COVID-19 Weekly Epidemiological Update

Edition 54, published 24 August 2021

In this edition:

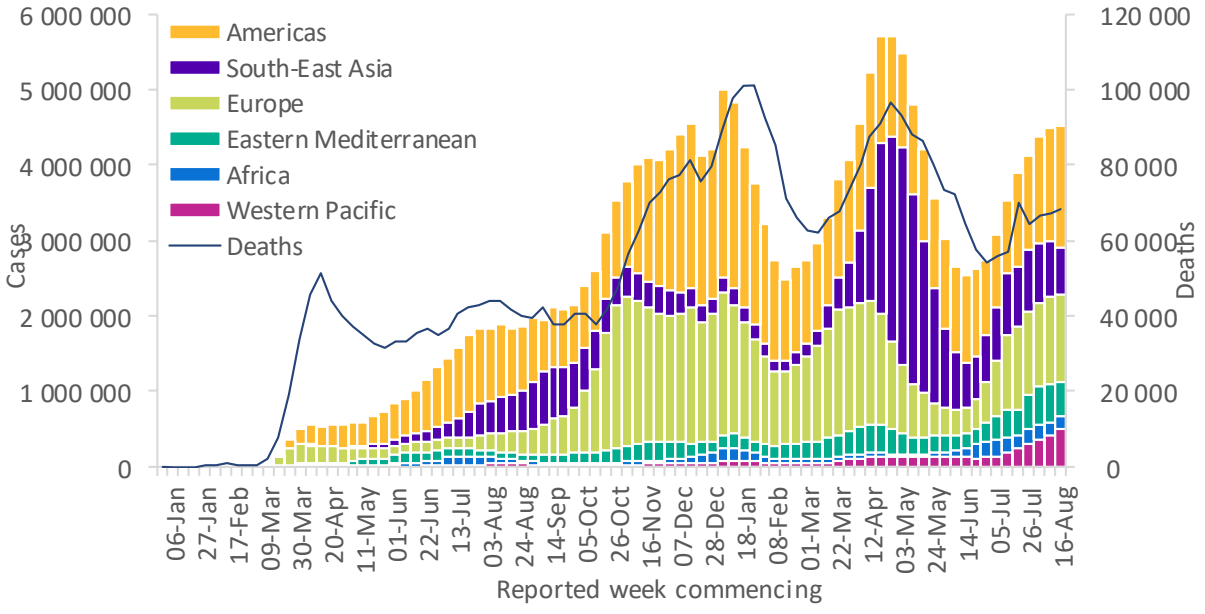
Global overview

Data as of 22 August 2021

With over 4.5 million new cases reported this week (16-22 August), the number of new cases reported globally seems to be stable after increasing for nearly two months (since mid-June) (Figure 1). The Regions of Western Pacific and Americas continue to report increases in new cases, with increases of 20% and 8% respectively as compared to last week. The South-East Asia and Eastern Mediterranean regions reported decreases in weekly incidence of 16% and 10% respectively. The European and African Regions reported case incidence rates similar to those reported last week.

The number of deaths reported globally this week remains similar to last week, with over 68 000 new deaths reported. Two Regions including Europe and Americas reported increases in new deaths of 11% and 10% respectively. The African and South-East Asia Regions reported decreases in new deaths of 11% and 10% respectively, whereas the numbers of deaths reported in the Eastern Mediterranean and Western Pacific Regions were similar to the numbers reported last week. The cumulative number of cases reported globally is now over 211 million and the cumulative number of deaths is just over 4.4 million.

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 22 August 2021**



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

The Regions reporting the highest weekly case and deaths incidence rates per 100 000 population remain the same as last week: the Regions of the Americas (158.8 new cases per 100 000 population; 2.1 deaths per 100 000 population) and Europe (124.9 new cases per 100 000 population; 1.3 deaths per 100 000 population) . The Eastern Mediterranean Regionalso reported a high weekly incidence in deaths (1.0 per 100 000 population).

The highest numbers of new cases were reported from the United States of America (1 020 072 new cases; 15% increase), the Islamic Republic of Iran (251 610 new cases; 7% decrease), India (231 658 new cases; 10% decrease), the United Kingdom (219 919 new cases; 11% increase), and Brazil (209 099 new cases; 1% decrease).

Globally, cases of the Alpha variant have been reported in 192 countries (three new countries since last week), territories or areas (hereafter countries), while 141 countries (four new countries) have reported cases of the Beta variant; 86 countries (no new country) have reported cases of the Gamma variant; and 163 countries (seven 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 22 August 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	1 623 891 (36%)	8%	81 746 260 (39%)	21 983 (32%)	10%	2 072 143 (47%)
Europe	1 165 092 (26%)	0%	63 662 465 (30%)	11 912 (17%)	11%	1 254 406 (28%)
South-East Asia	614 080 (14%)	-16%	40 522 861 (19%)	17 475 (26%)	-10%	627 864 (14%)
Eastern Mediterranean	450 624 (10%)	-10%	14 052 013 (7%)	7 115 (10%)	1%	256 504 (6%)
Western Pacific	513 581 (11%)	20%	5 844 252 (3%)	5 896 (9%)	3%	81 329 (2%)
Africa	158 595 (4%)	-3%	5 459 743 (3%)	3 958 (6%)	-11%	130 407 (3%)
Global	**4 525 863 (100%)**	**0%**	**211 288 358 (100%)**	**68 339 (100%)**	**1%**	**4 422 666 (100%)**

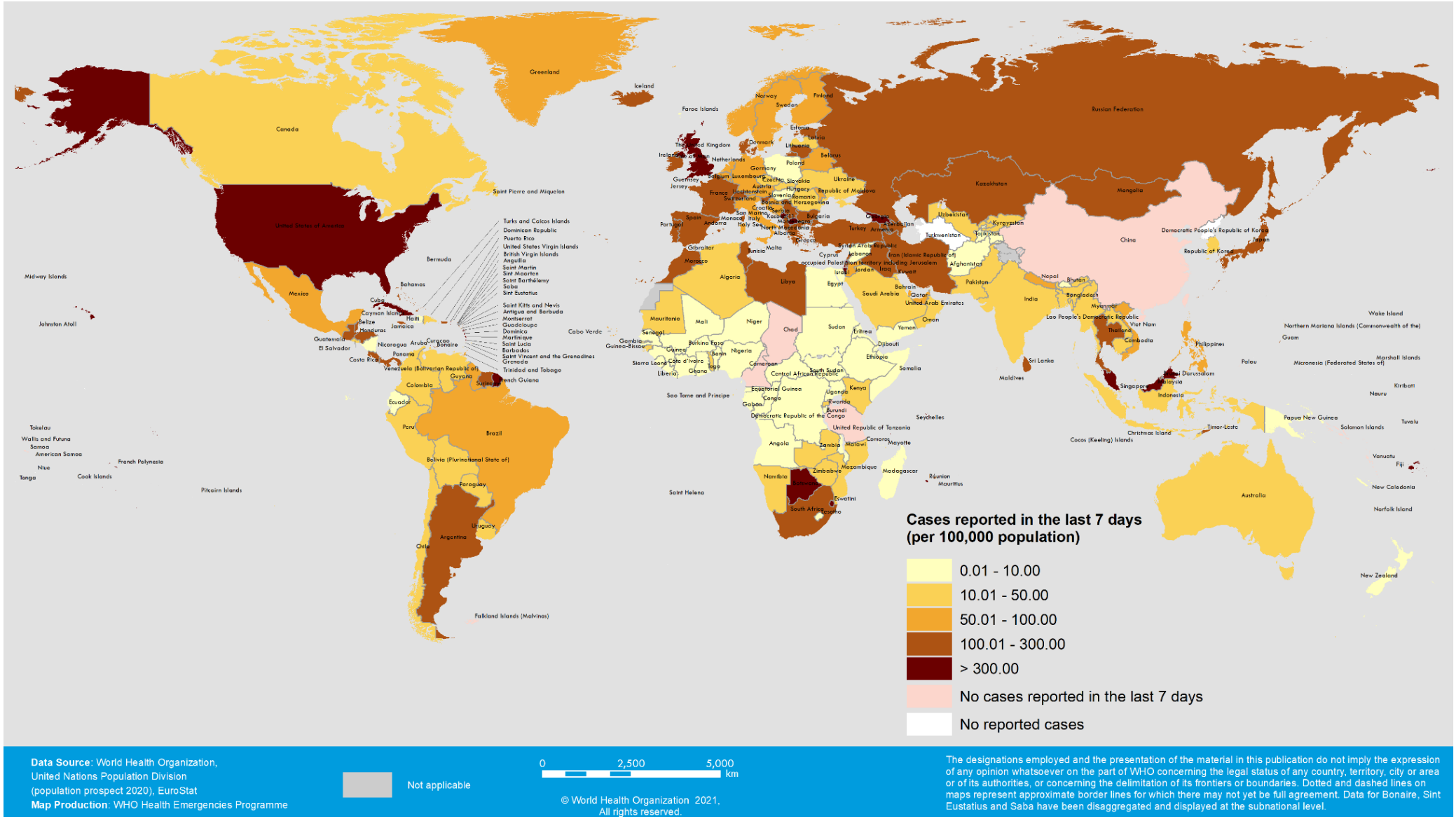
Percent change in the number of newly confirmed cases/deaths in past seven days, compared to seven days prior

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

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

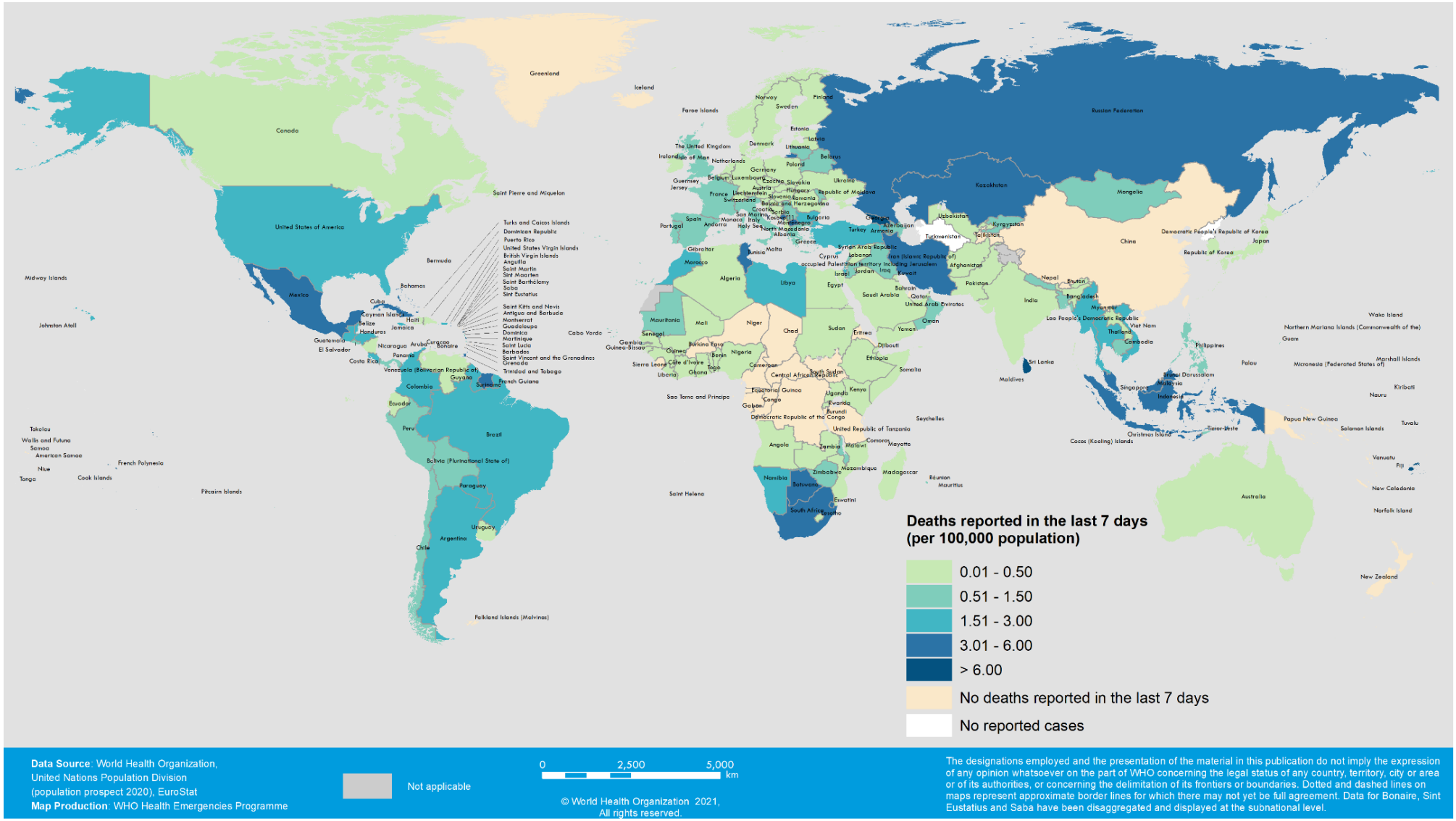
- WHO COVID-19 Dashboard
- WHO COVID-19 Weekly Operational Update and previous editions of the Weekly Epidemiological Update

Figure 2. COVID-19 cases per 100 000 population reported by countries, territories and areas, 16 – 22 August 2021**



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

Figure 3. COVID-19 deaths per 100 000 population reported by countries, territories and areas, 16 – 22 August 2021**



**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.

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 4, 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 10 August, new evidence has been published on the phenotypic characteristics of VOCs.

A preliminary population-level observational study conducted in Israel found that infection with the Alpha variant did not lead to higher case fatality rates. This finding contradicts previous studies from the United Kingdom that indicated an increase in the risk of severe outcomes and mortality associated with the Alpha variant[1].These findings could nonetheless be influenced by several factors such as much younger general population, high vaccination coverage and extensive free testing throughout Israel[2]. Another prospective longitudinal household study (preprint) found a higher secondary attack rate among cases infected with the Alpha variant (77.8%) as compared to those infected with non-VOCs (42.5%) in Norway, suggesting thepotential for very high household transmission levels for the Alpha variant. The same study also found that primary cases experiencing loss of taste/smell were associated with a significant increase in the onwards secondary attack rates, which could also be due to the observed increase in viral load [3,4] in these cases.[5]

A systematic review (preliminary study) which aimed tounderstand the impact of the Alpha and Gamma variants on the rates of hospitalization sof nine of these studies in the analysis. The study found that the relative risk of hospitalization is higher (between 1.4 to 2) for the Alpha variant as compared to non-VOCs. The evidence for hospitalization with the Gamma variant, compared to non-VOC was limited (only one

study was included), but the odds ratio of hospitalization was found to be much higher (above 2), particularly for cases between the age of 20-39 years.[6]

Results from a recent preprint study in the United States of America suggest that the Delta variant has greater replication fitness as compared to the Alpha variant, meaning that Delta has the propensity to replicate more easily and is in turn more infectious.[7] The study identified a key spike protein mutation (P681R at the furin cleavage site) as the molecular determinant for the enhanced fitness of the Delta variant and its dominance over the Alpha variant. In a systematic review (preprint) comparing the basic reproductive number (R_0) of the Delta variant to the early R_0 estimates of non-VOC strains, the mean R_0 of the Delta variant was found to be 5.08, far higher than the R_0 of non-VOC strains (2.79).[8] The authors of the study screened nearly 30 000 records, of which only 5 were identified as providing evidence that the true value of the R_0 of the Delta variant is likely under-estimated as the R_0 estimates in the studies identified were taken at the time when variable movement restrictions were in place in most parts of the world.

The emergence of these Variants of Concern highlight the importance of maintaining public health and social measures (PHSM) and the need to increase vaccination coverage against SARS-CoV-2. The timing of lifting these measures is critical as highlighted by a modelling study conducted in England whereby lifting the PHSM fully on 21 June, as originally planned, as opposed to 19 July, would have led to a peak of 3,400 (95% CI: 1,300-4,400) daily admissions to hospital due to the emergence of the Delta variant . Delaying the lifting of PHSL until 19 July reduced the peak in daily hospitalizations by nearly three fold to 1,400 (95% CI: 700-1500).[9] It is important to note that these hospitalization rates were based on estimates, including uncertainties as to the effectiveness of vaccines against the Delta variant, which require careful interpretation. Relaxation of PHSM should therefore be carefully and cautiously balanced against levels of vaccination coverage, and the circulation of Variants of Concern.

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

WHO label	Alpha	Beta	Gamma	Delta
Transmissibility	Increased transmissibility and secondary attack rate[10]	Increased transmissibility[11]	Increased transmissibility[12]	Increased transmissibility and secondary attack rate[13] Similar transmissibility between vaccinated and unvaccinated individuals[14–16]
Disease severity	Increased risk of hospitalization[17], possible increased risk of severity and mortality[1]	Not confirmed, possible increased risk of in-hospital mortality[18]	Not confirmed, possible increased risk of hospitalization[19]	Increased risk of hospitalization[20]

Risk of reinfection	Neutralizing activity retained [21], risk of reinfection remains similar[22]	Reduction in neutralizing activity reported; T cell response elicited by D614G virus remains effective[23]	Moderate reduction in neutralizing activity reported[24]	Reduction in neutralizing activity reported[25–27]
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[28]	No impact on RT-PCR or Ag RDTs observed[27]	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.*

Table 3. Summary of vaccine performance against Variants of Concern

	Anhui ZL-Recombinant	AstraZeneca-Vaxzevria	Beijing CNBG-BBIBP-CorV	Bharat-Covaxin	Gamaleya-Sputnik V	Janssen-Ad26.COV 2.5	Moderna-mRNA-1273	Moderna-mRNA-1273/ Pfizer BioNTech-Comirnaty	Novavax-Covavax	Pfizer BioNTech-Comirnaty	SII - Covishield	Sinovac-CoronaVac
Alpha[29,30]												
Summary of VE*	Protection retained against all outcomes											
- Severe disease	-	↓$_1$	-	-	-	-	↔$_1$	↔$_1$	-	↔$_3$	-	-
- Symptomatic disease	-	↔ to ↓$_3$	-	-	-	-	↔$_1$	↔$_1$	↓$_1$	↔$_3$	-	-
- Infection	-	↔ to ↓$_2$	-	-	-		↔$_1$	-	-	↔$_2$	-	-
Neutralization	↔$_2$	↓$_4$	↔$_1$	↔$_2$	↔$_2$	↔$_3$	↔ to ↓$_{11}$	↓$_1$	↓$_1$	↔ to ↓$_{34}$	↔$_1$	↔ to ↓$_5$
Beta[31–34]												
Summary of VE*	Protection retained against severe disease; reduced protection against symptomatic disease; limited evidence											
- Severe disease	-	-	-	-	-	↔$_1$	-	-	-	↔$_1$	-	-
- Symptomatic disease	-	↓↓↓$_1$	-	-	-	↔$_1$	-	-	↓↓↓$_1$	↔$_1$	-	-
- Infection	-	-	-	-	-	-	↔$_1$	-	-	↓$_1$	-	-
Neutralization	↔ to ↓$_3$	↓↓$_5$	↔ to ↓$_2$	↓$_2$	↓ to ↓↓$_2$	↓ to ↓↓$_5$	↓ to ↓↓$_{13}$	↓↓↓$_1$	↓↓↓$_1$	↓ to ↓↓$_{31}$	↓$_1$	↓ to ↓↓$_4$
Gamma												
Summary of VE*	Unclear impact; very limited evidence											
- Severe disease	-	-	-	-	-	-	-	-	-	-	-	-
- Symptomatic disease	-	-	-	-	-	-	-	-	-	-	-	-
- Infection	-	-	-	-	-	-	-	-	-	-	-	↔$_1$
Neutralization	↔$_1$	↓$_1$	-	-	↓$_1$	↓$_2$	↓$_6$	-	-	↔ to ↓$_{16}$	-	↔ to ↓$_3$
Delta[35]												
Summary of VE*	Protection retained against severe disease; possible reduced protection against symptomatic disease and infection; limited evidence											
- Severe disease	-	↔$_1$	-	-	-	-	↔$_1$	-	-	↔$_2$	-	-
- Symptomatic disease	-	↓↓$_2$	-	↓$_1$	-	-	-	-	-	↔ to ↓$_3$	-	-
- Infection	-	↓$_1$	-	-	-	-	-	-	-	↓$_1$	-	-
Neutralization	↔ to ↓$_2$	↓ to ↓↓$_4$	-	↔ to ↓$_3$	-	↓$_3$	↓$_3$	↓↓$_1$	-	↓ to ↓↓$_8$	↓$_2$	↓ to ↓↓↓$_2$

VE refers to vaccine effectiveness and vaccine efficacy
Summary of VE*: indicates the general conclusions but only for the vaccines evaluated against the specific variant
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.
"Moderna-mRNA-1273/Pfizer BioNTech-Comirnaty" indicates that both vaccines were evaluated together in study.
The number of studies is shown as subscripts: vaccine effectiveness and neutralization studies informing this table can be found on the VIEW-hub Resources page (https://view-hub.org/resources).
For individual vaccine effectiveness studies, see 'COVID-19 Vaccine Effectiveness Results Summary', reference numbers noted with a '#'. For a list of all neutralization studies, see 'COVID-19 Vaccine Neutralization Studies Table'.
References indicated by superscripts next to VOC name in column 1 are vaccine efficacy results from randomized controlled trials informing this table and are included in the reference section below.

Additional notes on VOC impacts on vaccines

- Studies presenting VOC-specific vaccine efficacy or effectiveness (VE) estimates for full vaccination (≥ 7 days post final dose) are assessed against a comparator VE estimate for that vaccine product 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 a 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 outcome even without a comparator if a very high VE estimate is reported against a VOC (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 for a product between different studies. In addition, the reductions summarized in the table represent VE point estimates and do not represent the uncertainty intervals around these estimates which vary substantially across studies. The reductions in VE noted should be interpreted with these limitations in mind.

Table 3 presents the impact of variants on product specific vaccine efficacy/effectiveness (VE) and quantifies the reduction in VE in the setting of 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 substantial protection, as is the case for AstraZeneca-Vaxzevria.

Since the 10 August update, four notable studies have assessed vaccine effectiveness against SARS-CoV-2 Variants of Concern. A test-negative case-control study from Qatar (preprint) evaluated the effectiveness of mRNA vaccines against symptomatic and severe COVID-19 disease due to Delta. VE against symptomatic Delta infection ≥ 14 days post second dose was 56.1% (95% CI: 41.4-67.2%) for Pfizer BioNTech-Comirnaty and 85.8% (95% CI: 70.6-93.9%) for Moderna-mRNA-1273. The lower VE for Pfizer BioNTech-Comirnaty may be explained by a lower VE against Delta and/or. by waning of protection with time . The VE against symptomatic disease due to Delta for Pfizer BioNTech-Comirnaty is lower than that found by studies conducted in the UK and Canada[36–38] where, due to the longer interval between doses, most of the study population had received their second dose 3 months later than in the study in Qatar. The same drop in VE was not observed in this study for the Moderna-mRNA-1273 vaccine, which may be due to the vaccine being introduced into Qatar three months later than Pfizer BioNTech-Comirnaty and being administered with a slightly longer dosing interval (i.e., 4 weeks instead of 3 weeks). Third, as the authors note, differential application of restrictions in Qatar could have contributed to a lower VE, with some restrictions in Qatar eased for the vaccinated while maintained for the unvaccinated. Importantly, VE against hospitalization and death due to Delta remained high (VEs of 97-100%) for both vaccines. Finally, persons with a prior history of SARS-CoV-2 infection were not excluded from this study which could downwardly bias VE estimates if a substantial proportion of the unvaccinated population has natural immunity.[39]

Two studies from the United States of America evaluated VE of Pfizer BioNTech-Comirnaty and Moderna-mRNA-1273 vaccines during a period of high Delta prevalence (June-July 2021). The first, a retrospective cohort study found decreased VE against infection among nursing home residents during June-July 2021 when Delta predominated as compared to the period of March-May 2021. VE against infection from June-July 2021 was 52.4% (95% CI: 48.0-56.4%) and 50.6% (95% CI: 45.0-55.7%) for Pfizer BioNTech-Comirnaty and

Moderna-mRNA-1273 vaccines, respectively. Corresponding VE during March-May were 74.2% (95% CI: 69.0-78.7%) and 74.7% (95% CI: 66.2-81.1%). It is not possible to know whether decreased VE during the later time period was due to the Delta variant or due to waning of protection. The estimates are also limited due to the inability to control for potential confounders.[40] The second study, a case-control study of adults ≥ 18 years, found VE of Pfizer BioNTech-Comirnaty or Moderna-mRNA-1273 vaccines found that protection against hospitalization ≥ 14 days post second dose was maintained during the period when Delta was predominant (VE of 84%, 95% CI: 79-89%) as compared to the pre-Delta period (VE of 87%, 95% CI: 83-90%).[41]

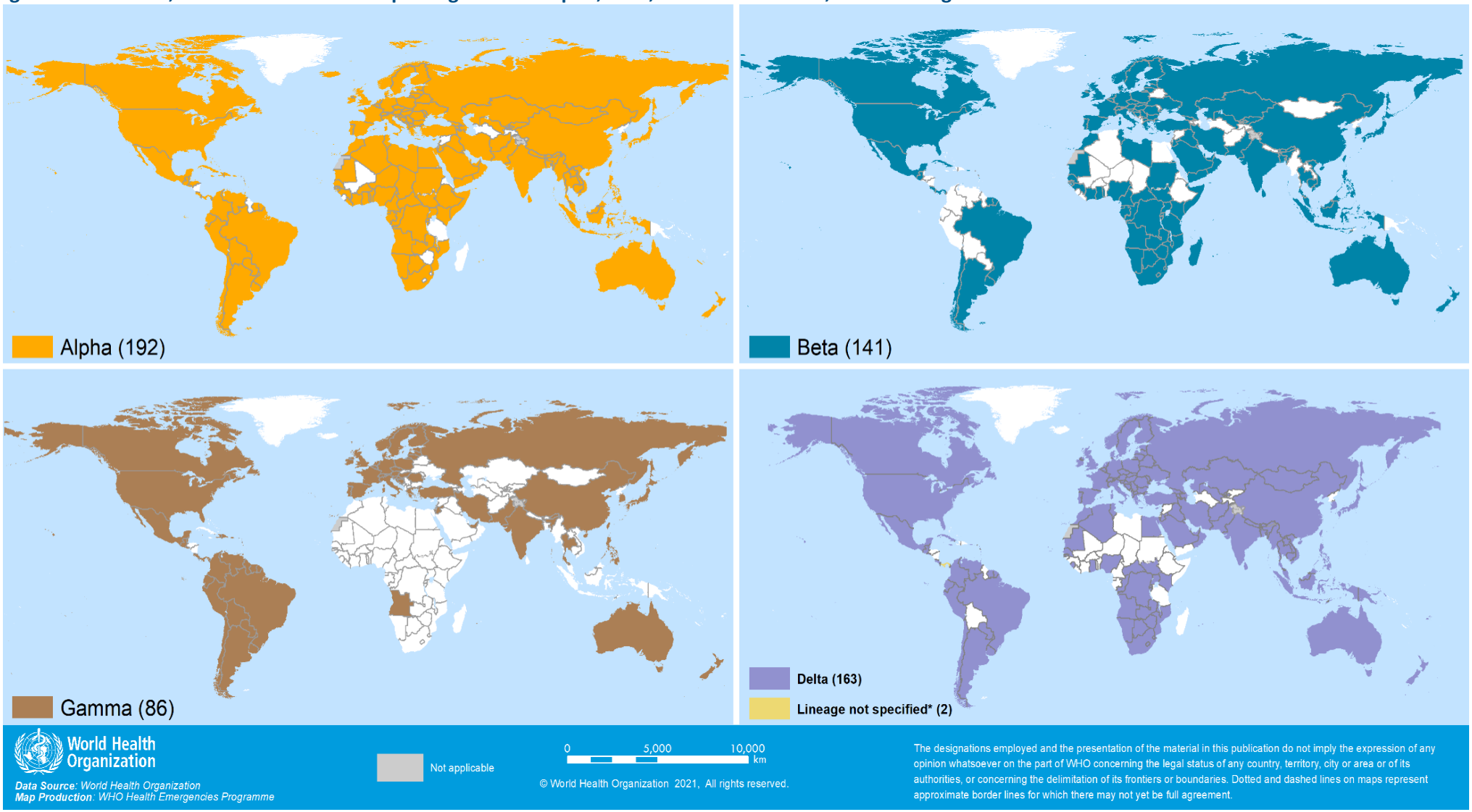
The fourth study, from the UK (preprint), assessed VE of Pfizer BioNTech-Comirnaty and AstraZeneca-Vaxzevria vaccines against SARS-CoV-2 infection (asymptomatic and symptomatic) among adults ≥ 18 years through a large survey ofrandomly selected households. The study compares VE during a period of high Alpha prevalence to that of a period of high Delta prevalence. Findings showed possible reduced effectiveness of AstraZeneca-Vaxzevria vaccine in the period when Delta was most dominant compared to when Alpha was dominant: 67% (95% CI: 62-71%) vs 79% (95% CI: 56-90%). No reduction was observed for Pfizer BioNTech-Comirnaty: VE was 78% (95% CI: 68-84%) during the period when Alpha was dominant and 80% (95% CI: 77-83%) during when Delta was most dominant. One-dose effectiveness for both vaccines was markedly lower: VE of nearly 60% during both periods for Pfizer BioNTech-Comirnaty and VE estimates of 63% and 46% for AstraZeneca-Vaxzevria during the time the Alpha and Delta variants were predominant, respectively. The study also estimates one-dose VE of Moderna-mRNA-1273 against SARS-CoV-2 during the period the Delta variant was predominant to be 75% (95% CI: 64% - 83%), higher than that of the other vaccines although this could be in part due to predominantly younger persons receiving Moderna-mRNA-1273.[42]

Together these studies provide evidence for the maintenance of high levels of protection against severe COVID-19 disease due to Delta. While there is some evidence that VE against SARS-CoV-2 infection and non-severe disease may be reduced with Delta, it is currently not possible to separate the effect of Delta from the effect of potential waning immunity, differential risk of exposure profiles between vaccinated and unvaccinated populations, spuriously low VE due to increasing levels of natural immunity in the unvaccinated population, or other potential confounding factors.

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 4. Countries, territories and areas reporting variants Alpha, Beta, Gamma and Delta, as of 24 August 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.*

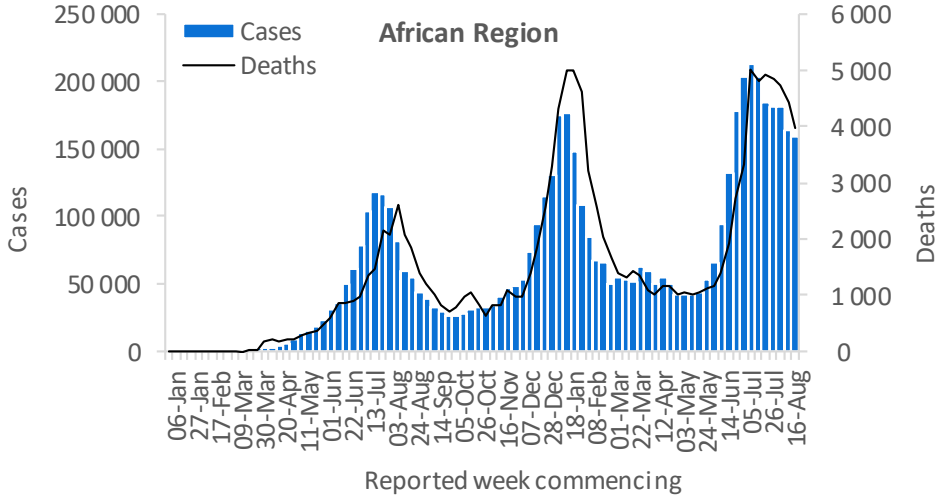
***Countries/territories/areas highlighted include both official and unofficial reports of VOC detections, and do not presently differentiate between detections among travellers (e.g., at Points of Entry) or local community cases. Please see Annex 2 for further details.*

WHO regional overviews – Epidemiological week 16 – 22 Aug 2021

African Region

The Region reported a similar weekly case incidence as compared to last week , with over 158 500 new cases reported this week. Overall, since the 5 July, the Region continues to show a declining trend in weekly new cases. This week, around half (53%) of the weekly new cases were reported from South Africa . Weekly new deaths have been declining for past four consecutive weeks, and a sharp decrease (by 11%) was reported this week as compared to last week, with just over 3900 new deaths reported . A total of 17 of 49 countries/territories/areas reported an increase in weekly case incidence, with highest increase reported in Benin and Sao Tome and Principe.

This week, the highest numbers of new cases were reported from South Africa (84 778 new cases; 142.9 new cases per 100 000 population; an 18% increase), Botswana (9703 new cases; 412.6 new cases per 100 000; a 32% decrease), and Kenya (8425 new cases; 15.7 new cases per 100 000; a 5% decrease). The highest numbers of new deaths were reported from South Africa (2382 new deaths; 4.0 new deaths per 100 000 population; a 6% increase), Algeria (218 new deaths; <1 new deaths per 100 000; a 22% decrease), and Kenya (148 new deaths; <1 new deaths per 100 000; a 27% decrease).

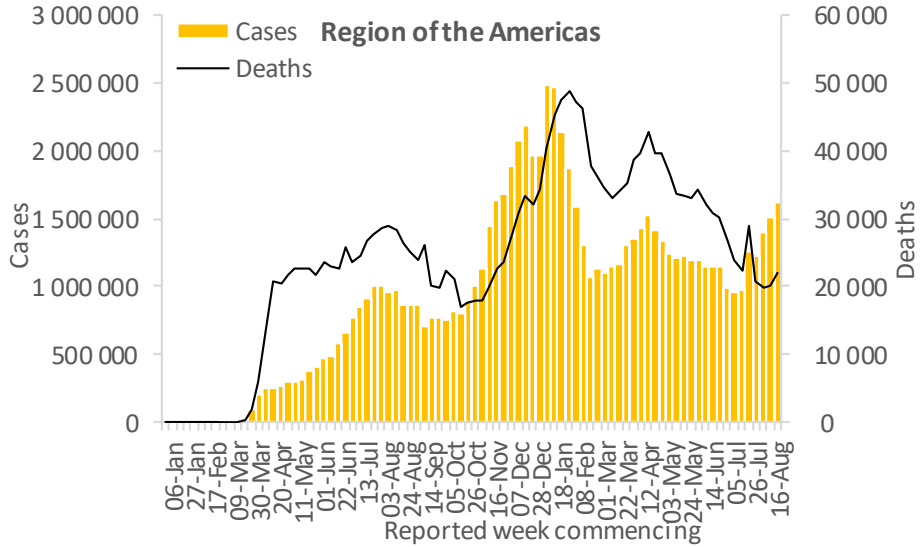


Updates from the African Region

Region of the Americas

The Region of the Americas reported over 1.6 million new cases and just under 22 000 new deaths, an 8% and a 10% increase respectively compared to the previous week. This increase is mainly driven by increase in cases in the United States of America which accounted for 63% of all new cases reported this week. Overall, cases continue to increase for past three weeks in the Region. In South America, most countries reported a decline in new cases, with the exception of El Salvador and Costa Rica which reported increases in new cases of 45% and 6% respectively as compared to last week.

The highest numbers of new cases were reported from the United States of America (1 020 072 new cases; 308.2 new cases per 100 000; a 15% increase), Brazil (209 099 new cases; 98.4 new cases per 100 000; a 1% decrease), and Mexico (128 779 new cases; 99.9 new cases per 100 000; a 4% increase). Similarly, the highest numbers of new deaths were reported from the United States of America (6712 new deaths; 2.0 new deaths per 100 000; a 58% increase), Brazil (5649 new deaths; 2.7 new deaths per 100 000; a 7% decrease), and Mexico (4666 new deaths; 3.6 new deaths per 100 000; a 27% increase).

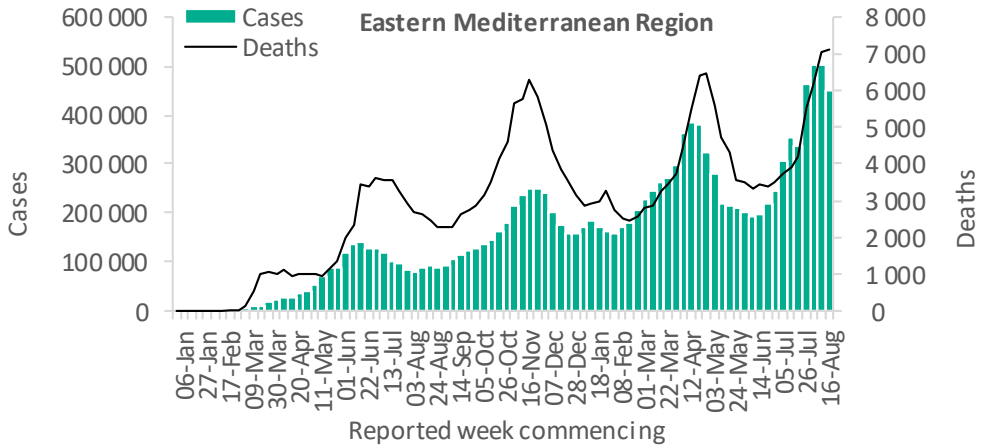


Updates from the Region of the Americas

Eastern Mediterranean Region

The majority of countries in the Eastern Mediterranean Region (13/22; 59%) reported declining trends this week and for the first time since the end of May, the Region reported a 10% decrease in cases, with just over 450 000 new cases this week. These declines were largely due to decreases in the number of new cases reported in the Islamic Republic of Iran, Morocco, Pakistan and Iraq, although it is important to note that there is still ongoing transmission in all countries in the Region and case numbers while declining, remain high in most countries. Following seven weeks of increasing death incidence, this week over 7100 new deaths were reported in the Region, a number s similar to that of the previous week. Eight out of the twenty-two countries reported increases in deaths over the past seven days.

The highest numbers of new cases were reported from the Islamic Republic of Iran (251 610 new cases; 299.6 new cases per 100 000; a 7% decrease), Morocco (54 212 new cases; 146.9 new cases per 100 000; a 16% decrease), and Iraq (50 702 new cases; 126.1 new cases per 100 000; a 21% decrease). The highest numbers of new deaths were reported from the Islamic Republic of Iran (4146 new deaths; 4.9 new deaths per 100 000; an 11% increase), Morocco (744 new deaths; 2.0 new deaths per 100 000; a 10% increase), and Tunisia (630 new deaths; 5.3 new deaths per 100 000; a 30% decrease).

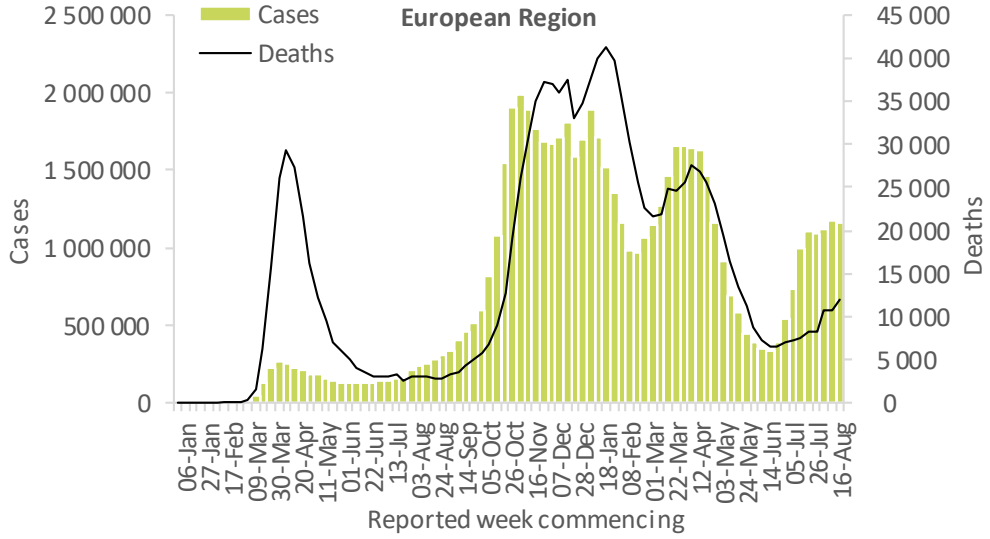


Updates from the Eastern Mediterranean Region

European Region

The number of new cases in the European Region remained similar to that of the previous week with over 1.1 million new cases reported. With just under 12 000 deaths reported this week, the weekly deaths in the Region represent the largest proportionate increase (11%) seen across all six WHO regions this week as compared to the previous week. In the past week, this increase in new deaths was largely due to increases in deaths reported in France (74%), Italy (54%) and Turkey (44%).

The highest numbers of new cases were reported from The United Kingdom (219 919 new cases; 324.0 new cases per 100 000; an 11% increase), Russian Federation (146 251 new cases; 100.2 new cases per 100 000; a 4% decrease), and Turkey (137 235 new cases; 162.7 new cases per 100 000; a 16% decrease).The highest numbers of new deaths were reported from Russian Federation (5545 new deaths; 3.8 new deaths per 100 000; a 1% decrease), Turkey (1322 new deaths; 1.6 new deaths per 100 000; a 44% increase), and Kazakhstan (930 new deaths; 5.0 new deaths per 100 000; a 0% decrease).

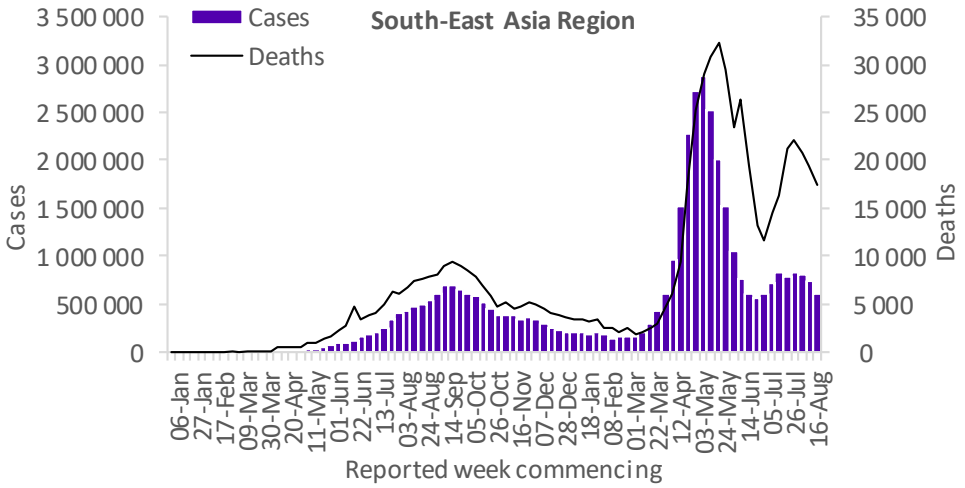


Updates from the European Region

South-East Asia Region

The South-East Asia Region reported over 614 000 new cases this week, a 16% decrease as compared to the previous week and the largest proportional decrease across all six WHO regions. All countries in the Region reported a decrease in the number of weekly cases, except from Maldives, Sri Lanka, and Timor-Leste where the number of new cases increased by 6%, 40%, and 59% respectively. This week the Region reported 17 000 new deaths, a 10% decrease respectively compared to the previous week, although half of the countries (5/10; 50%) continued to report increases.

The highest numbers of new cases were reported from India (231 658 new cases; 16.8 new cases per 100 000; a 10% decrease), Thailand (142 138 new cases; 203.6 new cases per 100 000; a 6% decrease), and Indonesia (125 102 new cases; 45.7 new cases per 100 000; a 34% decrease). The highest numbers of new deaths were reported from Indonesia (8784 new deaths; 3.2 new deaths per 100 000; a 16% decrease), India (3142 new deaths; 0.2 new deaths per 100 000; a 7% decrease), and Thailand (1768 new deaths; 2.5 new deaths per 100 000; a 31% increase).

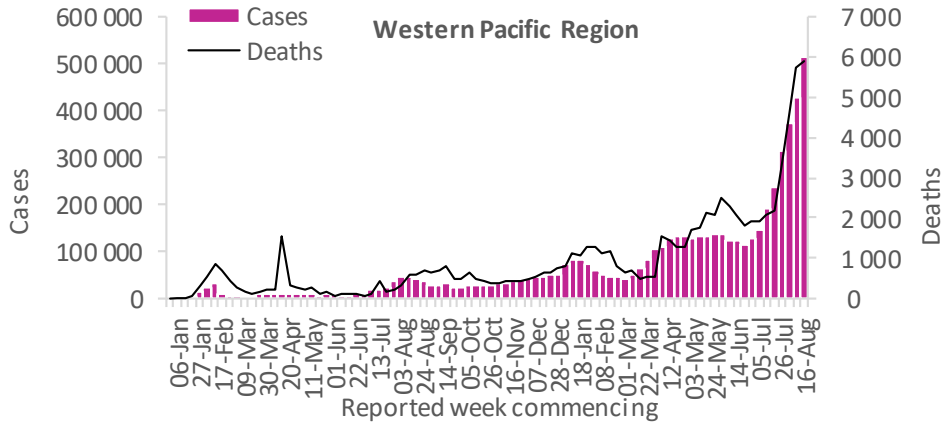


Updates from the South-East Asia Region

Western Pacific Region

The number of new cases in the Western Pacific Region continued to increase this week with over 513 000 new cases, a 20% increase as compared to the previous week. Regionally, 14 of the 18 countries (78%) reported increasing trends this week, although sharp increases in case incidence in Malaysia, Viet Nam, Japan and Philippines are responsible for much of the regional increase. In the past week, although the number of deaths remained similar to that of the previous week with just under 5900 new deaths reported, a quarter of the countries (6/24) in the region reported significant proportionate increases (<30%) in the number of new deaths reported.

The highest numbers of new cases were reported from Malaysia (150 933 new cases; 466.3 new cases per 100 000; a 7% increase), Japan (149 057 new cases; 117.9 new cases per 100 000; a 34% increase), and the Philippines (96 724 new cases; 88.3 new cases per 100 000; a 25% increase). The highest numbers of new deaths were reported from Viet Nam (2103 new deaths; 2.2 new deaths per 100 000; a 4% decrease), Malaysia (1708 new deaths; 5.3 new deaths per 100 000; a 7% decrease), and the Philippines (1526 new deaths; 1.4 new deaths per 100 000; a 24% increase).



Updates from the Western Pacific Region

Key weekly updates

WHO Director-General's key messages

- In his opening remarks at the 18 August media briefing on COVID-19, the Director-General called for
  - a moratorium on booster shots to help shift supply to those countries that have not been able to vaccinate their health workers or at risk-risk communities and are now experiencing major surge in cases.
  - equitable allocation of Interleukin-6 blockers, a drug that has shown a reduction in death amongst patients hospitalised with severe COVID-19.
- In his opening remarks at on 19 August, the Director-General provided an update on the setting up of a permanent International Scientific Advisory Group on the Origins of Novel Pathogens (SAGO) to establish a more systematic way of identifying the source of new outbreaks. SAGO will play a vital role in studying the emergence of new pathogens, including the origins of SARS-CoV-2.

Updates and publications

- Joint Statement from Unitaid and the World Health Organization (on behalf of the Access to COVID-19 Tools Accelerator) regarding availability of tocilizumab
- Call for experts to join Scientific Advisory Group for the Origins of Novel Pathogens
- Making clean cooking affordable and accessible during COVID-19: 'Pay-as-you-go' smart meters promote health equity, Nairobi

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 24 August 2021**

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Afghanistan	●	-	-	●	-
Albania	●	-	-	○	-
Algeria	●	-	-	●	-
Andorra	○*	○*	-	○*	-
Angola	●	●	●*	●	-
Anguilla	●	-	-	●	-
Antigua and Barbuda	●	●	●*	●*	-
Argentina	●	●	●	●	-
Armenia	●	-	-	●	-
Aruba	●	●	●	●	-
Australia	●	●	●	●	-
Austria	●	●	●	●	-
Azerbaijan	●	-	-	○	-
Bahamas	●	-	-	-	-
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	●	-	-	-	-
Burundi	●	●	-	●	-
Cabo Verde	●	-	-	●	-
Cambodia	●	●	-	●	-
Cameroon	●	●	-	-	-
Canada	●	●	●	●	-
Cayman Islands	●	●*	●	●*	-
Central African Republic	●	●	-	●	-
Chad	●	-	-	-	-
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	●	-	-	●*	-
El Salvador	●	-	●	●	-
Equatorial Guinea	●	●	-	-	-
Estonia	●	●	○	○	-
Eswatini	-	●	-	●	-
Ethiopia	●	-	-	-	-
Falkland Islands (Malvinas)	●	●	-	-	-
Faroe Islands	●	-	●	-	-
Fiji	-	-	-	●	-
Finland	●	●	●	●	-
France	●	●	●	●	-
French Guiana	●	●	●	●	-
French Polynesia	●	●	●	●	-
Gabon	●	●	-	-	-
Gambia	●	-	-	●	-
Georgia	●	○	-	●	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
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]	●	○	-	○	-
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	●	-	-	●	-
Netherlands	●	●	●	●	-
New Caledonia	●	-	-	-	-
New Zealand	●	●	○	○	-
Niger	●	-	-	-	-
Nigeria	●	●	-	●	-
North Macedonia	●	●	-	○	-
Northern Mariana Islands (Commonwealth of the)	○*	-	-	○*	-
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	●	●	-	-	-
Saint Pierre and Miquelon	-	-	-	●*	-

Country/Territory/Area	Alpha	Beta	Gamma	Delta	Unspecified B.1.617
Saint Vincent and the Grenadines	-	-	-	●*	-
Sao Tome and Principe	○	-	-	-	-
Saudi Arabia	●	●	-	●	-
Senegal	●	●	-	●	-
Serbia	●	-	-	●	-
Seychelles	●	●	-	●	-
Sierra Leone	-	-	-	○	-
Singapore	●	●	●	●	-
Sint Maarten	●	●	●*	●	-
Slovakia	●	●	-	●	-
Slovenia	●	●	●	●	-
Somalia	●	●	-	-	-
South Africa	●	●	-	●	-
South Sudan	●	●	-	●	-
Spain	●	●	●	●	-
Sri Lanka	●	●	-	●	-
Sudan	●	●	-	-	-
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 Virgin Islands	●	●	-	●	-
United States of America	●	●	●	●	-
Uruguay	●	●	●	●	-
Uzbekistan	●	●	-	○	-
Venezuela (Bolivarian Republic of)	●	-	●	●	-
Viet Nam	●	●	-	●	-
Wallis and Futuna	●	-	-	-	-
Yemen	●	●	-	-	-
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.
****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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