



Epidemiological Update Coronavirus disease (COVID-19)

21 August 2021

Executive Summary

- As of 20 August 2021, 210,112,064 confirmed cumulative cases of COVID-19 have been reported globally, including 4,403,765 deaths, for which the Region of the Americas contributed 39% of cases and 47% of deaths.
- Although the South America subregion continued to account for the highest proportions of monthly cases (54.6%) and deaths (79.8%) in the month of July for the Region of the Americas, a decreasing trend has been observed for the first time since February 2021. Meanwhile, the North America subregion has experienced an increase of 233% in cases compared to the previous month.
- As of 20 August 2021, Antigua and Barbuda, Argentina, Aruba, Brazil, Canada, the Cayman Islands, Chile, Costa Rica, Curacao, French Guiana, Guadeloupe, Guatemala, Martinique, Mexico, Panama, Puerto Rico, Sint Maarten, Suriname, the United States of America, and Uruguay have detected all four variants of concern (VOC).
- Among indigenous populations in 18 countries of the Americas, 604,264 cases were reported, including 15,027 deaths.
- A total of 24 countries and territories have reported 7,030 cumulative confirmed cases of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19, including 138 deaths.
- Regarding health workers, 39 countries and territories have reported 1,792,212 cases, including 10,302 deaths.

Table of Contents

Context.....	- 2 -
Global Situation Summary.....	- 3 -
Situation Summary in the Region of the Americas	- 4 -
Epidemiological Highlights.....	- 5 -
I. SARS-CoV-2 Variants	- 5 -
II. COVID-19 among older adults (≥60 years of age).....	- 10 -
III. COVID-19 during pregnancy.....	- 11 -
IV. COVID-19 among indigenous populations	- 16 -
V. COVID-19 among populations under 20 years of age.....	- 18 -
Multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19	- 21 -
VI. COVID-19 among health workers	- 24 -
Guidance for national authorities.....	- 28 -
References.....	- 29 -

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.¹ 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-19.²

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>.

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

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

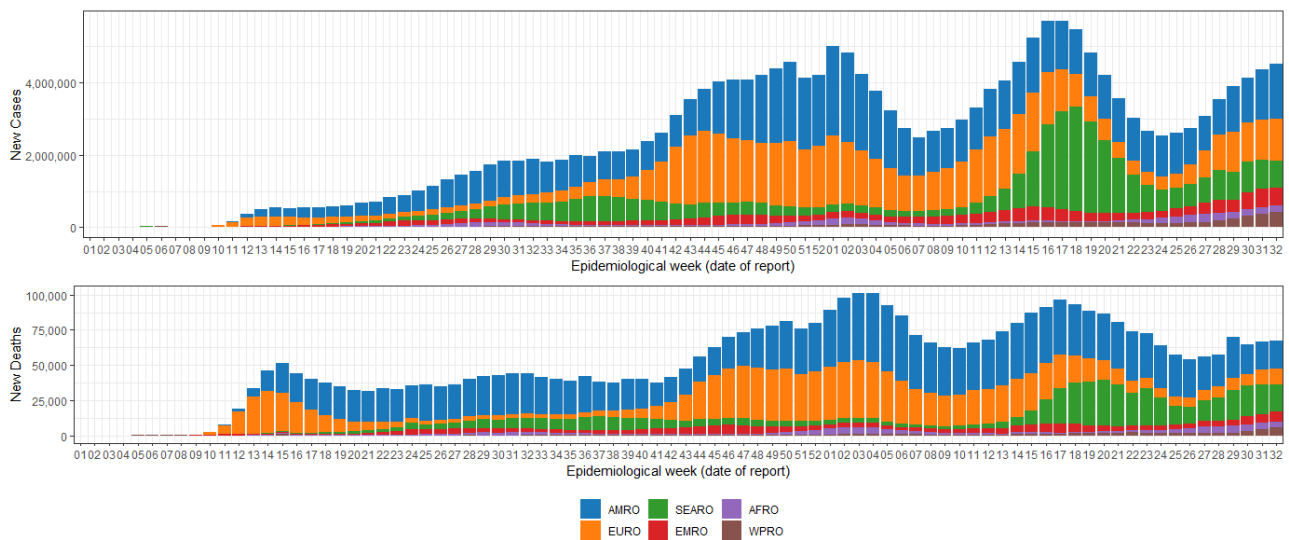
Global Situation Summary

Since the first confirmed cases of COVID-19 until 20 August 2021, a cumulative total of 210,112,064 confirmed cases of COVID-19 have been reported globally, including 4,403,765 deaths, representing a total of 19,784,373 additional confirmed cases and 310,801 additional deaths since the most recent PAHO/WHO Epidemiological Update on COVID-19 published on 22 July 2021.³

The global number of new cases has been increasing for the last two months, with over 4.4 million cases reported during epidemiological week (EW) 32 (8 – 14 August 2021) alone. This increasing trend is largely attributed to increases in the WHO Western Pacific Region and the WHO Region of the Americas, which reported increases of 14% and 8%, respectively, compared to the previous week.

Regarding deaths, all WHO Regions except for the WHO Western Pacific and the WHO Eastern Mediterranean regions reported a similar or decrease in the number of deaths in EW 32 compared to the previous week.

Figure 1. Distribution of global COVID-19 confirmed cases and deaths, by epidemiological week (EW) of report and WHO Region. As of EW 32 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 20 August 2021.

³ PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 22 July 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: <https://bit.ly/3zaBrFX>

Situation Summary in the Region of the Americas

Between January 2020 – when the first COVID-19 cases were detected in the Region – and 19 August 2021, a cumulative total of 81,227,027 confirmed cases of COVID-19, including 2,065,162 deaths, have been reported from all 56 countries and territories in the Region of the Americas.

Since the 22 July 2021 PAHO/WHO Epidemiological Update on COVID-19³ and as of 19 August 2021, 6,241,711 additional confirmed cases of COVID-19, including 99,926 additional deaths, have been reported in the Region of the Americas, representing an 8% increase in cases and a 5% increase in deaths.

In 2021 alone, between 1 January and 31 July 2021, a total of 41,307,985 confirmed cases, including 1,082,956 deaths, were reported in the Americas, with the subregions of North America and South America accounting for the highest proportions of cases (41.9% and 54%, respectively), while the Central America and the Caribbean and Atlantic Ocean Islands subregions accounted for 2.1% and 2% of the cases, respectively.

During the same period, South America accounted for 61.9% of the reported deaths, followed by North America (35.6%), Central America (1.6%), and the Caribbean and Atlantic Ocean Islands (0.8%) subregions.

Between January and June 2021, while monthly cases decreased in the North America subregion (by 95%), it increased in South America (by 50%), reaching a peak of over 4 million cases in June. Since then, the trends have reversed between the two subregions, with cases increasing in North America – a 233% increase compared to cases reported in June – and cases decreasing for the first time since February in South America during the month of July. (**Figure 2**).

In July 2021, the South America subregion continued to account for the highest proportions of monthly cases (54.6%) and deaths (79.8%) in the Region of the Americas, with a total of 2,659,777 cases and 109,010 deaths reported (**Figure 2**).

Figure 2. Distribution of confirmed COVID-19 cases and deaths, by subregion and month of report. Region of the Americas, 1 March 2020 to 31 July 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 19 August 2021, more than 2,895,410 complete genomic sequences have been shared globally through publicly accessible databases.

As of 19 August 2021, 54 countries and territories in the Americas have published a total of 915,769 SARS-CoV-2 genomes on the GISAID platform, collected between February 2020 and August 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, Saba, Saint Barthelemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Sint Eustatius, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos Islands, the United States of America, the United States Virgin Islands, 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 are periodically reviewed and updated, as necessary. Information on variants available at: <https://bit.ly/3gmGoEc>

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.⁴ The labels are available at: <https://bit.ly/2RTGXMN>

The list of SARS-CoV-2 variants, according to the WHO classification as of 13 August 2021,⁵ is available in **Table 1**.

⁴ 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/3xcARqs>

⁵ 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 13 August 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 P.1.4 P.1.6 P.1.7	Brazil
	Delta	B.1.617.2 AY.1 AY.2 AY.3 AY.3.1	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.¹⁰ Accessed on 18 August 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 20 August 2021.

	WHO Label			
	Alpha	Beta	Gamma	Delta
Number of countries/territories reporting cases globally*	190	138	82	148
Number of countries/territories reporting cases in the Americas**	49	24	36	42

Note:

*Global data correspond to the WHO COVID-19 Weekly Epidemiological Update. Published on 17 August 2021.⁶ Some countries/territories have reported more than one variant of concern (VOC).

**As of 20 August 2021

Source: WHO. COVID-19 Weekly Epidemiological Update. Published on 17 August 2021.¹¹

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.

Since April 2021, an exponential increase in VOC Delta samples globally has been observed. In July 2021, a global predominance of VOC Delta was observed in almost 90% of the samples worldwide, including Member States in the Americas.

On 8 August 2021, PAHO/WHO published an Epidemiological Update related to the increase of the Delta VOC and its potential impact in the Region of the Americas.⁷ In the Americas, as of 20 August 2021, 53 countries/territories have reported the detection of cases of VOC, including five additional countries/territories (El Salvador, Falkland Islands (Malvinas), Saint-Pierre and Miquelon, Saint Vincent and the Grenadines and the United States Virgin Islands) since the 22 July 2021 PAHO/WHO COVID-19 Epidemiological Update (**Table 3a-d**).³

As of 20 August 2021, the detection of all four VOC has been reported in Antigua and Barbuda, Argentina, Aruba, Brazil, Canada, the Cayman Islands, Chile, Costa Rica, Curacao, French Guiana, Guadeloupe, Guatemala, Martinique, Mexico, Panama, Puerto Rico, Sint Maarten, Suriname, the United States of America, and Uruguay.

⁶ WHO. Weekly epidemiological update on COVID-19. Available at: <https://bit.ly/3zyiHAP>

⁷ PAHO/WHO. Epidemiological Update: Increase of the Delta variant and its potential impact in the Region of the Americas. 8 August 2021, Washington, D.C. PAHO/WHO. 2021. Available at: <https://bit.ly/3y2Rm7K>

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

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

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

Country	Alpha	Beta	Gamma	Delta
Belize	√		√*	√*
Costa Rica	√	√	√	√
El Salvador	√		√*	√*
Guatemala	√	√	√	√
Honduras	√			
Panama	√	√	√	√*

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

Country	Alpha	Beta	Gamma	Delta
Argentina	√	√	√	√
Bolivia	√		√	
Brazil	√	√	√	√
Chile	√	√	√	√
Colombia	√		√	√
Ecuador	√		√	√
Paraguay	√		√	√
Peru	√		√	√
Uruguay	√	√*	√	√*
Venezuela	√		√	√

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

Country/Territory	Alpha	Beta	Gamma	Delta
Anguilla	√			√
Antigua and Barbuda	√	√	√*	√*
Aruba	√	√	√	√
Bahamas	√			
Barbados	√		√	√
Bermuda	√	√		√*
Bonaire	√		√	√
British Virgin Islands	√		√	√*
Cayman Islands	√	√	√	√*
Cuba	√	√		√*
Curacao	√	√*	√	√
Dominica	√			
Dominican Republic	√		√	
Falkland Islands (Malvinas)	√*	√*		
French Guiana	√	√	√	√
Grenada	√			√*
Guadeloupe	√	√	√	√
Guyana			√	
Haiti	√		√	
Jamaica	√			√*
Martinique	√	√	√	√
Montserrat	√		√*	
Puerto Rico	√	√	√	√
Saba				√
Saint Barthelemy	√			
Saint Lucia	√			√*
Saint Martin	√	√		
Saint Pierre and Miquelon				√*
Saint Vincent and the Grenadines				√*
Sint Maarten	√	√	√	√
Suriname	√	√	√	√*
Trinidad and Tobago	√		√	√*
Turks and Caicos	√		√	√
United States Virgin Islands	√	√*		√*

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

* Sequence is not available yet in an international repository.

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

Some of the articles published^{8,9,10}, 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.

According to a study¹¹ in the **United States of America** on the effectiveness of COVID-19 vaccines (Pfizer-BioNTech, Moderna and Janssen) in preventing hospitalizations among adults aged ≥65 years old, these vaccines were highly effective in preventing hospitalizations of laboratory-confirmed COVID-19 cases.

The study was conducted in a population of 7,280 persons aged 65 years or older between 1 February and 30 April 2021. The study estimated that the effectiveness of complete vaccination in preventing hospitalization among adults between 65-74 years of age was 96% for Pfizer/BioNTech and Moderna, and 84% for Janssen, while the effectiveness of partial vaccination in preventing hospitalization among the same age group was 84% and 91% for Pfizer/BioNTech and Moderna, respectively (Janssen only requires one dose so partial vaccination is not applicable). Similarly, among adults aged ≥75 years, the effectiveness of complete vaccination in preventing hospitalization was estimated at 91%, 96%, and 85% for Pfizer/BioNTech, Moderna, and Janssen, respectively, while the effectiveness of partial vaccination in preventing hospitalization among the same age group was 66% and 82% for Pfizer/BioNTech and Moderna, respectively.

Overall, the effectiveness of complete vaccination with Pfizer-BioNTech and Moderna (mRNA vaccines) was ≥91%, and with Janssen was ≥84% among adults aged 65 years or older. Additionally, the analysis demonstrated that all COVID-19 vaccines currently authorized in the United States are highly effective in preventing COVID-19-associated hospitalizations in older adults. However, it must be considered that the analysis was conducted prior to the predominance of the Delta VOC, and the circulation of all variants might affect vaccine effectiveness over time.

⁸ 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>

⁹ 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>

¹⁰ 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)

¹¹ Moline HL, Whitaker M, Deng L, et al. Effectiveness of COVID-19 Vaccines in Preventing Hospitalization Among Adults Aged ≥65 Years — COVID-NET, 13 States, February–April 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:1088–1093. DOI: <http://dx.doi.org/10.15585/mmwr.mm7032e3>

III. 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 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 20 August 2021, there have been a total of 271,230 SARS-CoV-2 infections among pregnant women, including 2,619 deaths (0.97% case-fatality rate), reported in 30 countries/territories for which information was available.

Compared to the data presented in the 22 July 2021 PAHO/WHO COVID-19 Epidemiological Update,³ this represents 12,871 additional cases and 244 additional deaths. During the same period, the highest relative increases in cumulative confirmed cases occurred in Cuba (45%, 1,388 cases) and Bolivia (26%, 847 cases). Among deaths, the highest relative increases were observed in Cuba (84%, 27 deaths) and Paraguay (34%, 29 deaths) (**Table 4**).

Table 4. SARS-CoV-2 infections and deaths among pregnant women, by country/territory. Region of the Americas. January 2020 to 20 August 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	20,832	190	0.91
Bahamas	101	1	0.99
Bolivia	3,263	31	0.95
Belize	315	2	0.63
Bermuda	11	0	0.00
Brazil †	13,840	1,189	8.59
British Virgin Islands	3	N/A	N/A
Canada	6,732	3	0.04
Cayman Islands	7	0	0.00
Chile	15,602	15	0.10
Colombia	15,593	158	1.01
Costa Rica	1,090	7	0.64
Cuba	3,067	32	1.04
Dominican Republic	1,195	45	3.77
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&	21,369	413	1.93
Panama &**	2,413	12	0.50
Paraguay &	2,109	85	4.03
Peru &	54,066	177	0.33
Saint Lucia	29	0	0.00
Suriname	487	2	0.41
United States of America**	94,519	103	0.11
Uruguay	1,438	12	0.83
Venezuela	550	13	2.36
Total	271,230	2,619	0.97

Note:

N/A: Data not available.

& Corresponds to pregnant and postpartum women

† The information presented for Brazil corresponds data extracted from the Influenza Epidemiological Surveillance Information System (SIVEP-Gripe).

* 20 August 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 22 July 2021 PAHO/WHO Epidemiological Update on COVID-19³

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 23 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 July 2021 and, for most countries, the numbers of cases and deaths reported this year have exceeded the numbers reported for all of 2020. Additionally, most countries have reported a higher maternal mortality ratio (MMR) in the current year.

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

Country	Year 2020			January - July 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 ^{&}	8,793	41	5.5	12,039	149	19.9
Belize	181	2	24.8	131	0	0.0
Bolivia	955	31	12.5	1461	N/A	N/A
Brazil	5,430	256	9.0	8,410	933	33.0
Canada	2,911	1	0.3	3,821	2	0.5
Chile	6,599	2	0.9	9,003	13	13.7
Colombia	7,929	56	7.7	4,503	64	17.4
Costa Rica	335	3	5.1	755	7	N/A
Cuba	180	0	0.0	2,887	32	29.4
Dominican Republic	707	36	21.7	488	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 ^{&}	10,530	205	10.1	8,105	161	15.3
Panama ^{&}	1,852	4	5.0	561	3	3.8
Paraguay ^{&}	599	1	0.7	1,289	55	38.4
Peru	40,818	81	14.3	11,951	87	15.5
Saint Lucia	5	0	0.00	24	0	0.0
Suriname ^{&}	184	2	18.9	303	0	0.0
United States of America	68,459	80	2.0	25,878	23	0.6
Uruguay	106	0	0.0	1,232	9	51.3
Venezuela	333	6	1.2	217	7	1.4

Note: [&] 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. Per 100,000 live new births.

N/A: Data not available

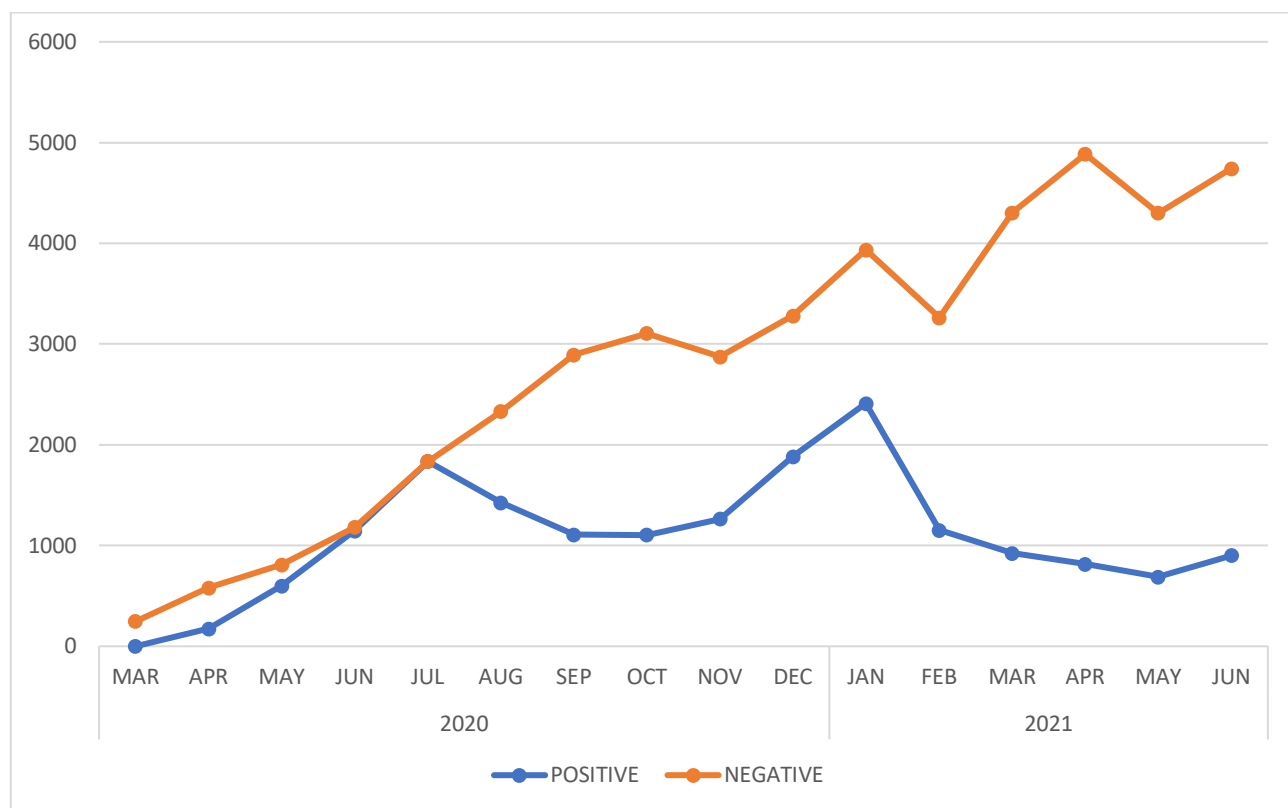
Source: Latin American Center for Perinatology/Women's Health and Reproductive Health (CLAP/SMR) and information shared with PAHO/WHO by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, health agencies, or similar and reproduced by PAHO/WHO

The following is a description of the epidemiological situation among pregnant and post-partum women confirmed for SARS-CoV-2 in **Mexico**.

Since June 2020 and as of 1 August 2021, a total of 20,329 confirmed COVID-19 cases, including 389 deaths, have been reported among pregnant and post-partum women, resulting in a case-fatality rate of 1.9%. Of the total reported cases, 91.1% were pregnant and 8.9% were post-partum women.

Cases reached a peak in January 2021, and after a decline in cases observed between January and May, an upward trend has been observed since then (**Figure 3**). Of the total number of pregnant women positive for SARS-CoV-2 for which data was available (n=19,958), 19.4% were hospitalized; currently, there are 569 hospitalized cases, of which 16.5% are in an intensive care unit (ICU). The age ranges from 11 to 49 years old and 47.6% are in the third trimester of gestation.

Figure 3. Distribution of pregnant and post-partum women positive (confirmed cases) and negative (suspected cases) for SARS-CoV-2 infection by date of symptom onset in Mexico. As of 1 August 2021.



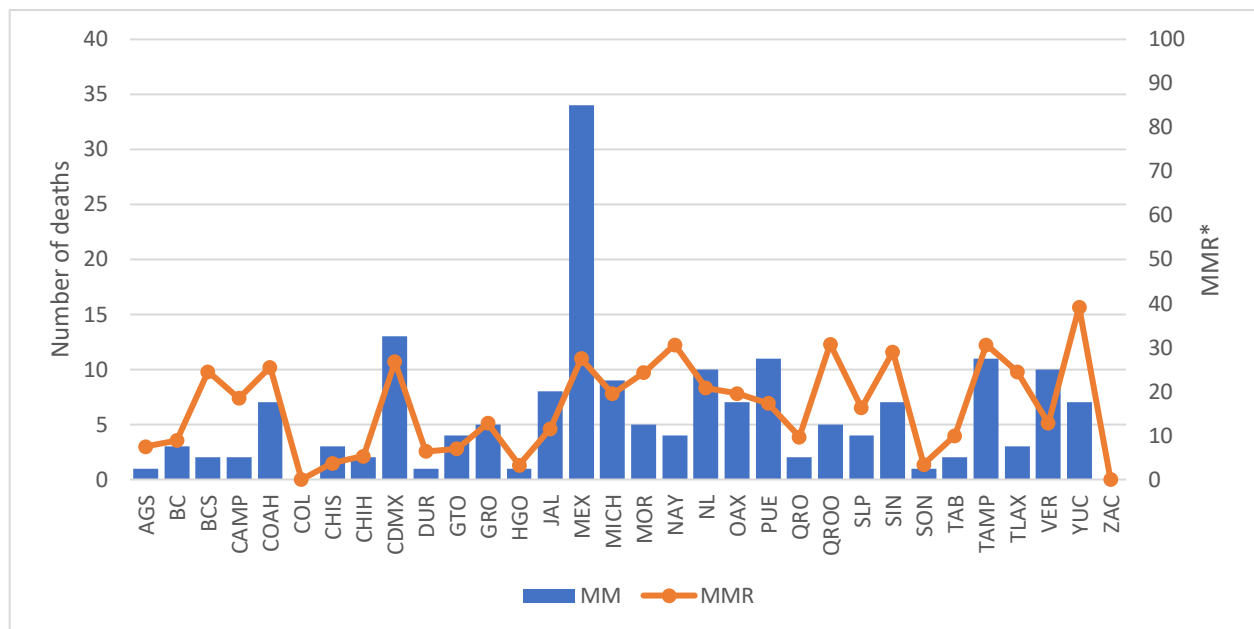
Source: Mexico Ministry of Health. Pregnant and post-partum women suspected for COVID-19, weekly epidemiological bulletin – Epidemiological week 30 of 2021.¹² Data reproduced by PAHO/WHO.

¹² Mexico Ministry of Health. Pregnant and post-partum women suspected for COVID-19, weekly epidemiological bulletin – Epidemiological week 30 of 2021. Available at: <https://bit.ly/3spctQy>

On 5 August 2021, the Mexico Ministry of Health issued an epidemiological alert¹³ due to the increase in maternal deaths associated with COVID-19 among pregnant and post-partum women; this increase has been observed since EW 27 of 2021 and has resulted in an increase of 7.1% in the MMR (16.4 deaths per 100,000 new live births as of EW 30 2021) compared to EW 26 of 2021 (15.3 deaths per 100,000 new live births), making COVID-19 the first cause of maternal deaths in Mexico. Of note, even though COVID-19 vaccination has been available for pregnant women over 18 years of age and with at least 9 weeks of gestation since May 2021 in Mexico, none of the maternal deaths reported since EW 27 of 2021 had a history of vaccination.

In terms of geographic distribution, the federal entities reporting the highest number of cumulative cases within this population were Mexico City (4,412), Guanajuato (1,262), and Nuevo León (1,235 cases). Related to deaths, for data available (n=184) for the year 2021, Mexico State accounts for 18% of COVID-19 deaths within this population reported in 2021. While MMR in this population is 16.4 maternal deaths per 100,000 live new births at the national level in 2021, it ranges from 0 to 39.2 maternal deaths per 100,000 live new births at the subnational level, with the highest being reported in the state of Yucatan (**Figure 4**).

Figure 4. Maternal mortality ratio (MMR) associated with COVID-19 by State. Mexico 2021. As of 1 August 2021.



Note: * MMR: Maternal mortality ratio per 100,000 live new births

AGS: Aguascalientes; BCS: Baja California Sur; COAH: Coahuila; CHIS: Chiapas; CDMX: Ciudad de México; GTO: Guanajuato; HGO: Hidalgo; MEX: México; MOR: Morelos; NL: Nuevo León; PUE: Puebla; QROO: Quintana Roo; SIN: Sinaloa; TAB: Tabasco; TLAX: Tlaxcala; YUC: Yucatán

Source: Mexico Ministry of Health. Pregnant and post-partum women suspected for COVID-19, weekly epidemiological bulletin – Epidemiological week 30 of 2021.¹² Data reproduced by PAHO/WHO.

¹³ Mexico Ministry of Health. Epidemiological Advisory – COVID-19 during pregnancy. Available at: <https://bit.ly/3st8By0>

When analyzing the data by pregnancy trimester, it can be noted that for cases, 47.2% were reported during the third trimester, while for deaths, most deaths occurred during the post-partum period (32.7%) and the third trimester (32.4%). Regarding demographics, most cases were reported among females aged 25 to 29 years old (29.2%), followed by the 30 to 34 years age group (23.3%), while 27% of deaths were reported in the 30 to 34 years age group followed by those aged 35 to 39 years (23.5%).

IV. COVID-19 among indigenous populations

Since January 2020 and until 20 August 2021, there have been 604,264 confirmed cases of COVID-19, including 15,027 deaths, reported among indigenous populations in 18 countries in the Region of the Americas for which information was available (**Table 7**). Compared to the data in the 22 July 2021 PAHO/WHO Epidemiological Update on COVID-19,³ this represents a decrease in cases due to retrospective adjustments, and 381 additional deaths. In comparison with the previous PAHO/WHO Epidemiological Update, the largest relative increase¹⁴ in cases was observed in Bolivia, with 35% (10,064 additional cases) while the largest relative increase in deaths was observed in Venezuela with 67% (45 additional deaths).

¹⁴ Relative increases may be a result of delayed notification.

Table 7. Cumulative number of confirmed cases and deaths of COVID-19 among indigenous populations in the Region of the Americas. January 2020 to 20 August 2021*.

Country	Number of COVID-19 confirmed cases	Number of deaths
Argentina	2,993	100
Belize	2,093	45
Bolivia	28,764	556
Brazil	52,425	785
Canada	33,533	384
Chile	66,724	1,193
Colombia	68,716	1,975
Costa Rica	2,321	34
Ecuador**	5,832	216
Guatemala**	18,924	676
Guyana**	95	6
Mexico	21,046	3,253
Panama**	5,807	102
Paraguay	482	56
Peru	30,720	670
Suriname	2,619	49
United States of America**	259,884	4,860
Venezuela	1,286	67
Total	604,264	15,027

Note:

* 20 August 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 22 July 2021 PAHO/WHO Epidemiological Update on COVID-19.³

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.

V. COVID-19 among populations under 20 years of age

Since the beginning of the pandemic, it has been apparent that children and adolescents, compared to other age groups, have a lower risk of illness and death from COVID-19. 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 and their caregivers, and the disruption of health and social protection services, among others.¹⁵

The evidence available to date suggests that children and adolescents are less susceptible to SARS-CoV-2 infection and 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 like 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.^{16,17,18,19,20}

Although further evidence is required, some studies suggest that children, as in the case of adults, may present long lasting symptoms related to SARS-CoV-2 infection.^{21,22} Findings from a prospective cohort study involving children aged 5 to 17-years-old in the United Kingdom showed that while disease is usually short and with low burden in children, a small proportion (<2%) presented with long-term illness after infection by SARS-CoV-2.²³

The following is a brief update on the hospitalizations among children and adolescents in **the United States**.

¹⁵ UN Sustainable Development Group. Policy Brief: The Impact of COVID-19 on children. April 2020. Available at: <https://bit.ly/38r1JbH>

¹⁶ 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. DOI: <https://doi.org/10.25561/84220>

¹⁷ 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. DOI: <https://doi.org/10.1001/jamapediatrics.2020.4573>

¹⁸ Viner, R. M., Russell, S., Saule, 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>

¹⁹ 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). DOI: <https://doi.org/10.1038/s41591-020-0962-9>

²⁰ Leichman 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>

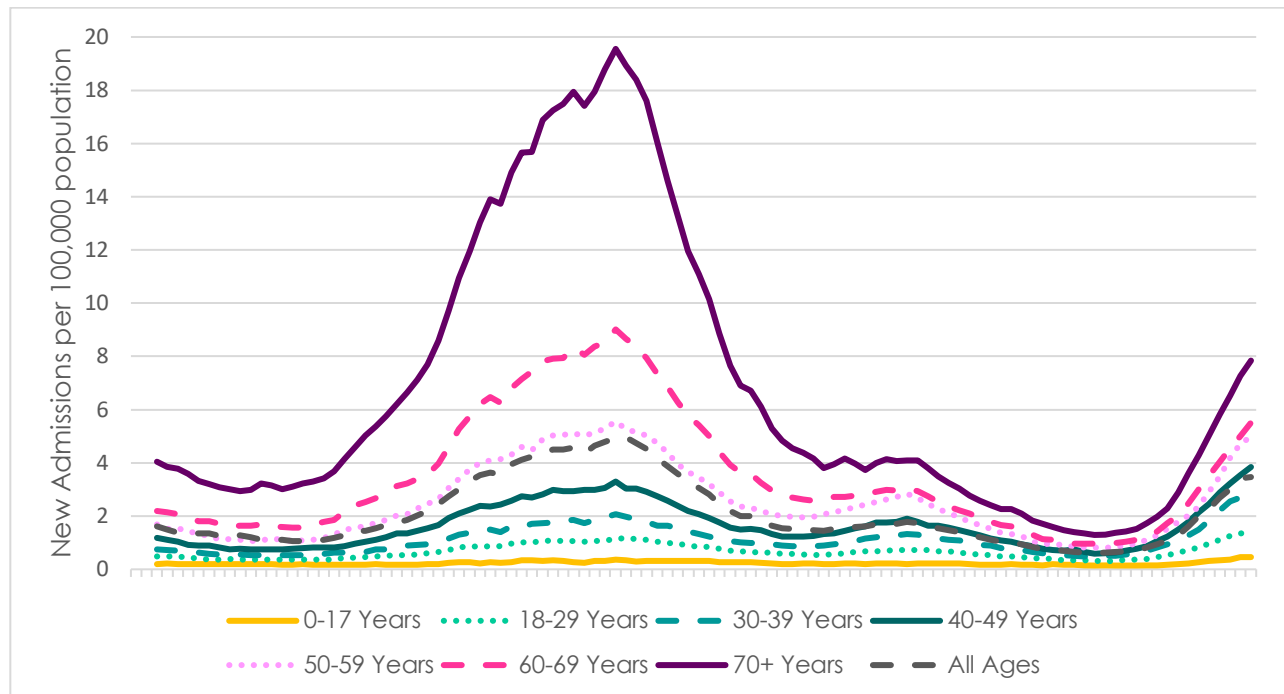
²¹ Buonsenso D, Munblit D, De Rose C, et al. Preliminary evidence on long COVID in children. *Acta Paediatr*. 2021;110(7):2208-2211. DOI: <https://doi.org/10.1111/apa.15870>

²² Brackel, L.H., Lap, C.R., Buddingh, E.P. et al. Pediatric long-COVID: An overlooked phenomenon? *Pediatric Pulmonology*, 2021 (56); 2495-2502. DOI: <https://doi.org/10.1111/apa.15870>

²³ Molteni, E., Sudre, C.H., Canas, L.S., et al. Illness duration and symptom profile in symptomatic UK school-aged children tested for SARS-CoV-2. *The Lancet Child & Adolescent Health*, 2021. DOI: [https://doi.org/10.1016/S2352-4642\(21\)00198-X](https://doi.org/10.1016/S2352-4642(21)00198-X).

In the United States, the rate of new hospital admissions has been increasing across all age groups, and the lowest rate continues to be reported among children and adolescents (**Figure 5**). However, a sharp increase in hospitalizations has been observed in this age group (<18 years old) in the United States in recent weeks (**Figure 6**). When analyzing the data by epidemiological week, it can be observed that the rate of new admissions among <18 years has shown an upward trend since EW 27. Within this age group, among children aged 0 to 4 years, this trend has been observed since EW 25. Furthermore, the 0 to 4 years age group has been reporting the largest increase in weekly hospitalization rates between EW 26 and EW 31 of 2021 (**Figure 7**).

Figure 5. New admissions of patients with confirmed COVID-19 per 100,000 population by age group. United States. August 2020 to 17 August 2021.



Source: United States CDC. COVID Data tracker – New hospital admissions.²⁴ Accessed on 19 August 2021. Data reproduced by PAHO/WHO.

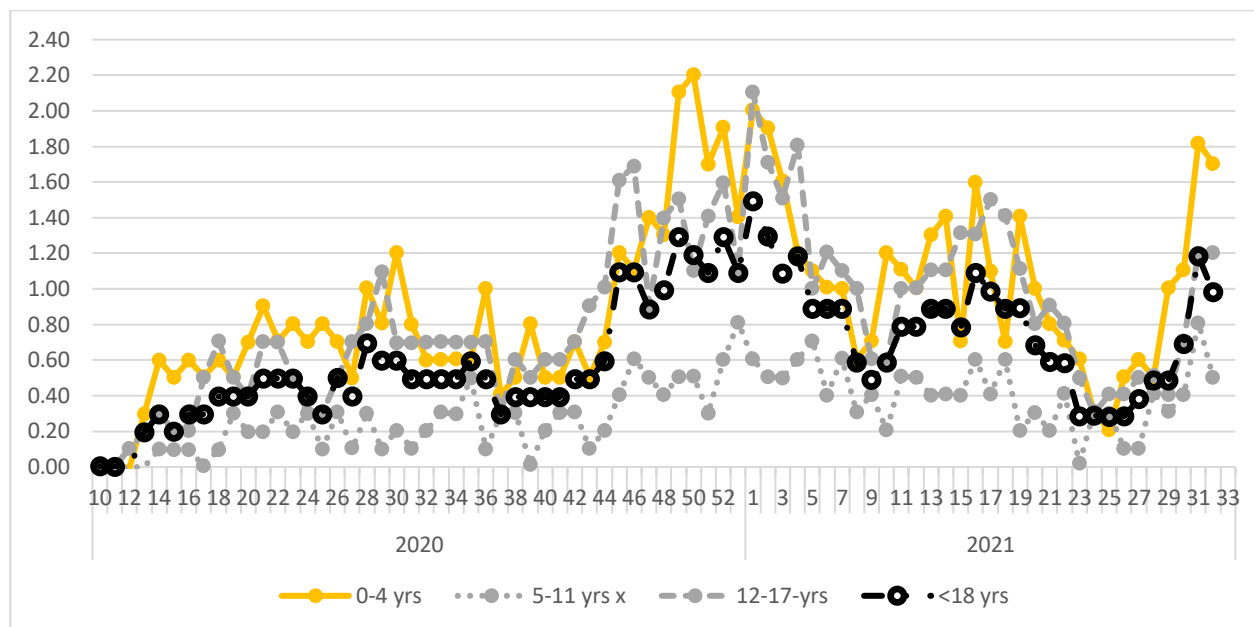
²⁴ United States CDC. COVID Data tracker – New hospital admissions. Available at: <https://bit.ly/3j2Pig4>

Figure 6. New admissions of patients with confirmed COVID-19 per 100,000 population among <18 years old. United States. August 2020 to 17 August 2021.



Source: United States CDC. COVID Data tracker – New hospital admissions. Accessed on 19 August 2021. Data reproduced by PAHO/WHO.

Figure 7. Weekly rate of new admissions of patients with laboratory-confirmed COVID-19 per 100,000 population among <18 years old, by age group. United States. March 2020 to 14 August 2021.



Source: United States CDC. COVID-NET – A weekly summary of U.S. COVID-19 hospitalization data.²⁵ Accessed on 19 August 2021. Data reproduced by PAHO/WHO.

²⁵ United States CDC. COVID-NET – A weekly summary of U.S. COVID-19 hospitalization data. Available at: <https://bit.ly/3D12Uw2>

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

Globally, various reports and scientific publications, have described groups of children and adolescents requiring admission to intensive care units (ICU) due to 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 is considered a rare event, 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 20 August 2021, a cumulative total of 7,030 confirmed cases of MIS-C temporally related to COVID-19, including 138 deaths (case-fatality rate 2%), have been reported in 24 countries/territories of the Region of the Americas (**Table 8**). During this same period, 21 countries and territories have officially reported to PAHO/WHO that they have not detected cases of MIS-C.

Since the 22 July 2021 PAHO/WHO Epidemiological Update on COVID-19³ and until 20 August 2021, there were 349 additional confirmed cases reported and 3 additional deaths.

As the numbers of cases of MIS-C increase, it is important that each country/territory characterizes the cases³² to better understand the clinical presentation, severity, treatment, and clinical outcomes.

Table 8. 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 20 August 2021*.

Country/Territory	Number of confirmed cases	Number of confirmed deaths
Argentina	208	1
Barbados	2	1
Bolivia	1	1
Brazil	1 196	73
Canada	135	0
Chile	373	5
Colombia	10	5
Costa Rica	42	0
Cuba	4	0
Dominican Republic	133	6
Ecuador	29	0
El Salvador	19	0
French Guiana	1	0
Guadeloupe	6	0
Guatemala	2	0
Honduras	3	0
Panama	81	2
Paraguay	122	8
Peru	14	0
Puerto Rico	*	*
Saint Martin	2	0
Trinidad and Tobago	29	0
United States	4 423	36
Venezuela	195	0
Total	7,030	138

Notes: *20 August 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.

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

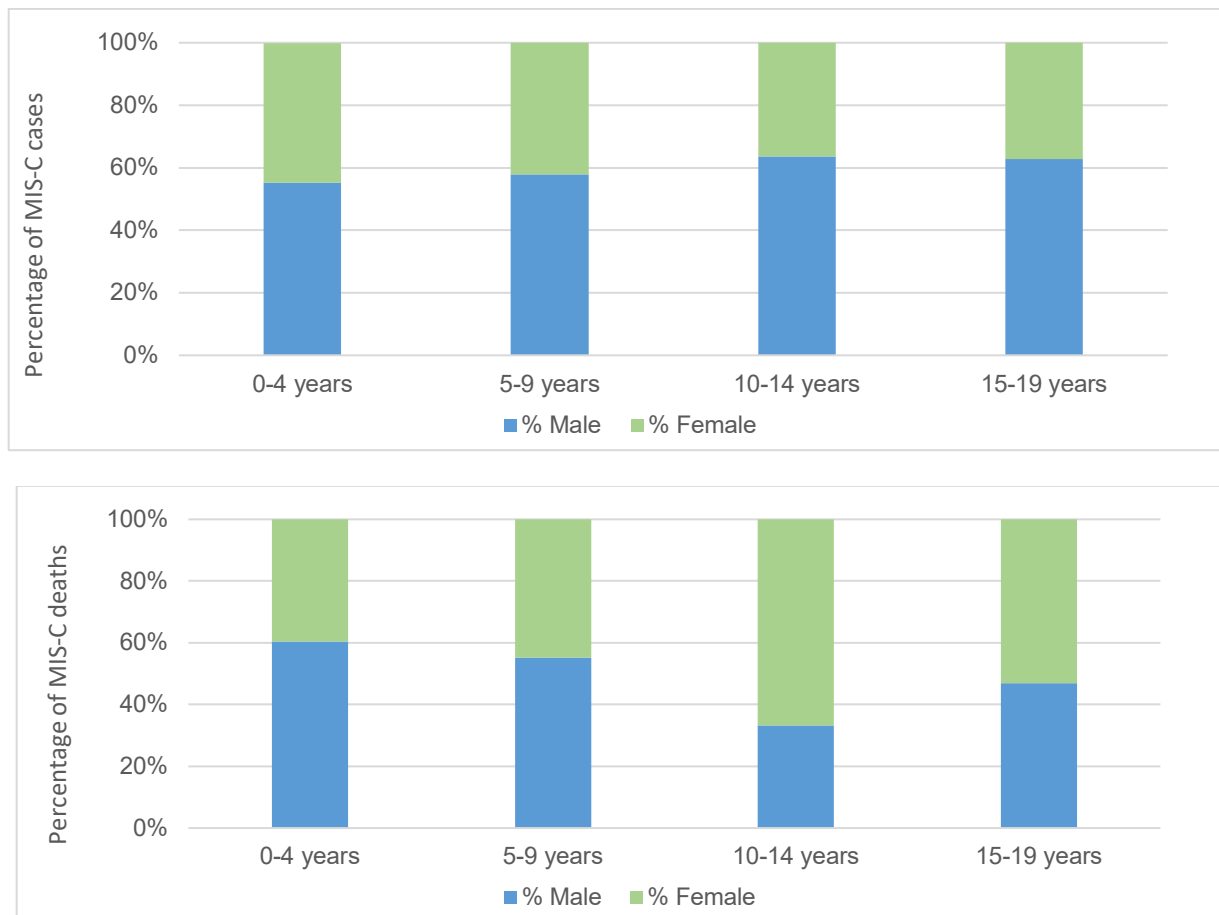
Of the total number of reported cases for which data on age and sex were available (n=6,592), the distribution of cases among age groups was 30% among 0 to 4 years, 34% among 5 to 9 years, 26% among 10 to 14 years, and 10% among 15 to 19 years (the United States of America includes 20-year-olds in this age group). Regarding the distribution by sex, 59% of the cases were male.

Among the 136 deaths for which data on age and sex were available, 35% were aged 0 to 4 years, 21% aged 5 to 9 years, 20% aged 10 to 14 years, and 24% aged 15 to 19 years. Regarding the distribution by sex, the gap between males and females is closer, with 51% of the deaths among males.

Among cases by age group, the distribution by sex generally aligns with the overall distribution by sex (59% male, 41% female) for the 0 to 4-year-olds (55% male, 45% female) and 5 to 9-year-olds (58% male, 42% female). However, the gap by sex is markedly pronounced among 10 to 14-year-olds (64% male, 36% female) and 15 to 19-year-olds (63% male, 37% female), with approximately two-thirds of cases occurring among males. **(Figure 8a)**

Regarding deaths by age group, the distribution by sex only aligns with the overall distribution by sex (51% male, 49% female) for the 5 to 9-year-olds (55% male, 45% female). Among 0 to 4-year-olds, the proportion of males is greater (60% male, 40% female), while conversely, among 10 to 14-year-olds (33% male, 67% female) and 15 to 19-year-olds (47% male, 53% female), there is a higher proportion among females. **(Figure 8b)**. The potential factors contributing to these differences warrant further investigation and should continue to be monitored.

Figure 8a-b. Percentage of confirmed cases and deaths of multisystem inflammatory syndrome among children and adolescents (MIS-C) temporally related to COVID-19 in the Region of the Americas, by age group and sex. May 2020 to 20 August 2021*.



Notes: *20 August 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.

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.

VI. COVID-19 among health workers

Since the first confirmed cases of COVID-19 were reported in the Region of the Americas and until 20 August 2021, at least 1,792,212 COVID-19 cases among health workers, including 10,302 deaths, have been reported according to the data made available by 39 countries and territories in the Americas (**Table 9**). This represents an increase of 28,897 cases and 24 additional deaths, since the 22 July 2021 Epidemiological Update.³ The total number of cases represents 12% of the estimated 15 million health workers in the Americas.²⁶

²⁶ PAHO/WHO. Weekly Press Briefing on COVID-19: Director's Opening Remarks, 12 May 2021. Available at: <https://bit.ly/3uEhbKC>

Table 9. Distribution of cumulative confirmed cases and deaths of COVID-19 among health workers in the Region of the Americas. January 2020 to 20 August 2021*.

Country/Territory	Number of confirmed cases of COVID-19	Number of deaths
Anguilla	6	0
Antigua and Barbuda	44	2
Argentina	96,626	597
Aruba	254	0
Bahamas**	505	13
Belize	340	2
Bermuda**	49	0
Bolivia**	27,791	357
Bonaire**	106	0
Brazil	503,238	703
British Virgin Islands	141	0
Canada	101,722	61
Cayman Islands	24	0
Chile	63,641	128
Colombia	65,081	322
Costa Rica	14,838	53
Curacao**	439	0
Ecuador	12,262	121
El Salvador**	6,609	72
Dominica	1	0
Dominican Republic	1,409	22
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	17,364	153
Peru	73,079	1,399
Saint Lucia	160	0
Saint Vincent and the Grenadines**	29	0
Sint Eustatius**	8	0
Sint Maarten**	54	0
Suriname	1,722	3
Turks and Caicos	97	0
United States of America	515,527	1,691
Uruguay	8,970	28
Venezuela	4,212	194
Total	1,792,212	10,302

Notes: * 20 August 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 22 July 2021 PAHO/WHO Epidemiological Update on COVID-19³

‡ 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.

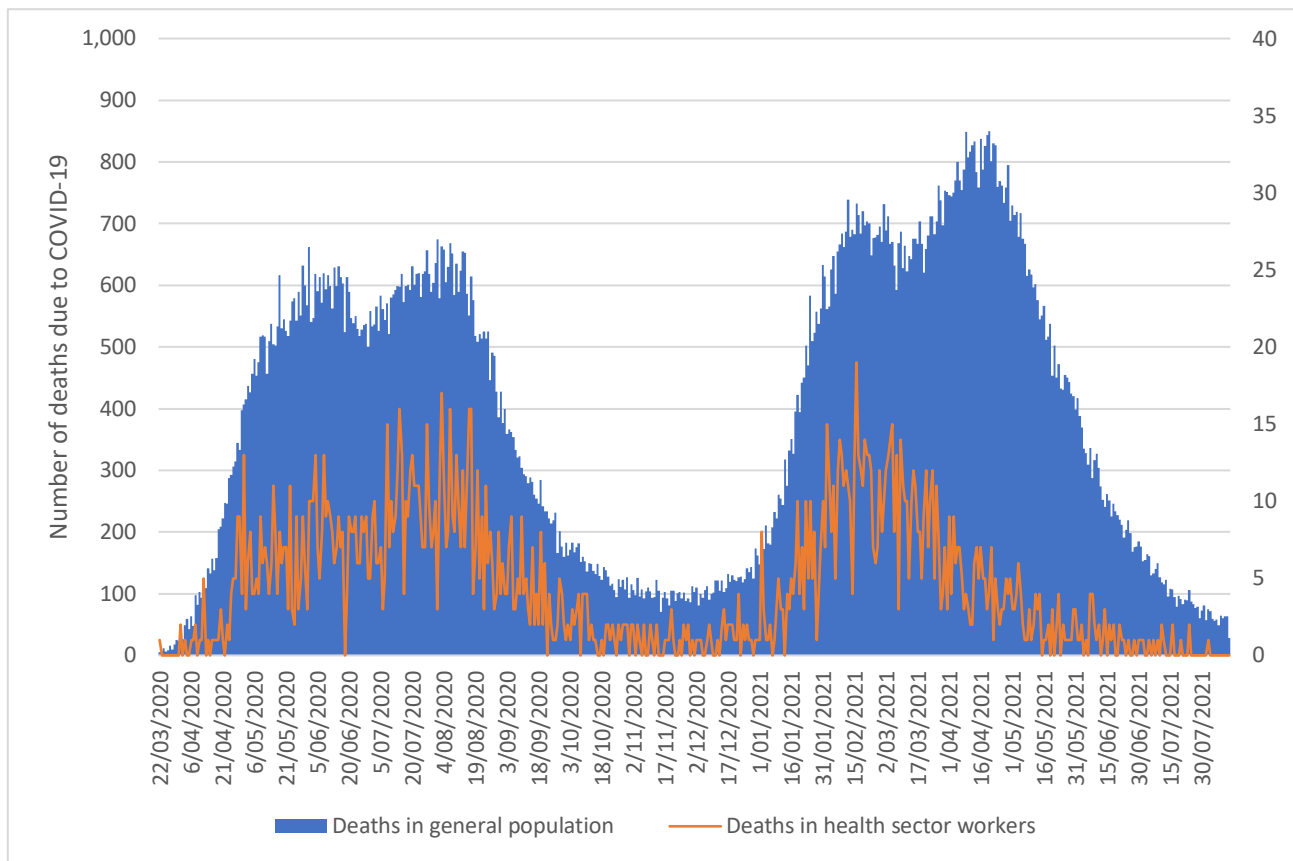
Source: Data provided by the IHR National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

The following is a brief description of the epidemiological situation among health workers confirmed for COVID-19 in **Peru**.

Since the first detected case of COVID-19 in the country²⁷ and as of 18 August 2021, 74,079 confirmed COVID-19 cases were reported among health workers in Peru, of which 6,456 were hospitalized and 1,399 died.

The evolution of COVID-19 cases and deaths among health workers has followed the trend observed in the country for most of 2020; however, the peak in cases was observed in the general population in August 2020, while for health workers, it was observed in June 2020. In 2021, a decrease in the proportion of both cases and deaths among health workers coincides with the start of the COVID-19 vaccination campaign in February 2021 and March 2021 for first and second doses, respectively. Of note, health workers were a prioritized group in Peru. Additionally, while there was an overall increase in deaths in the general population between January and the end of April 2021, deaths among health workers decreased following the start of the second dose of the COVID-19 vaccine administration in March 2021 (**Figure 9**).

Figure 9. Distribution of COVID-19 deaths among health workers and in the general population in Peru. As of 12 August 2021.



²⁷ 6 March 2020

Source: Peru Ministry of Health. COVID-19 among health workers dashboard.²⁸ Accessed on 18 August 2021. Data reproduced by PAHO/WHO.


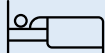





Regarding the department of residence, most cases (35.5%) and deaths (41.5%) were reported in the department of Lima. When analyzing the data by occupational group, the highest proportions of cases (38.4%) were reported among nursing technicians and assistants and nurses (25.7%). Regarding deaths, most occurred among nursing technicians and assistants (46%) and physicians (26.6%)

²⁸ Peru Ministry of Health. COVID-19 among health workers dashboard. Available at: <https://bit.ly/3iZlf4U>

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

References

1. PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 22 July 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: <https://bit.ly/3xYqdnh>
2. WHO. COVID-19 Weekly Epidemiological Update. Published on 17 August 2021. Available at: <https://bit.ly/3v6e0Mi>
3. Report by the **Argentina** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
4. Report by the **Belize** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
5. Report by the **Bolivia** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
6. Report by the **Brazil** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
7. Ministry of Health of **Brazil**. Available at: <https://bit.ly/3vb3JP2> and <https://bit.ly/2OnJAVg>
8. Report by the **Canada** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
9. Government of **Canada**. Coronavirus (COVID-19) and indigenous communities. Available at: <https://bit.ly/2lhCEWq>
10. Report by the **Chile** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
11. Report by the **Colombia** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
12. Report by the **Costa Rica** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
13. Report by the **Dominican Republic** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
14. Report by the **Brazil** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
15. Report by the **Mexico** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
16. Report by the **Netherlands** 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/>. Data on COVID-19 among Health Care Personnel. Available at: <https://bit.ly/3j3YGvW>.
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