

# **COVID-19 Weekly Epidemiological Update**

Data as received by WHO from national authorities, as of 25 April 2021, 10 am CET

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### **Global overview**

Globally, new COVID-19 cases increased for the ninth consecutive week, with nearly 5.7 million new cases reported in the last week – surpassing previous peaks (Figure 1). The number of new deaths increased for the sixth consecutive week, with over 87 000 new deaths reported. This week, all regions are reporting decreases in case incidence apart from the South-East Asia and Western Pacific regions. For the third consecutive week, the South-East Asia region reported the highest relative increases in both case and death incidences (Table 1). While a number of countries in the region are reporting upward trends, India accounts for the vast majority of cases from this regional trend and 38% of global cases reported in the past week. Similarly, all but two regions, South-East Asia and Eastern Mediterranean, reported declines in new deaths this week.



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

Reported week commencing

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

The highest numbers of new cases were reported from India (2 172 063 new cases; 52% increase), the United States of America (406 001 new cases; 15% decrease), Brazil (404 623 new cases; 12% decrease), Turkey (378 771 new cases; 9% decrease), and France (211 674 new cases; 9% decrease).

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	1 400 004 (25%)	-8%	60 951 004 (42%)	36 530 (42%)	-7%	1 481 266 (48%)
Europe	1 466 680 (26%)	-12%	50 714 995 (35%)	25 341 (29%)	-5%	1 061 218 (34%)
South-East Asia	2 269 114 (40%)	49%	19 965 648 (14%)	17 126 (19%)	81%	254 958 (8%)
Eastern Mediterranean	378 248 (7%)	-2%	8 822 942 (6%)	6 370 (7%)	17%	176 950 (6%)
Africa	49 453 (1%)	-9%	3 274 714 (2%)	1 155 (1%)	-1%	81 870 (3%)
Western Pacific	131 777 (2%)	3%	2 337 462 (2%)	1 304 (1%)	-10%	36 222 (1%)
Global	5 695 277 (100%)	8%	146 067 511 (100%)	87 826 (100%)	5%	3 092 497 (100%)

#### Table 1. Newly reported and cumulative COVID-19 cases and deaths, by WHO Region, as of 25 April 2021\*\*

\*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior \*\*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, 19-25 April 2021\*\*

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

## Special Focus: Update on SARS-CoV-2 variants

WHO, in collaboration with national authorities, institutions and researchers, continues to monitor SARS-CoV-2 variants of interest (VOIs) and variants of concern (VOCs), and assess these and other emerging variants based on the risk posed to global public health, including impacts on epidemiology and public health and social measures (PHSM). Here we provide an update on the geographical distribution, and emerging evidence surrounding phenotypic characteristics of designated VOIs and VOCs (Tables 2).

As surveillance activities to detect SARS-CoV-2 variants are strengthened at local and national levels, including by strategic genomic sequencing and sharing full genome sequences with publicly available platforms such as GISAID, the number of countries/areas/territories (hereafter countries) reporting VOCs continues to increase. Since our last update on 20 April, VOC 202012/01 has been detected in three additional countries, variant 501Y.V2 in three additional countries, and variant P.1 in two additional countries. As of 27 April, a total 139 countries have reported VOC 202012/01 (Figure 3), 87 countries VOC 501Y.V2 (Figure 4), and 54 countries VOC P.1 (Figure 5) – see also Annex 2. These distributions should be interpreted with due consideration of surveillance limitations, including differences in sequencing capacities and prioritization of samples for sequencing between countries.

	Nextstrain	Pango	GISAID	Alternate	First	Earliest	Characteristic spike
	clade	lineage	clade	name	detected in	samples	mutations
	20I/501Y.V1	B.1.1.7	GR/501Y.V1	<b>VOC 202012/01<sup>+</sup></b>	United	Sep 2020	69/70del, 144del, N501Y,
					Kingdom		A570D, D614G, P681H,
							T716I, S982A, D1118H
	20H/ <b>501Y.V2</b>	B.1.351	GH/501Y.V2 <sup>†</sup>	VOC 202012/02	South Africa	Aug 2020	D80A, D215G, 241/243del,
voc	+						K417N, E484K, N501Y,
							D614G, A701V
	20J/501Y.V3	B.1.1.28.1,	GR/501Y.V3	VOC 202101/02	Brazil and	Dec 2020	L18F, T20N, P26S, D138Y,
		alias P.1 <sup>+</sup>			Japan		R190S, K417T, E484K, N501Y,
							D614G H655Y, T1027I,
	/						V1176F
	20A/S.484K	B.1.525	G/484K.V3	-	United	Dec 2020	Q52R, A67V,
					Kingdom and		69//0del, 144del, E484K,
	222/24522	D 4 407 (			Nigeria		D614G, Q677H, F888L
	20C/S.452R	B.1.427/	GH/452R.V1	CAL.20C/L452R	United	Jun	S13I, W152C, L452R, D614G
		B.1.429			States of	2020	
	200/6 40414	D 4 4 20 2	<u>cp</u>		America	Augu 2020	
	20B/S.484K	B.1.1.28.2,	GR	-	Brazil	Apr 2020	E484K, D614G, V1176F
		allas P.Z					
	-	B.1.1.28.3,	-	PHL-B.1.1.28	Philippines	Feb 2021	141/143del, E484K, N501Y,
		alias P.3			and Japan		D614G P681H, E1092K,
VOI							H1101Y, V1176F
	20C	B.1.526 with	GH	-	United	Nov 2020	L5F, T95I, D253G, D614G,
		E484K or			States of		A701V, E484K or S477N
		S477N			America		
	20C	B.1.616	GH	-	France	Jan	H66D, G142V, 144del,
						2021	D215G, V483A, D614G,
							H655Y, G669S, Q949R,
			0/4500.10			<u>.</u>	N1187D
	-	B.1.61/	G/452R.V3	-	India		1452K, D614G, P681K,
						2020	

#### Table 2: SARS-CoV-2 variants of interest (VOI) and variants of concern (VOC), as of 27 April 2021

<sup>†</sup>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.



#### Figure 3. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01, as of 27 April 2021

#### Figure 4. Countries, territories and areas reporting SARS-CoV-2 variant 501Y.V2, as of 27 April 2021





#### Figure 5. Countries, territories and areas reporting SARS-CoV-2 variant P.1, as of 27 April 2021

#### Vaccine performance against VOCs

Available evidence on vaccine performance against VOCs have been highlighted in previous editions of the Weekly Epidemiological Update, most recently <u>13 April</u>, and are summarised in Table 3.

VOC 202012/01 (B.1.1.7)	501Y.V2 (B.1.351)	P.1 (B.1.1.28.1)		
Efficacy/effectiveness against disease or i	infection			
Protection retained against disease:	Reduced protection against disease, limited evidence	Limited evidence		
<ul> <li>No/minimal loss: AstraZeneca- Vaxzevria, Novavax-Covavax, Pfizer BioNTech-Comirnaty<sup>1-10</sup></li> <li>Asymptomatic infection:         <ul> <li>No/minimal loss: Pfizer BioNTech- Comirnaty<sup>11,12</sup></li> <li>Moderate/substantial loss (inconclusive, limited sample size): AstraZeneca-Vaxzevria<sup>2</sup></li> </ul> </li> </ul>	<ul> <li>Severe disease:</li> <li>No/minimal loss: Janssen Ad26.COV 2.5<sup>33</sup></li> <li>Mild-moderate disease:</li> <li>Moderate loss: Janssen-Ad26.COV 2.5, Novavax-Covavax<sup>33,34</sup></li> <li>Substantial loss (Inconclusive, limited sample size): AstraZeneca-Vaxzevria<sup>35</sup></li> </ul>	<ul> <li>No/minimal loss: Sinovac- CoronaVac <sup>42</sup></li> </ul>		
	<ul><li>Asymptomatic infection:</li><li>No evidence</li></ul>			
Neutralization				
<ul> <li>No/minimal loss: Bharat-Covaxin, Gamaleya-Sputnik V, Moderna- mRNA-1273, Novavax-Covavax, Pfizer BioNTech-Comirnaty, Beijing CNBG-BBIBP-CorV, Sinovac- CoronaVac<sup>13-32</sup></li> <li>Minimal/moderate loss: AstraZeneca-Vaxzevria<sup>2,28</sup></li> </ul>	<ul> <li>Minimal/modest loss: Beijing CNBG- BBIBP-CorV, Sinovac-CoronaVac<sup>36,37</sup></li> <li>Minimal to large loss: Moderna-mRNA- 1273, Pfizer BioNTech-Comirnaty<sup>13,14,18-</sup> 20,22-25,27-30,36,38-41</li> <li>Moderate to substantial loss: AstraZeneca-Vaxzevria, Gamaleya- Sputnik V, Novavax-Covavax<sup>20,28,31,40</sup></li> </ul>	<ul> <li>No/Minimal reduction: AstraZeneca-Vaxzevria, Sinovac-CoronaVac<sup>28,43</sup></li> <li>Minimal/moderate reduction: Moderna- mRNA-1273, Pfizer BioNTech-Comirnaty 14,15,22,25,27,28,39,41,43,44</li> </ul>		

#### Table 3: Summary of vaccine performance against variants of concern (VOC) relative to ancestral stains

Further to this, there is growing real-world evidence of the effectiveness of Pfizer BioNTech-Comirnaty vaccine against symptomatic disease as well as severe disease in health workers and adults in the United Kingdom and Israel during times when VOC 202012/01 was circulating or dominant, providing support for neutralization and vaccine efficacy (VE) results. Real-world evidence also points to high effectiveness against asymptomatic infection.<sup>3-11</sup> Analysis of nationwide surveillance data in Israel reported a VE of 94.1% (93.5-94.6) against asymptomatic infection ≥14 days post second dose among a large cohort of adults 16 years and older.<sup>11</sup> A second study reported a four-fold decrease in the risk of asymptomatic infection ≥12 days post dose one among health workers in the United Kingdom.<sup>12</sup>

Two effectiveness studies conducted in the United Kingdom have reported VOC 202012/01-specific VE estimates for two doses of Pfizer BioNTech-Comirnaty, and found no difference in effectiveness of the vaccine against disease caused by VOC 202012/01 as compared to other variants.<sup>3, 9</sup>

There is also growing real-world evidence showing a single dose of AstraZeneca-Vaxzevria is effective against symptomatic disease and infection in VOC 202012/01 settings.<sup>3,6-8</sup> Data is currently lacking on the effectiveness of two doses of AstraZeneca. Although moderate to substantial loss was observed with the AstraZeneca-Vaxzevria vaccine, the confidence intervals are broad and caution should be taken interpreting the results, given the limited sample size.<sup>2</sup>

Phase III clinical trial results from South Africa show vaccine efficacy of Janssen-Ad26.COV 2.5 vaccine to be 52% (95% CI: 30.3-67.4) against moderate to severe/critical disease when variant 501Y.V2 made up 95% of sequenced virus. Efficacy against severe critical disease was 73.1% (40.0-89.4), comparable to that found in the USA.<sup>33</sup> Although moderate to substantial loss was observed with the AstraZeneca-Vaxzevria vaccine, the confidence intervals are broad and caution should be taken interpreting the results, given the limited sample size.<sup>35</sup>

#### Variants of interest B.1.617

Emerging SARS-CoV-2 variants within Pango lineage B.1.617 were recently reported as a VOI from India and has recently been designated as VOIs by WHO. As of 27 April, over 1200 sequences have been uploaded to GISAID and assigned to lineage B.1.617 (collectively) from at least 17 countries; most sequences were uploaded from India, the United Kingdom, USA and Singapore.<sup>45</sup> However, this lineage comprises several sub-lineages, including B.1.617.1, B.1.617.2 and B.1.617.3, which slightly differ by their characteristic mutations. Both B.1.617.1 and B.1.617.2 were first identified in India in December 2020, and have been detected at increasing prevalence concurrent to the major upsurge observed in the country. B.1.617.3 was first detected in India in October 2020, but relatively fewer viruses matching this sub-lineage have been reported to date.

B.1.617 includes several mutations present in other VOIs / VOCs that have been associated with phenotypic impacts. Three characteristic mutations of this variant include L452R, P681R, and E484Q (the latter observed in sub-lineages B.1.617.1 and B.1.617.3). L452R has been identified in another VOI, B.1.427/ B.1.429, which has been associated with increased transmissibility, a reduction in neutralization by some (but not all) monoclonal antibody treatments, and a moderate reduction in neutralization in post-vaccination sera in the USA.<sup>46</sup> P681R is adjacent to the furin cleavage site, and (together with other mutations) may enhance binding and subsequent cleavage of the spike protein and enhances systemic infection and membrane fusion; potentially resulting in enhanced transmission.<sup>47</sup> Laboratory studies suggest that convalescent samples from individuals who had natural infection may have reduced neutralization against variants with an E484Q mutation.<sup>48</sup> Preliminary laboratory studies of a small number of convalescent sera samples of COVID-19 cases (n=17) and recipients of Novavax-Covaxin (n=28) were able to neutralize B.1.617.<sup>49</sup>

In India, heterogeneity in B.1.617 geographic distribution is observed across regions, with co-circulation of other VOCs (including VOC 202012/01 and 501Y.V2) and other variants (e.g., B.1.618), which collectively may be playing a role in the current resurgence in this country. Indeed, studies have highlighted that the spread of

the second wave has been much faster than the first.<sup>50</sup> Preliminary modelling by WHO based on sequences submitted to GISAID suggest that B.1.617 has a higher growth rate than other circulating variants in India, suggesting potential increased transmissibility, with other co-circulating variants also demonstrating increased transmissibility. Other drivers may include challenges around the implementation and adherence to public health and social measures (PHSM), and social gatherings (including mass gatherings during cultural and religious celebrations, and elections). Further investigation is needed to understand the relative contribution of these factors.

It remains unclear how generalizable laboratory-based studies of limited sample sizes, as well as studies of other variants with similar key mutations, are to the wider circulating B.1.617 variants. Further robust studies into the phenotypic impacts of these variants, including impacts on epidemiological characteristics (transmissibility, severity, reinfection risk, etc.) and impact on countermeasures, are urgently needed.

#### **WHO** recommendations

Virus evolution is expected and the more SARS-CoV-2 circulates, the more opportunities it has to mutate. Reducing transmission through established and proven disease control methods such as those outlined in the <u>COVID-19 Strategic Preparedness and Response Plan</u>, as well as avoiding introductions into 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 and its 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. National and local authorities are encouraged to continue strengthening existing PHSM, IPC and disease control activities. Authorities are also encouraged to strengthen surveillance and sequencing capacities and apply a systematic approach to provide a representative indication of the extent of transmission of SARS-CoV-2 variants based on the local context, and to detect unusual events.

#### **Additional resources**

- Working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern
- <u>COVID-19 new variants: Knowledge gaps and research</u>
- COVID-19 Situation Reports from WHO Regional Offices and partners: <u>AFRO</u>, <u>AMRO/PAHO</u>, <u>EMRO</u>, <u>EURO/ECDC</u>, <u>SEARO</u>, <u>WPRO</u>
- PAHO COVID-19 Situation Reports
- 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

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## **WHO regional overviews**

### **African Region**

The African Region reported over 49 000 new cases and over 1100 new deaths, a 9% and a 1% decrease respectively compared to the previous week. The number of weekly cases continues to oscillate over the last nine weeks, with an overall decreasing trend in deaths observed since the peak in mid-January. The highest numbers of new cases were reported from Ethiopia (10 719 new cases; 9.3 new cases per 100 000 population; a 17% decrease), South Africa (8690 new cases; 14.7 new cases per 100 000; a 7% increase), and Kenya (5031 new cases; 9.4 new cases per 100 000; an 18% decrease).

The highest numbers of new deaths were reported from South Africa (414 new deaths; 0.7 new deaths per 100 000 population; a 9% decrease), Ethiopia (203 new deaths; 0.2 new deaths per 100 000; a 12% increase), and Kenya (140 new deaths; 0.3 new deaths per 100 000; a 5% increase).



#### **Region of the Americas**

The Region of the Americas reported over 1.4 million new cases and over 36 000 new deaths, an 8% and a 7% decrease respectively compared to the previous week. The region has reported a decreasing trend in new cases in the last week after eight weeks of a gradual increase, the trend in new deaths also decreased in the last week. The highest numbers of new cases were reported from the United States of America (406 001 new cases; 122.7 new cases per 100 000; a 15% decrease), Brazil (404 623 new cases; 190.4 new cases per 100 000; a 12% decrease), and Argentina (166 024 new cases; 367.3 new cases per 100 000; a 3% increase).

The highest numbers of new deaths were reported from Brazil (17 667 new deaths; 8.3 new deaths per 100 000; a 12% decrease), the United States of America (4951 new deaths; 1.5 new deaths per 100 000; a 4% decrease), and Colombia (2882 new deaths; 5.7 new deaths per 100 000; a 26% increase).



#### **Eastern Mediterranean Region**

The Eastern Mediterranean Region reported over 378 000 new cases and over 6300 new deaths, a 2% decrease and a 17% increase respectively compared to the previous week. The trend in new cases has plateaued after ten weeks of an increase, whereas the trend in new deaths continues to increase sharply for the ninth consecutive week. The highest numbers of new cases were reported from the Islamic Republic of Iran (161 594 new cases; 192.4 new cases per 100 000; a 3% decrease), Iraq (54 301 new cases; 135.0 new cases per 100 000; a 3% increase), and Pakistan (39 858 new cases; 18.0 new cases per 100 000; a 17% increase).

The highest numbers of new deaths were reported from the Islamic Republic of Iran (2793 new deaths; 3.3 new deaths per 100 000; a 33% increase), Pakistan (905 new deaths; 0.4 new deaths per 100 000; an 18% increase), and Tunisia (514 new deaths; 4.3 new deaths per 100 000; a 7% increase).



### **European Region**

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The European Region reported over 1.4 million new cases and over 25 000 new deaths, a 12% and a 5% decrease respectively compared to the previous week. The trend in both new cases and deaths is decreasing in the last two weeks. The highest numbers of new cases were reported from Turkey (378 771 new cases; 449.1 new cases per 100 000; a 9% decrease), France (211 674 new cases; 325.5 new cases per 100 000; a 9% decrease), and Germany (145 156 new cases; 174.5 new cases per 100 000; a 1% increase).

The highest numbers of new deaths were reported from Poland (3383 new deaths; 8.9 new deaths per 100 000; a 6% decrease), the Russian Federation (2650 new deaths; 1.8 new deaths per 100 000; a 2% increase), and Ukraine (2537 new deaths; 5.8 new deaths per 100 000; an 8% decrease).



#### South-East Asia Region

The South-East Asia Region reported over 2.2 million new cases and over 17 000 new deaths, a 49% and an 81% increase respectively compared to the previous week. A very sharp rise in new cases and new deaths reported since early in March continues. The main driver of this increase in the region is the high numbers of new cases reported from India (2 172 063 new cases; 157.4 new cases per 100 000; a 52% increase). Additionally, high numbers of new cases were reported from Indonesia (37 029 new cases; 13.5 new cases per 100 000; similar to previous week), and Bangladesh (27 148 new cases; 16.5 new cases per 100 000; a 25% decrease).

The highest numbers of new deaths were reported from India (15 161 new deaths; 1.1 new deaths per 100 000; a 93% increase), Indonesia (1172 new deaths; 0.4 new deaths per 100 000; a 32% increase), and Bangladesh (669 new deaths; 0.4 new deaths per 100 000; an 8% increase).



### Western Pacific Region

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The Western Pacific Region reported nearly 132 000 new cases and over 1300 new deaths, a 3% increase and a 10% decrease respectively compared to the previous week. New weekly cases continue to increase for the seventh consecutive week while new deaths have decreased in the last two weeks following a peak in early April. The highest numbers of new cases were reported from the Philippines (63 364 new cases; 57.8 new cases per 100 000; a 13% decrease), Japan (32 312 new cases; 25.5 new cases per 100 000; a 22% increase), and Malaysia (17 393 new cases; 53.7 new cases per 100 000; a 27% increase).

The highest numbers of new deaths were reported from the Philippines (864 new deaths; 0.8 new deaths per 100 000; a 19% decrease), Japan (291 new deaths; 0.2 new deaths per 100 000; a 21% increase), and Malaysia (56 new deaths; 0.2 new deaths per 100 000; a 14% increase).



# Key weekly updates

#### WHO Director-General's key message

#### Opening remarks at the media briefing on COVID-19 – 23 April 2021:

- One year ago, WHO and many partners came together to launch the Access to COVID-19 Tools (ACT) Accelerator. The ACT Accelerator was conceived to rapidly develop vaccines, diagnostics and therapeutics; and to provide equitable access to those tools. The first objective has been achieved, though we have a long way to go on the second objective.
- We need countries and companies to:
  - share financial resources, to fully fund the ACT Accelerator;
  - $\circ$   $\;$  share vaccine doses to protect the most at-risk, not just the most-rich;
  - $\circ$   $\;$  share technology, know-how and intellectual property to scale up production; and
  - be transparent about their bilateral dose donations, so we know who has what.
- The ACT Accelerator needs 19 billion US dollars this year.

#### **Updates and publications**

- COVID-19 vaccines: Knowledge gaps and research priorities WHO ad hoc consultation
- Draft landscape and tracker of COVID-19 candidate vaccines
- COVID-19 and mandatory vaccination: Ethical considerations and caveats Policy brief
- <u>ACT now, ACT together 2020-2021 Impact Report</u>
- Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January-March 2021 Interim report
- WHO COVID-19 Clinical care bundle
- Expanding our understanding of post COVID-19 condition: report of a WHO webinar, 9 February 2021 24 April 2021
- Asthma and COVID-19: Scientific brief
- Disability considerations for COVID-19 vaccination: WHO & UNICEF Policy Brief
- <u>WHO COVID-19 Essential Supplies Forecasting Tool (COVID-ESFT)</u>
- COVID-19 News updates: Latest news from WHO on COVID-19 and other breaking health stories

# Technical guidance and other resources

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

## 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 25 April 2021\*\*

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Africa	49 453	3 274 714	291.9	1 155	81 870	7.3	
Ethiopia	10 719	250 955	218.3	203	3 531	3.1	Community transmission
South Africa	8 690	1 574 370	2 654.5	414	54 125	91.3	Community transmission
Kenya	5 031	156 318	290.7	140	2 603	4.8	Community transmission
Cameroon	4 267	65 998	248.6	72	991	3.7	Community transmission
Madagascar	3 645	35 262	127.3	55	593	2.1	Community transmission
Cabo Verde	1 809	21 784	3 918.1	12	201	36.2	Community transmission
Botswana	1 780	45 855	1 949.9	20	691	29.4	Community transmission
Algeria	1 250	120 736	275.3	46	3 198	7.3	Community transmission
Angola	1 192	25 492	77.6	16	577	1.8	Community transmission
Namibia	1 156	47 671	1 876.1	22	624	24.6	Community transmission
Rwanda	669	24 535	189.4	6	328	2.5	Community transmission
Democratic Republic of the Congo	604	29 498	32.9	11	756	0.8	Community transmission
Congo	594	10 678	193.5	7	144	2.6	Community transmission
Mali	580	13 560	67.0	33	462	2.3	Community transmission
Gabon	575	22 433	1 007.9	5	138	6.2	Community transmission
Nigeria	537	164 684	79.9	0	2 061	1.0	Community transmission
Mozambique	509	69 643	222.8	9	807	2.6	Community transmission
Zambia	473	91 317	496.7	11	1 245	6.8	Community transmission
Central African Republic	437	6 224	128.9	10	85	1.8	Community transmission
Zimbabwe	395	38 064	256.1	4	1 556	10.5	Community transmission
Senegal	351	40 082	239.4	9	1 099	6.6	Community transmission
Guinea	343	21 803	166.0	1	139	1.1	Community transmission
Seychelles	336	5 170	5 256.9	1	26	26.4	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Côte d'Ivoire	301	45 820	173.7	7	281	1.1	Community transmission
Equatorial Guinea	300	7 559	538.8	1	107	7.6	Community transmission
Тодо	291	12 787	154.5	2	121	1.5	Community transmission
Ghana	265	91 928	295.8	6	777	2.5	Community transmission
Burundi	241	3 853	32.4	0	6	0.1	Community transmission
Uganda	235	41 575	90.9	3	341	0.7	Community transmission
Burkina Faso	117	13 231	63.3	2	156	0.7	Community transmission
Eritrea	114	3 605	101.7	0	10	0.3	Community transmission
Benin	109	7 720	63.7	1	97	0.8	Community transmission
Gambia	87	5 820	240.8	3	173	7.2	Community transmission
South Sudan	83	10 515	93.9	0	114	1.0	Community transmission
Malawi	77	34 011	177.8	9	1 147	6.0	Community transmission
Mauritania	71	18 192	391.3	2	454	9.8	Community transmission
Chad	61	4 752	28.9	1	169	1.0	Community transmission
Niger	44	5 158	21.3	1	191	0.8	Community transmission
Eswatini	25	18 440	1 589.4	0	671	57.8	Community transmission
Sierra Leone	24	4 044	50.7	0	79	1.0	Community transmission
Sao Tome and Principe	23	2 298	1 048.6	0	35	16.0	Community transmission
Lesotho	19	10 728	500.8	1	316	14.8	Community transmission
Liberia	15	2 086	41.2	0	85	1.7	Community transmission
Comoros	14	3 829	440.3	0	146	16.8	Community transmission
Guinea-Bissau	14	3 724	189.2	1	67	3.4	Community transmission
Mauritius	3	1 206	94.8	1	16	1.3	Clusters of cases
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territories <sup>iii</sup>							
Réunion	918	19 343	2 160.5	6	141	15.7	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Mayotte	60	19 849	7 275.6	1	169	61.9	Community transmission
Americas	1 400 004	60 951 004	5 959.4	36 530	1 481 266	144.8	
United States of America	406 001	31 656 636	9 563.9	4 951	565 809	170.9	Community transmission
Brazil	404 623	14 237 078	6 697.9	17 667	386 416	181.8	Community transmission
Argentina	166 024	2 824 652	6 249.8	2 092	61 176	135.4	Community transmission
Colombia	121 122	2 740 544	5 386.0	2 882	70 446	138.4	Community transmission
Canada	58 519	1 164 581	3 085.6	342	23 883	63.3	Community transmission
Peru	56 604	1 745 655	5 294.4	2 558	59 012	179.0	Community transmission
Chile	45 463	1 162 811	6 082.9	687	25 742	134.7	Community transmission
Mexico	23 491	2 323 430	1 802.0	2 811	214 504	166.4	Community transmission
Uruguay	19 968	179 537	5 168.4	439	2 227	64.1	Community transmission
Paraguay	16 328	263 134	3 689.2	538	5 715	80.1	Community transmission
Ecuador	14 597	372 754	2 112.8	517	18 158	102.9	Community transmission
Guatemala	9 000	221 307	1 235.3	205	7 395	41.3	Community transmission
Venezuela (Bolivarian Republic of)	8 772	189 381	666.0	139	2 009	7.1	Community transmission
Bolivia (Plurinational State of)	8 532	295 892	2 534.8	158	12 783	109.5	Community transmission
Costa Rica	8 353	236 930	4 651.1	65	3 136	61.6	Community transmission
Cuba	7 844	100 318	885.7	69	581	5.1	Community transmission
Honduras	6 014	205 696	2 076.8	161	5 095	51.4	Community transmission
Dominican Republic	3 317	263 944	2 433.1	37	3 451	31.8	Community transmission
Panama	2 109	362 358	8 398.1	15	6 200	143.7	Community transmission
Jamaica	1 183	44 867	1 515.2	35	756	25.5	Community transmission
El Salvador	914	68 318	1 053.3	26	2 098	32.3	Community transmission
Guyana	806	12 448	1 582.6	10	277	35.2	Clusters of cases
Trinidad and Tobago	745	9 487	677.9	7	157	11.2	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Suriname	436	9 932	1 693.1	6	193	32.9	Clusters of cases
Bahamas	354	10 050	2 555.7	2	196	49.8	Clusters of cases
Saint Lucia	65	4 463	2 430.5	5	70	38.1	Community transmission
Belize	61	12 599	3 168.5	3	321	80.7	Community transmission
Barbados	47	3 820	1 329.3	0	44	15.3	Community transmission
Nicaragua	43	5 450	82.3	1	181	2.7	Community transmission
Haiti	40	12 958	113.6	0	251	2.2	Community transmission
Saint Vincent and the Grenadines	11	1 830	1 649.5	0	10	9.0	Community transmission
Antigua and Barbuda	9	1 222	1 247.8	0	31	31.7	Clusters of cases
Dominica	1	173	240.3	0	0	0.0	Clusters of cases
Grenada	0	159	141.3	0	1	0.9	Sporadic cases
Saint Kitts and Nevis	0	44	82.7	0	0	0.0	No cases
Territories <sup>iii</sup>							
Puerto Rico	6 879	127 450	4 455.0	69	2 263	79.1	Community transmission
French Guiana	745	18 826	6 303.0	3	98	32.8	Community transmission
Curaçao	348	12 022	7 326.3	19	99	60.3	Community transmission
Bermuda	255	2 315	3 717.5	6	23	36.9	Community transmission
Aruba	250	10 469	9 805.6	3	95	89.0	Community transmission
United States Virgin Islands	52	3 080	2 949.5	1	27	25.9	Community transmission
Anguilla	29	58	386.6	0	0	0.0	Sporadic cases
Bonaire	16	1 527	7 301.0	1	15	71.7	Community transmission
Sint Maarten	10	2 212	5 158.3	0	27	63.0	Community transmission
Cayman Islands	9	534	812.5	0	2	3.0	Sporadic cases
British Virgin Islands	7	194	641.6	0	1	3.3	Clusters of cases
Turks and Caicos Islands	7	2 376	6 136.7	0	17	43.9	Clusters of cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Falkland Islands (Malvinas)	1	63	1 808.8	0	0	0.0	Sporadic cases
Guadeloupe	0	12 927	3 230.7	0	194	48.5	Community transmission
Martinique	0	9 758	2 600.3	0	66	17.6	Community transmission
Montserrat	0	20	400.1	0	1	20.0	No cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Barthélemy	0	954	9 651.0	0	1	10.1	Clusters of cases
Saint Martin	0	1 710	4 423.3	0	13	33.6	Community transmission
Saint Pierre and Miquelon	0	25	431.4	0	0	0.0	Sporadic cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Eastern Mediterranean	378 248	8 822 942	1 207.3	6 370	176 950	24.2	
Iran (Islamic Republic of)	161 594	2 377 039	2 830.0	2 793	69 120	82.3	Community transmission
Iraq	54 301	1 025 288	2 549.0	269	15 217	37.8	Community transmission
Pakistan	39 858	790 016	357.6	905	16 999	7.7	Community transmission
Jordan	16 957	700 423	6 864.8	385	8 563	83.9	Community transmission
Tunisia	14 596	298 572	2 526.3	514	10 231	86.6	Community transmission
United Arab Emirates	13 701	508 925	5 145.6	19	1 569	15.9	Clusters of cases
Lebanon	11 112	519 615	7 612.9	230	7 116	104.3	Community transmission
Kuwait	9 544	265 404	6 214.7	71	1 511	35.4	Community transmission
Oman	8 610	185 278	3 628.2	121	1 942	38.0	Community transmission
Bahrain	7 222	170 335	10 010.4	32	620	36.4	Community transmission
Saudi Arabia	7 209	411 263	1 181.3	77	6 887	19.8	Community transmission
Egypt	6 086	221 570	216.5	304	12 998	12.7	Community transmission
Qatar	5 739	201 496	6 993.8	42	418	14.5	Community transmission
Libya	3 621	174 752	2 543.2	65	2 947	42.9	Community transmission
Morocco	3 590	509 037	1 379.1	44	8 988	24.4	Community transmission
Afghanistan	1 050	58 843	151.2	43	2 5 8 2	6.6	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Syrian Arab Republic	995	21 999	125.7	89	1 526	8.7	Community transmission
Sudan	651	33 673	76.8	92	2 300	5.2	Clusters of cases
Somalia	622	13 459	84.7	33	689	4.3	Community transmission
Yemen	335	6 109	20.5	56	1 176	3.9	Community transmission
Djibouti	334	10 746	1 087.7	18	132	13.4	Community transmission
Territories <sup>iii</sup>	· · ·			·			
occupied Palestinian territory	10 521	319 100	6 255.1	168	3 419	67.0	Community transmission
Europe	1 466 680	50 714 995	5 435.3	25 341	1 061 218	113.7	
Kosovo <sup>[1]</sup>	2 662	103 772		57	2 108		Community transmission
Turkey	378 771	4 591 416	5 444.0	2 403	38 011	45.1	Community transmission
France	211 674	5 390 187	8 287.6	2 110	102 031	156.9	Community transmission
Germany	145 156	3 287 418	3 952.8	1 650	81 564	98.1	Community transmission
Italy	92 074	3 949 517	6 622.1	2 345	119 021	199.6	Clusters of cases
Ukraine	78 761	2 025 271	4 630.9	2 537	42 323	96.8	Community transmission
Poland	70 831	2 758 856	7 268.2	3 383	65 415	172.3	Community transmission
Russian Federation	60 468	4 762 569	3 263.5	2 650	108 232	74.2	Clusters of cases
Netherlands	57 991	1 453 058	8 347.3	135	17 038	97.9	Community transmission
Spain	32 476	3 456 886	7 303.4	214	77 496	163.7	Community transmission
Sweden	31 748	938 343	9 085.8	31	13 923	134.8	Community transmission
Belgium	23 086	974 417	8 456.7	270	24 017	208.4	Community transmission
Kazakhstan	19 976	361 575	1 925.7	0	4 157	22.1	Clusters of cases
Hungary	19 010	769 518	7 876.7	1 441	26 625	272.5	Community transmission
Greece	18 286	331 730	3 094.9	553	9 950	92.8	Community transmission
Czechia	17 729	1 618 076	15 130.8	520	28 946	270.7	Community transmission
Romania	17 683	1 044 722	5 405.0	1 195	27 267	141.1	Community transmission
Serbia	17 673	677 972	9 787.8	242	6 196	89.5	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
The United Kingdom	17 232	4 403 174	6 486.1	157	127 417	187.7	Community transmission
Austria	15 318	603 419	6 779.2	205	9 821	110.3	Community transmission
Croatia	14 836	322 626	7 950.0	292	6 854	168.9	Community transmission
Azerbaijan	12 943	311 465	3 071.9	235	4 342	42.8	Clusters of cases
Bulgaria	11 137	397 100	5 712.5	721	15 859	228.1	Clusters of cases
Switzerland	9 750	643 562	7 436.1	28	9 899	114.4	Community transmission
Belarus	8 751	351 674	3 721.7	70	2 483	26.3	Community transmission
Georgia	8 393	303 751	7 614.4	86	4 025	100.9	Community transmission
Lithuania	7 666	241 297	8 636.0	88	3 848	137.7	Community transmission
Cyprus	6 169	61 576	6 934.2	10	298	33.6	Clusters of cases
Denmark	5 279	247 010	4 242.1	22	2 474	42.5	Community transmission
Bosnia and Herzegovina	5 175	195 471	5 958.0	405	8 242	251.2	Community transmission
Slovenia	4 943	236 612	11 289.5	38	4 523	215.8	Clusters of cases
Armenia	4 768	213 288	7 197.8	140	4 018	135.6	Community transmission
Latvia	3 958	114 955	6 025.9	53	2 101	110.1	Community transmission
Slovakia	3 937	379 911	6 960.8	389	11 495	210.6	Clusters of cases
North Macedonia	3 541	150 274	7 213.0	231	4 650	223.2	Community transmission
Portugal	3 404	833 964	8 100.0	17	16 959	164.7	Clusters of cases
Republic of Moldova	3 404	248 898	6 170.1	161	5 709	141.5	Community transmission
Norway	3 358	109 581	2 041.5	28	736	13.7	Community transmission
Ireland	2 966	246 204	4 959.4	37	4 872	98.1	Community transmission
Estonia	2 661	120 215	9 045.7	51	1 143	86.0	Clusters of cases
Uzbekistan	2 347	89 027	266.0	6	643	1.9	Clusters of cases
Kyrgyzstan	1 948	93 831	1 438.2	33	1 582	24.2	Clusters of cases
Finland	1 904	85 537	1 548.1	16	903	16.3	Community transmission
Luxembourg	1 456	66 202	10 573.6	5	790	126.2	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Israel	1 077	837 974	9 681.4	20	6 350	73.4	Community transmission
Albania	953	130 409	4 531.6	32	2 372	82.4	Clusters of cases
Montenegro	649	96 342	15 339.6	22	1 451	231.0	Clusters of cases
Andorra	253	13 024	16 856.3	1	124	160.5	Community transmission
Malta	222	30 149	5 859.1	3	412	80.1	Clusters of cases
Iceland	104	6 390	1 754.8	0	29	8.0	Community transmission
Liechtenstein	40	2 947	7 605.8	0	56	144.5	Sporadic cases
San Marino	37	5 047	14 871.2	3	89	262.2	Community transmission
Monaco	34	2 429	6 189.5	0	31	79.0	Sporadic cases
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories <sup>iii</sup>							
Isle of Man	10	1 585	1 864.0	0	29	34.1	No cases
Faroe Islands	1	663	1 356.8	0	1	2.0	Sporadic cases
Jersey	1	3 233	2 999.2	0	69	64.0	Community transmission
Gibraltar	0	4 283	12 712.6	0	94	279.0	Clusters of cases
Greenland	0	31	54.6	0	0	0.0	No cases
Guernsey	0	822	1 275.1	0	14	21.7	Community transmission
South-East Asia	2 269 114	19 965 648	987.7	17 126	254 958	12.6	
India	2 172 063	16 960 172	1 229.0	15 161	192 311	13.9	Clusters of cases
Indonesia	37 029	1 636 792	598.4	1 172	44 500	16.3	Community transmission
Bangladesh	27 148	742 400	450.8	669	10 952	6.7	Community transmission
Nepal	13 429	297 087	1 019.6	61	3 136	10.8	Clusters of cases
Thailand	13 108	55 460	79.5	39	140	0.2	Clusters of cases
Sri Lanka	4 147	100 586	469.7	21	638	3.0	Clusters of cases
Maldives	1 476	27 621	5 109.9	2	71	13.1	Clusters of cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Timor-Leste	572	1 808	137.1	1	3	0.2	Clusters of cases
Myanmar	76	142 704	262.3	0	3 206	5.9	Clusters of cases
Bhutan	66	1 018	131.9	0	1	0.1	Sporadic cases
Western Pacific	131 777	2 337 462	119.0	1 304	36 222	1.8	
Philippines	63 364	989 399	902.9	864	16 674	15.2	Community transmission
Japan	32 312	562 141	444.5	291	9 913	7.8	Clusters of cases
Malaysia	17 393	390 252	1 205.7	56	1 426	4.4	Community transmission
Mongolia	8 564	29 219	891.3	33	74	2.3	Clusters of cases
Republic of Korea	4 773	118 887	231.9	16	1 813	3.5	Clusters of cases
Cambodia	3 586	9 975	59.7	31	74	0.4	Sporadic cases
Papua New Guinea	932	10 670	119.3	13	102	1.1	Community transmission
China	191	103 464	7.0	0	4 856	0.3	Clusters of cases
Lao People's Democratic Republic	189	247	3.4	0	0	0.0	Sporadic cases
Singapore	158	60 966	1 042.1	0	30	0.5	Sporadic cases
Australia	153	29 658	116.3	0	910	3.6	Clusters of cases
Viet Nam	52	2 833	2.9	0	35	0.0	Clusters of cases
Fiji	15	87	9.7	0	2	0.2	Sporadic cases
New Zealand	7	2 245	46.6	0	26	0.5	Clusters of cases
Brunei Darussalam	2	223	51.0	0	3	0.7	Sporadic cases
Solomon Islands	0	20	2.9	0	0	0.0	No cases
Territories <sup>iii</sup>							
Guam	43	7 697	4 560.5	0	136	80.6	Clusters of cases
French Polynesia	38	18 734	6 669.1	0	141	50.2	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	2	164	284.9	0	2	3.5	Pending
Wallis and Futuna	2	449	3 992.5	0	5	44.5	Sporadic cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
New Caledonia	1	124	43.4	0	0	0.0	Sporadic cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases
Samoa	0	1	0.5	0	0	0.0	No cases
Vanuatu	0	3	1.0	0	0	0.0	No cases
Global	5 69 <mark>5 277</mark>	146 067 511		87 826	3 092 497		

\*See Annex: Data, table and figure notes

Country/Torritory/Aroa	VOC 202012/01	501Y.v2	P.1
Country/Terntory/Area	(B.1.1.7)	(B.1.351)	(B.1.1.28)
Afghanistan	Verified	-	-
Albania	Under verification	-	-
Algeria	Verified	-	-
Angola	Verified	Verified	-
Argentina	Verified	-	Verified
Armenia	Under verification	-	-
Aruba	Verified	Verified	Verified
Australia	Verified	Verified	Verified
Austria	Verified	Verified	Verified
Azerbaijan	Verified	-	-
Bahrain	Verified	-	-
Bangladesh	Verified	Verified	-
Barbados	Verified	-	-
Belarus	Verified	-	-
Belgium	Verified	Verified	Verified
Belize	Verified	-	-
Bolivia (Plurinational State			
of)	Verified*	-	-
Bonaire	Verified	-	-
Bosnia and Herzegovina	Under verification	-	-
Botswana	-	Verified	-
Brazil	Verified	Verified	Verified
Brunei Darussalam	Verified	Verified	-
Bulgaria	Verified	-	-
Cabo Verde	Verified	-	-
Cambodia	Verified	-	-
Cameroon	-	Verified	-

Country/Territory/Area	VOC 202012/01	501Y.v2	P.1
	(B.1.1.7)	(B.1.351)	(B.1.1.28)
Canada	Verified	Verified	Verified
Cayman Islands	Verified	-	-
Chile	Verified	Verified	Verified
China	Verified	Verified	Verified
Colombia	Verified	-	Verified
Comoros	-	Verified	-
Costa Rica	Verified	Verified	Verified
		Under	
Croatia	Verified	verification	-
Cuba	Verified	Verified	-
Curaçao	Verified	-	-
Cyprus	Verified	-	-
		Under	
Czechia	Verified	verification	-
Democratic Republic of			
the Congo	Under verification	Verified	-
Denmark	Verified	Verified	Verified
Dominican Republic	Verified	-	-
Ecuador	Verified	-	Verified
		Under	
Estonia	Verified	verification	-
Eswatini	-	Verified	-
Faroe Islands	-	-	Verified
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana	Verified	Verified	Verified
French Polynesia	Verified	-	Verified
Gambia	Verified	-	-

Country/Torritory/Aroa	VOC 202012/01	501Y.v2	P.1
Country/Terntory/Area	(B.1.1.7)	(B.1.351)	(B.1.1.28)
Georgia	Verified	-	-
Germany	Verified	Verified	Verified
Ghana	Verified	Verified	-
Gibraltar	Under verification	-	-
Greece	Verified	Verified	-
Grenada	Verified	-	-
Guadeloupe	Verified	-	-
Guyana	-	-	Verified
		Under	
Hungary	Verified	verification	-
Iceland	Verified	-	-
India	Verified	Verified	Verified
Indonesia	Verified	-	-
Iran (Islamic Republic of)	Verified	-	-
Iraq	Verified	-	-
			Under
Ireland	Verified	Verified	verification
Israel	Verified	Verified	-
		Under	
Italy	Verified	verification	Verified
Jamaica	Verified	-	-
Japan	Verified	Verified	Verified
Jordan	Verified	Verified	Verified
		Under	
Kazakhstan	Under verification	verification	-
Kenya	Under verification	Verified	-
Kosovo <sup>[1]</sup>	Verified	-	-
Kuwait	Verified	-	-
Kyrgyzstan	Verified*	Verified*	-

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Lao People's Democratic			
Republic	Verified*	-	-
Latvia	Verified	Verified	-
Lebanon	Verified	-	-
Lesotho	-	Verified	-
Libya	Verified	Verified	-
Liechtenstein	Verified	-	-
Lithuania	Verified	Verified	-
			Under
Luxembourg	Verified	Verified	verification
Malawi	Verified	Verified	-
Malaysia	Verified	Verified	-
		Under	
Malta	Verified	verification	Verified*
Martinique	Verified	-	-
Mauritius	Under verification	-	-
Mayotte	Verified	Verified	-
Mexico	Verified	-	Verified
		Under	
Monaco	Verified	verification	-
Montenegro	Verified	-	-
Morocco	Verified	-	-
Mozambique	-	Verified	-
Namibia	-	Verified	-
Nepal	Verified	-	-
Netherlands	Verified	Verified	Verified
New Caledonia	Verified	-	-
			Under
New Zealand	Verified	Verified	verification

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Nigeria	Verified	-	-
North Macedonia	Verified	Verified*	-
Norway	Verified	Verified	Verified
occupied Palestinian			
territory	Verified	Verified	-
Oman	Verified	-	-
Pakistan	Verified	-	-
Panama	Verified	Verified	Verified
Paraguay	-	-	Verified
Peru	Verified	-	Verified
Philippines	Verified	Verified	Verified
		Under	Under
Poland	Verified	verification	verification
			Under
Portugal	Verified	Verified	verification
		Under	
Puerto Rico	Verified	verification*	Verified
Qatar	Verified	Verified	
Republic of Korea	Verified	Verified	Verified
Republic of Moldova	Under verification	-	-
Réunion	Verified	Verified	Verified
Romania	Verified	Verified	Verified
		Under	
Russian Federation	Verified	verification	-
		Under	
Rwanda	Under verification	verification	-
Saint Barthélemy	Verified	-	-
Saint Lucia	Verified	-	-
Saint Martin	Verified	Verified	Verified
Saudi Arabia	Verified	-	-

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Senegal	Verified	-	-
Serbia	Verified	-	-
Singapore	Verified	Verified	-
Sint Maarten	Verified	-	-
Slovakia	Verified	Under verification	-
Slovenia	Verified	Verified	Under verification
South Africa	Verified	Verified	-
Spain	Verified	Verified	Verified
Sri Lanka	Verified	Verified	-
Suriname	Verified	Verified	Verified
Sweden	Verified	Verified	Under verification
Switzerland	Verified	Verified	Under verification
Thailand	Verified	Verified	-
The United Kingdom	Verified	Verified	Verified
Тодо	Verified	-	-
Trinidad and Tobago	Verified	-	Verified*
Tunisia	Verified	-	-
Turkey	Verified	Under verification	Under verification
Turks and Caicos Islands	Verified	-	-
Ukraine	Under verification	Under verification	-
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania	-	Under verification	-
United States of America	Verified	Verified	Verified

Country/Territory/Area	VOC 202012/01 (B.1.1.7)		P.1 (B.1.1.28)		Country/Territory/Area	VOC 20201 (B.1.1.7)
Uruguay	Verified	-	Verified	_	Viet Nam	Verified
		Under		_	Wallis and Futuna	Verified
Uzbekistan	Verified	verification	-	_	Zambia	-
Venezuela (Bolivarian					Zimbabwe	-
Republic of)	-	-	Verified			

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Viet Nam	Verified	Verified	-
Wallis and Futuna	Verified	-	-
Zambia	-	Verified	-
Zimbabwe	-	Verified	-

\*Newly reported in this update.

"Verified" indicates that information for this variant was received by WHO from official sources.

"Under verification" indicates that information for this variant was received by WHO from unofficial sources and will be reviewed as more information become available.

Variants VOC 202012/01 for Syrian Arab Republic, and 501Y.V2 for Uganda, were excluded this week based on further information received.

\*\*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 746 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.

<sup>[1]</sup> 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.

<sup>i</sup> 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).

<sup>ii</sup> 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: <u>Considerations for implementing and adjusting public health and social measures in the context of COVID-19</u>:

- 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 subcategorizations 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.

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

# Weekly Operational Update on COVID-19

# 26 April 2021

Issue No. 52



Confirmed cases<sup>a</sup> 146 689 258

Confirmed deaths **3 102 410** 

# The Syrian Arab Republic receives its first delivery of COVID-19 vaccines through the COVAX Facility

On 22 April, the Syrian Arab Republic received its first delivery from the COVAX Facility of 256 800 doses of the AstraZeneca/Oxford COVID-19 vaccine produced by the Serum Institute of India as reported by



Photo credit: North West Syrian Arab Republic (NWS) office

the WHO Regional Office for the Eastern Mediterranean. These doses are allocated to frontline health workers across the Syrian Arab Republic, including the northeast and northwest.

Dr Akjemal Magtymova, WHO Representative for the Syrian Arab Republic noted that this delivery "gives hope for the people in Syria, whose lives have been shattered by a decade of conflict and the devastating impact of the pandemic."

The COVID-19 vaccine doses were delivered in two shipments: 203 000 doses arrived in Damascus while another 53 800 doses were delivered to the northwest, an area that continues to witness armed conflict and people's displacement. More deliveries are planned for the Syrian Arab Republic in the coming weeks and months.

For further information, click the following links: link  $\underline{1}$ , link  $\underline{2}$  and link  $\underline{3}$ .

#### **Key Figures**



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



More than **5 million** people registered on <u>OpenWHO</u> and accessing online training courses across **31** topics in **50** languages



17 640 245 PCR tests shipped globally





**8 659 511** face shields shipped globally



**44 519 700** gloves shipped globally



**167** GOARN deployments conducted to support COVID-19 pandemic response



EMERGENCIES

HEALTH

**899 936 102** COVID-19 vaccine doses administered globally as of 22 April

<sup>a</sup> COVAX has shipped over **43.4** million vaccines to **119** participants as of 23 April

1

<sup>a</sup> See Gavi's <u>COVAX updates</u> for the latest COVAX vaccine roll –out data for participants

programme

For all other latest data and information, see the <u>WHO</u> <u>COVID-19 Dashboard</u> and <u>Situation Reports</u>





## From the field:

# WHO delivers life-saving oxygen concentrators to areas with increasing transmission in the Philippines

Since the start of the COVID-19 pandemic, affordable and sustainable access to oxygen has been a growing challenge in low- and middle-income countries. On 16 April, WHO delivered 50 oxygen concentrators and their accessories to the Philippines Department of Health (DOH) to support with a recent wave of COVID-19 cases. Access to oxygen is a sustainable investment in the health system to improve health outcomes beyond COVID-19 that require medical oxygen therapy.

While the Philippines has seen its national 7-day average of confirmed cases more than triple since 1 March, this delivery will supply three regions, which in particular could continue to have increasing SARS-CoV-2 transmission: Cagayan Valley, Central Luzon, and Calabarzon.

"Oxygen is an essential medicine and early access to oxygen therapy can make all the difference to patients with severe COVID-19," said Dr Rabindra Abeyasinghe, WHO Representative to the Philippines. "WHO is committed to support the DOH in providina increased access to medical oxygen therapy to help reduce case fatality rates and save lives."

Inspection of the items has been completed and movement of the stock to 14 facilities in Cagayan Valley, 10 facilities in Central Luzon and 20 facilities in Calabarzon is expected soon.



Caption: WHO delivered 50 Oxygen Concentrators and their accessories to the Department of Health, Philippines. Photo Credit: WHO/Dan Henry Garcia

Medical oxygen is used to maintain oxygen at sufficient levels in the body for it to function properly. Early initiation of oxygen therapy can help treat severe symptoms of COVID-19 and is associated with a decrease in loss of life among critical patients. Not all patients with COVID-19 will require medical supportive care or oxygen therapy.

For further information, click here.



## From the field:

# WHO Support Mission to Albania for infection prevention and control, clinical management and surveillance

A joint technical support mission from the WHO Health Emergencies Programme Balkans Hub deployed from 12 to 16 April 2021 to contribute to the COVID-19 response in Albania.

The mission focused on reviewing current capacities, identifying gaps and strengthening infection prevention control (IPC), clinical management, epidemiologic and



WHO Balkan Hub Team traveling to Albania. Credit: WHO

laboratory surveillance in the COVID-19 response. Consultations were held with national stakeholders to identify lessons learned and options for future reviews to learn and improve were explored such as an Intra- or After-Action Review (IAR and AAR).

Throughout the mission, the Balkan Hub Team worked in close collaboration with the WHO Albania Country Office and national counterparts on the following areas:

- Infection Prevention and Control: Using the WHO assessment tools for IPC and hospital preparedness, the team identified collaboration and support opportunities to strengthen the IPC structures in the University Hospital Center 'Mother Teresa' and the Durres Regional Hospital.
- Laboratories: The National Reference Laboratory Department of the Institute of Public Health (IPH) in Tirana was assessed during a visit using the WHO Laboratory Assessment Tool for COVID-19. Based on the analysis, recommendations on training needs were provided to further strengthen laboratory testing capacities including the development of quality management program.
- Surveillance, case investigation and contact tracing: The team met with the key institutions responsible for case investigation and contact tracing and defined key actions to improve the system including training, institutional capacity building, improving analysis and reporting of the data generated, enhancing risk communication and community engagement activities for contact tracing, and documenting best practices and lessons learned in case investigation and contact tracing.

The joint mission enabled the WHO team to better understand the current COVID-19 response in Albania, identify gaps across several key pillars of the emergency response and discuss future areas of further support from WHO.



## Pandemic learning response

# One Year of Pandemic Learning Response: Benefits of Massive Online Delivery of the World Health Organization's Technical Guidance

The WHO is expanding access to web-based learning for COVID-19 through its open-learning platform for health emergencies, OpenWHO. Throughout the pandemic, OpenWHO has continued to publish learning offerings based on the WHO's emerging evidence-based knowledge for managing the COVID-19 pandemic.

The World Health Organization (WHO) launched the first web-based learning course on COVID-19 on January 26, 2020, four days before the director general of the WHO declared a public health emergency of international concern.

<u>A newly published study</u> presents the various findings derived from the analysis of the performance of the OpenWHO platform during the pandemic, along with the core benefits of massive web-based learning formats.

The pandemic has shown that webbased learning is no longer a temporary replacement for direct training, but rather a new way for efficient more and equitable learning. experience The and findings reported herein provide guidance for any individual to be better prepared for subsequent instances where a major and fast learning response is required.







## HEALTH EMERGENCIES programme

### **Risk Communication, Community Engagement and Infodemic Management**

# Building capacity and empowering populations to address the COVID-19 infodemic

The spread of disinformation and misinformation overabundance of within the tsunami of an information known as an infodemic alongside the COVID-19 pandemic is growing а concern worldwide. The ways in which people are connected in their local communities often determines their perception of, use of and further sharing of information. This ultimately influences the uptake of protective behaviours during the pandemic, demonstrating that access to reliable health information about the COVID-19 pandemic through trusted information channels can save lives.

UNESCO and WHO joined forces on an initiative launched 8 April 2021, to support local media professionals to overcome challenges in providing reliable health information and deconstructing myths on COVID-19 vaccines.



© Clarisse Razaiarimanana / UNESCO

It is vital to build capacity among these media professionals, especially in developing countries with limited access to timely and accurate public health information.

WHO has developed ten brief audio messages which can be freely downloaded and broadcast by public, private and community radio stations globally on 8 topics: COVID-19 transmission, contact tracing, masks, schools, traditional markets, public gatherings, science evolution and vaccines.

These have already provided accurate and timely information through 2500 radio stations in nearly 130 countries in 20 languages, including the six official UN languages and various indigenous and local languages from countries in the WHO regions of Africa, the Americas, South-East Asia and the Western Pacific ranging from Afrikaans and Lingala to Aymara, Quechua and many more.

UNESCO and WHO will also support strengthening capacity and skills in an upcoming project for radio stations on pre-identified needs for broadcasting from a home during the pandemic, such as home studios, remote contributions, remote programming, remote broadcasting, transversal cloud approach, cyber security, and more.

For further information and to hear some of the messages, click here.



HEALTH EMERGENCIES programme

## **COVID-19 Partners platform**



# Launch of the COVID-19 Strategic Preparedness and Response Plan (SPRP 2021) on the Partners Platform

With the release of WHO's updated <u>COVID-19 Strategic Preparedness and Response Plan</u> (SPRP 2021), WHO is updating the <u>Partners Platform</u> to better serve countries to plan and monitor their pandemic response, cost resource needs and ensure all new country 2021 needs are visible by donors. WHO is working closely with partners and across the three levels of the organization (Regional Offices, Headquarters and Country Offices), to ensure country needs are visible to donors in the Platform's new functionalities to efficiently meet these needs.

One of the biggest changes made to the COVID-19 SPRP 2021 and the accompanying <u>Operational Planning Guideline</u> for countries is the addition of a tenth response pillar for vaccination. The COVID-19 vaccination effort is a highly collaborative process involving several internal and external partners, requiring close monitoring from a wide range of stakeholders.

To promote transparency and collaboration, authorized vaccine and administrators, including representatives from all stakeholders involved from governments, partners, will be able to utilize a new interactive dashboard to visualise vaccine resource needs by country, region, or globally.

Demonstrations for the new features on the Partners Platform will be rolling out to regional and country administrative users and key focal points starting the week of 26 April.


## **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 22 April 2021.

Shipped items as of 22 April 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	3 927 455	1 871 346	1 473 890	13 516 300	243 730	1 874 679	54 025 400	2 783 830
Americas (AMR)	7 479 900	1 046 132	10 550 962	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	1 852 365	954 985	7 627 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	509,000	653 700	609 520	1 756 900	13 438 900	424 780	2 276 548	41 701 500	6 011 350
South East Asia (SEAR)	1 440 000	3 185 800	2 409 218	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	11 325 450	10 666 807	17 640 245	8 659 511	44 519 700	1 596 367	7 622 579	200 095 426	20 673 565

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 <u>Strategic Preparedness and Response Plan</u> (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.



The 2021 SPRP priorities and resource requirements can be found <u>here</u>. The status of funding raised for WHO against the SPRP can be found <u>here</u>.



HEALTH EMERGENCIES programme

## **WHO Funding Mechanisms**

## **COVID-19 Solidarity Response Fund**

As of 16 April 2021, <u>The Solidarity Response</u> <u>Fund</u> has raised or committed more than US\$ 247 million from more than 665 040 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).



## Africa Infodemic Response Alliance launches Viral Facts Africa

The Solidarity Response Fund continues to enable WHO's efforts around the globe across technical areas, including the <u>Africa Infodemic Response Alliance</u> (AIRA) Secretariat activities.

As misinformation around the COVID-19 pandemic and vaccines continues to spread across Africa, WHO Regional Office for Africa (AFRO) is hosting the AIRA network, which includes members from UNICEF, Africa Centres for Disease Control and Prevention (CDC), International Federation of Red Cross and Red Crescent Societies (IFRC), Gavi and major regional fact checking organizations. This first of its kind regional network of fact-checking and media organisations, big data, artificial intelligence (AI) and leading inter-governmental and non-governmental organisations has launched Viral Facts Africa to work together to respond to infodemics.

Viral Facts is a new content initiative established to create engaging and shareable social media content based on facts and grounded in science. Viral Facts works with WHO AFRO and AIRA network members to address information gaps, debunk viral rumors, and promote community resilience to misinformation.

In a pre-launch phase, Viral Facts content was distributed by WHO AFRO social channels, reaching over 26 million people and driving over 1 million engagements. Viral Facts outputs include explainers on <u>vaccine approval processes</u>, myth busters on widespread persistent narratives around <u>masks</u>, debunks on specific health claims that have been circulating on <u>traditional remedies</u>. All Viral Facts content is open-licensed for reuse and distribution by AIRA partners and has been shared widely by regional agency accounts on Facebook, Twitter and Instagram, country office accounts, fact checkers, and included in regional media.

Viral Facts has also moved quickly to address high profile health news stories, with the goal of ensuring timely access to accurate and trustworthy information in rapidly changing and uncertain times - such as the pausing of the <u>AstraZeneca vaccine rollout in European countries</u>, and the pause of the <u>Johnson & Johnson vaccine rollout</u> in South Africa.

The AIRA and Viral Facts teams are working closely with country-level stakeholders including Ministries of Health to support the implementation of comprehensive infodemic management strategies, underpinned by established best practices and in cooperation with AIRA network members.

For further information, click here.



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## **COVID-19 Global Preparedness and Response Summary Indicators**<sup>a</sup>

## Countries have a COVID-19 preparedness and response plan



**Countries have a COVID-19 Risk** 

**Communication and Community Engagement** Plan (RCCE)<sup>b</sup> N=195



100% !

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

		N=195		
44 %	7%	50%		
22%		100%		

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

N=195



#### Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 N=195



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

		N=195	
	89 %		11%
37%		1	00%

Countries that have defined essential health services to be maintained during the pandemic N=195

46 %	20%	34%
22%		100%

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

_		N=195
35 %	63%	
29%		100%

Countries have a health occupational safety plan for health care workers

_			N=195
27.7 %	6 %	66.7%	
17%			100%

**Countries have COVID-19 laboratory testing** capacity



Target value

**Baseline value** 

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 <u>Global Humanitarian and Response Plan</u>. A full list of priority countries can be found <u>here</u>.

## <u>Priority countries</u> with multisectoral mental health & psychosocial support working group



<u>Priority countries</u> that have postponed at least 1 vaccination campaign due to COVID-19<sup>c</sup>

			11-04
	44%	56%	
0%	27%		

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



# <u>Priority countries</u> with an active & implemented RCCE coordination mechanism



# <u>Priority countries</u> with a contact tracing focal point



# <u>Priority countries</u> with an IPC focal point for training



**Target value** 

#### Notes:

c Source: WHO Immunization Repository



# HEALTH EMERGENCIES programme

## 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





# HEALTH EMERGENCIES programme

## Key links and useful resources



....

For updated GOARN network activities, click here.

## **WHO** case definition

For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection, published December 2020, click <u>here.</u>

## **EPI-WIN**

For EPI-WIN: WHO Information Network for Epidemics, click here

## **WHO Publications and Technical Guidance**

For updated WHO Publications and Technical Guidance on COVID-19, click <u>here</u>

For more information on COVID-19 regional response:

- African Regional Office
- <u>Regional Office of the Americas</u>
- Eastern Mediterranean Regional Office
- <u>European Regional Office</u>
- Southeast Asia Regional Office
- Western Pacific Regional Office

For the 20 April **Weekly Epidemiological Update**, click <u>here</u>. Highlights this week include:

- WHO COVID-19 global rapid risk assessment
- Pandemic influenza surveillance—drawing a parallel with the COVID-19 pandemic
- SARS-CoV-2 variants

### News

- For information on Greta Thunberg joining the WHO's call for vaccine equity, click <u>here</u>.
- For information on the ACT-Accelerator one year on, including the 'ACT Now, ACT Together: 2021 Impact Report, click <u>here</u>.
- For the statement on the seventh meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease(COVID-19) pandemic, click <u>here</u>.



# **COVID-19 Weekly Epidemiological Update**

### Data as received by WHO from national authorities, as of 18 April 2021, 10 am CET

In this edition:

- Global overview
- Special focus: Update on WHO COVID-19 global rapid risk assessment
- Special focus: Pandemic influenza surveillance drawing a parallel with the COVID-19 pandemic
- Special focus: SARS-CoV-2 variants
- WHO regional overviews
- <u>Key weekly updates</u>

## **Global overview**

Globally, new COVID-19 cases increased for the eighth consecutive week, with more than 5.2 million new cases reported in the last week – surpassing the previous peak in early January 2021 (Figure 1). The number of new deaths increased for the fifth consecutive week, an 8% increase as compared to the previous with over 83 000 new deaths reported. Last week the reported cumulative COVID-19 death toll surpassed 3 million lives; the pace of deaths is accelerating, it took nine months to reach 1 million deaths, another four to surpass 2 million, and just three to reach 3 million deaths.

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 18 April 2021\*\*



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

While all regions except the European Region reported an increase in incident cases in the last week, the largest increase continues to be reported by the South-East Asia Region, largely driven by India, followed by the Western Pacific Region (Table 1). All regions except the European and Western Pacific regions reported an increase in the number of weekly deaths, with the largest increase in the South-East Asia Region due to an

increase in deaths in India, followed by the Eastern Mediterranean Region, largely due to an increase in new deaths in the Islamic Republic of Iran.

The countries reporting the highest number of new cases represent three of the six WHO regions: India (1 429 304 new cases; 64% increase), the United States of America (477 778 new cases; 2% increase), Brazil (459 281 new cases; 1% decrease), Turkey (414 312 new cases; 17% increase), and France (233 275 new cases; 12% decrease).

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	1 525 505 (29%)	7%	59 551 000 (42%)	39 482 (47%)	8%	1 444 736 (48%)
Europe	1 624 060 (31%)	-3%	49 208 464 (35%)	26 302 (32%)	-3%	1 035 294 (34%)
South-East Asia	1 518 708 (29%)	57%	17 696 534 (13%)	9 447 (11%)	49%	237 832 (8%)
Eastern Mediterranean	386 176 (7%)	6%	8 444 694 (6%)	5 460 (7%)	23%	170 580 (6%)
Africa	54 297 (1%)	7%	3 225 261 (2%)	1 170 (1%)	14%	80 715 (3%)
Western Pacific	128 176 (2%)	15%	2 205 688 (2%)	1 444 (2%)	-8%	34 918 (1%)
Global	5 236 922 (100%)	14%	140 332 386 (100%)	83 305 (100%)	8%	3 004 088 (100%)

### Table 1. Newly reported and cumulative COVID-19 cases and deaths, by WHO Region, as of 18 April 2021\*\*

\*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior \*\*See Annex: Data, table and figure notes

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

- WHO COVID-19 Dashboard
- <u>WHO COVID-19 Weekly Operational Update</u>



Figure 2. COVID-19 cases per 100 000 population reported by countries, territories and areas, 12-18 April 2021\*\*

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

## Special Focus: Update on WHO COVID-19 global rapid risk assessment, 13 April 2021

As the COVID-19 pandemic, response and our understanding of the SARS-CoV-2 virus continue to evolve, WHO's most recent assessment is that the global public health risk remains very high. Under the Emergency Response Framework, WHO undertakes risk assessments and situation analyses on a regular basis to inform our response to emerging issues. In addition, WHO periodically formally reviews the current risk status of risks through an in-depth hazard, exposure and context assessment; as well as a review of the vulnerabilities and capacities to respond and to investigate the current risk to human health, risks of ongoing spread globally, and risk of insufficient control capacities. Such assessments are used as an internal-WHO decision- making tool, but they also additionally to support independent deliberations, including (but not limited to) meetings of the IHR Emergency Committee. Ten COVID-19 rapid risk assessments have been undertaken to date, and additional assessments have been completed for specific events surrounding the emergence of SARS-CoV-2 variants of concern (VOCs). Here, we provide a synopsis of the most recent in-depth global rapid risk assessment.

The COVID-19 pandemic shows no signs of easing, with global case and death incidence increasing at a concerning rate since mid-February 2021; a third of the global cumulative COVID-19 cases and deaths has been reported in the last three months alone, with weekly cases reaching similar levels as the previous peak in January 2021. Marked geographical variation in the pandemic trajectory continues to be observed at regional and country levels, with sharp rises observed in the South-East Asia, Eastern Mediterranean and Western Pacific regions in recent weeks. The global infection fatality ratio (IFR) was estimated between 0.1% to 1.0%, an increase from January largely driven by an increase in the Region of the Americas. Globally mortality rates continue to be higher for those over 40 years as well as for males as compared to females.

The resurgences in the last four months have likely been driven in part by both the emergence of SARS-CoV-2 VOCs and inconsistent use/early easing of public health and social measures (PHSM). As surveillance and sequencing activities to detect SARS-CoV-2 variant cases are strengthened, the number of countries reporting the three variants designated as global VOCs has increased. All three VOCs are associated with increased transmission. Additionally, some have been associated with increased disease severity (VOC 202012/01 and 501Y.V2), increased risk of immune escape (501Y.V2 and P.1), and/or significant reductions in neutralization (501Y.V2 and P.1) by convalescent or post-vaccine sera compared to wild-type/non-VOC variants, suggesting increased risk of vaccine failure or reinfection. In addition to the VOCs, six variants have thus far been designated as SARS-CoV-2 variants of interest (VOIs), and a further 19 variants are currently under investigation, highlighting that especially as global incidence remains high, there is continued risk of emergence of more variants with phenotypic implications and global importance in the coming months.

The high burden of COVID-19 globally has continued to challenge surveillance systems, leading to a large gap in the completeness of demographic information shared for reported cases. In line with the WHO surveillance guidelines, efforts are being made to strengthen surveillance and reporting, however, many challenges persist especially for low-income countries. The ongoing pandemic also continues to challenge public health and healthcare capacities in most countries, as often the same human resources are spread across clinical management and outbreak response activities including vaccine rollout. The recent increase in cases reported in most regions has added to the healthcare workload and aggravated shortages of resources and the capacity to care for both those with COVID-19 and patients with other illnesses; over 90% of countries have reported some level of service disruptions and almost 40% have reported disruptions to essential primary health care services.

Infection prevention and control (IPC) and PHSM have proven to be critical in mitigating and limiting transmission and deaths due to COVID-19. The use of PHSM must be continuously monitored and adjusted, especially in the context of VOCs, to account for the intensity of transmission as well as the capacity of the health system at both national and sub-national levels. While reports confirm that most people continue to support PHSM as part of national COVID-19 response strategies, pandemic fatigue is occurring, undermining the impact of PHSM on transmission. In some countries, a lack of trust in government responses and increasing

frustration and uncertainty about the duration of the pandemic, coupled with the economic impacts of the response to COVID-19, have led to protests against PHSM.

The cornerstone of treatment for COVID-19 remains early detection and clinical assessment along with the use of oxygen and systemic corticosteroid therapy for those with severe or critical COVID-19. Markets for personal protective equipment (PPE), PCR tests, and medical oxygen equipment have begun to adjust to the higher demand, and the Biomedical Consortium (part of the UN Supply Chain) continues to support the scale-up of oxygen supply in under-resourced settings, where supply chains remain vulnerable to manufacturing and transport shutdowns/restrictions. The supply chain network, however, continues to face constraints in the availability of containers and ships, adding challenges in maintaining the cold-chain requirements of COVID-19 vaccines from production to administration.

As of 12 April 2021, four vaccines have received Emergency Use Listing by WHO. A total of 781 million doses of COVID-19 vaccines have been administered in 196 economies. However, 24 economies (including 12 from the African Region and seven from the Western Pacific Region) have not yet started vaccination. The current uneven and inequitable access and distribution of COVID-19 vaccines is exacerbating global inequalities, which coupled with the emergence of VOCs, risks prolonging the pandemic.

With a COVAX target of 20-30% population coverage with a single vaccine dose by the end of the year, and considering that the proportion of the population with immunity acquired through infection is likely less than 25%, much of the global population is still susceptible to infection. Additionally, the degree and duration of immunity conferred by natural infection, COVID-19 vaccination or the combination of both are still being investigated, and some studies suggest that those who receive vaccines may still transmit SARS-CoV2 infection to susceptible contacts. While global vaccine acceptance generally remains high, country variations have been observed due to a multitude of reasons, including exposure to misinformation as well as the attitudes of local healthcare professionals, who can play an important role in building or undermining vaccine confidence.

While our understanding of the SARS-CoV-2 virus and the complex immune response triggered by it continues to grow, much still remains unknown including the effectiveness of vaccination in reducing transmission; the duration of immunity; the role of children in transmission; and the frequency and nature of post-COVID-19 condition ("long COVID"). The emergence of VOCs introduces further unknowns such as the potential for immune escape and as to how these changes in the virus affect the global epidemiology.

## **Additional resources**

<u>Further information about WHO risk assessment process</u>

# Special Focus: Pandemic influenza surveillance – drawing a parallel with the COVID-19 pandemic

Surveillance approaches for the COVID-19 pandemic have combined the use and adaptation of existing systems as well as the establishment of new systems to meet the surveillance objectives. The Global Influenza Surveillance and Response System (GISRS) is an example of this, and has been leveraged to support the critical need to monitor trends in concurrent community circulation of both SARS-CoV-2 and seasonal influenza (see 9 March 2021 Special Focus for background information). Here, we look at parallels between surveillance approaches to influenza and the COVID-19 pandemic.

Critically, under both influenza and COVID-19 pandemic scenarios, surveillance relies upon multiple systems to:

- Verify and detect emergence and transmission,
- Monitor the geographic spread and related morbidity and mortality, and
- Assess the severity and inform development and update of vaccines and other control measures.

The WHO guidance on public health surveillance during an influenza pandemic highlight the different surveillance objectives and components needed at different phases before, during and after a pandemic (Figure 3).





## **Alert Phase**

In the alert phase, surveillance objectives are focused on the detection of all cases and the verification of humanto-human transmission, with an aim to interrupt virus transmission and its geographic spread and understand the virus. Event-based surveillance, active case finding and routine influenza and other respiratory virus surveillance systems (e.g., GISRS), are useful in this phase.

Event-based surveillance (EBS) is undertaken routinely by public health authorities globally to support the rapid detection and early response to signals of outbreaks of influenza and other respiratory viruses with the potential to spread from animals to humans or cause human-to-human transmission. EBS can be used for example to detect signals of clusters/outbreaks of severe respiratory disease, infections among healthcare workers, unexpected changes in routine surveillance data trends, unusually high sales of pharmaceuticals used for respiratory disease treatment, illnesses in humans linked to animal outbreaks, etc. EBS is used routinely to support COVID-19 surveillance – supporting epidemic intelligence activities for the detection and investigation of unusual epidemiological trends or changes, which combined with surveillance from other formal and informal sources, support ongoing COVID-19 situation awareness, risk assessment and an evidence-based response.

Active case finding through contact tracing and cluster/outbreak investigation are recommended for interrupting SARS-CoV-2 transmission and are similarly recommended for finding new suspected cases, documenting potential human-to-human transmission, and providing targeted interventions to decrease the risk of illness and interrupt further transmission of pandemic influenza viruses.

## **Pandemic Phase**

Once it is clear community transmission is occurring, monitoring the situation remains critical to inform risk assessments and adjust public health interventions. During this phase, it is important to understand the virus evolution and its geographic spread, severity of disease and groups at high risk for severe disease. Surveillance activities would focus on obtaining high quality data and favour specificity over sensitivity (i.e., would not necessarily attempt to identify all cases). Wherever possible, the use and strengthening of existing surveillance systems should be favoured. Often different systems capture information for mild illness, severe illness requiring hospitalization, and mortality, which collectively provide a foundation for surveillance during the pandemic phase.

A healthcare-based surveillance approach serves as the primary approach for year-round influenza surveillance and is considered an essential surveillance approach for COVID-19 as well. During periods of heightened surveillance, other community-based case investigation and surveillance activities serve to provide additional epidemiological information.

- Sentinel surveillance: Existing influenza surveillance systems that use a sentinel approach emphasize collecting quality data for epidemiological and virological surveillance from a limited number of surveillance sites. Sentinel healthcare facilities are chosen based on representativeness, feasibility, and sustainability. The use of strict case definitions and testing all or a subset of cases is for surveillance purposes and not for case management or outbreak investigation. During a pandemic, ongoing sentinel surveillance aids in tracking trends; geographical spread; impact of response measures; transmission and virus characteristics, including the evolution and emergence of variants; and vaccine effectiveness. A sentinel approach to monitoring COVID-19 is recommended as a complementary approach to comprehensive surveillance at present and many countries use existing sentinel influenza surveillance systems to monitor trends in COVID-19 activity and virus characteristics.
- Non-sentinel surveillance: Influenza virological surveillance also relies on non-sentinel surveillance, where
  specimens may be collected from non-sentinel sites and where the results are more often used for clinical
  management and diagnostics. Compared to sentinel surveillance, information coming from non-sentinel
  surveillance is often not as detailed, and the cases selected for testing may not meet standard case
  definitions.
- Universal surveillance: Many countries perform universal surveillance for influenza and other respiratory
  pathogens, often relying on electronic health record data to collect information on all patients seeking care
  for an influenza-like illnesses (ILI) or severe acute respiratory illness (SARI), or individuals with a suspected or
  confirmed laboratory diagnosis of a notifiable respiratory pathogen (including influenza or COVID-19), to
  either supplement or replace sentinel surveillance. Currently <u>COVID-19 surveillance</u> aims to capture data from
  any and all COVID-19 cases, no matter where they are diagnosed.
- *Mortality surveillance:* Many countries monitor influenza-related mortality through surveillance of influenzarelated deaths (using death certificates) or through statistical analysis of excess mortality attributed to influenza. The regular counting of COVID-19 deaths on a daily or weekly basis is currently recommended as part of COVID-19 surveillance mortality monitoring, including through death certificates. While not commonly done during influenza epidemics, more frequent collection and reporting of influenza-related deaths may be warranted during the pandemic phase.

- Other sources:
  - It is estimated that around half of individuals infected with influenza do not seek healthcare for their illness.<sup>1</sup> Participatory surveillance for ILI involves the ongoing collection of self-reporting of symptoms from a voluntary cohort of participants who may not seek healthcare for their illness and complements data from healthcare-based surveillance systems. Some countries are also adapting current participatory surveillance systems or developing new ones for monitoring COVID-19.
  - Special studies and modelling can generate information on transmission dynamics, risk and severity during a pandemic. Work done since the 2009 influenza pandemic as part of pandemic influenza preparedness activities have informed the COVID 19 response.
  - Sero-epidemiological and transmission study protocols developed for use in a future influenza pandemic were immediately updated for use in the COVID-19 pandemic.

## **Reporting of data to WHO**

Current <u>public health guidance</u> recommends SARS-CoV-2 infections to be nationally notifiable, with case-based reporting on a voluntary basis, and detailed aggregated data reporting requested on a weekly basis to WHO.

During further influenza pandemics, similar reporting requirements may be recommended initially. As the pandemic continues, countries would shift towards monitoring the situation, and the consistent and timely reporting of routine aggregated influenza data to regional and global WHO platforms may shift to weekly reporting of routine influenza surveillance data. It remains critical to draw lessons and sustain the momentum of the COVID-19 response to further strengthen and standardize both local and global surveillance systems to enable a robust approach to future pandemics caused by influenza and other pathogens.

## **Additional resources**

- Global epidemiological surveillance standards for influenza
- Manual for the laboratory diagnosis and virological surveillance of influenza
- WHO Guidance for Surveillance during an Influenza Pandemic
- <u>Protocol to investigate non-seasonal influenza and other emerging acute respiratory diseases</u>

<sup>&</sup>lt;sup>1</sup> Ma W, et al. (2018) The healthcare seeking rate of individuals with influenza like illness: a meta-analysis, Infectious Diseases, 50:10, 728-735, https://doi.org/10.1080/23744235.2018.1472805

## Special Focus: Update on SARS-CoV-2 Variants

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) and assess these based on the risk posed to global public health (see also <u>working definitions</u>). National authorities may choose to designate other variants of local interest/concern. Detailed information on currently circulating VOCs and VOIs is available in previously published editions of the <u>Weekly Epidemiological Update</u>. Here we provide a brief update on the geographical distribution of the three VOCs as of 20 April 2021, as well as an update on detected VOIs (Table 2).

As surveillance activities to detect SARS-CoV-2 variants are strengthened at local and national levels, including by strategic genomic sequencing, the number of countries/areas/territories (hereafter countries) reporting VOCs and VOIs has continued to increase. Since our last update on 13 April, VOC 202012/01 has been detected in five additional countries, variant 501Y.V2 in five additional countries, and variant P.1 has been reported in two additional countries. As of 20 April, a total 137 countries have reported VOC 202012/01 (Figure 4), 85 countries variant 501Y.V2 (Figure 5), and 52 countries variant P.1 (Figure 6) – see also Annex 2. The information presented here should be interpreted with due consideration of surveillance limitations, including differences in sequencing capacities and prioritization of samples for sequencing between countries.

	Nextstrain clade	Pango lineage	GISAID clade	Alternate names	First detected in	Earliest samples	Characteristic mutations
	20I/501Y.V1	B.1.1.7	GR	VOC 202012/01 <sup>+</sup>	United Kingdom	Sep 2020	H69/V70 del, Y144 del, N501Y, A570D, P681H, S106/G107/F108 del
voc	20H <b>/501Y.V2</b> <sup>+</sup>	B.1.351	GH	VOC 202012/02	South Africa	Aug 2020	L242/A243/L244 del, K417N, E484K, N501Y, S106/G107/F108 del
	20J/501Y.V3	B.1.1.28.1, alias <b>P.1</b> <sup>†</sup>	GR	VOC 202101/02	Brazil and Japan	Dec 2020	K417T, E484K, N501Y, S106/G107/F108 del
	20C	B.1.525	G/484K.V3	-	United Kingdom and Nigeria	Dec 2020	H69-V70 del, Y144 del, Q52R, E484K, Q677H, D614G, and F888L
	20C/S.452R	B.1.427/ B.1.429	GH/452R.V1	CAL.20C/L452R	United States of America	Jun 2020	L452R, W152C, S13I, D614G
	20B/S.484K	B.1.1.28.2, alias P.2	GR	-	Brazil	Apr 2020	L18F, T20N, P26S, F157L, E484K, D614G, S929I, V1176F
VOI	Not yet assigned	B.1.1.28.3, alias P.3	Not yet assigned	PHL-B.1.1.28	Philippines and Japan	Feb 2021	141-143 del, E484K, N501Y, P681H
	20C	B.1.526 with E484K or S477N	GН	-	United States of America	Nov 2020	L5F, T95I, D253G, D614G, A701V, E484K or S477N
	20C	B.1.616	GH	-	France	Jan 2021	G142 del, D66H, Y144V, D215G, V483A, D614G, H655Y, G669S, Q949R, N1187D

## Table 2: SARS-CoV-2 variants of concern (VOC) and variants of interest (VOI), as of 20 April 2021\*

<sup>†</sup>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.



### Figure 4. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01, as of 20 April 2021

### Figure 5. Countries, territories and areas reporting SARS-CoV-2 variant 501Y.V2, as of 20 April 2021





### Figure 6. Countries, territories and areas reporting SARS-CoV-2 variant P.1, as of 20 April 2021

## **WHO** recommendations

The chances of SARS-CoV-2 mutating increases with its frequency of human and animal infections. Hence, reducing transmission of SARS-CoV-2 through established disease control methods as well as avoiding introductions into 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 and its 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. National and local authorities are encouraged to continue strengthening existing PHSM, IPC and disease control activities. Authorities are also encouraged to strengthen surveillance and sequencing capacities and apply a systematic approach to provide a representative indication of the extent of transmission of SARS-CoV-2 variants based on the local context, and the detection of unusual events.

## **Additional resources**

- Proposed working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern
- <u>COVID-19 new variants: Knowledge gaps and research</u>
- PAHO Epidemiological Update: Variants of SARS-CoV-2 in the Americas 24 March 2021
- PAHO COVID-19 Situation Reports
- WPRO COVID-19 Situation Reports
- <u>SEARO COVID-19 Situation Reports</u>
- EMRO COVID-19 Situation Reports
- Joint ECDC-WHO/EURO weekly surveillance report
- <u>Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health</u>
- 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**

The Africa Region reported over 54 000 new cases and over 1100 new deaths, a 7% and a 14% increase respectively compared to the previous week. The number of weekly cases continues to fluctuate over the last eight weeks, with no clear trend, while weekly deaths increased last week reflecting a large increase in deaths reported by South Africa. The highest numbers of new cases were reported from Ethiopia (12 981 new cases; 11.3 new cases per 100 000 population; a 7% decrease), South Africa (8153 new cases; 13.7 new cases per 100 000; a 35% increase), and Kenya (6103 new cases; 11.3 new cases per 100 000; a 14% decrease).

The highest numbers of new deaths were reported from South Africa (455 new deaths; 0.8 new deaths per 100 000 population; a 51% increase), Ethiopia (182 new deaths; 0.2 new deaths per 100 000; a 13% decrease), and Kenya (133 new deaths; 0.2 new deaths per 100 000; a 7% increase).



## **Region of the Americas**

The Region of the Americas reported over 1.5 million new cases and over 39 000 new deaths, a 7% and an 8% increase respectively compared to the previous week. The region has reported an overall increasing trend in new cases for the last eight weeks and new deaths for the last five weeks. The highest numbers of new cases were reported from the United States of America (477 778 new cases; 144.3 new cases per 100 000; a 2% increase), Brazil (459 281 new cases; 216.1 new cases per 100 000; a 1% decrease), and Argentina (160 747 new cases; 355.7 new cases per 100 000; a 29% increase).

The highest numbers of new deaths were reported from Brazil (20 031 new deaths; 9.4 new deaths per 100 000; a 2% decrease), the United States of America (5146 new deaths; 1.6 new deaths per 100 000; a 1% decrease), and Mexico (4673 new deaths; 3.6 new deaths per 100 000; a 48% increase).



## **Eastern Mediterranean Region**

The Eastern Mediterranean Region reported over 386 000 new cases and over 5400 new deaths, a 6% and a 23% increase respectively compared to the previous week. The upward trend in cases and deaths reported since February 2021 continues, with a sharper increase in new deaths the last two weeks. The highest numbers of new cases were reported from the Islamic Republic of Iran (166 367 new cases; 198.1 new cases per 100 000; a 29% increase), Iraq (52 832 new cases; 131.3 new cases per 100 000; a 6% increase), and Pakistan (34 190 new cases; 15.5 new cases per 100 000; a 3% increase).

The highest numbers of new deaths were reported from the Islamic Republic of Iran (2095 new deaths; 2.5 new deaths per 100 000; a 70% increase), Pakistan (765 new deaths; 0.3 new deaths per 100 000; a 21% increase), and Tunisia (482 new deaths; 4.1 new deaths per 100 000; a 59% increase).



## **European Region**

The European Region reported over 1.6 million new cases and over 26 000 new deaths. The region reported a slight decrease in new cases (3%) for the second week in a row, a sign that transmission in the region may be slowing as the number of new deaths also decreased (3%) for the first time following a five-week increasing trend. The highest numbers of new cases were reported from Turkey (414 312 new cases; 491.2 new cases per 100 000; a 17% increase), France (233 275 new cases; 358.7 new cases per 100 000; a 12% decrease), and Germany (143 994 new cases; 173.1 new cases per 100 000; a 28% increase).

The highest numbers of new deaths were reported from Poland (3611 new deaths; 9.5 new deaths per 100 000; a 4% increase), Ukraine (2772 new deaths; 6.3 new deaths per 100 000; a 3% increase), and Italy (2753 new deaths; 4.6 new deaths per 100 000; a 14% decrease).



## South-East Asia Region

The South-East Asia Region reported over 1.5 million new cases and over 9400 new deaths, a 57% and a 49% increase respectively compared to the previous week. The increasing trend in new cases and deaths, which appears to be accelerating, continued last week, with weekly cases rising sharply for the sixth consecutive week while weekly deaths rose for the fifth consecutive week. The trend in the region continues to be driven largely by the trajectory of the outbreak in India which reported the highest numbers of new cases (1 429 304 new cases; 103.6 new cases per 100 000; a 64% increase), followed by Indonesia (36 895 new cases; 13.5 new cases per 100 000; a 4% increase), and Bangladesh (36 315 new cases; 22.1 new cases per 100 000; a 25% decrease).

The highest numbers of new deaths were reported from India (7875 new deaths; 0.6 new deaths per 100 000; a 69% increase), Indonesia (885 new deaths; 0.3 new deaths per 100 000; a 26% decrease), and Bangladesh (622 new deaths; 0.4 new deaths per 100 000; a 39% increase).



## Western Pacific Region

The Western Pacific Region reported over 128 000 new cases and over 1400 new deaths, a 15% increase and an 8% decrease respectively compared to the previous week. Cases increased for the sixth consecutive week, while deaths decreased after rising for three weeks, continuing to largely reflect the trajectory of deaths reported by the Philippines, the most affected country in the region. The highest numbers of new cases were reported from the Philippines (72 848 new cases; 66.5 new cases per 100 000; a 5% increase), Japan (26 426 new cases; 20.9 new cases per 100 000; a 29% increase), and Malaysia (13 742 new cases; 42.5 new cases per 100 000; a 45% increase).

The highest numbers of new deaths were reported from the Philippines (1066 new deaths; 1.0 new deaths per 100 000; a 19% decrease), Japan (240 new deaths; 0.2 new deaths per 100 000; a 49% increase), and Malaysia (49 new deaths; 0.2 new deaths per 100 000; a 40% increase).



# Key weekly updates

## WHO Director-General's key message

## Opening remarks at the media briefing on COVID-19 – 19 April 2021:

- More than 3 million deaths have been reported to WHO. It took 9 months to reach 1 million deaths;
   4 months to reach 2 million, and 3 months to reach 3 million. Big numbers can make us numb, but each one of these deaths is a tragedy for families, communities and nations.
- Greta Thunberg has become the powerful voice of a younger generation demanding climate action. Greta announced a donation of 100 000 Euros from the Greta Thunberg Foundation in support of COVAX to provide vaccines to people in need.
- WHO has partnered with an alliance of the six largest youth development organizations in the world to form the Global Youth Mobilization, to empower young people to respond to the challenges created by the pandemic in their local communities.

## **Updates and publications**

- <u>Statement on the seventh meeting of the International Health Regulations (2005) Emergency</u> <u>Committee regarding the coronavirus disease (COVID-19) pandemic</u>
- <u>Global Advisory Committee on Vaccine Safety (GACVS) review of latest evidence of rare adverse blood</u> <u>coagulation events with AstraZeneca COVID-19 Vaccine (Vaxzevria and Covishield)</u>
- Pfizer BioNTech COVID-19 vaccine: What you need to know
- <u>COVID-19 News updates: Latest news from WHO on COVID-19 and other breaking health stories</u>

# Technical guidance and other resources

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

# 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 18 April 2021\*\*

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Africa	54 297	3 225 261	287.5	1 170	80 715	7.2	
Ethiopia	12 981	240 236	209.0	182	3 328	2.9	Community transmission
South Africa	8 153	1 565 680	2 639.9	455	53 711	90.6	Community transmission
Kenya	6 103	151 287	281.4	133	2 463	4.6	Community transmission
Cameroon	4 394	61 731	232.5	68	919	3.5	Community transmission
Madagascar	4 069	31 617	114.2	45	538	1.9	Community transmission
Botswana	1 401	44 075	1 874.2	35	671	28.5	Community transmission
Cabo Verde	1 346	19 975	3 592.7	12	189	34.0	Community transmission
Mali	1 275	12 980	64.1	24	429	2.1	Community transmission
Gabon	1 222	21 858	982.1	6	133	6.0	Community transmission
Namibia	1 192	46 515	1 830.6	38	602	23.7	Community transmission
Algeria	1 108	119 486	272.5	26	3 152	7.2	Community transmission
Eswatini	1 042	18 415	1 587.3	2	671	57.8	Community transmission
Angola	969	24 300	73.9	11	561	1.7	Community transmission
Zambia	926	90 844	494.1	8	1 234	6.7	Community transmission
Guinea	653	21 460	163.4	5	138	1.1	Community transmission
Mozambique	556	69 134	221.2	9	798	2.6	Community transmission
Тодо	549	12 496	150.9	3	119	1.4	Community transmission
Rwanda	523	23 866	184.3	8	322	2.5	Community transmission
Burundi	458	3 612	30.4	0	6	0.1	Community transmission
Nigeria	411	164 147	79.6	1	2 061	1.0	Community transmission
Ghana	403	91 663	295.0	17	771	2.5	Community transmission
Zimbabwe	396	37 669	253.4	14	1 552	10.4	Community transmission
Côte d'Ivoire	374	45 519	172.6	13	274	1.0	Community transmission
Senegal	367	39 731	237.3	13	1 090	6.5	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Democratic Republic of the Congo	352	28 894	32.3	0	745	0.8	Community transmission
Seychelles	344	4 834	4 915.2	1	25	25.4	Community transmission
Central African Republic	322	5 787	119.8	1	75	1.6	Community transmission
Uganda	227	41 340	90.4	1	338	0.7	Community transmission
Burkina Faso	158	13 114	62.7	2	154	0.7	Community transmission
Gambia	131	5 733	237.2	2	170	7.0	Community transmission
Malawi	129	33 934	177.4	11	1 138	5.9	Community transmission
Mauritania	116	18 121	389.7	2	452	9.7	Community transmission
Benin	96	7 611	62.8	3	96	0.8	Community transmission
South Sudan	92	10 432	93.2	0	114	1.0	Community transmission
Mauritius	91	1 203	94.6	3	15	1.2	Clusters of cases
Chad	75	4 691	28.6	1	168	1.0	Community transmission
Eritrea	44	3 491	98.4	0	10	0.3	Community transmission
Niger	42	5 114	21.1	2	190	0.8	Community transmission
Equatorial Guinea	40	7 259	517.4	0	106	7.6	Community transmission
Guinea-Bissau	32	3 710	188.5	0	66	3.4	Community transmission
Sierra Leone	27	4 020	50.4	0	79	1.0	Community transmission
Comoros	26	3 815	438.7	0	146	16.8	Community transmission
Sao Tome and Principe	12	2 275	1 038.1	0	35	16.0	Community transmission
Liberia	5	2 071	40.9	0	85	1.7	Community transmission
Lesotho	2	10 709	499.9	0	315	14.7	Community transmission
Congo	0	10 084	182.7	0	137	2.5	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territories <sup>iii</sup>							
Réunion	917	18 425	2 057.9	12	135	15.1	Community transmission
Mayotte	146	19 789	7 253.6	1	168	61.6	Community transmission
Americas	1 525 505	59 551 000	5 822.5	39 482	1 444 736	141.3	
United States of America	477 778	31 250 635	9 441.2	5 146	560 858	169.4	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Brazil	459 281	13 832 455	6 507.6	20 031	368 749	173.5	Community transmission
Argentina	160 747	2 658 628	5 882.5	1 734	59 084	130.7	Community transmission
Colombia	115 216	2 619 422	5 147.9	2 281	67 564	132.8	Community transmission
Canada	60 784	1 106 062	2 930.6	290	23 541	62.4	Community transmission
Peru	60 532	1 689 051	5 122.7	2 169	56 454	171.2	Community transmission
Chile	48 826	1 117 348	5 845.0	842	25 055	131.1	Community transmission
Mexico	27 875	2 299 939	1 783.8	4 673	211 693	164.2	Community transmission
Uruguay	21 623	159 569	4 593.6	425	1 788	51.5	Community transmission
Paraguay	14 664	246 806	3 460.3	479	5 177	72.6	Community transmission
Ecuador	13 280	358 157	2 030.0	366	17 641	100.0	Community transmission
Guatemala	9 667	212 307	1 185.0	189	7 190	40.1	Community transmission
Venezuela (Bolivarian Republic of)	8 148	180 609	635.1	131	1 870	6.6	Community transmission
Cuba	6 902	92 474	816.4	59	512	4.5	Community transmission
Bolivia (Plurinational State of)	6 711	287 360	2 461.7	197	12 625	108.2	Community transmission
Costa Rica	6 033	228 577	4 487.1	53	3 071	60.3	Community transmission
Honduras	5 134	199 682	2 016.1	168	4 934	49.8	Community transmission
Dominican Republic	3 441	260 627	2 402.6	29	3 414	31.5	Community transmission
Panama	2 151	360 249	8 349.2	29	6 185	143.3	Community transmission
El Salvador	1 913	67 404	1 039.2	24	2 072	31.9	Community transmission
Jamaica	1 565	43 684	1 475.2	52	721	24.3	Community transmission
Guyana	684	11 642	1 480.1	15	267	33.9	Clusters of cases
Trinidad and Tobago	419	8 742	624.7	5	150	10.7	Community transmission
Bahamas	279	9 696	2 465.6	5	194	49.3	Clusters of cases
Suriname	231	9 496	1 618.7	9	187	31.9	Clusters of cases
Haiti	78	12 918	113.3	0	251	2.2	Community transmission
Saint Lucia	69	4 398	2 395.1	1	65	35.4	Community transmission
Barbados	65	3 773	1 312.9	0	44	15.3	Community transmission
Belize	51	12 538	3 153.2	0	318	80.0	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Nicaragua	41	5 407	81.6	1	180	2.7	Community transmission
Antigua and Barbuda	31	1 213	1 238.7	1	31	31.7	Clusters of cases
Saint Vincent and the Grenadines	29	1 819	1 639.6	0	10	9.0	Community transmission
Dominica	7	172	238.9	0	0	0.0	Clusters of cases
Grenada	2	159	141.3	0	1	0.9	Sporadic cases
Saint Kitts and Nevis	0	44	82.7	0	0	0.0	Sporadic cases
Territories <sup>iii</sup>							
Puerto Rico	7 371	120 571	4 214.5	42	2 194	76.7	Community transmission
Curaçao	1 042	11 674	7 114.3	20	80	48.8	Community transmission
Martinique	871	9 758	2 600.3	7	66	17.6	Community transmission
Guadeloupe	623	12 927	3 230.7	5	194	48.5	Community transmission
French Guiana	532	18 081	6 053.6	1	95	31.8	Community transmission
Aruba	323	10 219	9 571.4	0	92	86.2	Community transmission
Bermuda	287	2 060	3 308.0	3	17	27.3	Community transmission
United States Virgin Islands	57	3 028	2 899.7	0	26	24.9	Community transmission
Bonaire	36	1 511	7 224.5	0	14	66.9	Community transmission
Sint Maarten	28	2 202	5 135.0	0	27	63.0	Community transmission
Saint Barthélemy	26	954	9 651.0	0	1	10.1	Clusters of cases
Turks and Caicos Islands	25	2 369	6 118.6	0	17	43.9	Clusters of cases
British Virgin Islands	9	187	618.4	0	1	3.3	Clusters of cases
Cayman Islands	9	525	798.8	0	2	3.0	Sporadic cases
Saint Martin	7	1 710	4 423.3	0	13	33.6	Community transmission
Falkland Islands (Malvinas)	2	62	1 780.1	0	0	0.0	Sporadic cases
Anguilla	0	29	193.3	0	0	0.0	Sporadic cases
Montserrat	0	20	400.1	0	1	20.0	No cases
Saba	0	6	310.4	0	0	0.0	No cases
Saint Pierre and Miquelon	0	25	431.4	0	0	0.0	Sporadic cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Eastern Mediterranean	386 176	8 444 694	1 155.5	5 460	170 580	23.3	
Iran (Islamic Republic of)	166 367	2 215 445	2 637.7	2 095	66 327	79.0	Community transmission
Iraq	52 832	970 987	2 414.0	270	14 948	37.2	Community transmission
Pakistan	34 190	750 158	339.6	765	16 094	7.3	Community transmission
Jordan	21 071	683 466	6 698.6	470	8 178	80.2	Community transmission
Lebanon	13 870	508 503	7 450.1	256	6 886	100.9	Community transmission
Tunisia	13 679	283 976	2 402.8	482	9 717	82.2	Community transmission
United Arab Emirates	13 287	495 224	5 007.1	21	1 550	15.7	Clusters of cases
Kuwait	10 156	255 860	5 991.2	37	1 440	33.7	Community transmission
Oman	8 663	176 668	3 459.6	74	1 821	35.7	Community transmission
Bahrain	7 711	163 113	9 586.0	34	588	34.6	Community transmission
Qatar	6 693	195 757	6 794.6	45	376	13.1	Community transmission
Saudi Arabia	6 418	404 054	1 160.6	63	6 810	19.6	Community transmission
Egypt	5 807	215 484	210.6	289	12 694	12.4	Community transmission
Libya	4 243	171 131	2 490.5	75	2 882	41.9	Community transmission
Morocco	3 759	505 447	1 369.4	53	8 944	24.2	Community transmission
Syrian Arab Republic	886	21 004	120.0	69	1 437	8.2	Community transmission
Djibouti	690	10 412	1 053.8	21	114	11.5	Community transmission
Afghanistan	633	57 793	148.5	18	2 539	6.5	Community transmission
Somalia	566	12 837	80.8	51	656	4.1	Community transmission
Yemen	494	5 774	19.4	88	1 120	3.8	Community transmission
Sudan	221	33 022	75.3	35	2 208	5.0	Clusters of cases
Territories <sup>iii</sup>							
occupied Palestinian territory	13 940	308 579	6 048.9	149	3 251	63.7	Community transmission
Europe	1 624 060	49 208 464	5 273.8	26 302	1 035 294	111.0	
Kosovo <sup>[1]</sup>	3 686	101 110		85	2 051		Community transmission
Turkey	414 312	4 212 645	4 994.9	1 906	35 608	42.2	Community transmission
France	233 275	5 178 513	7 962.1	1 965	99 921	153.6	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Germany	143 994	3 142 262	3 778.3	1 561	79 914	96.1	Community transmission
Poland	113 394	2 688 025	7 081.6	3 611	62 032	163.4	Community transmission
Italy	103 366	3 857 443	6 467.7	2 753	116 676	195.6	Clusters of cases
Ukraine	93 261	1 946 510	4 450.8	2 772	39 786	91.0	Community transmission
Russian Federation	60 711	4 702 101	3 222.1	2 596	105 582	72.3	Clusters of cases
Netherlands	52 986	1 395 233	8 015.1	152	16 904	97.1	Community transmission
Sweden	35 133	900 138	8 715.9	28	13 788	133.5	Community transmission
Spain	31 084	3 396 685	7 176.2	176	76 882	162.4	Community transmission
Hungary	30 344	750 508	7 682.1	1 767	25 184	257.8	Community transmission
Romania	24 174	1 027 039	5 313.5	1 066	26 072	134.9	Community transmission
Belgium	23 034	949 994	8 244.7	252	23 741	206.0	Community transmission
Serbia	20 823	660 299	9 532.7	254	5 954	86.0	Community transmission
Czechia	20 158	1 600 347	14 965.0	618	28 426	265.8	Community transmission
Greece	19 681	313 444	2 924.3	564	9 397	87.7	Community transmission
Kazakhstan	18 391	341 599	1 819.3	194	4 157	22.1	Clusters of cases
The United Kingdom	17 893	4 385 942	6 460.7	180	127 260	187.5	Community transmission
Austria	16 296	588 101	6 607.1	223	9 616	108.0	Community transmission
Croatia	15 274	307 790	7 584.5	254	6 562	161.7	Community transmission
Azerbaijan	14 943	298 522	2 944.2	228	4 107	40.5	Clusters of cases
Bulgaria	14 432	385 963	5 552.2	787	15 138	217.8	Clusters of cases
Switzerland	9 883	629 507	7 273.7	20	9 815	113.4	Community transmission
Belarus	8 060	342 923	3 629.1	69	2 413	25.5	Community transmission
Lithuania	7 458	233 631	8 361.6	73	3 760	134.6	Community transmission
Bosnia and Herzegovina	7 171	190 296	5 800.3	479	7 837	238.9	Community transmission
Georgia	6 962	295 358	7 404.0	62	3 939	98.7	Community transmission
Armenia	5 703	208 520	7 036.9	143	3 878	130.9	Community transmission
Slovenia	5 645	231 599	11 050.3	26	4 460	212.8	Clusters of cases
North Macedonia	5 576	146 733	7 043.0	237	4 419	212.1	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Slovakia	4 912	375 974	6 888.7	541	11 106	203.5	Clusters of cases
Denmark	4 630	241 731	4 151.5	13	2 452	42.1	Community transmission
Republic of Moldova	4 608	245 494	6 085.7	179	5 548	137.5	Community transmission
Cyprus	4 372	55 407	6 239.5	16	288	32.4	Clusters of cases
Norway	4 264	106 223	1 979.0	24	708	13.2	Community transmission
Latvia	3 757	110 997	5 818.4	62	2 048	107.4	Community transmission
Portugal	3 632	830 560	8 066.9	32	16 942	164.6	Clusters of cases
Estonia	3 380	117 554	8 845.5	72	1 092	82.2	Clusters of cases
Ireland	2 595	243 238	4 899.6	52	4 835	97.4	Community transmission
Finland	1 926	83 633	1 513.6	19	887	16.1	Community transmission
Uzbekistan	1 758	86 680	259.0	3	637	1.9	Clusters of cases
Kyrgyzstan	1 656	91 883	1 408.3	27	1 549	23.7	Clusters of cases
Albania	1 301	129 456	4 498.4	30	2 340	81.3	Clusters of cases
Montenegro	1 130	95 548	15 213.1	61	1 434	228.3	Clusters of cases
Israel	1 113	836 926	9 669.3	42	6 334	73.2	Community transmission
Luxembourg	1 096	64 746	10 341.0	17	785	125.4	Community transmission
Malta	379	29 927	5 816.0	7	409	79.5	Clusters of cases
Andorra	274	12 771	16 528.8	3	123	159.2	Community transmission
San Marino	54	5 010	14 762.2	1	86	253.4	Community transmission
Liechtenstein	51	2 892	7 463.8	0	54	139.4	Sporadic cases
Iceland	28	6 286	1 726.3	0	29	8.0	Community transmission
Monaco	22	2 395	6 102.8	0	31	79.0	Sporadic cases
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories <sup>iii</sup>							
Gibraltar	14	4 291	12 736.3	0	94	279.0	Clusters of cases
Jersey	2	3 232	2 998.3	0	69	64.0	Community transmission
Faroe Islands	1	662	1 354.8	0	1	2.0	Sporadic cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Guernsey	1	822	1 275.1	0	14	21.7	Community transmission
Isle of Man	1	1 575	1 852.2	0	29	34.1	No cases
Greenland	0	31	54.6	0	0	0.0	No cases
South-East Asia	1 518 708	17 696 534	875.5	9 447	237 832	11.8	
India	1 429 304	14 788 109	1 071.6	7 875	177 150	12.8	Clusters of cases
Indonesia	36 895	1 599 763	584.9	885	43 328	15.8	Community transmission
Bangladesh	36 315	715 252	434.3	622	10 283	6.2	Community transmission
Thailand	9 727	42 352	60.7	4	101	0.1	Clusters of cases
Nepal	3 933	283 658	973.5	36	3 075	10.6	Clusters of cases
Sri Lanka	1 591	96 439	450.4	22	617	2.9	Clusters of cases
Maldives	621	26 145	4 836.8	2	69	12.8	Clusters of cases
Timor-Leste	228	1 236	93.7	1	2	0.2	Clusters of cases
Myanmar	52	142 628	262.1	0	3 206	5.9	Clusters of cases
Bhutan	42	952	123.4	0	1	0.1	Sporadic cases
Western Pacific	128 176	2 205 688	112.3	1 444	34 918	1.8	
Philippines	72 848	926 035	845.1	1 066	15 810	14.4	Community transmission
Japan	26 426	529 829	418.9	240	9 622	7.6	Clusters of cases
Malaysia	13 742	372 859	1 152.0	49	1 370	4.2	Community transmission
Mongolia	6 472	20 655	630.1	21	41	1.3	Clusters of cases
Republic of Korea	4 560	114 114	222.6	29	1 797	3.5	Clusters of cases
Cambodia	2 151	6 389	38.2	14	43	0.3	Sporadic cases
Papua New Guinea	1 296	9 738	108.8	21	89	1.0	Community transmission
China	190	103 273	7.0	3	4 856	0.3	Clusters of cases
Singapore	175	60 808	1 039.4	0	30	0.5	Sporadic cases
Australia	109	29 505	115.7	1	910	3.6	Clusters of cases
Viet Nam	89	2 781	2.9	0	35	0.0	Clusters of cases
New Zealand	20	2 238	46.4	0	26	0.5	Clusters of cases
Lao People's Democratic Republic	9	58	0.8	0	0	0.0	Sporadic cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Fiji	4	72	8.0	0	2	0.2	Sporadic cases
Brunei Darussalam	2	221	50.5	0	3	0.7	Sporadic cases
Solomon Islands	0	20	2.9	0	0	0.0	No cases
Territories <sup>iii</sup>							
French Polynesia	44	18 696	6 655.6	0	141	50.2	Sporadic cases
Guam	29	7 654	4 535.0	0	136	80.6	Clusters of cases
Wallis and Futuna	6	447	3 974.7	0	5	44.5	Sporadic cases
New Caledonia	2	123	43.1	0	0	0.0	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	2	162	281.5	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	5 236 922	140 332 386		83 305	3 004 088		

\*See Annex: Data, table and figure notes

# Annex 2. List of countries/territories/areas reporting variants of concern as of 20 April 2021\*\*

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2	P.1 (B.1.1.28)
Afghanistan	Verified*	(0.1.331)	(01111120)
Albania	Not Verified		
Algeria	Verified		
Angola	Verified	Verified	
Argentina	Verified		Verified
Armenia	Not Verified*		
Aruba	Verified	Verified	Verified
Australia	Verified	Verified	Verified
Austria	Verified	Verified	Verified
Azerbaijan	Verified		
Bahrain	Verified		
Bangladesh	Verified	Not Verified	
Barbados	Verified		
Belarus	Verified		
Belgium	Verified	Verified	Verified
Belize	Verified		
Bonaire	Verified		
Bosnia and Herzegovina	Not Verified		
Botswana		Verified	
Brazil	Verified	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*	Verified

Country/Territory/Area	VOC 202012/01	501Y.v2	P.1
	(B.1.1.7)	(B.1.351)	(B.1.1.28)
China	Verified	Verified	Verified
Colombia	Verified*		Verified
Comoros		Verified	
Costa Rica	Verified	Verified	Verified
Croatia	Verified	Not Verified	
Cuba	Verified	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		Verified*
Estonia	Verified	Not Verified	
Eswatini		Verified	
Faroe Islands			Verified
Finland	Verified	Verified	Verified
France	Verified	Verified	Verified
French Guiana	Verified	Verified*	Verified
French Polynesia	Verified		Verified
Gambia	Verified		
Georgia	Verified		
Germany	Verified	Verified	Verified
Ghana	Verified	Verified	
Gibraltar	Not Verified		
Greece	Verified	Verified	
Grenada	Verified		
Guadeloupe <sup>+</sup>	Verified		

Country/Territory/Area	VOC 202012/01	501Y.v2	P.1	Cour
	(B.1.1./)	(B.1.351)	(B.1.1.28)	
Guvana			NOL	Maur
Bungany	Varified	Not Varified	vermeu	Mayo
	Verified	Not vermeu		Mexi
	Verified	Varified	Varified	Mona
Indonesia	Verified	vermeu	vermeu	Mont
Indonesia	Verified			Moro
Iran (Islamic Republic of)	Verified			Moza
Iraq	verified		Net	Nami
Ireland	Verified	Verified	NOL	Nepa
Israel	Verified	Verified	vermeu	Neth
Italy	Verified	Not Verified	Varified	New
lamaica	Verified	Not vermeu	vermeu	
	Verified	Varified	Varified	New
Japan	Verified	Verified*	Verified*	Niger
Jurudri	Verified	Not Varified	vermeu	North
Kazakristan	Not verified			Norw
Kenya	Not Verified	Verified		occup
KOSOVO	Verified			territ
Kuwait	Verified			Omar
Latvia	Verified	Verified		Pakis
Lebanon	Verified			Pana
Lesotho		Verified		Parag
Libya	Verified	Verified		Peru
Liechtenstein	Verified			Philip
Lithuania	Verified	Verified		
			Not	Polar
Luxembourg	Verified	Verified	Verified	Dort
Malawi	Verified	Verified		Portu
Malaysia	Verified	Verified		Puert
Malta	Verified	Not Verified		Qata
Martinique⁺	Verified			Кери

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
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	Verified
Paraguay			Verified
Peru	Verified		Verified
Philippines	Verified	Verified	Verified
Poland	Verified	Not Verified	Not Verified
Portugal	Verified	Verified	Not Verified
Puerto Rico	Verified		Verified
Qatar	Verified	Verified	
Republic of Korea	Verified	Verified	Verified

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
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	Vernied
Spain	Verified	Verified	Verified
Sri Lanka	Verified	Verified	
Suriname	Verified	Verified	Verified
Sweden	Verified	Verified	Verified
			Not
Switzerland	Verified	Verified	Verified

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Syrian Arab Republic	Not Verified*		
Thailand	Verified	Verified	
The United Kingdom	Verified	Verified	Verified
Тодо	Verified		
Trinidad and Tobago	Verified		
Tunisia	Verified		
			Not
Turkey	Verified	Not Verified	Verified
Turks and Caicos Islands	Verified		
Uganda		Not Verified	
Ukraine	Not Verified	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	Not Verified*	
Venezuela (Bolivarian			
Republic of)			Verified
Viet Nam	Verified	Verified	
Wallis and Futuna	Not Verified		
Zambia		Verified	
Zimbabwe		Verified	

\*New country added in this update.

<sup>+</sup>Variants 501Y.V2 and P.1 for Guadeloupe and Martinique were removed based on further information received. \*\*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.

<sup>[1]</sup> 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.

<sup>i</sup> 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).

<sup>ii</sup> 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: <u>Considerations for implementing and adjusting public health and social measures in the context of COVID-19</u>:

- 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.

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

# Weekly Operational Update on COVID-19

# 19 April 2021

Issue No. 51



# Confirmed cases<sup>a</sup> 141 057 106

# Confirmed deaths **3 015 043**

#### WHO trains critical care nurses in response to COVID-19

WHO continues to support the occupied Palestinian territory, including east Jerusalem during COVID-19 pandemic. In the March, a training workshop on the treatment of patients suffering from severe COVID-19 was delivered to nurses working in, or who will assigned be to. COVID-19 intensive care units (ICUs). Basic ICU training was already delivered to doctors in December 2020.



Credit: WHO Regional office/EMRO

Ten senior critical care nurses were identified as co-facilitators and lead instructors while virtual meetings with senior critical care nurses took place on a weekly basis to contextualize the training materials to best meet local needs.

A mission was then deployed from the WHO Regional Office for the Eastern Mediterranean to deliver a 3-day training of trainers' workshop in March 2021. Cascade training will be provided to 200 nurses through 10 two-day workshops attended by 20 nurses in each session.

Follow-up support will continue to be provided by WHO to ensure that the nurses are following best practices in the workplace. WHO also conducted an ICU assessment of COVID-19 hospitals and is planning for high dependency units training for doctors in the near future.

For more information, click here.



# 38 713 700 gloves shipped globally

**166** GOARN deployments conducted to support COVID-19 pandemic response



HEALTH

**792 796 083** COVID-19 vaccine doses administered globally as of 19 April

<sup>a</sup> COVAX has shipped over **39** million vaccines to **114** participants as of 16 April

<sup>a</sup> See Gavi's <u>COVAX updates</u> for the latest COVAX vaccine roll –out data

For all other latest data and information, see the <u>WHO</u> <u>COVID-19 Dashboard</u> and <u>Situation Reports</u>

#### **Key Figures**



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

More than **5 million** people registered on <u>OpenWHO</u> and accessing online training courses across **30** topics in **50** languages



**17 640 008** PCR tests shipped globally

**198 747 426** medical masks shipped globally



8 659 511 face shields shipped globally

EMERGENCIES programme

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HEALTH EMERGENCIES programme

# From the field:

#### Health for all in India during the COVID-19 pandemic

With the COVID-19 pandemic restricting access to health facilities, health care and frontline workers brought health services to the community in the heavily forested districts of Bijapur, Dantewada and Sukma in the Left-Wing Extremism (LWE)-affected Baster region in the state of Chhattisgarh. LWE, combined with dense forests, had made many of the areas unserviceable by health care workers, which has resulted in region having some of the poorest health indicators in the country.

WHO is providing technical expertise to the districts as part of its support to the state to reinforce the Health and Wellness Centre (HWC) programme as part of WHO's assistance to support <u>equitable access to health</u> <u>services</u> at sub-national levels through strengthening of local health systems with a focus on marginalized groups.

Frontline workers tested children for malaria in Bijapur district in door-to-door campaigns in remote areas under the Malaria Mukt Bastar Campaign (Malaria Free Bastar Campaign) and fever clinics were established outside health



Frontline workers testing children for malaria in Bijapur district as part of Malaria Mukt Bastar Campaign Credit: WHO/Dr Varun Kakde

facilities to protect health workers from exposure to COVID-19. A health call centre was established in Dantewada with WHO support to ensure uninterrupted essential health services to the community.

Since early 2019, WHO India has provided technical support to around 50% of existing subhealth centres in all three districts to be revitalized and upgraded to Health and Wellness Centres, which have become pivotal in providing uninterrupted essential health services during the pandemic. WHO provided planning and mentoring support for the reorganization of health services to improve efficiencies of auxiliary nurse midwives, rural medical assistants and community health officers on active surveillance and infection prevention and control (IPC) protocols. Training auxiliary nurse midwives and community health officers led to an increase in the frequency of home visits for COVID-19 surveillance and other health needs, including noncommunicable diseases (NCDs).

"From technical support to capacity building, WHO's support has been indispensable. Collaboration with WHO facilitated strengthening of district health systems for delivering essential health services during the pandemic in addition to the operationalization of quarantine centres, fever clinics, and a dedicated COVID-19 hospital," said Dr Chandra Bhan Prasad Bansod, Chief Medical and Health Officer and Civil Surgeon, Sukma.

For more information, click here.



HEALTH EMERGENCIES programme

# From the field:

#### Brunei Darussalam receives 24 000 COVID-19 vaccines via the COVAX Facility



Maswadi bin Haji Mohsin, Acting Permanent Secretary, Ministry of Health (second from right), Dr Haji Zulaidi bin Haji Abd Latif, Deputy Permanent Secretary, Ministry of Health (rightmost) and others receive COVAX vaccines at Brunei International Airport. Photo credit: Brunei Darussalam Ministry of Health

On 31 March 2021, 24 000 doses of the AstraZeneca/Oxford COVID-19 vaccine shipped to Brunei Darussalam, arriving on 2 April according to the Regional Office for the Western Pacific.

These COVID-19 vaccine doses are the first of a total of 100 800 doses expected in batches by the end of June by the COVAX Facility.

"WHO is in solidarity with the people of Brunei Darussalam

and partners in welcoming the arrival of the COVID-19 vaccines through the COVAX Facility," said Dr Ying-Ru Lo, Head of Mission and WHO Representative to Malaysia, Brunei Darussalam and Singapore. "Vaccines save lives and the arrival of these vaccines will help protect the priority groups identified by Brunei Darussalam – first and foremost health workers and other front-liners. Getting vaccinated, in combination with other proven public health measures, is a very important step for people to be protected against COVID-19."

It is still important for the public to remain vigilant and continue to take the usual precautions by adopting and practicing preventive measures as recommended, such as avoiding crowded places where possible, practicing physical distancing where necessary, wearing a face mask, staying home when you have flu-like symptoms, as well as frequently washing your hands.

The COVID-19 Vaccination Programme commenced on 3 April 2021, with a vaccination centre in each of the four districts, in three phases according to different priority population groups:

- **1. Phase one:** Front-liners, senior citizens ages 60 and above and students or individuals who will be studying abroad
- **2. Phase two:** Staff working at daycare centres, teachers and adults with comorbidities or at high risk of contracting COVID-19
- 3. Phase three: Other individuals who are 18 years and above

For the first phase, front-liners, specifically medical staff in Government and private health facilities across the country, will receive the vaccine first, followed by other front-liners.

For more information, click here.



### From the field:

# WHO supports Government of Nigeria to monitor health inequities and minimize health service disruptions amidst COVID-19 response

The COVID-19 pandemic has disrupted health services across the world, including Nigeria where people like Asabe Audu and Christine had their medical routines interrupted. Asabe Audu, an HIV positive civil servant, noted missing medication for two days, while Christine Agbo, reported missing her "routine blood sugar testing during the pandemic" due to costs.

WHO Nigeria is supporting the Government to monitor health inequities and strengthen to capacities for the use of disaggregated data, based on socio-economic stratification of the population, to drive evidencebased decisions for priority areas for health and health related interventions.

WHO is providing technical support for the policies and strategies that would ensure more people have financial access to quality health services.



Catalytic interventions such as the Integrated Medical Outreach, outbreak response to vaccine preventable disease, revitalizing primary health care and improving quality of maternal and child health services, are geared towards mitigating the inequities in health service delivery. This is supported by commitments from the government to a more systemic approach in addressing challenges with human resources needs, information management and use and sustainable financing in the health system.

"To improve this situation, we need to act on the social and economic determinants of health, by working across sectors to improve living and working conditions, and access to education, particularly for the most marginalized groups. Communities need to be engaged as partners, through their networks and associations, to shape and drive health and development interventions" stated Dr Walter Kazadi Mulombo, WHO Nigeria Country Representative.

For more information, click here.



# From the field:

# WHO Regional Office for Europe workshop and technical dialogue on COVID-19 surveillance, testing and contact tracing with the Regional Hygienic Stations in the Czech Republic

On 13 April, the WHO Regional Office for Europe, in collaboration with the WHO Country Office in the Czech Republic, held a workshop and technical dialogue on COVID-19 contact tracing and testing strategies with the newly appointed Chief Public Health Officer, representatives from the Czech National Institute of Public Health and the Regional Hygienic Stations.

In the Czech Republic, the Regional Public Health authorities (Hygienic Stations) play a significant role in the health system with responsibilities for a range of health public services. including epidemiological surveillance, emergency health immunization measures, logistics, and certifications and authorizations.



Srdan Matic WHO Representative of the Czech Republic, leading the discussion on the contact tracing and laboratory capacity. Credit: WHO/EURO

Throughout the COVID-19 pandemic, the Hygienic Stations proved crucial for testing, tracing and isolating and quarantining COVID-19 cases and contacts. Following the end of the state of emergency on 11 April 2021, public health measures and epidemiological follow-up responsibilities will primarily be at the regional level. These 14 regional public health offices are coordinated by the Chief Public Health Officer (Chief Hygienist) who is also the Deputy Minister of Health.

The virtual workshop held this week aimed to facilitate knowledge exchange and support regional authorities in further strengthening their response within the context of a sustained period of intense transmission, health workforce limitations, and changes in the command and control structure of the response. WHO shared advice and experiences from other settings on improving efficiency in contact tracing, especially during intense COVID-19 transmission when contacts may need to be prioritized (i.e., those with a higher degree of vulnerability and those with more contacts). Indicators were proposed to measure the performance of the current contact tracing system. Testing strategies were discussed, highlighting the merits of both RT-PCR and Antigen detecting Rapid Diagnostic Tests (Ag-RDT) in national testing strategies.

This forum allowed collaboration between WHO, the Ministry of Health and the Regional Hygienic stations, and provided an exchange on lessons learned, best practices and evidence to advocate for policy changes in future. Follow-up meetings may include sessions to examine the relaxation of public health and social measures in the Czech Republic using targets and thresholds set at regional levels.



### From the field:

# Addressing the mental health needs of the Nepali people during the COVID-19 pandemic

Since the COVID-19 pandemic, the prevalence of mental disorders, such as depression and anxiety, is expected to rise.

"The consequences of this health and social crisis are likely to get more pronounced among vulnerable population[s]" such as healthcare workers, older adults and persons with both physical and psychosocial disabilities noted Dr. Rajesh Sambhajirao Pandav, WHO Representative to Nepal.

WHO assisted the Ministry of Health and Population in developing a COVID-19 Mental Health & Psychological Support (MHPSS) intervention framework to continue delivering essential mental health services. A National Mental Health Strategy and Action Plan has been brought into implementation which aimed to improve access to quality essential health services.

The WHO and International Committee of the Red Cross Guideline of Psychological First Aid was translated and adapted to national context in collaboration with the Nepal Association of Clinical Psychologist in April 2020. This <u>document</u> served as a guide to Nepal's unique needs in the planning phase.

The WHO Country Office for Nepal held regular	mental health sub-cluster
meetings to coordinate work among partners, and	results through 2020 from
concerted actions are as follows:	

- more than 40,000 people received psychosocial support in some form;
- more than 20,000 children and adolescents were provided with essential mental health support;
- more than 3,000 health care providers were reached through stress management workshops and webinars on their mental health needs;
- > more than 160 community psychosocial counsellors were trained;
- more than 500 FM radio stations across the country were engaged to disseminate messages; and
- > partners operationalized several helpline services.

An online platform was also developed to support mental health needs of the health care providers which contained tips on mental health care, modules on stress management, webinars, audio-visual and Information, Education and Communication (IEC) materials, self-screening tools, and appointment and follow up services.

For further information, click here.



HEALTH EMERGENCIES programme

# Partnerships The Global Health Cluster - GHC



The Global Health Cluster (GHC) hosted the 27<sup>th</sup> annual <u>Partner Meeting</u> virtually this week from 14 - 15 April, to continue sharing good practices, lessons learned and updates on current work and developments.

The meeting featured a session on COVID-19 vaccination in humanitarian settings and the GHC <u>COVID-19 Task Team</u> presented on the roles and objectives of its newly formed COVID-19 Vaccine Working Group. The Global Health Cluster and the focal point for the WHO/Inter-Agency Standing Committee (IASC) Decision Group presented on the humanitarian buffer and facilitated a Q&A session.

All presentations from the Partner Meeting and the Note for the Record will be shared with participants and on the <u>Global Health Cluster website</u>.



HEALTH EMERGENCIES programme

### Public health response and coordination highlights

At the UN Crisis Management Team (CMT) meeting on 15 April 2021, **WHO** briefed on the epidemiological situation, reporting that new COVID-19 cases rose for the seventh consecutive week, and the number of new deaths increased for the fourth consecutive week.

**WHO** reported that the largest increase in cases was observed in the South East Asia and Eastern Mediterranean regions. **WHO** noted a worrying shift in some parts of South America, with increased incidence among younger populations.

**WHO** continues to monitor the spread and impact of SARS-CoV-2 Variants of Concern (VOCs). A decision framework for assessing the impact of SARS-CoV-2 VOCs on public health interventions is being developed following a global consultation on 29 March 2021. This will enable WHO to systematically collect and assess the evidence available, and, if necessary, to update guidance for countries on adjustments to public health and social measures.

**UN agencies** and partners were encouraged to continue advocating for countries to take a comprehensive approach in managing the pandemic. **UNICEF** underscored the tension between health considerations and livelihoods faced by many people around the world, particularly some parts of Africa. Emphasizing the importance of communications, UNICEF also noted that mixed and confusing messages in the media about vaccines is contributing to hesitancy and fatigue among populations and called for consistent international messaging on vaccines.

During the meeting, **WHO** also provided an update to the CMT on the progress of COVID-19 vaccine roll out, highlighting that unequal distribution of vaccines between and within countries is driving transmission and costing lives.

To date, high-income countries have administered, on average, 144 times more vaccine doses per 100 people than low-income countries, which is a striking differential in doses administered by income level. Further, underscoring this disparity, to date, approximately 89% of all vaccine doses administered to date globally have been administered in high-income and upper-middle income countries.

All of this highlighting the need for global solidarity in reaching at-risk groups rapidly and efficiently.



### **COVID-19 Preparedness**

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

Since the earliest stages of COVID-19, cities have been national epicentres of the pandemic and lessons to date have highlighted that these settings need to be better prepared for concurrent and future health emergencies. WHO and the Government of Singapore established a technical working group on urban preparedness, meeting six times between February 2021 to April 2021, including a final meeting last week. Members included representatives from Member States across all WHO regions, partners, city networks, international organizations and the three levels of WHO.

In these meetings, members shared their experiences of COVID-19 in cities, discussed challenges in urban preparedness, explored potential solutions, roles of stakeholders, and the tools and resources necessary for risk assessment, gap analysis and capacity building.

Members agreed on the following ten overarching key messages:



- 1. Health emergencies preparedness in cities and urban settings must be a priority at the highest level of government;
- 2. Preparedness goes beyond the health sector, especially at the level of service delivery;
- 3. Strengthened urban preparedness requires adequate investment;
- 4. It is critical to ensure that local / city level governments and communities are involved in national health emergency preparedness planning and activities;
- 5. Developing city-specific approaches to health emergency preparedness is paramount;
- 6. Involvement of urban communities, and their groups most at risk of vulnerability, is key to resilience and successful all-hazard risk management;
- 7. The improved use of local level data for action can help cities be better prepared;
- 8. There are many tools relevant to cities, but local governments need specific and targeted ones for health emergency preparedness;
- 9. Global solidarity is key to effective preparedness even at the local, urban level;
- 10. Support to countries from the international system can be better consolidated and aligned;

The meeting was closed by WHO Assistant Director-General Dr Jaouad Mahjour and the Deputy Secretary for Health of the Republic of Singapore, Dr Benjamin Koh who reiterated the importance of continued discussions and further work to advance urban preparedness.

WHO is finalising a meeting report and developing technical guidance on strengthening health emergency preparedness in cities and urban settings for use by national and local governments based on the working group's inputs and recommendations to be published mid-2021.



# **COVID-19 Partners platform**



Accelerating Operational Readiness for Response in Countries and in Partnership

For a public health response to an outbreak to be efficient, equitable, and inclusive of economic, social and humanitarian considerations, extensive strategic planning is required. The Partners Platform was created to support countries to develop a thorough emergency response, such as ensuring "last-mile" vaccine delivery through its role in coordinating applications for countries participating in the COVAX Facility and its real-time tracking of vaccine contributions and country needs.

Due to the increasingly growing role of Partners Platform to meet country needs, it is now in a unique position to support countries with operational readiness to limit the impact of future and concurrent acute emergency health risks. Operational readiness builds from an all-hazards preparedness approach, and readies hazard-specific operational response capabilities identified through risk assessments and prioritization exercises.

This aligns with the COVID-19 Strategic Preparedness and Response Plan (SPRP 2021) <u>Operational</u> <u>Planning Guideline</u>, which recommends evaluating national and subnational capacities to be operationally ready for and to respond to concurrent emergencies. Countries facing multiple emergencies are also recommended to align coordination, planning, financing and monitoring for COVID-19 response with broader emergency coordination.

WHO is thus expanding the Partners Platform's primary capabilities developed during the COVID-19 response (action checklists based on a strategic preparedness and response plan; country resource needs; and contribution mapping from donors and partners) to include operational readiness in the African Region, where two countries face concurrent emergencies with the COVID-19 pandemic and a current Ebola virus disease (EVD) outbreak, and 10 neighbouring countries face the risk of a simultaneous EVD outbreak.

WHO is collaborating across levels with the Regional Office for Africa to respond to the outbreaks in affected and at-risk areas, including through updating their national preparedness and response plans for EVD and their resource needs on the Partners Platform. The 12 countries can then track national implementation against the action checklist, in alignment with the strategic preparedness and response plan and operational guidelines for EVD, within the Partners Platform. In preparing strategic readiness and response plans for neighboring countries prior to the outbreak potentially crossing borders, rapid and precise actions will be enabled to minimize the outbreak's impact.



# **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 13 April 2021.

Shipped items as of 13 April 2021	Laboratory supplies			pry supplies Personal protective equipment					
Region	Antigen RDTs	Sample collection kits	PCR tests	Face shields	Gloves	Goggles	Gowns	Medical Masks	Respirators
Africa (AFR)	718 250	3 923 105	1 871 362	1 473 890	12 224 300	223 570	1 741 279	53 467 400	2 768 630
Americas (AMR)	7 479 900	1 046 132	10 550 962	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	1 852 360	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	509 000	653 700	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	11 325 450	10 662 457	17 640 008	8 659 511	38 713 700	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 <u>Strategic Preparedness and Response Plan</u> (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.



The 2021 SPRP priorities and resource requirements can be found <u>here</u>. The status of funding raised for WHO against the SPRP can be found <u>here</u>.



# WHO Funding Mechanisms

#### **COVID-19 Solidarity Response Fund**

As of 2 April 2021, <u>The Solidarity Response</u> <u>Fund</u> has raised or committed more than US\$ 246 million from more than 664 403 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\$ 246 Million



[individuals – companies – philanthropies]

### Pandemic learning response

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

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



#### **30 topical COVID-19 courses**

50 languages

**Over 2.8 million certificates** 

**5 100 751** COVID-19 Course enrollments



HEALTH **EMERGENCIES** 

programme

# **COVID-19 Global Preparedness and Response Summary Indicators**<sup>a</sup>

#### Countries have a COVID-19 preparedness and response plan

N=195 91 % 47% . 100%

**Countries have a COVID-19 Risk** 

**Communication and Community Engagement** Plan (RCCE)<sup>b</sup> N=195



100% !

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

		N=195
44 %	7%	50%
22%		100%

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

N=195



#### Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 N=195



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

		N=195	
	89 %		11%
37%		1	00%

Countries that have defined essential health services to be maintained during the pandemic N=195

46 %	20%	34%
22%		100%

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

_		N=195
35 %	63%	
29%		100%

Countries have a health occupational safety plan for health care workers

_			N=195
27.7 %	6 %	66.7%	
17%			100%

**Countries have COVID-19 laboratory testing** capacity



Target value

**Baseline value** 

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 <u>Global Humanitarian and Response Plan</u>. A full list of priority countries can be found <u>here</u>.

### <u>Priority countries</u> with multisectoral mental health & psychosocial support working group



Priority countries that have postponed at least 1 vaccination campaign due to COVID-19<sup>c</sup>

	44%	56%	
0%	27%		

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



# <u>Priority countries</u> with an active & implemented RCCE coordination mechanism



# <u>Priority countries</u> with a contact tracing focal point



# <u>Priority countries</u> with an IPC focal point for training



**Target value** 

#### Notes:

c Source: WHO Immunization Repository



# HEALTH EMERGENCIES programme

### 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





# HEALTH EMERGENCIES programme

### Key links and useful resources



# **GOARN**

For updated GOARN network activities, click here.

#### **WHO** case definition

For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection, published December 2020, click <u>here.</u>

#### **EPI-WIN**

For EPI-WIN: WHO Information Network for Epidemics, click here

# **WHO Publications and Technical Guidance**

For updated WHO Publications and Technical Guidance on COVID-19, click <u>here</u>

For more information on COVID-19 regional response:



- Regional Office of the Americas
- Eastern Mediterranean Regional Office
- European Regional Office
- Southeast Asia Regional Office
- Western Pacific Regional Office

For the 13 April **Weekly Epidemiological Update**, click <u>here</u>. Highlights this week include:

a special focus update is provided on SARS-CoV-2 variants

#### News

- For the statement on the occasion of the holy month of Ramadan by Dr Ahmed Al-Mandhari, Regional Director for the Eastern Mediterranean, click <u>here</u>.
  - The COVID-19 pandemic is still a real and present threat. This Ramadan, it is more important than ever to remain vigilant and make compromises for the sake of our health, as well as the health of our communities and loved ones.
- For the open call for applications (due 9 May) for the WHO training in infodemic management, click <u>here</u>.



# **COVID-19 Weekly Epidemiological Update**

Data as received by WHO from national authorities, as of 11 April 2021, 10 am CET

In this edition:

- Global overview
- <u>Special focus: SARS-CoV-2 variants</u>
- WHO regional overviews
- <u>Key weekly updates</u>

### **Global overview**

Globally, new COVID-19 cases rose for a seventh consecutive week, with over 4.5 million new cases reported in the last week (Figure 1). The number of new deaths increased for the fourth consecutive week, increasing by 7% compared to last week, with over 76 000 new deaths reported. The largest increases in case incidence were observed in the South-East Asia (most notably in India) and the Eastern Mediterranean regions (Table 1). All regions, except for the African Region and the Americas, reported increases in the number of deaths, with the largest increase of 189% from the Western Pacific Region (largely driven by a steep increase in new deaths in the Philippines) followed by 47% in South-East Asia.

#### Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 11 April 2021\*\*





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

The highest numbers of new cases were reported from India (873 296 new cases; 70% increase), the United States of America (468 395 new cases; 5% increase), Brazil (463 092 new cases; 8% decrease), Turkey (353 281 new cases; 33% increase), and France (265 444 new cases; 9% increase).

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	1 427 623 (31%)	5%	58 025 495 (43%)	36 599 (48%)	-2%	1 405 254 (48%)
Europe	1 630 624 (36%)	-4%	47 547 449 (35%)	26 853 (35%)	7%	1 008 251 (35%)
South-East Asia	965 591 (21%)	63%	16 177 826 (12%)	6 331 (8%)	47%	228 385 (8%)
Eastern Mediterranean	364 456 (8%)	22%	8 057 550 (6%)	4 398 (6%)	19%	165 010 (6%)
Africa	50 710 (1%)	-14%	3 171 006 (2%)	1 022 (1%)	-5%	79 545 (3%)
Western Pacific	111 833 (2%)	6%	2 077 516 (2%)	1 570 (2%)	189%	33 474 (1%)
Global	4 550 837 (100%)	11%	135 057 587 (100%)	76 773 (100%)	7%	2 919 932 (100%)

#### Table 1. Newly reported and cumulative COVID-19 cases and deaths, by WHO Region, as of 11 April 2021\*\*

\*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior \*\*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, 5-11 April 2021\*\*

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

### Special Focus: Update on SARS-CoV-2 Variants

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 <u>Weekly Epidemiological Update</u>. Here we provide an update on the geographical distribution, and emerging evidence surrounding impacts of VOCs on COVID-19 epidemiology, vaccines and diagnostics. We also update on a recent global consultation, and emerging VOIs.

The number of countries reporting VOCs continue to increase (Table 2, Figures 3, 4 and 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.

On 29 March 2021, WHO convened a Global Consultation on a Decision Framework for Assessing the Impact of SARS-CoV-2 VOCs on Public Health Interventions. This was the first global forum of stakeholders to outline the global risk assessment and framework, including critical steps for the detection, monitoring, and assessment of SARS-CoV-2 variants, and to provide an overview of the available evidence on current VOCs and their impact on public health interventions. Using COVID-19 vaccines as an example, WHO and partners reviewed potential decision-making processes with respect to analysing the impact of VOCs, evaluating and modifying vaccines, and issuing policy recommendations. While the existing COVID-19 vaccines are still effective against VOCs, the consultation provided the opportunity to consider the overall process for making changes to vaccines, should they be needed. Following the consultation, WHO is working with partners to further define the global risk monitoring and assessment framework for SARS-CoV-2 variants to fully elaborate decision-making processes, including recommending any changes to vaccine composition, and triggers for such decision making. The meeting report will be published in the coming weeks. A follow up consultation is tentatively planned for June 2021.

#### Table 2: Overview of emerging information on key variants of concern, as of 13 April 2021\*

PANGO lineage         B.1.1.7         B.1.351         B.1.28.1, alias P.1*           GISAD clade         GR         GR         GR           Atternate names         VOC 202012/01*         VOC 202012/02         VOC 202010/02           First detected by         United Kingdom         South Africa         Brazil / Japan           Earliest sample(s)         20 September 2020         December 2020           Key spike mutations         H69/V70 deletion; Y144         L242/A23/L244 deletion; K417N;         K417T; E484K; N501Y           Common mutation         SL06/G107/F108 deletion in non-structural protein 6 (nsp6)         Increased (13×690%) <sup>2</sup> ; increased risk of hospital (15.0) (55% CI: 1.20-2.13) times more transmissible than previously circulating variants <sup>3</sup> Increased, 14.9 (59%CI: 0.30)         Increased (13×690%) <sup>2</sup> ; increased risk of hospital more transmissible than previously circulating variants <sup>3</sup> Severity         Possible increased risk of hospital mortality other studies showing limited ting titrs: still remained above the levels expected to confer protection <sup>11</sup> Possible increased risk of rom creased risk of rom formal mater opacity, septected to confer protection <sup>11</sup> Decreased neutralization capacity, reinfections reported from Moderna, and Prizer.         Decreased neutralization reduction from several from studies range from minimal to substantial reductions have been found for the Oxford-AstraZeneca, <sup>30</sup> /44. <sup>30</sup> United to modest
GISAID clade         GR         GH         GR           Alternate names         VOC 202012/01 <sup>3</sup> VOC 202012/02         VOC 202101/02           First detected by         United Kingdom         South Africa         Brazil / Japan           Earliest sample(s)         20 September 2020         Early August 2020         December 2020           Key spike mutations         H69/V70 deletion; Y144         L542/A243/L244 deletion; K417N; E484K; N501Y         K417T; E484K; N501Y           Common mutation         106/G107/F108 deletion in non-structural protein 6 (nsp6)         Increased (L50 (95% C: 1: 1.20-2.13) times increased acondary attack rate (11% (95%C: 10.9-11.2%); among closer contacts]?         Increased (15.0 (95% C: 1: 1.20-2.13) times increased increased risk of in-hospital more transmissible than previous circulating variants <sup>2</sup> .           Severity         Possible increased risk of in-hospital mortality?. Other studies showing limited impact/mixed findings. <sup>3,4,2</sup> Possible increased risk of in-hospital mortality by 20% <sup>4,10</sup> Under investigation, limited impact <sup>2</sup> Potential impacts on vaccines         Sight reduction in neutralization pacify but over enter stome evidence from several neutralization post- vaccines of more substantial loss for AstraZeneca, and Sinopharm vaccines <sup>11,10</sup> Post-vaccine neutralization reductions from several from studies, showade minimal to substantial for Moderna and prizer.         - United to modest reduction in post-vaccine from soute acdises was retained, but on demonaca Gamelya, Single studies found more substantial red
Alternate names         VOC 202012/01         VOC 202012/02         VOC 202101/02           First detected by         United Kingdom         South Africa         Brazil / Japan           Earliest sample(5)         20 September 2020         Early August 2020         December 2020           Key spike mutations         H69/V70 deletion; Y144         L242/A233/L244 deletion; K417N;         K417T; E484K; N501Y           Common mutation         Stof/G107/F108 deletion in non-structural protein 6         (nsp6)           Transmissibility         Increased (A3%-90%) <sup>1</sup> , increased risk of in-no-structural protein 6         (nsp6)           Increased (JS) (95% CI: 1.20.2.13) times increased risk of in-hospital mortality <sup>2</sup> , Other studies showing limited impact/ <sup>1</sup> .         Increased risk of in-hospital mortality <sup>2</sup> .         Possible increased risk of in-hospital mortality <sup>2</sup> .           Severity         Possible increased risk of in-dispital mortality <sup>2</sup> .         Possible increased risk of in-hospital mortality <sup>2</sup> .         Under investigation, limited impact <sup>3</sup> .           Assessment of potential impacts on vaccines         No or minimal impact on post-vaccine neutralization reductions from several from studies range from minimal to substantial for Moderna and Pizer.         • Norta-structure neutralization reductions from several from studies range from minimal to substantial for Moderna and Pizer.         • Substantial reduction in nost-vaccine neutralization reductions from several from studies found more substantial for Moderena and Pizer.         • Substantial reduction
First detected by     United Kingdom     South Africa     Brazil / Japan       Earlest sample(s)     20 September 2020     Early August 2020     December 2020       Key spike mutations     He6/V70 deletion; Y144 deletion; Y144 deletion; Y145/70D; and P681H     E438/4, NS01Y     E438/4, NS01Y       Common mutation     1006/6107/F108 deletion in non-structural protein 6 (nsp6)     Increased (43%-90%)*, increased scondary attack rate (11% (95%C: 10.9-11.2%) among closer contacts) <sup>2</sup> Increased (15.0 (95% C: 1.2.02.13) times transmissible than previously circulating variants <sup>3</sup> .4     Increased, nore transmissible than previously circulating variants <sup>3</sup> .4       Severity     Possible increased risk of hospitalization <sup>6</sup> , severity and mort limigs. <sup>1,4,3</sup> Possible increased risk of in-hospital mortality'. Other studies showing limited impact/mixed findings. <sup>1,4,3</sup> Decreased neutralization capacity, suggesting potential increased risk of reinfection <sup>1,12,1,3</sup> Decreased neutralization reported <sup>1,4,15</sup> Potential impacts on vaccines     • No or minimal impact on post- vacine neutralization to Sinopharm vaccines <sup>11,14,15,8,31</sup> ; however there is some evidence of more substantial los for Astra2eneca, Movava, Bharat, Gamaleya, and Sinopharm vaccines <sup>11,14,15,8,31</sup> ; however there is some evidence of more substantial los for Astra2eneca, Movava, Bharat, Gamaleya, Sinopharm, and Sinovava vacines have each be evaluated by singl studies reporting no significant reporting no Signif
Earliest sample(s)     20 September 2020     Early August 2020     December 2020       Key spike mutations     H69/V70 deletion; Y144 deletion; Y017; AS700; and P681H     242/A23/L244 deletion; K417N; E484K; NS01Y     K417T; E484K; NS01Y       Common mutation     S106/G107/F108 deletion in non-structural protein 6 (nsp6)     Increased (43%-90%) <sup>1</sup> , increased secondary attack rate increased secondary attack rate increased isk of hospitalization <sup>5</sup> , severity and mortality <sup>1</sup> . Other studies showing limited impact/mixed findings <sup>1,8,9</sup> Increased isk of hospitalization <sup>5</sup> , severity and mortality <sup>1</sup> . Other studies showing limited impact/mixed findings <sup>1,8,9</sup> Increased isk of hospitalization capacity, suggesting potential increased risk of neutralization capacity but overall neutralization capacity but overall neutralization post- vaccines     Decreased neutralization reductions from several from studies range from minimal to substantial for Moderna and Pfizer <sup>4</sup> .     Under investigation, limited inpost vaccine from several from studies range from minimal to substantial for Moderna and Pfizer <sup>4</sup> .     • Limited to modest reduction from several from studies range from minimal to substantial for Moderna and Pfizer <sup>4</sup> .     • Limited to modest reduction in post vaccine for the Oxford-AstraZeneca, <sup>3</sup> .     • Efficacy against disease was retained in provertion of disease by Oxford- AstraZeneca, Novawa, and Pfizer <sup>4</sup> .     • Single studies forum der Sinoparm.     • Vereliminary vaccine effectiveness of Sinova ci settings without this variant. <sup>4,4</sup> • No significant reduction from teduction in neutralization tapage in prevention of disease by Oxford- AstraZeneca, Novawa, and Pfizer <sup>4</sup> .     • Increased fisk of refectiveness of Sinova ci effectiveness of Sinova ci in fection l
Key spike mutations       H69/V70 deletion; Y144 deletion; NS01Y, A5700; and P681H       L242/A243/L244 deletion; K417N; E484K; NS01Y       K417T; E484K; NS01Y         Common mutation       S106/G107/F108 deletion in non-structural protein 6 (nsp6)       Increased (13.50 (95% CI: 1.20-2.1.3) times more transmissible than previously circulating variant <sup>5,4</sup> Increased (13.50 (95% CI: 1.20-2.1.3) times more transmissible than previously circulating variant <sup>5,4</sup> Increased (13.50 (95% CI: 1.20-2.1.3) times more transmissible than previously circulating variant <sup>5,4</sup> Severity       Possible increased risk of hospitalization <sup>6</sup> ; severity and mortality: Other studies showing limited impact/mixed findings <sup>1,4,9</sup> Decreased neutralization capacity, suggesting potential increased risk of reinfection/breakthrough       Under investigation, limited impact <sup>2</sup> Potential impacts on vaccines       No or minimal impact on post- wacine neutralization transmissible than previously circulating variantial for Moderna and Pfizer.       Post-vaccine neutralization reductions from several form studies rang from minimal to substantial reductions have been found for the Oxford-AstraZeneca, Novava, Bharat, Gamaleya, Sinopharm, and Sinovax cucines <sup>1,1,1,24</sup> • Nois minimary suggestion of loss of neutralization for Sinovac.       • Limited to modest reduction for Sinovac.         • No significant reduction fin cotarge transmissible than previous of infection limited. Reduced effect reported for Oxford-AstraZeneca, Novava, and Pfizer* <sup>12</sup> • Limited to modest reduction for Sinovac.       • Limited to modest reduction for Sinovac.         • No significant reduction for Novavax and Bansen vaccines whe
deletion; N501Y; Å570D; and P681H     E484K; N501Y     Increased (as: 005% CI: 120-213) times increased secondary attack rate increased secondary attack rate increased secondary attack rate increased (as: 0105% CI: 120-213) times increased secondary attack rate intreased (as: 0105% CI: 120-213) times increased secondary attack rate intreased (as: 0105% CI: 120-213) times increased secondary attack rate intreased secondary attack rate intreased secondary attack rate intreased isk of hospitalization <sup>5</sup> , severity and mortality <sup>7</sup> . Other studies showing limited impact/mixed findings <sup>1, 1, 2</sup> Possible increased risk of in-hospital mortality by 20% <sup>410</sup> Under investigation, limited impact <sup>5</sup> Assessment of potential reinfection/breakthrough vaccines     • Nos or minimal impact on pos- vaccine neutralization capacity, suggesting potential increased risk of neutralization by Moderna, Pfize-BioNTech, Oxford-AstraZeneca, Novava, Bharat, Gamaleya, and Sinopharm vaccines <sup>11,1,1,2,1,1</sup> however there is some evidence of more substantial loss for AstraZeneca, Novava, Bharat, Gamaleya, Sinopharm, and Sinova vaccines hueutralization reported for Oxford- AstraZeneca, Novava, and Sinopharm vaccines <sup>11,1,1,2,1,1</sup> however there is some evidence of more substantial loss for AstraZeneca, Novava, and Sinova vaccines hueutralization, <sup>14,4</sup> • No significant change in prevention of lifection limited. Reduced effect reported for Oxford- AstraZeneca, Novava, and Pfizer <sup>14,13</sup> • Minimal to modest reduction for Sinovac.     • Minimal to substantial reduction for Sinovac.     • Limited to modest reduction for Sinovac more substantial reduction in norstrav vaccine afficacy against severed diseave was not assessed.     • Limited to modest reduction in post intervials, while effectiveness of Sinovac in setting of P.1 was estimated in Brazif <sup>1</sup> • Inferential Informate prevention of lindex redu
P681H         St06/G107/F108 deletion in non-structural protein 6 (nsp6)           Transmissibility         Increased (43%-90%) <sup>1</sup> , increased secondary attack rate [11% (95%C1: 10.9-11.2%) among doser contacts] <sup>2</sup> Increased [1.50 (95% C1: 1.20-2.13) times among doser contacts] <sup>2</sup> Increased [1.50 (95% C1: 1.20-2.13) times among doser contacts] <sup>2</sup> Increased isk of hospitalization's severity and mortality'. Other studies showing limited impact/mixed findings <sup>1.4.9</sup> Descreased risk of indings <sup>1.4.9</sup> Under investigation, limited impact <sup>1</sup> Assessment of potential reinfection/breakthrough         Slight reduction in neutralization capacity but overall neutralizing titers still remained above the levels expected to confer protection <sup>11</sup> Decreased neutralization capacity, suggesting potential increased risk of neutralization to post- vaccine neutralization by Moderna, Pizer-BioNTech, Oxford-AstraZeneca, <sup>32</sup> Post-vaccine neutralization reductions from several from studies range from more substantial reductions have been form to Substantial for Moderna and Prizer.         Ilmited to modest reduction for the Oxford-AstraZeneca, <sup>32</sup> Ilmited inpact*           No or minimal impact on post- vaccines         No or minimal impact on post- vaccine neutralization, <sup>31,16</sup> Substantial reductions have been form esvisatantial reductions have been for the Oxford-AstraZeneca, <sup>32</sup> Ilmited inpact*.         Ilmited inpact*.           No significant change in prevention of infection inneutralization. * No significant change in prevention of disease by Oxford- AstraZeneca, Novavax, and Prizer* <sup>327</sup> Significant change in prevention of disease by Oxford- AstraZeneca, Novavax, and Prizer
Common mutation         \$106/G107/F108 deletion in non-structural protein 6 (nsp6)           Transmissibility         Increased (43%-90%) <sup>1</sup> , increased (secondary attack rate [11% (95%CI: 10.9-11.2%) among closer contacts] <sup>2</sup> Increased (nsp6)         Increased (nsp6)           Severity         Possible increased risk of hospitalization <sup>6</sup> , severity and mortality <sup>1</sup> . Other studies showing limited impact/mixed findings <sup>1.8,9</sup> Possible increased risk of increased neutralization capacity, suggesting potential increased risk of neutralization capacity but overall neutralizing titters still remained above the levels         Decreased neutralization capacity, suggesting potential increased risk of reinfection <sup>1.12,13</sup> Decreased neutralization reductions reported <sup>16,13</sup> Decreased neutralization reductions for the Oxford-AstraZeneca product. <sup>23,40</sup> I.Linited to modest reduction in post-vaccine minimal to substantial for Moderna and Pfizer.         Post-vaccine neutralization reductions for the Oxford-AstraZeneca product. <sup>23,40</sup> I.Linited to modest reduction for the Oxford-AstraZeneca product. <sup>23,40</sup> I.Linited to modest reduction for the Oxford-AstraZeneca product. <sup>24,40</sup> I.Linited to modest reduction following vaccination in post-vaccine for the Oxford-AstraZeneca product. <sup>24,40</sup> I.Linited to modest reduction following vaccination in post-vaccine for the Oxford-AstraZeneca product. <sup>24,40</sup> Prelimi
TransmissibilityIncreased (43%-90%) <sup>1</sup> , increased secondary attack rate increased isSOGN 10_9-11_2%) among closer contacts] <sup>2</sup> Increased (150 (95% Ct : 1.20-2.13) times more transmissible than previously circulating variants <sup>4</sup> Increased, nore transmissible than previously circulating variants <sup>5</sup> SeverityPossible increased risk of hospitalization <sup>6</sup> , severity and mortality?. Other studies showing limited impact/mixed reinfection/breakthroughIncreased (150 (95% Ct : 1.20-2.13) times more transmissible than previously circulating variants <sup>4</sup> Increased, nore transmissible than previously circulating variants <sup>6</sup> Assessment of potential reinfection/breakthroughSlight reduction in neutralization capacity but overall neutralizing titers still remained above the levels expected to confer protection <sup>11</sup> Decreased neutralization reported to no for protection <sup>11</sup> Decreased neutralization reported to confer protection <sup>11</sup> Decreased neutralization support reported to no origin ficant oxford-Astra2eneca, Novavax, Bharat, Gamaleya, and Sinoyatar vaccines share ead, been evaluated by single studies reduction in neutralization. Sinoyation support on significant charge in prevention of infection limited. Reduced effect reduction in neutralization of disasse wara tained, but somewhat lower, in South Africa for the Novavax and Jansen vaccines when Sinovac <sup>47</sup> Initied impact. Preliminary vaccine efficary against severe disease wars not assessed attained of Oxford- Astra2eneca. <sup>30</sup> Initied Reduced effect regorted for Oxford- Astra2eneca. <sup>30</sup> Initie addition refution in more substantial reduction for Novavax and Jansen vaccine diftica or against severe disease was not assessedInitie additi
increased secondary attack rate [11% (95%CI: 10.9-11.2%) among closer contacts]2more transmissible than previously circulating variant3.4transmissible than previously circulating variant3.4SeverityPossible increased risk of hospitalization <sup>5</sup> , severity and mortality.1. Other studies showing limited impact/mixed findings 1.8.9Possible increased risk of in-hospital mortality by 20%4.10Under investigation, limited impact <sup>5</sup> Assessment of potential reinfection/breakthrough vaccineSlight reduction in neutralization capacity but overall neutralization post- vaccine neutralization post- vaccine neutralization post- vaccine neutralization post- vaccine neutralization post- vaccine neutralization spharm astraZeneca, Notavax, and Pfizer- Bhard, Gamaleya, Sinopharm, ad Sinova vaccines have each been evaluated by single study reporting no significant reported for Oxford- AstraZeneca, Novavax, and Pfizer-Post-vaccine neutralization for fixer- somewhat clower, in South ArtraZeneca, Novavax, and Pfizer- Sinovac in setting of P1 was estimated in prevention of infection limited. Reduced effect reported for Oxford- AstraZeneca, Novavax, and Pfizer Vost-vaccine reflection studies reported to setting of P1 was estimated in astal Sase, with wide confidence intrvals, while efficacy against mid-modrate COVID-19 dominat compared to setting of P1 was estimated in astal Sase, with wide confidence intrvals, while efficacy againt severe disease was netained, but setting of P1 was estimated in astall ses of Oxford- AstraZeneca, Novavax, and prevention of infection limited. Reduced effect reported for Oxford- AstraZeneca.32Post-vaccine elicase was netained, but setting of P1 was estimated inde
[11% (95%CI: 10.9-11.2%) among closer contacts]2circulating variant3.4circulating variant5.4SeverityPossible increased risk of hospitalization <sup>6</sup> , severity and mortality <sup>7</sup> . Other studies showing limited impact/mixed findings 1.8.9Possible increased risk of in-hospital mortality by 20%4.10Under investigation, limited impact 5Assessment of potential reinfection/breakthroughSlight reduction in neutralization capacity but overall neutralization type the levels expected to confer protection11Decreased neutralization required is of reinfection 5.12.13Decreased neutralization suggesting potential increased risk of reinfection 5.12.13Decreased neutralization capacity, reinfections reported 14.15Potential impacts on vaccine succine subtantial impact on post- vaccine sinopharm, and Sinova vaccines have each been evaluated by single studies reporting no significant reduction in neutralization.13.34 however there is some evidence of from severation for Sinoyacr.• Noi significant reduction sinopharm, and Sinova vaccines have each been evaluated by single studies reporting no significant reduction of disease by Oxford- AstraZeneca, Novavax, and prevention of infection limited. Reduced effect reported for Oxford- AstraZeneca.32Fellominary suggestion of loss of neutralization sub- settings without this variant.42 • No significant reported for Oxford- AstraZeneca.32• No significant reported for Oxford- AstraZeneca.32• No significant reported for Oxford- AstraZeneca.32•
Severitymong closer contacts}?Possible increased risk of hospitalization <sup>5</sup> , severity and mortality <sup>7</sup> . Other studies showing limited impact/mixed findings <sup>1,8,9</sup> Possible increased risk of in-hospital mortality by 20% <sup>4,10</sup> Under investigation, limited impact <sup>3</sup> Assessment of potential reinfection/breakthroughSlight reduction in neutralization capacity but overall neutralizing titers still remained above the levels expected to confer protection <sup>11</sup> Decreased neutralization readed risk of reinfection <sup>1,12,13</sup> Decreased neutralization capacity, suggesting potential increased risk of reinfection <sup>1,12,13</sup> Decreased neutralization capacity, reinfections reported <sup>14,15</sup> Potential impacts on vaccine vaccine sinopharm vaccines <sup>11,16,4331</sup> ; however thre is some evidence of more substantial loss for Astra2encea. <sup>32</sup> Post-vaccine neutralization post- stostmail reductions have been found for the Oxford-Astra2encea neutralization sinopharm vaccines <sup>11,16,4331</sup> ; however thre is some evidence of more substantial loss for Astra2encea. <sup>32</sup> • Not significant reduction for Sinovac- • Single studies reduction for Sinovac- • Single studies reporting no significant reporting of infection limited. Reduced effect reported for Oxford- Astra2encea, <sup>32</sup> • Single studies found modes reduction for Sinovac- • Single studies found modes reduction for Sinovac- • Single studies found modes reduction for Sinovac-• Preliminary suggestion of following vaccination with somewhat lower, in South Arica for
SeverityPossible increased risk of hospitalization <sup>6</sup> , severity and mortality <sup>7</sup> . Other studies showing limited impact/mixed findings <sup>1,8,9</sup> Possible increased risk of in-hospital mortality by 20% <sup>5,10</sup> Under investigation, limited impact <sup>5</sup> Assessment of potential reinfection/breakthroughSlight reduction in neutralization capacity but overall neutralization capacity but overall neutralization capacity. expected to confer protection <sup>11</sup> Decreased neutralization capacity, suggesting potential increased risk of reinfection <sup>3, 12, 13</sup> Decreased neutralization capacity, suggesting potential increased risk of reinfection <sup>3, 12, 13</sup> Decreased neutralization capacity, reinfections reported <sup>14, 15</sup> Potential impacts on vaccine• No or minimal impact on post- vaccine neutralization to Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax, Bharat, Gamaleya, Sinopharm, ad Sinovac vaccines have ead been evaluated by single studies reporting no significant reduction in neutralization. Beharat, Gamaleya, Sinopharm, ad Sinovac vaccines have ead been evaluated by single studies reporting no significant reporting for Oxford- AstraZeneca, Novavax, and Pfizer <sup>5-37</sup> Post-vaccine entervals, while efficacy against severe disease was not assessed• Limited inmact <sup>5</sup> • No significant change in prevention of infection limited. Reduced effect vastraZeneca, Novavax, and Pfizer <sup>5-37</sup> • No significant change in no settings without this variant struct vastraZeneca, Novavax, and Pfizer <sup>5-37</sup> • Preliminary suggestion of in sarsall study, SktraZeneca vaccine dificacy against severe disease was not assessed
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Assessment of potential reinfection/breakthroughSlight reduction in neutralization capacity but overall neutralization capacity. suggesting potential increased risk of reinfection <sup>3, 12, 13</sup> Decreased neutralization capacity, reinfections reported <sup>14, 15</sup> Potential impacts on vaccines• No or minimal impact on post- vaccine neutralization by Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax, Bharat, Gamaleya, and Sinopharm vaccines <sup>11, 16:93,31</sup> ; however there is some evidence of more substantial loss for AstraZeneca, <sup>32</sup> • Post-vaccine neutralization reductions have been found for Sinopharm. A single studies found modest reduction for Sinovac.• Limited to modest reduction in post-vaccine neutralization by Oxford- AstraZeneca, Moderna and Pfizer vaccines; however there is some evidence of more substantial loss for AstraZeneca, <sup>32</sup> • Umited to modest reduction for Sinopharm. A single studies found modest reduction for Sinovac.• Limited to modest reduction in post-vaccine more substantial reductions have been found for Sinovac and Jamsen vaccines when sotiv.V2 was dominant compared to settings without this variant. <sup>41, 42</sup> • Limited to modest reduction following vaccination with Sinovac <sup>47</sup> • No significant reduction limited. Reduced effect reported for Oxford- AstraZeneca. <sup>32</sup> • Novavax, and Pfizer <sup>35-37</sup> • Freliminary vaccine effectiveness of Sinovac in sotiv.V2 was dominant compared to settin
Assessment of potential reinfection/breakthroughSlight reduction in neutralization capacity but overall neutralizing titers still remained above the levels expected to confer protection <sup>11</sup> Decreased neutralization capacity, suggesting potential increased risk of reinfection <sup>3, 12, 13</sup> Decreased neutralization capacity, reinfections reported <sup>14, 15</sup> Potential impacts on vaccines• No or minimal impact on post- vaccine neutralization by Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax, Bharat, Gamaleya, and Sinopharm vaccines <sup>11, 15-30,31</sup> ; however there is some evidence of more substantial loss for astraZeneca, <sup>32</sup> • Post-vaccine neutralization subjest from several from studies range from minimal to substantial for Moderna and Pfizer vaccines; however there is some evidence of more substantial loss for astraZeneca, <sup>32</sup> • Limited to modest reduction from several from studies range from minimal to substantial reductions have been for Sinopharm. A straZeneca, <sup>32</sup> • Limited to modest reduction from several from studies range from minimal to substantial reductions have been found for Sinopharm. A single studies form found for Sinopharm. A single studies form for Sinovac and Sinovac and Janssen vaccines when softive vasa and Janssen vaccines when softive vasa and Janssen vaccine stude softings without this variant. <sup>41,42</sup> • Preliminary suggestion of loss of neutralization in get 21,82,38,45,46Preleminary suggestion of infection limited. Reduced effect reported for Oxford- AstraZeneca, <sup>32</sup> • Substantial study, AstraZeneca vaccine did not demonstrate avaccine efficacy against against severe disease was not assessed• Preliminary suggestion of loss of neutralization in setting of P.1 was estimated <br< th=""></br<>
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Potential impacts on vaccines• No or minimal impact on post- vaccine neutralization by Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax, Bharat, Gamaleya, and Sinopharm vaccines 11/163031; however there is some evidence of more substantial loss for AstraZeneca. <sup>32</sup> • Post-vaccine neutralization reductions from several from studies range from minimal to substantial for Moderna and Pfizer.• Limited to modest reduction in post-vaccine neutralization by Oxford- AstraZeneca, Moderna and Pfizer.• Bharat, Gamaleya, Sinopharm, and Sinovac vaccines have each been evaluated by single studies reporting no significant reduction in neutralization. <sup>33,34</sup> • No significant change in prevention of linesceb Oxford- AstraZeneca, Novavax, and Pfizer <sup>35-37</sup> • Efificacy against disease was retained, but somewhat lower, in South Africa for the Novavax and Janssen vaccines when S01Y-V2 was dominant compared to settings without this variant. <sup>41,42</sup> • In a small study, AstraZeneca vaccine did not demostrate vaccine efficacy against mild-moderate COVID-19 disease, with wide confidence intervals, while efficacy against severe disease was not assessed• Limited to modest reduction in post-vaccine neutralization by Oxford- AstraZeneca, Notavax, and Pfizer <sup>35-37</sup>
<ul> <li>Potential impacts on vaccines</li> <li>No or minimal impact on postvaccine neutralization by Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax, Bharat, Gamaleya, and Sinopharm vaccines <sup>11, 16-30,31</sup>; however there is some evidence of more substantial loss for AstraZeneca.<sup>32</sup></li> <li>Bharat, Gamaleya, Sinopharm, and Sinovac vaccines have each been evaluated by single studies reporting no significant reduction in neutralization.<sup>33, 34</sup></li> <li>No significant change in prevention of infection limited. Reduced effect reported for Oxford-AstraZeneca.<sup>32</sup></li> <li>Bustant Change in prevention of infection limited. Reduced effect reported for Oxford-AstraZeneca.<sup>32</sup></li> <li>StataZeneca.<sup>32</sup></li> <li>No significant change in prevention of infection limited. Reduced effect reported for Oxford-AstraZeneca.<sup>32</sup></li> <li>StataZeneca.<sup>32</sup></li> <li>No significant change in prevention of infection limited. Reduced effect reported for Oxford-AstraZeneca.<sup>32</sup></li> <li>Substantial study, AstraZeneca vaccine efficacy against severe disease was not assessed</li> </ul>
Potential impacts on vaccinesNo or minimal impact on post- vaccine neutralization by Moderna, Pfizer-BioNTech, Oxford-AstraZeneca, Novavax, Bharat, Gamaleya, and Sinopharm vaccines <sup>11, 1630,31</sup> ; however there is some evidence of more substantial loss for AstraZeneca. <sup>32</sup> Post-vaccine neutralization reductions from several from studies range from minimal to substantial reductions have been found for the Oxford-AstraZeneca product. <sup>29,40</sup> Minimal to modest reduction, however there is some evidence of more substantial loss for AstraZeneca. <sup>32</sup> Limited to modest reduction in post-vaccine meutralization by Oxford- AstraZeneca, Moderna and Pfizer.Bharat, Gamaleya, Sinopharm, and Sinovac vaccines have each been evaluated by single studies reporting no significant reduction in neutralization, <sup>33,34</sup> Single studies found more substantial reduction for Novavax and Gamaleya.Preliminary suggestion of loss of neutralization for Sinovac.No significant change in prevention of disease by Oxford- AstraZeneca, Novavax, and Pfizer <sup>35-37</sup> Efficacy against disease was retained, but softing without this variant. <sup>41,42</sup> Preliminary vaccine effectiveness of Sinovac in settings without this variant. <sup>41,42</sup> In a small study, AstraZeneca vaccine did not demonstrate vaccine efficacy against mild-moderate COVID-19 disease, with wide confidence intervals, while efficacy against severe disease was not assessedImited to modest reduction
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against severe disease was not assessed
and is undetermined. ***
<ul> <li>Information regarding vaccine impact on</li> </ul>
asymptomatic infection by SULY.V2
Potential impacts on Signed target failure (SGTE) No. None reported to date None reported to date
$\mathbf{v}_{\mathbf{v}}$
diagnostics limpact on Ag RDTs observed <sup>48</sup>
diagnostics     impact on Ag RDTs observed <sup>48</sup> Countries reporting cases     132 (2)     82 (2)
diagnostics     impact on Ag RDTs observed <sup>48</sup> Countries reporting cases (newly reported since the     132 (2)     82 (2)

<sup>+</sup>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/territories/areas.

#### Variant VOC 202012/01

Since our last update on 30 March, VOC 202012/01 has been detected in two additional countries. As of 13 April, a total of 132 countries across all six WHO regions have reported cases of this variant (Figure 3).

Several studies have shown increased transmissibility (including secondary attack rates), severity and mortality associated with VOC 202012/01 compared to non-VOC variants.<sup>1, 6-9, 49-53</sup> As mentioned in earlier publications, the likelihood of infection upon contact (secondary attack rate) is higher in people infected with VOC202012/01 than other variants. A recent technical briefing by Public Health England estimated the secondary attack rates to be 11% (95%CI: 10.9%-11.2%) higher among close contacts of cases who have not travelled between 5 January to 7 March 2021. Among the cases who travelled, secondary attack rates were estimated to be 1.9% (95% CI: 1.7%-2.2%); of note this population was not restricted to only close contacts and included several categories such as contacts on a plane linked by additional contact tracing.<sup>2</sup>

A recently published study which used datasets from several European countries and the United States of America estimated that VOC 202012/01 has a 43–93% higher reproduction number (95% CI: 38–130%) than previously circulating variants.<sup>1</sup> The study also assessed the severity of disease, but differing from other studies, suggested no clear evidence increased severity associated with VOC 202012/01; however, these estimates should be interpreted with caution given delays between infection and hospitalization or death (models were fitted through to 24 December 2020). Additionally, it has been shown that higher rates of transmission and case incidence may lead to more hospital admissions and strain on health systems – potentially impacting on patient outcomes. Two other recently published peer reviewed studies (an ecological study and a hospital-based cohort study) found no evidence of an association between VOC202012/01 and severe disease or death <sup>8, 9</sup>; again, the generalizability to these findings require further review against other evidence. Collectively, these studies highlighted the need for further research to better understand the impact of VOC 202012/01.

There is a growing body of evidence on vaccine-induced neutralizing antibody activity against VOC 202012/01, including for AstraZeneca, Moderna, Pfizer, Novavax, Bharat, Gamaleya, and Sinopharm vaccines.<sup>11, 16-30 31</sup> As noted in the <u>Weekly epidemiological Update published on 23 March</u>, the findings support that neutralizing activity is largely sustained against this variant. A recent evaluation of CD8+ T-cell from convalescent sera supports the likelihood of maintaining recognition of this variant; however, vaccine induced T-cell responses were not directly evaluated.<sup>55</sup> Evidence for vaccine protection against disease is available from randomized control trials and observational studies (AstraZeneca and Pfizer vaccines) and early evidence on prevention of infection of this variant by the AstraZeneca vaccine.<sup>55</sup>



#### Figure 3. Countries, territories and areas reporting SARS-CoV-2 VOC 202012/01 as of 13 April 2021

#### Variant 501Y.V2

Since the last update on 30 March, 501Y.V2 has been reported from two additional countries – totalling 82 countries across all six WHO regions (Figure 4).

Investigations from a recent study<sup>56</sup> showed five imported cases of variant 501Y.V2 was responsible for 14 transmission chains and a total 36 cases in France. It suggested that epidemiological characteristics, such as incubation period and transmissibility, seemed comparable to those described in China <sup>57-59</sup> before the emergence of the 501Y.V2 variant. This study also established that the secondary attack rate (confirmed or probable cases) was estimated at 76.9% and the tertiary attack rate was estimated at 73.3%. The study highlights that the lack of tertiary transmission outside of the personal sphere suggests that distancing and barrier measures were effective.

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.<sup>3, 18, 21, 24, 25, 27-29, 40, 46, 60, 61</sup> Findings from four recent studies report substantial reductions in neutralizing antibody activity for Moderna (9.7-fold reduction), Pfizer-BioNTech (14-fold and 8.8-fold reductions)<sup>30</sup>, Novavax (14.5-fold reduction) and Gamaleya (6.8-fold reduction) vaccines.<sup>22, 24, 61</sup> However, some studies report smaller reductions for Moderna and Pfizer-BioNTech vaccines.<sup>21, 26, 40</sup> Another recent study found 2.4 to 3.3-fold reductions in neutralizing activity induced by the Sinovac and Sinopharm vaccines.<sup>34</sup> Adding to the previously cited T-cell analyses from the <u>30 March update</u>, which suggested a likely maintenance of function, a further analysis of CD8+ T-cell responses from convalescent sera which also support the likely retention of function.<sup>55, 62</sup>



#### Figure 4. Countries, territories and areas reporting SARS-CoV-2 501Y.V2 as of 13 April 2021

#### Variant P.1

Since our last update, variant P.1 has been reported in seven additional countries. As of 13 April, this variant is reported in 52 countries across all six WHO regions (Figure 5).

Genomic surveillance and modelling studies based in Brazil suggest higher transmissibility of the P.1 variant when compared to Brazilian non-P.1 lineages.<sup>15, 63, 64</sup> Moreover, case fatality rates in Brazil increased in people older than 20 years in February 2021, when compared to January 2021, suggesting a potential association between P.1 and more severe disease.<sup>65</sup> Akin to similar observations with other VOCs elsewhere, it will be important to disentangle changes in disease severity from impacts of increased transmissibility/high incidence adding pressures to health systems and adversely impacting patient outcomes.

A recent study carried out in Italy in settings where both P.1 and VOC 202012/01 were co-circulating at significant levels highlighted that the P.1 variant was outcompeted by VOC 202012/01, which rapidly dominated in the majority of regions. The same study also highlighted potential cross-protection across variants.<sup>66</sup>

In Brazil, the proportion of variant P.1 increased from 28% of specimens collected in January 2021 to 73% in March 2021, based on the data generated from the Fiocruz Genomic Network and GISAID (Figure 5).<sup>67</sup> By geographic region of specimen collection, the proportion of variant P.1 was higher in the South east and North regions, which includes Amazonas State, compared to other regions.



# Figure 5. Proportion of lineages of SARS-CoV-2 identified in Brazil by month of sampling, February 2020 – March 2021



Several studies have measured the neutralization of variant P.1 by sera from those vaccinated with Pfizer, Moderna, AstraZeneca or Sinovac, including a recent report from the phase III randomized control trial of Sinovac in Brazil reporting seroconversion.<sup>17, 21, 25, 26, 28, 29, 46, 68, 69</sup> Based on these findings, the neutralization activity was reduced by 1.7 to 10-fold depending on the vaccine and individuals; for some vaccines, there was substantial variability in results across studies. One T-cell study concluded that responses against this variant were largely preserved and a recent CD8+ T-cell study of convalescent sera also inferred likely retention of activity.<sup>55</sup> Preliminary clinical outcome data are currently limited to a recent matched testnegative case-control study of healthcare workers in Manaus, Brazil at a time when P.1 was prevalent. It found the Sinovac vaccine to be 49.6% effective against symptomatic COVID-19 and 35.1% effective against asymptomatic infection, though these findings have not yet been peer-reviewed.<sup>70</sup>



#### Figure 6. Countries, territories and areas reporting SARS-CoV-2 P.1 variant as of 13 April 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 <u>working definitions</u>). 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 13 April 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.

Nextstrain clade	PANGO lineage	GISAID clade	Alternate names	First detected by	Earliest samples	Key spike mutations
20C	B.1.525	G/484K.V3	-	United Kingdom and Nigeria	Dec 2020	H69-V70 deletion; Y144 deletion; Q52R; E484K; Q677H; D614G; and F888L
20C/S.452R	B.1.427/B.1.429	GH/452R.V1	CAL.20C/L452R	United States of America	Jun 2020	L452R; W152C; S13I; and D614G
20B/S.484K	B.1.1.28.2, alias P.2	GR	-	Brazil	Apr 2020	L18F; T20N; P26S; F157L; E484K; D614G; S929I; and V1176F
Not yet assigned	B.1.1.28.3, alias P.3	Not yet assigned	PHL-B.1.1.28	Philippines and Japan	Feb 2021	141-143 deletion E484K; N501Y; and P681H
20C	B.1.526 with E484K or S477N	GH	-	United States of America	Nov 2020	L5F; T95I; D253G; D614G; A701V; and E484K or S477N
20C	B.1.616	GH	-	France	Jan 2021	G142 deletion; D66H; Y144V; D215G; V483A; D614G; H655Y; G669S; Q949R; and N1187D

#### Table 3: Overview of variants of interest (VOIs), as of 13 April 2021\*

#### **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, hospitalizations and deaths. 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.
- <u>COVID-19 new variants: Knowledge gaps and research</u>
- 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

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# **WHO regional overviews**

#### **African Region**

The African Region reported over 50 000 new cases and over 1000 new deaths, a 14% and a 5% decrease respectively compared to the previous week. Weekly cases incidence has fluctuated since late February 2021; however, deaths have continued an overall downward trend. The highest numbers of new cases were reported from Ethiopia (13 944 new cases; 12.1 new cases per 100 000 population; a 4% decrease), Kenya (7107 new cases; 13.2 new cases per 100 000; a 19% decrease), and South Africa (6026 new cases; 10.2 new cases per 100 000; a 14% decrease).

The highest numbers of new deaths were reported from South Africa (302 new deaths; 0.5 new deaths per 100 000 population; a 1% decrease), Ethiopia (210 new deaths; 0.2 new deaths per 100 000; a 38% increase), and Kenya (124 new deaths; 0.2 new deaths per 100 000; a 22% increase).



#### **Region of the Americas**

The Region of the Americas reported over 1.4 million new cases and over 36 000 new deaths, a 5% increase and 2% decrease respectively compared to the previous week. Cases have overall gradually increased since mid-February 2021. The highest numbers of new cases were reported from the United States of America (468 395 new cases; 141.5 new cases per 100 000; a 5% decrease), Brazil (463 092 new cases; 217.9 new cases per 100 000; an 8% decrease), and Argentina (124 728 new cases; 276.0 new cases per 100 000; a 52% increase).

The highest numbers of new deaths were reported from Brazil (20 512 new deaths; 9.7 new deaths per 100 000; a 3% decrease), the United States of America (5173 new deaths; 1.6 new deaths per 100 000; a 31% decrease), and Mexico (3166 new deaths; 2.5 new deaths per 100 000; a 6% increase).



#### **Eastern Mediterranean Region**

The Eastern Mediterranean Region reported over 364 000 new cases and just under 4400 new deaths, a 22% and a 19% increase respectively compared to the previous week. Upward trends in cases and deaths reported since February have continued, with steep increases this week compared to the previous week. The highest numbers of new cases were reported from the Islamic Republic of Iran (128 684 new cases; 153.2 new cases per 100 000; a 75% increase), Iraq (49 955 new cases; 124.2 new cases per 100 000; a 22% increase), and Jordan (35 520 new cases; 348.1 new cases per 100 000; a 21% decrease).

The highest numbers of new deaths were reported from the Islamic Republic of Iran (1233 new deaths; 1.5 new deaths per 100 000; a 78% increase), Pakistan (632 new deaths; 0.3 new deaths per 100 000; a 17% increase), and Jordan (578 new deaths; 5.7 new deaths per 100 000; a 12% decrease).



#### **European Region**

The European Region reported over 1.6 million new cases and over 26 000 new deaths, a 4% decrease and a 7% increase respectively compared to the previous week. The decrease in cases this week was reported after six consecutive weeks of increases since late February. Deaths continued to increase for a fifth week. The highest numbers of new cases were reported from Turkey (353 281 new cases; 418.9 new cases per 100 000; a 33% increase), France (265 444 new cases; 408.1 new cases per 100 000; a 9% increase), and Poland (136 089 new cases; 358.5 new cases per 100 000; a 27% decrease).

The highest numbers of new deaths were reported from Poland (3480 new deaths; 9.2 new deaths per 100 000; a 14% increase), Italy (3219 new deaths; 5.4 new deaths per 100 000; a 5% increase), and Ukraine (2681 new deaths; 6.1 new deaths per 100 000; a 13% increase).



#### South-East Asia Region

The South-East Asia Region reported over 965 000 new cases and over 6300 new deaths, a 63% and a 47% increase respectively compared to the previous week. There were steep increases in both cases and deaths, and the highest number of weekly cases was reported in the Region since the beginning of the pandemic. The highest numbers of new cases were reported from India (873 296 new cases; 63.3 new cases per 100 000; a 70% increase), Bangladesh (48 660 new cases; 29.5 new cases per 100 000; a 26% increase), and Indonesia (35 344 new cases; 12.9 new cases per 100 000; a 1% decrease).

The highest numbers of new deaths were reported from India (4652 new deaths; 0.3 new deaths per 100 000; a 51% increase), Indonesia (1201 new deaths; 0.4 new deaths per 100 000; a 37% increase), and Bangladesh (448 new deaths; 0.3 new deaths per 100 000; a 30% increase).



#### Western Pacific Region

The Western Pacific Region reported over 111 000 new cases and over 1500 new deaths, a 6% and a 189% increase respectively compared to the previous week. For a fifth consecutive week, the number of cases increased. The sharp rise in deaths were attributed to steep increases in deaths in the Philippines. The highest numbers of new cases were reported from the Philippines (69 164 new cases; 63.1 new cases per 100 000; a 3% decrease), Japan (20 536 new cases; 16.2 new cases per 100 000; a 28% increase), and Malaysia (9507 new cases; 29.4 new cases per 100 000; a 6% increase).

The highest numbers of new deaths were reported from the Philippines (1321 new deaths; 1.2 new deaths per 100 000; a 400% increase), Japan (161 new deaths; 0.1 new deaths per 100 000; a 15% decrease), and Malaysia (35 new deaths; 0.1 new deaths per 100 000; similar to the previous week).



# Key weekly updates

#### WHO Director-General's key message

#### Opening remarks at the media briefing on COVID-19 – 9 April 2021:

- A total of 196 countries have started vaccination.
- More than 700 million vaccine doses have been administered globally, but over 87% have gone to high income or upper middle-income countries, while low-income countries have received just 0.2%.
- WHO, Gavi, CEPI and other COVAX partners are working on several options for accelerating production and supply.

#### World Health Day

- World Health Day 2021: Building a fairer, healthier world
- For World Health Day, 7 April 2021, WHO issued five calls for urgent action to improve health for all
- <u>"Give a Breath for Health" campaign launched on World Health Day to kickstart global effort for</u> <u>purchasing oxygen and other life-saving supplies and therapeutics for COVID-19 patients starting in the</u> <u>Americas</u>

#### Publications

- Interim statement of the COVID-19 subcommittee of the WHO Global Advisory Committee on Vaccine Safety on AstraZeneca COVID-19 vaccine
- COVAX reaches over 100 economies, 42 days after first international delivery
- WHO COVID-19 infection prevention and control (IPC) pillar achievements, Feb 2020 Jan 2021
- Safe Ramadan practices in the context of COVID-19

#### Events

• <u>Webinar: Infection prevention and control and public health and social measures in light of the variants</u> of concern, 21 April 2021

# Technical guidance and other resources

- Technical guidance
- <u>WHO Coronavirus Disease (COVID-19) Dashboard</u>
- Weekly COVID-19 Operational Updates
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- <u>Research and Development</u>
- Online courses on COVID-19 in official UN languages and in additional national languages
- <u>The Strategic Preparedness and Response Plan (SPRP)</u> outlining the support the international community can provide to all countries to prepare and respond to the virus
- Updates from WHO regions:
  - o African Region
  - o <u>Region of the Americas</u>
  - o Eastern Mediterranean Region
  - o South-East Asia Region
  - o European Region
  - o Western Pacific Region
- Recommendations and advice for the public:
  - o <u>Protect yourself</u>
  - o <u>Questions and answers</u>
  - o <u>Travel advice</u>
- 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 11 April 2021\*\*

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Africa	50 710	3 171 006	282.6	1 022	79 545	7.1	
Ethiopia	13 944	227 255	197.7	210	3 146	2.7	Community transmission
Kenya	7 107	145 184	270.0	124	2 330	4.3	Community transmission
South Africa	6 026	1 557 527	2 626.1	302	53 256	89.8	Community transmission
Cameroon	3 417	57 337	216.0	72	851	3.2	Community transmission
Madagascar	2 286	27 548	99.5	44	493	1.8	Community transmission
Botswana	1 796	42 674	1 814.7	45	636	27.0	Community transmission
Mali	1 273	11 705	57.8	14	405	2.0	Community transmission
Zambia	1 118	89 918	489.1	11	1 226	6.7	Community transmission
Rwanda	1 100	23 343	180.2	3	314	2.4	Community transmission
Тодо	883	11 947	144.3	6	116	1.4	Community transmission
Algeria	854	118 378	270.0	24	3 126	7.1	Community transmission
Côte d'Ivoire	819	45 145	171.1	14	261	1.0	Community transmission
Cabo Verde	808	18 629	3 350.6	6	177	31.8	Community transmission
Gabon	773	20 636	927.2	8	127	5.7	Community transmission
Angola	752	23 331	71.0	10	550	1.7	Community transmission
Namibia	742	45 323	1 783.7	33	564	22.2	Community transmission
Nigeria	623	163 736	79.4	2	2 060	1.0	Community transmission
Ghana	586	91 260	293.7	10	754	2.4	Community transmission
Mozambique	573	68 578	219.4	7	789	2.5	Community transmission
Guinea	488	20 807	158.4	4	133	1.0	Community transmission
Senegal	411	39 364	235.1	14	1 077	6.4	Community transmission
Congo	403	10 084	182.7	2	137	2.5	Community transmission
Zimbabwe	362	37 273	250.8	14	1 538	10.3	Community transmission
Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
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Democratic Republic of the Congo	250	28 542	31.9	0	745	0.8	Community transmission
Burundi	243	3 154	26.5	0	6	0.1	Community transmission
Central African Republic	220	5 465	113.2	2	74	1.5	Community transmission
Equatorial Guinea	211	7 219	514.5	3	106	7.6	Community transmission
Benin	202	7 515	62.0	0	93	0.8	Community transmission
Seychelles	196	4 490	4 565.5	2	24	24.4	Community transmission
Malawi	166	33 805	176.7	8	1 127	5.9	Community transmission
Burkina Faso	153	12 956	62.0	2	152	0.7	Community transmission
Uganda	151	41 113	89.9	2	337	0.7	Community transmission
Gambia	143	5 602	231.8	3	168	7.0	Community transmission
Eritrea	113	3 447	97.2	0	10	0.3	Community transmission
Mauritania	88	18 005	387.2	1	450	9.7	Community transmission
South Sudan	85	10 340	92.4	2	114	1.0	Community transmission
Mauritius	78	1 112	87.4	0	12	0.9	Community transmission
Comoros	49	3 831	440.5	0	146	16.8	Community transmission
Niger	39	5 072	21.0	0	188	0.8	Community transmission
Chad	27	4 616	28.1	3	167	1.0	Community transmission
Eswatini	26	17 373	1 497.5	1	669	57.7	Community transmission
Sao Tome and Principe	23	2 263	1 032.6	0	35	16.0	Community transmission
Guinea-Bissau	17	3 678	186.9	1	66	3.4	Community transmission
Sierra Leone	6	3 993	50.1	0	79	1.0	Community transmission
Liberia	5	2 066	40.8	0	85	1.7	Community transmission
Lesotho	0	10 707	499.8	0	315	14.7	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesiii							
Réunion	922	17 508	1 955.5	8	123	13.7	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Mayotte	153	19 643	7 200.1	5	167	61.2	Community transmission
Americas	1 427 623	58 025 495	5 673.3	36 599	1 405 254	137.4	
United States of America	468 395	30 772 857	9 296.9	5 173	555 712	167.9	Community transmission
Brazil	463 092	13 373 174	6 291.5	20 512	348 718	164.1	Community transmission
Argentina	124 728	2 497 881	5 526.8	1 327	57 350	126.9	Community transmission
Colombia	76 158	2 504 206	4 921.5	1 506	65 283	128.3	Community transmission
Peru	60 174	1 628 519	4 939.1	1 954	54 285	164.6	Community transmission
Canada	50 442	1 045 278	2 769.5	249	23 251	61.6	Community transmission
Chile	49 044	1 068 522	5 589.6	792	24 213	126.7	Community transmission
Uruguay	26 378	137 946	3 971.1	322	1 363	39.2	Community transmission
Mexico	24 707	2 272 064	1 762.2	3 166	207 020	160.6	Community transmission
Paraguay	14 256	232 142	3 254.7	404	4 698	65.9	Community transmission
Ecuador	11 702	344 877	1 954.7	365	17 275	97.9	Community transmission
Venezuela (Bolivarian Republic of)	9 731	172 461	606.5	110	1 739	6.1	Community transmission
Guatemala	7 604	202 640	1 131.1	126	7 001	39.1	Community transmission
Cuba	7 190	85 572	755.5	22	453	4.0	Community transmission
Bolivia (Plurinational State of)	6 702	280 649	2 404.3	123	12 428	106.5	Community transmission
Honduras	4 822	194 548	1 964.2	144	4 766	48.1	Community transmission
Costa Rica	4 095	222 544	4 368.6	44	3 018	59.2	Community transmission
Dominican Republic	3 405	257 186	2 370.8	51	3 385	31.2	Community transmission
Panama	2 248	358 098	8 299.4	30	6 156	142.7	Community transmission
Jamaica	1 670	42 119	1 422.4	56	669	22.6	Community transmission
El Salvador	1 060	65 491	1 009.7	27	2 048	31.6	Community transmission
Guyana	512	10 958	1 393.2	17	252	32.0	Clusters of cases
Trinidad and Tobago	207	8 323	594.7	0	145	10.4	Community transmission
Bahamas	183	9 417	2 394.7	1	189	48.1	Clusters of cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Suriname	128	9 265	1 579.4	1	178	30.3	Clusters of cases
Haiti	52	12 840	112.6	0	251	2.2	Community transmission
Barbados	43	3 708	1 290.3	2	44	15.3	Community transmission
Nicaragua	40	5 366	81.0	1	179	2.7	Community transmission
Saint Lucia	40	4 329	2 357.5	3	64	34.9	Community transmission
Saint Vincent and the Grenadines	35	1 790	1 613.5	0	10	9.0	Community transmission
Belize	31	12 487	3 140.4	1	318	80.0	Community transmission
Antigua and Barbuda	12	1 182	1 207.0	2	30	30.6	Clusters of cases
Grenada	2	157	139.5	0	1	0.9	Sporadic cases
Dominica	0	165	229.2	0	0	0.0	Clusters of cases
Saint Kitts and Nevis	0	44	82.7	0	0	0.0	Sporadic cases
Territoriesiii							
Puerto Rico	4 339	113 200	3 956.9	26	2 152	75.2	Community transmission
Curaçao	1 798	10 632	6 479.3	22	60	36.6	Community transmission
Martinique	724	8 887	2 368.2	5	59	15.7	Community transmission
French Guiana	417	17 549	5 875.5	- 2	94	31.5	Community transmission
Guadeloupe	414	12 304	3 075.0	6	189	47.2	Community transmission
Bermuda	411	1 773	2 847.1	2	14	22.5	Community transmission
Aruba	393	9 896	9 268.9	6	92	86.2	Community transmission
Bonaire	90	1 475	7 052.4	3	14	66.9	Community transmission
United States Virgin Islands	40	2 971	2 845.1	0	26	24.9	Community transmission
British Virgin Islands	24	178	588.7	0	1	3.3	Clusters of cases
Sint Maarten	23	2 174	5 069.7	0	27	63.0	Community transmission
Saint Barthélemy	18	928	9 388.0	0	1	10.1	Clusters of cases
Saint Martin	16	1 703	4 405.2	0	13	33.6	Community transmission
Cayman Islands	15	516	785.1	0	2	3.0	Sporadic cases

Reporting	New cases	Cumulative	Cumulative cases per 100	New	Cumulative	Cumulative deaths per <u>100</u>	Transmission
Country/Territory/Area <sup>i</sup>	In last 7	cases	thousand	last 7 days	deaths	thousand	classification <sup>ii</sup>
	uays		population	last / days		population	
Falkland Islands (Malvinas)	8	60	1 722.7	0	0	0.0	Sporadic cases
Anguilla	4	29	193.3	0	0	0.0	Sporadic cases
Saint Pierre and Miquelon	1	25	431.4	0	0	0.0	No cases
Montserrat	0	20	400.1	0	1	20.0	No cases
Saba	0	6	310.4	0	0	0.0	No cases
Sint Eustatius	0	20	637.1	0	0	0.0	No cases
Turks and Caicos Islands	0	2 344	6 054.0	0	17	43.9	Clusters of cases
Eastern Mediterranean	364 456	8 057 550	1 102.5	4 398	165 010	22.6	
Iran (Islamic Republic of)	128 684	2 049 078	2 439.6	1 233	64 232	76.5	Community transmission
Iraq	49 955	918 155	2 282.7	248	14 678	36.5	Community transmission
Jordan	35 520	662 395	6 492.1	578	7 708	75.5	Community transmission
Pakistan	33 080	715 968	324.1	632	15 329	6.9	Community transmission
Lebanon	17 520	494 633	7 246.9	251	6 630	97.1	Community transmission
United Arab Emirates	13 914	481 937	4 872.8	25	1 529	15.5	Clusters of cases
Tunisia	11 962	270 297	2 287.0	304	9 235	78.1	Community transmission
Kuwait	9 715	245 704	5 753.4	64	1 403	32.9	Community transmission
Oman	7 987	168 005	3 289.9	66	1 747	34.2	Community transmission
Bahrain	7 632	155 402	9 132.8	23	554	32.6	Community transmission
Qatar	6 516	189 064	6 562.3	30	331	11.5	Community transmission
Libya	5 800	166 888	2 428.8	123	2 807	40.9	Community transmission
Saudi Arabia	5 627	397 636	1 142.2	57	6 747	19.4	Community transmission
Egypt	5 421	209 677	204.9	282	12 405	12.1	Community transmission
Morocco	3 856	501 688	1 359.2	49	8 891	24.1	Clusters of cases
Djibouti	1 213	9 722	984.0	21	93	9.4	Community transmission
Syrian Arab Republic	834	20 1 18	115.0	69	1 368	7.8	Community transmission
Somalia	648	12 271	77.2	59	605	3.8	Community transmission
Yemen	579	5 280	17.7	99	1 032	3.5	Sporadic cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Afghanistan	484	57 160	146.8	24	2 521	6.5	Community transmission
Sudan	0	31 833	72.6	0	2 063	4.7	Clusters of cases
Territories <sup>iii</sup>							
occupied Palestinian territory	17 509	294 639	5 775.6	161	3 102	60.8	Community transmission
Europe	1 630 624	47 547 449	5 095.8	26 853	1 008 251	108.1	
Kosovo <sup>[1]</sup>	4 492	97 424		70	1 966		Community transmission
Turkey	353 281	3 798 333	4 503.6	1 624	33 702	40.0	Community transmission
France	265 444	4 945 238	7 603.5	2 087	97 956	150.6	Community transmission
Poland	136 089	2 574 631	6 782.8	3 480	58 421	153.9	Community transmission
Germany	112 882	2 998 268	3 605.1	1 390	78 353	94.2	Community transmission
Ukraine	107 540	1 853 249	4 237.6	2 681	37 014	84.6	Community transmission
Italy	103 830	3 754 077	6 294.4	3 219	113 923	191.0	Clusters of cases
Russian Federation	60 496	4 641 390	3 180.5	2 612	102 986	70.6	Clusters of cases
Netherlands	47 307	1 342 329	7 711.2	150	16 754	96.2	Community transmission
Hungary	34 185	720 164	7 371.5	1 702	23 417	239.7	Community transmission
Romania	32 641	1 002 865	5 188.4	1 033	25 006	129.4	Community transmission
Sweden	30 382	857 401	8 302.0	22	13 621	131.9	Community transmission
Czechia	28 293	1 580 189	14 776.5	863	27 808	260.0	Community transmission
Spain	28 102	3 336 637	7 049.3	189	76 179	160.9	Community transmission
Serbia	25 111	639 476	9 232.0	278	5 700	82.3	Community transmission
Belgium	23 931	926 640	8 042.0	304	23 470	203.7	Community transmission
Greece	20 304	293 763	2 740.7	531	8 833	82.4	Community transmission
Austria	19 309	571 805	6 424.0	228	9 393	105.5	Community transmission
Bulgaria	19 272	371 531	5 344.6	844	14 351	206.4	Clusters of cases
Kazakhstan	17 348	323 208	1 721.3	151	3 963	21.1	Clusters of cases
The United Kingdom	16 290	4 368 049	6 434.4	254	127 080	187.2	Community transmission
Azerbaijan	14 865	283 579	2 796.9	231	3 879	38.3	Clusters of cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Switzerland	13 820	619 477	7 157.8	51	9 764	112.8	Community transmission
Croatia	12 490	292 516	7 208.1	250	6 308	155.4	Community transmission
Belarus	8 798	334 863	3 543.8	68	2 344	24.8	Community transmission
Bosnia and Herzegovina	8 279	183 125	5 581.7	555	7 358	224.3	Community transmission
North Macedonia	8 233	141 157	6 775.4	322	4 182	200.7	Community transmission
Slovenia	6 525	225 952	10 780.9	26	4 407	210.3	Clusters of cases
Republic of Moldova	6 492	240 886	5 971.4	277	5 369	133.1	Community transmission
Lithuania	6 462	226 173	8 094.7	78	3 687	132.0	Community transmission
Armenia	6 183	202 817	6 844.4	143	3 735	126.0	Community transmission
Slovakia	5 820	371 062	6 798.7	540	10 565	193.6	Clusters of cases
Norway	5 189	101 959	1 899.5	11	684	12.7	Community transmission
Estonia	4 775	114 174	8 591.1	79	1 020	76.8	Clusters of cases
Georgia	4 563	288 396	7 229.5	66	3 877	97.2	Community transmission
Denmark	4 383	237 101	4 072.0	11	2 439	41.9	Community transmission
Portugal	4 066	826 928	8 031.6	42	16 910	164.2	Clusters of cases
Cyprus	3 753	51 035	5 747.2	11	272	30.6	Clusters of cases
Latvia	3 373	107 240	5 621.5	63	1 986	104.1	Community transmission
Ireland	2 948	240 643	4 847.3	68	4 783	96.3	Community transmission
Finland	2 613	81 707	1 478.8	22	868	15.7	Community transmission
Albania	1 972	128 155	4 453.2	54	2 310	80.3	Clusters of cases
Israel	1 776	835 813	9 656.4	57	6 292	72.7	Community transmission
Montenegro	1 675	94 417	15 033.1	68	1 373	218.6	Clusters of cases
Luxembourg	1 545	63 650	10 166.0	18	768	122.7	Community transmission
Uzbekistan	1 299	84 922	253.7	3	634	1.9	Clusters of cases
Kyrgyzstan	1 213	90 227	1 383.0	16	1 522	23.3	Clusters of cases
Malta	359	29 548	5 742.3	5	402	78.1	Clusters of cases
Andorra	323	12 497	16 174.2	3	120	155.3	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
San Marino	151	4 956	14 603.1	1	85	250.5	Community transmission
Liechtenstein	64	2 842	7 334.8	0	54	139.4	Sporadic cases
Monaco	48	2 373	6 046.8	2	31	79.0	Sporadic cases
Iceland	33	6 258	1 718.6	0	29	8.0	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							
Isle of Man	4	1 574	1 851.1	0	29	34.1	No cases
Gibraltar	2	4 277	12 694.8	0	94	279.0	Clusters of cases
Jersey	1	3 230	2 996.4	0	69	64.0	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	1 273.5	0	14	21.7	Community transmission
South-East Asia	965 591	16 177 826	800.3	6 331	228 385	11.3	
India	873 296	13 358 805	968.0	4 652	169 275	12.3	Clusters of cases
Bangladesh	48 660	678 937	412.3	448	9 661	5.9	Community transmission
Indonesia	35 344	1 562 868	571.4	1 201	42 443	15.5	Community transmission
Thailand	3 498	32 625	46.7	2	97	0.1	Clusters of cases
Nepal	1 957	279 725	960.0	7	3 039	10.4	Clusters of cases
Sri Lanka	1 553	94 848	442.9	20	595	2.8	Clusters of cases
Maldives	873	25 524	4 721.9	0	67	12.4	Clusters of cases
Timor-Leste	294	1 008	76.5	1	1	0.1	Clusters of cases
Myanmar	97	142 576	262.0	0	3 206	5.9	Clusters of cases
Bhutan	19	910	117.9	0	1	0.1	Sporadic cases
Western Pacific	111 833	2 077 516	105.7	1 570	33 474	1.7	
Philippines	69 164	853 187	778.6	1 321	14 744	13.5	Community transmission
Japan	20 536	503 403	398.0	161	9 382	7.4	Clusters of cases

Reporting Country/Territory/Area <sup>i</sup>	New cases in last 7	Cumulative cases	Cumulative cases per 100 thousand	New deaths in	Cumulative deaths	Cumulative deaths per 100 thousand	Transmission classification <sup>ii</sup>
	days		population	last 7 days		population	
Malaysia	9 507	359 117	1 109.6	35	1 321	4.1	Clusters of cases
Mongolia	4 585	14 183	432.6	9	20	0.6	Clusters of cases
Republic of Korea	4 280	109 559	213.7	24	1 768	3.4	Clusters of cases
Papua New Guinea	1 585	8 442	94.4	7	68	0.8	Community transmission
Cambodia	1 549	4 238	25.3	10	29	0.2	Sporadic cases
China	216	103 083	7.0	2	4 853	0.3	Clusters of cases
Singapore	165	60 633	1 036.4	0	30	0.5	Sporadic cases
New Zealand	67	2 218	46.0	0	26	0.5	Clusters of cases
Viet Nam	63	2 692	2.8	0	35	0.0	Clusters of cases
Australia	55	29 396	115.3	0	909	3.6	Clusters of cases
Brunei Darussalam	5	219	50.1	0	3	0.7	Sporadic cases
Fiji	1	68	7.6	0	2	0.2	Sporadic cases
Lao People's Democratic Republic	0	49	0.7	0	0	0.0	Sporadic cases
Solomon Islands	0	19	2.8	0	0	0.0	No cases
Territoriesiii							
French Polynesia	19	18 652	6 639.9	0	141	50.2	Sporadic cases
Guam	19	7 625	4 517.8	0	136	80.6	Clusters of cases
Wallis and Futuna	16	441	3 921.4	1	5	44.5	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	1	160	278.0	0	2	3.5	Pending
Marshall Islands	0	4	6.8	0	0	0.0	No cases
New Caledonia	0	121	42.4	0	0	0.0	Sporadic cases
Samoa	0	4	2.0	0	0	0.0	No cases
Vanuatu	0	3	1.0	0	0	0.0	No cases
Global	4 550 837	135 057 587		76 773	2 919 9 <mark>32</mark>		

\*See Annex: Data, table and figure notes

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.28)
Albania			
Algeria	Verified		
Angola	Verified	Verified	
Argentina	Verified		Verified
Aruba	Verified		
Australia	Verified	Verified	
Austria	Verified	Verified	Verified
Azerbaijan	Verified		
Bahrain			
Bangladesh	Verified	Not 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	Verified	
Bulgaria	Verified		
Cabo Verde	Verified		
Cambodia	Verified		
Cameroon		Verified	
Canada	Verified	Verified	Verified
Cayman Islands	Verified		
Chile	Verified		Verified
China	Verified	Verified	Not Verified

Country/Territory/Area	VOC 202012/01	501Y.v2	P.1
Colombia	( <b>D</b> .1.1. <i>1</i> )	(B.1.351)	(B.1.1.28) Varified
		Varified	vermeu
		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		
Greece	Verified	Verified	
Grenada			
Guadeloupe	Verified		

## Annex 2. List of countries/territories/areas reporting variants of concern as of 13 April 2021\*\*

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

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

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

Country/Territory/Area	VOC 202012/01 (B.1.1.7)	501Y.v2 (B.1.351)	P.1 (B.1.1.2 <u>8)</u>
Thailand	Verified	Verified	
The United Kingdom	Verified	Verified	Verified
Тодо	Verified		
Trinidad and Tobago	Verified		
Tunisia	Verified		
Turkey	Verified	Not Verified	Not Verified
Turks and Caicos Islands	Verified		
Uganda			
Ukraine	Not Verified		
United Arab Emirates	Verified	Verified	Verified
United Republic of Tanzania		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	

\*\*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.

<sup>[1]</sup> 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.

<sup>i</sup> 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).

<sup>ii</sup> 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: <u>Considerations for implementing and adjusting public health and social measures in the context of COVID-19</u>:

- 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.

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

# Weekly Operational Update on COVID-19

## 12 April 2021

Issue No. 50



Confirmed cases<sup>a</sup> 135 646 617

# Confirmed deaths 2 930 732

# COVID-19 vaccines now in all countries of the Eastern Mediterranean Region

With the arrival of COVID-19 vaccines to Libya on 5 April, all 22 countries in the Eastern Mediterranean Region have received doses. To date, over 25 million doses have been administered regionally. As early as December 2020, countries began procuring vaccines from manufacturers, launching vaccination campaigns by early 2021.

The COVAX Facility delivered vaccines to 13 of

the countries, with the first shipment landing in Sudan on 3 March and the latest shipment arriving 5 April in Islamic Republic of Iran.

Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean, noted that despite progress, "we still see unfair distribution. Some countries have enough vaccines to protect their populations many times over, while others face significant shortages. COVID-19 cannot be defeated one country at a time. I urge all manufacturers and countries to join forces to ensure sufficient doses of vaccines. Our work needs to be guided by the need to protect people, save lives and end the pandemic. Political games and selfishness will not help, because no one is safe, until everyone is safe".

For further information, click here





Credit: WHO Country Office/Egypt

# Key Figures



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

More than **5 million** people registered on <u>OpenWHO</u> and accessing online training courses across **30** topics in **50** languages



globally



**198 747 426** medical masks shipped globally

8 659 511 face shields shipped globally



1 566 287 gloves shipped globally

**166** GOARN deployments conducted to support COVID-19 pandemic response



669 248 795 COVID-19 vaccine doses administered globally as of 8 April

<sup>a</sup> COVAX has shipped over **38** million vaccines to **104** participants as of 9 April

1

<sup>a</sup> See Gavi's <u>COVAX updates</u> for the latest COVAX vaccine roll –out data

For all other latest data and information, see the <u>WHO</u> <u>COVID-19 Dashboard</u> and <u>Situation Reports</u>





### From the field:

# Kingdom of Tonga receives 24 000 doses of COVID-19 vaccines through the COVAX facility

On 31 March 2021 the Kingdom of Tonga became the third country in the Pacific islands to receive COVID-19 vaccine doses with the arrival of 24 000 doses of the AstraZeneca/Oxford COVID-19 vaccine from the COVAX Facility to Nuku'alofa according to the Regional Office for the Western Pacific. The COVAX Facility is enabling equitable distribution of vaccines to countries which may not have direct access to manufacturers.

Dr Yutaro Setoya, Officer in Charge of the WHO Country Liaison Office for the Kingdom of Tonga said "Even though Tonga has no COVID-19 cases, the closure of the borders has an

intense impact on people's health, rights to nutrition, mental health...and the vaccination is a part of a larger strategy to strengthen health systems in Tonga for the longer term.

The COVID-19 vaccines are proven to protect people from severe disease and death. Used together with public health measures such as physical distancing and washing hands frequently, [this] will help mitigate the effects of the pandemic by reducing deaths and severe disease. This means Tonga can look at opening up gradually and the economic revival of the country."



Dr Yutaro Setoya, Officer in Charge, WHO Country Liaison Office for the Kingdom of Tonga, Minister for Health Hon Dr 'Amelia Tu'i'pulotu and other partners receive the vaccines in Nuku'alofa. Photo credit: WHO/Tonga

Minister for Health, Hon Dr 'Amelia Tu'i'pulotu, confirmed that the rollout will take place on Thursday 15 April 2021 and be implemented according to priority groups. The Ministry intends to first vaccinate frontline workers including staff from the Health Ministry and staff at airports and ports.

A National Technical Working Group (TWG) has been established to manage all aspects of the COVID-19 vaccine roll-out. The TWG is working closely with WHO and UNICEF to support health workers and all stakeholders involved in the rollout. This includes capacity building for frontline workers, coordinating resources for safe storage and vaccination capacity and providing timely information and knowledge to the public about the COVID-19 vaccine.

Tonga is not new to immunization campaigns and in the past the Health Ministry has had great success with vaccine rollout and community cooperation. It is anticipated that this rollout will be no different, as the Ministry continues to work together with the public in preparation for the national rollout.

The Ministry of Health acknowledges the support from the WHO, the New Zealand and Australian governments, Japan, and partners including the Asian Development Bank (ADB), World Bank and European Union, in obtaining vaccines to protect the people of Tonga from COVID-19.



### From the field:

# WHO's humanitarian health leadership in restoring essential services following a massive fire in the world's largest refugee camp

On 22 March 2021, a massive fire spread through three camps in the Rohingya refugee camp in Cox's Bazar, Bangladesh, causing eleven deaths, a significant number of injured and displaced more than 45 000 people.

Six health facilities were damaged or destroyed by the fire, including secondary health center а (Turkish Field Hospital) which played a key role as a referral facility in the camps. The WHO Emergency Preparedness and Response (EPR) stockpiling container located at the Turkish Field Hospital was damaged, losing medical supplies for the primary health care needs and emergency and trauma care of over 25 000 people.



An important secondary nearn facility in the Roningya refugee camps which is also housing a WHO container for emergency preparedness and response stockpiling, the Turkish Field Hospital was down to ashes within minutes. WHO Bangladesh

Restoration of essential health services remains a priority. WHO has rapidly coordinated the health sector emergency response to support the reestablishment of primary health care in the refugee camps, while strengthening the capacity of the healthcare workers in Cox's Bazar to manage burn injured patients and improve patient outcomes.

WHO logistical support with the supply of tents, equipment and medical commodities was provided to partners whose facilities were damaged or destroyed, including a Medical Camp Kit Tent to Reaching People in Need (RPN) to ensure the temporary provision of health services. To date, all primary health care facilities have restarted health services, at least on a limited scale. Discussions on reconstruction are currently ongoing, with the re-establishment of most health facilities expected shortly. Operational and logistic work is ongoing to ensure that the WHO Emergency Preparedness and Response (EPR) stockpiling container is fully functional for the upcoming monsoon and cyclone season.

Surveillance and reporting mechanisms were strengthened through Early Warning, Alert and Response System (EWARS), Mobile Medical Teams (MMTs) and health care facilities to timely detect, investigate and respond to any disease outbreak which could result from the fire incident, including Acute Water Diarrhea (AWD) and other priority communicable diseases.

WHO is working with the Turkish Field Hospital leadership and engineering to support the re-establishment of operational capacity. Equipment and supplies were provided, including 17 Trauma and Emergency Surgery Kits, 5 Interagency Emergency Health Kits with medicines and renewables, 1 cholera kit, 8 patient monitors and more.

For information on the immediate coordinated efforts to respond to the fire and recent trainings, click <u>here</u>.



### From the field:

# WHO supports Armenia to support and strengthen COVID-19 surveillance and contact tracing

During March 2021, WHO deployed technical expertise from the Regional Office for Europe to Armenia for a fourweek mission to work with WHO's country team in supporting Armenian health authorities to review and strengthen their COVID-19 surveillance and public health response measures.

Over the course of the mission, consultations were held with representatives



A shipment of 10 000 COVID-19 tests was procured by WHO to support Armenia's response to the pandemic. Credit: WHO

from the National Center for Disease Control (NCDC), Ministry of Health, and ARMED, the local e-health system provider.

These consultations helped inform several joint activities including:

- investigations of suspected COVID-19 re-infections and development of a methodology for reinfection surveillance;
- analyses of daily surveillance data and re-design of the national COVID-19 surveillance dashboard;
- > a review of the national contact tracing strategy currently in place; and
- > development of an algorithm for the selection of SARS-CoV-2 samples for sequencing.

A post-introduction review of the use of antigen rapid diagnostic tests (RDTs) for SARS-CoV-2 in Armenia was also performed. In epidemiological week 11, the effectiveness of RDTs in remote areas and for triage at hospitals was analyzed using the case-based data provided by the Armenian Ministry of Health.

Strengths and recommendations for improvement for the COVID-19 surveillance and epidemiological systems were submitted to the national health authorities at the close of the mission.



### **Risk Communication, Community Engagement and Infodemic Management**

#### Second WHO training in infodemic management: open call for applicants

As part of WHO's efforts to manage the infodemic in line with a comprehensive pandemic preparedness plan, WHO has opened applications for its second online global infodemic manager training in partnership with US Centers for Disease Control and Prevention (US CDC) and UNICEF.

There is an urgent need to address the infodemic in addition to the COVID-19 pandemic, as most countries are battling both. As the world accelerates the development and rollout of public health measures, making good health information accessible is as important as ever.

This training will generate crossdisciplinary infodemic managers that can be deployed to the field for infodemic response, build on the skills of national health authority staff in infodemic management and offer the opportunity for United Nations staff to learn more about it.



In the first training, nearly 300 participants from 78 countries across all six WHO regions were trained. Upon completion of the training, trainees who become WHO-certified infodemic managers will be added to a WHO roster for global deployments to different country assignments. Several trainees from the first cohort have already deployed, working on infodemic management with WHO and partners.

WHO, US CDC, UNICEF and partners invite applications from experienced professionals from the fields of epidemiology, behavioural science, risk communication, health service delivery/health care workers, digital health, policy making (in health and intersectoral), who are responding to the current COVID-19 and overlapping infodemics at country level.

- Online training runs for four weeks from 1 30 June 2021
- > Deadline for submission is 9 May 2021 at 18:00 Geneva, Switzerland time

Find the full guidelines for how to apply and further information on the training here.



### **COVID-19 Preparedness**

# Experiences of long-term care facilities (LTCFs) in managing the COVID-19 pandemic

facilitate the exchange То of good practices and lessons learnt, the third session of the 'Safe hospital' webinar series, organized on 18 March by WHO in collaboration with the International Hospital Federation (IHF) and the UN Office for Disaster Risk Reduction (UNDRR). focused on long-term care facilities (LTCFs) and services during the COVID-19 pandemic.

Participants from 101 countries and territories across all WHO regions attended.



F-1 Stadium converted into a COVID-19 facility (Picture courtesy: Felipe Cruz Vega, Mexico)

- The National Lead for Healthy Ageing, Qatar noted using 'telephone calls' and 'SMSmessaging' to support older people in the community in the absence of outpatient services, establishing a direct transfer system from the airport to geriatric quarantine units for older adults returning from seeking care internationally and implementing <u>WHO recommended IPC</u> <u>standards</u> for safer LTCFs.
- The Mexican Social Security Institute highlighted enabling the principles behind safe hospitals by expanding LTCF capacity in a number of ways such as the number and capacity of the health workforce (HWF). Surge capacity was expanded by converting both a Formula-1 stadium for quarantine and waiting areas of hospitals for COVID-19 treatment.
- Seoul National University, Republic of Korea, highlighted that given the majority of both residents and HWF are females, the importance of a gender-sensitive approach to the COVID-19 response, including by increasing women in leadership roles.
- The Chief Nursing Officer of Genesis HealthCare, USA utilized a "PPE calculator" and other innovative tools in LTCFs; collaborations with Brown University and the University of Pennsylvania enabled trend-analysis of COVID-19 cases for advocacy and actions to address PPE fatigue amongst staff.
- The Scottish Government Pandemic Response, United Kingdom of Great Britain and Northern Ireland, presented 'Open with care' guidance on balancing transmission risk and social isolation harms using an evidence-based, whole-of-society approach that emphasizes multilayered protection and "meaningful contact" with residents of LTCFs.

Register now for the concluding webinar in the series on 15 April that will focus on <u>health facilities</u> <u>post-COVID-19 and beyond: safe, functional, climate-resilient and environmentally sustainable</u>.



### Pandemic learning response:

WHO is expanding access to online learning for COVID-19 through its open learning platform for health emergencies, <u>OpenWHO.org</u> launched in June 2017. The platform has reached 50 languages and 5 million course enrolments, of which more than 80% are COVID-19 courses to transfer life-saving information to frontline responders, with the first COVID-19 course published on 26 January 2020.

These 30 free COVID-19 courses align with the <u>COVID-19 Strategic Preparedness and</u> <u>Response Plan</u> (SPRP 2021), with at least one course per each of the ten response pillars to support ongoing learning opportunities and capacity building globally to support achieving the SPRP 2021 objectives. Five additional COVID-19 courses are currently under development.

<u>COVID-19 course topics on the platform include:</u> an introduction to COVID-19, clinical care, infection prevention and control (IPC), COVID-19 vaccination training, national deployment and vaccination planning, vaccine-specific knowledge resources, guidance on mask use, long-term care, clinical management, rehabilitation of patients with COVID-19, leadership in IPC, staying healthy and safe at work, country capacitation, treatment facility design, the Go.Data tool, protective equipment, hand hygiene, waste management, decontamination of medical devices, injection safety, risk assessment for mass gatherings, occupational health and safety, eProtect pre-deployment training, country intra-action reviews, neglected tropical diseases in the pandemic context, COVID-19 risk communication, and public health emergency operations centres.





50 languages

**Over 2.8 million certificates** 

5 087 196 COVID-19 Course enrollments



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### **COVID-19 Partners platform**





The COVID-19 Partners Platform has just launched a new landing page to include a wider range of features that all visitors to the site will find useful - from our country administrators to donors and new users who are looking to understand more about this innovative WHO planning tool.

The new landing page includes:

- figures at a glance, showing real-time updates on total contributions made toward the pandemic response, how many countries are using the Platform's Action Checklist to inform their national plan, and more;
- > the most current technical guidance documents for COVID-19;
- an introductory video with Dr Mike Ryan, Executive Director of the WHO Health Emergencies Programme describing the impact of the Partners Platform in COVID-19 readiness and response planning;
- stories from the field, highlighting how specific countries, areas and territories have used the Partners Platform in their own national pandemic response;
- > a link to a user support page with helpful information including User Guides and Frequently Asked Questions, training materials, and the Partners Platform's Terms of Use and Privacy Policy.

Partners Platform users still benefit from easy direct sign-in access. All proprietary information will only be accessible inside the Platform after user sign-in. You can explore all of these changes at <a href="https://covid19partnersplatform.who.int/en">https://covid19partnersplatform.who.int/en</a>.



### **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 9 April 2021.

Shipped items as of 9 April 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	3 829 125	1 866 146	1 473 890	12 224 300	223 570	1 741 279	53 467 400	2 768 630
Americas (AMR)	7 479 900	1 046 132	10 720 012	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	1 802 440	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095
Europe (EUR)	459 000	658 050	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	11 275 450	10 572 827	17 753 922	8 659 511	38 713 700	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. \* Laboratory supplies data is as of 1 April 2021.



### **Appeals**

WHO's <u>Strategic Preparedness and Response Plan</u> (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 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.



The status of funding raised for WHO against the SPRP can be found <u>here</u>. Note: Data within the graph above undergoes periodic data verification and data cleaning exercises. Therefore, some subsequent small shifts in numbers is anticipated.



### **WHO Funding Mechanisms**

#### **COVID-19 Solidarity Response Fund**

As of 26 March 2021, <u>The Solidarity</u> <u>Response Fund</u> has raised or committed more than US\$ 246 million from more than 664 403 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).



# Alisson Becker and WHO Foundation launch campaign to raise resources and support treatment for COVID-19 patients starting in the Americas

Oxygen delivery is among the priorities identified in WHO's recently released <u>Strategic</u> <u>Preparedness and Response Plan for 2021</u>, for which the COVID-19 Solidarity Response Fund is seeking to raise funds from individuals, philanthropies, and corporates.

Champion goalkeeper Alisson Becker of the Brazilian national football team and Liverpool Football Club and World Health Organization (WHO) Goodwill ambassador for health promotion, is kickstarting a new global fundraising campaign, titled "Give a Breath for Health," driven by the WHO Foundation and WHO. The initiative aims to support the delivery of oxygen and other lifesaving supplies to health facilities treating patients with COVID-19 around the world. The first donation to the "<u>Give a Breath for Health</u>" campaign, made by Alisson, will contribute with supplies to locations in the Amazon.

Anil Soni, Chief Executive Officer of the WHO Foundation, noted that "The response to COVID-19 is bigger than any one country or government can manage alone. The 'Give a Breath for Health' campaign is an exciting example of how the COVID-19 Solidarity Response Fund can enable anyone, anywhere to support the urgently needed pandemic response efforts of WHO and its partners.".

"Working together we can overcome this difficult moment and I will do what I can to help my country, my Region, and the world, during the COVID-19 crisis," said Alisson Becker. "There remains a desperate need in many areas for supplies of essential medicines and equipment, including oxygen, to help keep people alive in our hospitals and clinics."

PAHO Director, Carissa F. Etienne noted a surge in COVID-19 cases in the Americas and that "as more and more patients require hospitalization, solidarity response efforts like the one led by Alisson Becker can help provide health care workers in the Region with much-needed supplies and equipment, including oxygen, to save lives."



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### **COVID-19 Global Preparedness and Response Summary Indicators**<sup>a</sup>

#### Countries have a COVID-19 preparedness and response plan

N=195 91 % 47% 100%

**Countries have a COVID-19 Risk** 

**Communication and Community Engagement** Plan (RCCE)<sup>b</sup> N=195



100% !

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

		N=195
44 %	7%	50%
22%		100%

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

N=195



#### Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 N=195



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

		N=195	
	89 %		11%
37%		1	00%

Countries that have defined essential health services to be maintained during the pandemic N=195

46 %	20%	34%
22%		100%

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

_		N=195
35 %	63%	
29%		100%

Countries have a health occupational safety plan for health care workers

_			N=195
27.7 %	6 %	66.7%	
17%			100%

**Countries have COVID-19 laboratory testing** capacity



Target value

**Baseline value** 

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 <u>Global Humanitarian and Response Plan</u>. A full list of priority countries can be found <u>here</u>.

### <u>Priority countries</u> with multisectoral mental health & psychosocial support working group



Priority countries that have postponed at least 1 vaccination campaign due to COVID-19<sup>c</sup>

	44%	56%	
0%	27%		

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



# <u>Priority countries</u> with an active & implemented RCCE coordination mechanism



# <u>Priority countries</u> with a contact tracing focal point



# <u>Priority countries</u> with an IPC focal point for training



Target value

#### Notes:

c Source: WHO Immunization Repository



### HEALTH EMERGENCIES programme

### 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





### HEALTH EMERGENCIES programme

### Key links and useful resources



### GOARN

For updated GOARN network activities, click here.

### **WHO case definition**

For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection, published December 2020, click <u>here.</u>

### **EPI-WIN**

For EPI-WIN: WHO Information Network for Epidemics, click here

### **WHO Publications and Technical Guidance**

For updated WHO Publications and Technical Guidance on COVID-19, click <u>here</u>

For more information on COVID-19 regional response: African Regional Office

- <u>Regional Office of the Americas</u>
- Eastern Mediterranean Regional Office
- European Regional Office
- Southeast Asia Regional Office
- Western Pacific Regional Office

# For the 6 April **Weekly Epidemiological Update**, click <u>here</u>. Highlights this week include:

Globally, new COVID-19 cases rose for a sixth consecutive week, with over 4 million new cases reported in the last week. The number of new deaths also increased by 11% compared to last week, with over 71 000 new deaths reported.

#### News

 For the Interim statement of the COVID-19 subcommittee of the WHO Global Advisory Committee on Vaccine Safety on AstraZeneca COVID-19 vaccine, click <u>here</u>.



# **COVID-19 Weekly Epidemiological Update**

Data as received by WHO from national authorities, as of 4 April 2021, 10 am CET

In this edition:

- Global overview
- WHO regional overviews

**Erratum:** Variants of Concern (VOCs) were incorrectly reported for Mauritania in the previous publications on 23 March and 30 March 2021. The country has not reported any VOCs to date.

### **Global overview**

Globally, new COVID-19 cases rose for a sixth consecutive week, with over 4 million new cases reported in the last week (Figure 1). The number of new deaths also increased by 11% compared to last week, with over 71 000 new deaths reported. The largest increases in case incidence were observed in the South-East Asia (most notably in India) and the Western Pacific regions (Table 1). All regions, except for the African Region, reported increases in the number of deaths, with the largest increase of 46% from the South-East Asia Region.



#### Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 4 April 2021\*\*

Reported week commencing

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

The highest numbers of new cases were reported from India (513 885 new cases; 38% increase), Brazil (505 668 new cases; 5% decrease), the United States of America (444 756 new cases; 5% increase), Turkey (265 937 new cases; 43% increase), and France (244 607 new cases; 4% decrease).

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	1 344 618 (33%)	3%	56 589 190 (43%)	37 185 (52%)	15%	1 368 633 (48%)
Europe	1 638 947 (40%)	-2%	45 877 941 (35%)	24 534 (34%)	2%	980 586 (34%)
South-East Asia	592 349 (14%)	36%	15 212 235 (11%)	4 317 (6%)	46%	222 054 (7%)
Eastern Mediterranean	297 763 (7%)	10%	7 693 094 (5%)	3 699 (5%)	7%	160 612 (5%)
Africa	58 858 (1%)	-6%	3 120 296 (2%)	1 077 (1%)	-20%	78 523 (2%)
Western Pacific	105 757 (2%)	25%	1 965 683 (1%)	543 (0%)	5%	31 904 (1%)
Global	4 038 292 (100%)	5%	130 459 184 (100%)	71 355 (100%)	11%	2 842 325 (100%)

Table 1. Newly reported and cumulative COVID-19 cases and deaths, by WHO Region, as of 4 April 2021\*\*

\*Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior. \*\*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, 29 March – 4 April 2021\*\*

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

### **WHO regional overviews**

#### **African Region**

The Region reported around 59 000 new cases and 1000 new deaths last week, a 6% and 20% decrease respectively compared to the previous week. The highest numbers of new cases were reported from Ethiopia (14 517 new cases; 12.6 new cases per 100 000 population; a 10% increase), Kenya (8747 new cases; 16.3 new cases per 100 000; a 5% decrease), and South Africa (7035 new cases; 11.9 new cases per 100 000; an 8% decrease).

The highest numbers of new deaths were reported from South Africa (306 new deaths; 0.5 new deaths per 100 000 population; a 46% decrease), Ethiopia (152 new deaths; <0.1 new deaths per 100 000; a 11% increase), and Kenya (102 new deaths; 0.2 new deaths per 100 000; a 13% decrease).



### **Region of the Americas**

The Region reported over 1.3 million new cases and over 37 000 new deaths, a 3% and a 15% increase respectively compared to the previous week. Overall, there has been an increasing trend in weekly case incidence over the last six weeks. The highest numbers of new cases were reported from Brazil (505 668 new cases; 237.9 new cases per 100 000; a 5% decrease), the United States of America (444 756 new cases; 134.4 new cases per 100 000; a 5% increase), and Argentina (82 102 new cases; 181.7 new cases per 100 000; a 46% increase).

The highest numbers of new deaths were reported from Brazil (21 094 new deaths; 9.9 new deaths per 100 000; a 26% increase), the United States of America (7536 new deaths; 2.3 new deaths per 100 000; an 8% increase), and Mexico (2992 new deaths; 2.3 new deaths per 100 000; an 18% decrease).



#### **Eastern Mediterranean Region**

The Region reported over 297 000 new cases and about 3700 new deaths, a 10% and a 7% increase respectively compared to the previous week. Both cases and deaths are on an upward trajectory with new cases increasing for the past eight weeks. The highest numbers of new cases were reported from the Islamic Republic of Iran (73 471 new cases; 87.5 new cases per 100 000; a 38% increase), Jordan (44 742 new cases; 438.5 new cases per 100 000; a 19% decrease), and Iraq (41 043 new cases; 102.0 new cases per 100 000; an 9% increase).

The highest numbers of new deaths were reported from the Islamic Republic of Iran (691 new deaths; 0.8 new deaths per 100 000; an 18% increase), Jordan (658 new deaths; 6.4 new deaths per 100 000; a 4% decrease), and Pakistan (539 new deaths; 0.2 new deaths per 100 000; a 50% increase).



#### **European Region**

After reporting a progressive increase in weekly cases for five weeks, the number of new cases reported this past week is similar to that reported in the previous week, with over 6.2 million new cases reported. The number of new deaths, however, has continued to increase for the past four weeks, with 24 000 new deaths reported. The highest numbers of new cases were reported from Turkey (265 937 new cases; 315.3 new cases per 100 000; a 43% increase), France (244 607 new cases; 374.7 new cases per 100 000; a 4% decrease), and Poland (187 551 new cases; 495.6 new cases per 100 000; a 3% decrease).

The highest numbers of new deaths were reported from Italy (3068 new deaths; 5.1 new deaths per 100 000; a 2% increase), Poland (3057 new deaths; 8.1 new deaths per 100 000; an 18% increase), and the Russian Federation (2634 new deaths; 1.8 new deaths per 100 000; a 3% decrease).



### South-East Asia Region

The Region reported over 592 000 new cases and 4300 new deaths, a 36% and a 46% increase respectively compared to the previous week. Case incidence rates have risen markedly through March, with a sharp increase in the past three weeks. The number of new deaths continued to increase in the past three weeks with a steep increase reported in past one week. India contributed 87% of new cases and 71% of new deaths in the Region in the past week. The highest numbers of new cases were reported from India (513 885 new cases; 37.2 new cases per 100 000; a 38% increase), Bangladesh (38 471 new cases; 23.4 new cases per 100 000; a 67% increase), and Indonesia (35 522 new cases; 13 new cases per 100 000; a 2% decrease).

The highest numbers of new deaths were reported from India (3071 new deaths; 0.2 new deaths per 100 000; a 71% increase), Indonesia (878 new deaths; 0.3 new deaths per 100 000; a 4% decrease), and Bangladesh (344 new deaths; 0.2 new deaths per 100 000; a 71% increase).



### Western Pacific Region

The Region reported over 106 000 new cases and over 500 new deaths, a 25% and a 5% increase respectively compared to the previous week. A steep increase in the number of new cases has been observed over the past four weeks. The highest numbers of new cases were reported from the Philippines (71 606 new cases; 65.3 new cases per 100 000; a 27% increase), Japan (16 018 new cases; 12.7 new cases per 100 000; a 43% increase), and Malaysia (8968 new cases; 27.7 new cases per 100 000; similar to the previous week).

The highest numbers of new deaths were reported from the Philippines (264 new deaths; 0.2 new deaths per 100 000; a 15% increase), Japan (190 new deaths; 0.2 new deaths per 100 000; a 13% decrease), and Malaysia (35 new deaths; <0.1 new deaths per 100 000; a 59% increase).



### 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
- <u>Research and Development</u>
- Online courses on COVID-19 in official UN languages and in additional national languages
- <u>The Strategic Preparedness and Response Plan (SPRP)</u> outlining the support the international community can provide to all countries to prepare and respond to the virus
- Updates from WHO regions:
  - o African Region
  - o <u>Region of the Americas</u>
  - o Eastern Mediterranean Region
  - o South-East Asia Region
  - o <u>European Region</u>
  - o Western Pacific Region
- Recommendations and advice for the public:
  - o <u>Protect yourself</u>
  - o <u>Questions and answers</u>
  - o <u>Travel advice</u>
  - EPI-WIN: tailored information for individuals, organizations and communities
- <u>WHO Academy COVID-19 mobile learning app</u>

## 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 4 April 2021\*\*

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Africa	58 858	3 120 296	278.1	1 077	78 523	7.0	
Ethiopia	14 517	213 311	185.5	152	2 936	2.6	Community transmission
Kenya	8 747	138 077	256.8	102	2 206	4.1	Community transmission
South Africa	7 035	1 551 501	2 616.0	306	52 954	89.3	Community transmission
Cameroon	6 251	53 920	203.1	58	779	2.9	Community transmission
Botswana	2 412	40 878	1 738.3	85	591	25.1	Community transmission
Côte d'Ivoire	1 858	44 326	168.0	18	247	0.9	Community transmission
Madagascar	1 838	25 262	91.2	68	449	1.6	Community transmission
Gabon	1 437	19 863	892.4	10	119	5.3	Community transmission
Тодо	1 388	11 064	133.6	3	110	1.3	Community transmission
Namibia	1 082	44 581	1 754.5	23	531	20.9	Community transmission
Zambia	1 073	88 800	483.0	17	1 215	6.6	Community transmission
Mozambique	994	68 005	217.6	20	782	2.5	Community transmission
Rwanda	934	22 243	171.7	11	311	2.4	Community transmission
Guinea	818	20 319	154.7	13	129	1.0	Community transmission
Cabo Verde	803	17 821	3 205.3	6	171	30.8	Community transmission
Algeria	774	117 524	268.0	25	3 102	7.1	Community transmission
Mali	659	10 432	51.5	15	391	1.9	Community transmission
Nigeria	624	163 113	79.1	17	2 058	1.0	Community transmission
Angola	548	22 579	68.7	7	540	1.6	Community transmission
Senegal	497	38 953	232.6	29	1 063	6.3	Community transmission
Democratic Republic of the Congo	406	28 292	31.6	11	745	0.8	Community transmission
Ghana	387	90 674	291.8	4	744	2.4	Community transmission
Seychelles	240	4 294	4 366.2	4	22	22.4	Community transmission
Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
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Benin	213	7 313	60.3	3	93	0.8	Community transmission
South Sudan	207	10 255	91.6	4	112	1.0	Community transmission
Uganda	195	40 962	89.6	0	335	0.7	Community transmission
Malawi	181	33 639	175.8	6	1 119	5.8	Community transmission
Mauritania	172	17 917	385.3	1	449	9.7	Community transmission
Mauritius	164	1 034	81.3	2	12	0.9	Community transmission
Central African Republic	158	5 245	108.6	8	72	1.5	Community transmission
Burundi	154	2 911	24.5	0	6	0.1	Community transmission
Burkina Faso	130	12 803	61.2	5	150	0.7	Community transmission
Eritrea	126	3 334	94.0	1	10	0.3	Community transmission
Equatorial Guinea	106	7 008	499.5	1	103	7.3	Community transmission
Zimbabwe	93	36 911	248.3	5	1 524	10.3	Community transmission
Comoros	92	3 782	434.9	0	146	16.8	Community transmission
Chad	88	4 589	27.9	4	164	1.0	Community transmission
Gambia	58	5 459	225.9	2	165	6.8	Community transmission
Niger	46	5 033	20.8	3	188	0.8	Community transmission
Guinea-Bissau	31	3 661	186.0	4	65	3.3	Community transmission
Sao Tome and Principe	30	2 240	1 022.1	1	35	16.0	Community transmission
Eswatini	29	17 347	1 495.2	2	668	57.6	Community transmission
Sierra Leone	25	3 987	50.0	0	79	1.0	Community transmission
Lesotho	21	10 707	499.8	0	315	14.7	Community transmission
Liberia	8	2 061	40.7	0	85	1.7	Community transmission
Congo	0	9 681	175.4	0	135	2.4	Community transmission
United Republic of Tanzania	0	509	0.9	0	21	0.0	Pending
Territoriesiii							
Réunion	1 025	16 586	1 852.5	13	115	12.8	Community transmission
Mayotte	184	19 490	7 144.0	8	162	59.4	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Americas	1 344 618	56 589 190	5 532.9	37 185	1 368 633	133.8	
Brazil	505 668	12 910 082	6 073.6	21 094	328 206	154.4	Community transmission
United States of America	444 756	30 304 462	9 155.4	7 536	550 539	166.3	Community transmission
Argentina	82 102	2 373 153	5 250.8	788	56 023	124.0	Community transmission
Colombia	60 711	2 428 048	4 771.8	1 132	63 777	125.3	Community transmission
Peru	55 961	1 568 345	4 756.6	1 299	52 331	158.7	Community transmission
Chile	49 565	1 019 478	5 333.1	768	23 421	122.5	Community transmission
Canada	31 263	987 918	2 617.5	176	23 002	60.9	Community transmission
Mexico	27 512	2 247 357	1 743.0	2 992	203 854	158.1	Community transmission
Uruguay	19 225	111 568	3 211.8	166	1 041	30.0	Community transmission
Paraguay	13 182	217 886	3 054.8	336	4 294	60.2	Community transmission
Ecuador	10 476	333 175	1 888.4	231	16 910	95.8	Community transmission
Venezuela (Bolivarian Republic of)	7 825	162 730	572.3	86	1 629	5.7	Community transmission
Cuba	6 798	78 382	692.0	17	431	3.8	Community transmission
Bolivia (Plurinational State of)	5 236	273 947	2 346.8	162	12 305	105.4	Community transmission
Honduras	3 389	189 726	1 915.5	86	4 622	46.7	Community transmission
Panama	2 833	355 850	8 247.3	39	6 126	142.0	Community transmission
Jamaica	2 702	40 449	1 366.0	47	613	20.7	Community transmission
Dominican Republic	2 199	253 781	2 339.4	32	3 334	30.7	Community transmission
Guatemala	1 986	195 036	1 088.6	81	6 875	38.4	Community transmission
Costa Rica	1 586	216 764	4 255.2	26	2 957	58.0	Community transmission
El Salvador	665	64 431	993.4	23	2 021	31.2	Community transmission
Guyana	439	10 446	1 328.1	10	235	29.9	Clusters of cases
Trinidad and Tobago	177	8 116	579.9	4	145	10.4	Community transmission
Bahamas	137	9 171	2 332.1	0	188	47.8	Clusters of cases
Saint Lucia	82	4 273	2 327.0	3	61	33.2	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Barbados	62	3 665	1 275.3	1	42	14.6	Community transmission
Haiti	52	12 788	112.2	0	252	2.2	Community transmission
Suriname	49	9 137	1 557.5	0	177	30.2	Clusters of cases
Antigua and Barbuda	48	1 170	1 194.7	0	28	28.6	Clusters of cases
Belize	41	12 456	3 132.6	0	317	79.7	Community transmission
Nicaragua	38	5 326	80.4	1	178	2.7	Community transmission
Saint Vincent and the Grenadines	34	1 755	1 581.9	0	10	9.0	Community transmission
Dominica	4	165	229.2	0	0	0.0	Clusters of cases
Grenada	0	155	137.7	0	1	0.9	Sporadic cases
Saint Kitts and Nevis	0	44	82.7	0	0	0.0	Sporadic cases
Territories <sup>iii</sup>							
Puerto Rico	3 236	108 861	3 805.2	17	2 126	74.3	Community transmission
Curaçao	2 186	8 834	5 383.5	11	38	23.2	Community transmission
Martinique	614	8 163	2 175.3	4	54	14.4	Community transmission
Aruba	430	9 503	8 900.8	4	86	80.5	Community transmission
Bermuda	415	1 362	2 187.1	0	12	19.3	Community transmission
Guadeloupe	378	11 890	2 971.6	4	177	44.2	Community transmission
French Guiana	210	17 132	5 735.9	7	96	32.1	Community transmission
Bonaire, Sint Eustatius and Saba	164	1 411	5 381.2	1	11	42.0	
Saint Barthélemy	53	910	9 205.9	0	1	10.1	Clusters of cases
Sint Maarten	33	2 151	5 016.1	0	27	63.0	Community transmission
Saint Martin	30	1 687	4 363.8	1	13	33.6	Community transmission
United States Virgin Islands	30	2 931	2 806.8	0	26	24.9	Community transmission
Turks and Caicos Islands	19	2 344	6 054.0	0	17	43.9	Clusters of cases
Cayman Islands	14	501	762.3	0	2	3.0	Sporadic cases
Anguilla	2	25	166.6	0	0	0.0	Sporadic cases
Falkland Islands (Malvinas)	1	52	1 493.0	0	0	0.0	No cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
British Virgin Islands	0	154	509.3	0	1	3.3	Clusters of cases
Montserrat	0	20	400.1	0	1	20.0	Sporadic cases
Saint Pierre and Miquelon	0	24	414.2	0	0	0.0	No cases
Eastern Mediterranean	297 763	7 693 094	1 052.7	3 699	160 612	22.0	
Iran (Islamic Republic of)	73 471	1 920 394	2 286.4	691	62 999	75.0	Community transmission
Jordan	44 742	626 875	6 143.9	658	7 130	69.9	Community transmission
Iraq	41 043	868 200	2 158.5	253	14 430	35.9	Community transmission
Pakistan	33 064	682 888	309.1	539	14 697	6.7	Community transmission
Lebanon	18 775	477 113	6 990.2	321	6 379	93.5	Community transmission
United Arab Emirates	14 954	468 023	4 732.1	27	1 504	15.2	Community transmission
Kuwait	8 811	235 989	5 525.9	60	1 339	31.4	Community transmission
Tunisia	8 632	258 335	2 185.8	226	8 931	75.6	Community transmission
Bahrain	6 952	147 770	8 684.3	18	531	31.2	Clusters of cases
Oman	6 180	160 018	3 133.5	31	1 681	32.9	Community transmission
Qatar	5 413	182 548	6 336.2	17	301	10.4	Community transmission
Libya	4 972	161 088	2 344.4	82	2 684	39.1	Community transmission
Egypt	4 892	204 256	199.6	278	12 123	11.8	Clusters of cases
Saudi Arabia	4 215	392 009	1 126.0	47	6 690	19.2	Sporadic cases
Morocco	3 474	497 832	1 348.8	44	8 842	24.0	Clusters of cases
Djibouti	1 260	8 509	861.2	6	72	7.3	Community transmission
Syrian Arab Republic	928	19 284	110.2	72	1 299	7.4	Community transmission
Somalia	785	11 623	73.1	58	546	3.4	Community transmission
Yemen	728	4 701	15.8	100	933	3.1	Community transmission
Afghanistan	382	56 676	145.6	27	2 497	6.4	Sporadic cases
Sudan	180	31 833	72.6	13	2 063	4.7	Community transmission
Territories <sup>iii</sup>							
occupied Palestinian territory	13 910	277 130	5 432.4	131	2 941	57.7	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Europe	1 638 947	45 877 941	4 915.1	24 534	980 586	105.1	
Turkey	265 937	3 445 052	4 084.8	1 155	32 078	38.0	Community transmission
France	244 607	4 679 794	7 169.5	1 991	95 875	146.9	Community transmission
Poland	187 551	2 438 542	6 443.2	3 057	54 941	145.2	Community transmission
Italy	137 794	3 650 247	6 037.3	3 068	110 704	183.1	Clusters of cases
Germany	112 985	2 885 386	3 443.8	1 093	76 963	91.9	Community transmission
Ukraine	101 646	1 745 709	3 991.7	2 379	34 333	78.5	Community transmission
Russian Federation	61 062	4 580 894	3 139.0	2 634	100 374	68.8	Clusters of cases
Netherlands	50 518	1 295 228	7 559.0	160	16 606	96.9	Community transmission
Hungary	45 552	679 413	7 033.0	1 532	21 504	222.6	Community transmission
Romania	38 045	970 224	5 043.3	976	23 973	124.6	Community transmission
Czechia	36 867	1 551 896	14 491.5	1 071	26 945	251.6	Community transmission
Serbia	32 748	614 365	8 822.3	271	5 422	77.9	Community transmission
Belgium	28 276	900 995	7 774.2	241	23 162	199.9	Community transmission
The United Kingdom	27 911	4 357 095	6 418.3	253	126 826	186.8	Community transmission
Sweden	26 914	813 191	8 052.0	22	13 498	133.7	Community transmission
Bulgaria	24 489	352 259	5 069.6	857	13 507	194.4	Clusters of cases
Austria	21 652	552 496	6 134.5	170	9 165	101.8	Community transmission
Greece	20 869	273 459	2 623.6	476	8 302	79.7	Community transmission
Azerbaijan	14 344	268 714	2 650.3	184	3 648	36.0	Clusters of cases
Kazakhstan	13 554	305 860	1 628.9	116	3 812	20.3	Clusters of cases
Croatia	12 804	280 026	6 821.1	165	6 058	147.6	Community transmission
Bosnia and Herzegovina	10 971	174 846	5 329.3	525	6 803	207.4	Community transmission
Spain	9 182	3 291 394	7 039.7	79	75 541	161.6	Community transmission
Switzerland	9 173	602 578	6 962.5	42	9 677	111.8	Community transmission
Republic of Moldova	8 734	234 394	5 810.5	307	5 092	126.2	Community transmission
Belarus	8 4 3 4	326 065	3 450.7	65	2 2 7 6	24.1	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Slovenia	7 382	219 422	10 554.5	41	4 368	210.1	Clusters of cases
Slovakia	7 332	365 242	6 689.9	529	10 025	183.6	Clusters of cases
North Macedonia	6 694	132 924	6 380.2	218	3 860	185.3	Community transmission
Armenia	6 317	196 634	6 635.8	128	3 592	121.2	Community transmission
Norway	5 836	96 770	1 785.0	17	673	12.4	Community transmission
Lithuania	5 770	219 711	8 070.8	58	3 609	132.6	Community transmission
Estonia	5 769	109 399	8 247.0	94	941	70.9	Clusters of cases
Denmark	5 669	232 718	4 017.8	15	2 428	41.9	Community transmission
Ireland	3 758	237 695	4 813.8	62	4 715	95.5	Community transmission
Georgia	3 532	283 833	7 115.1	60	3 811	95.5	Community transmission
Latvia	3 151	103 867	5 506.7	51	1 923	102.0	Community transmission
Cyprus	2 977	47 282	3 916.2	11	261	21.6	Clusters of cases
Portugal	2 820	822 862	8 069.9	41	16 868	165.4	Clusters of cases
Finland	2 561	78 106	1 409.7	29	846	15.3	Community transmission
Albania	2 542	126 183	4 384.7	52	2 256	78.4	Clusters of cases
Montenegro	2 090	92 517	14 730.5	58	1 303	207.5	Clusters of cases
Israel	1 588	833 200	9 626.2	59	6 231	72.0	Community transmission
Luxembourg	1 350	62 105	9 921.3	12	750	119.8	Community transmission
Uzbekistan	1 283	83 623	249.9	5	631	1.9	Clusters of cases
Kyrgyzstan	922	89 014	1 364.4	11	1 506	23.1	Clusters of cases
Malta	381	29 189	6 610.7	12	397	89.9	Clusters of cases
Andorra	365	12 174	15 756.2	2	117	151.4	Community transmission
San Marino	149	4 775	14 069.8	0	84	247.5	Community transmission
Monaco	72	2 326	5 927.0	1	29	73.9	Sporadic cases
Iceland	62	6 2 2 5	1 824.2	0	29	8.5	Community transmission
Liechtenstein	23	2 764	7 247.6	0	54	141.6	Sporadic cases
Holy See	0	26	3 213.8	0	0	0.0	Sporadic cases

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Tajikistan	0	13 714	143.8	0	91	1.0	Pending
Territories <sup>iii</sup>							
Kosovo <sup>[1]</sup>	5 908	92 932	4 995.3	76	1 896	101.9	Community transmission
Isle of Man	19	1 570	1 846.4	3	29	34.1	No cases
Jersey	4	3 229	2 967.8	0	69	63.4	Community transmission
Gibraltar	2	4 275	12 688.8	0	94	279.0	Clusters of cases
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	592 349	15 212 235	752.6	4 317	222 054	11.0	
India	513 885	12 485 509	904.7	3 071	164 623	11.9	Clusters of cases
Bangladesh	38 471	630 277	382.7	344	9 213	5.6	Community transmission
Indonesia	35 522	1 527 524	558.5	878	41 242	15.1	Community transmission
Sri Lanka	1 456	93 295	435.7	17	575	2.7	Clusters of cases
Maldives	1 248	24 651	4 560.4	1	67	12.4	Clusters of cases
Nepal	1 018	277 768	953.3	5	3 032	10.4	Clusters of cases
Thailand	393	29 127	41.7	1	95	0.1	Clusters of cases
Timor-Leste	234	714	54.2	0	0	0.0	Clusters of cases
Myanmar	102	142 479	261.9	0	3 206	5.9	Clusters of cases
Bhutan	20	891	115.5	0	1	0.1	Sporadic cases
Western Pacific	105 757	1 965 683	100.1	543	31 904	1.6	
Philippines	71 606	784 023	715.5	264	13 423	12.2	Community transmission
Japan	16 018	482 867	381.8	190	9 221	7.3	Clusters of cases
Malaysia	8 968	349 610	1 080.2	35	1 286	4.0	Clusters of cases
Republic of Korea	3 529	105 279	205.3	22	1 744	3.4	Clusters of cases
Mongolia	2 905	9 598	292.8	5	11	0.3	Clusters of cases
Papua New Guinea	1 652	6 857	76.6	16	61	0.7	Community transmission

Reporting Country/Territory/Area <sup>i</sup>	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 <sup>ii</sup>
Cambodia	456	2 689	16.1	9	19	0.1	Sporadic cases
China	187	102 867	7.0	0	4 851	0.3	Clusters of cases
Singapore	180	60 468	1 033.6	0	30	0.5	Sporadic cases
Australia	89	29 341	115.1	0	909	3.6	Clusters of cases
Viet Nam	39	2 629	2.7	0	35	0.0	Clusters of cases
New Zealand	25	2 151	44.6	0	26	0.5	Clusters of cases
Brunei Darussalam	8	214	48.9	0	3	0.7	Sporadic cases
Solomon Islands	1	19	2.8	0	0	0.0	No 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
Territories <sup>iii</sup>							
Wallis and Futuna	49	425	3 779.1	0	4	35.6	Sporadic cases
French Polynesia	26	18 633	6 633.1	0	141	50.2	Sporadic cases
Guam	19	7 606	4 506.6	2	136	80.6	Clusters of cases
Marshall Islands	0	4	6.8	0	0	0.0	No cases
New Caledonia	0	121	42.4	0	0	0.0	Sporadic cases
Northern Mariana Islands (Commonwealth of the)	0	159	276.2	0	2	3.5	Pending
Samoa	0	4	2.0	0	0	0.0	No cases
Vanuatu	0	3	1.0	0	0	0.0	No cases
Global	4 038 292	130 459 184	1 673.7	71 355	2 842 325	36.5	

\*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.

<sup>[1]</sup> 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.

<sup>i</sup> 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).

<sup>ii</sup> 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: <u>Considerations for implementing and adjusting public health and social measures in the context of COVID-19</u>:

- 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 subcategorizations 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.

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

# Weekly Operational Update on COVID-19

# 5 April 2021

Issue No. 49



Confirmed cases<sup>a</sup> 130 422 190

Confirmed deaths 2 842 135

#### Burundi goes digital in the fight against COVID-19

In Burundi, 141 health information system managers and laboratory assistants from all of its 47 health districts have received training from 22 - 27 March on the collection and electronic reporting of COVID-19 data.



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

accessing online training courses

across 30 topics in 47 languages

17 753 922 PCR tests shipped

198 747 426 medical masks

shipped globally

globally

More than **5 million** people registered on <u>OpenWHO</u> and

**Key Figures** 

The Ministry of Public Health and the Fight Against AIDS, with the support of WHO, organized a training held in Bujumbura aimed to strengthen skills on the use of smart phones for



Credit: WHO Country office Burundi

the transmission of surveillance, laboratory data and the management of COVID-19 cases at the health district level. WHO recently provided the Ministry's Public Health Emergency Operations Centre (PHEOC) with 200 smartphones as a key enabler of the digital system.

Digital data collection enables instant updating of the Alert and Early Response Centre in the PHEOC, with mapping of cases and rapid identification of close contacts of cases, thus improving the overall response. Individuals at the training remarked on how this will improve the quality of work by minimizing transcription errors, enabling verification of the authenticity of data and allowing for real-time monitoring, ultimately enabling daily reporting and analysis to guide response interventions at the PHEOC.

For further information in French, click here.



# undi 8 659 511 face shields shipped globally

**37 135 700** gloves shipped globally



**166** GOARN deployments conducted to support COVID-19 pandemic response



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547 727 346 COVID-19 vaccine doses administered globally as of 31 March

<sup>a</sup> COVAX has shipped over **33** million COVID-19 vaccines to **74** participants as of 1 April

1

<sup>a</sup> See Gavi's <u>COVAX updates</u> for the latest COVAX vaccine roll –out data

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For all other latest data and information, see the <u>WHO</u> <u>COVID-19 Dashboard</u> and <u>Situation Reports</u>



### From the field:

#### **COVID-19 Operational Support and Logistics Mission to the western Balkans**

During the COVID-19 pandemic, the timely movement of critical supplies and equipment has been one of the most challenging areas of the health response. Market failure, trade restrictions, and travel bans led to an acute shortage of essential supplies and has disrupted global supply chains. As new COVID-19 tools have been developed, additional pressures have been placed on countries to put in place needed customs, and regulatory processes to allow their importation and use.

Between 15 and 23 March 2021, health emergency logistics experts from the WHO Regional Office for Europe conducted a mission to support several countries in the western Balkans.

The aim was to conduct rapid procurement, assessments in logistics, customs clearance and human resource capacities in Serbia, Montenegro and North Macedonia identify potential develop capacity gaps and recommendations improve to end-to-end emergency supply chain processes.

During the mission, the team worked with local WHO staff and national partners involved in receiving and distributing supplies



related to COVID-19 response, including Ministries of Health, Institutes of Public Health, national labs, clearing agents and national regulatory authorities. Through these interactions, channels of communication were defined in each country to ensure fast and smooth processes for importation. The Regional Office team also shared knowledge and experiences on capacity assessments, procurement, transport, distribution, warehousing, and physical stock management, monitoring and evaluation with logistics staff.

In all three countries, the OSL experts monitored distribution of supplies at national level, reviewing the current procedures for the receipt, storage, distribution, and recording of medical commodities. To maintain good relations with national partners, existing partnerships were mapped out and new relationships and agreements with other UN Organizations and NGOs were proposed. Throughout the mission, the team worked to understand importation requirements and establish a fast-track procedure to clear all humanitarian cargos.

By increasing access and removing bottlenecks to essential supplies, including PPE to protect frontline health care workers, this work will increase the ability of health systems to save lives.



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#### From the field:

#### Somalia rolls out COVID-19 vaccines: WHO hears from some of the first to be vaccinated

On 15 March 2021, Somalia received 300 000 doses of the AstraZeneca/Oxford vaccine from the COVAX Facility. "I am so grateful to the Ministry of Health, WHO, the COVAX Facility and all other

agencies who have brouaht COVID-19 vaccines to Somalia as we all know we don't have money to buy these vaccines," says Dr Luul Mohamud. As the Dean of the Faculty of Medicine at the Jazeera University, a paediatric lecturer, and the former head of the paediatric the Banadir department at Hospital from 2007 to 2020. Dr Mohamud is passionate а advocate for vaccination.

Dr Luul is also a member of the COVID-19 taskforce at the Somali Medical Association that



Credit: WHO Country Office Somalia

worked with the Somali Government and partners on the preparation of protocols for COVID-19 case management, awareness raising, infection prevention and control, and training health care workers to address COVID-19. Dr Luul hopes people will focus on the vaccine's benefits over rare and minimal side-effects, a normal part of taking medicines.

"My message to all Somali people is to take vaccines – it is the only hope we have to defeat COVID-19 as our health system is very weak," says Dr Luul. "We cannot treat all cases, especially critical cases, due to the lack of equipment and specialised personnel like anaesthetists. I do hope people take this seriously - COVID-19 is a deadly disease all around the world."

Dr Aweis Olow Hassan, a medical doctor working along the front lines, requests all people who receive vaccines to share their experiences on social media and within their communities. "A lot of my medical colleagues stood back and waited for me to get vaccinated first. Once they saw I had no side-effects, apart from a sore arm - which is a common side-effect - my colleagues rushed to get the vaccine," says Dr Hassan, proud of being a positive influence on his peers.

"Everyone should take the vaccine for the sake of their own safety and that of the community," adds Dr Hassan. "Sadly, we are losing our golden grandfathers, grandmothers and parents to COVID-19. Please let's all wear masks, wash hands and take vaccines."

As of 21 March, 1267 people had already received vaccines in 4 of Banadir's hospitals; from 21 March onwards, COVID-19 vaccinations also started to roll-out to frontline workers and elderly people with chronic conditions in Somaliland and Puntland.

For further stories, click here.



### From the field:

# Solomon Islands receive 24 000 doses of COVID-19 vaccines through the COVAX facility

On 19 March 2021, Solomon Islands received 24 000 doses of the AstraZeneca/Oxford COVID-19 vaccine (COVISHIELD), manufactured by the Serum Institute of India (SII), via the COVAX Facility. This marks the second batch of vaccines to arrive in the Pacific islands through the COVAX Facility.

Islands Health Solomon Minister, Honourable Dr. Culwick Togamana, remarked "Several that months after WHO declared COVID-19 as a global pandemic, Solomon maintained Islands а COVID-19 free status. Though the virus managed to sneak into the country in early October 2020, it was met by well-prepared and disciplined frontline workers. quarantine stations and isolation wards that are up to infection.



Credit: WHO / Dinu Bubulici

prevention and control (IPC) standards, well equipped molecular laboratory that have prevented any community transmission till this day."

WHO Representative to Solomon Islands, Dr Sevil Huseynova highlighted that WHO is very glad to witness the historical moment. "We have been working hard with the government and UNICEF over the past few months to ensure the timely submission of the national vaccine deployment plan as well as all other necessary preparation work", while also acknowledging the efforts by the Ministry of Health team in preparing for the arrival of the vaccines

"From identifying priority groups, developing tracking systems to upskilling of staff for vaccine delivery. WHO will continue to work alongside our colleagues here to ensure we safely deliver these vaccines."

Vaccinations started on 24 March, with health workers and public servants on the frontline among the first to receive doses.

For more information, click here.



### **Risk Communication, Community Engagement and Infodemic Management**

# Social media & COVID-19: Outcomes of a global study of digital crisis interaction among Gen Z and Millennials

The COVID-19 pandemic has demonstrated how the spread of misinformation, amplified on social media and other digital platforms, is proving to be as much of a threat to global public health as the virus itself. Although young people are less at risk of severe disease from COVID-19, they are a key population that shares in the collective responsibility to limit transmission.

To better understand how young adults are seeking COVID-19 information, who they trust as credible sources and their awareness and actions around false news - a global study was conducted by WHO, Wunderman Thompson, the University of Melbourne and Pollfish. The study was conducted in 24 countries across all six WHO regions, with approximately 23 500 respondents between the ages of 18 and 40.

From the research, a brief <u>Key Insights</u> document and an <u>Interactive Dashboard</u> with disaggregated data by country, gender and age, have been developed with a more detailed report and analysis of the study being published in late April.



These can support WHO, governments, media, businesses, educational institutions and others to adapt and refine their health communication strategies, policies and recommendations to ensure they are relevant and appropriate to young people.

Young people should be enabled and empowered to navigate their digital world safely and wellinformed on COVID-19 to make choices that not only protect their health, but also the health of their families and communities.



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# **COVID-19 Partners platform**





The COVID-19 Partners Platform has just launched a new landing page to include a wider range of features that all visitors to the site will find useful - from our country administrators to donors and new users who are looking to understand more about this innovative WHO planning tool.

The new landing page includes:

- figures at a glance, showing real-time updates on total contributions made toward the pandemic response, how many countries are using the Platform's Action Checklist to inform their national plan, and more;
- the most current technical guidance documents for COVID-19;
- an introductory video with Dr. Mike Ryan, Executive Director of the WHO Health Emergencies Programme describing the impact of the Partners Platform in COVID-19 readiness and response planning;
- stories from the field, highlighting how specific countries, areas and territories have used the Partners Platform in their own national pandemic response;
- a link to a user support page with helpful information including User Guides and Frequently Asked Questions, training materials, and the Partners Platform's Terms of Use and Privacy Policy.

Partners Platform users still benefit from easy direct sign-in access. All proprietary information will only be accessible inside the Platform after user sign-in. You can explore all of these changes at <a href="https://covid19partnersplatform.who.int/en">https://covid19partnersplatform.who.int/en</a>.



### **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 1 April 2021.

Shipped items as of 1 April 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	3 829 125	1 866 146	1 473 890	10 646 300	223 570	1 741 279	53 467 400	2 768 630	
Americas (AMR)	7 479 900	1 046 132	10 720 012	3 333 200	4 752 000	322 940	1 613 020	55 136 330	7 669 760	
Eastern Mediterrane an (EMR)	1 178 300	1 625 220	1 802 440	954 985	7 613 000	206 480	839 322	27 317 550	1 502 095	
Europe (EUR)	459 000	658 050	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	11 275 450	10 572 827	17 753 922	8 658 511	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. \*Personal protective equipment data is as of 25 March

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



# **Appeals**

WHO's <u>Strategic Preparedness and Response Plan</u> (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 a 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 such as at 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.



The 2021 SPRP priorities and resource requirements can be found <u>here</u>. The status of funding raised for WHO against the SPRP can be found <u>here</u>.



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### WHO Funding Mechanisms

#### **COVID-19 Solidarity Response Fund**

As of 26 March 2021, <u>The Solidarity</u> <u>Response Fund</u> has raised or committed more than US\$ 246 million from more than 663 447 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\$ 246 Million 663 447 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, <u>OpenWHO.org</u>.

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





#### **30 topical COVID-19 courses**

47 languages

**Over 2.8 million certificates** 



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# **COVID-19 Global Preparedness and Response Summary Indicators**<sup>a</sup>

#### Countries have a COVID-19 preparedness and response plan

N=195 91 % 47% 100%

**Countries have a COVID-19 Risk** 

**Communication and Community Engagement** Plan (RCCE)<sup>b</sup> N=195



100% !

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

		N=195
44 %	7%	50%
22%		100%

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

N=195



#### Countries have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 N=195



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

	N=19	5
	89 %	11%
37%		100%

Countries that have defined essential health services to be maintained during the pandemic N=195

46 %	20%	34%
22%		100%

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

_		N=195	
35 %	63%		
29%		100%	

Countries have a health occupational safety plan for health care workers

_		N=195	
27.7 %	6 %	66.7%	
17%			100%

#### **Countries have COVID-19 laboratory testing** capacity



Target value

**Baseline 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 <u>Global Humanitarian and Response Plan</u>. A full list of priority countries can be found <u>here</u>.

#### <u>Priority countries</u> with multisectoral mental health & psychosocial support working group



<u>Priority countries</u> that have postponed at least 1 vaccination campaign due to COVID-19<sup>c</sup>

			11-04
	44%	56%	
0%	27%		

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



# <u>Priority countries</u> with an active & implemented RCCE coordination mechanism



# <u>Priority countries</u> with a contact tracing focal point



# <u>Priority countries</u> with an IPC focal point for training



**Target value** 

#### Notes:

c Source: WHO Immunization Repository



# HEALTH **EMERGENCIES**

### programme

#### 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

Generation Network for Epidemics, click here

□ For more information on COVID-19 regional response:

<u>African Regional Office</u>

- Regional Office of the Americas
- European Regional Office
- Eastern Mediterranean Regional Office
- Southeast Asia Regional Office
- Western Pacific Regional Office
- □ For the 30 March Weekly Epidemiological Update, click <u>here</u>. Highlights this week include:
  - COVID-19 and Health and Care Workers (HCWs)
  - SARS-CoV-2 variants
- □ For the WHO case definitions for public health surveillance of COVID-19 in humans caused by SARS-COV-2 infection published on <u>16 December 2020</u>, click <u>here</u>
- □ For updated WHO Publications and Technical Guidance on COVID-19, click here
- □ For updated GOARN network activities, click here
- □ For Ramadan campaign 2021 key messages from the Eastern Mediterranean Office, click <u>here</u>.