

COVID-19 Epidemiological Update

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In this edition:

- [Key highlights](#)
 - [Global overview](#)
 - [SARS-CoV-2 test positivity](#)
 - [Morbidity and Mortality trends](#)
 - [Hospitalizations and ICU admissions](#)
 - [SARS-CoV-2 variants circulation](#)
 - [WHO Regional Overview](#)
-

Key highlights

- During the four-week reporting period from 22 July to 18 August 2024, weekly SARS-CoV-2 PCR percent test positivity decreased from 12.4% in the first week of the reporting period to 10.2% in the last week, as detected in integrated sentinel surveillance within the Global Influenza Surveillance and Response System (GISRS). During this period, an average of 17 435 specimens across 88 countries were tested for SARS-CoV-2 each week. The highest percent positivity was reported in the Region of the Americas (ranging from 14.0% to 21.7% across 19 countries), followed by the European Region (18.0 % to 19.6% across 29 countries), the Western Pacific Region (9.1% to 9.2% across eight countries), the Eastern Mediterranean Region (5.8% to 6.7% across seven countries), the South-East Asia Region (2.8% to 4.3% across six countries), and the African Region (2.1% to 3.2% across 19 countries).
- Globally, JN.1 is the most reported variant of interest (VOI), now reported by 139 countries, accounting for 20.6% of sequences in week 33, having declined from a prevalence of 22.2% in week 30. WHO is currently tracking several SARS-CoV-2 variants; two variants of interest (VOIs): BA.2.86 and JN.1; and six variants under monitoring (VUMs): JN.1.7, JN.1.18, KP.2, KP.3, KP.3.1.1, and LB.1. SARS-CoV-2 variants KP.3.1.1 (a descendent lineage of JN.1 and a VUM) is showing increasing prevalence while LB.1 and JN.1.18, both also descendent lineages of JN.1 and VUMs, are showing stable prevalence globally. KP.3.1.1 accounted for 29.1% of the sequences shared in week 33 compared to 21.2% in week 30 while LB.1, and JN.1.18 accounted for 8.8% and 2.7% of sequences in week 33 compared to 8.8% and 2.2% in week 30, respectively. From available sequences shared globally, KP.3, KP.2, and JN.1.7 (all VUMs) are declining. KP.3 accounted for 21.9% of sequences in week 33 compared to 27.7% in week 30, while KP.2 declined to 13.7% in week 33 from 15.1% reported in week 30.
- SARS-CoV-2 wastewater surveillance remains important as an early warning system and for monitoring SARS-CoV-2 circulation. Around 30 countries from five WHO Regions have publicly available wastewater surveillance information. According to estimates obtained from wastewater surveillance, clinical detection of cases underestimates the real burden from 2 to 19-fold.
- Globally, during the 28-day period from 22 July to 18 August 2024, 91 countries reported COVID-19 cases, and 35 countries reported COVID-19 deaths. *Note that this does not reflect the actual number of countries where cases or deaths occur, as many countries have stopped or changed the frequency of reporting.* From the available data, the number of reported cases and deaths have increased during the 28-day period, with over 238 000 new cases and about 4400 new deaths, an increase of 23% and 44%, respectively, compared to the previous 28 days (24 June to 21 July 2024). *Trends in the number of new reported cases and deaths should be interpreted with caution due to decreased testing and sequencing, alongside reporting delays in many*

countries.

- During the 28-day period from 22 July to 18 August 2024, 45 and 32 countries provided data at least once on COVID-19 hospitalizations and admissions to an intensive care unit (ICU), respectively. From available data, over 27 000 new hospitalizations and about 860 new ICU admissions were reported during this period. Among the countries reporting these data consistently over the current and past reporting period, there was an overall decrease of 3% in new hospitalizations and 36% increase in new ICU admissions, respectively. The increasing trends ICU admissions is mainly driven by countries from the Region of the Americas and the European Region.
- Post-COVID-19 condition (PCC) continues to pose a substantial burden on health systems. It is challenging to estimate the incidence of PCC with high precision, but current data suggests that approximately 6% of symptomatic SARS-CoV-2 infections result in PCC symptoms^{*} While severe COVID-19 is a significant risk factor for PCC, over 90% of PCC cases arise following mild COVID-19 due to the sheer volume of infections. Vaccination appears to offer a protective effect, reducing the likelihood of developing PCC[†].
- WHO published the latest [COVID-19 Vaccination Insights Report](#) for quarter one (Jan-Mar) 2024. Globally, 9.8 million individuals received a dose of COVID-19 vaccine across 73 reporting Member States (MS) containing 22% of the global population. Among older adults, 4.9 million individuals received a dose across the 60 MS reporting on uptake in this group, corresponding to an uptake rate of 0.42% so far this year. Data collection for quarter two (April-June) is currently ongoing.

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

- Past editions of the [WHO Monthly Operational Update](#) and [Epidemiological Update on COVID-19](#)
- [WHO COVID-19 detailed surveillance data dashboard](#)
- [WHO COVID-19 policy briefs](#)
- [COVID-19 surveillance reporting requirements update for Member States](#)
- [Summary Tables of COVID-19 vaccine effectiveness \(VE\) studies and results \(last updated 5 September 2024\)](#)
- [Forest Plots](#) displaying results of COVID-19 VE studies (last updated 9 September 2024)
- [Special focus WEU on interpreting relative VE \(29 June 2022, pages 6-8\)](#)
- [Neutralization plots](#) (last updated 9 September 2024)
- [WHO COVID-19 VE Resources/Immunization Analysis and Insights](#)

^{*} [Estimated Global Proportions of Individuals with Persistent Fatigue, Cognitive, and Respiratory Symptom Clusters Following Symptomatic COVID-19 in 2020 and 2021 - PubMed \(nih.gov\)](#)

[†] [Post-acute Sequelae of SARS-CoV-2 Infection in the Pre-Delta, Delta, and Omicron Eras | New England Journal of Medicine \(nejm.org\)](#)

Global overview

Data as of 18 August 2024

SARS-CoV-2 test positivity rate from sentinel sites reflects the circulation of the virus in communities and is not much affected by reductions in disease surveillance. With the integration of SARS-CoV-2 into existing respiratory disease surveillance systems, more countries have started to report SARS-CoV-2 infections to the Global Influenza Surveillance and Response System (GISRS). Global and national data on SARS-CoV-2 PCR percent positivity are available on [WHO's integrated influenza and other respiratory viruses surveillance dashboard](#).

Globally, during the four-week reporting period (22 July to 18 August 2024), the percent positivity of the specimens tested from sentinel sites decreased from 12.4% to 10.2%, from an average of 88 countries per week. During this period, on average 17 435 specimens per week were tested for SARS-CoV-2 (Table 1).

Globally, the number of new weekly cases increased by 23% during the 28-day period of 22 July to 18 August 2024 as compared to the previous 28-day period, with over 238 000 new cases reported (Figure 2, Table 2). The number of new weekly deaths increased by 44% as compared to the previous 28-day period, with about 4400 new fatalities reported. As of 18 August 2024, over 776 million confirmed cases and over 7 million deaths have been reported globally. According to estimates obtained from viral loads in wastewater surveillance, clinical detection of cases underestimated the real burden 2 to 19-fold.^{‡,§,**}

Reported cases do not accurately represent infection rates due to the reduction in testing and reporting globally. During this 28-day period, only 39% (91 of 234) and 15% (35 of 234) of countries reported at least one case and death to WHO respectively. It is important to note that this statistic does not reflect the actual number of countries with cases. Additionally, data from the previous 28-day period are continuously being updated to incorporate retrospective changes made by countries regarding reported COVID-19 cases and deaths. Data presented in this report are therefore incomplete and should be interpreted considering these limitations. Some countries continue to report high burdens of COVID-19, including increases in newly reported cases and, more importantly, increases in hospitalizations and deaths – the latter of which are considered more reliable indicators given reductions in testing.

As many countries discontinue COVID-19-specific reporting and integrate it into respiratory disease surveillance, WHO will use all available sources to continue monitoring the COVID-19 epidemiological situation, especially data on illness and impact on health systems. COVID-19 remains a major threat, and WHO urges Member States to maintain, not dismantle, their established COVID-19 infrastructure. It is crucial to sustain early warning, surveillance and reporting, variant tracking, early clinical care provision, administration of vaccine to high-risk groups, improvements in ventilation, and regular communication.

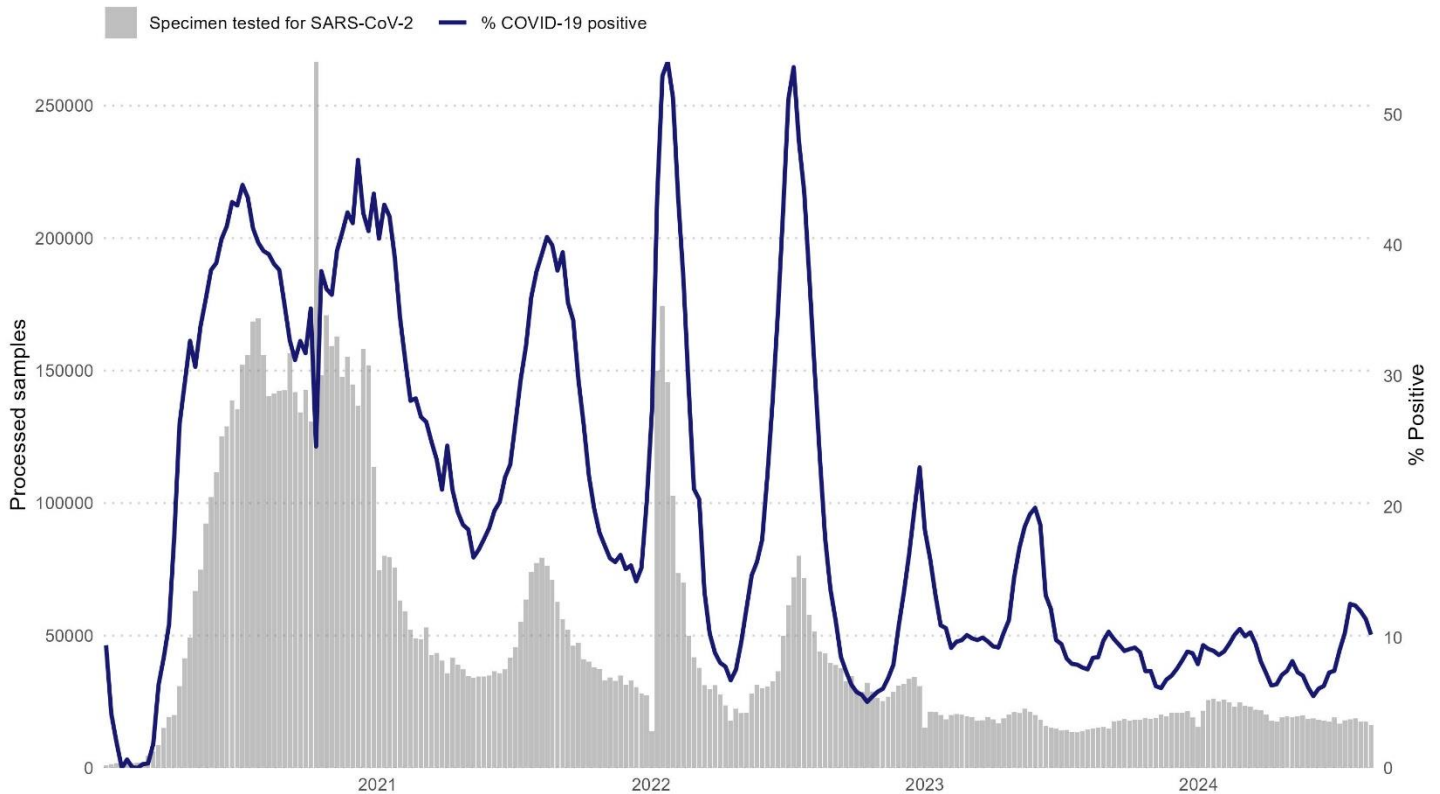
[‡] [Show us the data: global COVID-19 wastewater monitoring effectors, equity, and gaps](#)

[§] [Capturing the SARS-CoV-2 infection pyramid within the municipality of Rotterdam using longitudinal sewage surveillance](#)

^{**} [Omicron COVID-19 Case Estimates Based on Previous SARS-CoV-2 Wastewater Load, Regional Municipality of Peel, Ontario, Canada](#)

SARS-CoV-2 Test Positivity

Figure 1. Weekly SARS-CoV-2 percent test positivity reported to FluNet from sentinel sites, from 05 January 2020 to 18 August 2024


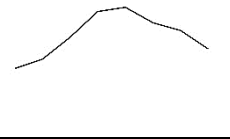
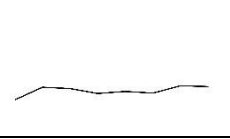
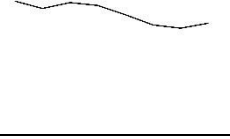
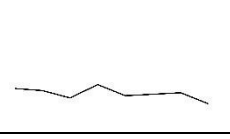
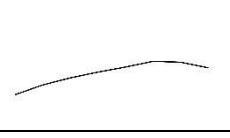
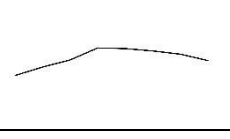


Source: *Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet; WHO Global Influenza Programme*

At the regional level, at the end of the reporting period (22 July to August 18 2024), the highest SARS-CoV-2 activity was observed in the European Region (changing from 19.6% to 17.1% across 29 countries), followed by the Region of the Americas (from 21.7% to 14.0% across 19 countries), Western Pacific Region (from 9.2% to 9.1% across eight countries), Eastern Mediterranean Region (from 5.8% to 6.7% across seven countries), South-East Asia Region (from 4.3% to 2.8% across six countries), and the Africa Region (from 2.1 % to 3.2% across 19 countries) (Table 1).

At the country level, 88 countries reported SARS-CoV-2 test positivity from sentinel sites at least once during the reporting period (Figure 3). From the first to the fourth week of the reporting period, 17% (15/88) of countries reported an increase of more than 2.5% in weekly percent positivity. The top five highest increases in percent test positivity during the reporting period were reported from: Ukraine (from 14.3% to 29.0%) Republic of Korea (from 29.3% to 43.4%), Haiti (from 0% to 11.8%), Switzerland (from 16% to 26.7%), and Brazil (from 2.5% to 11.1%). At the end of the reporting week ending on August 18, 2024, 39% (34/88) of countries reported elevated SARS-CoV-2 activity (10% test positivity or more) with the five highest being: Azerbaijan (100%), Cyprus (100%), Belgium (66.7%), Poland (57.1%), and Ireland (52.4%).

Table 1. SARS-CoV-2 test positivity as reported from sentinel sites by WHO Region during four-week reporting period (22 July to 18 August 2024)

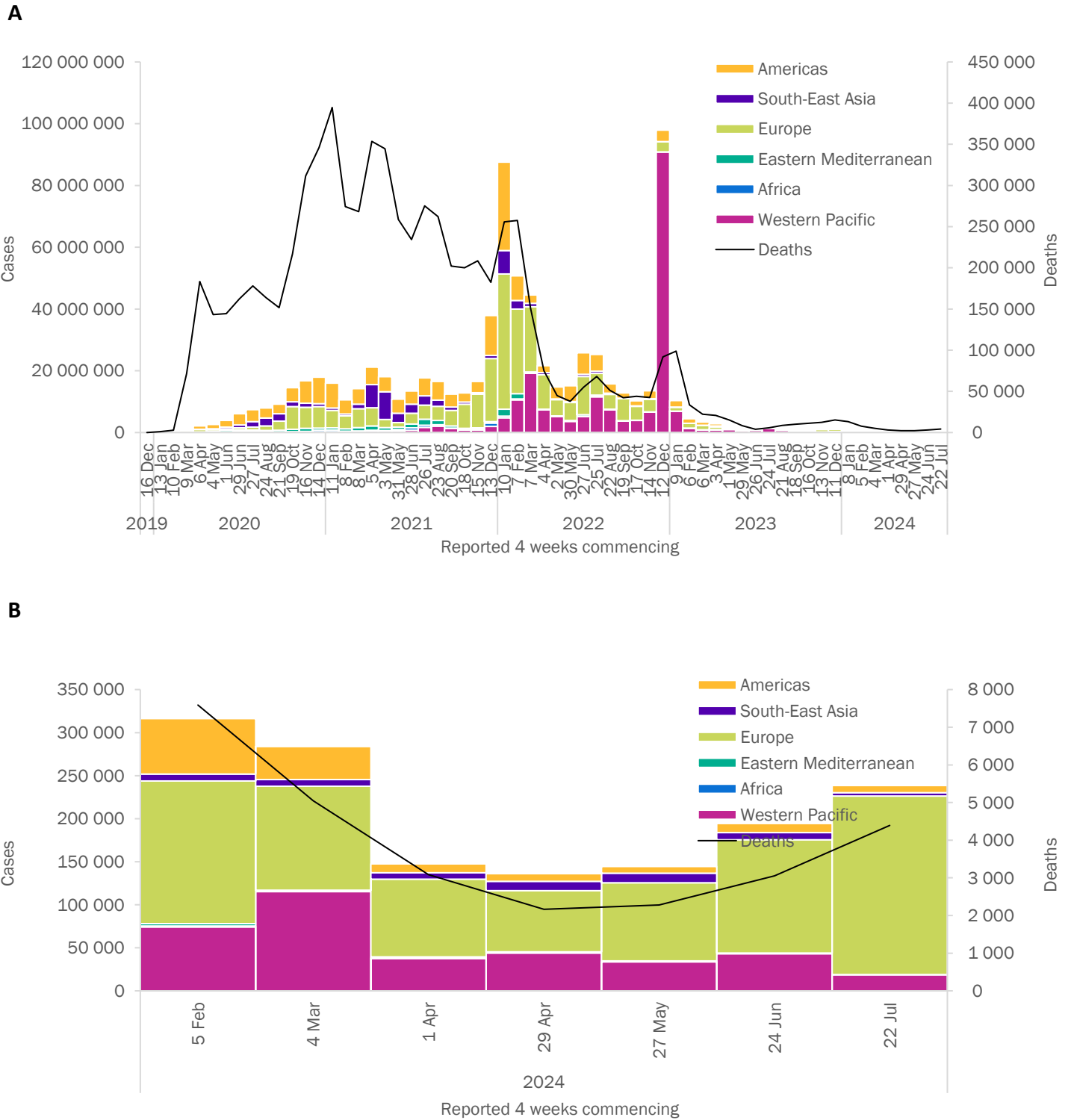
WHO Region	TPR trend for the past eight weeks [‡]	Number of countries reporting at least once	Weekly percent test positivity* (number of specimens tested)			
			2024-30	2024-31	2024-32	2024-33
Africa		19	2.1% (1525)	2.2% (1431)	1.9% (1390)	3.2% (1271)
Americas		19	21.7% (4853)	18.9% (4407)	17.4% (4241)	14.0% (4034)
Eastern Mediterranean		7	5.8% (671)	5.5% (654)	6.9% (627)	6.7% (612)
Europe		29	19.6% (1693)	17.7% (1546)	17.1% (1396)	17.1% (1358)
South-East Asia		6	4.3% (958)	4.6% (814)	4.8% (932)	2.8% (786)
Western Pacific		8	9.2% (9026)	10.3% (8531)	10.1% (8883)	9.1% (8102)
Global		88	12.4% (18 726)	12.0% (17 383)	11.4% (17 469)	10.2% (16 163)

[‡]From week 26 to week 33 2024

*Percent test positivity is calculated by dividing the number of SARS-CoV-2 detections by the number of specimens tested for SARS-CoV-2 and expressed in percentage. Data from previous weeks are updated continuously with adjustments received from countries

COVID-19 Morbidity and Mortality trends

Figure 2. COVID-19 cases and global deaths by 28-day intervals reported by WHO Region, as of 18 August 2024 (A); 5 February to 18 August 2024 (B)**



**See [Annex 1: Data, table, and figure note](#)

At the regional level, the number of newly reported 28-day cases decreased across four of the six WHO regions: the Western Pacific Region (-57%), the South-East Asia Region (-53%), the African Region (-51%), and the Region of the Americas (-23%); while case numbers increased in one WHO regions: the European Region (+58%). The number of newly reported 28-day deaths decreased across three regions: the African Region (-93%), the South-East Asia Region (-62%), and the Western Pacific Region (-17%); while death numbers increased in two WHO regions: the Region of the Americas (+60%), and the European Region (+21%).

At the country level, the highest numbers of new 28-day cases were reported from Italy (62 800 new cases; +127%), the Russian Federation (37 122 new cases; +64%), Greece (21 903 new cases; +26%), Romania (17 405 new cases; +332%), and Poland (11 599 new cases; +334%). The highest numbers of new 28-day deaths were reported from the United States of America (3223 new deaths; +65%), Italy (254 new deaths; +80%), Portugal (175 new deaths; -41%), Greece (162 new deaths; +40%), Sweden (135 new deaths; +611%), and New Zealand (79 new deaths; -37%).

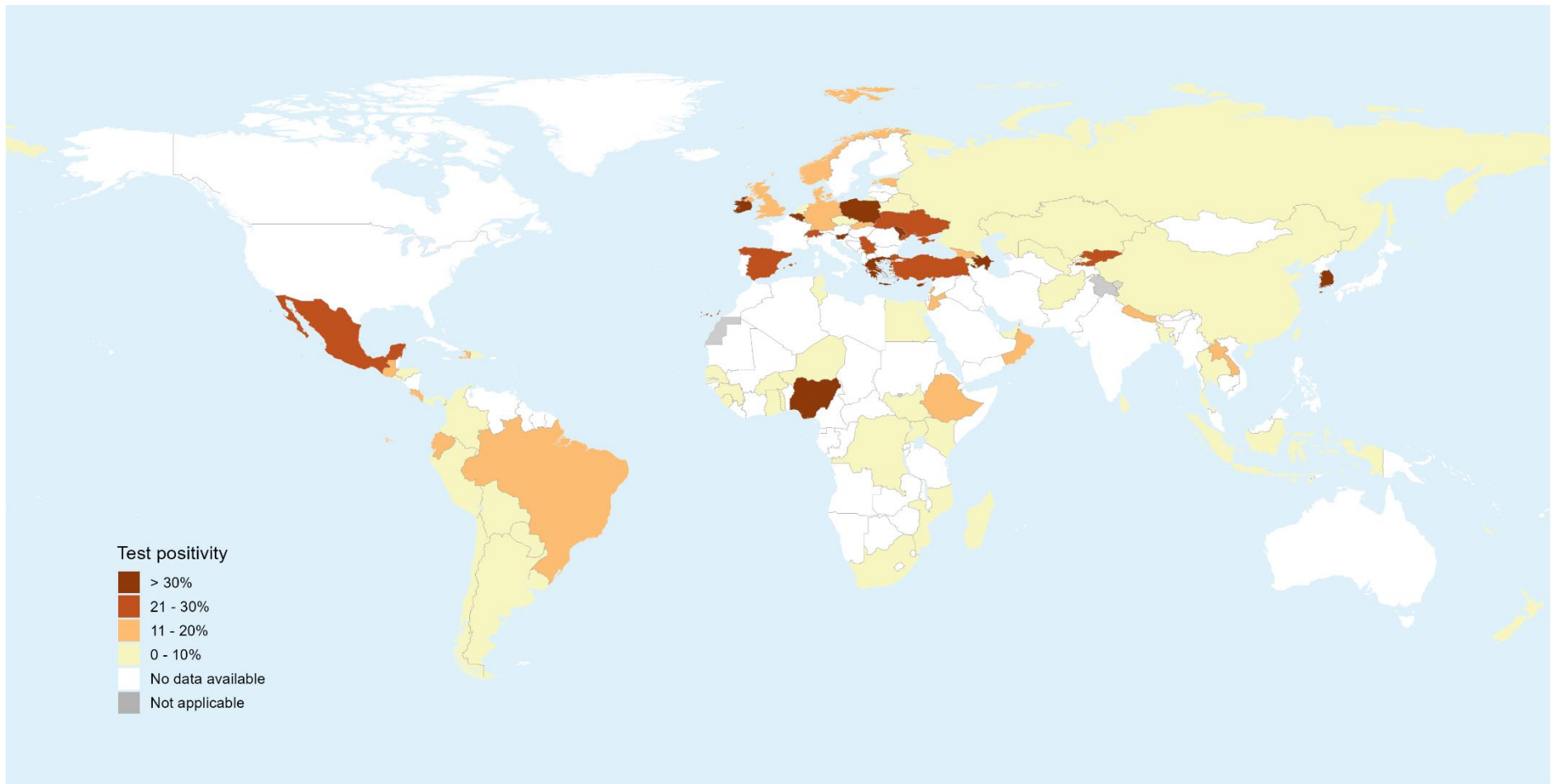
Table 2. Newly reported and cumulative COVID-19 confirmed cases and deaths by WHO Region, as of 18 August 2024**

WHO Region	New cases in last 28 days (%)	Change in new cases in last 28 days *	Cumulative cases (%)	New deaths in last 28 days (%)	Change in new deaths in last 28 days *	Cumulative deaths (%)	Countries reporting cases in the last 28 days	Countries reporting deaths in the last 28 days
Europe	207 217 (87%)	58%	279 839 772 (36%)	935 (21%)	21%	2 274 365 (32%)	32/61 (52%)	20/61 (33%)
Western Pacific	18 655 (8%)	-57%	208 556 812 (27%)	121 (3%)	-17%	421 392 (6%)	11/35 (31%)	4/35 (11%)
Americas	8 220 (3%)	-23%	193 293 860 (25%)	3 320 (76%)	60%	3 027 525 (43%)	21/56 (38%)	7/56 (12%)
South-East Asia	3 918 (2%)	-53%	61 315 364 (8%)	15 (0%)	-62%	808 814 (11%)	6/10 (60%)	3/10 (30%)
Africa	406 (0%)	-51%	9 582 654 (1%)	1 (0%)	-93%	175 528 (2%)	21/50 (42%)	1/50 (2%)
Eastern Mediterranean	0 (0%)	NA%	23 417 911 (3%)	0 (0%)	NA%	351 975 (5%)	0/22 (<1%)	0/22 (<1%)
Global	238 416 (100%)	23%	776 007 137 (100%)	4 392 (100%)	44%	7 059 612 (100%)	91/234 (39%)	35/234 (15%)

*Percent change in the number of newly confirmed cases/deaths in the past 28 days, compared to 28 days prior. Data from previous weeks are updated continuously with adjustments received from countries.

**See [Annex 1: Data, table, and figure notes](#)

Figure 3. SARS-CoV-2 percent test positivity from sentinel sites during the week ending on 18 August 2024

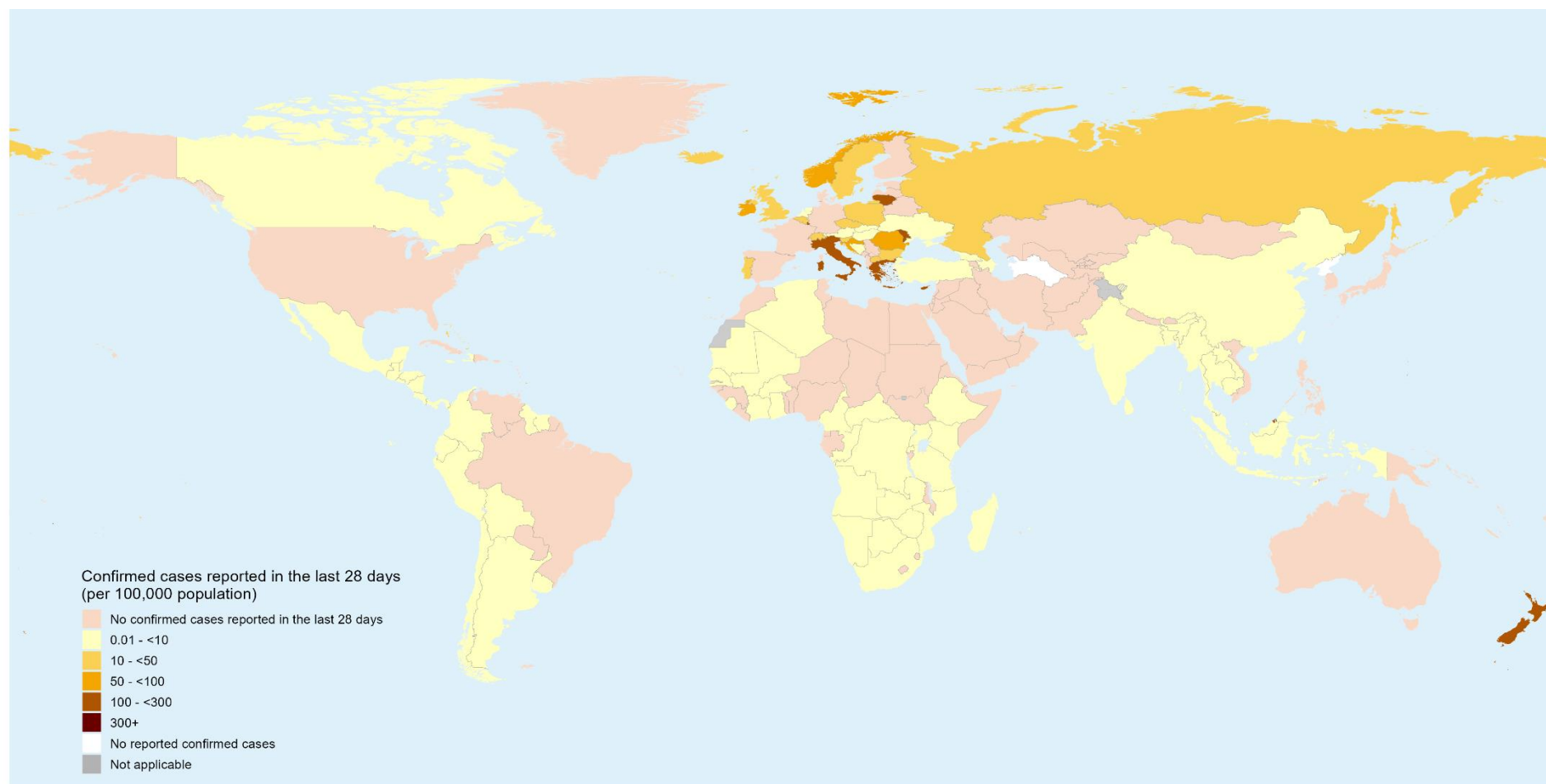


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Data Source: World Health Organization, Global Influenza Surveillance and Response System (GISRS)
Map Production: WHO Health Emergencies Programme
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Source: [Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet](#); WHO *Global Influenza Programme*

Figure 4. Number of confirmed COVID-19 cases reported over the last 28 days per 100 000 population, as of 18 August 2024**

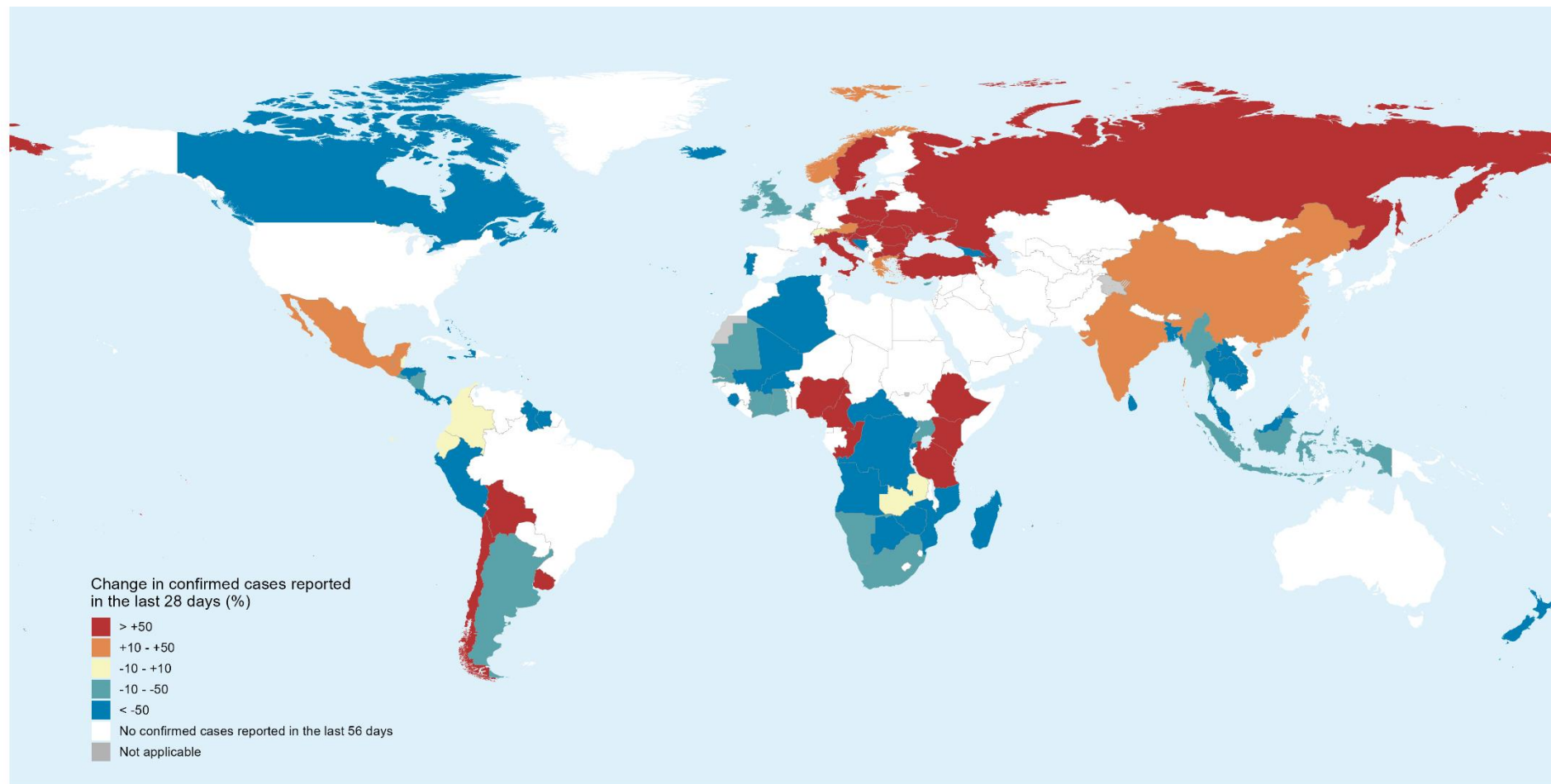


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Data Source: World Health Organization, United Nations Population Division, EuroStat
Map Production: WHO Health Emergencies Programme
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**See [Annex 1: Data, table, and figure notes](#)

Figure 5. Percentage change in confirmed COVID-19 cases over the last 28 days relative to the previous 28 days, as of 18 August 2024**

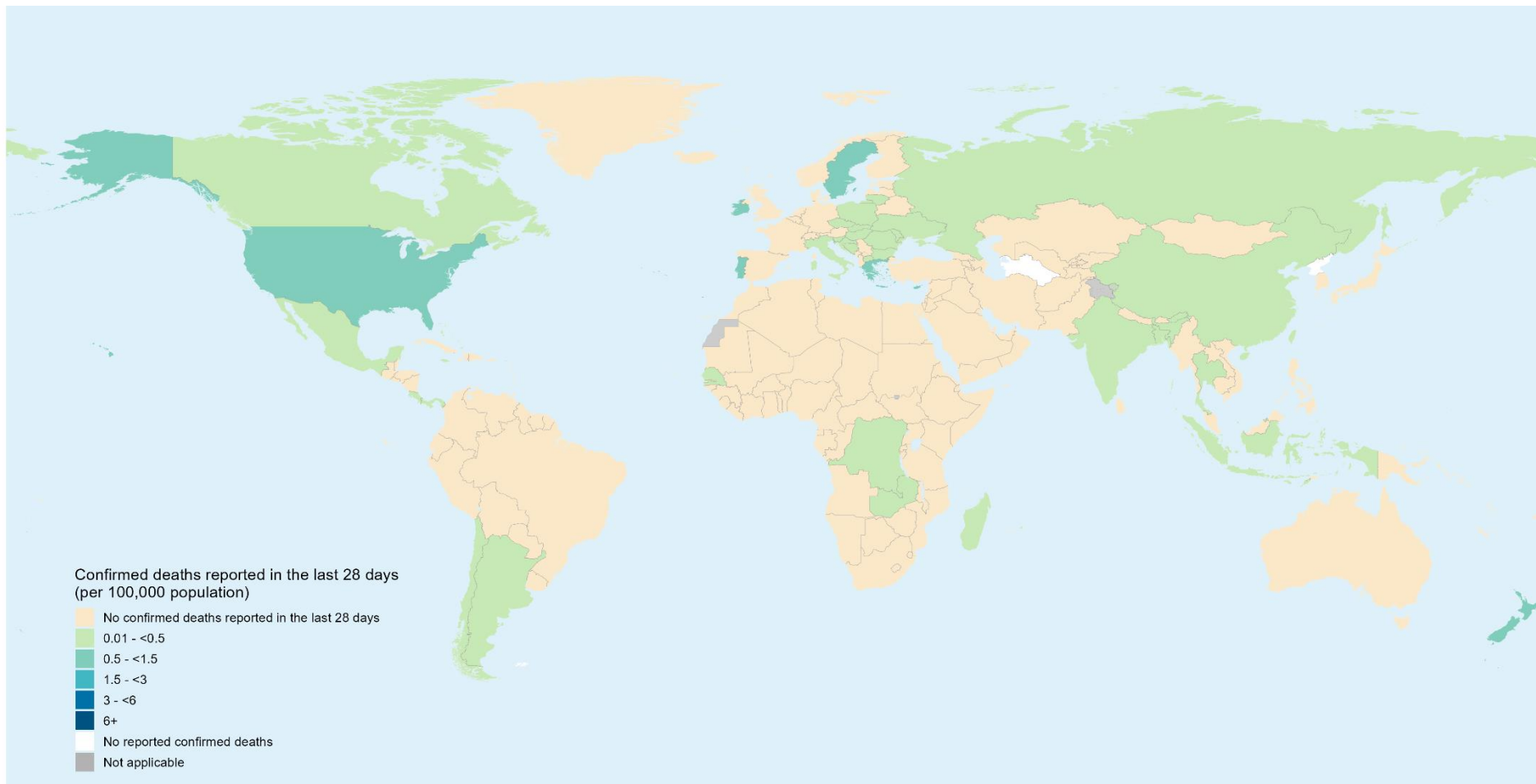


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Data Source: World Health Organization
Map Production: WHO Health Emergencies Programme
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**See [Annex 1: Data, table, and figure notes](#)

Figure 6. Number of COVID-19 deaths reported over the last 28 days per 100 000 population, as of 18 August 2024 **

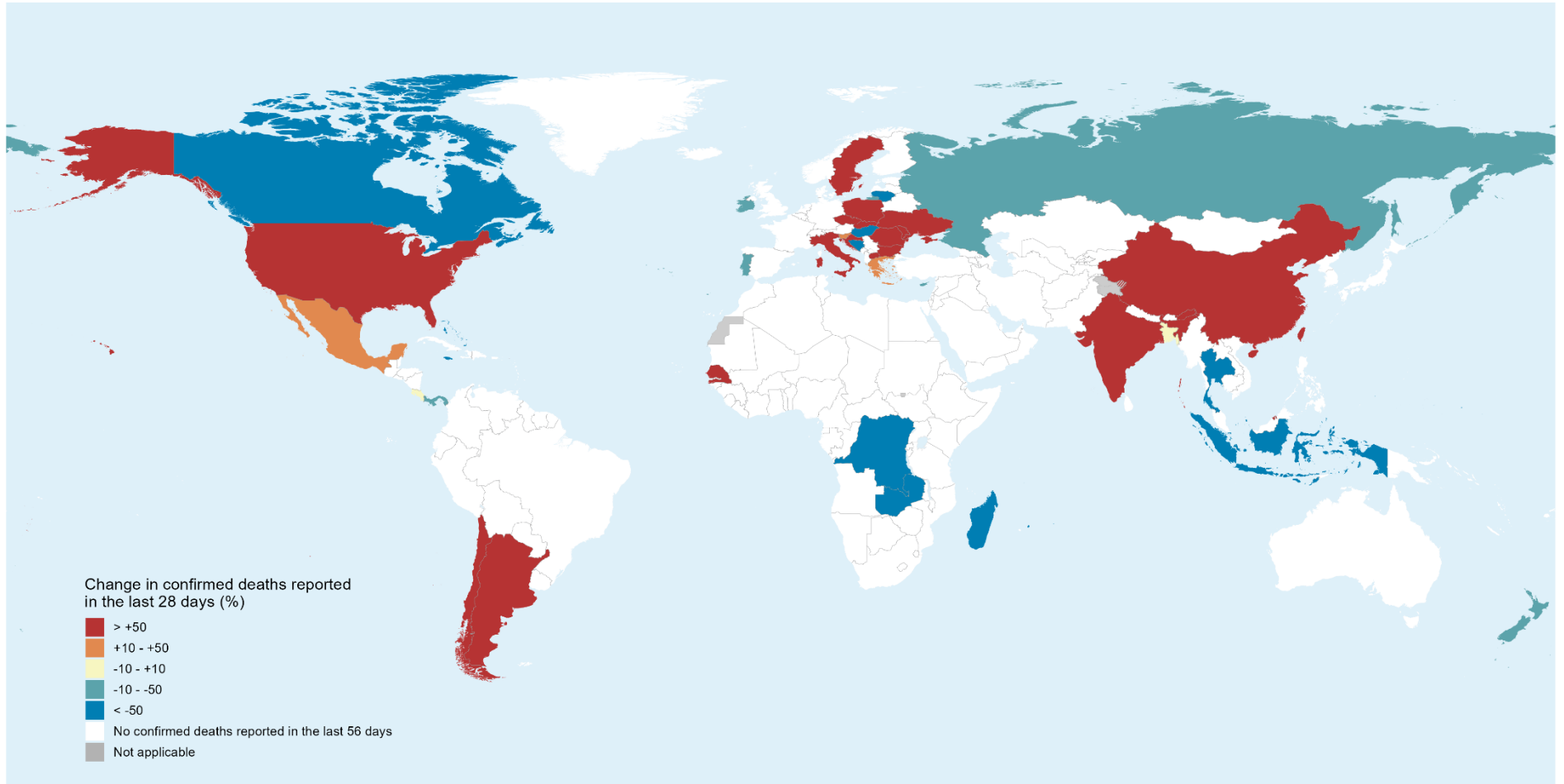


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Data Source: World Health Organization, United Nations Population Division, EuroStat
Map Production: WHO Health Emergencies Programme
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**See [Annex 1: Data, table, and figure notes](#)

Figure 7. Percentage change in confirmed COVID-19 deaths over the last 28 days relative to the previous 28 days, as of 18 August 2024**



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Data Source: World Health Organization
Map Production: WHO Health Emergencies Programme
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**See *Annex 1: Data, table, and figure notes*

Hospitalizations and ICU admissions

At the global level, during the 28 days from 22 July to 18 August 2024, a total of 27 227 new hospitalizations and 859 new ICU admissions were reported from 45 and 32 countries, respectively. Among the countries reporting these data consistently over the current and past reporting period, there was an overall marginal 3% decrease in hospitalization and 36% increase in new ICU admissions, respectively, compared to the previous 28 days (24 June to 21 July 2024) (Tables 3 and 4). The increasing trend is mainly driven by countries from the Region of the Americas and the European Region. Note that the absence of reported data from some countries to WHO does not imply that there are no COVID-19-related hospitalizations in those countries. The presented hospitalization data are preliminary and might change as new data become available. Furthermore, hospitalization data are subject to reporting delays. These data also likely include both hospitalizations with incidental cases of SARS-CoV-2 infection and those due to COVID-19 disease.

New hospitalizations

During the 28-day period from 22 July to 18 August 2024, 45 (19%) countries reported data to WHO on new hospitalizations at least once (Table 3). The Region of the Americas had the highest proportion of countries reporting data on new hospitalizations (22 countries; 39%), followed by the European Region (14 countries; 23%), South-East Asia Region (two countries; 20%), the Western Pacific Region (four countries; 11%), and the African Region (three countries; 6%). No country in the Eastern Mediterranean Region shared data during the period. The number of countries that consistently⁴ reported new hospitalizations for the period was 40 (17%) (Table 3).

Among the 40 countries consistently reporting new hospitalizations, 17 (44%) countries registered an increase of 20% or greater in hospitalizations during the past 28 days compared to the previous 28-day period: Ukraine (17 vs 3; >100%), Czechia (111 vs 23; >100%), Slovakia (125 vs 31; >100%), Bolivia (3 vs 1; >100%), Bosnia and Herzegovina (18 vs 8; >100%), Ecuador (224 vs 101; >100%), Uruguay (27 vs 14; 93%), Italy (3677 vs 2045; 80%), North Macedonia (16 vs 10; 60%), Mexico (963 vs 629; 53%), Chile (42 vs 28; 50%), Bangladesh (6 vs 4; 50%), Guatemala (3 vs 2; 50%), United States of America (5767 vs 4057; 42%), Brazil (1291 vs 963; 34%), Greece (3344 vs 2504; 34%), and Argentina (190 vs 156; 22%)

Table 3. Number of new hospitalization admissions reported by WHO regions, 22 July to 18 August 2024 compared to 24 June to 21 July 2024

Region	Countries reported at least once in the past 28 days		Countries reported consistently in the past and previous 28 days*		
	Number of countries (percentage)**	Number of new hospitalizations	Number of countries (percentage)**	Number of new hospitalizations	Percent change in new hospitalizations
Africa	3/50 (6%)	6	2/50 (4%)	0 [#]	N/A
Americas	22/56 (39%)	10 040	19/56 (32%)	9969	+34%
Eastern Mediterranean	0/22 (<1%)	N/A ⁺	0/22 (<1%)	N/A	N/A
Europe	14/61 (21%)	13 298	13/61 (20%)	13 297	+16%
South-East Asia	2/10 (20%)	2448	2/10 (20%)	2448	-64%
Western Pacific	4/35 (11%)	1435	4/35 (11%)	1435	-40%
Global	45/234 (19%)	27 227	40/234 (17%)	27 149	-3%

*Percent change is calculated for countries reporting consistently both in the past 28 days and the previous 28 days (comparison period).

**Number of countries reported / total number of countries in the region (percentage of reporting).

⁺ N/A represents not available or not applicable.

[#] WHO emphasizes the importance of maintaining reporting and encourages countries to report the absence of new admissions ("zero reporting") if there are no new hospital or ICU admissions during the week.

New ICU admissions

Across the six WHO regions, in the past 28 days, a total of 32 (14%) countries reported data to WHO on new ICU admissions at least once (Table 4). The Region of the Americas had the highest proportion of countries reporting data on new ICU admissions (15 countries; 27%), followed by the European Region (10 countries; 16%), the Western Pacific Region (five countries; 14%) and the African Region (two countries; 4%). No country from the South-East Asia Region and the Eastern Mediterranean Region shared data during the period. The proportion of countries that consistently reported new ICU admissions for the period was 12% (28 countries).

Among the 28 countries consistently reporting new ICU admissions, eight (29%) countries showed an increase of 20% or greater in new ICU admissions during the past 28 days compared to the previous 28-day period: Ecuador (93 vs 17; >100%), Chile (4 vs 1; >100%), Sweden (28 vs 9; >100%), Uruguay (6 vs 2; >100%), Italy (91 vs 49, 86%), Greece (55 vs 35; 57%), Ukraine (3 vs 2; 50%), and Brazil (411 vs 303; 36%)

Table 4. Number of new ICU admissions reported by WHO regions, 22 July to 18 August 2024 compared to 24 June to 21 July 2024

Region	Countries reported at least once in the past 28 days		Countries reported consistently in the past and previous 28 days*		
	Number of countries (percentage)**	Number of new ICU admissions	Number of countries (percentage)**	Number of new ICU admissions	Percent change in new ICU admissions
Africa	2/50 (4%)	0 [#]	2/50 (4%)	0	N/A
Americas	15/56 (27%)	563	13/56 (23%)	558	+53%
Eastern Mediterranean	0/22 (<1%)	N/A ⁺	N/A	N/A	N/A
Europe	10/61 (16%)	217	8/61 (13%)	195	+71%
South-East Asia	0/10 (<1%)	N/A	N/A	N/A	N/A
Western Pacific	5/35 (14%)	79	5/35 (14%)	79	-40%
Global	32/234 (15%)	859	28/234 (12%)	832	+36%

*Percent change is calculated for countries reporting consistently both in the past 28 days and the previous 28 days (comparison period).

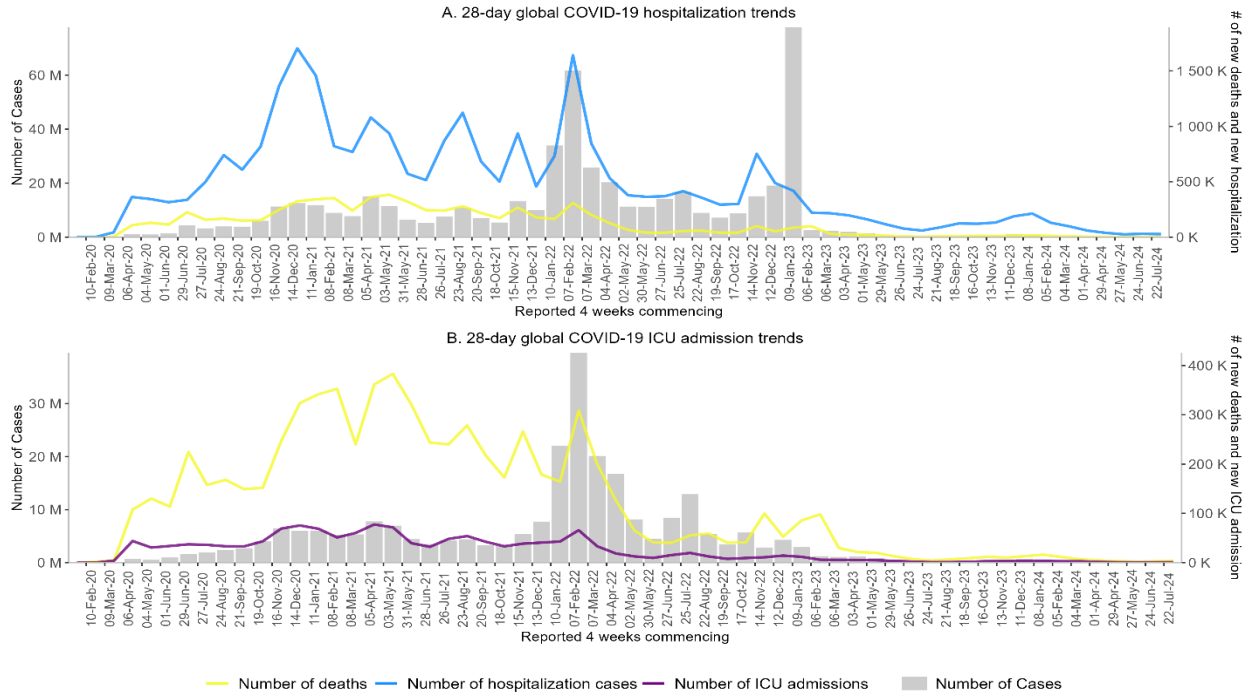
**Number of countries reported / total number of countries in the region (percentage of reporting).

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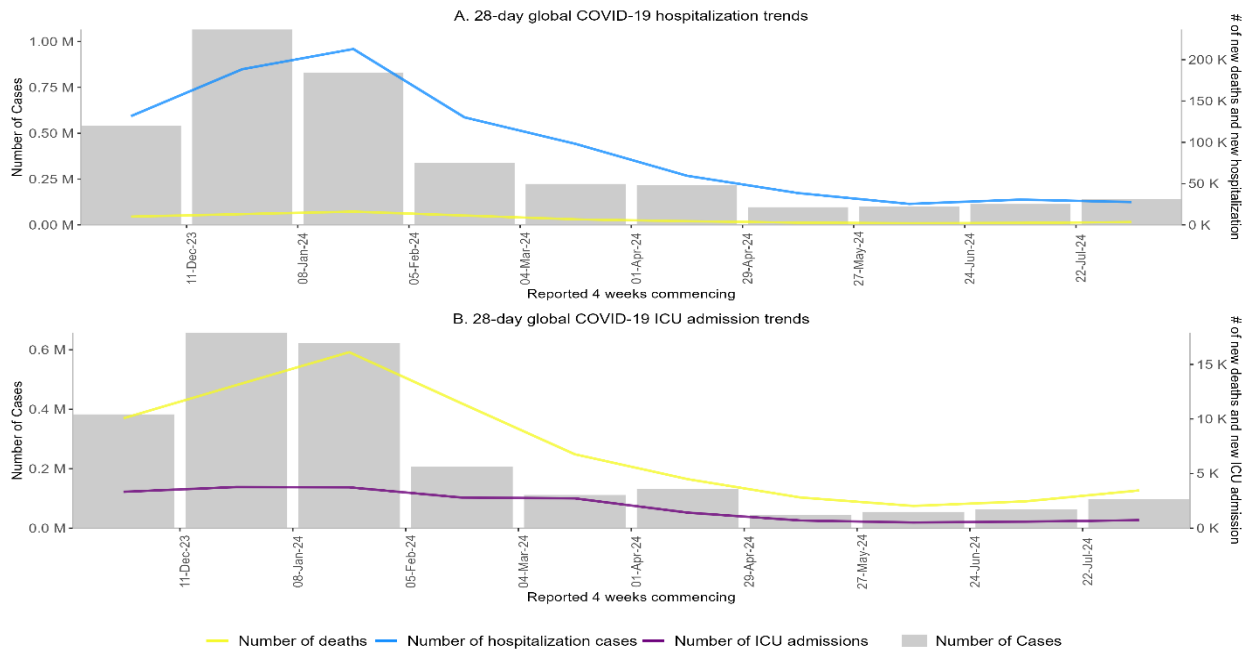
[#] WHO emphasizes the importance of maintaining reporting and encourages countries to report the absence of new admissions ("zero reporting") if there are no new hospital or ICU admissions during the week.

Figure 8. 28-day global COVID-19 hospitalization and ICU admission trends, from 10 February 2020 to 18 August 2024 (A); and from 11 December 2023 to 18 August 2024 (B)

A



B



Note: Recent weeks are subject to reporting delays and data might not be complete, thus the data should be interpreted with caution. Cases included in grey bars are only from countries reporting hospitalizations or ICU admissions, respectively.

Severity indicators

The incidence of ICU admissions per 1000 hospitalizations and the mortality rate per 1000 hospitalizations serve as critical indicators for monitoring the severity of COVID-19 during the pandemic, especially since case-based surveillance is no longer systematically conducted. The ICU admissions per 1000 hospitalizations allow us to evaluate the number of patients requiring intensive care in relation to the total number of hospitalizations, while number of deaths per 1000 hospitalization allow us to monitor deaths occurring among those hospitalized.

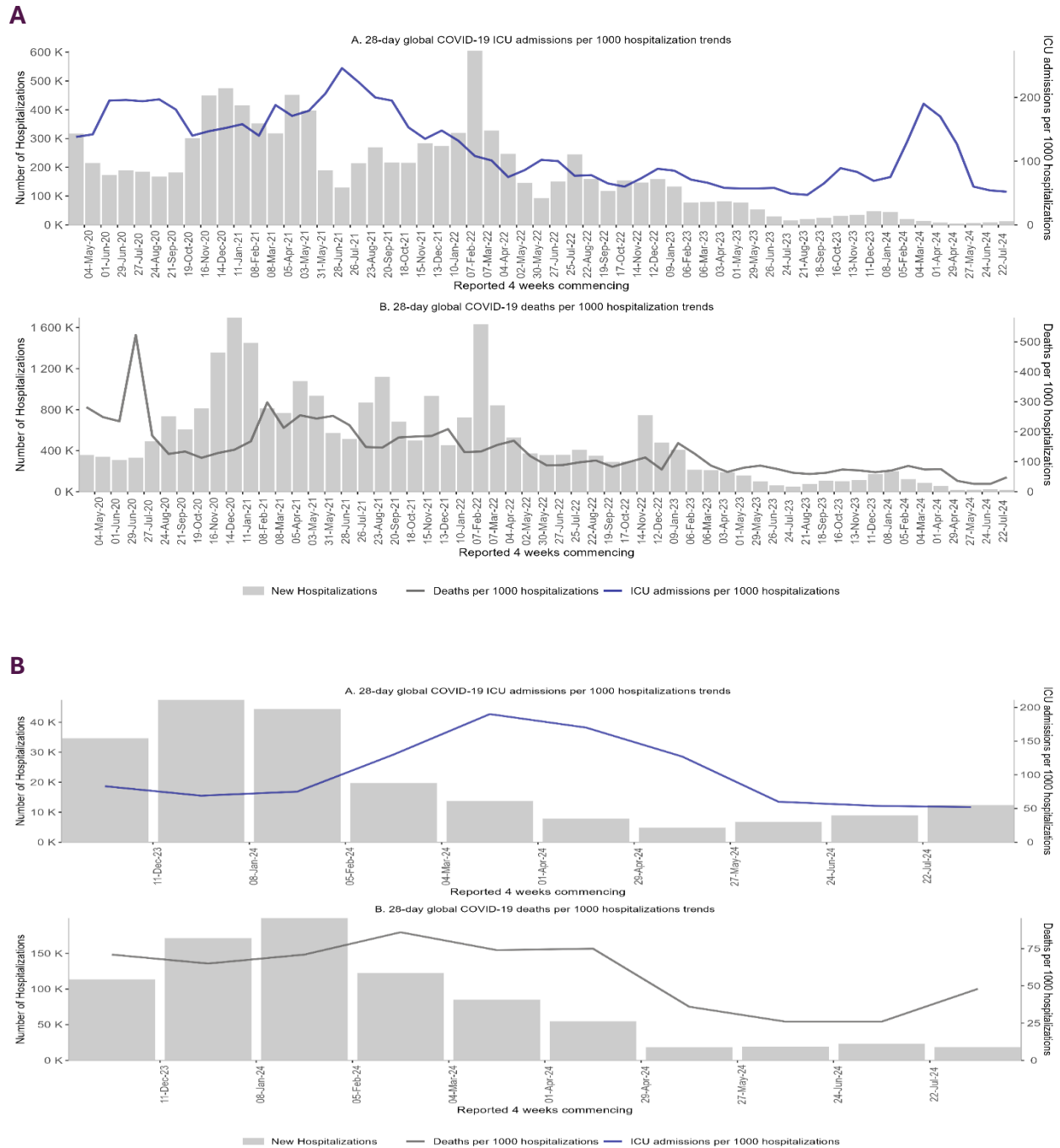
These indicators are subject to the same limitations mentioned in hospitalizations and ICU admissions section and their calculations are limited to the countries reporting all relevant data elements (hospitalizations, ICU admissions and deaths) in a given reporting period. It should be noted that there may be differences in reporting among countries. For instance, in some countries, hospitalization data may include ICU admissions, whereas in others, ICU admissions may be reported separately. Furthermore, it is important to consider that some deaths might have occurred outside of hospital facilities.

Overall, ICU admissions per 1000 hospitalizations have been decreasing since the peak in July 2021 when the rate was 245 per 1000 hospitalizations, dropping below 132 per 1000 hospitalizations at the beginning of 2022, and to less than 69 per 1000 hospitalizations by the end of 2023 (Figure 8). At the beginning of 2024, there was an increase in this rate, rising to above 191 per 1000 hospitalizations in March, and later declining to 52 per 1000 hospitalizations in July 2024. Note that due to limited reporting this does not suggest a global increase in the rate of new hospitalizations requiring intensive care. The number of countries reporting both ICU admissions and hospitalizations continues to decline, and a downward trend of admissions is observed in most of the reporting countries (Table 3 and 4). The combination of these two factors facilitates the fluctuations in the global trend driven by only one or two countries.

The deaths per 1000 hospitalization showed a consistent decline from June 2021 when they reached 253 per 1000 hospitalizations to a low level of 59 per 1000 hospitalizations in August 2023. Since the start of January 2024, the rate has continued to decline reaching 48 deaths per 1000 hospitalizations by the end of July 2024 (Figure 9).

Please note that the causes for these trends cannot be directly interpreted from these data, but likely include a combination of increases or decreases in infection-derived or vaccine-derived immunity, improvements in early diagnosis and clinical care, reduced strain on health systems, and other factors. It is not possible to infer a changed intrinsic virulence amongst newer SARS-CoV-2 variants from these data.

Figure 9. COVID-19 ICU per 1000 hospitalization and death per 1000 hospitalization, from 04 May 2020 to 18 August 2024 (A), and 11 December 2023 to 18 August 2024 (B)



Note: Recent weeks are subject to reporting delays and should not be interpreted as a declining trend. The ICU ratio figure is created from the data of the countries reported both new hospitalizations and new ICU admissions. The death ratio figure is created from the data of the countries that reported both new hospitalization and new deaths.

Source: WHO COVID-19 Detailed Surveillance Dashboard

SARS-CoV-2 variants of interest and variants under monitoring

Geographic spread and prevalence

Globally, during the 28-day period from 22 July to 18 August 2024, 33 795 SARS-CoV-2 sequences were shared through GISAID. In comparison, in the two previous 28-day periods, there were 42 432 and 37 047 sequences shared, respectively. The data are retrospectively updated periodically to include sequences with earlier collection dates, so the number of submissions in a given time period may change.

WHO is currently tracking several SARS-CoV-2 variants, including:

- Variants of interest (VOIs): BA.2.86 and JN.1
- Variants under monitoring (VUMs): JN.1.7, JN.1.18, KP.2, KP.3, KP.3.1.1 and LB.1

Table 5 shows the number of countries reporting VOIs and VUMs, and their prevalence from epidemiological week 30 (22 to 28 July 2024) to week 33 (12 to 18 August 2024). The VOIs and VUMs exhibiting increasing trends are highlighted in yellow, those that have remained stable are highlighted in blue, and those with decreasing trends are highlighted in green.

Globally, JN.1 is the most reported VOI (now reported by 139 countries), accounting for 20.6% of sequences in week 33 and having declined from a prevalence of 22.2% in week 30 (Figure 11, Table 5). Its parent lineage, BA.2.86, continues to show very low prevalence, accounting for 0.1-0.3% of sequences in each week between week 30 and week 33 (Figure 11, Table 5). The last [risk evaluation of JN.1](#) was published on 15 April 2024, with an overall evaluation of low public health risk at the global level based on available evidence.

The six listed VUMs are all JN.1 descendent lineages. KP.3.1.1 is showing increasing prevalence globally and within multiple regions, LB.1 and JN.1.18 are showing stable frequencies while KP.3, KP.2, and JN.1.7 are declining. KP.3 accounted for 21.9% of sequences in week 33 compared to 27.7% in week 30, KP.2 accounted for 13.7% of sequences in week 33 compared to 15.1% in week 30, JN.1.7 accounted for 0.1% of sequences in week 33 compared to 0.3% in week 30, JN.1.18 accounted for 2.7% of sequences in week 33 compared to 2.2% in week 30, LB.1 accounted for 8.8% in week 33 compared to 8.8% in week 30, and KP.3.1.1 accounted for 29.1% of sequences in week 33 compared to 21.2% in week 30.

There is heterogeneity in the number of sequences shared by regions and the relative proportions of SARS-CoV-2 variants between and within regions (Figure 10). For example, KP.3.1.1 has rapidly expanded with the European region over the past 28-days to reach over 25% of sequences from week 29. Conversely, KP.3.1.1 has been rare within the Western Pacific region (WPR) over the past 28-days, accounting for less than 2% of sequences in this period. There are further differences in prevalence within regions, for example KP.3.1.1 accounts for more than 35% of sequences in Spain in the past 28-days, compared to 16% in the United Kingdom. Further, whereas on average the prevalence of KP.3 is higher (48%-54%) than that of KP.2 (5%-15%) in the WPR in the last 28 days, KP.2 represents more than 45% of circulating variants over the same time period in Singapore (with KP.3 at 7%), with

the opposite trend seen in Japan where KP.3 accounts for more than 85% of circulating variants and KP.2 less than 3%.

With rates of testing and sequencing declining globally (Figure 11), it is increasingly challenging to estimate the severity impact of emerging SARS-CoV-2 variants. There are currently no reported laboratory or epidemiological reports indicating any association between VOIs/VUMs and increased disease severity. As shown in Figure 10 and Figure 11, low and unrepresentative levels of SARS-CoV-2 genomic surveillance continue to pose challenges in adequately assessing the variant landscape.

Table 5. Weekly prevalence of SARS-CoV-2 VOIs and VUMs, week 30 to week 33 of 2024

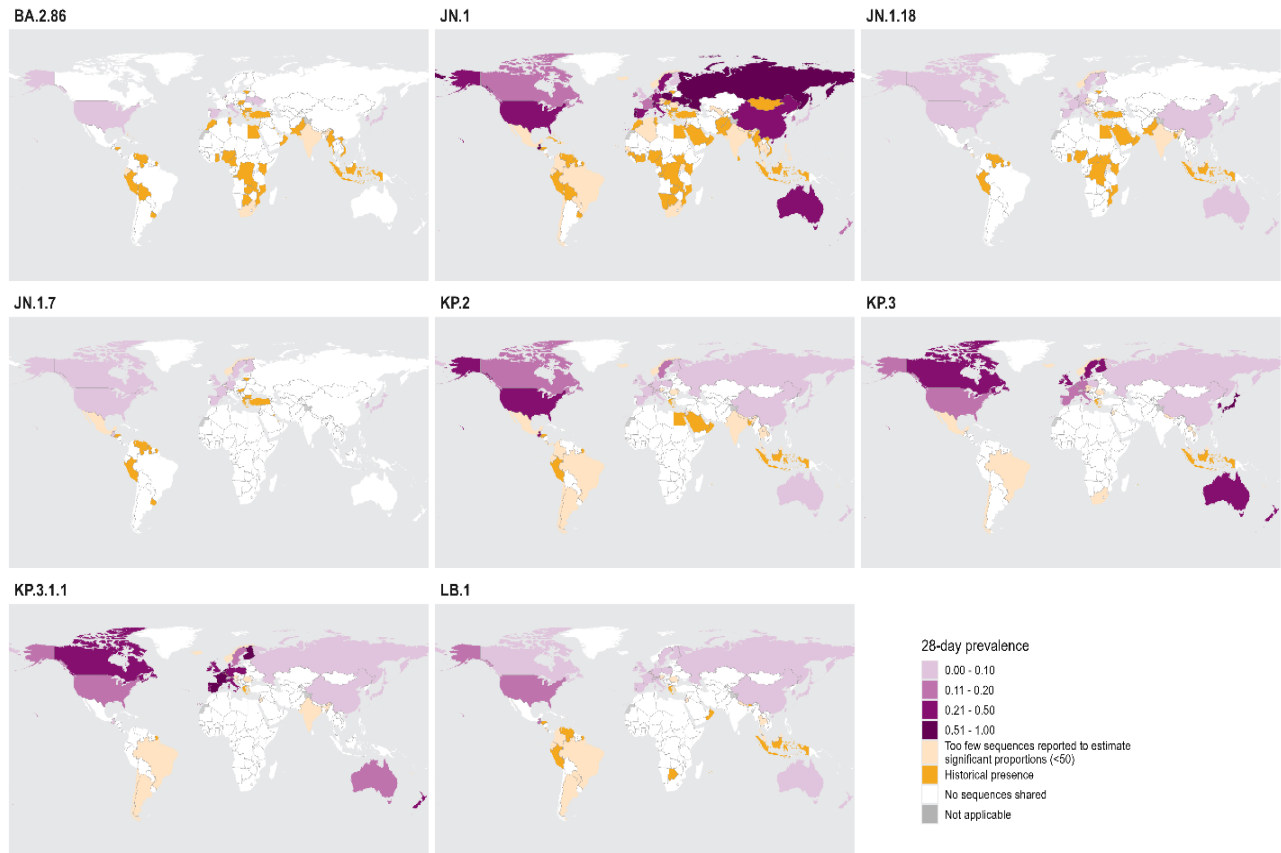
Lineage*	Countries [§]	Sequences [§]	2024-30	2024-31	2024-32	2024-33
VOIs						
BA.2.86	103	23936	0.3	0.1	0.3	0.1
JN.1	139	255450	22.2	22.0	21.0	20.6
VUMs						
JN.1.7	68	9322	0.3	0.2	0.3	0.1
KP.2	78	23377	15.1	15.0	14.8	13.7
KP.3	63	37684	27.7	26.4	23.9	21.9
KP.3.1.1	49	16551	21.2	24.4	27.8	29.1
JN.1.18	87	5737	2.2	2.1	2.8	2.7
LB.1	71	9918	8.8	8.1	7.6	8.8
Recombinant	143	488935	2.1	1.5	1.3	2.2
Unassigned	63	3897	0.1	0.1	0.2	0.7
Others	91	12321	0.1	0.1	0.1	0.1

[§] Number of countries and sequences are since the emergence of the variants. Note, however, that this does not apply to recombinants, unassigned and the other variants categories, and only from 1 June 2023.

* Includes descendant lineages, except those individually specified elsewhere in the table. For example, JN.1* does not include JN.1.7, JN.1.18, KP.2, KP.3, KP.3.1.1 and LB.1

Figure 10. Global 28-day prevalence of VOIs (BA.2.86 and JN.1) and VUMs (LB.1, JN.1.7, JN.1.18, KP.3, and KP.3.1.1), 22 July to 18 August 2024*

Global 28-day prevalence of VOIs and VUMs as of 18 August, 2024



* Reporting period to account for delay in sequence submission to GISAID.

+ Historical presence indicates countries previously reporting sequences of VOIs and VUMs but have not been reported within the period from 22 July to 18 August 2024

Figure 11. The distribution of SARS-CoV-2 variants in available sequence data from different time periods

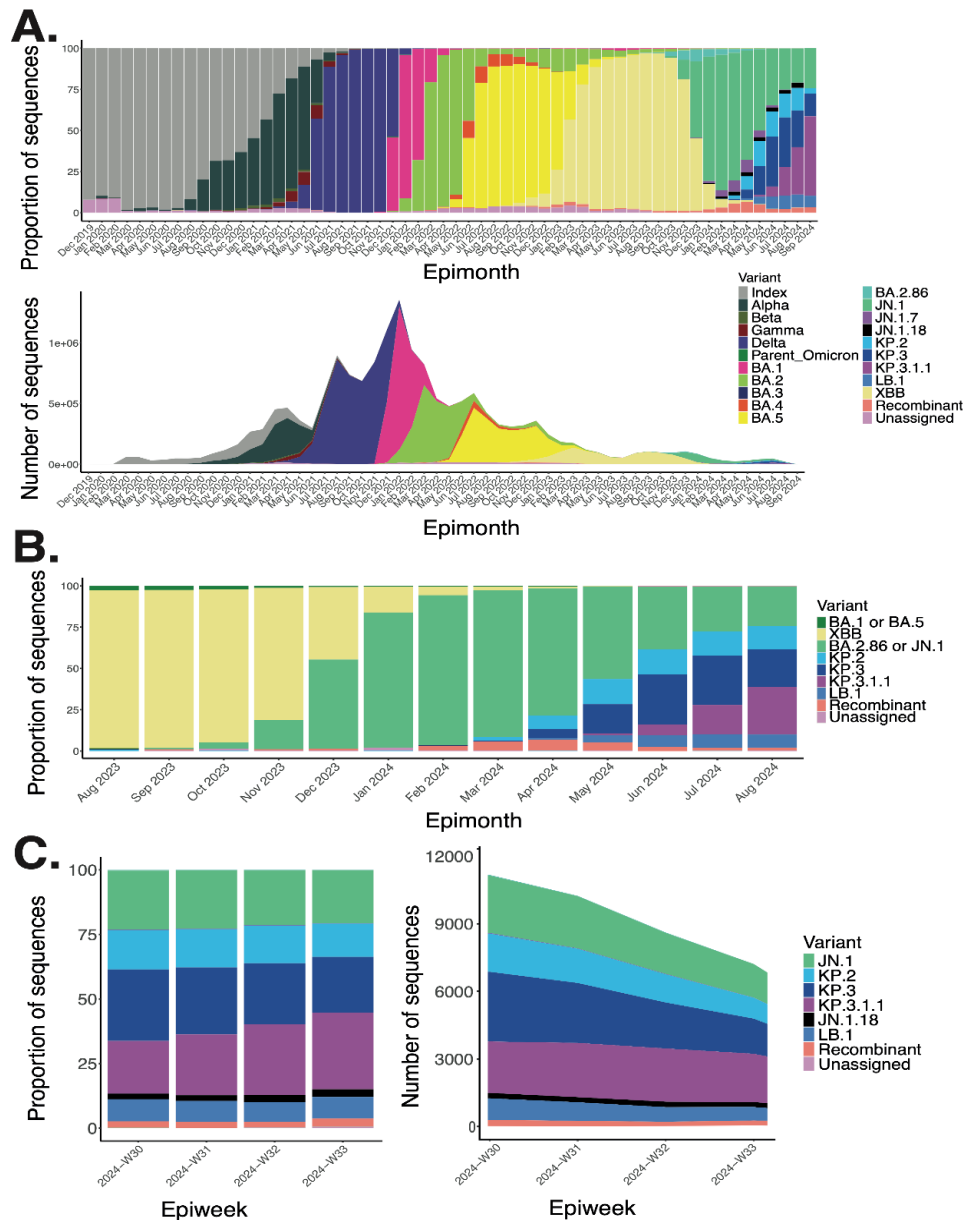


Figure 11. (A) The proportion (top panel) and number (bottom panel) of sequences belonging to each major SARS-CoV-2 variant in each month since the start of the pandemic. (B) The proportion of sequences belonging to each major SARS-CoV-2 variant in each month since August 2023. (C) The proportion (left panel) and number (right panel) of sequences belonging to each SARS-CoV-2 variant in each week from 22 July to 18 August 2024. In B and C, the variants shown include all descendent lineages, except for the descendent lineage(s) that are listed separately, for example KP.3 includes all the lineages that descend from KP.3 with the exception of KP.3.1.1 and its descendent sublineages that are instead included within KP.3.1.1. The *Unassigned* category includes lineages pending for a PANGO lineage name designation, *Recombinant* includes all SARS-CoV-2 recombinant lineages not listed here, and the *Other* category includes lineages that are assigned but not listed here. Source: SARS-CoV-2 sequence data and metadata from GISAID, from 22 July to 18 August 2024, downloaded on 7th September 2024.

Additional resources

- [Tracking SARS-CoV-2 Variants](#)
- [WHO statement on updated tracking system on SARS-CoV-2 variants of concern and variants of interest](#)
- [SARS-CoV-2 variant risk evaluation framework, 30 August 2023](#)
- [WHO JN.1 Updated Risk Evaluation, 9 February 2024](#)
- [WHO BA.2.86 Initial Risk Evaluation, 21 November 2023](#)

WHO regional overviews

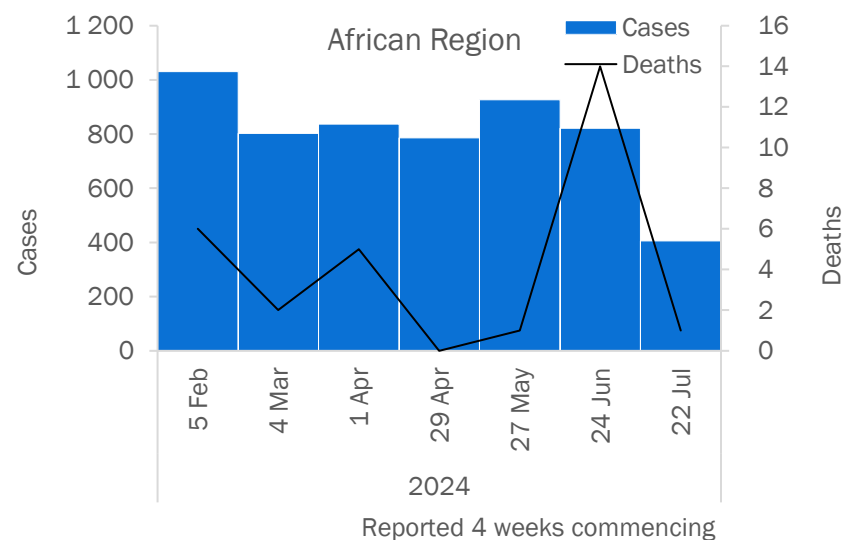
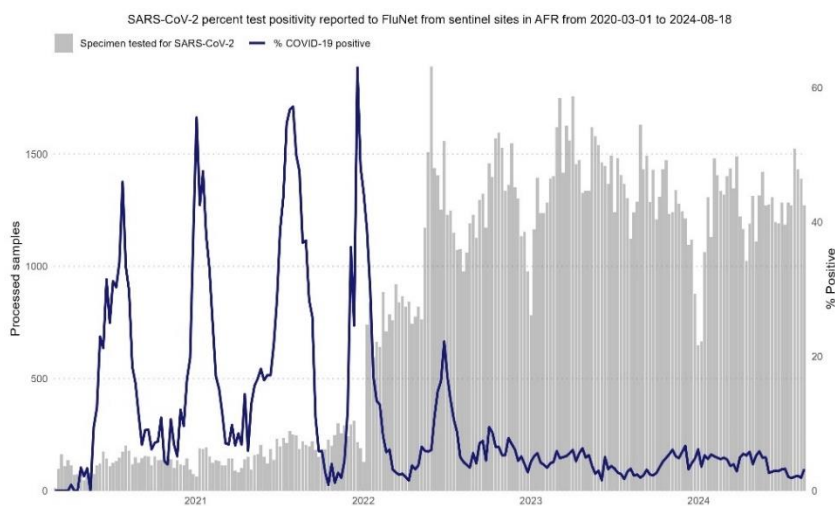
SAR-CoV-2 test positivity from sentinel sites and morbidity and mortality trends

African Region

The SARS-CoV-2 weekly percent test positivity from sentinel sites in the African Region changed from 2.1% to 3.2% across 19 countries who reported at least once during the four-week period. Two countries reported an increase of more than 2.5% in percent test positivity during the four-week reporting period: Ethiopia (from 4.4% to 12.1%) and Senegal (from 3.5% to 7.4%). Two countries have shown elevated SARS-CoV-2 activity (10% or more) in the final week: Nigeria (50%) and Ethiopia (12.1%). During the reporting period, the weekly average number of specimens tested was 1404.

During the 28-day reporting period (22 July to 18 August 2024), the African Region reported over 406 new cases, a 51% decrease compared to the previous 28-day period (24 June to 21 July 2024). Four (8%) of the 50 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Cameroon (17 vs three new cases; >100%), Congo (five vs one new cases; >100%), Kenya (three vs one new cases; >100%), and Ethiopia (27 vs 18 new cases; +50%). The highest numbers of new cases were reported from Mauritius (113 new cases; 8.9 new cases per 100 000; -46%), Zambia (86 new cases; <1 new case per 100 000; +4%), and Senegal (58 new cases; <1 new case per 100 000; -23%).

The number of new 28-day deaths in the Region decreased by 93% as compared to the previous 28-day period, with 1 new death reported. The highest numbers of new deaths were reported from Senegal (1 new death; <1 new death per 100 000; no death reported the previous 28-day period).



Updates from the [African Region](#)

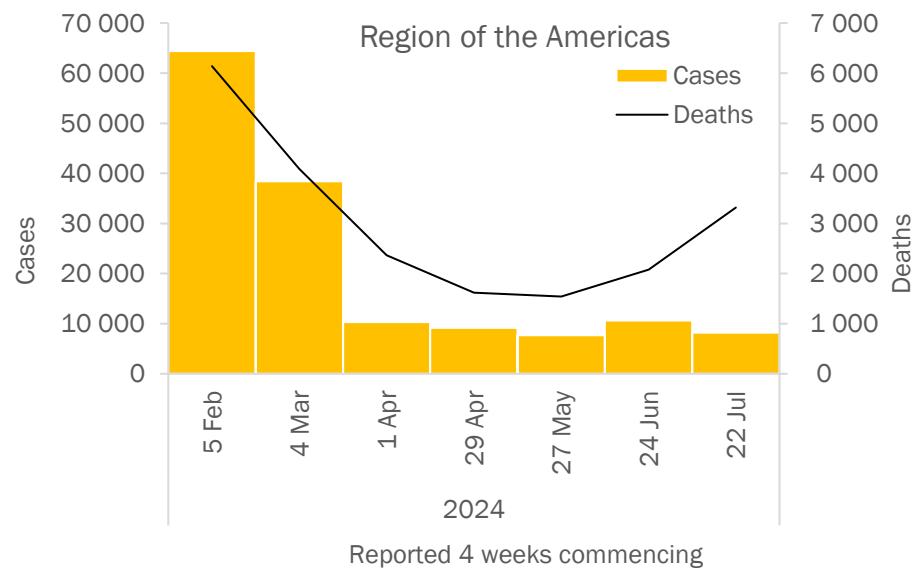
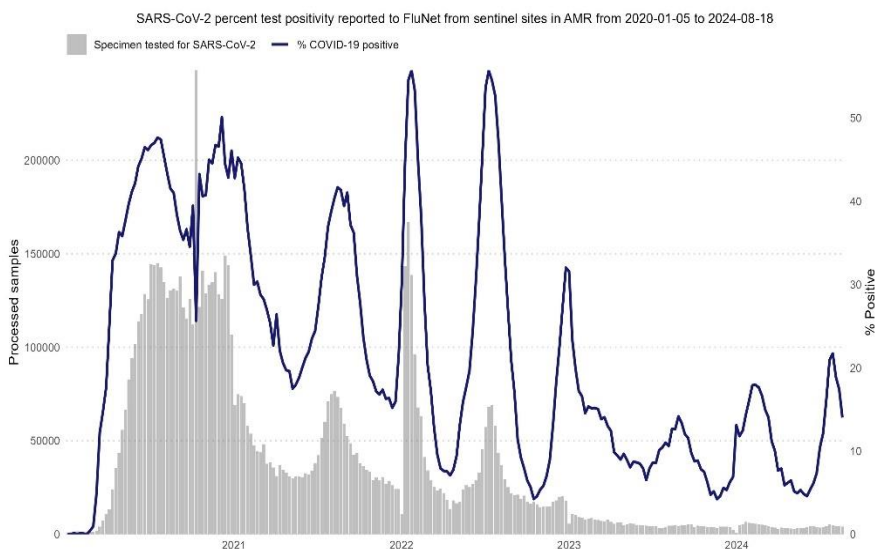
Source: Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet; WHO

Region of the Americas

The SARS-CoV-2 weekly percent test positivity from sentinel sites in the Region of Americas changed from 21.7% to 14.0% across 19 countries which reported at least once during the four-week period. Five countries reported an increase of more than 2.5% in percent test positivity during the four-week reporting period: Haiti (from 0% to 11.76%), Brazil (from 2.46% to 11.1%), Bolivia (from 0% to 7.7%), Ecuador (from 5.5% to 12.2%), and Paraguay (from 2.4% to 8.7%). Six countries showed elevated SARS-CoV-2 activity (10% or more) in the final week: Mexico (24.7%), Guatemala (20.0%), Costa Rica (13.4%), Ecuador (12.2%), Haiti (11.8%), and Brazil (11.1%). During the reporting period, the weekly average number of specimens tested was 4383.

During the 28-day reporting period (22 July to 18 August 2024), the Region of the Americas reported over 8220 new cases, a 23% decrease compared to the previous 28-day period. Four (7%) of the 56 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Uruguay (57 vs 26 new cases; >100%), Plurinational State of Bolivia (two vs one new cases; +100%), Chile (444 vs 242 new cases; +83%), and Barbados (243 vs 149 new cases; +63%). The highest numbers of new cases were reported from Colombia (3133 new cases; 6.2 new cases per 100 000; +8%), Mexico (2425 new cases; 1.9 new cases per 100 000; +11%), and Ecuador (501 new cases; 2.8 new cases per 100 000; +7%).

The number of new 28-day deaths in the Region increased by 60% as compared to the previous 28-day period, with 3320 new deaths reported. The highest numbers of new deaths were reported from the United States of America (3223 new deaths; 1 new death per 100 000; +65%), Mexico (66 new deaths; <1 new death per 100 000; +38%), and Panama (15 new deaths; <1 new death per 100 000; -32%).



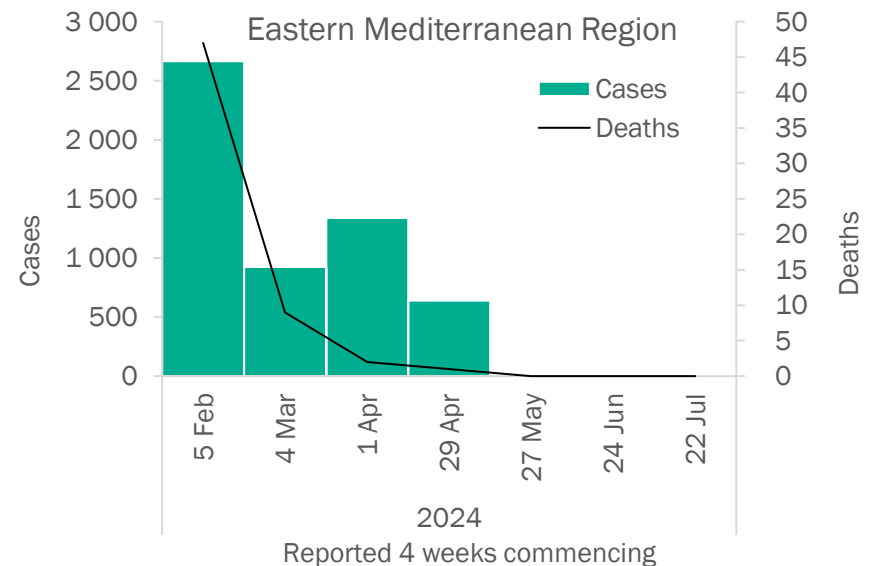
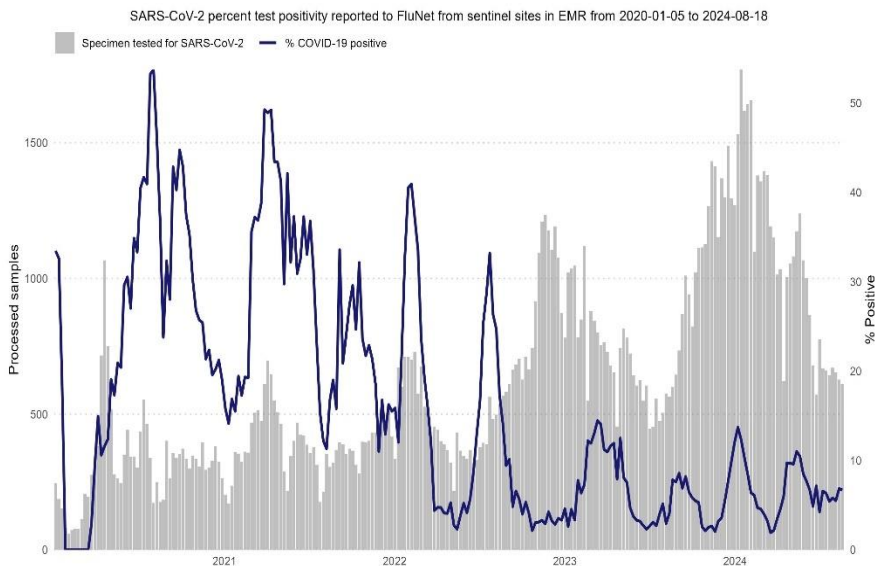
Source: Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet; WHO

Updates from the [Region of the Americas](#)

Eastern Mediterranean Region

The SARS-CoV-2 weekly percent test positivity from sentinel sites in the Eastern Mediterranean Region changed from 5.8% to 7.7% across seven countries which reported at least once during the four-week period. One country reported an increase of more than 2.5% in percent test positivity during the four-week reporting period: Jordan (from 3.6% to 16.2%). Three countries showed elevated SARS-CoV-2 activity (10% or more) in the final week: Lebanon (19.4%), Jordan (16.2%), and Oman (14.6%). During the reporting period, the weekly average number of specimens tested for SARS-CoV-2 was 701.

The Eastern Mediterranean Region did not report data for cases and deaths during this period



Source: Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet; WHO

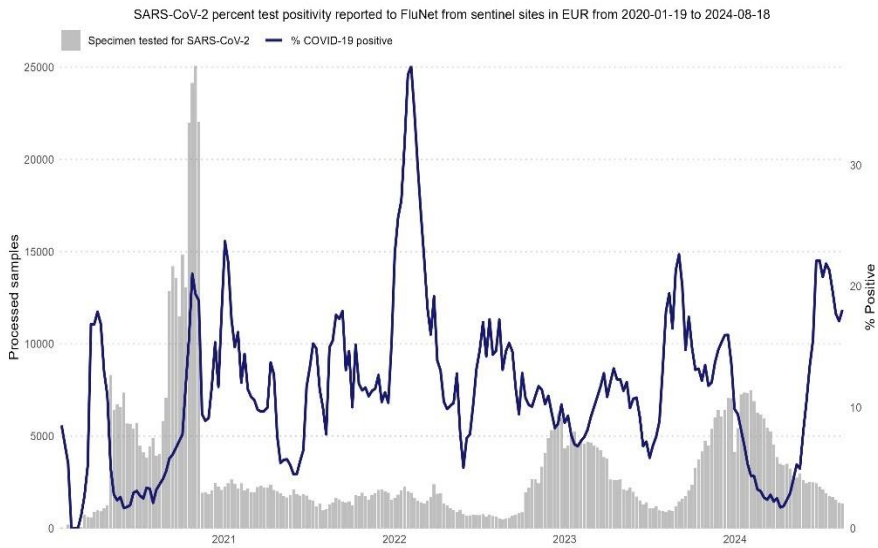
Updates from the Eastern Mediterranean Region

European Region

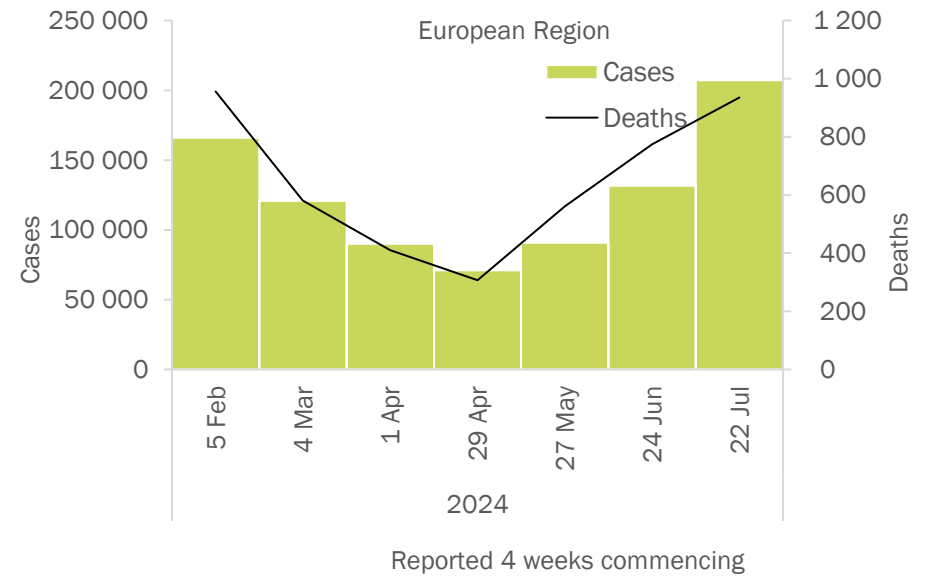
The SARS-CoV-2 weekly percent test positivity from sentinel sites in the European Region during the four-week reporting period changed from 19.6% to 17.6% across 29 countries which reported at least once during the four-week reporting period. Four countries reported an increase of more than 2.5% in percent test positivity during the four-week reporting period: Ukraine (from 14.3% to 29%), Switzerland (from 16% to 26.7%), Greece (from 30.7% to 35.1%), and Denmark (from 13.9% to 18%). Twenty-one countries showed elevated SARS-CoV-2 activity (10% or more) in the final week: Azerbaijan (100%), Cyprus (100%), Belgium (80%), Poland (57.1%), Ireland (52.4%), Slovenia (50%), Republic of Moldova (38.5%), Greece (35.1%), Ukraine (29%), Switzerland (26.7%), Kyrgyzstan (25%), Türkiye (24.1%), Spain (22.8%), Serbia (21.4%), Estonia (20%), Georgia (20%), Denmark (18%), Slovakia (16.7%), Germany (14.5%), Norway (14.3%), and the United Kingdom of Great Britain and Northern Ireland (11.4%). During the reporting period, the weekly average number of specimens tested for SARS-CoV-2 was 1514.

During the 28-day reporting period (22 July to 18 August), the European Region reported over 207 000 new cases, a 58% increase as compared to the previous 28-day period. Twenty (32%) of the 62 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Republic of Moldova (4 848 vs 503 new cases; >100%), Bulgaria (1 333 vs 158 new cases; >100%), North Macedonia (634 vs 114 new cases; >100%), Ukraine (973 vs 176 new cases; >100%), Lithuania (4 239 vs 931 new cases; >100%), Poland (11 599 vs 2 672 new cases; >100%), Romania (17 405 vs 4 027 new cases; >100%), Hungary (483 vs 119 new cases; >100%), Slovakia (354 vs 88 new cases; >100%), Türkiye (four vs one new case; >100%), Czechia (2 879 vs 927 new cases; >100%), Slovenia (625 vs 262 new cases; >100%), Sweden (2 940 vs 1 282 new cases; >100%), Italy (62 800 vs 27 660 new cases; >100%), Croatia (3 907 vs 1 812 new cases; >100%), Azerbaijan (248 vs 147 new cases; +69%), the Russian Federation (37 122 vs 22 574 new cases; +64%), Austria (65 vs 49 new cases; +33%), Norway (2 985 vs 2 353 new cases; +27%), and Greece (21 903 vs 17 396 new cases; +26%). The highest numbers of new cases were reported from Italy (62 800 new cases; 105.3 new cases per 100 000; +127%), the Russian Federation (37 122 new cases; 25.4 new cases per 100 000; +64%), and Greece (21 903 new cases; 204.3 new cases per 100 000; +26%).

The number of new 28-day deaths in the Region increased by 21% as compared to the previous 28-day period, with 935 new deaths reported. The highest numbers of new deaths were reported from Italy (254 new deaths; <1 new death per 100 000; +80%), Portugal (175 new deaths; 1.7 new deaths per 100 000; -41%), and Greece (162 new deaths; 1.5 new deaths per 100 000; +40%).



Source: [Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet](#); WHO



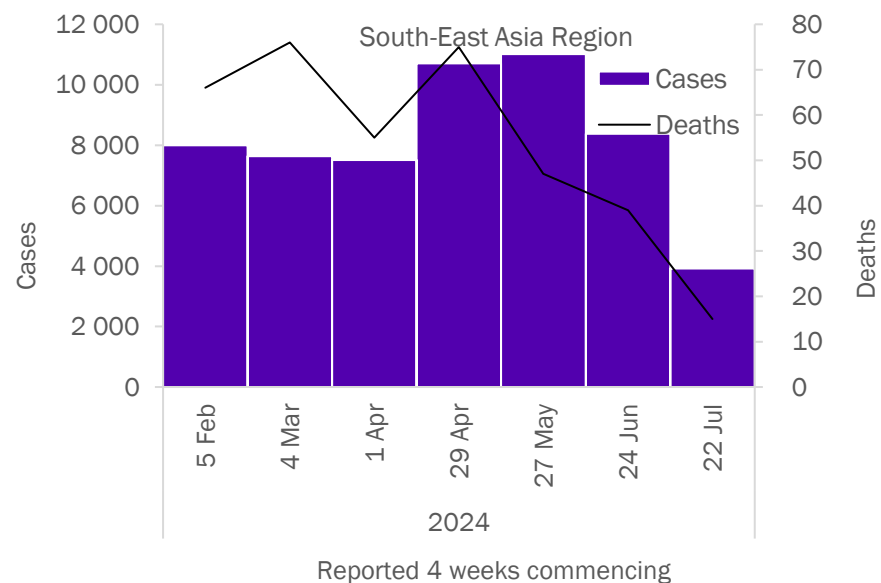
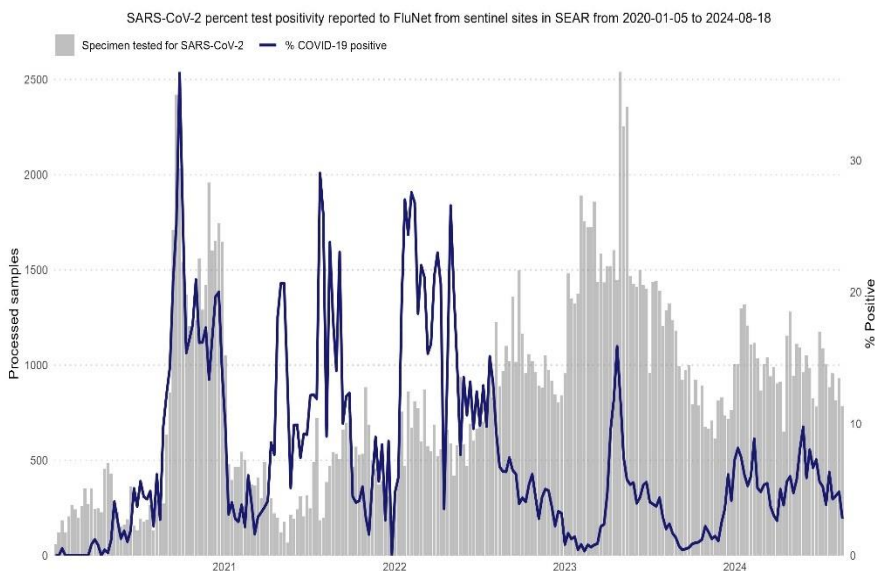
Updates from the [European Region](#)

South-East Asia Region

The SARS-CoV-2 weekly percent test positivity from sentinel sites in the South-East Region during the four-week reporting period changed from 4.3% to 2.8% across six countries which reported at least once during the four-week period. No country reported an increase of more than 2.5% in percent test positivity during the four-week reporting period. One country showed elevated SARS-CoV-2 activity (10% or more) in the final week: Nepal (13.2%). During the reporting period, the weekly average number of specimens tested for SARS-CoV-2 was 872.

During the 28-day reporting period (22 July to 18 August 2024), the South-East Asia Region reported over 3918 new cases, a 53% decrease as compared to the previous 28-day period. One (9%) of the 11 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in India (1 128 vs 908 new cases; +24%). The highest numbers of new cases were reported from Thailand (2442 new cases; 3.5 new cases per 100 000; -64%), India (1128 new cases; <1 new case per 100 000; +24%), and Indonesia (162 new cases; <1 new case per 100 000; -30%).

The number of new 28-day deaths in the Region decreased by 62% as compared to the previous 28-day period, with 15 new deaths reported. The highest numbers of new deaths were reported from Thailand (8 new deaths; <1 new death per 100 000; -77%), India (6 new deaths; <1 new death per 100 000; +200%), and Bangladesh (1 new death; <1 new death per 100 000; similar to the previous 28-day period).



Source: [Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet](#); WHO

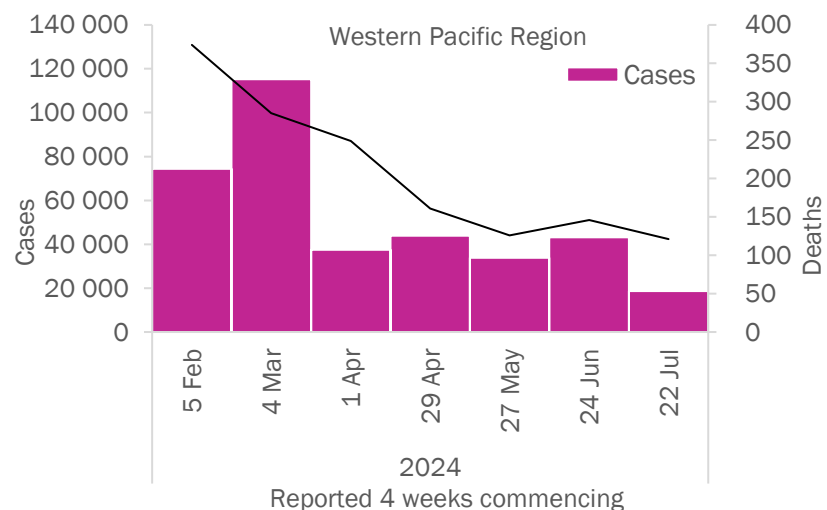
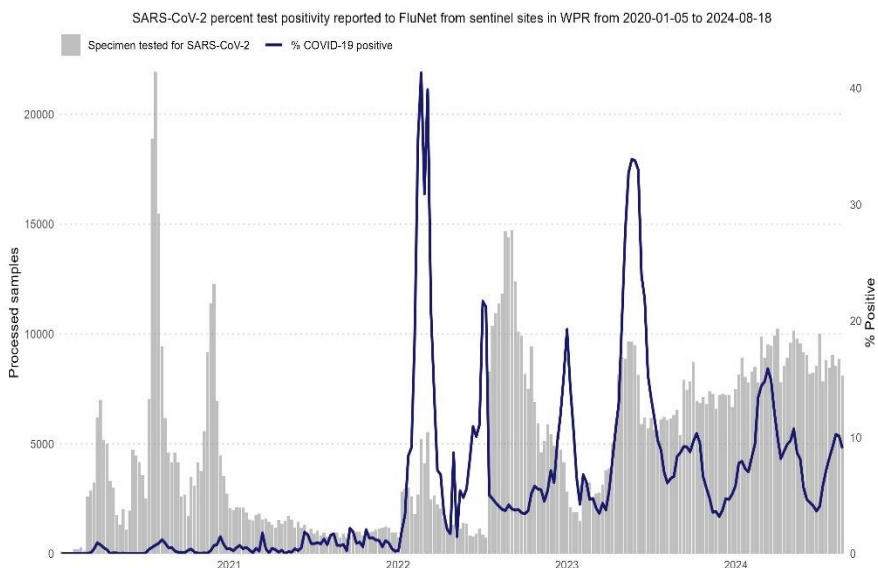
Updates from the [South-East Asia Region](#)

Western Pacific Region

The SARS-CoV-2 weekly percent test positivity from sentinel sites in the Western Pacific Region changed from 9.2% to 9.1% across eight countries which reported at least once during the four-week period. Three countries reported an increase of more than 2.5% in percent test positivity during the four-week reporting period: Republic of Korea (from 29.2% to 43.4%), Lao People’s Democratic Republic (from 10% to 14.3%), and New Zealand (from 4.5% to 8%). Two countries showed elevated SARS-CoV-2 activity (10% or more) in the final week: Republic of Korea (43.4%) and Lao People’s Democratic Republic (14.3%). During the reporting period, the weekly average number of specimens tested for SARS-CoV-2 was 8639.

During the 28-day reporting period (22 July to 18 August 2024), the Western Pacific Region reported over 18 000 new cases, a 57% decrease as compared to the previous 28-day period. Three (9%) of the 35 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in French Polynesia (79 vs 27 new cases; >100%), Tonga (13 vs seven new cases; +86%), and Cook Islands (31 vs 17 new cases; +82%). The highest numbers of new cases were reported from China (7794 new cases; <1 new case per 100 000; +15%), New Zealand (6943 new cases; 144 new cases per 100 000; -59%), and Malaysia (2576 new cases; 8 new cases per 100 000; -79%).

The number of new 28-day deaths in the Region decreased by 17% as compared to the previous 28-day period, with 121 new deaths reported. The highest numbers of new deaths were reported from New Zealand (79 new deaths; 1.6 new deaths per 100 000; -37%), China (39 new deaths; <1 new death per 100 000; +70%), and Brunei Darussalam (2 new deaths; <1 new death per 100 000; no death reported the previous 28-day period).



Source: [Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet](#); WHO

Updates from the [Western Pacific Region](#)

Annex 1. Data, table, and figure notes

Data presented are based on official laboratory-confirmed COVID-19 cases 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 incidences, and variable delays to reflecting these data at the global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/areas. In some instances, reporting frequencies between national and subnational level might be different and retrospectively completed. Differences are to be expected between information products published by WHO, national public health authorities, and other sources.

A record of historic data adjustment is available upon request by emailing epi-data-support@who.int. Please specify the countries of interest, time period, 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.

‘Countries’ may refer to countries, territories, areas or other jurisdictions of similar status. 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.

Annex 2. SARS-CoV-2 variants assessment and classification

WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 alter transmission or disease characteristics, or impact the effectiveness of vaccines, therapeutics, diagnostics or public health and social measures (PHSM) applied to control disease spread. Potential variants of concern (VOCs), variants of interest (VOIs) or variants under monitoring (VUMs) are regularly assessed based on the risk posed to global public health.

The classifications of variants will be revised as needed to reflect the continuous evolution of circulating variants and their changing epidemiology. Criteria for variant classification, and the lists of currently circulating and previously circulating VOCs, VOIs and VUMs, are available on the [WHO Tracking SARS-CoV-2 variants website](#). National authorities may choose to designate other variants and are strongly encouraged to investigate and report newly emerging variants and their impact.

WHO continues to monitor SARS-CoV-2 variants, including descendent lineages of VOCs, to track changes in prevalence and viral characteristics. The current trends describing the circulation of Omicron descendent lineages should be interpreted with due consideration of the limitations of current COVID-19 surveillance. These include differences in sequencing capacity and sampling strategies between countries, changes in sampling strategies over time, reductions in tests conducted and sequences shared by countries, and delays in uploading sequence data to GISAID.

Annex 3. SARS-CoV-2 test positivity

SARS-CoV-2 test positivity, as detected in integrated sentinel surveillance as part of the Global Influenza Surveillance and Response System (GISRS) and reported to FluNet, has fast become the most important measure of the circulation of the virus in communities with reduced surveillance activities.

Only data on respiratory specimens tested for SARS-CoV-2 and reported to FluNet from sentinel surveillance were included in the report. Countries may monitor respiratory virus activity using other surveillance approaches; however, those data were not included. Data reported to RespiMart from other sources of respiratory virus surveillance can be viewed [here](#).