Epidemiological Update Coronavirus disease (COVID-19)

9 February 2021

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]

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

Global Situation Summary

Since the first confirmed cases of COVID-19 until 8 February 2021, a cumulative total of 105,658,476 confirmed cases of COVID-19 have been reported globally, including 2,309,370 deaths, representing a total of 14,166,078 additional confirmed cases and 329,863 additional deaths, since the last PAHO/WHO Epidemiological Update on COVID-19[4] published on 15 January 2021.

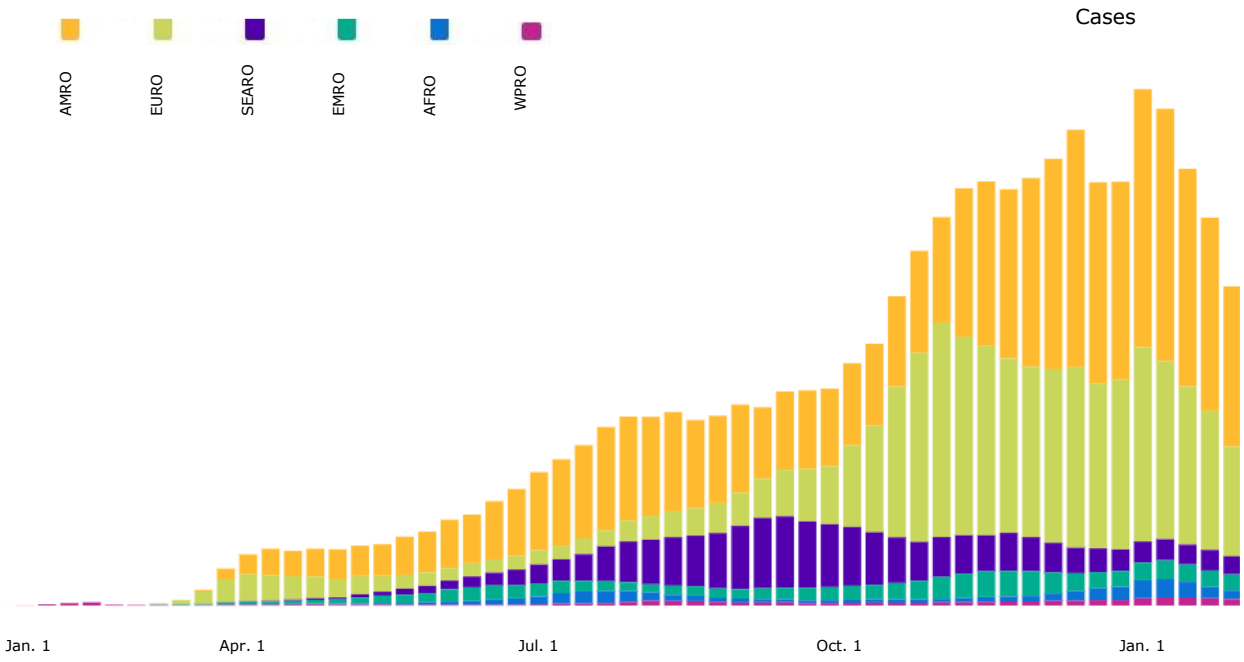
Of the total cumulative confirmed cases globally, 30% were notified between mid-December (Epidemiological Week (EW) 51) of 2020 and the end of January (EW 4) of 2021 (**Figure 1**),

[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] 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/36Xg2DY
[4] PAHO/WHO. Epidemiological Update: Coronavirus disease (COVID-19). 15 January 2021, Washington, D.C.: PAHO/WHO; 2021. Available at: https://bit.ly/3oOZrbD

while 30% of the deaths were reported between the beginning of December (EW 50) of 2020 and the end of January (EW 4) of 2021 (**Figure 2**).

From the notification of the first cases of COVID-19 until February 8, the WHO regions of the Americas and Europe represent 79% of all cases and 81% of total deaths. (**Figure 3**).

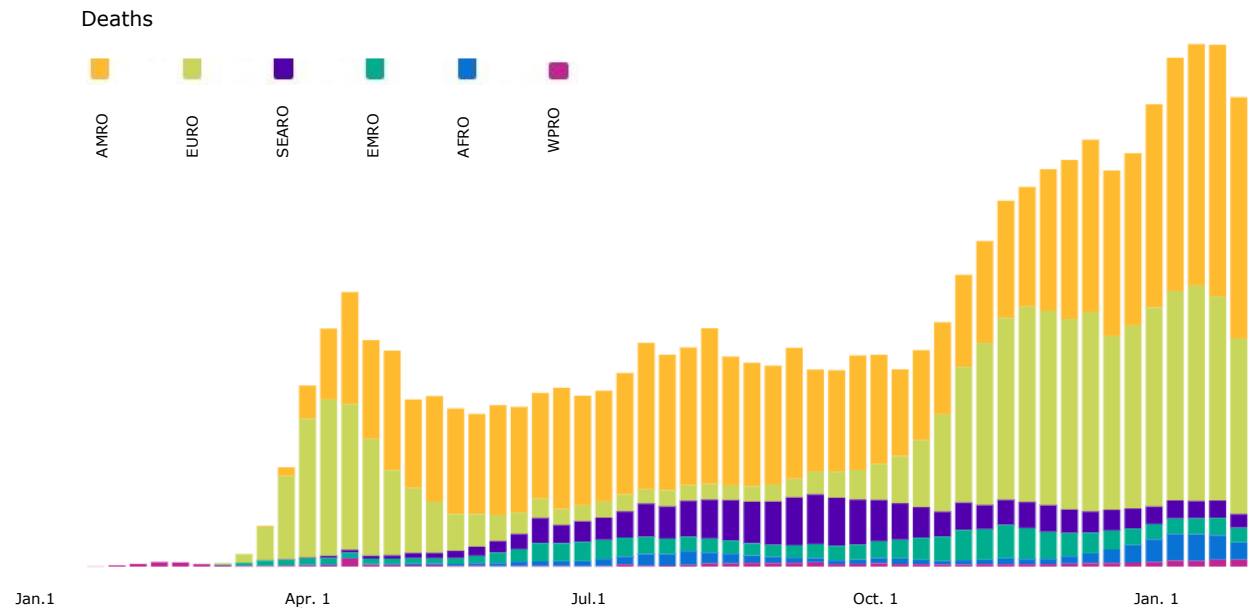
Figure 1. Distribution of COVID-19 cumulative confirmed cases by WHO Region January 2020 to January 2021.



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 February 2021. Available at: https://covid19.who.int. Accessed 8 February 2021.

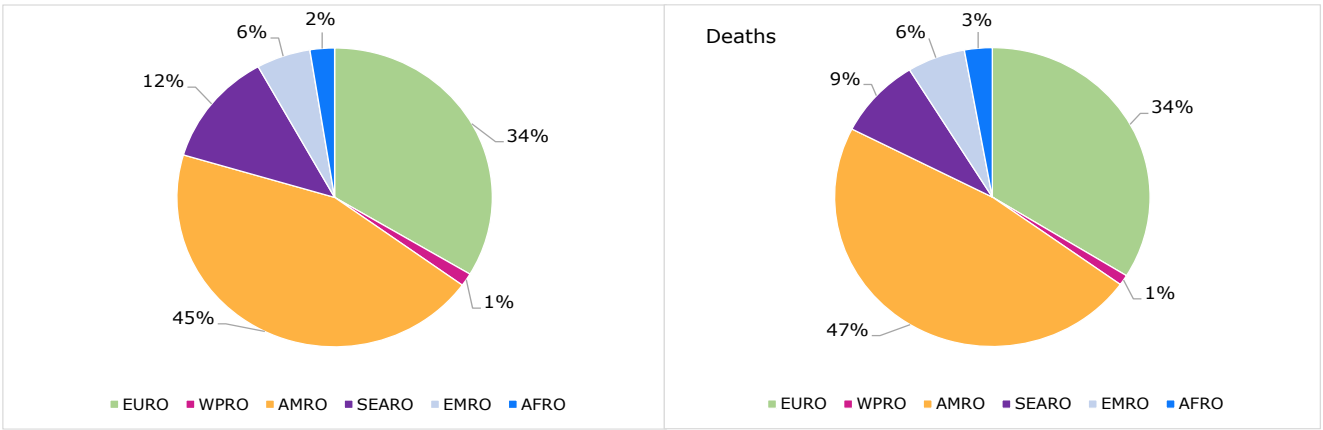
Figure 2. Distribution of COVID-19 cumulative confirmed deaths by WHO Region January 2020 to January 2021.



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 February 2021. Available at: https://covid19.who.int. Accessed 8 February 2021.

Figure 3. Distribution of COVID-19 cumulative confirmed cases and deaths by WHO Region. January 2020 to January 2021.



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 February 2021. Available at: https://covid19.who.int. Accessed 8 February 2021.

Situation Summary in the Region of the Americas

All 56 countries and territories in the Region of the Americas have reported COVID-19 cases and deaths.[5] Since the 15 January 2021 PAHO/WHO Epidemiological Update on COVID-19[4] and as of 8 February 2021, 6,574,308 additional confirmed cases of COVID-19, including 158,356 additional deaths, have been reported in the Region of the Americas, representing a 14% increase in cases and a 14% increase in deaths, figures lower than those observed in the period December 2020-January 2021.

In the subregions of North America[6] and Central America[7], the highest increase in cases was observed during the last quarter of 2020 (October-December), while in the subregions of South America[8] and the Caribbean and the Atlantic Ocean Islands[9] the largest increase was observed in the third quarter (July-September 2020).

On the other hand, if only the months of December 2020 and January 2021 are considered, there was an increase in the number of cases in all the subregions, the lowest in the North American subregion, with 0.5% and the highest in the Caribbean and the Atlantic Ocean Islands (29.5%). In the other subregions, the increases between those two months were 26.2% in South America and 6.2% in Central America.

When observing the trends in the last 7 days, the number of confirmed cases increased by more than 60% with a range between 62% and 1,433% in 6 countries and territories (Aruba, Cayman Islands, Falkland Islands (the) [Malvinas], Jamaica, Saint Barthelemy, and Saint Vincent and the Grenadines) in the subregion of the Caribbean and the Atlantic Ocean Islands. Related to deaths, there was an increase in confirmed deaths only in 3 countries: Cuba, Dominican Republic, and Suriname with 26%, 8%, and 40% respectively, and in most countries and territories of this subregion, there was a decrease in the number of confirmed cases, a situation that must be observed with caution (**Table 1**).

[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] Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.
[8] Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.
[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 Marteen, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos and the United States Virgin Islands.

Table 1. Observed trend of cases and deaths accumulated by COVID-19 in countries and territories of the Caribbean and the Atlantic Ocean Islands in the last 7 days, until February 8, 2021.

Country/Territory	Cases			Deaths			Recovered	Transmission Type
	7 Day MA* Trend	Cummulative	7day % change	7 Day MA* Trend	Cummulative	7day % change		
Anguilla		17	-100%				12	Sporadic cases
Antigua and Barbuda		316	148%		7	-100%	189	Sporadic cases
Aruba		7,223	6%		62	0%	6,834	Community transmission
Bahamas (the)		8,289	11%		176	-100%	6,837	Clusters of cases
Barbados		1,709	4%		18	0%	1,400	Community transmission
Bermuda		692	-80%		12	0%	670	Sporadic cases
Bonaire		368	-83%		3	0%	360	Community transmission
Cayman Islands		405	114%		2	0%	368	Sporadic cases
Cuba		33,484	2%		240	26%	27,594	Community transmission
Curacao		4,613	-24%		21	-100%	4,535	Community transmission
Dominica		121	0%				110	Sporadic cases
Dominican Republic (the)		224,119	-9%		2,843	8%	168,627	Community transmission
Falkland Islands (the) [Malvinas]		48	167%				29	Sporadic cases
French Guiana		16,296	-63%		79	0%	9,995	Community transmission
Grenada		148	0%		1	0%	146	Sporadic cases
Guadeloupe		9,302	46%		159	0%	2,242	Community transmission
Guyana		7,982	-1%		180	0%	6,966	Clusters of cases
Haiti		11,908	5%		246	-50%	9,177	Community transmission
Jamaica		17,298	98%		358	-57%	12,318	Community transmission
Martinique		6,521	10%		45	-100%	98	Community transmission
Montserrat		17	0%		1	0%	11	Sporadic cases
Puerto Rico		96,161	-27%		1,888	-10%	84,983	Community transmission
Saba		6	0%				6	Sporadic cases
Saint Barthelemy		425	1433%				94	Sporadic cases
Saint Kitts and Nevis		40	-33%				38	Sporadic cases
Saint Lucia		2,027	17%		19	0%	917	Community transmission
Saint Martin		1,377	-10%		12	0%	598	Community transmission
Saint Pierre and Miquelon		24	-100%				23	Clusters of cases
Saint Vincent and the Grenadines		1,283	62%		4	0%	415	Community transmission
Sint Eustatius		20	0%				20	Sporadic cases
Sint Maarten		1,936	-35%		27	0%	1,783	Community transmission
Suriname		8,671	-39%		161	40%	8,020	Community transmission
Trinidad and Tobago		7,616	-43%		135	0%	7,266	Community transmission
Turks and Caicos		1,695	-12%		9	-100%	1,319	Clusters of cases
Virgin Islands (UK)		141	-100%		1	0%	131	Clusters of Cases
Virgin Islands (US)		2,466	-44%		24	0%	2,371	Community transmission
Total		**474,764**			**6,733**		**366,502**	

Source: Information shared by the International Health Regulations (IHR) National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar 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 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, as of 9 February, more than 501,000 complete genomic sequences have been shared globally through publicly accessible databases.

As of 8 February 2021, 37countries and territories in the Americas have published 113,050 SARS-CoV-2 genomes on the GISAID platform, collected between February 2020 and February 2021. The countries and territories that have contributed are: Antigua and Barbuda, Argentina, Aruba, Belize, Bermuda, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Curaçao, Ecuador, El Salvador, United States of America, Guadeloupe, Guatemala, French Guyana, Jamaica, Mexico, Panama, Peru , Puerto Rico, Dominican Republic, Saint Barthelemy, Saint Eustatius, Saint Kitts and Nevis, Saint Lucia, Saint Martin, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

The ability to monitor viral evolution in near real time has a direct impact on the public health response to the COVID-19 pandemic.

There is a growing understanding of how genomic sequencing data (GSD) helps improve public health action, which is why expanding sequencing capacity in the Region is urged. Currently, sequencing capacity and data are not evenly distributed worldwide, with a skewed representation of the SARS-CoV-2 GSD from high-income countries. This bias must be considered when evaluating the presence or absence of a particular variant in a place and its relative frequency.

Globally and from a public health point of view, the following three variants of SARS-CoV-2 have generated concern: variant VOC 202012/01, lineage B.1.1.7, variant 501.V2, lineage B.1.351, and variant P.1, lineage B.1.1.28. The evaluation of available evidence regarding transmissibility, severity, antibody neutralization capacities, and potential impacts on vaccines is ongoing. In addition, the detection of other mutations with potential impact on public health is evaluated and monitored.

VOC 202012/01 variant, lineage B.1.1.7

On 14 December 2020, the United Kingdom authorities notified WHO of a variant named by the U.K. as SARS-CoV-2 VOC 202012/01. This variant contains 23 nucleotide substitutions and is not phylogenetically related to the SARS-CoV-2 virus circulating predominantly in the U.K. at the time it was detected. It is unknown how and where it originated.

As of 2 February 2021, 80 countries and territories in all six WHO Regions have reported either imported cases or community transmission of VOC 202012/01[10]. As of 8 February, 17 countries and territories within the Region of the Americas have reported this variant.

501.V2 variant, lineage B.1.351

On 18 December 2020, South African national authorities announced the detection of a new variant of SARS-CoV-2 that was spreading rapidly in three South African provinces. South Africa has named this variant 501Y.V2, due to a N501Y mutation. While the VOC 202012/01

[10] WHO. COVID-19 weekly epidemiological update. Published on 2 February 2021. Available at: https://bit.ly/3d02iwp

variant also has the N501Y mutation, phylogenetic analysis has shown that the 501Y.V2 detected in South Africa is a different variant.

As of 2 February 2021, 41 countries and territories in all six WHO Regions have reported cases of 501Y.V2.[10] As of 8 February, 4 countries within the Region of the Americas have reported this variant.

Variant P.1, lineage B.1.1.28

On 9 January 2021, Japan notified WHO about a new variant of SARS-CoV-2, B.1.1.28 (initially reported as B.1.1.248), detected in four travelers from Brazil. This variant is not closely related to the SARS-CoV-2 VOC 202012/01 variant or to the 501Y.V2 variant. On 13 January 2021, researchers in Brazil reported that this variant was detected since December 2020 in Manaus, Amazonas State, Brazil.[11]

As of 2 February 2021, 10 countries from four of the six WHO regions have reported cases of variant P.1, lineage B.1.1.28[10]. As of 8 February, 4 countries within the Region of the Americas have reported this variant.

Regarding the situation in the Americas, as of 8 February 2021, only the United States of America has reported the detection of all three variants in the above-mentioned paragraphs. Argentina and Canada have reported two of these variants and the rest of the countries/territories have reported just one (**Table 2**).

[11] Faria N, Morales I, Candido D. Genomic characterization of an emergent SARS-CoV-2 lineage in Manaus: preliminary findings. Available at: https://bit.ly/3a4n22X

Table 2. Detection of the SARS-CoV-2 VOC 202012/01 variant, the 501Y.V2 variant, and P.1, lineage B.1.1.28 variant in the Region of the Americas, as of 8 February 2021.

Country	VOC 202012/01	501Y.V2	P.1
Argentina	Yes	No	Yes
Aruba	Yes	No	No
Barbados	Yes	No	No
Brazil	Yes	No	Yes
Canada	Yes	Yes	No
Chile	Yes	No	No
Colombia	No	No	Yes
Cuba	No	Yes	No
Curacao	Yes	No	No
Dominican Republic	Yes	No	No
Ecuador	Yes	No	No
Jamaica	Yes	No	No
Martinique	Yes	No	No
Mexico	Yes	No	No
Panama	No	Yes	No
Peru	Yes	No	Yes
Saint Lucia	Yes	No	No
Trinidad and Tobago	Yes	No	No
United States of America	Yes	Yes	Yes
Uruguay	Yes	No	No

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

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

Aging is characterized by a progressive and heterogeneous decrease in the physiological reserve of all organ systems, although these take place at different rates, that will vary among individuals. There is a reduction in function and repair capacity. The increased risk of loss of functional reserve is exacerbated by the higher prevalence of coexisting diseases[12], conditions that increase as age advances, leading to a greater acquisition of infections, leaving older adults as one of the groups most vulnerable to losing their lives due to COVID-19. This explains the trend, observed in most countries, of people aged over 60 years old presenting age-specific mortality rates much higher than those of 59 years old and below. It

[12] Navaratnarajah A, Jackson S. The physiology of ageing. DOI: https://doi.org/10.1016/j.mpmed.2012.10.009

is expected that, by prioritizing this age group for receipt of the COVID-19 vaccines the corresponding mortality rate will decline.

One way to measure the impact of the COVID-19 pandemic on people aged 60 and over (older adults) is through age-specific mortality rates. Data are presented below for countries and territories for which information was available (**Table 3**).

Table 3. Proportion of population, cumulative cases, deaths, and age-specific mortality rates in older adults (≥60 years of age) specific to COVID-19. Select countries and territories of the Region of the Americas. 2020.

Indicator	Age group	Aruba	Bahamas	Curacao	Suriname
% General population	≤ 59 years old	78	88	75	82
	≥60 years old	22	12	25	12
% Cases	≤ 59 years old	84	86	85	89
	≥60 years old	16	14	15	11
% Deaths	≤ 59 years old	14	46	17	32
	≥60 years old	86	54	83	68
Age-specific mortality rate per 1,000 pop.	≤ 59 years old	0.08	0.25	0.02	0.07
	≥60 years old	1.85	2.08	0.37	1.23

Notes:
The population data used was obtained from the United Nations population projections for the year 2020. Available at: https://bit.ly/2K3RaC2.
*The data on cases and deaths reported in 2020. There may be differences in the dates that each country/territory provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

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

The data presented in Table 3 is not comparable between the 5 countries[13]; however, the following aspects can be observed:

- The proportion of the elderly population varies in a range of 11% to 25%.
- The proportion of COVID-19 cases in older adults is in a range of 12% to 16%.
- The proportion of deaths from COVID-19 in older adults is greater than 50% in (range 54% to 86%)
- Specific death rates for people 60 years and older exceed specific death rates for people under 60 years of age by a range of 8 to 23 times.

[13] Because the sources on the general population are different, the rates were not adjusted, and the time periods analyzed correspond to the year 2020, these vary among countries/territories due to different detection of the first and last COVID-19 cases reported within 2020.

III. COVID-19 during pregnancy

In a study published in the Lancet journal, additional deaths from both maternal and children under 5 years of age were estimated in 118 low- and middle-income countries as a result of the possible disruption of health systems and decreased access to food due to the COVID-19 pandemic. Three hypothetical scenarios were modeled, and additional deaths were estimated for a single month which were extrapolated for 3, 6, and 12 months, using the "Lives Saved Tool."

In the least severe hypothetical scenario (coverage reductions between 9.8% and 18.5% and 10% increase in wasting) over 6 months, would result in 253,500 additional infant deaths and 12,200 additional maternal deaths. While in the most severe scenario (coverage reductions between 39.3% and 51.9% and an increase in wasting of 50%) for 6 months, it would result in 1,157,000 additional infant deaths and 56,700 additional maternal deaths.

In all three scenarios, the reduced coverage of four interventions performed during delivery (parenteral administration of uterotonics, antibiotics and anticonvulsants, and clean delivery settings) would account for approximately 60% of additional maternal deaths. Regarding additional infant deaths, the increased prevalence of wasting would represent between 18% and 23% of these additional deaths and the reduced coverage of antibiotics for the treatment of neonatal pneumonia and sepsis and the reduction of the solution oral rehydration for diarrhea, together would account for about 41% of additional infant deaths.[14]

Although the estimates in this study are based on hypothetical scenarios, they are worth considering when making decisions.

Since the first reported cases of COVID-19 in the Americas until 8 February 2021, there were 156,988 SARS-CoV-2 positive cases among pregnant women reported, including 940 deaths (1%), in 19 countries/territories for which information was available (**Table 4**). Compared to the data in the 15 January 2021 PAHO/WHO Epidemiological Update[3], this represents an increase of 17,972 new cases and 138 new deaths. During the same period, the highest relative increases in confirmed cases and deaths were observed in Guatemala.

[14] Roberton T, Carter E D, Chou V B, et al. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. Lancet Glob Health 2020; 8: e901–08. May 12, 2020 https://doi.org/10.1016/ S2214-109X(20)30229-1

Table 4. Cumulative number of pregnant women positive for SARS-CoV-2 and deaths, and case fatality rate by country. Region of the Americas. January 2020 to 8 February, * 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	8,698	45	0.52
Bahamas	16	1	6.25
Bolivia	1,946	31	1.59
Belize**	103	2	1.94
Brazil	5,381	289	5.37
Chile	7,322	1	0.01
Colombia	7,695	58	0.75
Costa Rica	393	3	0.76
Cuba	230	0	0.00
Dominican Republic	323	19	5.88
Ecuador	1,738	25	1.44
El Salvador	269	9	3.35
Guatemala	1,834	22	1.20
Haiti**	76	4	5.26
Mexico[&]	13,059	266	2.04
Panama[&]	1,289	7	0.54
Paraguay	692	1	0.14
Peru[&]	41,403	76	0.18
United States of America	64,075	74	0.12
Uruguay**	82	0	0.00
Venezuela	364	7	1.92
Total	**156,988**	**940**	**0.60**

Notes:

*8 February 2021 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 January 2021PAHO/WHO Epidemiological Update on COVID-19[4]

[&] 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

Source: Latin American Center for Perinatology/Women's Health and Reproductive Health (CLAP/SMR) and information shared with PAHO/WHO by International Health Regulations (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 as of 8 February 2021, there have been 339,137 confirmed cases of COVID-19, including 4,743 deaths, reported among indigenous populations in 14 countries in the Region of the Americas for which information was available (**Table 5**). Compared to the data in the 15 January 2021 PAHO/WHO Epidemiological Update on COVID-19[4], this represents an increase of 35,403 confirmed cases including 337 additional 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 8 February, * 2021.

Country	Number of confirmed cases of COVID-19	Number of deaths
Bolivia**	3,485	151
Brazil	42,102	558
Canada	17,201	169
Colombia	34,484	1,070
Ecuador	4,937	194
Guatemala	11,176	341
Guyana**	95	6
Mexico**	13,565	1,965
Panama**	2,841	53
Paraguay	264	25
Peru**	28,916	160
Suriname	529	23
United States of America	178,681	N/A
Venezuela	861	28
Total	**339,137**	**4,743**

Notes:
N/A: data not available
*8 February 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 January 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.

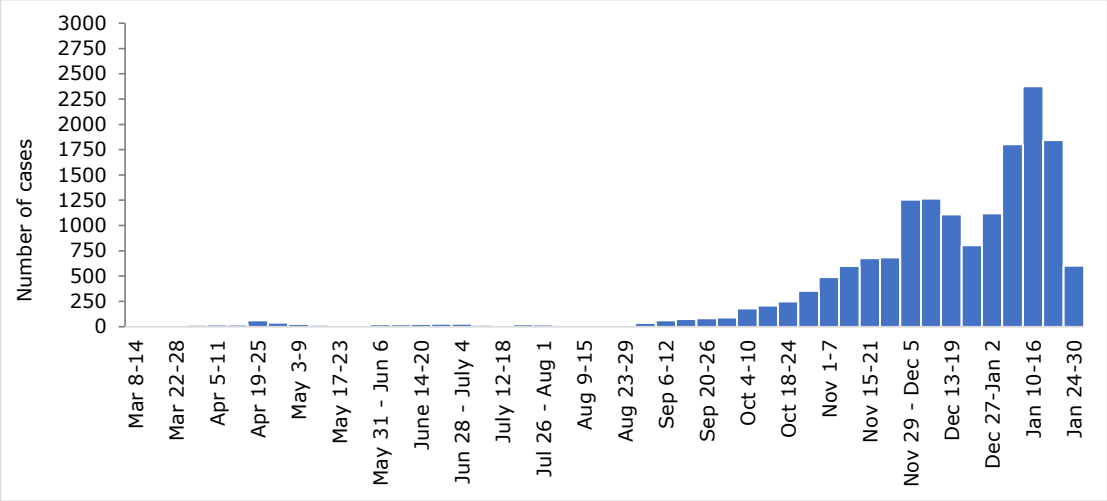
The following is a summary of the epidemiological situation of COVID-19 among indigenous populations in Canada.

In **Canada**, from the confirmation of the first COVID-19 case[15] to 2 February 2021, a total of 17,201 confirmed cases of COVID-19 were reported among indigenous populations, including 169 deaths. Of the total confirmed cases, 14,920 have recovered (87%). The provinces of Manitoba (4,595 cases) and Saskatchewan (4,493 cases) contribute with 53% of the total confirmed cases.

[15] 25 January 2021.

Of the total confirmed cases, women represent 50.4% and in the same total of cases, the groups 20 to 39 years of age and 40 to 59 years of age account for 55% of the total.

Figure 4. Distribution of confirmed COVID-19 cases on First Nations reserves of Canada, by date of report. 8 March 2020 to 30 January 2021.



Source: Data provided by Government of Canada[16] and reproduced by PAHO/WHO.

In Canada, there has been a sustained increase in the number of COVID-19 cases reported in indigenous peoples since the beginning of October, with a slight decrease towards the end of December, before increasing again in January, with figures higher than those observed in previous periods (**Figure 4**).

As of 19 January 2021, the reporting rate for COVID-19 cases among Indigenous peoples in Canada was 40% higher than the rate in the Canadian population[16].

[16] Government of Canada. Coronavirus (COVID-19) and indigenous communities. Available at: https://bit.ly/2IhCEWq, accessed 3 February 2021.

V. Multisystem inflammatory syndrome (MIS) in children and adolescents temporally related to COVID-19[17]

On 15 May 2020, WHO issued a Scientific Brief[18] on multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19 (MIS-C) 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-C 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-C continues to evolve, MIS-C has been observed temporally in relation to COVID-19.

Since the middle of May 2020, as of 8 February 2021, a total of 3,015 cumulative MIS confirmed cases, that temporally coincide with COVID-19, including 84 deaths have been reported by 17 countries/territories of the Region of the Americas that have officially notified PAHO/WHO or have published information through an official website (**Table 6**). This represents a relative increase of 9% in cases (278 additional cases) and 7% in deaths (7 additional deaths) since the 15 January 2021 PAHO/WHO Epidemiological Update on COVID-19[4].

As of 8 February 2021, 25 countries/territories have officially reported to PAHO/WHO that they have not detected cases of MIS.

As the cases of MIS increase, it is important that each country / territory characterize the cases[19], to contribute to closing the gaps in information, to improve the updating of clinical management and response measures.

[17] WHO. Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19. Preliminary case definition. Available at: https://bit.ly/2RBZzgr. 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.

[18] WHO. Multisystem inflammatory syndrome in children and adolescents with COVID-19. Scientific Brief. 15 May 2020. Geneva. Available at: https://bit.ly/3hEjqGk

[19] 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 8 February* 2021.

Country/Territory	Number of confirmed cases	Number of confirmed deaths
Argentina	112	1
Brazil	690	44
Canada	23	0
Chile	151	2
Costa Rica	27	0
Colombia	3	0
Cuba	3	0
Dominican Republic	103	5
Ecuador	8	0
El Salvador	18	0
French Guiana	1	0
Guadeloupe	4	0
Guatemala	2	0
Honduras	2	0
Panama	5	1
Paraguay	52	5
United States of America	1,811	26
Total	**3,015**	**84**

Note:
*8 February 2021 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.

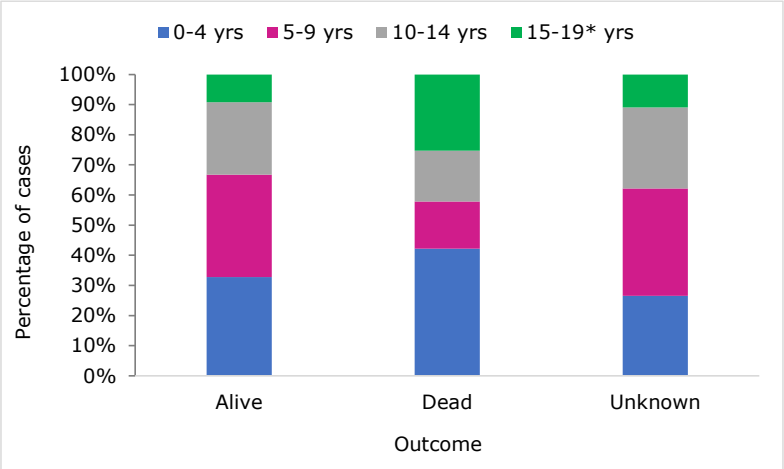
Sources: Data provided by the International Health Regulations National Focal Points or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

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

Of the total number of reported cases, for which data on age are available (n= 2,906), 66% were between 0 and 9 years of age at the time of illness (groups 0 to 4 years of age account for 32% and 5 to 9 years of age account for 34%) and only 10% were in the age group between 15 and 19 years*. Concerning the distribution by sex 57% of the cases were male.

Regarding the fatal cases, of the 83 cases for which data regarding the age was available (n=83), the highest proportion of deaths is observed among the 0–4-year-old age group (42%), followed by 15 -19-year-old age group (25%) (**Figure 5**).

Figure 5. Percent distribution of MIS cases in the Americas. May 2020 to 8 February 2021.



* The United States includes 20-year-olds in this group.

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

VI. COVID-19 among health workers

As of 2 February 2021, 37 million cases of COVID-19 among health workers from 183 countries and territories were notified to the WHO, a figure that represents 36% of the total cases globally. The median age of these cases was 42 years (interquartile range 27 to 60 years) and 68% were women.

In one of the systematic reviews commissioned by the WHO, 37 studies were identified in which the association of SARS-CoV-2 infection in health workers was evaluated, highlighting the following[20]:

- SARS-CoV-2 infections occurred among health workers in various roles (clinical or non-clinical) and departments/settings (including outpatient and non-COVID-19 care settings).
- There was no consistent difference in risk of infection between job titles, including between nurses compared with physicians, which represented the most reported health worker roles.
- There was no association found between sex or age and risk of SARS-CoV-2 infection or seropositivity in health workers.

[20] WHO. COVID-19 Weekly Epidemiological Update. Published 2 February 2021. Available at: https://bit.ly/36FjtiG

- African Americans and Hispanic health workers had an increased risk of SARS CoV-2 infection.

- Education and training in infection prevention and control were associated with decreased risk of SARSCoV-2 infection in health workers.

- Certain exposures such as those involving intubations, other aerosol-generating procedures, direct patient contact, or contact with bodily secretions were found to be associated with increased infection risk compared with less intensive or direct exposure; though evidence was inconsistent, likely related to confounding factors such as those related to the availability, distribution, and use of PPE.

- Evidence on the association between health worker infection and use of individual PPE measures (masks, gloves, gown, eye protection) and hand hygiene was limited. However, most studies found that availability and appropriate use of PPE as recommended by local authorities was associated with decreased risk of SARS-CoV-2 infection. Evidence on the use of N95 or FFP2 respirators versus medical/surgical masks was inconclusive and limited to two inconsistent observational studies. Further information on the use of masks in health facilities can be found in the interim guidance on mask use in the context of COVID-19.

- Three studies found that universal masking in health facilities was associated with decreased risk of SARS-CoV-2 infection in health workers[20].

From January 2020 to 8 February 2021, 30 countries/territories in the Americas have continued reporting cases and deaths among health care workers.

According to the information available on confirmed and reviewed data on cases and deaths, the information provided by 17 countries of the Americas indicates that as of 8 February 2021, 1,315,880 cumulative confirmed cases of COVID-19 have been reported, including 6,645 deaths in health care workers (**Table 7**).

Table 7. Confirmed COVID-19 cases and deaths among health care workers in the Americas. January 2020 to 8 February 2021*.

Country	Number of confirmed cases of COVID-19	Number of deaths
Argentina	75,317	446
Bahamas	223	3
Brazil	457,686	480
Chile	52,241	102
Colombia	39,241	201
Costa Rica	7,974	25
Ecuador	11,038	114
El Salvador	6,609	71
Dominican Republic	541	16
Guatemala	9,141	84
Jamaica	471	2
Mexico	219,180	2,996
Paraguay	7,836	43
Peru	30,675	589
Suriname	333	0
United States of America	393,104	1,347
Uruguay	2,592	5
Venezuela	1,678	121
Total	**1,315,880**	**6,645**

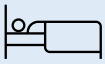
Note:
*8 February corresponds to the date of the most recent report; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

Sources: Data provided by the International Health Regulations (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 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 PAHO/WHO 2020 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, readiness, and response actions 	**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, & 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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12. Report by the **Guatemala** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email

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

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

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