



# Epidemiological Update COVID-19 among indigenous peoples in the Americas

5 August 2020

This Epidemiological Update on COVID-19 focuses on the situation among indigenous peoples in the Americas, particularly noting an increase in cases and deaths in indigenous communities. An initial summary of the overall COVID-19 situation in the Region of the Americas is also provided.

## General COVID-19 Situation Summary in the Americas

Since the first confirmed case of COVID-19 in the Region of the Americas<sup>1</sup> and until 2 August 2020, a cumulative total of 9,484,066 confirmed cases of COVID-19, including 359,376 deaths, have been reported.

Between 2 July and 2 August 2020, there were 4,185,187 additional confirmed cases of COVID-19, including 107,474 additional deaths, reported in the Region of the Americas. This represents a 77% relative increase in cases and a 42% relative increase in deaths. The largest relative increases in cases and deaths occurred in the subregions of Central America (130% increase in cases and 142% increase in deaths), the Caribbean and Atlantic Ocean Islands (98% increase in cases and 48% increase in deaths), and South America (82% increase in cases and 67% increase in deaths).

The highest proportions of new cases were reported in the Bahamas (476%), Costa Rica (385%), the United States Virgin Islands (376%), and Saint Pierre and Miquelon (300%), while the highest proportions of new deaths were reported in Costa Rica (863%), Venezuela (213%), and Colombia (198%).<sup>2</sup>

Between 2 July and 2 August 2020, seven countries and territories modified their COVID-19 transmission scenario, observing an increase in the transmission of cases, in order from greatest to least intensity in: Costa Rica (from clusters of cases to community transmission), Sint Maarten (from no cases to community transmission), Suriname (from clusters of cases to community transmission), the United States Virgin Islands (from clusters of cases to community transmission), Trinidad and Tobago (from sporadic cases to clusters of cases), Bonaire, Sint Eustatius, and Saba (from no cases to sporadic cases)<sup>3</sup>, and Saint Pierre and Miquelon (from no cases to sporadic cases).

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<sup>1</sup> 21 January 2020

<sup>2</sup> PAHO/WHO COVID-19 Daily Update. Available from: <https://bit.ly/38LzGmj> and accessed 3 August 2020.

<sup>3</sup> Bonaire, Sint Eustatius, and Saba: The transmission classification for Bonaire is Sporadic cases, Sint Eustatius is Sporadic cases, and Saba is No cases. The highest classification for all three islands is used by PAHO/WHO, designated as Sporadic cases.

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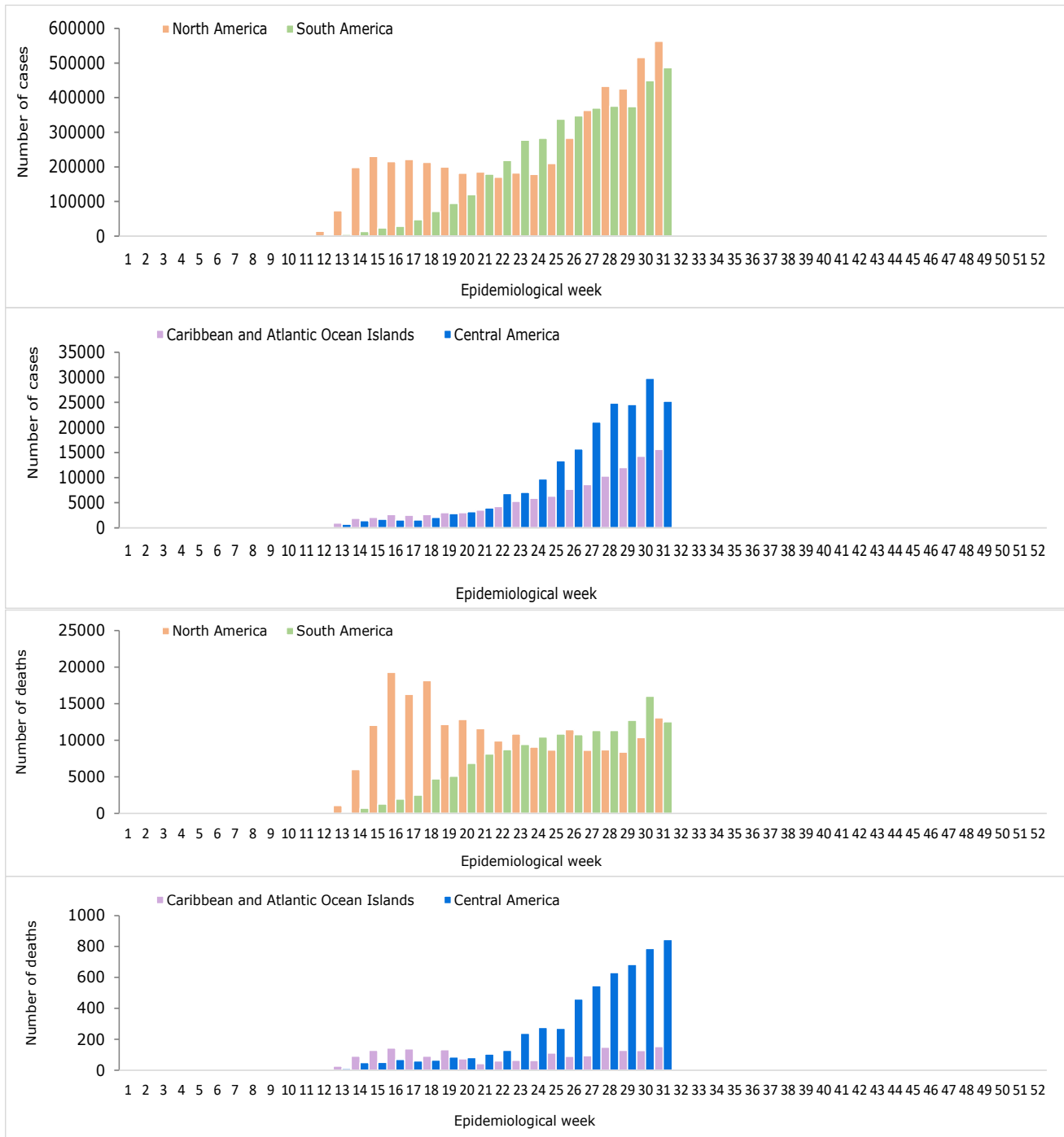
In contrast, a decrease in the intensity of transmission was observed in the Cayman Islands, for which the transmission scenario was modified from clusters of cases to sporadic cases.

As of 2 August 2020, Anguilla, the Falkland Islands, and Saint Kitts and Nevis, had not reported cases between 2 July and 2 August.

It should be noted that there is continuous variation in the transmission scenario for each country and territory and at the local level; therefore, the situation as of August 2 is subject to change in subsequent days.

In all geographic subdivisions within the Region, the increasing trend continues, both in the number of cases and number of deaths (**Figure 1**).

**Figure 1.** Distribution of confirmed COVID-19 cases and deaths, by epidemiological week (EW) and subdivision of the Americas. EW 1 to EW 31 of 2020.



**Source:** PAHO/WHO COVID-19 Daily Update. Available at: <https://bit.ly/38LzGmj>; accessed 3 August 2020.

## COVID-19 situation among the indigenous peoples in select countries

The following is an update on the COVID-19 situation among indigenous peoples in countries for which information is available.

In **Bolivia**, since the first confirmed cases<sup>4</sup> of COVID-19 in the country and as of 27 July 2020<sup>5</sup>, there have been 154<sup>6</sup> confirmed cases reported in the indigenous population (**Table 1**), including 4 deaths (2.6%).

**Table 1.** Distribution of positive cases of COVID-19 by original rural indigenous territories and protected areas. Bolivia, 10 March to 27 July 2020.

Original indigenous territories, protected areas and their communities	# Cases
Marka Quila Quila	3
Marka Valle Tinquipaya de Poroma	1
Marka Payaquillu San Lucas	1
Jatun Ayllu Chhaqi	1
Jatun Ayllu Yura	3
Total Nation Qhara-Qhara	9
Marka Sipe Sipe	3
Jatun Ayllu Kirkiawi	0
Total Nation Suras	3
Campesino Turco	7
Total Nation Jacha-Karangas	7
Marka Sevaruyu	3
Total Nation Killacas	3
APG Guarani	21
Itika Guasu	35
Guarani Iyambae	21
Total Nation Guarani	77
Total protected area Aguarague	53
Total protected area Tucabaca	2
Total of cases	154

**Source:** Data published by the National Coordinator of Defense of Original Rural Indigenous Territories and Protected Areas (CONTIOCAP)<sup>7</sup>, reproduced by PAHO/WHO.

The Guaraní indigenous people account for the majority of reported cases (77%), which with a population of 58,990<sup>8</sup>, would reach a crude incidence rate of 13.0 cases per 10,000 population.

<sup>4</sup> 10 March 2020.

<sup>5</sup> Data published by the National Coordinator for the Defense of Original Rural Indigenous Territories and Protected Areas (CONTIOCAP)

<sup>6</sup> Differences in the number of cases between this Update and the Alert published on 15 July is because the current data refers to specific nations.

<sup>7</sup> National Coordinator for the Defense of Original Rural Indigenous Territories and Protected Areas (CONTIOCAP). Available at: <https://bit.ly/398TuJc> Accessed on 3 August 2020.

<sup>8</sup> Center for Legal Studies and Social Research (CEJIS). Available at: <https://bit.ly/31hiMbV>, accessed on 3 August 2020.

In **Brazil**, since the first confirmed case of COVID-19 in the country<sup>9</sup> and as of 25 July 2020, there have been 24,609 cases of COVID-19 reported among indigenous peoples in the Indigenous Health Care Subsystem (SasiSUS, per the Portuguese acronym), of which 14,064 (58%) were confirmed, 9,433 (37%) were discarded, 226 (1%) were excluded, and 886 (4%) remain under investigation. The 34 Special Districts of Indigenous Health (DSEI, per the Portuguese acronym) all reported confirmed cases of COVID-19. Of the total confirmed cases, 259 (1.8%) died of COVID-19.

The North and Northeast regions continue to report incidence rates over 1,000 cases per 100,000 population, occurring in 17 out of 19 DSEI in the North Region and 3 out of 6 DSEI in the Northeast Region. In the Central-West, South, and Southeast regions, there has been a significant increase in cases compared to the figures provided in the 15 July 2020 PAHO/WHO Epidemiological Alert on COVID-19 in indigenous peoples<sup>10</sup>.

The highest mortality rates per 100,000 population have been reported in the DSEI in the North and Central-West regions, as shown in **Table 2**.

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<sup>9</sup> 26 February 2020.

<sup>10</sup> Pan American Health Organization / World Health Organization. Epidemiological Alert: COVID-19 among indigenous peoples in the Americas. 15 July 2020, Washington, D.C.: PAHO/WHO; 2020. Available at: <https://bit.ly/2PoRQRR>

**Table 2.** Distribution of COVID-19 cases and deaths among indigenous peoples assisted by SasiSUS, by DSEI, up to epidemiological week (EW) 30 of 2020. Brazil.

DSEI	Number of cumulative confirmed cases	Number of cumulative of confirmed deaths	Crude incidence rate per 100,000 pop.	Crude incidence mortality rate per 100,000 pop.	Case fatality rate (%)
<b>North Region</b>	<b>9708</b>	<b>150</b>	<b>2552.0</b>	<b>39.4</b>	<b>1.5</b>
Altamira	235	0	5265.5	0.0	0.0
Alto Rio Juruá	389	7	2138.3	38.5	1.8
Alto Rio Negro	624	12	2169.2	41.7	1.9
Alto Rio Purus	231	5	1819.2	39.4	2.2
Alto Rio Solimões	1036	29	1457.8	40.8	2.8
Amapá e Norte do Pará	681	3	5219.2	23.0	0.4
Guamá-Tocantins	904	17	5171.9	97.3	1.9
Kaiapó do Pará	887	8	14299.5	129.0	0.9
Leste de Roraima	1392	22	2620.8	41.4	1.6
Manaus	342	10	1086.5	31.8	2.9
Médio Rio Purus	110	1	1409.7	12.8	0.9
Médio Rio Solimões e Afluentes	205	8	908.9	35.5	3.9
Parintins	67	4	403.1	24.1	6.0
Porto Velho	281	4	2618.1	37.3	1.4
Rio Tapajós	1177	11	8828.4	82.5	0.9
Tocantins	350	4	2773.8	31.7	1.1
Vale do Javari	326	1	5168.0	15.9	0.3
Vilhena	153	1	2594.1	17.0	0.7
Yanomami	318	3	1134.2	10.7	0.9
<b>Center-West Region</b>	<b>1266</b>	<b>59</b>	<b>995.3</b>	<b>46.4</b>	<b>4.7</b>
Araguaia	60	1	1024.8	17.1	1.7
Cuiabá	345	9	4664.1	121.7	2.6
Kaiapó do Mato Grosso	36	1	721.6	20.0	2.8
Mato Grosso do Sul	405	10	514.7	12.7	2.5
Xavante	318	31	1433.2	139.7	9.7
Xingu	102	7	1263.6	86.7	6.9
<b>Northeast Region</b>	<b>2261</b>	<b>38</b>	<b>1375.5</b>	<b>23.1</b>	<b>1.7</b>
Alagoas e Sergipe	134	2	1073.5	16.0	1.5
Bahia	98	2	296.5	6.1	2.0
Ceará	406	5	1505.6	18.5	1.2
Maranhão	1243	21	3286.7	55.5	1.7
Pernambuco	151	7	388.7	18.0	4.6
Potiguara	229	1	1505.7	6.6	0.4
<b>South and Southeast Region</b>	<b>829</b>	<b>12</b>	<b>987.9</b>	<b>14.3</b>	<b>1.4</b>
Interior Sul	551	11	1317.1	26.3	2.0
Litoral Sul	203	1	810.3	4.0	0.5
Minas Gerais y Espírito Santo	75	0	440.3	0.0	0.0
<b>Total</b>	<b>14064</b>	<b>259</b>	<b>1860.6</b>	<b>34.3</b>	<b>1.8</b>
Crude Incidence rate	≥1000				
	501-999				
	≤500				
Crude mortality rate	70.0 - ≥100				
	30.1 -60.9				
	0.0 -30.0				
Case fatality rate	≥3.6				
	1.0 -3.5				
	0.0 - 0.9				

**Source:** Data published by the Special Secretary for Indigenous Health / Ministry of Health of Brazil ([www.saudeindigena.saude.gov.br](http://www.saudeindigena.saude.gov.br)) and reproduced by PAHO/WHO.

In **Canada**, since the first confirmed case of COVID-19<sup>11</sup> in the country and as of 31 July 2020, there have been 404 confirmed cases, including 6 deaths, reported among indigenous peoples. Cases have been distributed amongst the provinces of *Alberta* (152 cases), *Saskatchewan* (90 cases), *Ontario* (63 cases), *British Columbia* (64 cases), and *Quebec* (35 cases).<sup>12</sup>

In **Colombia**, since the first confirmed case of COVID-19<sup>13</sup> in the country and as of 30 July 2020, there have been 4,266 confirmed cases, including 151 deaths and 2,435 recovered, reported among indigenous peoples, representing 1.49% of the national cases, with a crude incidence rate of 223.9 cases per 100,000 indigenous people.

Among the indigenous peoples of Colombia (for which information is available), the indigenous nations with incidence rates greater than 1,000 cases per 100,000 population, in decreasing order, are the *Tikuna* (2,420.2 cases per 100,000 population), *Muisca* (1,384.2 cases per 100,000 population), *Andoque* (1,341.5 cases per 100,000 population), and *Mokana* (1,032.4 per 100,000 population) ; the *Andoque* peoples have a population of less than 1,000 (**Table 3**).

**Table 3.** Distribution of confirmed cases of COVID-19 and crude incidence rates among indigenous peoples by indigenous nation. Colombia, 6 March to 30 July 2020.

Indigenous nation	# Cases	Indigenous population	Crude incidence rate per 100.000 pop.	Indigenous nation	# Cases	Indigenous population	Crude incidence rate per 100.000 pop.
Ambaló	7	3,278	213.5	Awá	37	44,516	83.1
Andoque	11	820	1341.5	Curripaco	2	11,946	16.7
Bora	8	1,047	764.1	Embera	109	56,504	192.9
Cocama	28	3,221	869.3	Embera Katío	72	48,117	149.6
Coreguaje	1	3,257	30.7	Inga	92	19,561	470.3
Desano	6	3,641	164.8	Kamëntsa	1	7,521	13.3
Dujos (Tamas)	2	611	327.3	Kankuamo	56	16,986	329.7
Kichwa	2	3,688	54.2	Misak (Guambiano)	51	21,713	234.9
Kizgó	7	3,974	176.1	Mokana	383	37,099	1032.4
Kofán	4	1,816	220.3	Muisca	156	11,265	1384.8
Matapí	1	618	161.8	Murui (uitoto)	67	12,029	557.0
Muinane	2	2,113	94.7	Nasa (Paéz)	271	243,176	111.4
Piratapuyo	4	1,106	361.7	Pasto	437	163,873	266.7
Polindara	7	2,499	280.1	Piapoco	4	14,661	27.3
Sáliva	1	4,783	20.9	Pijao	330	51,635	639.1
Siona	2	2,599	77.0	Puinave	4	8,984	44.5
Tanimuca	1	991	100.9	Quillacinga	39	7,333	531.8
Yagua	3	984	304.9	Sikuani (Guahibo)	10	52,361	19.1
Yukuna	1	1,582	63.2	Tikuna	335	13,842	2420.2
Guayabero	2	2,960	67.6	Totoró	3	8,916	33.6
Tariano	1	210	476.2	Wayuu	117	380,460	30.8
Tucano	5	4,075	122.7	Wounaan (Waunana)	21	14,825	141.7
				Yanacona	42	34,897	120.4
				Zenú	860	307,091	280.0
				Embera Chamí	68	77,714	87.5
				U'wa	2	10,649	18.8
				Wiwa	2	18,202	11.0

**Source:** Data provided by the Colombia International Health Regulations National Focal Point and reproduced by PAHO/WHO.

<sup>11</sup> 25 January 2020.

<sup>12</sup> Government of Canada. Coronavirus (COVID-19) and Indigenous communities. Available from: <https://bit.ly/3efm1VI>, accessed 3 August 2020.

<sup>13</sup> 6 March 2020

In **Ecuador**, since the first confirmed case of COVID-19<sup>14</sup> and as of 20 July, there have been 1,453 confirmed cases, including 27 deaths (1.9%), reported among indigenous peoples of the Ecuadorian Amazon.

Similar to that observed in other countries in the Americas, the indigenous peoples that currently have a total population of less than 5,000 persons have the highest incidence rates. In the Ecuadorian Amazon, the Waorani and Secoya peoples have the highest incidence rates (**Table 4**).

**Table 4.** Distribution of COVID-19 cases and crude incidence rates among indigenous peoples of the Ecuadorian Amazon. Ecuador, 28 February to 20 July 2020.

Indigenous nation	# Cases	Indigenous population	Crude incidence rate per 100.000 pop.
Waorani	282	2,416	11672.2
Secoya	19	689	2757.6
Siona	5	611	818.3
Shuar	426	79,709	534.4
Shiwiari	4	1,198	333.9
Kichwa	698	328,149	212.7
Cofan	3	1,485	202.0
Achuar	15	7,865	190.7
Zapara	1	559	178.9

**Source:** Data provided by the Ecuador International Health Regulations National Focal Point. Calculation of incidence rates by PAHO/WHO using population data published by the Population and Housing Census 2010<sup>15</sup>.

In **Mexico**, since the first confirmed case of COVID-19 in the country<sup>16</sup> and as of 26 July, there have been 5,413 confirmed cases, including 766 deaths (14.2%), reported among persons that recognizes themselves as indigenous.

Of these cases, 61% were reported in the following federal entities: *Yucatan* (949 cases), *Oaxaca* (526 cases), *Mexico* (456 cases), *San Luis Potosí* (419 cases), *Mexico City* (392 cases), *Hidalgo* (285 cases), and *Tabasco* (285 cases). Overall, 62% of the deaths have been reported in the following federal entities: *Yucatán* (125 deaths), *Oaxaca* (98 deaths), *México* (81 deaths), *Puebla* (59 deaths), *Mexico City* (57 deaths), and *Quintana Roo* (56 deaths).

With respect to the characteristics of the cases, 58% were male and the median age was 48 years, while among the deaths, the median age was 63 years and 65% were male.<sup>17</sup>

In **Peru**, since the first confirmed case of COVID-19 in the country<sup>18</sup> and as of 28 July 2020, there have been 10,773 confirmed cases among Amazonian indigenous peoples, including 56 confirmed deaths and 35 deaths are under investigation.

<sup>14</sup> 28 February 2020

<sup>15</sup> Department of Health and Human Services. Indigenous Health Service. Available at <https://www.ihs.gov/coronavirus/>, accessed July 29.

<sup>16</sup> 27 February 2020

<sup>17</sup> Secretary of Health of Mexico. COVID-19 in Mexico: Overview of the population that recognizes itself as indigenous. Available at: <https://bit.ly/3i6mjAK>, accessed on 3 August 2020.

<sup>18</sup> 5 March 2020



In the Loreto Region, as of 29 July 2020, there have been 4,452 confirmed cases, including 23 deaths, reported among the Amazonian indigenous peoples.

In the Peruvian Amazon, which includes indigenous peoples with populations of less than 5,000, the indigenous nations of Resigaró, Orejón (Maijuna), Yagua, and Bora are notable in that they have reported incidence rates of more than 1,000 cases per 100,000 population (**Table 5**).

**Table 5.** Distribution of COVID-19 cases and crude incidence rates among indigenous peoples in the Loreto Region. Peru, 5 March to 29 July 2020.

Indigenous nation	# Cases	Indigenous population	Crude incidence rate per 100.000 pop.
Resigaró	3	7	42857.1
Orejón (Mai Huna, Maijuna)	42	278	15107.9
Bora (Miamuna)	146	1,112	13129.5
Mayoruna (Matse)	146	1,960	7449.0
Huitoto (incluye Murui, Meneca, Munaine)	133	1,996	6663.3
Achuar, Achual	857	17,214	4978.5
Urarina (Itukale, Shimaco, Kacha)	191	7,863	2429.1
Yagua (Yawa, Nihamwo)	242	12,151	1991.6
Quichua- Quichua Runa, Kichwa*	1,553	91,530	1696.7
Secoya (Aido Pia)	15	1,191	1259.4
Ticuna (Duuxugu)	109	10,665	1022.0
Wampis (Huambisa)	16	1,949	820.9
Candoshi - Murato	44	5,527	796.1
Cocama Cocamilla	270	48,210	560.0
Shapra	3	620	483.9
Shawi (Chayahuita, Kanpunan, Kampu Piyaw)	151	39,319	384.0
Jebero (Shiwilu, Sewelo)	10	2,771	360.9
Amahuaca	1	285	350.9
Awajun (Aguaruna, Aents)	59	34,277	172.1
Toyoeri	1	664	150.6
Shipibo - Conibo - Shetebo	17	34,277	49.6
Ocaina (Ivo 'Tsa)	1	5,602	17.9

\*Includes the Inga, Lamas, and Santarrosinos denominations.

**Source:** Data provided by the Peru International Health Regulations National Focal Point and reproduced by PAHO/WHO.

In the **United States of America**, since the first confirmed case of COVID-19 in the country<sup>19</sup> and as of 1 August 2020, there have been 32,525 confirmed cases reported across 12 areas of the Indian Health Service (IHS). Two IHS areas account for 57% of the confirmed cases: Navajo (10,559 cases) and Phoenix (7,872 cases).<sup>20</sup>

<sup>19</sup> 21 January 2020.

<sup>20</sup> United States Department of Health and Human Services. Indian Health Service. Coronavirus (COVID-19). Available from: <https://www.ihs.gov/coronavirus/> and accessed 3 August 2020.

In **Venezuela**, since the first confirmed case of COVID-19 in the country<sup>21</sup>, and as of 2 August 2020, there have been 179 confirmed cases, including 3 deaths, reported among indigenous peoples. Of these cases, 68.5% were reported in the state of *Bolívar* (123 cases) while the remaining cases were reported in the states of *Zulia* (43 cases, 2 deaths), *Amazonas* (12 cases), and *Delta Amacuro* (1 fatal case). The indigenous ethnic group that accounts for the majority of cases and deaths is Pemón, followed by Wayú.

## Guidelines for national authorities

The Pan American Health Organization / World Health Organization (PAHO/WHO) reiterates the recommendations made in the PAHO/WHO Epidemiological Alert on COVID-19 in indigenous peoples of 15 July 2020<sup>22</sup>, for Member States address the specific risk factors and vulnerabilities amongst indigenous peoples in the context of the COVID-19 pandemic, and ensure active participation of these communities in the planning and implementation of response measures, which must be specific to the communities and culturally-appropriate.

The following are recommendations regarding surveillance, laboratory, infection prevention and control measures, contact tracing and quarantine, treatment, dead body management, and prevention.

### Surveillance

As emphasized in previous PAHO/WHO COVID-19 Epidemiological Alerts and Updates, the following activities should be performed to interrupt the transmission of COVID-19:

- Early detection of suspected cases
- Laboratory confirmation
- Isolation
- Contact tracing and quarantining contacts

For early detection of suspected cases, it is recommended to have the participation of indigenous peoples, through their community leaders, during the development and implementation of any adopted strategies. PAHO/WHO recommends the following case definitions for COVID-19, available at: <https://bit.ly/2CHslrK>, which may be adapted for community surveillance.

COVID-19 surveillance strategies in indigenous communities should include: 1) community surveillance conducted by community members, 2) at the primary care level, 3) at the hospital level, 4) in health centers, 5) by using mortality data, and 6) through data from laboratory testing.

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<sup>21</sup> 13 March 2020.

<sup>22</sup> Pan American Health Organization / World Health Organization. Epidemiological Alert: COVID-19 among indigenous peoples in the Americas. 15 July 2020, Washington, D.C.: PAHO/WHO; 2020. Available at: <https://bit.ly/2PoRQRR>

For any of these strategies, it is important to have data disaggregated by ethnicity in order to identify related risk factors.

Event-based surveillance plays an important role, and community members should have mechanisms and resources available to report rumors or signals of public health importance through hotlines and other means. Attention should be given to rumors of clusters of cases or deaths related to fever and shortness of breath, and cases of fever and death after contact with a patient with COVID-19. These signals may indicate possible threats to public health, which may or may not be due to COVID-19. Rumors must be verified and investigated in order to determine the cause and provide prompt healthcare to all those who may need it.

## **Laboratory**

Confirmation of COVID-19 transmission among a population requires laboratory testing. PAHO/WHO recommends that all suspected cases be tested for COVID-19 according to the PAHO/WHO case definitions, available at: <https://bit.ly/2CHslrK>

It is critical to ensure access to diagnostic tests. However, in areas with high incidence and/or lack of capacity or access to laboratory testing, it is important to establish criteria to support prioritization of testing so that adequate measures to reduce the transmission of COVID-19 can be implemented. In such situations, testing should be prioritized for suspected cases who are:

- Individuals at-risk of developing severe forms of the disease,
- Those who will require hospitalization and specialized care to treat COVID-19,
- Health workers (including emergency medical service workers, non-clinical staff, and traditional healers) regardless of whether they are a contact of a confirmed case (to protect health workers and reduce the risk of nosocomial transmission), and
- The first symptomatic people in the village or community.

All suspected cases that cannot be tested for any particular reason should be considered as COVID-19 cases.

## **Implementation of infection prevention and control measures**

In the absence of treatment and vaccines for COVID-19, early identification and early isolation of confirmed and probable cases continue to be the most important measures to slow and interrupt COVID-19 transmission among isolated populations.

Once the presence of COVID-19 cases has been confirmed in an area or community, and when diagnostic tests are not available, suspected cases that cannot be tested should be isolated and

managed as COVID-19 cases, according to protocols for initial management of cases with acute respiratory illness (ARI) in the context of COVID-19<sup>23</sup>.

As part of the early identification of cases, health professionals should recognize patients with fever (axillary temperature >37.5 degrees Celsius), cough, and shortness of breath. Suspected cases should be offered a surgical mask (if they do not have an impediment to wearing it) and the patient should be isolated in a single room, if possible. Maintaining the family unit, particularly for young children, must remain a key principle in all isolation efforts. Whenever possible, children should be isolated with a caregiver. The caregiver should wear a surgical mask and be guided on frequent hand hygiene with soap and water or an alcohol-based solution (70%).

All suspected and confirmed cases should be isolated in a healthcare facility if resources permit, or in a designated community or additional temporary facility (or designated area in the community). Health authorities, along with community members, should apply locally-adapted approaches to support cases and their families during isolation to ensure their safety and well-being.

Every effort should be made to increase the capacity of these collective isolation facilities. Home isolation should only be considered when the aforementioned options are not feasible, or due to protective considerations for children and other vulnerable peoples; home isolation should be done for a short period of time, and only if the conditions of the home allow, while waiting for a transfer to a designated facility.

Additional recommendations on infection prevention and control practices in the community setting are available at: <https://bit.ly/2WcxpLX>

### **Contact tracing and quarantining contacts**

Tracing contacts should be conducted for all probable and confirmed cases. If laboratory testing cannot be performed, suspected cases should be considered as probable cases, and therefore their contacts should also be traced and monitored.

It is recommended to identify the contacts of each case and monitor their health status to detect the possible development of signs and symptoms of COVID-19 for 14 days from the last day of possible contact with the case. Community support is key to ensuring that the follow-up and monitoring of contacts is carried out properly, and that contacts follow quarantine recommendations. Ideally, during this period, all contacts should be quarantined in a dedicated facility for this purpose. In this situation, the well-being of family members who remain in the home during the quarantine period should be ensured.

When it is not feasible to quarantine contacts in a separate facility, contacts should be quarantined at home. Each contact should receive clear information about the contact tracing process, self-monitoring of signs and symptoms, and receive necessary resources (soap, masks in case they become symptomatic, etc.) for the quarantine period.

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<sup>23</sup> PAHO/WHO. Initial care of persons with acute respiratory illness (ARI) in the context of coronavirus disease (COVID-19) in healthcare facilities: assess the risk, isolate, refer. Interim recommendations, version 1 (12 April 2020). Available at: <https://bit.ly/2AXnuCo>

If it is not possible to trace all contacts, at a minimum, the identification of contacts among healthcare workers, home contacts, and close contacts, should be made. As part of this process, consideration should be given to supporting the livelihood and well-being (nutrition, etc.) of quarantined contacts and/or their dependents who cannot support themselves.

When quarantine affects childcare or another dependent, the specific situation must be considered. Preserving the family unit, particularly for young children, should remain a key principle and, where possible, children should be quarantined together with a caregiver. In all instances of quarantining contacts, measures to avoid family separation should be considered.

## **Treatment**

All mild cases with risk factors and all serious and critical cases should be treated in a health facility capable of meeting the needs of the patient, with the required level of care, and cultural sensitivity.

Based on current knowledge of the disease, most people infected with SARS-CoV-2 will develop a mild to moderate illness (including pneumonia) for which isolation and treatment can occur at a community center. However, approximately 20% to 30% of cases will require clinical care in a hospital setting with respiratory support available, which should be carefully planned. Health authorities must identify and designate hospitals that have the capacity to treat severe cases of COVID-19. It is important to plan how many beds and how many hospitals are needed based on the estimated number of cases and what medical equipment and personnel are available and needed.

It is also recommended to ensure the availability of oxygen supply systems. Planning should consider already available systems and how to increase capacity through the introduction of new oxygen supply systems (e.g. oxygen concentrators, liquid oxygen, amongst others). Additionally, it is important to ensure that all supplies and equipment are available.

Essential care includes monitoring of pulse oximetry, treatment of coinfections such as bacterial pneumonia, malaria, diarrhea, malnutrition with the appropriate use of antimalarials, antibiotics, and provision of oxygen therapy, when appropriate.

To expand care capacity, it is essential to consider not only structural elements such as beds, buildings, and equipment available, but also a trained and skilled workforce, as well as sufficient personal protective equipment (PPE) proportional to the increase in beds.

Regarding to case management, it is recommended to follow the protocols published in the Epidemiological Alert available at <https://bit.ly/2W8GNQz>

## **Appropriate dead body management**

With regard to appropriate dead body management in the context of COVID-19, it is important that national protocols and guidelines consider specific responses adapted to the traditions and customs of indigenous peoples and taking into account the recommendations outlined by PAHO/WHO. These responses must be respectful of their worldview and cultural diversity. It is important to incorporate a "relationship perspective" with families, communities, and the

population, using intercultural communication strategies and dialogue. From this, guidance and support measures can be developed that take the community and family context into account. In addition, various possible situations should be considered, for instance, if a death occurs in the hospital setting, at home, or in a situation of forced displacement, migration, deportation, amongst others<sup>24</sup>.

It is recommended to outline precautions that should be taken for burials, especially when there is intense transmission of SARS-CoV-2 within a community, so that they are carried out safely while aligning with the beliefs and religious and traditional practices of the community as much as possible. It is essential to engage with community leaders to adapt burial ceremonies in such a way that they do not compromise physical distancing measures.

Communities should be supported in the use of community case definitions to determine burial protocols in the absence of diagnostic testing capabilities.

The risk of viral transmission is low while preparing the deceased body of a person with COVID-19, and occurs mainly through contact with contaminated surfaces; therefore, the systematic application of standard precautions is crucial to prevent transmission.

In community burial settings, family members, traditional and religious leaders, health workers, and others who are generally involved in preparing a body for burial, should be supported with the necessary information, supplies, and personal protective equipment to reduce the risk of transmission. People at high-risk of serious illness, such as the elderly and individuals with comorbidities, should not participate in the preparation of the body for burial; however, this does not imply they should be excluded from the service.

## **Prevention**

Based on current evidence, SARS-CoV-2 virus is primarily transmitted between individuals through respiratory droplets and close contact, including indirect contact with objects or surfaces in the immediate environment that are contaminated from respiratory droplets from an infected person. Therefore, physical distancing is a critical measure for the prevention of COVID-19 (along with adequate hand hygiene).

Given this, it is recommended to involve communities, recognized leaders, influencers, local authorities (including the military and law enforcement), and partners to collectively identify the best methods to promote physical distancing. The simplest measures that can be implemented are contactless greetings and maintaining physical distance from others. Meetings and gatherings, even for religious purposes, should be minimized.

In some communities, isolation of cases may not be feasible; in these situations, it is important to identify—together with the community—alternatives that maximize physical distancing and hygiene measures and that minimize the risk of exposure and transmission associated with community movement.

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<sup>24</sup> Considerations on Indigenous Peoples, Afro-Descendants, and Other Ethnic Groups During the COVID-19 Pandemic. Available at <https://bit.ly/30dLDx0>

Communication is of particular importance when addressing COVID-19 among indigenous communities. It is important to ensure that information related to COVID-19 is translated, culturally adapted, and made accessible through the channels and formats that are available to these populations. Direct coordination with health services and with those responsible for managing public health information generated during the COVID-19 pandemic is necessary. While translation into indigenous and local languages is especially important, there are other aspects that are highly relevant in the context of the pandemic. Messages must be culturally adapted and consider the customs and ways of life of the population. Whenever possible, symbols and pictures should also be included to make messaging more understandable. Images used should be appropriate to the cultural context, and inappropriate technical language should be avoided. The ways in which messages are transmitted must be validated by the indigenous populations themselves. Images used in documents and on social media should be inclusive and should never stigmatize indigenous peoples.

Additionally, it is recommended to:

- Foster exchanges between traditional practitioners, ancestral therapists, and other community members with health authorities so that specific measures such as social distancing, diagnosis, isolation, and treatment take into account their worldviews, existing ancestral practices, and contexts. The importance and meaning of traditional medicine for indigenous peoples should also be considered.
- Strengthen the relationship between the health sector and indigenous leaders, taking into account their different worldviews and understanding of health and disease, amongst others. From the beginning and in conjunction with them, develop effective measures for prevention and family and community protection as it relates to the pandemic.
- Consider specific approaches that take into account different ways of life; for example, develop specific strategies that consider cultural differences for populations in urban areas, those residing in villages, indigenous migrant populations, or indigenous populations in voluntary isolation. Considering the vulnerability and exposure differences, and that not all indigenous communities will be affected by COVID-19 in the same way.
- Use existing mechanisms to promote participation adapted for COVID-19, such as intercultural dialogues.

With the support of the health sector, indigenous organizations must incorporate culturally appropriate prevention measures for their communities.



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