



Epidemiological Alert COVID-19 among indigenous peoples in the Americas

15 July 2020

In light of an increase in cases and deaths due to COVID-19 in indigenous communities in the Region of the Americas, the Pan American Health Organization / World Health Organization (PAHO/WHO) urges Member States to intensify efforts in order to prevent further spread of infection within these communities, as well as to ensure adequate access to healthcare services and to strengthen case management using culturally appropriate approaches. Furthermore, PAHO/WHO urges the implementation of preventive measures across all levels of the health system in order to reduce mortality associated with COVID-19.

Introduction

In the past 4 weeks, reported cases of coronavirus disease (COVID-19) have continued to increase in most countries and territories in the Region of the Americas. In particular, there has been a rapid increase in cases in some countries in Central America and South America. There is currently no indication, at the regional level, that the pandemic has reached its peak.

Since the first confirmed case of COVID-19 in the Region of the Americas¹ and until 14 July 2020, a cumulative total of 6,884,151 confirmed cases of COVID-19, including 290,674 deaths, were reported.

Between 24 June and 14 July 2020, there were 2,280,017 additional confirmed cases of COVID-19, including 60,509 additional deaths, reported in the Region of the Americas. This represents a 50% relative increase in cases and a 26% relative increase in deaths. The highest proportions of new cases were reported in Turks and Caicos (414%), Costa Rica (239%), and Antigua and Barbuda (185%), while the highest proportions of new deaths were reported in Venezuela (166%), Costa Rica (158%) and El Salvador (134%).

During the same period, the largest relative increases in cases and deaths occurred in the subregions of Central America (94% increase in cases and 95% increase in deaths) and South America (57% increase in cases and 43% increase in deaths).²

¹ 21 January 2020

² PAHO/WHO COVID-19 Daily Update. Available from: <https://bit.ly/38LzGmi> and accessed 15 July 2020.

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The COVID-19 pandemic poses a risk to the health of indigenous peoples, both those living in urban areas and those living in remote settlements or isolated areas, where access to health services is a challenge and there is often a limited capacity to serve the entire population.

Among indigenous populations, either living in remote settlements or isolated in urban areas, some of the risk factors that may be associated with higher COVID-19 mortality rates include malnutrition, insufficient access or complete lack of access to health systems as well as to potable water and basic sanitation, in addition to the existing high burden of parasitic diseases.

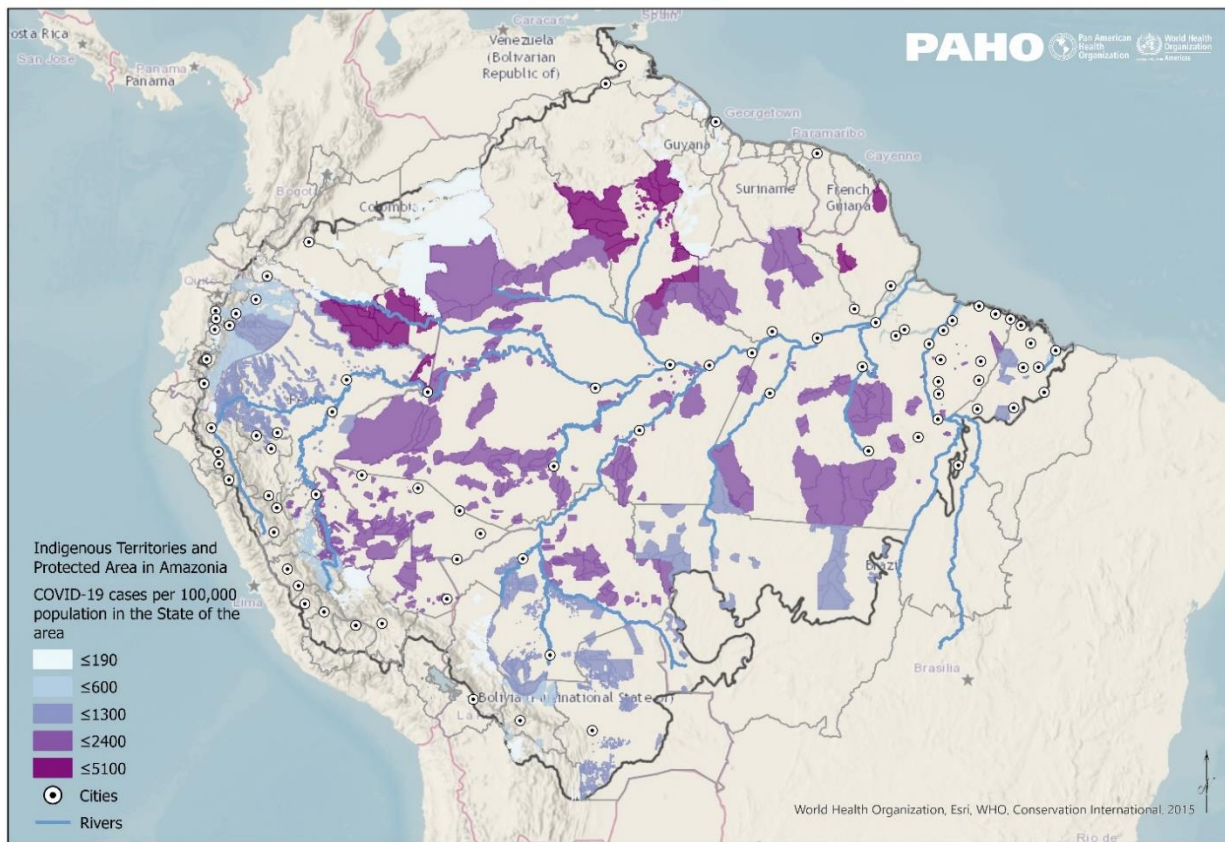
In addition to the aforementioned risk factors, which existed prior to the COVID-19 pandemic, indigenous populations in the Region of the Americas are faced with the following risk factors which put them in an even more precarious situation:

- The rate of interpersonal contact between indigenous and non-indigenous groups appears to be increasing in some countries. Interpersonal contact increases the risk of exposure to pathogens, including SARS-CoV-2, among these groups.
- The co-infection of COVID-19 with other high-prevalence diseases (e.g. tuberculosis) can lead to high mortality rates among indigenous groups.
- Isolated villages have a much higher population density than more easily reachable villages.
- The diet of many indigenous populations depends on hunting and fishing. These subsistence practices make containment measures difficult to implement.
- The frequent movement of indigenous groups through transnational territories increases the risk of exposure to circulating pathogens and the subsequent transmission of SARS-CoV-2 between neighboring countries.
- Clandestine logging and illegal mining activities can lead to outbreaks, even in isolated indigenous communities.
- The displacement of indigenous peoples previously settled in villages, in pursuit of social services and healthcare, has been associated with outbreaks of communicable diseases.

Situation in Select Countries

The COVID-19 situation among indigenous populations in countries for which information is available is presented below (**Figure 1**).

Figure 1. Cumulative incidence of COVID-19 among indigenous populations in South American countries.



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Map production:
PAHO Health Emergencies Department (PHE)
Health Emergency Information & Risk Assessment (HIM)

In **Bolivia**, since the first confirmed cases³ of COVID-19 in the country and as of 6 July 2020, there have been 31,249 confirmed cases, including 1,135 deaths (3.6%), reported among indigenous peoples (**Figure 2**).

Of the total cases, 70% were reported by the *Department of Santa Cruz* with 21,752 cases, including 574 deaths (2.6%)⁴, and 13% were reported by the *Department*

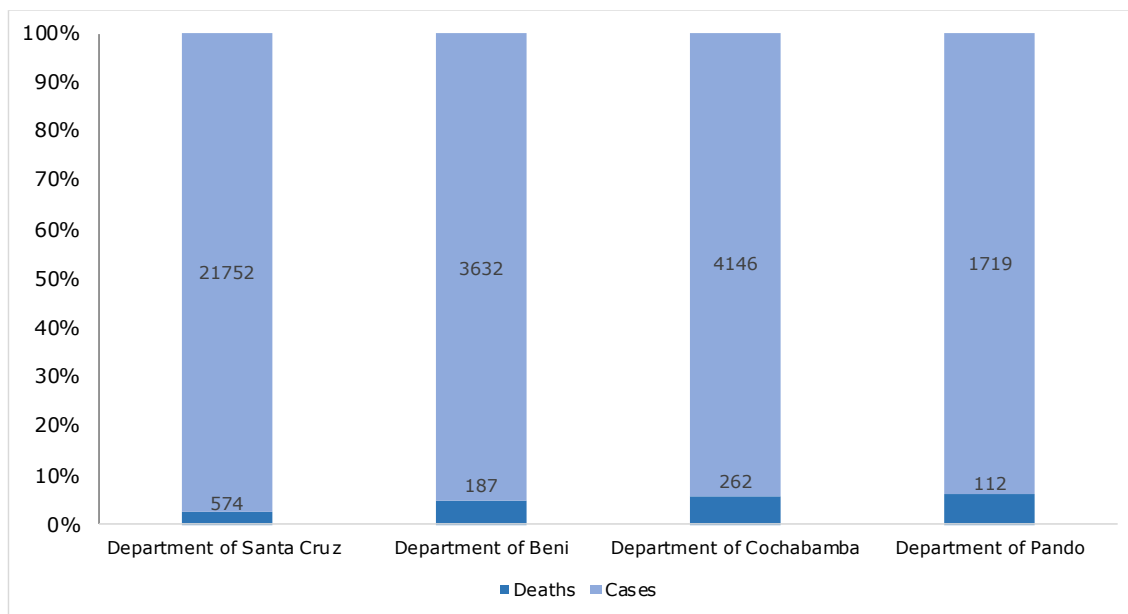
³ 10 March 2020.

⁴ Pan-Amazonian Ecclesial Network (Red Eclesial Pan amazónica). 6 July Report. Available from <https://redamazonica.org/covid-19-panamazonia/> and accessed 8 July 2020. Cases reported by the Diocese of San Ignacio de Velasco (710 cases, 1 death), the archdiocese of Santa Cruz de la Sierra (20,668 cases, 573 deaths), and by the Vicar of Ñuflo Chávez (374 cases).

of Cochabamba with 4,146 cases, including 262 deaths (6.3%)⁵. The Department of Beni reported 12% of cases, with 3,632 cases, including 187 deaths (5.1%)⁶. The remaining 6% of cases were reported by the Department of Pando, with 1,719 cases, including 112 deaths (6.5%)⁷.

Additionally, in the diocese of Coroico, 24 cases were reported, including 1 death (4.2%).

Figure 2. Distribution of COVID-19 cases and deaths by department. Bolivia, 10 March to 6 July 2020.



Source: Data published by the Pan-Amazonian Ecclesial Network (Red Eclesial Pan amazónica). Figure prepared by PAHO/WHO.

In **Brazil**, since the first confirmed case of COVID-19 in the country⁸ and as of 4 July, there have been 14,168 cases reported among indigenous peoples in the Indigenous Health Care Subsystem (SASISUS, per the Portuguese acronym), of which 7,946 cases (56%) were confirmed, 5,237 (37%) were discarded, 155 (1%) were excluded, and 830 (6%) remain under investigation. The 34 Special Districts of Indigenous Health (DSEI, per the Portuguese acronym) all reported confirmed cases of COVID-19. Of the total confirmed cases, 177 (2%) died of COVID-19.

As presented in **Figure 3**, the North and Northeast regions have reported the highest cumulative incidence rates, with some DSEIs reporting incidence rates as high as 1,077 to 7,496 cases per 100,000 population. The highest mortality rates per 100,000 population have also been observed

⁵ Pan-Amazonian Ecclesial Network (Red Eclesial Pan amazónica). 6 July Report. Available from <https://redamazonica.org/covid-19-panamazonia/> and accessed 8 July 2020. Cases reported by the Archdiocese of Cochabamba (3,407 cases, 218 deaths) and by Prel. Aiquile (739 cases, 44 deaths).

⁶ Pan-Amazonian Ecclesial Network (Red Eclesial Pan amazónica). 6 July Report. Available from <https://redamazonica.org/covid-19-panamazonia/> and accessed 8 July 2020. Cases reported by the Vicariate of Beni (3,566 cases, 186 deaths) and by the Vicariate Reyes (66 cases, 1 death).

⁷ Pan-Amazonian Ecclesial Network (Red Eclesial Pan amazónica). 6 July Report. Available from <https://redamazonica.org/covid-19-panamazonia/> and accessed 8 July 2020. Cases reported by the Vicariate of Pando (1,719 cases, 112 deaths).

⁸ 26 February 2020.

in these two regions, in the DSEIs of *Kaiapó do Pará* (112.8 cases per 100,000 population), *Xavante* (94.6 cases per 100,000 population), and in *Rio Tapajós* (75.0 cases per 100,000 population).

Figure 3. Distribution of COVID-19 cases among indigenous peoples assisted by SASISUS, by DSEI, up to epidemiological week (EW) 27 of 2020. Brazil.

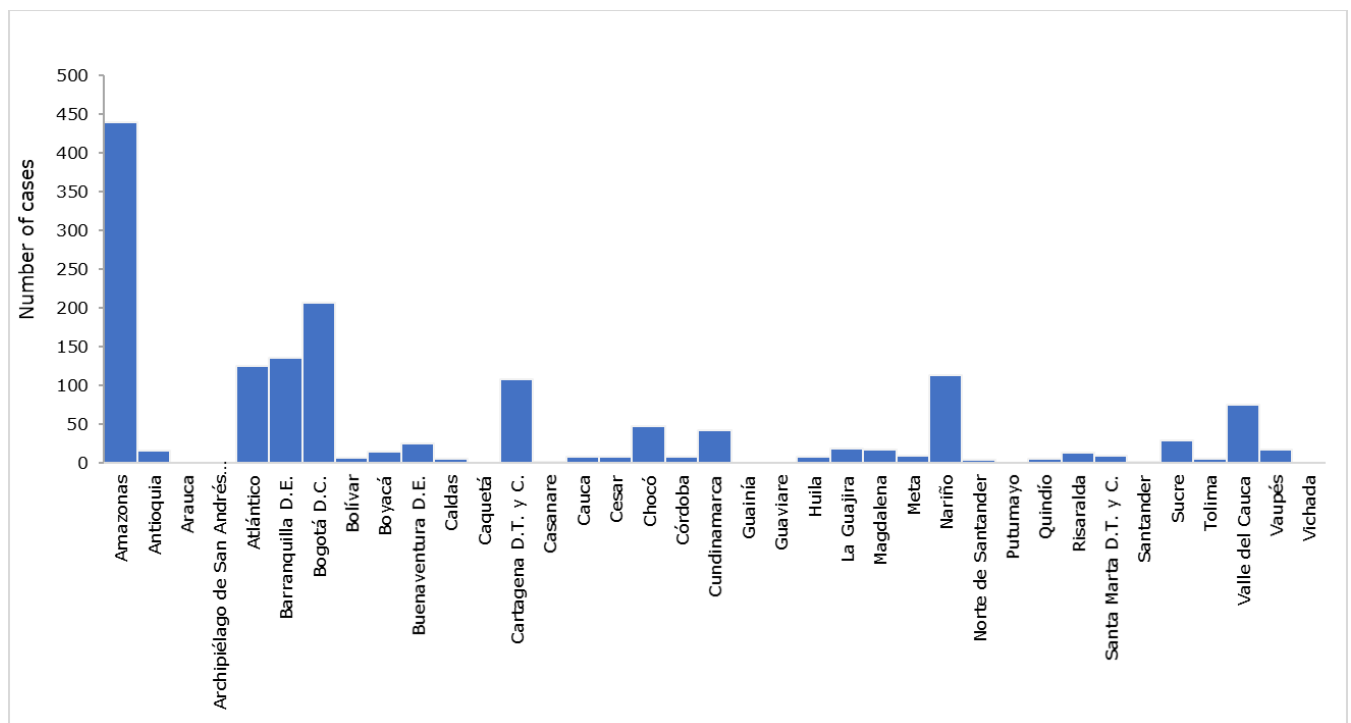
DSEI	Number of cumulative confirmed cases	Number of cumulative confirmed deaths	Incidence rate per 100,000 pop.	Mortality rate per 100,000 pop.	Case fatality rate (%)
North Region	5,417	112	1,424.0	29.4	2.1
Altamira	148	0	3,316.2	0.0	0.0
Alto Rio Juruá	196	4	1,077.4	22.0	2.0
Alto Rio Negro	382	11	1,328.0	38.2	2.9
Alto Rio Purus	186	4	1,464.8	31.5	2.2
Alto Rio Solimões	785	25	1,104.6	35.2	3.2
Amapá e Norte do Pará	481	1	3,686.4	7.7	0.2
Guamá-Tocantins	623	11	3,564.3	62.9	1.8
Kaiapó do Pará	465	7	7,496.4	112.8	1.5
Leste de Roraima	382	11	719.2	20.7	2.9
Manaus	242	10	768.8	31.8	4.1
Médio Rio Purus	26	1	333.2	12.8	3.8
Médio Rio Solimões e Afluentes	168	7	744.9	31.0	4.2
Parintins	65	3	391.1	18.1	4.6
Porto Velho	135	3	1,257.8	28.0	2.2
Rio Tapajós	748	10	5,610.6	75.0	1.3
Tocantins	83	0	657.8	0.0	0.0
Vale do Javari	119	0	1,886.5	0.0	0.0
Vilhena	12	0	203.5	0.0	0.0
Yanomami	171	4	609.9	14.3	2.3
Center-West Region	485	30	381.3	23.6	6.2
Araguaia	4	0	68.3	0.0	0.0
Cuiabá	68	5	919.3	67.6	7.4
Kaiapó do Mato Grosso	5	0	100.2	0.0	0.0
Mato Grosso do Sul	179	2	227.5	2.5	1.1
Xavante	176	21	793.2	94.6	11.9
Xingu	53	2	656.6	24.8	3.8
Northeast Region	1,595	28	970.3	17.0	1.8
Alagoas e Sergipe	84	2	672.9	16.0	2.4
Bahia	58	1	175.5	3.0	1.7
Ceará	335	4	1,242.3	14.8	1.2
Maranhão	862	14	2,279.3	37.0	1.6
Pernambuco	113	7	290.9	18.0	6.2
Potiguará	143	0	940.2	0.0	0.0
South and Southeast Region	449	7	535.0	8.3	1.6
Interior Sul	288	6	688.4	14.3	2.1
Litoral Sul	123	1	491.0	4.0	0.8
Minas Gerais y Espírito Santo	38	0	223.1	0.0	0.0
Total	7,946	177	1,051.2	23.4	2.2
Incidence rate	≥1,000				
	501-999				
	≤100 -500				
Mortality rate	70.0 - ≥100				
	30.1 -60.9				
	0.0 -30.0				
Case fatality rate	≥3.6				
	1.0 -3.5				
	0.0 - 0.9				

Source: Data published by the Special Secretary for Indigenous Health/Ministry of Health of Brazil (www.saudeindigena.saude.gov.br) and reproduced by PAHO/WHO.

In **Canada**, since the first confirmed case of COVID-19⁹ in the country and as of 8 July, there have been 334 confirmed cases, including 6 deaths, reported among indigenous peoples. Cases have been distributed amongst the provinces of *Alberta* (114 cases), *Saskatchewan* (84 cases), *Ontario* (59 cases), *British Columbia* (42 cases) and *Quebec* (35 cases).¹⁰

In **Colombia**, since the first confirmed case of COVID-19¹¹ in the country and as of 6 July, there have been 1,534 confirmed cases, including 73 deaths, reported among indigenous peoples according to available data from the COVID-19 database, published by the Government of Colombia¹². The highest numbers of cases have been reported by the *Department of Amazonas* (439 cases), followed by the *districts of Bogotá* (207 cases) and *Barranquilla* (136 cases) (**Figure 4**).

Figure 4. Distribution of confirmed cases of COVID-19 among indigenous populations by reporting department. Colombia, 6 March to 6 July 2020.



Source: Data published by the Government of Colombia. Figure prepared by PAHO/WHO.

⁹ 25 January 2020.

¹⁰ Government of Canada. Coronavirus (COVID-19) and Indigenous communities. Available from: <https://bit.ly/3efm1VI> and accessed 9 July 2020.

¹¹ 6 March 2020.

¹² Government of Colombia. Open data. Positive cases of COVID-19 in Colombia. Available from <https://bit.ly/3gFCZ1b> and accessed 7 July 2020.

Given that the number of reported cases among indigenous peoples depends on the completeness of information regarding ethnicity, when consulting another source of information, this source indicated that as of 6 July, there had been 4,112 cases reported, including 110 deaths (3%)¹³.

A third source indicated that in Colombia, the first case of COVID-19 among indigenous peoples was reported on 25 March, and that as of 2 July, there had been 1,175 cases, including 38 deaths, reported. The cases were geographically distributed among 47 municipalities and two non-municipal areas (Yavaraté (Vaupés) and La Chorrera (Amazonas)), with the greatest numbers reported as follows: Leticia (683 cases), Bogotá District (78 cases), Puerto Nariño (64 cases), Malambo (49 cases), Maicao (34 cases), Cumbal (33 cases), Quibdó (31 cases), Sampués (30 cases), Mallama (28 cases), Ipiales (22 cases), Yavaraté (16 cases), Aldana (11 cases), and Palmito (10 cases). The number of cases in the remaining municipalities varied between 1 and 7, in descending order: Cuaspud Carlosama (Nariño, 7 cases); Carmen de Atrato (6 cases); Algeria (5 cases); Popayán, Piendamó, Silvia (Cauca), Agustín Codazzi, Guachucal, Coyaima (Tolima), Cali (Valle del Cauca) and Mitú (4 cases each); Cartagena District, Turbaco (Bolívar), Uribe (La Guajira), Túquerres, and Sincelejo (3 cases each); Lorica and Córdoba (2 cases each); Riosucio (Caldas), López de Micay, Corinto, Caloto, Pueblo Bello (Cesar), Unión Panamericana, Medio Baudo (Chocó), Tuchín (Córdoba), Cota (Cundinamarca), Inírida (Guainía), Isnos (Huila), Distracción, Albania, San Andrés de Tumaco, Toledo (Norte de Santander), Pueblo Rico (Risaralda), and Buenaventura (1 case each).¹⁴

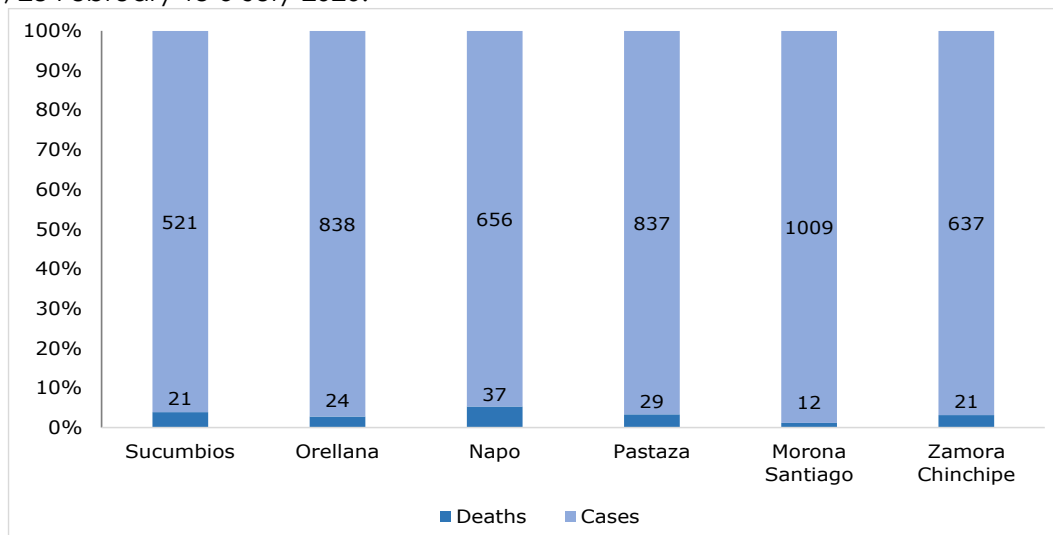
In **Ecuador**, since the first confirmed case of COVID-19¹⁵ and as of 6 July, there have been 4,498 confirmed cases, including 144 deaths (3.2%), reported among indigenous peoples. Of the total cases, 60% were reported in the provinces of *Morona Santiago* (1,009 cases), *Orellana* (838 cases), and *Pastaza* (837 cases), while 63% of the total deaths were reported in the provinces of *Napo* (37 deaths), *Pastaza* (29 deaths), and *Orellana* (24 deaths) (**Figure 5**).

¹³ Pan-Amazonian Ecclesial Network (Red Eclesial Pan amazónica). 6 July Report. Available from <https://redamazonica.org/covid-19-panamazonia/> and accessed 8 July 2020.

¹⁴ National Indigenous Organization of Colombia (ONIC). Special report. Situation of indigenous peoples facing the pandemic in Colombia: lessons and challenges. Available at: <https://bit.ly/3ffPqAi>; accessed 9 July 2020.

¹⁵ 28 February 2020

Figure 5. Distribution of COVID-19 cases and deaths among indigenous populations, by province. Ecuador, 28 February to 6 July 2020.



Source: Data provided by the Ecuador International Health Regulations National Focal Point and reproduced by PAHO/WHO.

In **Mexico**, since the first confirmed case of COVID-19 in the country¹⁶ and as of 12 July, there have been 4,092 confirmed cases, including 649 deaths (15.8%), reported among persons that recognizes themselves as indigenous.

Of these cases, 56% were reported in the following federal entities: *Yucatan* (646 cases), *Oaxaca* (455 cases), *Mexico* (324 cases), *San Luis Potosí* (235 cases), *Tabasco* (234 cases), and *Mexico City* (397 cases). Overall, 60% of the deaths have been reported in the following federal entities: *Yucatán* (96 deaths), *Oaxaca* (81 deaths), *México* (68 deaths), *Quintana Roo* (49 deaths), *Puebla* (47 deaths) and *Mexico City* (45 deaths).

In the **United States of America**, since the first confirmed case of COVID-19 in the country¹⁷ and as of 7 July, there have been 22,539 confirmed cases reported across 12 areas of the Indian Health Service (IHS). Two IHS areas account for 65% of the confirmed cases: *Navajo* (8,834 cases) and *Phoenix* (5,771 cases).¹⁸

In **Venezuela**, since the first confirmed case of COVID-19 in the country¹⁹, there have been 152 confirmed cases, including one death, reported among indigenous peoples. Of these cases, 63% were reported in the state of *Bolívar* (96 cases) while the remaining cases were reported in the states of *Zulia* (43 cases, 1 death), *Amazonas* (12 cases), and *Delta Amacuro* (1 case).

¹⁶ 27 February 2020.

¹⁷ 21 January 2020.

¹⁸ United States Department of Health and Human Services. Indian Health Service. Coronavirus (COVID-19). Available from: <https://www.ihs.gov/coronavirus/> and accessed 9 July 2020.

¹⁹ 13 March 2020.

Guidelines for national authorities

Available data indicates that the COVID-19 pandemic might aggravate the already difficult situation that many indigenous peoples in the Region of the Americas face. Given this, the Pan American Health Organization / World Health Organization (PAHO/WHO) recommends Member States address the specific risk factors and vulnerabilities amongst indigenous peoples in the context of the COVID-19 pandemic, and ensure active participation of these communities in the planning and implementation of response measures, which must be specific to the communities and culturally-appropriate.

The following are recommendations regarding surveillance, laboratory, infection prevention and control measures, contact tracing and quarantine, treatment, dead body management, and prevention.

Surveillance

As emphasized in previous PAHO/WHO COVID-19 Epidemiological Updates, the following activities should be performed to interrupt the transmission of COVID-19:

- Early detection of suspected cases
- Laboratory confirmation
- Isolation
- Contact tracing and quarantining contacts

For early detection of suspected cases, it is recommended to have the participation of indigenous peoples, through their community leaders, during the development and implementation of any adopted strategies. PAHO/WHO recommends the following case definitions for COVID-19, available at: <https://bit.ly/2CHslrK>, which may be adapted for community surveillance.

COVID-19 surveillance strategies in indigenous communities should include: 1) community surveillance conducted by community members, 2) at the primary care level, 3) at the hospital level, 4) in health centers, 5) by using mortality data, and 6) through data from laboratory testing. For any of these strategies, it is important to have data disaggregated by ethnicity in order to identify related risk factors.

Event-based surveillance plays an important role, and community members should have mechanisms and resources available to report rumors or signals of public health importance through hotlines and other means. Attention should be given to rumors of clusters of cases or deaths related to fever and shortness of breath, and cases of fever and death after contact with a patient with COVID-19. These signals may indicate possible threats to public health, which may or may not be due to COVID-19. Rumors must be verified and investigated in order to determine the cause and provide prompt healthcare to all those who may need it.

Laboratory

Confirmation of COVID-19 transmission among a population requires laboratory testing. PAHO/WHO recommends that all suspected cases be tested for COVID-19 according to the PAHO/WHO case definitions, available at: <https://bit.ly/2CHslrK>

It is critical to ensure access to diagnostic tests. However, in areas with high incidence and/or lack of capacity or access to laboratory testing, it is important to establish criteria to support prioritization of testing so that adequate measures to reduce the transmission of COVID-19 can be implemented. In such situations, testing should be prioritized for suspected cases who are:

- Individuals at-risk of developing severe forms of the disease,
- Those who will require hospitalization and specialized care to treat COVID-19,
- Health workers (including emergency medical service workers, non-clinical staff, and traditional healers) regardless of whether they are a contact of a confirmed case (to protect health workers and reduce the risk of nosocomial transmission), and
- The first symptomatic people in the village or community.

All suspected cases that cannot be tested for any particular reason should be considered as COVID-19 cases.

Implementation of infection prevention and control measures

In the absence of treatment and vaccines for COVID-19, early identification and early isolation of confirmed and probable cases continue to be the most important measures to slow and interrupt COVID-19 transmission among isolated populations.

Once the presence of COVID-19 cases has been confirmed in an area or community, and when diagnostic tests are not available, suspected cases that cannot be tested should be isolated and managed as COVID-19 cases, according to protocols for initial management of cases with acute respiratory illness (ARI) in the context of COVID-19²⁰.

As part of the early identification of cases, health professionals should recognize patients with fever (axillary temperature >37.5 degrees Celsius), cough, and shortness of breath. Suspected cases should be offered a surgical mask (if they do not have an impediment to wearing it) and the patient should be isolated in a single room, if possible. Maintaining the family unit, particularly for young children, must remain a key principle in all isolation efforts. Whenever possible, children should be isolated with a caregiver. The caregiver should wear a surgical mask and be guided on frequent hand hygiene with soap and water or an alcohol-based solution (70%).

All suspected and confirmed cases should be isolated in a healthcare facility if resources permit, or in a designated community or additional temporary facility (or designated area in the

²⁰ PAHO/WHO. 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. Interim recommendations, version 1 (12 April 2020). Available at: <https://bit.ly/2AXnuCo>

community). Health authorities, along with community members, should apply locally-adapted approaches to support cases and their families during isolation to ensure their safety and well-being.

Every effort should be made to increase the capacity of these collective isolation facilities. Home isolation should only be considered when the aforementioned options are not feasible, or due to protective considerations for children and other vulnerable peoples; home isolation should be done for a short period of time, and only if the conditions of the home allow, while waiting for a transfer to a designated facility.

Additional recommendations on infection prevention and control practices in the community setting are available at: <https://bit.ly/2WcxpLX>

Contact tracing and quarantining contacts

Tracing contacts should be conducted for all probable and confirmed cases. If laboratory testing cannot be performed, suspected cases should be considered as probable cases, and therefore their contacts should also be traced and monitored.

It is recommended to identify the contacts of each case and monitor their health status to detect the possible development of signs and symptoms of COVID-19 for 14 days from the last day of possible contact with the case. Community support is key to ensuring that the follow-up and monitoring of contacts is carried out properly, and that contacts follow quarantine recommendations. Ideally, during this period, all contacts should be quarantined in a dedicated facility for this purpose. In this situation, the well-being of family members who remain in the home during the quarantine period should be ensured.

When it is not feasible to quarantine contacts in a separate facility, contacts should be quarantined at home. Each contact should receive clear information about the contact tracing process, self-monitoring of signs and symptoms, and receive necessary resources (soap, masks in case they become symptomatic, etc.) for the quarantine period.

If it is not possible to trace all contacts, at a minimum, the identification of contacts among healthcare workers, home contacts, and close contacts, should be made. As part of this process, consideration should be given to supporting the livelihood and well-being (nutrition, etc.) of quarantined contacts and/or their dependents who cannot support themselves.

When quarantine affects childcare or another dependent, the specific situation must be considered. Preserving the family unit, particularly for young children, should remain a key principle and, where possible, children should be quarantined together with a caregiver. In all instances of quarantining contacts, measures to avoid family separation should be considered.

Treatment

All mild cases with risk factors and all serious and critical cases should be treated in a health facility capable of meeting the needs of the patient, with the required level of care, and cultural sensitivity.

Based on current knowledge of the disease, most people infected with SARS-CoV-2 will develop a mild to moderate illness (including pneumonia) for which isolation and treatment can occur at a community center. However, approximately 20% to 30% of cases will require clinical care in a hospital setting with respiratory support available, which should be carefully planned. Health authorities must identify and designate hospitals that have the capacity to treat severe cases of COVID-19. It is important to plan how many beds and how many hospitals are needed based on the estimated number of cases and what medical equipment and personnel are available and needed.

It is also recommended to ensure the availability of oxygen supply systems. Planning should consider already available systems and how to increase capacity through the introduction of new oxygen supply systems (e.g. oxygen concentrators, liquid oxygen, amongst others). Additionally, it is important to ensure that all supplies and equipment are available.

Essential care includes monitoring of pulse oximetry, treatment of coinfections such as bacterial pneumonia, malaria, diarrhea, malnutrition with the appropriate use of antimalarials, antibiotics, and provision of oxygen therapy, when appropriate.

To expand care capacity, it is essential to consider not only structural elements such as beds, buildings, and equipment available, but also a trained and skilled workforce, as well as sufficient personal protective equipment (PPE) proportional to the increase in beds.

Regarding to case management, it is recommended to follow the protocols published in the Epidemiological Alert available at <https://bit.ly/2W8GNQz>

Appropriate dead body management

With regards to appropriate dead body management in the context of COVID-19, it is important that national protocols and guidelines consider specific responses adapted to the traditions and customs of indigenous peoples, and taking into account the recommendations outlined by PAHO/WHO. These responses must be respectful of their worldview and cultural diversity. It is important to incorporate a "relationship perspective" with families, communities, and the population, using intercultural communication strategies and dialogue. From this, guidance and support measures can be developed that take the community and family context into account. In addition, various possible situations should be considered, for instance, if a death occurs in the hospital setting, at home, or in a situation of forced displacement, migration, deportation, amongst others²¹.

It is recommended to outline precautions that should be taken for burials, especially when there is intense transmission of SARS-CoV-2 within a community, so that they are carried out safely while aligning with the beliefs and religious and traditional practices of the community as much as possible. It is essential to engage with community leaders to adapt burial ceremonies in such a way that they do not compromise physical distancing measures.

²¹ Considerations on Indigenous Peoples, Afro-Descendants, and Other Ethnic Groups During the COVID-19 Pandemic. Available at <https://bit.ly/30dLDx0>

Communities should be supported in the use of community case definitions to determine burial protocols in the absence of diagnostic testing capabilities.

When preparing the body of a person infected with COVID-19, the risk of viral transmission is low, and occurs mainly through contact with contaminated surfaces; therefore, the systematic application of standard precautions is crucial to prevent transmission.

In community burial settings, family members, traditional and religious leaders, health workers, and others who are generally involved in preparing a body for burial, should be supported with the necessary information, supplies, and PPE to reduce the risk of transmission. People at high-risk of serious illness, such as the elderly and individuals with comorbidities, should not participate in the preparation of the body for burial; however, this does not imply they should be excluded from the service.

Prevention

Based on current evidence, SARS-CoV-2 virus is primarily transmitted between individuals through respiratory droplets and close contact, including indirect contact with objects or surfaces in the immediate environment that are contaminated from respiratory droplets from an infected person. Therefore, physical distancing is a critical measure for the prevention of COVID-19 (along with adequate hand hygiene).

Given this, it is recommended to involve communities, recognized leaders, influencers, local authorities (including the military and law enforcement), and partners to collectively identify the best methods to promote physical distancing. The simplest measures that can be implemented are contactless greetings and maintaining physical distance from others. Meetings and gatherings, even for religious purposes, should be minimized.

In some communities, isolation of cases may not be feasible; in these situations, it is important to identify—together with the community—alternatives that maximize physical distancing and hygiene measures and that minimize the risk of exposure and transmission associated with community movement.

Communication is of particular importance when addressing COVID-19 among indigenous communities. It is important to ensure that information related to COVID-19 is translated, culturally adapted, and made accessible through the channels and formats that are available to these populations. Direct coordination with health services and with those responsible for managing public health information generated during the COVID-19 pandemic is necessary. While translation into indigenous and local languages is especially important, there are other aspects that are highly relevant in the context of the pandemic. Messages must be culturally adapted and consider the customs and ways of life of the population. Whenever possible, symbols and pictures should also be included to make messaging more understandable. Images used should be appropriate to the cultural context, and inappropriate technical language should be avoided. The ways in which messages are transmitted must be validated by the indigenous populations themselves. Images used in documents and on social media should be inclusive and should never stigmatize indigenous peoples.

Additionally, it is recommended to:

- Foster exchanges between traditional practitioners, ancestral therapists, and other community members with health authorities so that specific measures such as social distancing, diagnosis, isolation, and treatment take into account their worldviews, existing ancestral practices, and contexts. The importance and meaning of traditional medicine for indigenous peoples should also be considered.
- Strengthen the relationship between the health sector and indigenous leaders, taking into account their different worldviews and understanding of health and disease, amongst others. From the beginning and in conjunction with them, develop effective measures for prevention and family and community protection as it relates to the pandemic.
- Consider specific approaches that take into account different ways of life; for example, develop specific strategies that consider cultural differences for populations in urban areas, those residing in villages, indigenous migrant populations, or indigenous populations in voluntary isolation. Considering the vulnerability and exposure differences, and that not all indigenous communities will be affected by COVID-19 in the same way.
- Use existing mechanisms to promote participation adapted for COVID-19, such as intercultural dialogues.

With the support of the health sector, indigenous organizations must incorporate culturally appropriate prevention measures for their communities.

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