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Americas

Epidemiological Update Coronavirus disease (COVID-19)

19 June 2021

Executive Summary

- As of 16 June 2021, 176,480,226 confirmed cumulative cases of COVID-19 have been reported globally, including 3,825,240 deaths, for which the Region of the Americas contributed 40% of cases and 48% of deaths.
- In May 2021, the South America subregion continued to contribute the largest number of cases and deaths, accounting for 3,930,933 cases and 118,593 deaths. This represents 73% and 79% of the cases and deaths reported, respectively, in the Region of the Americas during this month.
- As of 17 June 2021, Argentina, Aruba, Brazil, Canada, Mexico, Puerto Rico, and the United States of America have detected the four variants of concern (VOC).
- Among indigenous populations in 18 countries of the Americas, 552,328 cases were reported, including 13,562 deaths.
- A total of 23 countries and territories have reported 6,056 cumulative confirmed cases of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19, including 129 deaths.
- Regarding health workers, 35 countries and territories have reported 1,980,345 cases, including 9,819 deaths.

- 1 -

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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.¹ On 9 July 2020, the WHO Director-General announced the launch of the Independent Panel for Pandemic Preparedness and Response (IPPR), which will independently and comprehensively assess the lessons learned from the international health response to COVID-19.²

The seventh 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, 15 April 2021. The Director-General determined that the COVID-19 pandemic continues to constitute a PHEIC and accepted the advice of the Committee to WHO and issued the Committee's advice to States Parties as Temporary Recommendations under the IHR, available at: <https://bit.ly/3eO4yXP>.

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

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

Global Situation Summary

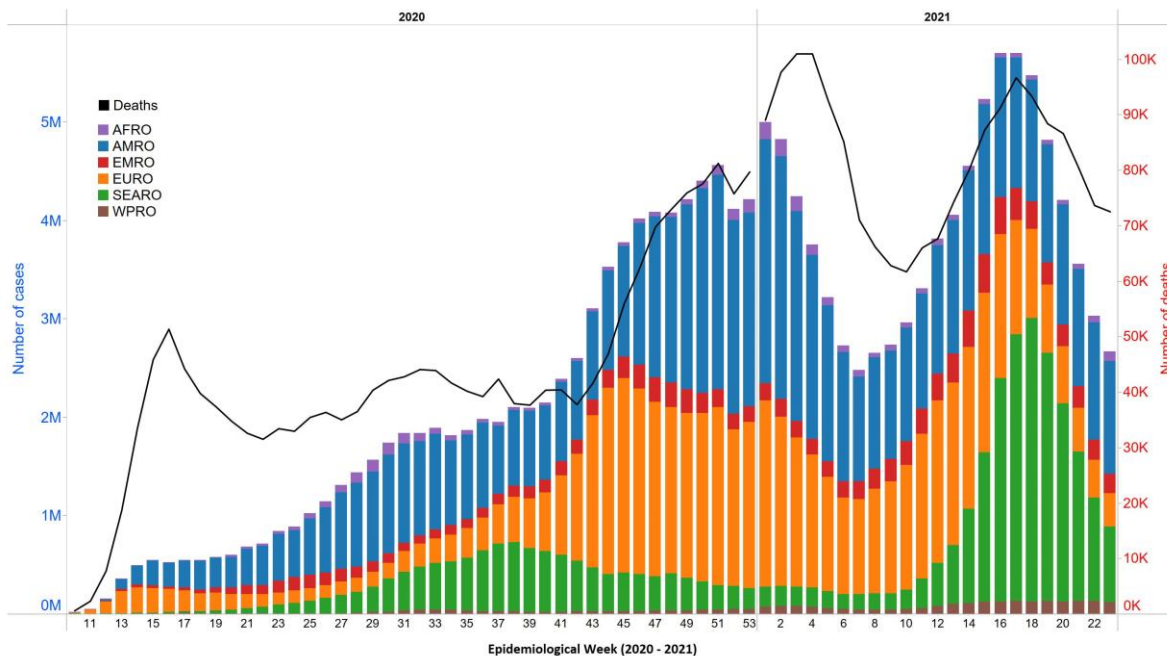
Since the first confirmed cases of COVID-19 until 16 June 2021, a cumulative total of 176,480,226 confirmed cases of COVID-19 have been reported globally, including 3,825,240 deaths, representing a total of 13,706,286 additional confirmed cases and 449,667 additional deaths since the last PAHO/WHO Epidemiological Update on COVID-19³ published on 18 May 2021.

At the global level, cases and deaths peaked for a second time this pandemic during epidemiological week (EW) 17 of 2021 (25 April – 1 May), when more than 5.7 million new cases including 96,718 deaths were reported (**Figure 1**). While the number of weekly cases was 14% higher during the second peak than the first peak (EW 1 of 2021), the number of weekly deaths decreased slightly (4.3%) during the second peak relative to the first peak. The majority of the cases and deaths reported globally during the first peak in 2021 were reported by the WHO Region of the Americas (49.6% of cases and 44.9% of deaths) and the WHO European Region (37.8% cases and 42.3% of deaths). During the second peak (EW 17), the highest proportions of weekly cases and deaths were reported by the WHO South-East Asia Region (47.6% of cases and 26.1% of deaths) and the Region of the Americas (23.3% of cases and 40.9% of deaths).

Since the second peak during EW 17 of 2021, cases and deaths have been on a downward trend for six consecutive weeks, with the Region of Americas once again contributing the highest proportion of weekly cases (43.1%) and deaths (43.9%), followed by the South-East Asia Region contributing 28.6% of cases and 36.3% of deaths as of EW 23. The large increase in cases and deaths in the South-East Asia Region during this period was driven primarily by India, which continues to report the highest number of new cases and deaths in that respective WHO Region. While the WHO African Region continues to have the lowest proportions of weekly cases (3.6%) and deaths (1.9%), during EW 23 of 2021, the Region experienced large increases in cases (44%) and deaths (20%) compared to the previous week. (**Figure 1**)

³ PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 18 May 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: <https://bit.ly/35BJJW>

Figure 1. Distribution of global COVID-19 confirmed cases and deaths, by epidemiological week (EW) of report. As of EW 23, 2021.



Note:

AFRO: WHO Regional Office for Africa; AMRO: WHO Regional Office for the Americas; EMRO: WHO Regional Office for the Eastern Mediterranean; EURO: WHO Regional Office for Europe; SEARO: WHO Regional Office for South East-Asia; WPRO: WHO Regional Office for the Western Pacific

Source: WHO Coronavirus (COVID-19) data reproduced by PAHO/WHO. Available at: <https://covid19.who.int/info/>. Accessed on 17 June 2021.

Situation Summary in the Region of the Americas

As of 16 June 2021, all 56 countries and territories in the Region of the Americas have reported a cumulative total of 70,103,320 confirmed cases of COVID-19, including 1,842,522 deaths⁴, since the detection of the first cases in the Region in January 2020.

Since the 18 May 2021 PAHO/WHO Epidemiological Update on COVID-19³ and as of 16 June 2021, 5,169,157 additional confirmed cases of COVID-19, including 254,663 additional deaths, have been reported in the Region of the Americas, representing an 8% increase in cases and a 16% increase in deaths.

In 2021, between 1 January and 31 May 2021, a total of 31,568,105 confirmed cases, including 840,670 deaths, were reported in the Americas, with the subregions of North America⁵ and South America⁶ accounting for the highest proportions of cases (49.3% and 47.5%, respectively), while

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/3kvigPD>.

⁵ Canada, Mexico, and United States of America.

⁶ Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.

the Central America⁷ and the Caribbean and Atlantic Ocean Islands⁸ subregions accounted for 1.7% and 1.4% of cases, respectively.

During the same period, South America accounted for 56.4% of the reported deaths, followed by North America (41.4%), Central America (1.4%), and the Caribbean and Atlantic Ocean Islands (0.61%) subregions.

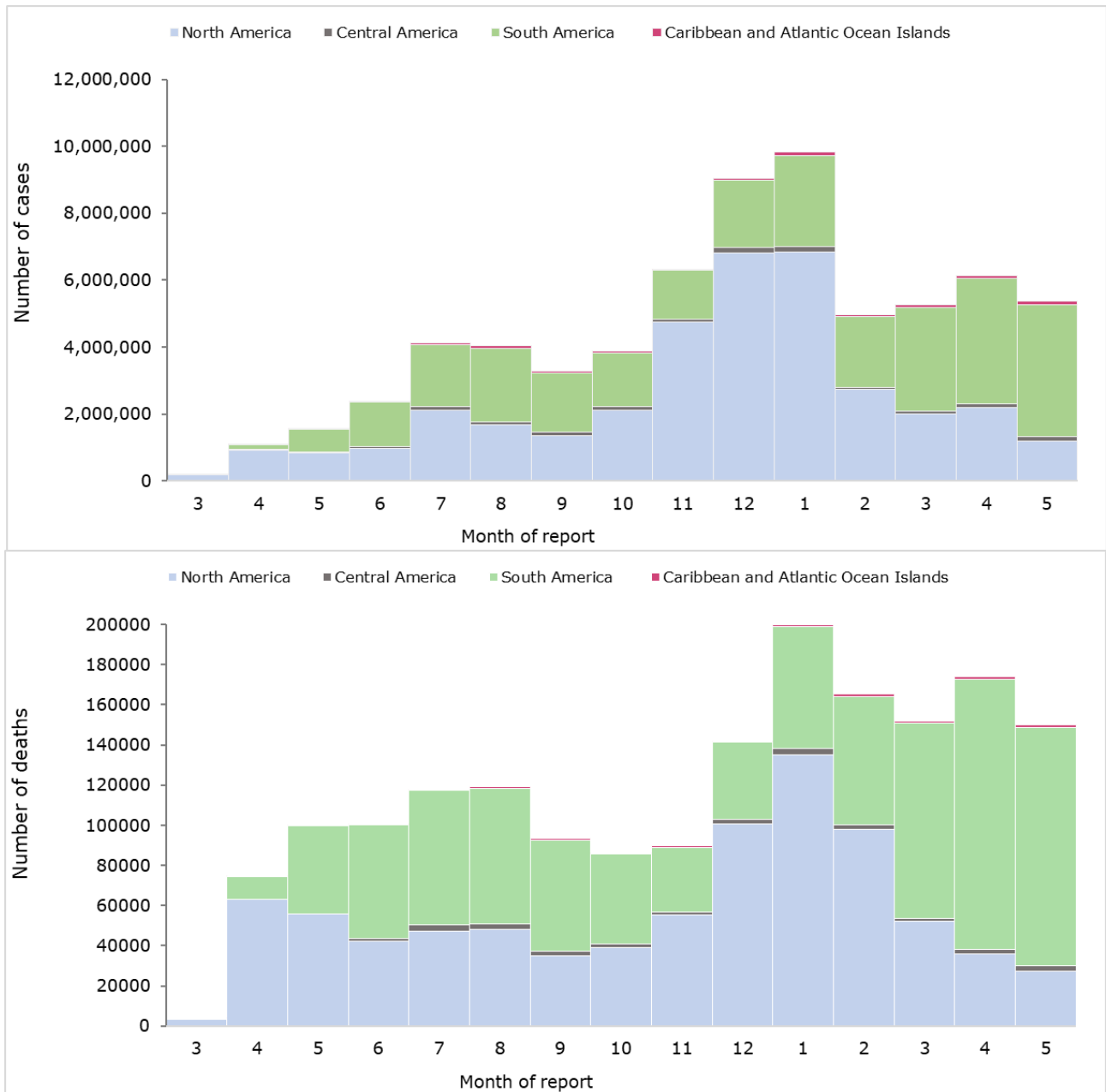
Since March 2021, South America has surpassed North America as the subregion contributing the highest proportions of cases and deaths per month (**Figure 2**). However, in North America, while new cases and deaths have declined in the United States of America and Mexico during the same period, cases in Canada doubled between March and April 2021 and deaths increased by 39% between March and May 2021.

In May 2021, the South America subregion continued to account for the highest proportions of monthly cases (73%) and deaths (79%) in the Region of the Americas, with 3,930,933 cases and 118,593 deaths reported (**Figure 2**). Most of the cases were reported by Brazil (1.9 million cases), Argentina (798,666 cases), and Colombia (541,345 cases), while Brazil (60,745 deaths), Peru (17,497 deaths) and Colombia (15,052 deaths) reported the highest numbers of deaths.

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

⁸ 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 confirmed COVID-19 cases and deaths, by subregion and month of report. Region of the Americas, 1 March 2020 to 31 May 2021.



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

Epidemiological Highlights

I. SARS-CoV-2 Variants

The appearance of mutations is a natural and expected event within the evolutionary process of viruses. Since the initial genomic characterization of SARS-CoV-2, this virus has been divided into different genetic groups or clades. In fact, some specific mutations define the viral genetic groups (also called lineages) that are currently circulating globally. Due to various microevolution processes and selection pressures, some additional mutations may appear, generating differences within each genetic group (called variants). It is important to mention that the names of the clade, lineage, variant, etc., are arbitrary and do not correspond to an official taxonomic hierarchy.

Since the initial identification of SARS-CoV-2 until 16 June 2021, more than 1,996,784 complete genomic sequences have been shared globally through publicly accessible databases.

As of 16 June 2021, 46 countries and territories in the Americas have published a total of 664,159 SARS-CoV-2 genomes on the GISAID platform, collected between February 2020 and June 2021. The countries and territories that have contributed genome data are: Anguilla, Antigua and Barbuda, Argentina, Aruba, Bahamas, Barbados, Belize, Bermuda, Bolivia, Bonaire, Brazil, the British Virgin Islands, Canada, the Cayman Islands, Chile, Colombia, Costa Rica, Cuba, Curaçao, the Dominican Republic, Ecuador, El Salvador, Grenada, Guadeloupe, Guatemala, French Guiana, Haiti, Honduras, Jamaica, Martinique, Mexico, Panama, Paraguay, 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, WHO provided proposed operational definitions for SARS-CoV-2 variants of interest (VOI) and variants of concern (VOC) and the associated actions that WHO will take to support Member States and their national public health institutes and reference laboratories, along with recommended actions that should be taken by Member States. The document includes general and non-exhaustive guidance on the prioritization of variants of greatest public health relevance in the broader context of SARS-CoV-2 transmission, and public health response mechanisms and established social distance measures. These definitions will periodically be reviewed and updated, as necessary. The full publication is available at: <https://bit.ly/3wjt8Gd>

On 31 May 2021, WHO announced assigning, simple, easy to say and remember labels for SARS-CoV-2 VOI and VOC; the labels do not replace existing scientific names rather they are intended to simplify public communications.⁹ The labels are available at: <https://bit.ly/2RTGXMN>

The list of SARS-CoV-2 variants, according to the WHO classification as of 15 June 2021¹⁰, is available in **Table 1**.

⁹ WHO. WHO announces simple, easy-to-say labels for SARS-CoV-2 Variants of Interest and Concern. 31 May 2021. Available at: <https://bit.ly/3xaARqs>

¹⁰ WHO. Weekly epidemiological update on COVID-19. Available at: <https://bit.ly/3zyiHAP>

Table 1. Variants of concern (VOC) and variants of interest (VOI), according to WHO classifications as of 15 June 2021.

SARS-CoV-2 Variants WHO classification	WHO Label	Pango lineage	First detected by
Variant of concern	Alpha	B.1.1.7	United Kingdom
	Beta	B.1.351	South Africa
	Gamma	P.1	Brazil
	Delta	B.1.617.2	India
Variant of interest	Epsilon	B.1.427/B.1.429	United States of America
	Zeta	P.2	Brazil
	Eta	B.1.525	Multiple countries
	Theta	P.3	Philippines
	Iota	B.1.526	United States of America
	Kappa	B.1.617.1	India
	Lambda	C.37	Peru

Source: WHO. Weekly epidemiological update on COVID-19¹⁰

Globally, an increase in the number of countries and territories reporting VOC and VOI continues to be observed (**Table 2**). However, this increase must take into account the limitations related to surveillance systems or surveillance mechanisms, as well as the capacity of the countries and territories to sequence samples and differences in the selection of samples to be sequenced.

Table 2. Summary of the countries/territories reporting cases of variants of concern (VOC), as of 17 June 2021.

Summary	WHO Label			
	Alpha	Beta	Gamma	Delta
Number of countries/territories reporting cases globally*	164	115	68	80
Number of countries/territories reporting cases in the Americas	40	18	28	10

Note:

*Global data correspond to the WHO COVID-19 Weekly Epidemiological Update. Published on 15 June 2021¹⁰. Some countries/territories have reported more than one variant of concern (VOC).

Source: WHO. COVID-19 Weekly Epidemiological Update. Published on 15 June 2021¹⁰

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Regarding the situation in the Americas, as of 17 June 2021, 43 countries/territories have reported the detection of cases of VOC, including two additional territories (Bermuda and Montserrat) since the 18 May 2021 PAHO/WHO COVID-19 Epidemiological Update³. As of 17 June 2021, the detection of all four VOC has been reported in Argentina, Aruba, Brazil, Canada, Mexico, Puerto Rico, and the United States of America. (**Table 3**)

Table 3. Countries and territories reporting variants of concern (VOC) in the Region of the Americas, as of 17 June 2021.

Country	Alpha	Beta	Gamma	Delta
Argentina	Yes	Yes	Yes	Yes
Aruba	Yes	Yes	Yes	Yes
Barbados	Yes	No	No	No
Belize	Yes	No	No	No
Bermuda	Yes	Yes	No	No
Bolivia	Yes	No	Yes	No
Bonaire	Yes	No	No	No
British Virgin Islands	Yes	No	Yes	No
Brazil	Yes	Yes	Yes	Yes
Canada	Yes	Yes	Yes	Yes
Cayman Islands	Yes	No	No	No
Chile	Yes	Yes	Yes	No
Colombia	Yes	No	Yes	No
Costa Rica	Yes	Yes	Yes	No
Cuba	Yes	Yes	No	No
Curacao	Yes	No	Yes	No
Dominica	Yes	No	No	No
Dominican Republic	Yes	No	Yes	No
Ecuador	Yes	No	Yes	No
French Guiana	Yes	Yes	Yes	No
Grenada	Yes	No	No	No
Guadeloupe	Yes	Yes	Yes	No
Guyana	No	No	Yes	No
Haiti	Yes	No	Yes	No
Jamaica	Yes	No	No	No
Martinique	Yes	Yes	Yes	No
Mexico	Yes	Yes	Yes	Yes
Montserrat	Yes	No	No	No
Panama	Yes	Yes	Yes	No
Paraguay	No	No	Yes	No
Peru	Yes	No	Yes	Yes
Puerto Rico	Yes	Yes	Yes	Yes
Saba	No	No	No	Yes
Saint Barthélemy	Yes	No	No	No
Saint Lucia	Yes	No	No	No
Saint Martin	Yes	Yes	No	No
Sint Maarten	Yes	Yes	No	Yes
Suriname	Yes	Yes	Yes	No
Trinidad and Tobago	Yes	No	Yes	No
Turks and Caicos	Yes	No	Yes	No
United States of America	Yes	Yes	Yes	Yes
Uruguay	Yes	No	Yes	No
Venezuela	Yes	No	Yes	No

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

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

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

Some of the articles published^{11,12,13}, or pre-published, on the impact of COVID-19 vaccination campaigns provide hope in achieving a decrease in mortality rates and hospitalizations in intensive care units (ICU) among older adults (≥60 years of age). However, it is important to consider that COVID-19 vaccination campaigns are not sufficient by themselves to prevent the transmission of SARS-CoV-2; therefore, public health and social distancing measures should be maintained in accordance with the epidemiological situation of each country and territory.

The trend that has been observed since the beginning of the pandemic, regarding mortality rates in older adults, is also observed in the **United States of America**. Accordingly, this age group is considered a vulnerable population and was prioritized during the vaccination campaigns that began in December 2020.

In a study conducted in the United States of America¹⁴, incidence rate ratios for four selected indicators were compared between two periods: prior to introduction of the COVID-19 vaccine (between 29 November and 12 December 2020) and after introduction of the vaccine (between 18 April and 1 May 2021). When comparing incidence rates, hospital admissions, emergency department visits, and reported deaths in adults aged ≥65 years and in adults aged 50-64 years with the 18-49 years age group as a reference group, a statistically significant decrease in the incidence rate ratio was observed for all indicators in both groups. This decrease was particularly marked when comparing the group of adults aged ≥65 years with the reference age group (18 to 49 years), where a decrease of 40%, 59%, 65%, and 66%, respectively, was observed for each of the indicators (**Table 4**). This decrease coincides with a high vaccination coverage of 82% (at least one dose) in this age group.

As of 1 May 2021, 82% of people aged ≥65 years, 63% of the 50-64 years age group, and 42% of the 18-49 age group had received at least one dose of COVID-19 vaccine.

¹¹ Cook TM, Roberts JV. Impact of vaccination by priority group on UK deaths, hospital admissions and intensive care admissions from COVID-19. Available at: <https://doi.org/10.1111/anae.15442>

¹² Leshem E, Wilder-Smith A. COVID-19 vaccine impact in Israel and a way out of the pandemic. *Lancet*. 2021 May 5 doi: 10.1016/S0140-6736(21)01018-7. Available at: <https://bit.ly/3hk18xC>

¹³ Haas E, Angulo F, et al. Impact and effectiveness of mRNA BNT162b2 vaccine against SARS-CoV-2 infections and COVID-19 cases, hospitalisations, and deaths following a nationwide vaccination campaign in Israel: an observational study using national surveillance data. *The Lancet*, 2021, ISSN 0140-6736, Available at: [https://doi.org/10.1016/S0140-6736\(21\)00947-8](https://doi.org/10.1016/S0140-6736(21)00947-8)

¹⁴ Christie A, Henley SJ, Mattocks L, et al. Decreases in COVID-19 Cases, Emergency Department Visits, Hospital Admissions, and Deaths Among Older Adults Following the Introduction of COVID-19 Vaccine — United States, September 6, 2020–May 1, 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:858–864. DOI: <http://dx.doi.org/10.15585/mmwr.mm7023e2>

Table 4. Incidence rate ratios of COVID-19 cases, by selected indicators, according to age group. United States of America, 29 November to 12 December 2020 and 18 April to 1 May 2021.

	29 November to 12 December, 2020			18 April to 1 May, 2021		
	≥65 (CI±)	50-64 (CI±)	18-49	≥65 (CI±)	50-64 (CI±)	18-49
Cases	0.68 (0.67-0.68)	0.85 (0.85-0.85)	1	0.4 (0.40-0.41)	0.71 (0.70-0.71)	1
ED visits	1.99 (1.96-2.01)	1.66 (1.64-1.68)	1	0.82 (0.80-0.84)	1.35 (1.33-1.37)	1
Hospital admissions*	9.6 (9.45-9.76)	3.5 (3.45-3.56)	1	3.33 (3.26-3.41)	2.27 (2.22-2.32)	1
Deaths	66.93 (62.11-72.29)	8.6 (7.92-9.38)	1	22.43 (20.17-25.18)	6.89 (6.12-7.82)	1

Note:

CI: Confidence interval

±CI 95%

*Corresponds to ≥70 years old

Source: Data from the U.S. CDC¹⁴ reproduced by PAHO/WHO.

III. COVID-19 during pregnancy

Although researchers continue to advance the knowledge base related to COVID-19 among pregnant women, helping to close existing knowledge gaps related to the impact of SARS-CoV-2 infection on the final outcome of pregnancy, it is necessary to continue collecting information to contribute to that knowledge base.

COVID-19 vaccination campaigns, together with social distancing measures, hand hygiene and the proper use of face masks, targeted to this population group are expected to impact the severity and mortality observed thus far.

Since the first reported cases of COVID-19 in the Americas and until 17 June 2021, there have been a total of 231,537 SARS-CoV-2 infections among pregnant women, including 1,453 deaths (0.63% case-fatality rate), reported in 29 countries/territories for which information was available.

Compared to the data presented in the 18 May 2021 PAHO/WHO COVID-19 Epidemiological Update³, this represents 29,436 additional cases and 182 additional deaths, and five additional countries/territories reporting data among pregnant women (Antigua and Barbuda, Bermuda, British Virgin Islands, Canada, and the Cayman Islands). During the same period, the highest relative increases in cumulative confirmed cases occurred in Suriname, while for deaths, the highest relative increase was observed in Uruguay (**Table 5**).

Table 5. COVID-19 during pregnancy, by country. Region of the Americas. January 2020 to 17 June 2021*.

Country	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	Case fatality rate (%)
Antigua and Barbuda	1	0	0.00
Argentina	16,332	102	0.62
Bahamas	43	1	2.33
Belize	247	2	0.81
Bermuda	11	0	0.00
Bolivia	2,416	31	1.28
Brazil	5,931	428	7.22
British Virgin Islands	3	0	0.00
Canada	6,069	1	0.02
Cayman Islands	7	0	0.00
Chile	14,142	12	0.08
Colombia	11,017	84	0.76
Costa Rica	656	3	0.46
Cuba	968	3	0.31
Dominican Republic	1,025	43	4.20
Ecuador	2,512	45	1.79
El Salvador**	272	9	3.31
Guatemala	1,033	10	0.97
Haiti	79	4	5.06
Honduras**	40	N/A	N/A
Mexico&	16,788	344	2.05
Panama&**	2,413	12	0.50
Paraguay&	1,621	44	2.71
Peru&	51,302	153	0.30
Saint Lucia	23	0	0.00
Suriname	424	2	0.47
United States of America	94,519	103	0.11
Uruguay	1,209	8	0.66
Venezuela	434	9	2.07
Total	231,537	1,453	0.63

Note:

N/A: Data not available.

& Corresponds to pregnant and postpartum women

*17 June 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 18 May 2021 PAHO/WHO Epidemiological Update on COVID-19³

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

IV. COVID-19 among indigenous populations

Since January 2020 until 17 June 2021, there have been 552,328 confirmed cases of COVID-19, including 13,562 deaths, reported among indigenous populations in 18 countries in the Region of the Americas for which information was available (**Table 6**). Compared to the data in the 18 May 2021 PAHO/WHO Epidemiological Update on COVID-19³, this represents 103,372 additional confirmed cases including 5,764 deaths; this large increase is in part due to the fact that some countries have updated their data reporting and include retrospective adjustments. In comparison with the previous PAHO/WHO Epidemiological Update, the largest increase in cases was observed in Costa Rica and Suriname, while the largest increase in deaths was observed in Peru.

Table 6. Cumulative number of confirmed cases and deaths of COVID-19 among indigenous populations in the Region of the Americas. January 2020 to 17 June 2021*.

Country	Number of COVID-19 confirmed cases	Number of deaths
Argentina	1,951	52
Belize	1,707	42
Bolivia	18,700	334
Brazil	49,301	699
Canada	30,406	346
Chile	40,745	703
Colombia	53,379	1,594
Costa Rica	540	33
Ecuador	5,832	216
Guatemala	16,034	538
Guyana**	95	6
Mexico	19,768	3,073
Panama**	5,807	102
Paraguay	426	47
Peru	44,439	860
Suriname	2,177	36
United States of America	259,884	4,860
Venezuela	1,137	21
Total	552,328	13,562

Note:

N/A: data not available

*17 June 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.

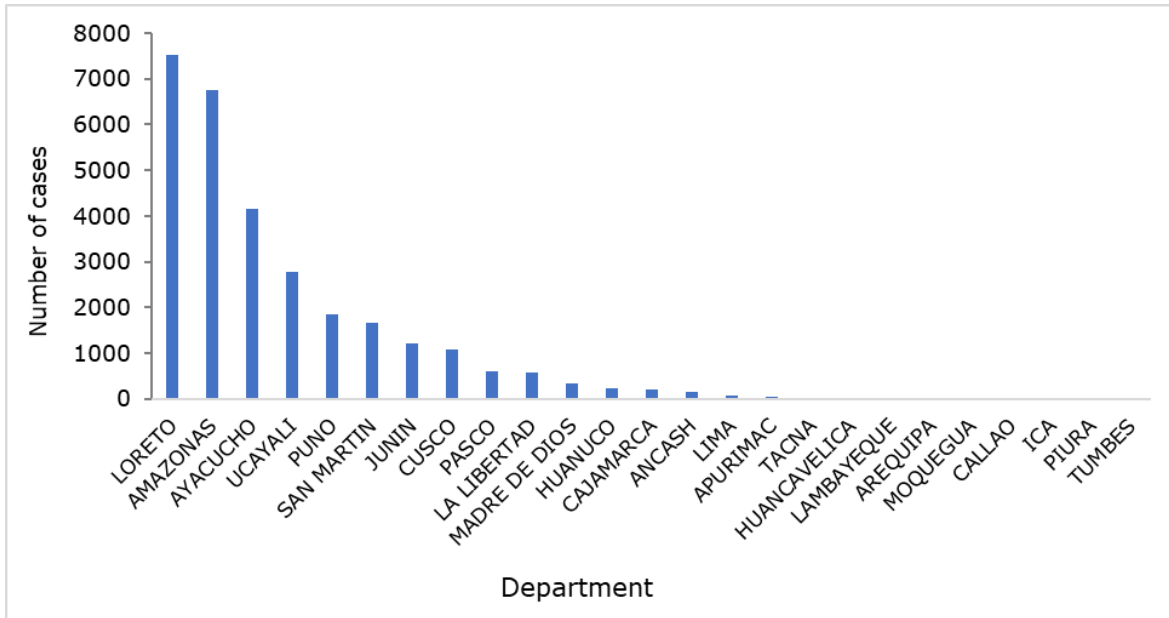
** No update since the 18 May 2021 PAHO/WHO Epidemiological Update on COVID-19³.

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.

The following is a description of the COVID-19 epidemiological situation among indigenous populations of Peru.

In **Peru**, since the confirmation of the first case of COVID-19 in the country¹⁵ and as of 8 June 2021, there have been 29,416 confirmed COVID-19 cases reported among indigenous peoples, including 619 deaths. Geographically, approximately two-thirds of those cases were reported among the Amazon region, specifically the departments of Loreto and Amazonas (25.6% and 23%, respectively) (**Figure 3**). The distribution of cases by age group shows 51% of cases among indigenous populations were reported among persons aged 30 to 59 years, followed by 20% among persons aged 18 to 29 years.

Figure 3. Distribution of confirmed COVID-19 cases among indigenous populations, by department. Peru, March 2020 to 8 June 2021.



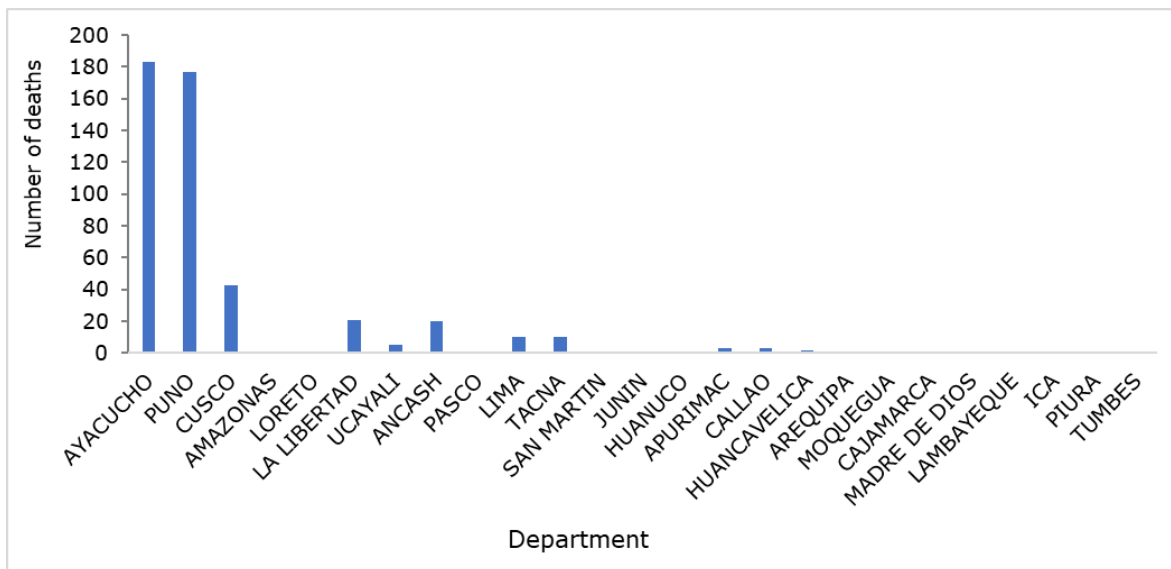
Source: Peru Ministry of Health.¹⁶ Data reproduced by PAHO/WHO.

While most cases were reported among the Amazon populations, most deaths were reported among the Andean populations in the departments of Ayacucho and Puno, representing 29.6% and 28.6% of the total deaths, respectively (**Figure 4**). By ethnicity, 74% of the total cases were among the Amazon populations, while 78% of total deaths were reported among Andean indigenous populations.

¹⁵ 6 March 2020

¹⁶ Peru Ministry of Health. 13 June 2021. Report COVID-19 among Amazon and Andino indigenous populations. Available in Spanish at: <https://bit.ly/357ipCZ>

Figure 4. Distribution of confirmed COVID-19 deaths among indigenous populations, by department. Peru, March 2020 to 8 June 2021.



Source: Peru Ministry of Health.¹⁷ Data reproduced by PAHO/WHO.

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

Since the beginning of the pandemic, it has been apparent that children and adolescents have a lower risk of illness and death from COVID-19 compared to other age groups. As well, it has been recognized that children and adolescents are being affected mainly by the measures taken to control the transmission of the virus. These indirect effects include the negative consequences of school closures, restrictions on the movement of people which limit opportunities for play and relationships with family and friends, the loss of work and income that also affect the mental health of caregivers and consequently the relationships between children and their caregivers, and the alteration of health and social protection service functions, among others.¹⁷

The evidence available thus far suggests that children and adolescents are less susceptible to SARS-CoV-2 infection and also transmit the virus less frequently than adults. When they acquire infection, they are generally asymptomatic and, when they do get sick, they usually have mild illness with symptoms similar to other common illnesses in these ages. Within the 0-19 age group,

¹⁷ UN Sustainable Development Group. Policy Brief: The Impact of COVID-19 on children. April 2020. Available at: <https://bit.ly/38r1JbH>

studies suggest that susceptibility and transmission are lower among children under 5 years of age than among older children and adolescents.^{18,19,20,21,22}

The following is an analysis of the epidemiological situation among populations under 20 years of age in **Argentina**.

Between EW 10 of 2020 and EW 21 of 2021, there were 375,293 confirmed cases of COVID-19 among populations under 20 years of age, including 220 deaths (0.05% case-fatality rate) and 341,364 (91%) have recovered. As of EW 21 of 2021, 9.9% of the cumulative total of COVID-19 cases reported in the country correspond to populations under 20 years of age (median age 15 years).

Between EW 13 and EW 20 of 2021, weekly cases have consistently exceeded the peak observed in EW 42 of 2020 consisting of 8,000 cases among this age group. In 2021, there was a peak in cases observed in EW 20, with approximately 23,000 cases reported. It should be noted that, as cases increase among the general population, those under 20 years of age are likely to have greater exposure to SARS-CoV-2.

Among deaths, the median age reported is 12 years. Infants under 1 year of age represented 2.7% of the total number of cases among the under 20 years of age population; however, they represented 25% of the deaths reported among the same group. An analysis of deaths by age group (0-4 years, 5-9 years, 10-14 years, 15-19 years) shows that most deaths occurred among the age groups of 0-4 years (38%) and 15-19 years (45%). The total deaths in the first 5 months of 2021 represent 60% of the total number of deaths reported in all of 2020 (**Figure 5**).

¹⁸ Gaythorpe, K. A., Bhatia, S., Mangal, T., et al. Children's role in the COVID-19 pandemic: a systematic review of early surveillance data on susceptibility, severity, and transmissibility. Imperial College London. 3–26. <https://doi.org/10.25561/84220>

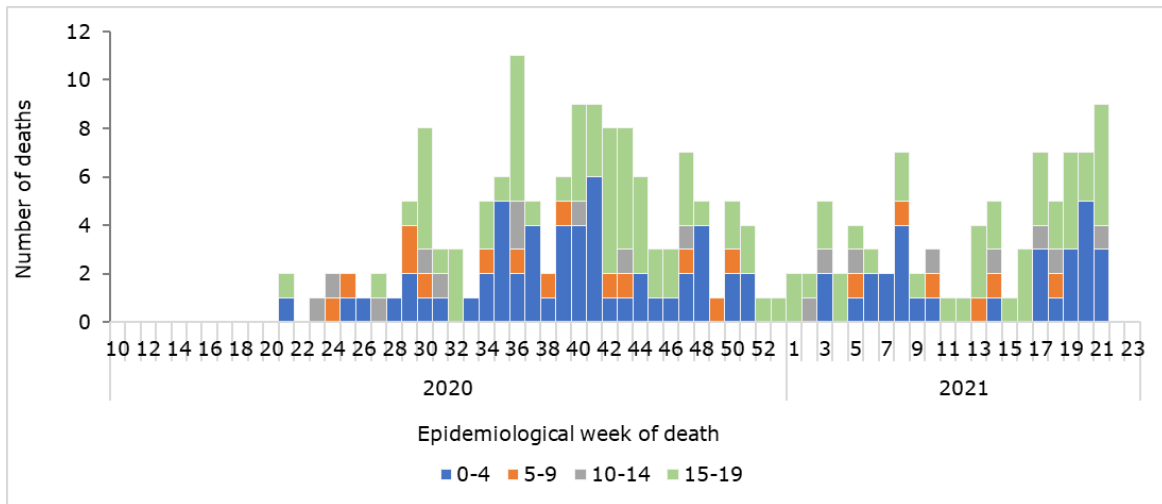
¹⁹ Viner, R. M., Mytton, O. T., Bonell, C., et al. Susceptibility to SARS-CoV-2 Infection among Children and Adolescents Compared with Adults: A Systematic Review and Meta-Analysis. *JAMA Pediatrics*, 175(2), 143–156. <https://doi.org/10.1001/jamapediatrics.2020.4573>

²⁰ Viner, R. M., Russell, S., Saulle, R., et al. Impacts of school closures on physical and mental health of children and young people: a systematic review. *MedRxiv*, 2021.02.10.21251526. <https://doi.org/10.1101/2021.02.10.21251526>

²¹ Davies, N.G., Klepac, P., Liu, Y. et al. Age-dependent effects in the transmission and control of COVID-19 epidemics. *Nat Med* 26, 1205–1211 (2020). <https://doi.org/10.1038/s41591-020-0962-9>

²² Leidman E, Duca LM, Omura JD, Proia K, Stephens JW, Sauber-Schatz EK. COVID-19 Trends Among Persons Aged 0–24 Years — United States, March 1–December 12, 2020. *MMWR Morb Mortal Wkly Rep* 2021; 70:88–94. DOI: <http://dx.doi.org/10.15585/mmwr.mm7003e1>

Figure 5. COVID-19 deaths by age group and by epidemiological week (EW) of death. Argentina. EW 10 of 2020 to EW 21 of 2021.



Source: Data published by the Argentina Ministry of Health²³ and reproduced by PAHO/WHO.

Multisystem inflammatory syndrome in children and adolescents (MIS-C) 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, 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-C occurs relatively infrequently, these cases present important challenges for health systems.

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

Between mid-May 2020 and 17 June 2021, a cumulative total of 6,056 confirmed cases of MIS-C temporally related to COVID-19, including 129 deaths, have been reported in 23 countries/territories of the Region of the Americas (**Table 7**). During this same period, 22 countries and territories have officially reported to PAHO/WHO that they have not detected cases of MIS-C.

Since the 18 May 2021 PAHO/WHO Epidemiological Update on COVID-19³ until 17 June 2021, one additional territory has reported confirmed MIS-C cases (Puerto Rico). During the same period there were 501 additional confirmed cases reported and 6 additional deaths.

²³ Argentina Ministry of Health. Report on COVID-19 among youths and adolescents as of 1 June 2021. Available in Spanish at: <https://bit.ly/3pJpYti>

As the numbers of cases of MIS-C increase, it is important that each country/territory characterizes the cases²⁴ in order to contribute to closing the gaps in information, particularly related to clinical management and response measures.

Table 7. Distribution of cumulative confirmed cases and deaths of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19 in the Region of the Americas, by country/territory. May 2020 to 17 June 2021*.

Country/Territory	Number of confirmed cases	Number of confirmed deaths
Argentina	161	1
Barbados	2	1
Brazil	1,019	65
Bolivia	1	1
Canada	110	0
Chile	314	5
Costa Rica	34	0
Colombia	8	4
Cuba	4	0
Dominican Republic	133	6
Ecuador	11	0
El Salvador	19	0
French Guiana	2	0
Guadeloupe	5	0
Guatemala	2	0
Honduras	3	0
Panama	81	2
Paraguay	95	8
Peru	3	0
Saint Martin	2	0
Trinidad and Tobago	29	0
United States of America	4,018	36
Total	6,056	129

Note:

*17 June 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-C in the Americas.

²⁴ World Health Organization (WHO). 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/2RBZzgr>

Of the total number of reported cases for which data on age and sex were available (n=5,443), the distribution of cases among age groups was 30% among 0 to 4 years, 34% among 5 to 9 years, 26% among 10 to 14 years, and 11% among 15 to 19 years (the United States of America includes 20-year-olds in this age group). Regarding the distribution by sex, 59% of the cases were male.

Among the 122 deaths for which data on age and sex were available, 41% were aged 0 to 4 years, 19% aged 5 to 9 years, 15% aged 10 to 14 years, and 25% aged 15 to 19 years. Regarding the distribution by sex, 48% of the deaths were male.

VI. COVID-19 among health workers

Since the first confirmed cases of COVID-19 were reported and until 17 June 2021, there were 1,980,343 COVID-19 cases among health care workers, including 9,819 deaths, per the data made available by 35 countries and territories in the Americas (**Table 8**). This includes twelve additional countries or territories reporting data among health workers (Antigua and Barbuda, Aruba, Bermuda, Bonaire, Canada, Cayman Islands, Curacao, Dominica, Grenada, Honduras, Sint Eustatius, and Sint Maarten), since the 18 May 2021 Epidemiological Update.³ The total represents 13% of the estimated 15 million health workers in the Americas.²⁵

²⁵ PAHO/WHO. Weekly Press Briefing on COVID-19: Director's Opening Remarks, 12 May 2021. Available at: <https://bit.ly/3uEhbKC>

Table 8. Distribution of cumulative confirmed cases and deaths of COVID-19 among health workers in the Region of the Americas. January 2020 to 17 June 2021*.

Country	Number of confirmed cases of COVID-19	Number of deaths
Antigua and Barbuda	2	2
Argentina	91,244	532
Aruba	244	0
Bahamas**	505	13
Belize	317	2
Bermuda	49	0
Bolivia	24,223	433
Bonaire	106	0
Brazil**	753,089	656
Canada	97,971	59
Cayman Islands	24	0
Chile	66,606	102
Colombia	59,302	285
Costa Rica	7,962	47
Curacao	439	0
Ecuador	12,262	121
El Salvador**	6,609	72
Dominica	1	0
Dominican Republic	1,164	22
Grenada	1	0
Guatemala	6,763	64
Haiti	808	1
Honduras	107	NA
Jamaica**	861	4
Mexico£	237,685	3,940
Panama	8,663	112
Paraguay	14,027	153
Peru	68,752	1,345
Saint Lucia	143	0
Sint Eustatius	8	0
Sint Maarten	54	0
Suriname	1,634	1
United States of America	507,491	1,646
Uruguay	8,197	28
Venezuela	3,032	179
Total	1,980,345	9,819

Note:

N/A: Data not available.

*17 June 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 18 May 2021 PAHO/WHO Epidemiological Update on COVID-19³


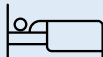





£ The information that Mexico presents corresponds to the occupation variable of the Epidemiological Surveillance System for Viral Respiratory Disease (SISVER). The analysis reflects the cases that reported performing a health-related occupation. It is important to clarify that the information collected in SISVER does not allow to identify if the contagion occurred in the workplace, at home or in the community; nor does it establish whether health personnel are currently working in a medical care unit.

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

Guidance for national authorities

PAHO/WHO continues to reiterate and update recommendations to support all Member States on management and protection measures for COVID-19 and reiterates the recommendations included in the PAHO/WHO Epidemiological Alerts and Updates on COVID-19 available at: <https://www.paho.org/en/epidemiological-alerts-and-updates>.

The following are guidance, scientific reports, and other resources published by PAHO/WHO and WHO.

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

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6. Report by the **Bolivia** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
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11. Report by the **Colombia** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
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13. Report by the **Dominican Republic** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
14. Report by the **Ecuador** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
15. Report by the **Grenada** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
16. Report by the **Guatemala** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email

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