COVID-19 Weekly Epidemiological Update

Edition 47, published 6 July 2021

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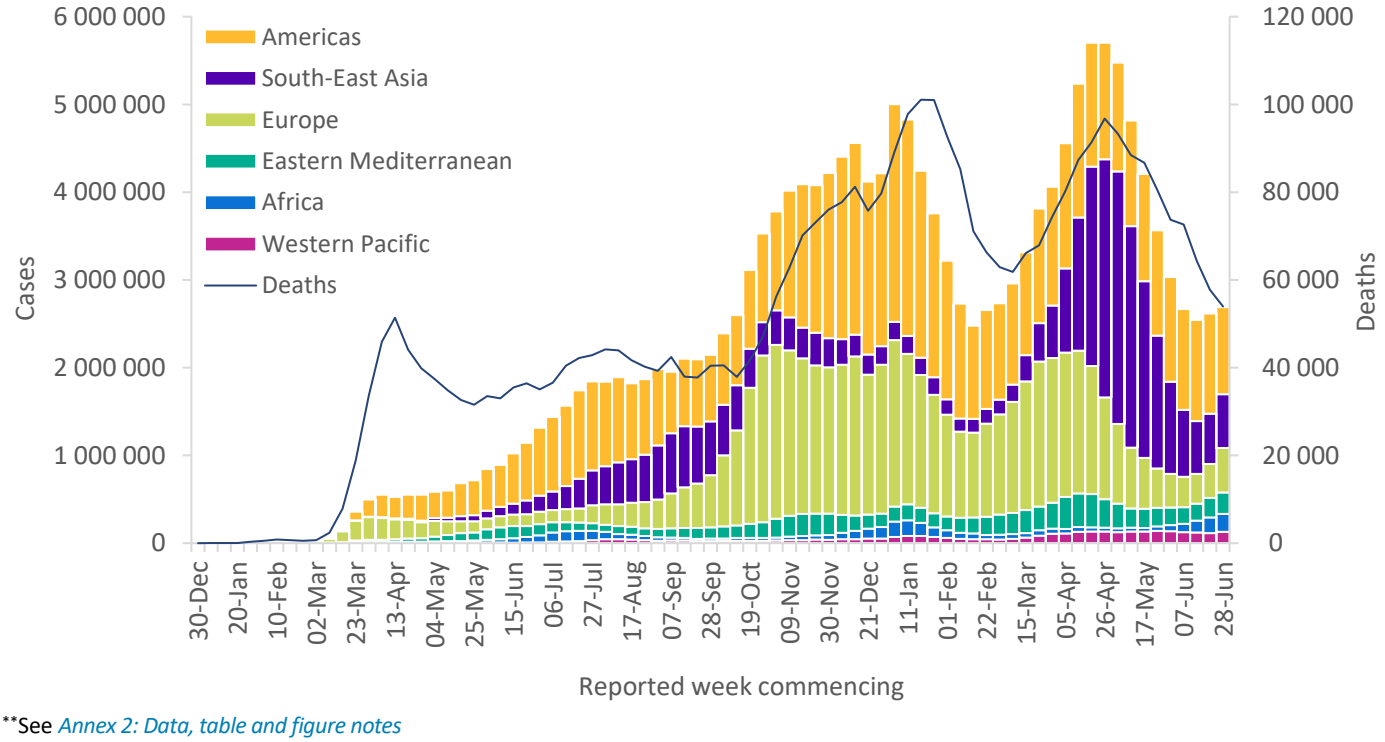
Global overview

Data as of 4 July 2021

Globally, after a decline in newly reported cases for seven consecutive weeks, there has been a slight increase in new weekly cases in the last two weeks, with over 2.6 million cases reported last week (28 June – 4 July 2021) as compared to the previous week (Figure 1). The number of weekly deaths continued to decrease, with just under 54 000 deaths reported in the past week, a 7% decrease as compared to the previous week. This is the lowest weekly mortality figure since early October 2020. The cumulative number of cases reported globally now exceeds 183 million and the number of deaths is almost 4 million.

This week, all Regions except the Americas reported an increase in new cases. The European Region reported a sharp increase in incidence (30%) whereas the African region reported a sharp increase in mortality (23%) as compared to the previous week (Table 1). All Regions, with the exception of the Americas and South-East Asia Regions, reported an increase in the number of deaths in the past week.

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



**See *Annex 2: Data, table and figure notes*

The highest numbers of new cases were reported from Brazil (364 709 new cases; 30% decrease), India (312 250 new cases; 11% decrease), Colombia (204 556 new cases; similar to last week), Indonesia (168 780 new cases; 35% increase), and the United Kingdom (161 805 new cases; 67% increase). Over the past week, the highest numbers of new cases per 100 000 population were reported from Seychelles (758 new cases per 100 000 population), Mongolia (472 new cases per 100 000 population), Colombia (402 new cases per 100 000 population), Namibia (367 new cases per 100 000 population) and Cyprus (324 new cases per 100 000 population).

Globally, cases of the Alpha variant have been reported in 173 countries, territories or areas (hereafter countries; one new country in the past week), Beta in 122 countries (three new countries), Gamma in 74 countries (two new countries) and Delta in 104 countries (7 new countries).

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

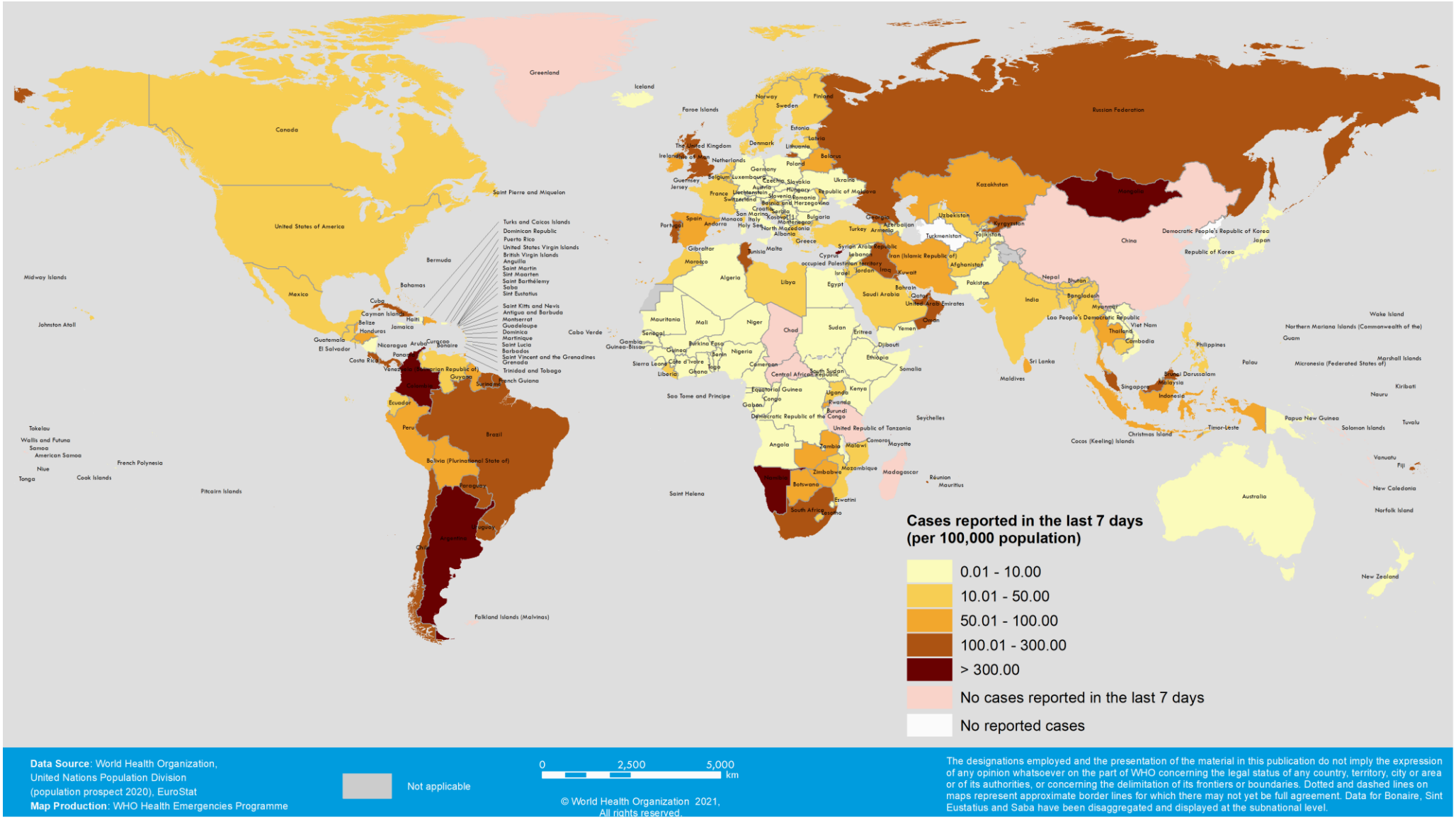
WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	992 023 (37%)	-13%	72 804 991 (40%)	26 721 (50%)	-11%	1 914 473 (48%)
Europe	505 790 (19%)	30%	56 235 850 (31%)	6 926 (13%)	6%	1 189 019 (30%)
South-East Asia	612 933 (23%)	7%	35 219 144 (19%)	11 542 (21%)	-12%	495 939 (12%)
Eastern Mediterranean	245 740 (9%)	11%	11 133 173 (6%)	3 479 (6%)	2%	218 804 (6%)
Africa	204 012 (8%)	15%	4 172 433 (2%)	3 359 (6%)	23%	97 682 (2%)
Western Pacific	128 063 (5%)	10%	3 631 664 (2%)	1 931 (4%)	7%	55 757 (1%)
Global	**2 688 561 (100%)**	**3%**	**183 198 019 (100%)**	**53 958 (100%)**	**-7%**	**3 971 687 (100%)**

**Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior*
**See *Annex 2: Data, table and figure notes*

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

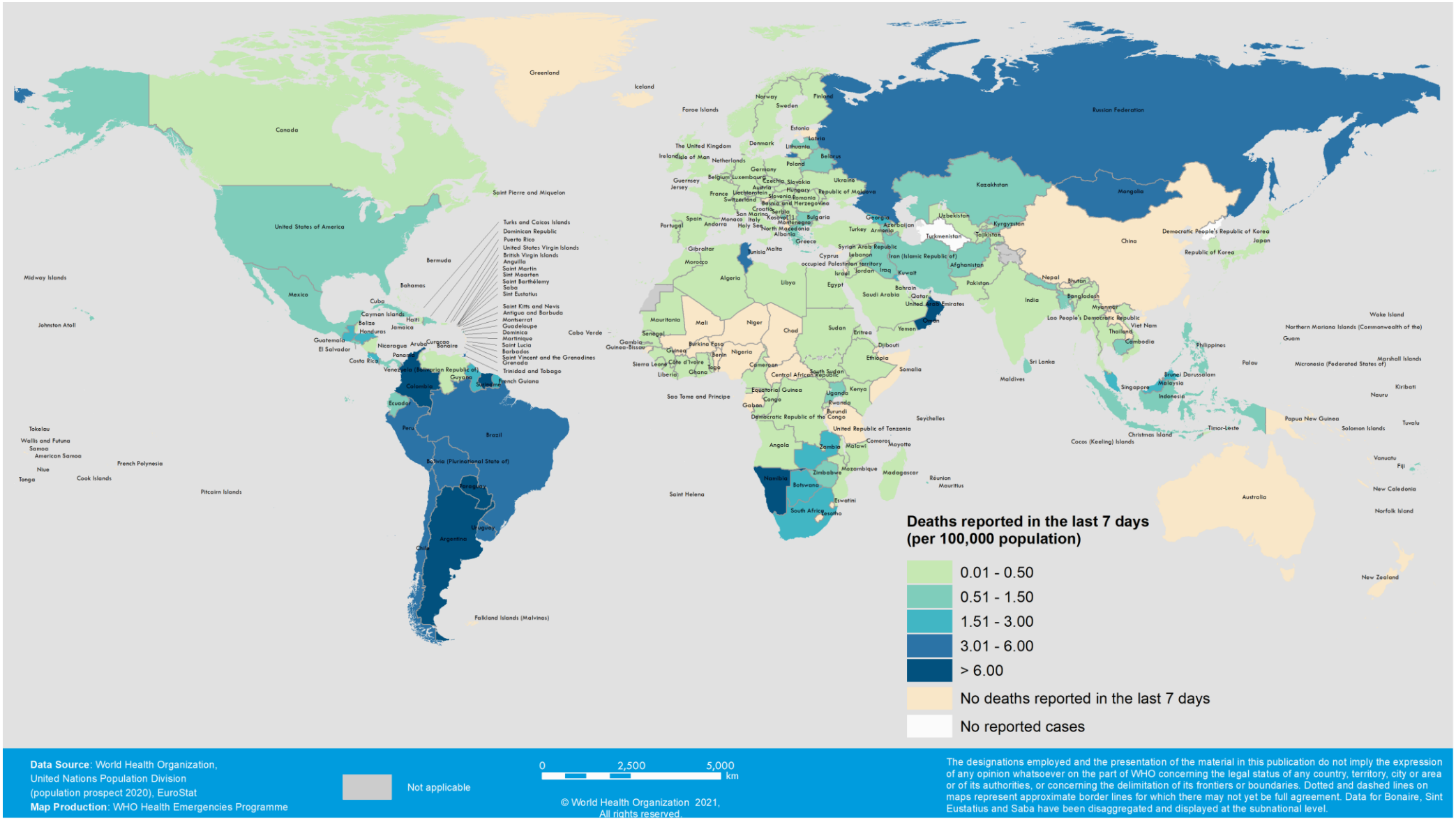
- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update and previous editions of the Weekly Epidemiological Update

Figure 2. COVID-19 cases per 100 000 population reported by countries, territories and areas, 28 June – 4 July 2021**



**See *Annex 2: Data, table and figure notes*

Figure 3. COVID-19 deaths per 100 000 population reported by countries, territories and areas, 28 June – 4 July 2021**



Data Source: World Health Organization, United Nations Population Division (population prospect 2020), EuroStat
Map Production: WHO Health Emergencies Programme

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city 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. Data for Bonaire, Sint Eustatius and Saba have been disaggregated and displayed at the subnational level.

**See *Annex 2: Data, table and figure notes*

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

WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 alter transmission or disease characteristics, or impact vaccine, therapeutics, diagnostics or effectiveness of public health and social measures (PHSM) applied by national authorities to control disease spread. "Signals" of potential Variants of Concern (VOCs) or Variants of Interest (VOIs) are detected and assessed based on the risk posed to global public health. National authorities may choose to designate other variants of local interest/concern and are encouraged to investigate and report on impacts of these variants. Here we provide updates on:

- Variant working definitions, and other variants and amino acid changes under monitoring
- Updates to the variant classifications
- Countries/territories/areas reporting the detection of VOCs

Variant working definitions, and other variants and amino acid changes under monitoring

Given the ongoing evolution in our understanding of the impacts of VOCs and VOIs, and the requirements for surveillance and response, WHO periodically reviews and adjusts working definitions (see Box 1 and WHO Tracking SARS-CoV-2 Variants website).

The revised set of definitions additionally formalizes a third category labelled 'Alerts for Further Monitoring', which includes variants with indications that they may pose a risk to global public health, depending on the evolving pandemic, but for which evidence of phenotypic or epidemiological impacts are less clear when compared to the listed VOCs or VOIs. These Alerts are reassessed regularly against criteria outlined in the VOI/VOC working definitions.

Box 1: SARS-CoV-2 Variant Working Definitions, last updated 6 July

Variant of Concern
A SARS-CoV-2 variant that meets the definition of a VOI (see below) and, through a comparative assessment, has been demonstrated to be associated with one or more of the following changes at a degree of global public health significance:

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

Variant of Interest
A SARS-CoV-2 variant:

- with genetic changes that are predicted or known to affect virus characteristics such as transmissibility, disease severity, immune escape, diagnostic or therapeutic escape; AND
- Identified to cause significant community transmission or multiple COVID-19 clusters, in multiple countries with increasing relative prevalence alongside increasing number of cases over time, or other apparent epidemiological impacts to suggest an emerging risk to global public health.

Alerts for Further Monitoring
A SARS-CoV-2 variant with genetic changes that are suspected to affect virus characteristics with some indication that it may pose a future risk, but evidence of phenotypic or epidemiological impact is currently unclear, requiring enhanced monitoring and further assessment pending new evidence.

See also the WHO Tracking SARS-CoV-2 Variants website for the latest working definitions, and currently designated VOCs, VOIs and Alerts for Further Monitoring, and further information.

In addition to these alerts, reported detections of VOCs with additional amino acid changes, which may or may not carry increased risk of additional phenotypic impacts, are being regularly assessed – e.g., Delta with K417N mutation or Alpha with E484K mutation. Notably, all variants, including VOCs and VOIs, are expected to continue to evolve over time given the ongoing high rates of transmission globally. A phenomenon whereby variants independently acquire the same or similar amino acid substitutions that may offer a competitive advantage (also known as convergent evolution) has been repeatedly observed over the course of the pandemic. Where there is evidence of a common constellation of amino acid changes that have sufficiently diverged from the parent VOC lineage, such sequences may be reclassified under Pango into sublineages to support ongoing investigations, tracking and scientific discourse. While it remains important to track and better understand the impacts of these variants, to date VOCs with additional notable amino acid changes comprise a small fraction of the total number of sequenced cases, and there remains limited direct evidence of further phenotypic impacts.

It is expected that our understanding of designated 'Alerts for Further Monitoring', VOCs with notable amino acid changes (including established sublineages) will evolve over time, and variants may be readily added/removed from these characterizations. WHO will, therefore, not be designating labels for these two categories of variants at this time, but where appropriate refer to these cases by their parent lineages (e.g., Delta includes B.1.617.2, AY.1, and AY.2; or Alpha (Pango lineage B.1.1.7; GISAID clade GRY (formerly GR/501Y.V1); Nextstrain clade 20I (V1)) includes B.1.1.7 with E484K. If these variants demonstrate changes in virus characteristics, compared to the parent lineage, in the future, and as such, are assessed as independently meeting the VOC or VOI definitions, then labels will be assigned accordingly.

Updates to the variant classifications

As the global public health risks posed by specific SARS-CoV-2 variants becomes better understood, WHO will continue to update the list of global VOIs and VOCs (Table 2) to support setting priorities for surveillance and research, and ultimately guide response strategies. These updates reflect emergence of new variants, changing epidemiology, and our evolving understanding of the phenotypic impacts of variants as new evidence becomes available. A previously designated Variant of Interest (VOI) or Variant of Concern (VOC) which has conclusively demonstrated to no longer pose a major added risk to global public health compared to other circulating SARS-CoV-2 variants, can be reclassified.

Based upon the latest round of assessments, VOIs Epsilon (B.1.427/B.1.429), Zeta (P.2), and Theta (P.3) were reclassified as 'Alerts for further monitoring'. While all three variants carry mutations with suspected and/or established phenotypic impacts, reported detections of these variants have decreased over time, suggesting a decline in their respective incidence worldwide, and diminishing public health risks relative to other VOCs and VOIs. Importantly, this assessment considers primarily global risks posed by these variants, and national authorities may choose to continue to designate these as variants of local interest/concern. Moreover, these variants will continue to be monitored, and if new evidence of impacts emerges, their classification will be reassessed.

Epsilon (B.1.427/B.1.429) has been associated with increased transmissibility, a modest decrease in susceptibility to some antibody treatments, and reduced neutralization by convalescent and post-vaccination sera.[1] As of 6 July, just under 50 000 sequences have been uploaded to GISAID from 45 countries.[2] Worldwide prevalence among sequenced samples has declined from 5% at peak in early February, to less than 0.5% of samples in recent months.[3] The vast majority of worldwide sequences (98%) were reported from the United States of America, where Epsilon has been progressively displaced by the emergence of Alpha, Gamma, Delta and other variants, and contributed <0.2% of sequenced samples collected during the weeks two weeks ending 19 June.[4] Moreover, available data suggest vaccines and treatments remain effective; prompting the Centers for Disease Prevention and Control to reclassify Epsilon from a local VOC on 29 June.[1]

Zeta (P.2) harbours spike amino acid change E484K, which has been implicated in resistant to neutralizing antibodies; however, lacks the constellation of mutations synonymous with other VOCs and VOIs. It emerged during October 2020 concomitantly to an increase in case incidence in parts of South America, suggesting a potential increase risk. The global prevalence of samples sequenced as Zeta has remained relatively low and progressively declined to very low levels (<0.5%) from March 2021. As of 6 July, 4439 sequences have been uploaded to GISAID from 42 countries. Half of global sequences (52%, n=2319) originate from Brazil, where prevalence peaked at ~55% in early January 2021. Following the emergence and dominance of VOC Gamma (P.1) in Brazil, prevalence of Zeta has fell to <2% of sequenced samples during April 2021 and has continued to decline.[5]

Theta (P.3) harbours several amino acid changes suggestive of increased resistance to neutralizing antibodies and is potentially more transmissible; however, overall detections of this variant have remained relatively low to date. As to 6 July, a total of 269 sequences were uploaded to GISAID from 14 countries. Most of these sequences (71%, n=191) were reported from the Philippines; predominantly in the Central Visayas Region, where a cluster of cases was identified earlier this year.[2] Globally over the past 3 months, only sporadic detections or small clusters of cases have been reported.

Updated working definitions, summary table of VOCs and VOIs, and a list of Alerts for Further Monitoring, are available on the WHO Tracking SARS-CoV-2 Variants website.

Geographic distribution

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 continues to increase (Figure 2, Annex 1). This distribution should be interpreted with due consideration of surveillance limitations, including differences in sequencing capacities and sampling strategies between countries.

Phenotypic characteristics

Available evidence on phenotypic impacts of VOCs is summarized in Table 3, as well as in previous editions of these COVID-19 Weekly Epidemiological Updates. Since the last detailed update on 22 June, new evidence has been published on the phenotypic characteristics of the Delta variant. Based on the estimated transmission advantage of the Delta variant, it is expected that Delta will rapidly outcompete other variants and become the dominant circulating lineage over the coming months.[6] Based on global data submitted to GISAID, the estimated effective reproductive number for the Delta variant is 55% (95%CI 43-68%) higher than the Alpha variant and 97% (95%CI 76-117%) higher relative to non-VOC/VOI.

In the European Region, based on the estimated transmission advantage of the Delta variant and using modelling forecasts, an estimated 90% of new SARS-CoV-2 infections are expected to be due to Delta by the end of August.[7] Early data from Scotland, from individuals who tested positive from 1 April to 21 June 2021, showed an increased risk of hospitalization (hazard ratio of hospitalization 1.8; 95%CI 1.4-2.3; data adjusted for age, sex, poverty index, temporal trend, and comorbidities) among cases infected with the Delta variant (as detected by screening of PCR S-gene positive samples), compared with those infected with the Alpha variant (S-gene target failure).[8]

In regards to the Alpha variant, findings from a recent study carried out in 2147 inpatients showed no overall increase in mortality [hazard ratio (HR) 1.01; 95% CI 0.79 – 1.28] or Intensive Therapy Unit (ITU) admission (HR 1.01; 95% CI: 0.75 – 1.37) associated with the Alpha variant as compared to other lineages after adjusting for age, sex, co-morbidities, care home residence, pregnancy and ethnicity. However, an analysis of gender-specific effects of the Alpha variant suggests an increased risk of mortality (HR 1.30; 95% CI: 0.95 – 1.78) and ITU admission (HR 1.82; 95% CI: 1.15 -2.90) in females infected with this variant as compared to other lineages. Males do not show an increased risk of mortality or ITU admission

(mortality HR 0.82, 95% CI 0.61-1.10; ITU HR 0.74, 95% CI 0.52-1.04); this indicates that women may potentially be at an increased risk of admission to ITU and at modestly increased risk of mortality.[9] Being among the largest studies of hospitalized patients, this study conducted in the United Kingdom provides useful information on disease course and progression, however, analysis of these patients may not provide information on disease severity across all SARS-CoV-2 infections in the population as a whole. Additionally, information on vaccination status for individual patients was not considered in this study.

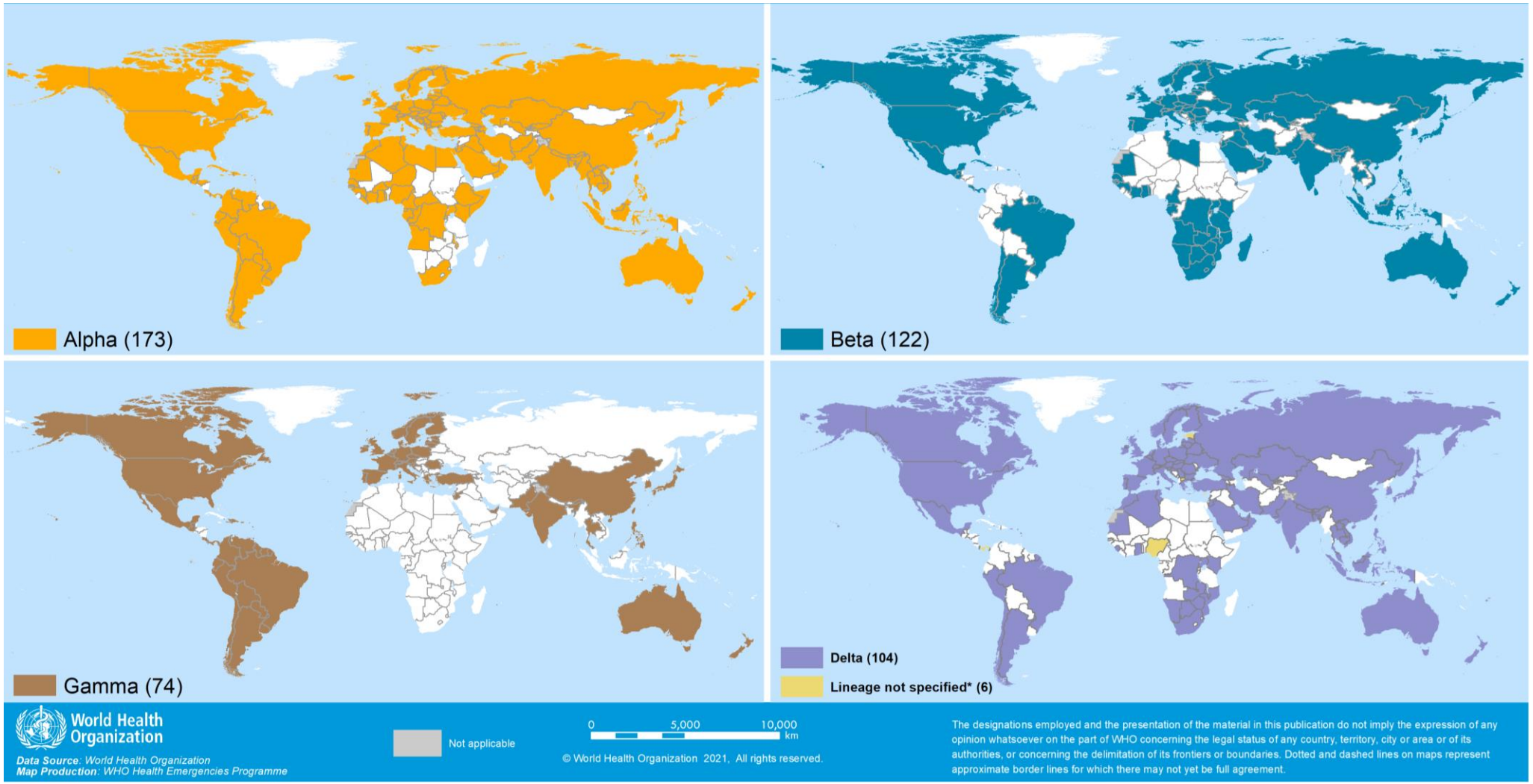
A preprint cohort study conducted in Norway analyzed 1103 unvaccinated individuals hospitalized for COVID-19 from 21 December 2020 to 25 April 2021. Among people infected with the Alpha variant, there was no difference in the length of stay in the hospital or ICU, and no significant difference in mortality up to 30 days following discharge as compared to those infected with non-VOCs .[10] This suggests that, while Alpha may increase the risk of hospitalization, other characteristics such as age and underlying risk factors likely influence the hospitalized patients' clinical course and the type of healthcare required.[10,11]

Table 3: Summary of phenotypic impacts* of Variants of Concern

WHO label	Alpha	Beta	Gamma	Delta
Transmissibility	Increased transmissibility and secondary attack rate[12]	Increased transmissibility[13]	Increased transmissibility[14]	Increased transmissibility and secondary attack rate[6,15,16]
Disease severity	Increased risk of hospitalization[17], possible increased risk of severity and mortality[18]	Not confirmed, possible increased risk of in-hospital mortality[19,20]	Not confirmed, possible increased risk of hospitalization[21]	Not confirmed, possible increased risk of hospitalization[22]
Risk of reinfection	Neutralizing activity retained,[23] risk of reinfection remains similar[24,25]	Reduction in neutralizing activity reported; T cell response elicited by D614G virus remains effective[26–29]	Moderate reduction in neutralizing activity reported[30,31]	Reduction in neutralizing activity reported[32]
Impacts on diagnostics	Limited impact – S gene target failure (SGTF); no impact on overall result from multiple target RT-PCR, No impact on Ag RDTs observed[33]	No impact on RT-PCR or Ag RDTs observed[16]	None reported to date	None reported to date

**Generalized findings as compared to previously/co-circulating variants. Based on emerging evidence, including non-peer-reviewed preprint articles and reports, all subject to ongoing investigation and revision.*

Figure 4. Countries, territories and areas reporting variants Alpha, Beta, Gamma and Delta, as of 6 July 2021**



**Includes countries/territories/areas reporting the detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.*
***Countries/territories/areas highlighted include both official and unofficial reports of VOC detections, and do not presently differentiate between detections among travellers (e.g., at Points of Entry) or local community cases. Please see Annex 2 for further details.*

VOC impacts on vaccines

Table 4 summarises the impact of variants on vaccine efficacy/effectiveness (VE) and quantifies the reduction in VE due to variants compared to VE in non-VOC settings. Of note, reductions in VE do not mean loss of protection, as indicated by the absolute VE estimate. For example, a 10 percent point reduction in VE against symptomatic disease for mRNA vaccines would still mean high vaccine effectiveness of ~85%. In addition, vaccines have shown higher VE against severe disease; thus, small reductions in VE against severe disease due to VOCs may still mean good protection, as is the case for AstraZeneca-Vaxzevria.

Since the 22 June update, phase 3 trial results for Bharat-Covaxin (not yet peer-reviewed) have been made available. This double-blind, randomized control trial included 25 798 participants aged 18 years and older, randomized to receive two doses of the vaccine or a placebo with 4 weeks in between doses. Overall vaccine efficacy against severe and symptomatic disease ≥ 14 days post second dose was 93.4% (95% CI: 57.1-99.8%) and 77.8% (65.2-86.4%), respectively. Among 130 SARS-CoV-2 positive samples, 79 (60.8%) were genotyped. VE against Delta symptomatic disease (65.2% (33.1-83.0%)) was lower than other typed variants; 90.1% (30.4-99.8%) against Kappa (B.1.617.1), and 73.0% (-2.2-95.2%) against all other variants, although numbers were small with overlapping confidence intervals.[34]

A test-negative case-control study in Ontario, Canada (not yet peer reviewed) assessed the effectiveness against variants of concern among 421 073 individuals aged 16 years and older, who were tested for SARS-CoV-2. The authors used a combination of whole genome sequencing and mutation screening by PCR to classify VOC. VE of two doses of both Pfizer BioNTech-Comirnaty and Moderna-mRNA-1273 against symptomatic disease ≥ 7 days post final dose was measured. VE for Pfizer BioNTech-Comirnaty was 93% (95% CI: 88-96%), 89% (86-91%), 84% (69-92%), and 87% (64-95%) against non-VOC, Alpha, Beta/Gamma, and Delta variants, respectively. VE of Moderna-mRNA-1273 was 92% (86-96%) against Alpha as compared to 89% (65-96%) against non-VOC (VE against Beta/Gamma and Delta not measured). A single dose of AstraZeneca-Vaxzevria resulted in a VE of 64-67% for non-VOC, Alpha and Delta, and a VE of 48% against Beta/Gamma. Two dose VE estimates for AstraZeneca-Vaxzevria were not provided due to insufficient numbers. The study also found two doses of Pfizer BioNTech-Comirnaty and Moderna-mRNA-1273 vaccines to provide very good protection against hospitalization or death due to Alpha and non-VOC (VE estimates of 94-96%), and two doses of Pfizer BioNTech-Comirnaty also had high VE against Beta/Gamma (95%); no data for Moderna-mRNA-1273 against Beta/Gamma. A single dose of Pfizer BioNTech-Comirnaty, Moderna-mRNA-1273 and AstraZeneca-Vaxzevria prevented 78%, 96% and 88% of hospitalizations/deaths due to Delta, respectively.[35]

Another study (not yet peer-reviewed) reported on the effectiveness of Sinovac-CoronaVac in Manaus, Brazil, during a time when the predominant circulating strain was Gamma (86% of genotyped SARS-CoV-2 were the Gamma variant during the peak of the epidemic in Manaus). The study used a test-negative case-control design to estimate VE among ~400 case-control pairs of health care workers. VE of two doses of the vaccine against symptomatic disease and against infection 14+ days post final dose was 36.8% (95%: CI -54.9-74.2%) and 37.9% (95% CI: -46.4 to 73.6%), respectively. Authors note the low VE estimate likely reflect a bias towards the null hypothesis as suggested by the finding that vaccinated individuals were much more likely to be infected than unvaccinated individuals in the period 0-13 days after receipt of the first dose (aOR 2.11, 95% CI 1.36-3.27). Authors also note that the analysis may have been underpowered to be able to detect a VE of lower than 70%.[36]

Four new studies (not yet peer reviewed) have evaluated the ability of vaccine sera to neutralize the Delta variant. While these four studies found relatively modest reductions in neutralization of the Delta variant by AstraZeneca-Vaxzevria (4.0-fold reduction), SII-Covishield (3.2-fold reduction), Moderna-mRNA-1273 (2.1-fold reduction), and Janssen-Ad26.COV 2.5 (1.6-fold reduction) relative to the reference strain, a larger reduction was found for the Pfizer BioNTech-Comirnaty (11.3-fold reduction) in one of the studies.[37–40] To date, five studies have evaluated neutralization of the Delta variant by Pfizer BioNTech-Comirnaty and report fold-reductions ranging from 1.4 to 11.3; two studies evaluating AstraZeneca-Vaxzevria have both reported an approximate 4-fold reduction; and single studies have found ~2-3-fold reductions by sera from individuals who had received Janssen-Ad26.COV 2.5, Moderna-mRNA-1273, Bharat-Covaxin, and SII-Covishield vaccines.[37–46]

Table 4. Summary of vaccine performance against Variants of Concern

Alpha	Beta	Gamma	Delta
Efficacy/effectiveness against disease or infection (full vaccination), see key below table			
Protection retained against all outcomes	Reduced protection against symptomatic disease, but retained against severe disease; limited evidence	Unclear impact; very limited evidence	Protection retained against severe disease; possible reduced protection against symptomatic disease and infection
Severe disease			
• ↔ to ↓: Moderna-mRNA-1273 (1), Pfizer BioNTech-Comirnaty (3), Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty (1) [35,47–49] • ↓: AstraZeneca- Vaxzevria (1) [49]	• ↔: Janssen Ad26.COV 2.5 (1), Pfizer BioNTech-Comirnaty (1)[48,50]	• No evidence	• ↔: AstraZeneca- Vaxzevria (1), Pfizer BioNTech-Comirnaty (1)[49]
Symptomatic disease			
• ↔: Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty (2), Pfizer BioNTech-Comirnaty (3)[35,47,51,52] • ↔ to ↓: AstraZeneca-Vaxzevria (3)[51–53] • ↓: Novavax-Covavax (1)[54]	• ↔: Janssen-Ad26. COV 2.5 (1)[50] • ↓↓↓: AstraZeneca-Vaxzevria (1), Novavax-Covavax (1)[55,56]	• ↔ to ↓: Sinovac-CoronaVac (1)[36,57]	• ↔ to ↓: Pfizer BioNTech-Comirnaty (3)[35,51,52] • ↓: Bharat-Covaxin (1)[34] • ↓↓: AstraZeneca- Vaxzevria (2)[51,52]
Infection			
• ↔: Pfizer BioNTech-Comirnaty (3)[52,58] • ↔ to ↓: AstraZeneca-Vaxzevria (2)[52,53]	• ↓: PfizerBioNTech-Comirnaty (1)[48]	• No evidence	• ↓: AstraZeneca-Vaxzevria (1), Pfizer BioNTech-Comirnaty (1)[52]
Neutralization (full vaccination), see key below table			
• ↔: Beijing CNBG-BBIBP-CorV (1), Bharat-Covaxin (1), Gamaleya-Sputnik V (1), Novavax-Covavax (1), Sinovac-CoronaVac (2)[59–63] • ↔ to ↓: Janssen-Ad26.COV 2.5 (2), Moderna- mRNA-1273 (9), Pfizer BioNTech-Comirnaty (26)[29,37,38,41,63–90] • ↓ to ↓↓: AstraZeneca-Vaxzevria (2)[53,68]	• ↔ to ↓: Anhui ZL-Recombinant (2), Beijing CNBG-BBIBP-CorV (2)[59,91,92] • ↓: Bharat-Covaxin (1)[42] • ↓ to ↓↓: Pfizer BioNTech-Comirnaty (27), Sinovac-CoronaVac (3)[29,39,41,59,62,64,65,68,70–74,76,77,80–82,86–89,91,93–97] • ↓ to ↓↓↓: Janssen-Ad26.COV 2.5 (3)[38,90,98] • ↓↓: AstraZeneca-Vaxzevria (3), Gamaleya-Sputnik V (1), Moderna-mRNA-1273 (10)[37,39,55,61,68,70,76,79,81,85,96,97,99–101] • ↓↓ to ↓↓↓: Janssen-Ad26.COV 2.5 (3)[38,90,98] • ↓↓↓: Novavax-Covavax (1)[59]	• ↔: Sinovac-CoronaVac (1)[102] • ↔ to ↓: Pfizer BioNTech-Comirnaty (11)[43,64,68,70,72,74,77,86,93,103] • ↓: AstraZeneca-Vaxzevria (1), Janssen-Ad26.COV 2.5 (2), Moderna-mRNA-1273 (4)[37,38,68,70,85,90,103]	• ↔: Janssen-Ad.COV 2.5 (1)[38] • ↓: AstraZeneca-Vaxzevria (2), Bharat-Covaxin (1), Moderna-mRNA-1273 (1)[37,39,42,44] • ↓ to ↓↓: Pfizer BioNTech-Comirnaty (5)[39,41,43–45]

Arrows generalize the magnitude of reduction in VE or neutralization: "↔" <10% reduction in VE, or VE >90% with no comparator, or that there was a <2-fold reduction in neutralization; "↓" 10 to <20% reduction in VE, or 2 to <5-fold reduction in neutralization; "↓↓" 20 to <30% reduction in VE, or 5 to <10-fold reduction in neutralization; "↓↓↓" ≥30% reduction in VE, or ≥10-fold reduction in neutralization. When more than one neutralization study is available, the interquartile range (25th and 75th percentiles) of fold-reductions across all studies for specific vaccine/variant was used.
The number of studies is shown in parentheses.
"Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty" indicates that both vaccines were evaluated together in study.

Additional resources

- Tracking SARS-CoV-2 variants
- COVID-19 new variants: Knowledge gaps and research
- Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health
- Considerations for implementing and adjusting public health and social measures in the context of COVID-19

Additional notes on VOC impacts on vaccines

- Studies presenting VOC specific VE estimates are assessed against a comparator VE estimate to determine level of reduction in VE. For symptomatic disease, VOC VE is compared against phase 3 randomised RCT results from non-VOC settings. For severe disease and infection, VOC VE is compared to non-VOC VE estimates from the same study when available (or to Alpha VE from same study when assessing Beta, Gamma, or Delta); with an exception for AstraZeneca Vaxzevria for severe disease (phase 3 RCT efficacy estimates against severe disease are used as comparator since within study comparator is unavailable) and for infection (phase 3 estimate of VE against infection due to non-VOC is available and used as comparator). In some instances, a study may be included for severe disease or infection even without a comparator if very high VE estimate against a VOC is reported (i.e., >90%).
- It is also important to note that studies vary in population, outcome definitions, study design and other methodological considerations, which may in part explain differences when comparing VE estimates between different studies. In addition, the reductions presented consider VE point estimates only and do not take into account the uncertainty around these estimates. The reductions in VE noted should be interpreted with these limitations in mind.

References

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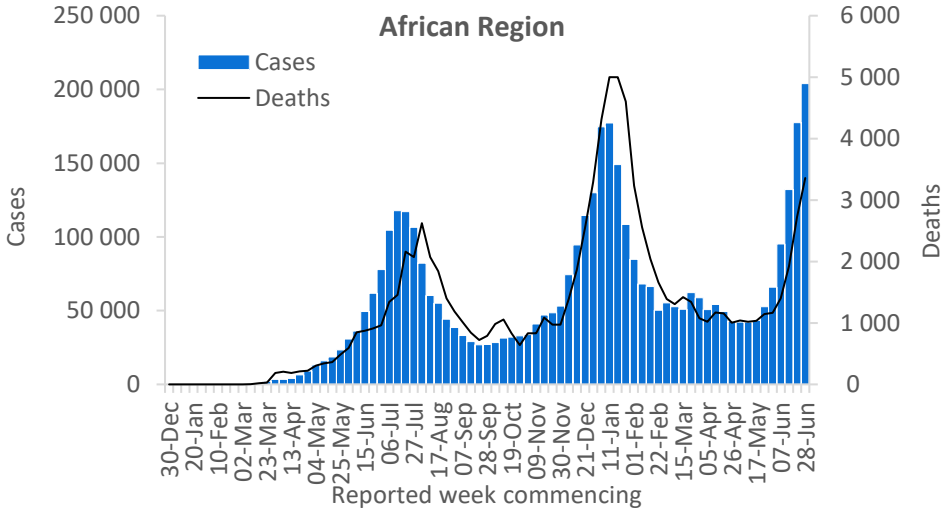
WHO regional overviews - Epidemiological week 28 June-4 July 2021

African Region

The African Region reported over 204 000 new cases and over 3300 new deaths, a 15% and a 23% increase respectively as compared to the previous week. For the sixth consecutive week, the region continues to show a marked increase in weekly case incidence and mortality; the Southern and Eastern parts of Africa remain the most affected areas on the continent. The highest numbers of new cases were reported from South Africa (132 450 new cases; 223.3 new cases per 100 000 population; a 28% increase), Zambia (16 456 new cases; 89.5 new cases per 100 000; a 14% decrease), and Namibia (9342 new cases; 367.7 new cases per 100 000; a 28% decrease).

The highest numbers of new deaths were reported from South Africa (1729 new deaths; 2.9 new deaths per 100 000 population; a 46% increase), Zambia (430 new deaths; 2.3 new deaths per 100 000; a 16% increase), and Uganda (325 new deaths; <1 new deaths per 100 000; a 34% increase).

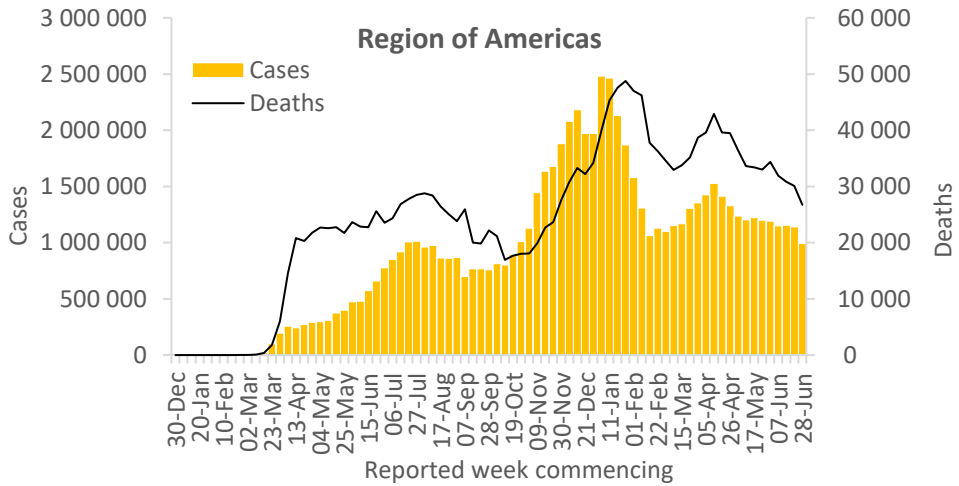


Updates from the African Region

Region of the Americas

The Region of the Americas reported over 992 000 new cases and over 26 000 new deaths, a 13% and an 11% decrease respectively compared to the previous week. The Americas is the only region showing a decrease in both weekly case incidence and mortality. For the first time since October 2020, the region reported under 1 million weekly cases. However, several countries from South America, Central America and the Caribbean are still reporting high case incidence and mortality over the past weeks. The highest numbers of new cases were reported from Brazil (364 709 new cases; 171.6 new cases per 100 000; a 30% decrease), Colombia (204 556 new cases; 402.0 new cases per 100 000; similar to the previous week), and Argentina (137 852 new cases; 305.0 new cases per 100 000; a 5% increase).

The highest numbers of new deaths were reported from Brazil (10 810 new deaths; 5.1 new deaths per 100 000; a 14% decrease), Colombia (4402 new deaths; 8.7 new deaths per 100 000; a 4% decrease), and Argentina (3403 new deaths; 7.5 new deaths per 100 000; a 9% decrease).

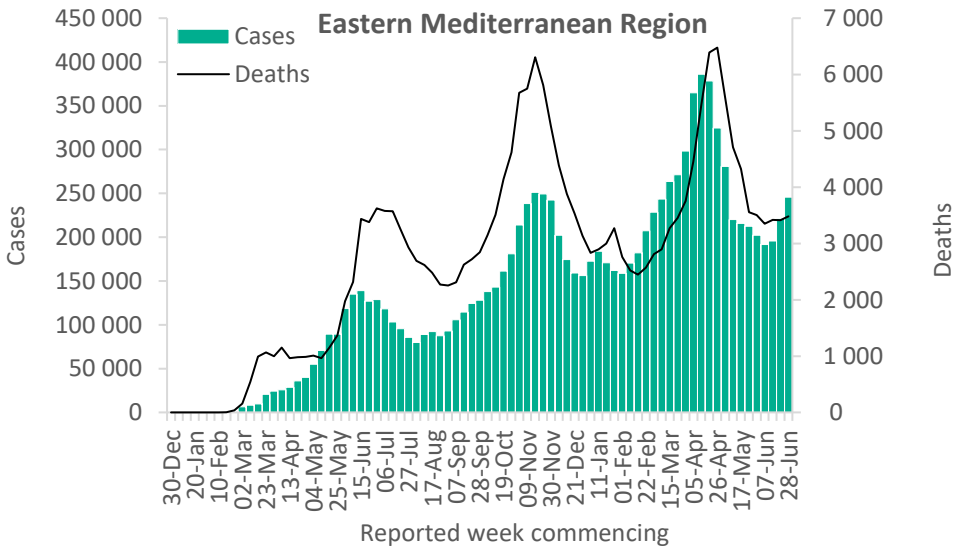


Updates from the Region of the Americas

Eastern Mediterranean Region

The Eastern Mediterranean Region reported over 245 000 new cases and over 3400 new deaths, an 11% and a 2% increase respectively as compared to the previous week. Following more than two months of decrease in weekly case incidence, for the third consecutive week the region showed an increase of case incidence, while mortality remained relatively stable for the past month. The highest numbers of new cases were reported from the Islamic Republic of Iran (83 054 new cases; 98.9 new cases per 100 000; a 17% increase), Iraq (43 979 new cases; 109.3 new cases per 100 000; a 16% increase), and Tunisia (35 452 new cases; 300.0 new cases per 100 000; a 59% increase).

The highest numbers of new deaths were reported from the Islamic Republic of Iran (916 new deaths; 1.1 new deaths per 100 000; a 7% increase), Tunisia (682 new deaths; 5.8 new deaths per 100 000; a 10% increase), and Afghanistan (549 new deaths; 1.4 new deaths per 100 000; a 4% increase).

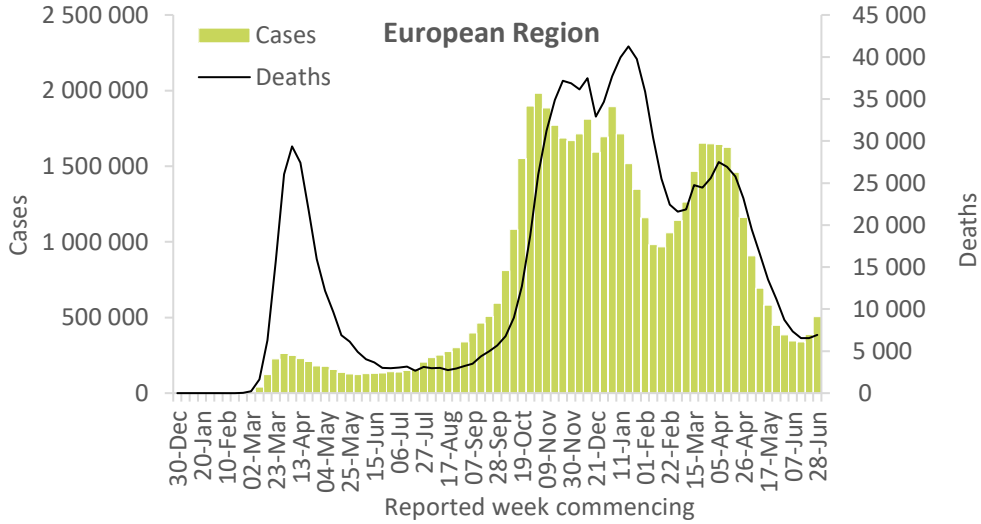


Updates from the Eastern Mediterranean Region

European Region

The European Region reported over 505 000 new cases and over 6900 new deaths. Following almost three months of declining trends, the region showed for the second consecutive week an increase in the number of new weekly cases and deaths, a 30% and a 6% increase respectively as compared to the previous week. The highest numbers of new cases were reported from the United Kingdom (161 805 new cases; 238.3 new cases per 100 000; a 67% increase), the Russian Federation (159 650 new cases; 109.4 new cases per 100 000; a 19% increase), and Turkey (36 224 new cases; 43.0 new cases per 100 000; a 7% decrease).

The highest numbers of new deaths were reported from the Russian Federation (4643 new deaths; 3.2 new deaths per 100 000; an 18% increase), Turkey (350 new deaths; <1 new deaths per 100 000; a 13% decrease), and Germany (276 new deaths; <1 new deaths per 100 000; a 25% decrease).

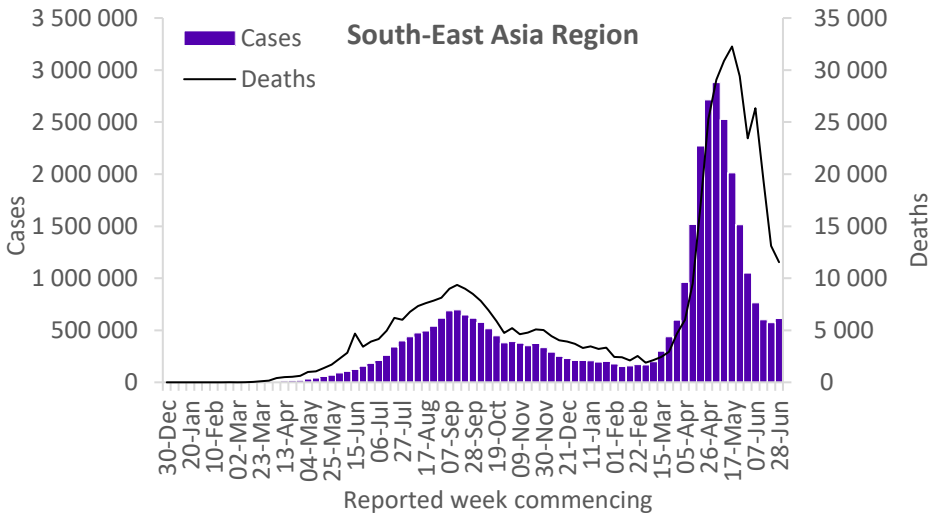


Updates from the European Region

South-East Asia Region

The South-East Asia Region reported just under 613 000 new cases and over 11 000 new deaths, a 7% increase and a 12% decrease respectively as compared to the previous week. Following a decreasing trend in weekly case incidence for almost two months, mostly driven by the decrease in cases reported in India, the region showed a slight increase of cases this week. Bangladesh, Indonesia, Myanmar and Thailand continue to report large increases in the number of newly reported cases and deaths for this week.

The highest numbers of new cases were reported from India (312 250 new cases; 22.6 new cases per 100 000; an 11% decrease), Indonesia (168 780 new cases; 61.7 new cases per 100 000; a 35% increase), and Bangladesh (56 511 new cases; 34.3 new cases per 100 000; a 54% increase).The highest numbers of new deaths were reported from India (6254 new deaths; 0.5 new deaths per 100 000; a 31% decrease), Indonesia (3444 new deaths; 1.3 new deaths per 100 000; a 39% increase), and Bangladesh (893 new deaths; 0.5 new deaths per 100 000; a 43% increase).



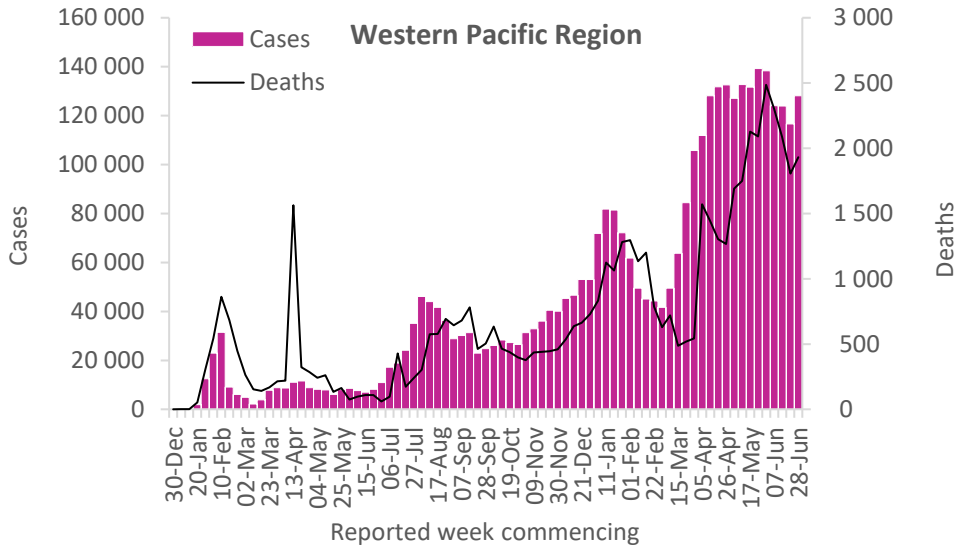
Updates from the South-East Asia Region

Western Pacific Region

The Western Pacific Region reported over 128 000 new cases and over 1900 new deaths, a 10% and a 7% increase respectively. Cambodia, Fiji and Malaysia, continue to report increases in both weekly cases and deaths.

The highest numbers of new cases were reported from Malaysia (44 145 new cases; 136.4 new cases per 100 000; an 18% increase), the Philippines (38 507 new cases; 35.1 new cases per 100 000; similar to last week), and Mongolia (15 478 new cases; 472.1 new cases per 100 000; a 4% decrease).

The highest numbers of new deaths were reported from the Philippines (819 new deaths; <1 new deaths per 100 000; a 16% increase), Malaysia (550 new deaths; 1.7 new deaths per 100 000; a 3% increase), and Japan (185 new deaths; <1 new deaths per 100 000; a 28% decrease).



Updates from the Western Pacific Region

Key weekly updates

WHO Director-General's key messages

- In his opening remarks at the media briefing on COVID-19 – 2 July 2021, the Director-General highlighted two ways for countries to push back against COVID-19 surges. These include:
    - **Strengthening public health and social measures (PHSM)-** including strong surveillance, strategic testing, early case detection, isolation and clinical care- remains critical. Additionally, masking, physical distance, avoiding crowded places and keeping indoor areas well ventilated remain the basis for the response.
    - **Equitable distribution or sharing of resources** such as protective gear, medical oxygen, tests, treatments and vaccines.
- In his introductory remarks at the event: Gender Equal Health and Care Workforce Initiative - 1 July 2021, the Director-General emphasized the need to address gender inequalities as a priority especially when majority of the world's health workers - almost 70% - are women. WHO is committed to advocating for decent and safe work conditions for all health and care workers.

Updates and publications

- **COVID-19 Vaccines and Vaccine Safety**
    - Ethical Framework for WHO's work in the ACT-Accelerator
    - Observational Study Protocol Template for sentinel surveillance of adverse events of special interest (AESIs) after vaccination with COVID-19 vaccines
- **International Travel**
    - Technical considerations for implementing a risk-based approach to international travel in the context of COVID-19: Interim guidance, 2 July 2021
    - Policy considerations for implementing a risk-based approach to international travel in the context of COVID-19, 2 July 2021
- **Essential Health Services**
    - Implementation guidance for assessments of frontline service readiness: strengthening real-time monitoring of health services in the context of the COVID-19 pandemic, 1 July 2021

Annex

COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region (reported in previous issues) are now available at: https://covid19.who.int/table

Annex 1. List of countries/territories/areas reporting Variants of Concern as of 6 July 2021**

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Afghanistan	●	-	-	-	-
Albania	●	-	-	-	-
Algeria	●	-	-	●	-
Angola	●	●	-	-	-
Antigua and Barbuda	●*	●*	-	-	-
Argentina	●	●	●	●	-
Armenia	○	-	-	-	-
Aruba	●	●	●	●	-
Australia	●	●	●	●	-
Austria	●	●	●	●	-
Azerbaijan	●	-	-	-	-
Bahrain	●	●	-	●	-
Bangladesh	●	●	-	●	-
Barbados	●	-	●	●	-
Belarus	●	-	-	○	-
Belgium	●	●	●	●	-
Belize	●	-	-	-	-
Bermuda	●	●	-	-	-
Bhutan	●	●	-	●	-
Bolivia (Plurinational State of)	●	-	●	-	-
Bonaire	●	-	-	-	-
Bosnia and Herzegovina	○	-	-	-	-
Botswana	-	●	-	●	-
Brazil	●	●	●	●	-
British Virgin Islands	●	-	●	-	-
Brunei Darussalam	●	●	-	-	-
Bulgaria	●	●	-	●	-
Burkina Faso	●	-	-	-	-
Cabo Verde	●	-	-	-	-
Cambodia	●	-	-	●	-
Cameroon	●	●	-	-	-
Canada	●	●	●	●	-
Cayman Islands	●	-	-	-	-
Central African Republic	●	-	-	-	-
Chile	●	●	●	●	-
China	●	●	●	○	-
Colombia	●	-	●	-	-
Comoros	-	●	-	-	-
Congo	●	-	-	-	-
Costa Rica	●	●	●	-	-
Croatia	●	●	○*	○	-
Cuba	●	●	-	-	-
Curaçao	●	-	●	-	●
Cyprus	●	●	-	-	●
Czechia	●	●	●	●	-
Côte d'Ivoire	●	●	-	-	-
Democratic Republic of the Congo	●	●	-	●	-
Denmark	●	●	●	●	-
Djibouti	●	●	-	-	-
Dominica	●	-	-	-	-
Dominican Republic	●	-	●	-	-
Ecuador	●	-	●	-	-
Egypt	●	-	-	-	-
Equatorial Guinea	●	●	-	-	-
Estonia	●	●	○	-	○
Eswatini	-	●	-	-	-
Ethiopia	○	-	-	-	-
Faroe Islands	●	-	●	-	-
Fiji	-	-	-	●	-
Finland	●	●	●	●	-
France	●	●	●	●	-
French Guiana	●	●	●	●	-
French Polynesia	●	●	●	●	-
Gabon	●	○	-	-	-
Gambia	●	-	-	●	-
Georgia	●	○	-	●	-
Germany	●	●	●	●	-
Ghana	●	●	-	●	-
Gibraltar	●	-	-	-	-
Greece	●	●	●	●	-
Grenada	●	-	-	-	-
Guadeloupe	●	●	●	●	-
Guam	●	●	●	●	-
Guatemala	●	●*	●*	-	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Guinea	●	●	-	-	-
Guinea-Bissau	●	●	-	-	-
Guyana	-	-	●	-	-
Haiti	●	-	●	-	-
Honduras	●	-	-	-	-
Hungary	●	○	-	○	-
Iceland	●	-	-	-	-
India	●	●	●	●	-
Indonesia	●	●	-	●	-
Iran (Islamic Republic of)	●	●	-	●	-
Iraq	●	●	-	-	-
Ireland	●	●	●	●	-
Israel	●	●	●	●	-
Italy	●	●	●	●	-
Jamaica	●	-	-	-	-
Japan	●	●	●	●	-
Jordan	●	●	●	●	-
Kazakhstan	○	○	-	●*	-
Kenya	●	●	-	●	-
Kosovo[1]	●	○	-	○	-
Kuwait	●	-	-	●	-
Kyrgyzstan	●	-	-	-	-
Lao People's Democratic Republic	●	-	-	●*	-
Latvia	●	●	●	○*	-
Lebanon	●	-	-	●*	-
Lesotho	-	●	-	-	-
Liberia	●	-	-	-	-
Libya	●	●	-	-	-
Liechtenstein	●	-	-	-	-
Lithuania	●	●	●	○	-
Luxembourg	●	●	●	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Madagascar	-	●	-	-	-
Malawi	●	●	-	●	-
Malaysia	●	●	-	●	-
Maldives	●	-	-	●	-
Malta	●	○	●	○	-
Martinique	●	●	●	●	-
Mauritania	●	●	-	●	-
Mauritius	○	●	-	●	-
Mayotte	●	●	-	-	-
Mexico	●	●	●	●	-
Monaco	●	○	-	-	-
Montenegro	●	-	-	-	-
Montserrat	●	-	-	-	-
Morocco	●	-	-	●	-
Mozambique	-	●	-	●	-
Myanmar	●	-	-	-	-
Namibia	-	●	-	○*	-
Nepal	●	-	-	●	-
Netherlands	●	●	●	●	-
New Caledonia	●	-	-	-	-
New Zealand	●	●	○	○	-
Niger	●	-	-	-	-
Nigeria	●	-	-	-	●
North Macedonia	●	●	-	-	●
Norway	●	●	●	●	-
Occupied Palestinian Territory	●	●	-	●	-
Oman	●	●*	-	●*	-
Pakistan	●	●	●	●	-
Panama	●	●	●	-	●
Paraguay	●	-	●	-	-
Peru	●	-	●	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Philippines	●	●	●	●	-
Poland	●	○	●	●	-
Portugal	●	●	●	●	-
Puerto Rico	●	●	●	●	-
Qatar	●	●	-	●	-
Republic of Korea	●	●	●	●	-
Republic of Moldova	○	-	-	-	-
Romania	●	●	●	●	-
Russian Federation	●	●	-	●	-
Rwanda	●	○	-	-	-
Réunion	●	●	●	○	-
Saba	-	-	-	●	-
Saint Barthélemy	●	-	-	-	-
Saint Lucia	●	-	-	-	-
Saint Martin	●	●	-	-	-
Sao Tome and Principe	●	-	-	-	-
Saudi Arabia	●	●	-	●	-
Senegal	●	●	-	-	-
Serbia	●	-	-	-	-
Seychelles	-	●	-	-	-
Sierra Leone	-	-	-	○*	-
Singapore	●	●	●	●	-
Sint Maarten	●	●	-	●	-
Slovakia	●	●	-	●	-
Slovenia	●	●	●	●	-
Somalia	●	-	-	-	-
South Africa	●	●	-	●	-
Spain	●	●	●	●	-
Sri Lanka	●	●	-	●	-
Suriname	●	●	●	-	-
Sweden	●	●	●	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Switzerland	●	●	○	●	-
Thailand	●	●	●	●	-
Timor-Leste	●	-	-	-	-
Togo	●	●	-	-	-
Trinidad and Tobago	●	-	●	-	-
Tunisia	●	●	-	●	-
Turkey	●	●	●	●	-
Turks and Caicos Islands	●	-	●	-	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Uganda	●	●	-	●	-
Ukraine	●	○	-	○	-
United Arab Emirates	●	●	●	●	-
United Kingdom	●	●	●	●	-
United Republic of Tanzania	-	●	-	-	-
United States of America	●	●	●	●	-
Uruguay	●	-	●	-	-
Uzbekistan	●	●	-	○	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Venezuela (Bolivarian Republic of)	●	-	●	-	-
Viet Nam	●	●	-	●	-
Wallis and Futuna	●	-	-	-	-
Zambia	-	●	-	●	-
Zimbabwe	-	○	-	●	-

**Newly reported in this update.*
"Unspecified B.1.617" reflects countries/territories/areas reporting detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.
"●" indicates that information for this variant was received by WHO from official sources.
"○" indicates that information for this variant was received by WHO from unofficial sources and will be reviewed as more information become available.
***Variant Beta for Kyrgyzstan and unspecified B.1.617 for Latvia were excluded this week based on further information received.*
****Includes countries/territories/areas reporting the detection of VOCs among travelers (e.g., imported cases detected at points of entry), or local cases (detected in the community). Efforts are ongoing to differentiate these in future reports. Excludes countries, territories, and areas that have never reported the detection of a variant of concern.*
See also Annex 2: Data, table and figure notes.

Annex 2. 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.

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

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

Technical guidance and other resources

- WHO technical guidance
- WHO COVID-19 Dashboard
- WHO Weekly Operational Updates on COVID-19
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- OpenWHO courses on COVID-19 in official UN languages and in additional national languages
- WHO Academy COVID-19 mobile learning app
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Recommendations and advice for the public:
  - Protect yourself
  - Questions and answers
  - Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities

COVID-19 Weekly Epidemiological Update

Edition 48, published 13 July 2021

In this edition:

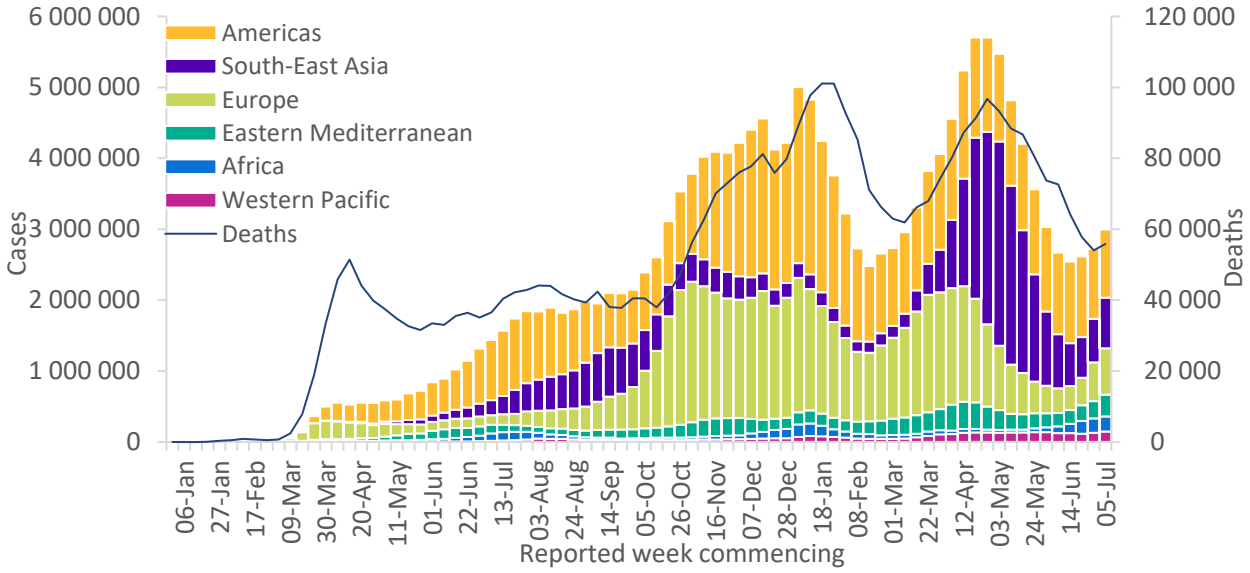
Global overview

Data as of 11 July 2021

The global number of new cases reported last week (5-11 July 2021) was nearly 3 million, a 10% increase as compared to the previous week (Figure 1). Following a steady decline for nine consecutive weeks, the number of weekly deaths increased by 3% this week compared to the previous week, with over 55,000 deaths reported. Globally, COVID-19 incidence increased with an average of over 400,000 cases reported each day as compared to 370,000 from the previous week. The cumulative number of cases reported globally is now over 186 million and the number of deaths exceeds 4 million.

This week, all Regions with the exception of the Americas recorded an increase in incidence. The Eastern Mediterranean Region recorded the largest increase in incidence (25%) followed by European Region with a 20% increase as compared to the previous week (Table 1). The African Region had the smallest percentage increase in incidence with a 5% increase. However, the region recorded a 50% increase in the number of deaths as compared to the previous week. The South-East Asia Region also recorded a significant increase in number of deaths, reporting a 26% increase as compared to the previous week. The Region of the Americas reported a 3% decline in incidence and an 11% decrease in number of deaths reported last week.

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



**See *Annex 2: Data, table and figure notes*

The highest numbers of new cases were reported from Brazil (333 030 new cases; 9% decrease), India (291 789 new cases; 7% decrease), Indonesia (243 119 new cases; 44% increase), The United Kingdom (210 277 new cases; 30% increase), and Colombia (174 320 new cases; 15% decrease). Over the past week, the highest numbers of new cases per 100 000 population were reported from British Virgin Islands (2497 new cases per 100 000 pop), Seychelles (763 new cases per 100 000 pop), Cyprus (673 new cases per 100 000 pop), Jersey (628 new cases per 100 000 pop), and Fiji (490 new cases per 100 000 pop).

Globally, cases of the Alpha variant have been reported in 178 countries, territories or areas (six new countries in the past week), while 123 countries (three new countries) reported cases of the Beta variant; 75 countries (three new countries) reported cases of the Gamma variant; 111 countries (15 new countries) reported cases of the Delta variant.

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

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	962 280 (32%)	-3%	73 767 194 (40%)	23 715 (42%)	-11%	1 938 190 (48%)
Europe	653 803 (22%)	20%	56 935 257 (31%)	6 926 (12%)	-1%	1 196 301 (30%)
South-East Asia	712 210 (24%)	16%	35 931 354 (19%)	14 600 (26%)	26%	510 539 (13%)
Eastern Mediterranean	306 986 (10%)	25%	11 440 249 (6%)	3 706 (7%)	7%	222 510 (6%)
Africa	213 694 (7%)	5%	4 386 419 (2%)	5 013 (9%)	50%	102 681 (3%)
Western Pacific	147 492 (5%)	15%	3 779 156 (2%)	1 870 (3%)	-3%	57 627 (1%)
Global	**2 996 465 (100%)**	**10%**	**186 240 393 (100%)**	**55 830 (100%)**	**3%**	**4 027 861 (100%)**

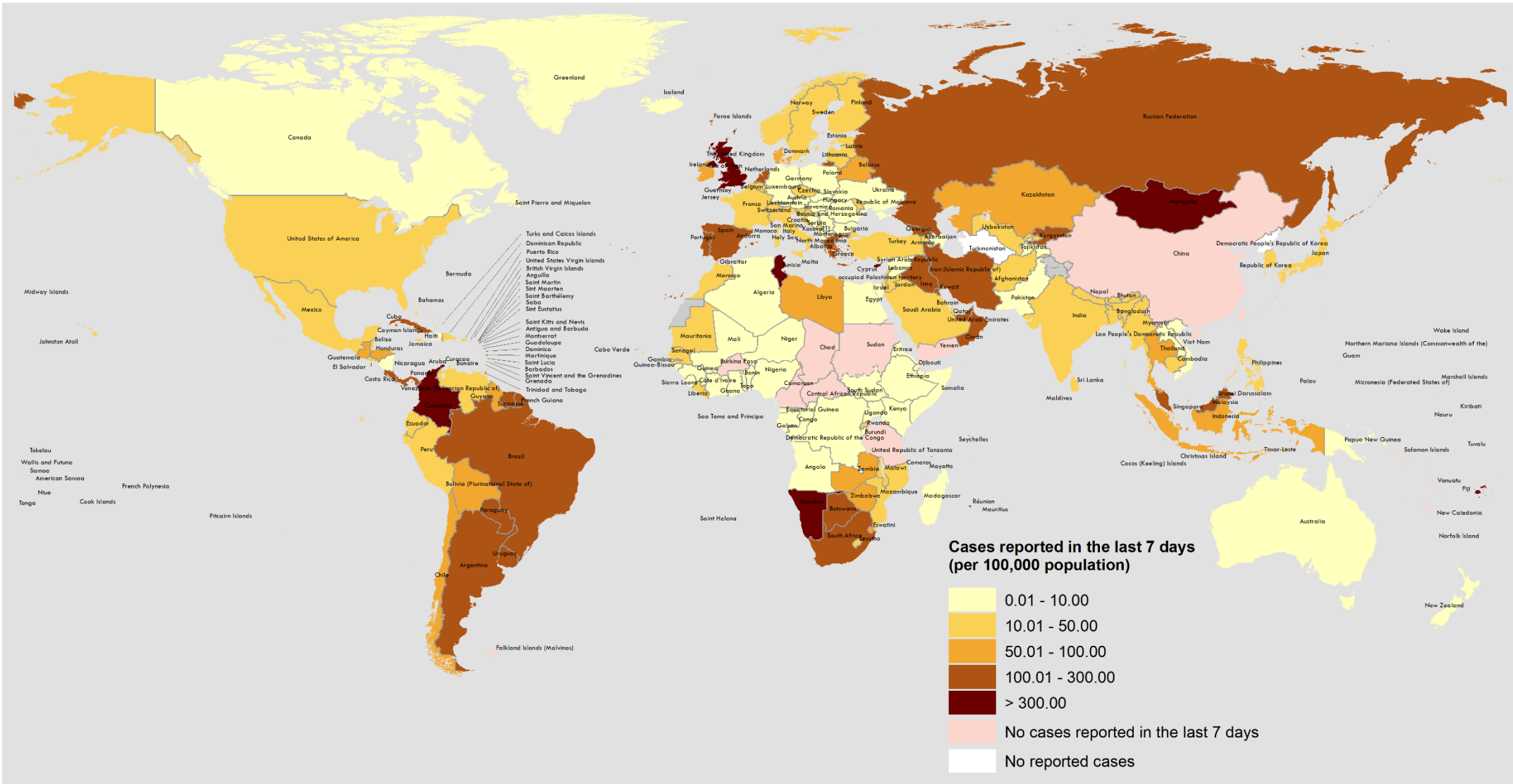
Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior

**See *Annex 2: 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 and previous editions of the Weekly Epidemiological Update

Figure 2. COVID-19 cases per 100 000 population reported by countries, territories and areas, 5 – 11 July 2021**



Data Source: World Health Organization, United Nations Population Division (population prospect 2020), EuroStat
Map Production: WHO Health Emergencies Programme

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city 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. Data for Bonaire, Sint Eustatius and Saba have been disaggregated and displayed at the subnational level.

**See *Annex 2: Data, table and figure notes*

Figure 3. COVID-19 deaths per 100 000 population reported by countries, territories and areas, 5 – 11 July 2021**

***Data Source**: World Health Organization*
United Nations Population Division (Population prospect 2020)
***Map Production**: WHO Health Emergencies Programme*

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city 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. [1] All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). Number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes. Data for Bonaire, Sint Eustatius and Saba have been disaggregated and displayed at the subnational level.

**See *Annex 2: Data, table and figure notes*

Special Focus: Update on WHO COVID-19 global rapid risk assessment

The COVID-19 pandemic continues to evolve, as does our understanding of the SARS-CoV-2 virus, and the response needed to control the spread and impact of the virus. In WHO's most recent rapid risk assessment, conducted on 9 July 2021, 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 situations. In addition, WHO periodically reviews the current risk status of public health events through an in-depth hazard, exposure and context assessment. This also includes a review of the vulnerabilities and capacities available to respond to the public health event 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; they are also used to support independent deliberations, including (but not limited to) meetings of the International Health Regulations (IHR 2005) Emergency Committee. To date, a total of 11 global rapid risk assessments have been undertaken for COVID-19, and additional assessments have been conducted 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 for COVID-19.

The global public health risks associated with COVID-19 remain very high. Following a two-month steady decline at the global level, case incidence rates remain high (once again approaching around 3 million new confirmed cases per week) and are increasing in most regions and in many countries. Following a decline in the death rate since the peak registered at the end of April 2021, a slight increase in deaths has been reported this week in comparison to the previous week, with several countries across all WHO regions with low levels of vaccination now reporting sharp increases in cases, hospitalizations, and deaths.

As the SARS-CoV-2 virus continues to circulate and evolve, emerging variants of interest and concern are being characterised by WHO and partners, to evaluate increased transmissibility and other potential phenotypic impacts. The four VOCs characterized to date (Alpha; Beta; Gamma, Delta) have demonstrated increased transmissibility. The Delta variant has now been detected in at least 111 countries across all six WHO regions in the last two months and has shown higher transmissibility than other VOCs identified to date. The increased transmissibility means that it is likely to become the dominant variant globally over the coming months. The emergence of more transmissible variants, coupled with the relaxation and inappropriate use of public health and social measures (PHSM) and increased social mobility and mixing, , and low vaccination coverage in many countries , continue to contribute to rapid surges in incidence, hospitalizations and deaths in many countries. Moreover, in large parts of the world, there remain gaps in epidemiological surveillance, testing, and genomic sequencing, and this limits our ability to monitor and assess the impact of current and future variants in a timely manner.

While almost a quarter (24.7%) of the world's population has received at least one dose of a COVID-19 vaccine (over three billion doses administered), there are vast inequities in vaccine distribution and administration with the majority of vaccines administered in a small number of high and upper-middle-income countries. The COVAX facility has been working to reduce this gap, but a large proportion of the world's population remains susceptible to SARS-CoV-2 infection. The breadth and quality of evidence of the efficacy and effectiveness of current vaccines against emerging variants remains limited; nevertheless, the available evidence suggests full vaccination offers high levels of protection against severe disease and death for all four VOCs, with mixed evidence as to the impacts on infection, mild-moderate disease, and transmission. Virus evolution and the phenotypic impacts of all variants, including potential immune escape, require close monitoring and assessment, including the possible need for future adjustments to vaccine composition, vaccination strategies and/or coverage targets.

In response to the COVID-19 pandemic, countries have moved in and out of restrictions of varying stringency over the past 18 months with many now facing considerable pressure to lift all remaining PHSM. Social mixing and mobility are increasing, in the forms of small- to large-scale gatherings and non-essential travel. Improper

planning or assessment of the risk of transmission during any gathering or travel provides opportunities for the virus to spread. Ongoing analyses evaluating the impact of VOCs in countries suggest that the individual- and community-level PHSM and infection prevention and control (IPC) strategies remain effective, including against current VOCs/VOIs. Suboptimal epidemiological surveillance, testing and contact tracing, isolation of cases and quarantine of contacts, and waning support and adherence to PHSM, are currently undoing gains made to date in controlling the pandemic.

Finally, supply shortages in vaccines, medical oxygen, personal protective equipment, laboratory tests, and other critical items continue to present key challenges in responding to the pandemic in the worst-affected countries. In 2021, maintaining the COVID-19 Supply Chain System has taken on an added dimension of complexity, given the requirement for ultra-cold-chain storage from production facilities to points of vaccine administration for some of the COVID-19 vaccines. In addition to the supply chain, the U$1.96 billion COVID-19 Strategic Preparedness and Response Plan for 2021 still has a 67% funding gap, straining resources for other urgent priorities such as vaccine deployment, epidemiological surveillance, contact tracing, and maintaining essential health services.

Additional resources

- Further information about WHO risk assessment process

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

WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 alter transmission or disease characteristics, or impact vaccine, therapeutics, diagnostics or effectiveness of public health and social measures (PHSM) applied by national authorities to control disease spread. "Signals" of potential Variants of Concern (VOCs) or Variants of Interest (VOIs) are detected and assessed based on the risk posed to global public health. As these risks evolve, WHO will continue to update lists of global VOIs and VOCs to support setting priorities for surveillance and research, and ultimately guide response strategies (for more information, please see the Tracking SARS-CoV-2 variants website).

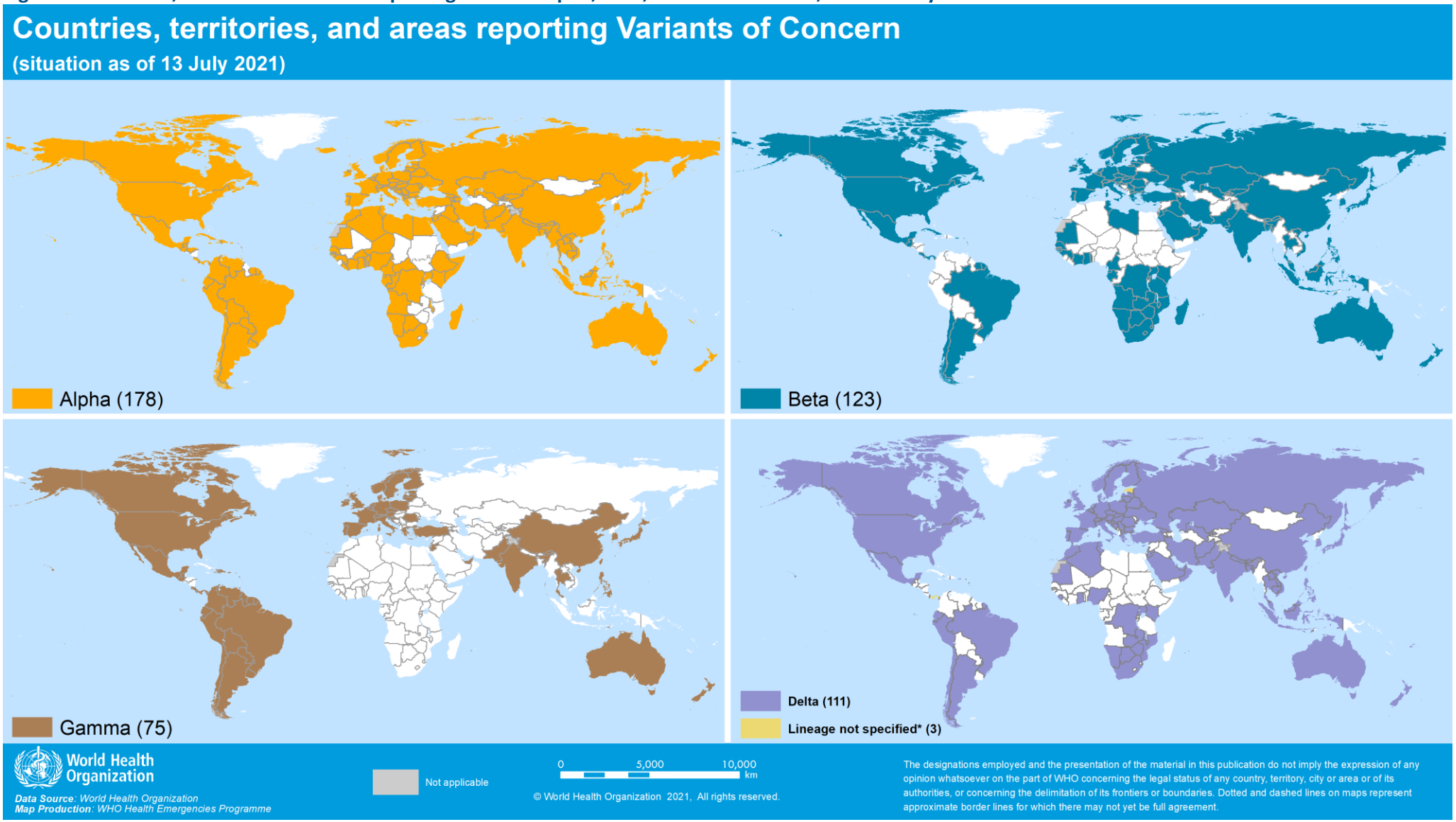
As surveillance activities to detect SARS-CoV-2 variants are strengthened at local and national levels, including by strategic genomic sequencing, the number of countries/areas/territories (hereafter countries) reporting VOCs has continued to increase (Figure 3, Annex 2). This distribution should be interpreted with due consideration of surveillance limitations, including differences in sequencing capacities and sampling strategies between countries. Nevertheless, an overall rise in COVID-19 cases due to the Delta variant is reported across all WHO regions. As of 13 July, at least 111 countries, territories and areas have reported detection of Delta variant, and this is expected to continue to increase, becoming the dominant variant globally in the coming months. The increased transmissibility associated with the Delta variant is likely to result in substantial increases in case incidence and greater pressure on healthcare systems, particularly in contexts of low vaccine coverage.

As countries gradually resume non-essential international travel, the introduction of risk mitigation measures aiming to reduce travel-associated exportation, importation and onward transmission of SARS-CoV-2 should be based on thorough risk assessments conducted systematically and routinely.

Additional resources

- COVID-19 new variants: Knowledge gaps and research
- Tracking SARS-CoV-2 variants
- 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
- Technical considerations for implementing a risk-based approach to international travel in the context of COVID-19: Interim guidance, 2 July 2021
- Landscape of observational study designs on the effectiveness of COVID-19 vaccination

Figure 3. Countries, territories and areas reporting variants Alpha, Beta, Gamma and Delta, as of 13 July 2021**



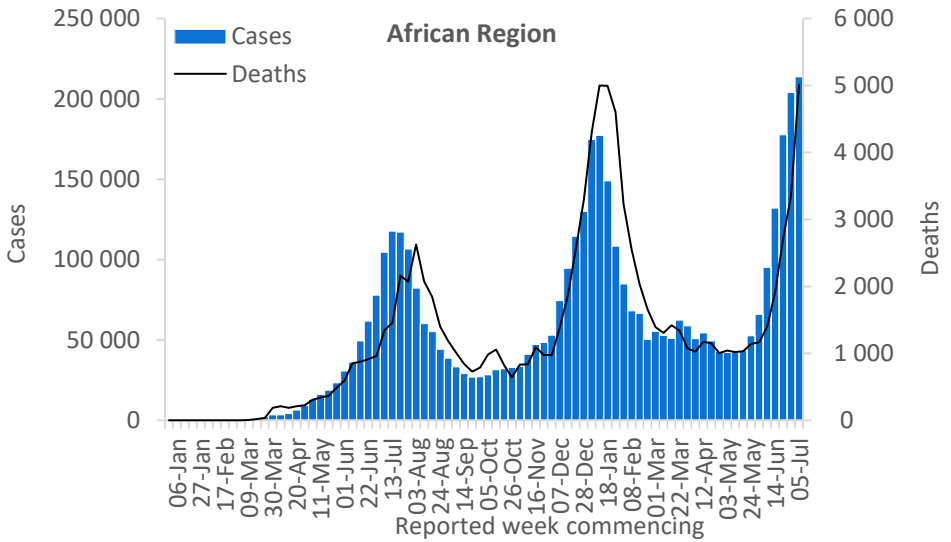
**Includes countries/territories/areas reporting the detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.*
***Countries/territories/areas highlighted include both official and unofficial reports of VOC detections, and do not presently differentiate between detections among travellers (e.g., at Points of Entry) or local community cases. Please see Annex 2 for further details.*

WHO regional overviews - Epidemiological week 5 – 11 July 2021

African Region

The weekly case incidence and deaths continues to increase for the past consecutive nine weeks and eight weeks, respectively. The African Region reported over 213 000 new cases and over 5000 new deaths, a 5% and a 50% increase respectively as compared to the previous week. In the past week, 62% of all new cases and 53% of all new deaths were reported from South Africa. The highest numbers of new cases were reported from South Africa (132 986 new cases; 224.2 new cases per 100 000 population; percentage difference similar to last week), Zimbabwe (13 188 new cases; 88.7 new cases per 100 000; a 72% increase), and Zambia (12 302 new cases; 66.9 new cases per 100 000; a 25% decrease).

The highest numbers of new deaths were reported from South Africa (2631 new deaths; 4.4 new deaths per 100 000 population; a 52% increase), Uganda (897 new deaths; 2.0 new deaths per 100 000; a 176% increase), and Zambia (378 new deaths; 2.1 new deaths per 100 000; a 12% decrease).

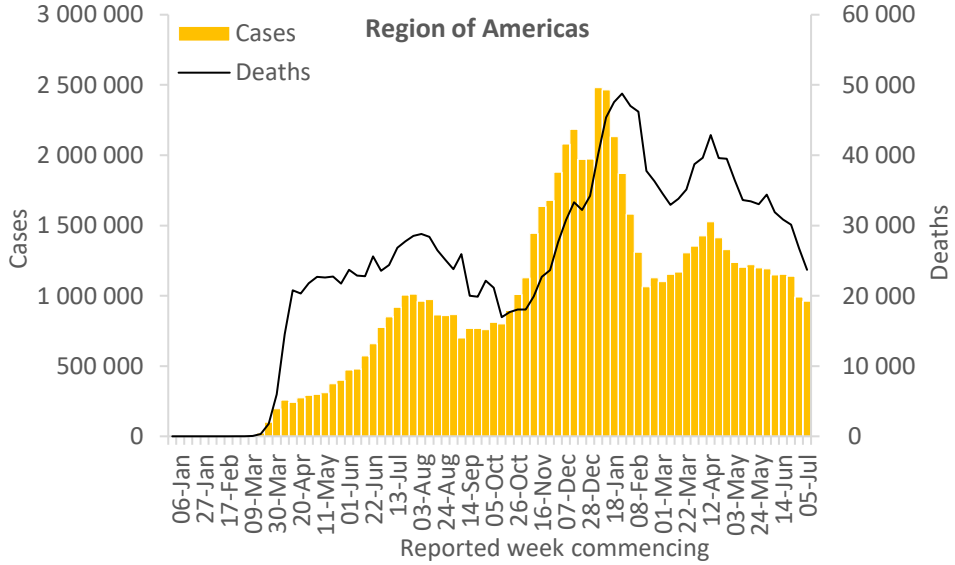


Updates from the African Region

Region of the Americas

The Region of the Americas reported over 962 000 new cases and over 23 000 new deaths, a 3% and an 11% decrease respectively as compared to the previous week. Overall, cases continue to decline in the region, however, large increases in case incidence were reported in small islands such as British Virgin Islands, Martinique, Barbados and Turks and Caicos Islands. The highest numbers of new cases were reported from Brazil (333 030 new cases; 156.7 new cases per 100 000; a 9% decrease), Colombia (174 320 new cases; 342.6 new cases per 100 000; a 15% decrease), and the United States of America (128 482 new cases; 38.8 new cases per 100 000; a 38% increase).

The highest numbers of new deaths were reported from Brazil (9736 new deaths; 4.6 new deaths per 100 000; a 10% decrease), Colombia (4008 new deaths; 7.9 new deaths per 100 000; a 9% decrease), and Argentina (2849 new deaths; 6.3 new deaths per 100 000; a 16% decrease).

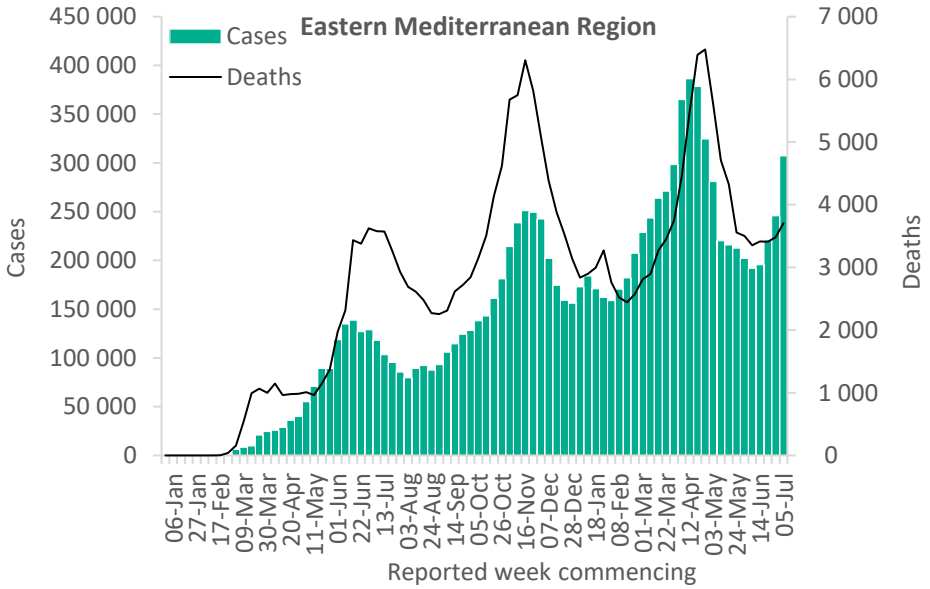


Updates from the Region of the Americas

Eastern Mediterranean Region

The Eastern Mediterranean Region reported just under 307 000 new cases and over 3700 new deaths, a 25% and a 7% increase respectively as compared to the previous week. This is the fourth consecutive week of increase in cases reported in the region. The highest numbers of new cases were reported from the Islamic Republic of Iran (114 749 new cases; 136.6 new cases per 100 000; a 38% increase), Iraq (56 535 new cases; 140.6 new cases per 100 000; a 29% increase), and Tunisia (52 076 new cases; 440.6 new cases per 100 000; a 47% increase).

The highest numbers of new deaths were reported from the Islamic Republic of Iran (1067 new deaths; 1.3 new deaths per 100 000; a 16% increase), Tunisia (983 new deaths; 8.3 new deaths per 100 000; a 44% increase), and Afghanistan (525 new deaths; 1.3 new deaths per 100 000; a 4% decrease).

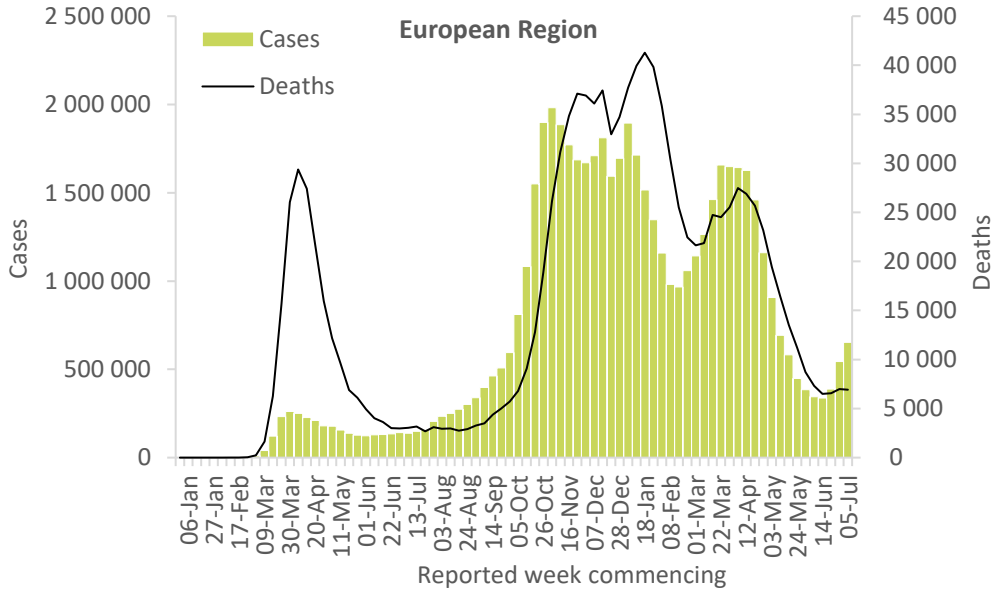


Updates from the Eastern Mediterranean Region

European Region

Cases in the European Region have been steadily increasing over the past month and this week, the Region reported over 653 000 new cases, a 20% increase as compared to the previous week. The number of new deaths reported regionally this week was similar to that of the previous week. The highest numbers of new cases were reported from the United Kingdom (210 277 new cases; 309.8 new cases per 100 000; a 30% increase), Russian Federation (172 392 new cases; 118.1 new cases per 100 000; an 8% increase), and Spain (52 824 new cases; 111.6 new cases per 100 000; a 19% decrease).

The highest numbers of new deaths were reported from the Russian Federation (5077 new deaths; 3.5 new deaths per 100 000; a 9% increase), Turkey (318 new deaths; 0.4 new deaths per 100 000; a 9% decrease), and Germany (201 new deaths; 0.2 new deaths per 100 000; a 27% decrease).

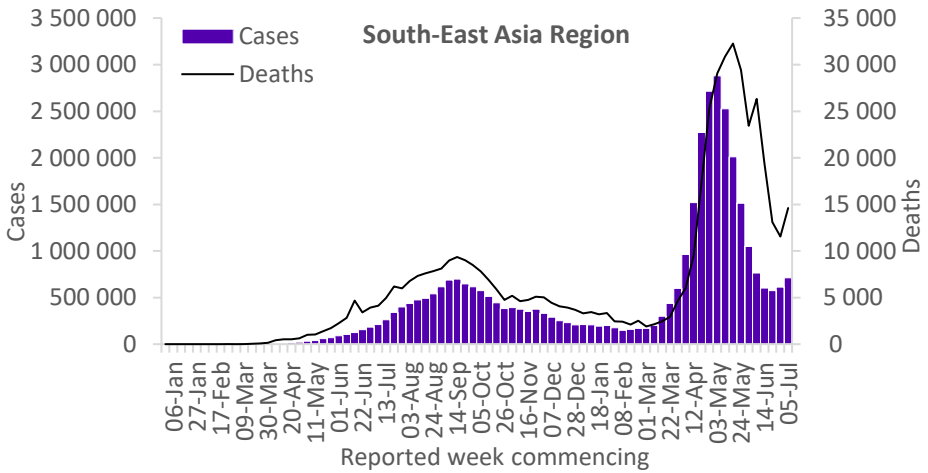


Updates from the European Region

South-East Asia Region

Although trends in the incidence of new cases in the South-East Asia Region are at much lower levels as compared to the region's highest peaks at the start of May, the Region is reporting another resurgence in cases with over 712 000 new cases reported in the Region this week, a 16% increase as compared to the previous week. More concerning is the number of new deaths: the past week saw over 14 000 new deaths, a 26% increase as compared to the previous week. The highest numbers of new cases were reported from India (291 789 new cases; 21.1 new cases per 100 000; a 7% decrease), Indonesia (243 119 new cases; 88.9 new cases per 100 000; a 44% increase), and Bangladesh (76 272 new cases; 46.3 new cases per 100 000; a 35% increase).

The highest numbers of new deaths were reported from India (6035 new deaths; 0.4 new deaths per 100 000; a 4% decrease), Indonesia (5882 new deaths; 2.2 new deaths per 100 000; a 71% increase), and Bangladesh (1354 new deaths; 0.8 new deaths per 100 000; a 52% increase).

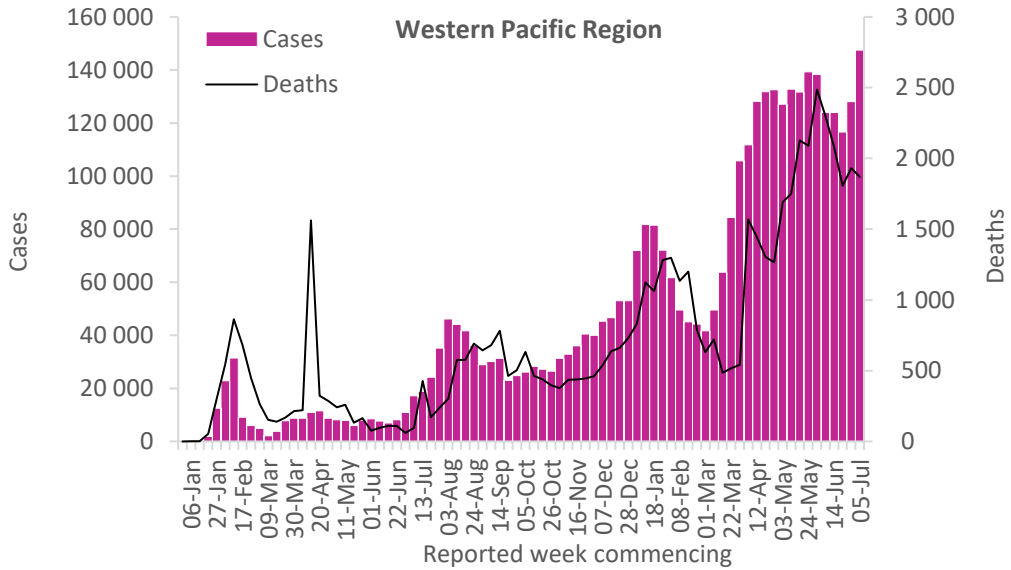


Updates from the South-East Asia Region

Western Pacific Region

The Western Pacific Region has reported increasing trends in case incidence for the past three weeks although deaths remain relatively stable. This week over 147 000 new cases and over 1800 new deaths were reported, a 15% increase and a 3% decrease respectively as compared to the previous week. The highest numbers of new cases were reported from Malaysia (54 584 new cases; 168.6 new cases per 100 000; a 24% increase), the Philippines (36 706 new cases; 33.5 new cases per 100 000; a 5% decrease), and Japan (13 314 new cases; 10.5 new cases per 100 000; a 22% increase).

The highest numbers of new deaths were reported from the Philippines (753 new deaths; 0.7 new deaths per 100 000; an 8% decrease), Malaysia (633 new deaths; 2.0 new deaths per 100 000; a 15% increase), and Cambodia (185 new deaths; 1.1 new deaths per 100 000; a 7% increase).



Updates from the Western Pacific Region

Key weekly updates

WHO Director-General's key messages

- In his opening remarks at the media briefing on COVID-19 – 7 July 2021, the Director-General highlighted:
    - the need for vaccinating 10 per cent of people in all countries by September and 40 per cent by the end of the year to position the world on the path to vaccinating 70 percent of the people in all countries by the middle of 2022.
    - the use of Interleukin-6 receptor blockers in patients who are severely or critically ill with COVID-19, a class of medicines that is lifesaving, especially when administered alongside corticosteroids.
- In his introductory remarks at the high-level event: Impact of violence on children's mental health- 8 July 2021, the Director-General emphasized the need to step up the efforts to improve the prevention, diagnoses and treatment of mental health conditions in children, and the need for building nurturing environments within families, schools and communities for children to achieve the right to be free from violence and enjoy high quality mental healthcare.

Updates and publications

- Infection prevention and control during health care when coronavirus disease (COVID-19) is suspected or confirmed
- COVID-19 Vaccines: safety surveillance manual. Module on safety surveillance of COVID-19 vaccines in pregnant and breastfeeding women
- Diagnostics, therapeutics, vaccine readiness, and other health products for COVID-19
- Modelling the health impacts of disruptions to essential health services during COVID-19
- WHO Global Clinical Platform for the Clinical Characterization of COVID-19: Statistical Analysis Plan, 7 July 2021
- Therapeutics and COVID-19: living guideline

Annex

COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region (reported in previous issues) are now available at: https://covid19.who.int/table

Annex 1. List of countries/territories/areas reporting Variants of Concern as of 13 July 2021**

Country/Territory/Area***	Alpha	Beta	Gamma	Delta	Unspecified
Afghanistan	●	-	-	●*	-
Albania	●	-	-	-	-
Algeria	●	-	-	●	-
Angola	●	●	-	-	-
Antigua and Barbuda	●	●	-	-	-
Argentina	●	●	●	●	-
Armenia	○	-	-	-	-
Aruba	●	●	●	●	-
Australia	●	●	●	●	-
Austria	●	●	●	●	-
Azerbaijan	●	-	-	-	-
Bahrain	●	●	-	●	-
Bangladesh	●	●	-	●	-
Barbados	●	-	●	●	-
Belarus	●	-	-	○	-
Belgium	●	●	●	●	-
Belize	●	-	-	-	-
Benin	●*	-	-	-	-
Bermuda	●	●	-	-	-
Bhutan	●	●	-	●	-
Bolivia (Plurinational State of)	●	-	●	-	-
Bonaire	●	-	-	-	-
Bosnia and Herzegovina	○	-	-	○*	-
Botswana	●*	●	-	●	-
Brazil	●	●	●	●	-
British Virgin Islands	●	-	●	-	-
Brunei Darussalam	●	●	-	-	-
Bulgaria	●	●	-	●	-
Burkina Faso	●	-	-	-	-
Cabo Verde	●	-	-	-	-
Cambodia	●	-	-	●	-
Cameroon	●	●	-	-	-
Canada	●	●	●	●	-
Cayman Islands	●	-	●*	-	-
Central African Republic	●	-	-	-	-
Chile	●	●	●	●	-
China	●	●	●	○	-
Colombia	●	-	●	-	-
Comoros	-	●	-	-	-
Congo	●	-	-	-	-
Costa Rica	●	●	●	-	-
Croatia	●	●	○	○	-
Cuba	●	●	-	-	-
Curaçao	●	-	●	-	●
Cyprus	●	●	-	○*	-
Czechia	●	●	●	●	-
Côte d'Ivoire	●	●	-	-	-
Democratic Republic of the Congo	●	●	-	●	-
Denmark	●	●	●	●	-
Djibouti	●	●	-	-	-
Dominica	●	-	-	-	-
Dominican Republic	●	-	●	-	-
Ecuador	●	-	●	●*	-
Egypt	●	-	-	-	-
Equatorial Guinea	●	●	-	-	-
Estonia	●	●	○	-	○
Eswatini	●*	●	-	-	-
Ethiopia	○	-	-	-	-
Faroe Islands	●	-	●	-	-
Fiji	-	-	-	●	-
Finland	●	●	●	●	-
France	●	●	●	●	-
French Guiana	●	●	●	●	-
French Polynesia	●	●	●	●	-
Gabon	●	○	-	-	-
Gambia	●	-	-	●	-
Georgia	●	○	-	●	-
Germany	●	●	●	●	-
Ghana	●	●	-	●	-
Gibraltar	●	-	-	-	-
Greece	●	●	●	●	-
Grenada	●	-	-	-	-
Guadeloupe	●	●	●	●	-
Guam	●	●	●	●	-
Guatemala	●	●	●	-	-
Guinea	●	●	-	-	-
Guinea-Bissau	●	●	-	-	-

Country/Territory/Area***	Alpha	Beta	Gamma	Delta	Unspecified
Guyana	-	-	●	-	-
Haiti	●	-	●	-	-
Honduras	●	-	-	-	-
Hungary	●	○	-	○	-
Iceland	●	-	-	-	-
India	●	●	●	●	-
Indonesia	●	●	-	●	-
Iran (Islamic Republic of)	●	●	-	●	-
Iraq	●	●	-	-	-
Ireland	●	●	●	●	-
Israel	●	●	●	●	-
Italy	●	●	●	●	-
Jamaica	●	-	-	-	-
Japan	●	●	●	●	-
Jordan	●	●	●	●	-
Kazakhstan	○	○	-	●	-
Kenya	●	●	-	●	-
Kosovo[1]	●	○	-	○	-
Kuwait	●	-	-	●	-
Kyrgyzstan	●	●*	-	-	-
Lao People's Democratic Republic	●	-	-	●	-
Latvia	●	●	●	○	-
Lebanon	●	-	-	●	-
Lesotho	-	●	-	-	-
Liberia	●	-	-	-	-
Libya	●	●	-	-	-
Liechtenstein	●	-	-	-	-
Lithuania	●	●	●	○	-
Luxembourg	●	●	●	●	-
Madagascar	●*	●	-	-	-
Malawi	●	●	-	●	-
Malaysia	●	●	-	●	-
Maldives	●	-	-	●	-
Malta	●	○	●	○	-
Martinique	●	●	●	●	-
Mauritania	●	●	-	●	-
Mauritius	○	●	-	●	-
Mayotte	●	●	-	-	-
Mexico	●	●	●	●	-
Monaco	●	○	-	○*	-
Montenegro	●	-	-	-	-
Montserrat	●	-	-	-	-
Morocco	●	-	-	●	-
Mozambique	-	●	-	●	-
Myanmar	●	-	-	-	-
Namibia	●*	●	-	●	-
Nepal	●	-	-	●	-
Netherlands	●	●	●	●	-
New Caledonia	●	-	-	-	-
New Zealand	●	●	○	○	-
Niger	●	-	-	-	-
Nigeria	●	-	-	●*	-
North Macedonia	●	●	-	○*	-
Norway	●	●	●	●	-
Occupied Palestinian Territory	●	●	-	●	-
Oman	●	●	-	●	-
Pakistan	●	●	●	●	-
Panama	●	●	●	-	●
Paraguay	●	-	●	-	-
Peru	●	-	●	●	-
Philippines	●	●	●	●	-
Poland	●	○	●	●	-
Portugal	●	●	●	●	-
Puerto Rico	●	●	●	●	-
Qatar	●	●	-	●	-
Republic of Korea	●	●	●	●	-
Republic of Moldova	○	-	-	-	-
Romania	●	●	●	●	-
Russian Federation	●	●	-	●	-
Rwanda	●	○	-	-	-
Réunion	●	●	●	○	-
Saba	-	-	-	●	-
Saint Barthélemy	●	-	-	-	-
Saint Lucia	●	-	-	-	-
Saint Martin	●	●	-	-	-
Sao Tome and Principe	●	-	-	-	-
Saudi Arabia	●	●	-	●	-
Senegal	●	●	-	-	-
Serbia	●	-	-	-	-
Seychelles	-	●	-	-	-
Sierra Leone	-	-	-	○	-
Singapore	●	●	●	●	-
Sint Maarten	●	●	-	●	-
Slovakia	●	●	-	●	-
Slovenia	●	●	●	●	-
Somalia	●	-	-	-	-
South Africa	●	●	-	●	-
Spain	●	●	●	●	-
Sri Lanka	●	●	-	●	-
Suriname	●	●	●	-	-
Sweden	●	●	●	●	-
Switzerland	●	●	○	●	-
Thailand	●	●	●	●	-
Timor-Leste	●	-	-	-	-
Togo	●	●	-	-	-

Country/Territory/Area***	Alpha	Beta	Gamma	Delta	Unspecified
Trinidad and Tobago	●	-	●	-	-
Tunisia	●	●	-	●	-
Turkey	●	●	●	●	-
Turks and Caicos Islands	●	-	●	-	-
Uganda	●	●	-	●	-
Ukraine	●	○	-	○	-
United Arab Emirates	●	●	●	●	-
United Kingdom	●	●	●	●	-
United Republic of Tanzania	-	●	-	-	-
United States of America	●	●	●	●	-
Uruguay	●	-	●	-	-
Uzbekistan	●	●	-	○	-
Venezuela (Bolivarian Republic of)	●	-	●	-	-
Viet Nam	●	●	-	●	-
Wallis and Futuna	●	-	-	-	-
Zambia	-	●	-	●	-
Zimbabwe	-	●	-	●	-

**Newly reported in this update.*
"Unspecified B.1.617" reflects countries/territories/areas reporting detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.
"●" indicates that information for this variant was received by WHO from official sources.
"○" indicates that information for this variant was received by WHO from unofficial sources and will be reviewed as more information become available.
*** Unspecified B.1.617 were excluded for Nigeria, Cyprus and North Macedonia this week based on further information.*
****Includes countries/territories/areas reporting the detection of VOCs among travelers (e.g., imported cases detected at points of entry), or local cases (detected in the community). Excludes countries, territories, and areas that have never reported the detection of a variant of concern*

See also Annex 2: Data, table and figure notes.

Annex 2. 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.

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 except, the names of proprietary products are distinguished by initial capital letters.

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

Technical guidance and other resources

- WHO technical guidance
- WHO COVID-19 Dashboard
- WHO Weekly Operational Updates on COVID-19
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- OpenWHO courses on COVID-19 in official UN languages and in additional national languages
- WHO Academy COVID-19 mobile learning app
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Recommendations and advice for the public:
  - Protect yourself
  - Questions and answers
  - Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities

COVID-19 Weekly Epidemiological Update

Edition 49, published 20 July 2021

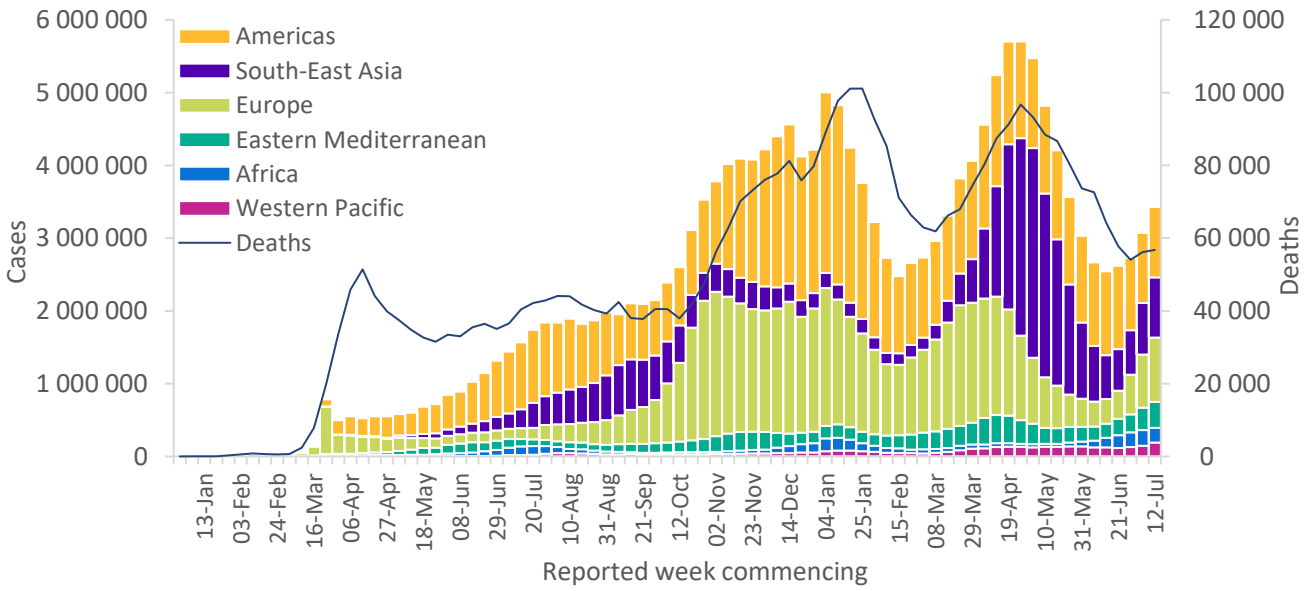
In this edition:

Global overview

Data as of 18 July 2021

The global number of new cases reported last week (12-18 July 2021) was over 3.4 million, a 12% increase as compared to the previous week (Figure 1). Globally, COVID-19 weekly case incidence increased with an average of around 490 000 cases reported each day over the past week as compared to 400 000 cases reported daily in the previous week. Following a steady decline for over two months, the number of weekly deaths reported was similar to the previous week, with almost 57 000 deaths reported. The cumulative number of cases reported globally is now over 190 million and the number of deaths exceeds 4 million. At this rate, it is expected that the cumulative number of cases reported globally could exceed 200 million in the next three weeks. Last week, four Regions (all except the Regions of the Americas and Africa) reported an increase in case incidence. The Western Pacific Region recorded the largest increase in case incidence as compared to the previous week, followed by the European Region (30% and 21%, respectively) (Table 1). The South-East Asia and Eastern Mediterranean Regions also recorded increases in case incidence, 16% and 15%, respectively, as compared to the previous week. The number of deaths increased in the South-East Asia and the Western Pacific Regions by 12% and 10%, respectively, as compared to the previous week. The African, Eastern Mediterranean and European Regions reported similar numbers of deaths as compared to the previous week, whereas the Region of Americas reported a 6% decrease.

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



**See *Annex 2: Data, table and figure notes*

The Region of the Americas and the European Region reported the highest weekly case incidence per capita, both reporting 95 new cases per 100 000 population, as well as the highest number of deaths per population over the past week, with 2.2 and 0.8 new deaths per 100 000 population, respectively. The Eastern Mediterranean and South-East Asia Regions reported 48 and 41 new cases per 100 000 population, respectively.

Despite efforts to extend vaccination coverage, many countries across all six WHO Regions continue to experience surges in COVID-19 cases. Over the past week, the highest numbers of new cases were reported from Indonesia (350 273 new cases; 44% increase), the United Kingdom (296 447 new cases; 41% increase), Brazil (287 610 new cases; 14% decrease), India (268 843 new cases; 8% decrease), and the United States of America (216 433 new cases; 68% increase).

Globally, cases of the Alpha variant have been reported in 180 countries, territories or areas (hereafter countries; six new countries in the past week), while 130 countries (seven new countries) have reported cases of the Beta variant; 78 countries (three new countries) have reported cases of the Gamma variant; and 124 countries (13 new countries) have reported cases of the Delta variant.

The increases in transmission appear to be driven by four factors: the circulation of more transmissible Variants of Concern (VOCs), relaxation of public health social measures originally intended to control transmission, increases in social mixing, and the large number of people who remain susceptible to SARS-CoV-2 infection as a result of inequitable vaccine distribution around the world.

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

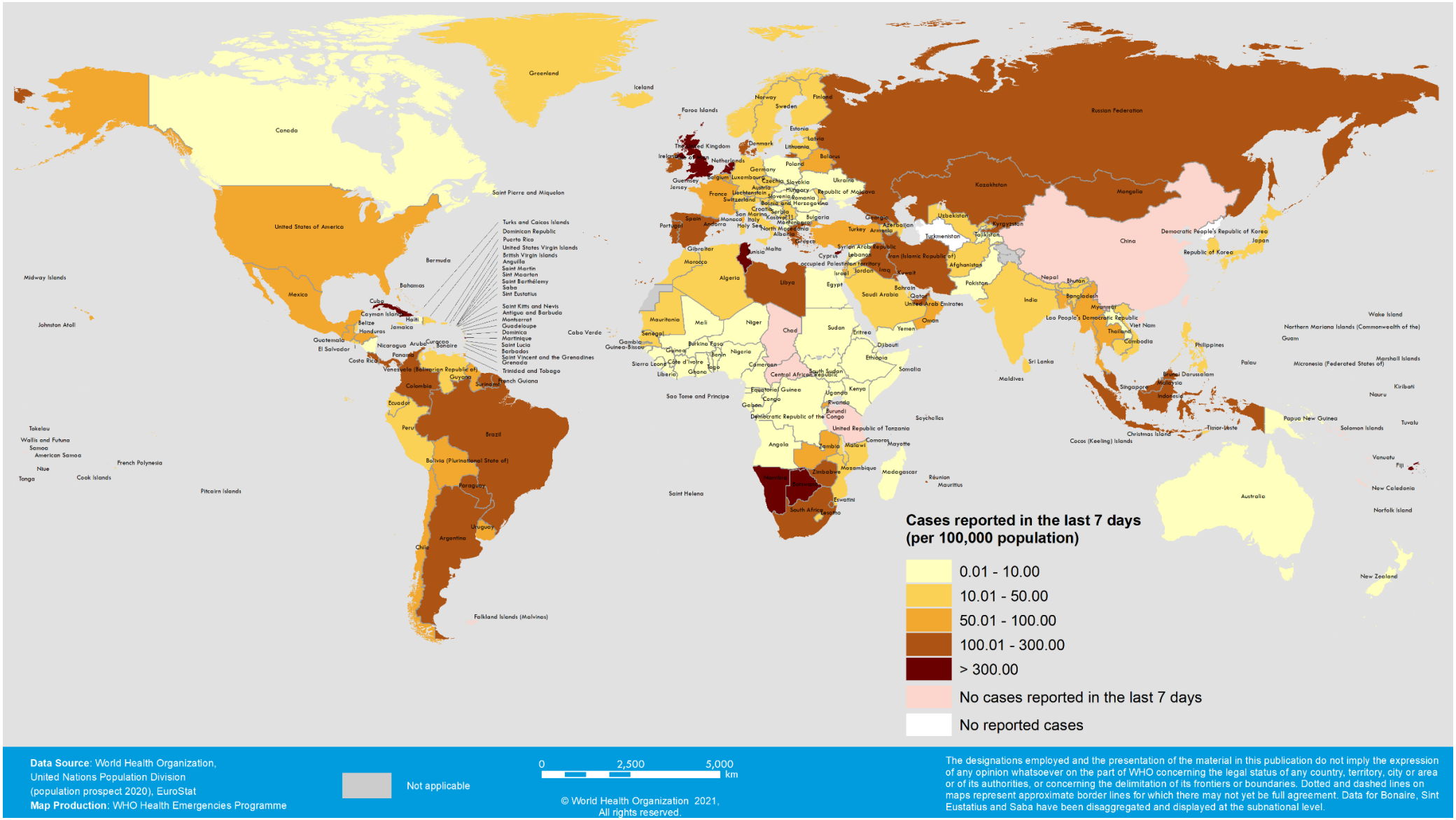
WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	967 205 (28%)	0%	74 734 644 (39%)	22 411 (39%)	-6%	1 960 619 (48%)
Europe	885 048 (26%)	21%	58 319 701 (31%)	7 173 (13%)	0%	1 204 780 (29%)
South-East Asia	829 552 (24%)	16%	36 760 906 (19%)	16 403 (29%)	12%	526 942 (13%)
Eastern Mediterranean	354 030 (10%)	15%	11 794 433 (6%)	3 875 (7%)	4%	226 399 (6%)
Africa	202 801 (6%)	-5%	4 589 220 (2%)	4 817 (8%)	-4%	107 498 (3%)
Western Pacific	191 009 (6%)	30%	3 970 165 (2%)	2 088 (4%)	10%	59 749 (1%)
Global	**3 429 645 (100%)**	**12%**	**190 169 833 (100%)**	**56 767 (100%)**	**1%**	**4 086 000 (100%)**

**Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior*
**See *Annex 2: Data, table and figure notes*

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

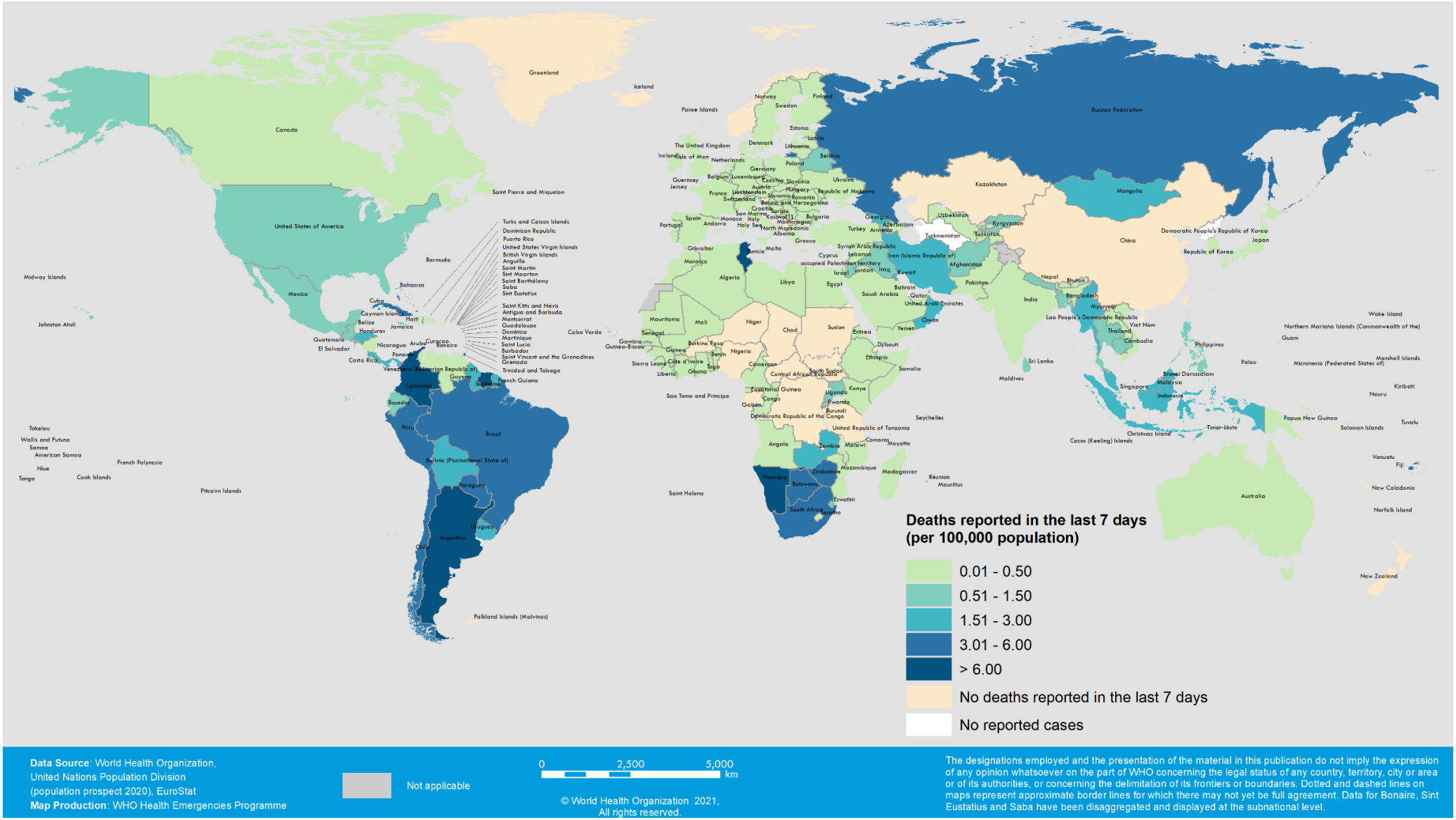
- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update and previous editions of the Weekly Epidemiological Update

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



**See *Annex 2: Data, table and figure notes*

Figure 3. COVID-19 deaths per 100 000 population reported by countries, territories and areas, 12 – 18 July 2021**



**See *Annex 2: Data, table and figure notes*

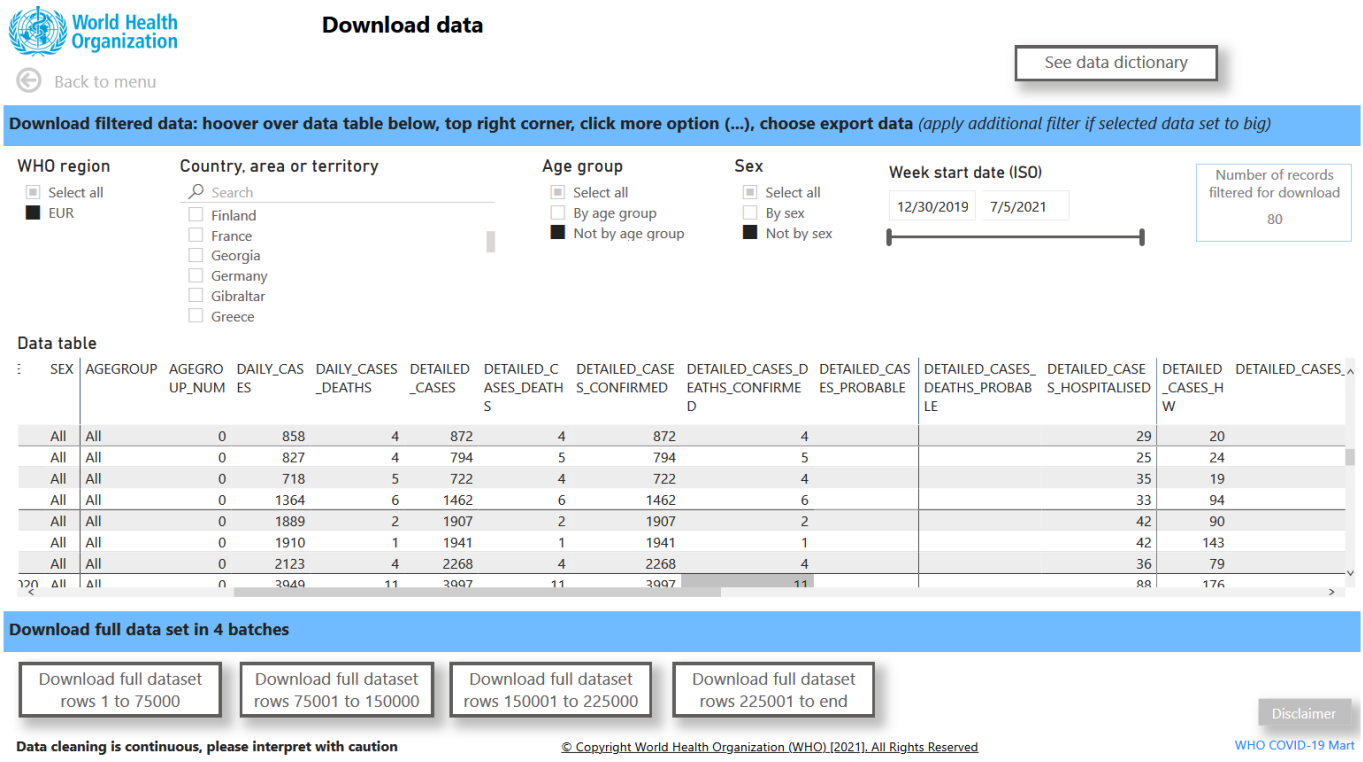
Special Focus: Release of a WHO COVID-19 detailed surveillance data dashboard, including a downloadable database feature

Over eighteen months into the COVID-19 pandemic, the need for global epidemiological surveillance for COVID-19 continues to be of high importance. The evolution of transmission patterns as the pandemic continues will likely be influenced by the impact of the COVID-19 vaccination campaigns and by the emergence of more transmissible variants, or variants with properties of immune escape. Timely and complete surveillance data are therefore key to monitoring these changes.

WHO has been conducting global surveillance of COVID-19 as part of the WHO's preparedness, readiness and response activities for COVID-19. Besides the daily count of confirmed COVID-19 cases and deaths, WHO has requested all Member States to report a minimum set of information using one of the two following mechanisms: a case report form; or via the weekly aggregated surveillance system, as specified in the Public Health Surveillance for COVID-19 interim guidance.

The data reported by Member States are now publicly available through the WHO COVID-19 detailed surveillance data dashboard, without editing or filtering by WHO. This dashboard complements the existing WHO COVID-19 dashboard and provides data by WHO Region and by country, stratified by age and sex, trends over time, case fatality ratios by age, testing, hospitalization, and data on health care workers. The WHO COVID-19 detailed surveillance data dashboard, and the downloadable dataset, provides the ability for users to conduct further analyses by country and over selected time periods.

Figure 4. WHO COVID-19 detailed surveillance dashboard which features a downloadable database



As of 16 July 2021, a total of 186 countries, territories, and areas had reported the minimum required information via case report forms and/or weekly aggregate surveillance to WHO. Of the 188 million cases reported globally at this time, WHO received information for 123 million cases (65%). Of these, sex was reported for over 95 million cases (77%), age reported for 76.5 million cases (62%), and age and sex combined was reported for 73.6 million cases (60%). To date, over 2.1 million cases and just under 7000 deaths among health workers have been recorded in the dashboard.

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

WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 alter transmission or disease characteristics, or impact vaccine, therapeutics, diagnostics or effectiveness of public health and social measures (PHSM) applied by national authorities to control disease spread. "Signals" of potential Variants of Concern (VOCs) or Variants of Interest (VOIs) are detected and assessed based on the risk posed to global public health. National authorities may choose to designate other variants of local interest/concern and are encouraged to investigate and report on impacts of these variants.

For updates on VOCs and VOIs, and a list of Alerts for Further Monitoring, are available on the WHO Tracking SARS-CoV-2 Variants website.

Geographic distribution

As surveillance activities to detect SARS-CoV-2 variants are strengthened at national and subnational levels, including through the expansion of genomic sequencing capacities, the number of countries/areas/territories (hereafter countries) reporting VOCs continues to increase (Figure 5, Annex 1). This distribution should nonetheless be interpreted with due consideration of surveillance limitations, including differences in sequencing capacities and sampling strategies between countries.

Phenotypic characteristics

Available evidence on phenotypic impacts of VOCs is summarized in Table 2, as well as in previous editions of these COVID-19 Weekly Epidemiological Updates. Since the last detailed update on 6 July, new evidence has been published on the phenotypic characteristics of the Delta variant.

As of 20 July 2021, a total of 2 418 133 SARS-CoV-2 sequences have been submitted to GISAID, a global science initiative and primary source that provides open access to genomic data. Over 220 000 (9%) of SARS-CoV-2 sequences submitted to GISAID are confirmed as the Delta Variant. As mentioned in our last update, based on the estimated transmission advantage of the Delta variant, it is expected that it will rapidly outcompete other variants and become the dominant circulating lineage over the coming months.[1] According to GISAID data, as of 20 July, the prevalence of Delta among the specimens sequenced over the past 4 weeks exceeded 75% in many countries worldwide including Australia, Bangladesh, Botswana, China, Denmark, India, Indonesia, Israel, Portugal, Russian Federation, Singapore, South Africa and the United Kingdom.

Growing evidence supports the increased transmissibility of the Delta variant as compared to non-VOCs. However, the exact mechanism for the increase in transmissibility remains unclear. A recent study from China during an outbreak of the Delta variant examined the time interval from the exposure of a quarantined population to the first positive PCR result and found that the interval may be shorter for the Delta variant when compared to non-VOCs [4 (IQR 3.00-5.00) days compared to 6 (IQR 5.00 to 8.00) days, respectively]. Moreover, the viral load of the first positive test of Delta infection was over 1200 times higher than non-VOCs, suggesting that this VOC may be able to replicate faster and be more infectious during the early stages of infection.[2]

A study from Canada analysing data from over 200 000 COVID-19 cases showed an increase in virulence of the Delta variant when compared to non-VOCs. Among the COVID-19 cases, the risk of hospitalization, ICU admission and death associated with the Delta variant compared to non-VOCs increased by 120% (93-153%), 287% (198-399%) and 137% (50-230%), respectively. Increased disease severity was also identified for Alpha, Beta and Gamma variants combined when compared to non-VOCs: 59% (49-69%) for hospitalization, 105% (82-134%) for ICU admission and 61% (40-87%) for death.[3]

Preliminary findings from a study in the United Kingdom, which measured antibodies in a cohort of 112 SARS-CoV-2-infected individuals, indicated significantly reduced neutralization titres (2.5 to 5-fold reduction) in sera from individuals infected with Delta, Beta or Alpha variants with a S:484K mutation (but not Alpha without any additional mutations) when compared to the non-VOCs.[4]

A recent modelling study simulated the effects of non-pharmaceutical interventions (NPIs) in the context of expanding vaccination coverage and the predominance of the Delta variant in Germany, while accounting for age-associated factors and commuting activities. The authors indicated that timely implementation of NPIs in combination with masks and testing would considerably reduce the chance of a further surge in infections.[5]

Table 2: Summary of phenotypic impacts* of Variants of Concern

WHO label	Alpha	Beta	Gamma	Delta
Transmissibility	Increased transmissibility and secondary attack rate[6]	Increased transmissibility[7]	Increased transmissibility[8]	Increased transmissibility and secondary attack rate[1,9,10]
Disease severity	Increased risk of hospitalization[11], possible increased risk of severity and mortality[12]	Not confirmed, possible increased risk of in-hospital mortality[13,14]	Not confirmed, possible increased risk of hospitalization[15]	Increased risk of hospitalization[3,16]
Risk of reinfection	Neutralizing activity retained,[17] risk of reinfection remains similar[18,19]	Reduction in neutralizing activity reported; T cell response elicited by D614G virus remains effective[20–23]	Moderate reduction in neutralizing activity reported[24,25]	Reduction in neutralizing activity reported[26]
Impacts on diagnostics	Limited impact – S gene target failure (SGTF); no impact on overall result from multiple target RT-PCR, No impact on Ag RDTs observed[27]	No impact on RT-PCR or Ag RDTs observed[16]	None reported to date	None reported to date

**Generalized findings as compared to previously/co-circulating variants. Based on emerging evidence, including non-peer-reviewed preprint articles and reports, all subject to ongoing investigation and revision.*

VOC impacts on vaccines

Table 3 presents the impact of variants on vaccine efficacy/effectiveness (VE) and quantifies the reduction in VE due to variants compared to VE in non-VOC settings. Of note, reductions in VE do not necessarily mean loss of protection, as indicated by the absolute VE estimate. For example, a 10-percentage point reduction in VE against symptomatic disease for mRNA vaccines would still mean high vaccine effectiveness of ~85%. In addition, vaccines have shown higher VE against severe disease; thus, small reductions in VE against severe disease due to VOCs may still mean good protection, as is the case for AstraZeneca-Vaxzevria.

Since the 6 July update, two notable studies have provided further evidence of the performance of mRNA vaccines against Alpha and Beta variants. The first, a test-negative case-control study in the United States of America, found that vaccination with two doses of Moderna-mRNA-1273 or Pfizer BioNTech-Comirnaty vaccines was 92.8% (95% CI: 83.0-96.9%) effective at preventing hospitalization due to the Alpha variant 14 or more days after receipt of the second dose; VE against all variants was 86.9% (95% CI: 80.4-91.2%). It should be noted that approximately 21% of the 1210 adults participating in the study were immunosuppressed.[28]

A second study, from Qatar, evaluated VE of Moderna-mRNA-1273 against SARS-CoV-2 infection and severe disease due to Alpha and Beta variants among a large cohort of adults using a matched test negative case-control design. Adjusted VE against infection due to the Alpha and Beta variants 14 or more days after receipt of the second dose was 100% and 96% (95% CI: 90.9-98.2%), respectively. Single dose VE against infection due to Alpha and Beta was reduced: 88.2% (95% CI: 83.8-91.4%) and 68.2% (95% CI: 64.3-71.7%), respectively. The study also evaluated VE of Moderna-mRNA-1273 against asymptomatic, symptomatic, and severe, critical, or fatal disease due to all variants (predominantly Alpha and Beta). VE of two doses of the vaccine ranged from 90-99% for these outcomes. VE of a single dose remained high for severe, critical or fatal disease (84%) but was markedly lower for asymptomatic and symptomatic disease at 47.3% (95% CI: 37.6-55.5%) and 66.0% (60.6-70.7%), respectively, thus, highlighting the importance of two doses.[29]

Table 3. Summary of vaccine performance against Variants of Concern

Alpha	Beta	Gamma	Delta
Efficacy/effectiveness against disease or infection (full vaccination), see key below table			
Protection retained against all outcomes	Protection retained against severe disease; possible reduced protection against symptomatic disease and infection	Unclear impact; very limited evidence	Protection retained against severe disease; possible reduced protection against symptomatic disease and infection
Severe disease			
• ↔: Moderna-mRNA-1273 (1), Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty (1), Pfizer BioNTech-Comirnaty (2)[28,30–32] • ↓: AstraZeneca- Vaxzevria (1) [31]	• ↔: Janssen Ad26.COV 2.5 (1), PfizerBioNTech-Comirnaty (1)[30,33]	• No evidence	• ↔: AstraZeneca- Vaxzevria (1), Pfizer BioNTech-Comirnaty (1)[31]
Symptomatic disease			
• ↔: Moderna-mRNA-1273 (1), Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty (1), Pfizer BioNTech-Comirnaty (3)[34–37] • ↔ to ↓: AstraZeneca-Vaxzevria (3)[35,36,38] • ↓: Novavax-Covavax (1)[39]	• ↔: Janssen-Ad26. COV 2.5 (1)[33] • ↓↓↓: AstraZeneca-Vaxzevria (1), Novavax-Covavax (1)[40,41]	• ↔ to ↓: Sinovac-CoronaVac (1)[42,43]	• ↔ to ↓: PfizerBioNTech-Comirnaty (3)[35–37] • ↓:Bharat-Covaxin (1)[44] • ↓↓: AstraZeneca- Vaxzevria (2)[35,36]
Infection			
• ↔: PfizerBioNTech-Comirnaty (1)[36] • ↔ to ↓: AstraZeneca-Vaxzevria (2)[36,38]	• ↔: Moderna-mRNA-1273 (1)[29] • ↓: PfizerBioNTech-Comirnaty (1)[30]	• No evidence	• ↓: AstraZeneca-Vaxzevria (1), Pfizer BioNTech-Comirnaty (1)[36]
Neutralization (full vaccination), see key below table			
• ↔: Anhui ZL-Recombinant (1), Beijing CNBG-BBIBP-CorV (1), Bharat-Covaxin (1), Gamaleya-Sputnik V (1), Novavax-Covavax (1) [45–49] • ↔ to ↓: Janssen-Ad26.COV 2.5 (3), Moderna-mRNA-1273 (9), Pfizer BioNTech-Comirnaty (27) Sinovac-CoronaVac (5)[23,45,48–84] • ↓ to ↓↓: AstraZeneca-Vaxzevria (2)[38,55]	• ↔ to ↓: Anhui ZL-Recombinant (2), Beijing CNBG-BBIBP-CorV (2)[45,85,86] • ↓: Bharat-Covaxin (1)[87] • ↓ to ↓↓: Moderna-mRNA-1273 (11), Pfizer BioNTech-Comirnaty (27), Sinovac-CoronaVac (4)[23,45,50–52,55,57–61,63,64,66–69,71,73–78,81,84,85,88–96] • ↓ to ↓↓↓: Janssen-Ad26.COV 2.5 (3)[79,80,97] • ↓↓: AstraZeneca-Vaxzevria (4), Gamaleya-Sputnik V (1)[40,47,55,68,93] • ↓↓↓: Novavax-Covavax (1)[59]	• ↔ to ↓: Pfizer BioNTech-Comirnaty, (12), Sinovac-CoronaVac (3)[51,55,57,59,61,64,74,82–84,88,99–101] • ↓: AstraZeneca-Vaxzevria (1), Janssen-Ad26.COV 2.5 (2), Moderna-mRNA-1273 (4)[55,57,73,78–80,100]	• ↔: Janssen-Ad.COV 2.5 (1)[79] • ↓: Anhui ZL-Recombinant (1), AstraZeneca-Vaxzevria (2), Bharat-Covaxin (1), Moderna-mRNA-1273 (2), SII – Covishield (1)[49,78,87,93,102–104] • ↓ to ↓↓: Pfizer BioNTech-Comirnaty (6)[71,84,93,99,102,103] • ↓ to ↓↓↓: Sinovac-CoronaVac (2)[49,81]

Arrows generalize the magnitude of reduction in VE or neutralization: "↔" <10% reduction in VE, or VE >90% with no comparator, or that there was a <2-fold reduction in neutralization; "↓" 10 to <20% reduction in VE, or 2 to <5-fold reduction in neutralization; "↓↓" 20 to <30% reduction in VE, or 5 to <10-fold reduction in neutralization; "↓↓↓" ≥30% reduction in VE, or ≥10-fold reduction in neutralization. When more than one neutralization study is available, the interquartile range (25th and 75th percentiles) of fold-reductions across all studies for specific vaccine/variant was used.
The number of studies is shown in parentheses.
"Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty" indicates that both vaccines were evaluated together in study.

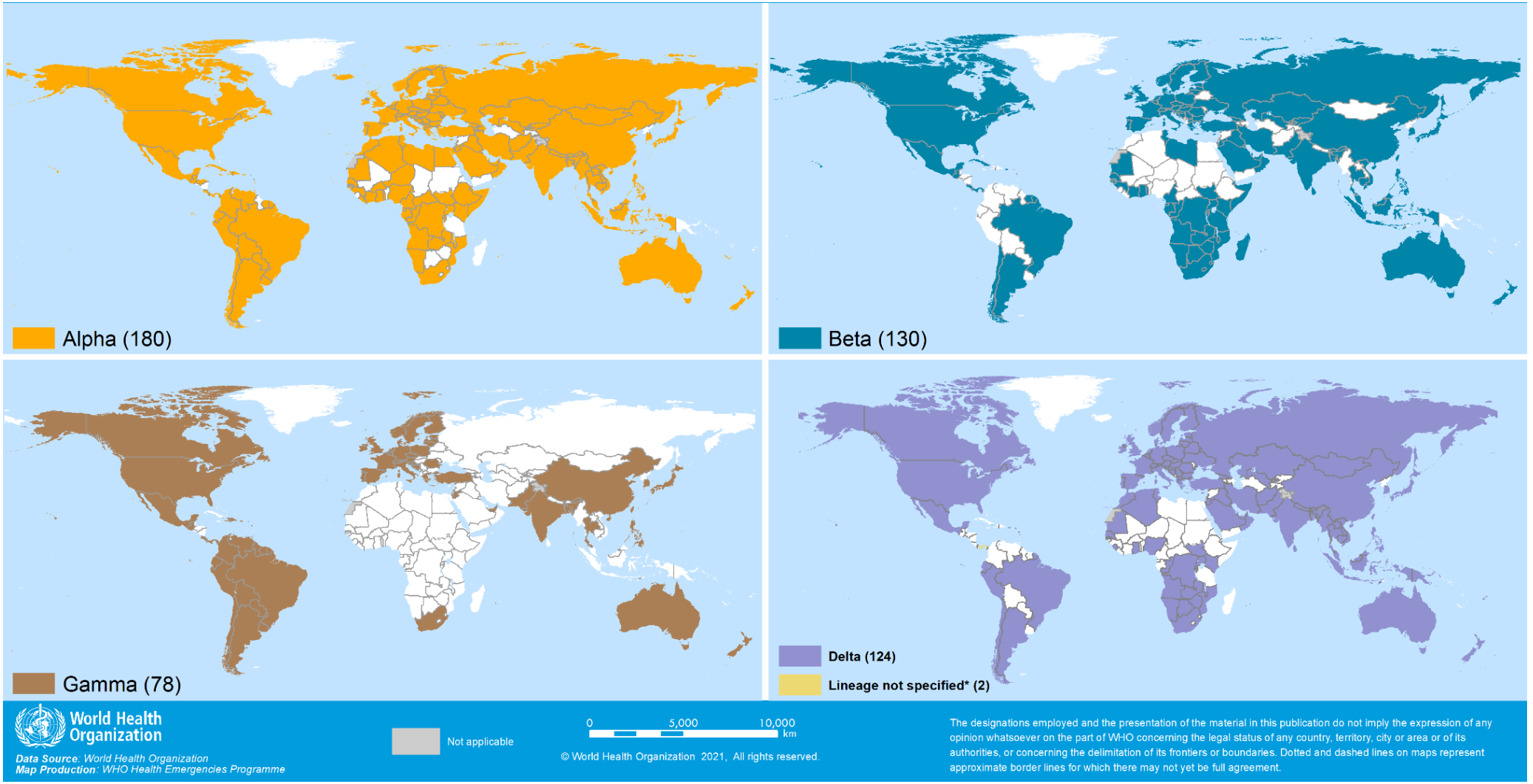
Additional notes on VOC impacts on vaccines

- Studies presenting VOC specific VE estimates for full vaccination (≥ 7 days post final dose) are assessed against a comparator VE estimate to determine level of reduction in VE. For symptomatic disease, VOC VE is compared against phase 3 randomised RCT results from non-VOC settings. For severe disease and infection, VOC VE is compared to non-VOC VE estimates from the same study when available (or to Alpha VE from same study when assessing Beta, Gamma, or Delta); with an exception for AstraZeneca Vaxzevria for severe disease (phase 3 RCT efficacy estimates against severe disease are used as comparator since within study comparator is unavailable) and for infection (when phase 3 estimate of VE against infection due to non-VOC is available and used as comparator). In some instances, a study may be included for severe disease or infection even without a comparator if very high VE estimate against a VOC is reported (i.e., >90%).
- It is also important to note that studies vary in population, outcome definitions, study design and other methodological considerations, which may in part explain differences when comparing VE estimates between different studies. In addition, the reductions presented consider VE point estimates only and do not take into account the uncertainty around these estimates. The reductions in VE noted should be interpreted with these limitations in mind.

Additional resources

- Tracking SARS-CoV-2 Variants
- COVID-19 new variants: Knowledge gaps and research
- Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health
- Considerations for implementing and adjusting public health and social measures in the context of COVID-19

Figure 5. Countries, territories and areas reporting variants Alpha, Beta, Gamma and Delta, as of 20 July 2021**



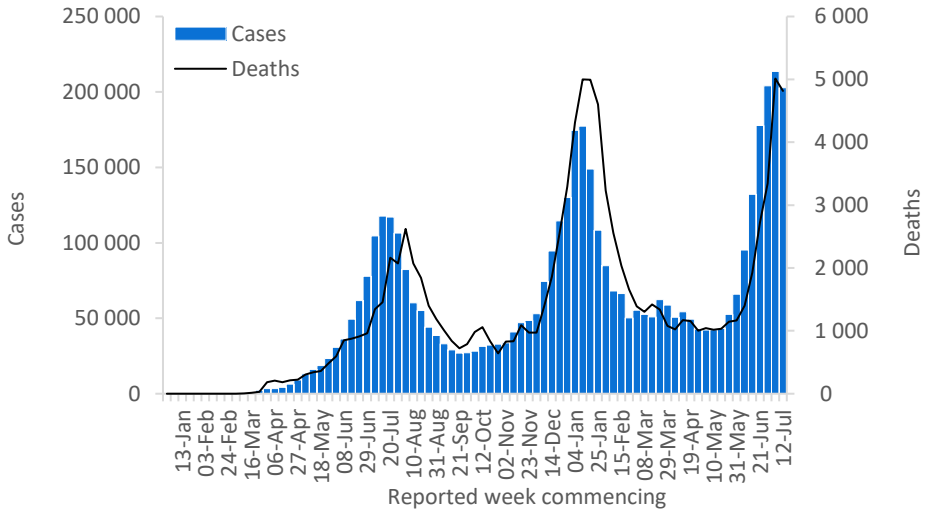
**Includes countries/territories/areas reporting the detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.*
***Countries/territories/areas highlighted include both official and unofficial reports of VOC detections, and do not presently differentiate between detections among travellers (e.g., at Points of Entry) or local community cases. Please see Annex 2 for further details.*

WHO regional overviews - Epidemiological week 12 – 18 July 2021

African Region

Following an increasing trend in the weekly number of new COVID-19 cases and deaths since early May 2021, the Region reported a slight decrease in case incidence (with over 202 000 new cases) and mortality (over 4800 new deaths) in the past week, as compared to the previous week. These trends were largely driven by decreases reported in South Africa, which reported the highest numbers of new cases (104 583 cases) and more than 50% of the cases reported in the region in the past week. Other countries reporting high numbers of new cases include: Zimbabwe (15 760 cases; 106.0 cases/100 000; +20%), and Botswana (10 745 cases; 456.9 cases/100 000; +172%), while the highest numbers of new cases per population were reported in Seychelles (545 cases/100 000; -28%), Botswana (see above) and Namibia (317 cases/100 000; -19%).

The highest numbers of new deaths were reported from South Africa (2538 deaths; 4.3 deaths/100 000; -4%), Namibia (595 deaths; 23.4/100 000; -109%), and Zimbabwe (462 deaths; 3.1 deaths/100 000; +73%).

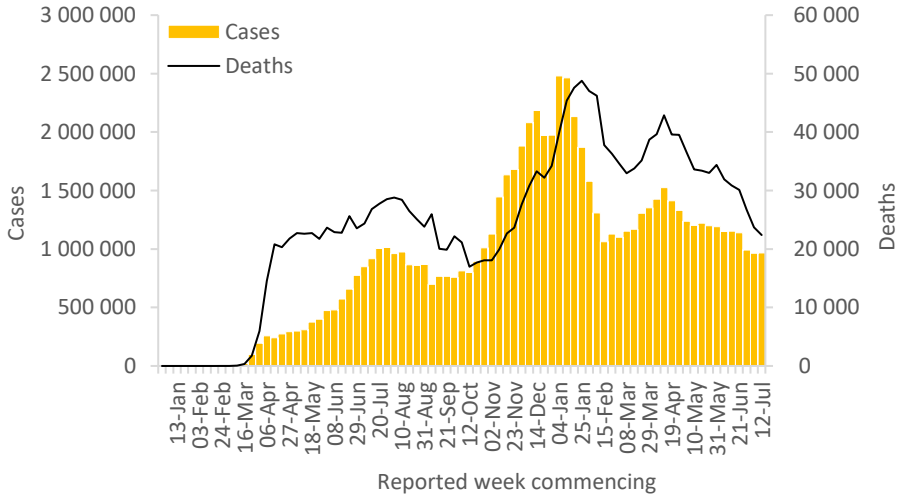


Updates from the African Region

Region of the Americas

The Region reported over 967 000 new cases, a similar number as compared to the previous week, and over 22 000 new deaths, a 6% decrease as compared to the previous week. A decline in weekly case incidence has been reported since the last peak in mid-April 2021, however, very high transmission levels and high mortality rates are still observed across many countries in the Region. The highest numbers of new cases were reported from Brazil (287 610 cases; 135.3 cases/ 100 000; -14%), the United States of America (216 433 cases; 65.4 cases/100 000; +68%), and Colombia (129 713 cases; 254.9 cases/100 000; -26%), while the highest numbers of new cases per population were reported in the British Virgin Islands (2900 cases/100 000; +16%), Martinique (574.8 cases/100 000; +425%) and Cuba (388.8 cases/100 000; +43%).

The highest numbers of new deaths were reported from Brazil (8710 deaths; 4.1 deaths/100 000; -11%), Colombia (3602 deaths; 7.1/100 000; -10%), and Argentina (2927 deaths; 6.5 deaths/100 000; similar to the previous week).

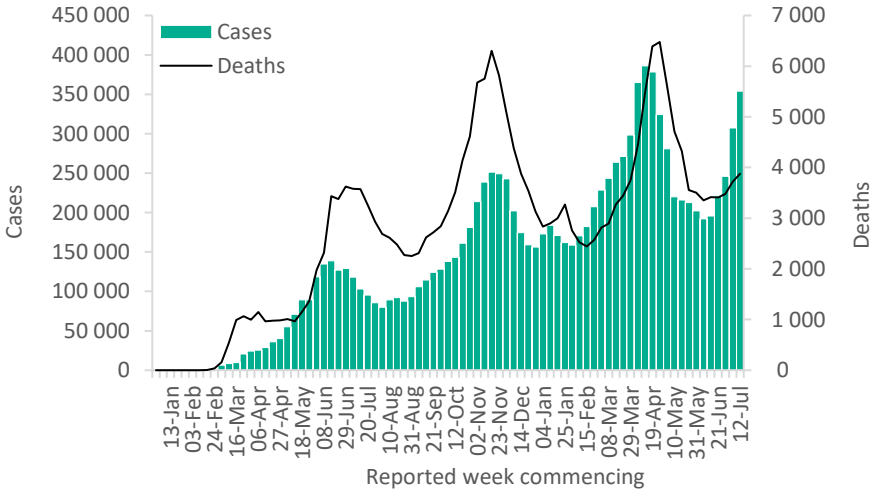


Updates from the Region of the Americas

Eastern Mediterranean Region

The Region has reported a marked increase in weekly case incidence for more than one month with over 354 000 new cases reported, a 15% increase as compared to the previous week. This increase has been driven mainly by surges in several countries in the Region including Iran, Iraq, Libya, Pakistan and Morocco. The Region reported over 3800 new deaths, a similar number as compared to the previous week.

The highest numbers of new cases were reported from the Islamic Republic of Iran (145 293 cases; 173.0 cases/100 000; +27%), Iraq (61 268 cases; 152.3 cases/ 100 000; + 8%), and Tunisia (49 777 cases; 421.2 cases/100 000; similar to the previous week), while the highest weekly case incidence per population was registered in Tunisia (see above), Kuwait (245.1 cases/100 000) and Libya (235.7 cases/100 000). The highest numbers of new deaths were reported from the Islamic Republic of Iran (1272 deaths; 1.5 deaths/100 000; +9%), Tunisia (1110 deaths; 9.4 deaths/100 000; +13%), and Afghanistan (423 deaths; 1.1 deaths/100 000; -19%).

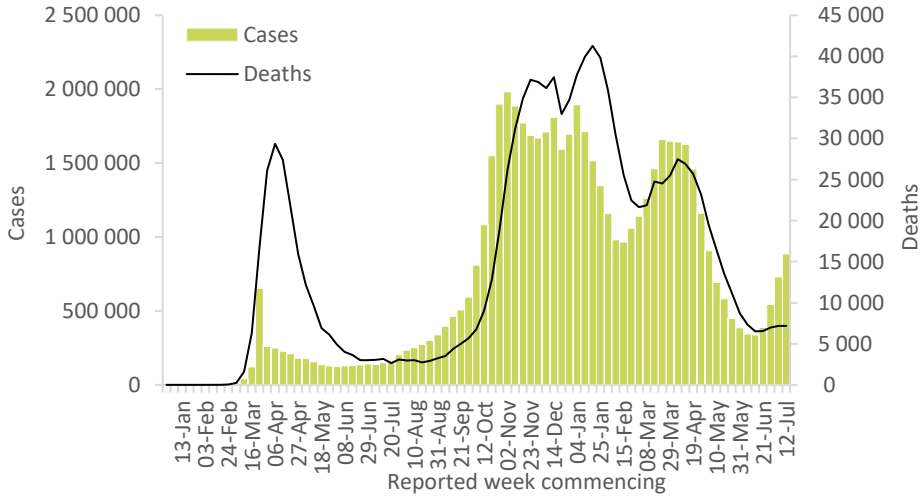


Updates from the Eastern Mediterranean Region

European Region

In the European Region, weekly case incidence has increased significantly across the past month, with over 885 000 new cases reported in the past week, a 21% increase as compared to the previous week. Over 7100 new deaths were reported in the past week, similar to the number reported during the previous week. The increase in reported COVID-19 cases in the Region since mid-June 2021 has been observed across all age groups, but has been most pronounced in those aged 15-24 years. The highest numbers of new cases were reported from the United Kingdom (296 447 cases; 436.7 cases/100 000; +41%), the Russian Federation (174 800 cases; 119.8 cases/100 000; similar to the previous week), and Spain (85 802 cases; 181.3 cases/100 000; -29%), while the highest weekly case incidence per population was registered in Jersey (1274 cases/100 000), Cyprus (779 cases/100 000) and Gibraltar (451 cases/100 000).

The highest numbers of new deaths were reported from the Russian Federation (5417 deaths; 3.7 deaths/100 000; +7%), Turkey (296 deaths; 0.4 deaths/100 000; -7%), and the United Kingdom (284 deaths; 0.4 deaths/100 000; +48%).

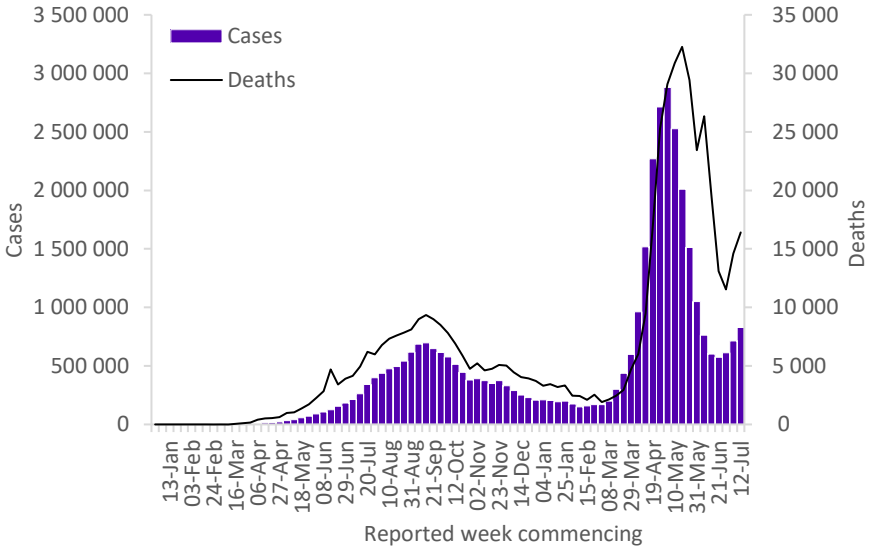


Updates from the European Region

South-East Asia Region

The Region reported over 829 000 new cases and over 16 000 new deaths, increases of 16% and 12%, respectively as compared to the previous week. Weekly case incidence and mortality in India and Sri Lanka continue to decline, with the regional trends being driven mainly by marked increases in Indonesia, Thailand and Myanmar. The highest numbers of new cases were reported from Indonesia (350 273 cases; 128.1 cases/100 000; +44%), India (268 843 cases; 19.5 cases/100 000; -8%) and Bangladesh (82 800 cases; 50.3 cases/100 000; +9%), while the highest weekly case incidence per population was registered in Maldives (150 cases/100 000), Indonesia (see above) and Thailand (96 cases/100 000).

The highest numbers of new deaths were reported from Indonesia (7118 deaths; 2.6 deaths/ 100 000; +21%), India (5569 deaths; 0.4 deaths/100 000; -8%), and Bangladesh (1475 deaths; 0.9 deaths/100 000; +9%).

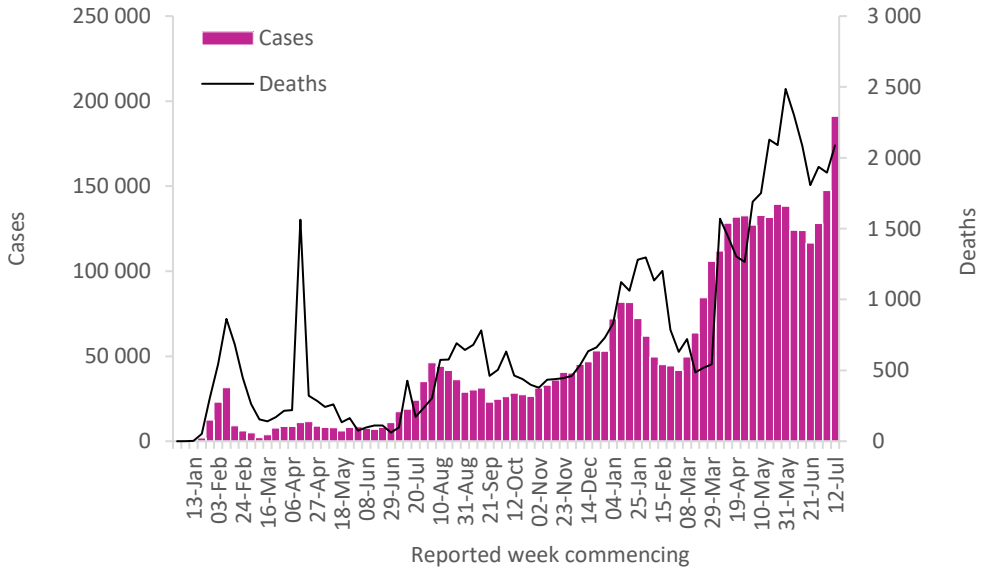


Updates from the South-East Asia Region

Western Pacific Region

Over the past week, weekly case incidence increased sharply in the Region with over 191 000 new cases reported, representing a 30% increase as compared to the previous week. This trend was driven mainly by increases in Fiji, Japan, Malaysia and Viet Nam. The Region reported over 2000 new deaths this week, a 10% increase as compared to the previous week. The highest numbers of new cases were reported from Malaysia (78 660 cases; 243.0 cases/100 000; +44%), the Philippines (35 235 cases; 32.2 cases/100 000; similar to the previous week), and Viet Nam (22 532 cases; 23.1 cases per 100 000; +146%), while the highest weekly case incidence per population was registered in Fiji (719 cases/100 000), Mongolia (297 cases/100 000) and Malaysia (see above).

The highest numbers of new deaths were reported from Malaysia (799 deaths; 2.5 deaths/100 000; +26%), the Philippines (782 deaths; 0.7 deaths/100 000; similar to the previous week), and Cambodia (195 deaths; 1.2 deaths/100 000; +5%).



Updates from the Western Pacific Region

Key weekly updates

WHO Director-General's key messages

- In his opening remarks at the Member State Information Session on Origins – 16 July 2021, the Director-General highlighted the proposed next steps that the WHO Secretariat will take to advance the studies to identify the origins of SARS-CoV-2. He emphasized that finding where the virus came from is essential, not only for understanding how the pandemic started and preventing future outbreaks, but also as an obligation to the families of the 4 million people who have lost someone they love, and the millions who have suffered.

- In his opening remarks at the 8th meeting of the IHR Emergency Committee on COVID-19 – 14 July 2021, the Director-General called for a massive push to vaccinate at least 10% of the population of every country by September 2021, at least 40% by the end of this year, and at least 70% by the middle of 2022. To reach these targets, he highlighted the need for 11 billion vaccine doses. He expressed his gratitude for the announcements made by the G7 countries that together will donate 870 million doses, primarily through COVAX, but emphasized that much more is needed, much faster.

Updates and publications

- Germany reinforces its commitment to support WHO's work, 16 July 2021
- Clinical features and prognostic factors of COVID-19 in people living with HIV hospitalized with suspected or confirmed SARS-CoV-2 infection, 15 July 2021
- COVID-19 pandemic leads to major backsliding on childhood vaccinations, new WHO, UNICEF data shows, 15 July 2021
- Latest updates on emergency use listing (EUL) status of COVID-19 vaccines, 15 July 2021
- Vaccine efficacy, effectiveness and protection, 14 July 2021
- WHO technical consultation on oxygen access scale-up for COVID-19, 14 July 2021
- Safe Eid al Adha practices in the context of COVID-19, 13 July 2021

Annex

COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region (reported in previous issues) are now available at: https://covid19.who.int/table

As of 20 July, WHO will stop collecting reports of national-level transmission classifications and displaying transmission classifications on the global COVID-19 dashboard. WHO however encourages Member States to continue the self-monitoring of transmission at the sub-national level to inform adjustments to PHSM.

Annex 1. List of countries/territories/areas reporting Variants of Concern as of 20 July 2021**

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Afghanistan	●	-	-	●	-
Albania	●	-	-	○*	-
Algeria	●	-	-	●	-
Angola	●	●	-	●*	-
Anguilla	●*	-	-	●*	-
Antigua and Barbuda	●	●	-	-	-
Argentina	●	●	●	●	-
Armenia	○	-	-	-	-
Aruba	●	●	●	●	-
Australia	●	●	●	●	-
Austria	●	●	●	●	-
Azerbaijan	●	-	-	-	-
Bahrain	●	●	-	●	-
Bangladesh	●	●	○*	●	-
Barbados	●	-	●	●	-
Belarus	●	-	-	○	-
Belgium	●	●	●	●	-
Belize	●	-	-	-	-
Bermuda	●	●	-	-	-
Bhutan	●	●	-	●	-
Bolivia (Plurinational State of)	●	-	●	-	-
Bonaire	●	-	-	-	-
Bosnia and Herzegovina	○	○*	○*	○	-
Botswana	-	●	-	●	-
Brazil	●	●	●	●	-
British Virgin Islands	●	-	●	-	-
Brunei Darussalam	●	●	-	-	-
Bulgaria	●	●	-	●	-
Burkina Faso	●	-	-	-	-
Burundi	●*	●*	-	●*	-
Cabo Verde	●	-	-	-	-
Cambodia	●	○*	-	●	-
Cameroon	●	●	-	-	-
Canada	●	●	●	●	-
Cayman Islands	●	-	●	-	-
Central African Republic	●	-	-	-	-
Chile	●	●	●	●	-
China	●	●	●	○	-
Colombia	●	-	●	-	-
Comoros	-	●	-	-	-
Congo	●	●*	-	●*	-
Costa Rica	●	●	●	-	-
Croatia	●	●	○	○	-
Cuba	●	●	-	-	-
Curaçao	●	-	●	-	●
Cyprus	●	●	-	○	-
Czechia	●	●	●	●	-
Côte d'Ivoire	●	●	-	-	-
Democratic Republic of the Congo	●	●	-	●	-
Denmark	●	●	●	●	-
Djibouti	●	●	-	-	-
Dominica	●	-	-	-	-
Dominican Republic	●	-	●	-	-
Ecuador	●	-	●	●	-
Egypt	●	-	-	-	-
Equatorial Guinea	●	●	-	-	-
Estonia	●	●	○	○*	-
Eswatini	-	●	-	-	-
Ethiopia	○	-	-	-	-
Faroe Islands	●	-	●	-	-
Fiji	-	-	-	●	-
Finland	●	●	●	●	-
France	●	●	●	●	-
French Guiana	●	●	●	●	-
French Polynesia	●	●	●	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Gabon	●	○	-	-	-
Gambia	●	-	-	●	-
Georgia	●	○	-	●	-
Germany	●	●	●	●	-
Ghana	●	●	-	●	-
Gibraltar	●	-	-	-	-
Greece	●	●	●	●	-
Grenada	●	-	-	-	-
Guadeloupe	●	●	●	●	-
Guam	●	●	●	●	-
Guatemala	●	●	●	-	-
Guinea	●	●	-	-	-
Guinea-Bissau	●	●	-	-	-
Guyana	-	-	●	-	-
Haiti	●	-	●	-	-
Honduras	●	-	-	-	-
Hungary	●	○	-	○	-
Iceland	●	-	-	-	-
India	●	●	●	●	-
Indonesia	●	●	-	●	-
Iran (Islamic Republic of)	●	●	-	●	-
Iraq	●	●	-	●*	-
Ireland	●	●	●	●	-
Israel	●	●	●	●	-
Italy	●	●	●	●	-
Jamaica	●	-	-	-	-
Japan	●	●	●	●	-
Jordan	●	●	●	●	-
Kazakhstan	○	○	-	●	-
Kenya	●	●	-	●	-
Kosovo[1]	●	○	-	○	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Kuwait	●	●*	-	●	-
Kyrgyzstan	●	●	-	-	-
Lao People's Democratic Republic	●	-	-	●	-
Latvia	●	●	●	○	-
Lebanon	●	-	-	●	-
Lesotho	-	●	-	-	-
Liberia	●	-	-	-	-
Libya	●	●	-	-	-
Liechtenstein	●	-	-	-	-
Lithuania	●	●	●	○	-
Luxembourg	●	●	●	●	-
Madagascar	-	●	-	-	-
Malawi	●	●	-	●	-
Malaysia	●	●	-	●	-
Maldives	●	-	-	●	-
Malta	●	○	●	○	-
Martinique	●	●	●	●	-
Mauritania	●	●	-	●	-
Mauritius	○	●	-	●	-
Mayotte	●	●	-	-	-
Mexico	●	●	●	●	-
Monaco	●	○	-	○	-
Mongolia	●*	-	-	●*	-
Montenegro	●	-	-	-	-
Montserrat	●	-	-	-	-
Morocco	●	-	-	●	-
Mozambique	○*	●	-	●	-
Myanmar	●	-	-	●*	-
Namibia	●	●	-	●	-
Nepal	●	-	-	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Netherlands	●	●	●	●	-
New Caledonia	●	-	-	-	-
New Zealand	●	●	○	○	-
Niger	●	-	-	-	-
Nigeria	●	-	-	●	-
North Macedonia	●	●	-	○	-
Norway	●	●	●	●	-
Occupied Palestinian Territory	●	●	-	●	-
Oman	●	●	-	●	-
Pakistan	●	●	●	●	-
Panama	●	●	●	-	●
Papua New Guinea	-	-	-	●*	-
Paraguay	●	-	●	-	-
Peru	●	-	●	●	-
Philippines	●	●	●	●	-
Poland	●	○	●	●	-
Portugal	●	●	●	●	-
Puerto Rico	●	●	●	●	-
Qatar	●	●	-	●	-
Republic of Korea	●	●	●	●	-
Republic of Moldova	○	-	-	-	-
Romania	●	●	●	●	-
Russian Federation	●	●	-	●	-
Rwanda	●	○	-	●*	-
Réunion	●	●	●	○	-
Saba	-	-	-	●	-
Saint Barthélemy	●	-	-	-	-
Saint Lucia	●	-	-	-	-
Saint Martin	●	●	-	-	-
Sao Tome and Principe	●	-	-	-	-
Saudi Arabia	●	●	-	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Senegal	●	●	-	●*	-
Serbia	●	-	-	-	-
Seychelles	-	●	-	-	-
Sierra Leone	-	-	-	○	-
Singapore	●	●	●	●	-
Sint Maarten	●	●	-	●	-
Slovakia	●	●	-	●	-
Slovenia	●	●	●	●	-
Somalia	●	○*	-	-	-
South Africa	●	●	○*	●	-
South Sudan	●*	○*	-	●*	-
Spain	●	●	●	●	-
Sri Lanka	●	●	-	●	-
Suriname	●	●	●	-	-
Sweden	●	●	●	●	-
Switzerland	●	●	○	●	-
Thailand	●	●	●	●	-
Timor-Leste	●	-	-	-	-
Togo	●	●	-	-	-
Trinidad and Tobago	●	-	●	-	-
Tunisia	●	●	-	●	-
Turkey	●	●	●	●	-
Turks and Caicos Islands	●	-	●	-	-
Uganda	●	●	-	●	-
Ukraine	●	○	-	○	-
United Arab Emirates	●	●	●	●	-
United Kingdom	●	●	●	●	-
United Republic of Tanzania	-	●	-	-	-
United States of America	●	●	●	●	-
Uruguay	●	-	●	-	-
Uzbekistan	●	●	-	○	-
Venezuela (Bolivarian Republic of)	●	-	●	-	-
Viet Nam	●	●	-	●	-
Wallis and Futuna	●	-	-	-	-
Zambia	●*	●	-	●	-
Zimbabwe	-	●	-	●	-

**Newly reported in this update.*
"Unspecified B.1.617" reflects countries/territories/areas reporting detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.
"●" indicates that information for this variant was received by WHO from official sources.
"○" indicates that information for this variant was received by WHO from unofficial sources and will be reviewed as more information become available.
*** Alpha was excluded for Benin, Botswana, Eswatini and Madagascar, and unspecified B.1.617 was excluded for Estonia this week based on further information.*
****Includes countries/territories/areas reporting the detection of VOCs among travelers (e.g., imported cases detected at points of entry), or local cases (detected in the community). Excludes countries, territories, and areas that have never reported the detection of a variant of concern*

See also Annex 2: Data, table and figure notes.

Annex 2. 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.

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 except, the names of proprietary products are distinguished by initial capital letters.

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

Technical guidance and other resources

- WHO technical guidance
- WHO COVID-19 Dashboard
- WHO Weekly Operational Updates on COVID-19
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- OpenWHO courses on COVID-19 in official UN languages and in additional national languages
- WHO Academy COVID-19 mobile learning app
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Recommendations and advice for the public:
    - Protect yourself
    - Questions and answers
    - Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities

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COVID-19 Weekly Epidemiological Update

Edition 50, published 27 July 2021

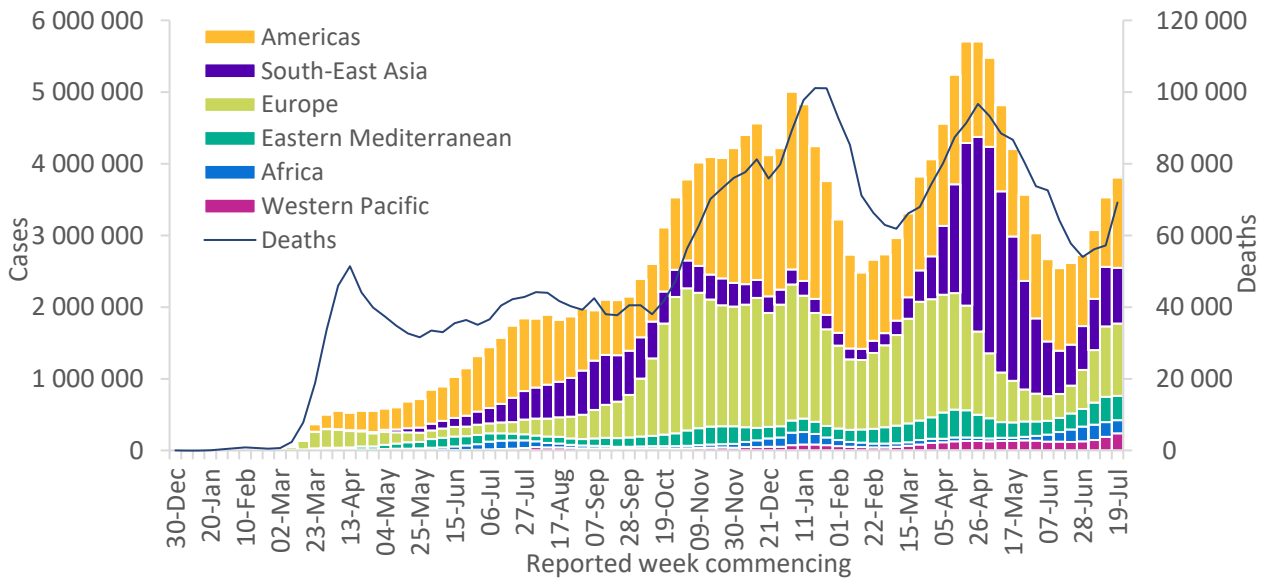
In this edition:

Global overview

Data as of 25 July 2021

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

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



**See *Annex 2: Data, table and figure notes*

The highest weekly case incidence rates per 100 000 population were reported by the Americas and European Regions, which reported 123.3 and 108.3 new cases per 100 000 population, respectively. The highest numbers of deaths per 100 000 population over the past week were observed in the Americas and South-East Asia Regions which reported 2.8 and 1.1 new deaths per 100 000 population, respectively.

Over the past week, the highest numbers of new cases were reported from the United States of America (500 332 new cases; 131% increase), Brazil (324 334 new cases; 13% increase), Indonesia (289 029 new cases; 17% decrease), the United Kingdom (282 920 new cases; 5% decrease), and India (265 836 new cases; similar to the previous week).

Globally, cases of the Alpha variant have been reported in 182 countries, territories or areas (hereafter countries; two new countries in the past week), while 131 countries (two new countries) have reported cases of the Beta variant; 81 countries (three new countries) have reported cases of the Gamma variant; and 132 countries (eight new countries) have reported cases of the Delta variant.

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

WHO Region	New cases in last 7 days (%)	Change in new cases in last 7 days *	Cumulative cases (%)	New deaths in last 7 days (%)	Change in new deaths in last 7 days *	Cumulative deaths (%)
Americas	1 260 598 (33%)	30%	75 995 514 (39%)	28 938 (42%)	29%	1 989 575 (48%)
Europe	1 010 270 (27%)	3%	59 009 652 (30%)	7 545 (11%)	-1%	1 211 783 (29%)
South-East Asia	775 618 (20%)	-7%	37 536 524 (19%)	21 334 (31%)	30%	548 276 (13%)
Eastern Mediterranean	338 605 (9%)	-4%	12 133 038 (6%)	4 225 (6%)	8%	230 676 (6%)
Africa	184 361 (5%)	-9%	4 773 581 (2%)	4 931 (7%)	2%	112 429 (3%)
Western Pacific	238 487 (6%)	25%	4 208 652 (2%)	2 159 (3%)	3%	61 908 (1%)
Global	**3 807 939 (100%)**	**8%**	**193 657 725 (100%)**	**69 132 (100%)**	**21%**	**4 154 660 (100%)**

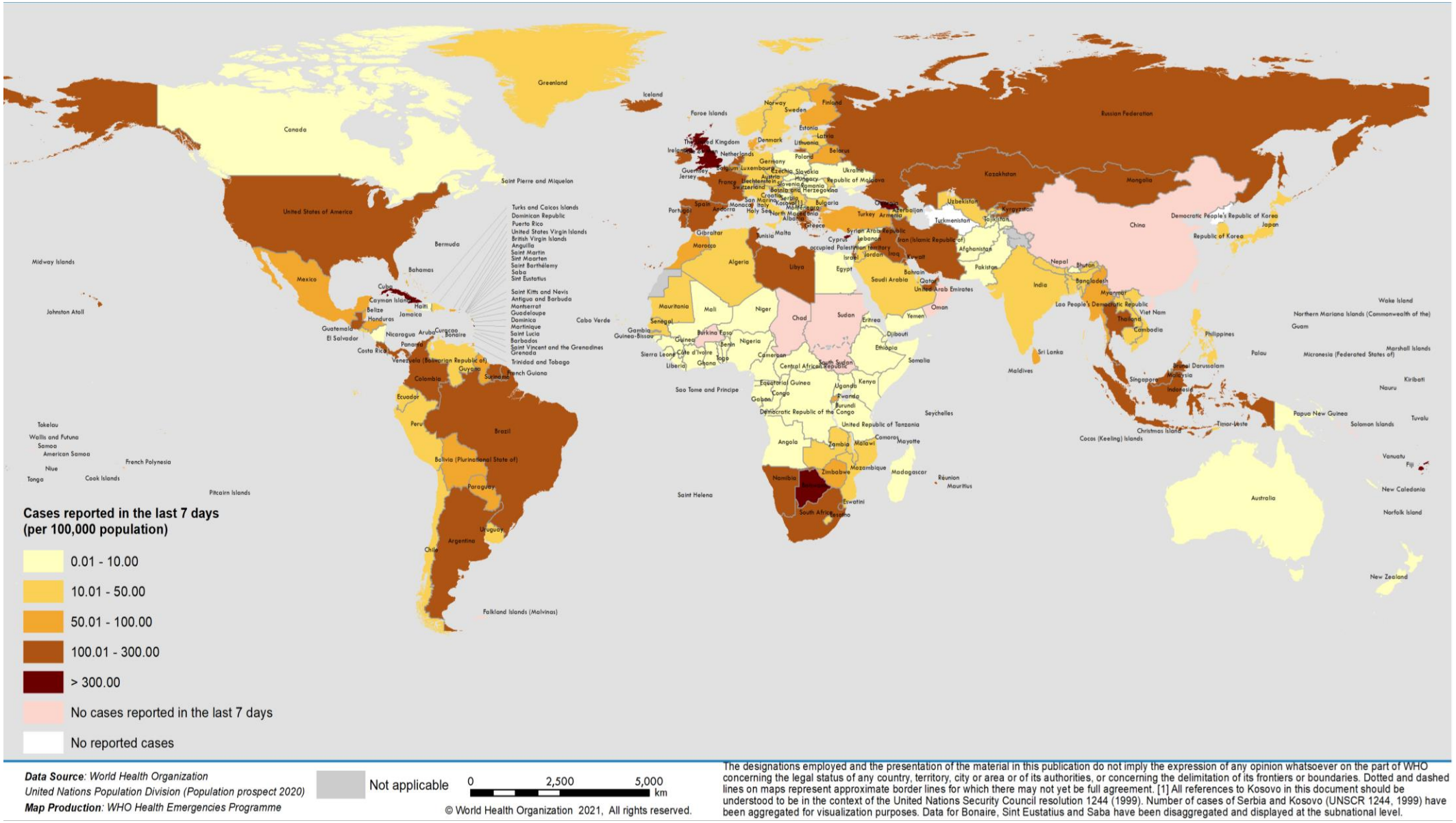
Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior

***See Annex 2: 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 and previous editions of the Weekly Epidemiological Update

Figure 2. COVID-19 cases per 100 000 population reported by countries, territories and areas, 19 – 25 July 2021**

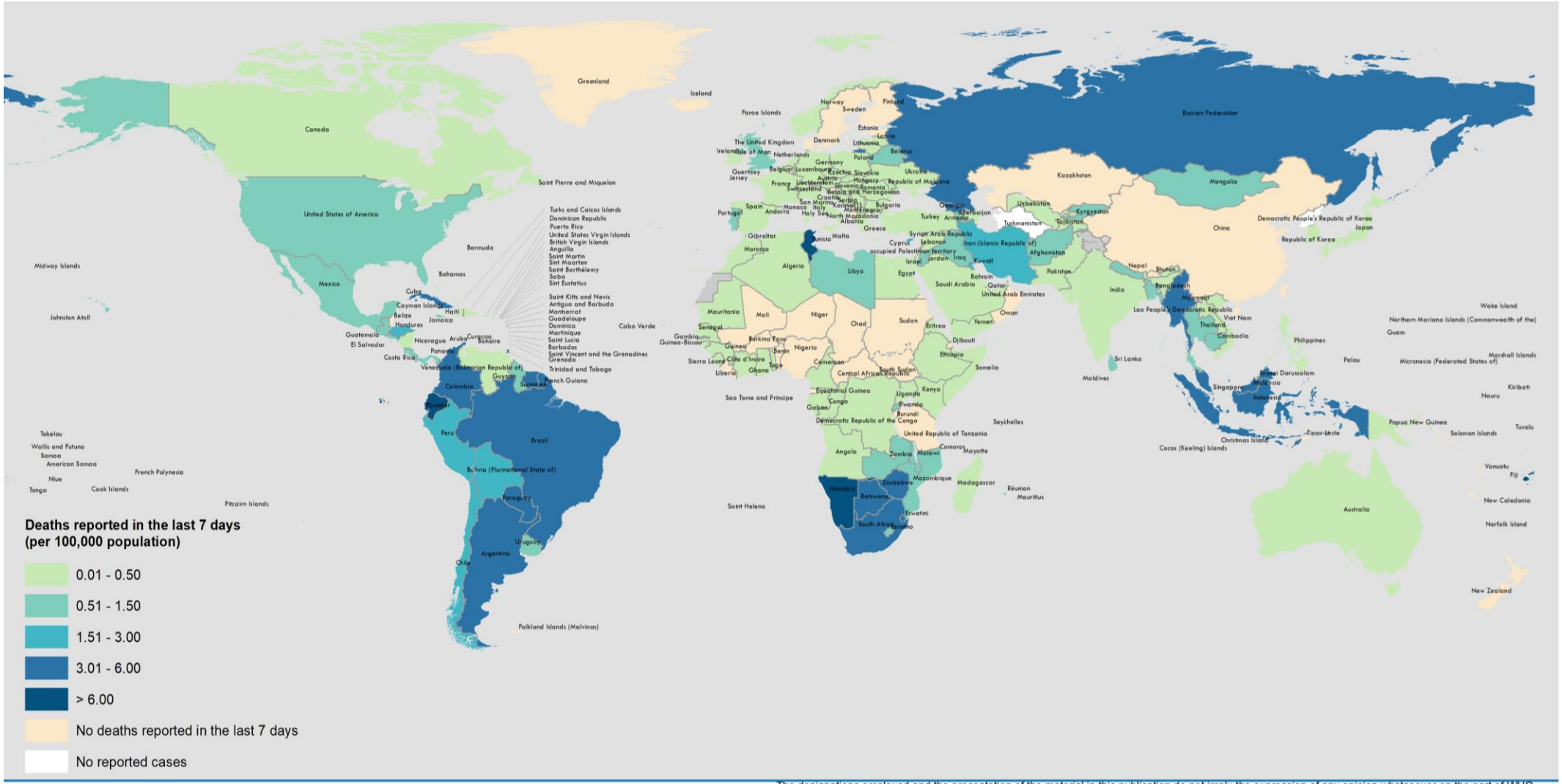


***Data Source**: World Health Organization*
United Nations Population Division (Population prospect 2020)
***Map Production**: WHO Health Emergencies Programme*

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city 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. [1] All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). Number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes. Data for Bonaire, Sint Eustatius and Saba have been disaggregated and displayed at the subnational level.

**See *Annex 2: Data, table and figure notes*

Figure 3. COVID-19 deaths per 100 000 population reported by countries, territories and areas, 19 – 25 July 2021**



***Data Source**: World Health Organization*
United Nations Population Division (Population prospect 2020)
***Map Production**: WHO Health Emergencies Programme*

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city 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. [1] All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999). Number of cases of Serbia and Kosovo (UNSCR 1244, 1999) have been aggregated for visualization purposes. Data for Bonaire, Sint Eustatius and Saba have been disaggregated and displayed at the subnational level.

**See *Annex 2: Data, table and figure notes*

Special Focus: Evaluations of the effectiveness of COVID-19 vaccines in real-world settings

As of 20 July 2021, six vaccine types (AstraZeneca-Vaxzevria, Janssen Ad26.COV 2.5, Moderna-mRNA-1273, Pfizer BioNTech-Comirnaty, COVID-19 vaccine BIBP, and Sinovac-CoronaVac) have received WHO emergency use listing (EUL) based, in part, on vaccine efficacy results from randomized controlled trials (RCTs). In contrast to vaccine efficacy, which is estimated in the controlled clinical trial setting, vaccine effectiveness, is estimated from observational (non-randomized) studies in real-world settings.

What is vaccine effectiveness?

Vaccine effectiveness (VE) is the percentage reduction in the risk or odds of disease or infection among vaccinated persons. It is important to note that breakthrough infections or disease (infection or symptomatic disease among individuals who have been fully vaccinated) are expected with all COVID-19 vaccines, even those with very high VE (such as greater than 90%), becoming more apparent as more of the population becomes vaccinated.

Evaluations of the effectiveness of multiple COVID-19 vaccines in different settings and populations are needed to assess how well these vaccines work in preventing symptomatic disease, severe disease, hospitalization, death, as well as infection and transmission, among other outcomes. Moreover, answers to some important public health questions can only be addressed by post-introduction VE studies, such as: whether additional doses would be needed to address declines in VE over time, or whether new vaccines or additional doses will be needed for SARS-CoV-2 variants of concern (VOCs). Vaccine effectiveness estimates may differ from the results of RCTs for valid reasons (e.g., different target populations, different vaccine schedule) or for invalid reasons (e.g., bias and confounding). However, biases and confounding can be minimized by careful planning, execution and analysis of VE studies.

How is vaccine effectiveness measured?

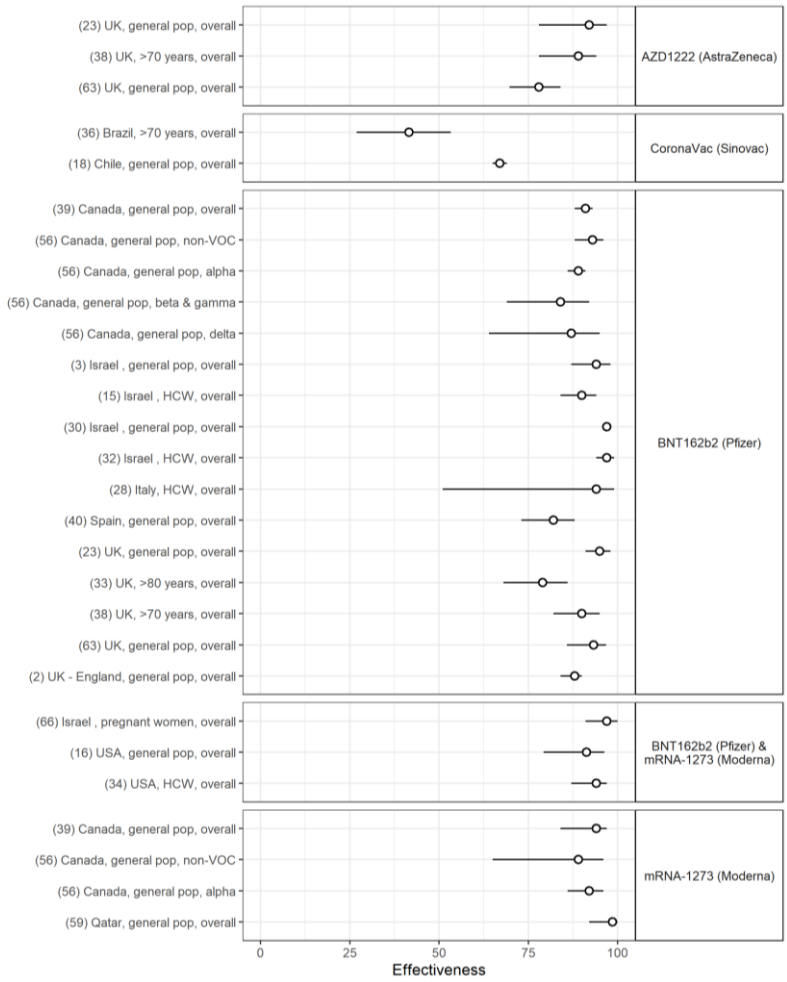
WHO has produced best practice guidance on how to undertake VE studies,[1] including for VOCs, and provides links to VE study protocols.[2] Two methodologies have been most widely used to evaluate COVID-19 VE to date[1]: the retrospective cohort and the test-negative design case-control study. Some of the largest COVID-19 VE studies have used a retrospective cohort design and linkable electronic databases that compare rates of infection or symptomatic disease between vaccinated and unvaccinated individuals.[3,4] Such large databases provide precise VE estimates and often allow adjustment for important confounders that can lead to bias, such as age, date of infection, geographic location and socioeconomic status.

The test-negative case-control design, where the vaccination status of persons testing positive for SARS-CoV-2 are compared to those who test negative, has also been widely deployed. The test-negative design is most often deployed among hospitalized patients or using an existing severe acute respiratory infection surveillance platform. This design minimizes confounding due to differences in healthcare- seeking behavior or access between vaccinated and unvaccinated persons, which can be present in traditional case-control studies.[1]

What evidence is available to date?

As of 20 July 2021, there have been over 90 VE studies made publicly available in peer-reviewed or pre-print literature, though the quality of these studies varies considerably.[5–7] The evidence base to date has been skewed, with 62% (58/93) of studies coming from three countries with early introduction of vaccination campaigns (i.e. Israel, the United Kingdom and the United States of America); and 71% (66/93) reporting on VE of only two vaccines - Pfizer BioNTech-Comirnaty and AstraZeneca-Vaxzevria. In general, symptomatic disease efficacy results from these studies, for fully vaccinated individuals, have been similar to the results of the RCTs that informed the WHO EUL decision (Figure 1). Overall, VE against severe disease, hospitalization and death has been higher than against non-severe symptomatic disease, with VE estimates for these more serious outcomes to be above 80% for AstraZeneca-Vaxzevria, Moderna-mRNA-1273, Pfizer BioNTech-Comirnaty, and Sinovac-CoronaVac. (See weekly summary table of Results of COVID-19 Vaccine Effectiveness Studies)

Figure 4. Vaccine effectiveness against COVID-19 symptomatic disease in fully vaccinated population



Note: Numbers in parentheses refer to references in the weekly summary table. Horizontal lines indicate the 95% confidence interval.

Although the VE against infection and asymptomatic infection are slightly lower than against symptomatic disease for AstraZeneca- Vaxzevria, Moderna-mRNA-1273, and Pfizer BioNTech-Comirnaty,[5,8–10] the VE estimates for these outcomes are almost uniformly ≥60%. Additionally, several studies have shown that the transmission to household members is reduced by approximately 50% when the infected household member was vaccinated with at least one dose as compared to unvaccinated.[5] Importantly, VE appears to be consistently higher for all outcomes after full vaccination, defined as at least 7-14 days after the final dose.

Vaccine effectiveness and VOCs

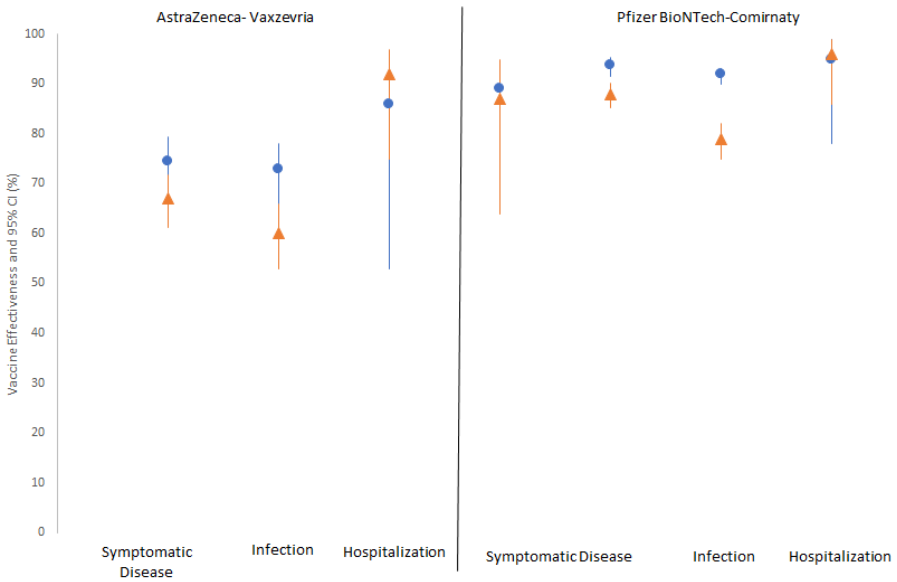
There is widespread concern that existing COVID-19 vaccines may have reduced VE against the four VOCs designated by WHO (see Tracking SARS-CoV-2 variants). Neutralization studies (laboratory studies of how well vaccine-induced antibodies reduce the effect of virus) have shown that there is a several-fold reduction in neutralization against the VOCs, specifically Beta, Gamma and Delta (see Weekly Epidemiological Update edition 49). However, a reduction in neutralization does not directly correlate with reduced VE. This can be explained by several reasons: 1) there is currently no known threshold of neutralization (i.e., correlate of protection) below which vaccines no longer protect; 2) some vaccines produce higher neutralizing antibody concentrations so reductions in neutralization will likely have a lesser effect on the VE for these vaccines[11]; 3) and other factors besides neutralizing antibody levels, such as cellular immunity, may maintain protection.

As an example, results of several studies evaluating VE of AstraZeneca-Vaxzevria and Pfizer BioNTech-Comirnaty against symptomatic disease and infection tend to be lower for the highly transmissible Delta variant as compared to the Alpha variant. However, this difference is reduced or not observed for severe disease outcomes, nor after receiving the second dose (Figure 2). More VE studies of additional vaccines against the Delta variant and other VOCs that look at multiple outcomes are needed to better characterize VE against VOCs (for more information on VOC impact on vaccines, see Weekly Epidemiological Update edition 49).

Conclusion

Although post-introduction VE studies are not a replacement for RCTs, they currently provide much of the rapidly emerging evidence for vaccine performance in real-world settings and can inform public health response and answer key public health questions that are not able to be answered by RCTs. WHO, along with its partners, will continue to track new evidence from published VE studies, as well as those that are ongoing and planned, to assure that they will contribute critical information for global, regional and national COVID-19 vaccine policy decisions.[5]

Figure 5. Comparison of Vaccine Effectiveness of Variants of Concern Alpha and Delta among fully vaccinated persons[3,4,12,13]



Variant Alpha is shown as a blue circle and variant Delta is shown as an orange arrow.

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

WHO, in collaboration with national authorities, institutions and researchers, routinely assesses if variants of SARS-CoV-2 alter transmission or disease characteristics, or impact vaccine, therapeutics, diagnostics or effectiveness of public health and social measures (PHSM) applied by national authorities to control disease spread. "Signals" of potential Variants of Concern (VOCs) or Variants of Interest (VOIs) are detected and assessed based on the risk posed to global public health. As these risks evolve, WHO will continue to update lists of global VOIs and VOCs to support setting priorities for surveillance and research, and ultimately guide response strategies (for more information, please see the Tracking SARS-CoV-2 variants website). National authorities may choose to designate other variants of local interest/concern and are encouraged to investigate and report on impacts of these variants.

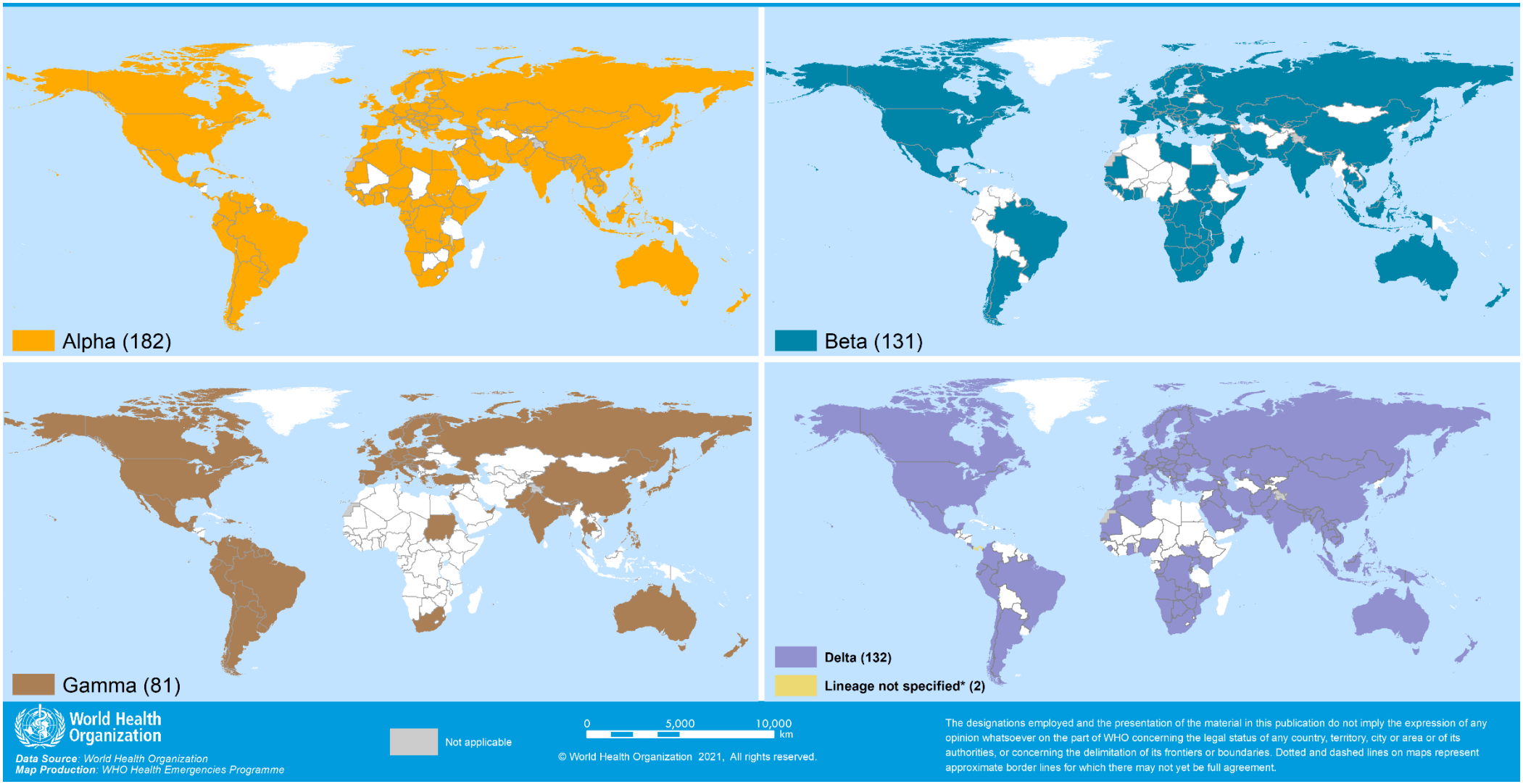
As surveillance activities to detect SARS-CoV-2 variants are strengthened at national and subnational levels, including through the expansion of genomic sequencing capacities, the number of countries/areas/territories (hereafter countries) reporting VOCs continues to increase (Figure 6, Annex 1). This distribution should nonetheless be interpreted with due consideration of surveillance limitations, including differences in sequencing capacities and sampling strategies between countries.

As countries gradually resume non-essential international travel, the introduction of risk mitigation measures aiming to reduce travel-associated exportation, importation and onward transmission of SARS-CoV-2 should be based on thorough risk assessments conducted systematically and routinely.

Additional resources

- Tracking SARS-CoV-2 Variants
- COVID-19 new variants: Knowledge gaps and research
- Genomic sequencing of SARS-CoV-2: a guide to implementation for maximum impact on public health
- Considerations for implementing and adjusting public health and social measures in the context of COVID-19

Figure 6. Countries, territories and areas reporting variants Alpha, Beta, Gamma and Delta, as of 27 July 2021**



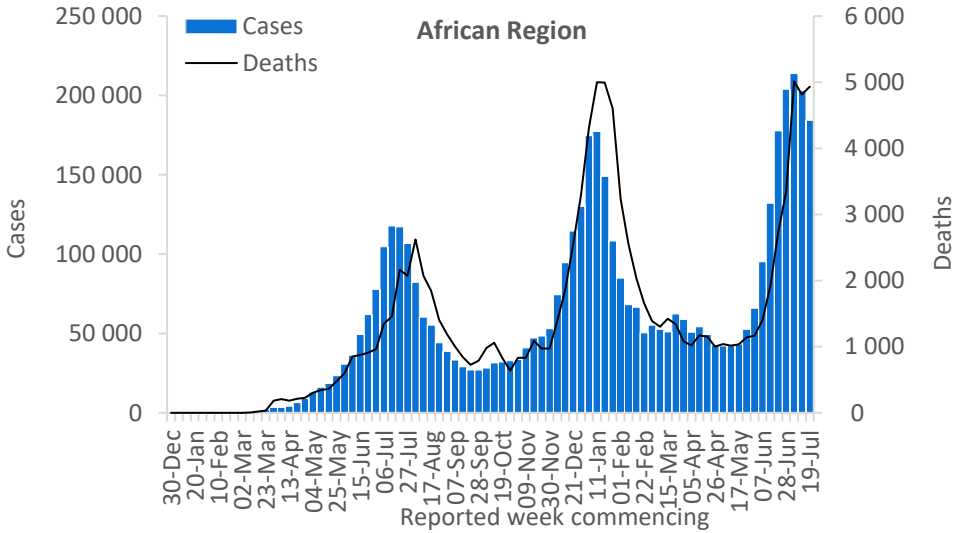
**Includes countries/territories/areas reporting the detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.*
***Countries/territories/areas highlighted include both official and unofficial reports of VOC detections, and do not presently differentiate between detections among travellers (e.g., at Points of Entry) or local community cases. Please see Annex 2 for further details.*

WHO regional overviews - Epidemiological week 19 – 25 July 2021

African Region

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

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

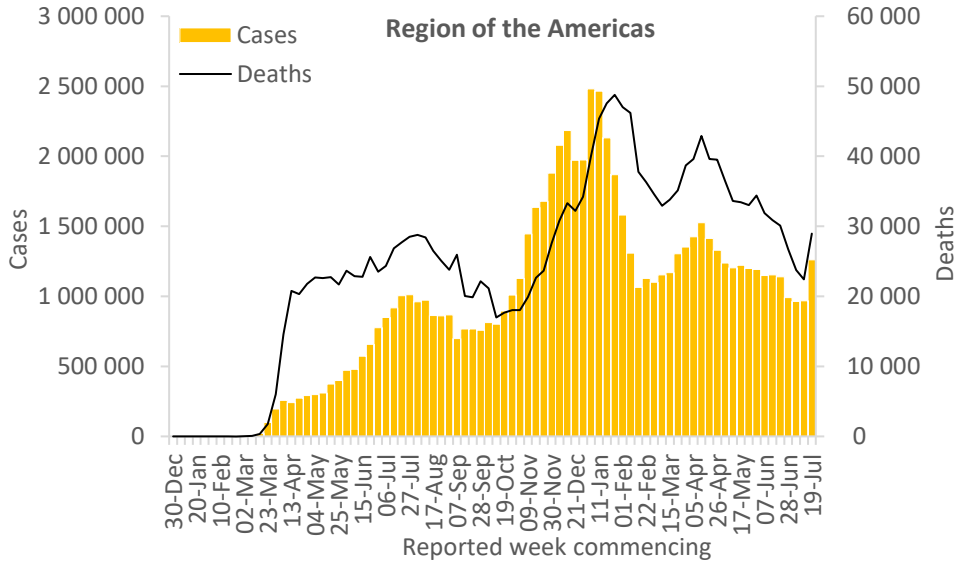


Updates from the African Region

Region of the Americas

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

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

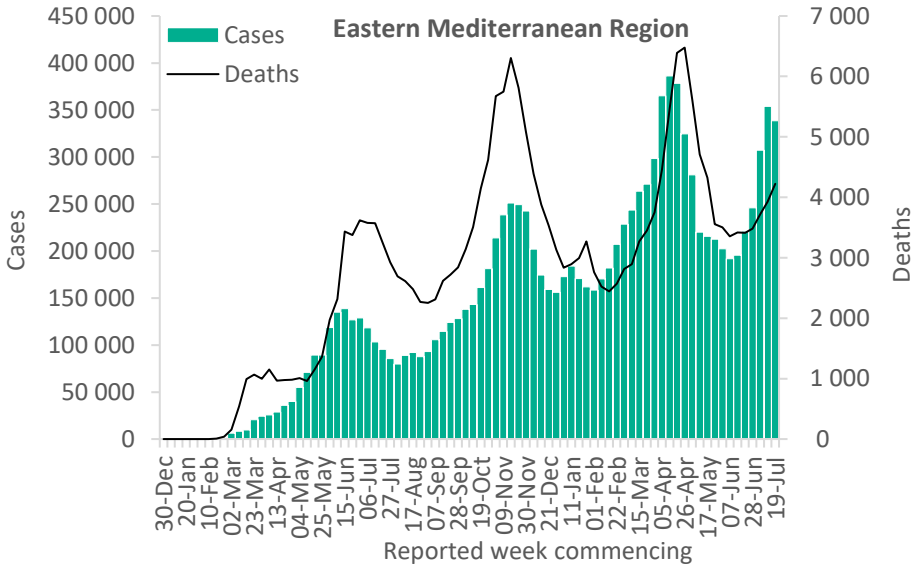


Updates from the Region of the Americas

Eastern Mediterranean Region

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

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

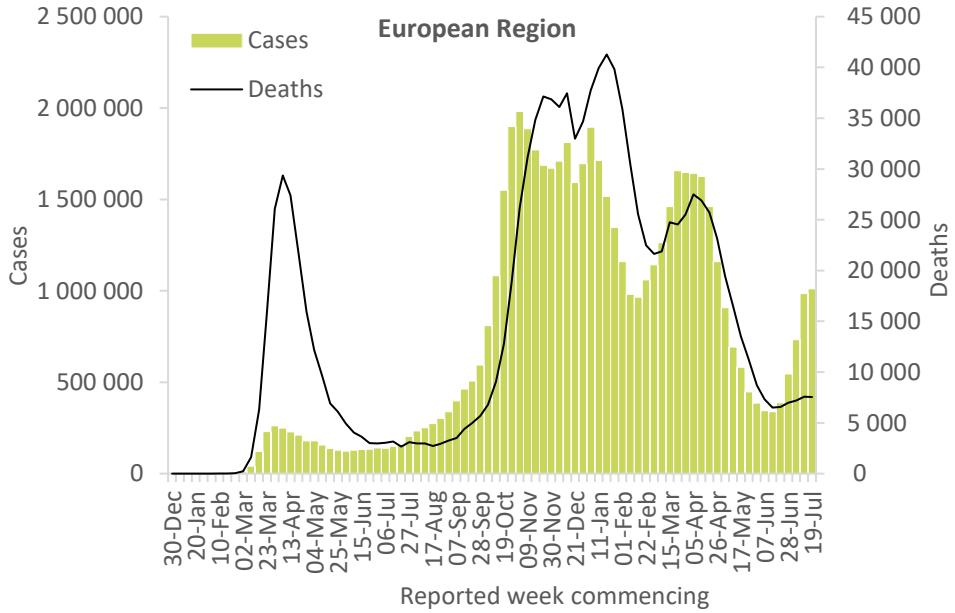


Updates from the Eastern Mediterranean Region

European Region

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

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

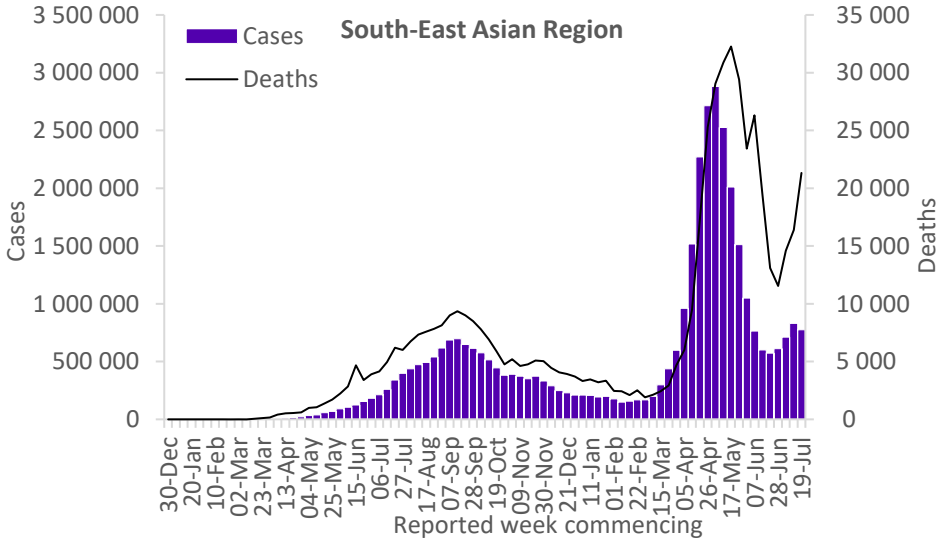


Updates from the European Region

South-East Asia Region

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

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

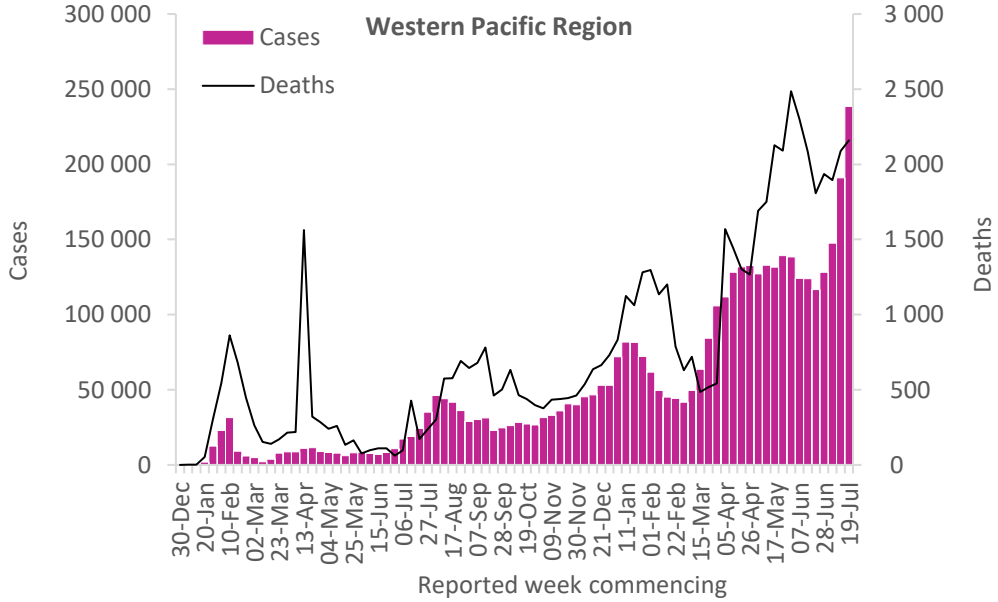


Updates from the South-East Asia Region

Western Pacific Region

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

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



Updates from the Western Pacific Region

Key weekly updates

WHO Director-General's key messages

- In his opening remarks at the WTO - WHO High Level Dialogue: Expanding COVID-19 Vaccine Manufacture to Promote Equitable Access - 21 July, the Director-General highlighted:
    - Over 3.5 billion vaccines have been distributed globally, but more than 75% of those have gone to just ten countries. To reach at least 40% of the global population by the end of the year, and 70% by the middle of 2022, we need 11 billion doses of vaccine, and dose sharing is vital to fill our current supply gap.
    - In July, WHO and our COVAX partners announced the first COVID-19 mRNA vaccine technology transfer hub, to be set up in South Africa. Additionally, WHO has prequalified numerous health technologies including vaccines from manufacturers in middle-income countries. These manufacturers have shown that they can produce according to international standards of quality, safety and efficacy.
    - WHO continues to provide technical assistance to companies to build capacity, especially in Africa, Asia, and Latin America, through the COVID-19 Technology Access Pool.

- In his speech at the 138th International Olympic Committee Session, the Director-General emphasized:
    - A massive global push to vaccinate against COVID-19 is needed - at least 10% of the population of every country by September 2021, at least 40% by the end of the year, and 70% by the middle of 2022.
    - WHO's top priority is universal health coverage, so that all people can access the health services they need, where and when they need them, without facing financial hardship.

Updates and publications

- Vaccine inequity undermining global economic recovery
- Guidance on conducting vaccine effectiveness evaluations in the setting of new SARS-CoV-2 variants: Interim guidance, 22 July 2021. Addendum to Evaluation of COVID-19 vaccine effectiveness
- Global minimum estimates of children affected by COVID-19-associated orphanhood and deaths of caregivers: a modelling study

Annex

COVID-19 confirmed cases and deaths reported in the last seven days by countries, territories and areas, and WHO Region (reported in previous issues) are now available at: https://covid19.who.int/table.

As of 27 July, the WHO Coronavirus (COVID-19) Dashboard will be updated once per day and the daily case and death counts for all WHO regions will be published by 23:59 CET/CEST on weekdays. Data reported over the weekend will be published on the following Monday as soon as they become available.

Annex 1. List of countries/territories/areas reporting Variants of Concern as of 27 July 2021**

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Afghanistan	●	-	-	●	-
Albania	●	-	-	○	-
Algeria	●	-	-	●	-
Angola	●	●	-	●	-
Anguilla	●	-	-	●	-
Antigua and Barbuda	●	●	-	-	-
Argentina	●	●	●	●	-
Armenia	○	-	-	-	-
Aruba	●	●	●	●	-
Australia	●	●	●	●	-
Austria	●	●	●	●	-
Azerbaijan	●	-	-	○*	-
Bahamas	●*	-	-	-	-
Bahrain	●	●	-	●	-
Bangladesh	●	●	○	●	-
Barbados	●	-	●	●	-
Belarus	●	-	-	○	-
Belgium	●	●	●	●	-
Belize	●	-	-	-	-
Bermuda	●	●	-	-	-
Bhutan	●	●	-	●	-
Bolivia (Plurinational State of)	●	-	●	-	-
Bonaire	●	-	-	-	-
Bosnia and Herzegovina	○	○	○	○	-
Botswana	-	●	-	●	-
Brazil	●	●	●	●	-
British Virgin Islands	●	-	●	-	-
Brunei Darussalam	●	●	-	-	-
Bulgaria	●	●	-	●	-
Burkina Faso	●	-	-	-	-
Burundi	●	●	-	●	-
Cabo Verde	●	-	-	-	-
Cambodia	●	○	-	●	-
Cameroon	●	●	-	-	-
Canada	●	●	●	●	-
Cayman Islands	●	-	●	-	-
Central African Republic	●	-	-	-	-
Chile	●	●	●	●	-
China	●	●	●	○	-
Colombia	●	-	●	●*	-
Comoros	-	●	-	-	-
Congo	●	●	-	●	-
Costa Rica	●	●	●	●*	-
Croatia	●	●	○	○	-
Cuba	●	●	-	-	-
Curaçao	●	-	●	●*	●
Cyprus	●	●	-	○	-
Czechia	●	●	●	●	-
Côte d'Ivoire	●	●	-	-	-
Democratic Republic of the Congo	●	●	-	●	-
Denmark	●	●	●	●	-
Djibouti	●	●	-	-	-
Dominica	●	-	-	-	-
Dominican Republic	●	-	●	-	-
Ecuador	●	-	●	●	-
Egypt	●	-	-	-	-
Equatorial Guinea	●	●	-	-	-
Estonia	●	●	○	○	-
Eswatini	-	●	-	-	-
Ethiopia	○	-	-	-	-
Faroe Islands	●	-	●	-	-
Fiji	-	-	-	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Finland	●	●	●	●	-
France	●	●	●	●	-
French Guiana	●	●	●	●	-
French Polynesia	●	●	●	●	-
Gabon	●	○	-	-	-
Gambia	●	-	-	●	-
Georgia	●	○	-	●	-
Germany	●	●	●	●	-
Ghana	●	●	-	●	-
Gibraltar	●	-	-	-	-
Greece	●	●	●	●	-
Grenada	●	-	-	-	-
Guadeloupe	●	●	●	●	-
Guam	●	●	●	●	-
Guatemala	●	●	●	-	-
Guinea	●	●	-	-	-
Guinea-Bissau	●	●	-	-	-
Guyana	-	-	●	-	-
Haiti	●	-	●	-	-
Honduras	●	-	-	-	-
Hungary	●	○	●*	○	-
Iceland	●	-	-	-	-
India	●	●	●	●	-
Indonesia	●	●	-	●	-
Iran (Islamic Republic of)	●	●	-	●	-
Iraq	●	●	-	●	-
Ireland	●	●	●	●	-
Israel	●	●	●	●	-
Italy	●	●	●	●	-
Jamaica	●	-	-	-	-
Japan	●	●	●	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Jordan	●	●	●	●	-
Kazakhstan	○	○	-	●	-
Kenya	●	●	-	●	-
Kosovo[1]	●	○	-	○	-
Kuwait	●	●*	-	●	-
Kyrgyzstan	●	●	-	-	-
Lao People's Democratic Republic	●	-	-	●	-
Latvia	●	●	●	○	-
Lebanon	●	-	-	●	-
Lesotho	-	●	-	-	-
Liberia	●	-	-	-	-
Libya	●	●	-	-	-
Liechtenstein	●	-	-	-	-
Lithuania	●	●	●	○	-
Luxembourg	●	●	●	●	-
Madagascar	-	●	-	-	-
Malawi	●	●	-	●	-
Malaysia	●	●	-	●	-
Maldives	●	-	-	●	-
Malta	●	○	●	○	-
Martinique	●	●	●	●	-
Mauritania	●	●	-	●	-
Mauritius	○	●	-	●	-
Mayotte	●	●	-	-	-
Mexico	●	●	●	●	-
Monaco	●	○	-	○	-
Mongolia	●	-	-	●	-
Montenegro	●	-	-	-	-
Montserrat	●	-	-	-	-
Morocco	●	-	-	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Mozambique	○	●	-	●	-
Myanmar	●	-	-	●	-
Namibia	●	●	-	●	-
Nepal	●	-	-	●	-
Netherlands	●	●	●	●	-
New Caledonia	●	-	-	-	-
New Zealand	●	●	○	○	-
Niger	●	-	-	-	-
Nigeria	●	-	-	●	-
North Macedonia	●	●	-	○	-
Norway	●	●	●	●	-
Occupied Palestinian Territory	●	●	-	●	-
Oman	●	●	-	●	-
Pakistan	●	●	●	●	-
Panama	●	●	●	-	●
Papua New Guinea	-	-	-	●	-
Paraguay	●	-	●	-	-
Peru	●	-	●	●	-
Philippines	●	●	●	●	-
Poland	●	○	●	●	-
Portugal	●	●	●	●	-
Puerto Rico	●	●	●	●	-
Qatar	●	●	-	●	-
Republic of Korea	●	●	●	●	-
Republic of Moldova	○	-	-	○*	-
Romania	●	●	●	●	-
Russian Federation	●	●	○*	●	-
Rwanda	●	○	-	●	-
Réunion	●	●	●	○	-
Saba	-	-	-	●	-
Saint Barthélemy	●	-	-	-	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Saint Lucia	●	-	-	-	-
Saint Martin	●	●	-	-	-
Sao Tome and Principe	●	-	-	-	-
Saudi Arabia	●	●	-	●	-
Senegal	●	●	-	●	-
Serbia	●	-	-	●*	-
Seychelles	-	●	-	-	-
Sierra Leone	-	-	-	○	-
Singapore	●	●	●	●	-
Sint Maarten	●	●	-	●	-
Slovakia	●	●	-	●	-
Slovenia	●	●	●	●	-
Somalia	●	○	-	-	-
South Africa	●	●	○	●	-
South Sudan	●	○	-	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Spain	●	●	●	●	-
Sri Lanka	●	●	-	●	-
Sudan	●*	●*	●*	-	-
Suriname	●	●	●	-	-
Sweden	●	●	●	●	-
Switzerland	●	●	○	●	-
Thailand	●	●	●	●	-
Timor-Leste	●	-	-	●*	-
Togo	●	●	-	-	-
Trinidad and Tobago	●	-	●	-	-
Tunisia	●	●	-	●	-
Turkey	●	●	●	●	-
Turks and Caicos Islands	●	-	●	-	-
Uganda	●	●	-	●	-
Ukraine	●	○	-	○	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
United Arab Emirates	●	●	●	●	-
United Kingdom	●	●	●	●	-
United Republic of Tanzania	-	●	-	-	-
United States Virgin Islands	-	-	-	●*	-
United States of America	●	●	●	●	-
Uruguay	●	-	●	-	-
Uzbekistan	●	●	-	○	-
Venezuela (Bolivarian Republic of)	●	-	●	-	-
Viet Nam	●	●	-	●	-
Wallis and Futuna	●	-	-	-	-
Zambia	●	●	-	●	-
Zimbabwe	-	●	-	●	-

**Newly reported in this update.*
"Unspecified B.1.617" reflects countries/territories/areas reporting detection of B.1.617 without further specification of lineage at this time. These will be reallocated as further details become available.
"●" indicates that information for this variant was received by WHO from official sources.
"○" indicates that information for this variant was received by WHO from unofficial sources and will be reviewed as more information become available.
*** Beta was excluded for Uruguay this week based on further information.*
****Includes countries/territories/areas reporting the detection of VOCs among travelers (e.g., imported cases detected at points of entry), or local cases (detected in the community). Excludes countries, territories, and areas that have never reported the detection of a variant of concern*

See also Annex 2: Data, table and figure notes.

Annex 2. 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.

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 except, the names of proprietary products are distinguished by initial capital letters.

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

Technical guidance and other resources

- WHO technical guidance
- WHO COVID-19 Dashboard
- WHO Weekly Operational Updates on COVID-19
- WHO COVID-19 case definitions
- COVID-19 Supply Chain Inter-Agency Coordination Cell Weekly Situational Update
- Research and Development
- OpenWHO courses on COVID-19 in official UN languages and in additional national languages
- WHO Academy COVID-19 mobile learning app
- The Strategic Preparedness and Response Plan (SPRP) outlining the support the international community can provide to all countries to prepare and respond to the virus
- Recommendations and advice for the public:
  - Protect yourself
  - Questions and answers
  - Travel advice
- EPI-WIN: tailored information for individuals, organizations and communities