed COVID-19 cases continued to rise for a fourth consecutive week, and the number of new deaths plateaued after a six week decrease.

WHO noted the global momentum towards increasing vaccine finance, manufacturing and distribution, but stressed that despite progress, lack of vaccine supply and inequitable distribution remain the biggest threats to end the acute phase of the pandemic. Recalling that there are 20 days remaining in the WHO Director-General's [call to action](#), **WHO** as the chair of the CMT, called for the UN system to renew the push for global vaccine equity.

WHO also reported that the decision of a number of countries to suspend administration of the Oxford/AstraZeneca COVID-19 vaccine in the past few weeks has negatively impacted global vaccine confidence despite many of these countries having announced resumption following [the review](#).

WHO advised on the need for concerted efforts by all members of the CMT to restore vaccine confidence. In addition, **WHO** informed that **Gavi** approved the COVAX Humanitarian Buffer for high-risk groups in humanitarian settings but emphasized that this must only be a measure of last resort and not a substitute for inclusion of these groups in national deployment and vaccination plans (NDVPs).

WHO acknowledged that a safe approach to mass gatherings and large meetings will be a critical step towards a slow return to normalcy and highlighted its collaboration with the UN Department for Safety and Security (UNDSS) in this regard.

Related to critical supply chain and goods, **WHO** informed that the full report of the UN COVID-19 Supply Chain System response assessment team will be made available to partners.

Finally, **WHO** noted that it will launch a “Sprint to September” communications campaign to advocate on behalf of frontline workers and vulnerable people effected by the pandemic.

Risk Communication, Community Engagement and Infodemic Management

COVID-19 infodemic management course: risk communication and community engagement (RCCE) challenges

An [infodemic management course](#) applies evidence-based guidance to the COVID-19 pandemic on how to sustain behavior change with approaches and proven activities from regions and countries launched in early February. This OpenWHO course has already reached 5,126 enrolled individuals from all six WHO Regions and 1,869 certificates have been delivered to those who completed the course.

The COVID-19 infodemic can lead to confusion, risk-taking and harmful behaviours with new challenges arising with the rapid spread of mis- and dis-information on social media. In some countries, misinformation has generated mistrust in governments, public health authorities and science. Thus, managing the infodemic is critical to managing the pandemic.



Photo credit: WHO Bangladesh/ Tatiana Almeida

The course covers key RCCE principles and illustrates how they can be operationalized in the context of an extended outbreak that affects different populations with varying risk levels. Illustrations from WHO headquarters, regions, and Ministries of Health provide concrete examples of messaging and other communication interventions developed during COVID-19.

This three-module course focuses on how countries, communities and individuals are managing public health and social measures by maintaining what's working while addressing challenges that still lie ahead for 2021. As countries are going in and out of restrictions, the COVID-19 pandemic is having significant impacts on people's everyday lives. The course will add training modules on finding solutions to RCCE challenges in the future.

Module 1

Defining RCCE, explaining key challenges and identifying tactics for managing uncertainty and building trust.

Module 2

Influencing risk perception to encourage healthy behaviors – describing concepts and identifying how and why risk perception varies as well as how different characteristics of health threats can be used in messaging to influence risk perceptions.

Module 3

Sustaining recommended behaviors for extended periods – identifies the limits of risk perception and fear. This session describes tactics such as nudging to encourage adherence.

COVID-19 Partners platform

WHO launched its updated COVID-19 Strategic Preparedness and Response Plan (SPRP) [Operational Planning Guideline](#) for 2021 on 3 March. In response, the [Partners Platform](#) is developing key tools in the ongoing and evolving response, which are scheduled to roll out in the coming weeks. Here is a preview of these tools in development and how they can be used to guide the planning and response actions of key stakeholders.

Changes to the Action Checklist:

The Partners Platform's technical leads are in discussion with Regional Focal Points to prioritize the Action Checklist. The Action Checklist, an original feature of the Partners Platform, helps countries develop or update a national response plan based on the 10 Pillars of response as laid out in the SPRP. The updates are scheduled to roll-out on the Partners Platform the week of 12 April.

The addition of Pillar 10 and TA/resource mapping:

One of the biggest changes made to the SPRP in 2021 was the addition of a tenth pillar for vaccine. The WHO worked with donors and global partners integral to the planning and implementation of vaccine introduction to develop an Action Checklist for vaccine, a digital space for countries to upload the National Deployment and Vaccination Plan (NDVP), and a separate vaccine dashboard that allows Partners Platform users, including donors, to view countries' vaccine resource needs and technical assistance that has been contributed. The NDVP folders have been in use by over 100 countries since February, and the Pillar 10 checklist and TA/resource mapping dashboard will roll-out the week of 19 April.

Expansion to other outbreaks and operational readiness: The Partners Platform was born from the urgent need for a centralized, transparent, real-time coordination of efforts to respond to COVID-19. It has proven to be an effective and efficient tool that has streamlined the modus operandi for outbreak response. As such, WHO will continue to offer use of the Partners Platform to countries for responding to and strengthening operational readiness for future outbreaks, including Ebola Virus Disease. This expansion will go live on the Partners Platform in mid-April.

2020 Strategic Preparedness and Response Plan (SPRP) and National Deployment and Vaccination Plan (NDVP) Achievements

6 525 users spanning across 1 007 organizations*

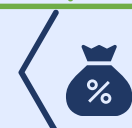


120 countries, territories and areas sharing national response plans

134 countries, territories, and areas are tracking actions under the pillars of Public Health for the entire national system



To date, 90 countries have shared resource needs totaling US\$ 9.3 billion across the nine response pillars



105 countries, territories, and areas sharing National Deployment and Vaccination Plans (NDVPs) via Partners Platform



77 donors have responded totaling approximately US\$ 9.1 billion



**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 25 March 2021.

Shipped items as of 25 Mar 2021	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	718 550	3 768 125	1 866 146	1 473 890	10 646 300	223 570	1 741 279	53 467 400	2 768 630
Americas (AMR)	7 342 300	1 046 132	10 543 278	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	1 178 300	1 625 220	1 785 140	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	459 000	664 550	609 520	1 756 900	8 938 900	414 860	1 757 548	40 911 500	5 423 350
South East Asia (SEAR)	1 440 000	3 185 800	2 408 970	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		228 500	346 834	768 700	3 060 000	311 927	463 710	14 974 146	2 102 035
TOTAL	11 138 150	10 518 327	17 559 888	8 659 511	37 135 700	1 566 287	6 970 179	198 747 426	20 070 365

Note: Data within the table above undergoes periodic data verification and data cleaning exercises. Therefore, some subsequent small shifts in total numbers of procured items per category are anticipated.

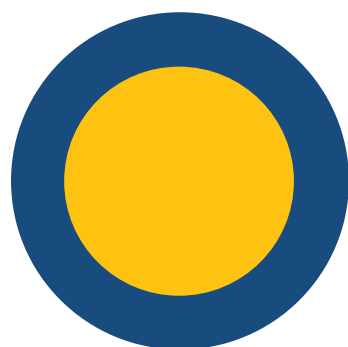
For further information on the **COVID-19 supply chain system**, see [here](#).

Appeals

WHO's [Strategic Preparedness and Response Plan](#) (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 and health systems strengthening for the roll out of COVID-19 tools (ACT-A). Of the US\$ 1.96 billion appealed for, US\$ 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. US\$ 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.

SPRP 2021 Requirements US\$ 1.96 billion



● 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*

Contributions to WHO for COVID-19 appeal

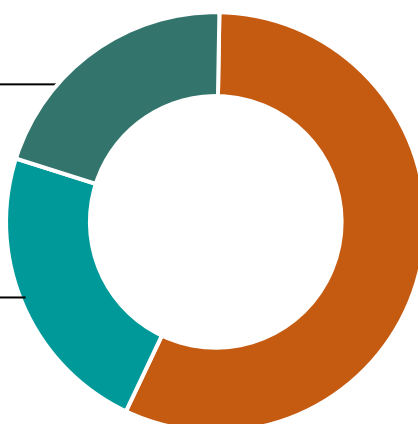
Data as of 24 March 2021

Total Received: US\$431 million

21.99%

Total Pledges: US\$458 million

23.36%



Gap: US\$1.07 billion

54.65%

The 2021 SPRP priorities and resource requirements can be found [here](#).
The status of funding raised for WHO against the SPRP can be found [here](#).

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

As of 19 March 2021, [The Solidarity Response Fund](#) has raised or committed more than US\$ 242 million from more than 663 118 donors.

The world has never faced a crisis like COVID-19. The pandemic is impacting communities everywhere. It's never been more urgent to support the global response, led by the World Health Organization (WHO).

More than **US\$ 242 Million**



663 118 donors

[individuals – companies – philanthropies]

Pandemic learning response

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.



5 046 007

COVID-19 Course
enrollments

29 topical COVID-19 courses

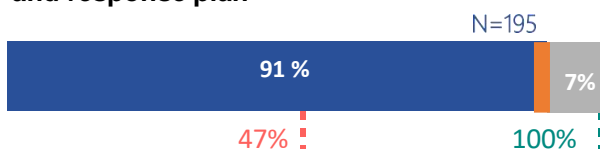
47 languages

Over 2.8 million certificates

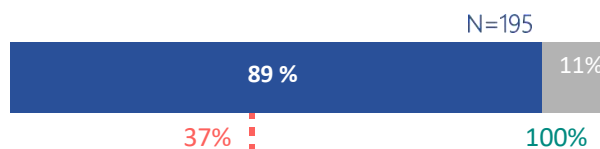


COVID-19 2020 Global Preparedness and Response Summary Indicators ^a

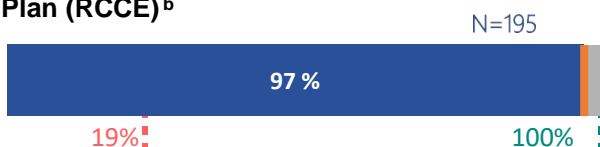
Countries have a COVID-19 preparedness and response plan



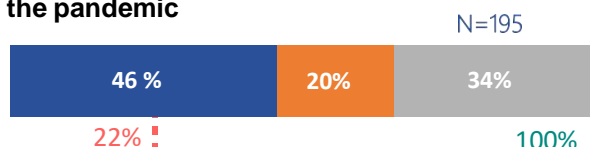
Countries have a clinical referral system in place to care for COVID-19 cases



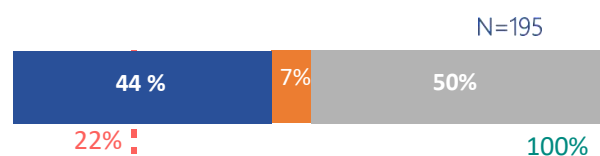
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE) ^b



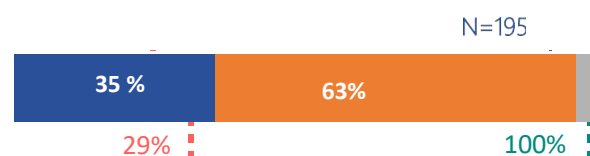
Countries that have defined essential health services to be maintained during the pandemic



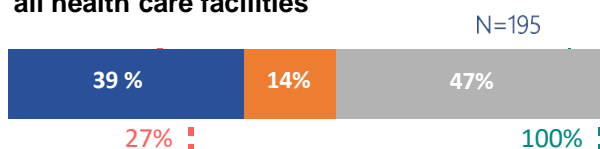
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



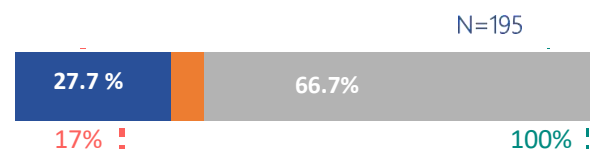
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



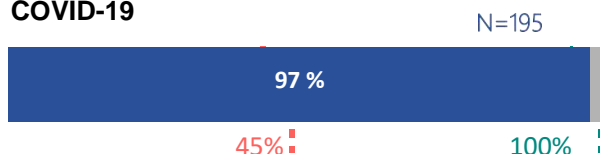
Countries with a national IPC programme & WASH standards within all health care facilities



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

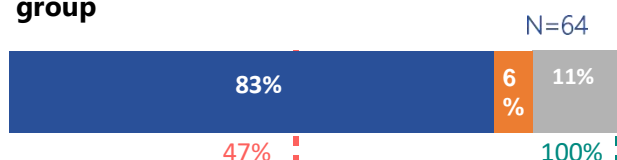
Notes:

^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

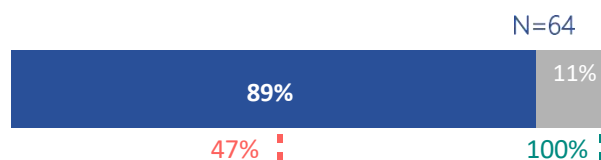
COVID-19 2020 Global Preparedness and Response Summary Indicators

Selected indicators within the 2020 Monitoring and Evaluation Framework apply to designated priority countries. A full list of priority countries for 2020 can be found [here](#).

Priority countries with multisectoral mental health & psychosocial support working group



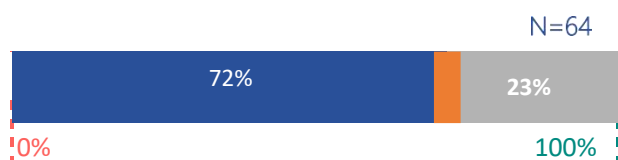
Priority countries with an active & implemented RCCE coordination mechanism



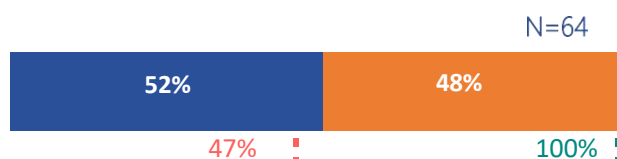
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19 ^c



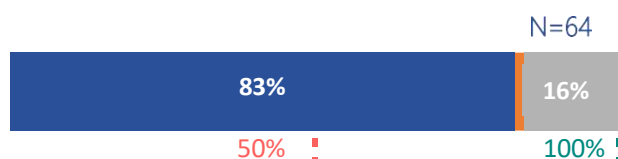
Priority countries with a contact tracing focal point



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



Legend

Yes

No

No information

Baseline value

Target value

Notes:

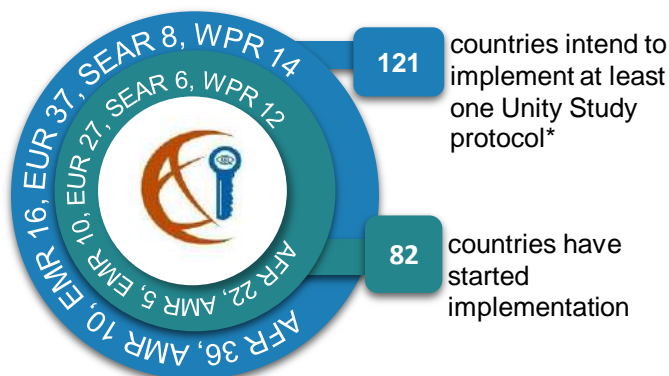
^c Source: WHO Immunization Repository

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.

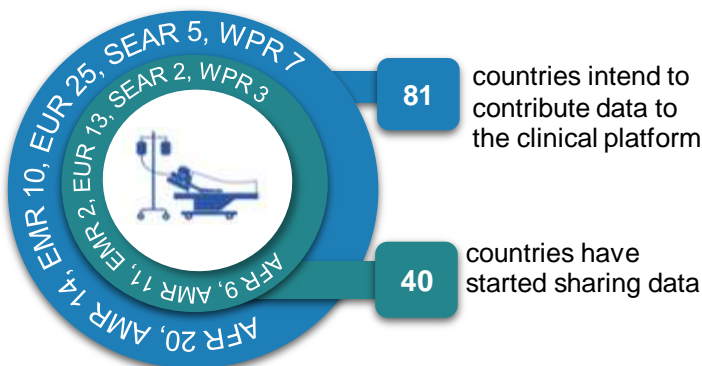
The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays



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.

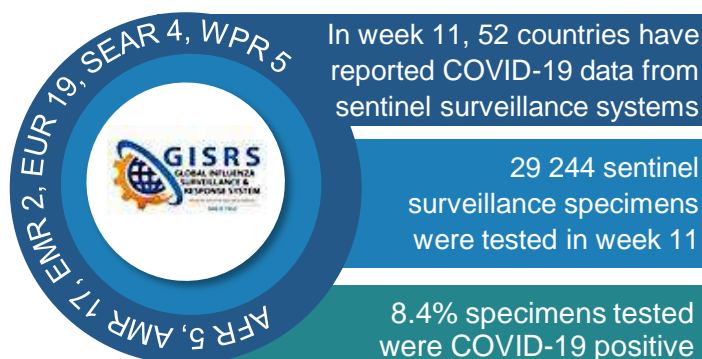
WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



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 SARS-COV-2



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 26 March **Weekly Epidemiological Update**, click [here](#). Highlights this week include:
 - Release of the WHO COVID-19 Detailed Surveillance Dashboard
 - SARS-CoV-2 variants of concern
- ❑ 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](#).
- ❑ On 19 March, the WHO Director-General provided [opening remarks at the media briefing](#) on COVID-19
 - Dr Tedros Adhanom Ghebreyesus noted in his remarks that WHO's Global Advisory Committee on Vaccine Safety "has recommended that the AstraZeneca vaccine's benefits outweigh its risks, with tremendous potential for preventing infections and deaths from COVID-19."
 - For the WHO Statement on AstraZeneca COVID-19 vaccine safety signals, click [here](#).

COVID-19 Weekly Epidemiological Update

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

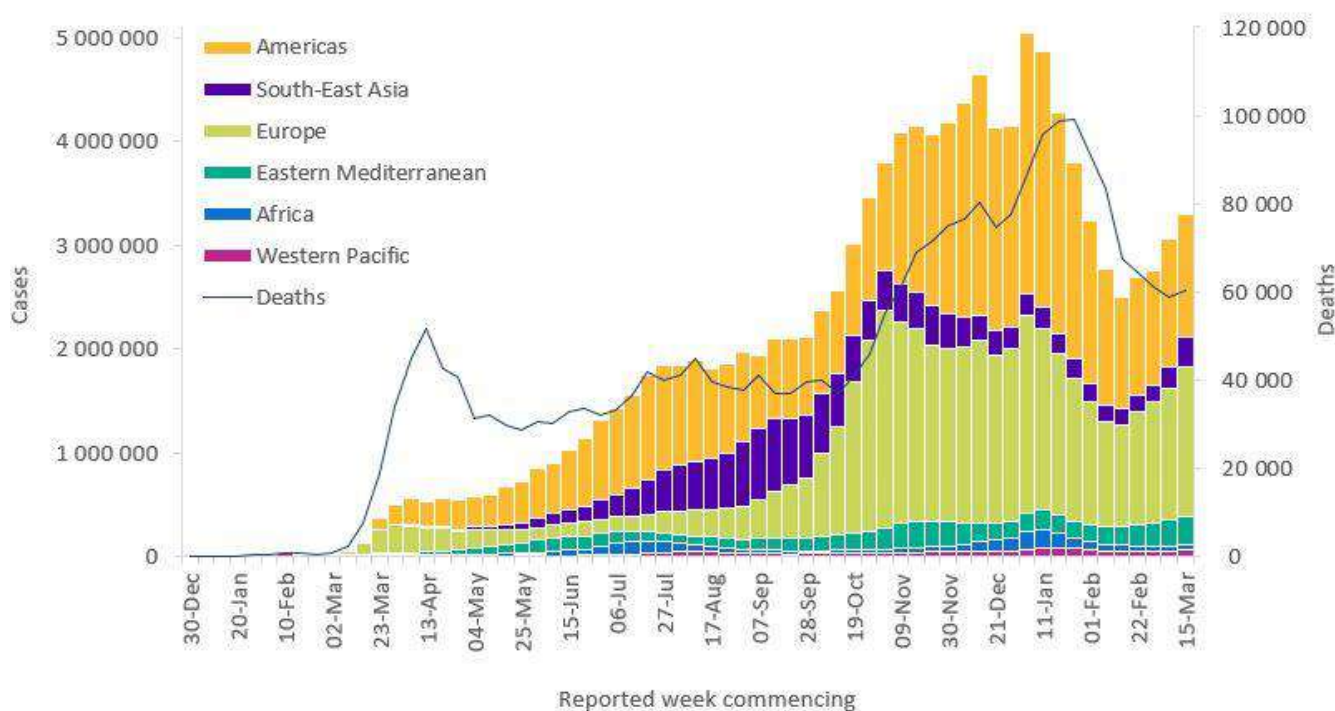
In this edition:

- [Global overview](#)
- [Special focus: Release of the WHO COVID-19 Detailed Surveillance Dashboard](#)
- [Special focus: SARS-CoV-2 variants of concern](#)
- [WHO regional overviews](#)
- [Key weekly updates](#)

Global overview

Globally, COVID-19 confirmed cases continued to rise for a fourth consecutive week, with just under 3.3 million new cases reported in the last week (Figure 1). At the same time, the number of new deaths reported plateaued after a six week decrease, with just over 60 000 new deaths reported. Marked increases in the number of new cases were reported from the South-East Asia, Western Pacific, European and Eastern Mediterranean regions, all of which have been on an upward trajectory in recent weeks. Case incidence in the African Region and the Region of the Americas has remained stable in recent weeks, notwithstanding concerning trends observed in some countries within these regions. The European Region and the Region of the Americas continue to account for nearly 80% of all the cases and deaths. The only WHO region to report a decline in new deaths this week was the Western Pacific where deaths fell by nearly a third, compared to the previous week.

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



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

The highest numbers of new cases were reported from Brazil (508 010 new cases; 3% increase), the United States of America (374 369 new cases; 19% decrease), India (240 082 new cases; 62% increase), France (204 840 new cases; 27% increase), and Italy (154 493 new cases; similar to previous week).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 21 March 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	1 173 561 (36%)	-5%	53 937 714 (44%)	31 040 (51%)	2%	1 299 243 (48%)
Europe	1 441 065 (44%)	13%	42 516 762 (35%)	21 772 (36%)	1%	929 332 (34%)
South-East Asia	298 438 (9%)	49%	14 182 826 (12%)	2 435 (4%)	14%	214 790 (8%)
Eastern Mediterranean	263 650 (8%)	8%	7 124 121 (6%)	3 253 (5%)	12%	153 446 (6%)
Africa	50 916 (2%)	-3%	2 999 152 (2%)	1 428 (2%)	10%	76 113 (3%)
Western Pacific	63 730 (2%)	29%	1 775 560 (1%)	486 (1%)	-33%	30 843 (1%)
Global	3 291 360 (100%)	8%	122 536 880 (100%)	60 414 (100%)	3%	2 703 780 (100%)

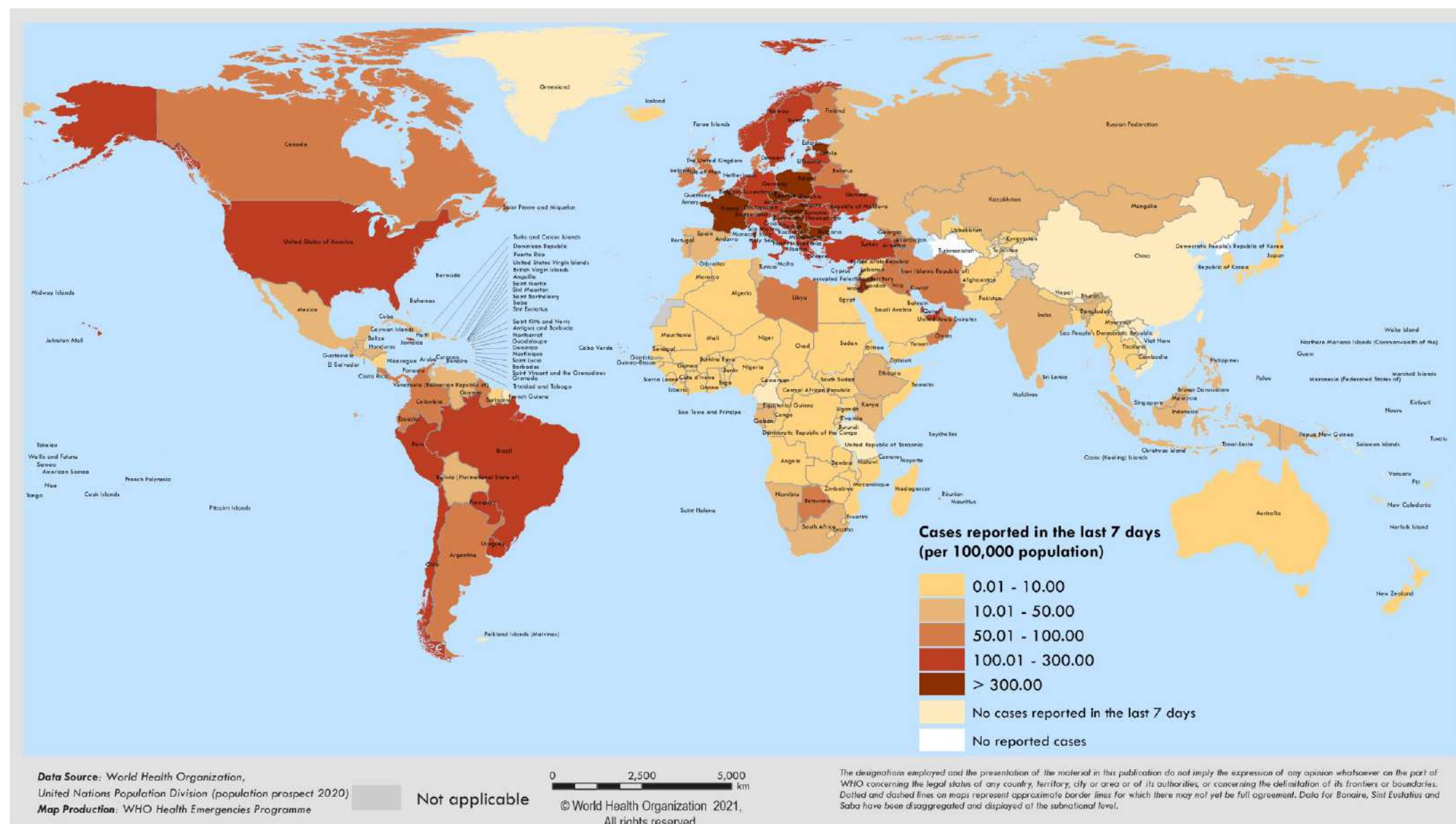
*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number; global totals may not equal 100%.

**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 by countries, territories and areas, 15-21 March 2021**



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

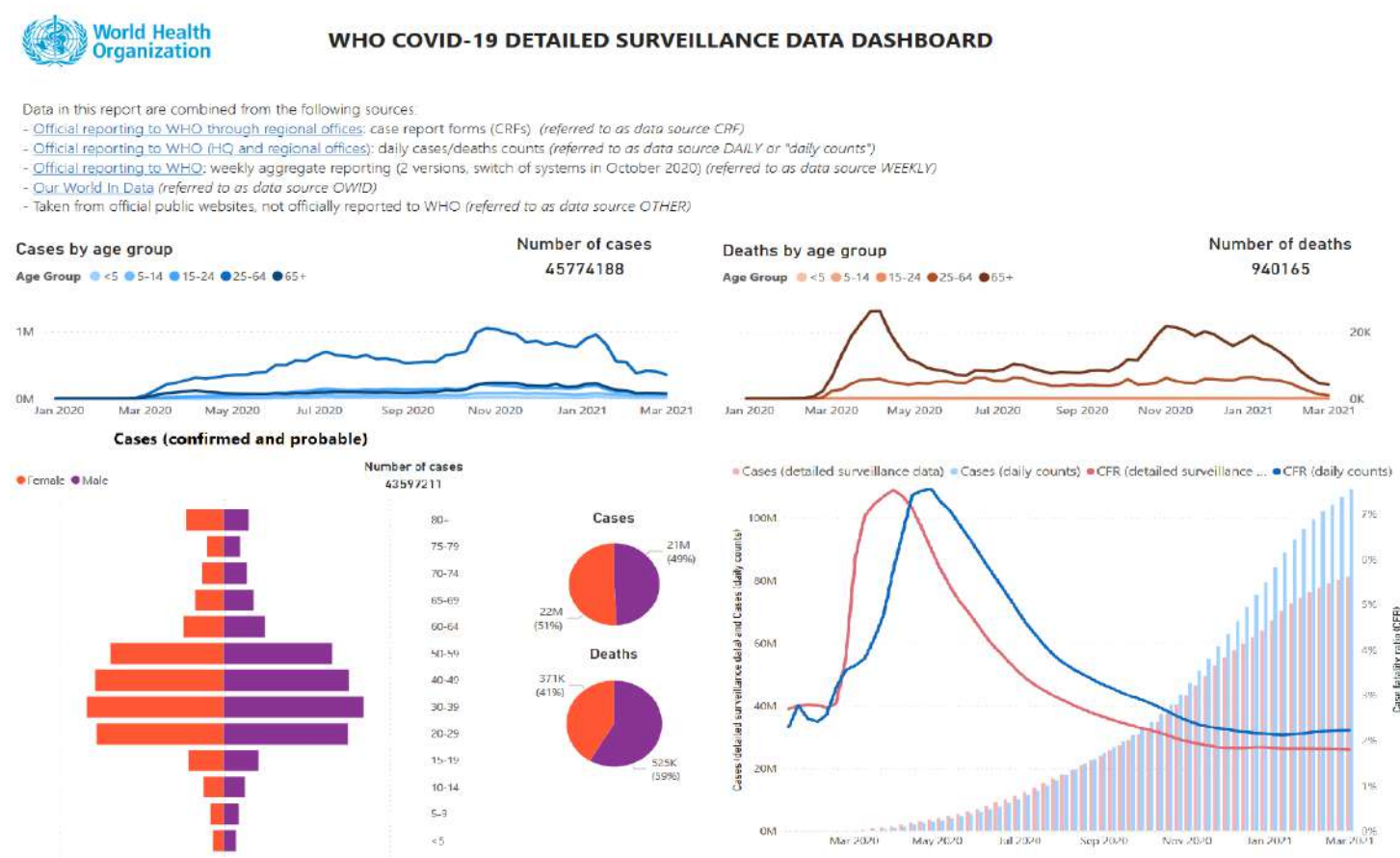
Special Focus: Release of the WHO COVID-19 Detailed Surveillance Dashboard

Over one year into the pandemic, WHO continues to conduct [global surveillance of COVID-19](#) as part of activities on [preparedness, readiness and response activities](#). The need for global surveillance of COVID-19 is greater than ever, as the implementation of vaccination campaigns and the appearance of variants are prone to impact the course of the epidemic, as transmission patterns evolve. Timely and complete surveillance data are key to monitoring these changes.

In addition to the daily count of confirmed cases and deaths of COVID-19, WHO requested all Member States to report a minimal set of information using a [case report form](#) or via the [weekly aggregated surveillance system](#) as specified in the [Public Health Surveillance for COVID-19 interim guidance](#). Member States report primarily via one of the systems; some have switched from case report forms to weekly reporting.

The data reported are now publicly available through the [WHO COVID-19 detailed surveillance data dashboard](#) (Figure 3), without editing or filtering by WHO. Features include stratification by age and sex, trends over time, case fatality ratios by age, testing, hospitalization, and data on health workers – all visible at country and regional levels. The dashboard provides the ability for users to conduct further analyses by country and selected time period.

Figure 3: Snapshot of the COVID-19 Surveillance dashboard



As of 14 March 2021, a total of 186 countries, territories and areas had shared detailed data, via case report forms or weekly aggregate surveillance with WHO. Of the 119 million cases reported globally at this time, WHO has received information for 86.4 million cases (73%). Sex was reported for over 59 million cases (50%), age reported for 45 million cases (38%), and age and sex combined was reported for 42 million cases (36%). There are also data on COVID-19 cases among health workers, with just over 1.6 million cases, and 25 000 deaths, recorded in the system.

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 interest (VOIs) and variants of concern (VOCs) is available from previously published editions of the [Weekly Epidemiological Update](#). Here we provide an update on the geographical distribution, and emerging evidence surrounding transmissibility and severity, and potential impacts on vaccines and diagnostics. We also update on emerging VOIs, and a recent workshop on enhancing sequencing for SARS-CoV-2.

Table 2: Overview of emerging information on key variants of concern, as of 23 March 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, alias P.1 [†]
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01 [†]	VOC 202012/02	-
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; and P681H	L242/A243/L244 deletion; K417N E484K, N501Y	K417T, E484K; N501Y
Key mutation in common	S106/G107/F108 deletion in Non-Structural Protein 6 (NSP6)		
Transmissibility*	Increased ^{1, 2} (36%-75%) ³ , increased secondary attack rate ⁴ (10% to 13%)	Increased [1.50 (95% CI: 1.20-2.13) times more transmissible than previously circulating variant ^{5, 6}	Increased, more transmissible than previous circulating variants ⁷
Severity*	Possible increased risk of hospitalization ⁸ , severity and mortality ⁴	Possible increased risk of in-hospital mortality by 20% ^{6, 9}	Under investigation, limited impact ⁷
Neutralization capacity*	Slight reduction but overall neutralizing titers still remained above the levels expected to confer protection ¹⁰	Decreased, suggesting potential increased risk of reinfection ^{5, 11, 12}	Decreased, reinfections reported ^{13, 14}
Potential impacts on vaccines*	<ul style="list-style-type: none"> No significant impact on post-vaccine neutralization by Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax and Bharat vaccines 15-18 No significant change in prevention of disease by Oxford-AstraZeneca, Novavax, and Pfizer¹⁵⁻¹⁷ Evidence for prevention of infection evidence limited. Reduced effect reported for Oxford-AstraZeneca.^{15, 18} 	<ul style="list-style-type: none"> Post-vaccine neutralization reductions range from minimal to moderate for Moderna and Pfizer, however there is also some evidence of more substantial reductions.¹⁹ A single study has evaluated Sinopharm.²⁰ Substantial reductions have been found for the Oxford-AstraZeneca product.^{21, 22} Results for Novavax and Janssen are pending. Efficacy against disease was retained, but somewhat lower, in South Africa when 501Y.V2 was dominant compared to settings without this variant.^{23, 24} In a small study, AstraZeneca did not demonstrate vaccine efficacy against mild-moderate COVID-19 disease, with wide confidence intervals, while efficacy against severe disease was not assessed and is undetermined.^{25, 26} There is no evidence to inform vaccine impact on asymptomatic infection by 501Y.V2. 	<ul style="list-style-type: none"> Limited to modest reduction in post-vaccine neutralization by Oxford-AstraZeneca, Moderna and Pfizer vaccines.^{19, 21, 27-31} Preliminary suggestion of loss of neutralization following vaccination with Sinovac³²
Potential impacts on diagnostics*	S gene target failure (SGTF). ²⁵ No impact on Ag RDTs observed ²³	None reported to date	None reported to date
Countries reporting cases (newly reported in last week)**	125 (7)	75 (11)	41(3)

[†]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.

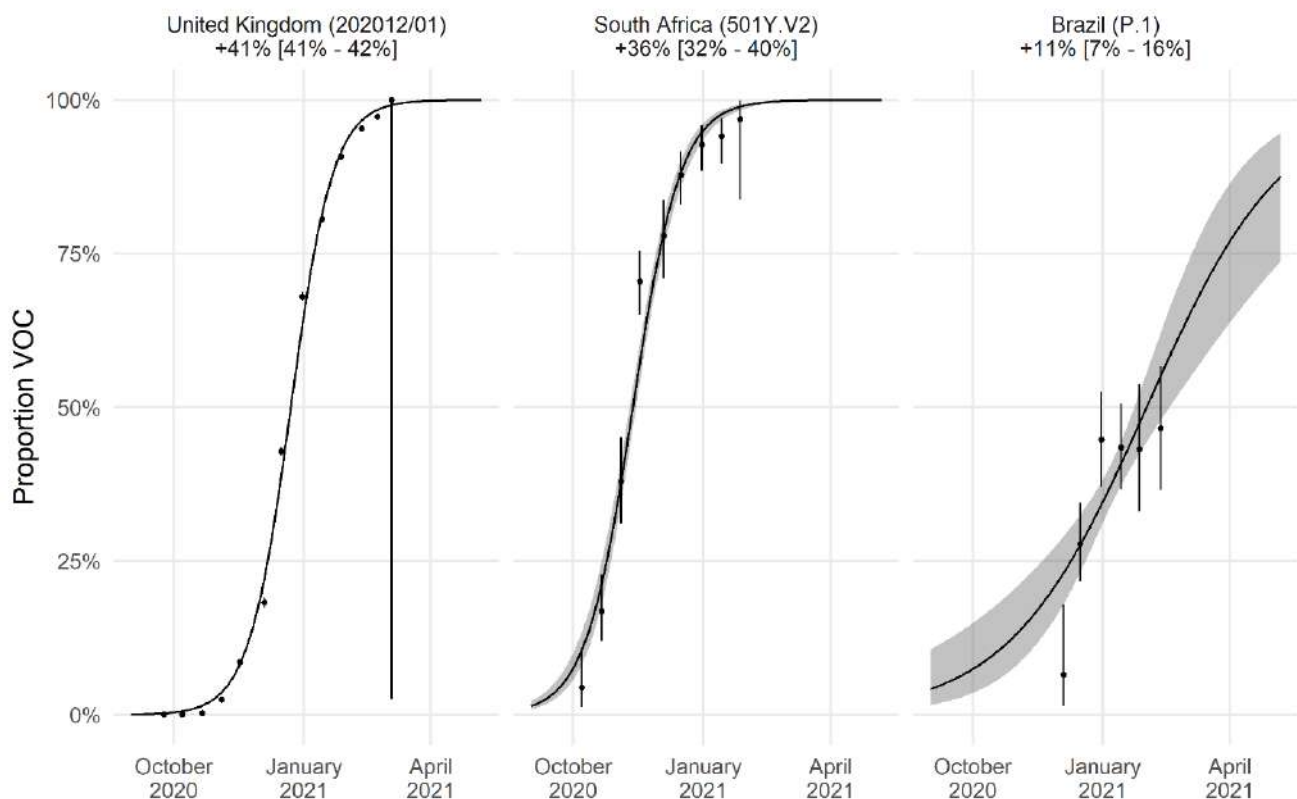
*Generalized findings as compared to non-VOC viruses. Based on emerging evidence from multiple countries, including nonpeer-reviewed preprint articles and reports from public health authorities and researchers – all subject to ongoing investigation and continuous revision.

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

The number of countries reporting VOCs has continued to increase (Table 2, Figures 5, 6 and 7, Annex 2). This information should be interpreted with due consideration of limitations of ongoing surveillance, including but not limited to differences between countries in sequencing capacity and which samples are prioritized for sequencing. WHO continues to advocate for strengthening surveillance and sequencing capacity, and a systematic approach to provide a representative indication of the extent of transmission of SARS-CoV-2 variants; based on the local epidemiological situation and capacity, and the detection of unusual events.

VOC 202012/01, 501Y.V2 and P.1 have commonly demonstrated an increase in transmissibility compared to wild-type (non-VOC) variants, and a veracity to rapidly replace other circulating strains. We analysed sequence data submitted to GISAID to determine the change in proportion of VOCs over time and calculate the associated change in transmissibility. Variants 202012/01, 501Y.V2 and P.1 rapidly replaced the wild-type variant in the United Kingdom, South Africa and Brazil, respectively (Figure 4). Using a logistic model of competitive growth, the additive increase in the effective reproduction number (R_t) relative to the wild-type variant was estimated at 41% (95% CI: 41–42%) for 202012/01, 36% (95% CI: 32–40%) for 501Y.V2, and 11% (95% CI: 7–16%) for P.1. The transmissibility of P.1 was higher when estimated only for the Amazonas region of Brazil (data not shown), suggesting more rapid replacement of the wild-type variant at a local level. However, the number of sequences was too low to meaningfully quantify the change in R_t . These analyses assume that sequence data submitted to GISAID is representative of the variants circulating in the region under consideration; if sequencing efforts are targeted at suspected VOCs, the rate of replacement and associated increased transmissibility of VOCs may be overestimated.

Figure 4. Proportion of SARS-CoV-2 202012/01, 501Y.V2 and P.1 variants over time in the United Kingdom, South Africa and Brazil, respectively. The estimated increase in R_t and associated 95% confidence interval is indicated below the country name.



Variant VOC 202012/01

Since our last update on 16 March, VOC 202012/01 has been detected in seven additional countries. As of 23 March, a total of 125 countries across all six WHO regions have reported cases of this variant (Figure 5).

Previous studies have shown VOC 202012/01 may be associated with an increased risk of hospitalization, severity and mortality.^{4, 8} A recently published matched cohort study provides additional evidence, highlighting that there is a higher risk of mortality when infected by VOC 202012/01. The study involved nearly 55 000 matched pairs of participants who tested positive for SARS-CoV-2 between 1 October 2020 and 29 January 2021 and were followed-up until 12 February 2021. Results showed an increased mortality hazard ratio of 1.64 (95% confidence interval 1.32 to 2.04). This ratio was associated with infection with VOC 202012/01 compared with infection with previously circulating variants, in patients who tested positive for COVID-19 in the community. Although this constitutes a comparatively low risk group overall, it represents an increase in deaths from 2.5 to 4.1 per 1000 detected cases.

Vaccine updates

There is a growing body of evidence on vaccine-induced neutralizing antibody activity against VOC202012/01, including for AstraZeneca, Moderna, Pfizer, Novavax, and Bharat vaccines. The findings support that neutralizing activity is largely sustained against this variant.^{10, 33} Additional evidence is available on the ability of vaccines to protect against disease from VOC 202012/01 are available for the AstraZeneca and Pfizer vaccines, from a randomized controlled trial (RCT) in the UK (AstraZeneca) and observational evidence (Pfizer and AstraZeneca) from the UK during the period when VOC 202012/01 was prevalent.¹⁷ Results from a test-negative case control study conducted in England from December 2020 to February 2021 when VOC202012/01 was very prevalent, showed the early real-world effectiveness of the Pfizer/BioNTech - BNT162b2 vaccine and AstraZeneca - ChAdOx1 vaccine against confirmed COVID-19, hospitalizations and deaths.¹⁷ This study also estimated effectiveness on the VOC202012/01. Both vaccines show that vaccination with either a single dose of BNT162b2 or ChAdOx1 was associated with a significant reduction in symptomatic COVID-19 cases in older adults (>70 years old) with even greater protection against severe disease.

Evidence for vaccines to protect against asymptomatic infection, which would influence community transmission, is limited to the RCT in the UK of the AstraZeneca product.¹⁵ Although effectiveness against disease was largely sustained against VOC202012/01, preliminary evidence suggests that the efficacy against asymptomatic infection is reduced in the face of this variant.

Figure 5. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 23 March 2021



Variant 501Y.V2

Since the last update on 16 March, 501Y.V2 has been reported from 11 additional countries – totaling 75 countries across all six WHO regions (Figure 6). In several areas within the African Region, variant 501Y.V2 has been reported to comprise a high proportion of sequenced samples, including over 90% of sequenced specimens in some settings.^{34, 35}

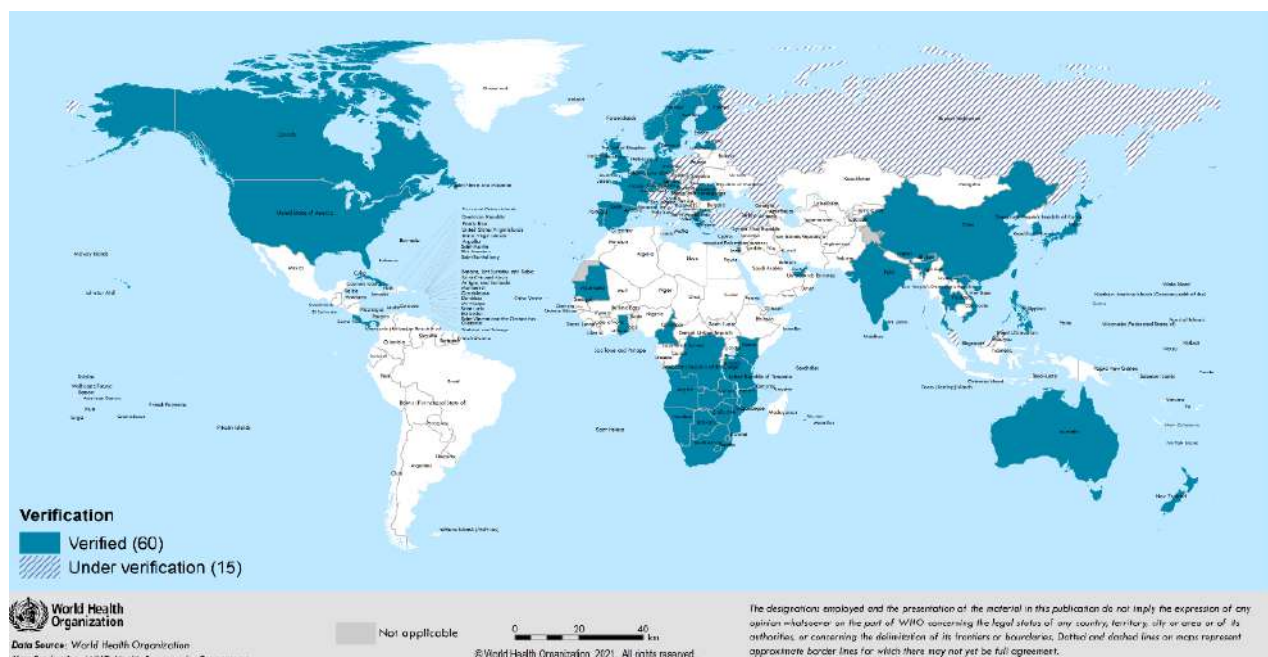
A newly released population-based study in South Africa, available in preprint, compared in-hospital mortality during its first wave peaking in mid-July 2020 to the second wave peaking in January 2021 when variant 501Y.V2 was the predominant variant. After adjusting for weekly hospital admissions, the risk of in-hospital mortality increased by 20% (adjusted odds ratio of 1.2, 95%CI 1.2-1.3).⁹

Vaccine updates

Reductions in neutralizing antibody activity against 501Y.V2 induced by vaccines or natural infection compared with wild-type (non-VOC) variants, have been documented in a substantial number of studies.^{5, 30} Findings from a recent study that analyzed convalescent plasma from 20 patients and sera from 22 participants of vaccine trials [Moderna SARS-CoV-2 mRNA-1273 vaccine (12 participants); Pfizer BNT162b2 COVID-19 vaccine (10 participants)] indicated that relative to wild-type variants, there was a substantial decrease in the neutralizing activity of convalescent plasma (9.4-fold) and sera from vaccinated participants (10.3 to 12.4-fold) against 501Y.V2.³¹ In addition, T-cell analyses suggest this component of the vaccine induced immune response is less influenced by the variants than the impact on the neutralization activity.³⁶

Evidence of vaccine efficacy against clinical disease from B.1.351 is available for AstraZeneca, Janssen and the Novavax vaccines.^{24, 37, 38} Comparisons are hampered by different case definitions, and trials sizes. Although there appears to be some reduction in efficacy compared with non-B.1.351 strains, both the Novavax and the Janssen product retain significant efficacy. The AstraZeneca trial found no statistically significant efficacy; however, this trial was of a small sample size, had only mild and moderate cases and used a dosing interval of 4 weeks.³⁷ Separate evidence indicates a longer dosing interval improves both immunogenicity and efficacy, which along with other evidence leave open the plausibility that efficacy against severe disease may be partially retained.

Figure 6. Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 23 March 2021



Variant P.1

Since our last update, variant P.1 has been reported in three additional countries. As of 23 March, this variant is reported in 41 countries across all six WHO regions (Figure 7).

A recent study analyzed the national health surveillance data of hospitalizations and frequency of variant P.1 in Manaus city, in Amazonas State, Brazil where this variant was first detected and has widely spread. Based on the preliminary findings, P.1 is found to be 2.5 times more transmissible (95% CI:2.3–2.8) compared to the previously circulating variant while the reinfection probability was found to be low i.e. 6.4% (CI:5.7–7.1%).³⁹ Two additional studies analyzed the genomic data from Manaus and estimated higher transmissibility of the P.1 variant.^{7, 14} However, these are preliminary findings and more studies are required to fully understand the transmissibility and severity of P.1 variant.

Vaccine updates

Numerous studies have measured the neutralization of variant P.1 by sera from those vaccinated with Pfizer, Moderna, AstraZeneca or Sinovac against SARS-CoV-2 virus including in Manaus.^{21, 27–32 19} Based on these findings, the neutralization activity was reduced by 2.6 to 10-fold depending on the vaccine and individuals. In particular, among people vaccinated with the Sinovac product (CoronaVac vaccine), the plasma failed to efficiently neutralize variant P.1 suggesting possibility of reinfection. One T-cell study concluded that response was largely preserved.³⁶ There are no clinical outcome data following vaccination which are needed to understand the implications of the limited to moderate loss of neutralization activity.

Figure 7. Countries, territories and areas reporting SARS-CoV-2 P.1 variant as of 23 March 2021



WHO Global workshop on enhancing sequencing for SARS-CoV-2, 19 March 2021

On 19 March 2021, WHO hosted a global workshop on enhancing sequencing to monitor SARS-CoV-2 evolution, bringing together stakeholders in a high level discussion to agree on a common vision and a global, coordinated plan to increase SARS-CoV-2 sequencing capacity, in order to strengthen detection of VOIs and VOCs. Over 800 participants joined this virtual workshop, including representatives from Ministries of Health,

academia and donors, engaging in discussions on the international sequencing landscape, available capacities and opportunities for network-driven strengthening of SARS-CoV-2 variant detection.

The workshop highlighted how we can leverage existing surveillance systems and structures, such as existing SARS-CoV-2 reference network, the Global Influenza Surveillance and Response System (GISRS), HIV, TB and Polio laboratory networks, to strengthen existing regional networks, and to build new sustainable capacity to generate and process sequencing data for SARS-CoV-2 and other infectious pathogens. Sequence and supporting meta-data sharing is critical to better understand virus evolution and to inform the COVID-19 response. The workshop outcomes were as follows:

- A situational overview of national and regional sequencing and data analysis capacities around the world and demonstration of ongoing support from Member States with capacities to support others.
- An agreement from participants on the importance of timely data sharing and a need to build capacity for sequencing, data processing leading to informed action.
- An agreement toward a global plan to enhance sequencing and analysis capacities and linking results with public health actions.

The workshop outlined the need for global coordination of sequencing capacity. WHO will provide the coordination role by providing a platform, leadership and coordination for future discussions, capacity building and network-based knowledge sharing. The workshop will inform discussions at the upcoming Global Consultation on a Decision Framework for Assessing the Impact of SARS-CoV-2 Variants of Concern on Public Health Interventions on 29 March 2021.

Emerging variants of interest (VOIs)

All viruses, including SARS-CoV-2, change over time resulting in the emergence of new variants, most without a direct benefit to the virus or other public health impacts. WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 result in changes in transmissibility, clinical presentation and severity, or if they impact on public health and social measures (PHSM). Systems have been established to detect “signals” of potential variants of interest or concern, as well as unusual events potentially associated with a variant, and assess these based on the risk posed to global public health (see also [working definitions](#)). A number of such signals are currently under assessment, and as new VOIs or VOCs are determined, WHO is committed to highlighting these to support prioritization for further monitoring and assessment. Table 3 summarises assessed and designated VOIs as of 23 March 2021. National authorities may choose to designate other variants of local interest/concern as every local situation is unique, with different variants circulating, requiring surveillance and response systems to adapt to their local epidemiological situation.

Table 3: Overview of variants of interest (VOIs), as of 23 March 2021*

Nextstrain clade	20C	20C/S:452R	20J
PANGO lineage	B.1.525	B.1.427/B.1.429	B.1.1.28.2, alias P.2
GISAID clade	G/484K.V3	GH/452R.V1	
Alternate names		CAL.20C/L452R	
First detected by	United Kingdom and Nigeria	United States of America	Brazil
First appearance	December 2020	June 2020	April 2020
Key spike mutations	H69-V70 deletion; Y144 deletion; Q52R; E484K; Q677H; D614G; and F888L	L452R; W152C; S13I; D614G	L18F; T20N; P26S; F157L; E484K; D614G; S929I; and V1176F

WHO recommendations

The potential for virus mutation increases with the frequency of human and animal infections. Therefore, reducing transmission of SARS-CoV-2 by using established disease control methods as well as avoiding introductions to animal populations, are critical aspects to the global strategy to reduce the occurrence of mutations that have negative public health implications. 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 as well as infection prevention and control (IPC) measures in health facilities has been effective in reducing COVID-19 case incidence, which has led to a reduction in hospitalizations and deaths among COVID-19 patients. Findings from new studies evaluating transmission, severity and impact on medical countermeasures will continue to help inform PHSM and IPC measures employed by Member States. National and local authorities are encouraged to continue strengthening existing PHSM, IPC and disease control activities, including epidemiological surveillance, strategic testing, and systematic sequencing of SARS-CoV-2 where feasible.

Additional resources

- [Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health](#)
- [Considerations for implementing and adjusting PHSM in the context of COVID-19](#)
- [Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern](#)
- [Disease Outbreak News on SARS-CoV-2 Variants, 31 December 2020](#)

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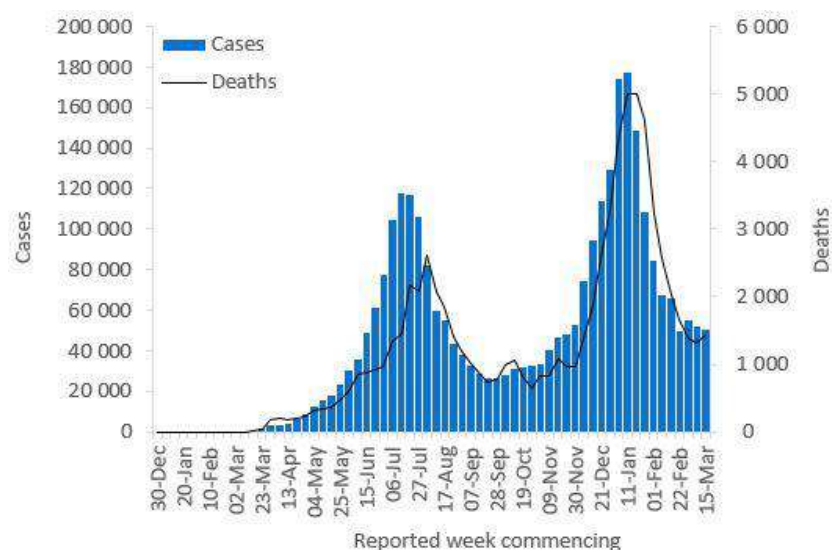
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WHO regional overviews

African Region

The African Region reported nearly 51 000 new cases and over 1400 new deaths, a 3% decrease and a 10% increase respectively compared to the previous week. This is the first time in eight weeks, that an increase in new deaths has been reported. The highest numbers of new cases were reported from Ethiopia (11 587 new cases; 10.1 new cases per 100 000 population; a 28% increase), South Africa (8387 new cases; 14.1 new cases per 100 000; a 2% increase), and Kenya (7358 new cases; 13.7 new cases per 100 000; a 66% increase).

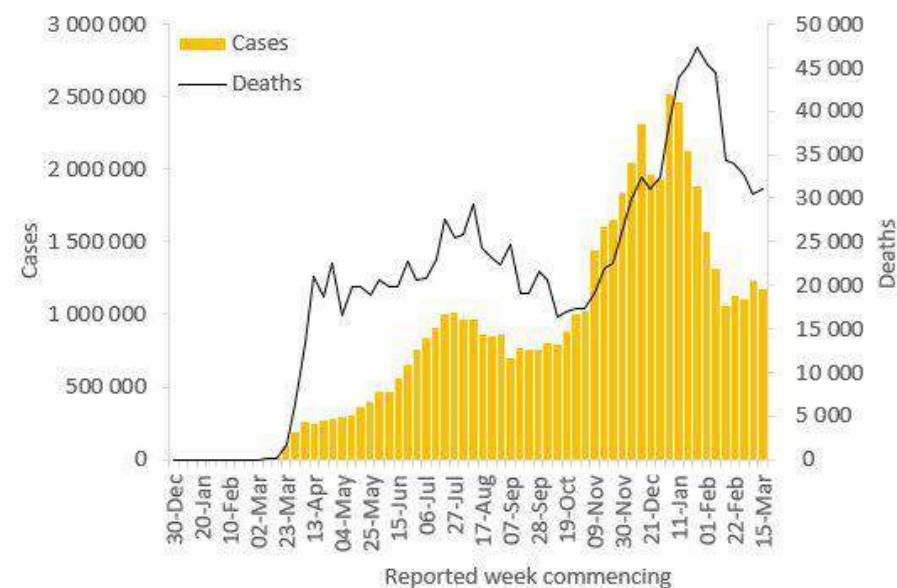
The highest numbers of new deaths were reported in the same countries, from South Africa (821 new deaths; 1.4 new deaths per 100 000 population; a 34% increase), Ethiopia (107 new deaths; 0.1 new deaths per 100 000; a 11% decrease), and Kenya (79 new deaths; 0.1 new deaths per 100 000; a 132% increase).



Region of the Americas

The Region of the Americas reported nearly 1.2 million new cases and just over 31 000 new deaths, a 5% decrease and a 2% increase respectively compared to the previous week. After six weeks of decline in deaths, this week there has been a slight increase reported. The highest numbers of new cases were reported from Brazil (508 010 new cases; 239 new cases per 100 000; a 3% increase), the United States of America (374 369 new cases; 113.1 new cases per 100 000; an 19% decrease), and Peru (49 035 new cases; 148.7 new cases per 100 000; a 11% increase).

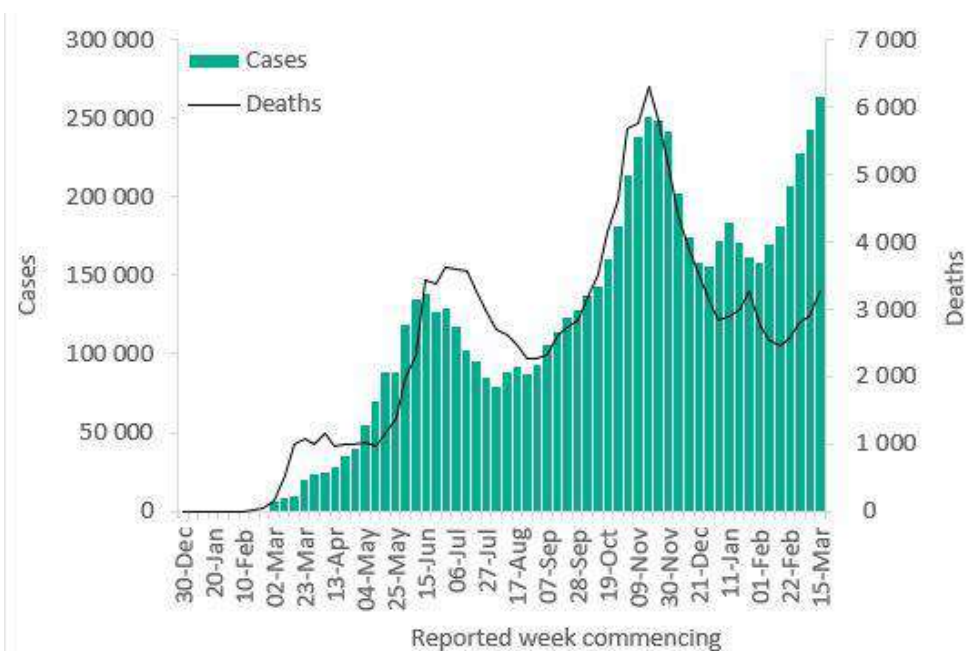
The highest numbers of new deaths were reported from Brazil (15 209 new deaths; 7.2 new deaths per 100 000; a 23% increase), the United States of America (7552 new deaths; 2.3 new deaths per 100 000; a 19% decrease), and Mexico (3368 new deaths; 2.6 new deaths per 100 000; a 21% decrease).



Eastern Mediterranean Region

The Eastern Mediterranean Region reported nearly 264 000 new cases and just over 3200 new deaths, an 8% and a 12% increase respectively compared to the previous week. New weekly cases have increased for the past six weeks and deaths have increased for the past four weeks. The highest numbers of new cases were reported from Jordan (57 666 new cases; 565.2 new cases per 100 000; a 21% increase), the Islamic Republic of Iran (54 445 new cases; 64.8 new cases per 100 000; a 6% decrease), and Iraq (35 072 new cases; 87.2 new cases per 100 000; a 13% increase).

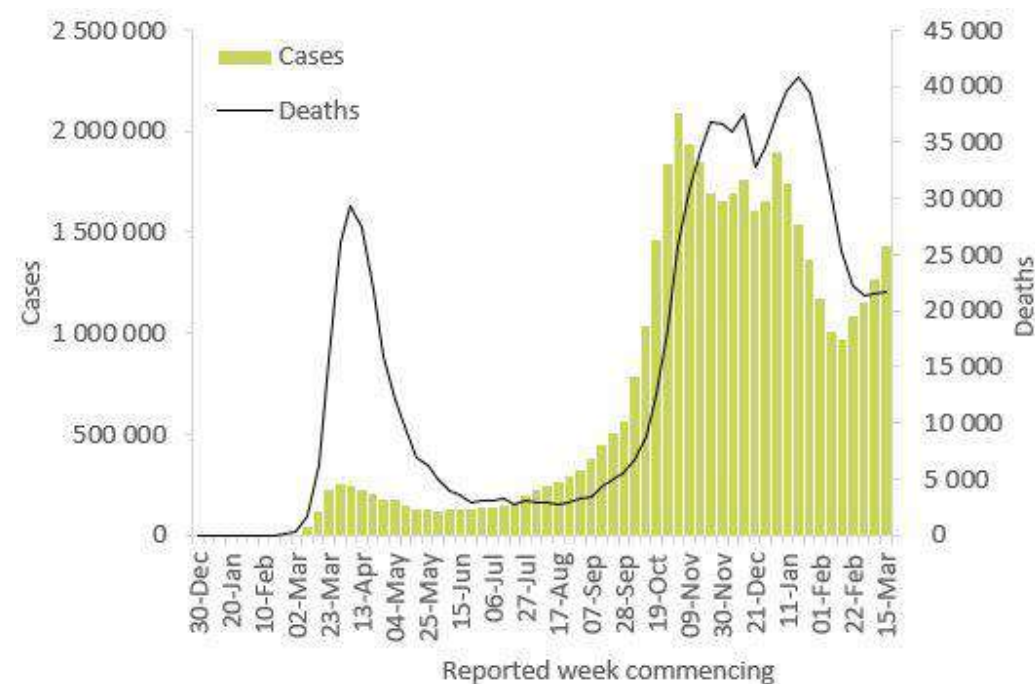
The highest numbers of new deaths were reported from the Islamic Republic of Iran (582 new deaths; 0.7 new deaths per 100 000; a 6% increase), Jordan (503 new deaths; 4.9 new deaths per 100 000; a 31% increase), and Lebanon (381 new deaths; 5.6 new deaths per 100 000; an 19% increase).



European Region

The European Region reported over 1.4 million new cases and nearly 22 000 new deaths, a 13% and a 1% increase respectively compared to the previous week. Cases in the Region have been steadily increasing over the past four weeks. The highest numbers of new cases were reported from France (204 840 new cases; 313.8 new cases per 100 000; a 27% increase), Italy (154 493 new cases; 255.5 new cases per 100 000; similar to the previous week), and Poland (151 918 new cases; 401.4 new cases per 100 000; a 36% increase).

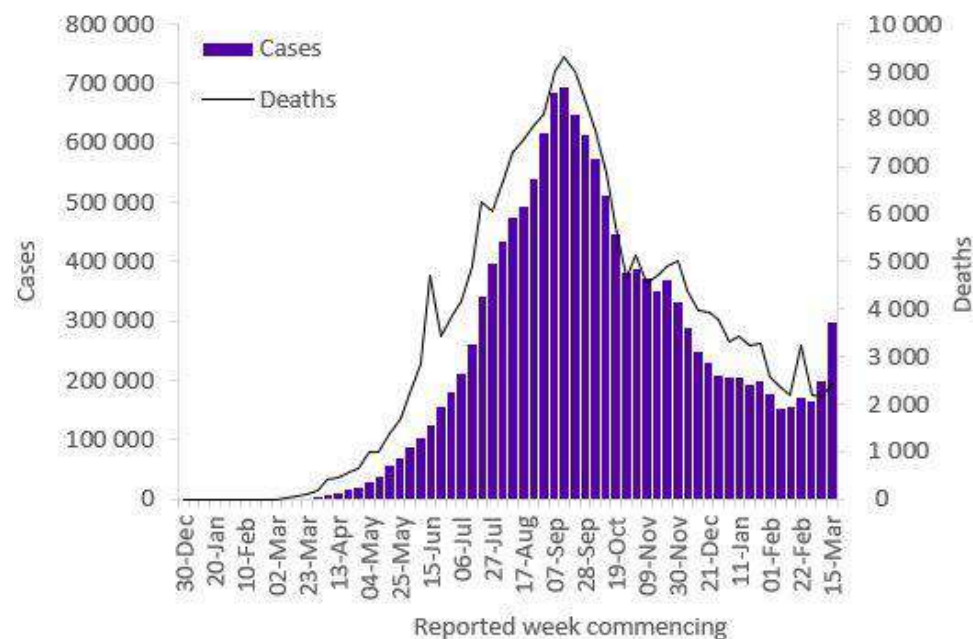
The highest numbers of new deaths were reported from Russian Federation (2940 new deaths; 2 new deaths per 100 000; a 2% decrease), Italy (2761 new deaths; 4.6 new deaths per 100 000; a 20% increase), and Poland (2122 new deaths; 5.6 new deaths per 100 000; a 12% increase).



South-East Asia Region

The South-East Asia Region reported over 298 000 new cases and over 2400 new deaths, a 49% and a 14% increase respectively compared to the previous week. Eighty per cent of all new cases were reported from India. The highest numbers of new cases were reported from India (240 082 new cases; 17.4 new cases per 100 000; a 62% increase), Indonesia (41 047 new cases; 15.0 new cases per 100 000; similar to the previous week), and Bangladesh (12 470 new cases; 7.6 new cases per 100 000; a 91% increase).

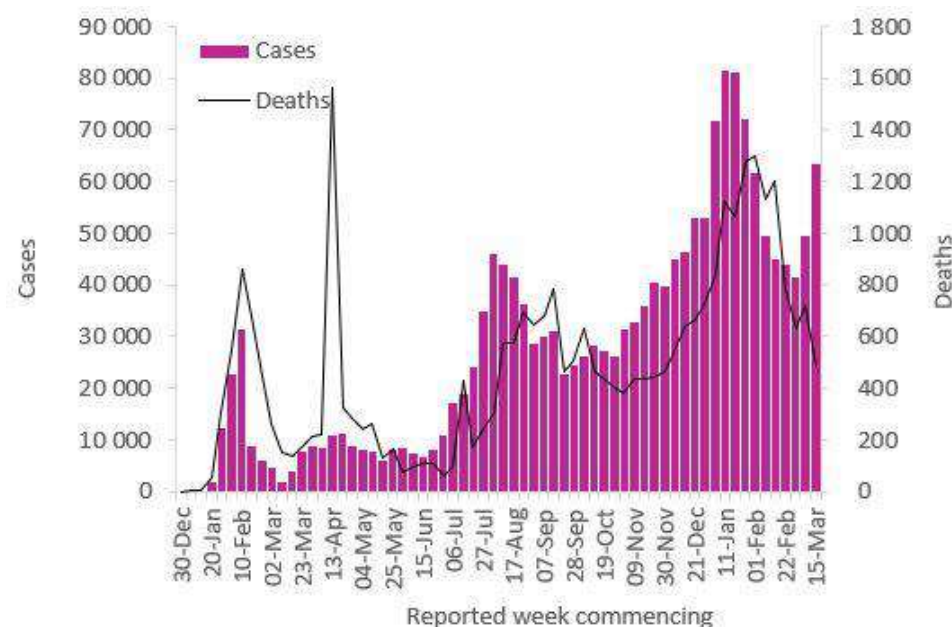
The same countries reported the highest numbers of new deaths in the region; India (1148 new deaths; 0.1 new deaths per 100 000; a 35% increase), Indonesia (1118 new deaths; 0.4 new deaths per 100 000; a 5% decrease), and Bangladesh (141 new deaths; 0.1 new deaths per 100 000; an 86% increase).



Western Pacific Region

The Western Pacific Region reported nearly 64 000 new cases and nearly 500 new deaths, a 29% increase and a 33% decrease respectively compared to the previous week. Although the number of new cases in the region has increased for the third consecutive week, the number of new weekly deaths continues to decline. The highest numbers of new cases were reported from the Philippines (39 445 new cases; 36 new cases per 100 000; a 55% increase), Malaysia (9304 new cases; 28.7 new cases per 100 000; a 12% decrease), and Japan (8765 new cases; 6.9 new cases per 100 000; a 11% increase).

The highest numbers of new deaths were reported from Japan (252 new deaths; 0.2 new deaths per 100 000; a 24% decrease), the Philippines (164 new deaths; 0.1 new deaths per 100 000; a 45% decrease), and the Republic of Korea (27 new deaths; 0.1 new deaths per 100 000; a 23% decrease). Japan and the Philippines reported 86% of new weekly deaths in the Region.



Key weekly updates

WHO Director-General's key message

[Opening remarks at the media briefing on COVID-19 – 19 March 2021](#): *'The Global Advisory Committee has recommended that the AstraZeneca vaccine's benefits outweigh its risks, with tremendous potential for preventing infections and deaths from COVID-19.'*

- [WHO statement on AstraZeneca COVID-19 vaccine safety signals](#)
- [Statement of the WHO Global Advisory Committee on Vaccine Safety \(GACVS\) COVID-19 subcommittee on safety signals related to the AstraZeneca COVID-19 vaccine](#)

Vaccine publications

- [Janssen Ad26.COV2.S \(COVID-19\) vaccine: Background document to the WHO Interim recommendations for use of Ad26.COV2.S \(COVID-19\) vaccine](#)
- [Interim recommendations for the use of the Janssen Ad26.COV2.S \(COVID-19\) vaccine](#)
- [How to monitor and report COVID-19 vaccine side effects](#)

COVID-19 Solidarity Response Fund 1 year Anniversary

- [COVID-19 Solidarity Response Fund marks first anniversary and appeals for continued support](#)

Separating newborns from mothers during COVID-19

- [New research highlights risks of separating newborns from mothers during COVID-19 pandemic](#)

Down Syndrome and COVID-19

- [World Down Syndrome Day, 21 March 2021](#)
- [Down Syndrome and COVID-19](#)

Tuberculosis (TB) and COVID-19

- [World TB Day, 24 March 2021](#)
- [Tuberculosis and 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](#)
 - [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](#)
- [WHO Academy COVID-19 mobile learning app](#)

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 March 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	50 916	2 999 152	267.3	1 428	76 113	6.8	
Ethiopia	11 587	185 641	161.5	107	2 647	2.3	Community transmission
South Africa	8 387	1 536 801	2 591.2	821	52 082	87.8	Community transmission
Kenya	7 358	120 163	223.5	79	1 987	3.7	Community transmission
Côte d'Ivoire	2 609	39 913	151.3	6	217	0.8	Community transmission
Zambia	1 799	86 273	469.3	25	1 178	6.4	Community transmission
Ghana	1 514	89 276	287.3	31	716	2.3	Community transmission
Mozambique	1 503	65 799	210.5	18	740	2.4	Community transmission
Botswana	1 395	35 493	1 509.3	34	458	19.5	Community transmission
Namibia	1 178	42 203	1 660.9	34	492	19.4	Community transmission
Nigeria	1 114	161 651	78.4	17	2 030	1.0	Community transmission
Guinea	970	18 562	141.3	6	108	0.8	Community transmission
Senegal	967	37 693	225.1	52	1 007	6.0	Community transmission
Algeria	923	116 066	264.7	21	3 055	7.0	Community transmission
Togo	790	8 839	106.8	9	102	1.2	Community transmission
Madagascar	757	22 113	79.9	14	340	1.2	Community transmission
Gabon	637	17 297	777.1	9	105	4.7	Community transmission
Rwanda	618	20 761	160.3	11	287	2.2	Community transmission
Democratic Republic of the Congo	530	27 467	30.7	9	726	0.8	Community transmission
Seychelles	443	3 616	3 676.8	1	16	16.3	Community transmission
Malawi	427	33 216	173.6	11	1 093	5.7	Community transmission
South Sudan	420	9 849	88.0	2	106	0.9	Community transmission
Mali	408	9 270	45.8	7	367	1.8	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	405	16 440	2 956.9	3	159	28.6	Community transmission
Angola	373	21 696	66.0	6	526	1.6	Community transmission
Benin	317	6 818	56.2	9	90	0.7	Community transmission
Gambia	316	5 255	217.4	8	161	6.7	Community transmission
Congo	235	9 564	173.3	3	134	2.4	Community transmission
Zimbabwe	191	36 662	246.7	9	1 510	10.2	Community transmission
Mauritania	177	17 587	378.2	4	446	9.6	Community transmission
Equatorial Guinea	174	6 736	480.1	2	100	7.1	Community transmission
Burundi	172	2 613	22.0	3	6	0.1	Community transmission
Burkina Faso	166	12 516	59.9	1	145	0.7	Community transmission
Chad	122	4 410	26.8	4	157	1.0	Community transmission
Guinea-Bissau	122	3 558	180.8	3	55	2.8	Community transmission
Mauritius	121	812	63.8	0	10	0.8	Clusters of cases
Uganda	107	40 651	88.9	0	334	0.7	Community transmission
Eritrea	80	3 118	87.9	0	7	0.2	Community transmission
Central African Republic	66	5 087	105.3	1	64	1.3	Community transmission
Sao Tome and Principe	64	2 142	977.4	2	34	15.5	Community transmission
Niger	61	4 918	20.3	4	185	0.8	Community transmission
Eswatini	49	17 283	1 489.7	4	665	57.3	Community transmission
Comoros	42	3 665	421.5	0	146	16.8	Community transmission
Liberia	12	2 042	40.4	0	85	1.7	Community transmission
Sierra Leone	11	3 948	49.5	0	79	1.0	Community transmission
Lesotho	5	10 535	491.8	0	309	14.4	Community transmission
Cameroon	0	38 988	146.9	0	588	2.2	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesⁱⁱⁱ							
Réunion	830	14 631	1 634.2	16	87	9.7	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
Mayotte	364	19 006	6 966.6	22	151	55.3	Community transmission
Americas	1 173 561	53 937 714	5 273.7	31 040	1 299 243	127.0	
Brazil	508 010	11 871 390	5 585.0	15 209	290 314	136.6	Community transmission
United States of America	374 369	29 437 770	8 893.5	7 552	536 008	161.9	Community transmission
Peru	49 035	1 451 645	4 402.7	1 233	49 897	151.3	Community transmission
Argentina	42 888	2 234 913	4 945.0	830	54 476	120.5	Community transmission
Chile	39 710	925 089	4 839.3	606	22 180	116.0	Community transmission
Mexico	30 139	2 187 910	1 696.9	3 368	197 219	153.0	Community transmission
Colombia	29 809	2 324 426	4 568.2	821	61 771	121.4	Community transmission
Canada	23 836	927 069	2 456.3	213	22 617	59.9	Community transmission
Paraguay	12 906	190 499	2 670.8	226	3 662	51.3	Community transmission
Ecuador	10 202	310 868	1 762.0	220	16 435	93.2	Community transmission
Uruguay	9 327	78 401	2 257.0	71	760	21.9	Community transmission
Bolivia (Plurinational State of)	5 484	263 808	2 260.0	138	12 041	103.2	Community transmission
Cuba	5 404	65 962	582.4	26	392	3.5	Community transmission
Guatemala	4 980	187 659	1 047.5	122	6 685	37.3	Community transmission
Jamaica	4 753	34 665	1 170.7	40	524	17.7	Community transmission
Venezuela (Bolivarian Republic of)	4 359	149 145	524.5	53	1 475	5.2	Community transmission
Honduras	4 189	181 357	1 831.0	97	4 422	44.6	Community transmission
Dominican Republic	3 373	248 989	2 295.3	56	3 269	30.1	Community transmission
Panama	2 994	350 220	8 116.8	54	6 035	139.9	Community transmission
Costa Rica	2 810	211 903	4 159.8	34	2 896	56.8	Community transmission
El Salvador	445	62 531	964.1	30	1 975	30.4	Community transmission
Guyana	417	9 486	1 206.0	6	212	27.0	Clusters of cases
Saint Lucia	124	4 113	2 239.9	7	55	30.0	Community transmission
Barbados	121	3 512	1 222.1	2	39	13.6	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
Bahamas	117	8 839	2 247.7	1	186	47.3	Clusters of cases
Haiti	82	12 714	111.5	1	251	2.2	Community transmission
Antigua and Barbuda	71	1 033	1 054.8	1	28	28.6	Clusters of cases
Trinidad and Tobago	52	7 821	558.8	0	140	10.0	Community transmission
Suriname	43	9 055	1 543.6	0	176	30.0	Clusters of cases
Nicaragua	35	5 251	79.3	1	176	2.7	Community transmission
Belize	30	12 400	3 118.5	0	316	79.5	Community transmission
Saint Vincent and the Grenadines	14	1 694	1 527.0	1	9	8.1	Community transmission
Grenada	3	154	136.9	0	1	0.9	Sporadic cases
Dominica	1	157	218.1	0	0	0.0	Clusters of cases
Saint Kitts and Nevis	1	44	82.7	0	0	0.0	Sporadic cases
Territoriesⁱⁱⁱ							
Puerto Rico	1 324	103 891	3 631.5	15	2 092	73.1	Community transmission
Curaçao	605	5 520	3 363.9	1	23	14.0	Community transmission
Guadeloupe	370	11 095	2 772.9	1	169	42.2	Community transmission
Aruba	352	8 624	8 077.5	4	81	75.9	Community transmission
Bonaire	286	919	4 394.0	0	6	28.7	Community transmission
Martinique	227	7 264	1 935.7	0	47	12.5	Community transmission
Turks and Caicos Islands	90	2 290	5 914.6	0	15	38.7	Clusters of cases
Saint Barthélemy	51	776	7 850.3	0	1	10.1	Clusters of cases
United States Virgin Islands	47	2 814	2 694.8	0	25	23.9	Community transmission
Bermuda	32	767	1 231.7	0	12	19.3	Sporadic cases
Saint Martin	21	1 633	4 224.1	0	12	31.0	Community transmission
Sint Maarten	15	2 093	4 880.8	0	27	63.0	Community transmission
Cayman Islands	7	475	722.8	0	2	3.0	Sporadic cases
Anguilla	1	22	146.6	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
British Virgin Islands	0	154	509.3	0	1	3.3	Clusters of cases
Falkland Islands (Malvinas)	0	51	1 464.3	0	0	0.0	No cases
French Guiana	0	16 764	5 612.7	0	87	29.1	Community transmission
Montserrat	0	20	400.1	0	1	20.0	Sporadic cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	No cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	263 650	7 124 121	974.8	3 253	153 446	21.0	
Jordan	57 666	526 666	5 161.8	503	5 788	56.7	Community transmission
Iran (Islamic Republic of)	54 445	1 793 805	2 135.7	582	61 724	73.5	Community transmission
Iraq	35 072	789 390	1 962.6	250	13 969	34.7	Community transmission
Lebanon	21 213	436 575	6 396.3	381	5 715	83.7	Community transmission
Pakistan	20 599	623 135	282.1	323	13 799	6.2	Community transmission
United Arab Emirates	14 233	438 638	4 435.0	45	1 433	14.5	Community transmission
Kuwait	9 473	217 933	5 103.1	50	1 215	28.5	Community transmission
Libya	6 698	150 341	2 188.0	139	2 487	36.2	Community transmission
Bahrain	4 922	135 326	7 953.0	17	498	29.3	Clusters of cases
Egypt	4 491	194 771	190.3	301	11 557	11.3	Clusters of cases
Tunisia	4 148	245 405	2 076.4	167	8 526	72.1	Community transmission
Oman	3 878	149 135	2 920.4	20	1 620	31.7	Community transmission
Qatar	3 439	173 206	6 011.9	7	272	9.4	Community transmission
Morocco	2 831	491 463	1 331.5	45	8 763	23.7	Clusters of cases
Saudi Arabia	2 594	384 653	1 104.9	39	6 602	19.0	Sporadic cases
Somalia	1 022	9 968	62.7	70	419	2.6	Community transmission
Syrian Arab Republic	839	17 240	98.5	59	1 153	6.6	Community transmission
Yemen	507	3 282	11.0	54	738	2.5	Community transmission
Djibouti	266	6 518	659.7	0	63	6.4	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
Sudan	224	31 147	71.0	33	1 986	4.5	Community transmission
Afghanistan	118	56 103	144.1	6	2 463	6.3	Clusters of cases
Territoriesⁱⁱⁱ							
occupied Palestinian territory	14 972	249 421	4 889.3	162	2 656	52.1	Community transmission
Europe	1 441 065	42 516 762	4 555.0	21 772	929 332	99.6	
France	204 840	4 180 829	6 405.1	1 813	91 613	140.4	Community transmission
Italy	154 493	3 356 331	5 551.2	2 761	104 642	173.1	Clusters of cases
Poland	151 918	2 058 550	5 439.2	2 122	49 300	130.3	Community transmission
Turkey	126 682	2 992 694	3 548.4	538	29 959	35.5	Community transmission
Germany	90 271	2 659 516	3 174.3	1 293	74 664	89.1	Community transmission
Ukraine	85 607	1 546 363	3 535.9	1 638	29 941	68.5	Community transmission
Czechia	70 469	1 469 547	13 722.6	1 441	24 667	230.3	Community transmission
Russian Federation	66 261	4 456 869	3 054.0	2 940	95 030	65.1	Clusters of cases
Hungary	55 106	571 596	5 916.9	1 310	18 262	189.0	Community transmission
Netherlands	43 547	1 194 520	6 971.3	217	16 260	94.9	Community transmission
Romania	37 522	892 848	4 641.1	693	22 132	115.0	Community transmission
The United Kingdom	37 451	4 291 275	6 321.3	658	126 122	185.8	Community transmission
Serbia	34 845	546 896	7 853.5	206	4 900	70.4	Community transmission
Belgium	27 278	837 006	7 222.0	175	22 707	195.9	Community transmission
Sweden	26 700	744 272	7 369.6	28	13 262	131.3	Community transmission
Bulgaria	24 602	302 480	4 353.2	732	11 966	172.2	Clusters of cases
Austria	20 737	508 744	5 648.7	165	8 817	97.9	Community transmission
Greece	16 090	235 611	2 260.5	383	7 421	71.2	Community transmission
Spain	12 381	3 206 116	6 857.3	185	72 793	155.7	Community transmission
Slovakia	11 366	348 869	6 390.0	516	9 044	165.7	Clusters of cases
Estonia	10 594	95 401	7 191.7	68	787	59.3	Clusters of cases
Republic of Moldova	10 493	214 203	5 310.0	237	4 531	112.3	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
Bosnia and Herzegovina	9 536	152 754	4 656.0	329	5 817	177.3	Community transmission
Kazakhstan	8 486	283 027	1 507.3	75	3 586	19.1	Clusters of cases
Belarus	7 965	309 293	3 273.2	61	2 148	22.7	Community transmission
Israel	7 381	824 716	9 528.2	80	6 064	70.1	Community transmission
Switzerland	7 216	577 905	6 677.4	43	9 455	109.2	Community transmission
North Macedonia	6 629	118 736	5 699.2	148	3 448	165.5	Community transmission
Croatia	6 594	257 639	6 275.8	96	5 773	140.6	Community transmission
Norway	6 513	84 553	1 559.7	9	648	12.0	Community transmission
Azerbaijan	5 798	245 490	2 421.2	63	3 339	32.9	Clusters of cases
Slovenia	5 656	205 511	9 885.4	25	4 259	204.9	Clusters of cases
Armenia	5 328	183 713	6 199.7	93	3 348	113.0	Community transmission
Finland	5 117	71 123	1 283.6	19	805	14.5	Community transmission
Denmark	4 930	224 848	3 881.9	9	2 399	41.4	Community transmission
Albania	3 728	120 541	4 188.7	103	2 133	74.1	Clusters of cases
Latvia	3 665	97 149	5 150.5	64	1 821	96.5	Community transmission
Lithuania	3 626	209 011	7 677.8	80	3 476	127.7	Community transmission
Ireland	3 473	229 831	4 654.5	51	4 585	92.9	Community transmission
Portugal	3 364	817 080	8 013.2	93	16 762	164.4	Clusters of cases
Cyprus	2 605	41 882	3 468.9	4	242	20.0	Clusters of cases
Georgia	2 491	277 480	6 955.8	52	3 700	92.8	Community transmission
Malta	1 637	27 904	6 319.7	19	369	83.6	Clusters of cases
Montenegro	1 610	85 763	13 655.1	40	1 169	186.1	Clusters of cases
Luxembourg	1 510	59 210	9 458.8	27	715	114.2	Community transmission
Uzbekistan	772	81 339	243.0	0	622	1.9	Clusters of cases
Kyrgyzstan	539	87 389	1 339.5	9	1 490	22.8	Clusters of cases
Andorra	253	11 481	14 859.3	1	113	146.2	Community transmission
San Marino	230	4 356	12 835.2	2	79	232.8	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
Monaco	67	2 173	5 537.2	0	27	68.8	Sporadic cases
Iceland	25	6 097	1 786.7	0	29	8.5	Community transmission
Liechtenstein	15	2 704	7 090.2	0	54	141.6	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
Territoriesⁱⁱⁱ							
Kosovo ^[1]	4 704	81 349	4 372.7	56	1 742	93.6	Community transmission
Isle of Man	340	1 432	1 684.1	1	26	30.6	No cases
Gibraltar	7	4 270	12 674.0	1	94	279.0	Clusters of cases
Jersey	2	3 224	2 963.2	0	69	63.4	Community transmission
Faroe Islands	0	661	1 352.7	0	1	2.0	Sporadic cases
Greenland	0	31	54.6	0	0	0.0	No cases
Guernsey	0	821	1 299.1	0	14	22.2	Community transmission
South-East Asia	298 438	14 182 826	701.6	2 435	214 790	10.6	
India	240 082	11 599 130	840.5	1 148	159 755	11.6	Clusters of cases
Indonesia	41 047	1 455 788	532.2	1 118	39 447	14.4	Community transmission
Bangladesh	12 470	568 706	345.3	141	8 668	5.3	Community transmission
Sri Lanka	2 246	89 846	419.6	18	544	2.5	Clusters of cases
Maldives	897	22 373	4 139.0	1	65	12.0	Clusters of cases
Thailand	876	27 803	39.8	4	90	0.1	Clusters of cases
Nepal	651	275 829	946.7	2	3 016	10.4	Clusters of cases
Timor-Leste	93	271	20.6	0	0	0.0	Clusters of cases
Myanmar	76	142 212	261.4	3	3 204	5.9	Clusters of cases
Bhutan	0	868	112.5	0	1	0.1	No cases
Western Pacific	63 730	1 775 560	90.4	486	30 843	1.6	
Philippines	39 445	656 056	598.7	164	12 930	11.8	Community transmission
Malaysia	9 304	331 713	1 024.9	23	1 229	3.8	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
Japan	8 765	455 638	360.3	252	8 812	7.0	Clusters of cases
Republic of Korea	3 025	98 660	192.4	27	1 696	3.3	Clusters of cases
Papua New Guinea	1 186	3 359	37.5	15	36	0.4	Community transmission
Mongolia	973	4 806	146.6	1	5	0.2	Clusters of cases
Cambodia	375	1 680	10.0	2	3	0.0	Sporadic cases
China	190	102 523	7.0	0	4 849	0.3	Clusters of cases
Singapore	96	60 184	1 028.7	0	30	0.5	Sporadic cases
Australia	80	29 192	114.5	0	909	3.6	Clusters of cases
New Zealand	30	2 097	43.5	0	26	0.5	Clusters of cases
Viet Nam	19	2 572	2.6	0	35	0.0	Clusters of cases
Brunei Darussalam	13	205	46.9	0	3	0.7	Clusters of cases
Fiji	1	67	7.5	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	0	49	0.7	0	0	0.0	Sporadic cases
Solomon Islands	0	18	2.6	0	0	0.0	No cases
Territoriesⁱⁱⁱ							
Wallis and Futuna	135	311	2 765.4	1	1	8.9	Sporadic cases
French Polynesia	49	18 576	6 612.8	0	141	50.2	Sporadic cases
New Caledonia	25	116	40.6	0	0	0.0	Sporadic cases
Guam	12	7 570	4 485.3	1	134	79.4	Clusters of cases
Northern Mariana Islands (Commonwealth of the)	7	157	272.8	0	2	3.5	Pending
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Samoa	0	4	2.0	0	0	0.0	No cases
Vanuatu	0	3	1.0	0	0	0.0	No cases
Global	3 291 360	122 536 880	1 572.0	60 414	2 703 780	34.7	

ⁱSee [Annex: Data, table and figure notes](#)

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

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Albania			Not Verified
Angola	Verified		Verified
Argentina		Verified	Verified
Aruba	Verified	Verified	Verified
Australia	Verified	Not Verified	Verified
Austria	Verified		Verified
Azerbaijan			Verified
Bahrain			Verified
Bangladesh			Verified
Barbados			Verified
Belarus			Verified
Belgium	Verified	Verified	Verified
Belize			Verified
Bonaire			Verified
Bosnia and Herzegovina			Not Verified
Botswana	Verified		
Brazil		Verified	Verified
Brunei Darussalam	Verified		Verified
Bulgaria			Verified
Cabo Verde			Verified
Cambodia			Verified
Cameroon	Verified		
Canada	Verified	Verified	Verified
Cayman Islands			Verified
Chile		Verified	Verified
China	Verified	Not Verified	Verified
Colombia		Verified	

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Comoros	Verified		
Costa Rica	Verified		Verified
Croatia	Not Verified		Verified
Cuba	Verified		
Curaçao			Verified
Cyprus			Verified
Czechia	Not Verified		Verified
Democratic Republic of the Congo	Verified		Verified
Denmark	Verified	Verified	Verified
Dominican Republic			Verified
Ecuador			Verified
Estonia	Not Verified		Verified
Eswatini	Verified		
Faroe Islands		Verified	
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana		Verified	Verified
French Polynesia			Verified
Gambia			Verified
Georgia			Verified
Germany	Verified	Verified	Verified
Ghana	Verified		Verified
Gibraltar			Not Verified
Greece	Verified		Verified
Guadeloupe	Verified	Verified	Verified
Hungary	Not Verified		Verified
Iceland			Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
India	Verified	Verified	Verified
Indonesia			Verified
Iran (Islamic Republic of)			Verified
Iraq			Verified
Ireland	Verified	Not Verified	Verified
Israel	Verified		Verified
Italy	Not Verified	Verified	Verified
Jamaica			Verified
Japan	Verified	Verified	Verified
Jordan			Verified
Kenya	Verified		Not Verified
Kosovo[1]			Verified
Kuwait			Verified
Latvia	Verified		Verified
Lebanon			Verified
Lesotho	Verified		
Libya			Verified
Liechtenstein			Verified
Lithuania			Verified
Luxembourg	Verified		Verified
Malawi	Verified		
Malaysia	Not Verified		Verified
Malta	Not Verified		Verified
Martinique	Verified	Verified	Verified
Mauritania	Verified		Verified
Mauritius			Not Verified
Mayotte	Verified		Verified
Mexico		Verified	Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Monaco	Not Verified		Verified
Montenegro			Verified
Morocco			Verified
Mozambique	Verified		
Namibia	Verified		
Nepal			Verified
Netherlands	Verified	Verified	Verified
New Caledonia			Verified
New Zealand	Verified	Not Verified	Verified
Nigeria			Verified
North Macedonia			Verified
Norway	Verified		Verified
occupied Palestinian territory	Not Verified		Verified
Oman			Verified
Pakistan			Verified
Panama	Verified		
Peru		Verified	Verified
Philippines	Verified	Verified	Verified
Poland	Not Verified		Verified
Portugal	Verified	Not Verified	Verified
Puerto Rico			Verified
Republic of Korea	Verified	Verified	Verified
Republic of Moldova			Not Verified
Réunion	Verified	Verified	Verified
Romania	Verified	Verified	Verified
Russian Federation	Not Verified		Verified
Rwanda	Not Verified		Not Verified
Saint Barthélemy			Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Saint Lucia			Verified
Saint Martin	Verified	Verified	Verified
Saudi Arabia			Verified
Senegal			Verified
Serbia			Verified
Singapore	Not Verified		Verified
Sint Maarten			Verified
Slovakia	Not Verified		Verified
Slovenia	Verified	Not Verified	Verified
South Africa	Verified		Verified
Spain	Verified	Verified	Verified
Sri Lanka	Verified		Verified
Sweden	Verified	Not Verified	Verified
Switzerland	Verified	Not Verified	Verified
Thailand	Verified		Verified
The United Kingdom	Verified	Verified	Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Trinidad and Tobago			Verified
Tunisia			Verified
Turkey	Not Verified	Not Verified	Verified
Turks and Caicos Islands			Verified
Ukraine			Not Verified
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania	Verified		
United States of America	Verified	Verified	Verified
Uruguay		Verified	Verified
Uzbekistan			Verified
Venezuela (Bolivarian Republic of)		Verified	
Viet Nam	Verified		Verified
Wallis and Futuna			Not Verified
Zambia	Verified		
Zimbabwe	Verified		

**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 March 2021

Issue No. 47



Confirmed cases^a
122 822 505

Confirmed deaths
2 709 041

Call for maintaining essential health services amid disruptions due to COVID-19 in South Asia

A [United Nations report](#) supported by WHO, cites examples of service disruptions including an 80% drop in the number of young children treated for severe acute malnutrition (SAM) in Nepal and Bangladesh, and a sharp drop in childhood immunizations in Pakistan and India as the region battles to contain COVID-19 cases, numbering 11 million by the end of 2020.



Credit: WHO/Nepal

Drastic cuts in the availability and use of essential public health services across South Asia due to COVID-19 may have contributed to an estimated additional 228 000 and 11 000 child and maternal deaths in 2020 respectively.

“Maintaining essential health services is an important pillar of WHO’s COVID-19 response strategy,” said Dr Poonam Khetrpal Singh, Regional Director of the WHO South-East Asia Region. The report calls for prioritizing essential health services for pregnant women, adolescents and young infants. Strengthening supply chains for the delivery of vaccines and other essential childhood medicines is also vital.

For further information, click [here](#).

Key Figures



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



164 GOARN deployments conducted to support COVID-19 pandemic response



20 070 365 respirators shipped globally



198 747 426 medical masks shipped globally



8 653 511 face shields shipped globally



37 105 700 gloves shipped globally



6 970 179 gowns shipped globally



More than **5 million** people registered on [OpenWHO](#) and accessing online training courses across **29** topics in **47** languages

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



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From the field:

Nigeria rallies over 7000 traditional leaders for community-based interventions against COVID-19

As part of concerted efforts to utilize community-based interventions, including sensitizing and mobilizing communities, WHO is building on the lessons learned from the critical role played by traditional and religious leaders in the achievement of a polio-free Nigeria.

These leaders have a unique capacity to mobilize, sensitize and convince their communities in support of any public health interventions. With WHO's support, the Nigerian government has engaged 7350 traditional and religious leaders across 11 priority states to execute community-based interventions including sensitization for voluntary testing, survivors' declaration of status to reduce stigma, voluntary disclosure of contacts by confirmed cases and adherence to preventive measures.



Credit: WHO Africa Regional Office

The key role played by traditional leaders in Northern Nigeria from 2009 was one of the top strategic partnerships that saw the end of polio in Nigeria by 2016. According to Professor Oyewale Tomori, a polio expert in Nigeria, "We soon figured out that even with full government support, we could not reach certain communities without engaging traditional leaders. As soon as we brought them on board, popular resistance to the vaccination campaigns disappeared."

In Kwara state, the traditional leaders' engagement resulted in an increase in individuals presenting for COVID-19 testing, from zero per week to 875 per week after the intervention, and weekly tests have remained higher than 300 samples in 2021. Likewise, in Sokoto, after the engagement of the traditional leadership under the Sultan of Sokoto, community testing increased from less than 100 in September 2020 to over 200 in March 2021.

WHO Country Representative, Dr Walter Kazadi Mulombo, is optimistic that engaging the traditional and religious institutions will similarly enhance community acceptance of COVID-19 vaccine. "As Nigeria introduces COVID-19 vaccine amidst low-risk perception, myths and doubts about the reality of the disease among the populace, the engagement of traditional leaders will be vital to address these and other erroneous beliefs.

For further information, click [here](#).

From the field:

Single Nucleotide Polymorphisms (SNP) assay training for the detection of SARS-CoV-2 variants of concern in the European Region

The WHO Regional Office for Europe has provided continuous support to virology laboratories involved in SARS-CoV-2 testing to improve quality management knowledge and implement detection methods for VOCs in central public health labs.

While it is normal for viruses to mutate, several new circulating SARS-CoV-2 variants have public health consequences, so called variants of concern (VOC). VOCs are identified based on the assessment of increased transmissibility or detrimental change in COVID-19 epidemiology an increase in virulence or change in clinical disease presentation; or a decrease in effectiveness of public health and social measures or available diagnostics, vaccines, or therapeutics. Three VOCs are currently under close scrutiny in the WHO European Region: B.1.1.7, B.1.351, and P1.



SNP assay training in Ukraine held from 15 - 18 March 2021 Credit: WHO/Europe

Genetic characterization is the main laboratory method used for the identification of VOCs, with SARS-CoV-2 whole genome characterization using high-throughput sequencing (HTS) providing the most complete picture. HTS is a costly and resource intensive method and thus, is not implemented in many countries across the WHO European Region.

WHO is supporting laboratories to conduct whole genome sequencing of SARS-CoV-2 samples and the transfer of more accessible technologies to rapidly identify the circulation of VOCs. Single Nucleotide Polymorphisms (SNP) assays allow the detection of single nucleotide changes within the SARS-CoV-2 genome such as the N501Y mutation, present in all three circulating VOCs, making it a reliable indicator for their detection. This method is quick, taking about two hours, and can be performed on samples that have tested positive for SARS-CoV-2 using polymerase chain reaction (PCR).

WHO/Europe is supporting countries to increase detection capacity for VOC by providing trainings on SNP assay performance for the detection of VOCs, programming of real time PCR instruments and helping with the interpretation of results in Bosnia and Herzegovina, Republic of Moldova, Kyrgyzstan and Ukraine. Further trainings are planned to support countries in detecting and containing the spread of VOCs.

From the field:

Regional ministerial working group highlights achievements and challenges as vaccines start rolling out in the Eastern Mediterranean Region

As part of support to countries, WHO's Regional Director for the Eastern Mediterranean, Dr Ahmed Al-Mandhari, has been engaging with ministers of health on a regular and sustained basis to build consensus, foster evidence-based decision-making, and identify areas of WHO support.

The first ministerial meeting of 2021 was held March 16, with 13 of 22 Ministers of Health and WHO representatives from the Region.

The meeting, led by Dr Ahmed Al-Mandhari, focused on reviewing the achievements and challenges of the COVID-19 situation and response, as well as identifying ways to strengthen WHO support. In his opening remarks, Dr Al Mandhari noted that "As we mark a year since WHO declared the COVID-19 a global pandemic, our Region has calibrated a wealth of experience, despite all challenges faced," he added, "The Regional Office is in close coordination with Member States to put together response plans based on evidence, science, and collaboration". Dr Al-Mandhari also emphasized that the pandemic has highlighted the essential role of leadership and coordination among countries of the Region.

Achievements discussed included predictive modelling studies helping inform national responses, with 7 countries in the Region regularly using modelling to inform public health management cooperation; improving clinical management and intensive care units' capacities also resulted in better patient outcomes. A common challenge identified related to the arrivals of vaccines through the COVAX Facility, including delays in the arrival of some shipments. WHO's role in ensuring countries were prepared to receive and roll-out vaccination campaigns was also discussed.

Dr Richard Brennan, Director of Health Emergencies for the Eastern Mediterranean, stated that the way forward in fighting this pandemic has been paved as WHO released its updated strategic objectives for 2021 that brought together the joint efforts required to suppress transmission, reduce exposure, tackle misinformation, reduce mortality and morbidity from all cases, and accelerate equitable access to new COVID-19 tools.

For further information, click [here](#).



From the field:

WHO supports outbreak control in Papua New Guinea as cases surge

WHO is working with the Government of Papua New Guinea (PNG) to prevent the spread of SARS-CoV-2 as mass gatherings to commemorate the country's founding Prime Minister threaten to accelerate already rising cases.

In February 2021, [cases rose sharply](#), with 449 cases reported in February alone, bringing the total to 1365 with 14 deaths. Hospitals are under pressure as the number of patients and health care workers infected with SARS-CoV2 mounts.



After former Prime Minister Grand Chief Sir Michael Somare died on 26 February, the country announced 12 days of mourning from 1 to 12 March. Commemorations include church services, community events, a state funeral with funeral procession and traditional “haus krai” (wake) gatherings.

In light of these commemorations, WHO is working with counterparts from the PNG National Department of Health (NDOH) to encourage safe mourning and minimize the risks posed by mass gathering during a pandemic. Dr Luo Dapeng, WHO Representative in Papua New Guinea, noted the importance of healthy behaviours for mourners such as “physical distancing, wear a mask, avoid crowds, clean their hands, stay home if they are unwell, and cough into a bent elbow or tissue.” A joint team recently visited Wewak, East Sepik, the home of the late Sir Michael, to support the province’s COVID-19 response and to work with health authorities to mitigate the risk of COVID-19 transmission during the mourning period.

WHO is also working with NDOH in provinces that have reported recent surges in cases with visits to assess needs and deliver training on topics such as surveillance, clinical management and infection and prevention control in numerous provinces, including East Sepik, West Sepik, Madang and the National Capital District.

In West Sepik, a joint team of experts from WHO, the NDOH and the Provincial Health Authority trained correctional services officers on protective measures after positive COVID-19 cases were reported there. They also met with prison wardens and their families to address their concerns and discuss preventive measures. In Madang, a joint team assessed laboratories and the screening process at Divine Word University campus.

For more information, click [here](#).

From the field:

Nepal's rapid timeline: From National Deployment and Vaccination Plan (NDVP) to successfully initiating COVID-19 vaccine campaign with WHO support

In Nepal, cases have consistently declined since October 2020 to March 2021, from approximately 3000 per day to now an average of 80 new cases daily. During this time, comprehensive preparedness for a national COVID-19 vaccine campaign was implemented.

In November, to prepare for COVID-19 vaccination roll-out, Nepal began ensuring regulatory preparedness, allowing for Emergency Use Authorization (EUA) of select vaccines. On 8 February, Nepal submitted their NDVP to WHO Partners Platform which accounted for vaccination of 20% of the population via the COVAX Facility, and prepared other procurement strategies, such as bilateral deals with manufacturers, for further population coverage.



WHO Nepal personnel conduction session site monitoring on the first day of vaccination. Photo credit: Kiran Khadka/WHO Nepal

Nepal's National Immunization Advisory Committee (NIAC) and the government's Family Welfare Division (FWD) proactively established a secretariat with WHO's help for decision-making on the use of COVID-19 vaccines. WHO supported FWD with holistic preparations including the development of operational guidelines, training packages, Information, Education and Communication (IEC) materials, a readiness assessment, and technical support for cascaded training and microplanning workshops. Late January, FWD rolled out national trainings for vaccinators and focal points on Adverse Events Following Immunization (AEFI) of over 2000 individuals, with support from WHO. WHO also supported developing a DHIS-2 dashboard on daily vaccinations and AEFIs for efficient monitoring.

Nepal's COVID-19 vaccination campaign launched with phase I from 27 January to 6 February, with the contribution of 1 million doses of vaccine by the Government of India, and 86% of the target for first dose of front-line health care and social workers was met. Nepal then welcomed a COVAX shipment on 7 March and the Honourable Prime Minister received his first dose, launching the second priority group for vaccination, those aged 65 years or older.

To ensure quality COVID-19 vaccination, the Government and WHO deployed staff with a checklist to monitor: immunization site management, session site logistics, vaccine safety, information management, AEFI preparedness and infection prevention and control (IPC) measures.

Of the total population, 5.5% of Nepal received one vaccine dose already, a result of Nepal successfully creating demand and an effective roll-out through holistic preparation and strong monitoring for course corrections. Nepal now proactively looks to the future to tackle anticipated challenges of uncertain logistics timelines, future funding shortfalls and the impact of a prolonged campaign on existing health services.

Coordinating WHO's publications during a public health emergency: 1-year anniversary of the COVID-19 Publications Review Committee

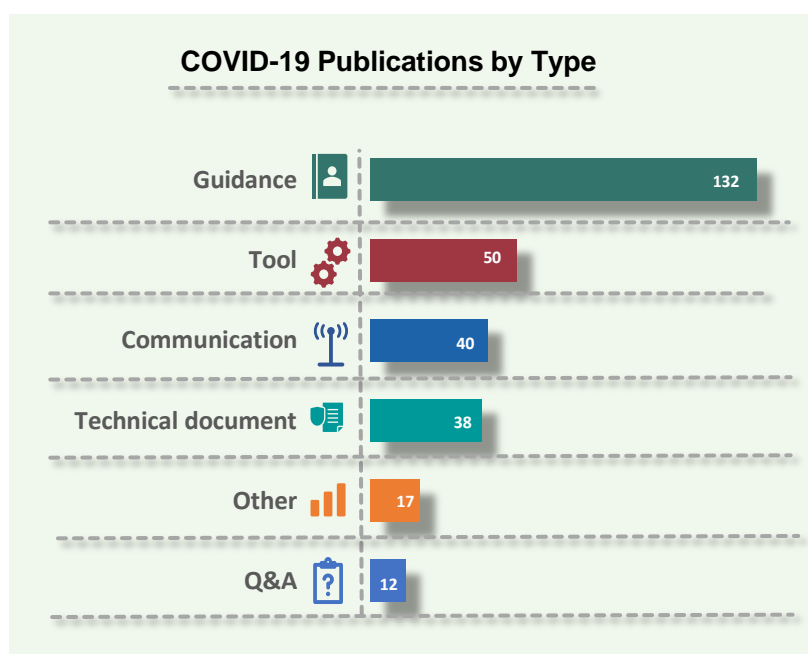
WHO plays a prominent role in health emergencies supporting countries to understand and manage risk, build resilience, and prepare for adequate emergency response and recovery actions. Thus, as the COVID-19 pandemic began to accelerate in early 2020, it became critical for WHO to provide and ensure access to up-to-date and evidence-based information and guidance. Since then, WHO has continuously renewed efforts to coordinate and deliver such information to Ministries of Health, health professionals, the public and partners worldwide.

Established on 18 March 2020 as a collaboration between the WHO Health Emergencies Programme and the Chief Scientist's Office, the COVID-19 Publications Review Committee (PRC) coordinates and provides internal quality assurance and oversight on the increasing number of COVID-19 related documents produced by WHO during the pandemic response.

Submissions to the PRC are reviewed to ensure adherence to internationally recognized methodological processes and standards and to ensure that evidence used is the best-available, timely, and relevant.

The PRC mandate covers all COVID-19 related publications, including, but not limited to, interim guidance documents, scientific briefs, evidence reviews, operational tools, joint statements and advocacy materials. The PRC is comprised of 23 staff experts stemming from several departments across WHO headquarters and regional offices who are appointed for a renewable term of six months by the Deputy Director-General. The PRC is chaired by the Health Emergencies Preparedness and Response department, with the Vice-Chair role held by regional offices on a rotating basis. All members assess submissions, provide reviews and constructive feedback to colleagues developing documents.

Since its establishment, the PRC has received over 1000 submissions, representing 687 unique documents, at either planning and/or final clearance stage, of which 289 were published. By way of comparison, prior to 2020, WHO typically published around 100 guidelines annually. Of the 289 publications, 141 (49%) come from the Incident Management Support Team at WHO headquarters, which was established on 2 January 2020 to coordinate the global operational response to the COVID-19 pandemic.



Partnerships

The Global Health Cluster - GHC

The Health Cluster released the [Health Cluster COVID-19 Updates](#), featuring the latest guidance and resources on the COVID-19 response and profiling Health Cluster partner, [Relief International](#). Presently, they are working in Sudan, where the health system requires additional support to meet the health needs of refugees fleeing the Northern Ethiopia region following the violent military confrontations that began in late 2020. Relief International is supporting by providing outreach, monitoring and services provision in the Um Rakuba camp in Sudan.



Health and Nutrition coordination meeting in Um Rakuba camp. Credit: Sudan Health Cluster

COVID-19 Partners platform

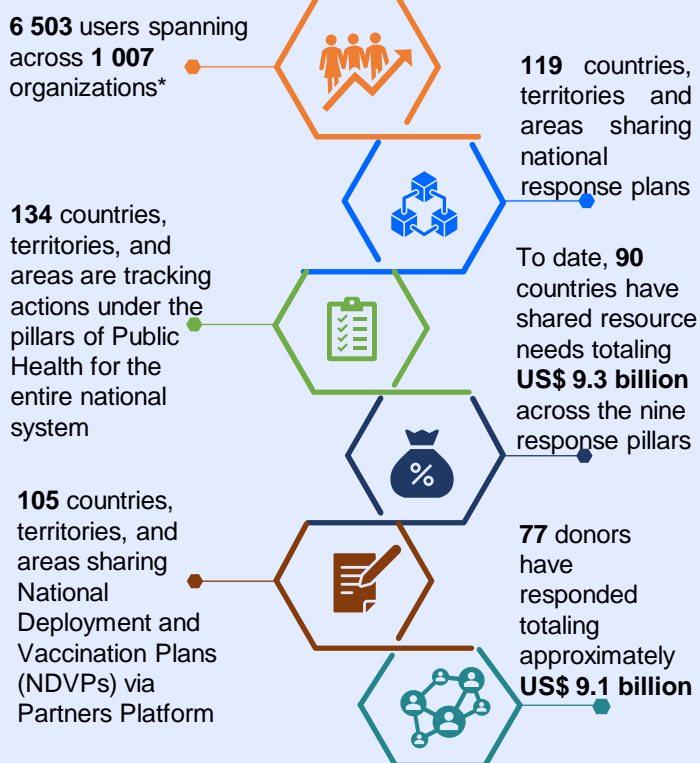
1 year anniversary of the Partners Platform

On March 16, the Partners Platform marked its one-year anniversary of supporting COVID-19 readiness and response capacities in countries, territories and areas.

First conceived by WHO and the UN Development Coordination Office as a companion tool to the COVID-19 Strategic Preparedness and Response Plan (SPRP) Operational Planning Guidelines, a year since its launch, the Platform has now guided 119 countries, territories, and areas in developing and uploading their COVID-19 national response plans, providing a space for countries to transparently cost resource needs and make them accessible to global donors.

Over time, with the development and production of SARS-CoV-2 vaccines, the Platform took on a coordinating role in the COVAX facility alongside the WHO's Department of Immunization, Vaccines, and Biologicals (IVB), and became the only place where countries can upload a National Deployment and Vaccination Plan (NDVP). As of this week, over 100 NDVPs have been submitted, 81 of which have already been reviewed by colleagues working on fragile, conflict-affected and vulnerable settings (FCV) in a matter of days for inclusion of vulnerable populations.

2020 Strategic Preparedness and Response Plan (SPRP) and National Deployment and Vaccination Plan (NDVP) Achievements



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

More work remains ahead however, as the Partners Platform's leadership seeks to update its Action Checklist to reflect the updated 2021 SPRP. The Partners Platform is also evolving as countries respond to concurrent acute health emergencies like Ebola virus disease (EVD), hand-in-hand with WHO's Regional Office for Africa. By expanding and rolling out technical assistance and resource needs for EVD operational readiness and response actions, Partners Platform will reduce parallel processes for these countries, streamlining support.

As always, the Platform looks forward to continuing to work with WHO's partners in the pandemic response, making sure that countries' needs remain sharply in focus.

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 March 2021.

Shipped items as of 19 March 2021	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	718 250	3 744 675	1 862 696	1 473 890	10 616 300	223 570	1 741 279	53 467 400	2 768 630
Americas (AMR)	7 342 300	1 046 132	10 543 278	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	1 178 300	1 625 220	1 785 140	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	617 500	652 750	616 770	1 750 900	8 938 900	409 900	1 757 548	40 911 500	5 423 350
South East Asia (SEAR)	1 440 000	3 185 800	2 408 970	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		228 500	346 834	768 700	3 060 000	311 927	463 710	14 974 146	2 102 035
TOTAL	11 296 350	10 483 077	17 563 688	8 653 511	37 105 700	1 561 327	6 970 179	198 747 426	20 070 365

For further information on the **COVID-19 supply chain system**, see [here](#).

Appeals

WHO's [Strategic Preparedness and Response Plan](#) (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 and health systems strengthening for the roll out of COVID-19 tools (ACT-A). Of the US\$ 1.96 billion appealed for, US\$ 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. US\$ 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.

SPRP 2021 Requirements US\$ 1.96 billion

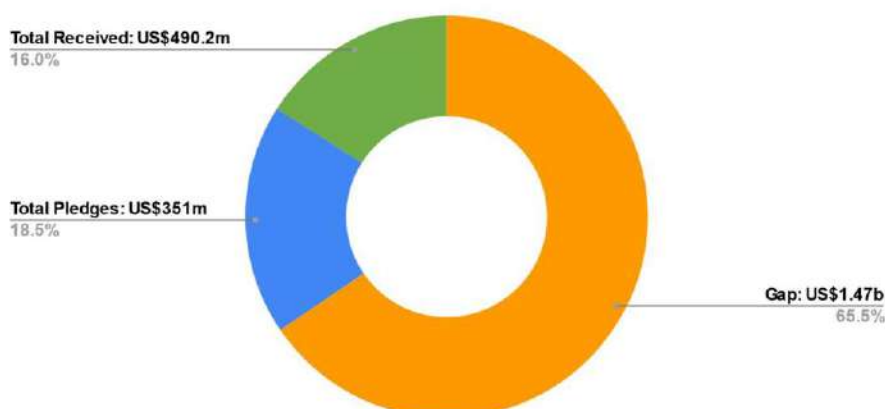


- Total WHO requirement under SPRP 2021
- Proportion of requirement attributed to ACT Accelerator*

**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*

Contributions to WHO for COVID-19 appeal

Data as of 17 March 2021



The 2021 SPRP priorities and resource requirements can be found [here](#).
The status of funding raised for WHO against the SPRP can be found [here](#).

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

As of 19 March 2021, [The Solidarity Response Fund](#) has raised or committed more than US\$ 242 million from more than 662,000 donors.

The world has never faced a crisis like COVID-19. The pandemic is impacting communities everywhere. It's never been more urgent to support the global response, led by the World Health Organization (WHO).

The Fund marked its one-year anniversary with Dr Tedros Adhanom Ghebreyesus, WHO Director-General remarking ***"I sincerely thank every individual, corporation and other organization for their donations to the Solidarity Response Fund, your generosity has made a difference."***, adding "we have seen what we can accomplish together in times of need".

For further information, click [here](#).

More than **US\$ 242 Million**



662 000 donors

[individuals – companies – philanthropies]

Pandemic learning response

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.



5 018 829
COVID-19
Course enrollments

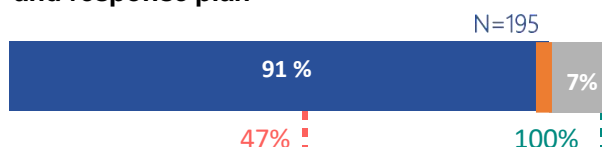
29 topical COVID-19 courses

47 languages

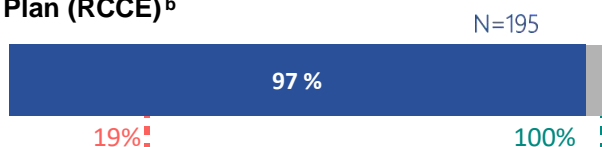
Over 2.7 million certificates

COVID-19 Global Preparedness and Response Summary Indicators ^a

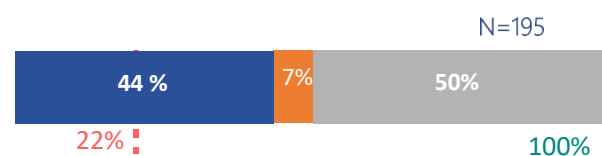
Countries have a COVID-19 preparedness and response plan



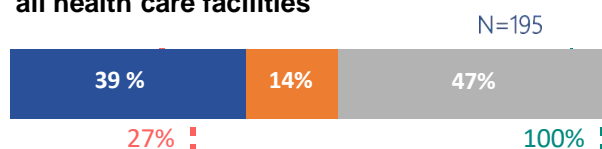
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE) ^b



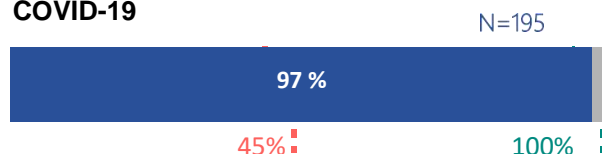
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



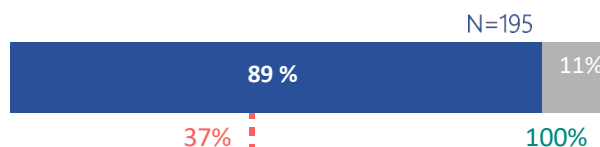
Countries with a national IPC programme & WASH standards within all health care facilities



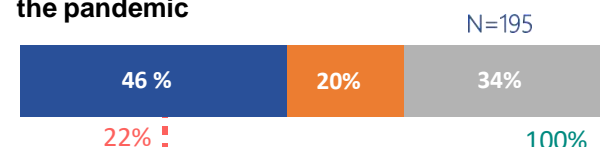
Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



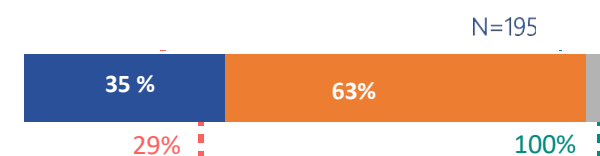
Countries have a clinical referral system in place to care for COVID-19 cases



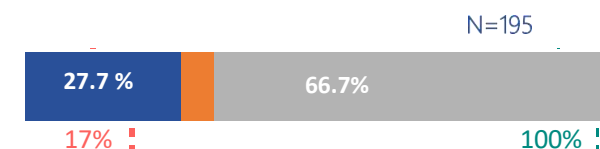
Countries that have defined essential health services to be maintained during the pandemic



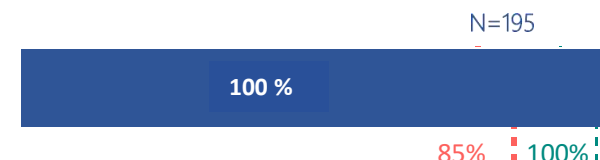
Countries in which all designated Points of Entry (PoE) have emergency contingency plans



Countries have a health occupational safety plan for health care workers



Countries have COVID-19 laboratory testing capacity



Legend



Yes



No



No information



Baseline value



Target value

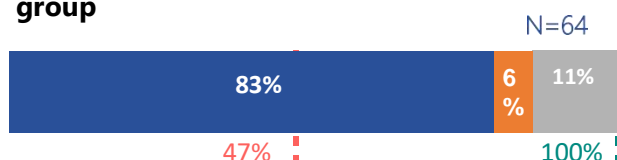
Notes:

^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

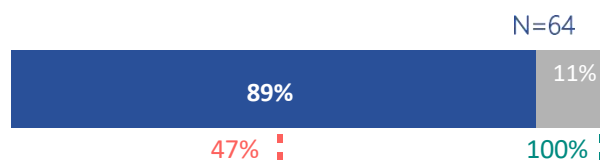
COVID-19 Global Preparedness and Response Summary Indicators

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



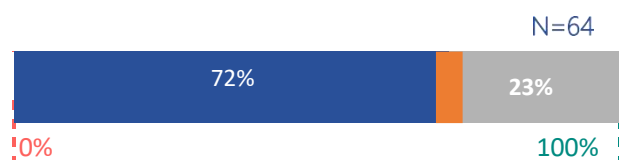
Priority countries with an active & implemented RCCE coordination mechanism



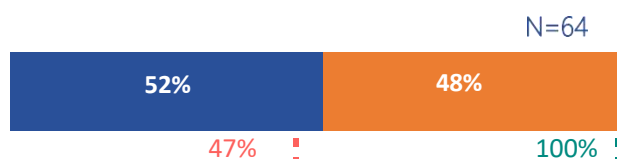
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19^c



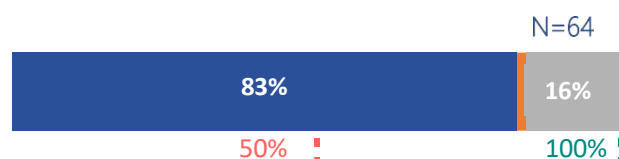
Priority countries with a contact tracing focal point



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



Legend

Yes

No

No information

Baseline value

Target value

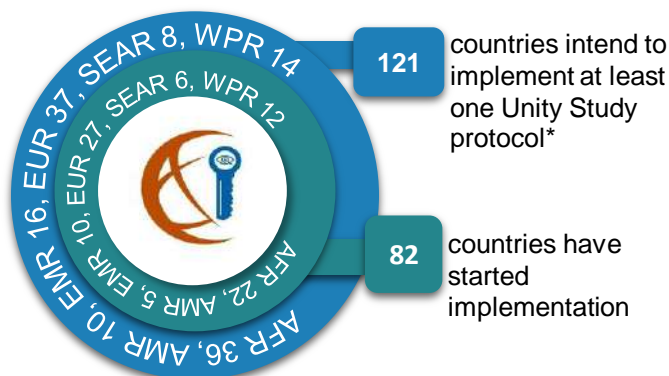
Notes:

^c Source: WHO Immunization Repository

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

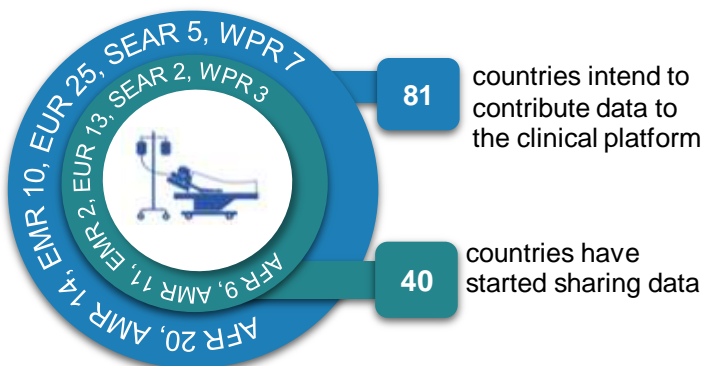
It enables any countries, in any resource setting, to gather rapidly robust data on key epidemiological parameters to understand, respond and control the COVID-19 pandemic.

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



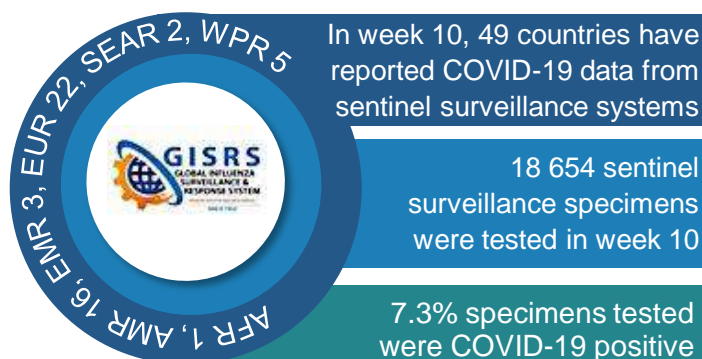
Global understanding of the severity, clinical features and prognostic factors of COVID-19 in different settings and populations remains incomplete.

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.



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 SARS-COV-2



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 16 March **Weekly Epidemiological Update**, click [here](#). Highlights this week include:
 - Overviews of global and regional epidemiological situation
 - Special focus sections on:
 - Building and maintaining trust - what countries should do to prepare communities for a COVID-19 vaccine, treatment, or a new test; and
 - SARS-CoV-2 variants of concern
- ❑ 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](#)
- ❑ For information on the COVID-19 vaccine, Ad26.COV2.S developed by Janssen (Johnson & Johnson)
 - WHO listing the COVID-19 vaccine for emergency use in all countries and for COVAX roll-out, click [here](#).
 - For the Interim Recommendations developed on the basis of the advice issued by the Strategic Advisory Group of Experts (SAGE), click [here](#).

COVID-19 Weekly Epidemiological Update

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

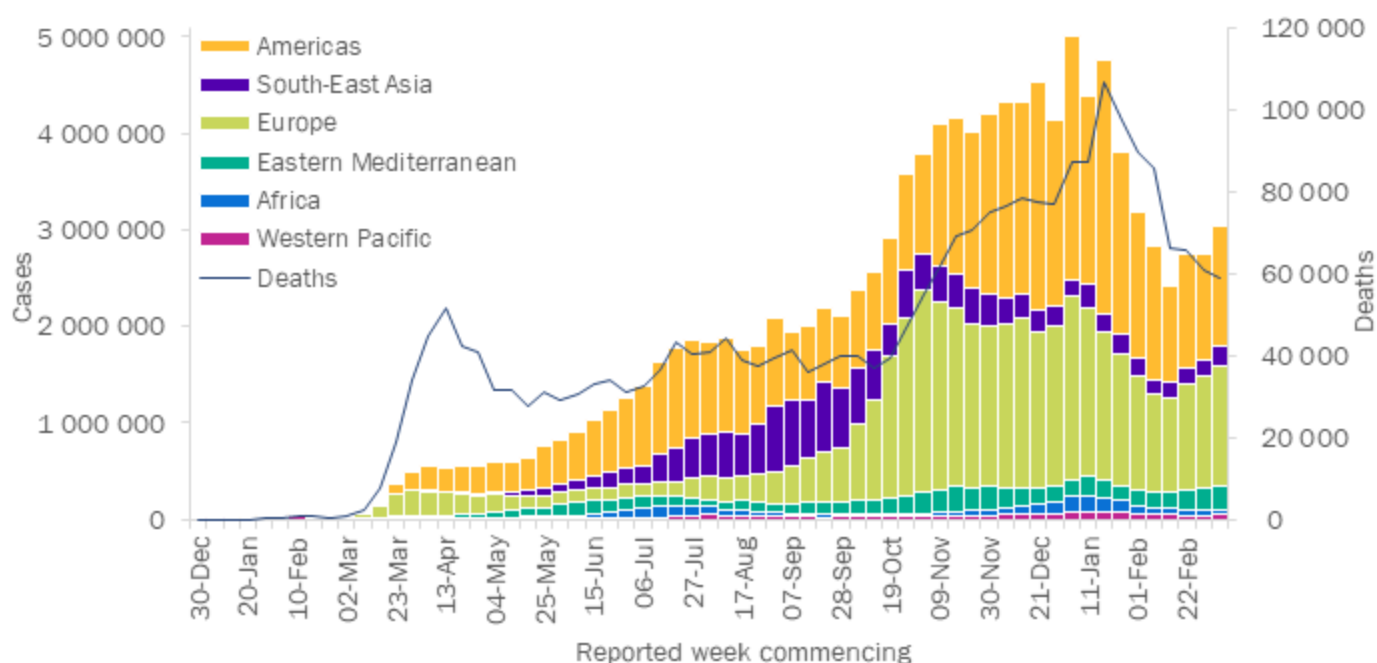
In this edition:

- [Global overview](#)
- [Special focus: Building and maintaining trust - what countries should do to prepare communities for a COVID-19 vaccine, treatment, or a new test](#)
- [Special focus: SARS-CoV-2 variants of concern](#)
- [WHO regional overviews](#)
- [Key weekly updates](#)

Global overview

New cases continue to rise globally, increasing by 10% in the past week to over 3 million new reported cases (Table 1). The number of new cases peaked in [early January](#) 2021 when there were just under 5 million cases reported in one week. New cases then declined to just under 2.5 million cases by the [week commencing 15 February](#). However, for the past three weeks new cases have increased. This week, the Americas and Europe continue to account for over 80% of new cases and new deaths, with rises in new cases seen in all regions apart from Africa, where incidence rates remained similar to the previous week. New deaths on the other hand continue to decline and are now under 60 000, since peaking in the week commencing [18 January](#) (when there were over 95 000 new deaths in the week). The last time when there were fewer than 60 000 new weekly deaths was four months ago, in the week commencing [9 November](#). This week, although new deaths declined globally, they rose in two WHO regions; the Eastern Mediterranean (by 7%) and the Western Pacific (by 14%).

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



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

The highest numbers of new cases were reported from Brazil (494 153 new cases; 20% increase), the United States of America (461 190 new cases; 8% increase), France (161 159 new cases; 12% increase), Italy (155 076 new cases; 12% increase), and India (148 249 new cases; 30% increase).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 14 March 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	1 241 439 (41%)	13%	52 763 406 (44%)	30 596 (52%)	-6%	1 268 186 (48%)
Europe	1 236 697 (41%)	6%	41 043 949 (34%)	20 977 (36%)	-1%	906 843 (34%)
South-East Asia	199 924 (7%)	19%	13 884 294 (12%)	2 141 (4%)	-3%	212 355 (8%)
Eastern Mediterranean	251 375 (8%)	14%	6 860 070 (6%)	2 955 (5%)	7%	150 173 (6%)
Africa	54 225 (2%)	0%	2 948 236 (2%)	1 309 (2%)	-6%	74 685 (3%)
Western Pacific	49 553 (2%)	19%	1 711 830 (1%)	720 (1%)	14%	30 357 (1%)
Global	3 033 213 (100%)	10%	119 212 530 (100%)	58 698 (100%)	-3%	2 642 612 (100%)

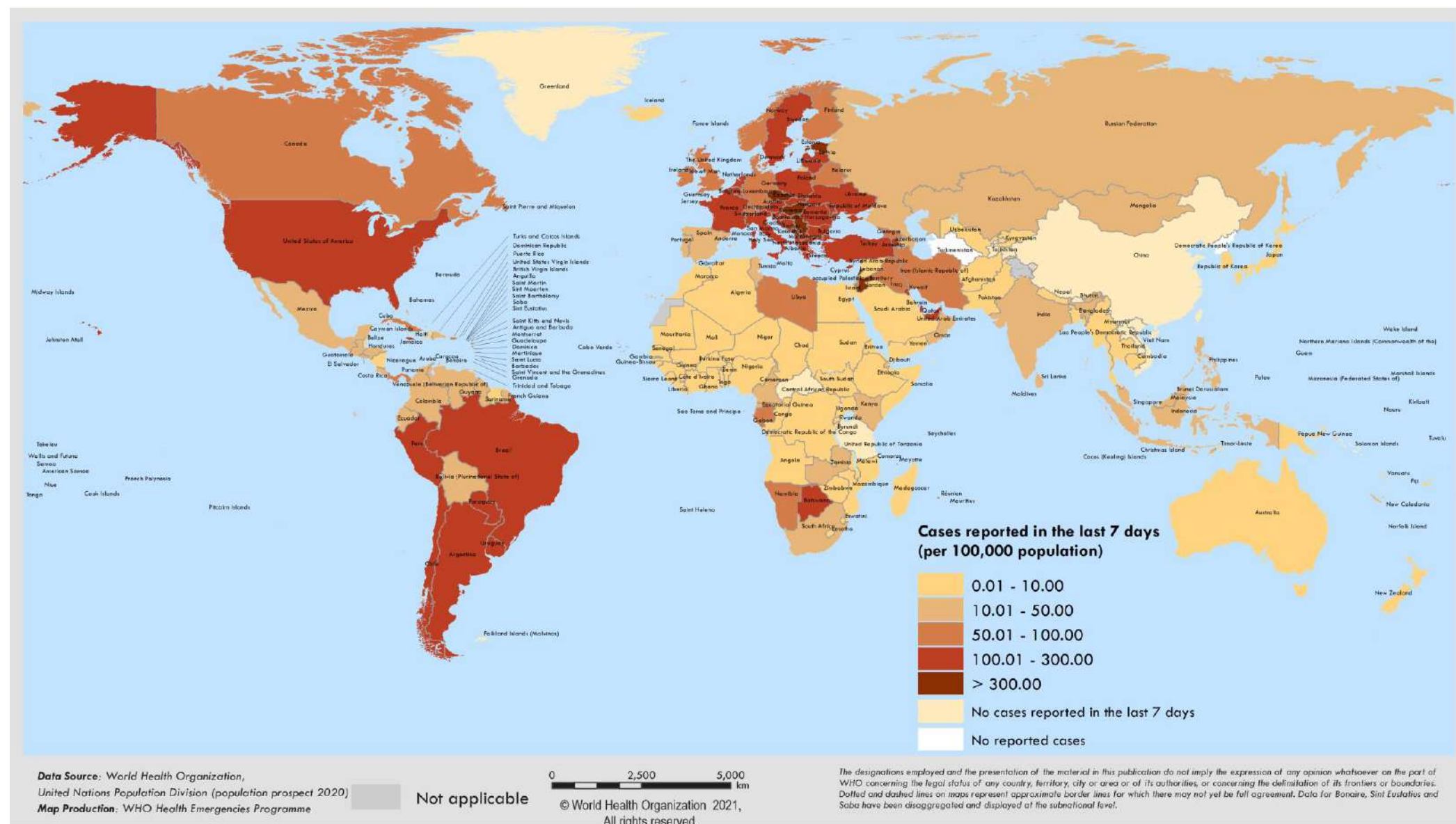
*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number; global totals may not equal 100%.

**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 by countries, territories and areas, 8-14 March 2021**



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

Special Focus: Building and maintaining trust - what countries should do to prepare communities for a COVID-19 vaccine, treatment, or a new test

As we move to the next critical phase of the response, when vaccines and other biomedical tools become more widely available, building trust and engaging communities remains essential. We have learned from previous epidemic responses that when communities fully engage and actively participate in the full cycle of planning, delivery and assessment for new biomedical tools, demand for these tools increases, leading to widespread and effective uptake and use.

Addressing community concerns

Social-behavioral data tell us that we have much to do in order to build and sustain trust in communities around the world.

People have concerns over the safety of vaccines and other biomedical tools made with unprecedented speed and with new technologies. These concerns must be acknowledged and addressed by providing individuals and communities with actionable, timely and credible health information from trusted sources and by providing the space and follow-up necessary to work through these concerns with trusted health or community leaders. Past epidemics have shown us just how quickly and widely individual or community fears can spread if not dealt with in a timely and comprehensive way.

Recent studies suggest that around 65% of global populations surveyed are willing to be vaccinated with a COVID-19 vaccine.¹ But this has fluctuated over time. The proportion of those likely to accept a COVID-19 vaccine varies significantly between regions and countries and within countries. The barriers to vaccine uptake are likely to be influenced by a large range of factors.² These include exposure to misinformation and rumours, which can negatively impact on vaccine confidence, as well as the role local health care professionals play in promoting vaccine uptake among their patients and communities.³

As the pandemic becomes protracted, pandemic fatigue is increasing. The growing fatigue, the stress caused by uncertainty, lower risk perceptions, and reduced trust in government responses, are taking a toll on the fabric of our communities. This has already led to stigma and discrimination in some settings as well as protests against public health and social measures in many countries.

This is why since the beginning of the pandemic, WHO has promoted and provided guidance on implementing a whole-of-society approach to ensure the widest array of stakeholders are actively involved in the introduction of new biomedical tools, while also supporting communities' broader trust in their health systems.

One of the ways WHO is supporting countries strengthen their engagement and empowerment strategies is through the publication of the [10 Steps to Community Readiness – What countries should do to prepare communities for a COVID-19 vaccine, treatment, or new test](#).

This is a new tool, developed by WHO, UNICEF, IFRC and the Global Outbreak and Alert Response Network (GOARN) through the Risk Communication and Community Engagement (RCCE) Collective Service (a new partnership launched in June 2020), to strengthen coordination and quality of practice for the COVID-19 pandemic response.

¹ Johns Hopkins University, WHO, GOARN, Facebook, MIT (2021) KAP COVID-19 - Vaccine acceptance around the world. <https://ccp.jhu.edu/kap-covid/vaccine-acceptance>

² Anthrologica (2020) Literature analysis: norms and practices relevant to COVID-19 in the Middle East and North Africa Region.

³ PERC (2020) Responding to COVID-19 in Africa: using data to find a balance Part II. <https://preventepidemics.org/covid19/perc/>

Figure 3: 10 Steps to Community Readiness



The tool is built around the recognition that the empowerment of people and communities is not an abstract idea, and there are concrete and measurable steps that can be taken to ensure citizens are engaged and ready to support new biomedical tools.

Though communication needs may be slightly different for each step, the principles that promote their safe and successful introduction remain the same.

The steps build on well-established RCCE principles that 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.

With the imminent arrival of new biomedical tools, investments in coordinated and proactive community engagement approaches, such as the 10 Steps to Community Readiness, are now needed more than ever. These approaches not only support the widest possible uptake of new tools but also support the continued maintenance of protective behaviours, such as mask wearing and physical distancing.

Additional resources:

- [Tools guidance and job aids to support implementing each of the 10 steps that lead to community readiness](#)
- [Ways the RCCE Collective Service supporting regions and countries](#)
- [Guidance on how to ensure people centered and community led approaches underpin the COVID-19 response](#)

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. Further information on the background of the variants of concern (VOCs) is available in previously published editions of the [Weekly Epidemiological Update](#). Here we provide an update on the geographical distribution of the three VOCs, considered as such by WHO and as reported by countries, territories and areas (hereafter countries) as of 16 March 2021; and emerging variants of interest (VOIs).

As surveillance activities, including systematic genomic sequencing, are strengthened at local and national levels to detect cases infected with SARS-CoV-2 variants, the number of countries reporting VOCs has continued to increase (Table 2, Figures 4-6, Annex 2). This information should be interpreted with due consideration of limitations of ongoing surveillance, including but not limited to differences between countries in sequencing capacity and which samples are prioritized for sequencing. WHO continues to advocate for strengthening surveillance and sequencing capacity, and a systematic approach to provide a representative indication of the extent of transmission of SARS-CoV-2 variants; based on the local epidemiological situation and capacity, and the detection of unusual events.

Table 2: Overview of emerging information on key variants of concern, as of 16 March 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, alias P.1[†]
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01[†]	VOC 202012/02	-
First detected by	United Kingdom	South Africa	Brazil / Japan
Earliest sample date	20 September 2020	Early August 2020	December 2020
Key spike mutations	H69/V70 deletion; Y144 deletion; N501Y; A570D; P681H	L242/A243/L244 deletion; K417N; E484K; N501Y	K417T, E484K; N501Y
Key mutation in common	S106/G107/F108 deletion in Non-Structural Protein 6 (NSP6)		
Countries reporting cases (newly reported in last week)**	118 (7)	64 (6)	38 (6)

[†]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).

Figure 4. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 16 March 2021



Figure 5. Countries, territories and areas reporting SARS-CoV-2 variant 501Y.V2 as of 16 March 2021

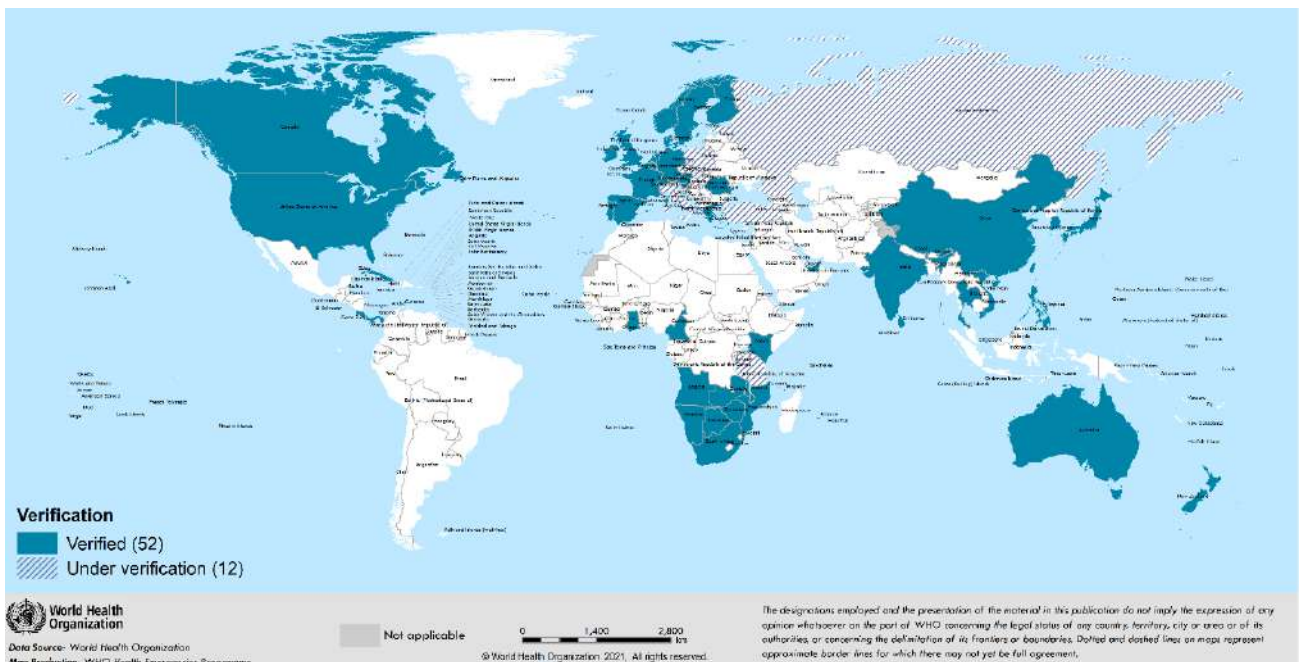
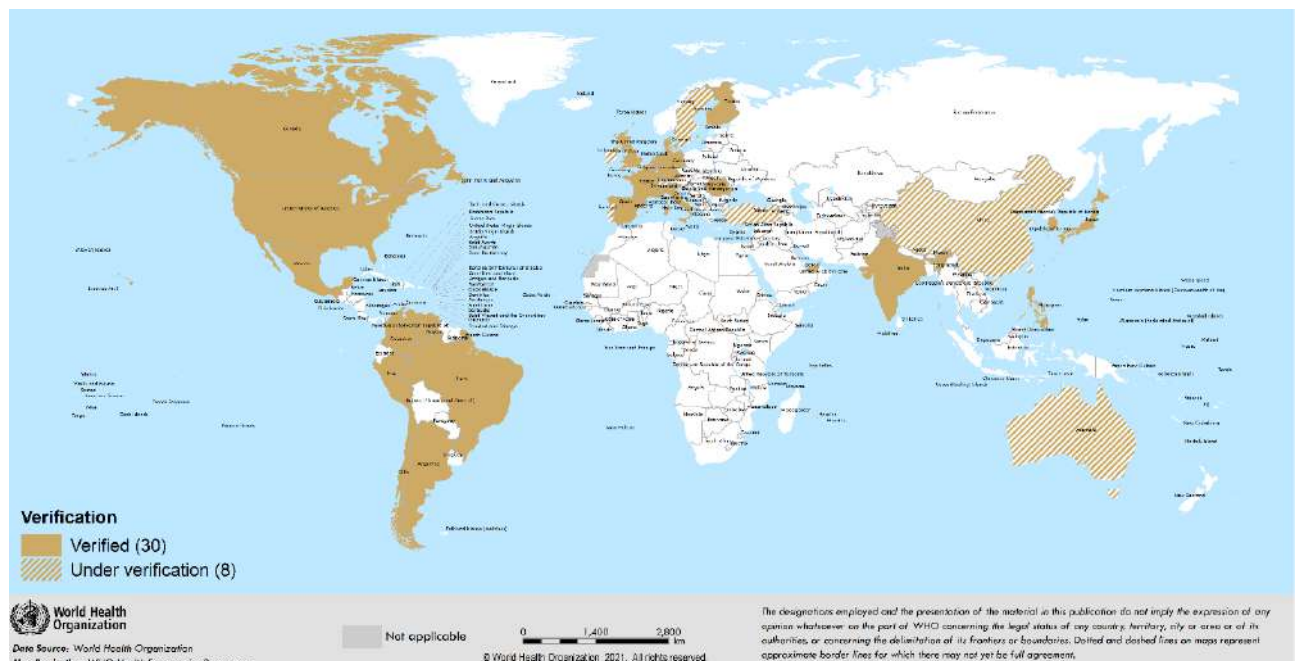


Figure 6. Countries, territories and areas reporting SARS-CoV-2 variant P.1 as of 16 March 2021



Emerging variants of interest (VOIs)

All viruses, including SARS-CoV-2, change over time resulting in the emergence of new variants, most without a direct benefit to the virus or other public health impacts. WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 result in changes in transmissibility, clinical presentation and severity, or if they impact on public health and social measures (PHSM). Systems have been established to detect “signals” of potential variants of interest or concern, as well as unusual events potentially associated with a variant, and assess these based on the risk posed to global public health (see also [working definitions](#)). Such signals are currently under assessment, and as new variants of interest VOIs or VOCs are determined, WHO is committed to highlighting these to support prioritization for further monitoring and assessment.

A SARS-CoV-2 variant, labelled CAL.20C/L452R (based upon the NextStrain subclade and key mutation), spanning PANGO lineages B.1.427 and B.1.429, has been designated as a VOI by WHO based on recent assessments and emerging evidence. This variant is characterized by a combination of three mutations in the receptor binding domain (RBD), namely S13I, W152C, L452R, of which the focus is on the L452R mutation. It was first detected during a local increase in COVID-19 cases in California, United States of America in June 2020. Surveillance has shown that it has since contributed to a substantive proportion of local COVID-19 cases in California, and has been detected in all US states and at least 26 other countries to date¹⁻⁴. Outside of the US, reported detections of this VOI are currently limited to a relatively low number of sequences, suggesting it has not yet resulted in widespread disease in other countries.

The assessment as a VOI follows preliminary, emerging evidence that this variant may be associated with phenotypic impacts which may pose an increased public health risk and COVID-19 control measures compared to other variants. This includes a possible increase in transmissibility,¹ mixed findings on potentially higher infectivity (based on PCR cycle thresholds as a proxy),^{1,5,6} and a slight reduction in neutralization for sera from recovered patients clinically diagnosed with COVID-19 and in vaccine recipients.^{1,7} The L452R mutation has been associated with a reduction in neutralization of monoclonal antibodies but further investigations are ongoing^{8,9}. The impact of this variant on disease severity is under investigation. These are preliminary findings, include non-peer review studies, and require further investigations. WHO is working with US Centers for Disease Control and Prevention (CDC) and the WHO Virus Evolution Working Group to further assess this VOI.

WHO recommendations and working definitions of VOI and VOC

The potential for virus mutation increases with the frequency of human and animal infections. Therefore, reducing transmission of all circulating SARS-CoV-2 viruses and variants by using established disease control methods, are critical aspects of the global strategy to reduce the occurrence of mutations that have negative public health implications. PHSM and infection prevention and control measures inside and outside of health facilities 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, as well as infection prevention and control (IPC) measures in health facilities, has been effective in reducing COVID-19 case incidence, which has led to a reduction in hospitalizations and deaths among COVID-19 patients. Findings from new studies evaluating transmission, severity and impact on medical countermeasures will continue to help inform PHSM and IPC measures employed by Member States. National and local authorities are encouraged to continue strengthening existing PHSM, IPC and disease control activities, including epidemiological surveillance, strategic testing, and systematic sequencing of SARS-CoV-2 where feasible.

On 25 February 2021, [proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern](#) were published. As SARS-CoV-2 is continuously evolving, and new signals of potential VOIs and VOCs are frequently detected, WHO aims to assess potential VOCs based on the risk posed to global public health. National authorities may choose to designate other variants of local interest/concern as every local situation is unique, with different variants circulating, requiring surveillance and response systems to adapt to their local epidemiological situation.

If potential VOIs or VOCs are detected, Member States are requested to inform WHO through established WHO Country or Regional Office reporting channels, submit genome sequences to publicly available databases (e.g., GISAID), and perform field and laboratory investigations (where appropriate) to improve understanding of potential impacts.

Additional resources

- [Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health](#)
- [Considerations for implementing and adjusting PHSM in the context of COVID-19](#)
- [Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern](#)
- [Disease Outbreak News on SARS-CoV-2 Variants, 31 December 2020](#)

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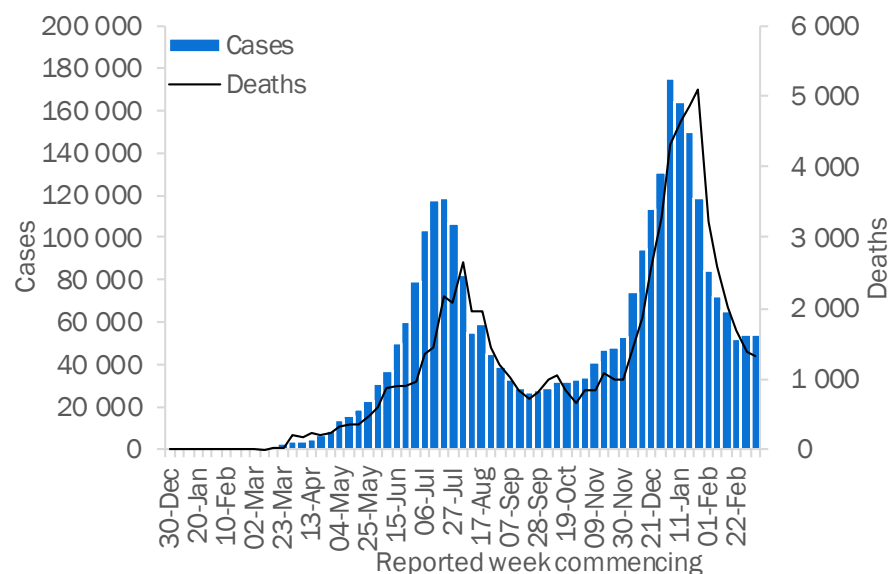
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WHO regional overviews

African Region

The African Region reported over 54 000 new cases, a number similar to last week, while deaths decreased by 6% compared to the previous week with just over 1300 deaths reported. The decreasing trend in deaths has been observed since early February 2021. The highest numbers of new cases were reported from Ethiopia (9025 new cases; 7.9 new cases per 100 000 population; a 29% increase), South Africa (8208 new cases; 13.8 new cases per 100 000; a 3% increase), and Kenya (5476 new cases; 10.2 new cases per 100 000; a 226% increase).

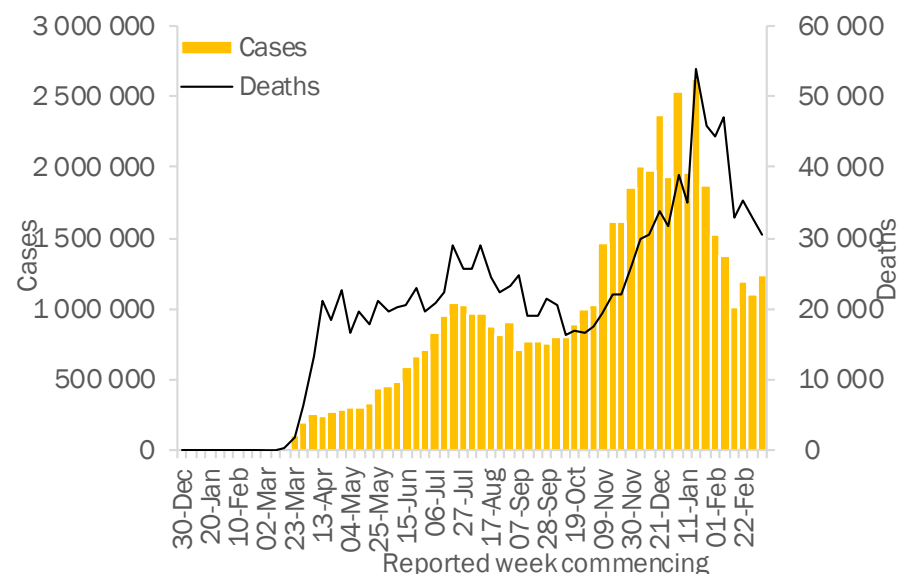
The highest numbers of new deaths were reported from South Africa (614 new deaths; 1.0 new deaths per 100 000 population; a 13% decrease), Ethiopia (120 new deaths; 0.1 new deaths per 100 000; an 82% increase), and Botswana (65 new deaths; 2.8 new deaths per 100 000; a 33% increase).



Region of the Americas

The Region of the Americas reported over 1.2 million new cases and over 30 000 new deaths, a 13% increase and a 6% decrease respectively compared to the previous week. Deaths continued to decrease for the second consecutive week. The highest numbers of new cases were reported from Brazil (494 153 new cases; 232.5 new cases per 100 000; a 20% increase), the United States of America (461 190 new cases; 139.3 new cases per 100 000; an 8% increase), and Peru (52 763 new cases; 160.0 new cases per 100 000; a 58% increase).

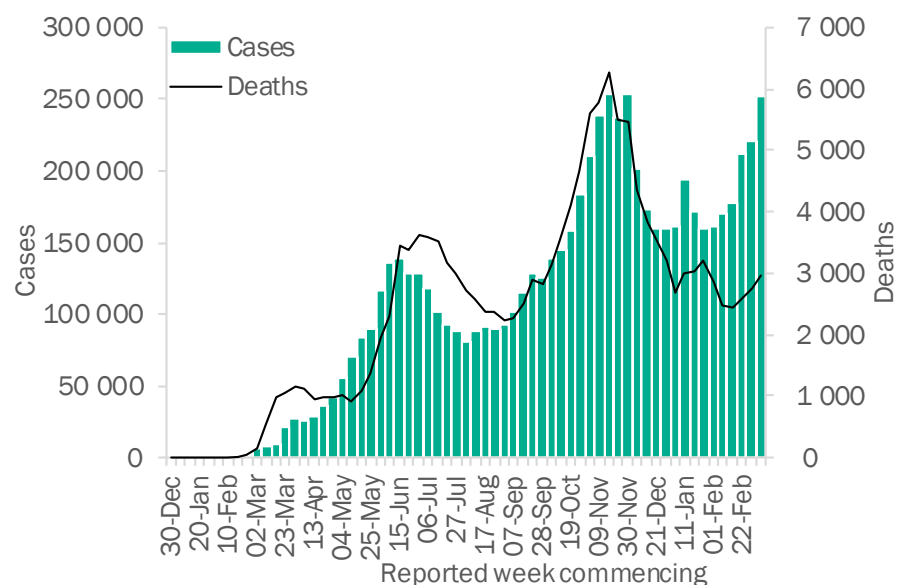
The highest numbers of new deaths were reported from Brazil (12 335 new deaths; 5.8 new deaths per 100 000; a 24% increase), the United States of America (9381 new deaths; 2.8 new deaths per 100 000; a 24% decrease), and Mexico (4273 new deaths; 3.3 new deaths per 100 000; a 16% decrease). These three countries accounted for 85% of deaths reported in the Americas this week.



Eastern Mediterranean Region

The Eastern Mediterranean Region reported over 251 000 new cases and just under 3000 new deaths, a 14% and a 7% increase respectively compared to the previous week. New weekly cases have increased for the past five weeks and deaths have increased for the past three weeks. The highest numbers of new cases were reported from the Islamic Republic of Iran (65 890 new cases; 78.4 new cases per 100 000; a 31% increase), Jordan (47 585 new cases; 466.4 new cases per 100 000; a 36% increase), and Iraq (31 129 new cases; 77.4 new cases per 100 000; a 1% increase).

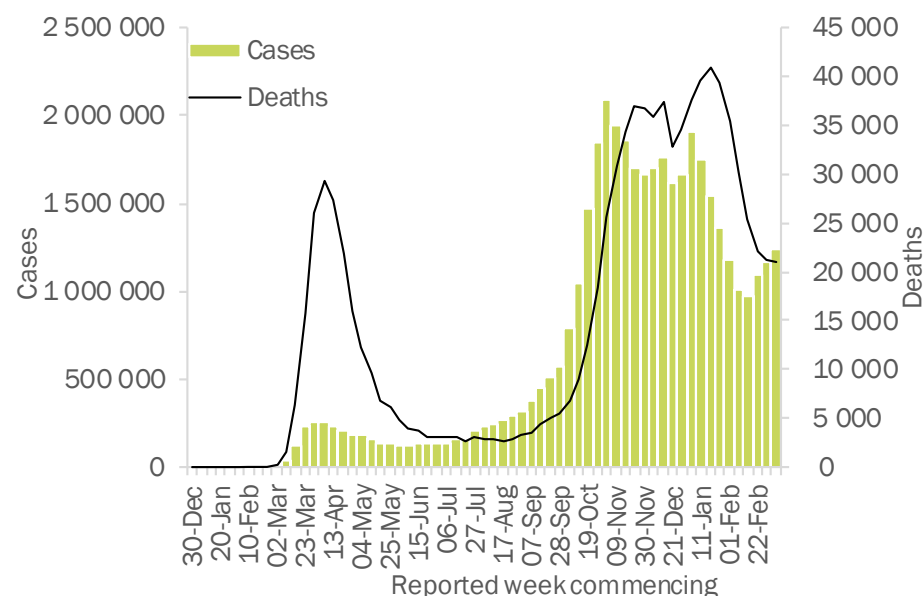
The highest numbers of new deaths were reported from the Islamic Republic of Iran (630 new deaths; 0.8 new deaths per 100 000; an 18% increase), Jordan (385 new deaths; 3.8 new deaths per 100 000; a 71% increase), and Lebanon (321 new deaths; 4.7 new deaths per 100 000; an 11% decrease).



European Region

The European Region reported over 1.2 million new cases and just under 21 000 new deaths, a 6% increase and a 1% decrease respectively compared to the previous week. Cases in the Region have been steadily increasing over the past three weeks while trends in new deaths have been consistently declining for the past eight weeks. The highest numbers of new cases were reported from France (161 159 new cases; 246.9 new cases per 100 000; a 12% increase), Italy (155 076 new cases; 256.5 new cases per 100 000; a 12% increase), and Poland (111 718 new cases; 295.2 new cases per 100 000; a 27% increase).

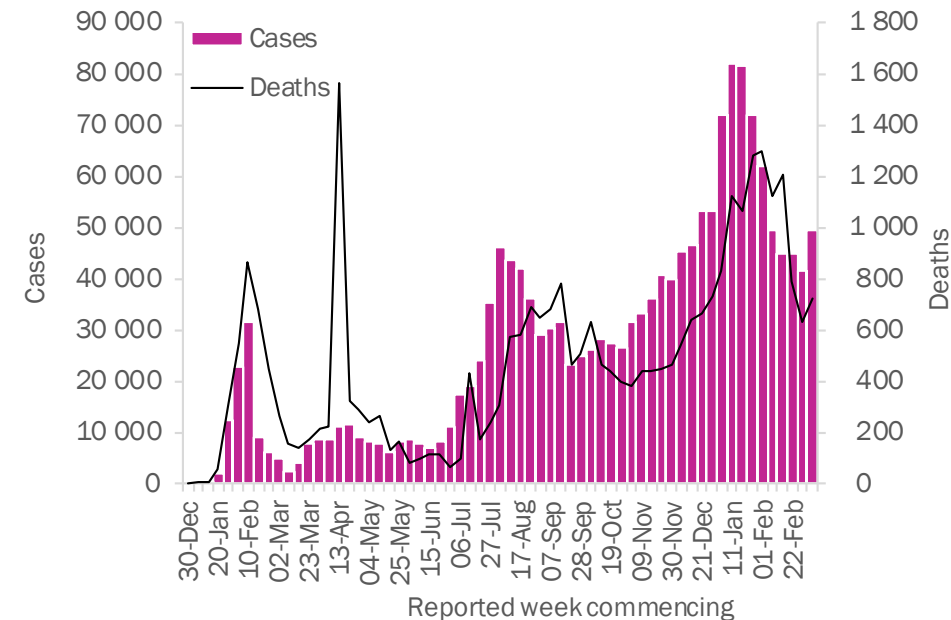
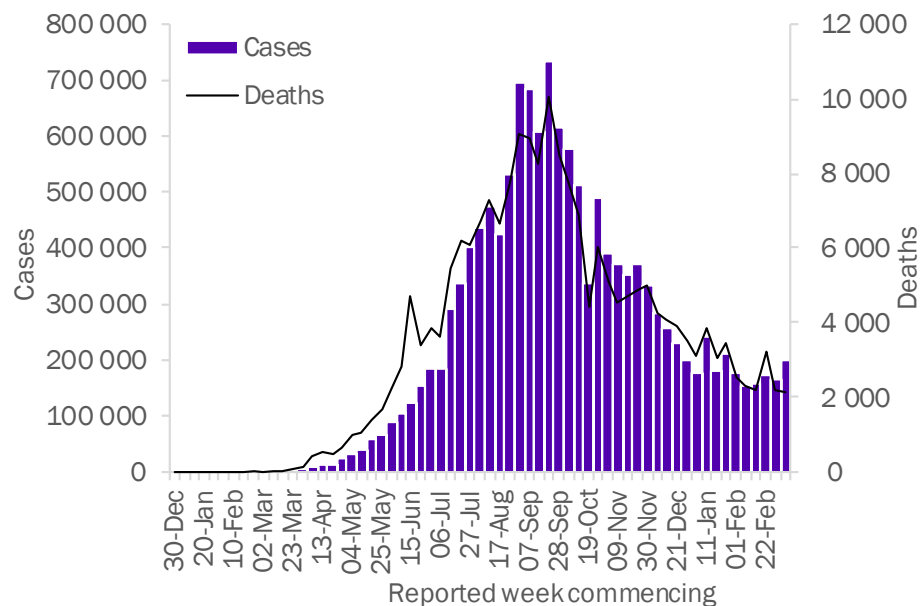
The highest numbers of new deaths were reported from the Russian Federation (2990 new deaths; 2.0 new deaths per 100 000; similar to the previous week), Italy (2303 new deaths; 3.8 new deaths per 100 000; an 11% increase), and Poland (1893 new deaths; 5.0 new deaths per 100 000; a 25% increase).



South-East Asia Region

The South-East Asia Region reported just under 200 000 new cases and just over 2100 new deaths, a 19% increase and a 3% decrease respectively compared to the previous week. The highest numbers of new cases were reported from India (148 249 new cases; 10.7 new cases per 100 000; a 30% increase), Indonesia (40 905 new cases; 15.0 new cases per 100 000; a 9% decrease), and Bangladesh (6512 new cases; 4.0 new cases per 100 000; a 67% increase).

The highest numbers of new deaths were reported from Indonesia (1175 new deaths; 0.4 new deaths per 100 000; similar to the previous week), India (851 new deaths; 0.1 new deaths per 100 000; a 21% increase), and Bangladesh (76 new deaths; <0.1 new deaths per 100 000; a 49% increase).



Western Pacific Region

The Western Pacific Region reported just under 50 000 new cases and over 700 new deaths, a 19% and a 14% increase respectively compared to the previous week. This is the first time in seven weeks that an increase in new cases has been reported with new deaths also showing an uptick. The highest numbers of new cases were reported from the Philippines (25 473 new cases; 23.2 new cases per 100 000; a 51% increase), Malaysia (10 632 new cases; 32.8 new cases per 100 000; a 21% decrease), and Japan (7917 new cases; 6.3 new cases per 100 000; a 10% increase).

The highest numbers of new deaths were reported from Japan (333 new deaths; 0.3 new deaths per 100 000; a 9% decrease), the Philippines (301 new deaths; 0.3 new deaths per 100 000; a 71% increase), and Malaysia (40 new deaths; 0.1 new deaths per 100 000; an 11% decrease).

Key weekly updates

WHO Director-General's key message

[Opening remarks at the media briefing on COVID-19 – 12 March 2021](#): *The inequitable distribution of vaccines remains the biggest threat to ending the pandemic and driving a global recovery.*

International Women's Day: Women and COVID-19

- [WHO signs MoU with Women in Global Health on International Women's Day](#)
- [Devastatingly pervasive: 1 in 3 women globally experience violence](#)
- [Women scientists capture public attention as COVID-19 rages across the world](#)

COVID-19 Vaccines

- [Waive COVID vaccine patents to put world on war footing](#)
- [WHO adds Janssen vaccine to list of safe and effective emergency tools against COVID-19](#)
- [GACVS COVID-19 Vaccine Safety subcommittee meeting to review reports on influenza-like illness in individuals vaccinated with COVID-19 vaccines](#)

COVID-19 Solidarity Response Fund

- [COVID-19 Solidarity Response Fund marks first anniversary and appeals for continued support](#)

ACT Accelerator strategy and budget

- [ACT-Accelerator releases prioritised strategy and budget for 2021 to change the course of the evolving COVID-19 pandemic](#)

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 March 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	54 225	2 948 236	262.8	1 309	74 685	6.7	
Ethiopia	9 025	174 054	151.4	120	2 540	2.2	Community transmission
South Africa	8 208	1 528 414	2 577.0	614	51 261	86.4	Community transmission
Kenya	5 476	112 805	209.8	38	1 908	3.5	Community transmission
Cameroon	3 274	38 988	146.9	37	588	2.2	Community transmission
Zambia	2 463	84 474	459.5	37	1 153	6.3	Community transmission
Botswana	2 440	34 098	1 450.0	65	424	18.0	Community transmission
Côte d'Ivoire	2 369	37 304	141.4	11	211	0.8	Community transmission
Nigeria	2 300	160 537	77.9	49	2 013	1.0	Community transmission
Mozambique	2 165	64 296	205.7	36	722	2.3	Community transmission
Ghana	1 670	87 762	282.4	45	685	2.2	Community transmission
Namibia	1 559	41 025	1 614.6	22	458	18.0	Community transmission
Madagascar	1 201	21 356	77.1	26	326	1.2	Community transmission
Gabon	1 143	16 660	748.5	6	96	4.3	Community transmission
Senegal	1 094	36 726	219.3	47	955	5.7	Community transmission
Guinea	1 052	17 592	134.0	9	102	0.8	Community transmission
Algeria	1 039	115 143	262.6	24	3 034	6.9	Community transmission
South Sudan	752	9 429	84.2	2	104	0.9	Community transmission
Rwanda	717	20 143	155.5	9	276	2.1	Community transmission
Togo	528	8 049	97.2	3	93	1.1	Community transmission
Democratic Republic of the Congo	469	26 937	30.1	5	717	0.8	Community transmission
Benin	430	6 501	53.6	6	81	0.7	Community transmission
Malawi	391	32 789	171.4	15	1 082	5.7	Community transmission
Mali	353	8 862	43.8	2	360	1.8	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	311	16 035	2 884.1	4	156	28.1	Community transmission
Angola	268	21 323	64.9	8	520	1.6	Community transmission
Equatorial Guinea	233	6 562	467.7	2	98	7.0	Community transmission
Seychelles	223	3 173	3 226.3	1	15	15.3	Community transmission
Zimbabwe	211	36 471	245.4	16	1 501	10.1	Community transmission
Burkina Faso	197	12 350	59.1	1	144	0.7	Community transmission
Gambia	180	4 939	204.4	1	153	6.3	Community transmission
Congo	150	9 329	169.1	0	131	2.4	Community transmission
Burundi	142	2 441	20.5	0	3	0.0	Community transmission
Sao Tome and Principe	140	2 078	948.2	1	32	14.6	Community transmission
Chad	127	4 288	26.1	13	153	0.9	Community transmission
Guinea-Bissau	124	3 436	174.6	3	52	2.6	Community transmission
Niger	117	4 857	20.1	9	181	0.7	Community transmission
Eritrea	116	3 038	85.7	0	7	0.2	Community transmission
Mauritania	101	17 410	374.4	0	442	9.5	Community transmission
Uganda	92	40 544	88.6	0	334	0.7	Community transmission
Mauritius	71	691	54.3	0	10	0.8	Clusters of cases
Eswatini	61	17 234	1 485.5	3	661	57.0	Community transmission
Comoros	32	3 623	416.6	1	146	16.8	Community transmission
Sierra Leone	19	3 937	49.4	0	79	1.0	Community transmission
Lesotho	8	10 530	491.5	2	309	14.4	Community transmission
Liberia	6	2 030	40.1	0	85	1.7	Community transmission
Central African Republic	0	5 021	104.0	0	63	1.3	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesⁱⁱⁱ							
Réunion	676	13 801	1 541.5	12	71	7.9	Community transmission
Mayotte	502	18 642	6 833.2	4	129	47.3	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
Americas	1 241 439	52 763 406	5 158.8	30 596	1 268 186	124.0	
Brazil	494 153	11 363 380	5 346.0	12 335	275 105	129.4	Community transmission
United States of America	461 190	29 063 401	8 780.4	9 381	528 456	159.7	Community transmission
Peru	52 763	1 402 610	4 254.0	1 358	48 664	147.6	Community transmission
Argentina	45 311	2 192 025	4 850.1	776	53 646	118.7	Community transmission
Mexico	38 466	2 157 771	1 673.6	4 273	193 851	150.4	Community transmission
Chile	34 896	885 379	4 631.6	566	21 574	112.9	Community transmission
Colombia	25 035	2 294 617	4 509.6	650	60 950	119.8	Community transmission
Canada	21 472	903 233	2 393.2	212	22 404	59.4	Community transmission
Paraguay	11 782	177 593	2 489.9	158	3 436	48.2	Community transmission
Ecuador	7 723	300 666	1 704.2	195	16 215	91.9	Community transmission
Uruguay	7 145	69 074	1 988.5	52	689	19.8	Community transmission
Cuba	6 473	60 558	534.7	25	366	3.2	Community transmission
Bolivia (Plurinational State of)	5 027	258 324	2 213.0	114	11 903	102.0	Community transmission
Jamaica	4 609	29 912	1 010.1	38	484	16.3	Community transmission
Honduras	4 148	177 168	1 788.7	78	4 325	43.7	Community transmission
Guatemala	3 637	181 974	1 015.7	79	6 546	36.5	Community transmission
Panama	3 483	347 226	8 047.4	74	5 981	138.6	Community transmission
Venezuela (Bolivarian Republic of)	3 430	144 786	509.2	51	1 422	5.0	Community transmission
Dominican Republic	2 956	245 616	2 264.2	51	3 213	29.6	Community transmission
Costa Rica	2 453	209 093	4 104.6	29	2 862	56.2	Community transmission
El Salvador	1 286	62 086	957.2	51	1 945	30.0	Community transmission
Guyana	340	9 069	1 153.0	6	206	26.2	Clusters of cases
Saint Lucia	175	3 989	2 172.3	5	48	26.1	Community transmission
Barbados	174	3 391	1 180.0	0	37	12.9	Community transmission
Antigua and Barbuda	149	962	982.3	6	27	27.6	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
Haiti	96	12 632	110.8	0	250	2.2	Community transmission
Bahamas	64	8 680	2 207.3	3	185	47.0	Clusters of cases
Suriname	46	9 012	1 536.2	1	176	30.0	Clusters of cases
Nicaragua	40	5 216	78.7	1	175	2.6	Community transmission
Trinidad and Tobago	40	7 769	555.1	1	140	10.0	Community transmission
Belize	35	12 370	3 110.9	1	316	79.5	Community transmission
Saint Vincent and the Grenadines	22	1 680	1 514.3	0	8	7.2	Community transmission
Dominica	12	156	216.7	0	0	0.0	Clusters of cases
Saint Kitts and Nevis	2	43	80.8	0	0	0.0	Sporadic cases
Grenada	0	151	134.2	0	1	0.9	Sporadic cases
Territoriesⁱⁱⁱ							
Puerto Rico	1 501	102 567	3 585.2	21	2 077	72.6	Community transmission
Guadeloupe	267	10 725	2 680.4	0	168	42.0	Community transmission
Aruba	263	8 272	7 747.8	2	77	72.1	Community transmission
Bonaire	178	633	3 026.5	1	6	28.7	Community transmission
Curaçao	164	4 915	2 995.3	0	22	13.4	Community transmission
Martinique	151	7 037	1 875.2	0	47	12.5	Community transmission
French Guiana	71	16 764	5 612.7	0	87	29.1	Community transmission
Saint Barthélemy	54	725	7 334.3	1	1	10.1	Clusters of cases
United States Virgin Islands	53	2 767	2 649.7	0	25	23.9	Community transmission
Saint Martin	31	1 612	4 169.8	0	12	31.0	Community transmission
Turks and Caicos Islands	28	2 200	5 682.1	1	15	38.7	Clusters of cases
Cayman Islands	17	468	712.1	0	2	3.0	Sporadic cases
Bermuda	13	735	1 180.3	0	12	19.3	Sporadic cases
Sint Maarten	12	2 078	4 845.9	0	27	63.0	Community transmission
Anguilla	3	21	140.0	0	0	0.0	Sporadic cases
British Virgin Islands	0	154	509.3	0	1	3.3	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
Falkland Islands (Malvinas)	0	51	1 464.3	0	0	0.0	No cases
Montserrat	0	20	400.1	0	1	20.0	Sporadic cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	No cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	251 375	6 860 070	938.7	2 955	150 173	20.5	
Iran (Islamic Republic of)	65 890	1 739 360	2 070.8	630	61 142	72.8	Community transmission
Jordan	47 585	469 000	4 596.6	385	5 285	51.8	Community transmission
Iraq	31 129	754 318	1 875.4	171	13 719	34.1	Community transmission
Lebanon	22 151	415 362	6 085.5	321	5 334	78.1	Community transmission
United Arab Emirates	16 169	424 405	4 291.1	78	1 388	14.0	Community transmission
Pakistan	13 808	602 536	272.8	310	13 476	6.1	Community transmission
Kuwait	9 032	208 460	4 881.3	45	1 165	27.3	Community transmission
Libya	6 161	143 643	2 090.5	112	2 348	34.2	Community transmission
Egypt	4 358	190 280	185.9	302	11 256	11.0	Clusters of cases
Bahrain	4 278	130 404	7 663.7	12	481	28.3	Clusters of cases
Tunisia	4 229	241 257	2 041.3	192	8 359	70.7	Community transmission
Qatar	3 292	169 767	5 892.5	3	265	9.2	Community transmission
Morocco	2 658	488 632	1 323.8	42	8 718	23.6	Clusters of cases
Oman	2 361	145 257	2 844.5	17	1 600	31.3	Community transmission
Saudi Arabia	2 234	381 708	1 096.4	32	6 556	18.8	Sporadic cases
Somalia	905	8 946	56.3	55	349	2.2	Community transmission
Syrian Arab Republic	476	16 401	93.7	36	1 094	6.3	Community transmission
Yemen	327	2 775	9.3	33	684	2.3	Community transmission
Sudan	266	30 873	70.4	29	1 940	4.4	Community transmission
Afghanistan	138	55 985	143.8	8	2 457	6.3	Clusters of cases
Djibouti	118	6 252	632.8	0	63	6.4	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
Territoriesⁱⁱⁱ							
occupied Palestinian territory	13 810	234 449	4 595.8	142	2 494	48.9	Community transmission
Europe	1 236 697	41 043 949	4 397.2	20 977	906 843	97.2	
France	161 159	3 975 989	6 091.3	1 828	89 800	137.6	Community transmission
Italy	155 076	3 201 838	5 295.6	2 303	101 881	168.5	Clusters of cases
Poland	111 718	1 906 632	5 037.8	1 893	47 178	124.7	Community transmission
Turkey	96 782	2 866 012	3 398.2	456	29 421	34.9	Community transmission
Czechia	77 747	1 399 078	13 064.5	1 509	23 226	216.9	Community transmission
Germany	69 063	2 569 245	3 066.5	1 471	73 371	87.6	Community transmission
Russian Federation	67 832	4 390 608	3 008.6	2 990	92 090	63.1	Clusters of cases
Ukraine	59 528	1 460 756	3 340.1	1 281	28 303	64.7	Community transmission
Hungary	50 473	516 490	5 346.5	1 079	16 952	175.5	Community transmission
The United Kingdom	40 477	4 253 824	6 266.1	1 045	125 464	184.8	Community transmission
Netherlands	35 811	1 151 180	6 718.3	243	16 045	93.6	Community transmission
Romania	30 331	855 326	4 446.1	585	21 439	111.4	Community transmission
Serbia	29 654	512 051	7 353.1	152	4 694	67.4	Community transmission
Sweden	23 431	712 527	7 055.2	30	13 146	130.2	Community transmission
Belgium	19 397	808 283	6 974.2	167	22 441	193.6	Community transmission
Austria	18 468	488 007	5 418.4	123	8 652	96.1	Community transmission
Spain	18 078	3 183 704	6 809.4	308	72 258	154.5	Community transmission
Bulgaria	18 067	277 878	3 999.1	641	11 234	161.7	Clusters of cases
Greece	15 543	219 521	2 106.1	333	7 038	67.5	Community transmission
Slovakia	14 113	337 503	6 181.8	692	8 528	156.2	Clusters of cases
Estonia	9 804	84 807	6 393.1	66	719	54.2	Clusters of cases
Republic of Moldova	9 105	203 710	5 049.9	203	4 294	106.4	Community transmission
Israel	7 903	806 257	9 314.9	62	5 925	68.5	Community transmission
Belarus	6 896	301 328	3 188.9	58	2 087	22.1	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
Bosnia and Herzegovina	6 720	143 218	4 365.3	241	5 488	167.3	Community transmission
Switzerland	5 937	567 967	6 562.6	37	9 359	108.1	Community transmission
Denmark	5 592	219 918	3 796.8	13	2 390	41.3	Community transmission
North Macedonia	5 275	112 107	5 381.0	115	3 300	158.4	Community transmission
Kazakhstan	5 194	273 521	1 456.7	67	3 456	18.4	Clusters of cases
Slovenia	4 765	199 855	9 613.3	26	4 218	202.9	Clusters of cases
Albania	4 735	116 813	4 059.1	112	2 030	70.5	Clusters of cases
Norway	4 547	78 040	1 439.5	7	639	11.8	Community transmission
Croatia	4 531	251 045	6 115.2	87	5 677	138.3	Community transmission
Portugal	4 304	813 716	7 980.2	157	16 669	163.5	Clusters of cases
Finland	3 943	66 006	1 191.3	19	786	14.2	Community transmission
Armenia	3 706	178 385	6 019.9	34	3 255	109.8	Community transmission
Ireland	3 659	226 358	4 584.2	115	4 534	91.8	Community transmission
Montenegro	3 502	83 690	13 325.0	55	1 122	178.6	Clusters of cases
Latvia	3 475	93 484	4 956.2	70	1 757	93.2	Community transmission
Azerbaijan	3 327	239 692	2 364.0	38	3 276	32.3	Clusters of cases
Lithuania	3 171	205 385	7 544.6	68	3 396	124.7	Community transmission
Cyprus	2 702	39 277	3 253.1	6	238	19.7	Clusters of cases
Georgia	2 138	274 989	6 893.4	72	3 648	91.4	Community transmission
Malta	2 051	26 267	5 948.9	21	350	79.3	Clusters of cases
Luxembourg	1 194	57 700	9 217.6	31	688	109.9	Community transmission
Uzbekistan	391	80 567	240.7	0	622	1.9	Clusters of cases
Kyrgyzstan	300	86 850	1 331.2	10	1 481	22.7	Clusters of cases
Andorra	209	11 228	14 531.8	0	112	145.0	Community transmission
San Marino	204	4 126	12 157.5	1	77	226.9	Community transmission
Monaco	88	2 106	5 366.4	1	27	68.8	Sporadic cases
Iceland	13	6 072	1 779.4	0	29	8.5	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
Liechtenstein	10	2 678	7 022.1	0	54	141.6	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
Territoriesⁱⁱⁱ							
Kosovo ^[1]	4 048	76 505	4 112.3	56	1 686	90.6	Community transmission
Isle of Man	486	1 092	1 284.2	0	25	29.4	No cases
Gibraltar	19	4 263	12 653.2	0	93	276.0	Clusters of cases
Faroe Islands	3	661	1 352.7	0	1	2.0	Sporadic cases
Jersey	2	3 222	2 961.4	0	69	63.4	Community transmission
Greenland	0	31	54.6	0	0	0.0	No cases
Guernsey	0	821	1 299.1	0	14	22.2	Community transmission
South-East Asia	199 924	13 884 294	686.9	2 141	212 355	10.5	
India	148 249	11 359 048	823.1	851	158 607	11.5	Clusters of cases
Indonesia	40 905	1 414 741	517.2	1 175	38 329	14.0	Community transmission
Bangladesh	6 512	556 236	337.7	76	8 527	5.2	Community transmission
Sri Lanka	2 264	87 600	409.1	33	526	2.5	Clusters of cases
Maldives	719	21 382	3 955.6	0	64	11.8	Clusters of cases
Thailand	557	26 927	38.6	1	86	0.1	Clusters of cases
Nepal	523	275 178	944.4	4	3 014	10.3	Clusters of cases
Myanmar	136	142 136	261.2	1	3 201	5.9	Clusters of cases
Timor-Leste	59	178	13.5	0	0	0.0	Clusters of cases
Bhutan	0	868	112.5	0	1	0.1	Sporadic cases
Western Pacific	49 553	1 711 830	87.1	720	30 357	1.5	
Philippines	25 473	616 611	562.7	301	12 766	11.6	Community transmission
Malaysia	10 632	322 409	996.1	40	1 206	3.7	Clusters of cases
Japan	7 917	446 873	353.3	333	8 560	6.8	Clusters of cases
Republic of Korea	3 164	95 635	186.5	35	1 669	3.3	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
Mongolia	672	3 833	116.9	2	4	0.1	Clusters of cases
Papua New Guinea	590	2 173	24.3	5	21	0.2	Community transmission
Cambodia	318	1 305	7.8	1	1	0.0	Sporadic cases
China	269	102 333	7.0	1	4 849	0.3	Clusters of cases
Australia	82	29 112	114.2	0	909	3.6	Clusters of cases
Singapore	68	60 088	1 027.1	1	30	0.5	Sporadic cases
Viet Nam	44	2 553	2.6	0	35	0.0	Clusters of cases
New Zealand	24	2 067	42.9	0	26	0.5	Clusters of cases
Brunei Darussalam	3	192	43.9	0	3	0.7	Sporadic cases
Fiji	3	66	7.4	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	2	49	0.7	0	0	0.0	Sporadic cases
Solomon Islands	0	18	2.6	0	0	0.0	No cases
Territoriesⁱⁱⁱ							
Wallis and Futuna	166	176	1 565.0	0	0	0.0	Sporadic cases
French Polynesia	68	18 527	6 595.4	1	141	50.2	Sporadic cases
New Caledonia	33	91	31.9	0	0	0.0	Sporadic cases
Guam	18	7 558	4 478.2	0	133	78.8	Clusters of cases
Northern Mariana Islands (Commonwealth of the)	5	150	260.6	0	2	3.5	Pending
Vanuatu	2	3	1.0	0	0	0.0	No cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Samoa	0	4	2.0	0	0	0.0	No cases
Global	3 033 213	119 212 530	1 529.4	58 698	2 642 612	33.9	

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

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

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Albania			
Angola	Verified		Verified
Argentina		Verified	Verified
Aruba			Verified
Australia	Verified		Verified
Austria	Verified		Verified
Bahrain			
Bangladesh			Verified
Barbados			Verified
Belarus			
Belgium	Verified	Verified	Verified
Belize			Verified
Bonaire			Verified
Bosnia and Herzegovina			Not Verified
Botswana	Verified		
Brazil		Verified	Verified
Brunei Darussalam	Verified		
Bulgaria			Verified
Cabo Verde			Verified
Cambodia			Verified
Cameroon	Verified		
Canada	Verified	Verified	Verified
Cayman Islands			Verified
Chile		Verified	Verified
China	Verified	Not Verified	Verified
Colombia		Verified	
Comoros	Verified		

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Costa Rica	Verified		Verified
Croatia	Not Verified		Verified
Cuba	Verified		
Curaçao			Verified
Cyprus			Verified
Czechia	Not Verified		Verified
Democratic Republic of the Congo			Not Verified
Denmark	Verified	Verified	Verified
Dominican Republic			Verified
Ecuador			Verified
Estonia	Not Verified		Verified
Faroe Islands		Verified	
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana		Verified	Verified
French Polynesia			Verified
Gambia			Verified
Georgia			Verified
Germany	Verified	Verified	Verified
Ghana	Verified		Verified
Gibraltar			Not Verified
Greece	Verified		Verified
Guadeloupe			Verified
Hungary	Not Verified		Verified
Iceland			Verified
India	Verified	Verified	Verified
Indonesia			Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Iran (Islamic Republic of)			Verified
Iraq			Verified
Ireland	Verified	Not Verified	Verified
Israel	Verified		Verified
Italy	Not Verified	Verified	Verified
Jamaica			Verified
Japan	Verified	Verified	Verified
Jordan			Verified
Kenya	Verified		
Kosovo ^[1]			Verified
Kuwait			Verified
Latvia			Verified
Lebanon			Verified
Libya			Verified
Liechtenstein			Verified
Lithuania			Verified
Luxembourg	Verified		Verified
Malawi	Verified		
Malaysia			Verified
Malta	Not Verified		Verified
Martinique			Verified
Mayotte	Verified		Verified
Mexico		Verified	Verified
Monaco			
Montenegro			Verified
Morocco			Verified
Mozambique	Verified		
Namibia	Verified		
Nepal			Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Netherlands	Verified	Verified	Verified
New Caledonia			
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	Verified	Verified
Poland	Not Verified		Verified
Portugal	Verified	Not Verified	Verified
Puerto Rico			Verified
Republic of Korea	Verified	Verified	Verified
Republic of Moldova			
Réunion	Verified	Verified	Verified
Romania	Verified	Verified	Verified
Russian Federation			Verified
Saint Barthélemy			Verified
Saint Lucia			Verified
Saint Martin			Verified
Saudi Arabia			Verified
Senegal			Verified
Serbia			Verified
Singapore			Verified
Slovakia	Not Verified		Verified
Slovenia	Verified		Verified

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
South Africa	Verified		Verified
Spain	Verified	Verified	Verified
Sri Lanka			Verified
Sweden	Verified	Not Verified	Verified
Switzerland	Verified	Not Verified	Verified
Thailand	Verified		Verified
The United Kingdom	Verified	Verified	Verified
Trinidad and Tobago			Verified
Tunisia			Verified
Turkey	Not Verified	Not Verified	Verified
Turks and Caicos Islands			Verified

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

Country/Territory/Area	501Y.v2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Ukraine			Not Verified
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania	Not Verified		
United States of America	Verified	Verified	Verified
Uruguay			Verified
Uzbekistan			Verified
Venezuela (Bolivarian Republic of)		Verified	
Viet Nam	Verified		Verified
Wallis and Futuna			
Zambia	Verified		
Zimbabwe	Verified		

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

16 March 2021

Issue No. 46



Confirmed cases^a

119 791 453

Confirmed deaths

2 652 966

Four countries in WHO South-East Asia Region (SEAR) get COVID-19 vaccines from COVAX Facility

The pace of COVID-19 vaccine deliveries continues as shipments from the COVAX Facility arrived in four WHO SEAR countries. Maldives, Nepal and Sri Lanka received over 620 000 doses of AstraZeneca/Oxford vaccine produced by Serum Institute of



Credit:WHO/SEARO

India on 7 March, and Indonesia welcomed its consignment of 1.1 million doses on 8 March according to Regional Office of SEAR.

Dr Poonam Khetrpal Singh, Regional Director, WHO South-East Asia Region noted “Equitable distribution of COVID-19 vaccines has been at the heart of the COVAX initiative, so that no country is left behind” yet, she continued “While vaccines are a critical tool, we need to remember that we also need to continue practising COVID appropriate behaviours to protect us as we live through this pandemic”.

The vaccines through COVAX Facility are expected to boost previous COVID-19 vaccination campaigns in the Region which has already benefitted nearly 25 million people. WHO and COVAX partners have been working closely with countries by training health workers and vaccinators, assessing and addressing gaps for planning, and managing and monitoring the activities during vaccination campaigns.

For further information, click [here](#).

Key Figures



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



159 GOARN deployments conducted to support COVID-19 pandemic response



20 070 365 respirators shipped globally



198 733 426 medical masks shipped globally



8 653 511 face shields shipped globally



37 070 700 gloves shipped globally



105 countries, territories, and areas sharing National Deployment and Vaccination Plans (NDVPs) via Partners Platform



More than **5 million** people registered on [OpenWHO](#) and accessing online training courses across **29** topics in **50** languages

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



**World Health
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HEALTH
EMERGENCIES
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From the field:

COVID-19 vaccines shipped by COVAX arrive in Fiji



Fiji became the first country in the Pacific islands to receive COVID-19 vaccine doses shipped via the COVAX Facility, a partnership between CEPI, Gavi, UNICEF and WHO.

This is a historic step towards achieving the goal to ensure equitable distribution of COVID-19 vaccines globally in what will be the largest vaccine procurement and supply operation in history.

According to the Regional Office of the Western Pacific, the arrival of 12 000 doses of the AstraZeneca/Oxford COVID-19 vaccine marks the first batch of vaccines to arrive in the Pacific region under the COVAX Facility, in its unprecedented effort to deliver at least two billion doses of COVID-19 vaccines by the end of 2021.

“WHO is proud to play our part in achieving this milestone in Fiji” said the Acting WHO South Pacific Representative, Dr. Akeem Ali. “I would like to acknowledge the hard work by the Ministry of Health & Medical Services team in preparing for the arrival of vaccines, from identifying priority groups, developing tracking systems to upskilling their staff to be able to safely deliver this vaccine. This arrival means that frontline workers and high-risk populations can begin to be vaccinated. WHO will continue to work alongside our colleagues from the Ministries of Health in Fiji and across the Pacific to continue to plan for their use of COVID-19 vaccines.”

The Fijian Ministry of Health and Medical Services is targeting frontline staff in line with global recommendations. This will include frontline healthcare workers, selected Fiji Airways staff; Airports Fiji Limited staff; Fiji Immigration Department; along with quarantine workers as the recipients of this first batch of vaccines to support the opening of Fiji borders.

Fiji, like other countries, will continue to apply tried-and-tested measures to successfully prevent and control transmission, such as physical distancing, ventilation and hand hygiene, alongside robust programmes to test, trace, isolate and treat.

For more information on the rollout of vaccines in Fiji, click [here](#).

From the field:

The Republic of Moldova is the first country the WHO European Region to receive COVID-19 vaccine through the COVAX facility

The Republic of Moldova is the first country in the WHO European Region to receive vaccines as part of the COVAX Facility global procurement mechanism. During the pandemic, over 180 000 Moldovans have been infected with the virus that causes COVID-19 and over 4000 have lost their lives because of it.

Showing strong bilateral solidarity with its neighbor, Romania previously donated doses of the AstraZeneca/Oxford COVID-19 vaccine to the Republic of Moldova on 27 February 2021, allowing the country to start vaccinating frontline health workers on 2 March.

On 4 March, the Republic of Moldova received a further 14 400 doses of AstraZeneca/Oxford vaccine, via the COVAX Facility, according to the Regional Office for Europe.

In anticipation of the arrival of the COVAX shipment, from 25 February to 5 March the WHO Country Office in the Republic of Moldova carried out a series of trainings and exercises with health care workers allowing them to familiarize themselves with immunization service delivery and COVID-19 immunization specific to the AstraZeneca/Oxford COVID-19 vaccine.



*COVAX shipment of vaccines to the Republic of Moldova.
Credit: WHO*

Trainings for the National Agency for Public Health were also conducted by the WHO Regional Office for Europe on surveillance and response to Adverse Events Following Immunization (AEFI). WHO also previously supported a readiness COVID-19 simulation exercise in the Republic of Moldova to prepare for vaccine deployment, described in the [22 February Issue](#).

This COVAX delivery is part of a first wave of arrivals in the Republic of Moldova, which will continue in the coming weeks, with the goal of vaccinating 20% of the population. As part of future waves of deliveries, the Republic of Moldova anticipates that the COVAX Facility will deliver 24 570 doses of Pfizer/BioNTech COVID-19 vaccine and up to 264 000 doses of AstraZeneca/Oxford COVID-19 vaccine to the Republic of Moldova in 2021.

For further information, click [here](#).

From the field:

COVID-19 Vaccines bring hope to Afghanistan

This time last year, Afghanistan had recorded 7 cases of COVID-19 and was racing against the clock to contain and respond to the rapidly evolving health crisis. On 8 March 2021, a monumental step was made as Afghanistan received its first COVAX shipment, one of the first countries to receive a delivery in the Eastern Mediterranean Region.

According to the WHO Country Office of Afghanistan, this shipment contained 468 000 doses of AstraZeneca/Oxford COVID-19 vaccines produced by the Serum Institute of India as well as 470 000 syringes and 4700 safety boxes, enabling the vaccination of priority group individuals including health workers, teachers and security personnel.

Over the past few months, WHO has supported the Government of Afghanistan in the planning and implementation of the vaccine rollout. To ensure the country is adequately prepared for the vaccine deployment, WHO worked closely with the Ministry of Public Health to support the development of a comprehensive vaccination strategy, including a vaccine distribution plan, training 1000 health workers on carrying out vaccinations and ensuring availability of systems for the surveillance of adverse effects.



Credit: WHO Country Office Afghanistan

To boost capacity, over 2000 newly recruited vaccinators are planned to attend WHO-supported training this month. Afghanistan has already begun vaccination activities through a February vaccine donation from the Government of India with 37 400 health workers already vaccinated. This COVAX shipment arrives at an opportune time to proceed uninterrupted with the vaccination campaign. Afghanistan will await the arrival of the remaining COVAX shipments to ensure minimum vaccination coverage of 20% of the population.

Dr David Lai, WHO Officer In Charge noted “vaccines only work when they are combined with public health strategies. We did not get here in one day and we won’t get out in one day either but today our hope is renewed. The endgame is clear. However, Afghanistan will need continued support from the international community to ensure the country which is already affected by decades-long conflict and insecurity doesn’t get left behind in the race to end COVID-19.”.

For further information, click [here](#).

From the field:

Djibouti receives COVID-19 vaccines through the COVAX Facility

Djibouti is among the first countries in the Eastern Mediterranean Region to receive COVID-19 vaccines following the arrival at Djibouti International Airport of a shipment of AstraZeneca/Oxford vaccine doses manufactured by the Serum Institute of India (SII), according to the Regional Office for the Eastern Mediterranean. The vaccines were delivered through the COVAX Facility that ensures fair and equitable distribution of COVID-19 vaccines to countries regardless of their income.

The delivery follows the arrival of a quantity of syringes, part of a Gavi-funded and supported global stockpile, delivered on behalf of the COVAX Facility on 27 February 2021.



Credit: WHO Country Office Djibouti

WHO has worked with national authorities to put a vaccination strategy in place that includes training vaccinators, ensuring vaccine safety, and surveillance for adverse effects. This first shipment of vaccines will support the vaccination of health care workers, people over 50 years of age and people with comorbidities.

For further information, click [here](#)

International Women's Day 2021: More women in leadership needed in the fight against COVID-19

"We need women not only on the frontlines but also in leadership" said the Director of the Pan American Health Organization (PAHO) Carissa F. Etienne, marking International Women's Day. "Women make up the great majority of health care workers but are underrepresented in global and national health leadership."

Across the Americas, nine out of ten nurses are women while only 25 percent of executive positions in hospitals are held by women. COVID-19 has swept across the Americas, infecting over 52 million people and killing more than 1.2 million. One million health workers have been infected by COVID-19, of whom 4000 have died, two thirds of them women.



Credit: PAHO

The pandemic has also affected women differently. There has been increasing domestic violence against women as they spend more time at home with their partners. Women have shouldered the burden of trying to hold down jobs while caring for children at home because of public health measures.

"We urge countries to develop policies not only for women but by women" Dr Etienne said.

For further information, click [here](#).

Challenging barriers women face accessing life-saving knowledge for COVID19 response: International Women's Day (IWD) 2021 #LearningSavesLives Series Webinar

The COVID-19 pandemic dramatically highlights the need of every frontline health worker, no matter how remote or isolated, to access life-saving knowledge and learning opportunities. As we look forward, reaching the light at the end of the tunnel of the pandemic will require decisive efforts to ensure that existing inequities are effectively tackled, especially those against women. While women make up 70% of the global health and social care workforce, they are often underpaid or unpaid. And while their contribution is outsized, women constitute less than 25% of leadership roles in health, thus limiting their contributions to decision and policy making.

The OpenWHO platform provides knowledge while offering the benefits of no cost, informative, easily accessible, simple and suitable for everyone. The COVID-19 pandemic has increasingly brought more women to the [OpenWHO](#) platform. Prior to the pandemic about 70-80% of learners in all courses were men, whereas now the learner enrolment is equal between women and men.

Yet, a survey among OpenWHO users conducted the first week in March 2021 found that among the top five challenges to access, female respondents were still twice as likely to choose time and cost compared to male respondents.



Credit: WHO / Christopher Black

During the IWD webinar, with 800 attendees from all WHO Regions, speakers #ChoseToChallenge the many barriers women face to access lifesaving information, training and learning. **“There has to be a place for women at every decision-making table. Women are not only doers, they need to shape the environment in which we are moving forwards”** said Dr Gaya Gamhewage, Head of Learning and Capacity Development, Health Emergencies Programme, World Health Organization.

Click here for the [Webinar video](#). Register for the Series' next Webinar [here](#).

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.



5 001 632
Course
enrollments

50 languages

29 topical courses

Over 2.7 million certificates



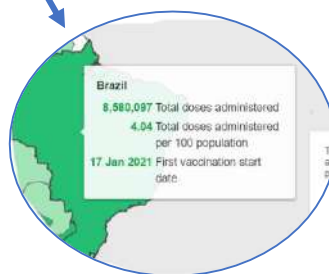
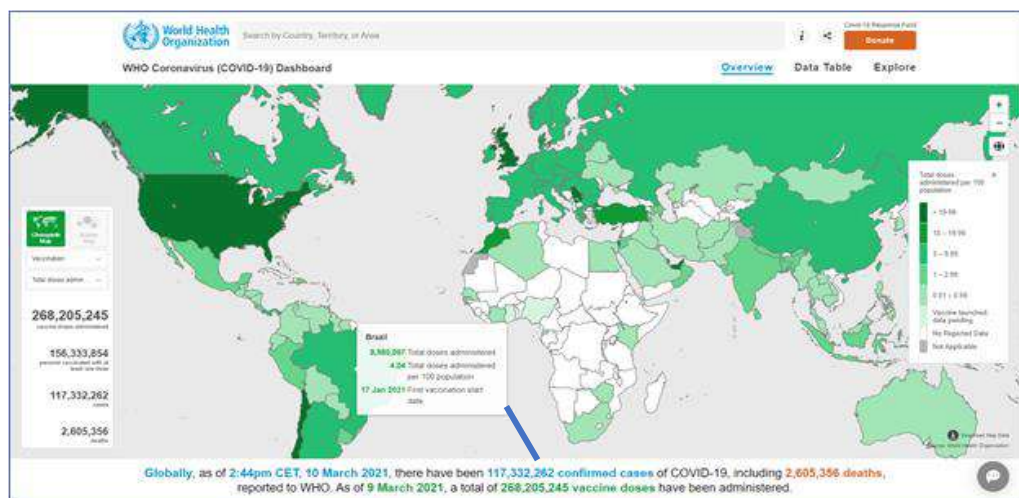
Vaccination data now available on the WHO COVID-19 Dashboard

In 2021 there have been massive multisectoral efforts to begin COVID-19 vaccination campaigns in full force around the globe. To better track and transparently share the status and progress countries are making in their COVID-19 vaccination efforts, WHO has begun collecting global vaccination data.

On 4 March 2021, vaccination data were published on the [WHO COVID-19 Dashboard](#). These data are viewed by selecting “Vaccination” from the dropdown panel on the left-hand side of the map.

Currently, the dashboard incorporates information useful to track global vaccine rollout, including total vaccination doses administered, persons vaccinated with at least one dose, and start date of vaccinations, by country, territory and area. More features, such as specifics on vaccine products authorized and administered by countries, will be added in the near future.

In collaboration with WHO Regional Offices, vaccination data will be updated at least once weekly using official reports from Member States, supplemented by publicly available data (for further source information, see [here](#)). For data on first use of vaccines in countries, the data aim to be updated in real time.



COVID-19 Preparedness

Consultative meeting on Joint External Evaluations (JEE) and State Party Self-Assessment Annual Reports (SPAR) to incorporate the lessons learnt from COVID-19 Pandemic

Recent reports of the IHR Review Committee, the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, and the Global Preparedness Monitoring Board have highlighted the need to refine and improve existing preparedness assessment tools, including incorporating lessons learnt from the COVID-19 pandemic. This was also mentioned in the resolution on '*Strengthening Preparedness for Health Emergencies; the Implementation of the IHR*' adopted at the 73rd World Health Assembly.

In follow-up to these recommendations, WHO conducted a virtual consultative meeting from 9 to 10 March 2021 to examine and incorporate lessons from COVID-19, in order to enhance preparedness assessments tools, including the SPAR, JEE and other components of the International Health Regulations (IHR) Monitoring and Evaluation Framework. The meeting was attended by over 180 participants from all WHO Regions including Member States, the three levels of WHO and partners.



First day of the Consultative meeting on SPAR and JEE / WHO

In his welcome remarks, Assistant Director General for Emergency Preparedness, Dr Jaouad Mahjour reminded participants of how COVID-19 and other recent health emergencies have shown that the world remains inadequately prepared to respond effectively to large scale epidemics and pandemics. Many countries have had significant gaps in capacities, leading to the widespread impact seen across the world. He underscored the importance of national planning and the fundamental links between preparedness assessments and capacity building. Dr Stella Chungong, Director of Health Security Preparedness, provided an overview of how the upcoming Universal Health Peer Review, a multisectoral intergovernmental peer review process built on mutual trust and accountability, [introduced by Director-General Dr Tedros Adhanom Ghebreyesus](#) at the 73rd World Health Assembly, would relate to the IHR monitoring and evaluation tools and other country assessment processes.

Participants shared experiences and lessons from COVID-19 preparedness and response from national, regional and partners perspectives, and provided recommendations for improvements needed in preparedness capacities and assessment tools, and the need to bridge the gap between assessments and capacity development.

A meeting report will be published once ready, and technical working groups will be established to further take forward the issues and possible approaches raised at the meeting.

COVID-19 Preparedness

COVID-19 Response Missions in the Eastern Mediterranean Region

To provide continuous tailored support to countries to strengthen the COVID-19 response at national, subnational, and community levels, the Regional Office for the Eastern Mediterranean Region (EMR) organized technical missions to Afghanistan, Pakistan, Tunisia, and Lebanon since September 2020. These modified and enriched Intra-Action Review (IAR) Missions included field visits and supported Ministries of Health in reviewing the COVID-19 response, documenting strengths, identifying areas of improvement, and providing recommendations to address gaps.

Key strengths identified from national responses to the COVID-19 pandemic include preparedness initiatives (e.g. COVID-19 National Taskforce in Lebanon) and utilizing existing systems such as for surveillance (e.g. polio systems in Afghanistan and Pakistan).

A whole-of-government approach and strong multisectoral coordination was also a main strength (e.g. Ministry of Health leadership, engagement of public and private sectors and UN agencies in Lebanon and Tunisia). Public health and social

measures contributed to decreasing transmission rates in the early phase of the pandemic (e.g. flights suspension and school closure in Lebanon; control measures after detecting the first cases in Tunisia) and diagnostic capacities were expanded in all four countries.

Health systems in many EMR countries were already fragile due to complex emergencies, causing challenges in maintaining essential health services. Consequently, countries visited had included this in their response, such as by developing a guide, facilitated by WHO, for service continuity in Pakistan. Another challenge identified was the implementation of control measures at points of entry, particularly during border reopening after the lifting of restrictive measures.

After each mission, key recommendations and findings were shared with the Region's Incident Management Support Team and WHO Representatives during mission briefings. Mission reports laid out recommendations which will be integrated into the EMR's 2021 Strategic Preparedness and Response Plan (SPRP) to ensure all EMR countries benefit from the lessons learned. Several missions are planned for 2021, with objectives adapted to the evolving COVID-19 situation and vaccine rollout, to continue strengthening the COVID-19 response across the Region.



Marwa Kamel, WHO Consultant visiting the Syrian refugee camp in Aarsal to review COVID-19 Risk Communication and Community Engagement activities for vulnerable high-risk groups during WHO mission to Lebanon / Credit: WHO Country Office Lebanon

COVID-19 Preparedness

WHO Safe Hospital Webinar Series: COVID-19 Management in Hospitals

The second webinar of the [WHO Safe Hospital Webinar Series: COVID-19 Management in Hospitals](#) organized by WHO in collaboration with the International Hospital Federation (IHR) and the UN Office for Disaster Risk Reduction (UNDRR) took place on 25 February 2021. The theme of the webinar was ‘Hospitals and National Strategic Plans for Emergencies and Disasters’. Multiple speakers from different countries shared innovative practices and experiences that have supported COVID-19 preparedness and response in hospital settings to facilitate exchange of lessons learned.

The WHO Country Representative, Nepal and the Chief of the national public health emergency operations centre (PHEOC) highlighted how the country's previous experience of managing earthquakes and other emergencies has informed aspects of COVID-19 response, including the coordination at all levels of government through EOC, supported by WHO and partners, and the designation of key national hospitals as “hubs” to support ‘satellite’ hospitals at the province and district levels.

A representative of the Sao Joao Hospital, Portugal, shared approaches for preparing the workforce by rapidly facilitating knowledge-transfer, updating national COVID-19 management guidelines to local contexts using the ‘Cascade-Training Model’, how testing in-patients every 5-days significantly reduced the risk of nosocomial-infection and how deployment of the health staff in-proportion to the activation of the COVID-19 response plan reduced levels of staff burn-out.



The Director of the International Center for Collaborative Research on DRR in Wuhan, China explained the whole-of-government approach and the ‘paired-assistance’ programme, which augmented health-workforce (HWF) deployment in hard-hit cities using dynamic risk-assessment-and-zoning that was instrumental in the deployment of 40 000 HWF within 20 days of the outbreak in Wuhan. Following that, WHO presented the [suite of health service capacity assessments in the context of COVID-19](#) that can be used to support rapid and accurate assessments of the current, surge and future capacities of health facilities throughout the different phases of the COVID-19 pandemic. The presentation included an overview of how the tools can be used in different context to scale up health facility capacities for COVID-19 risk management.

The next webinar in the series on 18 March 2021 will focus on [“Long-term care facilities and long-term care services in hospitals during a pandemic”](#).



COVID-19 Partners platform

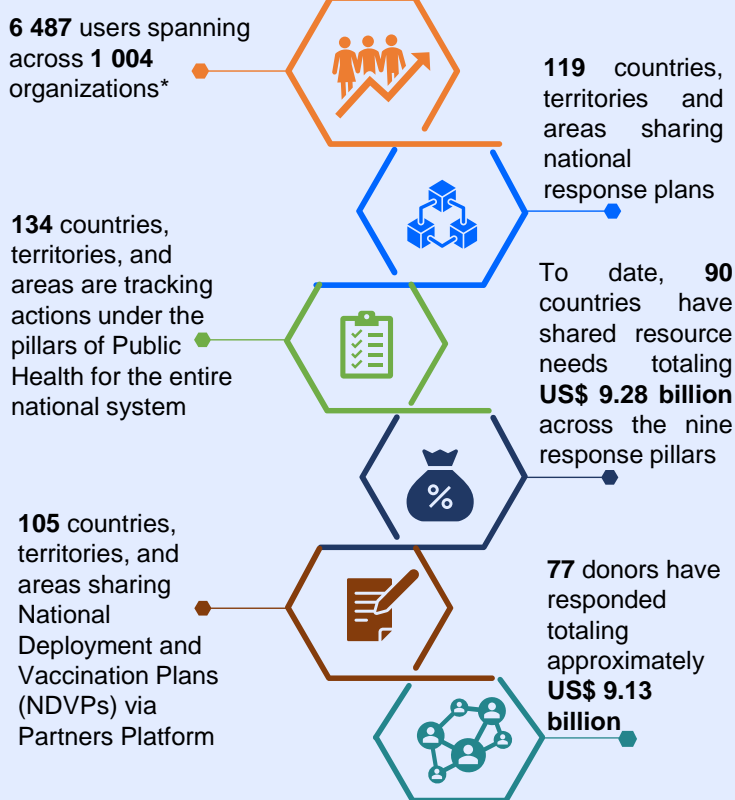
The Partners Platform continues to adapt its functionalities as WHO and its partners initiate and update components of the global response against COVID-19.

With the introduction of vaccines, the Partners Platform played a leading role in streamlining the application process for countries and donors participating in the COVAX facility.

Now, as the Strategic Preparedness and Response Plan (SPRP) for 2021 and its [Operational Planning Guideline](#) launch, building on last year's plan and a year of lessons learned to incorporate new objectives like countering misinformation and disinformation, and accelerating equitable access to new tools, the Partners Platform is working in parallel to integrate these objectives into the functionalities of its innovative digital space.

In early April, countries will be able, and are encouraged to update the national response plans to align with the 2021 SPRP Operational Planning Guideline.

2020 Strategic Preparedness and Response Plan (SPRP) and National Deployment and Vaccination Plan (NDVP) Achievements



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

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



Public health response and coordination highlights

At the UN Crisis Management Team (CMT) meeting on 10 March 2021, **WHO, UNESCO and UNICEF** briefed on the impact of the COVID-19 pandemic on education, including on the current situation of school closures.

WHO updated on the work of the Technical Advisory Group (TAG) of Experts on Educational Institutions and COVID-19, and highlighted the TAG's role in understanding the epidemiology of school transmission and leveraging research on educational institutions and COVID-19 to inform policy decisions.

In addition, **WHO** updated the CMT on COVID-19 vaccine roll out, noting that, globally, nine different vaccines are being administered across 129 economies and that of the 312 million doses administered to date, 78 per cent were in 10 countries.

WHO also informed that, as of 10 March, COVAX has shipped more than 30 million doses to 35 countries and COVAX currently has purchase orders for an additional 100 million doses for 70 countries.

The **UN Department of Operational Support (DOS)** updated on the work of inter-agency working group on COVID-19 vaccinations for UN staff, namely the development of a prioritization framework based on country risk/vulnerability and occupational and medical risks for personnel.

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

As of 12 March 2021, [The Solidarity Response Fund](#) has raised or committed more than US\$ 242 million from more than 662,000 donors.

The world has never faced a crisis like COVID-19. The pandemic is impacting communities everywhere. It's never been more urgent to support the global response, led by the World Health Organization (WHO).

More than **US\$ 242 Million**



662 000 donors

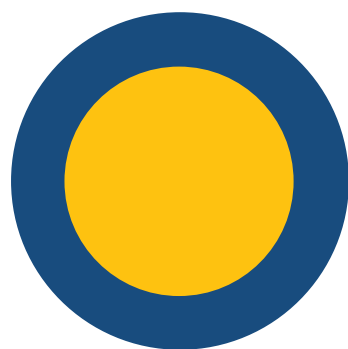
[individuals – companies – philanthropies]

Appeals

WHO's [Strategic Preparedness and Response Plan](#) (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 and health systems strengthening for the roll out of COVID-19 tools (ACT-A). Of the US\$ 1.96 billion appealed for, US\$ 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. US\$ 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.

SPRP 2021 Requirements US\$ 1.96 billion

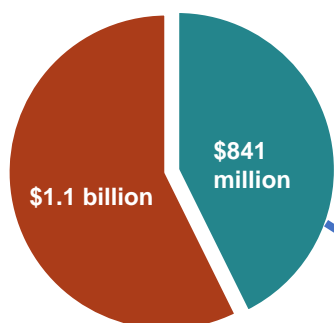


● Total WHO requirement under SPRP 2021

● Proportion of requirement attributed to ACT Accelerator*

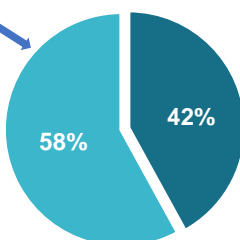
**Of the total US\$1.96 billion WHO requirement, US\$1.22 billion (62%) counts towards WHO's requirement for the Access to COVID-19 tools accelerator*

SPRP 2021 Requirement Progress (US\$)



■ Total funding received and pledged (42.9% of total requirement)

■ Gap against funding received and pledged



■ Total funding pledged

■ Total funding received

The 2021 SPRP priorities and resource requirements can be found [here](#).
The status of funding raised for WHO against the SPRP can be found [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 12 March 2021.

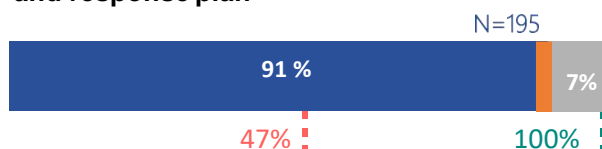
Shipped items as of 12 March 2021	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	718 250	3 718 135	1 855 696	1 473 890	10 594 300	214 610	1 727 279	53 453 400	2 768 630
Americas (AMR)	7 342 300	1 046 142	10 534 278	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	990 800	1 340 070	1 520 740	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	617 500	648 330	594 270	1 750 900	8 938 900	409 900	1 757 548	40 911 500	5 423 350
South East Asia (SEAR)	440 000	3 185 800	2 408 970	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		228 500	346 834	768 700	3 060 000	311 927	463 710	14 974 146	2 102 035
TOTAL	10 108 850	10 166 977	17 260 788	8 653 511	37 083 700	1 552 367	6 956 179	198 733 426	20 070 365

Note: Some EMR laboratory supplies have decreased from last week due to delays in shipments

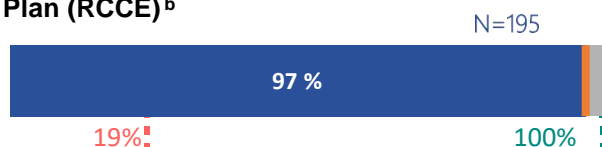
For further information on the **COVID-19 supply chain system**, see [here](#).

COVID-19 Global Preparedness and Response Summary Indicators^a

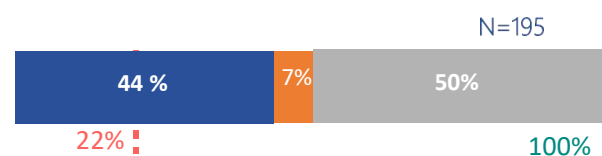
Countries have a COVID-19 preparedness and response plan



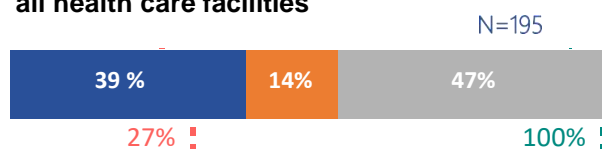
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE)^b



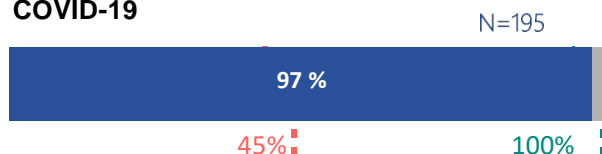
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



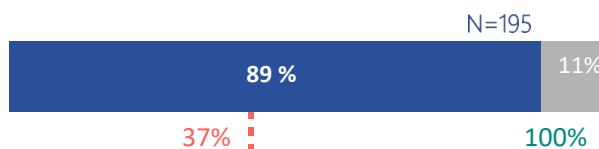
Countries with a national IPC programme & WASH standards within all health care facilities



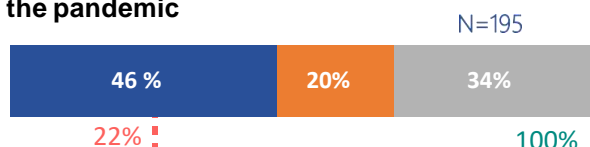
Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



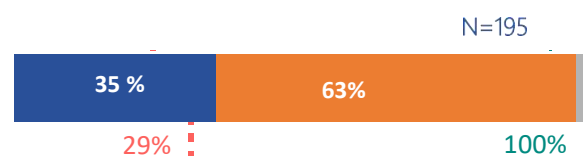
Countries have a clinical referral system in place to care for COVID-19 cases



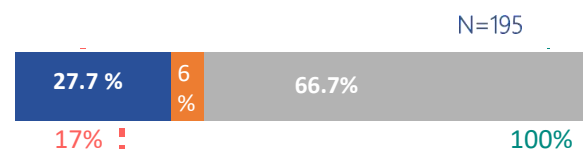
Countries that have defined essential health services to be maintained during the pandemic



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



Countries have a health occupational safety plan for health care workers



Countries have COVID-19 laboratory testing capacity



Legend



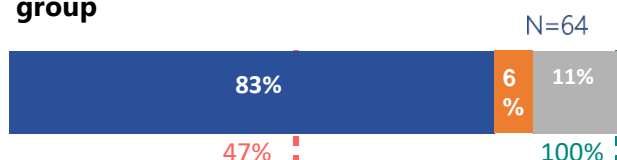
Notes:

^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

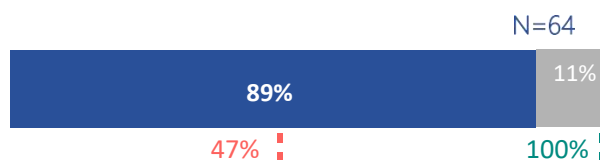
COVID-19 Global Preparedness and Response Summary Indicators

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



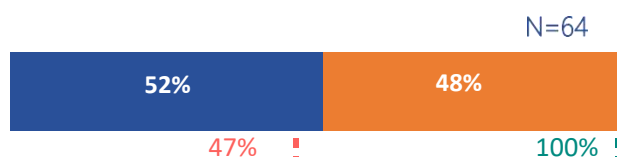
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19^c



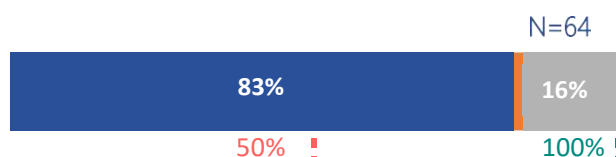
Priority countries with a contact tracing focal point



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



Legend

■ Yes

■ No

■ No information

--- Baseline value

--- Target value

Notes:

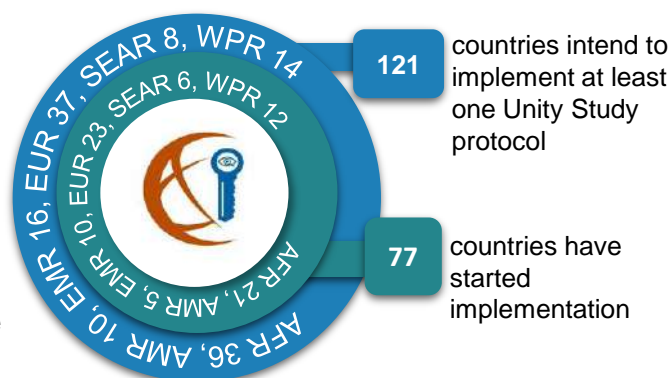
^c Source: WHO Immunization Repository

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.

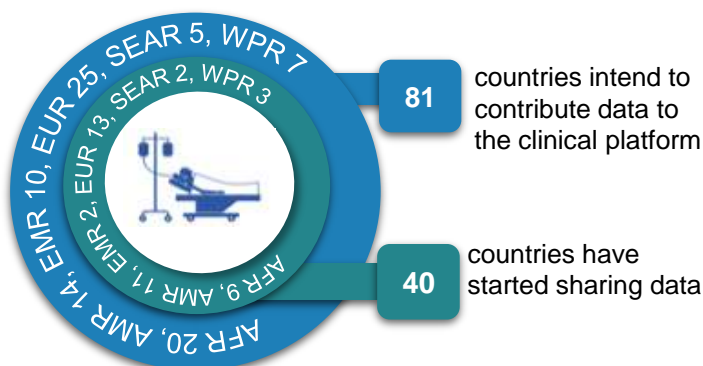
The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays



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.

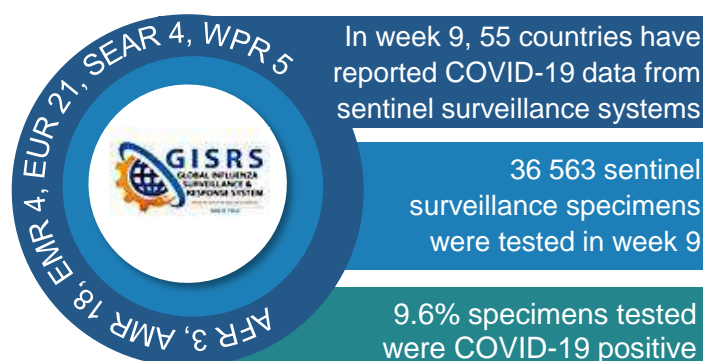
WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



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 SARS-COV-2





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 9 March **Weekly Epidemiological Update**, click [here](#). Highlights this week include:
 - Overviews of global and regional epidemiological situation
 - Special focus sections on:
 - Global Influenza Surveillance and Response System – best practices for integrating influenza and COVID-19 sentinel surveillance
 - SARS-CoV-2 sero-epidemiology in Kenya
 - SARS-CoV-2 variants of concern
- ❑ 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 7 March 2021, 10 am CET

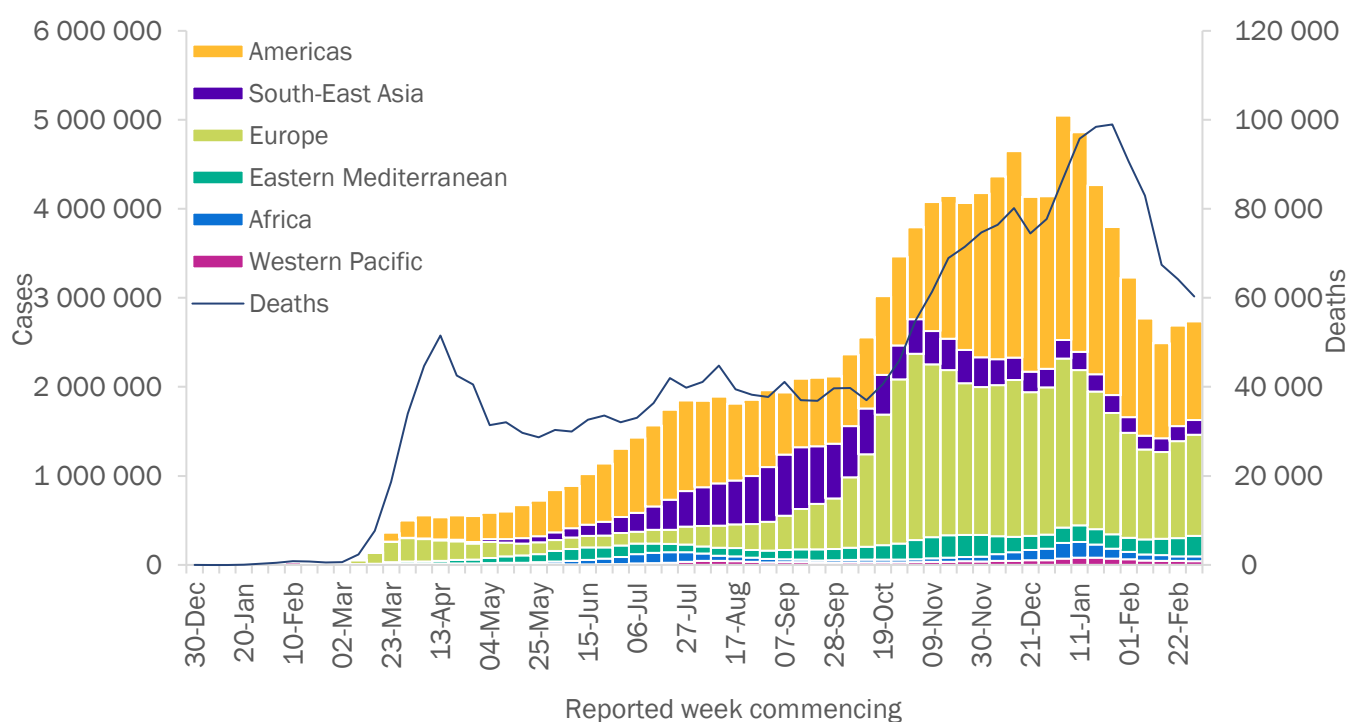
In this edition:

- [Global overview](#)
- [Special focus: Global Influenza Surveillance and Response System – best practices for integrating influenza and COVID-19 sentinel surveillance](#)
- [Special focus: SARS-CoV-2 sero-epidemiology in Kenya](#)
- [Special focus: SARS-CoV-2 variants of concern](#)
- [WHO regional overviews](#)
- [Key weekly updates](#)

Global overview

Over 2.7 million new cases were reported last week, a 2% increase compared to the previous week (Figure 1). The global case increase was driven by increases in the Eastern Mediterranean (10%), African Region (10%), and Europe (4%), while small declines were seen in the Americas (-2%), South-East Asia (-2%) and Western Pacific regions (-6%). Globally, around half of countries are seeing declines while the other half are experiencing increasing numbers of new cases. Global new deaths continued the downward trend observed since early February 2021, declining a further 6% compared to last week. Death rates declined in all regions except in the Eastern Mediterranean, where new deaths reported rose by 9%. The Americas and Europe account for around 80% of new cases and new deaths reported globally.

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



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

The highest numbers of new cases were reported from the United States of America (427 233 new cases; 10% decrease), Brazil (413 597 new cases; 11% increase), France (143 622 new cases; 4% decrease), Italy (138 937 new cases; 24% increase), and India (114 068 new cases; 9% increase).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 7 March 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	1 105 355 (40%)	-2%	51 531 438 (44%)	32 535 (54%)	-4%	1 237 781 (48%)
Europe	1 136 080 (42%)	4%	39 775 409 (34%)	20 770 (34%)	-6%	884 218 (34%)
South-East Asia	167 385 (6%)	-2%	13 684 394 (12%)	2 201 (4%)	-32%	210 214 (8%)
Eastern Mediterranean	228 543 (8%)	10%	6 616 840 (6%)	2 797 (5%)	9%	147 284 (6%)
Africa	55 341 (2%)	10%	2 895 549 (2%)	1 390 (2%)	-16%	73 381 (3%)
Western Pacific	41 677 (2%)	-6%	1 662 277 (1%)	630 (1%)	-20%	29 637 (1%)
Global	2 734 381 (100%)	2%	116 166 652 (100%)	60 323 (100%)	-6%	2 582 528 (100%)

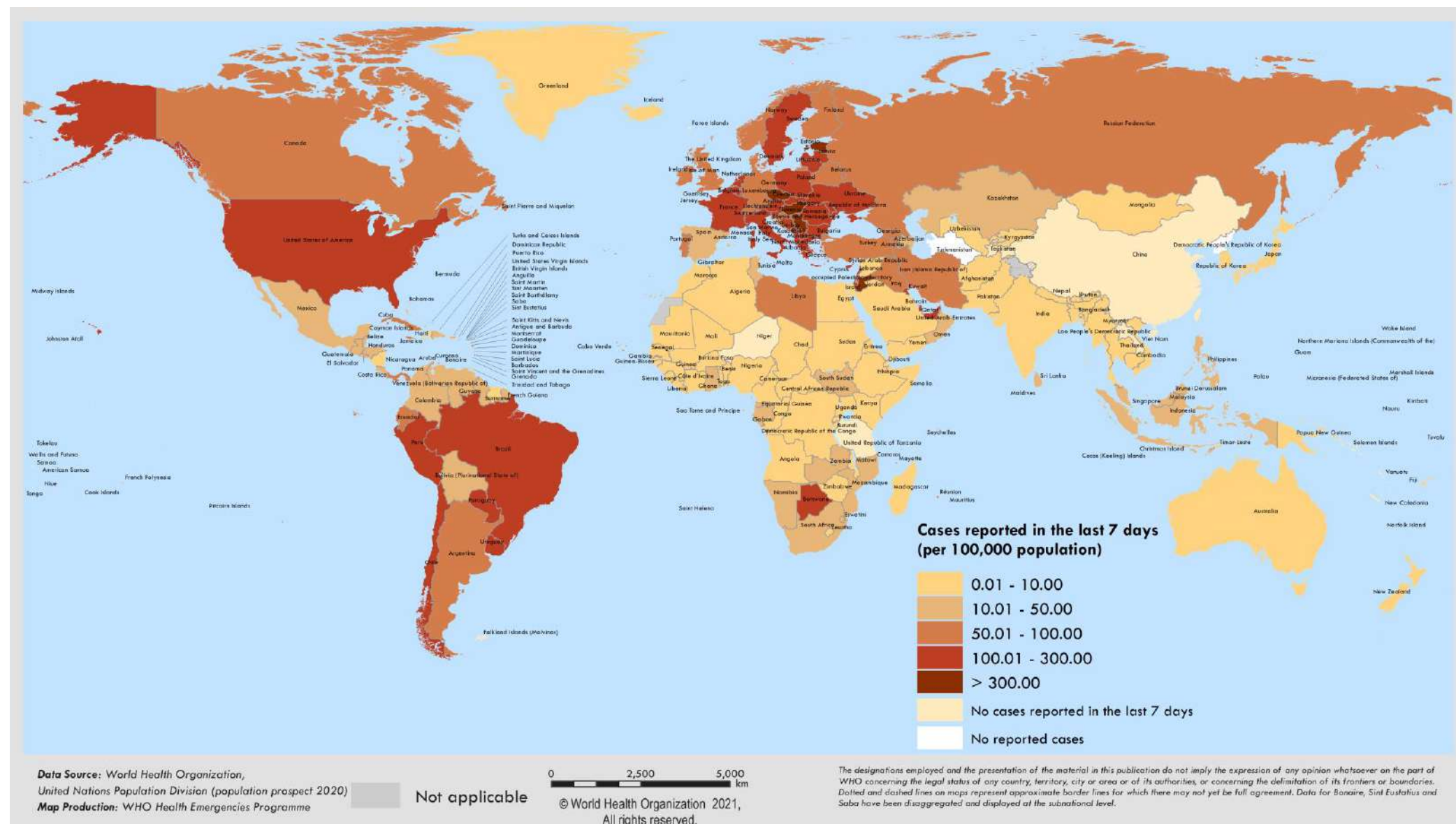
*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number; global totals may not equal 100%.

**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 by countries, territories and areas, 1-7 March 2021**



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

Special Focus: Global Influenza Surveillance and Response System – best practices for integrating influenza and COVID-19 sentinel surveillance

WHO [estimates](#) that seasonal influenza may result in 290 000 – 650 000 deaths each year due to respiratory diseases alone, with further deaths from other diseases such as cardiovascular disease, which can be influenza-related. SARS-CoV-2 is also a respiratory virus like influenza, but they are not the same virus. In 2020, there were around 1.8 million COVID-19 deaths. Influenza surveillance systems have been leveraged to support monitoring SARS-CoV-2 and have proven to be efficient, practical and sustainable. In this Special Focus, we look at how influenza surveillance systems work, how they are being used to provide effective support to monitor SARS-CoV-2 and other respiratory viruses, and provide some country examples.

How influenza surveillance systems work

[Influenza surveillance](#) uses complementary information from multiple systems to monitor influenza viruses and diseases, assess associated epidemic and pandemic risks including severity, and inform development and update of vaccines and control measures. Influenza is typically monitored using country information coming from:

- Syndromic disease surveillance – monitoring the frequency of a combination of symptoms associated with influenza in people seeking healthcare;
- Virological surveillance – testing all or a subset of ill patients for influenza and other respiratory viruses;
- Other data sources, such as excess mortality and participatory surveillance – monitoring the frequency of syndromes in people who may not seek healthcare for their symptoms; and,
- Event-based surveillance – looking for unusual events.

Influenza surveillance systems have been established in more than 100 countries and are functioning within the Global Influenza Surveillance and Response System (GISRS). For more than half a century, GISRS has been the global platform for surveillance and control of influenza, and other respiratory viruses.

How existing influenza systems are being used to monitor SARS-CoV-2

Influenza and other respiratory viruses, including SARS-CoV-2, are respiratory pathogens which can cause similar symptoms. This makes the use of existing respiratory syndromic surveillance an asset to monitor SARS-CoV-2 circulation, to complement other outbreak surveillance, and to monitor efforts of the COVID-19 pandemic response.

At the same time, using the same systems to monitor influenza and SARS-CoV-2 enables an assessment of the relative co-circulation of both viruses. This allows for concurrent national and global response measures for both influenza and COVID-19. WHO has provided [practical guidance](#) to countries to use existing systems for sentinel surveillance and laboratory testing algorithms for influenza and SARS-CoV-2.

As mentioned in the [Special Focus of 16 February 2021](#), since early 2020, more and more countries have started using the existing influenza surveillance systems to monitor COVID-19, continuing and even enhancing syndromic and virologic surveillance to understand community transmission trends for COVID-19 and influenza. So far, since the onset of the COVID-19 pandemic, influenza has been circulating at very low levels.

Influenza surveillance systems have been fully established in many developing and developed countries. These systems, which proved their value in the 2009 H1N1 pandemic, are ready resources in countries for national integrated surveillance for influenza, SARS-CoV-2 and other existing or future important respiratory viruses to public health. Influenza has been and will continue to be among the top global health threats via seasonal epidemics, zoonotic outbreaks and pandemics. Investing in influenza surveillance systems and pandemic preparedness are key to protecting national and global health security.

Country examples

Many countries have benefited from using their influenza surveillance systems to tackle COVID-19 without compromising their continued ability to protect people from the threat of influenza. Below we highlight some country examples.

- The existing influenza surveillance infrastructure in **Afghanistan**, from the the sentinel sites and staff who are experienced in sample collection to the expertise and resources at the National Influenza Centre, allowed for a rapid response to surveillance for COVID-19 following the detection of the first case in February 2020 in the country. Importantly, the country has continued to monitor trends in patients with influenza-like illness (ILI) and severe acute respiratory infections (SARI) seeking care at sentinel sites and to collect samples from these patients. In December 2020, the National Influenza Centre in Kabul implemented the sequential testing algorithm for these samples recommended in WHO's [interim guidance](#), first testing the samples for influenza, then testing the influenza-negative samples for SARS-CoV-2. Since then, SARS-CoV-2 has been detected in influenza-negative samples. Simultaneously, influenza B viruses have also been detected among sentinel samples indicating the likely community circulation of seasonal influenza as typically occurs in Afghanistan at this time of the year. The country plans to initiate the reporting of this information on COVID-19 testing of sentinel samples to the regional influenza data platform, [EMFLU](#), as they have been doing for influenza on a regular basis for many years.
- In April 2020, **Bhutan** developed a web-based, integrated influenza/COVID-19 surveillance reporting platform and published guidelines for an integrated [COVID-19 and influenza surveillance system](#) that scaled-up the existing influenza surveillance system to incorporate monitoring of the COVID-19 virus¹. The web-based integrated platform eased the work on healthcare staff on reporting daily ILI, SARI and COVID-19 cases. The number of SARI sites was increased from 11 to 50 hospitals and the number of ILI sites was increased from 7 to 186 health facilities. The laboratory network was also expanded to include SARS-CoV-2 testing centers, which has benefited influenza surveillance by ensuring a more regular supply of resources for testing samples for influenza as well. The data generated from integrated surveillance have been used to detect cases of both influenza and COVID-19 in the community, to monitor trends in both viruses and to provide epidemiological information in support of timely prevention and containment measures. Results of the integrated epidemiological and virological surveillance is published in the Weekly COVID-19 integrated Flu view and are being shared to relevant stakeholders, including COVID-19 task force, for evidence-based decision making within the country and for sharing information globally².
- In **Cambodia**, COVID-19 surveillance was integrated into existing influenza surveillance in March 2020, whereby all ILI and SARI cases at sentinel sites are tested for SARS-CoV-2 and influenza. Influenza samples collected in December 2019 were also retrospectively tested for COVID-19. Since March 2020, no COVID-19 cases have been detected among sentinel ILI and SARI cases giving confidence to the assessment that only sporadic cases of COVID-19 are occurring and there is no community transmission of SARS-CoV-2 in the country. ILI surveillance data are an important component of multisource surveillance, where data from multiple sources are used to assess the current epidemiological situation in the country, and support decision making for the COVID-19 response. Maintaining strong influenza surveillance throughout the pandemic was also critical to detect and respond to eight clusters of influenza A(H3N2) infections in various community and closed settings since August 2020.

¹Ministry of Health Bhutan (2020) *COVID-19 Integrated Influenza Surveillance Guideline*, <http://www.rcdc.gov.bt/web/wp-content/uploads/2020/05/COVID-19-Integrated-Influenza-Surveillance-Guideline-V1.pdf>

² Royal Government of Bhutan, *Royal Centre for Disease Control*, <http://www.rcdc.gov.bt>

- In Europe, countries are increasingly integrating SARS-CoV-2 into existing sentinel surveillance schemes in both primary and secondary care. **Albania**, for example, has adapted its existing SARI surveillance systems to monitor both influenza and COVID-19³. Additionally, in Europe, the excess weekly all-cause mortality monitoring was established to provide near real-time estimates of the impact of seasonal influenza. These systems have provided important insights into the mortality impact temporally associated with COVID-19 circulation⁴.

³ECDC/WHO, *Flu News Europe*, <https://flunewseurope.org/HospitalData/SARI>

⁴ Adlhoch C et al. (2021) Real-time monitoring shows substantial excess all-cause mortality during second wave of COVID-19 in Europe, October to December 2020, *Euro Surveill.* 2021;26(2):pii=2002023. <https://doi.org/10.2807/1560-7917.ES.2021.26.1.2002023>

Special Focus: SARS-CoV-2 sero-epidemiology in Kenya

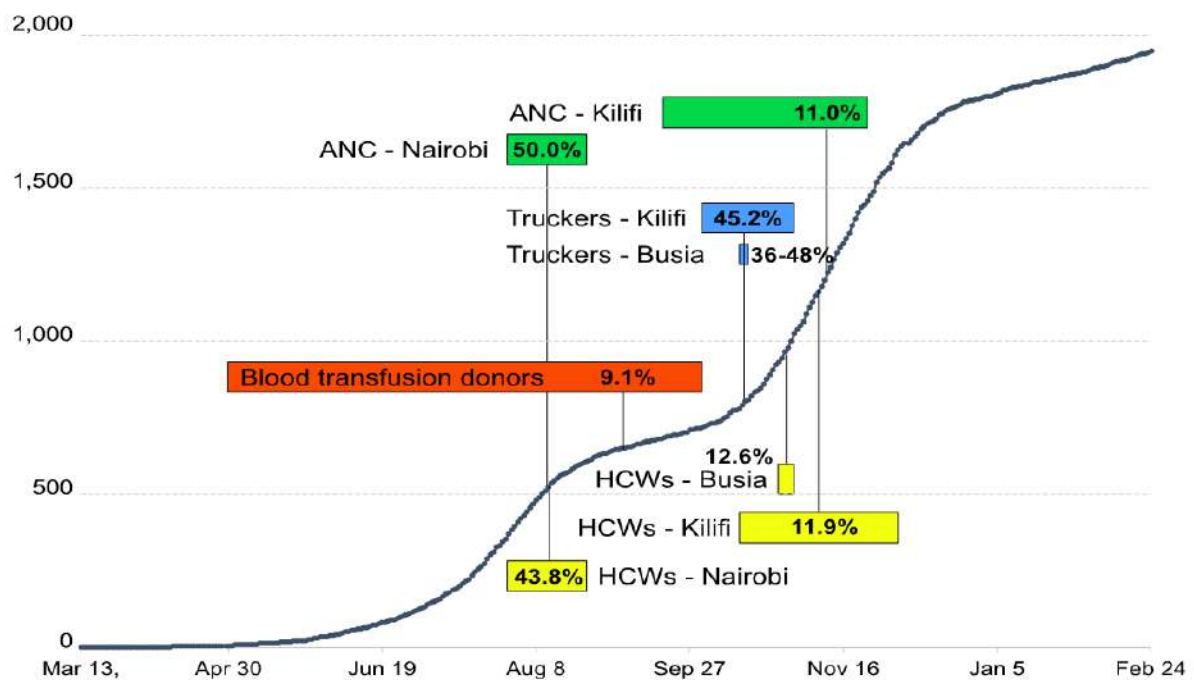
Solidarity II is a global collaboration led by WHO that promotes the implementation of serological surveys of SARS-CoV-2 (For more details, please see [Weekly Epidemiological Update published on 27 January 2021](#), and ["Solidarity II" global serologic study for COVID-19](#)). It provides a collaborative environment for public health agencies and academic institutions around the world to work together and hosts a weekly open forum to discuss recent findings in COVID-19 sero-epidemiological research. Every week over 100 investigators from public health agencies and academic institutions join to discuss the recent research progress, debate the scientific challenges and how to collaboratively solve them. On 26 February 2021, Solidarity II hosted the Kenya Medical Research Institute (KEMRI)-Wellcome Trust Research Programme (KWTRP), who gave a series of presentations on the sero-epidemiology of SARS-CoV-2 in Kenya.

Below we provide an update on the dynamics of SARS-CoV-2 infection across Kenya estimated in blood transfusion donors, seroprevalence in antenatal care screening, health care workers and truck drivers.

The laboratory of KEMRI participated in the [WHO Inter-lab study](#) to establish a WHO International Standard and Reference Panelⁱ. All of the presented studies are based on an in-house ELISA conducted at the KWTRP in Kilifi, Kenya. The assay uses an adaptation of the Krammer ELISA, previously presented at Solidarity II, to measure SARS-CoV-2 anti-Spike antibodies. [The assay](#) readout was optimized to selectively differentiate between those previously infected with SARS-CoV-2 and non-infected individuals. This assay was validated using over 900 locally-acquired serum/plasma samples from 2011-2018 with a specificity of 99%. Sensitivity was estimated to be 92.7%ⁱⁱ based on 179 PCR samples taken at least 7 days after a positive COVID-19 PCR test in Nairobi.

At the request of the Kenyan Government, the KWTRP developed protocols for sampling blood donors, attendees at antenatal care clinics (ANC), health care workers (HCW) and truck drivers at different settings across the country. The seroprevalence results ranged from 9 – 50% in the different populations at different time periods, these are summarised (Figure 3) in relation to the period of sampling and the cumulative number of PCR positive cases identified in Kenya.

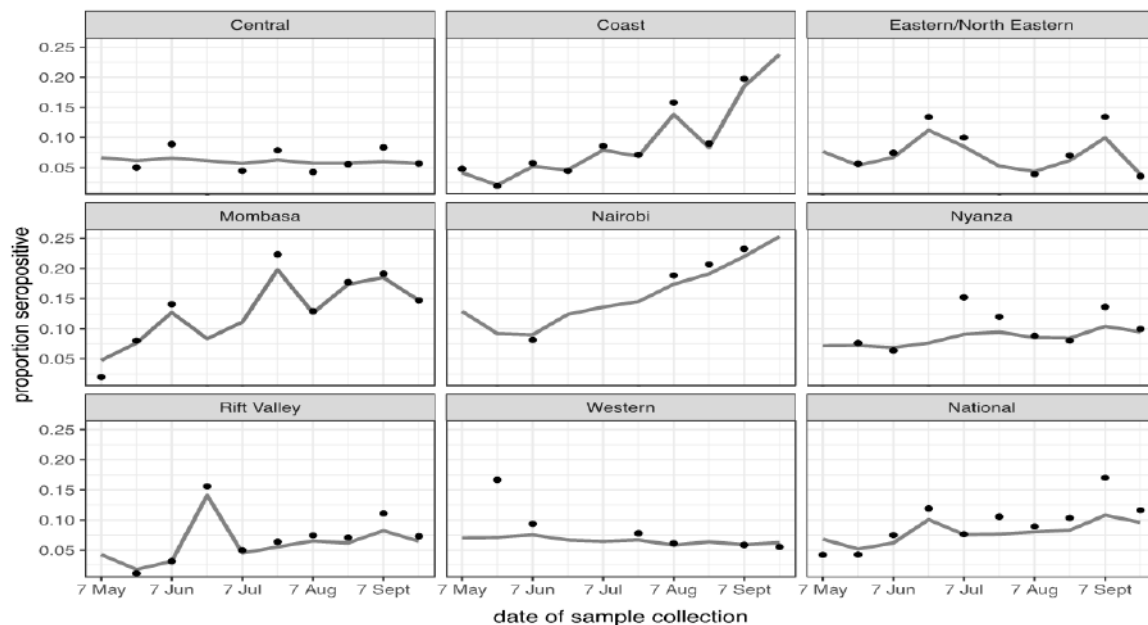
Figure 3: Cumulative confirmed COVID-19 cases per million population in Kenya and time point of the seroprevalence studies



The black line and y-axis represents the national cumulative incidence per 1 million population; each box represents the duration of the studies (the sampling period); the populations studied and the seroprevalence estimate. The vertical lines represent the midpoint for sampling dropping to the cumulative incidence curve.

A study of blood transfusion donors sampled nearly 10 000 donors from sites across the entire countryⁱⁱⁱ. Results were statistically adjusted on age, sex and region to the population structure of Kenya as well as being adjusted for assay test performance. Figure 4 illustrates the unadjusted estimates (dots) and the statistical model estimates for seroprevalence in eight regions and nationally. There is a marked rise in prevalence in the Nairobi and Coast regions throughout the first wave (March to September 2020) with a slightly earlier peak in Mombasa. At the end of the first wave, approximately one in ten Kenyans is estimated to have antibodies to SARS-CoV-2 and this rises to one in five in the major cities, Nairobi and Mombasa. Based on the estimates from the cumulative incidence in Kenya, approximately two in 1000 Kenyans have been confirmed as PCR positive COVID-19 cases in the same time period.

Figure 4: Seroprevalence estimates over time in eight regions and nationally in Kenya, May - September 2020



In August 2020, seroprevalence in 196 expectant mothers in Nairobi was estimated at 50% after adjustment for assay sensitivity and specificity^{iv}. In 419 mothers in Kilifi (Coast region), seroprevalence rose from 1.3% in September to 11.0% in November. Seroprevalence estimates in nearly 700 HCW varied geographically; in urban Nairobi in August, seroprevalence was 43.8% while in rural Kilifi and Busia in November, it was 11.9% and 12.6%, respectively. There was no association between health service role and seroprevalence suggesting that the cumulative incidence in HCWs was driven more by the community prevalence than by hospital-based risk. Truck drivers provide essential services in the pandemic and are subject to mandatory PCR testing every two weeks. Among 830 truck drivers, seroprevalence was 42.3% in October, varying little between the Coast Region (45.2%) and two sites in Busia in the Western Region (36.0%, 47.9%)^v. This illustrates a challenge in pandemic control where mobility of essential workers is necessary to support movement restrictions of the rest of the population.

All studies mentioned were conducted before the second wave (October 2020 to January 2021) of cases in Kenya. When viewing these results as estimates of cumulative incidence, they illustrate substantial under-ascertainment of infections by PCR testing. Additionally, the study in blood donors illustrates large regional heterogeneity in infection with much higher cumulative incidence in the cities.

Additional SARS-CoV-2 seroprevalence studies are ongoing in Kenya with support from WHO (Unity Studies). More information about WHO's work on SARS-CoV-2 seroepidemiology can be found [here](#).

ⁱ Mattiuzzo G et al. Establishment of the WHO International Standard and Reference Panel for anti-SARS-CoV-2 antibody. WHO/BS/2020.2403. 2020: WHO(Geneva) <https://www.who.int/publications/m/item/WHO-BS-2020.2403>

ⁱⁱ Uyoga S et al. Seroprevalence of anti-SARS-CoV-2 IgG antibodies in Kenyan blood donors. Science 2021;371:79-82

ⁱⁱⁱ Adetifa et al., Temporal trends of SARS-CoV-2 seroprevalence in transfusion blood donors during the first wave of the COVID-19 epidemic in Kenya. medRxiv 2021 <https://doi.org/10.1101/2021.02.09.21251404>

^{iv} Lucinde et al. Sero-surveillance for IgG to SARS-CoV-2 at antenatal care clinics in two Kenyan referral hospitals medRxiv 2021 <https://doi.org/10.1101/2021.02.05.2125073>

^v Kagucia et al. Seroprevalence of anti-SARS-CoV-2 IgG antibodies among truck drivers and assistants in Kenya medRxiv 2021 <https://doi.org/10.1101/2021.02.12.21251294>

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 editions 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 9 March 2021.

Results of ongoing studies of VOCs are summarized in Table 2 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, an increased number of reports of variants have been noted in a number of countries. As surveillance activities at local and national levels are strengthened, including systematic genomic sequencing to detect cases infected with SARS-CoV-2 variants, the number of countries reporting VOCs has continued to increase (Table 2, Figures 5, 6 and 7, Annex 2). This information should be interpreted with due consideration of limitations of ongoing surveillance, including but not limited to differences between countries in sequencing capacity and which samples are prioritized for sequencing. WHO continues to advocate for strengthening surveillance and sequencing capacity, and a systematic approach to provide a representative indication of the extent of variant transmission. New potential variants of interest (VOIs) or VOCs are currently under review and may be added to future updates.

Table 3: Overview of emerging information on key variants of concern, as of 9 March 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, alias P.1[†]
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01[†]	VOC 202012/02	-
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; and P681H	L242/A243/L244 deletion; K417N E484K, N501Y	K417N, E484K; N501Y
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}	Increased, more transmissible than previous circulating variants ⁶
Severity*	Possible increased risk of hospitalization ⁷ , severity and mortality ³	No impact reported to date ^{4, 5} , no significant change in-hospital mortality ⁸	Under investigation, limited impact ⁶
Neutralization capacity*	Slight reduction but overall neutralizing titers still remained above the levels expected to confer protection ⁹	Decreased, suggesting potential increased risk of reinfection ^{4, 10, 11}	Decreased, reinfections reported ¹²⁻¹⁴
Potential impacts on vaccines*	No significant impact on Moderna, Pfizer-BioNTech, and Oxford-AstraZeneca vaccines ¹⁵⁻¹⁸	Moderna and Pfizer-BioNTech: Reduction in the neutralizing activity, but impact on protection against disease not known. ¹⁵⁻¹⁸ Novavax and Janssen: 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. ^{19, 20} 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 ^{21, 22}	Under investigation
Potential impacts on diagnostics*	S gene target failure (SGTF). ²¹ No impact on Ag RDTs observed ²³	None reported to date	None reported to date
Countries reporting cases (newly reported in last week)**	111 (5)	58 (3)	32 (3)

[†]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 20212/01

Since our last update on 9 March, VOC 20212/01 has been detected in five additional countries. As of 9 March, a total of 111 countries across all six WHO regions have reported cases of this variant (Figure 5).

Figure 5. Countries, territories and areas reporting SARS-CoV-2 VOC 20212/01 as of 9 March 2021

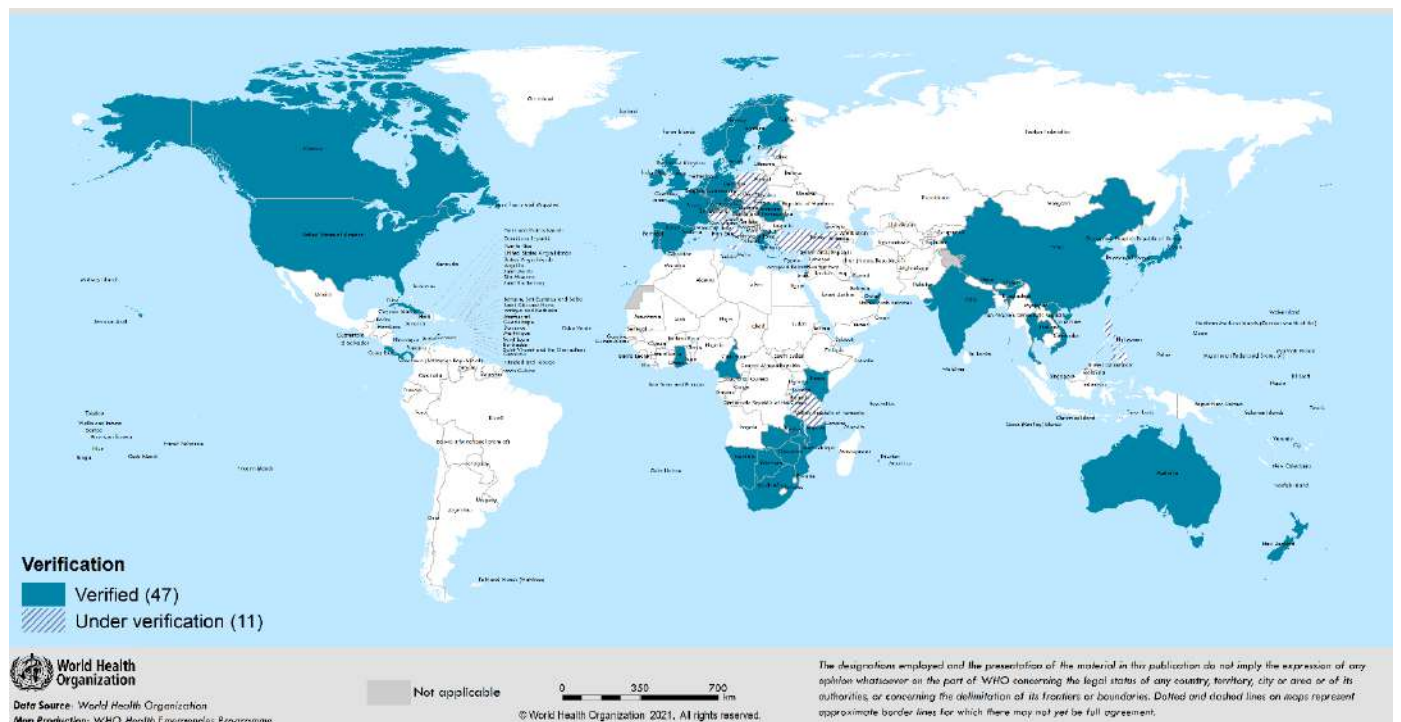


Variant 501Y.V2

Since the last update on 2 March, 501Y.V2 has been reported from three additional countries –totaling 58 countries across all six WHO regions (Figure 4). In several areas within the African Region, variant 501Y.V2 has been reported to comprise a high proportion of sequenced samples.³⁵

Reductions in neutralizing antibody activity against 501Y.V2 following either natural infection or vaccination have been documented^{4, 24} and discussed in past editions of the [Weekly Epidemiological Update](#). Findings from a recent study that analyzed convalescent plasma from 20 patients and sera from 22 participants of vaccine trials [Moderna SARS-CoV-2 mRNA-1273 vaccine (12 participants); Pfizer BNT162b2 COVID-19 vaccine (10 participants)] indicated that relative to the original SARS-CoV-2, there was a substantial decrease in the neutralizing activity of convalescent plasma (9.4-fold) and sera from vaccinated participants (10.3 to 12.4-fold) against the 501Y.V2 variant.¹⁸

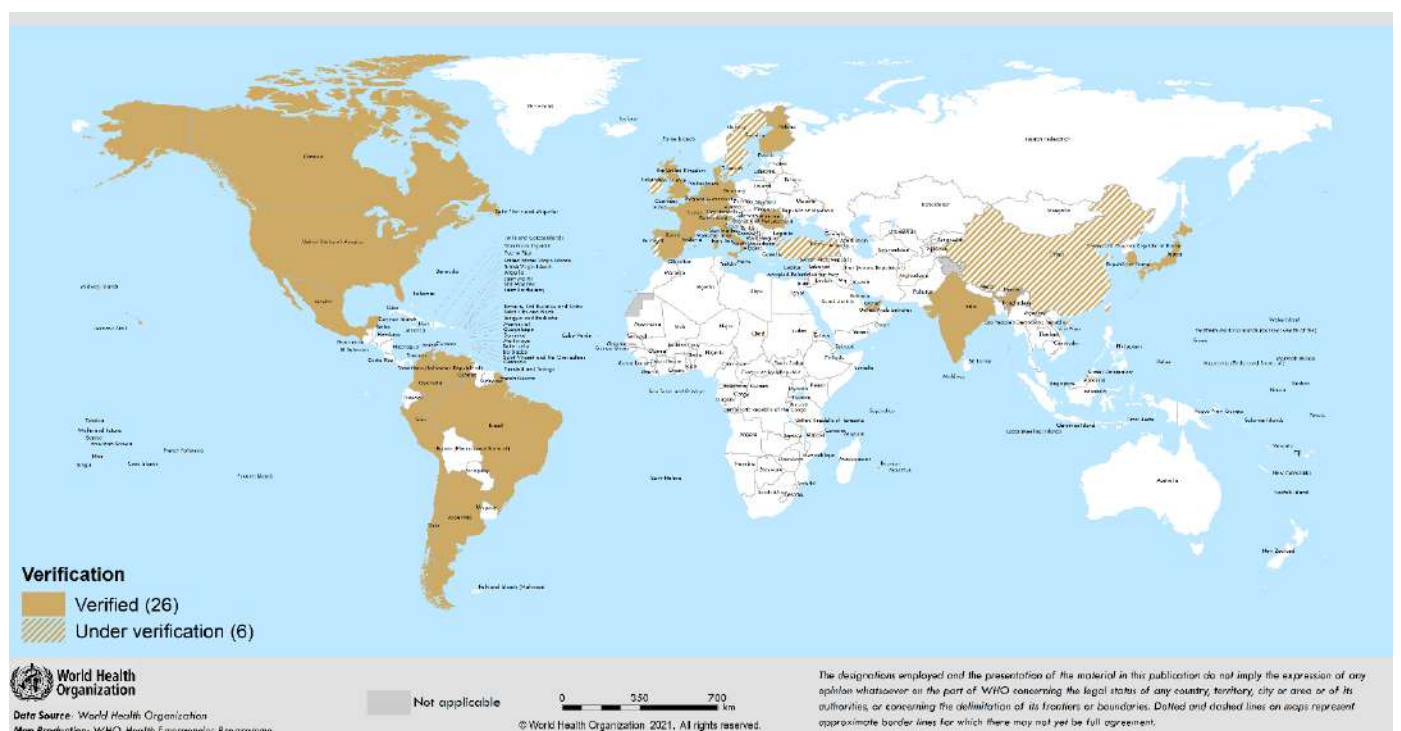
Figure 6. Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 9 March 2021



Variant P.1

Since our last update, variant P.1 has been reported in three additional countries. As of 9 March, this variant is reported in 32 countries across all six WHO regions (Figure 5).

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



Brazil has experienced high incidence and mortality due to COVID-19, recording over 11 million cases and 260 000 deaths (as of 7 March 2021); the second highest globally (figure 8). The burden of COVID-19 has been highly variable across the country, with Amazonas State and its capital Manaus, being the most affected⁶. There has been a sharp increase in cases and deaths reported in the month of January, however, both the cases and deaths have slowly started to decline in these states (figure 9), while remaining high or increasing in the country overall.

In a genomic survey conducted from 16 March 2020 to 13 January 2021 in 25 municipalities of Amazonas State, Brazil, several sequences were identified²⁵. Variant P.1, which was first detected in early December 2020 in Manaus in Amazonas state, displayed a rapid increase in prevalence through January 2021; accounting 24% (n=60) of sequences samples included in this study. Additionally, to better understand the emergence of P.1 in the Amazonas State, a real-time PCR assay was performed to detect the deletion at orf1ab (NSP6: S106del, G107del, F108del) – a deletion found in all three VOCs (P.1, B.1.1.7 and B.1.351). Upon evaluating the SARS-CoV-2 positive samples between 1 November 2020 through 31 January 2021 but not sequenced, no sample was found positive for the NSP6 deletion before 16 December, supporting low prevalence of VOC P.1 before mid-December 2020 in Amazonas. However, between mid-December 2020 and January 2021, positive samples with NSP6 deletion were very frequent. Collectively these studies highlight a sharp increase in prevalence of variant P.1 from 0% in November 2020 (n=0/88) to 73% during 1-15 January 2021 (n=119/162).

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

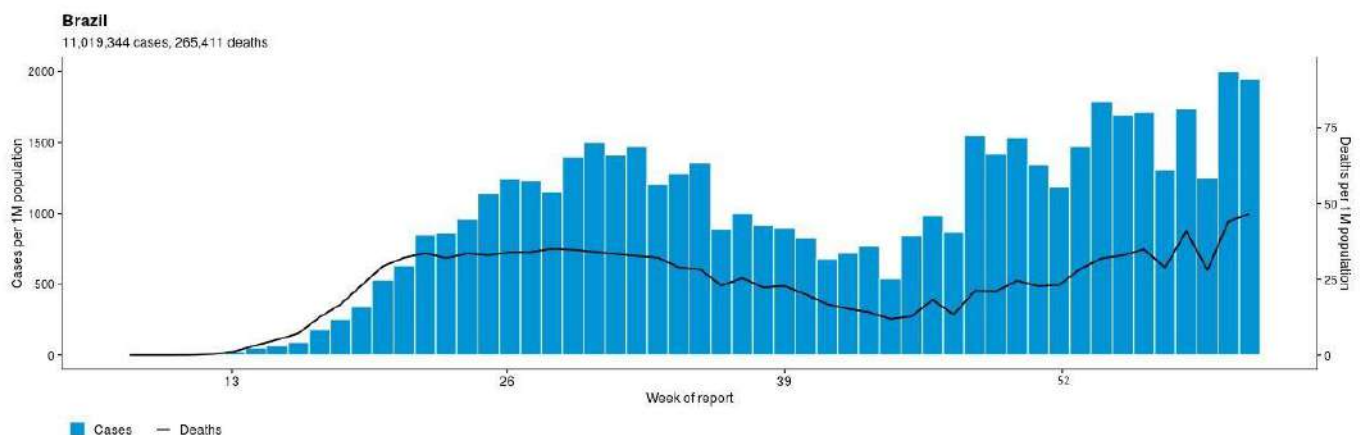
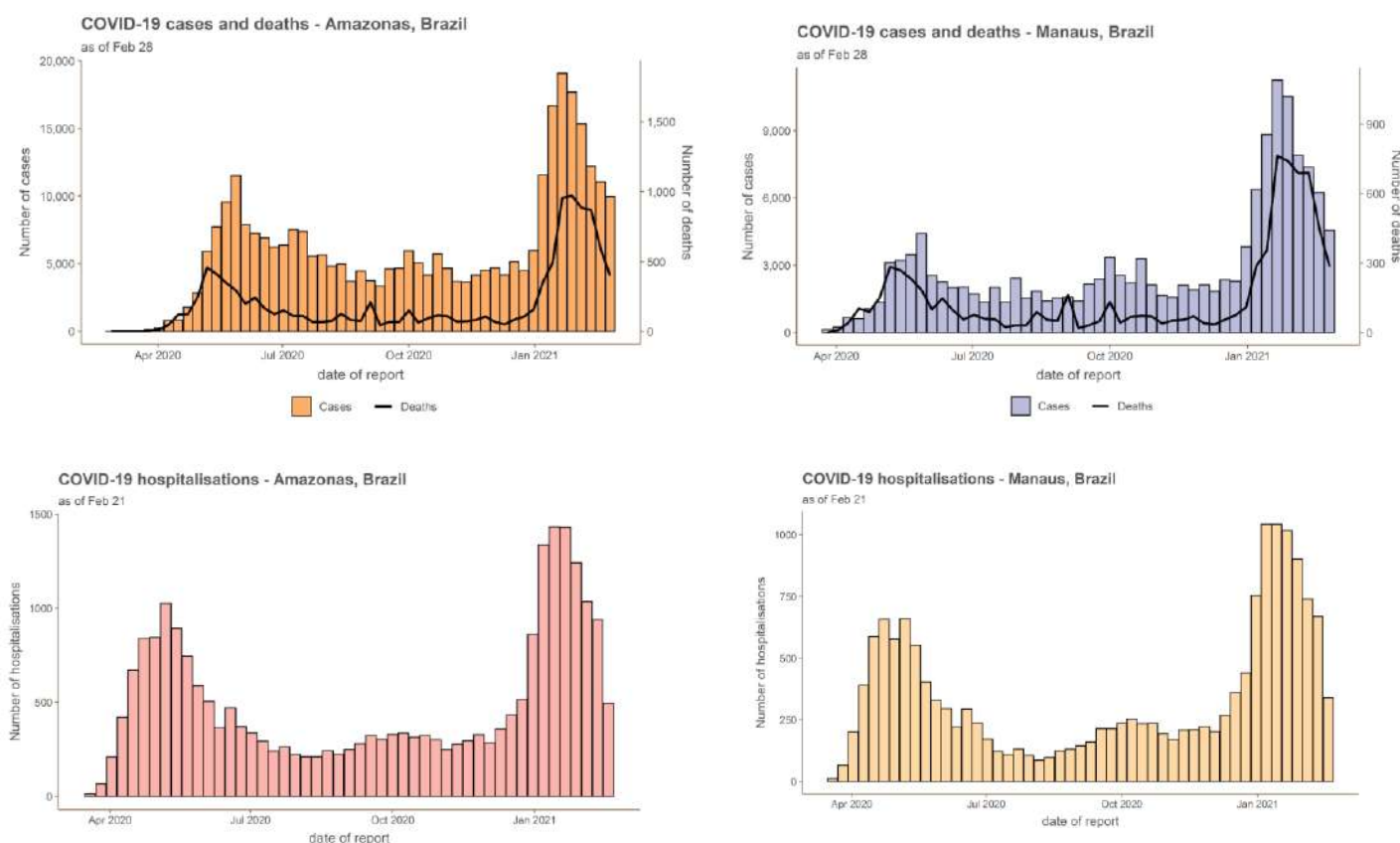


Figure 9: COVID-19 cases, deaths (as of 28 February 2021) and hospitalizations (as of 21 February) in Amazonas and Manaus, Brazil



Source: Ministry of Health Brazil

Based on preliminary investigations in Manaus, where this variant was initially identified, P.1 has shown to have increased transmissibility compared to previously circulating variants. It can evade 25% to 61% protective immunity provided by the previous infection, thereby making people susceptible to reinfection⁶. Additionally, it is 1.1–1.8 times more likely to result in mortality. Researchers have cautioned that these are preliminary findings and the results are not generalizable to other settings. More studies and genome sequencing data are required to assess the transmissibility and severity of variant P.1. It is also important to conduct these studies outside of Manaus as there has been a sharp increase in hospitalizations during the second wave which has resulted in collapsing of health systems in Manaus (figure 9). Therefore, it is difficult to determine the cause of high mortality which could be either due to variant P.1 or collapsed health systems or both.

WHO Recommendations

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 as well as infection prevention and control measures in health facilities has been effective in reducing COVID-19 case incidence, which has led to a reduction in hospitalizations and deaths among COVID-19 patients. Findings from new studies evaluating transmission, severity and impact on medical countermeasures will continue to help inform PHSM and IPC measures employed by Member States. National and local authorities are encouraged to continue strengthening existing PHSM, IPC and disease control activities, including epidemiological surveillance, strategic testing, and systematic sequencing of SARS-CoV-2 where feasible.

If potential VOIs or VOCs are detected, Member States are requested to inform WHO through established WHO Country or Regional Office reporting channels, submit genome sequences to publicly available databases (e.g., GISAID), and perform field and laboratory investigations (where appropriate) to improve understanding of potential impacts. For further information on see: [Proposed working definitions for SARS-CoV-2 variants of interest and variants of concern](#).

Resources

- [Proposed working definitions for SARS-CoV-2 variants of interest and variants of concern](#)
- [Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health](#)
- [Considerations for implementing and adjusting PHSM in the context of COVID-19](#)
- [Disease Outbreak News on SARS-CoV-2 Variants, 31 December 2020](#)

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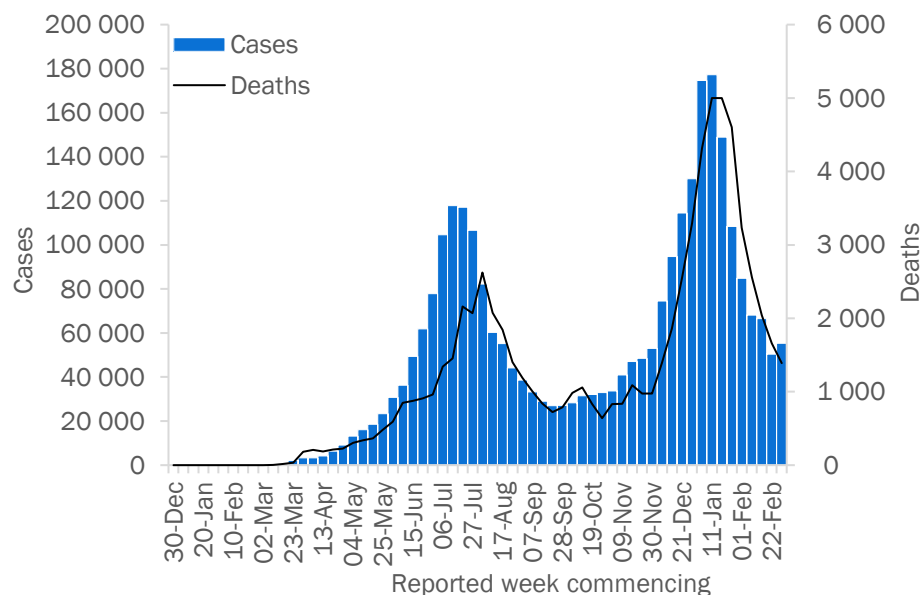
1. Investigation of novel SARS-CoV-2 variant - Variant of Concern 202012/01.19.
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WHO regional overviews

African Region

The Africa region reported over 55 000 new cases and over 1300 new deaths, a 10% increase and 16% decrease respectively compared to the previous week. Since new weekly case counts peaked in early January 2021, this is the first weekly increase following 6 weeks of decreasing case numbers. The highest numbers of new cases were reported from South Africa (7981 new cases; 13.5 new cases per 100 000 population; a 19% decrease), Ethiopia (6976 new cases; 6.1 new cases per 100 000; a 13% increase), and Zambia (4840 new cases; 26.3 new cases per 100 000; a 48% increase).

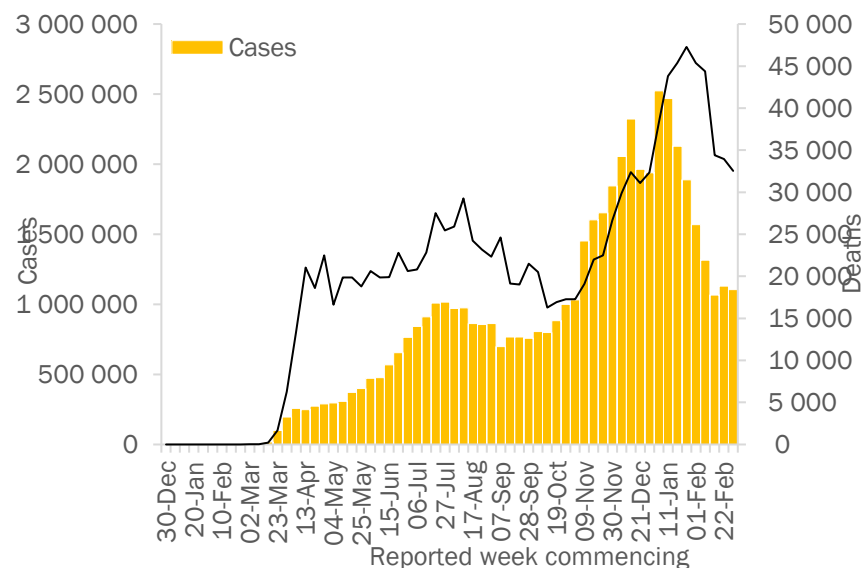
The highest numbers of new deaths were reported from South Africa (706 new deaths; 1.2 new deaths per 100 000 population; a 30% decrease), Ethiopia (66 new deaths; 0.1 new deaths per 100 000; a 21% decrease), and Nigeria (59 new deaths; <0.1 new deaths per 100 000; a 20% decrease).



Region of the Americas

The Region of the Americas reported over 1.1 million new cases and over 32 000 new deaths, a 2% and 4% decrease respectively compared to the previous week. The highest numbers of new cases were reported from the United States of America (427 233 new cases; 129.1 new cases per 100 000; a 10% decrease), Brazil (413 597 new cases; 194.6 new cases per 100 000; an 11% increase), and Argentina (42 517 new cases; 94.1 new cases; a 14% decrease). The United States and Brazil accounted for 76% of new weekly cases reported in the Americas.

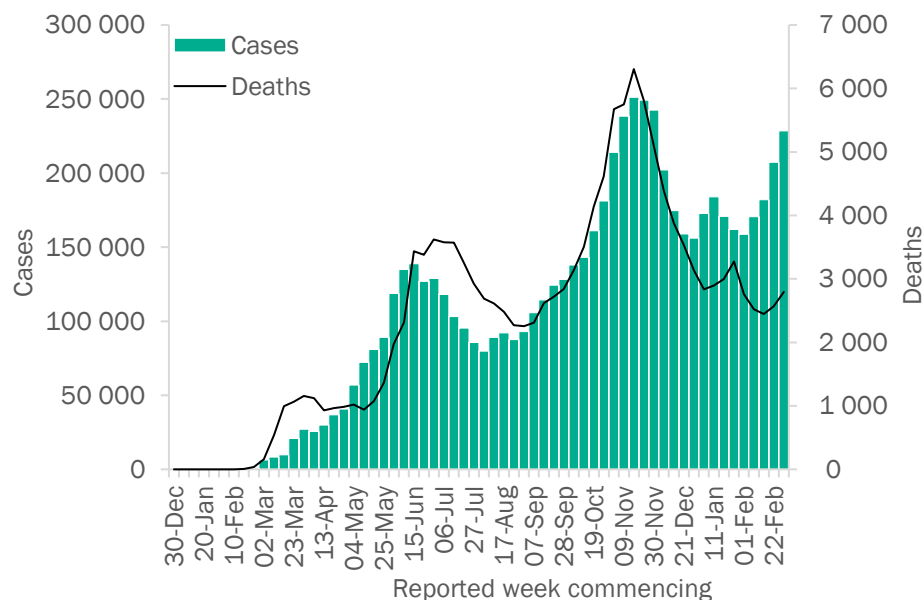
The highest numbers of new deaths were reported from the United States of America (12 315 new deaths; 3.7 new deaths per 100 000; a 17% decrease), Brazil (9935 new deaths; 4.7 new deaths per 100 000; a 23% increase), and Mexico (5104 new deaths; 4.0 new deaths per 100 000; a 7% decrease).



Eastern Mediterranean Region

The Eastern Mediterranean region reported just under 229 000 new cases and just under 2800 new deaths, a 10% and 9% increase respectively compared to the previous week. New cases have increased week on week for the past four weeks, while deaths have increased for the past two weeks. The highest numbers of new cases were reported from Islamic Republic of Iran (58 523 new cases; 69.7 new cases per 100 000; a 3% increase), Jordan (34 919 new cases; 342.2 new cases per 100 000; a 31% increase), and Iraq (30 948 new cases; 76.9 new cases per 100 000; a 13% increase).

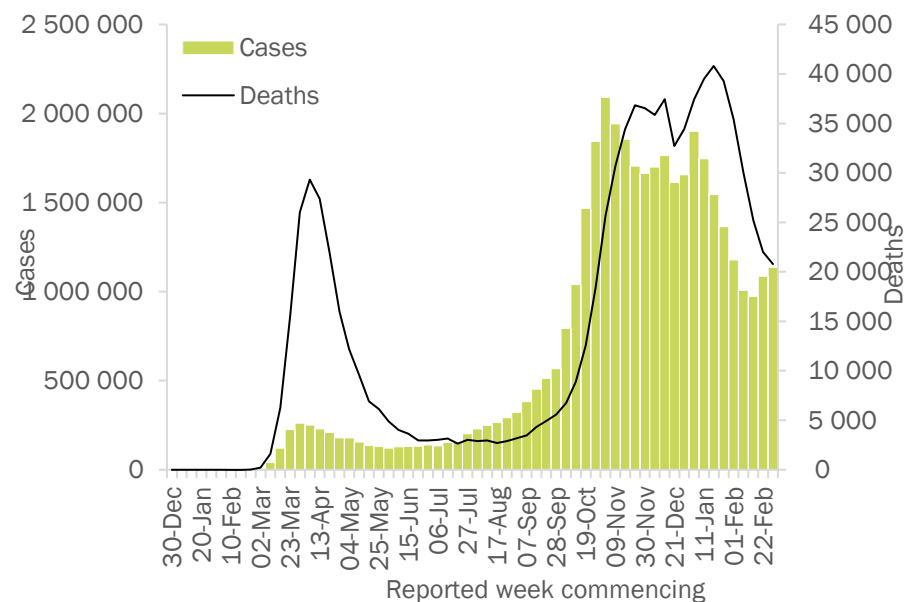
The highest numbers of new deaths were reported from Islamic Republic of Iran (614 new deaths; 0.7 new deaths per 100 000 population; an 8% increase), Lebanon (361 new deaths; 5.3 new deaths per 100 000; a 2% increase), and Pakistan (329 new deaths; 0.1 new deaths per 100 000; a 20% increase)



European Region

The European region reported over 1.1 million new cases and under 21 000 new deaths, a 4% increase and 6% decrease respectively compared to the previous week. Since early January 2021, new weekly cases have decreased overall; however, increases have been reported in the past two weeks. New weekly deaths have continued to decline since the mid-January 2021. The highest numbers of new cases were reported from France (143 622 new cases; 220.0 new cases per 100 000; a 4% decrease), Italy (138 937 new cases; 229.8 new cases per 100 000; a 24% increase), and Poland (87 928 new cases; 232.3 new cases per 100 000; a 29% increase).

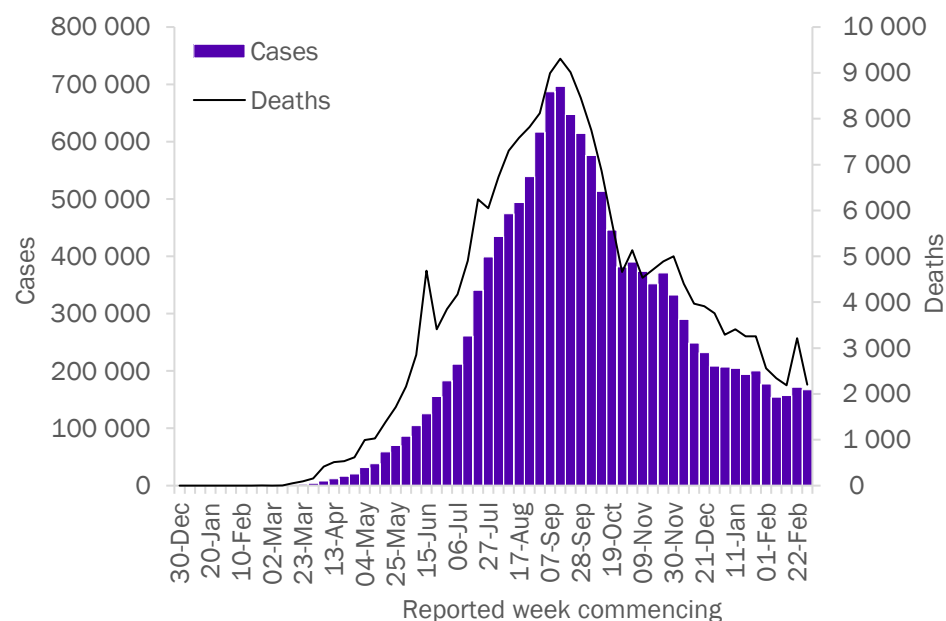
The highest numbers of new deaths were reported from the Russian Federation (2978 new deaths; 2.0 new deaths per 100 000; a 5% increase), France (2100 new deaths; 3.2 new deaths per 100 000; a 3% decrease), and Italy (2071 new deaths; 3.4 new deaths per 100 000; a 3% increase).



South-East Asia Region

The South-East Asia region reported over 167 000 new cases and 2200 new deaths, a 2% and 32% decrease respectively compared to the previous week. Progressive declines in case incidence observed mid-September 2020 have slowed in recent weeks, and increases have been observed in several countries in the region. The highest numbers of new cases were reported from India (114 068 new cases; 8.3 new cases per 100 000; a 9% increase), Indonesia (44 762 new cases; 16.4 new cases per 100 000; a 23% decrease), and Bangladesh (3893 new cases; 2.4 new cases per 100 000; a 39% increase).

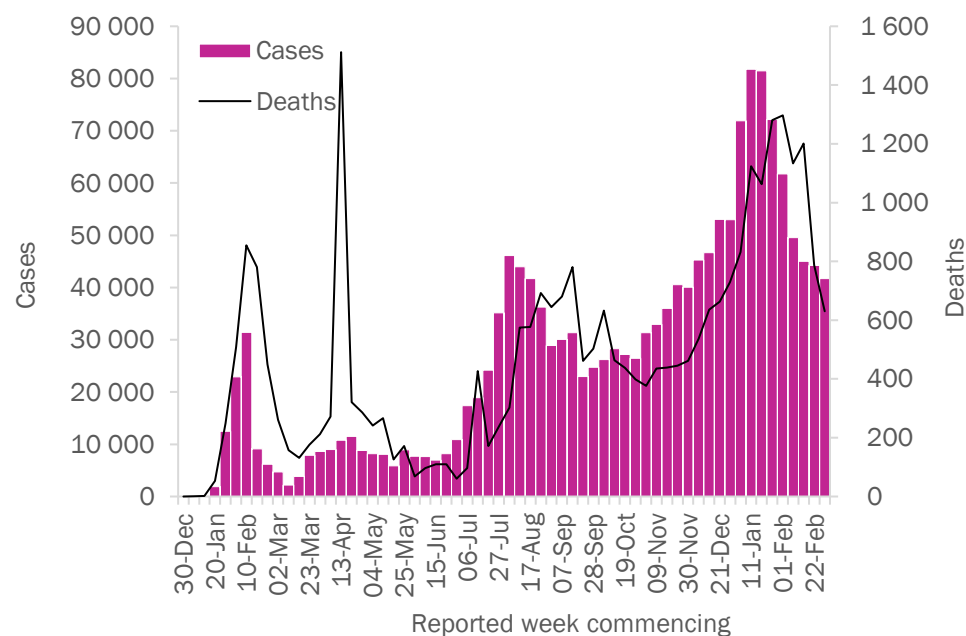
The highest numbers of new deaths were reported from Indonesia (1173 new deaths; 0.4 new deaths per 100 000; a 30% decrease), India (705 new deaths; <0.1 new deaths per 100 000; a 6% decrease), and Nepal (237 new deaths; 0.8 new deaths per 100 000; a 67% decrease). The spike in deaths observed last week were driven by retroadjustments in Nepal.



Western Pacific Region

The Western Pacific region reported over 41 000 new cases and over 600 new deaths, a 6% and 20% decrease respectively compared to the previous week. New weekly cases have continued to decrease since mid-January 2021, and deaths have decreased overall in recent weeks. The highest numbers of new cases were reported from Philippines (16 891 new cases; 15.4 new cases per 100 000; a 13% increase), Malaysia (13 462 new cases; 41.6 new cases per 100 000; a 25% decrease), and Japan (7216 new cases; 5.7 new cases per 100 000; similar to the previous week).

The highest numbers of new deaths were reported from Japan (367 new deaths; 0.3 new deaths per 100 000; a 17% decrease), Philippines (176 new deaths; 0.2 new deaths per 100 000; a 20% decrease), and Malaysia (45 new deaths; 0.1 new deaths per 100 000; a 36% decrease).



Key weekly updates

WHO Director-General key message

Governments and individuals must remember that vaccines alone will not keep up safe. Basic public health measures remain the foundation of the response.

[Opening remarks at Member States Information Session on COVID-19, 4 March 2021](#)

COVAX and vaccines

- [The effects of virus variants on COVID-19 vaccines](#)[First COVID-19 COVAX vaccine doses administered in Africa](#)
- [COVAX publishes first round of allocations](#)
- [Background document on the AZD1222 vaccine against COVID-19 developed by Oxford University and AstraZeneca](#)

Publications

- [WHO Living guideline: Drugs to prevent COVID-19](#)
- [COVID-19 vaccine checklist](#)
- [Health worker communication for COVID-19 vaccination flow diagram](#)
- [Roadmap to improve and ensure good indoor ventilation in the context of COVID-19](#)
- [Responding to the COVID-19 pandemic: WHO's action in countries, territories and areas, 2020](#)

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 7 March 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	55 341	2 895 549	258.1	1 390	73 381	6.5	
South Africa	7 981	1 520 206	2 563.2	706	50 647	85.4	Community transmission
Ethiopia	6 976	165 029	143.5	66	2 420	2.1	Community transmission
Zambia	4 840	82 011	446.1	57	1 116	6.1	Community transmission
Ghana	3 506	86 092	277.1	46	640	2.1	Community transmission
Mozambique	3 359	62 131	198.8	56	686	2.2	Community transmission
Botswana	3 288	31 658	1 346.2	49	359	15.3	Community transmission
Nigeria	2 820	158 237	76.8	59	1 964	1.0	Community transmission
Kenya	2 714	108 362	201.5	20	1 874	3.5	Community transmission
Côte d'Ivoire	2 304	34 935	132.4	8	200	0.8	Community transmission
Cameroon	1 965	35 714	134.5	28	551	2.1	Community transmission
Senegal	1 377	35 632	212.8	42	908	5.4	Community transmission
South Sudan	1 328	8 677	77.5	15	102	0.9	Community transmission
Namibia	1 233	39 877	1 569.4	19	437	17.2	Community transmission
Algeria	1 144	114 104	260.2	31	3 010	6.9	Community transmission
Gabon	953	15 517	697.2	7	90	4.0	Community transmission
Democratic Republic of the Congo	677	26 468	29.6	5	712	0.8	Community transmission
Togo	670	7 521	90.8	7	90	1.1	Community transmission
Guinea	646	16 540	125.9	4	93	0.7	Community transmission
Rwanda	636	19 426	150.0	6	267	2.1	Community transmission
Malawi	600	32 398	169.4	30	1 067	5.6	Community transmission
Benin	437	6 071	50.1	5	75	0.6	Community transmission
Cabo Verde	400	15 724	2 828.1	5	152	27.3	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
Congo	359	9 179	166.3	3	131	2.4	Community transmission
Seychelles	358	2 950	2 999.6	3	14	14.2	Community transmission
Equatorial Guinea	324	6 329	451.1	5	96	6.8	Community transmission
Madagascar	324	20 155	72.8	3	300	1.1	Community transmission
Angola	273	21 055	64.1	6	512	1.6	Community transmission
Zimbabwe	266	36 260	244.0	27	1 485	10.0	Community transmission
Mali	195	8 560	42.3	6	358	1.8	Community transmission
Chad	188	4 161	25.3	0	140	0.9	Community transmission
Burkina Faso	171	12 153	58.1	1	143	0.7	Community transmission
Eswatini	171	17 173	1 480.2	8	658	56.7	Community transmission
Sao Tome and Principe	152	1 938	884.3	3	31	14.1	Community transmission
Mauritania	130	17 309	372.3	3	442	9.5	Community transmission
Uganda	117	40 452	88.4	0	334	0.7	Community transmission
Burundi	110	2 319	19.5	0	3	0.0	Community transmission
Eritrea	97	2 944	83.0	0	7	0.2	Community transmission
Gambia	68	4 759	196.9	4	152	6.3	Community transmission
Guinea-Bissau	65	3 312	168.3	1	49	2.5	Community transmission
Lesotho	32	10 523	491.2	15	307	14.3	Community transmission
Sierra Leone	31	3 918	49.1	0	79	1.0	Community transmission
Central African Republic	24	5 021	104.0	0	63	1.3	Community transmission
Comoros	20	3 591	412.9	1	145	16.7	Community transmission
Liberia	14	2 024	40.0	0	85	1.7	Community transmission
Mauritius	10	620	48.8	0	10	0.8	Sporadic cases
Niger	0	4 740	19.6	0	172	0.7	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesⁱⁱⁱ							
Mayotte	1 279	18 140	6 649.2	23	125	45.8	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
Réunion	709	13 125	1 466.0	7	59	6.6	Community transmission
Americas	1 105 355	51 531 438	5 038.4	32 535	1 237 781	121.0	
United States of America	427 233	28 602 211	8 641.1	12 315	519 075	156.8	Community transmission
Brazil	413 597	10 869 227	5 113.5	9 935	262 770	123.6	Community transmission
Argentina	42 517	2 146 714	4 749.8	924	52 870	117.0	Community transmission
Mexico	42 423	2 119 305	1 643.7	5 104	189 578	147.0	Community transmission
Peru	41 931	1 358 294	4 119.6	1 397	47 491	144.0	Community transmission
Chile	29 065	850 483	4 449.0	532	21 008	109.9	Community transmission
Colombia	24 790	2 269 582	4 460.4	782	60 300	118.5	Community transmission
Canada	20 289	881 761	2 336.3	277	22 192	58.8	Community transmission
Ecuador	10 344	292 943	1 660.4	307	16 020	90.8	Community transmission
Paraguay	8 208	165 811	2 324.7	126	3 278	46.0	Community transmission
Cuba	5 674	54 835	484.1	26	344	3.0	Community transmission
Bolivia (Plurinational State of)	5 406	253 297	2 169.9	180	11 789	101.0	Community transmission
Uruguay	5 387	61 929	1 782.8	36	637	18.3	Community transmission
Honduras	4 109	173 020	1 746.9	130	4 247	42.9	Community transmission
Guatemala	4 002	178 337	995.4	93	6 467	36.1	Community transmission
Panama	3 962	343 743	7 966.7	87	5 907	136.9	Community transmission
Dominican Republic	3 651	242 660	2 236.9	69	3 162	29.1	Community transmission
Venezuela (Bolivarian Republic of)	3 061	141 356	497.1	33	1 371	4.8	Community transmission
Jamaica	2 486	25 303	854.5	29	446	15.1	Community transmission
Costa Rica	2 299	206 640	4 056.4	33	2 833	55.6	Community transmission
El Salvador	934	60 800	937.4	47	1 894	29.2	Community transmission
Saint Lucia	487	3 843	2 092.8	8	43	23.4	Community transmission
Barbados	223	3 217	1 119.4	4	37	12.9	Community transmission
Guyana	216	8 729	1 109.8	5	200	25.4	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
Haiti	106	12 536	109.9	1	251	2.2	Community transmission
Saint Vincent and the Grenadines	102	1 658	1 494.5	0	8	7.2	Community transmission
Antigua and Barbuda	87	813	830.2	7	21	21.4	Clusters of cases
Bahamas	58	8 600	2 186.9	1	181	46.0	Clusters of cases
Suriname	53	8 966	1 528.4	5	175	29.8	Clusters of cases
Belize	42	12 335	3 102.1	1	315	79.2	Community transmission
Nicaragua	34	5 176	78.1	1	174	2.6	Community transmission
Trinidad and Tobago	25	7 729	552.3	0	139	9.9	Community transmission
Grenada	3	151	134.2	0	1	0.9	Sporadic cases
Dominica	2	144	200.0	0	0	0.0	Clusters of cases
Saint Kitts and Nevis	0	41	77.1	0	0	0.0	Sporadic cases
Territoriesⁱⁱⁱ							
Puerto Rico	1 283	101 327	3 541.8	27	2 059	72.0	Community transmission
Guadeloupe	490	10 458	2 613.7	4	168	42.0	Community transmission
Aruba	205	8 009	7 501.5	4	75	70.2	Community transmission
Martinique	140	6 886	1 835.0	2	47	12.5	Community transmission
Turks and Caicos Islands	73	2 172	5 609.8	0	14	36.2	Clusters of cases
United States Virgin Islands	68	2 714	2 599.0	0	25	23.9	Community transmission
French Guiana	66	16 693	5 588.9	2	87	29.1	Community transmission
Saint Barthélemy	59	671	6 788.1	0	0	0.0	Clusters of cases
Bonaire	49	455	2 175.5	1	5	23.9	Community transmission
Curaçao	43	4 751	2 895.3	0	22	13.4	Community transmission
Saint Martin	27	1 581	4 089.6	0	12	31.0	Community transmission
Bermuda	17	722	1 159.4	0	12	19.3	Sporadic cases
Sint Maarten	15	2 066	4 817.9	0	27	63.0	Community transmission
Cayman Islands	13	451	686.2	0	2	3.0	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
British Virgin Islands	1	154	509.3	0	1	3.3	Clusters of cases
Anguilla	0	18	120.0	0	0	0.0	Sporadic cases
Falkland Islands (Malvinas)	0	51	1 464.3	0	0	0.0	No cases
Montserrat	0	20	400.1	0	1	20.0	Sporadic cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	No cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	228 543	6 616 840	905.4	2 797	147 284	20.2	
Iran (Islamic Republic of)	58 523	1 681 682	2 002.2	614	60 594	72.1	Community transmission
Jordan	34 919	421 415	4 130.3	225	4 900	48.0	Community transmission
Iraq	30 948	723 189	1 798.0	165	13 548	33.7	Community transmission
Lebanon	20 436	393 211	5 761.0	361	5 013	73.4	Community transmission
United Arab Emirates	19 642	408 236	4 127.6	97	1 310	13.2	Community transmission
Pakistan	9 931	588 728	266.5	329	13 166	6.0	Community transmission
Kuwait	9 538	199 428	4 669.8	42	1 120	26.2	Community transmission
Libya	5 024	137 482	2 000.8	62	2 236	32.5	Community transmission
Tunisia	4 413	237 028	2 005.5	193	8 167	69.1	Community transmission
Bahrain	4 348	126 126	7 412.3	25	469	27.6	Clusters of cases
Egypt	4 093	185 922	181.7	315	10 954	10.7	Clusters of cases
Qatar	3 278	166 475	5 778.3	5	262	9.1	Community transmission
Morocco	2 564	485 974	1 316.6	61	8 676	23.5	Clusters of cases
Saudi Arabia	2 413	379 474	1 090.0	36	6 524	18.7	Sporadic cases
Oman	2 308	142 896	2 798.2	21	1 583	31.0	Community transmission
Somalia	1 050	8 041	50.6	63	294	1.8	Community transmission
Syrian Arab Republic	392	15 925	91.0	35	1 058	6.0	Community transmission
Yemen	175	2 448	8.2	19	651	2.2	Community transmission
Sudan	145	30 540	69.6	7	1 895	4.3	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
Afghanistan	133	55 847	143.5	6	2 449	6.3	Clusters of cases
Djibouti	69	6 134	620.9	0	63	6.4	Community transmission
Territoriesⁱⁱⁱ							
occupied Palestinian territory	14 201	220 639	4 325.1	116	2 352	46.1	Community transmission
Europe	1 136 080	39 775 409	4 261.3	20 770	884 218	94.7	
France	143 622	3 814 830	5 844.4	2 100	87 972	134.8	Community transmission
Italy	138 937	3 046 762	5 039.1	2 071	99 578	164.7	Clusters of cases
Poland	87 928	1 794 914	4 742.6	1 516	45 285	119.7	Community transmission
Czechia	85 851	1 321 331	12 338.5	1 378	21 717	202.8	Community transmission
Russian Federation	76 697	4 322 776	2 962.1	2 978	89 100	61.1	Clusters of cases
Turkey	76 066	2 769 230	3 283.4	462	28 965	34.3	Community transmission
Germany	57 846	2 500 182	2 984.1	1 855	71 900	85.8	Community transmission
Ukraine	53 379	1 401 228	3 204.0	1 040	27 022	61.8	Community transmission
The United Kingdom	42 824	4 213 347	6 206.5	1 714	124 419	183.3	Community transmission
Hungary	37 418	466 017	4 824.0	899	15 873	164.3	Community transmission
Netherlands	31 642	1 115 508	6 510.2	262	15 803	92.2	Community transmission
Serbia	25 947	482 397	6 927.2	113	4 542	65.2	Community transmission
Israel	25 832	798 354	9 223.6	148	5 863	67.7	Community transmission
Romania	25 831	824 995	4 288.4	567	20 854	108.4	Community transmission
Sweden	23 077	684 961	6 782.3	35	13 003	128.8	Community transmission
Spain	17 900	3 142 358	6 720.9	409	70 501	150.8	Community transmission
Austria	15 772	469 539	5 213.4	135	8 529	94.7	Community transmission
Belgium	15 494	787 891	6 798.2	176	22 261	192.1	Community transmission
Slovakia	15 307	323 390	5 923.3	647	7 836	143.5	Clusters of cases
Greece	14 147	203 978	1 957.0	237	6 705	64.3	Community transmission
Bulgaria	13 105	259 811	3 739.1	426	10 593	152.5	Clusters of cases
Republic of Moldova	9 749	194 605	4 824.2	167	4 091	101.4	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
Estonia	9 403	75 003	5 654.1	64	653	49.2	Clusters of cases
Belarus	8 473	294 432	3 115.9	63	2 029	21.5	Community transmission
Albania	5 863	112 078	3 894.6	143	1 918	66.6	Clusters of cases
Kazakhstan	5 602	268 327	1 429.0	0	3 389	18.0	Clusters of cases
Portugal	5 568	809 412	7 938.0	236	16 512	161.9	Clusters of cases
Slovenia	5 459	195 086	9 383.9	31	4 168	200.5	Clusters of cases
Switzerland	5 145	559 627	6 466.2	28	9 278	107.2	Community transmission
Bosnia and Herzegovina	4 808	136 498	4 160.5	159	5 247	159.9	Community transmission
Finland	4 497	60 904	1 099.2	25	767	13.8	Community transmission
North Macedonia	4 350	106 832	5 127.8	59	3 185	152.9	Community transmission
Latvia	4 199	90 009	4 772.0	73	1 687	89.4	Community transmission
Ireland	3 719	222 699	4 510.1	106	4 419	89.5	Community transmission
Denmark	3 594	214 326	3 700.3	19	2 377	41.0	Community transmission
Croatia	3 541	246 514	6 004.8	64	5 590	136.2	Community transmission
Montenegro	3 482	79 771	12 701.1	56	1 059	168.6	Clusters of cases
Norway	3 459	73 493	1 355.6	10	632	11.7	Community transmission
Lithuania	3 069	202 214	7 428.1	84	3 328	122.3	Community transmission
Armenia	2 621	174 679	5 894.9	29	3 221	108.7	Community transmission
Azerbaijan	2 501	236 768	2 335.2	23	3 241	32.0	Clusters of cases
Cyprus	2 151	36 575	3 029.3	1	232	19.2	Clusters of cases
Georgia	2 093	272 851	6 839.8	66	3 576	89.6	Community transmission
Malta	1 997	24 216	5 484.4	16	329	74.5	Clusters of cases
Luxembourg	1 193	56 506	9 026.8	20	657	105.0	Community transmission
Kyrgyzstan	321	86 550	1 326.6	7	1 471	22.5	Clusters of cases
Uzbekistan	290	80 176	239.6	0	622	1.9	Clusters of cases
San Marino	206	3 922	11 556.4	2	76	223.9	Community transmission
Andorra	170	11 019	14 261.3	2	112	145.0	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
Monaco	66	2 019	5 144.7	2	26	66.3	Sporadic cases
Liechtenstein	15	2 663	6 982.7	1	53	139.0	Sporadic cases
Iceland	10	6 059	1 775.6	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
Territoriesⁱⁱⁱ							
Kosovo ^[1]	3 697	72 457	3 894.7	45	1 630	87.6	Community transmission
Isle of Man	131	606	712.7	0	25	29.4	No cases
Gibraltar	8	4 244	12 596.8	1	93	276.0	Clusters of cases
Jersey	5	3 220	2 959.6	0	69	63.4	Community transmission
Guernsey	2	821	1 299.1	0	14	22.2	Community transmission
Greenland	1	31	54.6	0	0	0.0	No cases
Faroe Islands	0	658	1 346.6	0	1	2.0	Sporadic cases
South-East Asia	167 385	13 684 394	677.0	2 201	210 214	10.4	
India	114 068	11 210 799	812.4	705	157 756	11.4	Clusters of cases
Indonesia	44 762	1 373 836	502.3	1 173	37 154	13.6	Community transmission
Bangladesh	3 893	549 724	333.8	51	8 451	5.1	Community transmission
Sri Lanka	2 446	85 336	398.5	29	493	2.3	Clusters of cases
Maldives	1 066	20 663	3 822.6	3	64	11.8	Clusters of cases
Nepal	590	274 655	942.6	237	3 010	10.3	Clusters of cases
Thailand	419	26 370	37.8	2	85	0.1	Clusters of cases
Myanmar	133	142 023	261.0	1	3 200	5.9	Clusters of cases
Timor-Leste	7	120	9.1	0	0	0.0	Clusters of cases
Bhutan	1	868	112.5	0	1	0.1	Sporadic cases
Western Pacific	41 677	1 662 277	84.6	630	29 637	1.5	
Philippines	16 891	591 138	539.5	176	12 465	11.4	Community transmission
Malaysia	13 462	311 777	963.3	45	1 166	3.6	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
Japan	7 216	438 956	347.1	367	8 227	6.5	Clusters of cases
Republic of Korea	2 799	92 471	180.4	31	1 634	3.2	Clusters of cases
Mongolia	295	3 161	96.4	0	2	0.1	Clusters of cases
Papua New Guinea	288	1 583	17.7	3	16	0.2	Community transmission
China	186	102 064	6.9	5	4 848	0.3	Clusters of cases
Cambodia	182	987	5.9	0	0	0.0	Sporadic cases
Singapore	95	60 020	1 025.9	0	29	0.5	Sporadic cases
Viet Nam	77	2 509	2.6	0	35	0.0	Clusters of cases
Australia	65	29 030	113.8	0	909	3.6	Clusters of cases
New Zealand	23	2 043	42.4	0	26	0.5	Clusters of cases
Fiji	4	63	7.0	0	2	0.2	Sporadic cases
Brunei Darussalam	3	189	43.2	0	3	0.7	Sporadic cases
Lao People's Democratic Republic	2	47	0.6	0	0	0.0	Sporadic cases
Solomon Islands	0	18	2.6	0	0	0.0	No cases
Territoriesⁱⁱⁱ							
French Polynesia	72	18 459	6 571.2	1	140	49.8	Sporadic cases
Guam	14	7 540	4 467.5	2	133	78.8	Clusters of cases
Northern Mariana Islands (Commonwealth of the)	2	145	251.9	0	2	3.5	Pending
Wallis and Futuna	1	10	88.9	0	0	0.0	Sporadic cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases
New Caledonia	0	58	20.3	0	0	0.0	Sporadic cases
Samoa	0	4	2.0	0	0	0.0	No cases
Vanuatu	0	1	0.3	0	0	0.0	No cases
Global	2 734 381	116 166 652	1 490.3	60 323	2 582 528	33.1	

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

Annex 2. List of countries/territories/areas reporting variants of concern as of 9 March 2021**

Country/Territory/Area	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			Verified
Barbados			Verified
Belgium	Verified	Verified	Verified
Belize			Verified
Bosnia and Herzegovina			Not Verified
Botswana	Verified		
Brazil		Verified	Verified
Brunei Darussalam	Verified		
Bulgaria			Verified
Cabo Verde			Verified
Cambodia			Not Verified
Cameroon	Verified		
Canada	Verified	Verified	Verified
Cayman Islands			Verified
Chile		Verified	Verified
China	Verified	Not Verified	Verified
Colombia		Verified	
Comoros	Verified		
Costa Rica	Verified		Verified
Croatia	Not Verified		Verified
Cuba	Verified		
Curaçao			Verified
Cyprus			Verified
Czechia	Not Verified		Verified
Democratic Republic of the Congo			Not Verified
Denmark	Verified	Verified	Verified
Dominican Republic			Verified
Ecuador			Verified
Estonia	Not Verified		Verified
Faroe Islands		Verified	

Country/Territory/Area	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana		Verified	Verified
French Polynesia			Verified
Gambia			Verified
Georgia			Verified
Germany	Verified	Verified	Verified
Ghana	Verified		Verified
Gibraltar			Not Verified
Greece	Verified		Verified
Guadeloupe			Verified
Hungary	Not Verified		Verified
Iceland			Verified
India	Verified	Verified	Verified
Indonesia			Verified
Iran (Islamic Republic of)			Verified
Iraq			Verified
Ireland	Verified	Not Verified	Verified
Israel	Verified		Verified
Italy	Not Verified	Verified	Verified
Jamaica			Verified
Japan	Verified	Verified	Verified
Jordan			Verified
Kenya	Verified		
Kosovo ^[1]			Verified
Kuwait			Verified
Latvia			Verified
Lebanon			Verified
Libya			Verified
Liechtenstein			Verified
Lithuania			Verified
Luxembourg	Verified		Verified
Malawi	Verified		
Malaysia			Verified
Malta	Not Verified		Verified

Country/Territory/Area	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Martinique			Verified
Mayotte	Verified		Verified
Mexico		Verified	Verified
Montenegro			Verified
Morocco			Verified
Mozambique	Verified		
Namibia	Verified		
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	Not Verified		Verified
Poland	Not Verified		Verified
Portugal	Verified	Not Verified	Verified
Puerto Rico			Verified
Republic of Korea	Verified	Verified	Verified
Republic of Moldova			Not Verified
Réunion	Verified	Verified	Verified
Romania	Verified	Verified	Verified
Russian Federation			Verified
Saint Barthélemy			Verified
Saint Lucia			Verified

Country/Territory/Area	501Y.V2 (B.1.351)	P.1 (B.1.1.28)	VOC 202012/01 (B.1.1.7)
Saint Martin			Verified
Saudi Arabia			Verified
Senegal			Verified
Serbia			Verified
Singapore			Verified
Slovakia	Not Verified		Verified
Slovenia	Verified		Verified
South Africa	Verified		Verified
Spain	Verified	Verified	Verified
Sri Lanka			Verified
Sweden	Verified	Not Verified	Verified
Switzerland	Verified	Not Verified	Verified
Thailand	Verified		Verified
The United Kingdom	Verified	Verified	Verified
Trinidad and Tobago			Verified
Tunisia			Verified
Turkey	Not Verified	Not Verified	Verified
Turks and Caicos Islands			Verified
Ukraine			Not Verified
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania	Not Verified		
United States of America	Verified	Verified	Verified
Uruguay			Verified
Uzbekistan			Verified
Venezuela (Bolivarian Republic of)		Verified	
Viet Nam	Verified		Verified
Zambia	Verified		
Zimbabwe	Verified		

**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

8 March 2021



Confirmed cases^a

116 363 935

Confirmed deaths

2 587 225

Historic roll-out of shipments from the COVAX Facility gathers pace



Photo credit: WHO Sudan Country Office

The "First Wave" initiative, a global pilot program in which some countries receive early delivery of a limited number of doses of COVID-19 vaccines as part of their total allotted quota from the COVAX facility is underway, marking a key milestone for countries.

On March 1, Colombia celebrated the arrival of 117 000 doses of COVID-19 vaccine. Paying tribute to the diligence of those involved, WHO Director-General Tedros Adhanom Ghebreyesus said: "Colombia, supported by COVAX partners, has worked incredibly hard preparing to receive its first wave of vaccines".

Meanwhile Sudan became the first country in the Eastern Mediterranean Region to receive COVID-19 vaccines with over 800 000 doses arriving from the COVAX Facility. Nigeria, the most populous country in the African Region, received 3.94 million doses to immediately begin vaccinating frontline workers. The COVAX Facility expects to deliver 90 million doses of COVID-19 vaccines to the African Region in the first quarter of 2021.

For further information, click for: [Colombia](#), [Sudan](#), [Nigeria](#)

Key Figures



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



157 GOARN deployments conducted to support COVID-19 pandemic response



20 060 365 respirators shipped globally



198 709 426 medical masks shipped globally



8 651 831 face shields shipped globally



37 040 900 gloves shipped globally



More than **4.9 million** people registered on [OpenWHO](#) and accessing online training courses across **27** topics in **45** languages

Register [here](#) for the OpenWHO webinar on 8 March to celebrate **International Women's Day 2021**: Create an equal future in a COVID-19 world

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



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From the field:

Cambodia among first countries to receive COVID-19 vaccines from COVAX Facility

On 2 March, 324 000 doses of the AstraZeneca/Oxford COVID-19 vaccine licensed to Serum Institute of India (SII) arrived at Phnom Penh International Airport, their first stop before being given to priority groups, including those at high risk of exposure such as frontline health workers and those who are most vulnerable to developing severe illness from COVID-19.



Photo caption: Boxes of vaccine doses at the Phnom Penh International Airport on 2 March 2021. Photo credit: ©WHO

These additional COVID-19 vaccines will provide the Royal Government of Cambodia (RGC) with another powerful tool in its ongoing efforts to combat COVID-19.

His Excellency Professor Mam Bunheng, Minister of Health, said “This is the best approach to maximising the impact of the limited supply of vaccines available in the initial phase”. He also urged everyone to continue following public health and social measures through the “3 do’s” of physical distancing, wearing a mask, and washing hands regularly while avoiding the “3 don’ts” of confined and enclosed spaces, crowded spaces, and touching each other.

These doses are the first of a total of 1.1 million doses that are expected to be provided in batches by the COVAX Facility by the end of May. Cambodia is expected to receive doses for 20% of its population (an estimated 7 million doses) from COVAX, with further batches continuing to arrive throughout the year.

The COVAX Facility is an unprecedented global effort to provide every country in the world with equitable access to safe COVID-19 vaccines as rapidly as possible. Cambodia is among the first countries in the Western Pacific Region to receive vaccines from COVAX.

Given the limited global supply of vaccines, the RGC is in the process of procuring, through numerous means, vaccines which have met its regulatory safety standards as quickly as possible to protect its citizens. Vaccines were first administered on 10 February, and to date more than 65 000 people have been vaccinated. The arrival of these additional vaccine doses will be a significant step closer towards achieving the RGC’s goal of vaccinating 10 million people.

For further information, [click here](#).

From the field:

WHO gives laboratory, cold chain equipment to Maldives to strengthen pandemic response, build resilient health systems

On 25 February, WHO handed over cold chain and laboratory supplies to the Ministry of Health Maldives to strengthen the pandemic response and support building a resilient health system.

The supplies will build a cold chain system for vaccines (COVID-19 and others) adequate to support vaccine management for the next 10 years while strengthening quality of care and quality testing for COVID-19, measles, rubella and Influenza.



Since the beginning of the pandemic, WHO has been working with Maldives government and partners for implementing scenario-based response with whole-of-government and whole-of-society buy-in. The procurement of essential medicines and consumables has helped Maldives maintain essential health services, which has been one of the key areas of focus throughout the response. With the help of WHO-provided test kits, Maldives has tested a staggering 75% of its population.

WHO South-East Asia Regional Director, Dr Poonam Khetrapal Singh remarked that “despite the country’s global connectedness and population density in capital Malé, COVID-19 cases and deaths in the country have been three times below the global average mortality per million population” as well as noting anticipation for Maldives continued “regional and global leadership throughout the vaccine roll-out and in the recovery from the crisis”.

Collaboration between WHO and Maldives has been a tradition and the Minister of Health, Mr. Ahmed Naseem, noted that “With WHO’s contributions, Maldives has made significant progress in its healthcare and development indicators over the past decades,” adding “Being a small island nation, Maldives is vulnerable to the impacts of socio economic transformations and environmental challenges. As such, it is imperative that we prioritize increasing our capacity for protecting health in an unstable and changing climate.”

For further information, click [here](#).

From the field:

Handover of the GOARN Rapid Response Mobile Lab at the Reception and Identification Centre in Lesvos, Greece

Last week marked the transfer of the GOARN Rapid Response Mobile Lab (RRML) in Lesvos, Greece to the Greek National Organization of Public Health (EODY). Following a fire on 8 September 2020 on Lesvos Island at the Moria refugee and migrant camp, the Emergency Medical Team (EMT) Secretariat supported deployments of EMTs from Norway and Germany comprised of experts including medical doctors, nurses and paramedics. They were tasked with supporting local authorities to establish a triage, testing and isolation facility for patients with COVID-19 and to provide essential health care services to those in need.

On 1 March, the European Mobile Lab, a type II RRML began operations under its new leadership of EODY, after a successful transition months in the making to two newly trained lab technicians.

The RRML, run by the Bernhard Nocht Institute of Tropical Medicine (BNITM) in Germany, had been deployed on 4 October 2020 by the Global Outbreak Alert and Response Network (GOARN) to Lesvos for an initial three-month period to support health providers at the Reception and Identification Centre (RIC) at Kara Tepe in COVID-19 PCR diagnostics and supportive analysis.



The handover of the RRML key to the Greek National Organization of Public Health Coordinator. Credit: WHO Country Office in Greece

In order to facilitate the continuity and sustainability of the lab's services, the laboratory deployment was extended by two months to ensure handover of the lab to EODY. During this period, the BNITM facilitated the training of lab technicians to familiarize them with the lab equipment and ensure a smooth capacity transfer.

BNITM, WHO and EODY jointly developed this exit strategy, including the capacity building. Then, from 26-28 February 2021, the WHO Greece Country Office's Migration and Health Officer oversaw and officiated the handover process of the RRML. The transition included a donation of goods and consumables with the goods transported to EODY storage facilities in the RIC at Kara Tepe.

Throughout the emergency response, WHO and BNITM have worked hand in hand, in close alignment with the Greek Government and in close contact with high level officials from the Ministry of Health, Ministry of Migration and Asylum, Ministry of Citizen Protection and the leadership of EODY. WHO would like to thank the BNITM for their contribution to the COVID-19 response.

Risk Communication, Community Engagement and Infodemic Management

New COVID-19 risk assessment quiz increases motivation to change behaviour


A new personal WHO COVID-19 risk assessment quiz is now available in the 6 UN languages. The quiz asks people to answer 10 questions on what they would do in different scenarios, such as seeing friends, going to a music event, having their hair cut and going to work.

Each question provides a response as to whether their actions are more or less risky, and what they can do to reduce their risk.

How do you decide when to go to indoor public places (such as bars, restaurants or religious services)?

(select all that apply)

- ☐ I choose not to go to indoor public places, especially where it can be crowded.
- ☐ I go if I know if there is good ventilation and I can keep at least a 1-metre distance from others.
- ☐ I go (and stay) only when I and everyone else wears a mask in crowded situations where we can't maintain the 1-metre distance.
- ☒ I go regardless of the virus and take no precautions.



Your behavior may be putting you and others at risk.

Tips to reduce the risk of contracting or spreading COVID-19:

- Avoid closed crowded indoor settings, especially when there is poor ventilation.
- If you have to go to a public building, maintain at least a 1-metre distance from others.
- Wear a mask and encourage others to wear a mask as well.

Within the first ten weeks of its use almost 36 000 people opened the quiz with 58% of those completing it reporting that the quiz motivated them to make behaviour changes.

By increasing the numbers of people following the recommended precautions, transmission can be reduced – which is more important than ever to reduce the number of variants of the virus. Countries can promote and link to the quiz, and a print version should be available next month.

Please click here for the quiz in the following languages: [English](#), [Arabic](#), [Chinese](#) (Simplified), [French](#), [Russian](#), [Spanish](#)

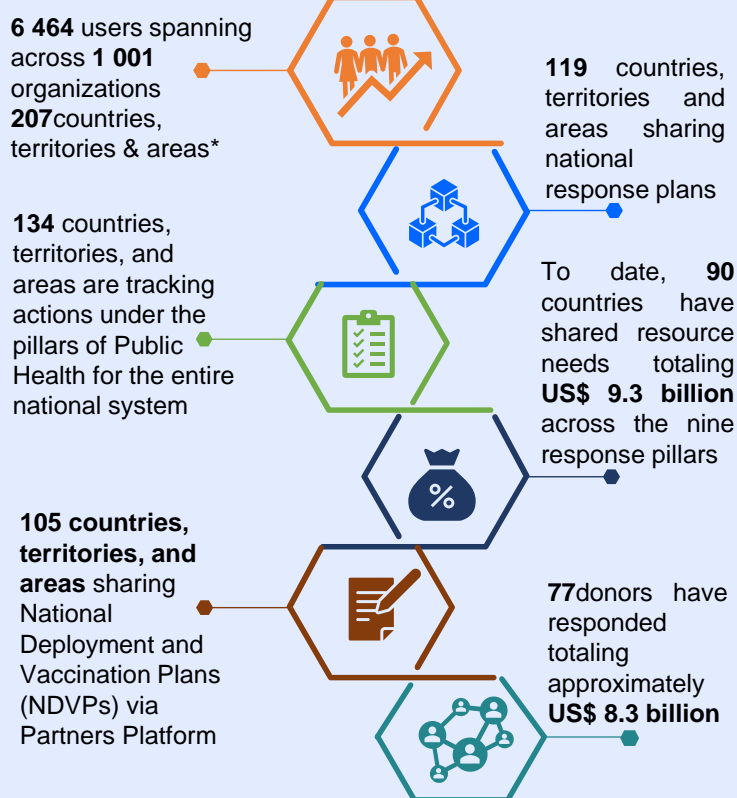
COVID-19 Partners Platform

Strategic Preparedness and Response Plan (SPRP) 2021 Operational Planning Guidelines and next steps for implementation

Last week the World Health Organization released its 2021 COVID-19 Strategic Preparedness and Response Plan ([SPRP](#)), which seeks to build on the world's global response to the virus and the knowledge we've acquired a year into the pandemic.

Accompanying the recently released SPRP 2021 are the soon to be released 2021 Operational Planning Guidelines. Written with the aim of translating acquired knowledge into practical, high-level strategic actions, the new guidelines' actions can be adapted as needed and implemented to meet countries' respective COVID-19 national and subnational contexts in the areas of capacity, income, and SARS-CoV-2 transmission to meet the SPRP's larger six strategic objectives (suppress transmission; reduce exposure; counter misinformation and disinformation; protect the vulnerable; reduce death and illness; accelerate equitable access to new tools, including vaccines, diagnostics and therapeutics).

2020 Strategic Preparedness and Response Plan (SPRP) and 2021 National Deployment and Vaccination Plan (NDVP) Achievements



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

The new operational guidelines will be featured prominently in the Partners Platform's updating of its own Action Checklist, which will include new recommended action items for countries to undertake organized under ten pillars of health preparedness and response; updated technical guidance references; and key areas for global and regional support to countries under each response pillar. As a living document, the guidelines' technical assistance will be regularly updated to meet an evolving epidemiological situation.

With these new guidelines, the [Partners Platform](#) continues to onboard new countries every day in order to foster collaboration between governments, aid in the development of national COVID-19 response plans and identify and bridge the serious resource gaps facing too many countries.



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 5 March 2021.

Shipped items as of 5 March 2021	Laboratory supplies			Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	718 250	3 695 735	1 825 642	1 472 210	10 594 300	208 690	1 717 279	53 429 400	2 758 630
Americas (AMR)	7 282 300	1 046 142	10 543 278	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	978 300	1 357 970	1 553 410	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	430 000	562 080	553 070	1 750 900	8 935 100	409 900	1 757 548	40 911 500	5 423 350
South East Asia (SEAR)	440 000	2 509 400	2 408 970	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		228 500	346 834	768 700	3 021 000	311 927	463 710	14 974 146	2 102 035
TOTAL	9 848 850	9 399 827	17 231 204	8 651 831	37 040 900	1 546 447	6 946 179	198 709 426	20 060 365

Note: The laboratory supplies data is as of 26 February 2021

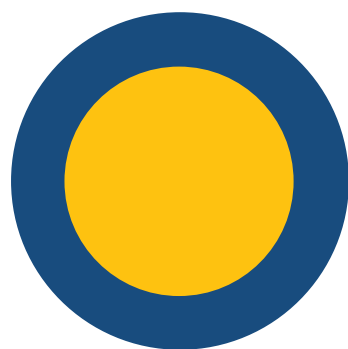
For further information on the **COVID-19 supply chain system**, see [here](#).

Appeals

WHO's [Strategic Preparedness and Response Plan](#) (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 and health systems strengthening for the roll out of COVID-19 tools (ACT-A). Of the US\$ 1.96 billion appealed for, US\$ 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. US\$ 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.

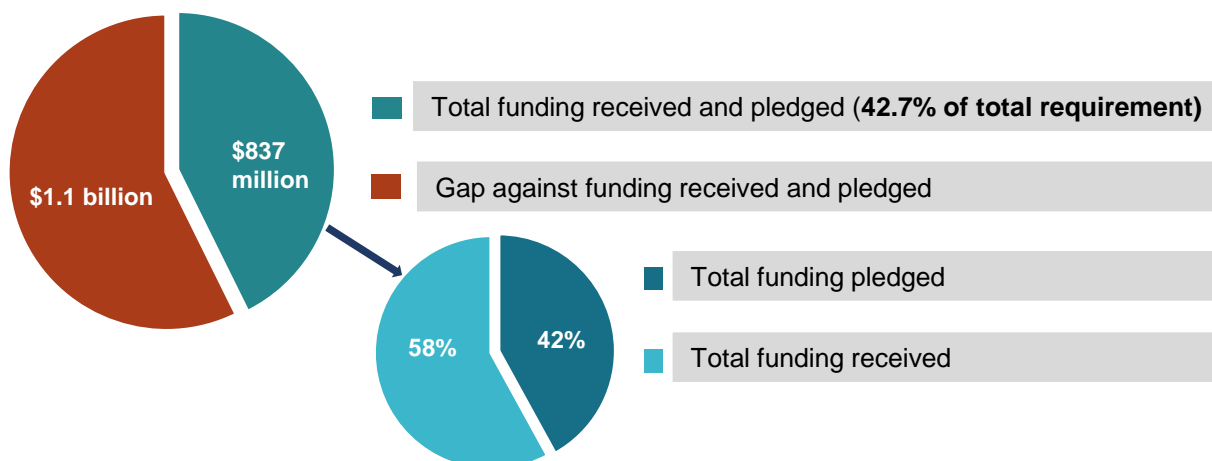
SPRP 2021 Requirements US\$ 1.96 billion



- 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*

SPRP 2021 Requirement Progress (US\$)



The status of funding raised for WHO against the SPRP can be found [here](#)

WHO Funding Mechanisms

COVID-19 Solidarity Response Fund

As of 26 February 2021, [The Solidarity Response Fund](#) has raised or committed more than US\$ 242 million.

From the Fund's March 13, 2020 launch through today leading companies and organizations and more than 660 000 individuals together contributed more than US\$651 million in fully flexible funding to support the WHO-led global response effort

More than **US\$ 242 Million**



660 000 donors

[individuals – companies – philanthropies]

Health Ops

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.

Register [here](#) for the webinar from OpenWHO on 8 March to celebrate **International Women's Day 2021**: Create an equal future in a COVID-19 world



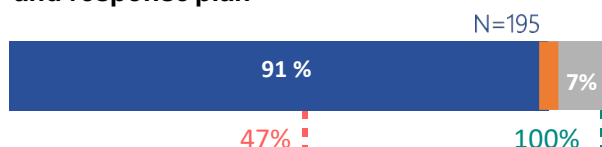
45 languages

27 topical courses

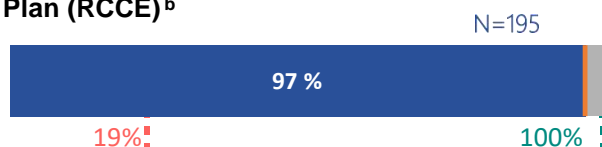
Over 2.7 million certificates

COVID-19 Global Preparedness and Response Summary Indicators^a

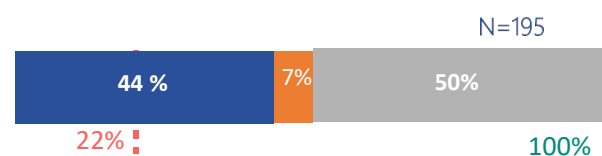
Countries have a COVID-19 preparedness and response plan



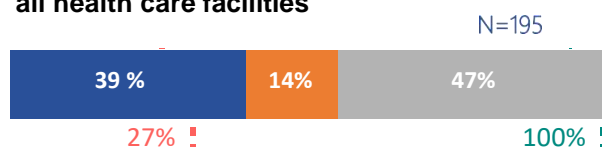
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE)^b



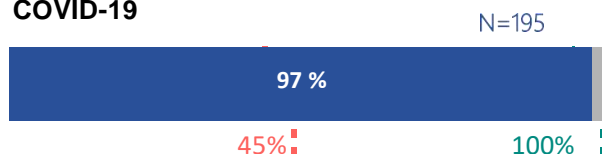
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



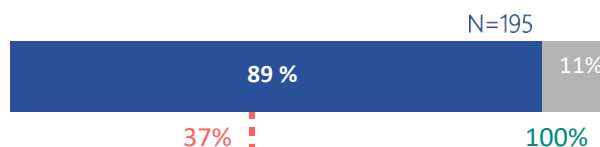
Countries with a national IPC programme & WASH standards within all health care facilities



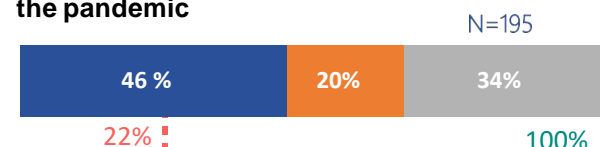
Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



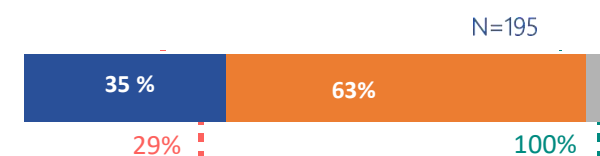
Countries have a clinical referral system in place to care for COVID-19 cases



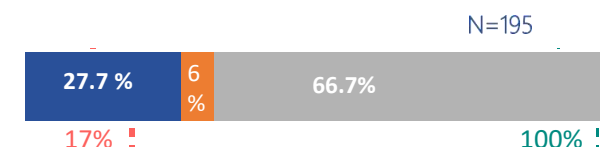
Countries that have defined essential health services to be maintained during the pandemic



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



Countries have a health occupational safety plan for health care workers



Countries have COVID-19 laboratory testing capacity



Legend



Yes



No



No information



Baseline value



Target value

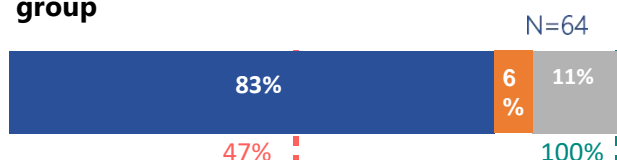
Notes:

^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

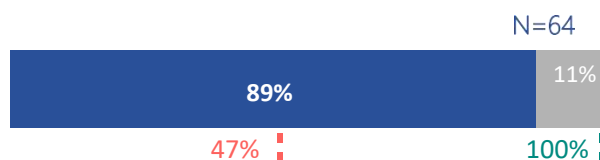
COVID-19 Global Preparedness and Response Summary Indicators

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



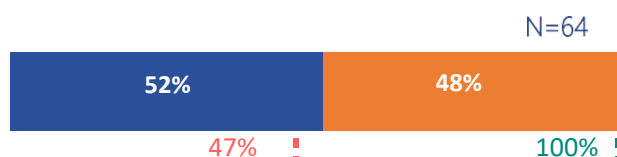
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19^c



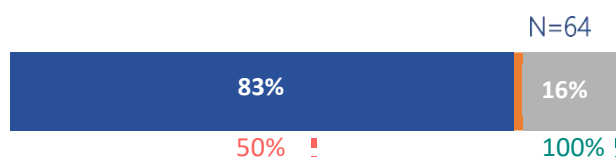
Priority countries with a contact tracing focal point



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



Legend

Yes

No

No information

Baseline value

Target value

Notes:

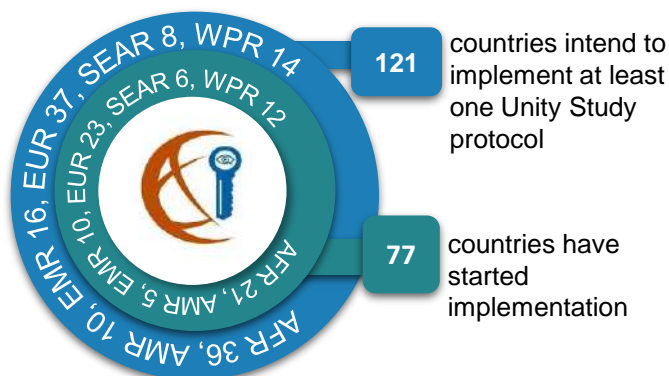
^c Source: WHO Immunization Repository

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.

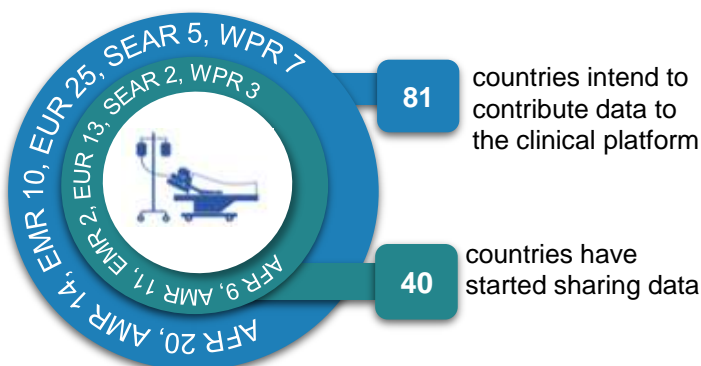
The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays



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.

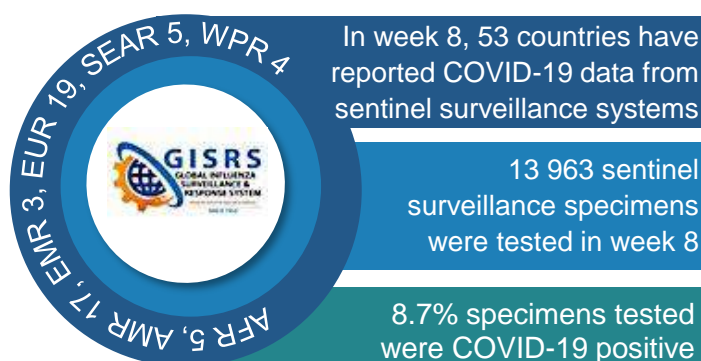
WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



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 SARS-COV-2





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 2 March 2021 **Weekly Epidemiological Update**, click [here](#). Highlights this week include:
 - Overviews of global and regional epidemiological situation
 - Special focus sections on:
 - COVID-19 trade, travel and points of entry
 - The importance of fit, filtration and breathability of non-medical (fabric) masks in the context of COVID-19
 - 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 28 February 2021, 10 am CET

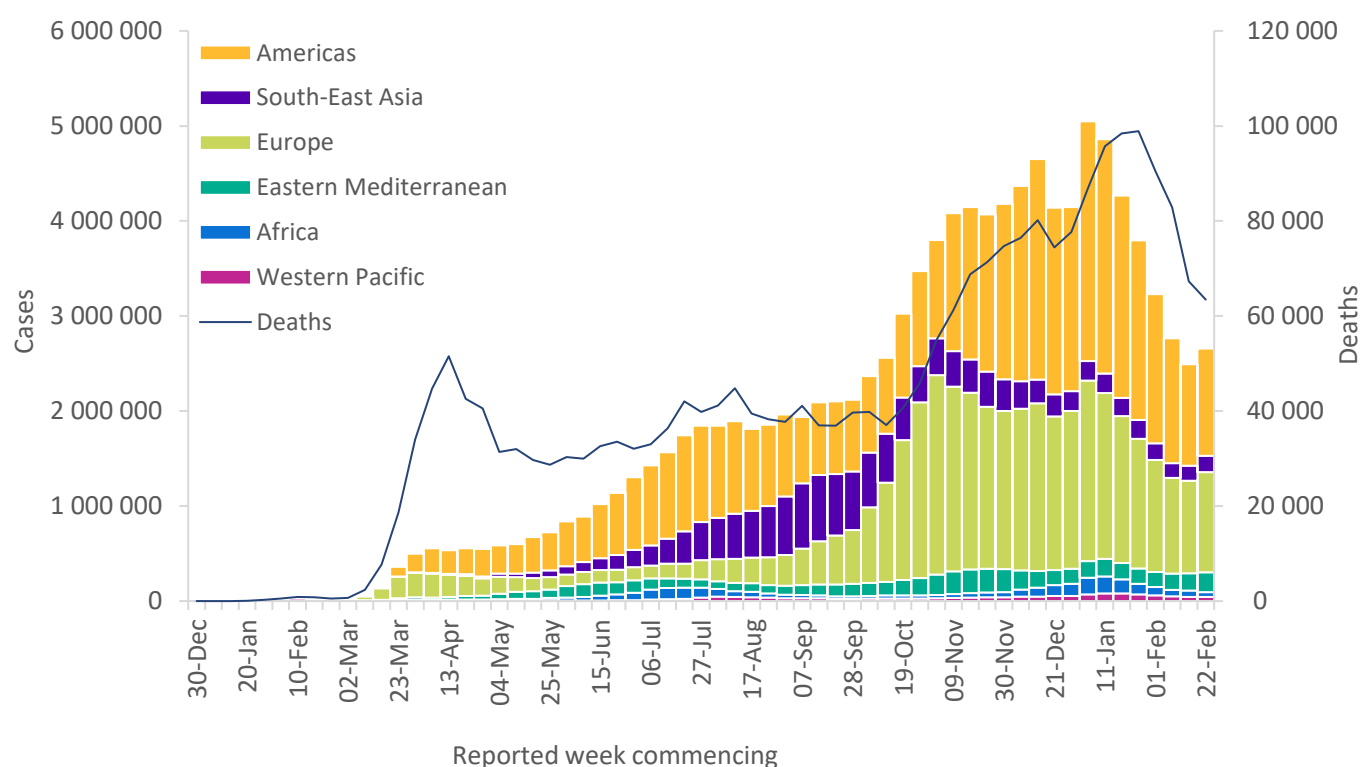
In this edition:

- [Global overview](#)
- [Special focus: COVID-19 trade, travel and points of entry](#)
- [Special focus: the importance of fit, filtration and breathability of non-medical \(fabric\) masks in the context of COVID-19](#)
- [Special focus: SARS-CoV-2 variants of concern](#)
- [WHO regional overviews](#)
- [Key weekly updates](#)

Global overview

Over 2.6 million new cases were reported last week, a 7% increase compared to the previous week, following six consecutive weeks of declining numbers (Figure 1). The global case increase was driven by increases in the Eastern Mediterranean (14%), South-East Asia (9%), Europe (9%) and the Americas (6%). Possible reasons for this increase include the continued spread of more transmissible variants of concern (VOCs), relaxation of public health and social measures (PHSM) and fatigue around adhering to PSHM measures. Basic public health measures remain the foundation of the response. For public health authorities, that means testing, contact tracing, isolation, supported quarantine and quality care. For individuals, it means avoiding crowds, physical distancing, hand hygiene, masks and ventilation. Furthermore, immunity conferred by vaccination takes weeks at the individual level, and it may take longer to observe impacts at the population-level.

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 28 February 2021**



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

The number of global new deaths continues to decrease, with over 63 000 new deaths reported last week, a 6% decrease as compared to the previous week. New deaths decreased in four regions, Europe, Africa the Western Pacific, and the Americas (by 15%, 19%, 35% and 1%, respectively), and increased by 47% in the South East Asia Region, partly due to retrospective reporting of deaths from Nepal. The Americas reported over 1.1 million new cases and nearly 34 000 deaths, which accounted for 42% of global cases and 53% of global deaths.

In the past week, the five countries reporting the highest number of new cases were the United States of America (472 904 new cases, a 2% decrease), Brazil (373 954 new cases, a 18% increase), France (149 959 new cases, a 14% increase), Italy (112 029 new cases, an 32% increase) and India (105 080 new cases, a 21% increase).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 28 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	1 129 929 (42%)	6%	50 426 060 (44%)	33 951 (53%)	-1%	1 205 245 (48%)
Europe	1 055 781 (40%)	9%	38 679 334 (34%)	21 302 (34%)	-15%	861 906 (34%)
South-East Asia	171 419 (6%)	9%	13 517 009 (12%)	3 217 (5%)	47%	208 013 (8%)
Eastern Mediterranean	207 177 (8%)	14%	6 388 249 (6%)	2 562 (4%)	5%	144 479 (6%)
Africa	50 324 (2%)	-24%	2 840 208 (3%)	1 659 (3%)	-19%	71 991 (3%)
Western Pacific	44 193 (2%)	-2%	1 620 582 (1%)	786 (1%)	-35%	29 006 (1%)
Global	2 658 823 (100%)	7%	113 472 187 (100%)	63 477 (100%)	-6%	2 520 653 (100%)

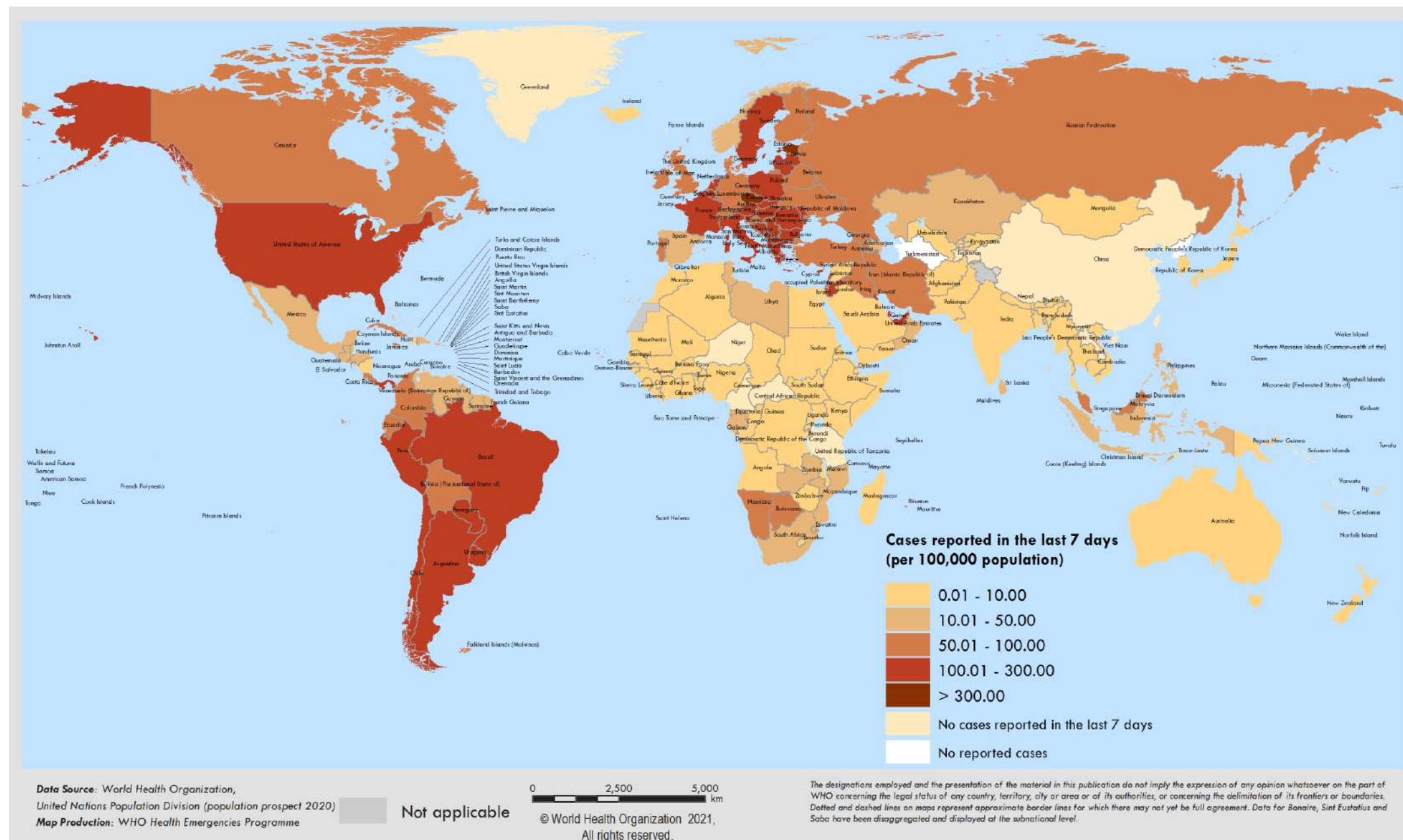
*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. Regional percentages rounded to the nearest whole number; global totals may not equal 100%.

**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, 22 February through 28 February 2021**



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

Special Focus: COVID-19 and international trade, travel and points of entry

The COVID-19 pandemic has had, and is having, a substantial impact on international trade and travel. In 2020, world passenger traffic fell by 2.7 billion passengers, or by 60% compared to 2019, causing a US\$ 371 billion loss of gross passenger operating revenues of airlines¹. In addition to the economic loss, travel restrictions are also having a direct impact on the lives and livelihoods of transport workers, most notably in the maritime sector. The International Maritime Organization (IMO) estimates that around 400 000 seafarers have been stranded on board commercial vessels, long past the expiry of their contracts and unable to be repatriated. A similar number of seafarers urgently need to join ships to replace these individuals².

WHO has been engaging with and supporting stakeholders in the travel sector across all points of entry (airports, ports, and ground crossings) since the start of the pandemic, and produced its first travel-related guidance in March 2020. All guidance documents can be found [here](#).

Managing the safe and effective recovery of international travel through a risk-based approach

To promote a safe and effective gradual recovery of international travel while managing the public health risks associated with the cross-border movement of people and goods, key stakeholders – including Member States, the travel industry and its affiliates, and the general public – requested further guidance from WHO on how to implement a risk-based approach to international travel. This was also echoed in the advice to WHO by the IHR (2005) Emergency Committee for COVID-19 at both its [fifth meeting](#) in October 2020, and its [sixth meeting](#) in January 2021.

In December 2020, WHO published [guidance](#) for national authorities on a step-by-step approach to decision-making for calibrating public health risk mitigation measures for international travel in the context of COVID-19. It is divided into three main sections: risk assessment, risk mitigation and risk communication. Key points include:

- During the COVID-19 pandemic, international travel should always be prioritized for emergencies and humanitarian actions, travel of essential personnel, repatriations, and cargo transport for essential supplies such as food, medicines, and fuel;
- As countries gradually resume international travel, introduction of risk mitigation measures aiming to reduce travel associated exportation, importation and onward transmission of SARS-CoV-2 should not unnecessarily interfere with international traffic and should be based on a thorough risk assessment that is conducted systematically and routinely;
- Decision-makers in Member States can conduct risk assessments through a mixed-method approach (explained in the guidance and the accompanying [risk assessment tool](#)) to calculate the additional burden presented by possible importation of COVID-19 cases and decide policies on the basis of whether they have the capacity to cope with this burden;
- International travellers should not be considered by nature as suspected COVID-19 cases or contacts. Therefore, WHO does not recommend travellers as a priority group for testing;
- The use of “immunity certificates” for international travel in the context of COVID-19 is not currently supported by scientific evidence and is therefore not recommended by WHO; and
- The overall health and well-being of communities should be at the forefront of considerations when deciding on and implementing international travel-related measures.

¹ ICAO (2021). Effects of Novel Coronavirus (COVID-19) on Civil Aviation: Economic Impact Analysis. https://www.icao.int/sustainability/Documents/COVID-19/ICAO_Coronavirus_Econ_Impact.pdf

² UN News (2021). ‘An unwanted prison sentence’ for seafarers stuck at home and stranded at sea. <https://news.un.org/en/story/2021/01/1081482>

COVID-19 diagnostic testing in the context of international travel

To limit transmission and reduce morbidity and mortality from COVID-19, countries around the globe have implemented public health and social measures (PHSM) for epidemic control. One measure considered by many countries and transport sector stakeholders is testing for SARS-CoV-2 in international travellers prior to travel, at points of entry or after travel. In addition to the risk-based travel guidance, WHO has published a [scientific brief on diagnostic testing](#), examining the requirements and issues around testing as a tool for mitigating cross-border transmission of SARS-CoV-2. It provides an overview of SARS-CoV-2 diagnostic assays and their performance and suitability for potential use in SARS-CoV-2 testing prior to departure, at points of entry and on arrival. It also raises the following key points:

- Testing at borders is not a substitute for other public health measures, especially robust contact tracing systems;
- WHO recommends that confirmed, probable and suspected cases for COVID-19 and contacts of confirmed or probable cases do not travel. WHO also advises that travellers who are unwell or any persons who are at an elevated risk for developing severe disease and dying from SARS-CoV-2 infection, including people 60 years of age or older or those with chronic diseases or underlying health conditions, delay or avoid travelling internationally to and from areas with COVID-19 community transmission; and
- A thorough risk assessment should be a key element of the decision-making process regarding SARS-CoV-2 testing policies for international travellers. Additionally, resources and capacity to offer testing for international travellers should be assessed critically to avert negative impact on testing in high-risk settings and high-risk groups.

Impact of new variants of concern on international travel restrictions

As [previously reported](#), evidence suggests that some newly identified variants of concern may have increased transmissibility as compared to previously circulating variants. It is likely that there will continue to be elevated risks of the exportation and importation of cases between countries via international travel, including cases of the new variants of concern. The impact on countries will depend on multiple factors including their epidemiological situation, the capacity of their health systems, and the implementation of other public health and social measures, as explained in the [WHO risk-based travel guidance](#).

Any measures imposed to prevent the importation of SARS-CoV-2 variants of concern must, therefore, be time limited; not prejudiced towards countries readily sequencing and sharing findings; based on thorough assessments of risk; and continuously adapted to emerging information.

Considerations regarding COVID-19 vaccination for international travellers

Following the advice of the IHR (2005) Emergency Committee for COVID-19 after its sixth meeting in January 2021, WHO published an [interim position paper](#) on considerations regarding proof of COVID-19 vaccination for international travellers. At the present time, national authorities and conveyance operators should not introduce requirements of proof of COVID-19 vaccination for international travel as a condition for departure or entry, given that there are still critical unknowns regarding the efficacy of vaccination in reducing transmission; duration of protection offered by vaccination; whether vaccination offers protection against asymptomatic infection; and possible exemption of people who have antibodies against SARS-CoV-2. In addition, considering that there is limited availability of vaccines, preferential vaccination of travellers could result in inadequate supplies of vaccines for priority populations considered at high risk of severe COVID-19. WHO also recommends that people who are vaccinated should not be exempt from complying with other travel risk-reduction measures. Should the requirement of proof of COVID-19 vaccination for international travellers be introduced in the future in accordance with IHR provisions, vaccines must be approved by WHO, be of suitable quality and universally available.

WHO is working with partners to establish a governance framework and specifications for a digital vaccination certificate for possible use at both national and international levels. Regardless of any technology implemented in the future, the COVID-19 vaccination status of international travellers should be recorded

through the International Certificate for Vaccination and Prophylaxis based on the model presented in Annex 6 of the IHR. The same format could be adapted once WHO pre-qualified COVID-19 vaccines become universally available, and relevant recommendations are provided under the IHR.

Systematically reviewing the evidence available to inform and update WHO's travel guidance

WHO commissioned a systematic review, with support from the Cochrane collaboration, on the evidence available up to June 2020 on the effectiveness of travel measures on reducing international transmission of COVID-19³. Subsequently, since October 2020, WHO has been convening the [International Travel and Health Guideline Development Group](#) (ITH GDG) to develop guidance documents based on systematic reviews of the evidence available on the efficacy, safety and harms of specific public health interventions for the mitigation of SARS-CoV-2 transmission before, during and after travel. The ITH GDG is currently focusing on air travel, which will be followed by maritime travel and travel via land.

The first publication, [Evidence to recommendations: COVID-19 mitigation in the aviation sector](#), describes the methodological approaches underpinning the work of the ITH GDG and presents an analytic framework that will inform interim guidance and recommendations. It presents the nine questions being addressed, which relate to infection prevention and control (IPC), health screening, quarantine and isolation, testing, contact tracing, risk communication and restriction of air travel, among others.

The second publication, [Evidence to recommendations: Methods used for assessing health equity and human rights considerations in COVID-19 and aviation](#), describes the process that WHO is undertaking to assess the reporting of key factors related to health equity and human rights in the primary literature of specific public health interventions as they relate to COVID-19 and aviation. Guidance documents to address these nine questions are currently being developed, using the methodologies described in these documents and will be published in the coming weeks.

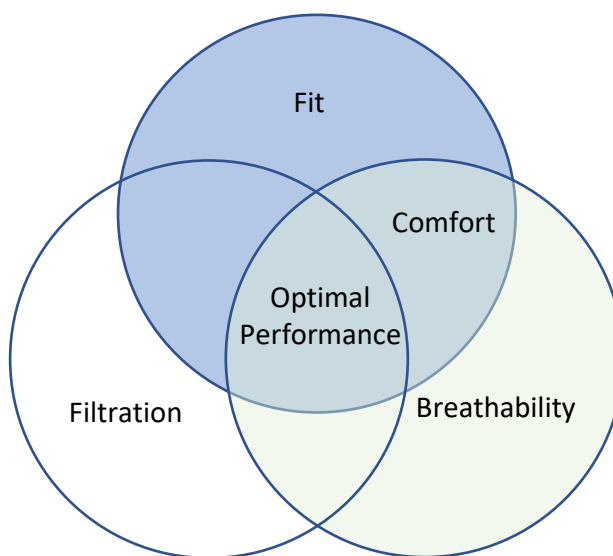
³ Cochrane (2020). Cochrane Rapid Review examines travel-related control measures to contain the COVID-19 pandemic.
<https://www.cochrane.org/news/cochrane-rapid-review-examines-travel-related-control-measures-contain-covid-19-pandemic>

Special Focus: The importance of fit, filtration and breathability of non-medical (fabric) masks in the context of COVID-19

Since January 2020, WHO has recommended the use of masks as part of a [comprehensive set of interventions to prevent the spread of SARS-CoV-2](#). There are many commercial non-medical (also called fabric or cloth) masks available; however, the multitude of voluntary international standards together with the absence of regulatory oversight has made it difficult for people to know if their masks are effective barriers.

When implemented with other public health and social measures, a mask can serve as an effective barrier to prevent transmission of the SARS-CoV-2 virus, provided that it fits well, has good filtration, and the wearer can easily breathe through it (Figure 3). When any of these three parameters are not optimized, the mask may be an ineffective barrier and/or uncomfortable to wear.

Figure 3. Illustration of the three essential parameters of filtration, breathability and fit



Good fit means the mask fully covers the nose, mouth and chin. There should be no leaks around the edges of the mask. The exhaled breath should be filtered through the surface of the mask.

Good filtration means the mask has the right fabric or combination of fabrics that filter droplets present in exhaled air.

Good breathability means the wearer can easily breathe through the material of the mask. Since masks are often rated in terms of their filtration, it is equally important to maximize breathability to ensure the wearer's comfort.

WHO first issued [guidance](#) on the composition of non-medical or fabric masks in June 2020 providing specific recommendations about the number of layers, their composition and performance, and the importance of fit. Where possible, to ensure adequate wearer comfort, the design and combination of textiles used in manufacturing the fabric masks should be independently tested for adequate fit, filtration and breathability. This is especially important for masks used for an extended period of time and/or in humid environments.

WHO continues to encourage governments to establish regulations for non-medical masks, and has published evidence-based recommendations on what to look for when purchasing a fabric mask, which are summarized below:

When purchasing a fabric mask, check the packaging for information that they have been laboratory tested:

- At least 70% filtration of particles or droplets measuring three microns (lower filtration is acceptable if the challenge particles/droplets are smaller);
- No more than 60 pascals of pressure difference per square centimetre (<60 Pa/cm²) (alternative measures such as air permeability or airflow resistance may be used);
- Guaranteed at least five cycles of washing with no performance reduction;
- No exhalation valves;
- Antimicrobial coatings or treatments are not required; if included, the treated layers must be away from the skin and be tested for inhalational and skin safety as per the [ISO](#) or [REACH](#) regulation requirements.

If there are no standards listed on the package, find a mask that has three layers, made up of:

- Inner layer made of absorbent cotton;
- Middle layer made of a non-woven spunbond polypropylene (i.e., a filter layer); and
- Outer layer made of a moisture resistant polyester or another layer of non-woven spunbond polypropylene.

More detailed information can be found in the annex section of the [guidance document](#). Breathability may be altered when additional layers are added to increase filtration. For example, adding a second mask over the first may increase filtration and fit, but can also make breathing more difficult and uncomfortable. If people have to take off a mask to breathe, the barrier is naturally lost.

Finally, a non-medical/fabric mask should always be stored properly in designated plastic bags or containers before and after use and should be cleaned daily when used, with soap or detergent and preferably hot water (60 degrees). If hot water is not available, wash the mask with soap or detergent using water at room temperature followed by boiling the mask for one minute.

Single use masks should always be disposed of properly, preferably into a closed bin after use. Masks should never be left out after use, as used masks may contain virus which may be transmitted to the wearer or others.

WHO continues to closely monitor masks that are being developed by industry, and encourages research into textile combinations and innovative designs that maximize fit, filtration, breathability and overall comfort. Consultations with scientists, ministries of health and public health institutions continue, and updates will be provided as the science in this field evolves.

For complete information on the selection of a mask, how to wear and maintain it, visit the [WHO mask webpage](#).

WHO technical guidance for mask use in the context of COVID-19 can be found [here](#).

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 VOCs as reported by countries, territories and areas (hereafter countries) as of 2 March 2021 ([Table 2](#), [Annex 2](#)). This information should be interpreted with due consideration of limitations of ongoing surveillance, including but not limited to differences between countries in sequencing capacity and which samples are prioritized for sequencing. WHO continues to advocate for strengthening surveillance and sequencing capacity, and a systematic approach to provide a representative indication of the extent of variant transmission. New potential variants of interest (VOIs) or VOCs are currently under review and may be added to future updates.

Although 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 and various vaccination programme implementations, there has been an increased number of reports of variants which are of concern. Many countries across all six WHO regions have started to report increases in new cases of COVID-19 in the past month, while it is difficult to ascertain the exact proportion of all new cases which may be attributable to VOIs and VOCs, summaries on the past week's updates on VOC 202012/01, 501Y.V2 and P.1 variants of concern are outlined below.

Table 2: Key characteristics of circulating variants of concern (as of 1 March 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, alias P.1[†]
GISAID clade	GR	GH	GR
Alternate names	VOC 202012/01[†]	VOC 202012/02	-
First detected by	United Kingdom	South Africa	Brazil / Japan
Earliest sample date	20 September 2020	Early August 2020	December 2020
Key spike mutations	<ul style="list-style-type: none"> • N501Y • D614G • A570D • P681H • H69/V70 deletion • Y144 deletion 	<ul style="list-style-type: none"> • N501Y • D614G • E484K • K417N • L242/A243/L244 deletion 	<ul style="list-style-type: none"> • N501Y • D614G • E484K • K417N
Key mutation in common	S106/G107/F108 deletion in non-structural protein 6 (nsp6)		
Number of countries reporting cases (newly reported in last week)**	106 (5)	56 (5)	29 [‡] (1)

* A more detailed version of this table is available in the [previous Weekly Epidemiological Update](#), and an updated version will be available in the next issue.

[†] While work is ongoing to establish an easy-to-pronounce and non-stigmatizing nomenclature for VOIs and VOCs, these are the names by which they will be referred to in this publication.

** Includes official and unofficial reports of VOCs detected in countries among travellers (imported cases) or community-based samples.

[‡] One country was removed and another added this week, resulting in the same total as reported in 23 February update

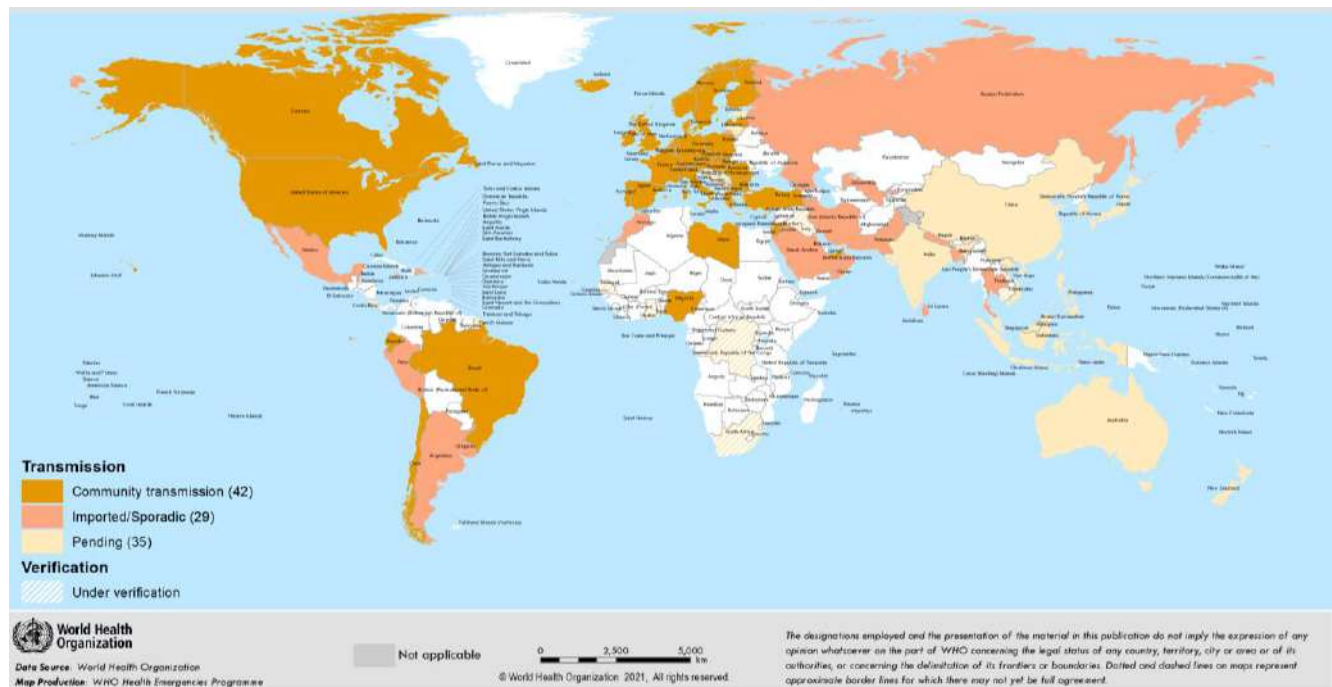
Proposed working definitions for SARS-CoV-2 VOIs and VOCs

As a supplement to last week's issue, a special edition was published with an overview of the [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. These definitions will be reviewed regularly and updated as necessary.

VOC 20212/01

Since our last update on 23 February, VOC 20212/01 has been detected in five additional countries. As of 2 March, a total of 106 countries across all six WHO regions have reported cases of this variant (Figure 4). Community transmission has been reported in at least 42 countries across four WHO regions, noting that transmission classification is currently incomplete for 35 (33%) countries reporting this variant.

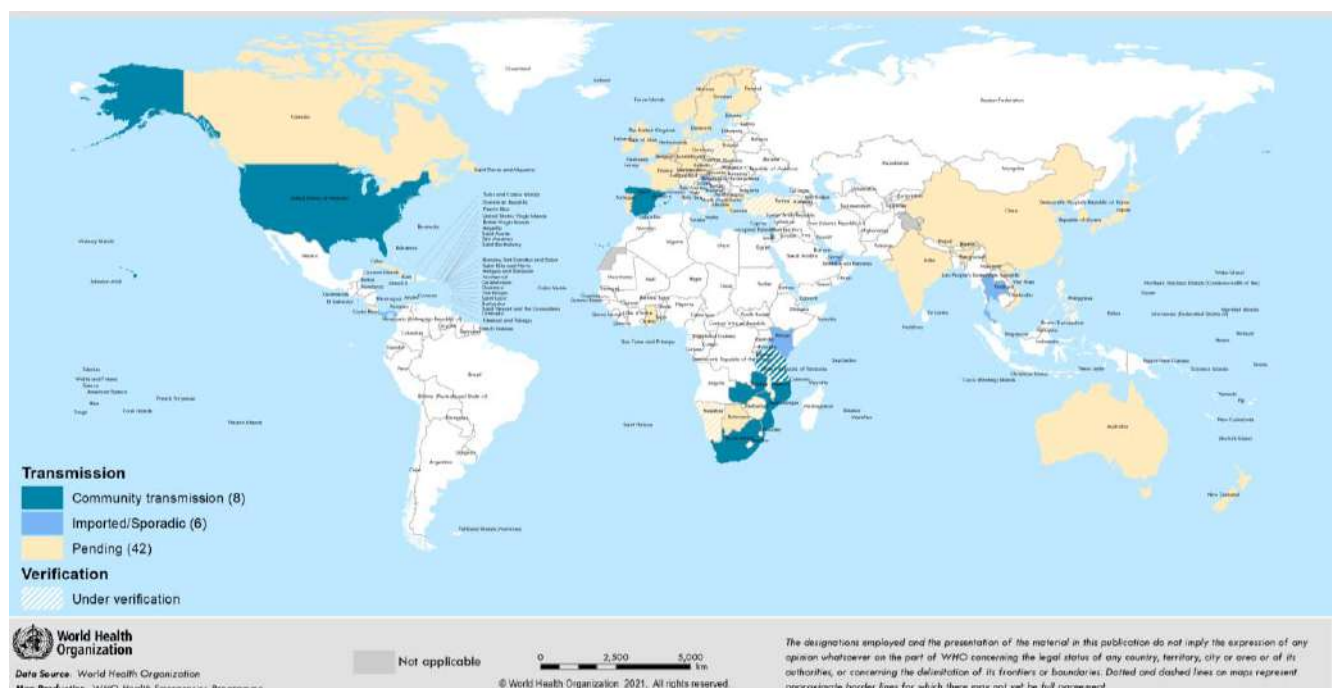
Figure 4. Countries, territories and areas reporting VOC 20212/01, as of 2 March 2021



501Y.V2

Since the last update on 23 February, 501Y.V2 has been reported from five additional countries – now totalling 56 countries across all six WHO regions (Figure 5). Community transmission of 501Y.V2 has been reported in eight countries across three WHO regions, noting the transmission classification is currently incomplete for 42 (75%) countries reporting this variant.

Figure 5. Countries, territories and areas reporting 501Y.V2, as of 2 March 2021



P.1

Since our last update, one country has corrected their reporting, and reporting from another amounted to one additional country. To date, this variant is reported in 29 countries across all six WHO regions (Figure 6). 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 nine (31%) countries reporting this variant.

Figure 6. Countries, territories and areas reporting P.1, as of 2 March 2021

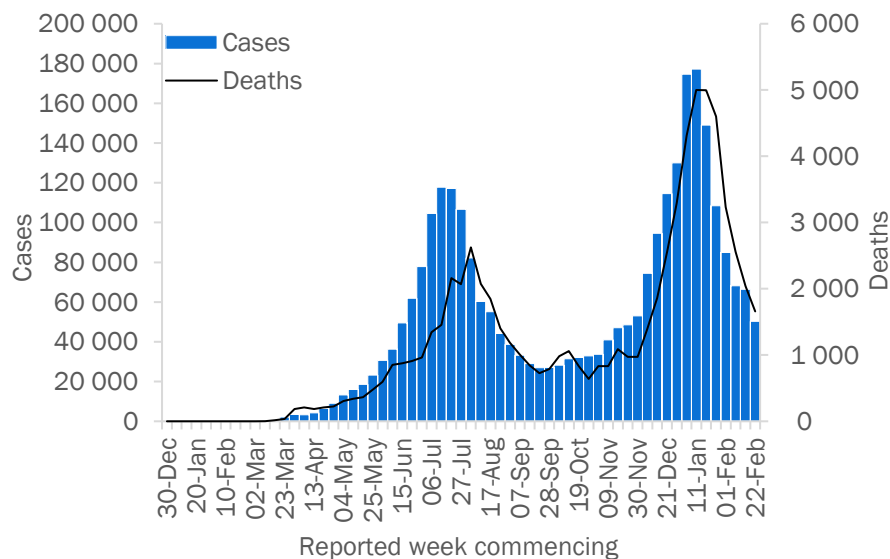


WHO regional overviews

African Region

In the past week, the African Region reported over 50 000 new cases and 1500 new deaths, a 24% and 19% decrease respectively compared to the previous week. This represents the largest decline as a percentage in new cases and the second largest decline of new deaths globally. In the region new cases in the past week rose in 17 of 49 (36%) countries and fell in 30 of 49 (64%). This week new deaths increased in 13 of 49 (28%) countries and declined in 24 of 49 (53%).

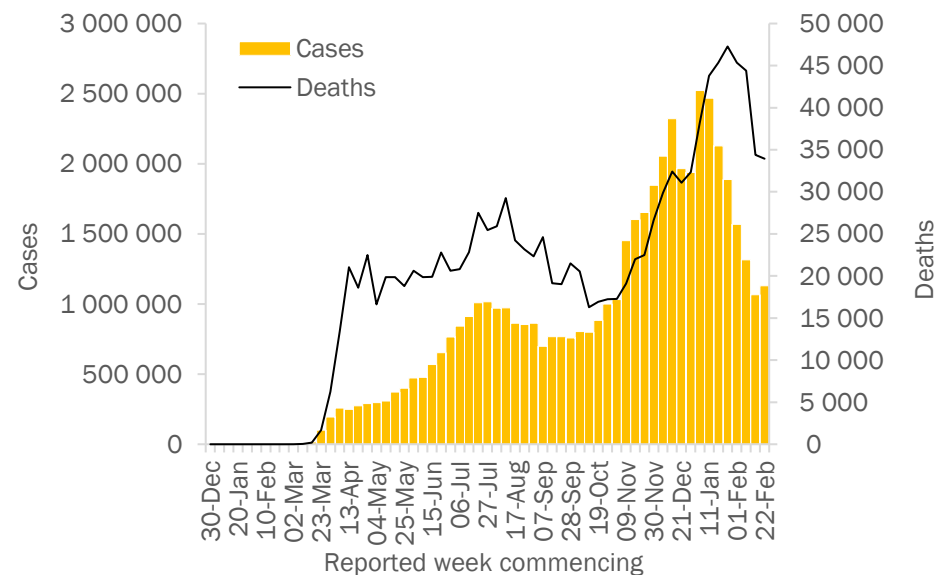
The highest numbers of new cases were reported in South Africa (9858 new cases; 16.6 new cases per 100 000 population; a 20% decrease), Ethiopia (6196 new cases; 5.4 new cases per 100 000; a 1% increase), and Nigeria (3864 new cases; 1.9 new cases per 100 000; a 34% decrease). The same countries reported the highest number of new deaths in the past week: South Africa (1001 new deaths; 1.7 new deaths per 100 000; an 11% decrease), Ethiopia (83 new deaths; 0.1 new deaths per 100 000; an 8% decrease), and Nigeria (74 new deaths; <0.1 new deaths per 100 000; a 12% decrease).



Region of the Americas

Over 1.1 million new cases and just under 34 000 new deaths were reported in the Region of the Americas this week, a 6% increase and 1% decrease respectively compared to the previous week. This represents the first rise in new cases since the week ending 10 January. This week, new cases rose in 22 of 56 (39%) countries and fell in 24 of 56 (43%). This week, new deaths increased in 11 of 56 (20%) countries and declined in 20 of 56 (36%).

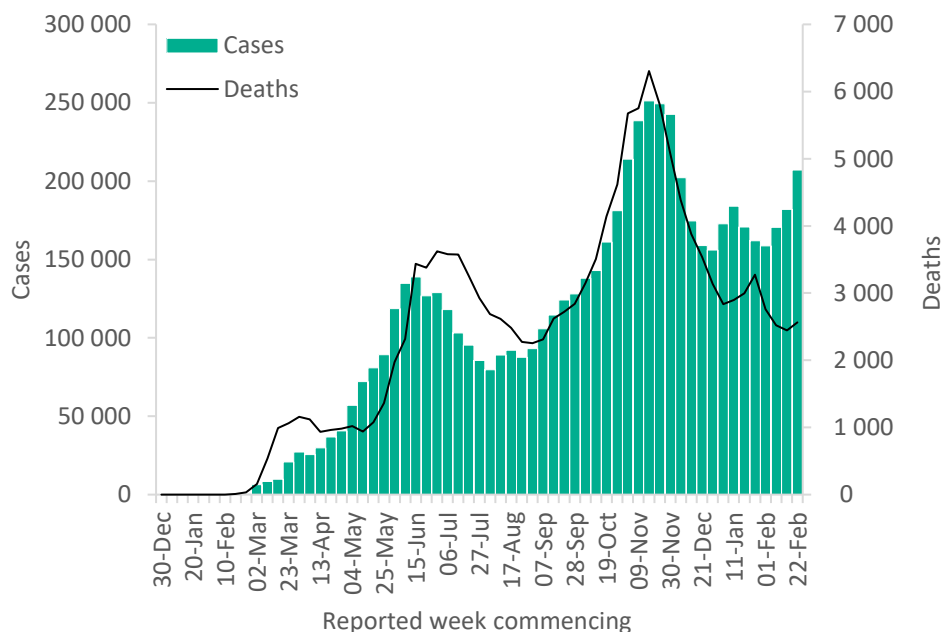
The highest numbers of new cases were reported from the United States of America (472 904 new cases; 142.9 new cases per 100 000 population; a 2% decrease), Brazil (373 954 new cases; 175.9 new cases per 100 000; an 18% increase) and Argentina (49 516 new cases; 109.6 new cases per 100 000; a 50% increase). The highest numbers of new deaths were reported from the United States of America (14 866 new deaths; 4.5 new deaths per 100 000; a 1% increase), Brazil (8070 new deaths; 3.8 new deaths per 100 000; an 11% increase), and Mexico (5509 new deaths; 4.3 new deaths per 100 000; a 14% decrease).



Eastern Mediterranean Region

In the past week, the Eastern Mediterranean Region reported over 207 000 new cases, a 14% increase compared to last week. The region reported just over 2500 new deaths, a 5% increase. Across the region 14 of 22 (64%) countries reported increases in new cases and 8 of 22 (36%) declined this week. New deaths rose in 13 of 22 countries (59%) and fell in 7 of 22 (32%).

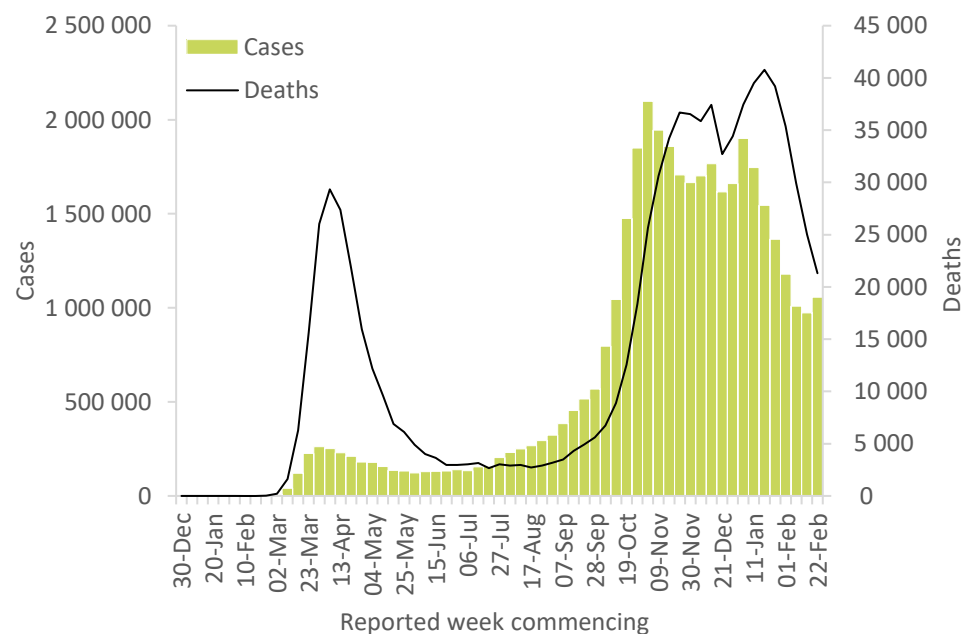
The three countries reporting the highest numbers of new cases this week were the Islamic Republic of Iran (57 078 new cases; 68 new cases per 100 000 population; a 3% increase), Iraq (27 491 new cases; 68.3 new cases per 100 000; a 19% increase) and Jordan (26 685 new cases; 261.5 new cases per 100 000; a 78% increase). The highest numbers of new deaths this week have been reported in the Islamic Republic of Iran (571 new deaths; 0.7 new deaths per 100 000 population; a 9% increase), Lebanon (355 new deaths; 5.2 new deaths per 100 000; a 6% increase) and Egypt (341 new deaths; 0.3 new deaths per 100 000; a 6% decrease).



European Region

The European Region reported over 1 million new cases and over 21 000 new deaths, an increase of 9% and decrease of 15% respectively when compared to the previous week. This represents the first rise in new cases since the week ending 10 January, and reverses declines made over the previous two reporting weeks. This week new cases rose in 36 of 61 (59%) countries and fell in 22 of 61 (36%) while new deaths rose in 16 of 61 countries (26%) and fell in 30 of 61 (49%).

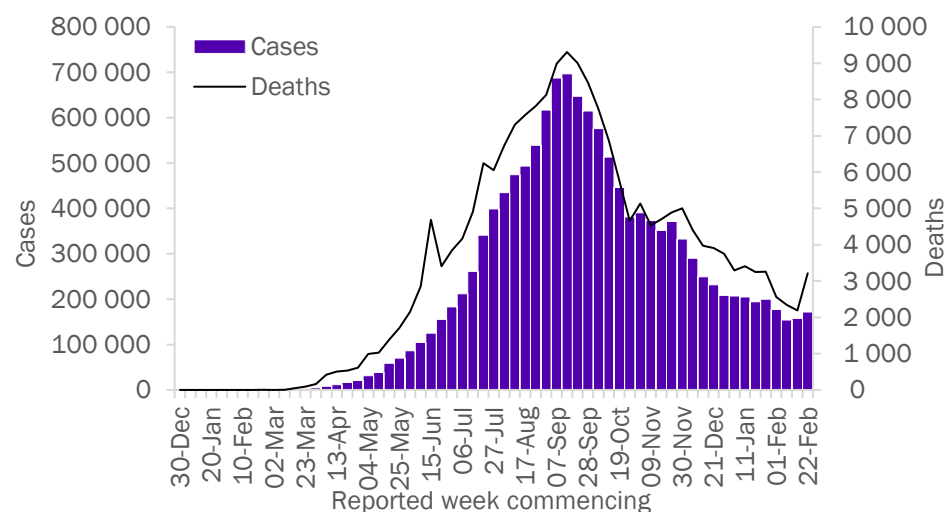
The three countries reporting the highest numbers of new cases were France (149 959 new cases; 229.7 new cases per 100 000; a 14% increase), Italy (112 029 new cases; 185.3 new cases per 100 000; an 32% increase), and Czechia (82 321 new cases; 768.7 new cases per 100 000; a 26% increase). The highest numbers of deaths were reported from the Russian Federation (2829 new deaths; 1.9 new deaths per 100 000; an 11% decrease), the United Kingdom of Great Britain and Northern Ireland (2340 new deaths; 3.4 new deaths per 100 000, a 32% decrease, and Germany (2204 new deaths; 2.6 new deaths per 100 000; a 24% decrease).



South-East Asia Region

In the past week, the South-East Asia Region reported over 171 000 new cases, an increase of 9% compared to last week while the region reported over 3200 new deaths, a 47% increase[†]. Across the region half of the countries (5/10; 50%) reported increases in new cases and the other half (5/10; 50%) declined this week. New deaths rose in 3 of 10 countries (30%) and fell in 5 of 10 (50%).

The three countries reporting the highest numbers of new cases were India (105 080 new cases; 7.6 new cases per 100 000; a 21% increase), Indonesia (57 721 new cases; 21.2 new cases per 100 000; a 5% decrease) and Sri Lanka (3410 new cases; 15.9 new cases per 100 000; a 26% decrease). The three countries reporting the highest numbers of new deaths this week were Indonesia (1665 new deaths; 0.6 new deaths per 100 000; a 21% increase), India (749 new deaths; 0.1 new deaths per 100 000; a 14% increase) and Nepal (712 new deaths; 2.4 new deaths per 100 000[†]).

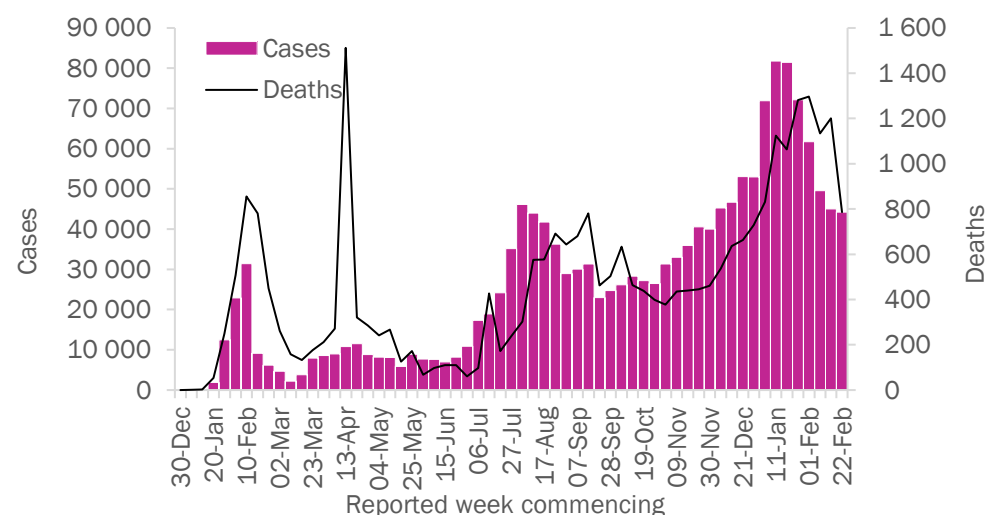


[†]The number of new deaths includes additional COVID-19 deaths in the past one year reported from different bodies managing COVID-19 pandemic within Nepal. The temporal distribution of these deaths is being confirmed

Western Pacific Region

The Western Pacific Region reported just over 44 000 new cases the past week, a 2% decrease compared to the previous week and reported just under 800 new deaths, a 35% decrease. Of the 22 countries in the region the number of new cases rose in 6 (27%) this week while they fell in 10 of 22 (45%). The number of new deaths increased in 1 of 22 countries (14%) and declined in 5 of 22 (23%) this week.

The three countries reporting the highest numbers of new cases in the region this week were Malaysia (18 043 new cases; 55.7 new cases per 100 000; a 2% decrease), the Philippines (14 959 new cases; 13.7 new cases per 100 000; a 24% increase) and Japan (7233 new cases; 5.7 new cases per 100 000; a 28% decrease). The three countries reporting the highest numbers of new deaths this week were Japan (443 new deaths; 0.4 new deaths per 100 000; a 12% decrease), the Philippines (221 new deaths; 0.2 new deaths per 100 000; a 61% decrease) and Malaysia (70 new deaths; 0.2 new deaths per 100 000; a 25% decrease).



Key weekly updates

WHO Director-General quote of the week

“Now is the time to use every tool to scale up <vaccine> production, including licensing and technology transfer, and where necessary, intellectual property waivers. If not now, then when?”

[Opening remarks at the media briefing on COVID-19, 26 February 2021](#)

2021 COVID-19 Strategic Preparedness and Response Plan

[COVID-19 Strategic Preparedness and Response Plan \(SPRP 2021\)](#)

Vaccinations

[ChAdOx1-S \[recombinant\], COVID-19 vaccine](#)

[COVID-19 vaccine doses shipped by the COVAX Facility head to Ghana, marking beginning of global rollout](#)

[No-fault compensation programme for COVID-19 vaccines is a world first](#)

Oxygen supply

[COVID-19 oxygen emergency impacting more than half a million people in low- and middle-income countries every day, as demand surges](#)

[The life-saving power of medical oxygen](#)

WHO funding in action

[How WHO transforms funding into action in regions around the world](#)

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 28 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	50 324	2 840 208	253.2	1 659	71 991	6.4	
South Africa	9 858	1 512 225	2 549.8	1 001	49 941	84.2	Community transmission
Ethiopia	6 196	158 053	137.5	83	2 354	2.0	Community transmission
Nigeria	3 864	155 417	75.4	74	1 905	0.9	Community transmission
Mozambique	3 804	58 772	188.0	43	630	2.0	Community transmission
Zambia	3 277	77 171	419.8	43	1 059	5.8	Community transmission
Ghana	2 930	82 586	265.8	22	594	1.9	Community transmission
Botswana	1 846	28 370	1 206.4	56	310	13.2	Community transmission
Kenya	1 655	105 648	196.5	37	1 854	3.4	Community transmission
Senegal	1 625	34 255	204.6	71	866	5.2	Community transmission
Namibia	1 349	38 644	1 520.9	16	418	16.5	Community transmission
Malawi	1 270	31 798	166.2	33	1 037	5.4	Community transmission
Algeria	1 196	112 960	257.6	21	2 979	6.8	Community transmission
Gabon	1 011	14 564	654.3	8	83	3.7	Community transmission
South Sudan	932	7 349	65.7	2	87	0.8	Community transmission
Rwanda	802	18 790	145.1	14	261	2.0	Community transmission
Côte d'Ivoire	717	32 631	123.7	7	192	0.7	Community transmission
Democratic Republic of the Congo	712	25 791	28.8	7	707	0.8	Community transmission
Guinea	591	15 894	121.0	3	89	0.7	Community transmission
Togo	583	6 851	82.8	2	83	1.0	Community transmission
Benin	491	5 634	46.5	5	70	0.6	Community transmission
Cabo Verde	325	15 324	2 756.2	4	147	26.4	Community transmission
Angola	283	20 782	63.2	8	506	1.5	Community transmission
Seychelles	264	2 592	2 635.6	1	11	11.2	Community transmission
Eswatini	238	17 002	1 465.5	5	650	56.0	Community transmission
Madagascar	233	19 831	71.6	5	297	1.1	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
Zimbabwe	226	35 994	242.2	26	1 458	9.8	Community transmission
Sao Tome and Principe	208	1 786	814.9	7	28	12.8	Community transmission
Equatorial Guinea	207	6 005	428.0	2	91	6.5	Community transmission
Burkina Faso	199	11 982	57.3	3	142	0.7	Community transmission
Congo	195	8 820	159.8	1	128	2.3	Community transmission
Chad	179	3 973	24.2	7	140	0.9	Community transmission
Burundi	178	2 209	18.6	0	3	0.0	Community transmission
Eritrea	162	2 847	80.3	0	7	0.2	Community transmission
Guinea-Bissau	156	3 247	165.0	2	48	2.4	Community transmission
Gambia	148	4 691	194.1	5	148	6.1	Community transmission
Uganda	136	40 335	88.2	1	334	0.7	Community transmission
Mauritania	96	17 179	369.5	5	439	9.4	Community transmission
Comoros	81	3 571	410.6	1	144	16.6	Community transmission
Mali	73	8 365	41.3	5	352	1.7	Community transmission
Sierra Leone	38	3 887	48.7	0	79	1.0	Community transmission
Lesotho	30	10 491	489.7	7	292	13.6	Community transmission
Liberia	22	2 010	39.7	0	85	1.7	Community transmission
Mauritius	7	610	48.0	0	10	0.8	Sporadic cases
Niger	7	4 740	19.6	2	172	0.7	Community transmission
Central African Republic	1	4 997	103.5	0	63	1.3	Community transmission
Cameroon	0	33 749	127.1	0	523	2.0	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesⁱⁱⁱ							
Mayotte	1 069	16 861	6 180.4	10	102	37.4	Community transmission
Réunion	854	12 416	1 386.8	4	52	5.8	Community transmission
Americas	1 129 929	50 426 060	4 930.3	33 951	1 205 245	117.8	
United States of America	472 904	28 174 978	8 512.0	14 866	506 760	153.1	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	373 954	10 455 630	4 918.9	8 070	252 835	118.9	Community transmission
Argentina	49 516	2 104 197	4 655.7	946	51 946	114.9	Community transmission
Peru	46 840	1 316 363	3 992.4	1 404	46 094	139.8	Community transmission
Mexico	46 391	2 076 882	1 610.8	5 509	184 474	143.1	Community transmission
Colombia	27 791	2 244 792	4 411.7	1 007	59 518	117.0	Community transmission
Chile	25 573	821 418	4 297.0	502	20 476	107.1	Community transmission
Canada	20 886	861 472	2 282.5	339	21 915	58.1	Community transmission
Ecuador	9 502	282 599	1 601.8	200	15 713	89.1	Community transmission
Paraguay	7 919	157 603	2 209.6	126	3 152	44.2	Community transmission
Bolivia (Plurinational State of)	7 215	247 891	2 123.6	219	11 609	99.5	Community transmission
Cuba	5 677	49 161	434.0	27	318	2.8	Community transmission
Uruguay	5 165	56 542	1 627.7	38	601	17.3	Community transmission
Honduras	4 834	168 911	1 705.4	142	4 117	41.6	Community transmission
Dominican Republic	4 507	239 009	2 203.3	65	3 093	28.5	Community transmission
Panama	4 442	339 781	7 874.8	109	5 820	134.9	Community transmission
Guatemala	3 404	174 335	973.1	125	6 374	35.6	Community transmission
Venezuela (Bolivarian Republic of)	3 181	138 295	486.3	30	1 338	4.7	Community transmission
Costa Rica	2 663	204 341	4 011.3	37	2 800	55.0	Community transmission
Jamaica	1 893	22 817	770.5	26	417	14.1	Community transmission
El Salvador	1 320	59 866	923.0	55	1 847	28.5	Community transmission
Saint Lucia	496	3 356	1 827.6	7	35	19.1	Community transmission
Barbados	317	2 994	1 041.8	3	33	11.5	Community transmission
Guyana	156	8 513	1 082.3	6	195	24.8	Clusters of cases
Haiti	156	12 430	109.0	3	250	2.2	Community transmission
Antigua and Barbuda	128	726	741.4	3	14	14.3	Clusters of cases
Bahamas	100	8 519	2 166.3	0	179	45.5	Clusters of cases
Belize	66	12 293	3 091.6	0	314	79.0	Community transmission
Suriname	59	8 913	1 519.4	2	170	29.0	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 Vincent and the Grenadines	58	1 556	1 402.6	2	8	7.2	Community transmission
Trinidad and Tobago	38	7 704	550.5	0	139	9.9	Community transmission
Nicaragua	36	5 142	77.6	1	173	2.6	Community transmission
Dominica	8	142	197.2	0	0	0.0	Clusters of cases
Grenada	0	148	131.5	0	1	0.9	Sporadic cases
Saint Kitts and Nevis	0	41	77.1	0	0	0.0	Sporadic cases
Territoriesⁱⁱⁱ							
Puerto Rico	1 209	100 044	3 497.0	75	2 032	71.0	Community transmission
Guadeloupe	513	9 968	2 491.2	4	164	41.0	Community transmission
Aruba	251	7 804	7 309.4	1	71	66.5	Community transmission
Martinique	153	6 746	1 797.7	0	45	12.0	Community transmission
Saint Barthélemy	137	612	6 191.2	0	0	0.0	Clusters of cases
Turks and Caicos Islands	101	2 099	5 421.3	0	14	36.2	Clusters of cases
French Guiana	98	16 627	5 566.8	2	85	28.5	Community transmission
Saint Martin	98	1 554	4 019.8	0	12	31.0	Community transmission
United States Virgin Islands	71	2 646	2 533.9	0	25	23.9	Community transmission
Curaçao	42	4 708	2 869.1	0	22	13.4	Community transmission
Sint Maarten	24	2 051	4 782.9	0	27	63.0	Community transmission
Bonaire	19	406	1 941.2	0	4	19.1	Community transmission
Cayman Islands	10	438	666.5	0	2	3.0	Sporadic cases
Bermuda	6	705	1 132.1	0	12	19.3	Sporadic cases
Falkland Islands (Malvinas)	2	51	1 464.3	0	0	0.0	No cases
Anguilla	0	18	120.0	0	0	0.0	Sporadic cases
British Virgin Islands	0	153	506.0	0	1	3.3	Clusters of cases
Montserrat	0	20	400.1	0	1	20.0	Sporadic cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Pierre and Miquelon	0	24	414.2	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
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	207 177	6 388 249	874.1	2 562	144 479	19.8	
Iran (Islamic Republic of)	57 078	1 623 159	1 932.5	571	59 980	71.4	Community transmission
Iraq	27 491	692 241	1 721.0	138	13 383	33.3	Community transmission
Jordan	26 685	386 496	3 788.0	132	4 675	45.8	Community transmission
United Arab Emirates	20 419	388 594	3 929.0	105	1 213	12.3	Community transmission
Lebanon	19 404	372 775	5 461.5	355	4 652	68.2	Community transmission
Pakistan	8 951	578 797	262.0	274	12 837	5.8	Community transmission
Kuwait	6 568	189 890	4 446.5	39	1 078	25.2	Community transmission
Tunisia	4 972	232 615	1 968.2	219	7 974	67.5	Community transmission
Bahrain	4 544	121 778	7 156.8	24	444	26.1	Clusters of cases
Egypt	4 286	181 829	177.7	341	10 639	10.4	Clusters of cases
Qatar	3 230	163 197	5 664.5	1	257	8.9	Community transmission
Libya	3 133	132 458	1 927.7	86	2 174	31.6	Community transmission
Morocco	2 462	483 410	1 309.7	67	8 615	23.3	Clusters of cases
Saudi Arabia	2 370	377 061	1 083.1	31	6 488	18.6	Sporadic cases
Oman	2 094	140 588	2 753.1	13	1 562	30.6	Community transmission
Somalia	1 102	6 991	44.0	37	231	1.5	Community transmission
Syrian Arab Republic	390	15 533	88.8	27	1 023	5.8	Community transmission
Sudan	170	30 347	69.2	14	1 880	4.3	Community transmission
Yemen	112	2 273	7.6	13	632	2.1	Community transmission
Afghanistan	110	55 714	143.1	11	2 443	6.3	Clusters of cases
Djibouti	43	6 065	613.9	0	63	6.4	Sporadic cases
Territoriesⁱⁱⁱ							
occupied Palestinian territory	11 563	206 438	4 046.7	64	2 236	43.8	Community transmission
Europe	1 055 781	38 679 334	4 143.9	21 302	861 906	92.3	
France	149 959	3 671 208	5 624.3	2 165	85 872	131.6	Community transmission
Italy	112 029	2 907 825	4 809.4	2 021	97 507	161.3	Clusters of cases
Czechia	82 321	1 235 480	11 536.9	1 125	20 339	189.9	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
Russian Federation	81 353	4 246 079	2 909.6	2 829	86 122	59.0	Clusters of cases
Poland	68 219	1 706 986	4 510.3	1 598	43 769	115.6	Community transmission
The United Kingdom	64 844	4 170 523	6 143.4	2 340	122 705	180.8	Community transmission
Turkey	61 288	2 693 164	3 193.3	520	28 503	33.8	Community transmission
Germany	55 777	2 442 336	2 915.0	2 204	70 045	83.6	Community transmission
Ukraine	43 393	1 347 849	3 081.9	879	25 982	59.4	Community transmission
Netherlands	32 188	1 083 961	6 326.1	343	15 542	90.7	Community transmission
Hungary	25 576	428 599	4 436.7	675	14 974	155.0	Community transmission
Spain	22 774	3 180 212	6 801.9	529	68 813	147.2	Community transmission
Serbia	22 328	456 450	6 554.6	108	4 429	63.6	Community transmission
Sweden	22 145	657 309	6 508.5	38	12 826	127.0	Community transmission
Romania	21 888	799 164	4 154.2	492	20 287	105.5	Community transmission
Israel	17 883	764 791	8 835.9	116	5 669	65.5	Community transmission
Belgium	15 971	771 510	6 656.9	159	22 071	190.4	Community transmission
Slovakia	15 940	308 083	5 642.9	684	7 189	131.7	Clusters of cases
Austria	13 888	453 767	5 038.3	147	8 394	93.2	Community transmission
Greece	10 913	189 831	1 821.3	196	6 468	62.1	Community transmission
Bulgaria	10 267	246 706	3 550.5	328	10 167	146.3	Clusters of cases
Belarus	8 969	285 959	3 026.2	63	1 966	20.8	Community transmission
Republic of Moldova	8 611	184 856	4 582.5	164	3 924	97.3	Community transmission
Estonia	7 984	65 600	4 945.2	54	589	44.4	Clusters of cases
Portugal	7 505	803 844	7 883.4	379	16 276	159.6	Clusters of cases
Albania	7 153	106 215	3 690.8	122	1 775	61.7	Clusters of cases
Kazakhstan	5 625	262 725	1 399.2	78	3 389	18.0	Clusters of cases
Slovenia	5 375	189 630	9 121.5	24	4 110	197.7	Clusters of cases
Switzerland	5 007	552 290	6 381.4	30	9 219	106.5	Community transmission
Latvia	4 701	85 810	4 549.4	76	1 614	85.6	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
Ireland	4 602	218 980	4 434.8	178	4 313	87.3	Community transmission
Lithuania	3 654	199 145	7 315.4	70	3 244	119.2	Community transmission
Denmark	3 651	210 732	3 638.2	25	2 358	40.7	Community transmission
Bosnia and Herzegovina	3 641	131 690	4 013.9	93	5 088	155.1	Community transmission
North Macedonia	3 451	102 482	4 919.0	79	3 126	150.0	Community transmission
Montenegro	3 428	75 833	12 074.0	49	999	159.1	Clusters of cases
Finland	3 122	56 407	1 018.0	16	742	13.4	Community transmission
Croatia	3 028	242 973	5 918.6	97	5 526	134.6	Community transmission
Georgia	2 403	270 758	6 787.3	75	3 510	88.0	Community transmission
Norway	1 927	70 034	1 291.8	15	622	11.5	Clusters of cases
Armenia	1 656	172 058	5 806.4	28	3 192	107.7	Community transmission
Malta	1 457	22 219	5 032.1	10	313	70.9	Clusters of cases
Luxembourg	1 345	55 313	8 836.3	14	637	101.8	Community transmission
Azerbaijan	1 294	234 267	2 310.5	23	3 218	31.7	Clusters of cases
Cyprus	1 271	34 424	2 851.2	2	231	19.1	Clusters of cases
Kyrgyzstan	344	86 229	1 321.7	6	1 464	22.4	Clusters of cases
San Marino	244	3 716	10 949.4	2	74	218.0	Community transmission
Uzbekistan	232	79 886	238.7	0	622	1.9	Clusters of cases
Andorra	177	10 849	14 041.3	3	110	142.4	Community transmission
Monaco	88	1 953	4 976.6	2	24	61.2	Sporadic cases
Liechtenstein	22	2 642	6 927.7	0	52	136.4	Sporadic cases
Iceland	4	6 049	1 772.6	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
Territoriesⁱⁱⁱ							
Kosovo	2 821	68 760	3 696.0	24	1 585	85.2	Community transmission
Isle of Man	26	475	558.6	0	25	29.4	No cases
Guernsey	9	819	1 296.0	0	14	22.2	Community transmission
Gibraltar	8	4 236	12 573.1	4	92	273.1	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
Jersey	2	3 215	2 955.0	1	69	63.4	Community transmission
Faroe Islands	0	658	1 346.6	0	1	2.0	Sporadic cases
Greenland	0	30	52.8	0	0	0.0	No cases
South-East Asia	171 419	13 517 009	668.7	3 217	208 013	10.3	
India	105 080	11 096 731	804.1	749	157 051	11.4	Clusters of cases
Indonesia	57 721	1 329 074	485.9	1 665	35 981	13.2	Community transmission
Sri Lanka	3 410	82 890	387.1	29	464	2.2	Clusters of cases
Bangladesh	2 807	545 831	331.4	58	8 400	5.1	Community transmission
Maldives	985	19 597	3 625.4	1	61	11.3	Clusters of cases
Nepal	714	274 065	940.6	712	2 773	9.5	Clusters of cases
Thailand	536	25 951	37.2	0	83	0.1	Clusters of cases
Myanmar	155	141 890	260.8	3	3 199	5.9	Clusters of cases
Timor-Leste	10	113	8.6	0	0	0.0	Sporadic cases
Bhutan	1	867	112.4	0	1	0.1	Clusters of cases
Western Pacific	44 193	1 620 582	82.5	786	29 006	1.5	
Malaysia	18 043	298 315	921.7	70	1 121	3.5	Clusters of cases
Philippines	14 959	574 247	524.0	221	12 289	11.2	Community transmission
Japan	7 233	431 740	341.4	443	7 860	6.2	Clusters of cases
Republic of Korea	2 682	89 674	174.9	46	1 603	3.1	Clusters of cases
Mongolia	280	2 866	87.4	0	2	0.1	Clusters of cases
Cambodia	272	805	4.8	0	0	0.0	Sporadic cases
Papua New Guinea	246	1 275	14.3	2	12	0.1	Community transmission
China	209	101 878	6.9	1	4 843	0.3	Clusters of cases
Singapore	67	59 925	1 024.3	0	29	0.5	Sporadic cases
Viet Nam	64	2 432	2.5	0	35	0.0	Clusters of cases
Australia	45	28 965	113.6	0	909	3.6	Clusters of cases
New Zealand	26	2 020	41.9	0	26	0.5	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
Fiji	3	59	6.6	0	2	0.2	Sporadic cases
Brunei Darussalam	1	186	42.5	0	3	0.7	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
Territoriesⁱⁱⁱ							
French Polynesia	41	18 387	6 545.6	2	139	49.5	Sporadic cases
Guam	19	7 526	4 459.2	1	131	77.6	Clusters of cases
New Caledonia	3	58	20.3	0	0	0.0	Sporadic cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Northern Mariana Islands (Commonwealth of the)	0	143	248.4	0	2	3.5	Pending
Samoa	0	4	2.0	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	2 658 823	113 472 187	1 455.7	63 477	2 520 653	32.3	

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

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

Country/Territory/Area ⁱ	501Y.V2 (B.1.351)	P.1 (B.1.1.28.1)	VOC 202012/01 (B.1.1.7)
Argentina		Verified	Verified
Aruba			Verified
Australia	Verified		Verified
Austria	Verified		Verified
Bahrain			Verified
Bangladesh			Verified
Barbados			Verified
Belgium	Verified	Verified	Verified
Belize			Verified
Bosnia and Herzegovina			Unverified
Botswana	Verified		
Brazil		Verified	Verified
Brunei Darussalam	Verified		
Bulgaria			Verified
Cambodia			Unverified
Canada	Verified	Verified	Verified
Cayman Islands			Verified
Chile		Verified	Verified
China	Verified	Unverified	Verified
Colombia		Verified	
Comoros	Unverified		
Costa Rica	Verified		Verified
Croatia	Unverified		Verified
Cuba	Verified		
Curaçao			Verified
Cyprus			Verified
Czechia	Unverified		Verified
Democratic Republic of the Congo			Unverified

Denmark	Verified	Verified
Dominican Republic		Verified
Ecuador		Verified
Estonia	Unverified	Verified
Faroe Islands		Verified
Finland	Verified	Verified
France	Verified	Verified
French Guiana		Verified
French Polynesia		Verified
Gambia	Verified	Verified
Georgia		Verified
Germany	Verified	Verified
Ghana	Verified	Unverified
Gibraltar		Unverified
Greece	Verified	Verified
Guadeloupe		Verified
Hungary	Unverified	Verified
Iceland		Verified
India	Verified	Verified
Indonesia		Verified
Iran (Islamic Republic of)		Verified
Iraq		Unverified
Ireland	Verified	Unverified
Israel	Verified	Verified
Italy	Unverified	Verified
Jamaica		Verified
Japan	Verified	Verified
Jordan		Verified
Kenya	Verified	
Kosovo ^[1]		Verified
Kuwait		Verified
Latvia		Verified
Lebanon		Verified

Libya			Verified
Liechtenstein			Verified
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	Unverified		Verified
Poland	Unverified		Verified
Portugal	Verified	Unverified	Verified
Puerto Rico			Verified
Republic of Korea	Verified	Verified	Verified
Réunion	Verified	Verified	Verified

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		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

1 March 2021



Confirmed cases^a

113 467 303

Confirmed deaths

2 520 550

WHO continues to support Viet Nam in enhancing capacity to test for COVID-19

In the last month, Viet Nam has seen a rise in confirmed COVID-19 cases. On February 19 to support Viet Nam's response to the current outbreak of COVID-19, the World Health Organization provided additional laboratory supplies to scale up testing in affected provinces.



Dr Kidong Park, WHO Representative in Viet Nam turned over sample collection kits to Prof Dang Duc Anh, Director of National Institute of Hygiene and Epidemiology (Photo: WHO Viet Nam/Loan Tran)

This is one part of comprehensive support WHO is assisting with to effectively limit the spread of COVID-19.

WHO Representative in Viet Nam, Dr Kidong Park, handed over 25,800 specimen collection kits to Professor Dang Duc Anh, Director of the National Institute of Hygiene and Epidemiology (NIHE) for distribution to provinces, in consultation with the General Department of Preventive Medicine (GDPM).

"Strong testing capability is an essential tool for addressing the challenges presented by this pandemic and for protecting communities", says Dr Kidong Park. "WHO remains committed in sustaining our support to the country not only in delivering supplies but also in continuing to provide technical assistance in the pandemic 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



20 060 365 respirators shipped globally



198 709 426 medical masks shipped globally



8 651 831 face shields shipped globally



36 640 900 gloves shipped globally



105 countries, territories, and areas sharing National Deployment and Vaccination Plans (NDVPs) via Partners Platform



More than **4.9 million** people registered on [OpenWHO](#) and accessing online training courses across **26** topics in **44** languages

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



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EMERGENCIES**
programme

From the field:

The global rollout of COVID-19 vaccine from the COVAX Facility begins in Ghana



In a historic step towards ensuring equitable global distribution of COVID-19 vaccines, on 24 February, 600 000 doses of the AstraZeneca/ Oxford vaccine arrived in Accra, Ghana from the Serum Institute of India in Pune. Ghana is the first country outside India to receive COVID-19 vaccine shipped via the COVAX Facility. This is the start of the largest vaccine procurement and supply operation in history, an unprecedented effort to deliver at least 2 billion doses of vaccine in 2021, including at least 1.3 billion donor funded doses to 92 Advanced Market Commitment (AMC) countries through COVAX AMC.

COVAX is co-led by Gavi, the Vaccine Alliance, WHO and the Coalition for Epidemic Preparedness Innovations (CEPI), working in partnership with UNICEF as well as the World Bank, civil society organizations, manufacturers, and others. COVAX partners have been supporting governments in readiness efforts including the development of national vaccination plans, support for cold chain infrastructure, and stockpiling syringes and safety boxes for their disposal, masks, gloves and other equipment to ensure that health workers can start vaccinating priority groups as soon as possible.

"We will not end the pandemic anywhere unless we end it everywhere," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "This is a major first step towards realizing our shared vision of vaccine equity, but we still have a lot of work to do with governments and manufacturers to ensure that vaccination of health workers and older people has begun in all countries within the first 100 days of 2021."

Although we now have multiple safe and effective vaccines against COVID-19, the increased spread of COVID-19 variants is a reminder that the vaccines must be urgently shared worldwide to reduce the prevalence of disease and end the pandemic.

COVAX Facility participants must have in place confirmation of national regulatory authorization criteria related to the vaccines delivered, indemnification agreements, national vaccination plans, as well as other logistical factors such as export and import licenses.

For further information on the roll-out of the COVID-19 vaccine in Ghana, click [here](#).

From the field:

Indonesia: WHO and the Ministry of Health continue collaboration in COVID-19 sero-epidemiological study and laboratory quality assurance

Well-functioning laboratories are the backbone of robust surveillance systems. Since March 2020, WHO has provided technical assistance and capacity building support to improve and scale up laboratory capacity across Indonesia.

With WHO support, the Ministry of Health has expanded SARS-COV-2 testing from 18 laboratories at the start of the pandemic to 612 laboratories by 22 January 2021 with over 900 laboratory technicians trained in polymerase chain reaction (PCR) testing, biosafety, and security.

As a part of the comprehensive strategy to improve SARS-COV-2 laboratory capacity in Indonesia, WHO has provided 248 sets of magnetic stands for distribution across the country for the manual nucleic acid extraction process.

A high-throughput automated sample preparation system for nucleic acid extraction was provided to the National Institute of Health Research and Development (NIHRD) to increase the SARS-CoV-2 testing



A training participant utilizes laboratory equipment during a practical training exercise on polymerase chain reaction (PCR) testing held by WHO. Credit: WHO

capacity by reducing the required time and number of laboratory staff needed to conduct testing.

A quality management mechanism is essential to ensure that COVID-19 laboratories provide accurate and reliable results. WHO and the United States Agency for International Development (USAID) Infectious Disease Detection and Surveillance have supported the NIHRD to distribute proficiency test panels to 177 laboratories with most already submitting the results for preliminary data analysis.

In July 2020, WHO and the Ministry of Health began conducting a sero-epidemiological study with over 10 000 individuals to assess the proportion of people with antibodies against SARS-CoV-2 by gender and age-group. Results are expected by end of March 2021.

WHO is now facilitating the transport of these samples to six selected laboratories for Enzyme Linked Immunosorbent Assay (ELISA) examination and to the NIHRD laboratory for quality control. Indonesia's participation in the sero-epidemiological study will contribute not only to the national public health response and policy decisions, but also to the global understanding of seroprevalence levels and control measures.

For further information, click [here](#)

From the field:

WHO Health Emergencies Programme Central Asia hub opens door to inter-country exchanges on Public Health Emergency Operations Centres



*Workshop of Kazakhstan PHEOC experts sharing their experience with their Kyrgyzstan counterparts.
Credit WHO Central Asia Hub*

Public Health Emergency Operations Centres (PHEOCs) play a critical role before, during, and after responses to public health events and emergencies as they serve as venues for designated public health emergency management personnel to coordinate operational information and resources for emergency management. Establishing and continuously strengthening PHEOCs contributes to a country's capacities to manage public health events and emergencies, as required under the core International Health Regulations (IHR) (2005).

WHO is providing ongoing support to Kyrgyzstan in establishing its PHEOCs at both central and provincial levels. From 15-20 February 2021, the WHO Health Emergencies Programme hub in Central Asia facilitated an exchange of experience and best practices between Kazakhstan and Kyrgyzstan in PHEOC management, with a focus on COVID-19 response. Having a well-established and functioning PHEOC, Kazakhstan's experience is providing guidance to Kyrgyzstan as the country builds and strengthens its own network of PHEOCs.

During the visit, PHEOC experts from Kazakhstan shared knowledge and lessons learnt about their centre's critical role in strategic information monitoring and modelling, particularly in the context of COVID-19. The exchange between the two countries was a first step in establishing further sub-regional collaboration and coordination facilitated by WHO. WHO Central Asia hub supports the enhancement of PHEOC capacities in the sub-region by providing technical and operational support, opening avenues for the exchange of information, and sharing experiences among the five countries (Uzbekistan, Kyrgyzstan, Kazakhstan, Tajikistan and Turkmenistan).

From the field:

WHO supports Iraq with vital consignment of medical technologies to boost COVID-19 containment efforts

On 20 February 2021, WHO delivered a shipment of medical supplies and equipment to the Ministry of Health of Iraq, with the aim of supporting national preparedness and response efforts to the COVID-19 pandemic. This shipment comes at an opportune time as the number of SARS-COV-2 infections began to drop towards the end of 2020, but rose again recently marking a concerning increase in February 2021.

This 129-pallet shipment complements two others delivered in 2020, worth over US\$ 5 million. This new delivery of medical technologies includes intensive care supplies and equipment, as well as spare parts for oxygen concentrators provided earlier by the Organization during a shortfall in oxygen supplies in July 2020.



Photo credit: WHO Iraq Country office

The consignment also includes personal protective equipment, electrocardiograph devices, oximeters, hospital bedding, furniture, and patient monitors, all of which come as timely support to the Ministry of Health's efforts to contain the new spike in COVID-19 cases. This series of shipments has equipped hospitals and the national health services to facilitate the management of a considerable number of patients hospitalized in critical and intensive care units.

"WHO continues to work in close collaboration with Iraqi health authorities and provides technical, operational and logistical support to address the increasing needs during this critical phase of the pandemic," said Dr Ahmed Zouiten WHO Representative in Iraq. "Our main objective is to curtail the transmission of COVID-19, and limit morbidity and mortality associated with the pandemic and scale up preparedness for a successful vaccine rollout to protect health workers, vulnerable populations and Iraqi citizens countrywide," Dr Zouiten added.

For further information, click [here](#)

Public health response and coordination highlights

At the UN Crisis Management Team (CMT) meeting on 24 February 2021, **WHO** reported on the epidemiological situation, noting that the number of global new cases and new deaths reported has continued to decrease – new cases have decreased for six consecutive weeks while new deaths have decreased for three consecutive weeks. This meeting marked one year since the activation of the CMT, **WHO**, as the chair, acknowledged the great work done by partners over the past year, and highlighted that the CMT has, to date, met 36 times and published 121 Crisis Updates through the UN Operations Crisis Centre (UNOCC).

WHO also highlighted the arrival of the first COVAX consignment in Ghana, noting that this was made possible through tremendous effort and collaboration among partners.

WHO and the World Organisation for Animal Health (OIE) briefed the CMT on the Global Study of the Origins of SARS-CoV-2. Both organizations suggested that the recent international expert mission to Wuhan improved the understanding of virus transmission in December 2019, and stressed that the search for a possible animal virus host or intermediate virus host will continue over the coming months.

Food and Agriculture Organization (FAO) provided inputs on managing SARS-CoV-2 risks in animals and from the One Health perspective. FAO highlighted the importance of having a One Health workforce at the national level, and suggested that negotiations have been completed with UNEP to become the fourth member of the Tripartite Agreement, which includes WHO, OIE and FAO.

Health Ops

WHO is expanding access to online learning for COVID-19 through its open learning platform for health emergencies, [OpenWHO.org](https://openwho.org).

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



4 932 953

Course enrollments

44 languages

26 topical courses

Over 2.6 million certificates

Partnerships

The Emergency Medical Teams - EMT

As of 24 February 2021, the Emergency Medical Team (EMT) response to COVID-19 has seen over 80 international deployments. These deployments have provided support to countries in every WHO Region with overwhelmed health systems.

In the Americas Region, over 16,700 inpatient beds were provided to expand capacities, including those for critical care of patients.



As part of the journey of the EMT Regional Training Center for Africa, the EMT Network supported the WHO academies first Mass Casualty Management (MCM) learning session for Ethiopia targeting preparedness and response mechanisms for MCM in the emergency units.



Finally, the Strategic Advisory Group of the Emergency Medical Teams Initiative has endorsed the update to the Classification and Minimum Standards for EMTs. This significant update follows the first version published in 2013 which introduced the classification system of EMTs and set minimum standards and guiding principles for EMTs responding in an emergency response to ensure quality of care in emergencies. The update will be launched at the World Health Assembly this May.

This updated version drew from many lessons learned throughout the last eight years especially in outbreaks such as the Ebola crisis and most recently, the COVID-19 pandemic.



COVID-19 Partners platform

New Strategic Preparedness and Response Plan (SPRP) builds on a year of COVID-19 research and response

The revised COVID-19 Strategic Preparedness and Response Plan (SPRP) for 2021 is now available for [download](#).

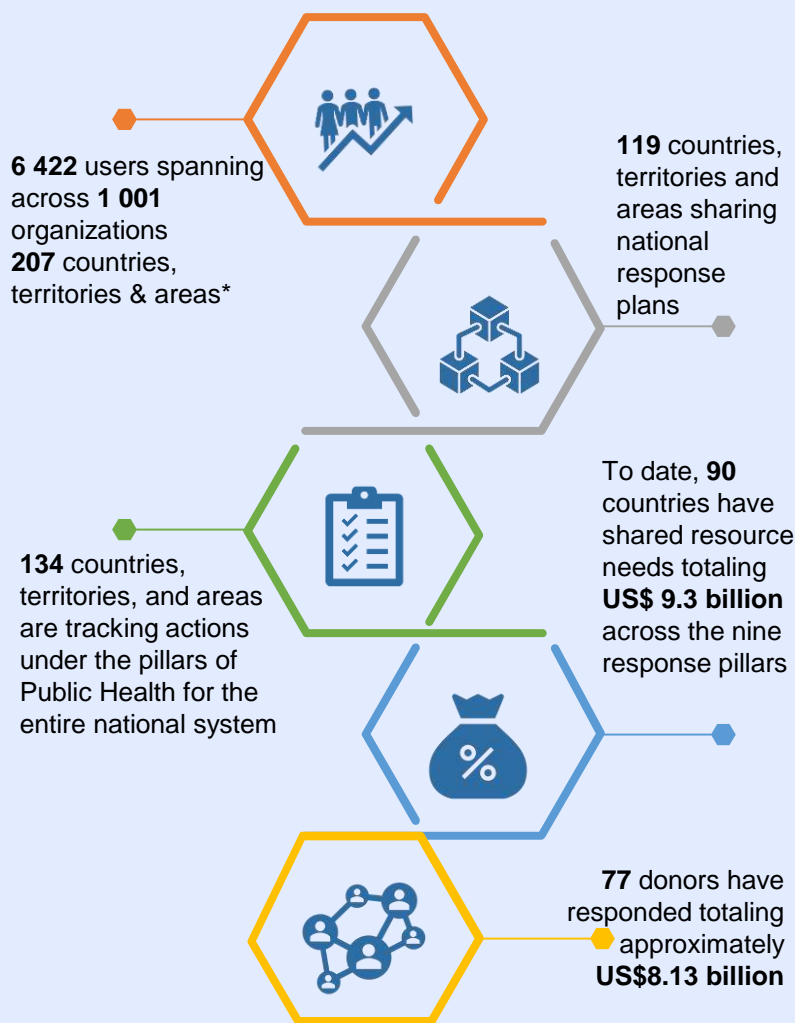
A great deal was learned over the course of 2020 about the SARS-CoV-2 virus and our collective response, and the document is aimed at updating the global strategic priorities in support of guiding the public health response to COVID-19 at national and subnational levels.

The SPRP 2021 Operational Guidelines are forthcoming, but other accompanying technical documents are currently available on the site. The Partners Platform will be updated in the coming weeks to reflect the forthcoming SPRP 2021 Operational Guidelines.

The [Partners Platform](#) plays a crucial role in enabling WHO at global, regional and country levels to seamlessly and efficiently collaborate with governments to develop and update national response plans, and with partners to identify and plan for urgent resource gaps.

For further information on funding SPRP 2021, see the *Appeals* section (pages 10-11).

2020 Strategic Preparedness and Response Plan (SPRP) Achievements



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

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

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 26 February 2021.

Shipped items as of 26 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)	718 250	3 695 735	1 825 642	1 472 210	10 194 300	208 690	1 717 279	53 429 400	2 758 630
Americas (AMR)	7 282 300	1 046 142	10 543 278	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760
Eastern Mediterranean (EMR)	978 300	1 357 970	1 553 410	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	430 000	562 080	553 070	1 750 900	8 935 100	409 900	1 757 548	40 911 500	5 423 350
South East Asia (SEAR)	440 000	2 509 400	2 408 970	371 836	2 125 500	86 510	555 300	6 940 500	604 495
Western Pacific (WPR)		228 500	346 834	768 700	3 021 000	311 927	463 710	14 974 146	2 102 035
TOTAL	9 848 850	9 399 827	17 231 204	8 651 831	36 640 900	1 546 447	6 946 179	198 709 426	20 060 365

Note: The WPR PCR test data is as of 19 February 2021

For further information on the **COVID-19 supply chain system**, see [here](#).

Appeals

On Thursday, 18 February 2021 WHO launched [the Strategic Preparedness and Response Plan](#) (SPRP) 2021 and seeks to raise US\$ 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.

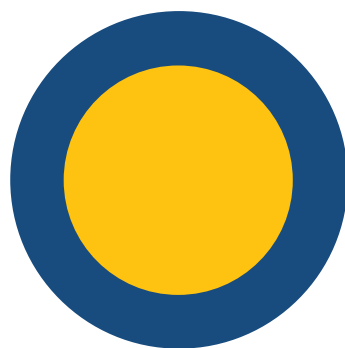
WHO’s SPRP 2021 is critical to end the acute phase of the pandemic, and as such the SPRP is an integrated plan bringing together efforts and capacities for preparedness, response, health systems strengthening for the roll out of COVID-19 tools (ACT-A). Of the \$1.96 billion appealed for, \$1.2 billion 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. Of the total appeal, \$643 million 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***

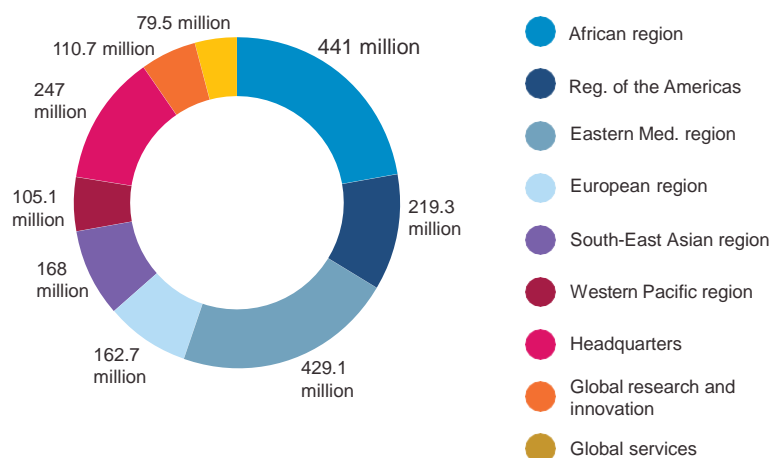
Of the total US\$1.96 billion WHO requirement, US\$1.22 billion (62%) counts towards WHO’s requirement for the Access to COVID-19 tools accelerator

The status of funding raised for WHO against the SPRP can be found [here](#)

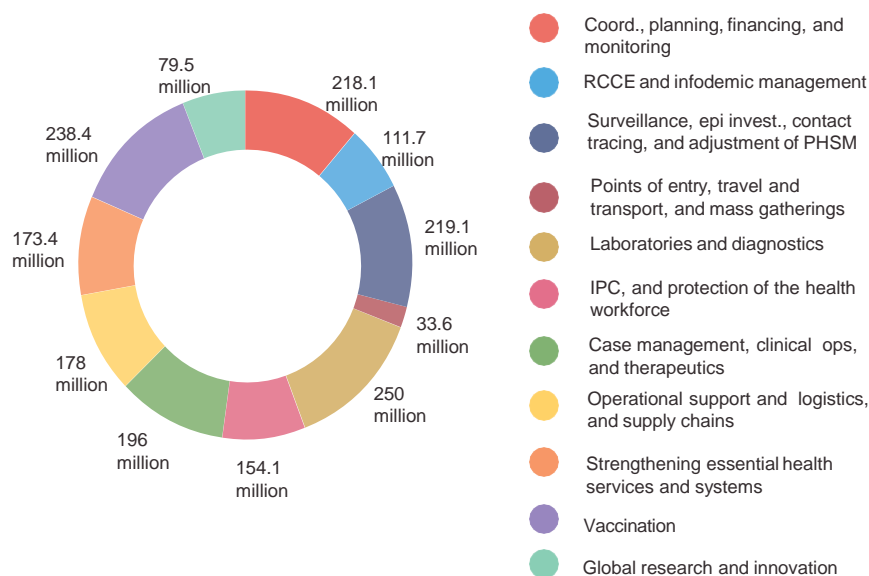
Appeals

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

As of 26 February 2021, [The Solidarity Response Fund](#) has raised or committed more than US\$ 242 million.

From the Fund's March 13, 2020 launch through today leading companies and organizations and more than 660 000 individuals together contributed more than US\$ 651 million in fully flexible funding to support the WHO-led global response effort

More than **US\$ 242 million**



660 000 donors

[individuals – companies – philanthropies]

The WHO Contingency Fund for Emergency (CFE)

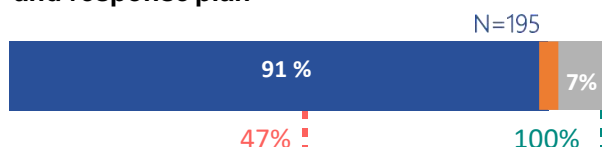
WHO's Contingency Fund for Emergencies (CFE) provided \$8.9 million for COVID-19 preparedness and response worldwide at the very onset of the outbreak when no other funding was available.

US\$ 8.9 Million released

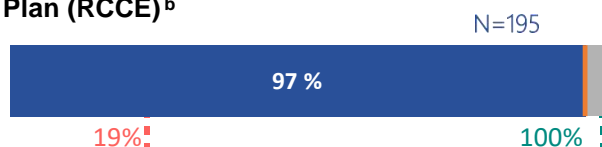
The WHO Contingency Fund for Emergencies 2019 Annual Report was published on 7 August. WHO is grateful to all donors who contributed to the fund allowing us to respond swiftly and effectively to emerging crises including COVID-19. Full report is available [here](#).

COVID-19 Global Preparedness and Response Summary Indicators^a

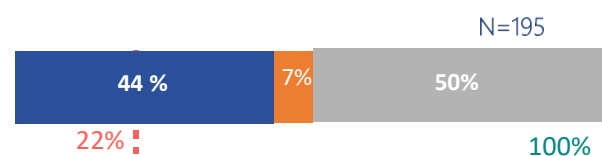
Countries have a COVID-19 preparedness and response plan



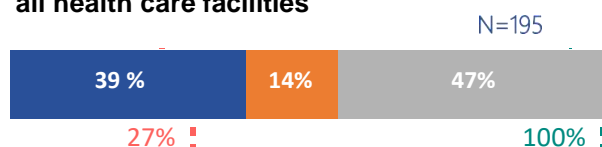
Countries have a COVID-19 Risk Communication and Community Engagement Plan (RCCE)^b



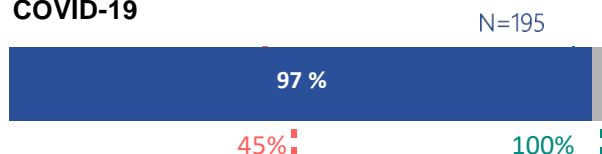
Countries have a national policy & guidelines on Infection and Prevention Control (IPC) for long-term care facilities



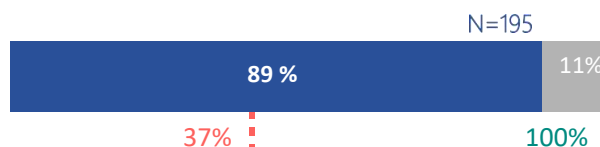
Countries with a national IPC programme & WASH standards within all health care facilities



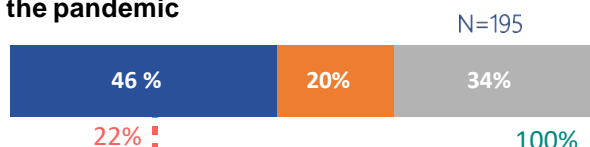
Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19



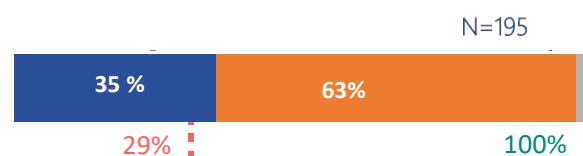
Countries have a clinical referral system in place to care for COVID-19 cases



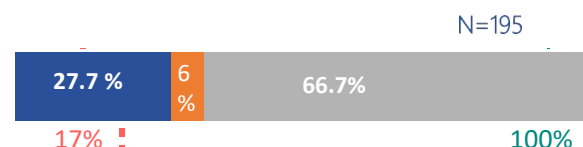
Countries that have defined essential health services to be maintained during the pandemic



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



Countries have a health occupational safety plan for health care workers



Countries have COVID-19 laboratory testing capacity



Legend



Yes



No



No information



Baseline value



Target value

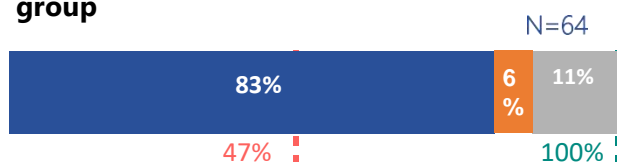
Notes:

^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

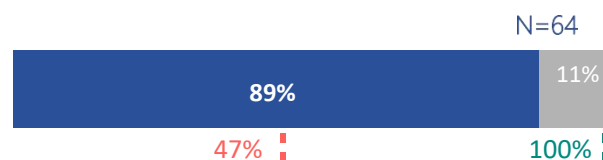
COVID-19 Global Preparedness and Response Summary Indicators

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



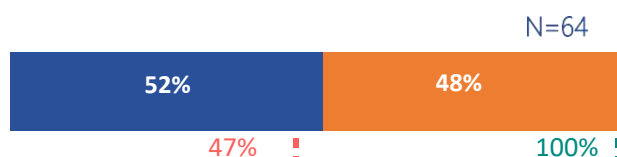
Priority countries that have postponed at least 1 vaccination campaign due to COVID-19^c



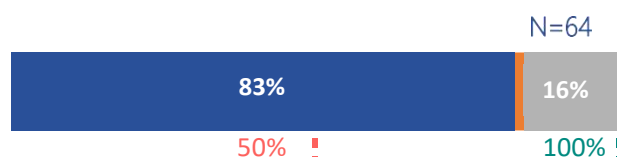
Priority countries with a contact tracing focal point



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



Legend

Yes

No

No information

Baseline value

Target value

Notes:

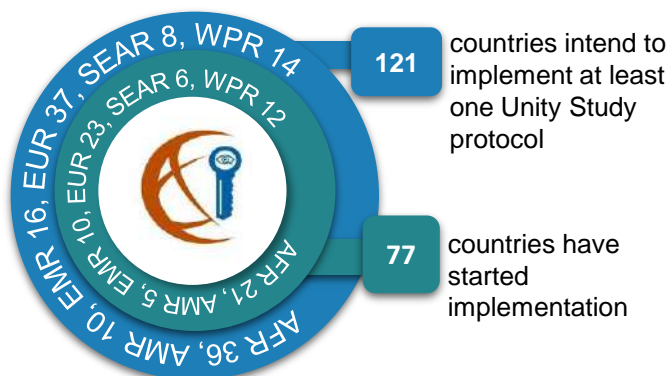
^c Source: WHO Immunization Repository

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.

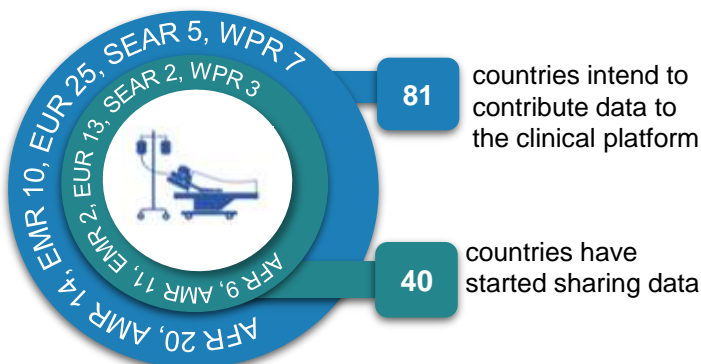
The Unity standard framework is an invaluable tool for research equity. It promotes the use of standardized study designs and laboratory assays



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.

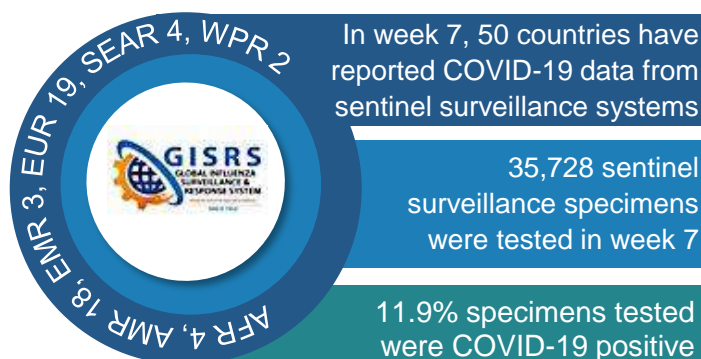
WHO invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform.



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 SARS-COV-2.





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:
 - WHO COVID-19 vaccine policy recommendations
 - SARS-CoV-2 variants of concern
 - Updates on publications and other news
- ❑ For a special edition, supplementary to the Weekly Epidemiology Update, click [here](#). Highlights include:
 - Working definitions for SARS-CoV-2 variants of interest and variants of concern and the associated actions all stakeholders should take
- ❑ 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](#)