

PAHO



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REGIONAL OFFICE FOR THE
AMERICAS

Epidemiological Update Coronavirus disease (COVID-19)

22 May 2020

Context

On 31 December 2019, Wuhan Municipality in Hubei Province, People's Republic of China, reported a cluster of pneumonia cases with unknown etiology. On 9 January 2020, the Chinese Center for Disease Control and Prevention (China CDC) reported a novel coronavirus as the causative agent of this outbreak. On 30 January 2020, the Director-General of the World Health Organization (WHO) declared the outbreak as a Public Health Emergency of International Concern (PHEIC) upon the advice of the International Health Regulations (2005) Emergency Committee. On 11 February, WHO named the disease COVID-19, short for "coronavirus disease 2019". The same day, the International Committee on Taxonomy of Viruses (ICTV) announced "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" as the name of the new virus which causes COVID-19. On 11 March 2020, COVID-19 was declared a pandemic by the WHO Director-General. On 30 April 2020, the International Health Regulations (2005) Emergency Committee reconvened at which time the declaration of 30 January 2020 was reaffirmed; the Director-General maintained that COVID-19 continues to constitute a PHEIC. The Committee's advice was accepted and issued to States Parties as Temporary Recommendations under the International Health Regulations.¹

Global Situation Summary

As of 22 May 2020, 4,962,707 confirmed cases and 326,459 confirmed deaths of COVID-19 have been reported globally among 215 countries, territories, or areas.² Countries with over 200,000 confirmed cases are the United States of America (1,525,186), Russia (317,554), Brazil (291,579), the United Kingdom (248,297), Spain (232,555), and Italy (227,364).² Confirmed cases reported for China have continued to decrease since mid-February, now totaling 84,520 confirmed cases, and China is no longer among the 10 countries with the highest number of confirmed cases. Substantial increases in the number of new COVID-19 cases continues in many regions, particularly in the Region of the Americas and Europe.

Countries with over 10,000 confirmed deaths are the United States of America (91,527 deaths), the United Kingdom (35,704 deaths), Italy (32,330 deaths), France (28,081 deaths),

¹ Statement on the third meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19): [https://www.who.int/news-room/detail/01-05-2020-statement-on-the-third-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-\(covid-19\)](https://www.who.int/news-room/detail/01-05-2020-statement-on-the-third-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-coronavirus-disease-(covid-19))

² WHO Coronavirus Disease (COVID-19) Dashboard: <https://covid19.who.int/>

Spain (27,888 deaths), and Brazil (18,859 deaths).³ Among these countries, since 19 April 2020 (date of the last Epidemiological Update for Coronavirus disease), Brazil's death toll has increased nearly 9-fold (from 2141 deaths), that of the United States of America has almost tripled (32,427 deaths) and the United Kingdom (15,464 deaths) has more than doubled its total deaths. These three countries contribute 45% of the total number of deaths reported globally.

The WHO risk assessment for COVID-19 at the global level is considered **Very High**, mainly because there is an international spread of cases to 215 countries/territories/states; the community transmission is ongoing in at least 40 countries/states/territories; transmission by infected individuals who are either symptomatic or before showing signs and symptoms; there is an uncertainty about lasting immunity post infection; there is limited testing capacity in some countries/states/territories; medical supply shortages due to increased demand, limited supply, export restrictions, and transport limitations; absence of specific therapeutic treatments; higher mortality among some high risk groups; stringent population-level control measures are unlikely to be sustainable in the long-term; uncertainty about the resurgence of outbreaks following relaxation of stringent control measures; the impact due to interruption of routine health services, routine vaccination and other disease control programs such as measles, polio, tuberculosis, and malaria, etc.

Situation summary in the Region of the Americas

In total, 54 countries/territories from the Region of the Americas have reported COVID-10 cases and deaths. As of 21 May 2020, there are 2,220,282 cases and 131,606 deaths reported.

North America

All three countries have reported confirmed increases in COVID-19 cases and deaths since the last Epidemiological Update. The overall reported confirmed cases have increased to 1,662,335 cases from 765,011 cases, and deaths have increased to 103,679 deaths from 36,359 deaths. Due to the particularly high number of cases in the United States of America, the North American sub-region contributes 75% of all cases (compared to 89% 19 April) and 79% of all deaths (compared to 89% 19 April) in the Region of the Americas. The decrease in proportion may be attributed to the growing increase in cases in Brazil, Chile, Peru and Mexico. The crude case-fatality rate (the number of reported deaths divided by the reported cases) in North America is 6.24%, the highest among the sub-regions in the Region of the Americas.

Figure 1. Presents the 7-day incidence trend as 22nd of May. No substantial change in the 7-day incidence of cases for US and Canada but continues increasing for Mexico and currently at its highest ever since the start of the outbreak (13 cases per 100,000 population). Last week (11 to 15 of May 2020) it was 10 cases per 100,000 population.

³ WHO Coronavirus Disease (COVID-19) Dashboard: <https://covid19.who.int/>

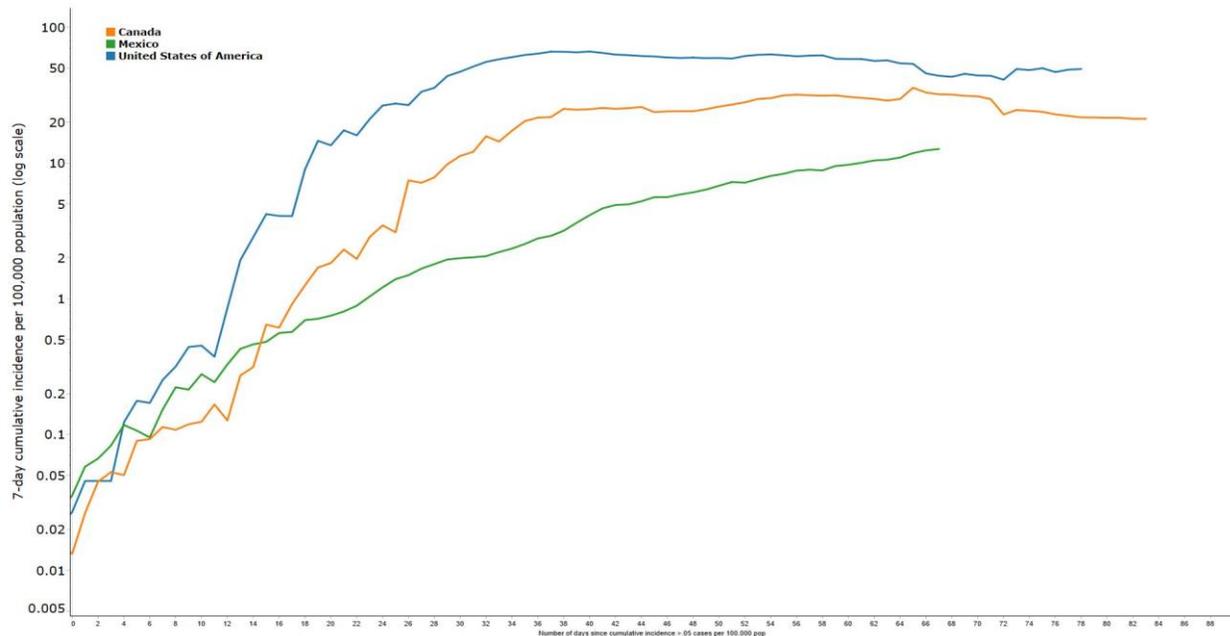


Figure 1. Seven-day incidence of cases in North America as of 21 May

The United States of America (distributed across all 50 states) accounts for the most cases and deaths for the region; 92% of cases and 88% of deaths. Twenty-nine states currently report more than 10,000 confirmed cases of COVID-19. Seventy-four percent of cases are among those between the ages of 18 to 64 years, however, hospitalization rate (cumulative rate, 60.5 per 100,000) remains highest among people 65 years of age and older (192.4 per 100,000) and 50-64 years (94.4 per 100,000).⁴

Total cases remain highest in the states of New York and New Jersey, with Illinois, Massachusetts, California, Pennsylvania, Michigan, and Texas also among states with over 50,000 confirmed cases. Deaths are also highest among those states, all with over 3,000 confirmed deaths (except Texas, 1,149 deaths) along with Connecticut.

In Canada, confirmed cases have been reported in 12 of the 13 provinces/territories; Nunavut remains the only territory with no confirmed cases. As of 21 May, Canada has 81,313 confirmed cases and 6,152 deaths, compared to 33,909 confirmed cases and 1,506 confirmed deaths as of 19 April. The province of Quebec accounts for 56% of cases and Ontario accounts for 30% of cases, a combined 86% of all cases in the country and an increase of 3% from the last Epidemiological Update (83%).⁵

In Mexico, there has been a substantial growth in the incidence of reported COVID-19 cases and deaths; a shift from the previous Epidemiological Update. Confirmed COVID-19 cases have increased 8-fold, from 7,497 to 59,567 confirmed cases, and deaths have increase 10-fold from 650 to 6,510 confirmed cases as of 21 May. Highest reported cases are in Mexico City, the State of Mexico, Baja California, and Tabasco.⁶

⁴ United States Centers for Disease Control and Prevention (CDC). Coronavirus Disease 2019 (COVID-19). Available at <https://bit.ly/2RJ2fcE>

⁵ Government of Canada. Coronavirus disease (COVID-19): Outbreak update. Available at <https://bit.ly/2RHJ56S>

⁶ Government of Mexico. Covid-19 México. Available at <https://bit.ly/2VxLHpg>

Central America⁷

As of 21 May, a total of 18,176 confirmed cases (increase from 5,885 confirmed cases as of 12 April), including 544 deaths (increase from 187 deaths as of 12 April), have been reported among the 7 countries in the Central American sub-region. Of the total number of confirmed cases, Panama has consistently reported the highest number of cases (9,977 cases, including 287 deaths), followed by Honduras (3,100 cases, including 151 deaths), Guatemala (2,265 cases, including 45 deaths), El Salvador (1,640 cases, including 32 deaths), and Costa Rica (897 cases, including 10 deaths) and Nicaragua (279 cases, including 17 deaths). On 21 May, the relative increase in cases was highest in Guatemala (6%) and Honduras (5%). The crude case-fatality rate in Central America is 2.99%, a slight decrease compared to the previous Epidemiological Update (3.17%).

Figure 2 Presents 7-day incidence trend for the Central America Subregion. It continues to accelerate in El Salvador (8 cases per 100,000 population), and Guatemala (5 cases per 100,000 population), and is currently at or near the highest levels observed since the start of the Pandemic in each country. Honduras remained the same as last week at 8 cases per 100,000 population with no significant changes – however the 7-day incidence in recent weeks are elevated and among the highest since the outbreak began. Between 19 and 20 May, Nicaragua reported 254 new cases (25 cases as of 19 May – 279 cases as of 20 May) which is reflected on the graph as a steep increase in the 7-day incidence. Due to the paucity of data from Nicaragua, the trends have been challenging to interpret, but with the latest data for the 7-day incidence, it can be inferred that Nicaragua is at least going through similar transmission intensity as its neighboring countries.

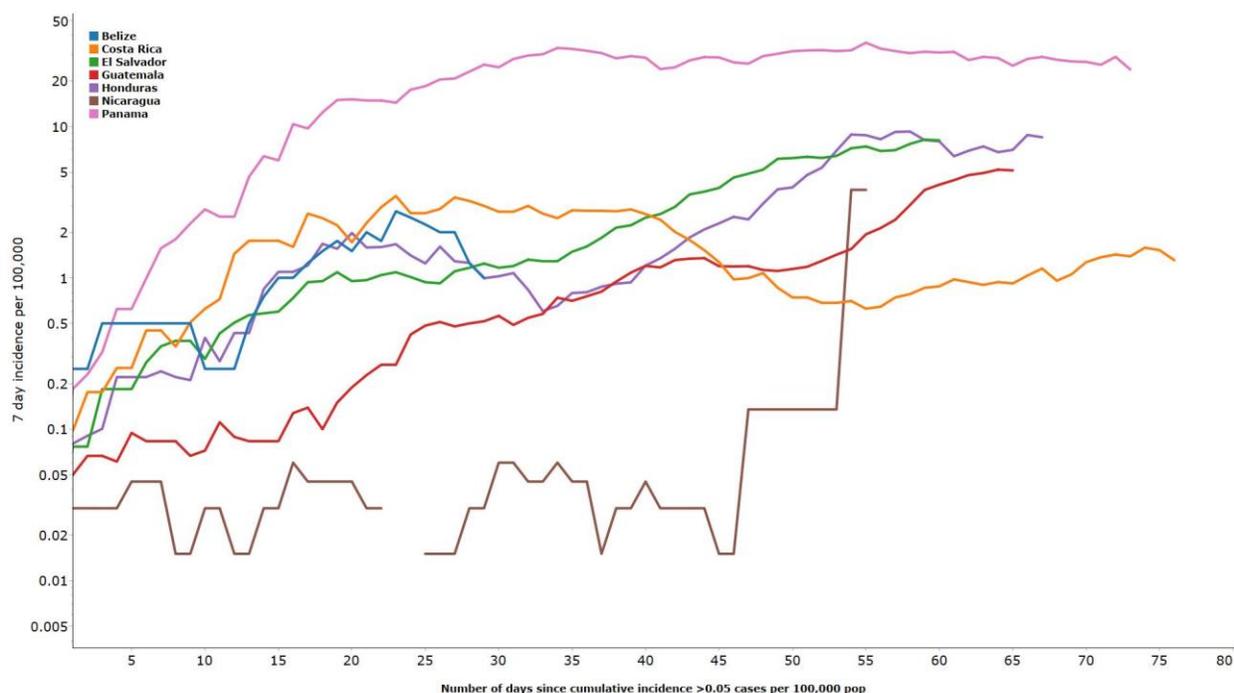


Figure 2. Seven-day incidence of cases in Central America as of 21 May

⁷ Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

Caribbean and Atlantic Ocean Islands⁸

The majority of the 34 countries/territories in this sub-region reported sporadic cases or clusters of cases of COVID-19, with only the Dominican Republic and Puerto Rico reporting community transmission at this time. As of 21 May, a total of 21,406 confirmed cases (increase from 8,428 cases as of 19 April), including 794 deaths (increase from 411 deaths as of 19 April), have been reported from the Caribbean and Atlantic Ocean Islands.

The Dominican Republic has reported 64% (13,657 cases) of cases and 56% (448) of deaths, an increase of 9% and 1% respectively compared to the previous Epidemiological Update. Puerto Rico and Cuba reported the second and third highest numbers of confirmed cases and deaths; 2,913 confirmed cases including 126 deaths in Puerto Rico and 1,908 cases including 80 deaths in Cuba. The crude case-fatality rate in the Caribbean and Atlantic Ocean Islands decreased from 4.87% to 3.70% since the last Epidemiological Update, no longer the highest among the sub-regions in the Region of the Americas.

Among the countries and territories in the Caribbean and Atlantic Ocean Islands subregion with a population >1 million people, Haiti continues to report an accelerated growth and the 7-day incidence of cases is currently at or near the highest levels observed since the start of the Pandemic with 4 cases per 100,000 population. The acceleration began around May 13 (1 case per 100,000 population), as can be seen in Figure 3. While no substantial change is noted in the Dominican Republic and Puerto Rico (slight increases and decrease) both remain areas with some of the highest 7-day incidence rates in the subregion. Slight increase in Jamaica which had been reporting a consistently downward trend. Cuba continues to report decreasing trends and Trinidad and Tobago has not reported a new case in 23 days. Other countries in the subregion with significant increase in the 7-day incidence compared to the previous week include French Guiana which reported 73 additional cases and the Cayman Islands which reported 25 additional cases (no shown in the figure).

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

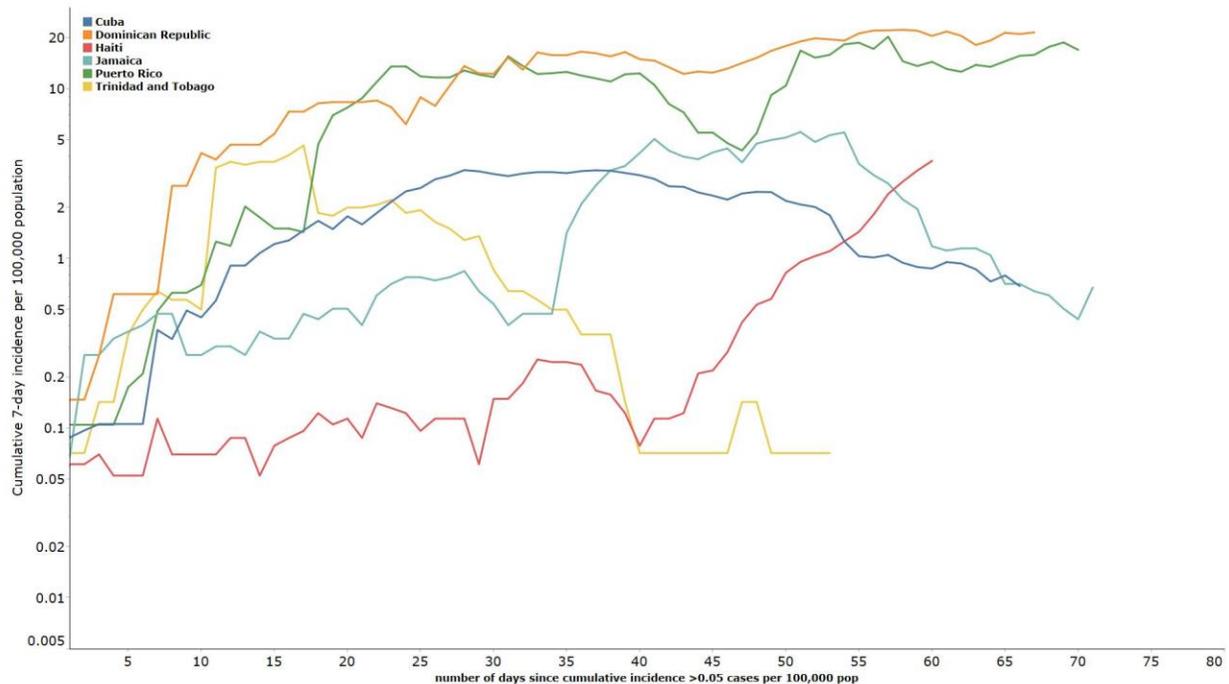


Figure 3. Seven-day incidence of cases in Caribbean and Atlantic Ocean Islands (pop > 1mil) as of 21 May

South America⁹

After North America, the sub-region with the highest number of confirmed cases and deaths reported to date remains South America. As of 21 May, the 10 countries in this sub-region have reported a total of 518,365 confirmed cases, including 26,589 deaths, which represents 23% of the total cases and 20% of the total deaths in the Region of the Americas. The proportion of total cases and total deaths from South America more than doubled since the last Epidemiological Update, when it was 9% for both total cases and total deaths. Among the South America countries, Brazil has reported the highest number of cases (291,579 confirmed cases, including 18,859 deaths), followed by Peru (104,020 confirmed cases, including 3,024 deaths), Chile (53,617 confirmed cases, including 544 deaths), and Ecuador (34,854 confirmed and probable cases, including 2,888 confirmed and probable deaths). The crude case-fatality rate in South America is 5.13%, the second highest among the sub-regions in the Region of the Americas.

The COVID-19 pandemic is accelerating in 8/10 South American countries – only Paraguay and Uruguay are reporting a relative decreasing trend. Uruguay showed a slight increase in past day, as can be seen in Figure 4. Venezuela is accelerating with 1.4 cases per 100,000 incidence – highest ever since outbreak began. Currently the highest incidence is in Chile (86 cases per 100,000), and Peru (84 cases per 100,000).

Brazil reported 19,951 new cases yesterday (21st of May), its highest daily incidence to date and an increase of more than 2,500 (14.6%) compared to the previous day. Brazil is also now

⁹ Argentina, Bolivia, Brazil, Colombia, Ecuador, Paraguay, Peru, Uruguay and Venezuela.

#3 globally in terms of total incidence, it's 7-day incidence continues to accelerate and is the highest currently since the outbreak began – 48 cases per 100,000 population.

Community transmission is reported in 8 of the 10 countries – Bolivia and Uruguay still report “clusters of cases”. Some countries like Peru and Ecuador use Rapid Diagnostic Test (RDT) for diagnostic testing, (to date, rapid diagnostic tests are not recommended for use by PAHO/WHO) and report their data as PCR or RDT. When only calculating for PCR positive cases, Peru (29% PCR positive)'s 7 day incidence rate goes down to 33 cases per 100,000 from 84 cases per 100,000 and Ecuador (40% PCR)'s 7 day incidence rate decreases from 25 cases per 100,000 to 15 cases per 100,000 population.

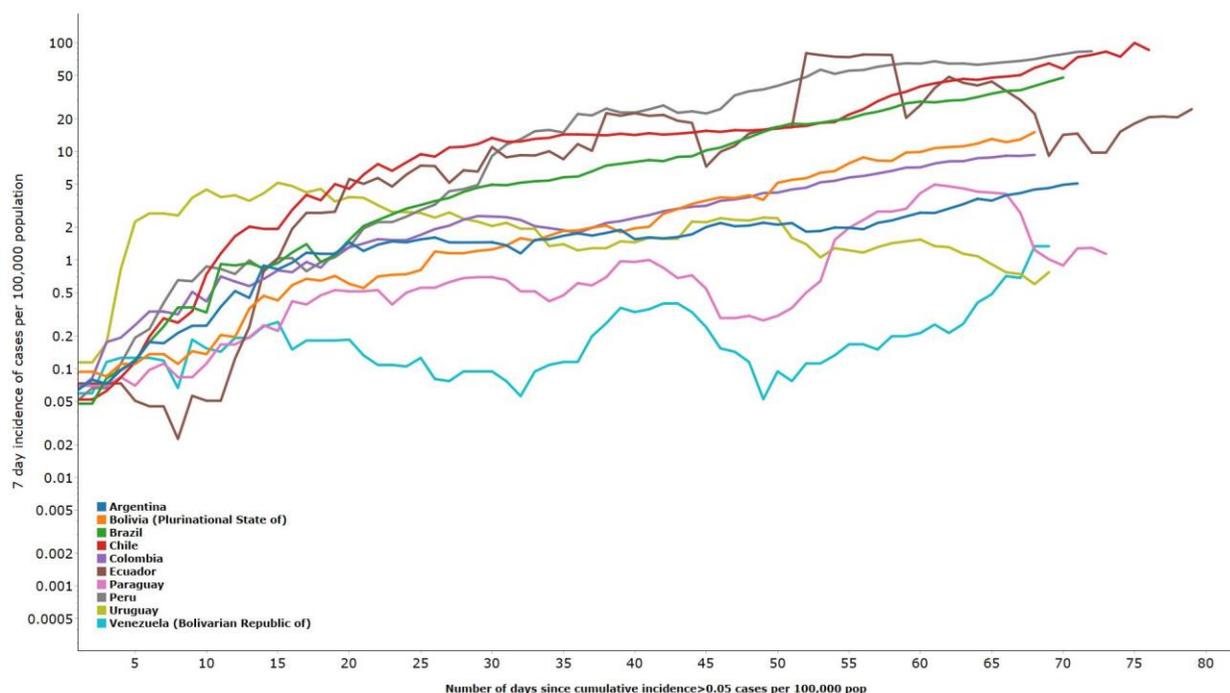


Figure 4. Seven-day incidence of cases in South America as of 21 May

Guidance and recommendations for national authorities

Given the ongoing reporting of COVID-19 cases in countries and territories in the Region of the Americas, PAHO/WHO continues to reiterate and update recommendations to support all Member States on measure to manage and protect against the disease. The International Health Regulations (2005) Emergency Committee first provided public health advice and recommendations to the Director-General on 22 January 2020. PAHO/WHO has developed, reinforced, and provided updates to recommendations since 28 February 2020.

1. Surveillance and reporting

Surveillance Strategies

The WHO updated the [Surveillance strategies for COVID-19 human infection](#) on 10 May 2020. The purpose of this document is to provide guidance on surveillance strategies, including types of surveillance, the importance of adapting national systems, and increasing surveillance-related efforts as needed.

COVID-19 surveillance is essential given the exponential growth of the disease. As a result, the identification and reporting of new cases should take place within 24 hours and be included in ongoing epidemiological analysis. It is further recommended that the disease be a mandatory notifiable disease with requirements for immediate reporting.⁸

Surveillance across all sites is important to capture all persons and communities, particularly those most vulnerable, to limit the spread of the disease. Surveillance sites for COVID-19 include surveillance (1) by individuals in the community, (2) at the primary care level, (3) hospital-based, (4) Sentinel-based using the existing Global Influenza Surveillance and Response System (GISRS), (5) enhanced for residential facilities and vulnerable groups, (6) mortality-based, and (7) by laboratory testing data. Event-based surveillance, participatory surveillance, and telephone hotlines may also be implemented to support the more comprehensive approaches.

In planning for and implementing sound surveillance practices for COVID-19, the following should be considered:

- Use, adapt and strengthen existing surveillance systems
- Include COVID-19 as a mandatory notifiable disease
- Implement immediate reporting where feasible
- Conduct surveillance at different levels of the health care system
- Establish population denominators to aid in data interpretation
- Establish laboratory testing denominators.¹⁰

Recommendations for the reporting of cases

PAHO/WHO requests that national authorities report **probable and confirmed** cases and deaths of COVID-19 within 48 hours of identification, by providing the data as outlined in the line listing template created for COVID-19 confirmed and probable cases and deaths and available at: <https://www.paho.org/en/documents/template-line-listing>.

PAHO/WHO requests the daily submission of the complete list of variables, in accordance with the variables regularly obtained from the established respiratory disease surveillance system. The variables required for monitoring are the name of the reporting country, date of report, case ID, date of onset of symptoms, age and age unit (month, years old), gender, case definition [probable/confirmed], and outcome [recovered-healthy/not recovered/decease].

Line-listing for COVID-19 confirmed and probable cases can be sent to: covid@paho.org.

Contact Tracing

¹⁰ Surveillance strategies for COVID-19 human infection. Available at: <https://www.who.int/publications-detail/surveillance-strategies-for-covid-19-human-infection>

The WHO provided interim guidance on [Contact tracing in the context of COVID-19](#) on 10 May 2020. The purpose is to present contact tracing as a tool for the control of COVID-19 and support on implementation.

Contact tracing, when systematically applied, can help sever human-to-human transmission chains thereby decreasing the effective reproduction number. This is done by identifying, assessing, and managing people who have or may have been exposed to COVID-19, from first point of exposure to 14 days thereafter. Steps in undertaking contact tracing include:

- Defining contacts,
- Identifying contacts,
- Informing contacts,
- Managing and monitoring contacts daily, including quarantining, and
- Data processes and analysis, including data management and analysis.¹¹

Each step is described in detail in the Interim Guidance for [Contact tracing in the context of COVID-19](#) document.

Member States should prepare as early as possible for a contact tracing plan and consider their workforce requirements. The earlier recruitment and preparations take place, at a time when there is no or low transmission, the more likely cases can be managed and maintained low. Factors to consider include the approximate number of contacts to be traced, physical and technological logistics of reaching those affected, cultural and socio-political contexts, security, tracing modalities and other resources. Electronic tools and information technology may be useful, but may not be accessible to all. Personnel is essential and contact tracers can be drawn from many settings; qualified individuals should be utilized over engaging medical personnel. PAHO/WHO also has several [trainings](#) available to support this strategy.

2. Laboratory

On 30 March 2020, PAHO/WHO updated the Laboratory Guidelines for Detection and Diagnosis of the Novel Coronavirus (COVID-19). Information on specimen collection and proper shipment; laboratory testing including a testing algorithm; and reporting of cases and test results can be found in this [interim guidance](#). The WHO Health Emergencies Preparedness and Response also produced [Laboratory biosafety guidance related to coronavirus disease \(COVID-19\)](#). Laboratories who are or will be testing for SARS-CoV-2 should assess their capacity to do so. The WHO developed a [Laboratory assessment tool](#) to guide organizations in examining their capacity and preparing for increased testing. Samples should always be collected by trained personnel and applying all biosafety instructions including the use of personal protective equipment appropriate for respiratory viruses.

Laboratories should continue to use the influenza laboratory algorithm recommended by PAHO for both routine surveillance of acute respiratory infection (ARI) and severe acute respiratory infection (SARI) as well as unusual cases. If influenza is detected, the routine influenza testing should be performed (including subtyping or genotyping) and report must be continued. If the sample is negative for Influenza, testing for SARS-CoV-2 should be considered.

¹¹ Contact tracing in the context of COVID-19. Available at: <https://www.who.int/publications-detail/contact-tracing-in-the-context-of-covid-19>

Although the co-detection of influenza (or other respiratory viruses) with SARS-CoV-2 is biologically possible, this is an unlikely event. Therefore, if a positive test result is obtained for another virus that explains the clinical picture, it is not necessary to continue to test the sample for SARS-CoV-2.

Patients fitting the COVID-19 case definition detected outside the routine influenza surveillance, should be tested initially for SARS-CoV-2. If negative, testing for influenza and other respiratory viruses may be considered.

As a result of the growing COVID-19 pandemic and shortages of laboratory-based molecular testing capacity and reagents, more rapid and easy-to-use devices are being developed to facilitate testing outside of laboratory settings. These test kits rely on protein detection from COVID-19 in respiratory samples or on the detection, in blood or serum, of human antibodies in response to the infection.¹² As these tests are not yet adequately validated and based on current evidence, WHO does not recommend their use for clinical decision making.

3. Infection Prevention and Control

Sustained human-to-human transmission of COVID-19 along with nosocomial transmission has been reported in most of the countries. Routes of transmission of COVID-19 include direct contact and droplet. Aerosol generating procedures (AGP) also play also a role in the transmission of COVID-19.

The following guidance on infection prevention and control are available:

- [Assessment of infection prevention and control practices in isolation areas in acute healthcare settings in the context of the novel coronavirus \(COVID-19\). Interim recommendations](#)
- [Care for health workers exposed to the new coronavirus \(COVID-19\) in health facilities](#)
- [Dead body management in the context of the novel coronavirus \(COVID-19\). Interim recommendations](#)
- [Technical specifications of medical devices for the case management of COVID-19 in healthcare settings](#)
- [Infection prevention and control guidance for long-term care facilities in the context of COVID-19](#)

4. Clinical management

To date, there is no specific drug or vaccine recommended to prevent or treat the novel coronavirus. Some specific treatments such as antivirals are under investigation and are

¹² Advice on the use of point-of-care immunodiagnostic tests for COVID-19: [scientific brief](#).

being tested through clinical trials. The use of antivirals has been reported in a published case-series of hospitalized patients with COVID-19.¹³ Those infected with COVID-19 should receive appropriate care to relieve and treat symptoms, and those with severe illness should receive best supportive care.

Implementation of timely, effective, and safe supportive therapies is vital for patients who develop severe manifestations of COVID-19.

The following guidance for clinical management of severe acute respiratory infection when COVID-19 is suspected are available:

- [COVID-19: Chloroquine and hydroxychloroquine research](#)
- [Guidelines for Critical Care of Seriously Ill Adult Patients with Coronavirus \(COVID-19\) in the Americas \(Short version\)](#)
- [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](#)
- [Ongoing Living Update of Potential COVID-19 Therapeutics: summary of rapid systematic reviews](#)

There is currently a lack of strong evidence in well-designed trials for specific drug recommendations, such as antivirals or immune modulators that have benefits for COVID-19 patients. In a recently published randomized controlled trial (small sample size) hydroxychloroquine sulfate did not show clinical effects in improving patient symptoms and accelerating virologic suppression.¹⁴

In addition, WHO published an Interim guidance (available at: <https://bit.ly/2Vzwsr6>) to meet the need for recommendations on home care for patients with COVID-19 presenting with mild symptoms and management of their contacts.

5. Health Systems and Services

To enhance the health systems and services response at the country level, guidance documents, capacity building, and direct support to countries has been provided.

The following documents have been developed to provide guidance and support:

- Technical note. Adapting the First Level of Care in the context of COVID-19 (Spanish only): <https://www.paho.org/es/documentos/nota-tecnica-sobre-adaptacion-primer-nivel-atencion-contexto-pandemia-covid-19>
- Checklist for the Management of Human Resources for Health in Response to COVID-19: <https://www.paho.org/en/documents/checklist-management-human-resources-health-response-covid-19>
- Ethics guidance for the use of scarce resources in the delivery of critical health care during the COVID-19 pandemic:

¹³ Ongoing Living Update of Potential COVID-19 Therapeutics: summary of rapid systematic reviews. Rapid Review, 8 May 2020", available at <https://iris.paho.org/handle/10665.2/52097>

¹⁴ COVID-19: Chloroquine and hydroxychloroquine research. Available at <https://bit.ly/3anQJKa>

- <https://www.paho.org/en/documents/guidance-and-strategies-streamline-ethics-review-and-oversight-covid-19-related-research>
- Technical Recommendation for the Selection of Alternative Medical Care Sites (AMCS): <https://www.paho.org/en/documents/technical-recommendations-selection-alternative-medical-care-sites-amcs>
 - Reliance for Emergency Use Authorization of Medicines and Other Health Technologies in a Pandemic (e.g. COVID-19): <https://iris.paho.org/handle/10665.2/52027>
 - Crisis Management during an Epidemic: General guidelines for efficient response coordination by national regulatory authorities. <https://iris.paho.org/handle/10665.2/52098>
 - Regulatory considerations on authorization of the use of convalescent plasma (PC) to address the COVID-19 emergency: <https://iris.paho.org/handle/10665.2/52036>
 - Preliminary recommendations for blood services: <https://www.paho.org/es/documentos/recomendaciones-preliminares-para-servicios-sangre-frente-al-potencial-impacto>
 - List of priority medical devices for COVID-19 response: <https://www.paho.org/en/documents/list-priority-medical-devices-context-covid-19>

Direct support to countries through virtual meetings has been provided for the reorganization and expansion of services, including the expansion of critical capacity (EMT/AMC) and with due attention to the first level of care and the continuation of essential services. This support has been complemented by webinars in English and Spanish on related technical topics.

Capacity building, including tools, training, and direct support to countries to conduct needs assessments of beds, staff time, medicines, medical supplies and PPEs, has been conducted in all subregions. These activities are coordinated and are supporting wider efforts within the organization for the procurement and distribution of critical supplies and equipment, including Emergency procurement, the PAHO Strategic Fund, and the UN COVID-19 Supply Chain System.

Elderly Health was fully integrated within the Incident Management System (IMS). An expert consultation was conducted to identify potential barriers, bottlenecks and knowledge needs to prevent increased mortality among older adults.

A road map to leverage occupational health programs for healthcare workers in the context of COVID-19 was developed.

An initiative to better coordinate and support national regulatory authorities on medicines and other health technologies in their response to COVID-19 was launched. This initiative included the development of technical documents, bi-weekly meetings, a List Serve, and a

repository of websites and relevant information, including regulatory responses on COVID-19. Information is available on the Regional Platform on Access and Innovation for Health Technologies (by its acronym in Spanish, PRAIS) and is shared with regulatory focal points. Information can be found at: <https://prais.paho.org/en/featured-links/>

Collaboration with relevant PAHO units of to enhance capacity for the procurement of critical medical devices (ventilators) and In Vitro Diagnostics (IVDs), including the development of framework and criteria for pooled procurement, regulatory processes, technical specifications, and criteria for selection and compliance of clinical management.

6. Non-pharmaceutical measures: Social distancing and International traffic-related measures

Non-pharmaceutical measures include personal protective measures, environmental measures, social distancing measures, and international traffic-related measures. This paragraph refers to social distancing measures, and international traffic-related measures, which are strictly intertwined.

Social distancing measures apply to individuals (e.g. isolation of cases and quarantine of contacts), or to the community (to specific segments of the population [e.g., home confinement for the elderly]), or to the population as whole (e.g., home confinement and closure of all non-essential businesses). These measures are not mutually exclusive. Coinciding with the declaration of the COVID-19 pandemic on 11 March 2020, community-wide measures have been adopted by an increasing number of countries. As of 10 April 2020, of the 35 countries in the America, all but one (Nicaragua) are implementing measures drastically restricting the movement of the population and involving the cancellation of routine and major mass gatherings, closure of businesses, closure of schools, and home confinement. Most countries which adopted community-wide measures, likely envisaging their time-limited duration, thanks to government efforts, currently implement community-wide measures go support their citizens in a variety of essential needs. Governments promulgated legal tools allowing for the provision of financial and fiscal protection to specific segments of the population; for the meeting of essential needs (e.g., food distribution schemes, maintenance of supermarkets in operations); as well as for the maintenance of essential services.

The actual or potential negative socioeconomic impact, determined by the adoption of stringent social distancing and travel-related measures, is translating into a mounting pressure on national leaders to call for a transition to less stringent measures which would allow the economy to regain some momentum, without precipitating a dramatic evolution of the pandemic. Mindful of that, PAHO has developed a [document](#) which aims at providing national authorities, across governmental sectors, with a framework to inform their decision-making process, over the coming months, concerning the adjustment of social distancing and travel related measures, which are strictly intertwined, without nullifying efforts and sacrifices incurred so far.

7. Risk Communication

Risk Communication is a core component of a public health intervention, with any disease outbreak or health emergency. As such, the WHO and PAHO have created communication materials, with a focus on higher risk populations, to inform both the public and health care workers about COVID-19. PAHO has created infographics and social media cards on [COVID-19 and HIV](#), [Tuberculosis and COVID-19](#), [What you need to know](#), [Tips for young people](#), [Ways to help the elderly and/or people with underlying conditions living alone](#), [Falsified medical products](#), [Vaccines and medical products](#), [Managing the bodies of deceased COVID-19 patients by mortuaries and funeral homes](#) and [by health workers](#), among others. These materials are promoted by PAHO country offices and are a resource for countries to use and/or adapt to their needs and realities.

In addition, PAHO has developed a brochure on [Caring for the mental health of health personnel during the COVID-19 pandemic](#). The brochure includes a series of key messages and reminders for essential workers based on WHO and PAHO's more in-depth technical guidance on mental health during emergencies.

PAHO/WHO has also developed a [COVID-19 Glossary on Outbreaks and Epidemics, a resource for journalists and communicators](#), with key concepts and terms commonly used during outbreaks and epidemics. This document aims to strengthen journalists' knowledge and further educate on COVID-19 and outbreaks. The glossary summarizes [the informative guide for journalists](#) developed by PAHO/WHO in April.

Recently, PAHO/WHO held a virtual workshop on how to cover the pandemic without spreading wrong information and on epidemiology 101 for journalists and communicators from around Latin America. More than 220 people participated in this [virtual training](#).