

# PAHO



Pan American  
Health  
Organization



World Health  
Organization  
REGIONAL OFFICE FOR THE  
Americas

## Epidemiological Update Coronavirus disease (COVID-19)

22 July 2021

### Executive Summary

- As of 21 July 2021, 191,281,182 confirmed cumulative cases of COVID-19 have been reported globally, including 4,112,538 deaths, for which the Region of the Americas contributed 39% of cases and 48% of deaths.
- In June 2021, the South America subregion continued to contribute the largest number of cases and deaths within the Region, accounting for 4,076,310 cases and 108,331 deaths. This represents 84% and 81% of the cases and deaths reported, respectively, in the Region of the Americas during this month.
- As of 21 July 2021, Argentina, Aruba, Brazil, Canada, Chile, Costa Rica, French Guiana, Guadeloupe, Martinique, Mexico, Puerto Rico, and the United States of America have detected all four variants of concern (VOC).
- Among indigenous populations in 18 countries of the Americas, 617,326 cases were reported, including 14,646 deaths.
- A total of 24 countries and territories have reported 6,681 cumulative confirmed cases of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19, including 135 deaths.
- Regarding health workers, 37 countries and territories have reported 1,763,315 cases, including 10,278 deaths.

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## Context

On 31 December 2019, the People's Republic of China notified a cluster of pneumonia cases with unknown etiology, later identified on 9 January 2020 as a novel coronavirus by the Chinese Center for Disease Control and Prevention. On 30 January 2020, the World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC). On 11 February 2020, WHO named the disease "coronavirus disease 2019 (COVID-19)," and the International Committee on Taxonomy of Viruses (ICTV) named the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)." On 11 March 2020, COVID-19 was declared a pandemic by the WHO Director-General.<sup>1</sup> On 9 July 2020, the WHO Director-General announced the launch of the Independent Panel for Pandemic Preparedness and Response (IPPR), which will independently and comprehensively assess the lessons learned from the international health response to COVID-19.<sup>2</sup>

The eighth meeting of the Emergency Committee convened by the WHO Director-General under the International Health Regulations (2005) (IHR) regarding the coronavirus disease (COVID-19) took place on Wednesday, 14 July 2021. The Director-General determined that the COVID-19 pandemic continues to constitute a PHEIC and accepted the advice of the Committee to WHO and issued the Committee's advice to States Parties as Temporary Recommendations under the IHR, available at: <https://bit.ly/3zlqUHF>.

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<sup>1</sup> WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020. Available at: <https://bit.ly/3cRssQZ>

<sup>2</sup> Independent evaluation of global COVID-19 response announced. Available at: <https://bit.ly/31hLJWp>

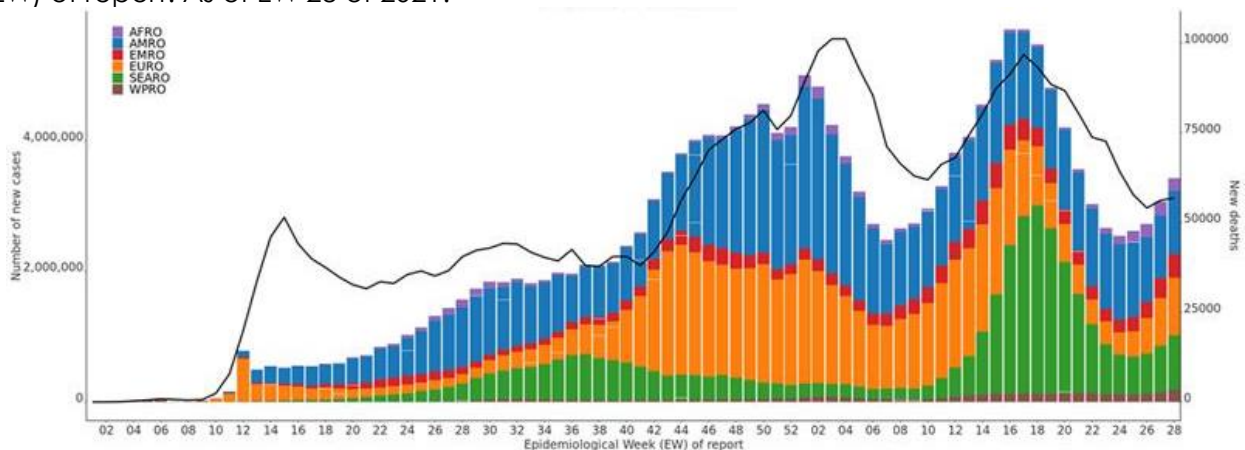
## Global Situation Summary

Since the first confirmed cases of COVID-19 until 21 July 2021, a cumulative total of 191,281,182 confirmed cases of COVID-19 have been reported globally, including 4,095,223 deaths, representing a total of 14,800,956 additional confirmed cases and 287,298 additional deaths since the last PAHO/WHO Epidemiological Update on COVID-19<sup>3</sup> published on 19 June 2021.

The majority of the cases and deaths reported globally during the first peak in 2021 were reported by the WHO Region of the Americas (49.6% of cases and 44.9% of deaths) and the WHO European Region (37.8% cases and 42.3% of deaths). During the second peak in epidemiological week (EW) 17 of 2021, the highest proportions of weekly cases and deaths were reported by the WHO South-East Asia Region (47.6% of cases and 26.1% of deaths) and the Region of the Americas (23.3% of cases and 40.9% of deaths).

Following a decline in cases between EW 19 and EW 24 of 2021, cases have been on an upward trend at the global level for the last four consecutive weeks, with the Region of Americas (27.6%) and the WHO European Region (27.5%) contributing the most to the weekly case totals as of EW 28. Although cases remained stable between EW 27 and EW 28 in the Region of the Americas (0.5% increase), the upward trend was observed across most WHO Regions during this period, particularly in the WHO European Region (31.9%), followed by the WHO Western Pacific Region (29.5%), and the WHO South-East Asia Region (16.5%). While the WHO African Region is now experiencing a decrease in cases (5.1%) and deaths (4.0%) compared to the previous week, the WHO African Region experienced large increases in cases and deaths over the past month, reporting approximately one million additional cases in one month (**Figure 1**).

**Figure 1.** Distribution of global COVID-19 confirmed cases and deaths, by epidemiological week (EW) of report. As of EW 28 of 2021.



**Note:**

AFRO: WHO Regional Office for Africa; AMRO: WHO Regional Office for the Americas; EMRO: WHO Regional Office for the Eastern Mediterranean; EURO: WHO Regional Office for Europe; SEARO: WHO Regional Office for South East-Asia; WPRO: WHO Regional Office for the Western Pacific

**Source:** WHO Coronavirus (COVID-19) data reproduced by PAHO/WHO. Available at: <https://covid19.who.int/info/>. Accessed on 19 July 2021.

<sup>3</sup> PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 19 June 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: <https://bit.ly/3iOUoUj>

## Situation Summary in the Region of the Americas

As of 19 July 2021, all 56 countries and territories in the Region of the Americas have reported a cumulative total of 70,103,320 confirmed cases of COVID-19, including 1,842,522 deaths<sup>4</sup>, since the detection of the first cases in the Region in January 2020.

Since the 19 June 2021 PAHO/WHO Epidemiological Update on COVID-19<sup>3</sup> and as of 19 July 2021, 4,827,736 additional confirmed cases of COVID-19, including 122,250 additional deaths, have been reported in the Region of the Americas, representing a 7% increase in cases and a 6% increase in deaths.

In 2021 alone, between 1 January and 30 June 2021, a total of 36,432,106 confirmed cases, including 973,946 deaths, were reported in the Americas, with the subregions of North America<sup>5</sup> and South America<sup>6</sup> accounting for the highest proportions of cases (42.6% and 53.9%, respectively), while the Central America<sup>7</sup> and the Caribbean and Atlantic Ocean Islands<sup>8</sup> subregions accounted for 1.9% and 1.6% of cases, respectively.

During the same period, South America accounted for 59.9% of the reported deaths, followed by North America (37.9%), Central America (1.5%), and the Caribbean and Atlantic Ocean Islands (0.7%) subregions.

Since March 2021, South America has surpassed North America as the subregion contributing the highest proportions of cases and deaths per month (**Figure 2**).

In June 2021, the South America subregion continued to account for the highest proportions of monthly cases (84%) and deaths (81%) in the Region of the Americas, with 4,076,310 cases and 108,331 deaths reported (**Figure 2**). Most of the cases and deaths were reported by Brazil (2 million cases and 54,054 deaths), Colombia (829,795 cases and 17,652 deaths), and Argentina (694,092 cases and 16,212 deaths).

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<sup>4</sup> Updated information on COVID-19, including situation reports, weekly press briefings, and the COVID-19 information system for the Region of the Americas is available at: <https://bit.ly/3kviqPD>.

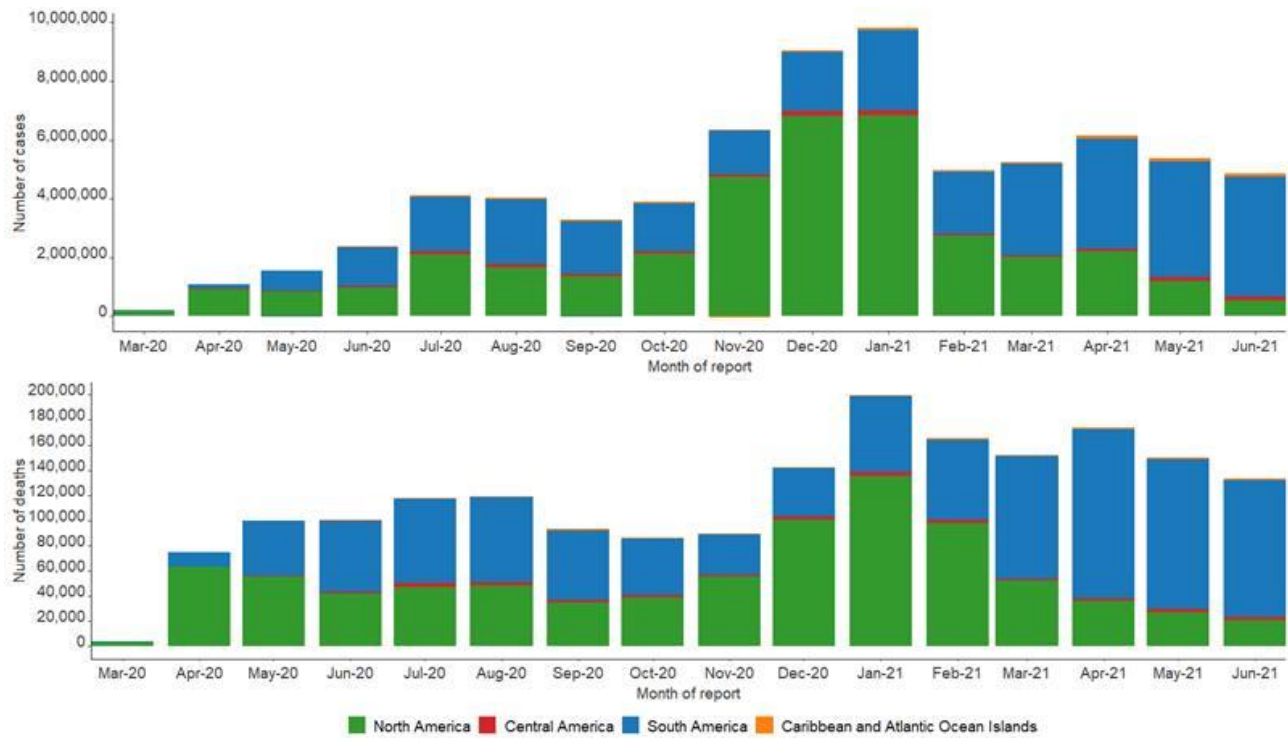
<sup>5</sup> Canada, Mexico, and United States of America.

<sup>6</sup> Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.

<sup>7</sup> Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

<sup>8</sup> Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, Bonaire, British Virgin Islands, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Falkland Islands, Grenada, Guadeloupe, French Guiana, Guyana, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saba, Saint Barthelemy, Saint Kitts and Nevis, Sint Eustatius, Saint Lucia, Saint Martin, Saint Pierre and Miquelon, Sint Maarten, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, and the United States Virgin Islands.

**Figure 2.** Distribution of confirmed COVID-19 cases and deaths, by subregion and month of report. Region of the Americas, 1 March 2020 to 30 June 2021.



**Source:** Information shared by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar and reproduced by PAHO/WHO.

# Epidemiological Highlights

## I. SARS-CoV-2 Variants

The appearance of mutations is a natural and expected event within the evolutionary process of viruses. Since the initial genomic characterization of SARS-CoV-2, this virus has been divided into different genetic groups or clades. In fact, some specific mutations define the viral genetic groups (also called lineages) that are currently circulating globally. Due to various microevolution processes and selection pressures, some additional mutations may appear, generating differences within each genetic group (called variants). It is important to mention that the names of the clade, lineage, variant, etc., are arbitrary and do not correspond to an official taxonomic hierarchy.

Since the initial identification of SARS-CoV-2 until 21 July 2021, more than 2,438,680 complete genomic sequences have been shared globally through publicly accessible databases.

As of 21 July 2021, 50 countries and territories in the Americas have published a total of 2,438,680 SARS-CoV-2 genomes on the GISAID platform, collected between February 2020 and July 2021. The countries and territories that have contributed genome data are: Anguilla, Antigua and Barbuda, Argentina, Aruba, Bahamas, Barbados, Belize, Bermuda, Bolivia, Bonaire, Brazil, the British Virgin Islands, Canada, the Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Curaçao, Dominica, the Dominican Republic, Ecuador, El Salvador, French Guiana, Grenada, Guadeloupe, Guatemala, Guyana, Haiti, Honduras, Jamaica, Martinique, Mexico, Montserrat, Panama, Paraguay, Peru, Puerto Rico, Saint Barthelemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Sint Eustatius, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

On 25 February 2021, WHO provided proposed operational definitions for SARS-CoV-2 variants of interest (VOI) and variants of concern (VOC) and the associated actions that WHO will take to support Member States and their national public health institutes and reference laboratories, along with recommended actions that should be taken by Member States. The document includes general and non-exhaustive guidance on the prioritization of variants of greatest public health relevance in the broader context of SARS-CoV-2 transmission, and public health response mechanisms and established social distance measures. These definitions will periodically be reviewed and updated, as necessary. The full publication is available at: <https://bit.ly/3wjf8Gd>

On 31 May 2021, WHO announced assigning simple labels for SARS-CoV-2 VOI and VOC that are easy to say and remember; the labels do not replace existing scientific names, but rather they are intended to simplify public communications.<sup>9</sup> The labels are available at: <https://bit.ly/2RTGXMN>

The list of SARS-CoV-2 variants, according to the WHO classification as of 6 July 2021<sup>10</sup>, is available in **Table 1**.

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<sup>9</sup> WHO. WHO announces simple, easy-to-say labels for SARS-CoV-2 Variants of Interest and Concern. 31 May 2021. Available at: <https://bit.ly/3xaARqs>

<sup>10</sup> WHO. Tracking SARS-CoV-2 variants. Available at: <https://bit.ly/36FXgQY>

**Table 1.** SARS-CoV-2 variants of concern (VOC) and variants of interest (VOI), according to WHO classifications as of 6 July 2021.

SARS-CoV-2 Variants WHO classification	WHO Label	Pango lineage	First detected by
Variant of concern (VOC)	Alpha	B.1.1.7	United Kingdom
	Beta	B.1.351 B.1.351.2 B.1.351.3	South Africa
	Gamma	P.1 P.1.1 P.1.2	Brazil
	Delta	B.1.617.2 AY.1 AY.2	India
Variant of interest (VOI)	Eta	B.1.525	Multiple countries
	Iota	B.1.526	United States of America
	Kappa	B.1.617.1	India
	Lambda	C.37	Peru

**Source:** WHO. Tracking SARS-CoV-2 variants.<sup>10</sup> Accessed on 14 July 2021.

Globally, an increase in the number of countries and territories reporting VOC and VOI continues to be observed (**Table 2**). However, this increase must take into account the limitations related to surveillance systems or surveillance mechanisms, as well as the capacity of the countries and territories to sequence samples, and differences in the selection of samples to be sequenced.

**Table 2.** Summary of the countries/territories reporting cases of SARS-CoV-2 variants of concern (VOC), as of 21 July 2021.

	WHO Label			
	Alpha	Beta	Gamma	Delta
Number of countries/territories reporting cases globally*	180	130	78	124
Number of countries/territories reporting cases in the Americas**	46	20	31	18

**Note:**

\*Global data correspond to the WHO COVID-19 Weekly Epidemiological Update. Published on 20 July 2021.<sup>11</sup> Some countries/territories have reported more than one variant of concern (VOC).

\*\*As of 21 July 2021

**Source:** WHO. COVID-19 Weekly Epidemiological Update. Published on 20 July 2021.<sup>11</sup>

Information shared by the International Health Regulations (IHR) National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies, or similar, and reproduced by PAHO/WHO.

<sup>11</sup> WHO. Weekly epidemiological update on COVID-19. Available at: <https://bit.ly/3zyiHAP>



Regarding the situation in the Americas, as of 21 July 2021, 48 countries/territories have reported the detection of cases of VOC, including five additional countries/territories (Anguilla, Antigua and Barbuda, Bahamas, Guatemala, and Honduras) since the 19 June 2021 PAHO/WHO COVID-19 Epidemiological Update<sup>3</sup> (Table 3a-d). As of 21 July 2021, the detection of all four VOC has been reported in Argentina, Aruba, Brazil, Canada, Chile, Costa Rica, French Guiana, Guadeloupe, Martinique, Mexico, Puerto Rico, and the United States of America.

**Table 3a.** Countries reporting SARS-CoV-2 variants of concern (VOC) in the North America subregion, as of 20 July 2021.

Country	Alpha	Beta	Gamma	Delta
Canada	Yes	Yes	Yes	Yes
Mexico	Yes	Yes	Yes	Yes
United States of America	Yes	Yes	Yes	Yes

**Table 3b.** Countries reporting SARS-CoV-2 variants of concern (VOC) in the Central America subregion, as of 20 July 2021.

Country	Alpha	Beta	Gamma	Delta
Belize	Yes	No	No	No
Costa Rica	Yes	Yes	Yes	Yes
Guatemala	Yes	Yes	Yes	No
Honduras	Yes	No	No	No
Panama	Yes	Yes	Yes	No

**Table 3c.** Countries reporting SARS-CoV-2 variants of concern (VOC) in the South America subregion, as of 20 July 2021.

Country	Alpha	Beta	Gamma	Delta
Argentina	Yes	Yes	Yes	Yes
Bolivia	Yes	No	Yes	No
Brazil	Yes	Yes	Yes	Yes
Chile	Yes	Yes	Yes	Yes
Colombia	Yes	No	Yes	No
Ecuador	Yes	No	Yes	Yes
Paraguay	Yes	No	Yes	No
Peru	Yes	No	Yes	Yes
Uruguay	Yes	No	Yes	No
Venezuela	Yes	No	Yes	No



**Table 3d.** Countries and territories reporting SARS-CoV-2 variants of concern (VOC) in the Caribbean and Atlantic Ocean Islands subregion, as of 20 July 2021.

Country/Territory	Alpha	Beta	Gamma	Delta
Anguilla	Yes	No	No	Yes
Antigua and Barbuda	Yes	Yes	No	No
Aruba	Yes	Yes	Yes	Yes
Bahamas	Yes	No	No	No
Barbados	Yes	No	Yes	Yes
Bermuda	Yes	Yes	No	No
Bonaire	Yes	No	No	No
British Virgin Islands	Yes	No	Yes	No
Cayman Islands	Yes	No	Yes	No
Cuba	Yes	Yes	No	No
Curacao	Yes	No	Yes	No
Dominica	Yes	No	No	No
Dominican Republic	Yes	No	Yes	No
French Guiana	Yes	Yes	Yes	Yes
Grenada	Yes	No	No	No
Guadeloupe	Yes	Yes	Yes	Yes
Guyana	No	No	Yes	No
Haiti	Yes	No	Yes	No
Jamaica	Yes	No	No	No
Martinique	Yes	Yes	Yes	Yes
Montserrat	Yes	No	No	No
Puerto Rico	Yes	Yes	Yes	Yes
Saba	No	No	No	Yes
Saint Barthelemy	Yes	No	No	No
Saint Lucia	Yes	No	No	No
Saint Martin	Yes	Yes	No	No
Sint Maarten	Yes	Yes	No	Yes
Suriname	Yes	Yes	Yes	No
Trinidad and Tobago	Yes	No	Yes	No
Turks and Caicos	Yes	No	Yes	No

**Note:** Data are provisional and subject to change as countries and territories make adjustments and retrospective analysis.

**Source:** Information shared by the IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar, and reproduced by PAHO/WHO.

## II. Continuity of essential health services during the COVID-19 pandemic

The COVID-19 pandemic has increased the demand for health services and has impacted several aspects of the health systems, compromising the delivery of health care for many health conditions. In order to maintain essential health services, reduce mortality, as well as to avoid indirect mortality, health systems must be well organized and prepared to face challenging situations, including emergencies. As a result, WHO has provided interim guidance to maintain essential services in the context of COVID-19. The document is available at: <https://bit.ly/3ipe2tg>

Although the baseline burden of disease and the extent to which COVID-19 has affected (e.g.: transmission scenario) health systems vary across countries, adaptations must be made to ensure continuity of essential health services while responding to the pandemic; these adaptations may require different approaches, even within the same country.<sup>12</sup>

Understanding the magnitude of the effects of the COVID-19 pandemic is necessary to develop mitigation policies and to allocate resources. For this reason, WHO conducted two rounds of key informant surveys<sup>13</sup> among Ministry of Health officials in five WHO Regions in 2020-2021 in order to assess the impact of the COVID-19 pandemic on up to 25 essential health services in countries.

At the global level, out of all countries who responded in the most recent round of the survey (n=135), 94% reported disruptions in at least one essential health service; more specifically, 34% reported disruptions in over half of services, 29% reported disruptions in 25%-49% of services, and 32% reported disruptions in less than 25% of services. Although the disruptions occurred both in low- and high-income countries, it was particularly marked in low-income countries.

Among the types of health services, primary care, rehabilitative, palliative, and long-term care were most commonly affected, which directly impact vulnerable populations. Additionally, disruptions have occurred across all major types of health services, including non-communicable diseases, management of mental, neurological and substance use disorders, neglected tropical diseases, infectious diseases, reproductive, maternal, newborn and adolescent health, and immunizations. The findings of these surveys highlight the importance of ensuring continuity of essential health services.

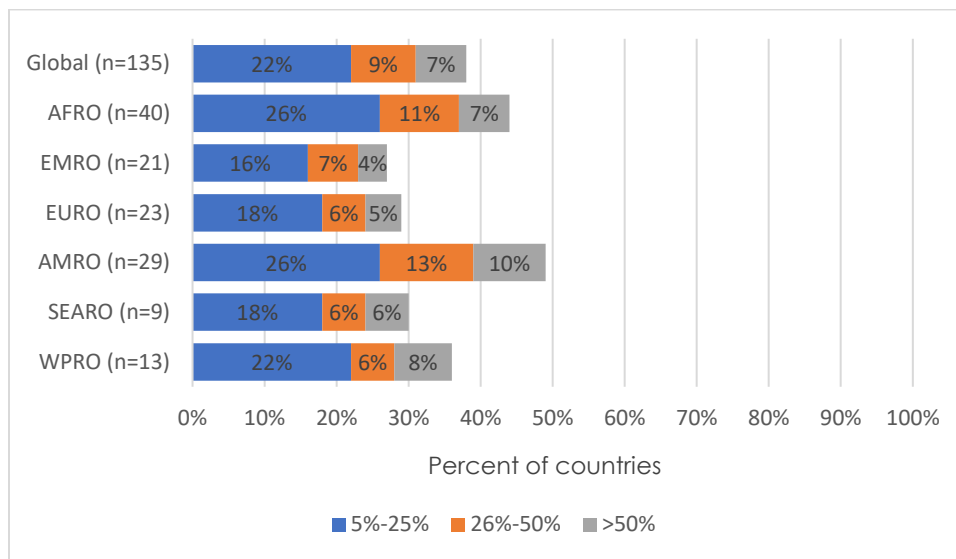
It is worth noting that, while there were differences in response rates across WHO Regions, the Region of the Americas reported the highest percentage of services disrupted within a particular Region; among countries who responded in the Region of the Americas (n=29), 10% reported a disruption in more than half of services, 13% reported a disruption in 26%-50% of services, and 26% reported a disruption in 5%-25% of services (**Figure 3**).

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<sup>12</sup> WHO. Maintaining essential health services: operational guidance for the COVID-19 context interim guidance. Available at: <https://bit.ly/3ipe2tg>

<sup>13</sup> WHO. Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic. Available at: <https://bit.ly/3wTMAw>

**Figure 3.** Average percentage of countries reporting disruptions across health service areas, by WHO Region. January-March 2021.



**Source:** WHO. Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January-March 2021.<sup>13</sup>

When analyzing the findings by the types of health services for the Region of the Americas, it is observed that the highest disruptions were reported among mental, neurological and substance abuse services (60% of countries) and immunization services (55% of countries).

Furthermore, the United States of America and Canada have reported the highest numbers of deaths related to substance abuse ever recorded since the beginning of the pandemic. Though the disruption of health services is not the only contributing factor to this increase, it is likely that the lack of support and disruption to emergency interventions contributed to this toll. In Canada, since the onset of the COVID-19 pandemic until December 2020, an 89% increase in deaths related to opioid toxicity compared to the previous year were recorded<sup>14</sup>, and in the United States, there was a 30% increase in drug overdose deaths when comparing data for 2020 to the previous year<sup>15</sup>.

Related to immunizations, most countries have had to postpone routine immunization services as health systems were overwhelmed by the COVID-19 pandemic. In October 2020, PAHO/WHO assessed the overall risk of the occurrence of new outbreaks of vaccine-preventable diseases (VPDs) (such as diphtheria, measles, and poliovirus) within the Region of the Americas as very high.<sup>16</sup>

<sup>14</sup> Government of Canada. Opioid- and Stimulant-related harms in Canada. Available at: <https://bit.ly/36PXhIK>

<sup>15</sup> United States CDC. Vital Statistics Rapid Release – Provisional drug overdose death counts. Available at: <https://bit.ly/3zg7wKT>

<sup>16</sup> PAHO/WHO. Vaccine-preventable diseases (diphtheria, measles, poliovirus) in the context of the COVID-19 pandemic: implications for the Regions of the Americas. Available at: <https://bit.ly/3rkDeVW>

### III. COVID-19 among older adults (≥60 years of age)

Some of the articles published<sup>17,18,19</sup>, or pre-published, on the impact of COVID-19 vaccination campaigns provide hope in achieving a decrease in mortality rates and hospitalizations in intensive care units (ICU) among older adults (≥60 years of age). However, it is important to consider that COVID-19 vaccination campaigns are not sufficient in and of themselves to prevent the transmission of SARS-CoV-2; therefore, public health and social distancing measures should be maintained in accordance with the epidemiological situation of each country and territory.

The trend that has been observed since the beginning of the pandemic, regarding mortality rates in older adults, is also observed in **Chile**. Accordingly, this age group is considered a vulnerable population and was prioritized during the vaccination campaigns that began in January 2021. The first group to be vaccinated were those aged 80 years or more, followed by persons aged 60 years and older, for which vaccination started approximately six weeks later, during EW 9 of 2021 (**Figure 4**).

In Chile, since the beginning of the pandemic and as of EW 24 of 2021, a total of 257,626 confirmed and probable cases were reported among older adults, representing 14.1% of cumulative cases in the country. In 2020, this population accounted for 16% of the total cases, while in 2021, this proportion decreased to 13%.

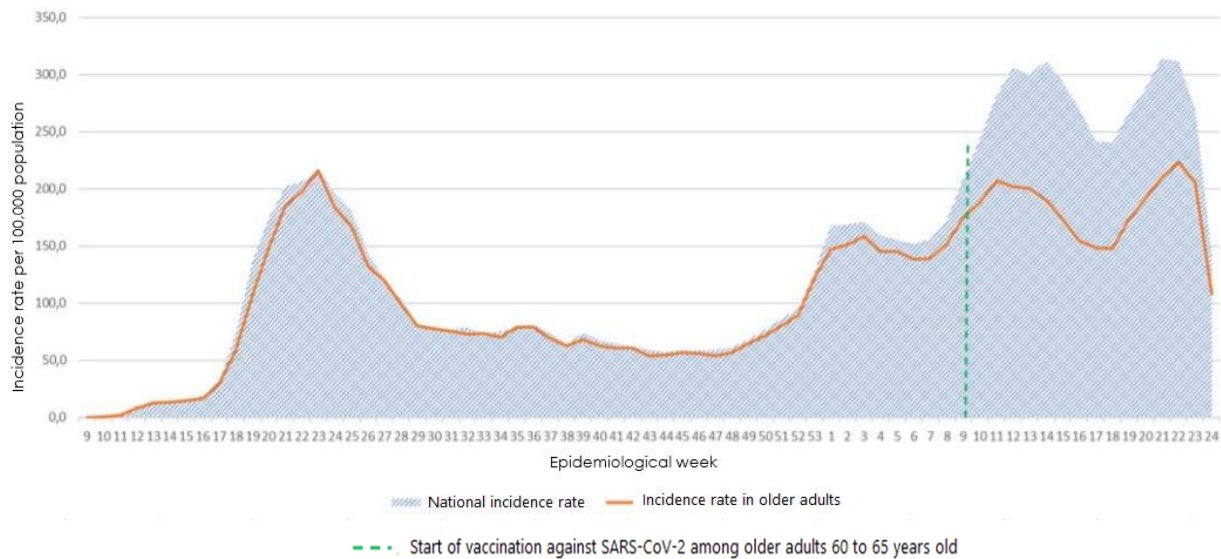
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<sup>17</sup> Cook TM, Roberts JV. Impact of vaccination by priority group on UK deaths, hospital admissions and intensive care admissions from COVID-19. Available at: <https://doi.org/10.1111/anae.15442>

<sup>18</sup> Leshem E, Wilder-Smith A. COVID-19 vaccine impact in Israel and a way out of the pandemic. *Lancet*. 2021 May 5 doi: 10.1016/S0140-6736(21)01018-7. Available at: <https://bit.ly/3hk18xC>

<sup>19</sup> Haas E, Angulo F, et al. Impact and effectiveness of mRNA BNT162b2 vaccine against SARS-CoV-2 infections and COVID-19 cases, hospitalizations, and deaths following a nationwide vaccination campaign in Israel: an observational study using national surveillance data. *The Lancet*, 2021, ISSN 0140-6736, Available at: [https://doi.org/10.1016/S0140-6736\(21\)00947-8](https://doi.org/10.1016/S0140-6736(21)00947-8)

**Figure 4.** Incidence rate of confirmed and probable COVID-19 cases among older adults and in the general population, by date of symptom onset. Chile. Epidemiological week (EW) 9 of 2020 to EW 24 of 2021.



**Source:** Chile Ministry of Health. Epidemiological description of individuals aged 60 years or more with COVID-19.<sup>20</sup>

Geographically, the distribution of COVID-19 cases among older adults varied between 2020 and 2021. In 2020, Magallanes and Antarctica Chilena region reported the highest incidence rate (8,948.6 cases per 100,000 older adults), followed by Arica and Parinacota region (4,879.6 cases per 100,000 older adults); in 2021, the highest incidence rate was reported in Los Ríos (6,602 cases per 100,000 population), followed by Tarapacá (6,204.5 cases per 100,000 older adults).

Related to hospitalizations, 53,222 (20.7%) of total cases among older adults were hospitalized, of which 22,026 (41.4%) were in the ICU and 9,181 (17.3%) required mechanical ventilation. In 2020, 26.9% of confirmed cases in older adults resulted in hospitalization; this proportion decreased to 15.6% in 2021. A total of 29,262 deaths were reported among older adults, of which 91.1% had comorbidities; the mortality rate among older adults in 2020 and 2021 were 433.5 deaths per 100,000 older adults and 425.6 deaths per 100,000 older adults, respectively. Moreover, the case-fatality rate decreased from 12.6% in 2020 to 10.4% in 2021.

<sup>20</sup> Chile Ministry of Health. Epidemiological description of individuals aged 60 years or more with COVID-19. Available at: <https://bit.ly/3ze0R54>

## IV. COVID-19 during pregnancy

Although researchers continue to advance the knowledge base related to COVID-19 among pregnant women, helping to close existing knowledge gaps related to the impact of SARS-CoV-2 infection on the final outcome of pregnancy, it is necessary to continue collecting information to contribute to that knowledge base.

COVID-19 vaccination campaigns, together with social distancing measures, hand hygiene and the proper use of face masks, targeted to this population group are expected to impact the severity and mortality observed thus far.

Since the first reported cases of COVID-19 in the Americas and until 21 July 2021, there have been a total of 258,359 SARS-CoV-2 infections among pregnant women, including 2,375 deaths (0.92% case-fatality rate), reported in 30 countries/territories for which information was available.

Compared to the data presented in the 19 June 2021 PAHO/WHO COVID-19 Epidemiological Update<sup>3</sup>, this represents 26,822 additional cases and 922 additional deaths; this large increase is in part due to the fact that some countries have updated their data reporting and have included retrospective adjustments. During the same period, the highest relative increases<sup>21</sup> in cumulative confirmed cases occurred in Antigua and Barbuda (75%, 3 cases) and Ecuador (75%, 7,695 cases, which may be in part due to a delay in reporting). Among deaths, the highest relative increases were observed in Costa Rica (57%, 4 deaths) and Canada (50%, 1 death) (**Table 4**).

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<sup>21</sup> The relative increases observed in Brazil and Honduras are a result of delayed reporting and retrospective adjustments.

**Table 4.** SARS-CoV-2 infections and deaths among pregnant women, by country/territory. Region of the Americas. January 2020 to 21 July 2021\*.

Country	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	Case fatality rate (%)
Anguilla	2	N/A	N/A
Antigua and Barbuda	4	0	0.00
Argentina	19,163	154	0.80
Bahamas	101	1	0.99
Bolivia**	2,416	31	1.28
Belize**	247	2	0.81
Bermuda**	11	0	0.00
Brazil <sup>‡</sup>	12,938	1,137	8.79
British Virgin Islands**	3	N/A	N/A
Canada	6,565	2	0.03
Cayman Islands	7	0	0.00
Chile	15,144	13	0.09
Colombia	12,432	120	0.97
Costa Rica	1,245	7	0.56
Cuba	1,679	5	0.30
Dominican Republic	1,191	45	3.78
Ecuador	10,207	48	0.47
El Salvador**	272	9	3.31
Guatemala	1,217	12	0.99
Haiti**	79	4	5.06
Honduras	818	56	6.85
Mexico <sup>&amp;</sup>	18,635	366	1.96
Panama <sup>&amp; **</sup>	2,413	12	0.50
Paraguay <sup>&amp;</sup>	1,888	56	2.97
Peru <sup>&amp;</sup>	52,769	168	0.32
Saint Lucia	25	0	0.00
Suriname	475	2	0.42
United States of America**	94,519	103	0.11
Uruguay	1,344	9	0.67
Venezuela	550	13	2.36
<b>Total</b>	<b>258,359</b>	<b>2,375</b>	<b>0.92</b>

**Note:**

N/A: Data not available.

<sup>&</sup> Corresponds to pregnant and postpartum women

<sup>‡</sup> The information presented for Brazil corresponds data extracted from the Influenza Epidemiological Surveillance Information System (SIVEP-Gripe).

\*21 July 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

\*\* No update since the 19 June 2021 PAHO/WHO Epidemiological Update on COVID-19<sup>3</sup>

**Source:** Latin American Center for Perinatology/Women's Health and Reproductive Health (CLAP/SMR) and information shared with PAHO/WHO by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, health agencies, or similar and reproduced by PAHO/WHO.



According to data obtained from 22 countries in 2021, compared to the data reported in 2020, an increase in both the number of cases and deaths among pregnant women positive for SARS-CoV-2 has been reported (**Table 5**). An increase has been observed from January through June 2021 and, for most countries, the number of cases and deaths reported this year has exceeded the numbers reported for all of 2020. In some instances, while the number of total reported cases was lower in 2021 (January through June) than in 2020, the number of deaths has exceeded those of 2020; this can be observed in Colombia, Peru, and Venezuela.

**Table 5.** Select COVID-19 indicators during pregnancy in countries of the Americas. 2020 and 2021 (January to June).

Country	Year 2020			1 January - 30 June 2021		
	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	MMR*	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	MMR*
Argentina <sup>&amp;</sup>	8,817	41	5.5	9,084	96	12.8
Bolivia	955	31	12.5	1,461	0	0.0
Brazil	5,462	288	10.1	7,476	849	30.1
Canada	2,913	1	0.3	3,629	1	0.3
Chile	6,623	3	1.5	8,521	10	13.4
Colombia	7,929	56	7.7	4,503	64	17.4
Costa Rica	335	3	5.1	210	0	0.0
Cuba	180	0	0.0	1,499	5	4.6
Dominican Republic	707	36	21.7	484	9	11.3
Ecuador	6,116	25	7.4	4,091	23	6.8
Guatemala	653	8	1.9	564	4	0.9
Haiti	76	4	1.5	3	0	0.0
Honduras	508	15	7.2	310	41	19.6
Mexico <sup>&amp;</sup>	10,530	205	10.1	8,105	161	15.3
Panama <sup>&amp;</sup>	1,852	4	5.0	561	3	3.8
Paraguay <sup>&amp;</sup>	599	1	0.7	1,289	55	38.4
Peru	40,818	81	14.3	11,951	87	15.5
Saint Lucia	5	0	0.0	20	0	0.0
Suriname <sup>&amp;</sup>	184	2	18.9	242	0	0.0
United States of America	68,459	80	2.0	25,878	23	0.6
Uruguay	82	0	0.0	1,262	9	19.2
Venezuela	333	6	1.2	217	7	1.4

**Note:** <sup>&</sup> Corresponds to pregnant and postpartum women

\* MMR Maternal mortality ratio, calculated using deaths among pregnant women (in some instances, including postpartum deaths) positive to SARS-CoV-2

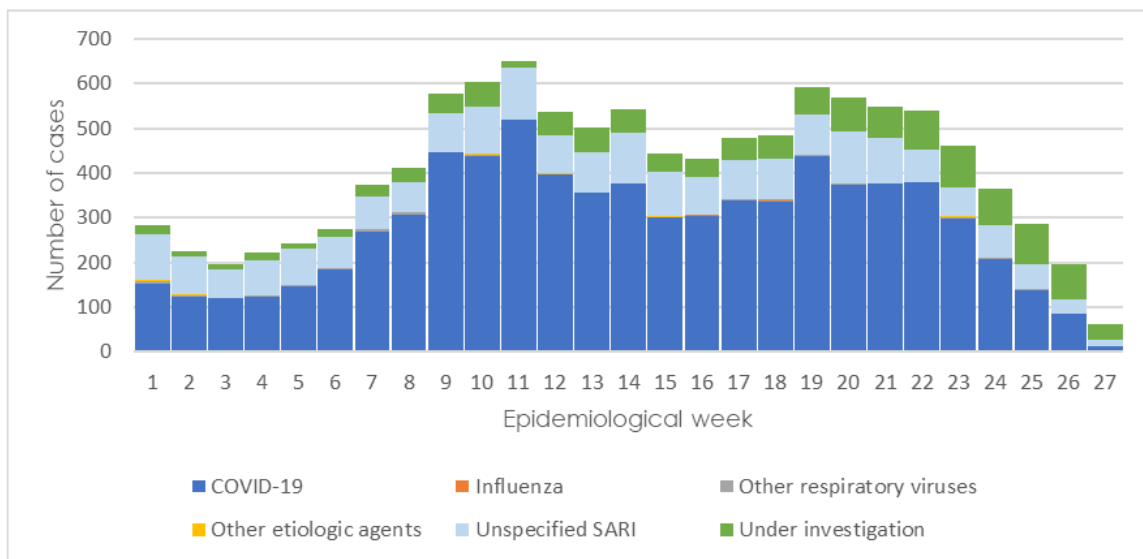
**Source:** Latin American Center for Perinatology/Women's Health and Reproductive Health (CLAP/SMR) and information shared with PAHO/WHO by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, health agencies, or similar and reproduced by PAHO/WHO

The following is a description of the epidemiological situation among pregnant women hospitalized with severe acute respiratory illness (SARI) confirmed for COVID-19 in **Brazil**.

Since February 2020 and as of July 2021, a total of 12,938 confirmed COVID-19 cases including 1,137 deaths have been reported among pregnant women, resulting in a case-fatality rate of 8.8%. When disaggregating the data by year, it can be observed that while 42% (5,462) of cumulative cases were reported in 2020, only 25% (288) of cumulative deaths were reported in the same year; with a peak of 225 weekly cases and 17 deaths. The following indicators show that the burden of deaths has been higher in the current year; a higher case-fatality rate has been observed in 2021, with 11,4% compared to 5,3% in 2020. Additionally, the maternal mortality ratio (MMR) in 2020 was 10.1 maternal deaths per 100,000 live births<sup>22</sup>, while in 2021, it currently stands at 30.1 maternal deaths per 100,000 live births, representing an increase of 192% compared to the previous year.

Between EW 1 of 2021 and as of EW 27 of 2021, a total of 11,163 pregnant women were hospitalized for SARI, of which 7,568 (67.8%) were confirmed COVID-19 cases and 1,325 (11.9%) remain under investigation. An increasing trend is observed starting in EW 4; between EW 7 and EW 23, cases have steadily surpassed the peak of 2020. Although the trend is now decreasing, cases remain at high levels; it is worth noting that the last 3 weeks (EW 25 to EW 27) may show an apparent decrease due to a delay in reporting (**Figure 5**). Of the total number of pregnant women hospitalized for SARI (n=11,163), 931 (8.3%) died; among these deaths, 831 (94%) were confirmed for COVID-19, representing the most frequently identified etiologic agent among SARI-related deaths among pregnant women (**Figure 6**).

**Figure 5.** Severe acute respiratory illness (SARI)-related cases in pregnant women, by epidemiological week (EW) of symptom onset and etiologic agent. Brazil. EW 1 to EW 27 of 2021.

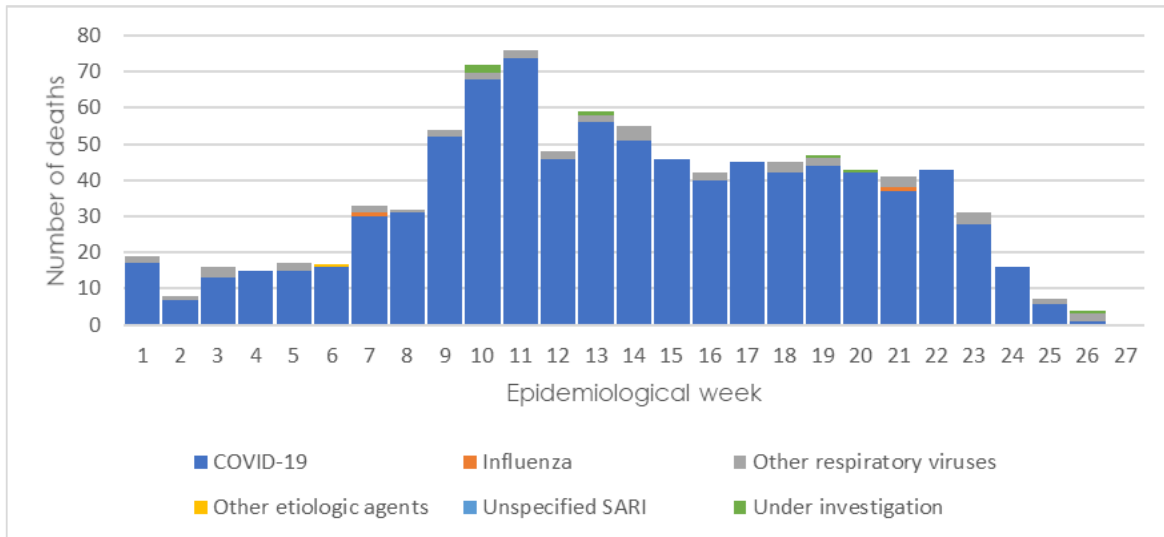


**Source:** Brazil Ministry of Health. Special epidemiological bulletin – Coronavirus disease COVID-19 number 71.<sup>23</sup> Data reproduced by PAHO/WHO.

<sup>22</sup> United Nations Department of Economic and Social Affairs. World Population Prospects 2019. Available at: <https://bit.ly/3hJOEzf>

<sup>23</sup> Brazil Ministry of Health. Special epidemiological bulletin – Coronavirus disease COVID-19: number 71. Available at: <https://bit.ly/3BeyHsC>

**Figure 6.** Severe acute respiratory illness-related deaths in pregnant women, by epidemiological week (EW) of symptom onset and etiologic agent. Brazil. EW 1 to EW 27 of 2021.



**Source:** Brazil Ministry of Health. Special epidemiological bulletin – Coronavirus disease COVID-19 number 71.<sup>23</sup> Data reproduced by PAHO/WHO.

In terms of geographic distribution, between EW 1 and EW 27 of 2021, the two federal units reporting the highest number of cases and deaths within this population were São Paulo (1,865 cases including 170 deaths) and Minas Gerais (700 cases including 103 deaths); the Southeast region of the country accounts for 40% and 42% of total COVID-19 cases and deaths, respectively. While the case-fatality rate in this population stands at 11.6% at the national level in 2021, it ranges from 9.5% to 14.8% at the regional level; the highest being reported in the Northern region.

When analyzing the data by pregnancy trimester, it can be noted that for cases and deaths for which this information was available (n=7,167 cases, n=816 deaths), 62% and 59% of cases and deaths, respectively, were reported during the third trimester.

Regarding demographics, the age group reporting the most cases were females aged 30 to 39 years old (45.6%), followed by the 20 to 29 years age group (37.6%), while 51% of deaths were reported in the 30 to 39 years age group.

## V. COVID-19 among indigenous populations

Since January 2020 and until 20 July 2021, there have been 617,229 confirmed cases of COVID-19, including 14,990 deaths, reported among indigenous populations in 18 countries in the Region of the Americas for which information was available (**Table 6**). Compared to the data in the 19 June 2021 PAHO/WHO Epidemiological Update on COVID-19,<sup>3</sup> this represents 64,901 additional confirmed cases including 1,428 deaths. In comparison with the previous PAHO/WHO Epidemiological Update, the largest increases in cases and deaths were observed in Chile, with 38% and 40% increase, respectively.

**Table 6.** Cumulative number of confirmed cases and deaths of COVID-19 among indigenous populations in the Region of the Americas. January 2020 to 21 July 2021\*.

Country	Number of COVID-19 confirmed cases	Number of deaths
Argentina	2,693	65
Belize**	1,668	41
Bolivia**	18,700	334
Brazil	51,334	741
Canada	32,597	372
Chile	65,884	1170
Colombia	63,250	1,813
Costa Rica	540	11
Ecuador	5,832	216
Guatemala	18,924	676
Guyana**	95	6
Mexico	21,046	3,253
Panama**	5,807	102
Paraguay	456	48
Peru	64,923	872
Suriname	2,556	44
United States of America**	259,884	4860
Venezuela	1137	22
<b>Total</b>	<b>617,326</b>	<b>14,646</b>

**Note:**

\* 21 July 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

\*\* No update since the 19 June 2021 PAHO/WHO Epidemiological Update on COVID-19<sup>3</sup>.

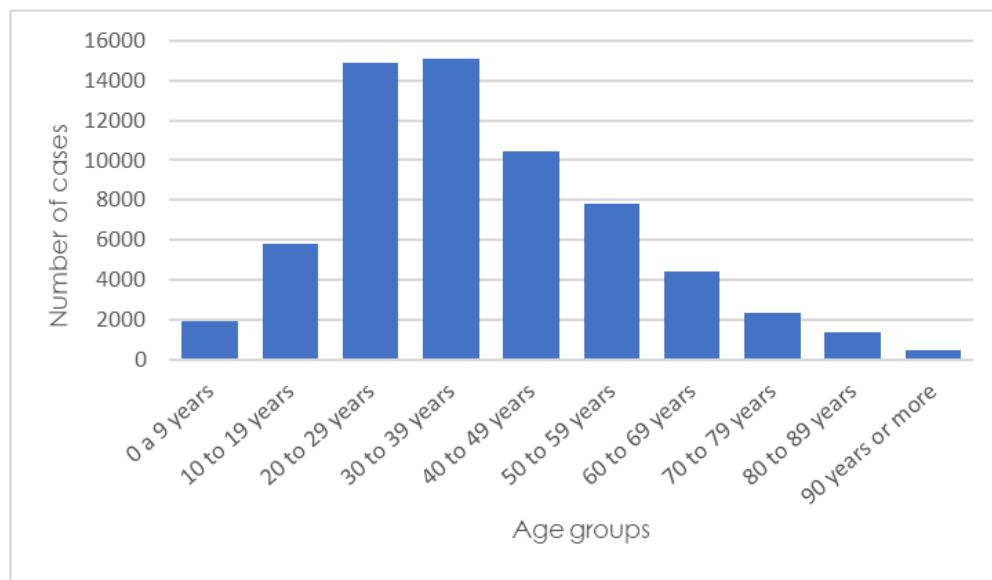
**Source:** Data provided by the International Health Regulations (IHR) National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, indigenous organizations, or similar and reproduced by PAHO/WHO.

The following is a description of the COVID-19 epidemiological situation among indigenous populations of Colombia.

In **Colombia**, since the confirmation of the first case of COVID-19 in the country<sup>24</sup> and as of 10 July 2021, there have been 63,250 confirmed COVID-19 cases reported among indigenous peoples (80 ethnic populations), including 1,813 deaths, resulting in a case-fatality rate of 2.9% in this population, compared to 2.5% in the general population. Of these total cases, approximately 2.5% (1,593 cases) are considered active and 59,844 have recovered. The total number of cases among indigenous populations in Colombia account for 1.4% of the total number of confirmed cases in Colombia.

The distribution of cases among indigenous populations by age group shows that the highest proportion of cases were reported in persons aged 30 to 39 years (24%), followed by persons aged 20 to 29 years (23%), and 40 to 49 years (16%) (**Figure 7**).

**Figure 7.** Distribution of confirmed COVID-19 cases among indigenous populations, by age group. Colombia, March 2020 to 10 July 2021.



**Source:** Colombia Ministry of Health.<sup>25</sup> Data reproduced by PAHO/WHO.

In terms of geographic distribution, Bogota D.C reported the majority of cases (9,502 cases), followed by the departments of Nariño (6,624 cases), and Córdoba (5,780 cases).

## VI. COVID-19 among populations under 20 years of age

Since the beginning of the pandemic, it has been apparent that children and adolescents have a lower risk of illness and death from COVID-19 compared to other age groups. Additionally, it has been recognized that children and adolescents are being particularly affected by the measures taken to control the transmission of the virus. These indirect effects include the negative consequences of school closures, restrictions on the movement of people which limit opportunities for play and relationships with family and friends, the loss of work and income that also affect the mental health of caregivers and consequently the relationships between children

<sup>24</sup> 6 March 2020

<sup>25</sup> Colombia Ministry of Health. 10 July 2021. COVID-19 among indigenous populations in Colombia. Available in Spanish at: <https://bit.ly/3hFrQk5>

and their caregivers, and the alteration of health and social protection service functions, among others.<sup>26</sup>

The evidence available to date suggests that children and adolescents are less susceptible to SARS-CoV-2 infection and also transmit the virus less frequently than adults. When they do acquire infection, they are generally asymptomatic but, when they do get sick, they usually have mild illness with symptoms similar to other common illnesses at these ages. Within the 0-19 age group, studies suggest that susceptibility and transmission are lower among children under 5 years of age than among older children and adolescents.<sup>27,28,29,30,31</sup>

### **Multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19**

Various reports and scientific publications, from different places worldwide, have described groups of children and adolescents requiring admission to intensive care units (ICU) with a multisystem inflammatory condition with some features similar to those of Kawasaki disease and toxic shock syndrome. Based on the available evidence, WHO has provided the case definition of this syndrome, called multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19, available at: <https://bit.ly/2RBZzgr>.

Although MIS-C occurs relatively infrequently, these cases present important challenges for health systems, and can lead to severe clinical presentations and even death.

In the Region of the Americas, PAHO/WHO began active surveillance of MIS-C cases in June 2020, inviting Member States to share a minimum set of epidemiological variables allowing for the characterization of MIS-C in the Region.

Between mid-May 2020 and 21 July 2021, a cumulative total of 6,681 confirmed cases of MIS-C temporally related to COVID-19, including 135 deaths, have been reported in 24 countries/territories of the Region of the Americas (**Table 7**). During this same period, 22 countries and territories have officially reported to PAHO/WHO that they have not detected cases of MIS-C.

Since the 19 June 2021 PAHO/WHO Epidemiological Update on COVID-19<sup>3</sup> and until 21 July 2021, there were 625 additional confirmed cases reported and 6 additional deaths. During this period, one new country (Venezuela) reported cases of MIS-C to PAHO/WHO for the first time.

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<sup>26</sup> UN Sustainable Development Group. Policy Brief: The Impact of COVID-19 on children. April 2020. Available at: <https://bit.ly/38r1JbH>

<sup>27</sup> Gaythorpe, K. A., Bhatia, S., Mangal, T., et al. Children's role in the COVID-19 pandemic: a systematic review of early surveillance data on susceptibility, severity, and transmissibility. Imperial College London. 3–26. <https://doi.org/10.25561/84220>

<sup>28</sup> Viner, R. M., Mytton, O. T., Bonell, C., et al. Susceptibility to SARS-CoV-2 Infection among Children and Adolescents Compared with Adults: A Systematic Review and Meta-Analysis. *JAMA Pediatrics*, 175(2), 143–156. <https://doi.org/10.1001/jamapediatrics.2020.4573>

<sup>29</sup> Viner, R. M., Russell, S., Saullé, R., et al. Impacts of school closures on physical and mental health of children and young people: a systematic review. *MedRxiv*, 2021.02.10.21251526. <https://doi.org/10.1101/2021.02.10.21251526>

<sup>30</sup> Davies, N.G., Klepac, P., Liu, Y. et al. Age-dependent effects in the transmission and control of COVID-19 epidemics. *Nat Med* 26, 1205–1211 (2020). <https://doi.org/10.1038/s41591-020-0962-9>

<sup>31</sup> Leidman E, Duca LM, Omura JD, Proia K, Stephens JW, Sauber-Schatz EK. COVID-19 Trends Among Persons Aged 0–24 Years — United States, March 1–December 12, 2020. *MMWR Morb Mortal Wkly Rep* 2021; 70:88–94. DOI: <http://dx.doi.org/10.15585/mmwr.mm7003e1>

As the numbers of cases of MIS-C increase, it is important that each country/territory characterizes the cases<sup>32</sup> in order to contribute to closing the gaps in information, particularly related to clinical management and response measures.

**Table 7.** Distribution of cumulative confirmed cases and deaths of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19 in the Region of the Americas, by country/territory. May 2020 to 21 July 2021\*.

Country/Territory	Number of confirmed cases	Number of confirmed deaths
Argentina	189	1
Barbados	2	1
Bolivia	1	1
Brazil	1,101	69
Canada	131	0
Chile	340	5
Colombia	9	5
Costa Rica	37	0
Cuba	4	0
Dominican Republic	131	6
Ecuador	13	0
El Salvador	19	0
French Guiana	2	0
Guadeloupe	5	0
Guatemala	2	0
Honduras	3	0
Panama	81	2
Paraguay	107	8
Peru	4	0
Puerto Rico	0	0
Saint Martin	2	0
Trinidad and Tobago	29	0
United States of America	4,274	37
Venezuela	195	0
<b>Total</b>	<b>6,681</b>	<b>135</b>

**Notes:** \* 21 July 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

According to the United States Centers for Disease Control and Prevention (US CDC) website, the data for the United States includes 52 US jurisdictions (including 49 states, New York City, Puerto Rico, and Washington, DC). Available at: <https://bit.ly/2SrKBOj>

**Sources:** Data provided by the International Health Regulations National Focal Points or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

<sup>32</sup> Case notification form available at: <https://bit.ly/371sXo1>



The following is a brief description of the epidemiological situation of MIS-C in the Americas.

Of the total number of reported cases for which data on age and sex were available (n=6,089), the distribution of cases among age groups was 30% among 0 to 4 years, 34% among 5 to 9 years, 26% among 10 to 14 years, and 11% among 15 to 19 years (the United States of America includes 20-year-olds in this age group). Regarding the distribution by sex, 59% of the cases were male.

Among the 129 deaths for which data on age and sex were available, 40% were aged 0 to 4 years, 19% aged 5 to 9 years, 16% aged 10 to 14 years, and 26% aged 15 to 19 years. Regarding the distribution by sex, 51% of the deaths were female.

## VII. COVID-19 among health workers

Since the first confirmed cases of COVID-19 were reported in the Region of the Americas and until 21 July 2021, at least 1,763,315 COVID-19 cases among health workers, including 10,278 deaths, have been reported according to the data made available by 37 countries and territories in the Americas (**Table 8**). Due to retrospective adjustments in cases in the data available, there were approximately 216,000 fewer cases, and 810 additional deaths, since the 19 June 2021 Epidemiological Update.<sup>3</sup> The total number of cases represents 12% of the estimated 15 million health workers in the Americas<sup>33</sup>.

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<sup>33</sup> PAHO/WHO. Weekly Press Briefing on COVID-19: Director's Opening Remarks, 12 May 2021. Available at: <https://bit.ly/3uEhbKC>

**Table 8.** Distribution of cumulative confirmed cases and deaths of COVID-19 among health workers in the Region of the Americas. January 2020 to 21 July 2021\*.

Country	Number of confirmed cases of COVID-19	Number of deaths
Antigua and Barbuda	44	2
Argentina	94,590	584
Aruba**	244	0
Bahamas**	505	13
Belize**	317	2
Bermuda**	49	0
Bolivia**	24,223	433
Bonaire**	106	0
Brazil	498,422	666
Canada	100,309	61
Cayman Islands**	24	0
Chile	60,606	102
Colombia	62,779	301
Costa Rica	8,107	52
Curacao**	439	0
Dominica	1	0
Dominican Republic	1,399	22
Ecuador	12,262	121
El Salvador**	6,609	72
Grenada	1	0
Guatemala	7,152	65
Haiti**	808	1
Honduras	13,668	115
Jamaica**	861	4
Mexico£	244,711	4,084
Panama**	8,663	112
Paraguay	16,358	182
Peru	70,687	1,383
Saint Lucia	147	0
Saint Vincent and the Grenadines	29	0
Sint Eustatius**	8	0
Sint Maarten**	54	0
Suriname	1,690	3
Turks and Caicos	97	0
United States of America	515,527	1,691
Uruguay	8,715	28
Venezuela	3,104	179
<b>Total</b>	<b>1,763,315</b>	<b>10,278</b>

**Notes:** \* 21 July 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

\*\* No update since the 19 June 2021 PAHO/WHO Epidemiological Update on COVID-19<sup>3</sup>


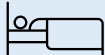





£ The information Mexico presents corresponds to the occupation variable of the Epidemiological Surveillance System for Viral Respiratory Disease (SISVER). The analysis reflects cases reported performing a health-related occupation. It is important to clarify that the information collected in SISVER does not allow to identify if the contagion occurred in the workplace, at home or in the community; nor does it establish whether health personnel are currently working in a medical care unit.

**Source:** Data provided by the IHR National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

## Guidance for national authorities

PAHO/WHO continues to reiterate and update recommendations to support all Member States on management and protection measures for COVID-19 and reiterates the recommendations included in the PAHO/WHO Epidemiological Alerts and Updates on COVID-19 available at: <https://www.paho.org/en/epidemiological-alerts-and-updates>.

The following are guidance, scientific reports, and other resources published by PAHO/WHO and WHO.

<p><b>Surveillance, rapid response teams, and case investigation</b></p> 	<p><b>Clinical management</b></p> 
<p>WHO resources available at: <a href="https://bit.ly/30zjmCj">https://bit.ly/30zjmCj</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/36DJi3B">https://bit.ly/36DJi3B</a></p>	<p>WHO resources available at: <a href="https://bit.ly/3li6wQB">https://bit.ly/3li6wQB</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/3sadTxQ">https://bit.ly/3sadTxQ</a></p>
<p><b>Laboratory</b></p> 	<p><b>Infection prevention and control</b></p> 
<p>WHO resources available at: <a href="https://bit.ly/3d3TJ1g">https://bit.ly/3d3TJ1g</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/3oD2Qen">https://bit.ly/3oD2Qen</a></p>	<p>WHO resources available at: <a href="https://bit.ly/3d2ckuV">https://bit.ly/3d2ckuV</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/3nwyOaN">https://bit.ly/3nwyOaN</a></p>
<p><b>Critical preparedness and response</b></p> 	<p><b>Travel, Points of entry, and border health</b></p> 
<p>WHO resources available at: <a href="https://bit.ly/3ljWHBT">https://bit.ly/3ljWHBT</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/36DJi3B">https://bit.ly/36DJi3B</a></p>	<p>WHO resources available at: <a href="https://bit.ly/3ivDivW">https://bit.ly/3ivDivW</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/36DJi3B">https://bit.ly/36DJi3B</a></p>
<p><b>Schools, workplaces, &amp; other institutions</b></p> 	<p><b>Other resources</b></p>
<p>WHO resources available at: <a href="https://bit.ly/3d66iJO">https://bit.ly/3d66iJO</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/36DJi3B">https://bit.ly/36DJi3B</a></p>	<p>WHO resources available at: <a href="https://bit.ly/33zXgRQ">https://bit.ly/33zXgRQ</a></p> <p>PAHO/WHO resources available at: <a href="https://bit.ly/36DJi3B">https://bit.ly/36DJi3B</a></p>

## References

1. PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 19 June 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: <https://bit.ly/3xYqdnh>
2. WHO. COVID-19 Weekly Epidemiological Update. Published on 20 July 2021. Available at: <https://bit.ly/3v6e0Mi>
3. Report by the **Antigua and Barbuda** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
4. Report by the **Argentina** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
5. Report by the **Brazil** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
6. Ministry of Health of **Brazil**. Available at: <https://bit.ly/3vb3JP2> and <https://bit.ly/2OnJAVg>
7. Report by the **Canada** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
8. Government of **Canada**. Coronavirus (COVID-19) and indigenous communities. Available at: <https://bit.ly/2lhCEWq>
9. Report by the **Chile** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
10. Report by the **Colombia** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
11. Report by the **Costa Rica** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
12. Report by the **Dominican Republic** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
13. Report by the **Ecuador** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
14. Report by the **Grenada** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
15. Report by the **Guatemala** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
16. Report by the **Mexico** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email

17. Report by the **Paraguay** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
18. Report by the **Peru** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
19. Report by the **Saint Lucia** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
20. Report by the **Suriname** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
21. Report by the **United Kingdom** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
22. **United States of America.** Centers for Disease Control and Prevention. Data on COVID-19 during Pregnancy. Available at: <https://bit.ly/2SWWyYT>. Multisystem inflammatory syndrome in children (MIS-C), available at: <https://www.cdc.gov/mis-c/>
23. Report by the **Uruguay** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
24. Report by the **Venezuela** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email