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Americas

Epidemiological Update Coronavirus disease (COVID-19)

9 November 2020

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, and on 31 July 2020, the WHO Director-General accepted the advice of the Emergency Committee, declaring that the COVID-19 pandemic continues to constitute a PHEIC, and issuing the temporary recommendations to States Parties under the International Health Regulations (IHR) (2005).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

Global Situation Summary

Since the 15 October 2020 PAHO/WHO Epidemiological Update on COVID-19³ and as of 8 November 2020, an additional 11,874,437 confirmed cases of COVID-19 have been reported globally, including 166,688 deaths, bringing the cumulative number of confirmed cases reported globally to 49,578,590, including 1,245,717 deaths.

As of 8 November 2020, of the global total, WHO Region of the Americas and the WHO European Region, represent 70% of the total confirmed cases and 78% of the total deaths. The Region of the Americas represents 43% (21,370,015) of the total confirmed cases and 53% (654,512) of the total deaths and the European Region represents 26% (13,135,548) of the total cases and 25% (311,336) of the total deaths.

¹ Statement on the fourth meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19). Available at: <https://bit.ly/3li7iOx>

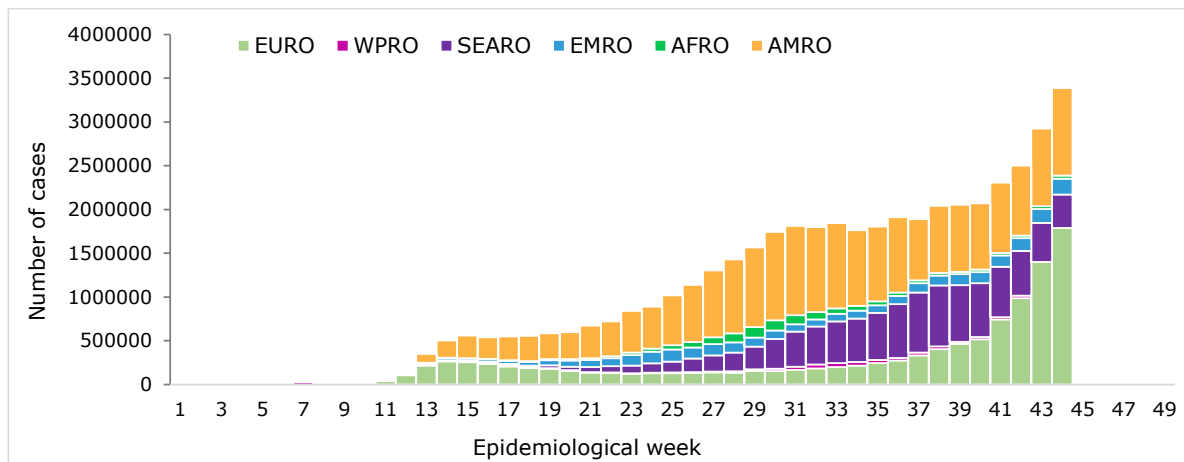
² Independent evaluation of global COVID-19 response announced. Available at: <https://bit.ly/31hLJWp>

³ PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 15 October 2020, Washington, D.C.: PAHO/WHO; 2020. Available at: <https://bit.ly/3682qVx>

Suggested citation: Pan American Health Organization / World Health Organization. Epidemiological Update: Coronavirus disease (COVID-19). 9 November 2020, Washington, D.C.: PAHO/WHO; 2020

Since the 15 October 2020 PAHO/WHO Epidemiological Update on COVID-19,³ the European Region as the highest relative increase in cases and deaths, with 6,026,767 additional cases (46%) including 62,838 deaths (20%) (**Figure 1**).

Figure 1. Distribution of COVID-19 cumulative confirmed cases by WHO Region and epidemiological week (EW). EW 1 – 44 of 2020.



WHO Regional Offices: AMRO: Americas Regional Office; SEARO: South East Asia Regional Office; EURO: European Regional Office; EMRO: Eastern Mediterranean Regional Office; AFRO: Africa Regional Office; WPRO: Western Pacific Regional Office

Source: WHO Coronavirus Disease (COVID-19) Dashboard. Data as of 8 November 2020. Available at: <https://covid19.who.int> Accessed 8 November 2020.

Situation Summary in the Region of the Americas

All 54 countries and territories in the Region of the Americas have reported COVID-19 cases and deaths.⁴ Since the 15 October 2020 PAHO/WHO Epidemiological Update on COVID-19³ and as of 5 November 2020, 592,561 additional confirmed cases of COVID-19, including 54,832 deaths, have been reported in the Region of the Americas, representing a 14.3% increase in cases and a 8.5% increase in deaths.

In the last 7 weeks (between 16 September and 4 November), a relative increase was observed, both in the number of cases and number of deaths across all subregions (**Figures 2 and 3**). The highest increase was observed in Central America subregion⁵, with a 30.7% increase in cases and a 24.9% increase in deaths, followed by the North America subregion⁶, with a 29.8% increase in cases and a 17.6% increase in deaths, the Caribbean and the Atlantic Ocean Islands subregion⁷, with a 29.7% increase in cases and an 24.4% increase in deaths, and the South

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

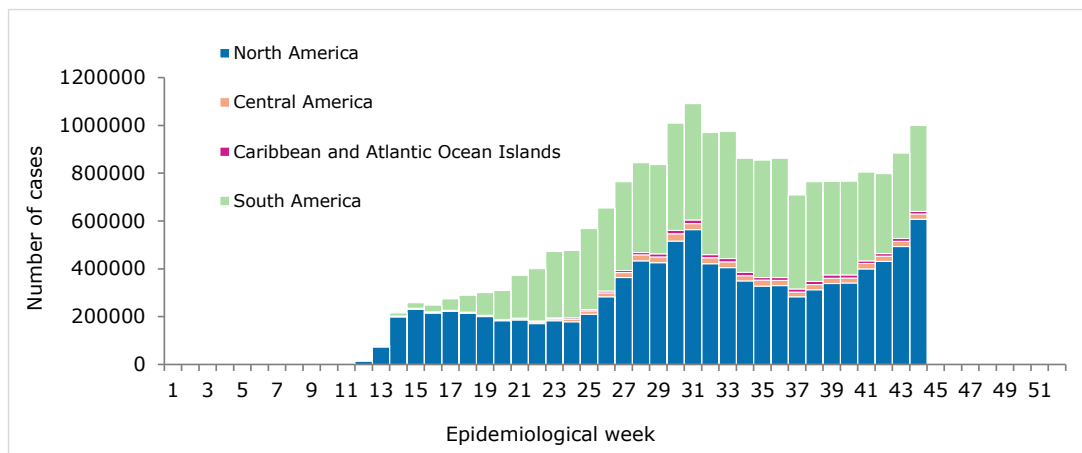
⁵ Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama

⁶ Canada, Mexico, and the United States of America

⁷ 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, French Guiana, Grenada, Guadeloupe, Guyana, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saint Barthélemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Pierre and Miquelon, Saint Vincent and the Grenadines, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos, and the U.S. Virgin Islands

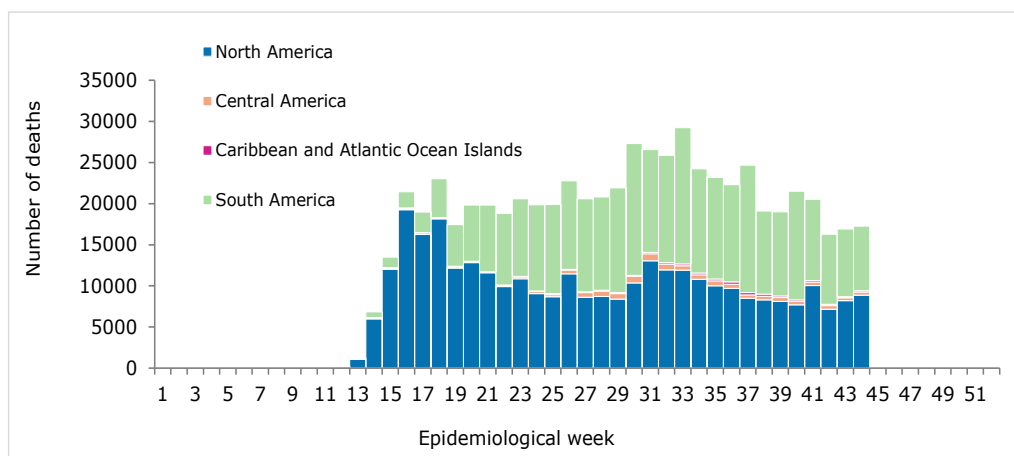
America subregion⁸, with a 26.1% increase in cases and a 22.3% increase in deaths. In the last 7 weeks, a relative increase in confirmed cases greater than 50% (range 52.0% to 80.8%) is observed in the Bahamas, Belize, Bonaire, Sint Eustatius and Saba⁹, Curacao, Dominica, Guadeloupe, Guyana, Jamaica, Martinique, Paraguay, Saint Barthelemy, and Saint Lucia. With respect to deaths, a relative increase of $\geq 50\%$ (range 50.0% to 80.5%) is observed in Argentina, the Bahamas, Belize, Bonaire, Sint Eustatius, and Saba,⁹ Costa Rica, Guadeloupe, Guyana, Jamaica, Paraguay, and Saint Martin.

Figure 2. Distribution of confirmed cases of COVID-19, by epidemiological week (EW) and subregion. Region of the Americas. EW 1 to EW 44 of 2020.



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

Figure 3. Distribution of confirmed COVID-19 deaths, by epidemiological week (EW) and subregion. Region of the Americas. EW 1 to EW 44 of 2020.



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

⁸ Argentina, the Plurinational State of Bolivia, Brazil, Colombia, Ecuador, Paraguay, Peru, and the Bolivarian Republic of Venezuela

⁹ Bonaire, Saint Eustatius and Saba reported together.

Epidemiological Highlights

I. COVID-19 during pregnancy

Since the first reported cases of COVID-19 in the Americas and until 5 November 2020, 98,767 pregnant women positives for SARS-CoV-2 were reported, including 549 deaths (1%), in 18 countries/territories for which information was available (**Table 1**).

Table 1. Number of pregnant women positives for SARS-CoV-2 and deaths, and the maternal mortality ratio (MMR), by country. Region of the Americas. 1 January to 5 November* 2020.

| Country | Number of pregnant women positives for SARS-CoV-2 | Number of deaths among pregnant women positives for SARS-CoV-2 | Maternal Mortality Ratio‡ |
|--------------------------|---|--|---------------------------|
| Argentina | 5,368 | 29 | 3.8 |
| Bolivia** | 341 | 13 | 5.3 |
| Belize | 45 | 1 | 12.5 |
| Brazil** | 2,256 | 135 | 4.7 |
| Chile | 6,929 | 2 | 0.9 |
| Colombia | 4,746 | 45 | 6.1 |
| Costa Rica | 204 | 3 | 7.8 |
| Dominican Republic | 267 | 17 | 8.3 |
| Ecuador | 1,336 | 24 | 6.8 |
| Guatemala | 501 | 5 | 1.0 |
| Haiti** | 213 | 3 | 1.1 |
| Mexico ^{&} | 7,319 | 159 | 9.4 |
| Panama ^{&} | 903 | 4 | 5.5 |
| Paraguay | 372 | 1 | 0.7 |
| Perú ^{&} | 32,830 | 54 | 9.4 |
| United States of America | 34,968 | 50 | N/A |
| Uruguay | 20 | 0 | 0.0 |
| Venezuela | 149 | 4 | 0.8 |
| Total | 98,767 | 549 | |

Table Notes:

N/A = Data not available

*5 November corresponds to the date of the most recent report; 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 15 October 2020 PAHO/WHO Epidemiological Update on COVID-19³

[&] Corresponds to pregnant and postpartum women

[‡] Corresponds to the maternal mortality ratio for COVID-19 among this group of women, per 100,000 live births. The number of live births was obtained from the 2019 PAHO/WHO Core Indicators: Health Trends in the Americas, available at: <https://bit.ly/2RvaMzD>

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

The following is a summary of the epidemiological situation of COVID-19 among pregnant women in select countries for which updated information is available.

In **Mexico**, since the confirmation of the first COVID-19 cases¹⁰ in the country until 3 November 2020, there were 196 cases of pregnant women and postpartum women positive for SARS-CoV-2 among indigenous populations, including three deaths (1.5%). Of these women, 6.0% are hospitalized in serious condition.

In **Panama**, since the confirmation of the first case of COVID-19 in the country¹¹ until 17 October 2020, 903 confirmed cases of COVID-19 in pregnant and postpartum women were reported, including 4 deaths (0.4%).

The four health regions that concentrate most COVID-19 cases among pregnant women (59%) are Metropolitana (25%), Panama Oeste (21%), San Miguelito (14%), and Chiriquí (9%).

Regarding deaths, a review and analysis of existing evidence (autopsy and file audit) of the 8 cases previously reported as COVID-19 deaths among pregnant women³, was conducted by the Panama National Commission for Maternal and Perinatal Mortality and found only 4 were directly due to COVID-19.

In **Uruguay**, since the confirmation of the first COVID-19 cases in the country¹² until 30 October 2020, 20 SARS-CoV-2 positive cases were reported among pregnant women, with no deaths reported among them. One of the cases was hospitalized. As of 30 October, 16 of the cases were recovered and four remain active cases.

II. COVID-19 among indigenous populations

Since the first confirmed cases of COVID-19 in the Region of the Americas and as of 5 November 2020, there have been 187,095 confirmed cases of COVID-19, including 3,572 deaths, reported among indigenous populations in 14 countries in the Region of the Americas for which information was available (**Table 2**). Compared to the data in the 15 October 2020 PAHO/WHO Epidemiological Update³ this represents an increase of 32,760 confirmed cases including 167 deaths. The largest relative increase¹³ in cases occurred in Canada and Guatemala, while Venezuela has the largest relative increase in the number of deaths reported.

¹⁰ 27 February 2020

¹¹ 9 March 2020

¹² 14 March 2020

¹³ Considering countries for which information was available.

Table 2. Confirmed cases of COVID-19 and deaths among indigenous populations in the Region of the Americas. 1 January to 5 November* 2020.

| Country | Number of confirmed cases of COVID-19 | Number of deaths |
|--------------------------|---------------------------------------|------------------|
| Bolivia | 3,451 | 151 |
| Brazil | 32,041 | 471 |
| Canada | 1,728 | 15 |
| Colombia | 23,479 | 794 |
| Ecuador | 3,141 | 103 |
| Guatemala | 14,316 | 321 |
| Guyana | 95 | 6 |
| Mexico | 10,419 | 1,494 |
| Panama** | 2,841 | 53 |
| Paraguay | 235 | 23 |
| Peru | 18,518 | 95 |
| Suriname | 424 | 12 |
| United States of America | 75,546 | N/A |
| Venezuela | 861 | 34 |
| Total | 187,095 | 3,572 |

Table Notes:

N/A: data not available

*5 November corresponds to the date of the most recent report; 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 15 October 2020 PAHO/WHO Epidemiological Update on COVID-19³.

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

The following is a summary of the epidemiological situation of COVID-19 among indigenous populations in Brazil.

In **Brazil**, since the confirmation of the first cases of COVID-19¹⁴ in the country and until 24 October 2020, in the Indigenous Health Subsystem (SASISUS, per its acronym in Portuguese), the 34 Special Indigenous Health Districts (DSEI, per its acronym in Portuguese) reported 32,041 confirmed COVID-19 cases, including 471 deaths (1.5%) among the DSEI.

The COVID-19 incidence rate among indigenous persons seen by SASISUS was 4,238.8 cases per 100,000 population and the case fatality rate was 62.3 per 100,000 population. The Northern region presents the highest number of cases (19,123), with an incidence rate of 5,026.9 per 100,000 population; this region concentrates 50% of the indigenous population of the DSEI (380,412 population). The Central-West region presents the highest case fatality rate (2.5%), being 1.7 times higher than the general fatality rate among the DSEI (1.5%).

In decreasing order, the highest incidence rates were observed in the following DSEIs: Kaiapó do Pará (18,378.2 per 100,000 population), Cuiabá (17,371.9 per 100,000 population), Altamira (15,326 per 100,000 population), and Kaiapó do Mato Grosso (14,391.7 per 100,000 population). The DSEIs with the highest case fatality rates were Cuiabá (310.9 per 100,000 population) followed by Vilhena (254.3 per 100,000 population) and Xavante (198.3 per 100,000 population) (**Table 3**).

¹⁴ 25 February 2020

Table 3.

Confirmed cases of COVID-19 and deaths, incidence rate, mortality, and case fatality rates by DSEI. Brazil, 25 February to 24 October 2020.

| DSEI | Number of cumulative confirmed cases | Number of cumulative deaths | Incidence rate per 100.000 pop. | Mortality rate per 100.000 hab. | Case fatality rate (%) |
|-----------------------------------|--------------------------------------|-----------------------------|---------------------------------|---------------------------------|------------------------|
| North region | 19,123 | 229 | 5,026.9 | 60.2 | 1.2 |
| Altamira | 684 | 1 | 15,326.0 | 22.4 | 0.1 |
| Alto Rio Juruá | 788 | 10 | 4,331.6 | 55.0 | 1.3 |
| Alto Rio Negro | 1,778 | 13 | 6,180.9 | 45.2 | 0.7 |
| Alto Rio Purus | 544 | 5 | 4,284.1 | 39.4 | 0.9 |
| Alto Rio Solimões | 1,859 | 35 | 2,615.8 | 49.2 | 1.9 |
| Amapá e Norte do Pará | 902 | 4 | 6,912.9 | 30.7 | 0.4 |
| Guamá-Tocantins | 1,415 | 17 | 8,095.4 | 97.3 | 1.2 |
| Kaiapó do Pará | 1,140 | 9 | 18,378.2 | 145.1 | 0.8 |
| Leste de Roraima | 2,343 | 47 | 4,411.3 | 88.5 | 2.0 |
| Manaus | 616 | 13 | 1,956.9 | 41.3 | 2.1 |
| Médio Rio Purus | 436 | 4 | 5,587.6 | 51.3 | 0.9 |
| Médio Rio Solimões e Afluentes | 435 | 8 | 1,928.7 | 35.5 | 1.8 |
| Parintins | 200 | 9 | 1,203.4 | 54.2 | 4.5 |
| Porto Velho | 858 | 7 | 7,994.0 | 65.2 | 0.8 |
| Rio Tapajós | 1,899 | 12 | 14,243.9 | 90.0 | 0.6 |
| Tocantins | 908 | 9 | 7,196.1 | 71.3 | 1.0 |
| Vale do Javari | 673 | 2 | 10,669.0 | 31.7 | 0.3 |
| Vilhena | 676 | 15 | 11,461.5 | 254.3 | 2.2 |
| Yanomami | 969 | 9 | 3,456.1 | 32.1 | 0.9 |
| Central-West Region | 6,091 | 152 | 4,788.8 | 119.5 | 2.5 |
| Araguaia | 251 | 5 | 4,286.9 | 85.4 | 2.0 |
| Cuiabá | 1,285 | 23 | 17,371.9 | 310.9 | 1.8 |
| Kaiapó do Mato Grosso | 718 | 3 | 14,391.7 | 60.1 | 0.4 |
| Mato Grosso do Sul | 2,547 | 64 | 3,236.7 | 81.3 | 2.5 |
| Xavante | 822 | 44 | 3,704.7 | 198.3 | 5.4 |
| Xingu | 468 | 13 | 5,797.8 | 161.1 | 2.8 |
| Northeast Region | 3,975 | 55 | 2,418.3 | 33.5 | 1.4 |
| Alagoas e Sergipe | 221 | 3 | 1,770.4 | 24.0 | 1.4 |
| Bahia | 517 | 7 | 1,564.1 | 21.2 | 1.4 |
| Ceará | 800 | 6 | 2,966.7 | 22.3 | 0.8 |
| Maranhão | 1,616 | 27 | 4,273.0 | 71.4 | 1.7 |
| Pernambuco | 299 | 8 | 769.8 | 20.6 | 2.7 |
| Potiguara | 522 | 4 | 3,432.2 | 26.3 | 0.8 |
| South and Southeast Region | 2,852 | 35 | 3,398.5 | 41.7 | 1.2 |
| Interior Sul | 1,856 | 28 | 4,436.6 | 66.9 | 1.5 |
| Litoral Sul | 788 | 6 | 3,145.5 | 24.0 | 0.8 |
| Minas Gerais y Espírito Santo | 208 | 1 | 1,221.2 | 5.9 | 0.5 |
| Total | 32,041 | 471 | 4,238.8 | 62.3 | 1.5 |
| Incidence rate | ≥10,000 | | | | |
| | 5,001-9,999 | | | | |
| | 1,001-5,000 | | | | |
| | ≤1,000 | | | | |
| Mortality rate | ≥101 | | | | |
| | 61.0-100.0 | | | | |
| | 30.1-60.9 | | | | |
| | 0.0-30.0 | | | | |
| Case fatality rate | ≥5.0 | | | | |
| | 3.6-4.9 | | | | |
| | 1.0-3.5 | | | | |
| | 0.0-0.9 | | | | |

Source: Data published by the published by the Special Secretary for Indigenous Health of Brazil¹⁵ and reproduced by PAHO/WHO.

¹⁵ Special Secretariat for Indigenous Health of Brazil. SESA epidemiological report. 28 October 2020. Available at: <https://saudeindigena.saude.gov.br/corona>

III. Multisystem inflammatory syndrome (MIS) in children and adolescents temporally related to COVID-19¹⁶

On 15 May 2020, WHO issued a Scientific Brief¹⁷ on multisystem inflammatory syndrome (MIS) in children and adolescents temporally related to COVID-19 in response to reports initially received from Europe and North America regarding clusters of children and adolescents requiring admission to intensive care units with a multisystem inflammatory condition with some features similar to those of Kawasaki disease and toxic shock syndrome. MIS has been characterized as an acute illness accompanied by a hyperinflammatory syndrome, leading to multiorgan failure and shock. While the scientific knowledge base regarding MIS continues to evolve, MIS has been observed temporally in relation to COVID-19.

As of 6 November 2020, a total of 17 countries/territories in the Region of the Americas have officially reported to PAHO/WHO or published information on an official website a total of 2,032 cumulative confirmed cases of MIS temporally related to COVID-19, including 63 deaths. (**Table 4**). This figure represents a relative increase of 13% (263 additional cases) in cases and 5% (3 additional deaths) in deaths compared to the data published in the 15 October 2020 PAHO/WHO Epidemiological Update³. Since the 15 October 2020 update, Guadeloupe has been added to the list of countries/territories that have reported confirmed cases of MIS.

Additionally, as of 6 November 2020, 23 countries/territories have officially reported to PAHO/WHO there have been no cases of MIS detected.

¹⁶ World Health Organization (WHO). Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19. Preliminary case definition. Available at: <https://bit.ly/2RBZzqr>. Defined as: Children and adolescents 0–19 years of age with measured or self-reported fever ≥ 3 days **AND at least two of the following:** a) rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands or feet); b) hypotension or shock; c) features of myocardial dysfunction, or pericarditis, or valvulitis, or coronary abnormalities (ECHO findings or elevated Troponin/NT-proBNP); d) evidence of coagulopathy (abnormal PT, PTT, elevated d-Dimers); or e) acute gastrointestinal problems (diarrhea, vomiting, or abdominal pain); **AND** elevated markers of inflammation such as ESR, C-reactive protein or procalcitonin; **AND** no other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes; **AND** evidence of COVID-19 (RT-PCR, antigen test or serology positive) or likely contact with patients with COVID-19. Note: Consider this syndrome in children with features of typical or atypical Kawasaki disease or toxic shock syndrome.

¹⁷ World Health Organization (WHO). Multisystem inflammatory syndrome in children and adolescents with COVID-19. Scientific Brief. 15 May 2020. Geneva. Available at: <https://bit.ly/3hEiaGk>

Table 4. Distribution of officially reported confirmed cases and deaths of multisystem inflammatory syndrome (MIS) in children and adolescents temporally related to COVID-19 in the Region of the Americas, by country/territory, as of 6 November* 2020.

| Country/Territory | Number of confirmed cases | Number of confirmed deaths |
|--------------------------|---------------------------|----------------------------|
| Argentina | 61 | 1 |
| Brazil | 496 | 34 |
| Canada | 3 | 0 |
| Chile | 139 | 1 |
| Costa Rica | 11 | 0 |
| Colombia | 3 | 0 |
| Cuba | 2 | 0 |
| Dominican Republic | 86 | 3 |
| Ecuador | 8 | 0 |
| El Salvador | 17 | 0 |
| French Guiana | 1 | 0 |
| Guadeloupe | 4 | 0 |
| Guatemala | 2 | 0 |
| Honduras | 2 | 0 |
| Panama | 5 | 1 |
| Paraguay | 29 | 3 |
| United States of America | 1,163 | 20 |
| Total | 2,032 | 63 |

Table Note:

*6 October corresponds to the date of the most recent report; 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.

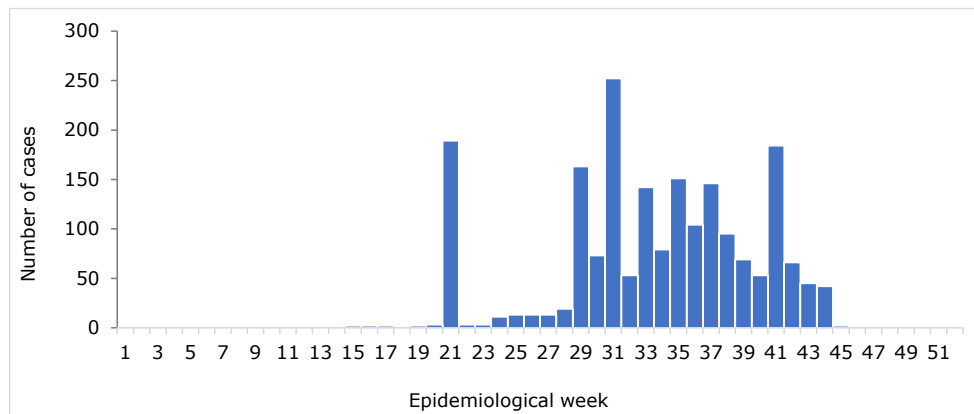
Sources: Data provided by the International Health Regulations National Focal Points or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

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

According to information shared by 17 countries/territories in the Region of the Americas, the first cases of MIS in the region were detected in epidemiological week (EW) 15 of 2020. Since then, until EW 44 of 2020, on average 66 cases have been reported weekly in the Americas. However, the data must be interpreted with caution, as not all countries/territories have reported their cases by epidemiological week (**Figure 4**) and not all countries/territories are applying the same confirmed case definition.

Brazil, Chile, and the United States of America account for 89% of the confirmed cases in the region; the United States represents 57% of that total. Regarding confirmed deaths, Brazil and the United States of America represent 54% and 32% of the total, respectively.

Figure 4. Confirmed MIS cases in the Region of the Americas. EW 15 to EW 44 of 2020.



Source: 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.

As mentioned in the 15 October 2020 PAHO/WHO Epidemiological Update³, it must be noted that since June 2020, case reports and case series have been published regarding a multisystem inflammatory syndrome in adults (MIS-A), similar to that presented in children.¹⁸

IV. COVID-19 among health care workers

Since the confirmation of the first COVID-19 cases in the Region of the Americas until 1 November, 851,868 confirmed cases were reported, including 2,503 deaths (0.3%) in health care workers from 27 countries/territories in the Americas, from which information is available.

The following is a brief description of the COVID-19 epidemiological situation among health workers in selected countries, for which updated information is available.

In the **United States of America**, a study¹⁹ was carried out of 438 adults hospitalized between 1 March 1 and 31 May 2020, who met the definition of healthcare personnel (HCP)²⁰, and analyzed according to the classification made by the COVID-19 Associated Hospitalization Surveillance Network (COVID-NET). Data on the health of the health workforce was collected by sites representing 98 counties in 13 states.²¹

Of the 438 cases analyzed that met the criteria for the study, 71.9% were women. The median age was 49 years (interquartile range, 38-57 years), 52.0% were non-Hispanic black, 27.4% were

¹⁸ Morris SB, Schwartz NG, Patel P, et al. Case Series of Multisystem Inflammatory Syndrome in Adults Associated with SARS-CoV-2 Infection — United Kingdom and United States, March–August 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1450–1456. DOI: <http://dx.doi.org/10.15585/mmwr.mm6940e1>

¹⁹ Kambhampati AK, O'Halloran AC, Whitaker M, et al. COVID-19–Associated Hospitalizations Among Health Care Personnel — COVID-NET, 13 States, March 1–May 31, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1576–1583. DOI: <http://dx.doi.org/10.15585/mmwr.mm6943e3>

²⁰ HCP was defined as people who work in healthcare settings, home healthcare services, or healthcare occupations within other settings (e.g., school nurses) who have the potential for exposure to infectious materials or patients. Healthcare professionals were stratified into two groups for analysis based on presumed level of patient contact (i.e., those generally expected to have direct patient contact and those not in direct contact) based on reported occupation.

²¹ California, Colorado, Connecticut, Georgia, Maryland, Michigan, Minnesota, Nuevo México, Nueva York, Ohio, Oregon, Tennessee y Utah.

non-Hispanic white, and 8.6% were Hispanic or Latino. Of the total, 67.4% worked in occupations where they were generally expected to have direct contact with patients, 36.3% carried out a nursing related occupation²² and 6.6% were assistants to patients and caregivers. Regarding underlying medical conditions 89.8% had at least one, of which obesity was reported most frequently (72.5%), followed by hypertension (40.6%) and diabetes (30.9%). 27.5% were admitted to an intensive care unit, 15.8% required invasive mechanical ventilation, and 4.2% died during hospitalization.

The findings in the report are subject to at least five limitations²³; probably one of the most important from a public health point of view is the fact that COVID-NET does not collect data on exposure history. It is unknown if the HCP was exposed to SARS-CoV-2 in the workplace or in the community, highlighting the need for community prevention efforts and infection prevention and control measures in healthcare settings.

In **Paraguay**, between 13 March and 2 November 2020, 15,486 exposures to COVID-19 cases have been reported in health care workers, of which 4,176 were confirmed, including 16 deaths. A total of 3,998 of these cases have been recovered.

Of the total deaths among the health care workers, 8 correspond to nursing personnel, 4 to physicians, and the remaining 4 to general services personnel. Regarding the sociodemographic characteristics, 6 were among the age group of 40 to 50 years, 4 were among the 51 to 61 years age group, 3 were ≥ 62 years-old, 2 among 29-39 age group, and 1 among 18-28 age group; 8 (50%) cases were male. With respect to geographic distribution 5 were from the Alto Paraná health region, 5 from the Central health region, 4 from the Capital, 1 from Concepción and 1 from Itapúa.

²² Including nurses (27,8%) y certified nurse assistants (8,5%).

²³ Limitations of the report include: the proportion of hospitalized HCPs being overestimated or underestimated, some estimates are unstable due to small sample size, exposure levels of HCP patients may have been misclassified, and COVID-19-associated hospitalizations may have been underestimated because laboratory confirmation depends on the physician's order to make them, as well as hospital policies.

Guidance and recommendations for national authorities

PAHO/WHO continues to reiterate and update recommendations to support all Member States on measures to manage and protect against COVID-19 and reiterates the recommendations included in the 26 August and 18 September 2020 Epidemiological Update on COVID-19.

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 care</p>  |
| <p>WHO resources, available at: https://bit.ly/30zmCj</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/36DJi3B</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/36DJi3B</p> | <p>WHO resources, available at: https://bit.ly/3d2ckuV</p> <p>PAHO/WHO resources available at: https://bit.ly/36DJi3B</p> |
| <p>Critical preparedness, readiness, and response actions</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, & 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> |

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