Epidemiological Update Coronavirus disease (COVID-19)

11 March 2021

Executive Summary

- Until 9 March 2021, a cumulative total of 116,736,437 confirmed cases of COVID-19, including 2,593,285 deaths, have been reported globally, for which the Region of the Americas accounted for 45% of the cases and 48% of the deaths.
- In the Americas Region, between December 2020 and February 2021, the highest proportions of cases were reported from the North America (68.9%) and South America (28.5%) subregions.
- In the Americas Region, between December 2020 and February 2021 for the first time since the notification of the first cases, South America contributes with a higher proportion of deaths (85%), surpassing North America (14.5%), as a result of the number of deaths that occurred in Brazil.
- As of 10 March 2021, 31 countries and territories in the Americas have reported the presence of variants of concern. Only the United States of America and Canada have notified all three.
- In some countries/territories, an increase in the number of pregnant and postpartum women with COVID-19 has been observed. As of 10 March 2021, a total of 172,552 SARS-CoV-2 positive pregnant women, including 1,017 deaths have been reported in the Americas since the first COVID-19 cases.
- The COVID-19 pandemic continues to negatively impact indigenous peoples, with 392,646 cumulative cases reported, including 5,605 deaths as of 10 March 2021.
- A special analysis on the epidemiological situation in Costa Rica and Guatemala is presented in the section on older adults, observing that in Costa Rica both women and men aged ≥80 years have the highest risk of illness and death from COVID-19. In Guatemala, on the other hand, the highest risk of illness was among males and females aged 60 and 69 years, and the highest risk of death was among females aged ≥80 years and among males aged 70 and 79 years.
- In the analysis of children and adolescents, in Costa Rica, female children and adolescents aged 5 years and older have a higher risk of illness than male children and adolescents.
- In Guatemala, at younger ages (< 15-year-olds), the risks of illness are similar for both sexes, but the risk is higher for males aged 15 to 19 years.
- Between May 2020 to 10 March 2021, 3,526 cumulative confirmed cases of multisystem inflammatory syndrome (MIS) were reported among children and adolescents temporally coinciding with COVID-19, including 95 deaths.
- While 2021 has deservedly been designated as the International Year of Health and Care Workers in appreciation and gratitude for their unwavering dedication in the fight against the COVID-19 pandemic, unfortunately, the number of cases and deaths in this group continues to grow, with 1,369,969 cumulative confirmed cases reported, including 7,389 deaths as of 10 March 2021.

Suggested citation: Pan American Health Organization / World Health Organization. Epidemiological Update: Coronavirus disease (COVID-19). 11 March 2021, Washington, D.C.: PAHO/WHO; 2021

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Context

On 31 December 2019, the People's Republic of China notified a cluster of pneumonia cases with unknown etiology, later identified on 9 January 2020 as a novel coronavirus by the Chinese Center for Disease Control and Prevention. On 30 January 2020, the World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC). On 11 February 2020, WHO named the disease "coronavirus disease 2019 (COVID-19)," and the International Committee on Taxonomy of Viruses (ICTV) named the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)." On 11 March 2020, COVID-19 was declared a pandemic by the WHO Director-General, 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]

[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

The sixth meeting of the Emergency Committee convened by the WHO Director-General under the International Health Regulations (2005) (IHR) regarding COVID-19 was held on Thursday, 14 January 2021[3].

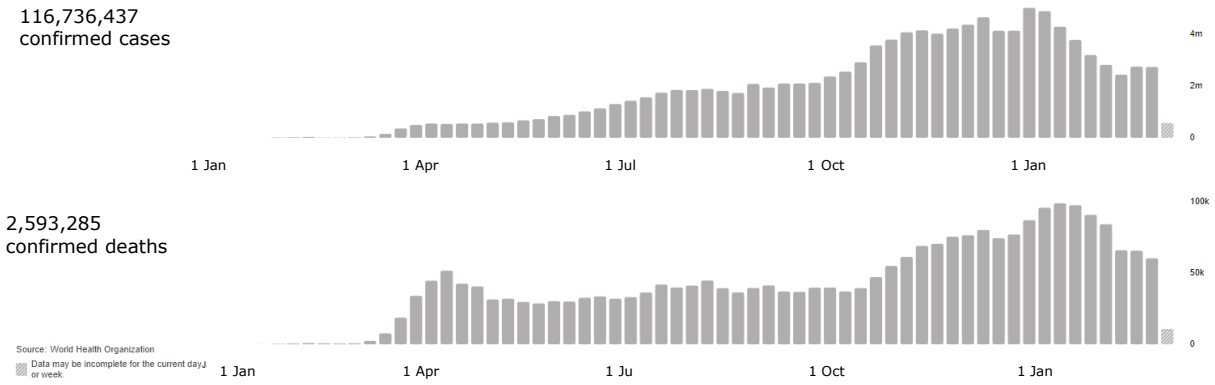
Global Situation Summary

Since the first confirmed cases of COVID-19 until 9 March 2021, a cumulative total of 116,736,437 confirmed cases of COVID-19 have been reported globally, including 2,593,285 deaths, representing a total of 11,077,961 additional confirmed cases and 283,915 additional deaths since the last PAHO/WHO Epidemiological Update on COVID-19[4] published on 9 February 2021.

Of the total cumulative confirmed cases globally, 31% were reported between 29 December 2020 (Epidemiological Week (EW) 53)) and 9 March (EW 10) of 2021; the same proportion of deaths were reported during the same period (**Figure 1**).

Globally, after observing a decrease in the number of reported cases since mid-January 2021, the number of cases has increased again since mid-February. The trend will have to be observed with caution in the coming months, while social distancing measures, public health measures, and vaccination campaigns continue to be implemented with different approaches in each country and territory.

Figure 1. Distribution of global COVID-19 confirmed cases and deaths, by week. January 2020 to March 2021.



Source: WHO Coronavirus Disease (COVID-19) Dashboard. Data as of 9 March 2021. Available at: https://covid19.who.int. Accessed 9 March 2021 at 10:41 a.m.

[3] WHO. Statement on the sixth meeting of the International Health Regulations (2005) Emergency Committee regarding the coronavirus disease (COVID-19) pandemic. Available at: https://bit.ly/36Xq2DY
[4] PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 9 February 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: http://bit.ly/3aOxZWG

Situation Summary in the Region of the Americas

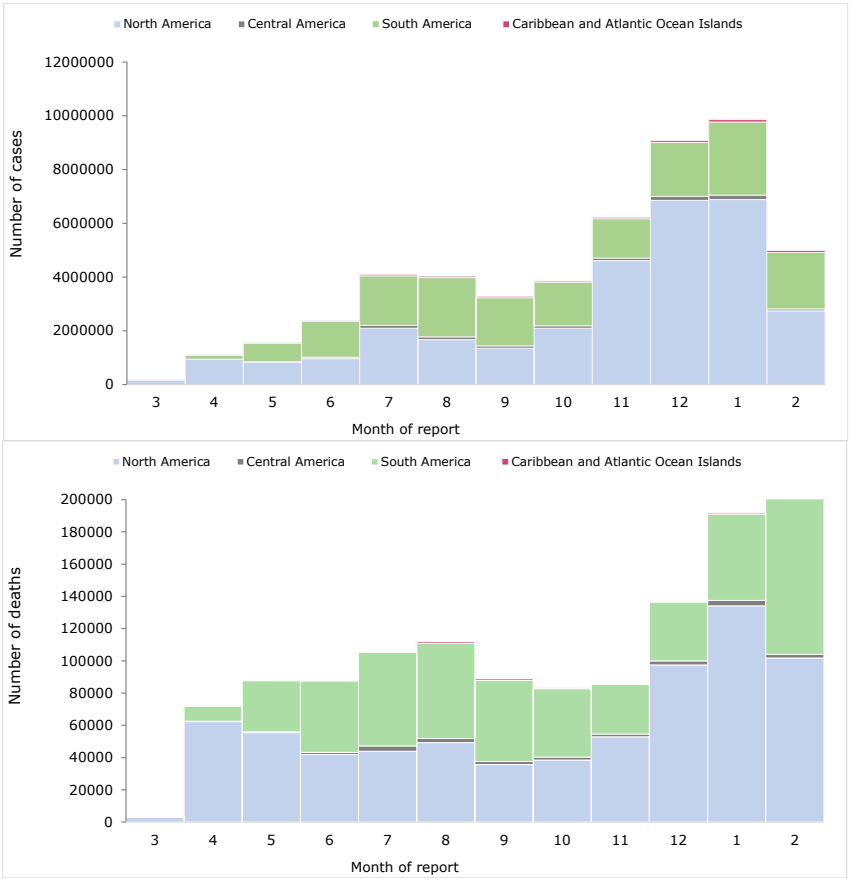
As of 9 March 2021, all 56 countries and territories in the Region of the Americas have reported a cumulative total of 52,038,090 confirmed cases of COVID-19, including 1,247,994 deaths[5], since the detection of the first cases in the Region in January 2020.

Since the 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4] and as of 9 March 2021, 4,617,288 additional confirmed cases of COVID-19, including 142,033 additional deaths, have been reported in the Region of the Americas, representing an 13% increase in cases and a 11% increase in deaths; these percentages are lower than those observed comparing the period between 8 December 2020 and 8 January 2021, when there was a 25% increase in the number of cases and a 16% increase in the number of deaths.

Between December 2020 and February 2021, the subregions of North America[6] and South America[7] accounted for the highest proportion of cases (68.9% and 28.5%, respectively), while the Central America[8] and the Caribbean and Atlantic Ocean Islands[9] subregions accounted for 1.6% and 1% respectively. During the same period, South America accounted for 85.0% of the reported deaths, followed by North America (14.5%), Central America (0.4%), and the Caribbean and Atlantic Ocean Islands (0.1%) (**Figure 2**).

[5] 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/3kvigPD.
[6] Canada, Mexico, and United States of America.
[7] Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.
[8] Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
[9] Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, Bonaire, British Virgin Islands, Cayman Islands, Cuba, Curacao, Dominica, Dominican Republic, Falkland Islands, Grenada, Guadeloupe, French Guiana, Guyana, Haiti, Jamaica, Martinique, Montserrat, Puerto Rico, Saba, Saint Barthelemy, Saint Kitts and Nevis, Sint Eustatius, Saint Lucia, Saint Martin, Saint Pierre and Miquelon, Sint Maarten, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos, and the United States Virgin Islands.

Figure 2. Distribution of COVID-19 confirmed cases and deaths, by subregion and month of notification. Region of the Americas, March 2020 to February 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.

Analyzing the trend of cases and deaths in the last 7 days in the Central America subregion, El Salvador and Guatemala are the only two countries in the subregion that reported an increase in cases, and there was no increase in deaths reported amongst any of the countries in this subregion; however, this trend will need to be observed with caution (**Table 1**).

Table 1. Observed trend of cases and deaths of COVID-19 in countries and territories in the Central America subregion in the last 7 days, until 9 March 2021.

Country	Cases			Deaths			Transmission Type
	7 Day moving average trend	#Cumulative	7 day % change	7 Day moving average trend	# Cumulative	7 day % change	
Belize		12,335	**-14%**		315	0%	Community transmission
Costa Rica		206,640	**-29%**		2,833	-7%	Community transmission
El Salvador		60,800	**48%**		1,915	0%	Community transmission
Guatemala		178,770	**22%**		6,479	**-20%**	Community transmission
Honduras		173,729	**-34%**		4,260	**-30%**	Community transmission
Nicaragua		5,176	-6%		174	0%	Community transmission
Panama		344,834	**-11%**		5,923	**-24%**	Community transmission
Subtotal		**982,284**			**21,899**		

Legend

>50% increase
10% to 50% increase
10 to -10% change
10% to 50% decrease
>50% decrease

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.

The following is a brief analysis of the epidemiological situation of COVID-19 in two selected countries in Central America: **Costa Rica** and **Guatemala**[10]. Additional details of the epidemiological situation in these two countries will be further presented in some sections of this Epidemiological Update.

The first cases of COVID-19 in Costa Rica and Guatemala were confirmed on 6 March 2020 and on 13 March 2020, respectively. Since then and until 28 February 2021, more than 100,000 cumulative cases had been reported in each country: 204,906 cases in Costa Rica, including 2,803 deaths, and 174,620 cases in Guatemala, including 6,464 deaths. Community transmission is occurring in both countries, and a downward trend in cases and deaths has been observed in recent months, which should be interpreted with caution.

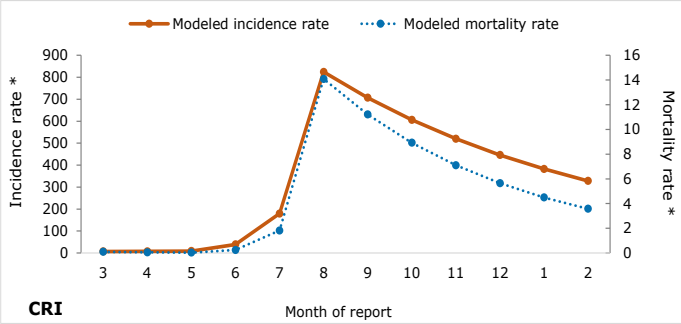
The monthly incidence and mortality rates per 100,000 population were analyzed for both countries using Joinpoint software to assess whether the observed changes in temporal trends are statistically significant.

In Costa Rica, when modeling the curve of monthly incidence rates, three changes in the trend were observed. The first, between March and May 2020, an almost stable trend is observed with a monthly percentage change (MPC) of 12.34% (not statistically significant). The second, between May and August 2020, there was an MPC of 359.52% (statistically significant). The third, between August 2020 and February 2021, there was a downward trend and an MPC of -14.24% (not statistically significant). With regards to the monthly mortality rate trend, three changes in the trend were observed. The first, between March and May 2020, there was an MPC of -40.25% (not statistically significant). The second, between May and August 2020, had a marked increase and an MPC of 674.03% (statistically significant). The

[10] The other Central American countries were excluded because the data necessary to include them in this analysis have either not been published or the COVID-19 case line-lists have not been shared with PAHO/WHO.

third, between August 2020 and February 2021, had an MPC of -20.42% (not statistically significant).

Figure 3. Modeled incidence and mortality rates of COVID-19. Costa Rica, March 2020 to February 2021.

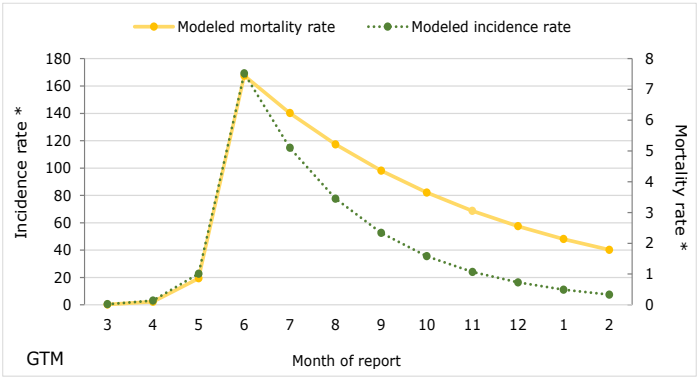


Notes:
* Rates per 100,000 population. Modeled with Joinpoint software
CRI: Costa Rica
The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data from the Costa Rica IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

In Guatemala, two changes were observed in the monthly incidence rates. The first, between March and June 2020, with an MPC of 767.08% (statistically significant) and for the second, between June 2020 and February 2021, there was a downward trend, with an MPC of -16.34% (also statistically significant) (**Figure 4**). With regards to mortality rates, two changes were observed as well. The first, between March and June 2020, had an increase with an MPC of 646.13%, and the second, between June 2020 and February 2021, had an MPC of -32.28%; both were statistically significant (**Figure 4**).

Figure 4. Modeled incidence and mortality rates of COVID-19. Guatemala, March 2020 to February 2021.



Notes:
* Rates per 100,000 population. Modeled with Joinpoint software
GTM: Guatemala
The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Guatemala IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

It should be noted that, although some of the changes indicated in the epidemic curves for both Costa Rica and Guatemala were statistically significant (it is necessary to evaluate at the national level the hypothesis about the causes of the identifies changes), the minimum following factors must be considered:

- Due to the incompleteness of the data, the rates were constructed based on the date of notification and not the date of symptom onset; therefore, the delay in notification influences the curve, and could cause the rates to differ from those constructed based on the date of symptom onset.
- The data represented do not correspond to the total number of cases.
- It is assumed that the population indicated in the denominator remains stable each month.

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 several microevolution processes and selection pressures, some additional mutations may appear, generating differences within each genetic group (called variants). It is worth mentioning 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 8 March 2021, more than 714,514 complete genomic sequences have been shared globally through publicly accessible databases.

As of 8 March 2021, 38 countries and territories in the Americas have published a total of 187,705 SARS-CoV-2 genomes on the GISAID platform, collected between February 2020 and March 2021. The countries and territories that have contributed genome data are: Antigua and Barbuda, Argentina, Aruba, Belize, Bermuda, Bolivia, Brazil, the British Virgin Islands, Canada, the Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Curaçao, the Dominican Republic, Ecuador, El Salvador, Guadeloupe, Guatemala, French Guyana, Jamaica, Mexico, Panama, Peru, Puerto Rico, Saint Barthelemy, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Sint Eustatius, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

On 25 February 2021, the WHO provided proposed working definitions for SARS-CoV-2 variants of interest (VOI) and variants of concern (VOC) and the associated actions that WHO will take to 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 context of wider SARS-CoV-2 transmission, and public health response mechanisms and established social distance measures.

These definitions will periodically be reviewed and updated, as necessary. The full publication is available at: https://bit.ly/2O173vt

Globally, an increase in the number of reported VOC and VOI has been observed; however, this increase must consider 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 variants of concern (VOC), as of 9 March 2021.

Summary	Name of the variant *		
	Variant B.1.1.7	Variant B.1.351	Variant B.1.1.28.1
Number of countries/territories reporting cases globally	111	58	32
Number of countries/territories reporting cases in the Americas	27	5	10

Note:
***** Name of PANGO lineage
Some countries/territories have reported more than one variant of concern (VOC).

Source: WHO. COVID-19 weekly epidemiological update. Published on 9 March 2021. Available at: https://bit.ly/3v6e0Mi

Regarding the situation in the Americas, as of 9 March 2021, 31 countries and territories have reported the detection of VOC cases, representing 11 additional countries and territories since the 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4]. Only Canada and the United States of America have reported the detection of all three VOC. (**Table 3**)

Table 3. Countries and territories reporting variants of concern (VOC) in the Region of the Americas, as of 9 March 2021.

Country	Variant B.1.1.7	Variant B.1.351	Variant B.1.1.28.1
Argentina	Yes	No	Yes
Aruba	Yes	No	No
Barbados	Yes	No	No
Belize	Yes	No	No
Brazil	Yes	No	Yes
Bonaire	Yes	No	No
Canada	Yes	Yes	Yes
Cayman Islands	Yes	No	No
Chile	Yes	No	Yes
Colombia	No	No	Yes
Costa Rica	Yes	Yes	No
Cuba	No	Yes	No
Curacao	Yes	No	No
Dominican Republic	Yes	No	No
Ecuador	Yes	No	No
French Guiana	Yes	No	Yes
Guadeloupe	Yes	No	No
Jamaica	Yes	No	No
Martinique	Yes	No	No
Mexico	Yes	No	Yes
Panama	No	Yes	No
Peru	Yes	No	Yes
Puerto Rico	Yes	No	No
Saint Barthélemy	Yes	No	No
Saint Martin	Yes	No	No
Saint Lucia	Yes	No	No
Trinidad and Tobago	Yes	No	No
Turks and Caicos	Yes	No	No
United States of America	Yes	Yes	Yes
Uruguay	Yes	No	No
Venezuela	No	No	Yes

Note: In the 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4], there was an omission that the variant B.1.1.28.1 had also been detected in Chile.

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)

As presented in previous PAHO/WHO Epidemiological Updates on COVID-19, one of the ways to measure the impact of the COVID-19 pandemic on people aged 60 and over (older adults) is through age-specific mortality rates; it is also important to analyze years of life lost (YLL) due to premature deaths.

In an analysis of the YLL due to premature death[11] in a sample of 81 countries[12], it was found there have been a total of 20,507,518 YLL due to COVID-19, as a result of the 1,279,866 deaths due to COVID-19. The average YLL per death is 16 years. Due to differences between countries in the ongoing pandemic, the results are representative of the point in time at which the analysis was performed.

The study sample results in an average age of 72.9 years at the time of death, with the 55 to 75-year-old age group accounting for 44.9% of the total YLL.

Differences were observed between countries according to their income, with a higher proportion of YLL corresponding to older people (≥60 years) in higher income countries and the opposite pattern appearing and a lower proportion of YLL among older people in low- and middle-income countries.

In regards to the analysis for **Costa Rica** and **Guatemala**, during the period studied[13], in both countries older adults (≥60 years) accounted for 12% of the total confirmed cases for which age data was available (204,563 cases and 142,534 cases, respectively).

In Costa Rica, the risk of illness among older adults (≥60 years) was lower than the risk among 59-year-olds and younger. In contrast, the risk for mortality rates was the opposite[14]; from June 2020 onwards, the risk of death among older adults was much higher than among 59-year-olds and younger (**Figure 5**).

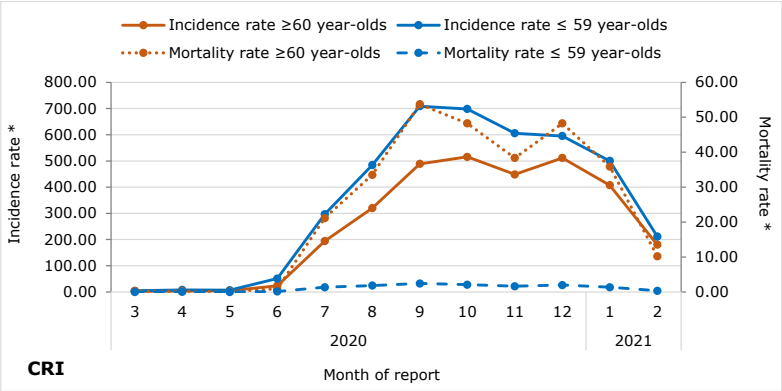
[11] Pifarré i Arolas H, Acosta E, López-Casasnovas G, et al. Years of life lost to COVID-19 in 81 countries. Available at: https://go.nature.com/2Oj9jxU

[12] The countries included the following in the Region of the Americas: Argentina, Bolivia, Brasil, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Haiti Jamaica, Mexico, Nicaragua, Panama, Peru, Suriname, the United States of America, and Uruguay.

[13] March 2020 to February 2021

[14] For the calculation of mortality rates, 2,818 deaths were considered for Costa Rica and 4,055 deaths for Guatemala, for which age and sex data were available.

Figure 5. Monthly age-specific incidence and mortality rates of COVID-19 among older adults (≥60 years) and people 59 years and younger. Costa Rica. March 2020 to February 2021.

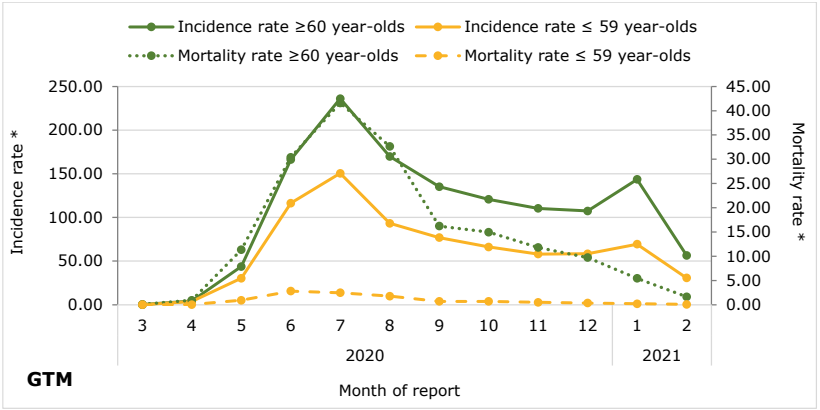


Note:
* Rates per 100,000 population. CRI: Costa Rica
The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Costa Rica IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

In Guatemala, between March and April 2020, the risk of illness among older adults (≥60 years) was similar to the 59 years and younger group; however, from June 2020 onwards, older adults (≥60 years) showed a higher risk of illness than those aged 59 years and under. With regards to the risk of death, there is a greater difference between both age groups from May 2020 onwards (**Figure 6**).

Figure 6. Monthly age-specific incidence and mortality rates of COVID-19 among older adults (≥60 years) and people 59 years and younger. Guatemala, March 2020 to February 2021.

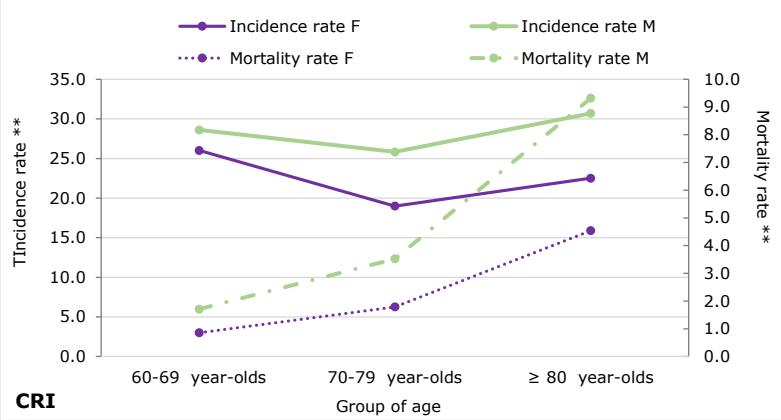


Note:
* Rates per 100,000 population. GTM: Guatemala
The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Guatemala IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

In Costa Rica, when analyzing the data for older adults and disaggregating it into three age subgroups (60-69 years, 70-79 years, and ≥80 years) and by sex, males across all 3 subgroups have incidence and mortality rates higher than those of females. Among both genders, persons ≥80 years have the highest risk of illness and death from COVID-19 (**Figure 7**).

Figure 7. Age-specific incidence and mortality rates of COVID-19 among older adults (≥60 years) by sex. Costa Rica, March to December 2020.



Note:

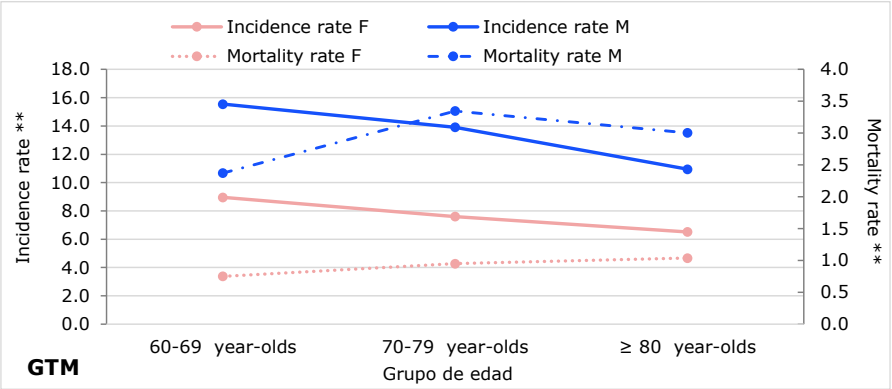
* Rates per 100,000 population. CRI: Costa Rica

The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Costa Rica IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

In contrast to Costa Rica, in Guatemala, the highest risk of illness is observed among persons aged 60-69 years for both sexes, while the highest risk of death is observed among females ≥80 years and among males aged 70-79 years (**Figure 8**).

Figure 8. Age-specific incidence and mortality rates of COVID-19 among older adults by sex. Guatemala, March to December 2020.



Note:

* Rates per 100,000 population. GTM: Guatemala

The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Guatemala IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

III. COVID-19 during pregnancy

Recently, there was widespread media coverage of a report of a pregnant woman with COVID-19 who at 25 weeks of gestation had sought medical care due to the absence of fetal movement, and for which intrauterine death was confirmed and subsequently, SARS-CoV-2 infection in the fetus[15]. This news highlights the need for further research on transplacental SARS-CoV-2 infection and its role in the outcome of pregnancy.

An investigation carried out in Brazil found that in 5 cases of stillbirth in women with confirmed COVID-19 and no other significant clinical or obstetric disorder, the intense placental inflammatory reaction raises the possibility of a direct effect of SARS-CoV-2 on the placenta, suggesting that fetal death could be a result of SARS-CoV-2 infection during pregnancy[16].

While monitoring of pregnant and postpartum women who are positive for SARS-CoV-2 is occurring in some countries of the Region of the Americas, there remains a lack of data on rates of abortion or stillbirth and the relationship between these occurrences and SARS-CoV-2 infection.

Since the first reported cases of COVID-19 in the Americas and until 10 March 2021, there have been a total of 172,552 SARS-CoV-2 positive cases among pregnant women reported, including 1,017 deaths (1%), in 21 countries/territories for which information was available (**Table 4**). Compared to the data presented in the 9 February 2021 PAHO/WHO Epidemiological Update[4], this represents an increase of 15,564 additional cases and 77 additional deaths. During the same period, the highest relative increases in cumulative confirmed cases occurred in Cuba and Panama, while for deaths, this was observed in Chile.

[15] The Times of Israel. *Hospital says 'high probability' fetus died of virus, in 1st such case in Israel*. 16 February 2021, Available at: https://bit.ly/2OwgHWE, Accessed 9 March 2021.
[16] Richtmann R, Torloni M, Oyamada Otani A et al. Fetal deaths in pregnancies with SARS-CoV-2 infection in Brazil: A case series. doi: 10.1016/j.crwh.2020.e00243. Available at: https://bit.ly/3bmYAvf

Table 4. COVID-19 during pregnancy, by country. Region of the Americas. January 2020 to 10 March 2021*.

Country	Number of pregnant women positives for SARS-CoV-2	Number of deaths among pregnant women positives for SARS-CoV-2	Case fatality rate (%)
Argentina	9,352	44	0.47
Bahamas	30	1	3.33
Bolivia	1,946	31	1.59
Belize**	103	2	1.94
Brazil	5,381	289	5.37
Chile	8,091	5	0.06
Colombia	7,929	60	0.75
Costa Rica	393	3	0.76
Cuba	401	0	0.00
Dominican Republic	351	37	10.54
Ecuador	1,738	25	1.44
El Salvador	272	9	3.31
Guatemala	1,834	22	1.20
Haiti**	76	4	5.26
Mexico[&]	14,399	307	2.13
Panama[&]	2,264	12	0.53
Paraguay	797	1	0.12
Peru[&]	41,403	76	0.18
United States of America	75,279	82	0.11
Uruguay	124	0	0.00
Venezuela	389	7	1.80
Total	**172,552**	**1,017**	**0.59**

Note:
*10 March 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 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4]
& Corresponds to pregnant and postpartum women

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.

IV. COVID-19 among indigenous populations

More than 476 million indigenous peoples inhabit territories that span all regions of the world, amounting to more than 6.2% of the world's human population and representing 5,000 different cultures. Just over 70% of all indigenous peoples live in Asia and the Pacific, 16% in Africa, followed by 11.5% in Latin America and the Caribbean, and the remainder in Europe and North America.[17]

The impact of the COVID-19 pandemic on indigenous peoples has further exposed the well-known pre-existing inequalities between indigenous and non-indigenous peoples. Among the factors that have contributed to this impact, extreme poverty and neglected can be considered, as indigenous peoples represent almost 19% of the extreme poor, regardless of

[17] United Nations. Concept Note: International Expert Group Meeting on the theme Indigenous Peoples and Pandemics, 7 to 11 December 2020, New York. Available at: https://bit.ly/3rpcT8d

the region or location where they may live and are almost 3 times more likely to be in extreme poverty compared to their non-indigenous counterparts.

During the current pandemic, indigenous leaders and organizations have pointed to the general absence of mitigation strategies and social protection policies designed to address their specific needs and situations. Likewise, they have also questioned the absence of effective mechanisms to promote the participation of their legitimate representatives in the relevant decision-making processes during the crisis, and insufficient access to culturally appropriate information campaigns on the pandemic in indigenous languages. These shortcomings have also raised many concerns about the lack of qualitative and quantitative public data on the health and socioeconomic impacts of the pandemic on indigenous peoples.[25.]

Since January 2020 until 10 March 2021, there have been 392,646 confirmed cases of COVID-19, including 5,605 deaths, reported among indigenous populations in 15 countries in the Region of the Americas for which information was available (**Table 5**). Compared to the data in the 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4], this represents 53,509 additional confirmed cases including 862 deaths.

Table 5. Cumulative number of confirmed cases of COVID-19 and deaths among indigenous populations in the Region of the Americas. January 2020 to 10 March 2021*.

Country	Number of confirmed cases of COVID-19	Number of deaths
Bolivia**	3,485	151
Brazil	44,174	592
Canada	22,451	248
Chile	27,445	N/A
Colombia	37,254	1,179
Ecuador**	4,937	194
Guatemala	11,710	454
Guyana**	95	6
Mexico	16,682	2,427
Panama	5,807	102
Paraguay	268	26
Peru	29,635	170
Suriname	551	28
United States of America	187,291	N/A
Venezuela	861	28
Total	**392,646**	**5,605**

Note:
N/A: data not available
*10 March 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 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4].

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 during childhood

Since the beginning of the pandemic, it has been understood that children and adolescents have a lower risk of illness and death from COVID-19 compared to other age groups. However, it is recognized that children and adolescents are being affected mainly by the measures taken to control the transmission of the virus. These indirect effects are the negative consequences of the closure of schools, restrictions on the movement of people limiting 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 modification of health and social protection services, among others. The number of studies documenting the magnitude of these effects on the health, development, and learning of children and adolescents is growing.[18]

While children and adolescents have a lower risk of illness and death from COVID-19 compared to other population groups, it has been reported that the clinical presentation in those who have been affected by SARS-CoV-2 has ranged from having no symptoms to needing hospitalization, intensive care, and, less frequently, death.

It should be noted that this group of the population, even if asymptomatic, can present with some sequelae and complications, such as those described in studies carried out with cases from different countries of Latin America[19], Brazil[20,21], and Cuba[22].

The following is an analysis based on the data available for **Costa Rica** and **Guatemala**. Incidence and mortality rates were calculated for children and adolescents between 0 and 19 years of age.

In Costa Rica, of the total number of cases for which age and sex data were available in this population group[23], 51% were female. Females present the highest risk of illness from 5-years-old and older, with incidence rates higher than the rate of both sexes in the strata between 10 to 14 years and 15 to 19 years (**Figure 9**). In 2020, 9 deaths among children and adolescents were reported (3 females and 6 males).

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

[19] Antúnez-Montes OY, Escamilla MI, Figueroa-Uribe AF, et. al. COVID-19 and Multisystem Inflammatory Syndrome in Latin American Children: A Multinational Study. January 2021. Available at: https://bit.ly/38nxCSy

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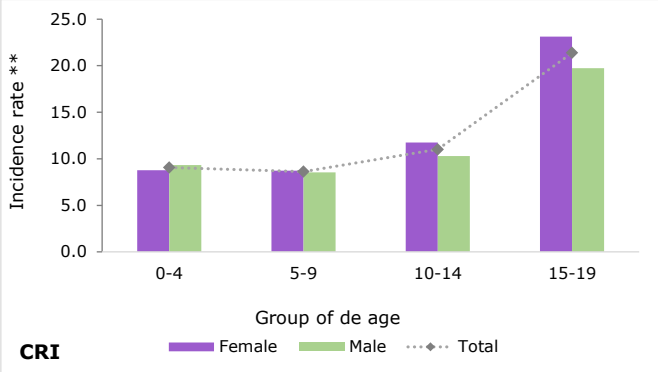
[21] Prata-Barbosa A, Lima-Setta F, Santos GRD, et.al. Pediatric patients with COVID-19 admitted to intensive care units in Brazil: a prospective multicenter study. Sept.- Oct. 2020. Available at: https://bit.ly/3ckegPw

[22] Vega L, Perez F, López L, et. al. Aspectos clínicos, epidemiológicos y cardiovasculares en niños convalecientes por COVID 19 en Villa Clara, Cuba. 2020. Available in Spanish at: https://bit.ly/2O9C7t0

[23] 17,927 cases

Figure 9. Age-specific incidence rates of COVID-19 among children and adolescents between 0 to19 years of age. Costa Rica, March to December 2020.

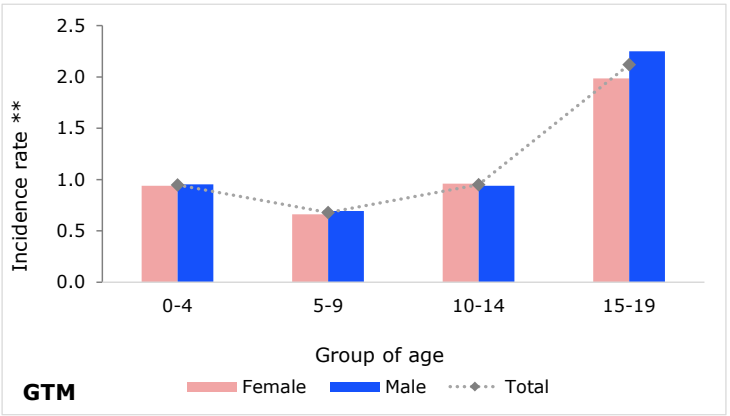


Note:
**Rates per 1,000 children and adolescents. CRI: Costa Rica
The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Costa Rica IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

In Guatemala, of the total number of cases for which age and sex data were available in this population group[24], 53% were male. In contrast to Costa Rica, the risk of illness amongst the four age groups is similar for both sexes, with the exception of the 15 to 19-year-old age group, for which there are slightly more males, with an incidence rate higher than the overall rate for both sexes (**Figure 10**). In 2020, there were 55 deaths reported among children and adolescents (31 females and 24 males). Most of the deaths (75%) were among the age groups of 0 to 4 years (45%) and 15 to 19 years (29%).

Figure 10. Age-specific incidence rates of COVID-19 among children and adolescents between 0 to19 years of age. Guatemala, March to December 2020.



Note:
**Rates per 1,000 children and adolescents. GTM: Guatemala
The population data used was obtained from the United Nations population projections for the year 2021. Available at: https://bit.ly/3c9GL2a

Source: Data shared by the Guatemala IHR National Focal Point (NFP) and analyzed by PAHO/WHO.

[24] 9,256 cases

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

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

Although MIS occurs relatively infrequently, these cases present important challenges for health systems.

In the Region of the Americas, since June of 2020, PAHO/WHO began active surveillance of MIS cases, inviting Member States to share minimum epidemiological surveillance variables permitting the characterization of MIS in the Region.

Between mid-May 2020 to 10 March 2021, a cumulative total of 3,526 confirmed cases of MIS that temporally coincide with COVID-19, including 95 deaths, have been reported by 20 countries/territories of the Region of the Americas (**Table 6**).

Since the 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4], 3 additional countries have reported confirmed MIS cases: Barbados, Bolivia, and Peru. Furthermore, there were an additional 511 confirmed cases reported, including 11 deaths. During this same period, 24 countries and territories have officially reported to PAHO/WHO that they have not detected cases of MIS.

As the numbers of cases of MIS increase, it is important that each country/territory characterizes the cases[25] in order to contribute to closing the gaps in information, particularly related to clinical management and response measures.

[25] Case Report Form for suspected cases of multisystem inflammatory syndrome (MIS) in children and adolescents temporally related to COVID-19. Available at: https://bit.ly/3cTmrUF

Table 6. Distribution of cumulative 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. May 2020 to 10 March 2021*.

Country/Territory	Number of confirmed cases	Number of confirmed deaths
Argentina	125	1
Barbados	1	1
Brazil	769	47
Bolivia	1	1
Canada	55	0
Chile	157	2
Costa Rica	30	0
Colombia	4	1
Cuba	3	0
Dominican Republic	129	5
Ecuador	8	0
El Salvador	19	0
French Guiana	1	0
Guadeloupe	4	0
Guatemala	2	0
Honduras	2	0
Panama	81	2
Paraguay	63	5
Peru	1	0
United States of America	2,071	30
Total	**3,526**	**95**

Note:
*10 March 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.

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

Of the total number of reported cases for which data on age were available (n= 3,322), 32% were aged 0 and 4 years, 33% aged 5 to 9 years, 25% aged 10 to 14 years, and 10% aged 15 and 19 years (the United States of America includes 20-year-olds in this age group). Regarding the distribution by sex, 58% of the cases were male.

Of the 90 fatal cases for which data on age were available, 40% were aged 0 to 4-years, 17% aged 5 to 9 years, 17% aged 10 to 14 years, and 27% aged 15 to 19 years.

VI. COVID-19 among health workers

While 2021 has deservedly been designated as the International Year of Health and Care Workers to recognize and thank the unwavering dedication of these workers in fighting the COVID-19 pandemic[26], the number of cases and deaths in this population unfortunately continues to increase.

From January 2020 to 10 March 2021, 30 countries/territories in the Americas have continued reporting cases and deaths among health workers.

According to the information available on reviewed data of confirmed cases and deaths, the information provided by 18 countries in the Americas indicates that a cumulative total of 1,369,969 confirmed cases of COVID-19 have been reported, including 7,389 deaths, in health workers between January 2020 and 10 March 2021 (**Table 7**).

Table 7. Distribution of cumulative confirmed cases and deaths of COVID-19 among health workers in the Region of the Americas. January 2020 to 10 March 2021*.

Country	Number of confirmed cases of COVID-19	Number of deaths
Argentina	77,698	456
Bahamas	336	3
Brazil	457,686	480
Chile**	52,241	102
Colombia	43,399	216
Costa Rica	7,974	25
Ecuador	11,038	114
El Salvador	6,609	72
Dominican Republic	770	19
Guatemala	9,141	84
Jamaica	678	3
Mexico	229,458	3,534
Panama	7,925	123
Paraguay	8,858	54
Peru**	30,675	589
Suriname	385	0
United States of America	420,075	1,387
Uruguay	3,345	7
Venezuela	1,678	121
Total	**1,369,969**	**7,389**

Note:
*10 March 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 9 February 2021 PAHO/WHO Epidemiological Update on COVID-19[4]

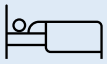
Source: Data provided by the IHR National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

[26] WHO. Year of the Health and Care Workers 2021. Available at: https://bit.ly/3cfleFp

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.

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

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15. Report by the **Suriname** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email

16. **United States**. Centers for Disease Control and Prevention. Data on COVID-19 during Pregnancy. Available at: https://bit.ly/2SWWyYT and https://www.cdc.gov/mis-c/

17. **Uruguay** Ministry of Public Health. Available at: https://bit.ly/3p7z8xy

18. Report by the **Venezuela** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email