

COVID-19 Epidemiological Update

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Key highlights

- SARS-CoV-2 PCR percent positivity was 7.3% from 79 countries during the week ending on 28 April 2024, as detected in integrated sentinel surveillance as part of the Global Influenza Surveillance and Response System (GISRS) and reported to FluNet.
- KP.3 and KP.2, both descendent lineages of JN.1 and variants under monitoring (VUMs) accounted for 20.0% and 9.6% of sequences in week 17 compared to 3.5% and 6.4% in week 14, respectively. Globally, JN.1 is the most reported variant of interest (VOI) (now reported by 130 countries), accounting for 54.3% of sequences in week 17 and having declined from a prevalence of 69.0% in week 14. The [updated risk evaluation for JN.1](#) was published on 15 April 2024, with an overall evaluation of low public health risk at the global level based on available evidence. WHO is currently tracking several SARS-CoV-2 variants: five VOIs – XBB.1.5, XBB.1.16, EG.5 BA.2.86 and JN.1; and four variants under monitoring (VUMs): JN.1.7, JN.1.18, KP.2 and KP.3.
- Globally, during the 28-day period from 1 to 28 April 2024, 92 countries reported COVID-19 cases and 35 countries reported COVID-19 deaths. *Note that this does not reflect the actual number of countries where cases or deaths occur, as many countries have stopped or changed the frequency of reporting.*
- From the available data, the number of reported cases and deaths have decreased during the 28-day period, with over 145 000 new cases and more than 2600 new deaths, a decrease of 48% and 44%, respectively, compared to the previous 28 days (4 to 31 March 2024). *Trends in the number of reported new cases and deaths should be interpreted with caution due to decreased testing and sequencing, alongside reporting delays in many countries.* According to estimates obtained from wastewater surveillance, clinical detection of cases underestimates the real burden from 2 to 19-fold.
- During the 28-day period from 1 to 28 April 2024, 44 and 33 countries provided data at least once on COVID-19 hospitalizations and admissions to an intensive care unit (ICU), respectively. From the available data, over 32 000 new hospitalizations and more than 400 new ICU admissions were reported during the 28-day period. Amongst the countries reporting these data consistently over the current and past reporting period, there was an overall decrease of 35% and 45% in new hospitalizations and new ICU admissions, respectively.
- The [global WHO COVID-19 dashboard](#) was updated and adapted with a new interface on 22 December 2023 to support WHO and Member States' work to transition from COVID-19 as an emergency to longer-term disease management, as outlined in WHO's COVID-19 [2023-2025 Updated Strategic Preparedness and Response Plan](#). The new dashboard will progressively incorporate more components throughout 2024. The link of the previous Global WHO Coronavirus (COVID-19) Dashboard will still be active and redirect users to the new one from 22 December onward.

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

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

Global overview

Data as of 28 April 2024

Globally, the number of new weekly cases decreased by 48% during the 28-day period of 1 to 28 April 2024 as compared to the previous 28-day period, with just under 0.1 million new cases reported (Figure 1, Table 1). The number of new weekly deaths decreased by 44% as compared to the previous 28-day period, with over 2600 new fatalities reported. As of 28 April 2024, over 775 million confirmed cases and over 7 million deaths have been reported globally. According to estimates obtained from viral loads in wastewater surveillance, clinical detection of cases underestimated the real burden 2 to 19-fold.^{1,2,3}

Reported cases do not accurately represent infection rates due to the reduction in testing and reporting globally. During this 28-day period, only 39% (92 of 234) of countries reported at least one case to WHO. It is important to note that this statistic does not reflect the actual number of countries with cases. Additionally, data from the previous 28-day period are continuously being updated to incorporate retrospective changes made by countries regarding reported COVID-19 cases and deaths. Data presented in this report are therefore incomplete and should be interpreted considering these limitations. Some countries continue to report high burdens of COVID-19, including increases in newly reported cases and, more importantly, increases in hospitalizations and deaths – the latter of which are considered more reliable indicators given reductions in testing. Global and national data on SARS-CoV-2 PCR percent positivity are available on [WHO's integrated influenza and other respiratory viruses surveillance dashboard](#). Recent data (epidemiological week 17, 22 to 28 April 2024) from sentinel sites show that the SARS-CoV-2 PCR percent positivity from reporting countries averages approximately 7.3% from 79 countries (Figure 2).

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

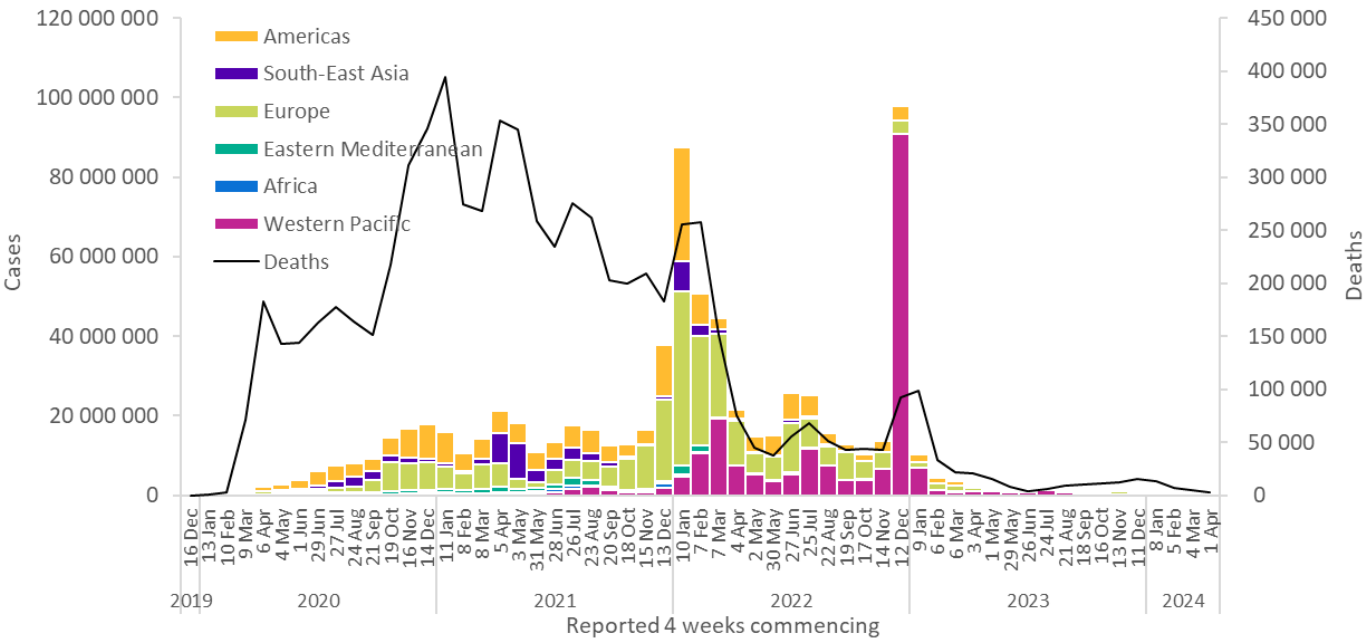
1. Show us the data: global COVID-19 wastewater monitoring effectors, equity, and gaps

2. Capturing the SARS-CoV-2 infection pyramid within the municipality of Rotterdam using longitudinal sewage surveillance

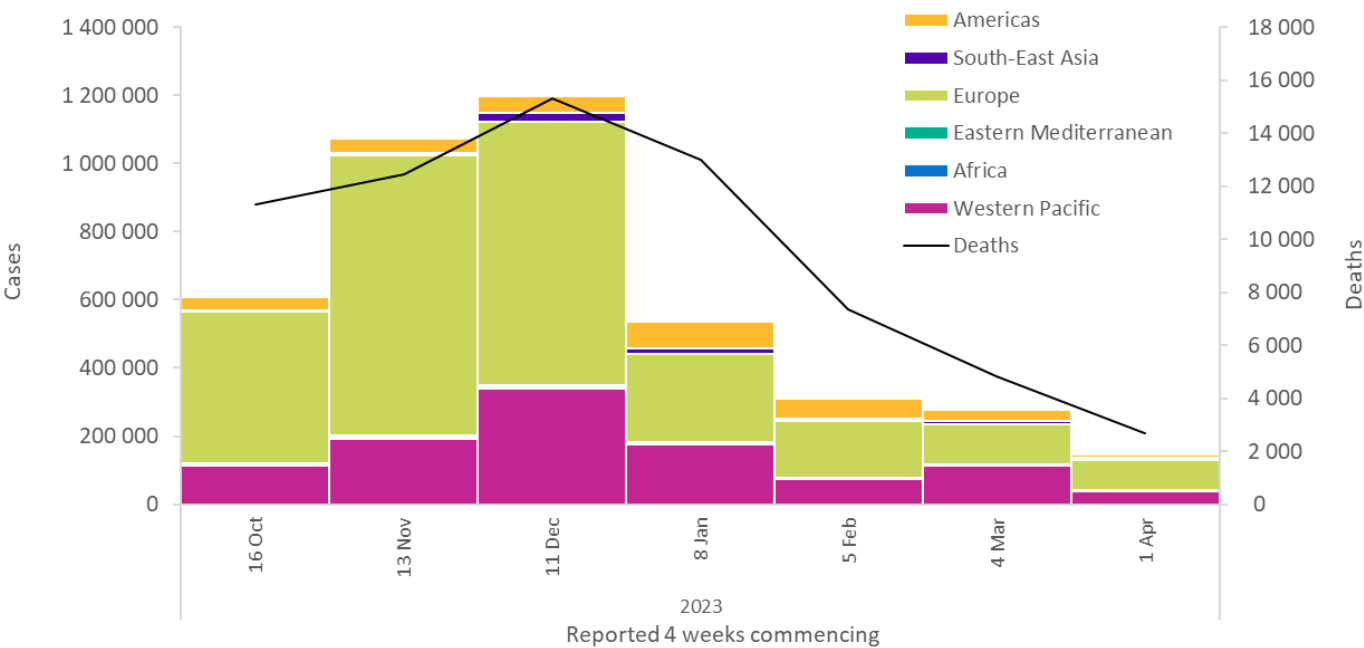
3. Omicron COVID-19 Case Estimates Based on Previous SARS-CoV-2 Wastewater Load, Regional Municipality of Peel, Ontario, Canada

Figure 1. COVID-19 cases and global deaths by 28-day intervals reported by WHO Region, as of 28 April 2024 (A); 16 October 2023 to 28 April 2024 (B)**

A



B



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

At the regional level, the number of newly reported 28-day cases decreased or remained stable across four of the six WHO regions: the Region of the Americas (-75%), the Western Pacific Region (-67%), the European Region (-25%), and the South-East Asia Region (-2%); while case numbers increased in two WHO regions: the African Region (+18%), and the Eastern Mediterranean Region (+45%). The number of newly reported 28-day deaths decreased across five regions: the Eastern Mediterranean Region (-78%), the Region of the Americas (-46%), the Western Pacific Region (-42%), the European Region (-31%), and the South-East Asia Region (-28%); while death numbers increased in the African Region (4 vs 1; +75%).

At the country level, the highest numbers of new 28-day cases were reported from the Russian Federation (69 311 new cases; -27%), Australia (18 483 new cases; -18%), New Zealand (11 180 new cases; -86%), the United Kingdom (6586 new cases; +6%), and China (5713 new cases; -47%). The highest numbers of new 28-day deaths were reported from the United States of America (1904 new deaths; -47%), the Russian Federation (254 new deaths; -12%), Chile (100 new deaths; -11%), Australia (87 new deaths; -44%), China (51 new deaths; -44%), and New Zealand (49 new deaths; -38%).

Table 1. Newly reported and cumulative COVID-19 confirmed cases and deaths, by WHO Region, as of 28 April 2024**

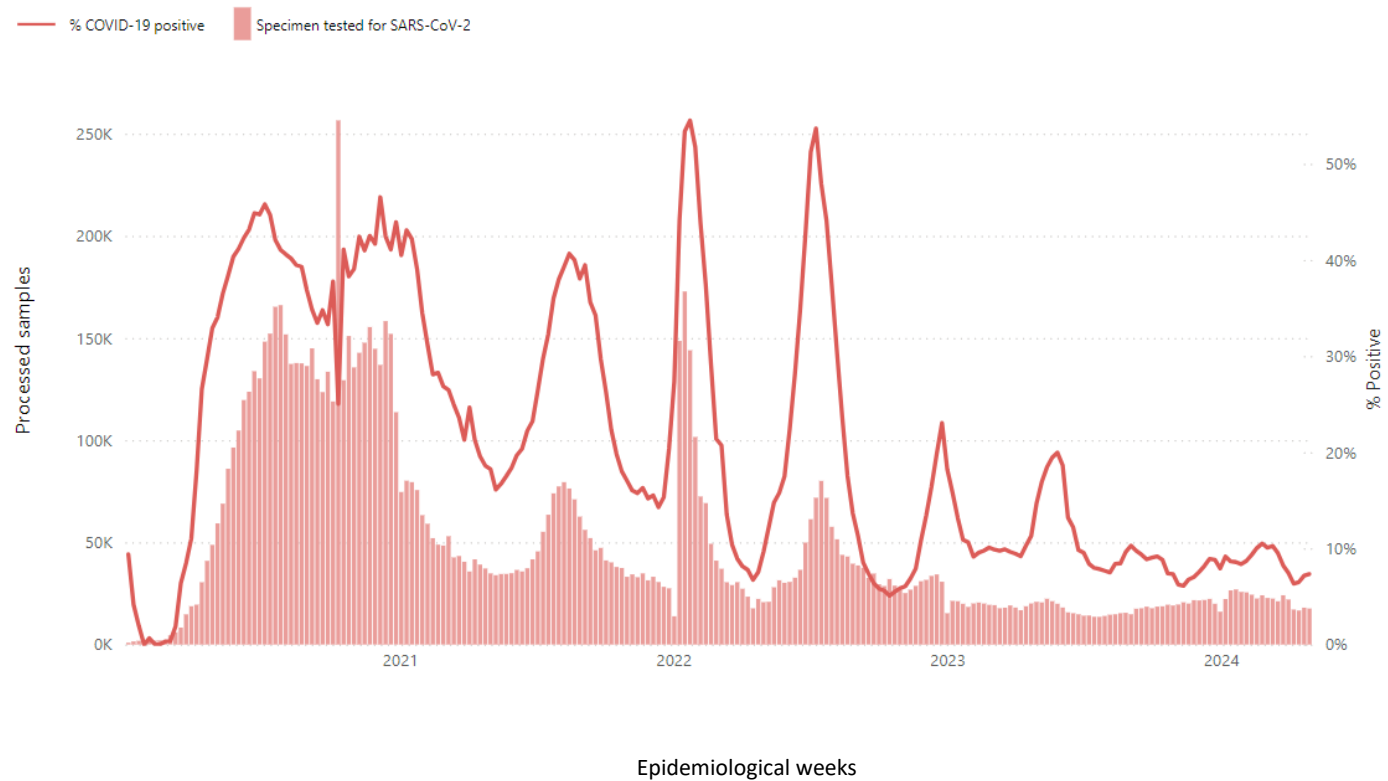
WHO Region	New cases in last 28 days (%)	Change in new cases in last 28 days *	Cumulative cases (%)	New deaths in last 28 days (%)	Change in new deaths in last 28 days *	Cumulative deaths (%)	Countries reporting cases in the last 28 days	Countries reporting deaths in the last 28 days
Europe	89 398 (61%)	-25%	279 334 693 (36%)	388 (14%)	-31%	2 272 097 (32%)	33/61 (54%)	15/61 (25%)
Western Pacific	37 923 (26%)	-67%	208 417 021 (27%)	189 (7%)	-42%	420 809 (6%)	13/35 (37%)	4/35 (11%)
Americas	8 636 (6%)	-75%	193 371 089 (25%)	2 059 (76%)	-46%	3 018 275 (43%)	13/56 (23%)	7/56 (12%)
South-East Asia	7 511 (5%)	-2%	61 281 343 (8%)	55 (2%)	-28%	808 638 (11%)	5/10 (50%)	4/10 (40%)
Eastern Mediterranean	1 338 (1%)	45%	23 417 273 (3%)	2 (0%)	-78%	351 974 (5%)	3/22 (14%)	2/22 (9%)
Africa	825 (1%)	18%	9 579 431 (1%)	4 (0%)	75%	175 510 (2%)	25/50 (50%)	3/50 (6%)
Global	145 631 (100%)	-48%	775 401 794 (100%)	2697 (100%)	-44%	7 047 316 (100%)	92/234 (39%)	35/234 (15%)

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

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

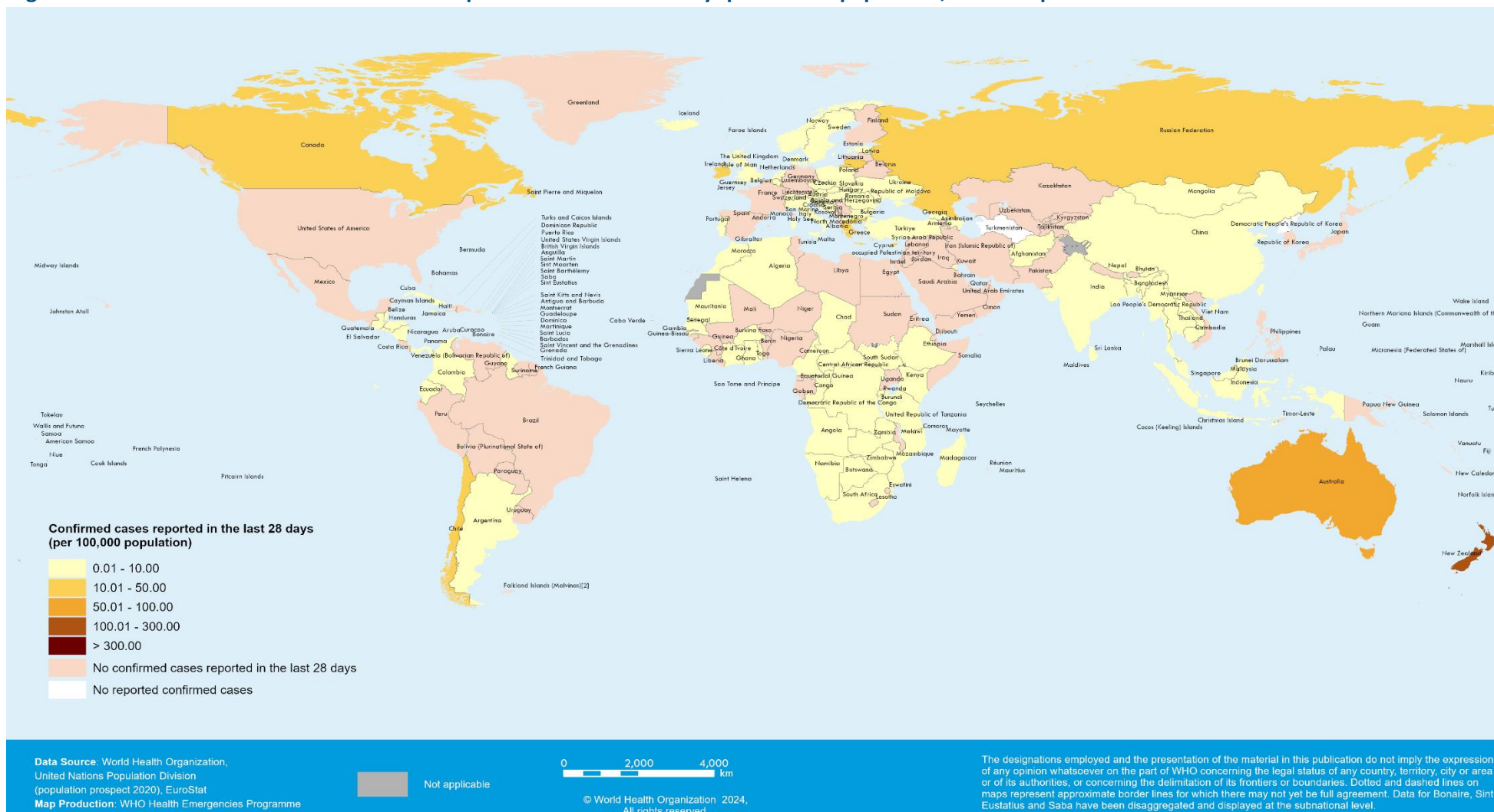
Figure 2. SARS-CoV-2 specimens tested, and test positivity rates reported to FluNet from sentinel sites; 5 February 2020 to 28 April 2024

SARS-CoV-2 tested specimens reported to FluNet from countries, areas and territories



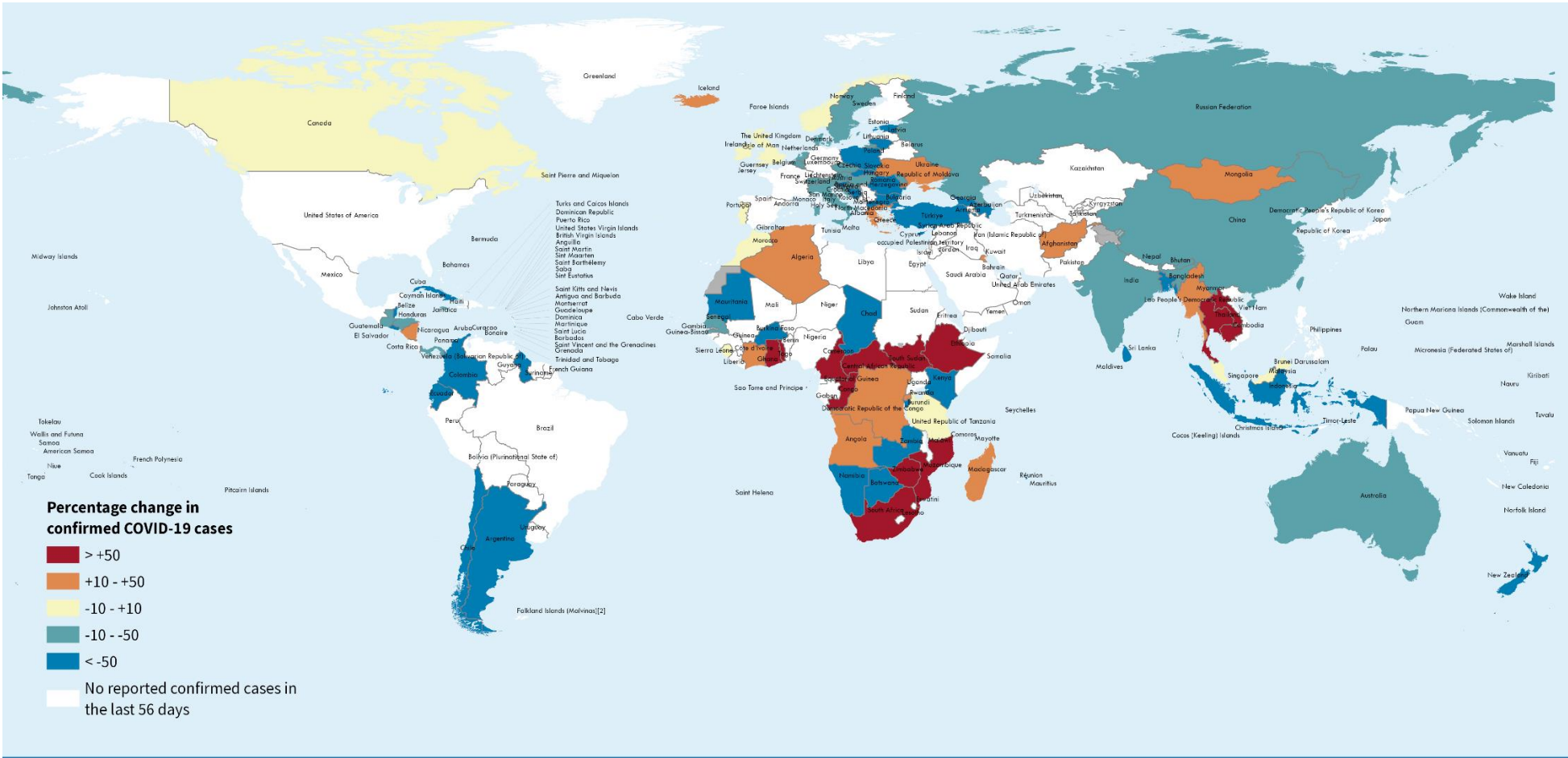
Source: *Influenza and SARS-CoV-2 surveillance data from GISRS reported to FluNet; WHO Global Influenza Programme*

Figure 3. Number of confirmed COVID-19 cases reported over the last 28 days per 100 000 population, as of 28 April 2024**



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

Figure 4. Percentage change in confirmed COVID-19 cases over the last 28 days relative to the previous 28 days, as of 28 April 2024**



Data Source: World Health Organization
Map Production: WHO Health Emergencies Programme

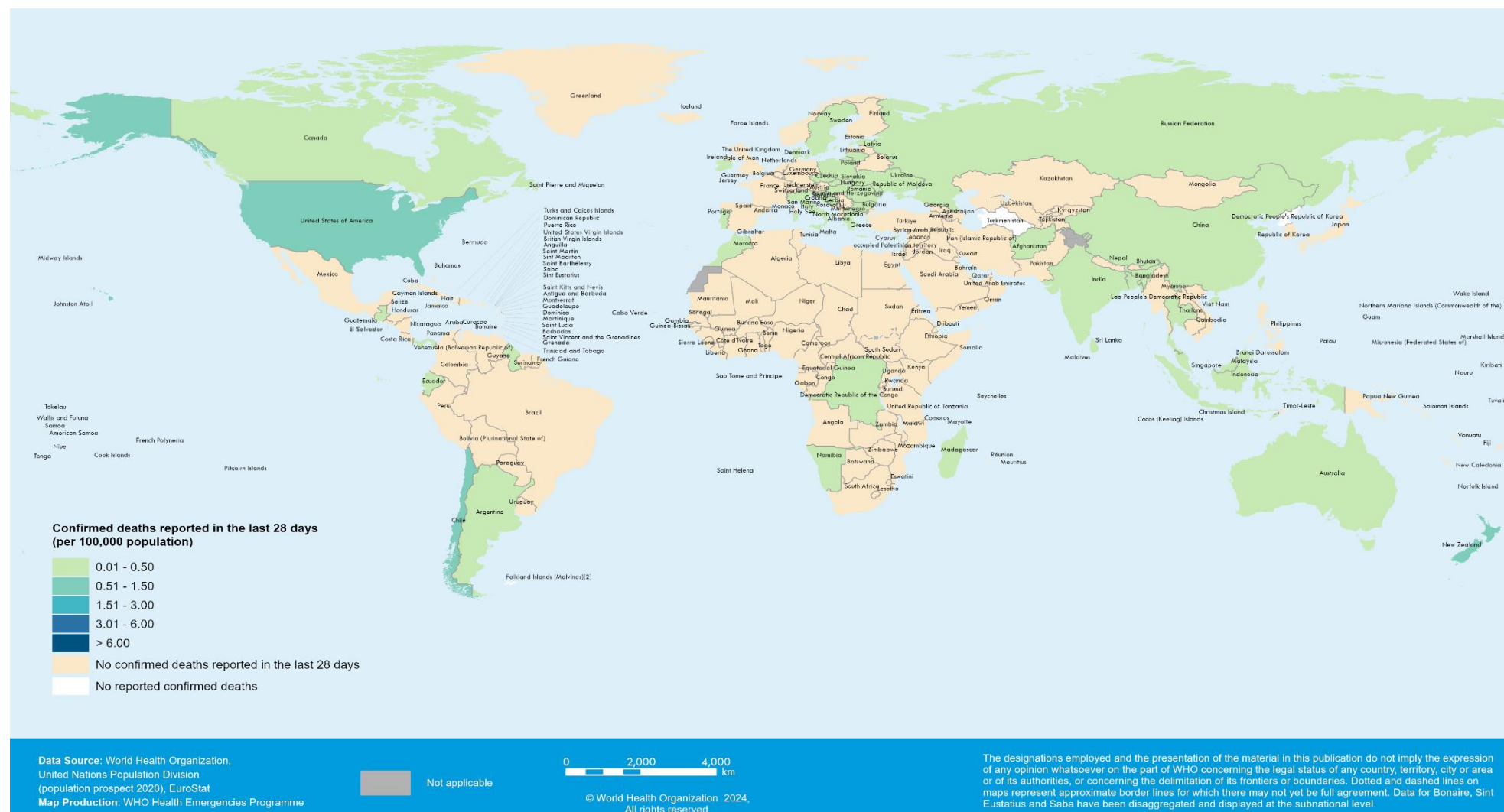
Not applicable

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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. [2] A dispute exists between the Governments of Argentina and the United Kingdom of Great Britain and Northern Ireland concerning sovereignty over the Falkland Islands (Malvinas). Data for Bonaire, Sint Eustatius and Saba have been disaggregated and displayed at the subnational level.

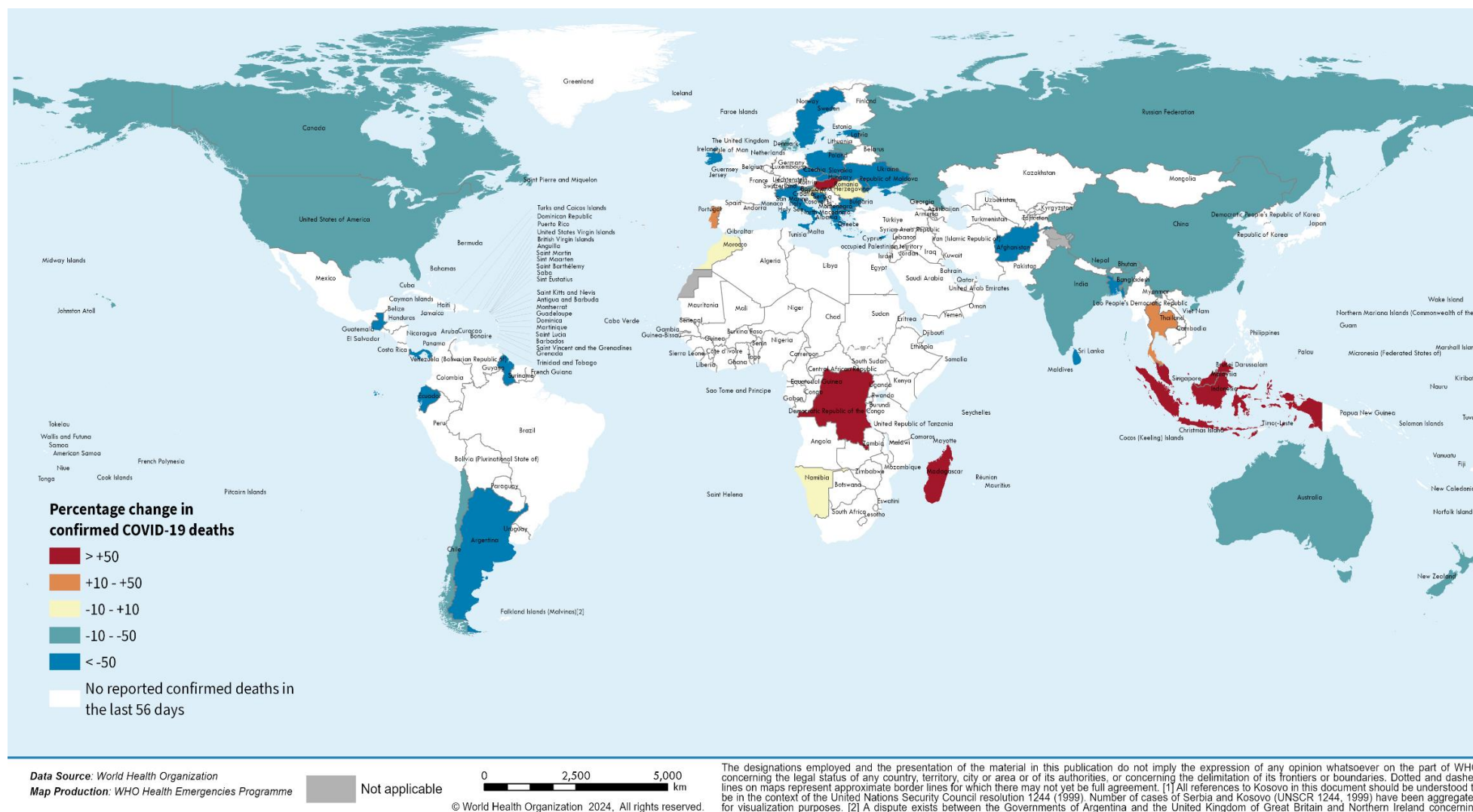
**See [Annex 1: Data, table, and figure notes](#)

Figure 5. Number of COVID-19 deaths reported over the last 28 days per 100 000 population, as of 28 April 2024 **



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

Figure 6. Percentage change in confirmed COVID-19 deaths over the last 28 days relative to the previous 28 days, as of 28 April 2024**



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

Hospitalizations and ICU admissions

At the global level, during the 28 days from 1 to 28 April 2024, a total of 32 766 new hospitalizations and 447 new intensive care unit (ICU) admissions were reported from 44 and 33 countries, respectively (Figure 7). Amongst the countries reporting these data consistently over the current and past reporting period, there was an overall decrease of 35% and 45% in new hospitalizations and new ICU admissions, respectively compared to the previous 28 days (4 to 31 March 2024) (Table 2 and 3). Note that the absence of reported data from some countries to WHO does not imply that there are no COVID-19-related hospitalizations in those countries. The presented hospitalization data are preliminary and might change as new data become available. Furthermore, hospitalization data are subject to reporting delays. These data also likely include both hospitalizations with incidental cases of SARS-CoV-2 infection and those due to COVID-19 disease.

New hospitalizations

During the 28-day period from 1 to 28 April 2024, 44 (19%) countries reported data to WHO on new hospitalizations at least once (Figure 7). The Region of the Americas had the highest proportion of countries reporting data on new hospitalizations (17 countries; 30%), followed by the South-East Asia Region (three countries; 30%), the European Region (16 countries; 26%), the Western Pacific Region (four countries; 11%), and the African Region (four countries; 8%). No country in the Eastern Mediterranean shared data during the period. The number of countries that consistently[§] reported new hospitalizations for the period was 17% (39 countries) (Table 2).

Among the 33 countries consistently reporting new hospitalizations, three (9%) country registered an increase of 20% or greater in hospitalizations during the past 28 days compared to the previous 28-day period: Malta (11 vs 5; +120%), Thailand (4299 vs 2305; +87%), and Brunei Darussalam (7 vs 4; +75%). The highest numbers of new hospital admissions were reported from the United States of America (24 128 vs 41 482; -42%), Thailand (4299 vs 2305; +87%), and New Zealand (722 vs 683; +6%).

[§] “Consistently” as used here refers to countries that submitted data for new hospitalizations and intensive care unit admissions for the eight consecutive weeks (for the reporting and comparison period).

Table 2. Number of new hospitalization admissions reported by WHO regions, 1 to 28 April 2024 compared 4 to 31 March 2024

Region	Countries reported at least once in the past 28 days		Countries reported consistently in the past and previous 28 days*		
	Number of countries (percentage)**	Number of new hospitalizations	Number of countries (percentage)**	Number of new hospitalizations	Percent change in new hospitalizations
Africa	4/50 (8%)	0 [#]	3/50 (6%)	0	N/A
Americas	17/56 (30%)	25 946	15/56 (27%)	25 334	-43%
Eastern Mediterranean	0/22 (<1%)	N/A *	0/22 (<1%)	N/A	N/A
Europe	16/61 (26%)	1533	14/61 (23%)	1521	-23%
South-East Asia	3/10 (30%)	4330	3/10 (30%)	4330	+83%
Western Pacific	4/35 (11%)	957	4/35 (11%)	957	+3%
Global	44/234 (19%)	32 766	39/234 (17%)	32 142	-35%

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

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

* N/A represents not available or applicable.

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

New ICU admissions

Across the six WHO regions, in the past 28 days, a total of 33 (14%) countries reported data to WHO on new ICU admissions at least once (Figure 8). The European Region had the highest proportion of countries reporting data on new ICU admissions (14 countries; 23%), followed by the Region of the Americas (nine countries; 16%), the Western Pacific Region (five countries; 14%), the South-East Asia (one country; 10%), and the African Region (four countries; 8%). The Eastern Mediterranean Region did not share data during the period. The proportion of countries that consistently reported new ICU admissions for the period was 12% (27 countries).

Among the 27 countries consistently reporting new ICU admissions, one (4%) country showed an increase of 20% or greater in new ICU admissions during the past 28 days compared to the previous 28-day period: Australia (77 vs 64; +20%). The highest numbers of new ICU admissions were reported from Australia (77 vs 64; +48%), Canada (55 vs 60; -8%), and Malaysia (32 vs 30; +7%)

Table 3. Number of new ICU admissions reported by WHO regions, 1 to 28 April 2024 compared to 4-31 March 2024

Region	Countries reported at least once in the past 28 days		Countries reported consistently in the past and previous 28 days*		
	Number of countries (percentage)**	Number of new ICU admissions	Number of countries (percentage)**	Number of new ICU admissions	Percent change in new ICU admissions
Africa	4/50 (8%)	1	3/50 (6%)	0 [#]	N/A
Americas	9/56 (16%)	275	6/56 (11%)	86	-68%
Eastern Mediterranean	0/22 (<1%)	N/A ⁺	0/22 (<1%)	N/A	N/A
Europe	14/61 (23%)	37	12/61 (20%)	33	-47%
South-East Asia	1/10 (10%)	3	1/10 (10%)	3	-80%
Western Pacific	5/35 (14%)	131	5/35 (14%)	131	+14%
Global	33/235 (14%)	447	27/235 (12%)	254	-45%

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

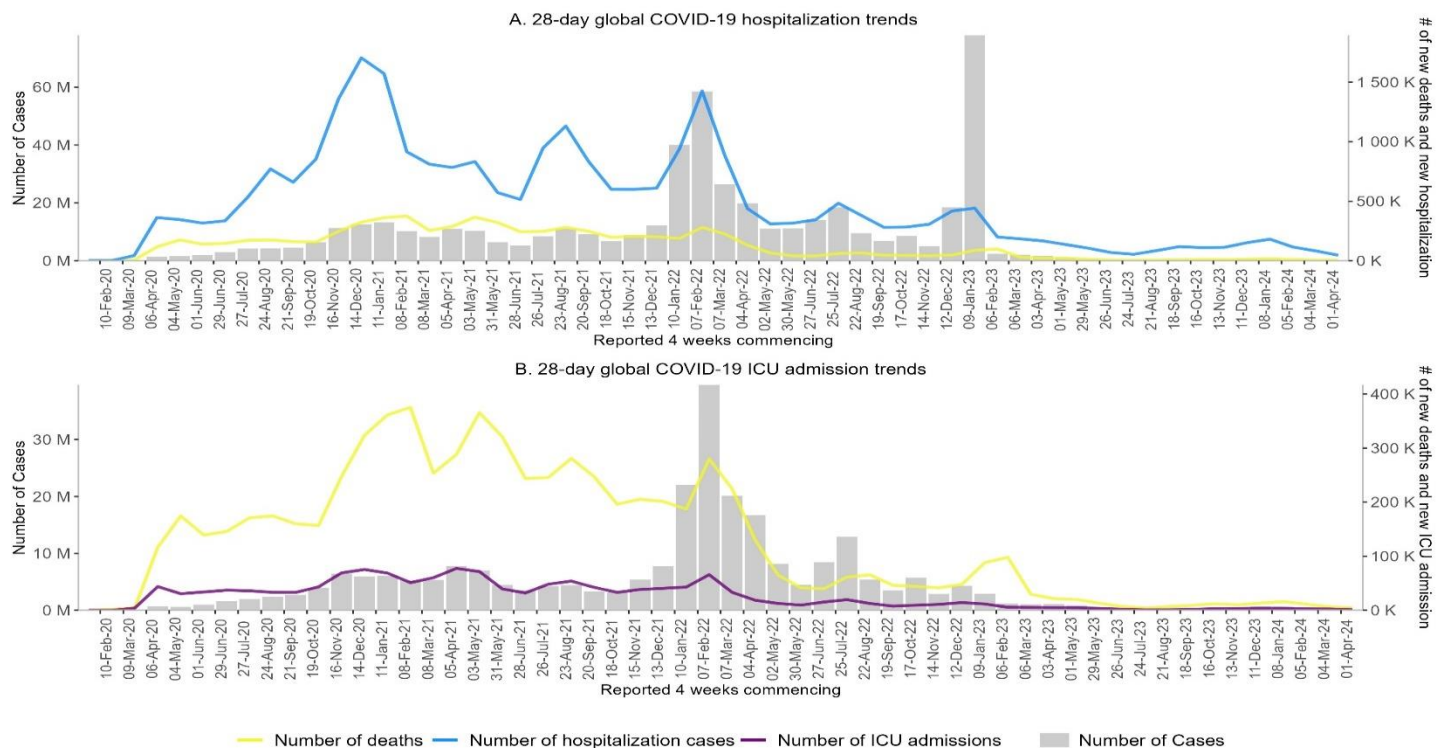
**Number of countries reported / total number of countries in the region (percentage of reporting).

⁺ N/A represents data not available or applicable.

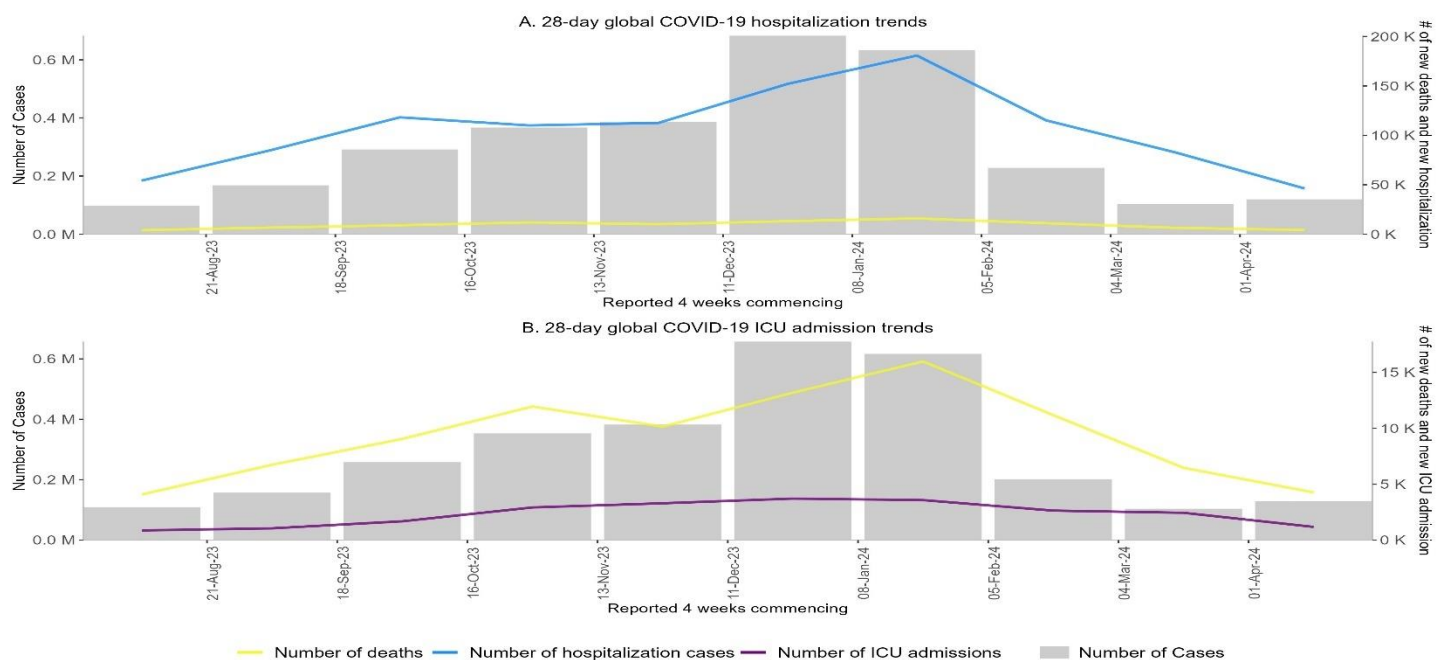
[#] WHO emphasizes the importance of maintaining reporting and encourages countries to report the absence of new admissions ("zero reporting") if there are no new hospital or ICU admissions during the week.

Figure 7. 28-day global COVID-19 new hospitalizations and ICU admissions, from 10 February 2020 to 28 April 2024 (A); and from 21 August 2023 to 28 April 2024 (B)

A



B



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

Severity indicators

The ICU-to-hospitalization ratio and death-to-hospitalization ratio have been key indicators for understanding COVID-19 severity throughout the pandemic. The ICU-to-hospitalization ratio is used to assess the proportion of patients requiring ICU admission in relation to the total number of hospitalizations. The death-to-hospitalization ratio is used to assess the proportion of deaths in relation to hospitalized patients.

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

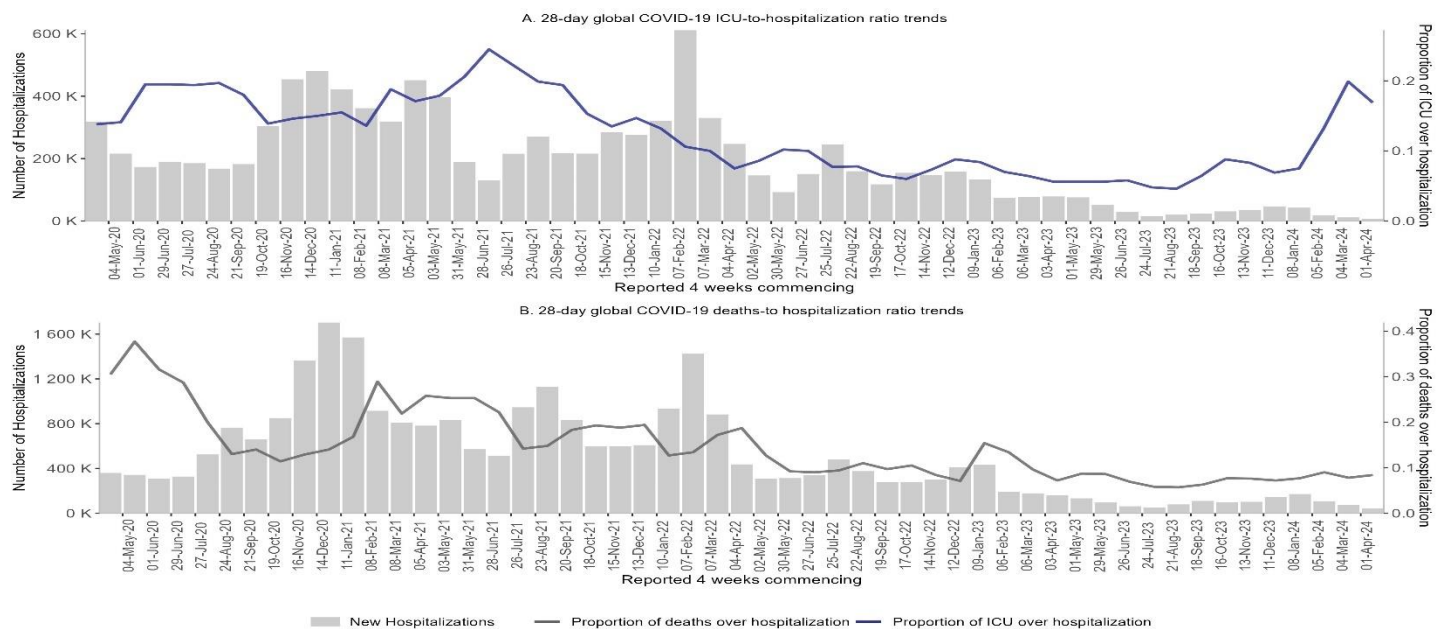
Overall, the ICU-to-hospitalization ratio has been decreasing since the peak in July 2021 when the ratio was 0.25, dropping below 0.15 since the beginning of 2022, and to less than 0.1 by the end of 2023 (Figure 8). Since the beginning of 2024, there has been an increase in this ratio, rising to above 0.2 in March, and declining to 0.16 in April 2024. We should note that due to limited reporting this does not suggest a global increase in the proportion of new hospitalizations requiring intensive care. The number of countries reporting both ICU admissions and hospitalizations continues to decline, and a downward trend of admissions is observed in most of the reporting countries (Table 2 and 3). The combination of these two factors facilitates the fluctuations in the global trend driven by only one or two countries.

The death-to-hospitalization ratio has been showing a general decline since July 2021. Since January 2023, it has remained under 0.15, varying between 0.06 to 0.10. This is an encouraging trend indicating a lower mortality risk among hospitalized individuals.

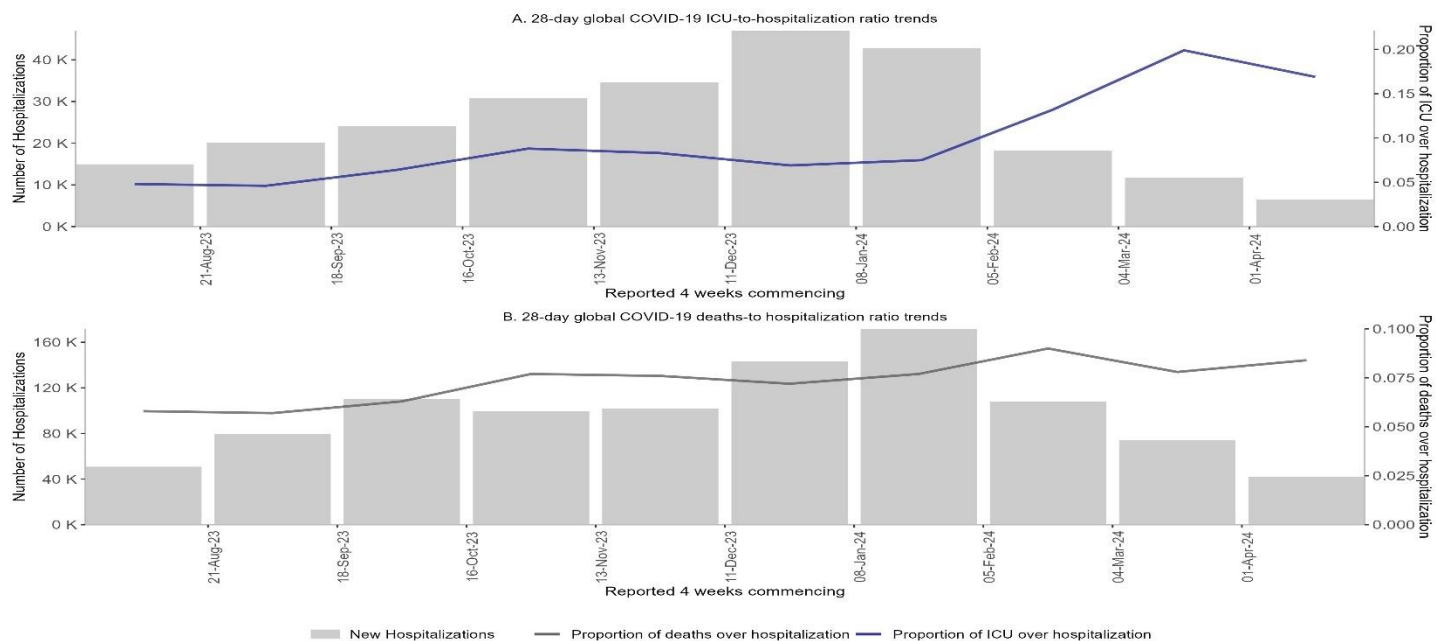
Please note that the causes for these trends cannot be directly interpreted from these data, but likely include a combination of increases in infection-derived or vaccine-derived immunity, improvements in early diagnosis and clinical care, reduced strain on health systems, and other factors. It is not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

Figure 8. COVID-19 ICU-to-hospitalization ratio and death-to-hospitalization ratio, from 04 May 2020 to 28 April 2024 (A), and 21 August 2023 to 28 April 2024 (B)

A



B



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

Source: [WHO COVID-19 Detailed Surveillance Dashboard](#)

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

Geographic spread and prevalence

Globally, during the 28-day period from 1 to 28 April 2024, 12 024 SARS-CoV-2 sequences were shared through GISAID. In comparison, in the two previous 28-day periods, there were 24 317 and 42 030 sequences shared, respectively. The data are periodically retrospectively updated to include sequences with earlier collection dates, so the number of submissions in a given time period may change.

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

- Five variants of interest (VOIs): XBB.1.5, XBB.1.16, EG.5, BA.2.86 and JN.1
- Variants under monitoring (VUMs): JN.1.7, JN.1.18, KP.2 and KP.3

Table 4 shows the number of countries reporting VOIs and VUMs, and their prevalence from epidemiological week 14 (1 to 7 April 2024) to week 17 (22 to 28 April 2024). The VOIs and VUMs exhibiting increasing trends are highlighted in yellow, those that have remained stable are highlighted in blue, and those with decreasing trends are highlighted in green.

Globally, JN.1 is the most reported VOI (now reported by 130 countries), accounting for 54.3% of sequences in week 17 and having declined from a prevalence of 69.0% in week 14 (Figure 10, Table 4). Its parent lineage, BA.2.86, continues to decline in prevalence, accounting for 0.5% in week 17 compared to 0.8% in week 14 (Figure 10, Table 4). The [updated risk evaluation for JN.1](#) was published on 15 April 2024, with an overall public health risk remaining low at the global level based on the newly gathered evidence as per the last updated risk evaluation published on 9 February 2024.

The other VOIs, XBB.1.5, XBB.1.16 and EG.5, have either decreased or been stable in global prevalence during the same period: XBB.1.16 had no reported sequences in week 17, a decrease from 0.1% in week 14; XBB.1.5 also had no reported sequences in week 17, a decrease from 0.1% in week 14; EG.5 similarly had no reported sequences in week 17, a decrease from 1.3% in week 14 (Figure 10, Table 4).

Four JN.1 descendent lineages, JN.1., JN.1.18, KP.2 and KP.3 were listed as VUMs on 3 May 2024 based on their genetic profile, prevalence and growth advantage globally and across the WHO regions. KP.2 accounted for 9.6% of sequences in week 17 compared to 6.4% in week 14, KP.3 accounted for 20.0% of sequences in week 17 compared to 3.5% in week 14, JN.1.7 accounted for 8.8% of sequences in week 17 compared to 9.2% in week 14, and JN.1.18 accounted for 0.8% of sequences in week 17 compared to 3.1% in week 14.

Sufficient sequencing data to calculate variant prevalence at the regional level during weeks 14 to 17 were available from three WHO regions: the Region of the Americas, the Western Pacific Region, and the European Region (Table 5). Among the VOIs, JN.1 was the most reported variant and showing a decreasing trend in all the three regions. The other VOIs in all three regions observed decreasing trends. For the VUMs, KP.2 and KP.3 showed increasing trends whereas JN.1.7 and JN.1.18 showed decreasing trends in the three regions.

With declining rates of testing and sequencing globally (Figure 10), it is increasingly challenging to estimate the severity impact of emerging SARS-CoV-2 variants. There are currently no reported laboratory or epidemiological reports indicating any association between VOIs/VUMs and increased disease severity. As shown in Figure 9 and Figure 10, low and unrepresentative levels of SARS-CoV-2 genomic surveillance continue to pose challenges in adequately assessing the variant landscape.

Table 4. Weekly prevalence of SARS-CoV-2 VOIs and VUMs, week 14 of 2024 to week 17 of 2024

Lineage*	Countries§	Sequences§	2024-14	2024-15	2024-16	2024-17
VOIs						
XBB.1.5	144	379340	0.1	-	0.1	-
XBB.1.16	132	127947	0.1	0.1	-	-
EG.5	112	219047	1.3	0.3	0.2	-
BA.2.86	94	22737	0.8	0.4	0.4	0.5
JN.1	130	189395	69.0	67.0	61.2	54.3
VUMs						
JN.1.7	58	5977	9.2	8.4	7.1	8.8
KP.2	27	1670	6.4	9.6	13.4	9.6
KP.3	20	830	3.5	5.9	11.2	20.0
JN.1.18	61	2275	3.1	2.8	1.6	0.8
Unassigned	75	30077	0.1	0.1	-	-



§ Number of countries and sequences are since the emergence of the variants.

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

Table 5. Weekly prevalence of SARS-CoV-2 VOIs and VUMs by WHO regions, week 14 to week 17 of 2024

Lineage* (week 14-2024 to 17-2024)	AMR	AFR¥	EMR¥	EUR	SEAR*	WPR
VOIs						
XBB.1.5	↓			↓		↓
XBB.1.16	↓			↓		↓
EG.5	↓			↓		↓
BA.2.86	↓			↓		↓
JN.1	↓			↓		↓
VUMs						
JN.1.7	↓			↓		↓
KP.2	↑			↑		↑
KP.3	↑			↑		↑
JN.1.18	↓			↓		↓

↑ Increasing trend
↓ Decreasing trend
↔ Stable trend

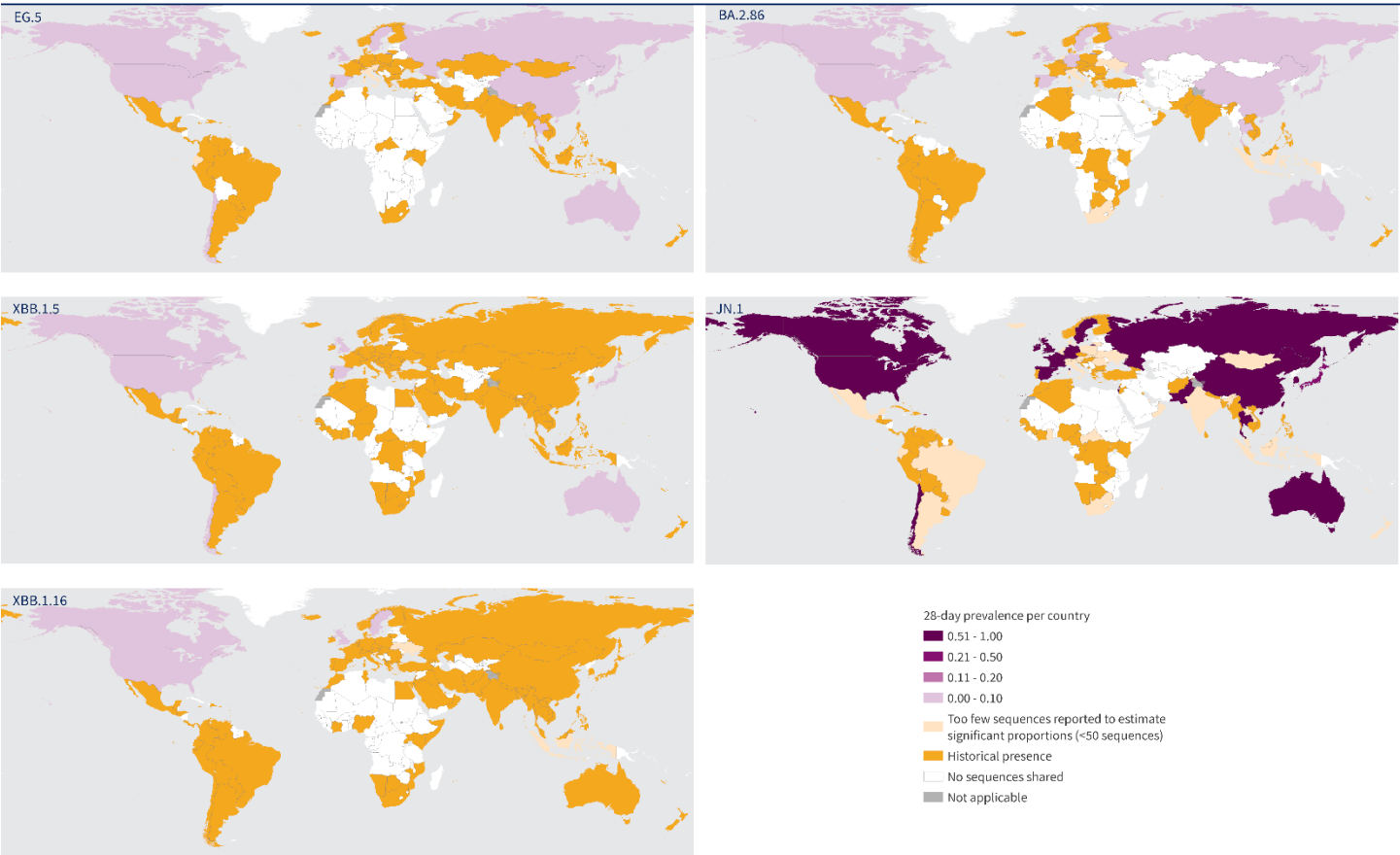
 Insufficient Data
 Most Prevalent variant(s)

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

¥ Due to the small numbers of sequences submitted in these regions, it has not been possible to determine trends for the VOIs and VUMs in these regions; this is also represented by the shaded cells in the table.

Figure 9. Global 28-day prevalence of XBB.1.5, XBB.1.16, EG.5, BA.2.86 and JN.1, 1 to 28 April 2024*

Global 28-day prevalence of EG.5, XBB.1.5, XBB.1.16, BA.2.86 and JN.1 (01 April 2024 to 28 April 2024)



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 Source: World Health Organization, Global Initiative on Sharing All Influenza Data
Map Production: WHO Health Emergencies Programme
Map Date: 10 May 2024

World Health Organization
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* Reporting period to account for delay in sequence submission to GISAID.
+ Historical presence indicates countries previously reporting sequences of VOIs but have not reported within the period from 1 to 28 April 2024

Figure 10. The (A) number and (B) percentage of SARS-CoV-2 sequences, from 1 to 28 April 2024

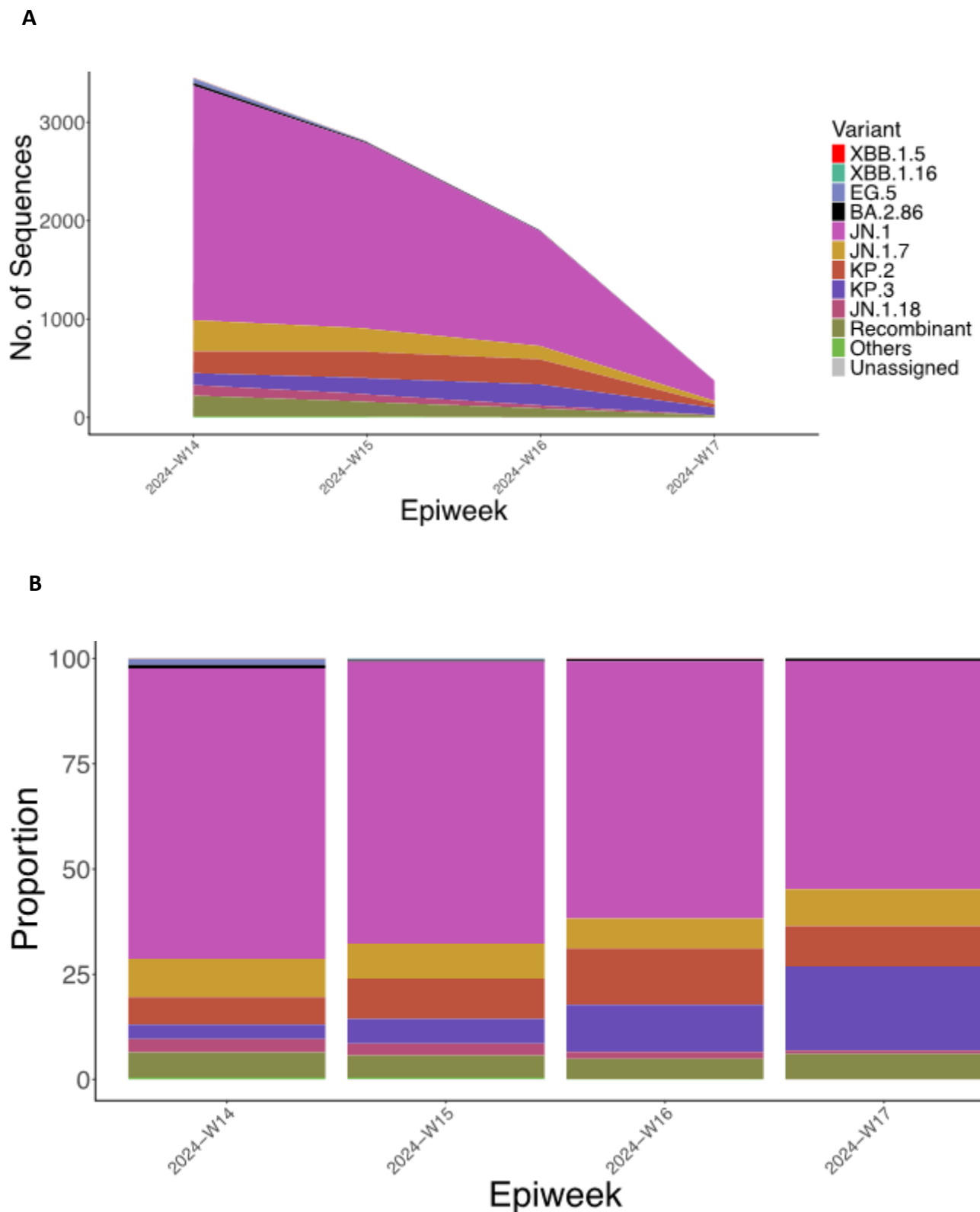


Figure 10. Panel A shows the number, and Panel B the percentage, of all circulating variants from 1 to 28 April 2024. The variants shown here include descendent lineages, except for the descendent lineage(s) listed here. The *Unassigned* category includes lineages pending for a PANGO lineage name designation, *Recombinant* includes all SARS-CoV-2 recombinant lineages not listed here, and the *Other* category includes lineages that are assigned but not listed here. Source: SARS-CoV-2 sequence data and metadata from GISAID, from 1 to 28 April 2024, downloaded on 13th May 2024.

Additional resources

- [Tracking SARS-CoV-2 Variants](#)
- [WHO Global COVID-19 Dashboard Variants Section](#)
- [WHO statement on updated tracking system on SARS-CoV-2 variants of concern and variants of interest](#)
- [SARS-CoV-2 variant risk evaluation framework, 30 August 2023](#)
- [WHO JN.1 Updated Risk Evaluation, 15 April 2024](#)
- [WHO BA.2.86 Initial Risk Evaluation, 21 November 2023](#)
- [WHO EG.5 Updated Risk Evaluation, 21 November 2023](#)
- [WHO XBB.1.5 Updated Risk Assessment, 20 June 2023](#)
- [WHO XBB.1.16 Updated Risk Assessment, 5 June 2023](#)

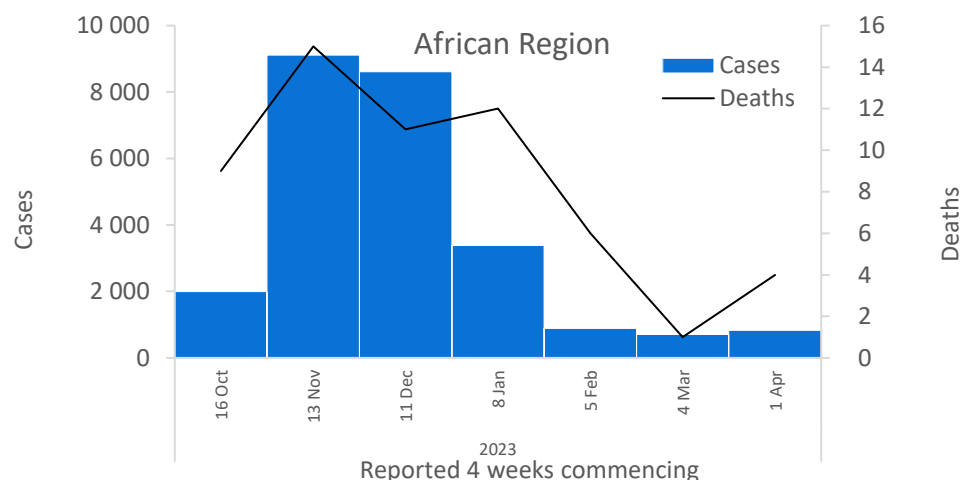
WHO regional overviews

Data for 1 to 28 April 2024

African Region

The African Region reported over 825 new cases, an 18% increase as compared to the previous 28-day period. 17 (34%) of the 50 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Ethiopia (11 vs one new cases; +1000%), Zimbabwe (six vs one new cases; +500%), Cameroon (50 vs nine new cases; +456%), Mozambique (29 vs seven new cases; +314%), Congo (four vs one new cases; +300%), Ghana (139 vs 41 new cases; +239%), South Sudan (three vs one new cases; +200%), South Africa (33 vs 12 new cases; +175%), Sierra Leone (31 vs 15 new cases; +107%), Algeria (14 vs seven new cases; +100%), Angola (60 vs 30 new cases; +100%), Togo (two vs one new cases; +100%), Sao Tome and Principe (24 vs 13 new cases; +85%), Madagascar (12 vs seven new cases; +71%), Democratic Republic of the Congo (217 vs 132 new cases; +64%), Rwanda (18 vs 12 new cases; +50%), and Côte d'Ivoire (26 vs 19 new cases; +37%). The highest numbers of new cases were reported from Democratic Republic of the Congo (217 new cases; <1 new case per 100 000; +64%), Ghana (139 new cases; <1 new case per 100 000; +239%), and Zambia (75 new cases; <1 new case per 100 000; -70%).

The number of new 28-day deaths in the Region increased by 300% as compared to the previous 28-day period, with 4 new deaths reported. The highest numbers of new deaths were reported from Democratic Republic of the Congo (2 new deaths; <1 new death per 100 000; no death reported the previous 28-day period), Madagascar (1 new death; <1 new death per 100 000; no death reported the previous 28-day period), and Namibia (1 new death; <1 new death per 100 000; similar to the previous 28-day period).

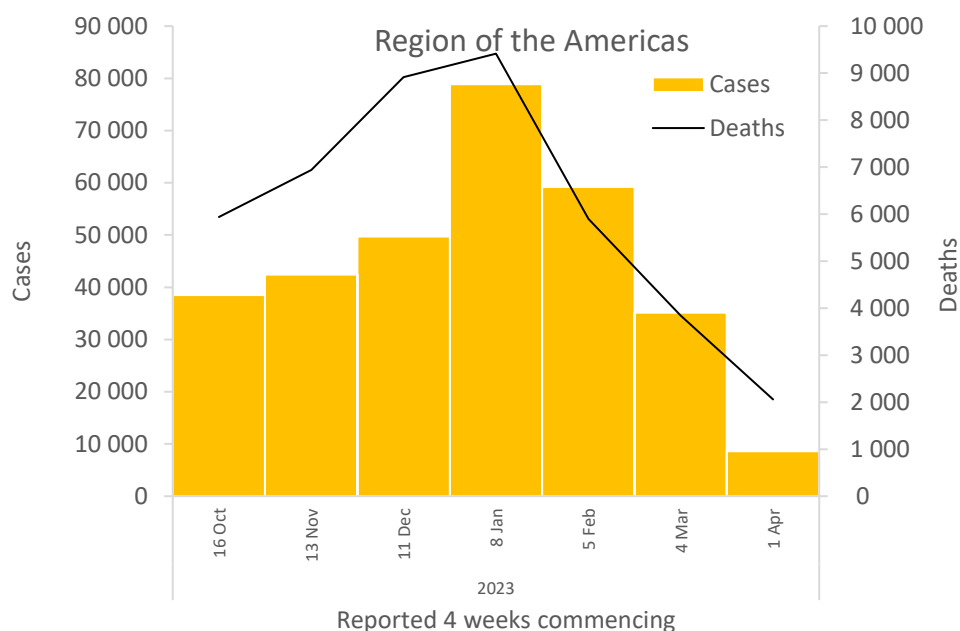


Updates from the [African Region](#)

Region of the Americas

The Region of the Americas reported over 8636 new cases, a 75% decrease as compared to the previous 28-day period. One (2%) of the 56 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Nicaragua (five vs four new cases; +25%). The highest numbers of new cases were reported from Canada (4230 new cases; 11.2 new cases per 100 000; -4%), Chile (2389 new cases; 12.5 new cases per 100 000; -89%), and Argentina (958 new cases; 2.1 new cases per 100 000; -83%).

The number of new 28-day deaths in the Region decreased by 46% as compared to the previous 28-day period, with 2059 new deaths reported. The highest numbers of new deaths were reported from the United States of America (1904 new deaths; <1 new death per 100 000; -47%), Chile (100 new deaths; <1 new death per 100 000; -11%), and Canada (48 new deaths; <1 new death per 100 000; -32%).

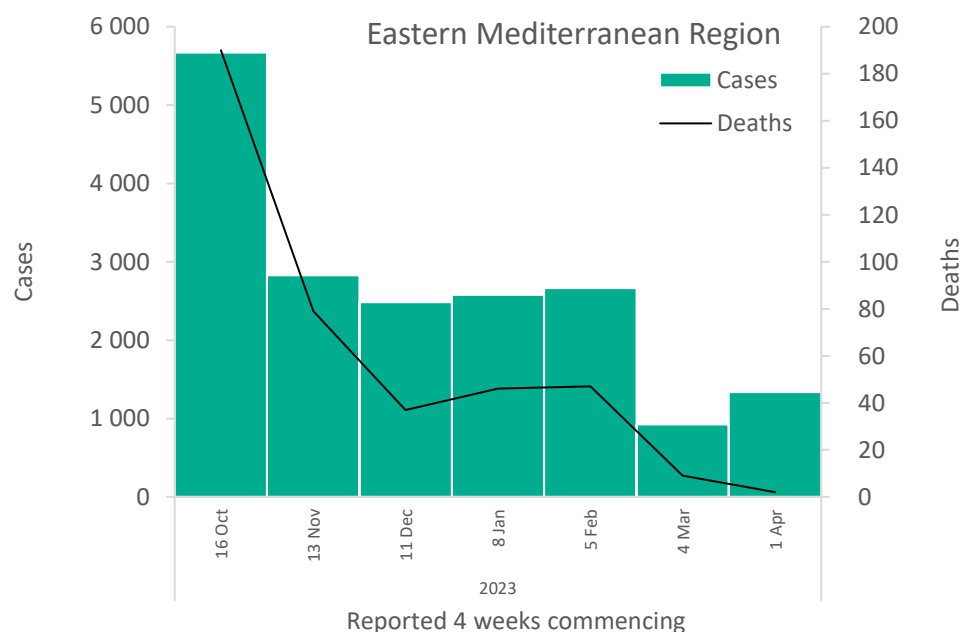


Updates from the [Region of the Americas](#)

Eastern Mediterranean Region

The Eastern Mediterranean Region reported over 1338 new cases, a 45% increase as compared to the previous 28-day period. Two (9%) of the 22 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Afghanistan (1 236 vs 841 new cases; +47%), and Kuwait (67 vs 46 new cases; +46%). The highest numbers of new cases were reported from Afghanistan (1236 new cases; 3.2 new cases per 100 000; +47%), Kuwait (67 new cases; 1.6 new cases per 100 000; +46%), and Morocco (35 new cases; <1 new case per 100 000; -3%).

The number of new 28-day deaths in the Region decreased by 78% as compared to the previous 28-day period, with 2 new deaths reported. The highest numbers of new deaths were reported from Afghanistan (1 new death; <1 new death per 100 000; -88%), and Morocco (1 new death; <1 new death per 100 000; similar to the previous 28-day period).

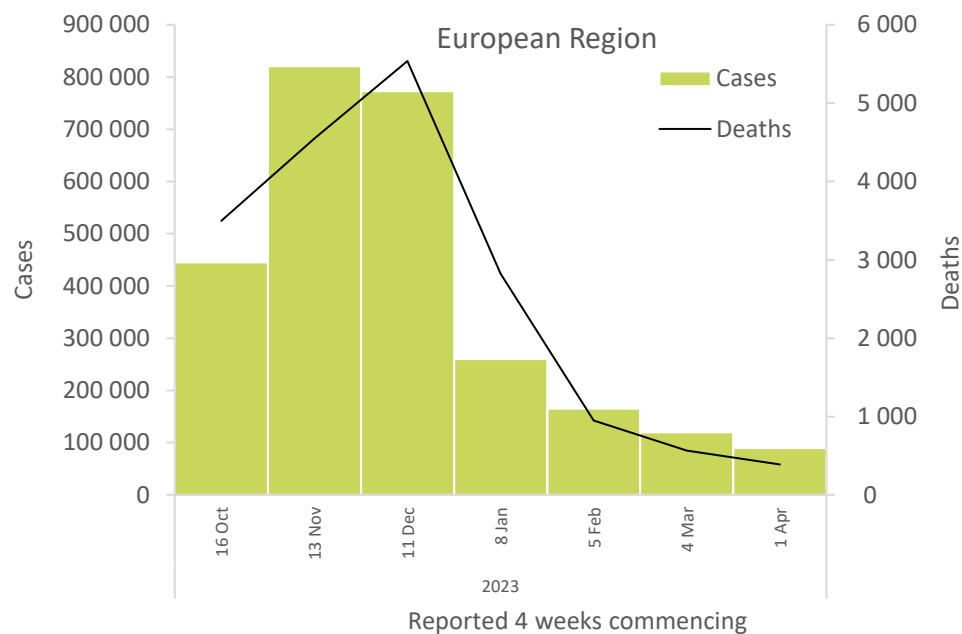


Updates from the [Eastern Mediterranean Region](#)

European Region

The European Region reported over 89 000 new cases, a 25% decrease as compared to the previous 28-day period. One (2%) of the 62 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Iceland (17 vs 12 new cases; +42%). The highest numbers of new cases were reported from the Russian Federation (69 311 new cases; 47.5 new cases per 100 000; -27%), the United Kingdom (6586 new cases; 9.7 new cases per 100 000; +6%), and Greece (4508 new cases; 42.1 new cases per 100 000; +14%).

The number of new 28-day deaths in the Region decreased by 31% as compared to the previous 28-day period, with 388 new deaths reported. The highest numbers of new deaths were reported from the Russian Federation (254 new deaths; <1 new death per 100 000; -12%), Italy (35 new deaths; <1 new death per 100 000; -52%), and Portugal (20 new deaths; <1 new death per 100 000; +43%).

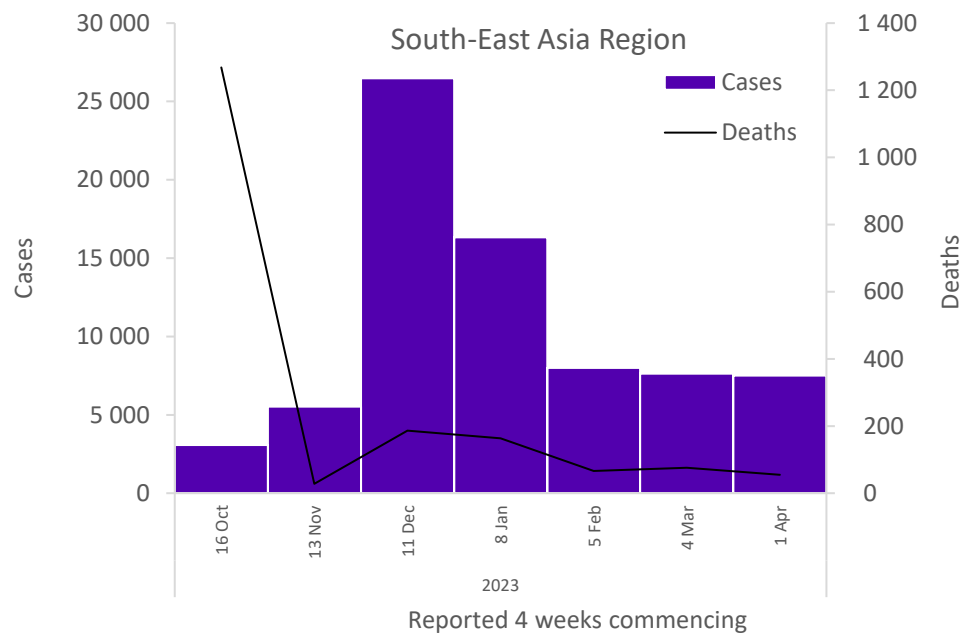


Updates from the [European Region](#)

South-East Asia Region

The South-East Asia Region reported over 7511 new cases, a 2% decrease as compared to the previous 28-day period. Two (18%) of the 11 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Thailand (4 299 vs 2 305 new cases; +87%), and Myanmar (141 vs 114 new cases; +24%). The highest numbers of new cases were reported from Thailand (4299 new cases; 6.2 new cases per 100 000; +87%), India (2593 new cases; <1 new case per 100 000; -37%), and Bangladesh (451 new cases; <1 new case per 100 000; -52%).

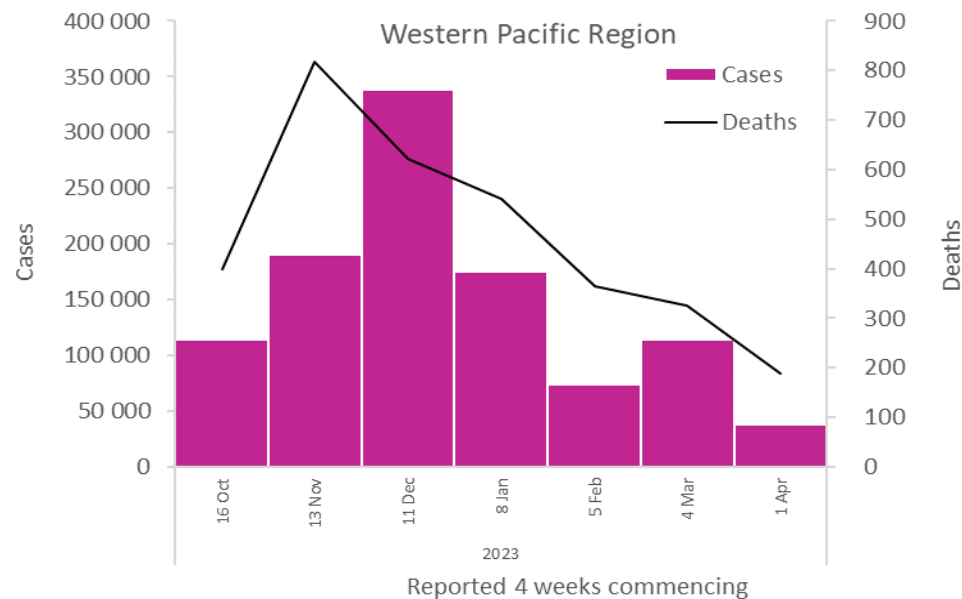
The number of new 28-day deaths in the Region decreased by 28% as compared to the previous 28-day period, with 55 new deaths reported. The highest numbers of new deaths were reported from India (33 new deaths; <1 new death per 100 000; -42%), Thailand (19 new deaths; <1 new death per 100 000; +36%), and Indonesia (2 new deaths; <1 new death per 100 000; +100%).



Western Pacific Region

The Western Pacific Region reported just under 38 000 new cases, a 67% decrease as compared to the previous 28-day period. Three (9%) of the 35 countries for which data are available reported increases in new cases of 20% or greater, with the highest proportional increases observed in Lao People's Democratic Republic (68 vs 14 new cases; +386%), Cambodia (13 vs five new cases; +160%), and Palau (42 vs 25 new cases; +68%). The highest numbers of new cases were reported from Australia (18 483 new cases; 72.5 new cases per 100 000; -18%), New Zealand (11 180 new cases; 231.8 new cases per 100 000; -86%), and China (5713 new cases; <1 new case per 100 000; -47%).

The number of new 28-day deaths in the Region decreased by 42% as compared to the previous 28-day period, with 189 new deaths reported. The highest numbers of new deaths were reported from Australia (87 new deaths; <1 new death per 100 000; -44%), China (51 new deaths; <1 new death per 100 000; -44%), and New Zealand (49 new deaths; 1 new death per 100 000; -38%).



Annex 1. Data, table, and figure notes

Data presented are based on official laboratory-confirmed COVID-19 cases and deaths reported to WHO by country/territories/areas, largely based upon WHO [case definitions and surveillance guidance](#). While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change, and caution must be taken when interpreting these data as several factors influence the counts presented, with variable underestimation of true case and death incidences, and variable delays to reflecting these data at the global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/areas. In some instances, reporting frequencies between national and subnational level might be different and retrospectively completed. Differences are to be expected between information products published by WHO, national public health authorities, and other sources.

A record of historic data adjustment is available upon request by emailing epi-data-support@who.int. Please specify the countries of interest, time period, and purpose of the request/intended usage. Prior situation reports will not be edited; see covid19.who.int for the most up-to-date data.

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

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

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

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

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