

PAHO



Epidemiological Update Coronavirus disease (COVID-19)

23 June 2020

Context

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

Highlights

On 22 May 2020, WHO, and UNICEF warned that disruption to routine vaccination leaves millions of children at risk, highlighting the ripple effect and disturbance that COVID-19 is having on essential areas of health care and disease prevention. On 26 May, the WHO released a manifesto for a healthy recovery from COVID-19, examining what we have learned so far from COVID-19 and actions to move toward a healthier environment.² Nevertheless, evolving challenges have continued around the maintenance of essential health services, the disruption to services for noncommunicable diseases, and supporting COVID-19 responders and frontline workers.³ Research and development around COVID-19 treatment has continued to evolve through the Solidarity Trial; the latest update suggested stopping the hydroxychloroquine arm of the trial.³

¹ Statement on the third meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19): <https://bit.ly/3erlb8f>

² WHO Manifesto for a healthy recovery from COVID-19: <https://bit.ly/2Nq2HKi>

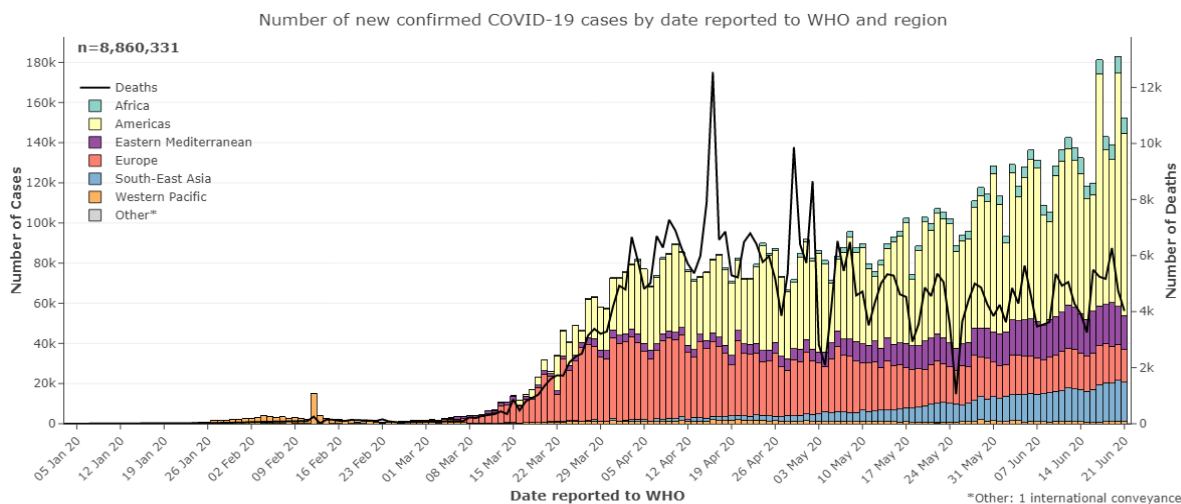
³ Events as they happen: <https://bit.ly/316FyVq>

Suggested citation: Pan American Health Organization / World Health Organization. Epidemiological Update: Coronavirus disease (COVID-19). 26 June 2020, Washington, D.C.: PAHO/WHO; 2020

Global Situation Summary

As of 22 June 2020, 8,860,331 confirmed cases and 465,740 confirmed deaths of COVID-19 have been reported globally among 216 countries, territories, or areas.⁴

Figure 1. Number of new cases of COVID-19 globally by date as of 22 June 2020



Source: WHO dashboard data as of 22 June 2020.

Since 22 May 2020⁵, the number of cases has nearly doubled, from 4,962,707, and the number of deaths has increased by over 100,000, from 326,459. Countries with over 200,000 confirmed cases are the United States of America (2,241,178 cases), Brazil (1,067,579 cases), the Russian Federation (592,280 cases), India (425,282 cases), the United Kingdom (304,335 cases), Peru (251,338 cases), Spain (246,272 cases), Chile (242,355 cases), Italy (238,499 cases), and the Islamic Republic of Iran (204,952 cases). This includes an additional 4 countries reaching over 200,000 cases in the last month: Chile, India, Iran, and Peru.² Confirmed cases reported for China have continued to decrease since mid-February, now totaling 85,018, up from 84,520 cases from 22 May. Substantial increases in the number of new COVID-19 cases continue in many regions, particularly in the Region of the Americas where the United States of America and Brazil are currently the only countries reporting cases of COVID-19 in the millions.⁶ (Figure 1).

Countries with over 10,000 confirmed deaths are the United States of America (119,453 deaths), Brazil (49,976 deaths), the United Kingdom (42,632 deaths), Italy (34,634 deaths), France (29,571 deaths), Spain (28,323 deaths), Mexico (20,781 deaths), and India (13,699 deaths).⁴ This includes an additional 2 countries reporting over 10,000 death in the last month: Mexico and India. Among these countries, since 22 May 2020, Brazil's death toll has continued to increase substantially: increasing 2.6-fold (from 18,859 deaths). Brazil, the United States of America and the United Kingdom account for 46% of the total number of deaths reported globally, a 1% increase from 22 May.

⁴ WHO Coronavirus Disease (COVID-19) Dashboard: <https://covid19.who.int/>

⁵ Date of publication of the prior PAHO/WHO Epidemiological Update on Coronavirus disease (COVID-19), available at: <https://bit.ly/2Zij0bo>

⁶ WHO Coronavirus Disease (COVID-19) Dashboard: <https://covid19.who.int/>

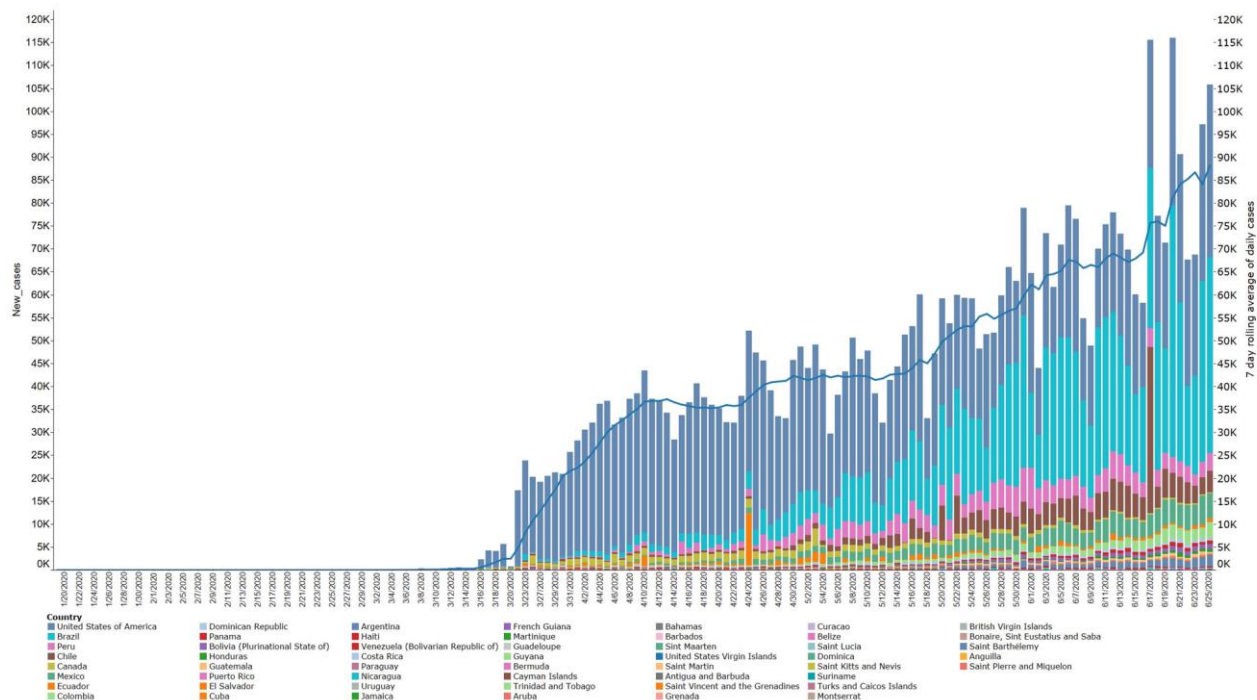
Ongoing efforts are necessary to control the spread of COVID-19 and maintain essential health services; the WHO, with guidance from the Emergency Committee, and collaboration with country offices and partners, provides recommendations in the areas of coordination, planning, and monitoring, One Health, essential health services, risk communication and community engagement, surveillance, travel and trade, preparedness, surveillance, additional health measures, health workers, food security, and research and development.⁷

Situation summary in the Region of the Americas

All 54 countries/territories from the Region of the Americas have reported COVID-19 cases and deaths. As of 22 June, there are 4,437,946 cases and 224,207 deaths reported, nearly twice the reported cases (2,220,282 cases) and deaths (131,606 deaths) since 22 May. Up to date information on COVID-19, including Situation Reports, Weekly Press Briefings, and the COVID-19 Information System for the Region of the Americas can be accessed online from the [Coronavirus Disease \(COVID-19\) pandemic](https://bit.ly/2ZaMgqY) page, available at: <https://bit.ly/2ZaMgqY>.

In the Region of the Americas, COVID-19 cases continue to occur at a rapid pace in many countries and territories. The 7-day rolling average of daily cases in the region of the Americas as of 25 June is 88,200 cases compared to 18 June when it was 75,991 – a 16% increase. (Figure 2).

Figure 2. Distribution of new COVID-19 cases by date of report and country. Region of the Americas. 21 Jan-25 Jun 2020



Source: WHO COVID-19 dashboard data. 25 June 2020.

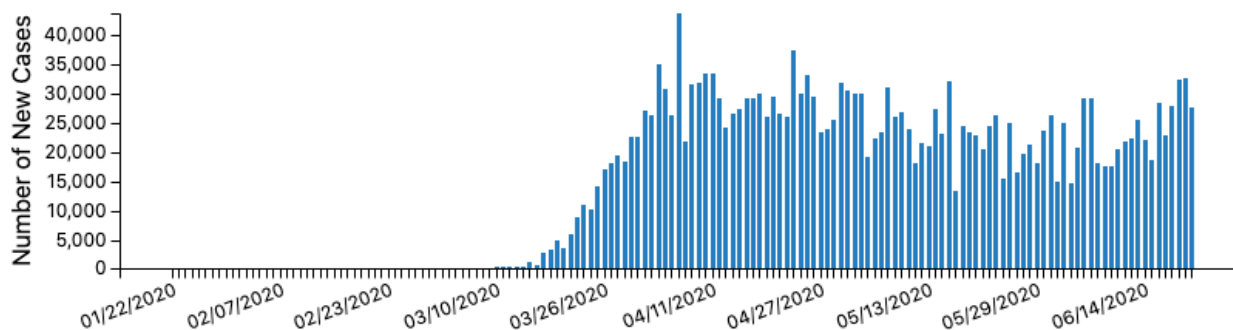
⁷ Statement on the third meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of coronavirus disease (COVID-19): <https://bit.ly/3erlb8f>

North America

Canada, Mexico, and the United States of America have reported confirmed increases in COVID-19 cases and deaths since the 22 May 2020 PAHO/WHO Epidemiological Update. The overall reported confirmed cases have increased to 2,550,635 cases from 1,662,335 cases, and deaths have increased to 150,016 from 103,679. Due to the particularly high number of cases in the United States of America, the North American sub-region contributes 57% of all cases (compared to 75% 22 May, and 89% 19 April) and 67% of all deaths (compared to 79% 22 May, and 89% 19 April) in the Region of the Americas. The decrease in proportion may be attributed in part to the increase in cases in Central and South America. The crude case-fatality rate in North America is 5.88% (6.24%, 22 May) the highest among the sub-regions in the Region of the Americas.

The United States of America accounts for the most cases and deaths for the North American region; 89% of cases and 80% of deaths, a 3% decrease and 8% decrease respectively compared to the 22 May PAHO/WHO Epidemiological Update. Figure 3 shows the number of new cases of COVID-19 in the United States of America by date. Thirty-nine states/Federal District have reported more than 10,000 confirmed cases of COVID-19, 10 additional since 22 May. Seventy-four percent of cases are among those between the ages of 18 to 64 years, however, hospitalization rate (cumulative rate, 94.5 per 100,000 population) remains highest among people 65 years of age and older (296.9 per 100,000 population) and 50-64 years (143. per 100,000 population).⁸ Hospitalization rates have increased overall (cumulative rate, 60.5 per 100,000 population), for people 65 years of age and older (192.4 per 100,000 population), and 50-64 years (94.4 per 100,000 population), compared to the previous report.

Figure 3. Number of new cases of COVID-19 in the United States of America by date. 22 January – 21 June 2020



Source: United States Centers for Disease Control and Prevention (CDC), Coronavirus Disease 2019 (COVID-19). Cases in the U.S. Last updated 22 June 2020.

Total cases are highest in the states of New York, California, New Jersey, Illinois, Texas, and Massachusetts, all reporting over 100,000 confirmed cases. Deaths are also high among those

⁸ United States Centers for Disease Control and Prevention (CDC). Coronavirus Disease 2019 (COVID-19). Available at <https://bit.ly/2RJ2fcE>

states, all with over 5,000 confirmed deaths (except Texas, 2,182 deaths), along with Pennsylvania and Michigan.⁹

In Canada, confirmed cases have been reported in 12 of the 13 provinces/territories; Nunavut remains the only territory with no confirmed cases. As of 22 June, Canada has 101,637 confirmed cases and 8,436 deaths, an increase from 81,313 confirmed cases and 6,152 deaths as of 22 May. The province of Quebec accounts for 54% of cases (54,835 cases) and Ontario accounts for 33% of cases (33,637 cases) in the country, a combined 87% of all cases and an increase of 1% from the 22 May PAHO/WHO Epidemiological Update (86%).¹⁰

In Mexico, the incidence of reported COVID-19 cases and deaths has increased. Confirmed COVID-19 cases and deaths have tripled, from 59,567 to 180,545 confirmed cases, and from 6,510 to 21,825 confirmed deaths, between 21 May to 22 June, 2020. Highest reported cases are in Mexico City, the State of Mexico, Baja California, and Tabasco.¹¹

In Mexico, there has been a substantial growth in the incidence of reported COVID-19 cases and deaths; a shift from the previous Epidemiological Update. Confirmed COVID-19 cases have increased 8-fold, from 7,497 to 59,567 confirmed cases, and deaths have increase 10-fold from 650 to 6,510 confirmed cases as of 21 May. Highest reported cases are in Mexico City, the State of Mexico, Tabasco, and Veracruz.¹²

Central America¹³

As of 22 June, the total of confirmed cases and deaths have tripled in the Central American sub-region, which includes Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. A total of 61,057 confirmed cases (increase from 18,176 confirmed cases as of 21 May), including 1,580 deaths (increase from 544 deaths as of 21 May), have been reported between the 7 countries in Central America. Of the total number of confirmed cases, Panama has consistently reported the highest number of cases (26,030 cases, including 501 deaths). Since the prior PAHO/WHO Epidemiological Update, Guatemala has surpassed Honduras in cases and deaths; Guatemala has reported 13,145 cases, including 531 deaths and Honduras has reported 12,825 cases, including 363 deaths. COVID-19 cases increased almost 600% in Guatemala and in Honduras cases quadrupled, since 21 May. El Salvador (4,808 cases, including 107 deaths), Costa Rica (2,213 cases, including 12 deaths), and Nicaragua (2,014 cases, including 64 deaths) report the next highest numbers of cases and deaths. Belize has had few confirmed cases and deaths, 22 and 2 respectively. The crude case-fatality rate in Central America is 2.58, a slight decrease compared to the prior PAHO/WHO Epidemiological Update (2.99%).

Caribbean and Atlantic Ocean Islands¹⁴

⁹ CDC COVID Data Tracker: <https://www.cdc.gov/covid-data-tracker/index.html#cases>

¹⁰ Government of Canada. Coronavirus disease (COVID-19): Outbreak update. Available at <https://bit.ly/2RHJ56S>

¹¹ Government of Mexico. Covid-19 México. Available at <https://bit.ly/2VxLHpg>

¹² Government of Mexico. Covid-19 México. Available at <https://bit.ly/2VxLHpg>

¹³ Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

¹⁴ Anguilla, Antigua and Barbuda, Aruba, the Bahamas, Barbados, Bermuda, Bonaire, Sint Eustatius and Saba, the British Virgin Islands, the Cayman Islands, Cuba, Curacao, Dominica, the Dominican Republic, the

The majority (20) of the 34 countries/territories in the Caribbean and Atlantic Ocean Islands sub-region continue to report sporadic cases or clusters of cases of COVID-19. In addition to the Dominican Republic and Puerto Rico, French Guiana, and Haiti now have community transmission. Ten countries/territories are reporting “no cases” currently.¹⁵ As of 22 June, a total of 46,666 confirmed cases (increase from 21,406 cases as of 21 May), including 1,127 deaths (increase from 794 deaths as of 21 May), have been reported from the Caribbean and Atlantic Ocean Islands.

The Dominican Republic has reported 59% of cases (27,370) and deaths (669) for the sub-region, a decrease in the proportion of cases (5%) but an increase in the proportion of deaths (3%) compared to the previous PAHO/WHO Epidemiological Update. Puerto Rico (6,564 cases, including 149 deaths), Haiti (5,211 cases, including 88 deaths), French Guiana (2,458 cases, including 8 deaths), and Cuba (2,315 cases, including 85 deaths) reported the next highest numbers of cases and deaths. Since the previous PAHO/WHO Epidemiological Update, French Guiana, Guyana, Haiti, Martinique, and Suriname have had marked relative increases in cases. The crude case-fatality rate in the Caribbean and Atlantic Ocean Islands decreased from 3.70% to 2.42% since the last Epidemiological Update.

South America¹⁶

After North America, the sub-region with the highest number of confirmed cases and deaths reported to date remains South America. As of 22 June, the 10 countries in this sub-region have reported a combined total of 1,779,588 confirmed cases, more than tripling the number of cases since the last report (518,365 confirmed cases, 21 May). Total deaths as of 22 June are 71,484, an increase from 26,589 reported death as of 21 May.

South America accounts for 40% of total cases and 32% of death in the Region of the Americas, an increase of 17% and 12% since the last report. All countries except for Uruguay (Clusters of cases) report presence of Community transmission. Brazil continues to report the highest number of cases and deaths (1,085,038 confirmed cases, including 50,617 deaths) in South America, followed by Peru (254,936 confirmed cases, including 8,045 deaths), and Chile (246,963 confirmed cases, including 4,502 deaths). In descending order, Colombia, Ecuador, Argentina, Bolivia, Venezuela, Paraguay, and Uruguay report less than 70,000 cases and 2,500 deaths. The crude case-fatality rate in South America is 4.02%, a decrease from the previous report (5.13%), and remaining the second highest among the sub-regions in the Region of the Americas.

Guidance and recommendations for national authorities

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

¹⁵ Anguilla, Aruba, Bonaire, Sint Eustatius, and Saba, the Falkland Islands, Montserrat, Saint Barthélemy, Saint Kitts and Nevis, Saint Pierre and Miquelon, Turks and Caicos, and the U.K. Virgin Islands.

¹⁶ Argentina, Bolivia, Brazil, Colombia, Ecuador, Paraguay, Peru, and Venezuela.

PAHO/WHO continues to reiterate and update recommendations to support all Member States on measures to manage and protect against the disease. The International Health Regulations (IHR) Emergency Committee first provided public health advice and recommendations to the Director-General on 22 January 2020. PAHO/WHO has developed, reinforced, and adapted recommendations since 28 February 2020.

1. Surveillance and reporting

Surveillance Strategies

PAHO/WHO recommends that the disease be a mandatory notifiable disease with requirements for immediate reporting.¹⁷

To interrupt COVID-19 transmission the following activities should be conducted:

- Early detection of suspect cases,
- Laboratory testing,
- Isolation,
- Contact tracing and quarantine of contacts.

Early detection of suspected case could be conducted by using a combination of strategies such as universal and nominal surveillance, sentinel surveillance of severe acute respiratory infections (SARI) and influenza-like illness (ILI), and event-based surveillance. Active case finding and SARI/ILI sentinel surveillance (in the Americas for over a decade for influenza and other respiratory viruses' surveillance) are critical to enhance surveillance activities, to detect and monitor COVID-19 transmission in the community. Maintenance of influenza virus's surveillance must be assured, given their epidemic and pandemic potential.

Aimed to limit the spread of the disease, COVID-19 surveillance should be conducted across all sites to detect all suspected cases including those occurring among vulnerable population.

Surveillance sites for COVID-19 include surveillance (1) by individuals in the community, (2) at the primary care level, (3) hospital-based, (4) sentinel-based using the existing Global Influenza Surveillance and Response System (GISRS), (5) enhanced for residential facilities and vulnerable groups, (6) mortality-based, and (7) by laboratory testing data. Event-based surveillance, participatory surveillance, and telephone hotlines may also be implemented to support the more comprehensive approaches.

To support countries in this regard, the WHO updated the [Surveillance strategies for COVID-19 human infection](#) on 10 May 2020 which provide guidance on surveillance strategies, including types of surveillance, the importance of adapting national systems, and increasing surveillance-related efforts as needed. A guide to the [Monitoring and evaluation framework. COVID-19 strategic preparedness and response](#), published 5 June, describes the monitoring and evaluation framework designed to assess the performance of country Strategic Preparedness and Response Plans and to track information required to support further analysis.

¹⁷ Surveillance strategies for COVID-19 human infection. Available at <https://www.who.int/publications-detail/surveillance-strategies-for-covid-19-human-infection>

COVID-19 surveillance is essential given the exponential growth of the disease. As a result, the identification and reporting of new cases should take place within 24 hours and be included in ongoing epidemiological analysis. It is further recommended that the disease be a mandatory notifiable disease with requirements for immediate reporting.¹⁸

Sound surveillance practices for COVID-19 should include:

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

Recommendations for the reporting of cases and deaths

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

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

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

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

Although the co-detection of influenza (or other respiratory viruses) with SARS-CoV-2 is biologically possible, this is an unlikely event. Therefore, if a positive test result is obtained for

¹⁸ Surveillance strategies for COVID-19 human infection. Available at <https://www.who.int/publications-detail/surveillance-strategies-for-covid-19-human-infection>

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

another virus that explains the clinical picture, it is not necessary to continue to test the sample for SARS-CoV-2.

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

As a result of the growing COVID-19 pandemic and shortages of laboratory-based molecular testing capacity and reagents, more rapid and easy-to-use devices are being developed to facilitate testing outside of laboratory settings.²⁰ These test kits rely on protein detection from COVID-19 in respiratory samples or on the detection, in blood or serum, of human antibodies in response to the infection.²¹ As these tests are not yet adequately validated and based on current evidence, PAHO/WHO does not recommend their use for clinical decision making.²²

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

- Defining contacts,
- Identifying contacts,
- Informing contacts,
- Managing and monitoring contacts daily, including quarantining, and
- Data processes and analysis, including data management and analysis.²³

As part of a comprehensive response to controlling the spread of COVID-19, health authorities have an ethical obligation to conduct rigorous contact and should ensure that data are managed responsibly, risks are minimized, the population is informed, and that data are promptly shared.²⁴

Member States which are planning to lift or adjust distancing measures should prepare as early as possible for a contact tracing plan and consider their workforce requirements. The earlier recruitment and preparations take place, at a time when there is no or low transmission, the more likely cases can be managed and maintained low. Factors to consider include the approximate number of contacts to be traced, physical and technological logistics of reaching those affected, cultural and socio-political contexts, security, tracing modalities and other resources. Electronic tools and information technology may be useful, for example, but may not be accessible to all. Personnel is essential and contact tracers can

²⁰ Information and criteria for prioritizing diagnostic tests for SARS-CoV-2 in order to address the procurement needs of health systems, 8 April 2020. Available at <https://iris.paho.org/handle/10665.2/52134>

²¹ Advice on the use of point-of-care immunodiagnostic tests for COVID-19: [scientific brief](#).

²² Interpretation of laboratory results for COVID-19 diagnosis, 6 May 2020. Available at <https://iris.paho.org/handle/10665.2/52138>

²³ Contact tracing in the context of COVID-19. Available at <https://www.who.int/publications-detail/contact-tracing-in-the-context-of-covid-19>

²⁴ Enhancing COVID-19 Mortality Surveillance in Latin America and the Caribbean through All-Cause Mortality Surveillance, May 2020. Available at: <https://iris.paho.org/handle/10665.2/52308>

be drawn from many settings; qualified individuals should be utilized over engaging medical personnel. PAHO/WHO also has several [trainings](#) available to support this strategy.

2. Infection Prevention and Control

Sustained human-to-human transmission of COVID-19 along with health facilities transmission has been reported in most of the countries. Routes of transmission of COVID-19 include direct contact and droplet.²⁵ Aerosol generating procedures (AGP) also play a role in the transmission of COVID-19.

PAHO recommends Member States to strengthen IPC measures at all level of care and surveillance of COVID-19 cases among health care workers.

3. Clinical management

To date, there is no specific drug or vaccine recommended to prevent or treat the novel coronavirus. Some specific treatments such as antivirals and immune modulators are being tested through clinical trials.²⁶ Those infected with COVID-19 should receive appropriate care to relieve and treat symptoms, and those with severe illness should receive best supportive care.

Implementation of timely, effective, and safe supportive therapies is vital for patients who develop severe manifestations of COVID-19. The safety of the patient suffering from COVID-19 is a key priority to improve the quality of care in the provision of health services. The use of medications such as ivermectin, antivirals, and immunomodulators, among others, should be done in the context of patient consented, randomized clinical trials that evaluate their safety and efficacy.

4. Health Systems and Services

Health services must adjust rapidly, sustaining and expanding public health and critical care capacities developed for the response to COVID-19. Disseminate and apply documents and tools for updating response and recovery plans and procedures in a cross-disciplinary and multi-sectoral way, to improve efficiency, reduce duplication of effort and enable coordinated collective actions. To enhance the health systems and services response at the country level, guidance documents (listed below), capacity building, and direct support to countries has been provided.

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

²⁵ For more information on modes of transmission of virus causing COVID-19, please refer to: <https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>. Access date June 12, 2020.

²⁶ Ongoing Living Update of Potential COVID-19 Therapeutics: summary of rapid systematic reviews. Rapid Review, 8 May 2020". Available at <https://iris.paho.org/handle/10665.2/52097>

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

WHO has published an [Emergency Global Supply Chain System \(COVID-19\) catalogue](#). This catalogue lists all medical devices, including personal protective equipment, medical equipment, medical consumables, single use devices, laboratory and test-related devices that may be requested through the COVID-19 Supply Portal.

An initiative to better coordinate and support national regulatory authorities on medicines and other health technologies in their response to COVID-19 was launched. This initiative included the development of technical documents, bi-weekly meetings, a List Serve, and a repository of websites and relevant information, including regulatory responses on COVID-19. Information is available on the Regional Platform on Access and Innovation for Health Technologies (PRAIS) and is shared with regulatory focal points. Information can be found at: <https://prais.paho.org/en/featured-links/>

5. Public Health and Social Measures: Social distancing and International traffic-related measures

Experience gained and lesson learnt at national level while responding to the COVID-19 pandemic, including evidence developed about effectiveness of non-pharmaceutical interventions in slowing the transmission of SARS-CoV-2 virus, as well as advances in strengthening national health systems since SARS-CoV-2 virus emerged, through the application of technology in an innovative and social distancing friendly manner, amongst others, are shaping a context in which decisions related to the adjustment of non-pharmaceutical interventions can progressively move away from a “trial and error basis”. Non-pharmaceutical measures include personal protective measures, environmental measures, social distancing measures, and international traffic-related measures.

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

essential services. Interim guidance has been developed for [Key planning recommendations for mass gatherings in the context of the current COVID-19 outbreak](#), to support the containment of COVID-19 in such populated settings.

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

6. Risk Communication

Risk Communication is a core component of a public health intervention, with any disease outbreak or health emergency. As such, the WHO and PAHO have created communication materials, with a focus on higher risk populations, to inform both the public and health care workers about COVID-19. PAHO has created [infographics and social media cards](#) on COVID-19 compared to other diseases and conditions, how to wear a mask safely, 5 steps to saving water when washing your hands, seasonal influenza, myth-busters, and addressing domestic violence in the context of COVID-19 (for policymakers and for communities), among others. These materials are promoted by PAHO country offices and are resources for countries to use and/or adapt for their needs and realities.

It is also important to take into consideration a gender-responsive approach, with any emergency response. The document [Key Considerations for Integrating Gender Equality into Health Emergency and Disaster Response: COVID-19, 4 June 2020](#) provides guidance on integrating considerations around gender-based inequalities, with a focus on COVID-19.

PAHO/WHO and partners have also developed videos on [Staying healthy at home](#), [Recommendations for coping with stress and mental well-being during isolation or quarantine](#), [Tips for Home Quarantine](#), [Social Distancing Practices](#), [Science of COVID-19](#), and [Environmental health recommendations for closed community spaces](#).

PAHO has also held a series of Facebook Live sessions with experts on topics like: [testing](#), [mental health](#), [myths about COVID-19](#), [coronavirus in objects and surfaces](#), [infection prevention](#), and [indigenous populations](#) and COVID-19. The main goal of these Facebook Live sessions is to clear up doubts that people may have on different issues related to COVID-19. Experts directly address questions from the public, clarifying perceptions and debunking myths that can hinder protective behavior.

Key documents

Surveillance

- [Surveillance strategies for COVID-19 human infection](#) published on 10 May 2020 provide guidance on surveillance strategies, including types of surveillance, the importance of adapting national systems, and increasing surveillance-related efforts as needed.
- [Monitoring and evaluation framework. COVID-19 strategic preparedness and response](#), published on 5 June, describes the monitoring and evaluation framework designed to assess the performance of country Strategic Preparedness and Response Plans and to track information required to support further analysis.
- [Medical certification, ICD mortality coding, and reporting mortality associated with COVID-19](#) published on 7 June with the purpose of identifying all deaths due to COVID-19 in all countries. As many countries do not yet following WHO international norms and standards for medical certificates of cause of death and ICD mortality coding, many COVID-19 deaths may not be captured.
- [Enhancing COVID-19 mortality surveillance in Latin America and the Caribbean through all-cause mortality surveillance](#), published on 15 June with a regional focus, this document expands on methods for the analysis of all-cause mortality as one approach to better understand the true burden of COVID-19. It is complimented by an adapted [tool](#) for excess mortality calculation.

Laboratory

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

Contact tracing

- [Contact tracing in the context of COVID-19](#) published on 10 May 2020. The purpose is to present contact tracing as a tool for the control of COVID-19 and support on implementation.
- [Considerations for the implementation and management of contact tracing for Coronavirus Disease 2019 \(COVID-19\) in the Region of the Americas](#) published on 2 June, to complement the document above.

Infection prevention and control

- [Assessment of infection prevention and control practices in isolation areas in acute healthcare settings in the context of the novel coronavirus \(COVID-19\). Interim recommendations](#)
- [Care for health workers exposed to the new coronavirus \(COVID-19\) in health facilities](#)
- [Dead body management in the context of the novel coronavirus \(COVID-19\). Interim recommendations](#)
- [Technical specifications of medical devices for the case management of COVID-19 in healthcare settings](#)
- [Infection prevention and control guidance for long-term care facilities in the context of COVID-19](#)
- [Advice on the use of masks in the context of COVID-19 \(only in English\)](#)
- [Criteria for releasing COVID-19 patients from isolation'](#) which provides an update to previous guidance. The updated criteria reflect recent findings that patients whose symptoms have resolved may still test positive for the COVID-19 virus for many weeks. Despite this positive test result, these patients are not likely to be infectious and therefore are unlikely to be able to transmit the virus to another person.

Clinical Management

- [Guidelines for Critical Care of Seriously Ill Adult Patients with Coronavirus \(COVID-19\) in the Americas \(Short version\)](#)
- [Initial care of persons with acute respiratory illness \(ARI\) in the context of coronavirus disease \(COVID-19\) in healthcare facilities: assess the risk, isolate, refer](#)
- [Ongoing Living Update of Potential COVID-19 Therapeutics: summary of rapid systematic reviews \(16 June\)](#)
- [Use of chest imaging in COVID-19: a rapid advice guide, 11 June 2020](#)

In addition, WHO published [Interim guidance](#) to meet the need for recommendations on home care for patients with COVID-19 presenting with mild symptoms and management of their contacts.

Health Systems and Services

- [Technical note. Adapting the First Level of Care in the context of COVID-19](#) (Spanish only)
- [Checklist for the Management of Human Resources for Health in Response to COVID-19](#)

- [Ethics guidance for the use of scarce resources in the delivery of critical health care during the COVID-19 pandemic](#)
- [Technical Recommendation for the Selection of Alternative Medical Care Sites \(AMCS\)](#)
- [Reliance for Emergency Use Authorization of Medicines and Other Health Technologies in a Pandemic \(e.g. COVID-19\)](#)
- [Crisis Management during an Epidemic: General guidelines for efficient response coordination by national regulatory authorities](#)
- [Regulatory considerations on authorization of the use of convalescent plasma \(PC\) to address the COVID-19 emergency](#)
- [Preliminary recommendations for blood services](#)
- [List of priority medical devices for COVID-19 response](#)
- [Considerations for the Reorganization of Cancer Services during the COVID-19 Pandemic, 26 May 2020](#)
- [Framework for the Response of Integrated Health Service Delivery Networks to COVID-19, 10 May 2020](#)
- [Maintaining essential health services: operational guidance for the COVID-19 context: interim guidance, 1 June 2020](#)